Secure Provider Website

Instructional Guide

Introduction

The Secure Provider Web is a secure website developed to allow Providers across Centene health plans to perform a variety of functions from their office. By registering and creating an account, a Provider can easily check patient eligibility, and view their patient list. Providers can view and submit both authorizations and claims through the website. A secure messaging feature allows a Provider to communicate with the health plan without having to pick up the telephone.

How to Use the Manual

This manual is intended to be a quick reference for using a tool or function offered on the website when a Provider or staff member needs assistance. The manual also explains many ways to use the site in order to get the most out of the resource.

System Requirements

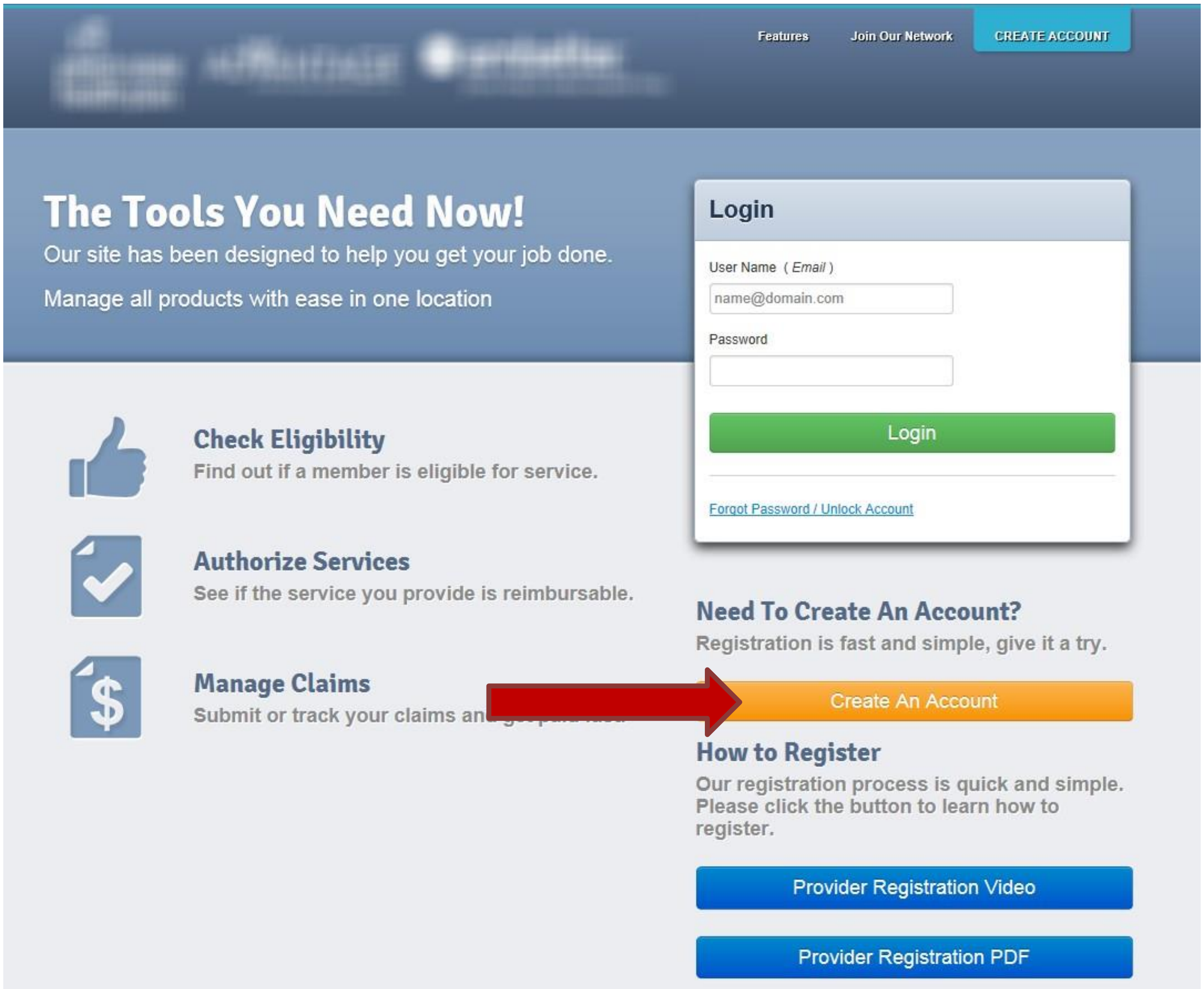
Access the secure provider website using Internet Explorer 10.0 or higher, Firefox and/or Google Chrome. Each browser should be updated to the most recent version available optimal performance.

Contents

Registration

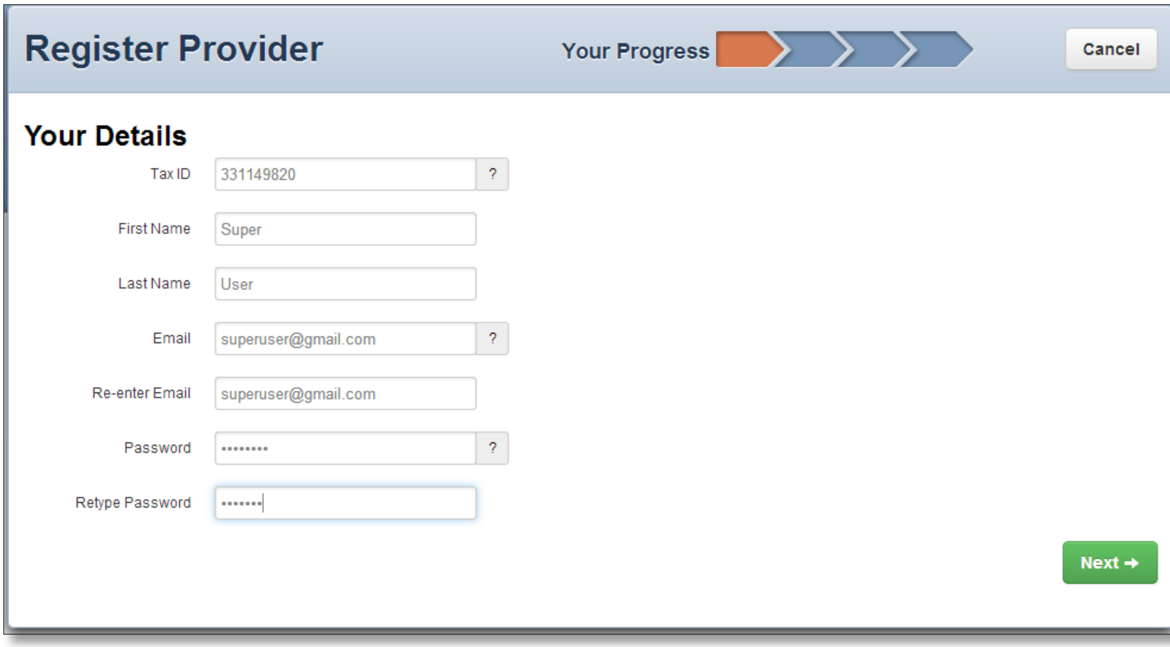
Create an account:

1. Click on 'Create An Account'.



Note: A video is available which will walk new users through the registration process. Or, for step by step printed instructions, click on the provider registration pdf.

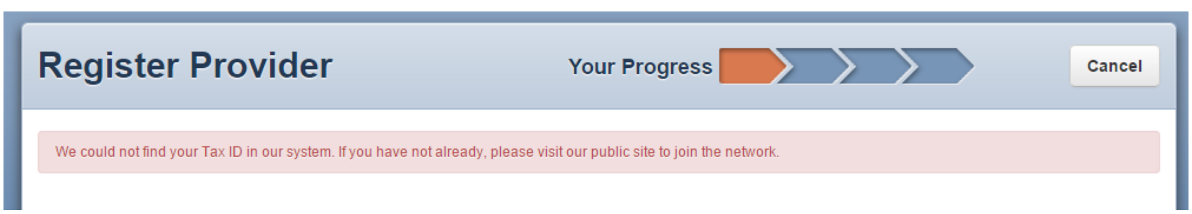
The screen below appears:



Enter the following information:

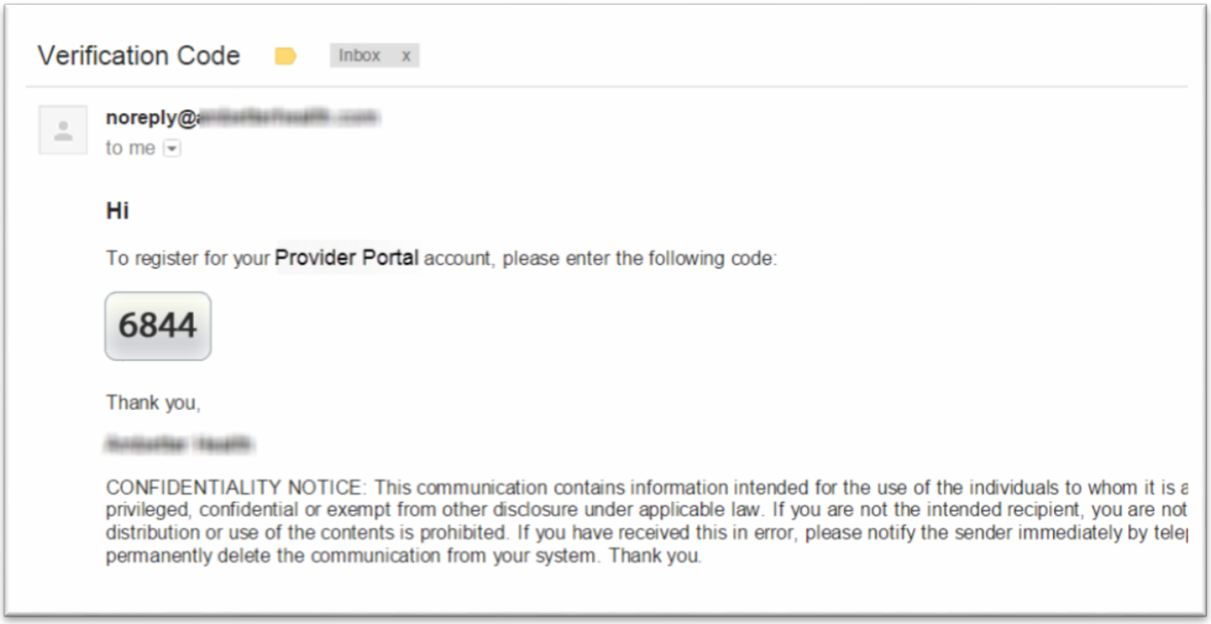
1. Enter Tax ID
2. Name
3. E-mail address
4. Create a password.
   Note: Passwords must be at least 6 characters in length, with at least one uppercase and lowercase letter, and at least 1 number or symbol (A@#$%&*8a).

If you receive error message: “We could not find your Tax ID in our system. If you have not already, please join our network.” Please return to our public site to join the network. Once your data is in our systems you'll be able to create your account.

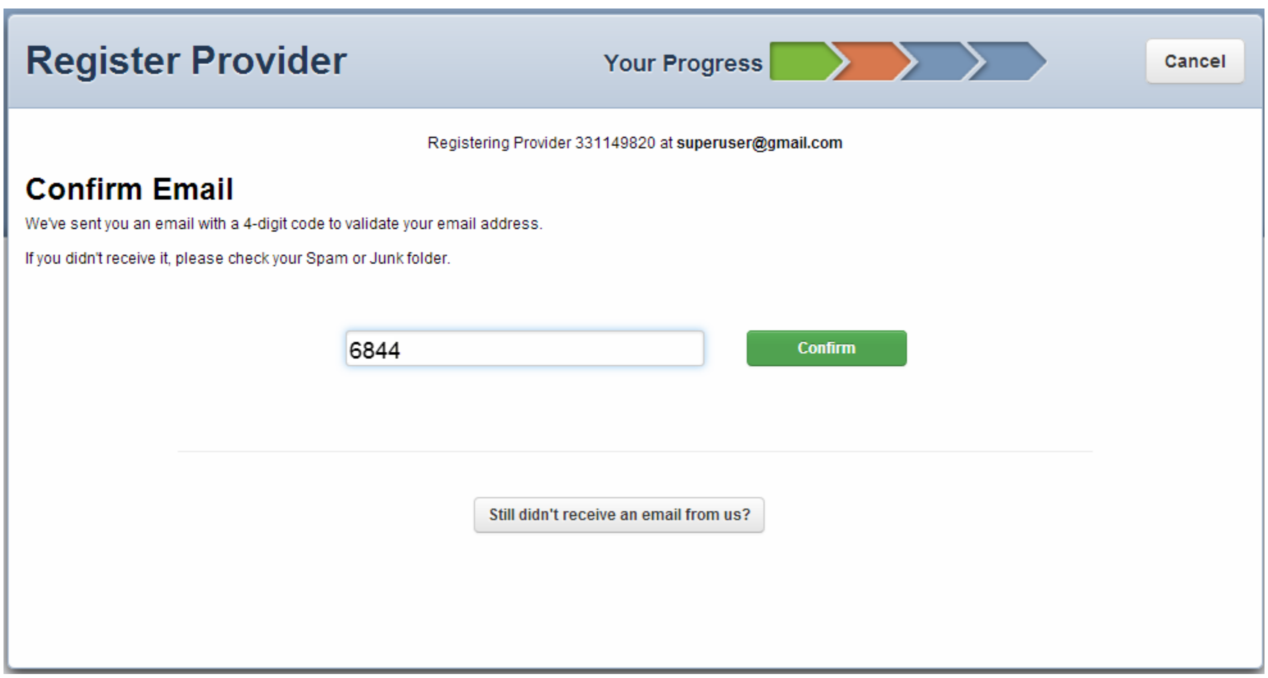


Note: Non-network providers can also use the secure provider portal once their TIN, NPI and billing information has been added to our claims system. Once an initial claim has been processed, the user should be able to create a secure account.

5. Confirmation Email will be sent to the email address provided during registration.

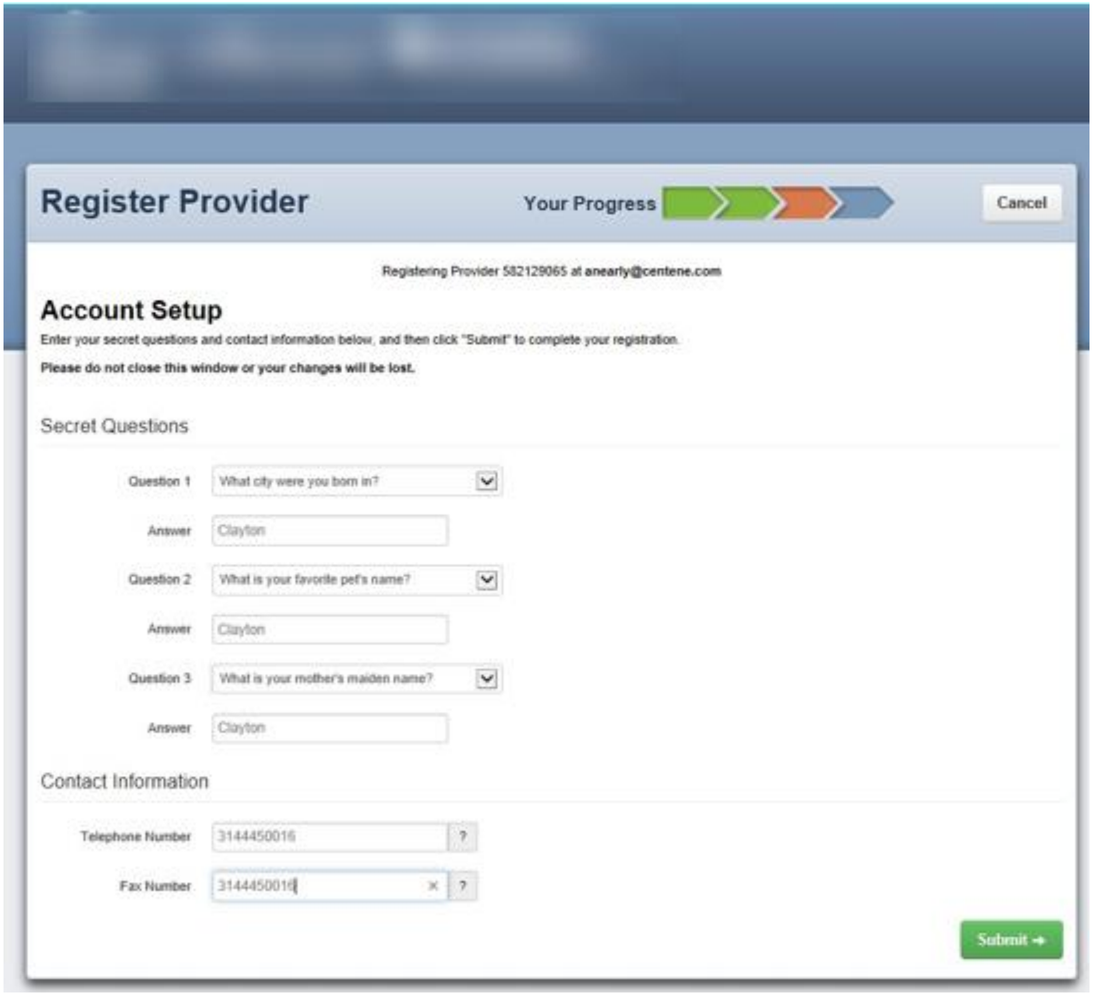


6. Enter the verification code



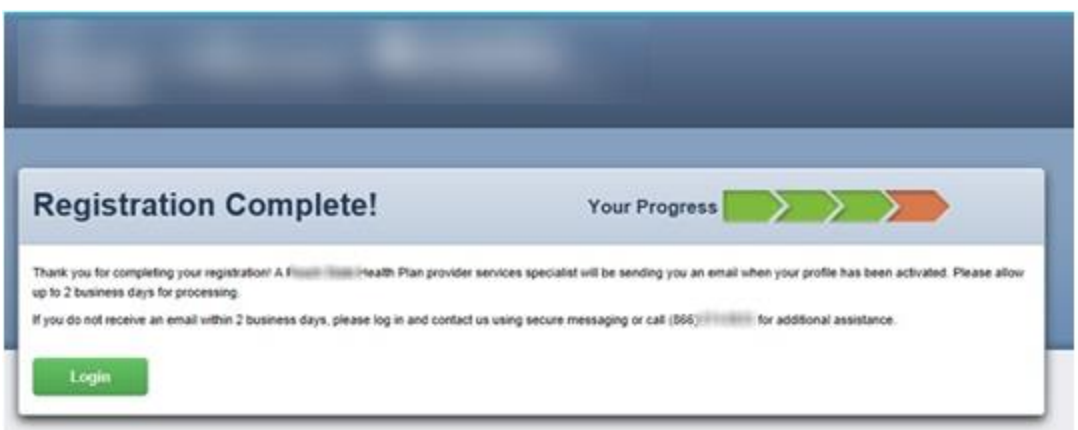
If you do not see the verification email in your inbox: Please check your junk or spam email folder

7. Begin by completing the secret questions for your account



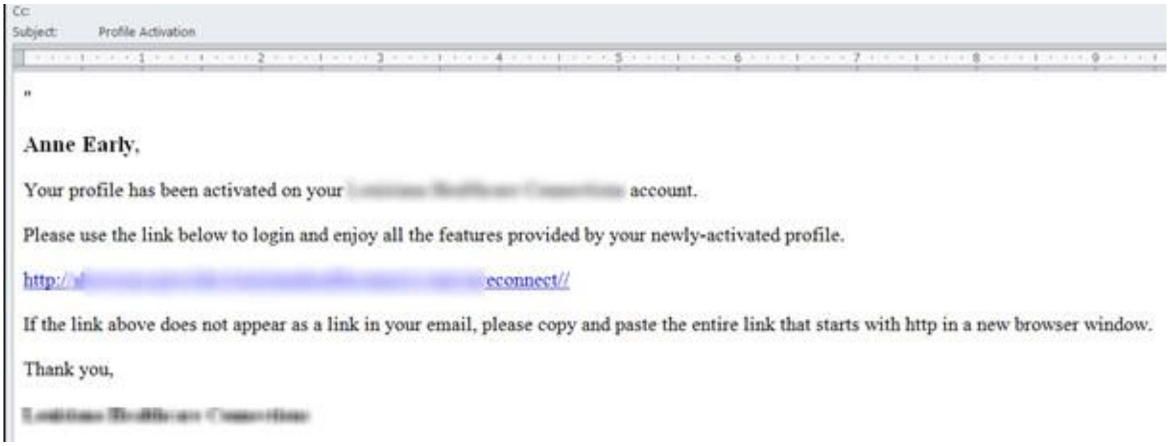
8. Hit Submit

The following screen appears:



Note: Until the plan verifies your user name, the only available options in the secure portal will be sending and receiving secure messages.

Note: the Health Plan will first verify your account (which can take up to 48 hours) and you will receive an email when the account has been activated.


Cc:

Subject: Profile Activation

Anne Early,

Your profile has been activated on your account.

Please use the link below to login and enjoy all the features provided by your newly-activated profile.

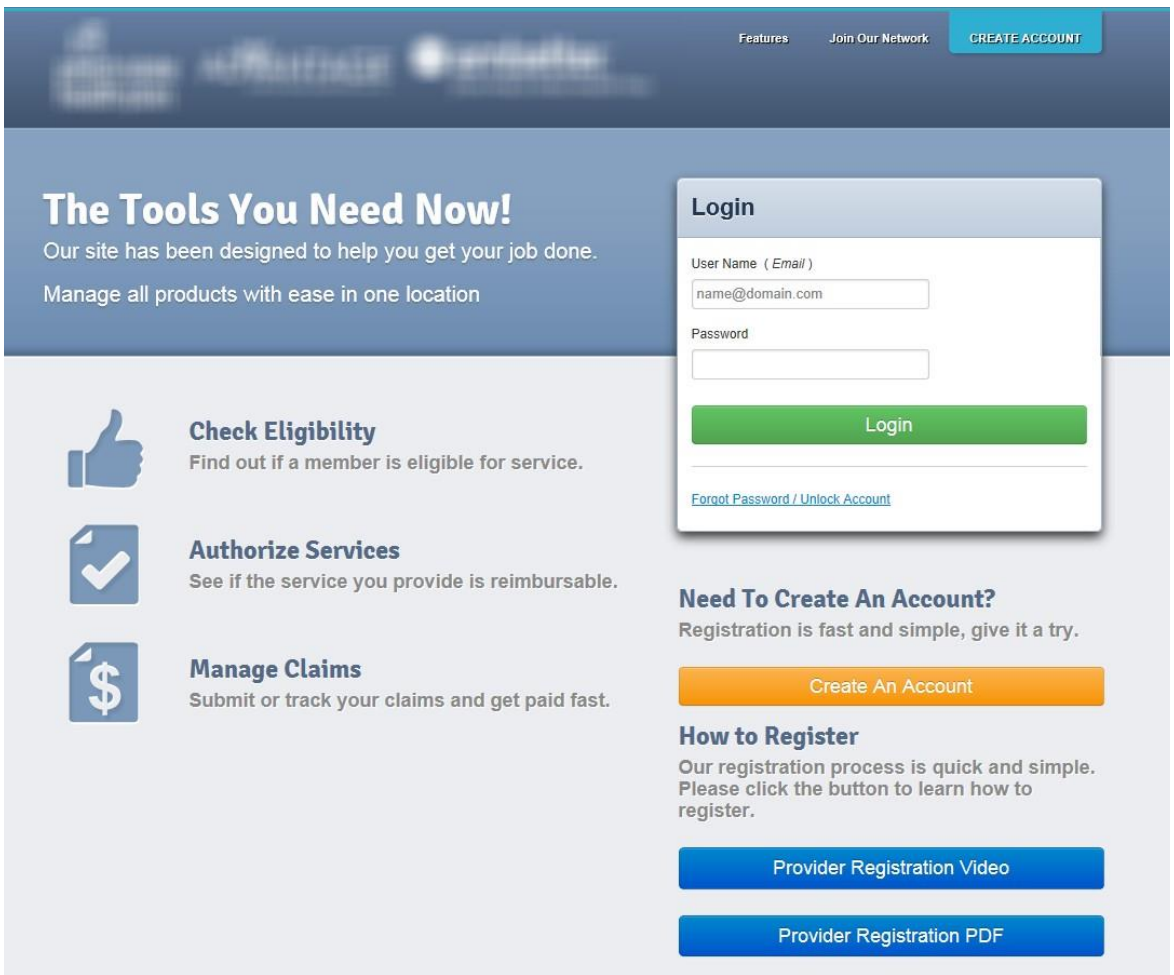
http://econnect//

If the link above does not appear as a link in your email, please copy and paste the entire link that starts with http in a new browser window.

Thank you,

Login

Below is the screen that allows you to Login to the secure provider portal.

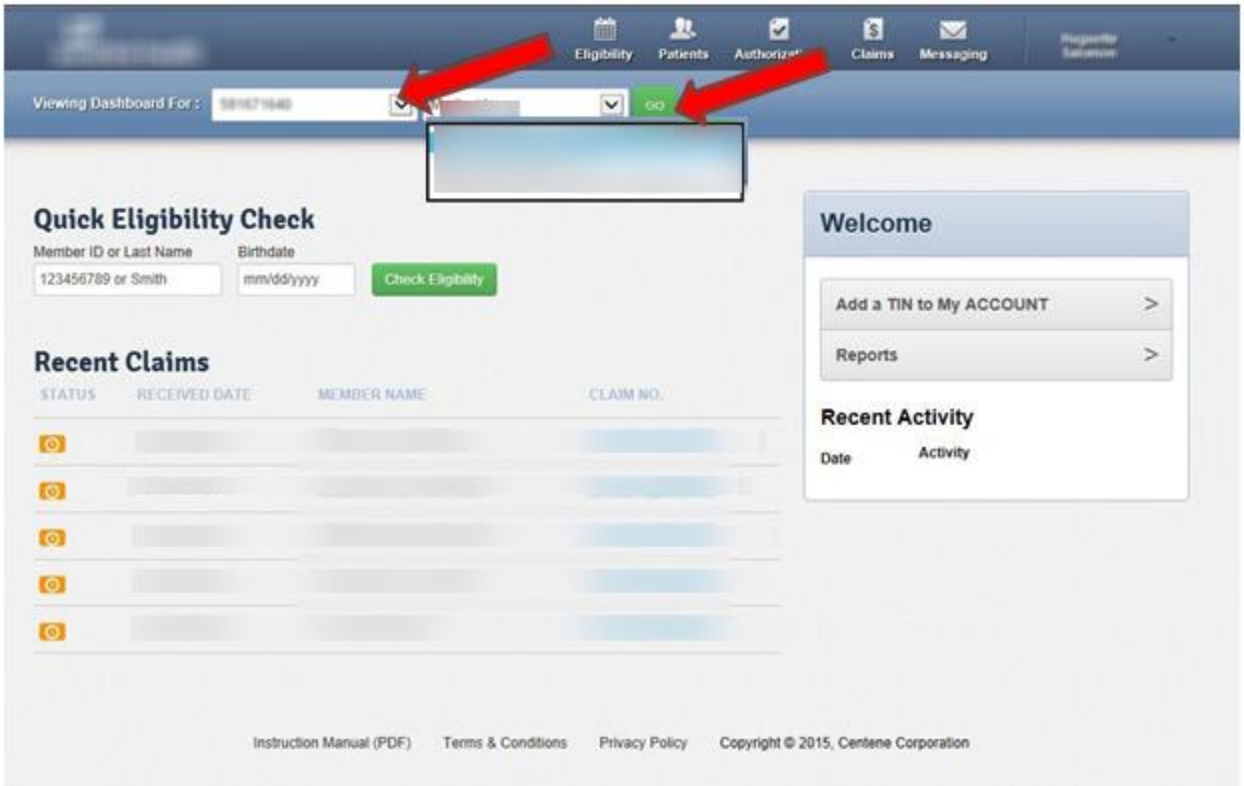


1. Enter user name
2. Enter Password
3. Click Login

The Dashboard

The Dashboard will appear after a user logs in.

1. Pick the Tax ID
2. Choose the appropriate Product
3. Select Go



Features accessible from the Dashboard are:

- Verify patient eligibility
- View and print your patient list *(PCP/PMP) (Some plans also have Health Home providers)*
- Submit and view authorizations
- Submit, view, correct, copy, void/recoup claims
- View provider related reports
- Send and receive secure messaging

  Note: *these features can vary by Health Plan and product*

From the Dashboard you can also:

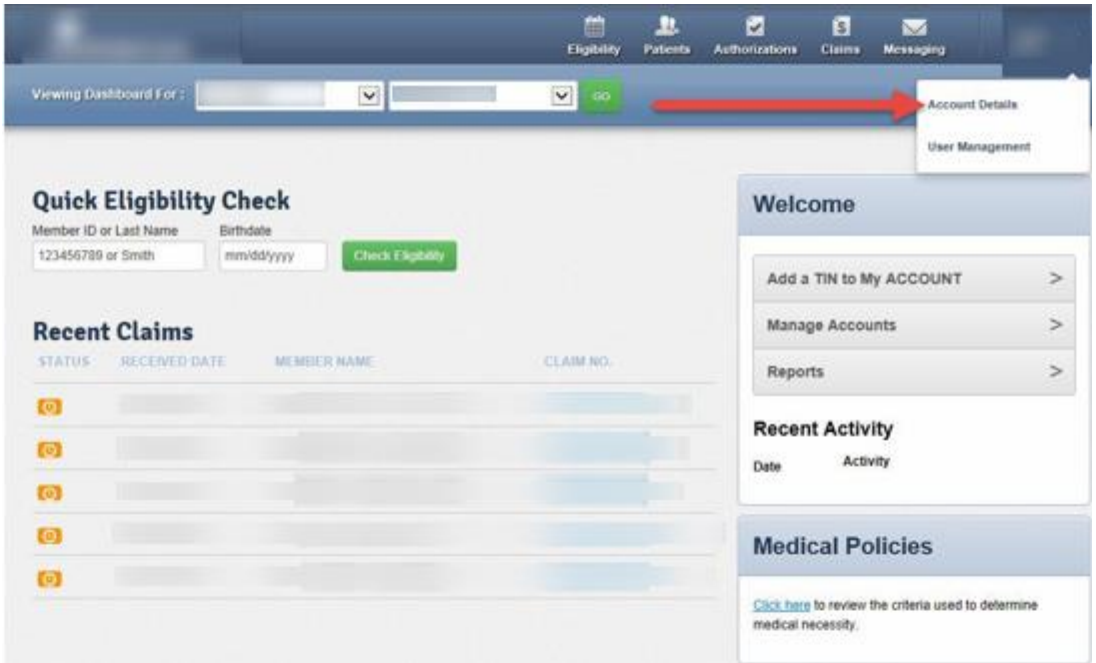
- Switch between Multiple Provider Tax ID's
- Switch between multiple products, i.e. Medicaid, Ambetter, Advantage Plans or MMP by using the drop down feature

  Note: Users only need one account to manage all of their health plan products. Once a user creates a secure account, all products will be added for them. A TIN must be affiliated to the product in the claims system for the product to appear. If a product is missing – contact your provider relations representative for assistance. It can take up to 24 hours for the new product to show up in the portal once it is updated.

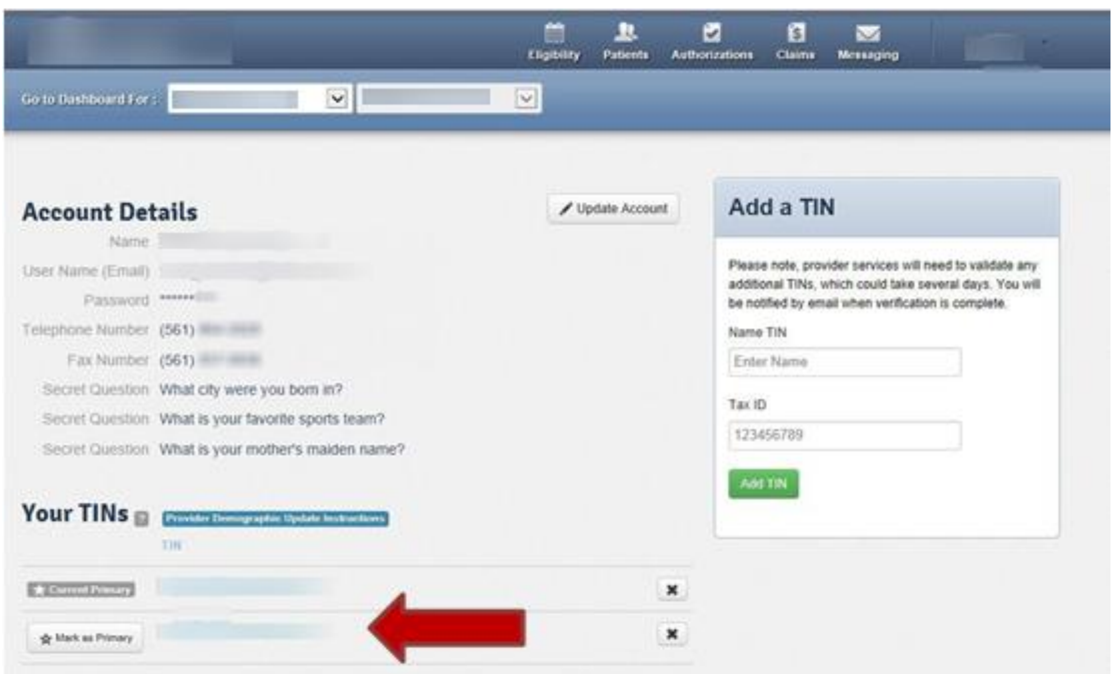
Your Account

To view your account:

1. Select the **drop-down arrow** next to your name in the upper right corner on the dashboard
2. Click **Account Details**



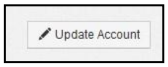
The following screen appears:



Note: Under Your TINs you see the Current Primary Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN.

Update an account

1. Click the **Update Account** button.



You are able to update the details of your account, and your security information.

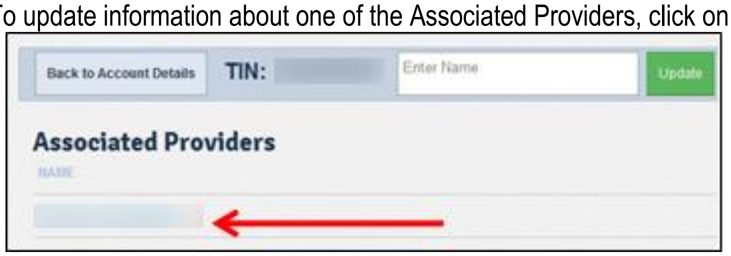
- Change/Update Name
- Change Password
- Change/Update Email
- Update Phone/Fax Numbers

To modify demographic information about the Specific TIN

1. Click on the individual TIN to update.

The following screen appears

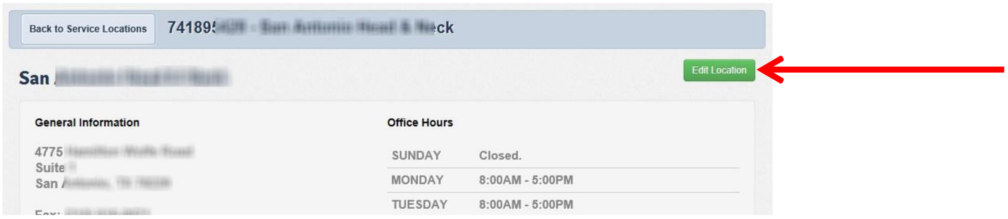
2. To update information about one of the Associated Providers, click on the name.



3. A list of possible Service Locations will appear

4. Click on the name associated to the address to update

The following screen appears.



4. Click Edit Location to update the provider information – This information will update the Find A Provider website
5. The following Transaction attributes will be available for edits - ***only one update within a transaction set is allowed per day.***

(If any additional updates are necessary – please contact your provider relations representative)

Transaction Set #1 - Provider Location Address

- Address1
- Address2
- City

Transaction Set #2 - Provider Location Phone

- Phone
- Fax

Transaction Set #3 - Provider Location Accessibility

- Accessibility (Yes or No)

Transaction Set #4 - Provider Office Hours

- Monday- Sunday (7 Data Attributes for each day)

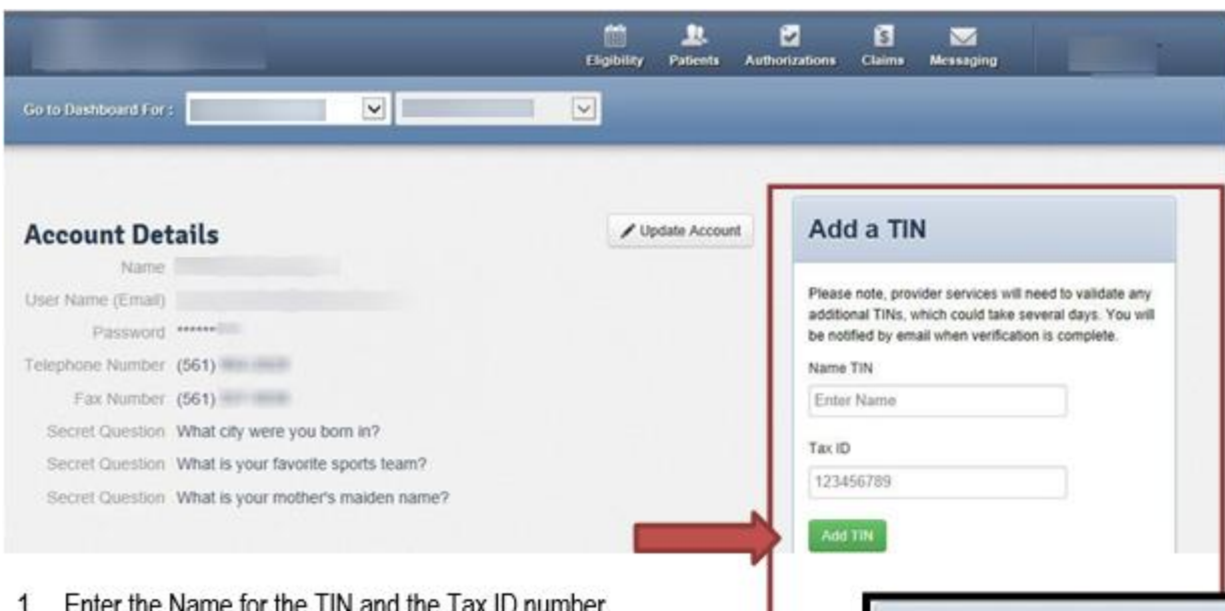
Transaction Set #5 - Practitioner Gender

- Gender

Transaction Set #6 - Practitioner Office Hours

- Monday- Sunday (7 Data Attributes for each day).

Adding a TIN to an account



1. Enter the Name for the TIN and the Tax ID number.
2. Click **Add TIN**.

Note: If the TIN entered is not found –the following message appears. Each new TIN added will require verification from the health plan and can take up to 48 hours to complete.

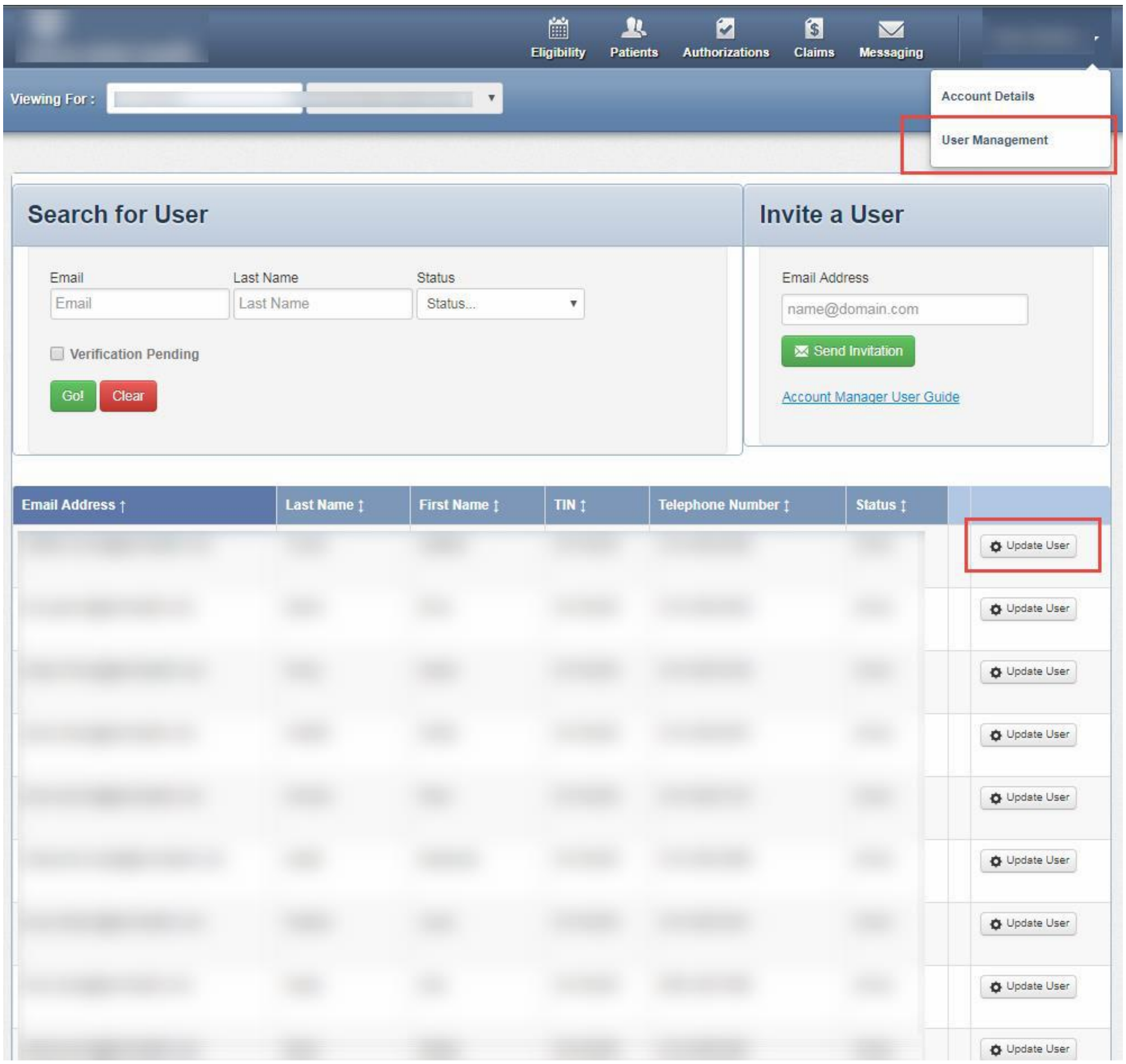
User Management

For Account Managers to manage their office staff/users associated to their practice:

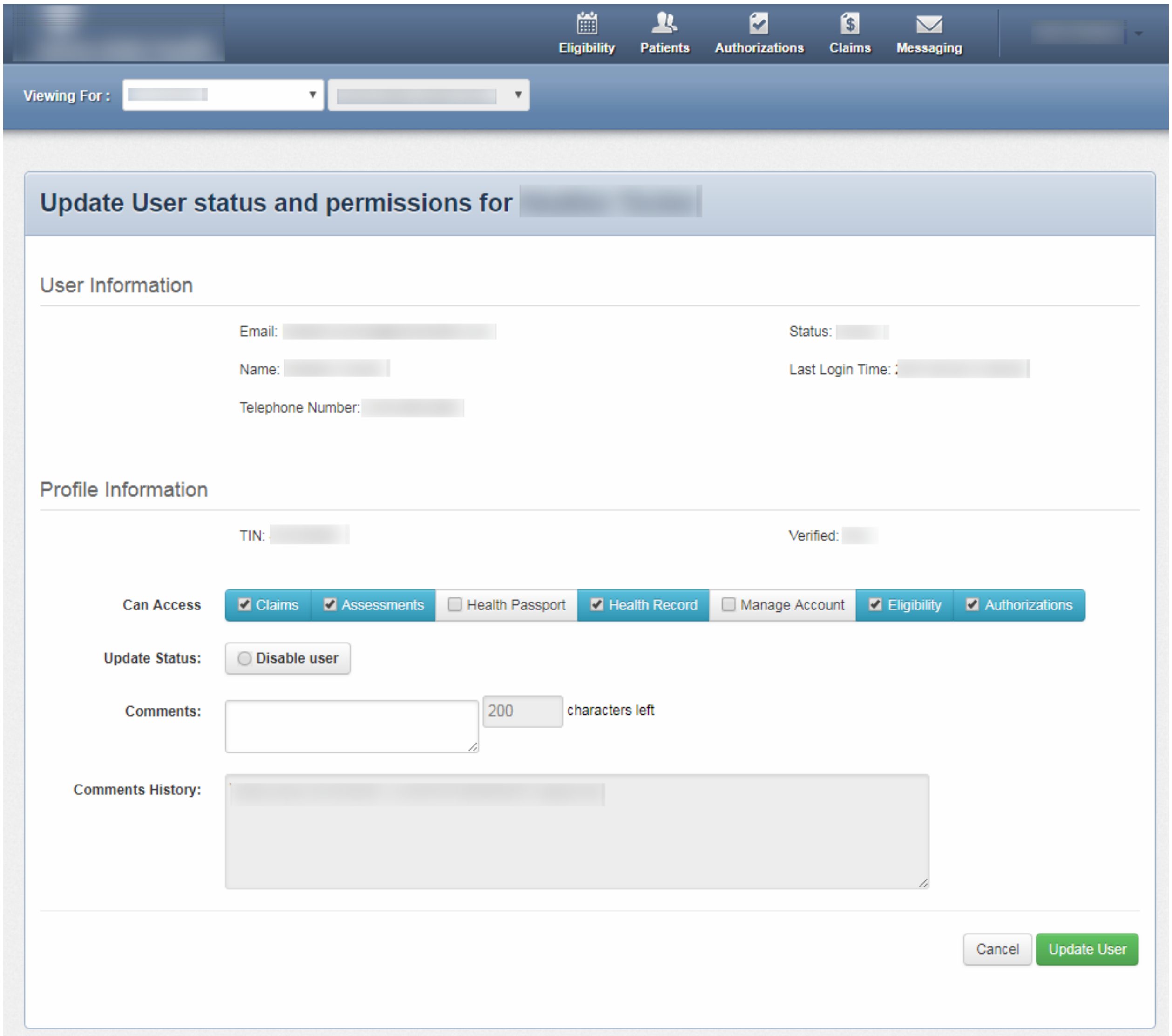
When using this feature you can disable/enable users, and manage permissions for your account.

1. Select the drop-down arrow next to your name in the upper right corner.
2. Select **User Management**.
3. Click **Update User** next to the user name.

If you do not have a User Management option it means you do not have the authority to act as the account manager.



The following screen appears:



1. Check/Uncheck the boxes according to what permissions each user should have.
2. Click **Update User**.

Account Permission Definitions:

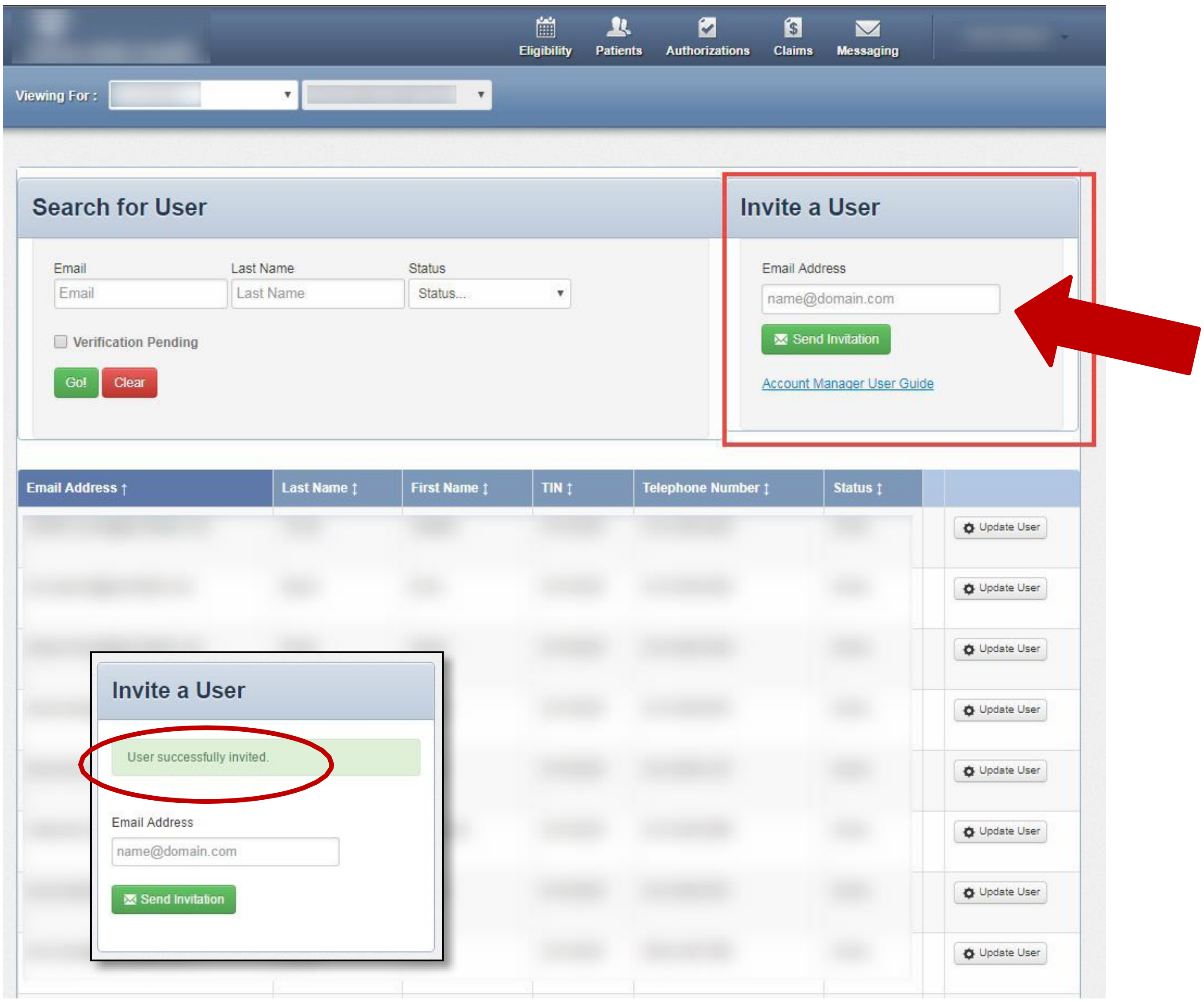
Health Record	Health history including visits and medications
Claims	Ability to view or submit claims
Manage Account	Provides access to all functions within the secure portal and is the Administrator for that TIN
Eligibility	Access to check eligibility
Health Passport	Only necessary for plans using Health Passport
Assessments	Ability to complete and submit HRA and/or NOP forms
Authorizations	Ability to view or submit authorizations

If you uncheck the **Manage Account** box, the identified user will not be able to manage other accounts. Once you click save you will return to the Support Users screen to manage additional users.
All changes take effect immediately

Invite a others to join your account

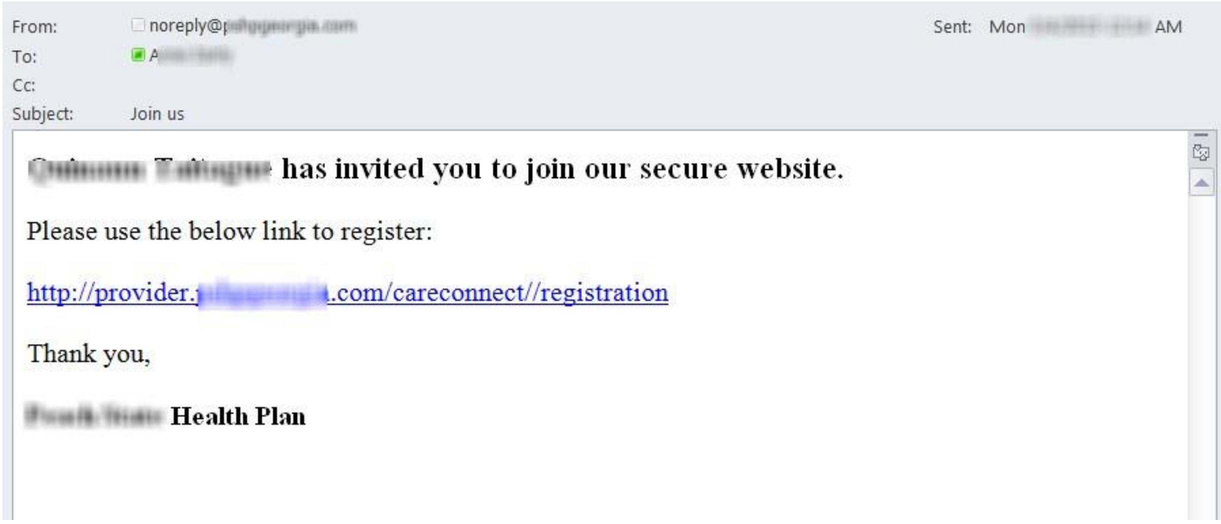
From the **Support Users** screen enter a user's email address to invite them to join your account.

1. Enter their Email Address in the email address field and click **Send Invitation**.



Note: A successful invitation email was sent when you see the following message

An example of the invitation email is shown below

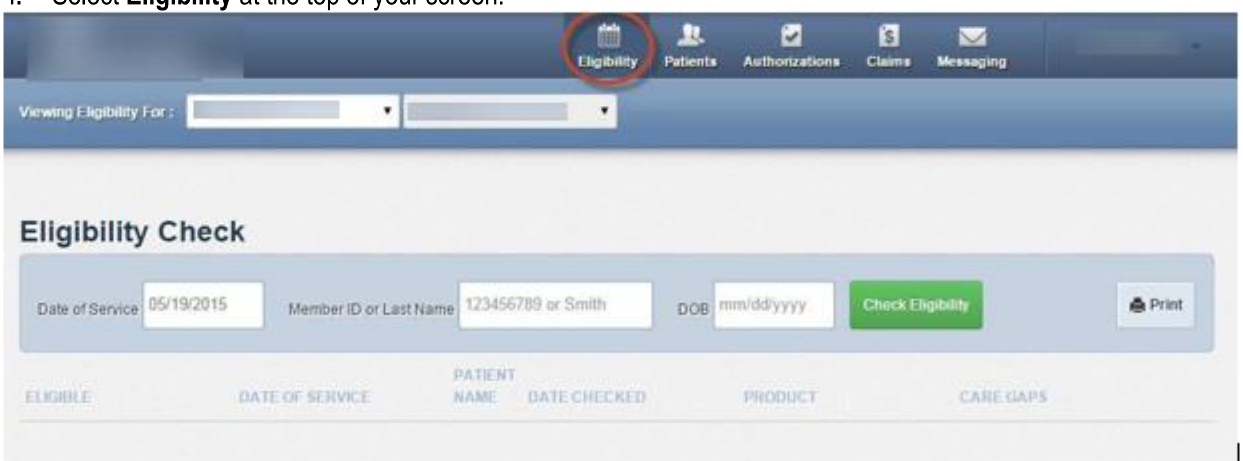


Note: Each new invitee will follow the registration process defined [here](#).

Verifying Patient Eligibility

To verify patient eligibility:

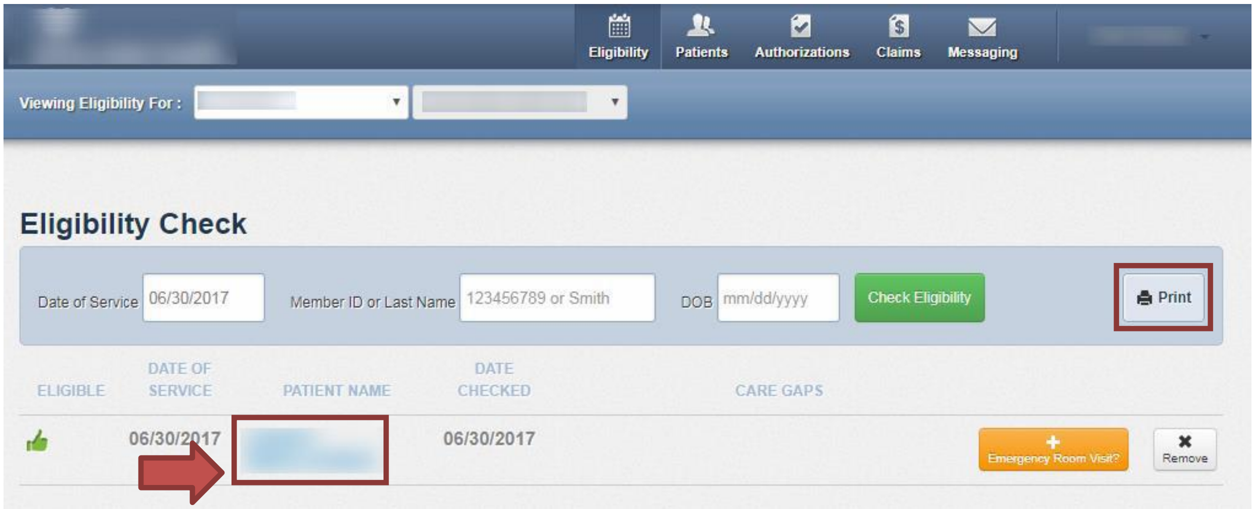
1. Select **Eligibility** at the top of your screen.



- Enter the **Date of Service (**if it is not today's date)
- **Member ID or Last Name**
- **Date of Birth** of the patient.

2. Click Check Eligibility.

The following screen appears:



This view contains:

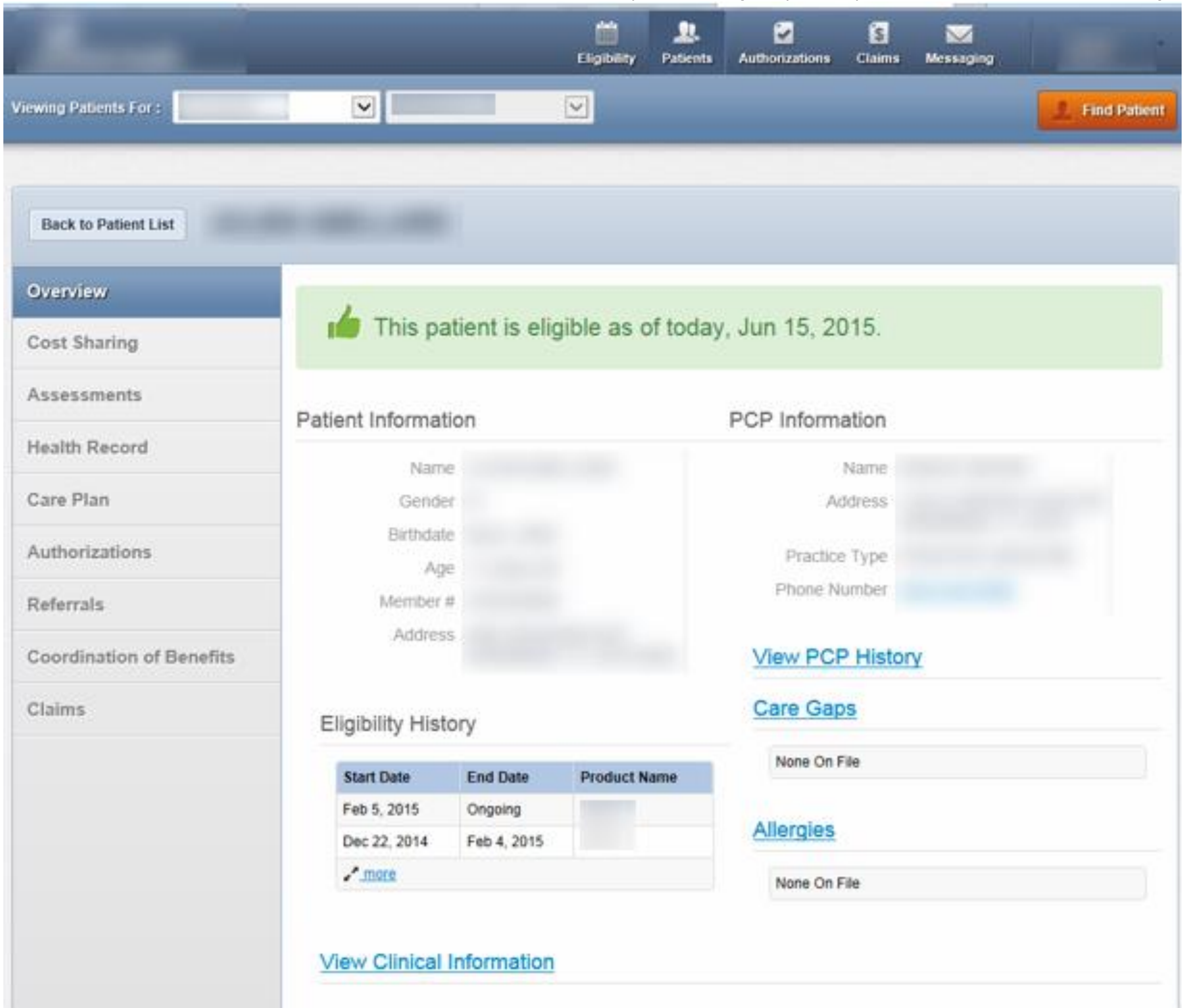
- Eligibility status
- Date of service
- Patient name
- Date checked
- Care gaps
- You can also add an Emergency Room visit for a patient from this screen to alert their case managers of their recent activity

1. To check additional patients, repeat the steps above.
2. To print the eligibility information click **Print**.
3. To open the Patient Record, click on the blue **Patient Name**.

Overview Tab on Patient Record

The Patient Record opens to the Overview tab and displays:

- Patient Information
- PCP Information
- PCP History
- Eligibility History
- Care Gaps
- Allergies



View Clinical Information displays

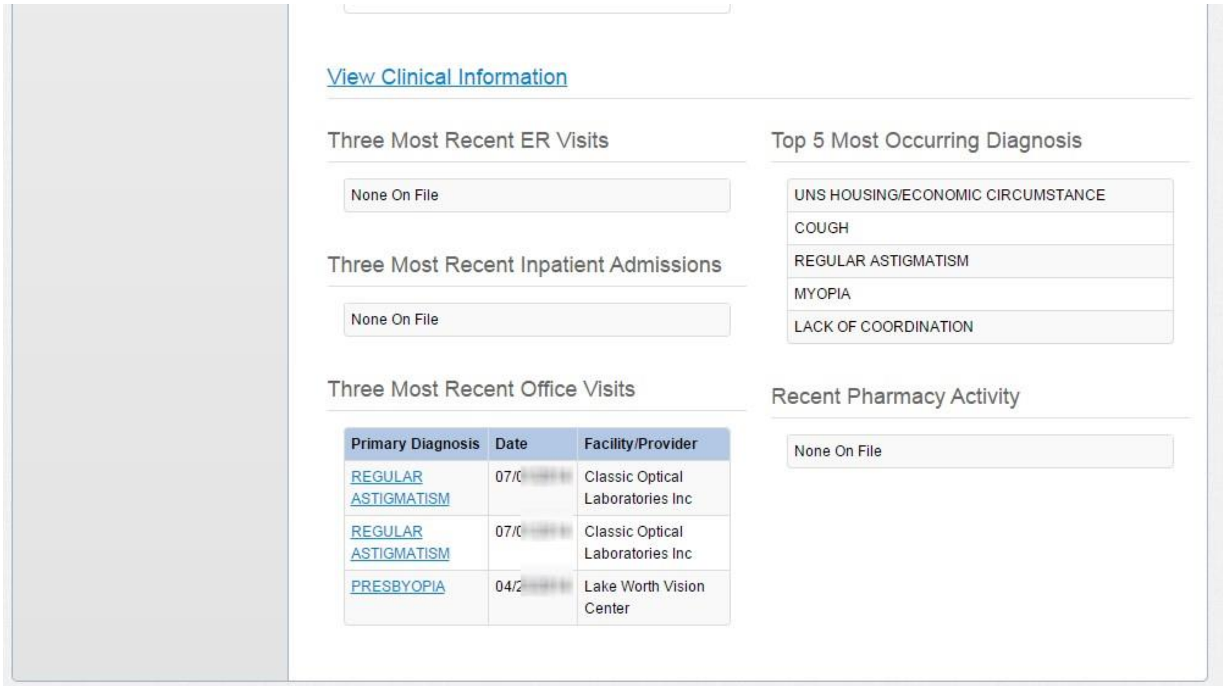
Three Most Recent ER Visits

5 Top Most Occurring Diagnosis

Three Most Recent Inpatient Admissions

Recent Pharmacy Activity

Three Most Recent Office Visits



Patient (Member) Record Components

Overview	Click Here to view the Overview Screen
Cost Sharing	The patient's portion of health care costs not covered by the plan.
Assessments	Any available assessments for this member will appear as well as Notice of Pregnancy NOP (if gender and age appropriate)
Health Record	The Health Record tab allows you to view a record of visits or medications for the patient
Care Plan	Care plans are created by the health plan's case manager to help manage the health.of the patient
Authorizations	The Authorizations tab of the patient record allows you to view current authorizations, and create new authorizations for the patient
Referrals	The Referrals tab allows you to send a member to specialized services
Coordination of Benefits	The Coordination of Benefits (COB) tab displays the other insurance information for the patient.
Claims	The Claims tab of the patient record allows you to view any recent claims for the patient, and also create a new claim

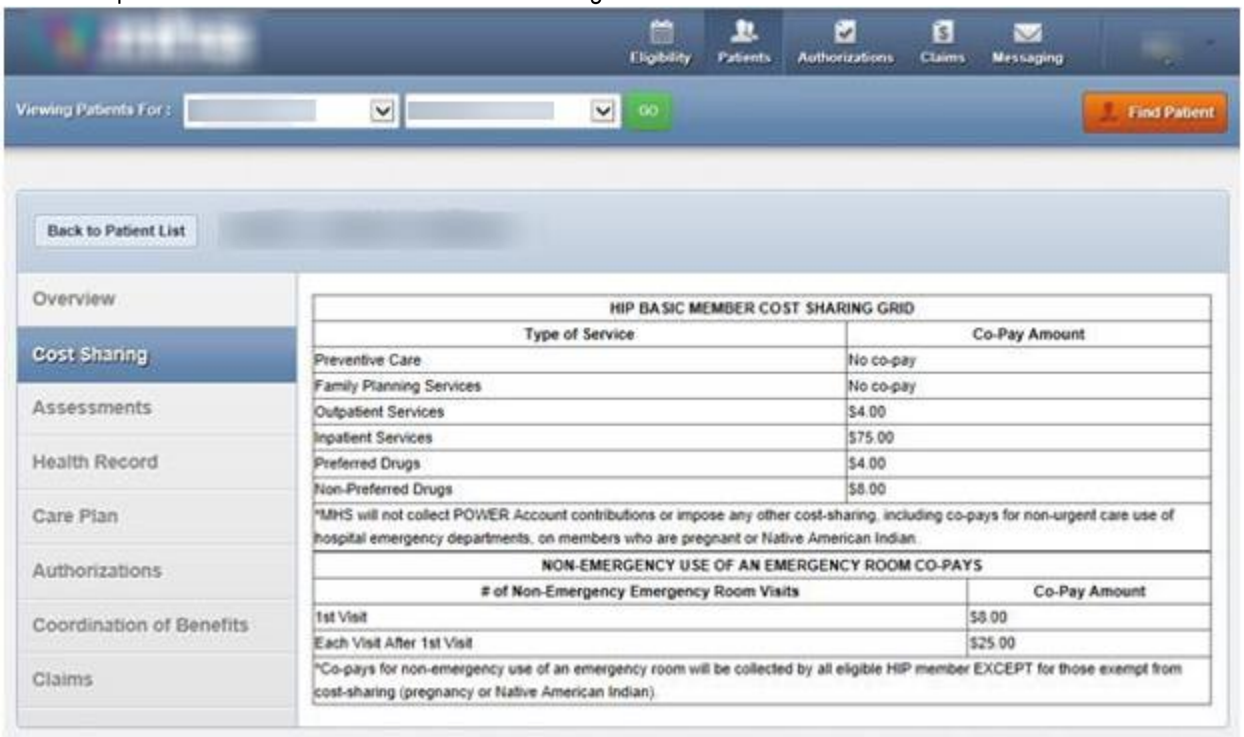
Note: Not all plans have all the listed components.

Cost Sharing

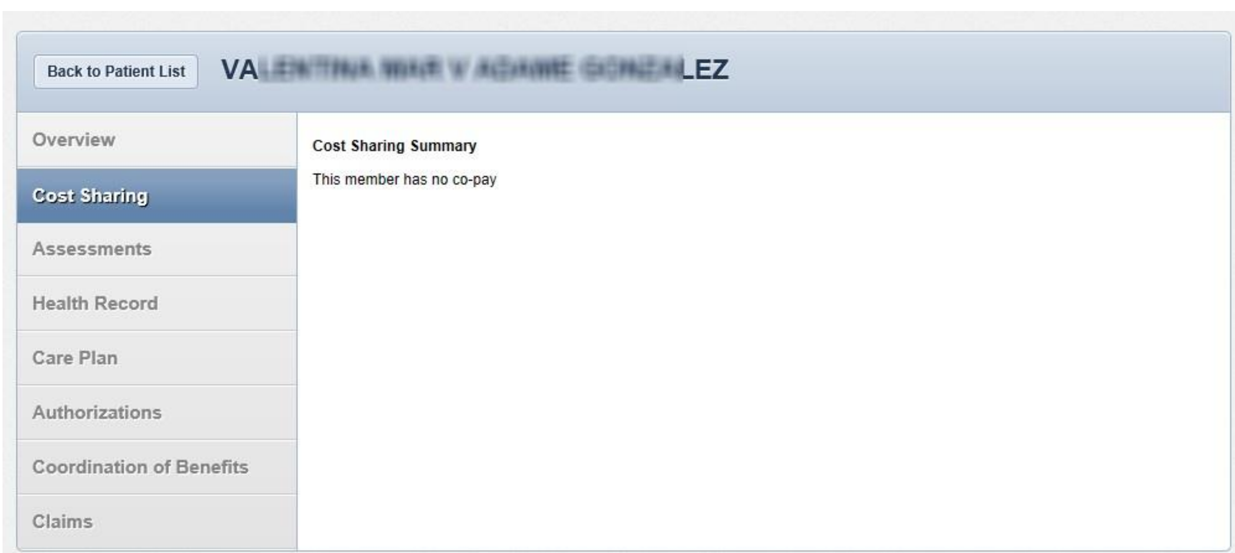
To access the cost sharing information from inside the member record:

1. Select Cost Sharing

This sample screens show a member with cost sharing:



This sample screens show a member without any cost sharing:

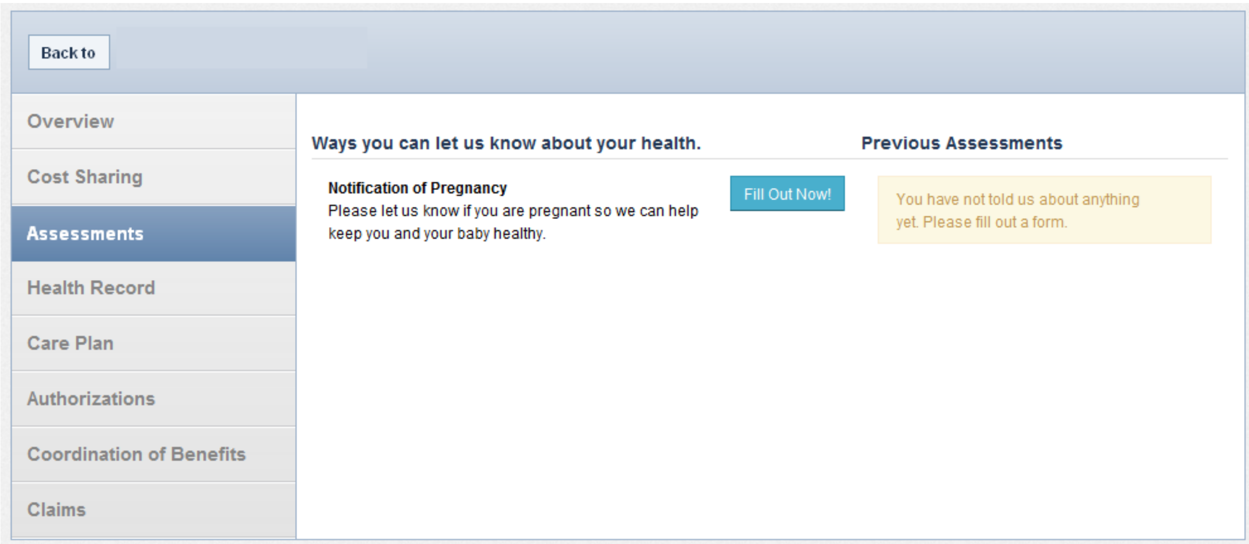


Assessments

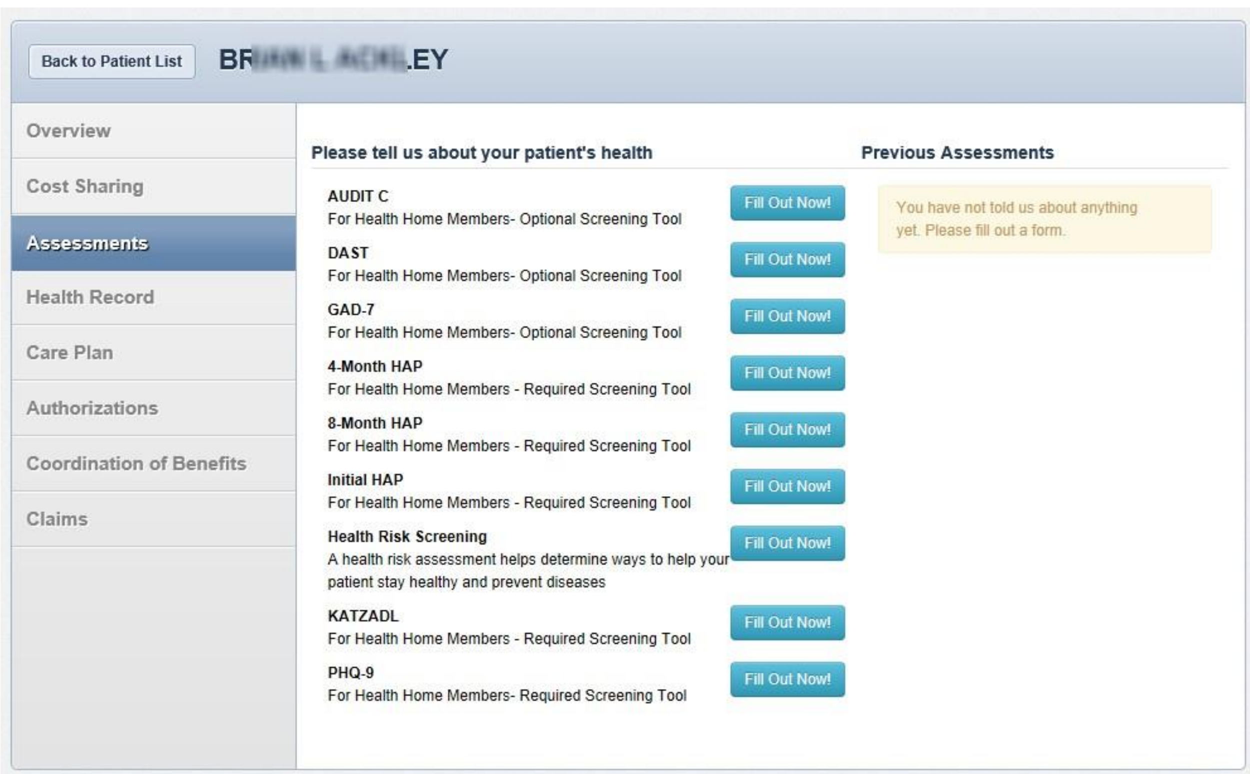
To access an assessment from inside the member record:

1. Select **Assessments** on the left.

The following screen displays the Notification of Pregnancy:



The following sample screen appears showing other assessments available for the provider to complete:

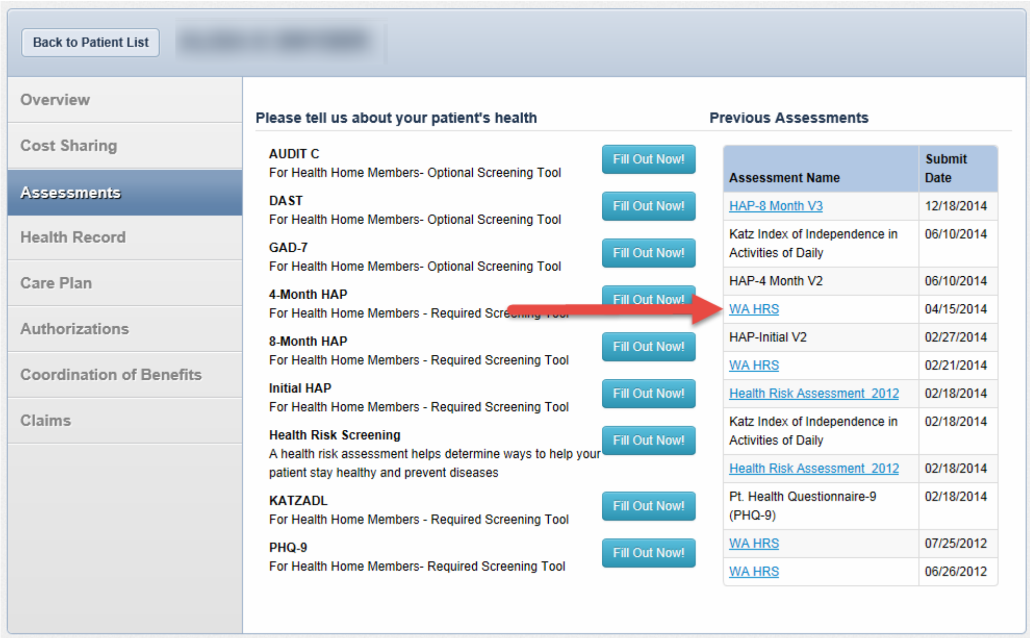


2. Select the **Fill out now** button
3. The questionnaire opens for data entry
4. Complete questionnaire
5. Select **Submit** button

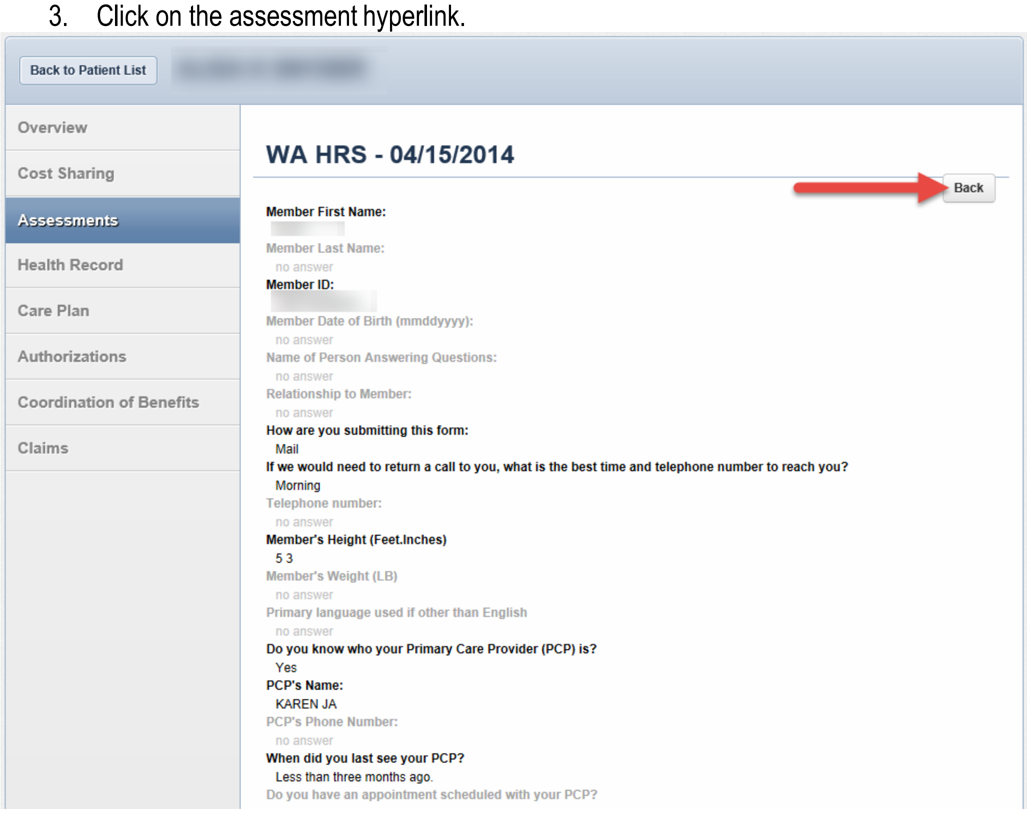
Viewing Submitted Assessment Responses

To access an assessment from inside the member record:

1. Select **Assessments** on the left.



2. Completed assessments will appear in a column on the right side of the health record.
3. Click on the assessment hyperlink.

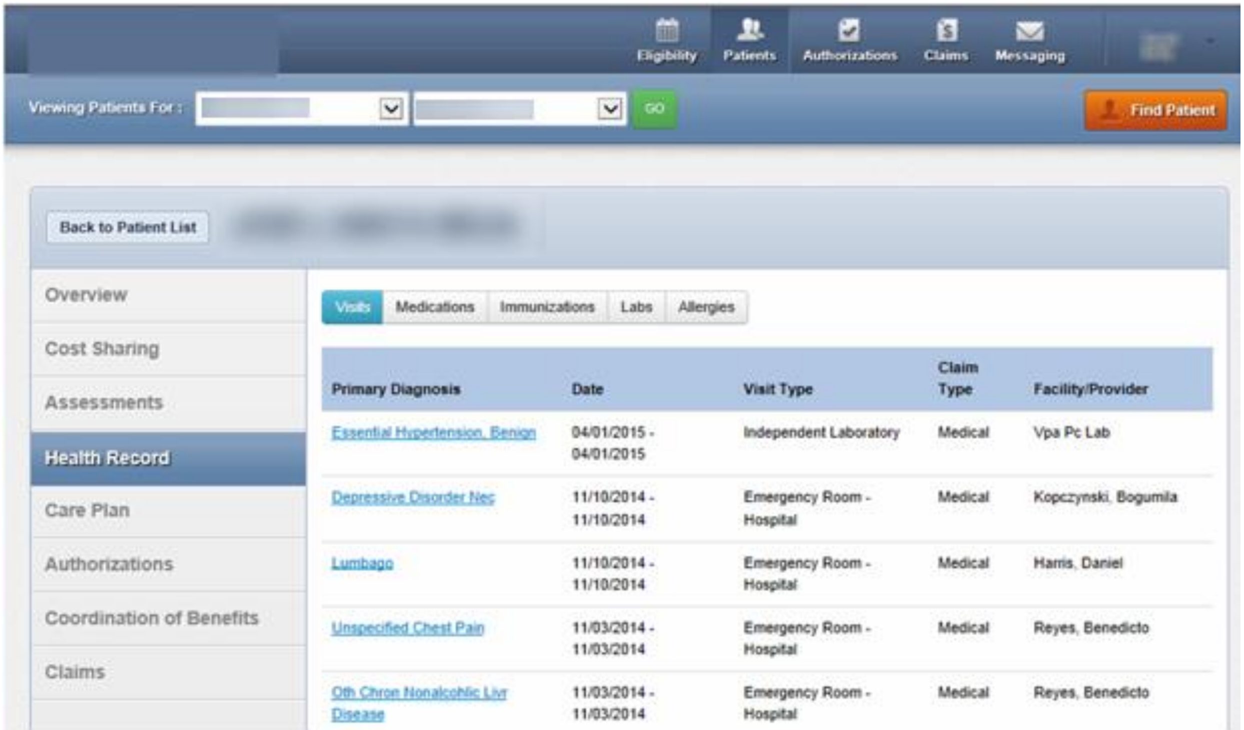


4. All of the completed responses appear in black font. Gray text means the question was not completed.
5. Click **Back** to return to the member's health record.

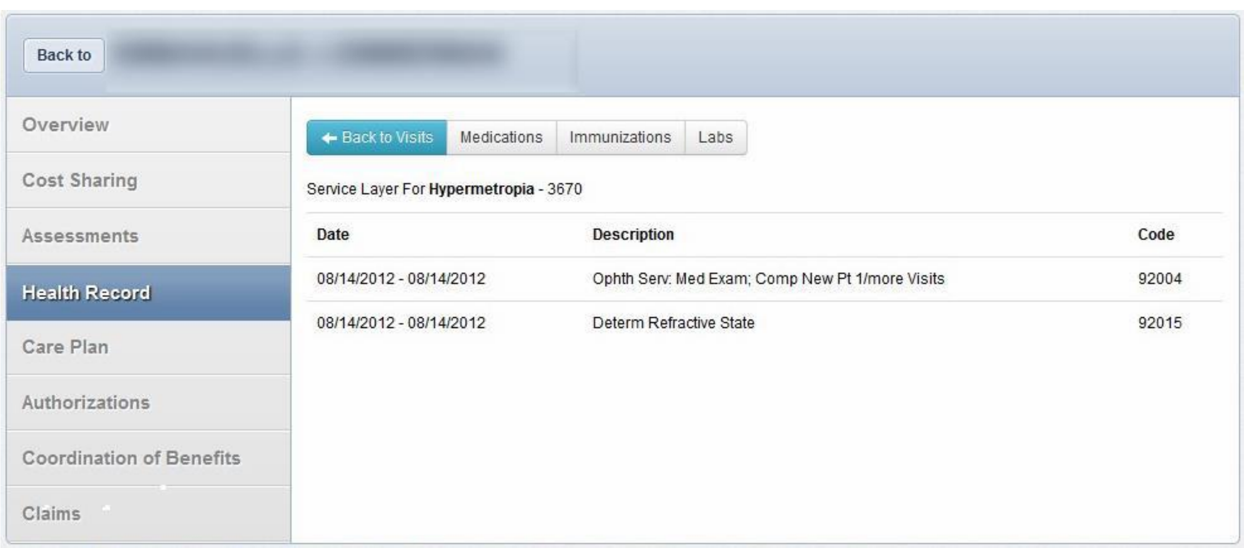
Health Record

To access the Members Health Record from inside the patient record

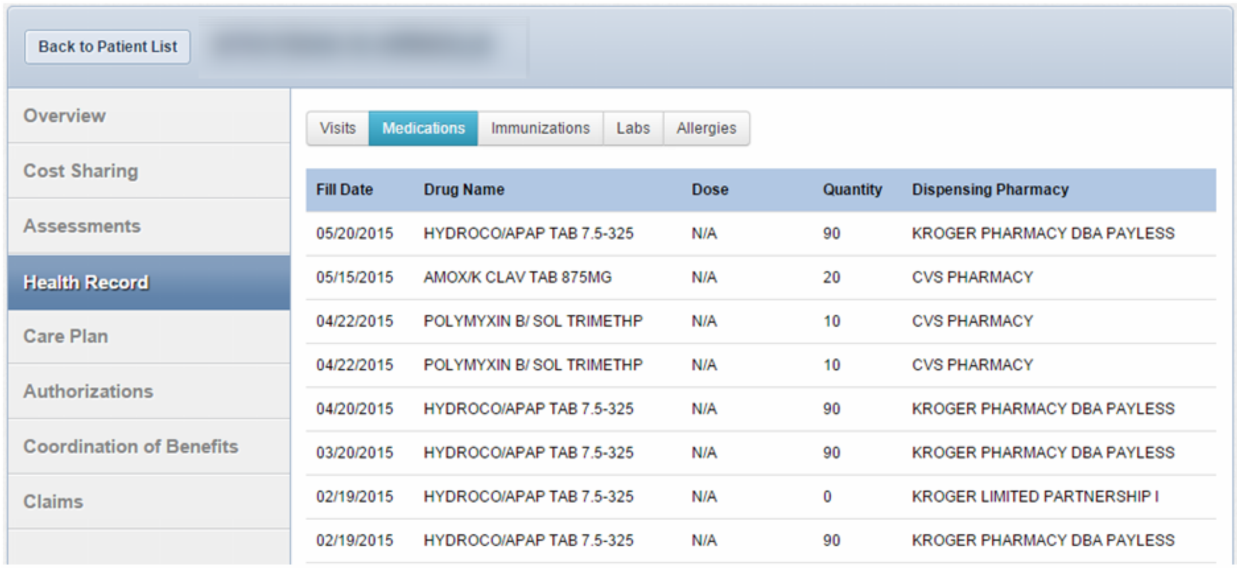
1. Select **Health Record.**
   The Health Record tab allows you to view a record of visits or medications for the patient.
2. Click on **Visits** to view any visit information (i.e. Office Visits, ER visits, etc.) for the patient.



a. To view details for the visit, click on the **Diagnosis Hyperlink**.

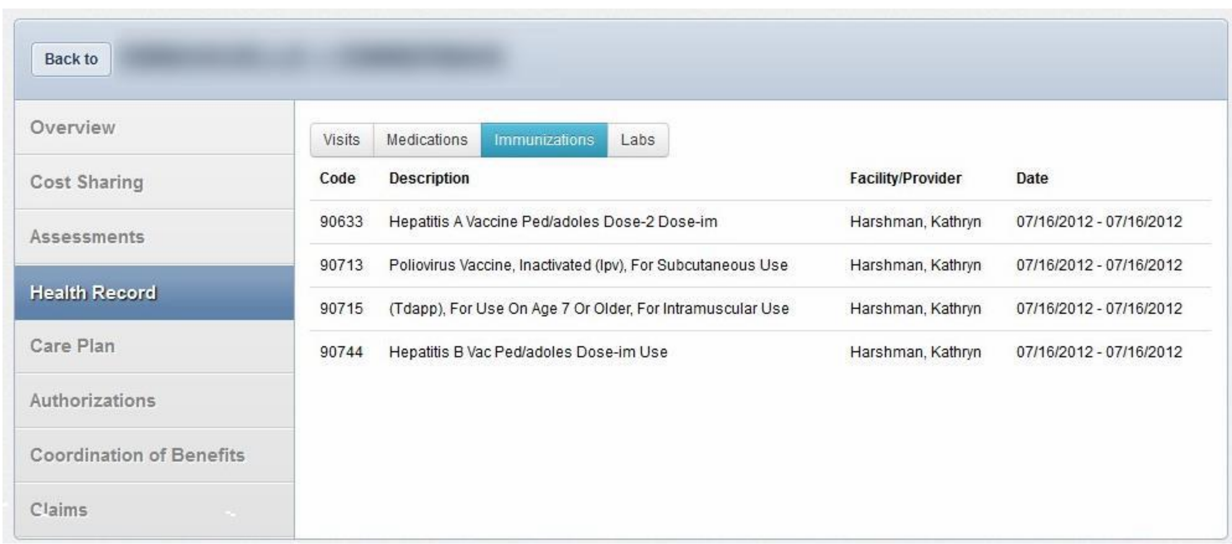


3. Click on **Medications** to view any medication information (i.e. Medications prescribed to a Member) for the patient.



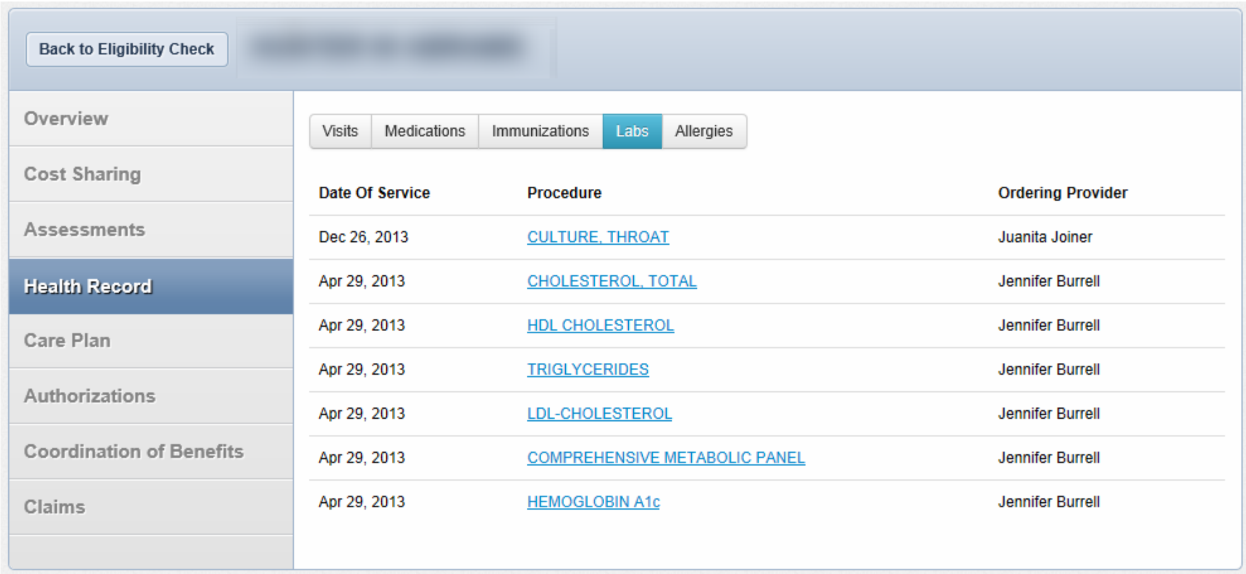
Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy
05/20/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS
05/15/2015	AMOX/K CLAV TAB 875MG	N/A	20	CVS PHARMACY
04/22/2015	POLYMYXIN B/ SOL TRIMETHP	N/A	10	CVS PHARMACY
04/22/2015	POLYMYXIN B/ SOL TRIMETHP	N/A	10	CVS PHARMACY
04/20/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS
03/20/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS
02/19/2015	HYDROCO/APAP TAB 7.5-325	N/A	0	KROGER LIMITED PARTNERSHIP I
02/19/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS

4. Click on **Immunizations** to view any vaccination received (i.e. Hepatitis, Influenza, etc.).



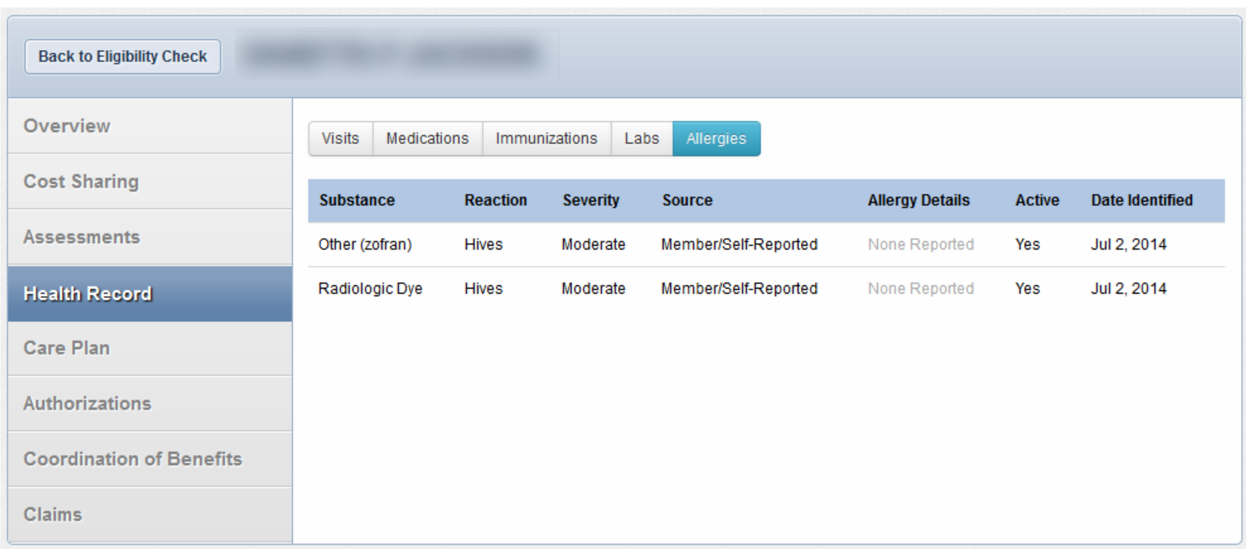
Code	Description	Facility/Provider	Date
90633	Hepatitis A Vaccine Ped/adoles Dose-2 Dose-im	Harshman, Kathryn	07/16/2012 - 07/16/2012
90713	Poliovirus Vaccine, Inactivated (Ipv), For Subcutaneous Use	Harshman, Kathryn	07/16/2012 - 07/16/2012
90715	(Tdapp), For Use On Age 7 Or Older, For Intramuscular Use	Harshman, Kathryn	07/16/2012 - 07/16/2012
90744	Hepatitis B Vac Ped/adoles Dose-im Use	Harshman, Kathryn	07/16/2012 - 07/16/2012

5. Click on **Labs** (i.e. Comprehensive metabolic panel, CBC) to view lab information for the member.



Note: For additional details about these lab values, click on the blue hyperlink of the test name.

6. Click on the **Allergies** (i.e. Sulfa, Codeine) tab to view the allergies for this member.



Note: Components appearing in the Patient Record are based on the last 18 months of claims data.

Care Plans

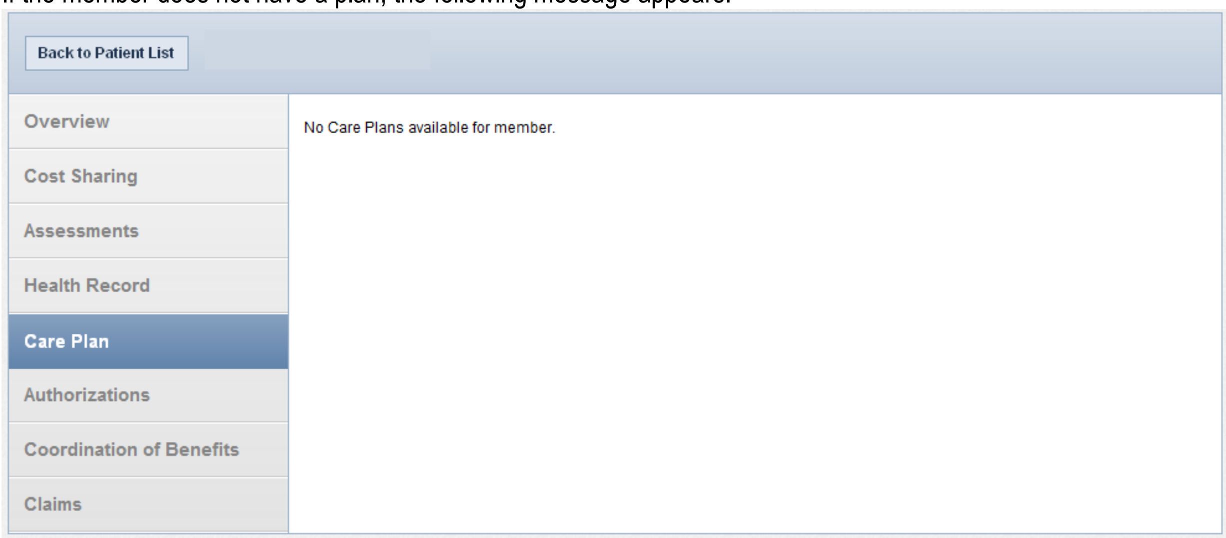
Providers can view three types of care plans;

1. Medical Care Plans are the most common and include medical terminology
2. Member Centric Care Plans include "Self-Management" in the title and can be viewed by the member
3. Free Text Care Plans are created by the case manager without a template

To access a care plan from inside the member record

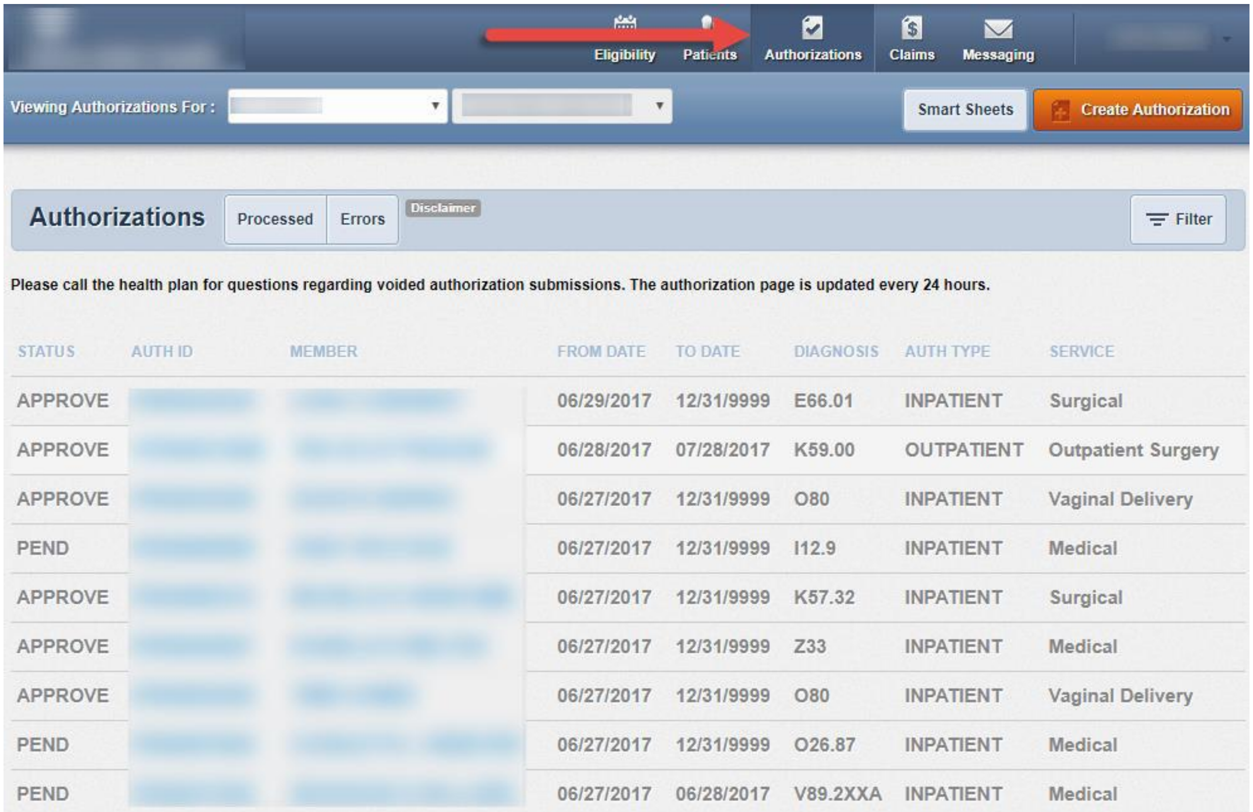
1. Select **Care Plan**

If the member does not have a plan, the following message appears:

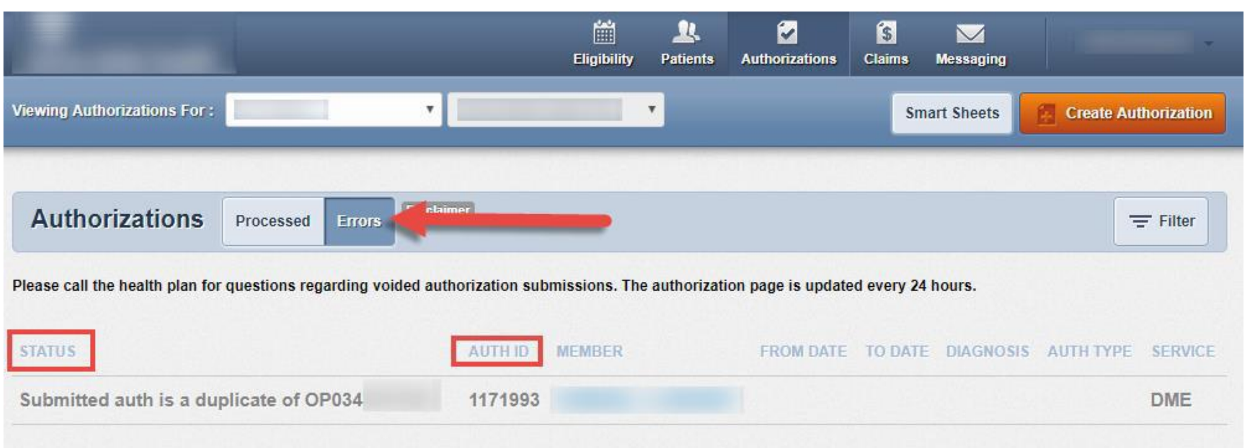


Authorizations

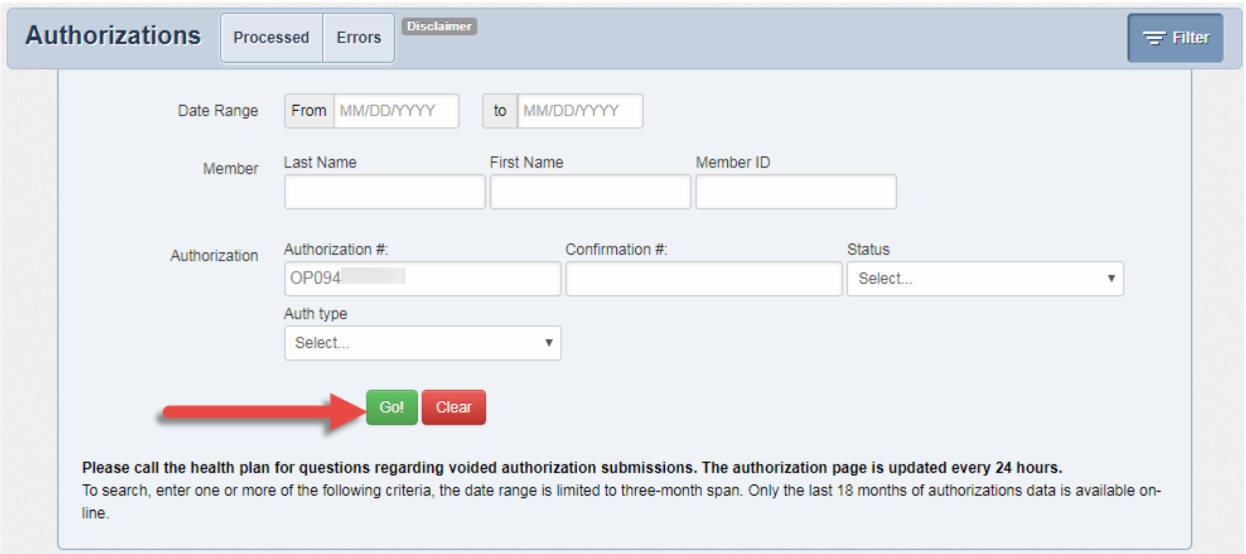
All processed prior authorizations requests submitted within the last 90 days will display the status, authorization ID, member name, date range for services, diagnosis, authorization type and service.



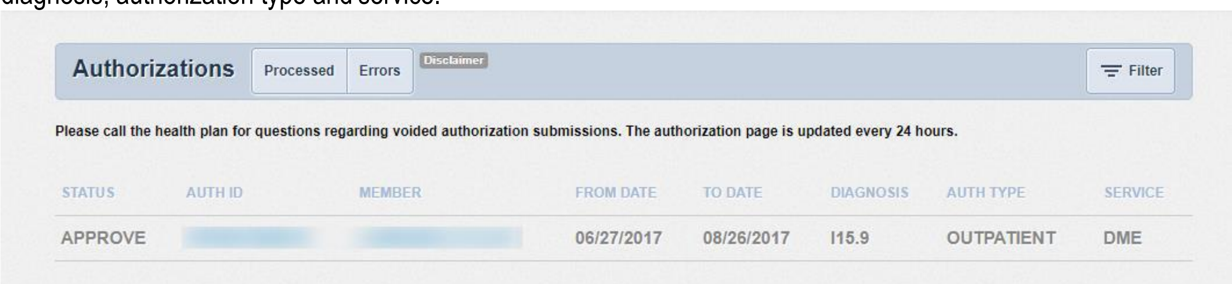
2. Click the **Error** button to view prior authorization requests. The status displays the **Authorization Number** and the **Auth ID** is the confirmation number received when submitting a request on the secure provider website.



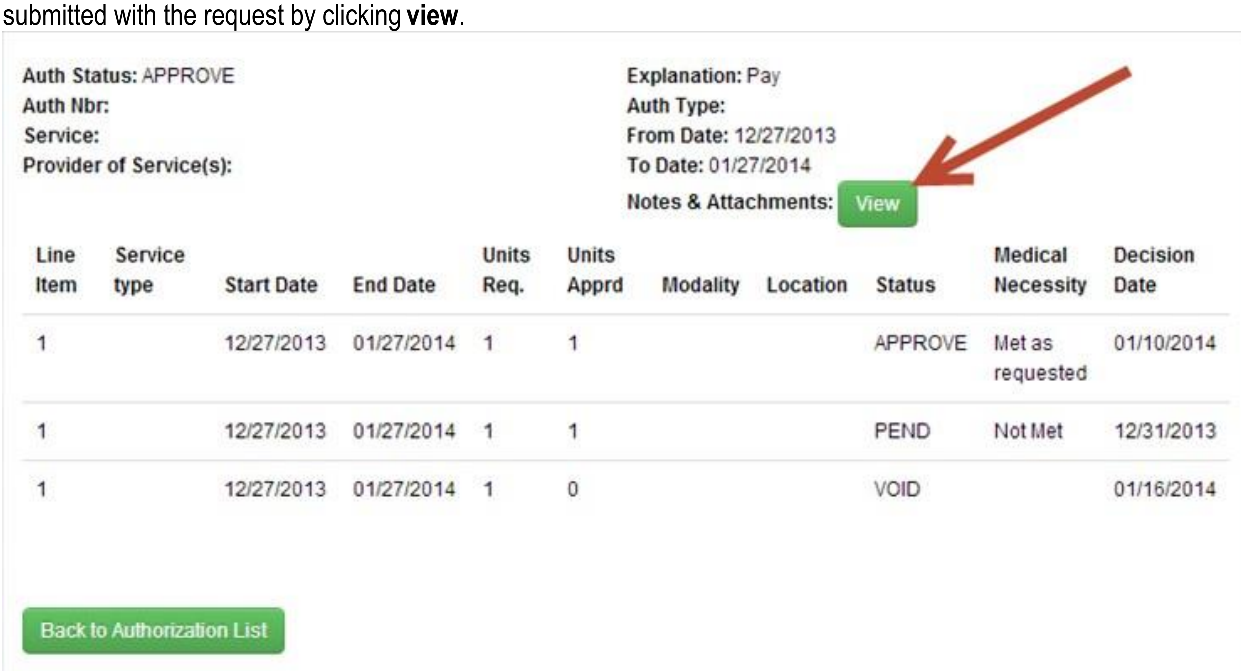
1. To view a prior authorization request, enter the **Authorization or Confirmation Number** in the field, and click **Search**.



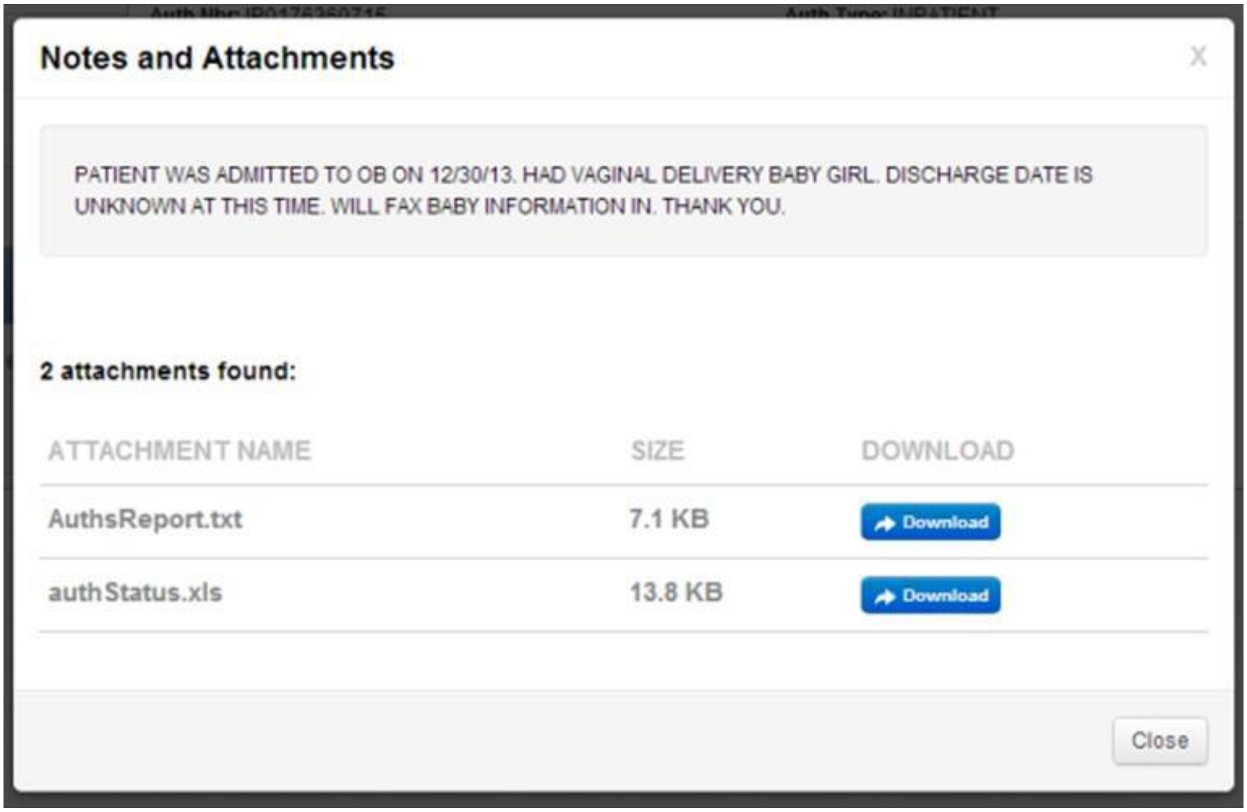
2. The prior authorization request will display the status, authorization number, member name, service date ranges, diagnosis, authorization type and service.



3. To view details of a prior authorization request, click the authorization number. Provider can view attached documents submitted with the request by clicking **view**.



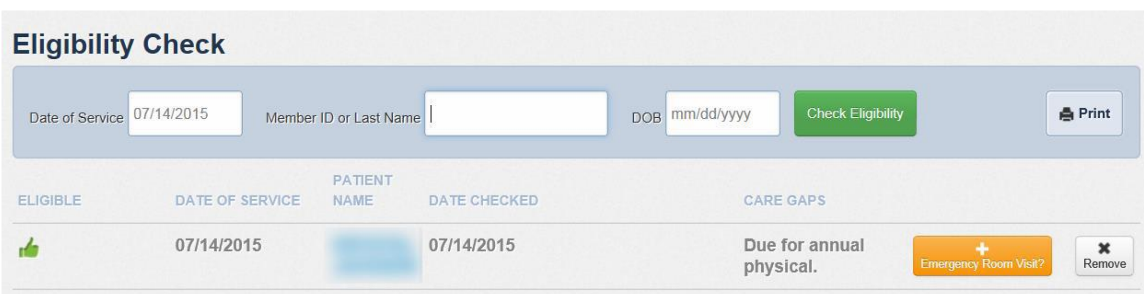
4. Notes and attachments will appear. Select download to view the document.



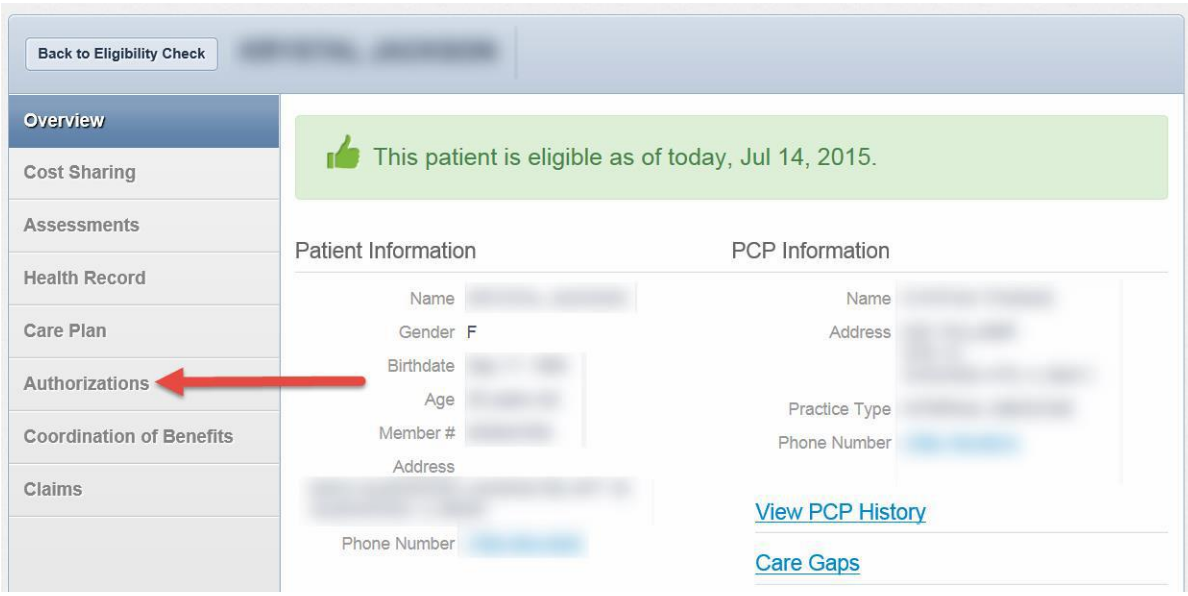
Create an Authorization:

To create an authorization for a patient

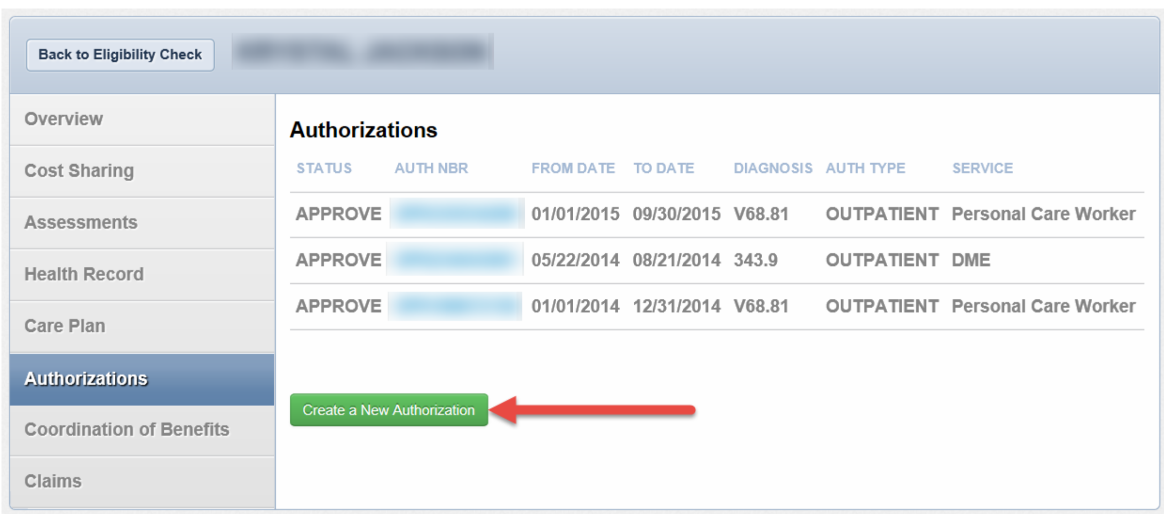
1. Enter the patient's last name or member ID and DOB. Check eligibility. Click on member's name to open the overview.



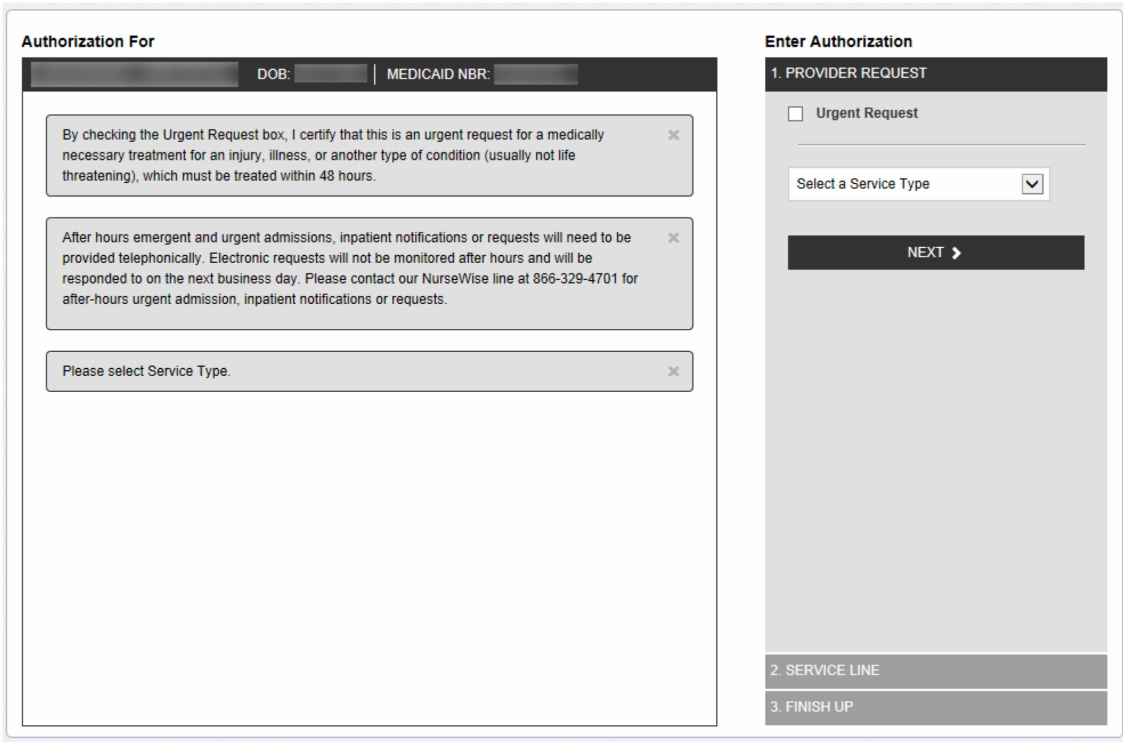
2. Select the authorization tab.



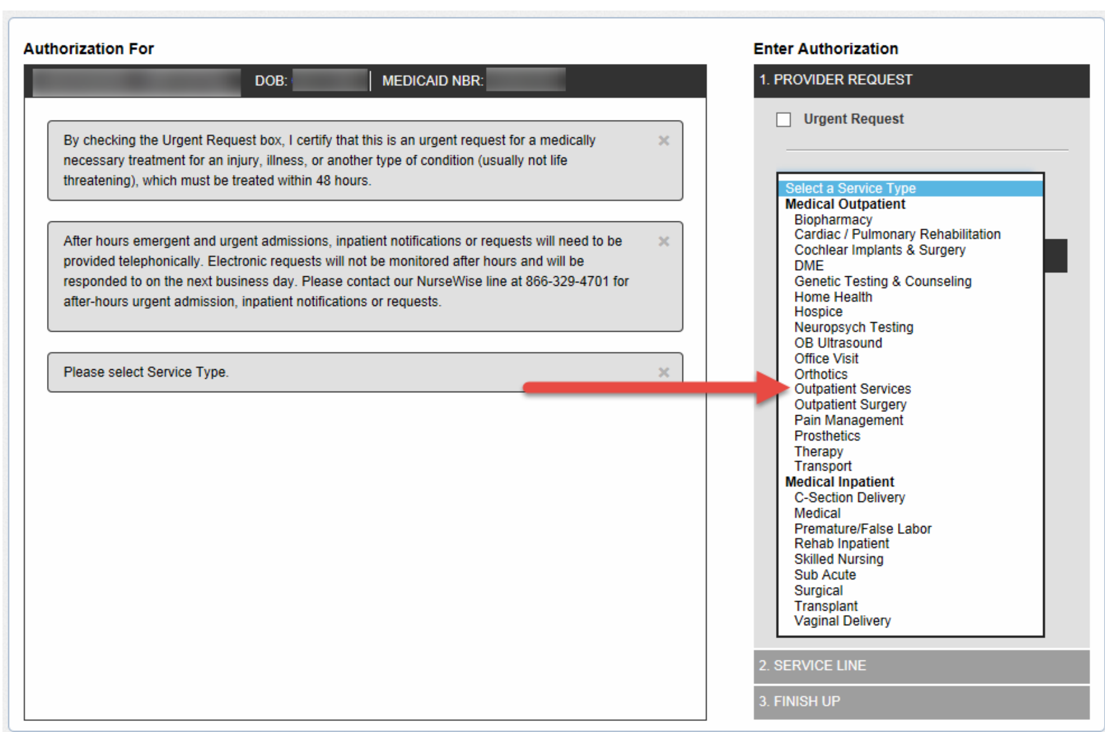
3. Authorizations displays requests previously submitted or create a new prior authorization request.



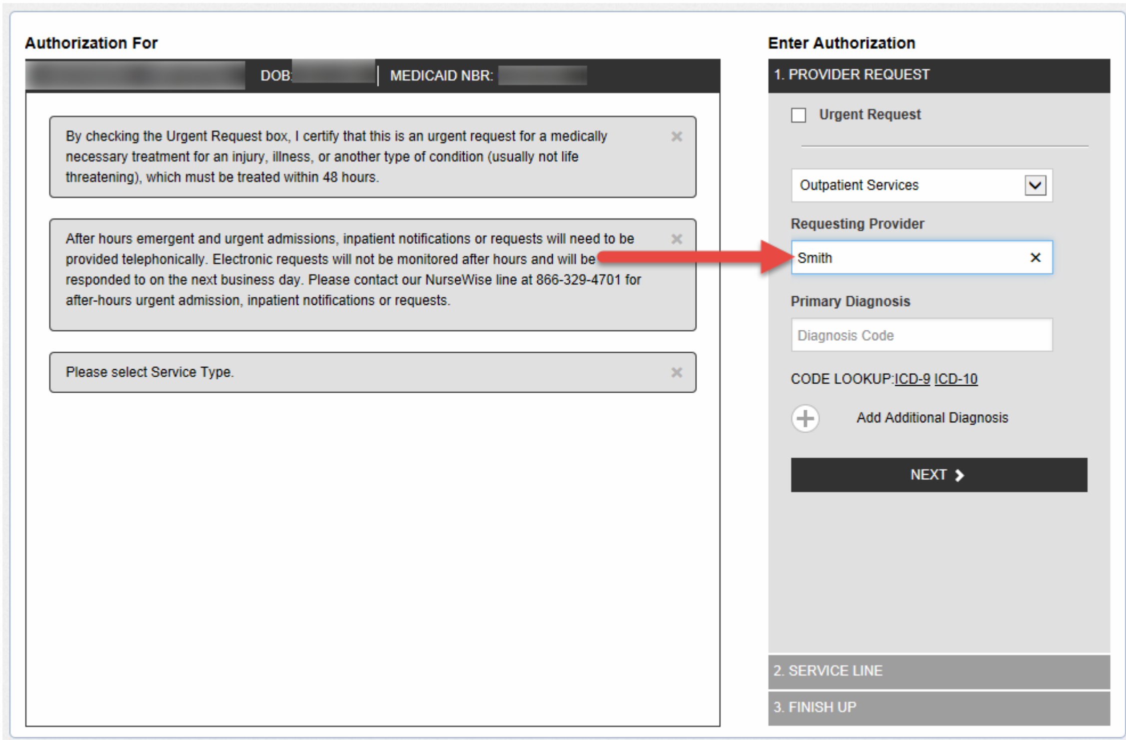
4. The authorization form opens and displays two sections. The left side will display definition of **Urgent Request, Disclaimer** and the completed fields for prior authorization as it is being created. The right side is where data is entered for **Provider Request, Service Line,** and **Finish Up**.



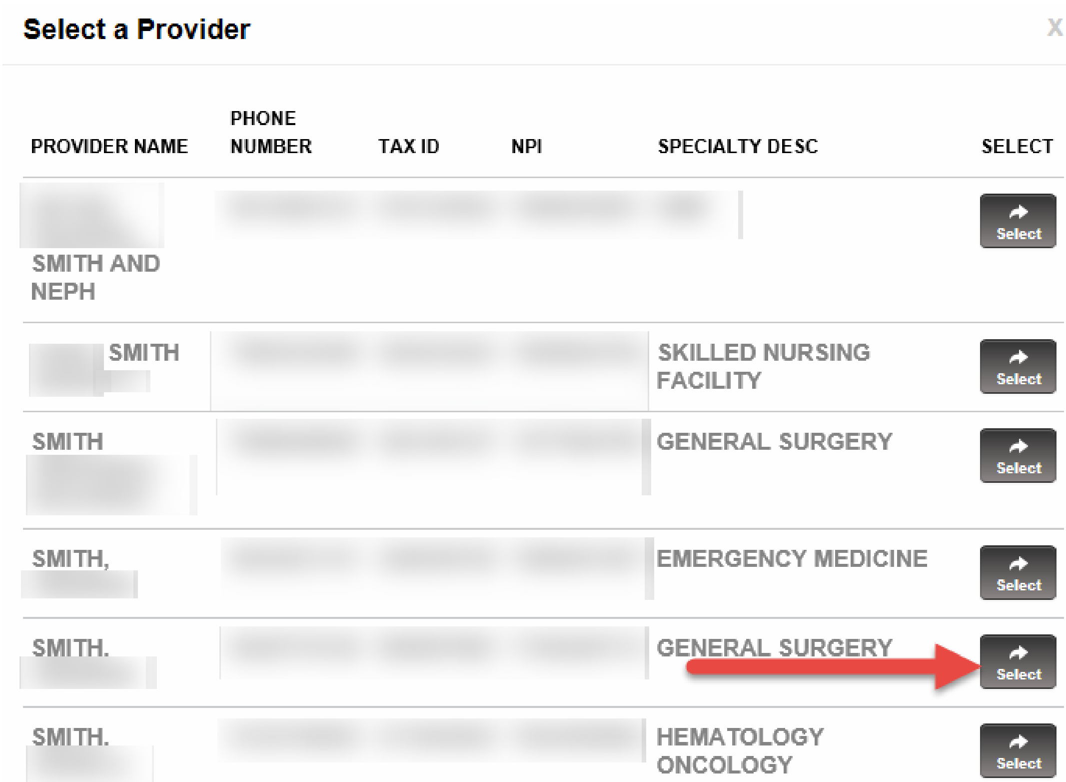
5. Select a **Service Type** from the drop-down list.



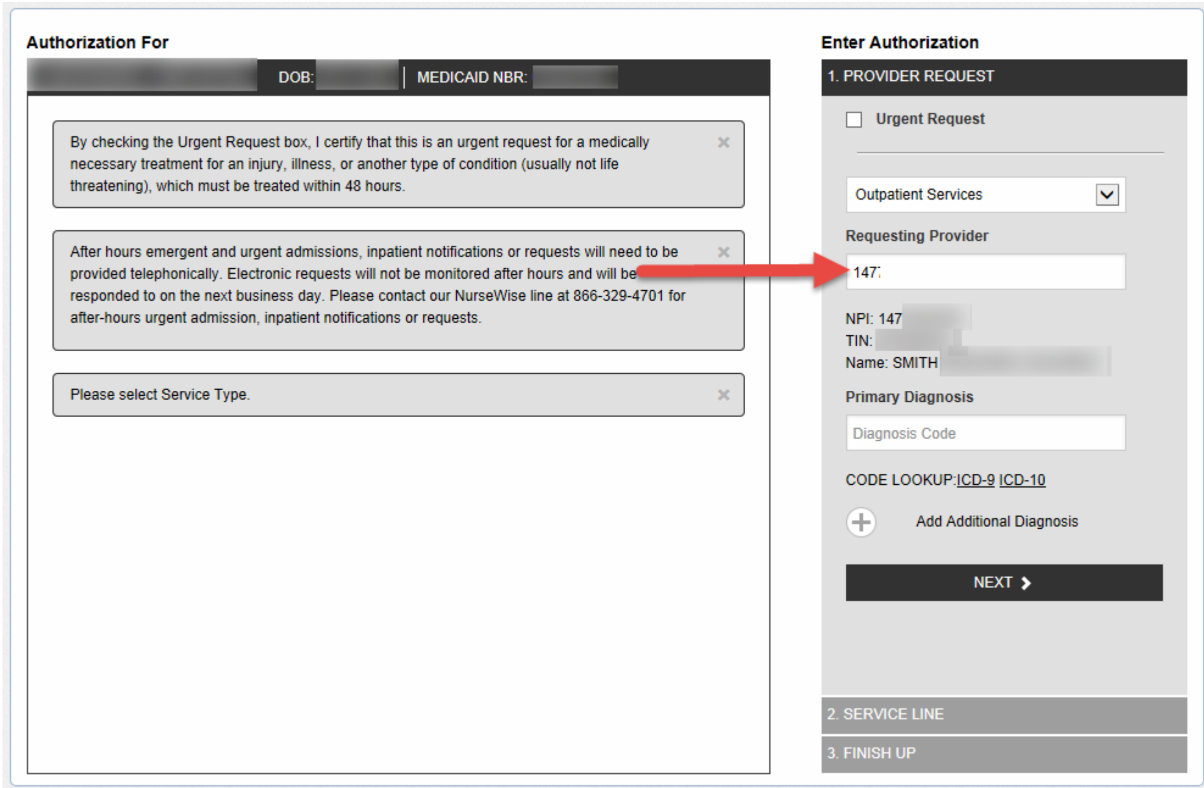
6. Once the service type is selected, the **Requesting Provider** information will display. The provider's last name or NPI number can be entered to search.



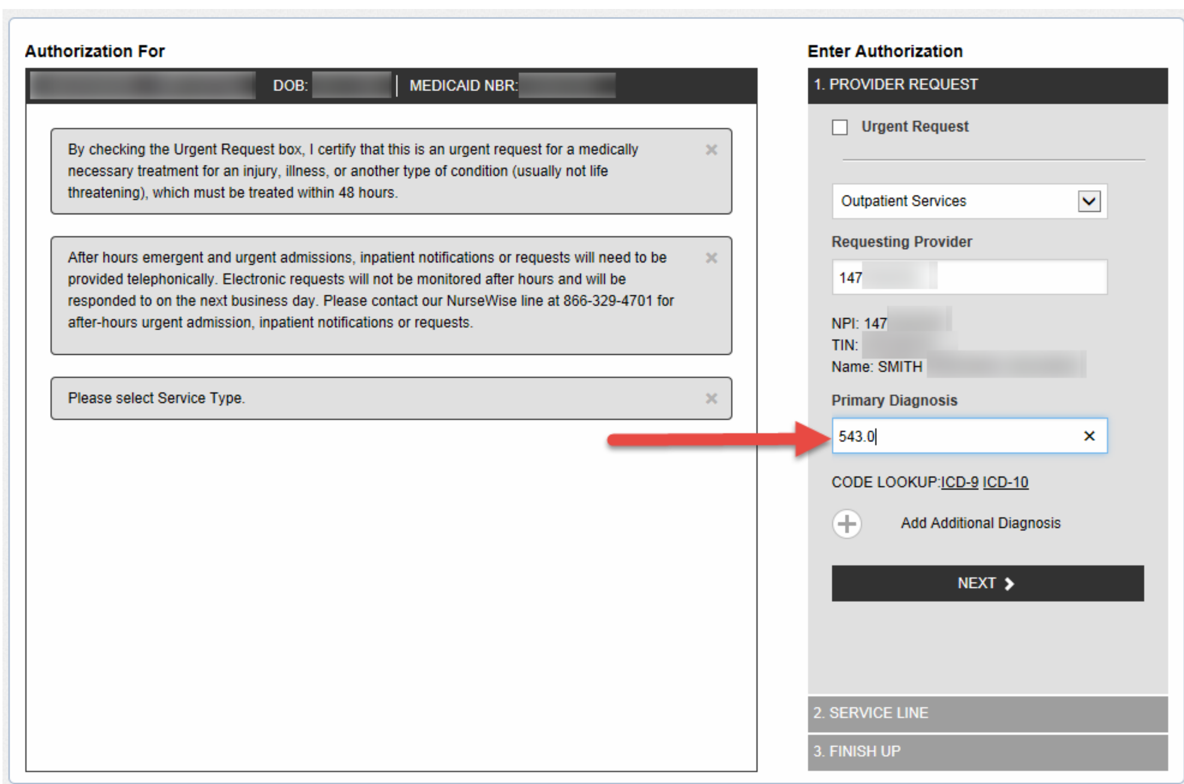
7. The list of providers and their specialty will display. Click select for the appropriate provider.



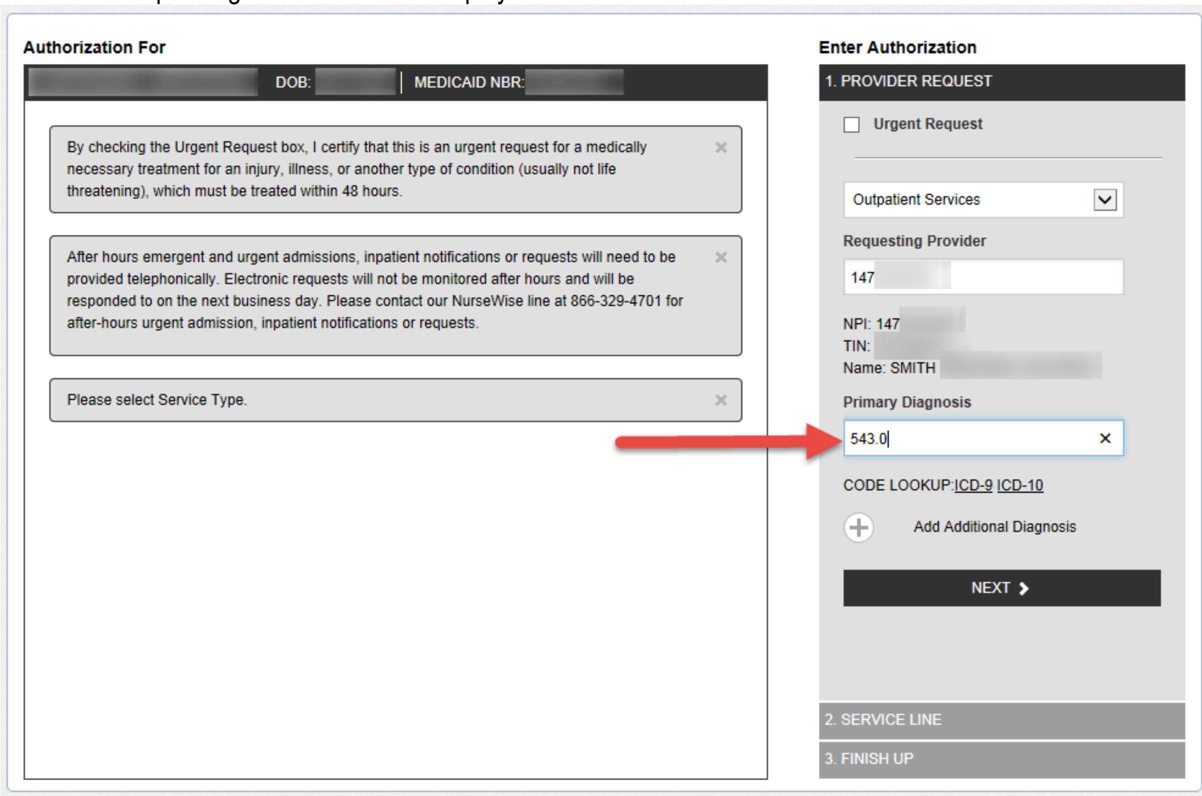
8. The requesting provider NPI will appear in the search field. Below will display the NPI, TIN and name.



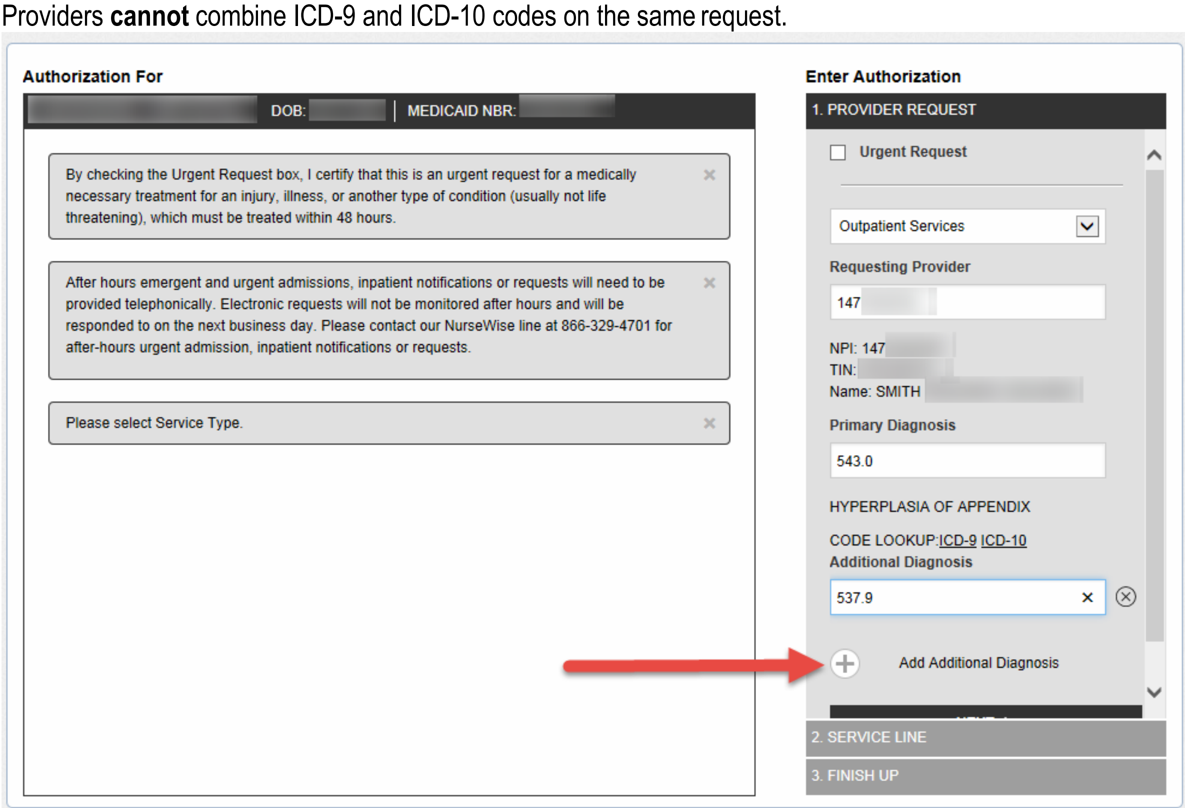
9. The **Primary Diagnosis** can be entered for known or hyperlinks to ICD-9 and ICD-10 are available.



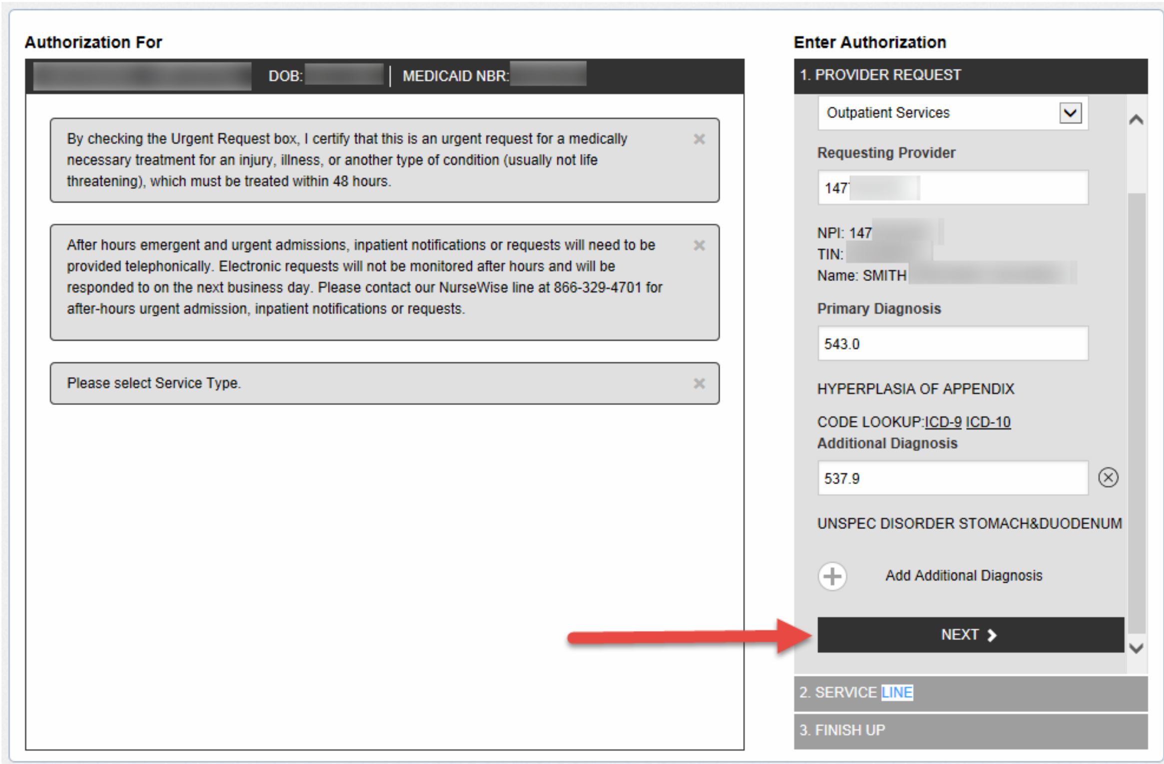
10. The corresponding clinical name will display under the CPT code entered.



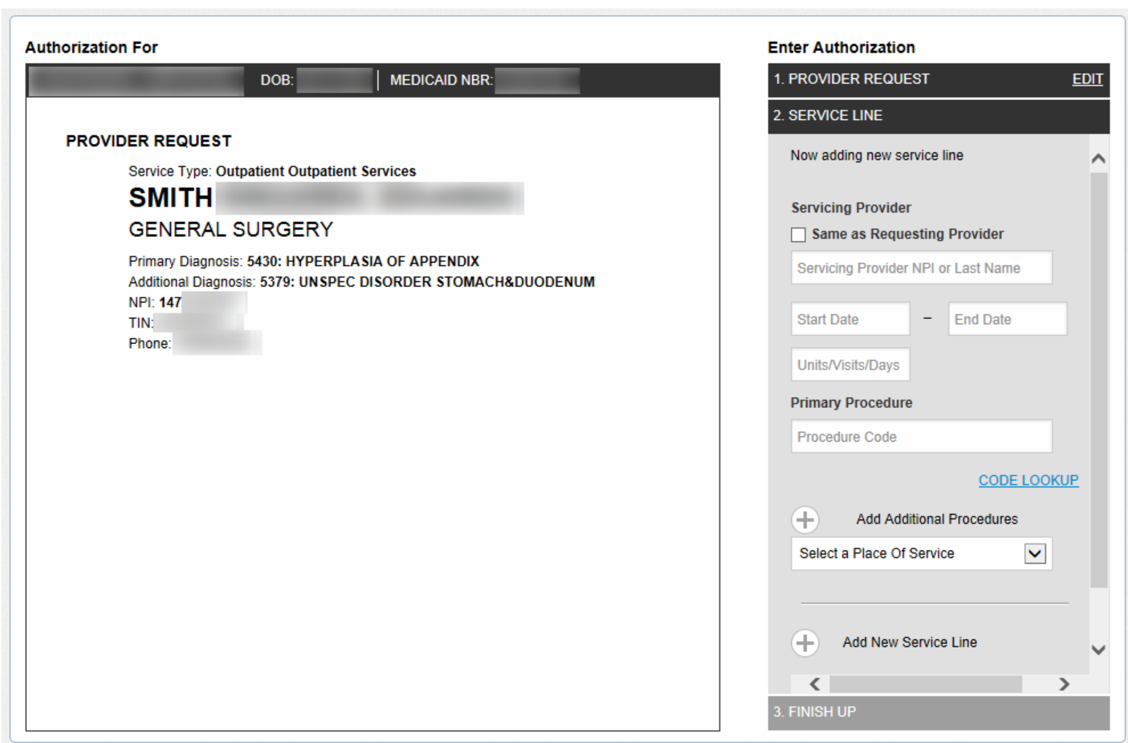
11. To add **Additional Diagnosis**, click on the + sign and the diagnosis field will appear. Enter the ICD code. Providers **cannot** combine ICD-9 and ICD-10 codes on the same request.



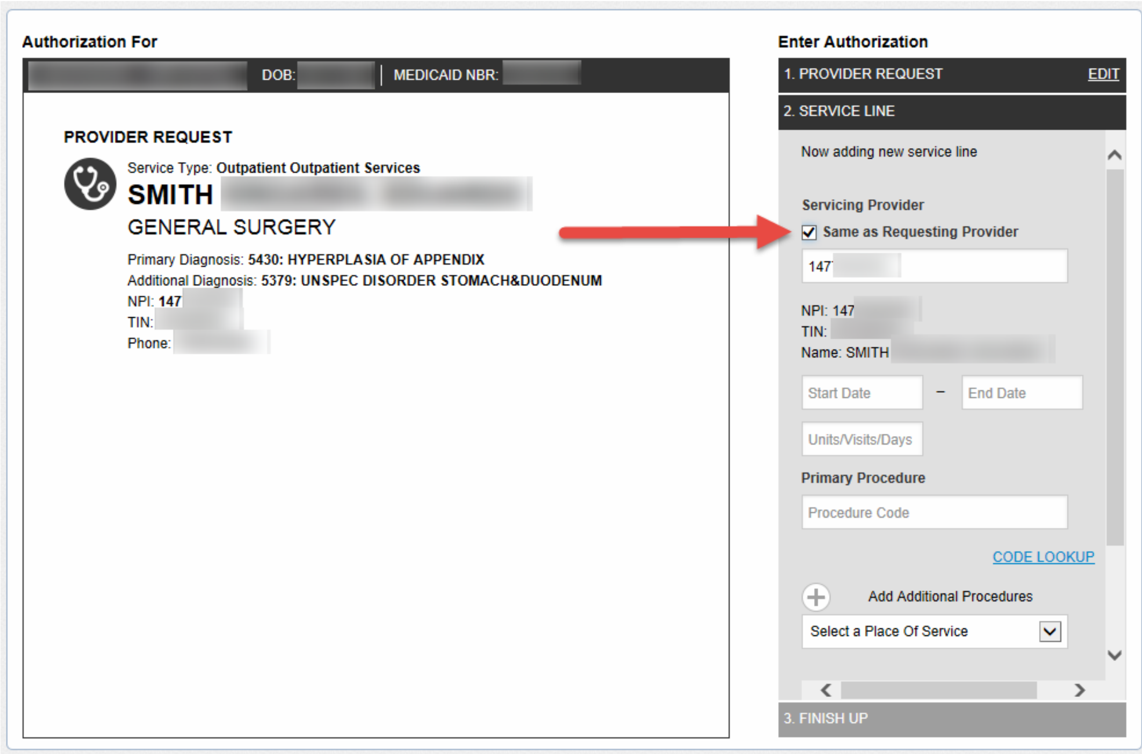
12. When all of the diagnosis codes have been entered, click on **Next**.



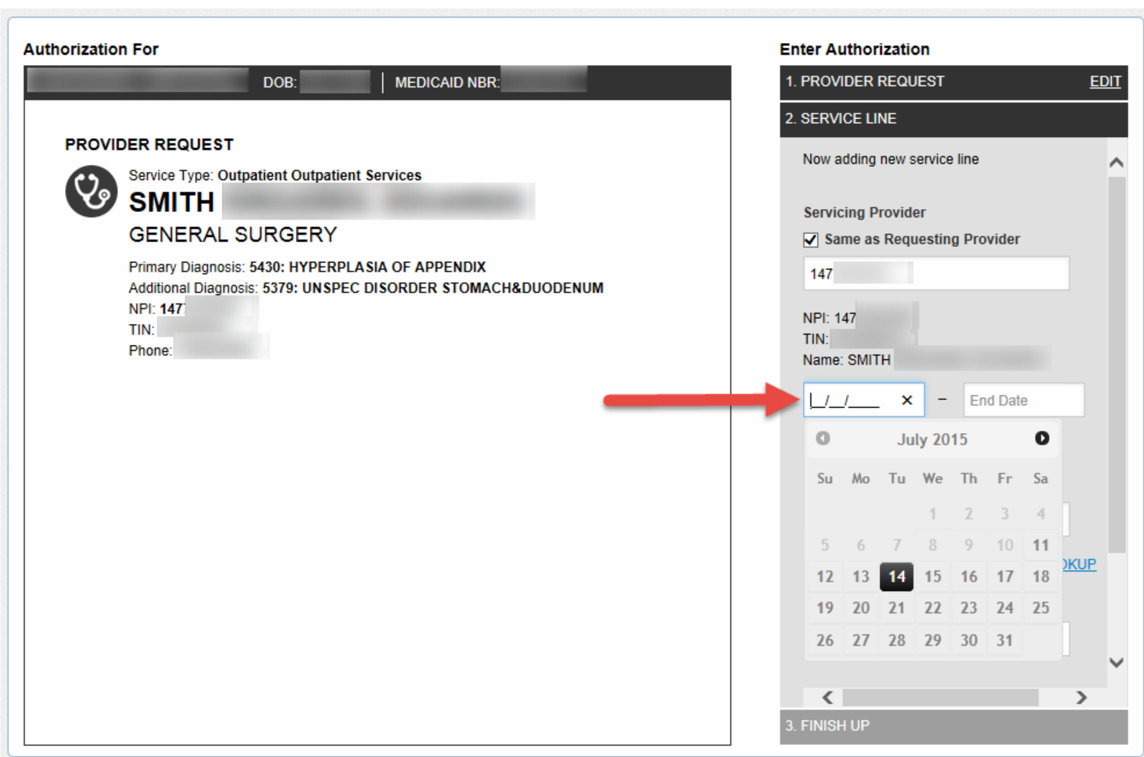
13. **Service Line** will open. The requesting provider information and the member's diagnosis display on the left side of the screen. Fields required for the service lines are on the right side on the form.



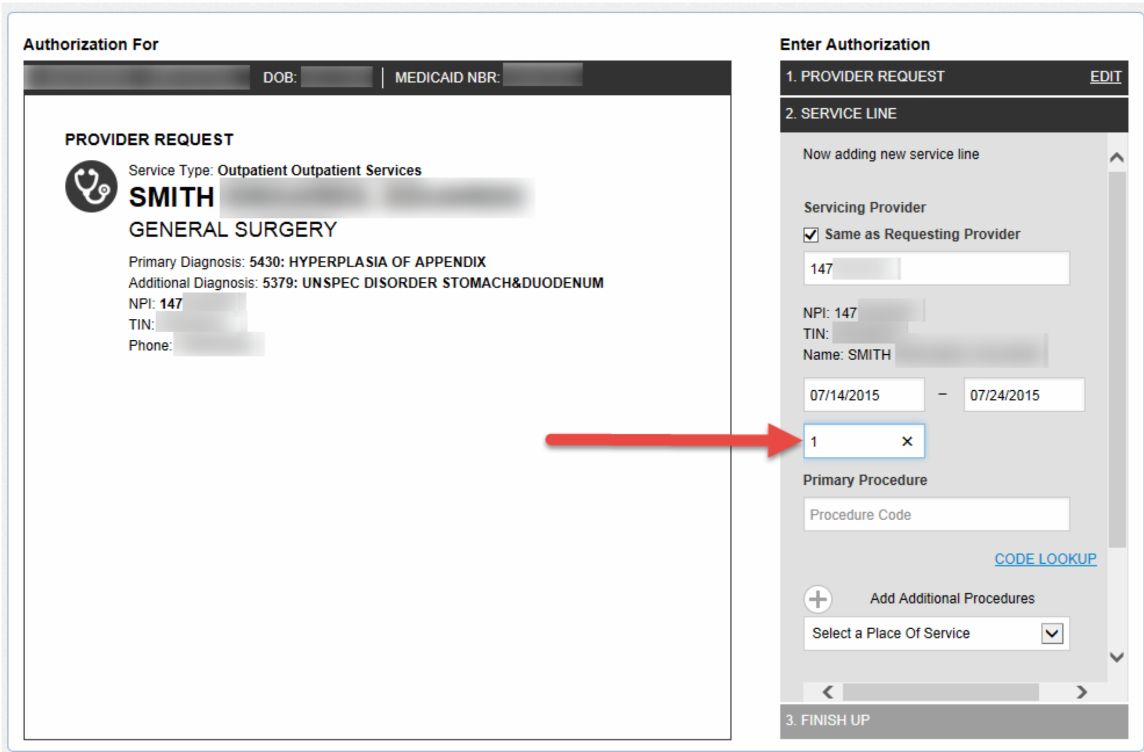
14. If the **Servicing Provider** is the same as the requesting provider, click the box. The provider information will auto-populate their name, NPI, and TIN. If the servicing provider is different, enter the provider's last name or NPI and search. When the names display, select the appropriate provider.



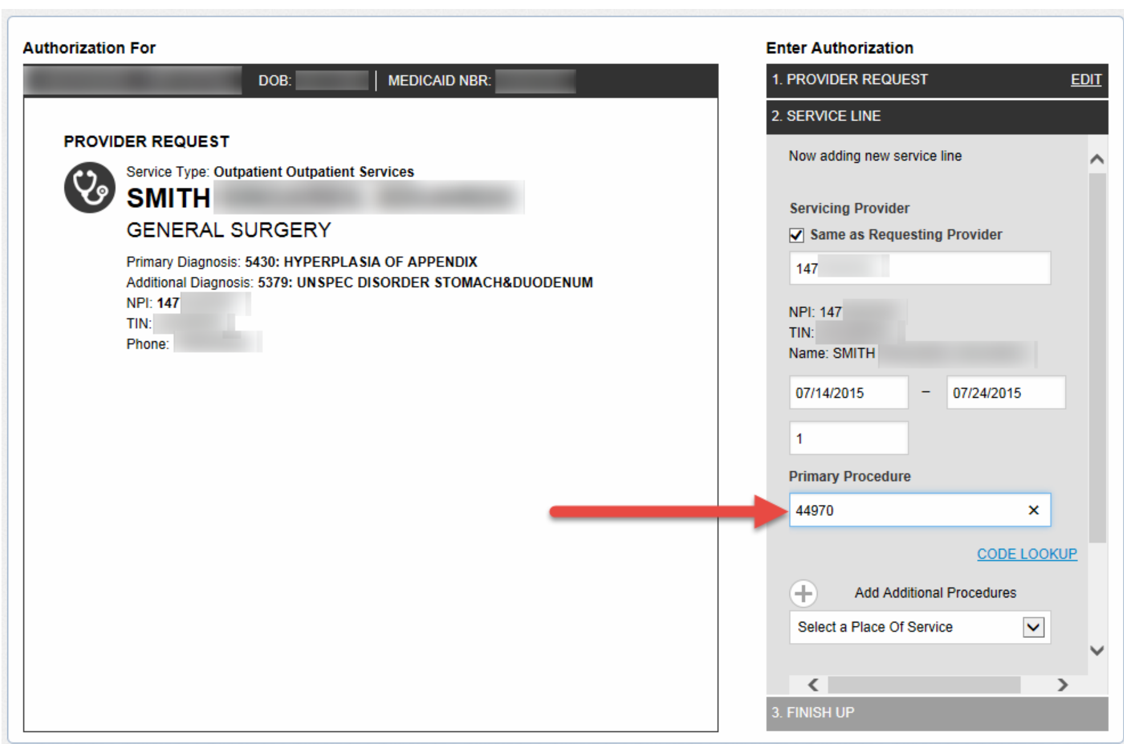
15. The **Start** and **End Date** fields have calendar widgets that appear when the user clicks inside the field.



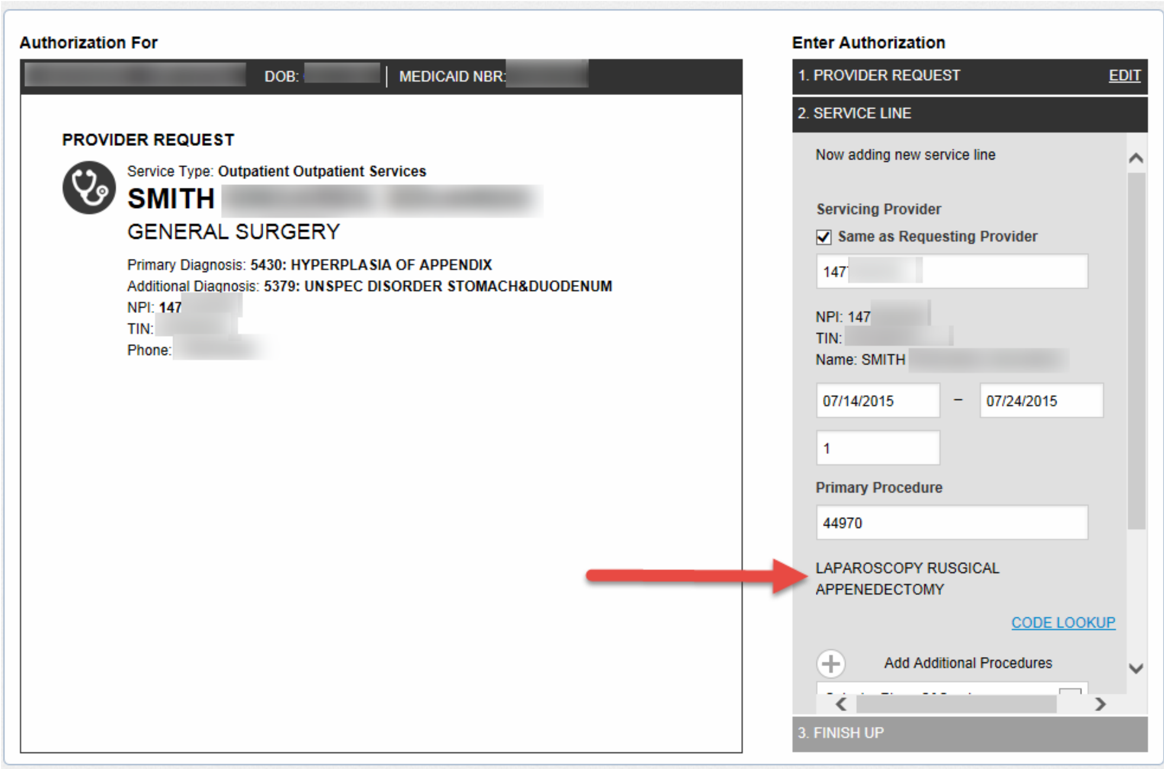
16. The requested number of days, visits, or units will be entered under the service dates.



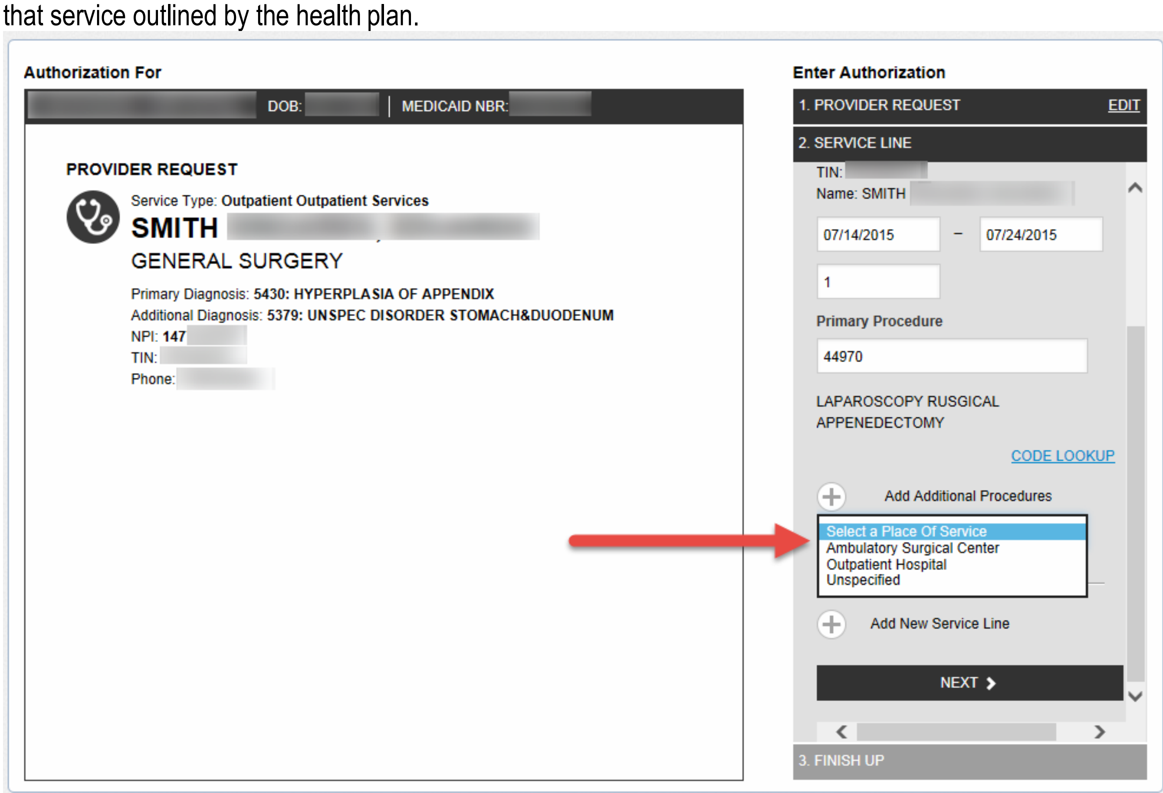
17. **Primary Procedure** codes can be entered into the field or can be searched for by the code lookup.



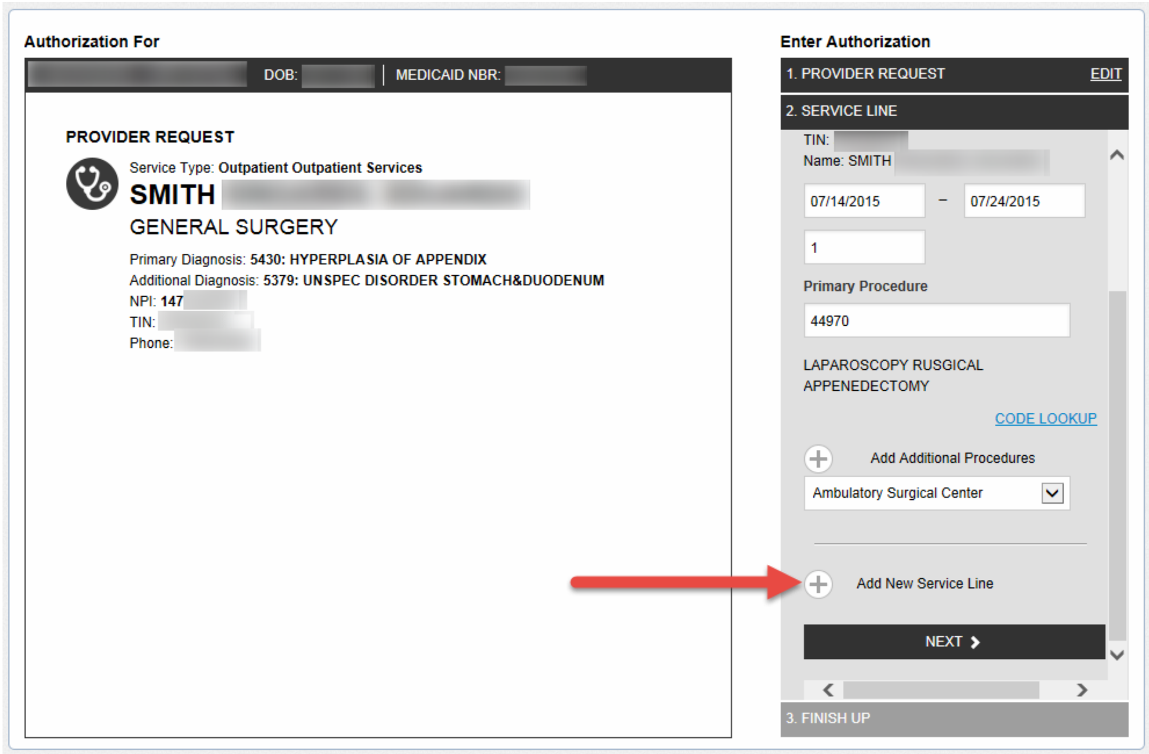
18. The corresponding procedure name will appear under the procedure code. Additional procedure codes can be entered by clicking on the + sign.



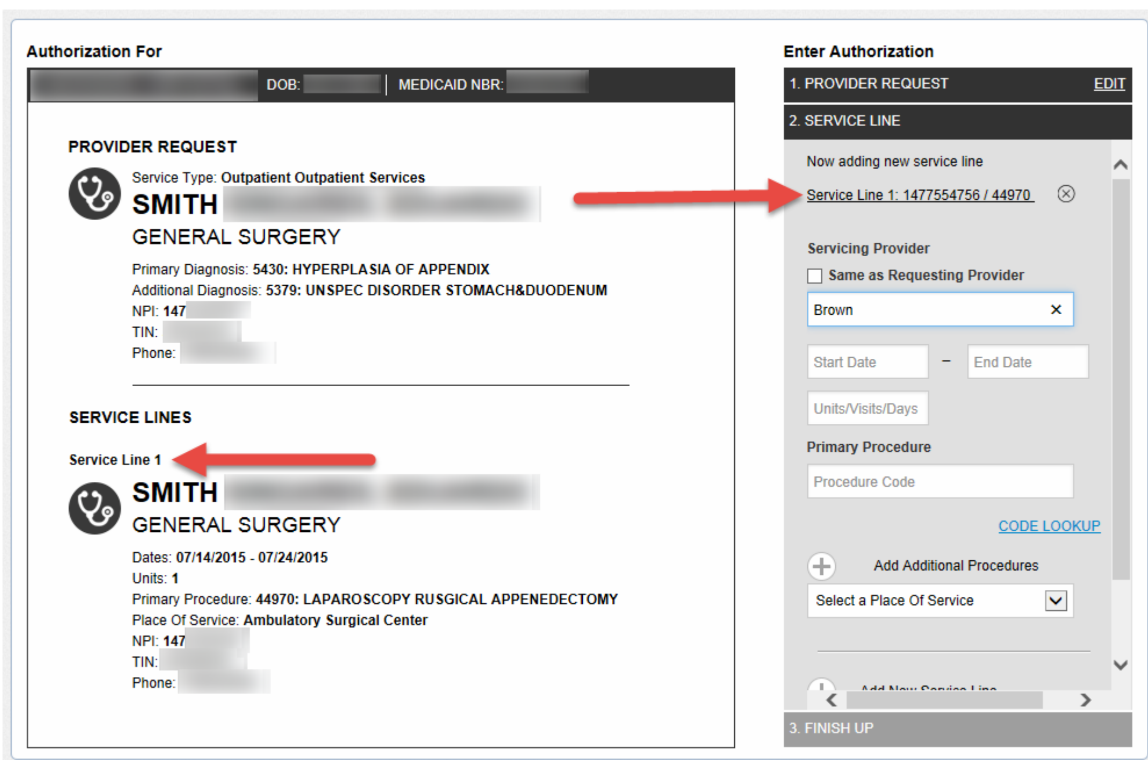
19. Scroll down to **Select a Place of Service** from a drop down menu. The menu will display locations available for that service outlined by the health plan.



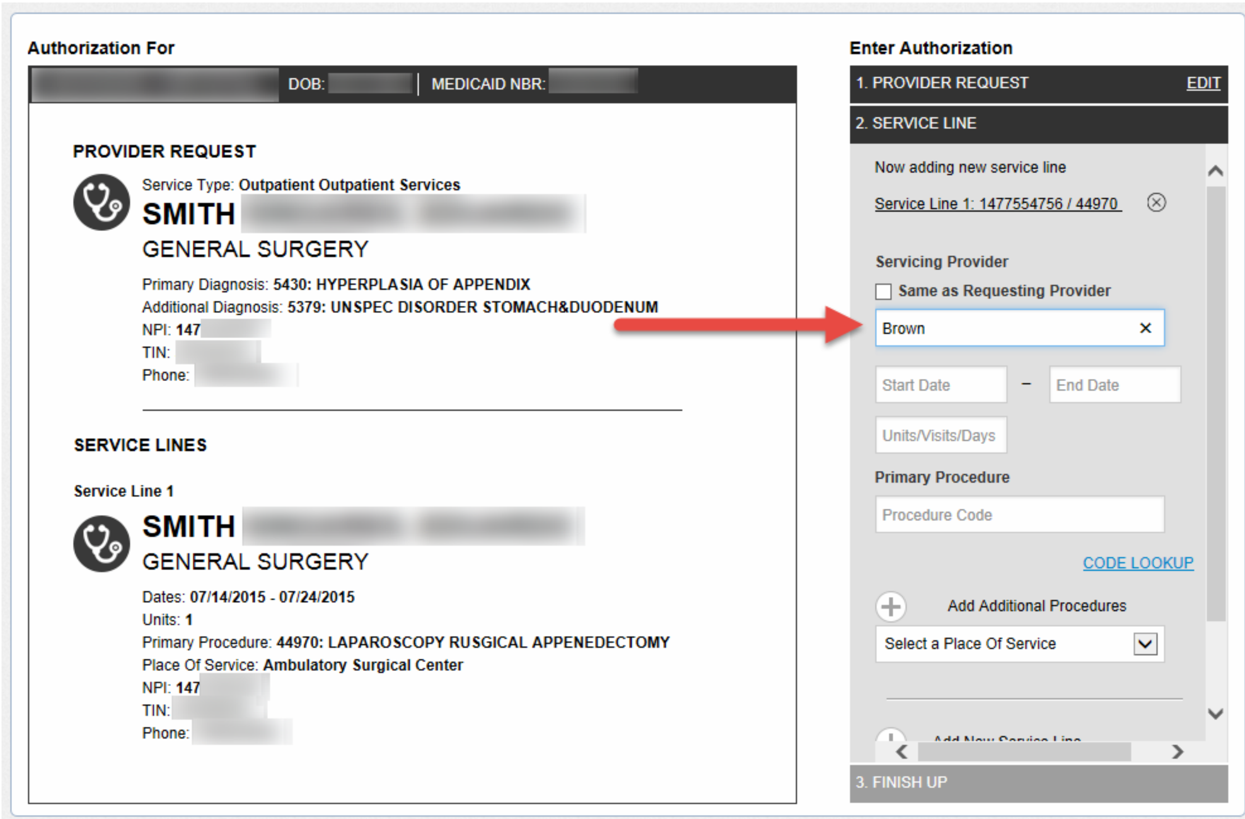
20. Under the place of service, the provider can **Add Service Lines** for more services by clicking the addition sign.



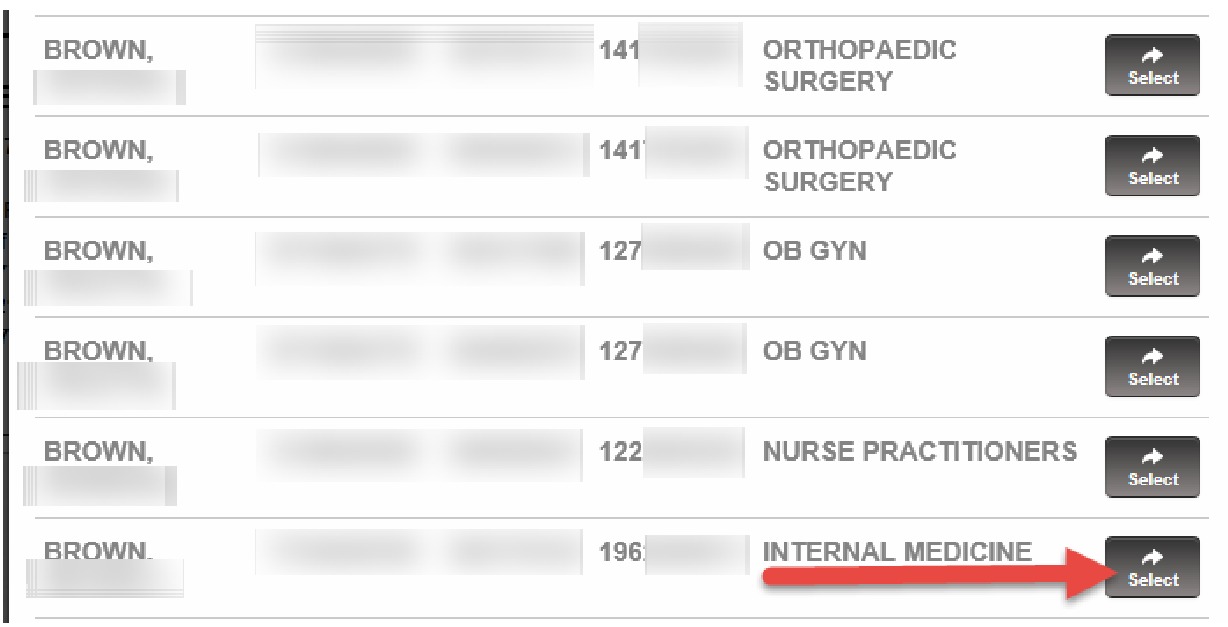
21. The first service line completed can be viewed in detail on the left side. If the first service line needed to be edited, click on underlined service line. If the service line needs to be removed, click the X.



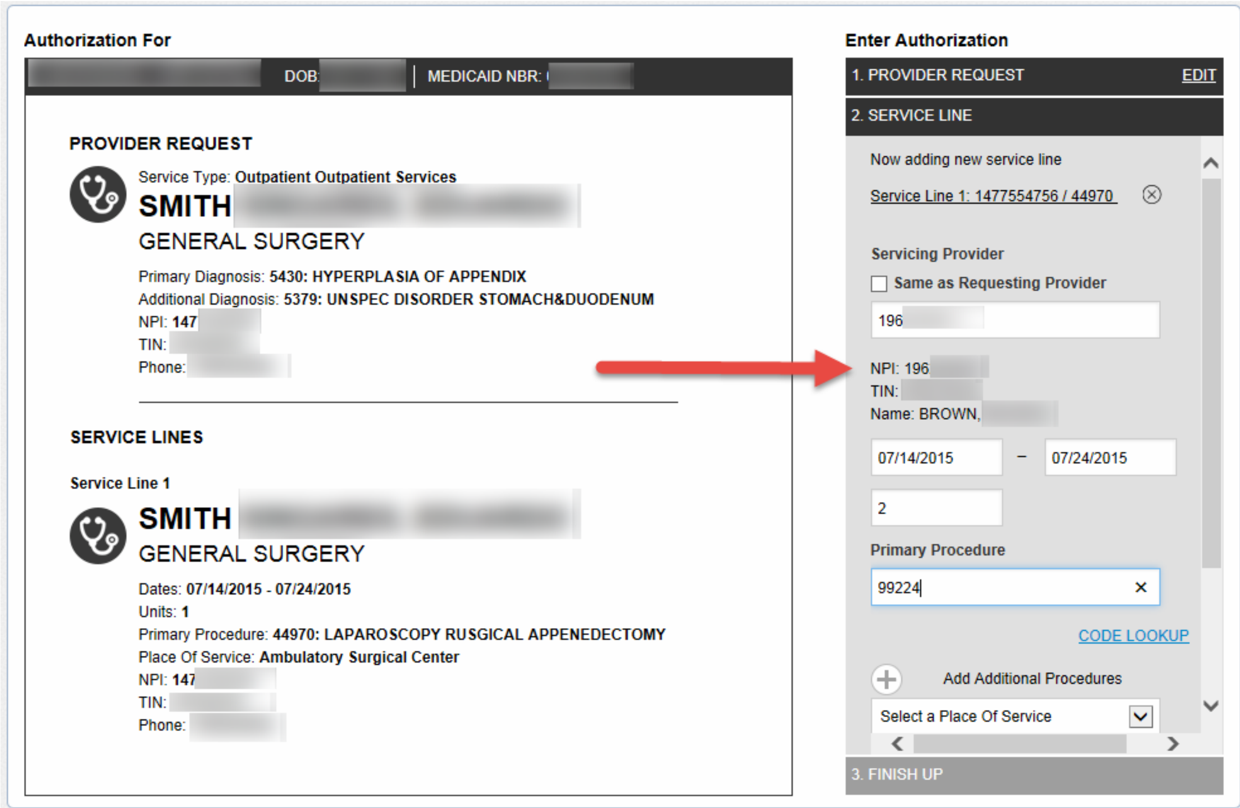
22. To start a second service line, the requesting provider will need to add the Requesting Provider. If the servicing provider is different than the requesting, search can be completed by entering the name of NPI number.



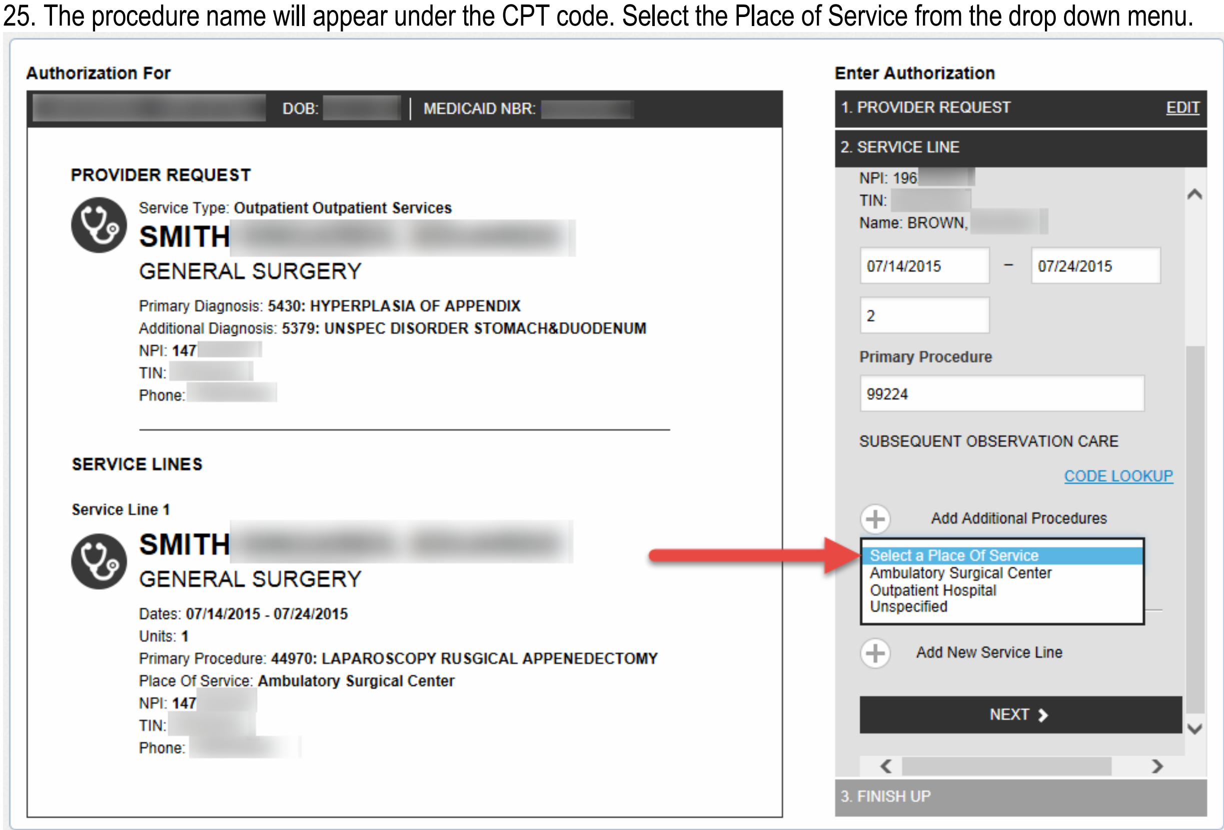
23. Select the appropriate provider:



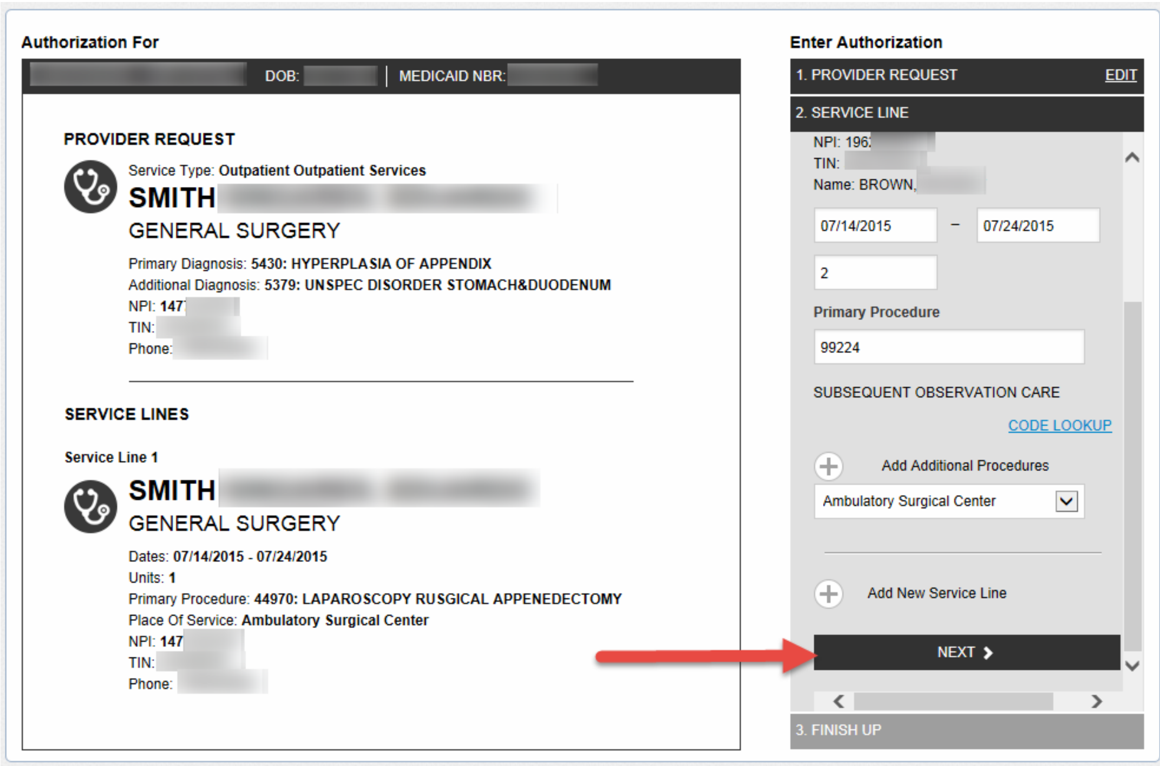
24. The provider's Name, NPI and Tin will display. Complete the start and end dates of services, the requested number of days, visits or units and the procedure code.



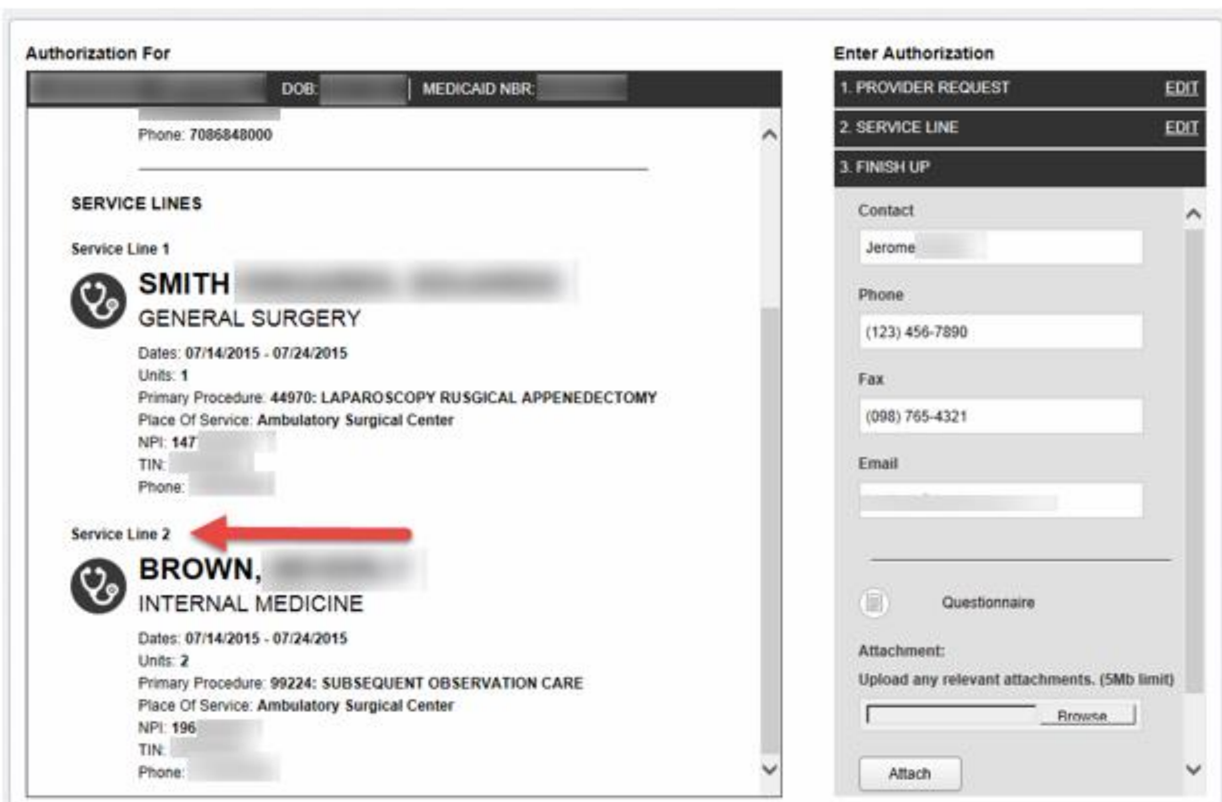
25. The procedure name will appear under the CPT code. Select the Place of Service from the drop down menu.



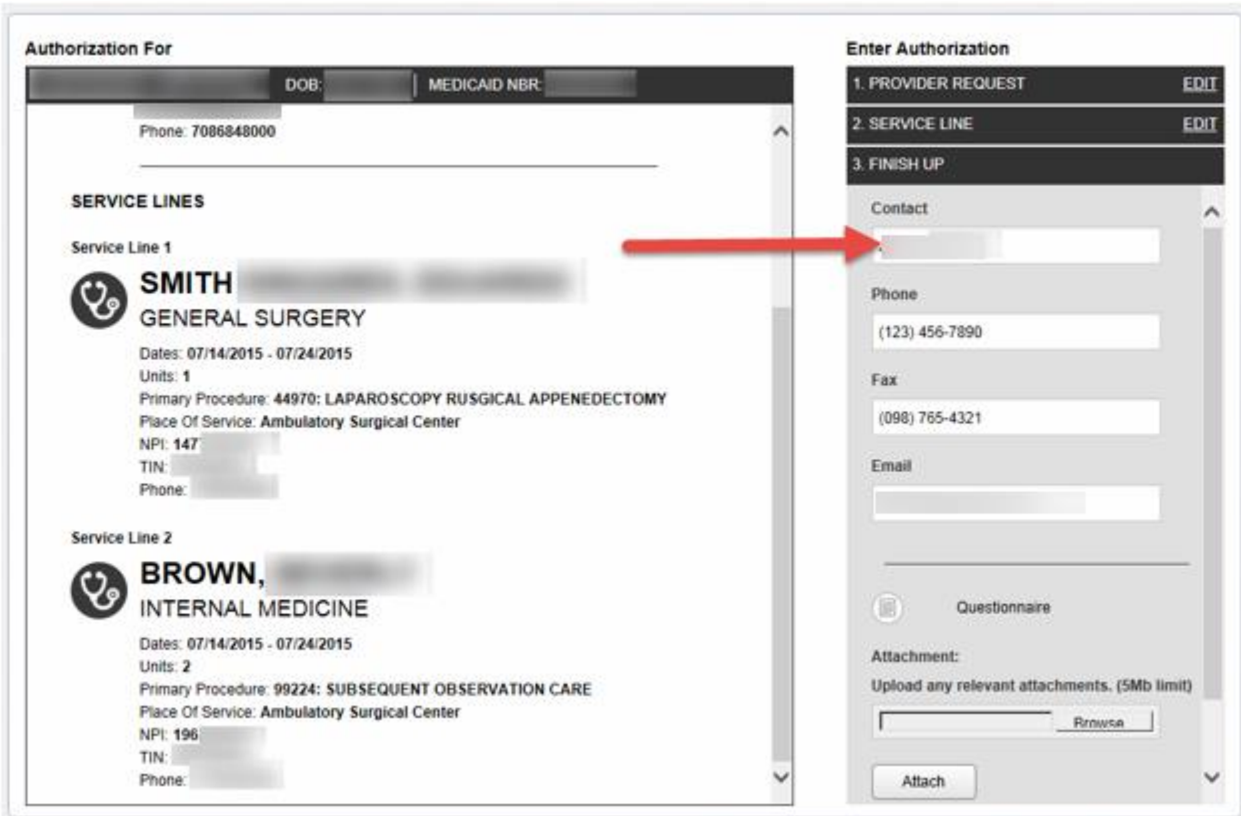
26. Click **Next**.



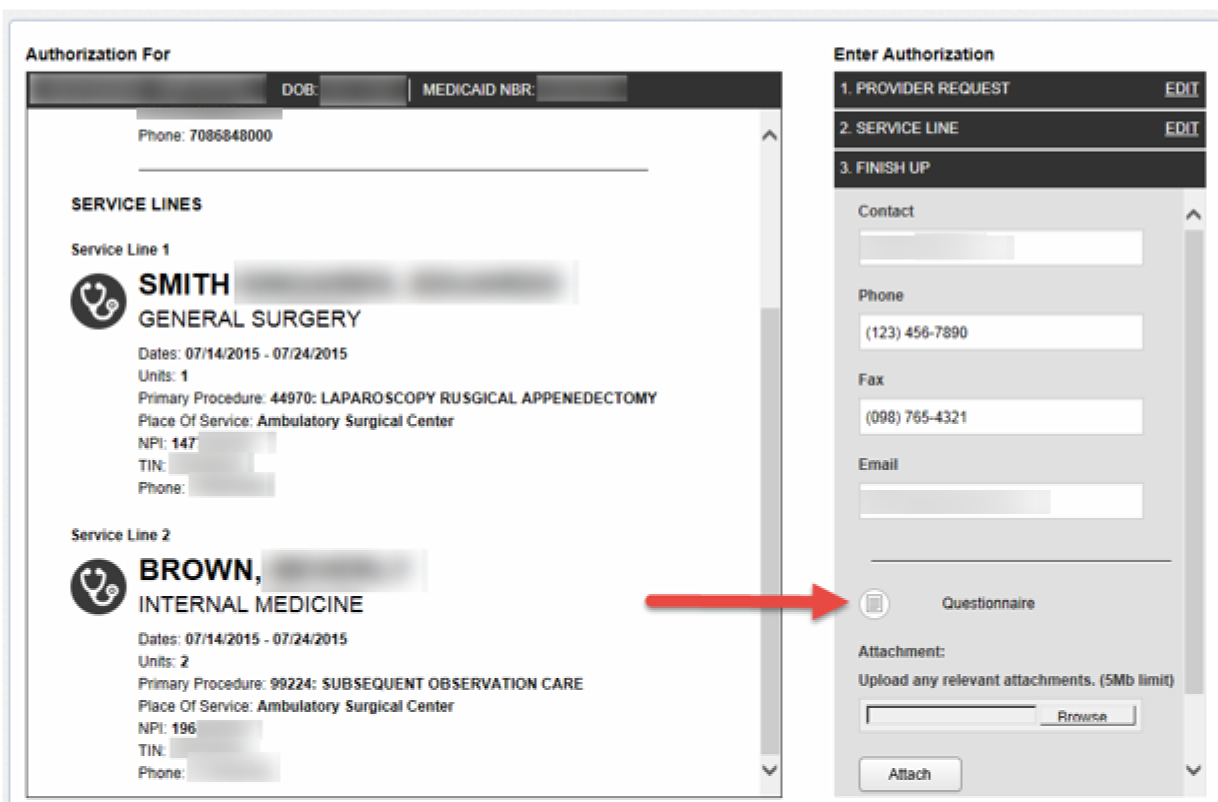
27. Once **Next** is clicked, scroll down on the left side. The second service line displays the provider information, service dates, days/visits/units, procedure code and place of service.



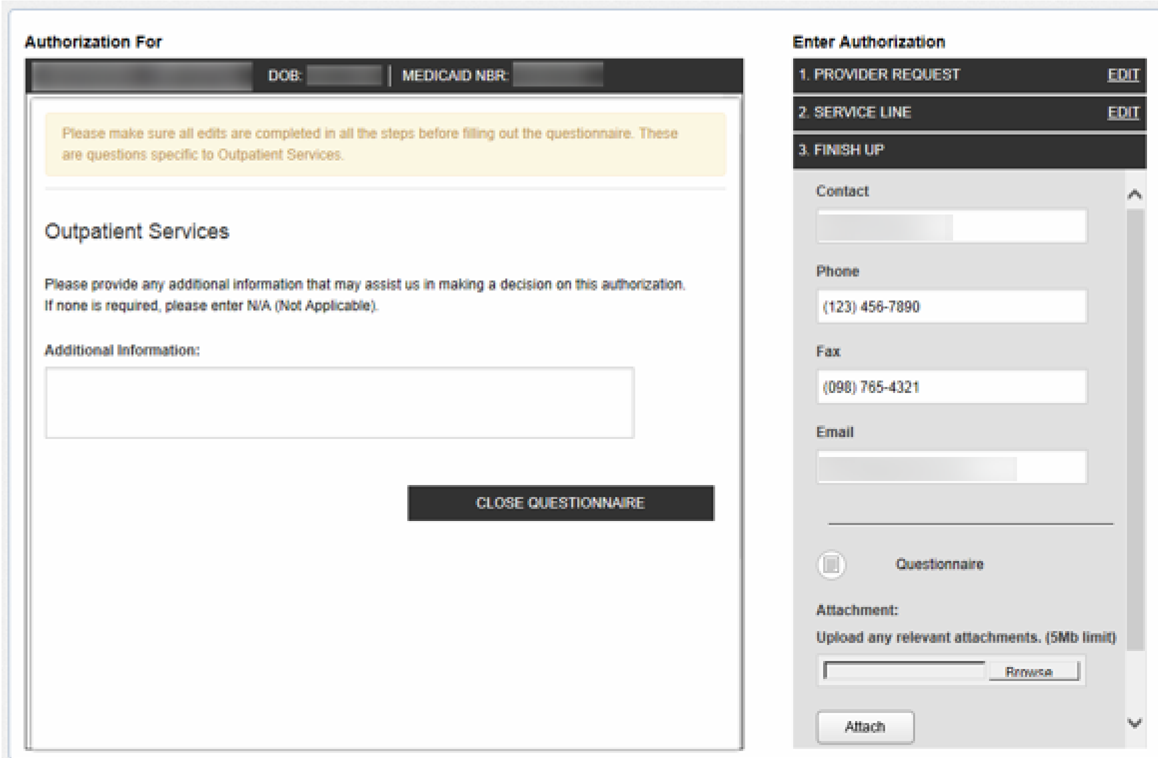
28. **Finish Up** auto-populates the user's name, phone, fax, and email address.



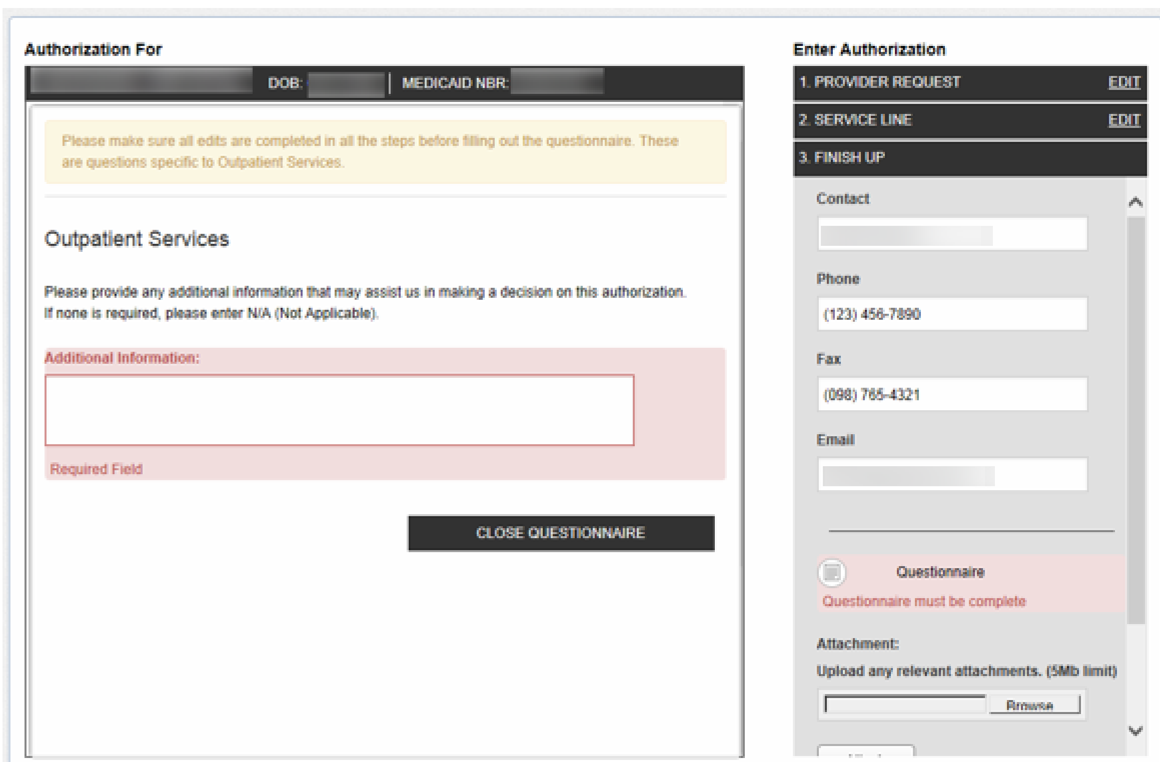
29. The Questionnaire is opened by clicking in the icon.



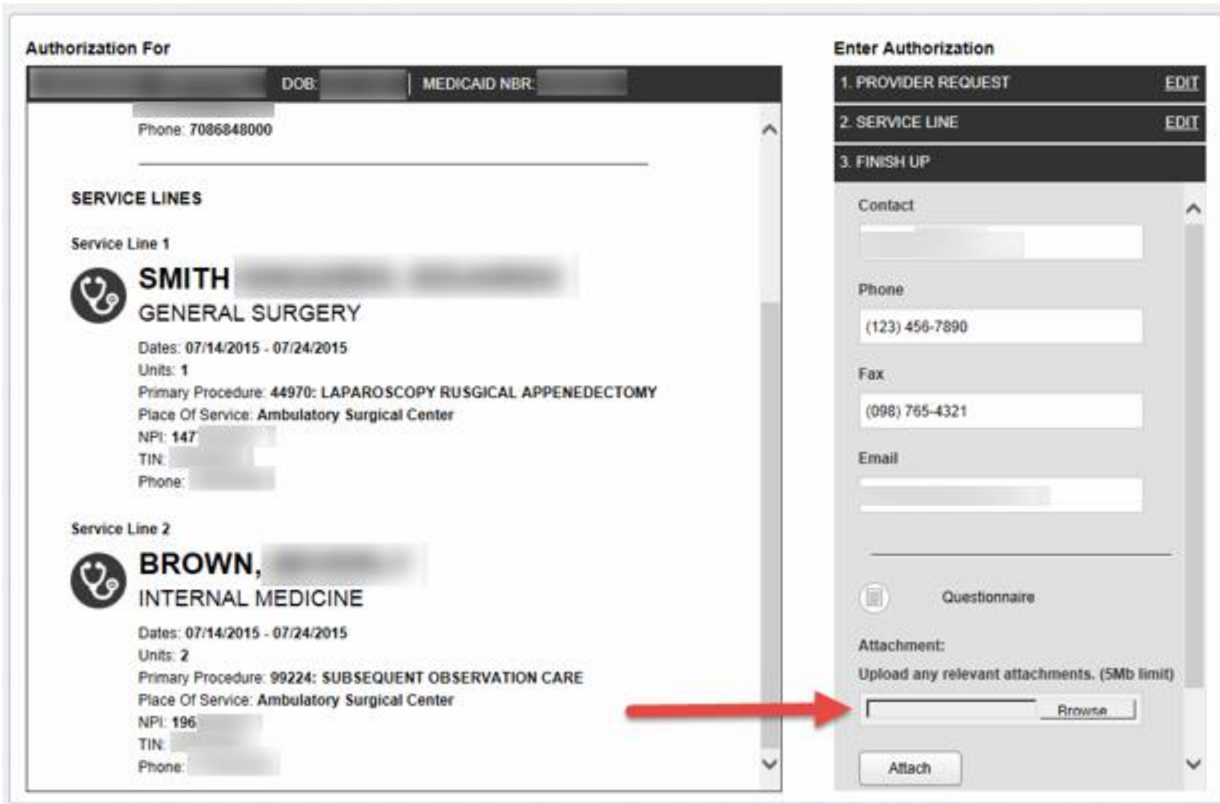
30. The questionnaire that displays will vary based on the service type selected. If additional information is not applicable, N/A must be entered.



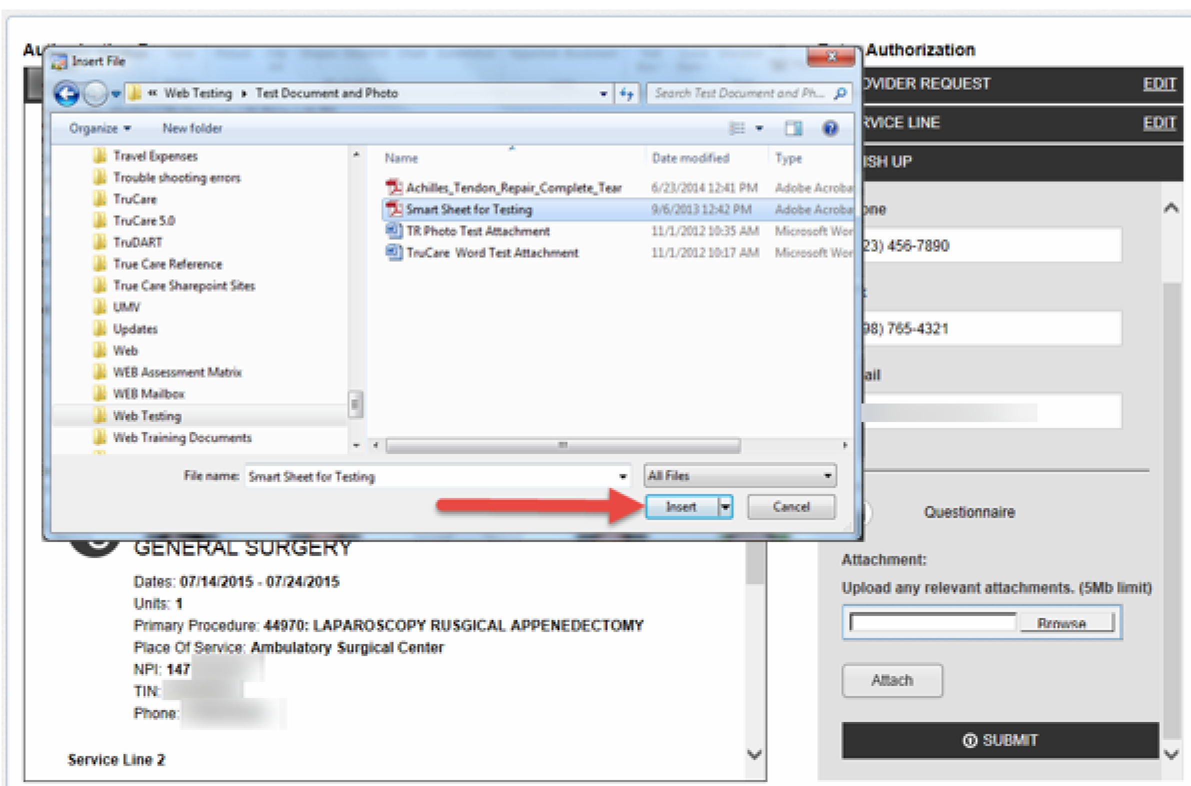
31. The questionnaire is a mandatory field. If it is not completed, an alert will appear.



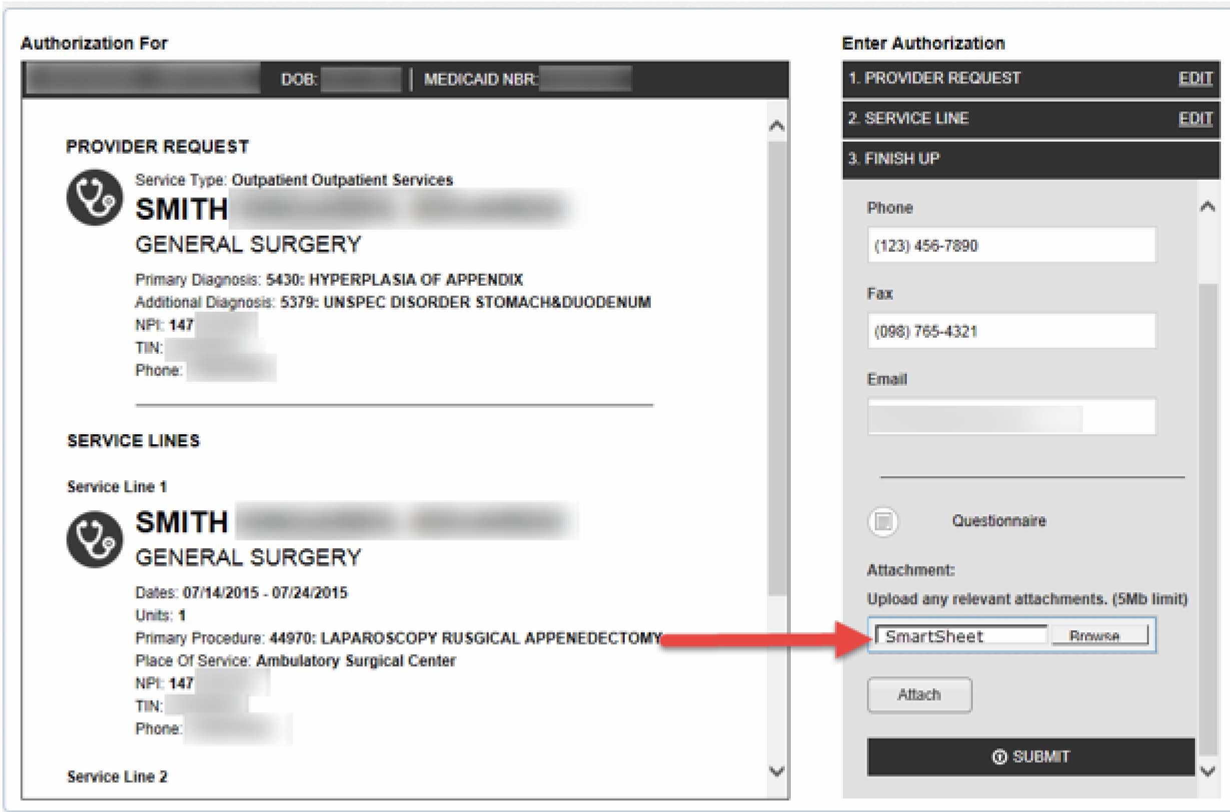
32. Up to five **Attachments** can be added to the prior authorization request. Click on **Browse**.



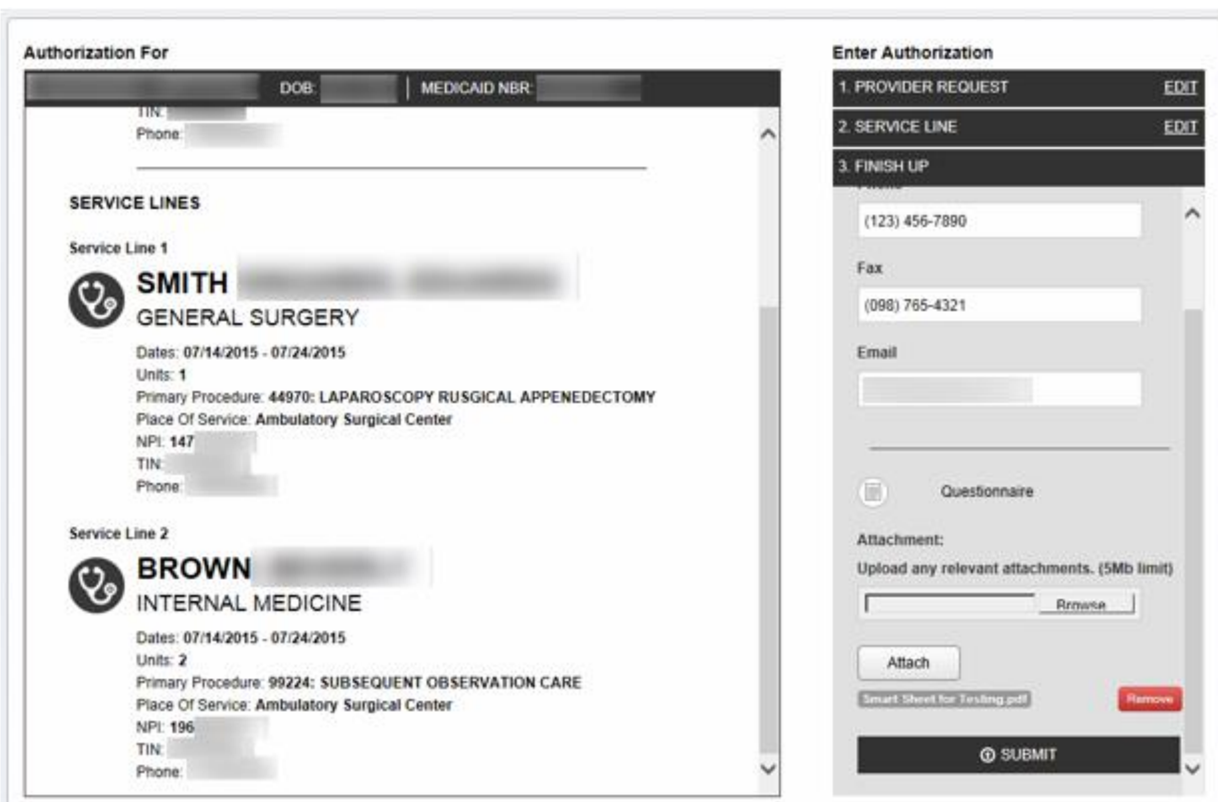
33. Highlight the appropriate document, image, smart sheet… Click **Insert.**



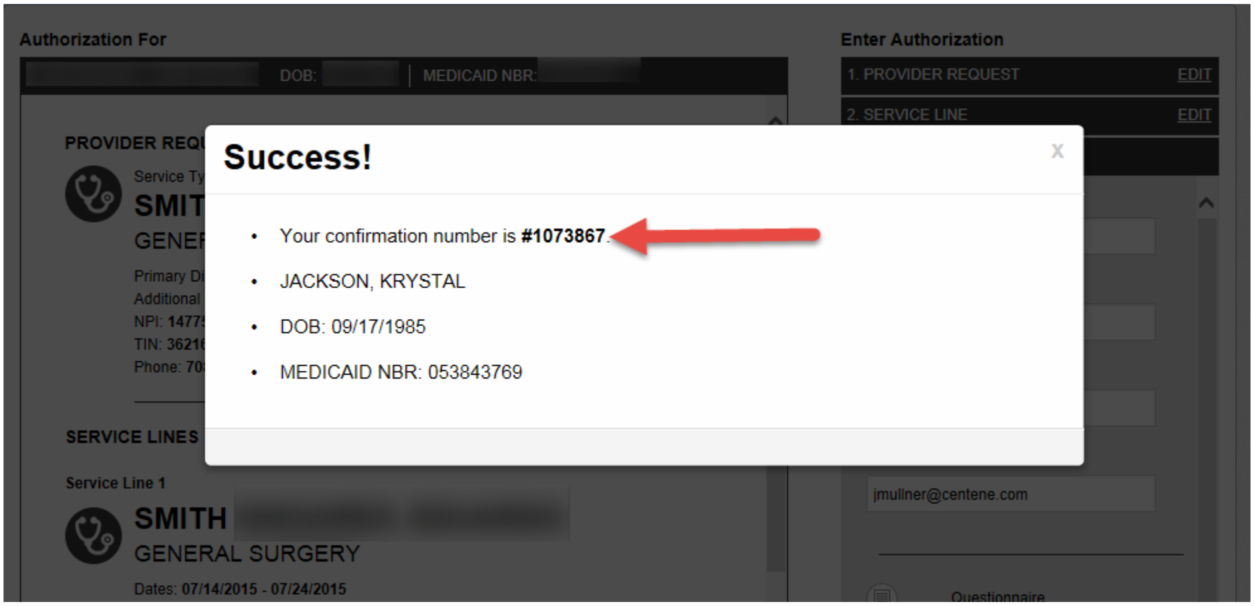
34. The document name will appear in the browse field



35. Verify that is the correct document. Click **Attach** and the document will appear below the button.



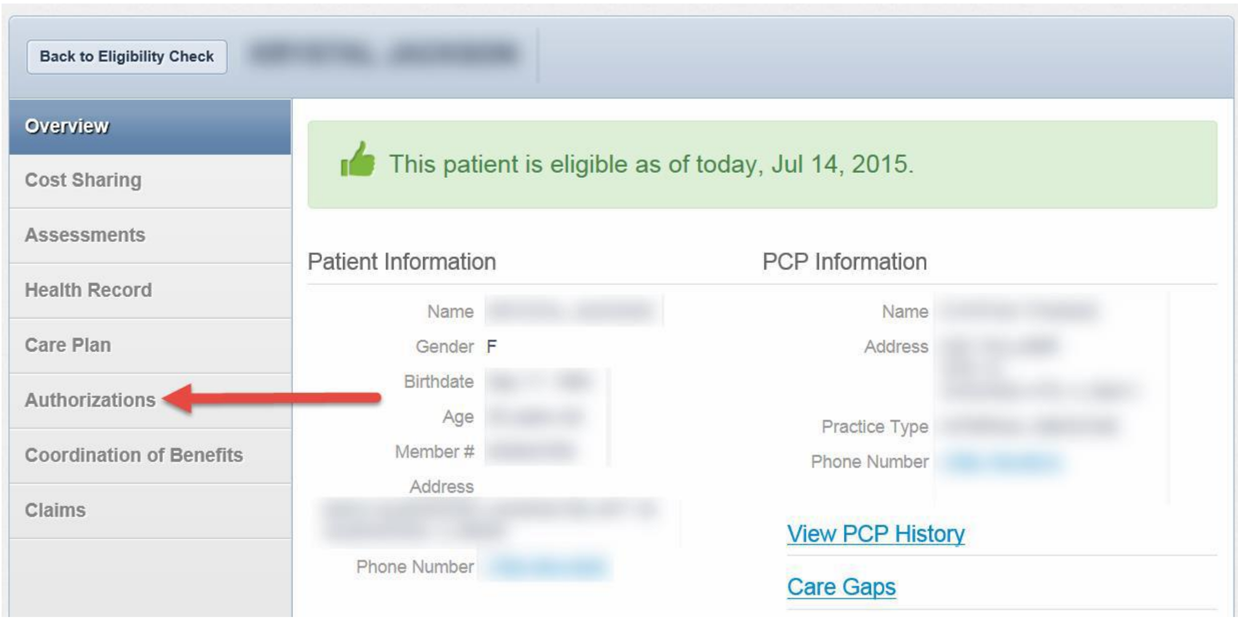
36. Click **Submit**. The request is assigned a confirmation number. This number should be recorded and used to determine the status of a missing authorization.



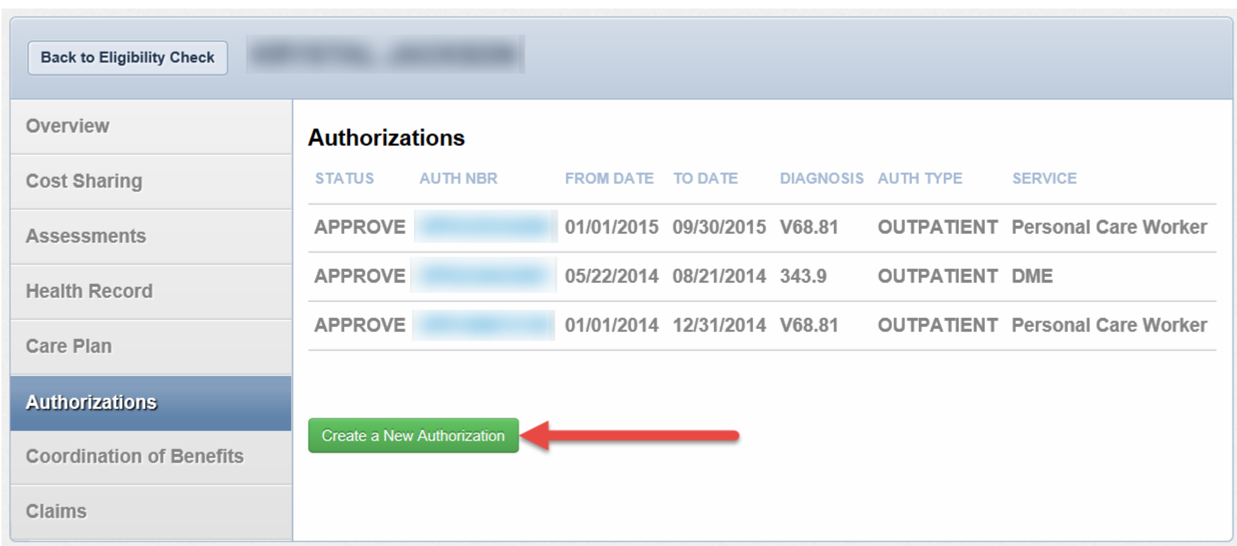
Smart Sheets

Smart sheets are evidence-based clinical guidelines that help providers determine if the desired treatment or procedure meets the criteria for approval. Completion provides the documentation required for clinical review and improves the turnaround time for determination of the prior authorization request.

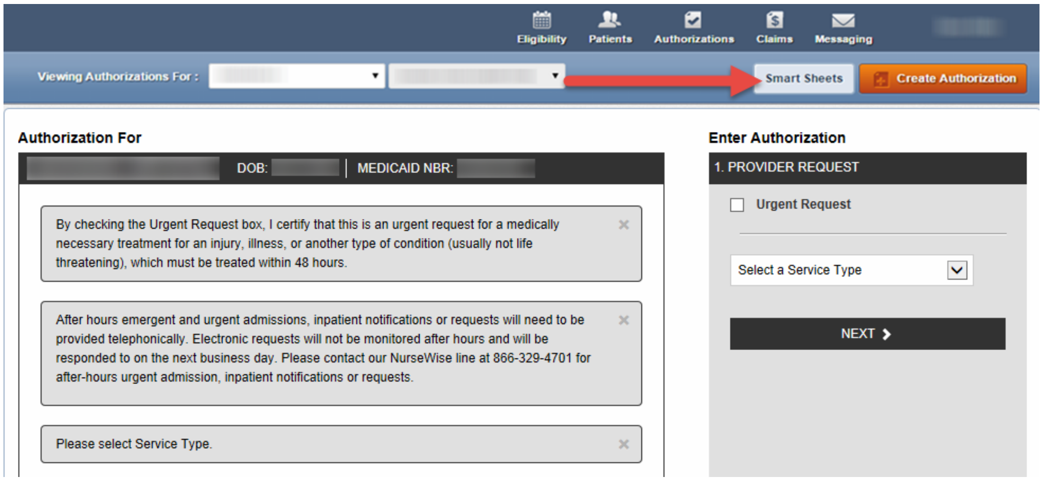
1. Select **Authorizations** from the member.



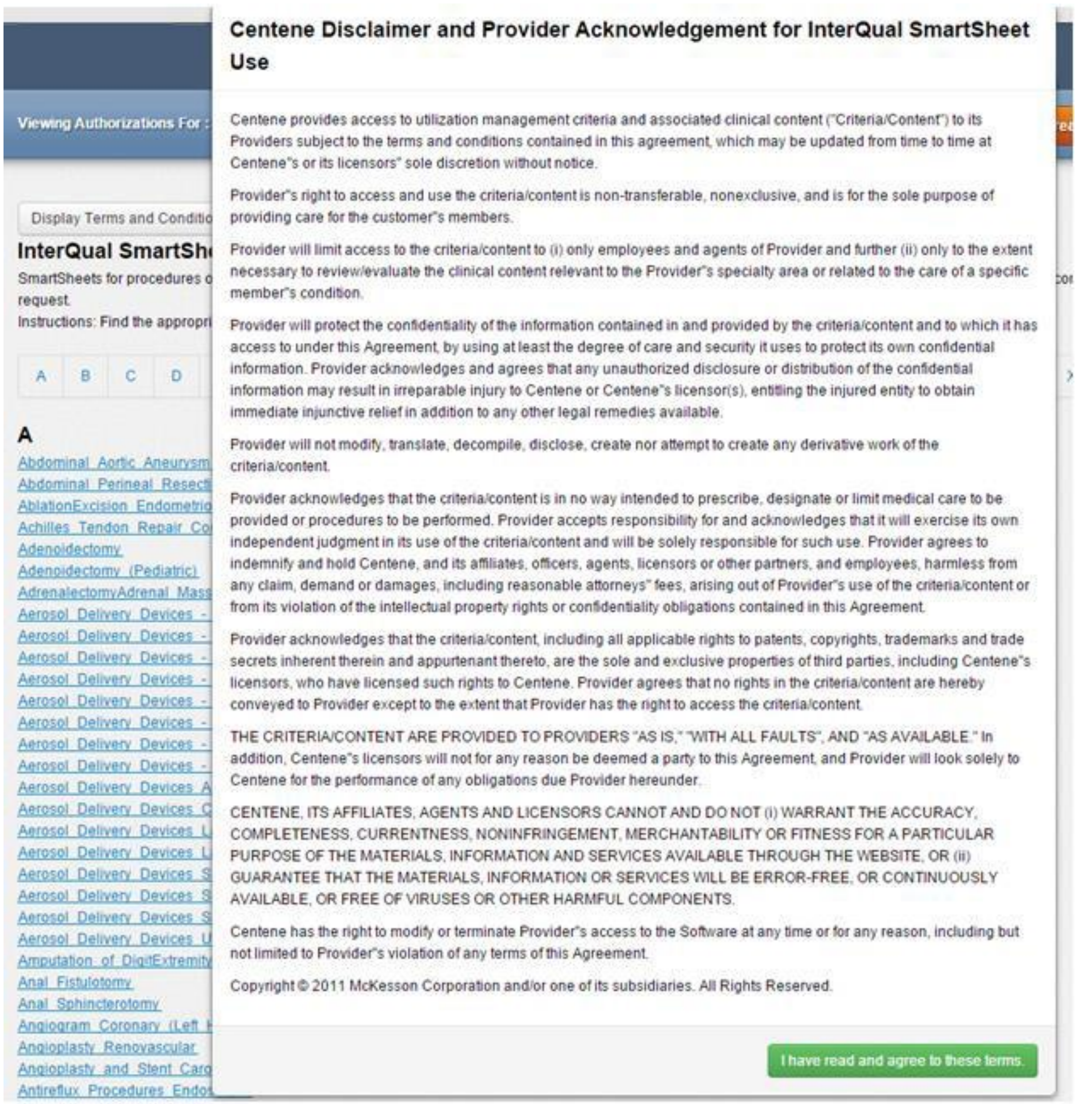
2. Click **Create a New Authorization**.



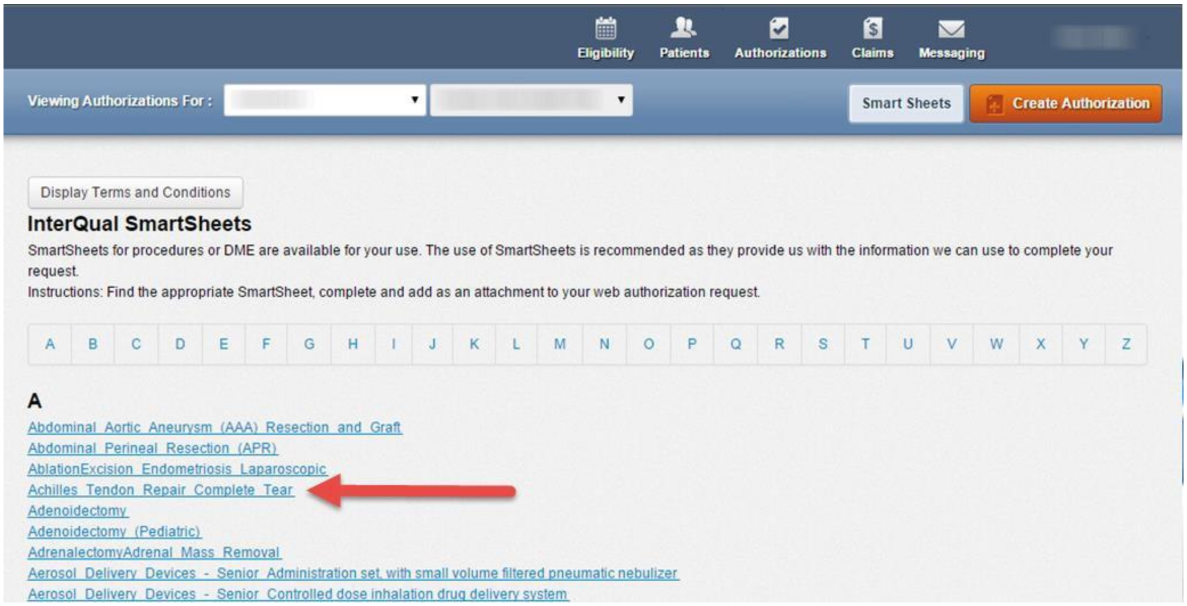
3. Click on **Smart Sheets**.



4. The disclaimer will appear to be read and acknowledged at the bottom of the screen.



5. Procedures are listed in alphabetical order. Click on appropriate hyperlink.



6. The Smart Sheet will open. Print, complete and save to your computer.

InterQual®

2012.2 Procedures Adult Criteria
Achilles Tendon Repair, Complete Tear

2012.2 Procedures Adult Criteria

Achilles Tendon Repair, Complete Tear[1]

PATIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 83.64, 83.73, 83.99

INDICATIONS (choose one and see below)

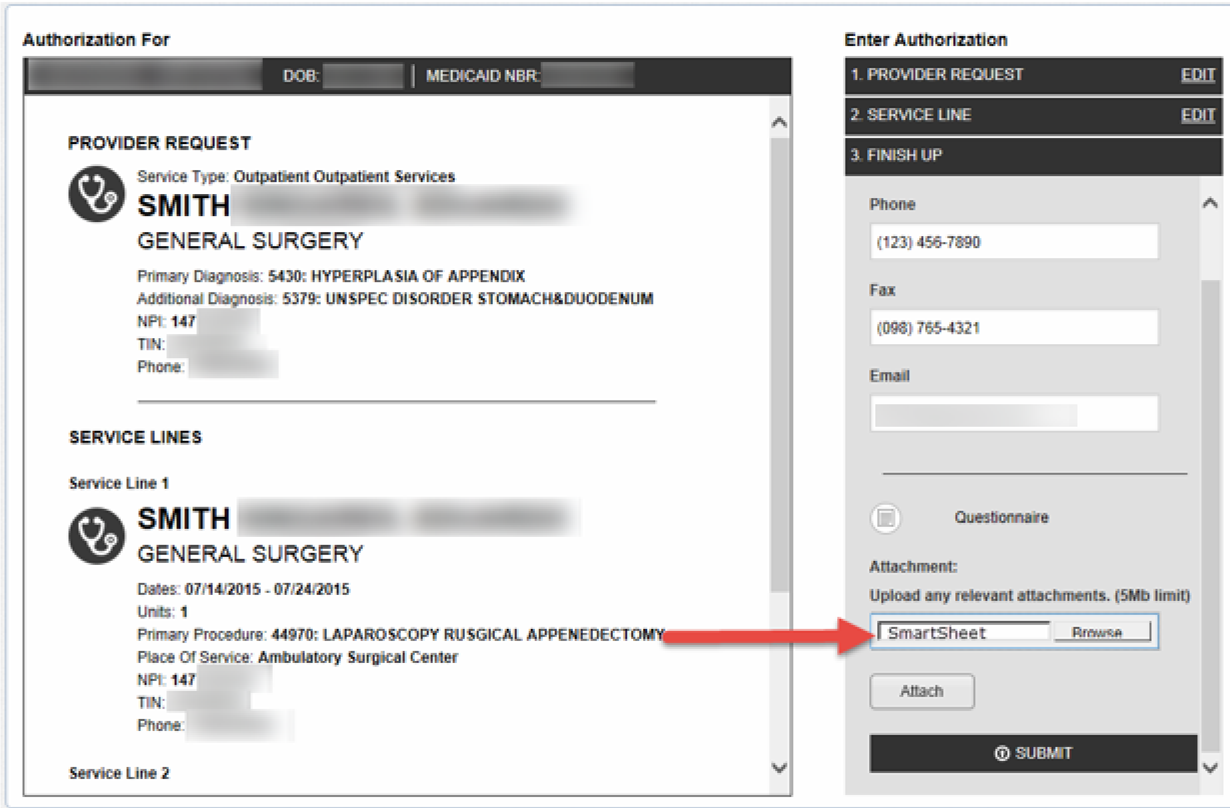
☐ 100 Complete tear
☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Complete tear **[Both]**[2]
- ☐ 110 Symptoms **[One]**[3]
  - ☐ 111 Pain at site
  - ☐ 112 Weakness of plantar flexion by Hx/PE
- ☐ 120 Findings **[One]**
  - ☐ 121 Palpable defect/gap in tendon
  - ☐ 122 Thompson's test abnormal[4]

Notes

(1)
These criteria address both acute and chronic rupture of the Achilles tendon. The goals of treatment are to restore length and tension of the tendon, thereby optimizing ultimate strength and function. There continues to be controversy as to whether operative or nonoperative treatment best achieves these goals. Several studies showed little difference in the recovery of normal function between operative and nonoperative cases (71% versus 63%). Operative repair can result in greater strength and a lower rate of rupture

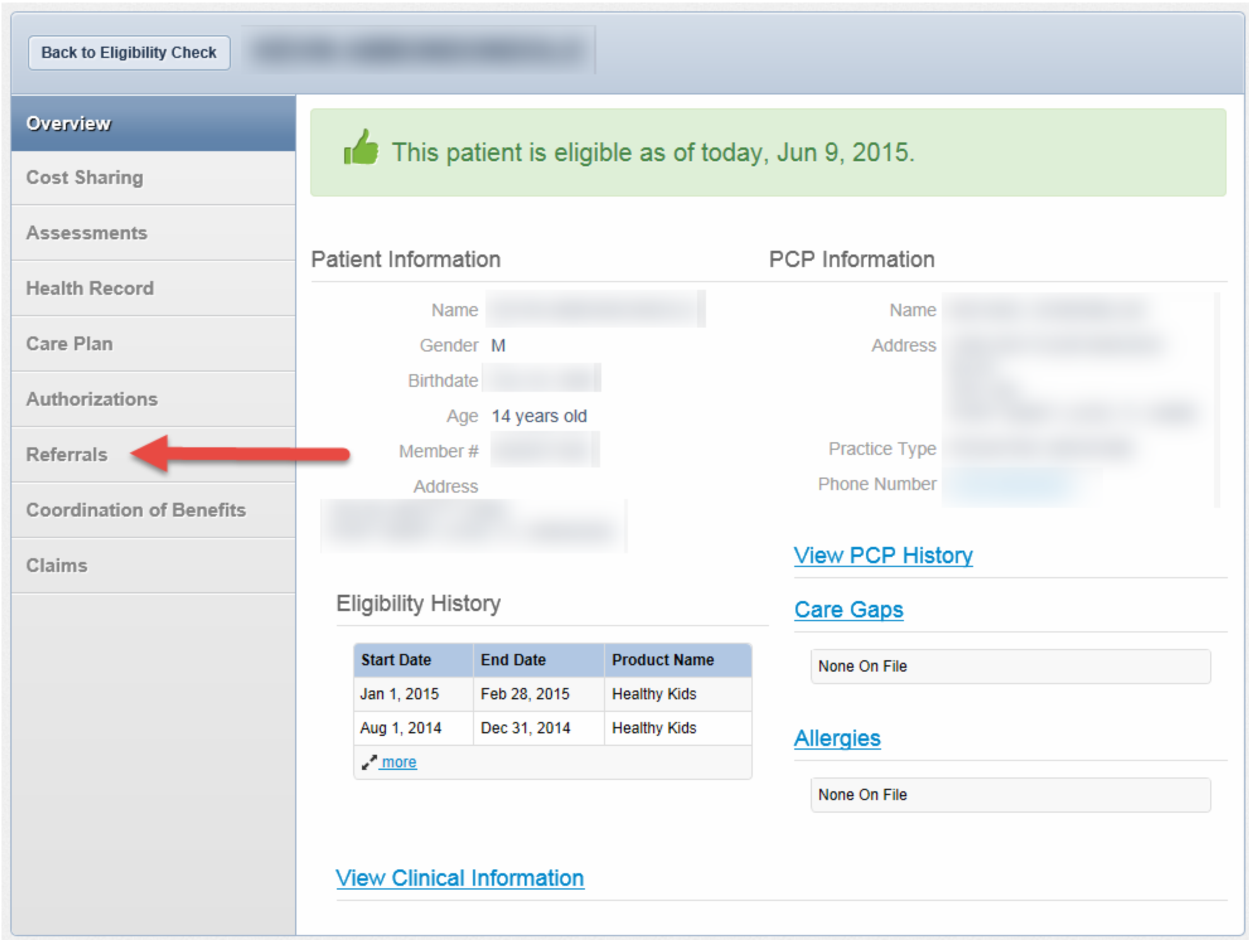
7. Add this document to the attachments when submitting a prior authorization request. This process is outlined in submitting an authorization.



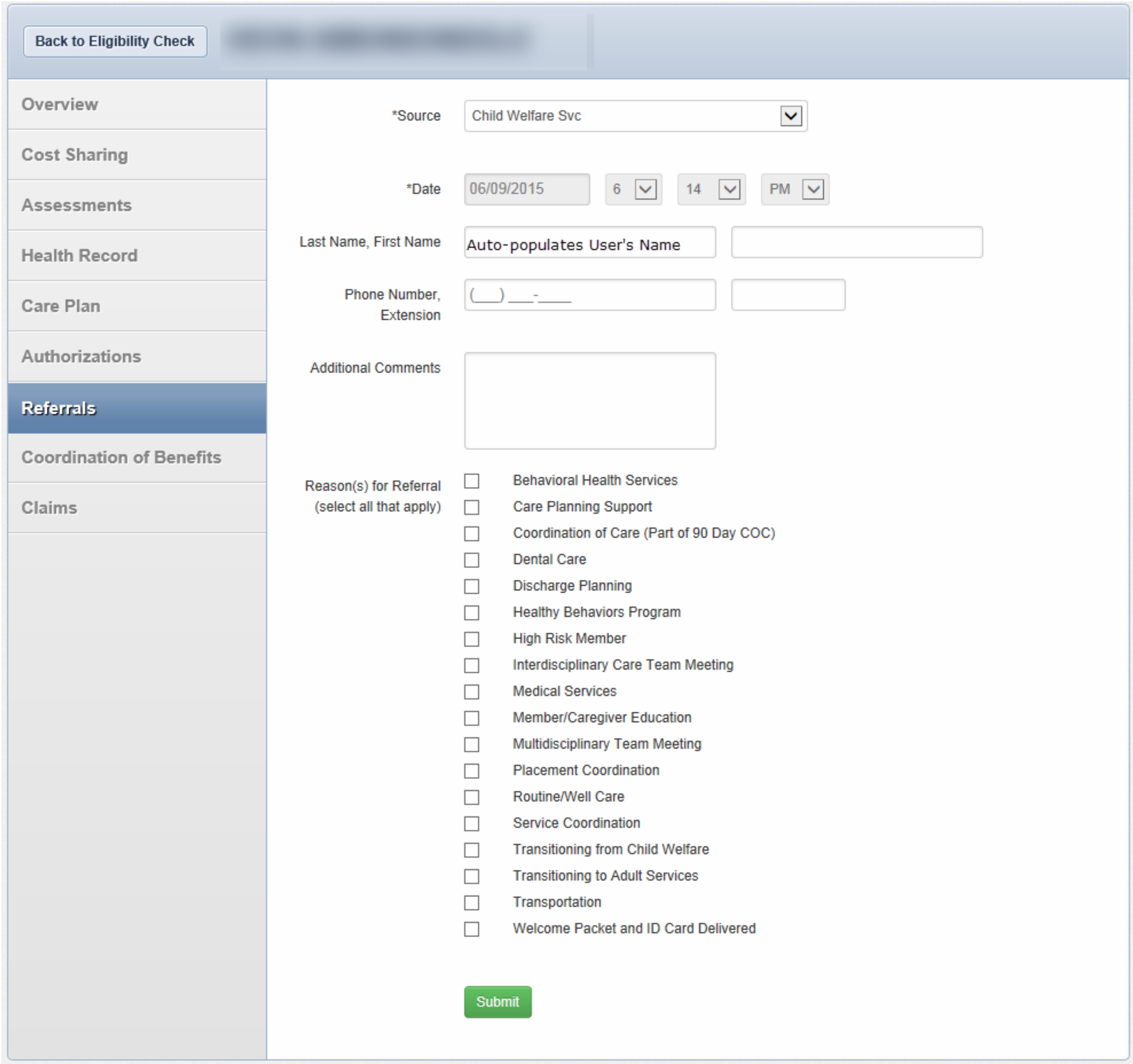
Referrals

To submit a referral, the provider can select specialized services for a member.

1. Select Referral



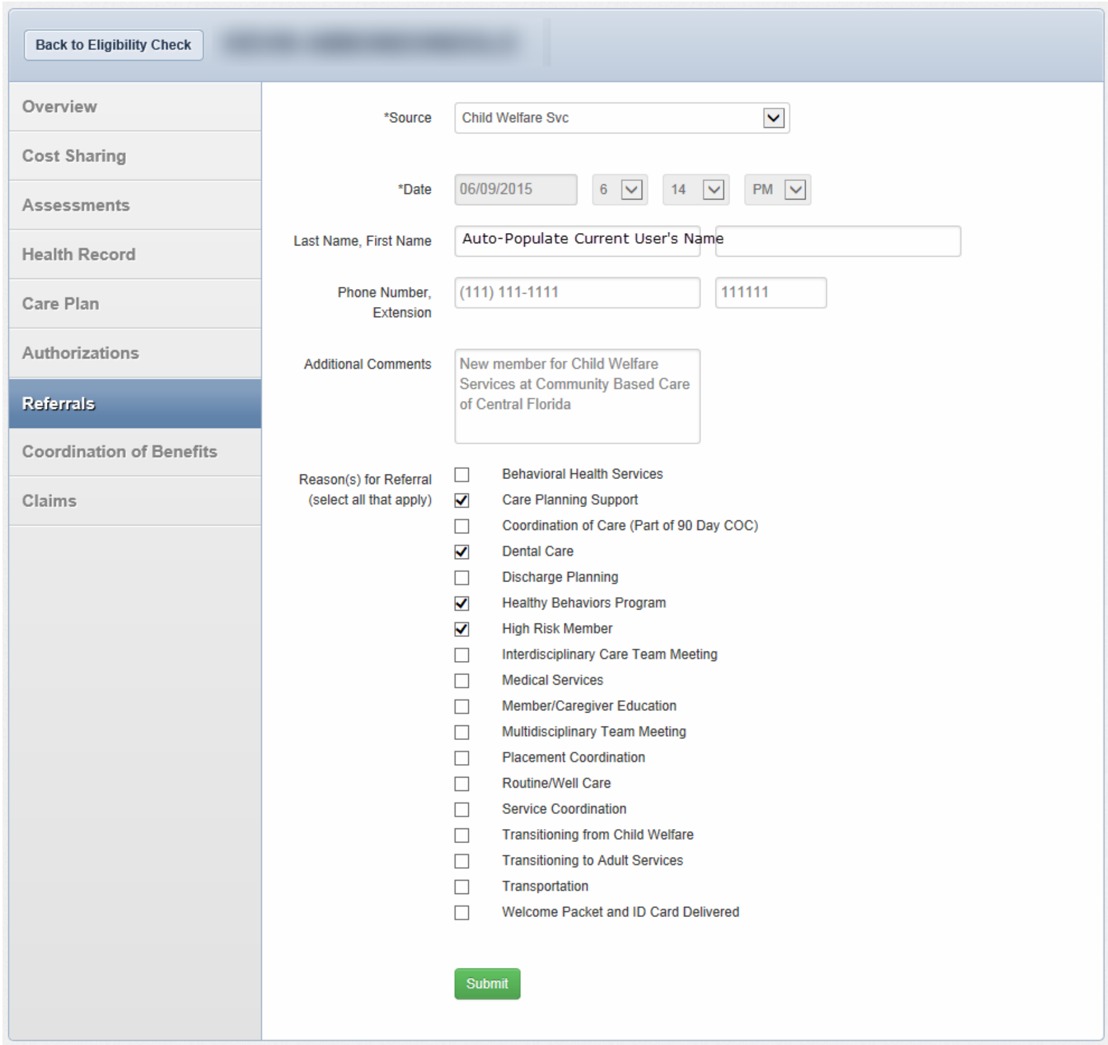
2. The Source can be a drop down menu with available types of referrals to select.
3. Referral form auto-populates the date, time and user's name.



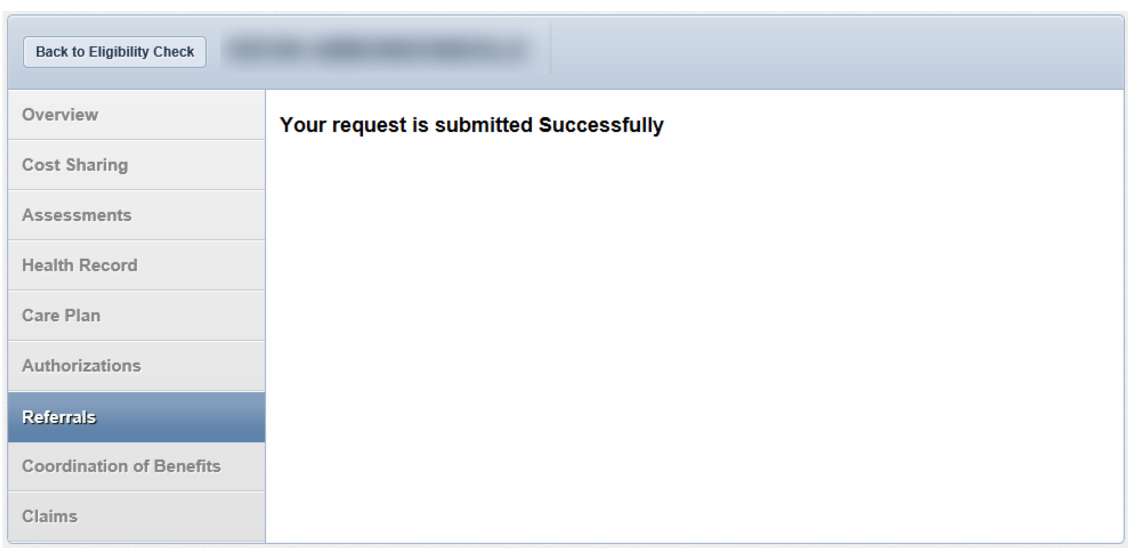
4. Complete the phone number and extension

5. Additional comments are an optional field

6. Select one or more boxes for Referral Reasons


Back to Eligibility Check
Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
*Source
Child Welfare Svc
*Date
06/09/2015
6
14
PM
Last Name, First Name
Auto-Populate Current User's Name
Phone Number, Extension
(111) 111-1111
111111
Additional Comments
New member for Child Welfare Services at Community Based Care of Central Florida
Reason(s) for Referral (select all that apply)
Behavioral Health Services
Care Planning Support
Coordination of Care (Part of 90 Day COC)
Dental Care
Discharge Planning
Healthy Behaviors Program
High Risk Member
Interdisciplinary Care Team Meeting
Medical Services
Member/Caregiver Education
Multidisciplinary Team Meeting
Placement Coordination
Routine/Well Care
Service Coordination
Transitioning from Child Welfare
Transitioning to Adult Services
Transportation
Welcome Packet and ID Card Delivered
Submit

7. Submit

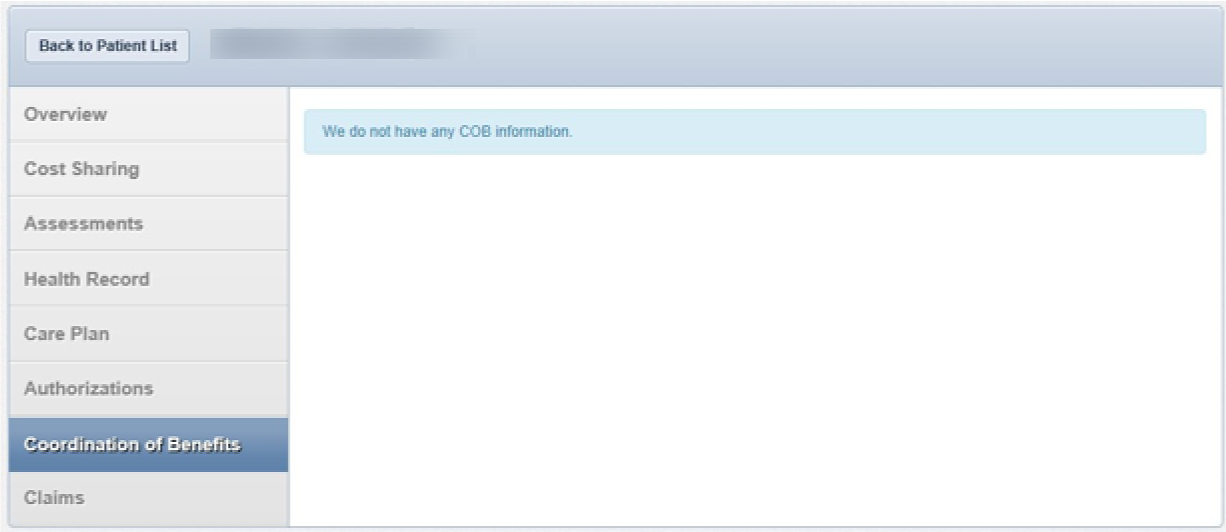

Back to Eligibility Check
Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Your request is submitted Successfully

Coordination of Benefits

To access the members coordination of benefits information from inside the patient record

1. Select Coordination of Benefits

The following screen appears showing no COB information is available for this member.



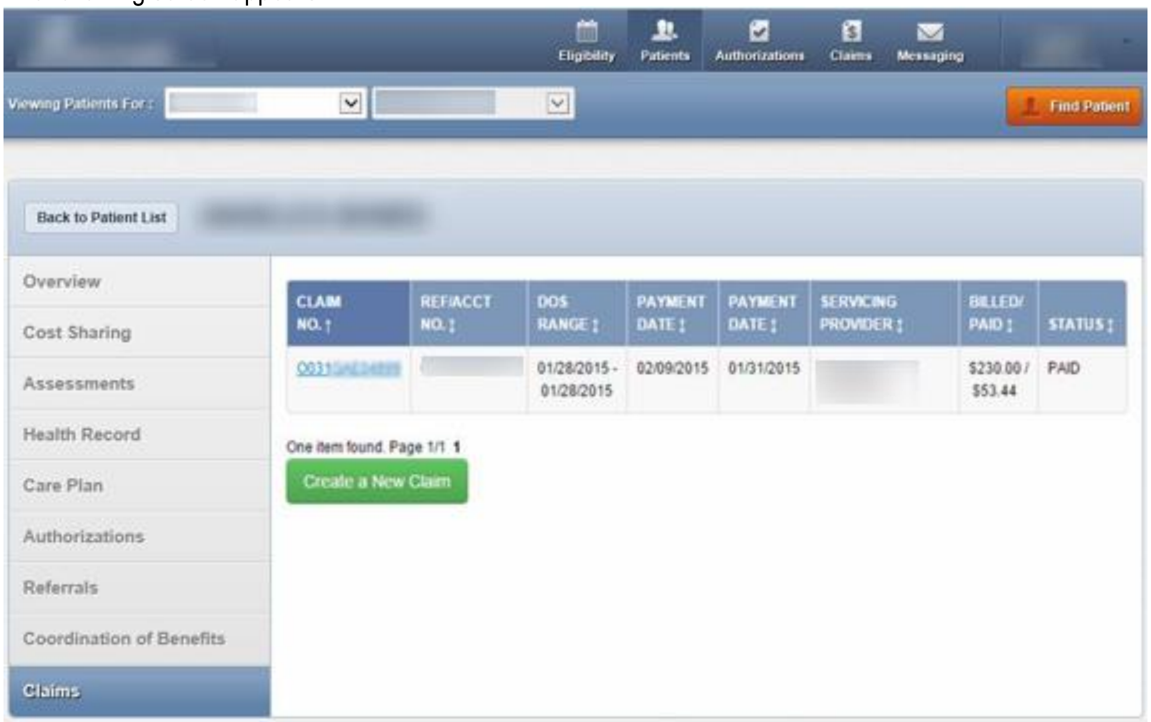
Claims

To access Claim information from inside the patient record,

1. Select **Claims** on the left.

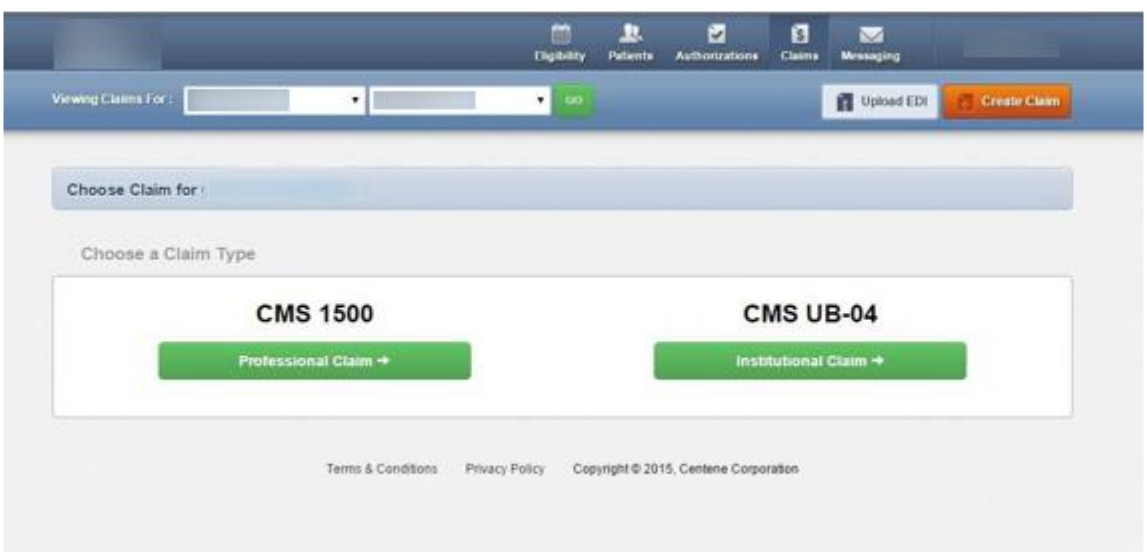
   Note: The Claims tab of the patient record allows you to view any recent claims for the patient, and also create a new claim. If the patient has any recent claims, they display on this tab.

The following screen appears:



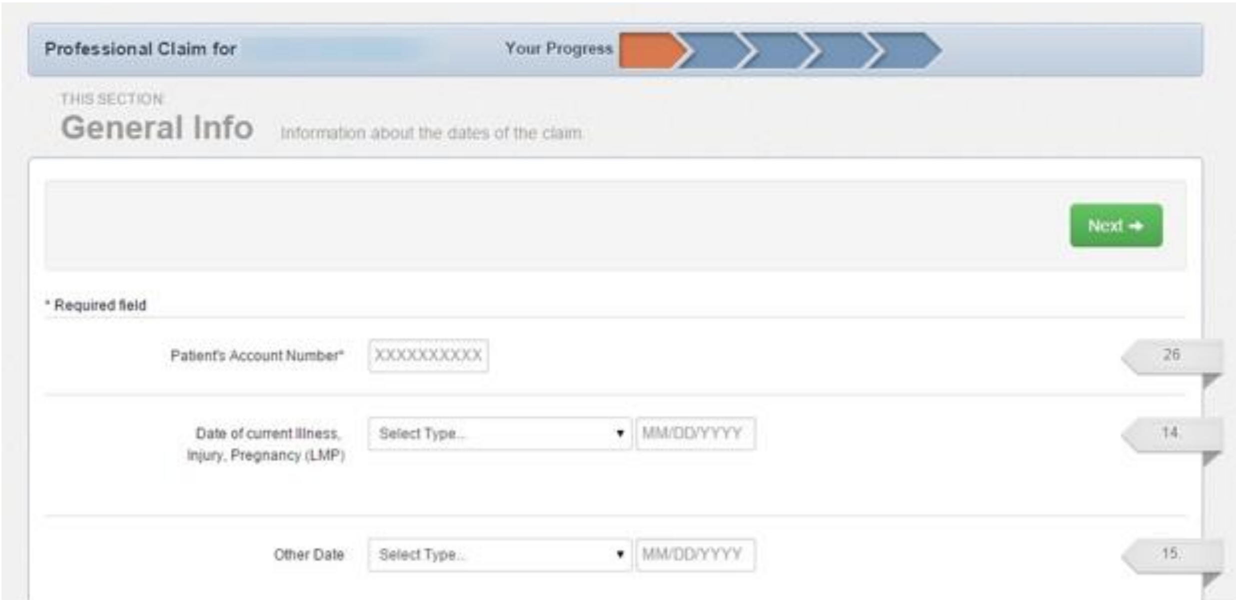
2. Click the Green Create a Claim button to begin a new claim for this patient.

The following screen appears:



1. Select **Professional Claim** by clicking the green button.

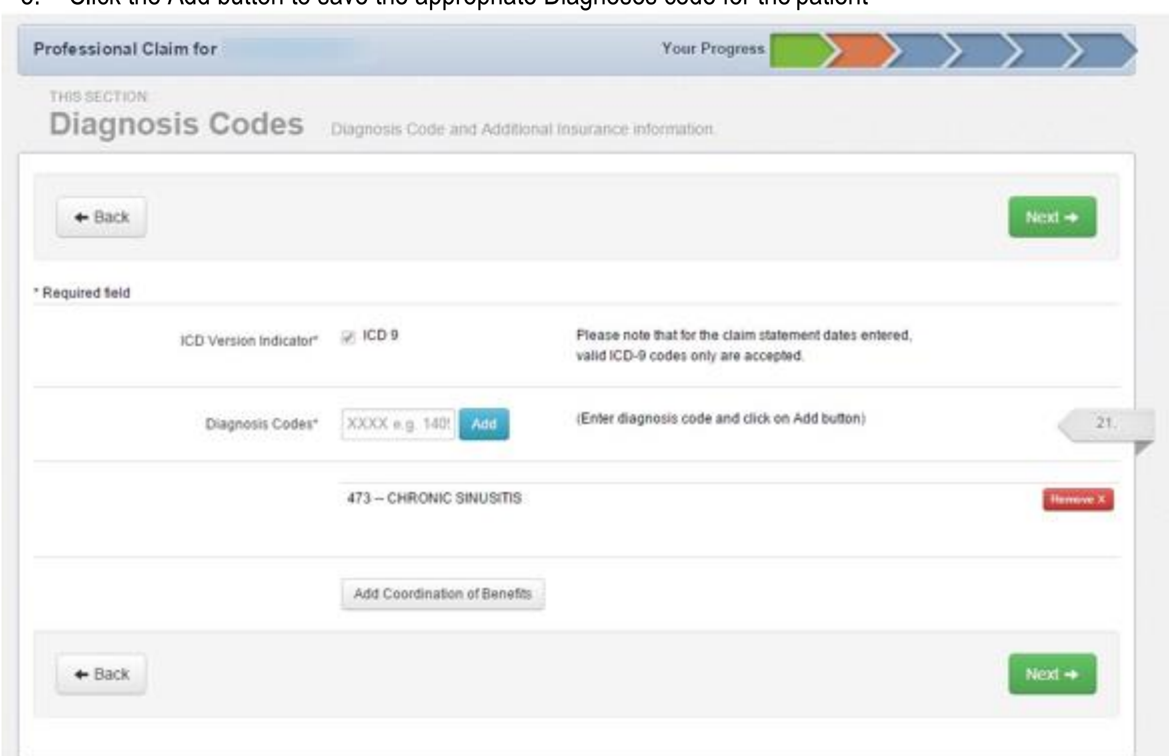
The following screen appears.



2. In the General Info section, populate the Patient's Account Number, and other information related to the patient's condition by typing into the appropriate fields.
3. Click **Next**.

Adding Diagnosis codes and coordination of benefits

4. Add the Diagnosis Codes for the patient in Box 21
5. Click the Add button to save the appropriate Diagnoses code for the patient



6. Click the **Coordination of Benefits Button** (if applicable) or the **Next** button.

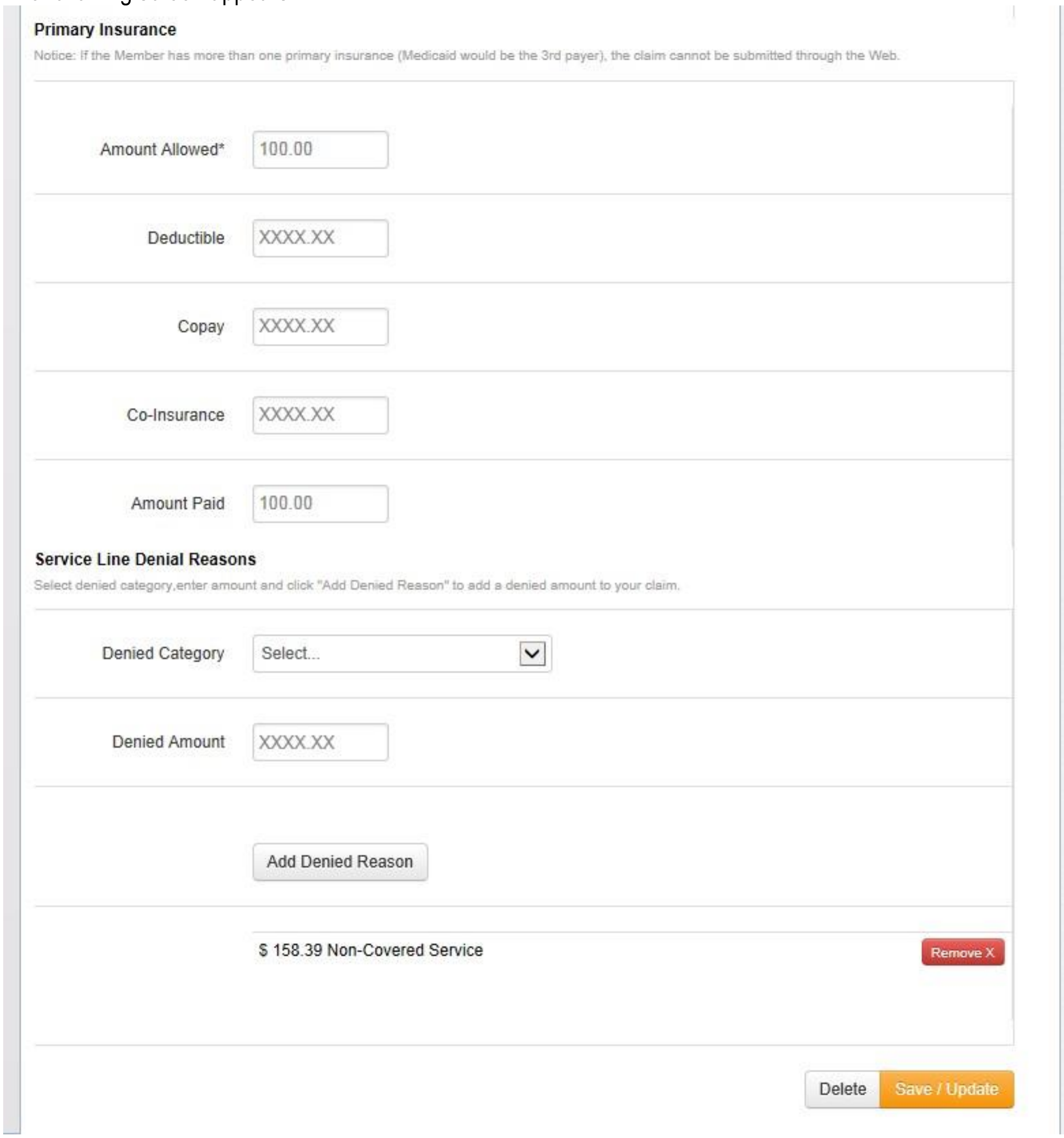
Adding Coordination of Benefits

7. Click Add Coordination of Benefits to include any payments made by another insurance carrier (if applicable)

   The following screen appears:

8. Enter the Carrier Type and the Policy Number
9. Click **Next**

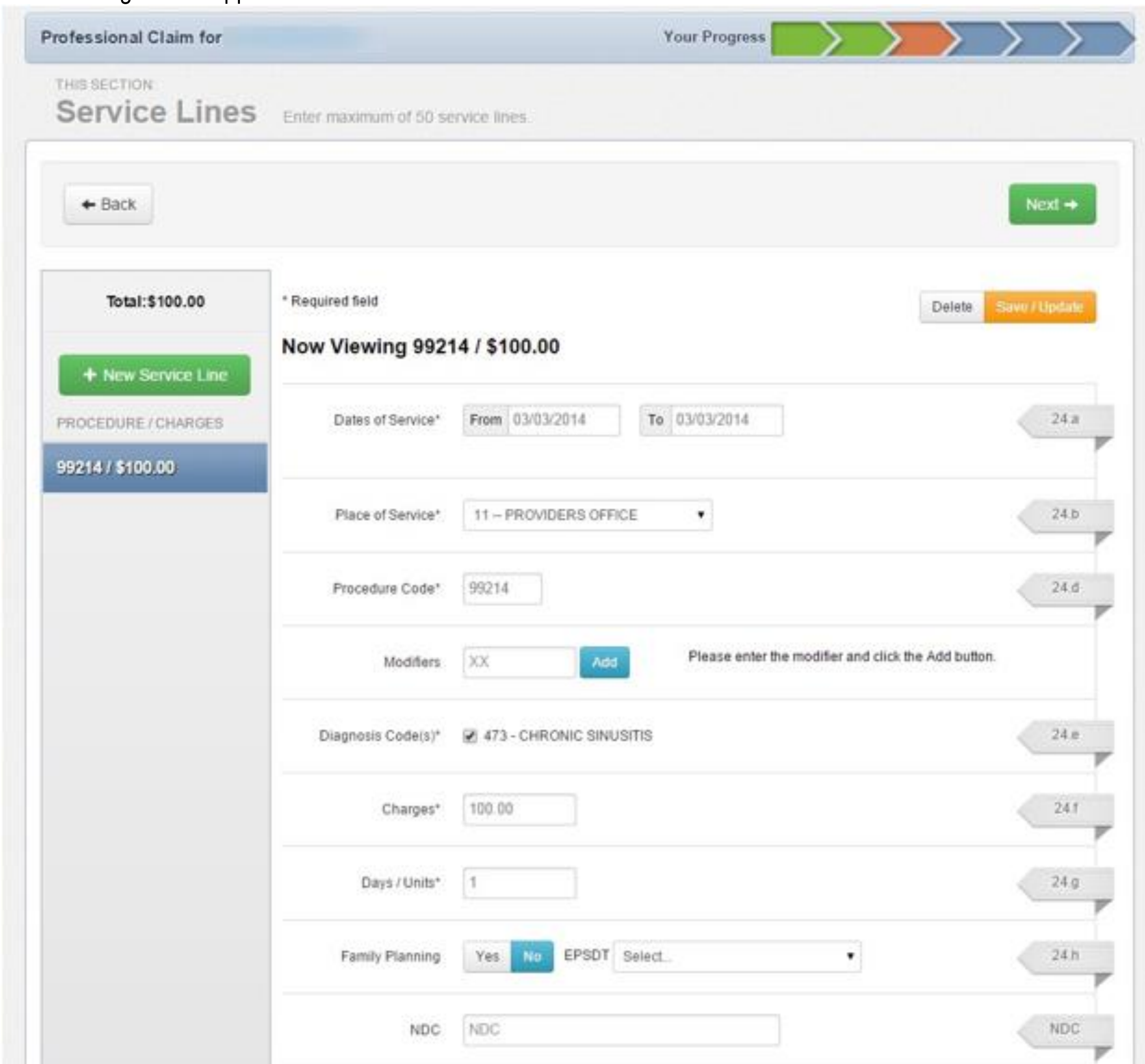
The following screen appears:



10. Enter the pertinent information from the primary insurance
11. Select Save/Update
12. Click Next

Adding Service Lines to the claim

The following screen appears:



13. In the Service Lines section, add your service line information.

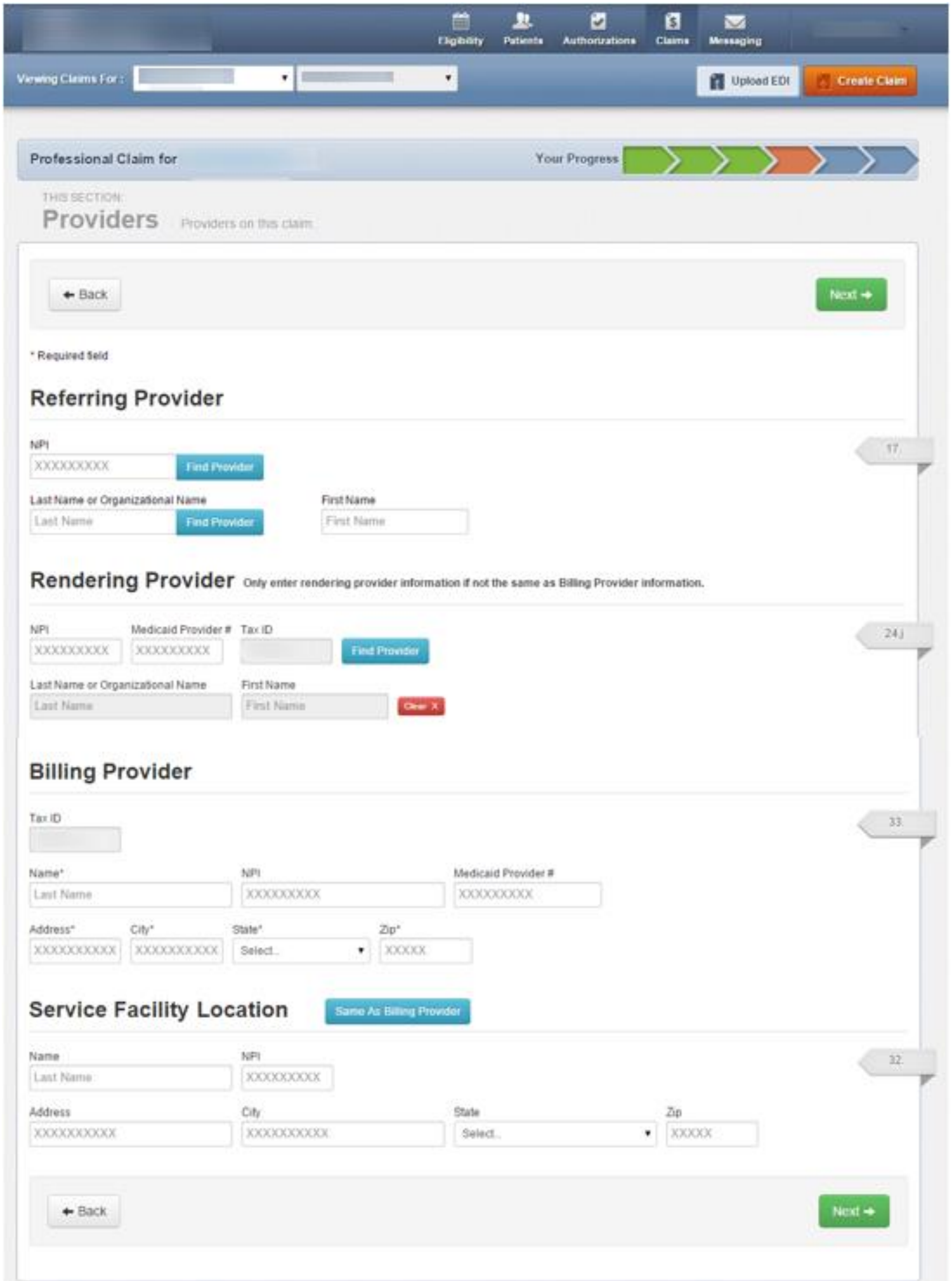
    *****Note:** When entering charges for the service billed, include the decimal point to ensure the data is populated accurately. For example, 99.00 convert to $99.00.

14. To add additional service lines, click the **Save/Update** button and then click the **New Service Line** button. Enter up to 99 service lines.

15. Click **Next**

Adding Provider Information to the claim

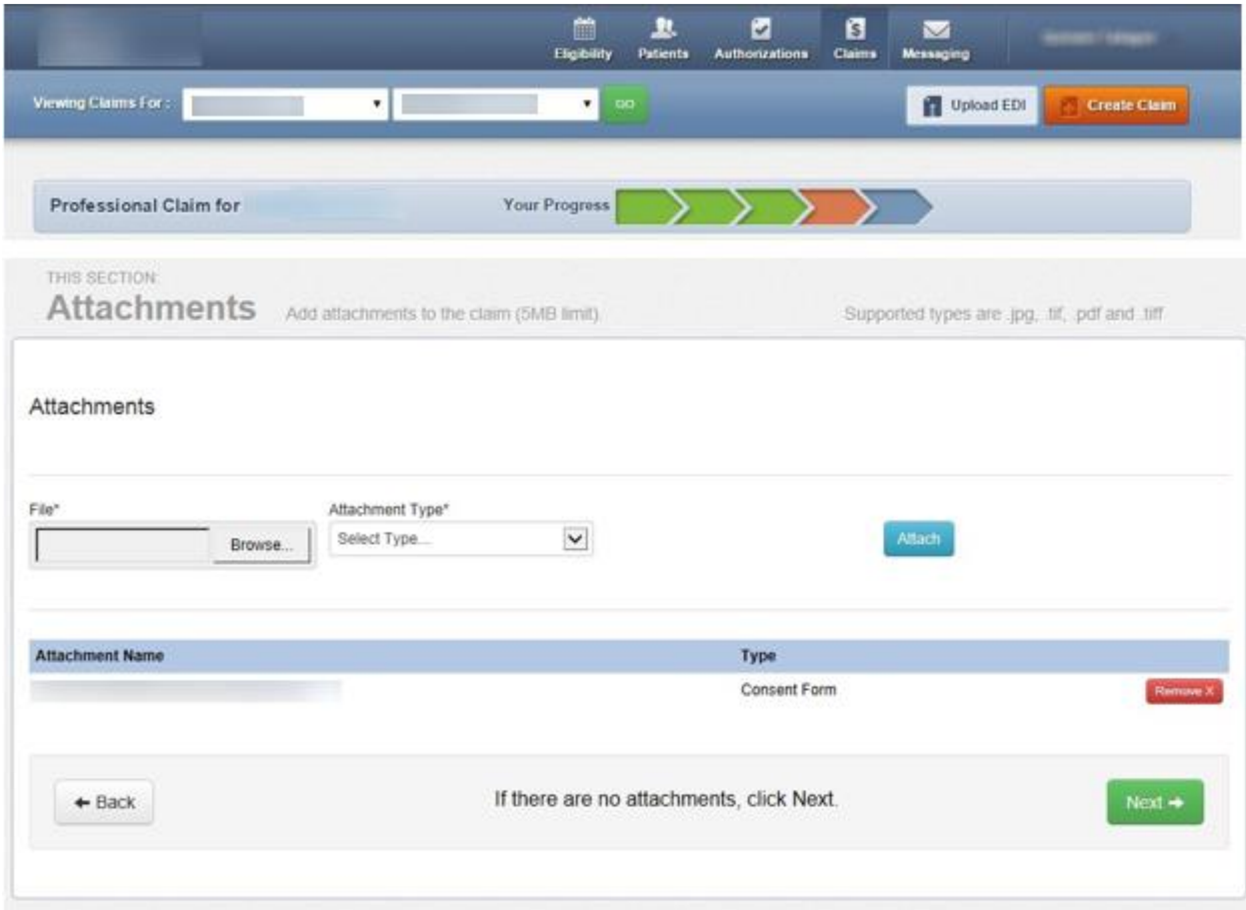
The following screen appears:



16. Enter referring and billing provider information
17. Enter Service Facility Location
18. Click **Next**

Adding Attachments to a claim.

The following screen appears:



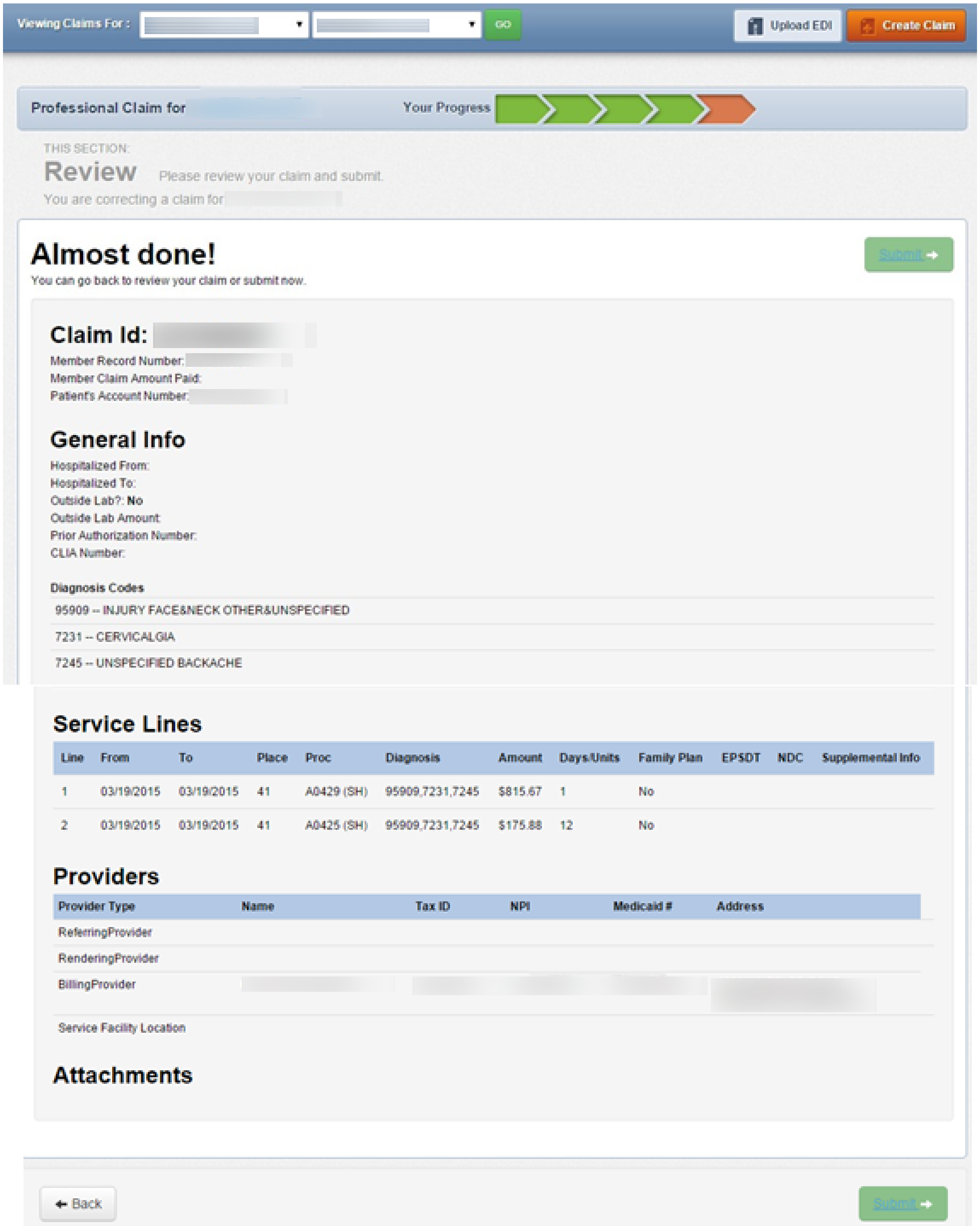
19. In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired.

    Note: If you have no attachments, skip this section

20. Click **Next**

The Review Section of the claim

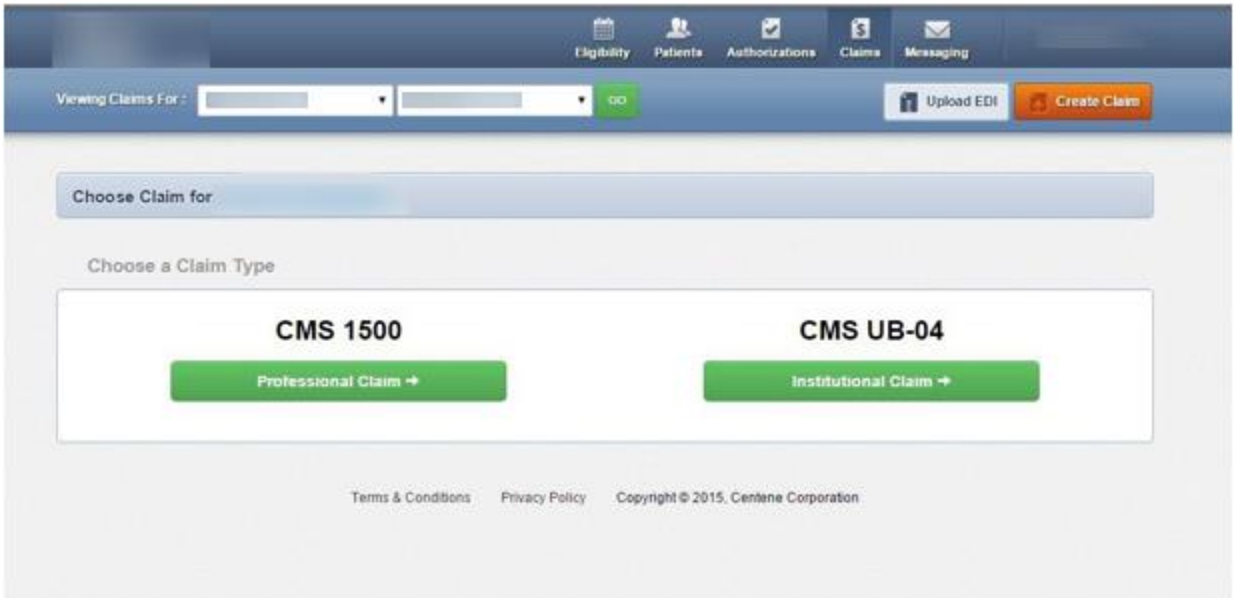
The following screen appears:



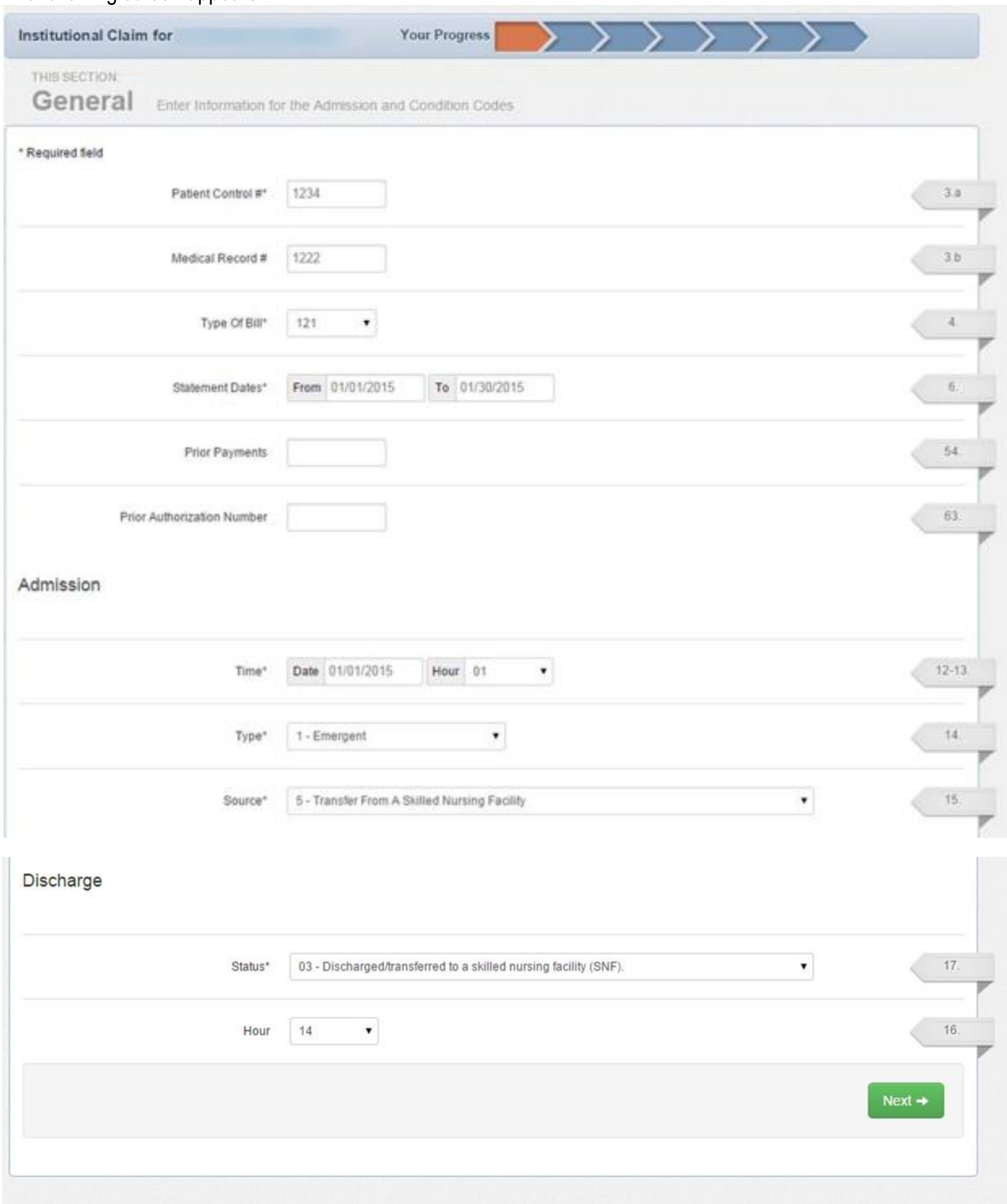
21. In the Review section, you can review the claim once again
22. Click **Submit**.

Creating an Institutional Claims

Select the CMS UB-04 **Institutional Claim** button from the member record



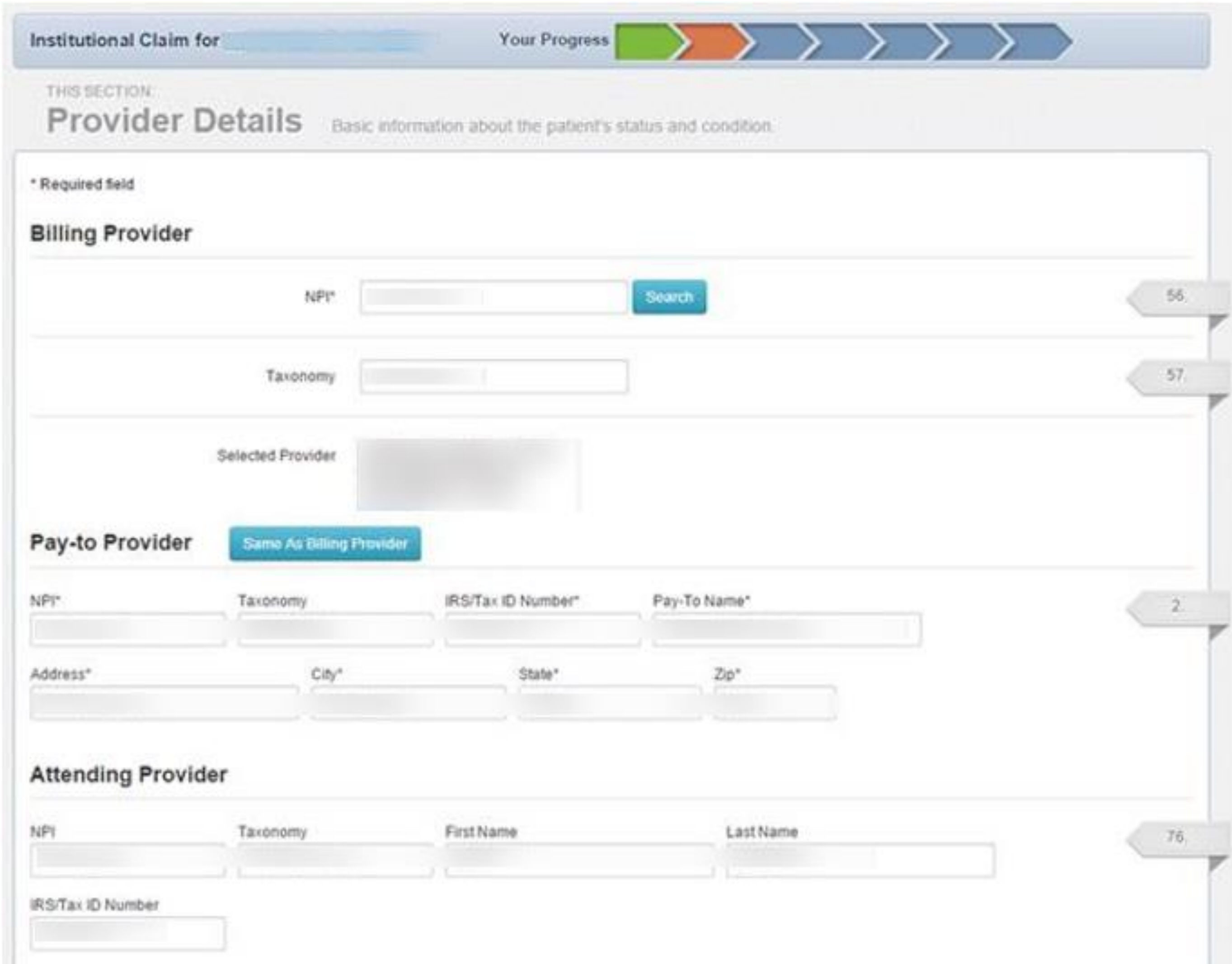
The following screen appears:



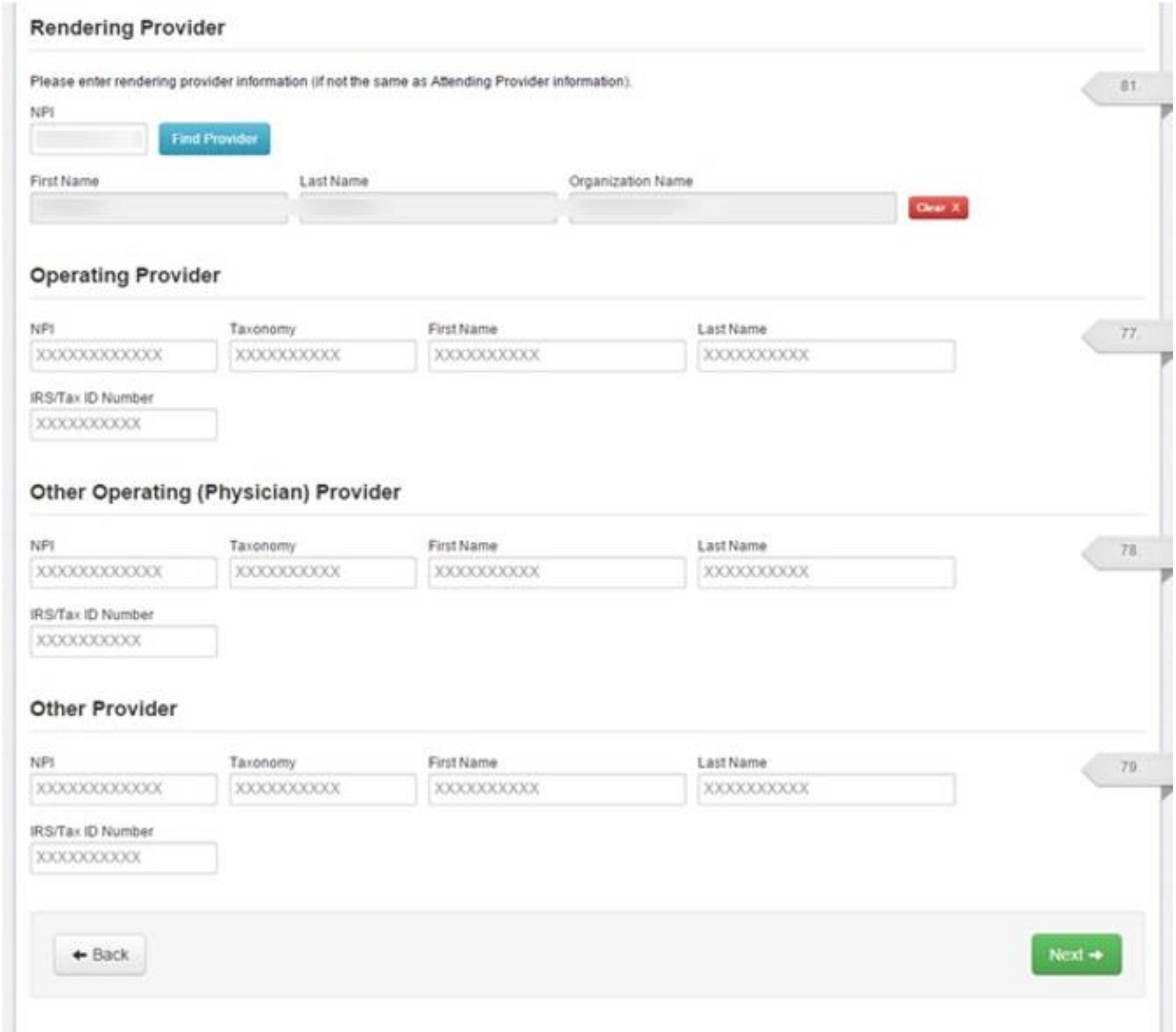
1. In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form.
2. Click **Next**

   Note: Hovering over the Claim Field Tabs to the right of the screen will help determine what field on the UB-04 form from which to obtain the information.

The following screen appears

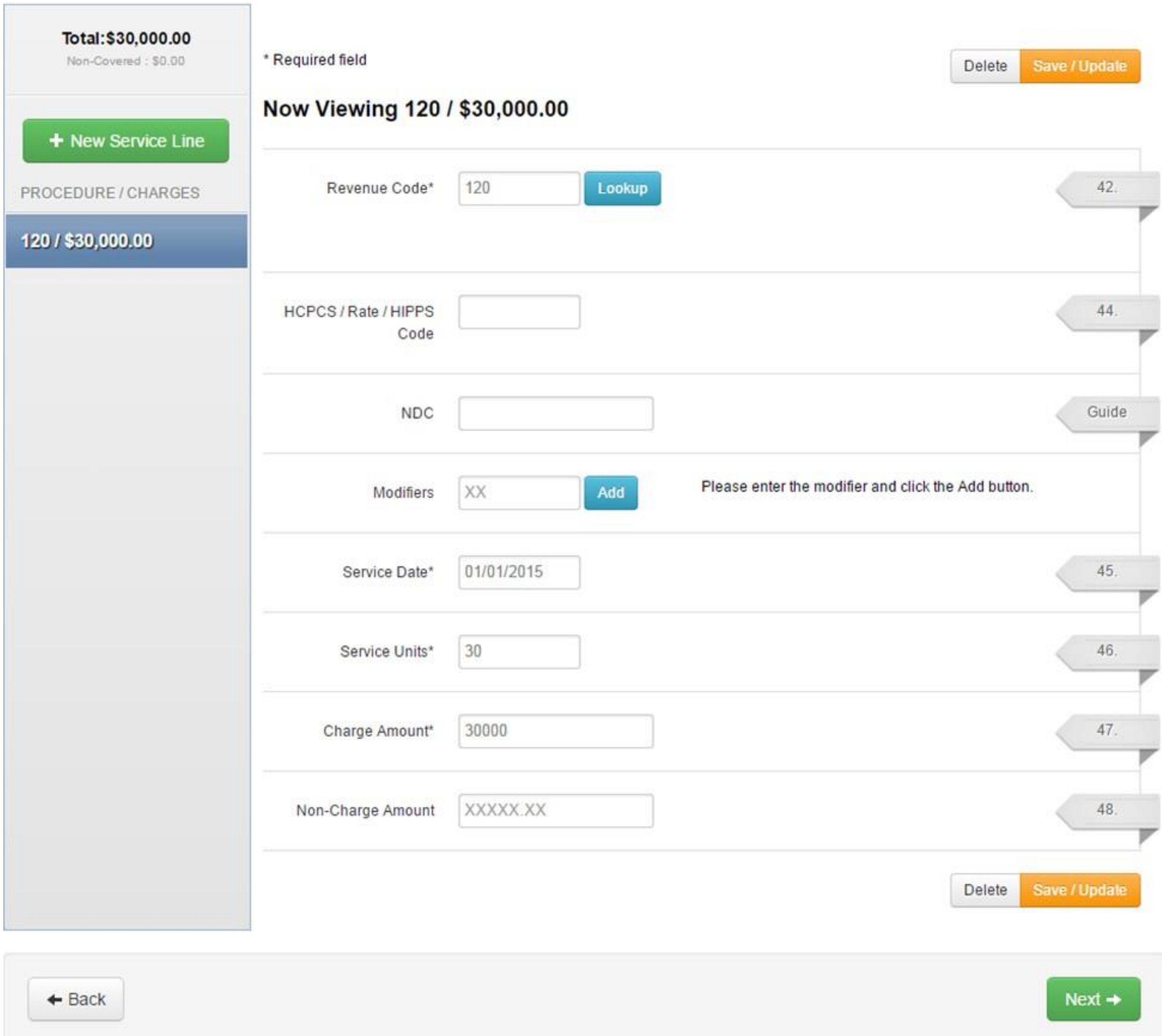


Continued:



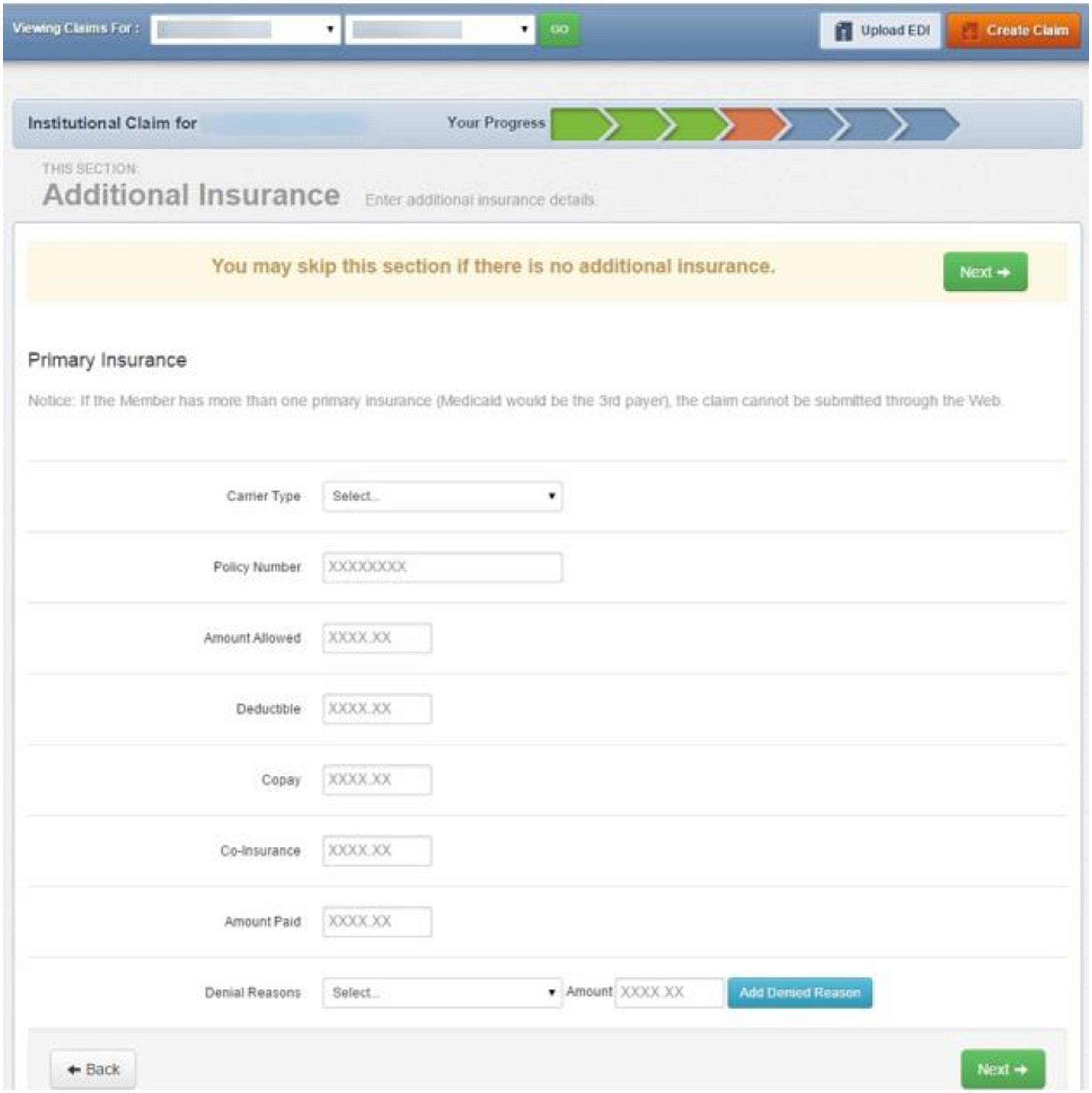
3. In the Provider Details section, enter the billing and other provider information in the appropriate fields.
4. Click **Next**

The following screen appears:



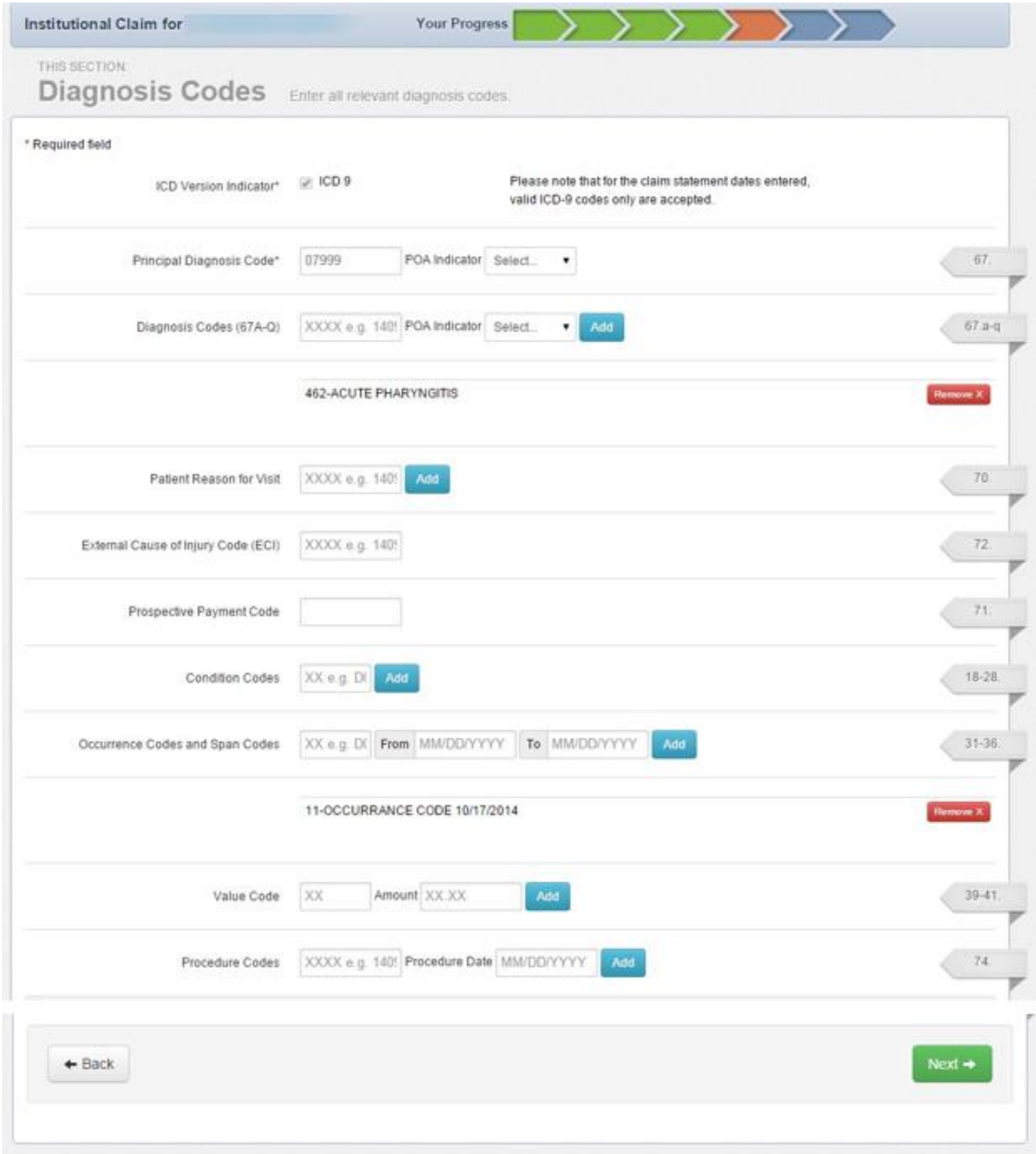
5. In the Service Lines section, enter the information about the services provided.
6. Click **Save/Update**, and to add a new service line
7. Click the **+ New Service Line** button on the left to add additional service lines.
   Note: You can enter up to 99 service lines. When all necessary service lines have been entered and saved
8. Click the **Next** button.

The following screen appears;



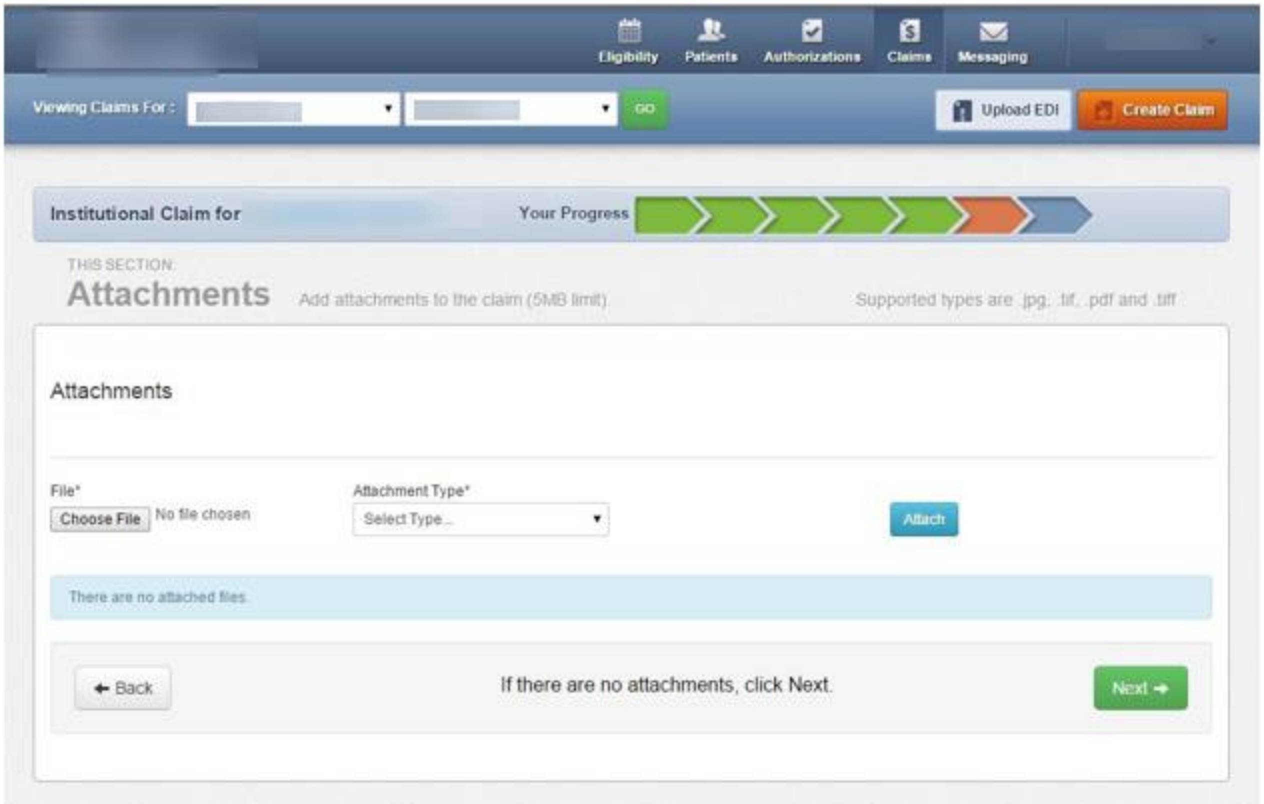
9. In the Additional Insurance section, enter any additional insurance details as needed. If there is no additional insurance, you may skip this section.
10. Click **Next**.

The following screen appears:



11. In the Diagnosis Codes section, enter all relevant diagnosis information.
12. Click **Next**.

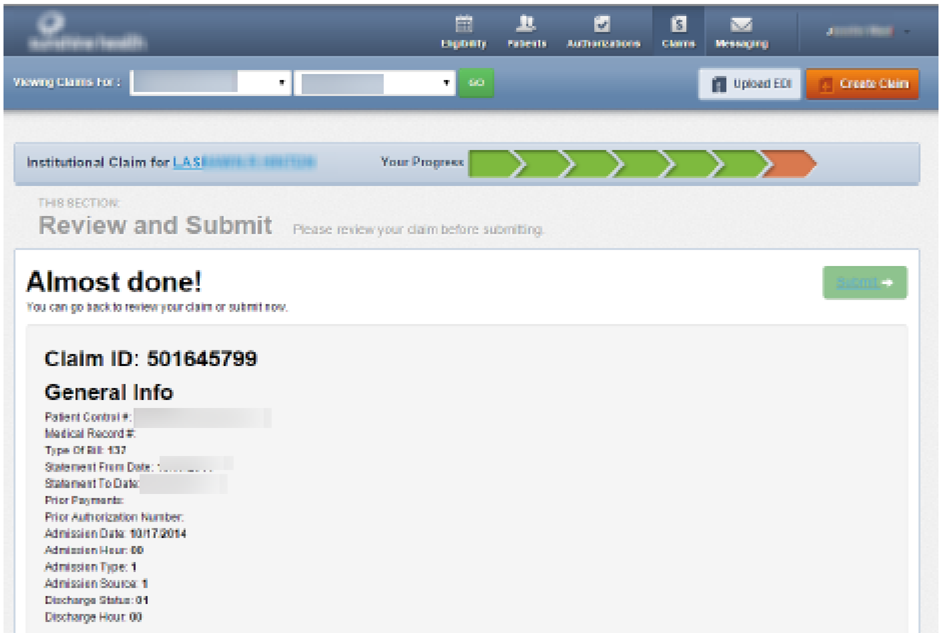
The following screen appears:



13. In the Attachments section, **Choose File** and **Attach** any relevant file to the claim.
14. Click **Next**

The following screen appears:

15. Review the claim
16. **Click Submit**



Viewing Claims For :

GO

Upload EDI

Create Claim

Institutional Claim for LAS

Your Progress

THIS SECTION:

Review and Submit

Please review your claim before submitting.

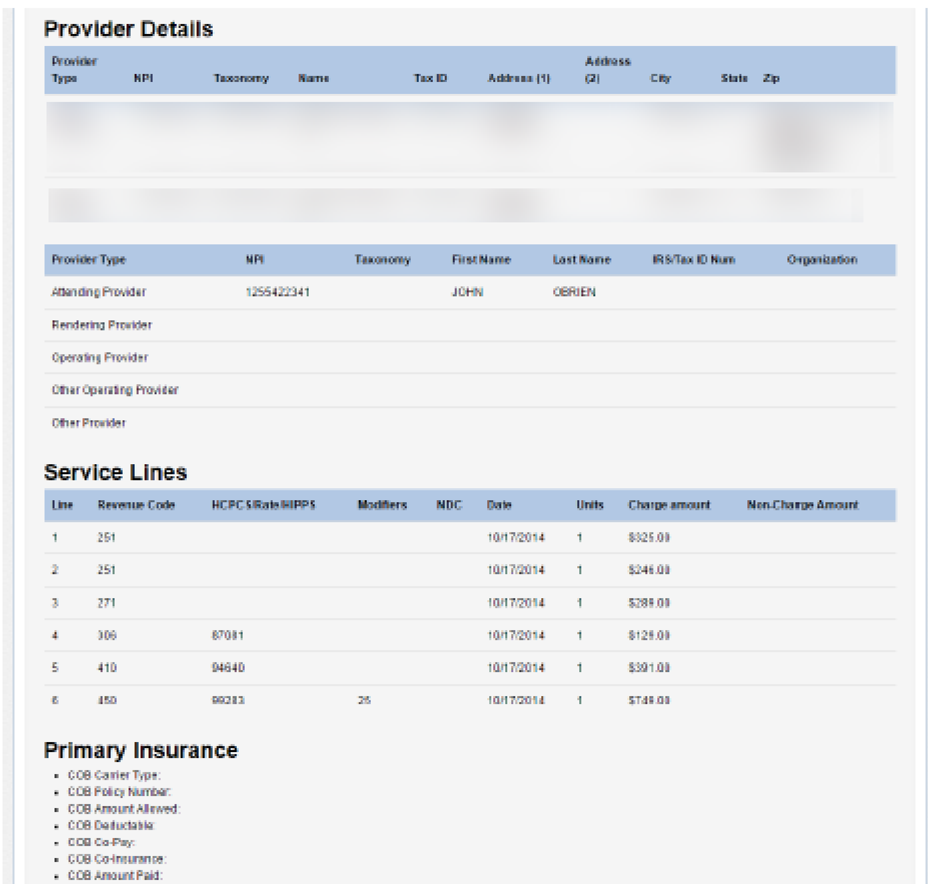
Almost done!

You can go back to review your claim or submit now.

Claim ID: 501645799

General Info

Patient Control #:
Medical Record #:
Type Of Bill: 137
Statement From Date:
Statement To Date:
Prior Payments:
Prior Authorization Number:
Admission Date: 10/17/2014
Admission Hour: 00
Admission Type: 1
Admission Source: 1
Discharge Status: 01
Discharge Hour: 00



Provider Details

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
Attending Provider	1255422341		JOHN	OBRIEN		
Rendering Provider						
Operating Provider						
Other Operating Provider						
Other Provider						

Service Lines

Line	Revenue Code	HCPCS/Rate/HIPPS	Modifiers	NDC	Date	Units	Charge amount	Non-Charge Amount
1	251				10/17/2014	1	$325.00	
2	251				10/17/2014	1	$246.00	
3	271				10/17/2014	1	$289.00	
4	306	87081			10/17/2014	1	$129.00	
5	410	94640			10/17/2014	1	$391.00	
6	450	99283	25		10/17/2014	1	$749.00	

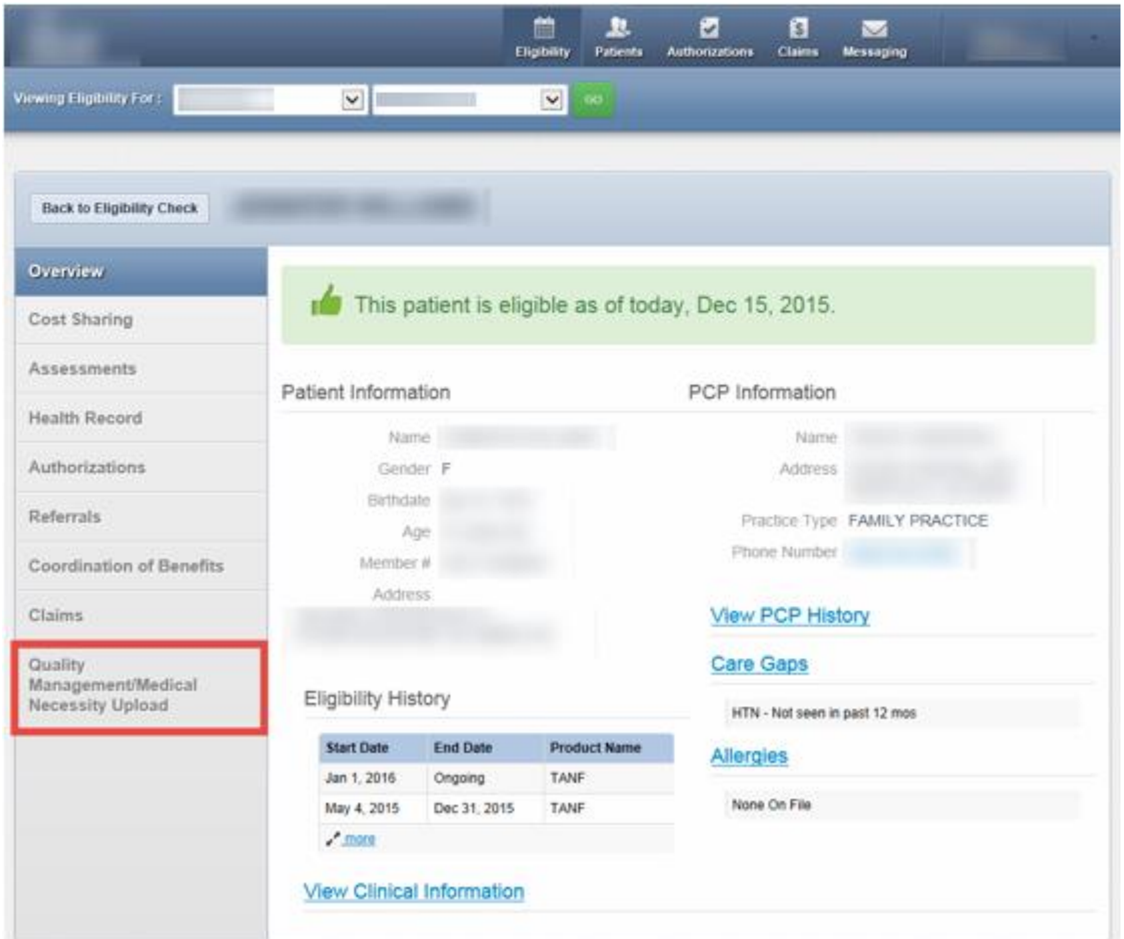
Primary Insurance

- COB Carrier Type:
- COB Policy Number:
- COB Amount Allowed:
- COB Deductable:
- COB Co-Pay:
- COB Co-Insurance:
- COB Amount Paid:

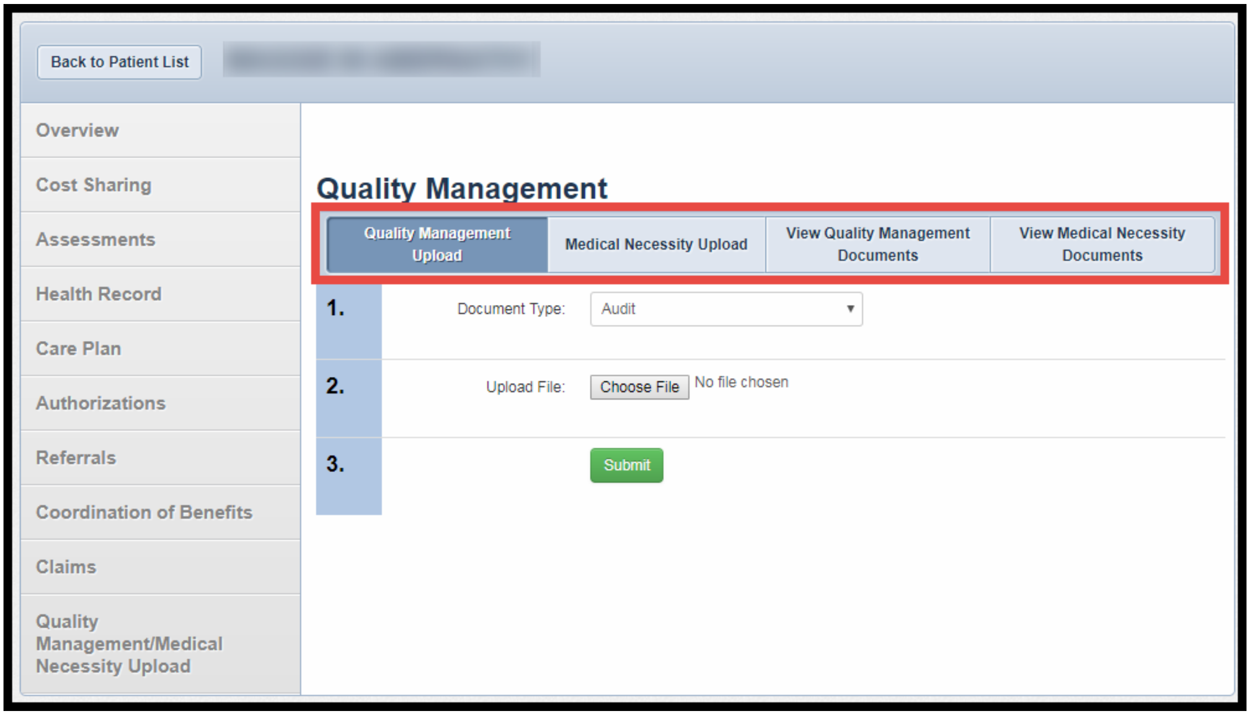
Uploading Documents for Quality Management / Medical Necessity Upload

To upload documents for quality management or medical necessity for a member's record,

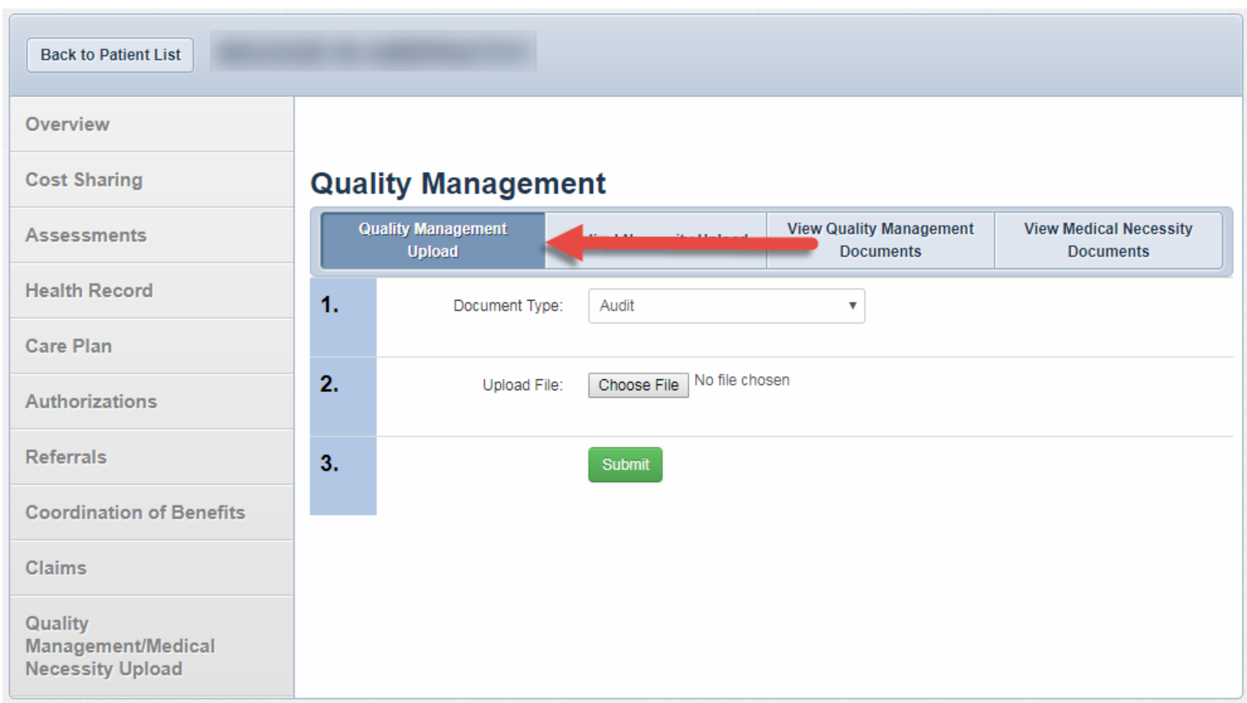
1. Click on Quality Management / Medical Necessity Upload



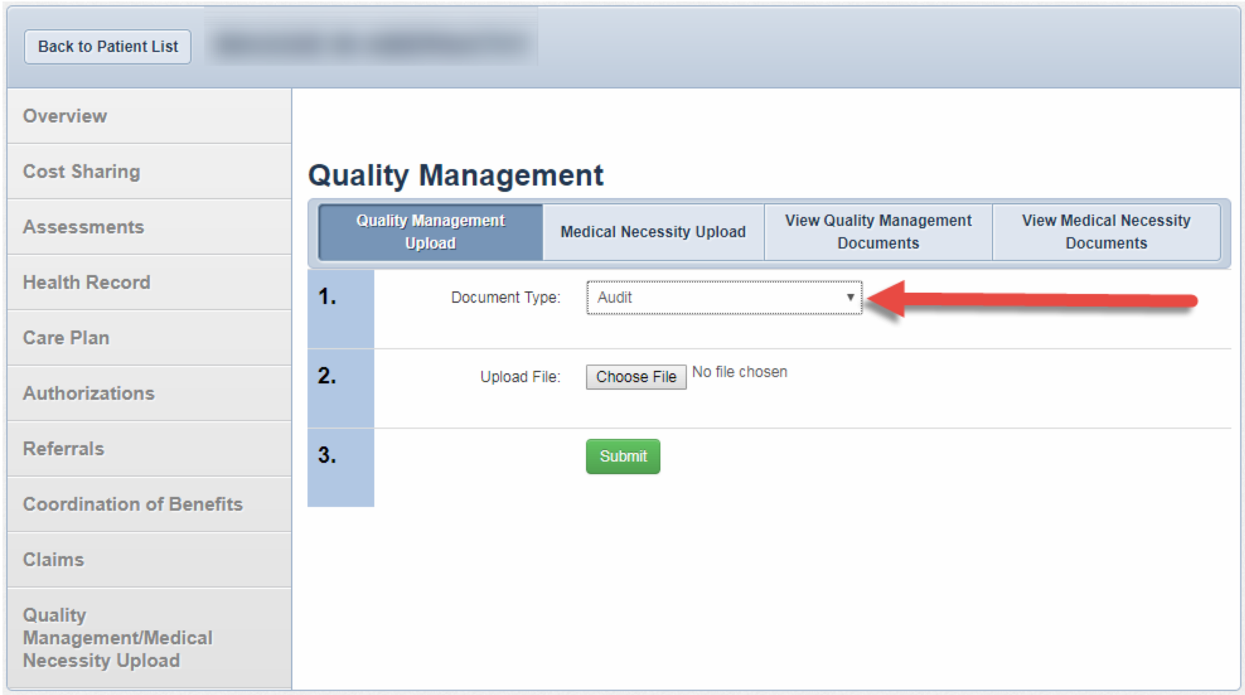
2. Providers can either Upload Documents or View Documents



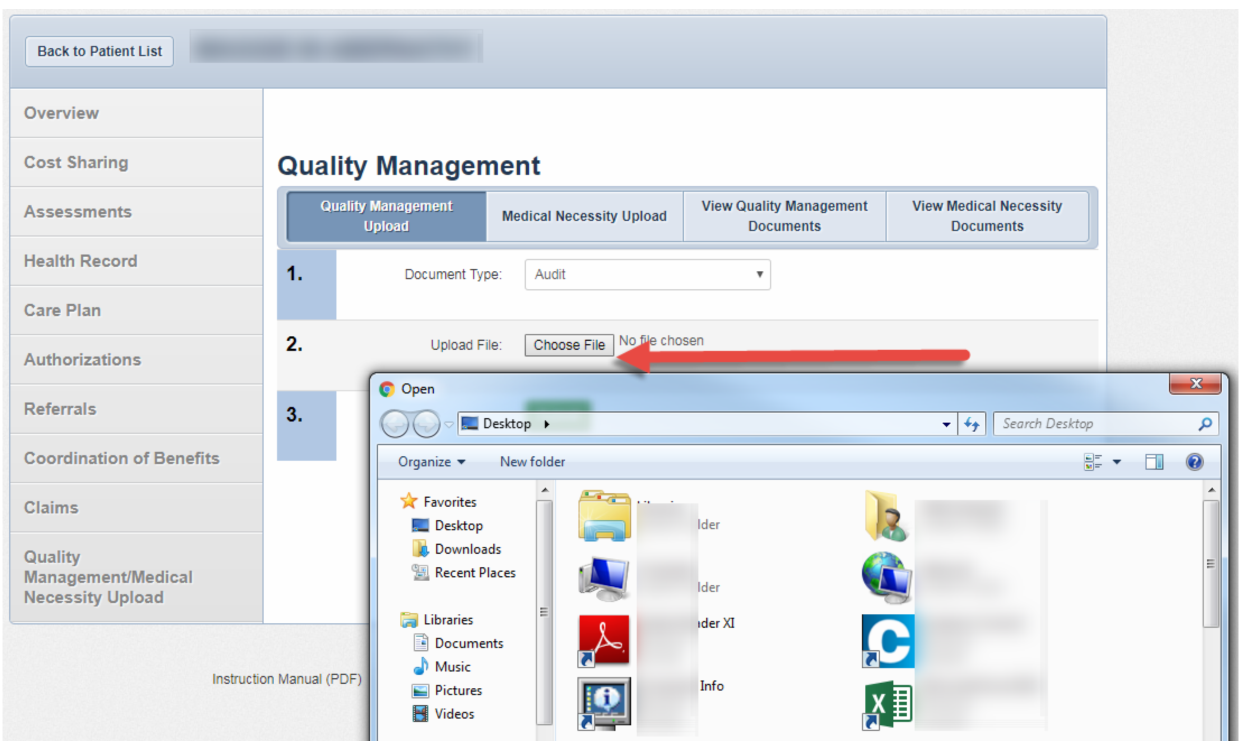
3. To Upload a Quality Management Document, click on **Quality Management Upload**



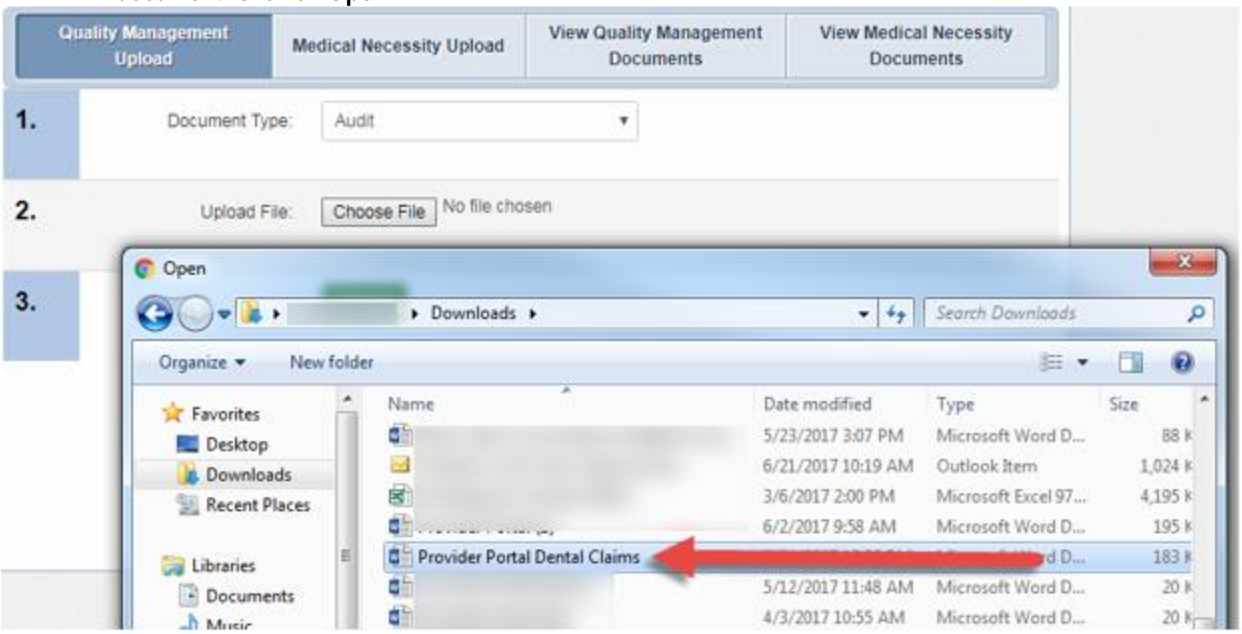
4. Click Document Type and select the category for documentation



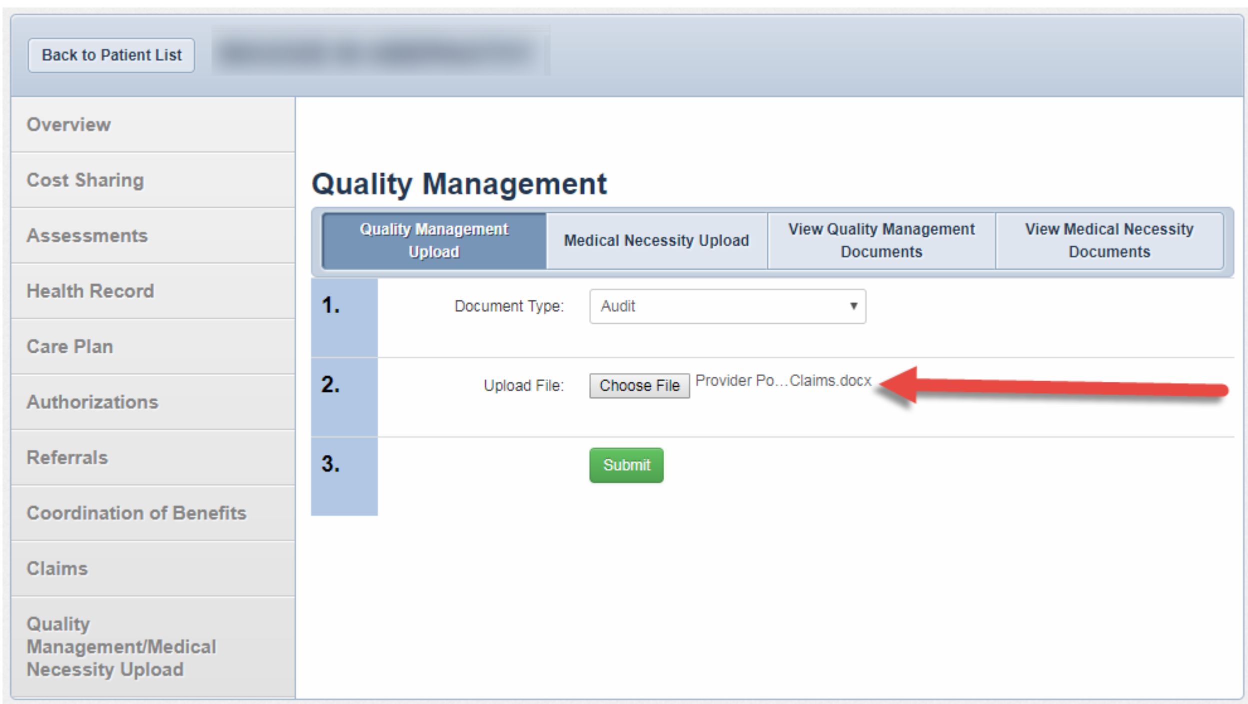
5. Click on Browse to open available documents



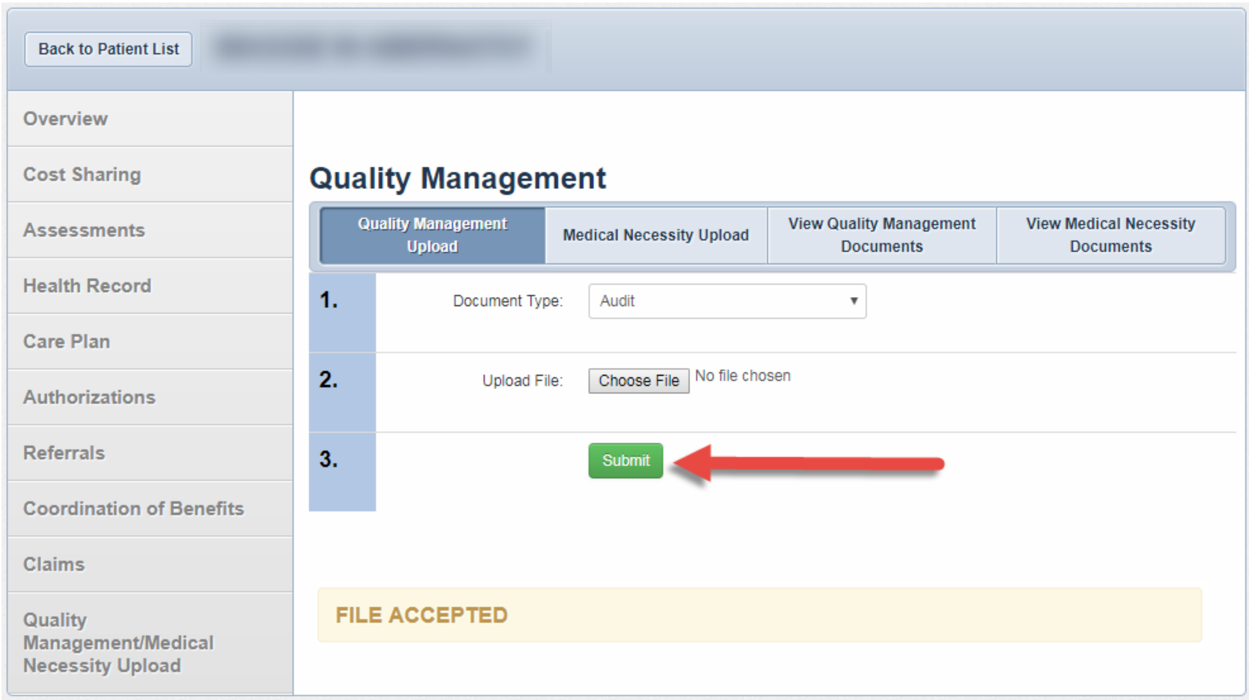
6. Highlight the document to be uploaded and the name will appear in the **File Name** field at the bottom of the document. Click on **Open**.



7. The document will appear in the browse window

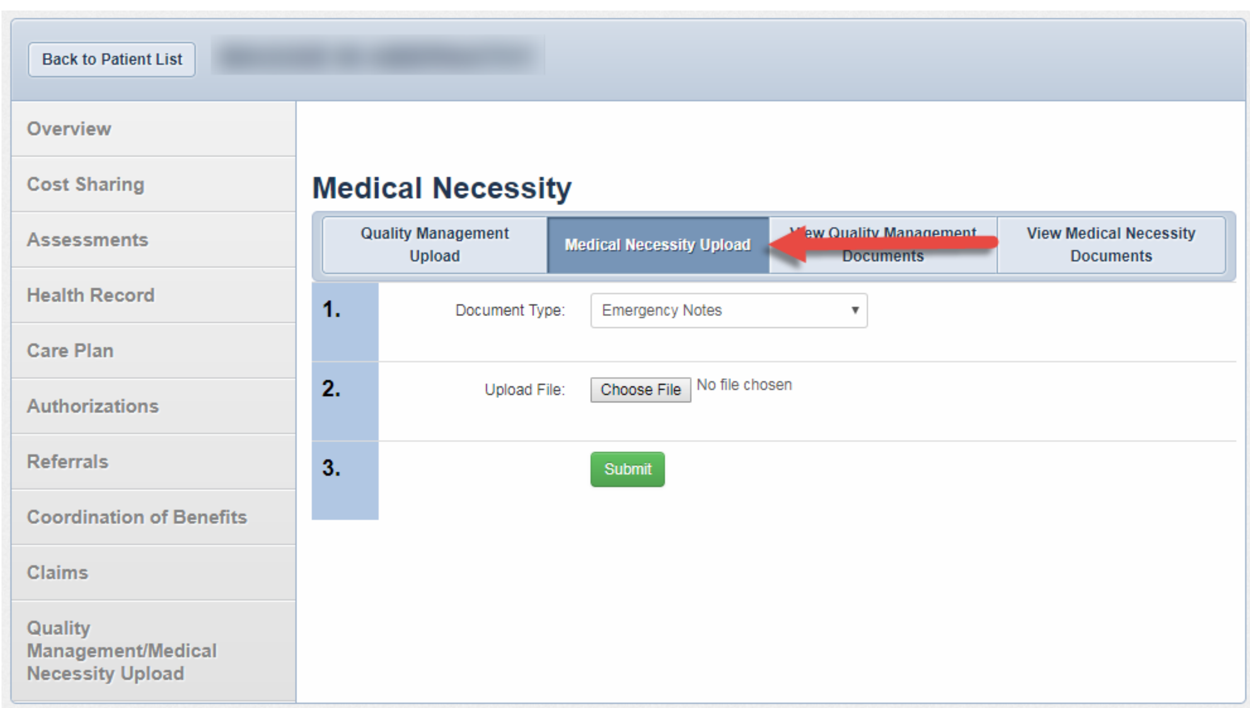


8. Click **Submit.** File Accepted will appear with a success

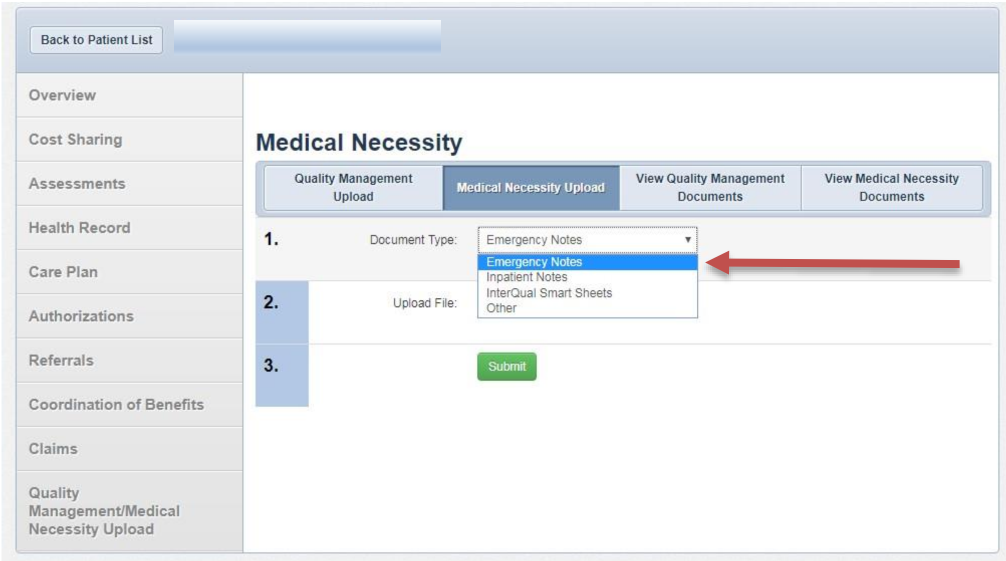


To Upload a Medical Necessity Document for a member's record

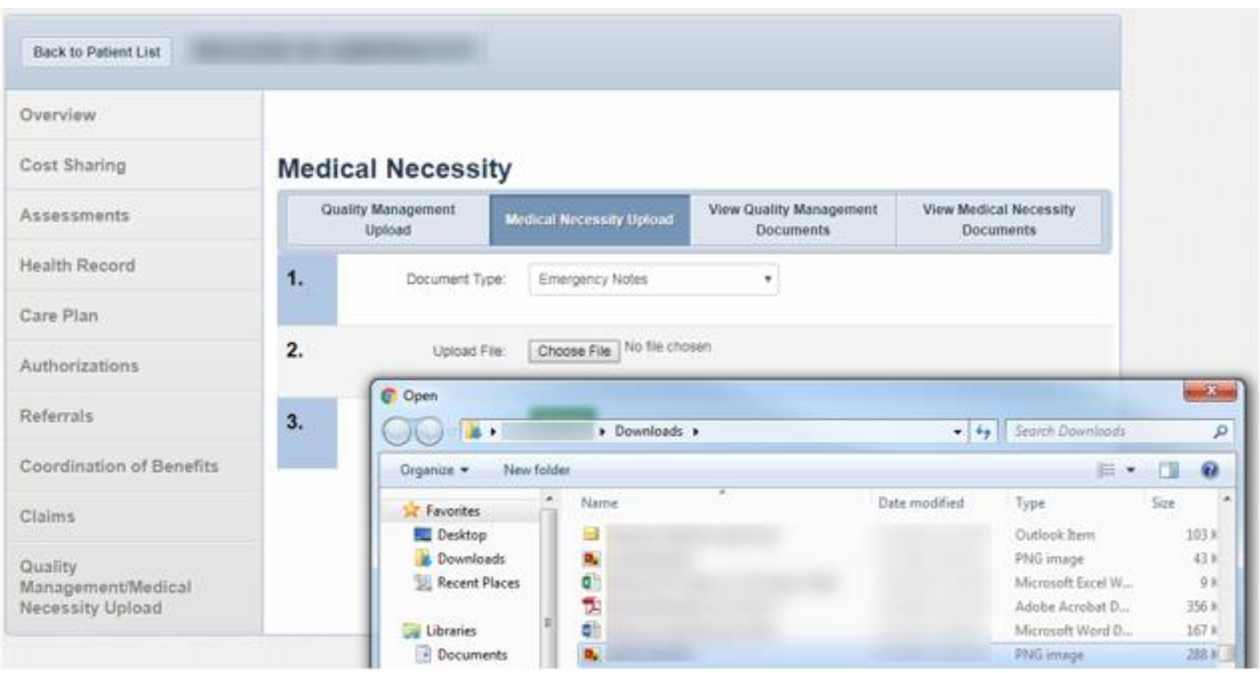
1. Click on Medical Necessity Upload



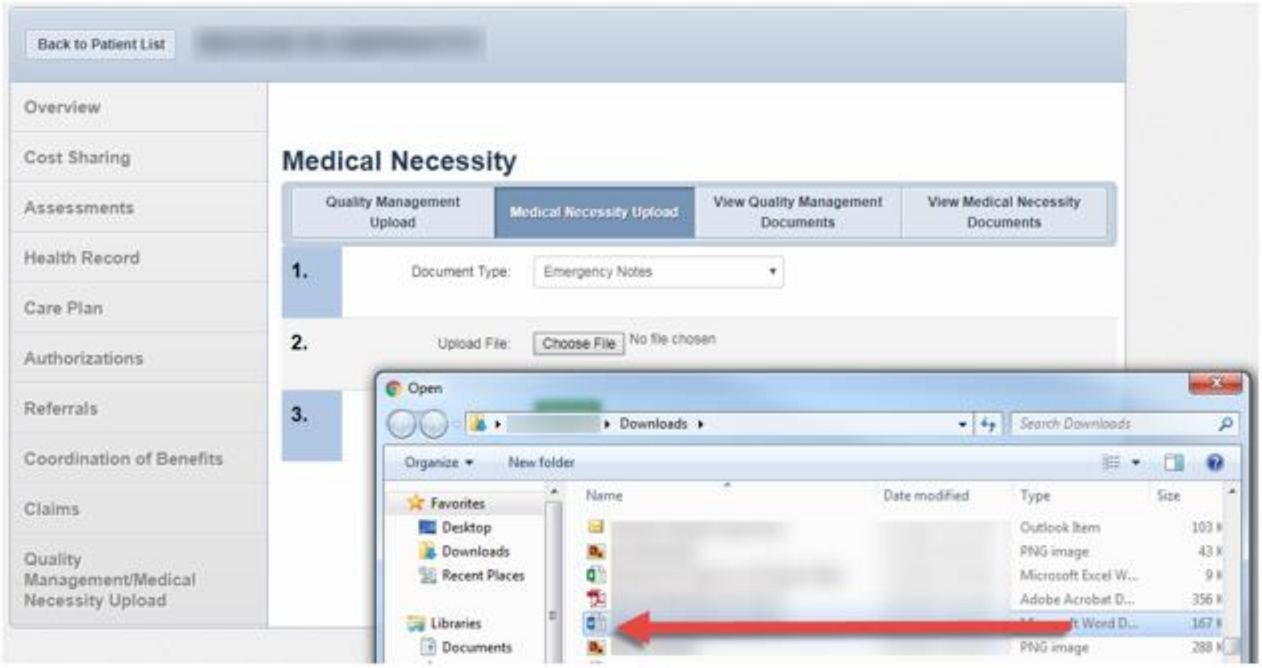
2. Click Document Type and select the category for documentation



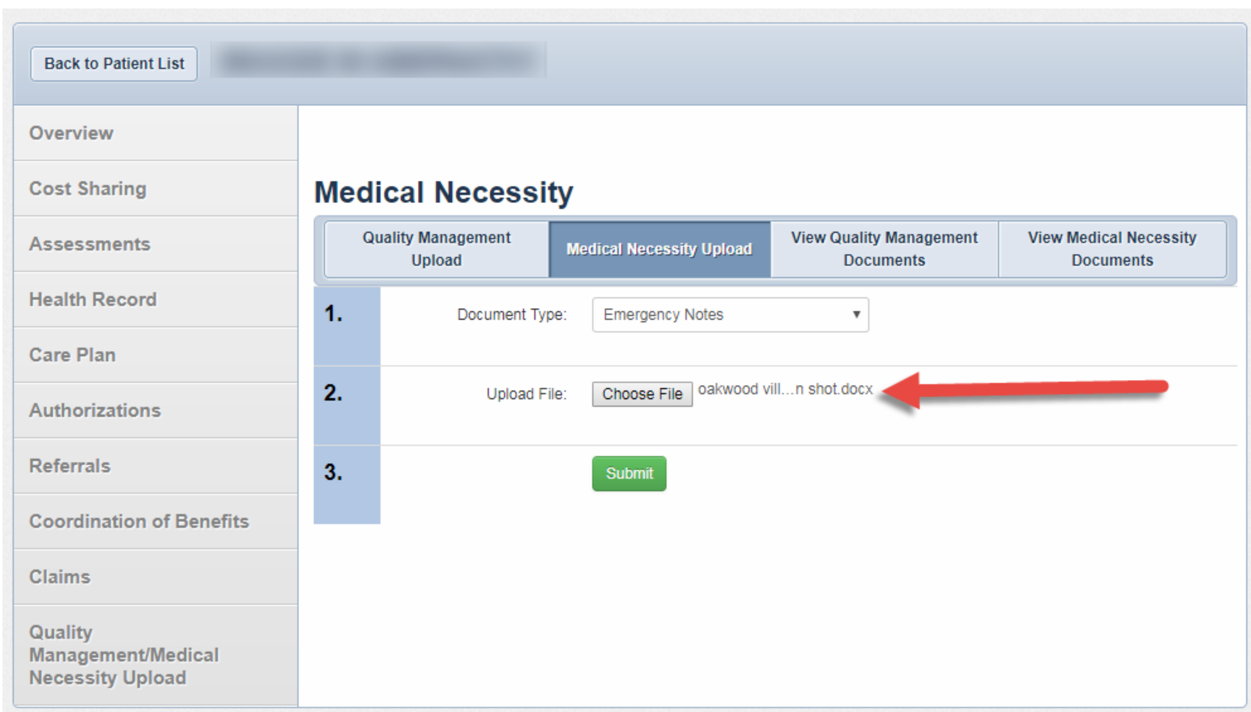
3. Click on Browse to open available documents



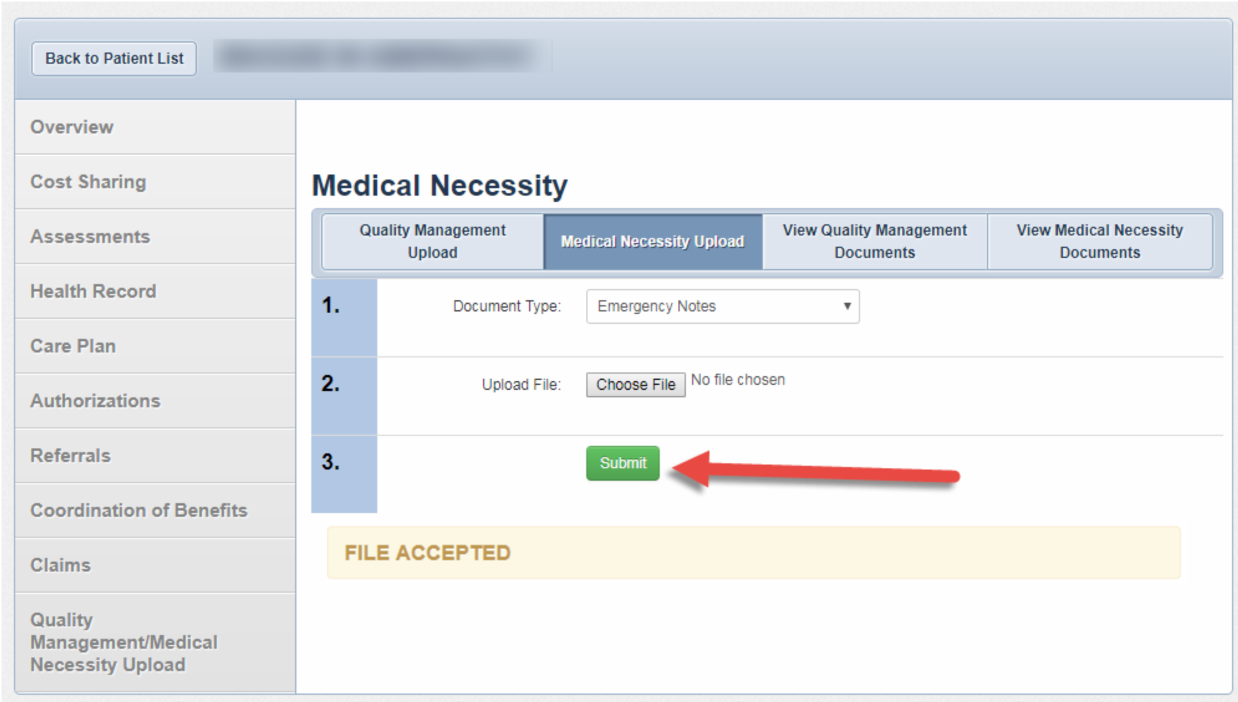
4. Highlight the document to be uploaded and the name will appear in the **File Name** field at the bottom of the document. Click on **Open**.



5. The document will appear in the browse window

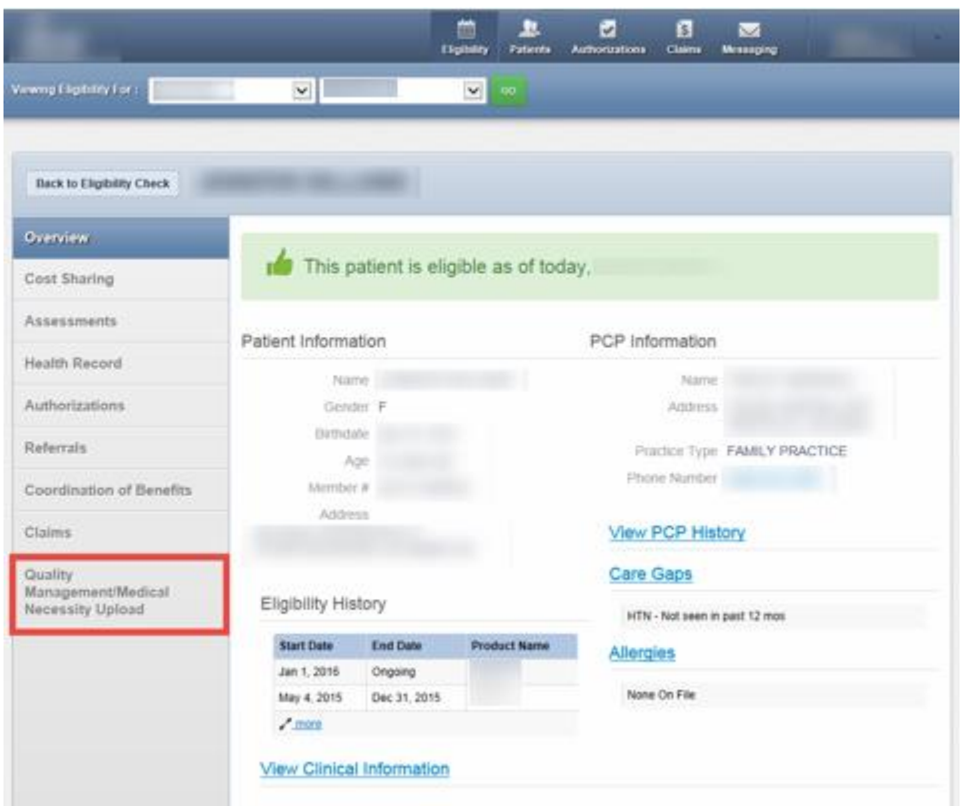


6. Click **Submit.** File Accepted will appear with a success

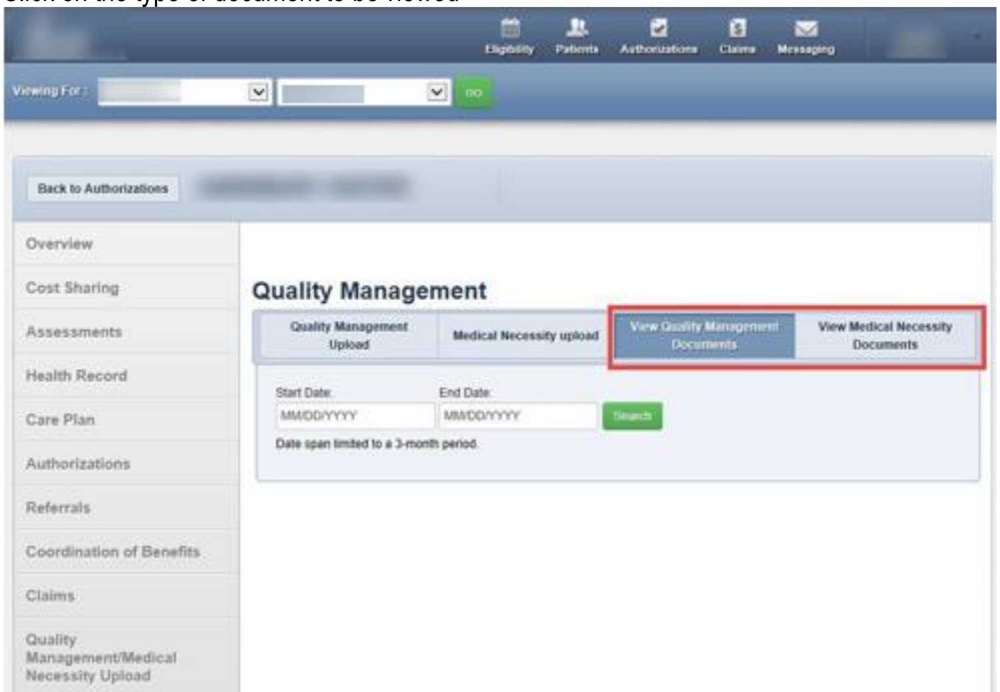


To View Uploaded Documents for Quality Management / Medical Necessity Upload

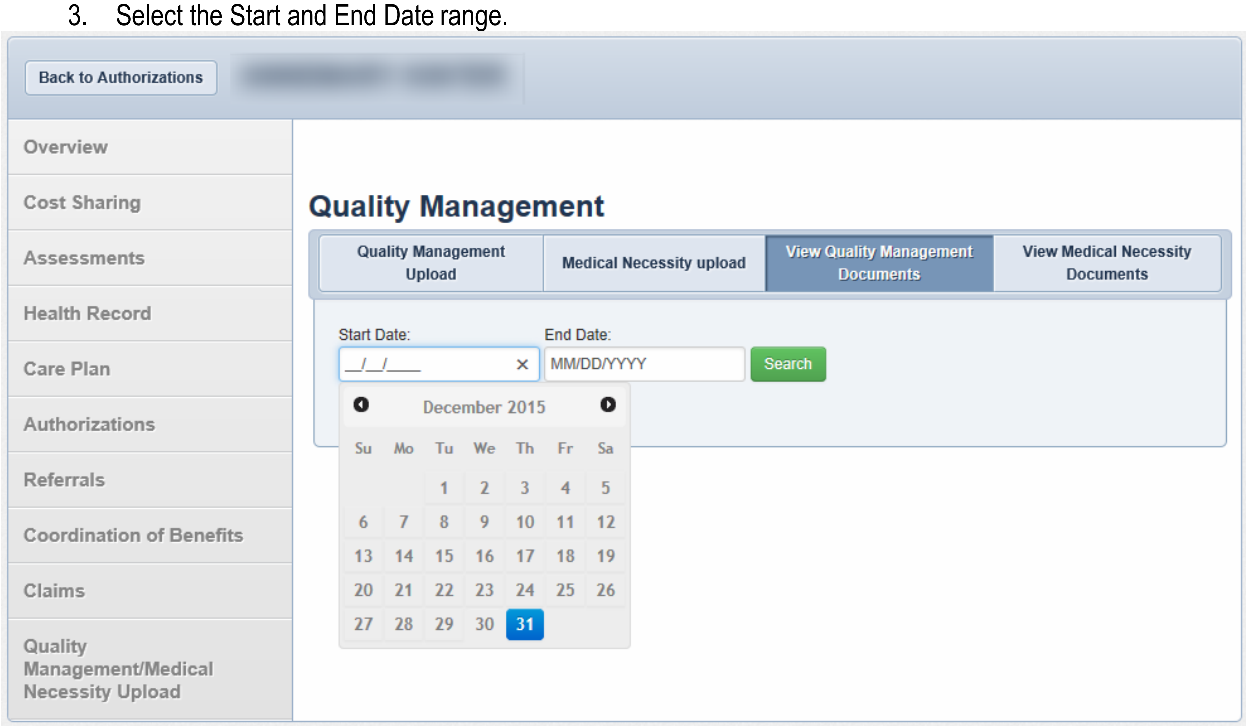
1. From the member's record, select Quality Management/Medical Necessity Upload



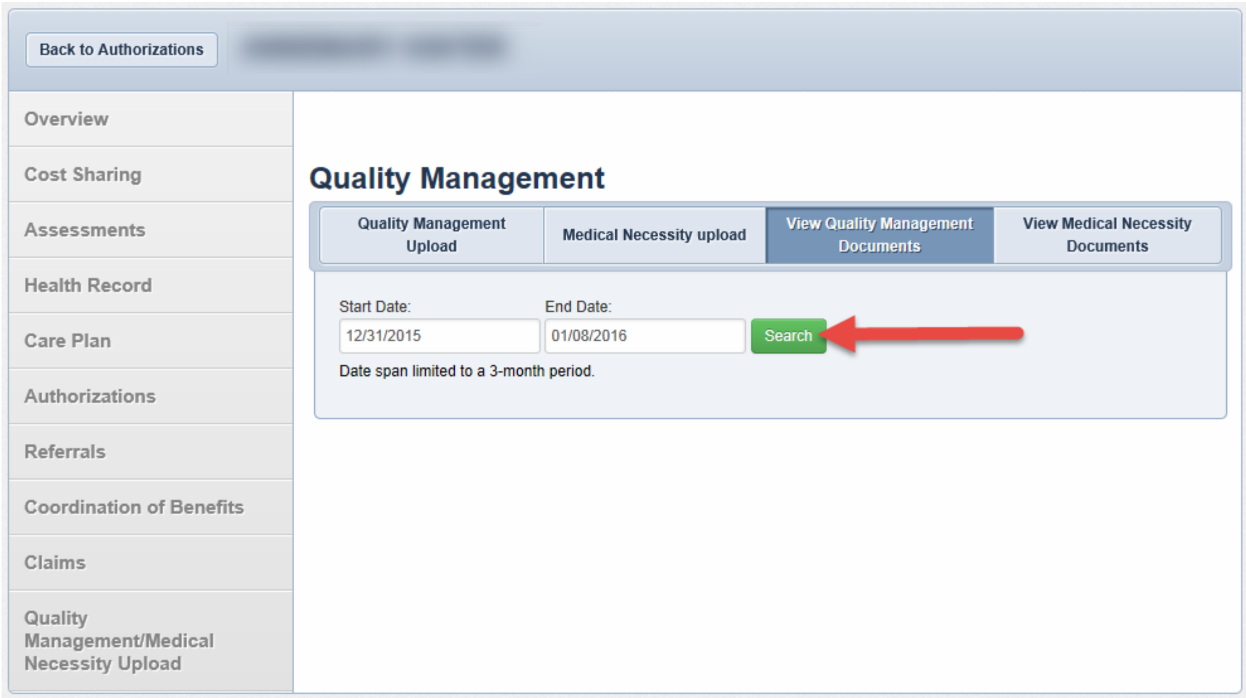
2. Click on the type of document to be viewed



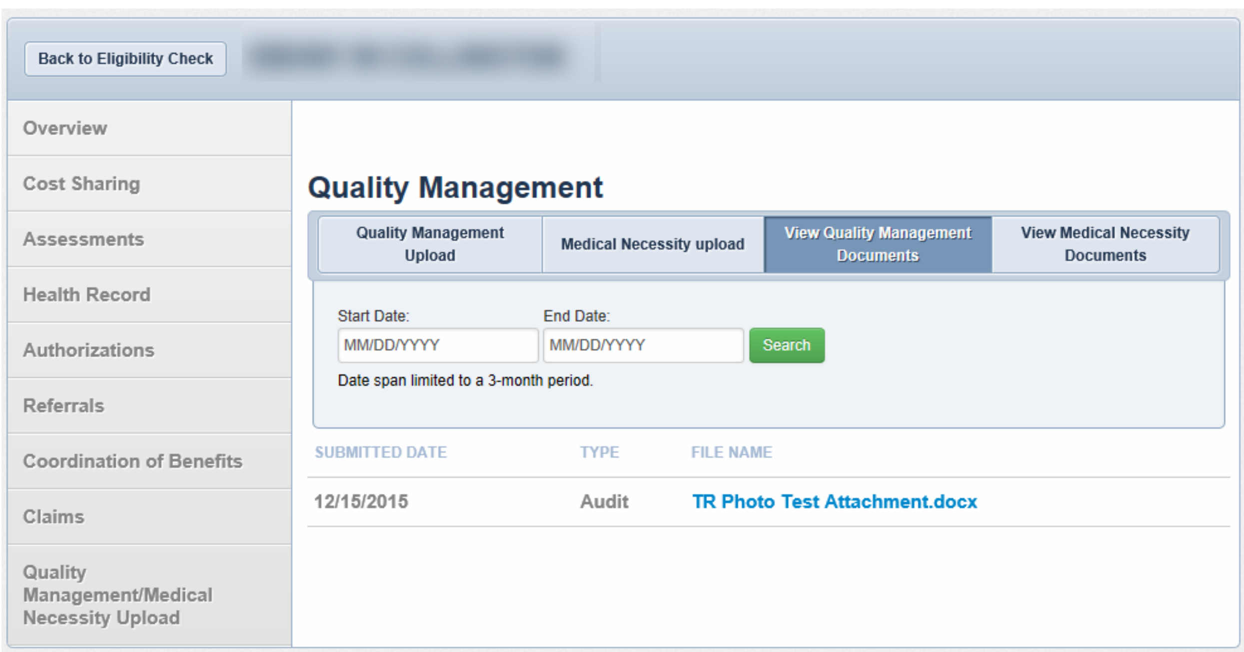
3. Select the Start and End Date range.



4. Click Search to display any documents submitted for that member

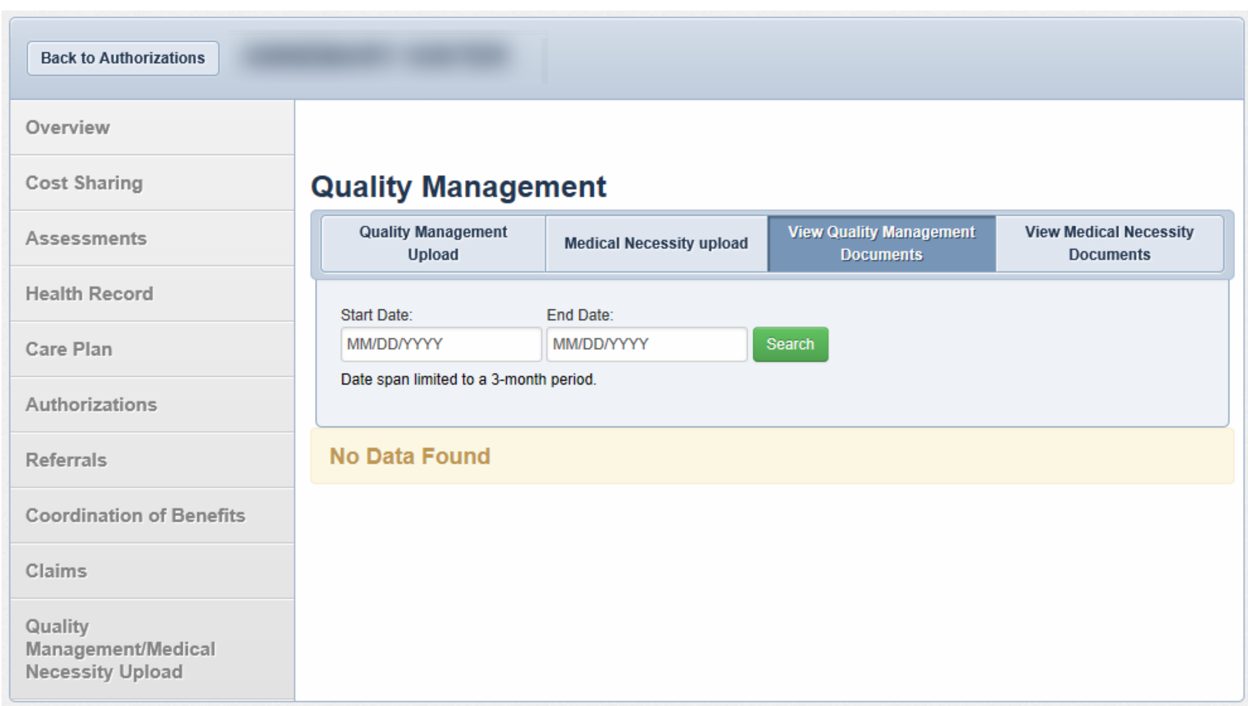


5. If documents are available, the list will display



6. Click on the name of the document to open and review

7. If there are not any documents to view, a message will appear.

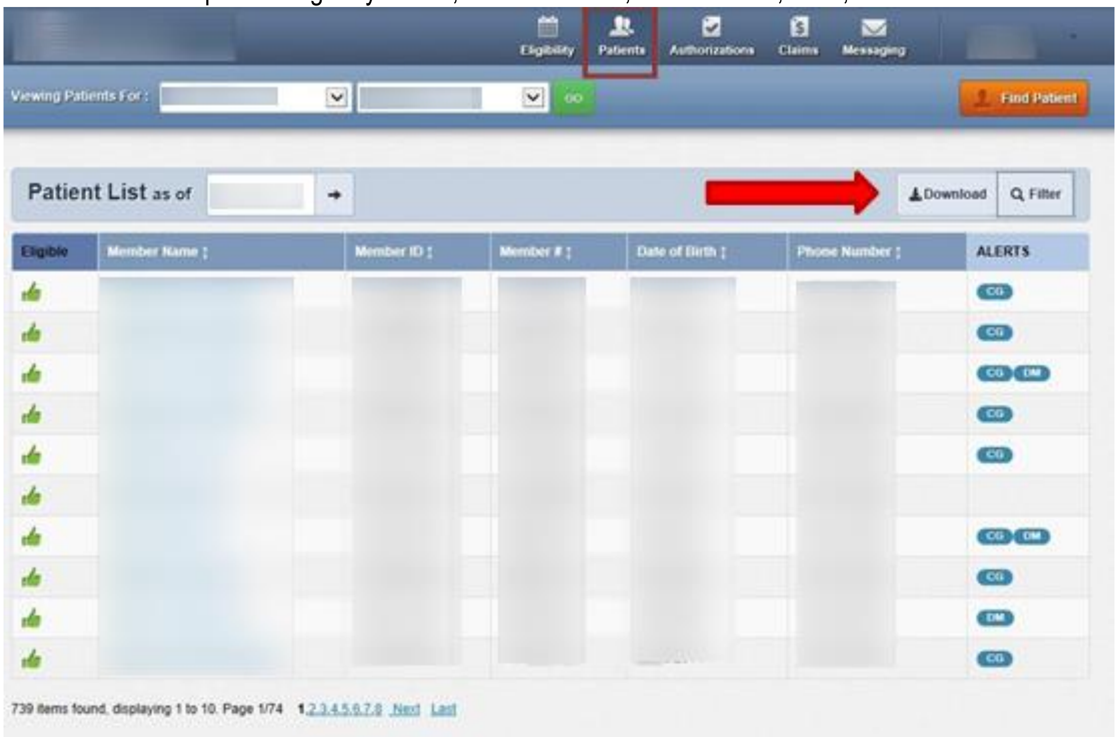


Patient List

To view, and download a patient list from the Dashboard (available for PCP's/PMP only)

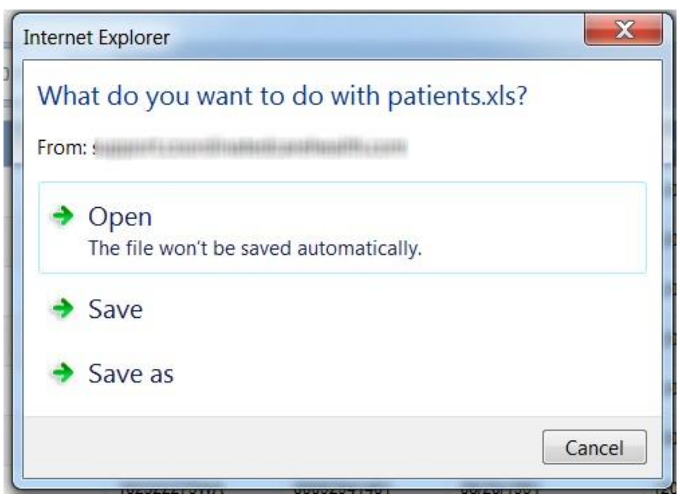
1. Click **Patients**
2. The Patient List appears

This view shows patient Eligibility Status, Member Name, Member ID #, DOB, Phone Number and Alerts



Downloading the Patient List

1. Click the Download Button

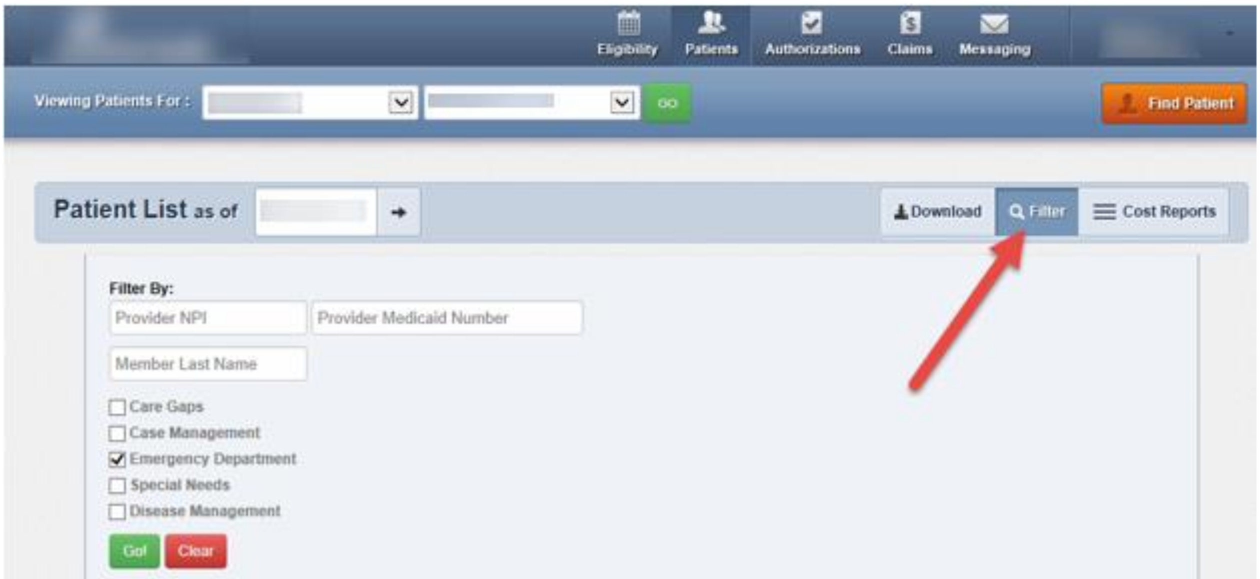


Note: A copy of the patient list in an Excel format will download.

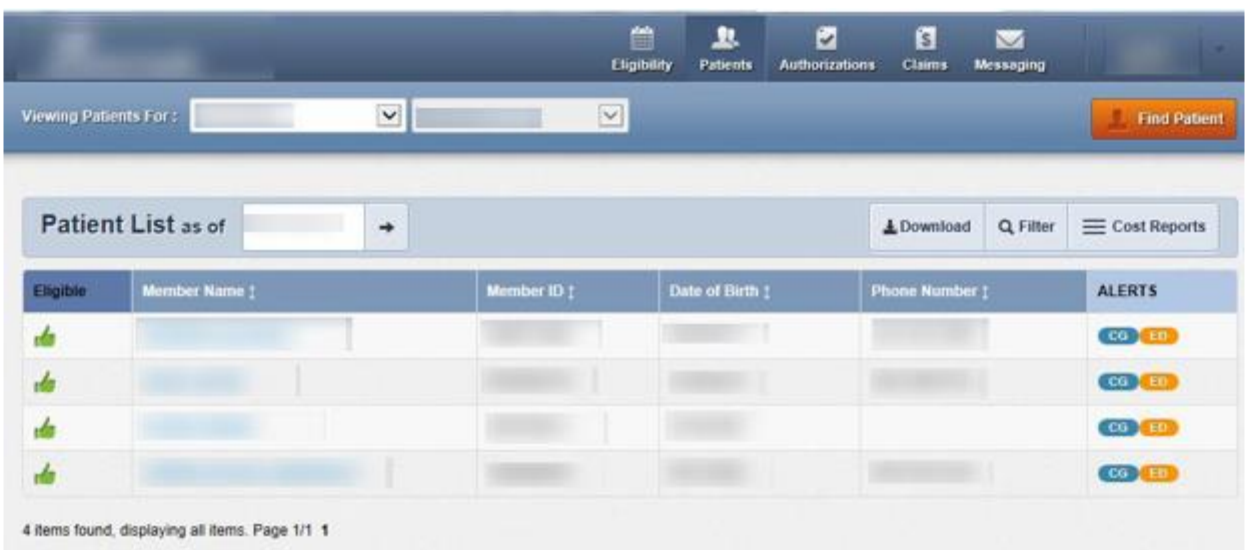
Filter the Patient List

To filter the patient list

1. Click **Filter**
2. Multiple filters can be applied for based on the Provider's NPI, Medicaid Number, Specific Member's Last Name or Specific Alert.
3. Click **Go**



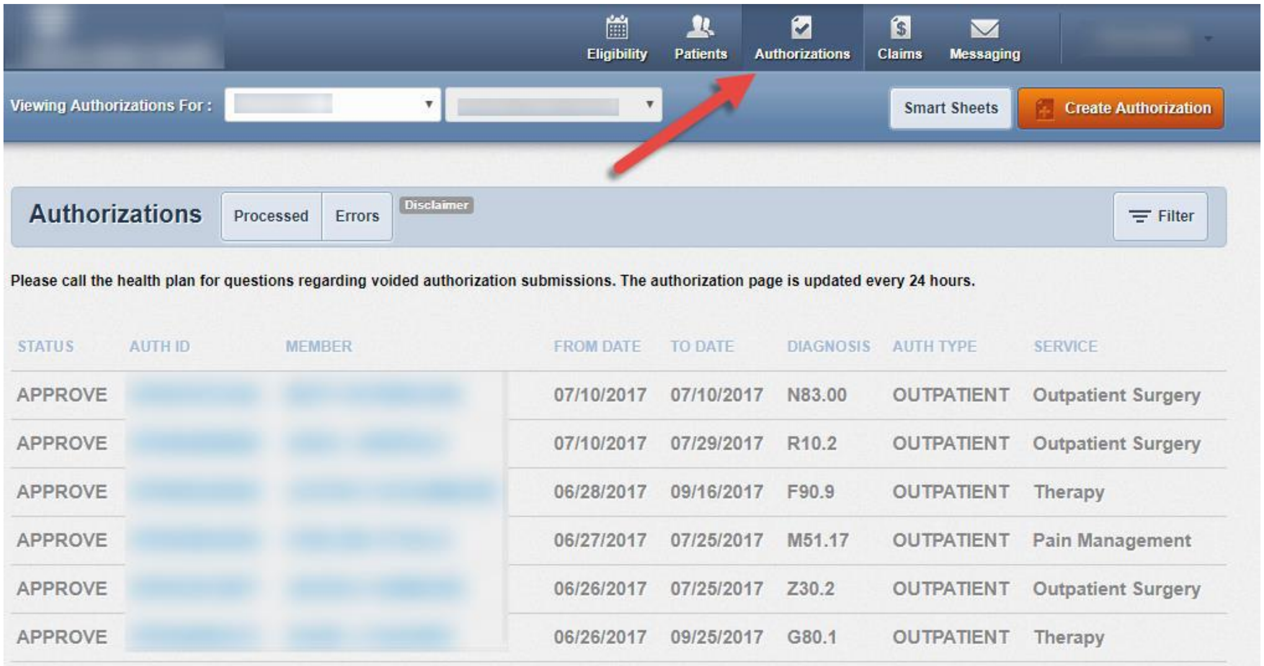
The following screen will appear:



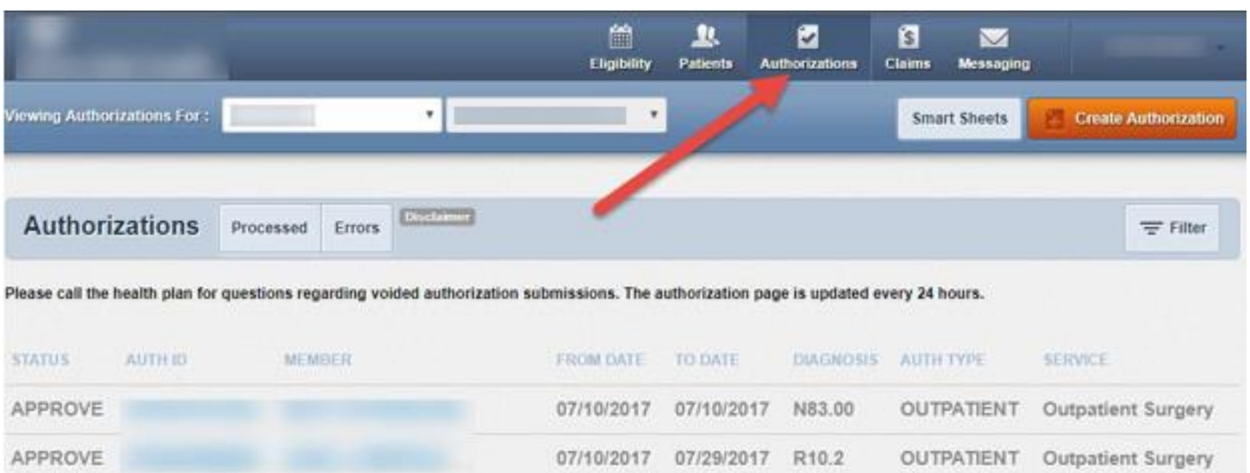
View Authorizations by TIN

1. Select **Authorization**
2. Authorizations will appear for that specific TIN and Product

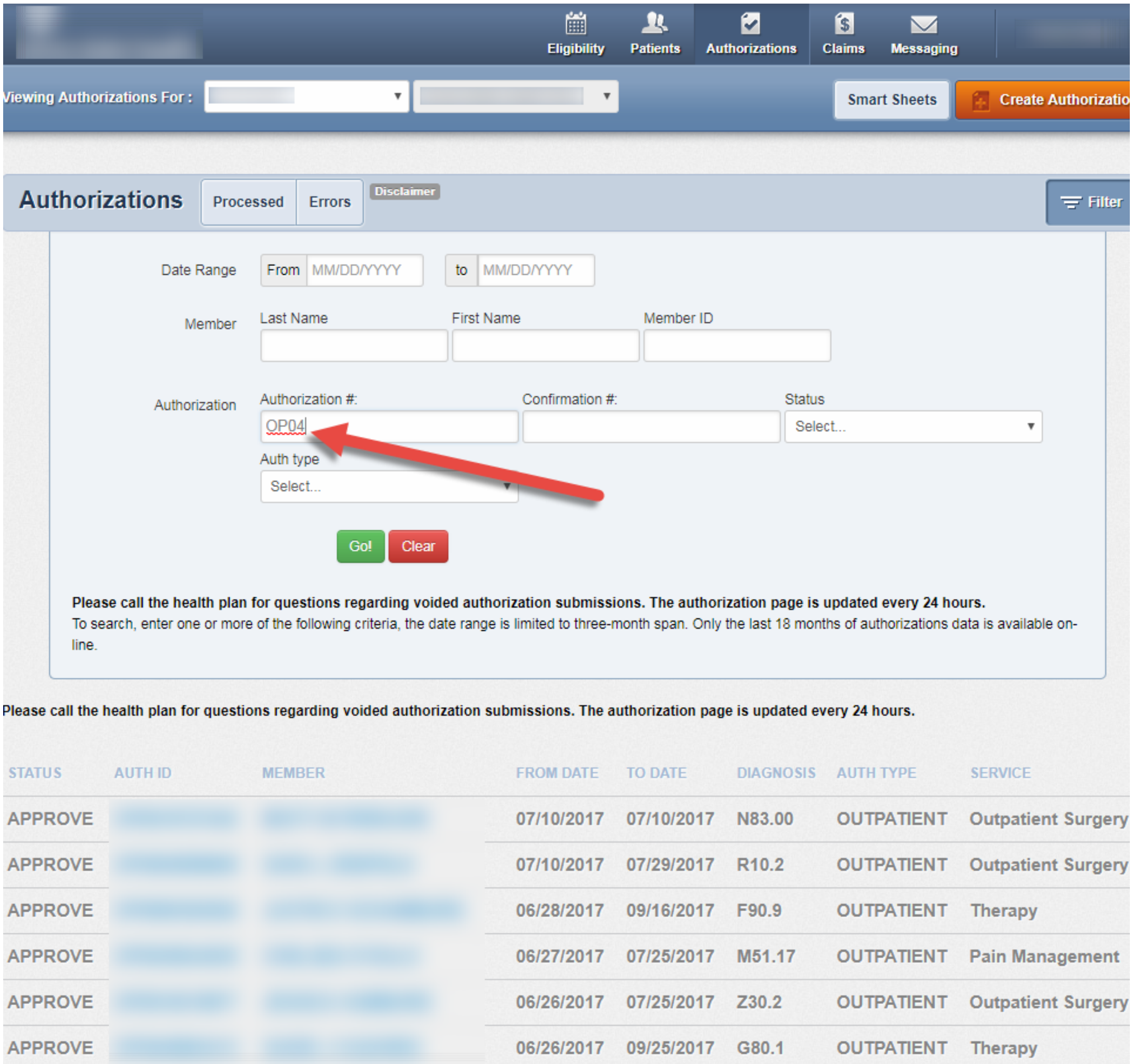
Prior authorization requests may take 24-48 hours to display on the authorization list. The authorizations will display for 90 days.



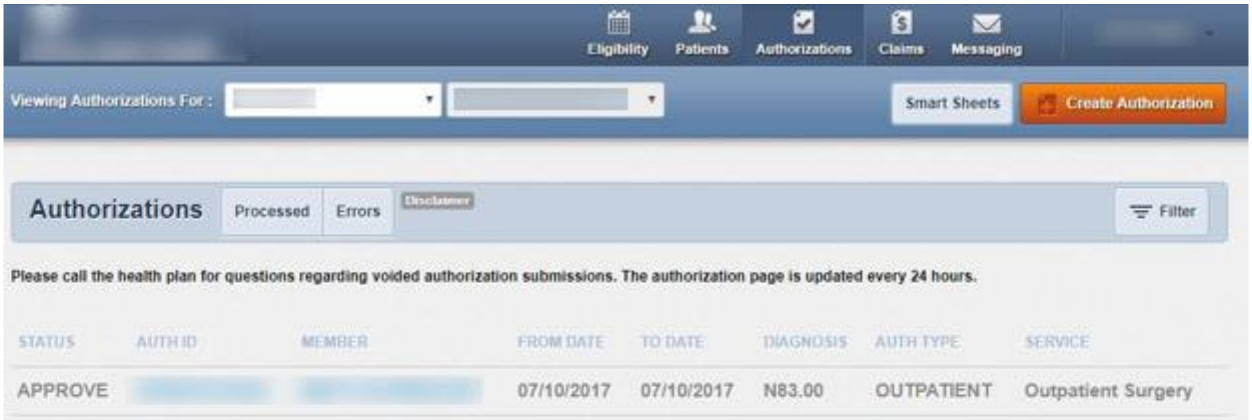
3. **Searching for Specific Authorization or Authorization #**



1. Click **Authorizations**
2. Enter the Authorization # in the free text filter box.
3. Click **Go**

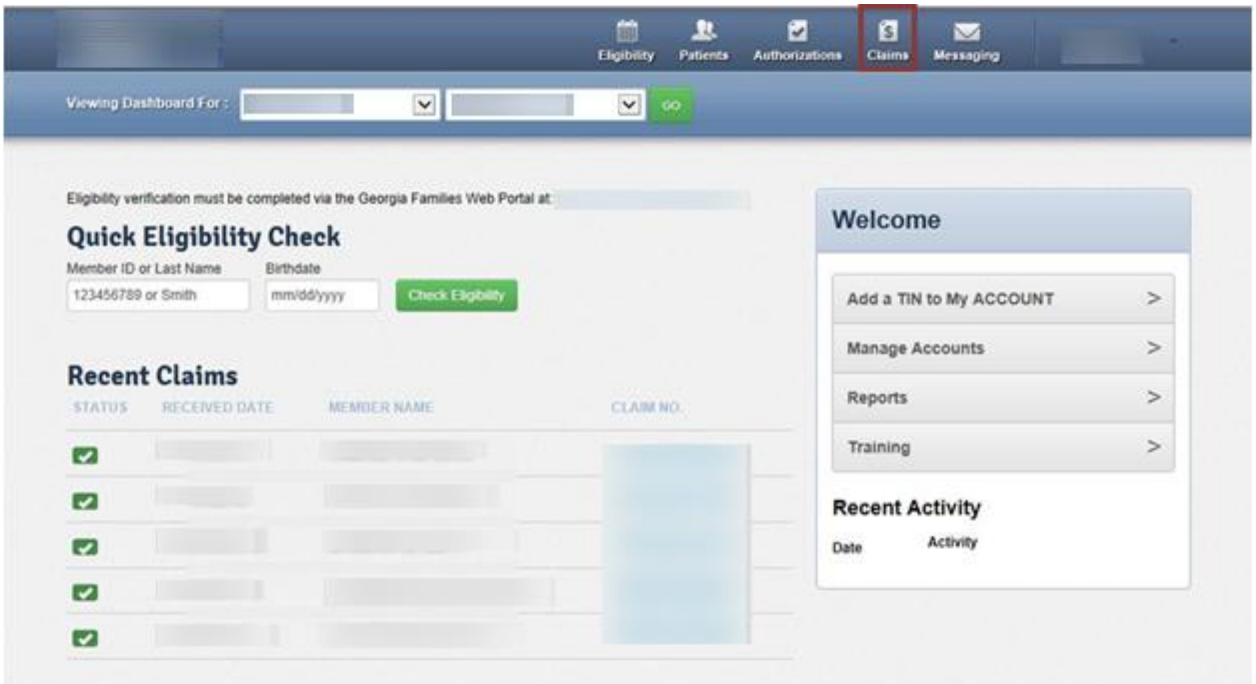


1. The specific authorization will appear.

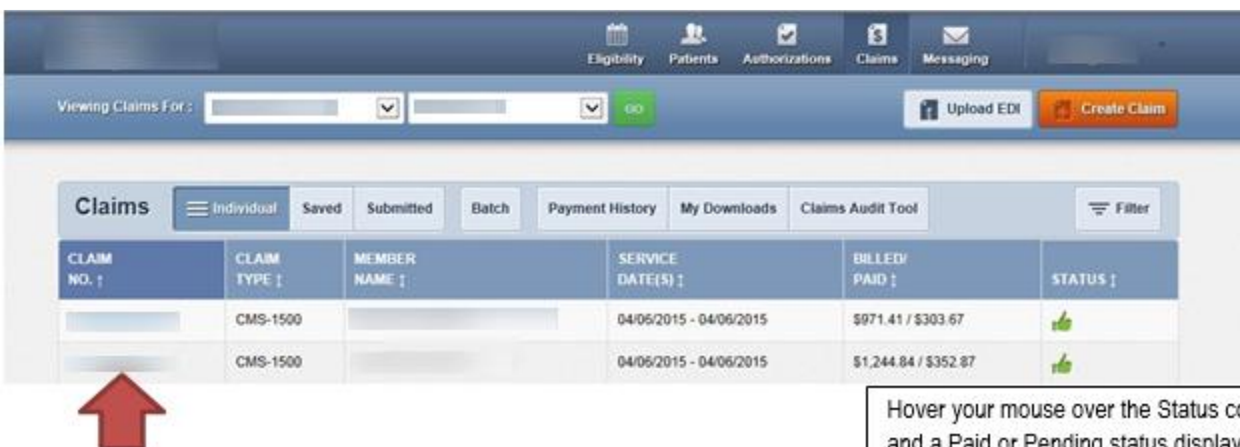


Viewing Claims:

1. Click **Claims** at the top of the dashboard.



2. Select **Individual**.



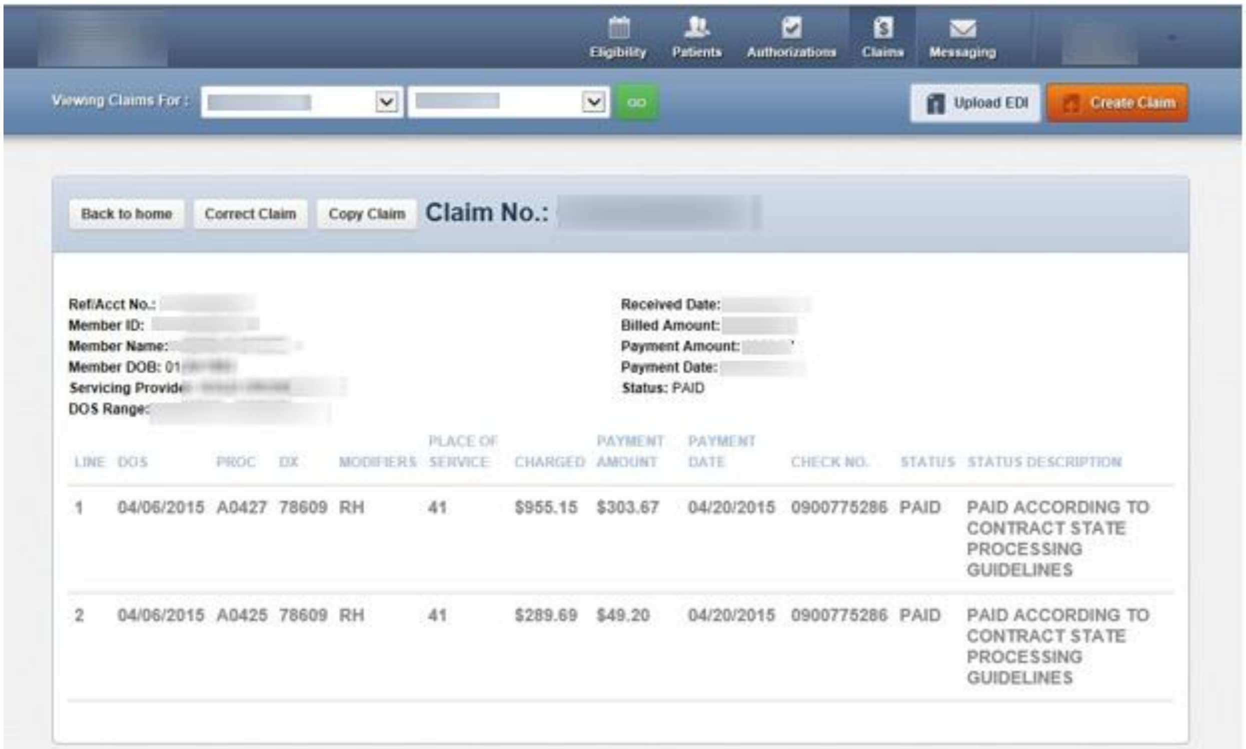
Hover your mouse over the Status column and a Paid or Pending status displays.

3. A list of individual claims appears and will display the following information:
   - Claim Number
   - Service Date
   - Member Name
   - Amounts Billed/Paid
   - Status

To view the details of the Individual claim

1. Click the blue **Claim Number** to open the claim.

The following screen appears:



Note: The Claim Details appear allowing you to see which services were covered and which were denied. You can view the payment amount and payment date, along with check number.

Correct Claim

To correct a claim

1. Click **Correct Claim**

.

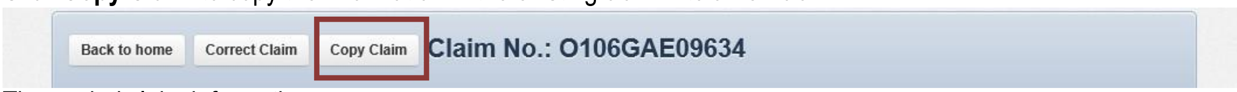
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information
5. Click **Submit**.

NOTE: Claim Corrections are not available if the provider data on the first submission is different than the corrected claim submission.

Copy Claim

To copy an existing claim:

1. Click **Copy Claim** to copy the information in the existing claim into a new claim.



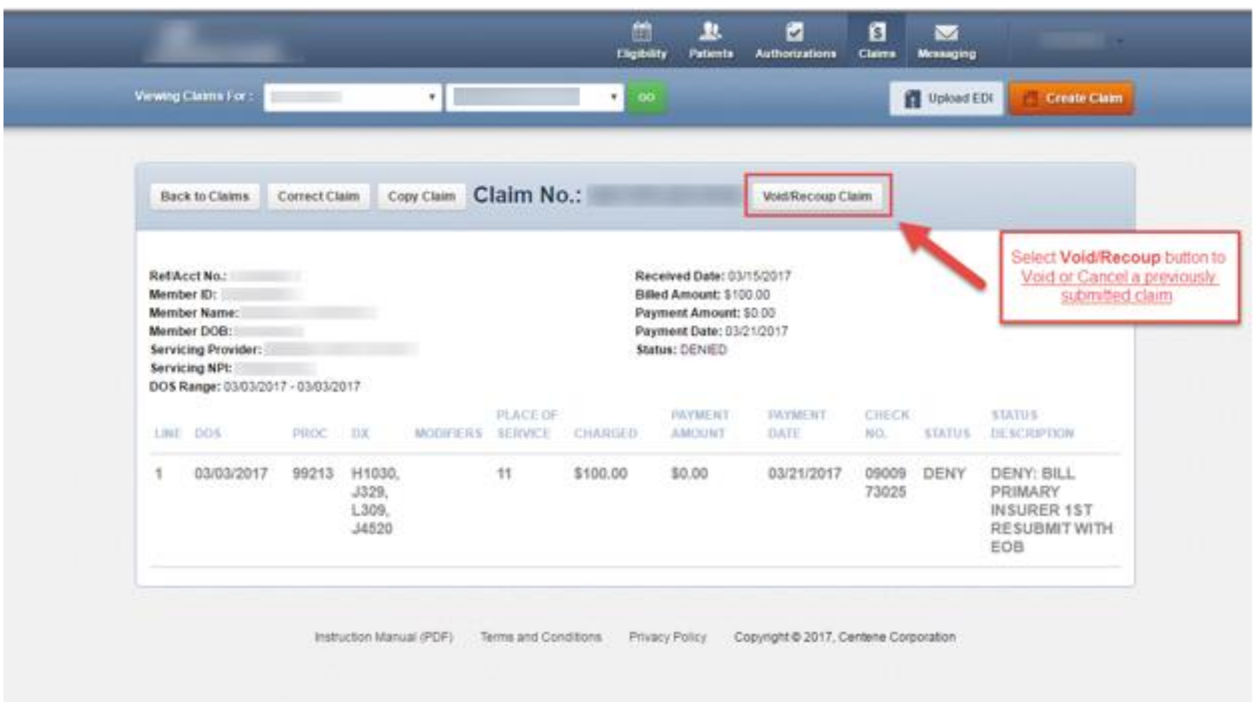
2. The copied claim information appears.
3. Proceed through the claims screens updating any information that may differ.
4. Click **Next** to move through the screens.
5. Review your claim
6. Click **Submit**.

<u>Void/Recoup Button (if applicable)</u>

<u>Void/Recoup claims are utilized when a user wants to void an original claim that has already been processed, and request a full recoupment of payment.</u>

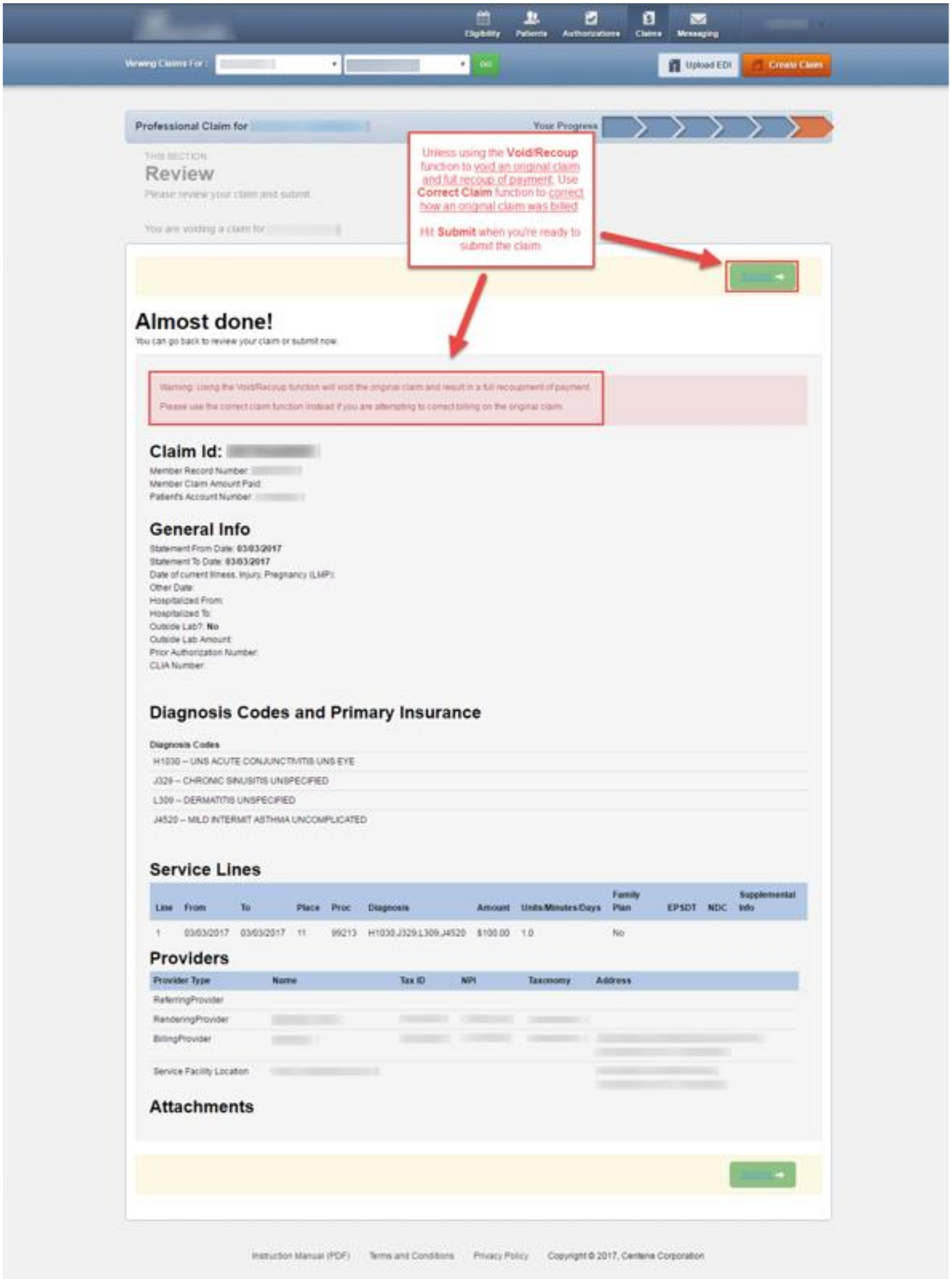
<u>*Please be advised, unless you are using the Void/Recoup function to void an original claim and full recoup of payment; the Correct Claim function should be used to correct how an original claim was submitted.</u>

1. Select Void/Recoup button to Void or Cancel a previously submitted claim.



HCFA 1500 claim example

Review appropriate claim information to be voided, and click Submit.



UB-04 claim example

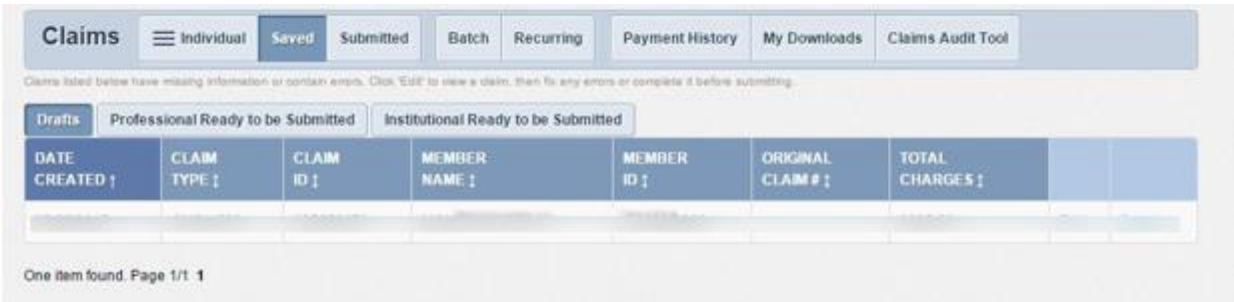
Review appropriate claim information to be voided, and click Submit.

Saved Claims

To view saved claims: Drafts, Professional or Institutional

1. Select **Saved**.

The following screen appears:



- **Drafts -** are those that have missing information or contain errors and have not been completed.
- **Professional Ready to be Submitted -** are claims that have been completed but not submitted
- **Institutional Ready to be Submitted** - are claims that have been completed but not submitted

2. Click **Edit** to view a claim
3. Fix any errors or complete it before submitting.
   OR
4. Click **Delete** to delete a saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.

Submitted Claims

To view submitted claims

1. Select Submitted

The following screen will show those claims created via the portal only

Batch **Claims**

To Submit Batch claims:

1. Select **Batch**
   The following screen appears:

2. To upload a batch of claims, click the **Upload EDI** button.
3. On the Batch Claims Upload screen, select the File Type of either **837I** or **837P**.

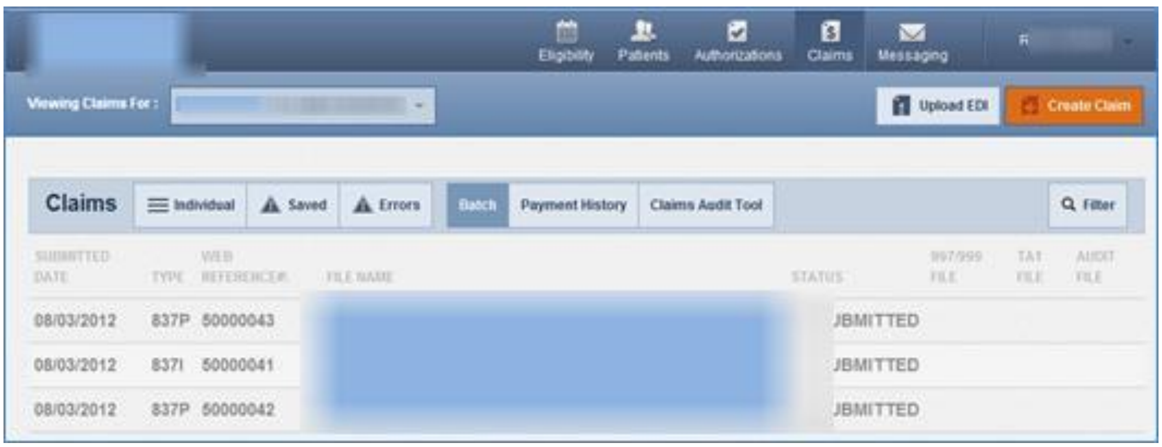
Note: For an Institutional Claims batch upload select 837I, for a Professional Claims batch upload select 837P.

4. Browse and **Attach** your batch claims file to upload. Be sure to check your codes before you click **Submit**.
   Note: On the batch claims upload screen, companion guides and a list of FAQs are provided as resources. An EDI Support telephone line and email address is provided for additional support with EDI files.
5. When a file is successfully uploaded, the Web Reference ID # is generated for your records.

To view submitted batch claims:

1. Click **Batch** to view batch claims submitted in a 3-month period.

2. Enter the information to filter your results by Start Date, End Date, Web Reference#, and Batch Claim Status. Click **Search**.



3. The submitted batch claims display showing: Submitted Date, Type, Web Reference #, File Name, and Status.

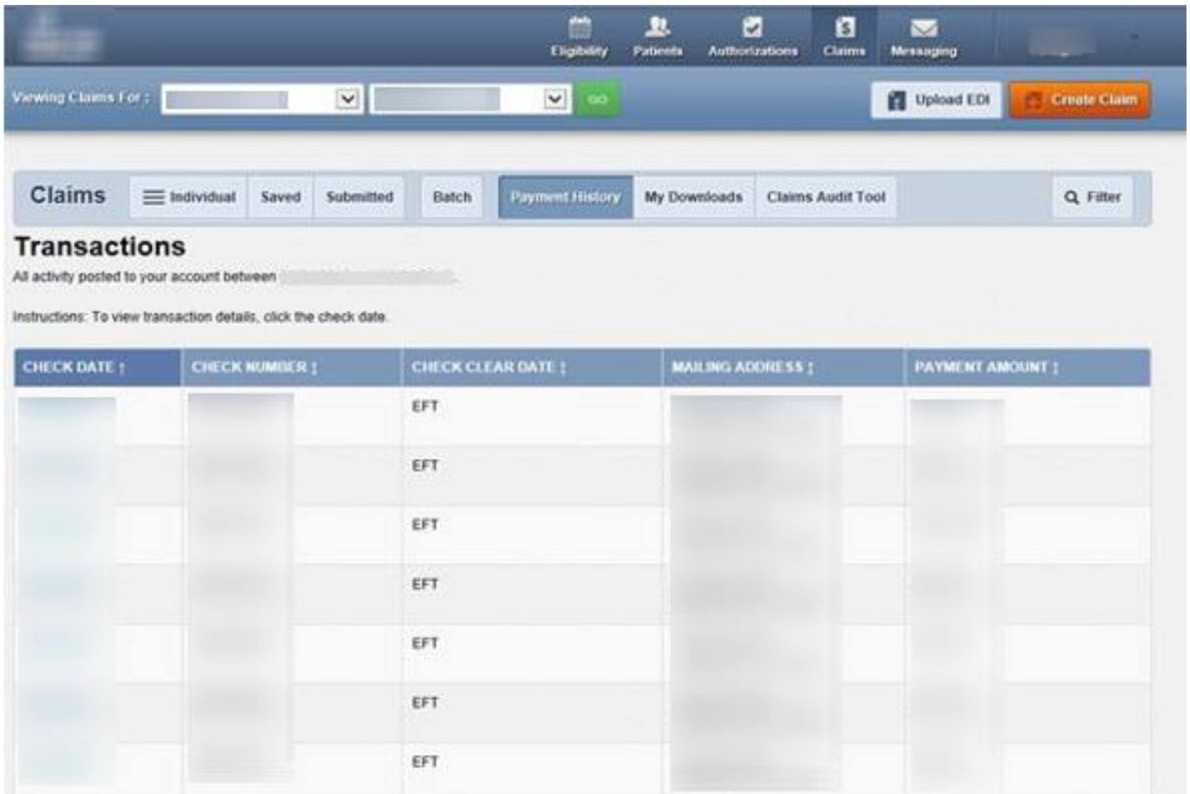
   Note: Only the last 18 months of batch claims submission history is available online. You will receive an explanation of payment (EOP) or 835 for your claims submission depending on your contract arrangement.

Payment History

To view claims payment history:

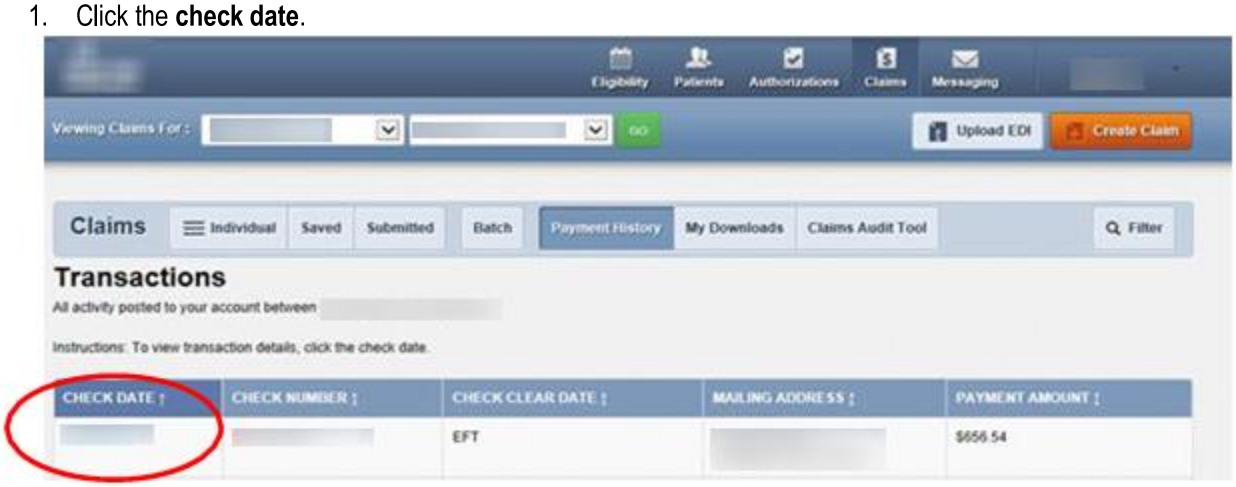
1. Click **Claims** from the Dashboard
2. Select **Payment History** to view the claims payment history.

The following screen will appear:



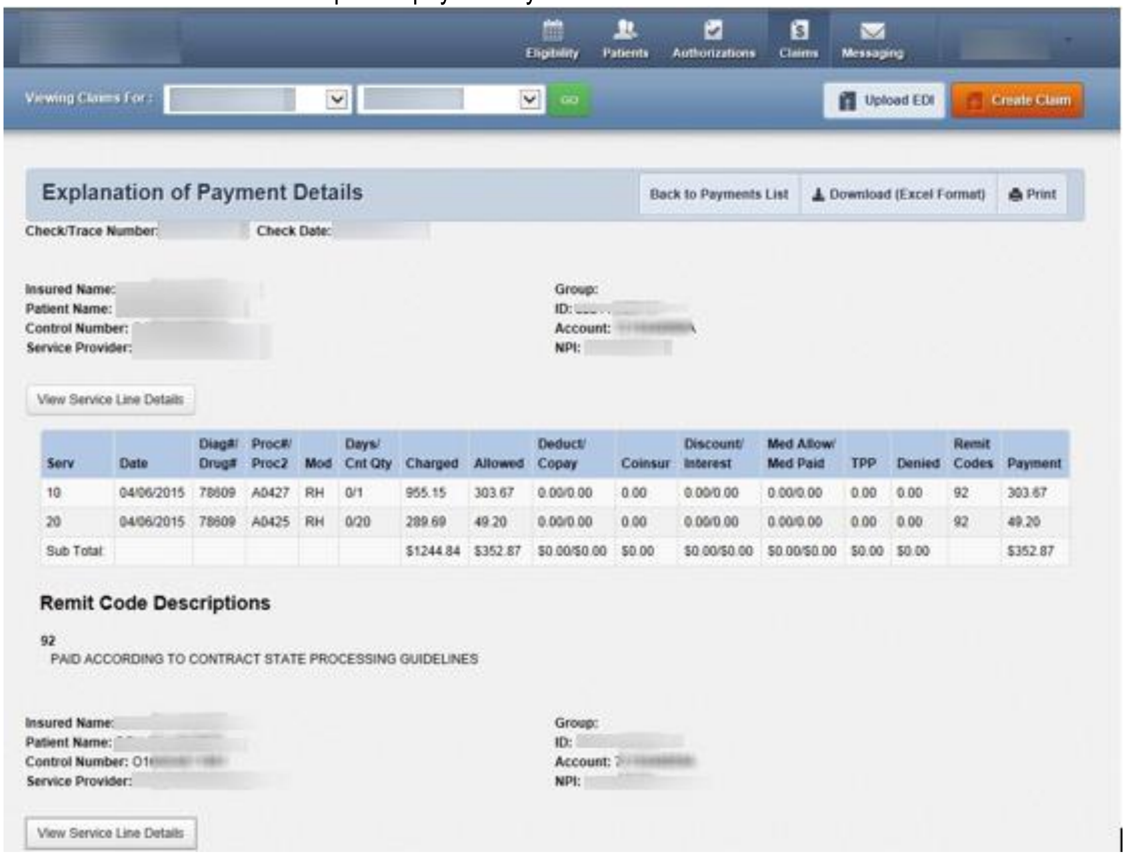
To view the Explanation of Payment details

1. Click the **check date**.



The following screen appears:

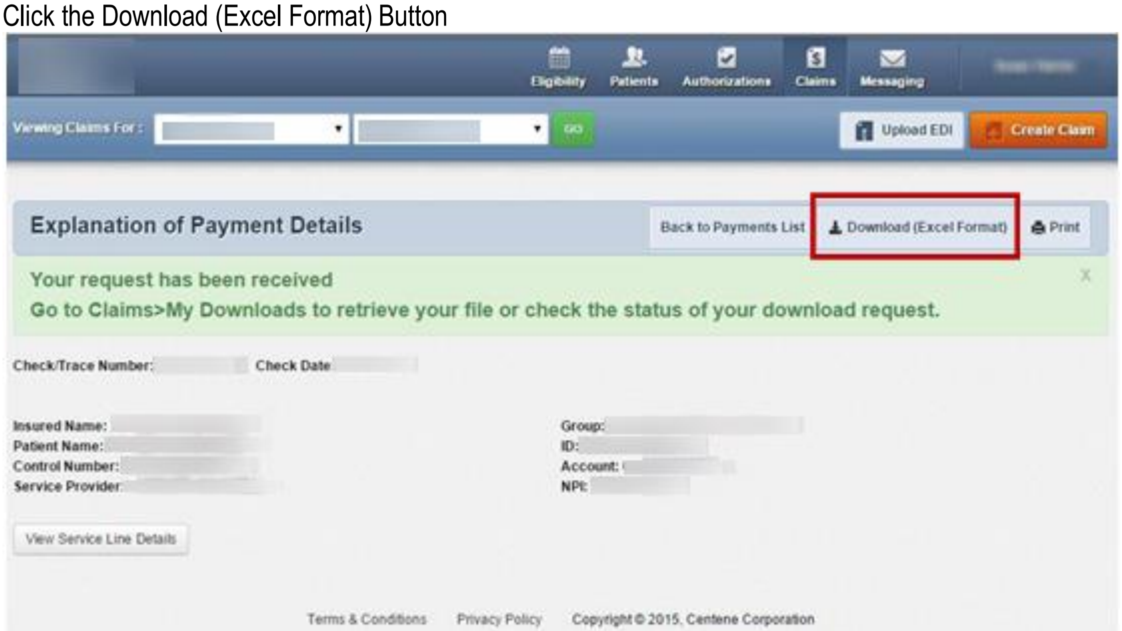
- The explanation of payment details displays the date and check number.
- This view shows each patient payment by service line detail made on the check.



Downloading an Explanation of Benefits

To download the EOP

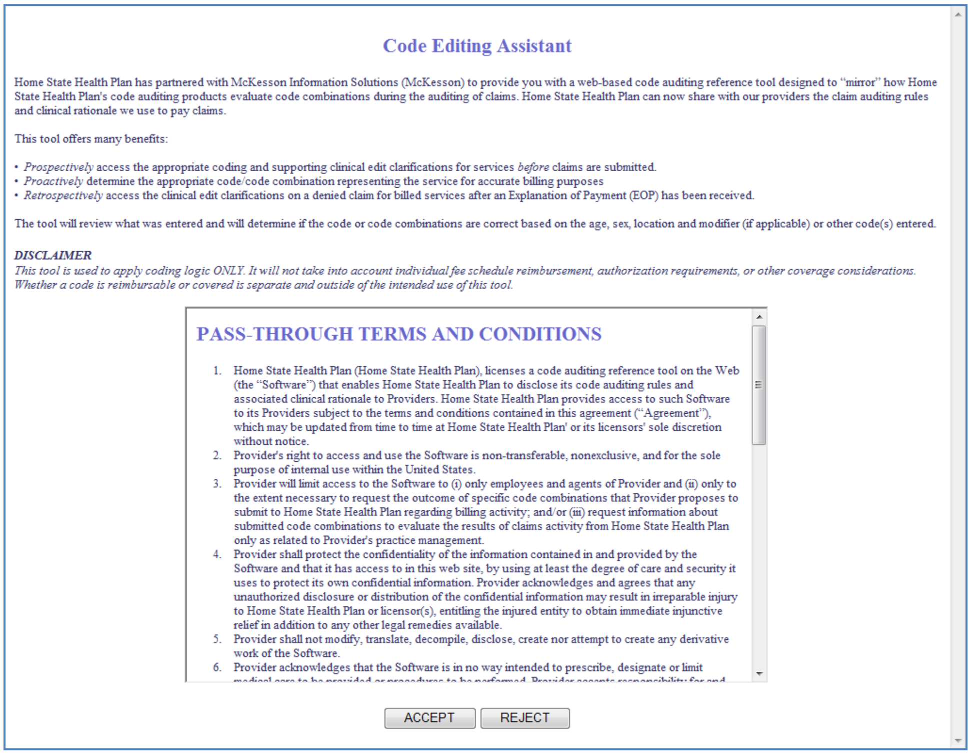
1. Click the Download (Excel Format) Button



Claims Audit Tool

To use the Claims Audit Tool

1. Select the **Claims Audit Tool**.



Code Editing Assistant

Home State Health Plan has partnered with McKesson Information Solutions (McKesson) to provide you with a web-based code auditing reference tool designed to "mirror" how Home State Health Plan's code auditing products evaluate code combinations during the auditing of claims. Home State Health Plan can now share with our providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted.
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes
- *Retrospectively* access the clinical edit clarifications on a denied claim for billed services after an Explanation of Payment (EOP) has been received.

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location and modifier (if applicable) or other code(s) entered.

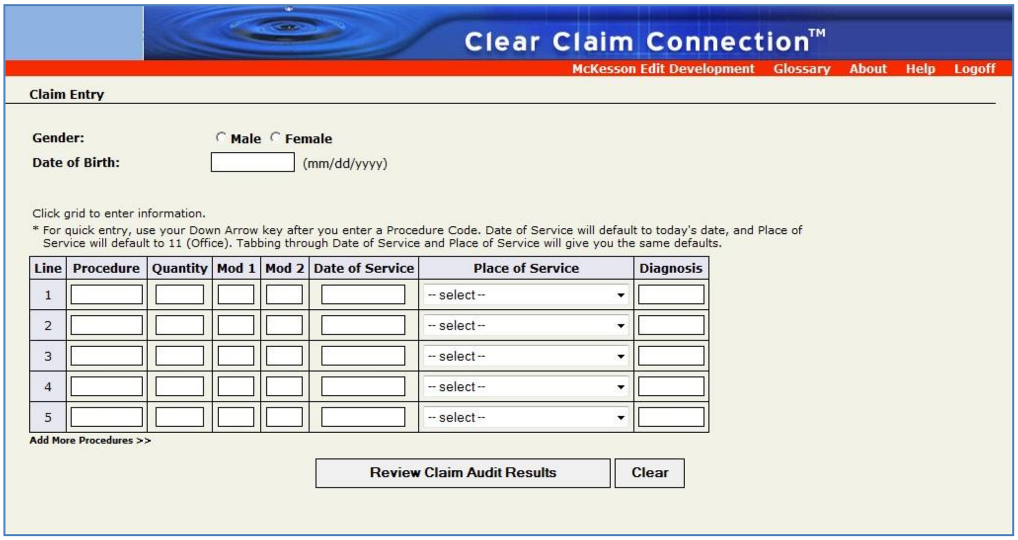
DISCLAIMER
This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

PASS-THROUGH TERMS AND CONDITIONS

1. Home State Health Plan (Home State Health Plan), licenses a code auditing reference tool on the Web (the "Software") that enables Home State Health Plan to disclose its code auditing rules and associated clinical rationale to Providers. Home State Health Plan provides access to such Software to its Providers subject to the terms and conditions contained in this agreement ("Agreement"), which may be updated from time to time at Home State Health Plan' or its licensors' sole discretion without notice.
2. Provider's right to access and use the Software is non-transferable, nonexclusive, and for the sole purpose of internal use within the United States.
3. Provider will limit access to the Software to (i) only employees and agents of Provider and (ii) only to the extent necessary to request the outcome of specific code combinations that Provider proposes to submit to Home State Health Plan regarding billing activity; and/or (iii) request information about submitted code combinations to evaluate the results of claims activity from Home State Health Plan only as related to Provider's practice management.
4. Provider shall protect the confidentiality of the information contained in and provided by the Software and that it has access to in this web site, by using at least the degree of care and security it uses to protect its own confidential information. Provider acknowledges and agrees that any unauthorized disclosure or distribution of the confidential information may result in irreparable injury to Home State Health Plan or licensor(s), entitling the injured entity to obtain immediate injunctive relief in addition to any other legal remedies available.
5. Provider shall not modify, translate, decompile, disclose, create nor attempt to create any derivative work of the Software.
6. Provider acknowledges that the Software is in no way intended to prescribe, designate or limit

ACCEPT REJECT

2. The Code Editing Assistant screen appears with terms and conditions to **Accept** or **Reject**.
3. Click **Accept**.



Clear Claim Connection™

McKesson Edit Development Glossary About Help Logoff

Claim Entry

Gender: Male Female

Date of Birth: (mm/dd/yyyy)

Click grid to enter information.

* For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.

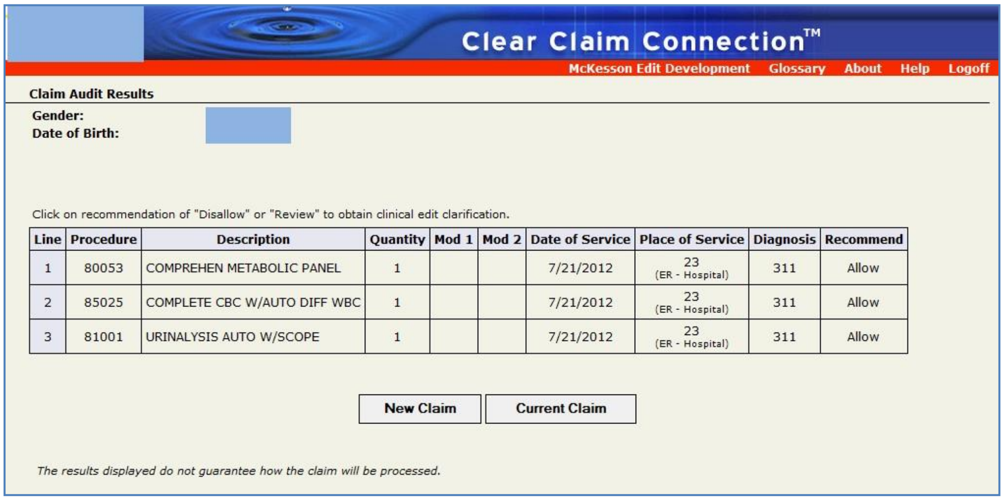
Line	Procedure	Quantity	Mod 1	Mod 2	Date of Service	Place of Service	Diagnosis
1						-- select --	
2						-- select --	
3						-- select --	
4						-- select --	
5						-- select --	

Add More Procedures >>

Review Claim Audit Results Clear

4. The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.
   Note: Date of Service defaults to today's date, and Place of Service defaults to 11 (Office) if not populated otherwise. Use the Tab key to move through the fields easily. If you have more than 5 procedure codes, click the **Add More Procedures** link.

1. Click the **Review Claim Audit Results** button.



2. The results of the claim audit display the Recommendation Status of Allow, Disallow, or Review.

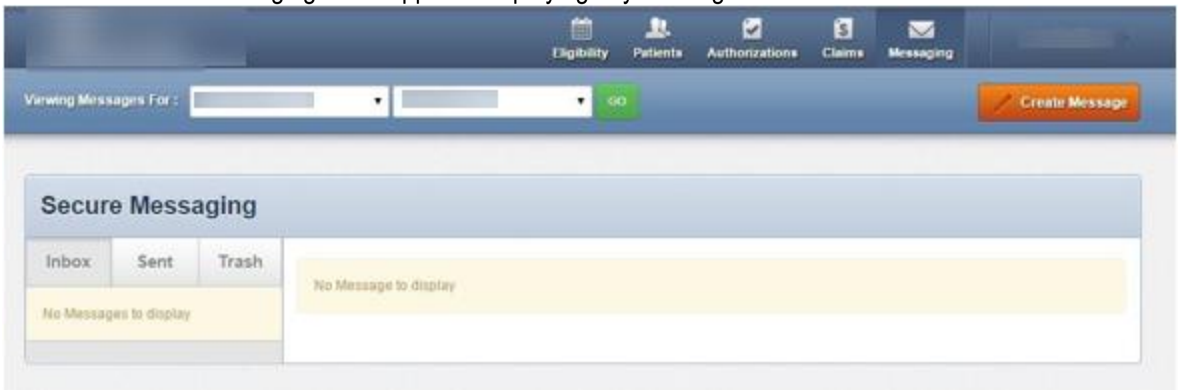
   Note: The results displayed do not guarantee how the claim will be processed, but assist in claims submittal.

   If the Recommendation Status states Disallow or Review, click the status for more clinical edit information.

Secure Messaging

To send a secure message:

1. Click **Messaging** from the Dashboard.
   The Secure Messaging Inbox appears displaying any messages for that user.

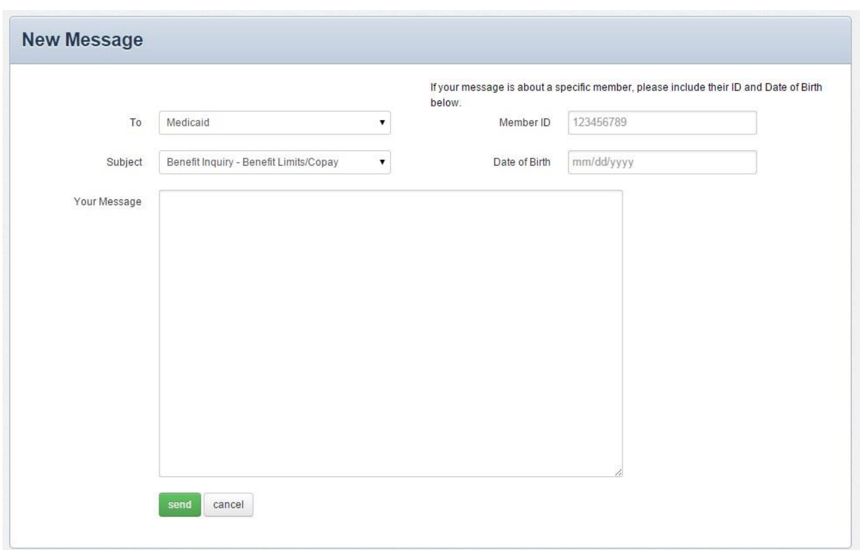


Create a Secure Message

To create a secure message.

1. Click Create Message

In the New Message screen, the To field populates and you are able to select a **Subject** from the drop-down menu.

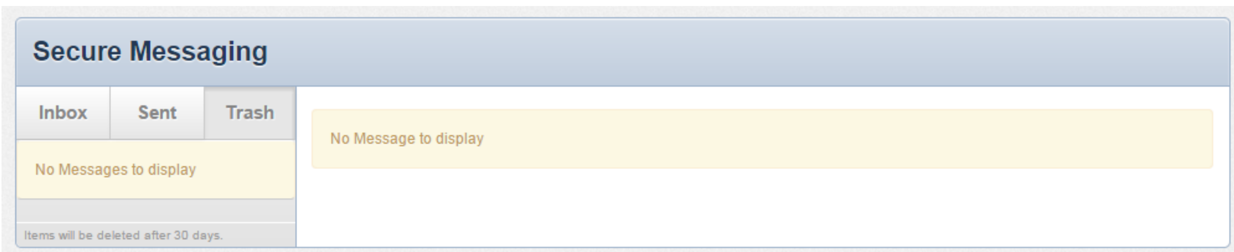


2. In the Your Message field you can free text type the message to the Health Plan staff.
3. Click **Send** when complete.
4. A confirmation message appears that your message successfully sent.

To view Sent messages:

1. Click **Sent**, and your sent messages appear.
2. To send to trash, click the **Send to trash** button Click Sent

To view messages sent to Trash:



3. Click **Trash**, and the messages sent to Trash appear.
   Note: The messages sent to Trash will be deleted after 30 days.
4. If a message is not trash but is found under the Trash tab, you can reverse it by clicking the **not trash** button.