The Office of the National Coordinator for Health Information Technology

Da Vinci Use Case Working Session:

Coverage Requirements Discovery (CRD)

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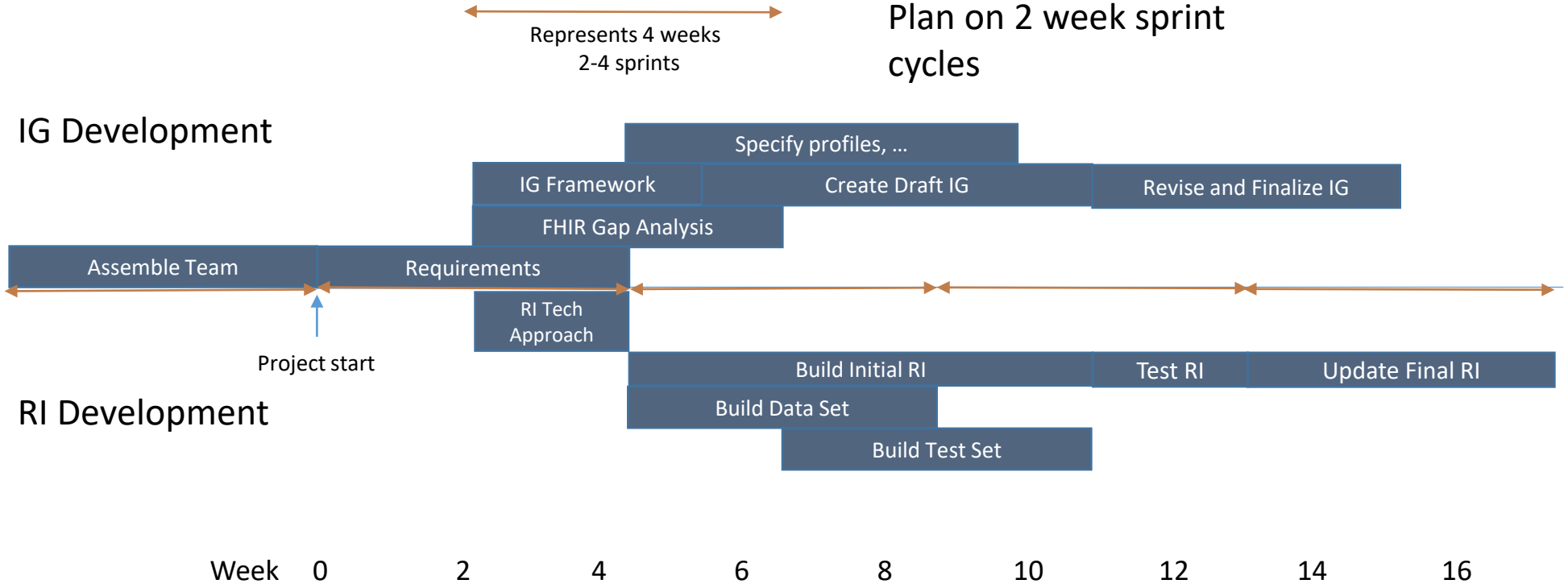
Coverage Requirements Discovery

Use Case Discussion

August 5, 2018

Project Timeline (small fast project)



Coverage Requirements Discovery

Low Complexity

SUMMARY

- Providers need to easily discover which payer covered services or devices have
  - Specific documentation requirements,
  - Rules for determining need for specific treatments/services
  - Requirement for Prior Authorization (PA) or other approvals
  - Specific guidance.
- With a FHIR based API, 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.
- The discovery may be based on
  - Plan conditions only (e.g. no need for PHI)
  - Member identification (PHI) in the event the specific plan is not known at the time of request
- Response may be
  - The answer to the discover request
  - A list of services, templates, documents, rules
  - URI to retrive specific items (e.g. template)

Category	Level of Effort
Effort	Medium
Complexity	Medium
Time to Ref Imp	3-6 mo
Source/HL7 WG	Finance CDS-Hooks
FHIR Fitness	Good
Standards Dev Scope (including IG)	Easy
Implementation Challenges	Medium

Clinical Scenario 1

- Mrs. Jones is a 35 y.o., previously healthy female who is seen by Dr. Good for a new onset headache that began abruptly 2 weeks prior to her visit. They are severe at times, last several hours and have been occurring with increasing frequency. Now they are occurring daily. Her physical including neurologic exam is normal. Dr. Good is concerned about an intracranial process.
- Dr. Good wants to order a head CT to check for any masses, but is unsure whether Mrs. Jones requires insurance authorization or documentation.
- Using an application within his EHR, he sends a CRD request to her insurer. Within a few seconds, the application **informs** Dr. Good that Mrs. Jones does need a prior-authorization form completed along with a copy of the applicable clinical documentation (Progress Note, prior studies, etc.).

Clinical Scenario 2

- Mrs. Smith is an 75 year-old on Medicare FFS with long standing COPD who has had slowly and progressively worsening shortness of breath with activity. In the office her room air saturation after a 5 minute walk is 84%. She has additional evaluation that reveals no new findings. Dr. Good wants to initiate home oxygen therapy for Mrs. Smith.
- Using an application in the EHR, Dr. Good performs a CRD query and is informed that specific testing and documentation is required to substantiate the need for home oxygen therapy
- Dr. Good retrieves the documentation templates which are prepopulated from the EHR and completes any remaining documentation requirements, signs the documentation and includes it in Mrs. Smith's medical record.

Clinical Scenario 3

- Mr. Light is a 45 y.o. generally healthy male who presents for an annual exam. His physical exam is normal. Dr. Good checks a basic metabolic panel and determines that Mr. Light's kidney function is diminished (Creatinine of 2.5) which is new compared to his function one year prior (Creatinine of 1). Dr. Good wants to refer Mr. Light to a nephrologist for further evaluation.
- Using an application in the EHR, Dr. Good performs a CRD query and is informed that he has to fill out a form (which is able to download), complete medication documentation, and submit it for prior-authorization.

Summary of Coverage Discovery

- Providers need to easily discover which payer covered services or devices have
  - Specific documentation requirements,
  - Rules for determining need for specific treatments/services
  - Requirement for Prior Authorization (PA) or other approvals
  - Specific guidance.
- With a FHIR based API, 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.
- The discovery may be based on
  - Plan conditions only (e.g. no need for PHI)
  - Member identification (PHI) in the event the specific plan is not known at the time of request or there is a need to perfect the response based on the the specific patient
- Response may be
  - The answer to the discover request
  - A list of services, templates, documents, rules
  - URI to retrieve specific items (e.g. template)

Actors

- Patient
- Hospital (system) (hospital, or acute care)
- Outpatient care organization
- Physician or registered nurse
- Payer

- Inpatient EHR
- Outpatient EHR
- Payer system

Actors in red will be the focus of this use case

Out of Scope

- Any HIPAA covered ASC X12 transaction
  - Eligibility verification as provided by the ASC X12N 270/271
  - Prior Authorization as provided by the ASC X12N 278
- Interaction with any intermediary (e.g. clearinghouse)
- Asynchronous responses (including batch)
- Pending review responses (?)
- Access to a healthcare directory
  - Determination of the endpoint address
- Authentication and Authorization
- Payer internal operations and decision making process

In Scope

- Discovery of Prior-Authorization (PA), Pre-Claim Review (PCR) requirements
  - Which services/devices require PA/PCR given the patient's insurer / plan
  - Is PA/PCR required for a specific device, service, treatment, referral
- Discovery of available Documentation Templates (DT)
  - Which DTs exist given the patients insurer/plan
  - Which DTs exist to assist in documenting medical necessity for a specific device, service, treatment, referral
  - Specific format of DTs for the above (printable, fillable, executable)
- Discovery of Rule Sets (RS)
  - Which RSs exist given the patients insurer/plan
  - Which RSs exist to assist in ordering, planning care, documenting medical necessity for a specific device, service, treatment, referral, alerts
  - Specific format of RSs for the above [executable (e.g. CDS-Hooks / Cards), flow-charts, decision tree, etc.)
- Discovery of Guidance Documents (GD)
  - Which GDs exist given the patients insurer/plan
  - Which GDs exist to assist in documenting medical necessity for a specific device, service, treatment, referral
  - Specific format of GDs for the above (CARDS/interactive, PDF/static, other)

Preconditions

- Patient is currently covered by Medicare, Medicaid, or a commercial payer (including as a TPA)
- Patient is being seen by a provider
- Provider is planning on prescribing a medication, therapy, procedure, service, device, or referral
  - Endpoint may vary based on type of benefit
- Provider is interested in determining if payer specific coverage requirements exist
- Provider has information on:
  - Payer covering patient
  - Plan information for the patient (required for non-PHI)
- Provider system supports
  - the CRD FHIR RESTful exchange
  - Discovery of the payer electronic endpoint for this API
  - Ability to authenticate to the payer endpoint if PHI is being exchanged
  - Ability to populate the FHIR request with required information
  - Ability to receive a response and present it appropriately to the provider (post condition)

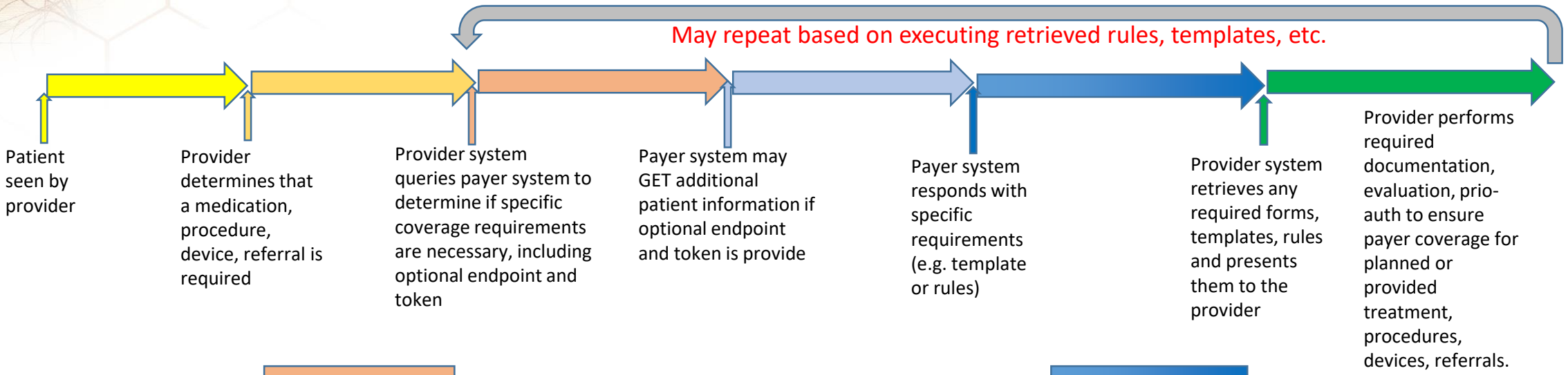
Post Conditions

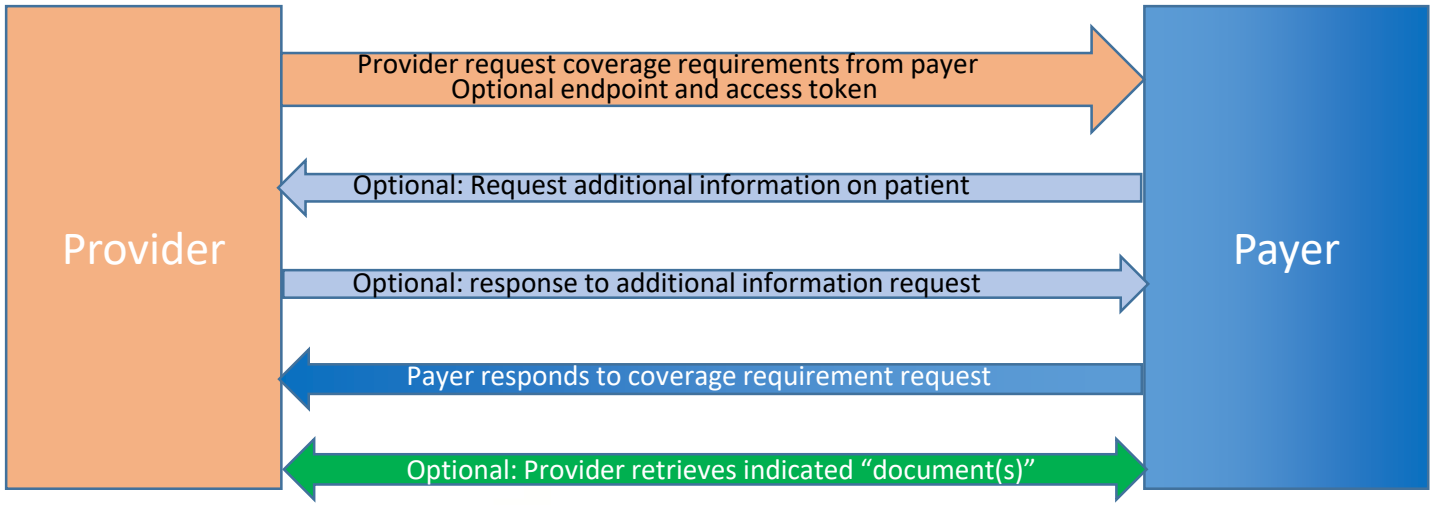
Provider has the information necessary to

- Continue without needing to consider any payer specific requirements
- Understand the need to document specific information to ensure coverage for the therapy, procedure, device, referral
- Understand the requirement to request prior-authorization for the specific therapy, procedure, device or referral
- Download executable documentation templates and/or executable rules to guide the documentation or decision making based on specific payer requirements for coverage.

Workflow

Note: May need workflow that is not point of service -- e.g. on scheduling, referral
Add scenarios to describe alternative workflows





Token lifetime – until response or short period of time

Two “Versions”

- No PHI version – may be used by Medicare FFS, Medicaid programs and some Commercial payers
- PHI version – may be used when the payer :
  - needs Patient Demographics to determine/confirm which product is covering the patient and use information to refine the response
  - Response is considered proprietary and payer needs to verify requester

Note: PHI version will require secure exchange, authentication and authorization

Note: authentication and authorization may be required by commercial payers for all exchanges

Responder Behaviors

- Simple question with qualified response (e.g. list of PA items) – simple look-up for payer
- Complex question with contextual or calculated response – requires complex review based on payer and provider context for the patient – still needs to be real-time
- Qualified response – may require out-of-band interaction (e.g. telephone call to provided number)
- Note: any of the above may include a URI that references the specific template, document, rule set
- Note: may need to defined additional responder behaviors or details

Potential Payer Information Resources

- Potential payer Information resources
- Database of PA, PCR, DT, RS, GD by:
  - Plan
  - Diagnosis
  - Procedure
  - Service
  - Referral
- Specific error conditions for queries with “not available” response
- Contact information for out-of-band communication
- Database items may be accessed directly by specific URI

PA = Prior Authorization
PCR = Pre Claim Review
DT = Documentation Templates
RS = Rule Sets
GD = Guidance Documents

Note: the solution for this use case may be considered a “service” by the FHIR definitions – may be a defined “operation”

Query Information Requirements (includes Cleveland)

Basic Who/Where/When

- Patient demographic information
  - All for PHI version (name, addr, dob, gender, MRN,….)
  - age, gender, state (non-PHI)
  - Diagnoses
- Payer information
  - payer, plan, product, network, group, member ID
- Provider demographic information
  - Provider: NPI, Name, role, specialty,
  - Organization: NPI (if applicable), tax ID, Name
  - Location: State, Name, address, contact information
  - Other: facility type/healthcare service
- Encounter Information
  - Date (date of encounter, date of service)

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What

- Service Information
  - device
  - medication
  - procedure
  - referral
  - notes:
    - HCPCS, ICD-10-CM, SNOMED-CT, RxNorm, CPT, LOINC (codes for computability).
    - if not provided, then what?
    - general categories? (e.g. adv. imaging)
- Request type:
  - prior-auth, pre-claim
  - templates
  - rules
  - documentation/guidance
  - documentation with claim?
  - all

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- Qualifications:
  - Response preference
    - accept only, allow alternative
  - computable only (e.g. CDS-Hooks CARDS)
  - standards specific (e.g. SMART plug-in)
  - other

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- Optional for Payer Query:
  - Endpoint
  - Access Token

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Potential Response Information Requirements

Basic Who/Where/When/What 1

- Patient demographic information (as provided)
- Provider demographic information (as provided)
- Encounter Information (as provided)
- Payer information
  - PHI version
    - payer, plan, product, subscriber ID
  - No PHI version (as provided)
    - payer, plan, product
  - Payer contact information
- Diagnoses / Service Information (as provided)
- Request type: (as requested and/or as available)
- Qualifications: (as requested and/or as available)

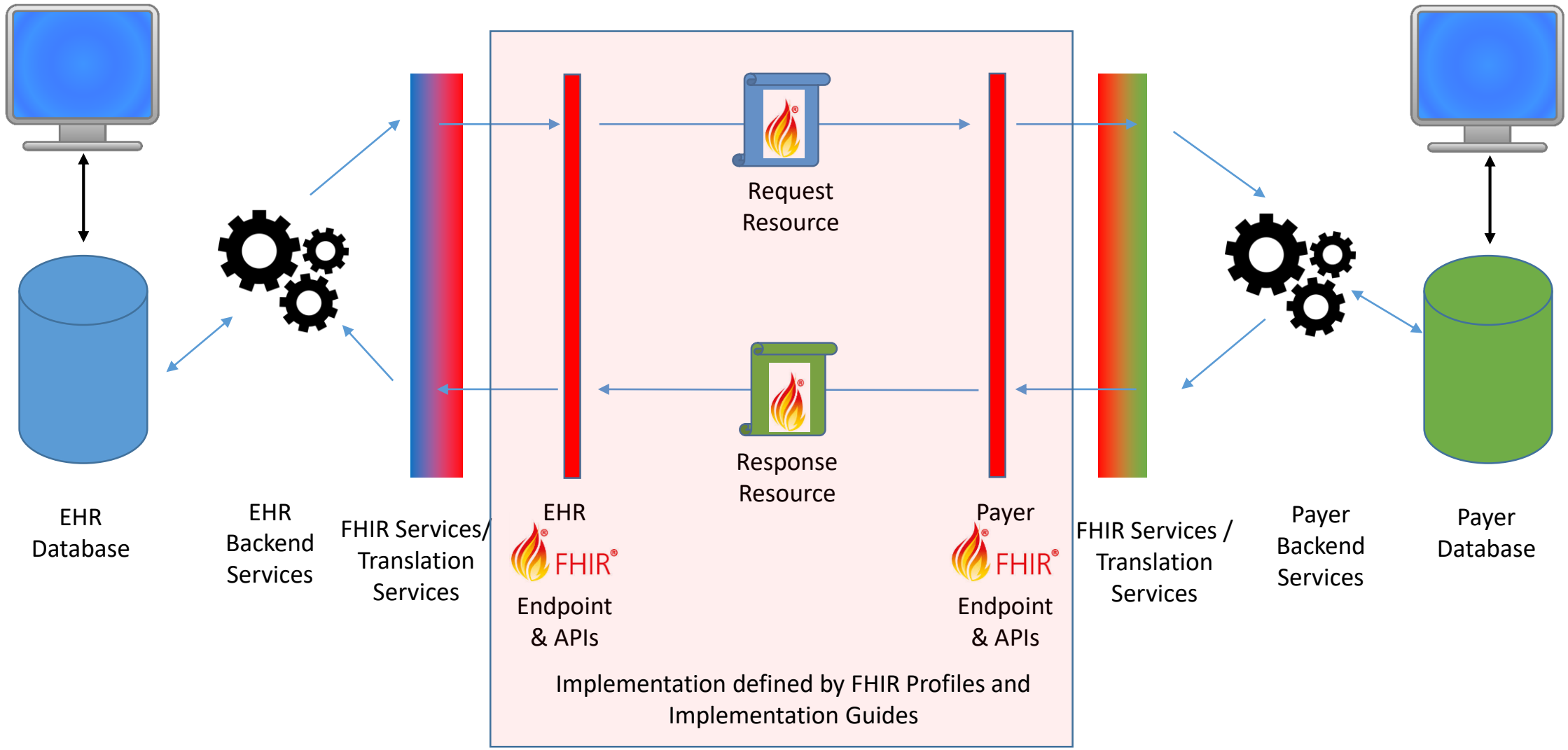
Response to Request (for each request type) 2

- Request type
- Coded response (N/A, INA (Information Not Available, Item(s) returned)
- reference (URI) to requested items (may include list, index, catalog) or resource
  - Include Mime Type
  - Executable Flag?
- Textual response for display
- Direct Address
- Expiration date (valid date range)
- Disclaimer (where is this displayed)

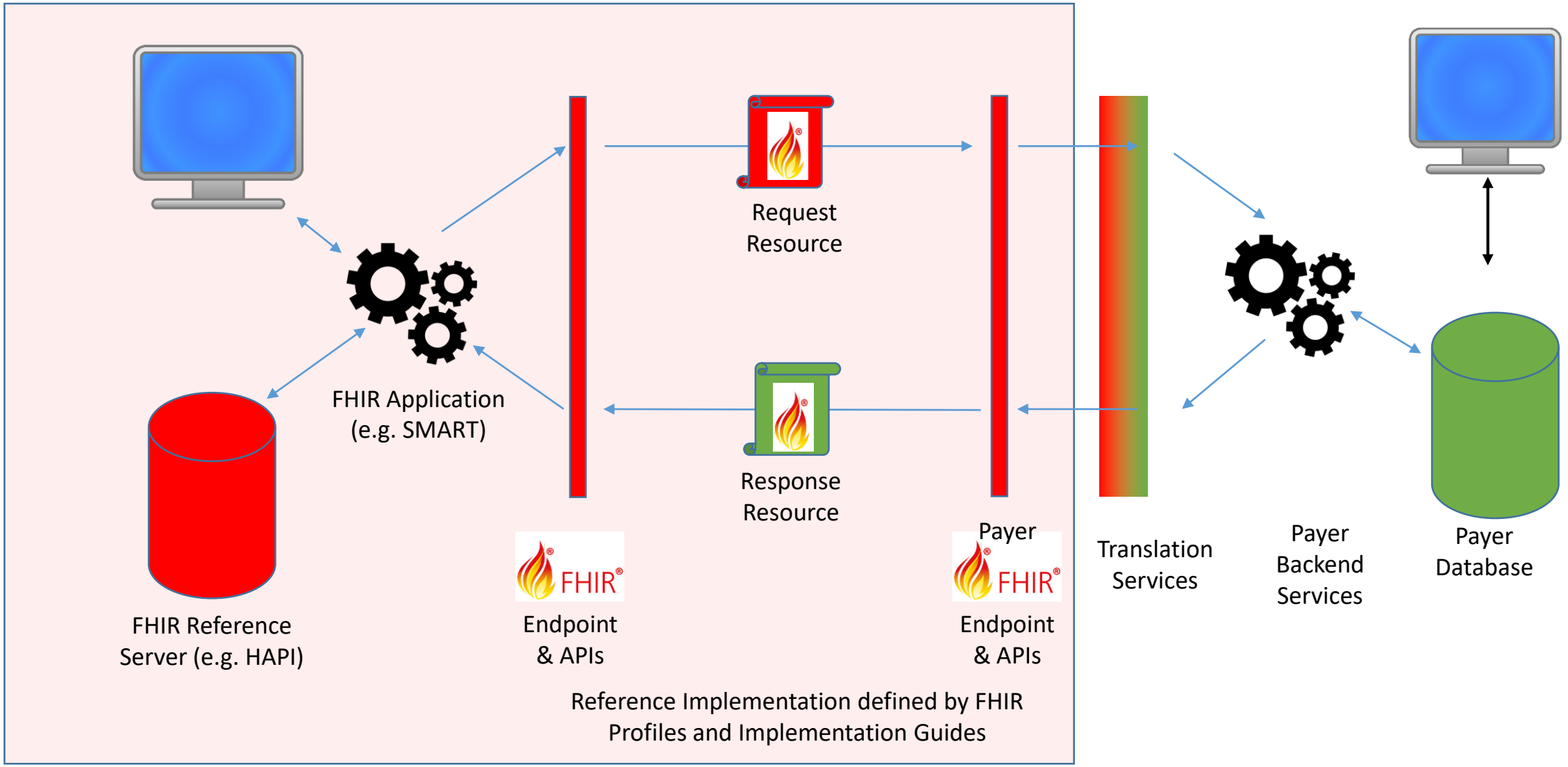
Implementation Notes: 3

- Backbone element for responses
- May need general codes (e.g. advanced imaging, DMEPOS item)

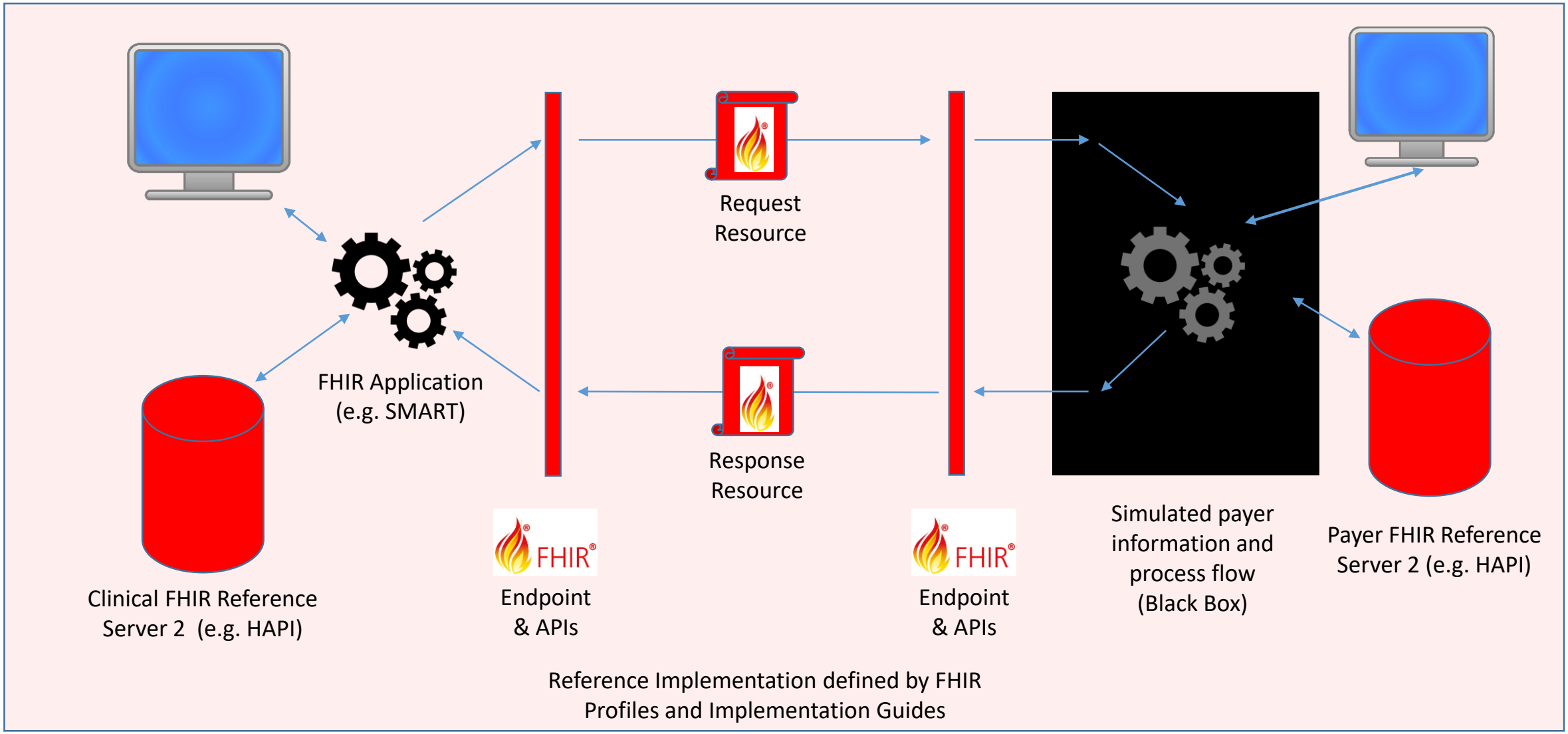
Pilot Implementation Architecture



Reference Implementation (1) Architecture



Reference Implementation (2) Architecture



Pilot Implementation Architecture
Coverage Discovery