

## Extenuating Patient Situations

### Overview

A number of extenuating patient situations make it impossible for providers to obtain a 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 or be assessed a penalty for lack of prior-authorization or admission notification even if the services meet the health plan's criteria for medical necessity. Also in these situations, *providers should contact the health plan prior to submitting a claim*. Claims will not be automatically denied or assess a penalty for lack of timely admission notification or for lack of prior-authorization as long as the health plan is contacted before the claim is submitted and the services meet the health plan's criteria for clinical necessity. *While the Plan does not have any Medicaid products, this language has been included to demonstrate the intent of the types of situation encountered.*

### I. "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. As such, 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. The patient is ***unable to tell*** the provider about their insurance coverage before treatment.

Acceptable reasons include:

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

B. The ***provider verified that no Medicaid coverage was in place at time of treatment***. It was later determined that Medicaid coverage was actually in place. C. The provider asked the patient about current coverage prior to the service, the patient provided current insurance coverage information and the ***provider verified that the coverage was in force at time of treatment***. After the patient was treated, it was discovered that another health plan takes precedent and is responsible for coverage.

1. ***Coverage retrospectively determined to be L&I***: During the scheduling process, these patients do not indicate that their condition is accident related. During or after treatment, the provider discovers that the service is accident/work related and L&I should be the insurance on the account.
2. ***Other primary insurance retrospectively discovered***: Coverage for these patients is verified with the health plan of record prior to treatment and any pre-auth/admission

notification requirements are met. After the patient is treated, the provider is notified that another health plan is primary. Two examples:

- a. Before treatment, DHSS benefits are verified with no other insurance on file at that time. Later, DHSS notifies the provider that commercial coverage was in place.
- b. Before treatment, the patient's father's health plan verifies eligibility. Later, the health plan notifies the provider that the other parent has coverage and that coverage is primary.

'Unable to Know' situations **DO NOT INCLUDE** when:

- The patient was able to communicate with the provider prior to being treated.
- The insurance coverage information supplied by the patient was not verified prior to the service(s). (The provider may have had insurance information on file for the patient and assumed it was still in force, or may have copied the patient's insurance card but not verified it). The provider later discovered that the previous coverage was no longer in force and had been replaced by a different coverage. The above situation *is not* an extenuating circumstance. The normal prior-authorization and/or admission notification practices for the health plan are to be followed.

## II. Not Enough Time Situations

These are situations where the patient requires immediate or very near term medical services that are typically related to a service already being performed, e.g. diagnostic, office visit, surgery, etc. Prior-authorization work is not completed prior to service delivery. (Note: These situations are only extenuating circumstances related to a pre-authorization and do not prevent a provider from notifying the health plan about an admission within the specified time period, e.g. 24 hours.) Not Enough Time situations are when:

- A. Patient is seen in a physician's office. The physician determines there is an acute need for diagnostic imaging or a hospital admission.
- B. Patient is undergoing a procedure (which may or may not require pre-auth). Once the procedure begins, it evolves into a different/additional/more complex procedure or identifies the need for an add-on surgery/procedure, which is often scheduled for the same day or late in the afternoon/evening for the next morning.

'Not Enough Time' situations **DO NOT INCLUDE** when:

- The provider performs a procedure or provides a service that is considered experimental or investigational where a health plan denial of coverage would result in patient financial responsibility.