A program of the Washington Healthcare Forum
Operated by OneHealthPort

Best Practice Recommendation for

Browser Capabilities for Prospective Review & Admission Notification

Version 8.83
<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>04/14/2009</td>
<td>Version 1.0</td>
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<tr>
<td>08/26/2009</td>
<td>Amended</td>
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<td>02/08/2010</td>
<td>Amended for clarification purposes:</td>
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<td></td>
<td>1. Acknowledgement of receipt (page 9) will only be for electronically submitted forms</td>
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<td>2. Status Information and to whom it will be available (page 9) is more clearly defined</td>
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<td>04/28/2010</td>
<td>Amended for clarification purposes:</td>
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<tr>
<td></td>
<td>1. This BPR does not apply to services that are covered under a member's pharmacy benefit (page 3)</td>
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<tr>
<td></td>
<td>2. Browser based access to status information about a pre-auth request will be provided regardless of how the request was submitted, e.g. fax, mail, electronic. (page 9)</td>
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<tr>
<td>06/07/2010</td>
<td>Amended to clarify that web sites should address the situation when a prospective review is not required (page 6 section e)</td>
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<tr>
<td>06/15/2010</td>
<td>Amended for clarification purposes:</td>
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<tr>
<td></td>
<td>1. This BPR does apply to mental health and chemical dependency services (page 3)</td>
</tr>
<tr>
<td></td>
<td>2. How to address carve-outs on the web site (page 5)</td>
</tr>
<tr>
<td>11/02/2010</td>
<td>Minor wordsmithing</td>
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<td>Reformatting of document - Amended for clarification</td>
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<tr>
<td></td>
<td>1. The OHP page must contain</td>
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<tr>
<td></td>
<td>• A contact telephone number for help with web navigation (page 5)</td>
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<tr>
<td></td>
<td>• Web site link for 'carve out' benefits (page 5)</td>
</tr>
<tr>
<td></td>
<td>2. A prospective review request may done via a form and/or interactive clinical questions (pages 6-7)</td>
</tr>
<tr>
<td></td>
<td>Recommended, but not yet required, capability: Any requirement for supporting documentation should be on health plan web site (05-30-12 – set as a required capability pg 6)</td>
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<tr>
<td>Issue Date</td>
<td>Explanation</td>
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</tr>
<tr>
<td>02/07/11</td>
<td>Clarified which type of Prospective Review Requests are within scope of this BPR (pg 7-8) Added an Appendix for Definitions of Prospective Review Requests (pg 15-16)</td>
</tr>
<tr>
<td>02/23/11</td>
<td>Added an Appendix the outlines Implementation Staging recommendation endorsed by work group on Jan, 27, 2011 (pg 17-18)</td>
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<td>06/01/11</td>
<td>• Reformating to distinguish between prospective review requirements and admission notification requirements • Clarify practices for specifying services on a prospective review request (pg 7-8)</td>
</tr>
<tr>
<td>06/22/11</td>
<td>• Define electronic and fax based practices for requesting prospective reviews (pg 6-9)</td>
</tr>
<tr>
<td>08/23/11</td>
<td>• Clarify practices for admission notification (pg. 5-6. 9-12) • Define practices for informing providers how to make changes to a previously submitted prospective review request (pg 9) • Health plans will provide training in the use of their web site (pg 4)</td>
</tr>
<tr>
<td>09/29/11</td>
<td>Clarification Change “provide” to “post on their web site” (pg 9)</td>
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<tr>
<td>11/07/11</td>
<td>Updated the Appendix to outline the OIC approved completion dates for all capabilities outlined in the BPR (pg 17-18)</td>
</tr>
<tr>
<td>02/27/12</td>
<td>Update – Providers will first refer to web site before calling (pg 4)</td>
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<tr>
<td>04/04/12</td>
<td>Clarification Urgent Pre-Service can be titled Urgent Pre-Service (aka ‘Expedited) for Medicare (pg 8,16)</td>
</tr>
<tr>
<td>05-30-2012</td>
<td>• Updated admit notification data set (pg. 10-</td>
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<td>Issue Date</td>
<td>Explanation</td>
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<tr>
<td>09/12/12</td>
<td>Clarifications about admission notification (pg 10-12) – remove misleading example, reference number needs to be on health plan web site</td>
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<tr>
<td>10/15/12</td>
<td>Remove Health Plan Routing ID from Admit Notification data set (pg 11)</td>
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<tr>
<td>10/30/12</td>
<td>Add requirement to put prospective review and admission notification phone numbers on the Pre-Service Directory, as well as navigation help phone numbers. (pg 5-6) Expand admission/discharge notifications to include single notifications as well as daily census (pg 10)</td>
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<td>11/14/12</td>
<td>Refine admission notification requirements to be more consistent with the capabilities of a system-to-system solution. (pg 9-14)</td>
</tr>
<tr>
<td>11/19/12</td>
<td>Criteria to be used when evaluating whether to add a data element to admit notification data set (pg 11-12)</td>
</tr>
<tr>
<td>03/28/13</td>
<td>Set conditions around health plan notifying providers about receipt of non-member admission notifications and mistaken discharge notifications. (pg 12-13)</td>
</tr>
<tr>
<td>12/31/13</td>
<td>Enhancements to address a) pre-authorization of referrals and b) posting pre-authorization and admit notification information at lowest level that it varies.</td>
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<tr>
<td>03/19/2014</td>
<td>• Aug 1, 2014 set as validation date for 12/31/13 capabilities • Enhancement to display processing timeframes when pre-auth request is made (pg 8-9). Validation date will be set in the</td>
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<td>09-28-2015</td>
<td>Major Revision 8.0</td>
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<td>03-21-2016</td>
<td>Language updates to be consistent with intent for broader prospective review of services, not just those where a prior authorization is required.</td>
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<td>09-26-2016</td>
<td>Enhancements to address: a) revised Pre-Service Directory, b) providing information about excluded benefits, c) always posting Clinical Review Criteria even when it is from a 3\textsuperscript{rd} party, and d) a ‘No Review’ status with clarifying information</td>
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<td>10-19-2016</td>
<td>Status must be reported on web site for all requests submitted via the web site OR via fax within 1 Business Day of the web site being down.</td>
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<td>11-23-2016</td>
<td>Clarification about handling patient specific excluded benefits. NO recommended implementation date.</td>
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<td>12-19-2016</td>
<td>Clarification that supporting documentation can be contained in the Clinical Review Criteria associated with the service. If Clinical Review Criteria is not associated with the service and supporting documentation is required, those requirements must be available via a link from the service.</td>
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<td>06-27-2017</td>
<td>Rename Clinical Guidelines and Medical Policies to Clinical Review Criteria to be consistent with the WAC.</td>
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<td>11-20-2017</td>
<td>Added an Overarching Intent Section</td>
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<td>04-23-2018</td>
<td>Significant enhancement of the Best Practice Recommendation for Supporting Documentation Requirements</td>
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<td>10-08-18</td>
<td>Update to reflect change from Workflow Navigator to Pre-Service Directory</td>
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<td>10-24-18</td>
<td>Added Supporting Documentation</td>
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<td>Version</td>
<td>Issue Date</td>
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<td>04-22-19</td>
</tr>
<tr>
<td></td>
<td>06-19-19</td>
</tr>
</tbody>
</table>
# Table of Contents

**Improvement Opportunity:** .................................................................................................................. 2
**Summary of Recommendation:** ............................................................................................................. 2
**Applicability:** ......................................................................................................................................... 2
**Background:** ........................................................................................................................................... 4
**Overarching Intent:** ………………………………………………………………….. 5
**Best Practice Recommendations:** ........................................................................................................... 6
  Health Plans .............................................................................................................................................. 6
    A. Support common method of accessing Health Plan Web Sites................................................. 6
    B. Prospective Review functionality ................................................................................................. 8
      1. Finding Prospective Review Requirements ................................................................. 8
        Eight Questions to be answered
        i. Is this an excluded benefit? ................. 9
        ii. Is this a non-covered benefit /service that may be covered? ................................. 10
        iii. Is a pre-authorization required? .......... 10
        iv. Is a change to a pre-authorization requirement pending … 10
        v. Is approval for service subject to a Medical Necessity Review? ............................. 11
        vi. Is approval of this service subject to any Professional Restrictions? ..................... 12
        vii. Does the medication need to be obtained from a specialty pharmacy? ............. 12
        viii. Is authorization of this service subject to submission of supporting documentation? 13
        Clinical Review Criteria ................................................................................................................. 17
        2. Requesting a Prospective Review .............................................................................................. 18
        3. Requesting changes to previously submitted Requests .................................................... 22
        4. Obtaining receipt and status information for a submitted Request ................................. 22
        5. Posting Updates to Medical Policies ....................................................................................... 24
    C. Admission Notification functionality ............................................................................................... 25
  Providers ................................................................................................................................................... 28
**Appendix:** .............................................................................................................................................. 30
  Definitions of Prospective Review Requests ....................................................................................... 30
  Pre-Service Directory Business Requirements, Definitions and Links ............................................. 32
BEST PRACTICE RECOMMENDATION

**Topic:** Browser Capabilities for Prospective Review & 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.*
- *These best practice recommendations apply to those situations where, prior to the care service being delivered, the provider needs to obtain information from and/or exchange information with the patient’s health plan in order to know whether the claim will pay. This will include pre-authorization requests, non-required pre-service review requests and the gathering of related information.*

**Improvement Opportunity:**

Health plans have differing prospective review and admission notification requirements. These differing requirements create training and logistical complexity for providers, as their staff try 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 providers’ prospective review and admission notification processes.

**Summary of Recommendation:**

Health plans will make interactive, browser-based capabilities available to providers to do the following:

1) Determine if a pre-authorization, post treatment utilization review and/or admission notification is required for a healthcare service
2) Submit prospective review requests and obtain status information
3) Confirm receipt of request and communicate authorization confirmation
4) Give notification of admission (if/as required by the health plan)

**Applicability**

This Best Practice Recommendation applies to health plans that require EITHER a) pre-treatment authorization and/or post-treatment Utilization Review, AND/OR b) an Admission Notification, in order for the related claim to adjudicate according to the member's benefits. This BPR *does not call for health plans to require* a Utilization
Review-based authorization or an Admission Notification as a pre-condition of claims payment. It only requires a health plan to provide information about their requirements.

Information related to non-Utilization Review-based eligibility and/or coverage determination requirements are outside the scope of this BPR except as they relate to transparency about excluded and non-covered benefits (as further specified on page 9 of this document).

- **Excluded Benefit** (or benefit exclusion): a service for which there is no benefit provided by the coverage plan. This includes investigational/experimental services.

- **Non-covered Benefit** (or non-covered): a service that will potentially not be covered and therefore not be paid. Reasons for non coverage include, but are not limited to; the service is an excluded benefit (as defined above), a pre-auth was not obtained for the service, the service did not meet Utilization Review requirements, the service was not performed by an in-network provider, deemed investigational, was not performed in the appropriate setting (facility vs. non facility), etc.

The best practices that are recommended in this document apply to the services outlined below whether the health plan directly performs the prospective review or outsources the performance of the prospective review to another organization, i.e. carve out. 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'. Applicable services include:

1. All services that are covered under a member's medical benefit for which a Prospective/Retrospective medical necessity review is performed, including behavioral health and chemical dependency services.

2. Provider Administered Medications - a medication that is given in a health care facility (e.g. hospital, infusion center, provider office) or via a home infusion provider. Some health plans cover these medications under the medical benefit and others cover these services under the patient’s pharmacy benefit. The best practice recommendations that apply to these services are outlined in this document so that providers have a standard and consistent approach for finding health plan requirements.

3. Provider Administration of Medications – this includes:
   a. The administration by a provider of the medications defined in 2 above
      Whether the medication itself is covered under the medical benefit or the pharmacy benefit, administration of the medication may be covered separately under the patient’s medical benefit.
b. The administration by a provider of a one-time dose of a self-injectable medication (Self-injectable meaning that a patient and/or caregiver can inject the medication at home). The purpose of a provider administering the one-time dose is to teach the patient and/or caregiver proper injection technique. The one-time dose of medication administered by the provider for the purposes of teaching may be covered under the pharmacy benefit, the medical benefit, or not covered. Administration of the medication may be covered separately under the patient’s medical benefit, whether the medication itself is covered under the medical benefit or the pharmacy benefit.

The best practice recommendations that apply to these services are outlined in this document so that providers have a standard and consistent approach for finding health plan requirements.

With the exception of Provider Administered Medications as described above, 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.

Washington State legislation calls for all health plans licensed in the State to adopt the recommended best practices. Ideally, all health plans and payers are encouraged to align with the Best Practice Recommendations. In those cases where a health plan has not adopted these practices, providers should encourage them to do so.

Note, federal plans, such as Medicare, TriCare and/or Employee Retirement Income Security Act (ERISA) plans may choose not to align with these practices. As such, Washington State health plans will need to follow federal practices for any associated products that they offer.

**Background:**

Different health plans have different requirements for pre-authorization/retrospective medical necessity reviews 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. Variations in requirements include:

1. For the same service, some health plans (and some groups within a health plan’s product line) provide benefit coverage and others do not.

2. For the same service, some health plans require pre-authorizations and/retrospective medical necessity reviews and some do not.

3. Different health plans require providers to request prospective reviews 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, email, text, 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 prospective review 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.

**Overarching Intent**

The best practices recommended below recognize that the optimal clinical and business process is to make medical necessity decisions prior to the service being rendered, not after it is rendered through chart review. Pre-service review is the most opportune time to have a peer-to-peer review, if indicated, and to have a positive impact on the quality of care the patient is receiving. Retrospective (post-service) medical necessity determinations should only be applied to situations that call for a retrospective review because the service was urgent (as defined in this BPR) and could not be delayed until prior-authorization was obtained.

Utilization Review is a process by which clinical staff or decision support software, in a health plan and/or provider organization, conduct a review of the service(s) requested to make a medical necessity and an authorization for payment decision based on defined medical policies/clinical criteria (also known as guidelines, decision rules, pathways).

This process may occur before or after the service is provided to the patient. The intent of utilization review is to ensure that the requested service(s) is:

- *Medically necessary* – Based upon patient’s condition and the evidence-based
effectiveness of the requested service to treat the condition for which the service is requested (right-service-right-time-for-right-reason)

- **Safe** - Reduce the risk of harm being done to a patient and evidence supports will not cause harm to patient

- ** Appropriately delivered in a cost effective manner** – Medical necessity determination may
  - modify, or otherwise limit, the scope of the clinical intervention that was requested, and/or
  - direct the patient and the requesting provider to another covered service under the patient’s coverage plan, that is more appropriate at this time for the current clinical condition (e.g. physical therapy before joint replacement)

These best practices support the above clinical/business process and recommend operational practices that will make the need for any medical necessity review to be transparent to the provider prior to service delivery.

**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 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 and admission notification information. That site will contain:

1. Prospective Review Links:
   a. Health plans will provide links to their Prospective Review information as outlined in the Pre-Service Directory Business Requirements contained in the Appendix.
   b. 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 include this information on the Pre-Service Directory, as described in the Business Requirements
c. Notes/Instructions/Contact information contained in the Pre-Service Directory will include:
   i. 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 prospective review or admission notification questions/issues.
   ii. Information that may help providers to find the information they want once they land on the linked page. This information should include a phone number that providers can call for help with Prospective Review issues that are not addressed on the health plan’s web site itself.
   iii. Indicate if any of the health plan’s products require a pre-authorization for a ‘referral’ to a provider, regardless of whether that referral is for an office visit and/or a service. (Requirements related to each individual product need not be specified here, only on the health plan site)

2. An Admit Notification Link:
   a. Standard naming convention: Admission Notification
   b. 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.
   c. Notes/Instructions: The notes/instructions should provide general information such as
      i. An admission notification is typically required, or
      ii. An admission notification is never required, or
      iii. 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/instructions should help providers find the policy/web submission once they land on the linked page. This information should include a phone number that providers can call for help with Admission Notification issues that are not addressed on the health plan’s web site itself.
B. Access to a Health Plan web site where Prospective Review information and related capabilities can be found for any care service, including but not limited to a visit, treatment, medication, procedure, admission, etc., that requires a pre or post service Medical Necessity Review by the health plan in order for the claim to be approved.

If a health plan product requires a pre-authorized ‘referral’ to a provider, the health plan web site must define/specify the ‘referral’ conditions under which a prospective review is required and the process to be followed by the provider to request the pre-authorization.

Prospective Review and Medical Review information must be accessible at the lowest level of variation, whether that be for a patient, an insured group or a health plan product. If Prospective Review and Medical Review 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. The objective of this Best Practice Recommendation is that the information made available to providers in support of their pre-service review of a specific service would mirror the claim adjudication processing requirements, e.g. authorization number required, medical review required, not an excluded service, etc. The intent is that a provider will have access, prior to delivering the service, to sufficient information to determine whether the service is subject to Benefit Limitations, Professional Restrictions, Prospective Review, or Medical Review which could result in denial of the claim.

Note: Ideally, the browser-based capabilities ‘Finding Prospective Review Requirements’ (as outlined in #1 below) and ‘Requesting Prospective Review’ (as outlined in #2 below) will be available for pre-authorization of a ‘referral’ to a provider. However, at the current time, these browser-based capabilities are not required for that type of pre-authorization. All other browser-based capabilities outlined below are required for that and all other types or pre-authorization.

Supported web site functions, whether the health plan manages the benefit directly or contracts with another entity to manage it for them, will include:

In a straightforward and intuitive manner…

1. Finding Prospective Review Requirements (at the lowest level of variation)
   a. Looking up/Searching for the care service by code, keyword or functional category.

      Provider Administered Medications will be searchable by

      o J code, for those medications that have a J code, AND
      o Brand name and generic name for all medications
b. For the selected patient, insured group or health plan product (whichever is the lowest level of variation), providing information at the appropriate level of detail to answer the following questions:

i. Is this an excluded benefit? (see definition above under Applicability)

Non-patient specific: The following information will be posted on the web site:

- **List of services that are provisionally excluded** based upon medical necessity, e.g. cosmetic services. This list of services will be displayed by CPT/HCPC codes and/or descriptions, depending on what is most meaningful. Services on this list must EITHER
  a. Be linked to the appropriate Clinical Review Criteria (d. below),
  OR
  b. The name and number of the appropriate clinical review criteria must be reported on the list along with the CPT/HCPC code. The Clinical Review Criteria must be available on the web site.

Notes:
- CPT/HCPC codes can be displayed in ranges if every code in the range is always excluded and if those ranges can be linked to the respective Clinical Review Criteria.
- Due to circumstances such as periodic code revisions and new procedures, the list of services in 1.a. and 1.b. may not be all-inclusive

- **List of services that are always excluded**, e.g., experimental/investigational services, e.g. custodial services. This list of services will be displayed by CPT/HCPC codes and/or descriptions, depending on what is most meaningful. Note – CPT codes can be displayed in ranges if every code in the range is always excluded.

- **Policy about always excluded experimental/investigational services** that address services/items not specifically listed and/or do not yet have CPT/HCPC codes.

Notes:
- Due to circumstances such as periodic code revisions and new procedures, the above two lists may not be all-inclusive
- Each list will contain a Revision Date, i.e. the most recent date when a change was made to the list.
- The above information will be updated at least annually
**Patient Specific:** As of November 1, 2019 (per WAC 284-43-2050) the web site will:

- Identify all services that are excluded from the patient’s coverage plan, or
- Clearly indicate if a service that is selected for that patient is an excluded benefit, i.e. the service is not part of the patient’s coverage.

ii. **Is this a non-covered benefit/service that may be covered?**

For some payors, e.g. Medicaid, benefits or services may be non-covered for all patients but may be covered for a specific patient because a different service, which is covered service that patient’s condition, is not clinically effective/appropriate, e.g. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) which is a Medicaid benefit for individuals age 20 and younger.

If a non-covered service for the plan/program may be covered for the specific patient based upon that client’s needs, indicate:

“This non-covered service may be covered depending upon patient’s needs. Pre-authorization (includes medical necessity review) required.”

iii. **Is a pre-authorization required?**

If so,

On the web site, in a pre-authorization list and/or in a pre-authorization tool, indicate “Pre-authorization (includes medical necessity review) required.” Also note any specific conditions under which the pre-authorization will be required, e.g. if the line-item exceeds a billed charge/ dollar threshold (such as, requiring notification if the charge for an unlisted code exceeds a specific/ set dollar amount.

Except in extenuating circumstance, if a pre-authorization is not obtained the claim will be denied and no post-service review will occur.

iv. **Is a change to a pre-authorization requirement pending?**

Health plans are typically aware of and notify providers in advance of changes in pre-authorization requirements. (e.g. WAC # WAC 284-170-421). Those pending changes include: a) when a service that doesn’t currently require a pre-authorization will require it as of a specific date in the future, and b) when a service that currently requires a pre-authorization will not require it as of a specific date in the future.
Pending pre-authorization changes will be made available on the health plan web site, either via the health plan’s browser tool and/or via a posted list:

- For services that don’t currently require a pre-authorization but will at a specified date in the future, the tool and/or list will identify the date when a pre-authorization will be required.

- For services that currently require a pre-authorization but will no longer at a specified date in the future, the tool and/or list will identify the date when a pre-authorization is no longer required.

If the pending changes are reported on a list which is separate and distinct from the health plan’s browser tool and/or current pre-authorization list (if either or both exist), then access to that pending changes list should be intuitive within the health plan’s web site. The link for that list will be contained within the Pre-Service Directory for that health plan.

Note: The scope of this best practice does not include whether or not a health plan maintains a history of when services did and did not require a pre-authorization.

v. Is approval for service subject to a Medical Necessity Review?

If so, the health plan web site will be transparent about that requirement.

For services subject to Medical Necessity Review (excluding unlisted or not otherwise specified [N.O.S.] codes, which often end in "99")

For the associated CPT code:

- Provide a link from the service to the related Medical Criteria(s) (item ‘d’ below)

- Indicate, on a web site list or tool, one of the below whichever applies to the service:
  
  - Medical necessity review will be performed. Providers are advised to request it pre-service. If not requested, it will be performed upon claims submission.
  
  - Medical necessity review will be performed upon claims submission, but not pre-service.

For services subject to Medical Necessity Review that are considered Unlisted Codes (often end in '99') or Not Otherwise Specified (N.O.S.) codes and/ or are not associated with a specific CPT code

- Using either a narrative policy or a code specific list/tool, indicate on the web site, with the language below as appropriate, if a medical necessity review will be performed.

  - Medical necessity review will be performed. Providers are
advised to request it pre-service. If not requested, it will be performed upon claims submission.

- Medical necessity review will be performed upon claims submission, but not upon pre-service request

  - If a medical necessity review will be performed, provide any specific instructions, if/as required, for submitting supporting documentation either pre-service or with the claim, as indicated

  - In the Pre-Service Directory, using the field ‘Handling Unlisted Procedures’, indicate the location of this policy or list/tool and the relevant information/instructions.

Notes:

- Use of the standardized payor practice language noted above is recommended as a best practice to promote transparency around prior authorizations and medical necessity review requirements. Inclusion of this language in this BPR only reflects that the specific practices referenced in the language exist, not that they are / are not endorsed as best practice.

- If the service is subject to any other clinical criteria, like site of service/ care/ supply, then that assessment will be identified and also included as part of the medical necessity review.

- Any medical necessity review done post-payment is considered an audit and is outside the scope of this workgroup.

- The timeframes and related requirements for processing pre-service medical necessity review requests will be the same as they are for Pre-Service Prospective Review requests. (See BPR- Standard Notification Timeframes for Pre-Authorization Requests)

- The process for requesting pre-service medical necessity review will be consistent with the process for a pre-service pre-authorization. (See item 2 below)

vi. Is approval of this service subject to any Professional Restrictions, including but not limited to:

  - Type of rendering provider

  - Site of Care / Place of service; Outpatient, Inpatient, Private Office, Home, Infusion center (as separate from hospital outpatient, i.e., private infusion center), Pharmacy

vii. For Provider Administered Medications, does the medication need to be obtained from a specialty pharmacy?*2?
If so, the web site should provide the name(s) of authorized specialty pharmacies, phone number(s) and/or web address(es).

Note: The provider may need to obtain an authorization for administration, which is covered under the medical benefit. Health plans are not billed by the provider for medications obtained from a specialty pharmacy, only the administration fees are billed. If the health plan has other requirements, they should be noted on the web site.

*2 - A specialty pharmacy is a pharmacy from which a medication must be obtained, as defined by the health plan, FDA, or pharmaceutical manufacturer for the purposes of tracking outcomes, adherence or quality/safety measures

If this benefit is managed by a separate entity not contracted by the health plan AND the health plan is aware of this benefit:

- What is the entity that is managing the benefit?
- What is the phone number or web page for that entity?

viii. Is authorization of this service subject to submission of supporting documentation?

If so,

Notes:

- This BPR considers that supporting documentation are materials submitted by provider organizations in order to demonstrate the medical necessity for a service. Documentation to support the need for a particular service beyond the benefit limits and constraints are outside the scope of this BPR.

- This BPR assumes that providers will access supporting documentation requirements by procedure code (e.g. CPT, HCPCS, ICD10 procedure code) and not by the name of the service.

Provider Organization Best Practice:

Each type of supporting documentation that is submitted, e.g. H&P, Medication List, Imaging Report, etc., should have the following information easily identifiable on that document:

- Patient’s name and identifier
- Date and time or service
- Servicing Provider

Health Plan Best Practice:

The health plan’s goal in requesting supporting clinical
documentation is to obtain the information that they need for clinical review without provider administrative staff having to interpret specific clinical elements of the criteria.

**Situation A:** If the service IS associated with a Medical Policy / Criteria that is developed and maintained by the health plan

The service will link directly to the respective Medical Policy / Criteria on the health plan’s web site. Supporting documentation requirements will be incorporated into the associated Medical Policy / Criteria.

If the service is associated with multiple Medical Policy / Criteria, that service will link to each of the Policies/Criteria and the related supporting documentation requirements within the Policy/Criteria may vary depending upon the associated diagnosis.

1. The location of Supporting Documentation Requirements for a service should be clearly identified within the respective on-line Medical Policy, either by a link to the requirements within the Policy document and/or to a separate on-line document,

2. The Supporting Documentation Requirements should be written so that:
   a. There is a clear distinction between the clinical policy criteria and the supporting clinical documentation that is to be provided, and
   b. Supporting documentation requirements are clear and specific, so that those documents can be easily located by provider administrative staff with reasonable knowledge of medical terminology and familiarity with the structure of medical records

3. Required Supporting Documentation definitions should align with the following:
   - **History and Physical (H&P):** Physical examination of the patient and the history of their present illness to include patient complaint, family and personal medical history, doctor’s objective findings identified while performing examination, organ systems examined, etc.
   - **Current Medication List:** A comprehensive list of over the counter and prescribed medications that the patient is currently taking, along with start dates and reason for medication.
   - **Progress Notes/Office Notes:** Notes made by a physician, nurse, social worker, physical therapist and other health
care professionals that describe the patient’s presenting problem, current condition, doctor’s objective findings identified while performing examination and the recommended treatment to be given/planned/currently receiving.

- The physician's progress notes usually focus on the medical or therapeutic aspects of the patient's condition and care.

- The progress notes of other caregivers record the medical conditions of the patient, usually focusing on the objectives stated in the nursing care plan. These objectives may include; responses to prescribed treatments, the ability to perform activities of daily living, acceptance or understanding of a particular condition or treatment.

- Inpatient progress notes are recorded daily. Clinic or office setting progress notes are usually recorded as account of each visit.

- **Consultation Notes:** Documentation of the patient’s problem, differential diagnosis, and recommended course of treatment from a specialty provider. Typically includes elements of the patient’s history and physical with regard to the medical condition presented. The notes may include an action plan or recommendation for the medical condition presented.

- **Orders for Ongoing Therapies:** Includes physician orders for type of treatments to be rendered and number of treatment sessions to be provided.

- **Imaging Report:** Radiologist interpretation, findings and possibly images from any imaging related to the current course of care.

- **Laboratory/Pathology results:** Values or findings from a lab test or pathology report related to the current course of care.

4. If/as appropriate, required supporting documentation material may be further qualified as follows:

- The required time frame of that material should be stated, e.g. the most recent, the last 3 months, etc.

- It should specifically state if anything other than the provider’s full and complete version of that material is required, e.g. summary.
5. If the health plan is looking for specific information within a required document related to the requested service, that information should be identified as part of the supporting documentation requirements, e.g. (note: these are only examples to demonstrate the concept and are no way required for any/or services or health plan)

- If the service is for genetic testing, the supporting documentation requirements may include verification that genetic counseling has been provided, e.g. summary notes from the counselor.

- If previous use of a more conservative treatment and length of time for such attempts is required in the clinical criteria, the supporting documentation requirement may call for demonstrating the more specific conservative treatment that was “tried and failed”.

6. For renewal or extension of a service, the policy will clearly identify what documentation is needed, which is likely to include updated documents from the original request and which may also require supplemental/additional documentation, e.g. documentation of progress/improvement for additional PT requests.

Situation B: If the service IS associated with a Medical Policy / Criteria that IS NOT developed and maintained by the health plan, for example but not limited to purchased criteria:

The health plan’s web site will provide access to supporting documentation requirements as described below:

1. A ‘standard set’ of required documentation that applies to ALL of the criteria that was not developed and maintained by the health plan

   a. That ‘standard set’ of documentation should be described at the highest, most generic level possible, e.g. recent history and physical by primary care or a specialist, specialty consultation notes, radiology reports and/or radiograph/CT/MR images or laboratory results, as described above in Situation A.3.

   b. That ‘standard set’ of documentation will be posted on their web site and the location of that posting will be put into the Pre-Service Directory that is maintained by OneHealthPort in the ‘Supporting Documentation Requirements’ data element

2. Criteria-specific documentation, in those cases when documentation in addition to the ‘standard set’ is required to
support the clinical criteria for a specific service, e.g. images for Blethoplasly

a. EITHER the specific documentation that is required will be described and posted on the web site,

b. OR the associated criteria that will be used for clinical review will be posted or linked on the web site

c. In either case, the location of the documentation or the criteria will be put into the Pre-Service Directory that is maintained by OneHealthPort as part of the instructions associated with the ‘Supporting Documentation Requirements’ data element

d. If provider administrative staff is unclear about what documentation to submit, they will involve clinical staff in the workflow

Situation C: If the service IS NOT associated with a specific medical policy / criteria but does have supporting documentation requirements,

The service will link directly to documentation requirements on the health plan’s web site and those supporting documentation requirements will be the same as described above in Situation A.3.

If the above information (ii. – vii.) cannot be provided for a specific patient, the health plan will make available on the web site at a plan/product level, a table of specific services, searchable by CPT code, with a column designating each of the above ii - vii, (as relevant to the service).

c. If specific Clinical Review Criteria must be met in order for the claim to be considered for payment, provide a link to the related Clinical Review Criteria that is used for medical review/utilization review (RCW 48.43.016 (3)). This information may be posted behind the health plan’s firewall.

The Clinical Review Criteria will include whether coverage for a specified service/medication is dependent upon another specific service/medication having been first tried or a specific value on a diagnosis test. If this information is not included in the Clinical Review Criteria, it needs to be available on the web site, with a link to it as described in c.iii above.

Per WAC 284-43-0160(3), Clinical Review Criteria means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.
d. When a care service does not require a Prospective Review or a post-service Medical 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 care services do not require a prospective review or a medical review unless otherwise indicated on the web site, AND/OR
- Language will be associated with each and every care service indicating whether or not a prospective review and/or a medical review is required.

2. Requesting a Prospective Review (pre-authorization and other pre-service medical reviews)

As described in sections B.1.b.ii - iv above, the web site will identify those services that require a pre-authorization request and those services for which a medical necessity review can be requested prior to the service.

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 and provide the associated processing timeframe, as appropriate:

Note: Processing of a Pre-Service Medical Necessity Review request will be the same as processing for the ‘Pre-Service’ type of Pre-Authorization request.

i. As part of the request process, request can be identified as Pre-Authorization or Medical Necessity Review

ii. All Pre-Authorization request types should be consistent with those defined in the BPR - Standard Notification Timeframe for PA Requests and contained in the Appendix.

iii. The following types of Pre-Authorization 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

iv. If the provider can choose from more than one type of Pre-Authorization request options (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.

v. Provide the health plan’s standard timeframe for processing the type of prospective review request that was made. This timeframe can be made available at any one of the following points in the process

a. Upon provider selection of a request type

b. Upon provider submission of the request, OR

c. Along with reference number associated with the request that is electronically made available to the provider.
Note: The timeframe assumes that the provider supplies all necessary information according to the schedule outlined in the BPR - Standard Notification Timeframe for PA Requests

vi. In some cases, the request may consist of a set of clinical questions that can be answered interactively on the website. These questions may be in addition to, or in place of, a prospective review 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 care service(s) for which a prospective review is being requested,

- Diagnosis/Procedure information
  Web forms/interactions should allow providers to enter those diagnoses and/or procedures that are related to care services for which a prospective review is being requested. 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.

- Clinical information
  The web forms/interactions may include a series of questions about clinical information related to the service that must be provided as part of the prospective review process. For required questions about clinical information (i.e. those that must be answered), the web form/interaction must either offer check list selection of appropriate clinical information or allow providers to submit ALL clinical information relevant to the specific request for services, and cannot restrict provider from sending this relevant information.

- Provider Administered Medication information
  For Provider Administered Medications, a code and description will be required to be submitted.

- Restrictions
  If authorization will be dependent upon some restriction, e.g. care setting in which the service takes place, type of organization/provider administering the medication, etc., the web/form interaction must include a question about that restriction with a check list of those responses for which an authorization will be considered.
• Excluded Benefit information  

(per WAC 284-43-2050, the implementation date for this capability is November 1, 2019.)

As part of pre-service review processing and website reporting, health plans will determine and report whether the entered service is an excluded benefit. (Diagnosis codes will need to be evaluated in order to make this determination.)

When a patient specific, pre-service review is requested on the website for a service that the health plan determines is excluded, the website will indicate that a review will not be performed because the service is either: a) a plan benefit exclusion or b) investigational/experimental. This information may be provided at the time the request is made (if the health plan has that capability) or as status (if the health plan doesn’t have the ability to provide the information at the time the request is made).

If the website can determine, at the time the request is submitted, that the request is for a contractually excluded service, it will ask if a denial notice is being requested. If the provider requests a denial notice, the notice will be produced in accordance with current operating procedures at the health plan. (Per NCQA UM Standards 4 and 7, a health plan must provide a denial notice if it was requested.)

The website may ask the provider whether the service/item requested is considered experimental/investigational.

d. Submit the request

• If the request/notification cannot be submitted electronically - either because the website 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.

• No provider signature will be required for the pre-authorization request. Signatures may still be required on internal documentation of the delivery of the Provider Administered Medication to the patient.

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:

Note: As noted in #B.2.b. above, processing of a Pre-Service Medical Necessity Review request will be the same as processing for the ‘Pre-Service’ type of Pre-Authorization request.

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. Provide status information on all prospective review requests regardless of how they were submitted, e.g. electronic, fax, mail, phone. If the request was submitted via the web site or the X12 278 transaction or was faxed or submitted by phone within 1 business day after any web site “downtime”, the status information must be provided on the web site. The minimum set of status information to be reported for a request is outlined in the following table.

The web site may or may not use the exact wording for the ‘Statuses’ listed below, but will provide the level of status information detailed in the table. When the exact Status word isn’t used, the status will be displayed along with the meaning of that status and the Additional Information listed in the table below that is relevant to that status.

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested</td>
<td>A prospective review has been requested by the provider organization and received by the health plan</td>
<td>Rationale;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not Covered - Benefit is Contract Exclusion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not Covered - Service is Experimental/Investigational</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No Pre or Post Service review required</td>
</tr>
<tr>
<td>No Review</td>
<td>A prospective review request has been received but will not be performed by the health plan</td>
<td>Note: this status does not need to be associated with the request if this information is provided at the time the</td>
</tr>
<tr>
<td>Status</td>
<td>Description</td>
<td>Additional Information</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provider Makes Request</td>
<td>The provider makes the request.</td>
<td></td>
</tr>
<tr>
<td>In Review</td>
<td>The prospective review request is being reviewed by the health plan.</td>
<td></td>
</tr>
<tr>
<td>Withdrawn</td>
<td>The prospective review request has been withdrawn by the requesting party, either provider or member.</td>
<td></td>
</tr>
<tr>
<td>Additional Information Requested</td>
<td>The prospective review request has been pended by the health plan awaiting additional clinical information from provider/vendor</td>
<td>Information needed by the health plan in order to make the decision. Either the information needs to be listed or a phone number given for where the provider can get the information.</td>
</tr>
<tr>
<td>Partial Denial</td>
<td>The prospective review request has been partially approved by the health plan and some services have been denied</td>
<td>Authorization number and related information</td>
</tr>
<tr>
<td>Approved</td>
<td>The prospective review request has been approved by the health plan.</td>
<td>Authorization number and related information</td>
</tr>
<tr>
<td>Denied</td>
<td>The prospective review request has been denied by the health plan.</td>
<td>Reason for denial and next steps pertaining to providers action (the next steps should outline the general options available to the provider – similar to what is typically put in the denial letter)</td>
</tr>
</tbody>
</table>

*1 If information is needed from the requesting provider in order to make the authorization decision, that information will be identified as specifically as possible. The information must include the date by which the information needs to be submitted and the consequences if not submitted by that date.

*2 Authorization number(s) as appropriate to the health plan, duration of authorization, information about any authorization limitation, e.g. care setting in which the service need to take place.

For Provider Administered Medications the following information will also be available on the web site:

- Units approved
- Dosage
- Route, e.g. IV, Subq, IV push, IV infusion, IM, PO
- Frequency
- Duration
• Typically the administration of the medication will be included in the authorization. If not, the information will indicate that the administration is not authorized.

• Type of rendering provider

• Site of Care / Place of service; e.g. Outpatient, Inpatient, Private Office, Home, Infusion center (as separate from hospital outpatient, i.e., private infusion center), Pharmacy

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.

The health plan’s web site will reflect the most current status of the request as of midnight of the day that a status change occurred.

5. Posting Updates to Medical Policies

Health plans periodically update their Medical Policies/Clinical Guidelines and most notify providers about these updates through Newsletters/Bulletins/Communications.

To provide ongoing transparency, historical reference to Medical Policy updates shall be made available to providers for at least a 12 month cycle. These updates shall be posted on the health plan’s web sites; either directly on a web page, in a web-based tool, or via a web-page linked document or series of documents, e.g. Newsletters/Bulletins/Communications.

At a minimum this Medical Policy update information will reflect:

• The name/number of the Medical Policy being updated

• The latest date of change for that Medical Policy,

• A synopsis of the change[s] made to the Medical Policy,

• Reference to the medical policy, either by way of a direct URL/web-link or directions to location on the health plan’s website.

This information will also be maintained in the Pre-Service Directory within a Composite Health Plan List and in the “Changes to Medical Policy and/or Payment Policies” data element for the health plan. The List and Data Element will contain the most direct website URL where the Medical Policy update information can be found along with any clarifying instructions, if/as necessary, for how to find that information from the URL.
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, they will have the following functionality:

1. **Access to the Admission Notification Policy via the Pre-Service Directory on the OHP site.**

   The Admission Notification Policy will be specific to the lowest level that the requirements vary, whether that be for a patient, an insured group or a health plan product. In other words, if the Admission Notification Policy is provided on the web site at the group or product level, those requirements needs to apply, without exception, to all patients in that group or with that product.

   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 the table under #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. **Electronically notifying about admission & discharge**

   a. Health plans will provide a method for electronic submission of admission/discharge notifications. Depending upon the hospital’s capability, these notifications can take the form of single patient admission/discharge or a daily census that includes the day’s admissions/ discharges. In either case,
health plans would only receive notifications for those patients 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 or discharge. (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 notifications and follow-up phone calls from the health plan:

<table>
<thead>
<tr>
<th>Data Elements</th>
<th>Definition/Comment (as necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facility Information</strong></td>
<td></td>
</tr>
<tr>
<td>o Name of Facility</td>
<td></td>
</tr>
<tr>
<td>o Facility Tax ID</td>
<td>Tax ID specific to the facility where the patient is located</td>
</tr>
<tr>
<td>o Facility NPI</td>
<td></td>
</tr>
<tr>
<td>o Facility Address</td>
<td>Physical location of the facility where the patient is located</td>
</tr>
<tr>
<td>o Facility City</td>
<td></td>
</tr>
<tr>
<td>o Facility State</td>
<td></td>
</tr>
<tr>
<td>o Facility zip</td>
<td></td>
</tr>
<tr>
<td>o Contact Person/Department</td>
<td></td>
</tr>
<tr>
<td>o Contact Phone number</td>
<td></td>
</tr>
<tr>
<td>o Contact Fax number</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Information</strong></td>
<td></td>
</tr>
<tr>
<td>o Name</td>
<td></td>
</tr>
<tr>
<td>o Date of Birth</td>
<td></td>
</tr>
<tr>
<td>o Facility’s Patient Identifying Number</td>
<td>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.</td>
</tr>
<tr>
<td>o Home Phone number</td>
<td></td>
</tr>
<tr>
<td><strong>Health Plan Information (for each coverage)</strong></td>
<td></td>
</tr>
<tr>
<td>o Health Plan Name</td>
<td></td>
</tr>
<tr>
<td>o Health Plan Identifying Member Number</td>
<td></td>
</tr>
<tr>
<td>o Coverage Order Responsibility</td>
<td>Primary, Secondary, Tertiary, etc – based on order in the file</td>
</tr>
<tr>
<td><strong>Admission/Discharge Information</strong></td>
<td></td>
</tr>
<tr>
<td>o Admission DateTime</td>
<td>Merged date-time field</td>
</tr>
<tr>
<td>o Attending Doctor Name</td>
<td></td>
</tr>
<tr>
<td>o Admitting Doctor Name</td>
<td></td>
</tr>
<tr>
<td>o Type of Admit</td>
<td>The anticipated bill type, at the time of notification, for this visit, e.g. Inpatient, Observation, ER, ICU, etc.</td>
</tr>
<tr>
<td>o Clinical Service Type</td>
<td>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</td>
</tr>
<tr>
<td>o Admission Source</td>
<td>The way in which the patient was admitted, e.g. scheduled, urgent, from ER, from Outpatient Clinic, etc.</td>
</tr>
<tr>
<td>o Reason and/or Diagnosis for Admit</td>
<td>Description and/or code that indicates why the patient was admitted</td>
</tr>
<tr>
<td>o Procedure Description/Codes</td>
<td>Description and/or code that indicates procedure(s) to be done</td>
</tr>
<tr>
<td>Data Elements</td>
<td>Definition/Comment (as necessary)</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>o Estimated Length of Stay</td>
<td></td>
</tr>
<tr>
<td>o Discharge Date Time</td>
<td>Merged date-time field</td>
</tr>
<tr>
<td>o Discharge Disposition</td>
<td>Where the patient will be going after discharge. Standard coded values</td>
</tr>
</tbody>
</table>

The following criteria will be used for evaluating whether an additional data element should be added:

i. A compelling reason will be presented by the requesting health plan for why the notification should require this field

ii. A majority of hospital systems will be able to send the information

iii. Adding the field as required will make sense to a majority of health plans that do electronic notification

Decisions about updating the data set will be made once a year and 6 months following a favorable decision will be allowed to implement.

c. Health plans will 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.

e. Health plans will confirm notification of electronic submission, if payment for services depends upon admission notification.

Providers need electronic confirmation that each patient’s admission notifications was received, so that they can take appropriate action to manually notify the health plan for any patient notification that was not received. These confirmations of receipt need to:

- Be available from the health plan in sufficient time so that, in the case of non-receipt, the provider can still give manual notification of the admission within the timeframe specified in the health plan’s admission notification policy.
- Contain sufficient information for the provider to use at a later point in time to confirm with the health plan that notification for that specific patient was provided

If during the processing of the admission notifications, the health plan determines that a notification is for a patient that does not have current coverage with the health plan, the health plan will notify the submitting hospital by phone, fax or an electronic method within 2 business days of receiving that patient’s admission notification. The health plan will inform hospitals of their intended notification method so that hospitals can implement it.
If the health plan begins to notice that the number of non-covered patient notifications received from a hospital is trending to more than 10% of the total number of notifications received from that hospital, they will contact the hospital so that the health plan and hospital can work together to resolve the issue. The 2 day notification timeframe for non-covered patients will become the best practice once the error trend has been resolved.

f. Hospitals will notify about discharges

As soon as possible, and no later than 24 hours after a patient discharge, the hospital will electronically submit a discharge notification to the appropriate health plan(s). The notification will have the discharge date-time field completed.

If a hospital determines that a discharge notification was submitted to a health plan in error, they will notify the health plan by phone, fax or an electronic method. Health plans will identify to the hospital the contact to notify if/when an erroneous discharge occurs.

Providers

Providers may have automated methods in place that are more efficient than the browser-based capabilities listed above. 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. Access Prospective Review information for a service and/or admission notification information -- 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. 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.
   b. Have all information necessary to make the request. For Provider Administered Medications this will include a code and drug name, prescribed dosage, route, frequency and duration and diagnosis code. Chart notes with clear documentation are also necessary in the following scenarios:
      • the medication requires trial of prior therapies as indicated in the authorization criteria, or
• the medication requires a specific result on a diagnostic test (e.g., Herceptin or Perjeta may require a specific positive report -path report or lab, e.g., HER2 status)
• the request is for a diagnosis not listed in the authorization criteria

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.

If admission notifications are required by the health plan, providers will submit them electronically – using the health plan’s electronic 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 it's entirely from the 'Definitions' section of the BPR-Standard Notification Timeframes for Pre-Authorization Requests.

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 (aka ‘Expedited’ for Medicare and for WAC 284-43-0160(10))** - 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.
   
   Note: WAC 284-43-0160 (37) refers to this as a ‘Standard Prior Authorization Request’

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.
# Pre-Service Directory

## Business Requirements

<table>
<thead>
<tr>
<th>Business Requirement</th>
<th>Implementation Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Using the Pre-Service Directory and the health plan websites will be easier than getting the same information by phone call</td>
<td></td>
</tr>
<tr>
<td>2. The Pre-Service Directory will be designed for frequent usage by a knowledgeable user but will support a first time user</td>
<td>Ideally no help text would be needed for usage. Instruction text should be available to a novice but not get in the way of an experienced user</td>
</tr>
</tbody>
</table>
| 3. For each health plan, the Pre-Service Directory will have five major categories of Services:  
   * See category definitions below*  
   * Advanced Imaging  
   * Behavioral/Mental Health  
   * General Pharmacy (see #5 below)  
   * Provider Administered Medications  
   * Visit/Services/Procedures | Providers need to know the Pre-Service Directory site(s) is different than the health plan web site, it is not a mistake or accident. |
|                                                                                     | Each category will clearly indicate whether the utilization management is being provided directly by the health plan or is ‘carved out’ and provided by a vendor. |
|                                                                                     | If/As a health plan carves out other services, e.g. Cardiology, Oncology, etc., these will be added as sub categories of services under the appropriate Service category and will be designated as “carved out”. |
| 4. *Per the BPR (A.3 page 6-7)*, contact information for functional help and for web site help for each category and sub-category of services will be available on the Pre-Service Directory. | For a particular health plan, contact information associated with multiple categories and sub-categories of services may be the exact same or may be different, depending upon whether or not the service is “carved out”. |
| 5. A minimum set of links will be associated with each of the categories/sub-categories of services.  
   * See link definitions below*  
   * If a health plan has multiple Pharmacy Benefit Managers (PBM), clicking on the General Pharmacy category will provide instructions for how the provider can access the prospective review requirements for the PBM that is appropriate for the patient. | For a particular health plan, the links associated with multiple category of services may go to the exact same page on the health plan web site, e.g. the links for Visits/Services/Procedures and Advanced imaging may go to the same site or one may go to the health plan’s site and the other may go to a vendor’s site for “carved out” services. |
<p>|                                                                                     | The links are navigation aids leading to a page on the health plan’s site. Health plan specific information and functions will only be hosted on that health plan’s site, e.g. Accessing member specific information (i.e. eligibility, professional restrictions, site of care, etc.) will only be done on the health plan’s site. |
| 6. Links &amp; associated instructions will provide access to the appropriate page on a health plan website where corresponding information can be found and/or an appropriate function can be performed. OHP login (or payor web site login) will be required to access secure information on a health plan’s site. |                                                                                               |</p>
<table>
<thead>
<tr>
<th>Business Requirement</th>
<th>Implementation Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Links will use an agreed upon naming convention that will bridge to the appropriate page on the health plan site, regardless of any health plan specific name for that type of information or function.</td>
<td>Different health plans might use a different name for the same basic information or function.</td>
</tr>
<tr>
<td>Clicking on a link will open a new browser window</td>
<td>A new browser window will maintain provider workflow.</td>
</tr>
<tr>
<td>The Pre-Service Directory will have the ability for a user to report when a link to a health plan site is not functioning. Once the non-function of the link is verified, the respective health plan will be contacted to request that the link be updated. All updates will be reflected on a Weekly Change Report</td>
<td>Some organization, likely OHP, will need to periodically verify the functioning of all links and respond to provider notifications about non-functional links.</td>
</tr>
</tbody>
</table>

**Definitions for Categories**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Imaging</td>
<td>Services related to radiological studies</td>
</tr>
<tr>
<td>Behavioral/Mental Health</td>
<td>Services addressing the behavior and/or mental health of a patient</td>
</tr>
<tr>
<td>General Pharmacy</td>
<td>Medications covered under a member’s pharmacy benefit</td>
</tr>
<tr>
<td>Provider Administered Medications</td>
<td>Medications &amp; Administration Services covered under a member’s medical benefit</td>
</tr>
<tr>
<td>Visits/Services/Procedure</td>
<td>Services, not listed above, covered under a member’s medical benefit</td>
</tr>
</tbody>
</table>

**Links for Pre-Service Directory**

<table>
<thead>
<tr>
<th>Pre-Service Directory Link Name</th>
<th>Information Accessed via the Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Policies / Clinical Guidelines</td>
<td>Information related to the written screens, decision rules, medical protocols, or guidelines used by the health plan as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.</td>
</tr>
<tr>
<td>Excluded and Non-Covered Services</td>
<td>Services that are excluded from coverage or are generally not covered. These are not member benefit exclusion.</td>
</tr>
<tr>
<td>Services Requiring Pre-</td>
<td>Services that are covered benefits and require a pre-authorization.</td>
</tr>
<tr>
<td>Pre-Service Directory Link Name</td>
<td>Information Accessed via the Link</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Authorization</td>
<td>Includes information about any coverage restrictions for those services, e.g. site of care/place of service? This will include specialty pharmacy specific restrictions if/as appropriate.</td>
</tr>
<tr>
<td>Medical Necessity Review Requirements</td>
<td>Services that are covered benefits, don’t require a pre-authorization but do require a medical necessity review prior to payment</td>
</tr>
<tr>
<td>Pre-Service Request On-line Submission</td>
<td>Interactive form and/or process that the provider would complete and submit when requesting a pre-service review</td>
</tr>
<tr>
<td>Pre-Service Request Status Inquiry</td>
<td>Interactive process for obtaining status information about a submitted pre-service request</td>
</tr>
<tr>
<td>Unlisted Procedure Processing</td>
<td>Health plan’s process and supporting documentation requirements related to Unlisted Procedures</td>
</tr>
</tbody>
</table>