WYOMING

A Manual for In-network Health Care Professionals and Hospitals

Policies and Procedures

Revised June 27, 2022

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Welcome!

Dear Wyoming Provider:

Welcome to the BCBSWY participating Provider family. You join more than 3,500 health care Providers across Wyoming offering health care to our Members. You have a direct impact on the satisfaction of our Members and the quality of the care they receive, and we appreciate your participation.

This manual will help keep you and your staff informed about Blue Cross and Blue Shield of Wyoming's (BCBSWY) operational policies and procedures.

The contents of this manual are contractually binding for compliance based on your Provider agreement with BCBSWY. Providers must follow all applicable BCBSWY policies and procedures, as well as those applicable to the covered Member. Contracting 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. It is also available online at BCBSWY.com by clicking "Providers" then "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,

Kris Urbanek, Director
Care Delivery & Provider Affairs
#WyomingTogether

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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. Neither this manual nor any statement in it constitutes a contract, policy, promise or obligation on the part of BCBSWY. This is not a legally binding document. Any conflicting provisions in your Participation Agreement or in a Member's benefit plan control over the conflicting provisions in the 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.

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.

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About Blue Cross and Blue Shield of Wyoming

Who We Are

Blue Cross and 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 up put down roots in 1945, everything we do is aimed at 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 methods of measurement

Our Mission

Our 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 healthcare 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

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Section 1 Join our Network

Contracting

Participating Providers are important partners in keeping healthcare 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. 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 that each network Provider is qualified by education, training, licensure and experience to deliver quality healthcare services to our Members.

Who needs to be credentialed?

The credentialing process needs to be completed by all Providers who wish to provide covered healthcare 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 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 post graduate 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/.

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 on the basis of 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 ten (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.

    a. 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.

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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 which it 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 ten (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; or

7. Provider takes any action or makes any communication which 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 who 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

Blue Cross Blue Shield of Wyoming (BCBSWY) maintains a formal Dispute Resolution Process to allow Providers to challenge decisions made by BCBSWY that affect the Provider's status as a Participating Provider in one or more of BCBSWY's Provider networks.

NOTE: The Dispute Resolution Process is not available to Participating Providers where the termination or removal from a BCBSWY Provider network was a result of:

1. Repeated non-performance of obligations without corrective action
2. Revocation of medical licensure
3. Violations of professional standards
4. The commission of unlawful acts.

These situations constitute grounds for termination for cause from the BCBSWY Provider networks, as outlined in the Participating Provider Agreement, and do not give rise to a right to BCBSWY's Dispute Resolution Process.

Upon being denied inclusion in the BCBSWY Provider network, or upon Provider's termination or removal from the BCBSWY Provider network, a Provider has the right to dispute the actions taken by BCBSWY with a written request to BCBSWY to initiate the Dispute Resolution Process. The Provider must include the following information in his/her written request:

- The nature of the problem,
- Previous attempts, if any, to resolve the issue, and
- Any other pertinent information.

The Provider may submit a request for the Dispute Resolution Process in writing, either by electronic mail, surface mail, special delivery or other source of written communication to BCBSWY at the following address:

Blue Cross Blue Shield of Wyoming
Attn: Provider Relations
P.O. Box 2266 Cheyenne, WY 82003
Provider.relations@bcbswy.com

The formal Dispute Resolution Policy is documented and reviewed at least annually by the Credentialing Committee. The Medical Director and at least one licensed Participating Provider sit on the Credentialing Committee.

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 is 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 of time 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 are more protected from fraud.
- 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. View this quick start guide to get started.

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 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

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.

BCBSWY requests that Providers inform Provider Relations by calling 888-666-5188 or emailing Provider.relations@bcbswy.com when they are no longer accepting new patients.

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Subcontractor Approval Process

Follow these instructions to Request Sub-contracting of Contracted Services:

- Subcontractors cannot start work until they have submitted a written request for sub-contracting and the Contractor/Provider has been granted written approval by BCBSWY.
- The primary Provider/contractor must identify those individuals to which it intends to sub-contract, including their location/address, credentials, and the specific services to be performed.
- The Provider/contractor must submit a copy of the sub-contracting agreement. This agreement must specify that the sub-contractor 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 sub-contractor 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 sub-contracting 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 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.

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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
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** I **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 I 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** I **Enrollments Center** I **ERA Enrollments**

Set up ERA Reporting Preferences…

- Click **Claims & Payments** I **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.

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Claim Status

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

1. Click **Claims & Payments I 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** I **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*

- Complete the following:
  - Provider Type
  - Place of Service

Helpful Hint:

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

Select the applicable **Benefit/Service Type** from the drop-down menu and complete the **patient information**.

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!

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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/ 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.

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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.

If you know the procedure codes, you can also search these procedure code lists found on our website here: Authorization Required Procedure Codes.

You'll see two lists—the first list always requires prior authorization, followed by a list of codes that is subject to BCBSWY medical policies and will deny for the following reasons if medical policy criteria is not met and an authorization is not on file:

- deny for no authorization; or
- deny for not medically necessary; or
- deny experimental/investigational; or
- deny for records

Authorization numbers are included for services which do not require BCBSWY prior authorization requests but may be required by your practice.

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. The authorization tool is found under ***Patient Registration***.

Click Here to see the BCBSWY Online Authorization Training Guide

You can also complete the Prior Authorization Request Form and submit it as instructed. Medical records will be required with each submission.

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

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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 14 calendar days from date of receipt.
- Urgent prior authorization requests will be processed within 3 calendar days from date of receipt.
- The Provider, rendering facility and Member will be notified in writing of the determination (via U. S. Mail).
- Once a determination has been made a fax response will be immediately sent.

Checking Authorization Status

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

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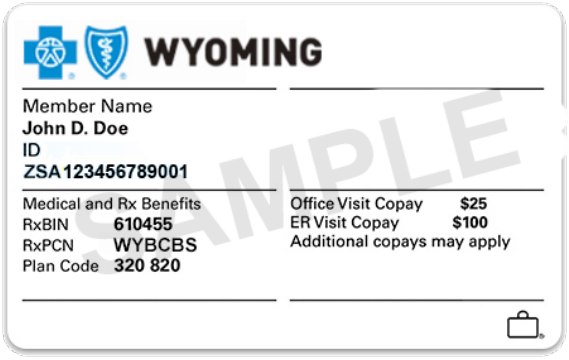
Prior Authorization Admission Request

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 on Medicare and has a contract number beginning with ZSM

Get Started

- Login to 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. 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.

First, go to ***Authorization Dashboard*** and find the ***Inpatient authorization*** that requires an extension. Then, select Update. Follow the prompts to complete the request.

Providers 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. 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?
Authorizations	307-432-2917	• Prior Authorization request • Service and admission inpatient authorizations • Pharmacy authorizations
Concurrent Review	307-432-2756	• Updates and records for current inpatient stays

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.

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
Medicare Denials QWY, YWY, ZRW, ZSD, ZSF, ZSH, ZSK, ZYW, and R.	Secondary authorization required.	Secondary authorization required.
Prefixes beginning with ZSM	No authorization required.	No authorization required.
All Prefixes	**CAR-T** **Transplants**	**CAR-T** **Transplants**

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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 showing 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

Fax:
307-432-2942

Helpful Hint:

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

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 ten 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.

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Section 4 Claim Processing

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

- 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**. BCBSWY has timely filing deadline of one year from the date of service. However, some groups have a deadline of less than a year. Therefore, we encourage providers to **submit claims within 60 days of the date of service** as timely filing may impact benefit determination.

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 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.

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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:

- 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 fields found below, as changes have occurred as of January 1, 2019.

- Sex
- Revenue code (if 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 (CCI) 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 CCI edits and Provider claims must follow the CCI standards.

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

Grace Period

The Affordable Care Act 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 has 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 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 Hint:

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, be sure to 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.

Field No.	Field Name	Explanation
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.
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.

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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 Blue Cross Blue Shield of Wyoming Member, please contact our Member Services department at 1-800-442-2376.

Payment Methodology

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

- 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 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 its 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, 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.

Effective April 1, 2014 when a Medicare primary claim is submitted to the Medicare intermediary, BCBSWY is asking 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.

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Process for Professional Claim Adjustments

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

1. Complete the Request for Claim Adjustment Form

2. 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

3. 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

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 which you are requesting the change.
- Please give a detailed explanation of changes you are requesting.
- 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 Blue Cross Blue Shield of WY, 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.

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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 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).

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Section 5 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 inquires.

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 three to four-character **prefix** (the first three positions of the identification number)
- The three-character **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 three-character 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 Router (out-of-area Members) to view the applicable Blue Plan's medical policy or general pre-certification/preauthorization information.

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, follow these simple 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 three to four-character 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 Blue Cross Blue Shield of Wyoming.

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 Blue Cross Blue Shield of Wyoming 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 healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare 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 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

2. **What is a "prefix?"**

The three-character 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:

	MEDICARE ADVANTAGE | HMO	Health Maintenance Organization

Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:	MEDICARE ADVANTAGE | MSA	Medical Savings Account
	MEDICARE ADVANTAGE | PFFS	Private Fee-For-Service
	MEDICARE ADVANTAGE | POS	Point of Service
	MA | PPO MEDICARE ADVANTAGE	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 three-character 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—Submit a HIPAA 278 transaction (referral/authorization) to Blue Cross Blue Shield of Wyoming.

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 three-character 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.

Contacts

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

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

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

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

Section 6 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.

The website at 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 7 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 by clicking on the **Providers tab** and then **Clinical Resources,** in the drop down 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.

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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

Hours:	Monday-Friday	6:00 AM -- 9:00 PM MT
	Saturday	7:00 AM -- 2:00 PM MT
	Sunday	10:00 AM – 2:00 PM 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. You can also verify eligibility and benefits for BCBSWY Members through this website.

To register and get started visit: 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

Hours: Monday-Friday 8:00 AM - 5:00 PM MT

Section 8 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. Healthcare 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: 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

Helpful Hint:

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

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Section 9 Communicating with BCBSWY

Availity Provider Portal

Availity Client Services Phone: 800-282-4548

Hours: Monday - Friday 6:00 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 7:00 a.m. to 5:00 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: 800-442-2376

Case Management

Phone: 307-829-3081

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Dental

Phone: 844-653-4057

Hours: Monday – Friday 8:00 AM – 5:00 PM 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

Fax Requests

Document Destination	Fax Number	What should be sent here?
Authorizations	307-432-2917	• Pre-authorization request • Initial inpatient hospital authorization • Pharmacy authorizations
Concurrent Review	307-432-2756	• Updates and records for current inpatient hospital stay
Appeals	307-432-2942	• All pre and post service appeals • Claim Adjustment forms and records • Records for denied claims
Medical Records	307-635-9366	• Requested medical records

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 8:00 AM – 5:00 PM 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.

Please do not contact the 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 email Provider.relations@bcbswy.com and let us know you would like to be added. An archive of past e-bulletins can be found at: BCBSWY.com/Providers/updates/

Vision

Phone: 1-800-584-2865

Hours:	Monday-Friday	6:00 AM -- 9:00 PM MT
	Saturday	7:00 AM -- 2:00 PM MT
	Sunday	10:00 AM – 2:00 PM MT

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