

Administrative Simplification

A program of the Washington Healthcare Forum
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Best Practice Recommendation for

Standard Notification Timeframes for Pre-Authorization Requests

Version 4.5

Version	
Issue Date	Explanation
04/14/2009	Version 1.0 /Rev 031909a
09/02/2009	Amended for Immediate Requests & misc. edits
04/28/2010	Amended to clarify distinction between making decision information available and notification of denial (pg 6)
06/07/2010	Amended to add "and no change in patient condition has occurred" to the first situation that is not considered Immediate. (pg 5)
12/01/2010	Per Dept of Labor rules, providers need to be notified by phone and in writing in case of urgent, adverse decision (page 6)
12/16/2010	Remove note about dependency on WAC change. Minor Formatting
04-04-2012	Clarification Urgent Pre-Service can be titled Urgent Pre-Service (aka 'Expedited) for Medicare (pg 5,8)
11-20-2014	Clarification <ul style="list-style-type: none"> • How days are counted (pg 5) • Urgent Pre-Service timeframe if no information is needed from provider (pg 8)
05-10-2015	<ul style="list-style-type: none"> • Applicable only to UR decisions • Decision Notification (pg 4-5) • Supplemental Review (pg 10-12)
06-15-2015	Refine definition of Concurrent Urgent requests so that it doesn't include outpatient services

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BEST PRACTICE RECOMMENDATION

Topic: Standard Notification Timeframes for Pre-Authorization Requests

Improvement Opportunity:

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

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

Summary of Recommendation:

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

Applicability:

This Best Practice Recommendation only applies in those situations when a health plan **requires** that a provider obtain a Utilization Review-based prior authorization for treatment in order for the related claim to pay according to the member's benefits. This BPR **does not call for health plans to require** Utilization Review-based authorization as a pre-condition of claims payment and these timeframes do not apply when health plans are providing medical review information as a service when requesting a pre-authorization is optional.

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.

Definitions:

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

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

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

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

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

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

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

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

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

Timeframes for Responding to Requests:

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

Considerations:

- The timeframes outlined below relate to the processing of pre-authorization requests and are NOT RELATED to the processing of claims.
- Unless otherwise specified, the timeframes are calendar days and not business days
- A day is counted regardless of the time when the request is received by the health plan or when the provider is notified of a decision. For example, day 1 and day 14 conclude at midnight whether the request was received at 7:00 AM or 11:00 PM on the first day.
- Decision Notification timeframes include making information about the decision available to the provider(s) and member, as described below:
 - For all requests:

Status information, i.e. whether a request is approved, denied, etc., should be available on the health plan's web site within the timeframes specified below, depending upon the type of request (See BPR-Browser Capabilities for more information about display of status information for all requests)
 - For requests with an adverse determination, i.e. when a request is denied or when requested services are not approved in full:

In addition to status information being posted on the health plan web site as referenced above, adverse determination notification should also occur.

All adverse determination notifications should contain the following information: a) the rationale for the decision, e.g. clinical criteria(s) that was not met, intervention(s) that was not taken, information that was not submitted, etc. b) the next step(s) in the course of treatment specified in the medical policy that was not taken (as appropriate), and c) next step(s) that can be taken by the provider if they don't agree with the decision of the health plan)

Ideally, and by January 1, 2017 at the latest, adverse determination information should be posted, within the notification timeframes specified below, on the health plan's web site in a manner that complies with HIPAA privacy requirements, AND

- For 'Urgent Pre-Service Requests' only, upon completion of the determination, the health plan will notify the provider of the outcome of the request. Notification may be made by phone, fax, or secure email. Additionally, the notification can include instructions to access the website for supporting information about the determination.
- The adverse determination information will be available to the ordering physician/ordering facility. The notification fax/secure email will be sent to the person/office that submitted the request.
- Posting of the adverse determination information on the health plan's web site will be archived as part of the status history for the related pre-authorization request.

Note: Health plans will document and post on their web their notification protocol in the case of web site downtime.

Until the health plan makes the adverse determination information available on its web site, the health plan will send the adverse determination information by fax and/or secure email, within the notification timeframes specified below, to the person/office that submitted the request.

In all cases of adverse determination, the member will be notified in writing by the health plan.

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

1. *Immediate Requests*

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

Notes:

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

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

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

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

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

- b. The health plan will make a decision about the Immediate Request within 60 minutes, or a mutually agreeable timeframe, once clinical information has been provided.
- The practitioner (or their designee) will give specific information about the situation and the service(s) being requested. If a test is being requested to determine the need for immediate treatment, the potential treatment should be included as part of the request. (This will eliminate the need for multiple Immediate Requests if the test indicates that treatment is necessary.)
 - The health plan will determine if the request meets the criteria of an Immediate Request. If it doesn't meet the criteria, the provider will be informed of the appropriate process to use.
 - For many patient situations, the health plan may want to speak directly to a practitioner within the provider office, e.g. an LPN, RN or MD and/or may want to involve a practitioner within the health plan. A practitioner in the provider office should be available when requesting an Immediate Pre-Authorization.
 - In those situations when a practitioner is not available and the practitioner's designee cannot provide sufficient information on the phone, the health plan may request a fax copy of chart notes that contains supporting information. The nature and type of supporting information will depend upon the patient condition and the service requested. If fax notes are sent, the provider must call the health plan back after the notes are sent to confirm that the notes were received and that sufficient information is provided.
 - If a decision cannot be made within the course of the call, the health plan and practitioner will make themselves available for another phone call within 60 minutes, or at a mutually agreed upon time.
- c. The decision made by the health plan will be one of the following:
- The requested service is authorized
 - The health plan will process the request as an Urgent Pre-Service Request (see #2 below). Reasons for this decision include:
 - This request does not meet the criteria for Immediate Request.
 - More information is needed to make a determination (i.e. results of a test or another opinion)
 - The requested service is denied

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

(References: *NCQA* - UM 5,A,2 *URAC* - UM 17a *ERISA* 2560.503-1 f.2.i)

If no information is needed from the patient or prescriber, decision notification will be within 48 hours of receiving the request.

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

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

3. *Concurrent Urgent Requests* -- This category only applies to requests for an extension of a previously authorized hospital stay.

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

The request needs to be received by the health plan at least 24 hours prior to expiration of the previously authorized hospital stay.

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

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

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

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

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

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

Best Practice Recommended Timeframe

Decision Notification - within 14 calendar days of receiving the request

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

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

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

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

- a. Make a decision, or
- b. Request additional documentation from the provider or member, as appropriate. The provider will respond to that request with the appropriate information within 5 calendar days. Upon receipt of all needed information, the health plan will make a final determination in no later than 4 calendar days. If a health plan has not received the requested information by calendar day 14, the health plan will have the option of denying the request or pending the request for a period not to exceed 45 days, from the date the provider received notification that additional information is required. In either case, denial or pend, the health plan will notify the member.

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

Industry Standard Timeframe

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

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

Best Practice Recommended Timeframe

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

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

Supplemental Review:

A supplemental review is may no longer be possible once a peer-2-peer review has been completed or after an appeal has been initiated.

Intent:

The intent of a Supplemental Review is for a health plan to possibly re-consider an adverse determination when appropriate supporting documentation was either not submitted by the provider, was deemed inadequate to make a determination, or was previously overlooked by the reviewing health plan.

A Supplemental Review is NOT appropriate when a determination was issued by the health plan and:

- The service(s) that were denied are not covered under the member's plan.
- No supporting information was overlooked or
- No new information is sent, or

- New information is not relevant to the case or
- Information is not received from the provider within the timeframes specified below

A Supplemental Review DOES NOT change the provider's or member's opportunity to appeal an adverse determination. Appeal rights are outlined in the provider and member contracts and may be plan specific. These appeal rights will remain intact and are separate from a plan's defined Supplemental Review process. A Supplemental Review may eliminate the need for an appeal or may expedite an approval/overturn if an appeal has already been initiated and the above requirements for a supplemental review are met.

Process:

Upon an adverse determination notification by the health plan, i.e. when any of the above authorization requests are denied or not approved in full, AND the requesting provider, within the initiation timeframes outlined below and prior to a claim being submitted, . . .

- a) Submits required information in support of the request that was available but not included with the initially submitted clinical documentation that was reviewed by the health plan,
OR
- b) Makes the health plan aware that the initially submitted clinical documentation contains required information that was missed/overlooked by the health plan and the health plan's internal review confirms that the information is present and was not taken into consideration when the determination was made

. . . The health plan will re-evaluate the request in light of the additional information.

A signature of the member or any other documentation from the member will not be required to initiate a Supplemental Review

If a provider initiates the Supplemental Review by contacting the health plan by phone, they may still be requested to supply specific documentation in support of the verbal explanation in order for the adverse determination to be reversed.

Once a supplemental review has been requested and/or additional information has been supplied, the health plan will complete the review and notify the provider in the timeframes outlined below. As a minimum, notification will include:

- If an adverse determination was reversed, updating any/all relevant status and adverse determination information that may be posted on the health plan's web site.
- If an adverse determination was not reversed, either updating the web site to indicate that an additional action has been taken since the adverse determination OR notifying the provider by phone, fax or secure email that the supplemental review has been concluded.

Provider Initiation and Health Plan Notification timeframes:

Type of Request	Provider Initiation (after adverse determination notification)	Health Plan Notification (after Provider Initiation)
Urgent Pre-Service	48 hours	48 hours
Concurrent Urgent	24 hours	24 hours
Non-Urgent Pre-Service & Concurrent	5 calendar days	4 calendar days

Recommended Best Practices:

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

Provider

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

Health Plan

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