



# *PRIOR AUTHORIZATION & PRECERTIFICATION OF ADMISSIONS & SERVICES*

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## I. Prior Authorization of Services (all providers)

According to either (or both) the provider's contracting agreement with Blue Cross or the member's benefit contract, prior authorization of services is required for:

### Type of Services

|   |   |
|---|---|
| Inpatient Hospital Or Medical Care Facility Services                    | REQUIRED  |
| Psychiatric or Substance Abuse Partial Day Treatment Program            | REQUIRED<br><a href="#">(New Directions)</a>                    |
| Outpatient (not partial day) Hospital or Medical Care Facility Services | REQUIRED only when designated by BCBSKS or the member contract  |
| Home Health Services  | REQUIRED  |
| Hospice Services  | REQUIRED  |
| Dialysis Center Services  | NOT REQUIRED  |
| Birthing Center   | NOT REQUIRED unless specifically requested by an employee group |

## II. Pre-Admission Certification/Concurrent Review – (hospitals and medical care facilities)

### A. Pre-Admission Certification

Hospitals and medical care facilities are **required** to provide notice for all BCBSKS members admitted for inpatient care. This should be done:

- prior to the admission;
- on the day of admission; or
- the first working day following a weekend or holiday

In cases where pre-admission certification is a requirement of a particular employer group and in the event the pre-admission certification is not obtained, the provider may be responsible for any penalties imposed by the group. Providers will be informed of groups that make this requirement.

### B. Concurrent Review

This is required for inpatient stays that extend past the initial approval period.

Pre-certification and concurrent reviews are conducted to determine the following:

1. Appropriateness of place of treatment, i.e., inpatient, outpatient department, or physician's office.
2. Length of stay
3. Admission as inpatient. Certain member contracts require preadmission certification.

### C. Outpatient

Providers agree to precertify outpatient services when implemented by BCBSKS. They will be notified in advance of the criteria to identify these situations.

**NOTE: There are many Blue Plans that require precertification for diagnostic imaging, such as, MRI and CT scans even though the ID card does not indicate this information. We encourage all providers/facilities to verify benefits with the member's Home Plan prior to providing services.**

### D. Delayed Review

Technically, only emergency or obstetrical admissions should occur during non-working hours and, therefore, (depending on the specific contract) would not require pre-admission certification. In cases where a scheduled admission occurs during non-working hours, which required pre-admission

certification, which was not obtained, the provider must contact us the next working day, at which time the review will be accomplished.

Some contracts may impose a member or provider penalty if required pre-admission certification is not obtained in **advance** of a scheduled admission. A review process occurring “after the fact” will **NOT** negate this penalty.

**E. MEDICARE BENEFITS EXHAUSTED**

For hospital admissions, pre-admission certification is normally not applicable if the member is enrolled in a Medicare Exclusion Rider. Medicare, as the primary payer, will determine the medical necessity of an inpatient stay. If, however, the member is enrolled in Medicare Part B but **not** Medicare Part A or if the Medicare inpatient days are exhausted, Blue Cross pre-admission certification is applicable.

**F. OBSTETRICAL ADMISSIONS**

Precertification is not required on OB admissions (both mother and baby) unless either remains hospitalized after 72 hours. If either are transferred to another hospital, the receiving hospital would need to obtain pre-admission certification.

**G. FEP OBSTETRICAL ADMISSIONS**

You do not need to precertify a maternity admission for a routine delivery. However, if a medical condition requires the mother to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then you must contact BCBSKS for precertification of additional days. Further, if the baby stays after the mother is discharged, then you must contact BCBSKS for precertification of additional days for the baby.

Additional maternity information can be found in the FEP section of this manual.

### III. New Directions Behavioral Health (hospitals/medical care facilities)

Blue Cross and Blue Shield of Kansas is affiliated with New Directions Behavioral Health for the review of mental health/substance abuse services.

They provide the following services 24/7:

- Review for approval/denial of pre-admission certification requests for inpatient hospitalizations, outpatient services, and partial-day treatment program services, utilizing established criteria to determine appropriateness.
- Concurrent review of length of stay authorizations
- Discharge planning and case management for continuing care once the patient is discharged from the hospital on selected cases
- Retrospective review of cases not prior authorized, and
- Appeals review and reconsideration on problem cases.

Providers can call our established pre-admission certification telephone number at 1-800-782-4437. Our reviewers will determine if New Directions is applicable to the specific Blue Cross member's contract. If so, your call will be redirected to New Directions, who will initiate and conduct the review activity. If New Directions is not involved, our reviewers will continue with the pre-certification.

When appropriate, providers can contact New Directions Behavioral Health direct. New Directions has available 24-hour review capability. New Directions telephone numbers are:

|              |                |
|--------------|----------------|
| Topeka Local | (785) 233-1165 |
| Toll Free    | 1-800-952-5906 |

## IV. Information Needed For Pre-Admission Certification (hospitals/medical care facilities)

The **minimum** information providers must furnish for us to make a pre-admission certification determination is:

- Patient's name
- Date of birth
- Member's name
- Identification number
- Provider's name
- Admitting physician's name
- Referral physician, if the contract required an initial referral
- Who performed the second surgical opinion (if required by the contract)
- Who is the primary care physician (if applicable)
- Planned date of admission
- Reason for admission, including:
  - ICD-9-CM admission diagnosis code and if applicable CPT/HCPCS code
  - Signs and symptoms that indicate the need for inpatient admission
  - Patient's history
  - Supportive laboratory, x-ray or consultant's reports
  - Outpatient treatment tried
  - Accident information (if applicable)
- Expected treatment which cannot be done on an outpatient basis and necessitates admission
- Expected length of stay

### A. WEB-BASED PRE-CERTIFICATION SYSTEM

The BCBSKS Web-based pre-certification system can be used for most hospital inpatient admissions.

Medical care facilities and providers who do not have access to the Web-based pre-certification system must contact BCBSKS by telephone for pre-certification, concurrent review, alternate care or case management. The telephone number is:

Toll Free     1-800-782-4437  
(be sure to listen to all the options)

Details on how to use the Web-based pre-admission certification system are available in the PROVIDER SERVICES section of the BCBSKS Web site

([www.bcbsks.com](http://www.bcbsks.com)). You can access our [Precertification Manual](#) or the online [training module](#) titled Hospital Pre-certification.

## V. Outcome And Billing Of Pre-Admission Certification (hospitals/medical care facilities)

### ADMISSION APPROVED

The pre-admission certification process is accomplished and approval is granted. Services are paid in accordance with contractual benefits.

For billing instructions see V. E. in this section.

### ADMISSION DENIED

The pre-admission certification or concurrent review process is accomplished and results in a denial.

1. The services are either not performed or they are performed in an agreed upon alternative cost effective setting.
2. The member disregards the notification and requests to have the services performed in an inpatient setting. If the member is notified in writing by the provider in advance of receiving services that specific services are medically unnecessary, then the member shall be financially responsible for payment of services determined to be medically unnecessary ([see NOPFO](#)).

Should this prior notification process not occur and the member utilizes a contracting hospital, the member will be held harmless from financial responsibility and the provider will write off those charges for medically unnecessary services.

3. The denial is appealed. BCBSKS follows URAC guidelines for precertification and concurrent review appeals. **These appeal options are only available prior to claim submission and are subject to time frames as established by BCBSKS, Department of Labor and URAC.** All precertification and concurrent review appeals will be reviewed concomitantly. Based on the type of admission, an expedited or standard appeal may be requested by the provider.

**Expedited Appeal (see Compliance & Appeals section)** – This appeal process is used for urgent care precertification and concurrent review requests. It should be requested within one business day of the verbal denial. Documentation for review must be faxed and should include all or part of the medical record and/or a written statement from

the provider. The plan has 72 hours to respond to this appeal. If the denial is reversed, the concurrent review process will continue.

**Standard Appeal** (see Compliance & Appeals section) – This appeal process is available for non-urgent care and must be requested within 180 calendar days of the date of the denial notification or denial letter and before the claim is submitted. Requests beyond 180 calendar days of initial notification or after the claim has been submitted have no further appeal rights under this provision. Documentation must be provided at the time of the appeal and should include all or part of the medical record and/or a written statement from the provider. BCBSKS has up to 30 days to provide a written response to this appeal.

#### **NO REQUEST FOR PRE-ADMISSION CERTIFICATION**

The claim will be suspended and reviewed. If it is determined to contain medically unnecessary services or services not performed in the most cost effective setting, the member will be held harmless and the contracting provider will write-off the charges, UNLESS THE MEMBER WAS NOTIFIED BY THE PROVIDER IN ADVANCE OF RECEIVING THE SERVICES THAT SPECIFIC SERVICES ARE MEDICALLY UNNECESSARY (NOPFO).

#### **ADVANCE NOTIFICATION TO THE MEMBER WHEN PRE-ADMISSION CERTIFICATION HAS BEEN DENIED OR NOT REQUESTED (NOPFO).**

A “NOTICE OF PERSONAL FINANCIAL OBLIGATION” form has been developed. The form should not be used as a “blanket” denial. An example is included in Section VII Compliance & Appeals.

#### **BILLING (UB04/837I) FOR ADMISSIONS REQUIRING PRE-ADMISSION CERTIFICATION**

- **ADMISSION APPROVED**  
Complete the inpatient claim in the normal manner. If an authorization number was issued to you, enter that number in Locator “63-TREATMENT AUTH” on the UB-04/837I claim.
- **ADMISSION DENIED**
- **If the TOTAL stay is denied not medically necessary, BCBSKS will:**
  - Deny the room and board as the patient’s/members responsibility if filed with a *Notice of Personal Financial Obligation* (NOPFO). If there is no NOPFO, the charges are a provider write-off.
  - Pay ancillary services as if they occurred on an out patient basis.
  - The provider must submit two claims

- One claim for the room and board charges
  - ◆ submit the claim HARD copy
  - ◆ type of bill = 110
  - ◆ show charges as non-covered
  - ◆ if you have a NOPFO signed by the patient/member, attach a copy
  - ◆ indicate in “REMARKS”:  
  
If a NOPFO was given, report something like “Non Covd Adm; pt notified; NOPFO attached.”  
  
If a NOPFO was not given, report something like “Non Covd Adm; pt was not notified.”
- The second claim should include all ancillary charges related to the admission
  - ◆ report 13X type of bill
  - ◆ include appropriate HCPCS/CPT coding.
- When processed, outpatient pricing guidelines will apply.
- **If PART of the stay is medically necessary and part is not, BCBSKS will:**
  - Deny the non-covered room and board charges as a provider write-off unless submitted with a *Notice of Personal Financial Obligation* (NOPFO).
  - Process the covered room and board charges and ALL of the ancillary charges (including those provided on the non-covered days). Payment will be made according to the MS-DRG for the admission.

If the physician does not discharge the patient the same day the hospital staff receives the inpatient medical necessity denial notice from BCBSKS medical review and if the patient remains an inpatient beyond the first non-covered day, the hospital will:

- File one claim reporting the charges for the entire admission. This includes the date of admission through the date when the physician discharges the patient.
- Report the covered and non-covered room and board charges on separate billing lines.
- The covered room and board “units” and charges would include the days beginning with the day of admission and up to but not including the day BCBSKS notified the hospital that the stay no longer meets inpatient medical necessity criteria.

- The non-covered room and board “units” and charges will begin with the day the hospital was notified of the non-coverage through the date of the physician discharge so the discharge day does not count as a unit nor are the room and board charges for this day.

When BCBSKS processes the claim, we will:

- Remove the non-covered room and board charges from the original claim and process them separately. These charges will be denied as a provider write-off unless the provider attached a copy of a Notice of Personal Financial Obligation (NOPFO) signed by the patient. If the NOPFO is included with the claim, the non-covered room and board charges will be denied as the patient’s responsibility.
- The “from” and “through” dates on the original claim will be changed to reflect only the covered dates of service. The MS-DRG payment calculation will be determined based on the number of covered days plus the ancillary charges incurred during the complete stay (including ancillary charges on the non-covered days).

The example below illustrates how a claim will be processed when a physician does not discharge the patient on the day that BCBSKS issues the denial notice.

|   |         |
|---|---------|
| DATE OF ADMISSION   | 4/1/09  |
| BCBSKS ADVISES THE HOSPITAL THAT THE PATIENT NO LONGER MEETS INPATIENT ACUTE CRITERIA | 4/8/09  |
| PHYSICIAN DISCHARGES THE PATIENT  | 4/10/09 |

When the hospital submits the claim they will show:

- Statement covers period for the complete stay “from” date 040109 and “through” date 041009
- Room and board for the covered days totaling 7 units.
- On a separate billing line, room and board for the non-covered days totaling 2 units.
- Ancillary charges for the entire stay.

BCBSKS will:

- Split the room and board charges for the two non-covered days onto a separate claim and deny the charges. This

claim will show “from” and “through” dates of 040809-041009 and 2 units. If a Notice Of Personal Financial Obligation (NOPFO) signed by the patient/member is included with the claim, the charges will be denied as the member’s responsibility. If no NOPFO is sent in, the charges will be denied as a provider write-off.

- Process all the remaining charges showing a statement covers period “from” and “through” dates of 040109-040809 for 7 units. The MS-DRG payment calculation will be based on the covered acute days and the ancillary charges for the complete stay.

### **INPATIENT STAY PAID BY PER DIEM**

- **If the TOTAL stay is denied not medically necessary, BCBSKS will:**

- Deny the room and board as the patient’s/member’s responsibility if filed with a *Notice of Personal Financial Obligation* (NOPFO). If there is no NOPFO, the charges are a provider write-off.
- Pay ancillary services as if they occurred on an outpatient basis.
- The provider must submit two claims.

- One claim should be for the accommodation charges only.

- ◆ submit the claim HARD copy
- ◆ type of bill = 110
- ◆ show charges as non-covered
- ◆ if you have a NOPFO signed by the patient/member attach a copy
- ◆ indicate in “REMARKS”:

If a NOPFO was given, report something like “Non Covd Adm; pt notified; NOPFO attached.”

If a NOPFO was not given report something like “Non Covd Adm; pt was not notified.”

- The second claim should include all ancillary charges related to the admission. The provider would:

- ◆ report 13X type of bill
- ◆ include appropriate HCPCS/CPT coding.

- When processed, outpatient pricing guidelines will apply.

- **If PART of the stay is medically necessary and part is not, BCBSKS will:**

- Allow the per diem for the covered days

- Deny the non-covered room and board charges as a provider write-off unless they are submitted with a *Notice of Personal Financial Obligation* (NOPFO).
- Process the ancillary services provided on the non-covered days as if they occurred on an outpatient basis.
- The provider must submit three claims.
  - One claim for the covered days. Standard inpatient billing guidelines for per diem paid providers would apply.
  - The second claim for the room and board charges incurred for the non-covered days.
    - ◆ submit the claim HARD copy
    - ◆ type of bill = 110
    - ◆ show charges as non-covered if you have a NOPFO signed by the patient/member attached a copy.
    - ◆ Indicate in “REMARKS”:  
  
If a NOPFO was given, report something like “Non Covd Adm; pt notified; NOPFO attached.”  
  
If a NOPFO was not given report something like “Non Covd Adm; pt was not notified.”
  - The third claim should include all ancillary charges that were provided on the non-covered days. The provider would:
    - ◆ report 13X type of bill
    - ◆ include appropriate HCPCS/CPT coding.
- When processed, outpatient pricing guidelines will apply.

The pre-admission certification should provide additional financial predictability as cases which are certified as medically necessary prior to admission will not be subsequently denied. (Payment is, as always, still subject to the eligibility of the services under the member’s contract.) If a pre-admission certification is not approved, you will have the opportunity to notify patients in advance that they will be financially responsible for medically unnecessary services.

### **INPATIENT ADMISSIONS TO A HOSPITAL BASED SKILLED NURSING FACILITY (SNF) OR SWING BED UNIT**

Beginning January 1, 2005, guidelines became effective for billing claims for inpatient admissions to a hospital based skilled nursing facility (SNF) or swing bed unit. These guidelines as outlined below require that these admissions

be billed under a skilled provider number and not an acute care hospital number.

Very few BCBSKS member contracts include coverage for inpatient skilled services and the guidelines below include information when they do or don't.

- When a patient is being discharged from acute to skilled care, this must be clearly reflected in the medical record. If it's a direct admission to skilled care, this too must be reflected in the record. (If the medical record does not reflect a discharge from acute to skilled care and the patient remains in the hospital you need to follow the guidelines as outlined earlier in this section for admissions beginning April 1, 2004).
- Skilled admissions must be prior approved by the BCBSKS medical review staff. When the patient is being transferred from acute to skilled care, this is usually handled through the concurrent review process.
- If the patient **has skilled benefits** and the skilled admission is prior approved, you will submit the charges for the entire stay (room and board plus all ancillaries) using your skilled provider number.
- If the patient **does not have skilled benefits** (or the stay is not approved), you must give them a Notice of Personal Financial Obligation (NOPFO) prior to the service in order to bill them for the non-covered room and board charges. When you submit a claim, the non-covered room and board charges will be billed using your skilled provider number (be sure to include a copy of the NOPFO) and the ancillary charges will be billed as an outpatient claim using your acute hospital number.
- For Competitive Allowance Program (CAP) the allowance for covered skilled admissions will be:
  - The lesser of charges or CAP MAP based on the MS-DRG assigned to the inpatient skilled stay.
  - For non-MAP'd MS-DRGs, the allowance is the providers charge less the applicable discount (i.e. Blue Choice).
  - For critical access hospitals that selected the CAH inpatient payment method, the allowance for covered skilled admissions will be the lesser of charges or the CAH inpatient allowance.

Below are two billing examples showing how claims should be filed:

**EXAMPLE 1: ACUTE PATIENT DISCHARGED TO SWING BED/SNF – HAS SKILLED BENEFITS**

Admitted acute: 12/1/09  
 Discharged to Skilled: 12/8/09  
 Discharged to Home: 12/16/09

The medical record reflects discharge to skilled care on 1/8/09. The skilled care is prior authorized.

You will **submit two** separate claims:

Claim 1:

|                      |                        |
|----------------------|------------------------|
| Provider Number:     | Acute Number           |
| Type of Bill:        | 111                    |
| Date of Service:     | 12/1/09 thru 12/8/09   |
| # of Days:           | 7 covered              |
| Include Charges For: | R & B plus ancillaries |

Claim 2:

|                      |                                  |
|----------------------|----------------------------------|
| Provider Number:     | Skilled Number                   |
| Type of Bill:        | 18X for swing bed<br>21X for SNF |
| Date of Service:     | 12/8/09 thru 12/16/09            |
| # of Days:           | 8 covered                        |
| Include Charges for: | R & B plus ancillaries           |

**EXAMPLE 2: ACUTE PATIENT DISCHARGED TO SWING BED/SNF – NO SKILLED BENEFITS**

Admitted acute: 12/1/09  
 Discharged to Skilled: 12/8/09  
 Discharged to Home: 12/16/09

At the time the patient was discharged to skilled, a Notice of Personal Financial Obligation was given to them.

You will **submit three** separate claims:

Claim 1:

|                      |                        |
|----------------------|------------------------|
| Provider Number:     | Acute Number           |
| Type of Bill:        | 111                    |
| Date of Service:     | 12/1/09 thru 12/8/09   |
| # of Days:           | 7 covered              |
| Include Charges For: | R & B plus ancillaries |

Claim 2:

|                      |                                     |
|----------------------|-------------------------------------|
| Provider Number:     | Skilled Number                      |
| Type of Bill:        | 18X for swing bed or<br>21X for SNF |
| Date of Service:     | 12/8/09 thru 12/16/09               |
| # of Days:           | 8 non-covered                       |
| Include Charges For: | R & B only                          |

Claim 3:

|                      |                       |
|----------------------|-----------------------|
| Provider Number:     | Acute Number          |
| Type of Bill:        | 131                   |
| Date of Service:     | 12/8/09 thru 12/16/09 |
| # of Days:           | Not applicable        |
| Include Charges For: | Ancillaries only      |

## VI. Home Health

### A. Initial Authorization

Home Health services require precertification. BCBSKS will communicate:

- Coverage or denial to the home health agency usually within one working day following the receipt of the initial request.
- A letter confirming the decision is sent. A copy of this confirmation letter needs to accompany the submitted claim.

### B. Subsequent Approval For Extended Services

- Approval is required for all services extending beyond the initial approval. As with the initial approval, the agency will be notified of the decision usually within one working day, followed by a confirmation letter. A copy of this letter would need to accompany your claim.

### C. Prior Authorization Procedures

The BCBSKS member contract requires prior authorization of all home health services.

- Prior authorization is done by telephone (1-800-782-4437) with a written letter sent following the call. Prior authorization is a requirement in the provider policies and procedures.
- A clinical update of the patient's condition is required before additional services are authorized.
- Medical records will be required for any service(s) not prior authorized.
- Home Health providers may use the home health OASIS as a part of the prior authorization process if it includes the following information:
  - The skilled service being requested per physician order to include frequency.
  - The medical reason the person can not get the service in another setting ie. outpatient or office setting.
  - Medical/physical limitations of the individual that would make the person be considered homebound.
  - Any other information that may be pertinent to the review process.

### D. Payment Reduction When Prior Authorization Is Not Obtained

The Policies and Procedures Payment Attachment for home health agencies, allows Blue Cross and Blue Shield of Kansas (BCBSKS) to assess a payment reduction when an agency fails to prior authorize services. The contract language reads:

Failure to preauthorize will result in a 25 percent reduction in payment with a maximum penalty of \$250 per treatment episode.

The payment reduction:

- ❖ Is a provider write-off
- ❖ Applies to medically necessary services that are not prior authorized,
- ❖ Will be applied to services that are initiated outside of normal business hours. The provider can however avoid the penalty on these cases by notifying BCBSKS by the end of the first business day following the service(s).
- ❖ Is applied per treatment episode, and
- ❖ Can only be assessed once per treatment episode.

A treatment episode:

- Is defined as the treatment period for that diagnosis and that plan of care,
- Begins when the physician orders home health care and the home health agency agrees to care for the patient,
- Ends when the patient stops receiving home health services. This could be because the patient's condition improves and they no longer need home health care, because the patient is admitted for inpatient care, or because the patient or the family chooses not to continue. (This is not an all-inclusive list.)

\*If a treatment episode ends and the patient later needs additional services, this starts a new treatment episode and the services must be prior authorized. If they're not, a payment reduction will be assessed.

#### **E. Medically Unnecessary or Experimental/Investigational Services**

The HHA shall not bill members for services which have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance that **specific** medically unnecessary or experimental/investigational services will be the member's responsibility. This notification is referred to as the Notice of Personal Financial Obligation. Generic or all-encompassing notifications without advanced written authorization by Blue Cross and Blue Shield of Kansas shall not be deemed to meet the specific notification requirement mentioned above. An example of a Notice of Personal Obligation appears in this manual in the chapter called Compliance and Appeals.

## VII. Hospice

Hospice benefits are not paid while the patient is an acute inpatient. The hospice per diem would be paid for the day of the actual hospital inpatient admission and for the day of discharge but for any days in between. For more information regarding hospice reimbursement and billing, see Section 12 of the Intuitional Relations Manual.

### A. Hospice Election

The Blue Cross medical and utilization review staff are not involved in the decision making process when a member elects hospice care. This decision is between the patient, the doctor, family members and the hospice. Once this decision is made, our staff and hospice personnel **must** communicate in order to insure that the coverage criterion as outlined in the member's contract is met.

The medical and utilization review department can be contacted by calling 1-800-782-4437.

### B. Initial Contact

At the time of initial contact, hospice personnel must be prepared to discuss:

- Physician certification regarding the patient's life expectancy of less than six months.
- BCBSKS must receive a copy of the hospice election form before claims can be processed. The Hospice Election form can be faxed to the pre-certification area at the time the services are prior authorized or it can be sent with the claim.
- Services to be provided, including but not limited to:
  - Nursing Care
  - Home Health Aide
  - Social Work Services
  - Physical Therapy
  - Occupational Therapy
  - Any other services
  - Lab Fees
  - Volunteer Support
  - Home Medical Equipment
  - Medical Supplies
  - Medications (including route and frequency)

AT ANYTIME THEREAFTER, IF THE PLAN OF CARE CHANGES, **BLUE CROSS MUST BE CONTACTED IMMEDIATELY**. This information can be mailed, faxed or telephoned.

### C. Prior Authorization

The BCBSKS member contract requires prior authorization of all hospice services.

- Prior authorization is done by telephone (1-800-782-4437) with a written letter sent following the call. Prior authorization is a requirement in the provider policies and procedures.
- A clinical update of the patient's condition is required before additional services are authorized.
- Medical records will be required for any service(s) not prior authorized.

Inpatient hospice services provided in a skilled nursing facility, hospital or other inpatient facility must be outlined and approved under the hospice inpatient program.

#### **D. Payment Reduction When Prior Authorization Is Not Obtained**

The Policies and Procedures Payment Attachment for hospice agencies, allows Blue Cross and Blue Shield of Kansas (BCBSKS) to assess a payment reduction when an agency fails to prior authorize services. The contract language reads:

Failure to preauthorize will result in a 25 percent reduction in payment with a maximum penalty of \$250 per treatment episode.

The payment reduction:

- Is a provider write-off
- Applies to medically necessary hospice services that are not prior authorized,
- Will be applied to services that are initiated outside of normal business hours. The provider can however avoid the penalty on these cases by notifying BCBSKS by the end of the first business day following the service(s).
- Is applied per treatment episode, and
- Can only be assessed once per treatment episode.

A treatment episode:

- Is defined as the treatment period for that diagnosis and that plan of care,
- Begins when the physician orders hospice care and the hospice agency agrees to care for the patient,
- Ends when the patient stops receiving hospice services. This could be because the patient is admitted for inpatient care or because the patient or the family chooses not to continue. (This is not an all-inclusive list.)

If a treatment episode ends and the patient later receives additional services, this starts a new treatment episode and the services must

be prior authorized. If they're not, a payment reduction will be assessed.

#### **E. Hospice Initial Evaluation**

Through our case management efforts, BCBSKS has identified the need to provide payment for initial patient evaluations. The evaluations are used to determine if the care the patient requires meets BCBSKS hospice coverage criteria.

To be eligible for reimbursement, initial evaluations will be handled as follows:

- Initial evaluations must take place in the member's home and not during a hospital stay.
- The hospice agency will notify BCBSKS prior to conducting an initial evaluation.
- Following the initial evaluation, the hospice agency will contact BCBSKS to prior authorize any additional services.
- The 25% payment penalty applies to all services (including initial evaluations) that are not prior authorized.
- The hospice agency will bill the initial evaluation with revenue code 0551 – Skilled Nursing Visit. No HCPCS code is required.
- The claim will be billed with the hospice provider number.

#### **F. Skilled Nursing**

The skilled nursing visit medical necessity guidelines to include homebound status will be applied when approving hospice on a per visit basis.

#### **G. Medically Unnecessary or Experimental/Investigational Services**

The Hospice shall not bill members for services which have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance that **specific** medically unnecessary or experimental/investigational services will be the member's responsibility. This notice is referred to as the Notice of Personal Financial Obligation. Generic or all-encompassing notifications without advanced written authorization by Blue Cross and Blue Shield shall not be deemed to meet the specific notification requirement mentioned above. In instances where medical necessity is questionable, the hospice may contact Blue Cross and Blue Shield of Kansas medical review department for a predetermination of coverage. An example of a Notice of Personal Financial Obligation appears in this manual in the chapter called Compliance and Appeals.

### **VIII. Dialysis Services**

Typically, dialysis services do not require prior authorization

BCBSKS retains the right to review all services for medical necessity or to determine their status as experimental/investigational services.

The Center shall not bill members for services which have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance that **specific** medically unnecessary or experimental/investigational services will be the member's responsibility. This notification is referred to as the Notice of Personal Financial Obligation. Generic or all-encompassing notifications without advanced written authorization by Blue Cross and Blue Shield of Kansas shall not be deemed to meet the specific notification requirement mentioned above. An example of a Notice of Personal Obligation appears in this manual in the chapter called Compliance and Appeals.

## IX. Birthing Center

Typically, birthing center services do not require prior authorization unless specifically requested by an employee group.

BCBSKS retains the right to review services for medical necessity or to determine their status as experimental/investigational services.

The Center shall not bill members for services which have been determined medically unnecessary or experimental/investigational unless the member has been given written notification in advance that **specific** medically unnecessary or experimental/investigational services will be the member's responsibility. This notification is referred to as the Notice of Personal Financial Obligation. Generic or all-encompassing notifications without advanced written authorization by Blue Cross and Blue Shield of Kansas shall not be deemed to meet the specific notification requirement mentioned above. An example of a Notice of Personal Financial Obligation appears in this manual in the chapter called Compliance and Appeals.