CAQH CORE

PROVIDER TOOLKIT

Prior Authorization Fast Facts

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FAST FACTS

What is the electronic prior authorization transaction?

The ASC X12 Health Care Service Review (278) transaction can be used by a provider, such as a hospital, to electronically request an authorization from a health plan.

The X12 278 transaction contains information of whom is making the request, for which member, details of the entities performing the services, where and when the services are to be performed, the approval status and why the services are needed by inclusion of the diagnosis and other unique data to support the reason for the request.

What are the benefits of using the electronic prior authorization transaction?

- Automates the function of entering prior authorization data directly into the Utilization Management (UM) database and/or systems used to assist the provider workflows.
- Reduces the need for phone requests and manual entry.
- Opportunity to reallocate FTEs required to support authorizations or allow staff to concentrate more on patient care versus administrative efforts.
- Improves the accuracy of requests as data is codified.
- Opportunity to facilitate faster UM review turn-around time as some responses can be returned in seconds.

What are the requirements under HIPAA?

Under HIPAA, HHS adopted certain standard transactions for the electronic exchange of health care data.

These transactions include:

- Payment and remittance advice
- Claims status
- Eligibility
- Coordination of benefits
- Claims and encounter information
- Enrollment and disenrollment
- **Referrals and authorizations**
- Premium payment

HIPAA-covered entities who conduct any of these transactions electronically must use an adopted standard from ASC X12N or NCPDP (for certain pharmacy transactions).

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In 2010, subsequent legislation introduced additional provisions that addressed the use of transactions, building upon the requirements already in place through HIPAA. Together, the provisions are referred to as Administrative Simplification because their purpose is to simplify the business of health care.

The new and expanded provisions included requirements for the adoption of operating rules for each of the existing transactions as well as standards for electronic funds transfer and electronic health care claims attachments. These provisions also established a new set of penalties that could be imposed on health plans for failure to comply.

What if a health plan does not offer the electronic prior authorization transaction to its providers?

A health plan must be able to support the electronic standard for a transaction if the plan performs the associated business function (whether electronically, on paper, via phone, etc. It may do this directly or through a clearinghouse.

What are the benefits of operating rules to support electronic prior authorization via the X12 278 transaction?

A health plan is not required by federal mandate to use the CAQH CORE Prior Authorization & Referral Operating Rules while conducting the X12 278 transaction. However, the operating rules, which were developed by CAQH CORE Participants, enhance the X12 278 by standardizing componentsof the prior authorization process, closing gaps in electronic data exchange to move the industrytowards a more fully automated adjudication of a request.