

Administrative Simplification
Policy Statement

Simplification Area: Referral, preauthorization & preadmission certification

Topic: Numeric billing codes on referrals and authorizations

Objective: Simplify authorization process

Eliminating the requirement to code referrals will reduce the administrative burden.

Expected Impact: *Hospitals & Practitioners* – Diagnoses and treatment codes are not always known at the time of referral. Providers are concerned that when codes on a referral do not match codes on a claim, the claim may be pended/denied. On average five minutes per referral is spent trying to determine the optimal code to use so that necessary treatment isn't constrained (resulting in another referral) and so that the resulting claim will not be rejected or denied. Three to five hours per month is spent on referral coding activities.

Synopsis:

When preparing referral notification, prior authorization or preadmission certification, **providers are strongly encouraged to numerically code the diagnoses and/or procedures.** This will expedite processing by the health plan. However, **if the code is not known,** the health plan will accept a clear narrative describing the need for the referral and the intended services.

Background:

As part of the adjudication process, health plans match any referrals/authorizations to submitted claims in order to verify that the care provided was authorized. For certain procedures, health plans also perform a clinical review of the care that was delivered to confirm necessity and compliance with contracted benefits. The adjudication and clinical review processes can be expedited, resulting in quicker turnaround of claims, if the referrals/authorizations include the appropriate numeric billing codes for the diagnoses and requested services.

Participating health plans understand it is not always possible for providers to determine, at the time of referral or authorization, which numerical codes will be used for billing. To minimize delays in getting authorizations and to simplify the process for providers,

participating health plans have established a policy around numerical codes on requested referrals and authorizations.

Policy Statement:

Health Plans will not routinely require providers or facilities to numerically code the diagnoses or procedures for the purposes of referral notification, prior authorization or preadmission certification. However, **providers are strongly encouraged to supply code(s) on the referral** whenever a specific service is being requested and/or a specific diagnosis has been established for the patient, AND the corresponding code is known by the provider. (“**IF YOU KNOW IT, SHOW IT**”) If the numeric code is not known, a clear narrative describing the need for the referral and the intended services is required. Referrals and claims can be processed much more quickly, if numeric billing codes are supplied on the referrals. (The health plans will not need to take time to code the referral and to contact the PCP to get clarification, when necessary.)

On occasion, the health plan may request the codes if available (per the Washington State Patient Bill of Rights).

Additionally, Health Plans will continue to require an admitting diagnosis/reason for inpatient services, but it does not need to be numerically coded.

All services, diagnoses and procedures must be coded on claims.