

# RECOMMENDATIONS FOR IMPLEMENTING ELECTRONIC PRIOR AUTHORIZATIONS

A Report  
prepared for  
the Maryland General Assembly  
Joint Committee on Health Care Delivery and Financing  
December 2011

Ben Steffen  
Acting Executive Director



## Commissioners

---

### *Marilyn Moon, Ph.D., Chair*

Vice President and Director, Health Program  
American Institutes for Research

Garret A. Falcone, Vice Chair  
Executive Director  
Charlestown Retirement Community

Kathryn L. Montgomery, Ph.D.  
Associate Dean, Strategic Partnerships &  
Initiatives  
University of Maryland School of Nursing

Reverend Robert L. Conway  
Retired Principal and Teacher  
Calvert County Public School System

Darren W. Petty  
Vice President  
Maryland State and DC AFL-CIO  
General Motors/United Auto Workers

John E. Fleig, Jr.  
Director  
United Healthcare

Glenn E. Schneider  
Chief Program Officer  
The Horizon Foundation

Helene Grady  
Associate Dean for Finance and Administration  
Johns Hopkins University School of Nursing

Craig P. Tanio, M.D.  
Chief Medical Officer  
JenCare Neighborhood Medical Centers

Kenny W. Kan  
Senior Vice President/Chief Actuary  
CareFirst BlueCross BlueShield

Adam J. Weinstein, M.D.  
Medical Director  
Nephrology and Transplant Services  
Shore Health System

Robert Lyles, Jr., M.D.  
Medical Director  
LifeStream Health Center

Randall P. Worthington  
President/Owner  
York Insurance Services, Inc.

Barbara Gill McLean  
Retired, Senior Policy Fellow  
University of Maryland School of Medicine

# Table of Contents

Executive Summary ..... 1

Report Limitations ..... 4

Introduction ..... 4

Literature Review ..... 5

Maryland Landscape ..... 7

Best Practices and Effective Strategies of Other States ..... 8

Recommendations ..... 11

Remarks ..... 15

Acknowledgements ..... 16

Appendix A: Background on the Development of National Standards ..... 18

Appendix B: Current Payer Prior Authorization Methods ..... 22

Appendix C: Current TPA Prior Authorization Methods ..... 23

## Executive Summary

In July 2011, the Joint Committee on Health Care Delivery and Financing of the Maryland General Assembly requested that the Maryland Health Care Commission (MHCC) develop recommendations around best practices and standards for electronic prior authorizations of prescription medications and medical services. Prior authorization is required by many state-regulated payers (payers) and third party administrators (TPAs)<sup>1</sup> before certain prescriptions for medications may be filled or medical services may be undertaken.<sup>2</sup> Prior authorizations are generally required when the payer or TPA wishes to conduct a medical review to ensure that the drug is prescribed properly or the medical service is warranted. Prior authorizations may be required for reasons such as the availability of low-cost generic alternatives, age restrictions, ensuring medical necessity, and higher than normal dosages. The prior authorization process varies widely from one payer or TPA to another; in most cases it is manual, relying heavily on faxes and phone calls. Requests for prior authorization often entail follow up for clarification or additional information before ultimately being approved or denied. Most providers and payers agree that there is room to improve the process.

The ideal solution to standardize the prior authorization request process would be national standards for sending prior authorization requests electronically from the provider's practice management or electronic health record (EHR) system directly to the payer or TPA's system. Such standards do not yet exist, though they have been in development for some time. There are two independent pilot programs related to prior authorization national standards currently being implemented: CVS CAREMARK is testing transaction standards for prescription medications, and the American Medical Association (AMA) is exploring opportunities around broad adoption of the standards for medical services. National standards are not expected to be available for broad adoption until 2015 or later. Once national standards are finalized, the Centers for Medicare and Medicaid Services (CMS) will require the transaction sets to be used under Section 1104, Administrative Simplification, of the *Patient Protection and Affordable Care Act of 2010*. Section 1104 requires all payers to have the capability of accepting prior authorization requests electronically using the national standard by January 1, 2016.<sup>3</sup>

The MHCC convened a multi-stakeholder workgroup (workgroup) to help develop recommendations for electronic prior authorization requests. In general, the consensus of the workgroup was to focus on short-term solutions that incrementally reduce the burden on providers, payers, and TPAs, and require minimal rework once national standards are adopted. Stakeholders are generally supportive of the recommendations and most preferred voluntary adoption as opposed to legislation. The MHCC intends to monitor payer and TPA progress with implementing the recommendations over the next year. The following recommendations are a result of the collaboration of the multi-stakeholder workgroup.

---

<sup>1</sup> State-regulated payors are insurers, nonprofit health services plans, or any other person that provides health benefit plans subject to regulation by the State. Self-insured health care plans and government plans are exempt from State insurance regulation under the Employee Retirement Security Act of 1974 (ERISA). State mandated health insurance benefits affect around 25 percent of insured Maryland residents. Additional information is available from the U.S. Department of Labor at: <http://www.dol.gov/dol/topic/health-plans/erisa.htm>. Third party administrators are identified based on their Maryland Corporation Income Tax Statement.

<sup>2</sup> Prior authorization does not include member coverage determination.

<sup>3</sup> §45 CFR Parts 160 and 162

## *Recommendations*

### *1. Provide a single sign-on option to payer and TPA websites.*

Payers with an annual premium of \$1 million or more and TPAs, such as pharmacy benefit managers (PBMs), with \$1 million or more in net income allocable to Maryland, must accept provider or clinical staff authentication for their prior authorization website or portal from a single sign-on authority, such as the state designated health information exchange (HIE), as determined by the MHCC.

### *2. Payers and TPAs will follow a phased approach to implement electronic prior authorization requests.*

#### *Phase 1*

State regulated payers and TPAs will include on their website and/or within their other customized online tool the medical services and prescription drugs that require prior authorization, as well as the key criteria used to make a final determination of a prior authorization request.<sup>4</sup> Where appropriate, the following information will be included: prior authorization group description, covered users, exclusion criteria, required medical information, age restrictions, prescriber/provider restrictions, coverage duration, and other pertinent information (for example, step therapy requirements).<sup>5</sup> Phase 1 must be completed by July 1, 2012.

#### *Phase 2*

Payers and TPAs will develop an online process to electronically accept prior authorization requests. The online process will be specific to the prescription medication or medical service requested and the patient's plan requirements for the medication or service. Upon submission of the electronic prior authorization request, a unique electronic tracking identification number (ID) from the payer/TPA will be assigned to the request. The provider will use the tracking ID for tracking prior authorization requests with the payer or TPA when additional information is required or when a query of a denial is requested by the provider. Payers and TPAs must be able to identify the request by the ID number across their systems, which include electronic, call centers, and fax systems. Phase 2 must be completed by December 1, 2012.

#### *Phase 3*

Electronic pharmacy prior authorization requests for which no additional information is needed and that meet the established criteria for approval should be approved in real-time.<sup>6</sup> The approval will be communicated to the submitter in real-time. For electronic non-urgent pharmacy prior authorization requests that are not immediately approved, a determination will be reached and notification of the determination will be delivered to the submitter within one business day of receiving all pertinent information.<sup>7</sup> For electronic non-urgent medical service

---

<sup>4</sup> Maryland Insurance Article §15-10B-05 requires the criteria used for utilization management determinations be provided to the Maryland Insurance Administration and to providers upon written request.

<sup>5</sup> §42 CFR 423.128(d)(2)(ii) and Chapter 3 Section 60.5.4 of the CMS Medicare Drug Benefit Manual require all approved utilization management criteria to be posted on Part D sponsor websites in the formulary section by November 15<sup>th</sup> of each year. The data requirements align with those provided for Medicare Part D.

<sup>6</sup> Real-time, as defined by the Workgroup for Electronic Data Interchange (WEDI), is the process being completed in a single communication session.

<sup>7</sup> Notification can include e-mail, phone call, or notification via the portal.

prior authorization requests, a determination will be made and notification of the determination will be delivered to the submitter in a timeframe not to exceed two business days from receiving all pertinent information.<sup>8</sup> It is the intended goal of the recommendations that payers and TPAs achieve the above mentioned timeframes related to prior authorization determinations no later than July 1, 2013. The MHCC will reconvene the workgroup prior to the end of 2012 to determine whether the timeframes require revision.

3. *Payers and TPAs will report to the MHCC.*

Payers and TPAs must submit a report to the MHCC by December 1, 2012. The report will include the status of the implementation of Phase 1 and Phase 2, as well as an outline of their plan for implementing Phase 3 including feedback on meeting the timeframes. Payers and TPAs will submit an additional report to the MHCC by December 1, 2013, which includes information related to the implementation of Phase 1 and Phase 2 and achieving the timeframes established in Phase 3. The MHCC will provide the criteria for each report.

4. *Require providers to utilize an electronic prior authorization process.*

By January 1, 2015, providers must utilize the online prior authorization process or their practice management, electronic health record, or electronic prescribing system to submit all prior authorization requests. Providers will have the option of applying to payors for an exception in extenuating circumstances, such as the lack of broadband Internet access.

---

<sup>8</sup> Notification can include e-mail, phone call, or notification via the portal.

## Report Limitations

This report contains recommendations for establishing an electronic prior authorization process for prescription medication and medical services. Information included in this report is based on the feedback obtained from providers, payers, and third party administrators (TPAs) that participated in the workgroup. A financial impact assessment pertaining to the adoption of each recommendation was not included in the scope of work. This report does not address provider workflow challenges that may occur as a result of wide-spread adoption of the recommendations.

## Introduction

In July 2011, the Maryland General Assembly Joint Committee on Health Care Delivery and Financing requested the Maryland Health Care Commission (MHCC) to develop recommendations around best practices for prior authorization of prescription medications and medical services. Prior authorization, also known as pre-certification, prior approval, prospective review, or prior notification, is the process payers and TPAs use to approve a medical service/procedure or prescription medication before it is performed or dispensed.<sup>9</sup>

The current prior authorization process is non-standard and typically manual, requiring providers to print and fax prior authorization forms to payers, pharmacy benefit managers (PBMs), radiology benefit managers (RBMs), behavioral health managers (BHMs), and other TPAs. Each state-regulated payer (payer) and TPA<sup>10</sup> has its own set of medical services and/or medications that require prior authorization, workflow for submitting and processing prior authorizations, and criteria for approving prior authorizations. In addition, self-insured groups often have their own unique prior authorization requirements. For the most part, prior authorization approvals may take anywhere from one day to more than a week to be approved.<sup>11</sup> Providers generally report this process is burdensome and that follow up activities are time consuming.<sup>12</sup>

The prior authorization process is manual largely due to the lack of a national standard for sending prior authorizations electronically from a provider's practice management, electronic health record (EHR), or e-prescribing system. A number of organizations are working on piloting and finalizing a national standard; standards are not expected to be in place until 2015 or later.<sup>13</sup> Recognizing that the manual processes are onerous to providers and their staff, some payers and TPAs provide a web portal for submitting prior authorization requests.<sup>14</sup> Other payers and TPAs are working towards an online submission process. Payers and TPAs with an existing portal report that utilization of the portals is low among Maryland providers.

---

<sup>9</sup> Prior authorization does not include member coverage determination.

<sup>10</sup> State-regulated payors are insurers, nonprofit health services plans, or any other person that provides health benefit plans subject to regulation by the State. Self-insured health care plans and government plans are exempt from State insurance regulation under the Employee Retirement Security Act of 1974 (ERISA). State mandated health insurance benefits affect around 25 percent of insured Maryland residents. Additional information is available from the U.S. Department of Labor at: <http://www.dol.gov/dol/topic/health-plans/erisa.htm>. Third party administrators are identified based on their Maryland Corporation Income Tax Statement.

<sup>11</sup> Maryland Insurance Article §15-10B-06 requires a determination within two business days; however it does not specify a notification timeframe. In addition, it does not apply to self-insured plans, which have 15 business days to make a determination.

<sup>12</sup> *Prior Authorization: Impact on Patient Care in Maryland, A Survey of the Members of the Maryland State Medical Society*, July 20, 2011. The survey was issued to 3,966 members, and results are based on 249 responses.

<sup>13</sup> For a detailed discussion on the development of national standards, see [Appendix A](#).

<sup>14</sup> See Appendices [B](#) and [C](#) for payer and TPA prior authorization request methods.

Leading payers and TPAs were asked to self-report on the volume or share of prior authorization requests processed in a one-year time period. The information provides some insight into the amount of prior authorizations in the state.

Number of Prior Authorization Requests in Maryland <sup>15</sup>		
Organization	Medical Services	Prescription Medications
<i>Payer</i>		
ACS - Medical Assistance FFS Pharmacy Program	Not Available	2010 – 143,944 YTD – 97,127
CareFirst	Less than 1% of claims	Less than 1% of claims
Kaiser Permanente	2010 – 48,971	2010 – 9,159
United Health Group	YTD – 46,489	Not Available
<i>TPA</i>		
CVS CAREMARK	N/A <sup>16</sup>	38 PA requests for every 1000 members/year <sup>17</sup>
Medco	N/A <sup>18</sup>	2010 Nationally – 1.35% of claims, approximately 2 million requests

The MHCC convened a multi-stakeholder workgroup (workgroup) that included providers, payers, PBMs, and other TPAs. The workgroup evaluated the current prior authorization process, as well as the work underway to adopt national standards. The workgroup agreed that recommendations should focus on short-term solutions that will reduce the current administrative burden in anticipation of a national standard. The consensus was that the interim solution should not create any state-specific standards that would cause later rework once a national standard has been implemented. Instead, the recommendations should streamline the prior authorization request process across payers and TPAs and improve upon the current determination and notification timeframes.

## Literature Review

In general, little debate exists around the prior authorization process being too manual and time consuming for payers and providers. These inefficiencies likely have a financial impact on the health care system. Improving the prior authorization process should, over the long term, allow providers to spend more time caring for patients, while at the same time eliminate administrative overhead and create efficiencies for a range of stakeholders in the health care system.

The prior authorization process offers opportunities for efficiencies among many payers, TPAs, and pharmacies. One study estimates that payers and TPAs spend \$10 to \$25 on every prior authorization request.<sup>19</sup> Another more recent study estimates that payers spend \$75 on each prior

<sup>15</sup> Maryland payers and TPAs were asked to provide the number of prior authorization requests they received in 2010 and year to date and provided this information in e-mail responses.

<sup>16</sup> TPAs do not process medical service prior authorization requests.

<sup>17</sup> Does not include Medicaid and Medicare which is significantly higher.

<sup>18</sup> TPAs do not process medical service prior authorization requests.

<sup>19</sup> Debi Reissman, Drug Benefit Trends, *What Is the Real Cost of Prior Authorization?* (2000): 12:22-24.



authorization request.<sup>20</sup> Much of this cost is associated with the manual nature of review and follow up. Most would agree the process is resource intensive; one payer estimated that roughly 20 percent of their staff works solely on prior authorization requests.<sup>21</sup> In interviews conducted for a recent industry environmental scan, one payer reported that about 80 percent of its prescription prior authorization requests require follow up.<sup>22</sup> In another report, it was found that more than 90 percent of prior authorization requests require a phone call or faxed request.<sup>23</sup>

Prior authorization request follow up typically requires phone calls between the provider, patient, pharmacist, and/or the payer or TPA. The completion of additional forms, as well as gathering additional information from patient records may also be required. The current prior authorization process is challenging for providers and their staff. In a recent study, physicians reported spending on average three hours per week on all interactions with payers, while nursing staff reported spending roughly 19 hours on average per physician per week, and clerical staff reported spending almost 36 hours per physician per week. In total, practices spent on average \$68,274 per physician per year on all interactions with payers, according to this survey. One third (one hour per week) of physicians' time spent on these interactions was spent on authorizations. Nursing staff spent the majority of their time on authorizations, averaging approximately 13 hours per physician per week, while clerical staff spent about 6 hours per physician per week on authorizations.<sup>24</sup>

Some payers have taken steps to attempt to improve the usability of their submission process by developing websites and reducing the need for follow up, such as by making formulary information available within the website where the prior authorization request is submitted. MVP Healthcare, a payer in New York, estimated an annual savings of \$2 million by automating its prior authorization process for imaging services.<sup>25</sup> A noteworthy point is that nearly all payers are investing in streamlined processes and pilot programs for electronic systems.

In a recent environmental scan conducted by MedChi, the Maryland State Medical Society, almost 52 percent of those who responded indicated that their practice spends between zero and 10 hours per week on prior authorizations for medical services and prescription medications; roughly 29 percent spend 11 to 20 hours per week on prior authorizations; and about 2 percent indicated they do not spend any time on prior authorizations.<sup>26</sup> According to the American Medical Association (AMA), about 63 percent of providers responding to a national survey reported waiting several days for approval on medical services, while approximately 69 percent indicated waiting several days for approval of prescription medications. About 13 percent indicated waiting more than a week for approval of medical services, and 10 percent waited more than a week for prescription

---

<sup>20</sup> Douglas Moeller, Managed Executive, *Manage Medical Advances with Automated Prior Authorization* (2009). Available at <http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=615491>.

<sup>21</sup> Point-of-Care Partners Presentation to the AMA, *Electronic Prior Authorization Overview*, (2011). Available at: [http://www.pocp.com/images/pdfs/ePA\\_Overview\\_for\\_AMA\\_4-4-11.pdf](http://www.pocp.com/images/pdfs/ePA_Overview_for_AMA_4-4-11.pdf).

<sup>22</sup> Point-of-Care Partners Presentation to the AMA, *Electronic Prior Authorization Overview*, (2011). Available at: [http://www.pocp.com/images/pdfs/ePA\\_Overview\\_for\\_AMA\\_4-4-11.pdf](http://www.pocp.com/images/pdfs/ePA_Overview_for_AMA_4-4-11.pdf).

<sup>23</sup> Douglas Moeller, Managed Healthcare Executive, *Manage Medical Advances with Automated Prior Authorization* (2009). Available at: <http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=615491>.

<sup>24</sup> Lawrence P. Casalino et al, *What Does It Cost Physician Practices To Interact With Health Insurance Plans*, *Health Affairs* 28.4 (2009): w533-w543.

<sup>25</sup> Douglas Moeller, Managed Healthcare Executive, *Manage Medical Advances with Automated Prior Authorization* (2009). Available at: <http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=615491>.

<sup>26</sup> *Prior Authorization: Impact on Patient Care in Maryland, A Survey of the Members of the Maryland State Medical Society*, July 20, 2011. The survey was issued to 3,966 members, and results are based on 249 responses.

medication approval.<sup>27</sup> Certain specialties are more often required to obtain prior authorizations, such as oncologists, who frequently prescribe expensive cancer screenings and treatments, and primary care providers who may prescribe non-life-saving or “lifestyle” prescriptions. A range of behavioral health services also routinely require prior authorizations.

Some have argued that much of the time providers spend on prior authorizations can be attributed to a lack of understanding or confusion over the need or requirements for a prior authorization. The AMA found in its recent survey that about 64 percent of providers indicated difficulty knowing which tests or services required a prior authorization, while approximately 67 percent indicated difficulty determining prior authorization needs for prescription medications.<sup>28</sup> Providers spend additional time trying to determine the need for prior authorization and are more likely to submit unnecessary prior authorization requests. Providers also spend time on prior authorizations responding to follow-up questions or appealing denials.<sup>29</sup> Even when using web-based systems which provide formulary information, the application may not be used properly, resulting in rejections and confusion.

## Maryland Landscape

Overall, the largest payer market share in Maryland belongs to CareFirst BlueCross BlueShield and United Healthcare. Nearly four other payers also have a notable presence in the state.

Approximately 31 PBMs operate in the state, as well as a number of managed care organizations (MCOs), BHM, and RBMs. In general, little consistency exists in how payers and TPAs have implemented prior authorizations; each has its own set of prior authorization processes. While a number of payers offer an online portal for requesting prior authorizations, very few of the PBMs operating in Maryland offer such a service. The predominant method for requesting a prior authorization continues to be a paper form that is faxed to the payer or TPA. Most payers make prior authorization forms available on their sites; however, at least five PBMs require providers to call and request the prior authorization form be faxed to their office. Additionally, the prior authorization forms can be difficult to find on payer and TPA websites because consistent navigation tools are not used across payers and TPAs.

As of 2010, only one fourth of the population under the age of 65 was covered under an insurance plan governed by Maryland insurance law and the Maryland Insurance Administration regulations. Around thirty-six percent of the population under the age of 65 was covered under an employer self-insured or self-funded plan.<sup>30</sup> Self-funded plans enter into “administrative services only” (ASO) contracts with payers and TPAs. At the direction of the employer, the ASO contracts stipulate which services and prescription medications require a prior authorization. The prior authorization process is then managed by individual payers and TPAs. These plans are governed by the federal *Employee Retirement Income Security Act of 1974* (ERISA), a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. Another 12 percent were in a *Federal Employee Health Benefit Program* (FEHBP).

---

<sup>27</sup> AMA Survey of Physicians on *Prior Authorization Requirements* May 2010.

<sup>28</sup> AMA Survey of Physicians on *Prior Authorization Requirements*, May 2010.

<sup>29</sup> AMA Survey of Physicians on *Prior Authorization Requirements*, May 2010.

<sup>30</sup> Maryland Insurance Administration, *2010 Health Benefit Plan Covered Lives Report*, (2010). Available at <http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/mdcoveredlivesreport-11-29-10.pdf>.

For each plan that covers prescriptions or medical services requiring a prior authorization, the payer or TPA (in the case of self-insured plans, in coordination with the employer) must determine what information is required to support the prior authorization request. This information is not standard across payers or TPAs, with the exception of the *Maryland Uniform Treatment Plan*, which is a standard form required to be used for behavioral health authorizations. For the most part, few payers and TPAs utilize a single standard form for prior authorization requests; the majority of payers and TPAs utilize forms specific to the medical service or prescription medication.

Payers that do provide standard prior authorization forms require a different form for medical services and prescription medications. The information required for each type of prior authorization is not standardized. In interviews with the payers and TPAs, it was noted that using a standard form typically increases the odds that a request for follow-up information will be required; this will most likely be a medication/medical service specific form that is faxed to the provider. The provider must then complete the additional form and fax it back to the payer or TPA, making the process more burdensome for all stakeholders. TPAs that specialize in radiology or therapeutic treatments are better able to use a standard form due to the limited number of services or prescription medications that require a prior authorization. Standard forms often include patient and requesting provider demographics, Current Procedural Terminology (CPT) codes or prescription medication name and dosage, International Classification of Diseases Ninth Revision (ICD-9) diagnosis codes, reason for request, and demographic information (medical services only) of the facility delivering care.

## Best Practices and Effective Strategies of Other States

A number of states have legislation pending that defines requirements for electronic prescribing (e-prescribing). One of the requirements is that if an electronic mechanism is used to send a prescription, it must include an electronic or automated prior approval process. Some bills detail requirements for the electronic prior approval process. States that have pending legislation include: California (SB 866), Georgia (SB 111), Massachusetts (S483), Missouri (SB 236), New York (S05646A, A08628), New Jersey (A3655, S2781), New Mexico (SB 117), North Carolina (SB 768), Oklahoma (HB-1503), South Carolina (H4071), and South Dakota (SB 127). Three other state legislatures, Hawaii, New Mexico, and Vermont, have requested a workgroup or an existing organization in the state create a report to make recommendations on how to standardize the prior authorization process and make it an electronic or automated process. Below are profiles of the only states that have passed legislation or implemented systems to support electronic prior authorizations.

### Minnesota

Minnesota Statute Chapter 336, Section 5, requires that prescription medication prior authorization requests must be submitted electronically and accepted by group purchasers effective January 1, 2015. Facsimile is not considered an electronic transmission.<sup>31</sup> Recognizing that the standards to transmit an electronic prior authorization (i.e., the X12 278 and the National Council for Prescription Drug Programs XML standard) were not ready to be used, Minnesota pursued a short-term solution to meet the January 1, 2015 deadline. The solution is a set of minimum website specifications for all payers and TPA sites, allowing providers to have a more standardized method

---

<sup>31</sup> Minnesota Session Law, Chapter 336-S.F., No. 2974, Section 5. Available at: <https://www.revisor.mn.gov/laws/?key=57997>.

of submitting a prior authorization request. The specifications include a single standard form that all providers must use, and all payers must accept. The form contains standard patient, prescriber, pharmacy, prescription drug, and patient clinical information.<sup>32</sup> Although standardized, providers cannot submit the form electronically. The form is available in a PDF format and providers must complete and print the form and then fax it to the payer/TPA. Beginning January 1, 2015, the form will need to be submitted electronically.

### ***Nevada***

In June 2011, the Nevada legislature passed a bill to establish a statewide health information exchange (HIE). Included in the bill and subsequent statute were two items relating to electronic prior authorizations. First, is to complete a study on how to create standards for electronic prior authorization.<sup>33</sup> Second, that the Director of the Department of Health and Human Services (DHHS) “prescribe by regulation, in consultation with the State Board of Pharmacy, standards for the electronic transmission of prior authorizations for prescription medication using a health information exchange.”<sup>34</sup> The statewide entity is in the process of creating an advisory board that will recommend policies, best practices, and standards to the DHHS. The advisory board is in preliminary discussions about the prior authorization process, and will create a detailed report on the standards for electronic prior authorizations for medications in the near future. The DHHS does not currently have a deadline for implementing an electronic prior authorization process.

### ***North Dakota***

In 2011, the North Dakota legislature passed a bill requiring that electronic prior authorizations for prescription medications be available to providers by August 1, 2013. The prior authorization must be available via the provider’s e-prescribing software. Insurance payers and TPAs must be able to accept the electronic prior authorization transmission. A facsimile is not considered an electronic transmission. Additionally, e-prescribing software cannot include advertisements for specific prescription medications or pharmacies, and while formulary and benefit information can be shown in the system, it cannot impede the selection of a specific prescription medication or pharmacy. The health information technology advisory committee will make recommendations on how best to standardize the prescription medication prior authorization process between providers and payers/TPAs.<sup>35</sup> The health information technology advisory committee is in the very early stages of developing recommendations. They are working to identify potential technical standards that can be used for the transactions.

### ***Oregon***

The Administration Simplification Executive Committee of the Oregon Health Leadership Council (OHLHC) is working with OneHealthPort on a secure, single sign-on initiative. OneHealthPort is a for-profit, privately owned organization, based in the state of Washington. The goal of the initiative is to enable providers to access multiple payer portals with one set of secure credentials. The initiative is not mandated by the legislature, but is rather a voluntary program led by the OHLHC. OneHealthPort performs identity management, authentication, digital identification provision, and

---

<sup>32</sup> The *Minnesota Uniform Form for Prescription Drug Prior Authorization Requests and Formulary Exceptions* is available at: <http://www.health.state.mn.us/asa/ufefpaform.pdf>.

<sup>33</sup> Nevada Revised Statutes, Chapter 313, Section 26.5.

<sup>34</sup> Nevada Revised Statutes, Chapter 313, Section 5.1.

<sup>35</sup> North Dakota Century Code, Chapter 23-01.

legal and information sharing agreement services. Providers utilize the OneHealthPort single sign-on to access individual payer websites. Their information is pre-populated to each payer site based on the credentials OneHealthPort maintains. Providers can then access any portion of the payers' portals and perform any functions on the site based on the permissions set by the payer. There is no standardization or requirement of what should be on the payers' site. While the initiative is fairly new, as of July 2011, seven health plans were participating in the initiative. As of June 2011, 4,731 provider organizations had registered with OneHealthPort, and 11,777 individuals were registered within those organizations. From March 2011 to June 2011, providers signed on using OneHealthPort 302,000 times.<sup>36</sup>

## **Utah**

The Utah Health Information Network (UHIN) is the state designated entity for Utah. UHIN maintains three types of exchanges: administrative (claims, eligibility, etc.), clinical, and credentialing. While the administrative exchange has the ability to transfer authorizations using the American National Standards Institute ASC X12 278 standard, it is not in use in the state, due to its lack of functionality. UHIN is piloting electronic prior authorizations utilizing its clinical health information exchange (cHIE) with a long term care facility. The cHIE uses Axolotl, now OptumInsight, technology to support the exchange. The system allows users to create unique forms. For the pilot, UHIN created a new form in the system that is available to the long term care facility via Axolotl's electronic medical record (EMR) Lite. The form is only for medical services. Additionally, the pilot is only with the state Medicaid agency that has a standard form for such requests. Providers at the long term care facility complete the form in the EMR-Lite and it is sent through the cHIE to the Medicaid agency. The agency reviewer then uses the EMR-Lite to view the prior authorization request and send a response back to the provider. Providers have the ability to attach clinical documentation to the request. The system is very similar to e-mail, but is processed through the cHIE, using the EMR-Lite.

## **Washington**

In Washington, Title 48.165 requires the Insurance Commissioner to appoint a lead organization to simplify and standardize the administrative processes between providers and payers. In 2009, the Washington Health Care Forum and OneHealthPort were appointed to oversee the administrative simplification process. The law is written in such a way to allow the private sector to lead the simplification effort without regulation from the Insurance Commissioner. If the private sector fails to reach consensus on best practices and standards for simplification, or they fail to achieve widespread adoption of the standards, the insurance commissioner has the authority to enact rules and regulations for all payers and providers in the state.<sup>37</sup>

OneHealthPort has two roles in the state of Washington. First, the organization provides a single sign-on authentication process for providers, which allows them to access payers' websites in the state. Payer participation in the single sign-on initiative is not required, but most payers in the state do participate in the program. Second, OneHealthPort works with payers and providers to create best practices and standards for simplifying administrative processes, including the prior authorization process. When OneHealthPort began to look at the prior authorization process, it

---

<sup>36</sup> Oregon Health Leadership Council, *Progress Report*, July 2011. Available at: <http://www.orhealthleadershipcouncil.org/wp-content/uploads/2011/07/Progress-Report-July-2011.pdf>.

<sup>37</sup> Title 48.165 RCW, *Uniform Administrative Procedures-Health Care Services*.

evaluated the American National Standards Institute ASC X12 278 transaction standard but determined that it was not ready for use; the timeline for when it would be ready was also unclear. Additionally, since prescription medication prior authorizations involve not only payers/TPAs and providers but also pharmacists; at this juncture, OneHealthPort has not included prescription medications in the simplification process.

## Recommendations

The goal of the recommendations is to reduce the administrative burden on providers, payers, and TPAs. Due to the current lack of national standards for electronic prior authorization requests sent from a practice management, EHR, or e-prescribing system, the recommendations aim to create a short-term solution that will result in minimal rework for payers and TPAs once a national standard is adopted. Once national standards are finalized, CMS will require a standard transaction set to be used under Section 1104, Administrative Simplification, of the *Patient Protection and Affordable Care Act of 2010*. Section 1104 requires all payers to have the capability of accepting prior authorization requests using the national standard by January 1, 2016.<sup>38</sup>

Most stakeholders are not in favor of legislating recommendations developed by the workgroup. General consensus exists among payers and TPAs for voluntary support of the recommendations and timeframes established by the workgroup. The MHCC intends to monitor payer and TPA progress with implementing the recommendations over the next two years. The recommendations are a result of the cooperation of the multi-stakeholder workgroup.

### 1. Provide a single sign-on option to payer and TPA websites.

Payers with an annual premium of \$1 million or more and TPAs with \$1 million or more in net income allocable to Maryland must accept provider or clinical staff authentication on their website or portal from a single sign-on authority, such as the state designated health information exchange (HIE), as determined by the MHCC.

Allowing providers single sign-on (SSO) access to all payer and TPA sites can significantly increase usage of websites and online portals, reduce administrative burden on providers and their staff, and generate cost savings in efficiencies. It would also remove from the payer and TPAs much of the administrative burden related to user identity management; the SSO authority would assume this responsibility.

Once the SSO authority has authenticated a provider or staff member, the individual can log into the SSO authority and access a payer or TPA website. The SSO authority sends a security assertion markup language (SAML) message to the payer or TPA's website or portal. The website or portal accepts the authentication, and through its own security protocols control what the provider or staff member may access. Once the SAML message is accepted, the transaction is complete and the SSO authority closes the communication channel.

As with any health care process where information is exchanged, privacy and security concerns exist that must be addressed. To date, organizations that are performing this type of SSO service, such as OneHealthPort in Washington and Oregon, have not had any security breaches. It is also important to note that the payers and TPAs will retain control of their websites or portals and will control what information each provider or staff member may access. Protected health information

---

<sup>38</sup> §45 CFR Parts 160 and 162

is not exchanged between the SSO authority and payer/TPA websites. Privacy and security concerns can be mitigated through the use of privacy agreements between the SSO authority, payer/TPAs, and providers/staff members. Based on the number of payers, TPAs, and covered lives in Maryland, it is estimated that approximately \$1 to \$1.5 million would be needed to build the necessary infrastructure to support this recommendation. An additional \$500,000 to \$1 million per year would be required to operate and maintain the technology.<sup>39</sup>

*2. Payers and TPAs will follow a phased approach to implement electronic prior authorization requests.*

*Phase 1*

Payers and TPAs will identify and include on their website and/or within their other customized online tools the medical services and prescription drugs that require a prior authorization, as well as the key criteria that will be used to make a final determination of a provider's prior authorization request.<sup>40</sup> Where appropriate, the following information will be included: prior authorization group description, covered users, exclusion criteria, required medical information, age restrictions, provider/prescriber restrictions, coverage duration, and other pertinent information (for example, step therapy requirements). Phase 1 must be completed by July 1, 2012.

Under 42 CFR 423.128(d)(2)(ii) and Chapter 3 Section 60.5.4 of the CMS Medicare Drug Benefit Manual, payers and TPAs must post their utilization management criteria on their websites by November 15<sup>th</sup> of each year. The information must follow the format of the health plan management system utilization management file that is submitted to CMS. In order to be consistent with CMS Medicare Part D requirements, where applicable it is recommended that payers and TPAs submit the same level of detail as provided for Medicare Part D. This information may be provided in a downloadable document format, or integrated into a payer's or TPA's websites. The information should be easily accessible.

While supportive of this recommendation, some payers and TPAs noted concern on the timeline proposed in the recommendation. The technical challenges of adding the utilization management criteria to a secure portal could make it difficult to meet the July 1, 2012 date.

*Phase 2*

State-regulated payers and TPAs will develop an online process to accept provider prior authorization requests. The online process will be specific to the prescription medication or medical service requested and the patient's plan requirements for the medication or service. Upon submission of the electronic prior authorization request, a unique electronic tracking identification number (ID) from the state-regulated payer/TPA will be assigned to the request. The provider can use the tracking ID for tracking prior authorization requests with the state-regulated payer or TPA when additional information is required or when a query of a denial is requested by the provider. State-regulated payers and TPAs must be able to identify the request by the ID number across their systems, which includes electronic, call center, and fax systems. Phase 2 must be completed by December 1, 2012.

---

<sup>39</sup> These estimated costs do not include payer and TPA implementation costs.

<sup>40</sup> Maryland Insurance Article §15-10B-05 requires the criteria used for utilization management determinations be provided to the Maryland Insurance Administration and to providers upon written request.

This recommendation will enable providers to have a single electronic method for submitting prior authorization requests. It will eliminate the need for providers to find and print a form, and subsequently fax the form to the payer or TPA. It should also eliminate or reduce the need for providers to call a customer service line to request a prior authorization. The online process should have smart logic so that when a provider inputs the patient's member ID number, and the medication or medical service, the form should then ask questions that are pertinent to that patient and the specific medication or service. An exception is the *Maryland Uniform Treatment Plan* for behavioral health. This standard form is required by law for all behavioral health prior authorization requests, but the form should be available in an electronic format, rather than a printable PDF.

When a provider or staff member submits the prior authorization request, they should receive a tracking or confirmation number that is unique to the request. The ID number verifies for the provider that the request has been received, but it does not guarantee approval of the request. The ID number should be associated with the prior authorization request within all of the organization's systems. Providers should be able to access information about the request via an electronic method, as well as via phone or fax using the ID number.

Payers and TPAs are supportive of implementing an online process for prior authorization requests, and as noted earlier in the report, most are already moving in this direction. However, some payers and TPAs expressed concern over the value, proposed timeframe to develop the technology, and the cost for implementing a unique electronic tracking ID.

### *Phase 3*

Electronic pharmacy prior authorization requests, where no additional information is needed and that meet the established criteria for approval, should be approved in real time.<sup>41</sup> The approval will be communicated to the submitter in real time. For electronic non-urgent pharmacy prior authorization requests that are not immediately approved, a determination will be reached and notification of the determination will be delivered to the submitter within one business day of receiving all pertinent information. For electronic non-urgent medical service prior authorization requests, a determination will be made and notification of the determination will be delivered to the submitter in a timeframe not to exceed two business days from receiving all pertinent information.<sup>42, 43</sup> It is the intended goal of the recommendations that payers and TPAs achieve the above mentioned timeframes related to prior authorization determinations no later than July 1, 2013. The MHCC will reconvene the workgroup prior to the end of 2012 to determine whether the timeframes need to be revised.

The objective of Phase 3 is to accelerate the timeframes for determination and notification in current Maryland statutes and federal rules. In order to approve pharmacy prior authorization requests in real-time, payers and TPAs must build sophisticated rules engines with algorithms that can use the information being entered by the provider or staff member to make an approval decision after the provider completes all required information. Only approvals can be made in real time. Under Maryland statute, if payers or TPAs make an adverse determination, it must be made

---

<sup>41</sup> Real-time, as defined by the Workgroup for Electronic Data Interchange (WEDI), is the process being completed in a single communications session.

<sup>42</sup> Notification can include email, phone call, or notification via the portal.

<sup>43</sup> Maryland Insurance Article §15-10B-06 requires prospective utilization management determinations to be made within two business days.



by a licensed physician or dentist.<sup>44</sup> Consequently, a prior authorization request that is leading to a denial must undergo clinical review.

Some medications require supporting documentation or free text information. In these cases, an automated algorithm is not capable of reading free text or attachments. These prior authorization requests would also require clinical review. In such situations, where a request cannot be approved in real time but rather requires clinical review, payers and TPAs should make a determination and notify the provider of the determination within one business day. Notification can be by any of the following methods: verbal, secure email, through an online system, or via another method that will meet the one business day requirement.

Prior authorization requests for medical services are typically more complex than prescription medication requests and often require attachments and free text entries. Building algorithms to automatically approve medical services are difficult and most requests require clinical review. The recommendation is that the determination will be made and the provider will be notified within two business days. Maryland statute currently requires only that a determination be made within two business days, with notification being made promptly. The recommendation improves upon the current law. Notification can be by any of the following methods: verbal, secure email, through an online system, or via another method that will meet the two business day requirement.

It is the intended goal of the recommendations that no later than July 1, 2013 payers and TPAs achieve the above mentioned timeframes related to prior authorization determinations. The MHCC will reconvene the workgroup prior to the end of 2012 to determine whether the timeframes require revision. It is recommended that payers and TPAs implement the electronic process first, and determine a path forward for real time approvals. Once payers and TPAs have used the online process for an extended period of time, the MHCC will be able to determine the availability of a real time approval system.

### *3. Payers and TPAs will submit reports to the MHCC.*

State-regulated payers and TPAs must submit a report to the MHCC by December 1, 2012. The report must include an update on the status of the implementation of Phase 1 and Phase 2, and an outline of their plan for implementing Phase 3, including feedback on meeting the shortened timeframes. State-regulated payers and TPAs must submit an additional report to the MHCC by December 1, 2013 that includes information related to the implementation of Phase 1 and Phase 2 and achieving the timeframes established in Phase 3.

The MHCC will provide payers and TPAs with the format for the reports, as well as guidelines to the information that should be included in the report. The information provided in the report due December 1, 2012, will be used to ensure that payers and TPAs are adopting the recommendations, and that they have a plan for Phase 3 of the recommendations, including an implementation timeframe.

### *4. Require providers to utilize an electronic prior authorization process.*

By January 1, 2015, providers must utilize the online prior authorization process or their EHR or e-prescribing system to submit all prior authorization requests. Providers will have the option of applying to payors for an exception in extenuating circumstances, such as the lack of broadband access.

---

<sup>44</sup> Maryland Insurance Article §15-10B-07.

Under the CMS EHR Incentive Program, providers must be meaningful users of EHRs by January 1, 2015, or they will face penalties in their Medicare reimbursement rates. In order to align with the timeframes set in the incentive program, and to encourage providers to adopt EHRs, the workgroup agreed that by January 1, 2015, providers should be required to use electronic methods to submit prior authorization requests. This may be via online websites or portals or the provider's practice management, EHR, or e-prescribing system, if a national transaction standard has been established and adopted by the industry.

## Remarks

The increase in health care expenditures has led to cost containment strategies to reduce inappropriate use of health services.<sup>45</sup> Payers and TPAs assert that prior authorization review is necessary to confirm that the services are provided in the most cost-effective manner. Providers believe the process for submitting and tracking prior authorizations is onerous and time consuming. Providers, payers, and TPAs agree that reengineering the prior authorization process is essential to ensuring that value exists in the process. Ultimately, the service should be a benefit to consumers by ensuring the medication or service prescribed by a provider is most appropriate to the consumer's diagnosis and history. The recommendations developed by the workgroup will advance the use of technology and create efficiencies and generate cost savings in the prior authorization process.

---

<sup>45</sup> American Academy of Family Physicians, Issue Brief: *Prior Authorizations for Imaging Services*, (2009).

## Acknowledgements

The MHCC recognizes the contribution in developing the recommendations made by a wide-range of stakeholders that participated on the workgroup. Nearly all leading payers and TPAs participated in the work effort. The high level of enthusiasm among the participants to identify the challenges and develop solutions is laudable. The MHCC thanks Genevieve Morris of Audacious Inquiry for her assistance in completing the work associated with the Prior Authorization report. Special thanks go to the following individuals for their participation in the workgroup.

Salliann Alborn  
Community Health Integrated Partnership

Peter Hulbert  
United Healthcare

Noel Brennan  
Delta

Pam Kasemeyer  
MedChi

Yoke-Cheng Cheah  
Kaiser Permanente

Ed Koza  
United Healthcare

Ned Cheston  
United Healthcare

Laurie Kuiper  
Kaiser Permanente

Steve Daviss  
Baltimore Washington Medical Center

Carol Mandel  
United Healthcare

Bob Enten  
Funk and Bolton Law

Paul Merrick  
Kaiser Permanente

Megan Famodu  
Kaiser Permanente

Rosa Nagle  
CareFirst BlueCross BlueShield

Chricia Ferguson  
CareFirst BlueCross BlueShield

Gene Ransom  
MedChi

John Fleig  
United Healthcare

Deborah Rivkin  
CareFirst BlueCross BlueShield

Richard Fornadel  
Aetna

Kimberly Robinson  
League of Life and Health Insurers of Maryland

Andy Friedell  
Medco

Alice Rothstein  
CVS CAREMARK

Alan Friedman  
Kaiser Permanente

Lauren Rowley  
CVS CAREMARK

Alicia Hawkins  
Coventry Health Care of Delaware, Inc.

Soumi Saha  
Kaiser Permanente

Lisa Hawkins  
WellPoint

Jay Schwartz  
MedChi

David Horrocks  
Chesapeake Regional Information System for Our Patients

Sarah Sheppard  
League of Life and Health Insurers of Maryland

John Stierhoff  
Venable

Jeff Tindall  
Cigna

Peter Walker  
Aetna

Dan Winn  
CareFirst BlueCross BlueShield

Joe Winn  
Aetna

Winston Wong  
CareFirst BlueCross BlueShield

## Appendix A: Background on the Development of National Standards

### *Electronic Prior Authorization Transaction Standards for Prescription Medications*

In 2006, the Agency for Healthcare Research and Quality (AHRQ), supported by a grant from CMS, chose five pilot sites to test a number of e-prescribing standards for readiness for use with Medicare Part D. The standards that were tested included the National Council for Prescription Drug Programs (NCPDP) Formulary and Benefit Standard Version 1.0 for transferring formulary and benefit information as well as the Accredited Standards Committee (ASC) X12N 278 Version 4010A1 and ASC X12N 275 Version 4010 with HL7 for prior authorization messages.<sup>46</sup> The pilot revealed both promise and several challenges. Beyond this pilot, there are very few initiatives to date which have passed the planning phase for enabling the fully electronic processing of prior authorization requests.

Receiving information on a patient's formulary and benefit plan is the first step in the prior authorization process. This information allows providers to know if a prescription medication is covered under the patient's plan, or whether a prior authorization is required. The pilot study found that the NCPDP Formulary and Benefit Standard Version 1.0 was technically able to electronically transfer this information.

However, the standard does have limitations. It does not offer the ability to provide patient-specific information; rather it supports plan-level information, which is only an approximation of the patient's benefits.<sup>47</sup> Currently the formulary and benefit information is available electronically through the e-prescription network Surescripts®. The file is transferred via a batch file process and includes a formulary status list, coverage list, a copay file, and an alternatives file. However, provision of this information to Surescripts is not required for insurance payers or TPAs, and those who do provide this information typically only provide the formulary status list. Additionally, since the transfer is a batch file process, the information is not real-time, and may not be accurate depending on how frequently payers and TPAs send updated files to Surescripts. Providers in the pilot indicated they were concerned about the accuracy of the formulary and benefit information.<sup>48</sup> In another study of the issue, providers expressed the same concern; about 43 percent of providers reported that at least 20 percent of the time formulary and benefit information was incomplete, and about 14 percent indicated that the information was not correct at least 20 percent of the time.<sup>49</sup>

The AHRQ/CMS pilot also tested the ASC X12N 278 health care services review transaction standard, which is a Health Insurance Portability and Accountability Act (HIPAA) standard, using a so-called "unsolicited model." In an unsolicited model, the questions and criteria for the prior authorization are stored on the point-of-care software systems. The providers know all of the questions for a specific prescription medication and can complete both generic and medication-

---

<sup>46</sup> ASC X12 was chartered by the American National Standards Institute over 30 years ago. The organization develops and maintains electronic data interchange standards and extensible markup language (XML) schemas.

<sup>47</sup> Michael Leavitt, *Pilot Testing of Initial Electronic Prescribing Standards – Cooperative Agreements Required Under Section 1860-D-(4) (e) of the Social Security Act as Amended by the Medicare Prescription Drug, Improvement, and Modernization Action (MMA) of 2003*, 2007. Please note that the pilot sites utilized RxHub, which is now Surescripts.

<sup>48</sup> National Opinion Research Center, *Findings from the Evaluation of E-Prescribing Pilot Sites*, AHRQ Publication No. 07-0047-EF (2007). Please note that the pilot sites utilized RxHub, which is now Surescripts.

<sup>49</sup> C. Jason Wang et al, *Journal of the American Medical Informatics Association, Perceptions of Standards-based Electronic Prescribing Systems as Implemented in Outpatient Primary Care: A Physician Survey*, 16.4 (2009): 493-502. Please note that the physicians surveyed utilized RxHub, which is now Surescripts.

specific fields offline, prior to commencing a specific prior authorization request. The process the pilot sites used for prior authorizations is as follows:

- Payers and TPAs publish drug-specific prior authorization requirements using the NCPDP Formulary and Benefits file specification;
- Prescribing systems use prior authorization flags to alert prescribers of authorization requirements;
- Prescribers provide needed information in the format of an electronic prior authorization request;
- Prescribing systems submit electronic prior authorization requests to payers/TPAs using the American National Standards Institute ACS X12 278 transaction, including appropriate patient information (diagnosis/conditions); and
- Payers/TPAs respond using the 278 response and potentially note the authorization result in the claim adjudication system.

The pilot study found that while the standard has the potential to ease the burden on providers, it was not technically able to process electronic prior authorizations for prescription medications.<sup>50</sup>

After the pilot was completed, AHRQ formed the electronic prior authorization workgroup. The group's goal was to create a roadmap and a prioritized agenda for moving forward with a standard prior authorization format. In 2008, the group determined that a further review of the 278 transaction standard was needed to determine what additional modifications could be made to accommodate electronic prescriptions.<sup>51</sup> The workgroup recognized that one standard was needed, and determined that NCPDP should be responsible for the standard for prescription medications. In 2009, after determining the 278 transaction would not be sufficient for prescription medications, NCPDP developed an XML standard that was based on the 278 transaction. While the initial standard has been developed, it has not yet been piloted and its usability is unknown.<sup>52</sup> Consequently, a national standard for electronically requesting a prescription medication prior authorization does not exist at this time.

There are two federal programs that encourage the use of e-prescribing: the CMS Electronic Prescribing (eRx) Incentive Program and the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. Both programs require eligible providers utilize an e-prescribing system or EHR that has the ability to provide formulary and benefit information, if it is made available by insurance payers or TPAs. Neither program requires that the system have the ability to transmit electronic prior authorizations.<sup>53, 54</sup> According to a recent blog post from the Office of the National Coordinator (ONC), there are no plans to include electronic prior authorizations as a requirement in either program. This is due to a lack of national standards for transmitting

---

<sup>50</sup> Michael Leavitt, *Pilot Testing of Initial Electronic Prescribing Standards – Cooperative Agreements Required Under Section 1860-D-(4) (e) of the Social Security Act as Amended by the Medicare Prescription Drug, Improvement, and Modernization Action (MMA) of 2003*, 2007. Please note that the pilot sites utilized RxHub, which is now Surescripts.

<sup>51</sup> *E-Prescribing Standards Expert Meeting Summary* AHRQ Publication No. 08-0062-EF (2008).

<sup>52</sup> National Council for Prescription Drug Programs. Available at: <http://www.ncdp.org/>.

<sup>53</sup> Medicare Program, Changes to the Electronic Prescribing (eRx) Incentive Program, Final Rule, 42 CFR Part 414 Federal Register, Vol. 76, No. 172, (2011). Available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22629.pdf>.

<sup>54</sup> Medicare and Medicaid Programs; Electronic Health Record Incentive Program, Final Rule, 42 CFR Parts 412, 413, 422 et al., Federal Register, Vol. 75, No. 144, (2010).

electronic prior authorizations, which has led to an inability of implemented EHR systems to transmit electronic prior authorizations for prescription medications.<sup>55</sup>

### ***Electronic Prior Authorization Transaction Standards for Medical Services***

CMS has mandated that the ASC X12 278 transaction is its HIPAA-approved standard for requesting prior authorization of medical services. The 4010 version of the standard, however, is not necessarily adequate for prior authorization requests, mainly because the transaction set is administratively focused, rather than clinically focused. Consequently, CMS has granted a waiver on the use of the ASC X12 278 transaction. The 5010 version of the standard is not required to be used until January 1, 2016. The following functionalities have been added to the 5010 version:<sup>56, 57</sup>

- Report procedure modifiers;
- Report revenue codes and rates;
- Request procedure ranges;
- Reserve a limited number of occurrences of a service within a defined time frame;
- Send and receive ICD 10-CM codes;
- Support for reconsideration requests prior to filing a formal appeal; and
- Clarify the patient condition segment, which creates separate implementation segments and rules for the following information: ambulance certification; durable medical equipment; oxygen therapy certification; functional limitation; chiropractic certification; activities permitted; and mental status.

The AMA has recommended that, in addition to the above changes in the 5010 version, the 278 transaction include 10 standard data elements that will allow a provider to submit a request and receive a maximum of one follow-up for additional information. Upon submission of these 10 data elements, providers will receive one of four possible near real-time responses: approved, denied, requires follow-up information, or does not require a prior authorization. The following is a list of the 10 data elements that the AMA workgroup has agreed upon:<sup>58</sup>

- Patient demographics: name of patient, patient ID, date of birth;
- Ordering physician demographics: name of ordering physician or health care provider, Type 1 NPI, telephone number;
- Rendering physician demographics: rendering physician, group, or facility professional name and TIN or NPI, Type 1 or Type 2 NPI;
- Rendering facility demographics if different than three: facility name where service will be performed, Type 2 NPI;
- Type of procedure/service/device being requested (CPT/HCPCS codes);
- Unit/volume of procedure/service/device being requested, default is one unit;
- Whether the request is emergency, urgent, or elective (default is elective);
- ICD-9-CM or its successor, primary diagnosis code(s);

---

<sup>55</sup> Doug Fridsma, Health IT Buzz, *E-Prescribing and Standards for E-Prior Authorization*, (2011). Available at: <http://www.healthit.gov/buzz-blog/from-the-onc-desk/eprescribing-standards-eprior-authorization/>.

<sup>56</sup> AMA White Paper, *Standardization of Prior Authorization Process for Medical Services*, (2011). Available at: <http://www.ama-assn.org/resources/doc/psa/standardization-prior-auth-whitepaper.pdf>.

<sup>57</sup> Large health plans must implement the HIPAA 5010 standards by January 1, 2012. Small health plans have until January 1, 2013 to comply with the CMS regulations.

<sup>58</sup> AMA White Paper, *Standardization of Prior Authorization Process for Medical Services*, (2011).

- Planned date(s) of service (Patient event date or start/end date for every procedure code); and
- Site of service (11-Office, 22-Outpatient Hospital, 24-Amb Surg Center, 12-Home, 21-Inpatient)

### *Current Electronic Prior Authorization Pilots*

Earlier in 2011, CVS CAREMARK® announced and began planning for an electronic prior authorization pilot for prescription medications. The go-live date for the project is January 1, 2012, and it will launch with three or four e-prescribing vendors. The pilot will only involve CVS pharmacies. The goal of the pilot project is to create a standard for prior authorizations that can be recommended to NCPDP for adoption as the national standard. The prior authorization process will integrate with providers' e-prescribing systems and will use the Surescripts network to request a prior authorization and receive a real-time response. CVS CAREMARK evaluated the NCPDP standard for use in the pilot and determined that it was not sufficient to support the prior authorization process for the following reasons:

- Lack of support for conditional logic in the question sets;
- Lack of an expiration date to ensure question set is current;
- Limitations with the priority/urgent indicator;
- Limitations with the prior authorization expiration date/details to identify how long approval is valid;
- Lack of an electronic appeal transaction;
- Lack of a cancellation option; and
- Lack of an appeal indicator.

Consequently, the CVS CAREMARK pilot will utilize the NCPDP standard for demographic information and common prescription medication information, but will modify the standard to better support electronic prior authorizations.<sup>59</sup> Once the new standard has been piloted and thoroughly tested, it will be presented to the NCPDP. They will follow their balloting process to approve the standard, make any necessary modifications, and publish the national standard. This process typically takes a few years to complete.

The AMA and NaviNet®, a real-time health care communications network vendor, are beginning a separate electronic prior authorization pilot for medical services. Pilot participants have not been chosen yet, and the sponsor organizations are in initial discussions to engage participants, but the planned start date of the pilot is January 1, 2012. The pilot is based on the recommendations made in the "Standardization of Prior Authorization Process for Medical Services" white paper.<sup>60</sup> The goal is to test the American National Standards Institute ASC X12 278 v5010 standards, as well as the 10 standard data elements cited earlier. The project is in the very early stages, and it is unknown when final national standard recommendations from the pilot would be ready.<sup>61</sup>

---

<sup>59</sup> CVS CAREMARK *Electronic Prior Authorization Pilot* Presentation to NCPDP, May 16, 2010.

<sup>60</sup> AMA White Paper, *Standardization of Prior Authorization Process for Medical Services*, (2011). Available at: <http://www.ama-assn.org/resources/doc/psa/standardization-prior-auth-whitepaper.pdf>.

<sup>61</sup> Information about the AMA pilot is based on the AMA Prior Authorization for Medical Services Workgroup Meeting on September 12, 2011.



## Appendix B: Current Payer Prior Authorization Methods<sup>62</sup>

Current Payer Prior Authorization Methods						
	Online Portal for Medical Services	Online Portal for Prescription Medications	Fax or Phone for Medical Services	Fax or Phone for Prescription Medications	List of Services or Medications Requiring PA Available on Site	Standard Form
Aetna	•		•	•	•	• <i>(both standard and specific)</i>
AMERIGROUP Community Care			•	•	•	•
CareFirst	• <i>(hospitals only)</i>		•	•		
Cigna	•	•	•	•		• <i>(both standard and specific)</i>
Coventry Health Care of Delaware, Inc.	•	•	•	•	•	•
Diamond Plan from Coventry Health Care of Delaware, Inc.	•	•	•	•	•	• <i>(both standard and specific)</i>
Humana	•			•	•	• <i>(both standard and specific)</i>
Jai Medical Systems			•	•	•	
Kaiser Permanente	•		•			•
Maryland Physician Care	•		•	•	•	• <i>(both standard and specific)</i>
Medstar			•	•	•	•
Priority Partners			•	•	•	
UnitedHealthcare and Prescription-Solutions	•	•	•	•	•	

<sup>62</sup> Payer websites were independently reviewed to determine current methods for prior authorization requests.

## Appendix C: Current TPA Prior Authorization Methods<sup>63</sup>

Current TPA Prior Authorization Methods				
	Online Portal for Prescription Medications	Fax or Phone for Prescription Medications	List of Prescription Medications Requiring PA Available on Site	Standard Form
Argus Health Systems	•		May be available in the online portal	
Atlantic Prescription Services		•	•	
Benecard Services		•		
BioScrip TPA Services		•		
Catalyst Rx		•	•	•
CVS CAREMARK		•		• <i>(both standard and specific)</i>
Envision Pharmaceutical Services		•		
Express Scripts		•		• <i>(both standard and specific)</i>
FutureScripts		•	•	
Health E Systems	•		May be available in the online portal	
HealthTrans		•		•
Innoviant (now part of PrescriptionSolutions, which is part of UnitedHealthcare)	•		May be available in the online portal	
Maryland Pharmacy Program (Medicaid FFS)		•	•	• <i>(both standard and specific)</i>
MaxorPlus		•	•	
Medco	•	•	May be available in the online portal	• <i>(both standard and specific)</i>
Medical Security Card Company - ScriptSave		•		
MedImpact Healthcare System		•	•	•

<sup>63</sup> TPA websites were independently reviewed to determine current methods for prior authorization requests.

**Current TPA Prior Authorization Methods *(continued)***

	Online Portal for Prescription Medications	Fax or Phone for Prescription Medications	List of Prescription Medications Requiring PA Available on Site	Standard Form
MemberHealth		• <i>(online form that allows fax or email request)</i>	•	
National Employee Benefit Companies-Ideal Scripts		•		
PharmaCare Management Services <i>(no website)</i>		•		
Prime Therapeutics		•		
Progressive Medical		•		
RxAmerica (part of CVS CAREMARK)	•	•		•
Scrip World		•	•	•
Tmesys (PMSI)		•		
WellDynerx		•		



MARYLAND  
HEALTH CARE  
COMMISSION

David Sharp, Ph.D., Director  
Center for Health Information Technology  
[www.mhcc.maryland.gov](http://www.mhcc.maryland.gov)