Administrative Simplification

A program of the Washington Healthcare Forum
Operated by OneHealthPort

Best Practice Recommendation for

Extenuating Circumstances around Pre-Authorization & Admission Notification

Version 3.4

Version	
Issue Date	**Explanation**
10-19-2107	Version 3.0
10-22-2019	Inclusion of IVIG Shortages
10-29-2021	Additional Unable to Know Circumstance: Patient can't be found in ProviderOne , using demographics given by the patient, when patient indicated self pay or commercial coverage that wasn't in effect.
08-01-2022	• Add 'Change to Information' as an Extenuating Circumstance • Update to include product shortage for ALL pre-authorized Physician Administered Drug as an Extenuating Circumstance
10-23-2023	• Update "For other Physician Administered Drugs" to include criteria when an equivalent is not available. • Add "Identification of original medication that is being replaced due to shortage" to documentation requirements section VI in the table.

Table of Contents

BEST PRACTICE RECOMMENDATION

Topic: Extenuating Circumstances around Pre-Authorization & Admission Notification

NOTES:

1. *This practice is in 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.*
2. *The terms prospective review and pre-authorization will be used interchangeably throughout this document.*
3. *There is a related WAC- WAC 284-43-2060 Extenuating circumstances in prior authorization. https://apps.leg.wa.gov/wac/default.aspx?cite=284-43-2060*

Improvement Opportunity:

There are a number of situations where providers are unable 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 and related appeals are likely to deny for lack of pre-authorization or admission notification even if the services meet the health plan's criteria for medical necessity.

Summary of Recommendation:

A number of extenuating circumstances are identified where providers are not 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, provider organizations and health plans should follow the recommended best practices 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 time period. ***Health plans will still evaluate the service(s) for benefit coverage and medical necessity.***

Applicability:

This BPR applies in those situations when a health plan requires a provider organization to obtain an authorization prior to services being delivered.

All health plans and provider organizations are encouraged to adopt and appropriately implement these Best Practice Recommendations. Since WAC 284-43-2060 does not apply to all health plans, 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.

Extenuating Circumstances:

The situations below outline a number of extenuating circumstance 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 the health plan's criteria for medical necessity.

I. Unable to Know Coverage

II. Unable to Anticipate Service

III. Inherent Components

IV. Misinformation

V. Delayed Notification

VI. IVIG Product Shortage

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. However, a prior authorization requirement does not need to be met in these circumstances.

I. Unable to Know Coverage

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

In these circumstances, the provider organization 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 contact the responsible health plan*** to request a pre-authorization or to notify the health plan of admission.

The three scenarios 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 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 patient indicated that ***they were self-pay*** OR ***indicated commercial medical coverage that could not be verified for the date of service***. Upon provider review of ProviderOne (or electronic eligibility response) for the date(s) of service, the patient did not have Medicaid eligibility.

For Medicaid patients (FFS or MCO), the following conditions are required for this to be an extenuating circumstance.

1. The patient indicated that they were self-pay,

   OR

   The patient indicated that they had commercial coverage AND the provider verified that the coverage was not in force during the month for which the treatment is provided.

AND

2. The provider verified in ProviderOne that no Medicaid coverage (under Fee for Service or Managed Medicaid Plan) was in place for the month of treatment for a patient with the demographic information given to the provider by the patient.

D. The provider ***verified that no Medicaid coverage (under any fee for service or managed care plan) was in place at time of treatment*** or that Medicaid coverage was secondary. It was later determined that at the time of treatment Medicaid coverage was actually in place, or was primary, or the patient was later enrolled in a Medicaid program retroactive to cover the service date.

There can be a gap 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 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 the provider to submit for retrospective authorization for services provided after the enrollment date.

E. 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 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-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, HCA-Medicaid benefits are verified with no other insurance on file at that time. Later, HCA-Medicaid notifies the provider that commercial coverage was in place.

   b. In coordination of benefit situations, the eligibility is verified with one of the coverages. Later, the health plan notifies the provider that the other 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)

'Unable to Know Coverage' 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.

Note to Providers: Best Practice is verifying that the patient's 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/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, e.g multiple employers, multiple responsible parties, etc.?
c. What are the birthdates of both parents?

a. & b. above is important to send to the health plan when checking on eligibility so that they can determine if a coordinate of benefit situation applies.

II. Unable to Anticipate Procedure

Defined as circumstances where the provider organization, 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.)

For the purpose of these Extenuating Circumstances, procedure is defined as a treatment, e.g. injection, medication, limb support or a diagnostic test such as imaging, biopsy that is covered under the patient's medical benefit. Medications

covered under a patient's pharmacy benefit are outside the scope of these circumstances.

A. In the course of an 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). i.e. 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'

Clarifying 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.

Any/all services would need to meet the below 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, etc.
- 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).

The patient was undergoing a procedure, and the need for a change in that procedure or the new for a different/additional procedure was identified as clinically necessary.

1. The need for a change in treatment or medication was identified, where delay could diminish clinical outcome.
2. Once the procedure (which may or may not require pre-authorization 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 above) DO NOT INCLUDE:

- When the provider performs a procedure or provides a service that is considered experimental or investigational.
- When the service is schedule for provider convenience rather than for clinical need.
- When 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, some 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 or of Supplemental Review (as defined in the BPR-Standard Notification Timeframes), 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 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.

IV. Change in Information or Mis-information

These are circumstances where the provider organization can demonstrate that either; 1) the pre-authorization requirement that was in effect on the date that a service was provided for a patient was more restrictive than the requirement that was posted on the health plan web site 60 days prior to the service date AND there was no pending requirement that was reported on the health plan's web site within 60 days prior to the service date that would take effect on or before the date of service. or 2) 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 BPR-Standard Timeframes for health plans where the WAC does not apply) and the provider can demonstrate that they met all of their 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-auth notification decision was given to the provider.

VI. Product Shortages of Physician Administered Drugs and Dosage Vials of Physician Administered Drugs that have been Pre-Authorized.

These are circumstances where the provider organization, due a recent Product Shortage, could not obtain the Physician Administered Drug or the Dosage Vial of the Physician Administered Drug that was pre-authorized for the patient

Note: This extenuating circumstance is a ***"one-time" situation*** when a product shortage is discovered by the provider and continuity in patient treatment does not allow sufficient time to get an alternative drug pre-authorized by the health plan. Prior to a subsequent administration to the patient, the provider must contact the health plan to get an authorization for an alternative drug.

Definitions:

a. *Drug Shortage* – As defined by the FDA, "…can occur for many reasons including manufacturing and quality problems, delays, and discontinuations. Manufacturers provide FDA most drug shortage information, and the agency works closely with them to prevent or reduce the impact of shortages."

   https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages

b. *Manufacturer* – An entity that manufactures drug[s] and sells either to a Supplier or, in some circumstances, directly to a Pharmacy.

c. *Manufacturer Shortage* – Would constitute a shortage so long as the product has no available &/or clinically appropriate generic versions available.

d. *Supplier* – An entity that purchases product from a manufacturer then sells and distributes to a Pharmacy.

e. *Supplier Shortage* – May be due to issues with the Supplier's ordering/ distributing process or could be due to an issue with the Manufacturer. A shortage with a Supplier does not necessarily constitute a shortage of product.

f. *Physician Administered Drug* – any covered outpatient drug that is typically provided or administered to a patient incident to a physician's service and billed by the provider. These drugs are usually injectable or intravenous drugs administered by a medical professional in a physician's office or other outpatient clinical setting. Medications not covered in this BPR are those that are considered to be "point of sale" or "self-administered".

A Product Shortage extenuating circumstance is when a prior-authorization/ pre-certification was obtained from the health plan for a specific:

- Physician Administered Drug product (HCPSC Code**)**, including IVIG, without any approval of an alternate Physician Administered Drug product (HCPSC Code), before the provider or health plan knew of or experienced any impact due to the product's shortage.

- 'Dosage vial' of a Physician Administered Drug product, without any approval of an alternate 'dosage vial' of the Physician Administered Drug product, before the provider or health plan knew of or experienced any impact due to a 'dosage vial' product shortage.

After the regimen of treatment was underway, a Product Shortage prevented the provider from obtaining the pre-authorized Physician Administered Drug /Dosage Vial and there was insufficient time for the provider to obtain a pre-authorization for an alternative before the next scheduled administration of the Physician Administered Drug to the patient.

Due to the clinical necessity of maintaining the requisite timing of the patient's next treatment in the regimen and prior to working out an approved process for further treatment, the provider organization:

1. For IVIG, substitutes a 'same family' alternative IVIG product appropriate to the patient's condition, i.e. same drug class and has similar indications.

2. For Dosage Vials, substitutes an alternative combination of 'dosage vials' of the authorized Physician Administered Drug equal to the pre-authorized 'dosage vial'

3. For Other Physician Administered Drugs, substitutes an evidence-based alternative to the pre-authorized drug that is within NCCN guidelines, or any evidence based clinical pathway, and compendia supported. All substitutions are subject to a clinical, medical necessity review and may be denied by the health plan if the drug does not meet criteria.

The extenuating circumstance applies to a single occurrence of substituting an alternative Physician Administered Drug or 'dosage vial' product, that is a covered benefit for the patient's plan. As soon as possible after becoming aware of the product shortage and its applicability to the specific patient's treatment, the provider contacts the health plan to work out an approved process for further treatments.

Under the extenuating circumstance, when the supporting documentation outlined below is provided to the health plan, the single occurrence of substituting an alternative covered Physician Administered Drug or 'dosage vial' product will not be denied for lack of pre-authorization but could be denied based on medical necessity.

Best Practice Recommendations

A. ***Transparency***: Health plans will post on their website the best practice recommended processes for communicating with providers about extenuating circumstance and resolving them.

B. ***Supporting Documentation***: Providers will provide the following documentation for verification by health plan 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, representative examples below as appropriate to the circumstance: Dated documentation, e.g. admission face sheet, obtained at the time of service indicating: a. The insurance information provided by the patient/representative b. The patient's/representative's inability to provide insurance information c. The patient's/representative's reporting self pay, Documentation dated at the time of inquiry, e.g. ProviderOne screen shot or electronic eligibility response, that verifies no Medicaid coverage for the date of service using demographics given by the patient -- (though eligibility at date of service was later confirmed for a different set of demographics or at a later time of inquiry), 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 A. 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, 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 the 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. Change in Information or Mis-Information	1. If the pre-authorization requirement on the date of service was more restrictive, then the supporting documentation would be ***a statement from the provider saying that* '*the pre-authorization requirement that was in place on the***

Extenuating Circumstance	Documentation from provider organization
	date of service was more restrictive than the pre-authorization requirement posted on the health plan's site within 60 days prior to the date of service AND that there was no pending requirement reported on the web site within 60 days of the date of service that would take effect on or before the date of service'. Screen shots of the health plan web site showing the less restrictive requirement and the absence of a pending requirement would be optimal but not required as health plans typically archive this information. 2. If misinformation was provided, then supporting documentation would be one of the following; dated screen shots from web site, or dated fax, or other dated source that shows the misinformation, OR name/date/phone number and possibly reference number of the phone call on which misinformation was provided.
V. Delayed Notification	Identify that supporting documentation and timeframe requirements associated with a pre-authorizations request were met. <u>Timely submission of pre-authorization request and support documentation</u> • Documentation indicating the date that 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 <u>Non-timely documentation request or decision notification from health plan</u> 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; <u>Timely verification of status of the pre-auth request</u> Documentation that the status of the request was checked within the decision timeframe to determine if information submitted by the provider, and the web site shows no indication of outstanding actions or documentation required of the provider.
VI. Physician Administered Drugs	If Manufacturer Shortage, submit documentation from the FDA

Extenuating Circumstance	Documentation from provider organization
and Dosage Vial Product Shortage	or ASHP websites as currently experiencing a Physician Administered Drug or Dosage Vial product shortage, OR If Supplier Shortage, submit documentation from at least 2 suppliers identified by the provider organizations that they could not supply the originally ordered and pre-authorized Physician Administered Drug or Dosage Vial product. In both cases, include: 1) Identification of original medication that is being replaced due to shortage 2) Documentation of the replacement HCPCS code, product name, strength, units, dates of service 3) Explanation / Rationale for the substitution (e.g., extenuating circumstances due to product shortage) 4) Reason why a new authorization could not be obtained before administering the substituted drug (e.g., patient is due for next dose before a new authorization request could be submitted for approval

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.

C. ***Notification and Decision Making***:

Providers organizations will notify the health plan of the Extenuating Circumstance in accordance with the process and timeframes outlined below.

Depending upon when the health plan is notified about the extenuating circumstance by the provider, their decision-making/notification process will align with the following

1. Before claim is submitted (when timeframe of claim submission is per contractual agreement and/or any other timely filing limitations that apply.)

   All health plans will have a process for providers to notify them about an Extenuating Circumstance BEFORE a claim is submitted, as long as that claim is submitted within one year from date of service. That process would include:

   a. The specific department to contact

   b. Language that the provider should use to indicate 'Extenuating Circumstance processing"

c. Clear definition of the supporting information required from the provider organization, including whether the contact information for the requestor should be provided

d. Within 30 calendar days of notification by the provider organization, the health plan will assess the extenuating circumstance and conduct a benefit coverage review and a medical necessity review and will inform the provider of the result, via payment, phone, fax and/or letter.

In cases where a health plan considers notification of any Extenuating Circumstance to be a 'retrospective pre-authorization', the prior authorization service window that they authorized for this service must include the actual date of service.

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

AND EITHER

2. <u>After claim is denied for lack of pre-authorization but before an Appeal is initiated</u>

   When the provider organization is being held financially liable for the cost of the denied service, health plans may have a process for provider organizations to follow when notifying them of an Extenuating Circumstance after a claim is denied and before an Appeal. That process would include:

   a. The specific department to contact

   b. Language that the provider should use to indicate 'Extenuating Circumstance processing"

   c. The type of provider organizations to whom this process applies, e.g. In-Network providers

   d. Timeframes/conditions under which this process applies

   e. Clear definition of the supporting information required from the provider organization, including whether the contact information for the requestor should be provided

   f. Within 30 calendar days of notification by the provider organization, the health plan will assess the extenuating circumstance and conduct a benefit coverage review and a medical necessity review and will inform the provider of the result, via payment, phone, fax and/or letter.

OR

3. <u>Once an Appeal has been initiated</u>

Health plans may have a process that provider organizations should follow to notify them of an Extenuating Circumstance once an Appeal has been initiated. ***Note***: Health plans that have a post claim process (b. above) which does not apply to ALL providers, will also have an Appeals process.

That process would include:

a. Language to use to indicate 'Extenuating Circumstance processing"

b. Clear definition of supporting information required from provider organization, including how providers should demonstrate they were not aware about a member's coverage

D. If the provider organization 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.