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BCBSWY Online Authorization Training Guide

3/16/2020 Version 2.5



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Disclaimer:

Updates to any part of this training guide or to any policy or procedure referenced in this guide may be made by BCBSWY at any time. BCBSWY may give notices of such updates in a variety of ways, including but not limited to issuance of a letter to Providers, publication in email bulletins or other publication of BCBSWY, or posting to the BCBSWY website, BCBSWY.com.

Nothing in the manual shall be interpreted as a guarantee of coverage of any service, treatment, drug or supply. Coverage or noncoverage is always governed exclusively by the terms of the Member's benefit plan. Accordingly, in case of any questions or doubt about coverage, Providers should contact Provider Support at 888-359-6592.

[Prior Authorization Overview](#)

When Blue Cross Blue Shield of Wyoming (BCBSWY) receives a prior authorization request from a Provider, it will be reviewed by our clinical staff. BCBSWY's Medical policies and clinical criteria are used in this review. Medical policies are available online for Providers and are searchable by title, CPT code and identification number.

A determination (approved or denied) will be rendered from the information submitted:

- Non-urgent prior authorization requests will be processed within 14 calendar days from date of receipt.
- Urgent* prior authorization requests will be processed within three calendar days from date of receipt.
- The Provider, rendering facility and member will be notified in writing of the determination (via U. S. Mail).
- Once a determination has been made a fax response will be immediately sent.

* For further explanation of the urgent prior authorization review criteria, please visit the U. S. Department of Labor.

Participants of some health plans may have terms of coverage or benefits that differ from the information presented here. The following information describes the general policies of Blue Cross Blue Shield of Wyoming and is provided for reference only. This information is **NOT A GUARANTEE OF PAYMENT**. To verify coverage or benefits or determine prior authorization requirements for a participant, call 1-800-442-2376 or go to the website [BCBSWY.com/providers/preadmin/](https://www.bcbswy.com/providers/preadmin/). The lists of the prior authorization requirements can be found below:

Prior Authorization – Admission Request is the process of notifying BCBSWY of a proposed inpatient stay.

Prior Authorization – Service Request is the process of notifying BCBSWY of a proposed service.

Helpful Hint:

CERTAIN SERVICES REQUIRE BOTH A SERVICE AUTHORIZATION AND ADMISSION AUTHORIZATION. IN THE CIRCUMSTANCES WHEN BOTH ARE REQUIRED, THE SERVICE AUTHORIZATION MUST BE APPROVED BEFORE BCBSWY CAN APPROVE THE ADMISSION AUTHORIZATION.

[Prior Authorization Online Requests](#)

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

Determine if a Prior Authorization Request is Required:

Determine prior authorization request requirements for a Member:

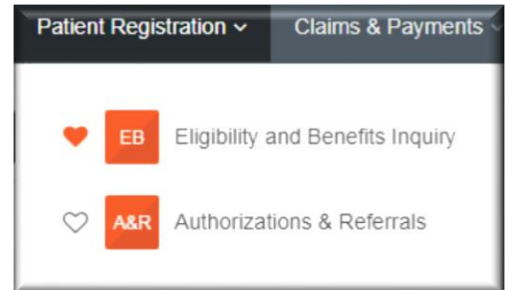
Call: 1-800-442-2376.

Check online a [list of procedure codes that always requires prior authorization](#) and a [list of procedure codes that is subject to BCBSWY medical policy](#).

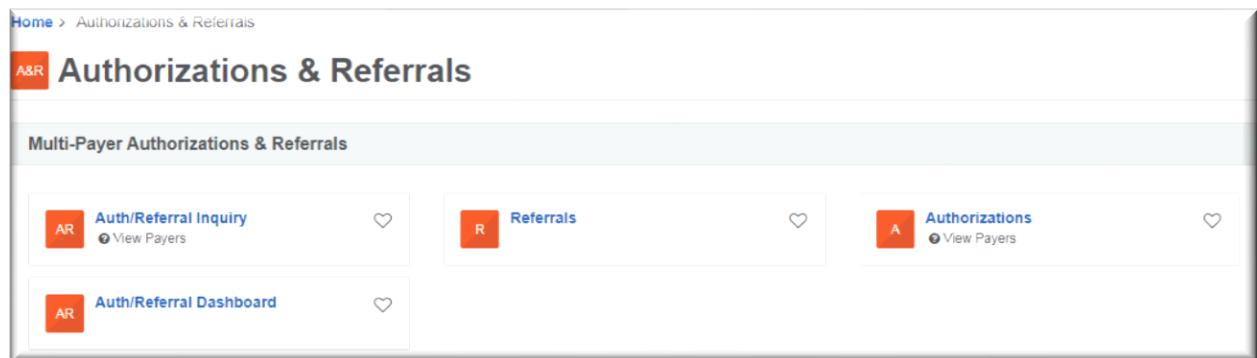
Complete a Prior Authorization Request:

For services which do require BCBSWY prior authorization requests, login to www.availity.com. For best results, use Internet Explorer or Chrome and turn off your popup blockers.

The **Authorization Tool** is found under **Patient Registration**. You can bookmark the tool by selecting the heart icon next to it. If you are unable to see the Authorization & Referrals tool, please contact your system administrator for permission.



Selecting the Authorizations & Referrals link will take you to the main Authorizations page.



From this screen, you can inquire about an existing authorization submission, submit an authorization request, or view the Authorization Dashboard. Please note BCBSWY does not currently track referrals.

[Submitting an Authorization](#)

To submit an authorization, select the  **Authorizations**  View Payers box from the Home page.

Select BCBSWY from the payer dropdown box, your transaction type and organization.

Authorizations

* indicates a required field

* Payer: ?

* Transaction Type:

* Organization:

This will take you to the BCBSWY Authorization Tool.

The BCBSWY Authorization tool allows you to submit authorizations for professional services, inpatient stays, and concurrent reviews for both medical and behavioral health.

A

Authorizations

Give Feedback

Go to Dashboard

New Request

SELECT A PAYER

Organization

Payer

Request Type

Next

In the Request Type dropdown, you choose Inpatient Authorization or Outpatient Authorization. We will walk through both authorization types. Starting first with Outpatient Authorizations (Service Requests).

[Outpatient Authorizations \(Service Request\)](#)

To begin an outpatient prior authorization, enter Member ID, Relationship, and Date of Birth.

The screenshot shows the 'Authorizations' form with a progress bar at the top indicating four steps: 1. Start an Authorization, 2. Add Service Information, 3. Rendering Provider/Facility, and 4. Review and Submit. The first step is active. Below the progress bar, there are three sections: 'Transaction Type' (Outpatient Authorization), 'Organization' (BCBS Wyoming), and 'Payer' (BCBSWY). To the right of these sections is the Wyoming logo. Below these sections is a 'PATIENT INFORMATION' section with three fields: 'Member ID' (a text input field), 'Relationship to Subscriber' (a dropdown menu with 'Self' selected), and 'Patient Date of Birth' (a date picker with a calendar icon).

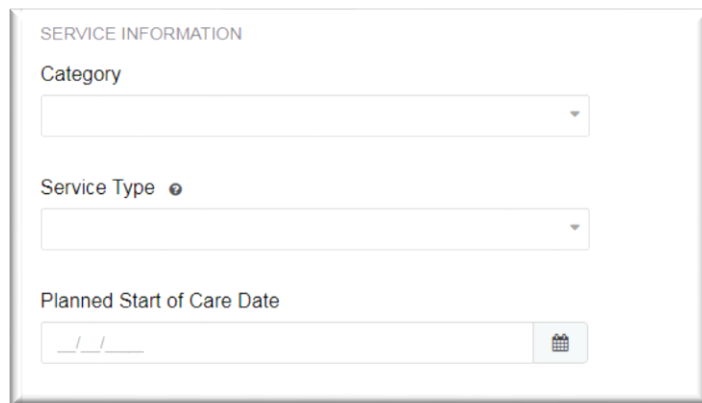
Then enter the Ordering/Requesting Provider's NPI and click Retrieve Provider Info. If you enter a group NPI, all of the providers associated with that group will be returned.

The screenshot shows the 'ORDERING/REQUESTING PROVIDER' section. It has a label 'NPI' above a text input field. To the right of the input field is a blue button labeled 'Retrieve Provider Info'. Below the input field is a checkbox labeled 'I don't know the Provider's NPI'.

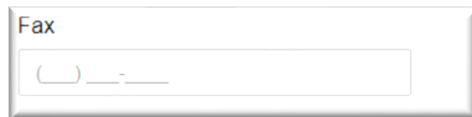
If you do not know the Ordering/Requesting Provider's NPI you can select the "I don't know the Provider's NPI" box and enter the provider's first and last name.

The screenshot shows the 'ORDERING/REQUESTING PROVIDER' section. It has two text input fields labeled 'First Name' and 'Last Name'. Below these fields is a blue button labeled 'Retrieve Provider Info'. Below the button is a checkbox labeled 'I don't know the Provider's NPI' which is checked.

Once you have selected the provider, their address information will pull from BCBSWY's database. Please confirm the address and enter the fax phone where authorization information can be sent. If you don't want a fax reply, enter (307) 999-9999.

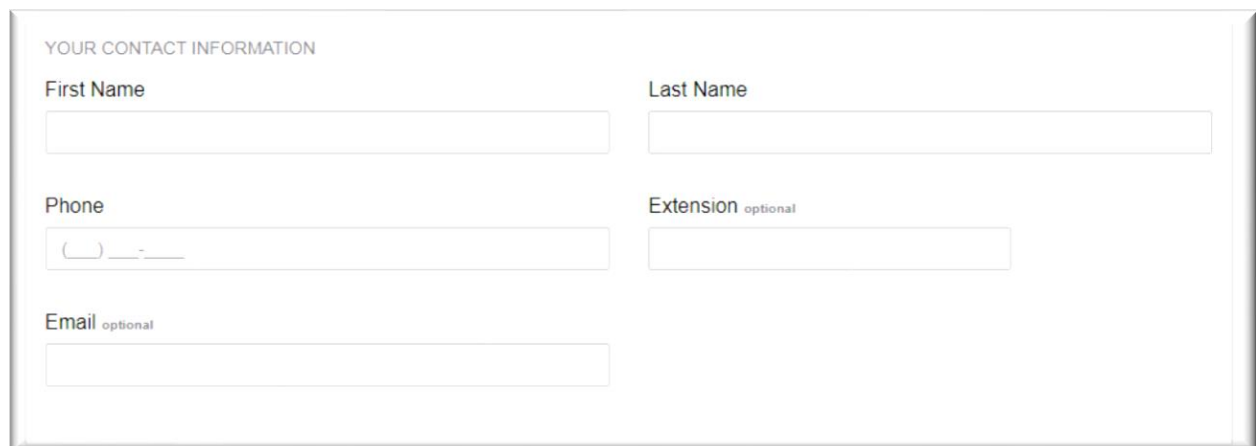


A form titled "SERVICE INFORMATION" with three fields: "Category" (a dropdown menu), "Service Type" (a dropdown menu with a help icon), and "Planned Start of Care Date" (a date picker with a calendar icon).



A form titled "Fax" with a single text input field for a phone number, including a placeholder for the area code in parentheses.

Then enter your contact information.




A form titled "YOUR CONTACT INFORMATION" with four fields: "First Name", "Last Name", "Phone", and "Extension" (marked as optional). There is also an "Email" field (marked as optional) at the bottom.

Then click Next. At this point, the system verifies the member's eligibility. Benefits will be denied if the patient is not eligible for coverage under the benefit plan on the date services provided or if services received are not medically appropriate and necessary.

Next, you will see the Service Information screen. Enter the Category, either "Behavioral Health" or "Medical". Then enter the Service Type; this is a high-level category like "Chemotherapy", and then select the Planned Start of Care Date. If this is a retro-authorization, select the date of service. BCBSWY accepts retro-authorizations up to 365 days in the past.





Next, select the diagnosis and procedure codes associated with the service. There can be multiple codes per service. Enter the quantity and units of the service as well. The Start Date should match the Planned Start of Care Date. Set the End Date to 365 days in the future to ensure enough time for the service to be rendered.

DIAGNOSIS CODE(S)

Diagnosis Code 

[Add another diagnosis code](#)

PROCEDURE CODE(S)

| | |
|--|--|
| Procedure Code  | Type |
| <div></div> | CPT/HCPCS |
| Quantity  | Unit Type |
| <div></div> | Units |
| Start Date | End Date |
| 10/08/2019  | 10/08/2019  |
| Add another procedure code | |

The next screen allows you to mark if the authorization is urgent. Please mark a prior authorization request **URGENT** if failure to receive treatment will result in a life or limb threatening situation. Non-urgent requests marked urgent will delay processing. BCBSWY does not recognize scheduling conflicts as an urgent request.

If the request is marked URGENT, you can also add additional comments on this screen.

SERVICE INFORMATION (CONTINUED)

Do any of the following apply ?


☐ The ordering physician, with knowledge of the member's medical condition, has determined that waiting the standard time for review would subject the member to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim, or the ordering physician has determined that waiting could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function.

Additional Information (Optional comments)

Enter a short optional message to the referred-to provider regarding the patient. Please tell us if patient has been discharged.

(150 characters remaining)

Then you will enter the Rendering Provider Information. This can be a Facility/Home Health/DME, a Group Practice, or a Provider. You will again be asked to enter that provider's NPI.



RENDERING PROVIDER

Provider Type

Select a Provider Type

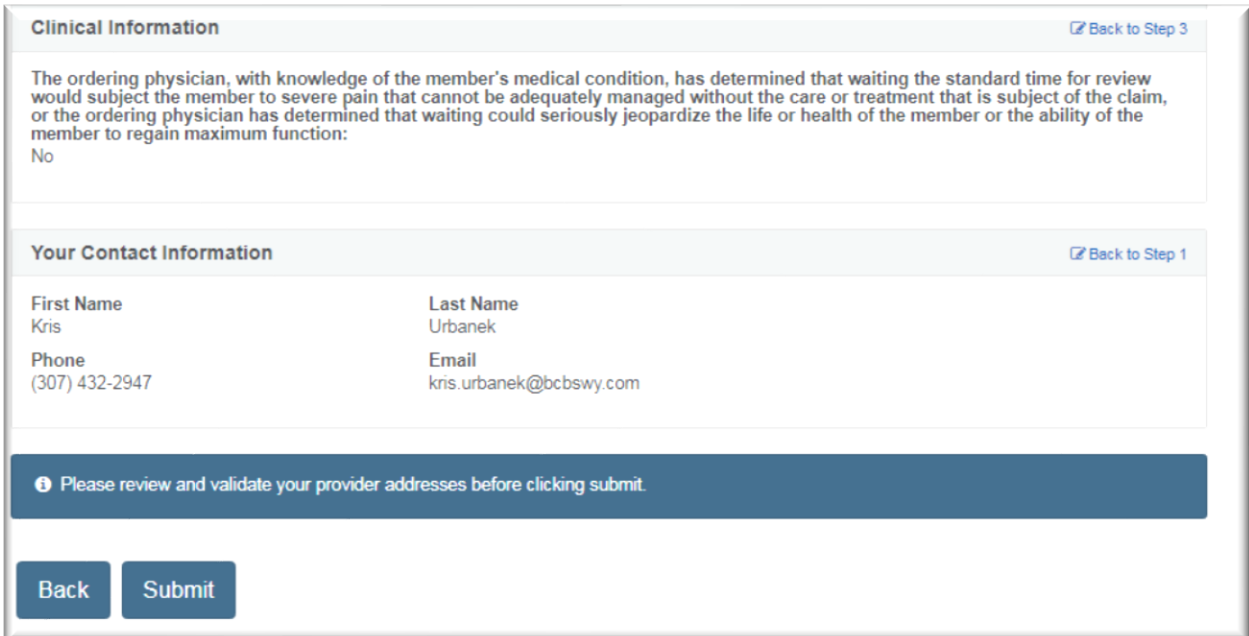
- Facility/Home Health/DME
- Group Practice
- Provider

Back Next

v2.1009.4

You will again be asked to enter that provider's NPI. After that, you will need to confirm the rendering provider's address and enter their fax number. After you click Next, you will be taken to a review screen.

At the review screen you can confirm all of the information you provided is accurate or you can edit any mistakes. Once you have confirmed your authorization is correct you can click Submit.



Clinical Information [Back to Step 3](#)

The ordering physician, with knowledge of the member's medical condition, has determined that waiting the standard time for review would subject the member to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim, or the ordering physician has determined that waiting could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function:

No

Your Contact Information [Back to Step 1](#)

| | |
|----------------|-------------------------|
| First Name | Last Name |
| Kris | Urbanek |
| Phone | Email |
| (307) 432-2947 | kris.urbanek@bcbswy.com |

Please review and validate your provider addresses before clicking submit.

Back Submit

You are then taken to a screen that allows you to submit your clinical documentation. Medical records will be required with each submission. The authorization is not able to be processed until this step is complete.

Select the “Add Clinical Documents” button and you will be redirected to a different website.

Print Add Clinical Documents

Certificate Information

Transaction Type
Outpatient Authorization

Certification/Reference Number
AVT-193

Status
Pending Attachment

Note
Please attach clinical documentation to support your request. Once submitted, your request will be reviewed by our Utilization Management team. You will be notified when this review has been completed.

On this website, you must click the “Accept” button to proceed to our Single Sign-On page where you can upload your records.

Home > Blue Cross Blue Shield of Wyoming > Single Sign-On

Single Sign-On

You are about to be re-directed to a third-party site away from Availity's secure site, which may require a separate log-in. Availity provides the link to this site for your convenience and reference only. Availity cannot control such sites, does not necessarily endorse and is not responsible for their content, products, or services. You will remain logged in to Availity.

Cancel Accept

Here you select your files, give them a subject and select Submit.

Subject★ Test Authorization

File★ Choose File Test Auth.pdf

Submit

Files cannot exceed 10 MB. Accepted file types .avi, .bmp, .doc, .docx, .gif, .gz, .jpeg, .pdf, .png, .pptx, .tif, .wmv, .xls, .xlsx, and .zip. The name of the attached file must be less than 40 characters long. You can only submit one file at a time. In order to submit multiple files, you must close the tab and update the authorization.

If the transaction is successful, you will receive the following message. Go ahead and close this window.

Thank You for your Input. Transaction has completed successfully.

Please close this window.

At this point you can go to the Dashboard or enter a New Request.



[Inpatient Authorizations \(Service and Admission Requests\)](#)

As mentioned earlier, Inpatient Authorizations can require both an authorization for the service being rendered and the inpatient admission. Basically, this means you will submit two authorizations, similar to how this is done on paper today.

First, the Service request. You will follow the same steps as the Outpatient Authorization. In fact, you will even select Outpatient Authorization on the first screen.

Secondly, the Admission request. A prior authorization admission request is the process of notifying BCBSWY of an inpatient stay. The participating Provider or Member must notify BCBSWY of **ALL** inpatient stays including maternity and emergency admissions. When a patient is transferred from one facility to another, the Provider of the receiving facility should notify BCBSWY.

A Provider should submit a request when:

- A patient is being scheduled for an inpatient stay
- A patient is being admitted for an inpatient stay
- A patient is a Federal Employee Plan (FEP) member and is in an observation status greater than 48 hours
- A patient is in an observation status and their contract number begins with the following prefixes QWY, YWY, ZRW, ZSC, ZSD, ZSF, ZSH, ZSK, ZSM, ZYW, and R.

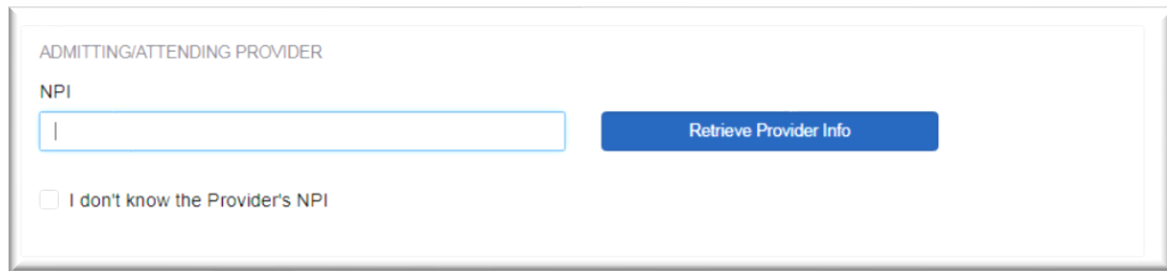
A Provider **does not** need to submit a request when:

- A patient is a FEP member and is in an observation status less than 48 hours
- A patient is on Medicare and has a contract number beginning with ZSM

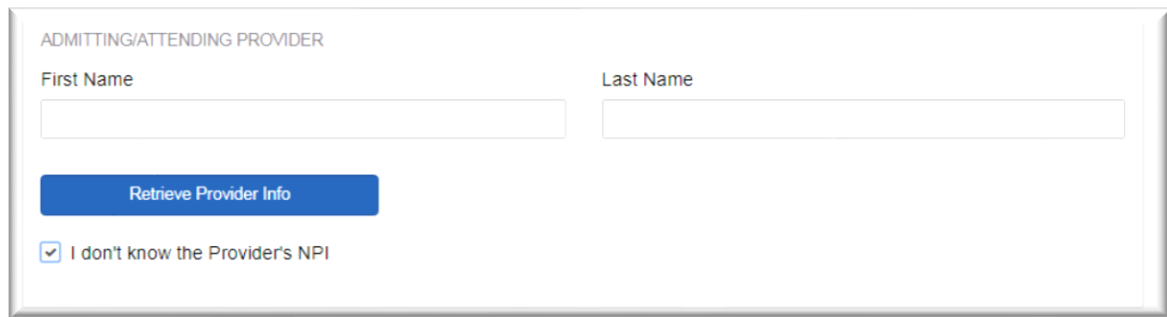
To begin, you will enter the Member's ID, Relationship and Date of Birth.

A screenshot of the 'Start an Authorization' form. At the top, there are four numbered steps: 1. Start an Authorization, 2. Add Service Information, 3. Rendering Provider/Facility, and 4. Review and Submit. The form is for 'Inpatient Authorization' and shows 'Organization' as 'BCBS Wyoming' and 'Payer' as 'BCBSWY'. The 'WYOMING' logo is on the right. Under 'PATIENT INFORMATION', there is a 'Member ID' field, a 'Relationship to Subscriber' dropdown menu (set to 'Self'), and a 'Patient Date of Birth' field with a calendar icon.

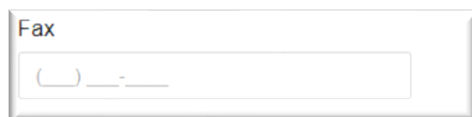
Next, you will enter the Attending/Admitting Provider information. If you enter a group NPI, all of the provider's association with that group will be returned.



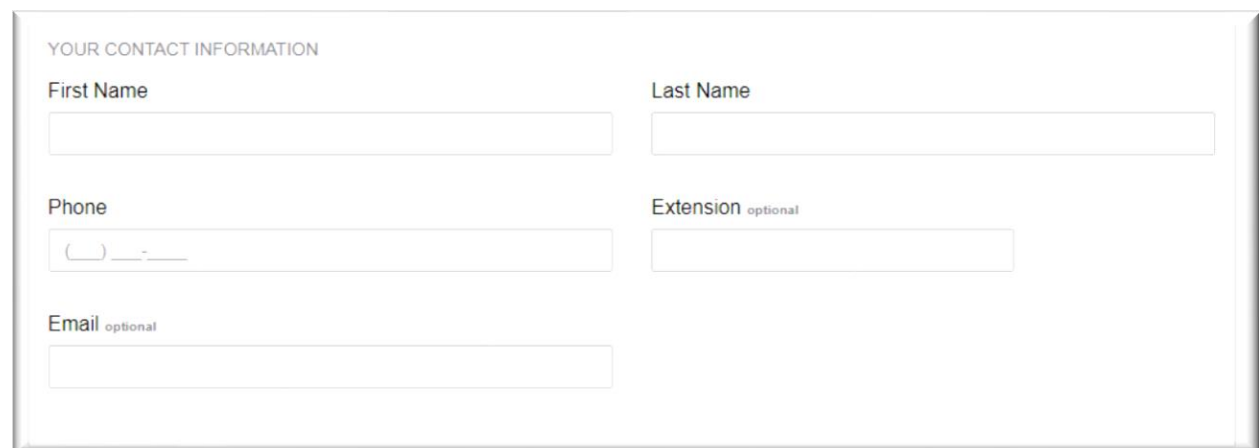
If you do not know the Attending/Admitting Provider's NPI, you can select the "I don't know the Provider's NPI" box and enter the provider's first and last name.



Once you have selected the provider, their address information will pull from BCBSWY's database. Please confirm the address and enter the fax phone where authorization information can be sent. If you don't want a fax reply, enter (307) 999-9999.

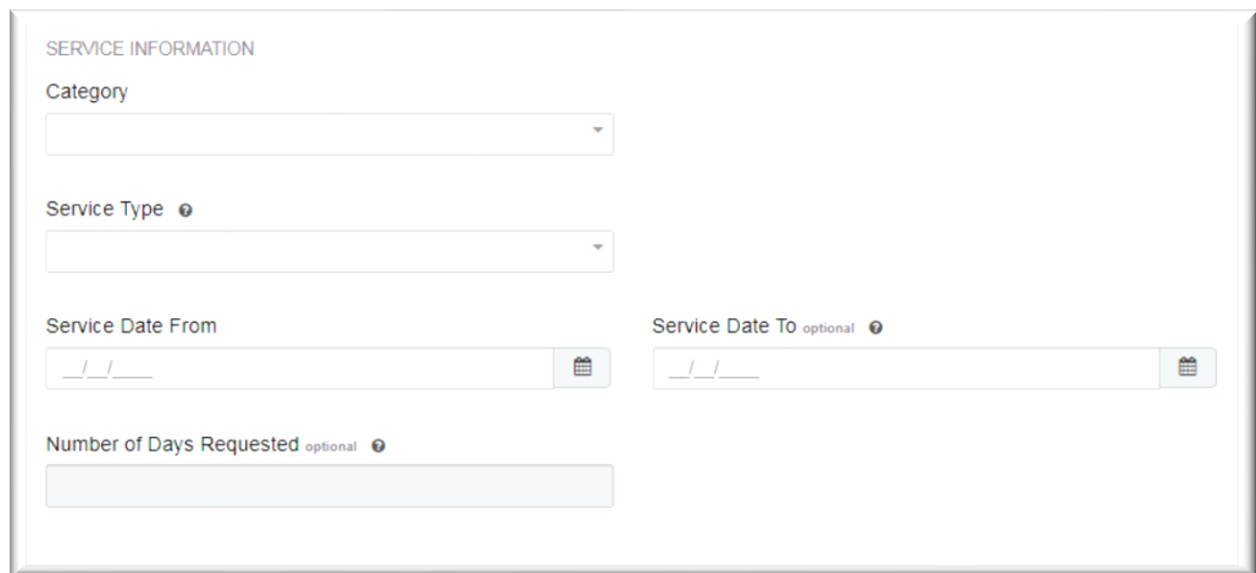


Then enter your contact information.



Then click “Next”. At this point, the system verifies the member’s eligibility. Benefits will be denied if the patient is not eligible for coverage under the benefit plan on the date services provided or if services received are not medically appropriate and necessary.

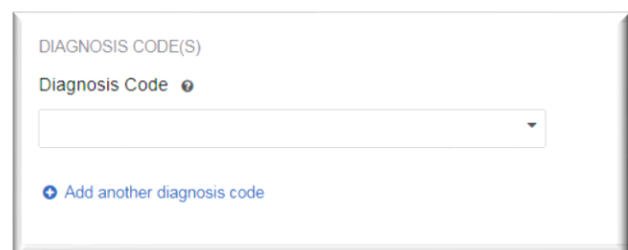
Next, you will see the Service Information screen. Enter the Category, either “Behavioral Health” or “Medical”. Then enter the Service Type, this is a high-level category like “Chemotherapy”, and then select the Service Date From and Service Date To dates. Do not include observation days. The system will calculate the number of days. If this is a retro-authorization, select the date of service. BCBSWY accepts retro-authorizations up to 365 days in the past.



The screenshot shows a form titled "SERVICE INFORMATION". It contains the following fields:

- Category**: A dropdown menu.
- Service Type**: A dropdown menu with a help icon.
- Service Date From**: A date input field with a calendar icon.
- Service Date To**: A date input field with a calendar icon, labeled as optional.
- Number of Days Requested**: A text input field, labeled as optional.

Next, select the diagnosis associated with the service. There can be multiple codes per service.



The screenshot shows a form titled "DIAGNOSIS CODE(S)". It contains the following elements:

- Diagnosis Code**: A dropdown menu with a help icon.
- Add another diagnosis code**: A blue link with a plus icon.

The next screen allows you to mark if the authorization is urgent. Please mark a prior authorization request **URGENT if failure to receive treatment will result in a life or limb threatening situation**. Non-urgent requests marked urgent will delay processing. BCBSWY does not recognize scheduling conflicts as an urgent request.

Additional comments can be entered on this screen, if the prior authorization is marked URGENT.

SERVICE INFORMATION (CONTINUED)

Do any of the following apply ?

☐ The ordering physician, with knowledge of the member's medical condition, has determined that waiting the standard time for review would subject the member to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim, or the ordering physician has determined that waiting could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function.

Additional Information (Optional comments)

Enter a short optional message to the referred-to provider regarding the patient. Please tell us if patient has been discharged.

(150 characters remaining)

Then, you will enter the Rendering Facility information.

RENDERING FACILITY

NPI

☐ I don't know the Provider's NPI

If you do not know the Rendering Facility information, you can look it up by name.

RENDERING FACILITY

Name

☒ I don't know the Provider's NPI

After you have selected the Rendering Facility's NPI, you will need to confirm the address and enter their fax number. After you click Next, you will be taken to a review screen.

At the review screen you can confirm all the information you provided was accurate or you can edit any mistakes. Once you have confirmed your authorization is correct you can click Submit.

Clinical Information [Back to Step 3](#)

The ordering physician, with knowledge of the member's medical condition, has determined that waiting the standard time for review would subject the member to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim, or the ordering physician has determined that waiting could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function:

No

Your Contact Information [Back to Step 1](#)

| | |
|--------------------------------|---|
| First Name Kris | Last Name Urbanek |
| Phone (307) 432-2947 | Email kris.urbanek@bcbswy.com |

Please review and validate your provider addresses before clicking submit.

Back

Submit

You are then taken to a screen that allows you to submit your clinical documentation. Clinical documentation will be required with each submission. The authorization is not able to be processed until this step is complete. Use the [Inpatient Authorization Supplemental Document](#) found on page 22 of this manual for this step.

Select the "Add Clinical Documents" button and you will be redirected to a different website.

Print

Add Clinical Documents

Certificate Information

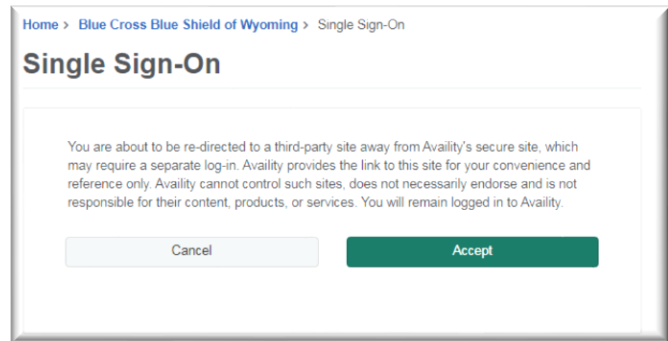
Transaction Type
Inpatient Authorization

Certification/Reference Number
AVT-194

Status
Pending Attachment

Note
Please attach clinical documentation to support your request. Once submitted, your request will be reviewed by our Utilization Management team. You will be notified when this review has been completed.

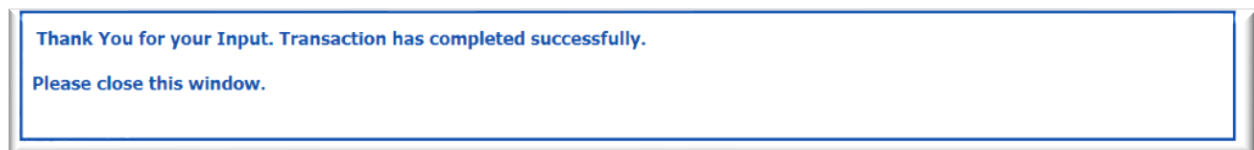
On this website, you must click the “Accept” button to proceed to our Single Sign-On page where you can upload your records.



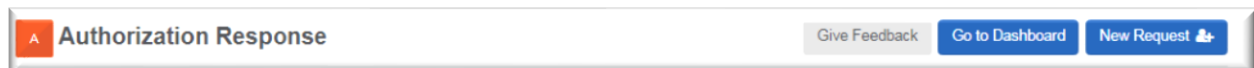
Here you select your files; give them a subject and select Submit.

Files cannot exceed 10 MB. Accepted file types .avi, .bmp, .doc, .docx, .gif, .gz, .jpeg, .pdf, .png, .pptx, .tif, .wmv, .xls, .xlsx, and .zip. The name of the attached file must be less than 40 characters long. You can only submit one file at a time. In order to submit multiple files, you must close the tab and update the authorization.

If the transaction is successful, you will receive the following message. Go ahead and close this window.



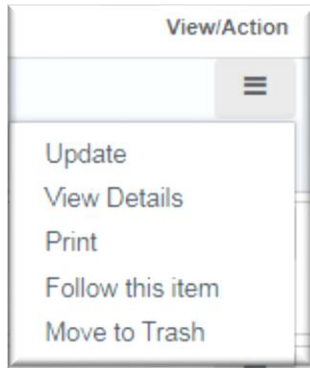
At this point you can go to the Dashboard or enter a New Request.



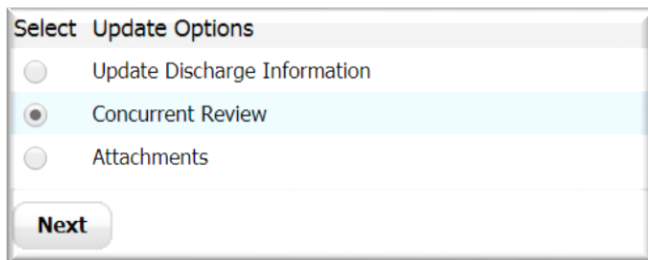
[Concurrent Review](#)

Once a patient has exhausted their initial authorized length of stay, you can request an extension through the portal. BCBSWY requires notification of discharge date.

First, go to Dashboard and find the Inpatient authorization that requires an extension. Then, select Update.



You will be sent to the Single-Sign On page. Click Accept. Next, you will select Concurrent Review.

A screenshot of a web application's 'Select Update Options' form. The form has a title 'Select Update Options' and three radio button options: 'Update Discharge Information', 'Concurrent Review', and 'Attachments'. The 'Concurrent Review' option is selected and highlighted in blue. Below the options is a 'Next' button.

You will need to update the From and To dates, the procedure codes (if appropriate) and add the number of days associated with the stay.

Associated Diagnosis Codes

Select Diagnosis Code Version: ICD 10

| Diagnosis Code | Diagnosis Description |
|----------------|--|
| S42.221S | 2-PART DISPLACED FRACTURE OF SURGICAL NECK OF RIGHT HUMERUS, SEQUELA |

Associated Procedure Codes

| Procedure | From | To | Days | Quantity |
|-----------|------------|------------|------|----------|
| CPT 99221 | 10/15/2019 | 10/18/2019 | 3 | 3 |

Days Requested: 3

Then you will select Attachment.

Upload and name your file supporting the request. Then click Next and you are done.

Back on the Dashboard, you will see that the status of the authorization changes to Pending Review.

Attach A file to Highview

Subject:

File: No file chosen

[Out of State Authorizations](#)

To create a prior authorization for out of state members, follow the same steps outlined above. When Availity checks the member's eligibility, you will be routed from the Blue Cross Blue Shield of Wyoming's Availity site to the other state's Availity site. Once routed, you may see different options for prior authorizations, depending on the out of state Blue plan. For example:

Pre-Service Review for Out-of-Area and Local Members

Select a review option

BCBSTX Welcomes [REDACTED]

IMPORTANT: You have been routed from Blue Cross Blue Shield of Wyoming to BCBSTX to conduct pre-service review for a BCBSTX member.

Please choose from the following options:

- Med-Surg
- Outpatient High-Tech Diagnostic Imaging
- Medical Policy

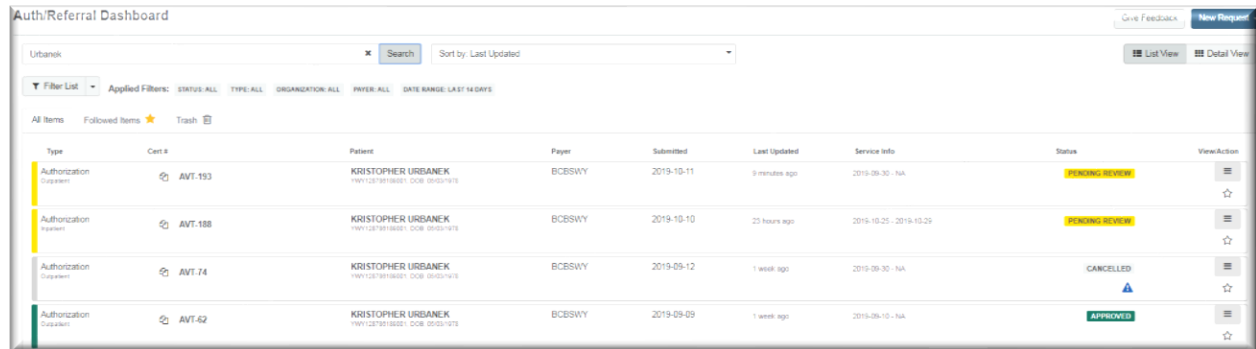
Please note that the pre-service review is not a substitute for checking eligibility and/or benefits and is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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v2.2.0

[Authorization Dashboard](#)

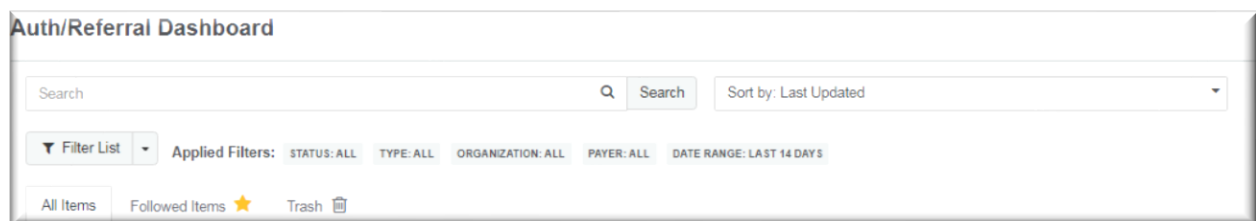
The Authorization Dashboard shows you the status of all authorizations in your organization. The AVT number allows us to find the authorization request if you call into our member service line.



The screenshot shows the 'Auth/Referral Dashboard' with a search bar and filters. Below the filters is a table of authorization requests. The table has columns for Type, Cert #, Patient, Payer, Submitted, Last Updated, Service Info, Status, and View/Action. The data rows show four authorization requests for Kristopher Urbanek, all with BCBWY as the payer. The statuses are 'PENDING REVIEW', 'PENDING REVIEW', 'CANCELLED', and 'APPROVED'.

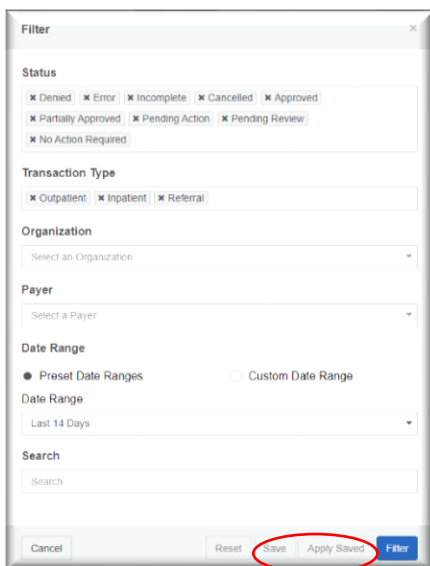
| Type | Cert # | Patient | Payer | Submitted | Last Updated | Service Info | Status | View/Action |
|---------------|---------|--------------------|-------|------------|---------------|-------------------------|----------------|-------------|
| Authorization | AVT-193 | KRISTOPHER URBANEK | BCBWY | 2019-10-11 | 9 minutes ago | 2019-10-30 - N/A | PENDING REVIEW | [Icons] |
| Authorization | AVT-188 | KRISTOPHER URBANEK | BCBWY | 2019-10-10 | 25 hours ago | 2019-10-25 - 2019-10-29 | PENDING REVIEW | [Icons] |
| Authorization | AVT-174 | KRISTOPHER URBANEK | BCBWY | 2019-09-12 | 1 week ago | 2019-09-30 - N/A | CANCELLED | [Icons] |
| Authorization | AVT-62 | KRISTOPHER URBANEK | BCBWY | 2019-09-09 | 1 week ago | 2019-09-10 - N/A | APPROVED | [Icons] |

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.



The screenshot shows the top section of the 'Auth/Referral Dashboard'. It includes a search bar with a magnifying glass icon and a 'Search' button. Below the search bar is a 'Filter List' dropdown and a section for 'Applied Filters' showing 'STATUS: ALL', 'TYPE: ALL', 'ORGANIZATION: ALL', 'PAYER: ALL', and 'DATE RANGE: LAST 14 DAYS'. At the bottom of this section are buttons for 'All Items', 'Followed Items' (with a star icon), and 'Trash' (with a trash can icon).

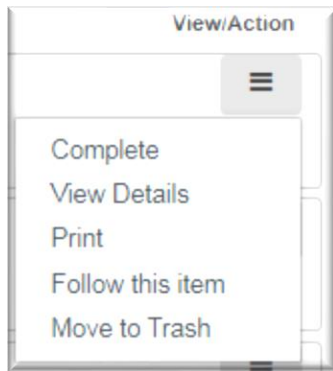
If you wish to save a frequently searched filter, you can do so by clicking on a filter type to see the filter detail window and click Save. To apply the saved filter view, click on the filter type and click Apply Saved.



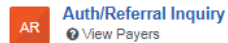
The screenshot shows the 'Filter' detail window. It has sections for 'Status' (with checkboxes for Denied, Error, Incomplete, Cancelled, Approved, Partially Approved, Pending Action, Pending Review, and No Action Required), 'Transaction Type' (with checkboxes for Outpatient, Inpatient, and Referral), 'Organization' (a dropdown menu), 'Payer' (a dropdown menu), 'Date Range' (with radio buttons for Preset Date Ranges and Custom Date Range, and a dropdown menu for Last 14 Days), and a 'Search' field. At the bottom are buttons for 'Cancel', 'Reset', 'Save' (circled in red), 'Apply Saved', and 'Filter'.

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

Additionally, the Dashboard allows you to see additional detail on each authorization.



[Authorization Inquiry](#)



Authorization inquiries can be accessed from the Authorization Home page, or from the Dashboard under New Request.

The Inquiry Tool allows you to look up a previous authorization by Authorization Number, Member ID, or Service Date.

A screenshot of the 'Authorization/Referral Inquiry' form. The form has a header with the title 'Authorization/Referral Inquiry' and three buttons: 'Give Feedback', 'Go to Dashboard', and 'New Request'. The form is divided into two main sections. The first section, 'SELECT A PAYER', contains three dropdown menus: 'Organization' (selected: BCBS Wyoming), 'Payer' (selected: BCBSWY), and 'Request Type' (selected: Outpatient Authorization). The second section, 'SEARCH INFORMATION', contains a 'Search By' dropdown menu (selected: Authorization Number) and a text input field for 'Authorization Number'. There are 'Clear' and 'Submit' buttons at the bottom of the form.

[Special Circumstances](#)

Transplants:

For questions about transplants or authorizations, call our transplant coordinator at 307-829-3081.

Residential Treatment Facility:

For questions about residential treatment facility authorizations, call 307-829-3081.

Federal Employee Plan (FEP) Prior Authorization:

For authorizations of the following services, please contact our FEP case management team at 1-800-210-7257.

- Applied Behavioral Analysis
- Gender Reassignment
- Residential Treatment Facility
- Skilled Nursing Facility/Center

[Secondary Insurance Authorizations](#)

Prior authorizations are required when BCBSWY provides secondary coverage in certain circumstances. Please reference the table below when determining if a secondary authorization is required. If you need assistance in identifying if a member has BCBSWY secondary coverage, please contact us.

Secondary authorizations are required except for admissions and Medicare Supplements.

| Member Prefix | Services | Admissions |
|--|------------------------------------|------------------------------------|
| QWY, YWY, ZRW, ZSC, ZSD, ZSF, ZSH, ZSK, ZYW, and R. | Secondary authorization required. | Not required |
| Medicare Denials QWY, YWY, ZRW, ZSC, ZSD, ZSF, ZSH, ZSK, ZYW, and R. | Secondary authorization required. | Secondary authorization required. |
| Prefixes beginning with ZSM | No authorization required. | No authorization required. |
| All Prefixes | CAR-T Transplants | CAR-T Transplants |



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Inpatient Authorization Supplemental Document

For inpatient admissions, please complete this supplemental form to ensure that online authorizations are processed correctly.

Patient Name: _____

Patient ID: _____

Admission Date: _____

Observation: ☐ No ☐ Yes Date: _____

CPT(s): _____

Frequently Asked Questions/Tips for Success

Q: Do I have to use Availity for prior authorizations?

A: No. Prior authorizations may be submitted by fax or phone, as in the past. However, using Availity will speed up the prior authorization process, as it removes the time needed to transcribe requests for placement in the system queue.

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

A: Prior authorizations will stay on the dashboard for 90 days unless a user adds it to 'followed items' by clicking on the 'star' icon on the right-hand side. If a permanent record of the prior authorization is required, it can be printed for the facility's records.

Q: For an inpatient stay, how many prior authorizations do I need to complete?

A: For an inpatient stay, a prior authorization is always needed. For services, a prior authorization is needed only if it appears on the prior authorization list found on the BCBSWY webpage <https://www.bcbswy.com/providers/preadmin/>.

Q: If a patient is admitted through the emergency room, does this qualify as "Urgent"?

A: No, this situation does not qualify for an "Urgent" request. If "Urgent" is selected and Medical Review determines this was not an urgent request, it will move back into the non-urgent review queue.

Q: If there are two entities working together to provide services to a patient (eg. external surgeons using a hospital for the surgery), can one entity submit the authorizations on behalf of the partner?

A: If there are two entities working together to provide services to a patient (eg. external surgeons using a hospital for the surgery and subsequent admission), one entity may submit both authorizations (for services and inpatient stay). However, each entity can only see their own authorizations in their dashboards. Therefore, BCBSWY suggests the submitting entity enter the fax confirmation of the partner entity to inform the partner entity of the authorization's approval once complete.

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.

Q: I'm trying to enter referrals into Availity, but it won't work. Why?

A: BCBSWY does not support the entry of referrals into Availity.

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

A: Enter today's date as the Service Date From and enter a date 365 days in the future for the Service Date To field.

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

A1: 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 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 the chance to change the address if needed.

Q: I tried to create a retro authorization for a Residential Treatment Center (RTC), but it hasn't been successful. What could be causing the issue?

A: Check the member's plan. Retro authorizations are not permitted for Federal Employee Plan (FEP) members for RTCs or Skilled Nursing Facilities.

Q: For units, I put in a number, but after review, it now has 10,000 units requested. What happened?

A: The BCBSWY authorization system subtracts units as they are used up in through claim submission. If a long-term service (eg. chemotherapy) runs out of units, the claim will deny. Therefore, BCBSWY changed the units requested to 10,000 to ensure claims don't deny because they ran out of units over time.

Q: How do I enter a CPT code on an inpatient authorization when there is no place for it in Availity?

A: When attaching documents, use the "[Inpatient Authorization Supplemental Document](#)" form found in this manual to record the CPT codes.

Q: How do I add days to an inpatient stay after the patient has exhausted their initial authorized length of stay?

A: You can do this through the Concurrent Review instructions found on page 15. Ensure the documentation for this request is attached before clicking "Next."

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 BCBSWY side of the transaction. Take screen shots capturing as much information as possible (including date, time, AVT number and Transaction ID). Call Availity Customer Support at 1-800-272-4548.

Q: I submitted a prior authorization request and it 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 the Provide tab on the BCBSWY website <https://www.bcbswy.com/providers/preadmin/>.

Q: How do we enter a prior authorization for a bilateral injection?

A: When entering an outpatient service, select one procedure code and one unit for one side and add another procedure code and one unit for the other side. In the required documentation, describe the sites for the injections.

Q: What items are used for matching prior authorizations to claims?

A: For inpatient stays, the following items are used for matching prior authorizations to claims: Date of Service To and From, Facility NPI, Member ID and the fact it's a UB claim. For outpatient services, the following items are used for matching prior authorizations to claims: CPT code occurring within the date range, Facility NPI, Member ID and confirmation enough units exist for the service. Authorization numbers are not needed in the claim submission.

Q: What do I do if the NPI isn't in the system?

A: Email BCBSWY Provider Relations at provider.relations@bcbswy.com to inform them the NPI isn't showing up in the system.

Q: Whenever I arrive at the dashboard, I only see the same kind of prior authorizations and any changes to the filters weren't saved. What's going on?

A: You may have saved and applied a set of filters. If you would like to change how your prior authorizations are shown on your dashboard, go to page 17 of this manual to save and apply a different set of filters.

Q: The procedure actually performed was different than the CPT code submitted on the original prior authorization. How do I change a CPT code on a prior authorization?

A1: For an inpatient stay where the change in CPT code will impact the number of days authorized, go to Concurrent Review and update with the new CPT code. If the change in CPT code will not affect the number of inpatient days, there is no need to contact BCBSWY.

A2: For outpatient services, if the change to the CPT code is a slight variation, there is no need to submit a change because the system will likely be able to match the prior authorization to the claim. If the change to the CPT code represents a significant modification to the procedure performed, and the claim is denied for lack of authorization, then submit a retro authorization through Availity and re-process the claim.

Q: Can providers do a Concurrent Review without changing the To/From Dates?

A. Providers must change the dates or they will most likely receive a cancellation, as it will appear as a duplicate request.

Q: How does an inpatient prior authorization need to change for a newborn if the infant needs to stay in the hospital beyond the initial stay?

A: For these situations, providers should call into the PAR line.

Q: What are the Prior Authorization Timeframes?

A:

| | URGENT | STANDARD |
|-----------------------|---------------|-----------------|
| Prior Authorizations | 72 Hours | 14 Days |
| Concurrent Reviews | 24 Hours | 72 Hours |
| Appeal Reviews | 72 Hours | 30 Days |
| Retrospective Reviews | N/A | 30 Days |