Oregon Health Leadership Council
Adminstrative Simplification project

The following best practice statements describe the recommended functionalities that should be provided by payers on their web sites that are intended for provider access. Required capabilites were determined to be those that all payers should comply with. Discretionary capabilites were determined to be those that payers can comply with at their discretion. However, providers would like to see attention paid to all of these capabilites every time payers update their web site functionalities. These capabilities are evaluated annually and feedback is given to payer representatives by providers.

Best Practice Statements

Required D = Discretionary

	Web Feature			R = R or D
0.00	**Single Sign On**	Payer participates on the single sign on portal operated by OneHealthPort		R
1.01	**Search criteria** - Web sites allow search by:	Patient name, with or without one additional criterion (e.g. DOB)		R
1.02		Patient ID number, with or without one additional criterion		R
2.00	**Member Search result** - Web sites display in the search results:	Patient name		R
2.02		Patient date of birth		R
2.03		Patient ID number		R
2.04		Group number		R
2.05		Group name		D
2.06		Patient address		D
2.07		Primary care provider, if the patient's plan requires selection of a primary care provider (e.g. Group, Medical Home)		R
2.07		Plan, product and network		R
2.08		Patient coverage dates, including the effective date and, if apppropriate, the termination date		R
2.09		Provide a link or tab to the eligibility area from the search results page		R
2.10		Policyholder name		R
2.11		Policyholder DOB		R
2.12		Policyholder gender		R
2.13		Policyholder relationship to patient		R
3.00	**Coordination of Benefits**	If payers have information about Coordination of Benefits, the following items are displayed:		R
3.01			Name of carrier	R
3.02			COB heirarchy (filing order)	R
3.03		The following items are displayed if available (in priority order):	Member ID	R
3.04			Effective date	R
3.05			Policyholder name	R
3.06			Policyholder DOB	R
3.07			Policyholder gender	R
3.08			Policyholder relationship to member	R
3.09			Termination date of other coverage	R
4.00	**Prior Authorization** Web sites provide:	A tool to determine if prior authorization, precertification, or admission notification is required, along with a list of broad categories that usually require these		R
4.01		The capability to check status of a prior authorization or precertification request online		R
4.02		The capability to request prior authorization or precertification online		R
4.03		The capability to notify payer of admission online		R
4.04		The capability to request a revision to the prior authorization or precertification online		R
4.05	One-stop-shopping tool:	The payer maintains information in the One-Stop-Shopping tool on the OneHealthPort provider site		R
5.00	**Benefits** - Web sites are to:	Contain benefit summaries, including at least the following:	Office calls	R
5.01			Hospital in/outpatient	R
5.02			Emergency services	R
5.03			Mental Health in/outpatient	R
5.04			Vision	R
5.05			Dental	R
5.06			Pharmacy	R
5.07			Chiropractic	R
5.08			General Medical care	R
5.09			Urgent care	R
5.10			Maternity	R
5.11			Well care	R
5.12			In/out of network benefits when appropriate	R
5.13		List deductible amounts, specify the appropriate time frame, and list services that are not subject to the deductibles		R
5.14		List deductible accumulators, updated no less than daily, based on adjudicated claims		R
5.15		List the coinsurance percentage, differences between in and out of network, and services to which the coinsurance applies		R
5.16		List the copayment amount and services to which the copayment applies, including, at a minimum, the following benefits:	Office calls	R
5.17			Hospital in/outpatient	R
5.18			Emergency services	R
5.19			Mental Health in/outpatient	R
5.20			Vision	R
5.21			Dental	R
5.22			Pharmacy	R
5.23			Chiropractic	R
5.24			General Medical care	R
5.25			Urgent care	R
5.26			Maternity	R
5.27			Well care	R
5.28			In/out of network benefits when appropriate	R
5.29		List out of pocket (stop loss) maximums and accumulators for both in and out of network		R
5.30		Provide a liability estimator, to provide patient estimates of out of pocket costs (the scope must include any service a patient may require)		R
6.00	**Claims** - Web sites are to:	Have the capability to do real-time claims adjudication on the web site		D
6.00		List service limitations and include utilization based on adjudicated claims		R
6.01		Provide the capability to request reprocessing online, for claims where no data has changed		R
6.02		Display claims adjudication information, including:	Coordination of benefits	R
6.03			Claim payment information (check number, amount, date)	R
6.04		Display claim codes:	Display denials and pended code details	R
6.05			Provide actionable information on what type of information is neede (for example: pre-existing conditions, accident information, chart notes)	R
6.06			Display HIPAA 835 remark codes and adjustment reason codes (ARCs), with description	R
6.07			Provide a list of proprietary codes	R
6.08		Post claims within one week of receipt of the claim		R
7.00	**Inquiries** - Web sites are to:	Provide the ability to receive electronic inquiries and respond within three (3) business days (providers should identify the nature of the inquiry)		R
7.01		Display termination and activation dates of HIPAA 835 remark codes and adjustment reason codes where applicable		D