

## **Pre-authorization for Elective Inpatient Admissions and Services Frequently Asked Questions**

### **OVERVIEW**

Pre-authorization/pre-certification will be required for all services that occur during an elective inpatient admission. An authorization must be on file to ensure proper claims payment. This includes all applicable professional and facility claims:

- Effective April 1, 2019, for professional services
- Effective May 1, 2019, for facility services

These requirements apply to all Regence plans (group, Individual, Uniform Medical Plan [UMP], Medicare Advantage) and the Blue Cross and Blue Shield Federal Employee Program® (BCBS FEP®) Blue Focus plan in Oregon and Utah. They **do not apply** to BlueCard® members outside of our four-state service area or to BCBS FEP Blue Focus, Basic Option and Standard Option members in Idaho and Washington.

Effective July 1, 2019, these requirements will apply to BCBS FEP Basic Option and Standard Option members in Oregon and Utah.

Claims will be subject to pre-authorization requirements. If pre-authorization is not obtained, we may administratively deny the primary surgeon claim and the facility claim. We do not deny associated claims related to administrative denials.

Facilities should continue to notify us of admission.

Professional providers can begin pre-authorizing these services and admissions now through Availity®'s electronic authorization tool.

### **Do associated services and ancillary providers, such as anesthesia, radiology or laboratory services, have to be pre-authorized?**

No. This pre-authorization requirement applies only to the primary surgeon claim and the facility claim.

### **Will professional claims be reviewed?**

Yes. Professional claims may be reviewed post-payment; if pre-authorization was not obtained, we may request a refund.

### **What are the most common procedures that will be affected by this change?**

We already required pre-authorization for most elective admissions prior to May 1, 2019. This new requirement applies to all elective admissions except child birth. This pre-authorization expansion includes such services as knee surgeries, hysterectomies, tubal ligations, vasectomies and gallbladder removal. We expect fewer than 1% of members who seek services to be affected by this new requirement.

### **Do these requirements apply to elective behavioral health services and admissions?**

Yes.

### **Do these requirements apply to pregnancy deliveries?**

No. Vaginal and C-section elective delivery admissions, as well as newborns, are exempt from these pre-authorization requirements.

## **Pre-authorization for Elective Inpatient Admissions and Services Frequently Asked Questions**

### **Do these requirements apply to hospice?**

No. Hospice admissions for non-BCBS FEP plans are exempt from these pre-authorization requirements. BCBS FEP plans will continue to require pre-authorization.

### **Which admissions are considered elective?**

Elective admissions are admissions that are not urgent or emergent. They typically occur in association with an elective procedure; for example, a surgery that is beneficial to the patient but does not need to be performed at a particular time.

### **What is the purpose of these pre-authorization changes?**

Reviewing inpatient stays, an industry standard, is part of our effort to ensure the member receives the right care in the right setting. An increasing number of procedures that have traditionally been done inpatient can now safely be performed in the outpatient setting for substantially less cost.

Pre-authorizing these admissions and professional services helps members and providers:

- For members, it alerts them pre-service to potential liability, which could occur if:
  - The pre-authorization is declined
  - The procedure isn't covered by their benefits
  - They have a procedure at an out-of-network facility
- For providers, it confirms whether the procedure is a covered benefit and is considered medically necessary.

### **How should professional providers request pre-authorization for these services and admissions?**

Providers should submit the pre-authorization request through the electronic authorization tool on the Availity Portal, which will ensure all required information is submitted. This tool allows providers to check the status of their request without having to contact us.

### **Where can I find the instructions about submitting a pre-authorization request through Availity?**

If you need help getting started, training is available in the Availity Learning Center. In the Availity Portal, click Help>Training>Get Trained and search the Availity Learning Center Catalog using keyword *authorizations*.

### **Do pre-authorization requests need to include the facility where the service and admission will occur?**

Yes. Without this information, the facility may not be notified of the pre-authorization.

### **If pre-authorization is approved for a service but the inpatient admission request is denied for place of service, how will the provider and facility be notified?**

Pre-authorization requests list the service/procedure code and the admission. Denials for admission are noted in the admission line. Providers and facilities will receive notification of the denial.

### **If we deny a request for either a service or the place of service, how do we notify the provider and the facility?**

We will notify the provider by phone, fax or letter.

## **Pre-authorization for Elective Inpatient Admissions and Services Frequently Asked Questions**

### **Are pre-authorization letters sent to the provider's physical or billing address?**

Letters are sent to the address listed on the pre-authorization request.

### **Does the facility need to request a separate pre-authorization in addition to the provider's pre-authorization for the procedure?**

No. The provider is responsible for requesting the pre-authorization, but the facility should confirm that a pre-authorization is in place.

### **Can the facility confirm the pre-authorization is complete in the Availity Portal?**

No. They will need to request the pre-authorization information, including the authorization number, from the provider.

### **Can the facility request the pre-authorization?**

It is the professional provider's responsibility to request the pre-authorization. These requirements concern elective inpatient stays at an acute care hospital. In these circumstances, the facility usually does not have the full clinical picture to request this pre-authorization and must rely on the provider to furnish this information.

These changes do not affect the current process for residential care facilities (RTC), partial hospitalizations (PHP), skilled-nursing facilities (SNF), long-term acute care (LTAC) and inpatient rehabilitation facilities (IPR).

### **If a facility has requested pre-authorization for admissions in the past, will their process change?**

No, it will not. Facilities can continue to request pre-authorization as they have in the past.

### **When is a denied claim considered provider liability?**

If the contracted provider does not obtain pre-authorization for the elective service, the denied claim is considered provider liability; providers cannot balance bill the members for provider liability.

### **When is a denied claim considered member liability?**

A denied claim is only considered member liability if the pre-authorization request was denied, the member was notified of this denial, and the member received the denied services.

### **How have you notified providers?**

The pre-authorization requirement for inpatient services was announced in our December 2018 issue of the provider newsletter, *The Connection*<sup>SM</sup>. We notified providers and facilities of the admissions change in our February 1, 2019, provider newsletter. The [pre-authorization pages](#) of our website have been updated to reflect the admissions pre-authorization requirement.