Blue Cross Blue Shield Blue Care Network of Michigan

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

Submitting acute inpatient authorization requests

Frequently asked question for providers

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

Updated Dec. 20, 2021

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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 inpatient admissions. This information applies to acute medical (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:

- For BCN commercial and BCN Advantage members, refer to the Behavioral Health chapter of the *BCN Provider Manual*. Look in the section titled "Authorization for behavioral health services."
- For Blue Cross commercial and Medicare Plus Blue members, refer to the Behavioral Health webpage in the Blue Cross section of the ereferrals.bcbsm.com website. In addition, refer to:
  - Medicare Plus Blue PPO Provider Manual
  - *Blue Cross PPO Provider Manual*, in the Psychiatric Care Services chapter and the Mental Health and Substance Abuse Managed Care Program chapter

Authorization requirements

Which inpatient admissions require authorization?

Acute inpatient medical admissions require authorization

Authorization is required for all acute inpatient medical 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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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
Initial acute medical admission				
Authorization request required?	Yes	Yes	Yes	Yes
How many days to request? (1)	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? (2)	Yes	Yes	Yes	Yes
Extension of inpatient stay (concurrent review / continued stay)				
Add days to original authorization? (3)	Yes	Yes	Yes	Yes
Attach clinical documentation? (2)	No (4)	Yes (4)	No	No
Discharge				
Add discharge date in e-referral?	Can be added but not required (4)	Can be added but not required (4)	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
Observation stay				
Authorization required?	No	No	No	No
Maternity admission, including emergency C-section				
Notify the plan by entering a request in e-referral?	Yes, for BCN commercial only	Yes, for BCN commercial only	Yes	Yes

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

(2) 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 What information should I submit with authorization requests that pend for clinical review? on page 8 of this document.

(3) 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 How many requests can I submit to extend a member's stay? on page 10 of this document.

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

Do you use the CMS two-midnight rule to make determinations on authorization requests for inpatient acute admissions?

In reviewing acute inpatient medical admissions, we use the InterQual® criteria as a guideline. Determinations on authorization requests are made based on medical necessity using InterQual criteria and any associated local rules. Our medical directors make the final determination about the most appropriate level of care based on their medical judgment. Determinations are not made based on the two-midnight rule.

To access the local rules, visit these webpages on our ereferrals.bcbsm.com website:

- Blue Cross Authorization Requirements & Criteria webpage
- BCN Authorization Requirements & Criteria webpage

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

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. You must provide clinical documentation that demonstrates that the InterQual® criteria have been met at the time you submit the request.

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 will go into effect for Blue Cross commercial, BCN commercial members, Medicare Plus Blue and BCN Advantage members admitted on or after March 1, 2022.

This applies to members with the following conditions:

- Allergic reaction
- Anemia
- Deep vein thrombosis
- Diabetic ketoacidosis
- Nausea / vomiting
- Nephrolithiasis

- Arrhythmia, atrial
- Asthma
- Chest pain
- COPD
- Dehydration
- Headache
- Heart failure
- Hypertensive urgency
- Hypoglycemia
- Intractable low back pain
- Pneumonia
- Pulmonary embolism
- Skin and soft tissue infection
- Syncope
- 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.

  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 after two days of hospital care.
- 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 as usual. Refer to the pertinent provider manual for information about how to submit an appeal.

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.

Submitting authorization requests

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.bcbsm.com website:

- Blue Cross Musculoskeletal Services page
- BCN Musculoskeletal Services page

Who 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. Include 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 summary

In the e-referral system, if you get an alert indicating a "possible duplicate," indicate in the Case Communication field of the request that the member is transferring to a new facility; this will result in the case pending for review. For more information about the Case Communication field, refer to the e-referral User Guide; look in the section titled "Submit an inpatient authorization."

Also, see the question What happens if I receive a duplicate message when loading an authorization? on page 13 of this document.

How should I submit authorization requests?

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

Submitting through the e-referral system
To access the e-referral system, do the following:

1. Log in as a provider on bcbsm.com.
2. Click *e-referral* on the Provider Secured Services welcome page.

If you haven't yet signed up for access to the e-referral system, click Sign Up or Change a User. Follow the instructions to complete the appropriate Provider Secured Services application forms.

Note: When the e-referral system is unavailable, follow the instructions on the document titled e-referral system planned downtimes 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 9 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:

- For BCN commercial and BCN Advantage admissions, complete the Request for Review of Initial Inpatient Admission form and attach it to the case in the e-referral system along with other pertinent documentation.
- For Medicare Plus Blue admissions, complete the Acute Inpatient Fax Assessment Form and attach it to the case in the e-referral system along with other pertinent documentation.
- For Blue Cross commercial admissions, gather the information listed below and attach it to the case in the e-referral system along with other pertinent documentation:
    - Member information (name, date of birth, etc.)

      Note: For newborns, include the name only if it's known.
    - Contract number
    - Diagnosis
    - Date of admission to the hospital (NICU or another unit)
    - Supporting clinical information.

The additional pertinent information should include:

- The InterQual® 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 (This applies only to Medicare Plus Blue and BCN Advantage members.)

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 BCN commercial and BCN Advantage admissions, complete the Request for Review of Initial Inpatient Admission form and fax it and other pertinent documentation to BCN at 1-866-313-8433. For newborns, include the name of the newborn, if known.
- For Medicare Plus Blue admissions, complete the Acute Inpatient Fax Assessment Form and fax it and other pertinent documentation to the fax number on the form.
- For Blue Cross commercial admissions, gather the information listed below and fax it to 1-800-482-1713:
  - Member information (name, date of birth, etc.)

    Note: Include the name of a newborn only if it's known.
  - Contract number
  - Diagnosis
  - Date of admission to the NICU (or to another unit)
  - Supporting clinical information.

The additional pertinent information should include:

- The InterQual® 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 (This applies only to Medicare Plus Blue and BCN Advantage members.)

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 nine requests for extension through the e-referral system. The e-referral system can accommodate only nine extension requests.
- Starting with tenth 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

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, you can add a Case Communication, attach clinical documentation, add an extension or add a new service.
- **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.

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 and click Sign up or Change a User.

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?

It depends on the member’s plan, as follows.

- For Blue Cross commercial members, an admission request submitted with an F diagnosis will be pended for review.
- For BCN commercial, BCN Advantage and Medicare Plus Blue members, a medical diagnosis code must be used on medical admissions. If you use an F code, a behavioral health questionnaire will open and the inpatient request will be routed in error to our Behavioral Health department.

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 at least 72 hours for processing the request.

If you don't know the actual surgery date, submit the expected admission date and the supporting clinical documentation. For Medicare Plus Blue and BCN Advantage members, 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.

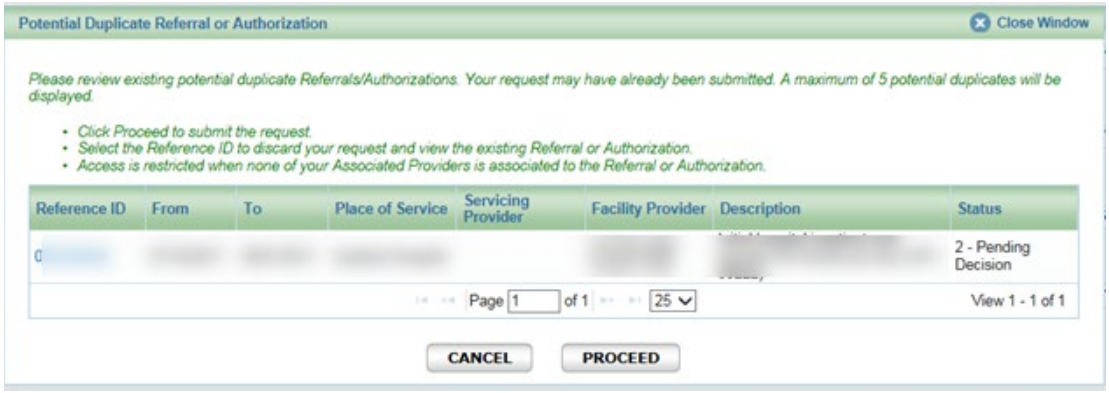
When the e-referral system shows that the request is "fully approved," what does that mean?

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.

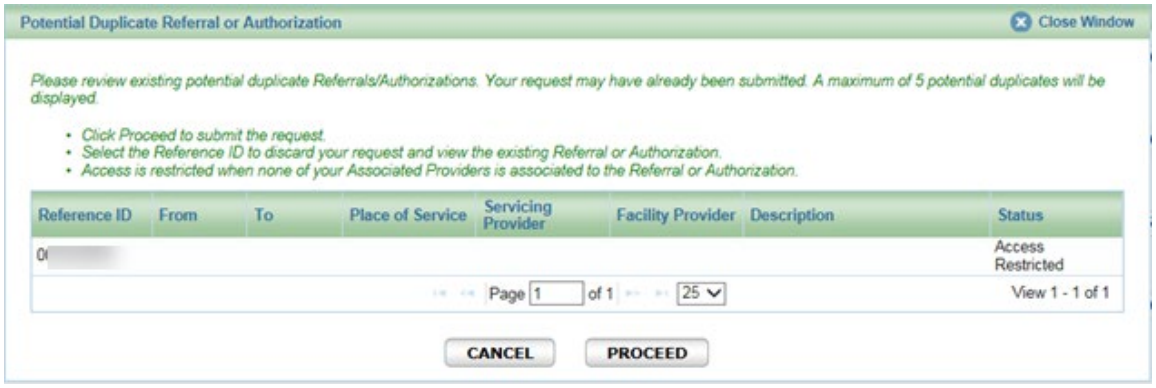
What happens if I receive a duplicate message when loading an authorization?

- 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:



  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

We take the e-referral system out of service once a month for routine maintenance. For the information you need during those times, refer to the document e-referral system planned downtimes 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 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."

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