# Authorization Submission FAQ

Inpatient and Outpatient authorizations for Commercial/FEP/Medicare members will be submitted in Availity Essentials. Authorizations that are delegated to eviCore or Prime Therapeutics Management Services (MPS) will have a single sign on (SSO) from Availity Essentials to the appropriate authorization site.

| | |
|---|---|
| **Error Resolution** | |
| Authorization was submitted and an AUTH number was not returned, what are next steps? | Please allow 2 hours for the system to send an update. Go to the Auth/Ref Dashboard and click on the submission line to push a system refresh. If no AUTH is returned after 2 hours, please fax in the authorization request. If this becomes a recurrent issue, please call Availity and/or open a support ticket in Availity Essentials. |
| Error returned in new tab when attempting to Single Sign-on to Predictal? | Please close the new tab and launch the SSO again from Availity Essentials. After second attempt, please clear cache, and cookies, and retry. If this becomes a recurrent issue, please call Availity and/or open a support ticket in Availity Essentials. |
| Patient Search is returning error "No Member Found," and Requesting Provider data was manually entered. | Error is related to the Requesting Provider's NPI not being listed/found in the NPI registry. Manual entry should only be used if no search results return when searching by NPI and Name.<br>If all conditions apply, fax in authorization request using the proper authorization form found on bluecrossmn.com. |
| **Contact Information** | |
| Authorization Support – Availity Essentials system | Contact Availity at 1-800-282-4548 |
| Authorization Support – Prime Therapeutics Management Services (MPS) | Contact Prime at 1-800-424-1706<br>http://www.gatewaypa.com/ |
| Authorization Support – eviCore system | Contact eviCore at 1-888-693-3211 |
| Authorization Support – eviCore PAC (Post Acute Care) | Contact eviCore PAC 1-855-252-1117<br>https://encore.evicore.com/portalserver/coreplatform/dashboard |
| Authorization Support - Other | Contact MN Provider Services at (651) 662-5200 or 1-800-262-0820 |
| Peer to Peer request voicemail box | Local (651) 662-0623 or (855) 315-4039 |
| **General Information** | |
| What does SSO stand for? | SSO stands for Single Sign-On. |
| How do I get to the training videos? | Log into Availity Essentials, go to Payer Spaces, Resources tab, and click on Access BCBSMN Learning and Development. Use keyword "authorizations." |
| Does Availity time out/log out after set time of inactivity? | Yes, Availity Essentials will log users out after 30 minutes of inactivity. Warning messages do appear prior to the end of the 30 minutes of inactivity. |
| What are the timeliness rules for authorization submissions? | There is no change to timeliness submission rules. |

| | |
|---|---|
| | • Inpatient authorizations/notification can be submitted five calendar days retro.<br>• Outpatient authorizations can be submitted forty-five calendar days in advance and up to fourteen calendar days retro if the claim has not been submitted.<br>**Important – delayed submissions do not guarantee approval or payment. |
| Authorization request denied missing some information. Can the request be resubmitted with the addition of the missing information? | No, all denied authorizations must be appealed. Appeals need to be submitted within 180 days from the denial determination date. |
| Is there a direct phone number for the prior authorization dept? | There is not a direct phone line. Please contact Provider Services. |
| Why does the confetti fall all over the screen after the auth is submitted when the status is other than approved? | The confetti feature is an indication of a successful submission within Availity Essentials. |
| Can one authorization be done for both the procedure and inpatient admit? | No, there is no change to this requirement. An inpatient authorization will need to be submitted for the hospital stay, and an outpatient authorization is required for the procedure/services. |
| How are authorization submissions for out of state members managed? | The request will start in Availity and then be routed to the member's coverage plan for completion. |
| What is the process to check the status of an authorization? | The Availity Dashboard will house all authorizations submitted by organization. An Auth/Ref Inquiry can be submitted using one of two query types.<br>• Authorization number<br>• Member id, NPI, To and From Date of Care |
| What is the process to withdraw a case? | Only pending cases can be withdrawn. Click Update from the Auth/Ref Dashboard. The system will do a single sign on into Predictal AAH. In Predictal AAH, click Withdraw bubble, enter reason for withdrawing, and then click Withdraw. |
| Can denial letters be accessed online? | Denial letters can be viewed and downloaded from Predictal. To get into Predictal, access the Auth/Ref Dashboard, click on the 3-line menu for the authorization, and select "Review Only".<br>This capability is being added on February 15, 2025 |
| What auth number goes on the claim form? | Authorization numbers will all start as AUTH-XXXXX for MN reviews. |
| Does this process apply to BCBS FEP plans as well? | Yes. This process applies to all FEP patients receiving services in MN. |
| Is Blue Cross the only Blue Plan using this program? | No, Florida Blue has also implemented the new authorization processes within Availity Essentials. Other plans will also be adapting in the future. |
| Will authorizations for other Blue Plans display on the Auth/Ref Dashboard? | No, those authorization requests will only display on the Highmark Availity Dashboard. |
| Will a PowerPoint submission document available? | Yes, the submission power point will be added to the training video in BCBSMN Learning & Development and under Resources in Availity Essentials Payer Spaces. |

| | |
|---|---|
| Do any previously submitted authorizations need to be resubmitted? | No, previous authorizations that were pending or determined are still valid. |
| What if the doctor is not in Availity? | If the provider is not returned by NPI search or Name search, then they can be manually entered. The NPI does need to be registered with NPI registry.<br><br>**Manually entered provider information is not retained for future authorization submissions. |
| What happens if I could not finish the authorization submission? | Incomplete authorization submissions can be finalized if the original request ended on page 2 or later. Go to the Auth/Ref Dashboard, click on Draft tab, find the Incomplete authorization request, go to the 3-line Action menu, and click Edit. This will open the incomplete authorization for completion. |
| **Outpatient Authorizations** | |
| **Question** | **Answer** |
| Where is the 'Is Auth Required' tool located? | The 'Is Auth Required' tool has been moved into the first step of the outpatient authorization submission.<br><br>There is a standalone 'Is Auth Required' tool located on our website https://www.bluecrossmn.com/providers/medical-management/prior-authorization-lookup-tool |
| Will the integrated Is Auth Required tool use the correct group number for the patient? | The Is Auth Required tool is now incorporated into the Outpatient submission. This change allows for the system to pull the correct group for the member based on the code(s) and start date entered. |
| If we get a response that 'No Auth is required' does the auth still need to be submitted? | No, if the response is received from the Outpatient Authorization submission process, then the auth does not need to be submitted. Please copy the transaction id for reference. However, if the response is received from the standalone tool on our website, please ensure the correct group number was used, and again copy the transaction id for reference. |
| Is the Predictal AAH system being discontinued? | No, Predictal will remain as MN utilization management site. Providers will use an SSO from Availity Essentials to Predictal for review of authorization determination details, download denial letter, and make updates on Inpatient stays. |
| Does a new request need to be created if some of the codes require authorization and others do not? | No, an authorization can be submitted with a combination of codes that do and do not require authorization.<br>**Medical drug authorizations need to be submitted independently of other codes. |
| Can pre-determinations be submitted in Availity Essentials? | Pre-determinations would only apply to Medicare Advantage programs. At this time, they can be submitted in Availity Essentials as a regular authorization. |
| What if an authorization is issued and revisions need to be made (code change)?<br>• Prior to services | A new authorization request will need to be submitted. |

| | |
|---|---|
| • After services rendered (but prior to claim submission) | If the authorization request is submitted after services have been rendered, please note the 14-calendar day retro submission must be prior to claim submission. |
| Will authorization approvals be faxed or only found on the dashboard? | Determination faxes will continue to be sent for both approval and denials. The status can be found on the Auth/Ref dashboard, and rationale can be viewed in Predictal using the "Review Only" option from the Actions menu. |
| Where can modifiers be added on the authorization submission? | Modifiers are not required as part of the authorization request. Modifier information can be added to the Provider Notes section. |
| What if the dates of care need to be changed on a determined authorization? | If the start date needs to be changed to an earlier date, a new authorization will need to be submitted to accommodate the dates not covered in the original request.<br><br>If the end date needs to be extended as approved services were not rendered during approved timeframe, please contact Provider Services to submit an update request. |
| With the move of MSK and Imaging moving to MN review, will all authorization submissions pend? | Yes, at this time all authorization submissions for MSK and Imaging will pend for review.<br>The change to have authorizations auto approve will be determined by compliance and determination stats. |
| What is the timeline to receive a determination for MSK and Cardiology/Radiology Advanced Imaging? | Timeline for final determination on initial authorization requests will be completed within the State of MN TAT guidelines (10 business days from receipt of request). |
| For two panel surgeries can we add two providers? | No, submit the authorization request using the primary surgeon's information. |
| If eviCore approved services for dates after 1/6/2025, can the eviCore auth be used or does a new one need to be submitted? | Any authorizations submitted to eviCore prior to the submit date of 1/6/2025, will be determined and applied to claims for the approved service dates up to the expiration date. |
| Why do I have to answer question if the information is noted in the attached clinicals? | The attestation questions are there as check and balances process. The system could not locate the information in the documentation and/or confirmation of information related to the patient's condition. |
| If the auth is entered with a 6-month time span, will it be approved for 6 months? | Depends on the request and medical necessity determination. |
| Since the facility location is option on the outpatient authorizations, can the location be changed without submitting a new authorization or requesting an update? | Yes, the physical location can change.<br>If the rendering practitioner changes, then a new authorization should be submitted.<br>If services are done in facility setting and the facility changes, a new authorization will need to be submitted. |
| When authorization is for DME, can the DME company be used as the Performing Provider? | Yes, if the DME company is a participating provider. |
| How does a renewal authorization for final months of DME need to be submitted as this is normally outside of the retro 14-day window? | Follow current process for submission. There is no change to this process. |

| | |
|---|---|
| Will authorizations get routed to eviCore to answer the questions? | Yes, if the request requires review by eviCore then Availity Essentials will SSO the request into eviCore for completion. |
| Can outpatient eviCore delegated service be submitted directly into the eviCore Portal or does this need to start in Availity? | For the most accurate response based on the member's current eligibility and benefits, we encourage providers to go through Availity, but providers can submit directly in the eviCore portal as well. |
| What service type should be used for Sleep study tests and medical equipment? | **Sleep Study** – Other Medical Outpatient Services<br><br>**Sleep related DME** – Other Medical Outpatient Services |
| What is the process if code(s) are to be reviewed by a delegated entity, however the authorization does not route to the reviewing entity? | If medical necessity review is required by a delegated entity and the system does not route to that portal, please contact the delegated entity directly to submit the request. |
| Will the auth route to Prime Therapeutics Management Services (Prime MPS) for medical drug authorizations? | Yes, Availity will SSO to Prime MPS for Medical drugs that require authorization.<br>**Use Service Type "Specialty Drugs and Chemotherapy" on the submission. |
| Can authorization requests for medical drugs be entered directly at gatewaypa.com (Prime MPS)? | For the most accurate response based on the member's current eligibility and benefits, we encourage providers to go through Availity, but providers can submit directly in the Prime MPS portal as well. |
| How do I initiate a Peer to Peer (P2P)? | Peer to Peer conversations regarding the denied service must occur prior to receipt of any appeal.<br>• Peer to Peer is to be used for information/clarification of the authorization denial prior to initiating an appeal.<br>• Reconsiderations/changes of the denial will not be issued by a P2P consult.<br><br>Providers call the peer-to-peer phoneline to request and schedule a call with our PA Support team.<br>• There's no specific time frame to request a P2P, however it's usually within the month the denial occurred and before the appeal is initiated.<br>• P2P's are not available for claim/Retro reviews or benefit denials.<br>Peer to Peer phone number (855) 315-4039. Local number (651) 662-0623 |
| **Clinical Attachments** | |
| **Question** | **Answer** |
| Can attached files be viewed? | Yes, click Update/Review Only for the Auth from the Auth/Ref Dashboard to SSO into Predictal to download and view clinical attachments. |
| Can additional clinicals be submitted after the original submission while the case is still pending? | Yes, click Update/Review Only for the Auth from the Auth/Ref Dashboard to SSO into Predictal to add additional attachments. |

| | |
|---|---|
| | Attachments cannot be added to authorizations with a determination except for Inpatient authorizations requests for a Concurrent stay. |
| If we are not able to submit clinicals at the time the auth is entered will there be a fax number to send them later? Sometimes we run out of time at the EOD or similar type situations where we need to come back to the auth to keep working on it. | No, a minimum of one attachment is required on every authorization to complete the submission process.<br><br>Incomplete authorizations submission are located on the Auth/Ref Dashboard under the Drafts tab. Click the 3-line action menu and click edit to finalize the submission. |
| Can more than one attachment be added at the time of submission? | Yes, multiple attachments can be added to the authorization request. Each document can be up to 10MB with a total combined size max of 100MB.<br><br>**Password protected documents will not be accepted. |
| What are the acceptable document types for attachments/clinicals? | *File formats accepted: DOC, DOCX, JPEG, PDF, PNG, TIF, WAV, WMV, XLS, ZIP, TXT, XLSX, TIFF, CSV*<br><br>**File names must be less than 40 characters. |
| If additional clinical info is required after the submission, will the dashboard or inquiry display the request for additional info, or will there be a call? | The status on the Auth/Ref Dashboard will change to "Pending Action" however there will not be an indication of what information is needed.<br><br>The provider will receive a call with a request for additional information details. |
| **Inpatient Authorizations/Notifications** | |
| **Question** | **Answer** |
| Why are attachments required for Inpatient authorizations? | MN requires an attachment/clinicals for all submissions.<br><br>FEP requires a Pre-Certification for Inpatient admit. Clinicals are required for review by the clinicians to determine medical necessity. |
| What is the process to update the start date and/or the discharge date or submit concurrent stay (when required) for Inpatient? | Access the Auth/Referral Dashboard, click on the 3-line menu for the request, and select Update. These updates will be made in Predictal. |
| For Inpatient notifications (Medical or Behavioral), is a discharge summary required when the discharge date is updated? | No documents are needed when the discharge date is updated. |
| Will the inpatient submissions show as pending until discharge or will they auto approve? | The system will auto approve Inpatient submissions (except FEP). The days approved will depend on the type of admit submitted. |
| Can eviCore Post Acute Care authorizations be submitted in Availity Essentials? | No, these requests will need to be submitted directly to eviCore. |
| Can NICU admit notifications/authorizations be entered in Availity Essentials? | Not currently, please fax in NICU admit/authorizations. |

| | |
|---|---|
| | |