

Prior Authorization Portal Guide



PRIOR AUTHORIZATION PORTAL USER GUIDE

Contents

Introduction.....	3
Users	3
Purpose	3
Log In.....	3
Access Issues:.....	3
Best Practice	3
Homepage	4
1. User Profile	4
2. Tabs.....	5
3. Find a Member.....	5
4. Authorizations.....	5
Searching for a Member.....	6
Creating an Authorization Request	8
Note:.....	10
Provider Not Found in Lookup.....	10
Providers with Multiple Affiliations.....	11
Assessments.....	15
Failed Submissions.....	18
Messages	18
Sending Messages.....	18
Viewing Messages.....	20
Message Tab.....	21
Message Inbox.....	21
Clinical Files	22
Searching for An Authorization	25
My Authorizations	25
Authorization Tab	25
Pinning a list view.....	27

Filtering a List.....	27
Opening a case.....	27
Reviewing an Authorization	28
Details Tab Screen	28
Care Request Tab Screen.....	29
Service Codes	30
Summary.....	30
Service Code Detail Screen.....	31
Diagnosis Codes Tab.....	31
Summary.....	32
Dx Details.....	32
Documentation Tab	32
View All	33
Resources.....	34
Need some help?.....	34
Review types.....	34
Settings for Auto Approval Submission.....	35

Introduction

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

Users

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

Purpose

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

Log In

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

Access Issues:

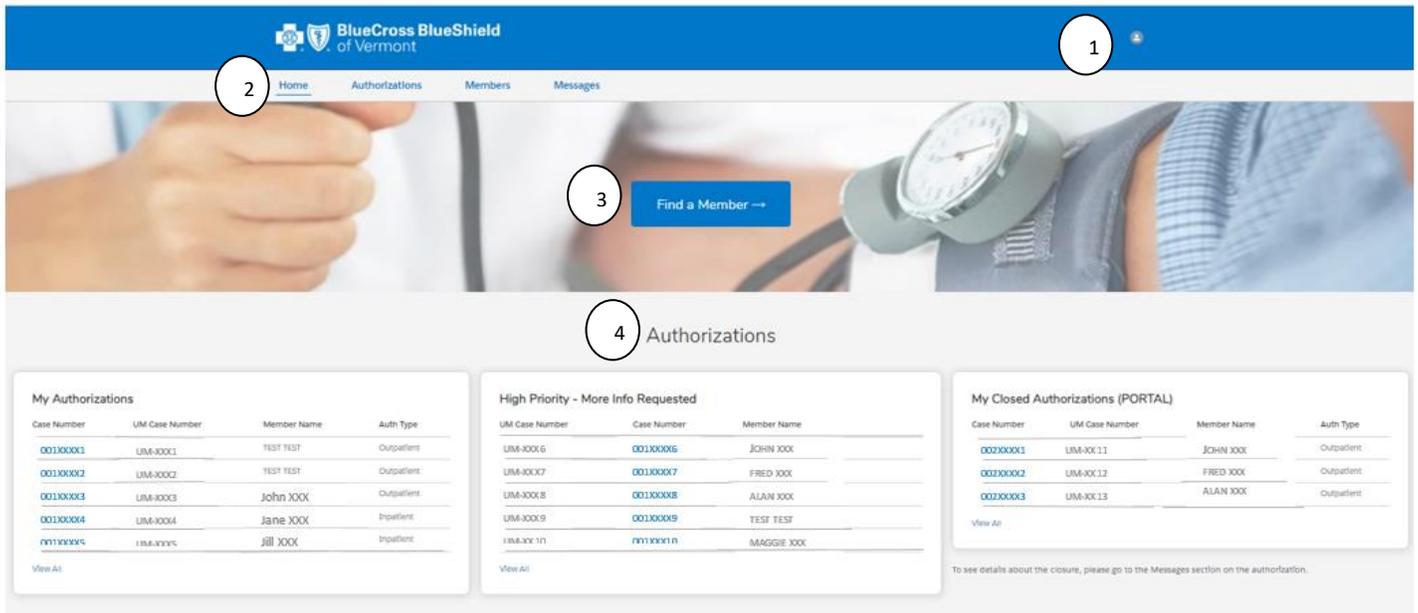
Access is set from the initial access to the Provider Resource Center. If access to the Prior Authorization Portal is not working, contact your individual provider relations representative, email providerrelations@bcbsvt.com or call 1-888-449-0443 (select option1).

Best Practice

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

Homepage

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



On this page you can:

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

1. User Profile

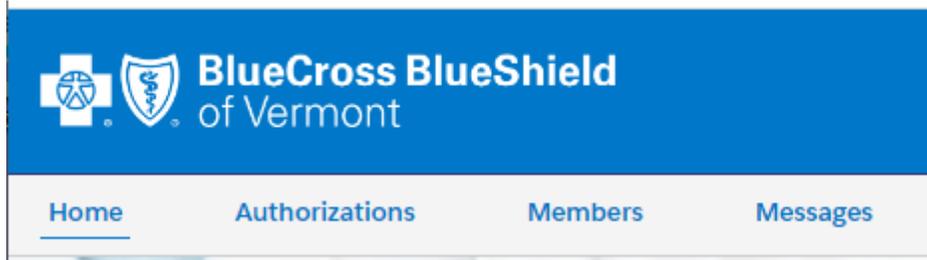


Click the person icon to log out of the system.

2. Tabs

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

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



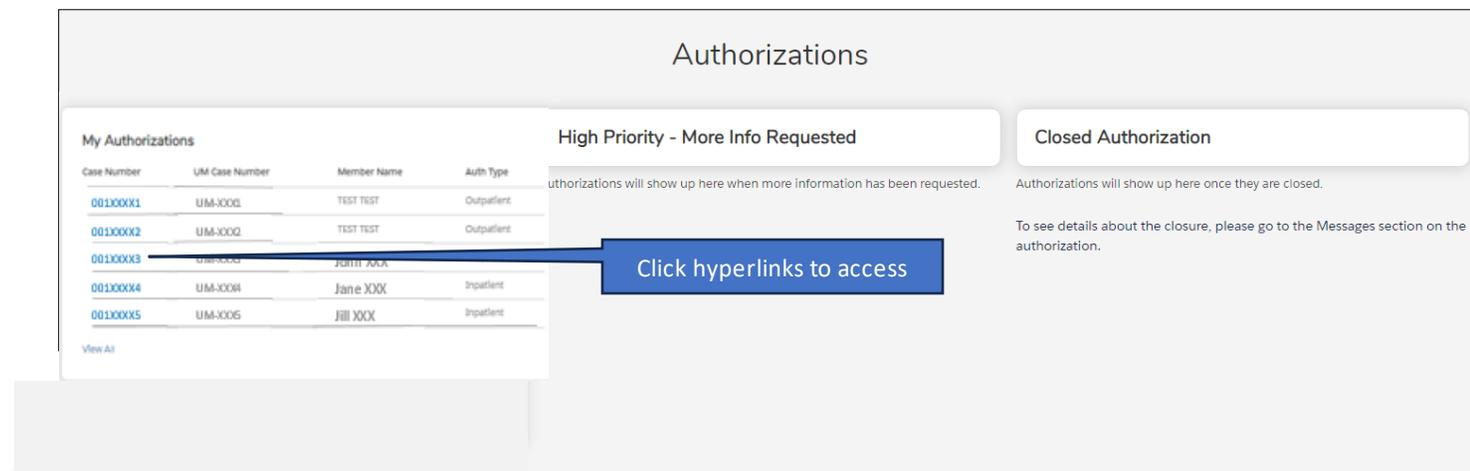
3. Find a Member

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

4. Authorizations

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

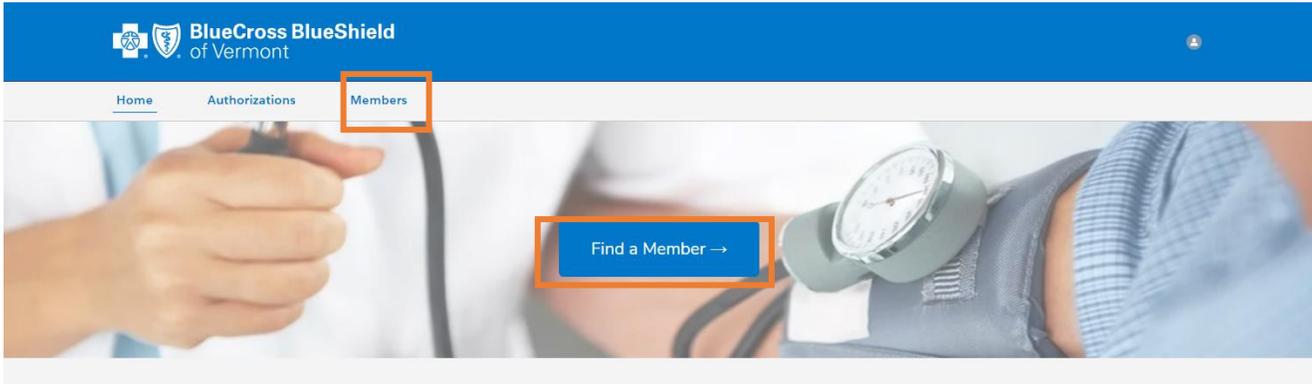
- My Authorizations
- High-Priority
- Closed Authorizations



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

Searching for a Member

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



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

A screenshot of the 'Find a Member' search form. The form has a title 'Find a Member' and a sub-section 'Member Search'. It contains four input fields: '* First Name' with the value 'J', '* Last Name' with the value 'D', '* Member ID (Enter full Member ID)' with the value 'V8XXX0000001', and '* Date of Birth' with the value 'Apr 28, 2023' and a calendar icon. A blue 'Next' button is located at the bottom right of the form and is highlighted with an orange box.

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

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

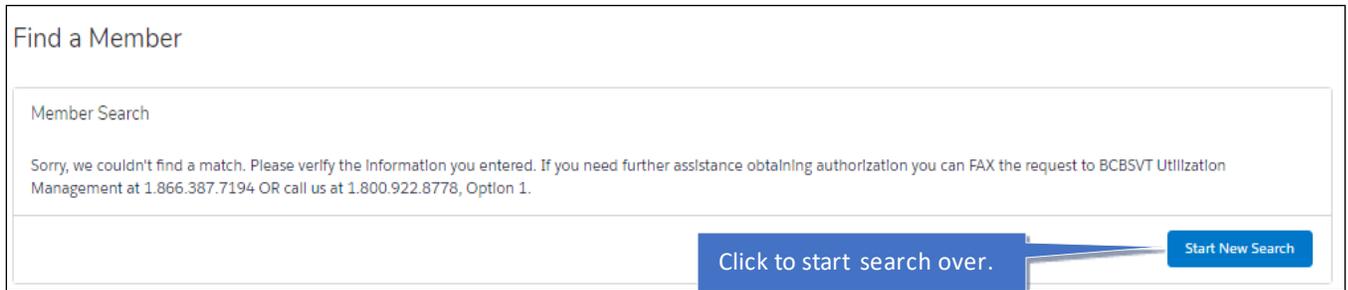
3. Click



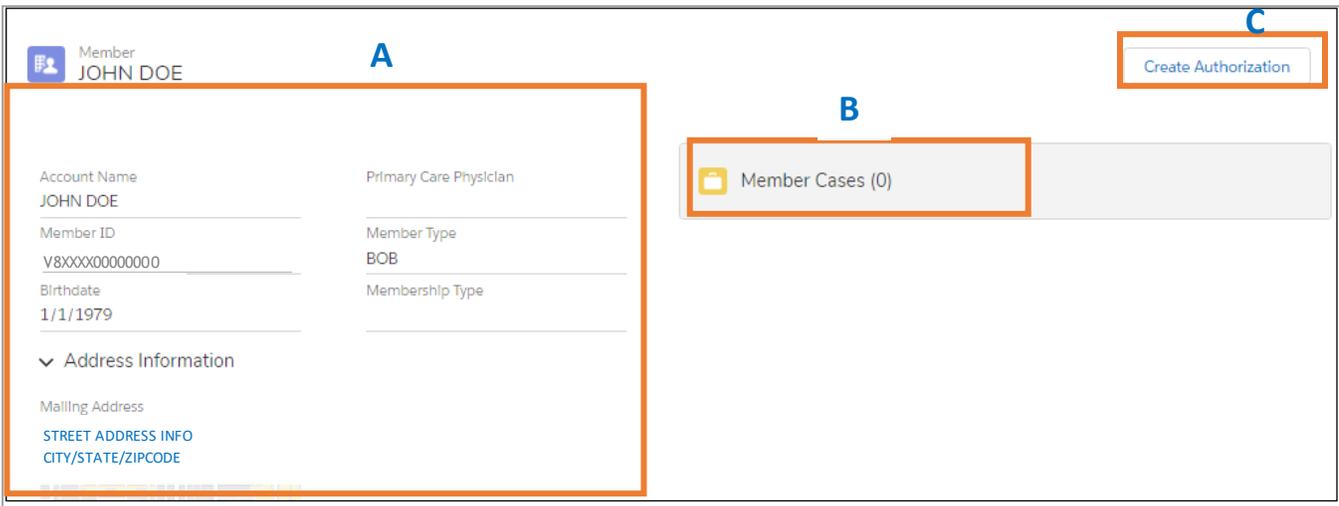
4. Any matching member information is populated (note: **only** active members will display):



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



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



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

Creating an Authorization Request

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

1. Find the member through [Member Search](#)

Create Authorization

2. From the Member profile page, click

3. **Service Details Screen**

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

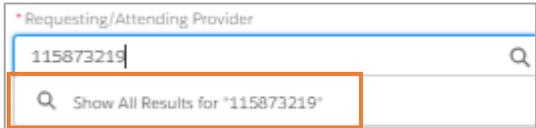
Create Authorization

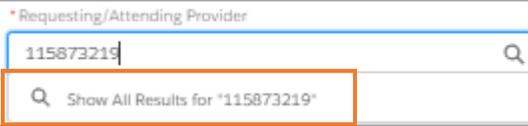
You are creating an authorization for Member ID: V8XXXX00000001

Please enter the service details for your authorization:

*In Outpatient	*Auth Start of Service
--None--	
*Rendering Provider Network	*Auth End of Service
In-Network	
*Name (PA Completed/Submitted By)	*Requesting/Attending Provider
	Search Healthcare Providers...
*Phone (PA Completed/Submitted By)	<input type="checkbox"/> Requesting/Attending Provider not found in the lookup
	*Servicing Provider/ Servicing Facility
	Search Healthcare Providers...
	<input type="checkbox"/> Servicing Provider/Servicing Facility not found in the lookup
	Fax (PA Completed/Submitted By)
	Email (PA Completed/Submitted By)
	you@example.com

Next

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

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

Note:

Provider Not Found in Lookup

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

Create Authorization

Requesting/Attending Provider Information

ALL ADDRESS FIELDS MUST BE COMPLETED. MISSING INFORMATION COULD DELAY AUTHORIZATION PROCESSING.

<p>* Name <input style="width: 90%;" type="text"/></p> <p>* Individual NPI <input style="width: 90%;" type="text"/></p> <p>Group/Practice NPI <input style="width: 90%;" type="text"/></p> <p>TIN Requesting Provider <input style="width: 90%;" type="text"/></p>	<p>* Phone Number <input style="width: 90%;" type="text"/></p> <p>Address (REQUIRED) Street <input style="width: 95%;" type="text"/></p> <p>City <input style="width: 60%;" type="text"/></p> <p>State/Province <input style="width: 60%;" type="text"/></p> <p>Zip/Postal Code <input style="width: 60%;" type="text"/></p> <p>Country <input style="width: 60%;" type="text"/></p>
--	--

Servicing Provider/Facility Is same as Requesting/Attending Provider

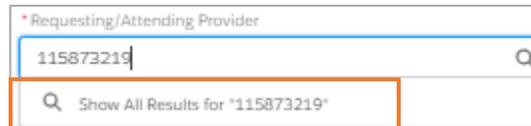
*all Red asterisks indicated required fields.

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

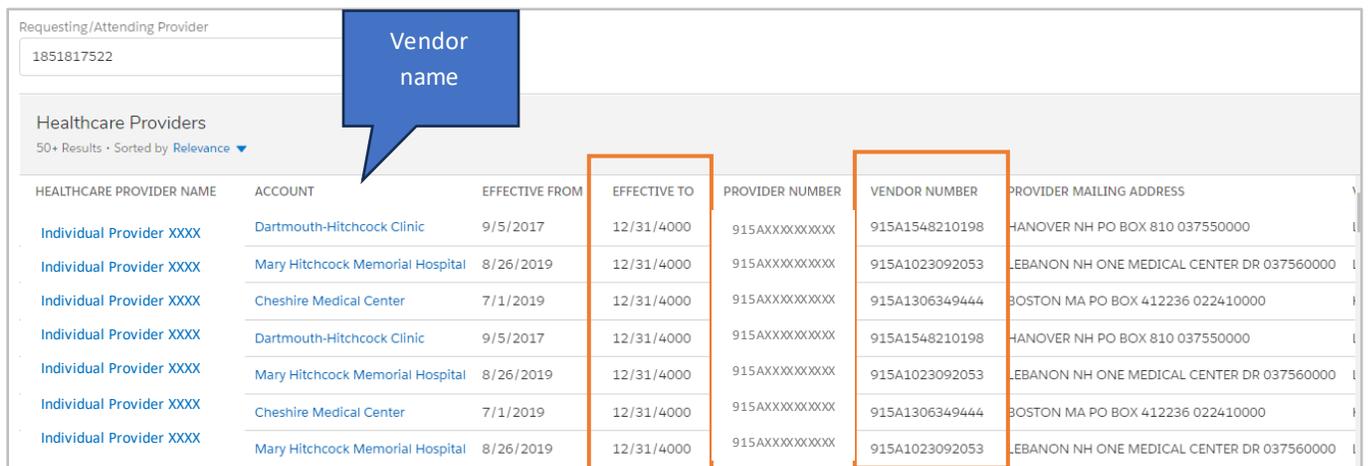
Providers with Multiple Affiliations

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

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



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



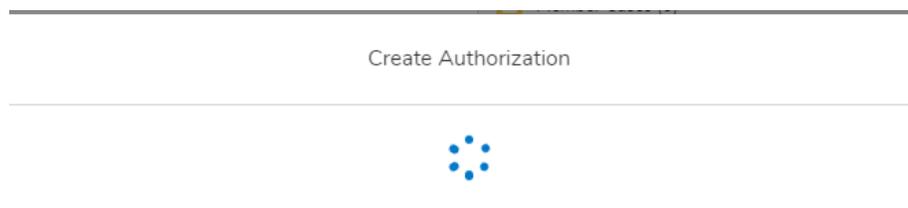
HEALTHCARE PROVIDER NAME	ACCOUNT	EFFECTIVE FROM	EFFECTIVE TO	PROVIDER NUMBER	VENDOR NUMBER	PROVIDER MAILING ADDRESS
Individual Provider XXXX	Dartmouth-Hitchcock Clinic	9/5/2017	12/31/4000	915AXXXXXXXXXXX	915A1548210198	HANOVER NH PO BOX 810 037550000
Individual Provider XXXX	Mary Hitchcock Memorial Hospital	8/26/2019	12/31/4000	915AXXXXXXXXXXX	915A1023092053	LEBANON NH ONE MEDICAL CENTER DR 037560000
Individual Provider XXXX	Cheshire Medical Center	7/1/2019	12/31/4000	915AXXXXXXXXXXX	915A1306349444	BOSTON MA PO BOX 412236 022410000
Individual Provider XXXX	Dartmouth-Hitchcock Clinic	9/5/2017	12/31/4000	915AXXXXXXXXXXX	915A1548210198	HANOVER NH PO BOX 810 037550000
Individual Provider XXXX	Mary Hitchcock Memorial Hospital	8/26/2019	12/31/4000	915AXXXXXXXXXXX	915A1023092053	LEBANON NH ONE MEDICAL CENTER DR 037560000
Individual Provider XXXX	Cheshire Medical Center	7/1/2019	12/31/4000	915AXXXXXXXXXXX	915A1306349444	BOSTON MA PO BOX 412236 022410000
Individual Provider XXXX	Mary Hitchcock Memorial Hospital	8/26/2019	12/31/4000	915AXXXXXXXXXXX	915A1023092053	LEBANON NH ONE MEDICAL CENTER DR 037560000

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

b. Click



(image below appears until the next screen loads)



4. From **the Procedure Screen**:

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

Create Authorization

* Procedure Code
 ✕

* Review Type

Quantity

Add another procedure code

* Start of Service

* End of Service

Click to add another procedure code

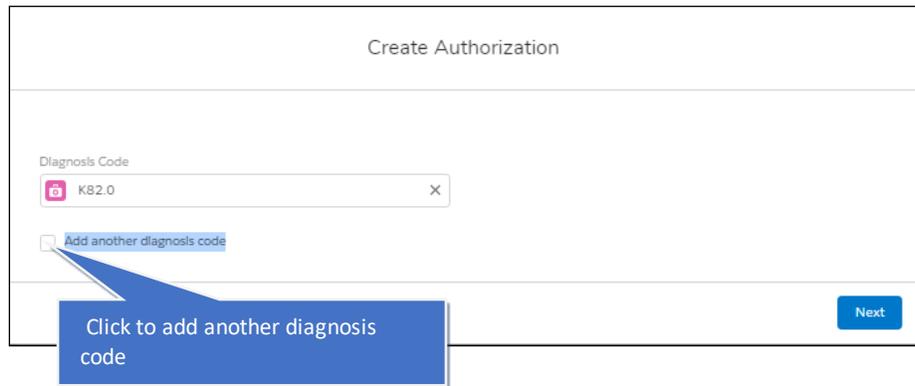
Field Name	Required	Format
Procedure code	Y	Type code and select from the codes that appear from the picklist that match the code required. (Note – codes must be selected from the picklist to be finalized). Codes will begin with . <i>*for eligible chiro services, only enter one code</i>
Review type	Y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

- b. Select

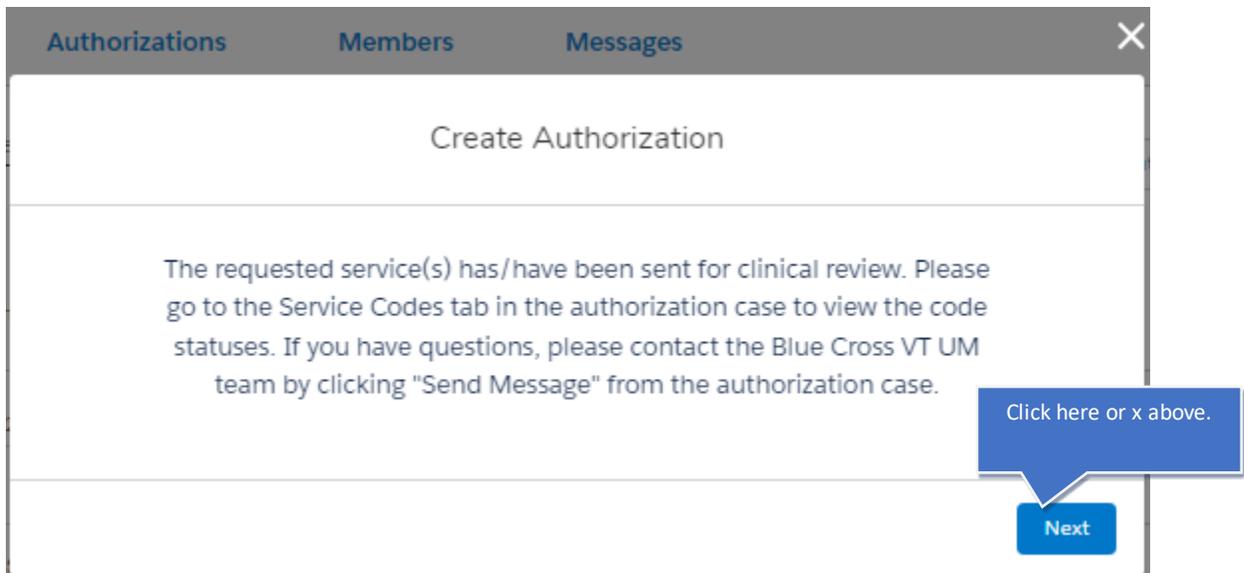


5. From **the Diagnosis code screen**

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



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



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

Create Authorization

Your authorization request has been submitted.

You may view the progress, send a message, and see the status in your Authorizations quick view from the homepage.

Click here or x above.

[Next](#)

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

Member Cases (6)				
UM Case Number	Case Number	Auth Decision	Date/Time Opened	
UM-1XXX	001XXXX1	Pending	5/8/2023, 10:34 AM	▼
UM-2XXX	001XXXX2	Pending	5/8/2023, 10:22 AM	▼
UM-3XXX	001XXXX3	Closed	4/12/2023, 11:49 AM	▼
UM-4XXX	001XXXX4	Pending	4/11/2023, 11:47 AM	▼
UM-5XXX	001XXXX5	Closed	4/11/2023, 9:28 AM	▼
UM-6XXX	001XXXX6	Pending	3/20/2023, 12:55 PM	▼

[View All](#)

Assessments

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

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

Follow the next steps on how to navigate and enter.

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

The screenshot shows a web interface titled "Create Authorization". At the top, there is a disclaimer: "DISCLAIMER: Assessment result of 'Criteria Met' does not guarantee approval of the requested service(s). For certain requests we must first check specific member benefits and the provider network to determine the medical necessity of an approval." Below the disclaimer is a bold instruction: "Open and complete the assessment draft below and click 'submit' before clicking to the next screen." A "GUIDELINES" section is visible. On the right, there is a "Card View" toggle switch which is active. The main content area features a table with the following data:

Type	Full Name	Last Modified Date
Pre Authorization	Name of Provider Submitting Auth	MM/DD/YYYY Time
Date Completed	Total Score	
	0.00	

Below the table, there is a "1/1" indicator. A blue button labeled "Assessment - Draft" is highlighted with an orange box. At the bottom right of the screen is a "Next" button.

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

Create Authorization

DISCLAIMER: Assessment result of "Criteria Met" does not guarantee approval of the requested service(s). For certain requests we must first check specific member benefits and the provider network to determine the medical necessity of an approval.

Open and complete the assessment draft below and click "submit" before clicking to the next screen.

Chiropractic Services Assessment title

> Guideline Information Scroll bar

Coverage Policy Not Met

Medic des

COVERAGE DETERMINATION

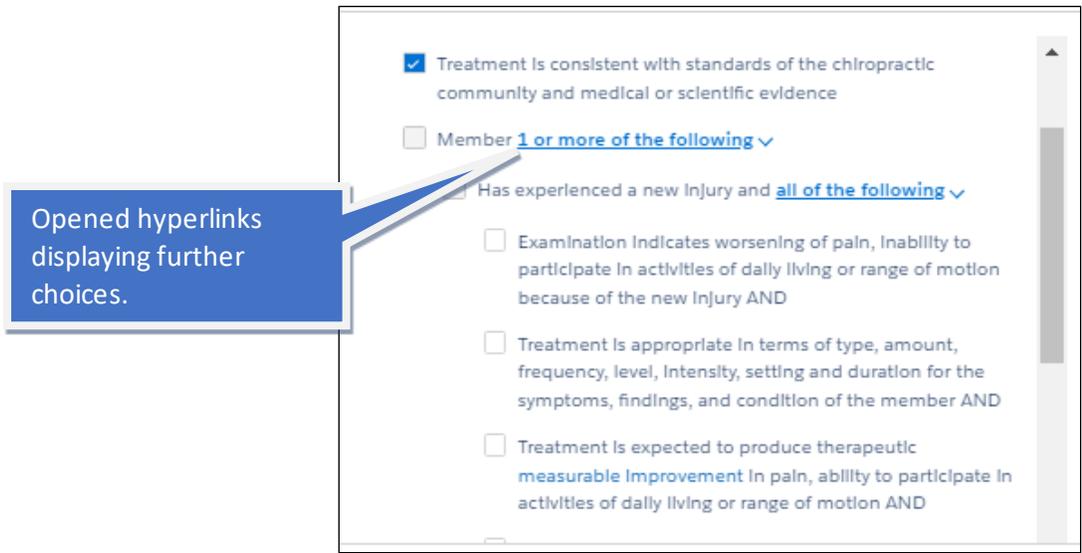
The use of Chiropractic Services may be Indicated by [all of the following](#) v

- The provider rendering the services is in the member's network
- Treatment is consistent with standards of the chiropractic community and medical or scientific evidence
- Member [1 or more of the following](#) >

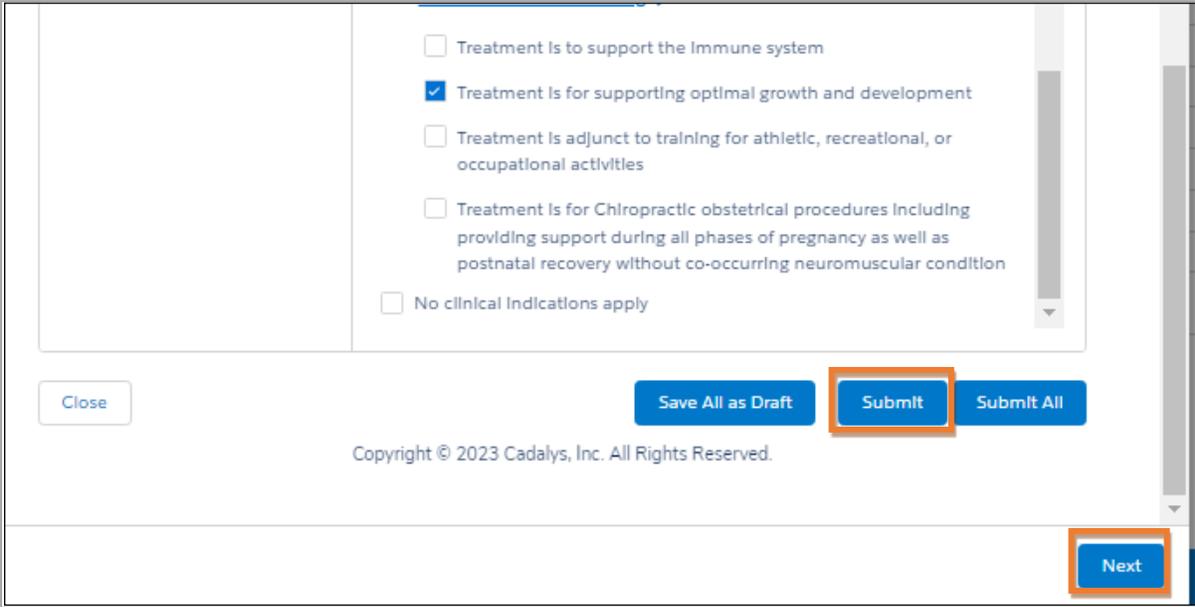
Next

Indicator for criteria met (green)/not met (red)

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



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



A message appears indicating the guideline was successfully completed.

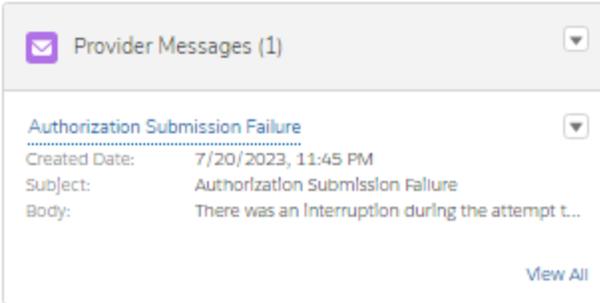


5. Click the [Next](#) button.
6. Providers will see:
 - a. In-network providers meeting the criteria will see an auto approval message for certain scenarios.
 - b. Out-of-Network and Third-party vendors will see a message that their request was submitted for clinical review and to check the homepage.

Failed Submissions

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

- The case in provider messages



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

Messages

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

Sending Messages

You can send a message to the Blue Cross VT staff regarding a case by clicking a [Send Message](#) button.

1. Go to the Case and open and click [Send Message](#).



Case
UM-3XXX

Send Message

New Clinical File

Details

Care Request

Service Codes

Diagnosis Codes

Documentation

Member

TEST TEST

Member ID

V8XXXXXXXX0001

Case Information

Case Number

0000XXX1

UM-3XXX

Case Record Type

Authorization - Retro/Preservice

Case Origin

UM Portal

Additional Information

Account

TEST TEST

Network

In-Network

Status

Clinical Support

Auth Decision

Pending

Auth Type

Outpatient

Message Inbox



Provider Messages (3)

Test - status of case

Created Da... 5/17/2023, 10:58 AM

Subject: Test - status of case

Body: Message Information sharing with ...

Authorization Created

Created Da... 3/15/2023, 11:07 AM

Subject: Authorization Created

Body: We received your Authorization Re...

Authorization Update

Created Da... 3/15/2023, 11:06 AM

Subject: Authorization Update

Body: We have received your request an...

View All

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

Send Message

Subject

Training Example of Note

Message

This is where you would type the information you want to send about this member related to this case. The UM staff will receive and can respond once you have submitted it.

[Send Message](#)

Clinical Support | Created Date: 5/15/2023, 11:07 AM

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

Message Inbox

 **Provider Messages (3+)**

[Training Example of Note](#)

Created Da... 5/17/2023, 11:04 AM

Subject: Training Example of Note

Body: This is where you would type the I...

[Test - status of case](#)

Created Da... 5/17/2023, 10:58 AM

Subject: Test - status of case

Body: Message Information sharing with ...

[Authorization Created](#)

Created Da... 3/15/2023, 11:07 AM

Subject: Authorization Created

Body: We received your Authorization Re...

View All

Newest message, click the title (hyperlink) to read the message.

Viewing Messages

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

Message Tab

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

View	
All Provider Messages	Able to see the messages from: <ul style="list-style-type: none"> • Prior Authorization Portal – provider messages and auto messaged created by the system. • Blue Cross VT – messages from Blue Cross VT staff
My Provider Messages	View of just Prior Authorization Portal messages not Blue Cross VT staff.

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

	Created Date ↑	Message F...	Case	UM ...	Provider Message Name	Subject
1	3/3/2023, 1:26 PM	UM Portal	0010XXXX	UM-X1...	Test 3-3-23	Test 3-3-23
2		Blue Cross VT	0020XXXX	UM-X2...	Response to 3-3-23	Response to 3-3-23 subject
3	4/4/2023, 3:52 PM	UM Portal	0030XXXX	UM-X3...	prov to um	
4	4/4/2023, 3:53 PM	Blue Cross VT	0040XXXX	UM-X4...	um to prov	um to prov
5	4/6/2023, 8:35 AM	UM Portal	0050XXXX	UM-X5...	Declslon Made	Declslon Made
6	4/6/2023, 8:36 AM	UM Portal	0060XXXX	UM-X6...	Declslon Made	Declslon Made
7	4/6/2023, 11:31 AM	Blue Cross VT	0070XXXX	UM-X7...	Declslon Made	Declslon Made

Message Inbox

Case messages are listed on the case page in the [Message Inbox](#).

The screenshot displays a case management interface for case 'UM-XXXX'. The main area shows case details such as Member ID (V8XXXXXXXX00001), Case Number (xxxxxxxn), and Case Origin (UM Portal). On the right, a 'Message Inbox' panel is open, showing a list of messages. A callout box labeled 'Link to message' points to the first message in the list, which has the subject 'test message' and was created on 3/16/2023 at 9:21 AM. The inbox also shows other messages like 'Authorization Created' and 'Authorization Update'.

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

Clinical Files

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

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

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

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

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

 Clinical Files (1)

[Click to see list of attached files](#)

Clinical Files Name	Created Date
Access Clinical Files	3/15/2023, 11:13 AM

[Shows clinical file name list \(not files attached\)](#) [View All](#)

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

[Home](#) [Authorizations](#) [Members](#) [Messages](#)

Case: 00100XXX

Uploaded By: UM Portal

Clinical Files Name: Access Clinical Files

 Files (2)

Title	Last Modified	Size
 Retest	6/5/2023, 11:41 AM	210KB
 Letter PDF	3/15/2023, 11:14 AM	327KB

[View All](#)

Searching for An Authorization

Users can see authorizations they create as well as authorizations:

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

My Authorizations

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

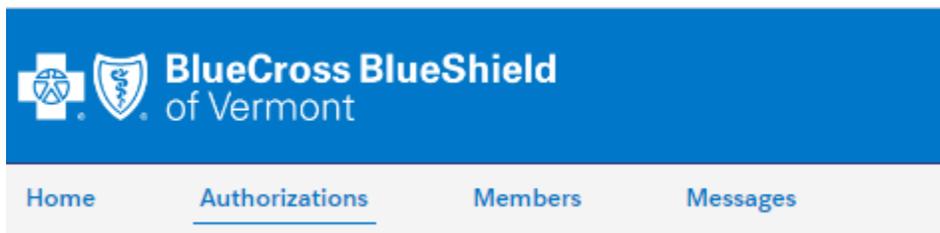
The screenshot shows the 'Authorizations' page with three main sections:

- My Authorizations:** A table with columns 'Case Number', 'UM Case Number', and 'Member Na'. It lists three entries: XXXXXX01 (UM-XXX1, MBR NO 1), XXXXXX02 (UM-XXX2, MBR NO 2), and XXXXXX03 (UM-XXX3, MBR NO 3). A 'View All' button is at the bottom.
- High Priority - More Info Requested:** A table with columns 'UM Case Number', 'Case Number', and 'Member Nan'. It lists one entry: UM-XXX4 (XXXXXX04, MBR NO 4). A 'View All' button is at the bottom.
- Closed Authorization:** A section with the heading 'Closed Authorization' and text: 'Authorizations will show up here once they are closed. To see details about the closure, please go to the Messages section on the authorization.'

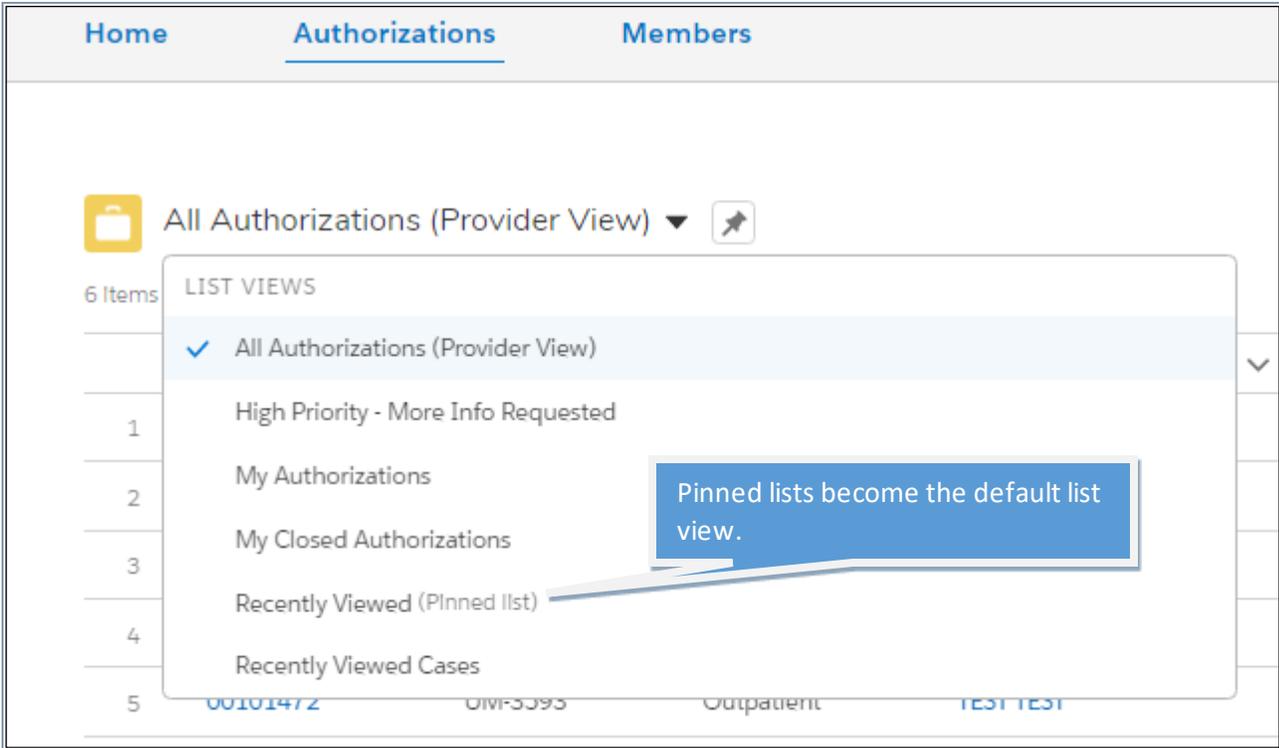
Authorization Tab

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

1. Click on the authorizations tab.



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



List View Descriptions:

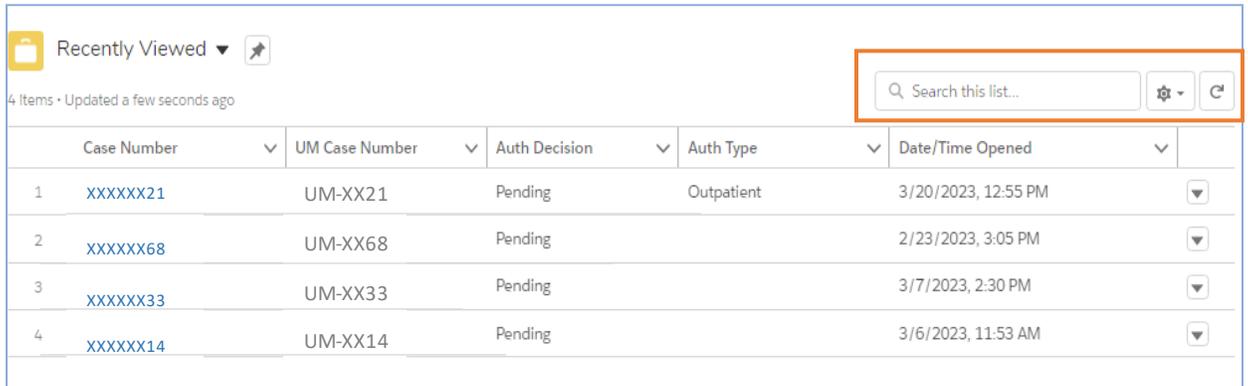
List View	Shows....
All Authorizations (Provider View)	All authorizations that the provider is listed as a creator, servicing or requesting provider
High Priority	All Authorizations with status for more information (requested by Blue Cross VT staff)
My Authorizations	Like front page – all authorizations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

Pinning a list view

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

Filtering a List

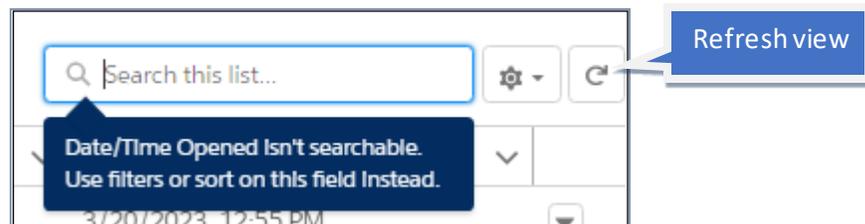
Filters are available at the top of each list view. Filters are specific to the list being reviewed so filters may be different.



The screenshot shows a list view titled "Recently Viewed" with a search bar and a table of items. The search bar is highlighted with an orange box. The table has columns for Case Number, UM Case Number, Auth Decision, Auth Type, and Date/Time Opened. The items are numbered 1 through 4.

	Case Number	UM Case Number	Auth Decision	Auth Type	Date/Time Opened	
1	XXXXXX21	UM-XX21	Pending	Outpatient	3/20/2023, 12:55 PM	▼
2	XXXXXX68	UM-XX68	Pending		2/23/2023, 3:05 PM	▼
3	XXXXXX33	UM-XX33	Pending		3/7/2023, 2:30 PM	▼
4	XXXXXX14	UM-XX14	Pending		3/6/2023, 11:53 AM	▼

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



Opening a case

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

My Authorizations 4 Items • Sorted by Case Number • Filters hyperlink In User's Case, Case Record Type • Updated a few seconds ago Search this list... Settings Refresh

Case Number ↑	UM Case Number	Member Name	Auth Type	Auth Decision	Date/Time Opened
1	XXXXXX25	John XXX		Pending	2/23/2023, 3:05 PM
2	XXXXXX14	Fred XXX		Pending	3/6/2023, 11:53 AM
3	XXXXXX38	Frank XXX		Pending	3/7/2023, 2:30 PM
4	XXXXXX21	TEST TEST	Outpatient	Pending	3/20/2023, 12:55 PM

Reviewing an Authorization

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

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

Case UM-XXXX Send Message New Clinical File

Details Care Request Service Codes Diagnosis Codes Documentation

Member TEST TEST	Account TEST TEST
Member ID V8XXXXXXXX00001	Network In-Network
Case Information	
Case Number xxxxxxx	Status Clinical Support
UM Case Number UM-XXXX	Auth Decision Pending
Case Record Type Authorization - Retro/Preservice	Auth Type Outpatient
Case Origin UM Portal	
Additional Information	

Message Inbox

Provider Messages (2)

Authorization Created
Created Date: 6/5/2023, 3:40 PM
Subject: Authorization Created
Body: We received your Authorization Request on 6/5...

Authorization Update
Created Date: 6/5/2023, 3:40 PM
Subject: Authorization Update
Body: We have received your request and it has been ...

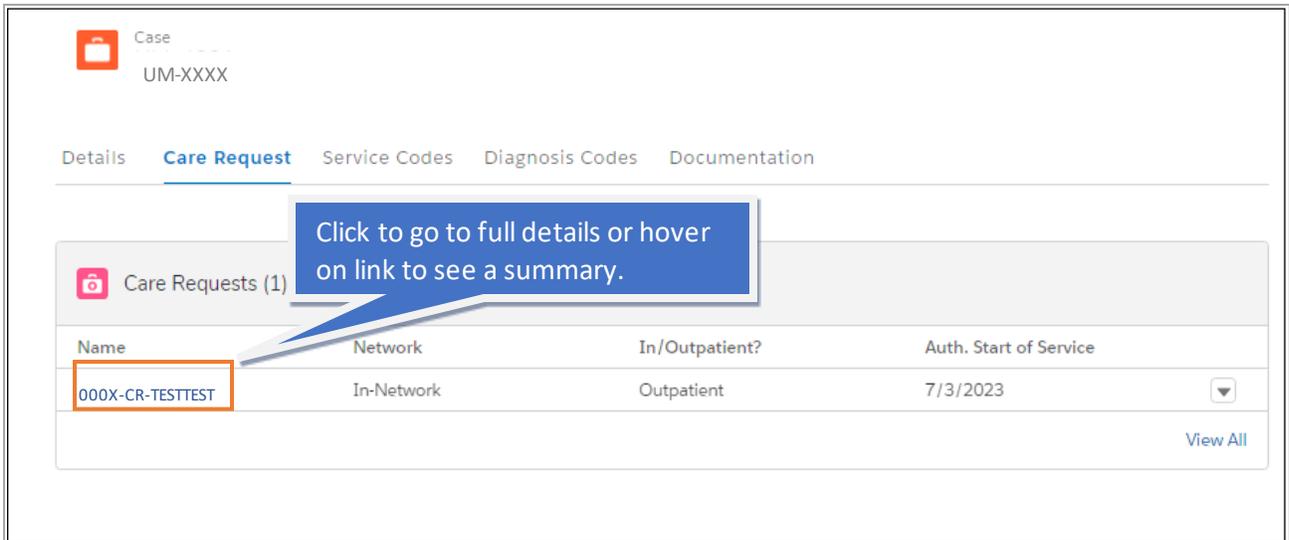
[View All](#)

Details Tab Screen

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

Care Request Tab Screen

1. Click on the Care Request tab to move your view to care request information. (**To go back to other tab screens, you must use the back arrow**).
2. Click on the Auth request hyperlink to get to your care request details or hover to see a summary of request information.



3. On the care request screen, you can review information submitted on the request as well as updates to the authorization date span based on the procedure auth requested. Sections include:
 - a. Authorization Information
 - b. Non-contracted Provider Information
 - c. Network Information
 - d. Service Information
 - e. Admission Information

Care Request
XXXX-CR-TESTTEST

Authorization Information

Name
_XXXX-CR-TESTTEST

Member ID
_V8000XXXX0001

In/Outpatient?
Outpatient

Setting
Home

Place of Service Code
4

Auth. Start of Service
7/3/2023

Auth. End of Service
4/28/2024

Non-Contracted Provider Information

Requesting/Attending Prov Individual NPI

Requesting/Attending Prov Group NPI

Requesting/Attending Provider

Requester Provider Name P
_

Servicing Provider/ Servicing Facility
LINCARE INC

Name (PA Completed/Submitted By)
R

Phone # (PA Completed/Submitted By)
999

Email Address(PA Completed/Submitted By)

Fax # (PA Completed/Submitted By)

Care Request Case
_XXXX0021

Servicing Provider/ Facility Name

Servicing Provider OR Facility NPI

Scroll to see other sections

Service Codes

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

Summary

Case
UM-XXX1

Details Care Request **Service Codes** Diagnosis Codes Documentation

Care Request Items (2)

Name	Procedure Code	Code Description	Decision
46XX-SCXX23	E0470	RESPIRATORY ASSIST DEVICE, B...	Approved
46XX-SCXX24`	00H003Z	INSERTION OF INFUSION DEVI...	Pending

View All

Current decision status by code.

Click to access service code details

Service Code Detail Screen

1. Click on the individual code name hyperlink or procedure code to access more details on the individual code. Information includes:
 - a. Code description
 - b. Date the request entered the Blue Cross VT internal system.
 - c. Start and end service date of authorization (this can be different than what you submitted based on the procedure submitted).
 - d. RFI (Request for Information details)
 - e. Current Decision
 - f. Review type
 - g. Case identifier information

Service Code XXXX-SCXX23	
▼ Care Request Item	
Procedure Code E0470	Quantity 1
Code Description RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONI	Decision Approved
Date Time In Building 6/5/2023, 3:38 PM	Review Type Non-Urgent
Deemed Received Date 6/5/2023, 3:38 PM	Created By Requester Provider Name, 6/5/2023, 3:38 PM
Start of Service 7/3/2023	Name XXXX-SCXX23
End of Service 4/28/2024	Care Request 46XX-CR-TESTTEST
RFI Sent On	Case 00XXX21
Information Due By	DME Purchase Price \$3,500
Decision Date	

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



Diagnosis Codes Tab

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

Summary

Case
UM-XXX1

Details Care Request Service Codes **Diagnosis Codes** Documentation

Diagnoses (1)

Name	Diagnosis Code	Code Description
XXX1-DX1881	G37.0	DIFFUSE SCLEROSIS OF CENTRAL NERVOUS... ▼

[View All](#)

Dx Details

Diagnosis
XXX1-DX1881

Diagnosis Code: G37.0 Name: 4631-DX1881

Code Description: DIFFUSE SCLEROSIS OF CENTRAL NERVOUS SYSTEM

Care Request: 46XX-CR-TESTEST

Care Request Case: 0000XXXX

Auth case number and member name

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



Documentation Tab

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

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

Details Care Request Service Codes Diagnosis Codes **Documentation**

Clinical Files (0)

Files (6)

Click to view letter

Title	Last Modified	Size
UM - Decision (Servicing-Provider) L...	5/3/2023, 9:53 AM	96KB
UM - Decision (Requesting-Provider...	5/3/2023, 9:53 AM	96KB
UM - Decision (Member) Letter to B...	5/3/2023, 9:53 AM	87KB
UM - Decision (Servicing-Provider) L...	5/3/2023, 9:50 AM	90KB
UM - Decision (Requesting-Provider...	5/3/2023, 9:50 AM	90KB
UM - Decision (Member) Letter to B...	5/3/2023, 9:50 AM	82KB

Click to view full list of files

View All



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

View All

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

Cases > XXXXX33

Files

6 Items • Sorted by Last Modified • Updated 6 minutes

Click to open

Download file

	Title	Last Modified ↓	Size	Source
1	UM - Decision (Servicing-Provider) Letter L...	5/3/2023, 9:53 AM	96KB	XXXXX33
2	UM - Decision (Requesting-Provider) Lette...	5/3/2023, 9:53 AM	96KB	XXXXX33 Download
3	UM - Decision (Member) Letter to BIANCA...	5/3/2023, 9:53 AM	87KB	XXXXX33
4	UM - Decision (Servicing-Provider) Letter L...	5/3/2023, 9:50 AM	90KB	XXXXX33
5	UM - Decision (Requesting-Provider) Lette...	5/3/2023, 9:50 AM	90KB	XXXXX33
6	UM - Decision (Member) Letter to BIANCA...	5/3/2023, 9:50 AM	82KB	XXXXX33

Resources

Need some help?

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

Review types

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

Type	When to Select
Post Service	The service date has already occurred.
Pre-Notification	In-patient request to notify Blue Cross VT and initiate review to confirm appropriateness of level of care and assist with discharge planning and coordination of care for services not requiring prior approval
Urgent	<p>Procedure or care that is subject to prior approval requirement that also has the following criteria:</p> <ul style="list-style-type: none"> • Not a post service • Related to a pre-service request that may put the member in potential danger if the decision is delayed more than 48 hours for the request. <p><i>Note: All urgent requests will pend for clinical review even if the assessment is completed and approved. This is due to communication requirements.</i></p>
Non-urgent	General prior approval requests that don't fall into the "urgent" definition (see above)
Concurrent	Requesting auth for additional services that are part of an ongoing course of treatment authorized before the last covered date
NEHP Urgent	<p>Procedure or care that is subject to prior approval requirement that also has the following criteria:</p> <ul style="list-style-type: none"> • Not a post service • Related to a pre-service request that may put the member in potential danger if the decision is delayed more than 48 hours for the request. <p><i>Note: All urgent requests will pend for clinical review even if the assessment is completed and approved. This is due to communication requirements.</i></p>
NEHP Non-Urgent	General prior approval requests that don't fall into the "urgent" definition (see above)

NEHP Cross Border Referral	Out of Network requests for services being performed out of the state of Vermont for NEHP members with a Vermont PCP
FEP Urgent	FEP urgent is define as an urgent care if waiting for the regular time limit for non-urgent could have the following impact: <ul style="list-style-type: none"> • Seriously jeopardize the member’s health or life; • Waiting could seriously jeopardize the member’s ability to regain maximum function; or • In the opinion of the provider with knowledge of the member’s condition, waiting would subject the member to severe pain that could not adequately be managed without care or treatment this is subject to prior approval requirement.
FEP Non-urgent	FEP procedures that do not fall within the definition of “urgent” (see above) but are on the prior approval list.
FEP Advance Benefit Determination	Request for coverage information regarding a non-urgent high-cost service, procedure or DME item which the FEP contract does not require precertification or prior approval before it is performed.
FEP Concurrent	FEP request related to continuing care or ongoing course of treatment subject to prior approval.
FEP Post-Service	The FEP member’s procedure has already occurred and required prior approval.

Settings for Auto Approval Submission

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

Auto Approval for	Setting	Service Type
<ul style="list-style-type: none"> • Continuous Positive Airway Pressure (CPAP) OR • Biphasic Positive Airway Pressure (BiPAP) 	Home	DME
Chiropractic Services <i>*only one procedure code required</i>	N/A or Multiple	Chiropractic Services
Monitored Anesthesia for an Endoscopy	Outpatient Hospital/Facility	Outpatient Surgery
Non-Emergency Ambulance	Ambulance	Land and Water Ambulance
Oral Appliance for Obstructive Sleep Apnea	N/A or Multiple	Dental
Sleep Study-Adult	N/A or Multiple	Sleep Study
Varicose Vein surgery	N/A or Multiple	Vein Surgery
Wireless Capsule Endoscopy	Outpatient Hospital/Facility	Outpatient Surgery