Best Practice Recommendation

for

Extenuating Circumstances around Pre-Authorization & Admission Notification
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BEST PRACTICE RECOMMENDATION

**Topic:** Extenuating Circumstances around Pre-Authorization & Admission Notification

**Notes:**

- Most health plans perform medical necessity review for a subset of the services for which they provide coverage. Some health plans require that providers request the review prior to delivery of those services, e.g., Pre-Authorization. Other health plans give providers the option of requesting the review prior to delivery of those services. Both of these situations are considered forms of Prospective Review. The recommended practices outlined in this document apply to all situations where a Prospective Review is required in order for a claim to pay.

  The terms prospective review and pre-authorization will be used interchangeably throughout this document.

- 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 one of the specific extenuating circumstances outlined in this document exist.

**Improvement Opportunity:**

Ideally, for services that require Prospective Review, providers will request the review prior to performing the service for the patient. However, there are a number of situations where it is challenging/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 specific set of extenuating circumstances under which pre-authorization and admission notification requirements are eased if the associated best practices are followed.

**Summary of Recommendation:**

A number of extenuating circumstances are identified under which providers may not be able to request a pre-authorization prior to treating the patient and/or to notify the health plan within a pre-defined time period of the patient's admission. If/when these circumstances occur, **providers should contact the health plan prior to submitting a claim and follow the recommended practices** so that their claims will not be automatically denied for lack of pre-authorization or for lack of timely admission...
notification, e.g. 24 hours. Health plans will still evaluate the service(s) for clinical necessity.

**Applicability:**

The best practices that are recommended in this document apply to all services that are covered under a member's medical benefit for which a Prospective Review is required, including mental health and chemical dependency, whether the health plan directly performs the Prospective Review or outsources the performance of the Prospective Review to another organization.

The best practices that are recommended in this document do not apply to services that are covered under a member's pharmacy benefit, since these services are provided at a point-of-service other than a physician's office or a hospital.

**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 may arise where the provider cannot / does not obtain a pre-authorization before services are delivered or cannot /does not notify the health plan within the specified time period of admission, e.g. 24 hours. In these situations, providers would like health plans to offer alternatives so that claims will not be denied strictly for lack of pre-authorization / notification

**Extenuating Circumstances:**

For the following set of extenuating circumstances when pre-authorization and/or admission notification requirements are not met, the health plan will evaluate the services for payment as long as they are contacted by the provider before the claim is sent and as long as the best practice recommendations are followed. When these best practices are followed, the health plans will not deny the claim for lack of obtaining a pre-authorization. The claim will still be reviewed for medical necessity.

For the purpose of these best practice recommendations, outpatient services refer to any and all services that are delivered in a non-ER, non-inpatient setting.
Extenuating circumstances fall into the following categories –

For outpatient services

I. Authorization Request for Outpatient Services Processed Post-Service

For all services – inpatient and outpatient

II. Unable to Know

IV. Inherent Components

For inpatient services

III. Not Enough Time

I. Authorization Request for Outpatient Services Processed Post-Service

This circumstance is only extenuating to the extent that it applies to outpatient services (as defined above) that have already been delivered. It does not apply to future outpatient services that may be part of a recurring treatment, some of which have already been delivered. Pre-service Prospective Review can still be requested for future services associated with a recurring treatment. Also, this circumstance does not apply to admission notification requirements.

Post-service Prospective Review requests can be placed up to 5 calendar days after the service has been delivered or started as long as the claim has not been received by the health plan and as long as:

Documentation can be provided, if/as requested by the health plan, to demonstrate that the provider could not reasonably expect the need for the service in question prior to performing the service due to one of the following:

1. An “urgent” clinical need for the service(s) where the “urgent” need was identified and documented for the date of service, and/or

*1 As defined in the BPR-Standard Timeframe

Urgent Care (aka ‘Expedited’ for Medicare) - any request for approval of care or treatment where 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.
Note: this extenuating circumstance includes when the patient is undergoing a procedure that was pre-authorized and, in the course of doing that procedure, the need for another procedure was identified and that procedure was performed. This situation is considered an Extenuating Circumstance:

- Even if the added procedure required that an alternative treatment had to be tried prior to that procedure.
- As long as the added procedure had not been previously requested and denied.

2. A requirement for clinical coordination of services was determined at the time of service, e.g. the patient has to travel 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, and/or

3. Inaccurate information about the need for a pre-authorization was given by the health plan representative or web site.

The grace period is not applicable:

a. For inpatient admissions
b. Where documentation about the extenuating circumstance does not exist
c. In situations where the failure to obtain a pre-authorization is related to operational workflow within the provider organization

Additionally:

a. The grace period does not eliminate the member’s financial penalty in situations where such a penalty is part of the member contract
b. 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.

Provider should note in their request that it is being submitted post-service due to a qualified extenuating circumstance, and briefly describe the circumstance.

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 pre-authorization, medical necessity can be assessed before resources are expended and claims can be submitted as soon as services are delivered.

II. Unable to Know

*This circumstance applies to all inpatient services and to outpatient services.*

These are circumstances under which 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 four 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 patient initially indicated that **they were self-pay and that no medical coverage was in place at time of treatment**. It was later determined that medical coverage was actually in place.

Example:

In some cases, patients would prefer to pay “out of pocket” rather than initiate COBRA coverage and having 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 to the month, thus providing coverage for a treatment that has already been delivered.

C. 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 at the time of treatment or the patient was later enrolled in a Medicaid program retroactive to cover the service date.

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).
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 provider to submit for retrospective authorization for services provided after the enrollment date.

D. 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.

3. **Identify theft**: The patient falsely posed as another individual using that individual’s health information as coverage for services. Coverage was verified. After the patient is treated, the provider discovers that the patient either:
   a) Had other insurance in their name that was applicable, or
   b) Discovers that the patient has no insurance, qualifies for Medicaid and helps to enroll the patient post-service with coverage retroactive to the time of service (aka ‘C’ above)

When one of the above listed ‘Unable to Know’ circumstances 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.
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.

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

The provider was able to communicate with the patient prior to giving treatment, but insurance coverage information was not obtained and/or 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 coverage was not in force.

The above situation is not an extenuating circumstance and the normal pre-authorization and/or admission notification practices for the health plan are to be followed.

**Note to Providers:** 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.?

Eligibility and Benefits should then be confirmed with the health plan at each time of service.

III. Not Enough Time

This circumstance applies only to inpatient services.

These are circumstances under which 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. (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 by a healthcare provider. The provider determines there is an acute need for 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 (where these additional procedures do require a pre-authorization),

Note: this includes the situation where, in the course of doing that procedure, the need for another procedure was identified and that procedure was performed. This situation is considered an Extenuating Circumstance:
- Even if the added procedure required that an alternative treatment had to be tried prior to that procedure.
- As long as the added procedure had not been previously requested and denied.

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.
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.

'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.

**When Recommended Best Practices are not Followed:**

For ‘Unable to Know’ and ‘Not Enough Time’ circumstances, 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.

**IV. Inherent Component Services**

This circumstance applies to inpatient and/or outpatient services with inherent components.

There are services that have multiple inherent components (see NOTES below). In some cases for some health plans, each component service requires its own pre-
When pre-service review is requested by a provider and, at the time of review (based on regulatory timelines consistent with the submitted requests), the health plan notices the absence of one or more inherent components of a service for which separate pre-authorization or medical necessity review will be required, the health plan will contact the provider electronically or by phone or fax to determine if all component services are submitted.

There may be situations when, at the time of a pre-service review, the provider did not include all inherent component services AND the health plan did not notice the absent components. Later, at the time of post-service medical necessity review or of Supplemental Review (as defined in the BPR-Standard Notification Timeframes), the health plan notices that a pre-authorization was obtained for only a subset of the inherent components. In these cases, the health plan will not deny the missing inherent component services for lack of a pre-authorization.

NOTES: Inherent component services – where one service is an essential attribute of another, i.e. one can’t be provided without the other. Examples might include:
• an infused/injectable medication and the service to administer that medication,
• a device and the procedure related to implanting the device,
• a sleep study and the interpretation of the study,
• the placement of a drainage tube and the radiological guidance,
• hyperbaric oxygen under pressure and the physician supervision.