U.S. Department of Health and Human Services

Office of the National Coordinator for Health Information Technology

Prior-Authorization

AHIC Extension/Gap

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1.0 Preface and Introduction

1.1 Background

In April and June of 2008, the American Health Information Community (AHIC) approved a recommendation to develop documents that address extensions/gaps from the use cases published between 2006 and 2008. One of the extensions/gaps prioritized for subsequent processing in the national health agenda activities in 2009 was prior-authorization. AHIC specifically requested that the 2009 Prior-Authorization Extension/Gap address the electronic exchange of prior-authorization and co-payment information between payors, providers, consumers, and/or related systems. The focus of this extension/gap document is to facilitate an improved experience for consumers and providers by decreasing the administrative burden associated with prior-authorization, decreasing delays to care, and improving access to and use of prior-authorization information.

This extension/gap document is being developed by the Office of the National Coordinator for Health Information Technology (ONC) to represent the AHIC priorities and provide context for the national health agenda activities, beginning with the selection of harmonized standards by the Healthcare Information Technology Standards Panel (HITSP). Components that need to be considered during the standards identification and harmonization activities include standardized vocabulary, data elements, datasets, and technical standards that support the information needs and processes of consumers, providers, and/or payors during prior-authorization activities. This document is the Final AHIC Extension/Gap. Feedback received on the AHIC Extension/Gap has been considered and incorporated into this document where applicable. HITSP has the opportunity to reuse standards, where applicable, from those previously recognized by the Secretary of Health and Human Services, to specify and constrain how they are to be used to advance interoperability and to work with standards development organizations to see that gaps in standards are filled.

1.2 Progress to Date

To date, the national health agenda, including the activities of AHIC and HITSP, has not formally addressed all of the interoperability considerations for the communication of prior-authorization information.

Previously published AHIC use cases incorporate several concepts that have been evaluated by HITSP and could be leveraged during standards harmonization for this extension/gap document.

- The 2008 Consultations and Transfers of Care Use Case includes the needs for communicating prior-authorization information between payors, providers, consumers, and/or related systems;
- The 2007 Medication Management Use Case includes the general information needs for communicating prior-authorization information for medications; and
- The 2009 Medication Gaps Extension/Gap includes the data standards needs for communicating prior-authorization information for medications.

2.0 Overview and Scope

2.1 Document/Request Overview

This extension/gap document is focused on information needs to facilitate the electronic exchange of prior-authorizations. The 2009 Prior-Authorization Extension/Gap document is divided into the following sections:

- Section 1.0, Preface and Introduction, describes the progress to date, the additional priorities identified by the AHIC, the resulting extensions/gaps, and their purpose;
- Section 2.0, Overview and Scope, describes the sections of an extension/gap document, the request being made to HITSP, and the scope of that request;
- Section 3.0, Functional Needs, describes the combination of end-user needs and system behaviors that support interoperability and information exchange;
- Section 4.0, Stakeholder Communities, describes individuals and organizations that participate in activities described in this extension/gap;
- Section 5.0, Issues and Obstacles, describes issues and obstacles that may need to be planned for, addressed, or resolved to achieve the capabilities described in the extension/gap;
- Section 6.0, References to Use Case Scenarios, describes various scenarios and information exchanges that assist in the communication of information. Scenarios may be from previously published 2006 – 2008 Use Cases and/or new scenarios may be described;
- Section 7.0, Information Exchange, describes information exchange capabilities needed to support the scenarios and the high-level information exchanges;
- Section 8.0, Data Set Considerations, identifies specific opportunities for identification of information and/or data relevant to this extension/gap document. These opportunities may support future identification, development, and harmonization of standards;
- Appendix A, Glossary, provides contextual descriptions of key concepts and terms introduced in this extension/gap document; and

- Appendix B, Analysis and Examples, identifies example components which may support electronic prior-authorization.

2.2 Scope

Prior-authorization can be described as the processes by which consumers, providers, and/or payors exchange information needed to evaluate eligibility, determine coverage, type and frequency of service, and communicate co-pay and alternative treatment options. The information exchanged may also include payors' prior-authorization business rules, as needed to convey such criteria for use by other systems. The focus of this extension/gap document is to decrease the overall burden associated with prior-authorization and to facilitate consumers' ability to access prior-authorization related information as appropriate. The internal processes and business rules by which payors determine prior-authorization, including pre-adjudication and pre-determination, are out of scope for this extension/gap document.

Therefore, the requirements for the 2009 Prior-Authorization Extension/Gap can be summarized as:

- The ability for payors to electronically communicate standardized prior-authorization information required by provider and/or consumer systems to facilitate automated workflow;
- The ability for provider and/or consumer systems to query and receive standardized prior-authorization information from payors and to incorporate and use that information in their electronic health records (EHRs), personal health records (PHRs), and/or other related systems;
- The ability for providers and/or consumers to electronically submit or edit prior-authorization requests to payors from within provider and/or consumer EHR, PHR, and/or related systems;
- The ability for payors to electronically communicate standardized prior-authorization decisions and co-payment information to providers and/or consumers; and,
- The ability for providers and/or consumers to electronically receive payor prior-authorization decisions and related information and to incorporate and use that information in EHRs, PHRs, and/or other related systems.

The identification, development, and harmonization of standards to support the interoperability associated with Prior-Authorization has been preliminarily addressed.

However, additional work with standards and professional organizations, care delivery organizations, and organizations providing information technology services and products to the healthcare industry is needed to support the interoperability needs associated with Prior-Authorization. As mentioned in Section 1.0, the needs expressed here have not yet been fully addressed by the national health agenda's standardization efforts. Examples of gaps in industry standards are outlined in the upcoming sections of this extension/gap document.

3.0 Functional Needs

This section describes a combination of end-user needs and system behaviors to support users during the exchange of prior-authorization information. Support for this exchange includes the development of interoperability standards for vocabularies, data elements, datasets, and other technical components that are implicit in these functional needs. Rather than an all-inclusive list of functional requirements, key capabilities are outlined below. The descriptions in this section are not intended to prescribe policy nor propose architectures required to implement capabilities.

A. The ability for consumers to participate in prior-authorization processes and information exchange.

   i. Consumers may need the ability to receive certain standardized payor 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.

   ii. Consumers may need the ability to use their PHR or similar systems to communicate prior-authorization information to provider and/or payor systems. Examples include supplying medical history or prior coverage information.

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.

   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.

   iii. The ability to electronically submit patient-specific prior-authorization requests and related information to payors.

   iv. The ability to request a modification or extension of a previously approved prior-authorization.

   v. Providers may need the ability to communicate prior-authorization information to another provider.

C. The ability for payors 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 payors 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 which clinical services and medications may need prior-authorization and what types of accompanying information are typically needed for approval.

   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.

   iii. The ability to electronically receive prior-authorization request submissions from providers and/or consumers and to process these requests within payor or third party intermediary systems.

   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.

   v. The ability to electronically communicate patient-specific prior-authorization decisions, co-payment, and co-insurance information to provider and/or consumer systems.

   vi. Particularly in the event of a rejection, a payor 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).

   vii. A payor may need the ability to communicate co-payment, co-insurance or other information related to patient responsibility for expenses.

4.0 Stakeholder Communities

Examples of stakeholders who may be directly or indirectly involved in the exchange of prior-authorizations have been listed below. Specific descriptions of each type of stakeholder can be found in the previous 2006 – 2008 AHIC Use Cases.

Stakeholders that may be directly involved in the exchange of prior-authorization information may include: Consumers, Providers, and Healthcare Payors.

Stakeholders that may assist in prior-authorization information communication may include: EHR System Suppliers, PHR System Suppliers, and suppliers of other related systems.

Stakeholders that may be sources or recipients of prior-authorization information may include: Consumers, Providers, Healthcare Payors, and Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS), or others.

5.0 Issues and Obstacles

A number of issues in today's health information technology environment are obstacles to achieving the healthcare data standardization and interoperability to promote patient safety, reduce healthcare costs, and increase the value of electronic health information exchange. Some general issues were described within the 2006 – 2008 AHIC Use Cases. Examples of specific issues and obstacles related to Prior-Authorization are outlined below.

A. Consumer Access to Prior-Authorization and Co-Payment Information:

i. Information exchanges surrounding prior-authorization have often been exclusive to providers and payors and/or the systems used by them. Additional consideration of consumer needs in this area is needed. Issues include a lack of familiarity with medical terminology, eligibility terminology, and policy or regulations that govern prior-authorization information.

ii. Consumer-driven health care encourages the consumer to play an increasingly active role in their own healthcare. In order to do so, consumers may need improved access to information surrounding prior-authorization, coverage and frequency limitations, treatment options, and co-payments associated with those options.

iii. Standards that support the electronic information exchanges, integration, and use of information by consumer systems may be necessary in order for consumers to actively participate in prior-authorization processes.

B. Provider Workflow:

i. It may be beneficial to consider impact to provider workflow when developing standards to support information exchange related to prior-authorization.

ii. The types of prior-authorization information exchanged between provider and payor may vary by payor and/or type of service, making it difficult to identify standards that support electronic prior-authorization information exchange.

iii. It may be difficult to properly and efficiently communicate prior-authorization unless bi-directional information exchanges are accommodated to facilitate timely communications.

iv. The current standards associated with electronic prior-authorization information exchange have not been widely adopted in payor, provider, or other systems.

v. Eligibility checking and prior-authorization are often closely related in terms of provider workflow. This should be considered when identifying standards to support prior-authorization information exchange.

vi. Standards should be flexible enough to accommodate workflow variability. Provider workflow may be highly variable within different provider settings.

vii. Providers and consumers may be subject unnecessary delays and duplication of effort unless providers have the ability to communicate prior-authorization information to another provider. For example, if one provider obtains prior-authorization which is pertinent to the work of another provider, either the prior-authorization information or the confirmed prior-authorization from the Payor may need to be communicated.

C. Payor Workflow:

i. Payor criteria and requirements surrounding prior-authorization are usually communicated in member policies and provider network agreements.

ii. Considering the provider workflow or the need for prior-authorization information exchange by electronic systems may require payors to modify certain processes.

iii. Payors may be reluctant to embrace an information exchange model that electronically communicates aspects of proprietary pricing models or competitive differentiation.

iv. Reliance on manual processes may be due to criteria and requirements variability as well as the lack of a widely implemented, appropriate standard.

v. Payor legacy systems may be difficult to configure in order to implement changes to prior-authorization standards and procedures.

D. Prior-Authorization Information Exchange:

i. A balance between payor electronic communication of certain information, such as list of eligible providers, versus payor response to provider and/or consumer queries for more specific or potentially proprietary information may need to be considered.

ii. Payor systems may not currently have the ability to electronically communicate and/or respond to provider and consumer systems. Similarly, provider and consumer systems may not currently offer functionality needed to incorporate and use such information.

iii. Current initiatives aimed at standards development for specific electronic aspects of prior authorization (e.g., medications) may need to be considered to minimize the risk of multiple or competing prior authorization standards.

6.0 References to Use Case Scenarios

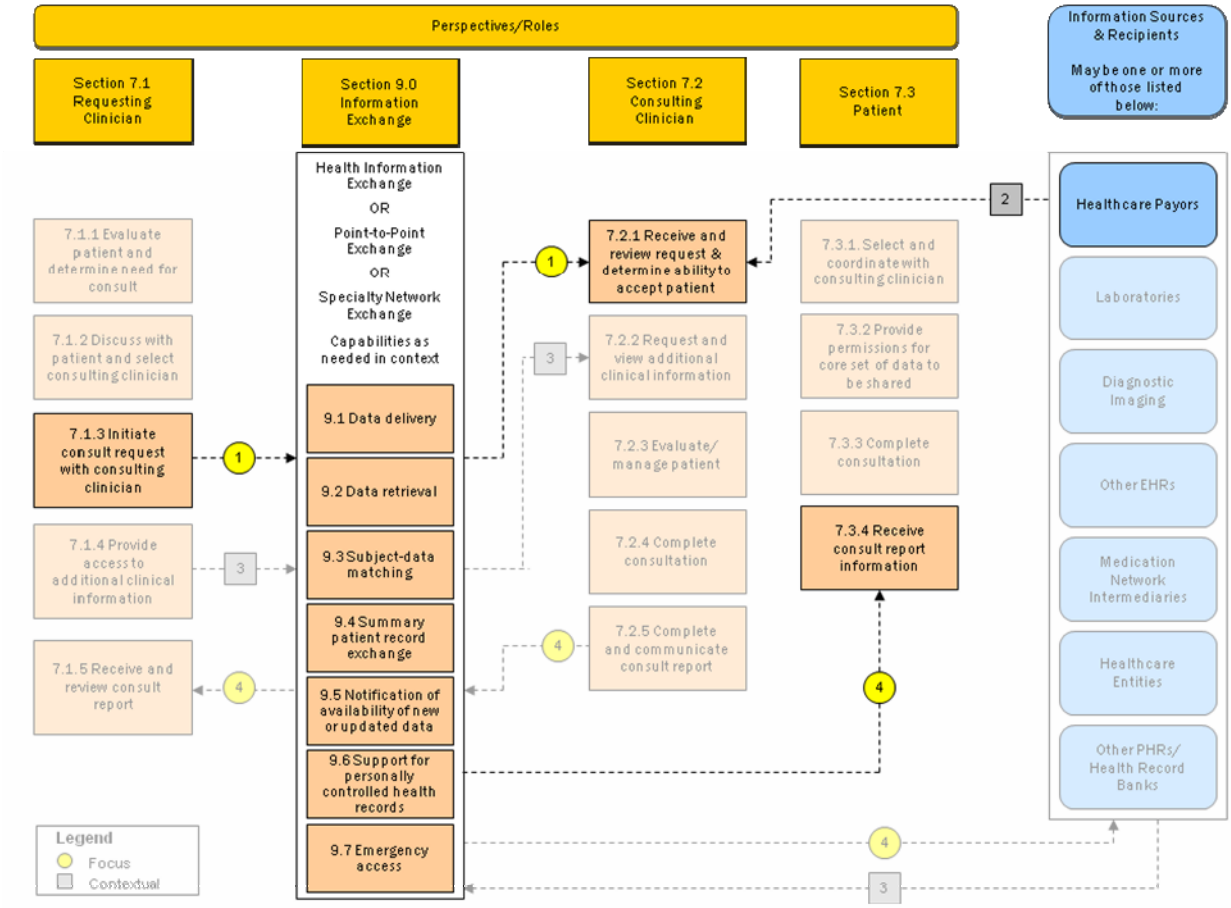
The 2009 Prior-Authorization Extension/Gap Document focuses on the exchange of a core set of information between payors, providers, and consumers. Specific events and information exchanges have been selected from 2006-2008 AHIC Use Cases for contextual purposes.

The 2008 Consultations and Transfers of Care Use Case contains a scenario that describes needs for communicating prior-authorization information between consumers, providers, payors, and/or related systems. The applicable scenario and information flows from the Consultations and Transfers of Care Use Case are included as figure 6-1.

The events and information flows in this use case that are relevant to the 2009 Prior-Authorization Extension/Gap are shown in bold. All other events and information flows have been faded out.

6.1 Reference to Prior Use Case: 2008 Consultations and Transfers of Care (Scenario 1)

Figure 6-1. Consultations



As expressed in the 2008 Consultations and Transfers of Care, event 7.1.3 and information flow 1, consult request and core patient information may be communicated from a provider via information exchange activities. In event 7.2.1 and contextual information flow 2, eligibility and authorization information may be communicated from a payor via information exchange activities. In event 7.3.4 and information flow 4, consult report information may be communicated to a patient via information exchange activities.

In the case of the 2009 Prior-Authorization Extension/Gap, consumers, providers, and payors may communicate prior-authorization criteria, requests, and related information via information exchange activities. The paths for flow 1 and 2 are the same as above, but may incorporate additional content. Information flow 2 is no longer contextual. The important component of the path for flow 4 is the one that supports information flow to the patient and, again, may have additional content from the original information flow. Prior-authorization information may be incorporated from PHRs, EHRs, and/or payor systems.

Therefore, information flows 1, 2, and 4 should be referenced when addressing Prior-Authorization.

7.0 Information Exchange

The information exchange requirements for the effective selection and communication of information associated with prior-authorizations may comprise:

- The ability for payors to electronically communicate standardized prior-authorization criteria to providers and/or consumers systems;
- The ability for providers and/or consumers to access, incorporate and use prior-authorization criteria at an appropriate level into EHRs, PHRs, and/or other related systems;
- The ability for providers and/or consumers to electronically request prior-authorization and communicate related information to payor systems;
- The ability for payors to electronically communicate prior-authorization decisions and co-payment information to providers and/or consumers systems; and
- The ability for providers and/or consumers to access, incorporate and manage prior-authorization decisions and co-payment information at an appropriate level in to EHRs, PHRs, and/or other related systems.

Examples of information exchange capabilities described above and in Section 3.0 may include: Data Delivery, Routing, Data Retrieval, and Subject Data Matching. Descriptions of each of these are in the previous 2006 – 2008 AHIC Use Cases

The functional capabilities may be provided fully or partially by a variety of organizations including: health information exchange organizations, integrated care delivery networks, provider organizations, health record banks, public health networks, specialty networks, and others.

While not described in this section, Health Information Exchange (HIE) and Point-to-Point exchanges assist in the completion of the processes described in this extension/gap document. Examples of HIEs and Point-to-Point exchanges can be found in the previous 2006 – 2008 AHIC Use Cases.

8.0 Prior-Authorization Dataset Considerations

The following non-exhaustive information categories and limited examples illustrate some of the information needs from this extension/gap document. Information needs have been organized according to communications which originate with Consumers and/or Providers or Payors.

Examples of components and processes which may serve as starting points to facilitate electronic prior-authorization workflow are included in Appendix B.

A. Consumer/Provider Originated Prior-Authorization Communication – Includes information needed to enable consumers and providers to receive prior-authorization criteria, decisions, and requests for additional information and to submit prior-authorization requests and queries for information.

i. Non patient-specific and non proprietary payor information

ii. Patient-specific Query

a. Query Information

(A) Query Identifier

(B) Query Date

b. Patient Information

(A) Name

(B) Member Number and Group Number

(C) Date of Birth

(D) Patient Identifying Information

(E) Address / Phone

c. Service Information

(A) Procedure Code(s)

(B) Diagnosis Codes(s)

iii. Prior-Authorization Request Submission – Includes information needed to enable providers to have the ability to electronically submit standardized prior-authorization requests that adhere to payor's current requirements.

a. Request Data

(A) Request ID

(B) Date

b. Patient Information

(A) Name

(B) Member Number and Group Number

(C) Date of Birth

(D) Patient Identifying Information

(E) Address / Phone

c. Provider Information

(A) National Provider Identifier (NPI) type I or II

(B) Payor's Provider ID (if NPI is unavailable)

(C) Provider Specialty Code

(D) Provider or Provider Entity Demographics

d. Requested Service Information

(A) Service type and/or description

(B) Procedure Code(s)

(C) Unit(s) per Procedure Code(s)

(D) Diagnosis

(a) Primary and secondary diagnosis codes and modifiers

(b) Original Diagnosis Date

(c) Subsequent Diagnoses

(d) Related or prior treatment(s)

e. Facility Information

(A) Facility Type

(B) Address

(C) NPI Type II

B. Payor Originated Prior-Authorization Communication – Includes information needed to enable payors to communicate which services require prior-authorization and under what circumstances, request submission procedures and evaluation

criteria, and requests for additional information and decisions. The standard may be required to accommodate broad payor dissemination of non patient-specific information, as well as targeted, patient-specific information in response to a provider or consumer query in a process analogous to eligibility request and response. It may be beneficial to leverage existing standards that support payor/provider communications and apply them to consumer systems.

i. Non patient-specific and non-proprietary payor information

   a. Payor Identifier

   b. Information Type

   c. Information Start Date

   d. Information End Date

   e. Text or Links to Information

ii. Patient-Specific Query Response

   a. Query Information

      (A) Query Identifier

      (B) Query Date

   b. Patient Information

      (A) Name

      (B) Member Number and Group Number

      (C) Date of Birth

      (D) Patient Identifying Information

      (E) Address / Phone

   c. Service Information

      (A) Procedure Code(s)

      (B) Diagnosis Codes(s)

   d. Criteria Information

      (A) Requested Service Coverage, Frequency Limitations, and/or Eligibility Information

      (B) Prior-Authorization Required? (Y/N)

      (C) Prior-Authorization Request Requirements

(D) Prior-Authorization Request Procedure(s)

iii. Requests for Additional Information - A process enabling payors to electronically return prior-authorization request to providers and specify the additional information needed to enable payor's review would ease workflow disruption.

a. Request Data

(A) Request ID

(B) Date

b. Patient Information

(A) Name

(B) Member Number and Group Number

(C) Date of Birth

(D) Patient Identifying Information

(E) Address / Phone

c. Additional Information Needed

(A) Instructions

iv. Prior-Authorization Decisions - A process to enable payors to electronically communicate prior-authorization decisions and co-pay information. When a prior-authorization request is denied, the ability to communicate the reasons for the decision and different treatment options, if applicable, may be beneficial.

a. Request Data

(A) Request ID

(B) Date

b. Patient Information

(A) Name

(B) Member Number and Group Number

(C) Date of Birth

(D) Patient Identifying Information

(E) Address / Phone

c. Decision Information

(A) Request Status

(B) Approval Status

(C) Explanation

(D) Patient Responsibility (cost to patient as co-payment, co-insurance, and/or deductible amounts)

(E) Different Treatment Options

Appendix A: Glossary

The 2006 – 2008 AHIC Use Cases contained general terms and their contextual descriptions. Listed below are the new terms that are specific to this extension/gap document.

Advanced Beneficiary Notification (ABN): A letter or form indicating a patient's financial responsibility for a service that may not be covered by the payor.

Consumers: Members of the public that include patients as well as caregivers, patient advocates, surrogates, family members, and other parties who may be acting for, or in support of, a patient receiving or potentially receiving healthcare services.

Co-Payment (Co-pay): A set or flat fee that a consumer is obligated to pay for specific healthcare service. For example, a common co-pay is $20 per physician office visit.

Healthcare Payors: Insurers, including health plans, self-insured employer plans, and third party administrators, providing healthcare benefits to enrolled members and reimbursing provider organizations.

Practice Management System: A system that facilitates the management of small and medium provider practices. It is able to handle many aspects of day-to-day operations such as appointment scheduling, maintaining payor information, billing and claims, and producing operational reports.

Pre-Adjudication: The processes and associated information exchanges required to approve services for payment through a payor organization, almost always before the service is provided.

Pre-Determination: The processes and associated information exchanges required to approve services for payment through a payor organization, almost always before the service is provided.

Prior-Authorization: The processes and associated information exchanges required to request, authorize, or approve services for payment through a payor organization.

Providers: The healthcare clinicians within healthcare delivery organizations with direct patient interaction in the delivery of care, including physicians, nurses, and other clinicians. This can also refer to healthcare delivery organizations, dentists and oral surgeons, pharmacies, and suppliers of durable medical equipment, prosthetics, orthotics, supplies (DMEPOS) or others.

Appendix B: Analysis & Examples

An analysis of the information exchange components associated with prior-authorization and examples of potential mechanisms are included in this appendix. The purpose of this appendix is to point out examples of the types of information needs that are appropriate for this extension/gap. These examples are not intended to be inclusive of all activities in this area.

Consumer and/or Provider Queries for Prior-Authorization Criteria

As stated previously, information surrounding prior-authorization may be highly variable and dynamic. Further, certain aspects of payor prior-authorization information may be considered proprietary. A process which allows consumer and/or provider systems to query, receive, and incorporate specific information related to prior-authorization would facilitate automated workflow.

An example of an analogous process which might be examined as part of efforts to automate prior-authorization, is the eligibility request and response transaction currently exchanged between payors and providers. A number of commonly used Health Information Technology standards might be employed to include aspects of prior-authorization in eligibility checking.

Payor Decisions and Requests for Additional Information

In addition to a mechanism which allows the electronic exchange of information as described above, prior-authorization often requires specific procedures and forms, which vary by payor. There are a number of existing mechanisms and standards which allow attachments and the exchange of electronically exchange parseable forms and documents.

Prior-Authorization Requests

The components described previously in this section may improve workflow by facilitating the electronic exchange of information normally associated with prior-authorization. Effective communication of such information may enable electronic submission and evaluation of prior-authorization requests. Although they may lack broad implementation, there are current standards associated with prior-authorization submission requests.