



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

Effective July 31, 2017, providers must use the e-referral system to submit authorization requests for Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus Blue PPO members. Below are answers to questions asked in a July 2017 webinar on this topic.

1. Q: Do providers need to submit preauthorization requests in the e-referral system for the following types of services for Blue Cross PPO or Blue Cross Medicare Plus Blue PPO members?

A: **Observation?** No. Currently, you do not need to submit requests for members in observation.

Outpatient high-tech radiology? You must submit outpatient high-tech radiology requests through AIM. Refer to the Blue Cross provider manuals and the Blue Cross Medicare Plus Blue PPO [Prenotification and Utilization Management page](#) for the high-tech radiology procedure codes that must be submitted to AIM for each line of business.

Maternity admissions? No. You do not need to submit routine maternity admissions, including emergency cesarean sections.

Extensions of admissions? Only UAW Retiree Medical Benefit Trust members and Blue Cross Medicare Plus Blue PPO require concurrent review. No concurrent reviews are required for other Blue Cross PPO members. You'll find the instructions for entering extension requests into the e-referral system in the [e-referral user Guide](#). Look in the subsection titled "Submit an Inpatient Authorization." These requests will not be accepted via fax.

2. Q: Do cases that have already received a "T" authorization in the prenotification system have to be re-entered into the e-referral system?

A: No. Cases that have already been entered into the prenotification system do not have to be re-entered into the e-referral system. Any request that was **not** entered into the prenotification system prior to July 31, 2017, must be entered into the e-referral system.

IMPORTANT: Updates to existing prenotifications must be submitted to urgentinpatientprecertrequests@bcbsm.com.

3. Q: For inpatient admissions submitted by a facility provider, does the approval cover the professional services provided during the admission?

A: Yes.



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

4. Q: Who submits the request for procedures that will occur during an inpatient admission?

A: Either the physician office or the facility can submit the request. Ancillary services do not require authorization.

*If the service is an elective procedure for a Medicare Plus Blue PPO member that requires prior authorization (see the “Services that require authorization” list found on [this page](#)) we require clinical information to support the need for the procedure. This information is generally best provided by the surgeon’s office. Operative notes submitted by the facility typically do not contain adequate indications for the surgery.

5. Q: What if pended case is locked for editing?

A: If a case is locked for editing, then the system is either processing the case or a nurse is reviewing it.

6. Q: How far in advance should an elective surgery request be submitted?

A: At least 14 days in advance of the date of procedure.

7. Q: What should a facility do if the surgeon’s office failed to obtain the prior authorization for an elective inpatient surgical admit for Medicare Plus Blue members that require authorization? (See the “Services that require authorization” list found on [this page](#))

A: Providers have a 90-day retroactive period to submit the authorization request, if needed. Remember, in order to obtain a prior authorization for an elective procedure, we need clinical information about the need for the surgery. We suggest that the request come from the surgeon’s office since operative notes typically do not contain adequate indications for the surgery.

8. Q: For inpatient admissions, should we select or enter the pertinent InterQual[®] criteria and indicate whether the admission meets the criteria?

A: No. The criteria are already incorporated into the e-referral system. There is no need for you to select or enter criteria.

9. Q: Should we enter a discharge date for inpatient admissions?

A: Yes. You should enter the discharge date if you know it into the “Case Communication” field in the e-referral system.

10. Q: For inpatient admissions, can we use procedure code *99222, like we do with Blue Care Network members?

A: For all acute care medical admissions, use procedure code *99222. For surgical admissions, use the procedure code that’s appropriate for each admission.

If the procedure is an elective surgical admission for a Medicare Plus Blue PPO member that requires prior authorization (see the “Services that require authorization” list found on [this page](#)), you should use the authorization requested by the surgeon’s office. There is no need to enter a separate authorization for the facility.

* CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

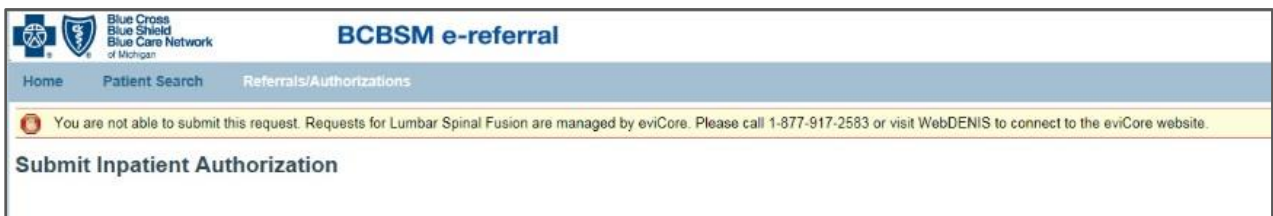
For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

11. Q: For eviCore managed spinal fusion cases, does the procedure as well as the admission require authorization?

A: For eviCore spinal fusion procedures that require prior authorization (see the document “Procedures that require clinical review by eviCore” located on [this page](#)) two authorizations are required; one for the procedure and one for the admission. The facility needs to load an authorization with procedure code *99222 in e-referral or you will receive a block message.

If you see this message below please change procedure code to *99222



12. Q: Can I continue to fax the supporting documentation for elective surgeries that were authorized prior to admission?

A: You should attach the documentation to the case in the e-referral system, in the “Case Communication” field. The instructions for doing that are in the *e-referral User Guide*, in the subsection titled “Create New (communication),” in the “Submit an Inpatient Authorization” section.

13. Q: Are there penalties if the authorization request is not submitted in a timely manner?

A: Sanctions may be applied when an authorization request is not entered in a timely manner. For inpatient acute admissions you may submit requests up to 60 days after the services have occurred. For more information, refer to the Provider Financial Responsibility guidelines in the provider manuals.

14. Q: How soon does Blue Cross make a determination on a request for authorization?

A: Under normal circumstances, for inpatient admissions Blue Cross makes a determination 24 to 48 business hours after the request is submitted.

15. Q: How do I get authorization numbers for physicians who see patients in different hospitals?

A: As long as the physician is listed as the “Servicing Provider,” you should be able to search for the authorization in your e-referral system account.

16. Q: Will the facility receive the denial letter for Blue Cross Medicare Plus Blue PPO members?

A: Both the member and the facility will receive the denial letter, in line with the guidelines published by the Centers for Medicare & Medicaid Services.

* CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

17. Q: Is there a peer-to-peer review option when requests are denied?

A: Yes. A peer-to-peer review option is available for nonapproval decisions for both Blue Cross PPO and Blue Cross Medicare Plus Blue PPO requests. To schedule a peer-to-peer review, facilities and professional providers should call the number on the denial letter.

18. Q: Is it only the attending physician who can conduct a peer-to-peer review? Can the physician advisor conduct a peer-to-peer review?

A: For Blue Cross PPO cases, either the attending or the physician advisor can conduct a peer-to-peer review.

19. Q: What is the process for appealing a nonapproval decision?

A: The denial letter sent to the provider contains a description of the provider's appeal rights and the appeals process.

20. Q: How will we find out how many days have been approved? Do we receive a fax with the determination?

A: You should check the e-referral system to find out the decision on a request. Once the determination has been made, you'll be able to access the authorization immediately in the e-referral system.

21. Q: Should we ask for a certain number of days to be authorized?

A: For acute care admissions, facilities should request authorization for three to seven days. The decision on the total number of days approved is based on clinical criteria. If the member remains in the facility beyond the number of days approved, concurrent review is required for the additional days.

Note: This applies only to UAW Retiree Medical Benefit Trust members and members with Blue Cross Medicare Plus Blue PPO coverage. No concurrent reviews are required for other Blue Cross PPO members at this time.

22. Q: Should we add updates on the last authorized day?

A: If additional days are needed, you should submit clinical information on the last covered day that supports the extension request. In-state providers will be notified of the determination via the Provider Communication field in the e-referral system. Out-of-state providers will be notified via fax or phone.

23. Q: If the member does not meet inpatient criteria, is there an option for a physician override, as was available in the prenotification system?

A: Physician overrides are **not** allowed in the e-referral system. If the admission does not meet InterQual criteria, the request will be pended for review by a nurse.



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

24. Q: Should we submit requests for inpatient admissions even if the attending and the hospital both support the admission?

A: Yes, and the clinical documentation needs to support the inpatient admission as well.

25. Q: When the determination states that the request is “fully approved,” does it mean that only the days requested are approved or that the entire inpatient admission (the days requested plus any additional days) is approved (as was the case in the prenotification system)?

A: For most Blue Cross PPO cases, the entire stay (the days requested plus any additional days) is approved. For UAW Retiree Medical Benefit Trust and Blue Cross Medicare Plus Blue PPO cases, only the days requested are approved. Any additional days (extensions) require a concurrent review.

26. Q: Is it possible that we will not receive approval for all the days requested?

A: Yes. If the clinical documentation does not support the need for all the days requested, the nurse reviewer will approve the number of days deemed appropriate based on industry standards. This applies only to UAW Retiree Medical Benefit Trust and Blue Cross Medicare Plus Blue PPO cases.

27. Q: What happens if I receive a duplicate message when loading an authorization?

A: If a provider is associated in any way with a duplicate case in the e-referral system, they will see the following details in the e-referral system for a duplicate.

Potential Duplicate Referral or Authorization Close Window

Please review existing potential duplicate Referrals/Authorizations. Your request may have already been submitted. A maximum of 5 potential duplicates will be displayed.

- Click Proceed to submit the request.
- Select the Reference ID to discard your request and view the existing Referral or Authorization.
- Access is restricted when none of your Associated Providers is associated to the Referral or Authorization.

Reference ID	From	To	Place of Service	Servicing Provider	Facility Provider	Description	Status
007223638	07/18/2017	08/01/2017	Inpatient Hospital			Initial hospital inpatient care, typically 50 minutes per day (CPT, 99222)	2 - Pending Decision

Page 1 of 1 25 View 1 - 1 of 1

* CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

Please review potential duplicates listed. If authorization applies to your patient/case no further action is necessary. DO NOT LOAD ANOTHER AUTHORIZATION. If a provider is NOT associated in any way with a duplicate case in the e-referral system, they will see the following details in the e-referral system for a duplicate.

Potential Duplicate Referral or Authorization
Close Window

Please review existing potential duplicate Referrals/Authorizations. Your request may have already been submitted. A maximum of 5 potential duplicates will be displayed.

- Click Proceed to submit the request.
- Select the Reference ID to discard your request and view the existing Referral or Authorization.
- Access is restricted when none of your Associated Providers is associated to the Referral or Authorization.

Reference ID	From	To	Place of Service	Servicing Provider	Facility Provider	Description	Status
007223638							Access Restricted

Page 1 of 1
25

View 1 - 1 of 1

CANCEL
PROCEED

If you get an alert indicating a “potential duplicate,” fax the request to us and we will load the case into the e-referral system

Fax requests for inpatient acute admissions to:

- Blue Cross PPO requests: 1-866-411-2585
- Blue Cross Medicare Plus Blue PPO requests: 1-866-464-8223

For Medicare Plus Blue elective surgical cases that require prior authorization (see the “Services that require authorization” list found on [this page](#)), please contact Care Management at 1-800-392-2512 to resolve any issues.

28. Q: What do I do when I’m attempting to update the authorization, such as add an extension or change the admission date, and the authorization is closed?

A: Authorizations which are “Closed” **cannot** be edited through e-referral. For “Open” cases, providers can only edit the case data if the case is in the status of “Pending Decision.” If the case status is “Fully Approved”, “Partially Approved” or “Denied” the original case data cannot be edited. However, providers can add a “Case Communication”, attach clinical documentation, add an extension, or add a new service to “Open” cases. To change the admission date after the case decision has been made or to add an extension to a closed case, fax the information to 1-866-411-2585.

* CPT codes, descriptions and two-digit modifiers only are copyright 2016 American Medical Association. All rights reserved.



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

29. Q: When a member is transferred to another facility, is it the sending or the receiving facility that should enter the request?

A: The receiving facility should submit the authorization request. If you get an alert indicating a “possible duplicate,” fax the request to us and we will load the case into the e-referral system:

Fax requests for inpatient acute admissions to:

- Blue Cross PPO requests: 1-866-411-2585
- Blue Cross Medicare Plus Blue PPO requests: 1-866-464-8223

30. Q: What if we don’t know the date of an upcoming elective surgery? Can we use the pended authorization with a date range as the authorization number?

A: All requests for admissions with elective surgeries should be submitted with an expected admission date and supporting clinical documentation. If the admission date needs to be changed, it can be made on a case with a pended status within the e-referral system up to 30 days after the original authorization date.

Note: The admission date on a case cannot be changed once a decision has been made. The date can be changed for cases that are pended. If you need to change the admission date, fax the request to us as follows:

Fax requests for inpatient acute admissions to:

- Blue Cross PPO requests: 1-866-411-2585
- Blue Cross Medicare Plus Blue PPO requests: 1-866-464-8223

31. Q: Do we need to submit an authorization request for a newborn who is not yet on the contract?

A: Facility providers should fax requests for temporary members, such as newborns admitted to a neonatal intensive care unit, to 1-866-411-2585. Include in the fax the following information:

- Demographics
- Contract number
- Diagnosis
- Date of admission to the NICU (or to another unit)

Note: For twins, send two separate faxes, identified as being for Baby A and Baby B.

Blue Cross will enter the newborns into the system manually.

For instructions on sending updates and discharge information for these temporary members, review Section IV in the [e-referral User Guide](#), under “Submit an inpatient authorization.” Look in the subsection titled “Submitting authorizations for sick/ill newborns.”

32. Q: Can we start to enter an authorization request and save it so we can finish it later?

A: No. Once you start an authorization request, you must finish it. Do not use the “Save As” button when you’re in the middle of an authorization request because that will save your entries as a template for future authorization requests.



Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Frequently asked questions about the e-referral system

For Blue Cross Blue Shield of Michigan PPO (commercial) and Blue Cross Medicare Plus BlueSM PPO

Updated October 2017

33. Q: What about referrals? What is the difference between a global referral and another type of referral?

A: Global referrals are not used for either Blue Cross PPO or Blue Cross Medicare Plus Blue PPO members.

34. Q: How do I save bookmarks in the e-referral system?

A: In the *e-referral User Guide*, look in the section titled “Bookmarks” for instructions on creating and saving bookmarks.

35. Q: What if I can't find my hospital or facility in the e-referral system?

A: Complete and submit the form to add or change a provider in the e-referral system. To access the form, visit ereferrals.bcbsm.com and click [Sign up or Change a User](#).