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 questions for providers

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

Updated February 2025

In this document

In this document, you'll find answers to commonly asked questions about the Blue Cross Blue Shield of Michigan and Blue Care Network 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
- Medicare Plus Blue
- BCN commercial
- 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 10 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
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 and summary in e-referral? Applies only when the case is still open in the e-referral system.	Yes, if available, but not required (4)	Yes, if available, but not required (4)	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 the question "What information should I submit with authorization requests that pend for clinical review?" on page 13 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 the question "How many requests can I submit to extend a member's stay?" on page 14 of this document.

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

Criteria 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 the criteria outlined in the following table.

Criteria	Members		For these admissions…
	Blue Cross commercial and BCN commercial	Medicare Plus Blue and BCN Advantage	
Interqual®	✓	✓	Medical / surgical admissions
Medical necessity	✓	✓	Medical / surgical admissions Refer to the question "How do we use medical necessity criteria when making determinations?", later in this document.
CMS Inpatient Only, or IPO, list		✓	Surgical admissions Refer to the question "Do we use CMS guidelines ~~in~~ making determinations? " later in this document.
CMS Two-Midnight Rule		✓	Medical / surgical admissions Refer to the question "Do we use CMS guidelines ~~in~~ making determinations? " later in this document.

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

How do we use medical necessity criteria when making determinations?

We apply medical necessity criteria to requests for acute medical / surgical admissions for all commercial and Medicare Advantage (Medicare Plus Blue and BCN Advantage) members.

Medical necessary services are those needed to diagnose or treat a physical or mental condition.

The fact that a health care provider has prescribed, performed, ordered or coordinated a service or course of treatment, or recommended or approved items or services does not, in itself, make such items or services medically necessary.

Those services provided in a hospital on an inpatient basis are ones that cannot be effectively furnished more economically on an observation or outpatient basis. To be medically necessary, the services must:

- Be widely accepted as effective

- Be appropriate for the condition or diagnosis
- Be essential based on nationally accepted evidence-based standards
- Cost no more than a treatment that is likely to result in a comparable health outcome
- Be provided in the most appropriate level of care and in a site in which they can be safely and reasonably provided
- Be medically appropriate based on adequate management of medical comorbidities and risk factors for death or complications

Do we use CMS guidelines in making determinations?

We use CMS guidelines to make determinations on requests related to Medicare Plus Blue and BCN Advantage requests. The guidelines are based on the 2024 CMS Medicare Advantage Final Rule**, which clarified and codified guidance to Medicare Advantage plans. Plans are required to follow and apply the Two Midnight Rule, which states that a Medicare Advantage plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when, based on a consideration of complex medical factors documented in the medical record, the admitting physician expects that either of (d)(1) – (d)(3) are satisfied. Refer to the Code of Federal Regulations "Admissions" 42 CFR 412.3(d) (1)-(3)**.

These guidelines include:

- **Three conditions —** According to CMS Medicare coverage guidelines, there are three conditions that require reimbursement for hospital-based services:
  - (d)(1) The two-midnight benchmark, according to which a patient is generally appropriate for hospital level of care if the patient meets 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.
  - (d)(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only (CMS IPO list). A Medicare Advantage plan cannot apply additional coverage criteria.
  - (d)(3) A case-by-case exception, in which the admitting physician expects the patient to require care only for a limited time that does not cross two midnights. In these cases, the factors that lead to the decision to admit to inpatient **must** be documented in the medical record to grant consideration, and the documentation must support the severity of the member's illness and the intensity of services.

- **The two-midnight presumption,** which:
  - 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**.
  - 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.

How do we use the CMS guidelines?

When making determinations on Medicare Plus Blue and BCN Advantage requests, we follow the two-midnight benchmark and the CMS requirement that allows coverage and payment only for services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member except as specifically allowed by Medicare.

Note: Refer to the US Government Publishing Office, Electronic code of federal regulations: part 412.3 – Prospective payment systems for inpatient hospital services. Admissions, at https://www.ecfr.gov**. Published Aug. 13, 2013. Updated Nov. 16, 2021.

Under the benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment when the physician does both of these:

- Expects the member, based on complex medical factors documented in the medical record to require a hospital stay that crosses at least two midnights
- Admits the member to the hospital based on that expectation

According to CMS, complex medical factors include the following:

- Member's medical history and current medical needs
- Types of facilities available to inpatients and outpatients
- The relative appropriateness of treatment in each setting
- The severity of the signs and symptoms exhibited by the member

- The medical predictability of something adverse happening to the member
- The need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the member should be admitted and
- The availability of diagnostic procedures at the time when and at the location where the member presents

Note: Refer to the CMS Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered under Part A**.

All hospital services must be reasonable and necessary in order to be covered. Medicare Part A payment is prohibited for care that is not medically necessary but that is rendered for social purposes or reasons of convenience. Factors that may result in an inconvenience to a member, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission.

Note: Refer to the Medicare Program Integrity Manual, Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services**.

For coverage of an inpatient admission under Medicare, the clinical documentation must clearly support the medical necessity of the inpatient admission as evidenced by severity of illness and intensity of services to warrant the need for inpatient medical care.

If the provider is uncertain that an inpatient admission is appropriate, then the provider should consider placing the member in observation status.

What is medical necessity?
Services that are medically necessary are those that are needed to diagnose or treat a physical or mental condition.

The fact that a health care provider has prescribed, performed, ordered or coordinated a service or course of treatment, or has recommended or approved items or services does not, in itself, make such items or services medically necessary. Those services provided in a hospital on an inpatient basis are ones that cannot be effectively furnished more economically on an observation or outpatient basis.

To be medically necessary, the services must:

- Be widely accepted as effective
- Be appropriate for the condition or diagnosis
- Be essential based on nationally accepted evidence-based standards
- Cost no more than a treatment that is likely to result in a comparable health outcome and
- Be the most appropriate level of care and site of service which can be safely and reasonably provided

- Be medically appropriate based on adequate management of medical comorbidities and risk factors for death or complications.
- For procedural services, be surgically appropriate for the condition or diagnosis based on the CMS Inpatient Only List or on nationally accepted, evidence-based standards

How do we use medical necessity considerations in making determinations?
CMS requires BCN Advantage and Medicare Plus Blue, as Medicare Advantage organizations, to provide coverage for all Part A and Part B Original Medicare covered services to its members; however, CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes as Original Medicare does for providers.

While BCN Advantage and Medicare Plus Blue do apply medical necessity criteria to determine coverage, the following criteria are not applied in the same manner as is required under Original Medicare:

- **Access:** BCN Advantage and Medicare Plus Blue enrollees must have access to all medically necessary Part A and Part B services. However, CMS doesn't require that Medicare Advantage plans provide the same access to providers as Original Medicare. (See the accessibility rules for Medicare Advantage plans in the Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections**, Section 110.)
- **Billing and payment:** Medicare Advantage plans aren't required to follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures as long as providers, whether contracted or not, are paid accurately, in a timely manner and with an audit trail.

Providers can refer to the Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections** for additional details about Medicare Advantage organizations.

All requests for the inpatient level of care are subject to a medical necessity review. A provider that has prescribed, performed, ordered, coordinated a service or treatment does not necessitate medical necessity. In making a determination to reimburse an inpatient level of care based on medical necessity, Blue Cross and BCN have the right to determine the medical necessity of the physician attesting to member requiring at least two midnights of hospital care. In our decisions, we consider the member's benefit plan, national/local medical coverage guidelines, our internal coverage criteria (InterQual criteria) as a source of medical evidence to support medical necessity and level of care, the member's medical history, physician recommendations and clinical documentation.

So as long as the hospital can demonstrate, through appropriate documentation, that the admitting physician's expectation is consistent with Medicare coverage rules, supplemented by our internal coverage criteria, they will be paid under Part A.

No service is covered unless it is medically necessary.

What other considerations do we use in making determinations for BCN Advantage and Medicare Plus Blue requests?

For BCN Advantage and Medicare Plus Blue requests:

- We use CMS coverage guidelines, the CMS Inpatient Only List, our internal coverage criteria (InterQual criteria), for all medical admissions, to make determinations of medical necessity.
- We require physician certification of inpatient status to ensure that a member's inpatient admission is reasonable and necessary. Certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B** and 42 CFR 412.3**.
- If an inpatient level of care is denied because it does not meet our internal coverage criteria (InterQual criteria) — that is, the admission was not medically necessary for inpatient reimbursement — the facility may bill and be reimbursed for Part B Inpatient Services that would be reasonable and necessary as the member was treated in an observation or outpatient status. No services should be billed as ancillary only (TOB 0121).

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 must providers do when submitting requests?

For inpatient acute medical / surgical admissions of Medicare Plus Blue and BCN Advantage members, we require that admitting physicians and facilities submit only requests that have a complete set of clinical information. Providers must:

- 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 clinical documentation that supports the medical necessity of a hospital admission that crosses two midnights, in line with the member's severity of illness, ~~and~~ the intensity of the services required, and the admitting physician's order to an inpatient level of care
- Attach all pertinent clinical information from the medical record to the authorization request to validate that an inpatient setting is appropriate. Include the following clinical documentation with the request:
  - Documentation from the emergency room or transferring facility that includes the date and time of the observational care (as applicable) and the physician's inpatient admission order with date and time
  - The InterQual subset and criteria used to support the decision for inpatient admission
  - The pertinent clinical information that validates that the InterQual criteria points have been met, including dates, times and trend documentation

    Note: Many criteria points have findings and interventions that require frequencies, dosages and time-based intervals to demonstrate InterQual indications have been met.
- Indicate the procedure code from the CMS inpatient surgical list that was used to support the decision for an inpatient surgical admission

If a request is pended for clinical review, our clinicians will use the clinical information you've submitted to support a medical necessity determination.

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 12 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	1. Enter the request into the e-referral system. 2. Immediately call (prior to the transfer): ○ Call 1-800-392-2512 during normal business hours. ○ 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). Note: If non-emergency air ambulance transport is needed, prior authorization is required. To request prior authorization, follow the instructions on the document titled Non-emergency air ambulance prior authorization program: Overview for Michigan and non-Michigan providers. Do this prior to the flight.
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	1. Enter the request into the e-referral system. 2. Immediately call 1-800-851-3904 to expedite it.

- **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?

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

Submitting a request for a procedure
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
- BCN Musculoskeletal Services

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:

Submit the prior authorization request
Submit a prior authorization request for each admission by completing the Acute inpatient hospital assessment form. Follow the instructions on the form to submit it.

Notes:

- 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.

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.

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 14 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 complete the Acute inpatient hospital 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® 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, 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.

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

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 19 requests for extension through the e-referral system. The e-referral system can accommodate only 19 extension requests.

- Starting with the 20th 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.

What's the time frame for making a determination on a 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 72 calendar days of receipt of request	Within 14 calendar days of receipt of request	Within 7 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.

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

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 who 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 document titled Michigan providers: BCN global referral, plan notification and prior authorization requirements.

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

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.

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.

Note: This includes gender reassignment surgeries, which should be entered as surgical admissions with the appropriate procedure code(s).

Exceptions:

- This does not include members who have a postoperative complication from an outpatient or ambulatory procedure and require inpatient admission as a result. For these admissions, enter *99222.
- For commercial members who require a musculoskeletal procedure that's not managed by TurningPoint Healthcare Solutions LLC, refer to the document Musculoskeletal procedure authorizations: Frequently asked questions for providers. Look at the question "For Blue Cross commercial members, is prior authorization required for musculoskeletal procedures that aren't managed by TurningPoint?"

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. Approvals of prior authorization requests involving F codes apply only to the medical portion of the admission.

Any other type of F diagnosis code would be representative of a behavioral health admission.

For ongoing behavioral health care, submit an appropriate behavioral health request. For information on behavioral health admissions, refer to the document titled Blue Cross Behavioral Health: Frequently asked questions for providers.

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.

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.

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.

What to do after business hours and on holidays

- 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.
- 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.
- For information 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 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 Getting Started.

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

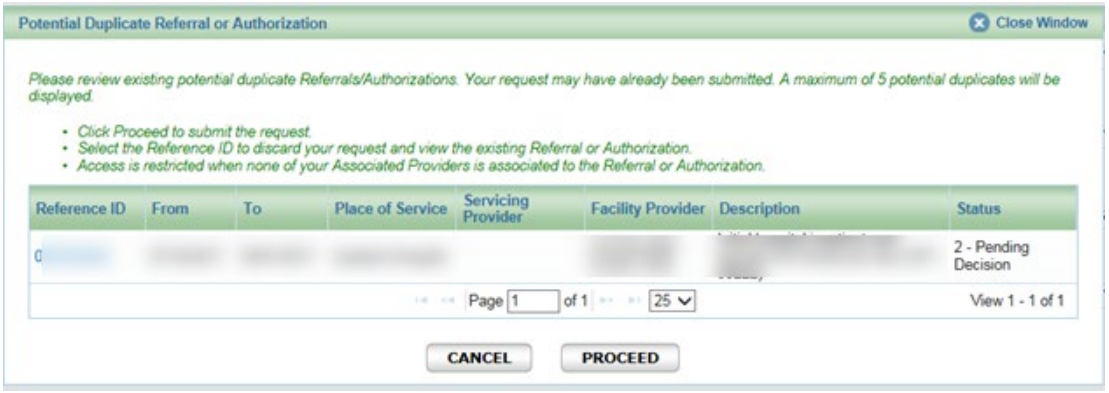
When you want to extend the stay or change the admission date or do something similar with an authorization request, here's how it works:

- **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.

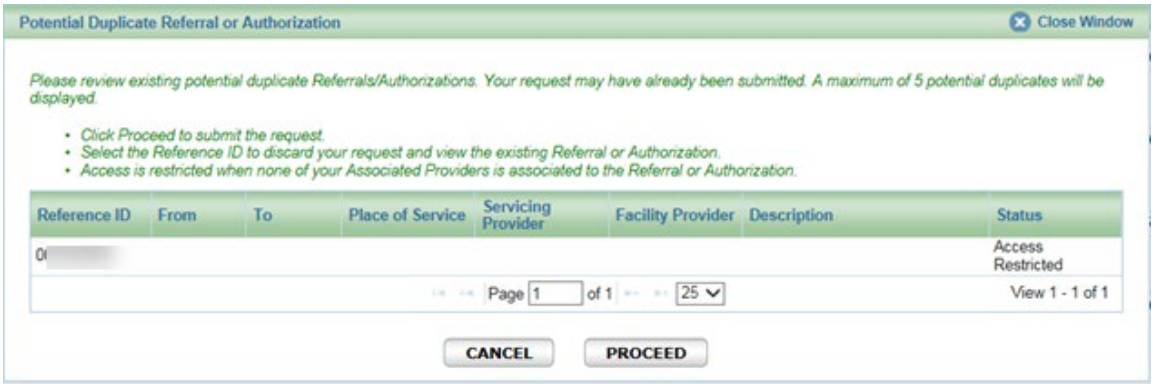
What happens if I receive a duplicate message when loading an authorization?

- 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.

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.

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 manner 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."

Additional information

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.”

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).

**Clicking this link means that you’re leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we’re not responsible for its content.

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