How Precertification works

Before a covered person enters a medical care facility on a non-emergency inpatient basis or receives certain medical services, the utilization review administrator will, in conjunction with the attending physician, certify the care as appropriate for plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the covered person. Have your provider contact Bywater at **(800) 337-0792** as soon as possible before services are scheduled to be rendered.

What information will need to be given?

- Name, identification number and date of birth of the Covered Person
- The relationship of the Covered Person to the Employee
- Name, identification number, address and telephone number of the Employee
- Name of Employer and group number
- Name, address, Tax ID # and telephone number of the admitting Physician
- Name, address, Tax ID # and telephone number of the Institution with the proposed date of admission and proposed length of stay
- Proposed treatment plan
- Diagnosis and/or admitting Diagnosis

If there is an emergency admission contact must be made within 72 hours if it is the weekend and 24 hours if week day of the first business day after admission.

The utilization review administrator will determine the number of days for medical care facility confinement or use of other medical services authorized for payment. Failure to follow this procedure may reduce reimbursement received from the plan.

- If a Covered Person fails to Pre-Certify any of the services listed below, allowable charges will be subject to a Pre-Certification penalty equal to 10% of Maximum Allowable Charge for the procedures, treatment and hospital room & board, with a minimum of $500. The Covered Person will be responsible for the portion of the billed charges not covered under the Plan due to the Pre-Certification penalty. The Pre-Certification penalty does not accumulate toward the Deductible or the Out-of-Pocket Maximum.

The following services must be precertified:

- Inpatient admissions, including Inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and Inpatient admissions due to a Mental Disorder or Substance Use Disorder
- Transplant Services
- Hospital observation stays of more than 48 hours
- Dialysis services
- Chemotherapy and radiation therapy
- Reconstructive surgeries
- Hyperbaric oxygen treatments
- Durable Medical Equipment, if rental longer than 30 days or a purchase, and insulin pumps with the exception of all other diabetic supplies
- Outpatient Substance Use Disorder programs;
- Outpatient Surgeries and Procedures
- Outpatient Private Duty Nursing
- Diagnostic testing outpatient including outpatient MRI/PET/ CT Scans
- Infusion services
- Home health care
- Genetic testing, including BRACA and BART
- Air and water ambulance transportation;
- Hospice care
- Spinal procedures
- Prosthetics
- Injection therapy specific to pain management programs
- Treatment/Surgical Procedures for Morbid Obesity
- Gender Dysphoria surgical treatment

Please check your plan document for a full list of services that require precertification