

**AUTOMATED ELECTRONIC PRIOR AUTHORIZATION
FOR PATIENTS, PROVIDERS AND PAYERS.**

- + INSTANT ACCESS AND THE ON-DEMAND GENERATION
- + TIDYING, ORGANIZING AND FINDING JOY IN ePA
- + THE 3D PATIENT AND THE UNSHACKLED REVIEWER



“GAIN PERSPECTIVES FROM THE PATIENT, PROVIDER AND PAYER ON THE IMPORTANCE OF ELECTRONIC PRIOR AUTHORIZATION (ePA) FROM STANSON HEALTH, A PINC AI™ SOLUTION.”
NADIA CHRISTENSEN, MD.

EXECUTIVE SUMMARY

Patients, providers and payers alike are feeling the pain of prior authorization (PA) in its current state.¹ The lack of a streamlined, automated, easily accessible approval process for medical tests and therapies wastes payers' and providers' time and money and delays patients' access to care.^{2,3} Payers are likely looking to streamline the process to gain efficiencies; easy cases can be automated leaving just the challenging ones for manual review. Providers, like myself, are striving to give patients the highest quality care as quickly as possible. Patients may be stressed waiting on approvals for the tests they need, which may impact their long-term prognosis.

With artificial intelligence (AI) using natural language processing (NLP), machine learning (ML) and clinician codified and validated PA policies, we have the content and technology designed to make PA easier, faster and less painful. The on-demand generation can have an instant PA process that rivals the ease of use of their rideshare, food ordering and movie streaming apps that makes their lives more enjoyable and productive. Join us and the on-demand generation in the transformation of PA.

ePA FOR PATIENTS: INSTANT ACCESS AND THE ON-DEMAND GENERATION

As a patient, the anxiety of waiting and the unknown is a terrible burden at a time when you're sick and at your most vulnerable. You're looking for a diagnosis, a treatment and an end to the illness. In pediatrics, I can't imagine the time prior to rapid group-A Strep testing when you had to have the patient wait 48 hours for a culture result. I doubt that in the 1970s providers asked a parent and their ill febrile child to wait the two days without antibiotics since the culture result was unknown.

We now know the result of rampant antibiotic use and the resistant organisms that result from overuse. The advent of the rapid Strep test⁴ in the 1980s brought instant certainty to the diagnosis, more appropriate antibiotic use and much more patient satisfaction. The instant access to a certain diagnosis is always a relief. Prior to the 1970s, there was no rapid at-home pregnancy test. In 1976, the first early pregnancy test⁵, a two-hour, at-home test became available and with it instant relief to women worldwide who no longer had to wait to see the doctor for the pregnancy diagnosis.



Although these advances in medicine were revolutionary for my parents, and common in my care of patients, they seem small in the eyes of our current patients and our young doctors. The new generation of patients and care providers know instant access, a world in which they have instant access to online books, tools and resources.

In the on-demand world, we stream our music playlist, order pizza online, utilize apps for ordering our groceries and use “Googling” as a verb. The world of medicine is shifting to an on-demand platform with the advent of online appointment scheduling, apps for our lab results and virtual visits with telemedicine. Instant PA is expected by the on-demand generation.

29%

REPORT A WAIT TIME OR
DELAY IN CARE OF AT LEAST 3
BUSINESS DAYS DUE TO PA.

DELAYS IN CARE

PA today is on the brink of a precipice – a time when the wait of a week is no longer amenable or tolerable for patients or providers. Ninety-three percent of the providers surveyed by the American Medical Association (AMA) in 2021 report delays in care due to PA and 82 percent report that PA can lead to treatment abandonment.⁶ These statistics from the AMA are well known in the industry and represent a cross sampling of providers. There are some instances when this delay may not result in harm. When my son slid into home plate playing little league baseball and couldn't stand up or bear weight, the wait for the MRI was inconvenient but not harmful. However, if we look beyond the simple cases and look at patients with serious diagnoses waiting for authorization to begin life-saving treatment, we're no longer dealing with simple anxiety and inconvenience, but rather saving a life. The American Society for Radiation Oncology (ASTRO) reports that 31 percent of patients see more than five days of treatment delay due to PA, and another 32 percent report a treatment delay of four to five days.⁷



90%

OF PROVIDERS REPORT
THAT PA HAS A NEGATIVE
IMPACT ON OUTCOMES.

PATIENT HARM

I don't have to go far to see the impact of patient harm due to delays in care. I know of a 65-year-old woman with Medicare who waited two months from initial abnormal mammogram to scheduling surgery for breast cancer. Each delay in this two-month period was a result of delays in scheduling and authorization to get an ultrasound, followed by a biopsy and seeing a specialist. In this two-month period, she went from having one lesion to three separate lesions. By the time of surgery one month later, she had 13 positive lymph nodes and was diagnosed with locally advanced breast cancer. She rightfully assumed that the three months between initial mammogram and surgery with the delay in authorizations contributed to her poorer prognosis.

In 2021 AMA survey on PA, 91 percent of providers report that PA has a negative impact on outcomes with 34 percent reporting adverse events due to PA and 24 percent reporting hospitalization as a result of a PA delay in care.⁸ Looking specifically at cancer care, *research in 2019 shows that each week of delay in lifesaving cancer therapy results in 1.2 percent to 3.2 percent increased risk of death.*⁹



DEMAND FOR IMPROVEMENT AND LEGISLATION TO IMPROVE CARE

In a 2018 Consensus to impact change, six organizations representing healthcare providers and payers partnered together to demand change in PA.¹⁰ Their goal was to improve the efficiency of PA in order to provide safe and timely care for patients. It's wonderful to see both providers and payers coming together to improve care.

88%

OF PROVIDERS REPORT THAT PA INTERFERES WITH CONTINUITY OF CARE.

IT'S POSSIBLE TO TURN A ONE-WEEK PROCESS INTO A SEAMLESS, INSTANT ePA.

ORGANIZATIONS DEMAND PA CHANGE

- + AMERICAN HOSPITAL ASSOCIATION® (AHA)
- + AMERICA'S HEALTH INSURANCE PLAN™ (AHIP)
- + AMERICAN MEDICAL ASSOCIATION® (AMA)
- + AMERICAN PHARMACIST'S ASSOCIATION® (APHA)
- + BLUE CROSS BLUE SHIELD® (BCBS)
- + MEDICAL GROUP MANAGEMENT ASSOCIATION® (MGMA)

However, almost four years later, despite the 2018 Consensus, an AMA 2021 update reports that prior authorization continues to harm patients and burden practices. Eighty-eight percent of providers report PA interferes with continuity of care and 62-65 percent report a lack of transparency as they state it's difficult to determine if a PA is required.¹¹ Phone is still cited as the most common method of completing PAs.¹²

With the failure of providers and payers to impact change, a new bill was introduced to Congress – The Improving Seniors' Timely Access to Care Act, H.R. 3107. This legislation's goal is to streamline PA for Medicare Advantage members by increasing transparency and accountability while reducing the burden of PA.¹³

In a 2022 brief, the office of inspector general found that Medicare Advantage organizations denied prior authorization for 13% of patients and payment requests for 18% of patients when they met Medicare coverage rules.¹⁴ We need to protect our patients. We need to make change.¹⁴

TRANSFORMATION OF PA: CDS-ENABLED INSTANT PA

For the on-demand generation, the desperately-needed transformation of PA can't be here soon enough. With the use of integration with hospital electronic health records (EHRs), integration with payer adjudication systems, codification of complex PA policies into decision trees navigated by a cloud-based rules engine, NLP and ML, *it's possible to turn a one-week process into a seamless, instant ePA.* As the provider places the order for an MRI, the cloud-based engine is triggered, insurance eligibility is completed and medical necessity is checked. If the provider is missing any needed information, the on-demand app asks the necessary questions in order to determine and finalize the medical necessity adjudication. The patient clinical scenario is confirmed with the provider and written back to the order along with the authorization number sent by the payer and transmitted to the furnishing provider.

The future of PA is here, and the patient can rest assured that their authorization has been completed. The patient is unburdened of the anxiety of waiting for their PA as they rideshare home, open the door for their online dinner delivery order, stream their favorite content and breathe a sigh of relief that they had access to Stanson Health, a PINC AI™ solution, offering an automated ePA solution to complete their authorization.

ePA FOR PROVIDERS

TIDYING, ORGANIZING AND FINDING JOY IN ePA

To do well in medicine requires organization, diligence and persistence. In my early days as a medical student, much consideration was put into organization as a tool to achieve clarity of mind. Everything on my desk was labeled, color coded like Marie Kondo had been there 19 years before her first book was even published. This same organization followed me into residency and private practice where I worked hard to keep all that I needed for my patients in place.

I knew going into medicine that I would fill out some forms – sports physical forms or a disability form for my patient to get a DMV disability placard while they healed. I never imagined the mountain that would pile on my desk when it came to PA.

BEARING THE LOAD AND COST OF PA

Looking back, the stack of PA forms on my desk years ago handled just by the front office staff was nothing compared to the struggle of providers today. In 2021, the AMA reports that 88 percent of providers state there's a burden associated with PA and describe this burden as high or extremely high.¹⁵ *The AMA reporting more globally across all physician specialties finds that providers on average complete 41 PAs per week. Two years ago in the 2019 survey that AMA reported 33 PAs per week. This is a staggering increase in just two years.*¹⁶

This volume of PAs require 13 hours or approximately two business days spent on PAs.¹⁷ For most practices with a larger number of providers, this means that management of PAs needs dedicated staff to exclusively work on PAs. The AMA reports that 40 percent of providers have hired staff who are dedicated to management of PA cases.¹⁸

LOSING TIME WITH PATIENTS

Not only is PA a burden to be managed and costly, but it also takes you away from patient care. I know a therapist in solo practice who used to spend five to six hours a week managing billing for her patients when she first went into private practice. Managing paperwork outside your area of expertise can become stressful and fill your desk with endless hours of busy work that clouds your vision as you're pulled away from patient care. This avalanche of paperwork isn't what we imagined when we went into medicine. Very quickly, this therapist saw the value of outsourcing billing. It could save her time, give her more hours to spend with her patients and give her the clarity she needed to better manage her practice.

Losing time with your patients is most acutely visible when your patients are at their sickest and need your help the most. The American Society for Radiation Oncology (ASTRO) reports that 18 percent of radiation oncologists spend more than 10 percent of their time on PA tasks and another 39 percent report spending 5-10 percent of their time on PA.¹⁹ In this specialty, 85 percent of providers need to generate multiple treatment plans for benefits managers in order to have their treatment approved and 44 percent need PAs for more than 50 percent of their patients.²⁰

Losing time is at its utmost burdensome when you feel that the time is wasted. ASTRO's 2019 report shows that 41 percent of radiation oncologists report that, between 76-100 percent of the time, the denials on appeal are overturned and 44 percent report that peer-to-peer reviews are not conducted by a radiation oncologist.²¹



ONLY **26%** OF
142 MILLION
 A TRANSACTIONS
 IN THE U.S. ARE
 FULLY ELECTRONIC

THE DEMAND FOR AUTOMATION

In medicine, outsourcing and automation are tools we frequently use to manage the demands of practice. For many years, physicians have outsourced billing and, more recently, providers have found online appointment scheduling is the new outsourcing of the 21st century. The new methods of outsourcing use cloud-based automation to provide better access for the patient and save time for both patients and providers.

Gone are the days when we used to sit on hold for 15 minutes just to get an appointment. Now, at your convenience, you can make an online appointment without having to wait for office staff to help you. For my generation, online appointments are a luxury, but for the young patients who live in the age of automation, online scheduling is a given when they use an app to order coffee, read library books and pay for their purchases.

SLOW ADOPTION OF ePA

The Council for Affordable Quality Healthcare (CAQH) in their annual 2021 report tracking health plan and provider adoption of fully electronic administrative transactions reports that only 26 percent of the 142 million PA transactions in the U.S. are fully electronic.²²

FIGURE 1 - MEDICAL PLAN ADOPTION OF PA

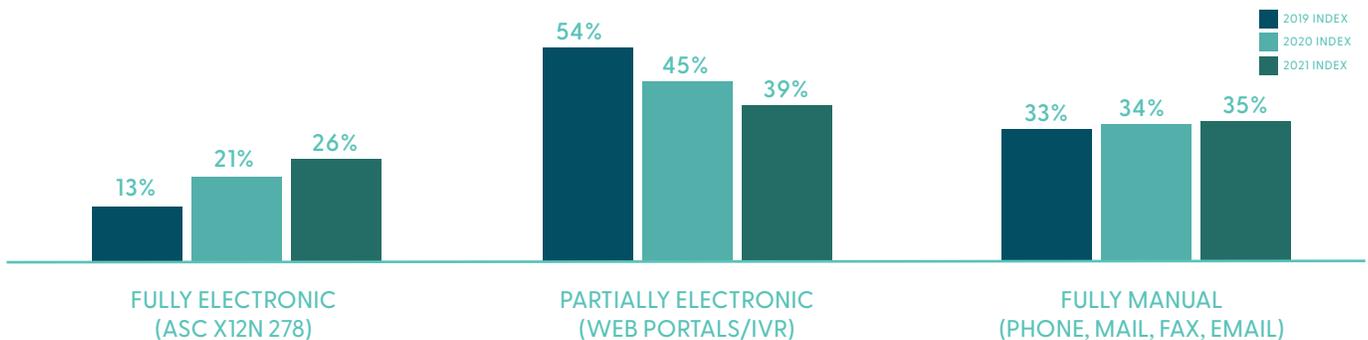


IMAGE SOURCE: 2021 CAQH INDEX

Industry adoption of full ePA is very slow. The CAQH in their white paper cite the following barriers to full ePA:²³

- 1. The need for consistency in data content.** The provider needs an efficient way to identify what to include in the PA request.
- 2. No federally mandated standard for attachment requirements for submission of clinical information.**
- 3. Lack of integration between clinical and administrative systems.** The provider must pull information from the EHR and manually type it in the management system from which the PA request is initiated.
- 4. Some states require manual intervention by phone, fax or secure mail.**
- 5. Lack of awareness on the side of providers that HIPAA regulations require health plans to offer full ePA via the 5010X217 278 Request and Response system.**
- 6. Limited vendor products that support fully automated ePA.**

TRANSFORMATION OF PA: CDS-ENABLED ePA WITH FULL PAYER INTEGRATION

For ePA to be fully automated, it's not enough to electronically submit and receive the authorization. A fully automated system requires the following characteristics:

- + **Embedded in provider EHR workflow.** The provider is no longer required to manually input clinical data from the EHR to the management system for PA.
- + **Executes at the point of care.** The provider interacts with the system during the care process as orders are placed. No additional staff is required to handle the authorization request.
- + **Includes benefits and eligibility verification.** As orders are placed, each order is sent to the payer to verify benefits and eligibility seamlessly with the provider unaware of the interaction between the system and the payer.
- + **Includes medical necessity adjudication.** The provider is no longer required to know beforehand the required criteria for approval of the intervention ordered. Annual subscription to this system ensures that the payer policies have been codified into complex decision tree rules and the system knows the requirements – the indications covered and all the required criteria for each indication.
- + **Leverages discrete codified and free text data from the EHR.** The provider is no longer required to manually provide the information that they just entered into the EHR again for the payer. The system can read the information in the EHR using NLP and ML, both in codified and free text format and understand the patient clinical scenario. In fact, the HHS ONC HITAC ICAD task force states in their vision statement the principle of “record once and reuse”, highlighting this very point.²⁴
- + **Manages missing information.** For the given indications that apply to the patient scenario, if the system detects any missing information, the system app opens to ask the provider about the missing information. The provider can answer these questions in real time to complete the case.
- + **Enables instant PA approval.** When the patient meets medical necessity criteria, the PA number is instantly provided and written back onto the order as the order is sent to the furnishing provider.
- + **Enables payer validation of the system.** The provider is no longer unsure that the PA will go through as the system has been validated, approved and fully integrated with the payer system.

In this new age of automation, CDS-enabled ePA with full payer integration is the ultimate outsourcing of PA. The heavy load of PA is lifted, days of waiting are replaced with instantaneous transactions and the mountain of paperwork clutter has been tidied and cleared away. This new freedom brings the needed clarity of vision, places the focus back on the patient and allows the provider to joyfully implement the practice they imagined.

ePA FOR PAYERS

THE 3D PATIENT AND THE UNSHACKLED REVIEWER

As a provider, I'm always amazed how specific medical advances have propelled medicine and opened doors that we couldn't have imagined. The advent of vaccines in 1796, penicillin in 1928 and organ transplants in 1954 are a few examples of our past. In the 21st century, human genome discoveries, targeted therapies for cancer and harnessing information technology is our reality.

Information technology has changed how we learn and practice medicine. In my days as a young medical student, I used 2D anatomy textbooks (I did love my Netter's), had huge pockets full of miniature textbooks handy on call nights and ran to the med school library to pull a full text. Today, pre-med students like my son use state-of-the-art 3D anatomy apps that show structures from all different angles, allowing you to slice away portions of a structure for a better view and showing video clips of functioning structures.



Medical students have a variety of apps on their phones that carry the books, calculators, drug references and all that was once out of reach. Patient care is much less about information gathering and much more about evidence-based treatments, shared decision making and improving outcomes.

LOW RATES OF ePA

PA is one area of healthcare that's still in need of transformation. The Council for Affordable Quality Healthcare (CAQH) in their annual report found that ePA rates are low and but show promise of increasing in the last two years.²⁵ Rates of ePA have risen from 13 percent to 26 percent between 2019 and 2021.²⁶ ePA is still far below rates of other transactions such as eligibility verification (89 percent), claim submission (97 percent) and claim payment (76 percent).²⁷

FIGURE 2 - MEDICAL PLAN ADOPTION OF FULLY ELECTRONIC ADMINISTRATIVE TRANSACTIONS

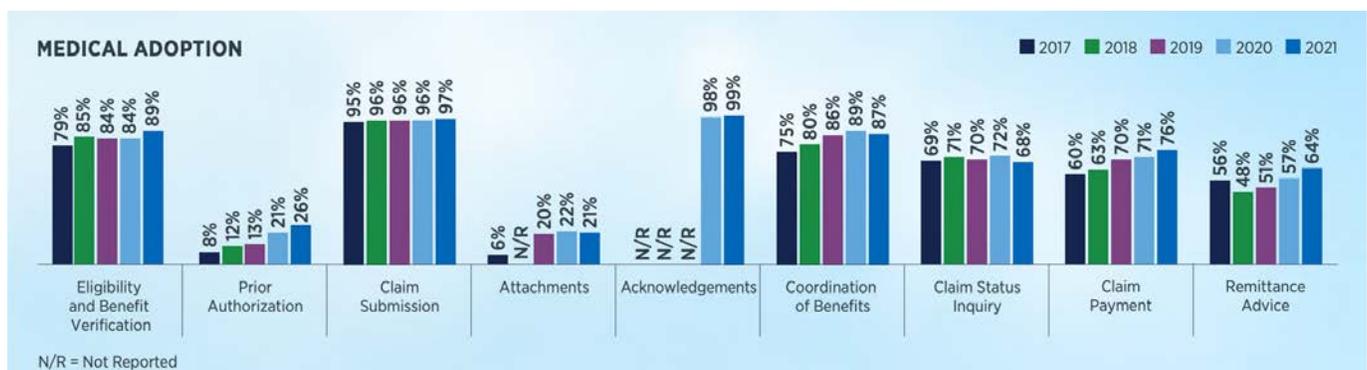


IMAGE SOURCE: 2021 CAQH INDEX

The CAQH states that prior authorization has been one of the most costly and time-consuming transactions to conduct.²⁸ *Despite the volume decrease of prior authorization with reductions in medical services and freezes on elective procedures with COVID, the medical industry could still see a cost savings of \$437 million annually by transitioning to fully electronic PA.*²⁹ This staggering price tag is not surprising when considering that the AMA reports PA is costly for the medical practice, with two days per week spent on completing PAs and 40 percent of practices having dedicated staff that is hired to manage the PA load.³⁰

DID YOU KNOW THAT A COST PER CASE COULD RANGE FROM

\$11.93
— TO —
\$17.91
PER INITIAL CASE REVIEWER?



HIGH COST OF CASE REVIEW

The AMA and CAQH are great at quantifying costs for the provider, but there's a gap of information around the cost of manual PA for the payer. What's the cost of manual case review? These statistics are difficult to find, as most payers will closely guard this proprietary information.

Hypothetically, a clinical case reviewer with an average of annual salary of \$93,124, fully loaded to the employer at \$107,432 (estimated base salary plus taxes, benefits, etc.), may take 10-15 minutes to review a chart and can work about six hours of a day on straight chart review.³¹ Therefore, we estimate a cost per case to be about \$11.93 to \$17.91 in direct cost for the initial case reviewer.

For a portion of cases, there's a need for a physician reviewer with direct cost/case double that of the initial reviewer. How do costs change with peer-to-peer conversations factored in? What's the cost of managing appeals?

When considering truly automated ePA, we can't ignore the cost of the payer case review. Today, payers may have some electronic pathways that may approve the easiest cases, but the majority of cases undergo manual case review. In order to make case review more efficient, a case can be made for using clinical decision support (CDS) tools to automate case review.

CDS-ENABLED CASE REVIEW WITH EXPLICIT CRITERIA

Medical necessity policies are evidence-based criteria that are annually updated and meant to be used by human reviewers who can use their best clinical judgment to interpret the intention of the policy as they perform case review. These policies were never intended to be consumed by an electronic system and only create a framework for the approving provider. With this framework, there is variability in interpretation as, after all, we're all human.

When reviewing the case of a teen with a headache, the reviewer is faced with either using the pediatric headache criteria strictly or considering if they should use the adult criteria since this teen has a family history of migraines. When reviewing a case involving suspected infection, is a high white blood cell (WBC) count always required? This is left to the discretion of the reviewer, as the policy may simply state based on imaging/lab results or signs/symptoms. Some payers may have additional training guides to help their reviewers have a deeper understanding of how they should interpret the policy.

Managing various documents that hold the source of truth and the inherent gaps left to the discretion of the human reviewer may result in approvals that to the practicing provider may seem not standardized. Translation of the policy to explicit criteria used in CDS-enabled ePA review helps both providers and payers.

PROVIDER

The approval criteria is no longer a black box; it's now clearly defined. Clarity of required criteria helps the provider learn about the required criteria during the order placement process. This learning effect alleviates the need for the provider to manually review the payer policies to gain an understanding of needed criteria and helps the provider learn when not to order a given test which isn't indicated. The provider can also see approvals within seconds of submission for patients who clearly meet criteria. We have all learned that not all patients "read the book" and present classically, or sometimes the provider note may be incomplete, and it's this smaller volume of cases that don't meet CDS-enabled ePA that are then moved into the traditional review process.

PAYER:

With CDS-enabled ePA, the payer now only needs to manually review a much smaller volume of cases and could see huge savings in cost of adjudication.

POLICY SIMILARITIES ACROSS PAYERS

Providers often wonder why different insurers have different policies and different requirements. Is it easier or harder to have a case approved for PA depending on the insurer? Across the industry, all payers are really looking at the same set of evidence – the same guidelines that are updated and released by national professional organizations and the same randomized controlled trials and meta-analyses that are conducted and published across the world.

In a world where humans interpret guidelines, it's perhaps understandable (though not necessarily justifiable) to have policies that word things differently. However, once all policies are translated into explicit criteria, it becomes harder to justify requiring providers to produce a different set of clinical facts for each payer in order to approve a given test for a specific patient scenario.

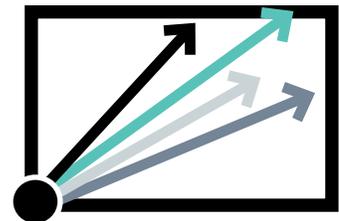
TRANSFORMATION OF PA: CDS-ENABLED ePA

As clinicians, we were always taught to consider the differential diagnosis for a patient. What are all the possible diagnoses that the patient's symptoms may represent, and then one by one and systematically consider each diagnosis in the differential. Manual case review is similar in that the case reviewer reads the chart and considers which of the given indications, as delineated by the payer medical necessity policy, apply to that patient. For each indication, they consider the required criteria and mentally take the patient down multiple paths of their imagined decision tree.

This process is time consuming and requires the case reviewer to have memorized all the applicable criteria for each path.

WITH EXPLICIT CRITERIA INCLUDING CLINICALLY DESIGNED DECISION TREES AND THE USE OF NLP AND ML:

- + a patient chart can be contextualized.
- + clinical narratives can be converted to codified medical concepts.
- + a clinical decision support engine can show a 3D view of the patient.



Similar to the anatomy apps, new technology can show the patient's case with 3D clarity of which indications applied to the patient and how far each path in the decision tree was traversed. For approved cases, there's nothing for the case reviewer to do. For the cases not approved, the reviewer can jump to contextualized sections looking specifically for the missing concepts while the path of required criteria is clearly outlined by the clinical decision support engine.

The case reviewer is no longer shackled to memorization of the policy, keeping up with exact updates and reviewing additional training manuals. Like patient care, case review is no longer about information gathering but about working by exception to consider what's needed for those cases that don't meet the classical criteria and focusing on evidence-based medicine to improve quality of care for the outlier patients.

THE STANSON HEALTH APPROACH TO PA

We're modernizing the PA process to make it better for everyone – payers, providers and patients. We've developed an automated PA solution, backed by AI and NLP, and designed to enable real-time adjudication based on your complex medical guidelines. It may be integrated directly into your existing utilization management systems.

WE WANT TO HELP MODERNIZE YOUR PA PROCESS AND IMPROVE THE CONTINUITY OF CARE BY:

- + Helping improve patient satisfaction by helping provide a better understanding of their plan of action before they leave the provider's office;
- + Streamlining provider workflow with PA determination at the point of care; and
- + Saving payers' time and expense with efficient management of expensive and complex conditions.

To learn more about how we can help make a difference in your PA process, visit stansonhealth.com/authorizations



ABOUT NADIA CHRISTENSEN, MD DIRECTOR, CLINICAL PRODUCT STANSON HEALTH, A PINC AI™ SOLUTION



Dr. Christensen is passionate about developing clinical products that empower clinicians to make the right decision, at the right moment in time, during a patient's care journey. If you want to see her animated, hand her a cup of coffee and ask her about CDS, integration of clinical content into EHRs, NLP, codified medical terminology and PA automation!

Dr. Christensen comes to Premier with 16 years of CDS build experience and currently manages the CDS-enabled electronic PA and Protecting Access to Medicare Act of 2014 (PAMA) products – products based on complex medical decision

trees used to assess appropriateness of care or adjudication of PA decisions.

Prior to Premier, Dr. Christensen worked with national organizations such as the National Comprehensive Cancer Network, created educational interventions used in randomized controlled trials and developed evidence-based order sets, quality improvement checklists and a variety of tools and products used to improve quality and efficiency of patient care. She has specific expertise in inpatient, ambulatory and oncology product development.

Dr. Christensen began her career as a private practice and urgent care pediatrician. She completed her pediatric internship and residency at Children's Hospital of Los Angeles, received her Doctorate in Medicine from University of Southern California (USC) Keck School of Medicine and earned her Bachelor of Science in Cellular, Molecular and Developmental Biology from University of New Hampshire.

In her spare time, Dr. Christensen has worked as an executive fundraiser (raising over \$59,000 for cancer research) and as the scientific director of cancer charities. In the days post-COVID-19, she can frequently be found with her cup of coffee in hand, walking her goldendoodle Luna in Manhattan Beach, California, where she lives with her husband Jon and two children.

PINC AI™ and Stanson Health are trademarks of Premier Healthcare Alliance, LP. Any other third-party trademarks referenced are trademarks of their respective trademark owners.

The content contained herein is for informational purposes only and is not intended to be a substitute for professional medical (including diagnosis or treatment), legal, or financial advice. Please consult your applicable professional to determine the impact on your organization. While Premier, inclusive of its affiliated entities, has made every attempt to ensure that the information contained in this e-book has been obtained from reliable sources, Premier is not responsible for any errors or omissions, or for the results obtained from the use of this information and hereby disclaims all warranties, express or implied. Opinions expressed herein are that of the author and may not represent the views of Premier or its affiliate entities. Forward looking statements are predictive in nature and reflect the author's beliefs at the time of the statement. Premier and its related entities do not endorse or recommend any non-Premier product, service, and/or any unrelated organization that may be referenced herein.

*American Hospital Association (AHA) is a registered trademark of American Hospital Association
America's Health Insurance Plan (AHIP) is a trademark of America's Health Insurance Plan
American Medical Association (AMA) is a registered trademark of American Medical Association
American Pharmacist's Association (APhA) is a registered trademark of American Pharmacist's Association
Blue Cross Blue Shield (BCBS) is a registered trademark of Blue Cross Blue Shield
Medical Group Management Association (MGMA) is a registered trademark of Medical Group Management Association*

REFERENCES

1. Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? Health Affairs (Millwood). 2009;28(4):w533–43. DOI: 10.1377/hlthaff.28.4.w533. Accessed at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.28.4.w533> Accessed: May 31, 2019.
2. Morra D, Nicholson S, Levinson W, et al. US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers. Health Affairs 2011 30:8, 1443-1450. Available at: <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0893> Accessed May 2022.
3. 2021 AMA Prior Authorization Physician Survey. January 2022. American Medical Association, Chicago, IL. <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf> Accessed June 3, 2019.
4. The Evolution of Group A Streptococcus Pharyngitis Testing. Available at: <https://www.aacc.org/clin/articles/2018/september/the-evolution-of-group-a-streptococcus-pharyngitis-testing> Accessed August 2020.
5. A Brief History of Pregnancy Tests. Available at: <https://www.livescience.com/37128-history-of-pregnancy-tests-ept-hcg.html> Access August 2020.
6. 2021 AMA prior authorization (PA) physician survey. Available at: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf> Accessed May 2022.
7. Prior Authorization and Cancer Patient Care: Executive Summary of Nationwide Physician Survey April 2019. Available at <https://www.astro.org/ASTRO/media/ASTRO/News%20and%20Publications/PDFs/ASTROPriorAuthorizationPhysician-SurveyBrief.pdf> Accessed August 2020.
8. 2021 AMA prior authorization (PA) physician survey. Available at: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf> Accessed May 2022.
9. Time to initial cancer treatment in the United States and association with survival over time: An observational study. Available at: <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0213209> Accessed August 2020.
10. Consensus Statement on Improving the Prior Authorization Process. Available at: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf> Accessed August 2020.
11. AMA 2021 Update: Measuring progress in improving prior authorization. Available at: <https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf> Accessed May 2022.
12. Ibid.
13. H.R.3107 - Improving Seniors' Timely Access to Care Act of 2019. Available at: <https://www.congress.gov/bill/116th-congress/house-bill/3107> Accessed August 2020.
14. OIG Brief 2022 - Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. Available at: <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>. Accessed May 2022.
15. 2021 AMA prior authorization (PA) physician survey. Available at: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf> Accessed May 2022.
16. Ibid.
17. Ibid.
18. Ibid.
19. Prior Authorization and Cancer Patient Care: Executive Summary of Nationwide Physician Survey April 2019. Available at: <https://www.astro.org/ASTRO/media/ASTRO/News%20and%20Publications/PDFs/ASTROPriorAuthorizationPhysician-SurveyBrief.pdf> Accessed August 2020.
20. Ibid.
21. Ibid.
22. 2021 CAQH Index, Working Together: Advances in Automation During Unprecedented Times Available at: <https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf> Accessed May 2022.
23. Moving Forward: Building Momentum for End-to-End Automation of the Prior Authorization Process. Available at: <https://www.caqh.org/sites/default/files/core/white-paper/CAQH-CORE-Automating-Prior-Authorization.pdf> Accessed August 2020.
24. Intersection of Clinical and Administrative Data Standards ("ICAD") Task Force of the Health Information Technology Advisory Committee ("HITAC") March 2020. Available at: <https://ncvhs.hhs.gov/wp-content/uploads/2020/04/G-ONC-HITAC-ICAD-overview-508.pdf> Accessed August 2020.
25. 2021 CAQH Index, Working Together: Advances in Automation During Unprecedented Times. Available at: <https://www.caqh.org/sites/default/files/explorations/index/2021-caqh-index.pdf> Accessed May 2022.
26. Ibid.
27. Ibid.
28. Ibid.
29. Ibid.
30. 2021 AMA prior authorization (PA) physician survey. Available at: <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>. Accessed May 2022.
31. Glassdoor – RN Clinical Reviewer Salary. Available at: https://www.glassdoor.com/Salaries/rn-clinical-reviewer-salary-SRCH_KO0,20.htm Accessed August 2020.