Administrative Uniformity Committee

Streamlining Health Care Administrative Transactions in Minnesota

AUC OPERATIONS COMMITTEE AGENDA

2:00 p.m. – 4:00 p.m., Tuesday, September 8, 2015

TIES Event Center, Hamline Room

1644 Larpenteur Avenue West, Falcon Heights, MN 55108

Teleconference line: 1-712-832-8300
Participant passcode: 337213

WebEx instructions:

1. To start the WebEx session, go to: https://health-state-mn-ustraining.webex.com
2. Under "Attend a Session," click "Live Sessions"
3. Click on the session for "AUC Operations"
4. Provide your name, email address, and the following password: Ops2010! (Note: The exclamation mark at the end is part of the password.)
5. Click "Join now"

Meeting Objectives:

- Vote on new member – Grand Itasca
- Discuss possible AUC role in ACO data analytics standardization
- Reviews and updates of other important topics – companion guide updates, workers' compensation e-billing, TAG updates

The table below shows the agenda items for the September 8, 2015 AUC Operations meeting with corresponding reference documents.

Note:

- The suggested reference documents are intended as general background and context for discussion items. Additional updates and information will be provided and discussed at the Operations meeting.
- It is **not** necessary to print out or bring the reference documents to the Operations meeting.
- A single pdf version of all the numbered reference documents will also be posted to the AUC Operations meeting information webpage at http://www.health.state.mn.us/auc/infoops.htm.

September 8, 2015 AUC Operations Agenda	Reference documents for agenda item
1. Meeting to order – Ann Hale, co-chair	
2. Anti-trust statement: http://www.health.state.mn.us/auc/pdfs/antitrust.pdf	
3. Introductions - Please e-mail your attendance to health.auc@state.mn.us	
4. Review and approve minutes from the last meeting	#1 – Minutes from the June Operations meeting

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September 8, 2015 AUC Operations Agenda	Reference documents for agenda item
5. Council of Health Plans -- single standard form for home health prior authorization	#2 - Council SBAR re. single standard form for home health prior authorization #3 - Proposed standard form for home health prior authorization #4 - Proposed form instructions
6. Vote on Grand Itasca membership to AUC	#5 - Grand Itasca membership form
7. Possible role for AUC in SIM data analytics standardization	#6 - Department of Human Services (DHS) SBAR re. data analytics standardization #7 - SBAR additional information (email with answers to Exec Committee questions regarding possible AUC assistance in standardizing data analytics)
8. Update on workers' compensation e-billing	#8 - Department of Labor and Industry workers' compensation e-transactions law enacted during the 2015 legislative session
9. Electronic prescription drug prior authorization (Rx ePA)	#9 - Electronic prescription drug prior authorization law #10- Consultant's report used in developing the AUC's Rx ePA companion guide (read especially pages for an overview of what the transaction does and how it works).
10. Additional updates and reports	
a. Companion Guide annual maintenance	#11 – Summary of companion guide annual maintenance timeline and progress to date
b. Voting items and voting	#12 – Summary of items recently approved at the TAG level to be voted on by the Operations Committee in the near future
c. Brief TAG Updates	
d. Relevant national activity/updates	#13 – ASC X12N Business Requirements and Technical Solutions (BRTS) Change Request (CR) 1359: 837 - Change request to continue AMT segment capabilities for reporting taxes Note: The Minnesota Uniform Companion Guides for the 5010 versions of the 837 Professional, Institutional, and Dental transactions include instructions for using the AMT segment to report MNCare Taxes. In developing the 6020 versions of the transactions, ASC X12 removed this tax reporting capability. The AUC submitted a change request to X12 to retain the MNCare tax

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September 8, 2015 AUC Operations Agenda	Reference documents for agenda item
	reporting capability via the AMT segment. The change request was described in the BRTS above, and was recently approved by a relevant subcommittee of X12. #14 CORE phase IV operating rules summary The Committee on Operating Rules for Information Exchange recently announced the availability of phase IV operating rules for a vote by CORE members. This summary from the CORE website provides an overview of the rules and the voting process. Additional information is available at links at the CORE phase IV website, http://www.caqh.org/core/caqh-core-phase-iv-rules.
11. Other Business	

Next Meeting: 2:00 p.m. – 4:00 p.m., December 8, 2015 (In-person & Teleconference/WebEx)

TIES Event Center, 1644 Larpenteur Avenue West, Falcon Heights, MN 55108

AUC OPERATIONS COMMITTEE MEETING MINUTES
2:00 p.m. – 4:00 p.m., Tuesday, June 9, 2015

TIES Event Center, Hamline Room
1644 Larpenteur Avenue West, Falcon Heights, MN 55108

AGENDA ITEM	DISCUSSION
1. Meeting to order – Ann Hale, co-chair	
2. Anti-trust statement: http://www.health.state.mn.us/auc/pdfs/antitrust.pdf	Ann Hale stated that members must comply with the AUC anti-trust statement during discussion; and to view details please visit AUC website.
3. Introductions – Please email your attendance to ann.hale@state.mn.us Attendance was taken.	On behalf of the AUC, Ann thanked Bob Aliperto for serving as the 2014 co-chair and presented him with a plaque in appreciation for his leadership, expertise, ideas and suggestions resulting a successful 2014 for the AUC.
4. Updates and reports a. Status of AUC testimony to NCVHS b. Brief TAG Updates c. Relevant national activity/updates d. Brief Minnesota legislative updates	a. Status of AUC testimony to the National Committee on Vital and Health Statistics (NCVHS) – Dave Haugen reported that NCVHS is conducting hearings June 16-17 as part of their biennial review process to evaluate and review the adopted standards and operating rules for administrative simplification. He presented the list of questions and data requests posed by NCVHS to the industry and the responses to CMS prepared and approved by the Claims DD TAG, Eligibility and EOB/Remit TAGs. Dave stated that the deadline to submit written comments to NCVHS is June 17. He noted that in addition to the topics named, the AUC experience with acknowledgments and non-HIPAA covered entities has been important and should be considered by NCVHS. The Executive Committee is requesting that Ops review and vote on the AUC response from June 9-15. Ann – extended thanks to TAG co-chairs and parties who worked on preparing the responses for review by Ops and submission to NCVHS so

quickly. She further stated MN has a lot to say about where we are and what we've done and it is important to provide feedback to NCVHS.

b. Brief TAG updates – Dave reminded members that the TAG updates are published in the monthly AUC Update (newsletter) and that meeting minutes and meeting information are posted on each individual AUC TAG's webpage.

Ann explained that the voting period for the E-vote request sent to the AUC Ops on May 21 to approve three best practices and C&TC Developmental and Social Emotional/Mental health Screenings SBAR response occurred over the Memorial Day holiday. She received an email from an Ops member expressing concern about the voting deadline and felt it should have been longer to account for members away for the holiday. As a result, an email was sent June 4 extending the deadline through Thursday, June 11.

Pete Anderson, EOB/Remit TAG co-chair, reported that CAQH CORE released the new code combinations and will start looking at new scenarios beginning in July. He further stated that presumably four months from now the business scenario that the TAG submitted, if accepted will come out in CORE's next update.

c. Dave Haugen reported that HHS announced they are moving forward on HPID certification rule and issued a request for information (RFI) on HPID enumeration structure. Their 60-day public comment period is opened until July 28, 2015. It was agreed that AUC should submit comments. Dave Andersen will convene the HPID TAG to draft comments on behalf of the AUC for Ops review and approval.

Dave Haugen reported that a recent WEDI newsletter discussed several workgroups; some of the issues and topics overlay with the AUC's. He stated MDH will continue to monitor WEDI bundled payments, payment models, and ICD-10 workgroups and asked that AUC members also be mindful of the workgroups' activities and to provide feedback to the AUC on relevant issues or topics that may impact the AUC.

d. Lisa Wichterman reported that the Department of Labor and Industry (DLI) had developed a statutory proposal to address issues in workers compensation e-billing identified at a joint MDH-DLI

	Workers Compensation Symposium conducted November 5, 2014. The DLI legislation requires attachments with outpatient bills using the 275 transaction no later than July 1, 2016; no later than January 1, 2016, payers must list the name(s) of their Clearinghouse(s), claim number, and name of a contact person on their website(s); and effective September 1, payers must provide the patient's name and patient control number on or with all payments made to a provider. The proposal includes enforcement authority. In responding to questions, Lisa noted that DLI is proposing version 5010 of the 275 transaction, DLI did not specify a format for sending medical records, and she is not sure whether rules will be developed. She stated the proposed e-billing legislation will be discussed further at an upcoming workers compensation meeting among the payers, DLI and their Commissioner. Lisa requested that any further questions regarding the proposed legislation be sent to her.
5. Discuss payer implementation of AUC Best Practices for Exchanging Grace Period Notification	Status check on implementation of the AUC HIX Grace Period Notification best practices: BCBS has implemented the 270/835 best practices; HealthPartners implemented the 270/271 best practice in March; Medica is looking at implementation.
6. Review AUC schedule and objectives for the remainder of the year a. Schedule next round of companion guide annual maintenance b. Response to CMS request for comments re HPID c. SIM Data Analytics update/planning d. Acknowledgment TAG re-forming	a. Dave Haugen reported the claims companion guides (837) were published in the Minnesota State Register June 1. b. Dave Anderson will convene the HPID TAG to prepare draft comments to CMS for AUC review, approval, and submission. HPID members will receive meeting notification soon. c. The Executive Committee met with staff of the Minnesota Departments of Health and of Human Services to discuss a possible role of the AUC to help standardize data analytics to be made available to Accountable Care Organizations (ACOs) as part of the State Innovation Model (SIM) grant now underway. The Executive Committee will follow-up by requesting that the SIM staff complete and submit an AUC SBAR to determine if their request is in scope for the AUC.

	d. Ann Hale announced that the Acknowledgment TAG is re-forming. She stated that Minnesota is in the forefront of requiring this transaction and that the TAG had completed important work. She solicited participation and commitment to serving on the Acknowledgment TAG. Contact Ann or Dave H. if interested.
7. Outreach, planning for ICD-10	There is great concern throughout the industry regarding provider readiness for the October 1, 2015 transition to ICD-10. The AUC is sharing it's website with the MN ICD-10 Collaborative. The Collaborative is working with a number of partners to provide outreach and education to small and rural providers.
8. Other Business	Two- and four-digit PMAP codes. Joe Schindler reported that the Health Plans are still meeting with DHS regarding this issue. Andrea Agerlie reported that DHS is working with Trisha Schimers (Allina) on a pilot. They just began exchanging data recently to determine what might be needed. Andrea will prepare an update as needed for September AUC Operations meeting.

AUC BUSINESS NEED EXPLANATION FORM (AUC SBAR)

Instructions for Completing the AUC SBAR

Purpose: To provide a formal communication method by which member organizations or non-member interested parties may request the AUC to consider working on a particular issue related to administrative simplification or to request clarification of Minnesota rules and regulations related to administrative simplification.

Instructions: Do not combine issues in a single SBAR. Complete a separate SBAR form for each individual issue that needs to be addressed. The completion of the AUC Medical Code TAG (MCT) Decision Tree is highly recommended prior to completion of the SBAR form(s). If completed, please submit the MCT Decision Tree form along with your completed SBAR.

Complete Sections II and III of the SBAR. Section I is to be completed by MDH staff and Section IV is to be completed by the AUC.

Medical Coding TAG Decision Tree Form

In order to streamline and expedite the SBAR review process, the AUC Medical Code TAG utilizes the MCT Decision Tree in its decision-making process for consideration of SBARs under the TAG's review. The MCT also requires SBAR submitters to use the form to ensure accurate and timely SBAR responses. The MCT Decision Tree form can be accessed from the AUC website at: http://www.health.state.mn.us/auc/forms.htm or by clicking on the link below in Step 1 below.

Step 1: Complete an MCT Decision Tree for each SBAR issue. Completing the MCT Decision Tree will enable a more thorough explanation of the SBAR issue(s) and prevent omission of critical or significant information.

Step 2: Fully complete Sections I and II. Incomplete or unclear analysis of the issue may cause unnecessary delay in the AUC response to the SBAR.

Section I

1. Provide contact information for person submitting the SBAR. Additional contact information may be required for the subject matter expert if different from the person completing the SBAR form.
2. The additional contact information is completed when the SBAR is being submitted on behalf of another individual who should also be notified of the AUC TAG meeting when the SBAR will be considered and who may or may not be a member of your organization.

   Please note: There may be a need to ask additional questions in order to clarify understanding of the issue as stated in the SBAR. The SBAR submitter and subject matter expert should be in attendance or available during the AUC TAG meeting and will be notified of meeting details at least one week prior to the SBARs' scheduled review date.

Section II

1. Provide an SBAR short title for your issue.
2. Describe the issue, using descriptive and concise language and/or examples as appropriate, and by answering the questions outlined below:

- **Situation**: Describe the type of problem or issue, e.g., coding or clarification/interpretation. What is the current business practice and why is it a problem or an issue? Would the continuance of the practice result in non-compliance of federal (e.g., CMS guidelines) and Minnesota administrative simplification rules and regulations?
- **Background**: In explaining the pertinent history of the business practice, state how it is used within your organization or within the industry today. What is the negative impact of the business practice if not addressed by the AUC?
- **Assessment**: Be specific and provide as much detail you feel is required to convey or explain why this issue should be addressed by the AUC. How would a change to this business practice benefit health care administrative simplification in Minnesota?
- **Recommendation**: What are you proposing as the solution to this issue that will benefit the health care administrative simplification in Minnesota or improve standardization of the administrative simplification process in Minnesota?

Step 3: Submit the completed SBAR(s) and MCT Decision Tree(s) to the AUC via email at: health.AUC@state.mn.us.

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received	**Log No.**	**Date Closed**	
Status: Exec Review Date	**Sent to TAG/WG**	**TAG Recommendation:** _____ Accept _____ Reject	**Decision to Originator**

REMINDER: Submit the completed SBAR and MCT Decision Tree form via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert)

SBAR Short title: Universal Health Plan/Home Health Agency Authorization Request Form	**Date: July 16, 2015**
Contact Information for person completing this form: **Name: Kathryn Kmit** **Title: Dir of Policy & Govt Affairs** **Email address: kmit@mnhealthplans.org** **Telephone: 651-645-0099 ext 13**	**Organization Information:** **Name: MN Council of Health Plans** **Address: 2550 University Ave West Suite 255 S St. Paul, MN 55114**

Complete for additional contact or Subject Matter Expert, as required:

Name: Kathryn Kmit
Title: See above
Email address: see above
Phone number: see above

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title:

S	**SITUATION** – Describe the current business practice (Please describe the problem or issue to be addressed: Home care agencies asked the Council to develop a standardized, uniform prior authorization form that the agencies could submit and health plans could accept.
B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): Health plans typically require prior authorization when home care services are requested for a patient. Each health plan has its own form. The variation in forms was administratively burdensome.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The Council of Health Plans worked with its largest health plans to compare and contrast the forms and then developed one form that would meet the needs of the health plans and home care providers. See attached.

R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: We recommend using this standardized, uniform form and making it available to all entities that require prior authorization for home care services in MN.

Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):

Date [SBAR Response Approved by TAG]:

Reviewed by [AUC TAG Name]:

AUC Co-Chair(s):

AUC Response:

Discussion/Summary:

Decision:

#3 - Proposed standard form for home health prior authorization
UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY AUTHORIZATION REQUEST FORM

Blue Plus	HealthPartners	Medica	MHP	UCare

Date:_____ Start of Care Date:_____ Initial Authorization: Y/N Continued Authorization: Y/N

Patient Information

Name:_____ Health plan ID:_____
DOB:_____ Address:_____
City, State, Zip:_____ Phone:_____

Primary Diagnosis for Home Care Services:_____
Other/Comorbid diagnosis:_____

Homebound: Y/N Location of Service: Member home_____ Assisted Living _____ Group Home _____
Foster Care _____ Customized Living _____ other _____

Home Care Agency Information

Agency Name: _____ NPI: _____Address: _____
City, State, Zip _____Contact Name: _____
Contact Phone:_____ Contact Fax:_____

MD/Ordering Provider Information

Name: _____ NPI: _____ Clinic: _____
Clinic Address:_____ City, State, Zip_____
Clinic/MD Contact Phone Number: _____ Fax number: _____
Date of last appointment: _____ Next visit date (If known):_____

Service Request Information:

Type of Service	Procedure Code	Number of Visits Requested	Frequency	Start Date (this request)	End Date (this request)

ClinicalInformation/Summary/Comments_____

_____

_____

Recent Hospitalization/Surgery: _____ D/C Date: _____

Submit current CMS 485/Home care plan of care and clinical notes to support authorization request along with request.

#4 - Proposed form instructions

List of Fields for the Universal Health Plan/Home Health Authorization Form

Health Plan

Indicate which health plan this request is being sent to

Date: this is today's date

Start of care date: this is the date upon which the services are being requested to start

Initial authorization – Y/N: indicate whether or not this is an initial authorization

Continued authorization – Y/N: indicate whether or not this is a continuation of an authorization

Patient Information

Name: this is the name of the patient

Health Plan ID: this is the policy number for the patient's coverage

DOB: this is the date of birth of the patient

Address: this is the address of the patient

City, State, Zip: more detail about the address

Phone: this is the best number to reach the patient – could be home or cell

Primary Diagnosis for Home Care Services: this is the diagnosis code that describes the patient's condition and reason for requesting home care services

Other/Comorbid diagnosis: indicate any other diagnosis codes that affect the patient's need for home health services

Homebound – Y/N: Indicate whether or not the patient is homebound

Location of service: Indicate specifically where the services will be provided

- Member home:
- Assisted Living:
- Group Home:
- Foster care:
- Customized Living:
- Other:

Home Care Agency Information

Agency Name: this is the name of the overall home care agency

NPI: this is the home care agency's provider number

#4 - Proposed form instructions

List of Fields for the Universal Health Plan/Home Health Authorization Form

Address: this is the address of the home care agency (Is it the main office or the satellite office where these services are provided out of?)

City, State, Zip: remainder of address information

Contact name: this is the best name of the person at the Home Care Agency to whom the health plan can contact about this specific patient

Contact phone #: this is the phone number of the best person at the Home Care Agency to whom the health plan can call when discussing this specific patient

Contact Fax #: this is the best fax number to use when communicating with the Home Care Agency

MD/Ordering Provider Information

Name: this is the name of the physician or provider who is ordering these services

NPI: this is the provider number associated with this physician or provider

Address: this is the main address of the physician or provider

City, State, Zip: this is the rest of the address for the physician or provider

Clinic/MD Contact Phone Number: This is the best number to use to reach this physician or provider directly

Fax Number: this is the best fax number to use to reach this physician or provider

Date of last appointment: this is the date of the last appointment this patient had with this physician or provider who is ordering these home care services

Next visit date (if known): this is the date of the next appointment that the patient has with the physician or provider who is ordering these home care services

Service Request Information

This section lists the type of service being requested; the procedure code associated with that service; the number of visits that the physician or provider is ordering of this service; the start date that this service should begin; and the end date when the service should end.

There are four lines available for the ordering physician or provider to complete if more than one line is needed.

Clinical Information/Summary/Comments: This section is to be filled out by the home care agency or the physician or provider who orders the service?

#4 - Proposed form instructions

List of Fields for the Universal Health Plan/Home Health Authorization Form

Recent Hospitalization/Surgery: Indicate the date that the patient had his/her most recent surgery

D/C Date: indicate the date of discharge for that most recent hospitalization/surgery

Submit current CMS 485 form/Home care plan of care and clinical notes to support authorization along with this form: This section should be completed with information that provides background and context on the patient's current situation. It should include clinical notes and other information from providers, etc., to help provide a complete picture of the patient's situation.

#5 - Grand Itasca membership form

August 10th, 2015

Administrative Uniformity Committee
c/o David Haugen, Minnesota Department of Health
85 East 7th Place
St. Paul, MN 55101

RE: Membership on the Administrative Uniformity Committee (AUC)

Dear Mr. Haugen;

On behalf of _Grand Itasca Clinic and Hospital_____, I wish to request membership on the AUC. This membership request is based on our organization's status as (please check one):

- X A provider
- ☐ A Payer/Group Purchaser
- ☐ A Provider Association
- ☐ A Payer Association

We agree to participate in at least two AUC Technical Advisory Groups (TAGs) or Work Groups (named below). The following individuals from our organization will participate in AUC as follows:

Org. Contact	**Role**	**E-mail Address**	**Phone Number**
Jennifer Notch	Primary representative, Operations Committee member	Jennifer.notch@granditasca.org	218-999-1711
Ed Tusa	Secondary representative, Operations Committee member	Ed.tusa@granditasca.org	218-999-1702
Jennifer Notch	Strategic Steering Committee representative	Jennifer.notch@granditasca.org	218-999-1711
Roxanne Christie	(*indicate TAG/Work Group name*) TAG or Work Group representative **Claims**	Roxanne.christie@granditasca.org	218-999-1725
Gretchen Danielson	(*indicate TAG/Work Group name*) TAG or Work Group representative **Medical Code**	Gretchen.danielson@granditasca.org	218-999-1502

We agree to abide by the AUC mission and governing principles as stated in the AUC by-laws.

Sincerely,

Jennifer Notch

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- **Recommendation**: What are you proposing as the solution to this issue that will benefit the health care administrative simplification in Minnesota or improve standardization of the administrative simplification process in Minnesota?

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#6 - Department of Human Services (DHS) SBAR re. data analytics standardization

AUC BUSINESS NEED EXPLANATION FORM (SBAR)

TO BE COMPLETED BY THE MINNESOTA DEPARTMENT OF HEALTH			
Date Received	**Log No.**	**Date Closed**	
Status: Exec Review Date	**Sent to TAG/WG**	**TAG Recommendation:** **_____ Accept** **_____ Reject**	**Decision to Originator**

REMINDER: Submit the completed SBAR and MCT Decision Tree form via email to the AUC at health.AUC@state.mn.us. The MCT Decision Tree is completed for medical coding issues only.

Section I – SBAR Short Title, Date, and Contact information (Person submitting the SBAR and/or Subject Matter Expert)

SBAR Short title: **Align Data Analytic Elements shared as part of ACO models**	**Date:** **08/03/15**
Contact Information for person completing this form: **Name: Heather Petermann** **Title: Manager, Care Delivery and Payment Reform** **Email address: heather.petermann@state.mn.us** **Telephone: 651-431-4120**	**Organization Information:** **Name: Department of Human Services** **Address: 540 Cedar Ave S., St. Paul, MN 55410**

Complete for additional contact or Subject Matter Expert, as required:

Name:

Title:

Email address:

Phone number:

Section II – SBAR information (Concise and specific description of the issue to be addressed stating the Situation, Background, Assessment, and Recommendation)

SBAR Issue Title:

S	**SITUATION** – Describe the current business practice(Please describe the problem or issue to be addressed: Providers receive a varying level of post adjudicated claims information from payers. To most effectively use the information, providers must be able to synthesize and aggregate these data streams. Lack of standardization around the availability of common information, field definitions, formats and timeframes creates costly challenges, potential errors and lack of understanding in interpreting and using information which diminishes the value and power of data analytics. As part of Minnesota's continued payment and care delivery reform efforts and through the State Innovation Model grant, a statewide goal has been established to increase the number of providers participating in accountable care arrangements as well as increase the number of Minnesotan's receiving well-coordinated care. Establishing recommendations for increased consistency around the information shared between payers and providers in these arrangements supports these goals by enabling more providers to participate and encouraging the exchange of data that can be used more meaningfully to impact care.

B	**BACKGROUND** – Explain the pertinent history of the business practice (How does this work today): In response to this situation, the SIM Multi Payer and Community Advisor Task Forces created a data analytics sub group to begin the process of developing recommendations to motivate and guide greater consistency in the sharing of prioritized data analytic elements among organizations involved in accountable care models (ACOs). The task forces started by sharing background information and report package of file samples related to the data that providers and payers in accountable care arrangements were sending or receiving. The subgroup, over the course of three workgroup meetings, put together high level principles and a list of prioritized areas for improved alignment that could be addressed in the current environment. This information would be available background to the AUC. In its first phase and first summary report, the workgroup identified five data analytic component areas where consistency around data format, frequency and content would be most impactful for a provider's ability to successfully participate in ACO models. A copy of the report along with other background material related to data analytics subgroup can be found on the DA subgroup page of MN's SIM website. The data analytic subgroup activity was not outlined as an explicit deliverable in the state's SIM plan so there are no formal metrics, or other evaluation requirements tied to this work. However, the SIM grant does expect the state of MN to advance the MN Accountable Health model in a multi-payer approach. Progress towards creating uniformity in a foundational analytic component will contribute to providers' ability to successfully participate in accountable models and demonstrates the commitment within Minnesota to identify collaborative solutions to address potential barriers.
A	**ASSESSMENT** – Summarize your analysis of this issue (what are your challenges, what type of organizations are impacted by these challenges – provider types, health plans, others? Please indicate how this applies to AUC's mission, vision, values, and strategy. Are there any national or community standards that exist or are being developed that might help address the situation? If so, please explain): The subgroup and task force recognize that another more detailed level of focus is needed in order to advance the phase one recommendations. Taskforce members expressed a desire to be able to demonstrate progress towards operationalizing at least one of the prioritized component areas while continuing the discussion around the phase two components. Although the scope of the work to be taken up in phase 2 by the subgroup is still being finalized, it is anticipated to focus on components related to health equity. To the extent this would dovetail with demographic components of the membership file being addressed through the AUC, the state staff supporting the efforts would be a conduit to connect both through SIM project management. One of the prioritized data analytic topic areas – enrollee demographics and contact information rose to the top as a foundational component in the information providers in accountable care arrangements receive. Understanding the "who" of the population being managed is a fundamental building block, but the inconsistent mechanisms for providing member lists creates challenges for ACO providers. Identifying a more aligned way for sharing demographic and enrollment files containing name, date of birth, address, beneficiary contact information and associated responsible providers and payers for that enrollee would be a helpful starting point. Some of the relevant data elements overlap with information that would be in an eligibility benefit inquiry and response transaction (270/271). However, the purpose and context of the exchange is different and would need to include additional details. Additionally, the task force members and subgroup representatives propose leveraging existing organizations with experience and knowledge around establishing best practice consensus on data standardization and uniformity. As an organization with a strong and favorable reputation in this area, the subgroup and SIM Taskforces are seeking the help of the AUC in advancing this work. Members currently participating in the task force subgroup or additional resources from their organizations would remain active participants along with AUC subject matter experts, but would look to the organizational processes of the AUC to help inform and provide a sustainable structure to the work.

R	**RECOMMENDATION** – What are you recommending, including any known timing that needs to be considered: • Recommend that the AUC convene a new Technical Advisory Group that can develop and disseminate best practices for implementing the administrative process around sharing ACO member files. • The TAG would work with ACO representatives, SIM task force/data analytic subgroup members, and other volunteers as available to create a guide around the file format and variable names that would be used to communicate an attributed member list. The elements preliminarily determined by the subgroup would include the member's name, date of birth, gender, address, phone number, primary payer, and their primary care provider, but may also include other demographic information such as race, ethnicity, and primary language. • Recommend that the TAG capitalize on current SIM engagement and momentum by addressing this topic to the extent possible in 2016. However, as health reform continues to move away from volume to value based payment arrangements, it is anticipated that there may be periodic or recurrent opportunities for this TAG to continue to improve and evolve guidelines around implementation and use of an ACO member file over the next several years. • Although the SIM data analytics sub group included other prioritized areas in its prioritized data analytic components, it is recommended that the scope of the AUC partnership reflect the more concrete foundational area of sharing membership information.
Section III – AUC Response (Include date SBAR recommendation was reviewed and approved by AUC TAG; coding issue addressed or SBAR issue title; whether TAG accepted or rejected recommendation requested in SBAR; explanation or basis for TAG decision and SBAR response will be placed in recommendation grid or companion guide):	
Date [SBAR Response Approved by TAG]: Reviewed by [AUC TAG Name]: AUC Co-Chair(s): AUC Response: **Discussion/Summary:** **Decision:**	

#7 - SBAR additional information (email with answers to Exec Committee questions regarding possible AUC assistance in standardizing data analytics)

From: Haugen, David (MDH)
Sent: Tuesday, August 11, 2015 8:26 AM
To: Petermann, Heather M (DHS) <Heather.Petermann@state.mn.us>; Rydrych, Diane (MDH) <Diane.Rydrych@state.mn.us>
Cc: Ann Hale (ann.m.hale@healthpartners.com) <ann.m.hale@healthpartners.com>
Subject: RE: AUC Exec Committee meeting next Monday, August 3 -- status of ACO Data Analytic SBAR?

Hi Heather –

Thank you for the SBAR. I am forwarding a response and request for additional detail below from Ann Hale.

Dave Haugen
****

Heather –

Thank you very much your recent SBAR regarding a possible role for the AUC in ACO data analytics standardization. We appreciate the work of the SIM Data Analytics Subgroup and DHS in identifying the issue as an important topic for the broader health care community.

We plan to discuss the SBAR at our next regular quarterly AUC meeting, scheduled from 2:00 p.m. – 4:00 p.m., September 8. In requesting your SBAR, we forwarded you several questions that we anticipated being raised or discussed at the September 8 AUC meeting. While your SBAR was very helpful, we are requesting additional detail and clarification prior to sending the SBAR to the AUC. Our goal is to send as comprehensive an SBAR as possible to the AUC in advance of the September meeting. This information will be important for a well-informed, effective discussion of the ACO data analytics standardization issue.

In particular, we are seeking greater detail regarding the scope, working relationships, and resources of the proposed project as outlined in our previous questions and below. In order for the information to be most timely to the AUC, it will be important to receive the requested information below by approximately mid-week next week, so that we can forward it to the AUC with ample time for its review and consideration prior to the September 8 meeting. We would also very much appreciate it if you and/or any other appropriate SIM/DHS/MDH representatives could be available at the meeting to present the SBAR and to respond to questions or any requests for additional information.

Again, thank you for your SBAR, and we very much appreciate any clarification or additional information regarding the questions below. We would be happy to add the requested information as an appendix to your SBAR, or if you prefer to incorporate it directly it in the SBAR, that would certainly be helpful as well.

Additional detail requested for SBAR:

Project scope:

- Is the proposed AUC work limited to standardization of file transfer and content format, or is the expectation broader?

Yes, the proposed scope of work being requested is limited to the transfer and content format.

- A key overarching issue in the development and use of data analytics is patient attribution. We understand from our previous meetings and the SBAR that the AUC will not be involved in patient attribution, which we think is

appropriate. However, like others in the community, we are interested in how will the patient attribution issue be addressed and any information that can be shared will be appreciated as well.

The issue that the data analytic subgroup focused on was how to have information available consistently for providers participating in accountable care type arrangements. There was certainly agreement that a foundational and priority component is having clarity and transparency around "who" is being included in the data analytics. This was not necessarily expressed as a need to have consistency or standardization in attribution methods. It was expressed as a desire to see standards around how to share the contact and demographic details for the people they are expected to manage (ie attributed members). There are no plans to address any other attribution issues within the timeline of the SIM grant. There are plans to use learnings from the Minnesota Accountable Health Model/SIM and feedback from stakeholders including IHPs, to inform ways to ensure that more Minnesotans, including those with complex care needs, are included in accountable models.

Relationships:

- The assessment section of the SBAR notes that "… the subgroup anticipates that it will continue the work in conjunction with other engaged stakeholder groups… ." Please provide additional information about the other stakeholder groups the subgroup will be working with, and how the subgroup and the other stakeholders will relate to the AUC.

At the time the first draft of the SBAR was submitted, it was only known that the SIM task forces expressed desire to have the subgroup continue its work in a second phase (although scope was TBD), and that there was a need to identify a more sustainable mechanism to move a foundational piece of phase 1 forward. While the specific scope of what the subgroup will take up in phase 2 is still being finalized, there is some consensus that the subgroup focus on analytic elements that can support health equity. This would involve continued outreach to communities impacted by health disparities to identify and understand the critical social determinants and culturally specific elements that impact population health. This work is closely related to the current legislatively directed efforts at MDH and DHS to look at socio demographic factors and risk adjustment options for quality measurement and payment. The subgroup will also work closely with the e-health advisory groups, and the community advisory task force. As the subgroup moves to a framework for these phase 2 components, it will not address nor actively pursue other avenues to address other phase 1 analytic components over the remaining timeline of the SIM grant. It would defer to the processes and structure of the AUC to foster alignment on the ACO member demographic files. SIM project management and DHS and MDH staff would be connected to both the subgroup and AUC and can provide a conduit to relate and connect the work where applicable.

- Similarly, we are seeking information regarding our previous questions of: "How will the work be integrated with and reflective of state, national, and federal level data analytic standardization? For example, how will this project learn from and be engaged with organizations such as Minnesota Community Measurement, Medicare, the national Workgroup on Electronic Data Interchange (WEDI), and others?"

Through the SIM Project Management team, DHS and MDH staff are connected to national forums that are working to address critical aspects of health reform including health information exchange, data analytics and payment reform. This question about connecting the work of ACO data analytic alignment to national and federal efforts was raised by SIM project management staff in recent conversations with technical advisors at ONC. They confirmed that MN is often at the forefront of these topics and they were not aware of any other groups who were as far along in addressing standards related to sharing of ACO information. This work is reflective of the recognition that aligned ways of sharing key data analytic components contributes to the efforts at improving patient care, population health and lowering costs.

- We read the July 31 "Health Reform Minnesota" newsletter and the article "Minnesota Awards $4 million for Data Analytics to Integrated Health Partnership Providers." It will be helpful to know more about how the award-based activity may relate to the data analytics standardization project, and especially how efforts and timelines of the awards related to supporting "the development of data analytic infrastructure" and "informing best practices" may relate to similar efforts focused on data analytics standardization.

#7 - SBAR additional information (email with answers to Exec Committee questions regarding possible AUC assistance in standardizing data analytics)

The data analytic grants to IHP providers is a parallel initiative that allows organizations to advance specific analytic projects, or invest in additional infrastructure to better use available information to manage cost and quality of care. The grant awards are not directly related to standardization efforts. However, a couple of the proposals receiving funding include projects at the organization level to combine information from payers with information from their E.H.R.s. These projects are in the beginning phases and will receive SIM funding through the end of 2016. Many of these organizations had representatives on the analytics subgroup or the SIM task force and will be sharing regular updates with SIM staff on their projects including lessons learned that can be used by the AUC and others. Project members from the organizations working on the data analytic grants will be likely candidates to volunteer as available contributors, reviewers, etc. to AUC the work where needed.

Resources:

We are seeking additional information and clarification regarding previously forwarded resource questions, including:

- What resources will be available? For how long?
  - SIM grant or other funding?
  - MDH/DHS staff?
  - Outside consultants?

There are no resources that are currently specifically allocated to this activity under approved SIM plans. However, it may be possible that there are some SIM funds that could be shifted or re-directed if approved by SIM leadership for activity that is directly related to SIM objectives. There are SIM funded state staff at DHS supporting data analytics for providers participating in Medicaid ACOs and some portion of their time could be used to help support this activity, particularly for providing connections to IHP analytic projects and contacts. SIM funded resources are expected to be available through the end of 2016.

- What is the role and function of the Data Analytics Vendor that was secured through an RFP process? Is the vendor also addressing data analytic standardization issues? Will the vendor be available to help the AUC with data analytics standardization issues? We would also like see the RFP and vendor response.

The role and function of the vendor secured through the RFP process is to provide support and technical assistance to new and existing Medicaid ACOs participating in the Integrated Health Partnership demonstration. Issues of standardization recommendations across payers is not in the scope of the contracted services for this vendor. The vendor is available to provide consultation to DHS related to ongoing improvements to the provision of information and to IHP participants related to its use in identifying opportunities for cost and care transformation. If there are questions within that scope that the AUC believes the vendor's consultative answers could be helpful or informative to them on, it may be feasible for the AUC to direct questions through a DHS staff member. It would not be feasible to amend the scope of the contract at this time to include issues related to standardization. Copies of the RFP and the vendor's response are attached.

- Other in-kind support? What about meeting space, logistics, etc.? Is this to be addressed through current AUC support?

A key rationale for looking to the AUC for assistance with this request is because of the favorable reputation the AUC has for securing consensus, and because the work needs a connection to a long-standing organization that will last beyond the formal SIM timelines and support. It would be most helpful if this activity was addressed with current AUC structures and support. DHS SIM Data Analytics staff could assist in arranging meeting space, or conferencing if needed, but would want to coordinate with current AUC for logistics such as posting on its website meeting announcements, minutes, etc. and disseminating recommendations through AUC membership.

Related to resources and their use are questions of accountability and impact. We are also seeking information regarding our previously raised questions regarding:

- What are the relevant accountability features of the SIM grant for the project? How will the project be evaluated and reported on to CMS as part of the SIM grant?

The SIM grant expects the state of MN to have a multi-payer approach to its work to advance the Minnesota Accountable Health model. The data analytic subgroup and its work was not outlined as a deliverable in the state's

#7 - SBAR additional information (email with answers to Exec Committee questions regarding possible AUC assistance in standardizing data analytics)

SIM plan, but rather grew from feedback to the SIM task forces about a barrier (inconsistence data feeds and packages received by providers) to successful provider participation in accountable care payment models. There are no explicit measures of accountability in the SIM grant that are related to the work of the data analytic subgroup, or the request being extended to the AUC. SIM driver leads report on a frequent (bi-weekly) basis to our CMS project officer, and also submits quarterly status reports. Forming the data analytic subgroup, and identifying mechanisms to address some of this barrier through bodies with multi-payer participation is described in these status reports as a way to demonstrates the state's commitment to collaborative solutions. This work is expected to indirectly contribute to SIM metrics such as the number of providers participating in accountable models, the number of Minnesota beneficiaries covered in accountable models.

- What might become of the work and the products of the project? If the AUC provides recommendations on data analytics standardization, how might those recommendations be put into practice? What are the possible next steps after providing recommendations?

Please contact us if you have questions or if we can be of any help. We'd be happy to arrange a meeting or phone call if you would like to discuss.

Thanks very much,

Ann Hale, on behalf of the AUC Executive Committee

David K. Haugen
Director, Center for Health Care Purchasing Improvement
Minnesota Department of Health
85 E. 7th Place, Suite 220
St. Paul, MN 55101
Phone: 651- 201-3573
Fax: 651-201-5179

For information regarding Minnesota's requirements for the standard, electronic exchange of common health care administrative transactions please go to http://www.health.state.mn.us/asa/.

#8 - Department of Labor and Industry workers' compensation e-transactions law enacted during the 2015 legislative session

CHAPTER 43--H.F.No. 2193

An act relating to workers' compensation; adopting recommendations of the workers' compensation advisory council regarding inpatient hospital payments; regulating electronic transactions; modifying injury reporting requirements; authorizing rulemaking; requiring a report;amending Minnesota Statutes 2014, sections 176.135, by adding a subdivision; 176.136, subdivision 1b; 176.221, subdivision 8; 176.231, subdivision 1; proposing coding for new law in Minnesota Statutes, chapter 176.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 176.135, is amended by adding a subdivision to read:

Subd. 7a. **Electronic transactions.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "workers' compensation payer" means a workers' compensation insurer and an employer, or group of employers, that is self-insured for workers' compensation;

(2) "clearinghouse" has the meaning given in section 62J.51, subdivision 11a; and

(3) "electronic transactions" means the health care administrative transactions described in section 62J.536.

(b) In addition to the requirements of section 62J.536, workers' compensation payers and health care providers must comply with the requirements in paragraphs (c) to (e).

(c) No later than January 1, 2016, each workers' compensation payer must place the following information in a prominent location on its Web site or otherwise provide the information to health care providers:

(1) the name of each clearinghouse with which the workers' compensation payer has an agreement to exchange or transmit electronic transactions, along with the identification number each clearinghouse has assigned to the payer in order to route electronic transactions through intermediaries or other clearinghouses to the payer;

(2) information about how a health care provider can obtain the claim number assigned by the workers' compensation payer for an employee's claim and how the provider should submit the claim number in the appropriate field on the electronic bill to the payer; and

(3) the name, phone number, and e-mail address of contact persons who can answer questions related to electronic transactions on behalf of the workers' compensation payer and the clearinghouses with which the payer has agreements.

(d) No later than July 1, 2016:

(1) health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the most recently approved version

of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter"), according to the requirements in the corresponding implementation guide. The ASC X12N 275 transaction is the only one that shall be used to electronically submit attachments unless a national standard is adopted by federal law or rule. If a new version of the attachment transaction is approved, it must be used one year after the approval date;

(2) workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the most recently approved ASC X12 electronic acknowledgment for the attachment transaction. If a new version of the acknowledgment transaction is approved, it must be used one year after the approval date; and

(3) if a different national claims attachment or acknowledgment requirement is adopted by federal law or rule, it will replace the ASC X12N 275 transaction, and the new standard must be used on the date that it is required by the federal law or rule.

(e) No later than September 1, 2015, workers' compensation payers must provide the patient's name and patient control number on or with all payments made to a provider under this chapter, whether payment is made by check or electronic funds transfer. The information provided on or with the payment must be sufficient to allow providers to match the payment to specific bills. If a bulk payment is made to a provider for more than one patient, the check or electronic funds transfer statement must also specify the amount being paid for each patient. For purposes of this paragraph, the patient control number is located on the electronic health care claim 837 transaction, loop 2300, segment CLM01, and on the electronic health care claim payment/advice 835 transaction, loop 2100, CLP01.

(f) The commissioner may assess a monetary penalty of $500 for each violation of this section, not to exceed $25,000 for identical violations during a calendar year. Before issuing a penalty for a first violation of this section, the commissioner must provide written notice to the noncompliant payer, clearinghouse, or provider that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2014, section 176.136, subdivision 1b, is amended to read:

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a ~~small hospital~~ Critical Access Hospital certified by the Centers for Medicare and Medicaid Services shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. ~~A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.~~

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a ~~or~~, 1c ~~or~~, paragraph (a), or section 176.1362 shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

(c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

EFFECTIVE DATE. This section is effective for billing and payment of inpatient hospital services, articles, and supplies provided to patients discharged on or after January 1, 2016.

Sec. 3. **[176.1362] INPATIENT HOSPITAL PAYMENT.**

Subdivision 1. **Payment based on Medicare MS-DRG system.** (a) Except as provided in subdivisions 2 and 3, the maximum reimbursement for inpatient hospital services, articles, and supplies is 200 percent of the amount calculated for each hospital under the federal Inpatient Prospective Payment System developed for Medicare, using the inpatient Medicare PC-Pricer program for the applicable MS-DRG as provided in paragraph (b). All adjustments included in the PC-Pricer program are included in the amount calculated, including but not limited to any outlier payments.

(b) Payment under this section is effective for services, articles, and supplies provided to patients discharged from the hospital on or after January 1, 2016. Payment for services, articles, and supplies provided to patients discharged on January 1, 2016, through December 31, 2016, must be based on the Medicare PC-Pricer program in effect on January 1, 2016. Payment for inpatient services, articles, and supplies for patients discharged in each calendar year thereafter must be based on the PC-Pricer program in effect on January 1 of the year of discharge.

(c) Hospitals must bill workers' compensation insurers using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program. The bill must be submitted to the insurer within the time period required by section 62Q.75, subdivision 3. For purposes of this section, "insurer" includes both workers' compensation insurers and self-insured employers.

Subd. 2. **Payment for catastrophic, high-cost injuries.** (a) If the hospital's total usual and customary charges for services, articles, and supplies for a patient's hospitalization exceed a threshold of $175,000, annually adjusted as provided in paragraph (b), reimbursement must not be based on the MS-DRG system, but must instead be paid at 75 percent of the hospital's usual and customary charges.

(b) Beginning January 1, 2017, and each January 1 thereafter, the commissioner must adjust the previous year's threshold by the percent change in average total charges per inpatient case, using data available as of October 1 for non-Critical Access Hospitals from the Health Care Cost Information System maintained by the Department of Health pursuant to chapter 144. The commissioner must annually publish notice of the updated threshold in the State Register.

Subd. 3. **Critical Access Hospitals.** Hospitals certified by the Centers for Medicare and Medicaid Services as Critical Access Hospitals shall be reimbursed as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 4. **Submission of information when payment is by MS-DRG.** Except when a postpayment audit is allowed under subdivision 6, an insurer must not require an itemization of charges or additional

documentation to support a bill from a non-Critical Access Hospital when all of the following requirements are met:

(1) the hospital must submit its charges to the insurer on the 837 institutional standard electronic transaction required by section 62J.536;

(2) an MS-DRG must apply to the hospitalization; and

(3) the hospital's total charges must be less than the threshold amount in subdivision 2, as annually adjusted.

Subd. 5. **Prompt payment requirement when MS-DRG payment is made.** (a) When the requirements in subdivision 4 have been met, the insurer must take one of the following actions within 30 days of receipt of the hospital's bill:

(1) pay the hospital's bill as provided in subdivision 1, with no reductions based on a review of charges for specific services, articles, or supplies; or

(2) deny payment for the entire hospitalization for one of the following reasons:

(i) the patient's workers' compensation injury claim is denied;

(ii) the diagnosis for which the patient was hospitalized is not related to the insurer's admitted workers' compensation injury; or

(iii) the hospitalization was not reasonably required to cure and relieve the employee from the effects of the injury under section 176.135 or rules adopted under section 176.83, subdivision 5.

(b) When the requirements of subdivision 4 are met, an insurer must not deny payment for one or more charges on the basis that the charge should have been bundled into another charge, or on the basis that a particular service, article, or supply was not reasonably required, except that the insurer may raise these issues during a postpayment audit under subdivision 6.

Subd. 6. **Postpayment audits; records; interest.** (a) The insurer may conduct a postpayment audit if both of the following requirements are met:

(1) the insurer paid the hospital's bill within 30 days according to the PC-Pricer program amount described in subdivision 1; and

(2) the amount paid according to the PC-Pricer program in subdivision 1 included an outlier payment.

(b) If an audit is permitted under paragraph (a), the insurer must request any additional records needed to conduct the audit within six months after payment. The records requested may include an itemized statement of charges. Within 30 days of the insurer's request, the hospital must provide the additional documentation requested. An insurer must not request additional information from a hospital more than three times per audit.

(c) An insurer must pay the hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional hospital charges following a postpayment audit. A hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's audit. Interest is payable by the insurer from the date payment was

due under this section or section 176.135. Interest is payable by the hospital from the date the overpayment was made.

Subd. 7. **Study.** The commissioner of labor and industry shall conduct a study analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2018.

Subd. 8. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.389, including subdivision 5, to: (1) implement this section and the Medicare Inpatient Prospective Payment System for workers' compensation; and (2) implement the Medicare Hospital Outpatient Prospective Payment System, or other fee schedule, for payment of outpatient services provided under this chapter by a hospital or ambulatory surgical center, not to take effect before January 1, 2017.

EFFECTIVE DATE. Subdivisions 1 to 6 are effective for billing and payment of inpatient hospital services, articles, and supplies provided to patients discharged on or after January 1, 2016. Subdivision 8 is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2014, section 176.221, subdivision 8, is amended to read:

Subd. 8. **Method and timeliness of payment.** (a) Except as otherwise provided in paragraph (b), payment of compensation under this chapter shall be by immediately payable negotiable instrument, or if by any other method, arrangements shall be available to provide for the immediate negotiability of the payment instrument.

All payment of compensation shall be made within 14 days of the filing of an appropriate order by the division or a compensation judge, unless the order is appealed or if a different time period is provided by this chapter.

(b) An employer or insurer responsible for payment of periodic monetary benefits under this chapter must send the payments by electronic funds transfer to a bank, savings association, or credit union, if requested by the employee or a dependent under section 176.111.

(1) If the employer or insurer has already established an electronic funds transfer arrangement with a bank, savings association, or credit union for the employee's account, the employer or insurer must begin sending periodic monetary benefit payments by electronic funds transfer to the bank, savings association, or credit union within 30 days after the employer or insurer receives a request from the employee or dependent containing the information in paragraph (c).

(2) If the employer or insurer does not already have an arrangement with the bank, savings association, or credit union for electronic funds transfer for the employee or dependent's account at the time of the request, the 30 days to begin sending periodic benefit payments by electronic funds transfer does not start to run until the arrangement has been established. The employer or insurer must make reasonable efforts to establish the electronic funds transfer arrangement within 14 days after receiving a request containing the information in paragraph (c).

(3) Payment of benefits is deemed to have been made on the date the payment is sent by electronic funds transfer to the employee or dependent's account at the bank, savings association, or credit union.

(c) The employee or dependent must provide the employer or insurer with the following information:

(1) a signed and dated written request for electronic funds transfer of benefits;

(2) the name and address of the bank, savings association, or credit union where the benefit payments are to be sent by electronic funds transfer;

(3) the account number to which the payments should be credited; and

(4) any other information or documentation required by the employer or insurer or the bank, savings association, or credit union necessary to implement electronic funds transfer.

(d) The employer or insurer must retain a copy of the request for as long as the benefits are being paid by electronic funds transfer. The employer or insurer paying the benefits must provide a copy of the request to the department upon request.

(e) Paragraph (b) does not apply if the employer or insurer reasonably determines that the periodic monetary benefit payments are likely to end before the electronic funds transfer can be arranged.

(f) The commissioner may assess a monetary penalty of $500 against the employer or insurer for a violation of paragraph (b) or (d). Before issuing a penalty for a first violation of paragraph (b) or (d), the commissioner must provide written notice to the employer or insurer that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 5. Minnesota Statutes 2014, section 176.231, subdivision 1, is amended to read:

Subdivision 1. **Time limitation.** Where death or serious injury occurs to an employee during the course of employment, the employer shall report the injury or death to the commissioner and insurer within 48 hours after its occurrence. Where any other injury occurs which wholly or partly incapacitates the employee from performing labor or service for more than three calendar days, the employer shall report the injury to the insurer on a form prescribed by the commissioner within ten days from its occurrence. An insurer and self-insured employer shall report the injury to the commissioner no later than 14 days from its occurrence. Where an injury has once been reported but subsequently death ensues, the employer shall report the death to the commissioner and insurer within 48 hours after the employer receives notice of this fact. An employer who provides notice to the Occupational Safety and Health Division of the Department of Labor and Industry of a fatality within the eight-hour time frame required by law, or of an inpatient hospitalization ~~of three or more employees,~~ within the ~~eight-hour~~ 24-hour time frame required by law, has satisfied the employer's obligation under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Presented to the governor May 15, 2015

Signed by the governor May 19, 2015, 3:45 p.m.

62J.497 ELECTRONIC PRESCRIPTION DRUG PROGRAM.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 2. **Requirements for electronic prescribing.** (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish, maintain, and use an electronic prescription drug program. This program must comply with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

(b) If transactions described in this section are conducted, they must be done electronically using the standards described in this section. Nothing in this section requires providers, group purchasers, prescribers, or dispensers to electronically conduct transactions that are expressly prohibited by other sections or federal law.

(c) Providers, group purchasers, prescribers, and dispensers must use either HL7 messages or the NCPDP SCRIPT Standard to transmit prescriptions or prescription-related information internally when the sender and the recipient are part of the same legal entity. If an entity sends prescriptions outside the entity, it must use the NCPDP SCRIPT Standard or other applicable standards required by this section. Any pharmacy within an entity must be able to receive electronic prescription transmittals from outside the entity using the adopted NCPDP SCRIPT Standard. This exemption does not supersede any Health Insurance Portability and Accountability Act (HIPAA) requirement that may require the use of a HIPAA transaction standard within an organization.

(d) Notwithstanding paragraph (a), any clinic with two or fewer practicing physicians is exempt from this subdivision if the clinic is making a good-faith effort to meet the electronic health records system requirement under section 62J.495 that includes an electronic prescribing component. This paragraph expires January 1, 2015.

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

(e) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

Subd. 4. **Development and use of uniform formulary exception form.** (a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.

(b) No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions.

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, 2016, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

History: *2008 c 358 art 4 s 3; 2009 c 79 art 4 s 3-6; 2009 c 102 s 3,4; 2009 c 173 art 1 s 1; 2010 c 336 s 4,5; 2012 c 253 art 1 s 1; 2014 c 291 art 6 s 1*

#10- Consultant's report used in developing the AUC's Rx ePA companion guide (read especially pages 14-21 for an overview of what the transaction does and how it works).

Current state of electronic prior authorization (ePA) standards for medications

For the Minnesota Department of Health

June 2013

Project: **MDH ePA Planning Assistance**
April - June, 2013

Date: June 25, 2013

By: Frank McKinney Group LLC
Frank McKinney, Analyst

Contents

Document goal and sections

This document provides a brief summary of efforts to create an electronic prior authorization (ePA) messaging standard for prescription medications—from initial efforts in the early 2000's to the NCPDP) message specification nearing finalization as a standard today.

It also provides a high-level overview of the NCPDP ePA messaging that introduces certain key aspects of the standard—to serve as a level-set for those new to it.

Document sections:

Section One: Background on Electronic Prior Authorization Standards

This section gives a brief history of industry efforts to develop and pilot electronic prior authorization standard, followed by additional background on the two major industry pilots, including approaches tested and results.

- **Brief history of electronic drug prior authorization activities** is a high-level timeline of ePA efforts over the past decade.
- **ePA pilots and other industry experience** summarizes two major industry pilots of electronic prior authorization messaging for prescription medications and also describes proprietary approaches to PA automation tried by individual organizations.

Section Two: The Current NCPDP ePA Standard

This section describes the development of the current NCPDP ePA standard and provides references to the standard's documentation.

- **Development of the current ePA standard** describes the effort resulting in the current NCPDP SCRIPT standard containing ePA messaging. The section covers the participants in the effort, alternatives considered, and remaining steps that must take place in order for the standard to gain American National Standards Institute (ANSI) approval—becoming a potential national standard. This section includes a timeline for completion of NCPDP approval steps.
- **About the standard** gives an overview of the NCPDP ePA messages and provides references to the standard's documentation.

Section Three: Adoption of the new NCPDP ePA Standard

- **Industry acceptance and other success factors** is a discussion of findings from past and current pilots, challenges and barriers to broader adoption identified through piloting, and industry acceptance of the current NCPDP ePA standard.
- **Path to a named national standard for medication ePA** discusses factors that may impact potential inclusion of the ePA standard in the Medicare Part D E-Prescribing Standards (which effectively determine the allowed message types and versions for e-prescribing).
- **State rules** overviews state-level activities related to prescription ePA.

1. Background on Electronic Drug Prior Authorization Standards

This section provides a brief history of industry efforts to develop and pilot electronic prior authorization standards, followed by an overview of industry experience piloting draft ePA standards and implementing proprietary approaches.

Brief history of electronic prior authorization activities

Insurance coverage for prescription medications is sometimes subject to preauthorization requirements, similar to other aspects of a patient's medical care. Today, providers typically obtain such "prior authorization" by filling out and faxing PA forms to the patient's pharmacy benefit management company. Because authorization rules vary by medication and because each payer and employer group can determine their own approval criteria, the process of locating the correct PA form and submitting it to the right party can be confusing and time-consuming. This can result in staff costs at the provider's office and delays in finalizing the patient's treatment.

The industry has grappled with how to improve the drug PA process through automation for a number of years. Early attempts attempted to standardize the authorization criteria itself, while more recent efforts focused on standardizing the communication between stakeholders while supporting variations in criteria.

Further, states including Minnesota have taken steps to promote electronic prior authorization within their borders. Minnesota, specifically, developed statutes (Section 62J.497, Subd. 5. *Electronic drug prior authorization standardization and transmissions)* directing the establishment of a standard drug ePA process by 2014 and requiring MN providers and health plans to support ePA by January 2015.

The following table summarizes the industry's experience at a national level, and also notes Minnesota-specific activities.

Aug 1996	HIPAA[1]	Names X12 278 "prior authorization" transaction standard.
Nov 2004	NCPDP ePA Task Group formed	HL7 PA Attachment created (2005), which attempts to standardize PA decision criteria using LOINC codes. Designed to be used in conjunction with X12 278 and 275 transactions.
2006	MMA[2] E-Prescribing Pilot Tests	X12 278 / X12 275 / HL7 PA Attachment approach tested. Piloters recommend moving to a single PA message standard with needed capabilities: conditionality, ability to tailor criteria. "Analysis shows that, in its current state, this standard is technically unable to convey the information needed to support this function for use in Part D."[3]
2008	CMS / AHRQ Expert Panel	Identified NCPDP as the Standards Development Organization (SDO) to develop ePA standard. Exception to HIPAA resolved (enabling prescription PA using an alternative to the X12 278).
2009	New NCPDP standard created	Developed by NCPDP as a single XML-based standard. Not pilot-tested. Minnesota established a "uniform drug PA form" for use by 2010.
2010	Minnesota statutes related to drug PA	Minnesota's legislature enacted a law that: • Directed the MN Administrative Uniformity Committee (AUC) to publish a drug ePA companion guide by January 2014 • Set a requirement for MN providers and payers to support electronic drug prior authorization by January 2015.
2011	Renewed Interest	Industry pilot using a draft enhancement to the NCPDP ePA standard. Legislation in several US states related to ePA.
2012/2013	Updated NCPDP ePA standard	Enhancement of the NCPDP ePA standard based on pilot experience. Stakeholders include NCPDP members, other industry participants. Applicable NCPDP workgroups vote to approve ePA standard in May 2013. Formal NCPDP Board of Trustees approval anticipated in mid-2013. Formal ANSI approval anticipated in mid-late 2013.
2014	Production use of enhanced NCPDP ePA standard	Major industry participants planning 2014 production use of the enhanced NCPDP standard: payers, EHR vendors, networks.

Some content above was adapted from NCPDP testimony to the NCVHS Subcommittee on Standards, November 2011. http://ncvhs.hhs.gov/111117p15.pdfePA pilots and other industry experience

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[1] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) included Administrative Simplification provisions identifying standards for electronic health care transactions among other provisions.

[2] Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003

[3] http://healthit.ahrq.gov/portal/server.pt/community/ahrq-funded_projects/654/e-prescribing_pilot_projects/24021

Electronic prior authorization standards have been piloted twice in the past decade. In addition, individual organizations have developed proprietary approaches to automate the PA process. These efforts and their outcomes are summarized below.

2006 MMA e-prescribing pilot

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 mandated that all plans and pharmacies participating in the Part D drug benefit support an electronic prescription program. This pilot evaluated a number of information exchange standards being considered for use in that program. HHS provided grants to five pilot sites to test standards for prescription messaging, formulary distribution and prior authorization.

Four of the pilot sites and one information exchange network participated in evaluation of a set of X12 and HL7 messages bundled together support the prescription prior authorization process. Specifically, the pilot tested the use of...

- the X12 278 Health Care Services Request for Review and Response ("prior authorization") transaction
- used in conjunction with the X12 275 Additional Information to Support a Healthcare Claim or Encounter ("wrapper") transaction carrying an HL7 PA Attachment document
- which in turn carried a draft HL7 PA Attachment CDA document intended to communicate standardized authorization criteria to the insurer.

The ePA pilot participants were Brigham & Women's Hospital, Ohio KePRO/UHMP, RAND Corporation, Achieve (a long-term care software vendor), and Surescripts (providing support to other piloters).

Experience

While preparing for use of the X12/HL7 message combination, pilot participants identified challenges applying the standardized criteria defined in the HL7 PA Attachment to the actual information needs of the health plans participating in the effort.

In particular, the HL7 PA Attachment focused on precise patient characteristics and observations (such as lab results and diagnoses), while the PA forms associated with prescription medications typically contained questions that referred to clinical information in more generalized or informal ways (e.g., referring to condition characteristics such as "exercise-induced asthma"). Due to this mismatch, few of the pre-defined criteria could be used in the pilot.

Further, "real-world" PA forms often included instructions related to the PA process and requests for confirmation by the prescriber of associated clinical risks or required patient follow-ups. Neither of these needs were supported by the HL7 PA Attachment.

Due to these limitations of the pilot standards, some pilot sites augmented the information exchange with approaches for communicating non-standardized PA criteria in a predictable way—similar to techniques underlying the current NCPDP ePA standard. These additional question definition approaches were layered on top of the X12 / HL7 messaging in order to fill gaps not supported by the standards being tested.

Finally, the use of multiple messages created overlaps in content between them. For example, the patient was represented multiple times in different ways across the messages. Piloters had to adopt conventions for populating these multiple instances of the same information in order to avoid confusion regarding the "source of truth" for duplicated information.

Findings

Due to the challenges discussed above, the federal Agency for Healthcare Research and Quality (AHRQ), which compiled results of the pilots, summarized the ePA findings as follows:

> "Because the combination of the X12N 278, X12N 275 and HL7 PA Attachment is cumbersome, confusing and requires expertise that may limit adoption, one standard transaction should be considered – one that is specifically designed for medication ePA. This standard should be a) organized by drug, b) support content logic (conditionality), numbering of questions and cardinality, c) provide for educational information and directions, d) support open ended questions and e) uniquely identify the patient."

2011-13 CVS Caremark pilot

In 2011, CVS Caremark initiated a pilot of an enhanced version of the 2009 NCPDP ePA standard with partners including Surescripts and prescriber system vendors NaviNet and Allscripts. The company stated at the outset its intent to "share both the transactions and the results from the implementation with the market and the appropriate ANSI-accredited standards organizations to help drive the adoption of ePA standards by payers and provider systems."

The messaging used in this pilot extends the 2009 NCPDP ePA standard, establishing key messaging features that address the weaknesses of earlier standards, including:

- criteria numbering and conditionality, enabling the provider system to dynamically show or hide PA questions based on answers already given
- support for instructions and payer contact information for getting help on completing required information
- concise message format tailored for medication prior authorization.

Experience

The pilot has operated in production settings for over a year, and participants report that the messaging was straightforward to implement and met business needs. The pilot messaging was used within different workflows in the participating provider systems, including within the medication ordering workflow of one system and in a provider portal for resolving PAs identified during claims processing in another system.

As planned, the pilot contributed its message definitions and experience to be used as a starting point for an enhanced NCPDP ePA standard. The 2013 version of the NCPDP standard builds on and refines the features introduced by this pilot.

Findings

While the pilot participants reported that the ePA messaging they used met business needs, the technical structures were based on a previous version of the NCPDP standard and needed to be updated to match the standard's current version.

In addition, the pilot transactions' support for an appeal process (enabling the provider to respond in cases when authorization is denied or has undesirable restrictions) was limited. The 2012 NCPDP ePA task group expanded support for this workflow in the final 2013 version of the standard.

Proprietary approaches to ePA

Over the past decade, payers and independent software and service providers have developed their own proprietary solutions for making medication prior authorization forms more readily available to providers.

A number of payers provide PDF versions of PA forms on online portals, which reduces the clinic time needed to locate and complete the forms. Also, vendors such as Cover My Meds have partnered with payers to warehouse PA forms and make them available in an online-fillable format.

However, in these solutions the clinic's input is still typically submitted to the payer in PDF or fax format for manual processing. As a result, overall processing time may not be significantly reduced by these approaches. An additional challenge encountered by third-party vendor solutions is maintaining a complete and up-to-date inventory of PA forms for a wide range of payers, plan groups and medications. Minnesota enacted requirements in 2009 for the development and use of a single PA form in 2010 by Minnesota prescribers, to be accepted by payers. However, as noted below, while the standardization of PA forms provides some benefits, they are not a true ePA solution. The Minnesota requirements did not include compliance and enforcement provisions, and anecdotal evidence indicates that use of the single PA form varied in practice.

In an October, 2011 ePA focus group coordinated by NCPDP, participating physicians commented on the need to bring the PA process up-stream, into the physician's workflow. Existing PDF and third-party solutions typically require that the appropriate PA form be located manually, reducing the opportunity for the prescriber to initiate PA during the ordering process where she could potentially resolve a PA requirement before transmitting the prescription to the pharmacy.

Current third-party web-based systems and online payer PA form portals provide benefits over a paper and faxed-based process, but the challenges identified above prevent them from being strong long-term solutions. It may be evidence of the limitations of web and PDF-based solutions that organizations with these systems in place were early piloters of fully electronic, message-based ePA processing.

2. The Current NCPDP ePA Standard

This section discusses how the current NCPDP ePA standard was developed, gives a high-level overview of how the standard works and provides references to the standard's documentation.

Development of the current ePA standard

Process and timeline for approval

NCPDP task groups and participating stakeholders

NCPDP convened two task groups to serve as forums supporting enhancement of the NCPDP ePA standard:

- ePA Workflow to Transactions Task Group
- ePA XML Sub Task Group.

Both task groups reported to NCPDP's Workgroup 11, which manages the organization's e-prescribing standard, SCRIPT. Participation in both groups was open to non-NCPDP members, and participants included individuals from a range of organizations and perspectives.

The *ePA Workflow to Transactions Task Group* provided a forum for determining the approach to be taken and to address non-technical topics such as regulatory and privacy considerations. The *ePA XML Sub Task Group* delved into the detailed information and workflow needs of stakeholders and produced the technical specifications for the resulting ePA messages. The outputs of the *Sub Task Group* were reviewed and approved by the main *Workflow to Transactions* task group, to which it reported.

The *ePA Workflow to Transactions Task Group* was an existing working group that re-commenced meetings in late 2011 and typically met every two weeks through the first three quarters of 2012, during which the current NCPDP ePA standard was being developed.

The *ePA XML Sub Task Group's* efforts ramped up in the second quarter of 2012 after the *Workflow* task group agreed that an enhanced NCPDP ePA standard should be developed. The group typically met weekly through the summer and fall of the year, and produced the specification and implementation guide for the standard, working closely with NCPDP staff.

Both the *ePA Workflow to Transactions Task Group* and the *ePA XML Sub Task Group* included participants from a range of organizations with different perspectives on the prior authorization process, including:

- physician groups (American Medical Association, provider organizations)
- pharmacies (retail chains, independent, long-term care / institutional, pharmacy organizations)
- payers / processors (health plans, pharmacy benefit managers, state Medicaids)

- regulatory representatives (CMS)
- system vendors (prescriber systems, pharmacy systems, exchange networks)
- pharmaceutical manufacturers
- other interested parties.

Approval process

NCPDP is an ANSI-accredited standards body, and follows a standards development process that typically begins with the identification of an opportunity to extend or adjust an NCPDP standard and ends with ANSI-approval of the resulting new or modified message specification. The steps from idea to final ANSI standard are summarized below:

(a) The idea for the modification or addition of a message is typically raised at an NCPDP Workgroup meeting, and a task group is frequently created to flesh out the idea and produce a concrete proposal.

(b) A request describing the proposed change or addition (a Data Element Request Form, or "DERF") is formally submitted for the Workgroup to evaluate during a quarterly Workgroup meeting. The NCPDP members present at the meeting vote to either:

- Approve the DERF, sending it to be voted on during the period before the next Workgroup meeting
- "Pend" the DERF, allowing additional time for the proposal to be adjusted or to educate stakeholders before bringing it to the next quarterly Workgroup meeting to be reevaluated, or
- Deny the DERF, requiring that the proposal be resubmitted for consideration in a future Workgroup meeting.

(c) When a DERF is approved for ballot, the change or addition it proposes gets combined with other approved DERFs in a ballot version of the standard, which is voted on prior to the next Workgroup meeting. NCPDP members and non-members may vote on the ballot and may provide comments suggesting changes to the balloted version of the standard.

(d) During the Workgroup meeting following the ballot, comments submitted during voting are adjudicated:

- Minor or editorial adjustments may be accepted by those attending the Workgroup meeting to immediately be applied to the approved standard.
- Substantive changes, if approved by the Workgroup, cause another ballot cycle, with voting taking place prior to the following Workgroup meeting.
- Comment found to be non-persuasive by the Workgroup are not applied to the standard and do not count against approval.

The ballot is considered approved by the Workgroup if it receives the required number of affirmative votes and if no comments force an additional ballot cycle.

(e) Other NCPDP entities approve ballot: Maintenance and Control, Standardization Committee, and the Board of Trustees.

(f) ANSI confirms that the appropriate process was followed during the process resulting in the new version of the standard, and if so, also gives its approval.

Approval timeline

- **Nov. 2011:** NCPDP task groups created to gather input and define proposed ePA messages
- **Nov. 2012:** Draft ePA DERF discussed by Workgroup 11 and pended to allow time to finalize the XML schema and implementation guide
- **Feb. 2013:** Proposed ePA messaging approved by NCPDP Workgroup 11 and sent to ballot
- **May 2013:** Ballot was completed with sufficient affirmative votes; comments were adjudicated by Workgroup 11 without the need for an additional ballot cycle. Approved also by the NCPDP Maintenance and Control Workgroup
- **Summer 2013:** Approval by the NCPDP Standardization Committee and Board of Trustees
- **Summer / Fall 2013:** Approval as an ANSI standard

Other ePA alternative considered: X12/HL7 messaging

At the outset of NCPDP ePA task group discussion in 2012, stakeholders including the American Medical Association suggested that the industry should adopt X12 transactions for pharmacy prior authorization, rather than developing a new ePA standard. The rationale is understandable: that use of a single standard for prior authorization of all types of medical services—including prescription medications— might simplify adoption by electronic medical record vendors and other stakeholders.

X12 messaging is widely used to retrieve patient eligibility for both medical and pharmaceutical benefits, and in the processing of medical claims. (Pharmaceutical claims, however, are processed using a separate HIPAA-named NCPDP D.0 transaction). The X12 standard also contains transactions supporting authorization for services and the exchange of related information, though these are not as widely used as the eligibility or claims messages, and are currently only used in relation to medical services.

The approach suggested by the AMA was very similar to the one piloted in the 2006 MMA e-prescribing pilots (described above). In a November, 2011 presentation to the National Committee for Vital and Healthcare Statistics standards subcommittee, the AMA described this approach as follows:

> ... the 275 provides the metadata (envelope) around the clinical information with HL7 Clinical Data [sic] Architecture (CDA) carrying the clinical information. Thus, we will use both the terms "275" and "275/HL7" to refer to this transaction. ...

> The 275/HL7... can be used ... to send clinical information as part of obtaining an ASC X12 278 prior authorization approval from a payer. ... It can be sent in parallel with the 278 transaction as supporting information. ... Future versions of the 275 could contain specific coded information ... related to the specific services being requested.

The table below identifies the specific X12 and HL7 transactions used in the approach proposed by the AMA to the NCPDP ePA task group:

Transaction	Current adoption for pharmacy benefits	Current adoption for medical benefits	Function / Notes
ASC X12 ver. 5010 278 Health Care Services Request for Review and Response	Not used	Some use	HIPAA-named standard for medical authorizations
ASC X12 ver. 5010 275 Additional Information to Support a Healthcare Claim or Encounter	Not used	Little use	Provides a standard "envelope" in which additional messages / attachments / standard data structures may be conveyed. Not named in HIPAA rules.
PA Attachment based on the HL7 Clinical Document Architecture (CDA)	Not yet developed	Not yet developed	This approach proposes use of a new HL7 CDA-based PA attachment that has not yet been developed. There is currently no HL7 working group actively pursuing this development.
Alternative to HL7 PA Attachment: Proprietary web portal process	n/a, not standard	n/a, not standard	The AMA has suggested use of a "URL portlet to a website; or an active HTML form that would carry PA questions specific to the authorization request direct to the physicians desktop" as an interim alternative to a standard HL7 PA attachment *

** www.ama-assn.org/resources/doc/psa/pa-approach-summary.pdf*

This approach was given much discussion during a number of NCPDP Prior Authorization Task Group meetings in the first half of 2012, with representatives of the AMA and X12 presenting their perspective. A point-by-point comparison between the X12 combination message approach and the proposed NCPDP messaging was developed and discussed by the group.

A vote was ultimately taken within that task group, with representation from a number of non-NCPDP members such as individuals from the AMA, X12 and other organizations. The group's decision, by a wide margin, was to complete development of a dedicated NCPDP standard rather than pursuing the alternative approach. Key considerations in that decision included:

- work has not begun on an HL7 CCDA document for carrying authorization-related details
- current adoption of the HL7 275 message by the industry is low
- negative findings by participants in 2006 CMS-sponsored pilots of a similar use of a 278/275/attachment model for prescription prior authorization
- industry experience with weaknesses of proprietary web portal-based PA solutions, and
- the positive outcome of a 2011/2012 pilot of NCPDP-based ePA messaging.

Representatives from the AMA continued to participate in the development of the NCPDP ePA messages after the group's decision to proceed with development of NCPDP messaging and provided valuable input which was incorporated into the final standard.

Overview of the NCPDP ePA standard

This section provides an overview of the NCPDP ePA standard and references to its documentation.

How ePA relates to the current "paper" PA process

ePA messaging...

- follows the same basic workflow as today's non-electronic prior authorization process
- supports the same ability for PBMs/payers to request information from providers to support the PA decision process (which is currently done using paper or PDF prior authorization forms)
- does not define standard PA questions nor does it identify the information that should apply to specific drugs. Each payer determines the information it needs and how it asks for it
- does provide a data format and framework that all payers can use to convey their "PA form questions" in a common way, enabling the provider system to present the questions and capture the provider's responses in a consistent manner, regardless of who the payer is
- also enables the provider system vendor to systematically retrieve needed PA information from the patient's electronic chart, when the payer includes optional "coded references" with its PA questions.

The two ePA workflow "models": Solicited and Unsolicited

In today's paper-based prior authorization process, the payer generally maintains a set of PA forms for its various member plans and for different medications. When the prescriber learns that one of their patient's prescriptions requires PA, they notify the patient's payer and are sent the appropriate PA form to be completed and returned. Or, they may visit the payer's website and download the form from there.

In today's process, the provider could hold on to a PA form and file it for future use, rather than "soliciting" a new form each time a PA is needed. However, ePA enables a system to quickly request

and receive the correct PA "form" for their specific patient and medication—which eliminates any benefit the provider might get today by maintaining a local file of PA forms. In addition, by initiating the process with the payer before filling out a PA form, the provider will avoid unnecessary work if it turns out that the patient does not actually require PA in the particular situation, which is a common occurrence.

Solicited workflow

Because of the ease of requesting the correct PA form in the electronic PA process, and because of benefit of avoiding unnecessary work when PA is ultimately not required, the mainstream of the industry is promoting a "solicited" workflow in which the PA process always begins with an initiation step, in which...

- the provider system sends a PAInitiationRequest message to the payer, containing the patient and medication for which PA is desired
- the Payer then responds with a PAInitiationResponse message that contains either:
    - the correct electronic PA "form" for the patient and medication, or
    - a message indicating that PA is not required for the patient/medication combination, or
    - a message indicating that an exception situation exists, for example, the patient's coverage has expired.

If PA is required for the patient, the provider system gathers the information requested in the PAInitiationResponse and continues on to the next ePA message: PARequest, with which the actual request for authorization is made. The payer then responds with a PAResponse message containing its determination.

Unsolicited workflow

In this workflow model, the provider system skips the step of asking the patient's payer for the appropriate PA form. The PAInitiationRequest and PAInitiationResponse messages are not used in this workflow. Instead, the provider system jumps to the step of collecting information that it predicts or has learned previously will be needed by the payer, and submits it in a PARequest message to the payer

The payer responds with a PAResponse message that may or may not include a PA determination as follows.

- If the payer is able to make a PA determination based on the information submitted, the PAResponse contains an indication of approval or denial.
- If the provider system did not include needed information in its request, the PAResponse will contain an electronic PA "form" indicating additional information needed.
- If another situation exists (e.g., patient not recognized, PA isn't required, etc.) the PAResponse will contain that information.

Patient privacy considerations

Because the unsolicited workflow will in some cases involve sending patient healthcare information to the payer when it is not needed (e.g., if PA isn't needed for the particular medication), this model raises patient privacy considerations that are avoided by the initiation step of the solicited model. This concern has been cited by several payers as a reason for their support of the solicited model.

ePA Message Types

The ePA standard is made up of messages that support four basic steps in the prior authorization process: *initiation* of the process, the actual *request* for PA, *appeal* of a PA determination, and *cancelation* of the process by the prescriber.

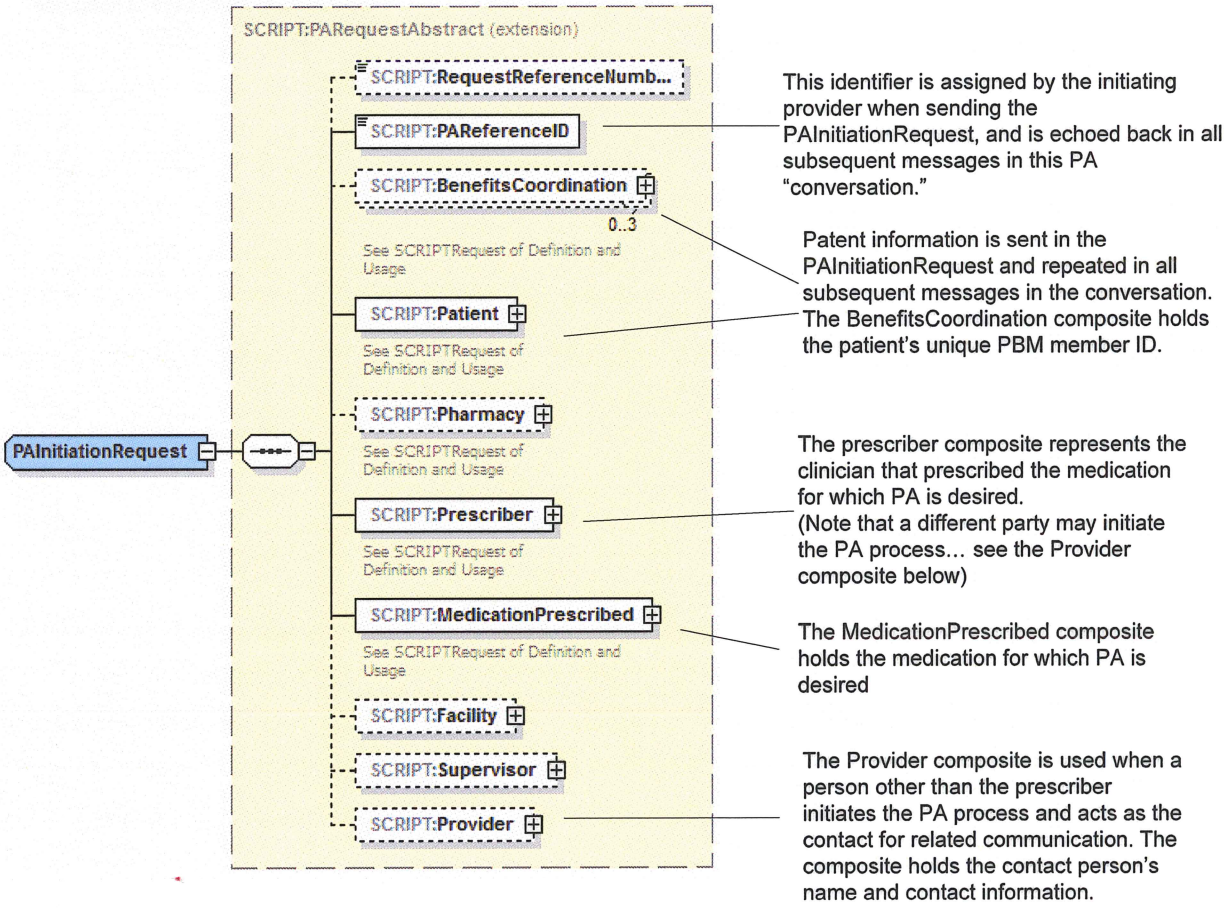
PA step	NCPDP ePA message type	Sender / receiver	Notes
Initiation	PAInitiation Request	Prescriber or other party ("initiating party") sends this message to the patient's payer or PBM	Starts the PA process Required in the "solicited" model, but not used in the "unsolicited" model
	PAInitiation Response	The payer/PBM returns this message to the initiating party	• Supplies the PA questions to be completed • Or indicates that PA isn't required • Or indicates an exception situation exists
Request	PARequest	Initiating party to payer/PBM	Contains the information requested by the payer and a request for approval
	PAResponse	Payer/PBM to initiating party	• Contains either Approval of PA • Or Denial of PA • Or a request for additional info • Or an indication that the PA case has been closed (e.g., if the patient's coverage has expired since initiation of the PA process)
Appeal	PAAppeal Request	Initiating party to payer/PBM	Submitted if the provider desires a change to the PA determination. May be submitted in response to an approval as well as denial, e.g., if the approval contained limitations on quantity or number of fills
	PAAppeal Response	Payer/PBM to initiating party	• Contains either Approval of the appeal request • Or Denial of the appeal request • Or a request for additional info • Or an indication that the PA case has been closed (e.g., if the patient's coverage has expired since initiation of the PA process)

PA step	NCPDP ePA message type	Sender / receiver	Notes
Cancel	PACancel Request	Initiating party to payer/PBM	Submitted if the provider wishes to stop the PA process, e.g., if they've decided to switch to an alternative medication
	PACancel Response	Payer/PBM to initiating party	Contains either: • Indication that the payer was able to cancel the process before it completed • Indication that the PA process couldn't be cancelled, e.g., because it had already completed before the cancellation request was processed

Common content in the ePA messages

Core content: patient, medication, prescriber, other

The prescriber, patient and medication, and other context elements that make up the PAInitiationRequest (below) are echoed in all later PA messages that the provider and payer exchange.



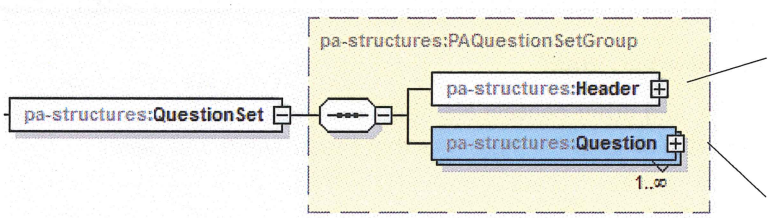
PA Question Set

The Question Set concept in the ePA standard represents the information needed by the payer in order to process the PA request. The same basic Question Set structure is used in multiple messages in the standard, though with variations based on the particular function of each message.

For example, the Question Set in response message types (PAInitiationResponse, PAResponse, PAAppealResponse) contain only the question definition, whereas Question Sets in the PARequest and PAAppealRequest also include elements that hold the prescriber's answers and other information required to process the authorization request.

The diagrams below illustrate the Question Set structure.

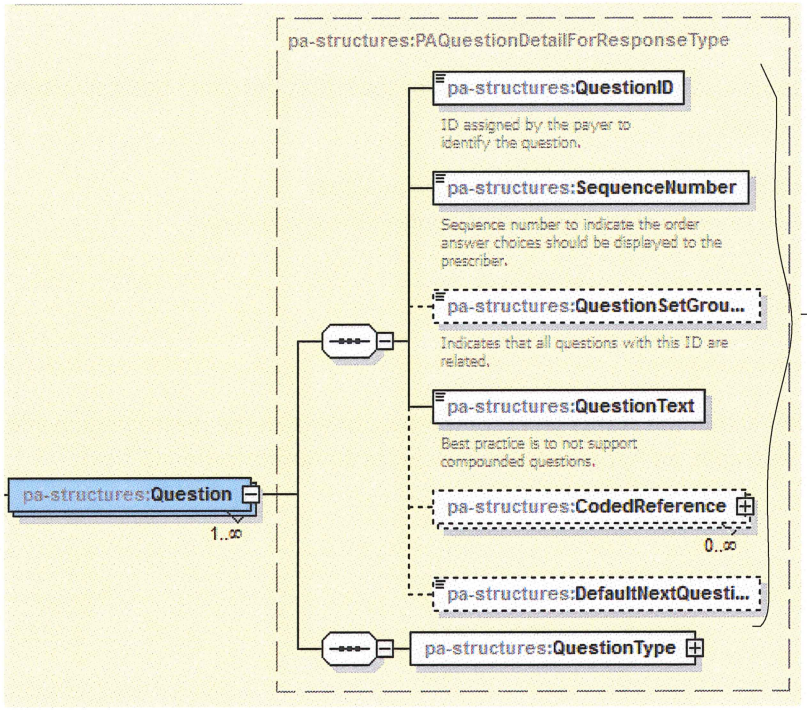
High-level information structure:



The Header contains information pertaining to the entire set of questions, including an ID for the set, a title, a description, and contact information at the payer

Each Question composite represents a single question on the PA "form". A QuestionSet must have at least one question

Data associated with every question:



Certain details apply to every question, regardless of whether it is a True/False question, multiple choice question, etc.:

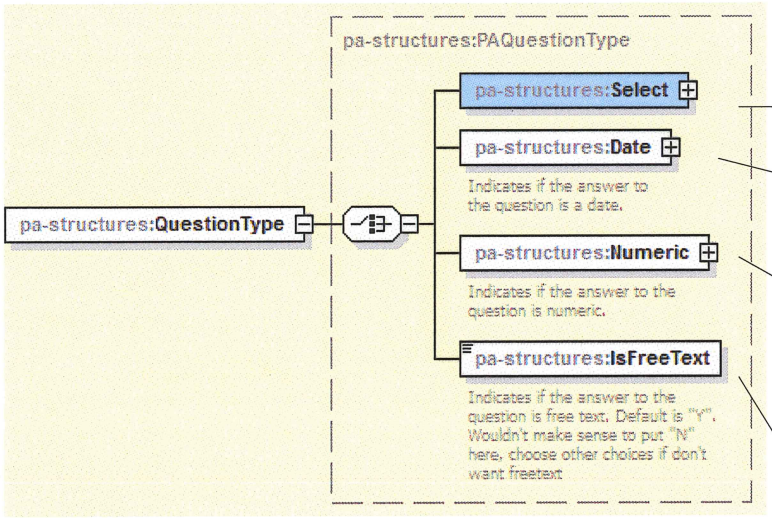
The QuestionID is a system-recognizable unique ID used to tie an answer to its associated question.

The SequenceNumber gives the basic order for the questions on a "form" (ignoring the effect of conditionality indicated in the Next Question elements, which may result in some questions not being presented)

The QuestionText is the human-readable form of the question

The CodedReference is an optional composite that gives an industry terminology-based ID (or multiple IDs) that can be used by the provider system to retrieve the desired information from the patient's electronic chart

Data associated with each question type:



The Select question type is used for True/False and multiple choice questions. Content includes the answers the user can choose from, a flag that indicates whether more than one answer can be chosen, etc.

Date questions request answers in the form of a date or date/time

The numeric question type includes elements that enable the payer to specify different questions to ask next, based on whether the answer is above / below / within or outside of a numeric range

FreeText questions ask for a simple textual answer

Response composites

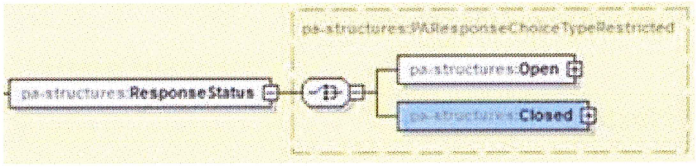
Each step in the PA process is supported by a pair of ePA messages, one of which is a *request* sent by the provider and the other which is a *response* returned by the payer/PBM.

While the particulars of the response composite differs in each of the steps, the same basic structure is used across the response messages:

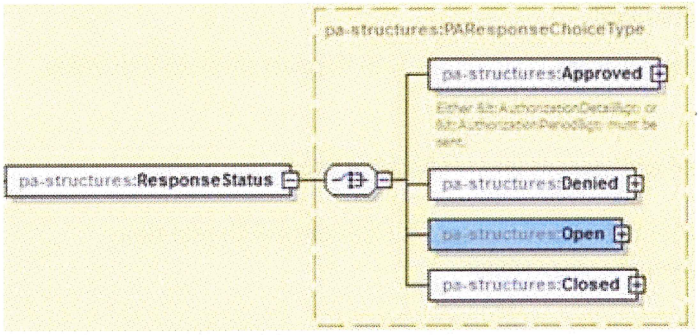
- ReferenceNumber (used only when communicating via a mailbox)
- ResponseStatus, with two or more status types that apply in the given step:
  - Open
  - Closed
  - Approved
  - Denied

Additional elements are included within the status-level composites, based on the message type and particular ResponseStatus. For example, an Approved status includes an Authorization ID field.

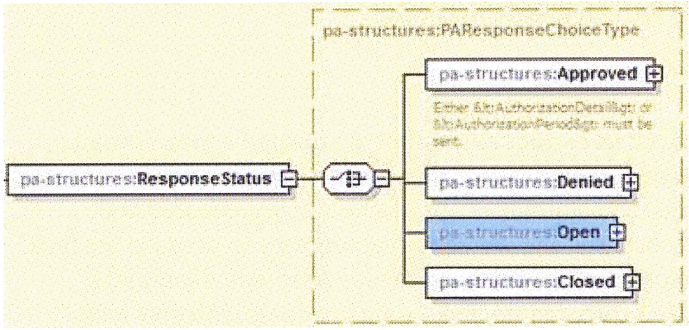
Below is a high-level comparison of the response options in each of the ePA response-type messages:



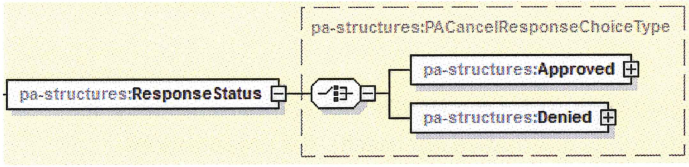
PAInitiationResponse



PAResponse



PAAppealResponse



PACancelResponse

Documentation

The ballot package that holds the implementation guide and XML specification for the SCRIPT version containing the ePA messaging standard is available to NCPDP members at the location below. This documentation will be removed after the approved standard is made available in the Standards section of the NCPDP website.

http://www.ncpdp.org/members/ballotstart.aspx

Follow the link to *My Voting History* and click the *Download the Maintenance Package* link for Ballot WG110053.

3. Adoption of the new NCPDP ePA Standard

This section identifies factors related to industry adoption of the ePA standard.

Industry acceptance and other success factors

Industry consensus on the NCPDP ePA standard

Interest in electronic prior authorization has increased significantly in the past three to four years, due to several factors including...

- experience with the limitations of web portals and other proprietary approaches
- maturation of the systems of stakeholders and increased experience with real-time electronic messaging in other areas of e-prescribing
- state-level rules mandating electronic prior authorization processes or problematic alternatives such as "uniform" PA form requirements, and
- economic and other factors.

The NCPDP task group process that produced its current ePA standard reflected a broad-based interest in moving forward with adoption of a standard electronic process. While a number of topics prompted lively debate among participants, and alternative approaches were compared and passionately argued, the group came to consensus and worked collaboratively to produce the final standard. The steps following submission of the ePA DERF have encountered remarkably little opposition, and approval of the ePA ballot occurred in the first round of voting, with only minor adjustments made to the standard.

Adoption timing expectations

While not all stakeholders have yet indicated support for the NCPDP ePA standard (notably, it appears the AMA is continuing to advocate for its alternative approach), the organizations representing the overwhelming majority of prescribers, health plans—and hence patients—have indicated they expect to implement the NCPDP standard. The largest e-prescribing network has announced its plans to be production-ready for ePA at the start of 2014, and large payer and provider system vendors have also indicated they would be up-and-running on the standard in the 2014/2015 timeframe.

In recent informal discussions between the author and a number of potential ePA implementers (provider system vendors, payers/PBMs), the key timing drivers identified were:

- state-level ePA rules;
- competition from Meaningful Use requirements (a factor that may slow adoption); and
- eventual naming of ePA as a Medicare Part D standard.

Path to a named national standard for medication ePA

The Medicare Part D E-Prescribing Standards (established according to the Medicare Modernization Act / MMA) effectively determine the message types and versions that e-prescribing participants must implement in their systems. The Part D standards do not, in and of themselves, require any party to engage in e-prescribing, but they do dictate the message standards that those who do e-prescribe must use when caring for Medicare Part D beneficiaries.

Below is an overview of the process by which the NCPDP ePA messages may eventually be added to the Part D e-prescribing standards, and the author's understanding of possible timing and considerations, based on informal conversations with involved stakeholders.

Process

The Centers for Medicare and Medicaid Services (CMS) typically determines the standards to be named for use in the Part D program based on industry input and the recommendations of the National Committee on Vital and Health Statistics (NCVHS), which serves as an advisory body to the Department of Health and Human Services on health data, statistics and health information policy.

The broad steps involved in adding or adjusting the set of Part D standards are:

- Industry testimony to the NCVHS standards subcommittee;
- A recommendation by NCVHS to the Secretary of HHS to add or change a Part D standard; and
- Rulemaking steps led by CMS, including formal public notice of the proposed change, a comment period, and a subsequent establishment of the final rule.

Status and possible timing

CMS representatives have participated in an ongoing discussion with the industry regarding experience with potential ePA standards, readiness for adoption of ePA and other considerations including compatibility with HIPAA-named administrative standards. NCVHS has also received testimony periodically on the status of ePA standards.

CMS appreciates the urgency for a national ePA standard, due in part to increasing activity to establish state level rules in this area. Also, efforts such as the 2009 AHRQ ePA Expert Panel have reported that the issue of compliance with HIPAA requirements has been discussed and resolved in principle among the necessary parties, enabling an NCPDP ePA standard to be named for use in medication prior authorization.

Representatives of CMS have informally indicated an interest in moving forward quickly with the process to add the NCPDP ePA messages to the Part D standards. Once initiated, the rulemaking steps identified above could be completed in approximately two years.

State rules related to medication prior authorization

Several states have enacted or are in the process of enacting rules related prior authorization for prescription medications. In several cases, the rules establish non-electronic "uniform PA forms" that can

be submitted by electronic or non-electronic means. But other states including Minnesota are making efforts to put in place electronic prior authorization processes using data exchange standards.

Below is a sampling of state-level activities as of May 2013. While not exhaustive, it gives an overview of efforts taking place today.

State	Scope	Status as of May 2013
Arizona	• Prescriptions • Establish study committee on ePA • Create recommendations on electronic PA • Uniform drug PA form	In process Last action 3/28/2013
Arkansas	• Prescriptions • Uniform drug PA form • Electronic submission (vague)	Passed Delivered to Governor 3/13/2013
Arkansas	• E-Prescribing study committee	Died 2011
California	• Prescriptions • Standard electronic prior auth. "form" • Process / timing • Electronic submission required • State must consider CMS PA forms and ePA standards	Passed 2011, 2012
Colorado	• Prescriptions • Process / timing • Uniform PA form • Defines electronic as via internet portal • Workgroup to develop standard ePA process • Must consider national standards	Sent to the Governor 5/14/2013
Connecticut	• Prescriptions, labs, imaging, other treatment • Uniform PA forms • Process / timing • Does not require electronic PA • Forms / PA process defined by the state must be consistent with national standards	In process Last action 3/11/2013
District of Columbia	• Prescriptions, tests, treatment • Standard electronic prior auth. "form" • Process / timing • Electronic submission required • State must consider CMS PA forms and ePA standards	Introduced 3/5/2013
Florida	• Medicaid managed care plans must post formularies • Managed care plans must accept pre-auth. requests electronically	Passed 2011
Georgia	• Prescriptions • Electronic messaging standard (NCPDP) • Payers required to support ePA • Optional for prescribers to use ePA process	Passed 2012
Hawaii	• Working group to recommend ePA approach	2011 passed
Hawaii	• Uniform PA form	2012 APPEARS NOT PASSED

State	Scope	Status as of May 2013
Iowa	• Prescriptions • Uniform PA form • Process / timing	Introduced 2/14/2013
Kentucky	• E-Prescribing rules • Directs state to consider NCPDP ePA standard	Passed 2012
Louisiana	• Establishes legislative working group	Senate, House established workgroup 2011
Louisiana	• Prescriptions • Medicaid only • Uniform PA form	In process Last action: 5/13/2013
Maine	• Prescriptions • Timing • Step therapy	Introduced 3/12/2013
Massachusetts	• Prescriptions, labs, other treatment • Standard PA forms • Process / timing • Required electronic acceptance by payer. Optional electronic submission by provider	Passed, signed by Governor – 2012
Massachusetts	• Uniform PA form (medical, prescription)	Died 2011
Michigan	• Prescriptions • Process / timing • Electronic / web submission • Uniform form (separate from electronic process)	Approved by Governor 5/14/2013
Mississippi	• Prescriptions • Uniform form (single standard form) • Process / timing • Electronic availability / submission (vague)	Passed, signed by Governor 4/23/2013
Mississippi	• Prescriptions • Working group to establish electronic PA process • Establish e-prescribing rules	Died 2011
Missouri	• Established ePA working group	Approved by Governor in 2012
Nevada	• Establishes a state HIE • Standards for prescription ePA • Workgroup to determine standard electronic PA	Approved by Governor in 2011
New Jersey	• Prescriptions • Uniform PA form	Introduced 2/1/2013
New Mexico	• Prescriptions • Uniform form (single standard form) • Electronic availability / submission (vague) • Process / timing	Passed 2013
New Mexico	• Set steps to establish standard process for ePA	Died 2011
New Mexico	• Directed legislative committee to hold hearing on ePA standards	Passed 2011

State	Scope	Status as of May 2013
New York	• E-prescribing software req'ts • Prescription PA • Electronic PA transmission • Process / timing	In process Last action 1/29/2013
North Carolina	• E-Prescribing • Ability to initiate PA from the eRx system • Electronic signature • "Real time" access to info the provider must supply for PA	In process Last action 4/2/2013
North Carolina	• E-Prescribing • Ability to initiate PA from eRx system • Submit PA electronically	In process Last action 3/20/2013
North Dakota	• Prescriptions • Electronic submission • Does not include uniform PA form rules	Passed, signed by Governor 4/10/2013
Oklahoma	• E-Prescribing • Prescription ePA • Medication history, current patient med list • Process / timing	In process Passed House. Last action 3/21/2013
Oklahoma	• Prescriptions • Uniform PA form	In process Last action 5/8/2013
Oregon	• Prescriptions • Uniform PA form • Electronic submission (non-specific)	In process Last action 5/7/2013
Texas	• Prescriptions • Uniform PA form (single form) • Process / timing • Electronic transmission	In process. HB 1032 last action 4/26/2013 SB 644 last action 5/20/2013 – placed on general state calendar
Utah	• Prescriptions • Working group • Standard PA form • National standards	Passed, signed by Governor 4/1/2013)
Vermont	• Prescriptions and other medical service • Uniform PA form or electronic submission • Approval statistical reporting • Electronic submission	Introduced 1/22/2013 (Senate), 1/24/2013 (House)
Vermont	• Prescription PA • Working group	Passed 2011. (Report issued Feb 2012
Washington	• Prescriptions, procedures, tests • Electronic transmission • Uniform PA forms • Process / timing	Signed by the Governor 5/10/2013 (Effective date 7/28/2013)

#11 – Summary of companion guide annual maintenance timeline and progress to date

2015 Companion Guide Annual Maintenance Update (as of 9/2/2015)

Draft timeline (as discussed at 6/9/15 AUC Ops meeting):

Proposed rule process	June 1 – September 28
30 day public comment period	September 28 – October 29
Adopted rule process	November 2 – February

Current status

Transaction	Status
Eligibility	Eligibility TAG reviewing guide
Claims, including applicable medical coding requirements	Claims DD and Medical Code TAGs reviewing guides
Payment/Advice	EOB/Remit TAG reviewing guides
Acknowledgments	Acknowledgment TAG completed and approved reviews and updates of 277CA, TA-1, and 999 guides. Revised guides will be forwarded to Operations for a vote in the near future.

#12 – Summary of items recently approved at the TAG level to be voted on by the Operations Committee in the near future

"Preview of Coming Attractions" (voting items coming Ops' way)

Below are brief summaries of several items that have recently been addressed at the TAG level and which will be sent to Ops for an email vote in the near future.

Claims DD TAG SBAR response

SBAR submitted requested date of service be added to Claims Attachment Cover Sheet. During the discussion it seemed to be an issue for only one payer, so the TAG denied recommendation to add DOS to the form and agreed to revise the instruction sheet to provide further guidance regarding the attachment control number.

Medical Code TAG SBAR response

The MCT approved the coding recommendations listed in the SBAR for a new covered service under Children's Therapeutic Services and Supports (CTSS), mental health service plan development.

Eligibility TAG revised best practice

The TAG revised the Service Type Inquiry/Response that was approved by Ops in May. However due to questions raised by an Ops member, TAG revisited the best practice and made revisions to clarify.

Proposed revised 277CA companion guide (proposed as v5.0)

The Acknowledgment TAG recently approved suggested revisions and updates to the companion guide.

Proposed revised TA1 companion guide (proposed as v3.0)

The Acknowledgment TAG recently approved suggested revisions and updates to the companion guide.

Proposed revised 999 companion guide (proposed as v3.0)

The Acknowledgment TAG recently approved suggested revisions and updates to the companion guide.

Proposed revised Acknowledgment best practice (PowerPoint version)

The Acknowledgment TAG recently approved suggested revisions and updates to the PowerPoint version of the Acknowledgment best practice.

Proposed revised Acknowledgment best practice (Word version)

The Acknowledgment TAG recently approved suggested revisions and updates to the PowerPoint version of the Acknowledgment best practice.

#13 – ASC X12N Business Requirements and Technical Solutions (BRTS) Change Request (CR) 1359: 837 - Change request to continue AMT segment capabilities for reporting taxes

ASC X12N

ASC X12N
Business Requirements and Technical Solutions

CR 1359

837 - Change request to continue AMT segment capabilities for reporting taxes

Jamie Mosteller

Version 5.1

Date Last Updated: 09/2/2015

Version Control Record

Version ID	Date	Coordinated By	Description of Change	Comments
1.0	1/21/2014	Doug Renshaw / Jamie Mosteller	Original draft	TGB/WG3 has their own CR open to handle their side of this issue
2.0	6/18/2015	Mark Carter	Technical Solution Added	
3.0	07/07/2015	Mark Carter	Business requirements expanded, Technical Solution modified.	TGB/WG3's CR1046 addressed "other" taxes and was not approved.
4.0	07/09/2015	Mark Carter	Business requirements modified, Technical solution modified.	Added 835 requirements and use cases and examples.
5..0	08/05/2015	Mark Carter	Removed 835 Requirements	TGB/WG3 will consider all Tax implications under CR1046.
5.1	08/21/2015	Mark Carter	Updated per TGC/WG3 vote comments	
5.1	8/26/2015	Mark Carter		Technical Solution ready for TGB/WG2 review.

Impacted Business Task Group/Work Groups

Impacted Business TG/WG #	Work Group Name	Impacted TR/Transaction	Comments
TGB/WG2	Billing and Encounters	837I (x260,x299) 837P (x259,x298) 837D (X261,x300) 837R (x262)	

BUSINESS REQUIREMENTS TEMPLATE

1. Introduction

1.1. Change Request

Title	Change request to add AMT segment capabilities for reporting State Care taxes in the 837 TR3's.
Business Reason	A number of states have instituted Provider care taxes that may be submitted on claims, and reported in remittances.
Description	Add AMT segment to the 837 to report State Care taxes that are not supported by procedure codes.

1.2. Additional Information

Segments and elements for Sales tax were eliminated in the current version of the 837 because a HCPCS procedure codes exist to report those taxes.

1.3. Current State

There is no place in the 837 to identify the State Care taxes from the provider's line item charge.

1.3.1. Future Use Cases

1. Medical Providers receipts from the rendering of some medical services and supplies are subject State Care taxes. The Medical Provider is responsible for remitting their State Care tax liability to the State.
2. Medical Providers are allowed to include the State Care tax amount in the line item charge for each covered service or supply. The Provider may or may not visibly identify the amount of the charge attributable to the State Care tax. A Provider that does not visibly identity the State Care tax may not be reimbursed for the tax in the payers adjudication process.
3. Medical Provider bills for a State Care tax covered service of $100, of which there is a $2 liability attributable to the State Care tax. The submitted line item charge is $102 and the provider chooses not to visibly identify that $2 is attributable to the State Care tax.
4. The payer will adjudicate the charge as if the entire $102 amount is for the billed service and there will be no consideration given to additional liability for the care tax. The payer will report the paid amount and any appropriate adjustments. There will be no reporting of the State Care tax since it was not considered in the adjudication. Note: When non-contracted fee schedules are used to adjudicate the service there is the possibility that the charge will be reduced to the fee schedule allowed amount and the payable amount will be less than if the State Care tax was visibly identified.
5. Medical Provider bills for a State Care tax covered service of $100, of which there is a $2 liability attributable to the State Care tax. The submitted line item

charge is $102 and the provider chooses to visibly identify that $2 is attributable to the State Care tax.
6. The payer will adjudicate the charge of $100 for the billed service and separately adjudicate the $2 State Care tax. The payer will report the paid amount and any appropriate adjustments and report the amount of the payment attributable to the State Care tax and adjustments to the State Care tax if appropriate. Note: When non-contracted fee schedules are used to adjudicate the service there is the possibility that the charge will be reduced to the fee schedule allowed amount and the payable amount will include the proportionally adjusted amount attributable to the State Care tax.

1.3.2. Expected Criteria/Outcome

State care taxes will have a place to be reported separate from the provider's charge.

1.3.3. Business Diagrams

Not applicable.

2. Requirements

2.1. Business Requirements

B.1. 837I, 837P, 837D 837R, Loop 2400 - Need the ability to have a new AMT segment for state care taxes.

B.2. New Code value(s) in DE 522 - Amount Qualifier Code is needed for the AMT01
B.2.1 Recommend code value definition as "State Care Tax"

B.3 – Situational Rule would only be required when the State Care Tax applies to the service line and the submitter is required to report that information to the receiver. If not required by this implementation guide, do not send.

B.4 TR3 Note added to state that the State Care Tax Amount would be included in the Line Charge Amount (SV102) for this service line.

B.5 TR3 Note added to state that Sales Tax would not be reported in the new State Care Tax Amount AMT segment

2.2. Business Assumptions

Not applicable

TECHNICAL SOLUTIONS TEMPLATE

3. Technical Solutions

3.1. Technical Solutions Phase 1

T1. Add new AMT segment to Loop ID 2400 in the TR3 837 Professional (successor to 006020X259), TR3 837 Institutional (successor to 006020X260), and Dental Health Care Claim, (successor to 006020X261, TR3 837 Claims Data Reporting (successor to 006020X262), Post-Adjudicated Claims Data Reporting: Professional (successor to 005010x298), Post-Adjudicated Claims Data Reporting: Institutional (successor to 005010x299) and Post-Adjudicated Claims Data Reporting: Dental (successor to 005010x300) [B1]

T1.1 Segment Name: State Care Tax [B1]
Segment Repeat to 1 [B2]
TR3 Segment usage to Situational [B3]
TR3 Example - AMT*SCT*20~

T1.2 Add new Segment Situational Rule [B3]

Required when State Care Tax applies to the service line and the submitter is required to report this information to the receiver. If not required by this implementation guide, do not send.

T1.3 Add new unique TR3 Note [B4]

The State Care Tax Amount must be included in the Service Line Charge Amount (SV102) of the related Service Line.

T1.4 Add new unique TR3 Note [B5]

Sales Tax is not reported in this Segment

T1.5 AMT01 - Set Data Element AMT01 (Amount Qualifier Code) TR3 usage to Required [B1]
AMT01 - Add Code value (DE 522 - Amount Qualifier Code) [B2.1]

SCT – State Care Tax

T1.6 AMT02 (Monetary Amount) Set TR3 usage to Required [B1]
AMT02 Industry Name – State Care Tax
Industry Definition: Tax reported for State purposes (not Sales Tax)

T1.7 AMT03 (Credit/Debit Flag Code) Set TR3 usage to Not Used [B1]

3.1.1. Technical Assumptions

TA1. Updates to the TR3 835 Health Care Claim Payment Advice (successor to 006020X258) to support all taxes are being considered in CR1046.

3.1.2. Technical Exceptions

TE1. Added PACDR guides to technical solution to address need. [T1]

3.1.3. Examples

3.1.4. Technical Diagrams

3.2. Technical Solutions Phase 2

3.2.1. Technical Assumptions

3.2.2. Technical Exceptions

3.2.3. Examples

Example 1.

Billed Procedure 99214 $100, $2 State Care Tax

Loop 2400 (837P)

SV1*HC:99214*102*UN*1*11**1**N**N*N~
AMT*SCT*2~

Example 2.

Billed Procedure A4465 $100, $2 State Care Tax Billed
Billed Procedure S9981 $100 $7 Sales Tax

Loop 2400 (837P)

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3.2.4. Technical Diagrams

3.3. Technical Solution Follow-up Actions

CAQH CORE Phase IV Rules

ALERT: Final balloting of the Draft Phase IV CAQH CORE Package, which includes the Operating Rules and Voluntary Certification Test Suite, is now underway.

See the updated Status below for more information

Overview of Remaining ACA-mandated Operating Rules

The Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act (ACA), Section 1104 requires the Secretary of the Department of Health and Human Services (HHS) to adopt and regularly update operating rules for each of the HIPAA-mandated healthcare administrative transactions. The remaining operating rules mandated in ACA Section 1104, for which there aren't operating rules, address the following five HIPAA-mandated administrative transactions:

- Health claims or equivalent encounter information
- Health plan enrollment/disenrollment
- Health plan premium payments
- Referral certification and authorization
- Health claims attachments

HHS will determine if operating rules finalized by CAQH CORE, the HHS-recognized ACA author for these existing HIPAA transactions, will be included in any regulatory mandates. Any such considerations will include an HHS public comment period.

NOTE: For more information on the ACA-mandated timelines see the CMS website HERE.

DRAFT Versions of the Phase IV CAQH CORE Operating Rules

Research, public input and rule development for Phase IV began in 2013. All CAQH CORE Operating Rules can address both transaction data content and infrastructure (e.g., connectivity, response time, system availability, etc.) requirements. The Draft Phase IV CAQH CORE Operating Rules address infrastructure requirements (see one page overview HERE), with data content to be added later if deemed appropriate. By focusing first on developing infrastructure requirements, CAQH CORE is able to build on its familiarity and resources to further national expectations for best practice infrastructure that support existing standards.

CONTACT CAQH CORE

Questions or requests for CAQH CORE? Email:

core@caqh.org

CAQH CORE PARTICIPANT CALENDAR

User ID (case sensitive)

Password (case sensitive)

Login

MANDATED OPERATING RULES

- View the Mandated Operating Rules Timeline

CORE EVENT LISTING

9/10/15
CAQH CORE & NACHA Joint National Webinar with Midwest Center for Women's Healthcare and Hospital Corporation of America, Inc. - Come join our partners from NACHA - The Electronic Payments Association – as we talk about the benefits of going paperless in your healthcare financial trans

10/22/15
CAQH CORE Town Hall National Webinar - This is your opportunity to learn about important industry updates and how they will affect your organization.

12/10/15
CAQH CORE Town Hall National Webinar - This is your opportunity to learn about important industry

STATUS: Per the CAQH CORE voting process, the Draft Phase IV CAQH CORE Operating Rules were drafted by Subgroups and then reviewed and approved by appropriate Work Groups. The rule package, which includes five draft rules and the Phase IV Voluntary CORE Certification Test Suite, is currently under ballot by Full CAQH CORE Voting Participating Organizations. The Full CORE Vote launched on Monday, August 3, 2015, and will close on Friday, August 28, 2015, a ballot period of four weeks. Should the Package be approved, it will move to the CAQH CORE Board for its vote, which is the final voting step. See below for more information on the CAQH CORE voting process.

Please note: The links below are to the DRAFT Phase IV CAQH CORE Operating Rules Package. The draft rules and test suite are subject to change throughout the formal CORE Voting Process. An updated version of the draft rules will be posted to this webpage when the Phase IV CAQH CORE Operating Rule Set is finalized or if any additional steps are agreed to by CAQH CORE prior to finalization.

The Draft Phase IV CAQH CORE Operating Rules Package includes the five draft operating rules and a Voluntary CORE Certification Test Suite:

The complete Draft Phase IV CAQH CORE Operating Rule Set is available HERE.

The individual rules can be accessed via the links below:

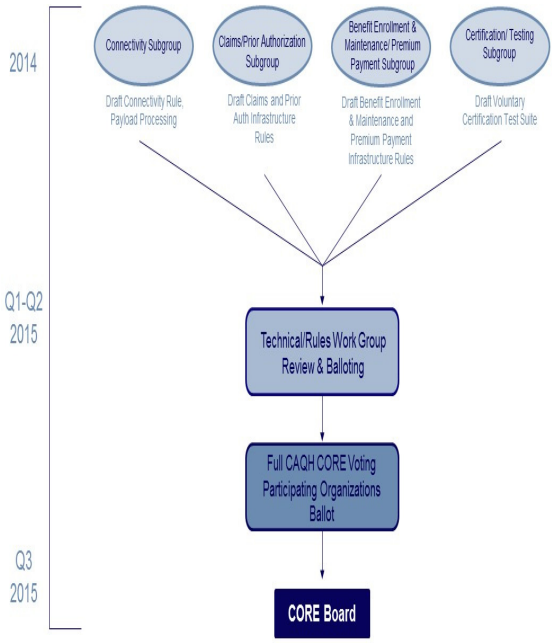
- Draft Phase IV CAQH CORE 450 Health Care Claim (837) Infrastructure Rule v4.0.0
- Draft Phase IV CAQH CORE 452 Health Care Services Review – Request for Review and Response (278) Infrastructure Rule v4.0.0
- Draft Phase IV CAQH CORE 454 Benefit Enrollment & Maintenance (834) Infrastructure Rule v4.0.0
- Draft Phase IV CAQH CORE 456 Premium Payment (820) Infrastructure Rule v4.0.0
- Draft Phase IV CAQH CORE 470 Connectivity Rule v4.0.0
  - Draft Phase IV CAQH CORE-Required Processing Mode and Payload Type Tables v4.0.0
  - XML Schema Specification (normative)
  - Web Services Definition Language (WSDL) Specification (normative)
- Draft Phase IV CAQH CORE Voluntary Certification Test Suite

Voting Process for the Phase IV CAQH CORE Operating Rules

All CAQH CORE Operating Rules are developed through active collaboration and coordination with subject matter experts through a transparent process that ensures balanced representation from key industry stakeholders. Each step has an established set of requirements such as quorums and approvals for Work Group approval. Please contact CAQH CORE at CORE@caqh.org for more information. Upon approval, it is anticipated that the final Phase IV CAQH CORE Operating Rules Set will be available in late Q3 2015, per the following timeline:

highlights for 2015 and how they affect your organization.

See all events



Getting Involved with CAQH CORE for Future Operating Rules

Two processes exist to submit suggestions/comments on the development of future CAQH CORE Operating Rules:

- ***CAQH CORE Rule Development Process:*** Participate directly in the rule development process as a CORE Participating Organization. Participation in CAQH CORE rule-making is open to any interested healthcare stakeholder, including health plans, providers, technology companies, government entities, trade associations, vendors, and standard-setting organizations. Please refer to the CAQH CORE Participation Application for information on how to become a CAQH CORE Participating Organization or email CORE@caqh.org
- ***Public Comment Process:*** Several opportunities for public comment accompany the Department of Health and Human Services (HHS) rule making process including submission of comments to the National Committee on Vital and Health Statistics (NCVHS), an advisory body to HHS, and during public comments periods for Interim Final Rules and Notices of Proposed Rule Making should the CAQH CORE operating rules be proposed for federal mandate.

What is Not Included in the Phase IV CAQH CORE Operating Rules: Health Claims Attachments

Section 1104 of the ACA includes the health claims attachment transaction in the list of electronic healthcare transactions for which the HHS Secretary must adopt a standard under HIPAA. To date, HHS has not adopted a standard for health claims attachments or indicated what standard(s) it might consider for the transaction, and an effective date for these operating rules is not included in the ACA. As such, the immediate focus of the Phase IV CAQH CORE Operating Rules will not include health claims attachments

Interim CAQH CORE Activities Related to Attachments

Since 2012, CAQH CORE has conducted extensive research to identify how regulatory requirements can help drive the adoption of electronic attachments. A market assessment was conducted in 2013 to identify business needs, data content and format requirements, technical infrastructure, and priorities for the exchange of attachments/additional information using administrative transactions. In 2014, CAQH CORE held listening sessions with over 300 participants to continue dialogue, discuss trends, and obtain data from current industry activities and experience. The findings of this research indicate that the vast majority of entities are still using paper to provide clinical data on a claim or other administrative transactions, and, when attachments are electronic, the most common formats are PDF, JPG, TIF, and Word.

Based on these findings, CAQH CORE supports an incremental, flexible use of operating rules to move attachments from paper to electronic documents, as recommended by NCVHS in its June 21, 2013 letter to the Secretary. For example, CAQH CORE Operating Rules could adopt requirements around a limited set of industry-neutral electronic document formats to quickly (two years) provide the industry with efficiencies and movement toward electronic formats; e.g., use of JPG and requiring a trace number or other tracing mechanism to link an attachment to its request. Additionally, based on CAQH CORE research, it is evident that industry-wide education will be key given the current level of knowledge of specific attachment-related standards such as HL7 C-CDA. CAQH CORE will support such industry education and coordinate with key stakeholders. After HHS adopts a standard for health claims attachments, there are a range of opportunities for CAQH CORE Operating Rules, such as:

- Use of LOINC attachment type codes to identify specific document/information needed
- Workflow/business rules for unsolicited attachments
- Scenario-based adoption of structured documents
- Potential ways to reduce the number of attachments

To research these needs, in 2015 CAQH CORE will conduct a pilot on Attachments options. To volunteer for the pilot, e-mail CAQH CORE at CORE@caqh.org.

Contacts

For more information about the mandated operating rules process contact CAQH CORE at CORE@caqh.org.

1900 K Street, NW
Suite 650
Washington, DC 20006

