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NEWS

THE PROMISE OF **INTEROPERABILITY** THROUGHOUT HEALTHCARE

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Three New Executives to Join HL7 Team

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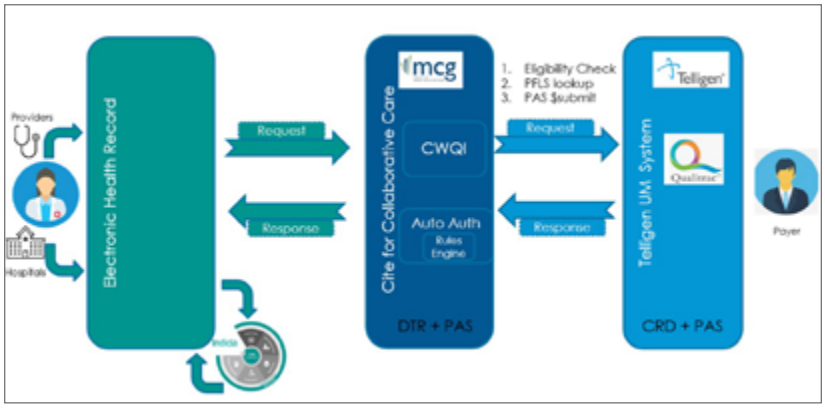
Telligen-MCG Interoperability Project on Prior Authorization

Prior Authorization is a process commonly used by payer organizations to determine medical necessity for services and manage healthcare costs. However, the process of requesting and receiving prior authorizations can be slow and inefficient. Prior authorizations are often solicited by fax or by using payer-specific portals. Fax submission requires manual transcription on the payer side - and may result in significant back-and-forth, requesting additional information prior to a decision being made. Re-keying information in payer-specific portals results in extra work for providers. The HL7 Prior Authorization Support (PAS) Implementation Guide strives to enable direct submission of prior authorization requests from EHR systems using the HL7 Fast Healthcare Interoperability Resources (FHIR®) standard. Direct submission of prior authorization requests from the EHR will reduce costs and burden for both providers and payers. It will also result in faster prior authorization decisions which will lead to improved patient care and experience.

Clients nationwide from state Medicaid programs and private self-insured plans use Telligen's Utilization management (UM) Portal, Qualitrac, to relieve the administrative burden for providers and staff while managing healthcare costs. Telligen is partnered with MCG for integrated clinical criteria and to automate authorization decisions. To reduce burden for providers further, and to take requests directly from Provider's EHR systems, Telligen has partnered with MCG on the Interoperability Project by implementing HL7 Da Vinci PAS implementation guide (see the diagram).

Interoperability Project Description

- Providers will be using MCG's Indicia as their documentation tool for clinical guidelines
- MCG's Collaborative Care will turn the data collected from EHR system, such as patient details, ordering provider details, treating facility details, service request details, patient's coverage details, and patient's clinical data, into HL7 FHIR resources and deliver a PAS FHIR Claim Bundle to Telligen's Qualitrac UM system
- Qualitrac UM system exposes a PAS FHIR API endpoint for incoming prior authorization requests. This endpoint is secured via OAuth2.0 protocol using Okta, a third-party identity provider
- Qualitrac system consumes the incoming PAS FHIR Claim Bundle, validates the FHIR resources, extracts the data, calls Qualitrac internal APIs to create prior authorization request, runs payer-specific rules and determines the outcome
- For the response, the Qualitrac system creates the PAS FHIR ClaimResponse Bundle and sends the same to the client (e.g., MCG). The bundle will contain information about disposition that will provide one of the following outcomes – Pended, Complete-Approved, Denied, Voided, Complete-Rejected
- For error scenarios, the Qualitrac system will return a OperationOutcome FHIR resource which will provide the error details to the client (e.g., MCG)
- Prior authorization involves several types of service requests such as inpatient, ambulatory, medication, durable medical equipment (DME), maternity, neonatal intensive care, orthopedic, pediatric, surgical, gastrointestinal, etc. For this interoperability project, our business



priority was focused more on concurrent and retrospective authorizations for emergent inpatient admissions. In due course, support for other service requests will be added to the Qualitrac PAS FHIR endpoint

Benefits of the Interoperability Project

- For payers, creation of a new channel to submit prior authorization requests directly from the EHR system
- Real-time prior authorization responses back to the Provider so that care can be delivered faster to the patients
- Elimination of multiple payer-specific portals. Providers can just submit prior authorization requests directly from their familiar EHR system, thus reducing burden to the providers

Future Enhancements

- Implement coverage requirement discovery (CRD), and documentation templates and rules (DTR) so that precise clinical data needed for the prior authorization request can be collected directly from the EHR system, thus eliminating the need for faxes or scanned records
- Implement support for revisions and extensions to the prior authorization requests
- Implement payer-initiated workflow so that final disposition can be conveyed back to the clients on prior authorization requests (useful for pended requests)
- Add support for attachments for prior authorization requests

Challenges to Adoption

- Though the HL7 Da Vinci project is trying its best to promote CRD/DTR/PAS implementations, there is still a certain degree of complexity around these specifications, thus hindering the participation from the industry. There should be a concerted effort to reduce complexity
- Some of the clinical workflow related items could be left to the implementers. As an example, for a prior authorization request, the response need not be synchronous. Asynchronous responses should also be supported by PAS implementation guide
- Another added complexity is asking payers to support X12 278 messaging (for HIPAA purposes) in addition to FHIR based exchange, which could be made optional for more adoption by the industry

Conclusion

Clinicians would be able to make more informed decisions and reduce workload (for providers and patients) if they had appropriate and timely information from payers at the time of decision making. Does this item or service require Prior authorization/additional documentation? Is this item or service covered? The Da Vinci Project thus aims to address the following important points for prior authorization:

- Reduce provider burden by eliminating faxing and numerous payer-specific portals
- Reduce improper payments and appeals
- Improve provider-to-payer information exchange
- Most importantly improve patient outcomes

Early adopters, like Telligen and MCG, are combining their efforts to understand and implement the Da Vinci implementation guides for Burden Reduction (CRD/DTR/PAS) and bring the lessons learned back to the provider-payer community, thus promoting interoperability across various care settings. ■

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