Da Vinci Prior-Authorization Support Project

Robert Dieterle
Da Vinci Program Management Office

March 20, 2019

Agenda for March 20, 2019

- HIPAA requirements for Prior-Authorization (PA)
- Da Vinci Overview
- Orientation to Da Vinci use cases
- Approach for PA support
- Alternative workflows

This presentation will refer to FHIR and SMART of FHIR These are registered trademarks

HL7® FHIR®

Current Prior-Authorization Environment

Providers

PA Request

Medical Records

Fax

Telephone

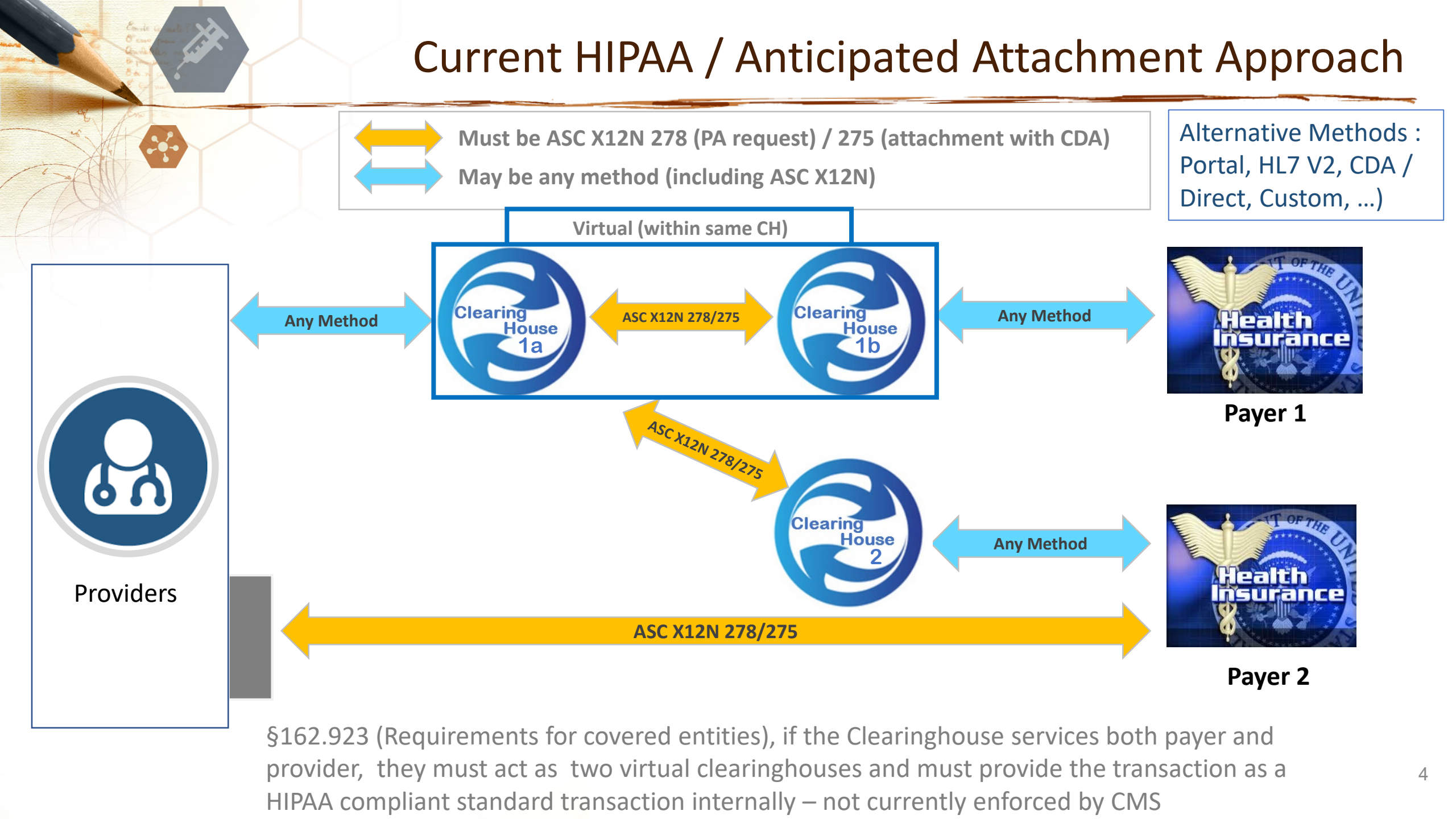
Portals

Electronic Transactions

Payers

Currently providers (ambulatory and in-patient) and payers exchange prior authorization requests and supporting medical records using a number of methods: telephone, fax, portals, and electronic transactions

Current HIPAA / Anticipated Attachment Approach



§162.923 (Requirements for covered entities), if the Clearinghouse services both payer and provider, they must act as two virtual clearinghouses and must provide the transaction as a HIPAA compliant standard transaction internally – not currently enforced by CMS

Challenge

Must be ASC X12N 278 (PA request) / 275 (attachment with CDA)

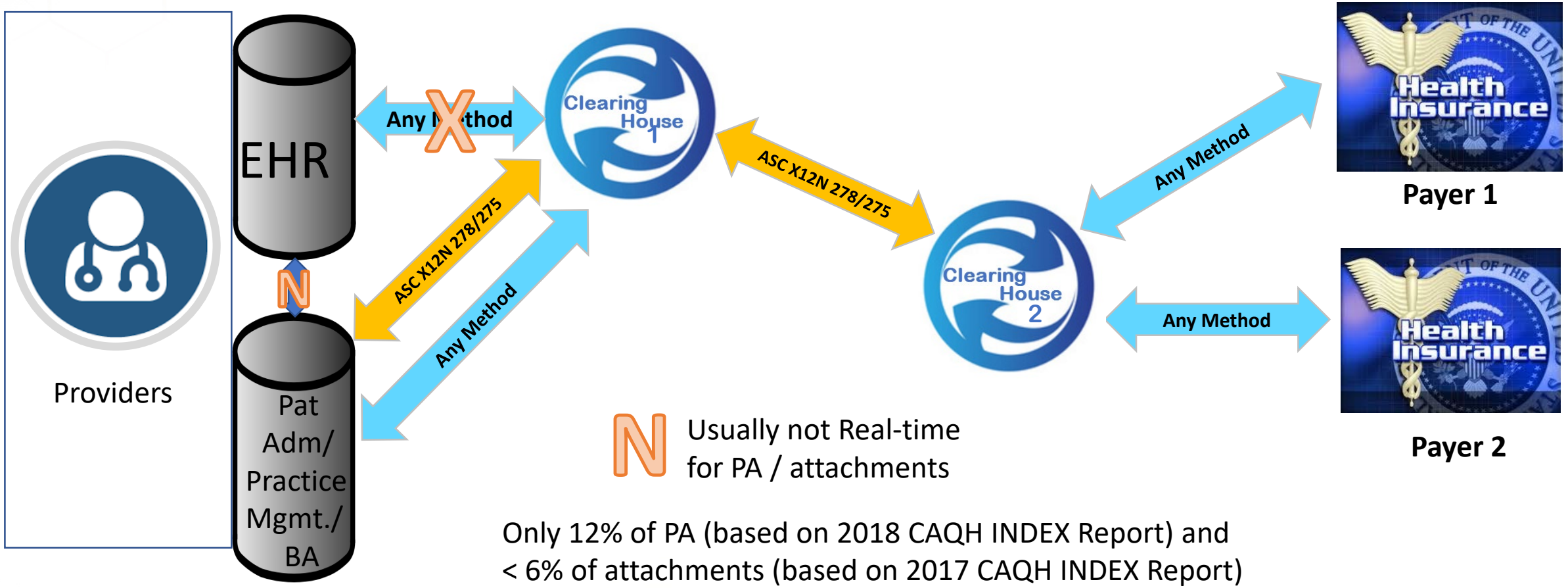
May be any method (including ASC X12N)

Most EHRs do not directly support ASC X12N 278 / 275 and
there is no generally implemented standard for real-time exchange with an EHR for PA

Challenge

Must be ASC X12N 278 (PA request) / 275 (attachment with CDA)

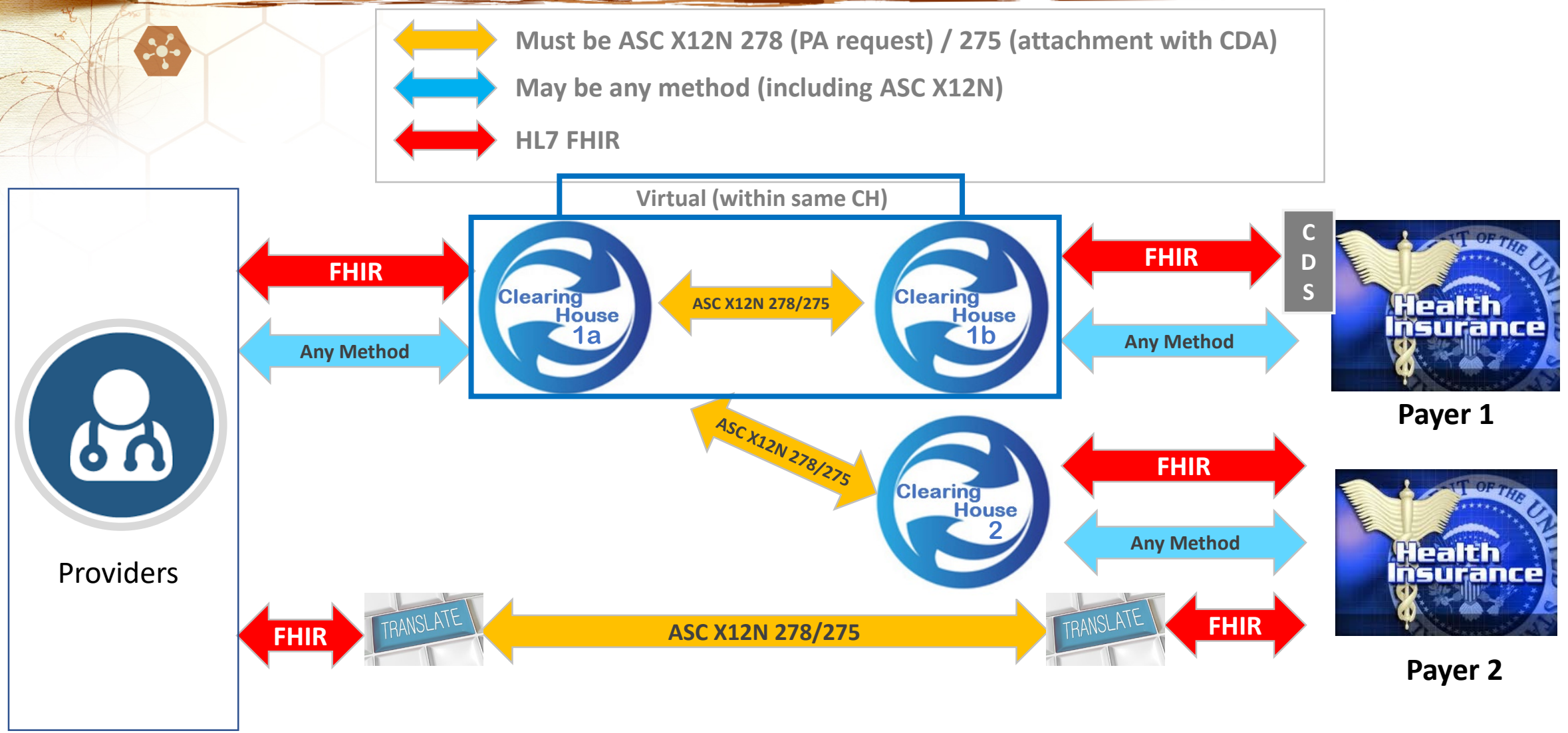
May be any method (including ASC X12N)



N Usually not Real-time for PA / attachments

Only 12% of PA (based on 2018 CAQH INDEX Report) and < 6% of attachments (based on 2017 CAQH INDEX Report) are electronic end to end

Future FHIR Enabled Solution



Translation by software, service, or third party (other than a clearing house)

Da Vinci Project Challenge

To ensure the success of the industry's **shift to Value Based Care**

By providing FHIR based solutions for provider to payer and provider to provider exchanges

Pre-Collaboration / Controlled Chaos:

Develop ***rapid multi-stakeholder*** process to identify, exercise and implement initial use cases.

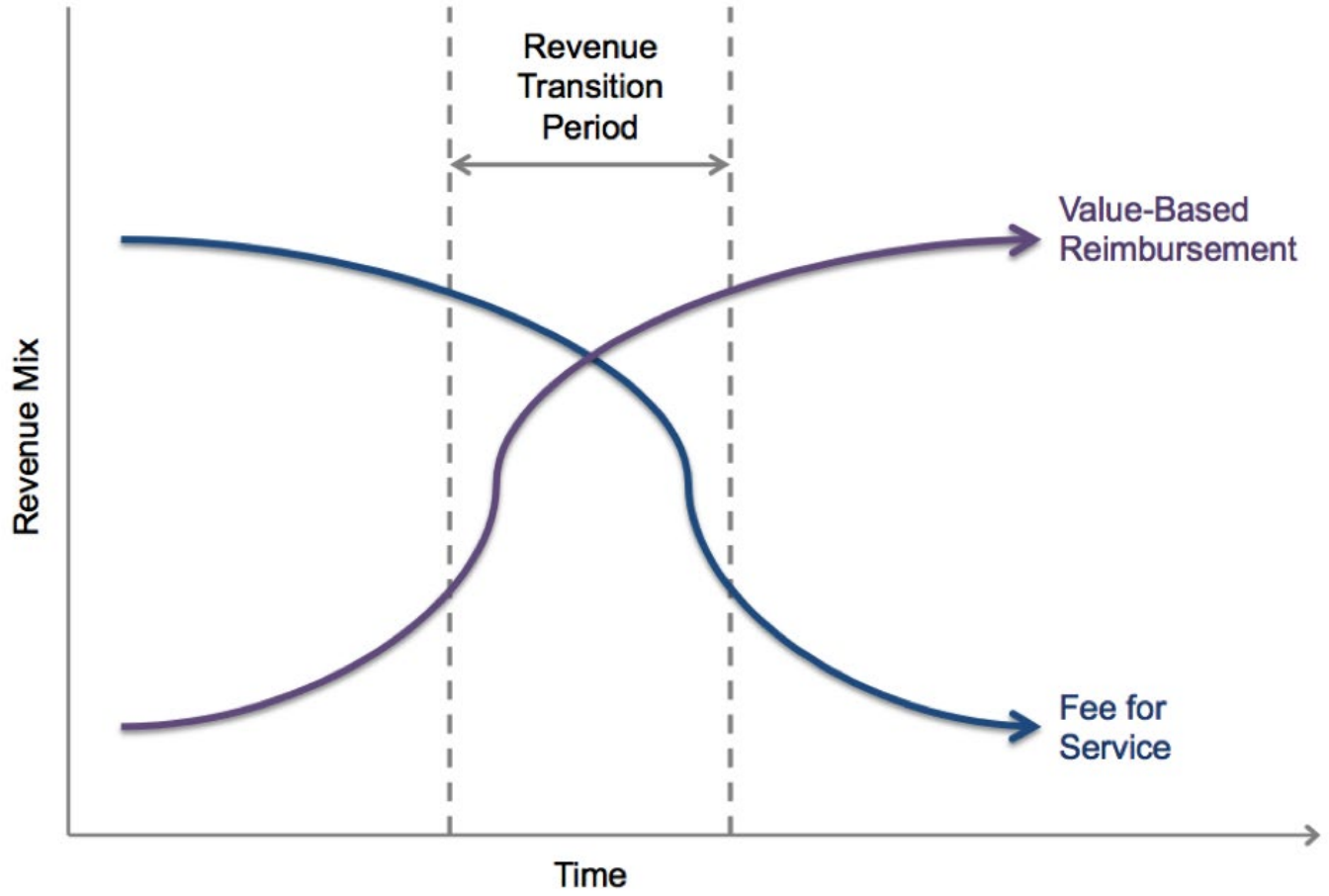
Collaboration:

Minimize the development and deployment of ***unique solutions.*** ***Promote*** industry wide ***standards*** and adoption.

Success Measures:

Use of FHIR®, implementation guides and pilot projects.

Empower End Users to Shift to Value

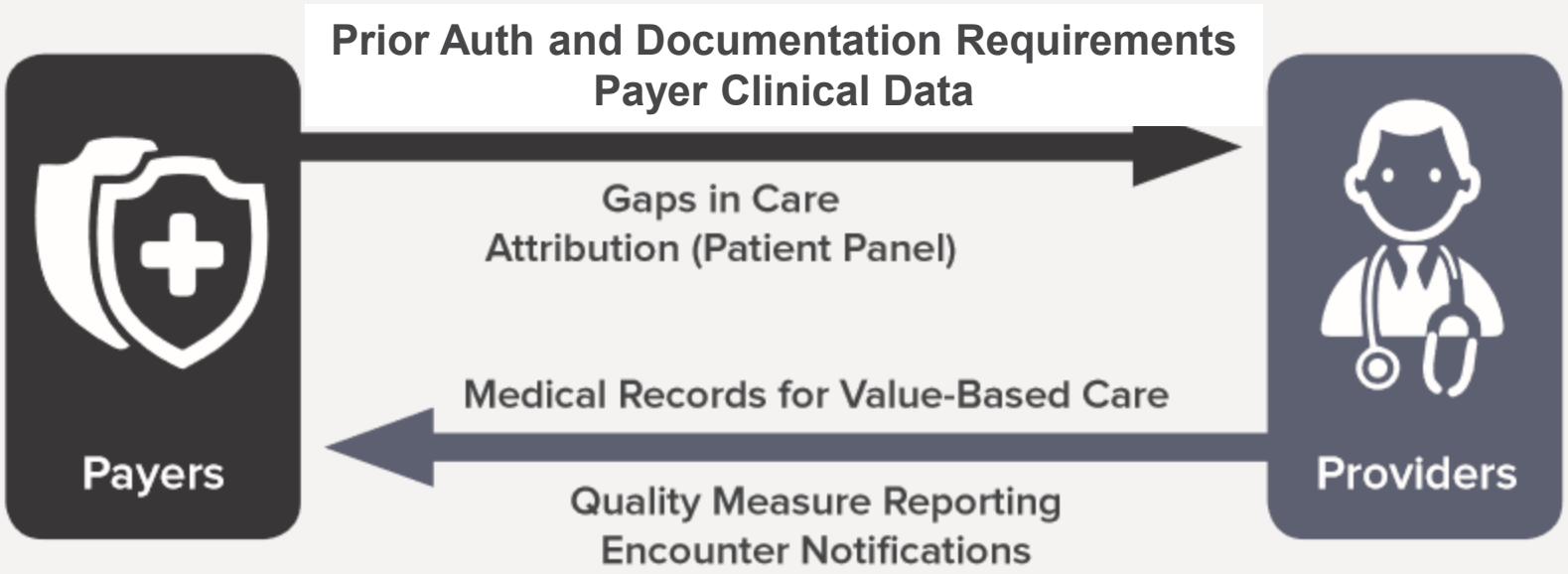


As a private industry project under HL7 International, Da Vinci will unleash critical data between payers and providers required for VBC workflows leveraging HL7® FHIR®

Source: © 2018 Health Catalyst

Focus

In Less Than Two Years, Da Vinci Efforts Will Drive Standards for the Exchange of Information Critical to Patient Care



Da Vinci Statistics

Open standards available through HL7 and
reference implementations available as open source on GitHub

Recent data from ONC has shown that more than four out of five hospitals and approximately two-thirds of clinicians report using EHRs that have implemented some version of the FHIR standard.

Members represent over 70% of all covered lives and installed EHR Users

Partial List of Da Vinci Members

Use Case Alignment

Data Exchange for Quality Measures	Coverage Requirements Discovery	Documentation Templates and Coverage Rules
Health Record Exchange: Clinical Data Exchange	Health Record Exchange: Payer Data Exchange	Prior-Authorization Support
Gaps in Care & Information	Risk Based Contract Member Identification	Alerts: Notification (ADT), Transitions in Care, ER admit/discharge
Performing Laboratory Reporting	Chronic Illness Documentation for Risk Adjustment	Patient Cost Transparency

Project Outputs

- ❑ Define requirements (technical, business and testing)
- ❑ Create Implementation Guide
- ❑ Create and test Reference Implementation (prove the guide works)
- ❑ Pilot the solution
- ❑ Deploy the solution

Use Case Status

- In HL7 ballot reconciliation as draft standard
- Under active development
- Planned 2019 Use Cases
- In Discovery

Use cases relevant to prior-authorization

Use Case Status

- In HL7 ballot reconciliation as draft standard
- Under active development

Coverage Requirements Discovery (CRD)

(Triggers and manages the conversation with the Payer)

Documentation Templates and Coverage Rules (DTR)

(Payer/coverage rules executable in clinical workflow)

Health Record Exchange: Clinical Data Exchange (CDex)

(Standards for conveying supporting documentation using FHJR)

Prior-Authorization Support

(workflow to exchange PA request/response and supporting documentation with a payer)

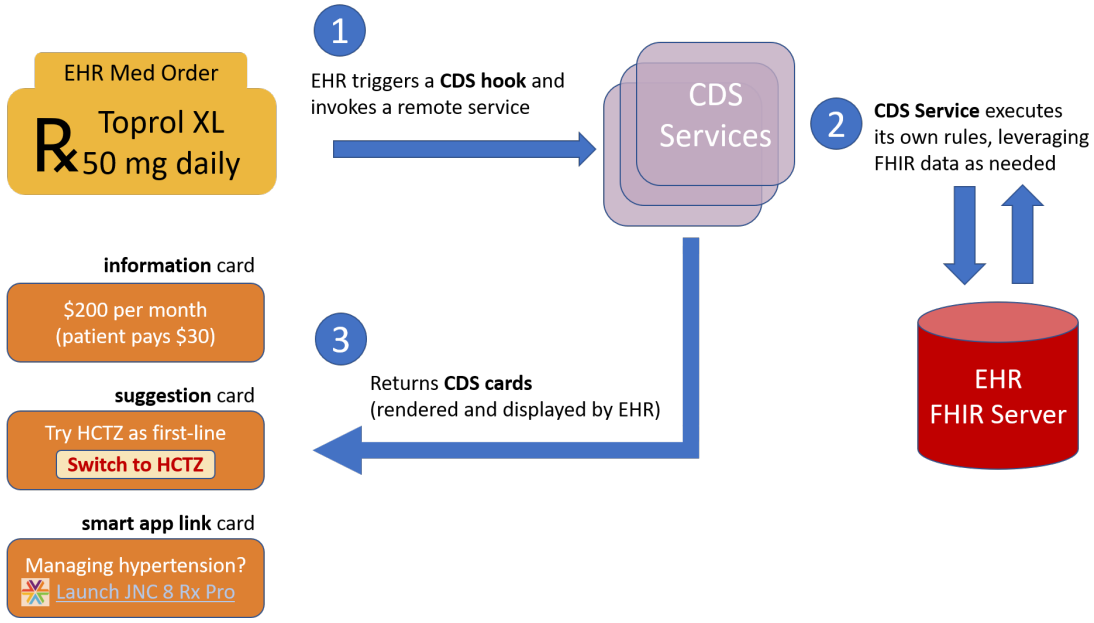
Da Vinci uses CDS Hooks to invoke Payer interactions

Technology Overview – CDS Hooks

Lightweight event-driven framework for integration of Clinical Decision Support Services into the EHR workflow

Features:

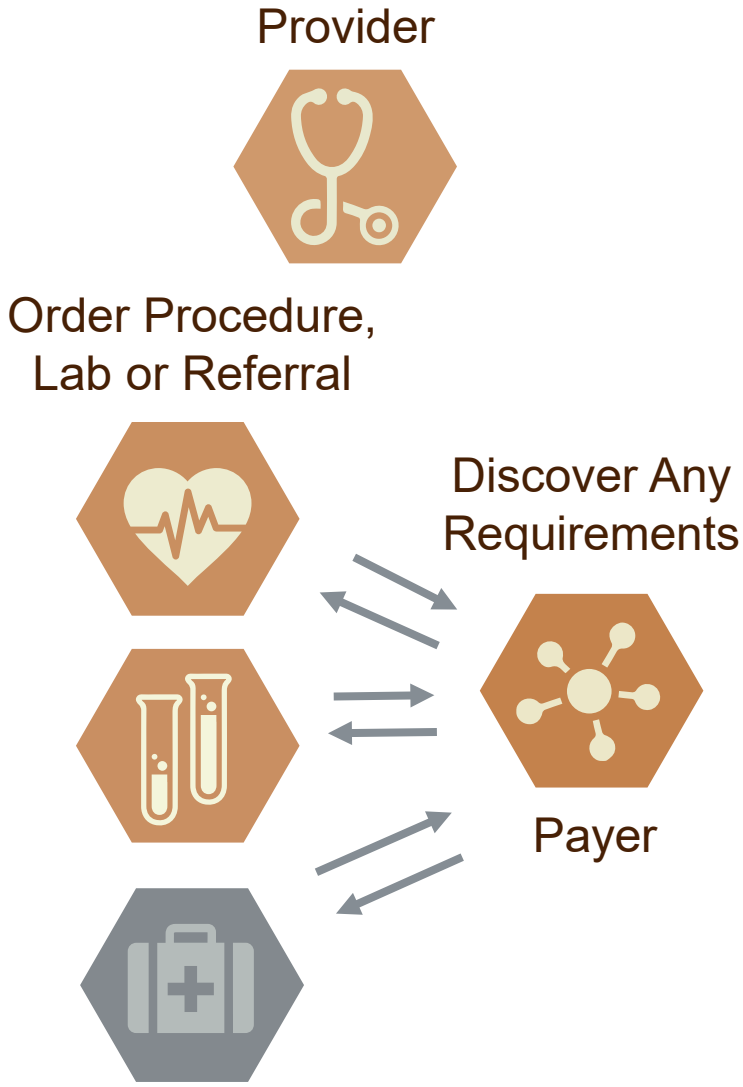
- Multiple triggers
- Context prefetch
- Provides secure token to access to patient record
- Multiple type of cards for return information/actions
  - Information / warning,
  - Suggestion, with FHIR resource(s)
  - App Launch (e.g. SMART on FHIR) with context
- Supported by Argonaut and major EHR vendors
- No end user training requirements
- Standardization of CDS integration



One of the initial use cases for CDS Hooks

Coverage Requirements Discovery Utilizing CDS Hooks

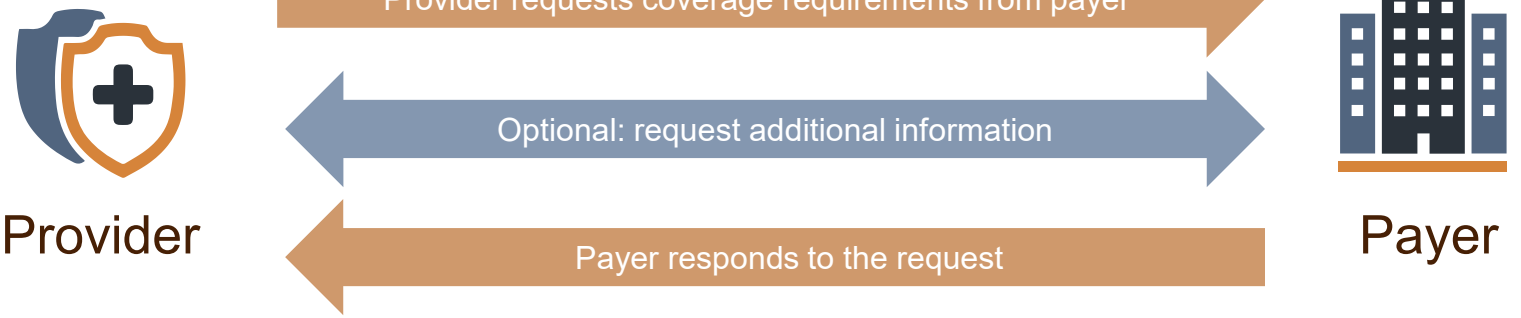
- Providers need to easily discover which payer covered procedure, DME or other medical service have
  - Requirement for Prior Authorization (PA) or other approvals
  - Specific documentation requirements,
  - Rules for determining need for specific treatments/services
  - Specific guidance.
- Using CDS Hooks, providers can discover in real-time specific payer requirements that may affect the ability to have certain services or devices covered by the responsible payer.
- Response may be
  - The answer to the discovery request
  - A list of services, templates, documents, rules
  - URL to retrieve specific items (e.g. template)



Coverage Requirements Discovery

1. Based on a specific clinical workflow event:
   scheduling,
   start of encounter,
   planning treatment,
   ordering,
   discharge
2. Provider's send CDS Hooks based request, with appropriate clinical context to the responsible payer
   a) Payer may request additional information from the provider EHR using existing FHIR APIs
   b) Payer responds to the EHR with any specific requirements that may impact the clinical decisions or coverage

Provider utilizes this information to make treatment decisions while considering specific payer coverage requirements.



Documentation Templates and Coverage Rules (DTR)

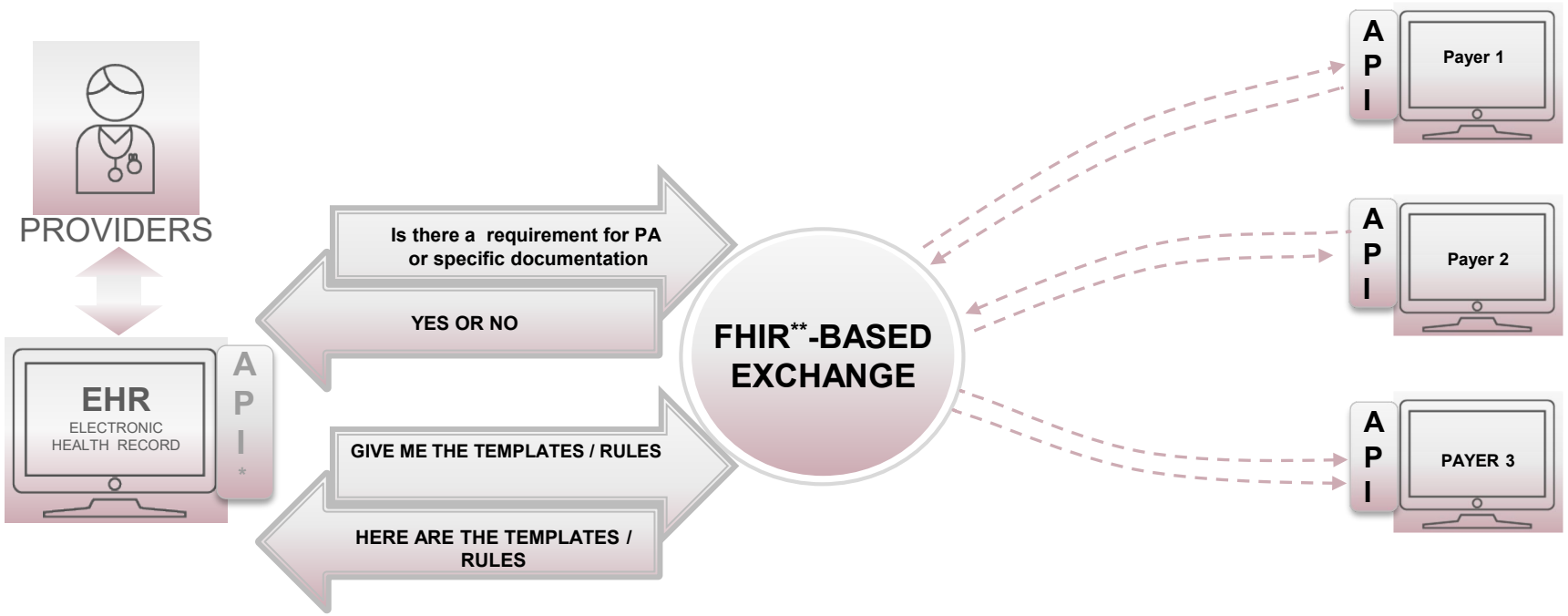
[Builds on CRD (CDS Hooks), CQL, SMART on FHIR and SDC]

- Providers need to easily incorporate payer requirements into their clinical workflow
  - Requirement for Prior Authorization (PA) or other approvals
  - Specific documentation requirements,
  - Rules for determining need for specific treatments/services
  - Specific guidance.
  - Capture missing information using Structured Data Capture (SDC)
- Uses a FHIR compliant standard (Clinical Quality Language: CQL) to represent payer “rules” for payer medical necessity and best clinical practice requirements that may affect the ability to have certain services or devices covered by the responsible payer.
- Information is retrieved directly from the EHR and does not require duplicate entry
- Provider input is only required for missing or ambiguous information.
- The template and rules may
  - Collect information for prior-authorization
  - Specify provider documentation requirements for coverage, medical necessity
  - Indicate clinical requirements including appropriate use
  - Collect specific documentation for quality measures
  - Respond with specific information as requested/documented in the template/rules

CMS Documentation Requirements Look-up Service (DRLS)

Based on a specific clinical workflow event:

- scheduling
- start of encounter
- ordering or planning treatment
- discharge



DRLS is the CMS instantiation of the Da Vinci Coverage Requirements Discovery (CRD) use case
Graphic taken from the CMS Special Open Door Forum (SODF) presentation

(Da Vinci Prior-Authorization Support Project)

Provider EHR

Provider Action

Pre Fetch

Provider Initiates App

SMART on FHIR Application

1) Get Payer PA Rules (CQL)
2) Retrieve information
3) Query missing information (SDC)
4) Send PA request with info
5) Receive and display result

1) CDS Hooks

Context with Access Token

2) Access Patient Record

optional

3) Return CARD(s)

Optional link to SMART App

4) Get Payer PA Rules

5) PA Request with MR*

6) PA Result*

Payer PA Service

Payer CDS

1) Evaluates request
2) Gets additional information
3) Issues cards (result or links)
4) If PA required, sends SMART on FHIR link and context

5) Send documentation rules

6) Evaluate PA request
7) Reply with PA result

*Conversion to/from ASC X12N required to meet HIPAA regulations

Approaches to Prior-Authorization

- Payer-Provider PA mediation (Da Vinci Prior-Authorization Support Project)
  - Is Prior-authorization required?
    - Yes, here are the rules for information required
    - Based on the rules assemble the information from the record
    - Query for missing information
    - Submit the request and information using current standards (e.g. X12N) to the payer for a decision
    - Receive the response (PAN, denial, additional request for information)
- Payer only PA mediation
  - Is Prior-Authorization Required?
    - Yes -- use access to record (as part of CDS Hooks, via token passed with request)
    - Payer accesses record and determines if PA requirements are met
    - Send PAN, denial, or request for information
- Provider only PA mediation (Auto Auth)
  - Is Prior-authorization required?
    - Yes, here are the rules for evaluation of information
    - Evaluate existing information
    - Query for and evaluate missing information
    - If documentation meets requirements issues PAN, if not , option to submit to payer or take “out-of-band”

Potential Payer Focused Prior-Authorization

Provider EHR

Provider Action

Pre Fetch

Provider receives PA result

1) CDS Hooks

Context with Access Token

2) Access Patient Record

optional

3) Return CARD with result

Optional link to SMART App if missing information

Payer PA Service

Payer CDS

1) Evaluates request
2) Gets required information
3) If PA required, evaluate documentation (may need to retrieve more information)
4) Reply with PA result via card

If information is incomplete, then revert to prior method

22

Potential Provider Focused Prior-Authorization

Provider EHR

Provider Action

Pre Fetch

Provider Initiates App

SMART on FHIR Application

1) Get Payer PA Rules (CQL)
2) Retrieve information
3) Query missing information (SDC)
4) Evaluate PA requirements
5) If pass, issue PAN
6) Return results of PA to payer

1) CDS Hooks

Context with Access Token

2) Access Patient Record

optional

3) Return CARD(s)

Optional link to SMART App

4) Get Payer PA Rules

5) Return result of PA

Payer PA Service

Payer CDS

1) Evaluates request
2) Gets additional information
3) Issues cards (result or links)
4) If PA required , sends SMART on FHIR link and context

5) Send documentation and PA rules

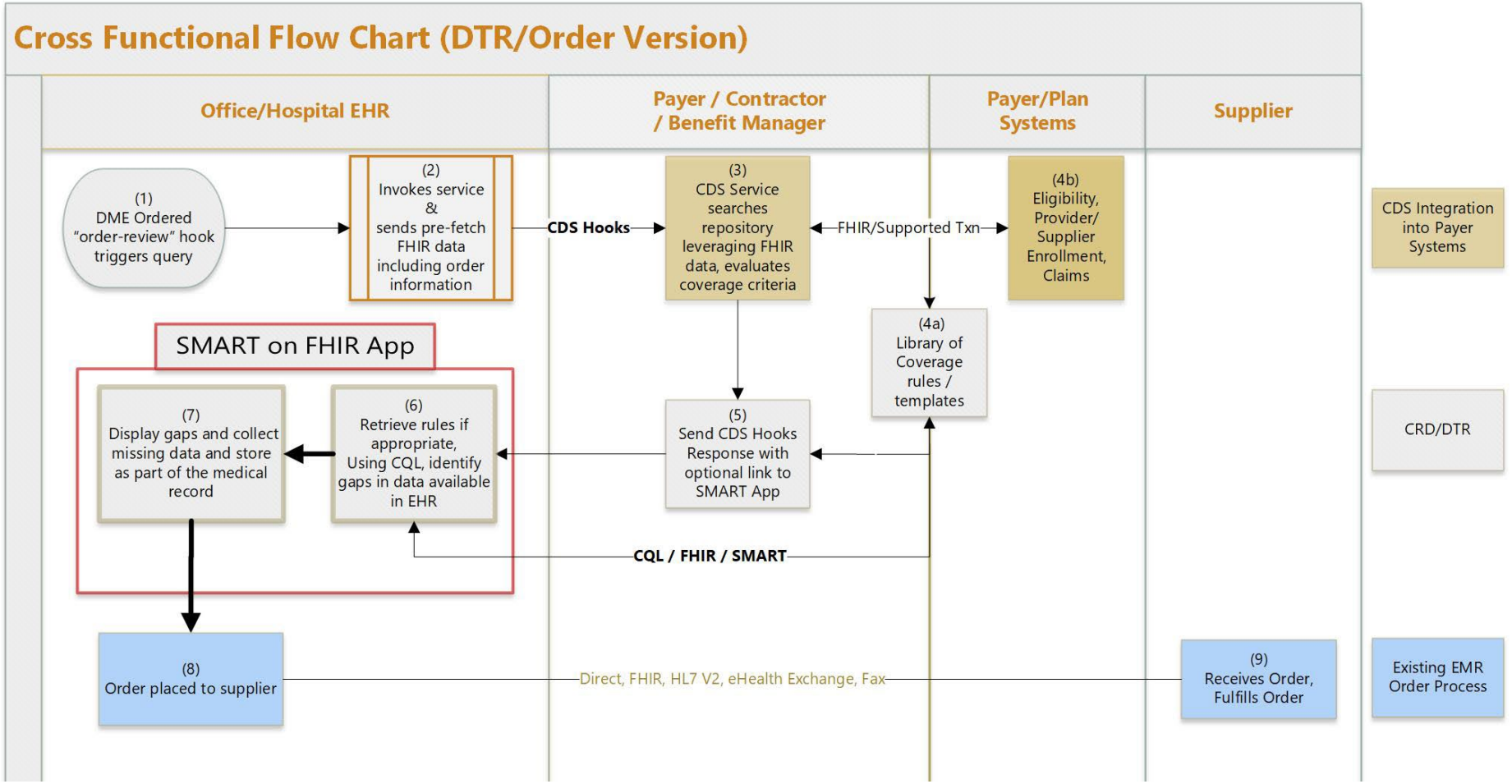
6) Receive result of PA

Summary

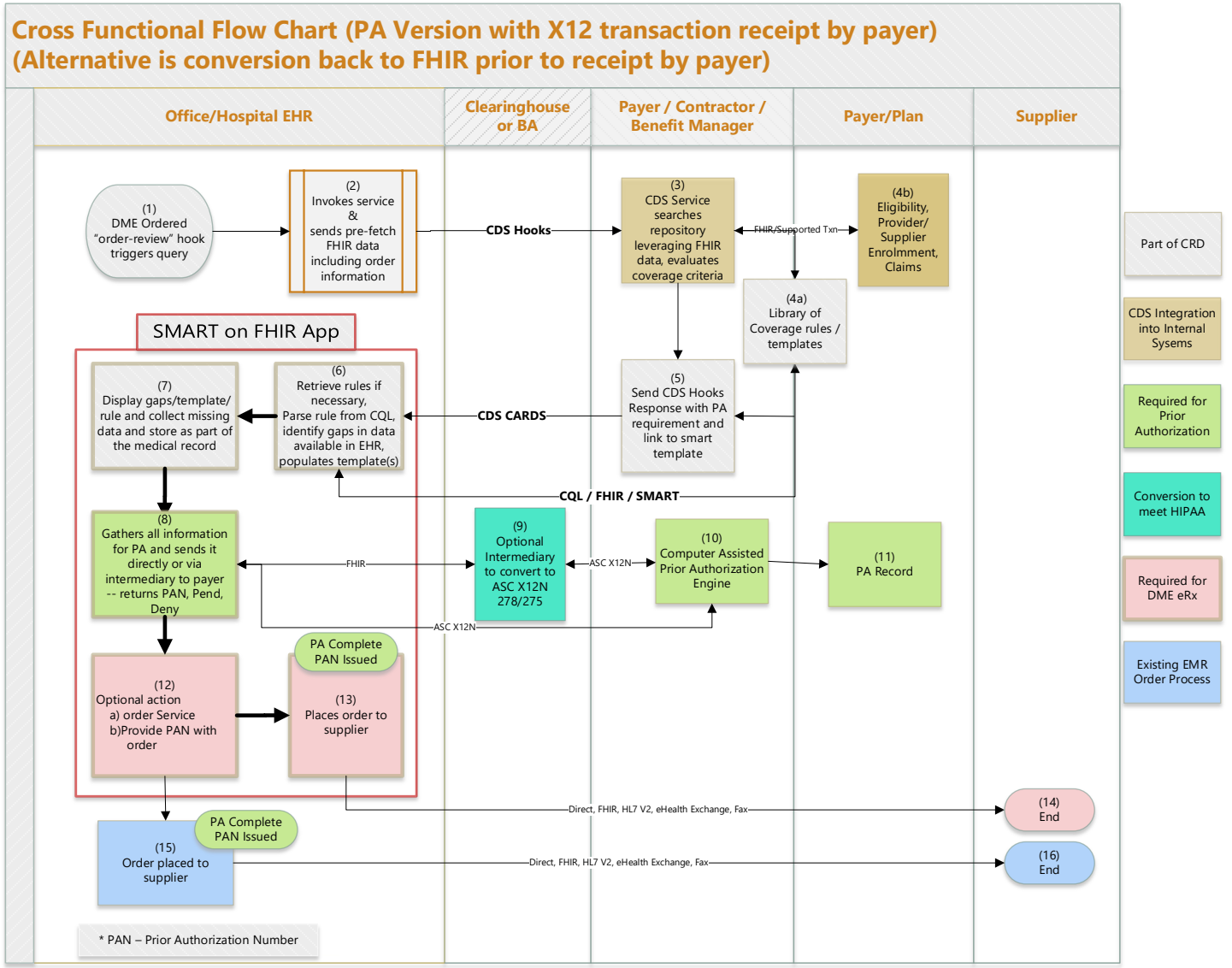
- Using new technologies (FHIR , CDS Hooks, SMART on FHIR, CQL) it is possible to integrate previously time intensive tasks into the clinical workflow to achieve significant efficiencies
- We can substantially reduce provider burden by
  1. Acquiring critical patient information while the patient is available
  2. Obtain prior-authorizations in real-time for certain common services
  3. Minimize rework by “getting it right the first time”
- One critical impact of improving the prior-authorization workflow is the improvement on patient care and experience.

Additional Information

CRD and DTR


Cross Functional Flow Chart (DTR/Order Version)
Office/Hospital EHR
Payer / Contractor / Benefit Manager
Payer/Plan Systems
Supplier
(1) DME Ordered "order-review" hook triggers query
(2) Invokes service & sends pre-fetch FHIR data including order information
CDS Hooks
(3) CDS Service searches repository leveraging FHIR data, evaluates coverage criteria
FHIR/Supported Txn
(4b) Eligibility, Provider/ Supplier Enrollment, Claims
(4a) Library of Coverage rules / templates
SMART on FHIR App
(7) Display gaps and collect missing data and store as part of the medical record
(6) Retrieve rules if appropriate, Using CQL, identify gaps in data available in EHR
(5) Send CDS Hooks Response with optional link to SMART App
CQL / FHIR / SMART
(8) Order placed to supplier
Direct, FHIR, HL7 V2, eHealth Exchange, Fax
(9) Receives Order, Fulfills Order
CDS Integration into Payer Systems
CRD/DTR
Existing EMR Order Process

CRD + DTR + Prior-Authorization Support



UNLOCKING PAYER INFORMATION TO IMPROVE CARE

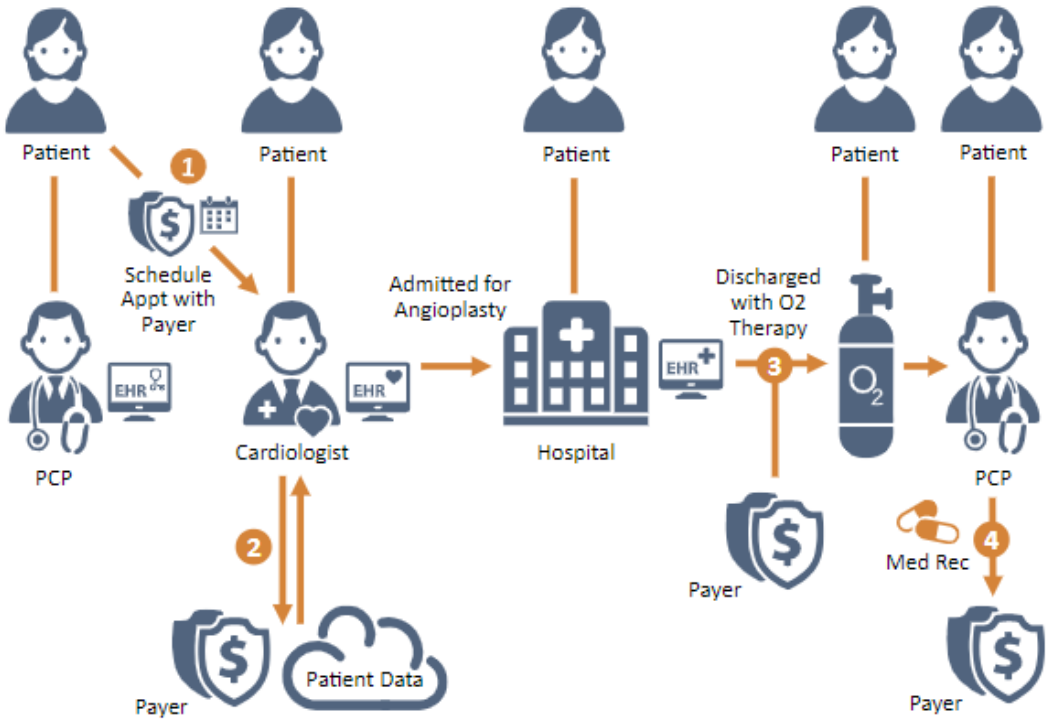
HIMSS19 Demonstration

CLINICAL SUMMARY

Da Vinci is demonstrating the ability to exchange information between payers and providers using HL7® FHIR® and CDS Hooks® as part of the Interoperability Showcase.

The vignette describes a clinical encounter for 78-year-old Asian women named Dara that starts with her primary care physician, proceeds to a cardiologist who admits Dara to the hospital for an angiogram and observation where it is determined that her chronic obstructive pulmonary disease has progressed to the point that she needs supplemental oxygen.

As Dara returns to her primary care physician, her previous medications are reconciled with those prescribed at discharge, the PCP reports the medication reconciliation, in support of a quality measure the Medicare Advantage program is following for its members.



The visual & table describes the interactions demonstrated, direction of each exchange, the FHIR standards used, the setting where the interaction is occurring and the participants.

Activities By the Numbers	Stats
Total practice runs	3
Total public runs	23
Filming runs	1
Total variations	14
Total roles	96
Total role system issues	7
Role availability	92.7%
AEGIS Touchstone available	100%
Total MCs	6
Total EHRs	2
Total Payer/Partner	4
Total Payer only	5
Total Sponsors	16
Number of visitors (approx.)	500
Percent that left during vignette	< 10 %

Each step represents a provider – payer exchange using FHIR IG