Administrative Simplification

Best Practice Recommendations for

Prior Authorization

Definitions
Timeframes for Responding to Requests
One-Stop-Shopping Tool
Payer Common Form Template

Version 1 – March 18, 2013

Table of Contents

A. Problem Statement/Improvement Opportunity

Vision:

To create a prior authorization administrative framework that is transparent, standard, and efficient for both payers and providers, through a collaborative work effort.

Problem Statement:

The current prior authorization environment is complex and challenging. Access, process standards, documentation, communication and requirements are inconsistent for both payers and providers.

Opportunity:

Create a common framework to efficiently obtain/administer authorizations and improve resource utilization to reduce costs and facilitate timely service and reimbursement.

B. Summary of Recommendation

Standard definitions are recommended for terms commonly used in prior authorization.

Regulatory time frames are correlated with the standard definitions to add clarity for payers and providers on which time frames are applicable by lines of business.

A One-Stop-Shopping tool is recommended on the OneHealthPort secure portal providing basic information for each payer, and links to prior authorization and admission notification areas of payer web sites.

A recommended template for a common form is provided to standardize the information routinely requested from providers.

Note: all regulation references are accurate as of the date of this version on the cover page.

C. Applicability

This Best Practice Recommendation (BPR) only applies:

In those situations when a health plan *requires* that a provider obtains a prior authorization for treatment in order for the related claim to be paid according to the member's benefits. This BPR *does not call for health plans to require* authorization as a pre-condition of claims payment and these timeframes do not apply when health plans are providing medical review information as a service, e.g. Benefit Advisory.

D. Definitions

Prior Authorization

Approval requested by a provider to a health plan in advance of a treatment plan, service, equipment or pharmaceuticals. A prior authorization request is a request to make a utilization management decision as to whether the requested service is medically necessary and/or covered under the benefit plan. In order for the request to be processed, it must be submitted with complete information; including correct coding and applicable supporting medical documentation. A prior authorization is not a guarantee of payment, subject to applicable State and Federal regulations.

Emergency

A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would: (a) place the health of the individual (and in the case of a pregnant woman, her health or that of her unborn child) in serious jeopardy, or (b) result in serious impairment to bodily functions, or (c) result in serious dysfunction of any bodily organ or part or (d) with respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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

The service had been pre-scheduled, was not **an emergency when scheduled and** no change in patient condition has occurred.

The service is for the convenience of the patient's schedule or physician's schedule.

The results of the service are not likely to lead to an immediate change in the patient's treatment.

Regular, Routine

Services that are not urgent or emergent in nature

Immediate

This definition is used by DMAP for Medicaid Fee for Service based on documented medical necessity to prevent serious harm to the patient. The request must be processed within 24 hours.

Expedited

This definition is used by Medicare. The following is from the Medicare Managed Care Manual (Rev. 105, Issued: 04-20-12):

> **CMS Medicare Managed Care Manual, Chapter 13, Section 50**
>
> (Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06)
>
> An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.
>
> Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial.

E. Timeframes for Responding to Requests

1. Considerations/Expectations:

The timeframes outlined below relate to the processing of pre-authorization requests and are NOT RELATED to the processing of claims.

Decision Notification timeframes include making information about the decision available to the provider(s) and member.

Information about whether a request was approved or denied should be available to the attending physician and/or the ordering physician and/or the facility and the covered person, either on the health plan's web site or from their call center.

The ordering physician/ordering facility and the covered person should be notified whenever there is an adverse determination, e.g. when a request is denied or when requested services are not approved in full.

Notification of the provider should be directed to person/office that submitted the request.

If requested information is not received from the provider within the timeframe specified, the request may be denied or pended.

Health plans will identify, on their web site, the guidelines/documentation that needs to be met in order for a pre-authorization request for a specific service to be approved.

Providers will submit, with the pre-authorization request, the required supporting documentation

2. Timeline for Responding to Regular, Routine Prior Authorization requests

Commercial Benefit Plans

Decision Notification: within 2 Business days of receiving the request.

Health plans and providers will share the responsibility of completing the decision and notification process within 2 business calendar days.

This BPR is based upon Oregon Revised Statutes ORS743.807 2(d):

> **743.807 Utilization review requirements for insurers offering health benefit plan.** 2(d) A provider request for prior authorization of

nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. [1997 c.343 §4; 2011 c.500 §29]

Medicare Advantage Benefit Plans

Decision notification: within 14 Calendar days of receiving request.

This BPR is based upon the Code of Federal Regulations, Title 42:

§ 422.568 Standard timeframes and notice requirements for organization determinations.

(b) *Timeframe for requests for service.* When a party has made a request for a service, the MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination. The MA organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization extends the timeframe, it must notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension.

Medicaid

Decision notification: within 14 calendar days.

This BPR is based upon Oregon Administrative Rules:

OAR 410-141-0420(6)(a)(D)

(D) For all other preauthorization requests, PHPs shall notify providers of an approval, a denial or a need for further information within 14 calendar days of receipt of the request. PHPs must make reasonable efforts to obtain the necessary information during that 14-day period. However, the PHP may use an additional 14 days to

obtain follow-up information, if the PHP justifies (to the Division upon request) the need for additional information and how the delay is in the interest of the Division member. The PHP shall make a determination as the Division member's health condition requires, but no later than the expiration of the extension.

3. Timeline for Responding to Urgent/Expedited Prior Authorization Requests

Commercial Benefit Plans – Urgent care claims

Decision Notification: within 72 hours of receiving the request.

This BPR is based upon the Code of Federal Regulations, Title 29:

2560.503 - 1 - Claims procedure.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

Medicare Advantage Benefit Plans- Expedited Prior Authorization Requests

Decision Notification: within 72 hours of receiving the request.

This BPR is based upon the Code of Federal Regulations, Title 42:

422.572 Timeframes and notice requirements for expedited organization determinations.

(a) *Timeframe.* Except as provided in paragraph (b) of this section, an MA organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, **but no later than 72 hours** after receiving the request.

(b) *Extensions*. The MA organization may extend the 72–hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization extends the deadline, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension. The MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

Medicaid

Decision notification: within 2 working days of receiving the request.

This BPR is based on Oregon Administrative Rules:

OAR 410-141-0420(6)(a)(B)

(B) PHPs shall make a determination on at least 95% of valid preauthorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in a skilled nursing facility. Preauthorization for prescription drugs must be completed and the pharmacy notified within 24 hours. If a preauthorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHP shall notify providers of such determination within 2 working days of receipt of the request;

4. Timeline for Responding to Immediate Prior Authorization Requests

Medicaid Fee for Service

Decision notification: within 24 hours of receiving the request.

An immediate request is used by DMAP for Medicaid Fee for Service based on documented medical necessity to prevent serious harm to the patient. The request must be processed within 24 hours.

F. Recommended Best Practices – Provider and Health Plan

Following are general statements of best practices that will ensure consistency:

Provider

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

Health Plan

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

G. One-Stop-Shopping Tool

Prior authorization One-Stop Shop

OneHealthPort has created an Administrative Simplification tool on its secure provider portal for Washington called “Pre-Auth/Admit Notification One-Stop-Shop”. Each health plan/payer furnishes links to their prospective review and admit notification information on their web site. OneHealthPort is prepared to add Oregon data to this site for payers doing business in Oregon.

Please review the site at http://www.onehealthport.com/worksmart/preauths.php in order to get a sense for the information that is needed from health plans. The top of that web page describes the information that is posted and the table contains information already posted by health plans.

OneHealthPort will work with the OHLC and its work groups to identify the best process for integrating information on Oregon Plans in the existing site.

BPR for Oregon

All health plans doing business in Oregon, who have not already posted data on the Washington site, should post their data to the Prior Authorization/Admit notification One-Stop-Shop on the OneHealthPort secure provider portal. Payers should work with OneHealthPort to create their listing on the site and maintain its ongoing accuracy. The goal is to have the tool operational by July 1, 2013.

H. Payer Common Form Template

Overview:

The template on the following page is recommended template for those payers that use a paper prior authorization form. This common form template includes the standard criteria and elements found in the majority of the payer forms in the market. This recommendation is a bridge to the ultimate goal of electronic prior authorization requests.

BPR Recommendation:

All payers using a paper prior authorization form should use the following template as a guide during their regular periods of updating their forms.

logo section

[PLAN MAILING ADDRESS 1
PLAN MAILING ADDRESS 2
PLAN CITY STATE ZIP]
Phone #: [(xxx) xxx-xxxx)]
Fax #: [(xxx) xxx-xxxx)]
Email:
xxxxxxxxx@xxxxxxxx.xxx

Instructions: This pre-authorization request form should be filled out by the provider requesting the service or DME. Please complete all applicable fields. Prior to completing this form, please confirm the patient's benefits and eligibility. Benefits for services received are subject to eligibility and Plan terms and conditions that are in place at the time services are provided.

Is this request Urgent? Defined as: A delay of service could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function. -Or- In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the disputed care or treatment. If this request is Urgent and meets the definition as indicated above, please check this box ☐ **Urgent Request**

Have you verified if pre-authorization is required? ☐ Yes ☐ No - *Please verify with the pre-authorization list on the [PLAN PREAUTH LIST hyperlink] or call the number on the back of the member's card.*
Is this request: ☐ New ☐ Authorization Extension ☐ Providing Additional Information
If you already have an authorization number, please list it here: _____

Section 1: Patient Information

Patient Name Last:_____ **First:**_____ **MI**___ **DOB** (MM/DD/YYYY) ____/____/_____

Patient's {PLAN NAME} Member ID #_____ **and Group Number:**_____

Patient's PCP Information (If Applicable)

Name:_____ **Phone** (_____)_____-_____ **ext.**_____ **Fax** (_____)_____-_____

Section 2: Provider Information

Please check one: You are the ☐ Requesting Provider ☐ Servicing Provider
Provider Name_____ **Tax ID Number**_____
NPI_____ **Phone** (_____)_____-_____ **Fax** (_____)_____-_____
Provider Address:_____
Who should we contact if we require additional information?
Name:_____ **Phone** (_____)_____-_____ **ext.**_____ **Fax** (_____)_____-_____

Section 3: Pre-Authorization Request

Date of service (if scheduled, MM/DD/YY)_____/_____/_____
Please check one: Outpatient Facility ☐ Inpatient Facility ☐ Office ☐ Other ☐ _____
Please check all that apply: Surgical ☐ DME ☐ Diagnostic ☐ Medical ☐ Office ☐ Other ☐ _____
Servicing or Treating Provider_____
Physical Address where services will occur:
Address:_____
City_____ **State**_____ **Zip**_____

If Inpatient:
Facility Name:
_____
Anticipated Admission (if scheduled, MM/DD/YY)
_____/_____/_____
Note: This form does not serve as a notification of admission. Please reference the Hyperlink to Plan's IP Notification instructions for instructions to notify us of an admission.

If DME:
Company Name_____
DME address_____
City_____ State_____ Zip Code_____
DME Rental ☐ Purchase ☐
Signed copy of prescription attached: ☐ Yes ☐ No
Invoice attached: ☐ Yes ☐ No

Please provide all ICD-9, CPT® or HCPCS codes and their descriptions, if available; this will help processing of your request.

ICD-9 code(s) and description(s)	CPT® or HCPCS code(s), description(s), and units or number of day requested	DME Only Line Item Cost
Primary:		$
Second:		$
Third:		$

Clinical Information / Medical Necessity (attach supporting medical records and include presenting symptoms and previous treatments):_____

Please submit the following clinical information with this form as appropriate for this request: History & Physical • Lab/Radiology/Testing Results • Current Symptoms & Functional Impairments • Treatment History • *Any other information such as chart notes that support medical necessity for the request. [Hyperlink to Plan's Medical Policy]*