Health Information Technology Advisory Committee

The Office of the National Coordinator for Health Information Technology

Transcript

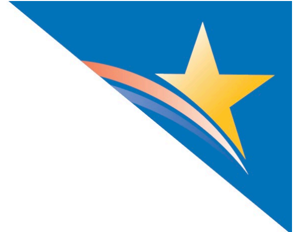
HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) e-PRIOR AUTHORIZATION REQUEST FOR INFORMATION TASK FORCE 2022

February 3, 2022, 10:00 a.m. – 11:30 a.m. ET

VIRTUAL

Speakers

Name	Organization	Role
Tammy Banks	**Individual**	**Co-Chair**
Sheryl Turney	**Anthem, Inc.**	**Co-Chair**
Hans Buitendijk	Cerner	Member
Rajesh Godavarthi	MCG Health, part of the Hearst Health network	Member
Jim Jirjis	HCA Healthcare	Member
Rich Landen	Individual/NCVHS	Member
Heather McComas	AMA	Member
Aaron Miri	Baptist Health	Member
Patrick Murta	Humana	Member
Eliel Oliveira	Dell Medical School, University of Texas at Austin	Member
Michelle Schreiber	Centers for Medicare and Medicaid Services	Member
Alexis Snyder	Individual	Member
Debra Strickland	Conduent/NCVHS	Member
Michael Berry	Office of the National Coordinator for Health Information Technology	Designated Federal Officer
Michael Wittie	Office of the National Coordinator for Health Information Technology	ONC Staff Lead
Alex Baker	Office of the National Coordinator for Health Information Technology	ONC Staff Lead



Call to Order/Roll Call (00:00:00)

Michael Berry
And, good morning, everyone, and thank you for joining the Electronic Prior Authorization RFI Task force. I am Mike Berry with ONC, and we are always happy that you could be with us. I just want to remind everybody your feedback is always welcome, which can be typed in the chat feature to everyone throughout the meeting, or it can be made verbally during the public comment period that is scheduled at about 11:20 Eastern Time this morning. So, let's begin roll call of our task force members. So, when I call your name, please indicate that you are present. Let's start with our cochairs. Sheryl Turney?

Sheryl Turney
Good morning.

Michael Berry
Tammy Banks?

Tammy Banks
Present.

Michael Berry
Hans Buitendijk?

Hans Buitendijk
Good morning.

Michael Berry
Raj Godavarthi?

Rajesh Godavarthi
Good morning.

Michael Berry
Jim Jirjis?

Jim Jirjis
Present.

Michael Berry
Rich Landen?

Rich Landen
Good morning.

Michael Berry
Heather McComas?

Heather McComas
Good morning.

Michael Berry
Aaron Miri? Patrick Murta?

Patrick Murta
Good morning.

Michael Berry
Eliel Oliveira? Michelle Schreiber? And, Debra Strickland? All right, thank you, everyone, and now, please join me in welcoming Sheryl and Tammy for their opening remarks.

Welcome Remarks, Review of Plan (00:01:23)

Sheryl Turney
Thank you so much. I wanted to first welcome Patrick. He has joined our task force since we last met, so, very happy to have you on board, and we also lost a member, Alexis Snyder, who was unable to work with us, so I do want to make note of that. I also want to thank everyone for going out and doing their homework. We got a lot of comments in our Google doc, so, thank you very much for that. We are going to have a robust discussion today, and I think we are going to have a lot of information that we are going to be able to discuss and share. We are going to talk a little bit today related to how we want to move forward and where we are in our timeline, so I am looking forward to that. Also, I wanted to say that we had discussed last meeting having a speaker come in from HL7 to provide a quick overview of the three Da Vinci implementation guides that are mentioned in the rule, and we do have someone coming in. He was not able to come today, but he will be coming to our next meeting next Thursday, so please look forward to that, Viet Nguyen, who is very active in Da Vinci and will make that presentation.

Also, the RFI mentions the C-CDA. Some of us, including myself, are not deep experts in the C-CDA, so if that is something that you are intimately familiar with as we get to the RFI and those discussions, we really would be happy to have people step up and provide additional technical background and/or overview of the C-CDA as we are discussing those questions that come up in the RFI. And, I am looking forward to the discussion today, and I will turn it over to Tammy.

Tammy Banks
All right. Are we ready to get into the discussion? I could not see the slides go, so I was not sure where we were at.

Sheryl Turney
This is the agenda. I will be happy to go over it, Tammy.

Tammy Banks
Either way. Whatever you want.

Sheryl Turney

Go ahead, and Tammy is going to lead the discussion today from the document. Go ahead.

Tammy Banks
We are just excited to get into the meat, right, Sheryl?

Sheryl Turney
Absolutely.

Review Comments from Working Document (00:04:20)

Tammy Banks
Okay. So, we are going to review the comments from the working document, and then we are going to move on into Section 1 and look at the three different questions in that area. We will have public comment, and then get to the homework and next steps. If you do not mind, Sheryl, I will take some of the homework and the RFI discussion as well, and we hope to jam-pack, again, a lot in this hour and a half because we do have a shortened timeframe, so we can move on to the next slide.

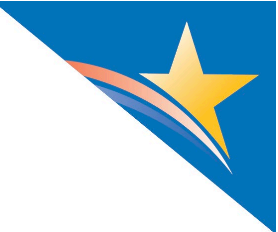
So, today, again, we are going to basically get into the major first discussion and get into the first few questions and discuss the report structure. Let me go on. All right. So, if I can switch over to my screen here.

Sheryl Turney
While you are doing that, Tammy, there was a note in the chat which I do think merits a conversation. So, as we are talking about attachments as well, if any of the panelists are knowledgeable in the attachment standards, I know that CAQH COREO had developed attachment standards that never got implemented as a final rule. That would probably merit some conversation as well. So, go ahead.

Tammy Banks
Perfect. So, the goals of our discussion today as we are going to review the additions to the functional capabilities during the last meeting and through the homework. I did not go through the transcripts, I did go through the comments, so, please, if I missed anything, let's get them captured and make sure we have consensus on those. Then, we are going to continue through the other two questions in Topic 1, focused on certified health IT functionality. We are going to assign RFI question areas just so we make sure that we have strong focus on each of these questions based on the strength of our workgroup members, and then, as Sheryl mentioned, identify or agree on subject matter experts and what information we are going to need to fill in the gaps through the rest of the questions as we go through this material.

So, the first question we were focusing on was the functional capabilities for the certified health IT modules, and capturing your information, these are the caveats, or things that we really need to think about, or include comments, recommended that these be included in the report, so I am going to go through them, and if anybody has any disagreement with any of these or wishes to embellish on them, again, we do not have to wordsmith, this is just the content at this point. Then, we at least can get consensus on what the points were and comments at the last meeting.

So, all PA requests should be triggered at the physician or designated healthcare provider discretion. Provider authorization responses must be for a patient-specific coverage benefit based on their plan



coverage. Payers are encouraged to routinely evaluate prior authorization submissions and/or rules that are typically approved and consider implementing a trust-and-verify framework, and there was a comment which elaborated on this a little bit more, which would be an example of gold carding, and Texas State has a requirement to offer gold carding programs.

PA-functional capabilities may occur in different systems, such as EMR, PMS, or the revenue cycle management system, smart app, and prior auth is not always an interaction between payer and provider. The care provider setting has option to choose preferred systems, internal/external app, etc. based on preferred workflow, remain cognizant of the impact on the workflow and if removing or adding burden to the process. Care provider and payer settings will be able to routinely and compliantly request and respond to PA requests timely if there is accurate actionable information within their workflows to drive the use.

Privacy and security of the data should be considered in EHR development along with the functional capabilities. Need to think through the patient involvement in all these data flows, how to keep the patient informed if he/she requests while not overwhelming with detail, and how to represent messaging to patients in plain language, not EDI code, and need to build into the provider workflow, which sometimes may be real-time in the patient and sometimes back-of-the-office staff work. Now, is there anything that I missed from the conversation last week or anything that someone does not necessarily agree with these caveats to the functional capabilities of the PA workflow? Rich?

Rich Landen

The comment is reacting to these. I do not have any comments about missing anything. But, two questions. One is we allude to, but do not specifically mention non-providers initiating electronic prior authorization. I think we had an example last call of the ME. The question is do we need to be a little bit more specific about other than providers initiating the ePA and how that would fit into the process? And then, the second concern is really a question. We talk about a physician or designated healthcare provider. Would there be any situations, any circumstances in which the patient himself or herself would initiate a prior auth request? I am not familiar with any, but it is a big, wide world out there. So, if anybody knows the answer to that.

Jim Jirjis

It depends on what you mean. This is Jim Jirjis, just to opine here. Medical services that have to be ordered by a credentialed, appropriate provider is what we are talking about here, right? So, the two circumstances that you are talking about are, by “provider,” we may mean their designated staff, and I think that is what you are trying to say by “designated health professional,” right?

Tammy Banks

Is that better, changing “provider” to “professional”? Would that be the terminology?

Jim Jirjis

It is technically correct, but “professional…”

Tammy Banks

“Staff”?

Jim Jirjis

Yeah, I would say "staff." I would be more explicit because that is the burden.

Rich Landen
Yeah, I just tend to think of that terminology as "vendor."

Jim Jirjis
Staff discretion you view as vendor?

Rich Landen
No, no, DME would be vendor rather than staff.

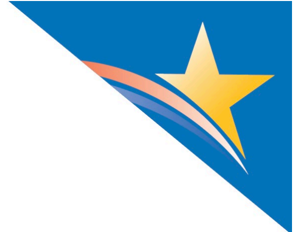
Jim Jirjis
True, but DME is not ordered by DME suppliers, right? They are ordered by healthcare professionals who are licensed to do so, and it is adjudicated by their staff that may act as an extension of that. Is that right? That is how I think of it.

Rich Landen
Okay, that is helpful. I agree it must be ordered by a healthcare professional, but isn't the actual prior auth request initiated by the DME vendor pursuant to the professional's order? I guess I am getting more into workflow there.

Sheryl Turney
Yeah, and I think the use case in one of the implementation guides is actually a DME vendor, Rich, so that is good to call out. I think that one was for oxygen, but the same scenario could be said for a wheelchair. It is going to be the wheelchair vendor that basically submits the prior auth requests based on a doctor's order that the wheelchair is needed, and then, whatever special requirements, because that is the one we used in our intersection of clinical and administrative data. When you need either special attachments or capabilities on the wheelchair, those are the things also that would have to be substantiated.

Tammy Banks
Just to put the genesis of this statement, I think the context when it was said was that the vendor cannot automatically submit PA request just because a CPT code was entered, that the physician or designated healthcare staff has to see it and actually submit it, so I think that was the context, so we are going to have to add the other use cases to it to make it a more robust response. Is that where we are going, Jim?

Jim Jirjis
I completely agree, and to me, let's think of future use cases. So, there are two situations here. There is the initial prior auth for DME, and in the future, that will obviously come from the doctor/patient encounter, etc., but in the future, when it comes time to renew it, then I could see services like apps that are developed as intermediaries, that part of the value they provide is anticipating when authorizations are going to expire and new ones are needed, so the reupping of an authorization may be initiated by third-party intermediaries, and then responded to, and obviously, you need the provider's order in the end to renew it, but the trigger piece was the word I have. It may not be triggered by the provider. It may be triggered by a new set of apps out there that are keeping track of making sure things do not lapse, and maybe communicating to patients



or to providers that "Hey, in four weeks, it is going to expire." That renewal might be triggered by someone different in the initial.

Hans Buitendijk

That could be triggered either by an individual like a physician/clinician/authorized to do that, but it could also be triggered as we progress in the level of automation and learning that policies are agreed to and established, therefore effectively representing the clinician's best practices and otherwise that that can be the trigger to.

Jim Jirjis

I agree, and somebody asked the question about patients. This is a great example in the DME space where we heard testimony after testimony in the ICAD Task force of frustrated parents and patients whose child had specific DME needs, and the amount of time it took if it lapsed, then they were in a pickle. And so, patient access and empowering the patient to maybe even initiate a renewal, I think, are the examples of where the patient would be involved. I think we all think of prior auth medical services as "Hey, you need the colonoscopy," and that is really between the provider and the payer, but when it comes to DME and quality of life, the patient being able to initiate/communicate…

Sheryl Turney

Right, and a prescription would be similar to that too, Jim, where they need the renewal, and another prior auth has to happen the following year, so, in that case, the patient could easily initiate the request that would then go to the doctor for the substantiation.

Jim Jirjis

[Inaudible – crosstalk] [00:16:14]

Sheryl Turney

So, I think those are two scenarios, and the DME is more complex because it might require multiple inputs from multiple healthcare professionals, but yeah, they definitely would be needed. We do need to reimagine the future. Today, it is limited because there are no apps that would allow for that communication to go across, but in the future, that will not be the case. I do see a hand up, too. Heather, do you want to…?

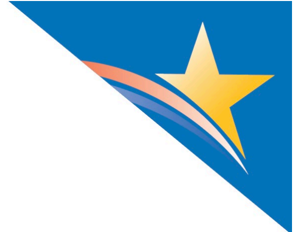
Heather McComas

Yeah, sure, and actually, Sheryl, just picking up your thread, you mentioned prescription drugs, and I was wondering if the task force members thought it was important for us to recognize the situation with prescription drugs. The RFI actually mentions the beginning, that there is the optional capability right now to support the NCPDP script ePA transactions, but it is an optional functionality, not required, and so, we are not really doing anything about certification for prescription drug electronic prior authorization in this conversation, so I wondered if we felt like we should comment on that, if that should say something about the prescription drug ePA being a required part of certification, and welcome others' thoughts on that.

Tammy Banks

So, Heather, where would you put that in the statement?

Sheryl Turney



It would be part of the capabilities.

Tammy Banks
Oh yeah, we will get there.

Sheryl Turney
We would have to include that as part of the functions and capabilities that we wanted to cover for prescription drugs, and we mentioned that in ICAD as well, especially when it relates to prior authorizations that would go from one payer to another. So, you go in November, you get your prior auth for your drug, and then you move to another payer in January, and that prior auth should go with you, so you do not have to go through that again. I do see some additional hands up. The next one that I saw was Patrick Murta.

Patrick Murta
Sure, thank you. I am not sure this applies directly here, but going in to say all medical prescription payer requests should be triggered, I totally agree with that, but there is a step before that in determining if PA is even required, so going directly to PA is quite an expensive transaction. I do not mean in dollars, but it is fairly heavy as it relates to 270 or other transactions, so a lot of work that we are doing from an industry perspective is determining with a lighter-weight transaction if there are even PA requirements for this particular medical procedure. So, calling out the fact that a lighter-weight transaction will eliminate a large percentage of expensive true PA interactions.

Tammy Banks
Can we hold on one second? We are going to get to the functional capabilities. This needs to be reworded. Is all the content in this bullet that should be there? And then, we will bring it back and wordsmith it at a later date, but is the intent there?

Sheryl Turney
And, we do have two more hands up.

Tammy Banks
Yeah, if it is on this topic, so we can move on and actually get to the functional capabilities. Jim?

Jim Jirjis
Am I next? My hand is up. I cannot see who else's hand is up.

Tammy Banks
Oh, Hans.

Hans Buitendijk
I thought it was Jim in front of me. I am trying to find my hand.

Tammy Banks
Jim, you are first, because it goes in order on my screen. Sorry, Hans.

Jim Jirjis

One thing I might consider, if I understand this list, is the goal in automating is to reduce the human effort, improve timeliness, etc., and improve transparency, right? But, I wonder if there are caveats in there. There is some performance in there, and one of our goals is to minimize the number of inappropriate PAs, like for example, the payer's job is to make sure healthcare costs do not get out of control. The provider's and the patient's job is to make sure they get the care they need. So, a prior auth process ought to include a balancing of reducing unnecessary applications for PA when they are not needed, the length of time to getting approval so it does not interfere with patient care, and some metric around performance. What are our goals? It is not just to automate, but it is to minimize the unnecessary effort and optimize the rapidity of approvals. I just wonder if we ought to recommend that design be oriented around those goals.

Tammy Banks
So, Jim, you were so good, and I will go through the transcript, but is there anything that you would add in this edition?

Jim Jirjis
"Prior auth process eliminates burden, looks at performance goals… Eliminates burden, meets performance goals to optimize **[inaudible] [00:21:17]** redundancies and unnecessary effort." I leave it broad because that I might have done a big process, only to find out it was not needed. I think you captured it there.

Patrick Murta
Jim, that is what I was trying to get to as well. Do not do it if you do not have to.

Jim Jirjis
Yeah, and if you do it, let's not have four weeks that it takes. The other thing I was going to add is one thing we are going to need to be careful of. We are focusing as if all of these are brand-new prior auths, right? And so, I wonder if we need to be more deliberate about the renewal, like we mentioned, but also the appeal process. So, in the event that all this works, and there is a denial, and there is an attempt to appeal, that appeal process is fairly opaque now, laborious, manual, or not automated. So, my recommendation to the group is that we are clear as we go forward in the next few weeks around making sure we are thinking of the initial prior auth, the renewal, and how we deal with appeals, because that is where all the effort and cost are. Each of those are buckets that are pretty big and may have different and subtle requirements.

Tammy Banks
Okay. Hans?

Hans Buitendijk
Yes, a question that I had that was triggered by a comment by Heather and inclusion of prescriptions. I completely agree that prior auth applies to prescriptions as well, but is that in scope of the RFI? Because there is the main conversation around either Da Vinci or X12, but there is already a flow for prescriptions with NCPDP out there. I just want to make sure. Is it in scope for this RFI, or is it out of scope, that this only looks at everything but prescriptions, given the current state of capabilities? I am okay wither way, but it will influence how comments are going to be made.

Heather McComas

Hey, Hans, it is Heather. I will jump in. I agree with you. The bulk of the questions in the RFI are obviously about medical services, and I would not expect that we would spend a lot of time on it, but given the fact that the script ePA transactions are optional right now, for certification purposes, it seems to me that it might make sense to comment on that if we are talking about requiring these other standards for medical services as part of certification. It seems like we want to comment on the fact that the prescription drug transactions are optional right now. That is my thought.

Hans Buitendijk
That probably makes a lot of sense to acknowledge that, indicate that there might be value there as well. We probably do not want to have a lot of comments or statements made to recognize it. There are already standards out there or whatever it might be, and we are not trying to comment on that, but we are really focusing on this particular area where there are fewer standards or different issues that we are trying to resolve. Thank you.

Tammy Banks
On that comment, could we focus on the medical services for today and put that on the additional consideration list? After we go through these functional capabilities, we will go back and have the conversation on two other points that were brought up yesterday and the pharmacy question today, the single versus bulk, the concurrent care authorizations, and the pharmacy services. Would that be acceptable to everybody, just so we can move forward, recognizing we are going to come back and adjust based on those other focuses?

Unknown Speaker
Agreed.

Tammy Banks
Okay. Anybody have anything else that I missed? Again, we can add. I just want to get agreement that these were in agreement with those so that we do not have to keep coming back to these comments because they are very important. Jim?

Jim Jirjis
One thing to consider, too, while we are focused on this is one of the use cases in our environment: During ICAD, when I assembled all our people who do this and got feedback about what the pain points were, there was one that I would like to explain, and you guys can decide if there is a bullet in there. It is about the coordination of multiple different business entity providers, for example, around a surgery. So, often, there is a time period in a scheduled appointment, but there may be anesthesia, there may be two different surgeons, there is a variety of different orchestrated approvals that occur as part of a package, and one thing I might say is the design should help improve transparency and performance.

What we heard is 80% of the prior auths would be done in the timeframe, but one was not, and then they had to start the whole process over because the one piece was not done and the timeline expired for the prior auth. So, I think a bullet about making sure coordinating for complex medical services and devices where multiple prior auths are required for that service, that this system needs to provide transparency and efficiency and minimize the unfortunate effects of the complexities and multiple prior auths for a single procedure, but you can make that more succinct, I am sure.

Tammy Banks
Can you help me just a little bit?

Heather McComas
What do we think about the word “bundle,” like bundling for an episode of care prior authorizations surgery and all the related services?

Tammy Banks
Yeah, corners of care per episode, right? Well, it is not even an episode, it could be bigger than that. “Episode of care…”

Jim Jirjis
Or medical service. I think this surgery with multiple different surgeons and anesthesiologists, etc., is a great example because I love the idea of bundling, but let’s add to the bundle. We are not just talking about a surgeon who has a bundle of CPT codes that make up a procedure and that bundle needs prior auth, we are also talking about the anesthesiologist and others that need prior auth, and I just want to make sure the bundle does not imply that it is just one provider who has a bundle of services because it may be multiple provider entities for a single service. The insurance companies do not view it as a single service. They are looking at the atoms, and it is a molecule.

Patrick Murta
It is actually authorization for an entire agreed-upon protocol.

Jim Jirjis
Yeah, there you go. Are there protocols for each of these, or is it just that the anesthesiologist needs to have prior auth?

Patrick Murta
Well, some of these do. If there is a protocol for a certain condition where you have a surgeon and whatever, then you can improve the entire protocol.

Jim Jirjis
I agree, I think we should plan for protocol, but also, there may be complexities I just described that do not have a protocol.

Patrick Murta
True.

Jim Jirjis
I think you nailed it. You are exactly right. Those protocols are complex. There are also complexities that do not have a protocol.

Tammy Banks
Is this close to getting the content, recognizing that we will wordsmith at another time?

Jim Jirjis

I would say coordination of care for a single medical service that actually consists of multiple providers and services that need prior auth. Are we getting closer? I would say single "medical" service because the payers do not view this as a single service, they view it as a set of atoms, and the providers are the ones that view it as a molecule that is a single service, such as "You are going to have this surgery." But, from a payer perspective, it is a micro set of individual prior auths, and there is no orchestration, and I am hoping these FHIR APIs on standardized data sets will enable companies to develop apps that do the kind of coordination we are talking about to improve efficiencies, reduce patient delays, etc.

Tammy Banks

That is a good point, and you have different physicians and staff doing different PAs for the same patient.

Sheryl Turney

And, that coordination is going to have to happen for advanced BOB also, so it just seems as though it makes sense to put it in here because in the end, when they get the approved prior authorization, the patient is going to want to know what it is going to cost them, and so, putting those bundled services together makes sense. I think Rich has had his hand up for quite a while, so why don't we move off wordsmithing this and capture Rich, and then we can move forward?

Rich Landen

Thanks, Sheryl. On this point we were just talking about, the comprehensive episode of care, and the previous point about streamlining renewals and appeals, it occurs to me that not initially, but before we finalize, we will want to step back and ask if adding these additional requirements expand the scope so much that it may not be feasible to implement, meaning that if we go back to the renewals, that is pretty straightforward in the normal workstreams, both provider and payer, but the appeals process, at least on the payer's part, is manual, and if we add that to the initial implementation, it makes it a heavier lift. Similarly, if we try and solve for the complex plan of care, that adds a lot, and it may jeopardize our chance of success. So, I am not at all advocating that we take these things out because they are clearly important, but I am suggesting later on, when we have a better picture, we go back and say maybe let's concentrate on the simpler stuff first, and then, as soon as we get success on the simpler stuff, let's add in the complexity of the appeals or the complex approvals.

Sheryl Turney

Great. And, that goes along with what we said in ICAD, which is to build a foundation and then allow for maturity and expansion, and that is exactly what you are suggesting.

Jim Jirjis

Can I comment on that?

Tammy Banks

Yes.

Rich Landen

But, I am also stating very clearly that if we can get them in the first round, that is what we want to do.

Jim Jirjis

I love the idea, because the appeal especially is very complex, but I think the job of this committee to me, in our report and RFI, if we could indicate that of course we would take this in a phased approach, and Phase 1 would include X, but we have to define Phase 1 to make sure that companies that have access to the data can do the complex services, and then we might say in Phase 2, once this is in place, we also need to evaluate the appeals process.

So, for example, I do not think we should take out the complex case because I do not think it adds to our complexity. It just makes sure that the rules are right. For example, I was going to jokingly say the Hans/Jim Jirjis future company that adjudicates prior auth for the low, low price… They need to be able to query on the patient's behalf. They need access to all the different providers, right? So, it does not mean necessarily that there is a lot of significant work for the rule and for our comments, but the design has to make sure that app developers, on behalf of patients, payers, or providers, actually have access to the full set of providers that they are going to be contributing to that medical surgery procedure. And so, it is a good set of principles so that when we are answering the RFI and what the ONC focuses on, we make sure that it gives access to the full picture, for example.

Tammy Banks

Jim, perfect comments and perfect segue. Before we move on to your comment, is there anybody who disagrees with anything that we have talked about this morning, and can we move on, keeping those caveats in mind? Seeing no hands, for this next section, I think we need to keep Jim's comments in mind. We are looking at what is the prior authorization, functional capabilities that are needed. Regardless of vendor, regardless of who is doing it, what are those functional capabilities needed? While we are looking at the minimum, we are also going to be looking at how to lead those innovators to that fully utopian workflow that we are talking about in those last two bullets, so let's focus on the basic and then move to the more innovative functional capabilities, but before we get adding, let's go through what we talked about last week and make sure we get agreement with the changes because some of them I made based on verbal comments, and I want to make sure that I have included and we are in agreement with these changes.

So, the first change is "added for a specific patient based on comments." Does anyone disagree or prefer a different terminology? Okay, the second is "added capture required information for and submit a query," and then, "added in real-time specific rules and documentation requirements for a patient-specific coverage benefit," and I use that language because that is what ICAD used, and I know it was also mentioned yesterday, "include detailed description of the predefined rules that must be satisfied for a particular PA, request to be approved, including the data the payer requires for approval to be granted." Would anybody change, agree, or disagree with this? Hans?

Hans Buitendijk

I have a question there, more on the first addition than the second part of it, "detailed description of the predefined rules." It is "captured required information for and submit." To me, I am not sure whether that clarifies it or, at least for me, starts to create confusion with No. 3. I think the intent here is that we obtain from the payer the information on what is needed to support and submit authorization, and that does not jump out as clearly from the addition that without it, it was clear, but including it made it fuzzier.

Tammy Banks
So, should it be stricken? This should be gone?

Hans Buitendijk
From my perspective, I think it was clear enough, but whomever introduced it felt it was not. I understand the direction, but it did not jump out as clearly as I had it before.

Sheryl Turney
But, there is a differentiation, though. What we are talking about here is capturing enough information to get the coverage rules. The third one is capturing the information the rule requires to submit the electronic prior authorization, so I just want to make that clear, that it was actually looking for two different pieces of information.

Hans Buitendijk
Okay, I understood. Then, maybe there is a way to make that a little… Okay, let me think about that because now, we are getting into wordsmithing. I think we are aligned on the intent.

Sheryl Turney
Well, we tried to separate it out because this was the way it was presented as a sample set from ONC, but they had one identified which would kick off the coverage requirement rule implementation guide, which is the query that goes and says, "What coverages does this patient have?", so then, when it gets it back, what are the documentation requirements to submit a prior auth for this type of service? The coverage is for the patient and the documentation requirements, and then, in No. 3, you collect all the information needed to submit the prior auth. That is how it is set up because it tried to align to the implementation guides, and the Da Vinci process is already set up.

Hans Buitendijk
Understood.

Rich Landen
Like Hans, I have a little bit of fuzziness here. So, the way I am rereading 1, 2, and 3, and like we just discussed on the previous page, the first transactions will be simple. So, No. 1 here, if I am thinking about it correctly, is a very lightweight transaction saying provider, patient, proposed service, is prior auth required? Response is a simple yes or no. If it is a yes, then I think what we are talking about system-wise is the payer system would return to the provider automatically everything we are talking about in No. 2, and then, once the provider receives all the information from the payer about what the requirements are of documentation and so on, then we go to Step 3, and the provider system then completes the package and ships it off to the payer.

Sheryl Turney
So, Tammy, it sounds like we are going to have to wordsmith this to make it clear what the capabilities are and who is the actor in that particular scenario. Heather raised her hand as well, but it does look like we need clarity around that since our own group is having these types of questions. We need to make it more clear.

Tammy Banks

Heather, we will get to you. Is there anybody who would like to take a stab on that and bring that back to the next call?

Hans Buitendijk

I am typing right now something to play with it.

Tammy Banks

Hans is assigned! Yes, I love doing that. Heather?

Heather McComas

I understand the confusion here, and I think there are some good examples of things in the chat. Sometimes, the payer might need to know more than just the patient and the service to tell you if prior auth is needed. It might be a site-of-service thing. I think some examples might be needed to make it more clear. Sometimes, a particular site of service might require prior auths. Sometimes, they might need to know the patient's gender, even, and there are other pieces of information that might be important for whether something requires prior auth, so I think that is what we are trying to get at here, and maybe some examples would help flesh this out a little bit.

Tammy Banks

Yeah, and I think that is where the note came, and Rich, I do not know if that was you, if they are going to require the actual physician name or if they are going to require certain information that may not be known when the prior auth is being sent, they payer needs to be cognizant of what information is actually available at the point in time. Patrick?

Patrick Murta

May I comment, Tammy, on No. 3? It is a very subtle one, but it says "collect clinical and administrative documentation." The ideal state would be that the information we collected automatically, using CQL or something else, is automatically queried from the EHR. Otherwise, you are still imposing a burden on providers or back-office staff to pull PDFs out of the system, and it also would improve efficacy on the payer side because they are requesting exactly what they need in an automated fashion as opposed to a provider henning and pecking through the EHR record.

Tammy Banks

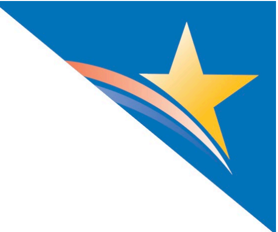
Is this what you wanted, Hans? Is this the change in verbiage that you are looking for?

Hans Buitendijk

On No. 3, automatic collection, I think we need to recognize that some of it will be automatically feasible, and other parts will require user invention because the data is not yet automatically available, so I would be careful to tie No. 3 to fully automated, rather to acknowledge that it needs to be collected, and it could be done automatically.

Sheryl Turney

You could say "automatic collection of clinical and administrative documentation as available," and then, certainly, it is going to be supplemented.



Hans Buitendijk

I would be a little bit careful with that as well because that looks like we are only looking for data that can be automatically done, but where a user needs to gather some information and scan something to become a PDF, whatever, because it is just not in the system or not yet retrievable in that way, you still need to have the ability to “merge” it with the data that is automatically collected so that you still provide the complete set of documentation necessary. We still need to have the full set of documentation submitted with the prior authorization that should not be the separate flow. We just need to acknowledge that on the provider side, not everything is going to be immediately automatically retrievable.

Jim Jirjis

Thank you, can I comment on that point?

Sheryl Turney

We need to speak to it as needs to be available to be combined with other data that is required for the prior authorization that may have to be collected outside of this EHR system. And then, we have a lot of hands up, so this is great.

Hans Buitendijk

Or, even within the EHR system. Do not assume that everything in the EHR system is automatically already retrievable for the purpose of this.

Sheryl Turney

Okay, that is a good point.

Tammy Banks

I am going to say software because this is EMR wherever it is, whoever is doing this capability, and I know it needs to be a different word. Jim, you go first.

Jim Jirjis

Hey, I wanted to comment on this point. I suggest that we change the wording from “we are going to automate this whole thing” to “we are going to use automation where appropriate to improve efficiency.” Let me tell you why I say that. I think Hans is right. I think we are understating the amount of things that cannot be automated from an EMR. There is magical thinking about data, and its readiness, and how it is represented. For example, an echocardiogram may not even be in the procedure section of the chart. It may be in the dictation section. So, though patient date of birth, address, and other things may be automated that nurses or staff are handwriting in forms now, the majority of it is a human being trying to understand that they need the echo, they need this.

So, I think we should just say we are going to utilize automation as a tactic, but really, we are about optimizing efficiency. I also want to point out that a human has to validate that the documents mine from the EMR the right ones for that procedure. That is tough to automate because automation typically works in a set of nonchanging, simple rules, and when there are complexities and differences in EMRs, you are going to need a human.

The other point I wanted to make is the timing point. The reason I keep saying in the messages that we ought to have some sort of recommend metric is that one of the metrics might be reduced denials because you can imagine an automated world where it queries, but accidentally submits a prior auth that gets denied because a procedure report has not yet entered the chart, and once something is denied, it gets pushed and relegated to the appeals process, which is very manual. So, if we talk about the design, automation should be used, but I want to make sure we keep pointing out the human involvement because that is the reality of the workflow because of the variety of the EMR data structures and the timing issue that could inadvertently create more burden by not having the provider or somebody determine when they are going to go ahead and submit the data for prior auth because the chart is complete.

Tammy Banks
Jim, that is a great point. I put that as a note for us to come back after we have the functionality. Raj, we will get to you. You are next. I have a question for you, Jim. Is that a point that we need to make overall? Do we want all these functional capabilities to be as automated as possible, or do you think it is specific for this number or this capability?

Sheryl Turney
Tammy, while he is thinking about it, I think it should be an overall principle that impacts the entire process.

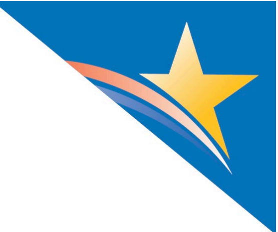
Tammy Banks
Yeah, I agree.

Jim Jirjis
So, what I would say is we want to leverage information systems to optimize the efficiency of this process. One of those is automating pre-populated. That is one tactic. Another tactic is creating a system that allows a human to select documents from the EMR that are appropriate, and another is a system that allows for timing issues to make sure premature submissions do not lead to increases in inappropriate denials. So, the language should be using technology and process to optimize this process, not that we are going to automate the whole thing, because that is really hard.

Sheryl Turney
That is a good point. When you are ready, Tammy, Raj has his hand up.

Tammy Banks
Okay, I will get that rewritten after reviewing the transcripts. Go ahead, Raj.

Rajesh Godavarthi
I absolutely agree with Jim's comment. It is pretty appropriate. My question is that as we go through this exercise of thinking about what is the ideal state, as we think about the long term, looking at all the questions from the RFI, most of the questions refer to where we start. So, as we look at the big picture, this is the best to do it. I am starting to think how far we would think. This is best to capture everything. To Jim's point earlier, we should think to the end state. But, I think this problem is so complex and so big, we can probably spend a lot of time keeping enhanced notetaking, but if you look at all the 20 or 30 questions, most of the questions are like "What is the best place to start given the complexity of this problem?" So, how would we



narrow the scope in our conversations where we can get to that? What is the fine line between these discussions?

Tammy Banks

Exactly, Raj. That was the big question, where we spend our time. And, unless we are in agreement with these functional capabilities, the other conversations are more difficult, so we are trying to get a basic agreement on what the overall functional capabilities are. Then, we can look at what standards are out there that currently provide these functional capabilities and go into those other conversations, but if we do not have this foundation, I think it is going to be harder to get to those questions. So, as we go through these, when you go back and do the homework, keep these in mind as you answer those other types of questions. So, we are not going to be spending three weeks on this, but it is important that today, we really focus and get the majority of what these foundational functional capabilities are, recognizing we can add and subtract as we go through the questions, but we all need to have agreement on what direction we are going. Is that helpful, Raj, and are you in agreement with that, or would you recommend a different approach?

Rajesh Godavarthi

No, it helps. I am just asking this question here.

Tammy Banks

Believe me, I am not good at circling and coming back, so I just want to put this to bed, this is the functional capabilities as best we can at this point in time, and then move on to those other questions, and then we will come back with the knowledge that we gleaned from those conversations.

Rajesh Godavarthi

Smart. Thank you.

Tammy Banks

Hans?

Hans Buitendijk

Just a quick follow-up note on Jim's comment that we are trying to optimize efficiency. I completely agree because of the board of the process, and that can then include, I think, as we describe it, not only the interaction between the system, but also what needs to lead up to it, like there is the need to potentially collect data by a person rather than the system because it is not automatable yet. I think once we get to the certification and capabilities, we have to be very careful as to what makes sense to be subject to certification and that systems need to do the same, like interoperability. Talk the same language, make sure that it is unambiguously clear, versus what the systems themselves do to help enhance it.

I think these have to be considerations, but we have to be very careful that that is largely opportunities and how it fits in that we are less likely to say that this is the way to do it. Therefore, you have seen over the years that certification criteria have been much more drifting toward the interoperability part because that is where we need to be in sync versus the functional capability parts inside the system, because that really depends on what the best way is in context that is very hard, if not impossible, to synchronize and harmonize

to a singular approach. But, just as a notion there, not with the intent overall, that is what we are trying to do, but we do not spend too much time on that when we get the certification and standards.

Tammy Banks

Hans, that is so important. These have to be in the right speak so that they can actually be implemented, and we cannot be verbose, right? So, I totally agree. Jim, can I assign you to take a look at that overall principle for next week, and putting that in the language and tone that you prefer? Because I think you really eloquently said it, and if you just spin on it a little bit, you can come up with something really great. Jim, go for it. You are on mute, by the way, so I know you just said yes. Excellent!

Jim Jirjis

No way! Hell no! Hey, one example. I get it the, RFI is focusing on really remedial, atomic things like data sets, is it C-CDA, FHIR, they are asking us to comment and all that. But, the reason I bring up these examples is not to make it complicated because we are not going to put in the rule the details around the medical service that have 15 doctors that have prior auth, but it may inform whether C-CDA, the push model, versus the restful FHIR model, it may imply if there is an ability to broadcast. Assume, for example, there is an app. How does it know who all the players are? It may color our comments as to which approach is appropriate by understanding some of these complex workflows. Otherwise, we could go down a path that, in the end, does not support the complex workflows.

Tammy Banks

Jim, I saw all these comments as supporting what you were saying in that you are the first iteration that when we come up with the end product, taking into account everything that you have been saying, we need the functional criteria that can be implemented, so I do not think anything was said counter to what you did. Please, keep expressing your comments because this is adding value to where work product is going to be and our principles around this. Raj?

Rajesh Godavarthi

Yeah, exactly. Jim, I really appreciate all your comments, so do not take anything as what I said. I am just trying to understand the scope. But, the comment I wanted to make here, Tammy, is the provider's concern of what the payer is automatically collecting. So, as we talk to providers in implementing this with a couple of customers, we need to know because this is a huge concern for them, how much data is flowing out unknowingly. So, how would we add some language to ensure the provider's discretion or something like that?

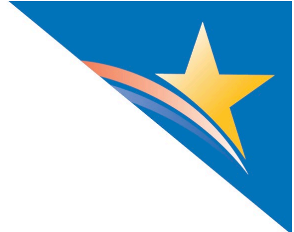
Tammy Banks

Can I ask a favor so that we can move along? Raj, after seeing your presentation, I know you know exactly what type of functional capabilities are needed in order to be successful in this collection arena. Is this anything that you would be willing to take a stab at and bring back next week?

Rajesh Godavarthi

Yeah, sure.

Tammy Banks



Because again, when you are looking at specs, it is a whole different speak with vendors than us trying to make sure that the end capability meets those needs, and so, I think it would be helpful because I think you understand what this is intended to mean, so how do we write it so that a developer understands and can make this happen?

Rajesh Godavarthi
Yeah, please put me in. Thanks.

Tammy Banks
Thank you for that. And, if anybody has any disagreement with these assignments or anything, let me know. I am just trying to move us along forward, and taking advantage of your expertise will just help us get where we need to be a little quicker. Anybody have anything else on 1 to 3, recognizing that Hans is going to work on the language for 2 based on our conversations, Raj is going to work on 3, and Jim is going to work on this overall principle?

Hans Buitendijk
I already put a draft in the chat.

Jim Jirjis
Raj, why don't we work together on that, since it is the same section?

Rajesh Godavarthi
Definitely, Jim.

Tammy Banks
Okay. You guys are testing my abilities here. Okay, that is not you.

Rajesh Godavarthi
If you put this in Google, we can also change these names later as we work together, Tammy. We can help you there.

Tammy Banks
Here it is. You have it.

Hans Buitendijk
Currently, Tammy, Sheryl, we have two Google documents that are running in parallel. If, at the end of the session, we understand which one we can touch, which one we cannot, where we should put our remaining comments in, etc., it would be helpful because we are going to go back and forth, looking back, adding some notes, and going forward.

Tammy Banks
Yeah. What I am going to do is take everything we have done today and drop it in a second column, and then, the comments will come under that document, so we will also preserve every meeting's work product, and the comments will be added based on that conversation. Does that make sense?

Rajesh Godavarthi
Yeah.

Hans Buitendijk
So, that ePA RFI Task force RFI questions worksheet will remain our main focus that we keep on adding onto?

Tammy Banks
Yeah, we will keep adding a column based on the discussion of the call. If I did not capture something appropriately on this call, in the comment, let me know. I will take a look at all your comments, and then incorporate them into the discussion document for the next meeting so that we keep moving forward, and you guys, I am on Pacific time, so I really appreciate everybody's comments, even when they come in the morning, but if there is any way you can do it before the morning of Thursday, that would be great, but it does not matter. We really want your comments.

Hans Buitendijk
So, you added an extra column to the RFI questions worksheet. That is the document in which you are going to do that?

Tammy Banks
Yes. That is the long-winded answer I was trying to say. That is why I do not write functional spec. Okay, back up to this one. And, what I use is a different color for every time we are having a conversation, so, blue is what we talked about yesterday, purple is what was added from you guys' comments during the homework period. So, Hans is suggesting to "capture and submit the necessary information through a query from the provider to the payer to enable the payer to return the documentation necessary to support the prior…"

Hans Buitendijk
That is an incomplete cut-and-paste. Let me try that again.

Tammy Banks
Oh, it could have been me.

Rajesh Godavarthi
Tammy, can we get all these comments to the next round? Because we are working on others too, right? Then we can review all of them together.

Tammy Banks
Yeah, keep answering the other questions because again, we will keep pulling them up, and I am going to assign different areas because Raj, the developer questions make sense for you to really focus in on so that, again, we will have robust comments every time we get to these things.

Rajesh Godavarthi
Okay.

Tammy Banks
So, let me go back to yours, Hans, because maybe I just did not do it right.

Hans Buitendijk
I will put it back in the chat with the full comment on the last one.

Tammy Banks
Yeah, I do not think I have it. Thank you very much. And, I will work on my skills, and we will be going from the Google doc. I am just not really Google-friendly yet. I am working on it.

Sheryl Turney
Your skills are pretty impressive.

Tammy Banks
Aw, bless your heart, Sheryl. Okay, "capture and submit the necessary information through a query from the provider to the payer to enable the payer to return the documentation requirements necessary to support the prior authorization request for the intended service procedure prescription at hand for coverage determination for the specific patient."

Hans Buitendijk
And, that is just for the first sentence, "include," etc.

Tammy Banks
Okay. So, "capture specific…"

Hans Buitendijk
That is the first sentence. The other one as is would work, at least for me.

Tammy Banks
Okay, and then, recognizing that we are going to have that overall document principle from Jim, which would apply to this, which means we want to automate as much of that as possible. Is that where you were intending, Hans, so that automation piece is not in it? Because that applies to all of these functional capabilities.

Hans Buitendijk
Correct. This is the capability, and then, automate as best as we can.

Sheryl Turney
And then, the second sentence starts with "include detailed description of predefined…" Yeah, there you go.

Hans Buitendijk
That would still be there, yeah.

Tammy Banks

Okay. So, I am going to bring this up just because I am a visual person. Does anybody have any comments on this proposal, with the caveat that the overall principle across all of these is going to be to automate all of these functional capabilities to the highest level possible? Rich, sorry.

Rich Landen
Yeah, I am still struggling with why No. 2 should be another query from the provider. Why can that not be an automated response from the payer, assuming all the information we talk about in No. 2 is actually submitted in No. 1?

Tammy Banks
I think where they were going is they do not believe that an automated response can be handled at this point in the game, that there may be some additional information that would be found outside the system?

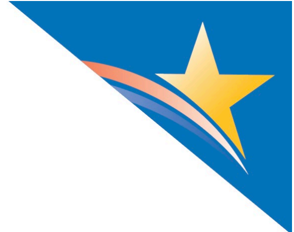
Jim Jirjis
Can I explain that?

Tammy Banks
Go ahead, Jim.

Jim Jirjis
So, let's look at coding for a minute. There is this notion where people who are not used to working with EMRs magically think that the EMRs are all standardized, their data models are the same, how they handle a colonoscopy, even the same entity. Some doctors may dictate, and it ends up in notes. Another might use a template, and it ends up in images. That is why we cannot automate it yet. The EMRs are more like the Tower of Babel. So, some things have been standardized, but many of the documents and how EMRs capture and represent them are so variable that a lot of this has to be selected by a provider or staff member right now. So, I think it surprises many people that you cannot just pluck things out of the EMR. There is context around it. I will quit bringing up that point.

Hans Buitendijk
In a way, I am agreeing with Rich in the sense that if I am looking at CRD as a Da Vinci specification for that first communication with the payer, 1 and 2 are actually combined. I am going to be asking and say, "For this Service ABC, do I need to have prior authorization?" But, just submission Service ABC is not enough, necessarily, for the payer to give the answer whether it needs the prior authorization or not, so there might be one, two, three, four attributes additionally that I needed for the payer to properly answer that question, which is what I think 2 is trying to describe. What is that dataset that I need to answer it? I apologize for the dog barking while I am speaking.

So, I think in that sense, two capabilities to highlight are that I need that extra data, but it is not the full set of data for the actual prior authorization. Depending on what now says, "Okay, yes, I need prior authorization," then the DTR is going to come back and say, "Oh, if that is the case, yes, you need authorization. These are the hundred things that you need to submit back in order to justify that." I can see that the alternative is not making that fully clear yet, but I would read it the same way as Rich, that 1 and 2 are actually about the same interaction, not necessarily 2 or 3.



Rich Landen
Yeah, I am still viewing this as two separate queries. The first one is if prior authorization is needed, and to answer that question, the payer needs all the data, irrespective of whether that is automated or manually considered. The second question is if prior authorization granted, if the decision is made and the authorization actually approved by the payer.

Sheryl Turney
Right, and I think, Rich, that 2 is actually not that. I think that is actually the third thing that we are talking about here. Remember, we are using Da Vinci use cases that were developed for multiple purposes, so each use case and each implementation guide is not just used for one thing. Documentation templates and rules were originally created to do gaps in care, and other things in addition to prior authorizations were added. So, you might have a person that has not had physical therapy yet and requires that before a prior authorization can be submitted, so the documentation templates and rules, as you are looking at it, this may all happen at the same time, but it is going after different information based on the state of the patient and where the patient is in the process.

So, even though we have separated out as 1 and 2, they may happen at the same time and return to more information that is more robust, but we should really be looking at it separately because we have not yet had the people come and provide that overview of how those implementation guides really work. I think that is the challenge I would say to you. Just leave it open until next week. When Viet comes, I think you are going to see how some of these things work together, and it cannot really be all combined into one thing because of how we are being asked to look at it and provide comments to it. I know Raj has his hand up as well.

Tammy Banks
Yeah, and Raj will be the last comment on this section, then I am going to be dropping it in that Google doc, so please add your comments to it this week. Raj?

Rajesh Godavarthi
Just to expand on Sheryl's answer to the question, the first question is if the prior auth is required. That is what we are using for the query. The second capture is for the payers to return documentation requirements for the query. They need more than just the service item or the codes they are sending. So, sometimes the line of business, sometimes the specialty, sometimes the provider information. So, the second one goes in detail of providing enough information so that payers can respond with appropriate documentation requirements. They work well together, but it is just capturing much more clearly what information we need from the payers to respond. Thanks, Tammy.

Tammy Banks
Okay. So, if this response was either denied or "We need to know your CPT code," so to speak, that is where 2 comes in, where you find and respond.

Patrick Murta
Yeah, you never get an approval on Step 1, right?

Tammy Banks

Yeah, sorry.

Patrick Murta
Step 1 is "Do I need to proceed with prior authorization? Here are five pieces of information." That is all it is. The response contains "Yes, for this service/patient/plan/context, prior authorization is required. Here are the rules, click here. These are the things that we need to process the authorization."

Rajesh Godavarthi
I can add more stuff to that one, Tammy.

Tammy Banks
Go for it.

Rajesh Godavarthi
I can wordsmith that step later.

Tammy Banks
This one?

Rajesh Godavarthi
No. 1.

Tammy Banks
Okay, cool. And then, what I do is when you put your comments in, then I will combine them and have a consensus including your comment, so whatever you say is going to be included in the conversation, right? So, with those assignments, what time is it? Let's go to 4. I realize that these are not in workflow order, and so, for the next meeting, I will put them in workflow order, and may lean on a few of you to do so, okay? "Electronically submit completed documentation for prior." I do not think we added anything there. No. 5, "Receiver requests response from a payer regarding approval denial, including a specific reason for denial and required action to appeal, or need for additional information, including detailed description of the documentation or required." Any thoughts? Are the additions fine based on our conversation?

Sheryl Turney
There was a piece missing on that one, Tammy. The first statement was "receive and record an acknowledgement of receipt from a payer," and then it went on to "receive a response." Somehow, it got separated in the document.

Tammy Banks
Okay, "receive and record an acknowledgement from the payer"?

Sheryl Turney
From a payer, yeah. And then, it went on to what you just said. I got it up on my other screen over here.

Tammy Banks
"Receive and record…payer…" Well, "acknowledgement response from a payer."

Sheryl Turney
Right. “Receive and record an acknowledgement from a payer.”

Tammy Banks
Okay. Raj?

Rajesh Godavarthi
I am just contemplating. Should we put any time aspect here? This is kind of a black box. Acknowledgement comes, but what about time limits? I do not see anything around this in the previous rule.

Tammy Banks
Yeah, and we will come back after we have all these functional capabilities honed out and go back through the timing infrastructure rules, block for a single prescription, those caveat the items above, okay?

Rajesh Godavarthi
Sure, thanks.

Tammy Banks
But, thanks for noting that so we know to take a look at this. Heather?

Heather McComas
Thanks, Tammy. I guess I have a little concern about the end of this saying they are asking for additional information, and I guess my hope is if the earlier stuff is done well, that would be very rare, right? Certainly, we do not want to force denial prematurely if something in the submitted information forces another question from the payer, but I worry that this indicates this is going to be a continual back and forth, and I think that is what we are trying to get away from, so I do not know if there is some way to qualify that. It seems to me that should be a hopefully rare situation if the previous steps are going well, and that transparency early on is the way it should be in this process.

Tammy Banks
Heather, could you put in the Google docs a caveat? Because we still need to have the capable functionality in the event it occurs, but I think your point is well versed. Just because there is functional capability does not mean we want to use it. So, I think that is a really good point. I call them caveats or principles above. Would that be okay, Heather?

Jim Jirjis
Can I make a comment on that point?

Tammy Banks
Go ahead, Jim.

Jim Jirjis
Heather, I wonder if there are people from the payer side that could enlighten us because the sense I get is that there are different categories of complexity, so there are prior auths we all have that just require a

couple data points, and Heather, your points are right on. And then, there are complex endocrine tumor testing things where there may be more of a complex, stepwise approach to evidence-based care for that patient that may be more complex and may need a dialogue back and forth, where the payer is saying, "Okay, now we need this." Now, I may be wrong, maybe it is simpler than that, maybe in these complex situations, what is provided real-time to the provider or their staff is, in fact, that complex algorithm, but even when you have that complex algorithm, there is still the notion of where you are in the testing cycle. Have you done the endocrine test first, then the second one, and then, based on the results of that, a third one? There may be some complexity. So, I wonder if it would be useful, Sheryl and Tammy, to take a look at the types of requests to see if that will inform our comments about the system capabilities.

Sheryl Turney

Yeah. I think that is a fair question, and I think someone else brought up just prior to that, Jim, something about prior authorizations with light qualifications. So, I am aware of a patient that was provided. "Well, yeah, you have to get a prior auth to get this test done, but we are not going to authorize this facility. You have to go somewhere else." And, more and more of those types of scenarios are occurring, so how does this handle that? Because from the patient's perspective, they are like, "I do not want to go to this other place because I cannot get my data in MyChart like I can for everything else because they are not part of it, so now, I am stuck with information that cannot be gathered digitally from all of my healthcare partners." And again, I am just presenting that because that is a real live situation. I do not know how or in what way this should handle that, but that scenario that you just mentioned absolutely can happen, and I see that Raj also raised his hand.

Rajesh Godavarthi

Yeah, I think to Jim's point, I have seen use cases where, when a patient is hemodynamically instable and you have enough information about oxygen saturation **[inaudible] [01:16:17]** or vitals, you have enough to say, "This is good. I do not need anything else to approve this," whereas scenarios of bariatric surgery and other procedures where it is a bit more complex for a payer to define those requirements, that is where you have the use cases where people ask, "Have they done enough therapies, have they done enough other things?" before they approve. So, at this point of where the maturities allow both things to happen, but eventually, as datasets mature, as workflows mature to have this point, I think we will get to that level of **[inaudible]**.

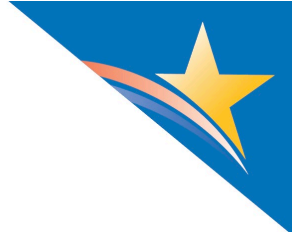
Tammy Banks

Okay, are we comfortable on this one? Do we want to come back and discuss the timing pieces? We need to add an overall principle about streamlining prior auth to ensure, obviously, the less steps, Heather will make it much more eloquent, and investigate use cases to ensure that this meets appropriate business needs? So, people who have the payer background, if you could just take a look at that piece, are there any other steps on this one, or otherwise, is this okay as is with the follow-ups signed? Hearing nothing, I am going to move to 6.

Sheryl Turney

And, I will look at that one after as well, Tammy.

Tammy Banks



Excellent. Thank you, Sheryl. And then, just added, again, we were going for the specificity, for the patient to have a specific reason. And then, here is an addition one that was added in the last call. And, if you do not mind, I am going to go for another five minutes, and then, I just want to take care of a couple follow-up things, okay? “Automated retrieval of data from external systems as appropriate.”

Sheryl Turney
So, just a point of info. We are going to delay the public comment for five minutes.

Tammy Banks
Oh, shoot.

Sheryl Turney
It is okay. Just finish, and we will delay it five minutes.

Tammy Banks
I forgot, I apologize, and that is a very important piece. Hans? You are on mute, so I bet you are saying you love everything.

Hans Buitendijk
Close. On 6, I like what is there, so I will get that, but what is the discussion about that the patient should be able to do such a query as well, not only the provider to get current status, but the patient themselves? I am just curious whether this is part of the discussion and what Sheryl mentioned.

Sheryl Turney
Hans, that was something that we brought forward from the intersection of clinical and administrative data because today, what we put in that recommendation is that the patient should be able to query their patient access API and get a status of the prior auth because often, the patient is the one who is wondering, “Where is it? Why is it not approved?” They are reaching out to providers, reaching out to payers, trying to get things moved forward. So, we said they should be provided with the automated status when they do the request for their patient information and to be able to get that through the patient access API.

Hans Buitendijk
Agreed, and therefore, would No. 6 be a provider or a patient query? That is what I was trying to say.

Tammy Banks
Oh, does it have to be two, or can it be one? I thought it would have to be two, but maybe not.

Hans Buitendijk
Well, that is that the provider would like to understand. It might be the same format and everything, but from a capability perspective, is the question that not only the provider wants to initiate a query to understand what the status is, but the patient, in light of Sheryl’s comments and ICAD, wants to do the same thing, effectively?

Jim Jirjis

Hans, there is one other group. Really, stakeholders need to have the ability to understand the status of a prior.

Sheryl Turney
Yes, all of the stakeholders. It could be a DME provider or whoever. So, it should just say that there should be a query capability, with the information going to the appropriate stakeholders, including the patient.

Hans Buitendijk
I think that clarification of stakeholders should be part of it, to recognize that we should not just think about the provider who submitted it.

Sheryl Turney
Yeah. If you want me to work on the wording of that one, Tammy, I will go in after and try to reword it based on what people are saying today.

Tammy Banks
I love it. Do I have enough there for you to understand where the conversation was going? I think we can get rid of this. I just thought it cannot be a provider because it is too many stakeholders. So, 8, "Automated retrieval of data from external systems as appropriate." I think this was raised by Hans just to clarify that if the functional capability is not within the EHR, it still needs to be pulled, either from a revenue cycle management PMS system or app, and so, that capability is needed. Okay, is 9 the same thing as 8? Everything that is in green is what was added in the comments after the conversation yesterday.

Sheryl Turney
This really speaks to our overall principle that we talked about that somebody had added in the document. So, I think we should assign this one. I think it is Jim who is looking at the overall, right?

Jim Jirjis
Yeah.

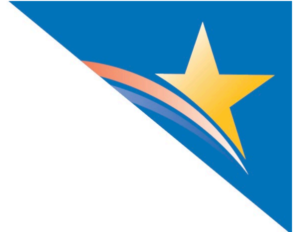
Tammy Banks
Okay, so if this needs to be a standalone or if it can be incorporated in the one that Jim was looking at?

Sheryl Turney
Yeah.

Hans Buitendijk
And, **[inaudible – crosstalk] [01:22:35]** as well is that looking at No. 3, it is probably a refinement in some areas of 3.

Jim Jirjis
Yeah.

Tammy Banks
"May be redundant to 3," okay.



Hans Buitendijk
With the collection from a health IT system in 3, we need to recognize it might be from different systems, it might need to be coordinated, and there might be some manual in there.

Tammy Banks
Excellent, okay. So, Jim will bring that one back.

Sheryl Turney
I think 10 is really what we just talked about for 6, so I think we need to combine those, and I really think we need to go to public comment now because we only have a minute left.

Tammy Banks
Okay, and then, can I come back after public comment and just finish up a couple things real quick?

Sheryl Turney
Yeah.

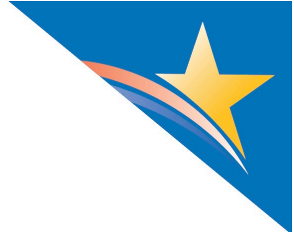
Tammy Banks
Okay, I will stop my share.

Public Comment (01:23:48)

Michael Berry
Absolutely. Can we pull up the public comment slide, please? All right. So, if you are on Zoom and would like to make a comment, please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are dialed in only on the phone, press *9 to raise your hand, and once called upon, press *6 to unmute your line. So, let's pause for a second and see if we have any public comments. I am not seeing public comments, but we will leave this slide up, or people can raise their hand until the end of today's meeting. So, I will turn it back to Tammy and Sheryl. Thank you.

Sheryl Turney
So, Tammy, just so we are all clear, you are going to take the notes that you captured today live, thank you for that, you are fabulous at it, by the way, and put those back into the Google doc, and then we are going to be asking all of our participants to take a look at the updated notes. So, let's give people one or two days to go in and make those adjustments to 1 through 10 that we discussed today, and then, let's say by Monday, hopefully, those updates would have been made so that the rest of the panelists can go in and either agree with the reworded functions or not?

But, we really do need to move forward for next week into some of the questions, so I think what we should do is agree next week to leave the functions where they are, and we will work on those offline, and we will start working on the questions because the questions are really specific about certification requirements and things that people are going to find both in the implementation guides, the C-CDA, the attachment rules, etc., so we will have Viet come next week and speak for about 10 or 15 minutes to provide an overview for everyone on the implementation guides. We did identify somebody who could speak to the C-CDA if we need a quick primer on that from our panelists, and then, again, I think there was someone today that



volunteered to potentially provide a quick overview of the attachment rules if that is necessary, and then, we can make good progress with our questions. Is that how you see it, Tammy?

Tammy Banks
Yeah, that is fine, and I also just want to have a couple minutes to assign the questions based on the background, and then also go through who we asked as subject matter experts and double-check if there is anybody else that we also want to add, and I can also do that right now while we are still on public comment period.

Sheryl Turney
Okay. Let's just ask if there are any comments on the phone because I do not see any in the Zoom meeting. Is anybody waiting for public comment?

I do not see anyone waiting, Sheryl.

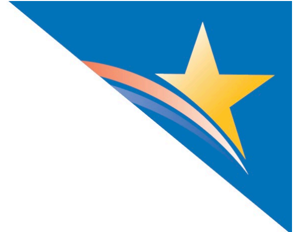
Sheryl Turney
Okay, then go ahead Tammy.

Tammy Banks
All right. I just have to wait until someone gives up the screen a minute. Okay, here we go. Thank you guys. I know we want to make sure this is perfect, but sometimes, at the beginning, we just have to get the intent so that we are all on the same page. And, you are going to notice in here there is a lot of purple. These are all additional functional capabilities that came in the comments, so we would really like you to address those. The more we can do via email, the better, and we had some additional comments on 2, 3, and 4, which I condensed.

So, what I am hopeful is that Topics 4, 5, 6, and 7, if you could really focus in on those areas that your background is. This is how I had assigned it. If anybody would like to be assigned to a different section or I have it inappropriate, Heather, I apologize, but just based on your expertise, I put you on patient and provider, and I am hopeful that everyone will want to take a look at the patient as well. However, we do have some really good comments on the patient section already.

And then, just to add on to Sheryl's comments, Viet will be coming. He is going to be focusing in on what functional capabilities are needed to support or would be built with the implementation guides that support the prior authorization, and then, the questions relating to these implementation guides, such as readiness and the workflow. If there is anything else you guys think you need to hear from him in order to accurately respond to those questions, just zip me an email and I will add that to his list. Hans, I am sorry I am putting you on the spot here, but Hans brought up a comment in our last conversation about how this is not just the EHR. If we want a successful prior authorization process, we really have to think about the different ways that providers may obtain that functionality, whether it be an external app that is integrated within the workflow, or working in coordination with the revenue cycle management or practice management system, or even just the revenue cycle practice management system to handle a lot of these functionalities.

So, he is working on that workflow so we can understand and have a visual of it a little bit better on where the functionalities reside, and with the certification, all of the vendors are under our purview, so this will be



important for us to understand as we move forward. That will be based on Hans's time. And then, the other SME we thought we needed is the attachment SME, and unless there is any argument or an expert on this call that would like to discuss the attachments, what is in place now, what are the functional capabilities, what attachment standard versions are in use by the EHR, how are the attachment requests and exchanges between all these vendors, how we support the decision support models, and preliminary guidance on specific PA RFI questions, I was going to reach out to WEDI. There are quite a few experts at WEDI that have already done research in this area, and I was going to get them on the call. So, comments on if we need more or any additions to this? I would appreciate it. Jim?

Jim Jirjis

I was just going to emphasize Hans's point about not assuming this is happening in the EHR. There may be other systems. And, I think the best way to do that is to assume a world where there is a third-party app that does all this because then, you do not make any erroneous assumptions that somebody has access to the data because they are the EMR. That will not preclude EMRs from developing these capabilities or others, but if we really assume for our thought processes that it is a third-party app, then I think that keeps us disciplined because the standards need to support a third-party app doing it.

Hans Buitendijk

And, that is a good point, Jim, and when you look at it that way, you will notice that the three Da Vinci interactions are insufficient. It does not mean that there are not standards for the other ones, but in order to do that, you need more interactions in order to make it work, and that is highlighted in that. That is what I am trying to figure out, a visual way to bring that out so it is recognized, and then we can act from it.

Sheryl Turney

I think we need to leave it here, Tammy.

Tammy Banks

Yup, all done. Thank you, guys. Sorry, I like to move forward.

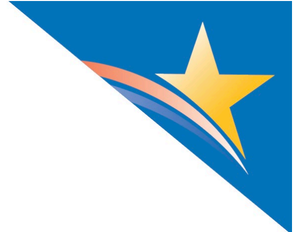
Sheryl Turney

I appreciate everybody for staying a little bit longer today. This has been a fabulous, fabulous conversation. I think we have the right panelists. I am so appreciative of everybody's input, and really look forward to the work in the next meeting. So, Tammy, Excel will send out an update that highlights everything that you just covered so we can clarify assignments, and please, if you have any questions, reach out to Tammy or myself and we will clarify those and get those resolved before we meet next.

Tammy Banks

And, I will have the updates in it by end of day Pacific Time, so if you do need this guidance, go in tomorrow, if that is acceptable. And again, we can do this back and forth via email, just as Raj says, so just because we are not working on Question 8, please put your stuff in there. I will continue to synthesize and have a consensus answer based on the feedback, so we can also have those conversations via the Google whatever thing. You guys all have a great day, because I will keep you on all day, because this is an exciting topic. Yes, Jim?

Jim Jirjis



One point is because of the participation we saw earlier, I recommend we add someone to the task force. I think we should add Hans's dog to the task force.

Tammy Banks
Oh, he was talking. I agree with what Hans's dog said. I was feeling the same at that point in time. Have a good one. Happy Thursday.

Sheryl Turney
All right, thank you. Bye.

Adjourn (01:33:21)