Commercial Carrier Utilization Review Requirements for Hospitals

(Accurate as of 1/12/22 at 8:00 am. Please check the MIA website for up to date information.)

	CareFirst	Kaiser	Aetna	Cigna	UnitedHealthcare
Applicability	All commercial business (insured and self-funded/ASO)	All commercial business (insured and self-funded/ASO) Utilization Management for PPO and out of network options in the Flexible Choice plans is through Permanente Advantage, and hospitals or providers can contact Permanente Advantage (PA) at 1-888-567-6847 to arrange for pre-certification of services as needed.	All commercial business (insured and self-funded/ASO)	All commercial business (insured and self-funded/ASO)	The waivers of prior authorization for specific types of facility transfers described below apply to all commercial business (insured and self-funded/ASO). For the remaining requirements, the policies below apply to all insured business, but there may be some variation for self-funded/ASO business.
Admissions	Emergency admissions- no prior authorization required. Require notification within 72 hours of the admission. Non-emergency admissions require prior authorization	All urgent and emergent admissions- no prior authorization required. Require notification within 24 hours of the admission to Emergency Care Management Department at 1-(800) 810-4766. In the case of an emergency, notification of admission is required as soon as reasonably practical.	Emergency admissions- No prior authorization required. Aetna requires notification of the admission within 24 hours and the claim is subject to retrospective review Non-emergency admissions require prior authorization	COVID-19 admissions would be considered emergent admissions and do not require precertification. Notification is requested as soon as is reasonable to allow CIGNA to assist with discharge planning. Retrospective review of medical necessity will be performed. Non-emergency admissions require precertification for those services on CIGNA's precertification list. If elective care is provided in a hospital that CIGNA is not aware of,	Emergent or Urgent admission- Notification of the admission is required within 24 hours of admission (however there could be differences in provider contracts that allow for more than 24 hours) Non-emergent admission-prior authorization required. If an Out-of-network provider contacts UHC prior to admission, a medical necessity review is completed.

				retrospective review of medical necessity will be performed.	
Elective surgeries	Prior authorization required. Members who meet criteria for requested services and have benefit will auto approve in 3 days. For postponed preauthorized elective procedures, CareFirst will honor and maintain them in an approved status for up to six months pending member eligibility. When surgeries are rescheduled, it will be the responsibility of the provider to contact the CareFirst Utilization Management Department (866-773-2884 or via the provider portal) and provide the new date of service to ensure the claims will pay appropriately. We expect the above protocol to be in place through February 15, 2022	Prior authorization required for: i. Abortions, Elective/Therapeutic ii. Anesthesia for Oral Surgery/Dental iii. Any Services Outside Washington Baltimore Metro Areas iv. Blepharoplasty v. Breast Surgery for any reason vi. Clinical Trials vii. Cosmetic and Reconstructive or Plastic Surgery viii. Dental Services Covered Under Medical Benefit ix. Gastric Bypass Surgery, Gastroplasty x. Investigational/ Experimental Services xi. Stereotactic Radiosurgery xii. Nasal Surgery (Rhinoplasty or Septoplasty) xiii. Oral Surgery xiv. Orthognatic Surgery xv. Outpatient Surgery –All Hospital Settings/Ambulatory Surgery Centers xvi. Pain Management Services xvii. Penile Implants	Prior authorization required	Elective surgeries- precertification required for codes on the precertification list. When code not on list and the service is customarily per-formed as an inpatient, Cigna requests notification to the extent possible as soon as is reasonable. Cigna does not deny claims for failure to secure authorization, however, retrospective review of medical necessity will be performed.	Requires prior authorization. Authorizations are valid for 90 days

		xviii. Post Traumatic (Accidental) Dental Services xix. Prostate Biopsies - Ambulatory Surgery Centers or Outpatient Hospital Setting xx. Scar Revision xxi. Sclerotherapy and Vein Stripping Procedures xxii. Uvulopalatopharyngoplasty (UPPP) xxiii. Transplant Services – Solid Organ and Bone Marrow The list periodically updated and may not be an all-inclusive list. Questions should be directed to the Provider Service Center at 1-800-810-4766, follow the prompts.			
Continued Stays (concurrent review)	Acute facilities where elective surgeries have been suspended- Concurrent review required after inpatient day 30. Acute facilities that have not suspended elective admissions -Concurrent review is required on day 4. Concurrent review is required on: -Day 15 for SNF and LTAC admissions -Day 11 for AR admissions -Day 22 for hospice admissions	The Utilization Management Department performs daily concurrent review of all hospital / facility admissions.	Concurrent review conducted within 24 hours and may also be subject to retrospective review.	Asks for whatever concurrent review hospital can provide to allow Cigna to assist with discharge planning. Claims not denied for failure to secure continued authorization. Retrospective review of medical necessity will be performed.	Perform medical necessity reviews for level of care and length of stay on concurrent admissions every two days.

Discharge	CareFirst Care Managers support the hospital Care Management team by providing support for any discharge needs such as arranging home health, DME, medication management, clinical education, transportation, and any needs identified to address their social determinants of health. For assistance, contact CareFirst Care Management at 1-866-773-2884.	Kaiser handles all the discharge planning and care coordination at Core hospitals from admission through discharge and post-acute care as needed. Patient Care Coordinators support patient care at non-core hospitals as well.	No requirements unless discharged or transferred to another facility or level of care. See requirements below.	Notification of the discharge date is appreciated, but not required, when the facility is able to do so.	No authorization or notification requirements. UHC offers discharge planning as needed. There is also a transition of care program to help members transition back into their homes/communities.
Facility transfers	No notification is required prior to acute-to-acute transfers. The receiving facility is responsible for providing notification of admission to the insurance carrier within 72 hours. No authorization is required for transfers from acute inpatient to: SNF, Acute Rehabilitation (AR), Long Term Acute Care(LTACH), Inpatient Hospice, Post-acute Behavioral Health facilities. The receiving facility is responsible for obtaining authorization within 72 hours of admission for all post-acute placements.	If Kaiser is not actively coordinating the member's care, additional notification and request for authorization is required from the acute care hospital for facility transfers, (including from one acute inpatient facility to another or from an acute inpatient facility to a skilled nursing facility (SNF), acute rehabilitation facility (AR), or long-term acute care hospital (LTACH)).	For SNF admission from acute care hospital prior authorization waived through January 31, 2022 for all commercial and Medicare advantage part C plans. Acute-to-acute, LTACH, and AR require pre-authorization	No precertification required for emergent transfers to any facilities (acute, SNF, LTACH, AR) for the purpose of freeing up bed space even if the transfer is to a non-participating provider For non-emergent transfers precertification is required.	For acute-to-acute transfer, prior authorization requirements suspended. Notification of the admission is required within 24 hours of admission (however there could be differences in provider contracts that allow for more than 24 hours) For an in-network SNF admission from acute care hospital, prior authorization waived through February 4, 2022. Notification of the admission is required within 24 hours of admission (however there could be differences in provider contracts that allow for more than 24 hours)

					Transfers to acute inpatient rehabilitation, long-term acute care hospital, and post sub-acute care rehabilitation facility- Prior Authorization is required for In-network providers. Medical necessity review is performed for Level of care. If admitted, concurrent review is performed throughout the stay to ensure medical necessity and assist with discharge planning. If an Out-of-network provider contacts us prior to admission, a medical necessity review is completed.
Post-discharge care (i.e. home-health care)	Care Managers outreach to Members, assess for individual needs, and provide identified post-discharge support.	In core facilities, Kaiser staff handles all the discharge planning and care coordination from admission through discharge and post-acute care as needed. Kaiser Patient Care Coordinators support patient care at non-core hospitals as well.	For discharges to home health in Maryland, no pre-authorization is required for in-network providers. Prior authorization required for out-of-network providers. Discharge to other states, requirements may vary.	No precertification required for home health care. If time allows, Cigna likes to participate in helping find home health care so services provided are in-network.	No prior authorization requirements for home health care