An independent licensee of the Blue Cross and Blue Shield Association

BCBSWY Online Authorization Training Guide

8/25/2022 Version 3.0

Prior Authorizations: General

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 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

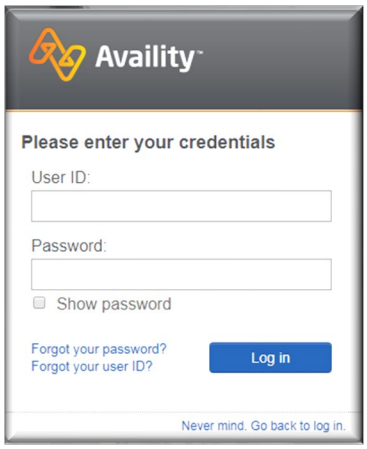
Prior Authorization requests are the exchange of information between Providers and BCBSWY to establish medical appropriateness and necessity of services.

Determine if a Prior Authorization Request is Required:

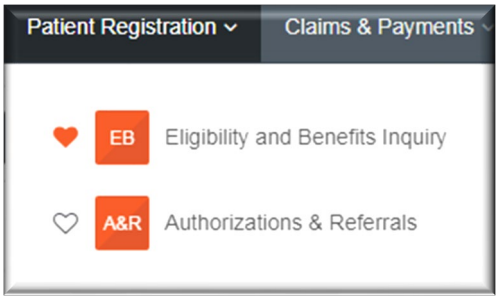
Determine prior authorization request requirements for a Member by calling 1-800-442-2376.

Complete a Prior Authorization Request:

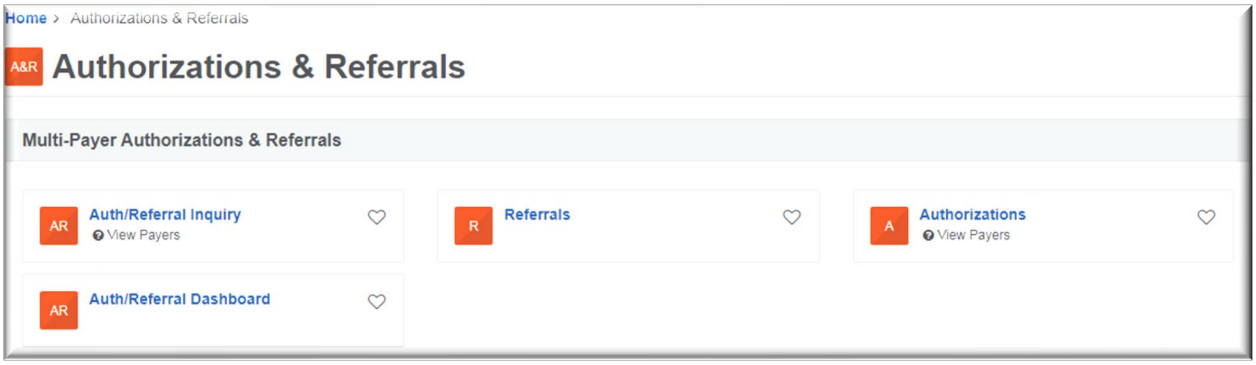
For services which do require BCBSWY prior authorization requests, login to www.availity.com. For best results, use Internet Explorer or Chrome and turn off your popup blockers.



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.

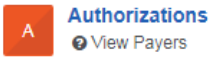


Selecting the Authorizations & Referrals link will take you to the main Authorizations page.



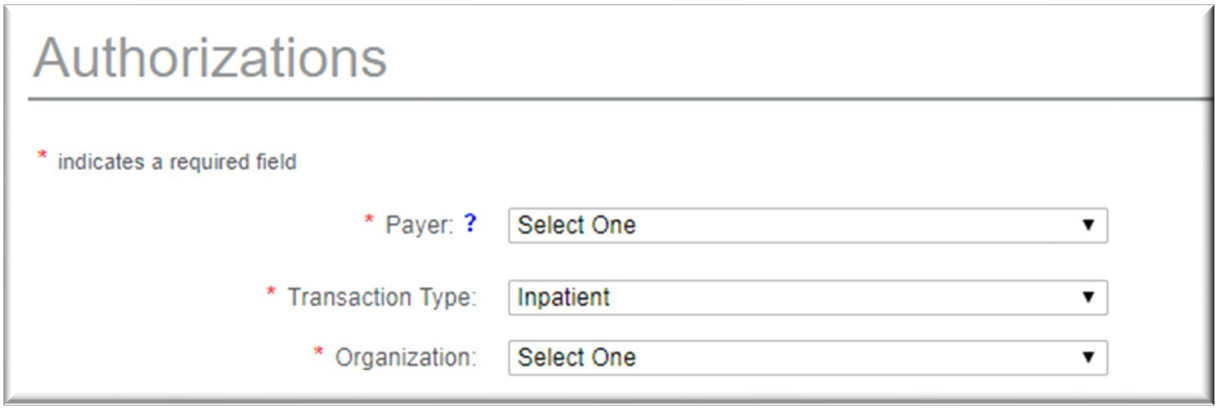
From this screen, you can inquire about an existing authorization submission, submit an authorization request, or view the Authorization Dashboard. Please note BCBSWY does not currently track referrals.

Submitting an Authorization

To submit an authorization, select the 

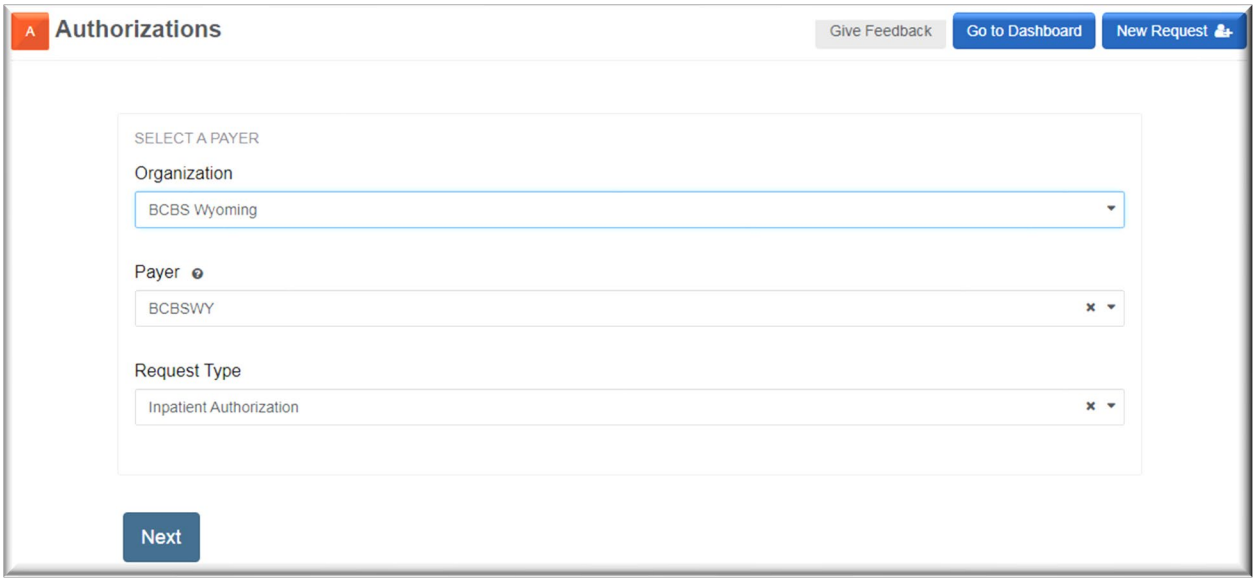
box from the Home page.

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



This will take you to the BCBSWY Authorization Tool.

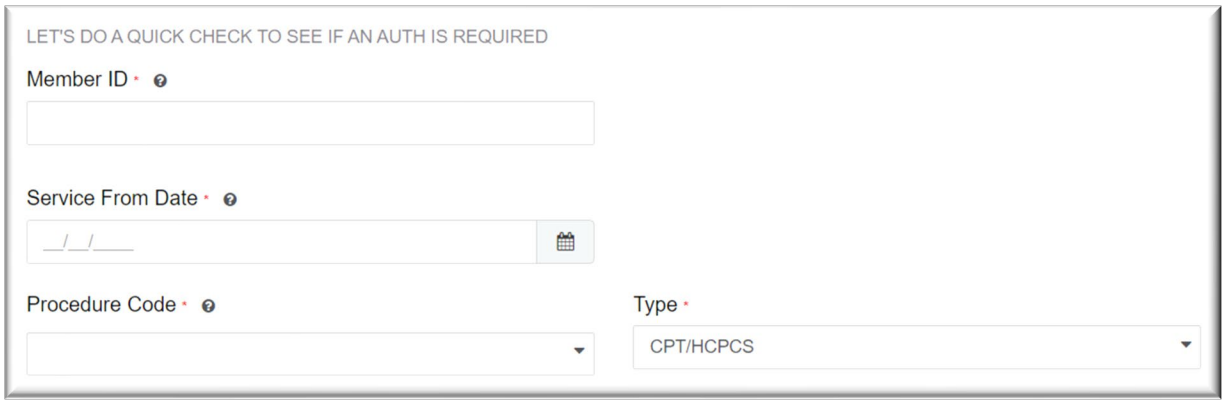
The BCBSWY Authorization tool allows you to submit authorizations for professional services, inpatient stays, and concurrent reviews for both medical and behavioral health.



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).

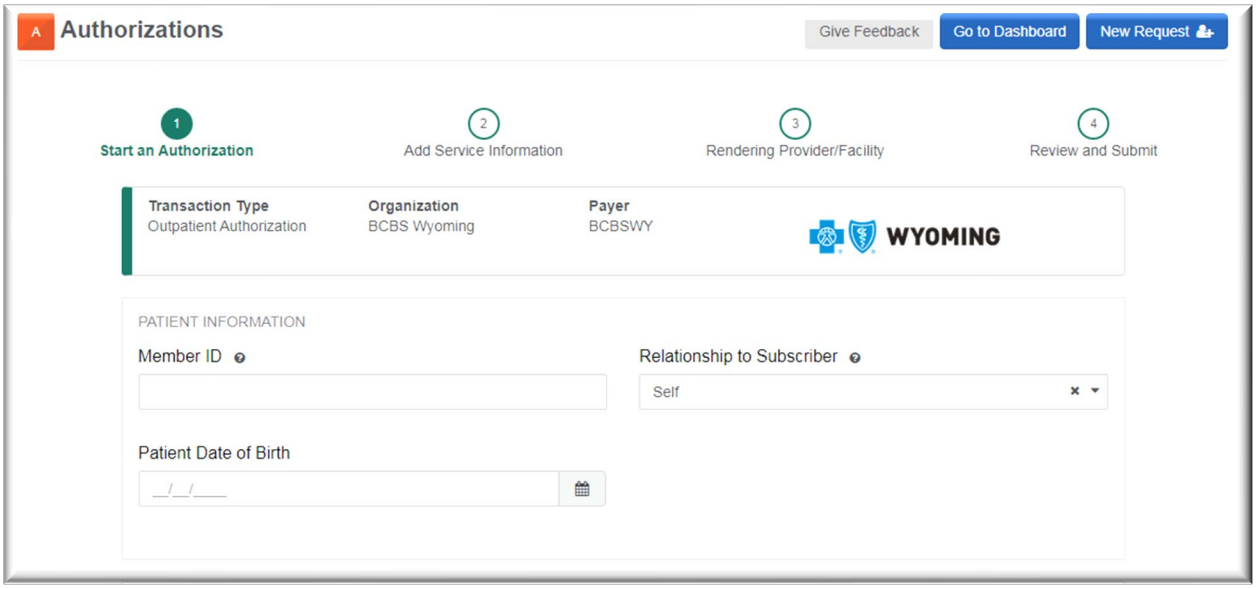
Outpatient Authorizations (Service Request)

Before you enter an outpatient prior authorization you can do an authorization pre-check for BCBSWY members. This simple tool will tell you if an authorization is required for the service you are requesting.

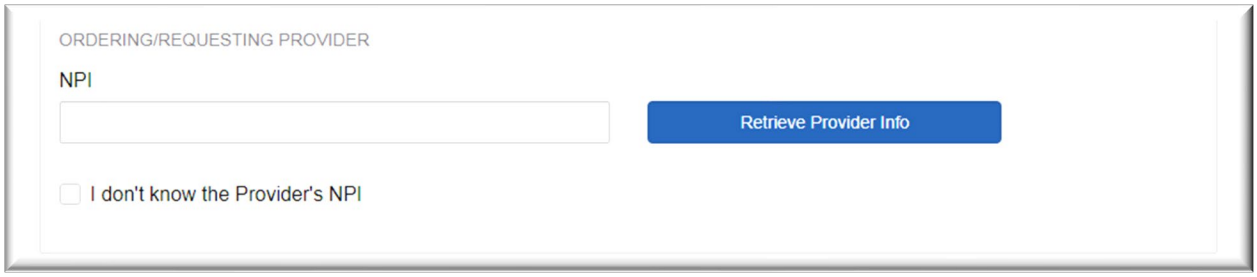


If an authorization is required select “Next Steps”. If not, the system will let you know that an authorization is not required. For BlueCard (out of state) and FEP members you should skip the authorization pre-check step.

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

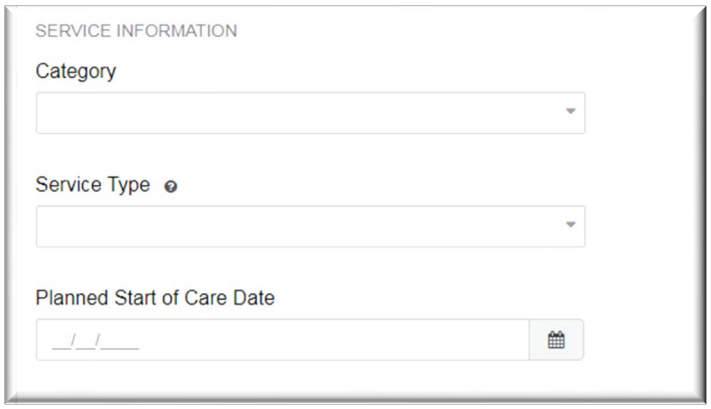


Then enter the Ordering/Requesting Provider's NPI and click Retrieve Provider Info. If you enter a group NPI, all of the providers associated with that group will be returned.

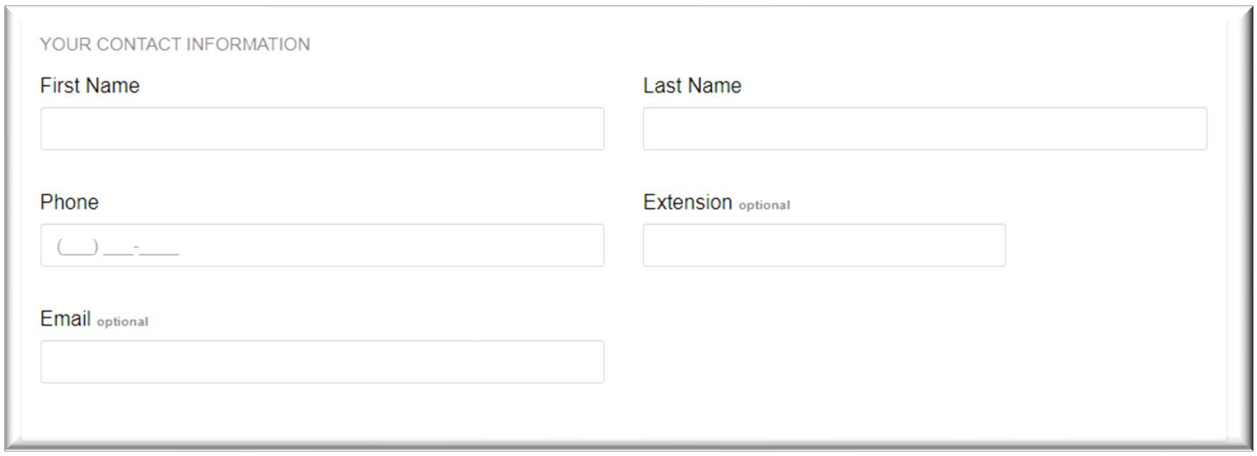


If you do not know the Ordering/Requesting Provider's NPI you can select the "I don't know the Provider's NPI" box and enter the provider's first and last name.

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.



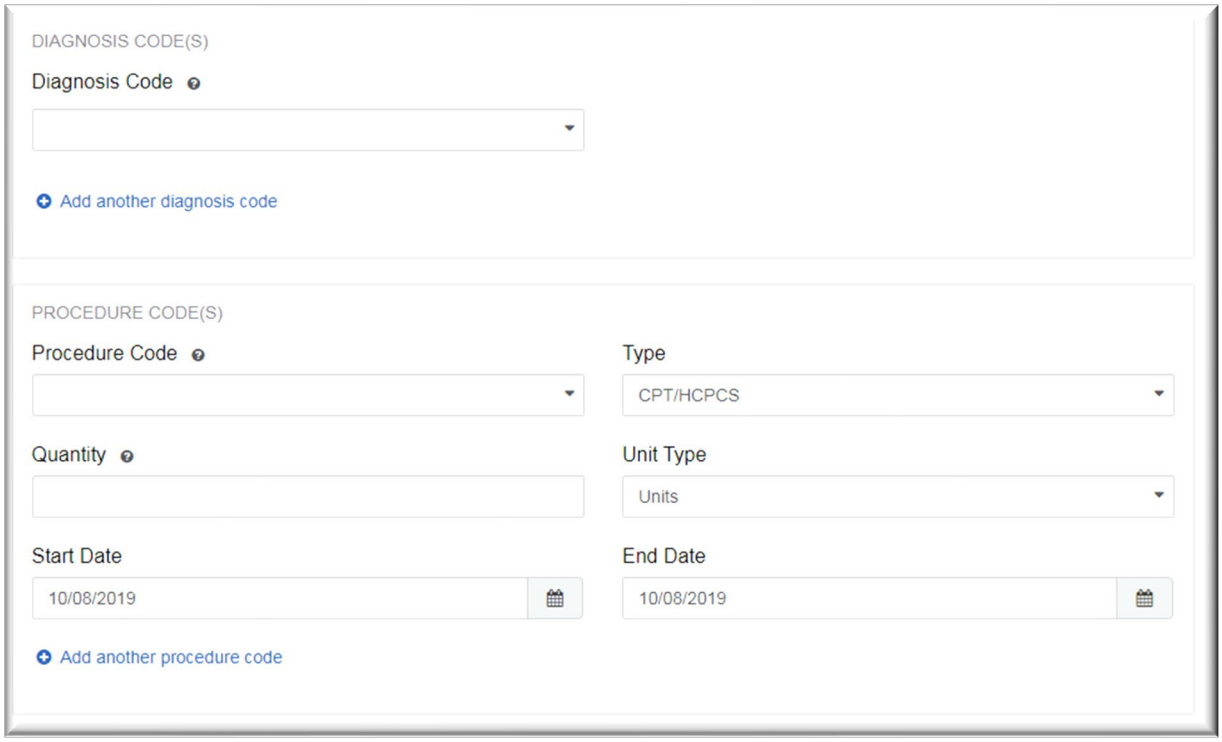
Then enter your contact information.



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.

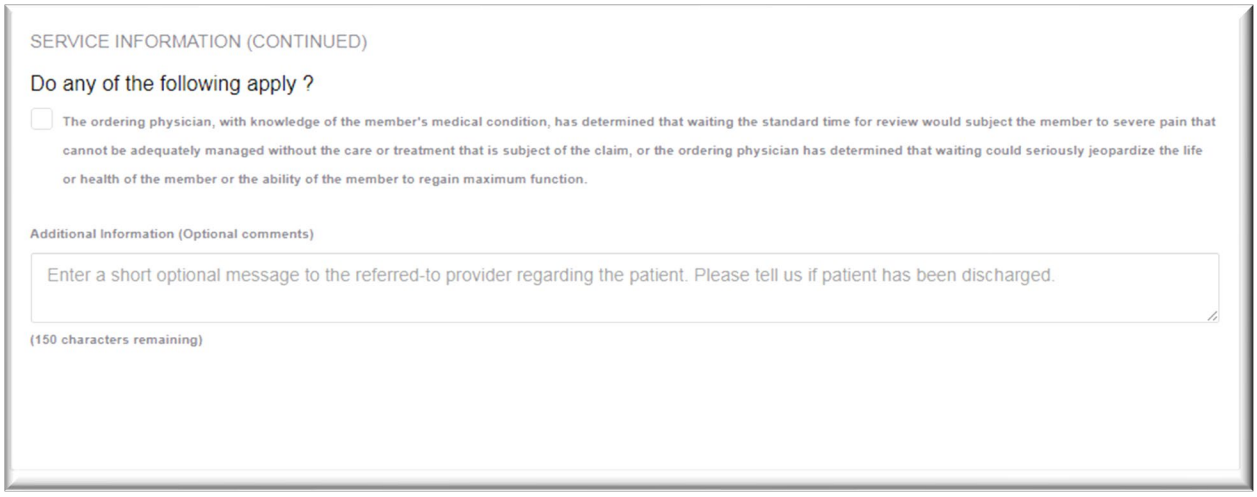
Next, you will see the Service Information screen. Enter the Category, either "Behavioral Health" or "Medical". Then enter the Service Type; this is a high-level category like "Chemotherapy", and then select the Planned Start of Care Date. If this is a retro-authorization, select the date of service. BCBSWY accepts retro-authorizations up to 365 days in the past. For retrospective authorizations where a claim has already been submitted, please include information about the claim in the documents uploaded.

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.

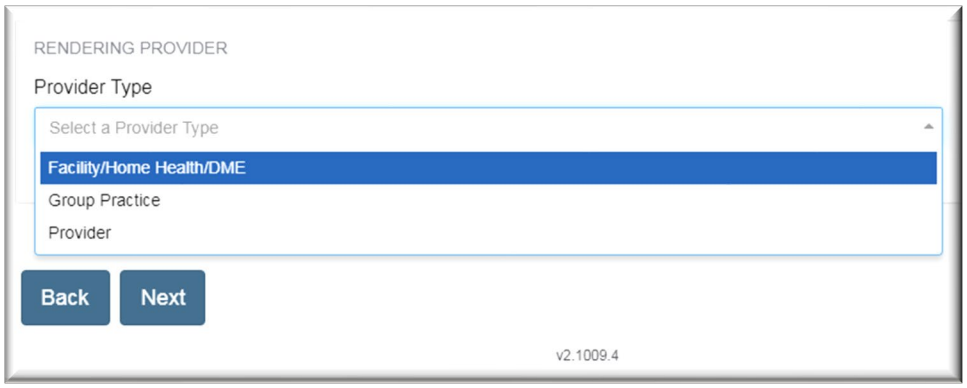


The next screen allows you to mark if the authorization is urgent. Please mark a prior authorization request **URGENT if failure to receive treatment will result in a life or limb threatening situation**. Non-urgent requests marked urgent will delay processing. BCBSWY does not recognize scheduling conflicts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

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

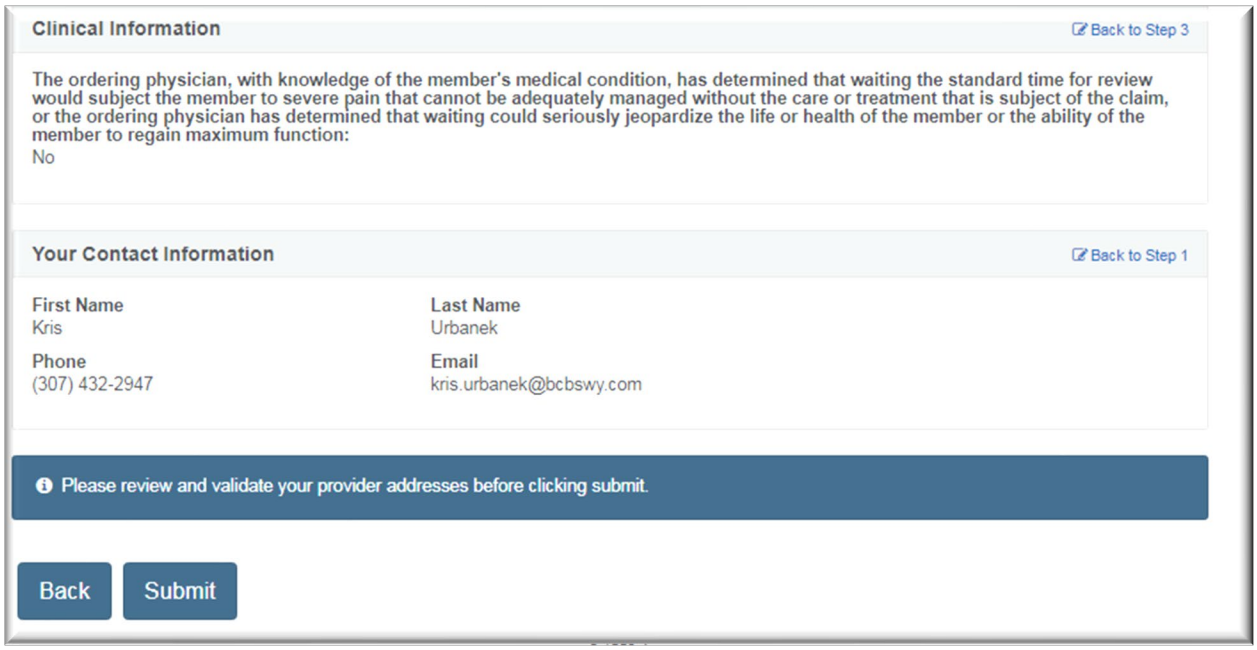


Then you will enter the Rendering Provider Information. This can be a Facility/Home Health/DME, a Group Practice, or a Provider. You will again be asked to enter that provider's NPI.



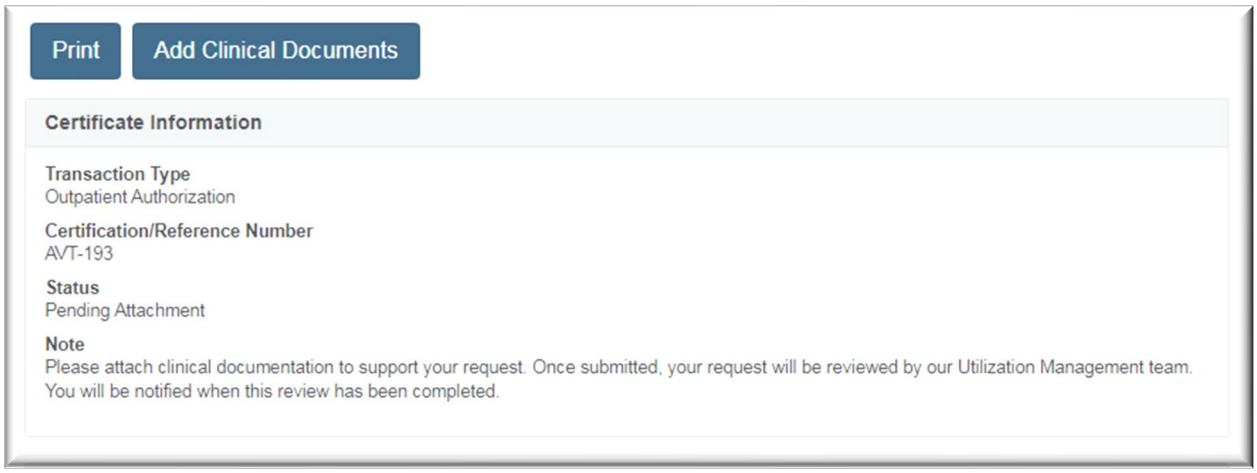
You will again be asked to enter that provider's NPI. After that, you will need to confirm the rendering provider's address and enter their fax number. After you click Next, you will be taken to a review screen.

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

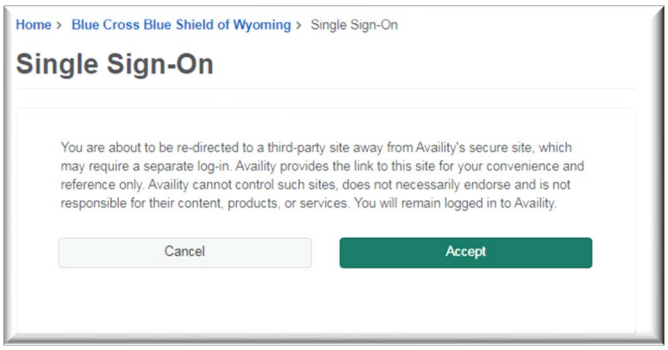


You are then taken to a screen that allows you to submit your clinical documentation. Medical records will be required with each submission. The authorization is not able to be processed until this step is complete.

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



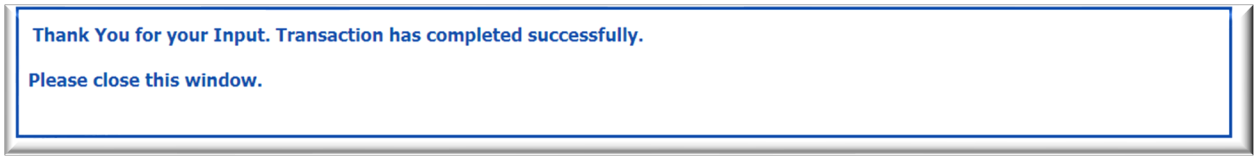
On this website, you must click the “Accept” button to proceed to our Single Sign-On page where you can upload your records.



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 and cannot have any spaces or symbols in the name. 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. Do not use the back button on this window. Using the back button could cause issues with the attachment.



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.

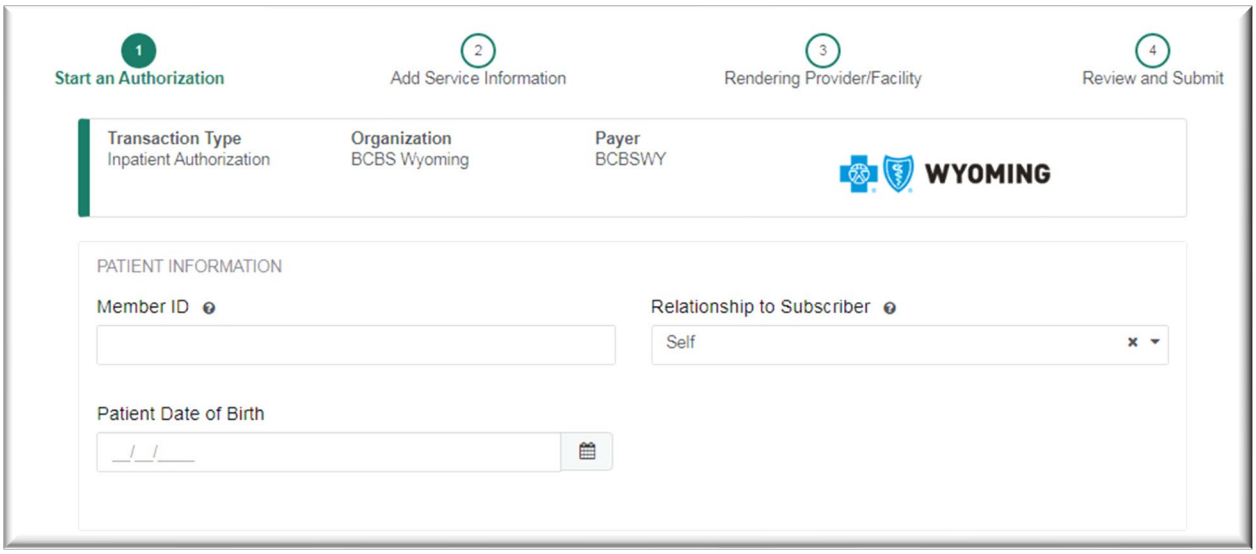
A Provider should submit a request when:

- 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

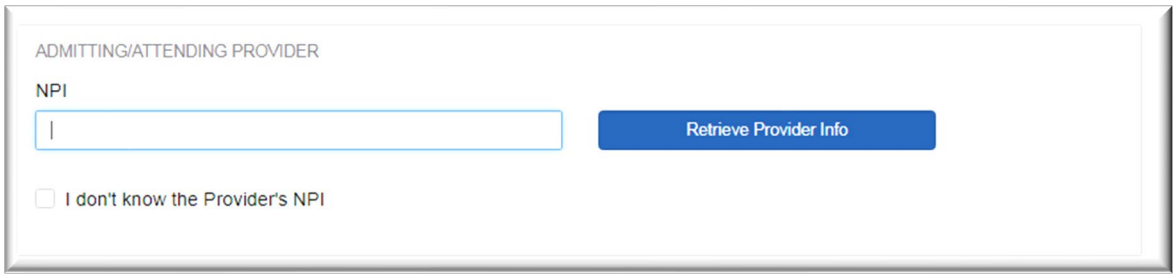
A Provider **does not** need to submit a request when:

- 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

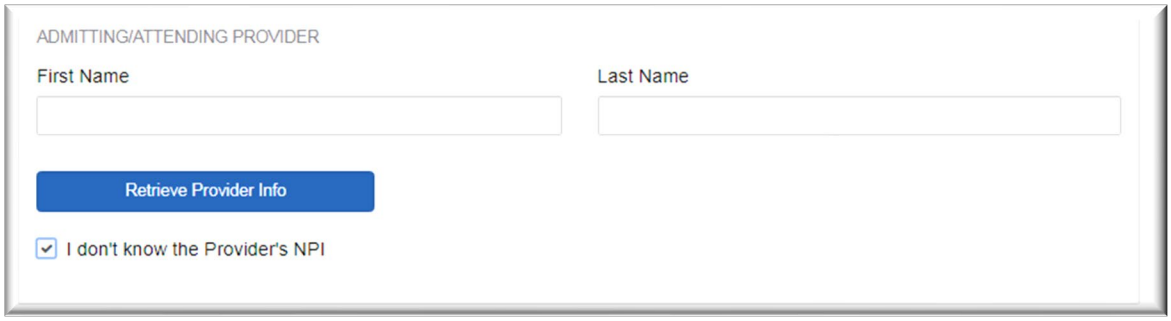
To begin, you will enter the Member's ID, Relationship and Date of Birth.



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.

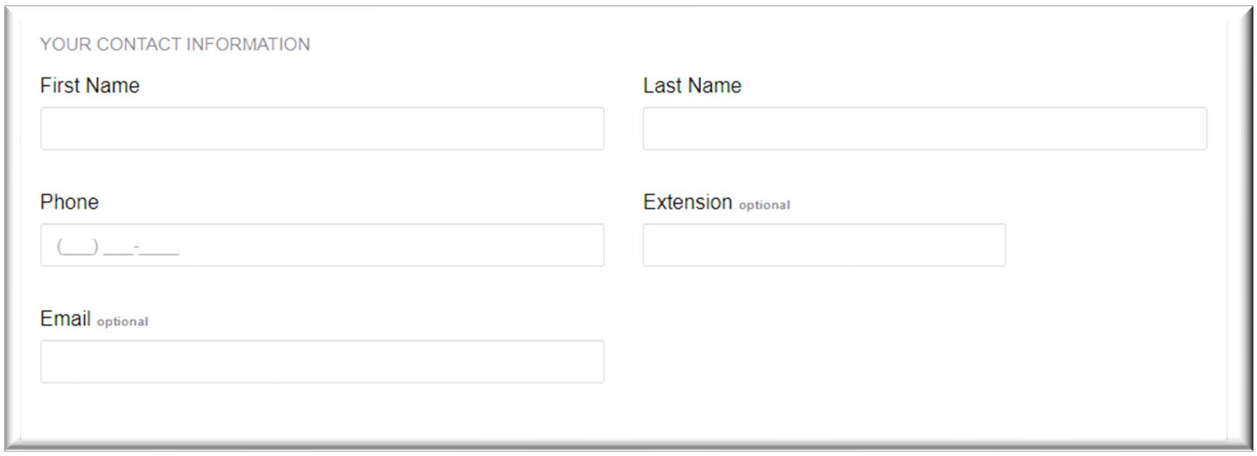


If you do not know the Attending/Admitting Provider's NPI, you can select the "I don't know the Provider's NPI" box and enter the provider's first and last name.



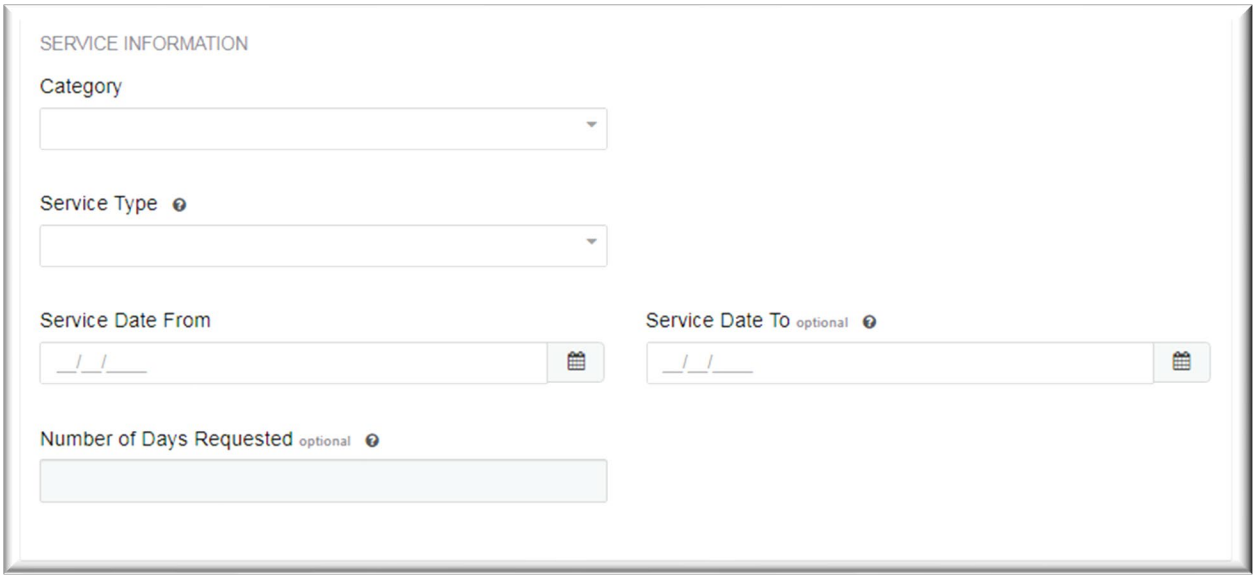
Once you have selected the provider, their address information will pull from BCBSWY's database. Please confirm the address and enter the fax phone where authorization information can be sent. If you don't want a fax reply, enter (307) 999-9999.

Then enter your contact information.

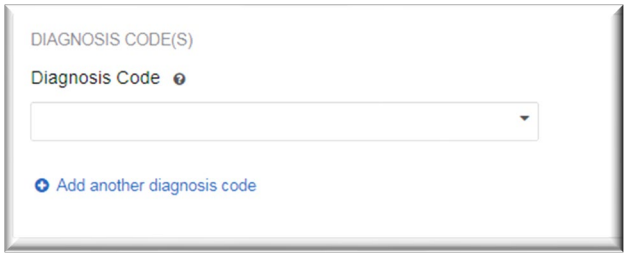


Then click “Next”. At this point, the system verifies the member’s eligibility. Benefits will be denied if the patient is not eligible for coverage under the benefit plan on the date services provided or if services received are not medically appropriate and necessary.

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. For retrospective authorizations where a claim has already been submitted, please include information about the claim in the documents uploaded.

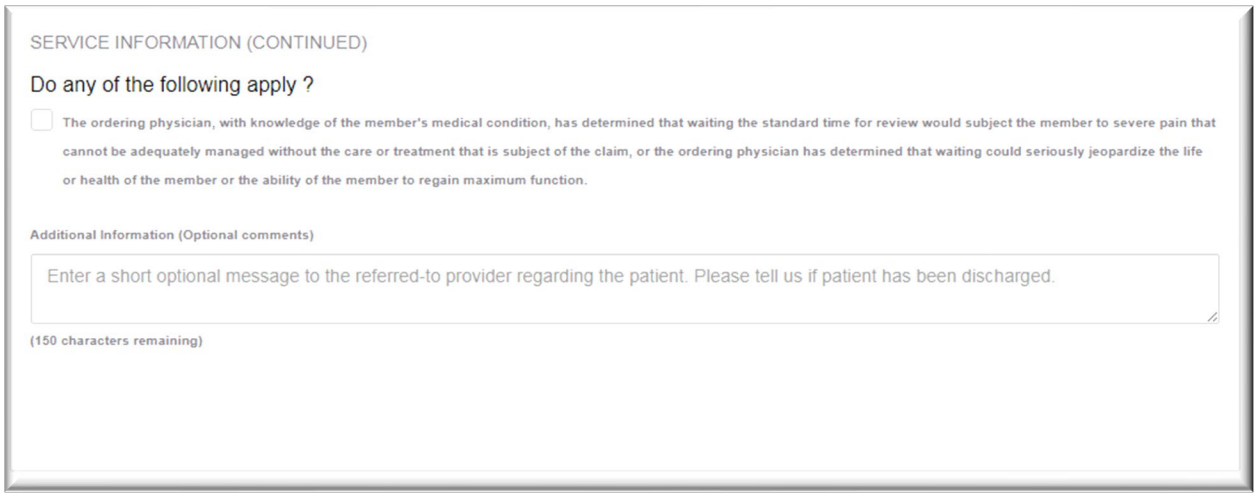


Next, select the diagnosis associated with the service. There can be multiple codes per service.

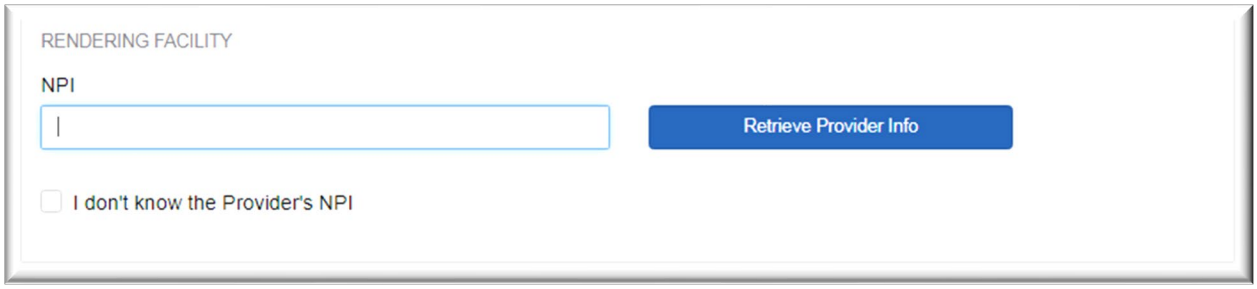


The next screen allows you to mark if the authorization is urgent. Please mark a prior authorization request **URGENT if failure to receive treatment will result in a life or limb threatening situation**. Non-urgent requests marked urgent will delay processing. BCBSWY does not recognize scheduling conflicts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

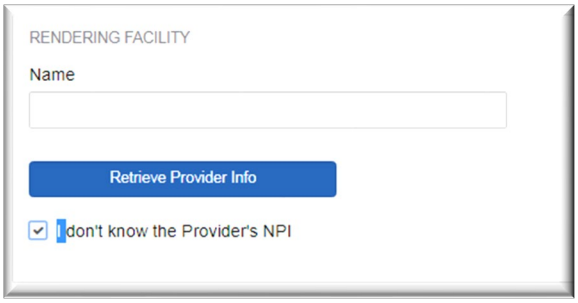
Additional comments can be entered on this screen, if the prior authorization is marked URGENT.



Then, you will enter the Rendering Facility information.

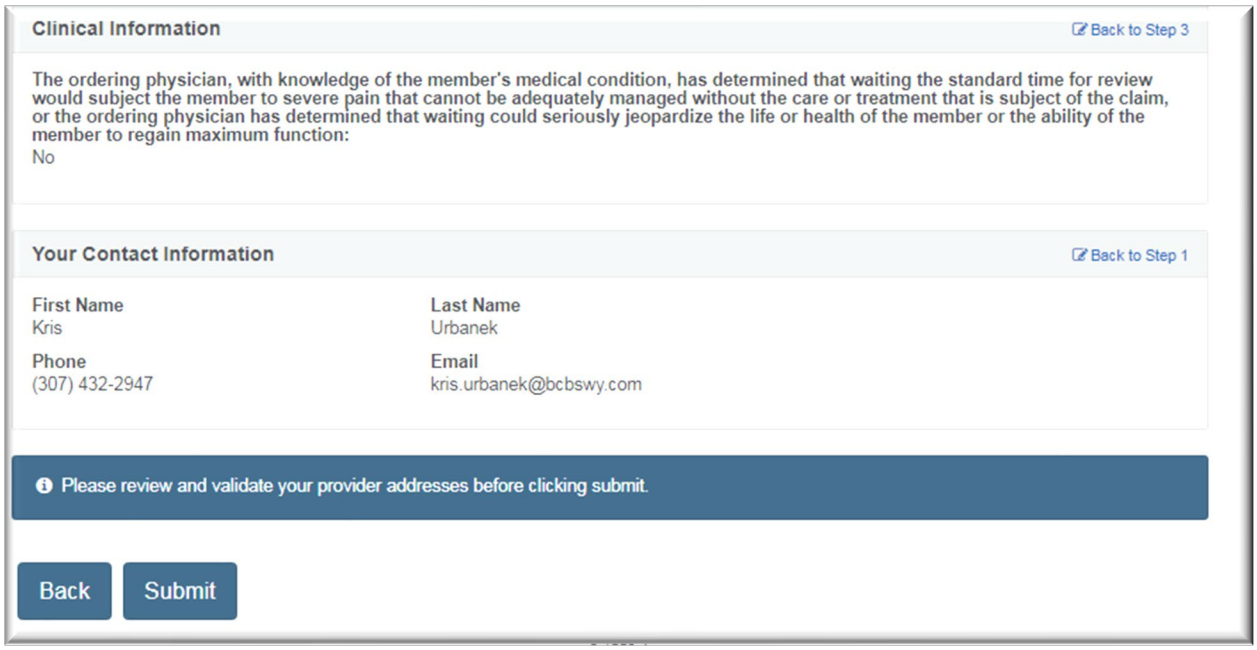


If you do not know the Rendering Facility information, you can look it up by name.



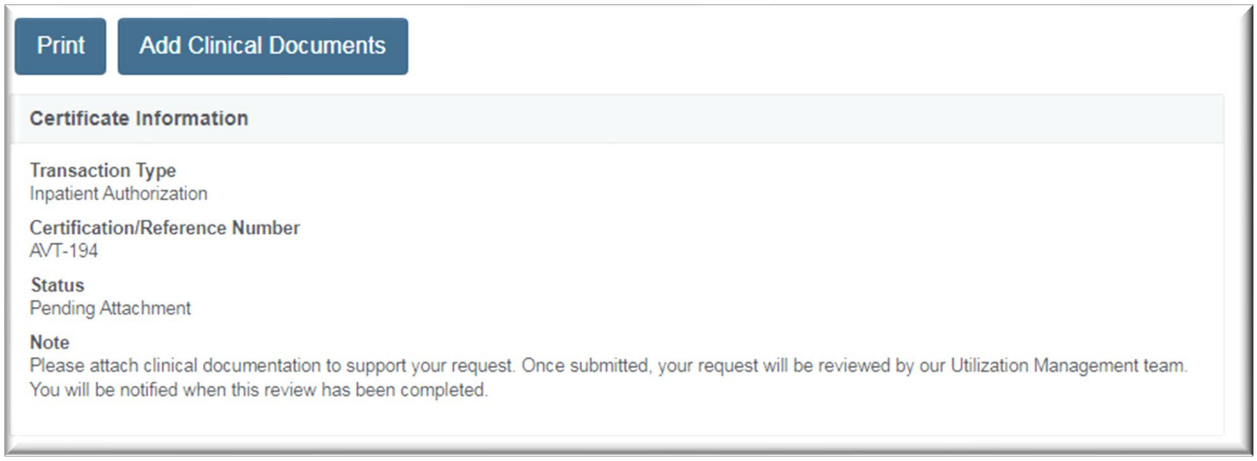
After you have selected the Rendering Facility's NPI, you will need to confirm the address and enter their fax number. After you click Next, you will be taken to a review screen.

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.

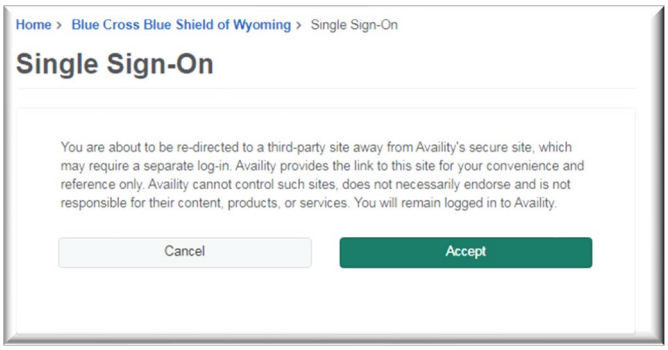


You are then taken to a screen that allows you to submit your clinical documentation. Clinical documentation will be required with each submission. The authorization is not able to be processed until this step is complete. Use the Inpatient Authorization Supplemental Document found on page 20 of this manual for this step.

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



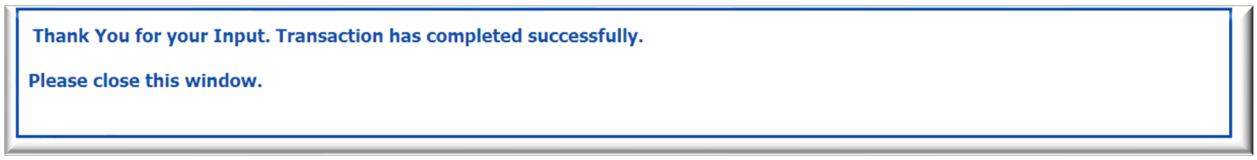
On this website, you must click the “Accept” button to proceed to our Single Sign-On page where you can upload your records.



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 and cannot have any spaces or symbols in the name. 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. Do not use the back button on this window. Using the back button could cause issues with the attachment.

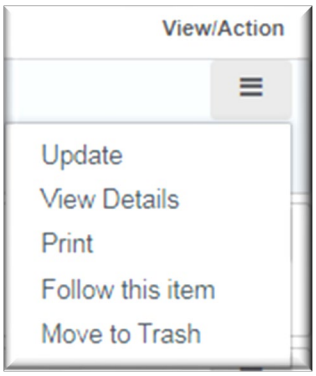


At this point you can go to the Dashboard or enter a New Request.

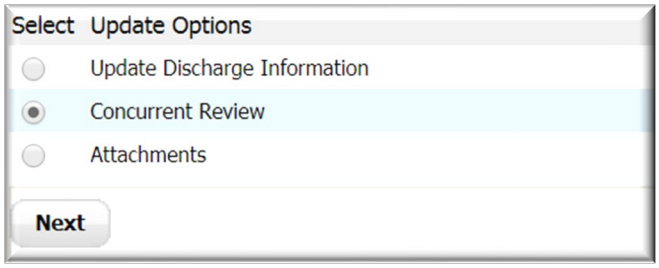
Concurrent Review

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.

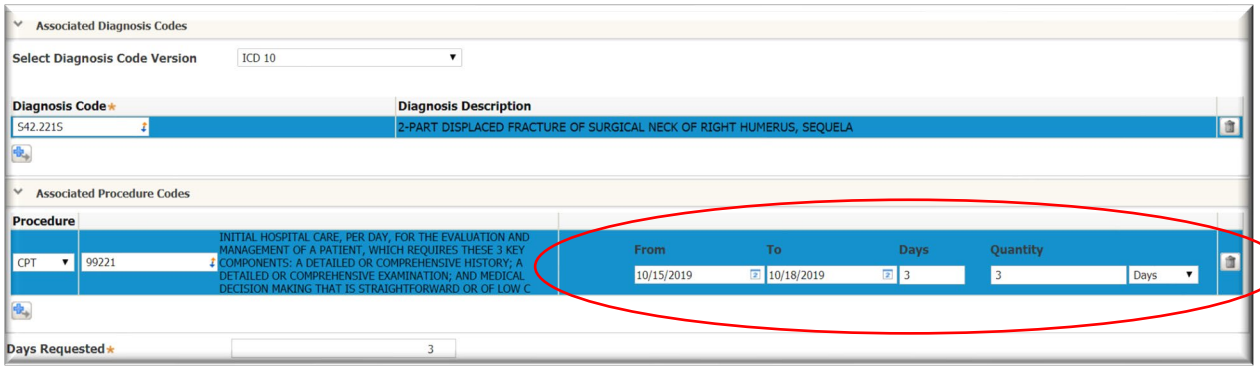
First, go to Dashboard and find the Inpatient authorization that requires an extension. Then, select Update.



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



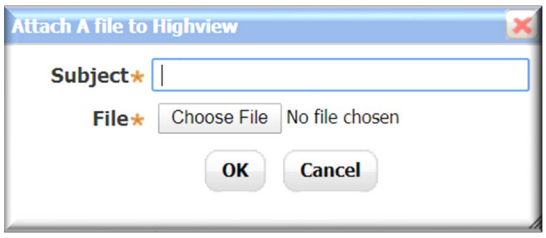
You will need to update the From and To dates, the procedure codes (if appropriate) and add the number of days associated with the stay.



Then you will select Attachment.

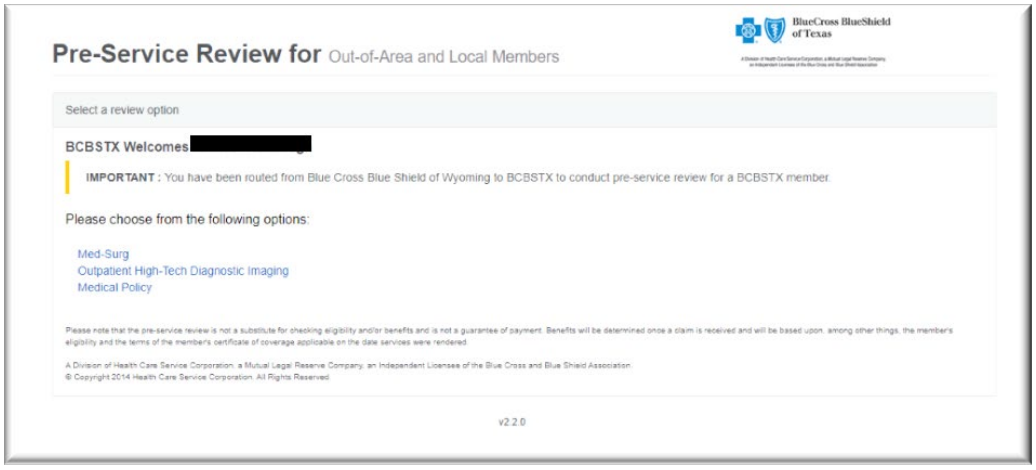
Upload and name your file supporting the request. Then click Next and you are done.

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



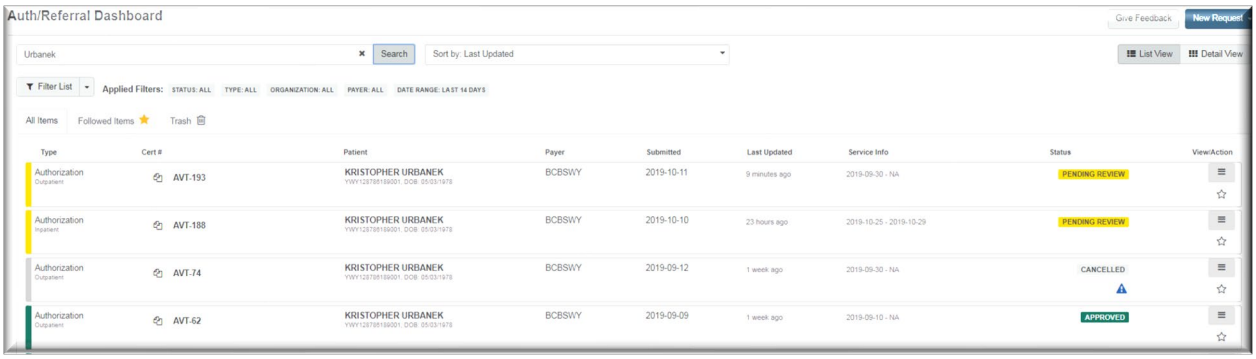
Out of State Authorizations

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:

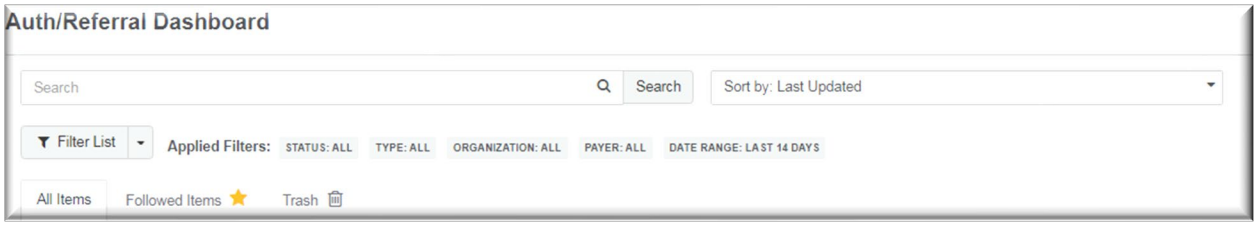


Authorization Dashboard

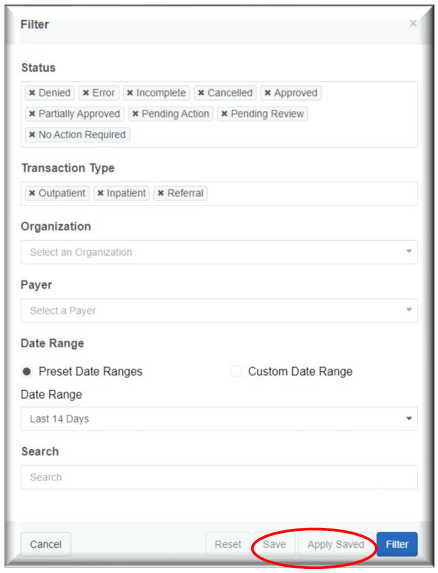
The Authorization Dashboard shows you the status of all authorizations in your organization. The AVT number allows us to find the authorization request if you call into our member service line.



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

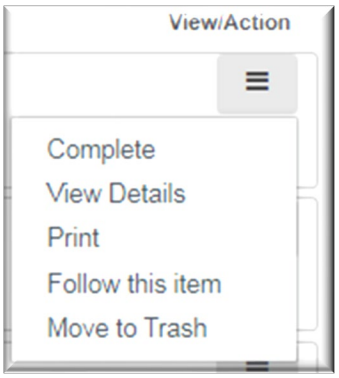


If you wish to save a frequently searched filter, you can do so by clicking on a filter type to see the filter detail window and click Save. To apply the saved filter view, click on the filter type and click Apply Saved.

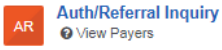


If you save and apply the filters, the data on the dashboard will always appear with these filters when you come into the dashboard.

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

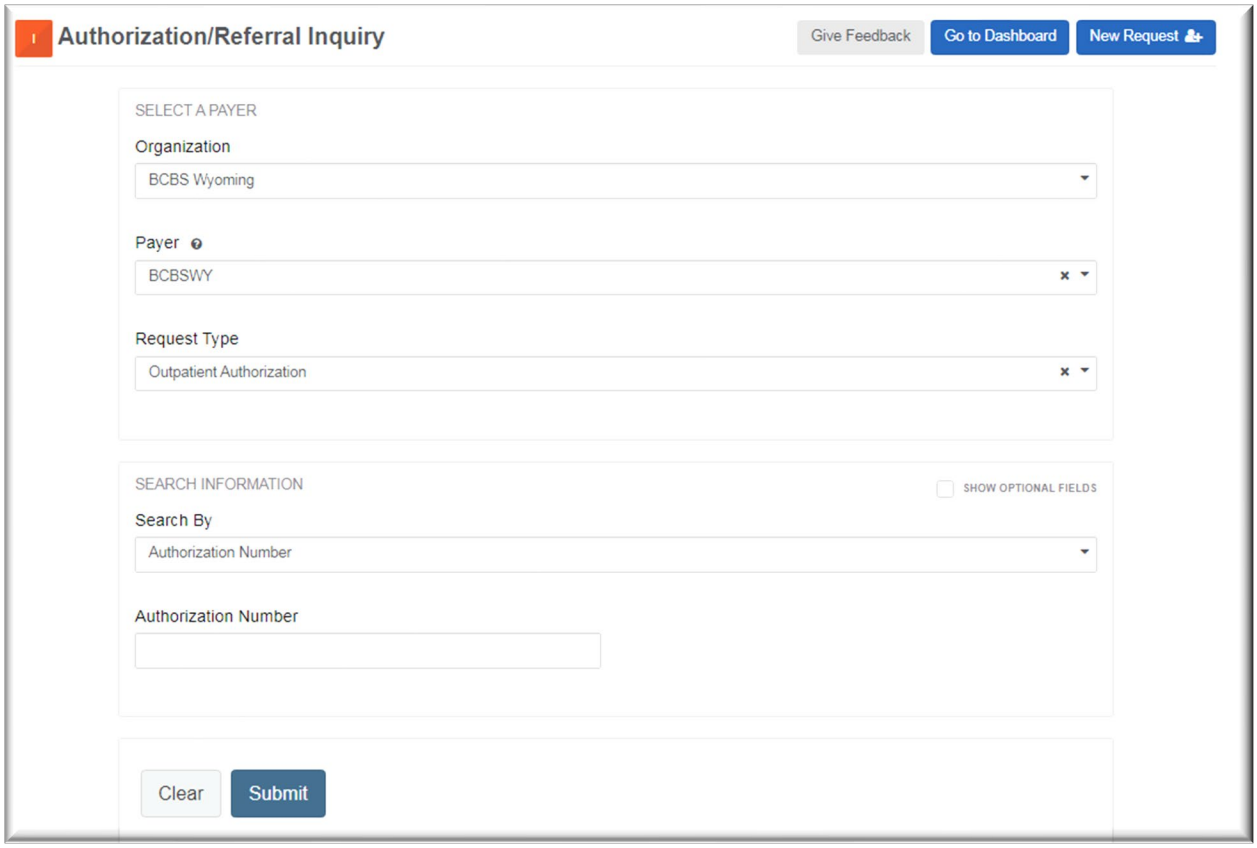


Authorization Inquiry

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.



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, ZSD, ZSF, ZSH, ZSK, ZYW, and R.	Secondary authorization required.	Not required
Medicare Denials QWY, YWY, ZRW, 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**

An independent licensee of the Blue Cross and Blue Shield Association

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: Effective April 1st, 2021 hospital inpatient and concurrent review authorizations are required to be submitted through the Availity portal. All other 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. 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.

You can also try the following troubleshooting tips.

- Turn off pop up blockers and Incognito settings.
- Clear cache and cookies. Completely log out of browser, and then log back in.
- Do not use the back-browser button.
- Only work one request at a time
- Do not have multiple windows or tabs open

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 submit a retro-authorization for a procedure after the claim has been processed?

A. Yes. Please note in the cover sheet of the clinical documentation that this is a retro-authorization and include the claim number.

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