Valer

Valer Prior Auth Glossary

Dive into our guide of industry terms for prior authorization and revenue cycle management. We're here to boost your know-how for all things prior auth.

Still have questions?

Just Drop Us A Line

A

Admission, Discharge, Transfer (ADTs) Feeds: Notifications sent via electric health records (EHRs) to alert other providers when a patient is admitted to a care setting, transferred to another facility or discharged from a care setting.

API: An acronym for Application Programming Interface – a software ntermediary that allows two applications to talk to each other.

Appeal: A formal request for review of a denied prior authorization. The healthcare provider or patient may appeal if they believe the denial was incorrect or unjust.

Appeals Process: The formal process by which healthcare providers or patients can challenge a denial of prior authorization or coverage decision made by the insurance company.

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Authorization: The approval granted by a healthcare insurance plan for a specific service, treatment, or referral. Some referrals may require prior authorization for coverage.

C

CDex: Clinical Data Exchange

Clinical Review: The process of assessing the medical necessity and appropriateness of a requested healthcare service, often conducted by medical professionals employed by the insurance carrier.

Closed-Loop Referral: A referral system that includes communication and feedback loops between the referring provider and the specialist, ensuring coordination of care and follow-up information.

CMS: The Centers for Medicare & Medicaid Services

CMS Interoperability and Prior Authorization Final Rule: The Centers for Medicare & Medicaid Services (CMS) released the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) on January 17, 2024. This final rule emphasizes the need to improve health information exchange to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. This final rule also focuses on efforts to improve prior authorization processes through policies and technology to help ensure that patients remain at the center of their care.

CRD (Coverage Requirements Discovery): The Coverage Requirements Discovery (CRD) is a component of the Da Vinci HL7 FHIR Project for electronic prior authorizations. CRD enables the exchange of coverage plan requirements from payers to providers at the time of treatment decisions, patient-specific with a goal to increase transparency for all parties of coverage that may impact services rendered, i.e., is prior authorization required, are there other predecessor steps; lab tests required, physical therapy.

CQL (Common Quality Language): A FHIR-compliant standard to represent payer "rules" for payer medical necessity and best clinical practice requirements that may affect the ability to have certain services or devices covered by the responsible payer.

CDS (Clinical Decision Support) Hooks: Provides a way to embed additional, near real-time functionality within a clinician's workflow of an EHR. A specified event(s) within the clinician's workflow triggers a CDS hook, which gathers the appropriate specified data elements through secure Fast Healthcare Interoperability Resources® (FHIR®) services. By utilizing FHIR services, CDS Hooks provides interoperability between multiple stakeholders operating on different platforms.

D

Diagnostic Code: A numerical code used to represent specific medical diagnoses, often according to the International Classification of Diseases (ICD) coding system.

DTR (Documentation Templates and Rules): DTR leverages FHIR Questionnaires combined with embedded CQL logic and associated value sets to retrieve existing information, prompt for additional relevant information, and manage the logic process of determining which questions need to be answered (and what answer choices are relevant). The function of rendering these questionnaires and capturing the information in patient-specific questionnaires. Responses can occur through SMART on FHIR applications or functionality embedded directly into the electronic health record (EHR).

E

EDI 278 Authorization and Referral Request: EDI 278 is the transaction request used to submit authorization and referral requests electronically.
an inpatient facility and insurers.

EDI 278I Prior Authorization and Notification Inquiry: EDI 278I is the transaction used to check the status of previously submitted authorizations and notifications.

EDI 278N Hospital Admission Notification: 278N is the exchange of admission notification data between an inpatient facility and insurers.

Electronic Health Record (EHR): An electronic version of a patient's medical history.

Electronic Prior Authorization (ePA): The digital submission and processing of prior authorization requests, which can streamline the approval process and reduce paperwork.

Expedited Prior Authorization: An accelerated process for obtaining approval for urgent or life-threatening medical services, typically with a quicker turnaround time.

Formulary: A list of prescription drugs covered by a health insurance plan and information on their tier or cost-sharing level. Prior authorization may be required for medications not on the formulary.

FQHCs (Federally Qualified Health Centers): FQHCs are primary care clinics that receive federal funds to provide healthcare services to underserved communities. They operate in both rural and urban areas designated as shortage areas.

Gold Carding: When payers waive prior authorization on services and prescriptions ordered by providers with a proven track record of prior authorization approvals.

Green Lighting: Using real-time, physician and code-specific data to avoid prior authorization requirements.

Healthcare Provider: A person or organization that provides medical services or care to patients. This can include hospitals, doctors, specialists, and other healthcare professionals.

HIPAA: The Health Insurance Portability and Accountability Act is a federal law passed in 1996 that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

HIPAA Compliance: HIPAA compliance refers to the rules and policies that healthcare organizations must implement to protect the privacy, security, and integrity of protected health information.

HITECH Act: The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 [PDF - 266 KB] provides HHS with the authority to establish programs to improve healthcare quality,

safety, and efficiency through the promotion of health IT, including electronic health records and private and secure electronic health information exchange. Learn more about select portions of the HITECH Act that relate to ONC's work.

HITRUST: The Health Information Trust Alliance is a non-profit that provides data protection standards and certification programs to help healthcare organizations safeguard sensitive information, manage information risk, and reach compliance goals.

HL7: Founded in 1987, Health Level Seven International is a not-for-profit, American National Standards Institute (ANSI) -accredited Standards Developing Organizations (SDOs) serving the healthcare industry with a focus on clinical and administrative data. HL7 is supported by members from over 50 countries, including over 500 corporate members representing healthcare providers, government stakeholders, payers, pharmaceutical companies, vendors/suppliers and consulting firms.

HL7 Da Vinci Project: The Da Vinci Project is a private-sector initiative that accelerates the adoption of HL7 FHIR as the standard to support and integrate value-based care (VBC) data exchange across communities.

HL7 FHIR: The Fast Healthcare Interoperability Resources 1 standard defines how healthcare information can be exchanged between different computer systems regardless of how it is stored in those systems.

HMO (Healthcare Maintenance Organizations): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage.

I

Insurance Carrier: See Payer

Interoperability: Interoperability refers to the ability of applications to exchange and make use of information.

M

Medical Authorization: When a service prescribed by the physician is not covered by the patient's insurance company, the PCP must obtain medical authorization. The physician needs to contact the insurance company or fill in the required forms to explain why the prescribed service is required and the supporting clinical factors.

Medical Necessity: The determination that a healthcare service or treatment is required to prevent, diagnose, or treat a medical condition and is consistent with generally accepted medical standards.

N

Network: A group of healthcare providers, including primary care physicians and specialists, contracted with an insurance plan or healthcare organization to provide services to covered individuals.

Notice of Action (NOA): A letter that health plans must send to patients when a requested service has been denied.

Notice of Admission (NOA): A one-time notification for a series of home health periods of care.

O

ONC: The Office of the National Coordinator for Health Information Technology (ONC) is at the forefront of the administration's health IT efforts and is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide, standards-based health information exchange to improve health care. ONC is the principal federal entity charged with coordinating nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

Out-of-Network: Healthcare providers or services that are not part of the contracted network of a specific insurance plan. Referring patients to out-of-network providers may result in higher costs for the patient.

P

Payer: A person, organization, or entity that pays for the care services administered by a healthcare provider. This most often refers to health insurance companies, which provide people with insurance that offers cost coverage and reimbursements for medical services. This could be a private insurance company or a government program.

Payer Connection: An electric connection point used to manage transactions/communications between healthcare services companies to payers and TPAs.

Payer Fax Form: Prior Authorization/Referral forms that are completed by healthcare organizations and submitted to insurance companies via electronic fax.

Payer Plan: Often referred to as a health plan, Payer plans are offered by insurance companies to assist in the cost and reimbursements for medical services.

Payer Portal: Payer portals allow healthcare organizations to pull prior authorizations and check the status of referrals.

Payer Web Form: An online form used to submit prior authorizations outside of electronic fax or portal submission.

PAS (Prior Authorization Support): Prior Authorization Support (PAS) is the administrative process for obtaining approvals. PAS typically involves submitting detailed information about the patient's medical condition and proposed treatment to the payer for review. PAS aims to ensure that the requested healthcare services are medically necessary and appropriate while also managing costs and ensuring compliance with insurance policies.

Peer-to-Peer Review: A utilization review process typically associated with a prior authorization denial whereby a conversation is requested between the requesting provider and a payer medical director to discuss medical necessity.

POS Plan (Point of Service Plan): A type of managed-care health insurance plan that provides different benefits depending on whether the policyholder uses in-network or out-of-network healthcare providers.

PPO (Preferred Provider Organization): A preferred provider organization (PPO) is a health insurance plan for individuals and families. PPOs involve networks that are made up of contracted medical professionals and health insurance companies. Healthcare facilities and practitioners, known as preferred providers, offer services to the insurer's plan policyholders at reduced rates.

Pre-Approval / Prior Approval: See Prior Authorization

Pre-Authorization: See Prior Authorization

Pre-Cert: See Pre-Certification

Pre-Certification: A process similar to prior authorization, whereby a request for approval for a service is performed without the need to verify medical necessity; typically entails verifying that a service is a covered benefit with a contracted, in-network provider and at an in-network facility.

Prescription Prior Authorization: A process required by some health insurance plans where healthcare providers must obtain approval from the insurance company before certain medications can be prescribed to patients. This approval ensures that the medication is medically necessary and appropriate based on the patient's condition and the insurer's coverage policies.

Primary Care Physician (PCP): The healthcare provider who serves as the patient's main point of contact for general health concerns and coordinates overall care, including making referrals to specialists when needed.

Prior Authorization / Prior Auth: Prior authorization—sometimes called pre-authorization or pre-certification—is a health plan cost-control process by which physicians and other health care providers must obtain advance approval from a

Prior Authorization Determination: A prior authorization determination refers to the decision made by a health insurance company regarding whether to approve or deny a request for coverage of a specific medical service, procedure, or medication. This determination is based on factors such as medical necessity, coverage policies, and clinical guidelines.

Prior Authorization Request or Submission: The provider or supplier submits a pre-claim review request and receives the decision prior to claim submission. However, the provider or supplier can render services before submitting the request. A provider or supplier submits the prior authorization or pre-claim review request with all supporting medical documentation to approve coverage for the item or service to their payer.

Prior Authorization Status: The indication of the current stage or condition of a request for approval of a medical service, procedure, or medication by a health insurance company. It typically includes whether the request is pending review, approved, denied, or requires additional information from the healthcare provider or patient.

Prior Authorization Verification: This involves confirming the details and requirements of a prior authorization request for a medical service, procedure, or medication. This process ensures that all necessary information is accurate and complete before submission to the health insurance company. It may involve checking patient eligibility, coverage criteria, and any specific documentation needed for approval.

Procedure Code: A numerical code that identifies specific medical procedures or services, often according to the Current Procedural Terminology or Healthcare Common Procedure Coding System.

Re-direct: A process where a requested service as part of a prior authorization is re-directed to either a preferred, in-network provider, facility, or both. Typically, to a preferred lower cost option for the payer.

Referral: A referral is an order from your PCP to see a specialist or receive certain medical services from some providers. Many HMOs require a referral before a patient gets medical care from anyone other than the primary care provider.

Referral Authorization: The requirement of a referral from your primary care doctor for most other medical services.

Referral Coordinator: A healthcare professional responsible for managing and facilitating the referral process, including obtaining authorizations, communicating with specialists, and ensuring follow-up care.

Referral Criteria: Specific guidelines or requirements that must be met for a referral to be considered appropriate, often based on medical necessity and established clinical guidelines.

Referral Form: A document healthcare providers use to formally request a referral for a patient. It typically includes information about the patient's condition, relevant medical history, and the reason for the referral.

Referral Leakage: The situation where patients seek care outside of their designated referral network, potentially leading to fragmented care and increased healthcare costs.

REST API: An API that adheres to the principles of the REST, or representational state transfer architectural style.

Retro Authorization: Is a process where the payer reviews a service that has already been performed to determine if it was covered under the patient's insurance policy and is medically necessary. This is typically done after the service has been completed and is used to recover payment for services that were not previously authorized.

Specialist: A healthcare provider with expertise in a specific area of medicine or healthcare, such as a cardiologist, dermatologist, or orthopedic surgeon.

Step Therapy: A process where a patient must try and fail one or more less expensive or risky treatments before the insurance company will approve a more costly or complex treatment.

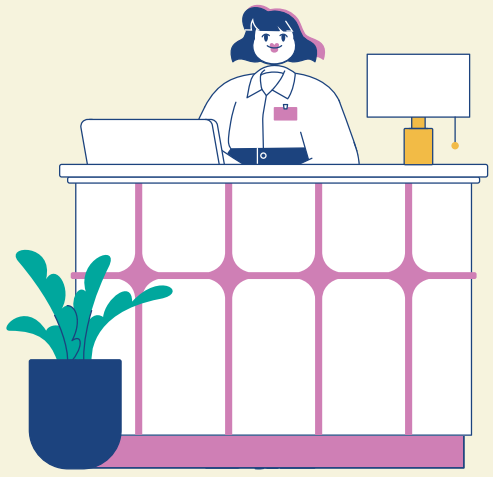
Sites of Care, Sites of Service: A preferred facility or location for the providing of a service; also see re-direct; an example is where a service is denied or changed to a different in-network, preferred facility; common examples are redirecting facility from a hospital setting to an ambulatory diagnostic imaging center or ambulatory surgery center. appropriate, often based on medical necessity and established clinical guidelines.

T

Third-Party Administrator (TPA): An administrative services provider that delivers support for self-insured health plans.

U

Utilization Management (UM): The evaluation and management of healthcare services to ensure they are medically necessary and cost-effective. Prior authorization and referral management are components of utilization management.



If you're ready to explore an option for prior authorization automation, we'd be happy to help.

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