

Here are the answers to common questions about Authorization Manager. For training materials, please refer to the Guides and Video Demonstrations area of Provider Central's [Authorization Manager](#) page.

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.

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AUTHORIZATION-SPECIFIC QUESTIONS

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, and, for inpatient authorizations, you can add discharge date and disposition. For other changes, you'll need to call us at 1-800-327-6716.

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

A: Some services require authorization by Carelon 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 Carelon or Tivity, you'll get a message to go to that site.
- You cannot upload documentation required by Carelon 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: For commercial HMO/POS and Medicare Advantage, the primary care provider, covering MD, or specialist with an active referral may request the global. For PPO members, the home care agency can submit the initial request.

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. The actual discharge date and disposition will be displayed under "View Authorizations – Medical." The discharge date and disposition date may be added for inpatient authorizations.

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.

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 then close Authorization Manager. Re-enter the tool, locate the authorization that has already been submitted, and attach clinical information.

GENERAL QUESTIONS

Q: Do you require us to use Authorization Manager?

A: Yes. We require participating providers to submit the following types of requests and inquiries electronically rather than by phone or fax for our commercial (HMO, PPO) and Federal Employee Program (FEP) members:

- Initial inpatient requests
- Initial service requests (includes requests for home care and physical therapy, which are considered an authorization)
- Outpatient referrals
- Initial mental health inpatient requests
- Initial mental health service requests
- Authorization status inquiries

Please note that the following requests cannot be submitted electronically and must continue to be submitted via fax:

- Any type of extension for an inpatient stay (this includes requests for additional physical, speech, and occupational therapy services)
- Transplants
- Interoperative neurological (spine) monitoring
- Concurrent reviews

Although we don't require electronic submission for these types of requests for Medicare Advantage members, we encourage you to use electronic submission for these members as well.

Q: If I work for multiple providers, do I have to sign in differently?

A: For groups with 20 or fewer providers, you will see a list of the providers in the dropdown. For groups with more than 20 providers, you must first click the Search button, then use the NPI to search for and select the provider as the requestor.

Your access to providers in Authorization Manager is connected to the providers registered for Provider Central and associated with your organization. If you work for multiple providers within a group, add the group's "professional" provider number to your Provider Central account for access to request on behalf of any providers that have a contractual link to that group.

Go to [Provider Central registration](#) to make any changes you need.

Q: Will we still receive approval by mail?

A: Yes, you will still receive the approval letter, either by fax or mail. (If you would like to be notified by fax, you must complete the [Automatic Fax Back Program Request Form](#).) You can also view and print the letter from the Correspondence section of Authorization Manager.

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. For some services, you may receive an automatic approval. A fax can take three days to be reviewed.

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: Yes.

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 your request is not for a procedure, please refer to the [List of required CPT and HCPCS codes](#) for the appropriate code to use for your service
- If you enter a CPT code that does not require authorization when rendered in an outpatient setting, an inquiry record will be generated automatically. You can use the inquiry number for your reference.
- You have the option to enter multiple codes for each request.
- All services require quantity and units. You must also update the start date field to the requested start date for your service.



AUTHORIZATION MANAGER

Questions & Answers

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. An inquiry number is helpful if your claim is denied for no authorization when the tool said none was needed.

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.

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 or New England plan 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 with a Massachusetts plan. For FEP members with an out-of-state plan, requests must be called or faxed in.

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.

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