



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>

Table of Contents

Improvement Opportunity:	5
Summary of Recommendation:	5
Applicability:	6
Background:	6
Best Practice Recommendations:	7
Health Plans	7
Providers	11
Appendix:	12
Definitions of Prospective Review Requests	12
Workgroup Endorsed Implementation Staging	14

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

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:

1. Browser-based access to up-to-date information about prospective review (e.g. pre-authorization, benefit advisory, etc.) and admission notification.
 - a. A common site(s) maintained by OneHealthPort will provide a standard way of offering access to 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.

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 below.

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 below.

Along with the title of the entry (as described 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 can be found along with a web form to notify the health plan about an admission, if notification is required
 - Notes/Instructions: Information that may help providers find the information they want once they land on the linked page

Note: The common site will make it clear which health plans do NOT require admit notification.

- b. Health plan web sites will provide easy access to Prospective Review information for a particular service, for a particular product. Supported web site functions will include:
 - Looking up/Searching for a service by code, keyword or functional category
 - Selecting a specific health plan product(s)

- 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?
- 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.

- Providing easy access to an on-line request if a pre-authorization is required or recommended (see 2 below).
 - Provide instructions, along with fax numbers/addresses if and as appropriate, for submitting attachments.
- d. 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.
- e. If admission notification is required, health plan web sites will provide easy access to
- Admission notification policy
 - On-line notification form if notification is required or recommended (see 2 below)
2. Browser-based interaction for requesting prospective review and for notifying about admission -- on each health plan's web site.

This interaction will allow providers to do any of the following:

- a. Complete the Admission Notification or Prospective Review Request
- Interactive instructions will be available for completing each data field on the Notification or Request.
 - For a Prospective Review Request:

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 remaining types of requests,

- *Urgent Pre-Service Requests*
- *Concurrent, Urgent Requests*
- *Non-Urgent Requests -- Pre-Service & Concurrent*

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.

- b. Submit the request/notification electronically via the web site,
 - 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. Browser-based access to receipt and status information on the health plan's web site about pre-authorization requests, including:
 - Acknowledgement of receipt for electronically submitted requests –including a reference number for use by the provider when inquiring about the request or for sending supporting documentation.
 - 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. pending, 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.

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 pre-authorization 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 pre-authorization - using the health plans' web sites:
 - a. If no attachments are required – Complete the request on-line and submit it electronically
 - b. 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 on a pre-authorization request, including retrieving the authorization confirmation -- using the health plans' web sites.
4. If required, give notification of admission – Complete the notification and submit it electronically -- using the health plans' web sites.

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* - 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 Endorsed Implementation Staging

The following recommendation for a staged implementation of best practice capabilities was endorsed by the Pre-Authorization Workgroup on January 27, 2010.

Phase I: Required Completion Date of 12-31-2010

BPR Capability	BPR Page#
1. A single web site link where Prospective Review information can be found	7
2. A single web site link where Admit Notification information can be found (if Admit Notification is required by the health plan)	7
3. Browser access to prospective review information for required services	8-9
4. Browser access to Admit Notification Policy (if Admit Notification is required by the health plan)	9
5. Browser-based interface to a Prospective Review Request form (and Admit Notification information if required by the health plan) that can be filled-in via the browser and printed off for submission to the health plan via fax or mail.	9-10

Phase 2: Required Completion Date not yet set.

BPR Capability	BPR Page#
1. Browser-based interface to a Prospective Review Request form (and Admit Notification information if required by the health plan) that can be filled-in via the browser and that the provider can choose to either a) print off for submission to the health plan via fax or mail, or b) submit electronically to the health plan.	10
2. Browser-based acknowledgement of receipt for electronically submitted forms, including a reference number.	11
3. Browser based access to status information about requests for pre-authorizations	11