

Chapter 13

Inpatient Hospital Notification and Authorization

An inpatient hospital notification is required for all members to ensure care coordination and that all inpatient hospital services paid under PrimeWest Health are medically necessary and consistent with the member's diagnosis or condition and cannot be provided on an outpatient basis. **Most inpatient admissions also require a Service Authorization.** Refer to the *Admissions Requiring Service Authorizations* section below for exclusions. The authorization does not determine member's eligibility; eligibility should be verified on admission, and routinely thereafter.

Hospitals shall comply with the following requirements:

1. Notify PrimeWest Health of non-emergency hospital inpatient admissions prior to or upon time of admission
2. In the event of an emergency admission, notify PrimeWest Health within 24 hours of the admission, or for admissions occurring during a weekend or holiday, by the end of the first working day thereafter
3. Make information related to the admission available to PrimeWest Health during the course of a member's hospitalization
4. Make information regarding the time and date of discharge and information regarding the treatment provided to the member available to PrimeWest Health within the next working day following a member's discharge

Service Authorization requirements apply when PrimeWest Health is primary, secondary, or tertiary payer for the member. Refer to the *Admissions Requiring Service Authorizations* section below for exclusions.

Requests for authorization after the service has been provided are subject to the same review criteria as those that are received prior to providing the service.

Receiving an approval for a [Service Authorization](#) request does not guarantee payment. Providers must follow PrimeWest Health billing policy guidelines, and the PrimeWest Health member must be eligible at the time the service is rendered.

Submission of an explanation of benefits (EOB) from the primary insurance with the claim will help ensure accurate reimbursement. In the event primary insurance denies the inpatient stay, PrimeWest Health would pay the entire claim if medical necessity is met using our criteria.

Definitions

Admission: The time of birth at a hospital or other act that allows the member to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Inpatient Service Authorization: The certification number indicating that, upon initial review, the member seems to qualify for an inpatient stay.

Admitting Physician: The physician who orders the member's admission to the hospital.

Concurrent Review: A medical record review completed to determine medical necessity of inpatient hospital services while the member is in the hospital. The review consists of admission review, continued stay review, and, when appropriate, procedure review.

Continued Stay Review: A review and determination of the medical necessity of continuing inpatient hospital service to the member.

Diagnostic Categories: The diagnostic classifications established under [MS 256.969](#), subd. 2, containing one or more diagnosis related groups (DRGs) under Medicare.

Diagnostic Category Validation: The process of comparing documentation in the medical record to the information submitted on the inpatient hospital billing claim to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Inpatient Hospital Service: A service furnished in the hospital and provided by or under the supervision of a physician after admission to a hospital, and outpatient services provided by the same hospital that immediately preceded the admission.

Medically Necessary: An inpatient hospital service that is consistent with the member's diagnosis or condition and under the admission guidelines cannot be provided on an outpatient basis.

A medically necessary health service is a service that is consistent with the member's diagnosis or condition and is:

1. Recognized as the prevailing medical community standard or current practice by the provider's peer group; and
2. Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or is a preventive health service.

Out-of-Area Hospital: A hospital located outside of PrimeWest Health's network of providers.

Principal Diagnosis: The condition established, after study, to be responsible for causing the admission to the hospital for inpatient hospital services.

Principal Procedure: A procedure performed for definitive treatment of the principal diagnosis rather than one performed for diagnostic exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Readmission: An admission that occurs within 15 days of a discharge, not including the day of discharge or the day of readmission. Retrospective review may be completed to determine if the admission and readmission are considered separate admissions, transfer admissions, or a readmission that is a continuation of the previous admission.

Retrospective Review: A review conducted after inpatient hospital services are provided to a member. The review is focused on validating the diagnostic category, verifying recertification (where applicable), and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, and if all medically necessary inpatient hospital services were provided.

Transfer: The movement of a member after admission from one hospital directly to another hospital with a different provider number, or to or from a unit of a hospital to another unit recognized as a rehabilitation distinct part by Medicare. Transfer also includes members who move to or from extended inpatient psychiatric services capacity under contract with the Minnesota Department of Human Services (DHS). Moving a member from a medical or surgical service to the acute psychiatric unit within the same hospital is not considered a transfer and must be billed as one continuous hospitalization.

Admissions Requiring Service Authorization

Most admissions require Service Authorization. Service Authorizations should be requested from PrimeWest Health at the time of admission for acute level of care. Admissions for uncomplicated obstetric (OB) delivery no longer require an authorization; however, notification of the admission is required. There is also an exception when Medicare Fee-for-Service (FFS) is primary: for members with Medicare FFS as primary, if Medicare pays for any service, no authorization is needed for PrimeWest Health to pay the copay or coinsurance. If Medicare denies or does not cover a service, all authorization rules apply. **Reminder: All admissions require inpatient hospital admission notification regardless if a Service Authorization is required.**

For Long-Term Acute Care and Acute Rehabilitation, Service Authorization should be obtained prior to admission.

All inpatient stays will be subject to concurrent review and continued stay review.

The medical records of patients covered under PrimeWest Health are subject to retrospective review to determine the medical necessity of inpatient services.

OB Service Authorizations

PrimeWest Health requires notification from hospitals of all hospital admissions, including obstetric (OB) deliveries. Previously, following notification, your hospital's Utilization Management/Utilization Review (UM/UR) department received a phone call from PrimeWest Health with a Service Authorization number for the hospital stay (followed by a written authorization letter). This process has changed for **uncomplicated OB delivery notifications only**.

Effective June 21, 2010, PrimeWest Health will no longer be providing a Service Authorization number for **uncomplicated OB deliveries (normal vaginal deliveries [NVDs] and C-sections)**. A Service Authorization number will no longer be required on claims you submit to PrimeWest Health for these services.

Even though a Service Authorization number will no longer be required on claims, you still need to notify PrimeWest Health when a member has been admitted to deliver a baby. The notification must include the following:

1. Mother's name, DOB, and PMI number
2. Infant's DOB and gender

Failure to notify PrimeWest Health with the above information following a delivery will result in delayed claims payment.

The newborn's hospital stay has not, and will not, need a Service Authorization **unless** the baby's hospital stay exceeds the mother's stay (i.e., the baby has complications requiring an extended nursery stay). In these instances, a Service Authorization for the baby's nursery stay will be required. PrimeWest Health will continue to require supporting medical information in order to make authorization determinations for the baby's stay.

Obtaining [Inpatient Service Authorization](#)

An admitting physician or hospital must obtain Service Authorization from PrimeWest Health when a member is admitted, readmitted, or transferred to acute inpatient care, and prior to admission when the plan is for a Long-Term Acute Care (LTAC) or Acute Rehabilitation admission.

Service Authorization can be requested in writing, by telephone, or facsimile. In the event that the notification is

attempted outside of normal business hours, PrimeWest Health is able to accept facsimile or confidential voicemail 24 hours per day, 365 days per year. A clinical administration staff member will return the call as soon as possible. Telephone and fax numbers are included at the end of this chapter.

Service Authorizations must include the following information:

1. Caller/requester name and contact information
2. Member's name, PrimeWest Health ID number, date of birth, and sex
3. Date of admission, or expected date of admission
4. Expected date of discharge
5. Admitting physician's name and National Provider Identifier (NPI)
6. Hospital's name, NPI, and city (and state when appropriate)
7. Admitting or principal diagnosis and a secondary diagnosis descriptor with codes, according to the most recent ICD-9-CM
8. Primary or principal procedure descriptor with code, when applicable, according to the most recent ICD-9-CM and anticipated date of surgery
9. Whether the member is a transfer from another hospital
10. Reason and source of the admission
11. Classification of request – prospective, concurrent, or retrospective
12. Specific medical criteria and information from the plan of care to determine whether or not admission is necessary. The suggested information would initially be limited to a history of present illness, full admission orders from the medical record, and laboratory data from admission date

If PrimeWest Health determines that, upon initial review, the admission seems to meet criteria, a Service Authorization number will be issued. The Service Authorization number can be used only for the admission requested.

The admitting physician or hospital that obtains authorization must inform all other providers of inpatient hospital services of the Service Authorization number. The Service Authorization number is not required, however, on claims submitted for inpatient services.

Readmissions, admissions to LTAC, and admissions to Acute Rehabilitation will have medical necessity applied before a Service Authorization admission number is issued. If the nurse reviewer for PrimeWest Health is unable to determine medical necessity, the case is referred to a physician. If the physician determines that the admission is medically necessary, authorization will be granted.

If the physician determines that the admission is not medically necessary, or is unable to determine if the admission is medically necessary, PrimeWest Health will deny the Service Authorization request. PrimeWest Health Clinical Administration will notify providers if additional medical information is needed to make a determination. Failure to provide legible or complete records will result in a denial of the request.

All requests will be acted upon within 10 business days of receipt. If the attending health care provider determines that waiting may harm the member, an urgent request can be requested and a decision will be given within 72 hours. Care related to emergency cases does not require authorization; once the member's condition is stabilized, authorization will be needed to continue services.

If the inpatient admission is denied, a written notice of the denial, with the reason for the denial clearly stated, is sent to the admitting physician, the hospital, and the member. The member is also informed of his/her Appeal rights. The physician and hospital are notified of their right to an Appeal.

Only a physician can deny inpatient hospital services for medical necessity not being met.

Concurrent, Continued Stay, and Retrospective Reviews

PrimeWest Health performs concurrent, continued stay, and retrospective reviews. A physician (secondary medical reviewer) is consulted if the medical record and other supporting information do not clearly demonstrate the medical necessity of the admission, continued stay, services provided, or the reasons for the member's discharge and readmission.

PrimeWest Health reserves the right to review all inpatient admissions to determine medical necessity, even if an inpatient Service Authorization has been granted. If this review (using InterQual™ criteria) determines that the admission did not meet medical necessity criteria, the review will be forwarded for secondary medical review.

If the secondary medical reviewer (physician) determines medical necessity was not established, PrimeWest Health will withdraw the Service Authorization number (provided by PrimeWest Health to the hospital during initial review) and notify the admitting physician and the hospital of the withdrawal. A denial letter will also be provided along with Appeal rights.

If a Service Authorization number was not yet provided and the secondary medical reviewer (physician) determines that medical necessity was not established, PrimeWest Health will deny a Service Authorization number and notify the admitting physician and the hospital of the denial and Appeal rights.

Denial, Withdrawal, or Retrospective Denial of Coverage for not Meeting Inpatient Criteria

If a Service Authorization number is withdrawn or it is determined that an admission that did not have a Service Authorization number did not meet inpatient hospital criteria, PrimeWest Health may recover all or part of the PrimeWest Health payment made to the attending physician, hospital, and other providers of inpatient hospital services.

If the Service Authorization number is denied or withdrawn, the services may be billed as outpatient observation hospital services only if the following apply: an inpatient bill has not been submitted and the total time the member was in the hospital was less than 48 hours.

Criteria to Determine Medical Necessity

The criteria used by PrimeWest Health's nurse review staff to determine medical necessity is called InterQual™. It is a multispecialty, clinically based application that utilizes clinical literature, community standards of practice, and national practice guidelines to help determine medical need and intensity of services to manage certain conditions. Criteria used in the decision making process is available upon request by calling or writing to the areas listed below.

Readmission

The medical records of inpatients readmitted to the hospital within 10 days will be reviewed by PrimeWest Health. The initial admission, discharge, and the readmission are reviewed to monitor quality of care (e.g., under-utilization of services, fragmented care, premature discharge) to determine if payment should be made for one or both hospitalizations, or if payment should be made according to transfer payment established by Minnesota Rules. If the decision is that the readmission is continuous with the previous admission, reconsideration may be requested through the provider Appeal process.

Medical records with clearly documented situations of patient preference, leaving the hospital against medical advice (AMA), patient noncompliance, physician/hospital convenience, or scheduling conflicts will not be sent through physician review. Situations of episodic illness (same or different episode) or prevailing medical standards, practice, and usage will be sent to physician review (secondary medical review) if the Utilization Management (UM) Care Coordinator cannot make a determination or the provider disagrees with the determination. The decision made by the secondary reviewer will be communicated to the provider. If the provider does not agree with it, reconsideration may be requested through the Provider Appeal process.

Medical records of an admission must clearly state the following:

1. The reason the member was discharged from the hospital
2. The member's status upon discharge

Medical records of a readmission must clearly state the following:

1. The reason the member was readmitted
2. The member's medical status at readmission

Readmission Criteria

Criteria used to determine whether a readmission is considered a second admission, continuous with the first admission, or eligible for transfer payment are as follows:

Criteria: A second admission is a readmission that resulted from one of the following circumstances:

1. During the first admission, the member left the hospital against medical advice (AMA) once the member understood the hospital course (usually within the initial hours of hospitalization). This "admission" should be billed as outpatient services.
2. During the first admission, the member was noncompliant with medical advice (i.e., the member was informed of his/her medical condition and fully understood the need for treatment and follow-up, yet refused to adhere to medical recommendations). The information provided to the member is documented in the medical record at the hospital of the first admission.
3. A new episode of the same diagnosis of an episodic illness or condition.
4. The recipient was discharged and readmission was medically necessary according to prevailing medical standards, practice, and usage.

Criteria: An admission continuous with the initial admission is a readmission that resulted from one of the following circumstances:

1. The member was discharged from the admitting hospital without receiving the procedure or treatment for the condition diagnosed during the admission because of the physician's or hospital's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the second admission is a continuation of the first and only one Service Authorization number is to be provided to the provider. If the admitting and readmitting hospitals are not the same, the second hospital is given a new Service Authorization number. Both hospitals need to know that they are going to receive **transfer payment** (applies to DRG hospitals only).
2. The member's discharge was not appropriate according to prevailing medical standards, practice, and usage. InterQual™ discharge criteria and, if necessary, secondary medical review will be used to determine if discharge was appropriate. If the discharge was not appropriate and the admitting and readmitting hospitals are the same, PrimeWest Health will authorize only one admission (the readmission is a continuation of the admission). If the admitting and readmitting hospitals are different, PrimeWest Health may withdraw the Service Authorization number for the initial admission and a new Service Authorization number will be generated for the second hospital. If PrimeWest Health provides both hospitals with a Service Authorization number, both hospitals need to know that they are going to receive **transfer payment** (applies to DRG hospitals only).

3. The preference of the member or his/her family that the treatment be delayed, the member be discharged without receiving the **necessary** procedure or treatment, and then be readmitted to the same hospital for the necessary procedure or treatment. In this situation, “preference” differs from AMA discharge because the choice is compatible with prevailing medical standards. If the admitting and readmitting hospitals are the same, the initial admission Service Authorization number will be given to the provider (the readmission becomes a continuation of the initial admission). If the admitting and readmitting hospitals are not the same, then a new Service Authorization number is entered for the second hospital, and *both* hospitals need to know that they are going to receive transfer payment. Transfer payment applies if the readmission to the new hospital is within hours of the discharge from the first hospital.
4. The readmission results from the same episode of the same diagnosis/disease of an episodic illness or condition. For readmissions to physical rehabilitation after transfer to acute care, it is necessary to determine if the member’s treatment can resume at or near the pre-transfer stage. If so, combine the admission and readmission. If the patient physically regressed or the functional level deteriorated during the acute care hospitalization and the treatment program must be repeated, the readmission is considered a second admission. Although the decision is not based on the length of stay (LOS) in rehabilitation or an acute hospitalization, LOS must be considered.

Criteria: An admission **eligible for transfer payment** is an inpatient discharge followed by a readmission that resulted from the circumstances noted above (an admission continuous with the initial admission) and the following:

1. The readmission results from a referral from one hospital to a different hospital because the member’s medically necessary treatment is outside the scope of the admitting hospital’s available services. In this case, both hospitals will have their own Service Authorization numbers if any of the following apply:
 - a. The admitting hospital admitted the member as an emergency
 - b. At the time of admission, the admitting hospital was unaware and had no reason to believe that the member’s treatment was outside the scope of the hospital’s available services
 - c. There is a physician or hospital scheduling conflict at the admitting hospital and the readmission is at a different hospital

If the first admission did not meet any of the criteria in a – c above, the admission event for the first hospital is void and the hospital is asked to bill for outpatient services.

PrimeWest Health Contact Information

PrimeWest Health Utilization Management
2209 Jefferson St, Ste 101
Alexandria, MN 56308
Phone: 1-866-431-0803; Monday – Friday, 8 a.m. – 4:30 p.m. (toll free)
Fax: 1-866-431-0804 (toll free)

The PrimeWest Health [Service Authorization forms](http://www.primewest.org) can be found on the PrimeWest Health website at www.primewest.org.

Legal References

[MS 256B.04](#)
[MS 256D.03](#)
[MS 256L.03, subd. 3\(b\)](#)
[MN Rules 9505.0500 – 9505.0540](#)
[MN Rules 9500.1090 – 9500.1140](#)
[42 CFR 456.50 – 456.245](#)
[42 CFR 482.30](#)