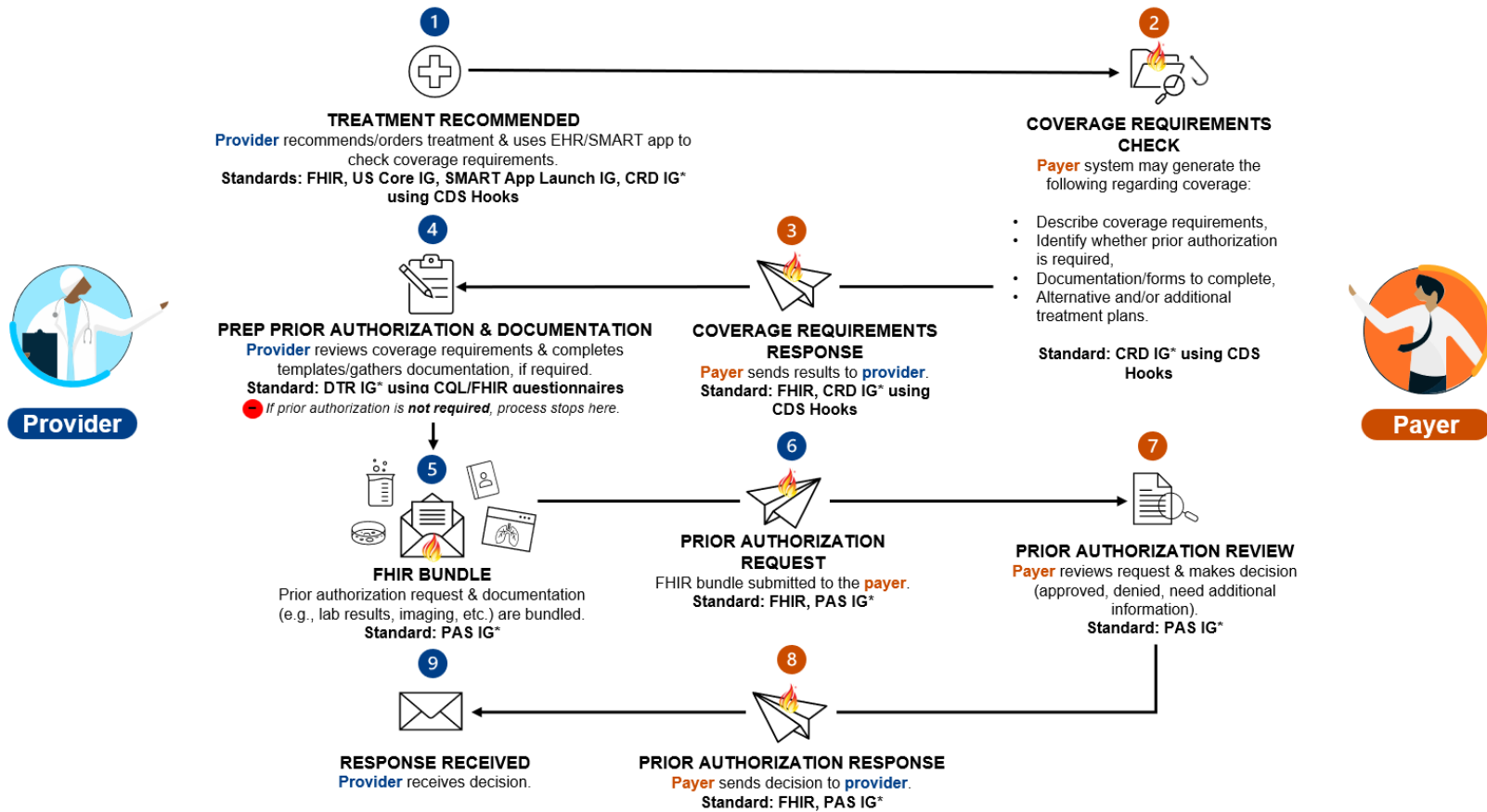


Prior Authorization Application Programming Interface Workflow

The CMS Interoperability and Prior Authorization final rule (CMS-0057-F) requires impacted payers¹ to implement and maintain a Prior Authorization Application Programming Interface (API) to support electronic prior authorization. Using the Prior Authorization API, providers can determine whether a prior authorization is required, identify documentation requirements, exchange prior authorization requests, and receive payer decisions from within their electronic health records (EHRs) or other health IT system. An electronic prior authorization for items and services workflow using the required and recommended technical standards and implementation guides (IGs) is depicted below. An asterisk (*) denotes recommended IGs.



Footnote 1 noted on following page.



Technical Standards And IGs

Required Standards

- **United States Core Data for Interoperability (USCDI):** USCDI is a standardized set of health data content for nationwide, interoperable health information exchange. It sets a foundation for sharing electronic health information to support patient care.
- **Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®):** The FHIR standard defines how health care information can be exchanged between different computer systems regardless of how it is stored in those systems. It enables health data, including clinical and administrative data, to be quickly and efficiently exchanged.
- **HL7 FHIR US Core IG:** This IG is a set of standards that define how health care systems in the United States exchange patient data using the FHIR format. It provides common rules and data templates for essential information like medications, allergies, and lab results to ensure consistency and interoperability. It serves as the foundation for secure, standardized health data sharing across EHRs, apps, and payers.
- **HL7 SMART Application Launch Framework IG:** This IG is a standard that allows third-party SMART apps to securely connect to provider health IT systems using the FHIR standard. It uses OAuth 2.0 for authorization, enabling apps to launch either inside an EHR interface or as standalone applications for patients and providers. This framework ensures consistent, secure access to health data across different systems and allows developers to create apps that extend the functionality of health IT.

Recommended Standards

- **HL7 Da Vinci—Coverage Requirements Discovery (CRD) IG:** This IG defines a workflow to allow payers to provide information about coverage requirements to providers through their EHR or other health IT system. The CRD IG enables the Prior Authorization API to inform a provider whether prior authorization is required, and provide information about the payers' prior authorization coverage rules, so the provider knows what is necessary to support prior authorization approval.
- **HL7 Da Vinci—Documentation Templates and Rules (DTR) IG:** This IG specifies how payer documentation requirements for prior authorization requests can be communicated to a provider. If necessary, this would allow providers to download questionnaires and populate them automatically with information from their EHR or other health IT systems to demonstrate medical necessity or other coverage requirements based on the payer's specific rules. The DTR IG can also automate the assemblage of documentation to support a prior authorization request. For instance, the DTR IG can be used to write rules that support automatic extraction of patient information from the EHR for the provider to review and confirm before submission.



- **HL7 Da Vinci—Prior Authorization Support (PAS) IG:** This IG enables prior authorization requests and decisions to be transmitted via FHIR API from within providers’ EHRs or other clinical systems. The PAS IG is the basis for: (1) assembling the information necessary to substantiate the clinical need for a particular treatment; and (2) submitting the assembled information and prior authorization request to the intended recipient. The PAS IG also defines capabilities for managing prior authorization requests, including checking the status of a previously submitted request, updating a previously submitted request, and canceling a request.

¹ “Impacted payers” are Medicare Advantage (MA) organizations, state Medicaid and Children’s Health Insurance Program (CHIP) fee-for-service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and issuers that offer individual market Qualified Health Plans (QHPs) on the Federally-facilitated Exchanges (FfEs).