Extenuating Circumstances for Prior Authorization and Admission Notification

NOTE TO PROVIDERS: Obtaining authorization prior to service delivery is the optimal practice 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 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

Several extenuating circumstances 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. Types of Extenuating Circumstances

Extenuating circumstances are defined by the WAC (i.e., step 5, a-c). Per WAC 284-43-2060, the following situations are extenuating circumstances:

A. A participating provider or facility is unable to identify from which carrier or its designated or contracted representative to request a prior authorization.
B. A participating provider or facility is unable to anticipate the need for a prior authorization before or while performing a service.
C. An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to delivery of the service.

II. Notifying Premera of an Extenuating Circumstance

To receive this consideration, provider organizations must notify Premera of extenuating circumstances within any of the following time frames:

A. Before a claim is submitted and within one (1) year of the date of service.
B. After a claim is denied, but before an appeal is initiated.
C. Once an appeal is initiated.

The process to notify Premera about an extenuating circumstance is posted on the Premera website:

A. Label the request: “Request for Consideration of Extenuating Circumstances”.
B. Include a request that Premera waive the administrative requirement for prior authorization or admission notification.
C. Provide a detailed explanation of the type of extenuating circumstance from the list above and how it resulted in inability to obtain prior authorization or perform admission notification.
D. Include pertinent identifying information, clinical information, and contact information for the requestor.
E. Submit the request to Premera’s Appeal Department:
   Premera Blue Cross
   Attn: Complaints & Appeals
   P.O. Box 91102
   Seattle WA 98111-9202

III. What Premera Will Do

If provider organizations follow these steps for extenuating circumstances, Premera will waive penalties for failing to prior authorize health care procedures when there is an extenuating circumstance that prohibits a provider from obtaining a required prior authorization or making a required notification.

Premera will process the service as if a prior authorization had been requested before service delivery, or notification of admission was given within the specified time frame. Services will still be subject to benefit coverage and medical necessity determinations.