

Extenuating Circumstances for Prior Authorization and Admission Notification

NOTE TO PROVIDERS: Obtaining authorization prior to service delivery is the optimal practice in order to mitigate provider and patient financial risk. By obtaining a prior authorization, medical necessity can be assessed before resources are expended and claims can be submitted as soon as services are delivered.

This policy is modeled after the Best Practice Recommendation that supports Washington Senate Bill 5346 and WAC 284-43-2060. Note that there are references to Medicaid in this policy, and while the Plan does not have any Medicaid products, inclusion of this language demonstrates the intent of the *Best Practice Act*.

Policy

A number of extenuating patient situations make it impossible for providers to obtain pre-authorization before treating the patient or to notify the health plan within the specified time period of a patient's admission (e.g., 24 hours). In these situations, claims for services are likely to deny for lack of prior-authorization or admission notification even if the services meet the health plan's criteria for medical necessity.

In these situations, providers should contact the health plan either before submitting a claim, or at the initiation of an appeal. Claims will not be automatically denied for lack of timely admission notification (e.g., 24 hours), or for lack of prior-authorization, as long as the services meet the health plan's criteria for medical necessity.

I. Authorization Request for Services Processed Post-Service

Post-service extenuating circumstance requests can be submitted either before a claim is submitted, or at the initiation of an appeal, as long as documentation can be provided to demonstrate the request could not be made before delivering service due to:

- A. A participating provider or facility was unable to identify the carrier (or designated or contracted representative) to submit the prior authorization request to
- B. A participating provider or facility was unable to anticipate the need for a prior authorization before or while performing a service;
- C. The time between when an enrollee was discharged from a facility and began receiving institutional/home health services was insufficient to submit the prior authorization;
- D. An "urgent" clinical need for the service(s) where the need was identified and documented for the date of service;
- E. A requirement for clinical coordination of services was determined at the time of service (e.g., the patient travels a long distance to access care, and the delivery of service at that

time would prevent return travel for the sole purpose of fulfilling the Pre-Authorization requirement); or

- F. Inaccurate information (or misinformation) about the need for a pre-authorization was provided by the health plan representative or displayed on the website.

NOTES:

- **Extenuating circumstances DO NOT APPLY** when documentation of the extenuating circumstance does not exist, or in situations where the failure to obtain pre-authorization was the fault of the provider/provider organization.
- The grace period does not eliminate the member's financial penalty in situations where the penalty is part of the member contract.
- Retro-denied eligibility will remain as an extenuating circumstance beyond the grace period. There may be other extenuating circumstances that remain beyond the grace period as well.
- The provider should indicate in their request that it is submitted post-service due to a **"qualified extenuating circumstance"** and briefly describe the circumstance.

II. 'Unable to Know' Situations

These are situations where providers do not have current insurance information on file for the patient and are unable to get correct insurance information from the patient. It is impossible for providers to contact the responsible health plan to request a pre-authorization for post-emergent services (e.g., surgery), or to notify the health plan of admission.

A. Patient Unable to Tell Provider about their Insurance Coverage before Treatment

Acceptable reasons include:

1. Trauma or Unresponsive Patient: These patients are usually brought in via 911 with no family, no ID, etc., and may be admitted as Jane/John Doe.
2. Psychiatric Patient: These patients are admitted through the Emergency Department for clinical conditions related to cognitive impairment.
3. Child not Attended by a Parent: These patients are children who need immediate medical attention and are brought in by someone other than their parent (e.g., babysitter, grandparent, etc.).
4. Non-English Speaking Patient: These patients do not speak English and a translator cannot be located in a timely manner.

B. Provider Verified no Medicaid Coverage at Time of Treatment or Medicaid Secondary

The provider verified that no Medicaid coverage was in place the time of treatment, or that Medicaid coverage was secondary, however later it was determined that at the time of treatment, Medicaid coverage was actually in place, or was primary, or the patient was later enrolled in a Medicaid program retroactive to cover the service date.

Sometimes there's a gap between the time of a patient's enrollment and the update of Medicaid's verification system to reflect the patient's enrollment (usually the early part of the month). If a provider verifies a patient's coverage during this time, it appears that the patient isn't enrolled at the time of treatment and is retroactively enrolled after treatment. Since the patient does not appear to have Medicaid coverage at the time of service, the provider proceeds as if the patient is a self-pay patient (i.e., doesn't request pre-authorization). Sometimes the physician the patient selects OR has been selected for them by Medicaid/Healthy Options hasn't seen the patient and will not issue a retrospective referral for treatment.

In other cases, a patient does not have Medicaid coverage at the time of treatment, but might be enrolled in Medicaid post-service. The retroactive enrollment would allow the provider to submit for retrospective authorization for services provided after the enrollment date.

C. Patient Indicated Self-Pay with no Medical Coverage at Time of Treatment

The patient initially indicated that they were self-pay and had no medical coverage in place at the time of treatment, however later it was determined that medical coverage was actually in place.

In some cases, the patient would prefer to pay 'out of pocket' rather than initiate COBRA coverage and have to pay the ongoing premium. However, a second care encounter could change the patient's mind and COBRA coverage would be initiated retroactively to the beginning of the month, providing coverage for a treatment that has already been delivered.

D. Provider asked Patient about Coverage before Service, Patient Provided Information and Provider Verified Coverage in Force at Time of Treatment

The provider asked the patient about current coverage before providing the service, the patient provided current insurance coverage information, and the provider verified that the coverage was in force at the time of treatment. After the patient was treated, however, it was discovered that another health plan is primary and is responsible for coverage.

- 1. Coverage Retrospectively Determined to be L&I:** During the scheduling process, these patients did not indicate that their condition was accident related. During or after treatment, the provider discovered that the service was accident/work-related so that L&I should have been the insurance on the

account.

2. **Other Primary Insurance Retrospectively Discovered:** Coverage for these patients was verified with the health plan of record before treatment and any pre-authorization/admission notification requirements were met. After the patient was treated, the provider was notified that another health plan was primary.
 - Example 1: Before treatment, HCA-Medicaid benefits were verified with no other insurance on file. Later, HCA-Medicaid notified the provider that commercial coverage was in place at that time.
 - Example 2: In dual coverage situations, the eligibility was verified with one of the coverages. Later, the health plan notified the provider that the other is primary.

E. Identity Theft: Patient Posed as Another Individual, Using their Health Insurance Coverage

The patient falsely posed as another individual using that individual's health information as coverage for services and the coverage was verified. After the patient was treated, the provider discovered that either:

1. The patient had other insurance in their name that was in force, or
2. The patient had no insurance, qualified for Medicaid and therefore helped them to enroll post-service with coverage retroactive to the time of service.

NOTE: 'Unable to Know' situations DO NOT INCLUDE situations where the provider was able to communicate with the patient prior to giving treatment, but the insurance coverage information was not obtained or was not verified before providing service, and the provider later discovered that the coverage was not in force.

III. 'Not Enough Time' Situations

Defined as circumstances where the provider organization, before seeing the patient, could not anticipate the need for a service requiring a pre-authorization, and any delay in the delivering the service in order to obtain an authorization would adversely impact the health of the patient.

'Not Enough Time' situations are when:

- A. The patient made an appointment for a consult with a provider and the need for any service except the E&M visit was not known at that time. In the course of the visit, the provider determines the need for a procedure to be urgent or acute.
 - Urgent*1 need (identified and documented for the date of service, and defined in the BPR-Standard Timeframe) is defined as: Urgent Care (aka 'Expedited' for Medicare), care or treatment without which the passage of time could:
 - Seriously jeopardize the life or health of the patient

- Seriously jeopardize the patient's ability to regain maximum function
- Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request
- Acute need (identified and documented for the date of service) is defined as care or treatment where the effectiveness largely depends on time-sensitive and rapid intervention where scheduling the patient to receive the treatment at another time would:
 - Negatively impact the quality of health of the patient (e.g. pain/restricted function, etc.)
 - Extend the timeframe for diagnostic confirmation/care coordination of a suspected acute condition and the delay would compromise health outcomes
 - Result in the patient incurring excessive travel and/or expense to return to obtain the service

B. The patient is undergoing a procedure (which may or may not require pre-authorization). Once the procedure begins, a different procedure or the need for an add-on surgery/procedure is identified. That procedure, which would have required pre-authorization, is typically performed at the time of the original procedure or scheduled for the same day. This situation is considered an extenuating circumstance as long as the added procedure has not already been requested and denied.

C. An enrollee is discharged from a facility and insufficient time exists for institutional or home health services to receive approval prior to delivery of the service.

NOTE: 'Not Enough Time' situations DO NOT INCLUDE situations where the provider performs a procedure or provides a service that is considered experimental or investigational (E&I).

IV. Inherent Component Services

These are circumstances where the provider organizations obtained a pre-authorization for at least one service in an inherently related set of services, but not for other inherently related services in the set.

Some services have multiple inherent components (see NOTES below). In some cases, health plans require each component to have its own pre-authorization review. In these cases, the health plan will not deny, for lack of pre-authorization, the inherent component service(s) within the set that were missing a pre-authorization.

An **inherent component extenuating circumstance** is when the health plan denies, for lack of pre-authorization, one of more services within an inherent component set, when at least one of the services in the set had been pre-authorized.

NOTES: Inherent component services, where one service is an essential attribute of another (i.e., one can't be provided without the other) include:

- Infused/injectable medication and the service to administer that medication
- Device and the procedure related to implanting the device
- Sleep study and the interpretation of the study
- Placement of a drainage tube and the radiological guidance
- Hyperbaric oxygen under pressure and the physician supervision

V. Misinformation

These are circumstances where the provider organization can demonstrate that a Health Plan representative and/or the Health Plan's website provided inaccurate information about the need for a pre-authorization or admission notification.

VI. Key Processes - Application

If provider organizations follow these recommended best practices for extenuating circumstances, health plans will process the service AS IF a pre-authorization had been requested before service delivery, or notification of admission was given within the specified time period of admission (e.g., 24 hours). Services will still be subject to benefit coverage and medical necessity.

Health plans will post on their website the best practice for communicating with providers about extenuating circumstances and how to resolve them. The best practices outlined below are listed by the timeframe-milestone when the provider organization notifies the health plan about an extenuating circumstance.

Before Claim is Submitted

All health plans will have a process for providers to follow in order to notify the health plan about an extenuating circumstance **BEFORE a claim is submitted**, as long as that claim is submitted within one (1) year of the date of service. The process includes:

- Name of the department to contact
- Language the provider should use to indicate 'Extenuating Circumstance processing'
- Clear definition of supporting information required from the provider organization, including whether the contact information for the requestor should be provided
- Processing expectations and decision/notification timeframes and methods

OR

After Claim is Denied but Before Appeal is Initiated

Some health plans will have a process that provider organizations should follow to notify them of an extenuating circumstance after a claim is denied and but before an appeal. The process includes:

- Name of the department to contact
- Language the provider should use to indicate 'Extenuating Circumstance processing'
- Type of provider organizations to whom the process applies (e.g., In-Network providers)
- Timeframes/conditions under which this process applies
- Clear definition of the supporting information required from the provider organization, including whether the contact information for the requestor should be provided
- Processing expectations and decision/notification timeframes and methods

Once an Appeal is Initiated

Health plans will have a process that provider organizations should follow to notify them of an extenuating circumstance once an appeal is initiated. **NOTE:** Health plans that have a post claim process (see #2 above) that does not apply to ALL providers, will also have an appeals process. The process includes:

- Language to use to indicate 'Extenuating Circumstance processing'
- Clear definition of supporting information required from provider organization, including how providers should demonstrate they were not aware of a member's coverage