Coverage Requirements Discovery FHIR IG Proposal
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Coverage Requirements Discovery

Owning work group name
Financial Management

Committee Approval Date:
TODO Please enter the date that the committee approved this IG proposal

Contributing or Reviewing Work Groups
• Attachments

FHIR Development Project Insight ID
1428

Scope of coverage
The IG is specific to the US Human financial claims process across all healthcare disciplines, though the primary focus is inpatient and outpatient primary care. The content is developed by a mix of payor and EHR representatives.

IG Purpose
One of the challenges in the US Healthcare environment is that clinicians are often unaware of the expectations of payor organizations around the delivery of care, requirements for pre-authorizations and other processes. The result is that payment can be delayed, changes must be made to therapy after initiation and/or additional overhead costs are incurred. Defining a standardized mechanism by which care delivery organizations and providers can query payors to find relevant guidance prior to care delivery will increase efficient delivery of care and corresponding payment.

Content location
https://github.com/HL7/davinci-crd

Proposed IG realm and code
us/davinci-crd

Maintenance Plan
This specification will be maintained by the FM work group once the Da Vinci project has completed initial development

Short Description
Provides a mechanism for healthcare providers to discover guidelines, pre-authorization requirements and other expectations from payor organizations related to a proposed medication, procedure or other service associated with a patient's insurance coverage. Supports both patient-specific and patient-independent information retrieval.

Long Description
This implementation guide allows practitioners and provider organizations to query payor organizations for any payor-specific expectations related to a proposed course of treatment. It leverages the CDS Hooks specification providing payer services with information about draft appointments, new encounters and other orders and proposals containing information such as drug codes, procedure codes and other service descriptions as well as information about the type of coverage or specific insurance involved. The payer can then provide information such guidelines for care, pre-authorization requirements, necessary first line treatments and/or other instructions and recommendations for care delivery related to the proposed course of treatment (and if specified), for the specified patient. This exchange can occur with either patient-identified or non-identified variants. This implementation guide does not replace existing standards such as the HIPAA X12 270, 271, and 278 transactions which are used to actually perform pre-authorizations and similar processes. Its purpose is to create awareness of what process steps are necessary.

Involved parties
This implementation guide has been developed by U.S. EHR, Payor and Provider organizations as part of the Da Vinci project

Expected implementations
In addition to a pilot reference implementation and testing at the Sept. 2018 and Jan. 2019 WGMs, several EHR, Payor and Provider organizations are expected to implement this implementation guide prior to the end of 2019

Content sources
Requirements are drawn from payor organizations as part of Da Vinci discussions. Some insights around pre-authorization data elements come from ANSI X12

Example Scenarios
- EHR performs coverage requirements discovery specifying an insurance plan type and a proposed medication. Payor returns a protocol indicating an alternate first-line medication and indicates that pre-authorization is required, providing a questionnaire that must be completed as part of the pre-authorization process
- Clinician performs coverage requirements discovery for a proposed physiotherapy. Payor organization queries the patient record to identify details about the patient's health conditions and recent procedures and identifies that no pre-determination or additional guidance is required.
- Hospital submits a patient's insurance information at the time of emergency admission. Insurer identifies the associated patient's insurance plan and notifies the hospital that any costs exceeding a base amount must receive prior clearance by the insurer

IG Relationships
This implementation guide will be "aligned" with US Core and will eventually be derived from US Core once that IG has been updated to align with FHIR R4.

Timelines
The intention is to perform initial balloting of the IG in the Sept. 20

When IG Proposal Is Complete
When you have completed your proposal, please send an email to FMGcontact@HL7.org

FMG Notes