Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Local Rules: Frequently asked questions

For Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠

July 2023

In this document, you'll find answers to the questions about the Blue Cross and BCN Local Rules for 2022 (non-behavioral health): Modifications of InterQual® acute care criteria that have been most frequently asked by providers. These rules apply to inpatient acute medical admissions of adults that occurred March 1, 2022, through July 31, 2023.

In this document

Questions that pertain to all requests

This section has questions that pertain to authorization requests for Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue, Blue Care Network commercial and BCN Advantage members.

Which hospitals do the 2022 Local Rules apply to?

The 2022 Local Rules (modifications of InterQual® acute care criteria) apply to all Michigan hospitals, for Blue Cross commercial Medicare Plus Blue, Blue Care Network commercial and BCN Advantage authorization requests for acute inpatient medical admissions.

For hospitals outside of Michigan, the 2022 Local Rules apply only to Medicare Plus Blue requests for acute inpatient medical admissions.

Is Blue Cross or BCN enforcing the 48-hour observation rule?

Blue Cross and BCN have updated the earlier language we used, which stated that an observation setting is not required.

Blue Cross and BCN are not telling hospitals that they need to provide 48 hours of observation or that hospitals must write an observation order. We are requesting that hospitals wait for two days and submit the authorization request on the third day along with all the pertinent clinical documentation.

The Local Rules are expected to help ensure the appropriateness of the level of care for the member and to decrease touchpoints and nonapprovals due to inadequate information.

Can we submit an authorization request for an inpatient admission before the two-day period, even if the request requires review and approval by a medical director?

For the 21 conditions identified in the Local Rules, requests for inpatient care should be submitted only after the two-day period has elapsed. The exception is for members in a critical care setting; for those members, you can submit the request prior to completion of the two-day period, along with all clinical documentation supporting the InterQual critical level of care.

If we submit an inpatient authorization request before the end of the two-day period, and the member isn't in a critical care setting, will the request go directly to a medical director even if it meets InterQual criteria?

If the member hasn't been in the hospital for two days and isn't in a critical care setting, we'll request that you wait until the member has been in the hospital for two days to send additional information about the member's condition. We'll make the request through the Case Communication field in the e-referral system or by calling the facility, or both.

The message we'll send says "Blue Cross/Blue Care Network has a local rule for this condition. Please provide information if the patient remains hospitalized on day 3 with same or worsening symptoms requiring continued treatment. We are granting you an extension to provide this information by (insert time and date). If the information is not received, you could be issued a non-approval."

On the third day, we'll review and process the case with or without the additional clinical information:

- If the request does not meet InterQual criteria, we'll refer it to a medical director for secondary review.
- If the member's stay in the hospital was less than the two days, we'll refer the case to a medical director for secondary review.

When the member transitions to inpatient care and Blue Cross and BCN apply the InterQual criteria after the two-day period, what InterQual day would be used?

We'll apply InterQual criteria episode day 3.

What happens if the member meets InterQual criteria on day 1 but is no longer stable for discharge and doesn't meet InterQual criteria on day 3?

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

For members in a critical care setting, you can submit the request prior to completion of the two-day period, along with all clinical documentation supporting the InterQual critical level of care.

What about a member who meets InterQual criteria on day 1, at admission, but is discharged before the two-day period has elapsed due to improving more quickly than expected?

If the member is appropriate for discharge within two days, Blue Cross and BCN will reimburse as observation. The hospital will need to submit a claim for observation reimbursement.

Note: Blue Cross and BCN don't require an observation order when reimbursing an observation claim.

If a member is admitted from the emergency department, would the entire ED stay count toward the admission criteria?

We'll apply episode day 3 criteria to determine whether the request meets InterQual and medical necessity criteria for an inpatient level of care. If these criteria are met and an inpatient admission is authorized then, as usual, the ED stay will be bundled with the DRG payment. If an inpatient stay is not authorized, then the ED stay may be billed separately.

Will you deny payment for anything more than the two-day period even though an inpatient level of care is appropriate and is being provided?

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

On day 3, we'll review and process the request.

If the request doesn't meet episode day 3 InterQual criteria, we'll request clinical document with medical necessity information. We'll refer the request and the clinical documentation to a medical director for secondary review.

Note: If the member can't be safely discharged from the hospital, that and the explanation would serve as the reason for an extended stay and, likely, for an admission.

Will the provider secondary review be accepted?

Yes. All secondary review documentation from the facility will be evaluated by the medical director and used to determine appropriateness for the inpatient level of care.

When will a peer-to-peer review be available?

You can request a peer-to-peer review after a nonapproval determination. This applies to Blue Cross commercial, BCN commercial, and BCN Advantage members. For more

information, refer to the document How to request a peer-to-peer review with a Blue Cross or BCN medical director.

For Medicare Plus Blue members, a peer-to-peer review cannot be requested; those nonapprovals can be appealed using the two-step appeal process described in the *Medicare Plus Blue PPO Provider Manual*.

For members who have diagnoses in line with InterQual criteria but whose stays are converted to inpatient after 24 hours, will these authorization requests be reviewed using the Local Rules or the InterQual criteria?

For members with one of the 21 conditions identified in the Local Rules, requests for inpatient care should be submitted only after the two-day period has elapsed. The exception is for members in a critical care setting; for those members, you can submit the request prior to completion of the two-day period, along with all clinical documentation supporting the InterQual critical level of care.

We'll apply InterQual criteria for episode day 3 for members who are not in a critical care setting:

- If the request meets criteria, we'll approve it.
- If the request does meet criteria, we'll refer it to a medical director for secondary review, along with the clinical documentation that was submitted.

A meningitis diagnosis is not included in the 21 conditions identified in the Local Rules and the InterQual criteria recommends only an observation level of care if testing is inconclusive. Once the diagnosis is confirmed, what level of care would be appropriate?

Meningitis was removed from the list of conditions identified in the Local Rules. Determinations on authorization requests for members with meningitis will be made using InterQual criteria.

Will a hospitalist provider be required to determine the level of care for their patients based on the insurance provider rather than the clinical presentation?

The hospitalist provider must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the

authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

If the request meets criteria, we'll approve it.

How would the Local Rules apply to a member who is receiving high-intensity care during the observation stay and who meets InterQual criteria at the time of admission but who may no longer meet InterQual criteria after the first two days?

For members who have one of the 21 conditions identified in the Local Rules and who are appropriate for discharge within two days, we'll refer the request to a medical director for a formal decision:

For requests that are nonapproved, Blue Cross and BCN will reimburse as observation. The hospital will need to submit a claim for observation reimbursement.

Note: Blue Cross and BCN don't require an observation order when reimbursing an observation claim.

If the member is not ready for discharge after the first two days, as indicated by the partial- or non-responder criteria of day 3, we'll approve an admission.

If episode day 3 InterQual criteria are not met, Blue Cross and BCN will refer for secondary review with the clinical documentation submitted by the hospital.

Do the Local Rules follow national/evidence-based protocols?

Blue Cross and BCN follow InterQual criteria, which are used nationally and are developed based on evidenced-based protocols. These criteria sets are used as guides to support our decisions in determining the appropriate level of care.

When we evaluate our inpatient use as compared to our competitors, we are in either a middle or high range of inpatient use, per Quality Compass. For the Milliman Benchmarks, we are closer to a loosely or moderately managed plan.

When we reviewed our members' inpatient use, we found that members are being admitted for certain conditions that could be cared for in observation.

We expanded our Local Rules to achieve consistency among Blue Cross and BCN products, to improve the clinical review process and to reduce the need for peer-to-peer reviews and appeals.

Is the InterQual criteria being used as a screening tool rather than as a "law" for nonapproval?

Blue Cross and BCN use the InterQual criteria as a guideline. If the InterQual criteria are not met, the request will be referred to a medical director for a medical necessity determination.

Does an observation stay allow for the same level of care as an inpatient admission?

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

If the request meets criteria, we'll approve it.

Will the Local Rules increase the number of nonapprovals?

It is not our intent to increase the number of nonapprovals. The Local Rules are expected to help ensure the appropriateness of the level of care for the member and to decrease nonapprovals due to inadequate information.

Will the Local Rules increase observation authorizations?

Blue Cross and BCN do not require authorization for observation. The Local Rules are expected to help ensure the appropriateness of the level of care for the member and to decrease nonapprovals due to inadequate information.

Will the Local Rules disrupt current clinical processes for patient care as well as prevent using an onsite provider to properly treat the member?

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

If the request meets criteria, we'll approve it.

Will a hospital need to provide Blue Cross and BCN members a written explanation of the two-day rule, since this may affect the care they'll receive by not being admitted in comparison to non-Blue Cross and non-BCN patients?

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

Follow the processes outlined in the provider manuals.

If a hospital has a contract that requires that members meet InterQual criteria, do the Local Rules circumvent the InterQual criteria and prevent members from being admitted?

The Participating Hospital Agreement, or PHA, does not specifically mention the InterQual criteria.* The PHA states this: "Precertification/ Preauthorization – a review process established by Blue Cross which includes a review of a patient's signs, symptoms and proposed treatment to determine whether they meet Blue Cross criteria for clinical appropriateness and/or level of care and, therefore, are eligible for payment. Precertification and Preauthorization are terms that can be used interchangeably."

The *Medicare Plus Blue PPO Provider Manual* states that Blue Cross uses InterQual criteria as a guideline. That manual is being updated to indicate that we can also apply the Local Rules.

The *BCN Provider Manual*, which applies to both BCN commercial and BCN Advantage, states that BCN can apply Local Rules.

The Criteria, Standards and Tools Used in the Utilization, Quality and Health Management Programs states this: "Blue Cross will provide hospital with current copies of all utilization reviews and quality assessment clinical screening criteria, standards, protocols, policies and procedures relevant to the Utilization Management Program and Quality Assessment Program including, but limited to, those used to determine whether Covered Services and Medically Necessary, met professionally recognized standards of care and are Covered Services and/or payable benefits."

Will a hospital be required to accept an observation level of payment for a Local Rules diagnosis that is treated at an inpatient level of care?

Members should be managed at an inpatient level of care only if it is appropriate. Our intent is to ensure that we have all the appropriate clinical information when making a

determination on an authorization request based on meeting InterQual criteria, medical necessity criteria or both.

For the 21 conditions identified in the Local Rules:

- Ten of these conditions rarely meet the InterQual criteria for admission, are usually handled in observation and are unlikely to result in an admission, based on InterQual criteria.
- Another ten of these conditions involve critical levels of care that (assuming appropriate clinical documentation) would support admission to a critical level of care. In those instances, you should submit the authorization request before the two-day period required for the Local Rules.

If the member's condition is not included among the 21 listed below, the authorization request would be processed as it is now and would be exempt from the Local Rules related to these conditions.

Note: Each condition listed below has multiple ICD-10 codes associated with it.

Criteria table

Local Rule condition	InterQual level of care criteria	InterQual level of care criteria subset
Allergic reaction	Observation	General Medical
Anemia	Observation/Acute/Critical	Anemia
Arrhythmia, atrial	Observation/Intermediate/Critical	Arrhythmia, Atrial
Asthma	Observation/Critical	Asthma
Chest pain	Observation	ACS
COPD	Observation/Acute/Intermediate/Critical	COPD
Dehydration	Observation	Dehydration Gastro
Deep vein thrombosis	Observation/Acute/Critical	Deep Vein Thrombosis
Diabetic ketoacidosis	Observation/Critical	Diabetic Ketoacidosis
Headache	Observation	General Medical - Neuro
Heart failure	Observation/Acute/Intermediate/Critical	Heart Failure
Hypertensive urgency	Observation	Hypertension
Hypoglycemia	Observation/Critical	Hypoglycemia

Local Rule condition	InterQual level of care criteria	InterQual level of care criteria subset
Intractable back pain	Observation	General Medical - General
Nausea / vomiting	Observation	Dehydration Gastro
Nephrolithiasis	Observation	General Medical
Pneumonia	Observation/Acute/Intermediate/Critical	Infection Pneumonia
Pulmonary embolism	Observation/Acute/Intermediate/Critical	Pulmonary Embolism
Skin and soft tissue infection	Observation	Infection Skin
Syncope	Observation	Syncope
Transient ischemic attack	Observation/Acute	Transient Ischemic Attack

Will Blue Cross and BCN change its administrative policies to be consistent across all lines of business?

Blue Cross and BCN are aligning their Local Rules across all lines of business to ensure consistency and to encourage hospitals to submit authorization requests with supporting clinical information on the third day.

How are Blue Cross and BCN addressing hospitals' concerns about the increased administrative burden that results from having to request authorization for medically necessary services?

Blue Cross and BCN are working hard to reduce the administrative burden that hospitals face.

However, when inadequate information is submitted, many requests that are nonapproved could have been approved had more complete information been submitted with the request.

When this occurs, Blue Cross and BCN must request additional clinical documentation to support the inpatient criteria. This sets in motion a series of back-and-forth communications as well as peer-to-peer discussions or other types of interactions that delay the final adjudication of the case for all the parties.

When more complete information is submitted, which is what we're trying to achieve through the Local Rules initiative, the requests can be processed more efficiently, with quicker decisions and fewer nonapprovals based on incomplete data.

What are the exclusions related to what InterQual criteria should be used and when?

Blue Cross and BCN use InterQual criteria as a guide; the Local Rules are additional requirements beyond the InterQual criteria. Hospitals' utilization management staff should have the knowledge and training necessary to apply the InterQual criteria and subsets appropriately.

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

We'll apply InterQual criteria for episode day 3 for members who are not in a critical care setting.

How do Blue Cross and BCN propose that hospitals handle the increased burden of having to check authorization requests for inpatient status many times a day?

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

We'll apply InterQual criteria for episode day 3 for members who are not in a critical care setting. If the request meets criteria, we'll approve it.

Blue Cross and BCN are working hard to reduce the administrative burden that hospitals face.

However, when inadequate information is submitted, many requests that are nonapproved could have been approved had more complete information been submitted with the request.

When this occurs, Blue Cross and BCN must request additional clinical documentation to support the inpatient criteria. This sets in motion a series of back-and-forth communications as well as peer-to-peer discussions or other types of interactions that delay the final adjudication of the case for all the parties.

When more complete information is submitted, which is what we're trying to achieve through the Local Rules initiative, the requests can be processed more efficiently, with quicker decisions and fewer nonapprovals based on incomplete data.

Due to the pandemic and hospital staffing shortages, would the Local Rules allow only immediate ICU admissions even though there are other patients that meet the InterQual criteria but there is no room in the ICU?

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

For members in a critical care setting, you can submit the authorization request before the two days has elapsed.

For requests that do not meet the InterQual criteria, does the secondary review take into consideration the complexity of the members' medical conditions?

Sometimes, the clinical complexity of the member is not always evident with the clinical information that is initially submitted and becomes apparent only upon review of the information submitted after two days.

We're asking that hospitals submit the authorization request with the clinical and applicable secondary provider documentation on the third day, to increase the likelihood of receiving the complete clinical representation of the complexity of the member's condition and support an inpatient level of care.

Are the InterQual criteria for episode day 3 used at the 49th-hour mark to assess the need for inpatient conversion?

Yes. Blue Cross and BCN will be using InterQual criteria for episode day 3 at the 49th-hour mark to assess the need for inpatient conversion.

On the third day, the hospital should submit all pertinent clinical information and relevant medical documentation to support the inpatient level of care.

Are intermediate and critical InterQual criteria subsets excluded from the Local Rules regardless of the diagnosis?

Blue Cross and BCN will accept requests submitted before the third day if the member is in a critical care setting, but hospitals must have clinical documentation that shows that the request meets the InterQual critical level of care.

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

Do the Local Rules conflict with Article II of the Participating Hospital Agreement?

The PHA* includes language that an observation setting is not required.

The PHA states: "Precertification/ Preauthorization – a review process established by Blue Cross which includes a review of a patient's signs, symptoms and proposed treatment to determine whether they meet Blue Cross criteria for clinical appropriateness and/or level of care and, therefore, are eligible for payment. Precertification and Preauthorization are terms that can be used interchangeably."

Do the Local Rules change the definition of "observation" by increasing the case mix index on observation members who have higher acuity and longer lengths of stay?

Blue Cross has updated the language that previously stated that an observation setting is not required.

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

The Local Rules are expected to help ensure the appropriateness of the level of care for the member and to decrease nonapprovals due to inadequate information.

Can the Local Rules cause members to be moved inappropriately to an outpatient place of service — for example, for persistent V-tach or nephrolithiasis with obstructive uropathy?

The Local Rule for arrhythmia is applicable only to atrial arrhythmias, as that is the only subset that has level-of-care criteria for observation.

If the diagnosis is hydronephrosis or genitourinary obstruction, then that diagnosis should be used. If neither is present, then the Local Rule would apply, which involves waiting two days to submit the request.

When the Local Rules are implemented, will a hospital have a difficult time receiving an inpatient approval for a member who would have previously qualified for inpatient care?

Blue Cross and BCN intend to align the Local Rules for all of our product lines. We expect that this will enable us to appropriately determine whether an admission should be reimbursed under an inpatient or observation level of care.

The Local Rules are expected to help ensure the appropriateness of the level of care for the member and to decrease touchpoints and nonapprovals due to inadequate information.

When a member doesn't meet the two-day threshold, why would the authorization request need to be sent to a medical director for further review?

If the member hasn't been in the hospital for two days and isn't in a critical care setting, we'll request that you wait until the member has been in the hospital for two days to send additional information about the member's condition. We'll make the request through the Case Communication field in the e-referral system or by calling the facility, or both.

The message we'll send says "Blue Cross/Blue Care Network has a local rule for this condition. Please provide information if the patient remains hospitalized on day 3 with same or worsening symptoms requiring continued treatment. We are granting you an extension to provide this information by (insert time and date). If the information is not received, you could be issued a non-approval."

On the third day, we'll review and process the case with or without the additional clinical information:

- If the member was discharged before two days has elapsed or on the third day, the hospital will need to submit a claim for observation reimbursement.

  Note: Blue Cross and BCN don't require an observation order when reimbursing an observation claim.

- If the member continues through day 3 and the request meets InterQual criteria, we'll approve it.

- If the member continues through day 3 and the request does not meet InterQual criteria, we'll refer it to a medical director for secondary review.

In all cases, the information to substantiate the need for inpatient admission should be included with the request to allow a medical director access to a fuller clinical representation of the complexity of the member's condition.

Why is the length of stay being used as a component for acute medical inpatient criteria?

Blue Cross and BCN are evaluating the individual medical circumstances of the member in addition to the length of stay to determine appropriate reimbursement.

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

Blue Cross and BCN are working hard to reduce the administrative burden that hospitals face.

However, when inadequate information is submitted, many requests that are nonapproved could have been approved had more complete information been submitted with the request.

When this occurs, Blue Cross and BCN must request additional clinical documentation to support the inpatient criteria. This sets in motion a series of back-and-forth communications as well as peer-to-peer discussions or other types of interactions that delay the final adjudication of the case for all the parties.

When more complete information is submitted, which is what we're trying to achieve through the Local Rules initiative, the requests can be processed more efficiently, with quicker decisions and fewer nonapprovals based on incomplete data.

Will Blue Cross and BCN invest in electronic systems to make information sharing more automated, as the Local Rules could have a negative impact on authorization approvals?

Blue Cross and BCN are exploring strategies to increase electronic automation and connectivity.

Will hospital-care-at-home programs be affected by the Local Rules?

The Local Rules do not to hospital-to-home admissions.

Will a member's conditions be defined by an ICD-10 code or other specific identifiers as opposed to the 21 listed conditions, which are vague?

The list of "vague" conditions and the level-of-care criteria are the same conditions and criteria that InterQual evaluated and published as a guideline in adjudicating cases nationwide. See the Criteria table earlier in this document.

It's likely that medically complex members that are among the "sickest of the sick." These members would have diagnoses that are not included in the 21 listed conditions or would have sufficient severity to support admission to a critical level of care and be exempt from the Local Rules related to the 21 conditions.

Are Blue Cross and BCN evaluating each individual authorization request based on the Local Rules or is this a broad list of conditions that hospitals must abide by for 48-hour observation?

The Local Rules apply only for the primary diagnosis on the case. However, for members with more complex conditions, hospitals should submit information about these conditions, along with the primary diagnosis, as this may affect the member's overall clinical representation.

Is the inclusion of anemia based on a DRG code for only chronic anemia?

Anemia could be either acute or chronic. However, if the anemia is due to an acute issue such as gastrointestinal bleeding, then gastrointestinal bleeding is the diagnosis that should be used.

What is the Blue Cross and BCN clinical criteria for observation for arrhythmia? What types of arrhythmias are being considered (V-fib, V-Tch, A-fib with RVR)?

The arrhythmia included in the list of 21 conditions is atrial arrhythmia. The other two criteria subsets for arrhythmia don't contain level-of-care criteria for observation.

Do the Local Rules apply to pediatric members who have asthma?

The Local Rules don't apply to pediatric authorization requests.

Questions that pertain only to Medicare Advantage requests

This section has questions that pertain only to authorization requests for Medicare Plus Blue and BCN Advantage members.

When will peer-to-peer review be available for Medicare Advantage requests?

Requests for a peer-to-peer review:

- Are not available for Medicare Plus Blue authorization requests. Medicare Plus Blue provides a two-step provider precertification appeal process. For more information, refer to the Medicare Plus Blue PPO Provider Manual.
- Are available for BCN Advantage authorization requests. For more information, refer to the document How to request a peer-to-peer review with a Blue Cross or BCN medical director.

Note: Peer-to-peer reviews are also available for Blue Cross commercial and BCN commercial requests.

Will there be a difference between BCN Advantage and Medicare Plus Blue, if the adverse determination is already given, as to whether a conversation is allowed?

To decrease the need for a peer-to-peer review, the hospital should include with the initial submission all pertinent clinical information as well as any medical necessity information documented by the attending physician or the physician advisor or both. This documentation should explain why an inpatient level of care is appropriate for the member's condition.

For BCN Advantage requests that are nonapproved, the hospital can request a peer-to-peer review. For more information, refer to the document How to request a peer-to-peer review with a Blue Cross or BCN medical director.

Note: Peer-to-peer reviews are also available for Blue Cross commercial and BCN commercial requests.

Peer-to-peer reviews are not available for Medicare Plus Blue authorization requests. Medicare Plus Blue provides a two-step provider precertification appeal process. For more information, refer to the Medicare Plus Blue PPO Provider Manual.

Do Blue Cross and BCN Medicare Advantage products follow the "two midnight" rule?

No. Neither Medicare Plus Blue nor BCN Advantage follows the "two midnight" rule. This is stated in:

- The Medicare Plus Blue PPO Provider Manual
- The BCN Advantage chapter of the *BCN Provider Manual*
- The 2022 Local Rules for Acute Care

Would the InterQual criteria supersede a provider's judgment for Medicare Advantage members who are not able to be admitted per the Center for Medicare & Medicaid Services' "two midnight" rule?

Blue Cross and BCN do not follow the "two midnight" rule, as stated in our provider manuals and in the 2022 Local Rules for Acute Care.

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who are not in a critical care setting and who have one of the 21 conditions identified in the Local Rules, we're asking that you don't submit the authorization request to us until after the first two days. This will allow you time to gather all of the pertinent clinical information and submit a more complete clinical representation of the member.

On day 3, we'll review and process the request.

If the request doesn't meet episode day 3 InterQual criteria, we'll request clinical document with medical necessity information. We'll refer the request and the clinical documentation to a medical director for secondary review.

For members in a critical care setting, you can submit the authorization request before the two days has elapsed.

For all requests, the hospital must include all pertinent clinical documentation that explains the medical necessity for an inpatient admission.

By requiring that all members with the specified conditions must remain in observation status for the first 48 hours, the CMS "two midnight" rule permits instances in which medical necessity would allow an inpatient status based on the treating physician's judgment of the need for a hospital level of care.

We've updated the language that previously stated that an observation setting is not required.

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

For members who have one of the 21 conditions in the Local Rules and who are not in a critical care setting, submit the authorization request on the third day, after the member has been in the hospital two days. We'll apply InterQual criteria for episode day 3:

- If the request meets criteria, we'll approve it.

- If the request doesn't meet criteria, we'll refer it to a medical director for secondary review, along with the clinical documentation that was submitted. Individual circumstances will be considered in the secondary review determination.
- If the member's stay in the hospital was less than the two days, we'll refer the case to a medical director for secondary review.

If the member is appropriate for discharge within two days, Blue Cross and BCN will reimburse as observation. The hospital will need to submit a claim for observation reimbursement.

Note: Blue Cross and BCN don't require an observation order when reimbursing an observation claim.

Are Blue Cross and BCN going to waive the case manager's obligation to provide the *Medicare Outpatient Observation Notice* and *An Important Message from Medicare About Your Rights*, since the Local Rules could increase their workload?

No. These are forms required by CMS and the obligation to provide them cannot be waived. Refer to the following manuals for information on the requirements to provide these forms:

- The Medicare Plus Blue PPO Provider Manual
- The BCN Advantage chapter of the *BCN Provider Manual*

The *MOON* form must be provided to the member until an admission is approved.

Blue Cross and BCN are not dictating what level of care to admit the member to. The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

Why don't Blue Cross and BCN follow the CMS definition of an observation?

Blue Cross and BCN **do** follow the CMS definition of observation level of care: Medicare Managed Plans can make determinations based on: medical necessity of plan-covered services; internal policies reviewed and approved by the medical director; involvement of the medical director; and the member's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes).

Observation status does not require authorization.

In addition, Blue Cross and BCN don't require an observation order when reimbursing an observation claim.

A likely unintended consequence of the Local Rules is reduced CMS payments to teaching hospitals, which will be disproportionally penalized under the rules. CMS currently pays a teaching hospital for the cost of indirect medical education, or IME, for inpatient services. By shifting cases to outpatient observation that are appropriately inpatient cases under CMS policy, hospitals will lose vital IME payments from CMS, putting additional financial strain on teaching hospitals.

Inpatient prospective payment systems, or IPPSs, were designed to cover the costs of inpatient stays and assure appropriate reimbursement for hospital services that could be delivered only in an inpatient setting.

"The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis." (Medicare Quality Improvement Organization Manual Chapter 4, Section 4110)

An important part of IPPSs was the appropriate use of observation stays to determine whether patients really needed care that could be provided only in an inpatient setting.

The Blue Cross and BCN Local Rules help to ensure that hospitalizations are appropriate when determining the level of reimbursement (inpatient versus observation).

The Local Rules requirement may result in Blue Cross patients receiving a lower level of care than non-Blue Cross patients for the same condition. This requirement would also be contrary to Medicare policy for observation services.

As a Medicare Advantage organization, Blue Cross and BCN are allowed to determine specific prior authorization program requirements that differ from traditional fee-for-service Medicare requirements.

The hospital must decide which level of care is appropriate for each member based on the member's severity of illness and the intensity of services needed (observation versus inpatient).

The Local Rules are expected to help ensure the appropriateness of the level of care for the member and to decrease nonapprovals due to inadequate information.

Medicare managed plans have the ability to make determinations based on: the medical necessity of plan-covered services; internal policies reviewed and approved by the medical director; involvement of the organization's medical director and the member's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes.

For members who have one of the 21 conditions identified in the Local Rules and who are not in a critical care setting, Blue Cross and BCN are asking that that the hospital does not submit the authorization request to us for two days. This allows the hospital time to gather all of the information and submit a fuller clinical representation of the patient.

*The Participating Hospital Agreement is relevant only for the Blue Cross commercial line of business.