



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 commercial and Medicare Plus Blue<sup>SM</sup>

Updated January 2021

Providers must use the e-referral system to submit authorization requests for Blue Cross Blue Shield of Michigan commercial and Medicare Plus Blue<sup>SM</sup> members. Below are answers to commonly asked questions about the process.

### Precertification Process Questions

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

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

A: The sending facility can submit the request on behalf of the receiving facility, or the receiving facility can submit the request when the member arrives. If you get an alert indicating a “possible duplicate,” indicate in the Case Communication section that the member is transferring to a new facility and the case will pend for review.

3. **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 must 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 6 months 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, email your request to [e-referralinquiries@bcbsm.com](mailto:e-referralinquiries@bcbsm.com)

4. **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 members not on the contract, such as newborns admitted to a neonatal intensive care unit, to 1-800-482-1713 and include in the fax the following information:

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

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



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- Supporting clinical documentation

**Note:** For twins, send two separate faxes, identified as being for Baby A and Baby B. If the name of the newborn baby or babies is known, indicate this with your request so they can be manually loaded accurately.

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.”

**5. Q: What do we do if we cannot enter an authorization for a member that we know has an eligible contract (for example, MESSA or FEP member)?**

A: Facility providers should fax requests for authorizations for any members, who do not appear in the e-referral system, but eligibility is active to 1-800-482-1713 and include in the fax the following information:

- Member Demographics
- Contract number
- Diagnosis
- Date of admission
- Supporting clinical documentation for admission

**6. 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.

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

A: Yes.

**8. 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.

\*If the service is an elective procedure for a Medicare Plus Blue 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.

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

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

**10. 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.

**11. Q: For inpatient admissions, do we need to select the pertinent InterQual<sup>®</sup> 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. However, you should submit the criteria that was used to admit the member if the case pends for clinical review.

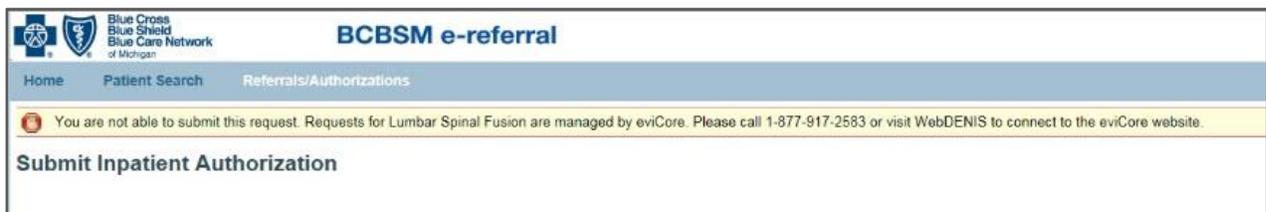
**12. Q: Should we enter a discharge date for inpatient admissions?**

A: No. You do not need to enter the discharge date in the e-referral system.

**13. Q: Does the procedure as well as the inpatient admission require authorization?**

A: It depends. For dates of service prior to Jan. 1, 2021, eviCore healthcare manages authorizations for some procedures for certain groups. For eviCore procedures that require prior authorization (see the "Procedures that require clinical review by eviCore" document 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 the following message, please change the procedure code to \*99222:



For dates of service on or after January 1, 2021, **TurningPoint** manages authorizations for orthopedic, pain management and spinal surgical procedures. For more information, refer to the "[Musculoskeletal procedure codes that require authorization by TurningPoint](#)" document on [ereferrals.bcbsm.com](http://ereferrals.bcbsm.com). One authorization will cover both the setting and the procedure. The facility does not need to submit a separate authorization. The ordering physician should secure the required authorization and provide the authorization numbers to the rendering facilities or providers.

**Note:** This applies to all Blue Cross commercial fully insured groups and select self-funded groups (it is being



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offered as a buy up to our self-funded population). To determine whether you need to submit prior authorization requests for Blue Cross commercial members, see “How do I know if I need to request prior authorization from TurningPoint for members who have coverage through Blue Cross commercial plans?” in the [Musculoskeletal procedure authorizations: Frequently asked questions for providers](#) document.

**14. 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.

**15. 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.

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

A: For acute care admissions, DRG facilities should request authorization for seven days or, if retrospective, the number of days the member stayed in your facility. For Non-DRG facilities, you should request 3-5 days or, if retrospective, the number of days the member stayed in your facility. 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 may be required for the additional days.

Note: Concurrent review applies only to Non-DRG facilities and UAW Retiree Medical Benefit Trust members. No concurrent reviews are required for DRG facilities or Medicare Plus Blue members.

**17. Q: Should we have extensions of admissions?**

A: Non-DRG facilities and UAW Retiree Medical Benefit Trust members require extensions to be added if the member stays beyond the original length of stay given. 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.

### e-referral System Questions

**18. 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. Wait a few minutes and then try again.



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**19. 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, you do not need to use the procedure code because the authorization is for the setting only and benefits and eligibility should be verified prior to entering the case into e-referral.

Some elective procedures require prior authorization as well as the approval of the inpatient setting (see the “Services that require authorization” list found on [this page](#))

**20. Q: Are there Questionnaires for Blue Cross commercial members like there are with Blue Care Network members?**

A: Yes, you may see questionnaires for surgical related procedures if the inpatient setting code 99222 is not used. These questionnaires will ask facilities and providers to attest that benefits and eligibility for the procedures entered have been verified.

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

A: If additional days are needed, you should submit an extension request to the original case confinement; however, if you are a DRG facility, you do not need to attach any additional clinical information. If you are a Non-DRG facility, you will need to attach clinical information that supports the request for additional days. In-state providers will be notified of the determination via the Provider Communication field in the e-referral system.

**22. 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.

**23. 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.

**24. Q: How will we find out how many days have been approved?**

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.

**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: If your facility is paid by DRG reimbursement, the entire stay is approved; however, the number of days must match the number of days the member stayed, so an extension may be required if the member stays beyond the original days approved. For Non-DRG facilities and UAW Retiree Medical Benefit Trust only the days requested are approved. Any additional days (extensions) require a concurrent review with the submission of supporting clinical information.

**26. 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

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CANCEL
PROCEED

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

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CANCEL
PROCEED

If you get an alert indicating a “potential duplicate,” and it is not a duplicate admission request, click Proceed and the request will pend for further review.



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**27. 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, email [e-referralinquiries@bcbsm.com](mailto:e-referralinquiries@bcbsm.com).

**28. 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.

**29. 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 commercial or Medicare Plus Blue members.

**30. 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.

**31. 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](http://ereferrals.bcbsm.com) and click [Sign up or Change a User](#).