

# Submitting acute inpatient authorization requests

Frequently asked question for providers

For Blue Cross commercial, Medicare Plus Blue<sup>SM</sup>,  
Blue Care Network commercial and BCN Advantage<sup>SM</sup>

Updated June 2024

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In this document, you'll find answers to commonly asked questions about the Blue Cross and BCN authorization requirements and processes for initial inpatient admissions and for transfers of admitted members to another acute care facility. Unless otherwise noted, this information applies to acute medical / surgical (non-behavioral health) admissions for these members:

- Blue Cross commercial
- BCN commercial
- Medicare Plus Blue
- BCN Advantage

This information doesn't apply to inpatient behavioral health admissions. For information on behavioral health admissions, refer to the document titled [Blue Cross Behavioral Health: Frequently asked questions for providers](#).

## Authorization requirements

Note: For requests that involve transfers of members, see the section titled "Transferring a member from one facility to another" on page 9 of this document. For information on requests that don't involve transfers, keep reading.

### Which inpatient admissions require authorization?

#### Acute inpatient medical / surgical admissions require authorization

Authorization is required for all acute inpatient medical / surgical admissions. Submit authorization requests through the e-referral system when admitting a member directly or when moving a member from observation to inpatient status, once the member is admitted to inpatient status and meets Blue Cross or BCN admission criteria.

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Our authorization program is provider facing. We do not deny care, services or treatment. Our program determines the appropriate level of care for reimbursement (observation versus inpatient).

## Some important things to know

Question	Blue Cross and BCN commercial admissions to DRG facilities	Blue Cross and BCN commercial admissions to non-DRG facilities	All Medicare Plus Blue admissions	All BCN Advantage admissions
<b>Initial acute medical admission</b>				
Authorization request required?	Yes	Yes	Yes	Yes
How many days to request? <sup>(1)</sup>	14 days	3-5 days	14 days	14 days
Attach clinical documentation if request is fully approved?	No	No	No	No
Attach clinical documentation if request is pended? <sup>(2)</sup>	Yes	Yes	Yes	Yes
<b>Extension of inpatient stay (concurrent review / continued stay)</b>				
Add days to original authorization? <sup>(3)</sup>	Yes	Yes	Yes	Yes
Attach clinical documentation? <sup>(2)</sup>	No <sup>(4)</sup>	Yes <sup>(4)</sup>	No	No
<b>Discharge</b>				
Add discharge date in e-referral?	Can be added but not required <sup>(4)</sup>	Can be added but not required <sup>(4)</sup>	Can be added but not required	Can be added but not required
Add discharge summary in e-referral?	Yes, if available, but not required	Yes, if available, but not required	Yes, if available, but not required	Yes, if available, but not required
<b>Observation stay</b>				
Authorization required?	No	No	No	No
<b>Maternity admission, including emergency C-section</b>				
Notify the plan by entering a request in e-referral?	Yes, for BCN commercial only	Yes, for BCN commercial only	Yes	Yes

<sup>(1)</sup> For retroactive requests, request the number of days the member stayed in the facility.

<sup>(2)</sup> See instructions for attaching documentation to the request in the [e-referral User Guide](#). Look in the "Submit an inpatient authorization" section for how to "Create New (communication)". In addition, see the question "What information should I submit with authorization requests that pend for clinical review?" on page 11 of this document.

<sup>(3)</sup> See instructions for entering extensions in the [e-referral User Guide](#). Look in the subsection titled “Submit an Inpatient Authorization” — specifically, the information titled “Extending an Inpatient Authorization.” In addition, see the question “How many requests can I submit to extend a member’s stay?” on page 13 of this document.

<sup>(4)</sup> Required for all UAW Retiree Medical Benefits Trust members in both DRG and non-DRG facilities

## What criteria are used in making determinations on inpatient admissions?

For inpatient acute medical / surgical admissions of Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage members, we make determinations on authorization requests based on medical necessity, using:

- InterQual criteria — for all medical / surgical admissions
- CMS Inpatient Only, or IPO, list — for Medicare Plus Blue and BCN Advantage surgical admissions
- Any associated local rules — for all medical admissions that occurred from March 1, 2022, through July 31, 2023

Our medical directors make the final determination about the most appropriate level of care based on their medical judgment.

For more information about the local rules that apply to admissions that occurred from March 1, 2022, through July 31, 2023, refer to the question “What are the local rules that apply to members with certain conditions?”, later in this document.

## For Medicare Plus Blue and BCN Advantage members, we’ll follow CMS guidelines and evidence-based criteria

For inpatient acute medical / surgical admissions of our Medicare Advantage (Medicare Plus Blue and BCN Advantage) members, Blue Cross and BCN use InterQual and our internal coverage criteria, along with applicable Medicare coverage guidelines, when making medical necessity determinations on requests for authorization.

### Three conditions

According to Medicare coverage guidelines, there are three conditions that require reimbursement for hospital-based services. These conditions are:

- The two-midnight benchmark
- An inpatient admission for a surgical procedure specified by Medicare as inpatient only (CMS IPO list).
- A case-by-case exception: The admitting physician expects the patient to require care only for a limited time that does not cross two midnights.

## CMS Final Rule

The 2024 CMS Medicare Advantage Final Rule provided guidance to Medicare Advantage plans regarding the presumption of the validity of hospital admissions crossing two midnights and the application of internal coverage criteria to requests for authorization of hospital admissions. That guidance states:

- **The two-midnight benchmark** states that a patient is generally appropriate for hospital level of care if the patient meets these two qualifications:
  - The admitting physician expects the patient to require a medically necessary hospital care spanning two or more midnights.
  - The expectation is **supported by the medical record clinical documentation of the member's severity of illness and the intensity of services required.**
- **The two-midnight presumption** is an instruction given to the Medicare Administrative Contractor, or MAC, which states that if the hospital stay spans two or more midnights, the hospital care is reasonable and necessary and thus will not select for review unless there is evidence of abuse or delays in the provision of care to qualify for the two-midnight presumption. The provider is given the benefit of doubt that these admissions meet medical necessity.

Note For information about MACs, see [What's a MAC](#)<sup>\*\*</sup>.

- **The two-midnight presumption doesn't apply to Medicare Advantage plans.** Because the presumption does not apply, CMS states that Medicare Advantage plans may conduct prior authorization, concurrent and retrospective reviews, using internal coverage criteria, on hospital care of any length of stay, to consistently interpret medical necessity, including the two-midnight rule. This means that provider decisions and clinical documentation must support and be substantiated in the medical record, to demonstrate the medical necessity of hospital care regardless of the total time spent in the facility.

Note See the CMS 2024 [Final Rule](#)<sup>\*\*</sup>.

## What requests we'll review

Blue Cross and BCN will review hospital authorization requests for the following based on the CMS 2024 Final Rule:

- **Less-than-two-midnight hospital admission.** We'll review such requests following the CMS case-by-case exception and apply the evidence-based factors as part of our internal coverage criteria to ensure the complex medical factors documented in the record support the medical necessity of hospital level of care. If the internal coverage criteria are not met at an acute, intermediate or critical level of care status, the authorization request will be reviewed by a Blue Cross/BCN medical director to determine medical necessity extending beyond the applicable internal coverage criteria.

- **Two-midnight admission.** We'll review such requests applying evidence-based factors as part of our internal coverage criteria to ensure the complex medical factors documented in the medical record support the medical necessity of the hospital level of care. If the internal coverage criteria are not met at an acute, intermediate or critical level of care status, the authorization request will be reviewed by a Blue Cross/BCN medical director to determine medical necessity extending beyond applicable evidence-based criteria.
- **Greater-than-two-midnight inpatient admission.** We'll review requests applying evidence-based factors as part of our internal coverage criteria and the CMS guidelines criteria to ensure the complex medical factors documented in the medical record support the medical necessity of the hospital level of care for acute, intermediate or critical level of care status. If criteria are not met, the authorization request will be reviewed by a Blue Cross/BCN medical director to determine medical necessity extending beyond the applicable evidence-based criteria.

Note: Hospital care per CMS and under the two-midnight benchmark includes the observation level of care. Blue Cross and BCN do not perform prior authorization, concurrent or retrospective review for the observation level of care. If hospital care meets observation criteria, then the facility should bill appropriately for the level of care.

## What providers must do

For inpatient acute medical / surgical admissions of Medicare Plus Blue and BCN Advantage members, we require admitting physicians and facilities to:

- Evaluate and document that their expectation of two or more midnights of medically necessary hospital care is reasonable and can be supported by documented medical evidence as required by CMS coverage guidelines.
- Submit documentation that supports the medical necessity of a hospital admission, in line with the member's severity of illness and the intensity of the services required.

## What are the local rules that apply to members with certain conditions?

**Important:** This information applies only to inpatient acute medical admissions of adults that occurred March 1, 2022, through July 31, 2023.

For certain conditions, authorization requests for acute medical admissions should be submitted only after the member has spent two days in the hospital. Once the two days has elapsed, the facility can submit the request to authorize an inpatient admission on the third day.

Note: This requires that the patient still receive treatment on day 3. Please attach relevant clinical documentation inclusive of day 1, 2 and 3 of the admission to support the level of care requested.

Exception: When a member is receiving intensive care services that require a critical care setting, you can submit the request prior to completion of the two-day period, along with all clinical documentation supporting the critical level of care.

We're aligning our local rules for all lines of business to reflect this change. This update to local rules went into effect for Blue Cross commercial, BCN commercial members, Medicare Plus Blue and BCN Advantage members admitted on or after March 1, 2022, through July 31, 2023.

This applies to members with the following conditions:

- |                      |                             |                                  |
|----------------------|-----------------------------|----------------------------------|
| • Allergic reaction  | • Deep vein thrombosis      | • Nausea / vomiting              |
| • Anemia             | • Diabetic ketoacidosis     | • Nephrolithiasis                |
| • Arrhythmia, atrial | • Headache                  | • Pneumonia                      |
| • Asthma             | • Heart failure             | • Pulmonary embolism             |
| • Chest pain         | • Hypertensive urgency      | • Skin and soft tissue infection |
| • COPD               | • Hypoglycemia              | • Syncope                        |
| • Dehydration        | • Intractable low back pain | • Transient ischemic attack      |

Once the request has been received, Blue Cross and BCN will conduct a medical necessity review based on the clinical documentation you submitted. InterQual criteria will be applied based on the member's condition at the time the clinical documentation is received:

- If InterQual criteria are met, the authorization request will be approved.
- If InterQual criteria aren't met, the authorization request will be sent to the plan medical director for review.
- If the member hasn't been in the hospital for two days and isn't in a critical care setting, Blue Cross and BCN will request that the facility 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.

**Note:** Submission of the request on day 3 must include documentation of clinical status and interventions as well as physician/RN documentation that demonstrates that the InterQual criteria have been met at the time the request is submitted. The documentation submitted must include clinical information from days 1, 2 and 3 of the stay.

After receiving the request from the hospital on the third day, Blue Cross and BCN will do the following:

- If the facility sent additional clinical information and it meets criteria, we'll approve the request.



- If the facility hasn't sent additional clinical information or has sent additional clinical information but it doesn't meet criteria, we'll refer the request to the medical director for review.

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: These local rules provide instructions only on **when** to submit the authorization request. They do not direct providers on how to write admission orders for observation or inpatient care.

We expect that this change will:

- Reduce the number of communications that typically accompany these types of authorization requests.
- Decrease denials for lack of clinical information, because all clinical documentation in support of the admission would be received while the member is still receiving care on day 3.
- Ensure appropriate reimbursement (inpatient versus observation level of care)

For most members, facilities can request peer-to-peer reviews, if desired. Refer to the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

In addition, facilities can appeal denial decisions. Refer to the pertinent provider manual for information about how to submit an appeal.

To access the local rules for admissions that occurred from March 1, 2022, through July 31, 2023, visit these webpages on our [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) website:

- [Blue Cross Acute Inpatient Medical and Surgical Admissions](#) webpage
- [BCN Acute Inpatient Medical and Surgical Admissions](#) webpage

## How do I request a peer-to-peer review?

When an authorization request is denied, you can ask to speak to a Blue Cross or BCN medical director in a peer-to-peer review. The purpose of a peer-to-peer review is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the services.

For details about the availability of peer-to-peer reviews as an option and how to submit a request for a peer-to-peer review, refer to the document [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

## How will I find out how many days have been approved?

Check the e-referral system. Once the determination has been made, you'll be able to access the authorization immediately in the e-referral system.



## Transferring a member from one facility to another

Note: For requests that don't involve transfers of members from one facility to another, see the section titled "Submitting authorization requests that don't involve a transfer" on page 10 of this document. For information on requests that involve transfers, keep reading.

### In what circumstances can transfers be requested?

Requests to transfer a member from one acute care facility to another may be submitted for medical necessity reasons but only when the attending physician determines that the member is stable or when a medical emergency exists.

Members may be considered for transfer when the services or procedures that the member requires are not available at the current facility or cannot be provided there safely.

In addition, primary care providers may request that a member be directly admitted from an emergency department in one facility to an inpatient bed in another acute care facility. This can occur only when the attending physician determines the member's medical condition is stable.

### How do I request authorization for a transfer?

Request authorization for the inpatient stay at the receiving facility as follows:

#### • For non-urgent requests:

Members	When to submit the request	How to submit the request
BCN commercial and BCN Advantage	Before the transfer	<ol style="list-style-type: none"> <li>1. Enter the request into the e-referral system.</li> <li>2. Immediately call (prior to the transfer): <ul style="list-style-type: none"> <li>○ Call 1-800-392-2512 during normal business hours.</li> <li>○ Call 1-800-851-3904 during normal business hours (to expedite) and outside of normal business hours (that is, on weekday evenings, weekends and holidays).</li> </ul> </li> </ol> <p>Note: If non-emergency air ambulance transport is needed, prior authorization is required. To request prior authorization, follow the instructions on the document titled <a href="#">Non-emergency air ambulance prior authorization program: Overview for Michigan and non-Michigan providers</a>. Do this prior to the flight.</p>
Blue Cross commercial and Medicare Plus Blue	Either prior to the transfer or within one business day after the member has arrived at the receiving facility	<ol style="list-style-type: none"> <li>1. Enter the request into the e-referral system.</li> <li>2. Immediately call 1-800-851-3904 to expedite it.</li> </ol>

- **For urgent transfers related to medical necessity**, facilities should transfer the member as soon as the attending physician deems the member medically stable. Blue Cross or BCN must be notified of the transfer within one business day of the transfer.

## Which facility should submit the authorization request for members transferred from one facility to another?

The sending facility can submit the request on behalf of the receiving facility, or the receiving facility can submit the request when the member arrives.

Be prepared to discuss the following information when you submit the request to transfer:

- Reason for the transfer
- Name of attending physician that has deemed the member stable for transfer
- Name of attending physician at the receiving facility
- Benefit/certificate pertaining to use of out-of-network providers, if applicable
- Availability of in-network providers, if applicable
- Pertinent clinical information and summary

## Submitting authorization requests that don't involve a transfer

### Who should submit authorization requests?

#### Who should submit the request for the admission itself?

Either the physician office or the facility can submit the authorization request for the admission.

#### What if the member needs a procedure during the admission and the procedure requires prior authorization?

Emergency procedures don't require authorization.

Non-emergency procedures may require authorization separate from the admission. Requests for elective procedures that require authorization must include clinical information to support the need for the procedure.

For musculoskeletal joint, spine and pain management procedures, you must submit prior authorization requests to TurningPoint Healthcare Solutions LLC, as appropriate. For more information, refer to these webpages on our [ereferrals.bcbm.com](https://www.bcbm.com) website:

- [Blue Cross Musculoskeletal Services page](#)
- [BCN Musculoskeletal Services page](#)

## How should I submit authorization requests that don't involve a transfer?

We accept authorization requests for acute inpatient admissions when they are submitted in one of these ways:

### Submitting through the e-referral system and using other methods

To submit a prior authorization request for acute inpatient care:

- For Blue Cross and BCN commercial members, complete the [Acute inpatient hospital assessment form](#). Follow the instructions on the form to submit it.

Note: [Michigan's prior authorization law](#)\* requires health care providers to submit prior authorization requests electronically for commercial members. Alternate submission methods are allowed in the case of temporary technological problems, such as a power or internet outage. Refer to the document [e-referral system maintenance times and what to do](#) for information about alternate methods that can be used when the e-referral system is not available or when providers are experiencing temporary technological problems.

- For Medicare Plus Blue and BCN Advantage members, complete the [Medicare Advantage inpatient assessment form](#). Follow the instructions on the form to submit it.

Providers in Michigan should access the e-referral system as follows:

1. Log in to our provider portal ([availity.com](#)\*\*).
2. Click on *Payer Spaces* and then click on the BCBSM and BCN logo.
3. Scroll down and click on the e-referral tile on the Applications tab.

If you haven't yet signed up for access to the e-referral system, click [Getting Started](#) and follow the instructions.

Note: When the e-referral system is unavailable or when you're experiencing temporary technological problems that prevent you from accessing it, such as a power or internet outage, follow the instructions on the document titled [e-referral system maintenance times and what to do](#).

### Fax requests for sick newborns and others not yet on the contract

Requests for sick newborns or for anyone else who has not yet been added to the subscriber's contract must be submitted by fax. For information on these requests, see the question "How should I submit authorization requests for members I can't find in the e-referral system?" on page 12 on this document.

## What information should I submit with authorization requests that pend for clinical review?

For acute inpatient admission requests that pend in the e-referral system, hospitals should do the following:

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- For Blue Cross commercial and BCN commercial admissions, complete the [Acute inpatient hospital assessment form](#) and attach it to the case in the e-referral system along with other pertinent documentation.
- For Medicare Plus Blue and BCN Advantage admissions, complete the [Medicare Advantage inpatient assessment form](#) and attach it to the case in the e-referral system along with other pertinent documentation.

The additional pertinent information should include:

- The InterQual<sup>®</sup> criteria subset used to support the decision for inpatient admission
- The clinical information that validates the InterQual criteria points that are met
- Relevant supporting medical necessity criteria outside of the InterQual criteria that supports the inpatient admission
- The procedure codes for surgical admissions, as applicable

Do not copy clinical information and paste it into the Case Communication field, as it's not viewable. Copying and pasting the clinical information into the e-referral system will result in a request to resubmit the information. Instead, attach the clinical documents to the case in the e-referral system.

## How should I submit authorization requests for members I can't find in the e-referral system?

Facility providers should fax requests for members they cannot find in the e-referral system. This includes, for example, newborns admitted to a neonatal intensive care unit who have not yet been added to the subscriber's contract.

Note: For twins, send two separate faxes — one identified as being for Baby A and the other identified as being for Baby B.

Specifically, do the following:

- For Blue Cross commercial and BCN commercial admissions, complete the [Acute inpatient hospital assessment form](#) and fax it and other pertinent documentation to the fax number on the form. For newborns, include the name of the newborn, if known.
- For Medicare Plus Blue and BCN Advantage admissions, complete the [Medicare Advantage inpatient assessment form](#) and fax it and other pertinent documentation to the fax number on the form.

The additional pertinent information should include:

- The InterQual<sup>®</sup> criteria subset used to support the decision for inpatient admission

- The clinical information that validates the InterQual criteria points that are met
- Relevant supporting medical necessity criteria outside of the InterQual criteria that supports the inpatient admission
- The procedure codes for surgical admissions, as applicable

When the nurse reviewer receives your fax, he or she will manually create a case for the newborn or other temporary member in the e-referral system and will fax the determination to the provider. That fax will have the number for the case in the e-referral system.

Once you find the case for the newborn or other temporary member in the e-referral system, you can attach updates or discharge information to the case using the Case Communication field, as you would with any member.

## How many requests can I submit to extend a member's stay?

When a member needs to stay in the hospital beyond the days already authorized, submit a request for an extension. Follow these guidelines:

- You can submit up to 14 requests for extension through the e-referral system. The e-referral system can accommodate only 14 extension requests.
- Starting with the 15th extension request, you must submit your request by phone or fax. The Blue Cross / BCN reviewers will adjust the last extension line in the e-referral system to include the additional days.

Note: To see the phone and fax numbers you should use, refer to the document [e-referral system planned downtimes and what to do](#). Look in the table and find the information for acute inpatient admissions.

## More information about submitting prior authorization requests through the e-referral system

### What do I do when I'm attempting to update the authorization request and the case is closed in the e-referral system?

When you want to extend the stay or change the admission date or do something similar with an authorization request, here's how it works:

- **Closed cases:** Cases in Closed status **cannot** be updated through the e-referral system.
- **Open cases:** For Open cases, add an extension line or new service and include a Case Communication. Be sure to attach clinical documentation.

- **Pended cases:** You can edit the case information only for cases in Pending Decision status.
- **Other cases:** If the case status is Fully Approved, Partially Approved or Denied, the original case data cannot be edited. To change the admission date after the determination has been made or to add an extension to a closed case, send an email to [e-referralinquiries@bcbsm.com](mailto:e-referralinquiries@bcbsm.com).

## Can I start to enter an authorization request and save it so I can finish it later?

No. Once you start an authorization request, you must finish it.

## How do I save bookmarks in the e-referral system?

To learn how to create and save bookmarks, refer to the [e-referral User Guide](#). Look in the section titled “Bookmarks.”

## What if I can't find my hospital or facility in the e-referral system?

Complete and submit the form to add or change a provider in the e-referral system. To access the form, visit [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com) and click [Getting Started](#).

## What additional information should I include in the request?

### Can I use procedure code \*99222 for an inpatient admission?

Submit your authorization requests in line with these guidelines:

- For acute care medical admissions, use procedure code \*99222.
- For surgical admissions, use the procedure code that's appropriate for each admission. However, the authorization is for the setting only unless the procedure code is part of a prior authorization program. In all instances, you should check the member's benefits and eligibility prior to submitting the request.

### For medical inpatient admissions, can I use an F diagnosis code on an authorization request?

If the admission is for acute medical stabilization related to drug or alcohol withdrawal, an F diagnosis code can be used. Make sure to use the appropriate withdrawal diagnosis code.

## What about elective surgeries?

### How far in advance should an elective surgery request be submitted?

Submit prior authorization requests for elective surgeries at least 30 days in advance of the date of the procedure or as soon as the surgery date is known. In addition, allow 14 calendar days for processing preservice requests.



If you don't know the actual surgery date, submit the expected admission date and the supporting clinical documentation. Also submit the pertinent procedure codes.

If the admission date needs to be changed later, you can change it on a case that has a pended status within the e-referral system. After the case is approved, you'll need to email your request to change the admission date to [e-referralinquiries@bcbsm.com](mailto:e-referralinquiries@bcbsm.com).

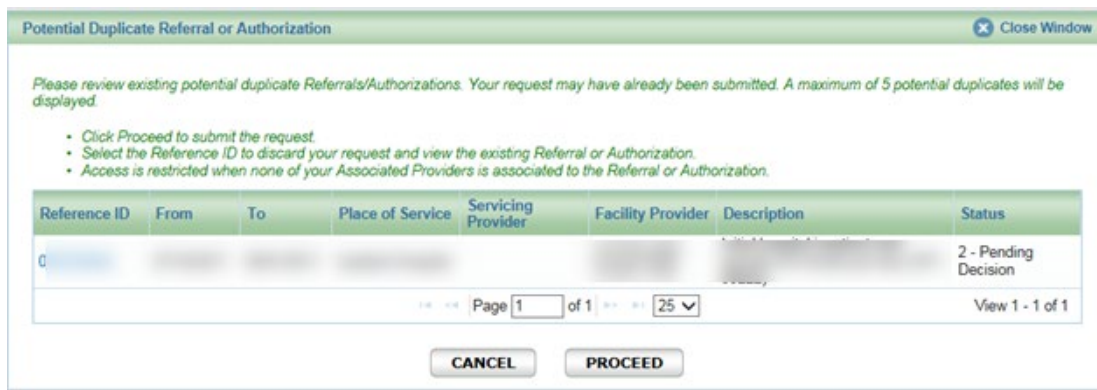
## When the e-referral system shows that the request is “fully approved,” what does that mean?

It depends on how the facility is reimbursed:

- If your facility is reimbursed on a DRG basis, the entire stay is approved. This includes the days in the original request plus any days approved via an extension request. However, the number of days in the authorization should match the number of days the member stayed.
- If your facility is not reimbursed on a DRG basis, only the specific days in the authorization are approved. You must submit an extension request if more days are needed.

## What happens if I receive a duplicate message when loading an authorization?

- If a provider **is** associated in any way with another case in the e-referral system, you'll see the following screen in the e-referral system for a duplicate:



Potential Duplicate Referral or Authorization Close Window

Please review existing potential duplicate Referrals/Authorizations. Your request may have already been submitted. A maximum of 5 potential duplicates will be displayed.

- Click Proceed to submit the request.
- Select the Reference ID to discard your request and view the existing Referral or Authorization.
- Access is restricted when none of your Associated Providers is associated to the Referral or Authorization.

Reference ID	From	To	Place of Service	Servicing Provider	Facility Provider	Description	Status
0							2 - Pending Decision

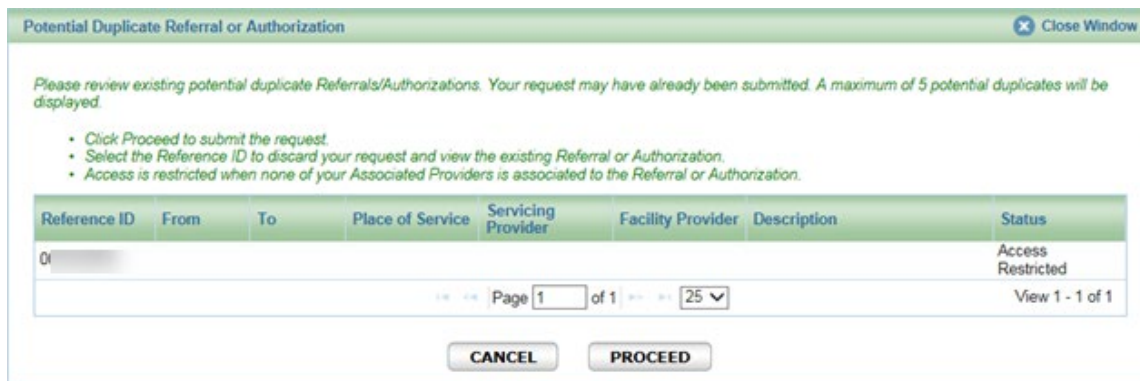
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CANCEL PROCEED

When you see this screen, review the potential duplicates that are listed by clicking on the reference ID. If one of those duplicates applies to your patient or request, no further action is necessary. **Important: Do not load another authorization request.**



- If the provider is **not** associated in any way with any of the duplicates, you'll see the following screen in the e-referral system for a duplicate:



If you get an alert indicating a “potential duplicate” but it is **not** a duplicate admission request, click *Proceed* and the request will pend for further review.

## Is a referral needed for an inpatient admission?

A referral is required for inpatient admissions that involve elective procedures. This applies only to BCN commercial and BCN Advantage members, as follows:

- A global referral is required for BCN commercial members who have a primary care physician that is part of a medical care group based in the East or Southeast region. The primary care physician should click “Submit Global Referral” in the e-referral system and enter the referral to a contracted provider.
- For BCN commercial or BCN Advantage members, a referral is required when the specialist or provider is not part of the provider network for the member’s health plan. The primary care physician should click “Submit Referral” in the e-referral system and enter the referral.

For more information about referral requirements for BCN commercial and BCN Advantage members, refer to the [BCN referral and authorization requirements for Michigan providers](#) document. Look in Section 2: Referral requirements.

Referrals are not used for Blue Cross commercial or Medicare Plus Blue members.

## What about after business hours and on holidays?

### After-hours phone number – for urgent requests only

You can call the Utilization Management department after-hours number at 1-800-851-3904 and listen to the prompts.

Note: Do not use the after-hours number to request authorization for routine inpatient admissions.

## Holiday closures

When our corporate offices are closed for a holiday, refer to the document [Holiday closures: How to submit authorization requests for inpatient admissions](#) for information on what to do.

## e-referral system planned downtimes for routine maintenance

For the information you need on what to do when the e-referral system is out of service due to software maintenance or upgrades, refer to the document [e-referral system maintenance times and what to do](#).

## Troubleshooting, claims, penalties and appeals

### What if a pended request is locked for editing?

When a request is locked for editing, it means the system is either processing the request or a nurse is reviewing it. Wait a while and try again.

### What if neither the facility nor the surgeon's office obtained the authorization required for an elective inpatient surgical admission?

You can submit a retroactive authorization request after the procedure performed, if needed. The request must be submitted in a timely fashion or sanctions may be applied.

With the request, you must submit clinical information that supports the need for the surgery.

### Can I bill with Condition Code 44?

You can review and follow the CMS guidelines on Condition Code 44—inpatient admission changed to outpatient. See [Transmittal 299](#)\*\* of Sept. 10, 2004, in the CMS Manual System.

### If my authorization request is denied, can I appeal that decision?

For information about submitting appeals of denied authorization requests, refer to the pertinent provider manual, as follows:

- Blue Cross commercial: Log in to the provider portal to access the *Blue Cross PPO Provider Manual*. Look in the “Appeals and Problem Resolution” chapter.
- Medicare Plus Blue: Open the [Medicare Plus Blue PPO Provider Manual](#). Look in the section titled “Appealing Medicare Plus Blue’s Decision.”
- BCN commercial: Open the *BCN Provider Manual*’s [Utilization Management chapter](#). Look in the section titled “Appealing utilization management decisions.”
- BCN Advantage: Open the *BCN Provider Manual*’s [BCN Advantage chapter](#). Look in the section titled “BCN Advantage provider appeals.”

## Time frames for making determinations on inpatient requests that don't involve transfers

### What's the time frame for making a determination on an acute inpatient authorization request that doesn't involve a transfer?

The time frame within which Blue Cross and BCN must make a determination on a request to authorize an acute inpatient admission depends on the type of request. Refer to the table below for the details.

Request for...	Line of business				Standard set by ...
	Blue Cross commercial	Medicare Plus Blue	BCN commercial	BCN Advantage	
Preservice urgent request	Within 72 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request	CMS NCQA Michigan Public Act 60 of 2022
Preservice standard request	Within 9 calendar days of receipt of request	Within 14 calendar days of receipt of request	Within 9 calendar days of receipt of request	Within 14 calendar days of receipt of request	CMS NCQA Michigan Public Act 60 of 2022
Concurrent standard request	Within 72 hours of receipt of request	Within 14 calendar days of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request	CMS NCQA Michigan Public Act 60 of 2022
Postservice standard request	30 calendar days	14 calendar days	30 calendar days	14 calendar days	CMS NCQA

Here's more information about the types of requests:

- **Standard:** Request to reimburse for services.
- **Expedited:** Request when standard time frame could seriously jeopardize the life or health of a member or the member's ability to regain maximum function. Requires that a physician attest to the need for an expedited request.
- **Preservice:** Request is received prior to receipt of care.
- **Concurrent:** Request is received while member is receiving care.
- **Postservice:** Request is received after member has been discharged.

# Submitting acute inpatient authorization requests

Frequently asked question for providers

For Blue Cross commercial, Medicare Plus Blue<sup>SM</sup>,  
Blue Care Network commercial and BCN Advantage<sup>SM</sup>

Updated June 2024

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## Reminder

Our authorization program is oriented toward providers, not members. We do not deny care, services or treatment. Our program determines the appropriate level of care for reimbursement (observation versus inpatient).

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