PriorityActions FOR PROVIDERS

Authorizations | Billing and payment

Welcome to our biweekly PriorityActions for providers, where you'll receive important information to help you work with us and care for our members.

You're receiving this email because you're a part of an Accountable Care Network (ACN) or Provider Organization (PO) with us. Please share relevant information with your provider groups and practices. Your Provider Strategy & Solutions Consultant remains your primary contact for support.

AUTHORIZATIONS

Non-urgent inpatient hospital transfers will require prior authorization before transfer starting Mar. 10, 2025

When a member is receiving **non-urgent** inpatient care, we'll soon require prior authorization before their care can be transferred to a different facility. This change will go into effect Mar. 10, 2025, and won't impact urgent / emergent hospital transfers.

Note: The transfer of a member's care between facilities is separate from ambulance transportation. An additional authorization request may be needed for the transportation service, depending on the type of transportation – see below for more.

How to submit a hospital transfer request

Either the transferring or receiving facility should submit a new Acute / Emergent authorization request through GuidingCare and include the following information:

- Reason for the transfer
- Accepting attending physician name at the receiving facility
- Other facilities considered if the transfer is out-of-network for the member's benefit
- Relevant clinical information
- Anticipated mode of transportation

The facility can ask for **expedited review** after submitting their authorization request in GuidingCare by calling:

- **During business hours**: Call our provider helpline at 1.800.942.4765.
- **After business hours**: Call our Utilization Management team directly at 1.800.269.1260.

Urgent / emergent transfers not impacted

There will be no change for urgent / emergent hospital transfers. If a member is experiencing a life-threatening condition and delay of transfer would jeopardize the health of the member, the receiving facility should submit for authorization **after** the transfer has occurred.

Liability when authorization isn't received

If prior authorization isn't approved before a non-urgent inpatient hospital transfer and our team later finds the transfer to be not medically necessary, we'll cover the stay at the outpatient level of care. The receiving facility will be liable for the difference between the outpatient and inpatient level of care.

Authorizations for transportation between facilities

Prior authorization is required for fixed wing air ambulance transportation. Ground transportation and rotary wing transport as part of a hospital-to-hospital transfer don't require prior authorization.

BILLING AND PAYMENT

New & updated billing policies are now available

We publish billing policies to offer transparency and help providers bill claims more accurately to reduce delays in processing claims, as well as avoid rebilling and additional requests for information.

The following billing policies were recently published to or updated in our Provider Manual. **These policies reflect our current requirements /**

system set up – they don't change the way you work with us or how you're reimbursed.

Note: If a policy is listed as a revision, the changes made are detailed on the last page of the policy.

- [Always / sometimes therapy](#) – new
- [Bladder scans](#) – new
- [Cardiac rehabilitation](#) – new
- [Care management services](#) – revision
- [Compression garments](#) – new
- [Critical access hospital (CAH) method II billing](#) – new
- [Durable medical equipment (DME) / prosthetic & orthotics modifiers](#) – revision
- [Endomyocardial biopsy with right heart catheterization](#) – new
- [Enteral nutrition](#) – new
- [Evaluation & management](#) – revision
- [Home health](#) – new
- [Lab & pathology](#) – revision
- [Maternity and prenatal care](#) – new
- [Medicare Annual Wellness Visit (AWV) and preventive care visits](#) – new
- [Negative pressure wound therapy pumps](#) – new
- [Skilled nursing facility](#) – new
- [Split / shared billing](#) – revision
- [Unlisted codes](#) – new

Reminder: Corrected claims must include the original claim ID

As a reminder, we require that corrected claims – submitted to either replace, correct or void an original claim that was partially or fully paid – include the original claim ID. We'll soon begin front-end rejecting corrected claims that have an invalid / incorrect original claim ID. This will apply to both facility and professional claims for all plan types.

Note: For claims that were fully denied, providers should submit a new claim rather than a corrected claim. This update doesn't impact this process.

Submitting corrected claims

If you've made a mistake on a claim submitted to us and would like to either correct, replace or void it, you can do so by [submitting a](#)

corrected claim. Per our Provider Manual, the corrected claim must include the following elements:

1. Appropriate frequency type code: 7 for correction or 8 for void
2. Original claim ID number

Instructions are available in our Provider Manual for submitting corrected claims for both facility / UB-04 and professional / CMS-1500 claims. Ensure the original claim ID included in the required corrected claim field is correct to avoid a front-end rejection.

Viewing front-end rejected claims

You can see your front-end rejected claims in:

- **Prism**, by using the Search Front-End Rejected Claims feature under the Claims tab
- **277 report** from your clearinghouse, if you work with one
- **Our service receipts**, if you've signed up

If you've received a front-end rejection on a corrected claim for an invalid / incorrect original claim ID, you'll see the following message:

"The original claim ID was entered incorrectly on this corrected claim. Please validate the original claim ID and resubmit."

Front-end rejections aren't denials. You can correct and resubmit the claim.

Questions?

Connect with your Provider
Strategy & Solutions Consultant, Terry Flaga .

Access an archive of our PriorityActions for providers emails here.