Enhanced Precertification Process Using Predictal

Contents

Overview

The Predictal tool is integrated through Availity Essentials, supplying providers with a faster pathway to submit precertifications and enhancing case management and utilization management (UM) 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.

This process will also be used for Medicaid Expansion referrals. You will need to ensure "referral" is selected; this is outlined in step 12 below.

Note: The terminology precertification, preauthorization and prior authorization are all used interchangeably.

Availity is an independent company providing provider portal services on behalf of Blue Cross Blue Shield of North Dakota (BCBSND).

How to Get Started

If you have not done so already, register for Availity Essentials. For the best experience, set Google Chrome as your default browser.

If you are already signed up for Availity Essentials, you must have access to the Authorization and Referrals section to be able to use 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 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.***

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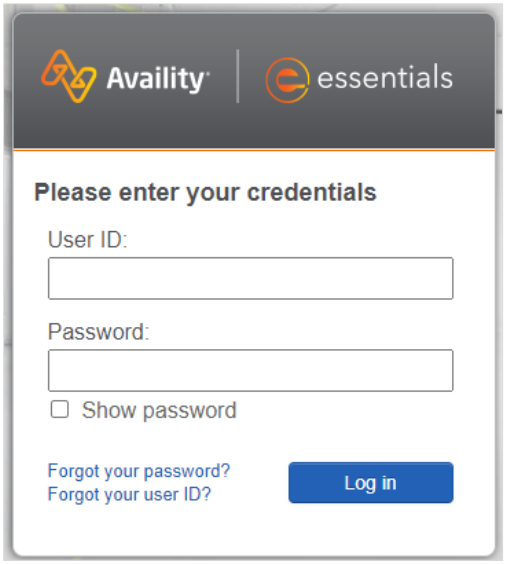
The administrator can grant access, when applicable, through the Maintain User Application on the Availity Essentials account dashboard.

Entering New Authorizations in Availity Essentials

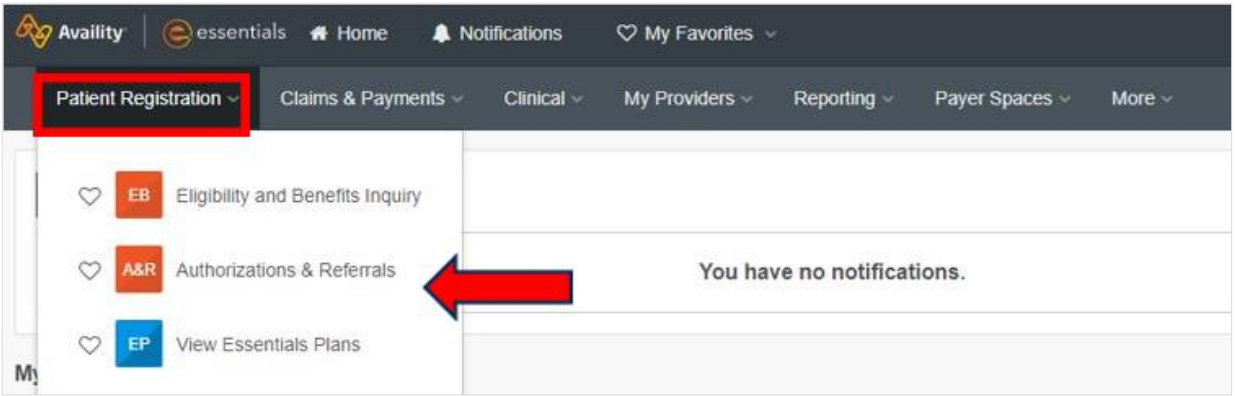
Step 1: Log in to Availity Essentials.

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

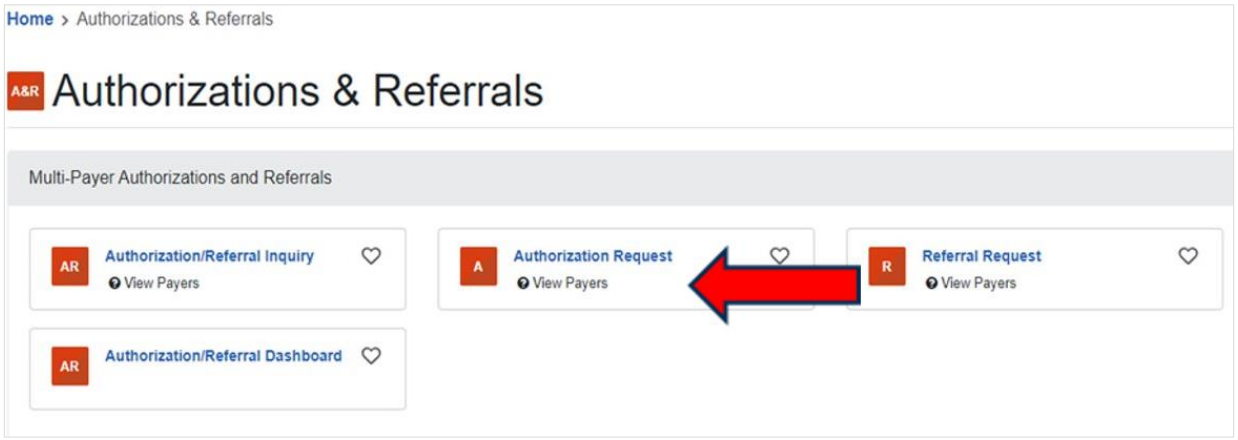


Step 2: Select the ***Patient Registration*** tab from the home menu, then select ***Authorization & Referrals.***

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.

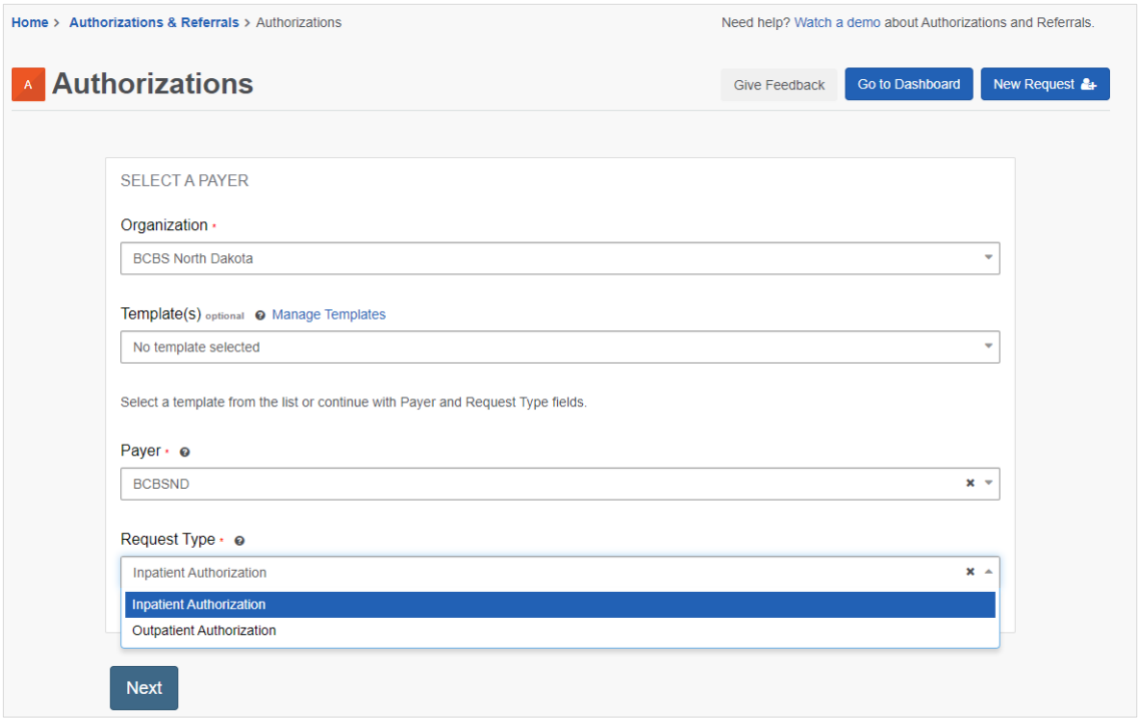
Note: Fields with * are required

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.***



Step 5: Select ***Next.***

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

Note: Note: Federal Employee Program (FEP), Medicare Supplements and NextBlue of North Dakota are excluded from this tool. See step 6a. below for more details.

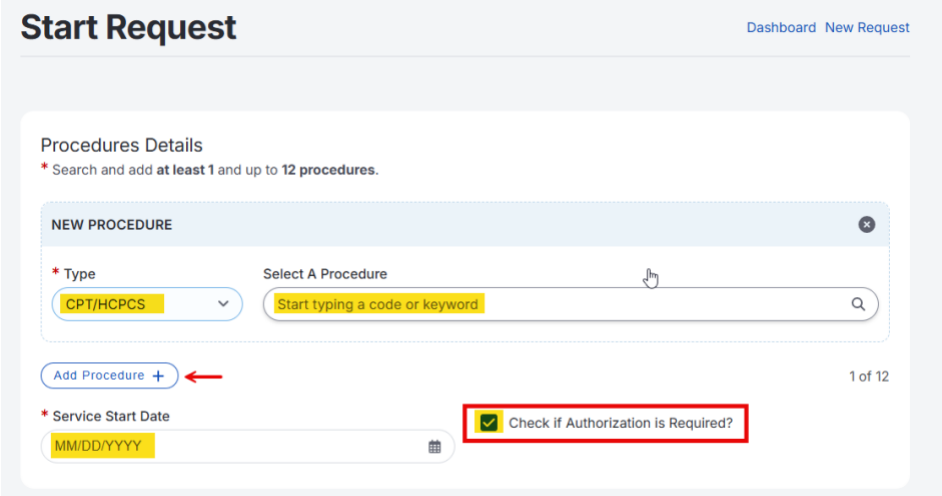
Step 6: Enter the Required Details.

a. Enter the ***Procedure Detail Information.***

   i. Procedure information and Service Start Date are required fields. Always check the box next to "Check if Authorization is Required" unless directed otherwise or as noted as an exception here.

      a. If this is a Medicaid Expansion referral, uncheck the box next to "Check if Authorization is Required," and proceed by entering the required fields.

      b. If this is for an FEP member, uncheck the box next to "Check if Authorization is Required," and proceed by entering the required fields.



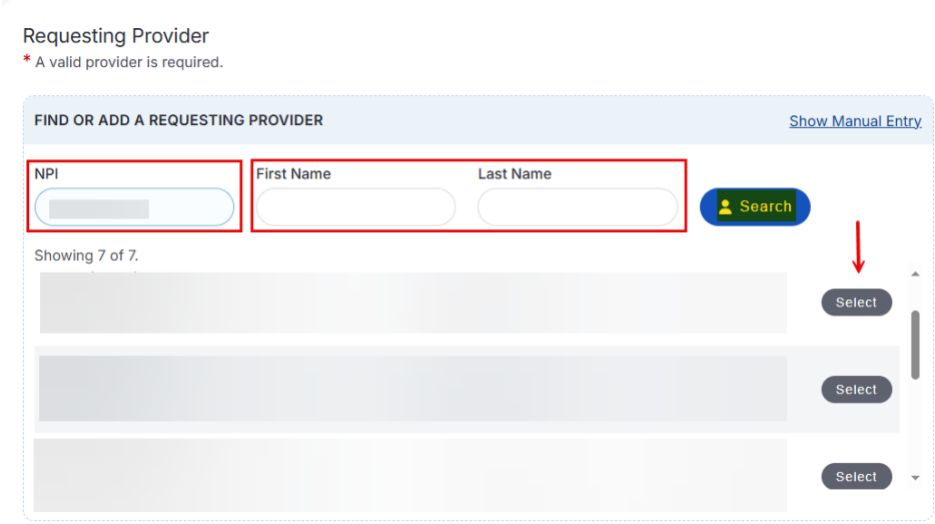
Once the information is entered, it will prompt you to enter the next set of required information.

b. Enter the ***Request Provider*** detail.

   i. Enter the NPI or provider First Name and Last Name, click ***Search.***

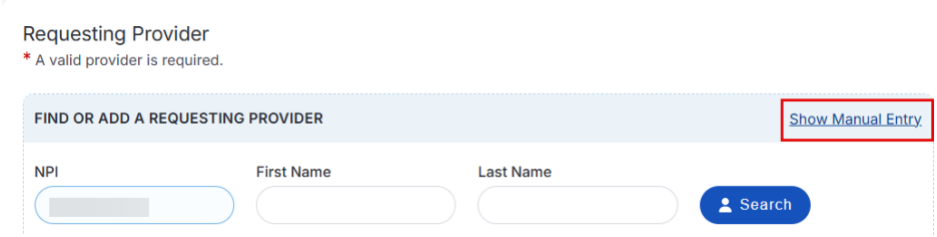
   ii. Once the details populate, find the appropriate provider name and click ***Select.***

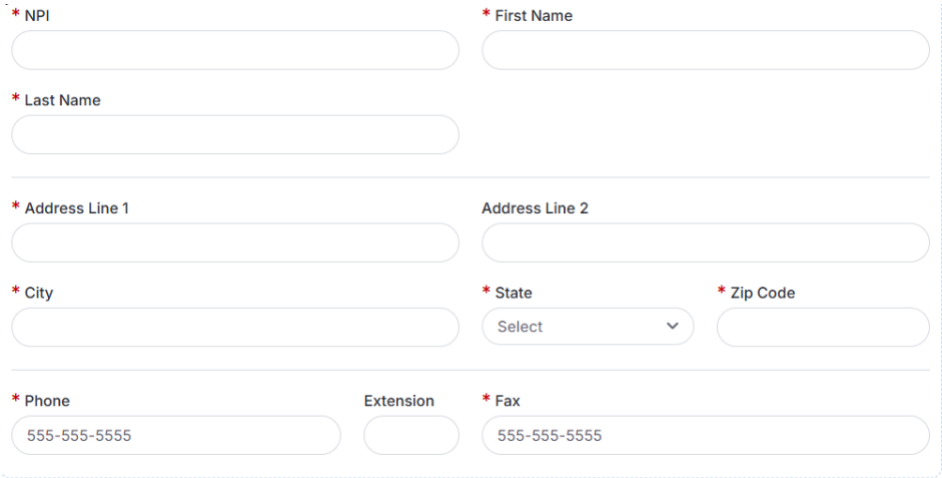
      a. Once clicking select, add the applicable fax number and any additional detail.



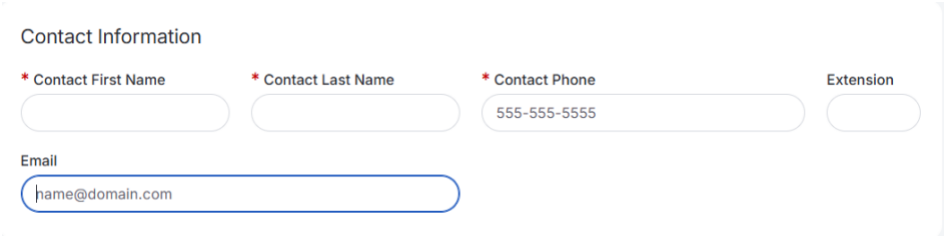
   iii. If you are unable to find the provider using the NPI or name search, click ***Show Manual Entry.***

      a. Enter all required information.



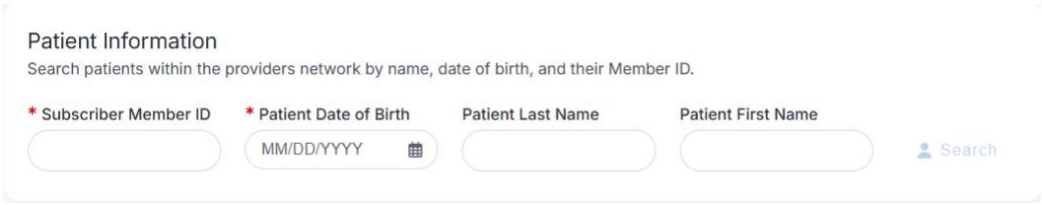


b. Enter Contact Information of the person entering the request or who would need the reply.

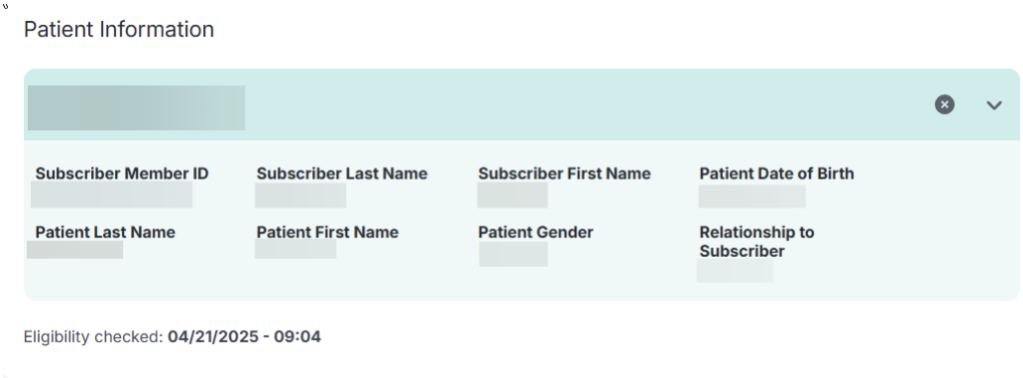


c. Enter Patient Information.

iv. Once information is entered, click ***Search.***

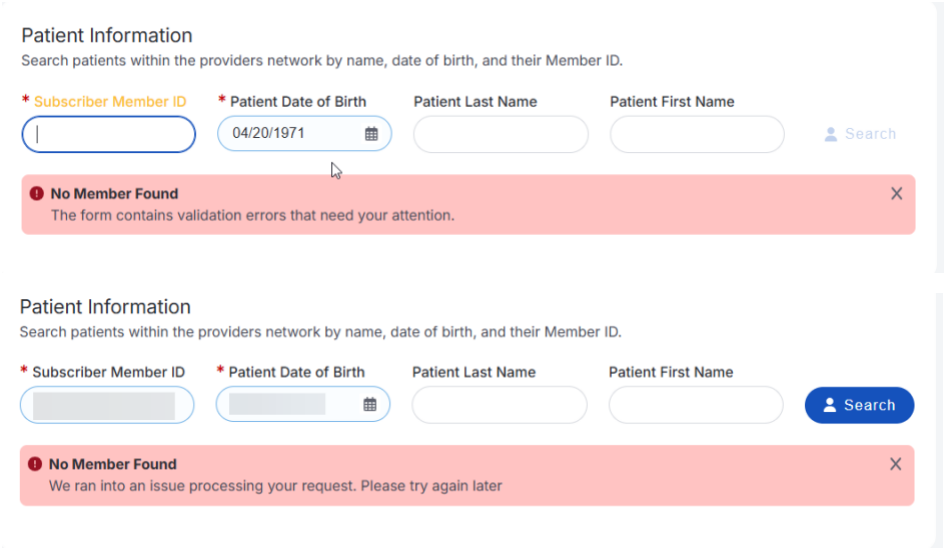


v. Eligibility checks are real time; if the information is accurate and accepted, the screen will show blue.



vi. If patient information is not accurate or the member is not eligible, you will receive an error message and will not be able to proceed. This may appear like the examples below:

a. If you receive an error message, check member eligibility in the Eligibility & Benefits (E&B) screen. If the member shows eligible in E&B but you cannot proceed in PA Checkpoint, call the Provider Service Department on the back of the member ID card.



c. Once all information is entered, click ***Continue*** at the bottom right-hand side of the screen.

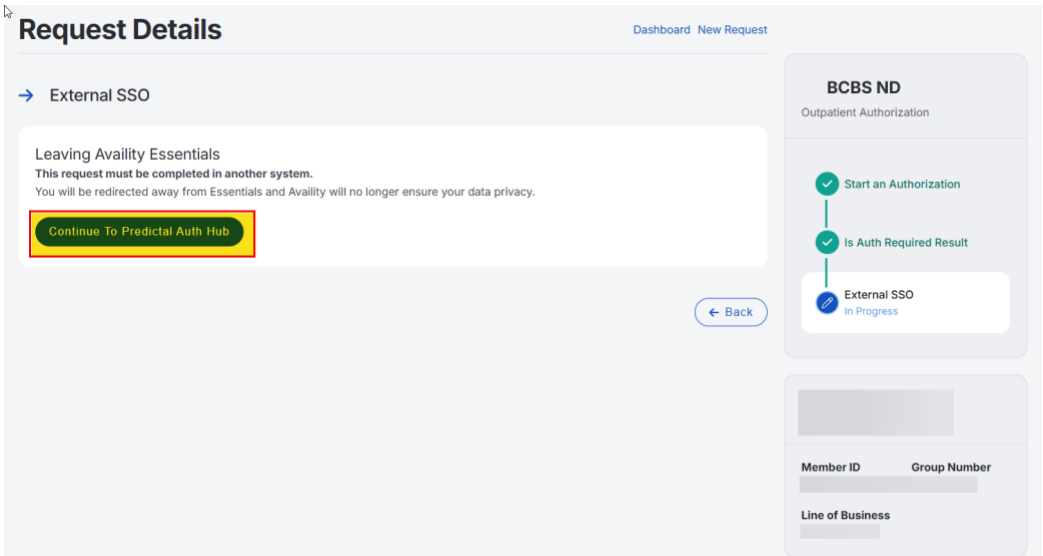
d. Results will populate on the next screen.

i. If no authorization is required, the screen will state “No Auth Required" in a green bubble on the right-hand side. This will stop the authorization process, and providers will not be able to proceed.

ii. If authorization is required for any of the searched codes, the screen will state “Auth Required” in a red bubble on the right-hand side. Any time "Auth Required" shows, the system will allow you to move forward to the authorization submission process.

e. Once the details and information have been reviewed on this screen, click ***Continue.***

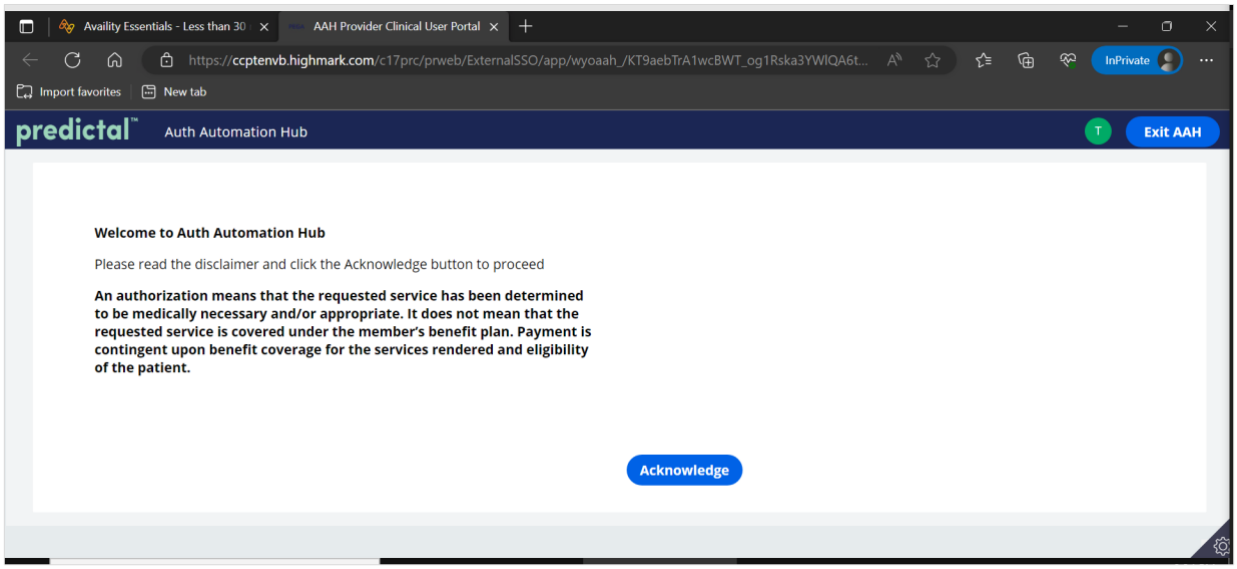
i. When the screen advances, you can click ***Continue to Predictal Auth Hub*** to start your authorization request.



ii. If you need to change any details, you have the chance to select ***back*** to update any information.

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

Step 7: Click ***Acknowledge.***



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

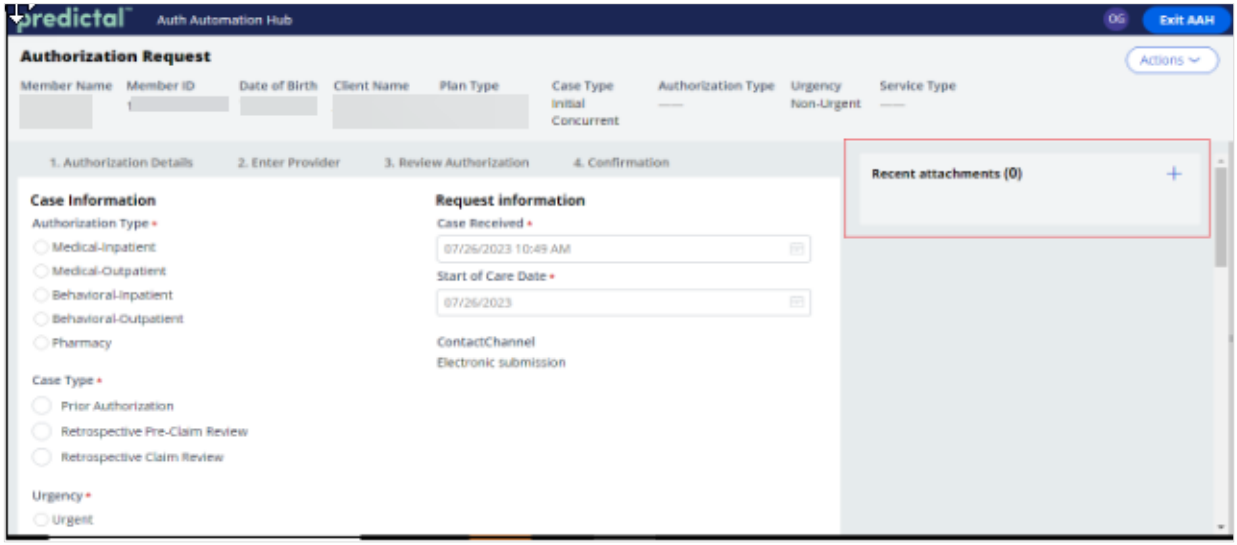
Buttons	
Save	This feature is intended to be used to save and come back later. It is best practice on any screen to click save if there is any possibility you will not complete the screen. Saving will not send anything to BCBSND for review.
Submit	The submit button takes the inputs from the screen and 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 8: The patient information will default from the member information entered within the Availity Essentials entry.

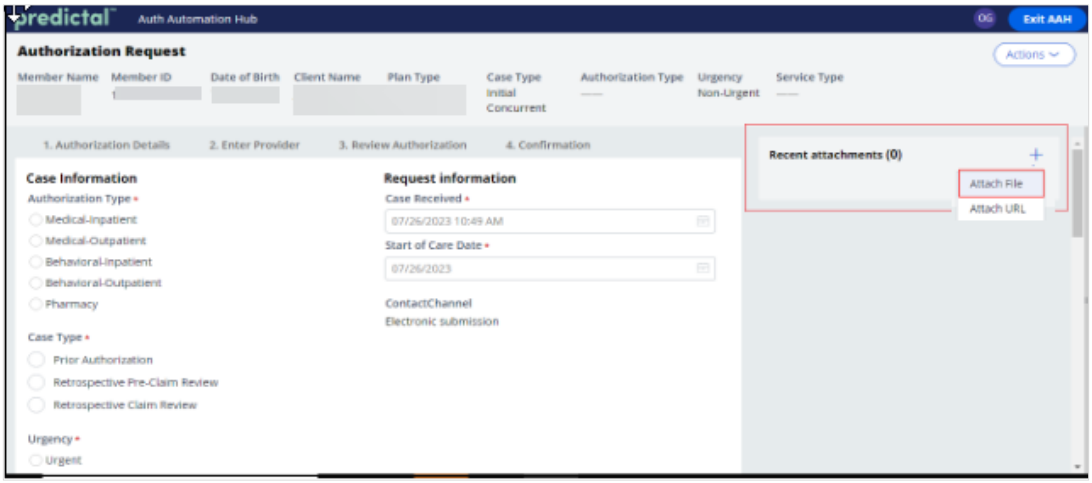
Providers will then follow the steps below for directions on how to fill out a new case request.

Step 9: Add supporting documentation in the ***Recent Attachments*** section by selecting 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.



1. A pop-up window will display.
    a. Select ***Attach File.***

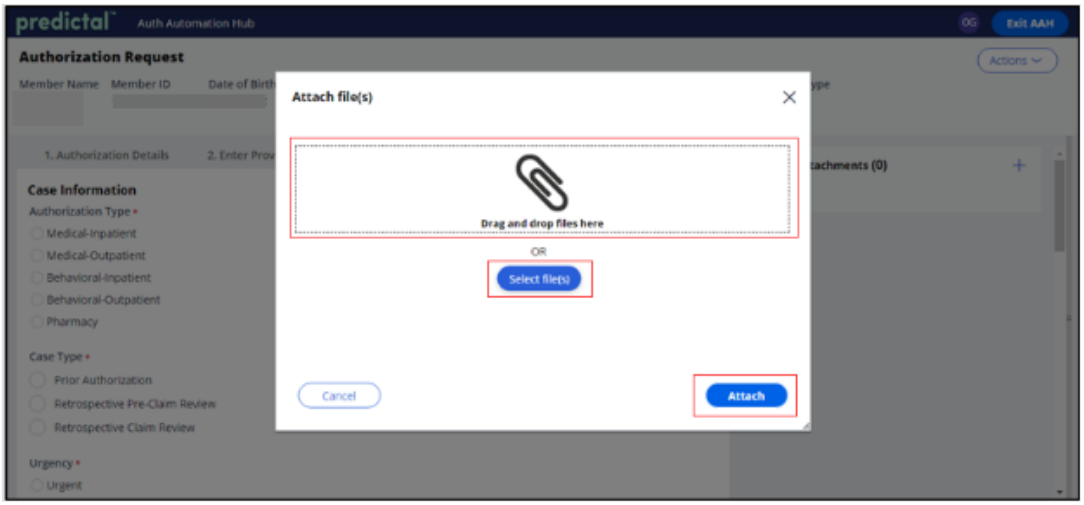


    b. Click the ***Select File(s)*** button. Select the file you wish to attach.

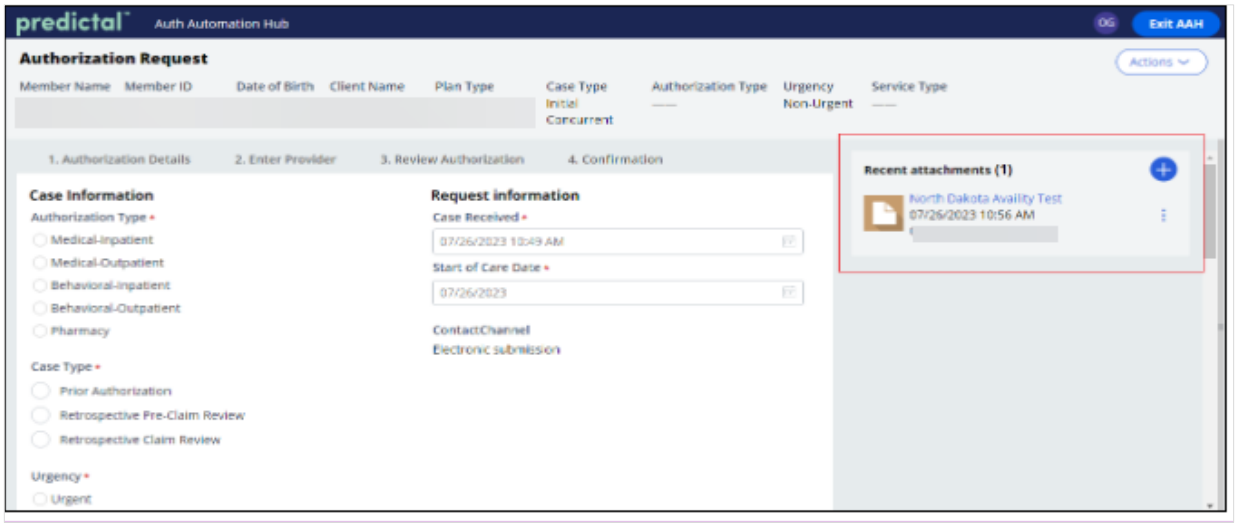
    OR

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

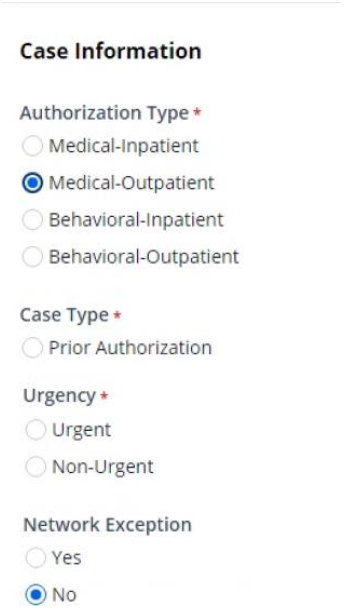
    d. Click ***Attach.***



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



Step 10: Complete the ***Case Information*** section based on your authorization submission.



a. **Authorization Type** - The tag on an authorization that determines if it is Medical versus Behavioral Health and Inpatient versus Outpatient. Use 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 approves 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.

b. **Case Type -** Providers will only use the **Prior Authorization** option, which is the standard request for review of services for benefits and medical necessity.

c. **Urgency**

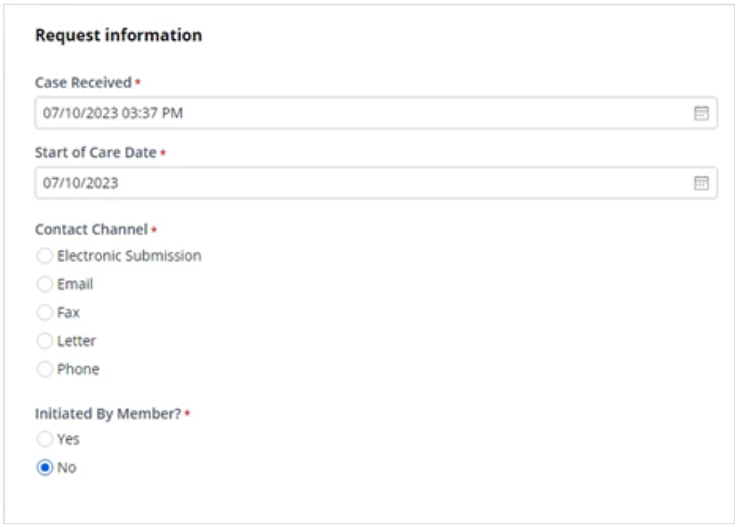
- Prior approvals or precertifications that are deemed urgent should be reviewed within 72 hours.
- For a request to be deemed urgent, the absence of treatment:
  - Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function

    OR

  - In the opinion of a health care provider with knowledge of the member's medical condition, it 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 seven (7) days or less.

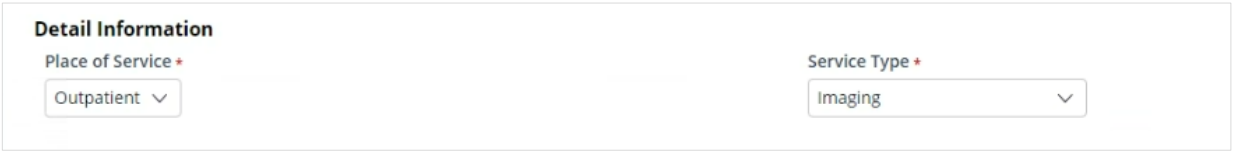
d. **Network Exceptions**- Will default to no. Please do not change the default.

Step 11: Complete the ***Request Information*** section based on the authorization submission.



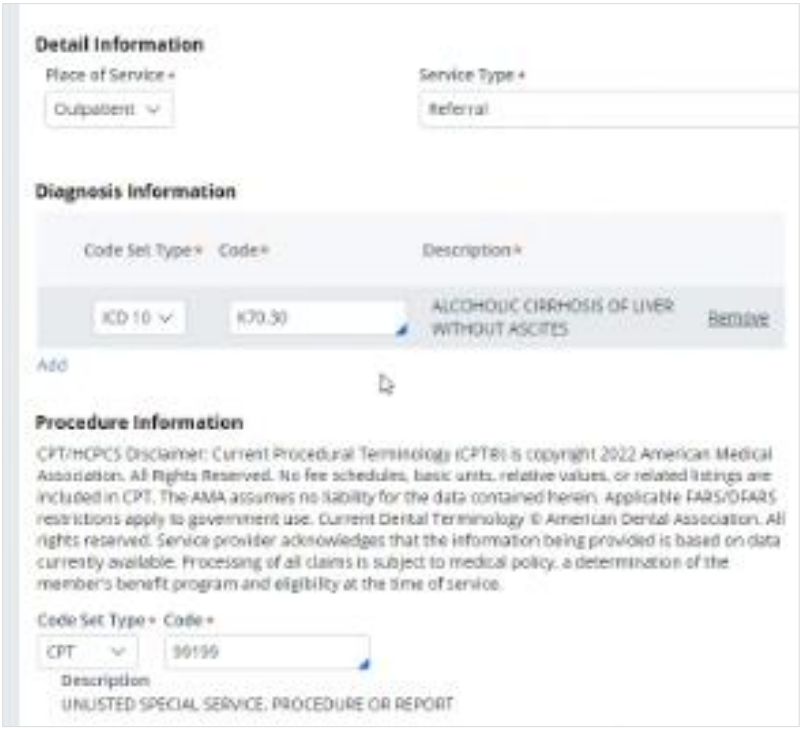
Step 12: Complete the ***Detail Information*** section based on the authorization submission.

Place of service will vary by type of authorization selected. Use the Choosing Service Types guide to assist you in determining which Place of Service and Service Type should be selected.



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 the 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.

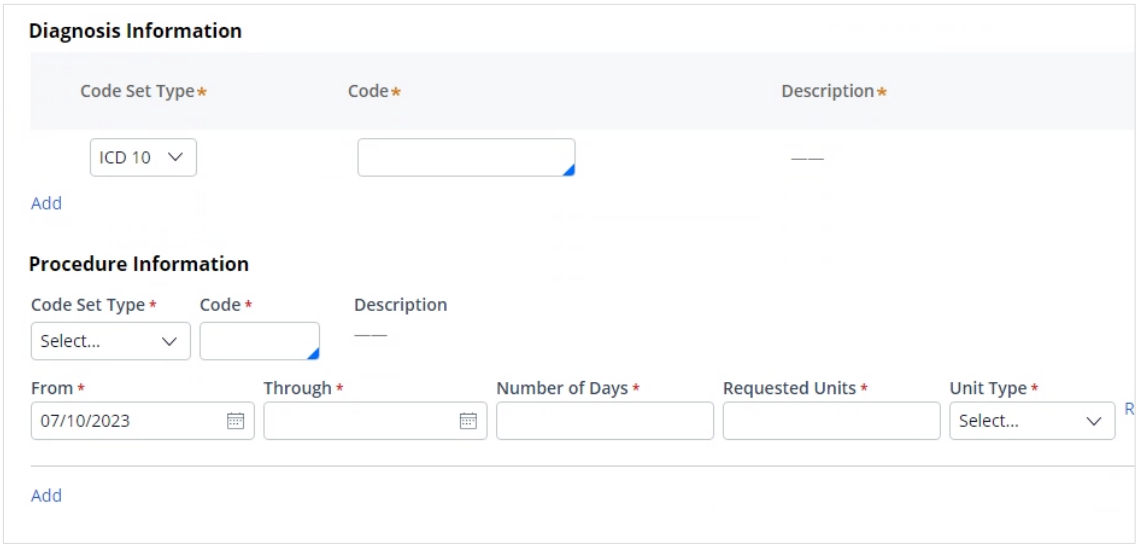


Step 13: Complete the ***Diagnosis Information*** and ***Procedure Information*** section based on the authorization submission.

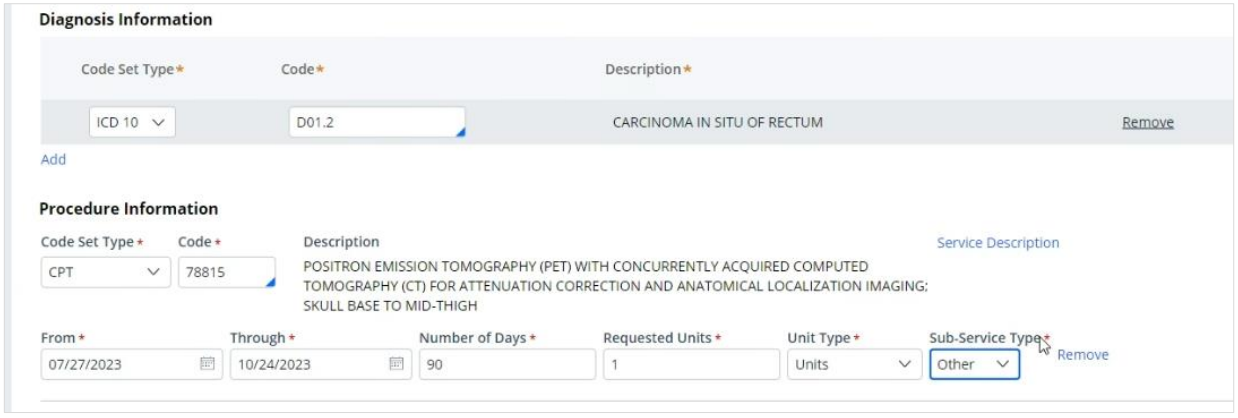
Note: For inpatient medical, a CPT code is not required. For inpatient planned surgical, a CPT code is required.

a. To add an additional blank Diagnosis field, click the blue ***Add*** button. To remove a blank code field, click ***Remove.***

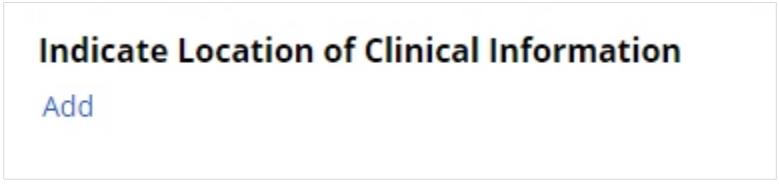
b. The From date will autopopulate to the today's date, Number of Days will autopopulate to 1, Request Units will autopopulate to 1 and Unit Type will autopopulate days; change these fields as necessary.



A completed example of these fields may look like this:



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



Step 14: Click ***Submit.***

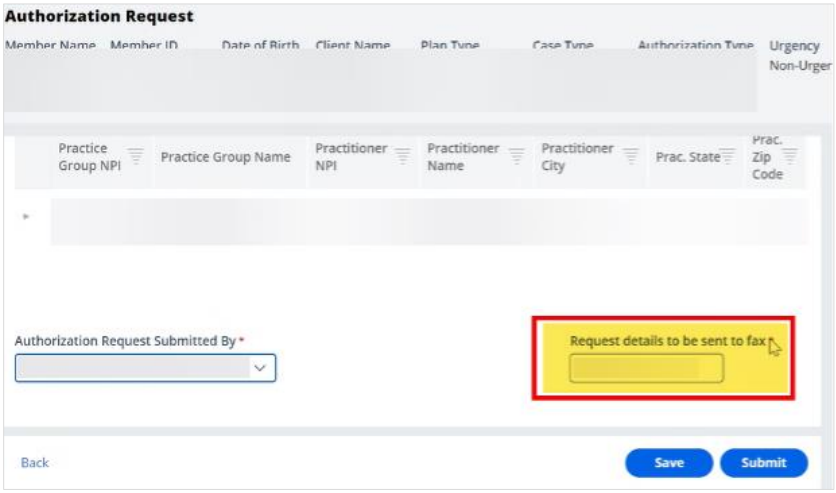
Step 15: Enter the ***Submitter Contact Information.***

Step 16: 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.

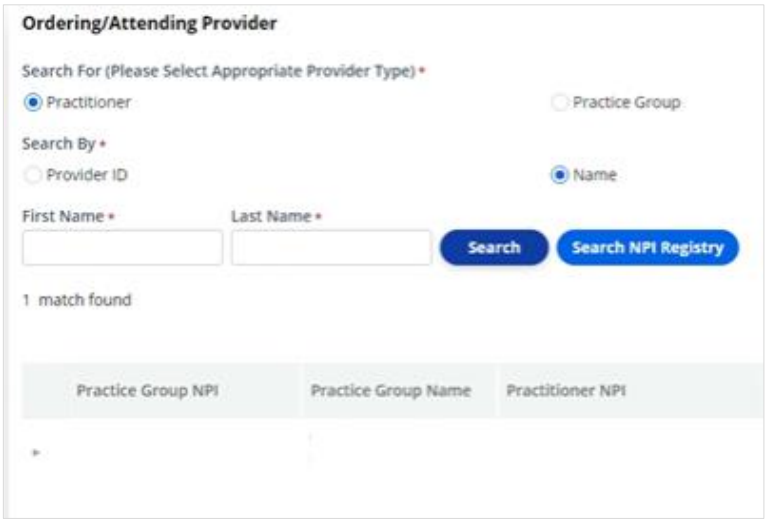
For outpatient requests, only a vendor is needed for Durable Medical Equipment (DME); otherwise, you only need to list the ordering provider. If you want the response to go to a different person, do not use the copy button function.

For inpatient requests, a Vendor (where the service is being done) and ordering Provider Details are always required.

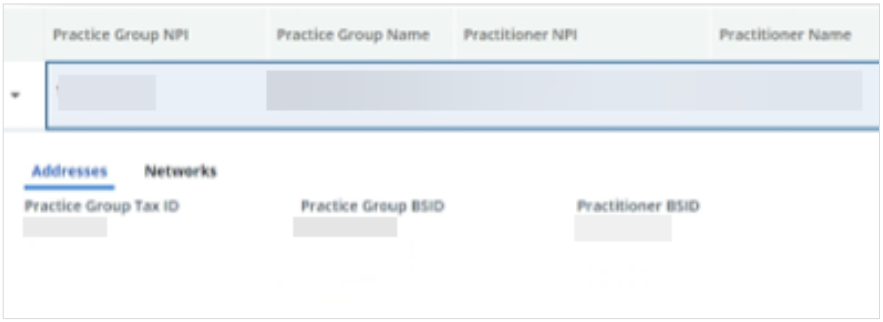


Step 17: Input the ***Provider Details.***

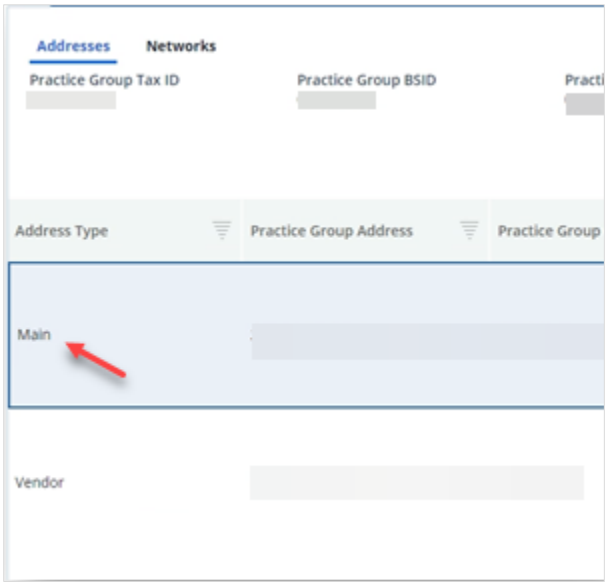
a. Search for the provider. Once you click ***Search,*** the records found will display under the search criteria.



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



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.



Select the ***Authorization Request Submitted By*** from the drop-down menu.

d. Click ***Submit*** at the bottom of the page.

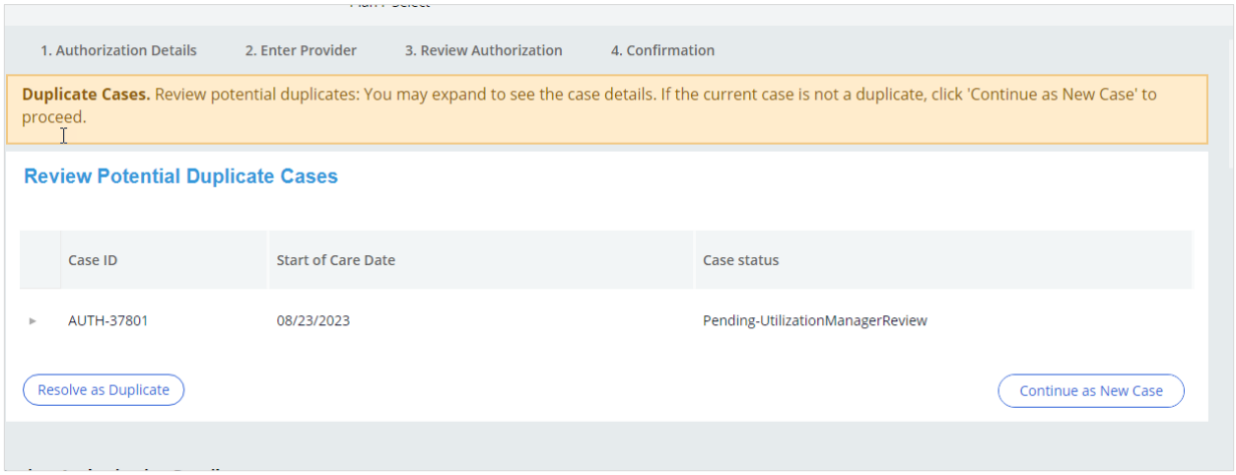
Note: When adding the Primary Fax #, ensure it is the fax number of the person who needs the final determination information.

Step 18: 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 19: 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.

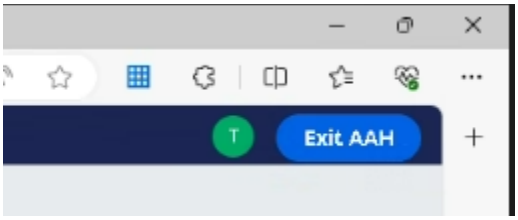
Note: If the case is a duplicate, highlight the duplicate case and click on the ***Resolve as Duplicate*** button and follow the prompts.



Step 20: 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.

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. 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.***

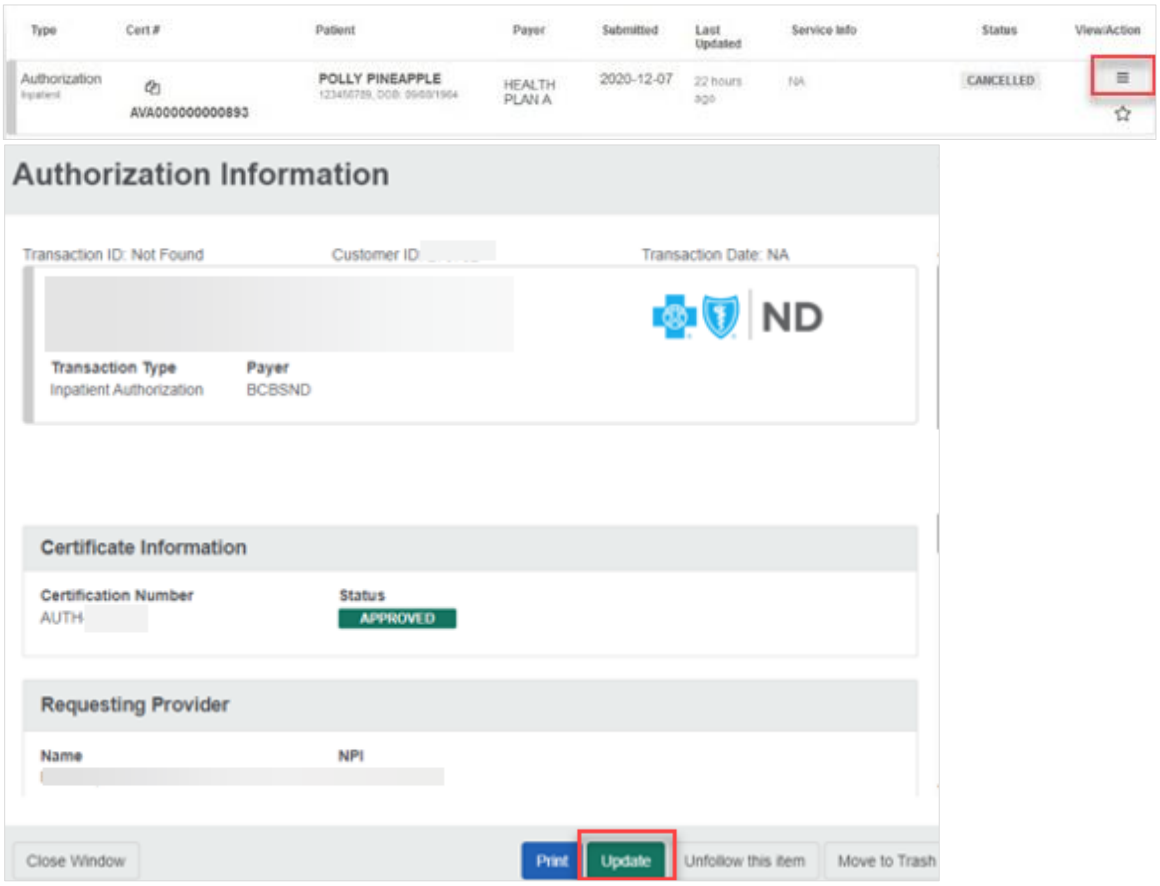
Step 2: Find the authorization on your dashboard that needs to be updated and initiate the review.

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

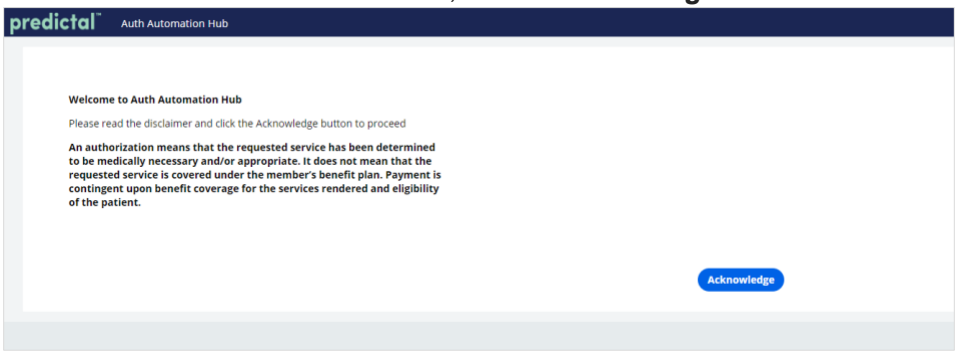
a. Click on the row on the auth in the dashboard and you will see a pop-up window which will have the details of the auth. At the bottom of the window, you will see an “Update” button. You can click on this button to initiate a secondary review for that auth.

   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.



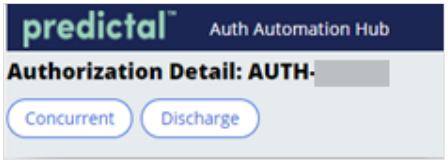
Step 3: After you select ***Update*** using either option 2a. or 2b., you will get redirected into Predictal. Once Predictal launches, click ***Acknowledge.***



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

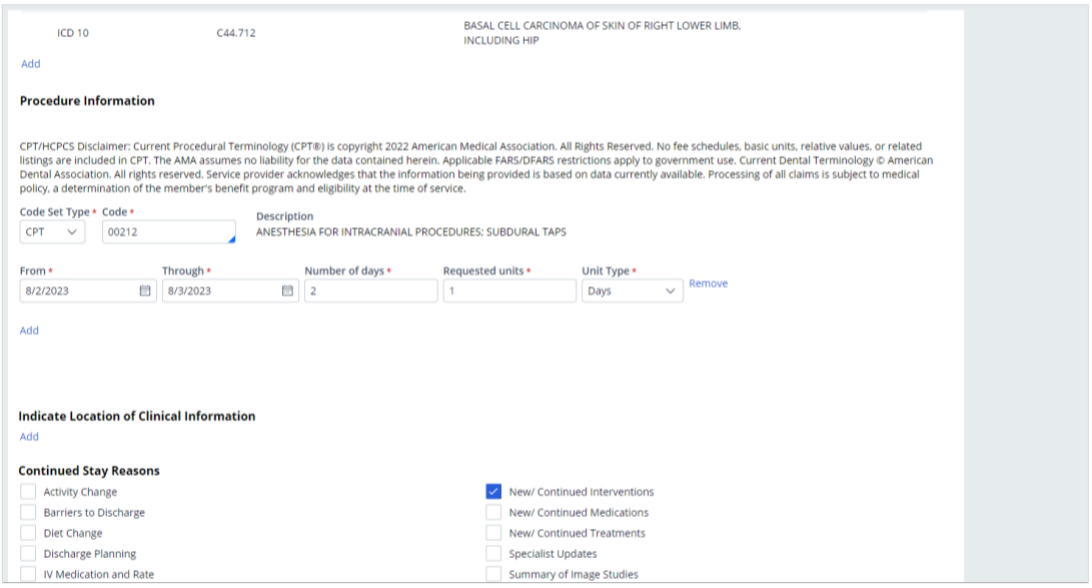
Note: You may notice two different terms, ***Extension*** and ***Concurrent.*** Extension is used for requesting additional services on outpatient reviews, and Concurrent is used to request additional days on inpatient reviews.

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

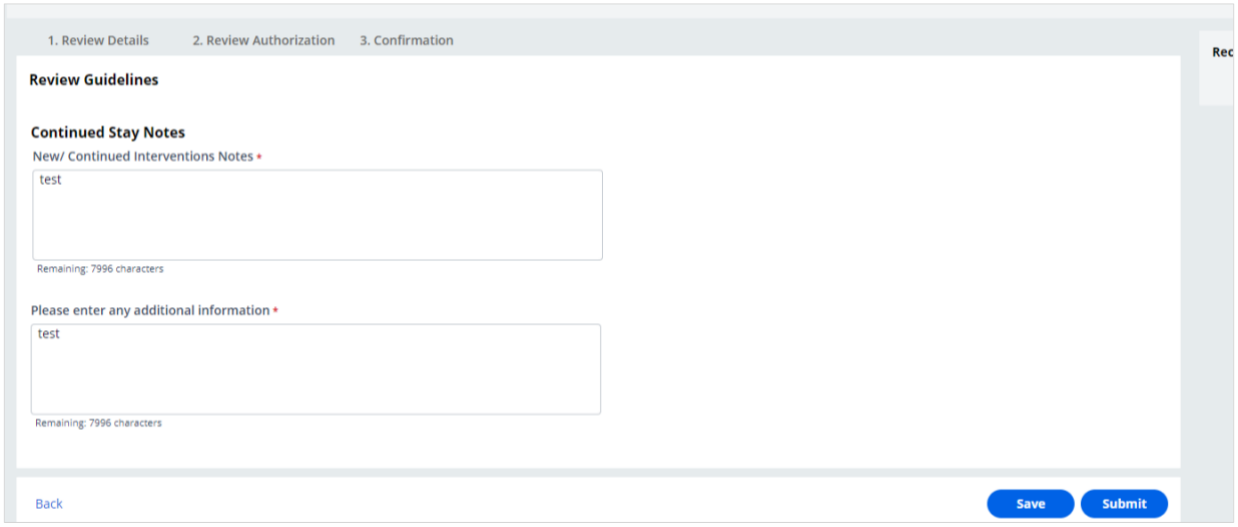


Step 5: In the next screen you will be able to:

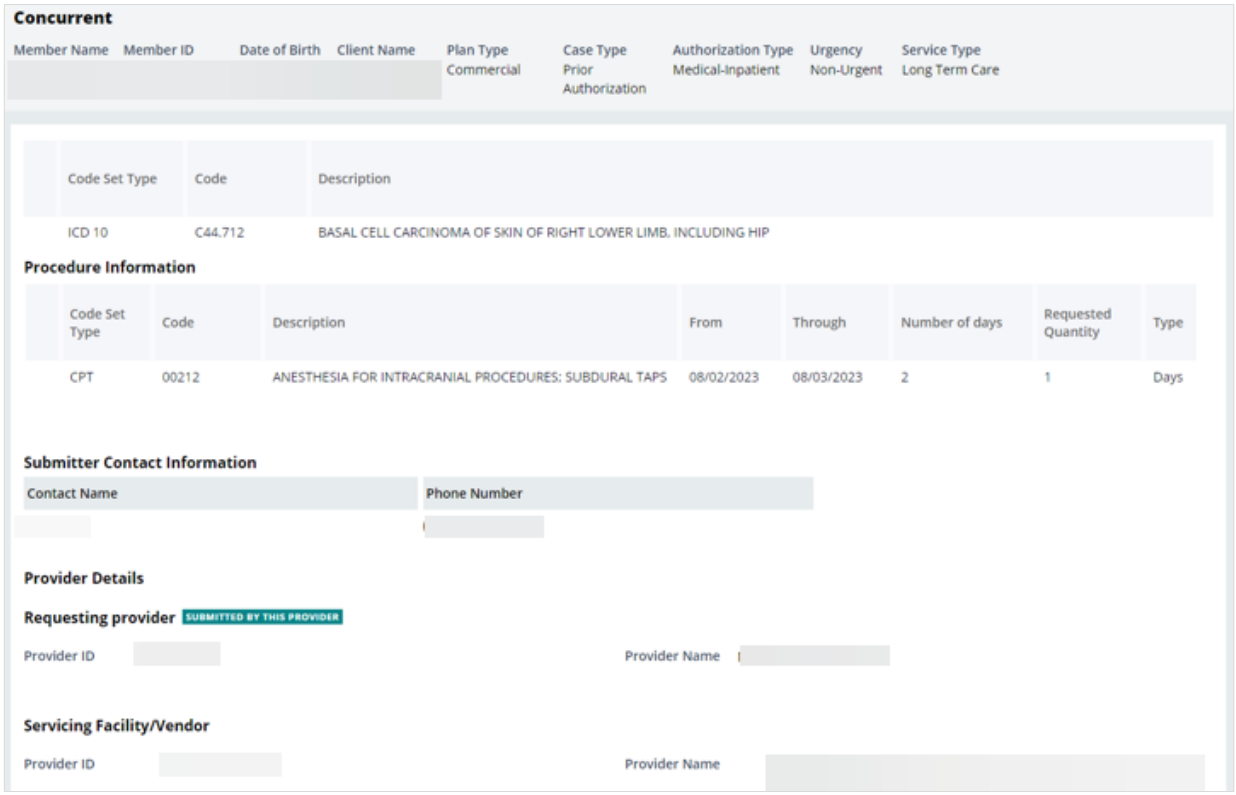
- Add additional documentation in the Recent Attachments section. Click the plus sign, and follow the same directions as listed in Step 9 above in the new case section.
- Enter the Procedure Information fields as noted by the asterisk and select the Continued Stay Reason. Click ***Submit*** when finished.



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



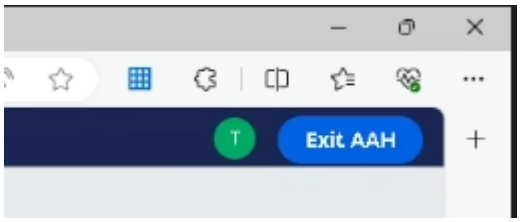
Step 7: Verify all the information you have entered is accurate and additional documentation was attached accordingly. Click ***Submit*** again.



Step 8: Your authorization number will be displayed.

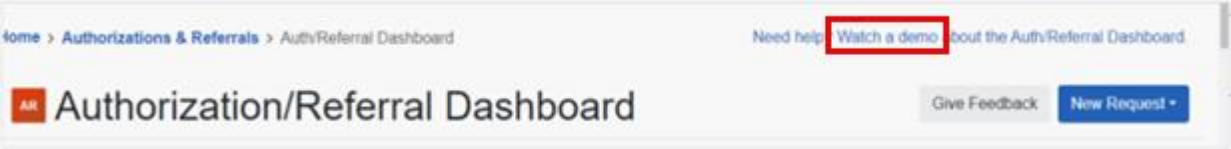
a. You will be able to watch the status of this authorization from your dashboard. More information on how to use your dashboard can be found below in section ***How to use your Dashboard.***

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



How to Use Your Dashboard

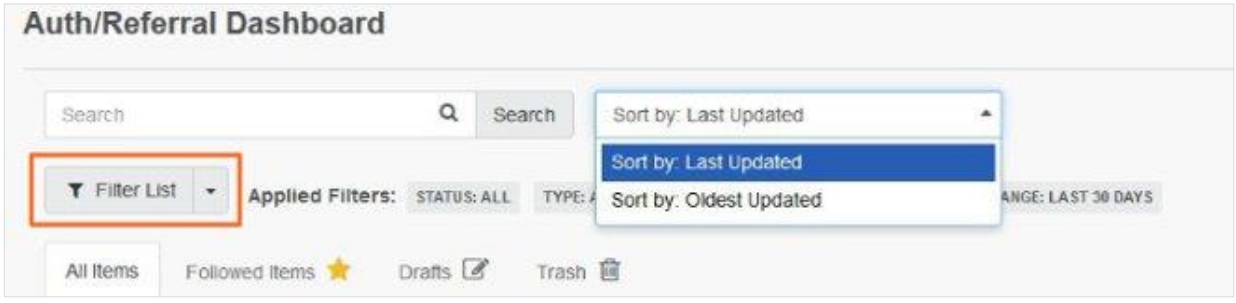
Providers can gain more insight into the dashboard by clicking "Watch a Demo," located within the Authorization/Referral Dashboard screen.



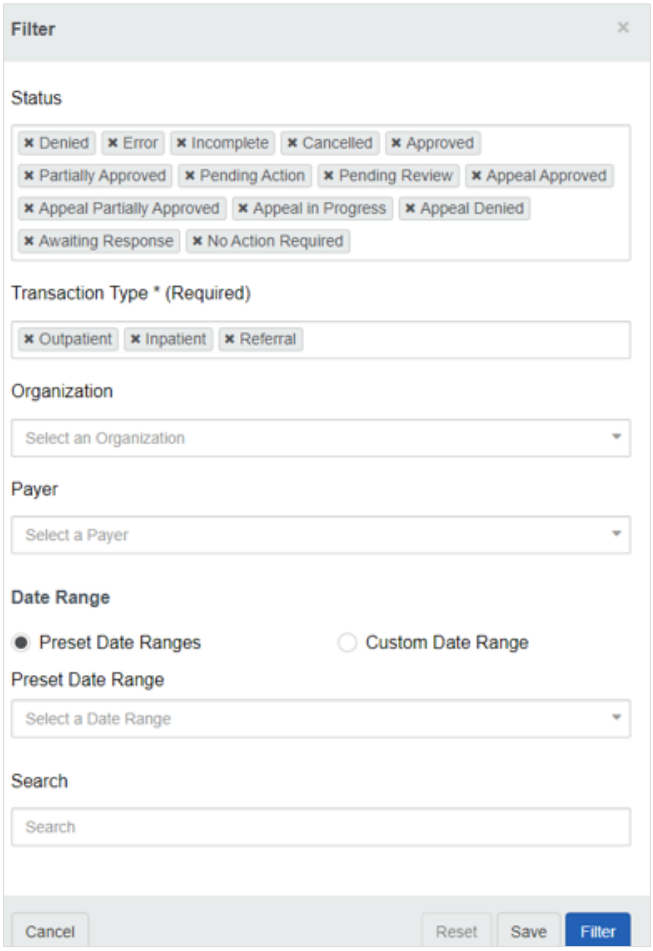
The Authorization Dashboard shows you the status of all authorizations in your organization. The AVT number allows us to find the authorization request if you call in to our member service line.

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.

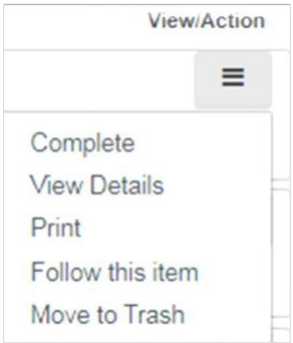
If you wish to save a frequently searched filter, you can do so by clicking on a filter type to see the filter detail window and click ***Save***. To apply the saved filter view, click on the filter type and click ***Apply Saved.***



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

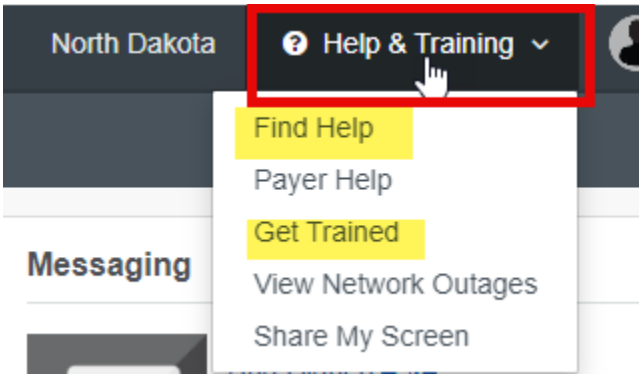


Additionally, the dashboard allows you to see additional details on each authorization. See section Authorization/Referral Dashboard Status Actions below.

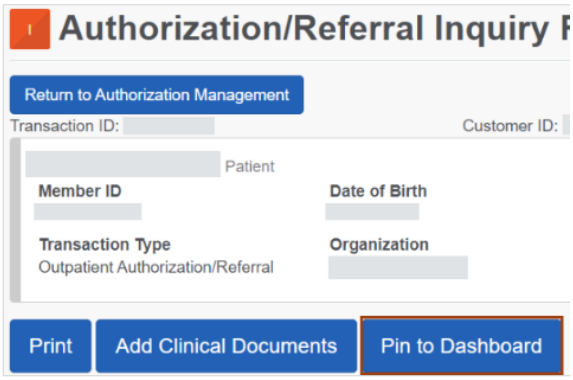


For more information on the dashboard:

- Watch the demo located on 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 items 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 requests.



Authorization/Referral Dashboard Status Actions

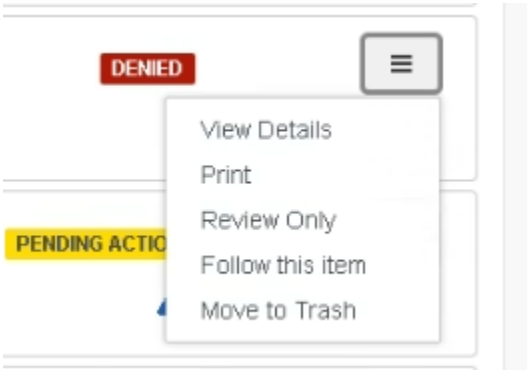
The status action within the Availity Essentials dashboard will let the provider know if action is required or not. If action is required from a provider, the steps on how to attach additional documentation are below.

These status categories may be displayed on 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.

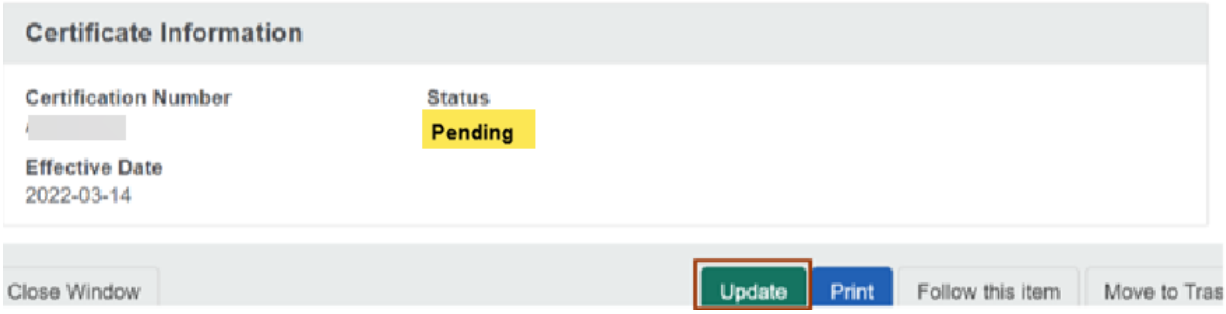
Providers can view additional details on a request when necessary. To do so, select the line and click the hamburger button on the right-hand side.



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

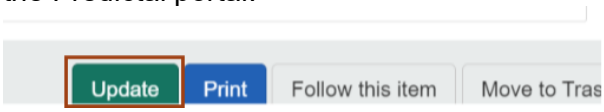
To verify if a provider needs to do anything on a case with a "Pending Action" status, click on the case or view details. On the additional pop-up screen under the “Certificate Information” section, you will see additional status details.



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.

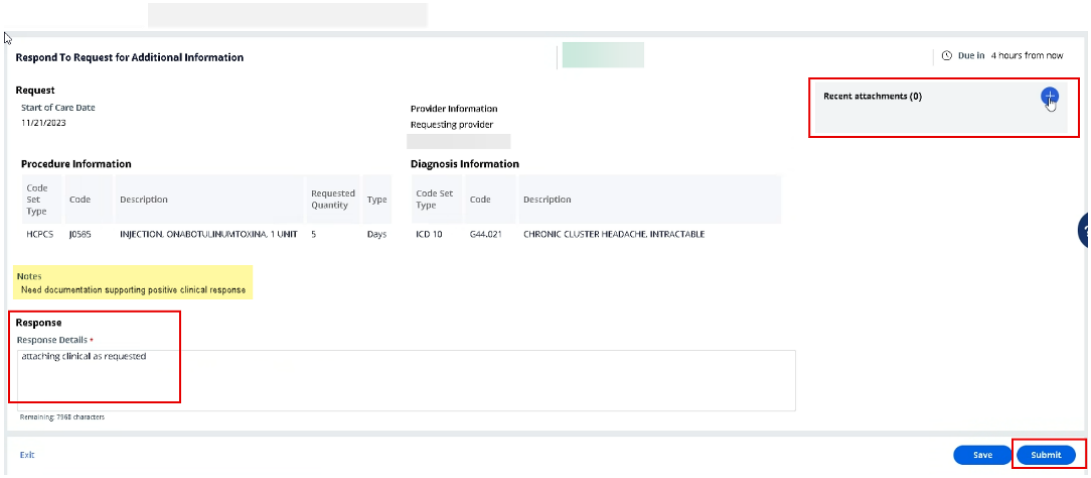


Step 2: Acknowledge, then click the ***Respond to Request for Additional Information*** button.

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

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 the Notes section. Requests may be delayed if submitted with no clinical documentation attached in the correct place.



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.

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 was the PA Checkpoint tool implemented?

A: The Prior Authorization Search tool will help simplify the prior authorization process for BCBSND, its members and their providers. By integrating this search tool within Availity Essentials, it will aid 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 was the Predictal tool implemented?

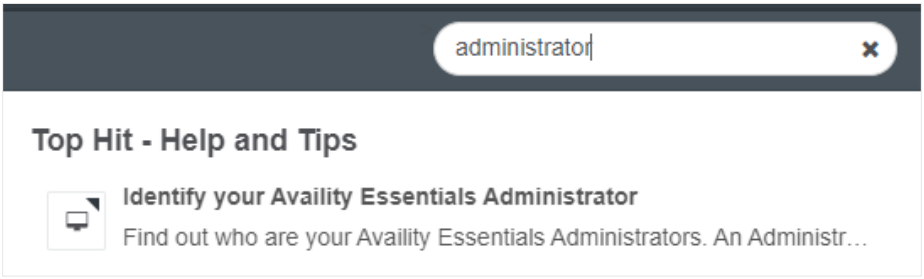
A: The implementation of the Predictal tool aims to improve the precertification process. It reduces manual intervention and helps identify cases through reporting that are likely to be approved or denied, allowing our staff and providers to prioritize their efforts and resources effectively.

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, if you have not yet registered, you can refer to our webpage https://www.bcbsnd.com/providers/news-resources/availity-essentials for more detail. If you run into any issues during the registration process, please contact Availity 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 investigated 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 log in and use the unique identification number (UIT). If the member information related to the precertification request is 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 gave providing the rational for denial.

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

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 use 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 canceled 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 cancel the request by calling the 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 nurses would be able to make edits. If a case needs to be edited, the provider can call the 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 UM 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 attached 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 and 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. The authorization will remain in a "pending" state, and it 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 to 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 and capture 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 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 800-282-4548. You can also find information online.

- 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 member’s ID card or your Provider Relations Partner at prov.partners@bcbsnd.com.