SCRIPT Electronic Prior Authorization
Transactions Overview

August 2013
Prior Authorization Impacts All Healthcare

**Patient frustration and treatment delay**
- PA unknown until patient has already left office
- Treatment might be delayed for days
- Reduced satisfaction

**Pharmacy challenge**
- Pharmacy call volumes increase to prescriber’s office, plan, etc.
- Transaction volume increases

**Prescriber hassle and disruption**
- Call back from pharmacy, must call plan, wait for faxed form, completes form and sends it back
- Turnaround time can be 48 hours or more

**Pharmacy challenge**
- Pharmacy call volumes increase to prescriber’s office, plan, etc.
- Transaction volume increases

**Pharmaceutical Obstacles**
- Delayed and abandoned prescriptions
- Extensive outlay for physician and patient administrative assistance

**PBM/Health plan inefficiency**
- Expensive and labor intensive process that creates frustration

Property of NCPDP
Electronic Prior Authorization Process for the Pharmacy Benefit

PATIENT
Visits Physician

PRESCRIBER
• Writes Prescription
• Submits PA Request
• Transmits Prescription

Drugs can be identified as requiring PA via
NCPDP Formulary & Benefit Standard

Eligibility via
ASC X12 270/271

Submit Required Patient Information via
NCPDP SCRIPT ePA Transactions

PAYER
• Determines PA Status, Criteria
• Compiles PA clinical rules
• Processes PA Requests
• Processes Drug Claims

Drug Claims are Submitted via
NCPDP Telecommunication

PHARMACY
• Dispense Drugs
• Files Drug Claims

Prescriptions are submitted via
NCPDP SCRIPT

Property of NCPDP
Electronic Prior Authorization History

- **HIPAA**
  - X12 278 named prior authorization transaction standard for non-retail pharmacy.
  - Telecom Standard named for retail pharmacy.

- **NCPDP ePA Task Group Formed**
  - Promote standardized automated PA adjudication; gaps identified.

- **CMS/AHRQ pushes forward**
  - Resolution of where standard should reside.
  - Value model created.

- **Renewed Interest**
  - Pilots conceived/initiated state legislative interest.

- **NCPDP Creates New Transactions**
  - Compatible with emerging technology.
  - No pilots.
  - HIPAA reconfirms use of X12 278 and Telecom Standard.

- **MMA ePrescribing Pilots**
  - Determined the X12 278 PA standard was inadequate for medications.

- **NCPDP Revises Transactions**
  - Pilot results incorporated into revised standard.


Property of NCPDP
The WG11 Prior Authorizations Workflow to Transactions Task Group had robust discussions on the use of the NCPDP SCRIPT Standard and the ASC X12 278 for prior authorization:

- Many perspectives were heard
- Alternatives were presented and discussed

A straw man vote on the alternatives was held in June 2012:

- 85% of task group participants voting preferred to move ahead with the NCPDP draft transactions

The Task Group focused on pharmacy benefit PA processing in its work.

With state mandate deadlines approaching, there was a sense of urgency to move forward with workable solutions that can evolve to include new capabilities.
SCRIPT STANDARD TRANSACTION REVIEW
Electronic Prior Authorization Transactions Status

- Transactions added to NCPDP SCRIPT Standard
  - Reusing definitions for common elements: Header, Patient, Prescriber, Pharmacy, Medication Prescribed, Benefits Coordination
  - Reusing Attachments
  - Reusing acknowledgement transactions: Status, Verify, and Error
- NCPDP SCRIPT Standard version 2013071 published July 2013
  - Available free of charge with NCPDP membership ([www.ncpdp.org](http://www.ncpdp.org))
  - SCRIPT Implementation Guide, XML schema, data dictionary and external code list
- NCPDP has been working with Department of Health and Human Services (HHS) for the naming of the electronic prior authorization transactions for the pharmacy benefit
  - HHS/OESS/CMS have been involved in all steps of the process, back to 2004
  - NCVHS issued recommendation of use to HHS
  - DSMO Change Request 1189 was filed
  - Regulatory processes underway
Electronic Prior Authorization Transactions

• Supports an electronic version of today’s PA process (i.e., PBM/payer provides prescriber with a set of questions they must answer for PA consideration) for medication and DME products covered by pharmacy benefit
• Provides a standard structure for exchanging the PA questions and answers between prescriber and payers, while allowing for payers to customize the wording of the questions
• Additionally supports elements that allow for automation of the collection of data required for PA consideration (i.e., coded references for each question (e.g., LOINC, SNOMED, CDA template) allowing an EMR vendor to systemically pull data from patient’s medical record)
• Supports both a solicited and unsolicited model
PA Transaction Overview

- **PAInitiationRequest/Response** (used in the solicited model only)
  - Prescriber requests the information required to accompany a PAREquest for a particular patient and medication.
  - PBM/payer responds with the information required to accompany a PAREquest or an indication a PA isn’t required for the patient and medication.

- **PAREquest/Response**
  - Prescriber sends the information requested in the PAInitiationResponse (solicited model) or information agreed upon outside of the PA transactions by the trading partners (unsolicited model).
  - PBM/payer responds with PA determination status (e.g., approved, denied, pended, more info required) and details specific to the status.
  - Repeat request/response transactions when more info required.
PA Transaction Overview

Other Transaction functions supported:

- **PAAppealRequest/Response**
  - Usage of these transactions is the same as the PAInitiationRequest/Response and PAREquest/Response transactions.

- **PACancelRequest/Response**
  - Prescriber requests a PAREquest that’s in process be canceled.
  - PBM/payer responds with a cancellation status.
Prescriber → PBM/Payer

Data Elements:

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Header</td>
<td>to, from, message ID, date/time sent</td>
</tr>
<tr>
<td>Prescriber</td>
<td>ID, specialty, name, address</td>
</tr>
<tr>
<td>Patient</td>
<td>ID, name, address, DOB, gender</td>
</tr>
<tr>
<td>Benefits Coordination</td>
<td>cardholder ID/name, health plan ID, group ID</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>ID, name, address</td>
</tr>
<tr>
<td>Medication Prescribed</td>
<td>ID, description-name/strength/dosage form, quantity</td>
</tr>
</tbody>
</table>

- Used in the solicited model only
  - Prescriber requests the information required to accompany a PARequest – what questions need to be answered, what information needs to be provided.

- Benefits Coordination information can be sent when available to be used by the PBM/payer to assist in identifying the patient’s coverage.
PAInitiationResponse

PBM/Payer → Prescriber

Data Elements:

<table>
<thead>
<tr>
<th>Header</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Echoed from initial request: Prescriber, Patient, Benefits Coordination, Pharmacy, Medication Prescribed</td>
<td></td>
</tr>
<tr>
<td>Response Detail</td>
<td>status indicating question set provided or PA not required</td>
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<tr>
<td>Question Set Header</td>
<td>title/instructions to display to prescriber</td>
</tr>
<tr>
<td>Question Set Detail &amp; Answer Choice</td>
<td>question/answer choice text, question type (e.g., multiple choice, numeric, date, free text), next question logic, coded reference (e.g., LOINC, SNOMED, CDA template ID) to systematically identify information required</td>
</tr>
</tbody>
</table>

- Used in the solicited model only
  - PBM/payer responds with the information required to accompany a PARequest
    - Information required provided as a question set (question/answers to display to prescriber) with optional support for coded references EMR can use to pull information from patient’s medical chart.

OR

- or an indication a PA isn’t required for the patient and medication
  - Specific to the patient’s coverage and the medication prescribed.
Prescriber → PBM/Payer

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</tr>
<tr>
<td>Completed Question Set</td>
<td>answers/information provided by the prescriber or EMR (i.e., answer selected/entered by the prescriber or information populated from the patient’s medical chart)</td>
</tr>
<tr>
<td>Attachment(s)</td>
<td>attachment type, attachment payload</td>
</tr>
</tbody>
</table>

- Prescriber sends the information requested in the PAInitiationResponse (solicited model) or information agreed upon outside of the PA transactions by the trading partners (unsolicited model).
- Attachments can be sent related to a specific question or for the request overall.
PBM/Payer → Prescriber

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<td>Response Detail</td>
<td>Determination status (e.g., approved, denied, pended, more info required), details specific to the status</td>
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<tr>
<td>Attachment(s)</td>
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- PBM/payer responds with PA determination status (e.g., approved, denied, pended, more info required) and details specific to the status.
  - Approved status: authorization details (start/end date, quantity, # of fills)
  - Denied status: denial reason, appeals details
  - More Information Required status: Question Set identifying additional information required

- Repeat request/response transactions when more info required.
- Attachments can be sent with more information related to the status (e.g., approval/denial letter).
PAAppeal Transactions

<table>
<thead>
<tr>
<th>PAAppealRequest</th>
<th>Prescriber → PBM/Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAAppealResponse</td>
<td>PBM/Payer → Prescriber</td>
</tr>
</tbody>
</table>

- Usage and definition of these transactions is the same as the PAInitiationRequest/Response and PARequest/Response with slight modifications to support appeals
  - PAAppealRequest/Response used to request and identify the information required to accompany a PAAppealRequest.
  - PAAppealRequest/Response used to send requested information and respond with determination status (e.g., approved, denied, pended, more info required) and details specific to the status.
  - PAAppealRequest/Response repeat if more information is required.
PACancel Request

Prescriber → PBM/Payer

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</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Cancel Detail</td>
<td>reason for canceling</td>
</tr>
</tbody>
</table>

- Prescriber sends a request to cancel a PARequest in process when PA no longer needed.
- Request includes reason from the prescriber for canceling the PARequest.
PACancel Response

PBM/Payer $\rightarrow$ Prescriber

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<tbody>
<tr>
<td>Echoed from initial request:</td>
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<tr>
<td>Prescribed</td>
<td></td>
</tr>
<tr>
<td>Response Detail</td>
<td>status indicating if the PA Request was canceled or not</td>
</tr>
</tbody>
</table>

- PBM/payer responds with status indicating if the PA Request was successfully canceled or not.
Thank you!

Questions:

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