e-referral User Guide

FOR BLUE CROSS® PHYSICIAN CHOICE PPO

A guide for submitting and checking the status of referral and authorization requests

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Confidence comes with every card.®

Starting Jan. 1, 2024, the Blue Cross Physician Choice PPO plan is closed for all individuals and groups. This content is intended for reference should any retroactive referrals or authorizations be necessary.

ereferrals.bcbsm.com

Dear Blue Cross Blue Shield of Michigan health care provider:

Welcome to e-referral (also known as CareAdvance Provider), Blue Cross and BCN's system for submitting and managing your referrals and authorizations electronically.

To get up and running on the e-referral application, you must have a Blue Cross Provider Secured Services ID and password. Some still refer to it as a web-DENIS ID, but Provider Secured Services provides access to all Blue Cross and BCN secured provider sites, including e-referral. All e-referral users in your office must have their own Provider Secured Services ID and password to log in to e-referral. Here's how to sign up:

1. Go to **ereferrals.bcbsm.com**
2. Click on the ***Sign Up or Change a User*** link and follow the instructions

Please note, if you work with a medical care group that handles referral and authorization requests, continue to follow your procedures for your medical care group.

Some services **do not** require a referral:

- Services from nurses, urgent care, walk-in clinics and chiropractors.
- Services from pathologists, anesthesiologists, radiologists, emergency (PARE) providers. They will be covered at the cost share level associated with the members' primary care physician.
- When a member is admitted to the emergency room. If the member is admitted to the hospital that coincides with an emergency room visit, services will pay at the cost share level of the member's primary care doctor selection.
- Women's services provided at an obstetrician-gynecologist are covered at the cost share level associated with the members' primary care doctor.
- Services from out-of-state providers. They are covered at the cost share level associated with the members' primary care doctor.

We welcome your suggestions on how we can make this and our other referral resources more helpful. Our goal is to make submitting and checking on referrals as easy as possible. You may send your recommendations to **providertraining@bcbsm.com**.

If you have technical concerns, call the Web Support Help Desk at 1-877-258-3932.

I would also like to suggest that each time you visit e-referral, stop by the welcome page at **ereferrals.bcbsm.com** to read recent news and get the latest updates for your staff. This site has a comprehensive collection of resources to assist you. Thank you for supporting our efforts to make referrals quick and easy.

Donna W. LaGosh

Donna W. LaGosh, Director
Provider Outreach

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Section I: Checking Member Eligibility and Benefits

You can access **both** e-referral and web-DENIS in one location. Just log in to Provider Secured Services and select web-DENIS to check member eligibility and benefits, or e-referral for referrals and authorizations. See the *Accessing e-referral* section in this guide for login instructions.

Before searching or selecting a member in e-referral, it's important to check their eligibility and benefits information to ensure their coverage is active. You can check eligibility and benefits in:

- web-DENIS
- Provider Inquiry's automated response system or speaking to a Provider Inquiry representative
- 270/271 electronic standard transaction
- Provider Inquiry

For more information, see the Patient Eligibility chapter of the BCBSM Provider Manual (available on web-DENIS within *BCBSM Newsletters and Resources* under the *Provider Manual* page).

To check via web-DENIS, log in to Provider Secured Services. Choose web-DENIS.
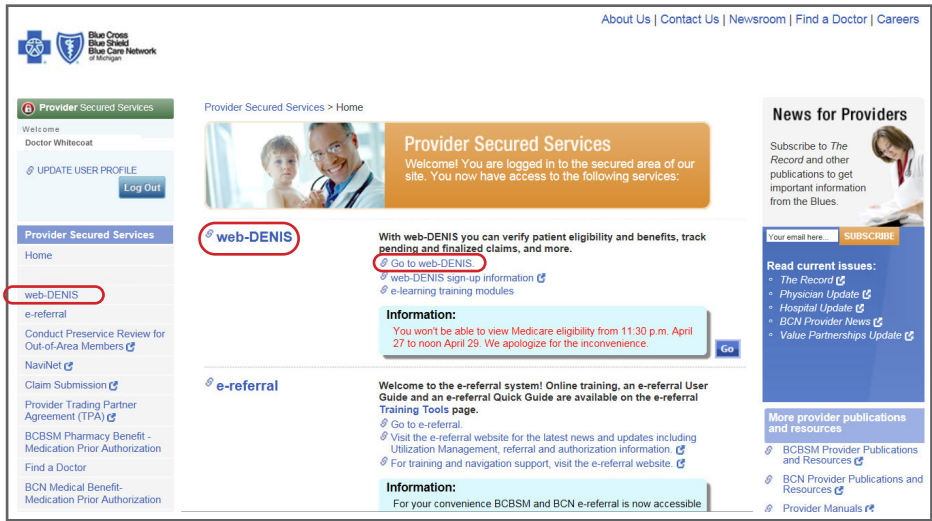
Choose Subscriber Info.
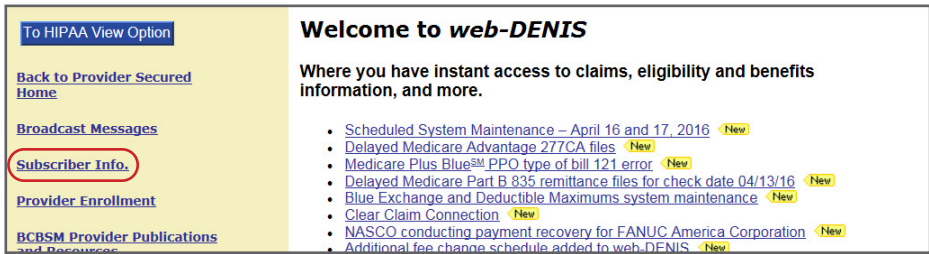
Checking member eligibility and benefits, cont.

Choose Eligibility/Coverage/COB
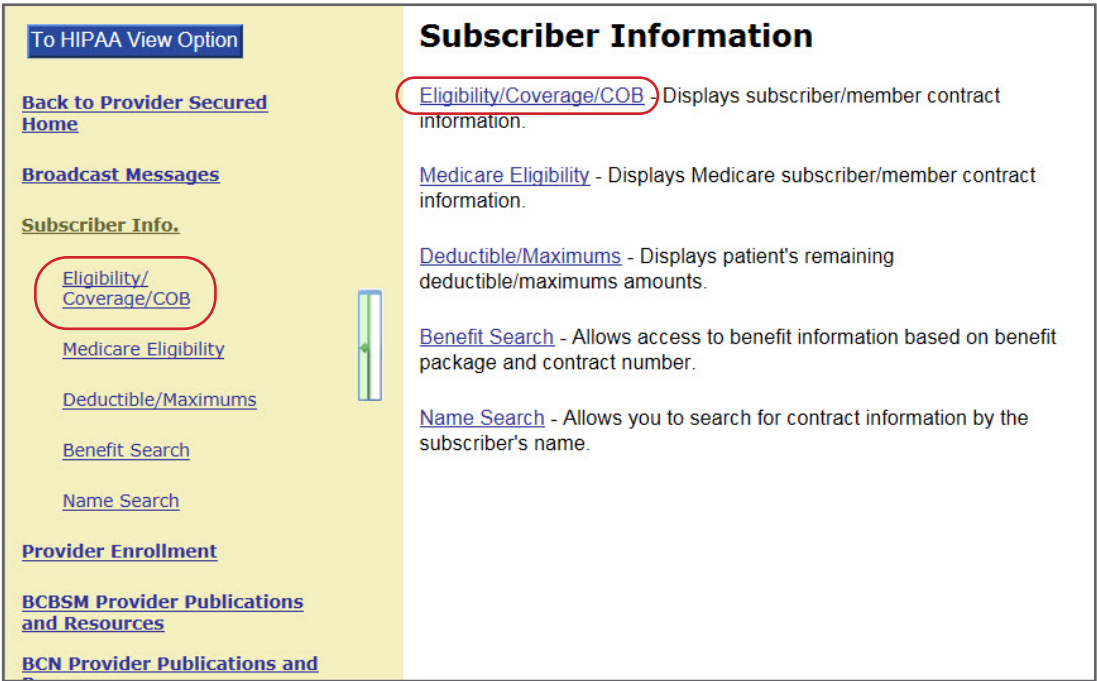
Enter the member's Contract Number, select the Line of Business button and click Enter.
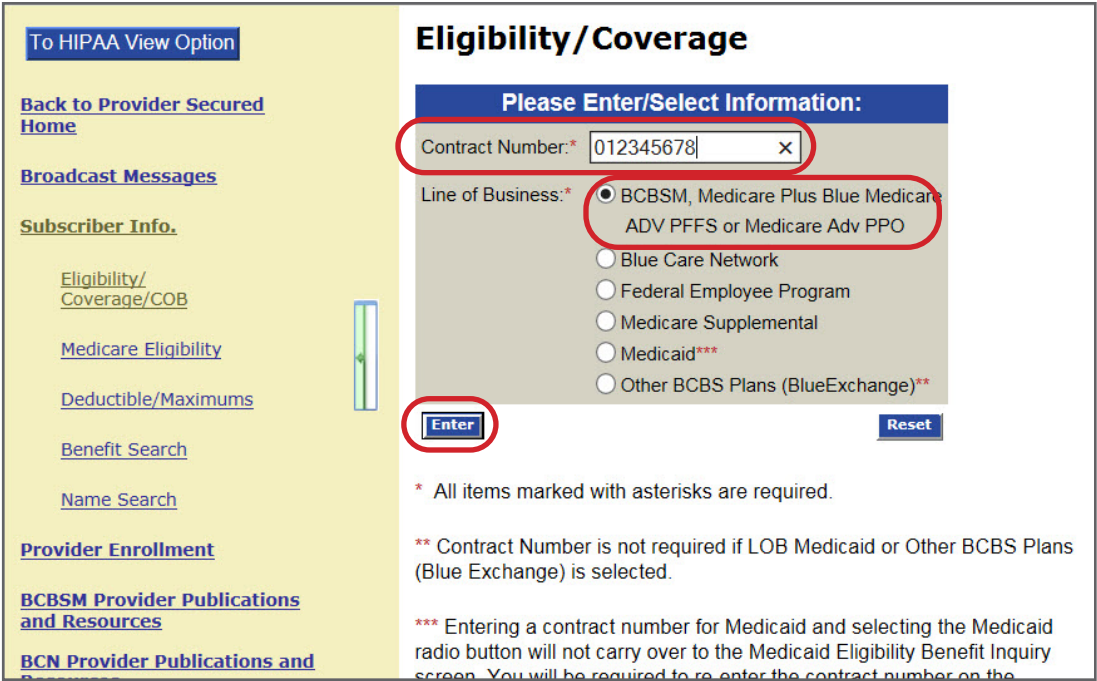
Checking member eligibility & benefits, cont.

The member's eligibility/coverage page includes several items to look for:

1. The member's product type is Physician Choice PPO
2. Make sure they have Active eligibility. Click MED under Detailed Benefits.
3. Physician Choice PPO product message to users
4. Member hyperlink to view primary care doctor information (see the next page)

Checking member eligibility and benefits, cont.

Clicking on the member's name will bring up their primary care doctor information. You may see Current PCP information, only Historical PCP information (up to the last two years), or both.

1. The member's product type is Physician Choice PPO
2. Next Contract – redirects user back to Contract input page
3. Eligibility Info – redirects user to Eligibility Information page
4. PCP Name – Redirects user to the **bcbsm.com** Find a Doctor page
5. End Date – Displayed as CURRENT for current day and beyond

Screen with **both** current PCP information and historical PCP information:

Screen with **no** current PCP information, **only** historical PCP information:

Checking member eligibility & benefits, cont.

Please note any product-specific messages/warnings posted under the member's information:

Identifying members that live outside the market area

Under the "Level 1 Exemption" column, there are three scenarios you may see:

- "Yes" only indicates that the member is living outside the market area and qualifies for Level 1 cost sharing.
- "Yes" plus a date range indicates that the member is in a Level 1 provider movement exemption and qualifies for Level 1 cost sharing during this time period. A Level 1 provider movement exemption is triggered when a member's selected Level 1 primary care doctor:
  - Changes OSCs (including Level 1 to Level 1)
  - Is no longer participating in the PPO network
  - Becomes a specialist

During this time, the member will receive Level 1 cost share for all services performed within the PPO network. The member will receive a letter in the mail and a message in the Member Portal notifying them of the provider movement exemption. At the end of the exemption period the member's cost share will again be determined based on the current primary care doctor selection.

- A "Yes" by itself plus a "Yes" with a date range. This means the member lives outside the network region and is exempt from all product rules and also in a Level 1 provider movement exemption. They are eligible for Level 1 cost sharing.

For more information on cost share levels, please visit **bcbsm.com** and click *Plan Documents and Forms* (under *Help*), *Physician Choice PPO* (under *Browse by Plan Type*).

Checking member eligibility and benefits, cont.

A member in the Grace Period exemption and eligible for Level 1 Cost Share:

> "Yes" indicates this Physician Choice PPO member is in a Level 1 provider movement exemption and is eligible for Level 1 Cost Share, the lowest out-of-pocket costs, during this time period.

> Here, this Physician Choice PPO member lives outside the market region and is exempt from all product rules. The member is eligible for Level 1 Cost Share, the lowest out-of-pocket costs.

A member that lives outside the market area **and** is in the provider movement exemption, eligible for Level 1 Cost Share:

Checking member eligibility & benefits, cont.

Display cost-share accumulators and remaining at a member and contract level

You can view the member's deductible and copay information by clicking the Deductible/Maximums button within the member's contract:

or choose the Deductible/Maximums button under the Subscriber Info option on the left and enter their contract number:

Then click their name.

Checking member eligibility and benefits, cont.

Display cost-share accumulators and remaining at a member and contract level

Depending on the member's benefits, the contract may show one or two rows for coinsurance.

Coinsurance is a percentage of the cost of a service that the member is responsible for paying. A coinsurance maximum provides a maximum dollar amount that the member will pay for coinsurance. Once the coinsurance maximum is reached, the member will no longer pay coinsurance for the rest of the benefit year, with the exception of certain services that are exempt from the coinsurance maximum.

Checking member eligibility & benefits, cont.

To continue checking benefits, click MED under Detailed Benefits.

Depending on the member's benefits, a pop-up window will appear launching Benefit Explainer or NASCO Benefits.

Benefit Explainer
Click Benefits.

Checking member eligibility and benefits, cont.

Under the Benefit Package Report tab, click Search to see a list of General Topics that display In Network and Out of Network coverage.

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The existing Explainer Benefit Package Report Dollar Value Summary has been enhanced to display Benefit Levels.

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A NASCO Benefit window will ask you to choose a Provider type and then the benefits information will show.

Section II: Accessing e-referral

Welcome to e-referral (also known as CareAdvance Provider).

For optimal e-referral performance, make sure your computer meets the following minimum requirements:
- Computer processor: computer with a 3.3 GHz Intel Core i3 processor or higher (or comparable)
- 4 GB memory (RAM)
- 10 GB hard drive space
- Monitor able to display 1024x768 pixels or higher
- Browser requirements: Microsoft Internet Explorer 9.0, and the latest versions of Firefox and Google Chrome

Keep your account active
If you already have a Provider Secured Services username and password, skip to the Log in instructions below. If you are new to e-referral, complete the Provider Secured Services application process and access the account immediately to set up your password after you receive your account information. After that, you should use it at least monthly to keep your account active. If your account becomes disabled, you will have to call the Web Support Help Desk at 1-877-258-3932 to get it reactivated.

Log in
Now you are ready to use e-referral. Just log in to Provider Secured Services and select e-referral. You can find the link to Provider Secured Services two ways:
1. Go to **bcbsm.com/providers** and click LOGIN. Make sure Provider is selected, then type in your username and password.
2. You can also access it by logging in at the top of **ereferrals.bcbsm.com**.

Log in to e-referral via Provider Secured Services.

Enter your ID – the same as your web-DENIS ID.
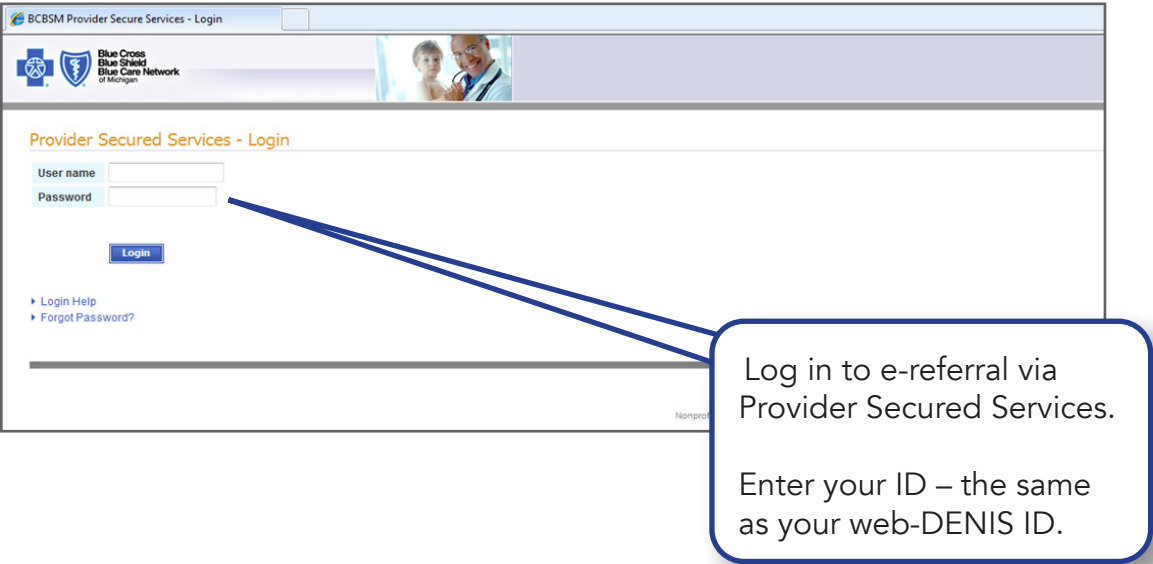
Accessing e-referral, cont.

If you experience any login issues, please contact the Web Support Help Desk at 1-877-258-3932.

The e-referral User Guide is available in full color in Adobe PDF file format on the e-referral home page at **ereferrals.bcbsm.com**. You can refer to it or download it as needed. It can be opened, viewed and printed using the Adobe Acrobat Reader® available free at **get.adobe.com/reader****.

Once Adobe Reader is installed on your system, the PDF file will automatically open and display the document. Depending on the type of Internet connection and the computer hardware you have, the file will open in a matter of seconds or a few minutes.

This e-referral User Guide can be downloaded to your hard drive. Just right-click on the link to the document and select "Save Target As" from the menu. Choose a location on your computer and select "Save." If you save it to your hard drive or print a copy, be sure to check back for updates. The date the publication was last updated is shown at the bottom of each page.

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After logging in, click any of the e-referral links.
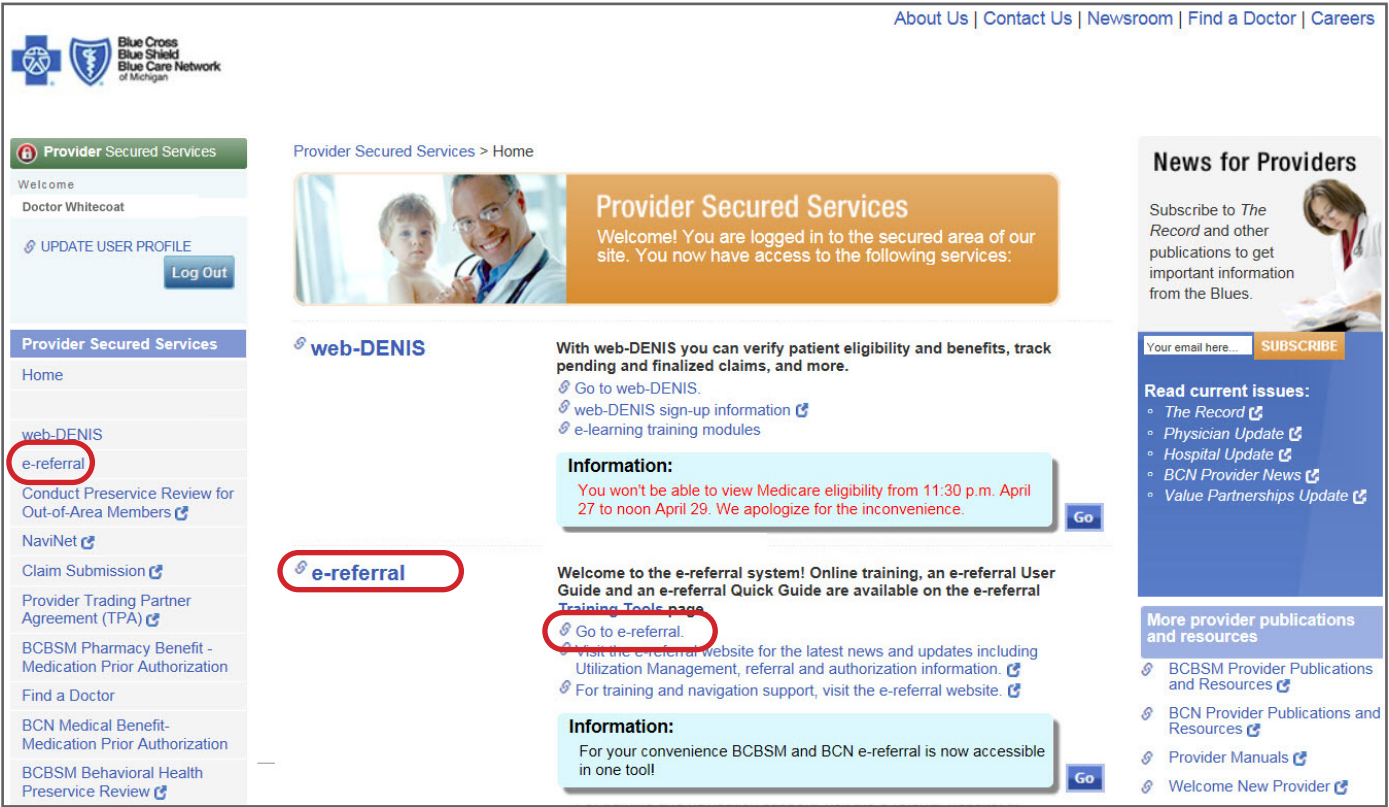
Section III: Navigating the Dashboard

Once you have logged into Provider Secured Services and selected e-referral you will be directed to a provider dashboard home page. The home page will default to the first provider in the list of providers for whom you have permission to view and submit referrals.

The list you see is a quick list of all your open cases that have been added or updated in the last 60 days. You can sort these cases by heading (Action items, Reference ID, Patient, From or To dates, Servicing Provider, Description, Status, Case Communication or Attachments). If you have many open cases, you may have to search through several pages to locate a specific one.
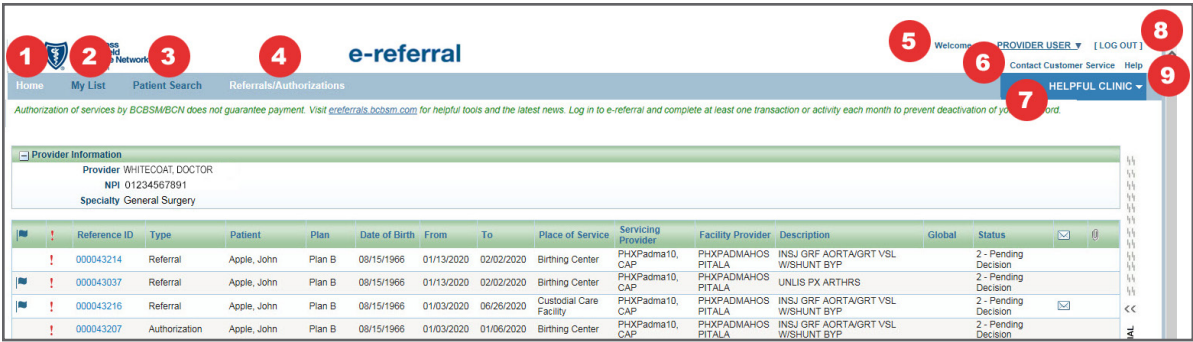
1. **In Focus** — The Provider In Focus bar is located at the top right of the screen. See the next page for more detail.
2. **My List** — This will display only the referrals and authorizations you have flagged to watch. Cases can be "unflagged" (checked) to remove from your My List. See the next page for more detail.
2. **Home** — The "Home" link returns you to the provider "dashboard" for the provider "In Focus".
3. **Patient Search** — The Patient Search link allows you to search for a member and view eligibility. NOTE: Rather than using this feature, Blue Cross recommends that you search for eligibility and benefit information in web-DENIS prior to referral or authorization activities. See the ***Checking member eligibility and benefits*** section in this guide for more information.
4. **Referrals/Authorizations** — You can search for or submit referrals or authorizations here.
5. **Logged in user name** — The logged in user's name is found in the upper right hand corner of the screen. The user's name includes a drop down menu of Bookmarks and Templates. See the ***Bookmarks*** and ***Templates*** sections in this guide for more detail.
6. **Log Out** — Click here to log off the application.
7. **Help** — A CareAdvance Provider online help resource center. If the question is Blue Cross-specific, please use this guide instead.
8. **Contact Us** — Key Blue Cross and BCN contact information can be found here.
9. **Site Tutorial** – The tutorial provides answers to questions you might have about working with patient information, referrals and authorizations, or any number of frequently asked questions. Check **ereferrals.bcbsm.com** for an FAQs document as well.

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In the Home page view, you can change the provider shown in the In Focus bar.

> In Focus bar
> Click the ▼ to expand the Provider information (see the next page for an expanded view)

The In Focus bar will default to one of the providers you have been provisioned to view or for whom you can submit referrals/authorizations. If you do not see a provider that should be in your Provider Set list, please fill out the **Request for Group ID Changes (PDF)** form found on **ereferrals.bcbsm.com** at the bottom of the **Sign Up or Change a User** page.

Use the In Focus bar when you are performing multiple case submissions for one patient. Here, you can change the provider "In Focus" to another provider for whom you are privileged to submit and view referral/authorizations.

The My List link will display only the referrals and authorizations you have flagged to watch. To remove a case from your My List, check the case then click the Remove Selected Rows button. You will see a prompt asking you if you are sure you want to remove the row from our list. Click OK or Cancel.

Navigating the dashboard, cont.

<u>Provider In Focus:</u> You will only have access to submit referrals for providers for whom you are provisioned to do so.

Clicking on the change link allows you to choose from your list of provider sets.

When searching for an associated provider, you can choose from Practitioner, Provider Group or Facility for a more accurate provider entry.

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The Authorizations and Referrals Dashboard is located below the Provider Information section of the main dashboard. The list you see is a quick list of all your open cases that have been added or updated in the last 60 days. You can sort these cases by heading (Action items, Reference ID, Patient, Plan, From or To dates, Servicing Provider, Description, Status, Case Communication or Attachments). If you have many open cases, you may have to search through several pages to locate a specific one.

1. **Flagged records** — These are the referrals and authorizations you have marked for follow up or watching.
2. **!** — This symbol indicates there is some action you must take to complete the case.
3. **Reference ID** – This is the case number for the requested or authorized service.
   Click the number to bring the case details into view.
4. **Type** — Authorization or referral.
5. **Patient** — The patient's name.
6. **Plan** — Indicates if it is a Blue Cross or BCN contract.
7. **Date of Birth** — The patient's date of birth.
8. **From** and **To** — These are the dates the referral/authorization covers.
   From = start date of the referral/authorization; **To** = end date of the referral/authorization.
9. **Place of Service** — Location where service(s) will be provided.
10. **Servicing Provider** — Name of provider performing the patient's service(s).
11. **Facility Provider** — Facility that provided the service(s).
12. **Description** — Captures the primary service on the request.
13. **Global** — A check mark indicates a global referral has been made.
14. **Status** — Here you will see one of the following messages:
    1. – Incomplete   4. – Partially Approved
    2. – Pending Decision 5. – Denied
    3. – Fully Approved   6. – Voided
15. ✉ — This icon indicates there is a message from Blue Cross to you on this case.
16. 📎 — This icon indicates that there is an attachment/documentation associated with this case.
17. **Site Tutorial** — The tutorial provides answers to questions you might have about working with patient information, referrals and authorizations, or any number of frequently asked questions. Check **ereferrals.bcbsm.com** for a **Blue Cross FAQs** document under the **Training Tools** page as well.

Section IV:
Searching for a Referral or Authorization

Before submitting a referral or authorization, you will be prompted to search for a member. Locating the patient's name prevents reentering information each time you conduct a search or submit a referral or authorization.

Note: If you are a primary care doctor, you will be excluded from viewing behavioral health authorizations and referrals for patients. This assures that privacy regulations around handling sensitive information are not violated.

Searching for a referral, cont.

When you select the Search option, you have the following functions:

You can search by **Reference ID**

A Reference ID is the case number assigned to a specific patient or service. Your results will only contain specific referrals that you are allowed to see. *Indicates a required field.

You can search by **Provider ID (National Provider ID)**

A Provider or Facility ID is the 10-digit National Provider ID assigned to the provider performing the patient's service(s). You must know the NPI in order to search by Provider or Facility ID. Your results will only contain specific referrals/authorizations that you are allowed to see.

Searching for a referral, cont.

You can also choose specific providers among the list of associated providers, in addition to the provider in focus, or you can choose "all." Click the blue button to select other providers.

Under both the Provider ID and Patient tab, you will see a Type drop-down menu. Here, you can select All, Authorization, Referral or Incomplete. It is recommended you choose All for better search results.

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You can search by **Patient**

Here, you can enter the Patient ID (if known) or use the 'Select' link. This will allow you to search by the Patient ID or name in conjunction with other criteria. To locate ALL referrals/authorizations for a patient, remove both the From and To dates. For more specific results, delete only the "To" date.

Checking the All Cases box will show:
- Any case (except behavioral health) the member has in the e-referral system. This includes cases outside your provider set.
- A case you cannot locate under the NPI.
- A specialty medical drug prior authorization for a case you're not associated with.

Once the All Cases box is checked, you will see all the member's cases (excluding behavioral health).

Click the Reference ID to view the case details.

> **NOTE TO FACILITY PROVIDERS:** Since July 31, 2017, select surgical procedures that required authorization and were previously entered in the prenotification system should now be submitted in e-referral. Please use the Submit Inpatient Authorization option from the Referrals/Authorizations drop-down menu. See the *Submitting an inpatient authorization* section of this guide for instructions.

Searching for a referral or authorization, cont.

Searching for a temporary member
When searching for a temporary member, such as a newborn that is not assigned to a contract number yet, use the Reference ID. Do not search by a contract number.

1

Select the Search option.

2

Search by Reference ID. A Reference ID is the case number assigned to a specific patient or service.

3

The Date of Birth indicates a newborn.

4

Do not search by a contract number since a temporary member will not show on the contract yet. In this example, only the father appears in the results after entering the contract number and clicking Select.

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Searching for a terminated member

When searching for a member that has been terminated, start your search with the Patient ID.
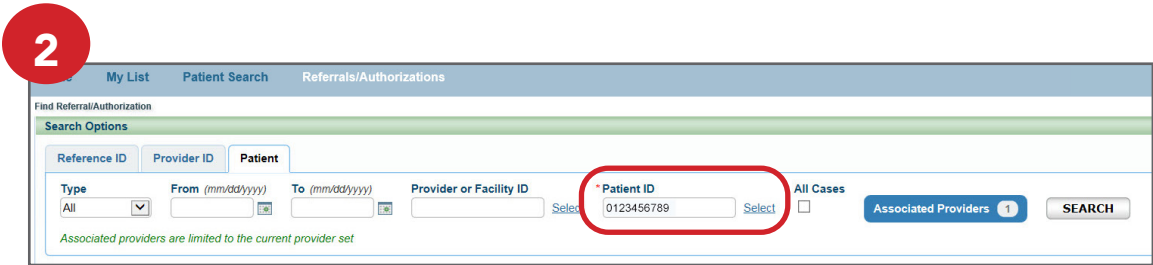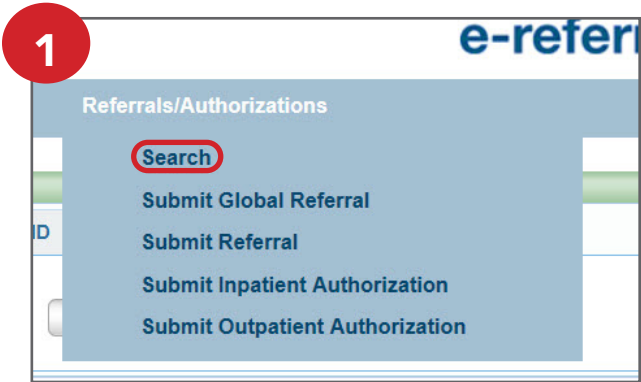
Click Select after entering the Patient ID.
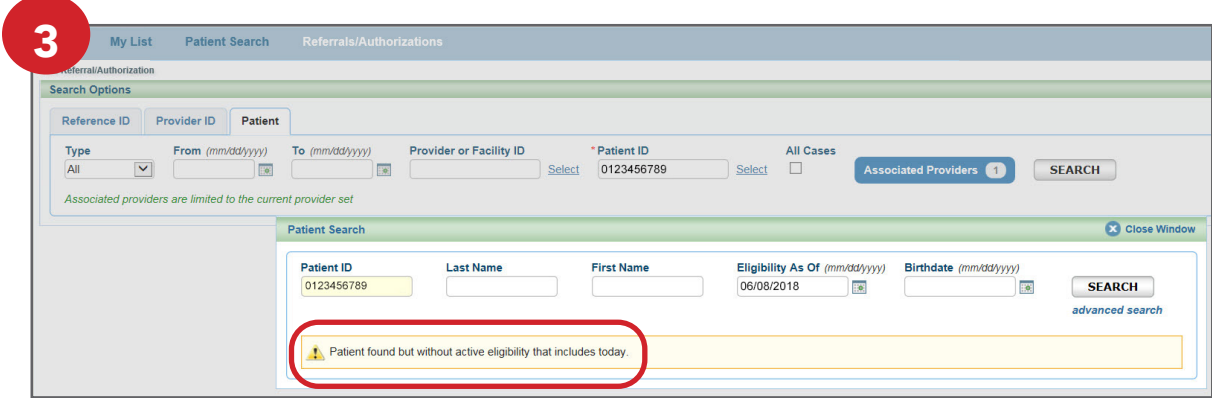
The Eligibility As Of field will default to the current date. Change the date to the date of service (date prior to termination) to locate the terminated member.
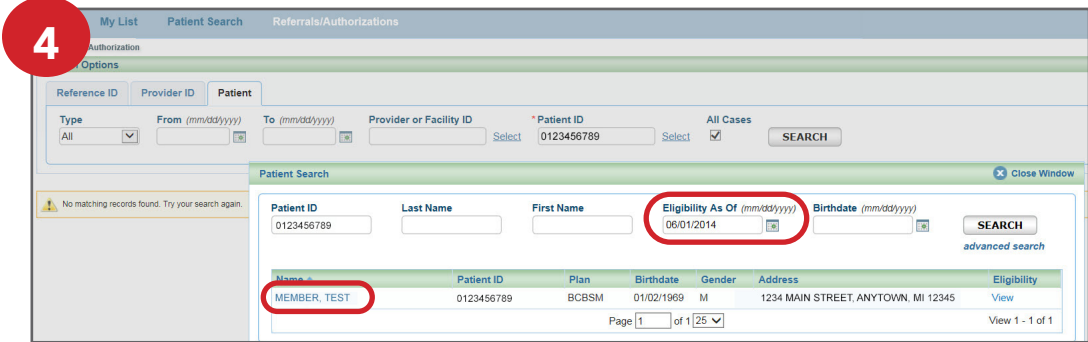
The terminated member appears when the Eligibility As Of date is changed to a date prior to their termination.

Searching for a referral or authorization, cont.

Searching for a terminated member, cont.

Click the Associated Providers option and select all providers by checking the check box next to Provider Name. This allows you to search for cases that are not assigned to you but opened to another provider in your provider set. Click Search.
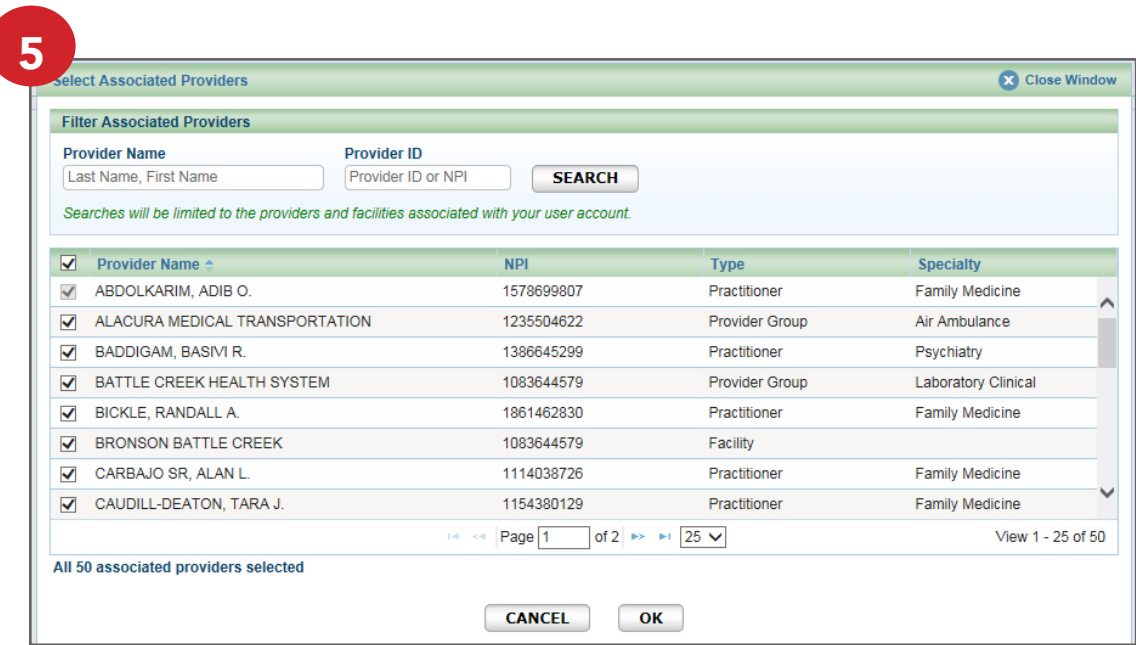
Check the box under "All Cases." This allows you to search for cases that may not be loaded into your provider set. Note: behavioral health cases will not be viewable.
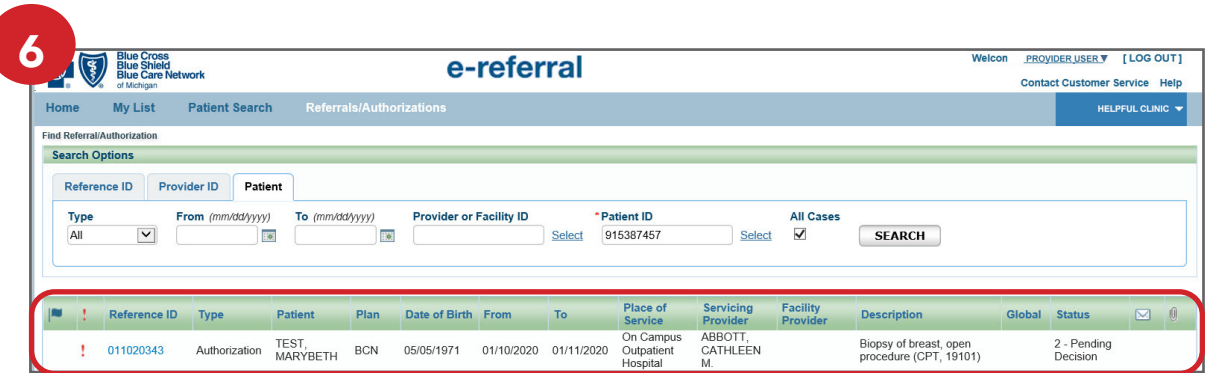
Section V: Submitting a Referral

When you submit a referral in the e-referral system for Physician Choice PPO members, it determines the member's out-of-pocket costs. Unlike BCN referrals, it doesn't determine approval or denial of services. To determine approval or denial of services, please submit an authorization. See the *Submitting an inpatient authorization* section of this guide for instructions.

To start your Referral submission, choose Submit Referral from the Referrals/Authorizations drop-down menu.
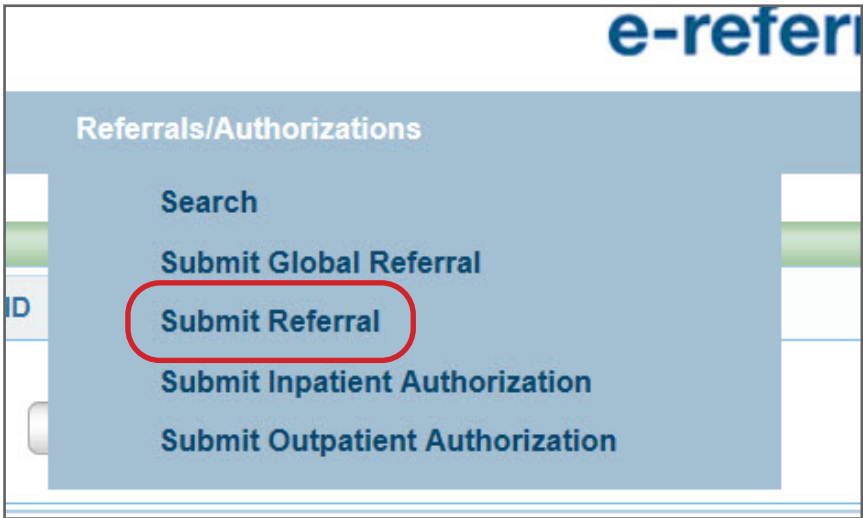
Note: Please do not use the Submit Global Referral option or you will receive an error message. You must start over using the Submit Referral option.
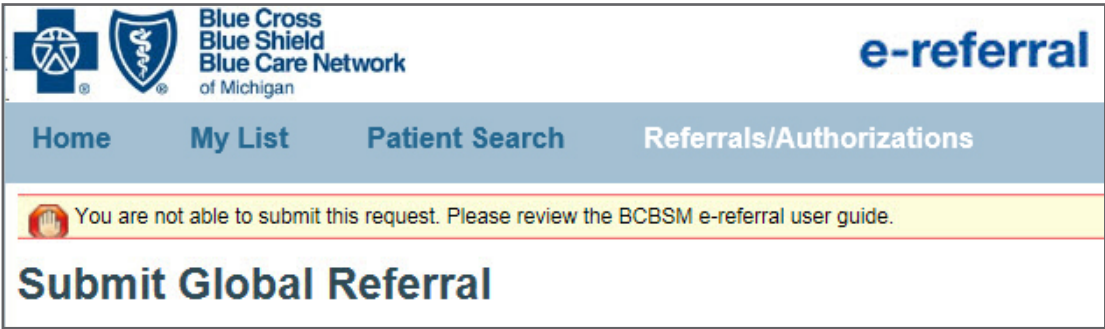
You will first be prompted to first search for a patient. You can search by Patient ID, Last Name/First Name **and** Birthdate (all required), Eligibility As Of (with Last Name/First Name or Patient ID) or click Advanced Search for more options. Choosing Birthdate also requires a partial last name **and** first name or the entire Subscriber ID. Click the Search button to view the results.

Submitting a referral, cont.
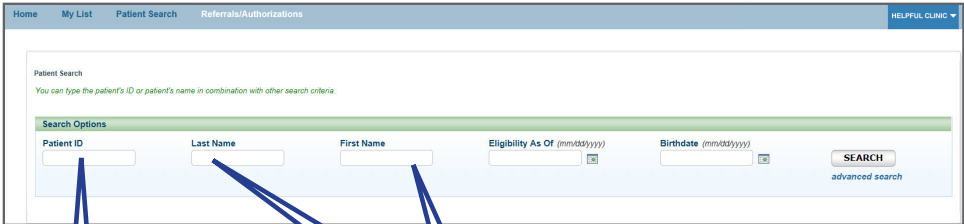
> Enter the patient's ID here. This is the patient's ID number minus the alpha prefix found on the front of their BCBSM identification card.

> Enter the patient's last name **and** first name or first name initial.

Once your patient is selected, complete all the required fields (indicated with *) on the Submit Referral screen. **Note:** You must be the member's primary care doctor in order to submit the referral or you will see an error message:
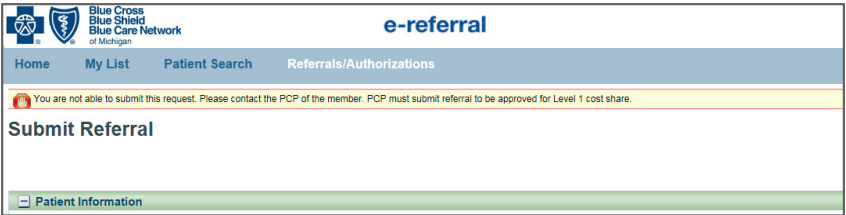
Service From/To. Enter the beginning date and end date of the referral.
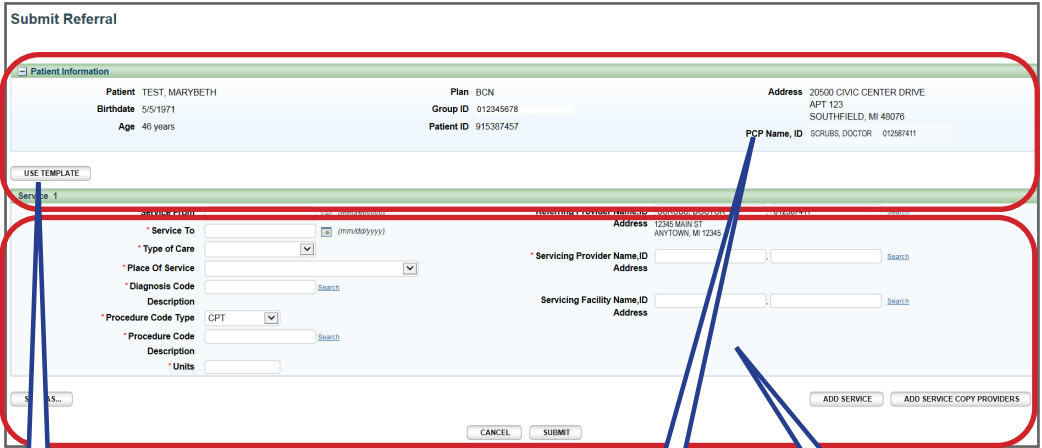
Use Template
You can use a template previously created from this screen. Please see the *Templates* section of this user guide for more information.

Patient information
This section includes the patient's information, primary care doctor name and NPI displayed, if available.

Service 1 section
Enter the case information here.

Submitting a referral, cont.

- **Type of Care**. The type of care values are specific to where the member originated for the service. These definitions will help when selecting a value in e-referral:

Direct — Use only to document inpatient admissions where the patient was admitted directly from a provider office or institution but bypassed a stay in the emergency room.

Elective — Typically selected for any planned services such as surgeries or treatments inpatient or outpatient.

Emergency — Member presented to the emergency room and was referred for care in another setting such as inpatient hospitalization or outpatient surgery.

Transfer —Member was transferred from another medical setting for the service being requested (e.g. member transferred from Skilled Nursing Facility to inpatient hospital for care).

Urgent — Member was transferred from urgent care setting for the service being requested (e.g. member seen in urgent care and sent to specialist for treatment of a condition).

- **Place of Service**
  You will see several options to choose from in the drop-down menu.
  Referrals routinely use Office for Place of Service:

Ambulance - Air or Water	Independent Laboratory
Ambulance - Land	Nursing Facility
Ambulatory Surgical Center	Off Campus Outpatient Hospital
Custodial Care Facility	Office
Emergency Room	On Campus Outpatient Hospital
End-Stage Renal Disease Treatment	Other Unlisted Facility **(do not use)**
Facility	Telehealth **(do not use)**
Home	Urgent Care Facility

- **Diagnosis Code**
  If a diagnosis code is unknown, you can search for it by a partial (or full) code number or English description. E-referral will search your bookmarks first and if no results are found, use the Search link. Under the Search link, you can look for codes by number, description (see below) or in your saved Bookmarks (please see the next page). For instruction on how to bookmark codes, please see the *Bookmarks* section.

Submitting a referral, cont.

- ○ **Diagnosis Code** – Search by **Description.** Choose an active code. Click on the code's link to populate the Diagnosis Code field for your Referral submission.

- ○ **Diagnosis Code** – Search by **Bookmarks**
  Select a diagnosis code from the list of your saved bookmarks.
  For more information on Bookmarks, please see the *Bookmarks* section.

- **Procedure Code Type**
  Select CPT or HCPCS. (CPT is default)
  CPT = American Medical Association's Current Procedural Terminology
  HCPCS = Healthcare Common Procedure Coding System

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Submitting a referral, cont.

• **Procedure Code**
If a procedure code is unknown, you can search for it by a partial (or full) code number or English description. E-referral will search your bookmarks first and if no results are found, use the Search link. Under the Search link, you can look for codes by number, description (see the next page) or in your saved Bookmarks (see the next page). For instruction on how to bookmark codes, please see the *Bookmarks* section.

o **Procedure Code** – Search by **Description.** Choose an active code.
Click on the code's link to populate the Diagnosis Code field for your Referral submission.

o **Procedure Code** – Search by **Bookmarks**
Select a procedure code from the list of your saved bookmarks.
For more information on Bookmarks, please see the *Bookmarks* section.

Submitting a referral, cont.

• **Units**
Enter the number of requested units here.

• **Referring Provider Name, ID**
Here, you can search for providers that you are provisioned to view. The Referring Provider must match the primary care doctor submitting the referral.

• **Servicing Provider Name, ID**
Enter the provider's name or NPI if known. Only those saved in your Bookmarks will display. Use the Search to locate a servicing provider by partial/full name, NPI, city, state, etc. You can also choose from your saved Servicing Providers in the Bookmarks tab.

Submitting an inpatient authorization, cont.

- **Servicing Provider Name, ID**
A provider may be listed multiple times – make sure to choose the correct one
Your provider search results may include several listings with the same name, NPI or address. The first listing is not always the correct one. In order to choose the correct provider, please follow these guidelines:

1 First, you must select the listing based on <u>where</u> the member is going to see the provider. In this example, the provider has the same NPI but different address locations.

2 If the provider has several listings with the same address, you must select the listing with the correct group affiliation.

3 **Note:** Not all provider addresses will be considered in network. If you select a listing that shows the provider is out of network, your submission will then have to go through an out-of-network review. For BCN commercial and BCN Advantage members, you will have to complete the **out-of-network providers questionnaire**.

Submitting a referral, cont.

- **Servicing Facility Name, ID**
When issuing a referral for a hospital-based group, please enter the facility NPI in the Servicing Facility ID field. A list of hospital NPIs is available on **ereferrals.bcbsm.com** under **Provider Search**.

- **Add Service/Add Service Copy Providers buttons**
We encourage providers to always use the these buttons to avoid re-entering provider data. The Add Service button is found on the bottom right of the Submit Referral screen. Click this to add an additional service if needed. You can add up to 10 procedure codes. The Add Service Copy Providers button is also found on the bottom right of the Submit Referral screen. Click this to add an additional service and any providers you have input in the Servicing Provider fields in Service 1 will be automatically duplicated in Service 2.

Once finished, click Submit to process or Cancel to delete without processing.

Submitting a referral, cont.

Once finished, click Submit to process or Cancel to delete without processing.
After you have submitted the referral information, your submission will look like this:

1. Reference ID and case status ▶
The check mark indicates you have successfully submitted or updated a referral.
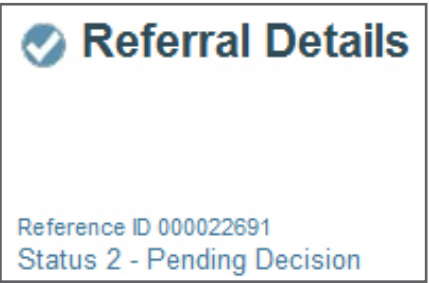
2. My List
Check this box to watch this referral. A flag icon will be shown next to it on the My List page.

3. Printer-Friendly
Click this to print your referral to a Referral Request Confirmation PDF file.

4. Edit
Click here to return to your referral submission to extend the dates.

5. Create New (communication) – preferred
This feature allows you to create a communication to Blue Cross on this referral case. Blue Cross will review the communication and respond in a timely manner. You can add an attachment to the communication. See the next page for more details.

6. Create New (note)
Creates a simple note to Blue Cross on this referral case (for example, person submitting, contact info).

7. New Referral/Global Referral/Inpatient/Outpatient
Use the New Referral button to create multiple cases for one patient.

Submitting a referral, cont.

Create New (communication)
To attach clinical information (both initial clinical and continued stay or discharge information) to the request in the e-referral system, click the Create New button in the Case Communication field.

In the dialog box that opens, enter a subject and your message. Fields marked with an asterisk are required. Click Attach File. Locate the document in your files and double-click so they upload. File formats accepted include: .bmp, .doc, .docx, .gif, .jpg, .pdf, .png, .ppt, .txt, .xls and .xlsx. Maximum file size is 10 MB. **Please ensure your file name does not contain any special characters or symbols as you will receive an error message.** In the dialog box, check off the items to be reviewed. Click Send.

The dialog box closes. You'll be able to see your attached documents after clicking the Subject link. **Note:** do not attach files to any denied requests.

You may also see an envelope icon with a blue dot in the Case Communication field. This icon indicates there is an unread message from Blue Cross to you on this case. Once you read the message, the blue dot disappears. You may choose to change it back to unread by clicking the envelope icon.

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Section VI: Submitting an Inpatient Authorization

Authorizations are not impacted by the Physician Choice PPO product and remain **required** for certain services in order to determine approval or denial. Use Submit Inpatient Authorization for all inpatient services. An inpatient authorization may also be referred to as precertification or recertification.

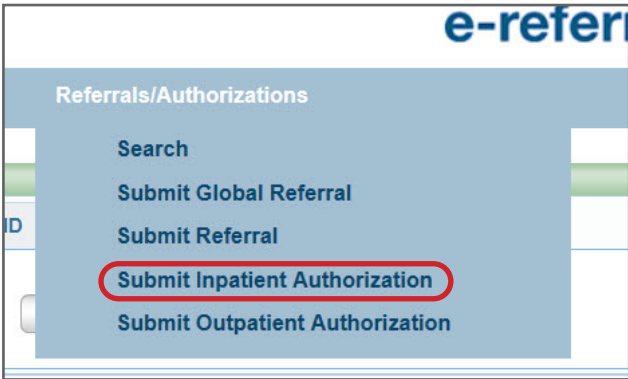> **NOTE TO FACILITY PROVIDERS:** Since July 31, 2017, select surgical procedures that required authorization and were previously entered in the prenotification system should now be submitted in e-referral. Please use the Submit Inpatient Authorization option from the Referrals/Authorizations drop-down menu.

When you submit an Inpatient Authorization, you will first be prompted to search for a patient. You can search by Patient ID, Last Name/First Name **and** Birthdate (all required), Eligibility As Of (with Last Name/First Name or Patient ID) or click Advanced Search for more options. Choosing Birthdate also requires a partial last name **and** first name or the entire Subscriber ID. Click the Search button to view the results.
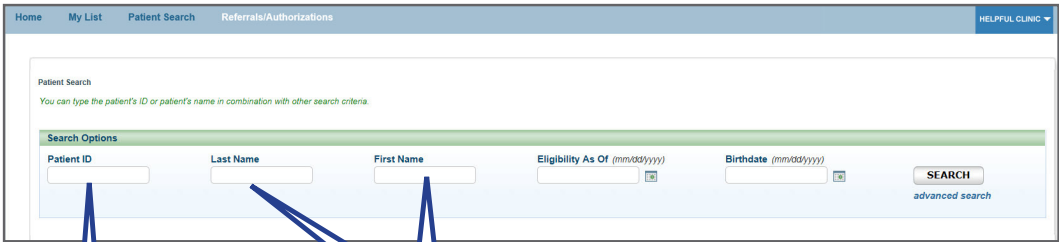
Enter the patient's ID here. This is the patient's ID number minus the alpha prefix found on the front of his or her the identification card.

Enter the patient's last name **and** first name or first name initial.

Submitting an inpatient authorization, cont.

Once your patient is selected, complete all the required fields (indicated with *) on the Submit Inpatient Authorization screen.

- **Admission Date**
Select the admission date from the calendar.

- **Length of Stay**
Enter the length of stay in days. Refer to **ereferrals.bcbsm.com**, select **Blue Cross** at the top, then click the **Authorization Requirements & Criteria** in the left navigation to find guidelines for length of stay entry.

- **Type of Care**. The type of care values are specific to where the member originated for the service. These definitions will help when selecting a value in e-referral:
Direct — Use only to document inpatient admissions where the patient was admitted directly from a provider office or institution but bypassed a stay in the emergency room.

Elective — Typically selected for any planned services such as surgeries or treatments inpatient or outpatient.

Emergency — Member presented to the emergency room and was referred for care in another setting such as inpatient hospitalization or outpatient surgery.

Transfer —Member was transferred from another medical setting for the service being requested (e.g. member transferred from Skilled Nursing Facility to inpatient hospital for care).

Urgent — Member was transferred from urgent care setting for the service being requested (e.g. member seen in urgent care and sent to specialist for treatment of a condition).

- **Place of Service**
Select from Custodial Care Facility, Inpatient Hospital, Inpatient Psychiatric Facility, Psychiatric Residential Treatment Center, Residential Substance Abuse Treatment Facility, or Skilled Nursing Facility.

Submitting an inpatient authorization, cont.

- **Primary Diagnosis Code**

This is the code of the patient's condition. If a diagnosis code is unknown, you can search for it by a partial (or full) code number or English description and click Search. You can also choose a diagnosis code from any saved under the Bookmarks tab.

- o **Diagnosis Code** – Search by **Description.** Choose an active code.
  Click on the code's link to populate the Diagnosis Code field for your Inpatient Authorization.

- o **Diagnosis Code** – Search by **Bookmarks**
  Select a diagnosis code from the list of your saved bookmarks.
  For more information on Bookmarks, please see the **Bookmarks** section.

Submitting an inpatient authorization, cont.

A primary procedure code is required for all medical and obstetrical entries. Please use a CPT code in these ranges for *medical* entries:

Urgent/Emergent Admissions *99222**	Initial and Consultation Service *99477 – *99480
Inpatient hospital care *99221 – *99239	Inpatient Neonatal and Pediatric Critical Care Services
Inpatient Consultation *99251 – *99255	*99466 – *99482
Critical Care Services *99291 – *99292	Inpatient medical rehab *97150
Newborn Care Services *99460 – *99465	Skilled Nursing Facility *99304 – *99306

- **Procedure Code Type**
  Select CPT, HCPCS, ICD9 (for retro entries prior to 10/1/2015) or ICD10. (CPT is default) CPT = American Medical Association's Current Procedural Terminology HCPCS = Healthcare Common Procedure Coding System

- **Primary Procedure Code**
  If a procedure code is unknown, you can search for it by a partial (or full) code number or English description. E-referral will search your bookmarks first and if no results are found, use the Search link. Under the Search link, you can look for codes by number, description (see below) or in your saved Bookmarks (see the next page). For instructions on how to bookmark codes, please see the **Bookmarks** section.

- o **Procedure Code** – Search by **Description**
  This is the description of the patient's condition. Choose an active code.

*CPT Copyright 2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
**Recommended code for Blue Cross members.

Submitting an inpatient authorization, cont.

- ○ **Procedure Code** – Search by **Bookmarks**
  Select a procedure code from the list of your saved bookmarks.
  For more information on Bookmarks, please see the **_Bookmarks_** section.

- • **Referring Provider Name, ID**
  This field is pre-populated with the provider you're logged in under (shown at the top).

- • **Servicing Provider Name, ID**
  Enter the provider's name or NPI. Only those saved in your Bookmarks will display. Use the Search to locate a servicing provider by partial/full name, NPI, city, state, etc. You can also choose from your saved Servicing Providers in the Bookmarks tab.

Submitting an inpatient authorization, cont.

- • **Servicing Provider Name, ID**
  A provider may be listed multiple times – make sure to choose the correct one
  Your provider search results may include several listings with the same name, NPI or address. The first listing is not always the correct one. In order to choose the correct provider, please follow these guidelines:

1 First, you must select the listing based on <u>where</u> the member is going to see the provider. In this example, the provider has the same NPI but different address locations.

2 If the provider has several listings with the same address, you must select the listing with the correct group affiliation.

Note: Not all provider addresses will be considered in network. If you select a listing that shows the provider is out of network, your submission will then have to go through an out-of-network review. For BCN commercial and BCN Advantage members, you will have to complete the **out-of-network providers questionnaire**.

3

Submitting an inpatient authorization, cont.

- **Servicing Facility Name, ID**

Enter the facility's name or NPI. Only those saved in your Bookmarks will display. Use the Search to locate a servicing facility by partial/full name, NPI, city, state, etc. You can also choose from your saved Servicing Facilities in the Bookmarks tab.

- **Admitting Provider Name, ID**

Enter the admitting provider's name or NPI if known. Only those saved in your Bookmarks will display. Use the Search to locate a servicing facility by partial/full name, NPI, city, state, etc. You can also choose from your saved Admitting Providers in the Bookmarks tab.

Once finished, click Submit to process or Cancel to delete without processing.

OPTIONAL: The Add Service button is found on the bottom right of the Submit Inpatient Authorization screen. Click this to add an additional service if needed.

OPTIONAL: Click the Save As button to create a template with this particular Inpatient Authorization criteria. You can choose this template in the future from the Use Template button. Once finished, click Submit to process or Cancel to delete without processing.

Submitting an inpatient authorization, cont.

Your submitted authorization will look like this:

1. Reference ID and case status ▶
The check mark indicates you have successfully submitted or updated an authorization.

2. My List
Check this box to watch this authorization. A flag icon will be shown next to it on the My List page.

3. Printer-Friendly
Click this to print your authorization to an Inpatient Request Confirmation PDF file.

4. Edit
Click here to return to your authorization submission to extend the dates. If the Edit button is greyed out, the case has been closed by Blue Cross. If you need to extend a stay on a closed case, please contact Blue Cross. You may also see an error message that says, "The case is unavailable because it's being reviewed. Please try again later." The case is locked because the Utilization Management team is working on it. Try editing the case later to give our team time to review and exit the case.

5. Create New (communication) – preferred
This feature allows you to create a communication to Blue Cross on this authorization case. Blue Cross will review the communication and respond in a timely manner. You can add an attachment to the communication. See the previous chapter for more details.

6. Create New (note)
Creates a simple note to Blue Cross on this authorization case (for example, person submitting, contact info).

7. New Referral/Global Referral/Inpatient/Outpatient
Use these buttons to create multiple cases for one patient.

Section VII: Bookmarks

E-referral's bookmark functionality allows you to create and save your most used diagnosis and procedure codes as well as providers and facilities. This tool helps streamline your referral entries.

There are two ways to create a bookmark. Choose Bookmarks from the drop-down menu at the top of the Home page or create them from within a patient's record.

To create a bookmark from the drop-down Bookmarks menu, follow these steps:

Choose Bookmarks
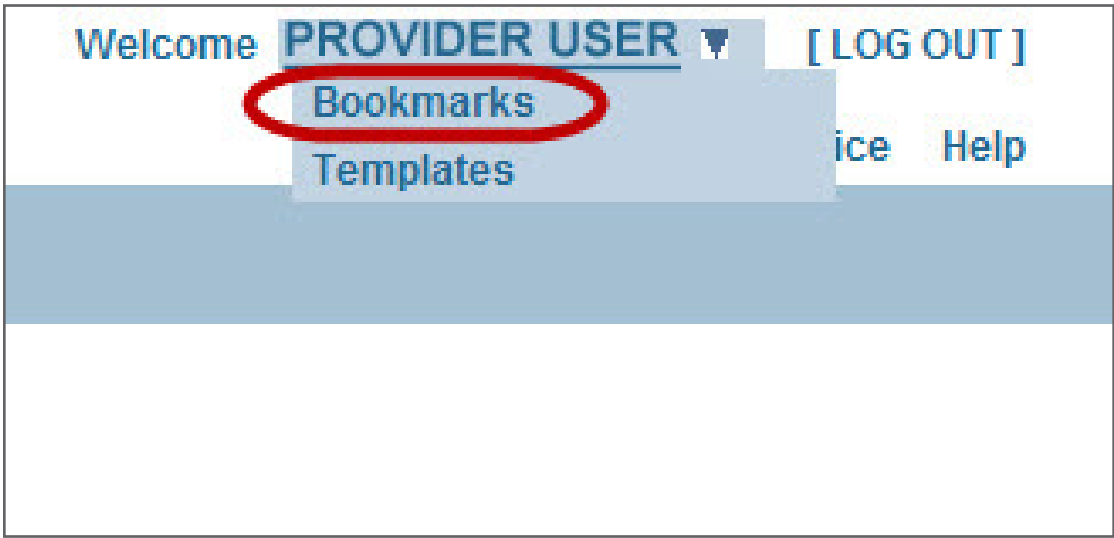
Select the bookmark type you'd like to manage from this screen.
Your choices are Categories, Code and Provider.
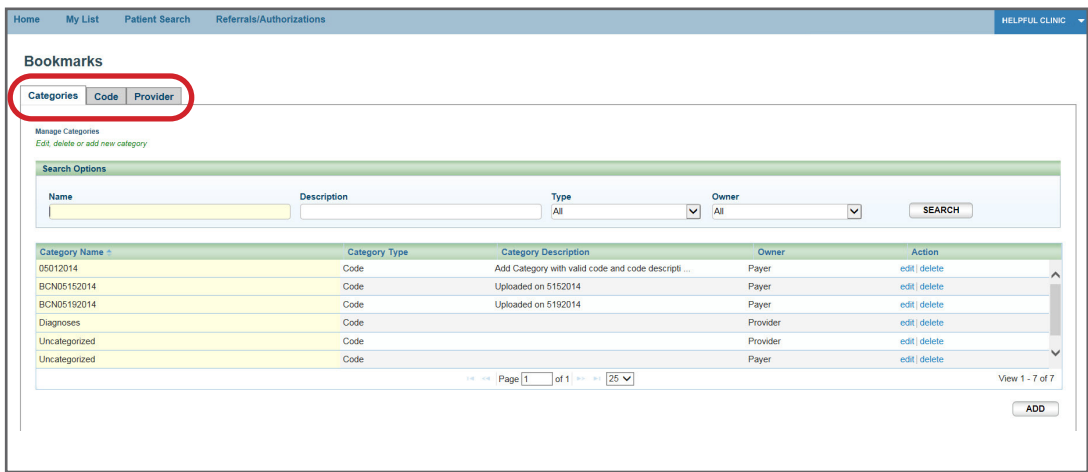
Bookmarks, cont.

On the Categories tab, you can edit, delete or add a new category. It is recommended that your office creates a standard group of categories for all users in your office. Categories are helpful if you frequently refer to certain providers (for example, Cardiologists at Beaumont, Internal Medicine at DMC). Choose Add.

If no categories are created, all codes and providers will be saved as "uncategorized."
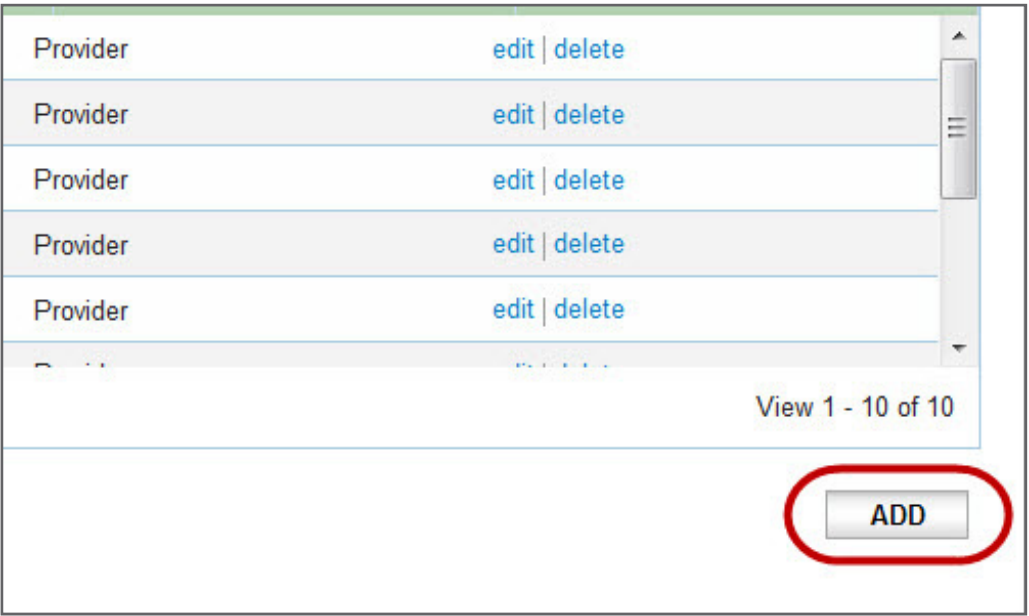
The Add Category window will open where you can create your new bookmark. Name your category and select the type – Code or Provider. Click Save.

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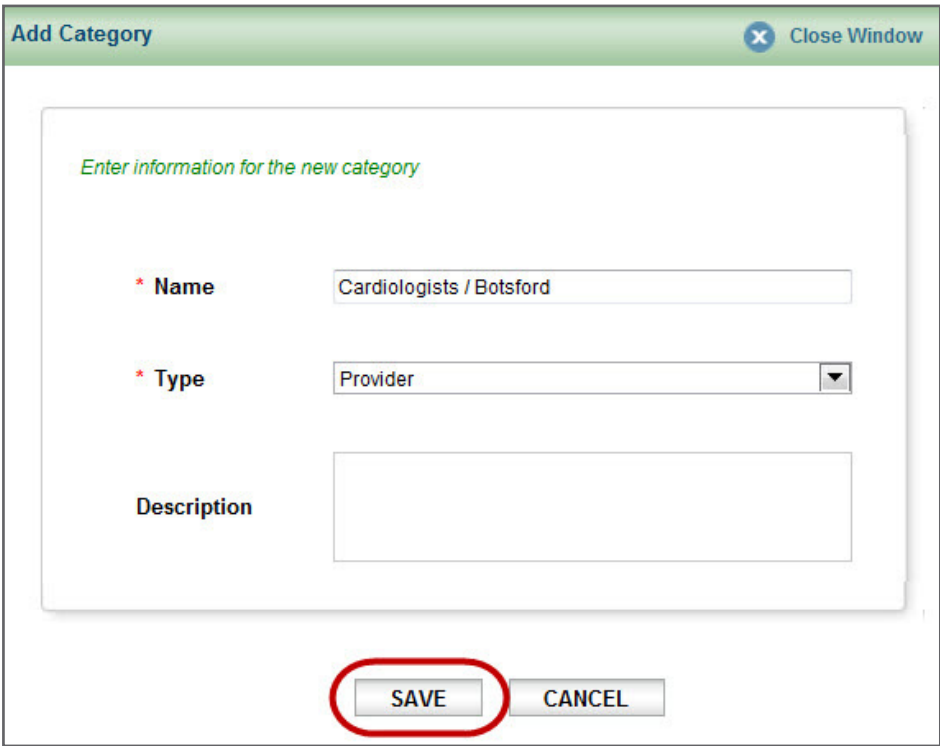
Bookmarks, cont.

On the Code tab, you can search for an existing bookmark or add a new one.

To search for an existing bookmark by code:

1. Enter a diagnosis **Code** if known, then select Search.
2. Enter a **Description** if known, then select Search.
3. Search by **Category**. These are the ones you created as bookmarks.
4. Search by **Owner – Payer** or **Provider**. Always choose Provider.

Under the Usage Type drop-down menu, you can sort from various diagnosis code types. BCN recommends selecting "All".

Bookmarks, cont.

To add a new bookmark:
To save your most used diagnosis and procedure codes, you can create bookmarks by choosing the Add Diagnosis or Add Procedure buttons.

Click the Add Diagnosis button and enter a full or partial diagnosis code or description and click Search.

Enter your search terms (for example, asthma). Choose the bookmark link to begin creating your bookmark on one of the **active** codes.

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Bookmarks, cont.

You will then be asked to choose a category for your new diagnosis code bookmark. Click Save.

You will see a Confirmation screen if you've successfully created the bookmark.

To add more bookmarks, click OK to close the Confirmation window and begin your search again.

Bookmarks, cont.

On the Provider tab, you can search for an existing bookmark or add a new one.

To search for an existing bookmark:

1. Enter an **NPI** if known, then select Search.
2. Enter a **Provider Name** if known, then select Search.
3. Under the **Category** drop-down menu, you can choose from the ones you created as bookmarks.
4. Under the **Usage Type** drop-down menu, you can choose from **Admitting, Servicing**, and **Servicing Facility** options. Please do not use **Referring**.

Bookmarks, cont.

To add a new bookmark:
To save your most commonly used providers and facilities, you can create bookmarks by choosing the Add Bookmark button found at the bottom of the Provider tab screen.
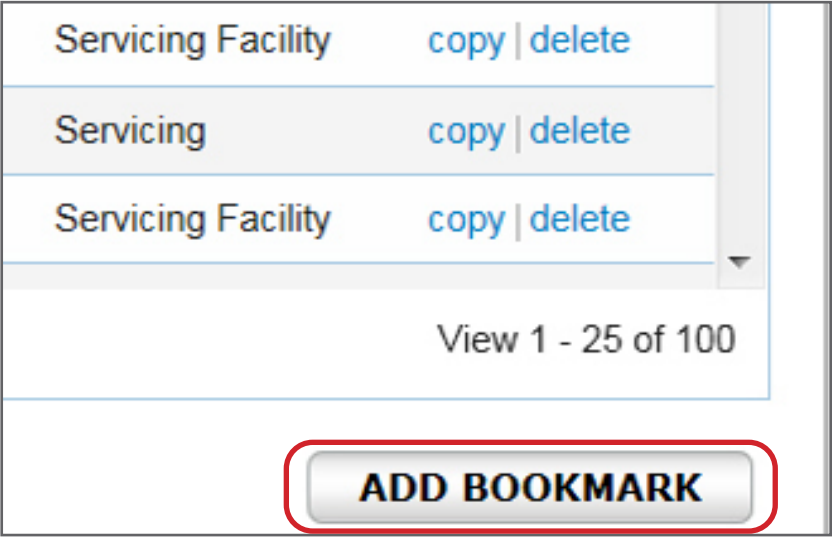
The Advanced Search option allows you to also search by ID and Specialty.
Note: If you receive multiple listings for a provider with the same information (for example, ID, Address), you must enter the provider's NPI to narrow your results.

After entering your search terms and receiving results, choose the bookmark link to begin creating your bookmark.
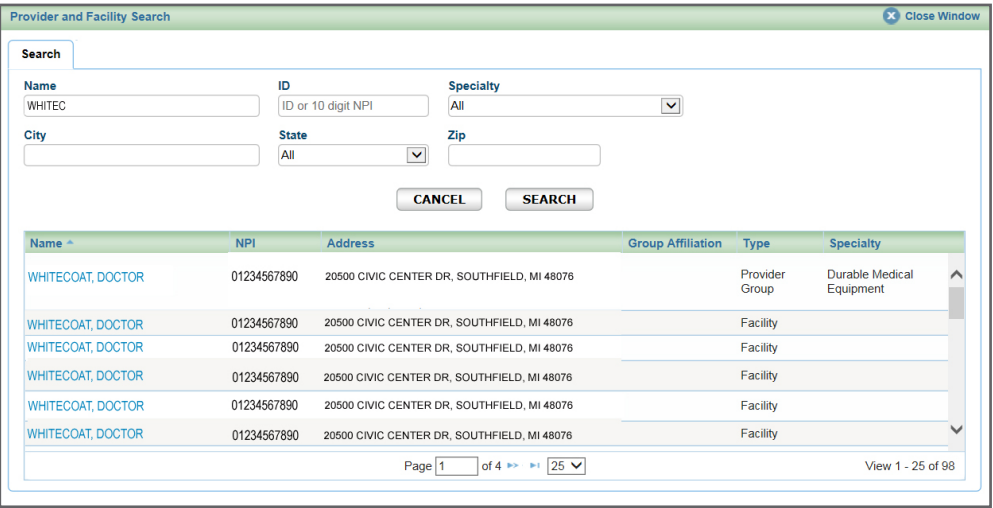
Bookmarks, cont.

You will then be asked to choose a category for your new provider bookmark. If you do not choose a category, the bookmark will be added to the Uncategorized folder and you will receive this message:
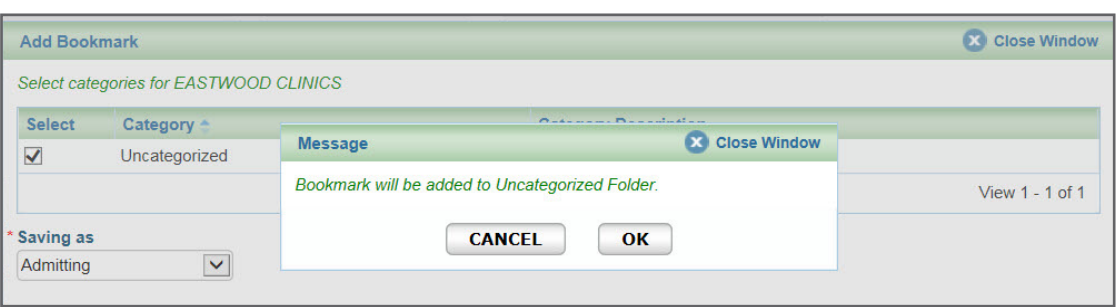
Click OK to save in the Uncategorized folder or Cancel to return and choose a category.

You are also required to choose from the Saving as menu. You choices are Admitting, Referring, Servicing, and Servicing Facility. Please do not use Referring. Once you have chosen a category and Saving as option, click Save or Cancel.
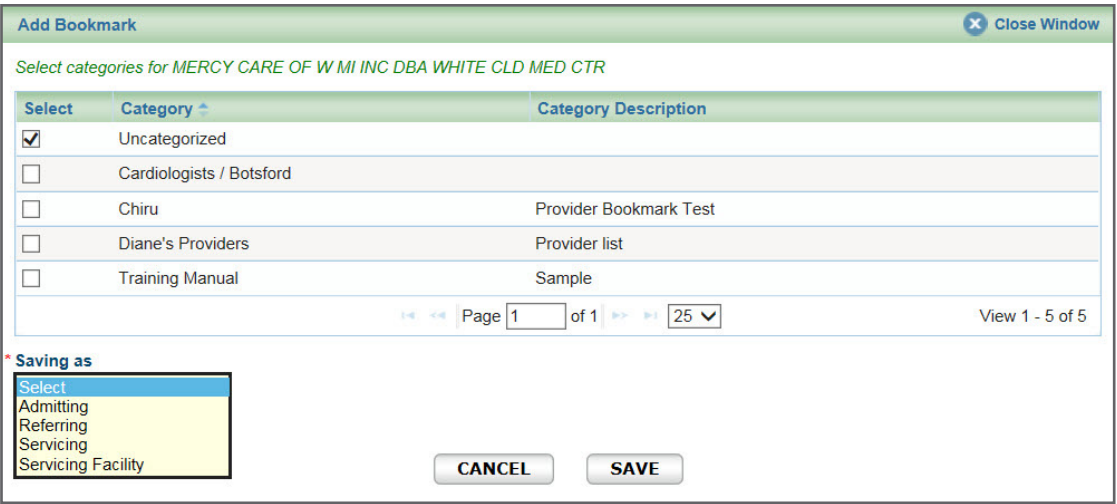
Bookmarks, cont.

To create a bookmark from within a case:

When you're in a case and ready to submit the referral, search for the Servicing Provider or Servicing Facility you wish to save as a bookmark.

1. Start by submitting a referral.
2. Search for the provider or facility you'd like to bookmark.
3. Click bookmark.

After the provider or facility has been successfully bookmarked, type in part of the provider or facility's name on the submission screen and they will begin to populate the search field.

Section VIII: Templates

E-referral allows you to create and use templates for your most used referrals. This tool helps streamline your referral/authorization entries.

To use templates, you need to have at least one category created before you create a template.

There are two ways to create a template. Choose Templates from the drop-down menu at the top of the Home page or create them from within a patient's record.

To create a template:
Choose Templates from the drop-down menu at the top of the Home page. The Manage Templates screen appears. You can create a new template category via the Categories tab or the Templates tab.

On the Categories tab, you can search for existing template categories or create a new one. **Templates must be stored in categories.** Each category can have only one kind of template form and form type (UM/Referral).

Click the Add New button to begin creating your category.

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Templates, cont.

Complete all the required fields (indicated with *). When finished, click Continue.

1. **Form:** Choose UM from the drop-down menu. **UM = Utilization Management**. UM consists of referrals, inpatient and outpatient authorizations.

2. **Form Type:** Choose Inpatient Auth, Outpatient Auth or Referral.

3. **Name:** Enter a name for your new category.

Click Save or Cancel. After clicking Save, a confirmation message will appear that you have successfully created your category.

Templates, cont.

On the Templates tab, you can search for an existing template or create a new one. Click the Add New button to begin creating your template.

The New Template pop-up box will appear. Complete all the required fields (indicated with *).

1. **Form:** Choose UM from the drop-down menu. **UM = Utilization Management**. UM consists of referrals, inpatient and outpatient authorizations.

2. **Form Type:** Choose Inpatient Auth, Outpatient Auth or Referral.

3. **Diagnosis Version:** Choose ICD10.

Click Continue or Cancel. After clicking Continue, you will be returned to the Manage Templates screen.

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Templates, cont.

On the Manage Templates screen, complete all the required fields (indicated with *).

1. *Category. Your template must be stored in a category. Choose from the options in the drop-down menu.

2. *Name. Enter a name for your template.

3. *Effective Date/Expiration Date. Enter a date range for your new claim template. Leave the Expiration Date blank for an open-ended template. When searching for a specific template with an effective or expiration date outside of the current date, this template will not be shown in search results. Adding Effective and Expiration dates helps tailor your template.

4. Active/Inactive. The active status indicates the template is searchable from the search menus available within the form type. When templates are created from existing UMs, this option is hidden and automatically set to ACTIVE. By default, templates downloaded from the payer are set to INACTIVE.

5. Service 1. Enter information into these options for a more specific template.

Click Save. You will be then be able to Edit or Copy the same information if needed.

Templates, cont.

To create a template from within a case:

When you're in a case and ready to submit a Referral, you can save what you input into the fields as a new template. Remember, you'll need to have at least one category created before you create a template.

1. Start by finding the patient you wish to submit the authorization for.

2. Fill in the required Service 1 information (all required fields are indicated with *). You must at least enter a Service From date to begin creating the new template.

3. Click Save As… and give your template a category and name.
   Note: you must create categories prior to saving your new template.

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To use a template within a case:

You can use a template you've previously created while submitting your outpatient authorization within a case.

Choose the Use Template button and begin your search.

Enter search terms in the Search Options section to locate your template. Click Search.

To use a template when outside a case:
1. Choose Templates from the drop-down menu at the top right of the Home page.
2. Click on the Templates tab and search by Name, Description, Category, Form.

The **Advanced Search** allows you to search by Procedure Code, Diagnosis Code, Created By (payer or provider), Active Status or Expired Status.

3. Click the Search button to view your results. You can also choose delete in the Action column to eliminate a template.

Once you have located and chosen your template, the Service 1 categories will be populated with that template's criteria. You will be then be able to Edit or Copy the same information if needed.

Section IX: Behavioral Health

Most, but not all, Blue Cross members have their behavioral health coverage managed by New Directions. You can use the New Directions WebPass tool online at **webpass.ndbh.com**** to request initial and concurrent reviews for inpatient, residential, partial hospitalization, applied behavior analysis and rTMS services and check the status of these requests. You can also call 1-800-762-2382. For Medicare Plus Blue℠ members, please see the **Behavioral Health e-referral User Guide** at **ereferrals.bcbsm.com** under the **Training Tools** and Blue Cross **Behavioral Health** pages.

For information about care management requirements for a customer group not managed by New Directions, contact a care manager using the toll-free number on the patient's card.

More information can be found in the Mental Health and Substance Abuse Managed Care Program Chapter of the *Blue Cross Blue Shield of Michigan Provider Manual*.

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e-referral contact information

For password reset and technical help

Contact Availity Client Services: 1-800-AVAILITY (282-4548)

For help using e-referral, contact your provider consultant.

To locate your provider consultant:

- Go to bcbsm.com/providers
- Click on *Contact Us* at the bottom of the page
- Click *Providers* under Contact Center
- Choose *Blue Cross Blue Shield of Michigan* from the *Select a plan type* drop-down menu
- Choose *Provider consultants* from the *Select a topic* drop-down menu
- Click the appropriate region or the physician organization consultants (PDF) link

Blue Cross
Blue Shield
Blue Care Network
of Michigan

ereferrals.bcbsm.com

W007519