Submit/View Referrals and Authorizations User Guide

For TRICARE West Providers

Key Points

- You can access the online referral management system through the provider portal.
- You can use the online referral management system to submit referral and authorization requests, view existing referrals and authorizations, and modify existing requests that are associated with your account.
- You can search for providers using the Provider Location Search box when creating a referral or authorization request.
- To search for providers by NPI, set the ID Type to “HCFA National Provider ID.” You can enter the NPI into the Other ID field.
- Wildcard characters (*) let you search for multiple key terms that start or end with the same letters. Use wildcard characters (*) to get more search results.
- Have questions that the main content didn’t address? Check the Frequently Asked Questions section at the end of this user guide!

Contents

Introduction

If a Military Treatment Facility (MTF) or the beneficiary's Primary Care Manager (PCM) cannot provide the service(s) or procedure(s) the beneficiary needs, TRICARE may require a referral or authorization so that the beneficiary can seek care with another provider. PCMs and providers can submit and modify requests for referrals and authorizations using the online referral management system on the TRICARE West Payer Space.

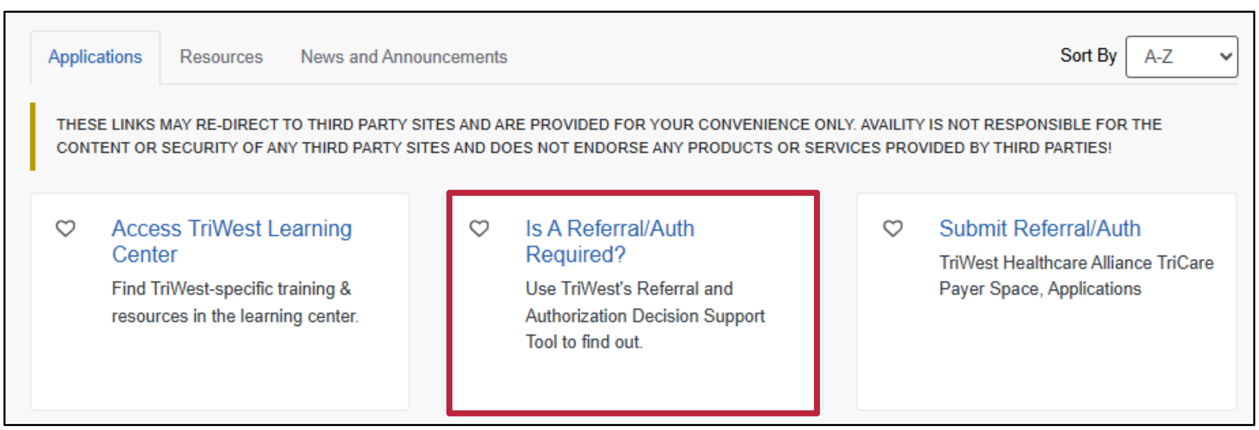
Note: *This guide is not comprehensive of features and may be subject to change. Access the latest version of this guide from the TRICARE West Payer Space in Availity.*

Is a Referral/Authorization Required?

Some services require a referral or authorization depending on the beneficiary's TRICARE plan. As an example:

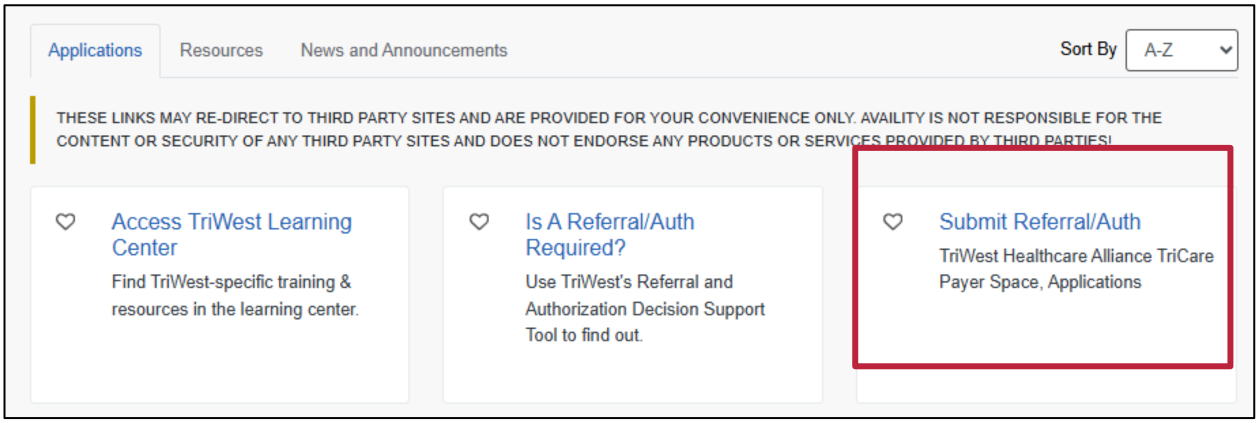
- **TRICARE Prime**: TriWest requires a referral from the PCM before beneficiaries can seek care from other providers.
- **TRICARE Select**: TriWest does not require referrals to seek care from TRICARE-authorized providers.

Providers can use the Referral and Authorization Decision Support (RADS) Tool to help determine when to submit online referrals and authorizations and when to provide clinical documents. Before performing services, you should access the RADS tool in Availity. Navigate to the TRICARE West Payer Space and select **Is A Referral/Auth Required?** to open the RADS tool.

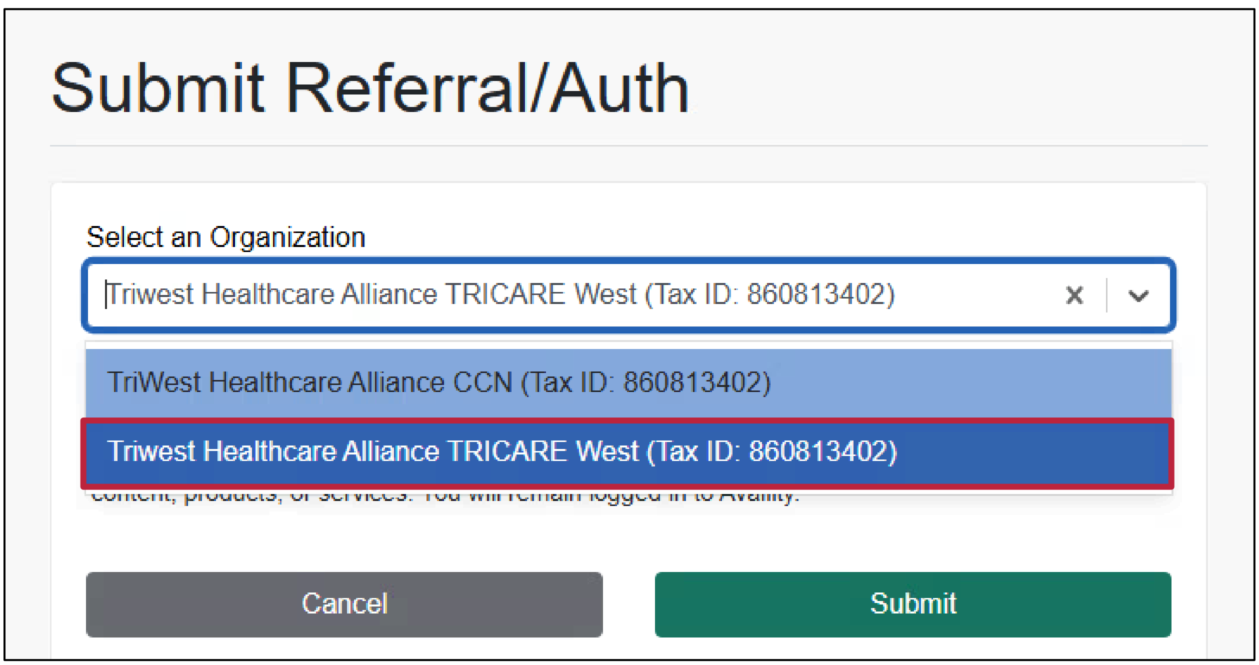


Submit a Referral or Authorization Request

If a beneficiary does require a referral or authorization, you can access the online referral management system in the Availity TRICARE West Payer Space. Log in to the provider portal and navigate to the TRICARE West Payer Space. For step-by step instructions and images on accessing the Payer Space, refer to the Registering and Accessing the TRICARE West Secure Provider Portal Quick Reference Guide. Navigate to the Applications tab, then select **Submit Referral/Auth**.



This will open the organization selection page. Select your organization from the drop-down menu, then select **Submit**. This will open the online referral management system.



To access the online referral management system, you must log in through Availity. Providers should use the referral management portal to fill out the questionnaire and submit the required clinical information.

The PCM or requesting provider is responsible for:

- Selecting the correct TRICARE beneficiary
- Identifying the appropriate Request Type (Episode of Care profile)
- Entering the requesting provider or facility
- Identifying the specialty for the care or services the beneficiary needs
- Adding diagnosis code(s)
- Providing a reason for referral, to communicate effectively with the servicing provider if needed

In some cases, the PCM or requesting provider may also be responsible for:

- Adding procedures, to include specific Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, quantity, and type
- Entering required clinical information into a survey
- Uploading relevant clinical document attachments to support requested services or communicate information to the servicing provider

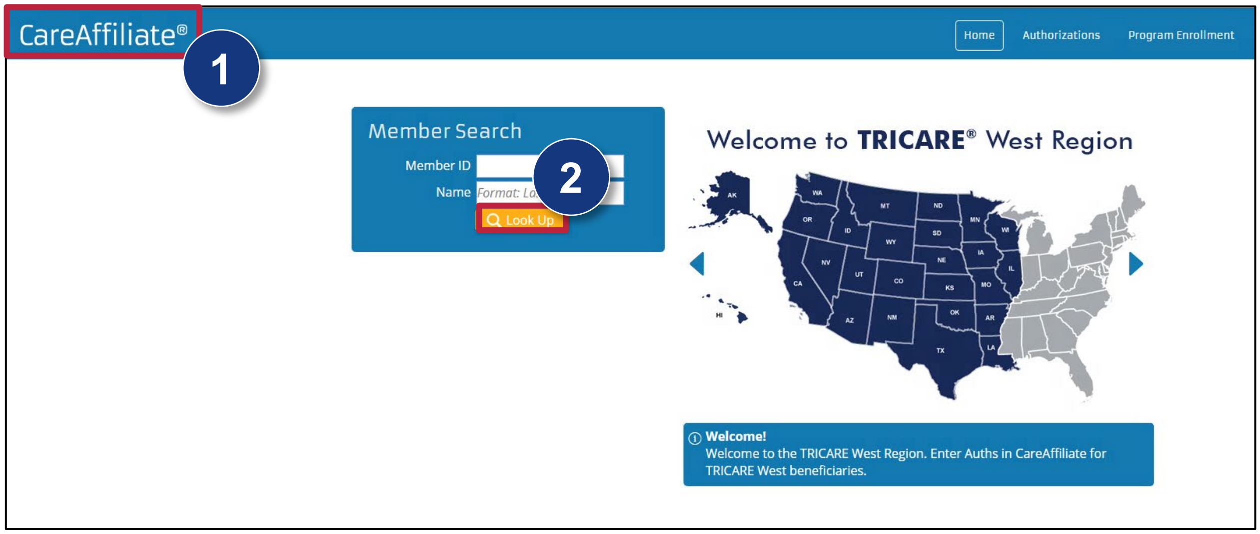
Follow the steps below to submit a referral or authorization request and attach supporting clinical information.
Note: *Attaching supporting clinical information helps reduce a request's processing time.*

Not Sure Where to Start?

1. **I can’t find my patient**: Refer to Step 1, pages 7–8.
2. **I can’t find a provider**: Refer to Step 3, page 12, and page 26, questions 3–4.
3. **I don’t know how to modify my referral or authorization request**: Refer to pages 23–25.

Step 1: Verify Beneficiary Demographics

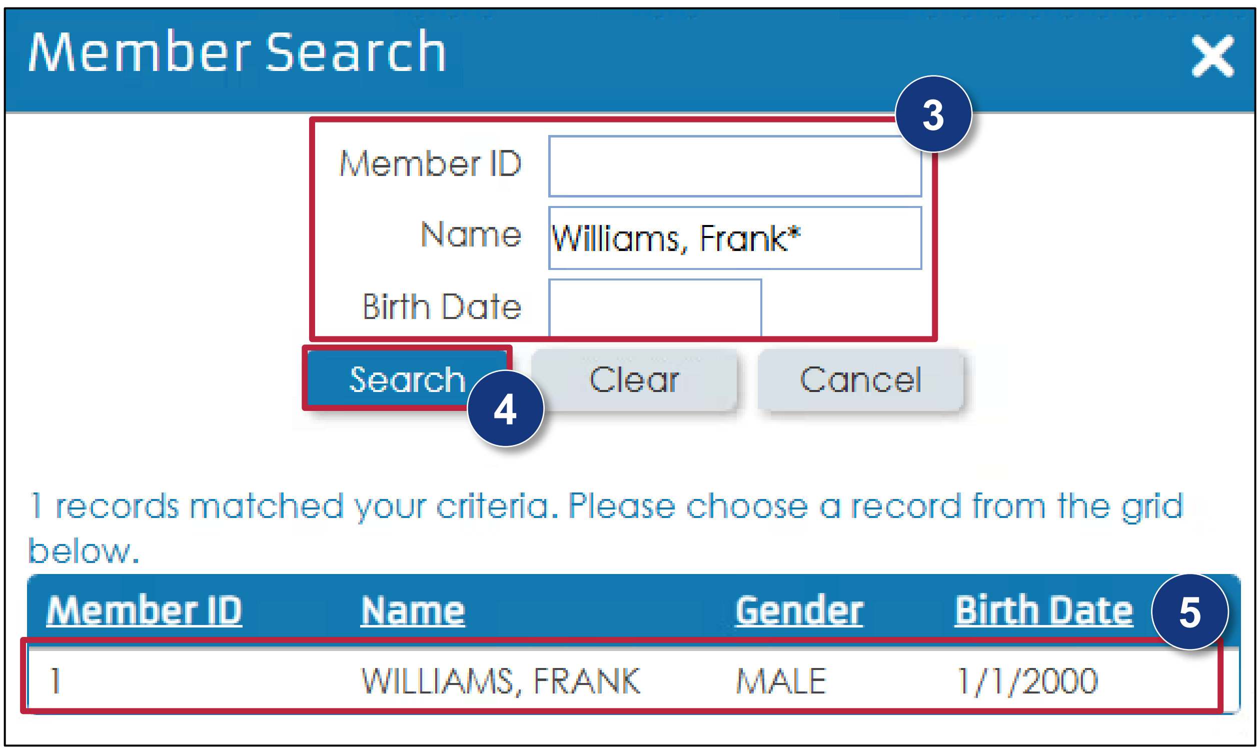
1. Navigate to the online referral management system home page.
2. Select the **Look Up** button. Since the fields have no information entered yet, the Member Search box will open.



3. Enter the beneficiary's name into the Name field or enter their Member ID into the Member ID field. When entering the name, enter the surname first, then the given name, then the middle initial (such as "Smith, John A").
   Note: *Search using only one search field, not both, for best results. Searches that are too broad (terms that return more than 1000 results) may time out your search. Narrow down your search with more key terms if needed. Use the 10-digit DoD ID on the front of the ID card or the 11-digit Department of Defense Benefits Number (DBN) as the member ID. You currently cannot use an SSN as a searchable Member ID. You must enter at least five characters before you can use a wildcard character (*) in the Name field.*

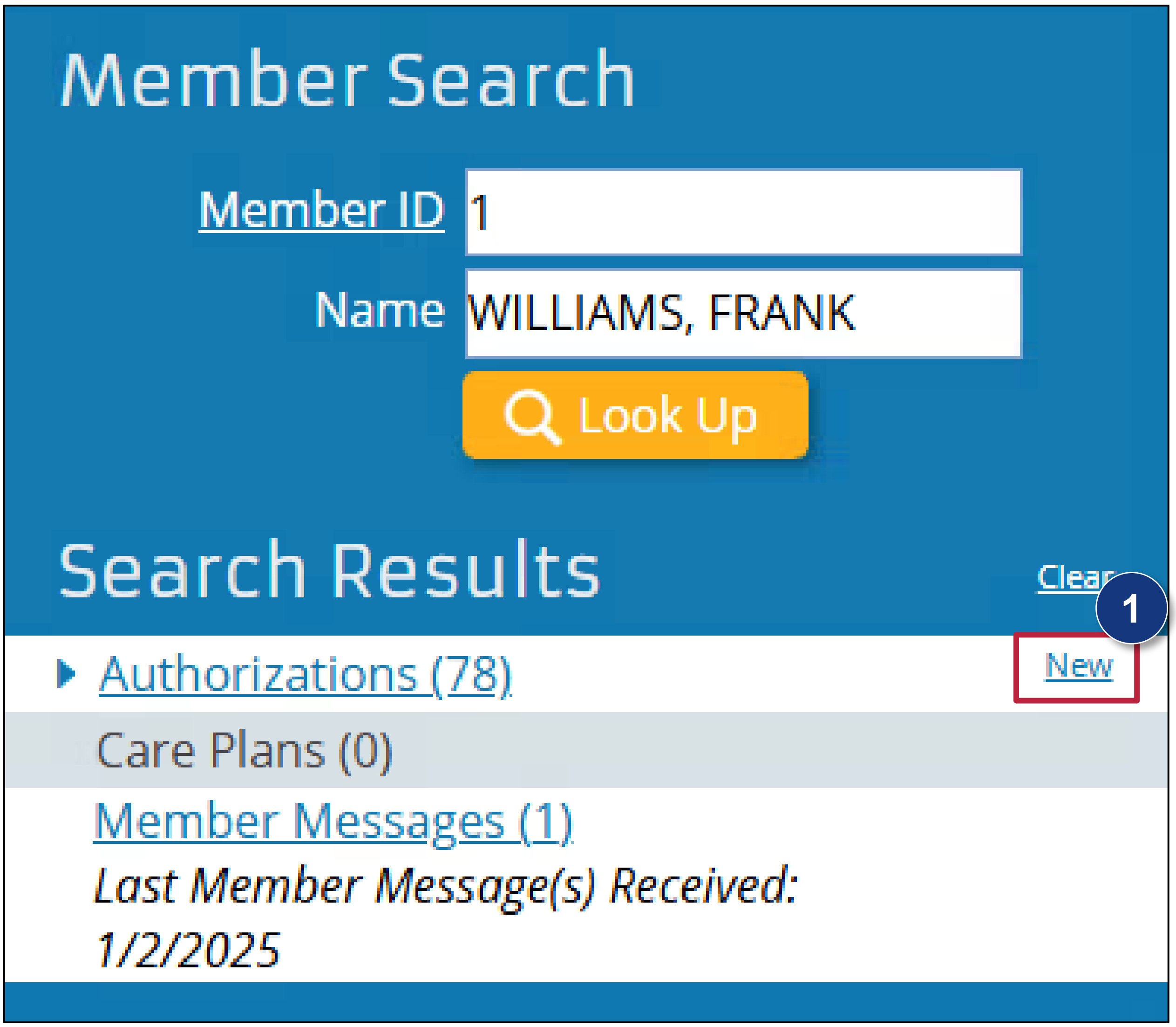
4. Select **Search**.
   Note: *A wildcard character (*) helps you search for multiple key terms that may start or end with the same letters. For example, entering "Wil*" as the surname will return beneficiaries named Williams, Willis, and more as search results.*

5. Select the beneficiary's record from the results.



Step 2: Create a New Authorization

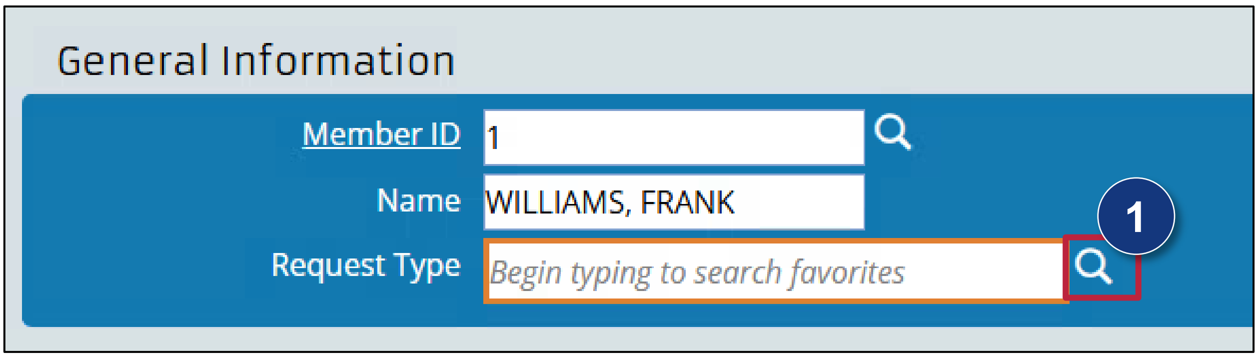
1. Select **New** after the member populates.
   Note: *The* ***Member ID*** *label is a selectable link that shows more member details like birth date, address, plan type, and coverage dates. Additionally, submitting referrals on the online referral management system uses the same submission pages as authorizations. For example, if you want to create a new referral request, you will still select* ***New*** *on the Member Search box.*



Step 3: Enter Required Fields on the Authorization Screen

After you create a new authorization, you'll need to complete all required fields on the Authorization screen.

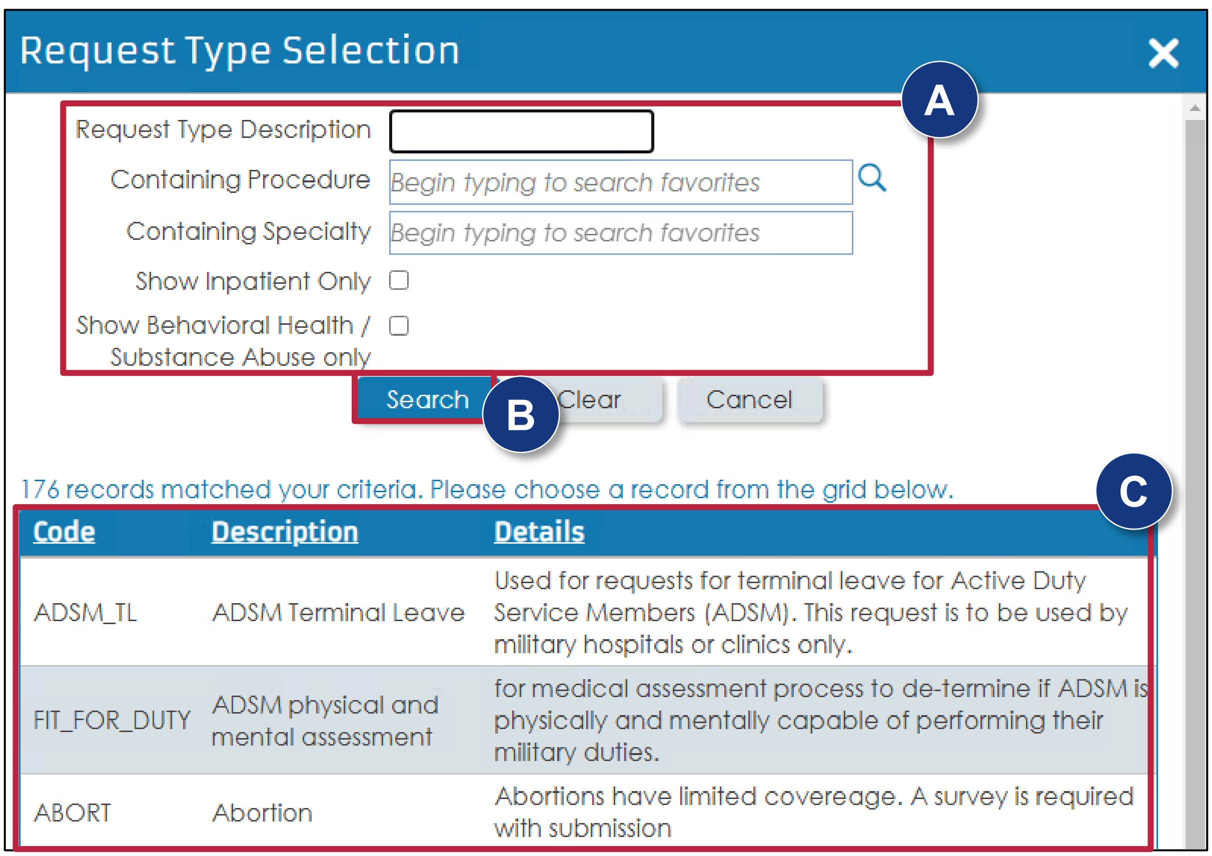
1. **Request Type**: Select the **lookup magnifying glass icon** to search for the correct Request Type (Episode of Care profile). The Request Type Selection box will open.



A. Enter search terms into the fields as needed. You can use keywords, and a wildcard character (*) before and/or after keywords, to narrow the result list.

B. Select **Search**.
Note: *If the Request Type you need doesn't appear, either select the closest Episode of Care profile, select EVAL & TREAT (if requesting a service) as the Request Type, or select OUTPATIENT MEDICAL AND TREAT (if requesting anything but a service) as the Request Type. If you select EVAL & TREAT or OUTPATIENT MEDICAL AND TREAT as the Request Type, you will need to manually list the appropriate Current Procedural Terminology (CPT) codes your request needs in the Service tab.*

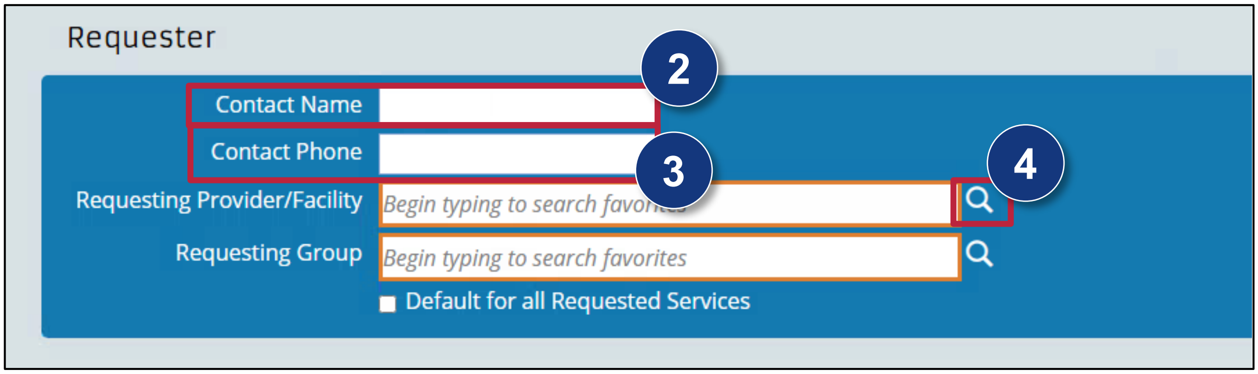
C. Select a Request Type from the results. The Request Type will now apply to your request. You'll return to the original Authorization page. After selecting the Request Type, the screen expands to include the Diagnoses, Services, Survey and Attachments sections. You can now complete the sections following General Information.
Note: *Fields with the watermark text "Begin typing to search favorites" will remember the terms you enter for later searches. As you use the online referral management system, the system remembers your commonly used Request Types, codes, providers, and more.*



2. **Contact Name**: This field should automatically fill in based on your profile on the provider portal. If nothing appears in this field, enter the contact's name.

3. **Contact Phone**: Enter the contact number.

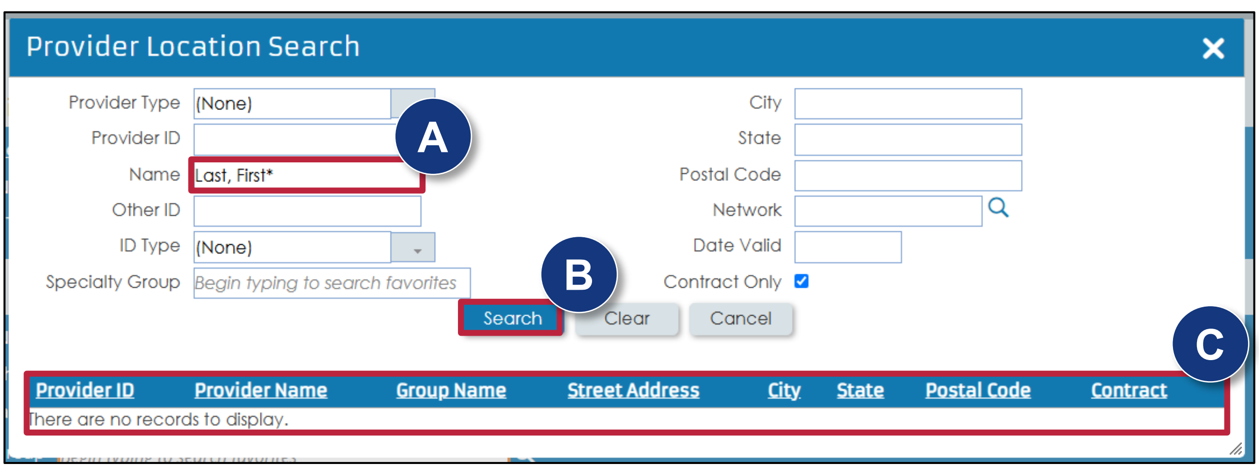
4. **Requesting Provider/Facility**: Use the **lookup icon** to search for and select the provider or facility. The Provider Location Search box will open.



   A. Enter either a provider's name (formatted "Last, First*") or a facility's name in the Name field. Provider name searches require a wildcard character (*) and a comma (such as "Smith, John*"). Facility or group names don't require a comma, and wildcard characters (*) are optional but recommended.
   Note: *You can search by just the provider's last name, but you must enter at least five characters before you can use a wildcard character (*). You can also search by the Health Care Financing Administration (HCFA) National Provider Identifier (NPI). Enter the NPI into the Other ID field. Then, select "HCFA National Provider Identifier" as the type in the ID Type field.*

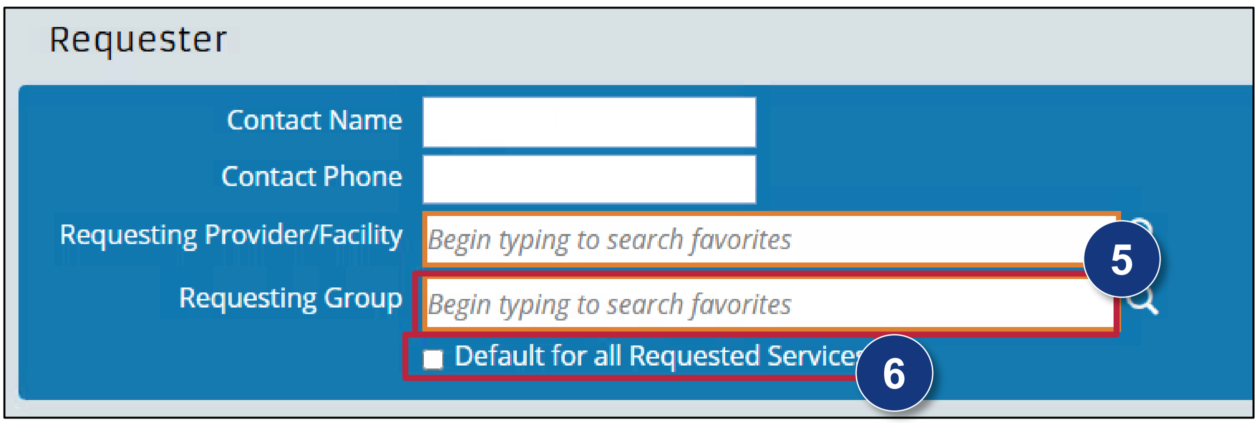
   B. Select **Search**. If the provider doesn't appear, refer to **Frequently Asked Questions**.

   C. Select a location from the results.

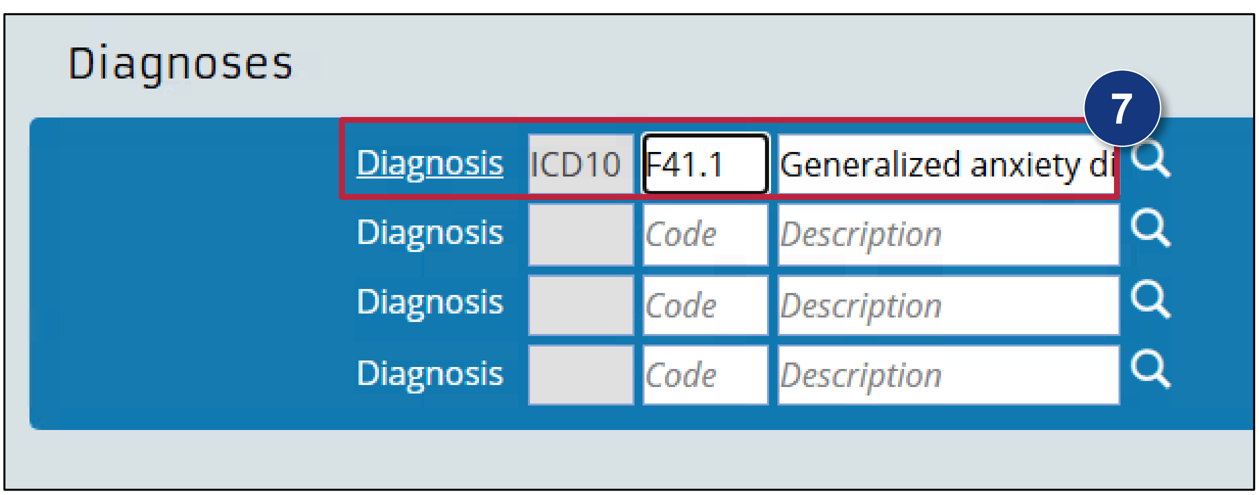


5. **Requesting Group**: If you selected a provider in the Requesting Provider/Facility field, this field displays the requesting group automatically. No entry is required. If you can't find your provider with the Requesting Provider/Facility field, select the **lookup icon** next to Requesting Group instead. This will open the Provider Location Search box; refer to steps **4A-4C** to learn how to use the Provider Location Search box. When searching by group, you will need to set the ID Type to "GROUP HCFA National Provider Identifier" instead of "HCFA National Provider Identifier."
Note: *If the provider's demographic information (such as address, phone, or fax number) is listed incorrectly or is not present, you may add or edit this information for a specific authorization. To make the change, select either the Requesting Provider/Facility field or the Requesting Group field. After the "Provider Affiliation Details" window appears, select Edit and then select OK.*

6. Select the **Default for all Requested Services** checkbox if you want to use the same contact and provider information for all services associated with the request.



7. Enter the appropriate diagnosis code in the fields. You must enter at least one diagnosis code.
Note: *Once you've entered a code, select* ***Tab*** *on your keyboard to automatically populate its Description field. You can use wildcard characters (*) while entering search terms for diagnosis codes. For this field, there is no minimum character limit before you can use a wildcard character (*).*



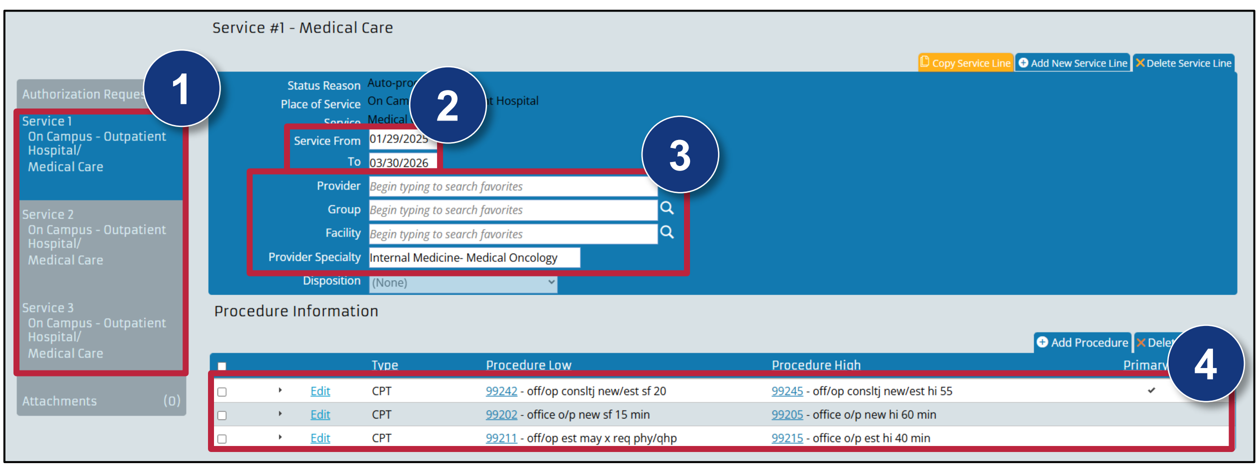
Step 4: Complete the Service Tab

1. Navigate to the **Service** tab.
   Note: *The Service(s) total and default procedures included will vary based on the Request Type (Episode of Care profile). Please complete all default Service tabs presented based on Request Type.*

2. Review the **Service From** and **To** fields. These may auto-populate with a default duration based on the Request Type used. Adjust the dates if necessary.

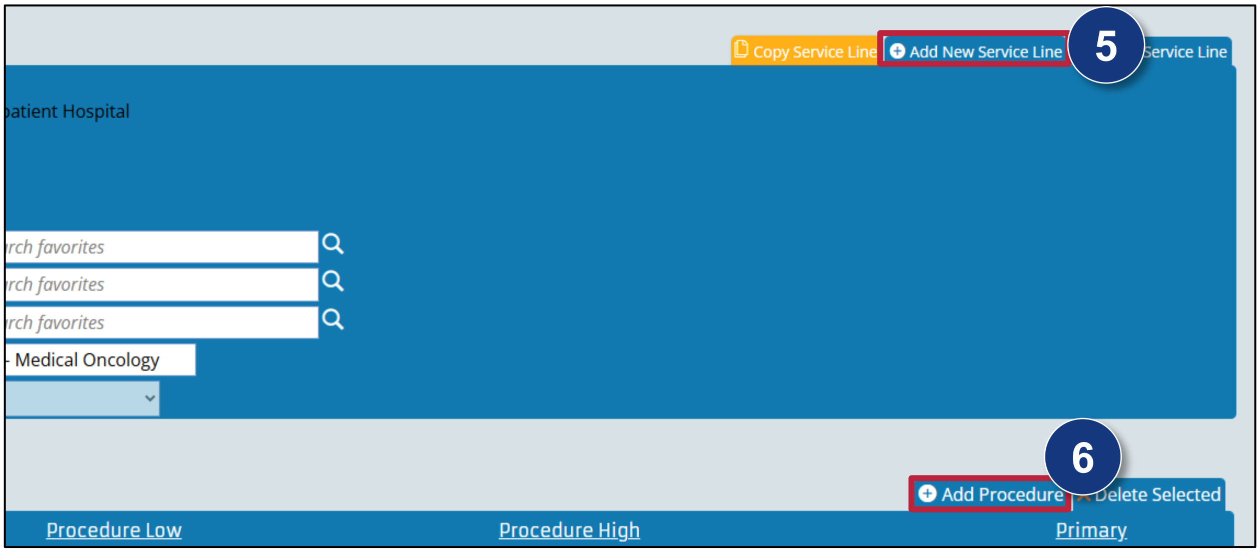
3. Fill in the servicing provider fields. You must provide a servicing Provider Specialty. If you need to make a directed referral, you must also enter either the Provider, Group, or Facility.
   Note: *The Provider, Group, and Facility fields have lookup icons. Selecting the icons brings up the Provider Location Search box, as shown in* ***Step 3: Enter Required Fields on the Authorization Screen****.*

4. Review the **Procedure Information** section. Some Request Types will automatically choose the allowed lines and procedures. For these Request Type, you can't enter additional lines or services. Other Request Types will let you add additional service lines or CPT codes as needed. **Do not delete the default CPT codes, such as office visits, which appear with your Request Type automatically**.
   Note: *Servicing providers are not required to bill for office visits if the beneficiary does not use those visits.*



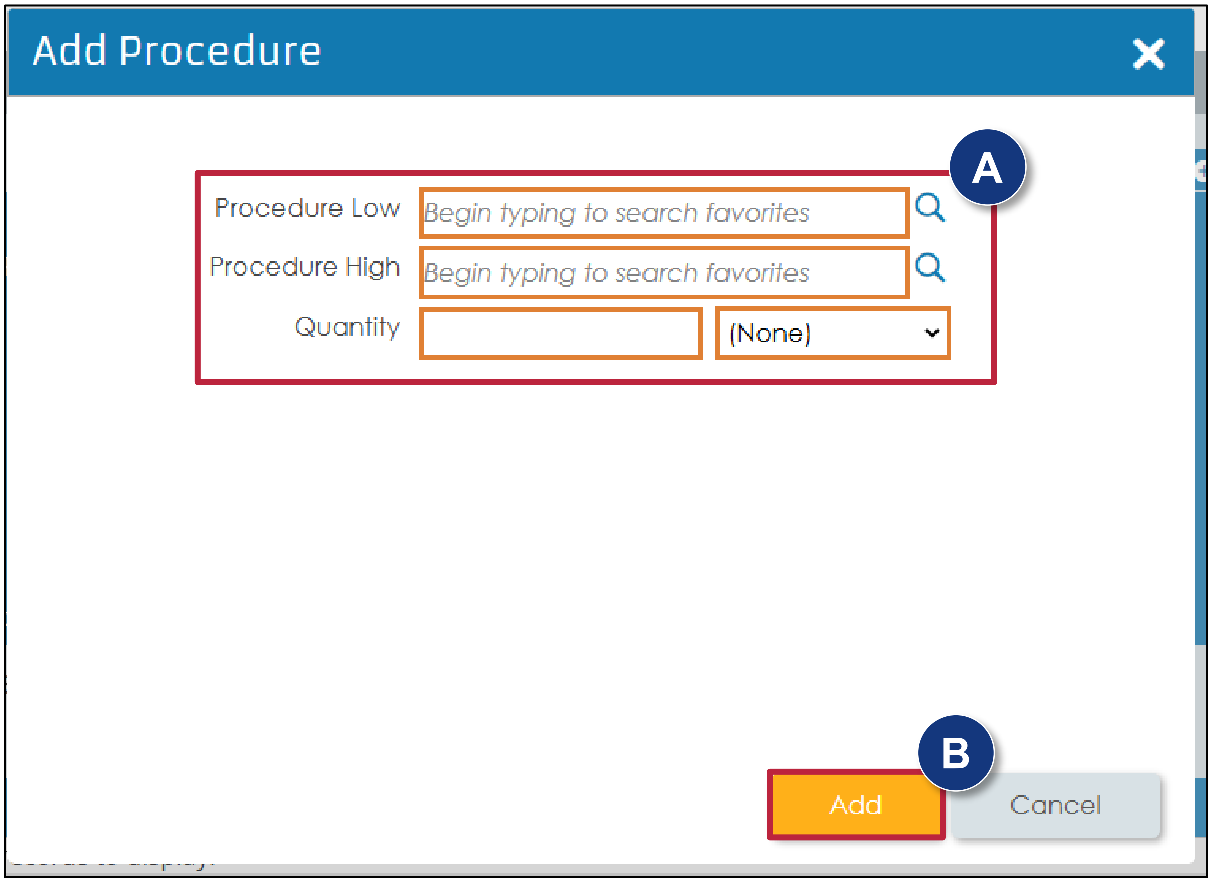
5. Select **Add New Service Line** to add a service line if needed. You can add a maximum of 10 lines or procedures per Service tab. Keep in mind that not all Request Types will allow you to add new service lines.
   Note: *If you want to copy the Place of Service and Service fields from an existing line to the new line, select* ***Copy Service Line*** *instead.*

6. Select **Add Procedure** if you need to add any additional procedures. The Add Procedure box opens.



A. Complete the required fields. Use the **Procedure Low** and **Procedure High** fields to help you search for the CPT codes you need.
Note: *You can use the Procedure Low and Procedure High fields to enter ranges for codes, or you can use the same code for both fields. You can also use wildcard characters (*) while entering search terms for procedures. For this box, there is no minimum character limit before you can use a wildcard character (*).*

B. Select **Add**. The procedure is displayed in the Procedure Information section.



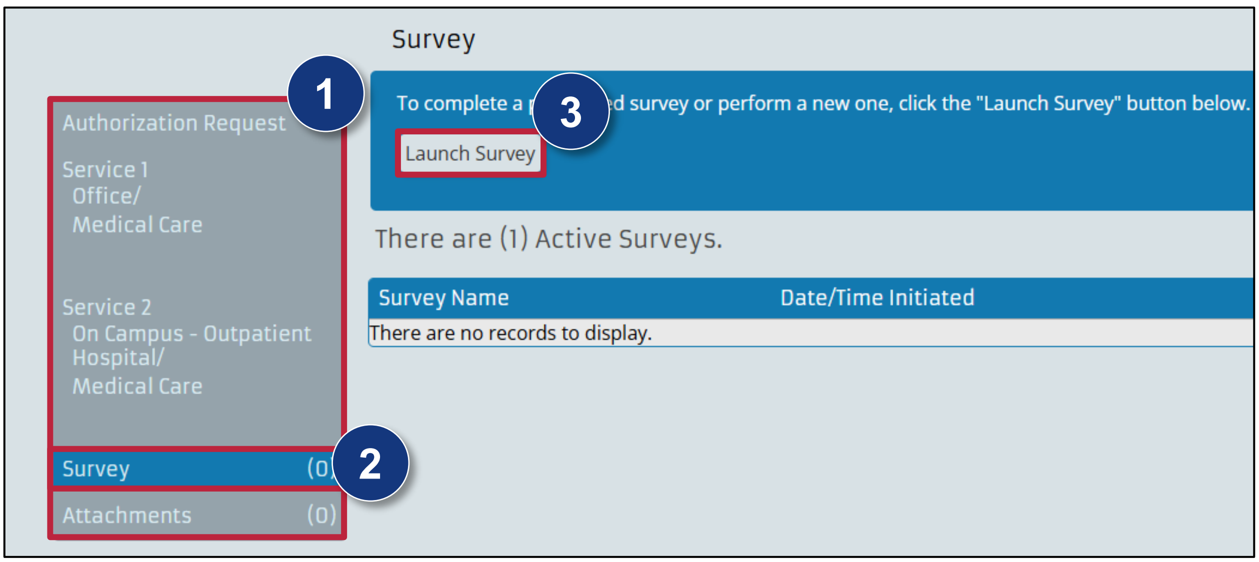
Step 5: Complete the Survey(s) or Assessment(s)

Some Request Types (Episode of Care profile) may require you to complete a survey or assessment before proceeding. This does not apply to all referrals/authorization requests.

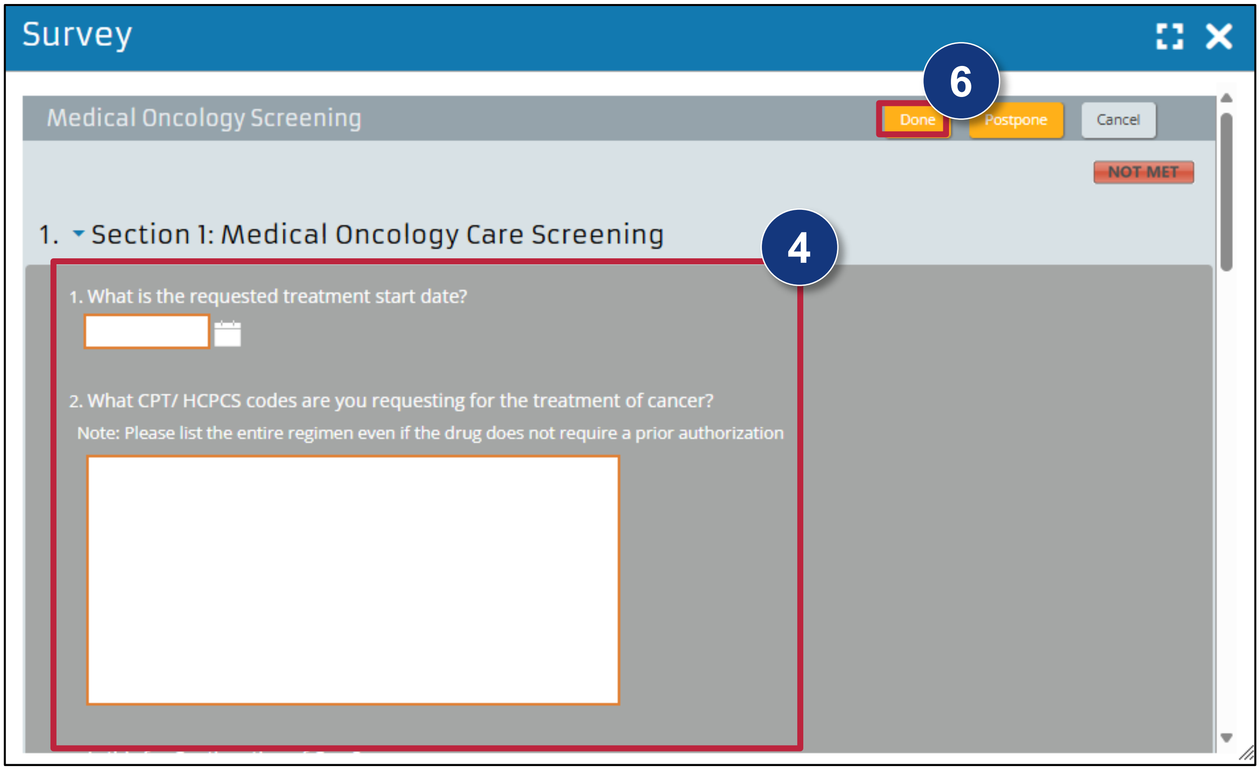
1. Review the Authorization Request panel for a Survey or Assessment section. If an **Assessment** tab appears, you can use it to suggest updates to patient and provider information, as well as give reasoning if your request needs a non-network provider. If no section for either appears, your Request Type does not require one—proceed to **Step 6: Attach Relevant Documentation (Recommended)**.

2. Select the **Survey** or **Assessment** tab.

3. Select **Launch Survey** or Launch Assessment depending on type.



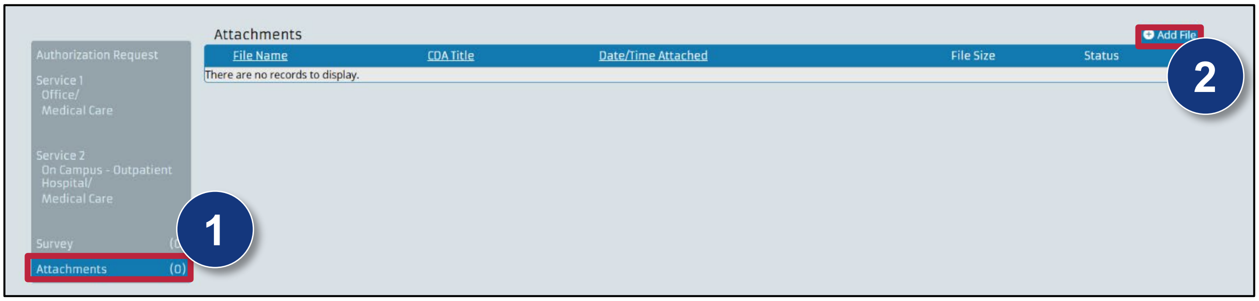
4. Complete all required questions, as well as all optional questions as appropriate.
5. Navigate back to the top of the page once done.
6. Select **Done**.



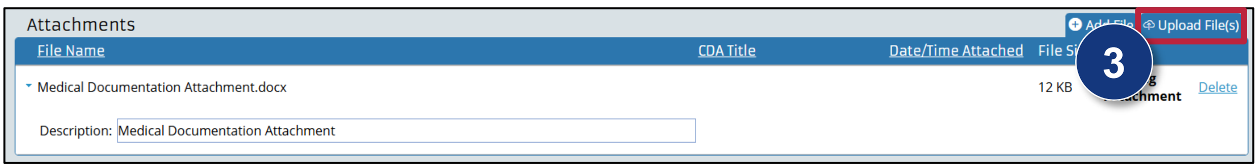
Step 6: Attach Relevant Documents (Recommended)

1. Navigate to the **Attachments** tab if you need to include any relevant documents, such as labs, proof of medical necessity, patient history, and/or imaging. You can only attach .pdf files.

2. Select **Add File** to start adding documents.
   Note: *If no attachments are necessary, skip this step and step 3.*

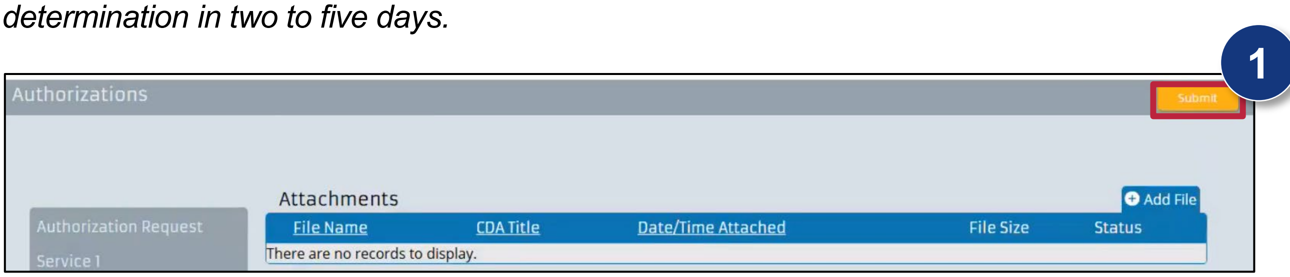


3. Select **Upload Files** once done.



Step 7: Submit the Request

1. Select **Submit** after entering all information.
   Note: *After TriWest approves or denies the referral or authorization, they will send a notification to the beneficiary and referring providers/PCM. Some requests may receive approval instantly, but for requests that require medical review or that add supporting attachments, they will receive a determination in two to five days.*



Once submitted, the beneficiary's record updates to display the authorization. You will also receive a reference number for the request. You can check the request's status on their record. Use the Record Search described in **Modify Existing Authorization Requests** to find their record and check back on your request status any time.

A. **Certified** means your request was fully approved.

B. **Modified** means that either some, but not all, lines of your request were approved, or all services were approved but with modifications. Some modifications may include simple demographic updates, such as a phone number or address. Check your request for further details. Your request is still considered approved, so you don’t need to take any further action; you may proceed with your referral or authorization.

C. **Not Certified** means your request was denied. Refer to **View Determination Letter** for more information.

D. **Pended** means your referral or authorization is in progress.

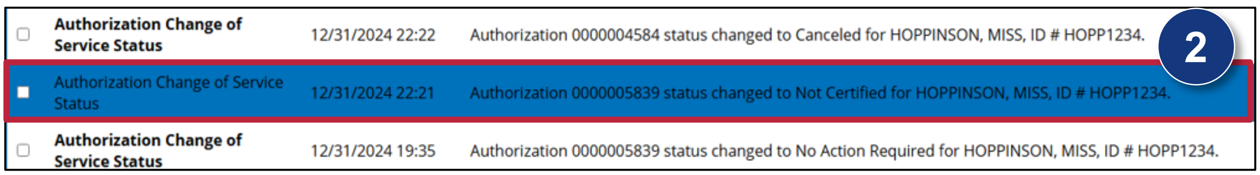
For additional information, select the **Help** link in the online referral management system. For step-by-step training, review the online referral management system training available within Availity.

View Determination Letters

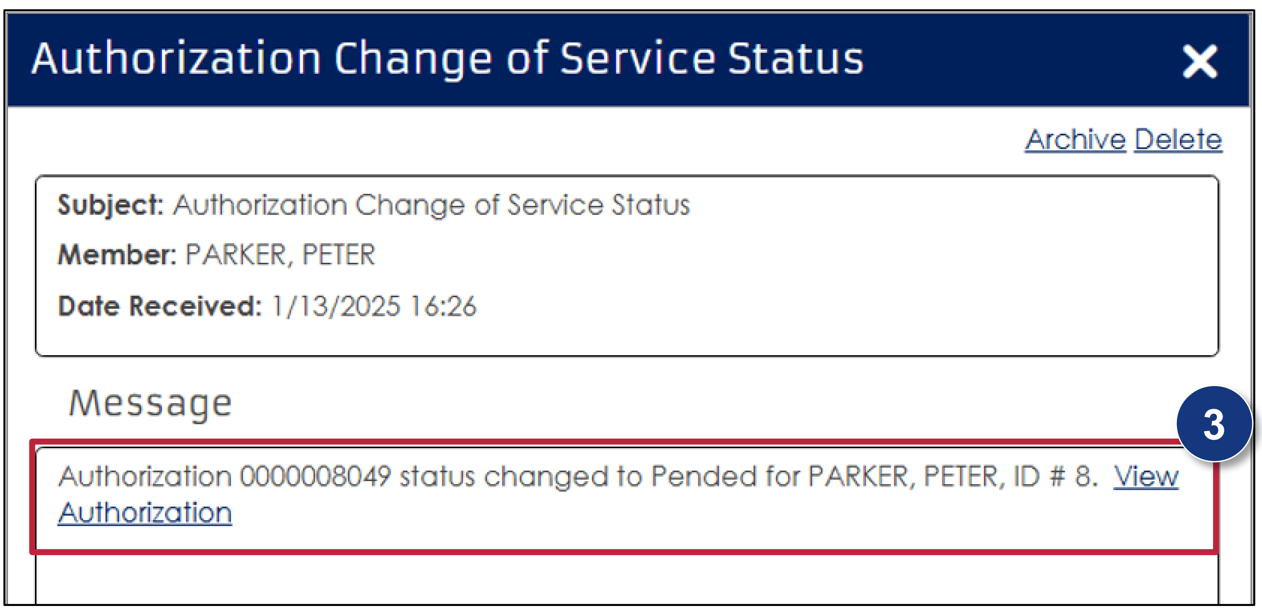
If your request receives a denial and the Not Certified status, you should review your determination letter for the denial reason and next steps. You can access the determination letter from the online referral management system.

1. Select **Messages** from the site ribbon. The Messages page will open.

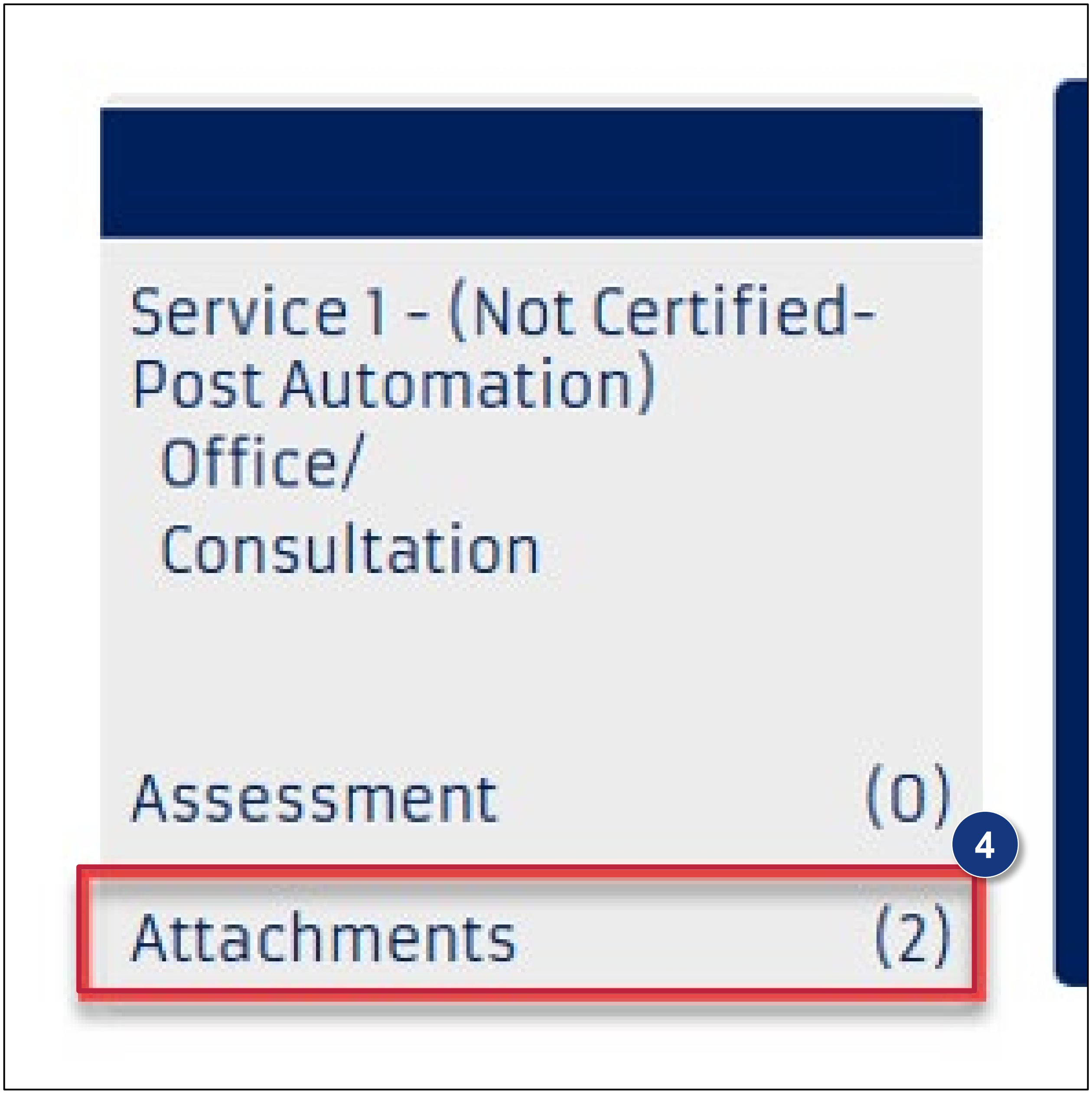
2. Locate and select the authorization request you want to view. The Status box opens.



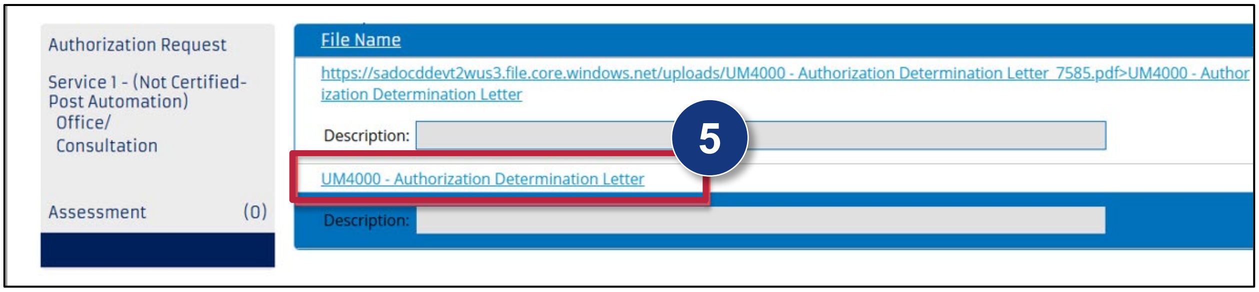
3. Select **View Authorization**. The Authorization Request page opens.



4. Select **Attachments**.



5. Locate and select the determination letter hyperlink.



Modify Existing Authorization Requests

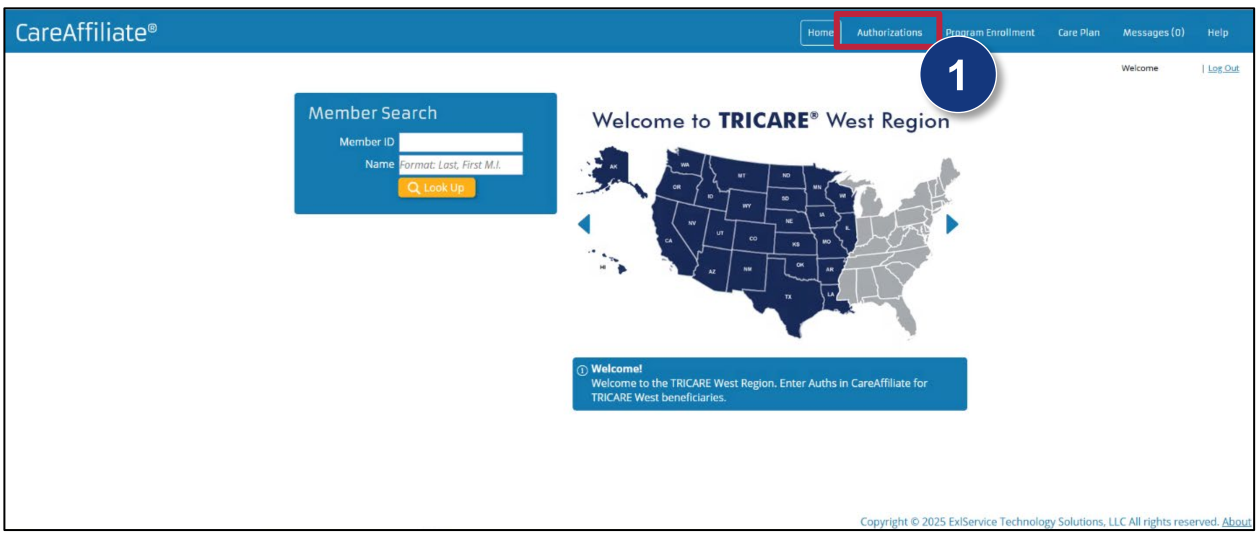
You can also use the online referral management system to modify existing authorization requests.

Only the referring provider can change their own requests. You can make as many changes as you need to a request if patient hasn't received the service yet. Referring providers cannot update requests if the patient has already received the service.

Approved referred providers can submit referrals or authorizations for any additional codes needed. If the original authorization expires during treatment, the PCM must request a new authorization. Include notes for continuity of care if needed.

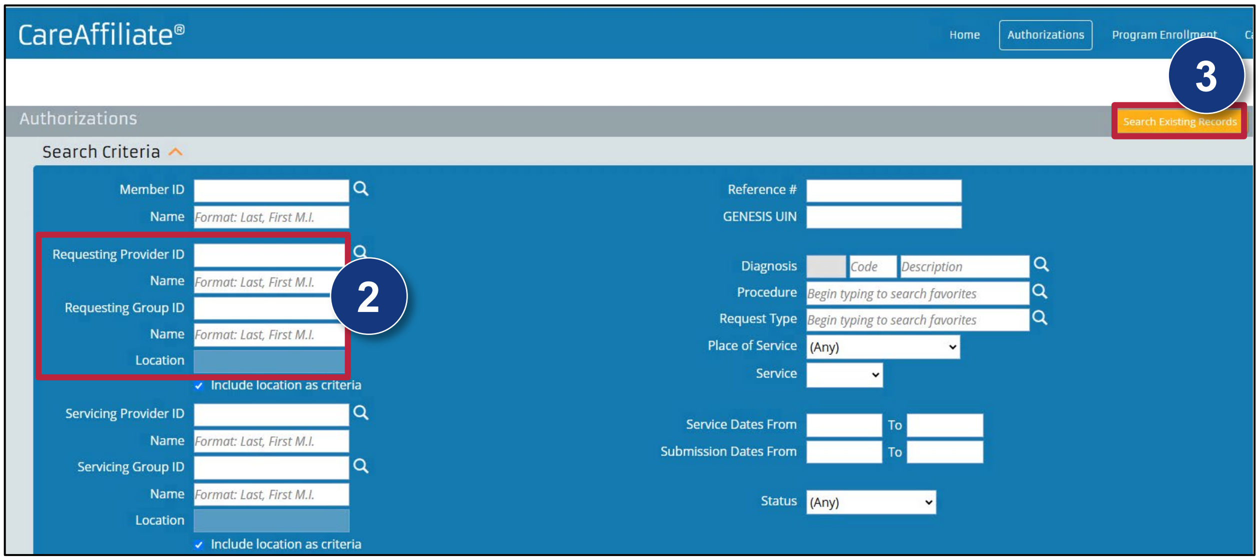
You can view the authorization record using the steps outlined in **View Determination Letters**, but this section will cover how to search for records manually.

1. Select Authorizations from the online referral management system home page.

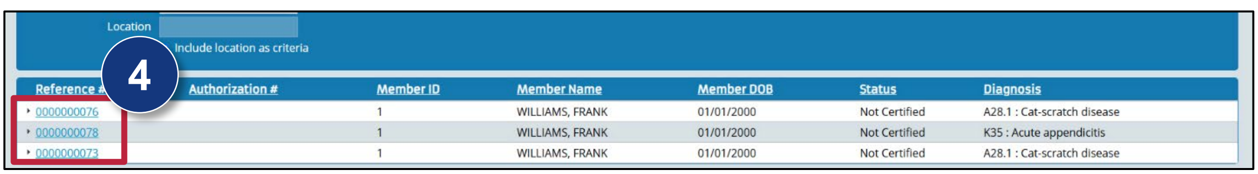


2. Enter appropriate search terms into the Search Criteria fields. For best results, search with an NPI in the **Requesting Provider ID** or **Servicing Provider ID** fields. If the provider still doesn't appear, try entering the NPI into the **Requesting Group ID** or **Servicing Group ID** fields.
   Note: *Avoid entering too many search terms at the start, as your search may return no results if too narrow.*

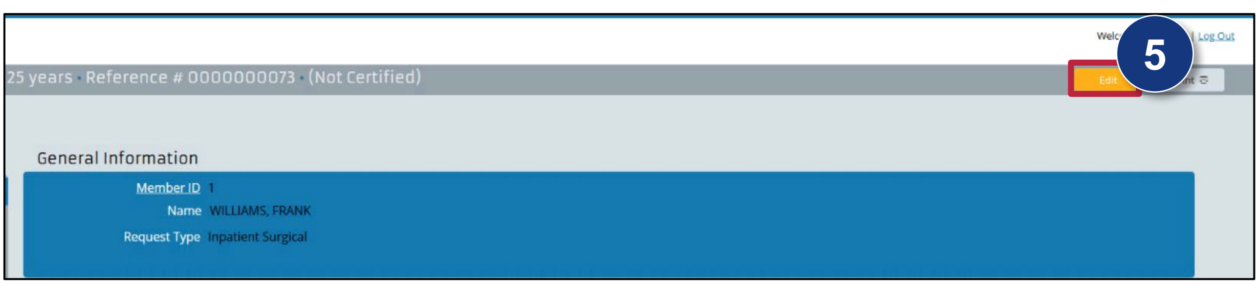
3. Select **Search Existing Records**.



4. Select the appropriate authorization record from the results.

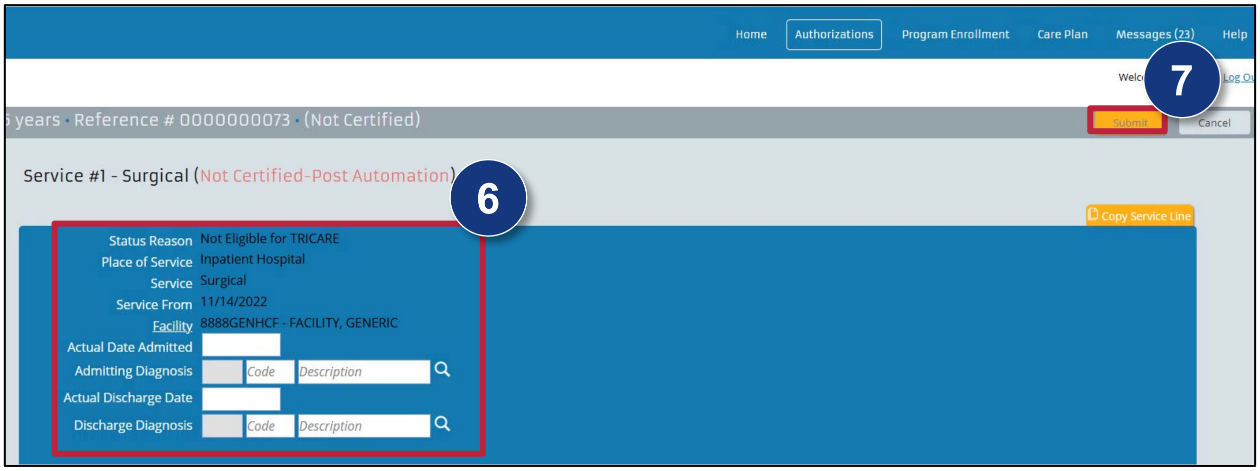


5. Select **Edit** to modify fields.



6. Edit or add services, notes, and attachments on the Authorization Request, Service, or Attachment tabs.

7. Select **Submit** once done.
Note: *You cannot edit the following fields after submitting a request: Place of Service, Service, Status Reason, Length of Stay.*

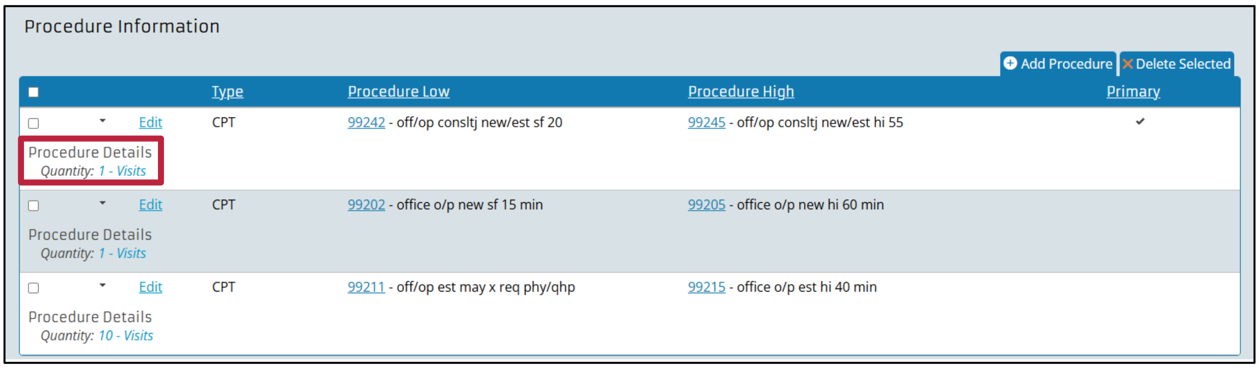


Frequently Asked Questions

1. **A provider has more than one address listed in the online referral management system. What happens if I select the incorrect address? Will my referral or authorization automatically receive a denial?**
   - No, the chosen provider address does not play a role in the referral and authorization determination. Selecting the incorrect address may prompt a review if the beneficiary does not have continuity of care (COC) with the provider before the request is approved or redirected.
   - Please note that if you cannot find the address you need, you can enter it manually. This change will only be made for the current authorization that is being requested and will not be a permanent change/addition in the system.
2. **What does the text next to the reference number on a referral or authorization mean?**
   - This is the request status. Refer to **Step 7: Submit the Request** for more information.
3. **How do I search for providers in the online referral management system? How do I search for a provider using their NPI?**
   - You can search for providers with the Provider Location Search box. Refer to page 10 for more information on accessing the box. To search with an NPI, enter the NPI into the Other ID field. Select the ID Type field and set it to HCFA National Provider ID.
4. **How do I troubleshoot finding the provider I am looking for using the Search function?**
   - Ensure you are formatting the names correctly. The search will return more results if you enter the surname first, then the given name and middle initial (such as “Smith, John A”). You can also use a wildcard character (*) to search for words that start or end with the same set of letters.
   - Searches that are too broad (terms that return more than 1000 results) may time out your search. Narrow down your search with more key terms if needed.
   - Uncheck the “Contract Only” checkbox. Leaving this checked may limit your search results.
   - If you are searching for a provider from existing records and they do not display, that may mean the provider has no existing authorizations entered in the online referral management system at the time of your search. All in-network providers will display when you are searching for a provider from a new authorization request.
   - The provider you’re looking for may be classified as a group. Try using search options for group providers or group IDs (such as using **Requesting Group** instead of **Requesting Provider/Facility** when opening the Provider Location Search).

5. **Does the online referral management system show how many visits are authorized for an approved request?**

   - Navigate to the Service tab on a request. In the Procedure Information section, select the drop-down arrow on any row. This will open the Procedure Details section, where you can view the Quantity.


Procedure Information

Add Procedure | Delete Selected

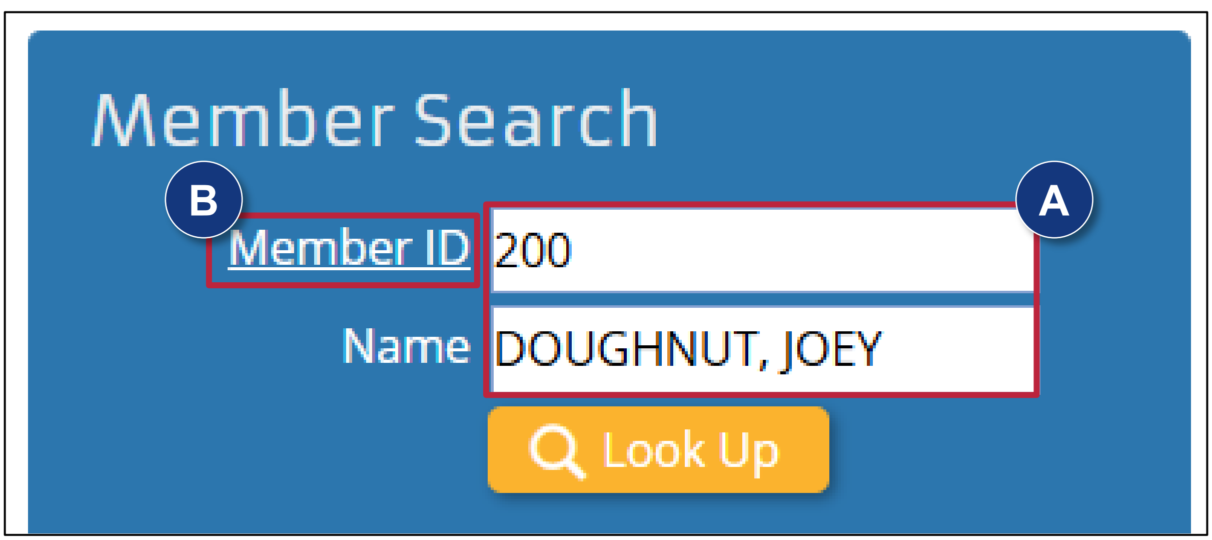
		Type	Procedure Low	Procedure High	Primary
	Edit	CPT	99242 - off/op consltj new/est sf 20	99245 - off/op consltj new/est hi 55	✔
Procedure Details Quantity: 1 - Visits					
	Edit	CPT	99202 - office o/p new sf 15 min	99205 - office o/p new hi 60 min	
Procedure Details Quantity: 1 - Visits					
	Edit	CPT	99211 - off/op est may x req phy/qhp	99215 - office o/p est hi 40 min	
Procedure Details Quantity: 10 - Visits					

6. **How can I check a beneficiary's coverage details?**

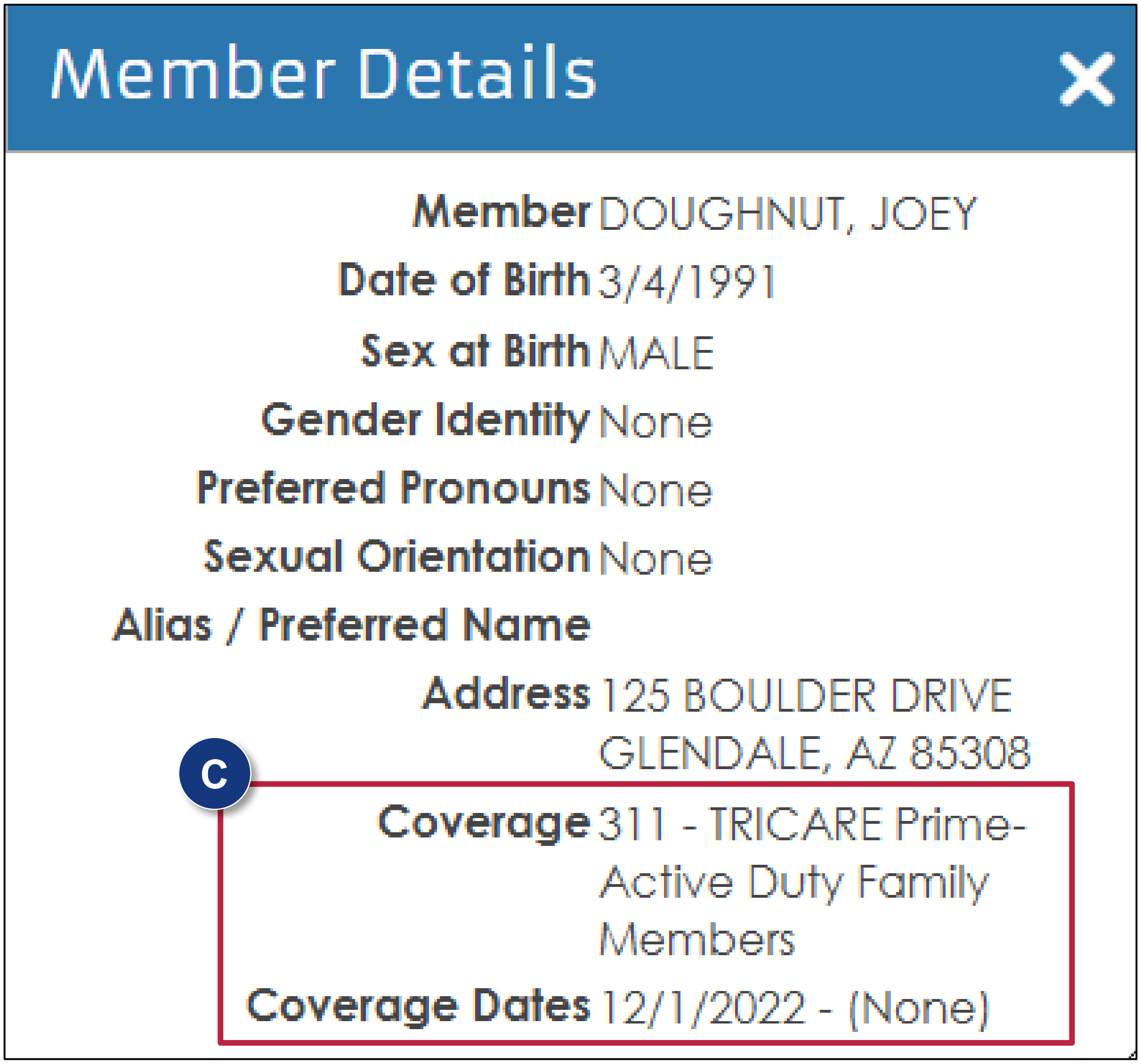
   - You can check this from their Member Details profile.

   A. Enter the beneficiary’s name and member ID into the Member Search fields. Refer to **Section 1: Verify Beneficiary Details** for more information on Member Search. Once you’ve entered the information, the Member ID hyperlink will appear.

   B. Select the **Member ID** hyperlink. The Member Details profile will open.



C. Review the listed coverage and coverage dates.

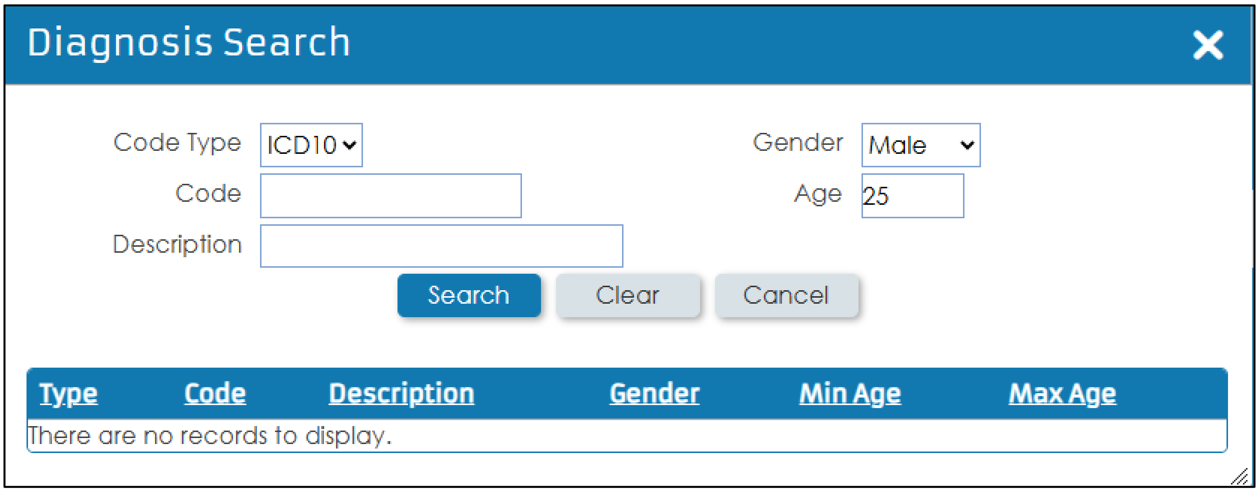


7. **What do I do if I need to modify an unchangeable field on my request, such as the Place of Service, Service, Status Reason, or Length of Stay fields?**

   - You will need to submit a new referral or authorization request.

8. **What if I don't know the exact diagnosis codes I need to add? Can I search for codes in the tool?**

   - Selecting the **lookup icon** next to the diagnosis code fields. This will open the Diagnosis Search box, which you can use to search for codes. Use wildcard characters (*) when entering terms into the Description field for best results.



9. **I can't view or edit an authorization or referral I made, even though I can receive notifications in the Message Center about the authorization or referral. Why did my permissions change?**

   - Check the provider portal to ensure you've selected the correct organization. You should always select the organization you intend to submit, view, and modify TRICARE referrals and authorizations from. If you have selected another organization, you may not be able to view or edit your TRICARE referrals and authorizations.
   - Check the provider portal to ensure your listed Provider ID is correct.

10. **Does TriWest accept retroactive authorizations?**

    - Yes, TriWest will accept retroactive authorizations if the service was within waiver time, extending back to January 1, 2025.

11. **Do I need to provide letters of attestation when submitting referral or authorization requests?**

    - No, letters of attestation are not required.

12. **Where can I learn more about referrals and authorizations?**

    - Visit the TriWest Learning Center and the Resources tab. You can access both from the TRICARE West Payer Space.