Kaiser Permanente Northwest Provider Manual 2018

Utilization Management

KAISER PERMANENTE®

Table of Contents

Section 4: Decision Making for Medical Service Requests

Appropriate utilization management (UM) contributes to the success of Kaiser Permanente (KP) and its members. UM's goal is to achieve optimum results by determining what resources are medically necessary and appropriate for an individual patient, and to provide those services to the patient in the right setting in a timely manner. Decisions about what is medically necessary and appropriate are based on evidence-based criteria, the practitioner's professional judgment, and assessment of the member's medical condition.

Effective UM doesn't mean withholding necessary services, even if those services may result in less-than-optimum outcomes. Each practitioner uses his/her clinical expertise to evaluate the care needs of the individual and arranges for those medically necessary services in the appropriate setting.

As a contracted provider with Kaiser Permanente, you acknowledge that KP conducts UM programs relating to health care services provided to members. This means you agree to participate in KP's UM programs, comply with KP's UM policies, and cooperate with KP's UM committees and staff. This means providing timely access to Kaiser Permanente Member medical records for KP UM staff.

The Kaiser Permanente Resource Stewardship and Utilization Management (RS/UM) program was designed to ensure the following:

1. Services are medically necessary, consistent with the patient's diagnosis, delivered at appropriate levels of care, and provided at the right time.
2. Authorized care matches the member's benefit.
3. Services are provided by Kaiser Permanente Northwest providers or contracted providers unless otherwise authorized.
4. Practitioners adhere to guidelines, standards, and criteria set by regulatory and accrediting agencies as is appropriate to health plan product and specific population (e.g., Commercial, Medicare, Medicaid):
    - KPNW uses medical necessity criteria based on sound clinical evidence to make RS/UM decisions (e.g., Milliman Care Guidelines, Medicare, Medicaid, and those developed by Kaiser Permanente) taking into account the local delivery system and members' individual circumstances.
5. The UM team of physicians, RNs, and support staff are trained and qualified to assess clinical information used to make UM decisions. Appropriately licensed health professionals supervise all review decisions, and licensed physicians review all denials that are based on medical necessity.

Utilization review decision-making is based only on appropriateness or medical necessity of services and the existence of coverage. Kaiser Permanente doesn't reward practitioners or other individuals for issuing denials for coverage nor are decisions about hiring, pay, promotions, or termination of employment based on the likelihood that denials will be supported. UM decision makers don't receive financial incentives for decisions that result in lower utilization.

4.2 Referrals and Authorizations

You must contact Kaiser Permanente Regional Referral Center at 503-813-4560 and get referral authorization before services are rendered, or determine whether a service requires prior authorization. Failure to do this may result in denial of payment. Prior written authorization ensures that only necessary and benefit-covered services are provided and that you, in turn, are paid for those services. Authorization is provided with the use of the Prior Authorization Request form.

Most services require prior authorization. To verify benefit coverage for prior authorization contact Member Services at 503-813-2000.

As a contracted provider, you're expected to provide timely feedback to Kaiser Permanente on the outcome of consultations, plans of care, and further testing and follow-up.

Kaiser Permanente provides diagnostic, imaging, and lab testing for members at Kaiser Permanente medical facilities, so please direct members to one of these facilities. For a current list of plan facilities, go to kp.org or call the Kaiser Permanente Member Services Department, Monday through Friday, 8:00 a.m. to 5 p.m., 1-800-813-2000, to request a Kaiser Permanente Medical Facility Directory.

Kaiser Permanente will pay for covered health care services only when Kaiser Permanente Referral and Authorization requirements are met. **This includes instances when Kaiser Permanente is the secondary payer for Kaiser Permanente Traditional/Deductible and Added Choice® Point-of-Service (POS) members and plan sponsors are the secondary payer for self-funded members.**

4.3 Procedure for Authorization Notices

The authorization contracted provider and the member will receive written notification of authorized services within state and federally required timeframes.

4.3.1 Authorized Contracted Provider Guidelines

Forward all work-up results to the referring plan provider with any other pertinent clinical information pertaining to the consultation. Call the referring plan provider if your findings are urgent.

If the authorized contracted provider determines that additional visits are medically necessary, the visits should be requested before the current date of authorization expires. Fax these requests to the Referral Management and Clinical Review Department at 877-800-5456 using the Pre-Authorization Request Form.

4.4 Authorization and Concurrent Review

Send requests for authorization of admissions (emergency or scheduled) to plan hospitals to the Regional Referral Center.

Authorization and concurrent reviews are determinations by Kaiser Permanente that an admission, extension of stay, or other health care service has been reviewed and meets the clinical requirements for medical necessity, appropriateness, level of care and/or effectiveness, and meets clinical criteria of the member's applicable health benefit plan.

Kaiser Permanente may conduct onsite or telephonic reviews at plan hospitals and/or facilities on a case-by-case basis. The hospital and/or facility's utilization review department is responsible for providing clinical information to Kaiser Permanente daily or as requested. As a contracted provider, you're required to facilitate UM reviews, including providing clinical information requested by KP and arranging for physicians and other staff to confer with KP practitioners.

The Kaiser Permanente UM staff uses approved criteria to determine medical necessity for acute hospital care. If the clinical information meets this criteria, we'll approve a specified number of days/services. If the clinical information doesn't meet this criteria, we'll refer the case to the Kaiser Permanente UM physician reviewer. We'll notify the attending physician and facility of the review results. The attending physician can request an expedited appeal of any Adverse Benefit Determination (see Section 4.9 of this manual).

Failure to provide clinical information for authorized days/services by the next assigned review date can result in a denial of all days/services beyond the initial authorization period, due to untimely clinical review.

4.4.1 Non-Emergent and Elective Inpatient Hospital Admissions and Services

For non-emergent or elective inpatient care, the health care provider must submit all information through the Community Provider Portal in accordance with regulatory compliance. Gather all supporting documents, including history and physical, clinical notes, physician's order, and the diagnosis codes and procedure codes.

Routine (non-urgent) authorization requests for hospital admissions and services will be handled according to the clinical situation, not to exceed 15 days. When a plan utilization review physician determines services to be time-sensitive, we'll address authorization requests within 72 hours of receipt with appropriate documentation. If we need additional information, we'll request it within the first 24 hours of notification, with up to 48 hours given for submission of requested information.

Once processed and approved, an authorization notice, with authorization number, will be returned by fax to the admitting physician. A copy will also be sent to the admitting plan facility.

4.4.2 Skilled Nursing Facility (SNF) Admissions

Patients who need admission for skilled nursing require authorization from the SNF placement desk at 503-499-5438. The SNF registered nurse (RN) placement coordinator will help transition the patient from the inpatient, clinic, emergency room, or home setting to a Kaiser Permanente contracted SNF. The SNF RN placement coordinator can also help determine Kaiser SNF benefits and available skilled days. The SNF placement desk is available 8:30 a.m. to 5:00 p.m., 7 days a week.

4.4.3 Scheduled Ambulance Transfers

Kaiser Permanente will pay for covered health care services only when Kaiser Permanente authorization requirements are met. Failure to get authorization before a scheduled transport can result in a denial of payment for the transport.

All scheduled ambulance transfers, including air ambulance, will be reviewed against Centers for Medicare and Medicaid Services (CMS) ambulance criteria as described in Chapter 10, Ambulance Services, Paragraph 4 of this document:
cms.gov/manuals/Downloads/bp102c10.pdf

Transportation by wheelchair van is not a covered benefit. The member is financially responsible for wheelchair transportation and the transferring facility should arrange the service.

Physicians and staff at any facilities can talk directly with a Northwest Permanente physician at the Regional Telephonic Medicine Center (RTMC), 24/7 at 877-813-5993 (toll free) or 503-735-2595 to arrange a safe transfer.

4.4.4 Home Health and Home Based Palliative Care

To get authorization for home health services, call the home health utilization nurse at 503-499-5200 or fax a request to 503-778-2504.

To get authorization for hospice and home based palliative care services, call the continuing care services utilization manager or back office supervisor at 503-778-2526 or 503-499-5239.

4.4.5 Transplants

Kaiser Permanente developed a national transplant network that consists of numerous centers of excellence across the nation. The health care provider must submit all information through the Community Provider Portal. All requests will be evaluated by the applicable specialty.

Complete the form with the patient's information and your provider information as outlined. Attach all supporting documents, including history and physical, clinical notes, physician's order, and the diagnosis codes and procedure codes with the Request for Internal Services.

4.5 Ancillary Services

The following sections of this manual summarize guidelines for lab, imaging, and therapy services.

4.5.1 Laboratory Services

All outpatient laboratory services are provided by Kaiser Permanente labs or the plan facilities identified in the Kaiser Permanente facility provider directory at kp.org. Include an ICD-10 code, NPI, and plan provider signature on all lab orders. If this information is not supplied to a Kaiser Permanente lab, a staff member will contact the requesting plan provider to ask for it. Orders will be returned via fax to the plan provider's office for completion. Once the completed order is received, the lab will process the samples for testing. Testing may be delayed and/or cancelled if the completed information is not received the following business day.

Please visit our Community Provider Portal for additional lab services information at: http://www.providers.kaiserpermanente.org/html/cpp_knw/laboratory.html

4.5.2 Imaging (Radiology) Services

All outpatient imaging services are provided by Kaiser Permanente medical facilities or the plan facilities identified in the Kaiser Permanente ancillary provider directory at kp.org. The written imaging order must include an ICD-10 code and the plan provider's signature. If this information is not supplied to a Kaiser Permanente imaging department, a staff member will contact the requesting plan provider to ask for it. A completed order can then be faxed to the imaging department. An imaging procedure can't be scheduled or performed without a written order signed by the requesting plan provider.

For a current list of plan facilities, see the Kaiser Permanente medical facility directory on the Community Providers website at www.kp.org.

4.6 Clinical Trials

Commercial member contracts don't cover clinical trials. However, if a member enrolls in one, routine costs for medically necessary conventional services received in connection with the clinical trial are covered if the service would've been covered absent the clinical trial, consistent with the coverage provided in the health benefit plan. This includes the type and frequency of any diagnostic modality typically covered for a patient who isn't enrolled in a clinical trial, isn't needed solely because of the trial, and is medically necessary as determined by a participating provider.

Excluded from coverage are:

- A service, item, or drug that is the subject of the clinical trial.
- A service, item, or drug provided only to satisfy data collection and analysis needs for the clinical trial and not used in the direct clinical management of the patient.
- An investigational or experimental drug or device that hasn't been approved for market by the Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient, a family member, or companion of the patient that are associated with the travel to or from a facility providing the clinical trial.
- An item or drug provided by the clinical trial sponsors free of charge for any patient.

The Medicare payment rules for Medicare-qualified clinical trials apply to Kaiser Permanente Medicare (Senior Advantage) Members. If a Kaiser Permanente Medicare (Senior Advantage) member wants to participate in a Medicare qualifying clinical trial, the member doesn't have to ask Kaiser Permanente for permission to do so. Medicare will pay most of the cost of the services associated with clinical trials less any deductible or coinsurance. In this instance, the member, not Kaiser Permanente, is responsible to pay any deductibles or coinsurance. Kaiser Permanente will continue to cover medically necessary conventional care consistent with the coverage provided in the member's health benefit plan.

For a service(s) related to a Humanitarian Device Exemption, authorization is required.

If a KP UM medical director provides approval, KP will reimburse at the rate specified in the provider contract, or if the provider contract is silent, then at the provider's acquisition rate.

4.7 Denied Authorizations

We may deny a referral or request for authorization for the following reasons:

- Services are deemed not medically appropriate.
- The patient doesn't meet membership eligibility requirements.
- The request for services is not a covered benefit or the benefit is exhausted.
- Services were performed without prior authorization.
- Refusal to use plan providers of Kaiser Permanente Northwest.

The reason for the denial will be stated in the Adverse Benefit Determination sent to the member and contracted provider. Adverse Benefit Determination letters will also inform

contracted providers of their right to have the denial reconsidered (reconsiderations are only offered for medical necessity denials). See Section 4.9 of this manual for more information.

All requests to appeal pre-service denials must be accompanied by the written permission of the member. You can find criteria used for making the decision by contacting the Member Relations Department at 503-813-4480. Members receive similar notices informing them of the decision and their appeal rights.

If you feel an Adverse Benefit Determination has been issued in error, write the Appeals Unit to request an Appeal of the Adverse Benefit Determination. See Sections 4.9 and 4.10 of this manual for more information regarding contracted provider appeal policies and procedures for fully insured members. For self-funded members, see Section 14 of this manual.

Contracted provider requests for retroactive authorizations are not accepted by the Referrals Management and Clinical Review Department. See Sections 4.9 and 4.10 of this manual for more information regarding provider appeal policies and procedures for fully insured members. For self-funded members, see Section 14 of this manual.

4.8 Medical Necessity Criteria

All services authorized by the Kaiser Permanente Resource Stewardship/Utilization Management Department will be evaluated for medical necessity based on these criteria:

- MCG (formerly Milliman Care Guidelines)
- Medicare criteria and regulations
- Medicaid criteria and regulations
- Kaiser Permanente internally developed criteria

You can review specific criteria by contacting Kaiser Permanente's Resource Stewardship/Utilization Management Department Regional Referral Center at 503-813-4560.

4.9 Reconsiderations and Appeals

NOTE: For self-funded members, see the Self-Funded Provider Manual.

Contracted providers can request a Reconsideration of any Medical Necessity initial pre-service decision made by Kaiser Permanente. Contracted providers can also, when appointed by their Kaiser Permanente member, appeal any pre-service decision made by Kaiser Permanente. The following sections describe the Kaiser Permanente Contracted Provider Reconsideration and Provider-appointed Appeal Guidelines and Processes. For information regarding Post-service Appeals, Payment Disputes, and Provider Appeals, see Section 5 of this manual.

4.9.1 Reconsideration of Decisions Following Initial Pre-Service Denial Determination

A plan provider can request, verbally or in writing and on behalf of a fully insured member, a Reconsideration of an Adverse Benefit Determination. Note: This process doesn't apply to benefit denials or Post-Service Claim payment denials.

Reconsiderations (also known as peer-to-peer discussions) are conducted between the contracted provider and the Kaiser Permanente physician reviewer who made the adverse benefit determination. If the physician reviewer cannot be available within three business days, he or she can designate another physician to review the reconsideration. To request reconsideration, contracted providers can call the Regional Referral Center at 503-813-4560.

Decisions on the reconsideration are made within three business days after receipt of the request for reconsideration, unless the medical condition of the member requires a quicker decision. If the reconsideration doesn't resolve the difference of opinion, plan providers can file a written appeal on behalf of the member. This requires the member's written consent.

Contact Kaiser Permanente Membership Services Unit at 800-813-2000 or 503-813-2000 with any questions or to get an Appointment of Representation (AOR) form. The reconsideration process isn't a prerequisite to the appeal process and isn't considered an appeal.

4.9.2 Standard Appeal Process of Initial Adverse Pre-Service Benefit Determinations

These guidelines for standard pre-service appeals apply to services that aren't urgent in nature:

- The requesting plan provider may submit a written appeal request along with a signed Appointment of Representation (AOR) form from the member to the Kaiser Permanente Appeals Unit at the following address:

  Kaiser Permanente
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232

  Note: If the service requested is urgent, the plan provider can ask for an expedited appeal without the member's consent by calling 1-800-813-2000 or 503-813-2000 or faxing a written appeal request to the Appeals Unit at 503-813-3985.

- If we don't get a signed AOR form with the standard appeal request, we'll notify the member in writing and ask him or her to complete the necessary AOR form, which will authorize the contracted provider to act on the member's behalf.

- The Kaiser Permanente Appeals Unit staff will review the documentation and contact the appealing contracted provider for additional information, if needed.

- We'll review pre-service appeals and provide written notification within state and federal required timeframes, no longer than 30 calendar days within receipt of the appeal request. An appropriate physician or behavioral health clinician makes all denial decisions when based on medical appropriateness. Physician reviewers participating in the appeal process will not have been involved in the initial determination nor be subordinates of a physician involved in the initial determination.

- If the initial decision is overturned, the Appeals Unit staff will process the request per department procedures. If the initial decision is upheld, the Appeals Unit staff explain the decision to you and, if applicable, provide information on any further appeal rights.

For Kaiser Permanente Senior Advantage Members: If the initial decision is upheld, the case will automatically be forwarded to the independent review entity used by Medicare for the final determination.

4.9.3 Expedited Pre-Service or Urgent Concurrent Appeals

An expedited appeal process is available when waiting the time period to resolve a standard appeal could seriously jeopardize the member's life, health, or ability to regain maximum function, or subject the member to severe pain that can't be adequately managed without the services that are the subject of the request. The requesting contracted provider can fax a written appeal request to the Kaiser Permanente Appeals Unit at 503-813-3985 or call 800-813-2000 or

503-813-4480.

- The Kaiser Permanente Appeals Unit staff will review the documentation and contact the appealing contracted provider for additional information if needed.
- We'll review the appeal as quickly as possible, not to exceed 72 hours of the appeal request. An appropriate physician or behavioral health clinician makes all denial decisions for medical appropriateness. Physician reviewers participating in the appeal process will not have been involved in the initial determination nor be subordinates of a physician involved in the initial determination.
- If the initial decision is overturned, the Appeals Unit staff will contact the contracted provider and the member verbally and in writing immediately after the determination. The request will be processed per department procedures.
- If the initial decision is upheld, the Appeals Unit staff will contact the contracted provider and the member verbally and in writing immediately after the determination. They'll explain the decision and, if applicable, provide information on any further appeal rights.

For Kaiser Permanente Senior Advantage Members: If the initial decision is upheld, the case will automatically be forwarded to the independent review entity used by Medicare for the final determination.

4.10 Retrospective or Post Service Review

Retrospective review occurs after the member has received care and after they or their provider has submitted a claim for payment. Staff in the Claims Department review and make decisions on claims. Staff in Clinical Review support the Claims Department in reviewing claims without a referral or authorization if there is an issue of medical necessity. These same staff review claims for appropriate coding and billing that require clinical expertise. Issues such as unbundling, upcoding, or undocumented services are reviewed in the Post Service area. All issues related to medical necessity decisions, experimental or investigational services, or issues related to potentially cosmetic services are reviewed by physician reviewers before a denial is issued.

We use these resources during the Post Service Review process:

- Centers for Medicare and Medicaid Services (CMS) policies
- Kaiser Permanente medical or payment policy
- American Medical Association (AMA) guidelines (e.g., Current Procedural Terminology, CPT®)
- Professional specialty organizations (e.g., American College of Surgeons, American Academy of Orthopaedic Surgeons, American Society of Anesthesiology)
- State and/or federal mandates
- Subscriber benefit contracts
- Provider contracts
- Specialty expert consultants

Therefore, our policies and review rules are developed using information gleaned from many sources. We designed our review rules to verify the clinical accuracy of procedure codes as they relate to those submitted on claim forms.

Note: While all codes may be acceptable to report, separate reimbursement might not be made. Reimbursement is based on many factors, such as the member's coverage; coding rules outlined by CMS, CPT and other nationally recognized entities such as those listed above; and federal and state regulations. We may perform line item reviews to verify coding and reimbursement.

This ensures that our members receive the right care at the right level at the right time at the appropriate cost. To accurately adjudicate claims and administer subscriber benefits, it's often necessary to request medical records or itemized statements. The following is a list of claims categories from which we may routinely ask you to submit clinical information. Some (e.g., specific modifiers) are discussed in more detail throughout this manual.

- Procedures or services that require precertification/preauthorization but did not go through the normal process before services were rendered
- Procedures or services involving determination of medical necessity, including but not limited to those outlined in medical policies/criteria
- Procedures or services that are or may be considered cosmetic or experimental/investigational
- Claims that require us to review medical records to determine if the service provided is covered
- Procedures or services reported with "unlisted," "not otherwise classified," or "miscellaneous" codes
- Procedures or services reported with CPT® modifiers 22, 62, 66, and 78
- Quality of care and/or quality improvement activities (e.g., data collection as required by accrediting agencies, such as NCQA)
- Claims involving coordination of benefits
- Claims being appealed
- Claims being investigated for fraud and abuse or potential inappropriate billing practices
- Claims for which services reported appear to have been unbundled
- Charges that aren't in line with the diagnoses on the claim submitted

This list is not intended to limit the ability of the Health Plan to request clinical records. There may be additional individual circumstances when we may ask for these records.

Services classified under the Humanitarian Device Exemption (HDE) must have an authorization prior to usage. Once authorized, the reimbursement would be based on invoice unless otherwise contracted. Medical Necessity Review does monitor claims for usage and reimbursement of such devices.

4.11 Payment Disputes

NOTE: See the Self-Funded Provider Manual for self-funded members.

Contracted providers should contact the Kaiser Permanente Provider Inquiry Department Monday through Friday, 9:00 a.m. to 4 p.m., at 503-735-2727 or 866-441-1221 with questions or concerns about a specific claim. Many questions and issues regarding claim payments and/or denials can be resolved quickly over the phone or via fax.

If, after contacting the Provider Inquiry Department, you don't agree with the answer or outcome, you can file a formal Payment Dispute using this process:

1. Submit a formal Payment Dispute using a document that contains the information necessary to investigate your issue.

   Send the Payment Dispute and any supporting documentation to:

   Kaiser Permanente
   Attention: Provider Appeals
   500 NE Multnomah St., Suite 100
   Portland, OR 97232

   Or fax to: 503-813-2017

2. Your Payment Dispute will receive special handling by a dedicated research specialist. We'll review your rationale for request, along with any applicable enclosures. We'll also consider all data available internally when researching your claims payment or denial.

3. If the initial decision is overturned, the research specialist will process the claim in dispute within 60 calendar days of receipt of the Payment Dispute form. Your Provider's Explanation of Payment (EOP) will serve to notify you that the claim has been paid.

4. If the initial decision is upheld, the research specialist will contact you in writing within 60 calendar days of receipt of the Payment Dispute form to explain the decision and offer information on any further appeal rights.

The payment dispute process is not a prerequisite to the appeal process described above. The plan provider can initiate an appeal, in writing and on behalf of the member, without going through the payment dispute process. The member's written consent might be required before an appeal can be filed on their behalf. Contact the Kaiser Permanente Appeals Unit at 800-813-2000 or 503-813-2000 to determine if this written consent is required.

4.12 Drug Formulary

The KP Regional Pharmacy Department uses the formulary system and evidence-based decision-making to determine which medications will be made available for practitioners to order. Plan providers must follow the KP formulary when prescribing medications to Kaiser Permanente members. Criteria for choosing medications to be included in the formulary are, in order of priority: safety, efficacy, and cost. Drugs are listed by the product our pharmacies dispense, which may be brand-name or generic.

The KPNW Regional Formulary & Therapeutics Committee (RFTC) annually reviews and maintains the pharmaceutical management procedures on an ongoing basis. You'll find the following policies and information on the Kaiser Permanente Northwest Community Provider Portal: http://providers.kaiserpermanente.org/html/cpp_knw/pharmacypolicies.html

- Therapeutic Equivalents
- Formulary Exception Process and Excluded Drug Review
- Formulary Change Request Form
- The Formulary Process
- Criteria-Based Consultation Prescribing/Step Therapy
- Copay/Coinsurance Requirements for Prescriptions

The RFTC also maintains the formulary and reviews medications to add or delete. Any practitioner may petition to have a medication added to the formulary by completing a Drug Formulary Change Request form (http://www.providers.kaiserpermanente.org/info_assets/cpp_knw/Formulary%20Change%20Request%20Form.pdf), by contacting Pharmacy Drug Information at 503-261-7910, or via email at NW.Drug.Information@kp.org. An exception process is in place to request the use of a non-formulary drug when deemed medically necessary by the practitioner.

You can review the RFTC Formulary at https://prospectivemembers.kaiserpermanente.org/kpweb/entryPage.do?cfe=422. This site is accessible to all members, practitioners, and providers. We post updates on the third Tuesday of each month. People without Internet access can get print copies by contacting the Pharmacy Department as noted below.

For more information about the KPNW Formulary Process or other pharmaceutical management policies and procedures, including criteria-based consultation prescribing, co-payment requirements and any other restrictions and/or limitations, or to get a copy of the KPNW drug formulary, contact Pharmacy Services at 503-261-7900, toll free at 1-888-572-7231, or via fax at 503-261-7978.

4.13 Extenuating Circumstances

These extenuating circumstances around pre-authorization and admission notification are based on the Best Practice Recommendations (BPR) put forth by the Washington Healthcare Forum operated by OneHealthPort but are applicable to all lines of business in Oregon and Washington.

Note: This practice is in addition to and **does not replace** the pre-authorization and admission notification practices currently in place with Kaiser Permanente. You must follow those practices unless one of the specific extenuating circumstances outlined in this section exist.

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

Summary:

It is recognized that there are a number of extenuating circumstances where providers aren't able to request a pre-authorization before 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, the recommended best practices will be followed so that claims and related appeals will be processed **as if** a pre-authorization had been requested or admission notification had been submitted within the required time period. ***Benefit coverage and medical necessity will still be evaluated for the service(s) requested.***

Extenuating Circumstances:

The circumstances below outline a number of extenuating situations when providers are not able to contact a patient's health plan prior to treating a patient and/or within a pre-defined period of the patient's admission. In these situations, 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 are covered benefits for the patient and meet Kaiser Permanente's criteria for medical necessity.

I. Unable to Know Coverage

II. Unable to Anticipate Service

III. Inherent Components

IV. Misinformation

V. Delayed Notification

*Notes***:**

- Any service for which a pre-authorization was previously denied for that patient does not qualify as an extenuating circumstance.
- Medical necessity criteria and benefit coverage **must be** met even in cases of extenuating circumstances. Only the prior authorization requirement does not need to be met in these circumstances.

I. Unable to Know Coverage

These are circumstances where the provider made every reasonable attempt but was unable to ascertain the responsible health plan so that any pre-authorization requirements, including admission notification, could be known or met.

In these circumstances, the provider does 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 request a pre-authorization or to notify the health plan of admission.

The scenarios are:

A. The patient is **unable to tell** the provider about their insurance coverage before treatment. Acceptable reasons include:

- **Trauma or unresponsive patients**: These patients are usually brought in via 911 with no family or ID and might 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.

B. The patient initially indicated **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 or that the patient was retroactively enrolled.

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 is primary and responsible for coverage.

D. 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. Has no insurance, qualifies for Medicaid, and helps enroll the patient post-service with coverage retroactive to the time of service (aka 'B' above)

Unable to Know Coverage situations **do not include:**

When the provider was able to communicate with the patient before giving treatment, but insurance coverage information was not obtained or was not verified before 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.

Providers are expected to verify each time that the patient's current insurance information is obtained from the patient by asking the following questions:

a. What is the current insurance coverage for this patient?

b. Are there any other insurance coverages for this patient, such as multiple employers, multiple responsible parties, etc.?

c. What are the birthdates of both parents for dependent children?

For a. & b. above, it's important to send to the health plan when checking on eligibility so that they can determine if a coordination of benefit situation applies

II. Unable to Anticipate Procedure

Defined as circumstances where the provider, prior to seeing the patient, could not anticipate the need for a procedure requiring a pre-authorization and any delay in the delivering the procedure in order to obtain an authorization would adversely impact the health of the patient. (See A.1. and A.2. below for definitions of *urgent* and *non-urgent-time-sensitive* circumstances.)

Procedure is defined as a treatment, e.g., injection, medication, limb support, or diagnostic test such as imaging or biopsy.

A. In the course of an Evaluation and Management (E&M) visit

The patient made an appointment with a provider and the need for any service except the E&M visit was not known at that time. In the course of the visit, the provider determines the need for an in-office procedure to be urgent or non-urgent-time-sensitive. That procedure is then provided in the course of the E&M visit and/or the patient is referred to another provider

for the urgent/time-sensitive procedure. The secondary provider may also determine the need for an alternative/additional urgent/time-sensitive procedure.

1. Need for the procedure was *urgent*

   In the course of the visit, the provider determines the need for an in-office procedure to be urgent (identified and documented for the date of service). In other words not providing the care would:

   - 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.

2. Need for the procedure was *non-urgent-time-sensitive*

   Note: The following are **possible examples** of applicable procedures:

   - Joint injection for pain, biopsy, imaging and/or limb support.
   - A change in treatment or medication where delay could diminish clinical outcome.

   However, any/all services would need to meet this criteria:

   In the course of the visit, the provider identifies a clinical condition for which they could not have anticipated the services that had to be provided in order to avoid negative health outcomes, those outcomes including but not limited to:

   - Adverse impact to the quality of health of the patient, e.g., pain/restricted function
   - Extending the timeframe for diagnostic confirmation/care coordination of a suspected acute condition and the delay would compromise health outcomes
   - Patient incurs excessive travel and/or expense to return to obtain the service

   These services might include but are not limited to curative, rehabilitative, or palliative actions whose clinical effectiveness largely depends on time-sensitive intervention.

   An extenuating circumstance does not apply when the service(s) occurs in the course of visit solely for the convenience of the provider.

B. In the course of a procedure (which may or may not require pre-authorization).

   Once the procedure begins, a different procedure or the need for an add-on procedure is clinically indicated. That newly indicated procedure requires pre-authorization.

   This scenario is only considered an extenuating circumstance if the newly indicated procedure is performed at the time of the original procedure or on the same day,

   Both Unable to Anticipate circumstances (A & B) **do not include when**:

   - The provider performs a procedure or provides a service considered experimental or investigational.
   - The service is scheduled for provider convenience rather than for clinical need.
   - The service does not meet benefit coverage or medical necessity criteria.

III. Inherent Component Services

These are circumstances where the provider organizations obtained a pre-authorization for at least one service in an inherently related set of services but not for other inherently related services in the set.

Some services have multiple inherent components (see **definition** below). In some cases, health plans require each component to have its own pre-authorization review. In these cases:

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 to determine if all component services are submitted. The preferred method is phone or electronic notification.

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, the health plan may notice that a pre-authorization was obtained for only a subset of the inherent components that were submitted on a claim. In these cases, the health plan will not deny the added inherent component service(s) for lack of pre-authorization.

An ***inherent component*** extenuating circumstance is when the health plan denies, for lack of pre-authorization, one or more services within an inherent component set when at least one of the services in the set had been pre-authorized.

Definition: Inherent component services where one service is an essential attribute of another, i.e., one can't be provided without the other. Examples 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

IV. Misinformation

These are circumstances where the provider organization can demonstrate that a health plan representative and/or the health plan's web site gave inaccurate information about the need for a pre-authorization or admission notification.

V. Delayed Notification

These are circumstances when the health plans decision/notification took longer than the timeframes outlined in the WAC 284-43-2000 (or Best Practice Recommendation (BPR) Standard Timeframes for health plans where the WAC does not apply) and the provider can demonstrate that they met all supporting documentation and timeframe requirements in submitting requested information, i.e., the service was provided after the pre-authorization was requested and after associated WAC/BPR documentation submission and notification

timeframes had passed, but before a pre-authorization notification decision was given to the provider.

Best Practice Recommendation

A. Providers will provide the following documentation to support the extenuating circumstance.

Extenuating Circumstance	Documentation from provider organization
I. Unable to Know Coverage	Identify extenuating circumstance condition that applies from section I. above along with appropriate documentation to support attempts made to determine coverage, and response from other health plan(s)that were queried, e.g., below as appropriate to the circumstance: • Dated documentation, e.g., admission face sheet, obtained at the time of service indicating: o The insurance information provided by the patient/representative o The patient's/representative's inability to provide insurance information o The patient's/representative's reporting self-pay • Verification of no Medicaid coverage (Provider One result) 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).
II. Unable to Anticipate Service In the course of an E&M visit (or referred-to visit)	Identify clinical rationale that applies. Applicable office visit chart note for either the date of service or the referral along with other clinical documentation (as needed), e.g., diagnosis, History and Physical (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. The treatment decision and supporting document may be submitted by the E&M provider and/or the referred-to provider, as appropriate, as outlined in section II. A. above.
IV. Delayed Notification	Identify that supporting documentation and timeframe requirements associated with a pre-authorizations request were met.

Extenuating Circumstance	Documentation from provider organization
	Timely submission of pre-authorization request and support documentation: • Documentation indicating the date the pre-authorization request was made and any faxes where supporting information was provided, **and/or** • Documentation of a call to the health plan to provide information, including if available, a reference number, time of call and name of who was spoken with and what was discussed, **and/or** • Evidence of mailed-in documentation in form of tracking number or postage stamp date Non-timely documentation request or decision notification from health plan Documentation (e.g., dated office phone log or dated electronic submission) indicating that a request for supporting documentation and/or a decision notification was not received (timely) from the health plan. Timely verification of status of the pre-authorization request Documentation that the status of the request was checked within the decision timeframe to determine if information submitted by the provider, and the website shows no indication of outstanding actions or documentation required of the provider.

Note: Submission of the above referenced documentation does not guarantee payment. Even if the extenuating circumstance applies, the service is subject to benefit coverage and medical necessity.

B. The health plan's decision-making/notification process will be completed within 30 days of notification of the extenuating circumstance by the provider organization. In addition to assessing the extenuating circumstance, the health plan will conduct a benefit coverage review and a medical necessity review and inform the provider of the result, via phone, fax, and/or letter.

   If the provider submits a claim for the service prior to the health plan completing this process, the claim may be denied for lack of pre-authorization.

   If the provider's claim is denied for lack of pre-authorization, the provider may request an appeal of the denial. Once an appeal has been initiated, the health plan's decision-making/notification process will be completed within the states' required timeframes for post-service review.

C. If the provider follows these recommended best practices for extenuating circumstances, health plans will process the service **as if** a pre-authorization had been requested prior to service delivery or notification of admission was given within the specified time period of admission, e.g., 24 hours. Services will subject to benefit coverage and medical necessity.