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| Policy Title: Acute Care UM Hospital Timely Notification Policy | Policy Number: |
| Owner Department: Acute Care UM | Effective Date: 01/01/2024 |
| Custodian: Acute Care UM Manager | Last Review / Revision Date |
| Approver: Executive Director Network and Utilization Management | Next Review Date |
| Review Period: 1 Year | Page: 1 of 8 |

**1. Policy Statement**

All (participating and non-participating) hospitals shall comply with the following requirements unless otherwise specified in Kaiser Foundation Health Plan of the NW (Kaiser Permanente) contract:

2. **Purpose**

An inpatient hospital notification is required for all members to ensure care coordination, and that all inpatient hospital services paid by Kaiser Permanente, are medically necessary and consistent with the member's diagnosis or condition and cannot be provided on an outpatient basis. Member eligibility is not determined through the notification process; eligibility should be verified on admission, and routinely thereafter.

**3. Scope/Coverage**

This policy applies to all participating and non-participating hospitals that provide care for Kaiser Permanente patients, unless otherwise specified in Kaiser Permanente contract.

**4. Definitions**

N/A

**5. Provisions**

**Inpatient Hospital Notification and Authorization.** All (participating and non-participating) hospitals shall comply with the following requirements unless otherwise specified in Kaiser Permanente contract:

5.1. Notify Kaiser Permanente of all emergency hospital observation and inpatient admissions within 24 hours of the admission, or for admissions occurring during a weekend or holiday, by the end of the first working day thereafter. Failure to notify Kaiser Permanente may result in denial or delay in payment of claims. For all Kaiser Permanente members, notification of admission and discharge can be made by calling 503-735-2595 or 877-813-5993 (toll free).

5.2. Notify Kaiser Permanente of patient admission for standard obstetric (OB) deliveries. However, no prior authorization is needed for these services and hospitals should bill post-discharge. Length of stay for standard OB deliveries is defined as

- Two (2)-day stay for vaginal delivery
- Four (4)-day stay for cesarean delivery

Authorization is required for admissions that exceed these standard lengths of stay. In such instances, Providers must provide Kaiser Permanente with notification of admission and clinical documentation along with a request for authorization within one (1) business day of exceeding the standard length of stay. Failure to notify Kaiser Permanente may result in denial or delay in payment of claims. For all Kaiser Permanente members, notification of admission and discharge can be made by calling the Regional Telephonic Medical Center at 503-735-2595 or 877-813-5993 (toll free).

5.3. Notify Kaiser Permanente of any Outpatient surgery in which the admission status changes to inpatient for any reason, within 24 hours of the admission, or for admissions occurring during a weekend or holiday, by the end of the first working day thereafter. Failure to notify Kaiser Permanente may result in denial or delay in payment of claims. For all Kaiser Permanente members, notification of admission and discharge can be made by calling the Regional Telephonic Medical Center at 503-735-2595 or 877-813-5993 (toll free).

5.4. Participating providers and non-participating providers are required to follow all applicable balance billing laws. Authorization must be obtained prior to providing covered and non-covered services. [2,3]

5.5. Provide clinical information for patient stay/services at the time of notification by faxing clinical information to Acute Care Utilization Management at 877-691-7634 unless clinical information is available through Care Everywhere.

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. Concurrent review determinations will be based solely on the medical information the Provider has made available at the time of the review determination.

The following elements are necessary for accurate and timely processing of an inpatient admission notification.

- Kaiser Permanente member name & medical record number
- Member date of birth (DOB), address and phone number
- Admission date – if discharged provide discharge date and disposition
- Facility name & National Provider Identifier (NPI)
- Admitting physician (first & last name) & National Provider Identifier (NPI)
- Admitting diagnosis and ICD-10 code if available
- Admission source (emergency, elective, etc.) and admission type (medical, surgical, etc.)
- Contact name & phone/fax number (for additional information if needed)

5.6. Notify Kaiser Permanente within one (1) business day of discharge. Discharge information should include the discharge date and discharge disposition.

5.7. **Extenuating Circumstances** [1]- These extenuating circumstances regarding 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. Providers must follow those practices unless one of the specific extenuating circumstances outlined in this section exist.

The circumstances below outline several extenuating situations when providers are not able to contact a patient's health plan prior to treating a patient and/or within the required notification time. In these situations, claims will not be automatically denied for lack of timely admission notification 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.

NOTE: 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.

5.7.1. **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:

5.7.1.1. 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.
- 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.

- 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.

- 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:
  - Had other insurance in their name that was applicable, or
  - Has no insurance, qualifies for Medicaid, and helps enroll the patient post-service with coverage retroactive to the time of service

**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 active.

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

- What is the current insurance coverage for this patient?*
- Are there any other insurance coverages for this patient, such as multiple employers, multiple responsible parties, etc.?*
- What are the birthdates of both parents for dependent children?

For starred items above, it is important to send to the health plan when checking on eligibility so that they can determine if a coordination of benefit situation applies

5.7.2. **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 delivering the procedure in order to obtain an authorization would adversely impact the health of the patient

**Procedure is defined as a treatment**, e.g., injection, medication, limb support, or diagnostic test such as imaging or biopsy.
**Unable to Anticipate Procedure does not apply 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.

5.7.3. **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 preauthorization 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

5.7.4. **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.

5.8. **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:**

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

| **Extenuating Circumstance** | **Documentation from provider organization** |
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| Unable to Know Coverage | Identify extenuating circumstance condition that applies from section 2.4 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:<br>• Dated documentation, e.g., admission face sheet, obtained at the time of service indicating:<br>o The insurance information provided by the patient/representative<br>o The patient's/representative's inability to provide insurance information<br>o The patient's/representative's reporting self-pay<br>• Verification of no Medicaid coverage (Provider One result) at the time of inquiry (though eligibility at date of service was later confirmed)<br>• 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). |
| Unable to Anticipate Service | Identify clinical rationale that applies. |

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| Delayed Notification | Identify that supporting documentation and timeframe requirements associated with a pre-authorization request were met.<br><br>Timely submission of pre-authorization request and support documentation:<br>• Documentation indicating the date the pre-authorization request was made and any faxes where supporting information was provided, and/or<br>• 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<br>• Evidence of mailed-in documentation in form of tracking number or postage stamp date<br><br>Non-timely documentation request or decision notification from health plan<br>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.<br><br>Timely verification of status of the pre-authorization request<br>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.

5.8.2. The health plan's decision-making and 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 dispute the denial by requesting a provider appeal. Once an appeal has been initiated, the health plan's decision-making and notification process will be completed within the required regulatory timeframes for post-service review.

5.8.3. 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 are subject to benefit coverage and medical necessity.

**6. References/Appendices**

6.1. Kaiser Permanente Oregon and SW Washington Provider Manual, Section 4: Utilization Management

6.2. Kaiser Permanente Oregon and SW Washington Provider Manual, Section 9: Medicare Advantage

6.3. MA Payment Guide for Out of Network Payments. https://www.hhs.gov/guidance/document/ma-payment-guide-out-network-payments-0

**7. Approval**

This policy was approved by the following representative of Kaiser Foundation Health Plan of the Northwest and Kaiser Foundation Hospitals Northwest.
Christi R. Roberts, Executive Director, Network and Utilization Management

Signature: _____ Date: _____