

Administrative Simplification

A program of the Washington Healthcare Forum
Operated by OneHealthPort

Best Practice Recommendation for

Browser Capabilities for Pre-Authorization & Admission Notification

Version	
Issue Date	Explanation
04/14/2009	Version 1.0
08/26/2009	Amended
02/08/2010	Amended for clarification purposes: <ol style="list-style-type: none"> 1. Acknowledgement of receipt (page 8) will only be for electronically submitted forms 2. Status Information and to whom it will be available (page 8) is more clearly defined
04/28/2010	Amended for clarification purposes: <ol style="list-style-type: none"> 1. This BPR does not apply <i>to services that are covered under a member's pharmacy benefit</i> (page 5) 2. Browser based access to status information about a pre-auth request will be provided <i>regardless of how the request was submitted, e.g. fax, mail, electronic.</i> (page 8)
06/07/2010	Amended to clarify that web sites should address the situation when a prospective review is not required (page 7 section d)
06/15/2010	Amended for clarification purposes: <ol style="list-style-type: none"> 1. This BPR does apply to mental health and chemical dependency services (page 5) 2. How to address carve-outs on the web site (page 7 section c)
11/02/2010	Minor wordsmithing Reformatting of document - Amended for clarification <ol style="list-style-type: none"> 1. The OHP page must contain <ul style="list-style-type: none"> • A contact telephone number for help with web navigation (page 7) • Web site link for 'carve out' benefits (pages 6-7) 2. A prospective review request may done via a form and/or interactive clinical questions (pages 8-9) Recommended, but not yet required, capability: Any requirement for supporting documentation should be on health plan web site (page 8)

Version	
Issue Date	Explanation
02/07/11	<p>Clarified which type of Prospective Review Requests are within scope of this BPR (pg 9-10)</p> <p>Added an Appendix for Definitions of Prospective Review Requests (pg 12)</p>
02/23/11	<p>Added an Appendix the outlines Implementation Staging recommendation endorsed by work group on Jan, 27, 2011</p>
06/01/11	<ul style="list-style-type: none"> • Reformatting to distinguish between prospective review requirements and admission notification requirements • Clarify practices for specifying services on a prospective review request (pg 10 & 12)
06/22/11	<ul style="list-style-type: none"> • Define electronic and fax based practices for requesting prospective reviews (pg 9,10,13)
08/23/11	<ul style="list-style-type: none"> • Clarify practices for admission notification (pg. 8,12-15) • Define practices for informing providers how to make changes to a previously submitted prospective review request (pg 11-12) • Health plans will provide training in the use of their web site (pg 7)
09/29/11	<p>Clarification</p> <p>Change “provide” to “post on their web site” (pg 11)</p>
11/07/11	<p>Updated the Appendix to outline the OIC approved completion dates for all capabilities outlined in the BPR</p>
02/27/12	<p>Update – Providers will first refer to web site before calling (pg 7)</p>
04/04/12	<p>Clarification</p> <p>Urgent Pre-Service can be titled Urgent Pre-Service (aka ‘Expedited) for Medicare (pg 11,17)</p>

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BEST PRACTICE RECOMMENDATION

Topic: Browser Capabilities for Pre-Authorization & Admission Notification

Notes:

- *Browser Capabilities are intended to be in addition to the use of the 278 Health Care Service Review transaction as required by HIPAA.*
- *Most health plans perform medical necessity review for a subset of the services for which they provide coverage. Some health plans **require** that providers request the review prior to delivery of those services, e.g. Pre-Authorization. Other health plans give providers **the option** of requesting the review prior to delivery of those services, e.g. Benefit Advisory. Both of these situations are considered forms of Prospective Review. The recommended practices outlined in this document apply to all Prospective Review situations (required and optional). However, this document **does not** call for health plans to change whether a request for this review by providers is required or optional prior to service delivery.*

The terms prospective review, pre-authorization and benefit's advisory will be used interchangeably throughout this document.

Improvement Opportunity:

Health plans have differing pre-authorization, benefit advisory and admission notification requirements. These differing requirements create training and logistical complexity for providers, as their staff tries to keep track of the various requirements and the different methods of communicating the information.

This document outlines a set of recommended best practices for using 'browser-based' capabilities to simplify the pre-authorization, benefit advisory and admission notification processes.

Summary of Recommendation:

Health plans that require pre-authorization or admission notification will make interactive, browser-based capabilities available to providers to do the following;

- 1) Determine if a pre-authorization and/or admission notification is required for a healthcare service
- 2) Submit preauthorization requests
- 3) Communicate authorization confirmation
- 4) Give notification of admission

Health plans that offer benefit advisory, and similar optional prospective review services, will make this information available to providers via interactive, browser-based capabilities.

Applicability

The best practices that are recommended in this document apply to all services that are covered under a member's medical benefit, including mental health and chemical dependency services. In those situations where the health plan has contracted with another organization to be responsible for prospective review and admit notification obligations for a specific set of service, i.e. "carve outs", the health plan must provide information about those carved out services as described in the section of this document titled 'Best Practice Recommendations - Health Plans'.

The best practices that are recommended in this document do not apply to services that are covered under a member's pharmacy benefit, since these services are provided at a point-of-service other than a physician's office or a hospital.

All health plans and provider organizations are encouraged to adopt and appropriately implement these Best Practice Recommendations as soon as practical. Providers should check the adoption matrix located at <http://www.onehealthport.com/worksmart/wsadoptionmatrix.php> to determine which health plans have adopted these practices and when they will be fully in place. In those cases where a health plan has not adopted these practices, providers should encourage them to do so.

Background:

Different health plans have different requirements for pre-authorization, benefit advisory and admission notification. Furthermore, even within a health plan, these requirements change over time. These differing requirements create training and logistical complexity for providers, as their staff tries to keep track of the various requirements and the different methods of communicating the information.

1. For the same service, some health plans require pre-authorizations and some do not.
2. Different health plans require providers to request pre-authorizations in different ways, e.g. call in the request, fax/mail in the request using a proprietary form, submit the request on-line.

Filling out paper forms and faxing/ mailing is the most complicated of these processes. Providers must maintain a) an inventory of forms from different health plans, b) instructions for completing those forms, and c) updated information about

fax numbers and mailing addresses for each health plan. After finding the appropriate form and completing it, the provider must then determine which fax number or mailing address to use to submit the request

3. Once a decision is made, health plans communicate authorization confirmation in different ways. The confirmation can be made available via the telephone, via a web site, or via a mail/fax communication. Providers must remember how to retrieve the authorization confirmation depending upon the health plan.
4. Providers also give notification of admission in different ways depending upon health plan. In some cases the telephone is used, in other cases the fax is used. Providers must keep track of different phone numbers and fax numbers for different health plans

A common, browser-based process for exchanging pre-authorization information, benefit advisory information and notification of admission between providers and health plans would make it easier for providers. This common, browser-based method would not preclude health plans from offering additional, even more efficient methods and/or personal services for exchanging information, e.g. person-to-person telephone communication, system-to-system exchanges. However, it would establish a “lowest common denominator” method for providers to use across health plans.

Best Practice Recommendations

Health plans will make the following browser-based capabilities available so that their contracted providers have access to the health plan's prospective review information (whether that is pre-authorization, benefits advisory, etc.) and the health plan's admission notification information. Health plans will provide training to contracted providers in the use of these browser-based capabilities.

Provider organizations will first refer to/use the health plan's web site to view, request or supply Prospective Review and/or Admit Notification information. If additional or more detailed information is needed to perform these functions than is on the web site, providers will contact the health plan by phone.

Health Plans

- A. Support for a common web site(s), maintained by OneHealthPort, which will provide a standard way of accessing prospective review information and admission notification information. On that site, health plans will provide the appropriate web site link(s), and related information, which providers can use.
 1. Each health plan will have at least one entry on this common site for those benefit related services for which they (the health plan) perform utilization management.

That entry will be titled "Medical" and it will contain the information listed in #3 below.

2. In those situations where the health plan has contracted with another organization to be responsible for prospective review and admission notification obligations for a specific set of benefit related services, i.e. "carve outs", the health plan will also have a separate entry(ies) on the common site for each of those carved out services. That entry(ies) will be titled with the category of services that are included in the carve out, e.g. Advanced Imaging, Mental Behavioral Health. It will contain the information listed in #3 below.
3. Along with the title of the entry (as described in #1-2 above), the information to be contained in each health plan entry is:

- A phone number, with an appropriate description, that providers can call for help in navigating the web site.

Note: Provider should only use the phone numbers for assistance in navigating the web site. It should not be used for the pre-authorization or admission notification questions/issues.

- A Prospective Review Link:
 - Standard naming convention: Prospective Review
 - Standard description convention: This is a link to the health plan web site where Prospective Review information for a set of benefits can be found. Prospective Review information refers to Pre-Authorization and Benefits Advisory as appropriate to the health plan.
 - Notes/Instructions: Information that may help providers find the information they want once they land on the linked page.
- An Admit Notification Links:
 - Standard naming convention: Admission Notification
 - Standard description convention: This is a link to the health plan web site where their Admission Notification Policy and web submission, including instructions can be found. The Admission Notification policy must identify the conditions under which an admission notification is required and, for each condition, the timeframe for notifying a health plan about the admission. (For more specifics about what needs to be contained in the policy, see section C.1 below) If notification is required upon an admission, the link must also direct the provider to the web submission capability.
 - Notes/Instructions: The notes/instructions should provide general information such as
 - An admission notification is typically required, or
 - An admission notification is never required, or

- An approved prospective review request serves as admission notification except in the following circumstances (list them)
If an admission notification is ever required, the notes/information should help providers find the policy/web submission once they land on the linked page.

B. Access to a Health Plan web site where Prospective Review information for a particular service, for a particular product can be found. Supported web site functions will include:

1. Finding Prospective Review Requirements

- a. Looking up/Searching for a service by code, keyword or functional category
- b. Selecting a specific health plan product(s)
- c. For a selected health plan product, providing information at the appropriate level of detail to answer the following questions:
 - Do I need to do something prior to patient treatment for the claim to pay?
 - If so, what?
- d. If specific clinical criteria must be met in order for the claim to be considered for payment, providing a link to related clinical guideline information

The following is currently a recommended, but not required, capability:

If the provider is expected to supply specific documentation with the initial request as evidence that the clinical guideline has been met, e.g. clinical notes, path report, etc. the web site will identify these requirements.

- e. When a service does not require a Prospective Review, the web site should inform a provider of such, in one of the following ways, as determined by the health plan:
 - Language will be clearly visible on the web page specifying that services do not require a prospective review unless otherwise indicated on the web site, AND/OR
 - Language will be associated with each and every service indicating whether or not a prospective review is required.

2. Requesting prospective review

NOTE: The intent of this Best Practice Recommendation (BPR) is to use automated methods to simplify and expedite the process of requesting prospective reviews. As such, this BPR calls for the use of an automated web form/interactive process to make the request. This BPR acknowledges that a manual review process by the health plan may be required if providers request services using descriptions for diagnoses and procedures rather than codes. As such, health plans may choose to make available to providers two different forms/processes, a) a web

form/interactive process with electronic submission when codes will be used and, b) a web form/interactive process with printing capability and instructions for fax only submission when descriptions are to be used.

If their automated systems have the capability, health plans may choose to provide a single web form /interactive process that a) allows for the entry of codes and/or descriptions and b) that allows for electronic and/or fax submission. However, having a single form/process with these capabilities is not required to be compliant with this BPR.

Unless otherwise specified, the following best practices are required of all prospective review request forms/processes:

a. Usage Instructions:

- If the health plan provides more than one request form, instructions regarding when and how to use each form will be clearly presented, so that providers don't fill out one form only to find out later that they needed to fill out the other form, e.g. clear explanation on the use of each form, an explanatory banner at the top of each form, etc.
- Interactive instructions will be available for completing each data field on the request form.
- Instructions, along with fax numbers/addresses if and as appropriate, for submitting the form / attachments will be clearly visible.

b. Specify the type of request, as appropriate:

NOTE: Making the following types of requests (as defined in the BPR - Standard Notification Timeframe for PA Requests and contained in the Appendix) are not within scope of this best practice:

- *Immediate Requests*: Per the BPR - Standard Notification Timeframe, these requests are best handled by phone between the provider and health plan
- *Post Service Requests that are made prior to claims submission*: Refer to BPR - Extenuating Circumstances around Pre-Authorization and Admission Notification
- *Post Service Requests that are made after claims submission*: Refer to the health plan's appeals policy

When making the following types of requests,

- *Urgent Pre-Service Requests*^{*1}
- *Concurrent, Urgent Requests*
- *Non-Urgent Requests -- Pre-Service & Concurrent*

*1 - for Medicare products this can be titled Urgent Pre-Service (aka 'Expedited' for Medicare)

If the provider can choose more than one type of prospective review request (e.g. Urgent Pre-Service, Concurrent Urgent, etc.) for the service being requested, all valid request types for that service must be presented to the provider for their selection.

If only one type of prospective review request is possible for the service being requested, it must be clear to the provider how it will be processed, e.g. urgent, concurrent, etc.

In some cases, the web site may present a set of clinical questions that can be answered interactively. These questions may be in addition to, or in place of, a prospective review request form.

c. Specify the service(s) for which a prospective review is being requested,

Providers should only make prospective review requests for those services for which some action such as pre-auth, benefit advisory, etc. is recommended or required, as specified on the health plan's web site.

Web forms/interactions should allow providers to enter those diagnoses and/or procedures that are related to services for which a prospective review is required or recommended. Web forms/interactions may be structured so that a fixed number of "primary" diagnoses/procedures are entered in one section of the form and the remaining diagnoses/procedures are entered in another section. If there is a maximum number of diagnoses and/or procedures that can be entered directly onto the form for a specific service(s), the web form/interaction should communicate that information to the providers along with instructions for how they are to communicate any additional diagnoses/procedures to the health plan.

d. Submit the request

- If the request/notification cannot be submitted electronically - either because the web site does not support that functionality or because paper supporting documentation must be submitted with the request/notification, allow the provider to print the request/notification and submit it via fax or surface mail (the printed version of the request/notification will contain the appropriate fax number and mailing address for the provider to use.)
- If the request/notification can be submitted electronically, but the information supplied by the provider that will be used by the health plan in making a decision (e.g. answers to clinical questions) cannot be retrieved by the provider at a later point in time (e.g. for audit purposes), allow the provider to print the request/notification for their records.

3. Requesting changes to previously submitted prospective review request.

Health plan will post on their web site the following information in regards to requesting changes to a previously submitted request – whether approved or in process:

- a. Instructions for how providers should request changes to already submitted requests.
 - b. Process that health plan will follow in evaluating change requests and notifying the provider.
4. Obtaining receipt and status information on the health plan's web site about prospective review requests, including:
- a. For those requests that were electronically submitted and not automatically approved or denied, provide acknowledgement of receipt including a reference number for use by the provider when inquiring about the request or for sending supporting documentation.
 - b. Status information on all requests regardless of how they were submitted, e.g. fax, mail, electronic. The status information will indicate whether or not the requested services will be pre-authorized as medically necessary. For those services that are requested, this information is to include status, e.g. pended, denied, approved, or other status relevant to the health plan, and confirmation number(s) as appropriate to the health plan.

This status information should be available to the provider/organization that requested the services, the provider/organization that is doing the services and, as appropriate, the facility/organization where the services are to be done.

C. If Admission Notification is required by the Health Plan,

For the purpose of this Best Practice Recommendation, an Admission Notification is defined as "providing confirmation to the health plan that a patient has been admitted so that the health plan has the starting point for monitoring the patient's utilization of benefits." By this definition, a prospective review of the procedure and service location for that procedure does not constitute an Admission Notification.

If the Health Plan requires an Admission Notification under any circumstances, their web site will have the following functionality:

1. Access to the Admission Notification Policy via the OneStopShop Page on the OHP site.

The policy should:

- a) clearly state the circumstances under which an admission notification is required, e.g.
 - an admission notification is required when a patient is admitted without an approved prospective review,
 - an admission notification is required in addition to a prospective review,
 - though an approved prospective review typically serves as an admission notification, an admission notification will be required if the scheduled admit date changes, etc.
- b) clearly state which ‘Types of Admit’ require an admission notification (see definition and examples in #2 below),
- c) lay out the timeframes providers should follow for submitting an admission notification, including any policies on late submission methods due to extenuating patient circumstances allowed (not allowed),
- d) indicate that, or under what circumstances, payment for services depends upon the admission notification, and
- e) if payment for services depends upon admission notification, outline the health plan timeframe and process for making a reference # available to providers.

2. Notifying about admission

- a. Provide a method for electronic submission of an admit census, e.g. by attaching a .csv or similar file type to a web page. This census would list those patients who were admitted during a specified day, that have coverage with the health plan and that have an Admit Type(s) specified in the health plan’s policy.
- b. Health plans can require providers to supply *no more than* the following data elements when notifying about a patient’s admission. (Note: all health plans may not require all of these data elements.) Supplying all data elements to all health plans will eliminate the possibility of rejected admission notifications and follow-up phone calls from the health plan:

Data Elements	Definition/Comment (as necessary)
Facility Information	
o Name of Facility	
o Facility Tax ID	
o Facility NPI	
o Facility Address	
o Contact Person/Department	
o Contact Phone number	
o Contact Fax number	
Patient Information	
o Name	
o Date of Birth	

Data Elements	Definition/Comment (as necessary)
○ Health Plan Identifying Number	
○ Facility's Patient Identifying Number	This is the number used by the provider to identify the patient. Providers would like health plans to have this number and use it to identify the patient.
○ Home Phone number	
○ Admission Date	
○ Attending Doctor Name	
○ Admitting Doctor Name	
○ Admission Time	
○ Type of Admit	The anticipated bill type, at the time of notification, for this visit, e.g. Inpatient, Observation, ER, ICU, etc.
○ Clinical Service Type	The primary clinical type of care that the patient will be receiving, e.g. med, surg, maternity, psych, rehab, etc. The health plan will match this service type to a benefit
○ Admission Source	The way in which the patient was admitted, e.g. scheduled, urgent, from ER, from Outpatient Clinic, etc.
○ Reason or Diagnosis for Admit	Description or code that indicates why the patient was admitted
○ Procedure Description/Codes	
○ Estimated Length of Stay	
○ Discharge Date	
○ Discharge Time	

- c. Provide instruction for how providers are to use this electronic notification method.
 - d. Health plans will also provide at least one other way, of their choosing, for receiving a census or a single patient admit notification, e.g. fax, phone, web interaction.
3. Confirm notification, if payment for services depends upon admission notification.

Within 2 business days of receipt of the admission notification, the health plan will make a reference number available to the submitting provider to confirm that the notification was received. Confirmation can either take the form of a reference number for the entire census or separate reference numbers for each patient on the census. In either case, the reference number needs to be researchable to each patient so that the provider can confirm that notification was provided for each individual patient.

Providers

Providers may have automated methods in place that are more efficient than the browser-based capabilities listed above, e.g. system generation and faxing of requests and notifications. Where these methods are in place, providers will continue to use them.

Otherwise providers will use browser-based capabilities to access the common-OHP web site(s) and Health Plans web sites, as appropriate, in order to:

1. Determine if a prospective review for a service or admission notification is required -- using the common-OHP web site(s) and the appropriate health plan web site.
2. Request a prospective review - using the health plans' web sites:
 - a. Only make requests for those services for which some action such as a pre-auth, benefit advisory, etc. is recommended or required, as specified on the health plan's web site.
 - b. Specify the requested service using a CPT code rather than a description, as the standard business practice. Use descriptions where necessary, as the exception rather than the rule.
 - c. If no attachments are required – Complete the request on-line and submit it electronically
 - d. If attachments are required
 - i. Complete the request on-line
 - ii. Check the health plan web site for instructions for sending attachments. For some health plans, attachments may be sent electronically. For other health plans, attachments may be sent via mail or fax.
3. Check on status of a prospective review request, including retrieving the authorization confirmation -- using the health plans' web sites.
4. If required by the health plan, complete the notification and submit it electronically – using the health plan's web based process.

Providers will only submit admission notifications for those 'Types of Admits' listed in the health plan's policy as required.

Appendix - Definitions of Prospective Review Requests

This material is extracted in its entirety from the 'Definitions' section of the BPR-Standard Notification Timeframes for Pre-Authorization Requests.

Definitions:

A pre-authorization request is a request by a provider of a health plan to make a Utilization Management decision as to whether the patient's insurance benefits will cover a treatment or service. Nationally recognized standards relating to pre-authorization requests are commonly defined and adopted by the following:

- The National Committee for Quality Assurance (NCQA) is a nationally recognized, non-profit organization that accredits and certifies health plans
- URAC is an independent, nonprofit organization that promotes health care quality through its accreditation and certification program.
- ERISA is the Employee Retirement Income Security Act of 1974 and sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries.

There are different types of requests depending upon the patient condition and when the request is made. These request types are based upon the following definitions.

1. *Immediate* – any request for approval of an intervention, care or treatment where passage of time without treatment would, in the judgment of the practitioner, result in an imminent Emergency Room Visit or Hospital Admission and deterioration of the patient's health status. The intent of the intervention is to determine if an immediate change to the current treatment plan is required. The request can be for a diagnostic service or for a procedure. If the request is for a diagnostic service, the request should also include the follow-up procedure that may be indicated.

An Immediate Request will typically be made by staff from the following treatment locations in the course of a patient's visit:

- Walk-in Clinic
- Urgent Care Clinic
- Hospital Outpatient Clinic
- Physician Office

Situations that are NOT considered Immediate include, but are not limited to,

- The service being requested had been pre-scheduled, was not an emergency when scheduled and no change in patient condition has occurred.
- The request is for coverage of services that is experimental or in a clinical trial.
- The request is for the convenience of the patient's schedule or physician's schedule.
- The results of the requested service are not likely to lead to an immediate change in the patient's treatment.

2. *Urgent Care (aka 'Expedited' for Medicare)* - any request for approval of care or treatment where the passage of time could:
 - Seriously jeopardize the life or health of the patient
 - Seriously jeopardize the patient's ability to regain maximum function,
 - Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
3. *Pre-Service* – any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services.
4. *Post Service* – any request for approval of care or treatment that has already been received by the patient (e.g. retrospective review).
5. *Concurrent Review* – any request for an extension of previously authorized inpatient stay or previously authorized ongoing outpatient service, e.g. physical therapy, home health, etc.

Appendix - Work Group Recommended and OIC Approved Dates for Implementation Staging

The following completion dates for a staged implementation of best practice capabilities were recommended by the Pre-Authorization Workgroup on October 26th, 2011 and approved by the OIC on November 7, 2011.

Prospective Review Requirements

High Level Summary of BPR Capability	BPR Page#	Completion Date
1. Post the health plan's Prospective Review information onto the OHP one-stop-shop Page, including services that are "carved out"	7-8	December 2010
2. Browser access to health plan's prospective review information	9	December 2010
3. Browser-based interface to a Prospective Review Request form, the results of which <i>can be printed off</i> either for a) submitting to the health plan via fax/mail or b) retaining for internal verification purposes	9-11	December 2010
4. Post, on the health plan's web site, a) instructions for providers on how to request changes to a submitted request and b) process that health plan will use to evaluate and notify providers of decisions	11-12	December 2011
5. Browser-based interface to a Prospective Review Request form (or interactive process) that can be <i>electronically submitted</i> to the health plan. The results of this interaction can also be printed and so that it can be retained for internal review verification purposes.	10-11	December 2012
6. Browser-based acknowledgement of receipt for electronically submitted forms, including a reference number.	12	December 2012
7. Browser based access to status information about requests for prospective review by all appropriate provider organizations.	12	December 2012

Admission Notification Requirements

High Level Summary of BPR Capability	BPR Page#	Completion Date
1. Post the health plan's Admission Notification information onto the OHP one-stop-shop Page, including services that are "carved out",	7-8	December 2011
2. Post, on the health plan's web site, their Admission Notification policy in a manner that makes it easily accessible via the OHP one-stop-shop Page	12-13	December 2011
3. Browser-based method for submitting an admission notification 'census' file.	13-14	April 2013
4. At least one other way for providers to submit admission notification information	14	April 2013
5. Browser-based access to a reference number for the submitted census to confirms health plan receipt	15	April 2013