

Administrative Simplification
Policy Guidelines

Simplification Area: Referrals and Prospective Reviews

Topic: Similarities and Difference in Health Plan Requirements regarding Notification

Objective: Clarify requirements for Providers & Standardize where possible

Expected Impact: *Patient* – The patient’s experience can be negatively impacted when a referral or prospective review is not completed when it is required. Scheduling of the service may be delayed and/or the patient may receive a bill.

Medical Practices – PCP/Specialist staff can spend up to 5 minutes per referral/pre-authorization determining whether a patient’s health plan needs to be notified and if an authorization is required. If they don’t check on the health plan’s policy, staff can spend 15 minutes creating a new referral and/or 30-45 minutes getting authorization only to find out that authorization is not required. On average, a small-mid size practice spends 12 hours/month determining how to process referrals/pre-authorizations for the different health plans.

Hospitals – Significant time is spent training staff about the variations across health plans in review/authorization policies and procedures. And it is almost impossible to assemble the necessary materials from the different health plans to prepare the training. 50-100 hours of staff time is typically required to follow-up and appeal claims that were denied as a result of confusion in review/authorization processing requirements. (The dollar volume of unnecessary denials is projected at \$500,000 - \$1,000,000/year depending upon size of hospital. Only some of this is recoverable.)

Health Plans – 125 hours/month of staff time is typically required to process/respond to referrals and requests for pre-authorizations that are not required.

“One stop shop” reports that define policies across health plans should:

- Reduce practitioner staff time that is currently spent trying to determine what action is required for a given health plan.
- Enable better allocation of staff to the work that is actually required by the health plans
- Reduce the number of unnecessary claim denials along with the corresponding follow-up/appeal activity and revenue loss.
- Reduce health plan staff time in responding to unnecessary requests.

Access Instructions:

Use this link to customize your own reports of referral and prospective review processing requirements by health plan.

http://www.wahealthcareforum.org/adminsimp/Referral_Review/Index.htm

- Referral Guidelines for Managed Care Products Pages 5-6 below
- Prospective Review Guidelines for all Products Pages 7-9 below
- Inpatient Stay Review for Fee-for-Service Products Page 10 below

Background:

There are many situations when providers must notify health plans about the care that is to be delivered to a health plan's member. Notification allows the health plan to confirm that the member is still eligible and that the proposed care is consistent with a member's coverage.

Notification requirements for each health plan are not well understood by providers. Furthermore, differences in terminology and notification requirements between health plans create additional confusion. Providers do not always know what information they need to communicate to which health plan and under what circumstances. Extra work, processing delays and claim denials can result.

To begin to reduce this complexity, participating health plans have agreed upon common terminology and a common framework for describing their notification requirements. This framework is a set of three policy templates that offer a 'one stop shop' of notification requirements for providers. Providers can go to one place to see what each health plan requires. The framework also provides a basis for discussion about the differences in policies between health plans. These discussions have already led to some changes in policy, in the interest of standardization. Other opportunities may arise.

Guidelines:

Three reports have been developed to describe similarities and differences in referral and prospective review requirements across health plans.

Requirement Reports	Applies When . . .	General Requirements
Referral Guidelines Coverage: Managed Care Products only	Applies when a Primary Care Provider (PCP) requests another practitioner, or facility such as a hospital, to perform services.	Typically, the health plan should be notified prior to services being rendered in order to ensure reimbursement at highest benefit level.
Prospective Review Guidelines Coverage: Managed Care and Fee-for-Service/ Indemnity Products	Applies when a treating provider (or organization) requests a Pre-Authorization or Benefit Advisory to determine if the proposed care is consistent with a health plan's medical policy/clinical review criteria. (These are typically services that are provided in/by a facility.)	In those cases when a health plan may assume payment responsibility, a request for Pre-Authorization is required prior to service delivery. In those cases when the review will help the provider to assess the probability of payment, the request for Benefit Advisory can be made pre or post care.
Inpatient Stay Review	Applies when a treating facility	Authorization from the health

Requirement Reports	Applies When . . .	General Requirements
Coverage: Fee-for Service/Indemnity Products	notifies a health plan about inpatient admission and extended stay.	plan must be received prior to admission or extended stay in order to ensure reimbursement at highest benefit level.

In each of these templates, participating health plans describe when they require some form of notification or review. Providers are encouraged to call their representative, assigned by that health plan . . .

- If they have a question about a service that is not on this list, or
- If they encounter a situation where they believe that a health plan is not following the practices as described

Referral Requests for Managed Care Products

Definition of Referral –this is the communication process where a patient’s Primary Care Provider (PCP) notifies the health plan that the patient is being referred to a specialist or a facility for a service(s) related to a health condition. Referrals apply primarily to managed care patients. Communication with a health plan is IN ADDITION to the communication that should take place between a patient’s primary care giver and a specialist. Practitioner communication is a key component of good clinical practice.

Different health plans have different requirements for referrals.

- Some health plans don’t require referrals at all, or only require them for certain services.
- Some health plans just require notification about a referral in order for the related claim to pay.
- Other health plans require that referrals be approved by them prior to service delivery in order for a related claim to pay.

Check the referral grid for requirements by health plan.

There are a variety of different terms that are used for the referral process. These terms relate to health plan specific processing steps and requirements. These terms include, but may not be limited to, **referral, referral request, referral notification, referral authorization.**

Note: There are situations where a PCP will refer a managed care patient to a specialist/facility for a service that requires pre-authorization by a health plan. Depending upon the health plan and the specific service, both a referral and a prospective review may be required. In those cases, the PCP must initiate the referral and the specialist/facility must request a pre-authorization.

Considerations in Using the Report:

1. *This report only applies to Managed Care Products.* For the purpose of this template, Managed Care Products are those that require a Primary Care Provider (PCP) to be designated for a member, in order for the member to receive the highest level of benefit. Products that do not require the designation of a PCP are considered to be Fee-for-Service/Indemnity products.
2. *This report identifies those services for which a practitioner must notify the responsible health plan by way of a referral request.* Typically, Managed Care Products require notification of the health plan when the PCP refers a patient to another practitioner or facility.

Referrals are required under the following conditions in order for benefits to be payable at the highest reimbursement level:

- The patient’s insurance coverage is a managed care products

- The service will typically be delivered by (or directly ordered by) a practitioner who is not the PCP and/or the service will be delivered in a facility other than the PCP's location.

In most cases, the Primary Care Provider (PCP) is responsible for initiating the referral notification to the appropriate health plan. However, once the PCP refers the patient to a specialist for treatment (and the health plan has received notification of this referral), requirements differ by health plan.

- **For FCHP, Molina, Premera:** the specialist can submit referral requests to the health plan for diagnostic and DME services. The specialists cannot submit referral requests to other specialists.
- **GHC:** the specialist can only submit a referral request for surgery or DME for a service that was referred to them by the PCP.
- **For Regence BlueShield:** the specialist can submit referral requests to the health plan for diagnostic and DME services. The specialists cannot submit referral requests to other specialists unless the PCP has indicated to the health plan that the specialist is to "assume management".

Some services require a referral as a pre-requisite for payment. Some services require a clinical review. Some services require both. This report identifies those services requiring a referral request. The report titled 'Prospective Review Requests for All Products' identifies those services that require a clinical review.

3. *This report does not apply in those cases where the health plan has delegated utilization management to a medical group. (Delegated medical group may have different referral request policies.)*
4. *This report may not apply in those cases when a health plan is offering administrative services to self insured groups. Each self insured group may have different referral requirements.*
5. *A referral is not a guarantee of payment, only a notification. The patient must be eligible at the time of service and benefits must apply.*
6. *Retroactive referrals, (i.e. the creation of a referral by a PCP AFTER the patient has been treated by another care provider), will be denied. The only exception is the case when an administrative delay held up the referral from being sent to the health plan prior to referral services being delivered to the patient. Even in this case, the need for a referral must have been **documented** in the patient's chart by the PCP prior to the patient being seen by referred-to care provider. In the case of administrative delay, the PCP should contact the health plan for instructions on processing a retroactive referral.*

7. *Indicate the Referring Physician on the claim.* To streamline the processing of a claim and to ensure that benefits are paid at the maximum benefit level, the referring physician should be indicated in box 17 on the HCFA 1500 and/or in box 83 on the UB92.

Prospective Review Requests for All Products

Definition of Prospective Review – the communication process where the rendering facility/provider (which may be a PCP, a specialist or a facility) asks the health plan to determine whether to-be-delivered procedures/services, a) satisfy medical review criteria, and b) are covered by the patient’s benefits. Prospective Reviews apply to all patients as described on the prospective review grid.

For certain services, some health plans require providers to request a prospective review prior to service delivery in order for the related claim to pay. Once a prospective review is completed, these health plans will guarantee payment for specified services that are delivered to a patient within a defined period of time. This type of prospective review is typically called a **pre-authorization or a prior-authorization**.

Though increasing rare, some health plans require providers to request approval for a specific number of inpatient stay days prior to patient admission in order for the related claim to pay. This type of prospective review is typically called a **pre-cert or a pre-certification**.

Other health plans will perform a prospective review upon request, but do not require providers to get a prospective review. Upon request, the health plan will tell the provider whether the services meet their medical criteria and whether the services are covered by the patient’s benefit. However, they will not guarantee payment prior to service delivery. These health plans want to make sure that the patient remains eligible for coverage at the time of service delivery. This type of prospective review is typically called a **benefits advisory**.

Note: There are situations where a PCP will refer a managed care patient to a specialist/facility for a service that requires pre-authorization by a health plan. Depending upon the health plan and the specific service, both a referral and a prospective review may be required. In those cases, the PCP must initiate the referral and the specialist/facility must request a pre-authorization.

There may be slight differences in these definitions between health plans. Feel free to check with any health plan for their specific definitions and for when pre-certifications are required.

Considerations in Using the Report:

Note: The treating provider is responsible for contacting the health plan to request a prospective review. The Primary Care Provider (PCP) should only request the prospective review if they are providing one of the services listed in the template.

1. *This report applies to ALL products -- Managed Care Products and Fee-for-Service/ Indemnity Products.* Health plans have medical policies/clinical review criteria for the procedures/conditions listed in this template. When a claim for one of these procedures is submitted, the health plan typically reviews the associated policy/criteria as part of the adjudication process. For many procedures, health plans offer prospective clinical reviews in

order to assess the appropriateness of care before it is rendered. In some cases, the prospective reviews are required as a pre-requisite for payment. The requirement for clinical review applies across all of a health plan's product lines (i.e., for Managed Care and for Fee-for-Service/Indemnity products), regardless of who performs the procedure or where the procedure is performed.

2. *This report may not apply in those cases when a health plan is offering administrative services to self-insured groups.* Each self-insured group may have different prospective review requirements.
3. *This report identifies procedures/conditions for which health plans will perform a **prospective clinical review**, before care is delivered.* In most cases, performing a prospective review will streamline the adjudication process. However, there are some circumstances (e.g., high dollar claim amount, procedure billed differently than approved, etc.) where a claim for service may be reviewed retrospectively even when a prospective review was performed.

There are two types of prospective clinical reviews that may be offered by a health plan, 'Pre-Authorization' and 'Benefit Advisory'.

- *Pre-Authorization:* A Pre-Authorization will determine whether the requested procedure/patient condition is consistent with the health plan's medical criteria AND whether the patient is eligible for the services as part of their contracted benefits. If the services meet the health plan's medical criteria and the patient is eligible for those services, the health plan assumes payment responsibility, as long as services are delivered within a specified period of time (which may vary across health plans).

For FCHP and for Regence BlueShield, the start date for a pre-authorization is the date that the authorization was given by the health plan, and the end date is the last day of the next sequential month following the start date. For example, if the start date is anytime in August 2002, the end date is September 30th, 2002. If the service cannot be performed in this timeframe, the provider should call the health plan for an extension. No additional paperwork will be required as long as the request was made before the end date.

GHC requires a referral for every service that is pre-authorized. The start date and end date of the pre-authorization will be the same as the start date and end date of the referral. Tolerance days around the referral will apply to the pre-authorization as well.

This definition of Pre-Authorization is intended to be consistent with the Patient's Bill of Rights. (Note: Self-insured groups and FEP may have a different definition of Pre-Authorization as they are not subject to Washington State Bill of Rights – also see item #2 above.)

- *Benefit Advisory:* A Benefit Advisory will determine whether the requested procedure/patient condition is consistent with the health plan's medical criteria AND is a contracted benefit. The health plan will not assume payment responsibility at the time of the Benefit Advisory, since the patient's eligibility and benefits status may be different when the

services are actually delivered. A Benefit Advisory will confirm to the practitioner whether or not the procedure/conditions meets the health plan's medical criteria.

For Managed Care Products, some services require referral notification as well as a prospective clinical review. This template identifies those services for which a health plan will perform a prospective clinical review. The template titled 'Referral Requests for Managed Care Products' identifies those services that require referral notification.

4. *For any service, all health plans will prospectively provide a benefit and eligibility quote (BEQ) over the phone.* A BEQ will determine whether the procedure is covered under the patient's policy. A BEQ does not commit the health plan to payment responsibility.

Other procedures/conditions not listed on this report will be covered by the responsible health plan subject to patient eligibility, medical necessity and benefit applicability at the time the service is delivered. For these procedures/conditions, a clinical review will be performed at the time of claims processing.

Inpatient Stay Review for Fee-for-Service Products

Note: The treating provider is responsible for contacting the health plan to request an Inpatient Stay review.

1. *This report applies to Fee-for-Service/Indemnity Products.* Policy requirement for Managed Care Products are described in the template titled 'Referral Requests for Managed Care Products'.
2. *This report uses the following definitions.*
 - Pre-Notification – Notification prior to a patient's admission
 - Notification – Notification after a patient's admission
 - Length of Stay Review – Review of a patient's length of stay upon initial admission to the facility
 - Concurrent Review – Review of a patient's length of stay at some point in time after initial admission to the facility