MASSACHUSETTS

AUTHORIZATION MANAGER GUIDE

Providers can use the Authorization Manager tool to:

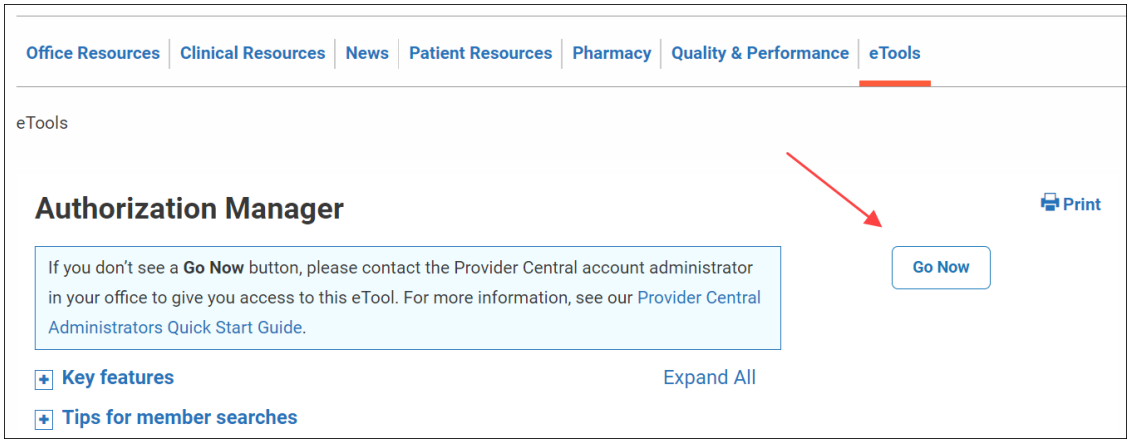
- Submit and view **authorization requests** for Blue Cross Blue Shield of Massachusetts members* and
- Submit and view **referrals** for Blue Cross Blue Shield of Massachusetts members*

*Blue Cross Blue Shield of Massachusetts members who have selected a Massachusetts primary care provider.

This guide will walk you through:

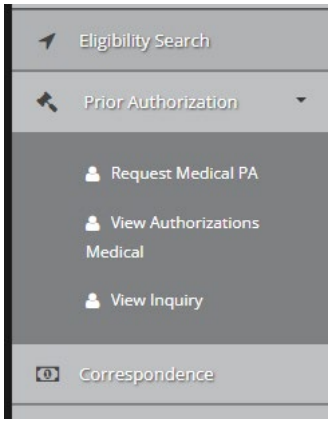
Click here for more information about Provider Central and how to register.

ACCESSING AUTHORIZATION MANAGER

Step	Action
1	Go to Provider Central at **bluecrossma.com/provider** and log in with your username and password. ➡ Not registered? Click **Register** to sign up.
2	Go to the **eTools** tab and click Authorization Manager. Then click the **Go Now** button. 
3	Authorization Manager (powered by MHK) opens displaying the *Medical Authorizations* screen. 

NAVIGATING FROM THE LEFT PANE

Once Authorization Manager opens, you'll see several options in the left navigation menu:

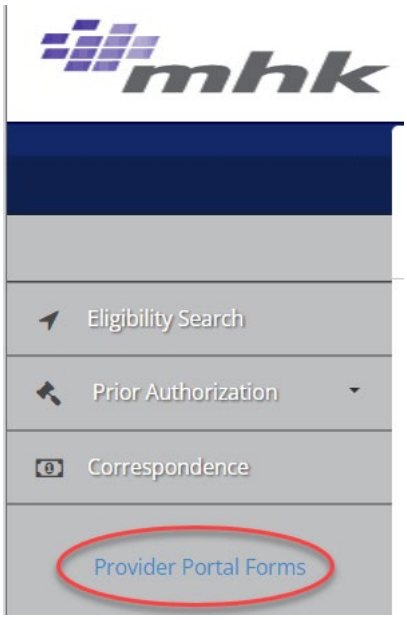


Select	To
Eligibility Search	Search for a member. There are two ways to perform this search. You may search by: • Member date of birth, subscriber ID number, and suffix; or • First and last name, date of birth, and subscriber ID number. *Please note:* • Requests for **twins** require a Member date of birth, subscriber ID number, and suffix search. • Requests for **Federal Employee Plan members with an out-of-state plan** must be called or faxed in.
Request Medical PA	Start a new prior authorization request or referral.
View Authorizations Medical	View authorizations or referrals for the provider listed in the **Requesting Provider** field (this is also the default screen that shows when a provider first signs in).
View Inquiry	Access records that were created when you submitted an inquiry for a service that doesn't require an authorization or referral.
Correspondence	View any correspondence created in Authorization Manager that's associated with the provider who signed in (requesting providers only). *Note*: Servicing providers and facilities can view all correspondence on a specific case from the Member Auth Details screen after clicking the authorization number link.

The left margin also displays a link to Provider Portal Forms library on Provider Central.

If you're entering authorizations for *initial* treatment, certain types of care will require you to submit a specific form.

Click the **Provider Portal Forms** link and then click the left margin option, **Authorization**.



If you	Then
Attach the form to your request	• Make sure you fill out any required fields in the tool. • You don't need to complete non-required fields that contain the same information found on the form.

Examples of forms with links:

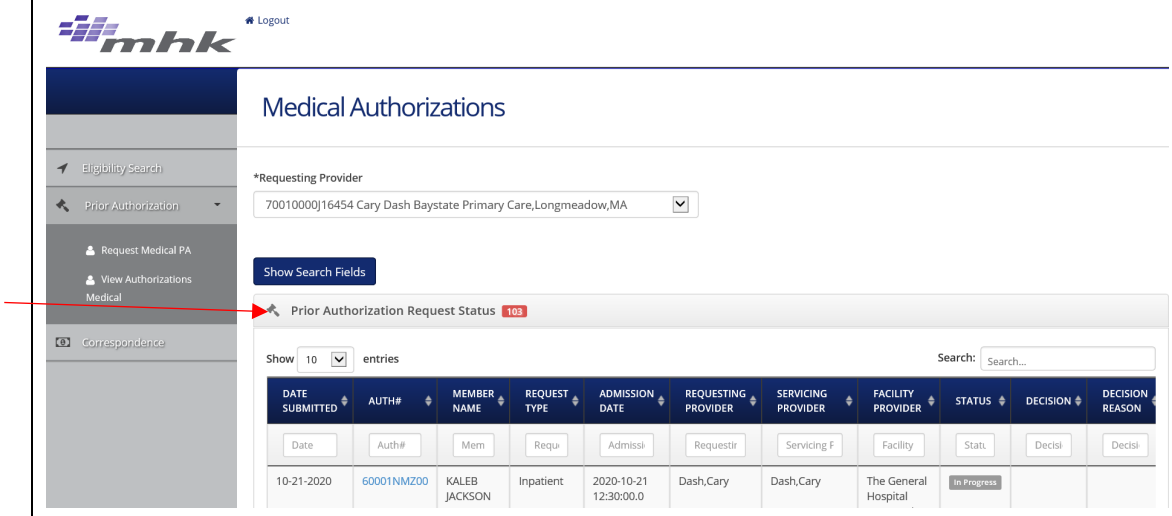
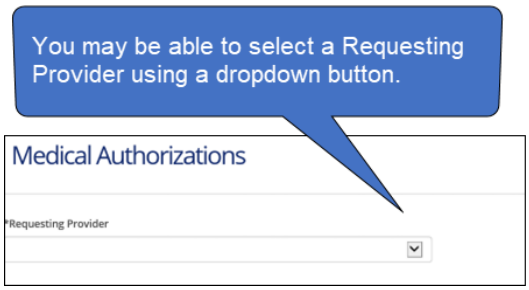
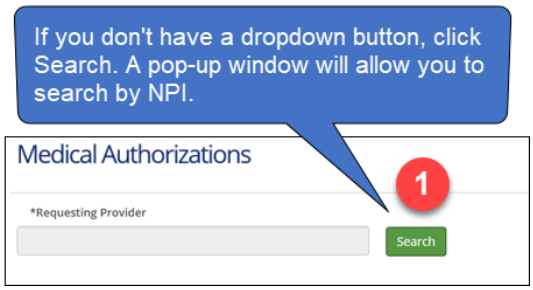
For	See
Ambulance (ground)	Pre-authorization for Non-Emergent Ground Ambulance Transport
Bariatric surgery	Medical policy #379 Surgical Management of Obesity
IMRT/PBRT	Medical policy #325: Request for Clinical Exception to BCBSMA Intensity Modulated Radiation Therapy (IMRT) Policy and Notification Medical policy #678: Request for Clinical Exception to BCBSMA Charged Particle (Proton Beam) Policy and Notification
Managed care out-of-network	Managed Care Out-Of-Network Request You can upload this form to Authorization Manager for outpatient rehab and home health care providers that are out-of-network. However, out-of-network specialist referrals must be faxed in.
Mass Collaborative	Prior Authorization Request Forms
Mental health	Applied Behavior Analysis Service Request Form Behavioral Health – Level of Care Psychological and Neuropsychological Assessment Repetitive Transcranial Magnetic Stimulation Request (rTMS)
SNF/Rehab/LTCH	Initial Precertification Form for SNF/Rehab/LTCH (skilled nursing services, long-term care hospital, or rehabilitation hospital)

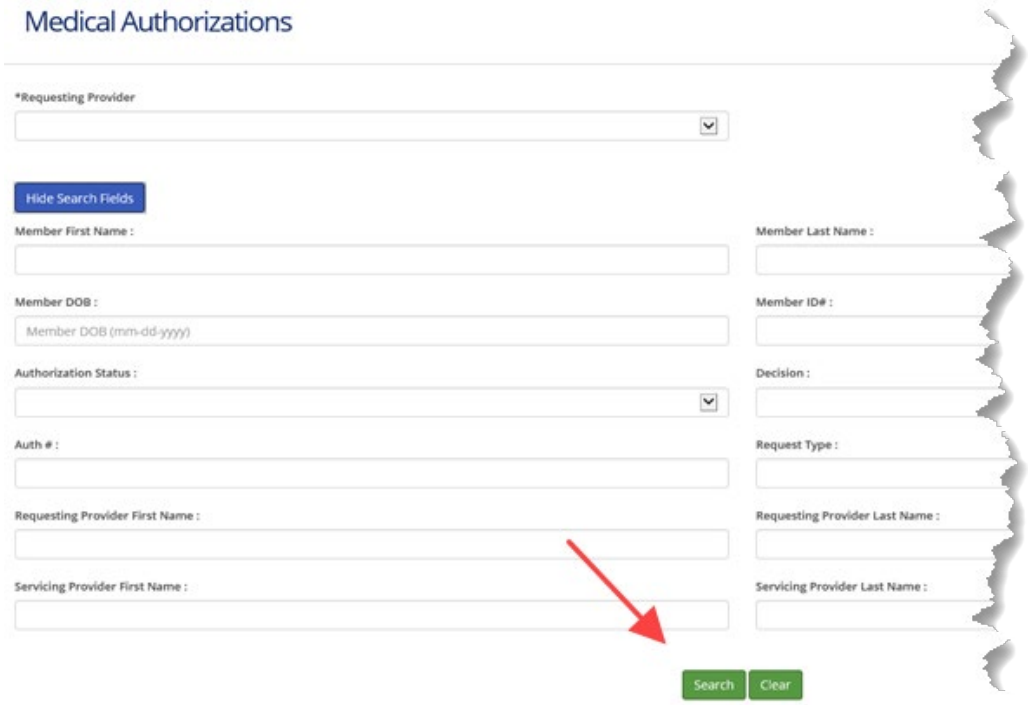
For	See
Transgender requests	Medical policy #901: Gender Affirming Services (Transgender Services) Medical policy #902: Electrolysis for Gender Affirming Services (Transgender Services)

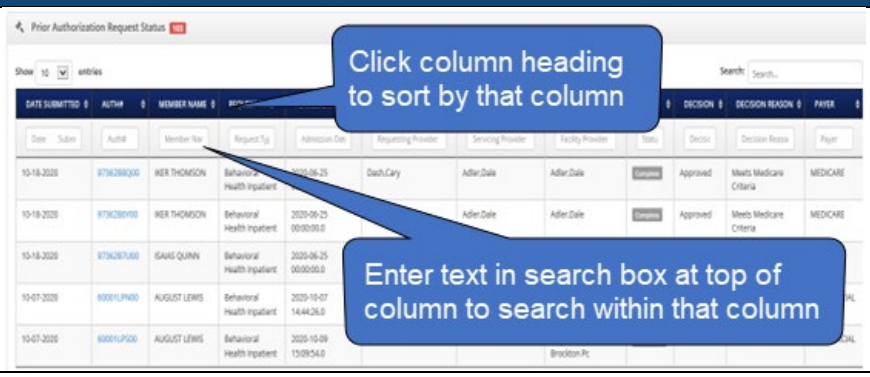
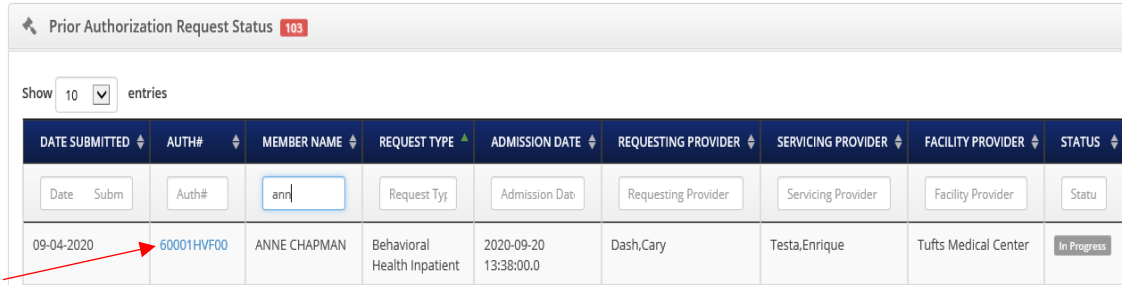
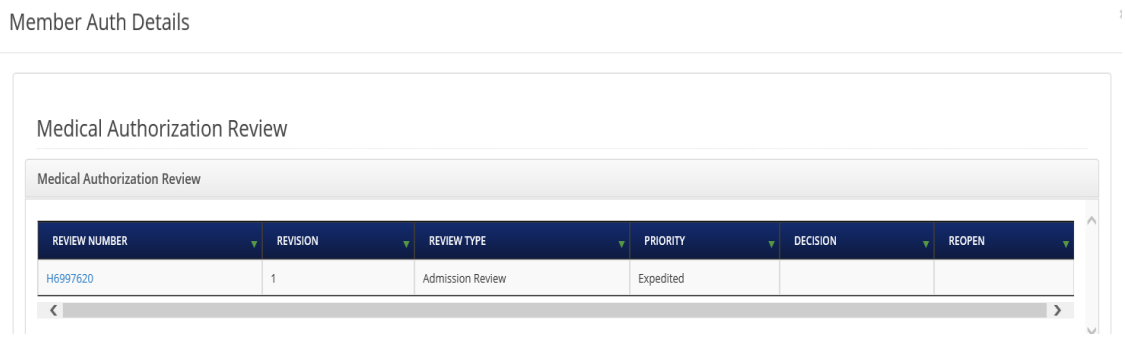
When you've completed the form, please include it as an attachment to your authorization request (see step 11).

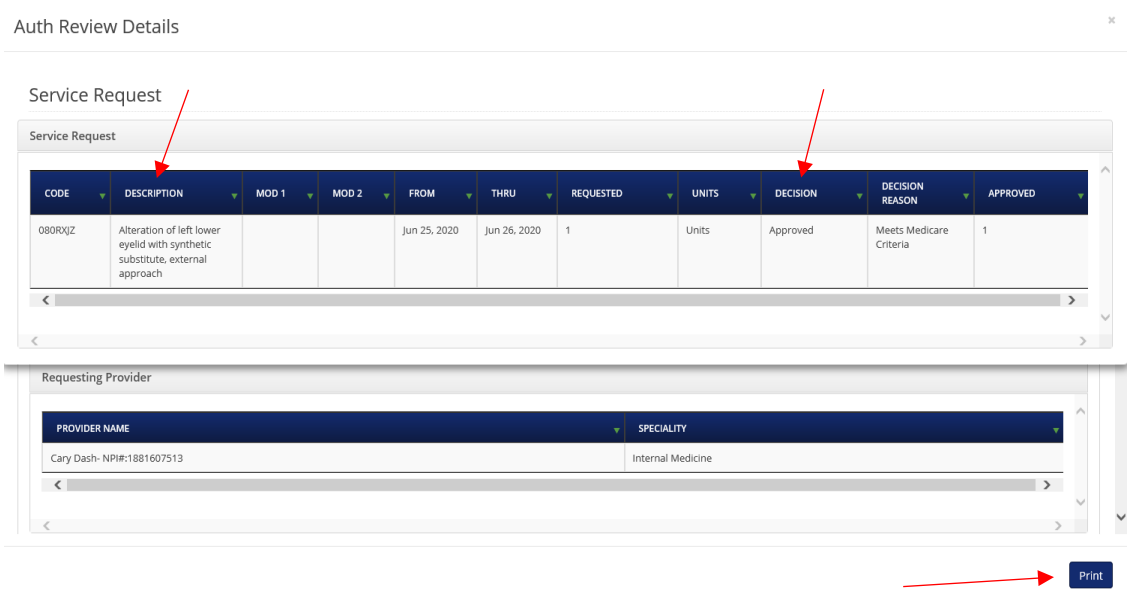
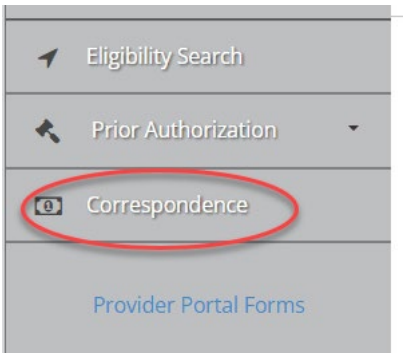
SEARCHING FOR EXISTING AUTHORIZATIONS AND REFERRALS

This section will show you how to search for existing authorizations and referrals created in the tool.

Step	Action
1	Go to the Medical Authorizations screen. Individual providers will see their authorization results displayed under Prior Authorization Request Status.  Go to step 3. Providers in groups may display a different screen based on the number of providers in their group.   Go to step 2.

Step	Action
2	Use the search fields to find specific authorizations by member.  Required fields are marked with an asterisk (*). Once you've entered your search criteria, click **Search**. 
3	Search results will display as shown below. You can: • Sort each column by clicking on the column heading. • Use the search boxes under each column heading to search within that column.

Step	Action
	
4	Once you find the authorization you are looking for, click on the blue authorization number to view it. 
5	The Member Auth Details screen displays.  From here, you can scroll down to view: • Correspondence • CPT/HCPCS codes • Diagnosis • Medical authorization review details • Notes • Provider and specialty • Servicing provider details • Supporting documents Click on the Review Number to see case details.

Step	Action
6	The Auth Review Details page shows the description of the request and what the decision was: approved or denied.  You can print the results as a PDF using the “print” button at the bottom of the page. Or, you can go to the Correspondence option to print in a letter-type format. 

ENTERING AUTHORIZATION REQUESTS AND REFERRALS

Please note
Services needing approval by a vendor such as Carelon Medical Benefits Management or WholeHealth Living, Inc (Tivity) cannot be entered at this time.

Request types	
Outpatient requests	Inpatient requests
• Service request (outpatient medical) • Behavioral health service request (outpatient behavioral health) • Outpatient referral	• Inpatient (inpatient medical) • Behavioral health inpatient

Important

1. When entering an authorization request or referral, you will not have the ability to save and complete later. **Nothing is saved until you submit it**. If there is no activity for 15 minutes, the system will time out and you will lose what you've entered.

2. In addition, you will need to call or fax your request to us in these situations:

    - Federal Employee Program members with out-of-state plans. We need to manually enter these members into our system.

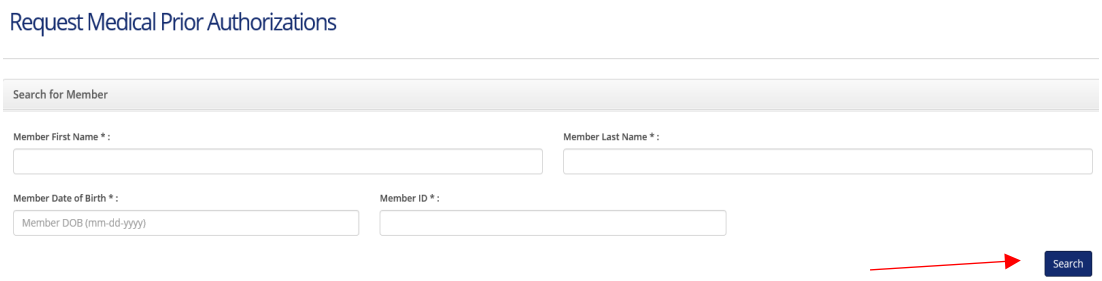
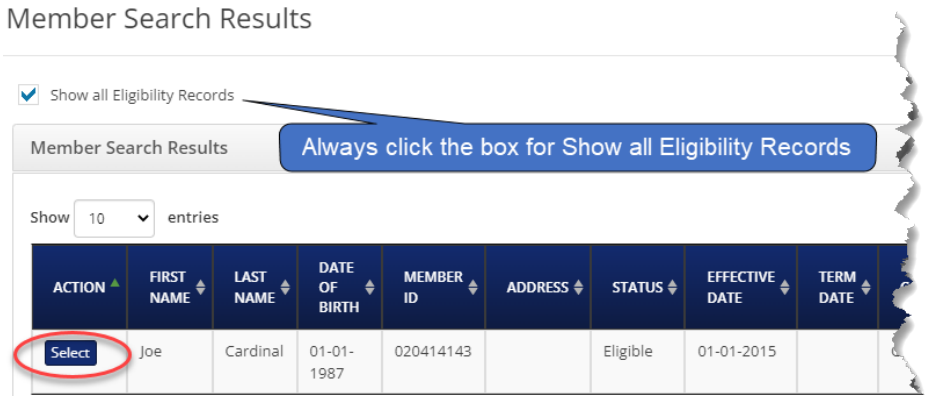
Referrals
You can use Authorization Manager to submit outpatient specialist referrals for our managed care members. Refer to Step 5 in the table below.

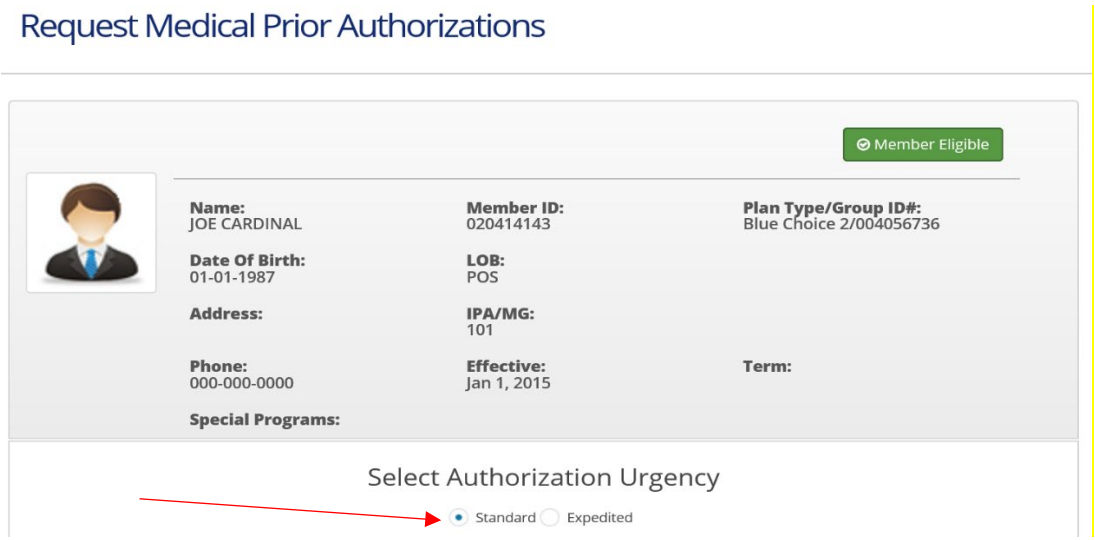
- Primary care physicians can enter specialist referrals, including for fertility services and oral surgery consults.
- Fertility /Assisted Reproductive Technology (ART) specialists can submit referrals for early pregnancy monitoring (EPM). For tips, go to the Guides and Video Demonstrations section on our Authorization Manager page.

Referrals to **out-of-network specialists** need to be faxed in on the Managed Care Out-of-Network Request Form. This is not required for Blue Choice members; they must self-refer to out-of-network providers.

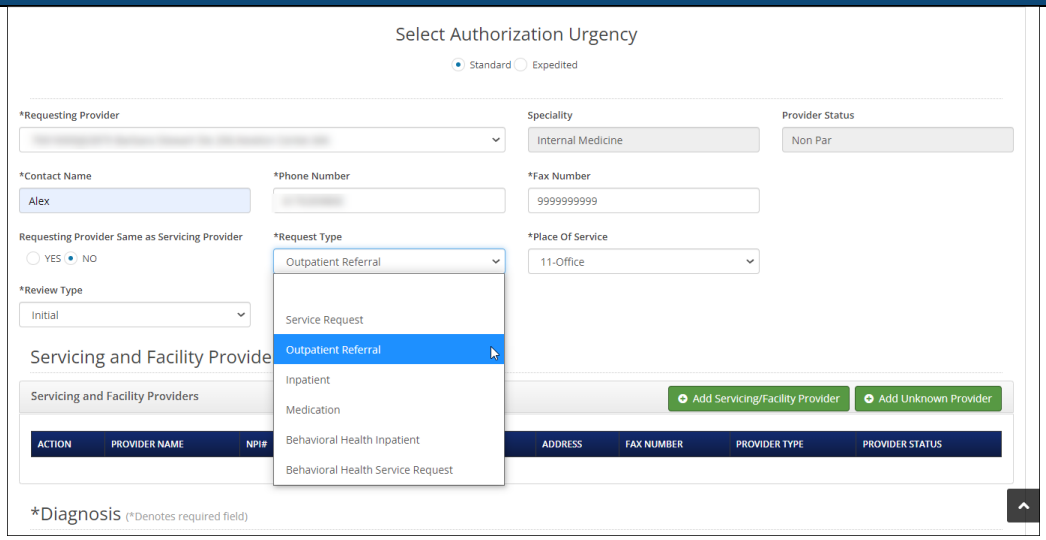
Outpatient rehabilitation and home health care services are service requests, not referrals, and must be entered as a service request. For tips, go to the Guides and Video Demonstrations section on our Authorization Manager page.

To see a list of services that do **not** require a referral, visit the Referrals page on Provider Central.

Step	Action
1	Sign into Authorization Manager. The provider information fields will be pre-populated with your information.
2	Click on **Request Medical PA** in the window on the left side of the screen. The *Request Medical Prior Authorizations* window will display.  Search for the member by entering member first name, member last name, date of birth, and member ID. These required fields are indicated with an asterisk. Click **Search**. Note: If you initiate an authorization and a duplicate exists, you will get an error message: **Duplicate Authorization Case exists. Case number – 123456789**.
3	Member search results are displayed.  Click the box, “Show all Eligibility Records.” This will show any recently terminated plans. Then click **Select** under the Action column.

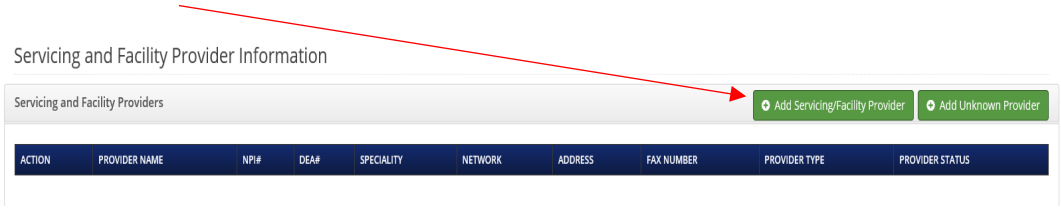
Step	Action
	Note: if the member has more than one active plan, select the one that's appropriate for the service date.
4	Case window opens.  Select Authorization Urgency (Standard or Expedited). Only use "Expedited" when the patient and provider believe that postponing care could place the patient's life, health, or ability to regain maximum function in serious jeopardy.
5	• Add contact name, phone number, and fax number. • For the item, "Requesting Provider Same As Servicing Provider," select **Yes** if the requestor is a doctor or licensed provider. • Use the dropdowns to select **Request Type**, **Place of Service**, and **Review Type**.

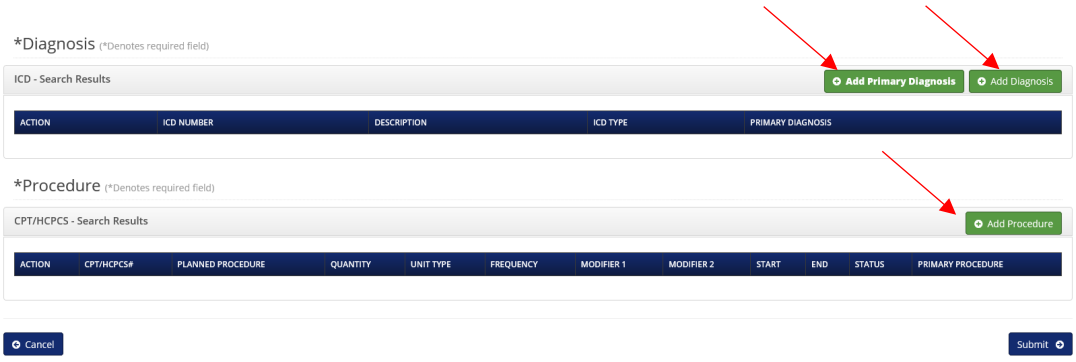
Step	Action



For	Select
Request type	From the appropriate option from the dropdown list: • Service request • Outpatient referral • Inpatient • Behavioral health inpatient • Behavioral health service request • Medication (click here for details about requesting a medication authorization)
Review type	Initial. Note: for outpatient requests, initial is the only option. Initial means the first request. Concurrent requests are not available. Retroactive requests **For** / **You can** HMO members: Select a date going back as far as 90 days. PPO members: Call or fax if you need an authorization to begin beyond 90 days. Phone: 1-800-327-6716 Fax: 1-888-282-0780 For **inpatient**, select admitted or pre-cert admission.
Place of service	Appropriate place of service from the dropdown.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>6</td><td>Servicing and Facility Provider Information
Provider information is pre-populated if the servicing and requesting provider are the same. If needed, additional provider information may be added.
For inpatient requests, add bed type, admit type, admit from, and admit date.
For admit date: Even if the patient has not yet been admitted, you can enter the Requested Admit Date into the From field and the Actual Admit Date field as well. 

Add a facility if service will not be in a doctor’s office. 
</td></tr>
<tr><td>7</td><td>Enter the diagnosis and procedure codes.

Use the green boxes (Add Primary Diagnosis, Add Diagnosis, or Add Procedure) to add the codes. You can search by code or description. We recommend that you use an initial request code in the first position. For a list of initial codes by provider type, click here. 

<table>
<tr><th>For</th><th>Enter</th></tr>
<tr><td>Emergency room, inpatient, or urgent care</td><td>• Diagnosis (required)
• Procedure codes (if available)</td></tr>
<tr><td>All other requests</td><td>• Diagnosis (required)
• Procedure codes (required)</td></tr>
</table></td></tr>
</table>

Step	Action
	Referrals • **Important:** Procedure code 99243 is required, as well as a diagnosis. If no diagnosis is available, you may enter general symptoms (R68.89). • If the specialist bills using a different procedure code, it will not affect the claim. **Using the primary CPT or HCPCS code in the first position** Since there is such a wide range of codes, for the service types below, we recommend that you enter the initial request codes shown in the table in the first position.

Service type	CPT or HCPCS codes
Home health care	**For managed care:** Using a single HCPCS code will create a global authorization that will include all disciplines. **For PPO:** Each discipline requires its own authorization. Refer to List of required CPT and HCPCS codes. (This resource is also available on the Provider Central Authorization Manager page.)
Neuropsychological testing	96132, 96133
Occupational therapy	97165
Physical therapy	97161
Psychological testing	96130, 96131
Speech therapy	92507
Wound vac	97605, 97606, A6550, A7000, A7001, E2402, K0743, K0744, K0745, K0746

Services that must be authorized by a vendor (Carelon or WholeHealth Living)

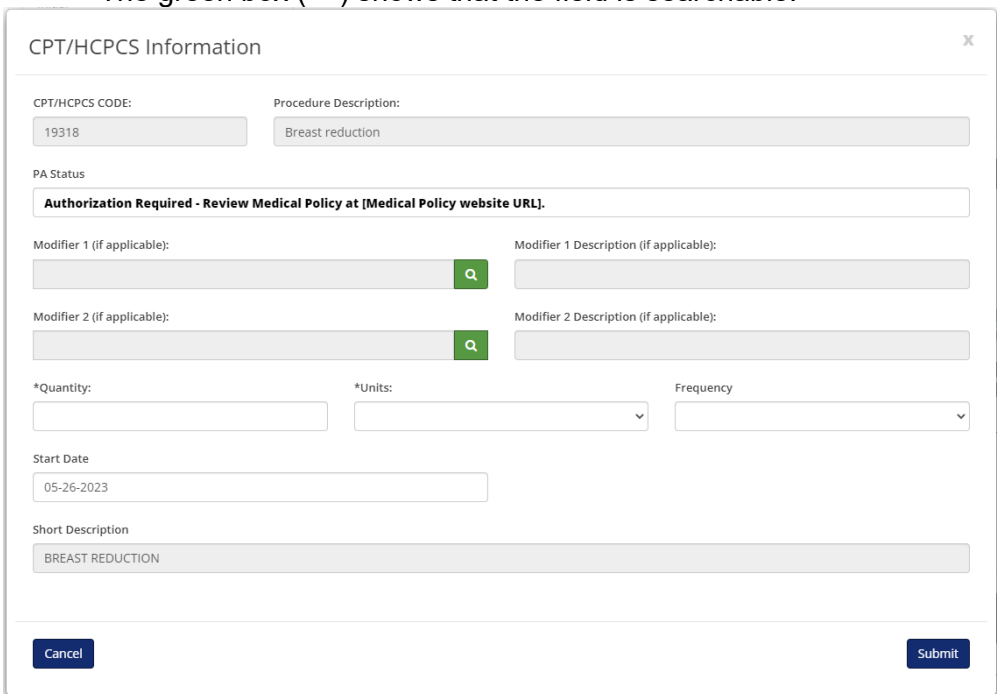
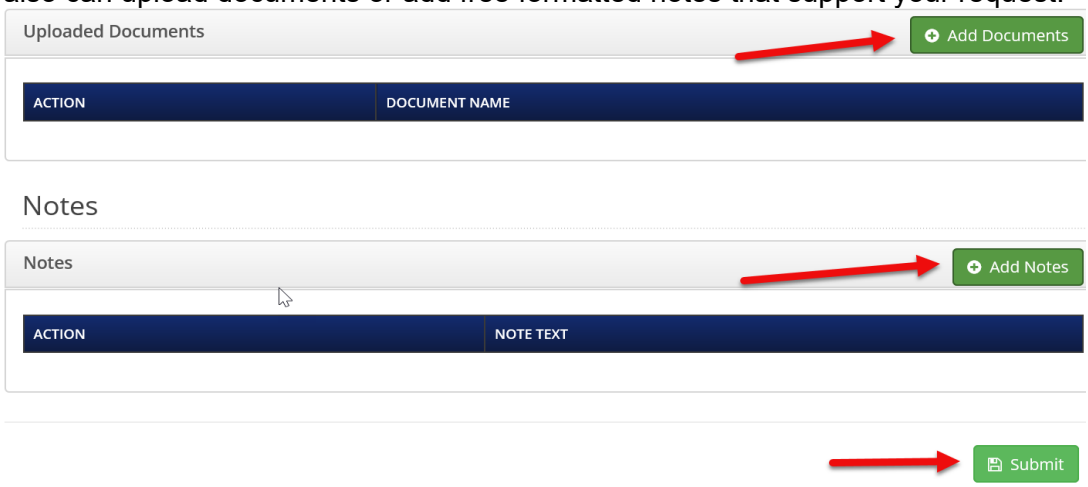
- For examples of more detailed messages that may display based on the procedure code submitted, click here.
- You will not be able to proceed with prior authorization.
- You can check the authorization status, but for details and any related correspondence, go to the vendor's portal.

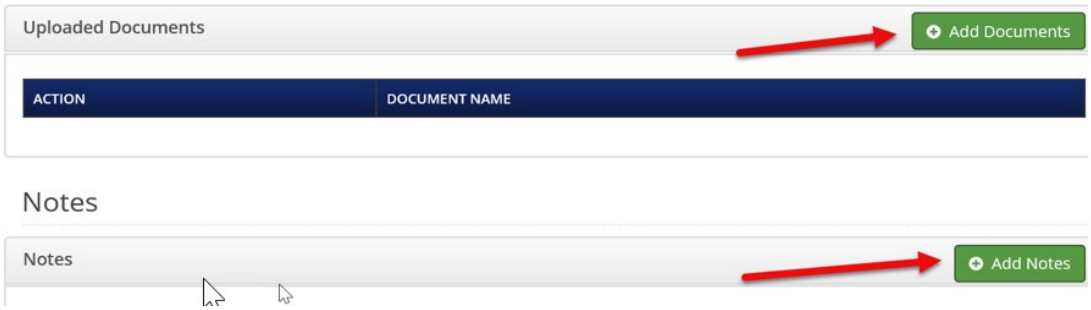
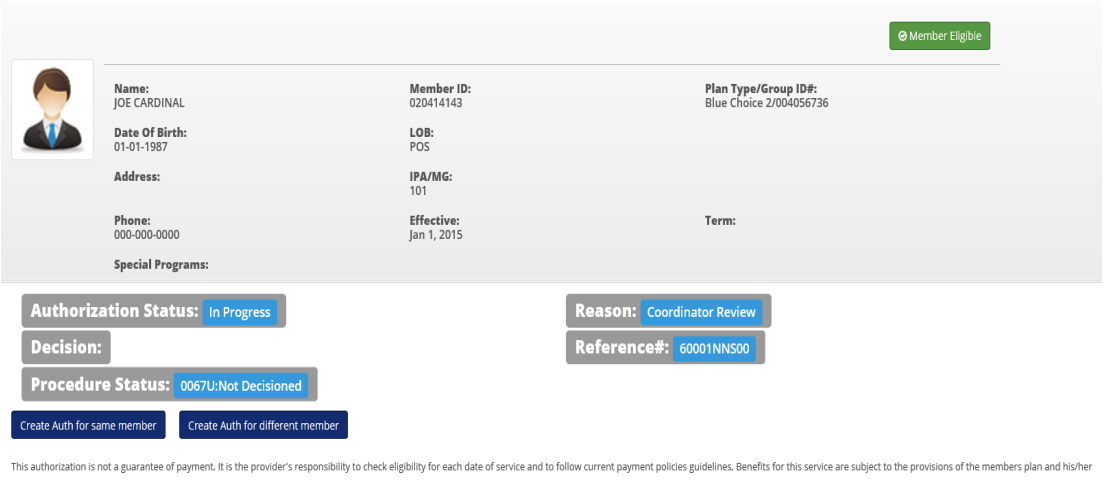
If you ignore the message and try to proceed with the authorization, you will get a pop-up message: "Cannot create authorization."

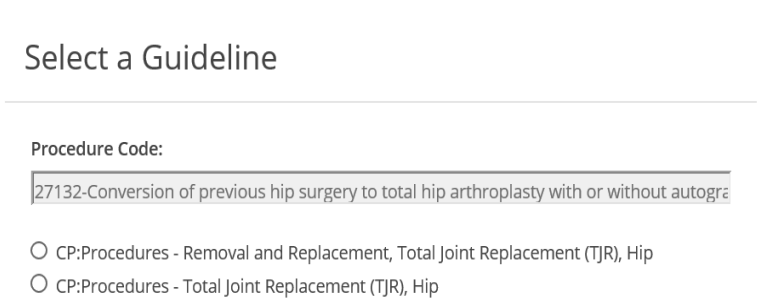
If submitting multiple procedure codes, do not submit services that involve a vendor with those that do not.

To learn more about the services authorized by vendors, visit Provider Central at bluecrossma.com/provider and go to **Clinical Resources>Prior Authorization**.

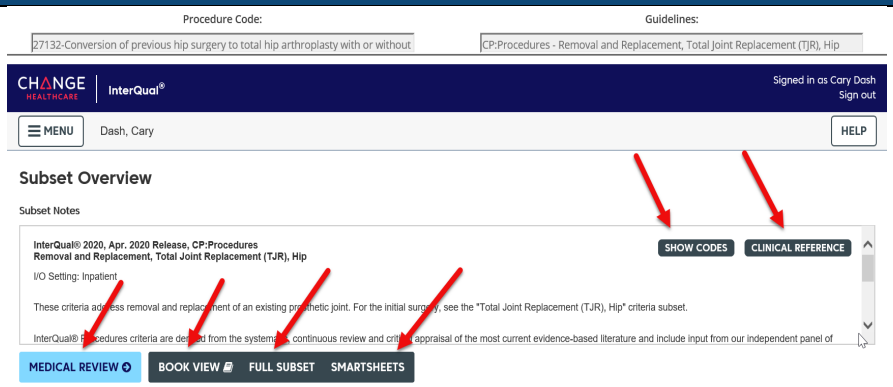
Always view the Status field to see if authorization is required.

Step	Action
8	Add information such as quantity, units, and frequency (as applicable). Be sure to update the **Start Date** field to the requested start date for the service. Notes: • An asterisk shows that the information is required. • The green box ( ) shows that the field is searchable. 
9	Click **Submit**. If any required information is missing, you will be prompted to add it. You also can upload documents or add free formatted notes that support your request. 

Step	Action
	Do not attach clinical for urgent/emergent admissions for EMR facilities, or in-network outpatient rehab, home health care, or referral requests. (However, documentation – the Managed Care Out-of-Network Request Form—*is* required for out-of-network outpatient rehab and home health care.)
10	Review the details of your request for accuracy. You can go back and make revisions until your request is submitted again, as in step 11. If needed: • Add supporting documentation (you can browse and import files in these formats: Docx, Excel, PDF, Text, Word, and image/photo files). • Add a free-formatted note. 
11	Submit the authorization. Once you submit the authorization request, you can no longer edit it; however, you still can attach clinical documentation. For an inpatient case, you can also add a discharge date and disposition.  Please note the message that appears at the bottom of the screens:

Step	Action
	"This authorization is not a guarantee of payment. It is the provider's responsibility to check eligibility for each date of service and to follow current payment policy guidelines. Benefits for this service are subject to the provisions of the member's plan and their eligibility on the dates of service."
12	Complete the medical review if available. This step is currently available for: • Joint surgery • Spine surgery • Pain management You can use Authorization Manager to complete the InterQual® medical necessity checklist for certain procedures performed both in outpatient and inpatient settings for all Blue Cross Blue Shield of Massachusetts members. Note that this applies to surgeries in inpatient settings, as well as outpatient. **How it works** If you enter a CPT code for spine surgery, joint surgery, or pain management, you will be routed to InterQual when you submit your authorization request. Then: 1. The InterQual **Select a Guideline** window will display as a checklist.  From the list, make selections based on the patient's severity of illness, test results, comorbidities, complications, and intensity of services. 2. The **Subset Overview** will display. There are a number of options that will give you more details (see red arrows).

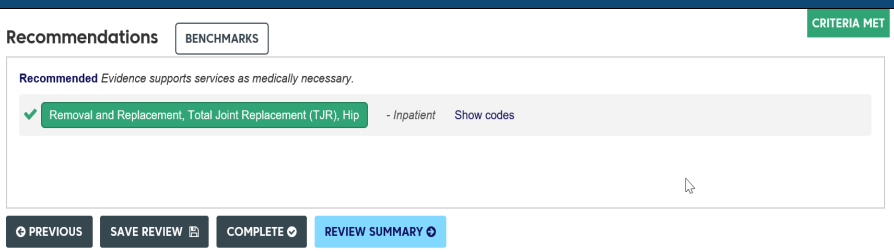
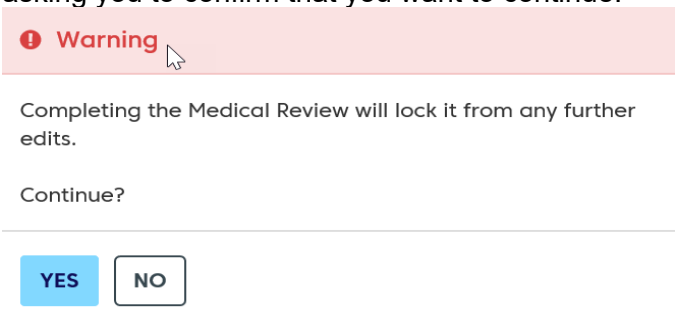
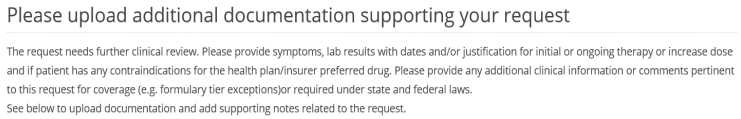
Step	Action



a. Click **Show codes** to view applicable CPT and ICD-10-CM codes.
b. Click **Clinical reference** and scroll down to view available clinical references with links to PDFs.
c. Click **SmartSheets** to print or download the SmartSheet form.
    - If you fill out InterQual through the Medical Review pages of Authorization Manager, you do not need to submit the SmartSheet form to us, since it contains the same information as Authorization Manager. The information you enter through InterQual will determine if the criteria have been met and **your request might be auto-approved.**
        - If you don't have the clinical information handy, you may want to print out the SmartSheet and give it to the clinician to complete before starting your request. Then you can enter that information into InterQual.
    - If you're unable to complete the InterQual critieria and have already clicked Submit in Step 11, close Authorization Manager and return to **upload** clinical information to the case you created.
        - To find the case you created, refer to the section, "Searching for existing authorizations and referrals" in this manual.
    - If you entered the InterQual criteria and they were not met or were partially met, please upload additional clinical information.

3. When you're ready to proceed, click **Medical Review**. You'll be asked a series of questions. Once you've answered each one, the next one will display.
    a. If you cannot answer all of the questions, leave them unanswered and attach your clinical documentation. The case will pend for clinical review.

4. Once you've completed the question section, you'll be taken to a **Recommendations** window. You can select **Review Summary** or one of the other options displayed.

Step	Action
	 5. Click **Complete** to finish the InterQual process. You'll get a Warning pop-up, asking you to confirm that you want to continue.  6. You'll be returned to Authorization Manager. **Outcomes following the medical review** • In most cases, if InterQual criteria are met and the member's eligibility is active, the authorization will be approved automatically. • If the criteria aren't met or the case doesn't auto-approve, the authorization will pend for manual review. You will be given the option to attach additional documents to support your request and our clinical intake team may fax or call you for additional information. • Everyone whose case doesn't auto-approve will see the message below. It's necessary to upload clinical information only if the InterQual criteria weren't met. 
13	You now can submit another authorization for the same member, or a new authorization for a different member.

FREQUENTLY ASKED QUESTIONS

Q: Will correspondence created by another vendor be available in Authorization Manager?

A: No, any correspondence created by other vendors will not be available. You can view authorization details, but not correspondence. Vendors' letters are not available.

Q: As my patient's primary care provider, will I be able to view authorizations and referrals in Authorization Manager?

A: Yes, as long as you are the requesting, servicing, or primary care provider, you'll be able to see authorizations and referrals that are linked to your provider group.

Q: If another vendor, such as Carelon or WholeHealth Living, must authorize my service, can I initiate the request through Authorization Manager?

A: No, you must request the authorization from the vendor. However, you will be able to view the authorization in the tool once a decision is available.

Q: When I get an authorization through Carelon, I get an order number. Is that the same as the authorization number?

A: No, the two numbers are completely different. The order number does not show in Authorization Manager, so please refer to the authorization number (not the order number) when speaking to Blue Cross.

Q: Are the Actual Admit Date and Request Admit Dates the same?

A: Yes, enter the same date in both fields, even for future requests.

Q: When searching for the status of an authorization under my NPI, what identifiers will I see?

A: You will see **canceled**, **complete**, or **in progress**. There are other values appearing on the dropdown, but they are not in use.

Q: My request shows approved but it also says in progress. What does that mean?

A: Your initial requested days/units have been approved. The status will remain **in progress** until the patient has been discharged or the services provided are complete. For example, the patient has been admitted to an acute facility. The initial authorization is for five days. The authorization will be kept **in progress** in case additional days are requested. Once the member is discharged, the authorization status will change to **complete.**

GLOSSARY

Term	Definition
Admission review	Initial inpatient review.
Canceled	Authorization request withdrawn or voided.
Completed	Authorization request was built, decisioned, and finalized.
Concurrent review	Subsequent inpatient review.
Continued review	Subsequent service request (outpatient) review.
Correspondence	Communications initiated from within the review section of the case, including approval and denial letters, requests for information, and outgoing faxes.
Decisioned	A decision on an authorization request: approved, denied, or partially denied.
Initial	The first service request (outpatient) review.
In progress	A request that is open awaiting a decision or potential concurrent review.
No auth required	Shows when the request does not require authorization.
Prospective review	This type of review is conducted before an inpatient admission or before an outpatient service is rendered. Prospective review is sometimes referred to as pre-certification, pre-authorization, prior authorization, or pre-service review.
Reference number or ID	Blue Cross Blue Shield of Massachusetts refers to this as an authorization number. On some screens, it is referred to as auth number or case number. Reference number = auth number = case number = auth ID
Request type	Identifies the type of request and level of care. There are five request types: • Medical: inpatient and outpatient (service request) • Behavioral health: inpatient and outpatient (service request) • Medication
Review type	Type of review requested (initial request and concurrent request).
Service category	The general description of the types of services provided. Each service category is typically broken down into sub-categories defining the level of care. Examples: • Medical: outpatient rehab, ambulance, referrals, and high-tech radiology. • Behavioral health: ABA, alternative levels of care, outpatient, and procedures.
Service request	An outpatient or any non-24-hour level of care request (behavioral health only).
Status	Identifies where the case is (in progress, approved, canceled).
Sub-category	Related to the service category dropdown values, further describing the service provided. Examples of outpatient rehabilitation include physical therapy, occupational therapy, speech therapy.
Void	A case that has been voided due to a data entry error or because it's a duplicate case.
Withdrawn	A request which has been withdrawn by the member or provider.

EXAMPLES OF MESSAGE CODES

Vendor/service type	Message displayed
Carelon must authorize the procedure	Authorization is required for this service. Authorizations are administered by Carelon. Please submit request to the Carelon portal via link from the BCBSMA portal or via phone at 1-866-745-1783.
Chiropractic services for visits 13 and beyond	Authorization may be required for covered visits 13 and beyond. To obtain an authorization, Blue Cross Blue Shield of Massachusetts-participating chiropractors should log on to bluecrossma.com/provider.
Non-emergency ground ambulance	Authorization is required for non-emergent ground ambulance. Log on to **bluecrossma.com/provider** and click on Clinical Resources>Coverage Criteria & Guidelines>Medical>Medical for information about our policy and documentation requirements.
Transplants	Authorization required/check member's benefits for Blue Distinction Center of Excellence transplant requirements.
Benefit plan restrictions	Review the patient's benefits because either they have no benefit for this service, or their account has unique benefits. Go to ConnectCenter to check benefits.

Go back to services that must be authorized by another vendor

MEDICATION REQUESTS

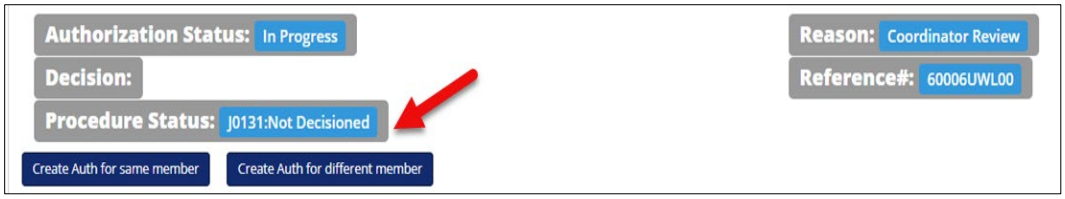
You can use Authorization Manager to request authorization for medications that you buy and bill us for, and that are administered using the member's medical benefits.

Note: Home Infusion Therapy requests must be faxed in.

Required information for medication requests

Field name	Use this value
Request type	Medication
Place of service	11-Office or 22-On Campus-Outpatient Hospital
Review type	• Initial - Part B and HIT (for patients with **Medicare**) • Initial - HIT or Medical (for **all other** patients)
CPT/HCPCS#	Appropriate "J" code to designate the medication you're requesting

- Medication requests will pend with a "Not Decisioned" message:



- You can view the status of your request no matter how you submit it.
- For urgent requests, select Expedite. We will respond within 24 hours.
- **Questions?** Call Pharmacy Operations at **1-800-366-7778**.

Document History

Date	Changes
8/20	New document
5/21	Addition of instructions for medication requests
11/21	• Updates to the section, "Authorizations based on service type by product" • Addition of referral submission information and medical review/InterQual information • New document number
5/1/22	Removed hysterectomy from list of surgeries requiring medical review.
8/4/22	Replaced "Online Services" with "ConnectCenter" in the section, Examples of Message Codes.
1/23	Removed WholeHealth Networks phone number in the section, Examples of Message Codes.
3/23	Updated the medical review step (step 12) on page 17 to clarify when the medical review process is applicable.

6/23	Added information about the View Inquiry feature. Updated screenshots and clarified instructions. Updated name of WholeHealth Networks to WholeHealth Living.
8/24	Updated to include instructions for entering requests for a twin.

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