

# HITSP Pharmacy to Health Plan Authorization Request and Response Transaction

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HITSP/T79



Healthcare Information Technology Standards Panel

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## 1.0 INTRODUCTION

### 1.1 OVERVIEW

The Healthcare Information Technical Standards Panel (HITSP) Pharmacy to Health Plan Authorization Request and Response Transaction is intended to provide a mechanism for a pharmacy to request approval from a health plan to authorize certain healthcare products and services, as 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.

The Pharmacy Prior Authorization is done for evaluation of impact for (but not restricted to):

- Alternative medications – information is retrieved so the pharmacy and patient can discuss alternatives available (such as generic or lower tier products). The alternative choice may require a modification of the prescription
- Patient liability and plan restrictions – information is retrieved so the pharmacy can discuss with the patient their financial impact. The pharmacy and patient can discuss if that course of therapy is still to be done or decide if another therapy should be pursued
- Whether clinical protocols/regiments/therapies have been followed

For HITSP purposes, the term “Health Plan” is used for prior pharmacy authorization which allows a Pharmacy Benefit Manager (PBM), payer, processor, health plan, or any entity to perform the approval process on behalf of the health plan. While each of these entities may perform other functions in the healthcare arena, specifically for processing pharmacy products and services, the prior pharmacy authorization functions as, and is grouped together, under one term “Health Plan.”

The HITSP Pharmacy to Health Plan Authorization Request and Response Transaction uses the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Prior Authorization Suite of Transactions. These Transactions provide standards to accommodate the exchange of information between an information requester (pharmacy settings) and any information source such as a review entity, utilization management organization, health plan, an insurance company or a third-party administrator. The NCPDP Prior Authorization Suite of Transactions is request and response based, used in real-time or batch environments.

The HITSP/TP46 Medication Formulary and Benefits Information Transaction Package may also be used if the pharmacy would like to only check eligibility, or if the pharmacy would like to perform a predetermination of benefits.

### 1.2 COPYRIGHT PERMISSIONS

#### COPYRIGHT NOTICE

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### 1.3 REFERENCE DOCUMENTS

A list of key reference documents and background material is provided in the table below. HITSP maintained reference documents can be retrieved from [www.hitsp.org](http://www.hitsp.org).



**Table 1-1 Reference Documents**

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

## 1.4 CONFORMANCE

This section describes the conformance criteria, which are objective statements of requirements that can be used to determine if a specific behavior, function, interface, or code set has been implemented correctly.

### 1.4.1 CONFORMANCE CRITERIA

In order to claim conformance to this construct specification, an implementation must satisfy all the requirements and mandatory statements listed in this specification, the associated HITSP Interoperability Specification, its associated construct specifications, as well as conformance criteria from the selected base and composite standards. A conformant system must also implement all of the required interfaces within the scope, subset or implementation option that is selected from the associated Interoperability Specification.

Claims of conformance may only be made for the overall HITSP Interoperability Specification or Capability with which this construct is associated.

### 1.4.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

A HITSP Interoperability Specification or Capability must be implemented in its entirety for an implementation to claim conformance to the specification. HITSP may define the permissibility for interface scoping, subsetting or implementation options by which the specification may be implemented in a limited manner. Such scoping, subsetting and options may extend to associated constructs, such as this construct. This construct must implement all requirements within the selected scope, subset or options as defined in the associated Interoperability Specification or Capability to claim conformance.



## 2.0 TRANSACTION DEFINITION

### 2.1 CONTEXT OVERVIEW

The HITSP Pharmacy to Health Plan Authorization Request and Response Transaction is intended to provide a mechanism for a pharmacy to request approval from a health plan to authorize certain healthcare products and services, as required by the patient's health plan contract. The health plan responds to the pharmacy whether the product or service is approved.

The NCPDP Telecommunication Standard Implementation Guide - Prior Authorization Suite of Transactions allows authorization, authorization and adjudication of the claim or service, deferment, or pending request for review.

The Information Receiver interface initiates a request to the Information Source interface for purposes of health plan benefit coverage determination and referral services. This transaction occurs through the NCPDP Telecommunication Standard Implementation Guide - Prior Authorization Suite of Transactions and includes the following:

- Pharmacy Prior Authorization Request and Billing
  - This transaction allows the pharmacy to request simultaneous adjudication/capture of the transaction by the health plan upon approval of the Pharmacy Prior Authorization. This transaction allows the Pharmacy Prior Authorization function and the adjudication/capture function to happen within one request
- Pharmacy Prior Authorization Reversal
  - This transaction allows the pharmacy to request the processor to cancel a previously approved Pharmacy Prior Authorization request. Pharmacy Prior Authorization reversals are used to back out the request for authorization, but not any claims submitted against the Pharmacy Prior Authorization
- Pharmacy Prior Authorization Inquiry
  - This transaction allows the pharmacy to request the status of a previously transmitted Pharmacy Prior Authorization from the health plan.
- Pharmacy Prior Authorization Request Only
  - This transaction allows the pharmacy to only request a prior Pharmacy Prior Authorization from the health plan and exclude the processing of the claim or service

The Information Source interface responds to the query initiated by the Information Receiver interface for health plan authorization. The health plan authorization information request will determine the following transactions:

- Approve the Pharmacy Prior Authorization
- Approve the health plan authorization and adjudication of the claim or service
- Determine Pharmacy Prior Authorization was captured, but no judgment has been made
- Determine status of a Pharmacy Prior Authorization request; is the request deferred
- Determine if there is an error in the transaction or processing, or the health plan does not approve the Pharmacy Prior Authorization request



## 2.1.1 INTERFACES

**Table 2-1 Interfaces**

Interface	Description	Used in Component/ Standard	Transaction/Content	T/C Optionality
Information Receiver for Health Plan Authorization	The system that initiates a request to the Information Source for Health Plan Authorization about an individual's health insurance requirements to obtain an authorization approval for purposes of benefit coverage determination in order to refer a patient for healthcare services	NCPDP Telecommunication Standard Implementation Guide – Prior Authorization Suite of Transactions	Health Plan Authorization Information Request	R
			Health Plan Authorization Information Response	R
Information Source for Health Plan Authorization	The system which holds and maintains the information regarding the individual's health insurance requirements related to an authorization for benefit coverage	NCPDP Telecommunication Standard Implementation Guide – Prior Authorization Suite of Transactions	Health Plan Authorization Information Request	R
			Health Plan Authorization Information Response	R

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

The following table describes the implementation constraints placed on the interfaces, transactions, or content. The constraint codes listed below correspond to the codes placed in the Interface and Transaction/Content optionality column in Table 2-1 above.

## 2.1.2 INTERFACE INTERACTIONS

**Figure 2-1 Pharmacy to Health Plan Authorization Request and Response**



## 2.1.3 CONDITIONS AND ASSUMPTIONS

**Table 2-2 Context**

Assumptions, Pre-conditions, Post-conditions, and Triggers	Type of Context
It is expected that the Security Framework under which this Transaction operates is in accordance with the Interoperability Specification that references this construct. Therefore all applicable HITSP Security and Privacy constructs are implemented as required	Pre-condition
Individual is known to health plan	Pre-condition
Individual's formulary and benefits are known to health plan	Pre-condition
Pharmacy determines a prior authorization must occur	Trigger





Assumptions, Pre-conditions, Post-conditions, and Triggers	Type of Context
The Information Receiver for Health Plan Authorization processes the response received from the Information Source for Health Plan Authorization and determines to provide the products or services and to obtain reimbursement	Post-condition

### 2.1.3.1 REQUIRED OUTPUT

**Table 2-3 Required Output**

Required Output	Format/Usage
The Information Receiver for Health Plan Authorization provides authorization status information to the user of the system	Via user interface

### 2.1.4 DATA FLOWS

T79-[MSG-1-1] Implementations **SHALL** support the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version 5.1 suite of transactions.

Below are the data mappings and constraints for the NCPDP Telecommunication Standard Version 5.1.

The legend for transaction set data element mapping follows the format below:

<fieldnumber>\_<fieldname>

For example:

202-B2\_Service Provider ID Qualifier

**Table 2-4 NCPDP Telecommunication Standard Implementation Guide Data Element Mapping**

Constraint ID	NCPDP Data Element	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T79-[DET1-1]	<u>202-B2_Service Provider Id Qualifier</u>	Data Qualifier Code Set 8.35 Dispensing Pharmacy	Information Receiver for Health Plan Authorization Or Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization Or Information Source for Health Plan Authorization	R	T42-[DE-8.35-1] Service/Provider ID Qualifier in the Transaction Header Segment <b>SHALL</b> be '01" for the National Provider ID
T79-[DET1-2]	<u>201-B1_Service Provider ID</u>	8.35 Dispensing Pharmacy	Information Receiver for Health Plan Authorization Or Information Source for Health Plan Authorization	Information Receiver for Health Plan Authorization Or Information Source for Health Plan Authorization		T42-[DE-8.35-2] Service/Provider ID in the Transaction Header Segment <b>SHALL</b> be the National Provider ID



## 2.2 LIST OF HITSP CONSTRUCTS

Table 2-5 List of HITSP Constructs

Construct Name	Description	Transaction/Content
No applicable HITSP constructs		

### 2.2.1 CONSTRUCT DEPENDENCIES

This is an optional route.

Table 2-6 Construct Dependencies

Construct	Depends On (Name of Component that it depends on)	Dependency Type (Pre-condition, Post-condition, General)	Purpose (Reason for this dependency)
HITSP/T79-Pharmacy to Health Plan Authorization Request and Response	HITSP/TP46-Medication Formulary and Benefits Information	General	To provide eligibility information (if needed) and formulary and benefit information before obtaining a prior authorization. These functions can all be obtained during the claim processing functions, but HITSP/TP46 can be used if pre-information is determined to be needed

### 2.2.2 ADDITIONAL CONSTRAINTS ON REQUIRED CONSTRUCTS

Table 2-7 Additional Constraints on Required Constructs

Constraint ID	Data Element	Construct	Constraint	Constraint Type (Pre-condition, Post-condition, General)	Purpose (Reason for this constraint)
No applicable constraints					

## 2.3 STANDARDS

### 2.3.1 REGULATORY GUIDANCE

Table 2-8 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.



### 2.3.2 SELECTED STANDARDS

**Table 2-9 Selected Standards<sup>1</sup>**

Standard	Description
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: 1. Eligibility Verification 2. Claim 3. Service 4. Information Reporting 5. Prior Authorization 6. Predetermination of Benefits For more information visit <a href="http://www.ncdp.org">www.ncdp.org</a> 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.0 for use in the next round of HIPAA

### 2.3.3 INFORMATIVE REFERENCE STANDARDS

**Table 2-10 Informative Reference Standards**

Standard	Reason for Use
No applicable informative reference standards	

<sup>1</sup> Includes the Prior Authorization Suite of Transactions that provide standards to accommodate the exchange of information between an information requester (pharmacy settings) and any information source such as a review entity, utilization management organization, health plan, an insurance company or a third-party administrator.



## 3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

- A listing of all HITSP Constraints defined within this document

### 3.1 HITSP CONSTRAINTS DEFINED IN THIS DOCUMENT

This section lists all the constraints defined in this document.

**Table 3-1 Constraints**

Constraint ID	Constraint Description
T79-[MSG-1-1]	Implementations SHALL support the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide Version 5.1 suite of transactions.
T79-[DET1-1]	Service/Provider ID Qualifier in the Transaction Header Segment <b>SHALL</b> be '01" for the National Provider ID
T79-[DET1-2]	Service/Provider ID in the Transaction Header Segment <b>SHALL</b> be the National Provider ID



## 4.0 DOCUMENT UPDATES

The following sections provide the history of all changes made to this document.

### 4.1 DECEMBER 10, 2008

The changes in this construct address the following comments received during the Public Comment and Inspection Testing period (September 29 – October 24, 2008).

No comments were received.

### 4.2 DECEMBER 18, 2008

Upon approval by the HITSP Panel on December 18, 2008, this document is now Released for Implementation.

### 4.3 JUNE 30, 2009

Minor editorial changes were made to this document. Removed boilerplate text for simplification. The term “actor” was replaced with “interface”.

### 4.4 JULY 8, 2009

Upon approval by the HITSP Panel on July 8, 2009, this document is now Released for Implementation.

### 4.5 JANUARY 18, 2010

This document has been update to reflect the HITSP Transaction Template Version 2.7

This document has been modified to reflect HITSP/TN903 Data Architecture approach.

The following changes have been made:

- Section 1.3 Table 1-1 addition of HITSP/TN903 and HITSP/TN904 as References
- Section 2.1 Table 2-1 Interfaces Removal of duplicate constraints
- Section 2.1 Addition of Message Constraints per HITSP/TN903 format
- Addition of Section 2.1 Data Mapping per HITSP/TN903
- Section 3.0 Addition of Constraint Reference Appendix

### 4.6 JANUARY 25, 2010

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

