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Understanding electronic precertification requests and notifications

How to determine if a procedure requires precertification

All services that require precertification can be submitted by using the Precertifcation Add or Notification transactions.

All inpatient stays require precertification. You can find out if a specific procedure requires precertification using our Precertification Code Search Tool.[1]

The tool is available at **www.aetna.com**. Under "Quick Links," select "Check Precertification List."

The Precertification Code Search Tool:

- Allows you to enter a valid five-digit CPT or HCPCS code
- Tells you whether precertification is required, based on the code entered
- Provides information about the precertification process for services, such as radiology, that are administered through external vendors

To streamline the data input process, submit an eligibility transaction prior to performing a precertification request. Once you submit an eligibility transaction, many vendors' systems will automatically pre-fill all necessary fields for a precertification request submission.

Use your current process to verify a member's eligibility, benefits coverage and plan limitations.

[1]The Precertification Code Search Tool provides a procedure code-based search of the participating provider precertification list. Please note that the absence of a procedure code from the precertification list does not imply coverage.

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Required information

To prepare for a successful precertification request or notification submission, have the following information available:

- Provider identifiers
  - The National Provider Identifier (NPI) numbers of the requesting, attending and admitting physicians, as well as the facility NPI. You can find these numbers through the DocFind® online referral directory, available through our **secure provider website**.
- Contact name and phone number
- Member ID number and date of birth
- Valid diagnosis code (799 series not accepted for notification submission)
- Precertification or notification type (admission, general/outpatient services, ambulance, durable medical equipment)
- Place of service

Depending on the precertification or notification type, you may need to include the following additional information:

- Reason for admission (type of service), admission date and requested length of stay. For emergency room or urgent admissions, indicate one day.
- Procedure code and procedure date.

Where to turn for help

Need more help with electronic precertification requests? Use the "Contact Us" link available on **www.aetna.com**. Or call your vendor's customer service help line for help.

Responses you can receive about your precertification request or notification

Precertification request

Certified in total

- All requested services have been approved.

Modified

- The request has been approved but has been modified. For example, only a portion of the requested length of stay was approved.

Rejected

- No certification ID will be returned; however, a unique tracking number is returned for reference purposes.
- Most information originally included in the precertification request is returned in the response.
- A rejection explanation, along with the information that was in error, is returned in the response.

Pended for medical review

- The requested services require additional review and additional information in most instances.
- Use the precertification inquiry transaction to check the status of this pended request.

Precertification notification

Successful response

- A successful notification response will generate a notification receipt number.

Rejected

- No notification receipt number will be returned.
- Most information originally included in the notification will be returned in the response.
- A rejection explanation, along with the information that was in error is returned in the response.

Using the precertification inquiry transaction

Use the precertification inquiry transaction to check the status of previously submitted precertification or notification requests associated with the requesting provider. You can narrow your search by using a specific certification or receipt number.

Provider call-back procedures for precertification and notification requests

Type	Response details	Call-back procedure
Admission request	Pended for medical review Admission date has already occurred	• Return call made to the facility Utilization Review department to obtain additional clinical information.
Admission request	Pended for medical review Prior to actual admission date	• Return call made to admitting physician to obtain additional clinical information.
Admission request	Certified in total	• No return call made to the physician. • For scheduled admissions, facility will be contacted on scheduled admission date to verify admission. • For active admissions, facility will be contacted during concurrent review process to verify discharge.
Admission request when Medicare is primary	Pended for medical review	• No return call made to the physician. • If medical criteria are met, an administrative denial is issued. If medical criteria are not met, a standard denial is issued.
Ambulatory services request	Pended for medical review Service date has already occurred	• Return call made to requesting physician. • Will be advised that precertification protocol was not obtained. Claims should be submitted; no precertification event will be entered.
Ambulatory services request	Pended for medical review Prior to actual procedure date	• Return call made to attending physician to obtain additional clinical information.
Ambulatory services request	Certified in total	• No return call made to the physician.
Ambulatory services request	Rejected No action required	• No return call made to the physician. • The procedure code does not require precertification.
Home health care request when Medicare is primary	Pended for medical review	• If request is for services greater than 35 hours/week or for private-duty nursing, a return call will be made to the physician. • If the request is for services less than 35 hours/week, a return call may or may not be made, based on staff availability.

The term precertification here means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.