Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Extenuating Circumstances

This policy is modeled after the Best Practice Recommendations that support Washington State Senate Bill 5346 and regulatory requirements of WAC 284-43-2060.

This policy and process is applicable to all plans issued or renewed on or after January 1, 2018 by Regence with exception of Extenuating Circumstances Criteria #7 below. *Extenuating Circumstances criteria # 7 is applicable to plans issued on or after January 1, 2018 by Regence in WA State only excluding Medicare Advantage and FEP.

This policy does not apply to prescription drug services.

Overview

Obtaining required pre-authorization prior to service delivery is the optimal practice to mitigate provider and member financial risk, however several extenuating circumstances may make it impossible, before treating the member, to obtain a prior authorization.

Claims will not be administratively denied for lack of prior authorization so long as we are contacted before the claim is submitted, the specific extenuating circumstance is documented (suggested supporting documentation is outlined below) and such circumstance meets at least one of the Extenuating Circumstances criteria outlined below. If we are contacted after the claim is submitted, the administrative denial may be disputed as an extenuating circumstance via the appeal process if the specific extenuating circumstance is documented, as noted above, and such circumstance meets at least one of the Extenuating Circumstances criteria outlined below.

NOTE: If we are contacted after the claim is submitted but still in process, the administrative denial on the claim must be disputed via the appeal process post claim denial. We are unable to stop claims processing.

In addition, even if the service(s) meet the below Extenuating Circumstances criteria, we will still review for appropriateness, level of care, medical necessity and benefit coverage under the criteria for the applicable plan based on the information available to the provider or facility at the time of treatment.

The criteria and procedures that participating providers and facilities must follow to notify Regence of an extenuating circumstance pre-claim submission or to dispute a claim denied for no pre-authorization are outlined below.

Extenuating Circumstances Criteria

The following seven exceptions to obtaining pre-authorization may qualify as an Extenuating Circumstance:

1. **Member presented with an incorrect member ID card or member number or indicated they were self-pay, and that no coverage was in place at the time of**

treatment, or the participating provider or facility is unable to identify from which carrier or its designated or contracted representative to request a pre-authorization.

Examples:

- The provider verified that no medical coverage was in place at time of treatment. It was later determined that medical coverage was in place. In some cases, patients prefer to pay out of pocket rather than initiate COBRA coverage and 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.
- 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.
- Coverage retrospectively determined to not be related to an accident or work-related injury. During the scheduling process, these patients indicate that their condition is accident related. During or after treatment, the provider discovers that the service is not accident/work related.
- Other primary insurance retrospectively discovered: Coverage for these patients is verified with the health plan of record prior to treatment and any pre-authorization/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, Department of Social and Health Services (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.

This DOES NOT INCLUDE when the provider could communicate with the member prior to giving treatment, but insurance coverage information was not obtained and/or was not verified prior to the service(s). This situation is not an extenuating circumstance. The normal prior authorization and/or admission notification practices are to be followed.

Note to Providers: Best practice is verifying that current insurance information is on file, which can help reduce the number of 'Unable to Know Coverage' situations. Each time a patient is seen, providers should obtain comprehensive coverage information from the guarantor/member.

2. Natural disaster prevented the provider or facility from securing a pre-authorization or providing hospital admission notification.

3. Member is unable to communicate (e.g., unconscious) medical insurance coverage. Neither family nor collateral support present can provide coverage information.

Examples:

- 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.
- Psychiatric patients: These patients are admitted through the Emergency Department for clinical conditions related to cognitive impairment.
- 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.
- Non-English speaking patients: These patients don't speak English and a translator cannot be obtained in a timely manner.

4. Compelling evidence the provider attempted to obtain pre-authorization. The evidence shall support the provider followed our policy and that the required information was entered correctly by the provider office into the appropriate system.

Note: A copy of the faxed pre-authorization request showing the information was entered correctly indicating the member health plan information and a fax confirmation from the fax machine showing the fax was successfully sent to the appropriate health plan fax number will be considered compelling evidence.

5. A surgery which requires pre-authorization occurs in an urgent/emergent situation. Services are subject to review post-service for medical necessity

6. A participating provider or facility is unable to anticipate the need for a pre-authorization before or while performing a service or surgery.

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

Examples:

- Patient is seen in a physician's office and the physician determines there is an acute and immediate need for diagnostic imaging or a hospital admission.
- Patient is undergoing a procedure which may or may not require pre-authorization. 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.

This DOES 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.

An extenuating circumstance DOES NOT APPLY when the service or services occur during an office visit solely for the convenience of the provider.

***7. 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. *NOTE:**

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Notifying Regence About an Extenuating Circumstance

Pre-Claim Submission

Call the **Provider Contact Center** to notify us of an extenuating circumstance

The following may be requested:

Member name, DOB, ID #

Provider name and ID

Date of Service

Description of extenuating circumstance that was present

Supporting documentation of the extenuating circumstance will be requested to be faxed to (866) 273-1820

Suggested supporting documentation is outlined below.

Notification of an extenuating circumstance may also be faxed directly to (866) 273-1820 and must include ALL the following:

Member Name, DOB and ID

Provider name and ID

Date of Service

CPT codes

Description of extenuating circumstance that was present

Fax cover sheet should include “Extenuating Circumstance” in subject line:

Return Fax #

Supporting documentation (suggested documentation is outlined below)

Note: Claims submitted prior to receiving a written response from Regence regarding the extenuating circumstance request may be subject to the administrative denial.

Post Claim Administrative Denial

Use the adverse determination appeal form (PDF) to dispute a claim that has denied for no pre-authorization. Please complete the form and follow the instructions outlined in the section that applies to ‘Denials for Pre-authorization not obtained’.

Please fax the completed form and all extenuating circumstance supporting documentation as applicable to: (866) 273-1820.

Suggested supporting documentation is outlined below.

Extenuating Circumstance Supporting Documentation

Submit the following documentation to support an extenuating circumstance as applicable:

Dated documentation, e.g. admission face sheet, obtained at the time of service indicating: The insurance information provided by the patient/representative or the patient's/representative's inability to provide insurance information or the patient's/representative's reporting self-pay.

Verification of no coverage such as Availity screenshot at the time of inquiry (though eligibility at date of service was later confirmed).

Dated documentation obtained at time of service showing eligibility confirmation from another payer, e.g. web eligibility screen shot or copy of electronic eligibility confirmation, AND/OR that payer's EOB denying the service as not eligible for coverage (e.g. denied due to alternate primary coverage).

Applicable office visit chart notes for either the date of service or the referral along with other clinical documentation (as needed), e.g. diagnosis, H & P, failed alternative treatment(s), or interim/alternative treatment(s) as appropriate, indicating the medical necessity for the procedure and the rationale for providing the procedure at that time without prior authorization, i.e. procedure is time sensitive or emergent.

A copy of the faxed pre-authorization request showing the information was entered correctly indicating the member health plan information and a fax confirmation from the fax machine showing the fax was successfully sent to the appropriate health plan fax number.

Any other documentation felt to support an extenuating circumstance was present.

Note: Submission of the above referenced documentation does not guarantee payment. Even if the Extenuating Circumstance criteria applies, the service is subject to benefit coverage and medical necessity under post service review.