



Prior Authorization Industry Landscape

Tuesday, September 25, 2018
3:00 – 4:00 pm ET

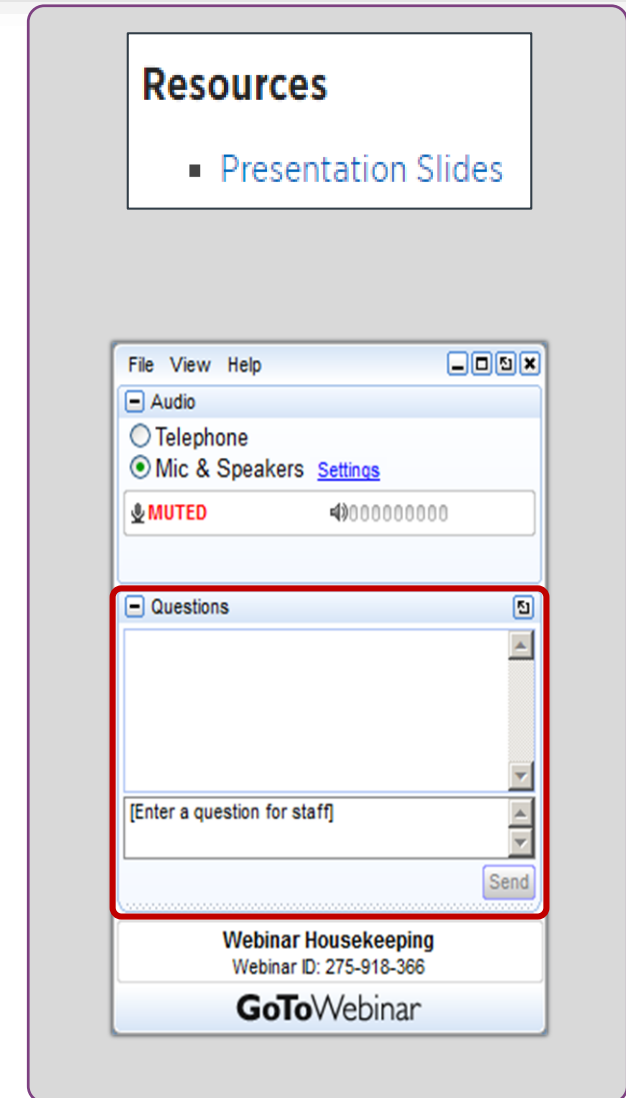
Logistics

Presentation Slides and How to Participate in Today's Session

You can download the presentation slides at www.caqh.org/core/events after the webinar.

- Click on the listing for today's event, then scroll to the bottom to find the Resources section for a PDF version of the presentation slides.
- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**



Session Outline

- Prior Authorization Level Set
- Industry Efforts on Prior Authorization
 - ✓ American Medical Association Perspective
 - ✓ WEDI Perspective
- Overview of CAQH CORE Scope & Draft Phase V Operating Rules
- Q&A

Acknowledgments

CAQH CORE thanks the guest presenters for today's webinar.



Heather McComas

Director, Administrative Simplification
Initiatives
American Medical Association



Stephanie (Geihe) Bronshvayg
Healthcare Transactions Manager
athenahealth



Rhonda Starkey
Director, eBusiness Services
Harvard Pilgrim Health Care

The Prior Authorization Challenge



Prior authorization (PA) began as a means to manage the utilization of healthcare resources: people, time and dollars. PA requires providers to request approval from a health plan before a patient can be referred to another provider (e.g., specialist), or before a specific procedure, service, device, supply or medication is provided to the patient. Each step of the prior authorization process **is labor-intensive and generates time-consuming and costly administrative burden** in the industry.

Fast Facts

PA within the Context of Other Administrative Transactions

The PA process is separate from the patient eligibility and claims processes. Siloed processes can jeopardize provider reimbursement and/or result in unintended patient out of pocket costs.

Example 1. Even if a PA is approved, the patient's eligibility may not be confirmed, or may have changed.

Example 2. Even if a PA is approved, edits may be applied to the claim and the service may still be denied.

Volume

Over 150 million* PAs per year (in the medical, commercial market alone).

Submission Method*

35% manual (phone, fax, email); 57% partially automated (web portal), 8% fully electronic (ASC X12N v5010 278 Prior Authorization Request and Response (278)).

Wait Times**

Approx. 64% of physicians report waiting at least one business day for a PA response, and 30% report waiting at least 3 business days. 92% of Providers surveyed by the AMA reported that the prior authorization process delays patient care.**

Potential Savings

Full adoption of the standard prior authorization transaction (X12/v5010 278 Request and Response) by health plans and healthcare providers could result in a savings of \$6.84 per transaction, for the portions of the prior authorization process included in the X12/v5010 278 Request and Response.

Sources: *CAQH Index (2017); commercial market figures only. | **AMA PA Physician Survey (2017).

Continued Industry Engagement to Address Prior Authorization

- The Phase IV CAQH CORE Operating Rule for prior authorization represents the CAQH CORE Board and Participants' commitment to promoting uniformity and accelerating industry adoption of electronic prior authorization.
- The National Committee on Vital and Health Statistics (NCVHS) recommended*:
 - Additional research to understand barriers to improving the prior authorization process.
 - Development of additional operating rules to address these barriers.
 - “Encouragement of payers and providers to standardize across all systems to ensure consistency in transmitting and receiving information. This would include payer portals, service request systems, etc.”
- Significant public and private sector interest in addressing challenges throughout the prior authorization continuum.
 - July 31, 2018 Senate Health, Education, Labor and Pensions (HELP) Committee hearing on "[Reducing Health Care Costs: Decreasing Administrative Spending](#)" was the third in a series of hearings the committee has held on reducing health care costs – prior authorization was a key topic in multiple testimonies.
 - Multiple industry statements and guiding principles from multi-stakeholder and provider coalitions.
 - [CAQH CORE Board open letter](#) to the authors of the [Consensus Statement on Improving the Prior Authorization Process](#).
 - Other complementary work efforts include [AMA research](#), WEDI PA Subworkgroup, HL7, HATA, DaVinci Project use case, etc.

*[Letter to the Secretary - Findings from Administrative Simplification Hearing](#), [Letter to the Secretary - Recommendations for the Proposed Phase IV Operating Rules](#), [Review Committee Findings and Recommendations on Adopted Standards and Operating Rules](#).



Prior Authorization Industry Landscape: AMA Perspective

Heather McComas
Director, AMA Administrative Simplification Initiatives
CAQH CORE Webinar
September 25, 2018

Setting the Stage: Discussion Roadmap

1. Building the case for change

- Research
- Grassroots stories

2. Reform efforts

- Principles
- Consensus statement



A person wearing a white lab coat is holding a tablet computer. The tablet screen displays a grid of small, indistinct images, possibly medical scans. The person's left hand is at the bottom of the tablet, and their right hand is touching the screen. A silver watch is visible on their left wrist. The background is a dark, textured surface, possibly a brick wall. The entire image has a semi-transparent purple overlay.

AMA Prior Authorization Research

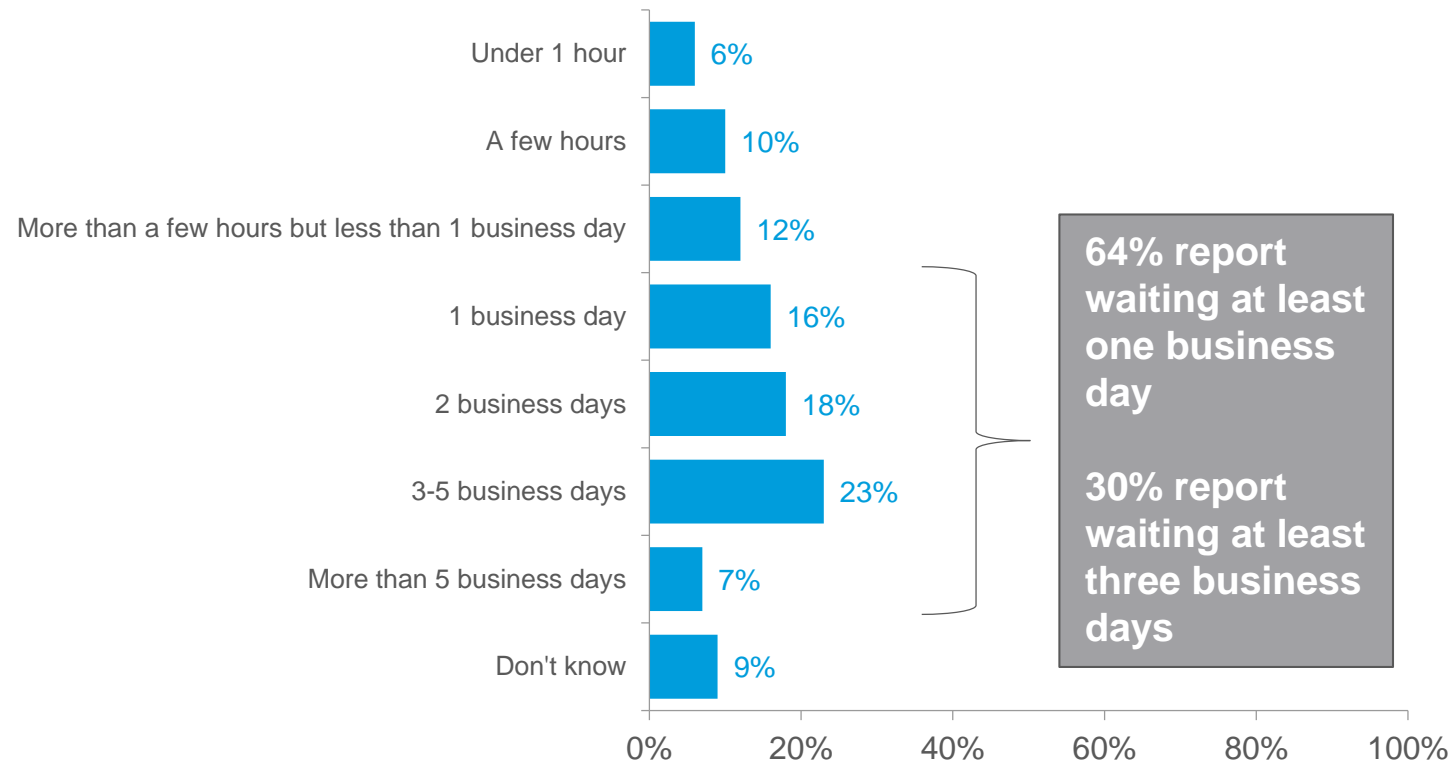
2017 AMA Survey Overview

- 1000 practicing physician respondents
- 40% PCPs/60% specialists
- Web-based survey
- 27 questions
- Fielded in December 2017



Average PA Response Wait Time

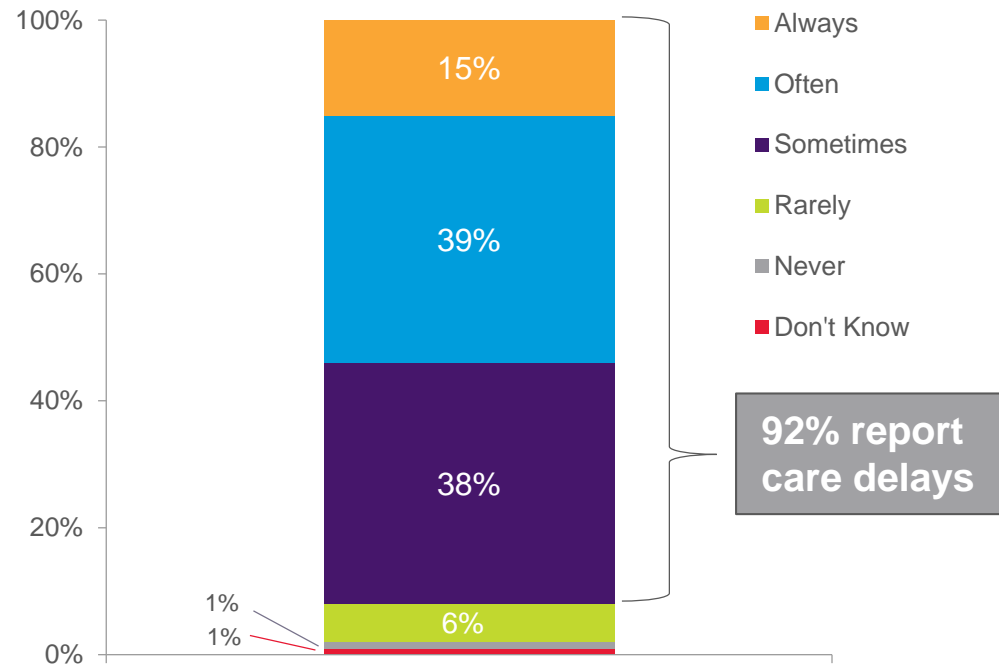
Question: In the last week, how long on average did you and your staff need to wait for a prior authorization (PA) decision from health plans?



Total does not equal 100% due to rounding.

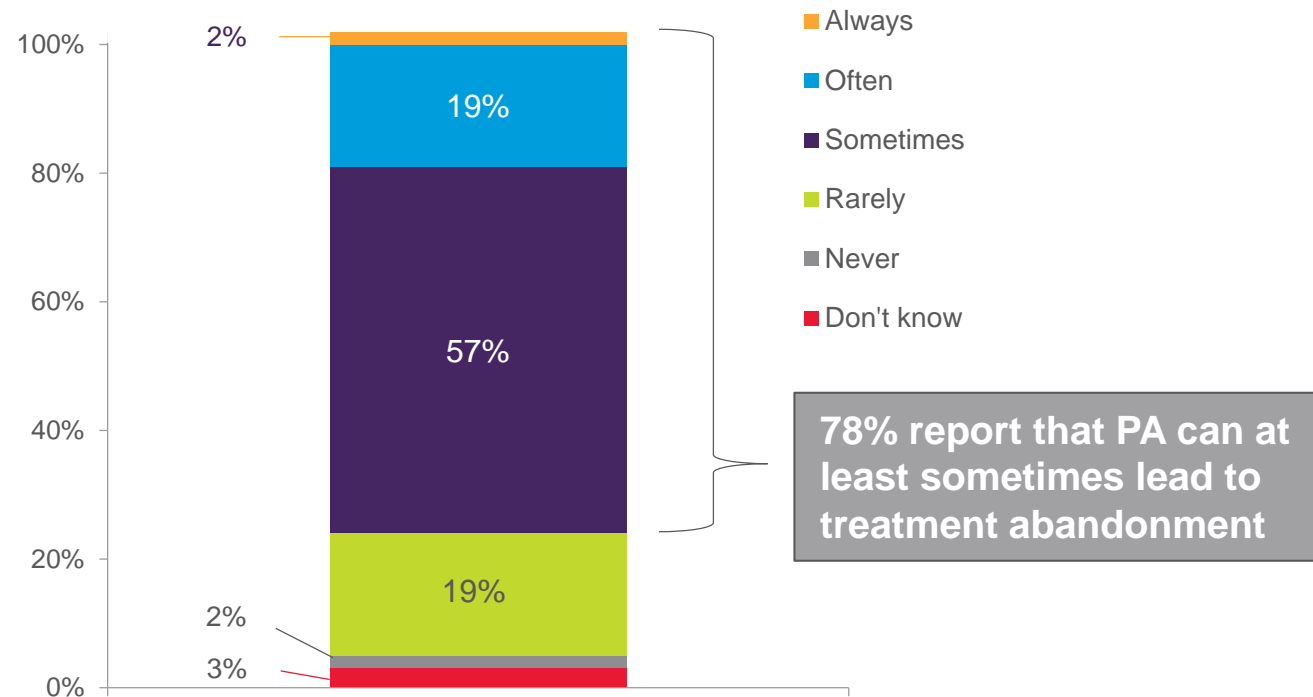
Care Delays Associated With PA

Question: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



Treatment Abandonment Associated With PA

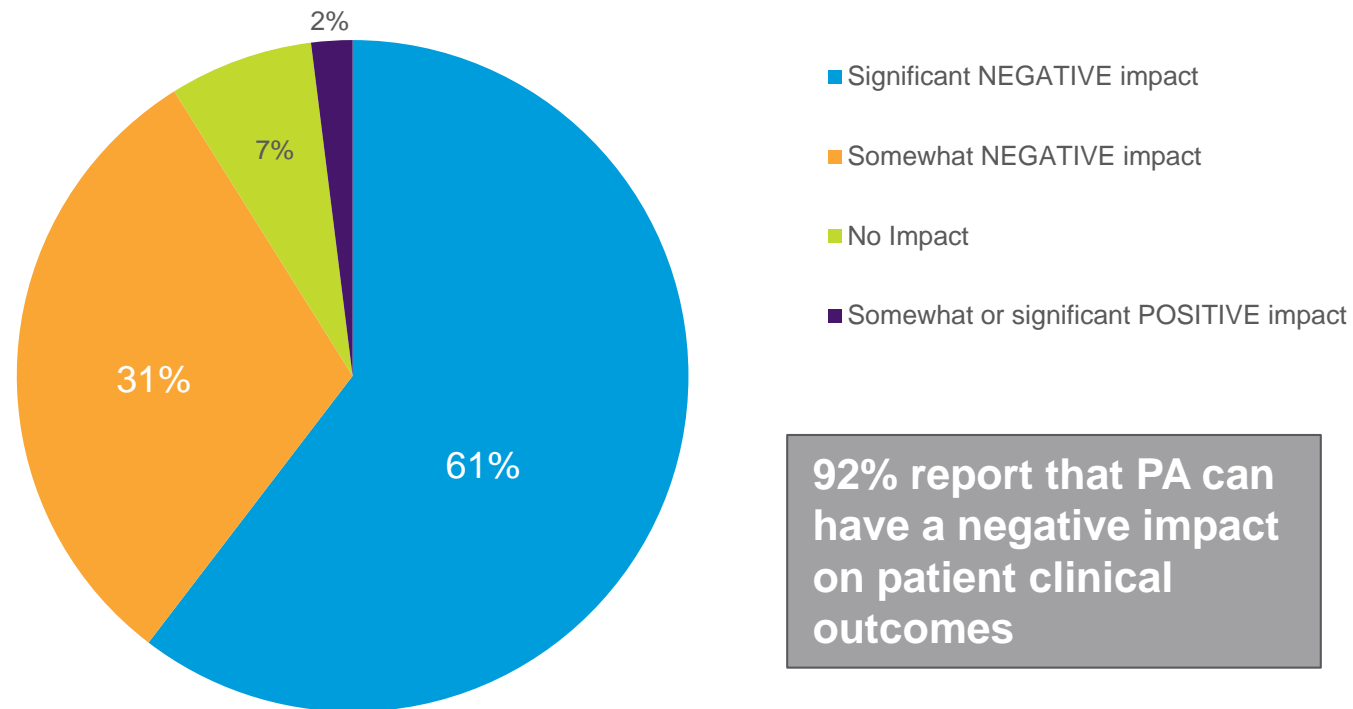
Question: For those patients whose treatment requires PA, how often do issues related to this process lead to patients abandoning their recommended course of treatment?



Total does not equal 100% due to rounding.

Impact of PA on Clinical Outcomes

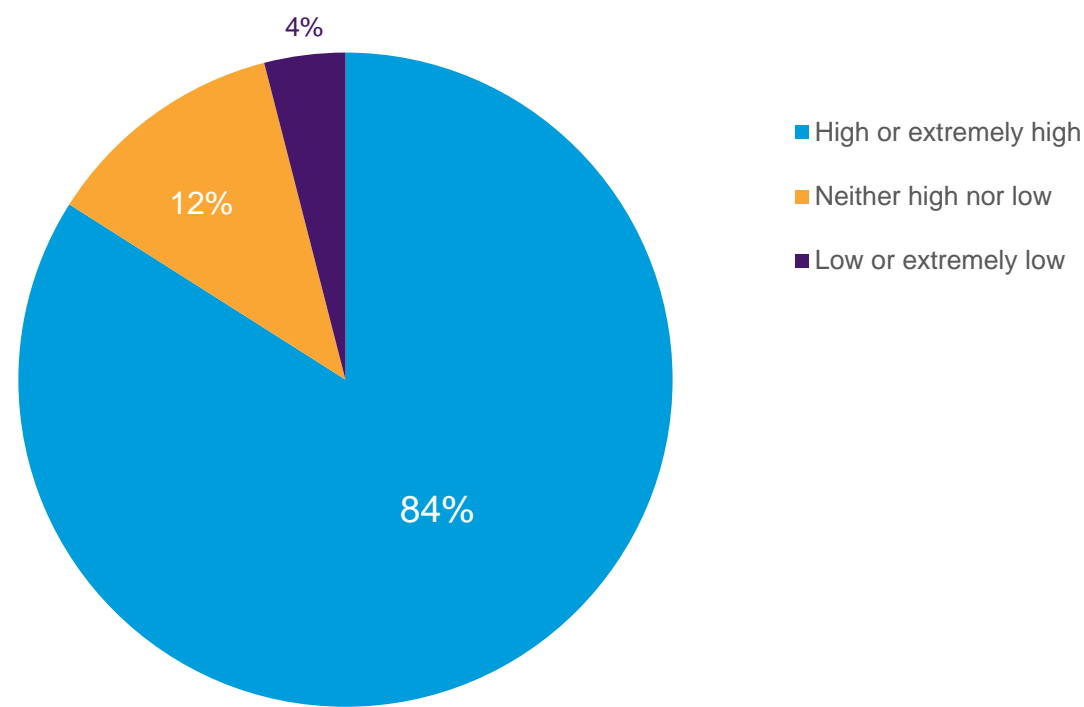
Question: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



Total does not equal 100% due to rounding.

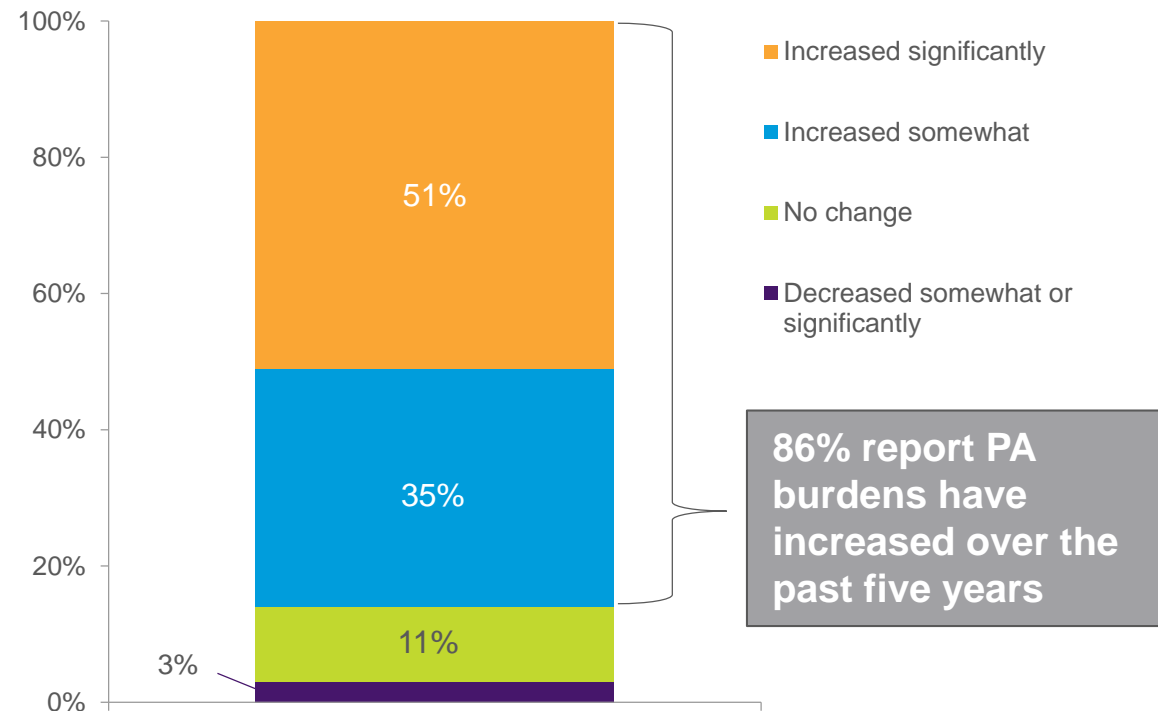
Physician Perspective on PA Burdens

Question: How would you describe the burden associated with PA for the physicians and staff in your practice?



Change in PA Burden Over the Last 5 Years

Question: How has the burden associated with PA changed over the last five years for the physicians and staff in your practice?



Additional PA Practice Burden Findings

- **Volume**

- **29.1 average total PAs** per physician per week*
 - 13.9 average prescription PAs per week
 - 15.1 average medical services PAs per week

- **Time**

- Average of **14.6 hours** (approximately two business days) spent each week by the physician/staff to complete this PA workload

- **Practice resources**

- **34%** of physicians have staff who work exclusively on PA

*Total PAs per week rounded after combining prescription and medical services PAs.

A woman with curly hair and glasses, wearing a blue sleeveless top and a stethoscope, is sitting in a clinical setting. She is holding a tablet and smiling. The background shows medical equipment, a sink, and a counter. The entire image has a purple tint.

Prior Authorization Grassroots Stories

New AMA Grassroots Website: **FixPriorAuth.org**

Prior authorization hurts patients and physicians. It's time to **#FixPriorAuth.**

Click below to discover how prior authorization affects you.



I am a patient



I am a physician

- Physician and patient tracks
- Social media campaign drives site traffic and conversation
- Call to action: Share your story
- Most impactful stories collected in site gallery

Your prior authorization stories matter

See how patients

the appeals process.



"The authorization was refused, so I appealed. It was refused again, even though I pointed to the agent on the other side of the line that the patient met the criteria."

– Dr. Sussana L.

[Read More >](#)

My daughter had ALS. Her doctor ordered a PET scan of her brain. The appointment was set, medical transportation was set, co-pay paid. The day before the test the hospital called to say the prior authorization had not been received. My daughter passed away the day before we were supposed to go for the rescheduled test.

– Kathy M.



3 of 47



"The day before the test the hospital called to say the prior authorization had not been received. My daughter passed away the day before we were supposed to go for the rescheduled test."

– Kathy M.

[Read More >](#)



[Read More >](#)

scans that would help my doctor perform surgery."

– Linda L.

[Read More >](#)

"I have had to make multiple calls and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings."

– Dr. Nina S.

[Read More >](#)

I have had to make multiple calls and wait as long as 2 weeks trying to obtain authorization for an MRI when there were abnormal mammogram or pelvic sonogram findings. The patients become increasingly anxious about their condition and sometimes angry at me because they think I'm either withholding care or not concerned about their needs.

– Dr. Nina S.



"During my pain management appointment, my doctor had tried to prescribe a painkiller, but it has been denied. I have been in constant pain."

– Sherri H.

[Read More >](#)



[←](#) [→](#) 20 of 47

[Read More >](#)

"I have to do a prior authorization



"Now the surgery to remove the thyroid, 2 masses, 14 lymph nodes, and a parathyroid has been denied, pending questionable medical necessity."

– Megan T.

[Read More >](#)



"Prior authorizations take up



My 8-year-old had 2 large masses on the thyroid. It took a month and a half to finally get the approval and paperwork sent to the hospital. We had our first appointment and then 5 days later a biopsy that took hours and hours on the phone to get the prior authorization. Then the results came back cancerous. After hours and hours of phone calls after meeting with the surgeons, surgery was scheduled after the prior authorization was received. Now the surgery to remove the thyroid, 2 masses, 14 lymph nodes, and a parathyroid has been denied, pending questionable medical necessity. More info has been sent in and still is kicking back denied. Results from the removed items - cancer.

– Megan T.

  14 of 47



Some damn nerve doctors' wishes for patients!"

Philline G.

[Read More >](#)



"I had a patient die due to lack of prior authorization for acetaminophen for a UTI."

– Dr. Philline K.

A healthcare professional, likely a nurse or doctor, is shown from the chest down, wearing blue scrubs and a stethoscope. They are holding a tablet computer with both hands, looking at the screen. The background is blurred, showing what appears to be a hospital room with a bed. The entire image is overlaid with a semi-transparent purple filter.

Prior Authorization Principles and Consensus Statement

Prior Authorization and Utilization Management Reform Principles

- Underlying assumption: utilization management will continue to be used for the foreseeable future
- Sound, common-sense concepts
- 21 principles grouped in 5 broad categories:
 - Clinical validity
 - Continuity of care
 - Transparency and fairness
 - Timely access and administrative efficiency
 - Alternatives and exemptions

<div><div>American Medical Association</div><div>American Academy of Child and Adolescent Psychiatry</div><div>American Academy of Dermatology</div><div>American Academy of Family Physicians</div><div>American College of Cardiology</div><div>American College of Rheumatology</div><div>American Hospital Association</div><div>American Pharmacists Association</div><div>American Society of Clinical Oncology</div><div>Arthritis Foundation</div><div>Colorado Medical Society</div><div>Medical Group Management Association</div><div>Medical Society of the State of New York</div><div>Minnesota Medical Association</div><div>North Carolina Medical Society</div><div>Ohio State Medical Association</div><div>Washington State Medical Association</div></div>	<div><div>Prior Authorization and Utilization Management Reform Principles</div><div><p>Patient-centered care has emerged as a major common goal across the health care industry. By empowering patients to play an active role in their care and assume a pivotal role in developing an individualized treatment plan to meet their health care needs, this care model can increase patients' satisfaction with provided services and ultimately improve treatment quality and outcomes.</p><p>Yet despite these clear advantages to adopting patient-centered care, health care providers and patients often face significant obstacles in putting this concept into practice. Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care. However, health plans and benefit managers contend that utilization management programs are employed to control costs and ensure appropriate treatment.</p><p>Recognizing the investment that the health insurance industry will continue to place in these programs, a multi-stakeholder group representing patients, physicians, hospitals and pharmacists (see organizations listed in left column) has developed the following principles on utilization management programs to reduce the negative impact they have on patients, providers and the health care system. This group strongly urges health plans, benefit managers and any other party conducting utilization management ("utilization review entities"), as well as accreditation organizations, to apply the following principles to utilization management programs for both medical and pharmacy benefits. We believe adherence to these principles will ensure that patients have timely access to treatment and reduce administrative costs to the health care system.</p></div></div>
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Prior Authorization Reform Workgroup

- American Medical Association
- American Academy of Child and Adolescent Psychiatry
- American Academy of Dermatology
- American Academy of Family Physicians
- American College of Cardiology
- American College of Rheumatology
- American Hospital Association
- American Pharmacists Association
- American Society of Clinical Oncology
- Arthritis Foundation
- Colorado Medical Society
- Medical Group Management Association
- Medical Society of the State of New York
- Minnesota Medical Association
- North Carolina Medical Society
- Ohio State Medical Association
- Washington State Medical Association

Over 100 additional organizations have signed on as supporters of the Workgroup efforts following the January 2017 release of the Principles.

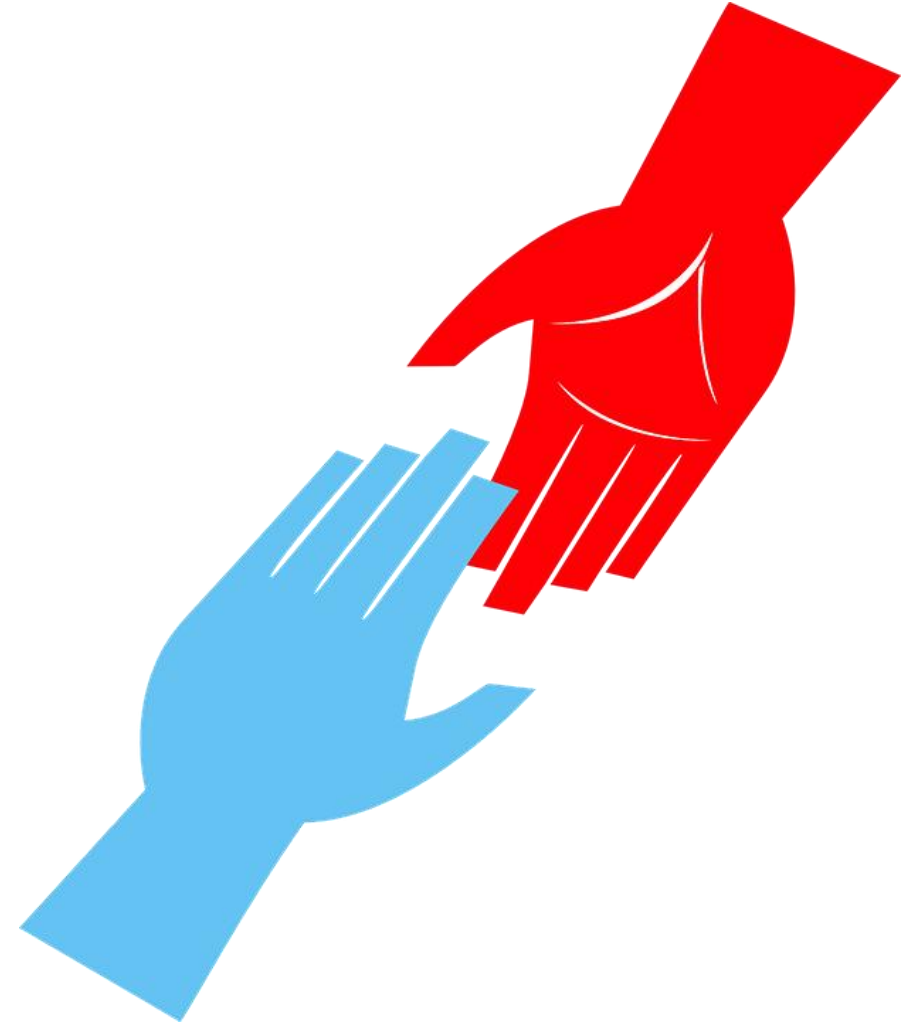
PA Principles and Electronic Prior Authorization

Principle #12

A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests ***exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits***. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.

Outreach Targets for Principles

- **Utilization management entities**
 - Health plans
 - Benefit managers
- **State legislators/regulators**
- **Health plan accrediting bodies**
 - URAC
 - NCQA
- **Standards organizations**
- **Media**



Consensus Statement on Improving the Prior Authorization Process

- Released in January 2018 by the AMA, AHA, AHIP, APhA, BCBSA, and MGMA
- Five “buckets” addressed:
 - Selective requirements to reduce volume of providers subject to PA
 - Regular review of services/ drugs requiring authorization
 - Improved transparency and communication
 - Protections for continuity of care
 - Automation to improve efficiency transparency



Consensus: Automation to Improve Transparency and Efficiency

Agreement to:

- *Encourage health care providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization (i.e., National Council for Prescription Drug Programs [NCPDP] ePA transactions and X12 278)*
- *Advocate for adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) to reduce administrative burdens associated with prior authorization*
- *Advocate that health care provider and health plan trading partners, such as intermediaries, clearinghouses, and EHR and practice management system vendors, develop and deploy software and processes that facilitate prior authorization automation using standard electronic transactions*
- *Encourage the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative costs, and covered alternatives (1) to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and (2) via websites easily accessible to contracted health care providers*

Providers and Health Plans Agree on PA Automation

- Health plans, benefit managers, and providers should all accelerate adoption of the standard electronic transactions for pharmacy and medical services PA (NCPDP ePA transactions and X12 278)
- All intermediaries – EHR vendors, clearinghouses, etc. – should also support these transactions, as PA automation is not possible without the support of these stakeholders



A close-up photograph of a person's hands typing on a laptop keyboard. A silver stethoscope is resting on the keyboard in the lower-left foreground. The entire image is overlaid with a semi-transparent purple filter. The text "AMA Resources and Links" is centered in a white serif font.

AMA Resources and Links

AMA Prior Authorization Weblinks

- AMA Prior Authorization Resources: www.ama-assn.org/prior-auth
- AMA Prior Authorization Grassroots Advocacy: FixPriorAuth.org



Questions



Heather McComas

- Director, AMA Administrative Simplification Initiatives
heather.mccomas@ama-assn.org





Prior Authorization Landscape

Stephanie (Geihe) Bronshvayg



What is WEDI?

WEDI (Workgroup for Electronic Data Interchange) is a nonprofit organization focused on the use of health IT to improve healthcare information exchange – enhancing quality of care, improving efficiency and reducing costs

Created by the Secretary of Health and Human Services (HHS) in 1991 and **named in the HIPAA Legislation as an advisor to the Secretary of HHS**, WEDI continues to be the place where the leading health plans, providers, vendors, and government agencies come for information, education, and innovation on health IT.

Website: www.WEDI.org

WEDI helps member organizations:

Ignite Industry Transformation

Why follow when you can lead health IT's path forward?

1

Showcase Their Impact on Healthcare

Don't be your sector's best-kept secret.

2

Make a Mark on Federal HIT Initiatives

Decisions are being made. Is your voice being heard?

4

Gain First-Hand Knowledge and Insights

Are you "In the know" with tomorrow's challenges?

3



How Does WEDI work?



**Health care
Information exchange
areas broken into
workgroups and sub-
work groups**



**To participate,
members join regular
calls**



**Anyone can join – just
need to sign up on
the WEDI website:
www.WEDI.org**



**WEDI also hosts
regular conferences
where members
interact**



Prior Authorization Sub-workgroup

Sub-work group Focus: Developing a multi-stakeholder lead white paper on the guiding principles that should be implemented to drive adoption and value of the Prior Authorization Health Services Review transaction (x12 278)

The white paper is intended to:

- Outlines the Prior Authorization terms and various workflows
- Identifies barriers to transaction adoption
- Develops best practices to overcome each barrier



What is the Health Services Review Transaction?



Health Services Review (ANSI x12 278) transaction is a standard electronic transaction that has the ability to put a Prior Authorization on file with the payer and to check the status of a pending Prior Authorization request

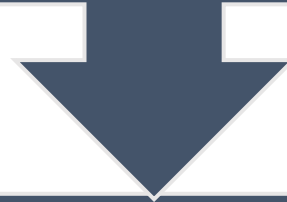


However, transaction adoption has been low due to various challenges



The Prior Authorization White Paper

Goal: Drive industry adoption of the transaction by articulating best practices to overcome the various high-level barriers of adoption



Method: Meet virtually every other week to discuss various parts of the paper

Diverse group of active participants
across the industry

Every voice can be heard

2018 NATIONAL CONFERENCE

October 15 - 17, 2018
Crystal Gateway Marriott | Arlington, VA
#WEDINational



WEDI is a nonprofit organization focused on the use of health IT to improve healthcare information exchange – enhancing quality of care, improving efficiency and reducing costs.

"I'd like to extend my congratulations to WEDI for their continued industry leadership and vision in tackling healthcare's most challenging issues."

Aneesh Chopra
The 1st Chief Technology Officer
United States

Telehealth Resource Guide

by Samantha Holvey | Aug 02, 2018
Table 1 provides a list of telehealth resources that the Telehealth Workgroup identified as being useful and informative for the industry. This list is not all inclusive. The Telehealth Workgroup plans to review and update this list semiannually. Please contact the Telehealth Workgroup co-chairs to have additional resources considered for inclusion in the guide.

The scope of this document is to provide telehealth resources and the goals are to:
Provide a convenient place to access various telehealth resources;
Identify telehealth resources that are relevant, up-to-date, and represent a diversity of views on the topic; and
Provide relevant federal and state regulations and policies.
Download the Telehealth Resource Guide.

- Workgroup Resources
- Payment Models
- Health Information Exchange
- Health Plan ID
- ICD-10
- Security & Privacy
- Data Exchange
- Telehealth
- Genomics
- Virtual Clipboard
- Care Coordination
- Provider Information

- Claim Status
- Acknowledgements
- Attachments
- Claims
- Dental
- Eligibility and Benefits
- Remittance Advice & Payment (ERA/EFT)
- Prior Authorization**
- Property & Casualty Electronic Medical Bill (eBill)
- Provider Information



WEDI Announced Age
National Conference 2
Sep 12, 2018, 11:15 AM



WEDI Announces Age
National Conference 2018
Sep 5, 2018, 11:13 AM



WEDI Connection: August
2018

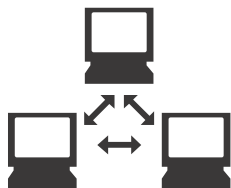
How can you get involved?

Go to www.WEDI.org and sign up!

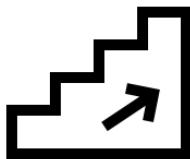
Overview of CAQH CORE Scope & Draft Phase V Operating Rules

CAQH CORE Vision for Prior Authorization

Introduce targeted change to propel the industry collectively forward to a prior authorization process optimized by automation, thereby reducing administrative burden on providers and health plans and enhancing timely delivery of patient care.



The [Phase IV Prior Authorization Operating Rule](#) established foundational infrastructure requirements such as connectivity, response time, etc. and builds consistency with other mandated operating rules required for all HIPAA transactions.



The **Draft Phase V Operating Rules** address needed data content in the PA transaction and enable greater consistency across other modes of PA submissions.

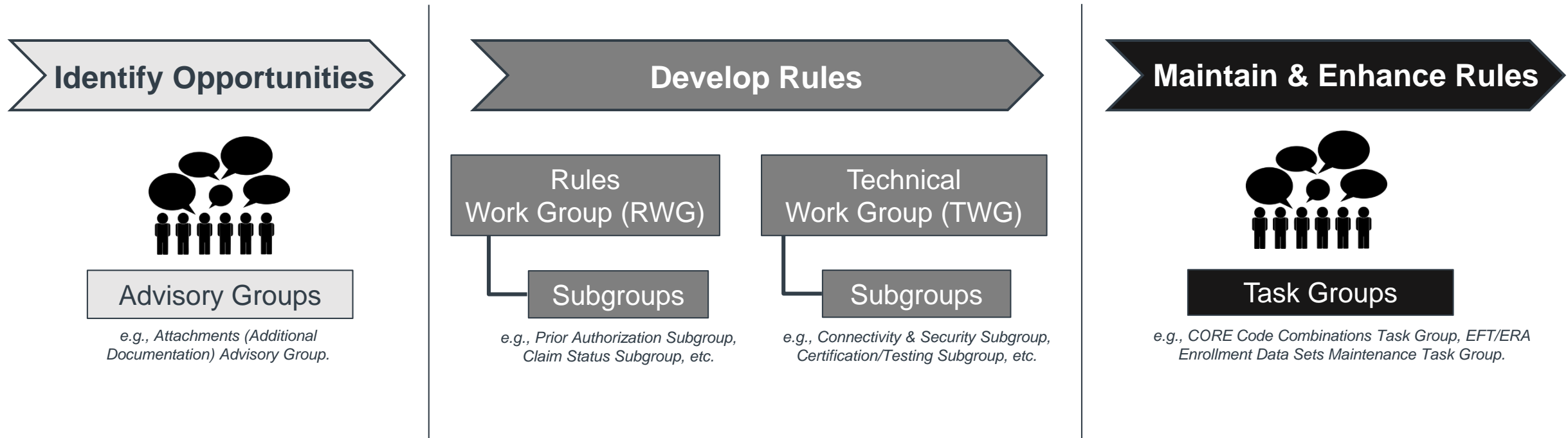
Automation Spectrum



Manual	Partially Automated	Optimized
Entirety of provider and health plan workflows, including request and submission, is manual and requires human intervention, e.g., telephone, fax, e-mail, etc.	Parts of the PA process are automated and do not require human intervention, but some parts still require human touch. Typically includes manual submission on behalf of provider which is received by health plan via a more automated tool (portals, ASC X12 278).	Entire PA process is at its most effective and efficient by eliminating unnecessary human intervention and other waste. Optimized PA process includes automating internal provider/health plan workflows.

CAQH CORE Rule Research, Development & Maintenance Group Structure

CAQH CORE Participating Organizations play a critical role in all aspects of the rules lifecycle.
All Groups are open to and chaired by CAQH CORE Participants.



Scoping the Prior Authorization Rule Opportunities

PA Advisory Group

- From Fall 2016 through Summer 2017, a multi-stakeholder CAQH CORE PA Advisory Group vetted potential PA operating rule opportunity areas against agreed-upon evaluation criteria.
 - The initial PA opportunities list was developed via thorough review and analysis, such as NCVHS testimonies, ACA Review Committee, industry forums and discussions, CAQH CORE industry surveys and X12 v5010X217 278 TR3.
 - The PA Advisory Group conducted an environmental scan to hone in on pain points and understand the potential benefit of the various opportunity areas.

PA Subgroup

- The resulting opportunities list was used by the CAQH CORE PA Subgroup, which represents more than 50 multi-stakeholder organizations, to specify operating rule draft requirements.
- Over the past six months, the PA Subgroup defined key rule requirements related to the data content of the X12 278 Request/Response Transaction and Prior Authorization Web Portals. This was achieved by participating in surveys, feedback forms, straw polls and industry discussion.

Draft Phase V CAQH CORE Prior Authorization Operating Rules

The Draft Phase V Prior Authorization Rules focus on **standardizing key components of the prior authorization process**, closing gaps in electronic data exchange to move the industry toward a **more fully automated adjudication of a request**. These efficiencies enable **shorter time to final adjudication and more timely delivery of patient care**.

CAQH
CORE

DRAFT
RULE

X12/v5010 278
Request/
Response
Data Content

DRAFT
Requirements

✓

Consistent patient identification to reduce common errors and associated denials.

✓

Consistent review of diagnosis, procedure and revenue codes to allow for full health plan adjudication.

✓

Consistent use of codes to indicate errors/next steps for the provider, including need for additional documentation.

✓

Detection and display of code descriptions to reduce burden of interpretation.

CAQH
CORE

DRAFT
RULE

Prior
Authorization
Web Portals

DRAFT
Requirements

✓

Application of standard X12 data field labels to web portals to reduce variation in data elements to ease submission burden and encourage solutions that minimize the need for providers to submit information to multiple portals.

✓

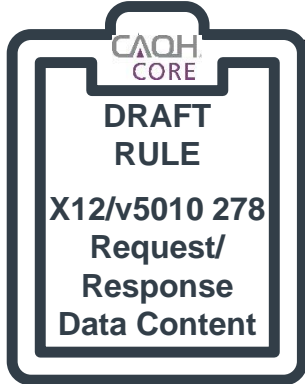
Confirmation of receipt and acknowledgment of PA submission to reduce manual follow-up for providers.

✓

System availability requirements for a health plan to receive a PA request, to enable predictability for providers.

NOTE: The CAQH CORE Prior Authorization Subgroup is currently reviewing and refining these draft rule requirements prior to sending to the Rules Work Group. While in the review process, draft rule requirements are subject to change.

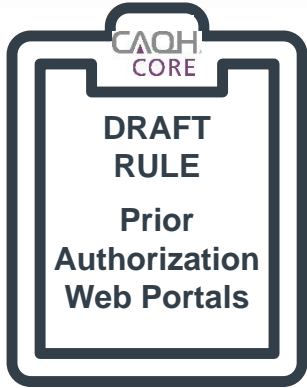
Draft Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule



Additional Detail

- The Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule requirements target one of the most significant problem areas in the prior authorization process: requests that are pended due to missing or incomplete information, primarily medical necessity information.
- These enhancements reduce the unnecessary back and forth between providers and health plans and enable shorter adjudication timeframes and reduced staff resources spent on manual follow-up.
- The rule requirements reduce barriers to adoption by:
 - Strengthening the data submitted by the provider and the communication of next steps by the health plan.
 - Easing the burden of interpretation on the provider by standardizing code use through uniform use and requiring display of code descriptions.
 - Allowing for more efficient review and adjudication of requests, by focusing on key aspects of the prior authorization process that can most benefit from systems and application development.








Draft Phase V CAQH CORE Prior Authorization Web Portals Rule



Additional Detail

- The Phase V CAQH CORE Prior Authorization Web Portal Rule builds a bridge toward overall consistency for the prior authorization request and response by addressing fundamental uniformity for data field labels, ensuring confirmation of the receipt of a prior authorization request and providing for system availability.
- The rule reduces administrative burden and encourages pathways to automation by:
 - Requiring use of the X12/v5010 278 Request and Response TR3 implementation names for the web portal data field labels, which supports the HIPAA-mandated standard transaction.
 - Adhering to the requirements outlined in the Phase V CAQH CORE Prior Authorization (278) Request / Response Data Content Rule when the portal operator maps the collected data from the web portal to the X12/v5010 278 Request and Response transaction.
 - Reducing variation in data elements to ease submission burden and encourage technology solutions to minimize the need for providers to submit information to multiple portals.

Phase V CAQH CORE Prior Authorization Operating Rule Development Timeline

	2018				2019	
	Q1	Q2	Q3	Q4	Q1	Q2
Phase V Rule Development <ul style="list-style-type: none"> PA Subgroup (PASG) Develops and Refines Rule Options. PASG Develops Draft Rules. <i>Rules Work Group (RWG) Reviews Draft Rules.</i> 						
Phase V Certification & Testing Development <ul style="list-style-type: none"> Certification & Testing Subgroup (CTSG) Develops Test Suite. Technical Work Group (TWG) Reviews Test Suite. 						
CAQH CORE Phase V Voting <ul style="list-style-type: none"> All CAQH CORE Participant Vote. CAQH CORE Board Vote & Approval. 						 

We are here

CAQH CORE Group Information

Join Today

Why join a CAQH CORE group?

Contribute to the development of implementable operating rules for targeted industry change, resulting in meaningful improvements for providers, health plans and patients.

CAQH CORE Group Name	Group Focus	Current Group Objectives	Target Launch & Meeting Cadence (Tentative)
Phase V Rules Work Group	Rule Review	Review the Draft Phase V Operating Rules developed by the Prior Authorization Subgroup; participate in ballot to approve the draft rules to move on to an All CORE Participant Vote.	<ul style="list-style-type: none">Launched September 2018.Cadence: Once monthly; September-November 2018 period.
Phase V Certification & Testing Subgroup	Test Suite Development	Develop the Certification Test Suite for the Phase V CAQH CORE Operating Rules.	<ul style="list-style-type: none">Target Launch: Q4 2018.Cadence: Once monthly; targeted for the October 2018-January 2019 period.
Phase V Technical Work Group	Test Suite/Technical Specification Review	Review technical rules (when applicable); review the Certification Test Suite for Phase V CAQH CORE Operating Rules (developed by the Certification & Testing Subgroup).	<ul style="list-style-type: none">Target Launch: Q1 2019.Cadence: Once monthly; targeted for the January-March 2019 period.

CORE Certification and CORE Endorsement

Organizations can demonstrate adoption of the CAQH CORE operating rules and electronic transactions through CORE Certification, including prior authorization.

Polling Question

Are you interested in getting involved in the CAQH CORE Prior Authorization effort?

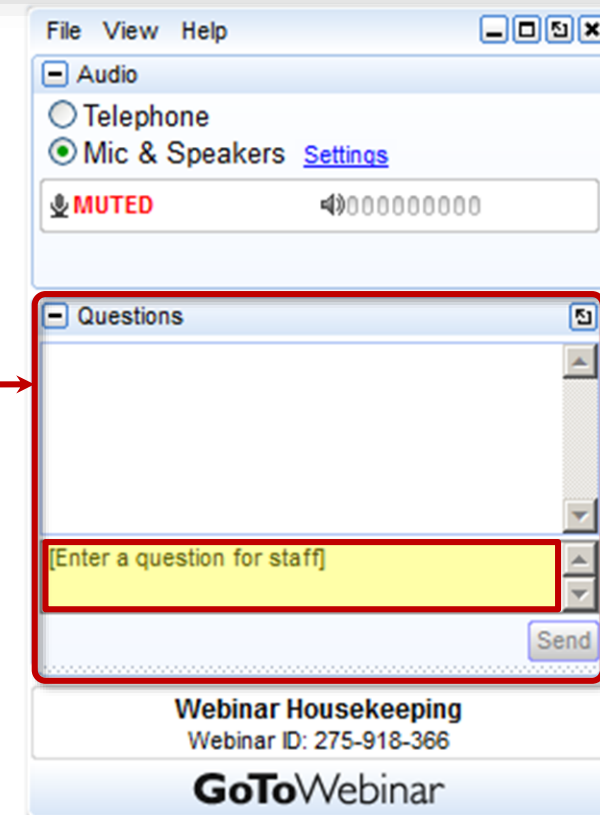
- I am a CORE Participant interested in joining the Phase V Rules Work Group.
- I am a CORE Participant interested in joining the Phase V Technical Work Group.
- I am a CORE Participant interested in joining the Phase V Certification Testing Work Group.
- I am interested in learning more about CORE Participation.
- I am interested in learning about possible rule adoption pilot projects to measure return on investment.

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



Download a copy of today's presentation slides at caqh.org/core/events

- Navigate to the Resources section for today's event to find a PDF version of today's presentation slides.
- Also, a copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.

Resources

- [Presentation Slides](#)

Thank you for joining us!



@CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.