

Administrative Simplification

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Best Practice Recommendation for

Standard Notification Timeframes for Pre-Authorization Requests

Version	
Issue Date	Explanation
04/14/2009	Version 1.0 /Rev 031909a
09/02/2009	Amended for Immediate Requests & misc. edits
04/28/2010	Amended to clarify distinction between making decision information available and notification of denial (pg 6)
06/07/2010	Amended to add "and no change in patient condition has occurred" to the first situation that is not considered Immediate. (pg 5)
12/01/2010	Per Dept of Labor rules, providers need to be notified by phone and in writing in case of urgent, adverse decision (page 6)
12/16/2010	Remove note about dependency on WAC change. Minor Formatting
04-04-2012	Clarification Urgent Pre-Service can be titled Urgent Pre-Service (aka 'Expedited) for Medicare (pg 5,8)

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BEST PRACTICE RECOMMENDATION

Topic: Standard Notification Timeframes for Pre-Authorization Requests

Improvement Opportunity:

Pre-authorization decisions impact the timely scheduling of resources necessary to provide patient care. Clear and consistent expectations about decision timeframes will simplify the scheduling process resulting in more timely delivery of care to the patient.

This document recommends best practice standard timeframes for processing pre-service authorization requests for emergent/elective/scheduled inpatient and outpatient services/procedures, for concurrent review requests, for post service requests and for notifying providers of the decision.

Summary of Recommendation:

Pre-Authorization decisions will be made and providers will be notified within timeframes that meet or exceed standards established by the National Committee for Quality Assurance (NCQA), based upon the acuity of the patient's need for care or treatment. (Note: NCQA timeframes are consistent with those of URAC and ERISA.) In some cases, a more accelerated Best Practice timeframe is suggested. In all cases, these timeframes are the longest that the decision making and notification process should take. In many situations, the process will be more timely.

Applicability:

This Best Practice Recommendation only applies:

1. in those situations when a health plan **requires** that a provider obtain a prior authorization for treatment in order for the related claim to pay according to the member's benefits. This BPR **does not call for health plans to require** authorization as a pre-condition of claims payment and these timeframes do not apply when health plans are providing medical review information as a service, e.g. Benefit Advisory.
2. to services that are covered by the health plan. Non-covered services, e.g. those that are experimental and investigative, do not apply.

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.

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.

Timeframes for Responding to Requests:

For those types of requests where timeframes have been established by NCQA, URAC and ERISA, the timeframe indicated below are consistent. In some cases, a more accelerated Best Practice timeframe is suggested.

Considerations:

- The timeframes outlined below relate to the processing of pre-authorization requests and are NOT RELATED to the processing of claims.
- Unless otherwise specified, the timeframes are calendar days and not business days
- A day is counted regardless of the time when the request is received by the health plan or when the provider is notified of a decision. For example, day 1 concludes at midnight whether the request is received at 7:00 AM or 11:00 PM.
- Decision Notification timeframes include making information about the decision available to the provider(s) and member.
 - Information about whether a request was approved or denied should be available to the attending physician and/or the ordering physician and/or the facility and the covered person, either on the health plan's web site or from their call center.
 - The ordering physician/ordering facility and the covered person should be notified whenever there is an adverse determination, e.g. when a request is denied or when requested services are not approved in full. If the request is 'Urgent', notification will be by phone and in writing. Otherwise, notification will be in a manner determined by the health plan, i.e. by phone, mail, fax, etc.

Notification of the provider should be directed to person/office that submitted the request.

- These timeframes represent the longest period that a decision should take. In many situations, decisions will be more timely.
- If requested information is not received from the provider within the timeframe specified, the request may be denied or pended.

1. *Immediate Requests*

Decision Notification: Within 60 minutes, or a mutually agreeable timeframe, after eligibility and benefits have been verified AND sufficient clinical information has been provided to the health plan.

Notes:

- Immediate situations are also addressed in the BPR - Extenuating Circumstances as a 'Not Enough Time' situation. That Best Practice applies when providers choose not to request a pre-authorization prior to treating the patient.
- This Best Practice assumes that a practitioner in the provider office will be available, if and as necessary, for a phone conversation with the appropriate person in the health plan. If a practitioner is not available, the health plan may request the practitioner's designee to fax chart notes in support of the request.

Health plans will put into operations a documented process allowing providers to request an Immediate pre-authorization. This process will be in effect during a health plan's normal business hours. After normal business hours, providers should handle these situations as 'Not Enough Time' situations as outlined in the BPR - Extenuating Circumstances.

Providers need to check with each health plan to find out their specific process. All processes will have the following Recommended Best Practice steps:

- a. Providers will be given a phone number that they can call to request an Immediate pre-authorization.
 - With some health plans, the phone call will confirm a patient's eligibility and benefits AND process the Immediate request.
 - With other health plans, the phone call will only process the Immediate request. In these cases, in order to expedite the process, the provider must have confirmed, prior to the call, that the patient's eligibility coverage and benefits are applicable to the service.

Note: **WAC 284-43-410** states *"Each carrier when conducting utilization review shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered unless the prior authorization was based upon a material misrepresentation by the provider."* Obtaining an Immediate Pre-Authorization when the patient's eligibility coverage and benefits are not applicable will be considered a material misrepresentation.

- b. The health plan will make a decision about the Immediate Request within 60 minutes, or a mutually agreeable timeframe, once clinical information has been provided.
 - The practitioner (or their designee) will give specific information about the situation and the service(s) being requested. If a test is being requested to determine the need for immediate treatment, the potential treatment should be included as part of the request. (This will eliminate the need for multiple Immediate Requests if the test indicates that treatment is necessary.)
 - The health plan will determine if the request meets the criteria of an Immediate Request. If it doesn't meet the criteria, the provider will be informed of the appropriate process to use.
 - For many patient situations, the health plan may want to speak directly to a practitioner within the provider office, e.g. an LPN, RN or MD and/or may want to involve a practitioner within the health plan. A practitioner in the provider office should be available when requesting an Immediate Pre-Authorization.
 - In those situations when a practitioner is not available and the practitioner's designee cannot provide sufficient information on the phone, the health plan may request a fax copy of chart notes that contains supporting information. The nature and type of supporting information will depend upon the patient condition and the service requested. If fax notes are sent, the provider must call the health plan back after the notes are sent to confirm that the notes were received and that sufficient information is provided.
 - If a decision cannot be made within the course of the call, the health plan and practitioner will make themselves available for another phone call within 60 minutes, or at a mutually agreed upon time.
- c. The decision made by the health plan will be one of the following:
 - The requested service is authorized

- The health plan will process the request as an Urgent Pre-Service Request (see #2 below). Reasons for this decision include:
 - This request does not meet the criteria for Immediate Request.
 - More information is needed to make a determination (i.e. results of a test or another opinion)
- The requested service is denied

2. Urgent Pre-Service Requests (aka 'Expedited' for Medicare)

Decision Notification: within 72 hours of receiving the request. (References: *NCQA* - UM 5,A,2 *URAC* - UM 17 a *ERISA* 2560.503-1 f.2.i)

If information is needed from the patient or the provider, the health plan will ask for that information within 24 hours of getting the request from the provider. The patient or provider is given 48 hours to provide the information; then the health plan has 48 hours from due date or receipt of information, which ever is earlier, to make the decision.

Requests that are indicated, by the provider, to be 'Urgent' must fit the criteria outlined above in section 'Types of Pre-Authorization Requests'. If the request does not fit the urgent criteria, the health plan will process it as a Non-Urgent Request and will notify the provider as such within the decision notification timeframe.

- ## 3. Concurrent Urgent Requests -- This category applies to requests for an extension of a previously authorized inpatient stay or previously authorized ongoing outpatient service, e.g. physical therapy, home health, etc.

Decision Notification: within 24 hours of receiving the request (References: *NCQA* - UM 5,A,3 *URAC* - *UM* 19,b,i&ii *ERISA* 2560.503-1 f.2.ii)

The request needs to be received by the health plan at least 24 hours prior to expiration of the previously authorized inpatient stay or previously authorized ongoing outpatient services.

Note: This timeframe only pertains to extending inpatient days and ongoing outpatient services that were previously authorized. Extending inpatient days and ongoing outpatient services that were not previously authorized is outside the current scope of this Best Practice Recommendation.

Requests that are indicated, by the provider, to be 'Urgent' must fit the criteria outlined above in section 'Types of Pre-Authorization Requests'. If the request does not fit the

urgent criteria, the health plan will process it as a Non-Urgent Request and will notify the provider as such within the decision notification timeframe.

4. *Non-Urgent Requests -- Pre-Service & Concurrent:*

Industry Standard Timeframe & WAC 388-501-0165 that governs Medicaid

Decision Notification –within 15 days of receiving the request with a provision for a 15 day health plan extension. (References: *NCQA* - UM 5,A,1 *URAC* - UM 17,b *ERISA* 2560.503-1 f.2.iii.A)

The health plan has up to 15 days to make a decision. If within that time period the health plan determines that they require additional information, they can request the information from the provider. (URAC and Medicaid require the health plan to notify the member if more than 15 days will be required to make the decision.) The patient or provider is given up to 45 days to provide the information. (In accordance with state regulations, some health plans, e.g. Medicaid programs, may require patients and providers to respond in a period of less than 45 days.) The health plan has an additional 15 days, starting at due date or receipt of information whichever is earlier, to make the decision.

Best Practice Recommended Timeframe

Decision Notification - within 14 calendar days of receiving the request

Health plans and providers will share the responsibility of completing the decision and notification process within 14 calendar days. To ensure that this timeframe can be met:

1. Health plans will identify, on their web site, the guidelines/documentation that needs to be met in order for a pre-authorization request for a specific service to be approved.
2. Providers will submit, with the pre-authorization request, the supporting documentation, e.g. for a PET Scan, clinical notes or records will be sent showing the qualifying condition that is present.

The following describes the longest timeframe a step should take in the decision making process. Health plans and providers will make their best effort to complete these steps in an even more timely manner.

Upon receipt of a request, a health plan will have no more than 5 calendar days to either:

- a. Make a decision, or
- b. Request additional documentation from the provider or member, as appropriate. The provider will respond to that request with the appropriate information within 5 calendar days. Upon receipt of all needed information, the health plan will make a final determination in no later than 4 calendar days.

If a health plan has not received the requested information by calendar day 14, the health plan will have the option of denying the request or pending the request for a period not to exceed 45 days, from the date the provider received notification that additional information is required. In either case, denial or pend, the health plan will notify the member.

5. *Post Service Requests* -- This category applies to requests for retrospective review prior to claim submission

Industry Standard Timeframe

Decision Notification –within 30 days of receiving the request with a provision for a 15 day health plan extension. (References: *NCQA* - UM 5,A,4 *URAC* - UM 18,a ERISA 2560.503-1 f.2.iii.B)

The health plan has up to 30 days to make a decision. If within that time period the health plan determines that they require additional information, they can request the information from the provider. (URAC and Medicaid require the health plan to notify the member if more than 15 days will be required to make the decision.) The patient or provider is given up to 45 days to provide the information. (In accordance with state regulations, some health plans, e.g. Medicaid programs, may require patients and providers to respond in a period of less than 45 days.) The health plan has an additional 15 days, starting at due date or receipt of information whichever is earlier, to make the decision.

Best Practice Recommended Timeframe

Decision Notification – within 30 calendar days of receiving the request, excluding time waiting for information from provider or member.

The health plan has a total of 30 calendar days to make a decision, excluding time waiting for information from provider or member. If the health plan asks for information from the member or the provider before 30 calendar days expire, there is a pause in the 30 calendar day timeframes. The patient or provider is given up to 45 days to provide the information. (In accordance with state regulations, some health plans, e.g. Medicaid programs, may require patients and providers to respond in a period of less than 45 days.) The 30 calendar day timeframe for making the decision resumes upon due date or receipt of information, whichever is earlier.

Recommended Best Practices:

These Best Practice Recommendation apply to pre-service authorization requests for emergent/elective/scheduled inpatient and outpatient services/procedures, for concurrent review requests, for post service requests and for notifying providers of the decision.

Provider

1. Request pre-authorization decisions using the communication methods appropriate to the health plan. Send any supporting documentation required by the health plan along with the request. Note, health plans may have different guideline/documentation requirements and methods depending upon the type of service being pre-authorized.
2. Indicate the type of pre-authorization requested, e.g. Immediate Request, Urgent Pre-Service Request, Post-Service Request, etc.
3. Respond in a timely manner to health plan requests for additional information. Be sure to fill in any form and/or answer any specific questions sent to you by the health plan.
4. Encourage your patient to respond to information requests from health plans in a timely manner.

Health Plan

1. Identify, on the web site, the guidelines/documentation requirements that need to be met in order for a pre-authorization request for a specific service to be reviewed.
2. Process the pre-authorization request and provide notification of decision within the timeframes outlined above. Decisions could be made sooner.
3. Notify providers of decision using established communication methods.