Administrative Simplification

A program of the Washington Healthcare Forum
Operated by OneHealthPort

Best Practice Recommendation for

Browser Capabilities for Prospective Review & Admission Notification

Version 11

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 9) will only be for electronically submitted forms 2. Status Information and to whom it will be available (page 9) is more clearly defined
04/28/2010	Amended for clarification purposes: 1. This BPR does not apply *to services that are covered under a member's pharmacy benefit* (page 3) 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)
06/07/2010	Amended to clarify that web sites should address the situation when a prospective review is not required (page 6 section e)
06/15/2010	Amended for clarification purposes: 1. This BPR does apply to mental health and chemical dependency services (page 3) 2. How to address carve-outs on the web site (page 5)
11/02/2010	Minor wordsmithing Reformatting of document - Amended for clarification 1. The OHP page must contain • A contact telephone number for help with web navigation (page 5) • Web site link for 'carve out' benefits (page 5) 2. A prospective review request may done via a form and/or interactive clinical questions (pages 6-7) 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)

Version	
Issue Date	**Explanation**
02/07/11	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)
02/23/11	Added an Appendix the outlines Implementation Staging recommendation endorsed by work group on Jan, 27, 2011 (pg 17-18)
06/01/11	• Reformatting to distinguish between prospective review requirements and admission notification requirements • Clarify practices for specifying services on a prospective review request (pg 7-8)
06/22/11	• Define electronic and fax-based practices for requesting prospective reviews (pg 6-9)
08/23/11	• 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)
09/29/11	Clarification Change “provide” to “post on their web site” (pg 9)
11/07/11	Updated the Appendix to outline the OIC approved completion dates for all capabilities outlined in the BPR (pg 17-18)
02/27/12	Update – Providers will first refer to web site before calling (pg 4)
04/04/12	Clarification Urgent Pre-Service can be titled Urgent Pre-Service (aka ‘Expedited) for Medicare (pg 8,16)
05-30-2012	• Updated admit notification data set (pg. 10-

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	11) • Revised language related to posting clinical guideline information so as to cover copyright limitation (pg 6) Set an implementation date of 12/31/2012 for this capability (pg 17)
09/12/12	Clarifications about admission notification (pg 10-12) – remove misleading example, reference number needs to be on health plan web site
10/15/12	Remove Health Plan Routing ID from Admit Notification data set (pg 11)
10/30/12	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)
11/14/12	Refine admission notification requirements to be more consistent with the capabilities of a system-to-system solution. (pg 9-14)
11/19/12	Criteria to be used when evaluating whether to add a data element to admit notification data set (pg 11-12)
03/28/13	Set conditions around health plan notifying providers about receipt of non-member admission notifications and mistaken discharge notifications. (pg 12-13)
12/31/13	Enhancements to address a) pre-authorization of referrals and b) posting pre-authorization and admit notification information at lowest level that it varies.
03/19/2014	• 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

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	future. • Add Discharge Disposition to Admit-Discharge Notification Data Set (pg 13)
09-28-2015	Major Revision 8.0
03-21-2016	Language updates to be consistent with intent for broader prospective review of services, not just those where a prior authorization is required.
09-26-2016	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 3rd party, and d) a 'No Review' status with clarifying information
10-19-2016	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.
11-23-2016	Clarification about handling patient specific excluded benefits. NO recommended implementation date.
12-19-2016	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.
06-27-2017	Rename Clinical Guidelines and Medical Policies to Clinical Review Criteria to be consistent with the WAC.
11-20-2017	Added an Overarching Intent Section
04-23-2018	Significant enhancement of the Best Practice Recommendation for Supporting Documentation Requirements
10-08-18	Update to reflect change from Workflow Navigator to Pre-Service Directory
10-24-18	Added Supporting Documentation

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	requirements for Purchased Criteria
01-10-19	Transparency for medical necessity review requirements when not included as part of pre-authorization
01-16-19	Transparency update for service usually not covered that may be covered
04-22-19	Transparency of pending pre-authorization changes
06-19-19	Posting Updates to Medical Policies
09-23-19	Medicaid: Working with HCA & MCOs
09-28-20	• Change Pre-Service Directory to quick reference web site • Update pre-authorization requirements for post-stabilization / post-evaluation services • Update transparency requirements for admit notification information • Add transparency requirements for peer-2-peer process
10-29-21	Medicaid FFS & MCO: Transparency of non-covered services
07-07-22	Update to include specificity for Place(s) of Services
10-23-23	Added “Transitioning Pre-Service Review to a 3rd Party Vendor”
12-13-23	Added health plans and 3rd party vendors must provide capability for providers to request review 14-days prior to the effective date (pg 20)

Table of Contents

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 in a Place of 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 in the below 'Best Practice – Health Plan section B.1.b.i' 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 in 'Places of Service' 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.

   The term 'Place of Service' is used throughout these best practice recommendations. The definition of Place of Service is the CMS set of possible types of care locations (i.e., where care is to be delivered), e.g., office, ASC, Outpatient, Hospital, Home, etc. that may or may not have different benefit coverage or pre-authorization requirements but that can be uniquely specified for the purpose of coding and billing for a service.

2. Provider Administered Medications (aka Physician Administered Drugs) - 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 (aka Physician Administered Drugs) – 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 in a Place of 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 in a Place of 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.

Unless otherwise indicated, the Recommended Best Practices focus exclusively on the use of web-based tables/lists or interactive tools or interactive forms. The use of paper-based documents/forms is not a recommended best practice and as such it is outside of scope of any BPR and is not addressed.

The intent of the Best Practice Recommendation is to specify "what" information will be transparent on each health plan's web site. The intent is not to specify "how" that information will be displayed on the site. As such, variation in how information is displayed across health plans is likely.

Health Plans

A. Support for a quick reference web site(s), maintained by OneHealthPort, which will provide a standard way of accessing pre-service information. (https://www.onehealthport.com/health-plan-pre-service-information)

   That 'Health Plan Pre-Service Information' site will contain

   - Pre-Service Links - Health Plans will provide the most direct website link (.url) to where their Pre-Authorization information is reported
   - Medical Policy / Guideline Updates – Health Plans will provide the most direct website link (.url) where their Medical Policy update information can be found along with any clarifying instructions, if/as necessary, for how to find that information (see page 23 below)

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

      - J code, for those medications that have a J code, AND
      - 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, in Places of Service, that are excluded from the patient's coverage plan, or
- Clearly indicate if a service, in a Place of Service, that is selected for that patient is an excluded benefit, i.e., the service is not part of the patient's coverage.

On the web site, benefit coverage information for a specific service will indicate any coverage exclusions by Place of Service. This can be done either by:

i. Listing all Places of Services that are covered, OR

ii. Listing all Places of Service that are excluded

Per WAC 284-43-2050.

"(4) Effective November 1, 2019 … the online process must provide the information required for a provider or facility to determine for an enrollee's plan for a specific service:

(a) If a service is a benefit;"

See 'Section B.2.c.Excluded Benefit Information' for description of how Excluded Benefits are to be handled as part of the Pre-Authorization request process.

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

Some payors may have benefits or services that are typically non-covered, but exceptions may be made to provide coverage for those typically non-covered services to a specific patient because the covered services are not clinically effective/appropriate services to treat the patient's condition.

For Medicaid Patients - Coverage through Medicaid Fee For Service (FFS) or Managed Care Organizations (MCO):

- The web site should:
    - Display, via a list or dynamic look-up, service codes with an indication of benefit coverage,
    - When a service code is indicated as not being covered:
        - *Coverage*: Outline the processes & requirements, specific to non-covered services, that must be followed to request authorization for coverage for these services on behalf of the patient

          Post links to any necessary forms to complete.
        - *Billing*: If other than normal claims submission is required, describe any specific instructions for billing non-covered services, e.g., Single Case Agreement (SCA) or other special processing documentation. *(Note: not all MCOs require special billing for non-covered services)*
- If the request for coverage is approved, the authorized services will be processed for payment. Payment authorization will not be rescinded at time of claim submission due to a reconsideration of medical necessity. If this happens in Medicaid FFS, providers may escalate to HCA (HCAASOOPERATIONS@HCA.WA.GOV). For claims associated with the MCOs, providers should contact the MCO and may also copy HCA at (HCAMCPROGRAMS@HCA.WA.GOV).

For other payors:

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-specific needs. Pre-authorization (includes medical necessity review) required."

iii. Is a pre-authorization required or pending, i.e., will be required at a specific date in the future?

IF NO:

When a care service does not require a Prospective Review or a post-service Medical Review, the web site will 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.

IF YES:

Finding Pre-Authorization Requirements for Services & Place of Service

1. Regardless of whether a web site uses a static table/list or an interactive tool:
    a. For all services requiring a pre-authorization, 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.
    b. For Provider Administered Medications, pre-authorization requirements will include whether or not the use of a specialty pharmacy (see below section B.1.b.vi) is required for any/all Places of Service.
    c. Pending changes to pre-authorization requirements will be transparent and finding that information should be intuitive within the health plan's web site.
        - For services that don't currently require a pre-authorization but will at a specified date in the future, the date when a pre-authorization will be required will be identified.

          For a specific service that is an existing covered benefit for the patient (and not a 'new code'), the web site will provide at least 60-days' notice before a "no pre-authorization requirement" is changed to a "pre-authorization requirement", either for that service or for that service in a specific place of service. WAC 284-170-421 (6) (a).

          If the provider scheduled a service for a patient more than 60 days before the treatment date, it is possible that the health plan may change the pre-auth requirement after the service was scheduled and before the 60-day notification requirement, As such it is the Best Practice for providers to continue to check the health plan's web site for current pre-authorization requirements and relevant pending pre-authorization within 60 days of treatment date

          There may be situations where an outside agency/ legislation/regulation directs a health plan (e.g., HCA directs MCO) to change their pre-authorization requirements in a

timeframe that does not allow the health plan to give 60-day notice of the change. In these situations, a provider may have scheduled a service at a time when a pre-authorization is not required and then, by the time the service is given, a pre-authorization is required. An extenuating circumstance would apply in this situation. (see BPR-Extenuating Circumstance – Section IV. Change in Information or Mis-Information)

- For services that currently require a pre-authorization but will no longer at a specified date in the future, the date when a pre-authorization will no longer be required will be identified

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.

2. In those cases where pre-authorization requirements for services are specified in a web site static table/list:

   a. In the header / description of the table/ list will be a statement that clearly defines that 'pre-authorization requirements for services in the table/list will be the same for all Places of Service unless otherwise specified with that service.',

      AND

   b. For each specific service in the table/list, the table/list will indicate the pre-authorization requirement(s) for that service.

      In those situations when a specific service in the table/list has different pre-authorization requirements by Place of Service,

      i. The 'default' pre-authorization requirement for that service (i.e., the requirement that applies to most if not all Places of Service) will be displayed, along with

      ii. For each Place of Service for which there is a variation from the 'default', that Place of Service and the associated pre-authorization requirement will be displayed.

      If separate pre-authorizations are required for the service and for the Place of Service, the table/list will indicate that separate pre-authorizations are required and will indicate where the provider can find the process for requesting a pre-authorization for the desired place of service

3. In those cases where pre-authorization requirements for services are specified via an interactive tool,

a. If the interaction with the tool for the specified service DOES NOT query the provider for the Place of Service, then the result of the interaction will:

   i. Clearly indicate that the pre-authorization requirement for the service is the same for all Places of Services, OR

   ii. Will indicate the pre-authorization requirements for all Places of Service

   For each Place of Service where separate pre-authorizations are required for the service and for the Place of Service, the result of the interaction will indicate that separate pre-authorizations are required and will indicate the process for requesting a pre-authorization for the Place of Service

b. If the interaction with the tool for the specified service DOES query the provider for the Place of Service, then the result of the interaction will indicate the pre-authorization requirement for the Place of Service entered by the provider.

   If separate pre-authorizations are required for the service and for the Place of Service, the result of the interaction will indicate that separate pre-authorizations are required and will indicate the process for requesting a pre-authorization for the Place of Service.

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

   Once a pre-authorization request is approved for a service in a specific Place of Service, that authorization will be honored as long as it is valid (e.g., authorization date range has not expired) The claims will pay for the authorized Place of Service regardless of any changes in pre-authorization requirements after the approval was given.

Identify when and how Peer-to-Peer discussions can be scheduled

The purpose of this process is to connect a patient's care provider with a health plan physician to discuss the denial of a requested pre-authorization. Health plans may refer to this process as "Peer-to-Peer" or by another name such as "Medical Director Call". If the health plan refers to the process as other than "Peer-to-Peer", the description "Peer-to-Peer" will be included on the web page, along with the health plan's process name, so that the provider knows that they have found the correct process on the health plan's web site.

i. Identify Conditions/Situations under which a peer-to-peer can cannot be

requested

The following are ***examples*** of possible conditions. Each health plan will list their own specific conditions, which may or may not include the below.

- Peer to peer discussion will be available when services are denied because medical treatment guidelines/criteria are not met
- Peer to peer discussions will not be available for services denied as noncovered benefits, including exceeding a benefit limitation
- Peer to peer discussion will not be available after an appeal has been requested

ii. *Identify Intent/Expectations about possible outcome of a peer-to-peer*

The intent should clearly state what the provider can expect as an outcome of the discussion.

The following are ***examples*** of possible conditions. Each health plan will list their own specific conditions which may or may be one of the below.

- The outcome will be limited to an explanation of the decision, OR
- The denial may be reversed based upon further understanding of the situation, e.g., additional relevant and supporting documentation is provided, clarification provided during peer-to-peer discussion, OR
- Other condition

iii. Give instructions to providers for requesting a peer-to-peer

Instructions will include but may not be limited to answering the following questions:

- *What is the request timeframe* for a peer-to-peer, e.g., request made within #days (business or calendar) from pre-authorization denial
- *What is the process* (for each possible depending upon type of service, e.g., pharmacy, medical, behavioral health), to include:

  <u>Scheduling the peer-to-peer</u>

  - Methods for scheduling (e.g., phone, online form, etc.)
  - How peer-to-peer discussion dates/times will be determined
  - Who will contact whom and relevant phone numbers at the time of the peer-to-peer

  <u>Participants in the discussion</u>

- Who will represent the health plan?
- Who should represent the provider?

- *What if unable to connect?*

  If the provider does not call or cannot be reached at the scheduled time,

  - What will the health plan provider do, e.g., call back again in a set time, leave a message for provider to call, etc.
  - Can the provider reschedule the peer-to-peer? <<Yes/No>> If Yes, how?

iv. 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

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)

v. Is approval of this service subject to any Professional Restriction?, 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

vi. 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?

vii. 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.

<u>Situation A</u>: 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 m edical 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.
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 Blethoplasty
    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. 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

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

If a health plan or the 3rd party vendor designated by the health plan requires or will require a provider to obtain a pre-authorization, the health plan or their 3rd Party must have the capability for the provider to request a pre-authorization, via standard methods such as an on-line system, at any time during at least a 14-day period before the effective date.

As described in sections B.1.b.ii - iii 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 web site. 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,

- Place of Service

  When requesting a pre-authorization for a service, the web form/ interaction will query the provider for the Place of Service by allowing them to select from the complete set of CMS Places of Service. The health plan will process the pre-authorization request appropriately for the specified Place of Service.

- 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., 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 web site reporting, health plans will determine and report whether the entered service in the Place of 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 web site for a service in a Place of Service that the health plan determines is excluded, the web site 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 web site can determine, at the time the request is submitted, that the request is for a contractually excluded service in a Place of 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 web request 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 web site does not support that functionality or because paper supporting documentation must be submitted with the request/notification, allow the provider to print the request/notification and submit it via fax or surface mail (the printed version of the request/notification will contain the appropriate fax number and mailing address for the provider to use.)
- If the request/notification can be submitted electronically, but the information supplied by the provider that will be used by the health plan in making a decision (e.g., answers to clinical questions) cannot be retrieved by the provider at a later point in time (e.g., for audit purposes), allow the provider to print the request/notification for their records.
- 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.

Status	Description	Additional Information
Requested	A prospective review has been requested by the provider organization and received by the health plan	
No Review	A prospective review request has been received but will not be performed by the health plan Note: this status does not need to be associated with the request if this information is provided at the time the provider makes the request.	Rationale; • Not Covered - Benefit is Contract Exclusion • Not Covered - Service is Experimental/Investigational • No Pre or Post Service review required • More information required for Unlisted Procedures
In Review	The prospective review request is being reviewed by the health plan	
Withdrawn	The prospective review request has been withdrawn by the requesting party, either provider or member	
Additional Information Requested	The prospective review request has been pended by the health plan awaiting additional clinical information from provider/vendor	Information needed by the health plan in order to make the decision [*1] Either the information needs to be listed or a phone number given for where the provider can get the information.
Partial Denial	The prospective review request has been partially approved by the health plan and some services have been denied	Authorization number and related information[*2]
Approved	The prospective review request has been approved by the health plan.	Authorization number and related information[*2]

Status	Description	Additional Information
Denied	The prospective review request has been denied by the health plan.	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)

[*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.

c. Communications about Pre-Authorization Approval

Pre-Authorization Approval Communications are those communications sent by the Health Plan to the provider to notify them of approval of a service(s) submitted on a pre-authorization request. These communications may include

letters, web portal and/or other forms of written notification compliant with WAC 284-43-2050.

For approved service(s), i.e., services that are covered and pre-authorized, the health plan's communication will indicate the service(s) that have been approval by, as a minimum, "repeating back" the information supplied by the provider about that service(s) on their pre-authorization request. The 'repeated back' information will include, but might not be limited to:

- Service Code
- Date (or Date Range) for providing the service
- Provider Information
- Place of Service

  Ideally, the communication will repeat back the approved 'Place of Service'.

  Otherwise, the communication will indicate that the Place of Service submitted by the provider is not approved and will point them to where/how they can find an approved Place of Service.

Other information that may be reported as part of the approval communication, which is broader than the BPR, might include:

- Service Codes Ranges
- Diagnosis Code Ranges
- Whether the patient or patient representative can request an exception for the Place of Service

Once a pre-authorization request is approved for a service in a specific Place of Service, that authorization will be honored as long as it is valid (e.g., authorization date range has not expired) The claims will pay for the authorized Place of Service regardless of any changes in pre-authorization requirements after the approval was given.

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 on OHP's 'Health Plan Pre-Service Information' web page within the 'Medical Policy/Guideline Update List by Health Plan.' The List 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

6. Transitioning Pre-Service Review to a 3rd Party Vendor

   a. Ability for provider to request Pre-Authorization

      If a health plan or the 3rd party vendor designated by the health plan requires or will require a provider to obtain a pre-authorization, the health plan or their 3rd Party must have the capability for the provider to request a pre-authorization, via standard methods such as an on-line system, at any time during at least a 14-day period before the effective date.

      If the third party is unable to accept pre-authorization requests and process them per WAC timeframes within 14 days of the effective date, the health plan is responsible to accept and process the requests per WAC timeframe regulations until the third party is able to do so.

   b. Provide written notification to the providers about the 3rd Party and post information on their website that indicates:

      i. The third-party vendor's name

      ii. The website where services can be submitted for review, telephone and fax numbers if applicable

      iii. Instructions for submitting review, including whether the provider will be expected to supply their providers, facility, TIN, NPI or other demographic information

      iv. The date when providers can start submitting pre-authorization review requests to the third party. (see '6.a. above)

      v. The location of training materials and instructions for submission of requests for services

vi. The location of registration instructions and materials, along with how to request training

c. Provide written notification to the providers about the service that is being delegated to the 3rd Party and post information on their website that indicates:

i. The service(s) that will require review including any related CPT/HCPC codes and diagnosis codes

ii. Any location or place of service requirement or limitation

iii. The effective date pre-authorization or pre-service review will be required for the service

iv. The location of medical policies for the service, including if the policies belong to the third party-vendor, the health plan, or another entity (e.g., purchased criteria like Milliman, Change Healthcare, etc.)

v. The medical policies for the service shall be available to the provider at the time when prior authorization requests are accepted

d. If the service being transitioned is currently being reviewed by the health plan for pre-authorization indicate:

i. Whether pre-authorizations which were previously reviewed and approved by the health plan will be honored

ii. Whether members will be notified of the change

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 a scheduled admission and any/all related procedures does not constitute an Admission Notification.

If the Health Plan requires an Admission Notification under any circumstances, i.e., admits that are scheduled and unscheduled, e.g., emergency/urgent:

1. The respective Information will be posted on the health plan web site:

d. Admission Notification Information will be specific to the lowest level that the Admission Notification requirements vary.
- Product
- Group

- Place of Service e.g., inpatient medical facility, observation, behavioral health facility, etc.
- Scheduled or unscheduled admission
- Etc.

If admission notification requirements vary by product, group, place of service, etc., separate policies will be posted.

e. Admission Notification Information will:

i. Indicate whether it applies when the coverage is primary or secondary or both

ii. Clearly state the circumstances under which an admission notification is required (whatever is required by the health plan), e.g.

- An admit notification is required for every admission, or
- An admit notification is required for every unscheduled admission and when the scheduled date of a pre-authorized admission changes

iii. Lay out the required timeframe (no less than 24 hours) for submitting notification and all required documentation that must be included with the notification. Include any policies on late submission methods due to extenuating patient circumstances allowed / not allowed.

iv. Identify acceptable methods for submitting the notification and accompanying documentation, e.g., "real time electronic system", web portal, fax, phone etc.

v. Indicate that, or under what circumstances, payment for services depends upon the admission notification, e.g., notification of discharge date is also required for the claim to pay (if/when this is relevant), and

vi. If payment for services depends upon admission notification, outline the health plan timeframe and process for making a reference # available to providers.

Note: The transparency of any/all pre-authorization requirements related to an admission, e.g., scheduled admission, post-evaluation and post-stabilization service, is addressed in section 1.b.iii (page 9) of the BPR-Browser Capabilities.

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:

Data Elements	Definition/Comment (as necessary)
Facility Information	
o Name of Facility	
o Facility Tax ID	Tax ID specific to the facility where the patient is located
o Facility NPI	
o Facility Address	Physical location of the facility where the patient is located
o Facility City	
o Facility State	
o Facility zip	
o Contact Person/Department	
o Contact Phone number	
o Contact Fax number	
Patient Information	
o Name	
o Date of Birth	
o Facility's Patient Identifying Number	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.
o Home Phone number	
Health Plan Information (for each coverage)	
o Health Plan Name	
o Health Plan Identifying Member Number	
o Coverage Order Responsibility	Primary, Secondary, Tertiary, etc. – based on order in the file
Admission/Discharge Information	
o Admission DateTime	Merged date-time field
o Attending Doctor Name	
o Admitting Doctor Name	
o Type of Admit	The anticipated bill type, at the time of notification, for this visit, e.g., Inpatient,

Data Elements	Definition/Comment (as necessary)
	Observation, ER, ICU, etc.
o Clinical Service Type	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
o Admission Source	The way in which the patient was admitted, e.g., scheduled, urgent, from ER, from Outpatient Clinic, etc.
o Reason and/or Diagnosis for Admit	Description and/or code that indicates why the patient was admitted
o Procedure Description/Codes	Description and/or code that indicates procedure(s) to be done
o Estimated Length of Stay	
o Discharge Date Time	Merged date-time field
o Discharge Disposition	Where the patient will be going after discharge. Standard coded values

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

A. Using the Browser for Pre-Service Functions

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.

4. Submitting Admission Notifications

    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.

B. Medicaid: Working with HCA & the Managed Care Organizations (MCOs)

In Washington State, patients can be eligible for one of two types of Medicaid:

- Fee-for-Service (FFS) Medicaid is the responsibility of HCA-Medicaid.
- Managed Medicaid is the responsibility of one of the Managed Care Organizations (MCOs) to which the patient is assigned. The MCOs provide this coverage per contract with HCA-Medicaid.

Patients can switch eligibility from FFS and MCO and from one MCO to another.

PreService processes are different for FFS and MCOs. Some PreService processes may be different between MCOs.

The following are similarities and differences that can be expected when working with HCA and the MCOs:

1. Adherence to the Best Practice Recommendations (BPRs)

   HCA has agreed to follow the BPRs and following them is part of the HCA-MCO contract. Providers should follow the above best practices when working with both HCA and the MCOs

2. Difference in coverage for a service

   All services that are indicated as 'C' - Covered on the HCA fee schedules are covered by FFS and by the MCOs. However, the MCO may cover a service that is indicated as 'NC' – Not Covered on the fee schedules.

   Note: Coverage does not equate to payment. A service can be covered but not paid because it isn't medically necessary.

   Per the contract between HCA and MCOs,

   a. A service covered by HCA must be covered by the MCO. In the case of a national MCO payer that has different coverage policies, Washington State coverage policy for a service should always be applied rather than a more restrictive national coverage policy. When an MCO does not cover a service that is indicated as covered on the HCA fee schedule, providers should send an email to hcamcprograms@hca.wa.gov with Attn: Section Manager - MCRA in the subject line.

   b. A service that is not covered by HCA may be covered by the MCO. Single case agreements (SCA) may not be the optimal way to address these situations. As provider organizations renegotiate their contract with the MCOs, discussions should highlight the problems with SCAs and explore alternative approaches.

3. Determination of non-coverage for a service

   If HCA does not cover a service that is covered by Medicare, the non-covered service will either be listed in a Medicaid WAC (chapter 182, especially 182-501-0070 & 182-531-0150) or the Health Technology Clinical Committee (HTCC) will typically have a non-coverage determination that specifies the substantial evidence regarding the safety, efficacy, and cost-effectiveness of the technology that supports the contrary determination, (WAC 182-55-035). However, since healthcare technology is constantly evolving there may not always be an HTCC determination.

a. FFS patient: If a service is denied for non-coverage and there is no associated Medicaid WAC or HTCC determination, use the "contact us" form on the HCA portal.

b. MCO patient: Either Medicaid WAC, a HTCC determination or an MCO medical policy / clinical guideline will exist for all services that are denied for non-coverage. If none of these exist, send an email to hcamcprograms@hca.wa.gov Attn: Section Manager - MCRA in the subject line.

4. Adhering to Primary Guidelines

   HCA encourages, but does not require, the MCOs to follow "primary guidelines", i.e., if the patient also has primary commercial coverage, the MCO should honor the primary's contract and either don't require authorizations/referrals as the secondary coverage or pay on the claims according to the primary's contract (coordinate benefits)

   If the primary payer does not authorize a service, the providers should request a Pre-Authorization from the MCO.

5. Difference in other business practice across MCOs.

   There may be situations where an MCO has a business practice that is different than the other MCOs, e.g., timeframes for enrollment of providers, coding edits, billing requirements, etc.

   The HCA contract gives the MCOs latitude to manage their book of business and as such, the MCOs can have different tools and policies. For example, an MCO's medical policy / guidelines can be less restrictive than HCAs, or an MCO may not require a pre-authorization when HCA does. If providers would like to confirm that an MCO's atypical practice is approved by HCA, they should send an email to hcamcprograms@hca.wa.gov Attn: Attn: Section Manager - MCRA in the subject line.

6. Escalation Procedures

   a. *Managed Care related*: If the issue is related to an appeal that has failed and the provider organization feels strongly that the appeal should be reversed, it can be escalated by sending a description of the issue to hcamcprograms@hca.wa.gov Attn: Section Manager - MCRA in the subject line

   b. *Managed Care related*: If the provider first contacted the MCO about an issue/question (those listed above, issues/questions about non-payment or general questions) and was unable to resolve it or get it answered, hcamcprograms@hca.wa.gov should be used. Receipt of the email will be acknowledged. The timeframe and scope of response will depend on the issue.

c. *Fee-For-Service related*: Contact-US web tool should be used for FFS related issues/questions. It is a secure form for PHI. If the information to be provided cannot fit into the free text field of the form, EITHER

- On the form, indicate that there is more information to be submitted than can fit on the form and request to be contacted, OR
- Instead of using the Contact HCA form, send the information to askmedicaid@hca.wa.gov.

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.