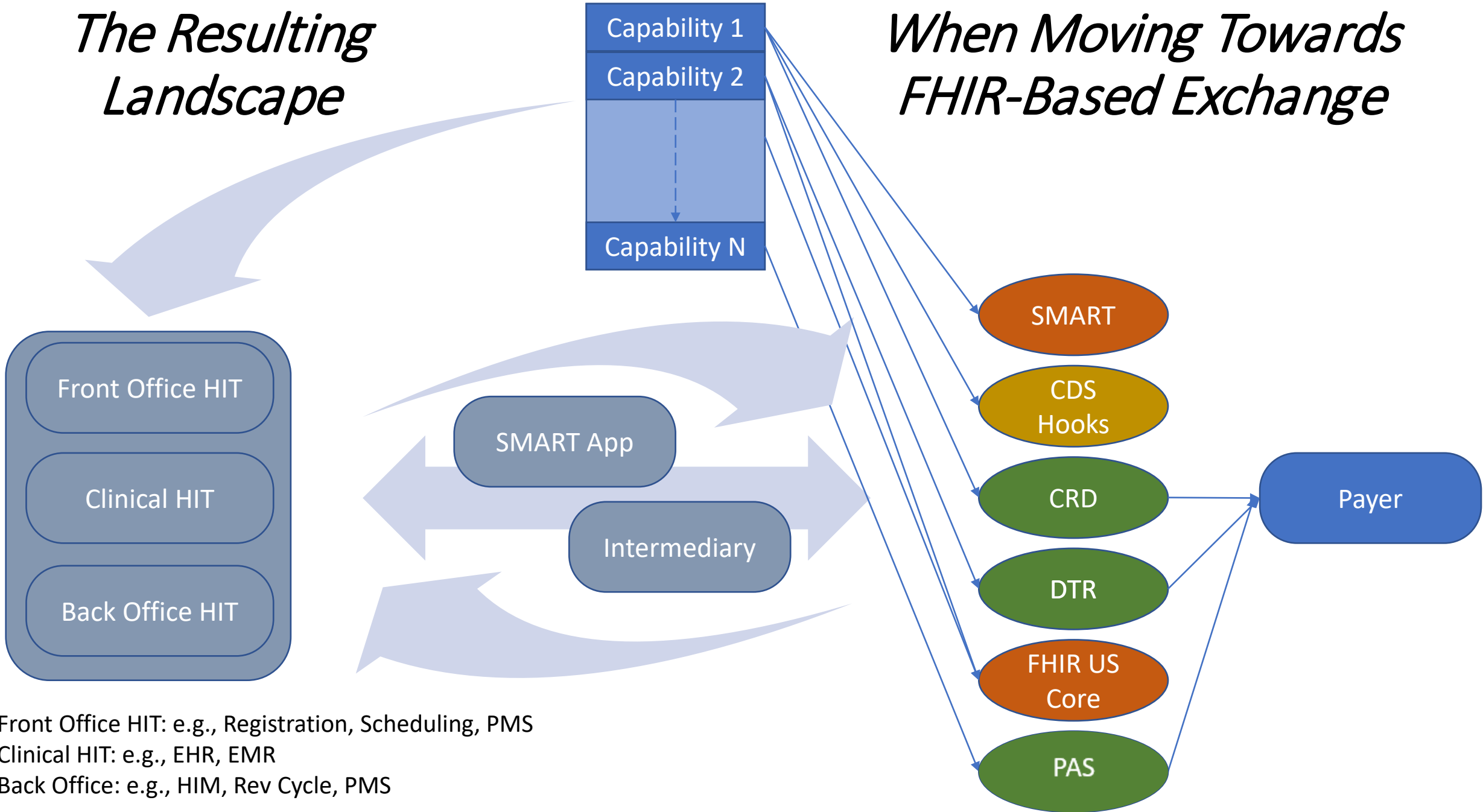# Supporting a Prior Authorization Workflow would involve multiple HIT systems

- Prior Authorization may be initiated in a Scheduling, Registration, Practice Management, or EHR system

- Supporting data may reside in an EHR, HIM, or other source systems

- Data relevant to claims and billing are maintained Revenue Cycle or Practice Management systems

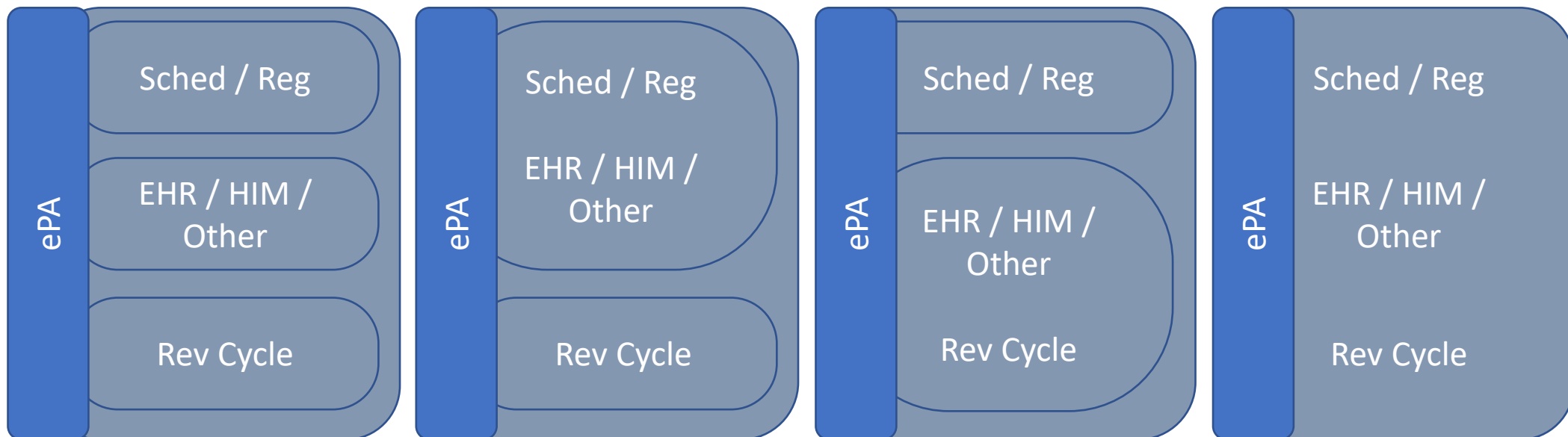- SMART Applications may be used to support specific steps in the process.

The Resulting Landscape

When Moving Towards FHIR-Based Exchange

Capability 1
Capability 2
Capability N

Front Office HIT
Clinical HIT
Back Office HIT

SMART App
Intermediary

SMART
CDS Hooks
CRD
DTR
FHIR US Core
PAS

Payer

Front Office HIT: e.g., Registration, Scheduling, PMS
Clinical HIT: e.g., EHR, EMR
Back Office: e.g., HIM, Rev Cycle, PMS

Provider HIT can be configured many ways

- It may be one system, fully integrated, or multiple, interoperable systems.
  - Relevant data for ePA therefore may need to be accessed by/from different systems, and triggered by different systems.

ePA	Sched / Reg
	EHR / HIM / Other
	Rev Cycle

ePA	Sched / Reg
	EHR / HIM / Other
	Rev Cycle

ePA	Sched / Reg
	EHR / HIM / Other
	Rev Cycle

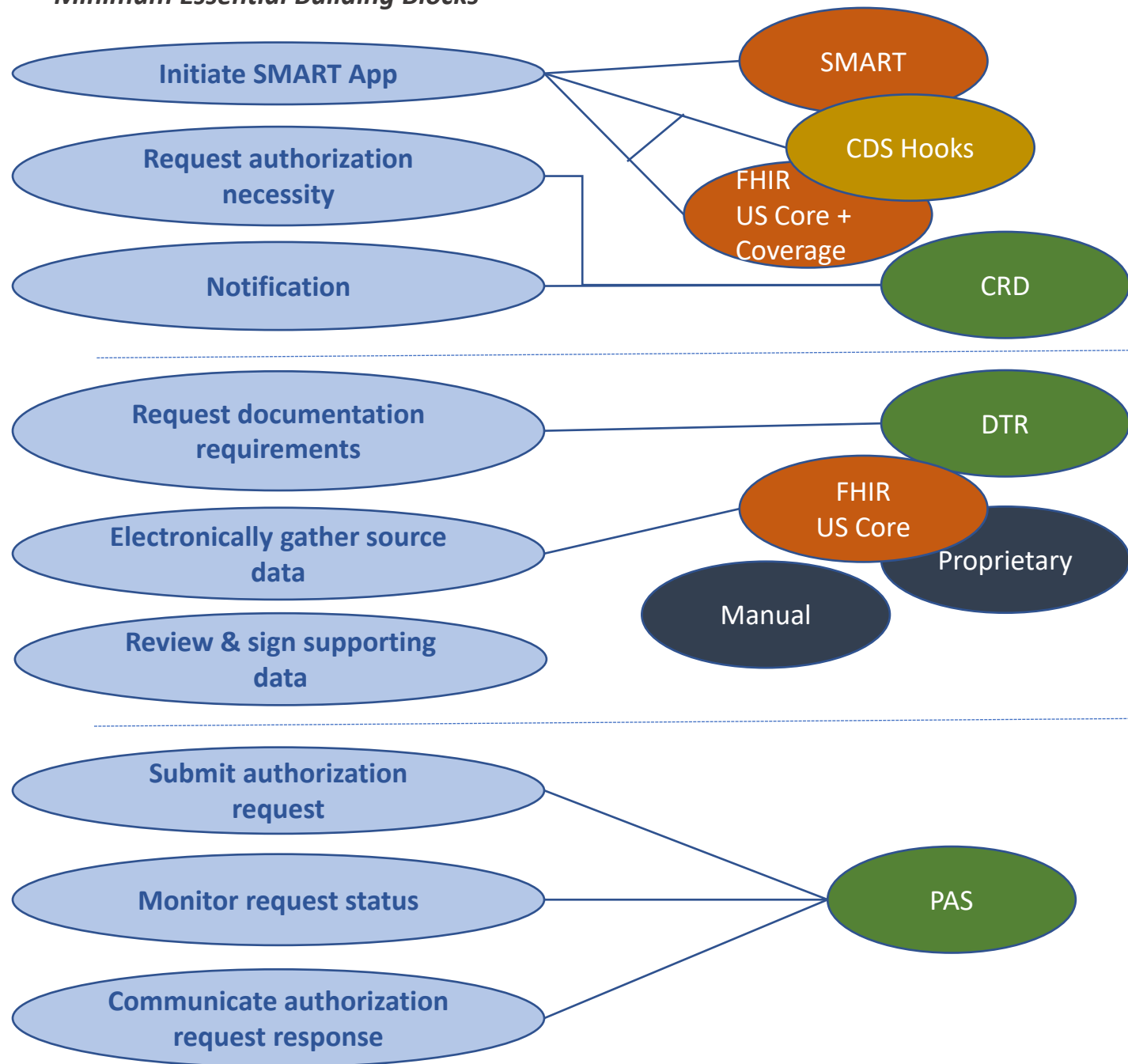| ePA	Sched / Reg
	EHR / HIM / Other
	Rev Cycle

The Certification Challenge Therefore is:

- The current Da Vinci IGs address the main interactions necessary, but these interactions are not sufficiently organized yet to support unambiguous scope definitions essential for certification criteria at a more granular level than IGs.
  - **The current IGs would yield a more coarse certification approach where a more granular approach is necessary.**

- Valid and demonstrated distribution of capabilities to date do not necessarily require full support of the Da Vinci IGs by any particular system.

- Certifying one system for their role in ePA does not yield the intended value of certification. All or none should be subject to certification as this involves multiple systems that need to interact.

- Therefore, ePA certification should not just be part of CEHRT, but focus on CHIT that can be distributed across ePA actors in a modular fashion, not just EHR actors **on the provider side.**

The following slides illustrate the need for more granular building blocks considering different, valid configurations.

| Capability 1 – Identify need for authorization |
| Capability 2 – Obtain supporting documentation requirements |
| Capability 3 – Gather supporting documentation |
| Capability 4 – Review & Sign supporting documentation |
| Capability 5 – Submit authorization request including supporting documentation |
| Capability 6 – Track authorization request status |
| Capability 7 – Request additional supporting information |
| Capability 8 – Gather additional supporting information |
| Capability 9 – Communicate authorization disposition |

Minimum Essential Building Blocks

Initiate SMART App

Request authorization necessity

Notification

SMART

CDS Hooks

FHIR US Core + Coverage

CRD

Request documentation requirements

Electronically gather source data

Review & sign supporting data

DTR

FHIR US Core

Proprietary

Manual

Submit authorization request

Monitor request status

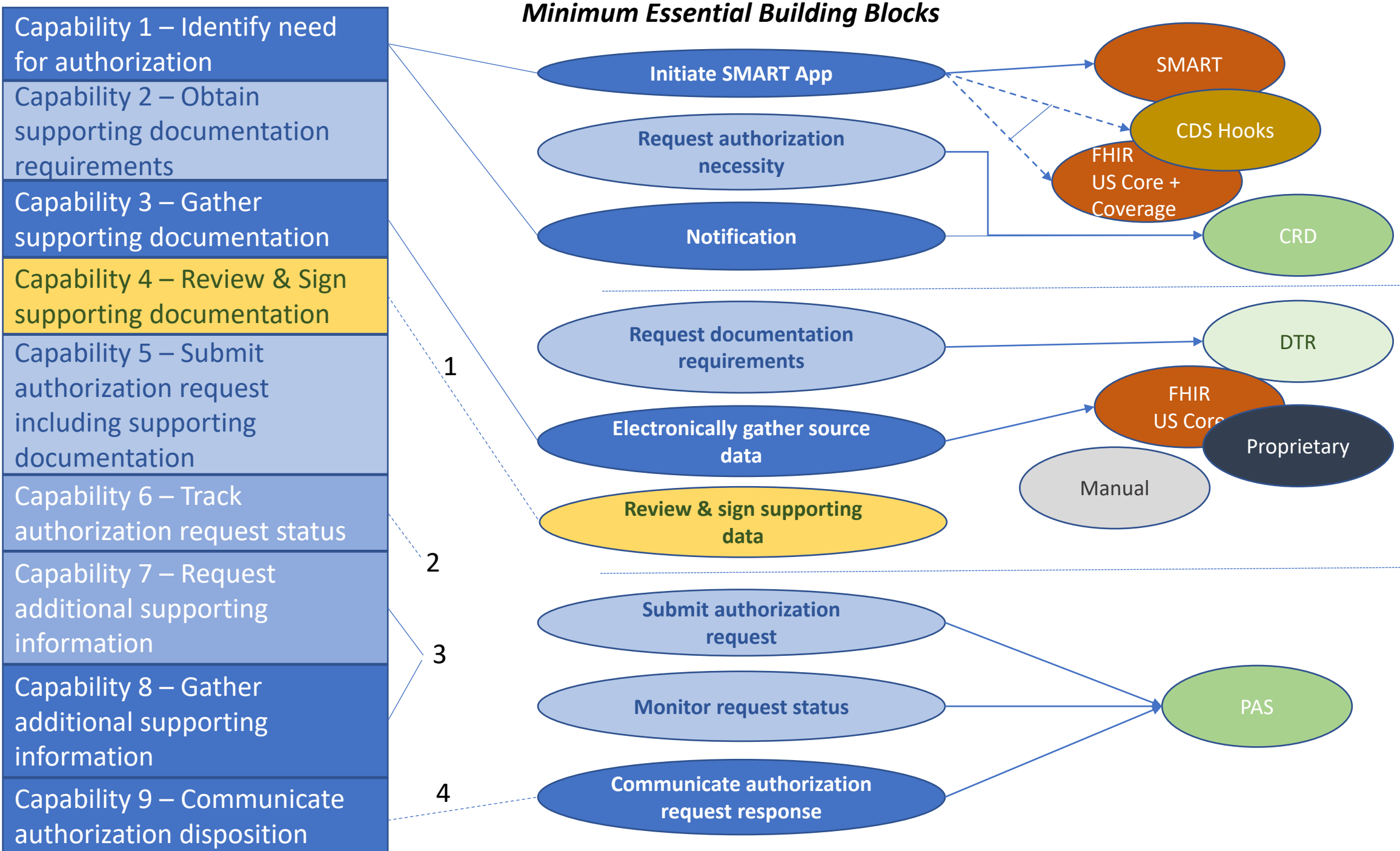Communicate authorization request response

PAS

Two Examples on how these capabilities and interactions can be distributed across different HIT modules

- Provider HIT, with a SMART App, manages the ePA workflow
  - An EHR (or Reg, Sched) initiates a SMART App that manages the ePA workflow
  - A SMART App largely manages the ePA workflow and interactions with the various payers
  - Various HIT (e.g., HIM for documents, pop health repository) may be the source of data for supporting an authorization
  - A Back Office system receives authorization data to include for claims submissions later.
- Provider HIT, without a SMART App, manages all of the ePA workflow
  - An EHR manages the majority of the ePA workflow
  - Various HIT (e.g., HIM for documents, pop health repository) may still be the source of data for supporting an authorization
  - A Back Office system receives authorization data to include for claims submissions later.

- *These are illustrative to the need for more granular organization of implementation guidance published to date. Other valid configurations exist.*

Provider HIT / SMART App Configuration

Example where most of the ePA support happens in the SMART App
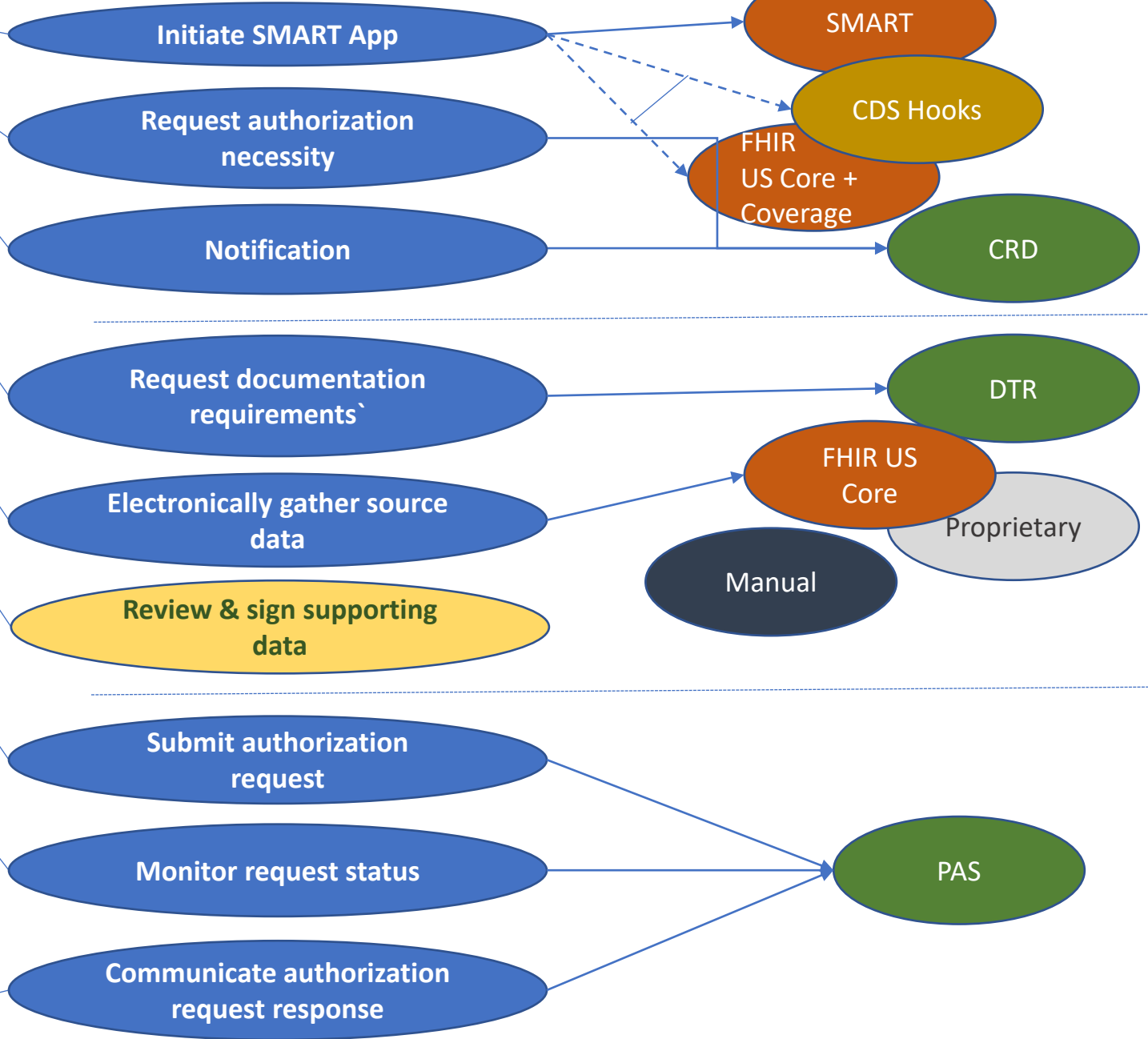
EHR/Reg/Sched - minimum

Capability 1 – Identify need for authorization

Capability 2 – Obtain supporting documentation requirements

Capability 3 – Gather supporting documentation

Capability 4 – Review & Sign supporting documentation

Capability 5 – Submit authorization request including supporting documentation

Capability 6 – Track authorization request status

Capability 7 – Request additional supporting information

Capability 8 – Gather additional supporting information

Capability 9 – Communicate authorization disposition

Minimum Essential Building Blocks

Initiate SMART App

Request authorization necessity

Notification

Request documentation requirements

Electronically gather source data

Review & sign supporting data

Submit authorization request

Monitor request status

Communicate authorization request response

SMART

CDS Hooks

FHIR US Core + Coverage

CRD

DTR

FHIR US Core

Proprietary

Manual

PAS

Open Questions for EHR

1. Does the EHR have to be able to final review/sign? Or can it be it SMART App and EHR has to store something in the record? Or could the HIM provide that if really needed?
    1. Need transparency of what data is pulled to provider.
    2. Need the submitting HIT module to hold on to the request and data submitted.
    3. Not aware of anybody who requires the submitted data set to be stored beyond the HIT module that submitted it.

2. Does the EHR need to do this to keep ordering provider informed of progress, or should that remain in the SMART App?

3. Uses in DTR approach in version currently in ballot, following Capability 2 and 3

4. While the EHR needs to be informed to then be able to either progress or stop (and find alternatives), the current PAS interaction may not be right as it is using a resource that is not used in an EHR.
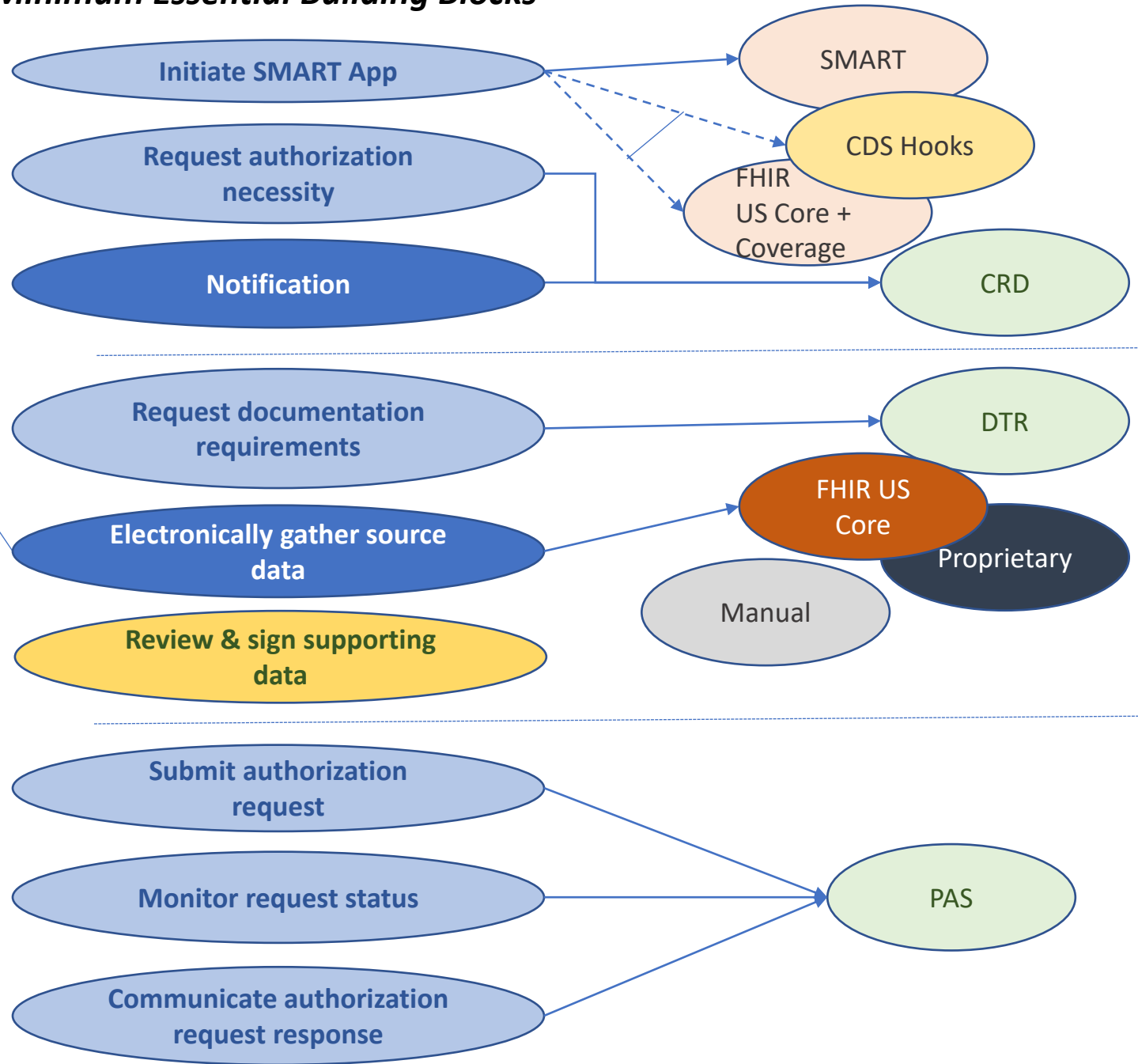
Potential gaps for SMART App

1. What is the request from payer to provider to ask for more information? CDex? Concern is then that the format of receiving documentation requirements in DTR is different than here.
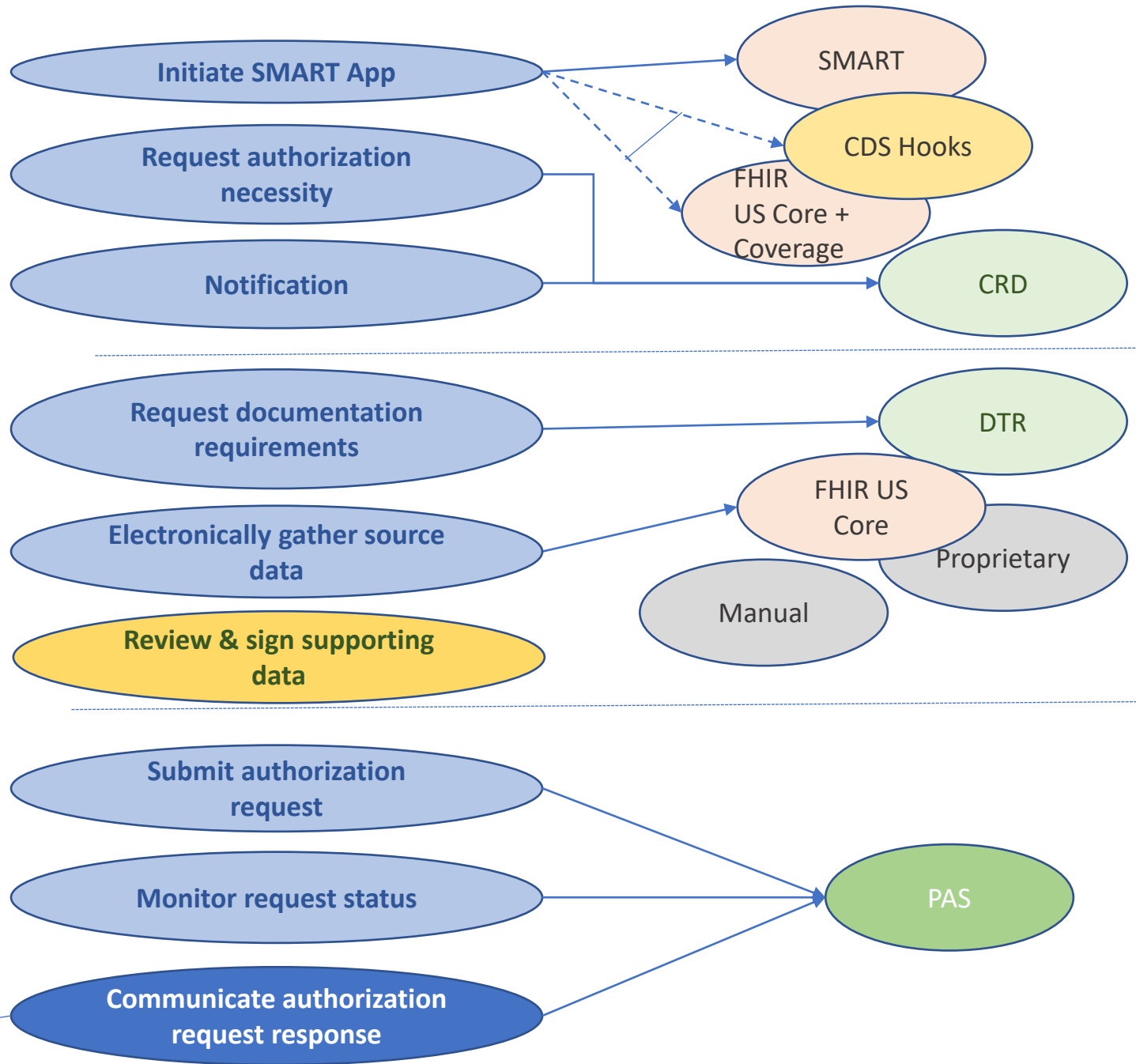
Other Source - minimum

Capability 1 – Identify need for authorization
Capability 2 – Obtain supporting documentation requirements
Capability 3 – Gather supporting documentation
Capability 4 – Review & Sign supporting documentation
Capability 5 – Submit authorization request including supporting documentation
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Capability 9 – Communicate authorization disposition

Minimum Essential Building Blocks

- Initiate SMART App
- Request authorization necessity
- Notification
- Request documentation requirements
- Electronically gather source data
- Review & sign supporting data
- Submit authorization request
- Monitor request status
- Communicate authorization request response

- SMART
- CDS Hooks
- FHIR US Core + Coverage
- CRD
- DTR
- FHIR US Core
- Proprietary
- Manual
- PAS

Rev Cycle/PMS - minimum

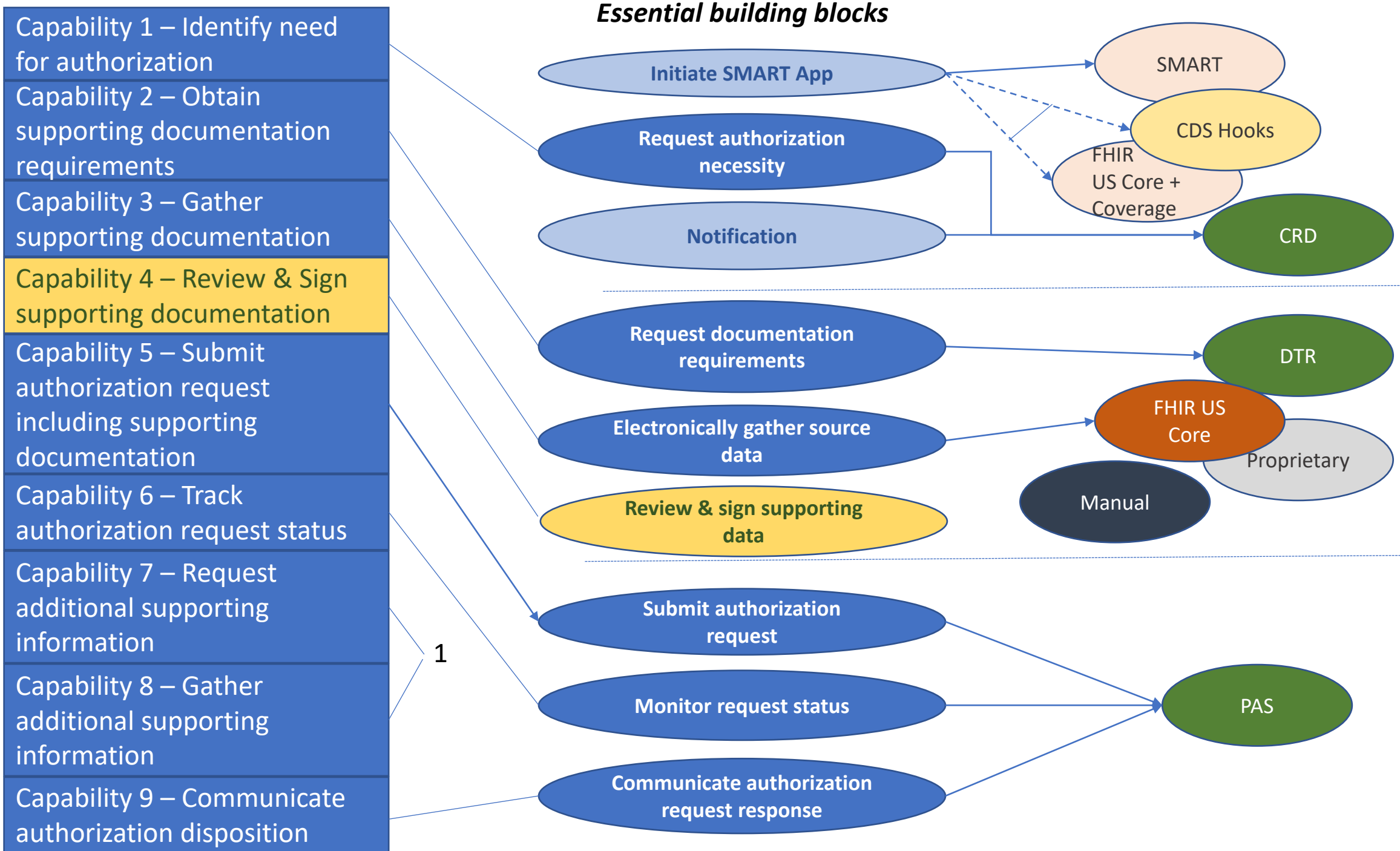| Capabilities	Activities	Standards

Capability 1 – Identify need for authorization

Capability 2 – Obtain supporting documentation requirements

Capability 3 – Gather supporting documentation

Capability 4 – Review & Sign supporting documentation

Capability 5 – Submit authorization request including supporting documentation

Capability 6 – Track authorization request status

Capability 7 – Request additional supporting information

Capability 8 – Gather additional supporting information

Capability 9 – Communicate authorization disposition

Initiate SMART App → SMART

Request authorization necessity

Notification → CRD

FHIR US Core + Coverage

CDS Hooks

Request documentation requirements → DTR

Electronically gather source data → FHIR US Core

Proprietary

Manual

Review & sign supporting data

Submit authorization request → PAS

Monitor request status

Communicate authorization request response

No SMART App

Example where the provider HIT, primarily EHR, manages the full ePA workflow

EHR
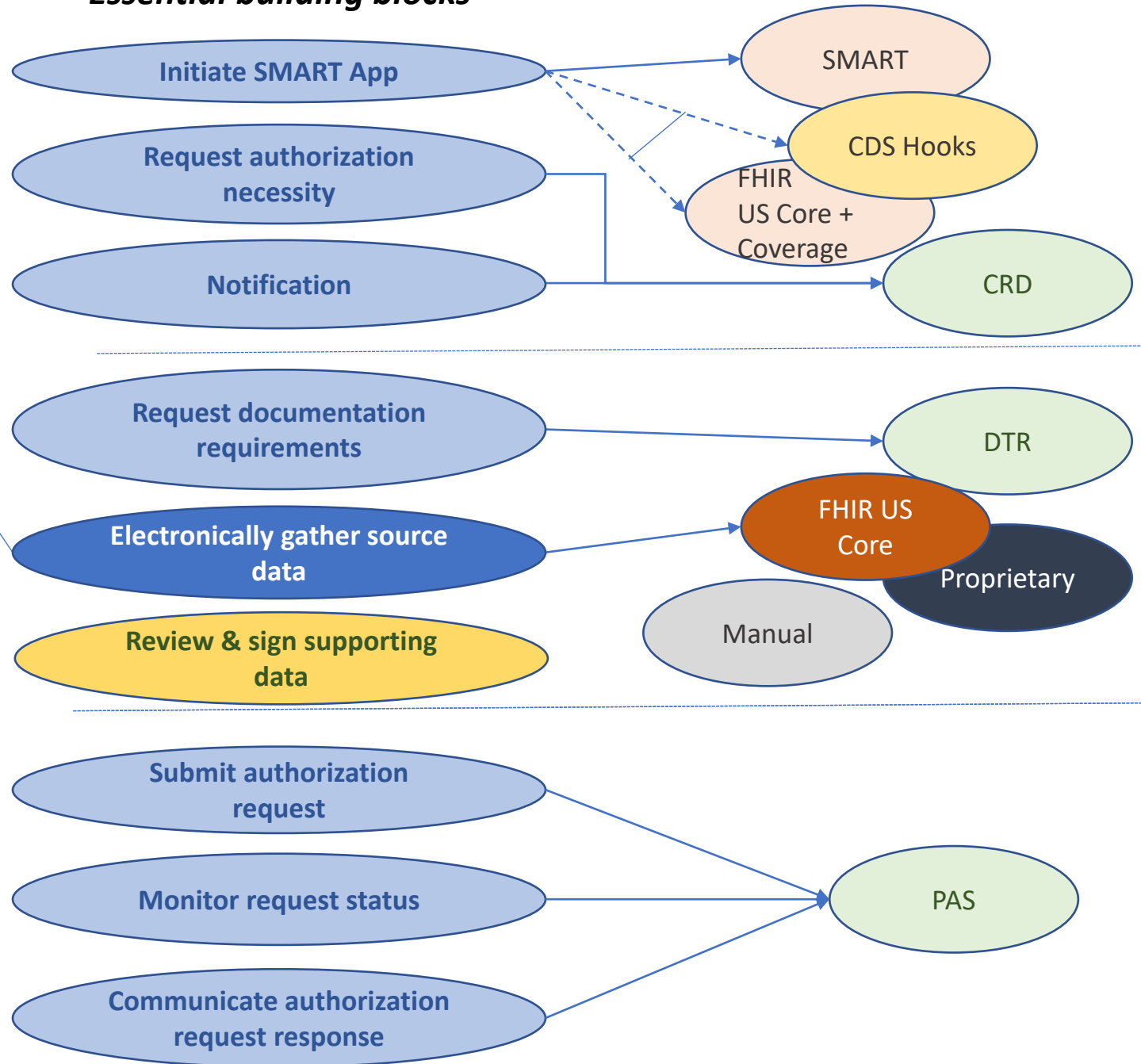
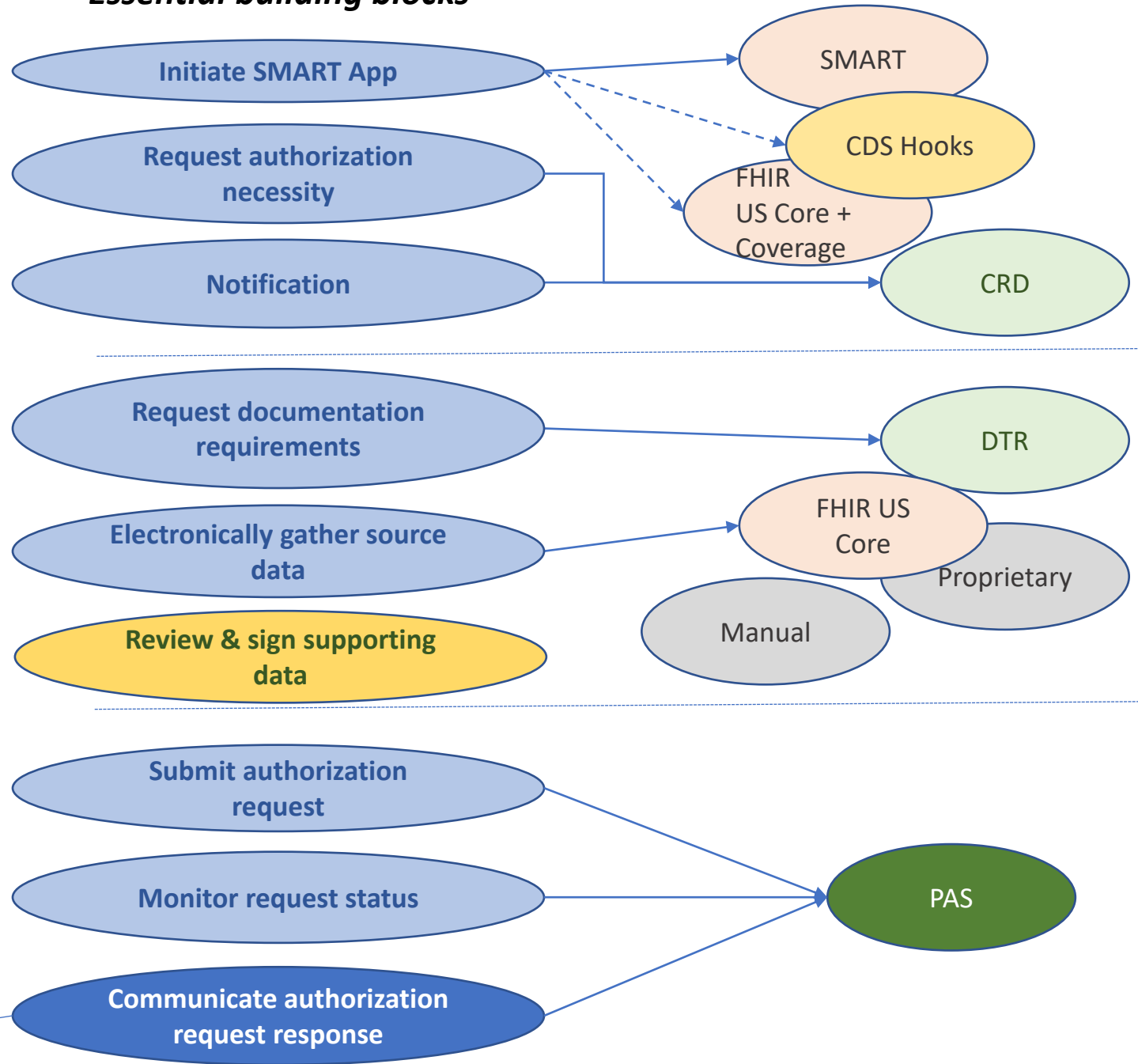| Capability 1 – Identify need for authorization |
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| Capability 9 – Communicate authorization disposition |

Essential building blocks

- Initiate SMART App
- Request authorization necessity
- Notification
- Request documentation requirements
- Electronically gather source data
- Review & sign supporting data
- Submit authorization request
- Monitor request status
- Communicate authorization request response

SMART

CDS Hooks

FHIR US Core + Coverage

CRD

DTR

FHIR US Core

Proprietary

Manual

PAS

1

Potential gaps for EHR/Sched/HIM

1.Updated DTR and PAS IG are going through ballot that indicate upon a status of Pending, there is a need for additional information effectively re-invokes DTR-based data gathering.

Considerations

- Current Da Vinci IGs are not sufficiently granular to enable certification criteria where multiple HIT on the provider side is involved to manage the workflow.

- We have not sufficiently matured these implementation guidance in production across the entire workflow to understand the exact boundaries of the necessary building blocks.

- The building blocks in these slides provide a perspective on what they could look like, but not a consensus based perspective yet.

- The current HL7 ballot cycle provides an opportunity to provide feedback/input on what these building blocks should be, that then can be published and matured as part of the IGs, enabling certification criteria to identify with less ambiguity what is expected.

A potential roadmap __sketch__ to certification

- Consider multiple stages, __e.g.__:
  - Stage 1:
    - Provider: Only establish a functional requirement
    - Payer HIT: Establish standards and certification criteria for payer HIT using CRD, DTR, and PAS
    - Provider HIT: Do not set certification criteria with standards specifications for provider HIT, but with payer APIs in play would effectively be encouraged to use the relevant standard interactions of CRD, DTR, and PAS
  - Stage 2:
    - Provider HIT: Establish certification criteria at the established building block level (not full CRD, DTR, and/or PAS) for provider focused HIT once building blocks have matured (scope and specifications)
    - Provider: Establish functional requirement and use of certified HIT
- Focus on CRD and PAS related capabilities first, followed by DTR
  - In Stage 1 CRD and PAS would be the focus with DTR optional (enabling maturation given DTR complexity)
  - Once DTR has sufficiently matured, introduce that potentially in one stage