



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

In-lab sleep studies managed by Blue Cross and BCN

Frequently asked questions for providers

For Blue Cross commercial and BCN commercial

Dec. 30, 2025

In this document

General questions.....2

 Which procedure codes require prior authorization?2

 Which groups and members have prior authorization or plan notification requirements?3

Prior authorization.....3

 What is the process for requesting prior authorization?.....3

 What documentation should I submit with a prior authorization request?.....5

 How do I submit prior authorization requests if the e-referral system isn't available?5

 What should I do if I have questions after submitting a prior authorization request?.....6

 How long does the prior authorization process take?6

 How can providers and members determine the outcome of a prior authorization request?.....6

 How long are prior authorization approvals valid?7

 What criteria do Blue Cross and BCN use to make determinations on prior authorization requests?..7

 What happens if I submit a request to Blue Cross or BCN when I should have submitted it to Carelon, or vice versa?7

 What is the reconsideration process for denied prior authorization requests?7

 How do I appeal an adverse determination?7

 Can I submit retroactive authorization requests?.....7

 Does prior authorization guarantee payment?.....8

Plan notification8

 What is the process for submitting plan notification?.....8

Training8

 Is training available?8

For dates of service on or after Nov. 3, 2025, health care providers will need to do the following for in-lab sleep studies and the implantation of hypoglossal nerve stimulation devices for most Blue Cross Blue Shield of Michigan and Blue Care Network commercial members:

- Submit prior authorization requests for most adult commercial members (ages 18 and older) to Blue Cross or BCN Utilization Management through the e-referral system.
- Submit plan notification for pediatric BCN commercial members to BCN Utilization Management through the e-referral system when the service will be performed in Michigan's East or Southeast region. Plan notification alerts BCN about scheduled services and facilitates claims payment. Clinical review isn't required.



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

In-lab sleep studies managed by Blue Cross and BCN

Frequently asked questions for providers

For Blue Cross commercial and BCN commercial

Dec. 30, 2025

These requirements apply when services are performed in Michigan or in other states.

Note: If you need to submit a retroactive authorization request after Nov. 3, 2025, for a sleep study that occurred before Nov. 3, 2025, submit the retroactive request to Carelon Medical Benefits Management. Carelon will accept retroactive requests through Jan. 31, 2026.

General questions

Which procedure codes require prior authorization?

For dates of service on or after Nov. 3, 2025:

- The following procedure codes will continue to require prior authorization or require plan notification: *64582, *95805, *95807, *95808, *95810 and *95811.
- The following procedure codes will no longer require prior authorization: *64583 and *64584.

For dates of service on or after Jan. 1, 2026: Procedure code *64568 requires prior authorization.

To determine which procedure codes require prior authorization, see the document titled [Procedure codes for which providers must request prior authorization](#).

To determine whether a procedure code requires prior authorization for a specific member and where to submit the prior authorization request:

1. Log in to our provider portal (availability.com**).
2. Click *Patient Registration* and then click *Authorizations & Referrals*.
3. Click *Authorization Request*.
4. Enter the requested information.

Availity Essentials™ will tell you whether you need to submit a prior authorization request for the member. For detailed instructions, see the document titled [Determining prior authorization requirements for members](#).

Which groups and members have prior authorization or plan notification requirements?

Starting Nov. 3, 2025, submit prior authorization requests or plan notification to Blue Cross and BCN for in-lab sleep studies both in Michigan and in other states as follows:

Line of business	Details
Blue Cross commercial	<p>Providers must request prior authorization for the following groups and members:</p> <ul style="list-style-type: none"> • All fully insured groups, including MESSA — for adult members only • Most self-funded groups — for adult members only. See the exceptions below • All adult members with individual coverage
BCN commercial	<ul style="list-style-type: none"> • Providers must submit prior authorization requests for all adult members (ages 18 and older) • Providers must submit plan notification for pediatric BCN commercial members through the e-referral system when the in-lab sleep study will be performed in Michigan’s East or Southeast region. Plan notification alerts BCN about scheduled services and facilitates claims payment. Clinical review isn’t required.

Exceptions for Blue Cross commercial self-funded groups:

- Carelon will continue to manage prior authorizations for in-lab sleep studies for adult Blue Cross commercial members who have commercial coverage through Chrysler, Delphi/Aptiv, General Motors or UAW Retiree Medical Benefits Trust. You’ll no longer need to submit prior authorization requests for pediatric members. For more information, see the document titled [Frequently asked questions about Carelon: For cardiology, radiology \(high technology\) and sleep studies \(in lab\)](#).
- Members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®, the State of Michigan and select Ascension Health groups don’t require prior authorization for in-lab sleep studies.

Prior authorization

What is the process for requesting prior authorization?

Blue Cross and BCN’s prior authorization process for sleep studies takes advantage of new and scalable artificial intelligence and automation capabilities that are available through Availity® AuthAI. The process provides:

- A simplified submission process
- Reduced manual effort
- Quick turnaround time

Here's how the prior authorization process works:

Note: To learn how to view a demonstration of this process, see the [Is training available?](#) section at the end of this document.

1. The health care provider creates a prior authorization request in the e-referral system.

Tip: To learn how to access the e-referral system, see the [Getting Started](#) page on **authorizations.bcbsm.com**. Look for the section titled "Submit prior authorization requests."

2. The provider attaches all clinical documentation to the request. To do this, click the *Create New* button in the Case Communication field, add a subject and then click the *Attach File* button.

Notes:

- You can upload many different file formats and you can attach multiple files. There's a 50 MB limit per file. For more information, see the [e-referral User Guide](#).
- If the system doesn't allow you to upload clinical documentation, please wait five minutes and try again; feel free to do other work while you wait. If the issue persists, call the Blue Cross Blue Shield of Michigan Web Support Help Desk at 1-877-258-3932.

3. The provider clicks the AuthAI questionnaire assessment link.

Note: If the questionnaire doesn't open, please wait five minutes and try again; feel free to do other work while you wait. If the issue persists, call the Blue Cross Blue Shield of Michigan Web Support Help Desk at 1-877-258-3932.

4. Based on the uploaded clinical documentation, the questionnaire is populated using artificial intelligence and automation.
5. The provider does two things:
 - Reviews the answers in the questionnaire. Click the *Modify* button to change an answer.
 - Answers additional questions, if needed. Providers are prompted to answer additional questions when the system is unable to populate the answers to certain questions because information isn't present in the clinical documentation or when the system can't read the uploaded clinical documentation due to poor scan quality.
6. The provider clicks the *Continue* button.

7. The provider submits the questionnaire by clicking the *Submit Authorization* button.

Important: If the provider doesn't click the *Submit Authorization* button, the request will automatically pend for clinical review.

8. Within approximately five minutes, one of the following will happen:
- If all criteria are met, the request will be approved.
 - If Blue Cross or BCN needs additional information to process the request or the case has been pended for medical review, that will be noted in the Case Communication field in the e-referral system.

Although we use artificial intelligence to approve requests, we don't use AI to deny requests. Any requests that can't be approved through the process outlined above will be manually reviewed by an appropriate clinician. You can check the status of your requests through the e-referral system; see the [e-referral User Guide](#) for details.

This process adheres to regulatory and legislative guidelines.

What documentation should I submit with a prior authorization request?

Submit all clinical information related to the service or procedure you're requesting. This includes, but isn't limited to:

- Symptoms of sleepiness
- Daytime sleepiness determined by an assessment tool (Epworth Sleepiness Scale or the Stanford Sleepiness Scale)
- Past medical history
- Presence of other health conditions
- Neck circumference
- Body mass index, or BMI

For repeat sleep studies, include the purpose of the repeat test and the results of the initial sleep study.

How do I submit prior authorization requests if the e-referral system isn't available?

If the e-referral system isn't available, providers should do the following:

- **For non-urgent requests**, wait and submit the prior authorization request when the system is available. For more detailed information, see the document titled [e-referral system maintenance times and what to do](#).

- **For urgent requests**, call the Utilization Management department at 1-800-392-2512 for assistance obtaining an authorization. Be prepared to fax your request with all pertinent clinical documentation during periods of downtime.

What should I do if I have questions after submitting a prior authorization request?

If you have questions after submitting a prior authorization request, call the Utilization Management department at 1-800-392-2512 for assistance.

How long does the prior authorization process take?

As noted earlier, you'll receive determinations on requests that are approved through AI and automation within approximately five minutes of submitting a request.

If the request is pended for clinical review, you'll be notified of the decision as follows:

- For standard requests, we'll make a determination within seven days of submission.
- For urgent requests, we'll make a determination or request additional information within 72 hours of submission.

If we ask for additional information, you should submit it as soon as possible.

How can providers and members determine the outcome of a prior authorization request?

You can find decisions on prior authorization requests in the e-referral system.

If a request is pended for clinical review:

- If we need additional information to make a determination, we'll make a courtesy call to the contact who submitted the request.
- We'll notify you when a request has been pended to a medical director for additional review.

If a request is denied, we'll send a letter to the primary care provider (for BCN members), the facility and other providers and to the member. The letter contains the reasons for the denial, along with instructions for filing an appeal. Providers who have access to the e-referral system can also view the determination online as soon as one is made.

See the following sections later in this document:

- [What is the reconsideration process for denied prior authorization requests?](#)
- [How do I appeal an adverse determination?](#)

How long are prior authorization approvals valid?

Authorizations are valid for at least 60 days.

What criteria do Blue Cross and BCN use to make determinations on prior authorization requests?

Blue Cross and BCN use our medical policies to make determinations on prior authorization requests. To view Blue Cross and BCN medical policies:

1. Go to bcbsm.com/providers.
2. Click *Resources*.
3. Click the *Search Medical Policies* button.
4. Enter the pertinent procedure code in the Policy/Topic Keyword field and then press *Enter*.

What happens if I submit a request to Blue Cross or BCN when I should have submitted it to Carelon, or vice versa?

If you submit a request to Blue Cross or BCN that should have been submitted to Carelon, you'll receive a notification that will redirect you to submit the request to Carelon.

Likewise, if you contact Carelon about procedures that are managed by Blue Cross or BCN, you'll be redirected to Blue Cross or BCN.

What is the reconsideration process for denied prior authorization requests?

You can request a peer-to-peer review to review the case with a physician.

To learn how to request a peer-to-peer review, see the document titled [How to request a peer-to-peer review with a Blue Cross or BCN medical director](#).

How do I appeal an adverse determination?

For information about appealing requests that aren't approved, see the denial letter.

Can I submit retroactive authorization requests?

Yes. You can submit retroactive authorization requests for up to two years after the procedure is performed.

If you need to submit a retroactive authorization request after Nov. 3, 2025, for a sleep study that occurred before Nov. 3, 2025, submit the retroactive request to Carelon Medical Benefits Management. Carelon will accept retroactive requests through Jan. 31, 2026.

Does prior authorization guarantee payment?

Prior authorization doesn't guarantee payment. Claims submitted for these services will also be subject, but not limited to, the following:

- Member eligibility at the time services were provided
- Benefit limitations and/or exclusions
- Appropriateness of codes billed
- Medical necessity review, if prior authorization wasn't obtained before services were provided

Plan notification

What is the process for submitting plan notification?

To learn how to submit plan notification for pediatric BCN commercial members, see the [e-referral User Guide](#). In *Section IV: Referrals and Authorizations*, look for subsection *3. Submit a referral*.

You don't need to attach clinical documentation when submitting plan notification.

Training

Is training available?

Yes. To view a demonstration on submitting prior authorizations for in-lab sleep studies through the e-referral system, go to Blue Cross and BCN's Provider Training site, search for *sleep* and launch the *Enhanced prior authorization process for sleep studies for commercial patients mini module*.

To access the training site, follow these steps:

1. Log in to our provider portal at availity.com.**
2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
3. Click the *Provider Training Site* tile in the Applications tab.
4. Select an organization and click *Submit*.

For issues regarding access to or navigating the site, email ProviderTraining@bcbsm.com.



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

In-lab sleep studies managed by Blue Cross and BCN

Frequently asked questions for providers

For Blue Cross commercial and BCN commercial

Dec. 30, 2025

***CPT Copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.**

**Clicking this link means that you're leaving the Blue Cross Blue Shield of Michigan and Blue Care Network website. While we recommend this site, we're not responsible for its content.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services. For more information, go to our authorizations.bcbsm.com website.