



# A Manual for In-network Health Care Professionals and Hospitals

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## **Policies and Procedures**

**Revised May 28, 2026**

## Welcome!

Dear Health Care Provider:

Welcome to the Blue Cross Blue Shield of Wyoming's (BCBSWY) Participating Provider family. You join more than 5,130 health care Providers across Wyoming offering health care to your members. As a health care professional, you have a direct impact on the satisfaction of our members and the quality of the care they receive.

This manual is dedicated to keeping you and your staff informed about BCBSWY operational policies and procedures.

Providers must follow all applicable BCBSWY policies and procedures, as well as those applicable to the covered person. Providers agree to provide appropriate information to their employees, agents, and representatives consistent with this commitment.

It is important to familiarize yourself with the information provided in this manual and have it readily available as a reference. This manual is regularly updated and is available for your convenience online at [BCBSWY.com](http://BCBSWY.com) by clicking "Providers" then "Office Resources". The online version of the manual contains the most current and updated information.

If you have any suggestions on how we can improve this manual as a comprehensive resource for you, please let us know.

Sincerely,

A handwritten signature in black ink that reads "Logan Trautwein". The signature is written in a cursive style with a large initial 'L' and 'T'.

Logan Trautwein, Director  
Provider Affairs & Payment Integrity

## Disclaimer

This manual is provided for the convenience of BCBSWY Participating Providers. BCBSWY makes no representations or warranties with respect to the content of this manual.

BCBSWY reserves the right to revise this manual without obligation to notify any person of such revisions or changes. BCBSWY further reserves the right to change any contract, policy, benefit plan or process reference in this publication without updating this publication.

Updates to any part of this manual or to any policy or procedure referenced in this manual 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](http://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.

Unless otherwise indicated, all references in the manual to "company" or "BCBSWY" refer to Blue Cross Blue Shield of Wyoming.

## About Blue Cross and Blue Shield of Wyoming

### Who We Are

Blue Cross Blue Shield of Wyoming (BCBSWY) is a member of the national Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. BCBSWY is a not-for-profit health insurer with offices throughout the state. Ever since a small group of caring, persistent Wyoming women helped set roots in 1945, we have sought to provide better health care for the people of Wyoming.

### Financial Stability

Although the Blue Cross and Blue Shield Association does not act as a guarantor of each Plan's financial obligations, all Plans are subject to uniform financial standards established by the Association. These standards are intended to foster a system in which each Plan maintains adequate resources to meet its obligations to customers.

BCBSWY monitors financial and operational performance through strict customer service and claims processing standards, performance guarantees and other measurement methods.

### Our Mission

Blue Cross Blue Shield of Wyoming's mission is to help Wyoming citizens receive and pay for the health care they need to live healthy and productive lives.

### Accreditation

BCBSWY holds URAC accreditation. URAC is an independent, nonprofit health care accrediting organization promoting health care quality through accreditation, education and measurement. URAC's Health Plan Accreditation is a nationally recognized symbol of excellence, respected throughout the health care industry and by the federal and state governments as an assurance that an organization meets rigorous standards and measures of quality and operational integrity, with a strong focus on consumer protection and empowerment.

The standards are grouped into the following areas of importance to Provider networks:

- Network management
- Credentialing
- Quality Management, including quality measures reporting requirements
- Health Utilization Management

For additional information about URAC, visit [URAC.org](https://www.urac.org)

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## Section 1            Join our Network

### Contracting

Participating Providers are important partners in keeping health care affordable for our Members. To join our network or request copies of your existing contract, please call 888-666-5188 or email [Provider.relations@bcbswy.com](mailto:Provider.relations@bcbswy.com). We'll send you contract materials for your review and discuss next steps.

### Credentialing Guidelines

#### **What is credentialing?**

The credentialing process allows us to review, evaluate and approve (or disapprove) Provider participation in our network(s). This ensures each network Provider is qualified by education, training, licensure and experience to deliver quality health care services to our Members.

#### **Who needs to be credentialed?**

The credentialing process needs to be completed by all Providers who wish to provide covered health care services to our Members and are requesting network participation with BCBSWY.

This includes:

- Institutions (including acute care hospitals, skilled nursing and surgical centers)
- Facilities (DME, home health, home infusion)
- Licensed and independent practitioners

#### **What are our credentialing criteria?**

To qualify for network participation, applicants are required to meet the following criteria, as applicable:

- For participating Providers, login to [CAQH.org](http://CAQH.org) to complete the application process and grant BCBSWY access.
- For Institutions/Facilities submit a fully completed, signed application to BCBSWY through DocuSign. You can request an application [here](#).
- Maintain staff appointment in a network hospital or facility, as applicable.
- Possess required education from an appropriately accredited school.
- Successful completion of postgraduate residency training or specialty board certification, as applicable.
- Possess a valid, active license, DEA and controlled substance registration in the State of Wyoming, as applicable.
- Have the required levels of individual professional liability coverage. Recommended levels of coverage are \$1 million per incident and \$3 million aggregate.

- Be free of conviction for any criminal offense punishable as a felony, or engagement in any improper act related to the qualifications, functions or duties of a Provider.
- Maintain absence of Medicare/Medicaid sanctions, fines, fraud or suspensions from either program.

Additional information on the Credentialing process can be found on our website here: [BCBSWY.com/providers/credentialing/](https://www.bcbswy.com/providers/credentialing/).

## Participating Provider Responsibility

Specific obligations of each Participating Provider are stated in the Provider Agreement and its attachments and addendums. Participating Providers are obligated to the general responsibilities as outlined below. Participating Providers are primarily and solely responsible for exercising professional judgment on all matters of professional practice with regard to a Member including, but not limited to, the selection, course, amount and duration of the medical care for the Member. Additional obligations include, but are not limited to, the following:

1. Allow BCBSWY to publish Provider's name and contact information in any BCBSWY publication or directory listing its Providers.
2. Notify BCBSWY of any changes in Provider's name, contact information, billing address, taxpayer identification number, or ownership status within thirty (30) days of the change.
3. Utilize the Availity Provider portal, BCBSWY's toll-free help numbers, and BCBSWY's internet website.
4. Comply with all credentialing requirements and notify BCBSWY immediately if they are no longer in compliance with BCBSWY's credentialing requirements.
5. Ensure that the charges for Covered Services provided to a Member will not exceed the regularly established charges made to the general public for the same services.
6. Comply with all BCBSWY claims processes (see Claims Processing for more information).
7. Agree not to charge Members any amounts in excess of the set reimbursement amount for covered services (see Provider Payment Process for more information).
8. Cooperate with BCBSWY regarding communication and resolution of appeals and grievances.
9. Not discriminate against any Member based on their BCBSWY Membership, source of benefit payment, health status or status on any current federal listing of protected classes.
10. Abide by applicable federal laws, executive orders and regulations regarding equal opportunity and affirmative action.
11. Comply with all applicable federal and state laws, all applicable professional standards and provide Covered Services in accordance with practices and standards prevailing in Provider's medical community at the time of treatment and in conformity with BCBSWY's Medical Management Program.
12. Comply with the BCBSWY policies and procedures.

13. Educate Provider's employees on administrative requirements (i.e., pre-certifications, pre-authorization, appeals, referrals).
14. Establish and maintain policies, procedures and controls to ensure that no confidential, sensitive, privileged or Protected Health Information is used or disclosed by the Provider in violation of any federal or state law or regulation, including the Health Insurance Portability and Accountability Act (HIPAA).
15. Maintain their respective medical records, Member information and Claims information as required by applicable state and federal laws and regulations or 10 years, whichever is longer.
16. Provide BCBSWY with reasonable and timely access to Member's medical records and Claims information upon request. This information may be requested for the investigation of appeals or grievances, verification of claims, to assess the quality of care, or as required by applicable state and federal authorities.
17. Provider may be part of a Part 2 Program under 42 C.F.R. Part 2 and must agree to certain mandatory provisions regarding the use and disclosure of substance abuse treatment information.

To the extent that in performing its services, Provider holds itself out as providing, and provides, substance use disorder diagnosis, treatment, or referral for treatment, Provider acknowledges and agrees that it is a Part 2 Program for the purpose of such federal law; acknowledges and agrees that in receiving, storing, processing or otherwise dealing with any such patient records, it is fully bound by the Part 2 regulations.

18. Provider agrees to validate relevant provider information, address, and contact information every 90 days. Failure to do so will result in removal from the directory. Visit [BCBSWY.com/providers/](https://www.bcbswy.com/providers/) and choose "Availity Directory Validation Training Guide" in the right rail for complete instructions.
19. Provider agrees to update any location change. Participating Providers are obligated to notify BCBSWY of any changes in Provider's name, contact information, billing address, taxpayer identification number, or ownership status within 30 days of the change.

## Preserving Confidentiality

As a Participating Provider with BCBSWY, and outlined in the Provider contract, Participating Providers agree to the following responsibilities regarding Privacy, Use and Retention of Information:

1. Agree to establish and maintain policies, procedures, and controls to ensure that no confidential, sensitive, privileged or Protected Health Information obtained from the other party under the terms of this Agreement, is used, disclosed by the party, its agents, officers, or employees in violation of any federal or state law or regulation, including the Health Insurance Portability and Accountability Act (HIPAA).
2. All information and materials provided by BCBSWY to Provider shall remain proprietary to BCBSWY, including contracts, reimbursement rates and methodology, operation manuals and any information regarding BCBSWY's business activities, which are not otherwise available to the general public. Provider shall not disclose any such information or materials or use them except as may be required to perform Provider's rights and responsibilities under this Agreement or as required by law.
3. Each party shall furnish to the other party, upon request and at no cost to the requesting party, reasonable and timely access to Member's medical records and Claims information as is necessary to enable the requesting party to carry out its rights and responsibilities under this Agreement.
4. The parties shall make a Member's records available to applicable state and federal authorities involved in assessing the quality of care or investigating Member appeals or grievances.
5. Parties shall maintain their respective medical records, Member information and Claims information as required by applicable state and federal laws and regulations or 10 years, whichever is longer.

## Provider Suspension and Termination

Certain events may result in the reduction, suspension, or termination of network participation privileges. A participating Provider can be terminated from the network for the following reasons:

1. Provider fails or refuses to provide or arrange the provision of Covered Services to Members in a professionally acceptable manner.
2. Provider's license is suspended, revoked or restricted in any material way that would affect the ability of Provider to provide Covered Services to Member.
3. Provider's professional liability insurance or generally liability insurance, as required by this Agreement, is terminated and no replacement coverage is obtained without lapse or gap in coverage.
4. Where applicable, Provider is suspended or expelled from participation in the Medicare or Medicaid program.
5. Where applicable, Provider's bankruptcy or insolvency, or Provider's seeking of protection of the bankruptcy courts, or Provider's creditors filing an action against the Provider in the bankruptcy courts.
6. Provider's knowing or deliberate submission of false or misleading Claim information to BCBSWY.
7. Provider takes any action or makes any communication that fundamentally undermines or could fundamentally undermine the confidence of Members, potential Members, their employers, unions, physicians, Providers or the public in BCBSWY or in the quality of care provided to Members.

If the Medical Director determines that the Provider is engaged in a behavior or is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of consumers, the Provider may be immediately suspended pending the results of an investigation.

## Dispute Resolution Process

To respect Providers' rights while simultaneously protecting members, BCBSWY maintains a formal mechanism to address participating Provider alleged violations and resolve participating provider disputes. This Dispute Resolution Process aligns with the contract between BCBSWY and participating providers who deliver health care services. The Dispute Resolution Process is not available for certain types of issues such as repeated non-performance of obligations without corrective action, revocation of medical licensure, violations of professional standards, or the commission of unlawful acts. These situations constitute Termination for Cause, as outlined in the contract.

*Addressing Alleged Violations* - All participating Provider alleged violations of BCBSWY's contractual requirements or the provider's competency or conduct are addressed. All reports of violations are investigated, and actions are taken according to the findings and the appropriate disciplinary steps outlined in the contract.

*Providers' Right to Dispute* - All participating Providers have the right to dispute actions taken by BCBSWY **[NM 4-3(b)(i)]** that relate to the following:

- o A health care practitioner's status within the provider network **[NM 4-3(a)(i)]**
- o Any action by BCBSWY related to professional competence or conduct **[NM 4-3(a)(ii)]**
- o Suspension of participation status due to member health, welfare, or safety **[NM 4-3(a)(iii)]**
- o Disputes involving administrative matters **[NM 4-3(a)(iv)]**

The provider may submit additional information to BCBSWY in writing, either by electronic mail, postal service, special delivery, or other means of written communication.

BCBSWY staff will send an acknowledgement letter to the provider within 10 business days of receipt of the dispute request. For disputes that do not impact a provider's network participation status, a summary of the findings and determination following a thorough investigation are summarized in writing and mailed to the provider within 20 business days of the receipt of the dispute request. **[NM 4-3(b)(ii), (iii)]**

For dispute requests that impact a practitioner's status in the BCBSWY Provider network, a hearing panel is scheduled, formed, and convened to review the dispute according to the timelines set forth below. **[NM 4-3(b)(ii)]** The hearing panel includes at least one participating provider who is not otherwise involved in BCBSWY network management and who is a clinical peer of the participating provider who has filed the dispute. **[NM 4-4(a)(i)]** Written notification of the hearing panel is provided in writing to the disputing practitioner at least 60 calendar days prior to the date of hearing **[NM 4-4(a)(ii)]** and includes the following:

- o An explanation of the reasons for the proposed adverse action **[NM 4-4(b)(i)]**
- o Reference to the evidence or documentation for the proposed adverse action **[NM 4-4(b)(ii)]**
- o A description of the practitioner's right to an in-person hearing **[NM 4-4(b)(iii)]**
- o A description of the practitioner's right to be represented by legal counsel **[NM 4-4(b)(iv)]**

Upon the scheduled date, the hearing panel is convened virtually. The panel carefully and thoroughly reviews all the information surrounding the case, including all information that the provider who filed the dispute presents to BCBSWY to support his/her case. The findings and determination of the Hearing Panel Review are summarized in writing and this notification is sent to the disputing provider via mail **[NM 4-3(b)(iii)]** within 60 calendar days after the hearing closure. **[NM 4-4(a)(iii)]**

*Provider Suspension for Consumer Safety* - If a BCBSWY CMO/Medical Director is of the opinion that the provider is engaged in a behavior, or is practicing in a manner, that appears to pose a significant risk to the health, welfare, or safety of consumers, the provider may be immediately suspended pending the results of the investigation. BCBSWY provides written notification to the provider of the suspension along with the process to initiate a dispute. A suspended participating provider will not receive funding to continue services or receive new referrals from BCBSWY.

## Provider Payment Process

In all instances where BCBSWY is the insurer of the Member, BCBSWY will reimburse the Provider directly for Covered Services at the lesser of Provider's charge or the Maximum Allowable Amount, minus any Cost Sharing Amounts. (In instances where BCBSWY is only providing third-party administrative claims processing services, BCBSWY does not assume any financial risk or obligation with respect to the payment of Claims.) BCBSWY will also provide a weekly payment summary of Covered Services, Non-covered Services, and Cost Sharing

Amounts that are billable to a Member.

As a participating Provider with BCBSWY, and outlined in the provider contract, Participating Providers agree to the following responsibilities regarding the payment process:

1. Accept as payment in full from BCBSWY the lesser of provider's charges or the Maximum Allowable Amount, minus any Cost Sharing Amounts, for Covered Services.
2. Agree to not charge Members any amounts in excess of the set reimbursement amount. provider may still bill the Member for Non-covered Services and Cost Sharing Amounts identified as billable on the payment summary provided by BCBSWY.
3. Agree to not routinely waive or otherwise forgive, write-off, or fail to charge Member for any Cost Sharing Amounts. Provider shall make reasonable efforts to collect Cost Sharing Amounts from Member. This provision shall not prohibit the Provider from accepting a lesser amount in individual hardship cases, or where the Provider offers a prompt payment incentive discount.
4. Acknowledge that Provider shall not seek payment for Covered Services from a Member where Provider has not been paid for said Covered Services due to BCBSWY's insolvency, breach or termination of the Provider Agreement, by either party for any reason. This provision does not prohibit the Provider from collecting Cost Sharing Amounts or fees for Non-covered Services. In the case of BCBSWY's insolvency, services for a Member shall continue for the period for which premium payments have been made.
5. Acknowledge and agree Provider shall not be eligible for reimbursement under the Provider Agreement for Covered Services rendered during any period that Provider's license, registration or certification is suspended or revoked.
6. In the event a Provider identifies an overpayment by BCBSWY, notify BCBSWY of such overpayment by using the [Claim Adjustment form](#), and hold the funds pending direction from BCBSWY. Do not send a voluntary paper check. If you receive a formal written request for a refund, please follow the instructions on the letter. When notifying BCBSWY of an overpayment, Provider shall provide as much information as is available to facilitate investigation of the overpayment and any coordination of benefits by BCBSWY with other insurance. Provider acknowledges that BCBSWY may, in addition to any other remedy, cover the same by offsetting the amounts overpaid against current and future amounts due and/or seek refund from the Provider.
7. Immediately refund to Member any sums Member pays to Provider in error and/or in excess of Member's Cost Sharing Amounts.
8. Use its best efforts to identify and inform BCBSWY when a Member may be eligible for coverage from another payor including, but not limited to, a different health plan, liability insurer, worker's compensation or occupational disease coverage, Medicare or other government programs. Provider will further use its best efforts to collect payment from third-party payors first, using its customary collection procedures, whenever such payors have primary responsibility to pay for Covered Services in accordance with the

Coordination of Benefits and third-party liability requirements of the Member's Benefit Document.

Electronic payment listings are available on the Availity portal and can be viewed, printed, or saved.

**Helpful Hint:**

Claims identified as overpayments are shown as Provider Adjustments on your ERA and in the Future Offset detail section of mailed remittances. The amounts of these payments are not factored into the check/EFT that you receive notice on. If you feel the refund is being requested in error, please contact Provider Relations within 45 days of being notified to avoid an offset. Claims are automatically corrected and reprocessed, resulting in an offset approximately 60 days after receiving notice on a remittance.

## Electronic Funds Transfer (EFT)

EFT is BCBSWY's preferred method for Provider payments. Take advantage of BCBSWY's electronic solutions by signing up today for payments by electronic funds transfer (EFT). EFT helps you streamline your operations and reduce your administrative costs. Consider these benefits:

- Reimbursements are deposited to your account faster.
- EFT payments don't get delayed or lost in the mail.
- EFT payments have greater fraud protection.
- Bank fees are lower.
- You save time by making fewer trips to the bank.

Setting up EFT is a fast and reliable method to receive your payments from BCBSWY. EFT requests are completed using Availity.

## Provider Directory & Availability

As a credentialed and participating Provider, your name and Provider demographics are included in the Provider directory, which is available to Members and featured on our website, [BCBSWY.com](https://www.bcbswy.com) under "Find a Doctor." Listings are updated weekly. BCBSWY makes every effort to ensure the information in the Provider directory is current and accurate, based on the information provided to us.

**To update practice/office information use this form:**

[BCBSWY.com/docs/Providers/Application\\_Credentialing\\_Practice\\_Information.pdf](https://www.bcbswy.com/docs/Providers/Application_Credentialing_Practice_Information.pdf)

BCBSWY maintains a network of Providers sufficient to provide adequate access to cover community capacity. This is assured by monitoring the availability of service Providers. BCBSWY has set a performance goal of 90% of Participating network primary and specialty Providers who are accepting new patients.

## Subcontractor Approval Process

Follow these instructions to request Subcontracting of Contracted Services:

- Subcontractors cannot start work until they have submitted a written request for subcontracting and the Provider/Contractor has been granted written approval by BCBSWY.
- The primary Provider/Contractor must identify those individuals to which it intends to subcontract, including their location/address, credentials, and the specific services to be performed.
- The Provider/Contractor must submit a copy of the subcontracting agreement. This agreement must specify that the subcontractor will be subject to all the terms of the original written Provider agreement with Blue Cross & Blue Shield of Wyoming.
- The Provider/Contractor must submit evidence that the subcontractor is appropriately licensed including the Primary Source Verification of the sub-contractor's credentials/clinical license and good standing by the NPDB and OIG, as applicable. The Provider/Contractor must also submit their policy and procedure for verification and re-credentialing of the sub-contractor.
- All received requests for subcontracting will be considered once all required documents have been submitted.
- BCBSWY may request additional documentation for consideration.
- BCBSWY will review complete requests and notify the Provider/Contractor in writing within 90 calendar days of receipt of the request. BCBSWY will include the determination to allow or deny the subcontracting request. If approved, BCBSWY will provide the date the subcontracting may be initiated.

## Section 2 Provider Services

### Availity Web Portal

The Availity web portal offers secure online access to manage the care of your patients with the ability to check eligibility and benefits, manage claims and remittances, request authorizations and complete other secure administrative tasks online. Availity is a multi-payer site where a single user ID and password lets you work with BCBSWY and other participating payers online.

### Advantages of using Availity Web Portal

Benefits include:

- **No charge** – Health plan transactions are available at no charge to Providers, while at the same time saving time and money.
- **Accessibility** – Availity web portal functions are available 24 hours a day from any computer with Internet access.
- **Standard Responses** – Availity returns responses from multiple payers in the same format and screen layout, providing users with a consistent look and feel.
- **Commercial and Government Payers** – Access to data from BCBSWY, Medicare, Medicaid and other commercial carriers. (See [Availity.com](http://Availity.com) for a full list of payers)
- **Compliance** – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

### Electronic Data Interchange (EDI)

We also use Availity to offer a full suite of EDI health information exchange services through a single online connection to the Availity Intelligent Gateway. BCBSWY will offer the Availity Intelligent Gateway to let you:

- Submit claim transactions (837I/P/D), Member eligibility (270), claim status (276), etc. 24 hours a day, seven days a week.
- Receive claim acknowledgment (277CA) and claim payment/remittance advice (835) transactions.

## Register for Availity Web Portal

1. You will need the following information:
  - Physical and billing addresses
  - Tax ID (EIN or SSN)
  - NPI
  - Primary specialty/taxonomy
  - Check or EFT information
2. Go to [Availity.com](https://www.availity.com)
3. Select **Register** at the top of the page.
4. Scroll down the page and hover the cursor over the **Providers** tile, and then click **REGISTER**.
5. Complete the selection for a new user, accept the agreement terms, and then click **Sign Up**.
6. Enter and confirm your email address and personal information to set up your account. Click **Next**.
7. The administrator will receive an email from Availity with a temporary password and next steps. You may then begin adding other users for your organization.
8. For registration guidance or tips, [view or print this quick guide](#).
9. If you need further assistance with Availity, please contact Availity Client Services at 1-800-AVAILITY (282-4548).
10. Please note that it may take up to five days to complete registration.

### Helpful Hint:

Are you already an existing user?

If you are, then select **Yes, I have an Availity User ID**.

Enter your credentials, and accept the terms, click Sign Up to create a new account.

## BCBSWY Availity Payer Space

All the resources you need to work with BCBSWY can be found in our Availity Payer Space. The **Resources** tab will be your place to find:

- [BCBSWY Medical Policy](#)
- Contract Information
- Claims Policies
- Dispute Resolution Process
- Forms, additional policies and more

We also regularly post news and announcements in our payer space.

## Helpful Training

The Availity Learning Center has a selection of topic-based webinars ranging from 3-30 minutes.

### The Availity Portal Onboarding – Training Program includes:

- Brief video tour
- Checklists for new users and Admins (including a downloadable PDF for Admins)
- Tips, timesavers, etc.
- Instructions to use Self-Service and Support
- A link to the new **Plot Your Learning Path** feature in the ALC Forum

You can also view the BCBSWY Provider webinar for tools and tips on using Availity. Here is how to find it:

1. Login to [Availity](#)
2. Select **Help & Training | Get Trained**
3. The Availity Learning Center will open a new web browser tab
4. In the **Catalog**, search by keyword “Wyoming”
5. Enroll for the course – **Introduction to Availity for BCBSWY Providers On-Demand**

## Submitting Claims

**To submit via direct data entry ...**

- Click **Claims & Payments** and select either **Professional Claim** or **Facility Claim**.

**To upload your claims via the portal ...**

- Click **Claims & Payments | EDI Reporting Preferences** and set up your preferences.

**To send and receive batch submissions using transport method FTP...**

- Go to **Help & Training > My Support > Open A Ticket** and submit your ticket. Availity will send you a response that includes your mailbox information.

## Remittance Viewer

The remittance viewer is an Availity tool that allows Providers to view, sort, save and print remittance information. The viewer can be accessed by both Providers and Provider’s billing service. To enroll to receive the 835 Electronic Remittance Advice (835 ERA) follow these steps:

- Click **My Providers | Enrollments Center | ERA Enrollments**.

**Set up ERA Reporting Preferences...**

- Click **Claims & Payments | EDI Reporting Preferences** and then the **Claim Payment/Advice** tab.

**Note:** After you have enrolled to start receiving your 835 ERAs you can access the Remittance Viewer by selecting Claims & Payments from the main menu.

## Claim Status

You can also check claim status easily in Availity in three easy steps.

1. Click **Claims & Payments | Claims Status and Remittance Inquiry** will drop down – click on the link.
2. On the next screen you will see **Claims Status**. Select **BCBSWY** under the **Organization** drop down – **select BCBSWY under Payer** and then click continue.
3. Under the search you will enter **Provider Information, Patient Information & Claim Information**, then click submit. This will populate the information on the status of the claim.

## Verify Eligibility and Benefits

An eligibility and benefits inquiry should be completed for every patient at every visit to confirm Membership, verify coverage and determine other important information, such as the patient's copay, coinsurance, and deductible amounts. Eligibility and benefits inquiries may be completed online easily and efficiently using the Availity Eligibility and Benefits tool. To get started:

1. Click **Patient Registration | Eligibility and Benefits Inquiry**.
2. Select **BCBSWY** from the Payer drop-down for local policies.
3. Select **Other Blue Plans** for out-of-state policies. Select the applicable Provider name from Express Entry Provider drop-down to auto populate the NPI Field\*.
4. Complete the following:
  - Provider Type
  - Place of Service
5. Select the applicable Benefit/Service Type from the drop-down menu and complete the patient information.

### Helpful Hint:

\*Use the billing **NPI (Type 2)** to receive accurate benefit quotes.

Once an eligibility and benefits request is completed, a new **Patient Card** will appear in **Patient History Lists**.

## Uploading Documents in Availity

It's easy to upload documents for appeals, corrected claims, medical records (for reasons other than Prior Authorizations) or invoices through Availity. This is a great alternative to faxing or mailing documents and is more efficient since it provides a record of the date the documents were received and downloaded and makes it easier to track documentation of submission dates.

View this [training- guide](#) to get started!

## Section 3

## Clinical Guidelines

### Medical Policies

BCBSWY continuously updates and adds new medical policies. These policies offer clarification to authorization requests or claims denials and are necessary to support our claims processing system. You can access our medical policies through the BCBSWY Availity payer space or at [BCBSWY.com/Providers/policy/](https://www.bcbswy.com/Providers/policy/) in an easy-to-search format. We recommend referring to the website each time you consider submitting prior authorization requests to determine BCBSWY requirements.

### Medical Necessity

In determining if a service, procedure, or supply is medically necessary, BCBSWY utilizes the following definition: A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

- Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
- Provides for the diagnosis, direct care, and treatment of the Member's condition, illness, disease or injury;
- Is in accordance with professional, evidence-based medicine and recognized standards of good medical practice and care; and
- Is not primarily for the convenience of the Member or Provider.

A medical service, procedure or supply shall not be excluded from being a Medical Necessity solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

- Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

This information is NOT to be relied upon as pre-admission or prior authorization request for health care services and is **NOT A GUARANTEE OF PAYMENT**.

## Experimental/Investigational

A drug, device, or medical treatment or procedure is experimental or investigational:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, treatment, or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. If reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

## Prior Authorization Request

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

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 to be relied upon as prior authorization for health care services and is **NOT A GUARANTEE OF PAYMENT**. To verify coverage or benefits or determine prior authorization requirements for a participant, call 1-800-442-2376.

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

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

### Helpful Hint:

To understand the flows of the workbaskets, see our Service Type Chart at [BCBSWY.com/providers/preadmin/](https://www.bcbswy.com/providers/preadmin/)

## Prior Authorization Service Request

### Determine if a Prior Authorization Request is Required:

You can verify coverage or benefits or determine pre-admission or prior authorization request requirements for a Member using [Availity.com](https://www.availity.com).

Benefits will be denied if the patient is not eligible for coverage under the benefit plan on the date services are provided or if services received are not medically appropriate and necessary.

#### 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.

### Complete a Prior Authorization Request:

For services which do require BCBSWY prior authorization requests, login to [Availity](https://www.availity.com). The authorization tool is found under ***Patient Registration***.

[Click Here to see the BCBSWY Online Authorization Training Guide](#)

Using Availity will speed up the prior authorization process, as it removes the time needed to transcribe requests for placement in the system queue.

Hospital inpatient, concurrent review and outpatient authorizations are required to be submitted through the Availity portal for in-state providers. All other prior authorizations may be submitted by fax or phone, as in the past. Please complete the [Prior Authorization Request Form](#), and submit it as instructed. Medical records will be required with each submission.

Providers should only submit FEP authorization requests for services to BCBSWY if those services occur in the state. BCBSWY cannot approve or deny an FEP authorization that is conducted in a different state.

Please mark a prior authorization request **URGENT** if **failure to receive treatment will result in a life or limb threatening situation or if member pain is severe.**

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#### Helpful Hint:

BCBSWY does not recognize scheduling conflicts as an urgent request.

## Processing a Prior Authorization Request:

When 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.

### Helpful Hint:

Provide the fax number and name of **individual who should receive the fax determination.**

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

- Non-urgent prior authorization requests will be processed within 5 calendar days from date of receipt.
- Urgent prior authorization requests will be processed within 72 hours 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.

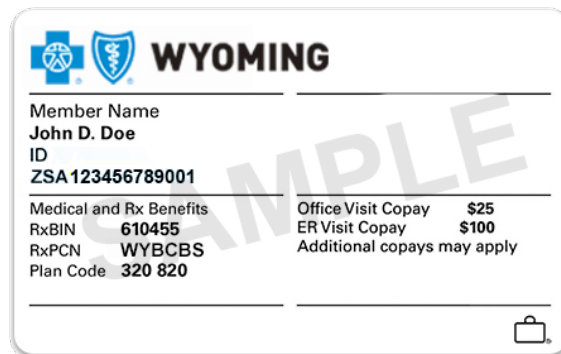
## Checking Authorization Status

You can use the Availity authorization dashboard to see the status of all authorizations submitted online for your organization.

## Prior Authorization Admission Request

A prior authorization admission request is the process of notifying Blue Cross Blue Shield of Wyoming (BCBSWY) of an inpatient stay. The participating Provider or Member must notify BCBSWY of ALL inpatient hospital 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.

Our Member IDs begin with the following prefixes: QWY, YWY, ZRW, ZSD, ZSF, ZSH, ZSK, ZSM, ZSP, ZYW, and R (FEP).



For all other prefixes, use [Availity](#) to find the appropriate Blue Plan prior authorization admission requirements or call 1-800-676-2583. If you process the authorization through Availity it will route to the appropriate plan based on the prefix.

### To complete the Pre-Admission Review:

A Provider should complete an admission request to BCBSWY when:

- A patient is being scheduled for an inpatient stay.
- A patient is being admitted for an inpatient stay.
- A patient is a FEP Member and is in an observation status greater than 48 hours.

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

- A patient is a FEP Member and is in an observation status less than 48 hours.
- A patient is a FEP member who is being admitted or receiving care outside of Wyoming. Authorizations should be submitted to the Blues plan in the state in which the care is being rendered.
- A patient is on Medicare and has a contract number beginning with ZSM.

### Mental Health Prior Authorization

- For authorizations related to mental health and substance abuse care including detox, residential treatment, partial hospitalization, and specialized services, including but not limited to, electroconvulsive therapy (ECT) or transcranial magnetic stimulation (TMS), please submit through Availity. Our Mental health and substance abuse team is also available to assist you with the authorization process at 1-844-946-6319.
- For authorizations related to mental health and substance abuse care including acute psychiatric care in a hospital, intensive outpatient, outpatient counseling

services, or medications, please submit authorizations through Availity as needed. Our Member Services Department can assist you with any questions or concerns.

- For mental health and substance abuse care questions, you can also visit our website at [BCBSWY.com/members/member-mental-health-and-substance-abuse-resources/](https://www.bcbswy.com/members/member-mental-health-and-substance-abuse-resources/) for further information.

## Get Started

- Log into [Availity](#). The Authorization Tool is found under *Patient Registration*. Complete the prior authorization service request (if required) AND admission request.
- You should only call 307-829-3081 to request the following admissions: Skilled Nursing Facilities, In-Patient Hospice Care, Acute Rehabilitation Facilities, Transitional Care Units, Swing bed admissions, Residential Treatment Facilities, Transplants. Be prepared to include the following information:
  - Name of caller, caller's facility, and caller's phone number
  - Name of patient, patient's date of birth, patient's policy number
  - Date of admission
  - Admitting diagnosis **including** diagnosis codes
  - Admitting procedure **including** CPT codes
  - Physician's name **including** spelling, physician's address and fax number
  - Facility name, facility address and fax number
  - Type of stay – Outpatient, Observation, or Inpatient

Once the information is received and processed, we will fax you an authorization number and an initially authorized length of stay. [Prior Authorization Request](#) may be required for services being performed.

## Concurrent Review:

Once a patient has exhausted their initial in-patient hospital authorized length of stay, you can request an extension through the [Availity](#) portal. BCBSWY requires notification of discharge date.

When submitting a concurrent review, ensure the authorization you are adding additional days to has a status of APPROVED or DENIED.

First, go to **Authorization/Referral Dashboard** and select the hamburger menu (three small parallel lines) and select **UPDATE** from the menu.

Providers should only call 307-829-3081 to request the following admissions: Skilled Nursing Facilities, Inpatient Hospice Care, Acute Rehabilitation Facilities, Transitional Care Units, Swing bed admissions, Residential Treatment Facilities, Transplants. BCBSWY requires notification of discharge date and you can fax this to the concurrent review fax number.

| Document Destination     | Fax Number   | What should get sent here?   |
|--------------------------|--------------|--|
| <b>Authorizations</b>    | 307-432-2917 | <ul style="list-style-type: none"><li>• Prior Authorization request</li><li>• Service and admission inpatient authorizations</li><li>• Pharmacy authorizations</li></ul> |
| <b>Concurrent Review</b> | 307-432-2756 | <ul style="list-style-type: none"><li>• Updates and records for current inpatient stays</li></ul>  |

## Special Circumstances:

### CAR-T:

For questions, benefits, and authorizations call our transplant coordinator 307-829-3081.

### Transplants:

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

### Residential Treatment Facility:

For questions about residential treatment facility authorizations call 307-829-3081. Learn more at [BCBSWY.com/members/member-mental-health-and-substance-abuse-resources/](https://www.bcbswy.com/members/member-mental-health-and-substance-abuse-resources/).

### Newborn Admission Request:

Admission requests are not required per the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) unless the newborn is admitted for more than 48 hours (vaginal delivery) or 96 hours in the case of cesarean delivery.

## FEP Prior Authorization:

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

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

### Helpful Hint:

\*FEP does not permit retroactive authorizations.

## Secondary Insurance Authorization

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                       |
| <b>Medicare Denials</b><br>QWY, YWY, ZRW, ZSD, ZSF, ZSH, ZSK, ZYW, and R. | Secondary authorization required.  | Secondary authorization required.  |
| <b>Prefixes beginning with ZSM</b>  | No authorization required.         | No authorization required.         |
| <b>All Prefixes</b>   | <b>CAR-T</b><br><b>Transplants</b> | <b>CAR-T</b><br><b>Transplants</b> |

## Appeals and Peer to Peer Conversations

Providers may request appeals for Prior Authorization Requests and Concurrent Reviews, which have been denied. The specific appeals process may vary from that outlined below depending on a Member's specific benefit plan and state and/or federal regulations.

An appeal can be submitted by a Member, Provider or facility. Appeals can be submitted up to 180 days from the date of the denial notice from BCBSWY.

Appeals should be submitted in writing. BCBSWY does not require the use of any specific forms.

**Appeals should include the following components to help with timely determinations:**

- A letter stating the denied services and the reason you feel the denial should be

overturned; and

- The clinical documentation explaining why the denied services should be considered medically necessary or should be considered on an individual basis.

Once BCBSWY receives an appeal request, the appeal documentation is reviewed by medical review staff. Upon determination, BCBSWY will provide written notification to you and the Member.

If you are unsatisfied with the determination of your appeal, please call Member Services at 800-442-2376 for further assistance.

Appeals should be sent to BCBSWY by mail or fax.

**Mail:**

Member Services  
Blue Cross Blue Shield of Wyoming  
PO Box 2266  
Cheyenne, WY 82003-2266

**Helpful Hint:**

Include information such as claim number, authorization number, and other Member issue identifiers.

**Fax:**

307-432-2942

**Peer-to-Peer Conversations**

Peer-to-Peer conversations are discussions between a physician and a BCBSWY Medical Director regarding denied services. BCBSWY offers Peer-to-Peer conversations for prior authorization requests denied for ***not demonstrating medical necessity or deemed investigational***. Benefit denials are not eligible for a Peer-to-Peer Conversation.

A Peer-to-Peer Conversation may be requested by a physician’s representative who has access to the following information:

- Physician’s schedule
- Physician’s general rationale for a conversation regarding the denial

The representative will also be asked to confirm that the physician has reviewed the BCBSWY denial documentation including any applicable Medical Policies.

The physician who rendered or requested denied services must participate in the Peer-to-Peer conversation. If the physician is unavailable for a conversation, a colleague may be allowed on a case-by-case basis.

Peer-to-Peer conversations may be requested up to ten calendar days from the date of the denial notice from BCBSWY. BCBSWY may accept Peer-to-Peer conversations past 10 calendar days on a case-by-case basis.

To schedule a Peer-to-Peer conversation, please call Provider Support at 888-359-6592. A representative will take your information and within one business day, a representative from our Medical Review Department will call to schedule a time for the conversation.

## Emergency Services

Our priority is to ensure that BCBSWY members are able to receive medically necessary care when and where they need it.

Members are encouraged to seek services for medical care from network providers whenever possible. However, in some situations, network providers may not always be accessible. BCBSWY has written policies in place to assure that members have access to care for emergency services:

### Emergency Services

- BCBSWY has contracted with agencies to provide emergency services that are immediately responsive to consumers in their care.
- BCBSWY also facilitates the consumer's effort to identify an emergency care provider that is out of the network area when necessary.

## Site of Care Infusion Drugs

Blue Cross Blue Shield of Wyoming site of care program requires certain services that may have been received in a hospital setting to now only be authorized in the most cost-effective setting, such as an infusion center, provider's office, or via home health. If needed, BCBSWY will assist members with finding an appropriate site for care.

**If a member is affected by this program, it will be noted in the authorization letter.**

If administration of the list of drugs below are not approved to be performed in an inpatient or outpatient hospital setting members can receive infusion treatments at facilities such as free-standing infusion center, doctor's office, pharmacy, or via home health. Failure to receive the service in an approved location could result in the denial of claims.

Please be advised that while the service has been approved as medically appropriate, the member's benefits require this service be provided in specific locations.

Our site of care team is available Monday-Friday, 8 a.m.-5 p.m., by calling **307-823-6095** to assist you.

Please visit [BCBSWY.com/providers/site-of-care/](https://www.bcbswy.com/providers/site-of-care/) for more information.

## Section 4 Billing Guidelines

### Ambulance Guidelines

#### Air Ambulance

Claims from providers of emergency and non-emergency air ambulance services provided within the United States, U.S. Virgin Islands and Puerto Rico are to be filed to the local Plan's service area in which the point of pickup ZIP code is located.

Claims billed by a facility that includes air ambulance services as part of the facility's negotiated arrangement are outside the scope of these claims filing guidelines. Such claims are filed to the facility's local Plan.

For air ambulance when the member's pick-up location is outside the United States, U.S. Virgin Islands and Puerto Rico, claims must be filed to the Blue Cross Blue Shield Global Core medical assistance vendor for processing through the Blue Cross Blue Shield Global Core Program.

Plans must validate the point of pickup ZIP code based on the following CMS guidelines for air ambulance claims:

- In item 23 of the CMS 1500 Health Insurance Claims Form, billers shall code the 5-digit ZIP code of the point of pickup. If the ZIP code is not in the Plan's service area, the claim must be rejected.
- For electronic claims, validate the origin information (ZIP code of the point of pickup), as sent in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.
- When Form UB-04 is used for air ambulance service, billers shall populate boxes 39-41 with the 5-digit ZIP code of the point of pickup.

#### Claims Filing Instructions

- Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.
- Value: Five-digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
- For electronic claims, validate the origin information (ZIP code of the point of pickup) as sent in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.
- Claims without a point of pickup ZIP code, or with multiple ZIP codes, will be rejected.
- The format for a ZIP code is five-digit. If a nine-digit ZIP code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim will be rejected.

#### Ground Ambulance

Claims from providers of emergency and non-emergency ground ambulance services provided within the United States, U.S. Virgin Islands and Puerto Rico are to be filed to the local Plan.

For ground ambulance when the member's pickup location is outside the United States, U.S. Virgin Islands and Puerto Rico, regardless of where the provider's headquarters is located, claims should be filed to the Blue Cross Blue Shield Global Core medical assistance vendor for processing through the Blue Cross Blue Shield Global Core Program.

**Note:**

The base rate payment is inclusive of all items and services furnished during both air and ground transports.

## Ambulatory Surgery Center (ASC)

The ASC maximum allowance includes nursing and technician services; use of the facility; drugs including take-home drugs; biologicals; surgical dressings, casts and equipment directly related to provision of the surgical procedure and materials for anesthesia. The rate does not include items such as physicians' fees; laboratory, x-rays, EKGs, and durable medical equipment for use in the patient's home.

### How are special supply items reimbursed?

Supply items are generally included in the facility reimbursement with the following exception: When the cost of a device or multiple devices permanently inserted into the body exceeds \$750 and is not included in the maximum allowance, you may be reimbursed the invoice amount of this item plus 10%, less any and/or coinsurance amounts. Some allowances assume deductible inclusion

Use the TC modifier when billing for the technical component of radiology services.

of the cost of implants. When implants are billed separately, allowances for other facility services may be reduced. Shipping and handling charges may not be billed separately. An invoice must be submitted with the claim to be considered for reimbursement. All other supply items and disposables are included in the facility reimbursement.

All implants must be billed using L8699. The ambulatory surgery center must bill for the special supply item on the same claim as the facility charges.

### How is the reimbursement for multiple and bilateral procedures calculated?

BCBSWY will use the following schedule when calculating the allowable reimbursement for multiple surgeries:

**Primary Procedure** – The lesser of the Provider's charge or 100% of the ASC maximum allowance.

**Second Procedure** – The lesser of the Provider's charge or 50% of the ASC maximum allowance.

**3rd – 5th Procedure** – The lesser of the Provider's charge or 25% of the ASC maximum allowance.

The primary procedure is the procedure with the highest maximum allowance. The maximum allowance of the other procedures determines their rank (i.e. the procedure with the second highest maximum allowance is second, the procedure with the third highest maximum allowance is third, etc.)

Charges that are considered incidental or integral to the primary procedure will not be reimbursed in addition to the primary procedure. No more than five facility charges for surgical procedures will be considered for reimbursement during the same 24-hour period.

## How is the reimbursement for multiple injections/multiple levels calculated? How will multiple scopes performed in the same setting be reimbursed?

BCBSWY will use the guidelines for multiple and bilateral procedures explained above when reimbursing injections and multiple scopes. However, the additional procedure must be a separately billable procedure. In determining bundling and unbundling of services, BCBSWY will follow the same guidelines utilized for services billed by the physician.

## How are incidental procedures reimbursed?

No facility reimbursement is provided when the procedure can be performed in the physician's office or is not medically indicated. Additionally, no reimbursement is to be made for incidental procedures.

## Claim filing instructions

All claims for surgical facility charges must be submitted on the CMS 1500. Procedure codes used by the facility must match procedure codes billed by the surgeon.

## Anesthesia Billing Guideline

### Modifiers Impacting Anesthesia Reimbursement

- **Modifiers - QY, - QK** (Medical Direction of 1 or 2-4 anesthesia procedures)  
The Maximum Allowable Amount for services submitted with a - QY or - QK modifier will be 50% of the Maximum Allowable Amount for services submitted without these modifiers.
- **Modifier - AD** (Medical Direction of more than 4 anesthesia procedures)  
Services submitted with an -AD modifier will be reimbursed at 3 base units regardless of procedure. No time units will be reimbursed for procedures submitted with this modifier.
- **Modifier - QX** (Qualified non-physician under Medical Direction)  
The Maximum Allowable Amount for services submitted with a - QX modifier will be 50% of the Maximum Allowable Amount for services submitted without this modifier.

### Informational Only Codes

- Qualifying circumstances codes are only payable when general anesthesia is performed. CPTs in the category of qualifying circumstances codes include 99100, 99116, 99135, and 99140.

### Physical Status Modifiers

- BCBSWY will make additional reimbursement for physical status modifiers according to the following table. No additional reimbursement will be made for physical status modifiers not on the table.

| <b>Modifier</b> | <b>Additional<br/>Time Units</b> |
|-----------------|----------------------------------|
| P3              | 1                                |
| P4              | 2                                |
| P5              | 3                                |

### Emergency Anesthesia

- CPT 99140 (emergency anesthesia) is allowed in situations where a delay in treatment would lead to threat to life or body part. 99140 will not be allowed based solely on the time of day or because a procedure was not scheduled prior to the decision for surgery.

## Labor/Deliver Anesthesia

- 01960 is allowed at base units only; no time units are allowed.
- 01967 is allowed at base units only; no time units are allowed. However, base units are increased by 4 to allow for patient monitoring.
- Add-on codes 01968 and 01969 are allowed at base units plus time units. Time should be reported for only the cesarean portion of the procedure. **Note:** Add-on codes must be billed in addition to the code for the primary procedure performed on the same claim.
- 01961 is allowed at base units plus time.

## Nerve (Pain) Blocks, Injections and Catheter Placement (62320-62327, 64400-89, 64505-64530)

- Injections, blocks or catheter placements for post-operative pain management, and not as the means of surgical anesthesia, should be billed with modifier -59 to indicate these procedures were performed for post-operative pain management.
- If these procedures are performed **before the induction** or **after the conclusion** of the primary means of surgical anesthesia, the time spent on them should not be added to the reported anesthesia time.
  - If a catheter is placed, CPT 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. CPT 01996 is not reportable on the same DOS as the catheter placement. Reimbursement for daily pain management is limited to a maximum of 3 days.

## Billing Guidelines

Anesthesia services must be billed on a CMS 1500 with CPT codes 00100- 01999.

- Units on the claim form (Box 24G) must be equal to the time anesthesia was administered in **minutes**. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance.
- When multiple surgical procedures are performed during a single anesthetic administration report only the anesthesia code with the highest base unit value. The time reported is the combined total for all procedures.
- Under no circumstances will two anesthesiologists be paid for a single anesthesia administration. If anesthesiologists are in a group practice, one member may provide the pre-anesthesia examination while another performs other portions of the service. The medical record should indicate the services furnished and the Provider who furnished them. However, only one member of the group would bill for the entire anesthesia service. The claim should be submitted under the NPI number of the Provider who was in attendance during the majority of the anesthesia administration.

## Chiropractic Coding

When providing chiropractic manipulation therapy services, it is essential that you submit the Current Procedural Terminology (CPT) Codes intended for chiropractic manipulations. These CPT codes are inclusive of the associated pre- and post-manipulation services as well.

E&M codes are reserved for office consultations that meet 2 of the 3 key components required for evaluation and management services. In order to apply benefits correctly, it is important that you submit the appropriate codes for the services you provided to our members.

We recognize five spinal regions for chiropractic manipulative treatment (CMT), billing more than five regions on a date-of-service by a single provider will be denied.

BCBSWY allows chiropractors to bill new and established office visit codes (99202-99204 and 99211-99214). Any other E&M code(s) billed will be rejected as not permissible even if billed alone without any other services.

**New Patient** - A new patient is one who has not received any professional services from the chiropractor or another chiropractor in the same group practice within the past three years. New patient visits will be payable once every 36 months per chiropractor. Chiropractic claims with new patient E&M codes will hold in adjudication to verify the service is an initial visit for the patient.

**Level of Care** – Claims with code 99204 or 99214 will be reviewed periodically and Medical Records may be requested. Codes 99205 and 99215 will deny as billed in error.

### **Chiropractic Manipulation Therapies**

Chiropractic manipulations therapy (CMT) is reported with codes:

- 98940 Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
- 98941 Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- 98942 Chiropractic manipulative treatment (CMT); spinal, 5 regions
- 98943 Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions

For Chiropractic Manipulative Treatment (98940-98943) to be reimbursable:

- Documentation must include location of pain/condition for which treatment is being sought
- Specific spinal regions adjusted and technique used
- Response to the treatment/adjustment, including whether or not the pain/condition being treated increased, reduced or eliminated the problem
- Each manipulation reported must be related to the patient's complaints and a relevant symptomatic spinal or extraspinal level

For time-based codes, such as 97140, to be reimbursable with CMT, the time-based code must be submitted with a -59 modifier and records must clearly document the following:

- Manipulation was not performed to the same anatomic region or a contiguous anatomic region e.g., cervical and thoracic regions are contiguous; cervical and pelvic regions are noncontiguous
- The clinical rationale for a separate and identifiable service must be documented e.g., contraindication to CMT is present
- Description of the manual therapy technique(s)
- Location e.g., spinal region(s), shoulder, thigh, etc.
- Time i.e., number of minutes spent in performing the service associated with this procedure meets the timed-therapy services requirement

### **DME**

Generally, DME is eligible for coverage when the equipment meets all of the following criteria:

- Serves a medical purpose; AND
- Generally, not useful to a person in the absence of illness, injury or disease; AND

- Used in the patient's home/place of residence; AND
- Reasonable and medically necessary for the individual patient; AND
- Prescribed by a physician within the scope of his/her license; AND
- Does not serve as a comfort or convenience item; AND
- Has been approved by the U.S. Food and Drug Administration (FDA) (where applicable) and is otherwise generally considered to be safe and effective for the purpose intended.

## Physical Medicine

For physical medicine services (97010-97140 and 97530. Common therapies include Manual Therapy, Therapeutic Activities, Therapeutic Exercises, Neuromuscular Reeducation) to be considered for coverage, the following conditions must be documented to support the CPT codes:

- The therapy must be of a skilled nature and require the services of a skilled provider.
- The services/therapy must not be maintenance in nature. Ongoing physical medicine treatment after a condition has stabilized or reached a clinical plateau (maximum medical improvement) does not qualify as medically necessary and would be considered "maintenance care."
- Services performed must achieve a specific diagnosis-related goal.
- There must always be a documented expectation that the patient will, in fact, achieve reasonable improvement over a predictable period of time for the services to be eligible for reimbursement.

## Digital Breast Tomosynthesis

Digital Breast Tomosynthesis (DBT) will only be reimbursed when done in conjunction with traditional 2D mammography as an add-on service. There are currently four CPT codes that represent DBT services:

- 77061 - Digital breast tomosynthesis; unilateral
- 77062 - Digital breast tomosynthesis; bilateral
- 77063 - Screening digital breast tomosynthesis, bilateral; add-on
- G0279 - Diagnostic digital breast tomosynthesis, unilateral or bilateral; add-on

BCBSWY will only reimburse DBT services billed using CPT codes 77063 and G0279. These codes represent DBT being performed as an add-on service.

Digital Breast Tomosynthesis services billed using code 77061 or 77062, will be denied as provider liable.

## Durable Medical Equipment

When billing for durable medical equipment (DME) Providers need to bill the NU, RR, or UE modifier as appropriate based on whether the equipment was provided as a purchase, rental or used.

If no modifier is submitted for DME, we assume the equipment was provided as a purchase.

Claims for Durable/Home Medical Equipment (DME/HME) need to be sent to the Plan in whose service area the equipment was shipped to, or purchased at a retail store. If the Provider is not contracted with that Plan, the claim will be considered as out of network and subject to the No Surprises Act.

## Home Infusion

### **Ancillary Claims Filing**

Professional Claims from a Home Infusion Therapy (HIT) Provider should be filed to the Blue Plan where the service was rendered (which may be the member's home or equivalent setting). Even if a HIT Provider employs traveling health care professionals or renders services in multiple states, professional HIT claims should be submitted to the state Local Plan where the service was rendered.

Please note, professional HIT claims that are not submitted to the Local Plan where the service was rendered may be denied and require the provider to resubmit the claim to the correct Plan. If the Provider is not contracted with that Plan, the claim will be considered as out of network and subject to the No Surprises Act.

### **Enteral and Parenteral Nutrition Infusions**

The HCPCS "S" codes for home infusion services are based on a "per diem" reimbursement. The HCPCS "S" codes for enteral and parenteral nutrition home infusion services are based on a "per diem" reimbursement methodology (S9341 – S9343, S9364 – S9368). The per diem includes all supplies, care coordination and professional pharmacy services. The per diem code is billed for each day that a patient receives an infusion and services are rendered in person from the provider. Other nursing services and drug products are billed separately from the per diem.

Reimbursement is allowed separately for the following supplies: ambulatory infusion pumps (E0779-E0781). BCBSWY may allow separate reimbursement for other supplies on a case-by-case basis. Per diems will only be reimbursable when services are rendered in person in the patient's home. Provision of medications and remote support alone is not sufficient for a provider to be eligible for per diem reimbursement.

### **Catheter Care**

Bill catheter care per diems (S5497, S5498, S5501, S5502) when provided as a stand-alone therapy. Insertion by a nurse of a PICC line (S5522) or midline (S5523) is coded separately from the other nursing visit codes and per diems. Supplies required from non-routine catheter procedures such as de-clotting supplies (S5517), repair kits (S5518), PICC insertion supplies (S5520) and midline insertion supplies (S5521) are coded separately.

### **Hydration Therapy**

Bill hydration therapy per diems (S9373-S9377) when provided as a stand-alone therapy.

### **Other Infusion Types**

The HCPCS "G" codes for home infusion services are to be used for billing. Billing for "G" codes includes professional services, including nursing services, furnished in accordance with care coordination, patient training and education, remote monitoring, and monitoring services for the provision of home infusion therapy. Infusion pumps, home infusion drugs, other supplies, are to be billed separately. A "G" code is billed for each day that a patient receives an infusion and services are rendered in person from the provider.

Home infusion therapy (HIT) is billed based upon type: intravenous infusion, subcutaneous infusion, and intravenous chemotherapy or complex drug. Billing for each code type is differentiated based upon "first visit" status. A visit is considered a first visit when it has been at least 60 days since a patient has received *any* home infusion therapy services billed with a "G" code.

All HIT services require at least one non-oral drug or biological to be billed alongside the “G” code. This drug determines the type mentioned above.

| Code  | Description  |                       |
|-------|--|-----------------------|
| G0068 | Administration of Intravenous infusion drug in home                      | General Visit         |
| G0069 | Administration of Subcutaneous infusion drug in home                     |                       |
| G0070 | Administration of Intravenous chemotherapy or other complex drug in home |                       |
| G0088 | Administration of Intravenous infusion drug in home                      | 1 <sup>st</sup> Visit |
| G0089 | Administration of Subcutaneous infusion drug in home                     |                       |
| G0090 | Administration of Intravenous chemotherapy or other complex drug in home |                       |

Services billed with G codes will only be reimbursable when services are rendered in person in the patient’s home. Provision of medications and remote support alone is not sufficient for a provider to be eligible for HIT reimbursement.

### Multiple Therapies

If multiple therapies that would be billed using a per diem S code are done on the same date of service, append the following modifiers to the per diem S codes:

- SH – Second concurrently administered infusion therapy
- SJ – Third or more concurrently administered therapy

Only one G code is reimbursable each day. If two or more home infusion drugs or biologicals from two (or more) different payment categories are administered to an individual concurrently on a single infusion calendar day, one payment.

If both a service billed using a per diem and service billed using a G code are performed on the same day both codes should be submitted. Payment will only be made for the G code.

### Other Payments

Providers who do not render in-person infusions and are not eligible to be reimbursed a per diem or “G” code may still be eligible to be reimbursed for compounding services or for supplies as detailed below.

- **Compounded Drugs** : Compounded Sterile Preparation (CSP) means a preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance.
- BCBSWY will not reimburse for compounding services that are limited to altering a drug product with saline or similar substance.
- Drug Compounding should be billed with S9430. S9430 should be billed per dose of the compounded medication.
- Reimbursement for S9430 includes all professional pharmacy services rendered in relation to providing the compounded medication to the patient.
- **Medical Supplies** : Medical supplies that are consumable, expendable, disposable, or non-durable and that are used for treatment of a patient’s specific illness, injury, may be reimbursed separately using the appropriate HCPCS code.

## Drugs

Code all drugs with a HCPCS or CPT code. If a specific code is not available you may use J3490, J3590, J7799, or J9999. Provide the narrative, NDC number, and dosage/units supplied, in field 24D on the CMS - 1500 form. Use drug units as described in the HCPCS or CPT description of the code.

## Prior Authorization

Prior authorization is not required for home infusion administrative services. However, the infusion medication may require prior authorization. Please review the list of medication and services at [BCBSWY.com/providers/preadmin](http://BCBSWY.com/providers/preadmin) or contact case management to receive benefit information and prior authorization for services.

## Home Based Services

If a product (Examples: Home infusion medications, enteral formula, DME) is shipped to Wyoming, the patient's address must go in box 32 of HCFA 1500 as the service location. Claims should be submitted with Place of Service 12 if shipping to the patient's home.

If a product (Examples: Home infusion medications, enteral formula, DME) is shipped to Wyoming, the rendering provider's office must go in box 32 of HCFA 1500 as the service location. Claims should be submitted with the appropriate Place of Service code for the rendering provider's office.

Taxonomy code must be clearly indicated by appending modifier ZZ in top box of 24I(i) and by entering the taxonomy code above the billing provider NPI in box 24J.

## Hospice Care

Hospice services may include skilled nursing care, personal care aide, medical social services, and counseling/pastoral care. For inpatient hospice services performed in a hospital setting, the allowed amount includes home health care visits and skilled nursing services even if they are provided by a home health agency. All necessary medical equipment, supplies, drugs, and biologicals are also included in the maximum.

Charges related to physician services, outpatient radiation therapy and/or chemotherapy used to control distressing symptoms and illness are covered separately. Other services can be billed separately include enteral feedings, total parenteral nutrition (TPN), and medically necessary diagnostic services.

1. BCBSWY does not reimburse for inpatient hospice services when a member's benefit plan excludes inpatient hospice services.
2. Bereavement counselling and hospice cannot be billed on the same date of services by the same provider.
3. Dates of service on a hospice claim cannot span multiple months.

## Benefit Authorization

All inpatient hospice (Revenue Code 0655 or 0656) requires authorization through our Case Management Department. To obtain an authorization please call 1-307-829-3081. Be aware that not all BCBSWY contracts have an inpatient benefit.

To qualify for the inpatient hospice, benefit the member must meet the following criteria:

1. Prognosis of six months of life or less with hospice certification.
2. Services must be palliative care that cannot be provided by home hospice. Curative care does not qualify.
3. Cannot be for patient convenience e.g. patient has no caregiver.

### Coding

Hospice services should be billed on a UB04 with one of the following Types of Bill.

### Type of Bill Selection

| Type of Bill | Description                          |
|--------------|--------------------------------------|
| 812          | Admission Claim (Nonhospital-Based)  |
| 822          | Admission Claim (Hospital-Based)     |
| 813          | Continuing Claim (Nonhospital-Based) |
| 823          | Continuing Claim (Hospital-Based)    |
| 814          | Discharge Claim (Nonhospital-Based)  |
| 824          | Discharge Claim (Hospital-Based)     |

Revenue codes should be accompanied by an appropriate HCPCS code.

**Please Note:**

Home Hospice and Inpatient Hospice Revenue Codes cannot be billed on the same claim nor on the same day.

The following table highlights the appropriate Procedure/Revenue code combinations.

### Revenue Code Billing

| Revenue Code | Wyoming Description | HCPCS Code |
|--------------|---------------------|------------|
| 0651         | Home Hospice        | Q5001      |
| 0652         | Home Hospice        | BLANK      |
| 0655         | Inpatient Hospice   | Q5006      |
| 0656         | Inpatient Hospice   | Q5006      |

### Coverage From and Through Dates

| Claim Type       | Coverage Date | Wyoming Description                  |
|------------------|---------------|--------------------------------------|
| Initial Claim    | From Date     | Admission Date                       |
| Initial Claim    | Thru Date     | End Date of Services Billed on Claim |
| Subsequent Claim | From Date     | Date After Last Billed Service Date  |
| Subsequent Claim | Thru Date     | End Date of Services Billed on Claim |

The admission date is the date the hospice care began at date of service. (Outpatient/Inpatient) BCBSWY description of dates may differ from other payers including Medicare.

## Condition Code

| Condition Code | Description   |
|----------------|---|
| BLANK          | Use for initial claims submission   |
| D0             | Use for correction of from date referred to by Medicare as the election date<br><b>*This can only be billed with occurrence code 56</b> |

## Occurrence Codes and Dates

An occurrence code of 27 is required with the date of admission. The date of admission must match the from date on the claim.

An occurrence code of 56 may be used on claim where there is a correction of the from date referred to by Medicare as the election date. **\*This can only be billed with condition code D0.**

## Medicare Considerations

For claims where Medicare is secondary and inpatient hospice is not a benefit of BCBSWY the provider is required to bill using the following code combination: Revenue Code 0659, HCPCS A9270, and a GY modifier.

If you are submitting a secondary claim the bill charges must be the same as shown on the EOMB. In order to be reimbursed for G0337 providers must bill on a HCFA 1500.

## Hospital Acquired Conditions /Preventable Medical Errors

Never Events are adverse events or errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. Never Events include Hospital Acquired Conditions (HACs) and preventable medical errors.

BCBSWY will review claims with a diagnosis identified in claims processing as a HAC. Medical records will be requested if necessary. If, after review, it is determined that the HAC was caused by treatment received at the facility, BCBSWY will adjust payment on the claim accordingly.

If extra days are found to be as a result of the HAC, BCBSWY will not pay for those extra days.

## Incident To Billing

Except as specified below, BCBSWY does not permit credentialed physicians to submit claims on behalf of other non-credentialed or non-physician practitioners (NPPs).

NPPs who are eligible to receive their own National Provider Identification (NPI) and who are credentialed must submit their claims directly to BCBSWY under their own NPI.

BCBSWY does not permit the usage of modifiers CO (Occupational Therapy Assistant) or CQ (Physical Therapy Assistant).

### Provisionally Licensed/Residents

BCBSWY does not credential provisionally licensed Providers or Residents until they are fully licensed. Claims would not be recognized for those providers until credentialing is fully complete. Claims should be submitted under the supervising provider NPI until fully licensed.

### Locum Tenens

BCBSWY is not always contracted with locum tenens or substitute providers. For services provided in the first 180 calendar days of a locum tenen's tenure, claims should be submitted with the established physician's NPI and a Q6 modifier. For services beyond the 180th day, claims must be submitted under the locum tenen's NPI.

## Lab Bundling

When a Provider performs all tests listed in a Multi-test Laboratory Panel, the provider bills the appropriate CPT code for the panel. Reimbursement for a Multi-test panel will be based on the number of tests in the panel.

When only a portion of the tests included in a panel are performed, reimbursement for those individual tests will be allowed based on the number of tests performed.

The reimbursement for the individual test will be made based on an allocation of the maximum allowable amount for the number of tests billed.

Allowances for individual tests will vary based on the number of bundled tests billed. The total reimbursement for the individual tests may not exceed the maximum allowable amount for the number of tests performed.

## Breast Pumps

### Breast Pumps

When breast pumps are covered, the reimbursement for services is based on the Maximum Allowable Amount for each HCPCS code listed below:

| HCPCS Code | Description                     |
|------------|---------------------------------|
| E0602      | Breast Pump, Manual, Any type   |
| E0603      | Breast Pump, Electric, Any type |

Reimbursement is allowed only with a physician's prescription or with documentation of a pending or recent birth for the patient filing the claim. Only purchase of new devices is allowed. Rental devices are not covered unless there is documentation of medical necessity for a particular patient (see Medical Policy for criteria).

Reimbursement is based on the lower of the Maximum Allowable Amount or the charge submitted on the claim.

Subject to medical necessity and medical management approval, reimbursement may be made on the following codes:

| Code Type | Number      | Brief Description  | Policy Instructions     |
|-----------|-------------|--|-------------------------|
| HCPCS     | A4281-A4286 | Accessories, Breast Pump                                       |                         |
| HCPCS     | E0604       | Breast Pump, Hospital Grade, electric (AC and/or DC, any type. | Prior Approval Required |

## Laboratory Services

### Ancillary Claims Filing

Independent Clinical Laboratories should file claims to the local Plan. The local Plan, as defined for laboratory services, is the Plan in whose service area the specimen was drawn based on the location of the referring provider.

### Blood Collection/Venipuncture (CPT 36415/36416, 36591/36592 and S9529)

- CPT 36415/36416, 36591/36592 and S9529 will be reimbursed when blood is specifically collected to send out to an independent or reference laboratory.
- If any test is performed on the sample(s) in the Provider's office the blood collection/venipuncture will be denied as included in the reimbursement for the laboratory procedure performed.
- Only one 36415/36416 will be reimbursed per day from the same Provider.
- This is not a guarantee of reimbursement as all procedures are based on Member eligibility and benefit.
- When more than one venipuncture procedure code is billed by the same provider on the same date of service payment will be made on only one code. The remaining codes will deny as included in as follows:
  - 36416, 36591, 36592, and S9529 are included in 36415
  - 36416, 36591, and 63592 are included in S9529
  - 36591 and 36592 are include in 36416 per CCI
  - 36591 is included in 36592 per CCI

#### **Handling Charges (CPT 99000/99001)**

- CPT 99000/99001 will be reimbursed if a sample is being sent out to an independent or reference laboratory.
- These codes will be denied as included if the sample(s) were drawn for testing only at the Provider's location.
- Only one 99000/99001 will be reimbursed per day from the same Provider.
- This is not a guarantee of reimbursement as all procedures and tests are based on Member eligibility and benefit.

## Physical Medicine and Massage Therapy

### **Physical Medicine**

For physical medicine services (97010-97150, 97530-97546, 98925-98929, and 98940-98943) to be reimbursable, the following must be documented:

- The therapy must be of a skilled nature and require the services of a skilled provider.
- Services performed must achieve a specific diagnosis-related goal.

### **Massage Therapy**

BCBSWY will not reimburse for massage therapy services (97124) when billed with other physical medicine procedures.

Regardless of any modifier, massage therapy will be denied as provider liable when performed on the same date of service with physical medicine procedures.

| Code | Denial | To Codes |
|------|--------|----------|
|------|--------|----------|

|       |                 |   |
|-------|-----------------|---|
| 97124 | Provider Liable | 97110, 97112-97113, 97116, 97139-97140, 97150, 97530, 97533, 97535, 97537, 97542, 97545-97546, 98925-98929, 98940-98943 |
|-------|-----------------|---|

Reimbursement for massage therapy services provided without a physical medicine therapy is subject to the member's benefit plan. Some benefit plans may not cover this service.

## Sick and Well

### **Preventive (Well) visits accompanied by problem-focused (Sick) visits**

When a preventive visit (99381-99387, 99391-99397 or G0402) is completed on the same day as a problem-focused visit (99202-99215, 99218-20, 99224-99226) the provider should append a -25 modifier to the problem-focused visit to indicate that a significant, separately identifiable evaluation and management service occurred.

Documentation should clearly support a separate problem-oriented service. A non-routine diagnosis code must be submitted with the problem-oriented service.

Reimbursement will be made for both a preventive visit and a problem-focused visit on the same day by the same performing Provider when the problem-focused visit is billed with a modifier -25.

A problem-oriented code with a modifier -25 should **not** be billed for the following encountered during a preventive visit:

- Insignificant or trivial problems encountered during a preventive exam.
- Routine services like the refilling of a prescription.

## Surgical

To ensure more timely and accurate processing of surgical claims, it is important that Providers submit claims using the guidelines in this document.

BCBSWY uses the National Correct Coding Initiative (NCCI) when determining bundling, modifier usage, the use of surgical assistants, and other matters related to surgical reimbursement.

### **Bundling**

- Bundling is determined according to the Medicare Correct Coding Initiative (CCI) and is reviewed prior to applying any adjustments documented in this policy. Procedures are frequently included in the global value of other procedures. Listing of separate codes is not appropriate when a procedure is included in the global value of another. If a procedure is included in the global value of another billed code, the procedure will be denied as provider liable.

### **Bilateral Procedures**

- Bilateral procedures must be billed on one line and identified with a modifier -50. The profile for this line is automatically increased to 150% of the single procedure's Profile. This is applied prior to any Multiple Surgical Reductions that may apply. Each bilateral procedure line is considered a single procedure for the purposes of determining and applying the Multiple Surgical Reduction. If billed separately on two lines, the second procedure will be denied as a duplicate.

- The modifier –50 must be listed in the first position if multiple modifiers are billed.

### Multiple Surgical Reductions

- Multiple surgical reductions are determined based on the lesser of the Profile or the provider's charges for each procedure billed (Benefit Base). The Maximum Allowable Amount for the Primary procedure is 100% of the Profile. For any allowed additional procedures, after the Primary procedure, the Maximum Allowable Amount is reduced to 50% of the Profile.
- **The Primary procedure is the procedure with the greatest Benefit Base (the lesser of the profile or the provider's charge). If there is more than one code with the same Benefit Base, the rank will be determined based on the order in which each line item appears on the claim.**

### Add-On Codes

- Add-on codes must be billed in conjunction with the primary code and are not subject to multiple surgical guideline reductions. Profiles for these procedures have already been reduced to reflect multiple surgical reductions. The Maximum Allowable Amount for procedures that are identified as Add-On Codes will be 100% of the Profile.

### Multiple Endoscopy Reductions

- When multiple endoscopic procedures are performed, related procedures are organized into family groupings of procedures, and the Maximum Allowable Amounts are reduced prior to other applicable Multiple Surgical Reductions. Procedures are considered in the same family grouping if they have the same base code. The basis to determine which procedures and associated base codes are subject to multiple endoscopy reductions is the National Physician Fee Schedule Relative Value File from the Federal Register. Actuary uses appropriate gap filling methodologies, where they determine necessary, to supplement this source.
- Within each family grouping, the Maximum Allowable Amount for each procedure is determined as follows:
  - *Primary Procedure Code:* Maximum Allowable Amount is the Profile amount. The Primary Procedure Code is the procedure code with the greatest Benefit Base. If there is more than one code with the same Benefit, the rank will be determined based on the order in which each line item appears on the claim.
  - All other related procedure codes: Maximum Allowable Amount is the difference between the related code's Profile and the base code's Profile. If the Profile for the base code is greater than or equal to the Profile for the related code, the Maximum Allowable Amount for the related code will be 0.
- The Maximum Allowable Amount for the family grouping is the sum of the procedure code level Maximum Allowable Amounts. If the claim includes other surgical procedure codes or other multiple endoscopy families, the family grouping is considered a single procedure for the purposes of determining and applying the Multiple Surgical Reduction.

### Other Modifiers Affecting Surgical Reimbursement

- The descriptions below assume that there is no multiple surgery reduction within a given claim. Where there is, the multiple surgery rules are applied before the modifier adjustments. In such cases, the percentages described below would not necessarily refer to the Profile. They would instead refer to the Maximum Allowable Amount as determined by the multiple surgery rules.

### **Modifier -22 (Increased Procedural Services):**

- Procedures, billed by a physician, that indicate the work required was substantially greater than typically required are identified with a modifier -22. Generally, there is no additional reimbursement for modifier -22. However, Medical Review Staff, at their discretion, may review records on a case-by-case basis.

### **Modifier -53 (discontinued Procedure):**

- The Maximum Allowable Amount for Discontinued Procedures (-53) identified with modifier -53 will be 70% of the Profile.

### **Modifiers -54, -55, 56 (Portion of Surgical Service):**

- Procedures where only a portion of the surgical service is performed are identified with modifiers -54, -55 or -56 may be reimbursed:
  - **Modifier -54 (Surgical Care Only)**
  - **Modifier -55 (Postoperative Management Only)**
  - **Modifier -56 (Preoperative Management Only)**

### **Modifier -62 (Co-Surgeons):**

- Procedures reported by physicians to indicate that two physicians worked together as primary surgeons performing distinct part(s) of a procedure may be reimbursable.

### **Surgical Assistants**

Providers are eligible for reimbursement when providing surgical assist services for procedures which are of such complexity that they require a surgical assistant. If CCI does not support a surgical assistant, charges submitted will be denied as a Provider liability. When appropriate, a surgical assistant should bill as follows:

- **Assistant Surgeon (modifier –80)** – reported by physicians only to indicate the physician provided surgical assistant services for a particular procedure.
- **Minimum Assistant Surgeon (modifier –81)** – reported by physicians only to indicate that a physician provided minimal surgical assistance when another surgeon’s presence is not typically required for the entire procedure.
- **Teaching Facility Only, Qualified Resident Not Available (Modifier -82)** - reported by licensed surgical assistant in a teaching facility when a qualified resident is not available.
- **Assistant -at -Surgery Service (modifier –AS)** – reported by licensed surgical assistants (physician assistant, nurse practitioner, clinical nurse specialist, etc.) to indicate surgical assistant services were provided for a particular procedure.

### **Other modifiers**

When appropriate, Providers should utilize modifiers such as:

- Reduced Services (modifier -52)
- Discontinued Procedure (modifier -53)
- Surgical Care Only (modifier -54)
- Postoperative Management Only (modifier -55)
- Preoperative Management Only (modifier -56)
- Distinct Procedural Service (modifier -59)

The above is only a partial list. Providers may wish to use NCCI to determine whether or not a particular modifier is appropriate and what specific documentation may be necessary.

### Medicare CCI

- Medicare CCI is used to determine whether reimbursement for a surgical assistant is appropriate. Reimbursement is only appropriate in the first two cases below:
  - **Medicare CCI “Allowed”** - If the Medicare CCI indicates that a surgical assistant is allowed, documentation is not necessary.
  - **Medicare CCI “Allowed with Documentation”** - If the Medicare CCI indicates a surgical assistant is only allowed with documentation, the provider must submit an operative note which documents the assistant’s role in the surgery. Medical Review determines if the documentation supports the use of the assistant.
  - **Medicare CCI “Assistant Not Allowed:** - If the Medicare CCI indicates a surgical assistant is not allowed, there will be no reimbursement made and charges will be the provider’s liability.
  - NOTE: Multiple surgical assistants are rarely appropriate. Further, where co-surgeons are utilized, it is rare that any assistant is necessary. There will be no reimbursement for a second surgical assistant, nor for any surgical assistant in conjunction with co-surgeons.

### Telemedicine

BCBSWY encourages the use of medically appropriate telemedicine by our network providers to improve access to care for our members. Reimbursable telemedicine is a real-time interactive face-to-face service that may involve a store and forward component.

Reimbursable telemedicine services are professional office, outpatient, or inpatient services that are medically appropriate to be rendered at a distance, and within the provider’s scope of practice. Eligible providers must be licensed in Wyoming and provide the same standard of care as in-person encounters. Controlled substance prescribing and general principles of appropriate prescribing for purposes of telemedicine must adhere to prescriptive practices standards as outlined by the Wyoming Board of Pharmacy. Medical records must be maintained for each encounter with an assessment and treatment plan as would be entered for an in-person encounter. The medical record should document that a telemedicine visit was consented to by the member, claim submission for provider reimbursement will occur and additional/alternative services may be required to provide the necessary level of care.

Only those services currently reimbursable in an office, outpatient, or inpatient setting will be allowed for payment. No provider-to-provider consultations, such as telephone consultations will be reimbursed. Store and forward is the transmission of pre-recorded video or photographic information. Store and forward is not independently reimbursable.

Reimbursable telemedicine services are professional office, outpatient, or inpatient services that are

medically appropriate to be rendered at a distance.

Telemedicine can be used directly to an established patient's home or other remote non-clinical locations.

- Services must be medically appropriate to be rendered at a distance.
- Provider-to-provider consultations are not reimbursable.

Reimbursable telemedicine services shall not have originating and distant sites in the same physical facility.

Telecommunications technologies must comply with applicable federal and state legal requirements of health/medical information privacy, including compliance with HIPAA.

### **Billing**

Professional services are paid to the consulting/distant provider.

- Modifier 95 or GT identifies the telemedicine service
- Place of Service Code 02

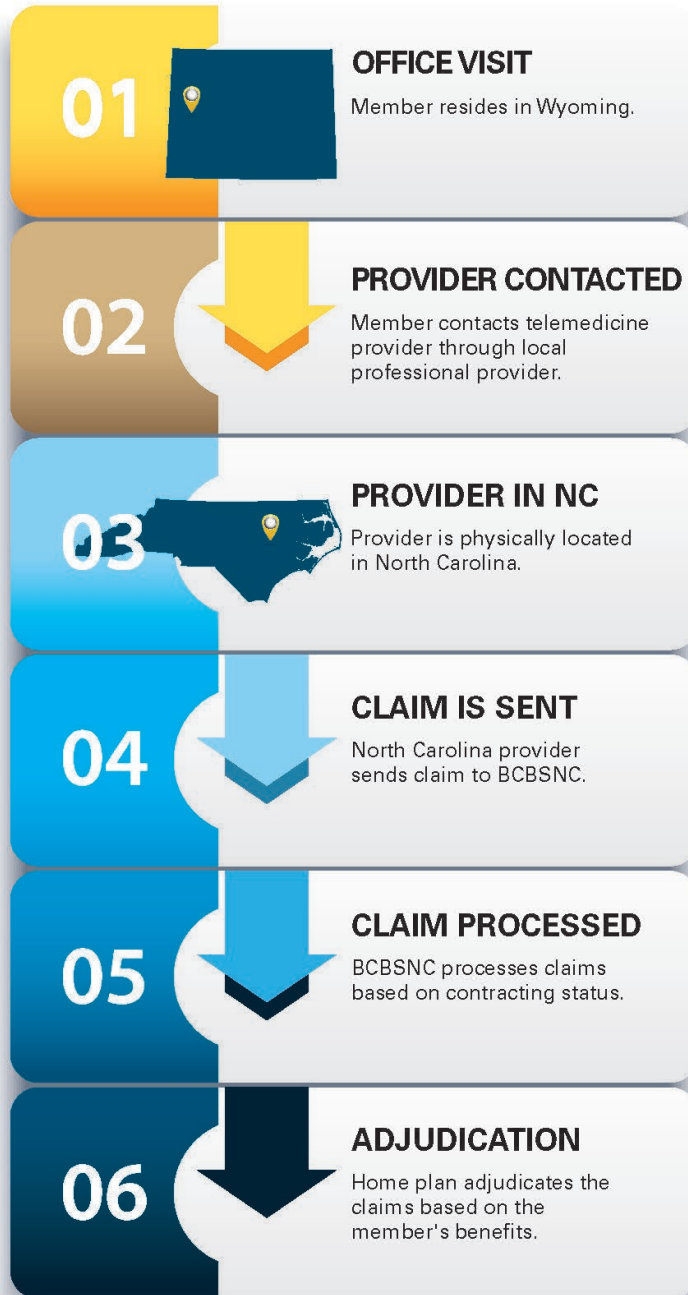
The originating site will not be reimbursed for professional services rendered via telemedicine.

The distant site will not be reimbursed for the telemedicine originating site fee (HCPCS Q3014). Provider must use a CMS 1500 or 837P claim.

### BlueCard Rules

The provider rendering medical services via telemedicine **must submit claims to the Plan in whose Service Area the Provider is physically located** when performing the services. Distance site providers **must be contracted and credentialed in the state they are located, unless employed by an in state contracted Provider**, for the telemedicine visit to be considered in-network.

### EXAMPLE



## Section 5

## Claim Processing

Participating Providers are encouraged to submit claims electronically through Availity, our electronic claims clearinghouse. The Availity portal also lets Providers do the following:

- View institutional and professional claims;
- View claim status;
- View Member eligibility & benefits;
- Verify Coordination of Benefit information;
- View and print electronic payment listings.

If claims cannot be filed electronically, Providers must submit claims on forms approved by the Center for Medicare and Medicaid Services (CMS) and the Uniform Billing Committee of claims, to assess the quality of care, or as required by applicable state and federal authorities.

**As outlined in the Provider contract, Participating Providers agree to the following responsibilities for the submission of claims.**

1. Charges for Covered Services provided to a Member will not exceed the regularly established charges made to the general public for the same services.
2. Not submit claims containing pass-through billing items.
3. Submit claims for Covered Services on behalf of the Member in a timely manner.
4. Upon request, Provider agrees to provide any documentation necessary to support the information contained in the Claim.
5. Allow BCBSWY or its duly authorized agent, to examine and reproduce Provider's records to the extent reasonably necessary for the purposes of verifying the claims for
6. Covered Services, provided that it does so only upon reasonable notice and during normal business hours. All such audits will be conducted in compliance with federal and state laws governing the right of privacy and confidentiality of patient records. BCBSWY shall also have the right to perform post-payment reviews of Provider's records related to all claims filed.

### Clean Claim Policy

Blue Cross Blue Shield of Wyoming requires all Providers to submit clean claims to the plan. Clean Claim format is defined below as follows:

- Claim is submitted on an acceptable claim form or electronically with all required fields completed with accurate and complete information.
- Claim is submitted with accurately lined text.
- Services are eligible, provided by an eligible Provider, and provided to a person with coverage.
- Claim has no material defect or impropriety, including, but not limited to any lack of required substantiating documentation or incorrect coding including new CCI coding requirements.

- There is no dispute regarding the amount claimed.
- The payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation.
- Claim does not require special treatment or review on regular basis.

### **Professional/Institutional Providers (1500 / UB04)**

Claims should include basic information with specific emphasis on the following fields:

- Sex
- Revenue, CPT or HCPCS codes as applicable
- Charge information and units
- ID qualifier code (ZZ)
- Taxonomy code
- Rendering Provider's (type 1/individual) National Provider Identifier (NPI)
- Billing Provider's name, address (type 2/group) National Provider Identifier (NPI)
- Accident date and qualifier (if applicable)
- Ambulance pickup zip code (if applicable)
- Four-digit zip code extension on all addresses

### NCCI Coding Edits

The National Correct Coding Initiative (NCCI) uses a standardized set of claims processing code edits that form uniform national standards to assure accurate billing and claims payment. The BCBSWY system is compliant with NCCI edits and Provider claims must follow the NCCI standards.

Claims that do not follow NCCI edits will reject from the system and will be denied.

### Grace Period

The Affordable Care Act (ACA) requires a 90-day grace period for certain Members who purchased their health plan on the Health Insurance Marketplace. This grace period applies after the individual has paid at least one month's premium within the benefit year and the next payment is not received by the due date for the following month.

In cases when the Member has become delinquent on their premium, BCBSWY will take the following steps, as defined by the ACA:

- BCBSWY will process claims for services received during the first month (30 days) of the grace period.
- BCBSWY will pend claims for services received during the second and third months of the grace period until the full premium for the 90-day grace period is received. Providers will be notified that the claim cannot be paid until the premium is received. The notification will also inform Providers of the possibility of denied claims if the premium is not received by the end of the three-month (90 days) grace period. If the full premium is received, claims will automatically be processed. Providers will not need to resubmit the claims.
- After the third month (90 days) without full payment of premium, the Member's health

plan will be cancelled, and the pended claims will be denied. The Member will be responsible for payment of services received during this time. BCBSWY will not retract payment for dates of service within the first month of the grace period.

- BCBSWY will notify Members about unpaid premiums and grace period status by sending a delinquent premium letter as well as including a notation on their Explanation of Benefits.
- Grace period provisions may apply to certain BlueCard Members.
- Prescription drug benefit claims submitted during the second and third months will be rejected.
- If you have a prior authorization determination notification that states a Member is currently in a grace period, please call BCBSWY Member services to verify the Member status.

## Third-Party Premium Payments

This policy applies to fully insured commercial lines of business, including individual/family plans and group plans. It does not apply to government program plans, including Medicare Supplemental plans or FEP.

Blue Cross Blue Shield of Wyoming will only accept premium payments from the policyholder (group or individual), a family member of the insured, or entities from whom we are required by law to accept premium payments.

Blue Cross Blue Shield of Wyoming will accept third-party payment for premium directly, as required by federal law, from the following entities:

- The Ryan White HIV/AIDS program under title XXVI of the Public Service Act;
- Indian Tribes, tribal organizations or urban Indian organizations; and
- State and Federal Government programs.

BCBSWY may choose, in its sole discretion, to allow payment from not-for-profit foundations, provided those foundations meet non-discrimination requirements and pay premiums for the full policy year for each of the Covered Individuals at issue.

BCBSWY may choose, in its sole discretion, to accept premium payments from third parties but only when each of the following criteria have been demonstrated:

- The third-party payer is not a Health Care Provider, Supplier, Facility or Clinic; and
- The third-party payer is not an employer seeking to pay or paying premiums on behalf of members enrolled or seeking to enroll in an individual/family plan (excluding a self-employed individual paying for his/her own coverage); and
- The third-party payer does not have any direct or indirect financial interest in the payment of the premium.

BCBSWY has the discretion to reject payments from third-party payers in accordance with law.

## Process for Submitting a Claim Denied for No Authorization

If a claim is denied for lack of authorization, BCBSWY permits a retro authorization. To submit a retro authorization follow the same steps as a [prior authorization](#), except notify BCBSWY of the claim impacted by providing BCBSWY with an adjusted claim form, include the claim number or a copy of your remittance advice (indicate claim in question).

### Helpful Hints:

- FEP will reduce Member benefits if prior authorization is not pre-approved prior to the service or admission.
- FEP does not permit retroactive authorizations for Residential Treatment Facility or Skilled Nursing Facility/Center.

**Note, retro authorization processes may be different for BlueCard claims.**

## 1500 Form Required Fields

The following table explains the various **REQUIRED** fields of the paper CMS-1500 form. The numbers correspond to those on the CMS-1500 02/12 claim form. Supplemental and voluntary information fields are labeled **NOT REQUIRED**.

In addition to completing the required fields, please format your paper claims according to the [Tips for Submitting OCR claims guideline](#). Required fields on an electronic claim may vary. Consult with your vendor or Availity to confirm required fields for electronic transactions.

| Field No. | Field Name   | Explanation  |
|-----------|--|--|
| 1a        | Insured's ID Number                                | Enter the Member's BCBS number as it appears on the identification card.   |
| 2         | Patient's Name                                     | Enter the patient's name.  |
| 3         | Patient's Birth Date and Sex                       | Indicate the month, day and year of birth and check the appropriate box.   |
| 4         | Insured's Name                                     | Enter the Member's name as it appears on the identification card.  |
| 5         | Patient's Address                                  | NOT REQUIRED   |
| 6         | Patient Relationship to Insured                    | Check the appropriate box for relationship of patient to the Member.   |
| 7         | Insured's Address                                  | NOT REQUIRED   |
| 8         | Reserved for NUCC Use                              | NOT REQUIRED   |
| 9         | Other Insured's Name                               | NOT REQUIRED   |
| 10        | Is Patient's Condition Related to:                 | Check the appropriate box if the Member's condition is related to employment or an auto accident, or check "other" if appropriate. |
| 11        | Insured's Policy Group or FECA Number              | NOT REQUIRED   |
| 12        | Patient's or Authorized Person's Signature         | NOT REQUIRED   |
| 13        | Insured's or Authorized Person's Signature         | NOT REQUIRED   |
| 14        | Date of Current Illness/Injury/or Pregnancy        | Enter the date (month, day, year) the Member became injured. Required for primary diagnosis in the 800-999 range.                  |
| 15        | Other Date   | If an Accident Date needs to be reported, enter the date along with qualifier "439."   |
| 16        | Dates Patient Unable to Work in Current Occupation | NOT REQUIRED   |

|                  |   |   |
|------------------|---|---|
| 17               | Name of Referring Physician or Other Source | NOT REQUIRED  |
| 17a              | Blank                                       | NOT REQUIRED  |
| 17b              | NPI   | Enter the National Provider Identifier (NPI) number of the referring, ordering or supervising Provider. |
| <b>Field No.</b> | <b>Field Name</b>                           | <b>Explanation</b>  |

|     |  |  |
|-----|--|--|
| 18  | Hospitalization Dates Related to Current Services                                      | NOT REQUIRED   |
| 19  | Additional Claim Information   | REQUIRED FOR NOC/NOS CODES   |
| 20  | Outside Lab  | NOT REQUIRED   |
| 21  | Diagnosis or nature of illness or injury which relates to the service line below (24E) | Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Specify the ICD codes. This should include no more than twelve diagnosis codes as indicated on the form. Enter up to twelve diagnosis codes in order of priority using the degree of specificity. |
| 22  | Resubmission Code  | NOT REQUIRED   |
| 23  | Prior Authorization Number   | Prior Authorization Number NOT REQUIRED. Leave blank, or if applicable enter the prior authorization number given to you. The 5-digit point of pick-up ZIP code is required on all ambulance claims. The ZIP code must be reported in item 23 on the 1500 claim form.                          |
| 24a | Date of Service  | Enter the month, day and year for each service. If you are providing the same level or medical care for consecutive dates, include the from/to dates.  |
| 24b | Place of Service   | Enter the appropriate place of service code.   |
| 24c | EMG (emergency)  | NOT REQUIRED   |
| 24d | Procedures, Services or Supplies   | Describe the services rendered using current CPT, HCPCS or ASA procedure codes. Attach reports when billing unlisted procedure codes.  |
| 24e | Diagnosis Pointer  | Enter the appropriate letter identifier that corresponds to the appropriate diagnosis for the service performed.   |
| 24f | Charges  | Enter the charge for the service performed.  |
| 24g | Days or Units  | Enter the number of units for the service provided. Enter time in minutes as the units for Anesthesia services. For ambulance mileage round to the nearest tenth of a mile.  |
| 24h | EPSDT/Family Plan  | NOT REQUIRED   |
| 24i | ID Qualifier   | NOT REQUIRED   |
| 24j | Rendering Provider Number  | Enter the individual (type 1) NOP or the rendering Provider in the bottom portion of 24j.  |
| 25  | Federal Tax ID Number  | Enter the Tax ID number of the billing Provider.   |
| 26  | Patient's Account Number   | NOT REQUIRED   |
| 27  | Accept Assignment  | NOT REQUIRED   |

|    |                        |  |
|----|------------------------|--|
| 28 | Total Charge           | Total charge for the services. Enter 00 in the cents area if the amount is a whole number. |
| 29 | Amount Paid            | NOT REQUIRED   |
| 30 | Reserved for NUCC Use  | NOT REQUIRED   |
| 31 | Signature of Physician | Enter the name of the Provider or indicate signature is on file.                           |

| Field No. | Field Name                                | Explanation  |
|-----------|---|--|
| 32        | Service Facility Location                 | Enter the address where the service was rendered.  |
| 32a       | Service Facility Location Information-NPI | NPI of service facility location. The NPI of the location where services were provided must be included. |
| 33        | Billing Provider Info                     | Enter the name, address and telephone number of the billing Provider.                                    |
| 33a       | Billing Provider NPI                      | Enter the organizational (type 2) NPI.   |

## UB04 Required Fields

The UB-04 claim form, also known as the CMS-1450 form, is approved by the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee for facility and ancillary paper billing.

The following table explains the various **REQUIRED** fields of the paper UB-04 claim form.

| Field No. | Description               | Inpatient               | Outpatient   |
|-----------|---------------------------|-------------------------|--------------|
| 1         | Provider Name and Address | Required                | Required     |
| 2         | Pay-To Name and Address   | NOT REQUIRED            | NOT REQUIRED |
| 3a        | Patient Member Number     | NOT REQUIRED            | NOT REQUIRED |
| 3b        | Medical Record Number     | NOT REQUIRED            | NOT REQUIRED |
| 4         | Type of Bill              | Required                | Required     |
| 5         | Federal Tax ID Number     | Required                | Required     |
| 6         | Statement Covers Period   | Required                | Required     |
| 7         | Future Use                | N/A                     | N/A          |
| 8a        | Patient ID                | Required                | Required     |
| 8b        | Patient Name              | Required                | Required     |
| 9a-e      | Patient Address           | Required                | Required     |
| 10        | Patient Birthdate         | Required                | Required     |
| 11        | Patient Sex               | Required                | Required     |
| 12        | Admission Date            | Required                | Required     |
| 13        | Admission Hour            | Required                | NOT REQUIRED |
| 14        | Type of Admission/Visit   | Required                | NOT REQUIRED |
| 15        | Source of Admission       | Required                | NOT REQUIRED |
| 16        | Discharge Hour            | Required                | NOT REQUIRED |
| 17        | Patient Discharge Status  | Required                | NOT REQUIRED |
| 18-28     | Condition Codes           | Required, if applicable | NOT REQUIRED |
| 29        | Accident State            | NOT REQUIRED            | NOT REQUIRED |

|       |                                    |                         |                         |
|-------|------------------------------------|-------------------------|-------------------------|
| 30    | Future Use                         | N/A                     | N/A                     |
| 31-34 | Occurrence Codes and Dates         | Required, if applicable | Required, if applicable |
| 35-36 | Occurrence Span Codes and Dates    | NOT REQUIRED            | NOT REQUIRED            |
| 37    | Future Use                         | N/A                     | N/A                     |
| 38    | Responsible Party Name and Address | Required                | Required                |
| 39-41 | Value Codes and Amounts            | Required, if applicable | NOT REQUIRED            |
| 42    | Revenue Code                       | Required                | Required                |
| 43    | Revenue Description                | Required                | Required                |
| 44    | HCPCS/Rates                        | Required, if applicable | Required, if applicable |
| 45    | Service Date                       | NOT REQUIRED            | Required, if applicable |
| 46    | Units of Service                   | Required                | Required                |
| 47    | Total Charges (by Revenue Code)    | Required                | Required                |

| Field No. | Description                                    | Inpatient               | Outpatient              |
|-----------|--|-------------------------|-------------------------|
| 48        | Non-Covered Charges                            | NOT REQUIRED            | NOT REQUIRED            |
| 49        | Future Use                                     | N/A                     | N/A                     |
| 50        | Payer Name                                     | Required                | Required                |
| 51        | Health Plan ID                                 | NOT REQUIRED            | NOT REQUIRED            |
| 52        | Release of Information Certification           | Required                | Required                |
| 53        | Assignment of Benefit Certification            | Required                | Required                |
| 54        | Prior Payments                                 | Required, if applicable | Required, if applicable |
| 55        | Estimated Amount Due                           | Optional                | Optional                |
| 56        | NPI  | Required                | Required                |
| 57        | Other Provider IDs                             | NOT REQUIRED            | NOT REQUIRED            |
| 58        | Insured's Name                                 | Required                | Required                |
| 59        | Patient's Relation to the Insured              | Required                | Required                |
| 60        | Insured's Unique ID                            | Required, if applicable | Required, if applicable |
| 61        | Insured's Group Name                           | Required, if applicable | Required, if applicable |
| 62        | Insured's Group Number                         | Required, if applicable | Required, if applicable |
| 63        | Treatment Authorization Codes                  | Required, if applicable | Required, if applicable |
| 64        | Document Control Number                        | Optional                | Optional                |
| 65        | Employer Name                                  | NOT REQUIRED            | NOT REQUIRED            |
| 66        | Diagnosis/Procedure Code Qualifier             | NOT REQUIRED            | NOT REQUIRED            |
| 67        | Principal Diagnosis Code/Other Diagnosis Codes | NOT REQUIRED            | Required                |
| 68        | Future Use                                     | N/A                     | N/A                     |
| 69        | Admitting Diagnosis Code                       | Required                | NOT REQUIRED            |
| 70        | Patient's Reason for Visit Code                | NOT REQUIRED            | Required                |
| 71        | PPS Code                                       | NOT REQUIRED            | NOT REQUIRED            |
| 72        | External Cause of Injury Code                  | Required, if applicable | Required                |
| 73        | Future Use                                     | N/A                     | N/A                     |
| 74        | Principal Procedure Code/Date                  | Required, if applicable | NOT REQUIRED            |
| 75        | Future Use                                     | N/A                     | N/A                     |
| 76        | Attending Provider Name/NPI                    | Required                | Required                |

|       |                              |                         |                         |
|-------|------------------------------|-------------------------|-------------------------|
| 77    | Operating Physician Name/NPI | Required, if applicable | Required, if applicable |
| 78-79 | Other Provider Name/NPI      | Required, if applicable | Required, if applicable |
| 80    | Remarks                      | Required, if applicable | Required, if applicable |
| 81a-e | Code-Code Field              | Required, if applicable | Required, if applicable |
|       | B3 Taxonomy Code Qualifier   | Required                | Required                |

## Coordination of Benefits

Coordination of Benefits can be a complicated issue and is one of the top reasons for overpayments to Providers. In order to assist you with determining primary and secondary coverage, we have listed some general guidelines. Should you have questions regarding coverage, contact the Plan who issued the coverage *prior to* filing a claim for services. Coordination of Benefit denials occur when Member information is not current with BCBSWY.

Use the rule that most accurately applies to the situation:

### Rule # 1- Dependent or Non-Dependent

- The Plan that covers the person other than as a dependent, for example as an employee, Member, subscriber, or retiree is primary. The Plan that covers the person as a dependent is secondary.

### Rule # 2 - Child Covered Under More Than One Plan:

- The primary Plan is the Plan of the parent whose birthday is earlier in the year if:
  - The parents are married; or
  - The parents are not separated; or
  - A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage; or
  - If both parents have the same birthday, the Plan that has covered either of the parents longer is primary.

If you have any questions regarding coordination of benefits for a BCBSWY Member, please contact our Member Services department at 1-800-442-2376.

## Payment Methodology

The following guidelines can also be found in your Provider contract and outline Maximum Allowable Amount, balance billing, and Member cost share. Providers agree to the following:

- Accept as payment in full from BCBSWY the lesser of Provider's charges or the Maximum Allowable Amount, minus any Cost Sharing Amounts, for Covered Services.
- Agree not to charge Participants any amounts in excess of the reimbursement amount. Provider may still bill the Member for Non-covered Services and Cost Sharing Amounts identified as billable on the payment summary provided by BCBSWY.
- Agree not to routinely waive or otherwise forgive, write-off, or fail to charge Member for any Cost Sharing Amounts. Provider shall make reasonable efforts to collect Cost

Sharing Amounts from Member. This provision shall not prohibit the Provider from accepting a lesser amount in individual hardship cases, or where the Provider offers a prompt payment incentive discount.

- Provider shall not seek payment for Covered Services from a Member where Provider has not been paid for said Covered Services due to BCBSWY's insolvency, breach of contract, or the termination of the provider contract by either party for any reason. This provision does not prohibit the Provider from collecting Cost Sharing Amounts or fees for Non-covered Services. In the case of BCBSWY's insolvency, services for a Member shall continue for the period for which premium payments have been made.
- Provider shall not be eligible for reimbursement for Covered Services rendered during any period of time that the Provider's license, registration or certification is suspended or revoked.
- In the event Provider identifies an overpayment by BCBSWY, notify BCBSWY of such overpayment, and hold the funds pending direction from BCBSWY. When notifying BCBSWY of an overpayment, Provider should provide as much information as is available to facilitate investigation of the overpayment and any coordination of benefits by BCBSWY with other insurance. BCBSWY may, in addition to any other remedy, cover the same by offsetting the amounts overpaid against current and future amounts due and/or seek refund from the Provider.
- Immediately refund a Member any sum the Member pays in error and/or in excess of Participant's Cost Sharing Amounts.
- Inform BCBSWY when a Member may be eligible for coverage from another payor including, but not limited to, a different health plan, liability insurer, worker's compensation or occupational disease coverage, Medicare or other government programs. Provider will further use its best efforts to collect payment from third-party payors first, using its customary collection procedures, whenever such payors have primary responsibility to pay for Covered Services in accordance with the coordination of benefits and third-party liability requirements of the Member's Benefit Document.
- Providers should use their best efforts to identify whether the injury or illness for which a Member is receiving Covered Services is related to or caused by the Member's employment or by accidental means. Once identified, the Provider agrees that it will appropriately notify BCBSWY of such a circumstance through proper coding of the Claim on the claim form submitted to BCBSWY.

## Submission of Medicare Secondary Claims

Since January 1, 2006, all Blue Cross Blue Shield Plans, including Blue Cross Blue Shield of Wyoming (BCBSWY), have been required to process Medicare crossover claims for services covered under Medigap and Medicare Supplemental products received from the Centers for Medicare & Medicaid Services (CMS). This resulted in the automatic submission of Medicare secondary claims to the Blue Plan secondary payer and eliminated the need for the Provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, this

has also allowed Medicare crossover claims to be processed more uniformly nationwide.

When a Medicare primary claim is submitted to the Medicare intermediary, BCBSWY asks Providers to wait 30 calendar days from the Medicare remittance date before submitting the secondary claim to BCBSWY. This allows the Medicare crossover claim time to be transmitted to us from Medicare and reduces the number of duplicate claims processed throughout the system.

The claims submitted to the Medicare intermediary will be crossed over to BCBSWY or another Blue Plan after the claim has been processed by the Medicare intermediary. This means that the Medicare intermediary will release the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. By allowing the Medicare crossover claim to process with BCBSWY or another Blue Plan you will reduce your office work effort and the number of duplicate claim denials on your Provider Remittance Advice.

Providers should always submit services that are covered by Medicare directly to Medicare. Even if Medicare benefits may exhaust or have exhausted, continue to submit claims to Medicare to allow for the crossover process to occur and for the Member's benefit policy to be applied.

Medicare secondary claims, including those with Medicare exhaust services, that are received by BCBSWY within 30 calendar days of the Medicare remittance date or with no Medicare remittance date may not be processed and may be returned to the Provider by BCBSWY.

## Process for Professional Claim Adjustments

When you identify the need for a claim adjustment, we ask that you use the following process:

1. If able, please submit an electronic claims correction using these [instructions here](#).
2. Otherwise, complete the Request for [Claim Adjustment Form](#) after reading the instructions.
3. Mail or fax the form to our Member Services department.

**Fax:** 307-432-2942    **Mail:** Member Services  
BCBSWY  
PO Box 2266  
Cheyenne, WY 82003-2266

4. Include applicable documentation (e.g. copy of claim, EOB, remittance information, Workers Compensation information, etc.)

### These requested changes require medical documentation:

- Units of service changes
- Benefits appeal
- Pricing appeal

*Please upload these items in Availity.*

### The following changes **do not** require medical documentation:

- Dollar amount
- Additional adjusted charges
- Procedure codes
- Diagnosis codes
- Modifiers

### **Additional information to know:**

- Include the date of service and claim number of the claim that you are requesting the adjustment.
- Please give a detailed explanation of your requested adjustment changes.
- When submitting chart notes or medical information, submit an explanation of why this information is being submitted. If the information being submitted was requested by BCBSWY, please attach a copy of the request.
- When submitting claim appeal letters, please attach supporting documentation (chart notes, X-ray reports, etc.).
- The **Request for Professional Claim Adjustment** form should be used for services **submitted on a CMS-1500**.
- The **Request for Institutional Claim Adjustment** form should be used for services **submitted on a UB-04**.
- Include the full name (first and last name) and telephone number of the person submitting the adjustment request.
- Submit only one claim per inquiry form.
- When using these forms, enter the total amount of the claim prior to the adjustment.
- We will deduct any overpayment from your BCBSWY weekly payment.

### Tips for Submitting OCR (Optical Character Recognition)

#### **Tips for Submitting Paper Claims**

All Providers are encouraged to submit their claims electronically. Providers should register at [Availity.com](http://Availity.com) to enable electronic submission.

If electronic claims submission is not an option, paper claims must be submitted according to the following guidelines. This will ensure timely and accurate processing of claims through the OCR system.

- For professional service claims, use red CMS-1500 claim forms, version 02-12. For institutional claims, use red UB-04 claim forms. Photocopies or carbon copies of claims are not acceptable through the OCR system.
- Print claims in a 10 – 12 size font using a black ink or laser print. Other colors and handwriting are often too light to be read correctly by the OCR equipment.
- Avoid the use of red pen, markers or blue/green highlighters. The OCR equipment drops all red print when processing and any information written in red will “drop out” and be missed.
- Align the claim form so that all information is contained within the appropriate box. Poorly aligned data may be read incorrectly or missed entirely, resulting in incorrect processing of the claim.
- Use ALL CAPS when printing the information.
- Confirm the correct patient Member ID; using an old Member ID will cause the claim to be returned.
- Please do not submit via fax.

**Mail:** Blue Cross Blue Shield of Wyoming  
PO Box 2266  
Cheyenne, WY 82003-2266

**Remember to complete all required fields of the CMS-1500 form or CMS-1450 (UB-04 forms).**

## Telemedicine Claims

For telemedicine services, all Providers contracted with BCBSWY should send claims to BCBSWY. Occasional exceptions do exist. Please read the below for more detailed explanations.

### **Telemedicine Claims Filing**

#### **Vendor solutions**

Claims are filed directly to BCBSWY for services rendered by a vendor's participating telemedicine provider. Exception: Non-participating telemedicine providers should file claims to local plan based on their physical location.

#### **Local Participating Provider solutions**

Participating providers (individual providers and provider groups/facilities operating out of a brick-and-mortar office) may use telemedicine as a modality when treating their patients. Claims must be filed with BCBSWY.

#### **Out-of-Area Virtual Support Providers**

Providers who reside outside of Wyoming and are employed by a brick-and-mortar provider group/facility located in Wyoming to render virtual services to their members. Claims must be filed by the provider/group facility to BCBSWY.

## Section 6

## BlueCard® Program

BlueCard is a national program that enables Members of one Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan's service area. BlueCard links participating health care Providers with the independent BCBS Plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement.

To ensure easy administration for you and a positive experience for your patients, BCBSWY is your single point of contact for claims, customer service, and Provider education-related inquiries.

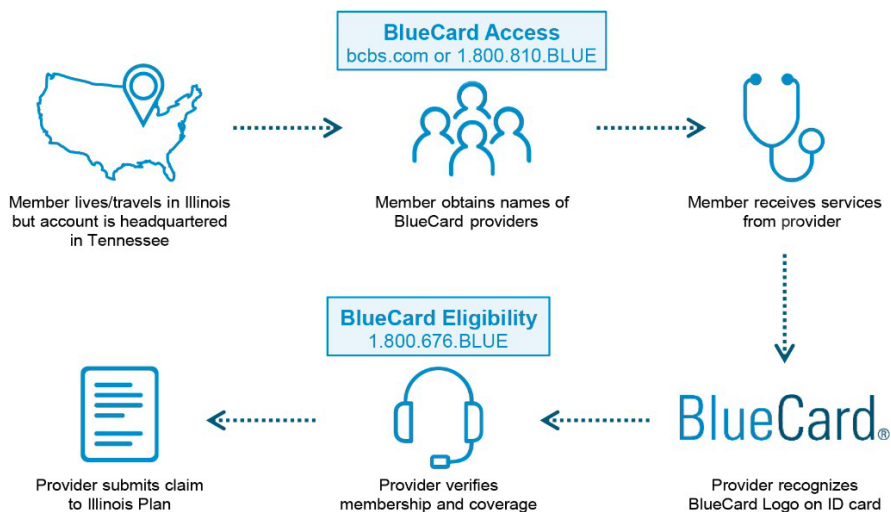
### How the BlueCard Program Works

**1. Identify BlueCard Members** - The main identifiers are:

- PPO in a suitcase logo, for eligible PPO Members
- Empty suitcase logo, for Traditional, POS or HMO Members
- A **prefix** (the first three positions of the identification number)
  - The **prefix** correctly routes BlueCard claims for processing.

**2. Check Eligibility and Benefits**

- **Telephone:** Call the Blue Card Eligibility® line at **800-676-BLUE (2583)**. Enter only the prefix on the Member's ID number and your call will be routed to the Member's home plan.
- **Electronic:** Submit an electronic eligibility and benefits inquiry (270 transaction) to BCBSWY via the [Availity®](#) Provider Portal.



### 3. Obtain Pre-certification/Preauthorization for BlueCard Members, When Applicable

- **Telephone:** Call the BlueCard Eligibility line at 800-676-2583 and ask to be transferred to the Medical Management Department.
- **Electronic:** Use the [Pre-Cert/Pre-auth Search \(out-of-area Members\)](#) to view the applicable Blue Plan's medical policy or general pre-certification/preauthorization information. You can also visit [Availity.com](#).

**Submit all BlueCard claims electronically** to BCBSWY for faster service.

### How to Avoid Claims Delays and Rejections

One of the biggest reasons for claim delays within BlueCard® is incorrect or missing prefixes and identification numbers on claims. To help avoid delays, use the following steps:

1. **Copy** – First make copies of the front and back of the Member's ID card and pass this information on to your billing staff. Be sure that the Member has the most current ID card.
2. **Look** – Find the prefix. For BlueCard®, the prefix identifies the Member's Blue Plan or national account. It is also critical for confirming Membership and coverage.
3. **Contact** – Once you've identified the prefix, call BlueCard® Eligibility at 1-800-676-BLUE (2583) to verify the Member's eligibility and coverage.
4. **Submit** – After you include all the necessary information, submit the claim to BCBSWY.

#### Helpful Hint:

When you're referring a patient or a patient's information to a Provider where there is not a face-to-face encounter, include copies of the ID card and the complete identification number, which includes the prefix.

#### Helpful Hint:

For faster processing, please submit your claims electronically to your local Blue Plan.

If you have questions, please **call BCBSWY at 1-800-442-2376**.

## BlueCard Frequently Asked Questions

### BlueCard Basics

#### 1. What Is the BlueCard Program?

BlueCard is a national program that enables members of one BCBS Plan to obtain health care service benefits while traveling or living in another BCBS Plan's service area. The program links participating health care providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you conveniently submit claims for patients from other BCBS Plans, domestic and international, to your local BCBS Plan.

Your local BCBS Plan is your sole contact for claims payment, adjustments, and issue resolution.

#### 2. What products are included in the BlueCard Program?

The following products/claims are included in the BlueCard Program:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization), including Blue High Performance Network (Blue HPN)
- POS (Point of Service)
- Standalone vision
- Standalone prescription drugs

*NOTE: STANDALONE VISION AND STANDALONE SELF-ADMINISTERED PRESCRIPTION DRUGS PROGRAMS ARE ELIGIBLE TO BE PROCESSED THRU BLUECARD WHEN SUCH PRODUCTS ARE NOT DELIVERED USING A VENDOR. CONSULT CLAIM FILING INSTRUCTIONS ON THE BACK OF THE ID CARDS.*

#### 3. What products are excluded from the BlueCard Program?

The following products/claims are excluded from the BlueCard Program:

- Stand-alone vision
- Stand-alone dental
- Medicare Advantage
- The Federal Employee Program (FEP)

#### 4. What is the BlueCard Managed Care/POS model?

The BlueCard Managed Care/POS model is for members who reside outside of their BCBS Plan's service area. Under the BlueCard Managed Care/POS model, members are enrolled in Blue Cross Blue Shield of Wyoming network and have a primary care physician (PCP). You can

recognize BlueCard Managed Care/POS members who are enrolled in Blue Cross Blue Shield of Wyoming network through the member ID card as you do for all other BlueCard members.

## **5. Are HMO patients serviced through the BlueCard Program?**

Occasionally BCBS HMO members affiliated with other BCBS Plans will seek care at your office or facility. You should handle claims for these members the same way as you do for Blue Cross Blue Shield of Wyoming members by submitting them to the Blue Cross Blue Shield of Wyoming.

### **Identifying members and ID Cards**

#### **1. How do I identify members?**

When members from BCBS Plans arrive at your office or facility, be sure to ask them for their current ID card. The main identifier for out-of-area members is the prefix. The ID cards may also have:

PPO in a suitcase logo, for eligible PPO/EPO members

PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network

Blank suitcase logo

An HPN in a suitcase logo with the Blue High Performance Network (HPN) name in the upper right or lower left corner, for Blue HPN EPO members.

**Note:** *If you are not a BlueHPN provider, it's important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas.*

#### **2. What is a “prefix?”**

The prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the BCBS Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

#### **3. What do I do if a member has an identification card without a prefix?**

Some members may carry outdated identification cards that may not have a prefix. Please request a current ID card from the member.

#### **4. How do I identify BlueCard Managed Care/POS members?**

The BlueCard Managed Care/POS model is for members who reside outside their BCBS Plan's service area. BlueCard Managed Care/POS members are enrolled in Blue Cross Blue Shield of Wyoming network and primary care physician (PCP) panels. You can recognize BlueCard Managed Care/POS members who are enrolled in Blue Cross Blue Shield of Wyoming network through the member ID card as you do for all other BlueCard members.

#### **5. How do I identify Medicare Advantage members?**

Members will not have a standard Medicare card; instead, a BCBS logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

|   |   |  |
|---|---|--|
| <p><b>Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:</b></p> |  | Health Maintenance Organization                  |
|   |  | Medical Savings Account                          |
|   |  | Private Fee-For-Service                          |
|   |  | Point of Service                                 |
|   |  | Network Sharing Preferred Provider Organization. |

When these logos are displayed on the front of a member’s ID card, it indicates the coverage type the member has in his/her BCBS Plan service area or region. However, when the member receives services outside his/her BCBS Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

**Blue Cross Blue Shield of Wyoming** participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with **Blue Cross Blue Shield of Wyoming**. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

*Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier’s service area. Providers should refer to the back the member’s ID card for language indicating such restrictions apply.*

## 6. How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign BCBS Plan members. These ID cards will contain prefixes. Please treat these members the same as domestic Blue Plan members.

### Verifying Eligibility and Coverage

#### How do I verify membership and coverage?

For Blue Cross Blue Shield of Wyoming members, contact 1-888-359-6592 or use Availity.

For other BCBS Plan members, contact Blue Cross Blue Shield of Wyoming electronically using Availity or BlueCard Eligibility by phone to verify the patient’s eligibility and coverage:

Electronic—Submit a HIPAA 270 transaction (eligibility) to Blue Cross Blue Shield of Wyoming.

Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583).

## **Utilization Review**

### **How do I obtain utilization review?**

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their BCBS Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility).

You may also contact the member's Plan on the member's behalf. You can do so by:

For Blue Cross Blue Shield of Wyoming members, contact 1-888-359-6592 or use Availity.

For other BCBS Plans members,

Phone—Call the utilization management/pre-certification number on the back of the member's card. If the utilization management number is not listed on the back of the member's card, call BlueCard Eligibility 1.800.676.BLUE (2583) and ask to be transferred to the utilization review area.

Electronic— Use Availity for prior authorization.

## **Claims**

### **1. Where and how do I submit claims?**

You should always submit claims to Availity or contact 1-888-359-6592. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the prefix. Do not make up prefixes. Claims with incorrect or missing prefixes and/or member identification numbers cannot be processed.

### **2. How do I submit claims for international Blue members?**

The claim submission process for international BCBS Plan members is the same for domestic BCBS Plan members. You should submit the claim directly to Blue Cross Blue Shield of Wyoming.

### **3. How do I handle COB claims?**

If after calling 1.800.676.BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan and Blue Cross Blue Shield of Wyoming is the primary payer, submit the claim with information regarding COB to Blue Cross Blue Shield of Wyoming.

If you do not include the COB information with the claim, the member's BCBS Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

### **4. How do I handle Medicare Advantage claims?**

Submit claims to Blue Cross Blue Shield of Wyoming. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a BCBS Plan.

### **5. How do I handle traditional Medicare-related claims?**

When Medicare is the primary payor, submit claims to your local Medicare intermediary.

All BCBS claims are set up to automatically cross over (or forward) to the member's BCBS Plan after being adjudicated by the Medicare intermediary.

#### **6. How do I submit Medicare primary / BCBS Plan secondary claims?**

For members with Medicare primary coverage and BCBS Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.

When submitting the claim, it is essential that you enter the correct BCBS Plan name as the secondary carrier. This may be different from the local BCBS Plan. Check the member's ID card for additional verification.

Be certain to include the prefix as part of the member identification number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage and key to facilitating prompt payments.

***When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the BCBS Plan:***

If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate BCBS Plan and the claim is in process. **DO NOT** resubmit that claim to Blue Cross Blue Shield of Wyoming; duplicate claims will result in processing and payment delays.

If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue Cross Blue Shield of Wyoming with the Medicare remittance advice.

In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.

#### **7. When will I get paid for claims?**

Contact Blue Cross Blue Shield of Wyoming at 1-888-359-6592 or [BCBSWY.com](http://BCBSWY.com).

### **Contacts**

#### **1. Who do I contact with claims questions?**

Contact Blue Cross Blue Shield of Wyoming at 1-888-359-6592 or [BCBSWY.com](http://BCBSWY.com).

#### **2. How do I handle calls from members and others with claims questions?**

If members contact you, advise them to contact their BCBS Plan. Refer them to the front or back of their ID card for a customer service number. A member's BCBS Plan should not contact you directly. If the member's Plan contacts you to request another copy of the member's claim, refer the Plan to Blue Cross Blue Shield of Wyoming.

#### **3. Where can I find more information?**

For more information:

Visit Blue Cross Blue Shield of Wyoming Web site at [BCBSWY.com](http://BCBSWY.com).

Call Blue Cross Blue Shield of Wyoming at 1-888-359-6592.

Contact your Blue Cross Blue Shield of Wyoming provider service representative.

## Section 7 Federal Employee Program (FEP)

The numerous independent BCBS companies across the United States, through their participation in the FEP, insure 4 million federal government employees, dependents and retirees. FEP is the largest private health insurance contract in the world. 65 percent of all federal employees and retirees who receive their health care through the government's Federal Employee Health Benefits Program (FEHBP) are Members of an independent BCBS company. BCBSWY participates in the FEP program for federal employees located in Wyoming.

Providers should only submit FEP authorization requests for services to BCBSWY if those services occur in the state. BCBSWY cannot approve or deny an FEP authorization that is conducted in a different state.

The website at [FEPBlue.org](http://FEPBlue.org) is devoted exclusively to the FEP program. Because the Office of Personnel Management negotiates the benefits and premiums of this plan annually on a nationwide basis, the benefit information is updated each year. A printable PDF file may be downloaded from the website for future reference. Up-to-date information on Providers, pharmacy programs and resources, such as Blue Health Connection, also is available on this site. Newsletters provide health and benefit information for federal employees, including those who are overseas. Links to health-information sites also are listed.

For more information, call FEP Customer Service at 800-200-5220.

### FEP Members Age 65 Without Medicare

Under Federal Law (5 U.S.C. 8904 (b)), FEP is required to limit payments for inpatient hospital care and for physician care to benefits the Member would be entitled to if he or she had Medicare coverage.

We are required to pay no more than the Medicare fee schedule amount for services provided to Federal retirees and annuitants age 65 and older who are not enrolled in Medicare Part B. The law makes the Provider's Medicare participating agreement binding. The patient is not responsible for any amounts over the Medicare fee schedule amount and Providers may collect no more than the equivalent Medicare amount.

## Section 8

## Pharmacy, Dental & Vision

### Pharmacy - PRIME

Prime Therapeutics, LLC. (Prime) provides pharmacy benefit management for Blue Cross Blue Shield of Wyoming. Prime, privately owned by not-for-profit Blue Cross and Blue Shield plans including BCBSWY, works side-by-side with groups to manage overall health care benefits.

#### **How to Request Prior Authorization**

Blue Cross and Blue Shield of Wyoming's Pharmacy Services Department, in collaboration with our pharmacy benefit manager Prime Therapeutics, LLC., develops programs and resources to inform both physicians and their patients about the appropriate, cost-effective use of pharmaceuticals. Given the rising cost of health care, some groups have chosen to implement programs that promote appropriate therapy through pharmacy preauthorization programs.

The preauthorization request forms are available at [BCBSWY.com](http://BCBSWY.com) by clicking on the **Providers tab** and then **Clinical Resources**, in the dropdown menu select **Prescription Drug Tools**. The forms are located below the subheading of **Prior Authorizations**, which will redirect you to Prime's website.

#### **FEP RX**

FEP follows the same set of medical policies and requires Prior Approval (PA) regardless of where the drug/prescription is obtained. These medical policies are maintained by Caremark, the FEP pharmacy benefit administrator.

*Note the following:*

- Drugs administered by a pharmacy that require prior approval must be submitted to Caremark.
- Drugs administered by a physician or facility that require prior approval must be submitted to BCBSWY.

#### **Outpatient Prescription Drugs**

Under some Blue Cross and Blue Shield of Wyoming plans, benefits for certain prescription drugs and covered services administered in an outpatient setting will only be available for in-network benefits if they are obtained from a participating pharmacy and processed under the Member's BCBSWY prescription drug plan.

An outpatient setting includes a home, physician's office, outpatient hospital or other outpatient facilities. It does not include a hospital emergency room.

Medical Providers who administer the drug(s) in the outpatient setting will be reimbursed only for the administration under the Member's medical plan.

## Vision

BCBSWY vision benefits will be administered by Davis Vision. If you already have an existing relationship with Davis Vision, it will continue.

If you are interested in joining the Davis Vision network Providers, please go to the Davis Vision website [here](#) and click on “**Provider**” or call 1-800-584-3140.

The contracting and credentialing process takes 90 days or less.

Medical related vision benefits will continue to be offered under BCBSWY medical benefits. You can submit medical vision claims electronically using the [Availity Provider Portal](#).

### **Contact BCBSWY Vision Customer Service:**

**Phone:** 1-800-584-2865

|                             |                     |
|-----------------------------|---------------------|
| <b>Hours:</b> Monday-Friday | 6 a.m. – 9 p.m. MT  |
| Saturday                    | 7 a.m. – 2 p.m. MT  |
| Sunday                      | 10 a.m. – 2 p.m. MT |

## Dental

BCBSWY dental benefits are administered by BCBSWY using United Concordia Dental as our dental claim administrator.

All dental care claims should be submitted electronically through the dental Provider portal, My Patients' Benefits® at [wy.dentalcoverage.com](http://wy.dentalcoverage.com). You can also verify eligibility and benefits for BCBSWY Members through this website.

To register and get started visit: [wy.dentalcoverage.com](http://wy.dentalcoverage.com). After you select a site administrator you will need to your Provider ID or NPI number and Provider Tax ID (EIN or SSN) to get started.

Medical-related dental benefits will continue to be offered under BCBSWY medical benefits under your existing network agreement with BCBSWY. You can submit medical dental claims electronically using the Availity Provider Portal.

### **Contact BCBSWY Dental Customer Service:**

**Phone:** 844-653-4057

|                             |                    |
|-----------------------------|--------------------|
| <b>Hours:</b> Monday-Friday | 8 a.m. – 5 p.m. MT |
|-----------------------------|--------------------|

## Section 9                      Quality Management

### Blue Distinction Specialty Care

The Blue Distinction Specialty Care Program is a program through the BCBSA. It is a national designation program that recognizes health care facilities that demonstrate expertise in delivering quality care safely, effectively, and cost-efficiently.

There are two levels of designation:

- Blue Distinction Centers: Health care facilities recognized for their expertise in delivering specialty care.
- Blue Distinction Centers+: Health care facilities recognized for their expertise in delivering specialty care and cost efficiency. Health care facilities must meet nationally established, objective quality measures for the Blue Distinction Center designation in order to be considered for the Blue Distinction Centers+ designation.

Specialty Care programs available include the following: Bariatric Surgery, Cardiac Care, Cancer Care, Knee and Hip Replacement, Maternity Care, Spine Surgery, Substance Abuse, and Transplants.

For more information go to: [BCBS.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care](https://www.bcbs.com/about-us/capabilities-initiatives/blue-distinction/blue-distinction-specialty-care)

#### **Helpful Hint:**

FEP Members are required to prior authorize Blue Distinction services at a Blue Distinction Center.

## Section 10 Communicating with BCBSWY

### Availity Provider Portal

**Availity Client Services Phone:** 800-282-4548

**Hours:** Monday - Friday 6 a.m. to 5:30 p.m. MT

### BCBSWY Provider Support

Provider Support Representatives can assist with routine benefits and claims questions. They can also verify receipt of prior authorization requests and status.

**Phone:** 1-888-359-6592

**Hours:** Monday - Friday 7 a.m. to 5 p.m. MT

To comply with HIPAA privacy rules and regulations, Provider Support must verify the identity and authority of each Provider contacting Provider Support. Be prepared to give the following information when calling Provider Support:

- Caller's name
- Rendering Provider's NPI number
- Provider name
- Telephone number
- Patient's Member ID
- Patient's name
- Date of service
- Type of service being provided

### BlueCard®

**Eligibility Line:** 800-676-BLUE (2583)

**Hours:** Varies based on the plan location

**Claims:** 800-359-6592

### Case Management

**Phone:** 307-442-2376

## Dental

**Phone:** 844-653-4057

**Hours:** Monday – Friday 8 a.m. – 5 p.m. MT

For questions related to claims submission via Speed eClaim®, contact **Dental Electronic Services** at 800-633-5430.

### Paper Claim Submission:

**Mail to:**

Dental Claims Administrator  
PO Box 69406  
Harrisburg, PA 17106-9406

**FEP**

Dental Claims Administrator  
PO Box 69401  
Harrisburg, PA 17106-9401

**Helpful Hint:**

Understand the below workflows better at [BCBSWY.com/providers/preadmin/](http://BCBSWY.com/providers/preadmin/)

## Fax Requests

| Document Destination                     | Fax Number   | What should be sent here?   |
|--|--------------|---|
| <b>Authorizations</b>                    | 307-432-2917 | <ul style="list-style-type: none"><li>• Pre-authorization request</li><li>• Initial inpatient hospital authorization</li><li>• Pharmacy authorizations</li></ul>    |
| <u><a href="#">Concurrent Review</a></u> | 307-432-2756 | <ul style="list-style-type: none"><li>• Updates and records for current inpatient hospital stay</li></ul>   |
| <u><a href="#">Appeals</a></u>           | 307-432-2942 | <ul style="list-style-type: none"><li>• All pre and post service appeals</li><li>• Claim Adjustment forms and records</li><li>• Records for denied claims</li></ul> |
| <u><a href="#">Medical Records</a></u>   | 307-635-9366 | <ul style="list-style-type: none"><li>• Requested medical records</li></ul>   |

## Federal Employees Program

**Phone:** 1-800-200-5200

**Hours:** Monday – Friday 7 a.m. to 3:30 p.m. MT

## Pharmacy/PRIME

**Phone:** 1-877-794-3574

**Hours:** 24 hours a day, 7 days a week

## Provider Relations

**Phone:** 1-888-666-5188

**Hours:** Monday – Friday      8 a.m. – 5 p.m. MT

Provider Relations assist Providers and their office staff and provide information about BCBSWY's programs and procedures. For questions regarding the contents of this manual, please direct them to [Provider.relations@bcbswy.com](mailto:Provider.relations@bcbswy.com).

Please do not contact Provider Relations with routine claim or benefit questions. You may obtain immediate answers to those questions by calling Provider Support at 888-359-6592.

## Directory Changes

Go to:

[Practice / office information form](#)

## Provider E-Bulletins

To receive e-mail notification of helpful tips and reminders and other important announcements from BCBSWY, please visit [BCBSWY.com/providers/providers-news-sign-up/](http://BCBSWY.com/providers/providers-news-sign-up/) to be added. An archive of past e-bulletins can be found at: [BCBSWY.com/Providers/updates/](http://BCBSWY.com/Providers/updates/)

## Vision

**Phone:** 1-800-584-2865

|               |                 |                     |
|---------------|-----------------|---------------------|
| <b>Hours:</b> | Monday – Friday | 6 a.m. – 9 p.m. MT  |
|               | Saturday        | 7 a.m. – 2 p.m. MT  |
|               | Sunday          | 10 a.m. – 2 p.m. MT |