

Administrative Simplification

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Best Practice Recommendation for

*Extenuating Circumstances around Pre-
Authorization & Admission Notification*

Version	
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04-14-2009	Version 1.0
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06-02-2010	Amended as follows: "Health Plans should have a link on their web site that describes their policy". (per 01-27-10 meeting)

Table of Contents

Improvement Opportunity:..... 3

Summary of Recommendation:..... 3

Background: 3

Unable to Know Situations..... 4

Not Enough Time Situations..... 5

Best Practice Recommendations:..... 6

Unable to Know Situations..... 6

Not Enough Time Situations..... 7

BEST PRACTICE RECOMMENDATION

Topic: Extenuating Circumstances around Pre-Authorization & Admission Notification

*NOTE: This practice is addition to and **DOES NOT REPLACE** the Pre-Authorization and Admission Notification practices that are currently in place with each health plan. Those practices must be followed unless the specific extenuating circumstances outlined in this document exist.*

Improvement Opportunity:

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 for lack of pre-authorization or admission notification even if the services meet the health plan's criteria for clinical necessity.

This document outlines a set of recommended best practices for providers and health plans to follow, *only in these specific extenuating situations*, to prevent claims from denying for lack of a pre-authorization or admissions notification.

Summary of Recommendation:

This document outlines a number of extenuating situations when providers are not able to contact a patient's health plan prior to treating them and/or within a pre-defined period of the patient's admission. In these situations, ***providers should contact the health plan prior to submitting a claim.*** Claims will not be automatically denied for lack of timely admission notification, e.g. 24 hours, or for lack of pre-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.

Applicability:

All health plans and provider organizations are encouraged to adopt and appropriately implement these Best Practice Recommendations as soon as practical. Providers should check with the health plan to determine if they have implemented these and encourage the health plan to adopt them if they have not yet put them in place.

Background:

A number of health plans require providers to:

- Get selected services pre-authorized before treating the patient, and/or
- Notify the health plan of a patient's admission within the specified time period of the admission, e.g. 24 hrs.

If these steps are not taken, the claim for that service is likely to deny even if the services meet the health plan's criteria for clinical necessity.

Situations routinely arise where the provider is unable to obtain a pre-authorization before services are delivered or to notify the health plan within the specified time period of admission, e.g. 24 hours. In these situations, providers would like health plans to evaluate the claim AS IF those requirements had been met.

Extenuating circumstances fall into two categories – 'Unable to Know Situation' and 'Not Enough Time Situations'. The following lists each of those circumstances

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. The three Unable to Know situations are:

- 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 don't 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.

There can be a lag time between a patient's enrollment and the update of Medicaid's verification system to reflect the patient's enrollment, typically around the early part of each month. If a provider verifies a patient's coverage during this lag 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-authorizations. (Sometimes the physician which the patient selects OR has been selected for them by Medicaid/Healthy Options hasn't seen the patient and won't issue a retrospective referral for treatment).

- 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, DSHS benefits are verified with no other insurance on file at that time. Later, DSHS 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 pre-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. Pre-auth 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.

Best Practice Recommendations for 'Unable to Know' Situations:

Provider

Having a patient's current insurance information on file can help reduce the number of 'Unable to Know' situations. Each time a patient is seen, providers should obtain comprehensive coverage information from the guarantor/patient by asking the following questions:

- What is the current insurance coverage for this patient?
- Are there any other insurance coverage for this patient, e.g multiple employers, multiple responsible parties, etc.?

When one of the above listed 'Unable to Know' situations occur the provider should:

1. Contact the health plan *when* the coverage information is obtained from the patient and *BEFORE* the claim is submitted.
2. Explain to the health plan the extenuating circumstance that prevented them from requesting a pre-authorization or notifying of patient admission. Provide necessary documentation if requested.

Health Plan

In these extenuating situations, the health plan should NOT automatically deny the claim because a pre-auth was not obtained prior to service delivery or that notification was not

provided within the specified time period of admission *as long as the provider contacted the health plan prior to submitting the claim.*

1. Health Plans should have a Policy in place that allows for, and describes operational procedures related to, retrospective review of services when these extenuating circumstances prevent the provider from obtaining a required pre-authorization or giving notification within the specified time period after admission, e.g. 24 hours.

Health Plans should have a link on their web site that describes their policy.

2. When contacted by a provider about one of the above listed 'Unable to Know' situations, the health plan should:

If the service(s) requires a pre-auth,

- a. Assess the service for clinical necessity using the same criteria, AS IF the provider had requested a pre-auth before the service was performed.
- b. Process the claim AS IF a pre-auth had been requested prior to service delivery.

If notification of admission is required,

Process the claim AS IF notification of admission was given within the specified time period of admission, e.g. 24 hours.

Best Practice Recommendations for 'Not Enough Time' Situations:

Provider

When one of the above listed 'Not Enough Time' situation occurs the provider should:

1. Contact the health plan as soon as possible and not later than 1 business day after the service was provided to the patient AND before a claim is submitted.
2. Explain to the health plan the extenuating circumstance that prevented them from requesting a pre-authorization. Provide necessary documentation if requested.

Health Plan

In these extenuating situations, the health plan should NOT automatically deny the claim because a pre-auth was not obtained prior to service delivery *as long as the provider contacted the health plan prior to submitting the claim.*

1. Health Plans should have a Policy in place that allows for, and describes operational procedures related to, retrospective review of services when these

extenuating circumstances prevent the provider from obtaining a required pre-authorization.

Health Plans should have a link on their web site that describes their policy.

2. When contacted by a provider about one of the above listed 'Not Enough Time' situations, the health plan should:
 - a. Assess the service for clinical necessity using the same criteria, AS IF the provider had requested a pre-auth before the service was performed.
 - b. Process the claim AS IF a pre-auth had been requested prior to service delivery.

When Recommended Best Practices are not Followed:

If the provider does not notify the health plan of the extenuating circumstance prior to submission of the claim, the service and/or elapsed admit days will likely be denied. If the extenuating circumstances are made known to the health plan upon appeal, the health plan will :

- Assess the service/admit days for clinical necessity using the same criteria, AS IF the provider had requested a pre-auth before the service was performed.
- Reprocess the claim AS IF a pre-auth had been requested prior to service delivery.