PRIOR AUTHORIZATION PORTAL USER GUIDE

Provider Relations

Contents

Introduction

The Prior Authorization Portal is a web-based portal associated with the internal software program for Blue Cross Vermont. This tool allows providers the ability to securely access real-time Member information, submit new authorization requests and check the status on submitted requests.

Users

This reference document will assist staff with appropriate security access to the Prior Authorization Portal for submission and review of authorizations for a provider office.

Purpose

This guide is intended to help with basic navigation, features, and functionality of the Prior Authorization Portal including submission and review authorizations as well as sending messages to Blue Cross prior approval staff.

Log In

- Network providers can access the tool with their existing Provider Resource Center sign in.
- Out of State Providers contracted with their local Blue Cross Plan access the site through a designated link on that contracted Blue Plan's site.
- Third Party Vendors (such as Optum) – separate access will be set based on the relationship.

Access Issues:

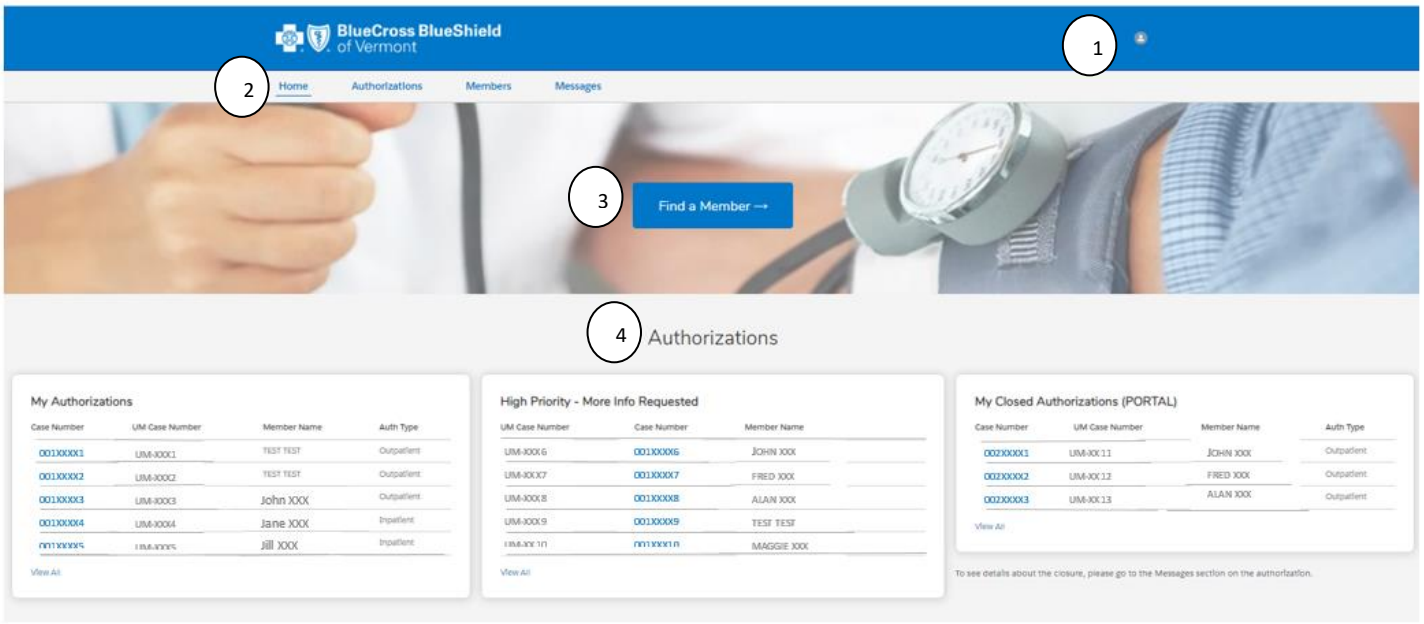
Access is set from the initial access to the Provider Resource Center. If access to the Prior Authorization Portal is not working, contact your individual provider relations representative, email providerrelations@bcbsvt.com or call 1-888-449-0443 (select option1).

Best Practice

In order to keep the software working at its best, make sure to clear your cache images and files from your history through settings on your browser. This ensures the fastest processing and no potential software glitches in your work on authorization submissions and reviews.

Homepage

When first entering the tool, users are brought to the homepage. The homepage gives a snapshot of different options available to search or review in addition to other functions. Functions are described in detail later in the guide. This section introduces home page quick selection options.



On this page you can:

- Log out of the program.
- Go to other tabs to review authorizations, search members and review messages related to your provider identification/group.
- Search for a member
- Review a snapshot of current authorizations, high priority requests and closed authorizations.

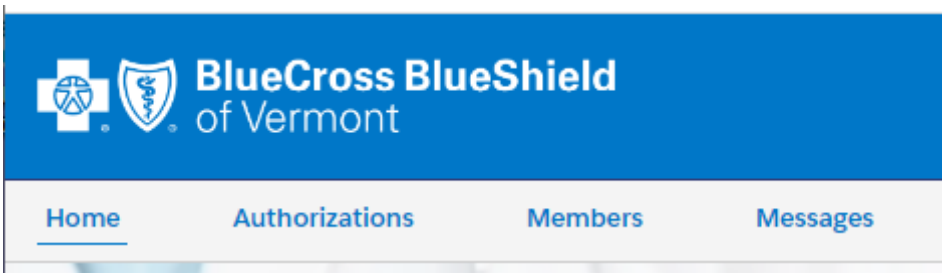
1. *User Profile*

Click the person icon to log out of the system.

2. *Tabs*

At the top of the home page, four sections are available and will show as underlined when on that section. Each item is reviewed in further detail in the pages following the homepage review.

- Home (landing page)
- Authorizations
- Members
- Messages



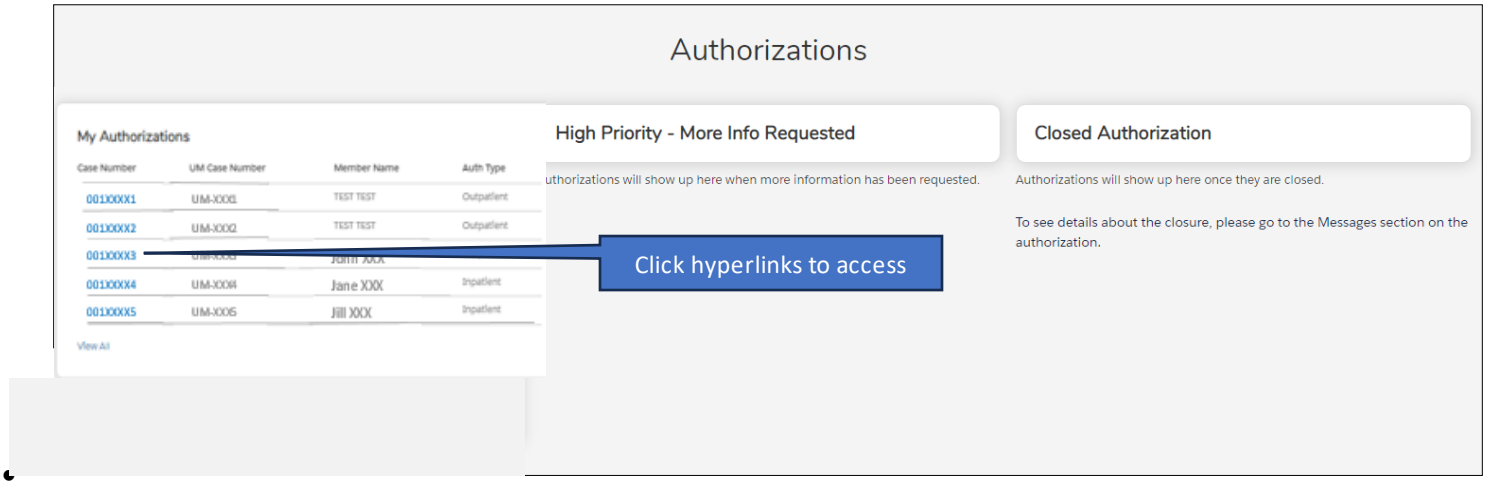
3. *Find a Member*

You are able to go to the search a member page by clicking the Find a Member Button.

4. *Authorizations*

The homepage shows three separate views reflecting authorizations created by the user (Note: for a full list of authorizations related to your provider number, click the Authorizations tab). Sections are:

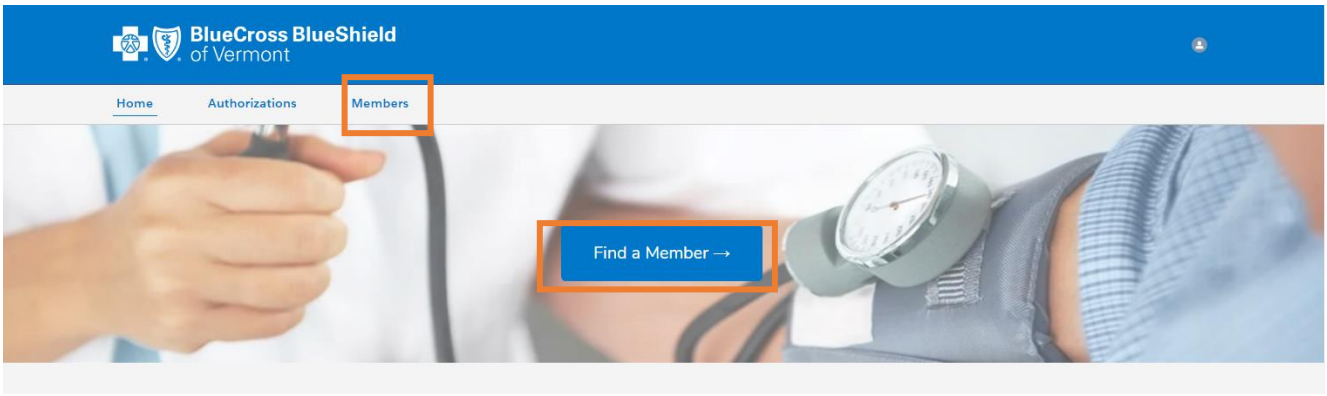
- My Authorizations
- High-Priority
- Closed Authorizations



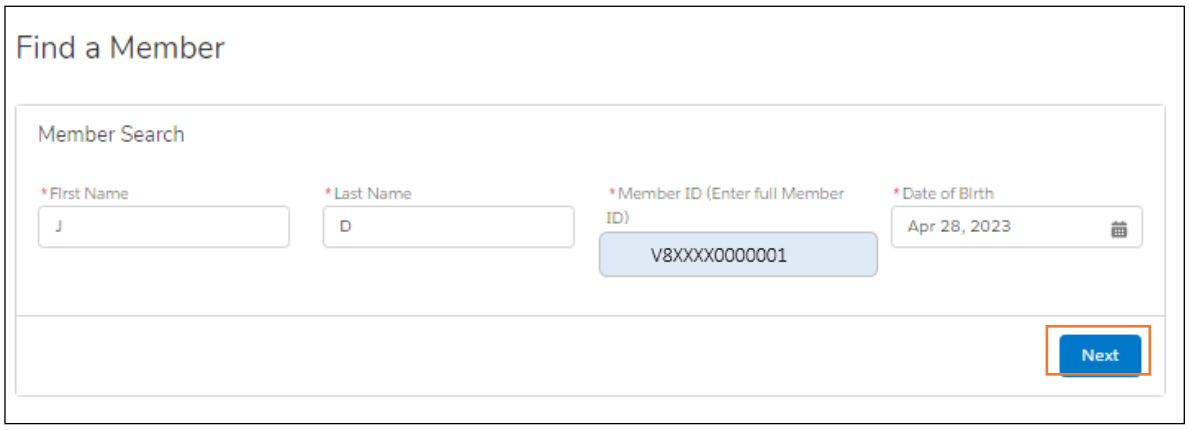
By clicking on the hyperlink, you can go directly to the case to review the information and any updated decisions, files or messages.

Searching for a Member

Authorizations start with member information. Members can be found by either clicking the "Find a Member" button or going to the Members tab on the homepage ribbon.



1. Click **Find a Member** button (or click Members tab on ribbon that brings you to same location).



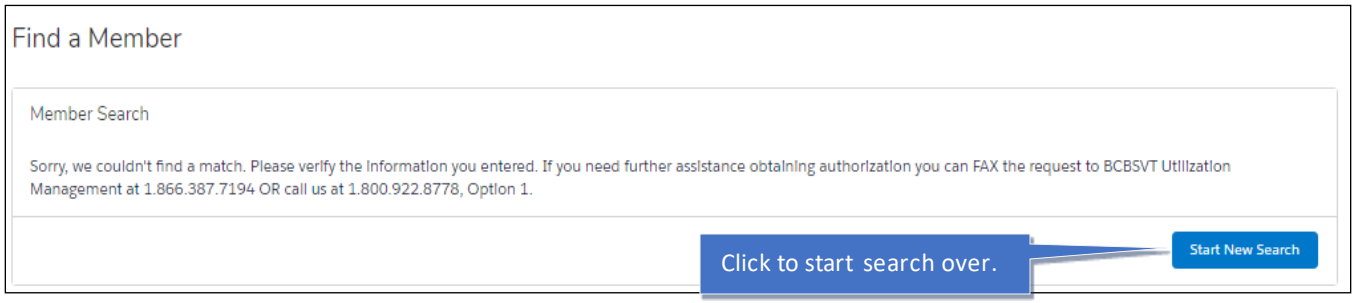
2. Enter Information in fields (all fields are required):

Field Name	Required	Format
First Name	Y	Full or partial information (such as first letter of name)
Last Name	Y	Full or partial information (such as first letter of name)
Member ID	Y	Full Mbr id including the dependent code starting with the member prefix for all lines of business. *(see example above in Member ID field*)
Date of Birth	Y	Full DOB *(ie – 01/01/1961*) or use calendar icon

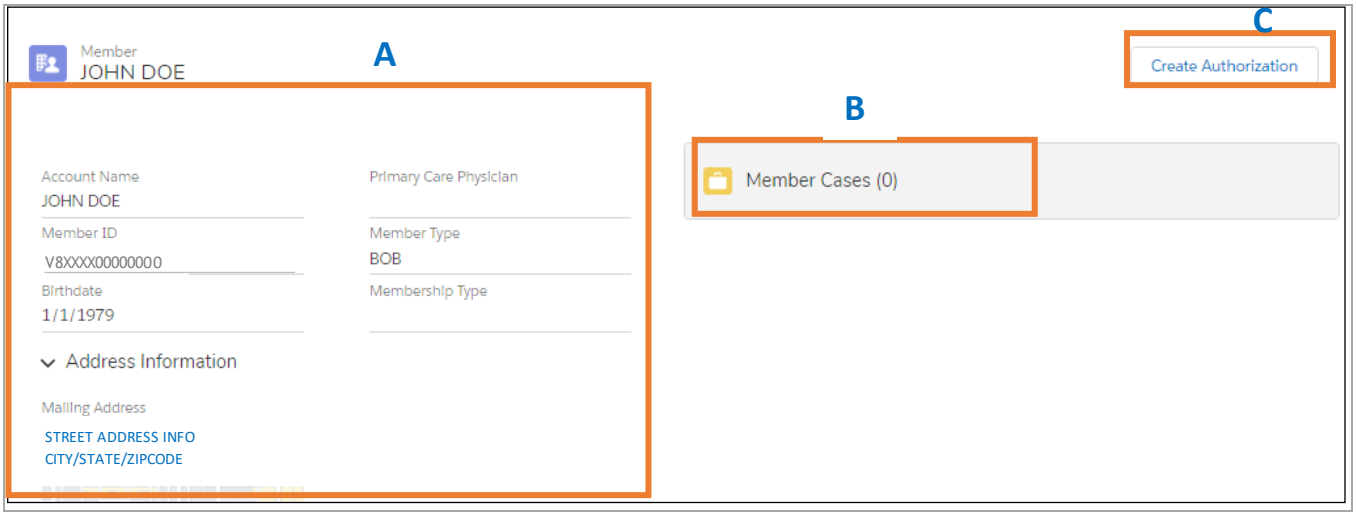
3. Click 

4. Any matching member information is populated (note: **only** active members will display):

If there Is no match, the user sees an error message:



5. Click the member hyperlink to go to the member's profile page. The user can review membership information, create a new authorization or review authorization requests they or someone in their office associated with the same provider access submitted in the past.



A. Demographics – User can verify member's individual account information.
B. Member Cases – Any cases submitted within the provider's office associated with the (tax id) about this member is listed.
C. Create Authorization – create a new authorization request linked to this member (only active membership able to create authorizations).

Creating an Authorization Request

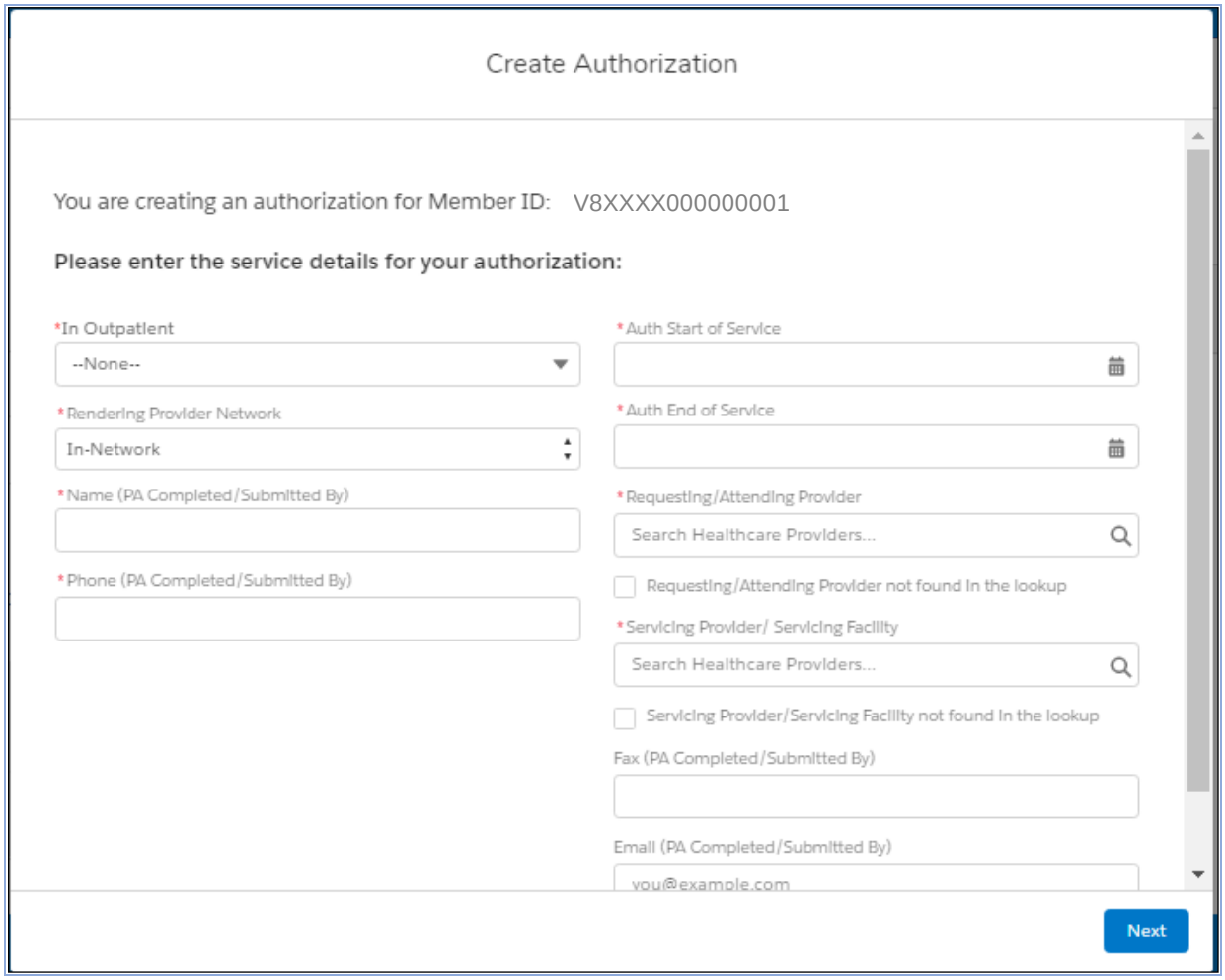
Providers create and submit authorizations from the portal to be reviewed by Blue Cross VT staff. Authorizations may be reviewed, and decisions made based on the information submitted by the provider. Please note that the information presented may be limited by the user's assigned role. Authorizations can only be created with an active membership.

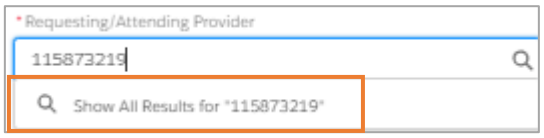
1. Find the member through Member Search

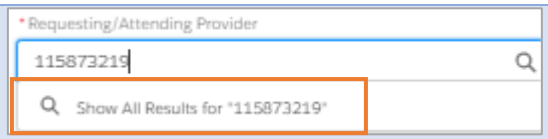
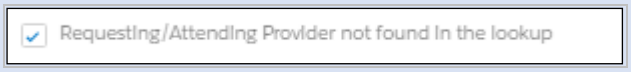
2. From the Member profile page, click 

3. **Service Details Screen**

   a. From the new window, enter the service details for the auth (Note – **all fields with * are required**).



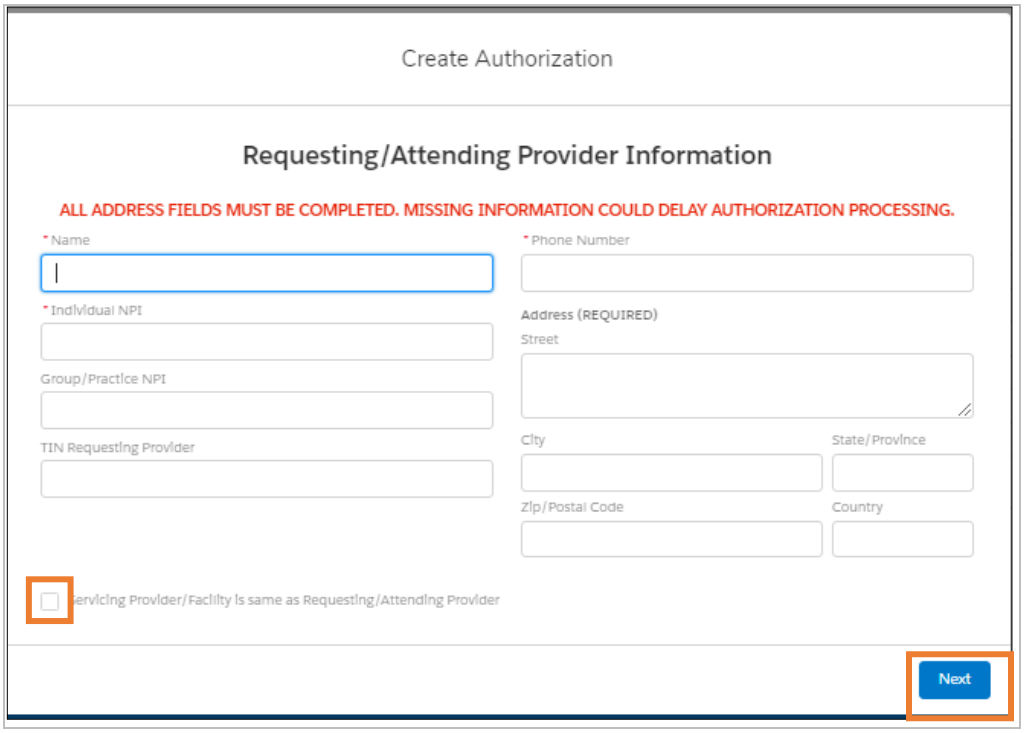
Field Name	Required	Format
In Outpatient	Y	click the drop-down list and select either Inpatient or Outpatient (this triggers required information in fields following initial selection).
Setting	Y	drop down choices are based on inpatient or outpatient choice
Admit Level (Inpatient)	Y	Drop-down selection choices based on initial Inpatient selection
Service Type (outpatient)	Y	Drop-down selection choices based on initial Outpatient selection
Rendering	Y	Dropdown selection of in our out of network selections
Name	Y	name of person completing the authorization request
Phone	Y	number of person completing authorization request
Auth Start of Service	Y	Type or use calendar icon and complete date
Auth end of Service	Y	Same direction as start of service
Requesting/Attending Provider	Y	Type NPI and click the magnifying glass to access the name list to choose from.  The selection should show  in the field with the name. (Note – Names must be selected from the picklist to be valid – only active providers listed). **See section after for provider not found in lookup and Multiple affiliations look up after table.* If not found through field and picklist, Click box 
Service Provider/Servicing Facility	Y	Type NPI and click the magnifying glass to access the name list to choose from.

		 The selection should show in the field with the name. (Note – Names must be selected from the picklist to be valid – only active providers listed). **See section after for provider not found in lookup and Multiple affiliations look up after table.* If not found through field and picklist, Click box 
Fax (PA completed/Submitted	N	Type phone # if submitted by Fax
Email (PA completed/Submitted	N	Enter information if sent by email.

Note:

Provider Not Found in Lookup

*If the Requesting/Attending Provider field or Service Provider/Servicing Facility are unknown and the box checking, fill out the boxes that pop up.



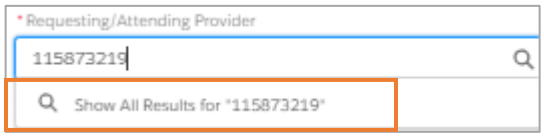
*all Red asterisks indicated required fields.

*Click the check box if servicing provider/facility is the same information.

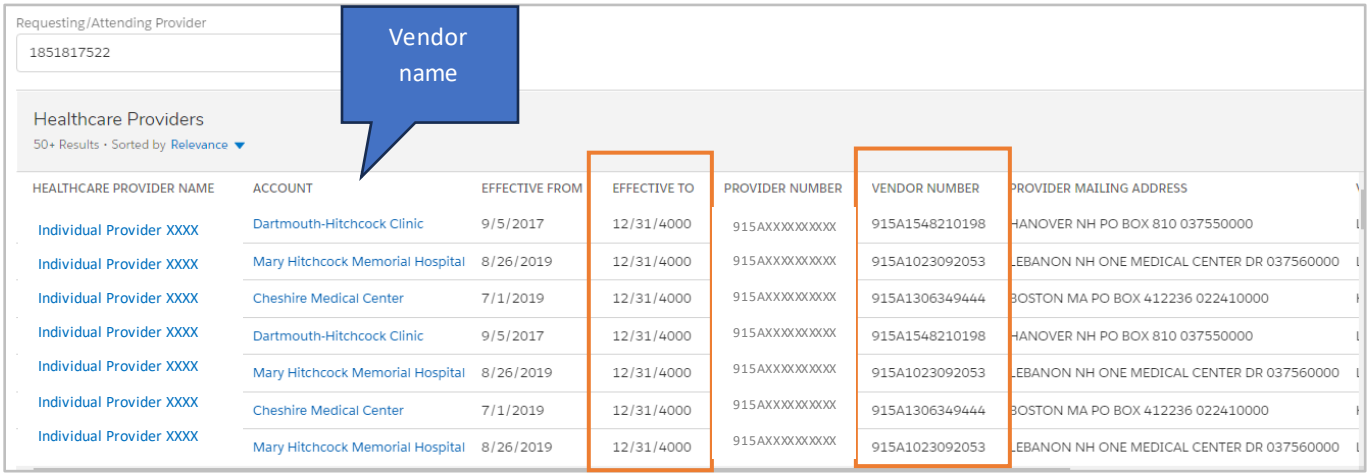
Providers with Multiple Affiliations

If a provider has multiple affiliations with different serving vendors, it is important to select the correct provider/vendor combination when choosing the attending or servicing provider.

1) Enter the NPI in the field and select the magnifying glass for “show all results.”



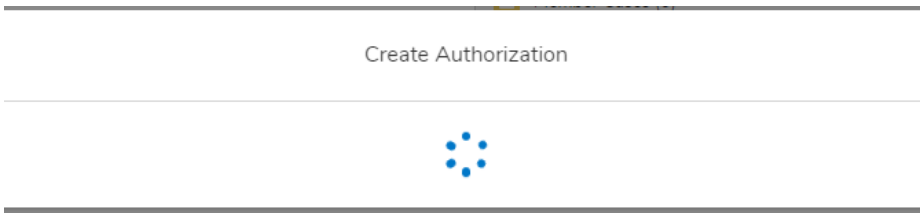
2) A new screen will open which will show the provider and any affiliations relationships. Select the vendor number affiliated with the provider in the request and verify the “Effective To” is 12/31/4000 (active).



1) Click the line to populate into the field. (Make sure to verify is before the name).

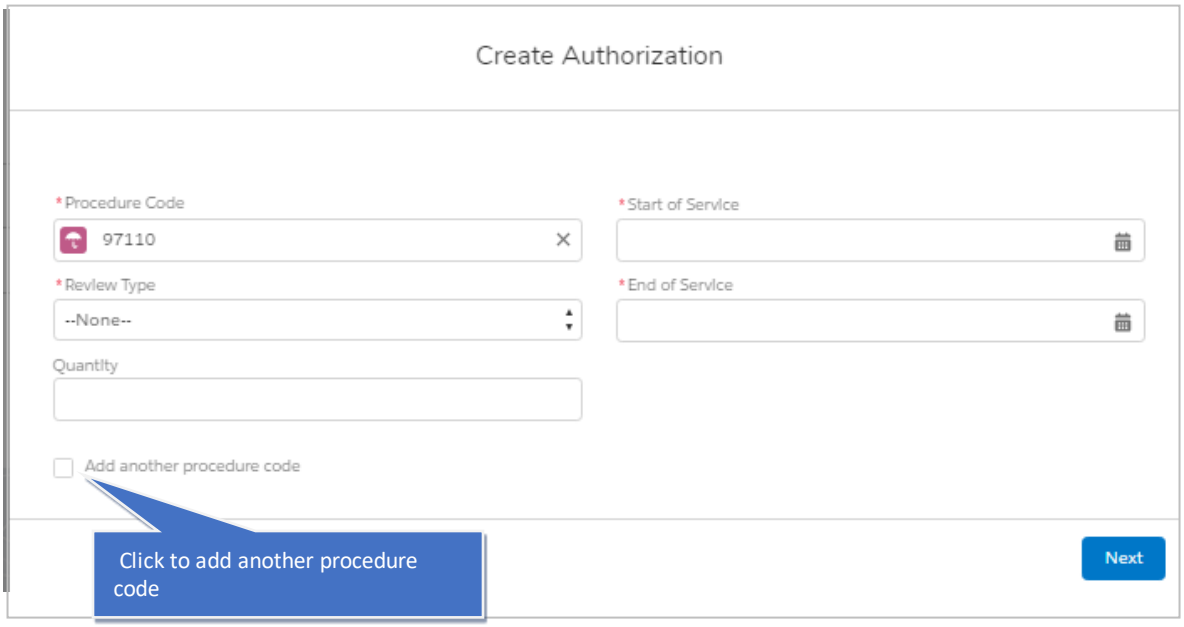
b. Click Next

(image below appears until the next screen loads)



4. From **the Procedure Screen**:

   a. Complete the fields (Note – all fields with * are required)**. Note** – dates do not carryover from the former screen so make sure to verify dates being entered here for accuracy.

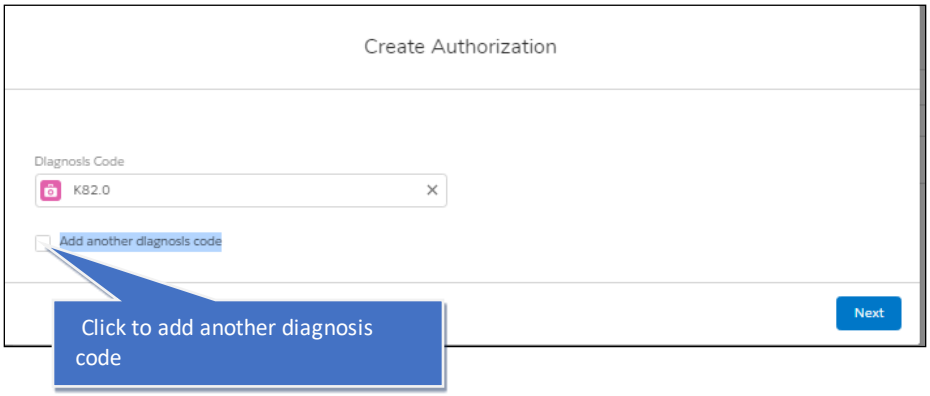


Field Name	Required	Format
Procedure code	Y	Type code and select from the codes that appear from the picklist that match the code required. (Note – codes must be selected from the picklist to be finalized). Codes will begin with  . **for eligible chiro services,* ***only*** *enter one code*
Review type	Y	Select from the drop-down menu. (for list of types and when to select click here <hyperlink>)
Quantity	N	Number of visits or days
Start of Service	Y	Type or select through the calendar icon
End of Service	Y	Type or select through the calendar icon
Add another Procedure Code	N	Click box if multiple codes are being submitted. Filled box looks like

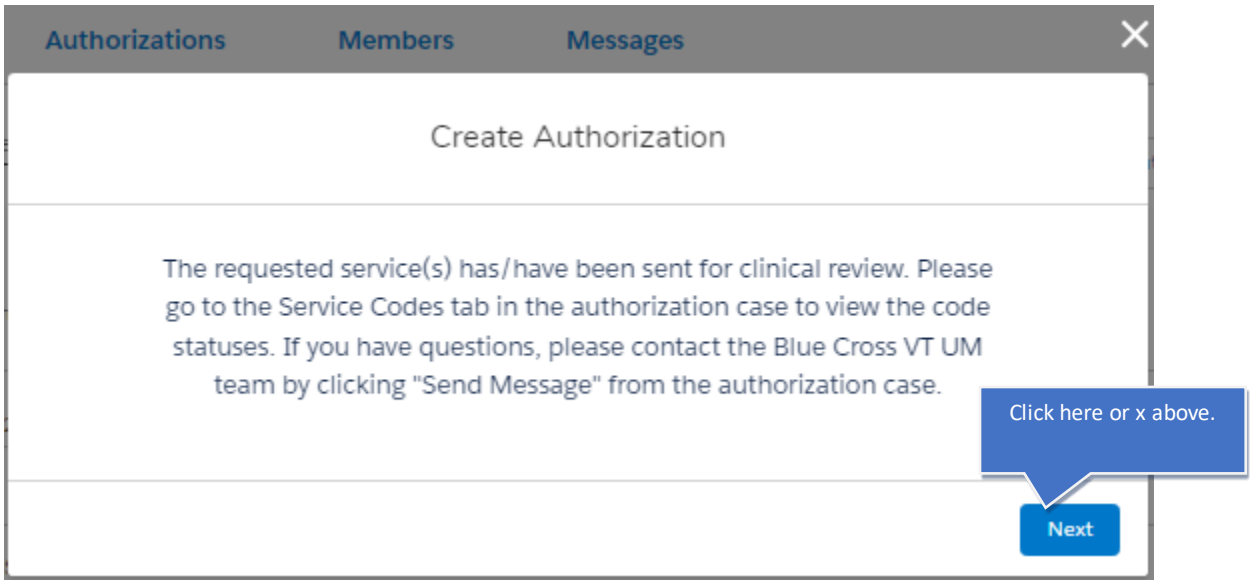
   b. Select 

5. From **the Diagnosis code screen**

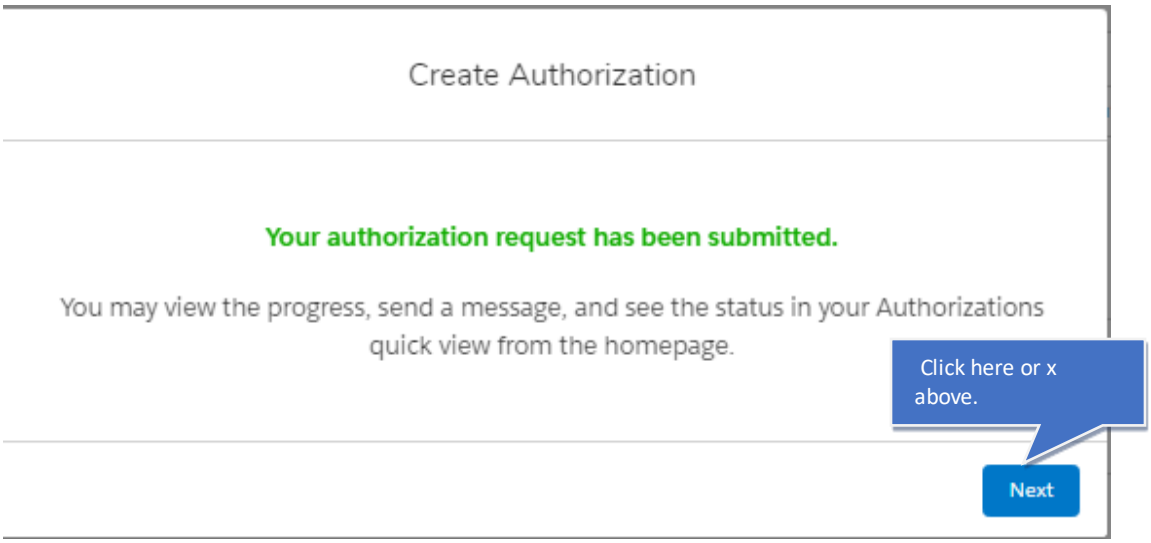
   a. Enter the code then select from the results box (this field is optional) and click **Next.**



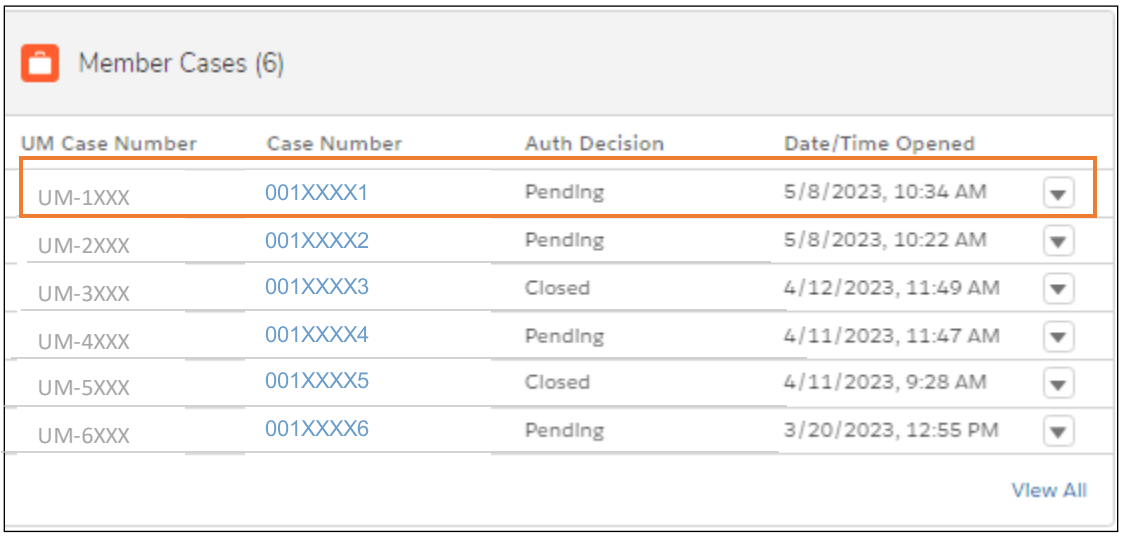
6. Depending on the provider and information submitted, the request goes to an assessment that must be completed **or** indicates the request has been sent for clinical review. (See information in next section on how to complete an assessment.) Below is the image for a request sent for clinical review.



   a. Click Next to finalize submission and the following box appears indicating submission.



b. Once submitted, the user is directed to the member page and the authorization appears in the member case box at the top. (The authorization also appears on the home page under “My authorizations”).



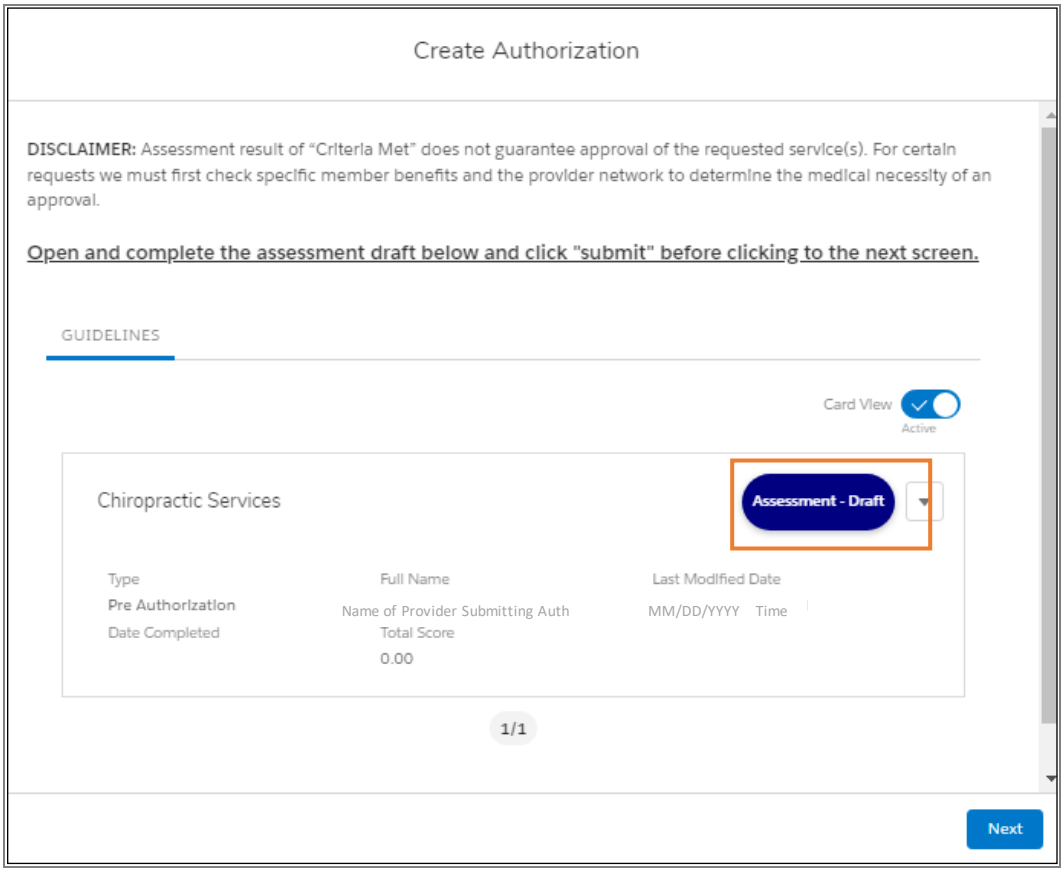
Assessments

Certain authorization requests require an assessment be completed. Once procedure and diagnosis fields are complete, if an assessment is required, additional screens requesting additional information will appear. The assessment asks questions that determine if required criteria is met. (*See list of auto approval types on page 33*).

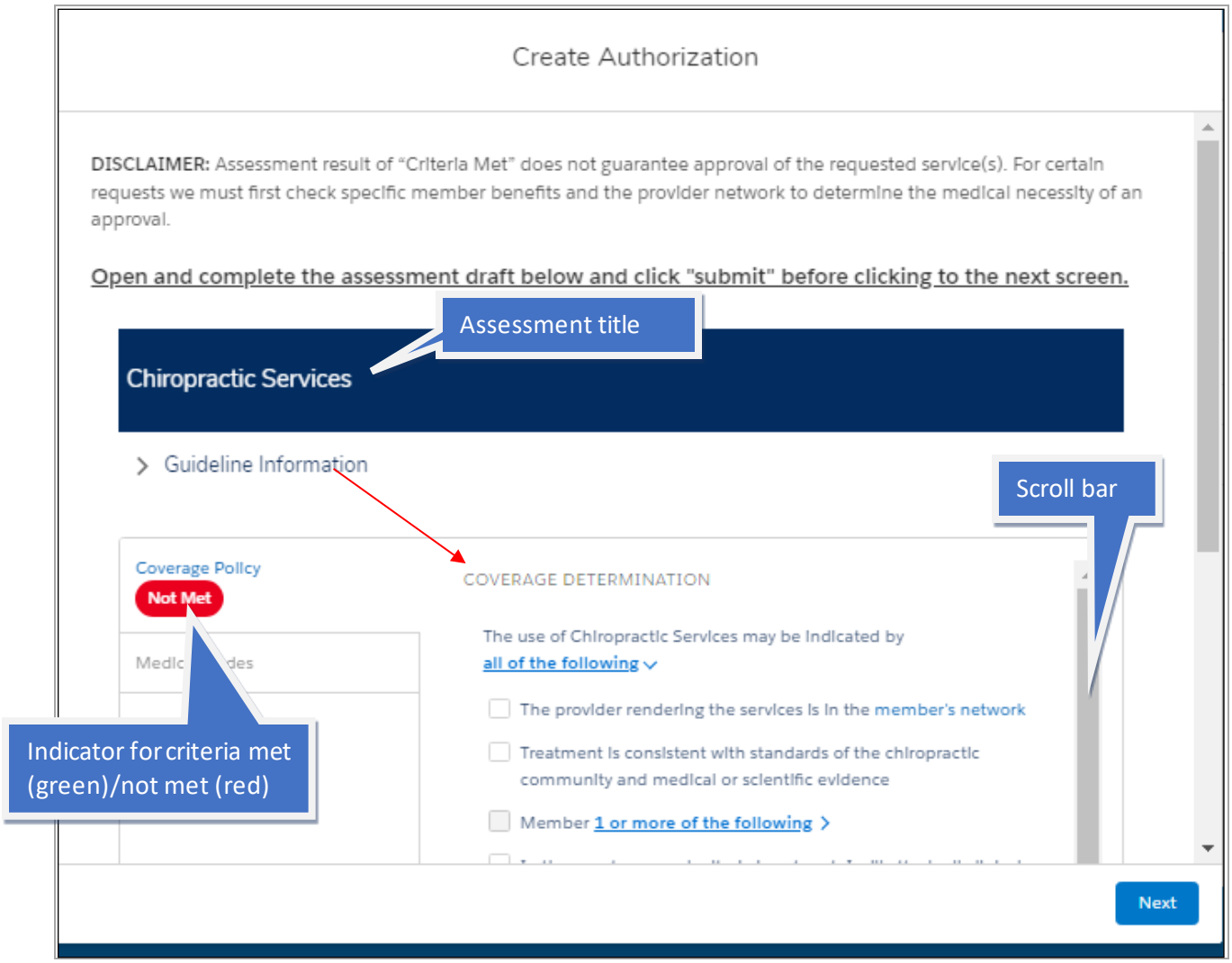
- In-network providers (Blue Cross VT or any other Blues Plan) will be able to receive auto approvals if the criteria is met, based on the assessment questions.
- Out of Network providers receives a notification that the information requires further review for a decision.

Follow the next steps on how to navigate and enter.

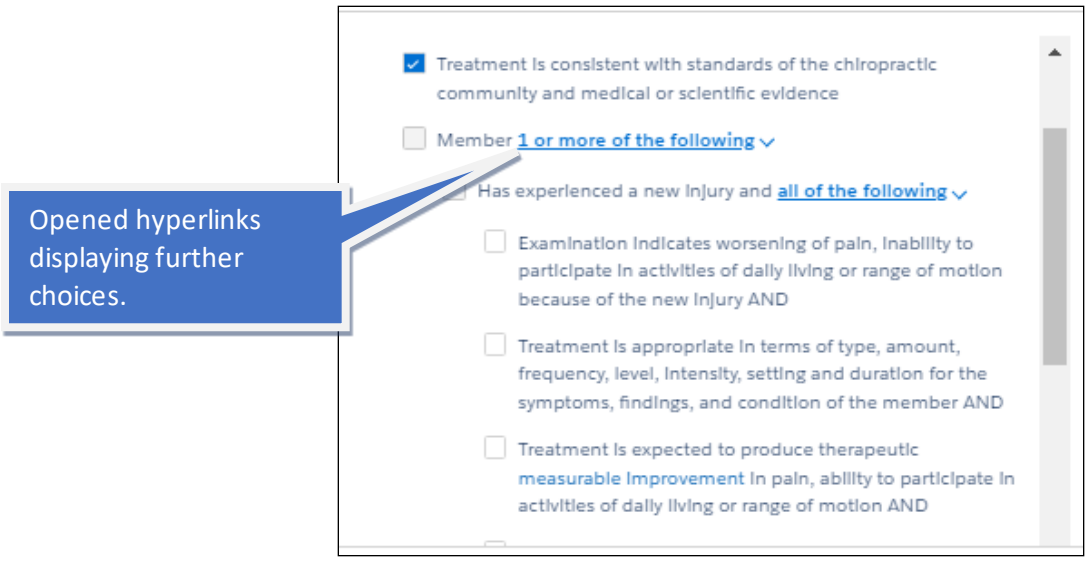
1. Click the **Assessment-Draft** button to open to criteria questions:



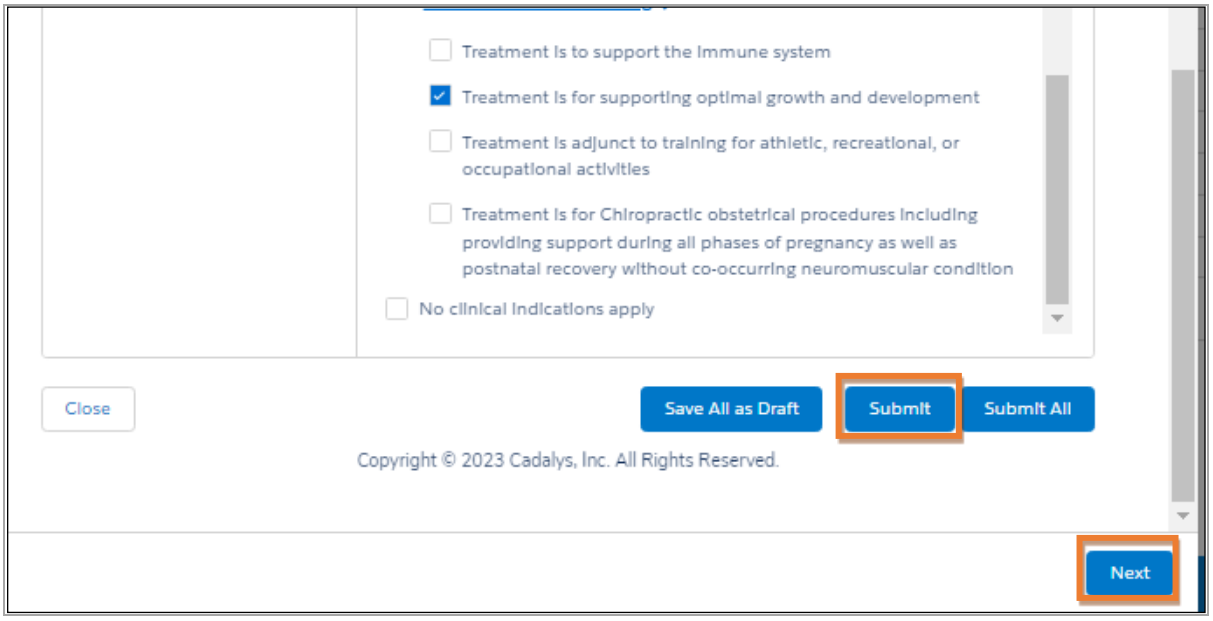
2. At first the assessment indicates the criteria "not met" with a red button. Users answer questions under **Guideline Information,** and if all criteria is met based on the built in logic, the button will change to "met" with a green button.



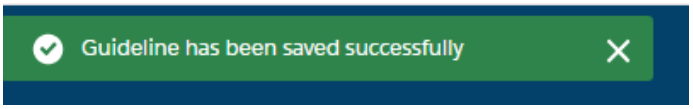
3. The Guideline Information has a list of criteria that must be completed. Hyperlinks open further questions so make sure to click them to open further options to select.



4. Once completed, the coverage bubble reflects green for criteria met or remains red to reflect it has not been met. Scroll to the bottom of the page and click the Submit button.



A message appears indicating the guideline was successfully completed.

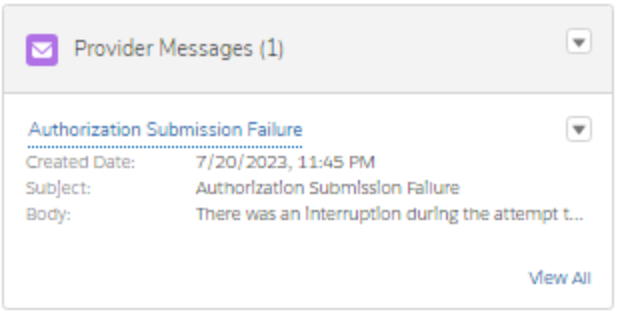


5. Click the Next button.
6. Providers will see:
    a. In-network providers meeting the criteria will see an auto approval message for certain scenarios.
    b. Out-of-Network and Third-party vendors will see a message that their request was submitted for clinical review and to check the homepage.

Failed Submissions

In certain situations, the case submission might fail (ie – not all screens completed). In this situation failed submissions can be identified from:

- The case in provider messages



- The Auth tab which will request Auth decision as "Submission Failure".

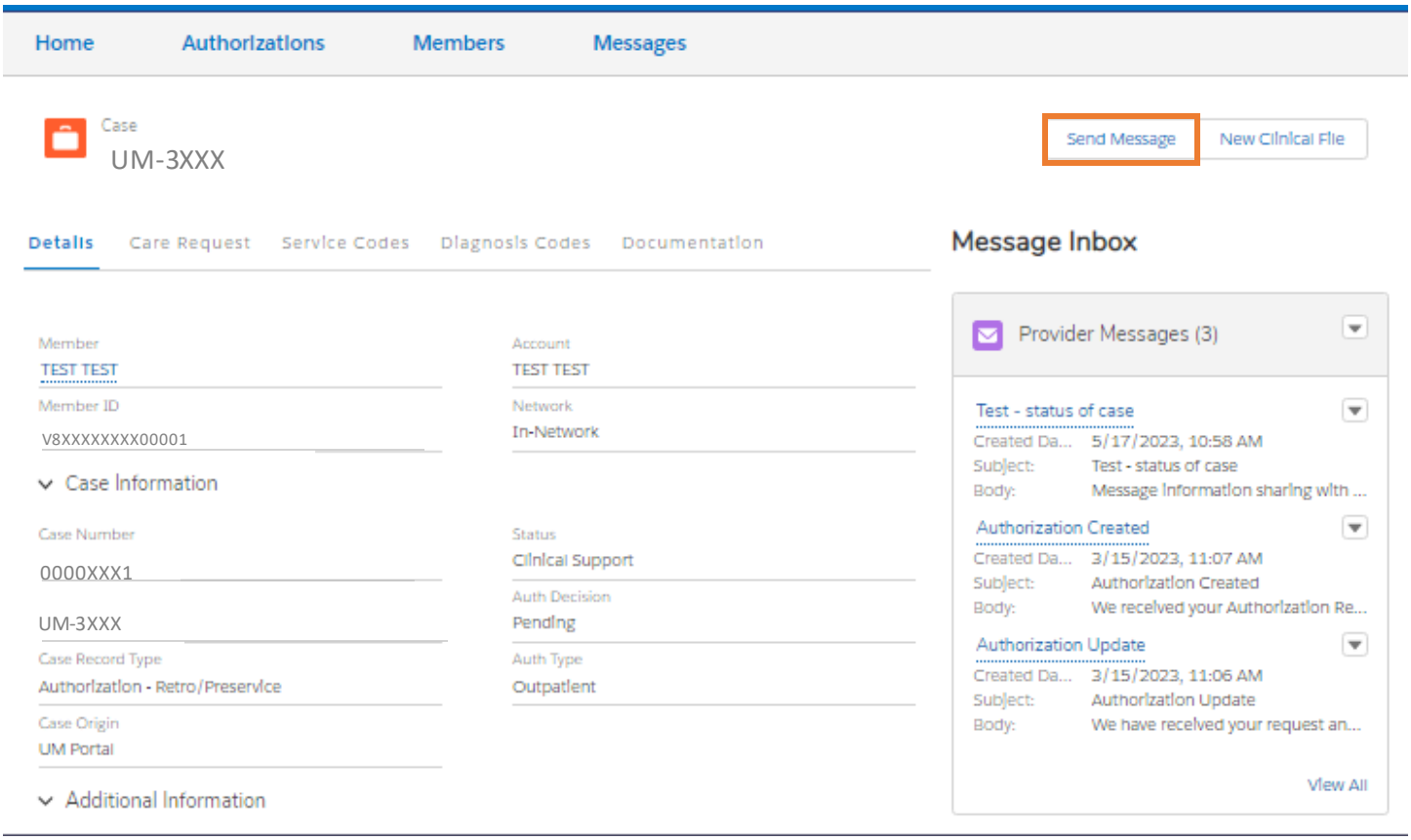
Messages

Messages can be located through the individual case screen or through the Messages tab. They can be created to report process of the authorization, ask/respond to questions, or send clinical files for the authorization case. Messages can be seen if the user is either the authorization creator or a provider listed in the authorization (requesting/rendering or facility).

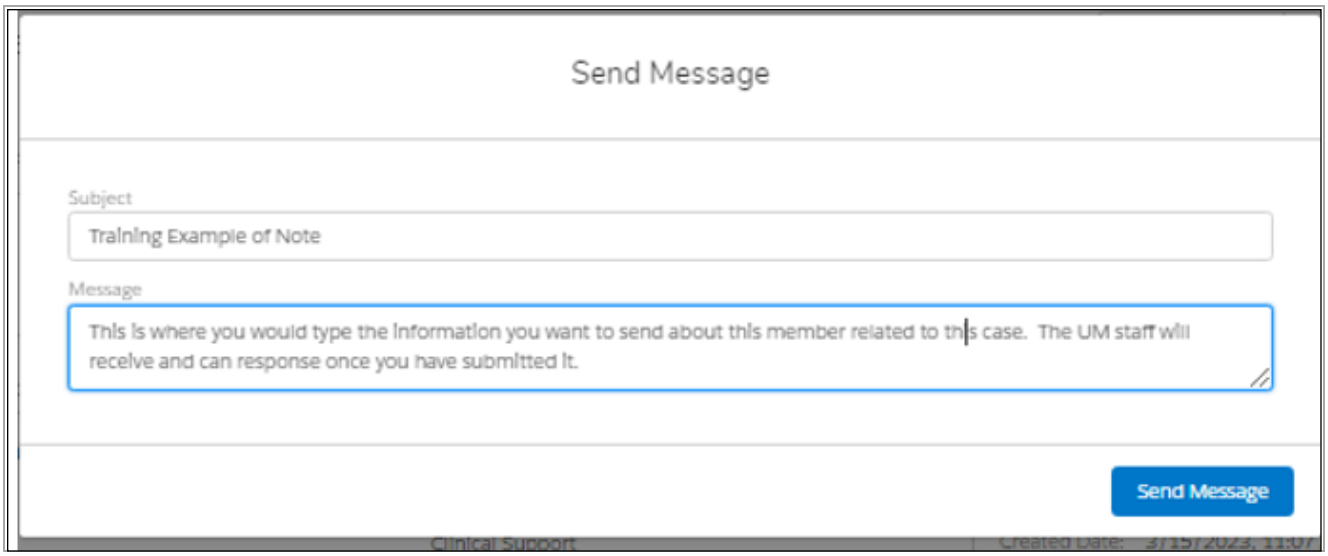
Sending Messages

You can send a message to the Blue Cross VT staff regarding a case by clicking a Send Message button.

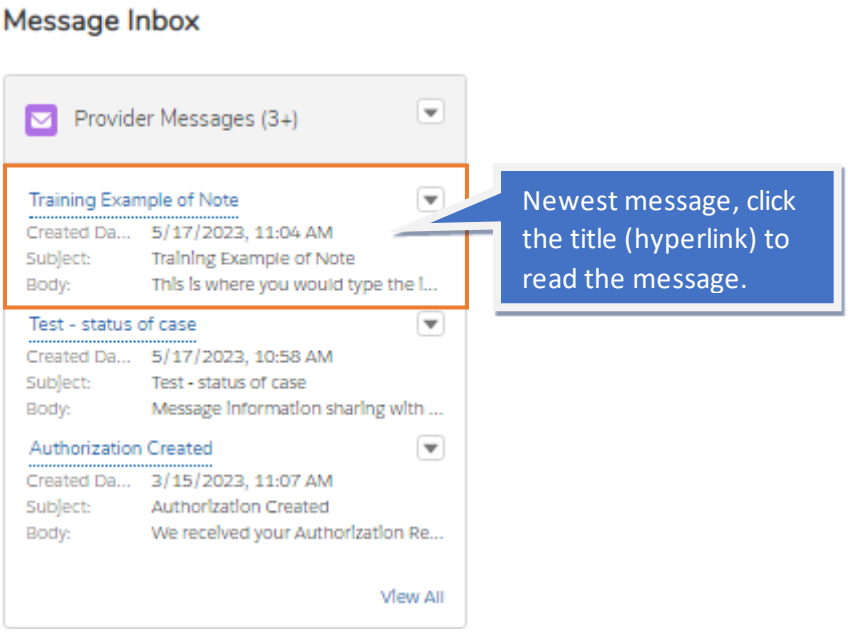
1. Go to the Case and open and click **Send Message**.



2. A new screen open, fill out the Subject line and message text.



3. Once a subject and message are complete, click the Send Message button.
   The message is sent real-time and shows up at the top of the case's message list.



Viewing Messages

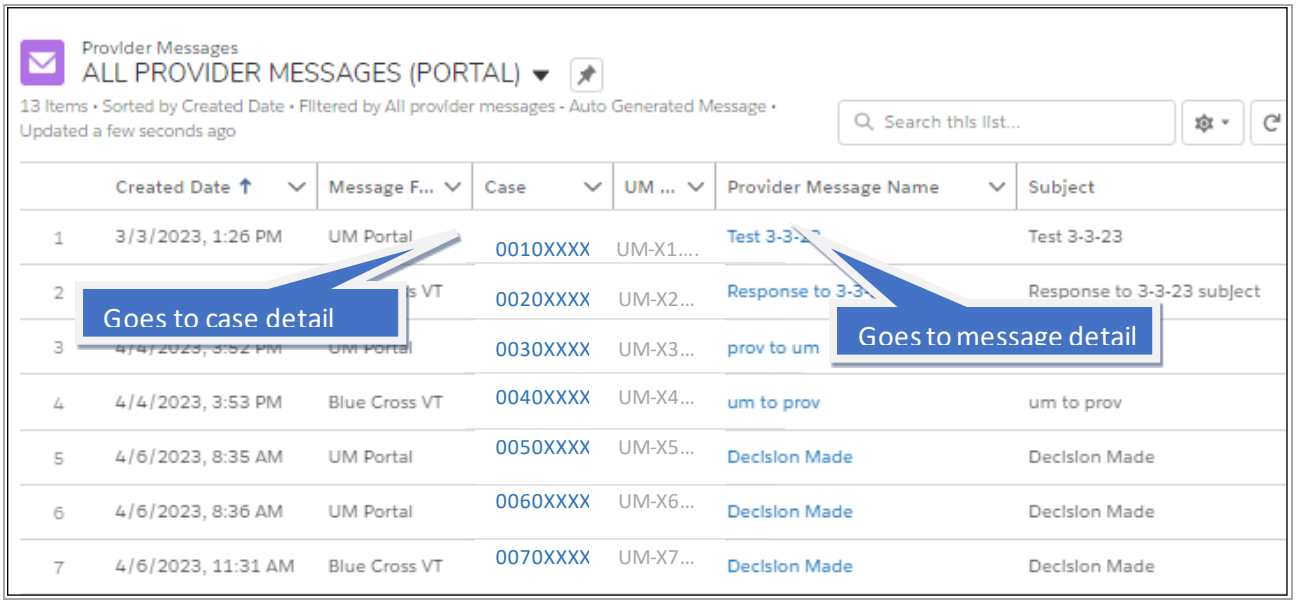
Messages are created when an authorization is successfully submitted or when other information is submitted such as updates, requests, questions, or attachments. Messages are found through the Message Tab on the home page or by accessing the case.

Message Tab

1. On the home page click on the message tab.
2. The message page appears with a list view of messages. There are two options to view.

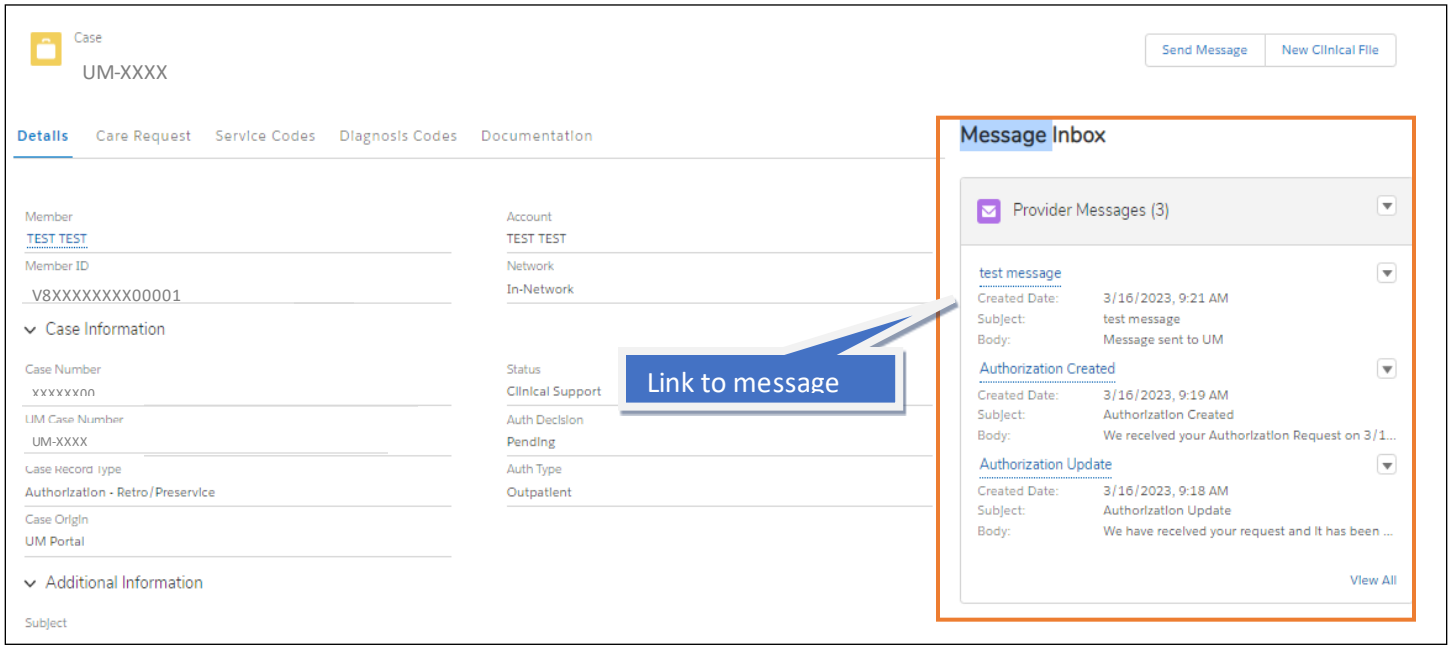
View	
All Provider Messages	Able to see the messages from: • Prior Authorization Portal – provider messages and auto messaged created by the system. • Blue Cross VT – messages from Blue Cross VT staff
My Provider Messages	View of just Prior Authorization Portal messages **not** Blue Cross VT staff.

3. Review the information and click a hyperlink to see more.
   - Case column – link goes to case detail screen.
   - Provider Message name – link goes to message details.



Message Inbox

Case messages are listed on the case page in the Message Inbox.

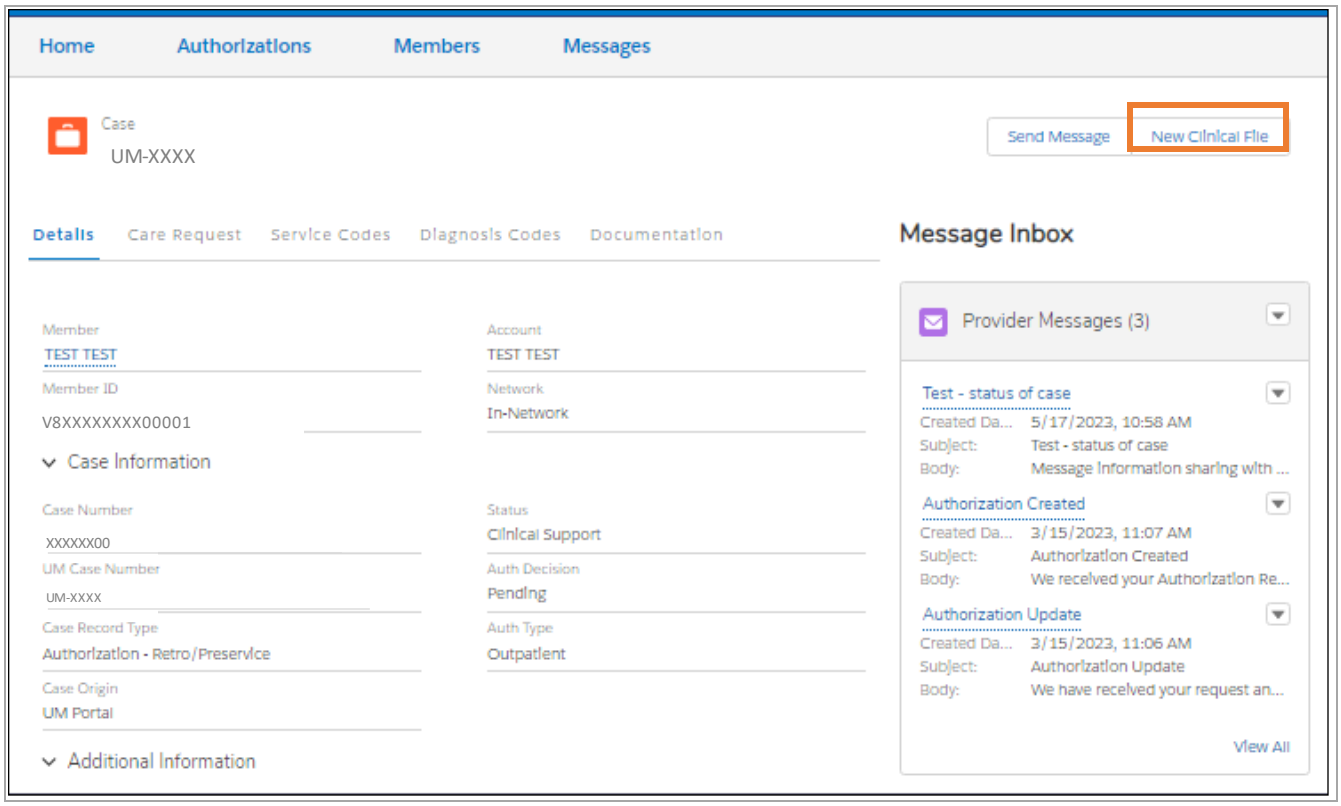


Inbox messages communicate the date, subject and some of the text. Click the hyperlink on the individual message to read or click "view all" to see an entire list of messages related to this case.

Clinical Files

Providers have the ability to submit clinical files to Blue Cross VT separately from sending messages. **These files are only accessible by secured staff and any clinical information should be submitted through this function.**

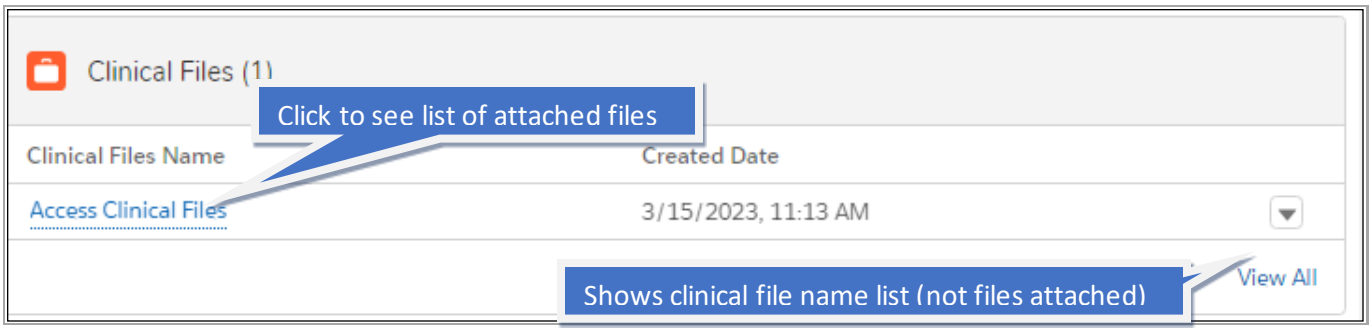
1. At the case level, click the **New Clinical File** button at the top of the case page.



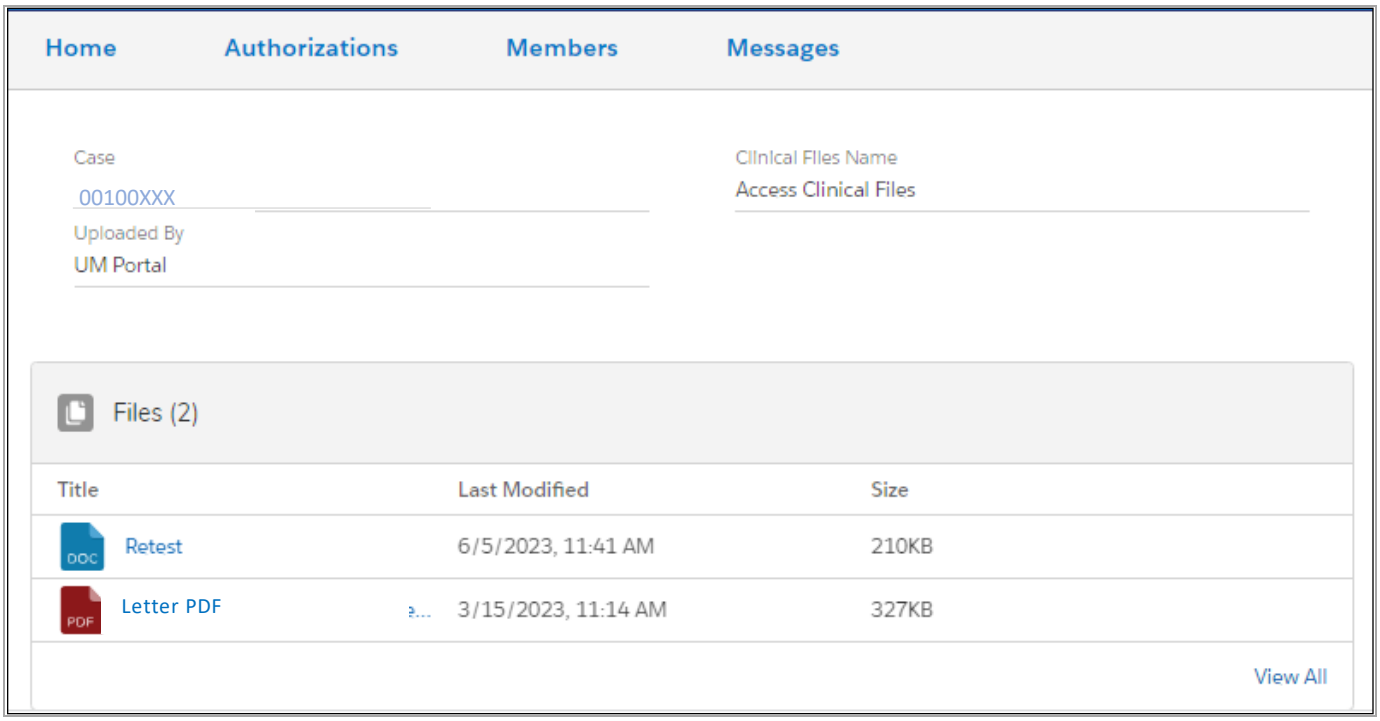
2. In the New Clinical File screen, click the Upload file or drop the file and attached the selected file.

a. The Uploaded file displays under “Uploaded files” and click Attach button when done.

4. Attached files will populate as a hyperlink. Clinical Files shows “(1)” but in order to verify files attached, click the hyperlink which will take you to the current list of uploaded files.



a. **Access Clinical file** opens to a new screen with details on the uploads and files listed.



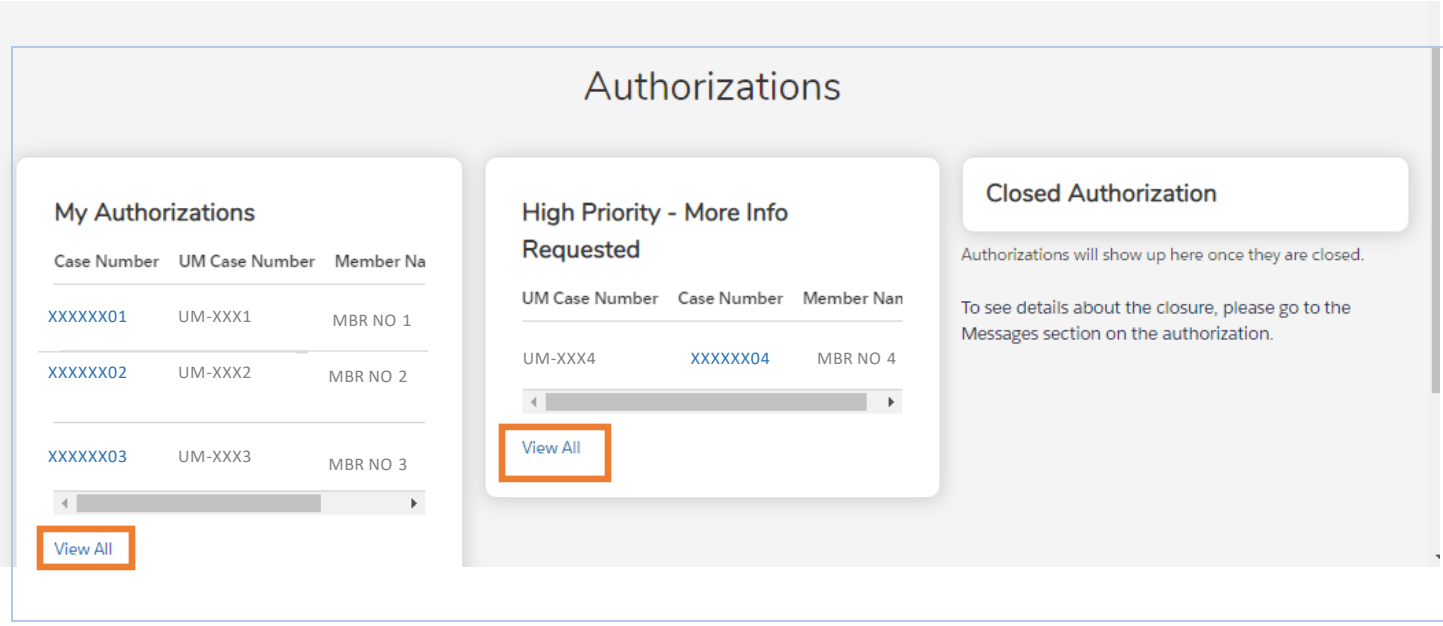
Searching for An Authorization

Users can see authorizations they create as well as authorizations:

- Created by users with the same NPI or Tax ID #
- With them listed as a requesting or service provider

My Authorizations

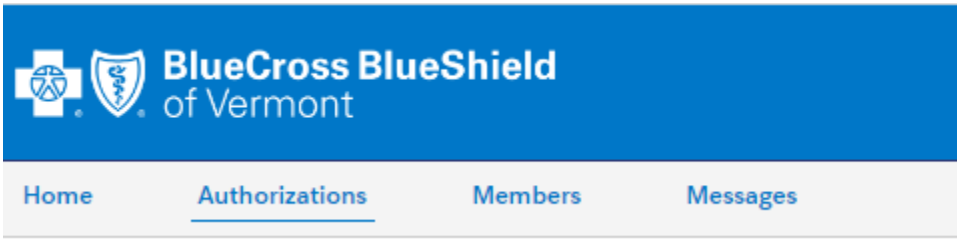
1. On the main page authorizations created by user are displayed. Review sections for authorization and click hyperlink or click on "View all" to expand the search.



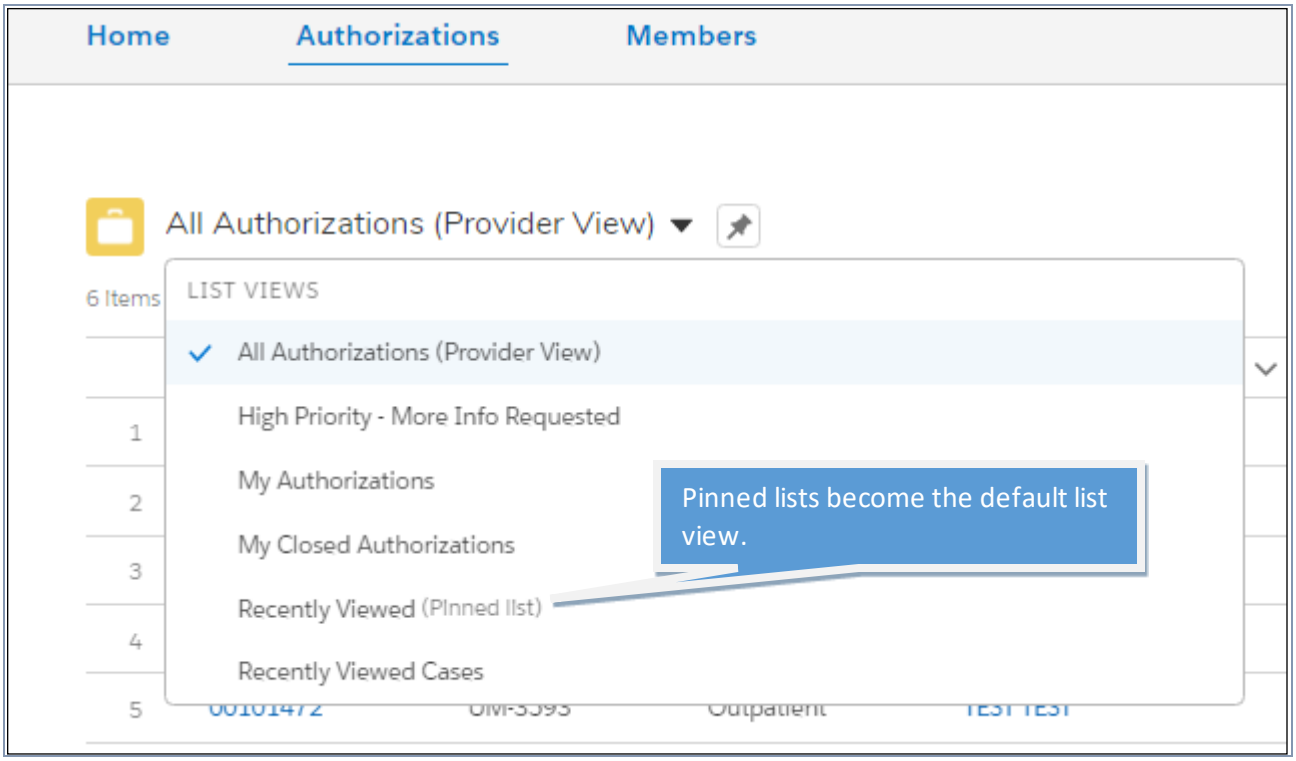
Authorization Tab

Authorizations can be viewed based on the "list view" selected by the user.

1. Click on the authorizations tab.



2. From the Authorization Tab, click the drop-down selection and choose an option:



List View Descriptions:

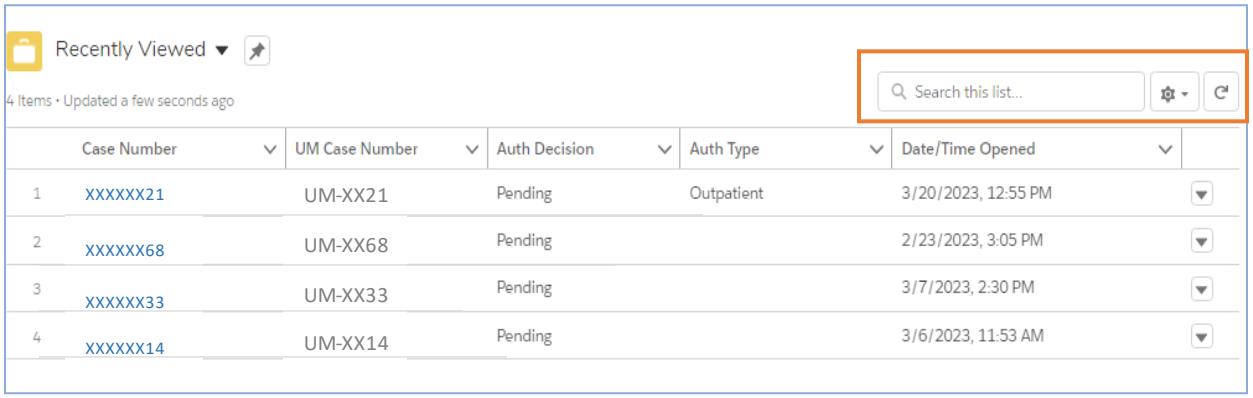
List View	Shows….
All Authorizations (Provider View)	All authorizations that the provider is listed as a creator, servicing or requesting provider
High Priority	All Authorizations with status for more information (requested by Blue Cross VT staff)
My Authorizations	Like front page – all authorizations provider created
My Closed Authorizations	All provider created authorization reflecting closed status
Recently Viewed	Recent records viewed by the user
Recently Viewed Cases	Similar to recently viewed but displaying different information columns (subject, status & case owner alias)

Pinning a list view

To save a list view as a “favorite” click the  which turns blue  and indicates that the selected list is now “pinned”

Filtering a List

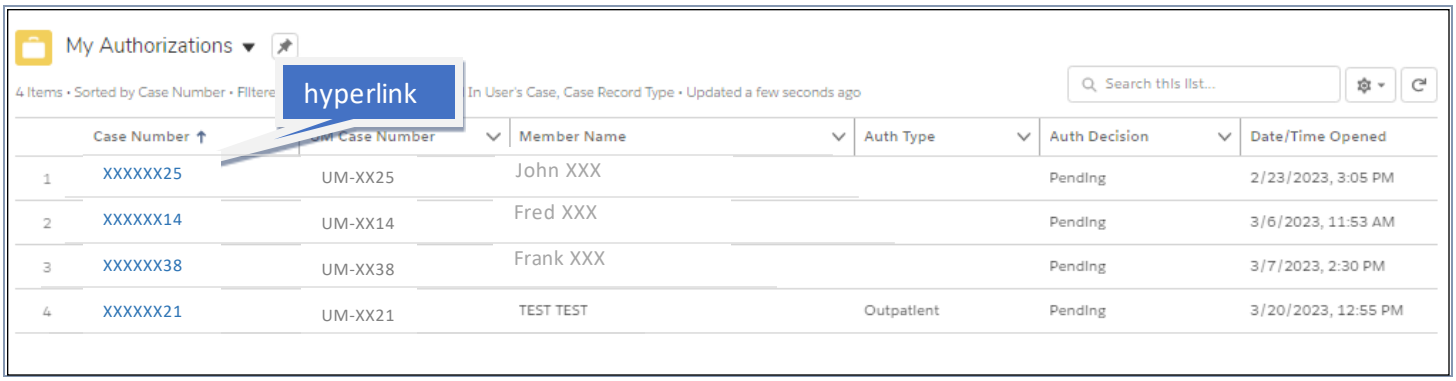
Filters are available at the top of each list view. Filters are specific to the list being reviewed so filters may be different.



Users can enter a word in the search field to try and filter to a specific case or type of case. The search Field indicates what columns cannot be used. Note: this is specific to the view list columns for each option.

Opening a case

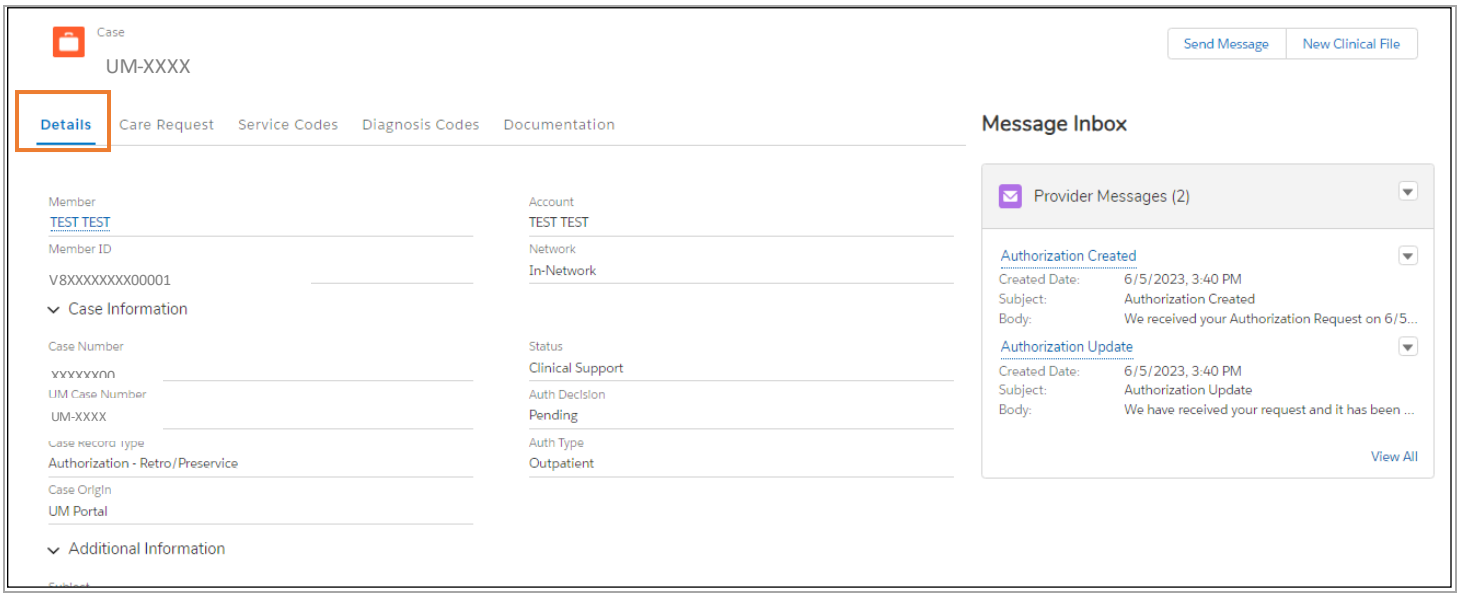
Click on the blue hyperlink to open an authorization request (case).



Reviewing an Authorization

Once the authorization is created, you can go back and access the information to see updates, decisions, and documentation (letters and files).

1. From the home page or authorization tab, select your authorization.
2. You land on the details screen of the authorization. The message inbox is seen on every tab screen.



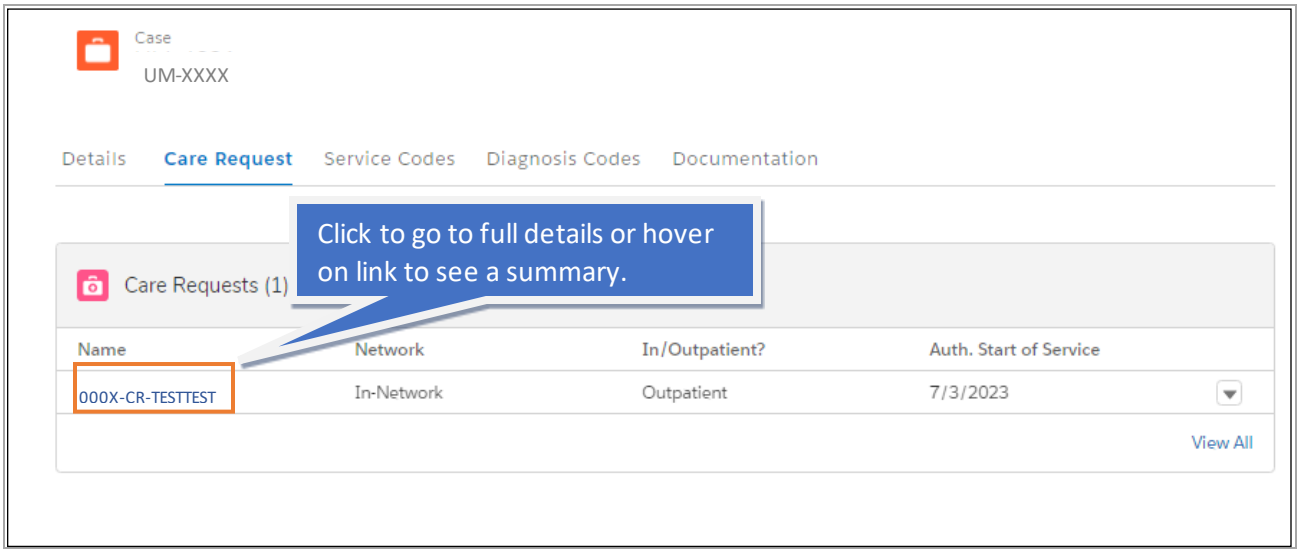
Details Tab Screen

You are able to see information you've submitted as well as the current status and decision of the authorization request. Each authorization is identified by two case numbers, either one can be used to identify the request with the internal Blue Cross VT staff.

Care Request Tab Screen

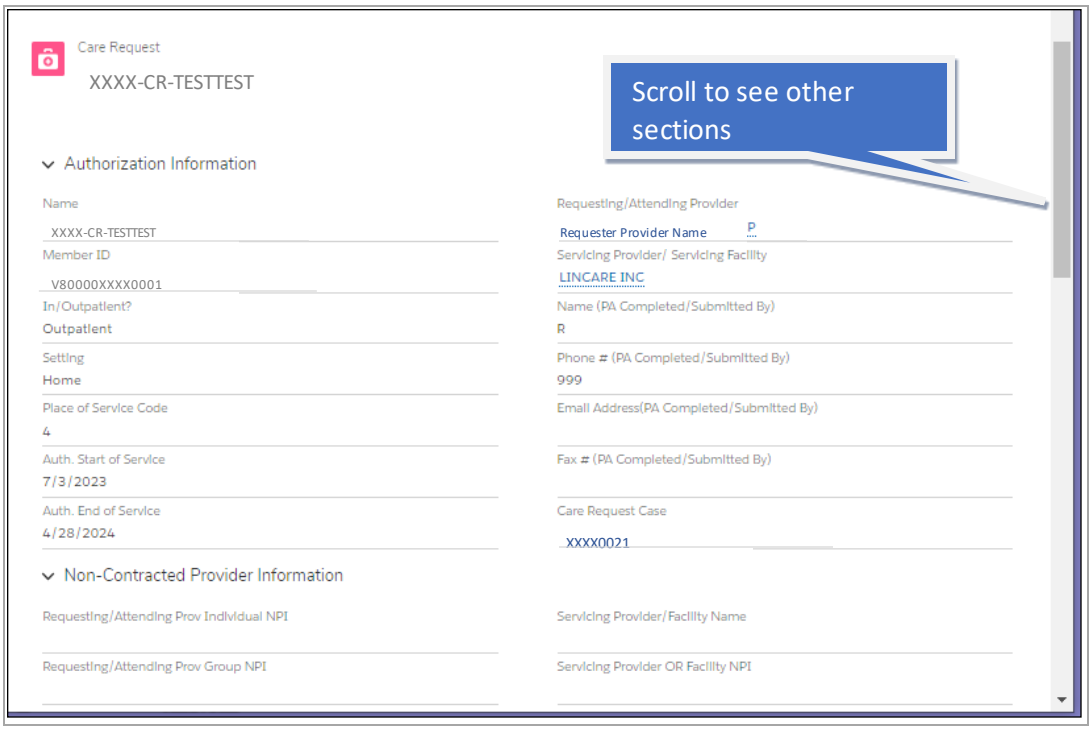
1. Click on the Care Request tab to move your view to care request information. (***To go back to other tab screens, you must use the back arrow).***

2. Click on the Auth request hyperlink to get to your care request details or hover to see a summary of request information.



3. On the care request screen, you can review information submitted on the request as well as updates to the authorization date span based on the procedure auth requested. Sections include:

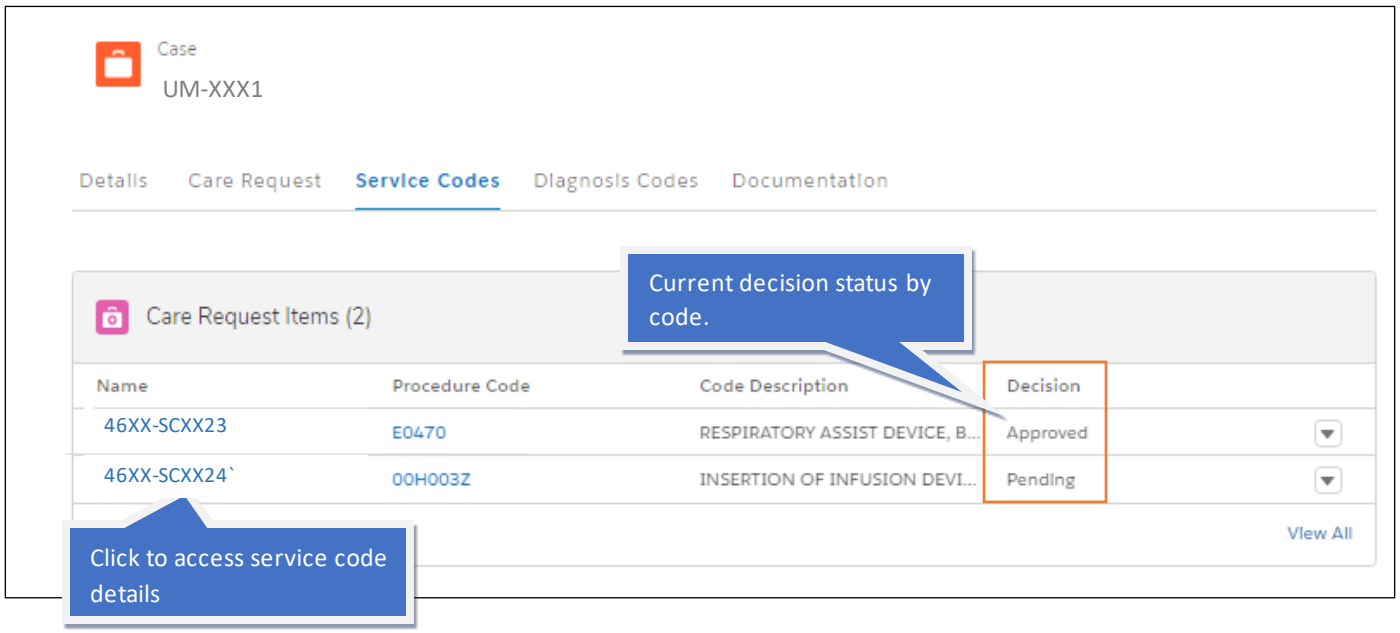
    a. Authorization Information
    b. Non-contracted Provider Information
    c. Network Information
    d. Service Information
    e. Admission Information



Service Codes

1. Review the summary screen for code summary and current decision status or click on the individual codes for more information. (***To go back to other tab screens, you must use the back arrow).***

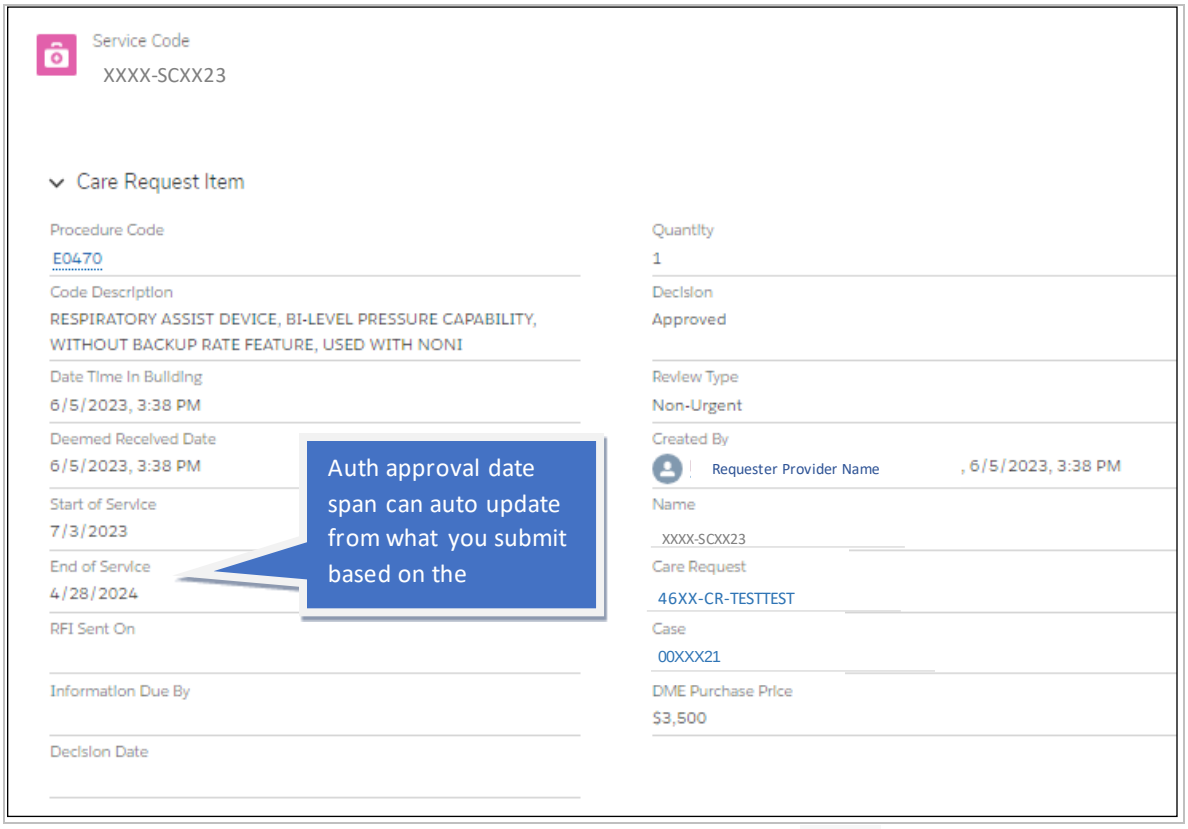
Summary



Service Code Detail Screen

1. Click on the individual code name hyperlink or procedure code to access more details on the individual code. Information includes:

    a. Code description
    b. Date the request entered the Blue Cross VT internal system.
    c. Start and end service date of authorization (this can be different than what you submitted based on the procedure submitted).
    d. RFI (Request for Information details)
    e. Current Decision
    f. Review type
    g. Case identifier information

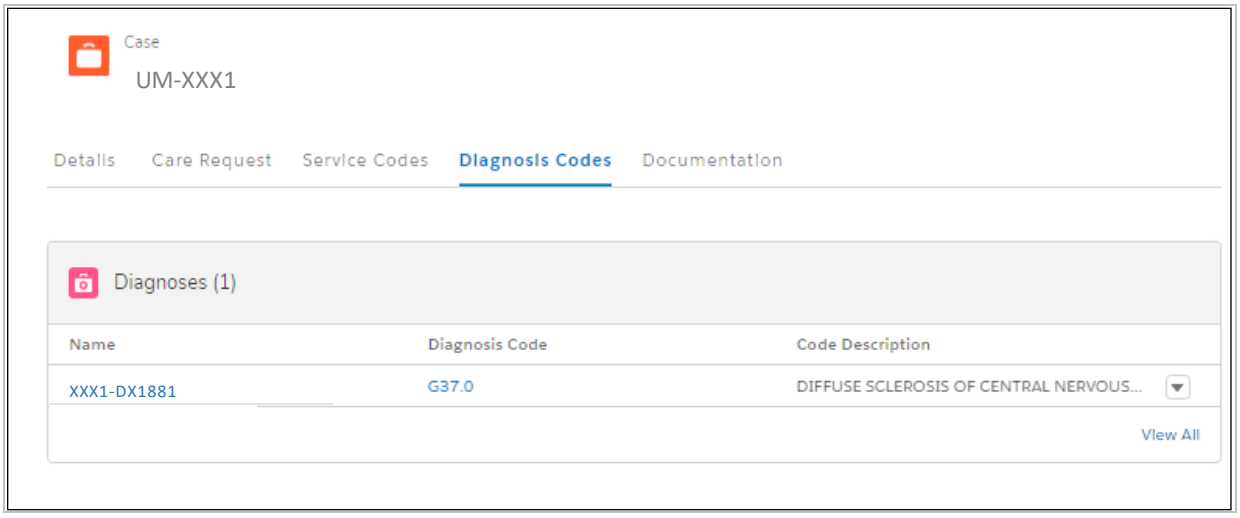


Note: Use the browser back button to go back to the case detail page.

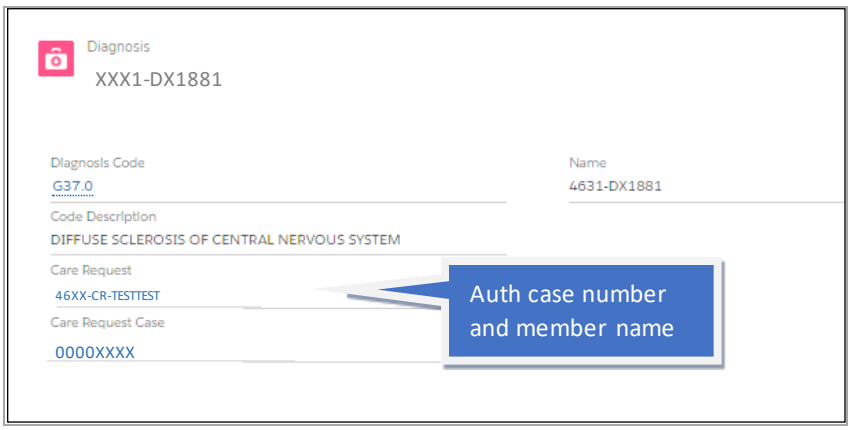
Diagnosis Codes Tab

All diagnoses display as a summary. By clicking on the link, the case information displays with the code description.

Summary



Dx Details

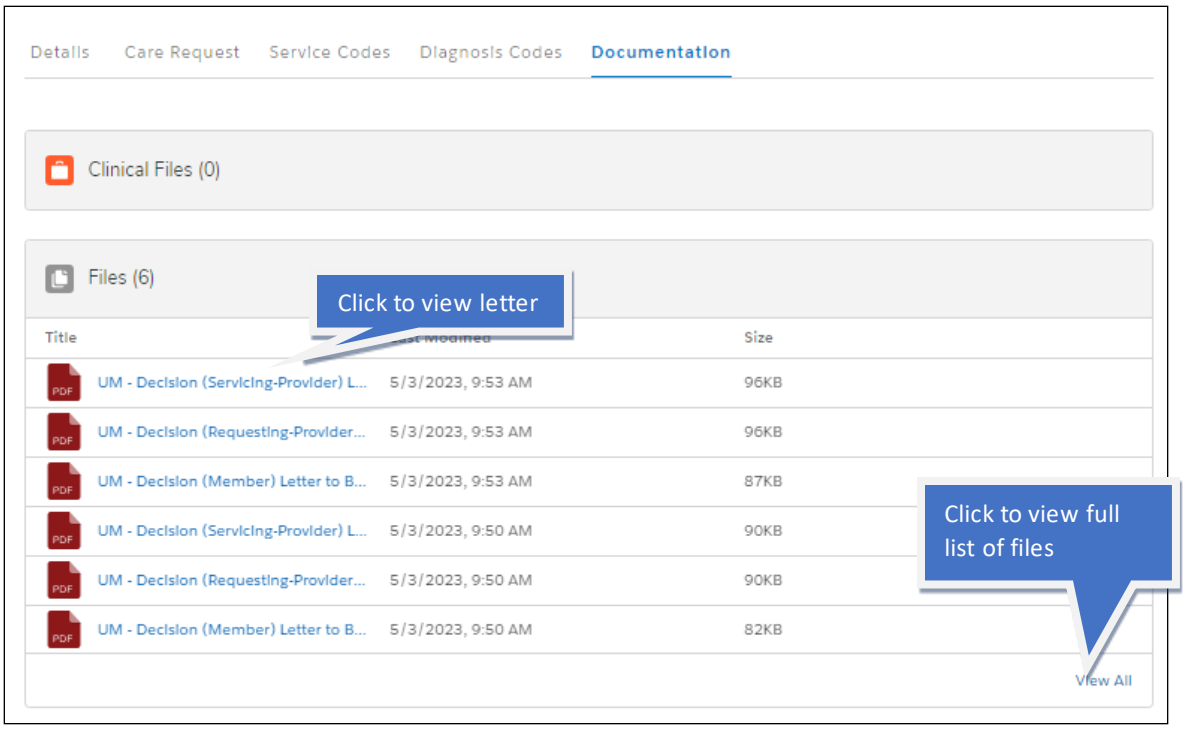


Note: Use the browser back button to go back to the case detail page.

Documentation Tab

Documentation related to the case is located on the documentation tab under two separate sections.

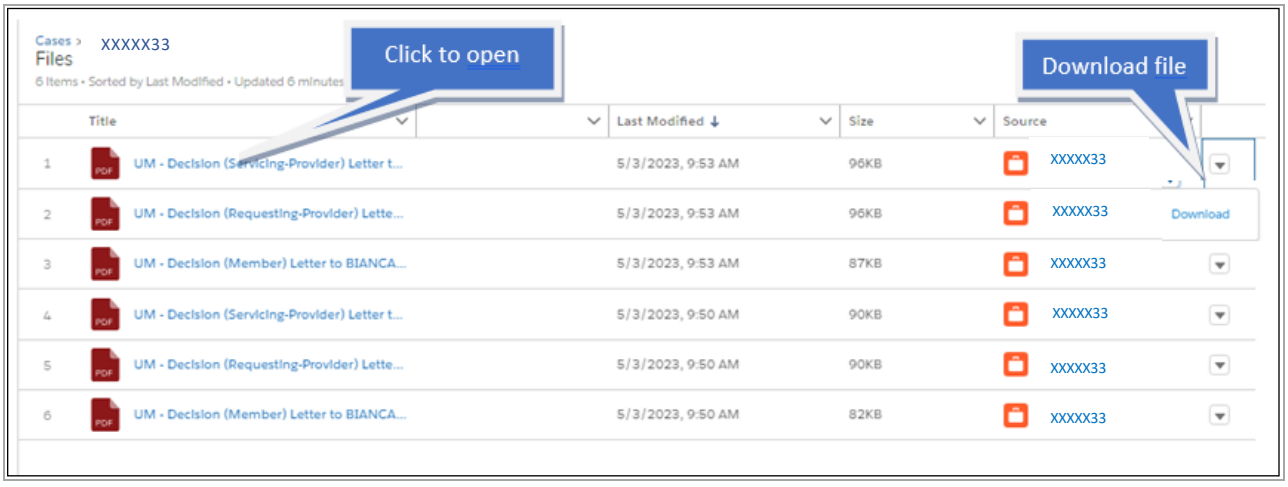
- **Clinical Files** (files the provider (you) submits to Blue Cross VT)
- **Files** – documents shared by Blue Cross VT to the provider (typically these are decision letters related to the case). Click on the hyperlink from the main box or click "view all" to have a list of all files related to this case. The file can be downloaded either from the PDF view or by clicking "download".



Note: Use the browser back button to go back to the case detail page.

View All

By clicking on the View all, you can see a list of all the files sent by Blue Cross VT related to the case. You can access the file by clicking on the title or clicking download to have the file download to your computer.



Resources

Need some help?

- Blue Cross VT Contracted Provider – contact your Provider Relations Consultant directly or if you are not sure who that is:
    - Call 1-888-449-0443 (option 1)
    - Email Providerrelations@bcbsvt.com
- Out of State providers with questions:
    - Authorization question – 1-800-922-8778 or Customerservice@bcbsvt.com
    - Access issue – contact your local Blue Plan for help

Review types

Select the review type that best fits the request at the service code screen. Below is a table of different types of requests and the criteria that should be met to select it.

Type	When to Select
Post Service	The service date has already occurred.
Pre-Notification	In-patient request to notify Blue Cross VT and initiate review to confirm appropriateness of level of care and assist with discharge planning and coordination of care for services not requiring prior approval
Urgent	Procedure or care that is subject to prior approval requirement that also has the following criteria: • Not a post service • Related to a pre-service request that may put the member in potential danger if the decision is delayed more than 48 hours for the request. *Note: All urgent requests will pend for clinical review even if the assessment is completed and approved. This is due to communication requirements.*
Non-urgent	General prior approval requests that don't fall into the "urgent" definition (see above)
Concurrent	Requesting auth for additional services that are part of an ongoing course of treatment authorized before the last covered date
NEHP Urgent	Procedure or care that is subject to prior approval requirement that also has the following criteria: • Not a post service • Related to a pre-service request that may put the member in potential danger if the decision is delayed more than 48 hours for the request. *Note: All urgent requests will pend for clinical review even if the assessment is completed and approved. This is due to communication requirements.*
NEHP Non-Urgent	General prior approval requests that don't fall into the "urgent" definition (see above)

NEHP Cross Border Referral	Out of Network requests for services being performed out of the state of Vermont for NEHP members with a Vermont PCP
FEP Urgent	FEP urgent is define as an urgent care if waiting for the regular time limit for non-urgent could have the following impact: • Seriously jeopardize the member's health or life; • Waiting could seriously jeopardize the member's ability to regain maximum function; or • In the opinion of the provider with knowledge of the member's condition, waiting would subject the member to severe pain that could not adequately be managed without care or treatment this is subject to prior approval requirement.
FEP Non-urgent	FEP procedures that do not fall within the definition of "urgent" (see above) but are on the prior approval list.
FEP Advance Benefit Determination	Request for coverage information regarding a non-urgent high-cost service, procedure or DME item which the FEP contract does not require precertification or prior approval before it is performed.
FEP Concurrent	FEP request related to continuing care or ongoing course of treatment subject to prior approval.
FEP Post-Service	The FEP member's procedure has already occurred and required prior approval.

Settings for Auto Approval Submission

Contracted providers are able to get automatic decisions related to specific services. Below are the setting and service type selections related to each scenario:

Auto Approval for	**Setting**	**Service Type**
• Continuous Positive Airway Pressure (CPAP) **OR** • Biphasic Positive Airway Pressure (BiPAP)	Home	DME
Chiropractic Services **only one procedure code required*	N/A or Multiple	Chiropractic Services
Monitored Anesthesia for an Endoscopy	Outpatient Hospital/Facility	Outpatient Surgery
Non-Emergency Ambulance	Ambulance	Land and Water Ambulance
Oral Appliance for Obstructive Sleep Apnea	N/A or Multiple	Dental
Sleep Study-Adult	N/A or Multiple	Sleep Study
Varicose Vein surgery	N/A or Multiple	Vein Surgery
Wireless Capsule Endoscopy	Outpatient Hospital/Facility	Outpatient Surgery