

ENHANCED AUTHORIZATION PROCESS USING THE PA CHECKPOINT TOOL AND PREDICTAL



ND

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Overview

This applies to only BCBSND Medicaid Expansion and Commercial lines of business.

The PA Checkpoint and Predictal tools are integrated through Availability Essentials providing providers with a faster pathway to check if a service requires prior authorization, as well as submit a precertification. This enhances the case management and utilization management team processes.

Providers will access Predictal through a single sign on (SSO) to complete the online precertification and the request will be directly routed to a nurse for review – skipping the manual set up needed for faxed submissions. Providers will access the PA Checkpoint tool through the Authorization section of Availability Essentials.

The Predictal tool process will also be utilized for Medicaid Expansion referrals. You will need to ensure "referral" is selected; this is outlined in step 12 below. Medicaid Expansion referrals do not go through PA Checkpoint. This is also noted within the PA Section.

Note: The terminology precertification, preauthorization and prior authorization are all used interchangeably, but refer to the same process.

Before Getting Started

If you have not done so already, [register for Availability Essentials](#). For the best experience, set Google Chrome as your default browser.

If you are already signed up for Availability Essentials, you must have access to the Authorization and Referrals section to be able to utilize this process. If you do not have access, an error

message will display. You will need to contact your Availity Essentials facilities administrator to give you the proper authorization access.

You can find your facilities appropriate administrator information by:

1. Going to your **Account | My Account**.
2. On the My Account page, click the **Organization(s)** tab.
3. Then click **Open My Administrators**.

The administrator can grant access when applicable through the Maintain User Application on the Availity Essentials account dashboard.

Check if Authorization is required in Availity Essentials

Prior Authorization requests are the exchange of information between Providers and BCBSND to establish medical appropriateness and necessity of services.

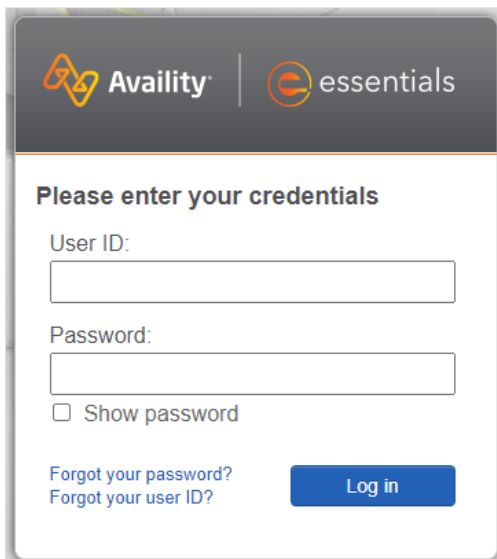
There are several ways to determine if a service requires prior authorization for a member:

- Call BCBSND Provider Services by calling the number on the back of the member ID card
- Utilize the website: <https://www.bcbsnd.com/providers/policies-precertification/prior-authorization>
- Utilize the Availity Essentials provider portal

The below steps will assist you in using the Availity Essentials provider portal:

Step 1: Log into Availity Essentials. Providers **must** use Google Chrome web browser.

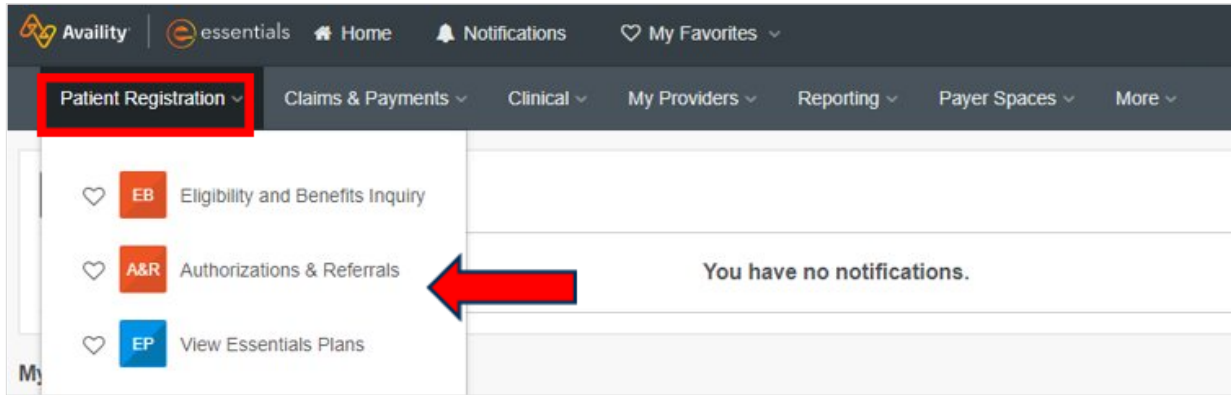
<https://apps.availity.com/availity/web/public.elegant.login>



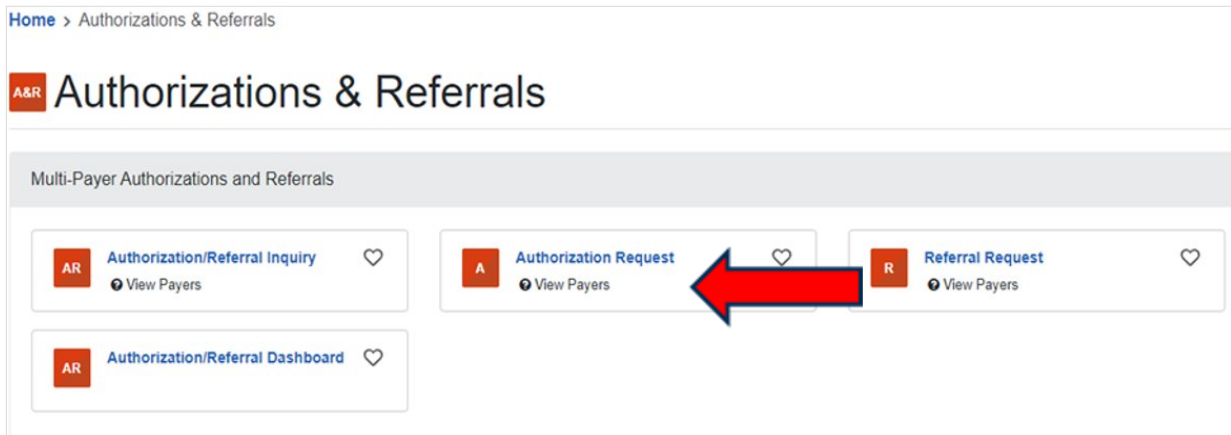
The screenshot shows the login interface for Availity Essentials. At the top, there are logos for 'Availity' and 'essentials'. Below the logos, the text 'Please enter your credentials' is displayed. There are two input fields: 'User ID:' and 'Password:'. Below the password field, there is a checkbox labeled 'Show password'. At the bottom left, there are links for 'Forgot your password?' and 'Forgot your user ID?'. At the bottom right, there is a blue 'Log in' button.

Step 2: Select the **Patient Registration** tab from the home menu, then select **Authorization & Referrals**.

Note: You must have access to perform this functionality to complete an authorization, if you do not have access you will need to contact your Facility Availity Essentials Administrator.



Step 3: Select the **Authorization Request** option.



Step 4: Enter in the **Organization**, **Payer**, and **Request Type** details.

Note: Fields with * are required

- a. Enter your **Organization Name** or select from the drop-down menu.
- b. Template - not applicable.
- c. Select the appropriate **Payer**.
- d. Enter the appropriate **Request Type** of **Inpatient Authorization** or **Outpatient Authorization**.
 - i. Choose inpatient for when the patient will be in an inpatient setting and will need to authorize room and board.
 - ii. Choose Outpatient for approval of a service.



Home > Authorizations & Referrals > Authorizations Need help? Watch a demo about Authorizations and Referrals.

A Authorizations Give Feedback [Go to Dashboard](#) [New Request](#)

SELECT A PAYER

Organization ▼
BCBS North Dakota

Template(s) optional [Manage Templates](#)
No template selected ▼

Select a template from the list or continue with Payer and Request Type fields.

Payer ⊗
BCBSND x ▼

Request Type ⊗
Inpatient Authorization x ▲
Inpatient Authorization
Outpatient Authorization

[Next](#)

Step 5: Select *Next*.

This will take you to the BCBSND PA Checkpoint Authorization Tool.

Step 6: Start your *Authorization*.

a. Enter the ***Patient and Procedure Information***.

- i. You may be able to select the patient from the drop-down menu if you have completed a request for this member in the past.
- ii. If not, enter the Member ID or Unique Member Identifier (UMI) as it appears on the Member ID card.
- iii. Add the member's date of birth.
- iv. Identify the member relationship.
- v. Select the appropriate service from date, procedure code and type.

Once the fields are complete, select Next.

Member ID ⊗

Service From Date ⊗

Procedure Code ⊗ Type ⊗

[Add another procedure code](#)

Note: If this is a Medicaid Expansion referral request, click Skip.

of the applicable benefit plan, applicable in denial of payment.

Back Next Skip

Results will populate on the next screen:

If no authorization is required, the screen will state "NO AUTH REQUIRED." This will stop the authorization process and providers will not be able to proceed.

No Authorization Required

Service From - To Date
2023-08-24

Procedure Code 1
G9873

Status
NO AUTH REQUIRED

If Authorization is required for any of the searched codes, the screen will state "AUTH REQUIRED" and allow you to move forward by clicking **Next Steps**.

Status
AUTH REQUIRED

Print Next Steps

Reminder: Federal Employee Program (FEP), Medicare Supplements and NextBlue of North Dakota are excluded from this tool.



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A Authorizations Give Feedback Go to Dashboard New Request

1 **Start an Authorization** 2 Add Service Information 3 Rendering Provider/Facility 4 Review and Submit

Transaction Type Inpatient Authorization	Organization BCBS North Dakota	Payer BCBSND	
--	--	------------------------	--

PATIENT INFORMATION

Select a Patient

Search by any combination of patient name (first and last), DOB, or Member ID.

Member ID

Relationship to Subscriber

Patient Date of Birth

- b. Add the **Admitting/Attending Provider**. Choose the appropriate provider result and verify and complete any needed information that may be missing.

ADMITTING/ATTENDING PROVIDER

NPI

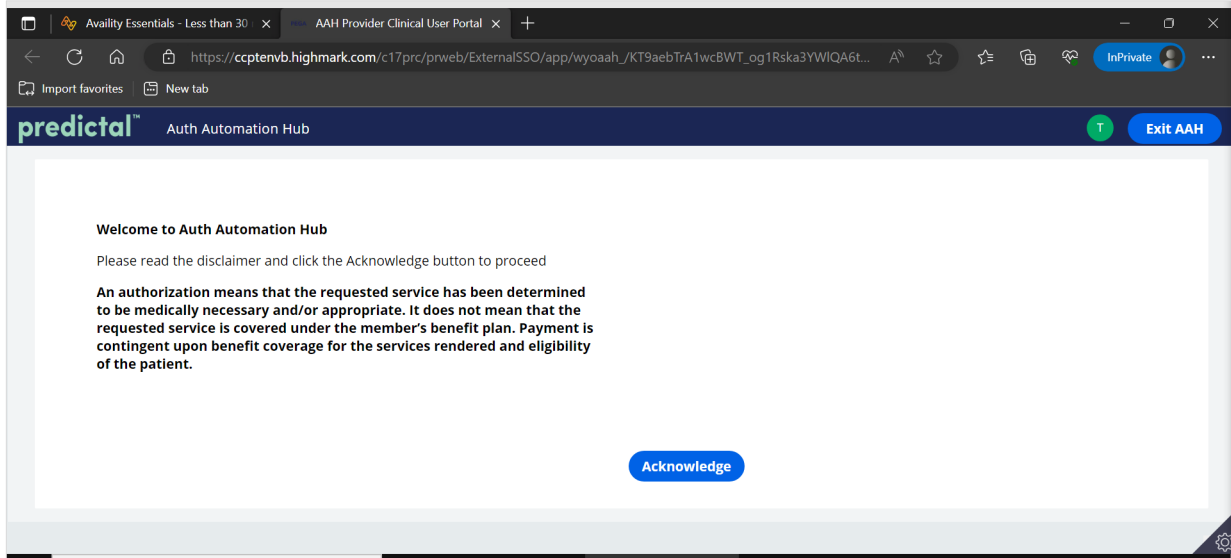
I don't know the Provider's NPI

- c. Verify your **Contact Information**.
- d. Click **Next**.

Note: Providers will then be transitioned into the Predictal system to continue with the request. Separate sign-in is not required.

Entering New Authorizations

Step 1: Click *Acknowledge*.



Important Note: The save and submit buttons that may appear while submitting a case have different functionalities.

Buttons

Save

This feature is intended to be used to save and come back later. It is best practice on any screen to click save if there is any possibility you will not complete the screen.

Saving will not send anything to BCBSND for review.

Submit

The submit button takes the inputs from the screen and then processes them taking you to the next page in the workflow. On some screens there may not be a back button. It is important that before you click submit you are sure of the inputs on the screen.

Step 2: The patient information will default from the member information entered within the Availity Essentials entry.



Providers will then follow the steps below for directions on how to fill out a new case request.



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Step 3: Add supporting documentation in the **Recent Attachments** section, select the + symbol.

Note: Ensure all documentation to support the medical necessity of the service you are requesting is included. Providers will not be able to attach documentation after a case is submitted to BCBSND for review.

The screenshot shows the Predictal Auth Automation Hub interface. At the top, there is a header with the Predictal logo and 'Auth Automation Hub'. Below the header, there is a table with columns for Member Name, Member ID, Date of Birth, Client Name, Plan Type, Case Type, Authorization Type, Urgency, and Service Type. The table contains one row of data. Below the table, there are four steps: 1. Authorization Details, 2. Enter Provider, 3. Review Authorization, and 4. Confirmation. The 'Review Authorization' step is active. On the left, there is a 'Case Information' section with radio buttons for Authorization Type (Medical-Inpatient, Medical-Outpatient, Behavioral-Inpatient, Behavioral-Outpatient, Pharmacy) and Case Type (Prior Authorization, Retrospective Pre-Claim Review, Retrospective Claim Review). There is also an 'Urgency' section with a radio button for 'Urgent'. On the right, there is a 'Request information' section with fields for Case Received (07/26/2023 10:49 AM), Start of Care Date (07/26/2023), and ContactChannel (Electronic submission). At the bottom right, there is a 'Recent attachments (0)' section with a plus sign (+) to add attachments.

1. A Pop-up window will display.

a. Select **Attach File**.

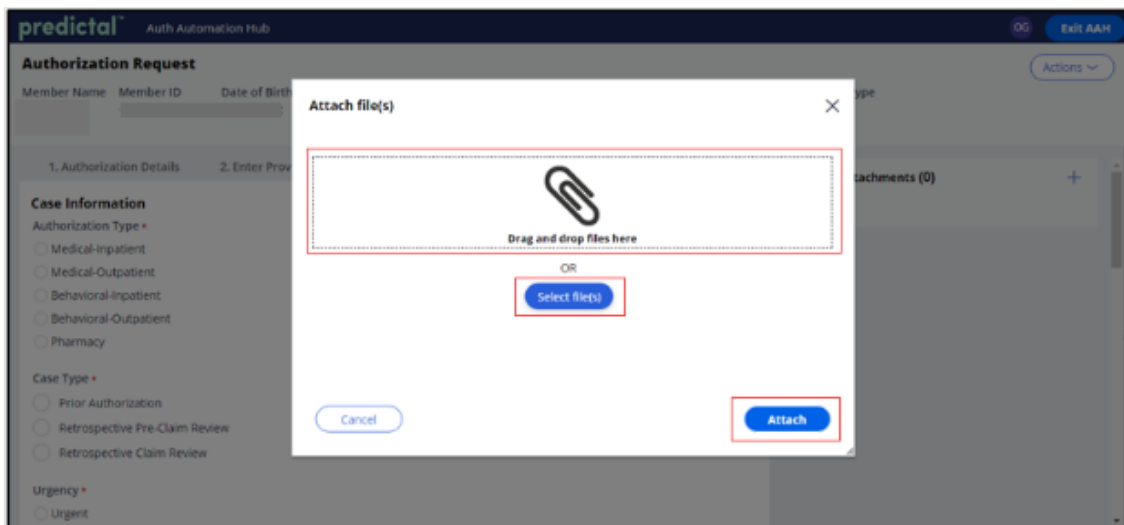
The screenshot shows the Predictal Auth Automation Hub interface with a pop-up window over the 'Recent attachments (0)' section. The pop-up window has two options: 'Attach File' and 'Attach URL'. The 'Attach File' option is highlighted with a red box.

b. Click the **Select File(s)** button. Select the **File** you wish to attach.

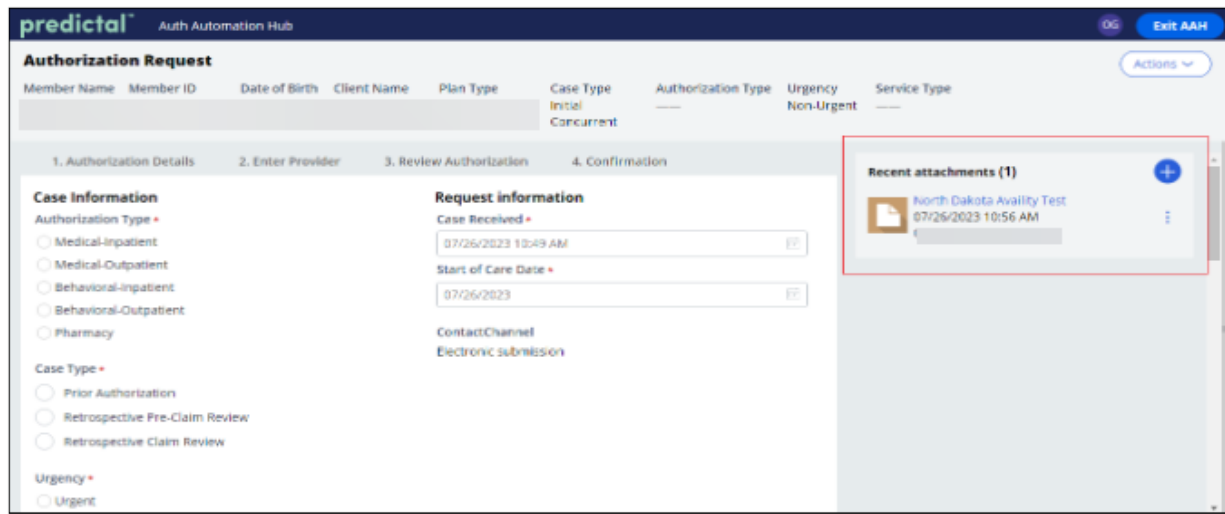
OR

c. Drag and drop the file here in the paperclip field.

d. Click **Attach**.



The attachment will display in the **Recent Attachments** section when uploaded.



Step 4: Complete the **Case Information** section based on your authorization submission.

Case Information

Authorization Type *

- Medical-Inpatient
- Medical-Outpatient
- Behavioral-Inpatient
- Behavioral-Outpatient

Case Type *

- Prior Authorization

Urgency *

- Urgent
- Non-Urgent

Network Exception

- Yes
- No

- e. **Authorization Type**- Is the tag on an authorization that determines if it is Medical versus Behavioral Health and Inpatient versus Outpatient. Utilize the place of service guide attached to Step 12.

Inpatient Versus Outpatient Distinction

Inpatient	The authorization signifies approval or denial for days .
Outpatient	The authorization signifies approval or denial for a specific Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. This is approving a code and the units allotted for the specific code. The date range indicates the timeline for the approval or denial and the units listed.

- f. **Case Type** - Providers will only utilize the **Prior Authorization** option, which is the standard request for review of services for benefits and medical necessity.
- g. **Urgency**
 - Prior Approvals or Precertification that are deemed urgent should be reviewed within 72 hours.
 - For a request to be deemed urgent, the absence of treatment:
 - Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function

OR

- In the opinion of a Health Care Provider with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment being requested.
- If the request does not meet the above criteria, it will be considered non-urgent and should be reviewed within 15 days.
 - Depending upon inventory, reviews should be addressed within 7 days or less.

h. **Network Exceptions-** will default to no. Please do not change the default.

Step 5 Complete the **Request Information** section based on the authorization submission.

Request information

Case Received *

Start of Care Date *

Contact Channel *
 Electronic Submission
 Email
 Fax
 Letter
 Phone

Initiated By Member? *
 Yes
 No

Step 6: Complete the **Detail Information** section based on the authorization submission.

Place of service will vary by type of authorization selected. Utilize the [Choosing Service Types guide](#) to assist you in determining which Place of Service and Service Type should be selected.

Detail Information

Place of Service *

Service Type *

- a. As noted earlier in this document, Medicaid Expansion referrals are also submitted through the authorization process. If you are submitting a Medicaid Expansion referral select your Place of Service, and then choose Referral in the Service Type drop down menu. You will complete remaining asterisked fields, as necessary.
 - i. See section **Referrals for Out-of-Network Services** for more information on what requires a referral, as well as additional coding information, such as using CPT 99199 for Medicaid Expansion referrals.



Detail Information

Place of Service +
Outpatient

Service Type +
Referral

Diagnosis Information

Code Set Type*	Code*	Description*	
ICD 10	K70.30	ALCOHOLIC CIRRHOSIS OF LIVER WITHOUT ASCITES	Remove

Add

Procedure Information

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Code Set Type* Code*
CPT 99199

Description
UNLISTED SPECIAL SERVICE, PROCEDURE OR REPORT

Step 7: Complete the **Diagnosis Information** and **Procedure Information** section based on the authorization submission.

Note: For inpatient medical a CPT code is not required. For inpatient planned surgical, a CPT code is required.

- a. To add an additional blank Diagnosis field, click the blue **Add** button. To remove a blank code field, click **Remove**.
- b. The from date will auto-populate to the today's date, number of days will auto-populate to 1, request units will auto-populate to 1, and Unit Type will auto-populate days; change these fields, as necessary.

Diagnosis Information

Code Set Type*	Code*	Description*
ICD 10		---

Add

Procedure Information

Code Set Type* Code* Description
Select... [] ---

From* Through* Number of Days* Requested Units* Unit Type*

07/10/2023 [] [] [] [] Select... []

Add

A completed example of these fields may look like this:

Diagnosis Information

Code Set Type*	Code*	Description*	
ICD 10	D01.2	CARCINOMA IN SITU OF RECTUM	Remove

[Add](#)

Procedure Information

Code Set Type*	Code*	Description	
CPT	78815	POSITRON EMISSION TOMOGRAPHY (PET) WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPHY (CT) FOR ATTENUATION CORRECTION AND ANATOMICAL LOCALIZATION IMAGING; SKULL BASE TO MID-THIGH	Service Description

From*	Through*	Number of Days*	Requested Units*	Unit Type*	Sub-Service Type*	
07/27/2023	10/24/2023	90	1	Units	Other	Remove

Note: The *Indicate Location of Clinical Information* section is not a required field at this time. Proceed to next step.

Indicate Location of Clinical Information

[Add](#)

Step 8: Click **Submit**.

Step 9: Enter the **Submitter Contact Information**.

Step 10: Copy the provider information or manually enter the details.

Note: The system retrieves the Ordering/Attending Provider details from the Availity Essentials portal. Providers have the option to copy the same performing provider by clicking on the **'Copy as Performing Provider'** button.

For outpatient requests only a vendor is needed for Durable Medical Equipment (DME), otherwise you only need to list the ordering provider. If you want the response to go to a different person do not use the copy button function.

For inpatient requests, a vendor (where the service is being done) and ordering provider details are always required.



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Authorization Request

Member Name Member ID Date of Birth Client Name Plan Type Case Type Authorization Type Urgency
Non-Urgent

Practice Group NPI	Practice Group Name	Practitioner NPI	Practitioner Name	Practitioner City	Prac. State	Prac. Zip Code
▶						

Authorization Request Submitted By *
[Dropdown]

Request details to be sent to fax
[Text Input]

Back Save Submit

Step 11: Input the *Provider Details*.

- Search for the provider. Once you click **Search** the records found will display under the search criteria.

Ordering/Attending Provider

Search For (Please Select Appropriate Provider Type) *

Practitioner Practice Group

Search By *

Provider ID Name

First Name * Last Name *

[Text Input] [Text Input] Search Search NPI Registry

1 match found

Practice Group NPI	Practice Group Name	Practitioner NPI
▶		

- Click on the record which will highlight in blue and begin to display additional information.



Practice Group NPI	Practice Group Name	Practitioner NPI	Practitioner Name

Addresses **Networks**

Practice Group Tax ID	Practice Group BSID	Practitioner BSID

- c. Select the **Record** for the location address where you want the rationale letter to be sent. Providers must open the caret symbol and click on the correct record to highlight the information, if this step is missed, an error message will display.

Address Type	Practice Group Address	Practice Group
Main		
Vendor		

- d. Select from the drop down the **Authorization Request Submitted By**.
- e. Click **Submit** at the bottom of the page.

Note: When adding the Primary Fax #, ensure it is the fax number of the person who needs the final determination information.

Step 12: Review all the input information and click **Submit**.

Note: If you need to make any corrections, use the back button in the bottom left-hand corner.

Step 13: If there are any duplicate cases, where the information entered is the same for both submissions, a message will appear on your screen. Click **Continue As New Case** if the cases are not truly a duplicate.

Note: If the case is a duplicate, highlight the duplicate case and click on the **Resolve as Duplicate** button and follow the prompts.

1. Authorization Details 2. Enter Provider 3. Review Authorization 4. Confirmation

Duplicate Cases. Review potential duplicates: You may expand to see the case details. If the current case is not a duplicate, click 'Continue as New Case' to proceed.

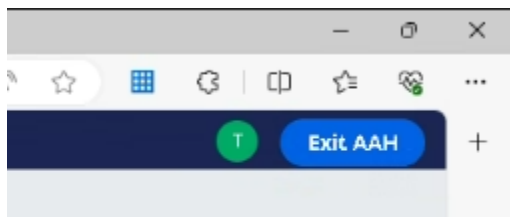
Review Potential Duplicate Cases

Case ID	Start of Care Date	Case status
AUTH-37801	08/23/2023	Pending-UtilizationManagerReview

Resolve as Duplicate Continue as New Case

Step 14: Review all information entered, click **Submit** if you are done and it will get assigned to BCBSND. Your authorization number will be displayed to you.

- You will be able to watch the status of this authorization from your dashboard. More information on how to use your dashboard can be found below in section **How to use your Dashboard**.
- Exit after each submission by clicking the blue “Exit AAH” button in the top right-hand corner.



Entering Concurrent/Extension Reviews Authorizations in Availity Essentials

Concurrent/extension reviews would apply for Residential Treatment Centers, Inpatient Rehabilitation, Skilled Nursing Facility, Transitional Care Facilities, Long Term Acute Care, Home Health, 1915i (Medicaid Expansion only), and Hospice (FEP only).

Step 1: *Go to your dashboard in Availity Essentials.* More information on how to use your dashboard can be found below in section **How to use your Dashboard**.


Step 2: Find the authorization on your dashboard that needs to be updated and initiate the review.

There are two ways to initiate a concurrent/extension review from your dashboard:

- Click on the row on the auth in the dashboard and you will see a pop-up window which will have the details of the auth and at the bottom of the window you will see an “Update” button. You can click on this update button to initiate a secondary review for that auth.

OR


Click on the hamburger icon which can be found on each AUTH row on the dashboard on the right most side of each row. Upon clicking this icon, you will see an “update” option you can select.

Type	Cert #	Patient	Payer	Submitted	Last Updated	Service Info	Status	View/Action
Authorization Inpatient	AVA000000000893	POLLY PINEAPPLE 123456789, DOB: 05/09/1964	HEALTH PLAN A	2020-12-07	22 hours ago	NA	CANCELLED	

Authorization Information

Transaction ID: Not Found Customer ID:

Transaction Date: NA



Transaction Type	Payer
Inpatient Authorization	BCBSND

Certificate Information

Certification Number	Status
AUTH	APPROVED

Requesting Provider

Name	NPI
<input type="text"/>	<input type="text"/>

Close Window
Print
Update
Unfollow this item
Move to Trash

Step 3: After you select **Update** using either option 2a. or 2b., you will get redirected into Predictal. Once Predictal launches, click **Acknowledge**.

predictal™ Auth Automation Hub

Welcome to Auth Automation Hub

Please read the disclaimer and click the Acknowledge button to proceed

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

Acknowledge

Step 4: Choose the type of review: Extension or Concurrent.

Note: You may notice two different terms, **Extension** and **Concurrent**. Extension is used for requesting additional services on outpatient reviews, and Concurrent is used to request additional days on inpatient reviews.

Note: Discharge notifications for Medicaid Expansion members need to be faxed.



Step 5: In the next screen you will be able to:

- Add additional documentation in the Recent Attachments section, click the plus sign, and follow the same directions as listed in Step 9. above in the new case section.
- Enter the Procedure Information fields as noted by the asterisk and select the Continued Stay Reason. Click submit when finished.



ICD 10
C44.712
BASAL CELL CARCINOMA OF SKIN OF RIGHT LOWER LIMB, INCLUDING HIP

Add

Procedure Information

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Code Set Type *	Code *	Description			
CPT	00212	ANESTHESIA FOR INTRACRANIAL PROCEDURES; SUBDURAL TAPS			

From *	Through *	Number of days *	Requested units *	Unit Type *	
8/2/2023	8/3/2023	2	1	Days	Remove

Add

Indicate Location of Clinical Information

Add

Continued Stay Reasons

<input type="checkbox"/> Activity Change <input type="checkbox"/> Barriers to Discharge <input type="checkbox"/> Diet Change <input type="checkbox"/> Discharge Planning <input type="checkbox"/> IV Medication and Rate	<input checked="" type="checkbox"/> New/ Continued Interventions <input type="checkbox"/> New/ Continued Medications <input type="checkbox"/> New/ Continued Treatments <input type="checkbox"/> Specialist Updates <input type="checkbox"/> Summary of Image Studies
--	---

Step 6: You can then enter Continued Stay Notes or add any additional information. Click Submit.



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1. Review Details 2. Review Authorization 3. Confirmation

Review Guidelines

Continued Stay Notes
New/ Continued Interventions Notes *

test

Remaining: 7996 characters

Please enter any additional information *

test

Remaining: 7996 characters

Back Save Submit

Step 7: Verify all the information you have entered is accurate and additional documentation was attached accordingly. Click Submit again.

Concurrent

Member Name	Member ID	Date of Birth	Client Name	Plan Type	Case Type	Authorization Type	Urgency	Service Type
				Commercial	Prior Authorization	Medical-Inpatient	Non-Urgent	Long Term Care

Code Set Type	Code	Description
ICD 10	C44.712	BASAL CELL CARCINOMA OF SKIN OF RIGHT LOWER LIMB, INCLUDING HIP

Procedure Information

Code Set Type	Code	Description	From	Through	Number of days	Requested Quantity	Type
CPT	00212	ANESTHESIA FOR INTRACRANIAL PROCEDURES: SUBDURAL TAPS	08/02/2023	08/03/2023	2	1	Days

Submitter Contact Information

Contact Name	Phone Number

Provider Details

Requesting provider SUBMITTED BY THIS PROVIDER

Provider ID	Provider Name

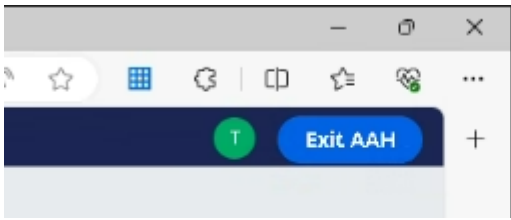
Servicing Facility/Vendor

Provider ID	Provider Name

Step 8: Your authorization number will be displayed.

- a. You will be able to watch the status of this authorization from your dashboard. More information on how to use your dashboard can be found below in section ***How to use your Dashboard.***

b. Click the blue “Exit AAH” button in the top right-hand corner when done.



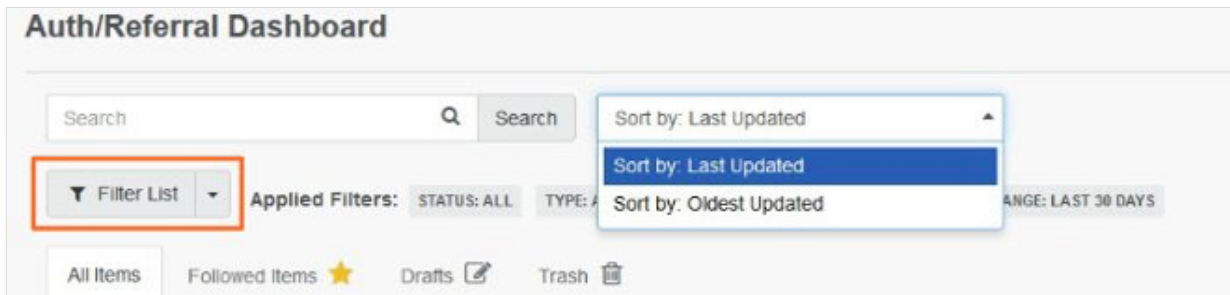
How to Use Your Dashboard

The Authorization Dashboard shows you the status of all authorizations in your organization. The authorization number allows us to find the authorization request if you call into our Customer Contact Center service line.

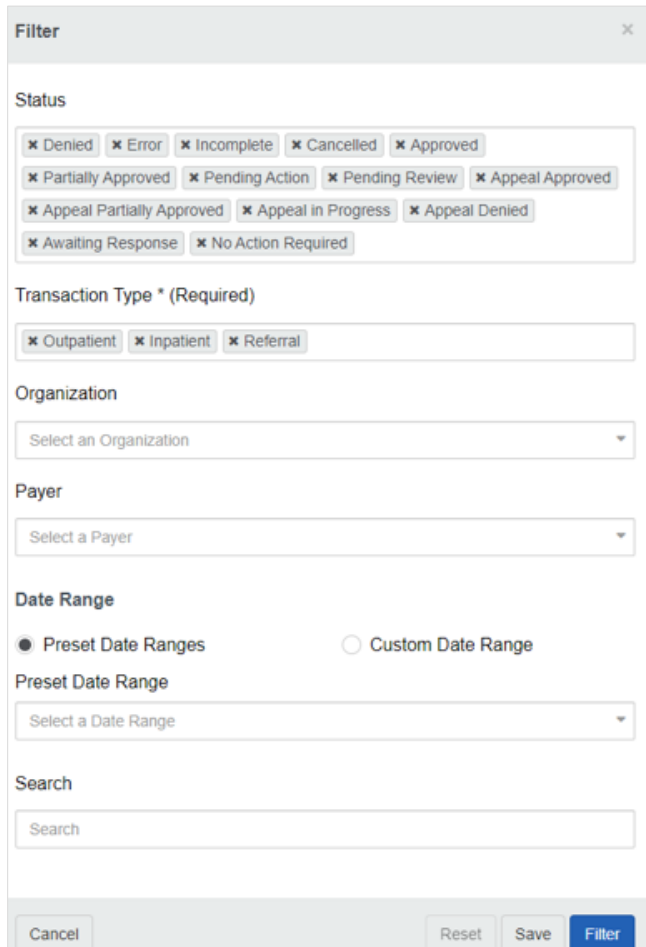
Type	Cert #	Patient	Payer	Submitted	Last Updated	Service Info	Status	View/Action
Authorization Inpatient	AVA000000000893	POLLY PINEAPPLE 123456789, DOB: 09/09/1964	HEALTH PLAN A	2020-12-07	22 hours ago	NA	CANCELLED	⋮ ☆
Authorization Outpatient	NA	SALLY STRAWBERRY 987654321, DOB: 05/03/1976	ABC HEALTH PLAN	2021-01-04	23 hours ago	NA	DENIED	⋮ ☆
Authorization Inpatient	AVA0000000001210	BOB BANANA 3672651741, DOB: 05/03/1976	HEALTH PLAN B	2020-12-22	1 day ago	2020-12-22 - NA	PENDING REVIEW	⋮ ☆

The Dashboard has a variety of filters and a search bar to allow you to quickly find the authorization you are looking for. You can flag and follow those authorizations of interest.

If you wish to save a frequently searched filter, you can do so by clicking on a filter type to see the filter detail window and click Save. To apply the saved filter view, click on the filter type and click Apply Saved.



If you save and apply the filters, the data on the dashboard will always appear with these filters when you come into the dashboard.



Filter [X]

Status

Denied
 Error
 Incomplete
 Cancelled
 Approved
 Partially Approved
 Pending Action
 Pending Review
 Appeal Approved
 Appeal Partially Approved
 Appeal In Progress
 Appeal Denied
 Awaiting Response
 No Action Required

Transaction Type * (Required)

Outpatient
 Inpatient
 Referral

Organization

Select an Organization [v]

Payer

Select a Payer [v]

Date Range

Preset Date Ranges
 Custom Date Range

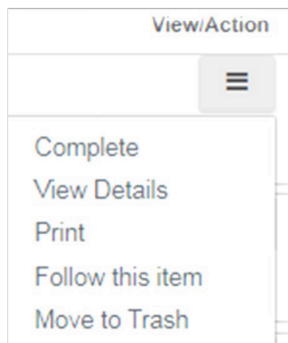
Preset Date Range

Select a Date Range [v]

Search

Search [input]

Additionally, the Dashboard allows you to see additional detail on each authorization. See section Authorization/Referral Dashboard Status Actions below.



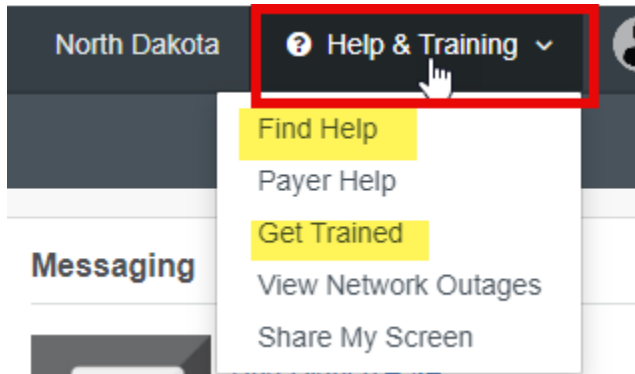
View/Action

[Menu Icon]

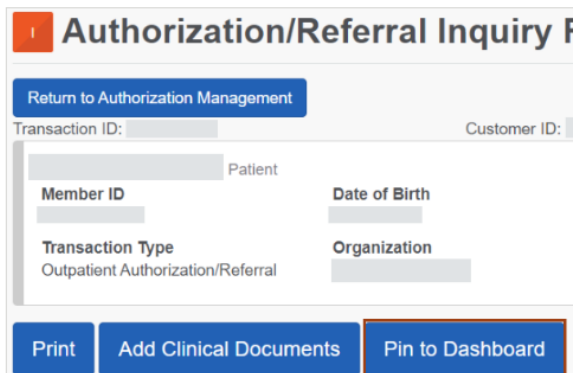
- Complete
- View Details
- Print
- Follow this item
- Move to Trash

For more information on the dashboard:

- Watch the demo located within the Authorization/Referral Dashboard screen or in the Help & Training, **Get Trained** section.
 - Use Help & Training, **Find Help**, to search for documentation on authorizations and referrals.



- A good article to search is “**View requests on the Authorization and Referral Dashboard.**” This document will give you tips on how to use the dashboard as well as how to pin to your dashboard. Pinning to your dashboard helps you manage requests that don’t automatically display on it. This includes but is not limited to requests that were not submitted through Availity Essentials or previously determined/closed aged requests.



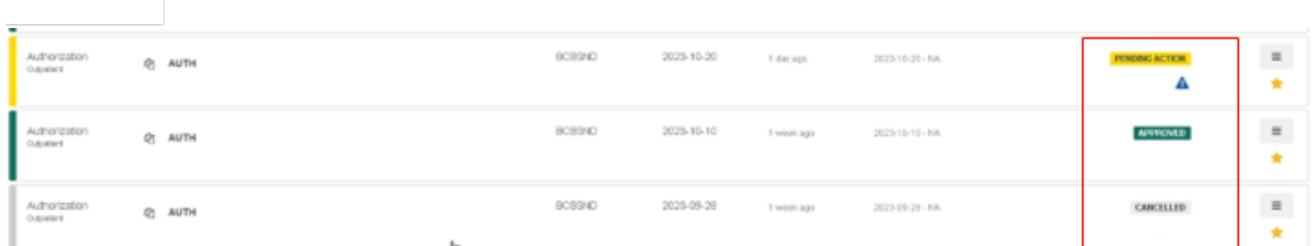
Authorization/Referral Dashboard Status Actions

The status action within the Availity Essentials dashboard will let the provider know if action is required or not. If action is required from a provider, the steps on how to attach additional documentation is below.

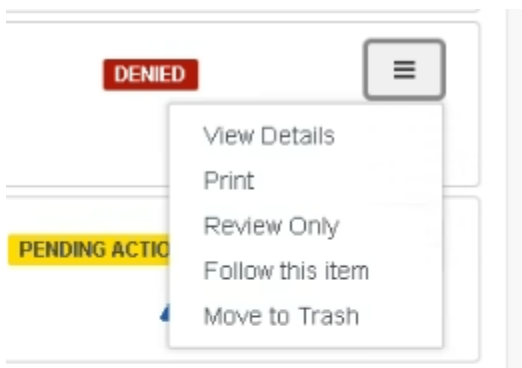
These status categories may display within the Availity dashboard.

Availity Dashboard Status	
Approved	The request has been approved by BCBSND.
Partially Approved	BCBSND has approved some, but not all of the request.
Cancelled	The request has been cancelled by BCBSND.
Denied	The request has been denied by BCBSND.
Pending Review	The provider's request has been submitted and is with BCBSND for review.
Pending Action	The request needs provider attention to proceed.

Here is an example of what the status may look like on your dashboard.



Providers can view additional details on a request, when necessary. To do so, select the line and click the hamburger button on the right-hand side.



- If the request was cancelled or denied you will only be able to click **Review Only**.
 - Selecting Review Only allows providers to navigate to Predictal to view the decision reasoning.
- If the request was approved, click **View Details**.

- If the review is pending, waiting for provider details, click **Update**.
 - See Step 1 below for more details.
 - Only the provider who submitted the authorization can update it.

To verify if a provider needs to do anything on a case with a "Pending Action" status, click on the case or view details. Within the additional pop-up screen, under the "Certificate Information" section you will see additional status details.

Certificate Information

Certification Number [Redacted]	Status Pending
Effective Date 2022-03-14	

Close Window
Update
Print
Follow this item
Move to Tras

Certificate Information Status

In Progress	Waiting for the request to be assigned to BCBSND for review. No provider action needed.
Pending	BCBSND has pended the authorization request while waiting for the requested information. Provider action needed.

Follow the steps below for a Pending Action status:

Step 1: Click the **Update** button on the Authorization Information screen which then redirects to the Predictal portal.

Update
Print
Follow this item
Move to Tras

Step 2: Acknowledge, then click the **Respond to Request for Additional Information** button.

predictal Auth Automation Hub

Authorization Detail: AUTH-23655

Respond to Request for Additional Information
Extension

Note: This button will only display if information is still needed, and request has not been fulfilled.



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Step 3: Review the **Notes** section to determine the action needed. Type in the action taken in the Response Details box and attach your additional documentation on the right-hand side. Click Submit.

- a. Clinical documentation must be attached before submitting. BCBSND cannot accept medical information inserted into Notes section. Requests may be delayed if submitted with no clinical documentation attached in the correct place.

Respond To Request for Additional Information Due in 4 hours from now

Request
Start of Care Date: 11/21/2023
Provider Information: Requesting provider

Procedure Information

Code Set Type	Code	Description	Requested Quantity	Type
HCPCS	J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT	5	Days

Diagnosis Information

Code Set Type	Code	Description
ICD-10	G44.021	CHRONIC CLUSTER HEADACHE, INTRACTABLE

Notes
Need documentation supporting positive clinical response

Response
Response Details +
attaching clinical as requested

Remaining: 7583 characters

Exit Save Submit

Step 4: Once you click Attach, you are ok to close by clicking Exit AAH.

- a. You will not get notification that it has been submitted.

An authorization means that the requested service has been determined to be medically necessary and/or appropriate. It does not mean that the requested service is covered under the member's benefit plan. Payment is contingent upon benefit coverage for the services rendered and eligibility of the patient.

Case Information

Authorization Type: Medical-Outpatient
Start of Care Date: 11/07/2023
Service Type: [REDACTED]
Place of service: Outpatient
Injectable Drug: [REDACTED]
Case Determination: Pend

Member Information

Plan Type: Commercial
Group Name: [REDACTED]

000011200
Sex: FEMALE

Note: Once the request for additional information is received by BCBSND, the status will return to In Progress, until the request is completed. Once approved or denied the Dashboard status and Authorization Information will update. You may need to click on the authorization to have it refresh the status.

Frequently Asked Questions (FAQ)

Q: Why is the PA Checkpoint tool being implemented?

A: The Prior Authorization process for BCBSND, its members and their providers. By integrating this search tool within Availity Essentials, it will aide in a more fluid process for services that need prior authorization, as it will feed into the next step of the Predictal process.

Q: Why is the Predictal tool being implemented?

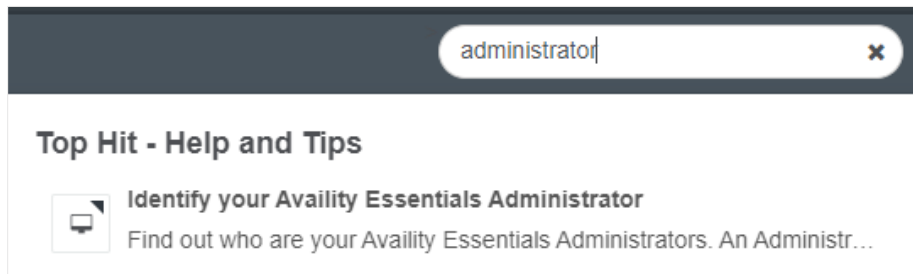
A: The implementation of the Predictal tool aims to improve the precertification process. It reduces manual intervention and helps identify cases through reporting that are likely to be approved or denied, allowing our staff and providers to prioritize their efforts and resources effectively.

Q: I'm a provider and don't have access to Availity Essentials, what do I do?

A: Please reach out to your organization's Availity Essentials administrator. They can help you obtain the necessary access to Availity Essentials. Alternatively, you can check out our webpage by going to BCBSND.com. Make sure you're on the provider facing webpage, you can change in the top ribbon. Once you're on the provider facing webpage, scroll down and on the right-hand side you should see a 'Register now' link. You will click that link and follow the prompts. If you run into any issues, please contact the Availity contact support.

Q: How do I know who my Availity Administrator is?

A: You can use the Keyword Search function within Availity Essentials, searching Administrator. From there you will find resources available to help you with steps to determine your facility administrator.



Q: A CPT code in Availity says I do/do not need authorization, but your website states differently. What should I do?

A: Contact Provider Services to have it looked at further.

Q: How long will the prior authorization stay on the dashboard?

A: Prior authorizations will stay on the dashboard for 90 days. If a permanent record of the prior authorization is required, it can be printed for the facility's records.

Q: My precertification was denied, can you tell me why?

A: You will receive rationale for denied requests. How you see the rationale will vary depending on the type of access you have.

- If you have access to Availity Essentials; please login and use the unique identification number (UIT) and member information related to the precertification request and within the portal, you should be able to see the rational for denial upon a business day of receiving your denial.
- If you do not have access to Availity Essentials; please contact your administrator assistant to gain access. However, it takes time to gain access; you should see a letter to the address you provided providing the rational for denial.
- If you are out of state and don't have access to Availity Essential; you can expect a letter to the address, you provided providing the rational for denial.

Q: I do not see the PA Checkpoint and/or Predictal tool in my Availity Essentials system?

A: The process of using PA Checkpoint and Predictal is a seamless transition within Availity Essentials to the tool; you will not have a separate sign on or button to click to utilize this feature. If you do not see these tools, you may need to contact your Availity Essentials administrator.

Q: If I create an erroneous authorization request, can I just send it to "Trash" and have it removed?

A: A prior authorization can be cancelled if it is sent to "Trash" before adding clinical documents. If clinical documents have already been attached, moving a prior authorization from the dashboard to the "Trash" does not cancel the prior authorization. Currently, there is no way to void an authorization request. However, you can the cancel request by calling the Utilization Management (UM) department at 800-952-8462.

Q: Can I edit once a case has been submitted?

A: Providers cannot edit a case. Only the UM (Utilization Management) nurses would be able to make edits. If a case needs to be edited, the provider can call the Utilization Management (UM) department at 800-952-8462.

Q: How do I enter a date range if I'm not sure when the service will happen?

A: Enter today's date in the Service Date From field and our Utilization Management team can make applicable changes according to policy.

Q: I submitted a prior authorization request, and it hasn't gone anywhere. What's wrong?

A: All prior authorization requests require the attachment of documents to support the request. If attachments are not provided, the request is not able to be processed. For inpatient requests, the completed form "Inpatient Authorization Supplemental Document" included within this manual will serve as documentation needed for CPT codes. Medical records for outpatient services are also acceptable documents to attach to the request.

A2: Check the size of the attachment and the name of the attachment. If the attachment file size is greater than 10MB or the file name is longer than 40 characters, the attachment requirement is not met, and the authorization will remain in a "pending" state which will not be processed.

Q: When I look up the National Provider Identifier (NPI) for my facility, there are several addresses. Which one do I select?

A: Select the address where you want the letter sent. You will have a chance to change the address if needed.

Q: I submitted a prior authorization request, and it was completed successfully. When I viewed it later, it now says “Cancelled.” Why?

A: There are some services programmed into the system that do not need prior authorization. If your request is for one of these services, the system will automatically cancel the request. If the cursor is placed over the Cancelled button, it will specify “No auth required.” For a list of required prior authorizations, go <https://www.bcbsnd.com/providers/policies-precertification/precertification-overview>.

Troubleshooting Technical Errors

Q: I cannot advance screens to submit my authorization, who do I contact?

A: Start by contacting Availity Essentials Client Services technical support. If they are unable to assist you, they may tell you to contact BCBSND. When contacting BCBSND, please be descriptive with the issue.

Q: I am receiving a time-out error and/or my screen will not advance.

A: Try clearing the cache in your browser security settings. As noted above, Google Chrome will provide the best experience. If the error continues, please contact Availity Essentials for direct support.

Q: When creating a prior authorization request, I received a “404 Page Not Found Error.” What happened?

A: If this error displays, it likely means there is a server error either on the Availity side or the BCBSND side of the transaction. Take screenshots capturing as much information as possible (including date, time, AVT number and Transaction ID). Call Availity Customer Support at 1-800-272-4548.

Q: What do I do if I receive an “object” error message?

A: Follow the To Get Started section above to manage your organization. You may need to add a provider data for your organization in addition to each practitioner. If you continue to have issues, please contact Availity Essentials for direct support.

We’re Here for You

Need help with Availity Essentials registration or login? Call their Client Services at 1-800-282-4548.

- Additional Availity Essentials tips can be found at bcbsnd.com/providers/news-resources/availity-essentials.
- The BCBSND [Commercial](#) and/or [Medicaid Expansion](#) Provider Manuals

For additional support, contact the Provider Service phone number on the back of the members ID card, or your Provider Relations Partner at prov.partners@bcbsnd.com.