SPECIAL eBULLETIN

FOR FACILITY PROVIDERS **NOVEMBER 26, 2019**

URGENT/EMERGENT AUTHORIZATION REQUESTS FOR INPATIENT ADMISSIONS

BILLING OUTPATIENT SERVICES WHEN INPATIENT DENIED

Highmark requires medical necessity review for unplanned (urgent/emergent) inpatient admissions. If a claim for an unplanned inpatient admission is submitted to Highmark without the required authorization, the claim will be rejected and the member cannot be billed for the services.

If Highmark determines that the medical necessity criteria are not met for an unplanned inpatient admission, the facility has the option to appeal the decision. At the time of a denial determination, the facility is informed of the right to appeal and the process for initiating an appeal.

CLAIM SUBMISSION GUIDELINES

For emergency (urgent, unplanned) admissions, the hospital is asked to obtain an authorization within forty-eight (48) hours of the admission or as soon as the necessary clinical information is available.

- If the inpatient admission is authorized, the hospital should follow normal billing protocols and report the emergency room or observation services on the member's inpatient claim.
- If the inpatient admission is not authorized, the hospital should report the services provided as an outpatient claim after deciding not to appeal the inpatient denial or after the denial has not been overturned upon appeal.

Highmark recommends that facilities wait to submit claims until authorization determinations are made and, if inpatient admission is not authorized, until the facility decides whether it will pursue an appeal. All outpatient services, including observation, may be billed when it is determined that inpatient admission is not medically necessary. If an inpatient claim was submitted, an outpatient claim can be submitted if the inpatient claim was rejected.

If an inpatient authorization request was denied due to Highmark's determination that observation is a more appropriate level of care, an outpatient claim for observation services can be submitted for reimbursement and medical records should be clearly documented as observation (see below).

If a facility submits an inpatient claim to Highmark without seeking preservice review and the required authorization, the claim will deny. The facility can request a retrospective review and submit the applicable medical records for the claim to be considered for payment. Appeal rights would apply in the event of a medical necessity denial.

Note: Condition code 44 should not be billed to Highmark on an outpatient claim when an inpatient admission has been denied (applies to traditional Medicare only).

HIGHMARK

MEDICAL RECORD DOCUMENTATION FOR OBSERVATION SERVICES

Medical records are expected to demonstrate the consistency between the physician order (physician intent), the services actually provided (inpatient or outpatient), and the medical necessity of those services, including the medical appropriateness of the inpatient or observation stay.

If billing for observation services when it is determined that criteria are not met for inpatient, the medical record must clearly support that the order is for observation (and not inpatient admission).

- It must be dated and include a timed order to observe that will support the number of hours billed.
- It must indicate that the member is designated as observation status.
- If applicable, it must clearly document the reason for the inpatient to be changed to observation status (e.g., provider agrees entire encounter is appropriate as outpatient observation in lieu of an inpatient admission).

AUTHORIZATION SUBMISSIONS VIA NAVINET®

Facilities are reminded to use the **Authorization Submission** transaction in NaviNet for urgent/emergent inpatient admissions to expedite the authorization process. Requests should be submitted once it is clear that the member requires inpatient level of care and there is a physician order for inpatient.

If it is determined that the member only requires observation services, an authorization is not required and a request should not be submitted.

The Auth Inquiry transaction in NaviNet can be used to check the status of a request or to determine whether an inpatient authorization has already been issued. (Select **Auth Inquiry and Report** from the Workflows for this Plan menu.)

ONLINE RESOURCES AVAILABLE

For additional information on authorizations, billing, and reimbursement, please reference these online resources available on the Provider Resource Center:

- **Highmark Reimbursement Policy Bulletin RP-039: Outpatient Services Prior to an Inpatient Admission:** To access on the Provider Resource Center, select **CLAIMS, PAYMENT & REIMBURSEMENT**, and then click on **Reimbursement Policy**.
- **Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method Manual:** This manual is accessible only on the Provider Resource Center in NaviNet – select **CLAIMS, PAYMENT & REIMBURSEMENT**.
- **Highmark Provider Manual**: (Access on the Provider Resource Center by selecting **MANUALS** from the Quicklinks bar that spans across the top.)
  - **Chapter 5.2: Authorizations**
  - **Chapter 5.5: Denials, Grievances, & Appeals**
  - **Chapter 6.3: Facility (UB-04/837I) Billing**