Administrative Simplification

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Best Practice Recommendation for

Health Plan Web Capabilities for Pharmacy Benefits and Pre-Authorization

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BEST PRACTICE RECOMMENDATION

Topic: Health Plan Web Capabilities for Pharmacy Benefits and Pre-Authorization

Notes:

- *Browser Capabilities are intended to be in addition to the use of the 278 Health Care Service Review transaction as required by HIPAA.*
- *For the purpose of this document, the term pre-authorization includes any authorizing related action that needs to be taken prior to dispensing of the medication in order for a claim to pay. Interchangeable terms for those Pre-Authorization actions include, but are not limited to pre-authorization, pre-auth, pre-cert, prior auth, prospective review etc.*

Improvement Opportunity:

Health plans have differing pre-authorization requirements and processes, most of which are paper-based. These differing requirements create training and logistical complexity for prescribers, as their staff tries to keep track of the various requirements and the different methods of communicating the information. Processing paper takes time as it moves back and forth through fax queues and impacts how quickly a medication can be dispensed.

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

Summary of Recommendation:

Health plans that require pre-authorization will make interactive, browser-based web capabilities available to prescribers to do the following;

1. Determine if a pre-authorization is required for a medication
2. Submit preauthorization requests
3. Communicate authorization confirmation
4. Give status information about the request

Applicability

The best practices that are recommended in this document apply to all services that are covered under a member's pharmacy benefit whether the health plan directly performs the practice or outsources the practice to another organization, e.g. PBM. References in this document to best practice recommendations for "health plan" means the inclusion of the

health plans, payers as well as any other outsourced organization eg PBM, that are performing those services.

All health plans, prescriber and pharmacy organizations are encouraged to adopt and appropriately implement these Best Practice Recommendations as soon as practical.

Background:

Different health plans have different requirements for pre-authorization most of which are paper based. 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. Processing paper takes time as it moves back and forth through fax queues and impacts how quickly a medication can be dispensed.

1. For the same medication, some health plans require pre-authorizations and some do not.

2. Different health plans require prescribers to use different paper forms to request pre-authorizations.

   Filling out paper forms and faxing/mailing are complicated and time-consuming processes. Prescribers 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.

3. Once a pre-authorization decision is made, health plans communicate authorization confirmation in different ways. The confirmation can be made available via the telephone or via a mail/fax communication. Prescribers must remember how to retrieve the authorization confirmation depending upon the health plan.

A browser-based web process for exchanging pre-authorization information between prescribers and health plans would make it easier for prescribers and would expedite the overall process. This 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 prescribers to use across health plans.

Best Practice Recommendations

Health plans will make the following browser-based web capabilities available so that their contracted prescribers have access to the health plan's Pre-Authorization

information. Health plans will provide training to contracted prescribers in the use of these browser-based web capabilities.

Prescriber organizations will first refer to/use the health plan's web site to view, request or supply Pre-Authorization information. If additional or more detailed information is needed to perform these functions than is on the web site, prescribers 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 pharmacy benefits, formulary and Pre-Authorization information. On that site, health plans will provide the appropriate web site link(s), and related information.
    1. Each health plan will have an entry on this common site.
    2. The information to be contained in each health plan entry is:
        a. Benefits and Formulary Link:
            i. Standard naming convention: Benefits and Formulary

            This is a link to the web site where Benefits and Formulary information can be found.

            ii. Help
                - Web Help – This is the phone number for help with navigating the web site
                - Questions – This is the phone number for help with benefits and formulary information that is not on the web site.

            iii. Notes/Instructions: Information that may help prescribers find the information they want once they land on the linked page.

        b. Pre-Authorization Link:
            i. Standard naming convention: Pre-Authorization

            This is a link to the web site where Pre-Authorization information can be found.

            ii. Help
                - Web Help – This is the phone number for help with navigating the web site
                - Questions – This is the phone number for help with Pre-Authorization information that is not on the web site.

            iii. Notes/Instructions: Information that may help prescribers find the information they want once they land on the linked page.

c. Emergency Fill Link

i. Standard naming convention: Emergency Fill

This is a link to the web site where the Emergency Fill Policy can be found. If the health plan does not support 24*7 response to utilization management requests, followup claim payment guidelines can be also found at the link.

ii. Help

- Web Help – This is the phone number for help with navigating the web site
- Questions – This is the phone number for talking to someone about an Emergency Fill situation.

iii. Notes/Instructions: Information that answers the following questions

- Does the health plan provide 24*7 utilization management support for Emergency Fill situations?. Yes/No
- If 'No' – what are the business hours for utilization management support for Emergency Fill situations?

B. Access to a Health Plan web site where Benefits, Formulary and Pre-Authorization information and related capabilities can be found for covered medications.

Benefits, Formulary and Pre-Authorization information must be accessible at the lowest level that the coverage requirements vary, whether that be for a patient, an insured group or a health plan product. If the information is provided on the web site at the group or product level, those requirements need to apply, without exception, to all patients in that group or with that product.

Supported web site functions will include:

1. Finding Benefits, Formulary and Pre-Authorization Requirements (at the lowest level of variation)
   a. Looking up/Searching for a medication by generic or brand name
   b. Selecting the specific patient, insured group or health plan product(s)
   c. Determining if the medication is covered though the medical benefit or pharmacy benefit
   d. For the selected patient, insured group or health plan product, providing information at the appropriate level of detail to answer the following questions:
      - Is the medication covered?
      - What is the tiering, if any?
      - What, if any, is the applicable deductible?

- What are dispensing constraints, if any, e.g. dosing, refills, pharmacy restrictions, etc.?
- Does it need to be prospectively reviewed for the claim to pay?
- Are there less costly equally effective alternatives?

e. If specific clinical criteria must be met in order for the claim to be considered for payment,
   - if posting the clinical criteria is not prohibited due to copyright limitations, provide a link to the related clinical guideline information that is used for medical review/utilization review,
   - if posting the clinical criteria is prohibited due to copyright limitations,
     - indicate the vendor of the clinical criteria that is being used, e.g. Interqual, Milliman, etc.
     - provide a contact where clinical guideline information can be obtained in a timely manner
   - in all cases, provide the specific documentation that must be sent to support the medical necessity, e.g. clinical notes, path report, etc.

f. When a medication does not require a Pre-Authorization, the web site should inform a prescriber 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 care services do not require a Pre-Authorization unless otherwise indicated on the web site, AND/OR
   - Language will be associated with each and every care service indicating whether or not a Pre-Authorization is required.

2. Requesting Pre-Authorization

NOTE: The intent of this Best Practice Recommendation (BPR) is to use automated methods to simplify and expedite the process of requesting Pre-Authorizations. 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 prescribers request services using descriptions for diagnoses rather than codes. As such, health plans may choose to make available to prescribers two different forms/processes, a) a web form/interactive process with electronic submission when diagnosis codes will be used and, b) a web form/interactive process with printing capability and instructions for fax only submission when diagnosis 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 Pre-Authorization 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 prescribers 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, the requisite form and provide the associated processing timeframe, as appropriate:

i. All request types should be consistent with those defined in the 'BPR – Emergency Fills and Notification Timeframes for PA Requests' and contained in the Appendix.

ii. If the prescriber can choose from more than one type of Pre-Authorization request options for the medication being requested, all valid request types for that medication must be presented to the prescriber for their selection.

iii. Provide the health plan's standard timeframe for processing the type of Pre-Authorization request that was made. This timeframe can be made available at any one of the following points in the process
   a. Upon selection of a request type
   b. Upon submission of the request, OR
   c. Along with reference number associated with the request that is electronically made available to the prescriber.

   Note: The timeframe assumes that the prescriber supplies all necessary information according to the schedule outlined in the 'BPR – Emergency Fills and Notification Timeframes for PA Requests'

iv. In some cases, the request may consist of a set of clinical questions that can be answered interactively on the web site. These questions may be in addition to, or in place of, a Pre-Authorization request form.

If the request is immediately approved or denied as part of this interactive process, no timeframe needs to be provided.

c. Specify the medication(s) for which a Pre-Authorization is being requested,

Prescribers should only make Pre-Authorization requests for those medications for which some action such as pre-auth, pre-cert, etc. is recommended or required, as specified on the health plan's web site.

Web forms/interactions should allow prescribers to enter those diagnoses that are related to medications for which a Pre-Authorization is required or recommended. Web forms/ interactions may be structured so that a fixed number of "primary" diagnoses are entered in one section of the form and the remaining diagnoses are entered in another section. If there is a maximum number of diagnoses that can be entered directly onto the form for a specific service(s), the web form/interaction should communicate that information to the prescribers along with instructions for how they are to communicate any additional diagnoses 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 prescriber 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 prescribers to use.)
- If the request/notification can be submitted electronically, but the information supplied by the prescriber that will be used by the health plan in making a decision (e.g. answers to clinical questions) cannot be retrieved by the prescriber at a later point in time (e.g. for audit purposes), allow the prescriber to print the request/notification for their records.

3. Requesting changes to previously submitted Pre-Authorization 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 prescribers should request changes to already submitted requests.

b. Process that health plan will follow in evaluating change requests and notifying the prescriber.

4. Obtaining receipt and status information on the health plan's web site about Pre-Authorization 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 prescriber 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 prescriber organization that requested the services.

        See 'BPR – Exchanging & Processing information about Pharmacy Benefit Management' for best practices related to notifying pharmacy and patients about pre-authorizations.

Prescribers

Prescribers may have automated methods in place that are more efficient than the browser-based capabilities listed above. Where these methods are in place, prescribers will continue to use them.

Otherwise prescribers 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. Only make requests for those services for which a Pre-Authorization action is recommended or required, as specified on the health plan's web site.

    b. Specify the diagnosis using ICD9/ICD10 codes rather than descriptions, 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 Pre-Authorization request, including retrieving the authorization confirmation -- using the health plans' web sites. Status information will be available within the best practice notification timeframes based upon the type of request – Urgent or Standard. Supply relevant chart notes when requested and respond in a timely manner to support the pre-authorization request.

Appendix - Definitions of Pre-Authorization Requests

This material is extracted in it's entirely from the 'Definitions' section of the BPR-BPR-Emergency Fills & Notification Timeframes for Pre-Authorization Requests.

Definitions:

A pre-authorization request is a request by a prescriber 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. *Urgent Care Review Request* - 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.

2. *Standard Review Request* – any request for approval of care or treatment where the request is a) made in advance of the patient obtaining medical care or services, or b) a renewal of a previously approved request