MASSACHUSETTS

AUTHORIZATION MANAGER

Questions & Answers

Here are the answers to common questions about Authorization Manager with links to additional information on Provider Central.

Important reminder about prefixes
When submitting authorization requests:

- You **don't** need the three letter prefix for most Blue Cross members.
- You **do** need the "R" for Federal Employee Program (FEP) members.

Click the links to go directly to a specific topic:

Provider Central resources:

- Authorization Manager to go live February 15 (news article)
- Authorization Manager Guide
- Authorization Manager webinar recording
- Authorization Manager webinar slides
- Quick tip for inpatient hospitals
- Quick tip for home health care providers, physical & occupational therapists, and skilled nursing facilities
- Quick tip for medications
- Quick tip for mental health providers

All of these resources can be printed out. You also can sign in to Provider Central. Go to **eTools>Authorization Manager** and look under **Resources**.

- Authorization-specific questions
- General questions
- InterQual – automatic launch for some outpatient surgeries
- Plan-specific questions
- Specific service type questions

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AUTHORIZATION-SPECIFIC QUESTIONS

Q: Can we view authorizations submitted before February 15?

A: Yes. We have migrated more than a year's history of authorizations into the tool. The default search using the provider sign-in will display authorizations created within the last 30 days. Use the advanced search function to search past a 30-day period.

Q: Are there any resources I can use when submitting authorizations for inpatient admissions, home health care, physical therapy, and skilled nursing facilities?

A: Yes, we've developed Quick Tips to help you know what information is needed for inpatient admissions, physical therapy, skilled nursing facilities, and home health care. See links to Quick Tips above.

Q: If a service requires an authorization today, can we use this tool to submit it tomorrow?

A: Yes.

Q: Will we be able to see what CPT codes were authorized when we view a request?

A: Yes, the tool is very explicit about displaying authorized codes.

Q: Can I use the tool to extend an authorization already on file?

A: No. Just use the tool for the **initial** authorization requests. Follow the current process and fax in the request for an extension. However, you'll be able to see the **status** of the extension request in Authorization Manager and also upload supporting documentation to the tool.

Q: Once a request has been submitted, can I make a correction, or do I need to call?

A: After you've submitted your request, you can attach supporting documents, but for other changes, you'll need to call us at 1-800-327-6716.

Q: How does Authorization Manager work with outside vendors like AIM and WholeHealth Networks (Tivity)?

A: Some services require authorization by AIM and Tivity. You should continue to use these vendors as you do today for services such as genetic testing and advanced imaging authorizations.

- If you enter a code that requires authorization by AIM or Tivity, you'll get a message to go to that site.
- You cannot upload documentation required by AIM or Tivity to Authorization Manager.

Once the outside vendor has made a decision on the authorization request, you will be able to view it in Authorization Manager.

Q: Who can request a global authorization for home care services?

A: Both the primary care and servicing provider can submit a request for initial global home health care authorization, and both will be able to view it.

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Q: If we need a same-day outpatient authorization, does it then need to be expedited?

A: No, you don't need to expedite this type of request.

Q: What are the criteria for expedited authorization requests?

A: The expedited category should be used only when you and the patient believe that postponing care could place the patient's life, health, or ability to regain maximum function, in serious jeopardy.

Q: Can a provider administrator submit an authorization request using this tool, or must it be the admitting clinician?

A: Yes, they can, if the administrator is tied to their Provider Central registration.

Q: What are turnaround times for authorization?

A: Existing turnaround times for authorization are not changing with Authorization Manager. Turnaround time will vary based on the type of service. Submitting via the portal will allow us to process your requests more quickly.

Q: Will the inpatient authorization through date on the portal reflect the actual discharge date once the member is discharged?

A: No, the inpatient authorization through date on the portal will always reflect all the days approved for the admission. We do capture the actual discharge date in the Utilization Management system, but it does not display on the portal.

INTERQUAL – AUTOMATIC LAUNCH FOR SOME OUTPATIENT SURGERIES

Q: I submitted a case with InterQual and criteria was met. Why wasn't my case immediately approved?

A: In some instances, the member's benefits may require the case to pend for additional review. For example, requests for Federal Employee Program members will pend for review because of Federal Employee Program requirements.

Q: Which version of InterQual is Blue Cross using?

A: Each year on July 1, Blue Cross Blue Shield of Massachusetts upgrades InterQual to the current year. On July 1, 2021, we will be moving from 2020 criteria to 2021 criteria.

Q: If I'm not ready to complete the InterQual criteria, what should I do?

A: We encourage you to submit InterQual with the case, however, in some cases, it may make sense to delay submitting the case until InterQual can be completed. Even if you cannot answer all the questions, please answer as many as possible and attach the clinical documentation and we will complete the review.

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GENERAL QUESTIONS

Q: Will the view for Medicare Advantage members change on February 15?
A: Yes, you can see expanded options. However, the overall look of Authorization Manager won't change.

Q: Will you require us to use Authorization Manager?
A: No, we're not mandating it, but we do encourage you to try it as it's a more efficient tool. If you choose to continue with business as usual, we will still take faxes and calls. We suggest that you give it a try – it will save you time on the phone.

Q: If I work for multiple providers, will I have to sign in differently?
A: For groups with 20 or more providers, you will see a list of the providers in the dropdown. You also will be able to search by their names. It's all tied to the original registration through Provider Central. Go to Provider Central registration to make any changes you need.

Q: Is this tool replacing medical policies and SmartSheets?
A: No. Medical policies and SmartSheets are still available. SmartSheets and our surgical day care lists are not interactive tools and don't have details by type of plan. We recommend that you use Authorization Manager because it has interactive capability and is the best resource for detail by member.

However, if you don't have the clinical information handy, you may want to print out the SmartSheet and give it to the clinician to fill out, then you can enter that information into InterQual. Please note that out-of-state providers don't have access to InterQual and need to print out and fax SmartSheets to us.

Q: Will we still receive approval by mail?
A: Yes, you will still receive the approval letter, either by fax or mail. You can also view and print the letter from the Correspondence section of Authorization Manager.

Q: Will the documentation required today still be required?
A: Yes. We have not changed documentation requirements.

Q: What are the types of services that require authorization?
A: They are the same as those that require authorization today. The best way to verify if authorization is required is to enter the CPT code and diagnosis in the tool.

Q: Is there a different turnaround time when requesting services online?
A: No. The turnaround time is the same. An advantage you have when uploading documents to Authorization Manager is that they will be there immediately. A fax can take three days to be reviewed.

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Q: If we receive a message that no authorization is required, do we still need to call?

A: No. You can trust that message and, in fact, can print it out if you wish. That will give you the reference number if you need it. We don't want you to have to call and wait for an answer when wait times can be high.

Q: Are there plans for day 2 changes, such as being able to extend an authorization via the tool?

A: Yes. There is a lot more functionality available via the tool. We've started off with basic functionality, but we are looking to include the ability to extend an existing authorization and request an appeal. We also plan to add medical necessity criteria through InterQual to make the criteria transparent.

Q: Can we use Authorization Manager to submit referrals?

A: No. You can view a referral once it's submitted and check its status but you cannot submit it via Authorization Manager. Please continue to submit referrals the way you do today.

Q: Will we only be able to request referrals on Change HealthCare? Will it give a stop for outpatient services like physical therapy or home care, and direct them to Authorization Manager?

A: All referrals should be entered as they are today. Currently there are no stops in place that will prevent you from requesting outpatient services through Change HealthCare. In the future we plan to direct all authorization requests to go through Authorization Manager and we will give advance notice of this change.

Q: How does Authorization Manager's code feature work?

A: When entering an authorization request, you'll be asked to enter procedure and diagnosis codes.

- You can enter specific codes for CPT, HCPCS, or ICD, or you can enter a description of the service and select the code from a dropdown list.
- If you enter a CPT code that does not require authorization when rendered in an outpatient setting, you'll get a message stating that.
- You have the option to enter multiple codes for each request.
- Some services require modifier and units. If required information is not entered, you will get a message.

Q: If we enter a service code and get the message that no authorization is required, can we print that screen?

A: Yes, you can print the screen. This will give you a tracking number if you need it when speaking with us. A tracking number is helpful if your claim is denied for no authorization when the tool said none was needed.

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Q: Are you changing the way you communicate with us about authorization requests, for instance the daily fax report?

A: Yes, fax communications will change.

- You will no longer receive a daily summary of all decisioned cases if you receive this today.
- You will receive an individual fax for each case when it is decisioned.
- We will continue to fax or mail confirmation letters for authorizations. The portal will house all correspondence so we encourage you to check there before calling us.
- If we need additional information, we'll request it the same way we do today.
- Patients will not be able to view authorization letters on their portal.
- You cannot opt out of paper communications yet.
- You still have the option of calling us with questions.

Q: If a patient has more than one insurance, how does that impact the authorization process?

A: We have made no changes to the authorization process for patients with more than one insurance. Authorization requirements are waived if another insurance paid primary for a member.

Q: If we opt not to use Authorization Manager to submit a request, can we still check its status in the tool?

A: Yes, once it's entered you can check status, upload any supporting documentation, and view related correspondence.

PLAN-SPECIFIC QUESTIONS

Q: Can we use Authorization Manager for members of other Blues plans (BlueCard)?

A: No. Authorization Manager is only for Massachusetts members who have selected a Massachusetts primary care provider.

Q: Can we use Authorization Manager for out-of-state members?

A: It depends. The key is where their primary care provider is located, so:

- **Yes**, for New England Health Plan members who live out-of-state and have a Massachusetts primary care provider.
- **No**, for New England Health Plan members who have an out-of-state primary care provider.

Q: Can we use Authorization Manager for patients with a Rhode Island plan and a Massachusetts primary care provider?

A: Yes, as long as the New England Health Plan member has a Massachusetts primary care provider.

Q: Can we use this tool for Federal Employee Program (FEP) members?

A: Yes, you can use Authorization Manager to submit authorizations for FEP members.

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Q: Do you still require us to submit the prefix on the member's policy?

A: You do not need to submit the prefix when entering the member's ID number into Authorization Manager (except the R in front of Federal Employee Program members). However, for claim submission, we still require the prefix for all members.

When initiating an authorization request, you must enter the member's name, date of birth, and ID number.

SPECIFIC SERVICE TYPE QUESTIONS

Applied Behavioral Analysis (ABA)

Q: Can we use Authorization Manager to request authorization for ABA services?

A: Yes. Please fill out the required fields in the portal, attach the Applied Behavior Analysis Service Request Form, and include CPT codes. You can upload clinical information to support your request.

Q: When the early intervention program is billing on behalf of the ABA provider, do they enter the early intervention program as the requesting and servicing provider?

A: Yes, enter the name and NPI number as it will appear on the claim as the servicing provider in Authorization Manager. The requesting provider can be the same or different.

Q: Will this be the tool that needs to be used for ABA requests for children in Early Intervention under age three?

A: Yes.

Q: What are ABA autism services considered? Service requests?

A: No, they are considered behavioral health service requests.

Behavioral or mental health

Q: Does this apply to mental health authorizations, including in-home therapy and therapeutic mentoring?

A: Yes. Submit as behavioral health service requests.

Q: If mental health outpatient clients have not needed authorization, will they need one now?

A: No, we have not changed our authorization requirements.

Q: For outpatient TMS services, do I still have the option to fax the TMS request form instead of submitting it through Authorization Manager?

A: Yes, you do.

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Q: For in-home therapy authorizations, you request treatment plans, assessment, and goals for the client which the clinician won't have until they do the intake. How we can have the intake without authorization?

A: The authorization cannot be submitted without a CPT code. Call or fax your request if you don't have a code.

Botox

Q: Would we submit for Botox authorization in the tool or continue with specialty pharmacy?

A: No, Botox authorizations continue to be requested through specialty pharmacies.

CT scans

Q: How far out are we able to obtain authorization for a chest CT?

A: Submit your request through AIM as you do today.

Dermatology

Q: What generic procedure code would you enter when referring to a dermatologist? If I entered 99204, would that prevent the specialist from billing any other code?

A: You don't need an authorization for this type of visit. Submit a referral request as you do today.

Habilitative

Q: Are there instructions posted for submitting habilitative physical and occupational therapy?

A: Follow physical and occupational therapy guidelines and include the required modifier. You can also use the Quick tip for home health care providers, physical & occupational therapists, and skilled nursing facilities.

Home health

Q: Will we be able to submit all home health authorizations on the new portal? If yes, will the quantity and timeframe still apply? For HMO plans, will they still require the PCP to issue the global authorization first?

A: Yes, you can submit home health authorizations. The same rules apply to the quantity and timeframe approved. For HMO plans, the primary care provider must request the global authorization first.

Q: For home care provider types, if we bill using revenue codes, would entering HCPCS codes interfere with the authorizations aligning with our claims?

A: There should not be an issue because the CPT/HCPCS code drives the service approved, not the revenue code.

Hospice

Q: Can we submit authorization requests for hospice services?

A: Most hospice services don't require an authorization (except the Federal Employee Plan which *does* require it). You can use Authorization Manager to check requirements.

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Infusions

Q: If infusions are done in the office (a medical benefit), can I use Authorization Manager?

A: All medications must be authorized by call or fax to Clinical Pharmacy.

Medications

Q: Can this tool be used for a buy & bill medication that is generally authorized under the medical (not pharmacy) benefit?

A: All medications must be authorized by call or fax to Clinical Pharmacy.

Q: Can I use this tool to authorize medications?

A: No, you should continue to request medication authorization through Clinical Pharmacy.

Neuropsych/psych testing

Q: For neuropsychological and psychological testing, do we still need to complete the existing prior authorization form and attach it, or will all information be submitted through Authorization Manager? And, what is the maximum number of hours we can request?

A: The form is still required. You can submit your request through Authorization Manager and upload the form. The maximum number of hours requested has not changed.

Newborns/neonatal

Q: Can I use Authorization Manager to request authorization for a newborn whose mother has been discharged, even when the baby hasn't been added to policy yet? Would it be submitted under the mother's ID number?

A: No, please call or fax your request for newborns who have not yet been added to a policy.

Physical therapy

Q: Does this apply to outpatient physical therapy and can we request visits instead of units?

A: Yes, and you can request authorization for physical therapy visits as you do today.

Q: How would you obtain a prior authorization for a facility (acute rehab) requesting approval for patient admission and stay?

A: Please see the Authorization Manager Quick Tips for details.

Q: If you are requesting a physical therapy authorization and the patient will be doing a combination of in-clinic and telehealth, what do you put for place of service?

A: Please use place of service telehealth or outpatient facility. You can use the same authorization to bill for the service as long as it's billed under the same NPI.

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Radiation

Q: Will prior authorization for radiation be available on the tool, or will I still have to fill out a specific form for the service? And if so, do we need to enter each code billed or just the primary code for treatment?

A: Yes, you can request authorization through Authorization Manager. The form is still required; you should upload it through the tool. Only the primary code is required.

Outpatient rehab facility

Q: Since the primary care provider initiates the initial referral for outpatient rehab, will the outpatient rehab facility use the tool to add visits or would we continue faxing because we are not initiating?

A: Please continue to fax your requests.

SNF

Q: Will skilled nursing and inpatient rehab facilities still be required to complete the pre-certification form and upload it?

A: The pre-certification form is not required but it is helpful to us. As long as you include all of the information in your request, you don't have to attach the form.

Speech language pathology

Q: Can we use Authorization Manager for speech, language, pathology services beyond the first 26 visits authorized by the primary care provider? And, is a doctor's signature required?

A: Authorization for speech, language, pathology services is not required.

Surgery

Q: If we submit a pre-certification admission request for surgery, will it include both the procedure and the admission (example: inpatient joint replacement surgery)?

A: Yes, when you enter your request, pick the servicing provider for the procedure and facility for the admission.

Telehealth

Q: If a referral was authorized for an office visit, would it be covered if it ended up being a telehealth visit?

A: All referrals should be entered as they are today. Refer to our Telehealth payment policies on Provider Central for more information about telehealth visits.

Back to top

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