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Best Practice Recommendation for

*Browser Capabilities for Pre-Authorization
& Admission Notification*

Version	
Issue Date	Explanation
04/14/2009	Version 1.0
08/26/2009	Amended
02/08/2010	Amended for clarification purposes: 1. Acknowledgement of receipt (page 7) will only be for electronically submitted forms 2. Status Information and to whom it will be available (page 7) is more clearly defined
04/28/2010	Amended for clarification purposes: 1. This BPR does not apply <i>to services that are covered under a member's pharmacy benefit</i> (page 4) 2. Browser based access to status information about a pre-auth request will be provided <i>regardless of how the request was submitted, e.g. fax, mail, electronic.</i> (page 7)
06/07/2010	Amended to clarify that web sites should address the situation when a prospective review is not required (page 6 section d)
06/15/2010	Amended for clarification purposes: 1. This BPR does apply to mental health and chemical dependency services (page 4) 2. How to address carve-outs on the web site (page 6 section c)

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BEST PRACTICE RECOMMENDATION

Topic: Browser Capabilities for Pre-Authorization & Admission Notification

Notes:

- *Browser Capabilities are intended to be in addition to the use of the 278 Health Care Service Review transaction as required by HIPAA.*
- *Most health plans perform clinical necessity review for a subset of the services for which they provide coverage. Some health plans **require** that providers request the review prior to delivery of those services, e.g. Pre-Authorization. Other health plans give providers **the option** of requesting the review prior to delivery of those services, e.g. Benefit Advisory. Both of these situations are considered forms of Prospective Review. The recommended practices outlined in this document apply to all Prospective Review situations (required and optional). However, this document **does not** call for health plans to change whether a request for this review by providers is required or optional prior to service delivery.*

Improvement Opportunity:

Health plans have differing pre-authorization, benefit advisory and admission notification requirements. These differing requirements create training and logistical complexity for providers, as their staff tries to keep track of the various requirements and the different methods of communicating the information.

This document outlines a set of recommended best practices for using ‘browser-based’ capabilities to simplify the pre-authorization, benefit advisory and admission notification processes.

Summary of Recommendation:

Health plans that require pre-authorization or admission notification will make interactive, browser-based capabilities available to providers to do the following;

- 1) Determine if a pre-authorization and/or admission notification is required for a healthcare service
- 2) Submit preauthorization requests
- 3) Communicate authorization confirmation
- 4) Give notification of admission

Health plans that offer benefit advisory, and similar optional prospective review services, will make this information available to providers via interactive, browser-based capabilities.

Applicability

The best practices that are recommended in this document apply to all services that are covered under a member's medical benefit, including mental health and chemical dependency services. In those situations where the health plan has contracted with another organization to be responsible for prospective review and admit notification obligations for a specific set of service, i.e. "carve outs", the health plan's web site must provide information about those carved out services as described in the section of this document titled 'Best Practice Recommendations - Health Plans'.

The best practices that are recommended in this document do not apply to services that are covered under a member's pharmacy benefit, since these services are provided at a point-of-service other than a physician's office or a hospital.

All health plans and provider organizations are encouraged to adopt and appropriately implement these Best Practice Recommendations as soon as practical. Providers should check the adoption matrix located at <http://www.onehealthport.com/worksmart/wsadoptionmatrix.php> to determine which health plans have adopted these practices and when they will be fully in place. In those cases where a health plan has not adopted these practices, providers should encourage them to do so.

Background:

Different health plans have different requirements for pre-authorization, benefit advisory and admission notification. Furthermore, even within a health plan, these requirements change over time. These differing requirements create training and logistical complexity for providers, as their staff tries to keep track of the various requirements and the different methods of communicating the information.

1. For the same service, some health plans require pre-authorizations and some do not.
2. Different health plans require providers to request pre-authorizations in different ways, e.g. call in the request, fax/mail in the request using a proprietary form, submit the request on-line.

Filling out paper forms and faxing/ mailing is the most complicated of these processes. Providers must maintain a) an inventory of forms from different health plans, b) instructions for completing those forms, and c) updated information about fax numbers and mailing addresses for each health plan. After finding the

appropriate form and completing it, the provider must then determine which fax number or mailing address to use to submit the request

3. Once a decision is made, health plans communicate authorization confirmation in different ways. The confirmation can be made available via the telephone, via a web site, or via a mail/fax communication. Providers must remember how to retrieve the authorization confirmation depending upon the health plan.
4. Providers also give notification of admission in different ways depending upon health plan. In some cases the telephone is used, in other cases the fax is used. Providers must keep track of different phone numbers and fax numbers for different health plans

A common, browser-based process for exchanging pre-authorization information, benefit advisory information and notification of admission between providers and health plans would make it easier for providers. This common, browser-based method would not preclude health plans from offering additional, even more efficient methods and/or personal services for exchanging information, e.g. person-to-person telephone communication, system-to-system exchanges. However, it would establish a “lowest common denominator” method for providers to use across health plans.

Best Practice Recommendations

Health Plans

Health plans will make the following browser-based capabilities available so that their contracted providers have access to the health plan's prospective review information (whether that is pre-authorization, benefits advisory, etc.) and the health plan's admission notification information:

1. Browser-based access to up-to-date information about prospective review (e.g. pre-authorization, benefit advisory, etc.) and admission notification.
 - a. A common site(s) maintained by OneHealthPort will provide a standard way of offering at least one link per health plan for access to prospective review information and one link per health plan for access to admission notification information. (OHP explanation: we may need multiple links for some health plans because we have sites that rely on OHP to span different vendors since they do not have one single website to offer all lines of business.)
 - For the Prospective Review Links:
 - Standard naming convention: Prospective Review Information
 - Standard description convention: This is a link to the health plan web site where their Prospective Review information can be found. Prospective Review information refers to Pre-Authorization and Benefits Advisory as appropriate to the health plan.
 - For the Admit Notification Links:

- Standard naming convention: Admit Notification Policy
 - Standard description convention: This is a link to the health plan web site where their Admission Notification Policy can be found along with a web form to notify the health plan about an admission, if notification is required
 - The common site will make it clear which health plans do NOT require admit notification.
- b. Health plan web sites will provide easy access to Prospective Review information for a particular service, for a particular product. Supported web site functions will include:
- Looking up/Searching for a service by code, keyword or functional category
 - Selecting a specific health plan product(s)
 - For a selected health plan product, providing information at the appropriate level of detail to answer the following questions:
 - Do I need to do something prior to patient treatment for the claim to pay?
 - If so, what?
 - If specific clinical criteria must be met in order for the claim to be considered for payment, providing a link to related clinical guideline information
 - Providing easy access to on-line request form if a pre-authorization is required or recommended (see 2 below).
 - Provide instructions, along with fax numbers/addresses if and as appropriate, for submitting attachments.
- c. 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 service, i.e. "carve outs", the health plan's web site must provide the following information about those carved out services:
- Contact information for the responsible organization
 - Categories of services that are included in the carve out.
- d. When a service does not require a Prospective Review, the web site should inform a provider of such, in one of the following ways, as determined by the health plan:
- Language will be clearly visible on the web page specifying that services do not require a prospective review unless otherwise indicated on the web site, AND/OR
 - Language will be associated with each and every service indicating whether or not a prospective review is required.
- e. If admission notification is required, health plan web sites will provide easy access to
- Admission notification policy

- On-line notification form if notification is required or recommended (see 2 below)
2. Browser-based interaction for requesting pre-authorizations and for notifying about admission -- on each health plan's web site.

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

- Complete a request for pre-authorization and/or complete a notification of admission.
 - Interactive instructions will be available for completing each data field.
 - When requesting pre-authorizations, providers will be able to specify the request types, e.g. Immediate, Urgent, Pre-Service, etc.
 - Submit the request/notification electronically via the web site,
 - Print the request/notification and submit it via fax or surface mail (the printed version will contain the appropriate fax number and mailing address for the provider to use.)
3. Browser-based access to receipt and status information on the health plan's web site about pre-authorization requests, including:
- Acknowledgement of receipt for electronically submitted forms – including a reference number for use by the provider when inquiring about the request or for sending supporting documentation.
 - Status information on all requests regardless of how they were submitted, e.g. fax, mail, electronic. The status information will indicate whether or not the requested services will be pre-authorized as medically necessary. For those services that are requested, this information is to include status, e.g. pended, denied, approved, or other status relevant to the health plan, and confirmation number(s) as appropriate to the health plan.

This status information should be available to the provider/organization that requested the services, the provider/organization that is doing the services and, as appropriate, the facility/organization where the services are to be done.

Providers

Providers may have methods in place that are more efficient than the browser-based capabilities listed above, e.g. system generation and faxing of requests and notifications and/or auto-authorization capabilities with health plans. Where these methods are in place, providers will continue to use them.

Otherwise providers will use browser-based capabilities to access the common-OHP web site(s) and Health Plans web sites, as appropriate, in order to:

1. Determine if a pre-authorization for a service or admission notification is required -- using the common-OHP web site(s) and the appropriate health plan web site.
2. Request a pre-authorization - using the health plans' web sites:
 - a. If no attachments are required – Complete the request on-line and submit it electronically
 - b. If attachments are required
 - i. Complete the request on-line
 - ii. Check the health plan web site for instructions for sending attachments. For some health plans, attachments may be sent electronically. For other health plans, attachments may be sent via mail or fax.
3. Check on status on a pre-authorization request, including retrieving the authorization confirmation -- using the health plans' web sites.
4. If required, give notification of admission – Complete the notification and submit it electronically -- using the health plans' web sites.