



The State of Prior Authorization in the Medicare Fee for Service Program



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Agenda

- 1. Medicare Fee for Service (FFS) Prior Authorization (PA)**
- 2. New Industry Efforts to Reduce Provider Burden of PA**
 - 1) Medicare FFS Documentation Requirement Lookup Service**
 - 2) New FHIR Standard for Attachment**
 - i. Electronic Submission of Medical Documentation (esMD)
 - ii. Volume of Medical Record Review
 - 3) New FHIR Standard for PA Requests**

Medicare FFS Definition of Prior Authorization (PA)

- Prior authorization (PA) **does not create new clinical documentation requirements.**
- Instead, it requires the same information that is already required to support Medicare payment, just **earlier in the process.**
- PA allows providers and suppliers to address issues with claims **prior to rendering services and submitting claims for payment,** which has the potential to reduce appeals for claims that may otherwise be denied.
- Medicare FFS believes using a PA process will help ensure that all relevant coverage, coding, and payment requirements are met before the service is rendered to the beneficiary and before the claim is submitted.

Providers and Prior Authorization

Medicare FFS is listening...

- 1. Providers have said it is too difficult to figure out when PA is required.**
 - As part of provider listening sessions, CMS and ONC have heard repeated suggestions that payer should:
 - Publically disclose, in a searchable electronic format, a payer's requirements (including prior authorization requirements) for coverage of medical services.
- 2. Once the provider knows PA is required, the associated requirements and processes are burdensome and difficult to complete.**
 - Lack of standardization and effective technology solutions to automate these processes.
 - Not only difficult for the rendering provider, it is especially difficult for ordering provider.
 - Some payers require providers to fill out PA forms.
 - Medicare FFS would like to leverage data already present in the EHR to reduce re-documentation in the clinical note.

New Da Vinci Standards to Help Reduce Provider Burden







1. New FHIR Standards that Medicare FFS is using to create a Documentation Requirement Lookup Service (DRLS)
2. New FHIR Standard for Attachments
3. New FHIR Standard for PA Requests

1. Medicare FFS Documentation Requirement Lookup Service (DRLS)

What is the DRLS?

DRLS will allow providers to discover prior authorization and documentation requirements at the time of service in their electronic health record (EHR) or integrated practice management system through electronic data exchange with a payer system

DRLS Goals:

		Reduce provider burden
		Reduce improper payments and appeals
		Improve “provider to payer” information exchange

Why is Medicare FFS Interested in the DRLS?



What We Heard from Providers



CMS requirements are excessive



Documentation requirements are too hard to find

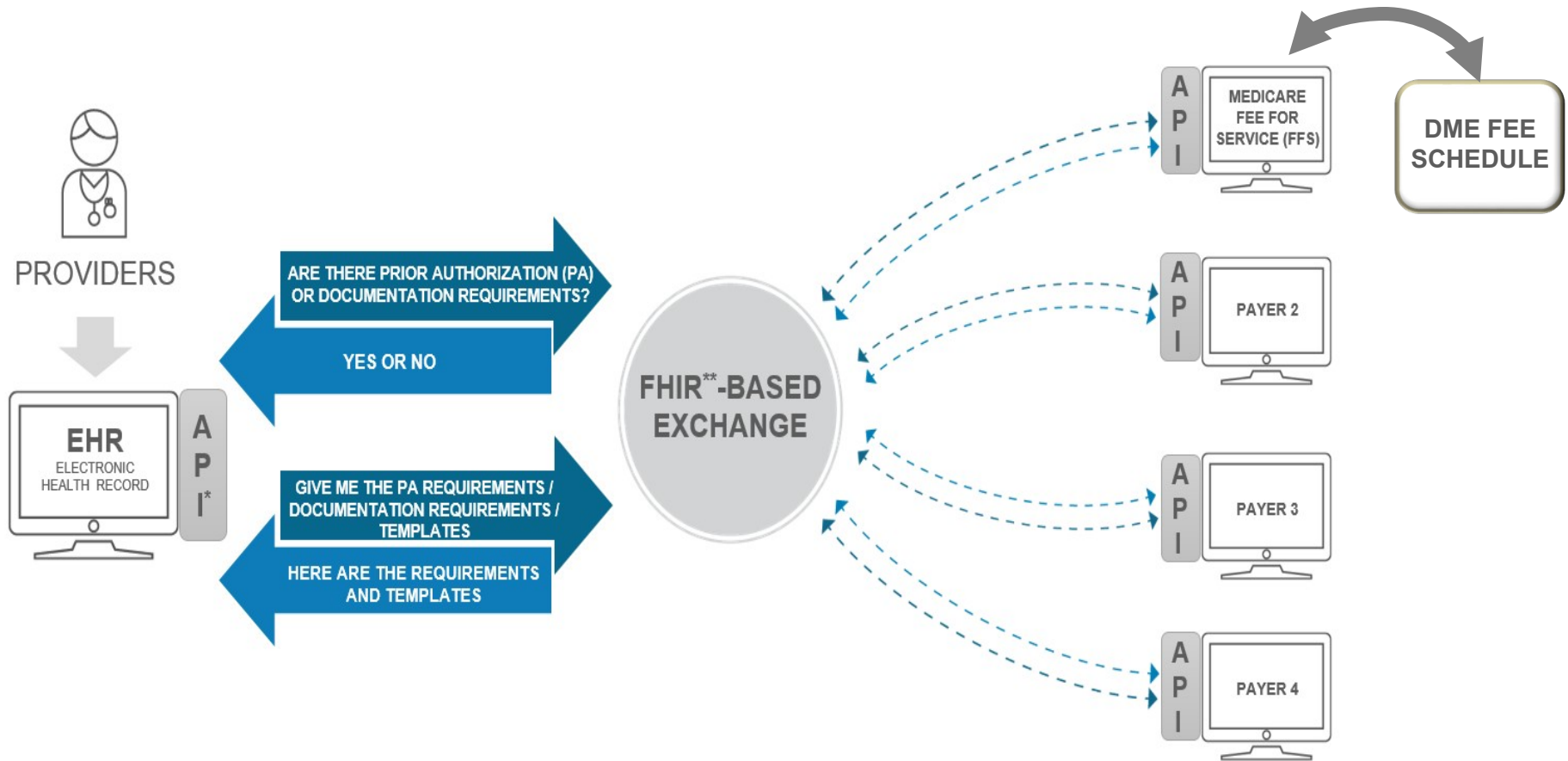


Providers are afraid of audits

[The American Medical Association \(AMA\): Prior Authorization and Utilization Management Reform Principles](#)

“Utilization review entities should publically disclose, in a **searchable electronic format**, patient-specific utilization management **requirements**, including prior authorization, applied to individual drugs and medical services. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers **what supporting documentation is needed** to complete every prior authorization and step therapy override request.”

How Will DRLS Work for Providers?



*API – APPLICATION PROGRAMMING INTERFACE
**FHIR – FAST HEALTHCARE INTEROPERABILITY RESOURCES

[go.cms.gov/MedicareRequirementsLookup](https://www.go.cms.gov/MedicareRequirementsLookup)

Example of Documentation Requirements and Cost Transparency



PROVIDER

Medicare Fee For Service -- Home Oxygen Therapy Requirements

- 1) diagnoses requiring supplemental oxygen
- 2) testing to confirm hypoxia in chronic stable state performed and evaluated
- 3) documentation that alternative therapies were tried and not completely effective
- 4) patient is mobile if portable O2 supplies are ordered
- 5) [click here](#) for information regarding Group 1 and Group 2 criteria

Patient Monthly Cost Information (Florida) Metro / Rural Copay (20%)

E0424: Stationary compressed gaseous oxygen system	\$14.64 / \$26.94
E0431: Portable gaseous oxygen system	\$ 7.32 / \$13.47
E0433: Portable liquid oxygen system	\$ 7.32 / \$13.47
E0439 : Stationary liquid oxygen system	\$14.64 / \$26.94
E0441: Stationary gaseous oxygen system	\$ 9.78 / \$12.84
E1390: Oxygen concentrator (85% or greater O2)	\$14.64 / \$26.94

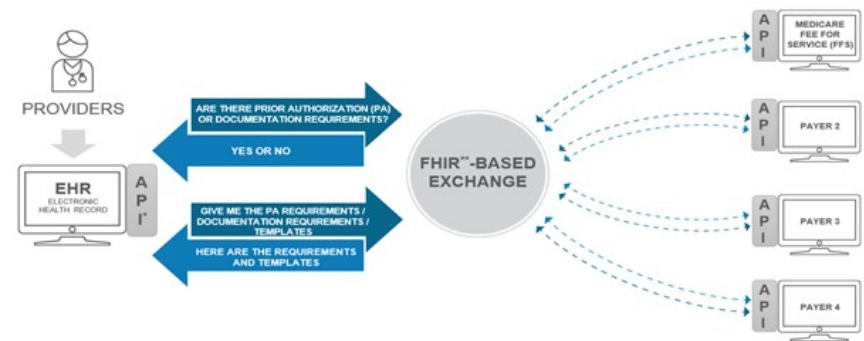
Subject to deductible and may be covered by supplemental insurance

How Will The Team Accomplish the Goals?

- **CMS/CPI hired MITRE to work with the Da Vinci Team to:**
 - Create implementation guides based on FHIR standards
 - Create reference implementation to prove it works
 - Launch pilots



The commercial vendor community will have access to a CRD Implementation Guide and Reference Implementation available in the public domain to accelerate its development of standards-based solutions that work with DRLS.



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**FHIR – FAST HEALTHCARE INTEROPERABILITY RESOURCES

Leveraging Industry Efforts

The Da Vinci Project:

- **Convened by HL7 International**
 - A Health Care Standards Development Organization
- **Da Vinci is an industry-led effort to:**
 - Establish a *rapid multi-stakeholder* process to identify and implement critical use cases *for the exchange of information between payers and providers*
 - *Minimize* the development and deployment of *unique solutions*
 - *Focus on* reference architectures that will promote *industry-wide standards and adoption*
- **Members include:**
 - *12 payers, 10 HIT Vendors, 3 EHRs, 6 Providers*





Da Vinci Project Use Cases: DRLS

DRLS is based on these two use cases



Project Deliverables

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

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





2. New FHIR Standard for Attachments

Da Vinci Project Use Cases: Clinical Data Exchange



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The FHIR CDex Standard

Medicare FFS is closely monitoring the HL7 workgroup creating the Clinical Data Exchange (CDex) Standard.

Interested parties can sign up for the Da Vinci Public Listserv by following the link below:

<https://confluence.hl7.org/display/DVP/Da+Vinci>

Any HL7 member can join the CDex work group

Calls by visiting: <http://www.hl7.org/concalls/Default.aspx>

Attachments are Important to Medicare FFS

1. Volume of Medical Record Review
2. Electronic Submission of Medical Documentation (esMD)
 - Currently uses the CONNECT Standard

Volume of Medical Record Review

In Calendar Year 2017 the total Program Payments for Medicare Parts A and B was **\$337.0 billion**

Medicare Medical Review Contractors typically only conduct medical review on less than 1% of claims

CMS Fast Facts January 2019 Version

SOURCE: CMS/Office of Enterprise Data & Analytics

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html>

Electronic Submission of Medical Documentation

- The Electronic Submission of Medical Documentation (esMD) system **enables providers to send medical documentation to review contractors electronically.**
- The system is **Exchange compatible**, based on standards developed by the Office of the National Coordinator (ONC) for Health Information Technology.
- Most recently, the esMD initiative has developed the capability to **send requests electronically** and also **receive medical records generated according to common standards for EHRs.**
- Allowing health care providers to submit requested records directly from their own systems promises to **further reduce burden.**





3. New FHIR Standard for PA Requests

Da Vinci Project Use Cases: PA Support



Project Deliverables

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NCVHS Recommendations

- NCVHS has recommended that HHS should promote and facilitate voluntary testing and use of new standards.
- A good example of a new standard to test for HIPAA would be the HL7 FHIR standard, currently in pilot for various use cases, including prior authorization with various public-private sector organizations, including the CMS.

The FHIR PA Support Standard

Medicare FFS will be closely monitoring the HL7 workgroup creating the Prior-Authorization Support Standard.

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Any HL7 member can join the Prior Authorization Support Project Calls by visiting:

<http://www.hl7.org/concalls/Default.aspx>

Comments or Questions?



General Comments/Recommendations?

To monitor DRLS progress or for information on upcoming SODF calls:

go.cms.gov/MedicareRequirementsLookup

Feedback and suggestions on the Documentation Requirement Lookup Service can be sent to:

MedicareDRLS@cms.hhs.gov