**January 25, 2010**
**Version 1.0**

# HITSP Communicate Referral Authorization Capability

## HITSP/CAP141


*Submitted to:*

**Healthcare Information Technology Standards Panel**

*Submitted by:*

**Capabilities Team**

# DOCUMENT CHANGE HISTORY

| Version Number | Description of Change | Name of Author | Date Published |
|---|---|---|---|
| 0.0.1 | Populate Template | Capabilities Team | September 30, 2009 |
| 0.0.2 | Review Copy | Selected Perspective, Domain and/or Tiger Team reviewers | November 9, 2009 |
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| 1.0 | Released for Implementation | Selected Perspective, Domain and/or Tiger Team reviewers | January 25, 2010 |

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# FIGURES AND TABLES

# 1.0 INTRODUCTION

This Healthcare Information Technology Standards Panel (HITSP) document is divided into Requirements Analysis, External Capability Options, Design Specifications and Standards sections which may be used by analysts, architects and implementers. Analysts refer to this document to determine if the Capability satisfies their requirements. Architects and system implementers refer to this document as the architectural specifications for a system design, while software developers will use a Capability as the source of the design for interoperable information exchange.

This Healthcare Information Technology Standards Panel (HITSP) Capability document is divided into five sections: Requirements Analysis, External Capability Options, Design Specification, Standards and the Appendix. All sections may be useful to analysts and architects. However as shown in Table 1-1, different readers may find specific sections of greater interest and utility. This table is provided as an aid to readers to assist them in identifying sections to focus on. Readers are encouraged to review all sections of this document to further their understanding of HITSP's work.

**Table 1-1 Reader's Guide for Capability**

| Document Section | Section Number | Intended Audience | Information Contained |
|---|---|---|---|
| Section 2.0 Requirements Analysis | 2.1 Introduction | Policy Managers<br>Policy Analysts<br>Executive Leadership | Provides an overview of the requirements which this Capability addresses, and identifies the system roles supported by the Capability |
| | 2.2 Requirements | Program Managers<br>Policy Analysts<br>Executive Leadership<br>Architects<br>Business Analysts | Defines the actual information exchanges supported by the Capability in terms of exchange actions and exchange content. It shows how these roles can be assigned at a higher level to real world systems, such as an Electronic Health Record |
| Section 3.0 External Capability Options | 3.1 Security and Privacy | Policy Analysts<br>Architects<br>Business Analysts<br>Developers | Describes the integrated and optional security and privacy functions supported by the Capability |
| Section 4.0 Design Specification | 4.1 Requirements Mapped to Constructs | Program Managers<br>Architects<br>Business Analysts<br>Developers | Maps the information exchanges developed in requirements to the actual HITSP construct used by the Capability to support the exchange |
| | 4.2 Constraints and Assumptions | Business Analysts<br>Developers | Lists the context that is necessary to use the Capability, including constraints, assumptions, pre-conditions, post-conditions and triggers |
| | 4.3 Specified Interfaces by System Role | Business Analysts<br>Developers | Identifies the constructs and their interfaces assigned to each system role. It also lists the implementation conditions for use |
| Section 5.0 Standards | 5.1 Standards Used | Program Managers<br>Policy Analysts<br>Architects<br>Business Analysts<br>Developers | Lists regulatory guidance, selected standards and informative references used by the Capability and all its supporting constructs |
| | 5.2 Standards Gaps and Overlaps | Program Managers<br>Policy Analysts<br>Architects<br>Business Analysts<br>Developers | Identifies gaps or overlaps in standards to implement the Capability including a plan to resolve issues |

## 1.1 CAPABILITY OVERVIEW

This Capability addresses interoperability requirements that support electronic inquiry and response to authorizing a patient (health plan member) to be referred for service by another provider or to receive a type of service or medication under the patient's health insurance benefits.

The Capability supports the transmittal of a patient's name and insurance identification number with the request for the type of service. It also includes the following optional requirements:

- Identification of the type of service or medication requested for benefit coverage (does not guarantee payment by insurance provider)
- Communication of a referral notification number or authorization number from the Payer System to the Provider System

It provides clinicians and pharmacists with information about each patient's medical insurance coverage and benefits. For the prior-authorization transaction, X12 is used in the medical setting and NCPDP is used in a pharmacy setting. The transaction may include information on referral or authorization permission.

## 1.2 SCOPE

A Capability enables business and policy requirements for a business need to be implemented through information exchanges specified in HITSP constructs. The objective of a Capability is to provide the bridge between the business, policy and implementation disciplines by defining a set of information exchanges at a level relevant to policy and business decisions and specifying the use of HITSP constructs sufficiently for implementation. A Capability supports stakeholder requirements and business processes and includes information content, infrastructure, security and privacy. The design of Capabilities leverages existing HITSP constructs and communication methodologies. As new constructs become available, the scope of this Capability may be extended.

## 1.3 COPYRIGHT PERMISSIONS



## 1.4 REFERENCE DOCUMENTS

A list of key reference documents and background material is provided in the table below. These documents can be retrieved from www.hitsp.org Web Site.

**Table 1-2 Reference Documents**

| Reference Document | Document Description |
|---|---|
| HITSP Acronyms List | Lists and defines the acronyms used in this document |
| HITSP Glossary | Provides definitions for relevant terms used by HITSP documents |
| TN900 - Security and Privacy | TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs |
| TN903 – Data Architecture | TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs |
| TN904 – Harmonization Framework and Exchange Architecture | TN904 is a reference document that provides the overall context for use of the HITSP Harmonization Framework and Exchange Architecture |

## 1.5 GUIDANCE FOR USE OF A CAPABILITY

NOTE: For questions related to details on HITSP Capabilities and HITSP System Roles, please refer to HITSP/TN904 Harmonization Framework and Exchange Architecture Technical Note.

To use a HITSP Capability, a HITSP Interoperability Specification or an implementation conformance statement must assign specific systems to one or more HITSP Capability System Roles and identify how the HITSP Capability Options are to be addressed. In order to assign systems to HITSP System Roles, the reader uses Table 2-3 Supported Information Exchanges to determine what systems can support the specific information exchanges required. For an example of how HITSP System Roles and systems are mapped, readers can consult a HITSP Interoperability Specification Table 3-3 Orchestration of Capabilities by System. In the case of an Implementation Guide, systems can be assigned to HITSP System Roles using a similar methodology.

The use of a HITSP Capability implies that these specific rules will be followed:

- For each HITSP Capability System Role listed in Table 2-2 Capability's System Roles, the defined responsibilities of that HITSP Capability System Role are supported. Responsibilities for the HITSP Capability System Role are defined as support for the HITSP Construct interfaces listed in Section 4.3 Specified Interfaces by System Role. Support implies that the system assigned to the HITSP Capability System Role makes the associated HITSP construct interfaces available for use by other systems. For those HITSP construct interfaces in Section 4.3 that have associated content optionality, the HITSP Capability System Role must comply with the optionality condition listed in Table 4-8 Implementation Conditions.
- Responsibilities also include the constraints and assumptions associated with use of a Capability, as outlined in Table 4-3 Context. For those Capabilities with Section 3.2 options, the following additional rules apply:

1. Each topology option listed in Table 3-2 Topology Related Options should be supported by the implementation

1. Each content import option listed in Table 3-3 Content Import Options should be supported by the implementation
2. Each document content option listed in Table 3-4 Document Content Options should be supported by the implementation

# 2.0 REQUIREMENTS ANALYSIS

The following table is provided as an aid to readers to assist them in identifying the parts of this section to focus on. Readers are encouraged to review all sections of this document to further their understanding of HITSP's work.

**Table 2-1 Reader's Guide for Section 2.0**

| Document Section | Number | Intended Audience | Information Contained |
|---|---|---|---|
| Section 2.0 Requirements | 2.1 Introduction | Policy Managers<br>Policy Analysts<br>Executive Leadership | Provides an overview of the requirements which this Capability addresses. It lists, describes and diagrams the external interfaces and relates these to the system roles supported by the Capability. It shows how these roles can be assigned at a higher level to real world systems, such as an EHR |
| | 2.2 Requirements | Program Managers<br>Policy Analysts<br>Executive Leadership<br>Architects<br>Business Analysts | Defines the actual information exchanges supported by the Capability in terms of exchange actions, exchange content, constraints mapped to the initiating and responding system roles that participate in these exchanges |

## 2.1 INTRODUCTION

Table 2-2 summarizes the system roles of the Capability. Section 2.2 identifies how these system roles participate in the set of information exchanges.

**Table 2-2 Capability's System Roles**

| System Role | System Role Definition |
|---|---|
| Clinician Authorization Requestor | Communication of Clinician Authorization request |
| Clinician Authorization Responder | Communication of Clinician Care Authorization |
| Pharmacy Authorization Requestor | Communication of Pharmacy Authorization request |
| Pharmacy Authorization Responder | Communication of Pharmacy Authorization |

## 2.2 REQUIREMENTS

### 2.2.1 INFORMATION EXCHANGES

Table 2-3 defines each of the Information Exchanges supported by this Capability in terms of the Exchange Action (EA) or Exchange Content (EC) used.

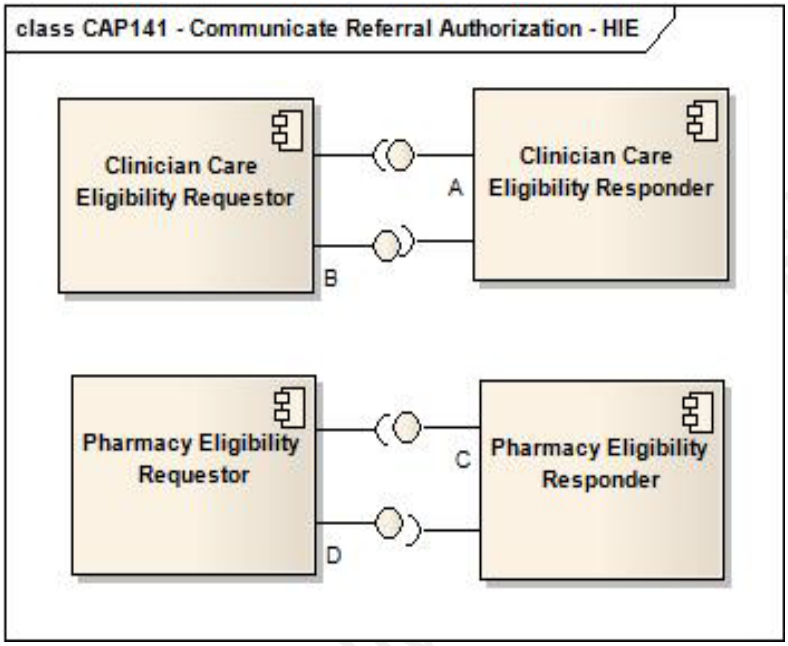
**Table 2-3 Supported Information Exchanges**

| Information Exchange Identifier | Exchange Action | Exchange Content |
|---|---|---|
| A | Request | Request for Health Plan to authorize certain healthcare services |
| B | Respond | Health Plan Response for healthcare services |
| C | Request | Request for Health Plan to authorize certain pharmacy products or services |
| D | Respond | Health Plan Response for pharmacy products or services |

Figure 2-1 identifies how this Capability supports various system roles within multiple system architectures. For example, either an Electronic Health Record (EHR) system or a Health Information

Exchange (HIE) might fill a document repository system role in an information exchange). In an implementation architecture, system roles may be combined locally (e.g., Hospital EHR System) and in others, the system roles may be provided by multiple-distributed trusted third parties (e.g., pharmacies within an HIE).

**Figure 2-1 Information Exchanges Between System Roles**



# 3.0 EXTERNAL CAPABILITY OPTIONS

The following table is provided as an aid to readers to assist them in identifying the parts of this section to focus on. Readers are encouraged to review all sections of this document to further their understanding of HITSP's work.

**Table 3-1 Reader's Guide for Section 3.0**

| Document Section | Number | Intended Audience | Information Contained |
|---|---|---|---|
| Section 3.0 External Capability Options | 3.1 Security and Privacy | Policy Analysts<br>Architects<br>Business Analysts<br>Developers | Describes the integrated and optional Security and Privacy functions supported by the Capability |

This section is primarily for architects, engineers and analysts. It allows those who consider using this Capability to evaluate and/or constrain the options that are externally made available for the Capability implementers.

Interoperability among system roles defined by this Capability often requires the selection of consistent options.

## 3.1 SECURITY AND PRIVACY

The application of Security and Privacy is highly influenced by the privacy and security policies. The HITSP Security and Privacy Technical Note (HITSP/TN900) provides a detailed discussion of the security and privacy constructs, including consideration and appropriate context for needed security and privacy related policy decisions. Security and privacy constructs are integrated comprehensively into the Service Collaborations. The actual constructs used and the way that the constructs are used is dependent on the policies and physical setting. Conformance claims are against the security and privacy constructs that are chosen to enforce the policies.

# 4.0 DESIGN SPECIFICATION

The following table is provided as an aid to readers to assist them in identifying the parts of this section to focus on. Readers are encouraged to review all sections of this document to further their understanding of HITSP's work.

**Table 4-1 Reader's Guide for Section 4.0**

| Document Section | Number | Intended Audience | Information Contained |
|---|---|---|---|
| Section 4.0 Design Specification | 4.1 Requirements Mapped to Constructs | Program Managers<br>Architects<br>Business Analysts<br>Developers | Maps the information exchanges developed in requirements to the actual HITSP construct used by the Capability to support the exchange |
| | 4.2 Constraints and Assumptions | Business Analysts<br>Developers | Lists the context that is necessary to use the Capability, including assumptions, pre-conditions, triggers and post-conditions and triggers |
| | 4.3 Specified Interfaces by System Role | Business Analysts<br>Developers | Identifies the constructs and their interfaces assigned to each system role. It also lists the implementation conditions for use |

## 4.1 REQUIREMENTS MAPPED TO CONSTRUCTS

### 4.1.1 CONSTRUCTS

Table 4-2 defines the mapping of the Information Exchanges supported by this Capability in terms of the Exchange Action (EA), Exchange Content (EC) and any Constraints applied to the Information Exchange with specific initiating and/or responding system interfaces. This provides the traceability of constructs to the information exchanges identified in Section 2.0 above. Content modules and terminology components are not listed here because they are referenced by other constructs, but do not provide an interface. HITSP/TN903 discusses how content modules and terminology components are referenced by other constructs.

**Table 4-2 Information Exchanges Mapped to Constructs**

| Information Exchange Identifier | Exchange Type | Construct Identifier | Description |
|---|---|---|---|
| A , B, C, D | Action | HITSP/SC114 – Administrative Transport to Health Plan | The HITSP Administrative Transport to Health Plan Service Collaboration provides the transport mechanism for conducting administrative transactions with health plans |
| A - Request for Health Plan to authorize certain healthcare services | Content | HITSP/T68 – Patient Health Plan Authorization Request and Response | The HITSP Patient Health Plan Authorization Request and Response Transaction provides a mechanism for a healthcare provider (other than a retail pharmacy) to request approval from a health plan to authorize certain healthcare services, when required by the patient's health plan contract. The information exchanged includes, but is not limited to, approval status for coverage, allowed service provider(s), and certification dates for services that are included in the patient's health plan benefits. The response from the health plan indicates that the health plan has determined that the particular service(s) will or will not be covered, and what is the level of coverage if that information is available from the health plan |
| B - Health Plan Response for healthcare services | | | |
| C - Request for Health Plan to authorize certain pharmacy products or services | Content | HITSP/T79 – Pharmacy to Health Plan Authorization Request and Response | The Pharmacy to Health Plan Authorization Request and Response Transaction provides a mechanism for a pharmacy to request approval from a health plan to authorize certain healthcare products and services, as |

| Information Exchange Identifier | Exchange Type | Construct Identifier | Description |
|---|---|---|---|
| D - Health Plan Response for pharmacy products or services | Content | | required by the patient's health plan contract. The health plan responds to the pharmacy's request for the approval of products and/or services. The information exchanged includes, but is not limited to, approval status for coverage of the products and/or services that are included in the patient's health plan benefits and/or authorization limitations |

## 4.2 CONSTRAINTS AND ASSUMPTIONS

Table 4-3 specifies the context that must be provided in order to use the Capability, identifying any assumptions, pre-conditions, post-conditions, and triggers relevant for use of the Capability.

**Table 4-3 Context**

| Assumptions, Pre-conditions, Post-conditions, and Triggers | Type of Context |
|---|---|
| Patient Identities (name, demographics etc.) are known and are consistent with policies. In this regard, it is expected that the Health Plan's Member ID is known and related to the Provider's Financial & Administrative System accordingly | Pre-condition |
| Health Information Exchange (HIE) or clearinghouse can serve as intermediary for data in many implementation variants. The various alternative options are not shown | Assumption |
| Entities have pre-established a business relationship to exchange information | Pre-condition |
| Authentication service to authenticate requestors and/or data submissions from various locations | Pre-condition |
| Security and privacy policies, procedures and practices are commonly implemented to support acceptable levels of consumer/patient security and privacy | Pre-condition |

## 4.3 SPECIFIED INTERFACES BY SYSTEM ROLE

This section specifies interfaces in terms of the System Roles identified in Table 2-2 Orchestration of System Roles.

Table 4-4 specifies interfaces for the Care Authorization Requestor system role as defined in Table 2-2.

**Table 4-4 Clinician Authorization Requestor System Role Mapped to HITSP Construct Interfaces**

| Construct Interface | Interface Type | T/TP/SC or Content | T/SC/Content Optionality |
|---|---|---|---|
| Information Receiver for Health Plan Authorization | Initiating | Administrative Transport to Health Plan (HITSP/SC114) | R |
| | | Health Plan Authorization Information Request (HITSP/T68) | C141 [201] |

Optionality Legend: "R" for Required, "O" for Optional, or "C" for Conditional

Table 4-5 specifies interfaces for the Care Authorization Responder System Role as defined in Table 2-2.

**Table 4-5 Clinician Authorization Responder System Role Mapped to HITSP Construct Interfaces**

| Construct Interface | Interface Type | T/TP/SC or Content | T/SC/Content Optionality |
|---|---|---|---|
| Information Source for Health Plan Authorization | Responding | Administrative Transport to Health Plan (HITSP/SC114) | R |
| | | Health Plan Authorization Information Response (HITSP/T68) | C141 [201] |

Optionality Legend: "R" for Required, "O" for Optional, or "C" for Conditional

Table 4-6 specifies interfaces for the Pharmacy Authorization Requestor system role as defined in Table 2-2.

**Table 4-6 Pharmacy Authorization Requestor System Role Mapped to HITSP Construct Interfaces**

| Construct Interface | Interface Type | T/TP/SC or Content | T/SC/Content Optionality |
|---|---|---|---|
| Information Receiver for Health Plan Authorization | Initiating | Administrative Transport to Health Plan (HITSP/SC114) | R |
| | | Health Plan Authorization Information Request (HITSP/T79) | C141 [202] |

Optionality Legend: “R” for Required, “O” for Optional, or “C” for Conditional

Table 4-7specifies interfaces for the Pharmacy Authorization Responder System Role as defined in Table 2-2.

**Table 4-7 Pharmacy Authorization Responder System Role Mapped to HITSP Construct Interfaces**

| Construct Interface | Interface Type | T/TP/SC or Content | T/SC/Content Optionality |
|---|---|---|---|
| Information Source for Health Plan Authorization | Responding | Administrative Transport to Health Plan (HITSP/SC114) | R |
| | | Health Plan Authorization Information Response (HITSP/T79) | C141 [202] |

Optionality Legend: “R” for Required, “O” for Optional, or “C” for Conditional

Table 4-8 specifies optionality conditions referenced in Table 4-4 through Table 4-7 above.

**Table 4-8 Implementation Conditions**

| Condition Code | Condition Description |
|---|---|
| C141[201] | SHALL be supported if a Clinician system -Exchange Content is HITSP/T68 |
| C141[202] | SHALL be supported if a Pharmacy system - Exchange Content is HITSP/T79 |

# 5.0 STANDARDS

The following table is provided as an aid to readers to assist them in identifying the parts of this section to focus on. Readers are encouraged to review all sections of this document to further their understanding of HITSP's work.

**Table 5-1 Reader's Guide for Section 5.0**

| Document Section | Number | Intended Audience | Information Contained |
|---|---|---|---|
| Section 5.0 Standards | 5.1 Standards Used | Program Managers<br>Policy Analysts<br>Architects<br>Business Analysts<br>Developers | List regulatory guidance, selected standards and informative references used by the Capability and all its supporting constructs |
| | 5.2 Standards Gaps and Overlaps | Program Managers<br>Policy Analysts<br>Architects<br>Business Analysts<br>Developers | Identifies gaps or overlaps in standards to implement the Capability including a plan to resolve issues |

## 5.1 STANDARDS USED

### 5.1.1 REGULATORY GUIDANCE

Table 5-2 lists any regulatory guidance that determines or constrains use of standards.

**Table 5-2 Regulatory Guidance**

| Regulation | Description |
|---|---|
| Health Insurance Portability and Accountability Act (HIPAA) – Administrative Simplification | A listing of national standards plus rules adopted by federal regulation for electronically communicating specified administrative and financial healthcare transactions, and protecting the security and privacy of healthcare information, as applied to the three types of defined covered entities: health plans, healthcare clearinghouses, and healthcare providers who conduct any of the specified healthcare transactions. For more information see the Code of Federal Regulations, Title 45, Parts 160, et. Seq |

### 5.1.2 SELECTED STANDARDS

Table 5-3 lists the standards selected as relevant to this Capability.

**Table 5-3 Selected Standards**

| Standard | Description |
|---|---|
| Accredited Standards Committee (ASC) X12 278 Transaction Version Standards Release 004010 | The objective of the Health Care Service Review – Request for Review and Response (278) is to provide for the exchange of service review requests from a healthcare provider to a health plan, and a corresponding response from the health. plan to that healthcare provider. This transaction can be used by health care providers to request approval and coverage information on the patient for a particular service type or service. This standard is required by HIPAA. This standard is required by regulatory guidance. |
| Accredited Standards Committee (ASC) X12 278 Transactions Standard Version 4010, using the Insurance Subcommittee (X12N) Addenda 004010X94A1 | Many of the version X12N 004010 Implementation Guides, including all of those adopted under HIPAA, have Addenda that contain updates – only – to the original Implementation Guides. These Addenda are identified as version 004010A1. Implementation Guide 004010X094A1 describes transactions for Health Care Service Review – Request for Review and Response. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com. This standard is required by regulatory guidance |

| Standard | Description |
|---|---|
| Accredited Standards Committee (ASC) X12 278 transactions standard version 4010, using the Insurance Subcommittee (X12N) Implementation Guides Version Reference Numbers 004010X094 | Detailed Implementations Guide based on release 004010 of the X12 standards. These Implementation Guides provide details on the use of X12 standards to accomplish specific transaction functions. Some of the version 004010 Implementation Guides, but not all, have been adopted as Implementation Specifications under HIPAA. This standard is required by regulatory guidance. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com |
| National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version 5.1 | Provides prescription claim transactions between Providers and Adjudicators, and between Adjudicators (aka Payer-to-Payer). The Telecommunication Standard Implementation Guide supports the following processes:<br>• Eligibility Verification<br>• Claim<br>• Service<br>• Information Reporting<br>• Prior Authorization<br>• Predetermination of Benefits<br>For more information visit www.ncpdp.org.<br>Version 5.1 of this document was named in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It should be noted that the industry has requested Version D.Ø for use in the next round of HIPAA |

### 5.1.3 INFORMATIVE REFERENCE STANDARDS

Table 5-4 includes reference standards that inform the overall semantic interoperability.

**Table 5-4 Informative Reference Standards**

| Standard | Description |
|---|---|
| Not applicable | |

## 5.2 STANDARDS GAPS AND OVERLAPS

Table 5-5 identifies the information exchange requirements and known standards gaps, along with the recommended resolutions to the gaps.

**Table 5-5 Information Exchange Requirements (IER) and Associated Standards Gaps**

| IER Gap Description | Responsible HITSP TC | Design Approach | Required Standards Now Unavailable for Constructs | SDO Working on Unavailable Standards | Expected Availability |
|---|---|---|---|---|---|
| Consumer requests a Provider list ASC X12 274 | AFDTC | Update CAP 141 and T68 | ASC X12 274 transaction is not currently designed to allow consumers to make this inquiry | ASC X12 | To be determined |
| Consumer Request Eligibility Benefits | AFDTC | Update CAP 141 and T68 | ASC X12 270 not currently designed to interact with consumers | ASC X12 | To be determined |
| Consumer sends Prior Auth information to a Payer or Provider system from their PHR or similar system | AFDTC | Update CAP 141 and T68 | There are no current standards available today that include the PHR system. This requires a change to ASC X12 278 | ASC X12 | To be determined |
| Consumer uses this PHR or similar system to communicate prior-authorization information to a provider or payer system | AFDTC | Update CAP 141 and T68 | No standards available today that includes the PHR system. Change needed to ASC X12 278 to support medical history | ASC X12 | To be determined |

| IER Gap Description | Responsible HITSP TC | Design Approach | Required Standards Now Unavailable for Constructs | SDO Working on Unavailable Standards | Expected Availability |
|---|---|---|---|---|---|
| Provider send Prior Auth request for information to a Payer about non-patient specific Prior Auth information | AFDTC | Update CAP 141, T68 and T79 | Neither the X12 278 nor NCPDP Formulary and Benefit real-time transactions support this function today | ASC X12<br><br>NCPDP | To be determined<br><br>NCPDP not able to ascertain the business needs for the exchange cited. If business need should materialize, NCPDP will be glad to participate in standardization efforts. |
| Query for patient-specific prior-authorization criteria | AFDTC | Update CAP 141 and T68 | The ASC X12 271 eligibility transaction today cannot provide information about the prior-authorization criteria. It also may not provide alternative treatments | ASC X12 | To be determined |
| Respond to non patient-specific eligibility request by a consumer or provider for specific service, treatment, therapy, etc. or a list of services | AFDTC | Update CAP 141 and T68 | ASC X12 271 does not provide eligible benefit coverage for non-patient specific procedures or therapies | ASC X12 | To be determined |
| Respond to non patient-specific eligibility request by a consumer or provider for specific service, treatment, therapy, etc. or a list of services | AFDTC | Update CAP 141 and T79 | NCPDP not currently designed to interact with a consumer | NCPDP | NCPDP not able to ascertain the business needs for the exchange cited. If business need should materialize, NCPDP will be glad to participate in standardization efforts. |
| Respond to patient-specific prior-authorization or eligibility queries from consumers | AFDTC | Update CAP 141, T68 and T79 | ASC X12 and NCPDP do not support the consumer | ASC X12<br><br>NCPDP | To be determined<br><br>NCPDP not able to ascertain the business needs for the exchange cited. If business need should materialize, NCPDP will be glad to participate in standardization efforts. |
| Particularly in the event of a rejection, a payer may need the ability to communicate an explanation for a prior-authorization decision as well as to communicate information on alternative treatment options or an Advanced Beneficiary Notification (ABN) | AFDTC | Update CAP 141 and T68 | The gap is being able to communicate alternate treatment options for medical benefits | ASC X12 | To be determined |

Table 5-6 lists any standards overlaps and describes plans to resolve each of the overlaps.

**Table 5-6 Information Exchange Requirements and Associated Standards Overlaps**

| Requirement Number | Summary Description | Standard Overlap | Recommended Resolution |
|---|---|---|---|
| None | | | |

# 6.0 APPENDIX

This section may include additional materials referenced throughout this document, such as requirements analysis tables and figures. If the Capability is yet to be implemented, it may contain the candidate standards, for Tier 2 evaluations.

The following legacy Interoperability Specifications were used to derive this Capability:

- HITSP/IS04 Emergency Responder Electronic Health Record
- HITSP/IS08 Personalized Healthcare
- HITSP/IS09 Consultations and Transfers of Care
- HITSP/IS77 Remote Monitoring

Table 6-1 describes the requirements from the 2009 Medication Gaps document which are incorporated in this Capability.

**Table 6-1 Functional Requirements**

| Functional Requirement | Information Exchange | Data Requirements | Analysis |
|---|---|---|---|
| Pharmacy-initiated prior authorization for medication orders | C | | Existing NCPDP Telecom transactions |
| Prescriber to Pharmacy communication of Prior Authorization independent of medication order<br>Prior Authorization communication from prescriber to LTC facility | GAP | Need to consider how to completely describe a prior authorization. Possibly as a structured document | No current mechanism available to send prior-authorization information from prescriber to pharmacy or other provider/LTC facility (independent of a medication order). This could be a new CAP, related constructs, and possibly standards GAPs |
| Prescriber acquiring Prior Authorization of medication | A, B | | HITSP/CAP141 refers to HITSP/T68 for prescriber obtaining prior-authorization from the PBM/Payer (no changes needed) |
| Plan Formulary for Medication Orders – query for plan formulary information | C, D | | HITSP/T79 deals with Pharmacy Health Plan queries |

Table 6-2 describes the requirements from the 2009 Prior-Authorization Extension/Gap document which are incorporated in this Capability.

**Table 6-2 Mapping of Prior-Authorization Functional Requirements to Information Exchange Requirements**

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| A. The ability for consumers to participate in prior-authorization processes and information exchange | i. Consumers may need the ability to receive certain standardized payer or provider information related to prior-authorization within their PHR or similar systems. Examples include provider lists or eligibility coverage information for various services and frequency limitations | Gap | Provider List | Provider list could use the ASC X12 274 modified to support the consumer as a receiver. However, ASC X12 274 transaction is not currently designed to allow consumers to make this inquiry. Not sure the ASC X12 274 supports a request function either |
| | | Gap | Eligibility coverage information | Eligibility information would use the ASC X12 270/271 modified to support the consumer as a receiver. ASC X12 270 transactions are not currently designed to interact with a consumer. Consumer Identification would be added to the ASC X12 270/271 and 274 transactions to fill a gap. |
| | | Gap | Formulary and benefits information | Formulary and benefits information – Gap - not currently designed to interact with a consumer. Process outlined in HITSP/TP46 Medication Formulary and Benefits Information – ASC X12N 270/271 Eligibility with NCPDP Formulary and Benefit Standard supports the exchange of benefit information Gap – need development of consumer-friendly nomenclature. NOTE: Could be done by the application, assuming that the consumer/provider is not going to read a raw X12 or NCPCP transaction |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| | ii. Consumers may need the ability to use their PHR or similar systems to communicate prior-authorization information to provider and/or payer systems. Examples include supplying medical history or prior coverage information | Gap - See Analysis | Prior - Authorization Information | There are no current standards available today that include the consumer business actor function. This will require a change by ASC X12 to the 278 transaction. Would need to also consider a consumer communicating with pharmacy when pharmacy-based prior-authorizations are required |
| | | A, B See Analysis | Medical History | A potential gap, the ASC X12 278 transaction may need additional functionality to support all medical history. Some medical history can be exchanged with an authorization request. Could be a gap if not sufficient. Question: Medical history information would be useful for a referral to provider; do we know what information is being contemplated here (e.g., a complete history, certain aspects then which ones; medical conditions that necessitate a service, treatment, therapy, etc. can be reported)?<br>The X12 274 is an inquiry/response transaction, but it does not currently support the consumer as an information receiver |
| | | Gap - See Analysis | Prior coverage information | Prior coverage is NOT part of prior-authorization, would be a gap, but is this really required? We are not familiar with the need. The ASC X12 278 can communicate previous prior-authorization information. We are wondering if a previous prior-authorization is required rather than Prior Coverage, which would be supported today in the ASC X12 278 and HITSP/T68 |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
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| B. The ability for providers to access standardized prior-authorization information and to incorporate and/or use the information within an EHR or related system | i. The ability to receive non patient-specific prior-authorization information such as eligibility and reimbursement guidelines. Providers may receive more detailed information than the consumer for treatment, payment, and operations. For example those particular clinical services and medications that may need prior-authorization and the types of accompanying information that are typically needed for approval | A, B (Gap )<br><br>C, D (Partial Gap) | Eligibility guidelines information<br><br>Reimbursement guidelines | Neither the X12 nor NCPDP real-time transactions support this function today.<br>As a gap solution, we might ask ASC X12 to change the 278 transaction to allow the health plan to send an attachment, which would include a PDF document of the administrative guidelines.<br>Alternatively, we could also ask HL7 to develop a discrete CDA dataset for this purpose and to create an AIS booklet. This CDA would then be returned in the ASC X12 278 as describe above for the PDF document.<br>Pharmacy has the ability to perform real-time prior-authorization functions - HITSP/T79 Pharmacy to Health Plan Authorization uses the NCPDP Telecommunication Standard for real-time prior-authorization requests, prior-authorization billings, prior-authorization inquiries for pharmacies.<br>Process outlined in HITSP/TP46 Medication Formulary and Benefits Information – ASC X12N 270/271 Eligibility with NCPDP Formulary and Benefit Standard supports the exchange of benefit information<br>As a gap solution, NCPDP Formulary and Benefit standard exchange might be enhanced for more general information than it currently has.<br>NCPDP batch transaction standard might include information for formulary and benefits in unsolicited mode for the medication environment<br>Note: Provider administrative guides and Web Sites supplied by payers are available today for physicians and hospitals to access |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| | ii. The ability to query for patient-specific prior-authorization criteria, such as when verifying coverage or eligibility for a specific medical service. The ability to review such information without actually submitting a prior-authorization request may reduce workflow disruption and help providers to aid consumers in evaluating their treatment options with respect to their insurance coverage and/or associated costs<br>Note: What is being described is not a Prior Authorization function, it is an eligibility function, that already exists | A, B (Partial Gap)<br><br>C, D | Prior - Authorization Information | HITSP/T68 provides for ASC X12 270/271 for eligibility/benefit inquiries. The eligibility transaction today cannot provide information about the P.A. criteria, it also may not provide alternative treatments; these would be a gap. However, the ASC X12 270/271 does support the pointer to the Formulary and Benefit information (HITSP/TP46) which does provide more of this info.<br>The eligibility transaction could be modified to report in a message segment required information to obtain an authorization approval<br>HITSP/T79 Pharmacy to Health Plan Authorization uses the NCPDP Telecommunication Standard for real-time PA requests, PA billings, PA inquiries for pharmacies<br>HITSP/CAP141 refers to HITSP/T79.<br>HITSP/T79 depends on HITSP/HITSP/TP46-Medication Formulary and Benefits Information to provide formulary and benefit information.<br>There is an industry task group (NCPDP-X12) building XML ability to exchange PA questions/answers (criteria) |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| | iii. The ability to electronically submit patient-specific prior-authorization requests and related information to payers | A, B<br><br>C, D | Prior - Authorization Information | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the PBM/Payer (no changes needed)<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM/Payer (no changes needed).<br>Industry pilot indicates that v5010 may be a better version, but may still have some gaps that were addressed in X12 version 5050 or above. There is an industry task group (NCPDP-X12) building XML ability to exchange prior-authorization questions/answers (criteria).<br>Alternative solutions may be developed for the pharmacy medication side.<br>HITSP/T79 Pharmacy to Health Plan Authorization uses the NCPDP Telecommunication Standard for real-time prior-authorization requests, prior-authorization billings, prior-authorization inquiries for pharmacies<br>The HITSP AFDTC will address moving to 5010 and 5050 in 2010 |
| | iv. The ability to request a modification or extension of a previously approved prior-authorization | A, B<br><br>C, D | Prior - Authorization Information | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer. (No changes needed)<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM (No changes needed) |
| | v. Providers may need the ability to communicate prior-authorization information to another provider | A, B<br><br>C, D | Prior - Authorization Information | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer (No changes needed).<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM. (No changes needed).<br>Need to determine the business need for a pharmacy-to-pharmacy exchange of prior-authorization information |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
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| C. The ability for payers to electronically communicate standardized prior-authorization information to provider and/or consumer systems. Information related to prior-authorization is highly variable, and certain aspects may be considered proprietary. A process which allows payers to electronically communicate prior-authorization information may need to accommodate these factors | i. The ability to broadly disseminate certain types of non patient-specific information such as a list of eligible providers or different therapies. For example indicate which clinical services and medications may need prior-authorization and what types of accompanying information are typically needed for approval | A, B (Partial Gap)<br>Provider List<br><br>A, B (Partial Gap)<br>Non patient-specific procedures or therapies<br><br>A, B<br>Respond to non patient-specific eligibility request by a consumer or provider<br><br>C, D<br>Medications Prior-Authorization | Provider List<br><br>. | HITSP/T68 - A list of providers within a health plan for multiple specialties would use the ASC X12 274 transaction.<br>Question: what is meant by "broadly disseminate?" Payers can send this information today to those providers who need the information, but each transmission would have a specific provider identified. If this is meant to put provider lists to a public Provider Directory, this transaction can also accommodate that function.<br>However, payers might send such a list to providers or directories in an unsolicited transmission.<br>HITSP/T68 would have an X12 gap for showing alternate therapies, treatment, etc., if a requested service, procedure, etc. was not covered There are no current standards available today that include the consumer business actor function.<br>This is a gap that will require a change by ASC X12 to the 278, 274, and 271 transactions.<br>HITSP/CAP141 refers to HITSP/T79 for Pharmacy to Health Plan HITSP/T79 depends on HITSP/HITSP/TP46 Medication Formulary and Benefits Information to provide formulary and benefit information.<br>HITSP/T79 Pharmacy to Health Plan Authorization uses the NCPDP Telecommunication Standard for real-time prior-authorization requests, prior-authorization billings, prior-authorization inquiries for pharmacies |
| | ii. The ability to communicate patient-specific prior-authorization or eligibility information in response to consumer and/or provider queries. Examples include outpatient therapy or home health service information specific to an individual patient's coverage | B, A (Partial Gap)<br><br>D, C | | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer. The gap is support of the consumer<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM. The gap is support of the consumer |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| | iii. The ability to electronically receive prior-authorization request submissions from providers and/or consumers and to process these requests within payers or third party intermediary systems | B, A (Partial Gap)<br><br>D, C (Partial Gap) | | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer. The gap is support of the consumer<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM. The gap is support of the consumer.<br>Note: Recent industry pilot indicates that v5010 may have some functional gaps that were addressed in X12 version 5050 or above.<br>There is an industry task group (NCPDP-X12) building XML ability to exchange PA questions/answers (criteria) |
| | iv. The ability to communicate a request for additional information such as clinical justification or treatment history in order to make a prior-authorization decision | B, A<br><br>D, C | | HITSP/CAP141 refers to HITSP/HITSP/T68 for provider obtaining prior authorization from the Payer. The gap is support of the consumer.<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM. The gap is support of the consumer |
| | v. The ability to electronically communicate patient-specific prior-authorization decisions, co-payment, and co-insurance information to provider and/or consumer systems | B, A (Partial Gap)<br><br>D, C (Partial Gap) | | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer. The gap is support of the consumer. Co-payments and co-insurance information related to an approved prior-authorization request would not be supported in ASC X12 278, this would be gap in HITSP/T68. However, the eligibility transactions ASC X12 270/271 will report this information for a patient specific inquire about a service, procedure, treatment, medication, or therapy.<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM. The gap is support of the consumer. Can provide co-payment or co-insurance information at the patient level |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| | vi. Particularly in the event of a rejection, a payer may need the ability to communicate an explanation for a prior-authorization decision as well as to communicate information on alternative treatment options or an Advanced Beneficiary Notification (ABN) | B, A (Partial Gap)<br><br>D, C | | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer. The content would be an explanation of benefits or reason for denial. The gap is being able to communicate alternate treatment options for medical benefits. This will need to be assigned to the ASC X12.<br>Note: Medical benefit - If the patient wants to proceed, the patient will need to sign an ABN or equivalent form and pay out of pocket. We will need to have a place in the response for the payer to indicate this need, or suggest a form be signed.<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM |
| | vii. A payer may need the ability to communicate co-payment, co-insurance or other information related to patient responsibility for expenses | A, B<br><br>D, C | | HITSP/CAP141 refers to HITSP/T68 for provider obtaining prior authorization from the Payer. The gap is support of the consumer<br>HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM. The gap is support of the consumer |
| Prior Authorization for Medication Orders | i. Pharmacy-initiated prior authorization | D, C | | HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM (no changes needed) |
| | ii. Prescriber to Pharmacy communication of Prior Authorization associated with a new medication order | C, D | Need to consider if additional Prior Authorization elements need to be added to SCRIPT (other than Prior Auth number) | HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM (no changes needed).<br>NCPDP SCRIPT 10.1 supports sending a Prior Authorization number and status indicator with the medication order |

| Functional Requirements | | Information Exchange Requirement(s) (includes security requirements) | Data Requirements | Analysis |
|---|---|---|---|---|
| | Iii .Prescriber to Pharmacy communication of Prior Authorization independent of medication order Prior-Authorization communication from prescriber to LTC facility | GAP | | No current mechanism available to send prior-authorization information from prescriber to pharmacy or other provider/LTC facility (independent of a medication order). This would be a new CAP, related constructs, and possibly standards GAPs<br>No current mechanism available to send prior-authorization information from prescriber to LTC facility (independent of a medication order). This could be a new CAP, related constructs, and possibly standards GAPs |
| | iv. Prescriber acquiring Prior-Authorization of medication | C, D | | HITSP/CAP141 refers to HITSP/T79 for prescriber obtaining prior authorization from the PBM/Payer (No changes needed) |
| Plan Formulary for Medication Orders | i. Query for plan formulary information | C, D | | HITSP/CAP141 refers to HITSP/T79 for Pharmacy to Health Plan HITSP/T79 depends on HITSP/HITSP/TP46-Medication Formulary and Benefits Information to provide formulary and benefit information |

# 7.0 DOCUMENT UPDATES

This section provides the history of changes made to this document.

## 7.1 SEPTEMBER 30, 2009

No changes. This is the first published version of the document.

## 7.2 NOVEMBER 9, 2009

Minor wording changes in Section 4.3 to provide clarity.

Updated Table 2-3 and Table 2-4.

Updated table containing Information Exchange Requirements and Associated Standards Gaps wording:

- Consumer business actor function changed to PHR system

## 7.3 JANUARY 18, 2010

- Reformatted to the new HITSP Capability template version 2.3
- Minor grammatical changes made throughout the document
- Section 1.1modified to clarify when X12 and NCPD standards would be used
- Table 2-2 modified to reflect new system roles
- Table 2-3 exchange content updated.
- Table 5-3 was updated with a new description for ASC X12 278

The following changes have been made to address Public Comments.

- 8200, 8201, 8202, 8203, 8204, 8205, 8206, 8208, 8209, 8210, 8258, 8765, 8768

The full text of the comments along with the Technical Committee's disposition can be reviewed on the HITSP Public Web Site.

## 7.4 JANUARY 25, 2010

Upon approval by the HITSP Panel on January 25, 2010, this document is now Released for Implementation.