

[Minimum Requirements for Precertification](#)

Below are the minimum requirements for inpatient pre-certification. This list may not be all-inclusive of all requirements under your Employer sponsored Group Health Plan. Please review the pre-admission provisions in your Benefits Booklet for any additional requirements under your plan.

Your Group Health Plan may also require pre-certification for certain outpatient procedures. Please review the pre-admission provisions in your Benefits Booklet for any additional requirements under your plan.

[Pre-admission Review](#)

Non-urgent Care Admission

Pre-admission reviews the request for a hospital admission and the number of days for the hospital stay to determine whether the admission and the number of days for the hospital stay are within the guidelines of the Plan. All non-urgent care hospital admissions must be pre-certified before a hospital admission by calling the CMS Managed Care Department at their toll-free number.

Urgent Care Admission

An “*Urgent Care*” admission is one where application of the time period for making non-urgent care determinations could either:

- 1. Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or*
- 2. In the opinion of a physician with knowledge of the medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care, which is the subject of the claim.*

If a covered person is admitted to the hospital for an “Urgent Care” admission, as defined above, then no pre-certification is required for that admission. However, the CMS Managed Care Department must be notified within the first business day following the “Urgent Care” admission by calling its toll-free number.

Questions regarding decisions made by Utilization Review may be directed to the CMS Managed Care Department by calling its toll-free number.

[Mothers and Newborns](#)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Maternity stays exceeding either the 48 hour or 96 hour period, require certification by the CMS Managed Care Department or benefits may not be payable for the remainder of the hospital stay. Please see the “Newborns’ and Mothers’ Health Protection Act Notice” provision in the General Information section of the Plan.

Organ or Tissue Transplant

In addition, the covered person should contact the CMS Pre-admission Review Department as soon as reasonably possible following the date on which the covered person's attending physician has indicated that the covered person is a potential candidate for an organ or tissue transplant or a potential donor for an organ or tissue transplant.

Pre-admission Review Non-compliance Penalty

If a covered person does not comply with the Pre-admission Review certification requirements, eligible charges for inpatient care will be covered as specified on the Schedule of Benefits.

Concurrent Stay Review

Concurrent Stay Review occurs while the covered person is in the hospital. If the CMS Managed Care Department is advised of the need for hospitalization for a longer period of time than that was certified by Pre-admission Review, the physician will be asked to provide the CMS Managed Care Department with additional medical information to evaluate the need for the extended stay.

If the covered person is confined in an inpatient facility longer than originally certified by the CMS Managed Care Department and the extended stay is not certified through the Concurrent Stay Review process, benefits may not be payable for the remainder of the hospital stay.

Medical Case Management

Medical Case Management focuses on acute or chronic conditions that result from serious or debilitating illnesses or injuries by coordinating the needs of the covered person, the family, the health care providers and the employer.

Second Surgical Opinion - CMS Request

If a covered person is requested by the CMS Managed Care Department to obtain a second surgical opinion for an inpatient surgical procedure, eligible charges will be covered as specified on the Schedule of Benefits. The physician giving the second opinion must not be in medical practice with the physician who first recommended surgery. Charges are covered for a third opinion if the first and second opinions differ. After obtaining a second surgical opinion, it is the covered person's decision whether or not to have the surgery, no matter what the results are from the second opinion.

Second Surgical Opinion - CMS Request Non-compliance Penalty

If a covered person fails to obtain a second surgical opinion when requested by the CMS Managed Care Department, eligible charges will be covered as specified on the Schedule of Benefits.

IMPORTANT: The utilization of Managed Care is not a guarantee of benefits under the Plan. Charges are subject to all Plan provisions.

Any charges submitted to the Plan for payable benefits are required to be medically necessary as defined by your self-funded Employer Group Plan.

If you have questions about pre-certification please call the Managed Care Vendor listed on your ID card.

If you have questions regarding your benefits please call the CMS Customer Service number listed on your ID card.