Keystone First
Family of Health Plans

# NaviNet Medical Authorizations Participant Guide

Corporate Clinical Systems Training Department

| | |
|---|---|
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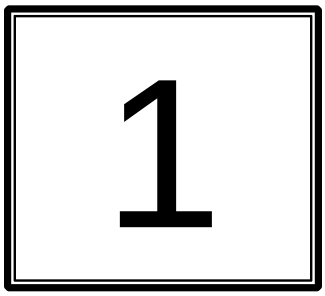
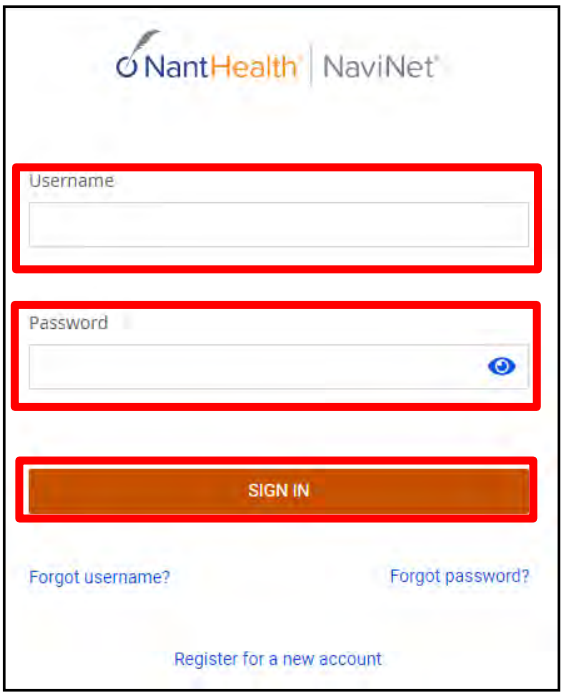


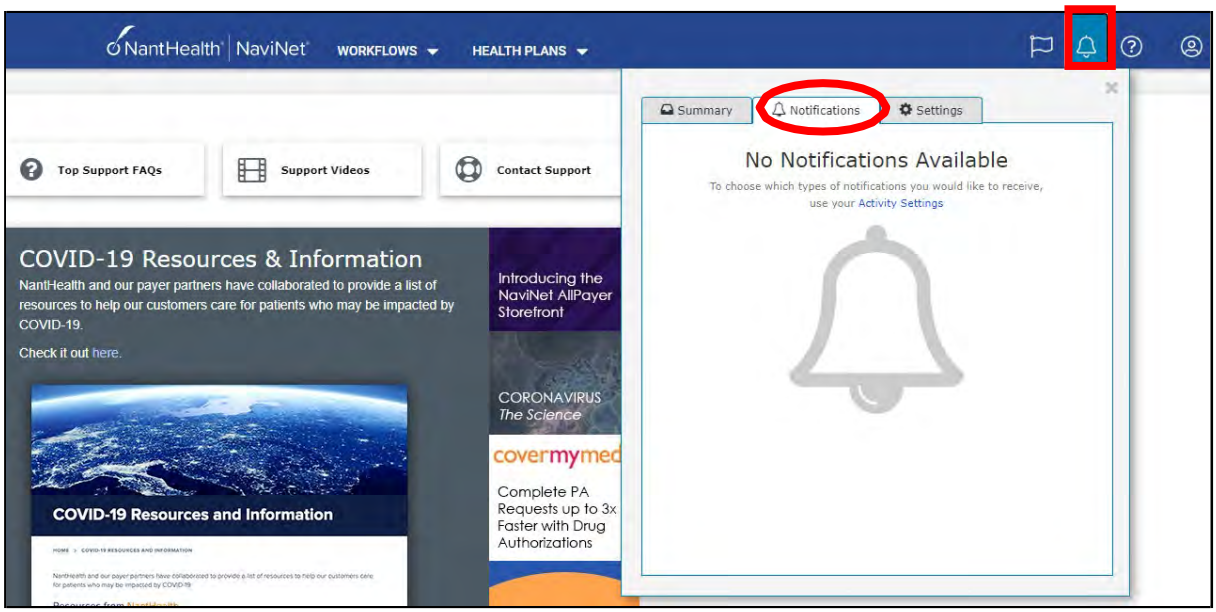

# 1 LOGGING IN TO NAVINET

## Logging in to NaviNet

| Step | Action |
|---|---|
| 1. | Access NaviNet using the following address: **https://navinet.navimedix.com.**<br>The following web browsers are supported: Chrome, Firefox, Safari, and Edge.<br>  |
| 2. | Enter your **Username** |
| 3. | Enter your **Password** |
| 4. | Click **Sign In**<br>***Result**: The NaviNet Home screen will be displayed* |

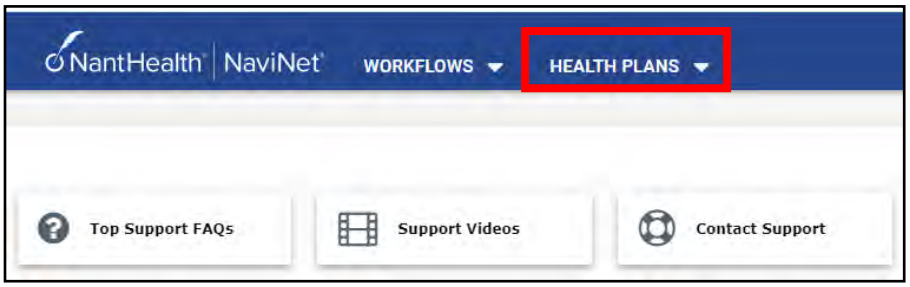
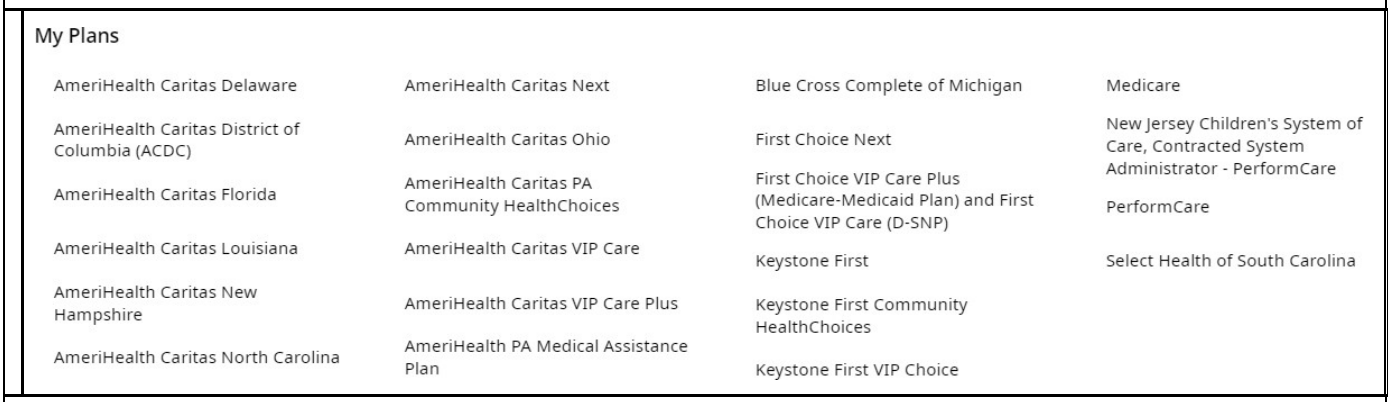
# Logging in to NaviNet (cont'd)

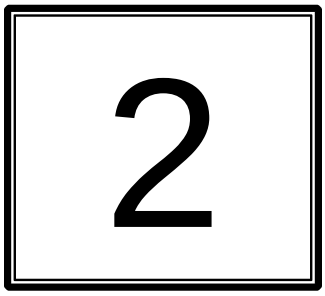
Notifications are an important part of the communication process between the health plan and the provider. Users can opt to receive notifications whenever a request is sent from the health plan to the provider. Notifications can be managed from the bell icon in the top right banner on the home page. Additional information regarding notification settings can be found in the Request For More Information (RFMI) chapter.



## Logging in to NaviNet (cont'd)

The NaviNet Home Page is not health plan-specific. To locate a health plan, follow the steps below:

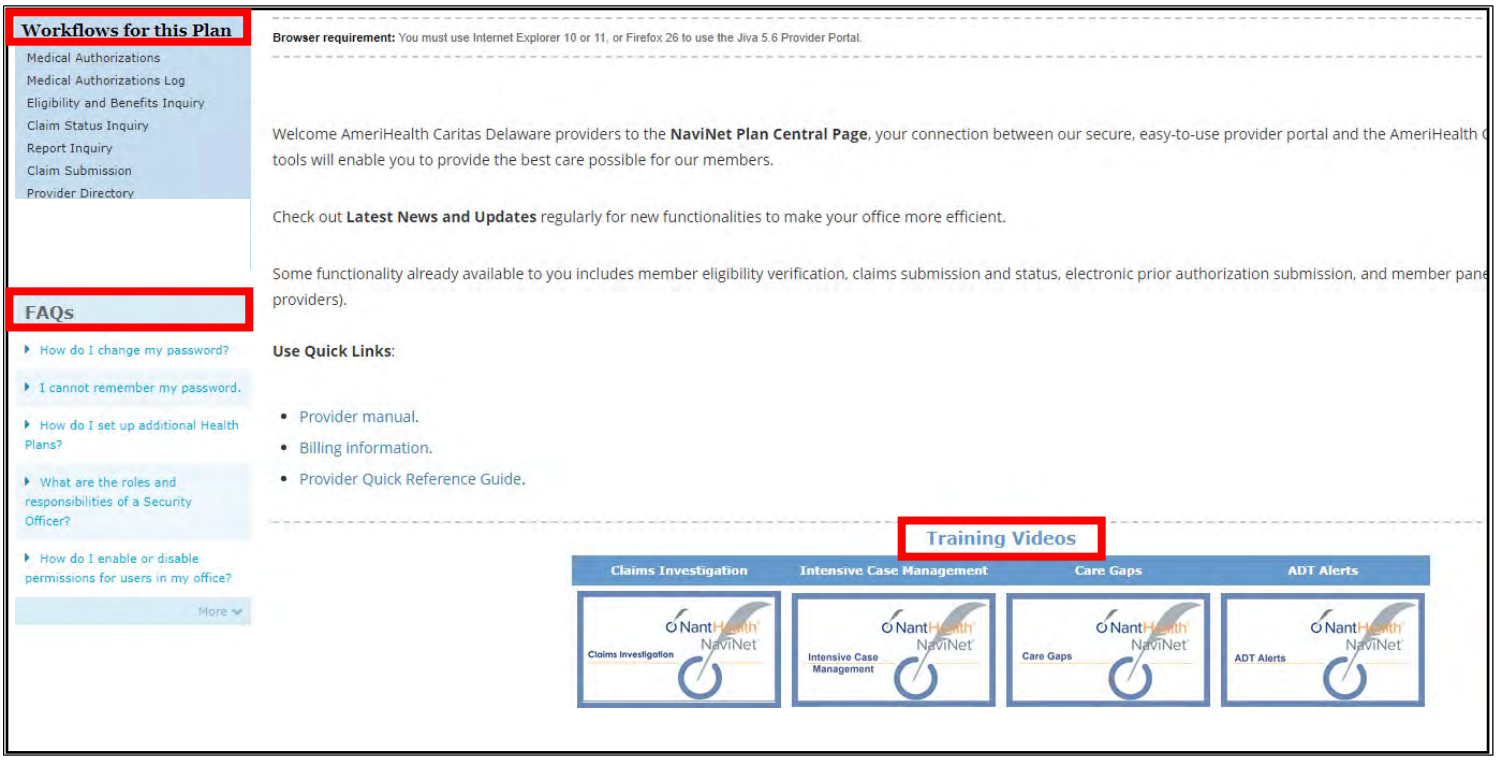
| Step | Action |
|---|---|
| 1. | Click on **HEALTH PLANS** in the top menu.<br>  |
| 2. | Select the appropriate health plan from the displayed list. Once the appropriate health plan is selected, the user will be directed to Plan Central, see the next chapter for additional details.<br>  |




# 2 PLAN CENTRAL

# Plan Central Overview

Plan Central is the health plan specific homepage.

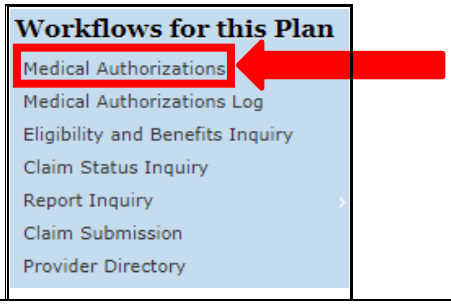
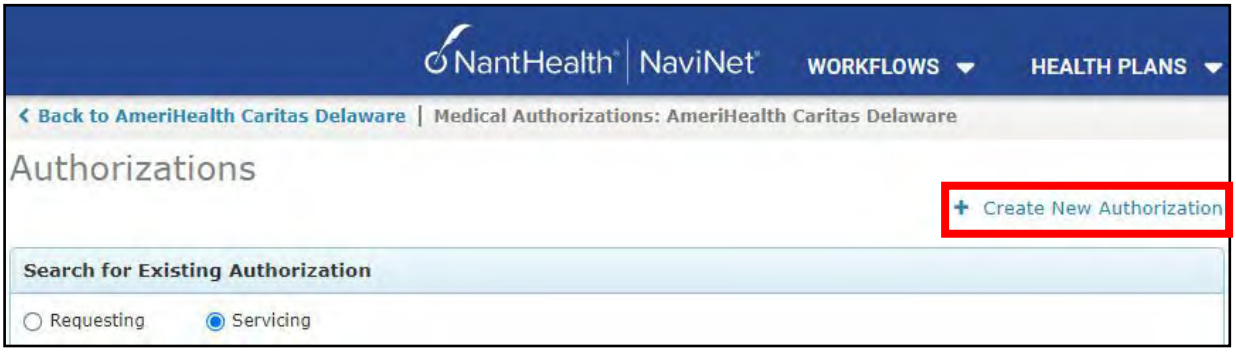



| Plan Central | Topic | Description |
|---|---|---|
| **Workflows for this Plan** | Plan specific options | • Various functionalities are available to include initiating medical authorizations, inquiries, etc. |
| **FAQs** | Frequently Asked Questions | • Includes answers to questions frequently asked. |
| **Training Videos** | Training Videos | • Instructional videos on system usage. |

# 3 CREATING A NEW AUTHORIZATION

## Creating a New Authorization

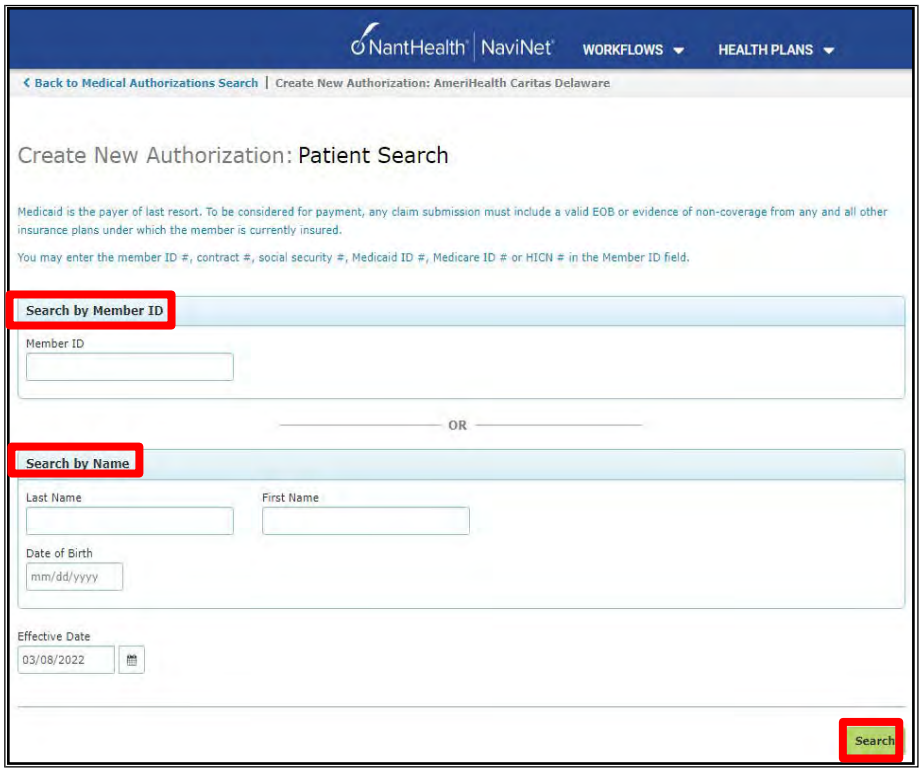
To create a new authorization:

| Step | Action |
|---|---|
| **1.** | Launch **Medical Authorizations** under Workflows for this Plan**.**<br>  |
| **2.** | Click **Create New Authorization**<br>  |

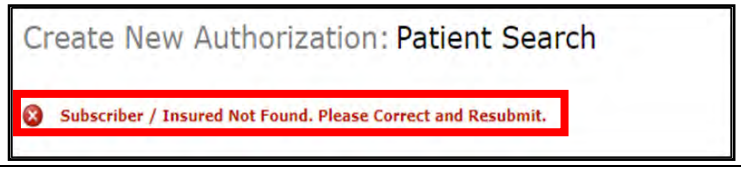
## Creating a New Authorization (cont'd)

| Step | Action |
|---|---|
| **3.** | Enter patient search criteria information then select **Search**. The patient search screen allows the user to search by Member ID or Search by Name. If searching by name, the member's first name, last name, and date of birth (DOB) are required. |

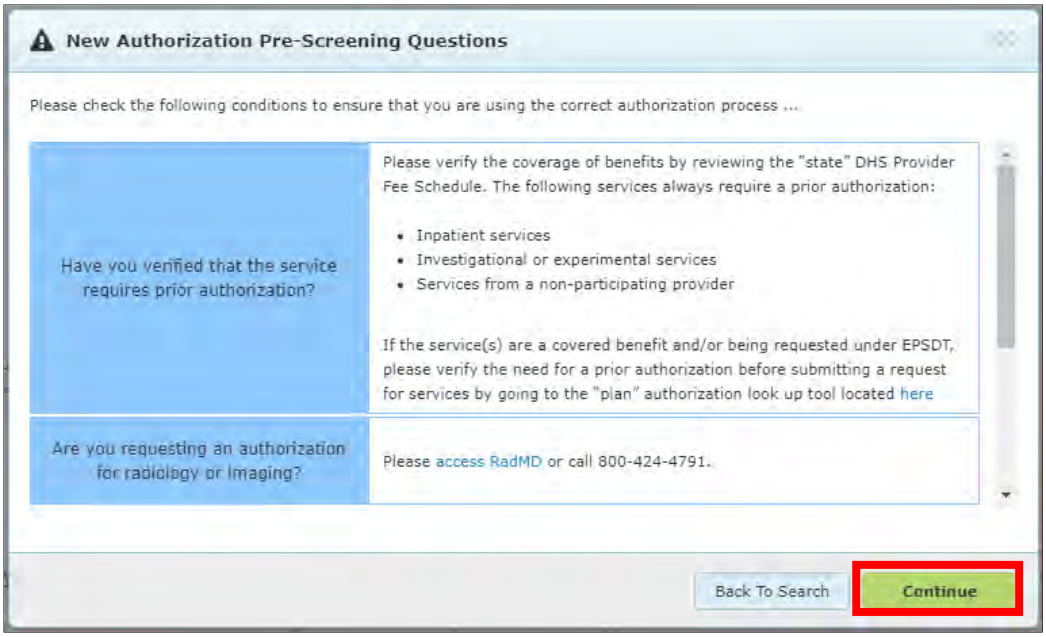
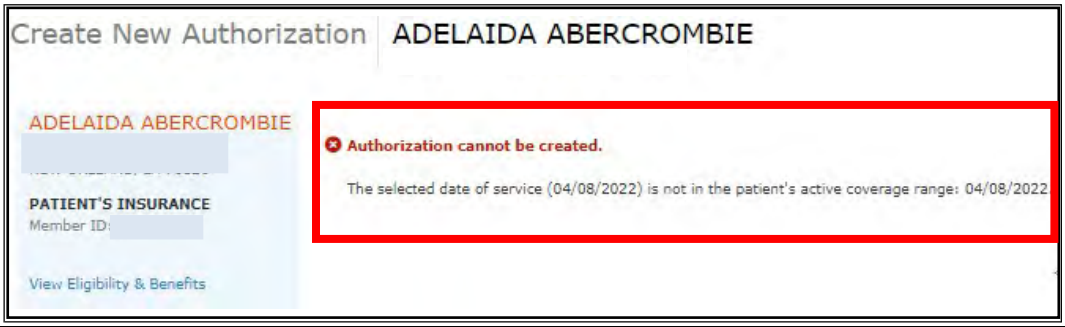
| | |
|---|---|
| | If there are multiple matches based on criteria entered, the user will get a search results screen. On the search results screen, the user selects the appropriate member from the list returned. If there is an exact match, the user is taken to the pre-screening questions. |




**Note:** If you enter an incorrect/invalid member ID you will receive the following:



## Creating a New Authorization (cont'd)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>4.</td><td>Address the pre-screening questions pop up box and select Continue.<br>Note: If a member is not active with the health plan, you will not be advanced to the pre-screening questions.
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>The member has active coverage</td><td>The provider will be advanced to the New Authorization Pre-Screening Questions<br> 
<br>The purpose of the New Authorization Pre-Screening Questions is to ensure that the user is following the correct authorization process. It is important to scroll through the questions to ensure that there is not a more appropriate avenue for your specific request. These questions are specific based on the health plan.</td></tr>
<tr><td>The member is ineligible</td><td>The provider will receive the authorization cannot be created message.<br> 
</td></tr>
</table>
</td></tr>
</table>

## Creating a New Authorization (cont'd)

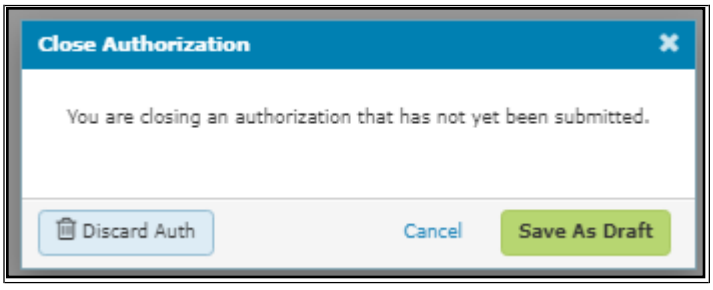
| Step | Action |
|---|---|
| **5.** | Enter service type and place of service, then select **Next** |

**View Eligibility & Benefits** is available to view under the member's demographic information.

**Service Type –** Select the appropriate service type. Based on the service type selected the user may or may not be prompted to enter the place of service. For example, if the request is for home health care the user will not be prompted to select a place of service because the place of service is in the home. If the service type is physical therapy the user will be prompted to specify a place of service (comprehensive outpatient rehabilitation facility, home, independent clinic, off campus-outpatient hospital, office). If an inpatient service type is selected the user will not be prompted to enter a place of service on this screen.

| If… | Then… |
|---|---|
| Creating an outpatient episode | Continue to the next step (step 6) |
| Creating an inpatient episode | Continue to step 7 |

**Note:** At any time while creating an authorization if you wish to close or save the request select ✖ Close/Save which will enable the following pop up and allows the user to discard auth, cancel, and save as draft.

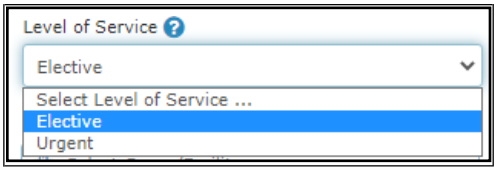



**Discard Auth** – deletes the request

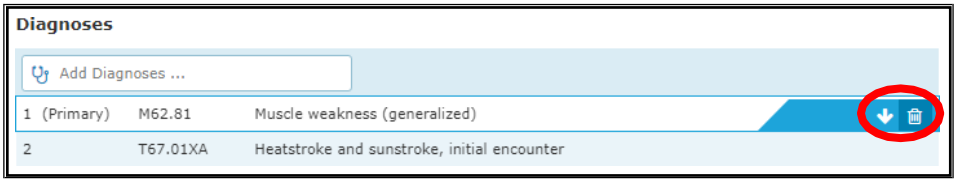
**Cancel** – allows the user to continue

**Save As Draft** – allows the user to come back and complete the request later

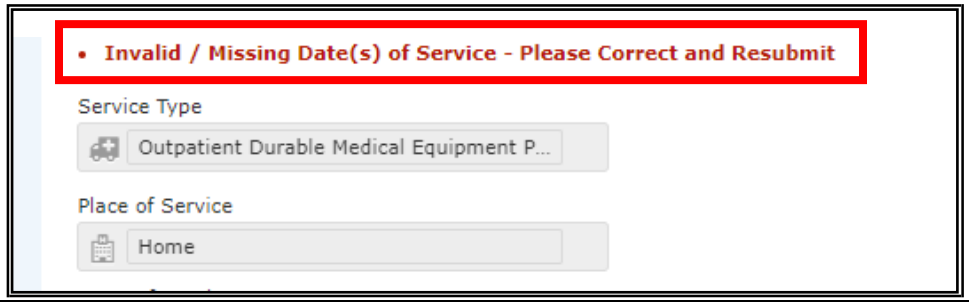
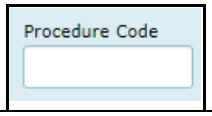
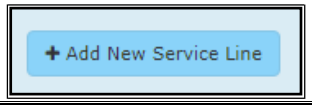
# Creating a New Authorization - Outpatient Request

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>6.</td><td>Complete information in the required fields following the guidelines outlined below for an Outpatient Request. Outpatient request can be entered up to 365 days in advance.
<table>
<tr><td>Date of Service</td><td>This defaults to the current date and is not available to be changed.<br>
</td></tr>
<tr><td>Level of Service</td><td>Choose the appropriate selection from the drop-down list – elective or urgent.<br> 

<table>
<tr><th>If</th><th>Then</th></tr>
<tr><td>Elective</td><td>Services scheduled in advance that do not involve a medical emergency</td></tr>
<tr><td>Urgent</td><td>Unscheduled admission of patient. An unexpected illness or injury that needs prompt medical attention.</td></tr>
</table></td></tr>
<tr><td>Requesting Provider</td><td>Choose the appropriate selection from the drop-down list. Requesting provider is the provider that is requesting the service.<br>
</td></tr>
<tr><td>Servicing Provider</td><td>Choose the appropriate selection from the drop-down list. Servicing provider is the provider completing the service.<br>
</td></tr>
<tr><td>Diagnoses</td><td>This is a look up field (max number of diagnosis codes that can be attached is 12).<br>

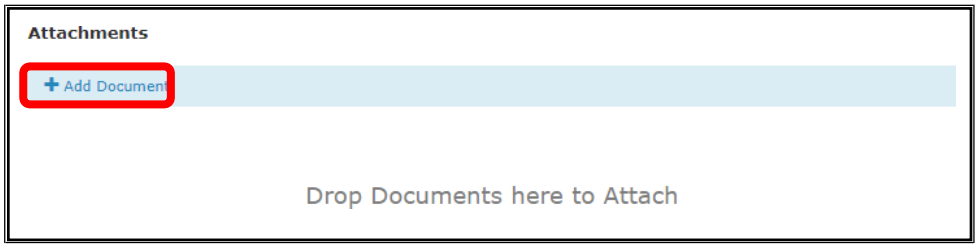
<br>Note: The user can change the primary diagnosis if more than 1 diagnosis exists and there is also the ability to delete diagnosis that may have been entered in error. The user can hover over the row to reorder (arrow) and or delete (trashcan) the diagnosis.<br> 
</td></tr>
</table></td></tr>
</table>

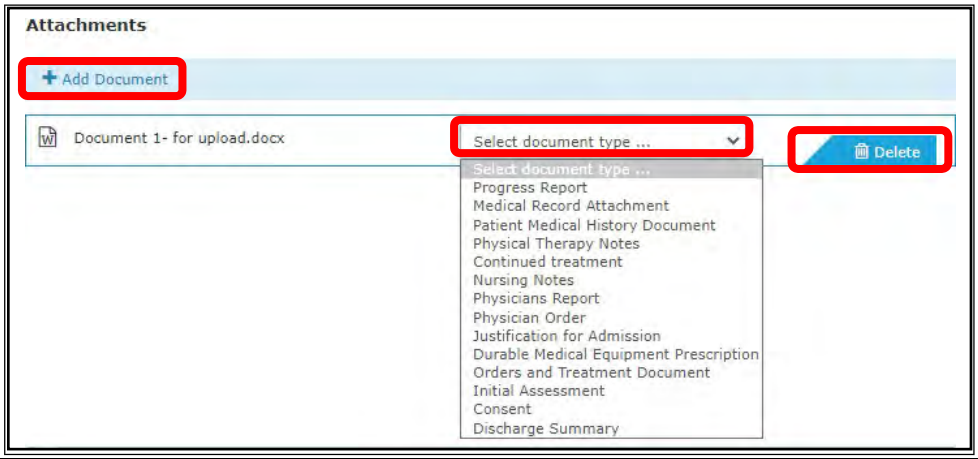
## Creating a New Authorization - Outpatient (cont'd)

| Step | Action | |
|---|---|---|
| 6. | **Services** | |
| | **From / To** | **From** (start date) **/ To** (end date)<br> <br>**Note:** The user will not be able to submit requests for identical service codes for the same dates. The error message below will be received when the system detects a duplication of services for the same date range. If InterQual is applicable the error message will appear after InterQual is completed. If InterQual is not applicable, the error message will appear when the user clicks **Submit.**<br>  |
| | **Procedure Code** | Free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free text and not a lookup field. The user will not be notified if an incorrect code is entered so it is very important for the user to enter the correct code.<br>  |
| | **Modifiers** | Free text field. This is not a mandatory field.<br> |
| | **Units** | Free text numeric value.<br> |
| | **Add New Service Line** | The user must add new service line for the system to recognize the request even if only adding 1 request or 1 service. The **Add New Service Line** will also be utilized when adding additional service requests.<br>  |

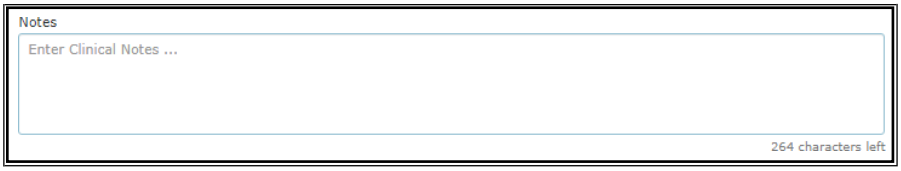
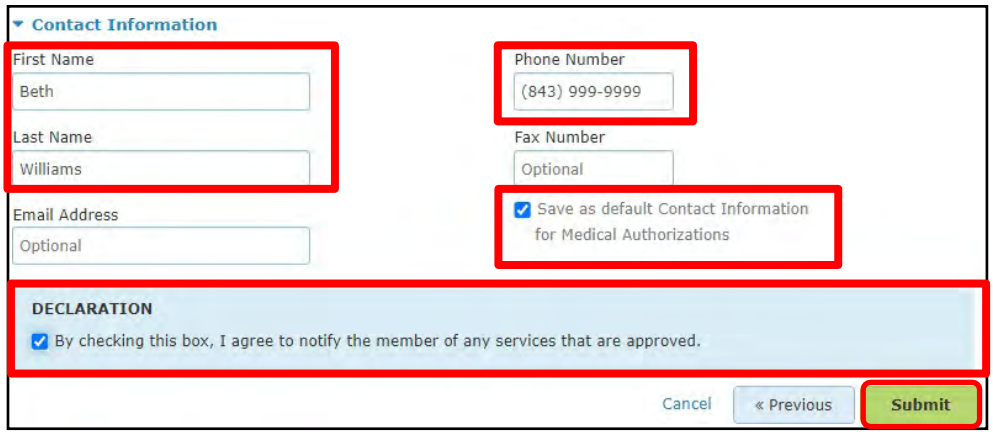
## Creating a New Authorization – Outpatient (cont'd)

| Step | Action | |
|---|---|---|
| 6. | **Attachments** | |
| | **+ Add Document** | Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). The user may attach up to 10 documents. The user can identify the document type based on the drop down list. If the user attaches a document, the document type is mandatory. Select document type drop down. The user also has the ability to delete any document attached in error. |



| Step | Action |
|---|---|
| 6. | **Notes** |

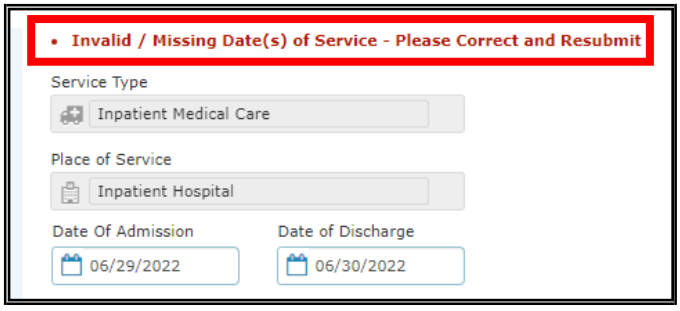
| | |
|---|---|
| **Notes** | Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters.<br>  |
| **Contact Information** | Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete.<br>**Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future.<br>  |

*****Proceed to Step 8 for InterQual instructions*****

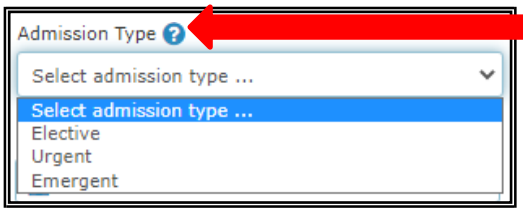
# Creating a New Authorization – Inpatient Request

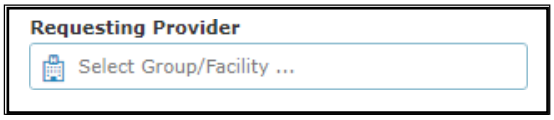
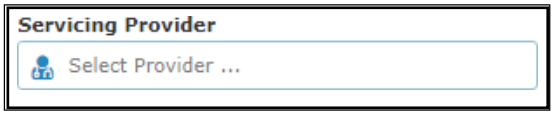
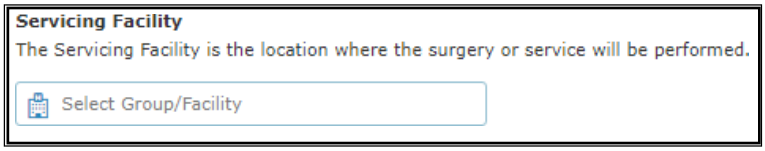
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>7.</td><td>Complete information following the guidelines outlined below for an inpatient request:
<table>
<tr><td>Service Type</td><td>Select the appropriate service type and place of service according to the request.<br>

<table>
<tr><td>Service Type</td><td>Type of service to be provided to the member. (Based on the service type, the system will request for the user to enter the place of service.)</td></tr>
<tr><td>Place of Service</td><td>Location in which services will be rendered.</td></tr>
</table>
Once service type is select, click Next to continue.<br>
</td></tr>
<tr><td>Date of Admission/<br>Date of Discharge</td><td>Date of admission is a mandatory field. Date of discharge is optional because it may not be known at the time the request is initiated. However, providers can record the members discharge date by amending the inpatient authorization request (refer to Amending an Authorization chapter).<br>

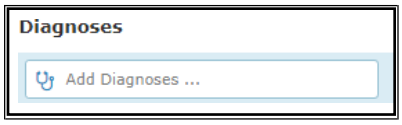
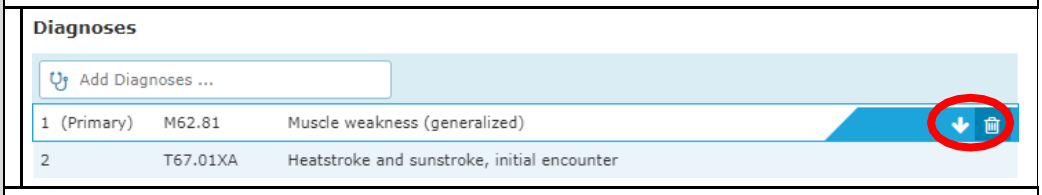
Note: The user will receive the message below if the dates of service overlap in the same case.<br> 
</td></tr>
</table></td></tr>
</table>

## Creating a New Authorization – Inpatient Request (cont'd)

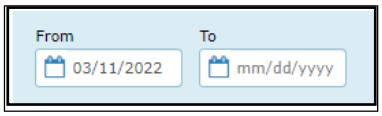
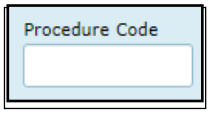
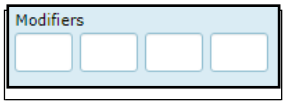
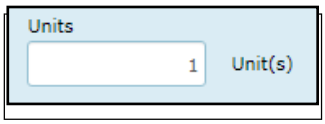
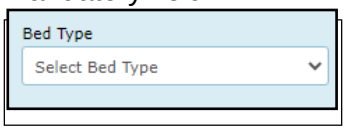
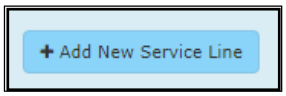
<table>
<tr><th>Step</th><th colspan="2">Action</th></tr>
<tr><td>7.</td><td>Admission Type</td><td>Select the appropriate admission type from the drop-down list – Elective, Urgent, or Emergent.<br> 

The question mark beside admission type provides information regarding the types of admissions.
<table>
<tr><th>If</th><th>Then</th></tr>
<tr><td>Elective</td><td>Potential admission for illness/injury enrollee not currently admitted</td></tr>
<tr><td>Urgent</td><td>Potential admission for illness/injury that can be treated in a 24-hour period and if left untreated could rapidly become a crisis or emergency, enrollee not currently admitted</td></tr>
<tr><td>Emergent</td><td>Concurrent review, enrollee is currently admitted</td></tr>
</table></td></tr>
<tr><td></td><td>Requesting Provider</td><td>Select the appropriate provider from the drop-down list. Requesting provider is the provider that is requesting the service.<br> 
</td></tr>
<tr><td></td><td>Servicing Provider</td><td>Select the appropriate servicing provider from the drop-down list. Servicing provider is the provider completing the service (also known as the attending provider).<br> 
</td></tr>
<tr><td></td><td>Servicing Facility</td><td>The servicing facility is the location where the service will be performed.<br> 
</td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

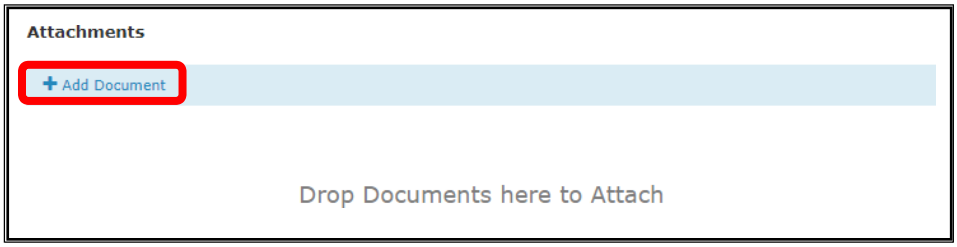
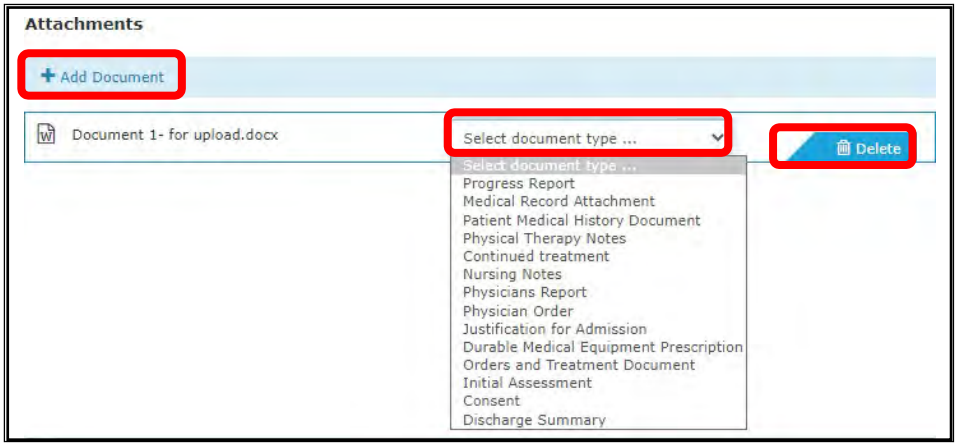
## Creating a New Authorization – Inpatient (cont'd)

| Step | Action |
|---|---|
| 7. | **Diagnoses**<br>**Diagnoses**<br>Look up field (max number of diagnosis codes that can be attached is 12).<br>  <br><br>**Note:** The user can change the primary diagnosis if more than 1 diagnosis exists and there is also the ability to delete a diagnosis that may have been entered in error. The user can hover over the row to reorder using the arrow icon and or delete the diagnosis by selecting the trash icon.<br>  <br> |

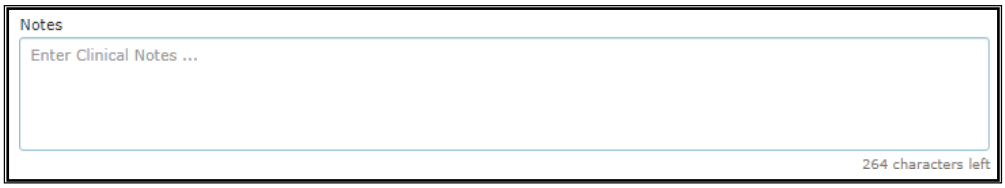
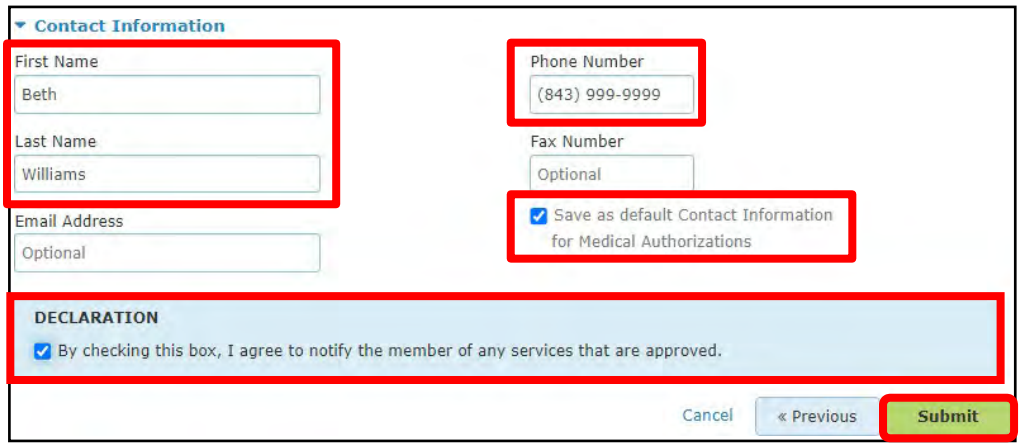
## Creating a New Authorization – Inpatient (cont'd)

| Step | Action | |
|---|---|---|
| 7. | **Services** | |
| | **From / To** | From (start date) / To (end date). From and To dates are mandatory. If the To date is unknown, advance it by 1 day from the From date.<br>  |
| | **Procedure Code** | Free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free text and not a bokup field. The user will not be notified if an incorrect code is entered so it is very important for the user to enter the correct code. If this is an inpatient only request and there is no procedure code do not place anything in the procedure code field.<br>  |
| | **Modifiers** | This is a free text field and is not mandatory.<br>  |
| | **Units** | Free text numeric value. For the inpatient request, units are equivalent to days.<br>  |
| | **Bed Type** | Select the appropriate bed type from the drop down list. This is a mandatory field.<br>  |
| | **+ Add New Service Line** | The user must add new service line for the system to recognize the request. The **Add New Service Line** will also be utilized when adding additional service requests.<br>  |

## Creating a New Authorization – Inpatient (cont'd)

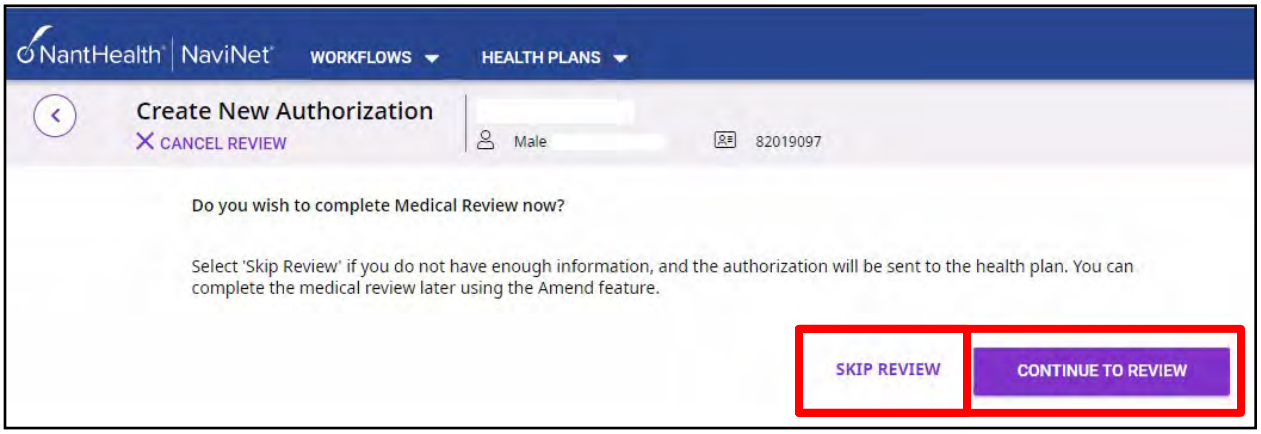
| Step | Action | |
|---|---|---|
| 7. | **Attachments** | |
| | **Add Document** | Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). The user may attach up to 10 documents. If the user attaches a document, the document type is mandatory. The user also has the ability to delete any document attached in error.<br>  <br>  |

| Step | Action |
|---|---|
| 7. | **Notes** |

| | |
|---|---|
| **Notes** | Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters.<br>  |
| **Contact Information** | Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete.<br>**Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future.<br>  |

## Creating a New Authorization – InterQual – Outpatient and Inpatient

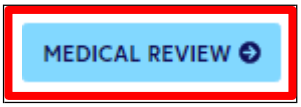
If you need training or have questions regarding the use of InterQual criteria, please contact Change Healthcare.

| Step | Action |
|---|---|
| **8.** | After completion of the previous steps, when the user selects **Submit**, InterQual criteria may or may not launch. InterQual criteria is launched based on the diagnosis code and or the service code and if there are criteria to launch for the diagnosis code and or service code that is identified in the episode. If InterQual criteria is not launched after the user submits the request, the user may receive a status of pending or an automatic approval. |
| **9.** | The message below will populate indicating the InterQual page is loading.<br> |
| **10.** | Once routed to InterQual, users will have two options 'Skip Review' or 'Continue to Review.'<br>  |

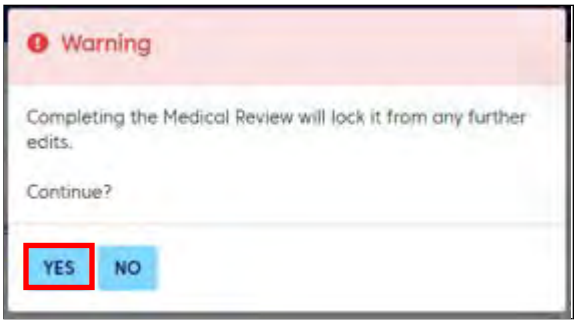
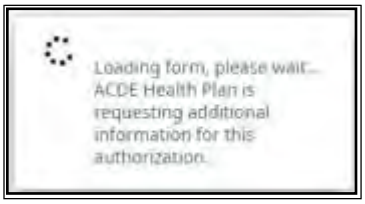
| If.... | Then... |
|---|---|
| **Skip Review** | The user will return to the authorization details page and will be provided with a summary of the request along with the status and the pending authorization number.<br>***Note:***<br>*If the InterQual medical review is skipped, the medical review is completed by the health plan. If additional information is needed to complete the medical review, a Request For More Information (RFMI) will be sent to the provider through the NaviNet Provider Portal.* |
| **Continue to Review** | The user will be presented with the appropriate InterQual Subset and should complete the clinical questions/medical review prior to submission.<br>***Note:***<br>*If the InterQual medical review is completed and the InterQual criteria is met, there is the possibility of an automatic approval.* |

## Creating a New Authorization - InterQual (cont'd)

| Step | Action |
|---|---|
| **11.** | |

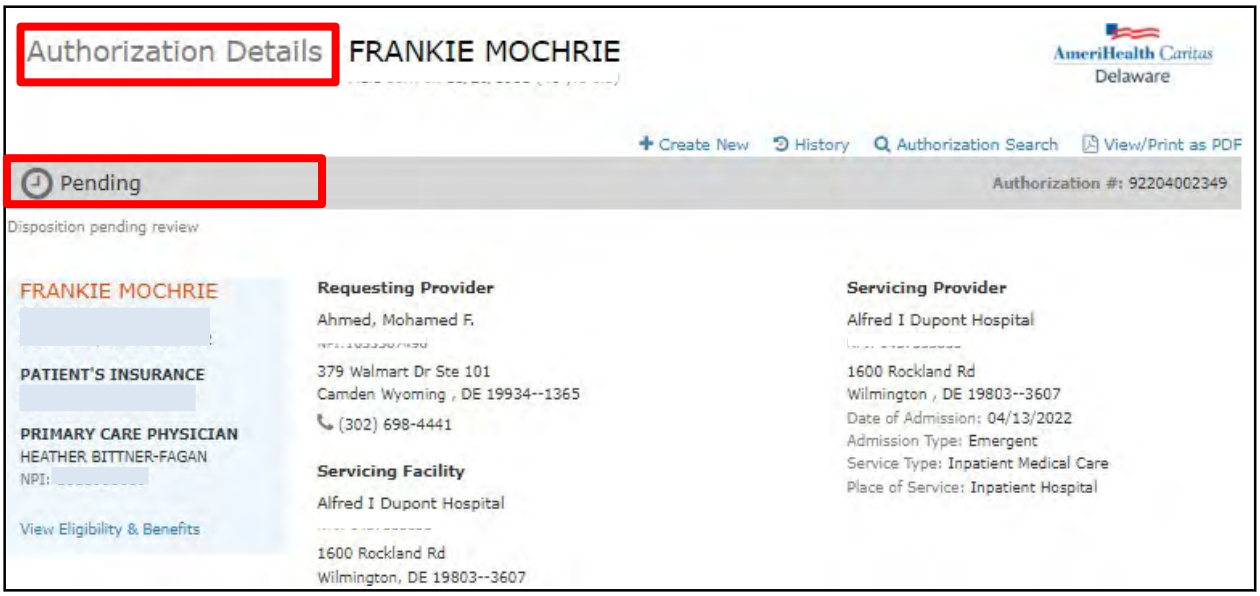
| | |
|---|---|
| **Outpatient** | The system will determine the criteria set and subset based on the diagnosis code and the procedure code (if applicable). To begin the review, click on medical review at the bottom of the screen.<br> <br>Answer the questions as they relate to the patient/member. |
| **Inpatient** | The system will direct the user to a guideline selection page. Select the most appropriate guideline then click on medical review.<br>  <br>Select the day on which you wish to complete the medical review then select the pertinent findings/interventions. |

## Creating a New Authorization - InterQual (cont'd)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>12.</td><td>At the end of the InterQual review…
<table>
<tr><th>If….</th><th>Then….</th></tr>
<tr><td>Q&A criteria is used (outpatient)</td><td>After all questions have been answered the no remaining questions message will display: Click view recommendations to continue.</td></tr>
<tr><td>Decision tree is used (inpatient)</td><td>Address all pertinent findings/interventions based on the day selected for the review. At the end of the review the user will receive criteria met or criteria not met. Regardless of if the criteria meet or does not meet, the user should continue.</td></tr>
</table></td></tr>
<tr><td>13.</td><td>When the review is complete, click Complete, then select YES to continue.<br> 
</td></tr>
<tr><td>14.</td><td>The following notice which indicates that the user is being sent back to NaviNet from InterQual.<br> 
</td></tr>
</table>

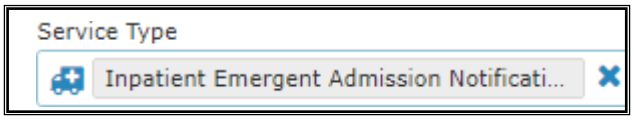
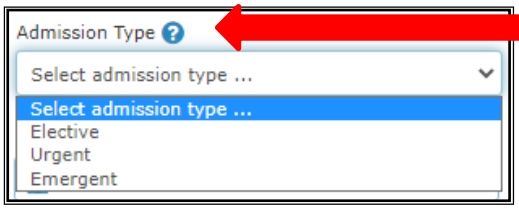
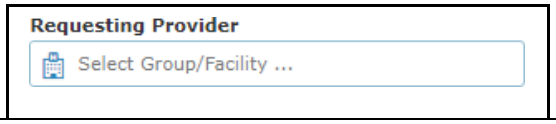
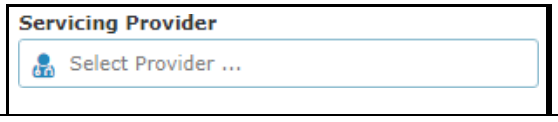
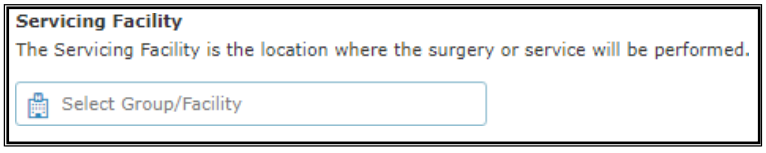
## Creating a New Authorization - InterQual (cont'd)

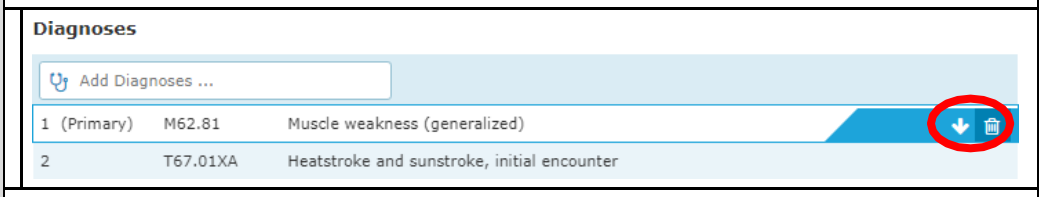
| Step | Action |
|---|---|
| **15.** | Once the user arrives back in NaviNet, it defaults to the authorization details screen. |



## Creating a New Authorization – Inpatient Emergent Admission Notification

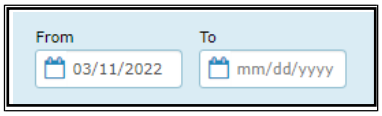
| Step | Action |
|---|---|
| **6.** | Refer to steps 1-5 above under the heading Creating a New Authorization. Complete information following the guidelines outlined below for an Inpatient Emergent Admission Notification. If the user is identified as non-clinical, the user may report an Emergency Admission utilizing the steps below. |

| | |
|---|---|
| **Service Type** | Select the Service Type (users should select Inpatient Emergent Admission Notification as their service type).<br>  <br>Click **Next** to continue.<br> |
| **Date of Admission/ Date of Discharge** | Date of Admission is a mandatory field. Date of Discharge is optional because it may not be known at the time the request is initiated.<br> |
| **Admission Type** | Select the appropriate admission type– Elective, Urgent, or Emergent.<br>  <br>The question mark provides information regarding the types of admissions. |
| **Requesting Provider** | Requesting provider is the provider that is requesting the service.<br>  |
| **Servicing Provider** | Servicing provider is the provider completing the service, also known as the attending provider.<br>  |
| **Servicing Facility** | Servicing Facility is where the service will be performed.<br>  |

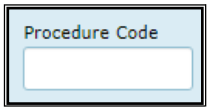
| Step | Action |
|---|---|
| 6. | **Diagnoses**<br>**Diagnoses**<br>Diagnoses is a look up field (max number of diagnosis codes that can be attached is 12).<br> <br>**Note:** The user can change the primary diagnosis if more than 1 diagnosis exists and there is also the ability to delete a diagnosis that may have been entered in error. The user can hover over the row to reorder (arrow icon) and or delete (trash icon) the diagnosis.<br>  |

| Step | Action |
|---|---|
| 6. | **Services** |

From (start date) / To (end date). From and To dates are mandatory. If unsure of the To date, advance it by 1 day from the From date.

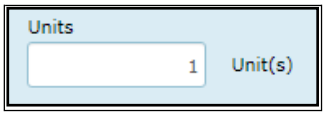



This is a free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free text and not a lookup field. The user will **not** be notified if an incorrect code is entered so it is very important that the correct code is entered. If this is an inpatient (IP) only request and there is no procedure code do not enter anything in the procedure code field.



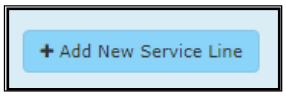

This is a free text field and is not a mandatory field.

Free text numeric value. For the inpatient request, units are equivalent to days.

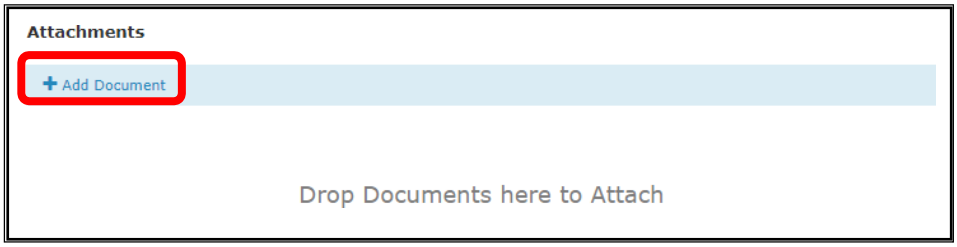


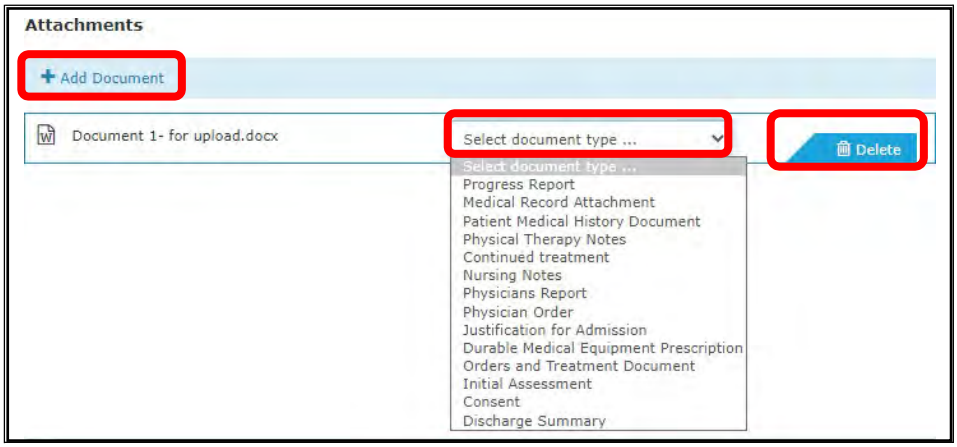

Select bed type from the drop down list. This is a mandatory field.

Click on **Add New Service Line** for the system to recognize the request. **Add New Service Line** will also be utilized when adding additional service requests.

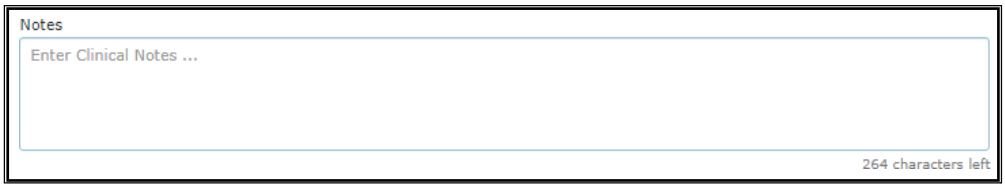
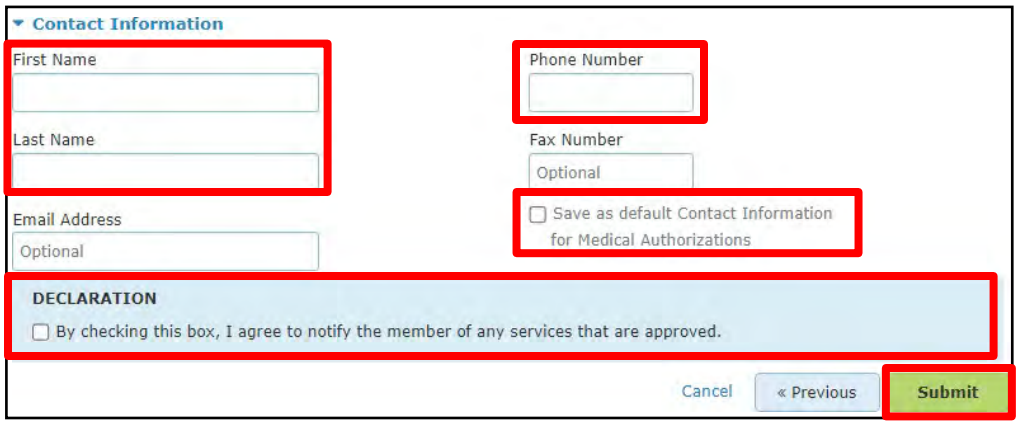


| Step | Action | | |
|---|---|---|---|
| 6. | **Attachments** | | |
| | **Add Document** | Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). Up to 10 documents may be attached. If a document is attached, the document type is mandatory. Documents attached in error may be deleted. | |

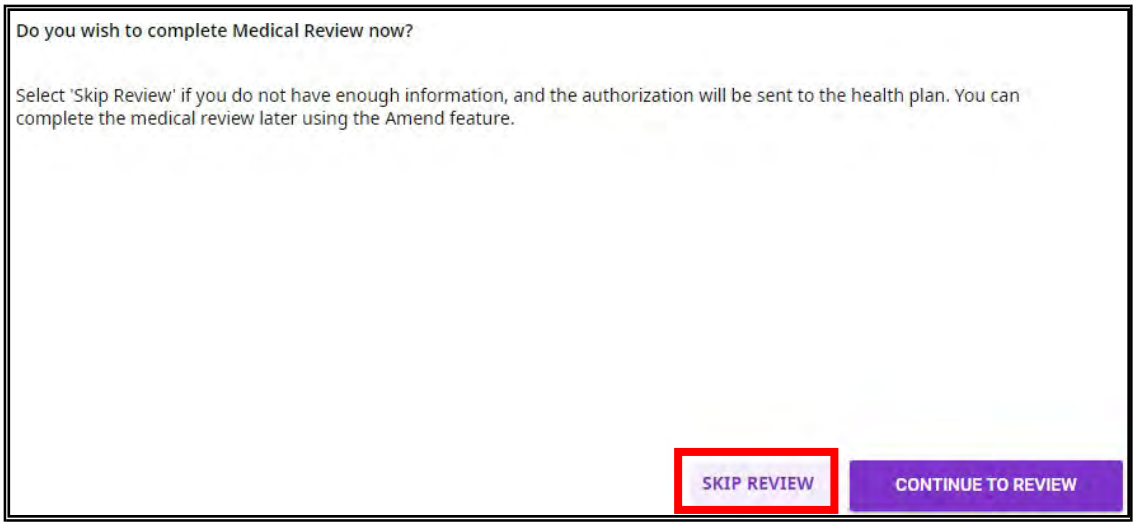


| Step | Action |
|---|---|
| 6. | **Notes** |

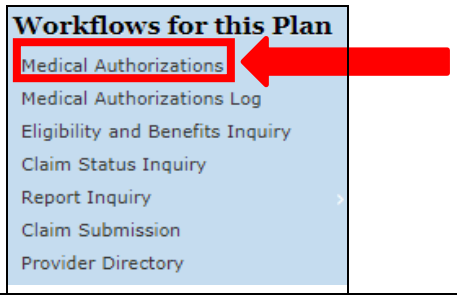
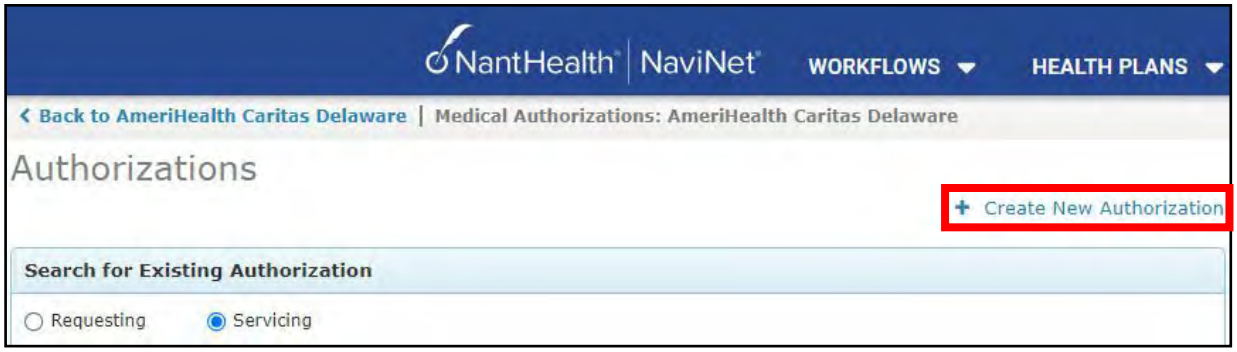
| | |
|---|---|
| **Notes** | Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters.<br>  |
| **Contact Information** | Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete.<br>**Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future.<br>  |

**Note:** Non-clinical users may follow the steps below to bypass the InterQual Review.

| Step | Action |
|---|---|
| **7.** | The message below will populate indicating the InterQual page is loading.<br> |
| **8.** | The system will offer non-clinical users the option to by-pass InterQual Medical Review. To bypass the InterQual review, select "Skip Review.<br>  <br>**Note:** After selecting Skip Review, the user will be routed back to the authorization page notifying them of the status. |

## Creating a New Authorization – Inpatient Delivery Notification

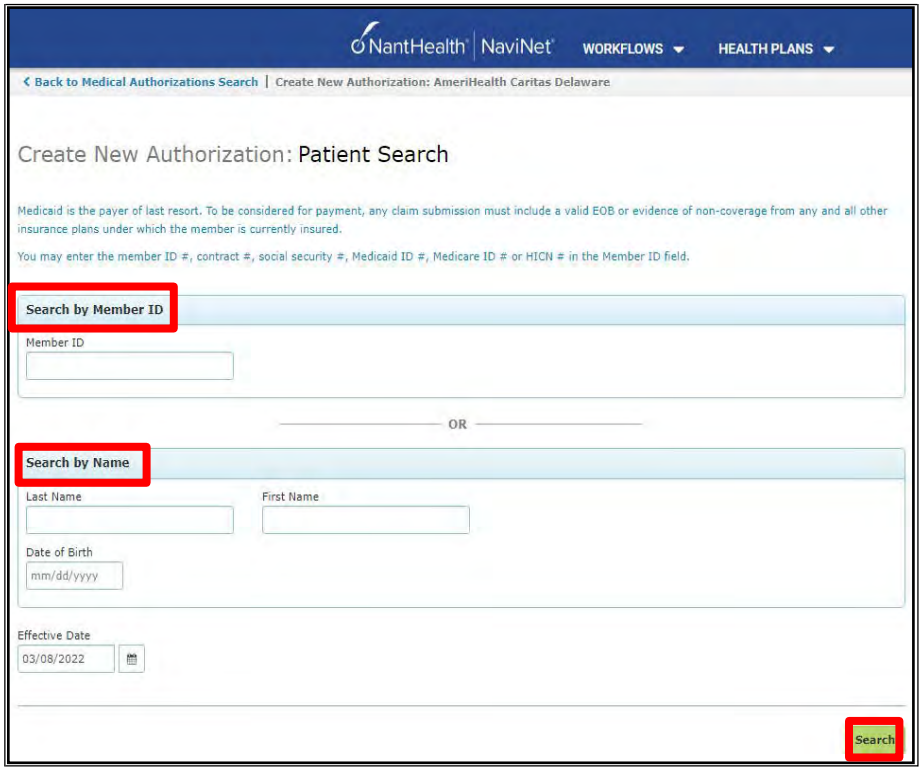
To create an Inpatient Delivery Notification:

| Step | Action |
|---|---|
| **1.** | Launch **Medical Authorizations** under Workflows for this Plan**.**<br>  |
| **2.** | Click **Create New Authorization**<br>  |

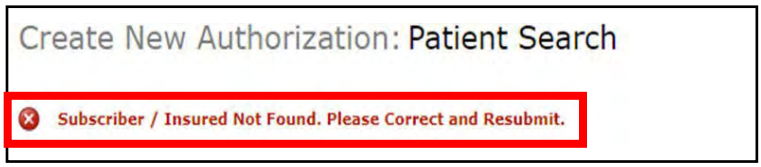
## Creating a New Authorization – Inpatient Delivery Notification (cont'd)

| Step | Action |
|---|---|
| **3.** | Enter patient search criteria information then select **Search**. The patient search screen allows the user to search by Member ID or Search by Name. If searching by name, the member's first name, last name, and date of birth (DOB) are required. |

| | |
|---|---|
| | If there are multiple matches based on criteria entered, the user will get a search results screen. On the search results screen, select the appropriate member from the list returned. If there is an exact match, the user is taken to the pre-screening questions. |

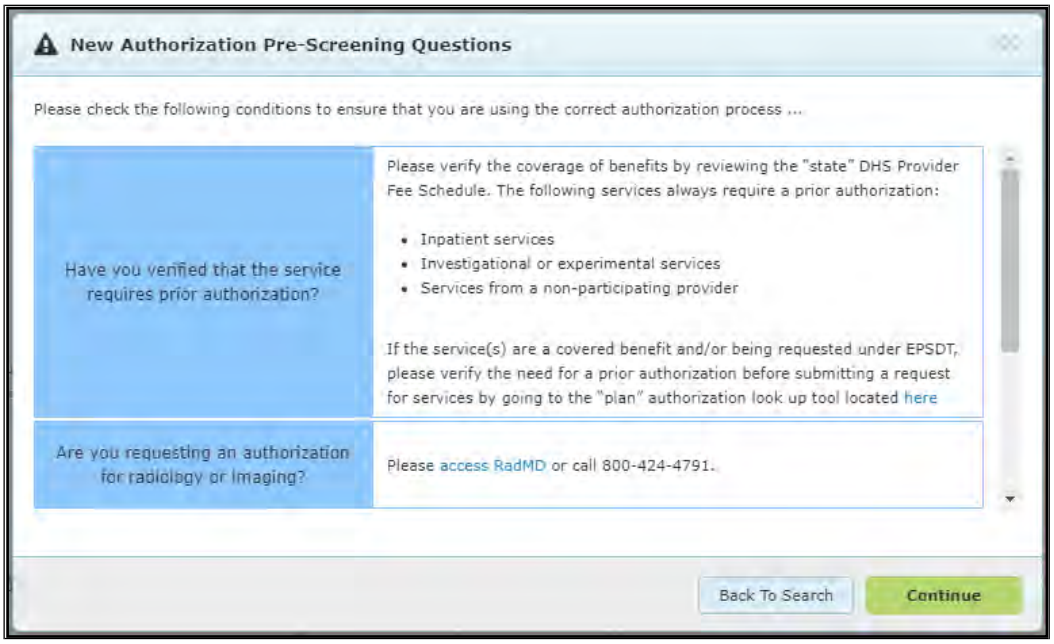



**Note:** If an incorrect/invalid member ID is entered, the message below appears:

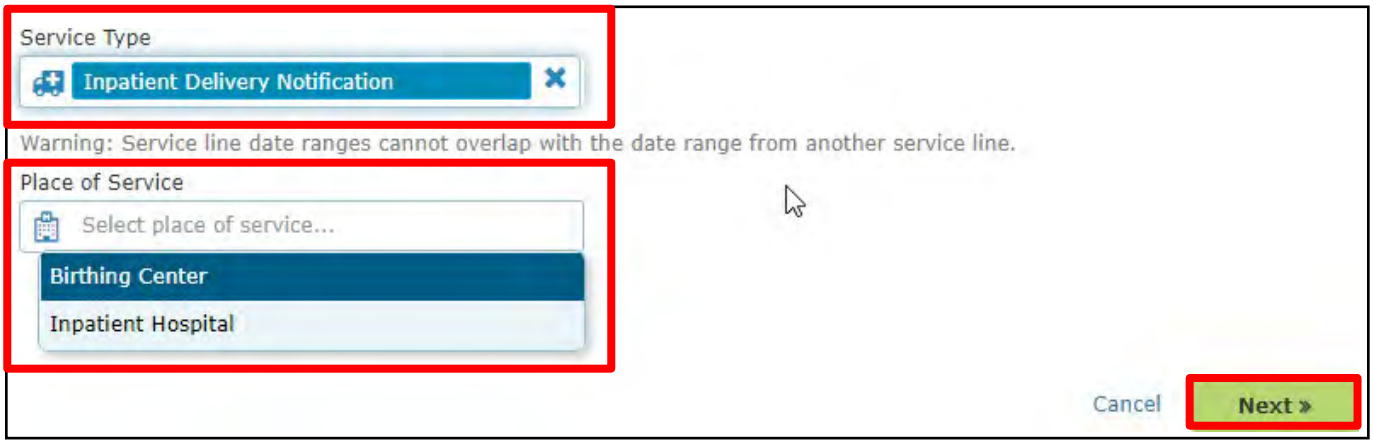
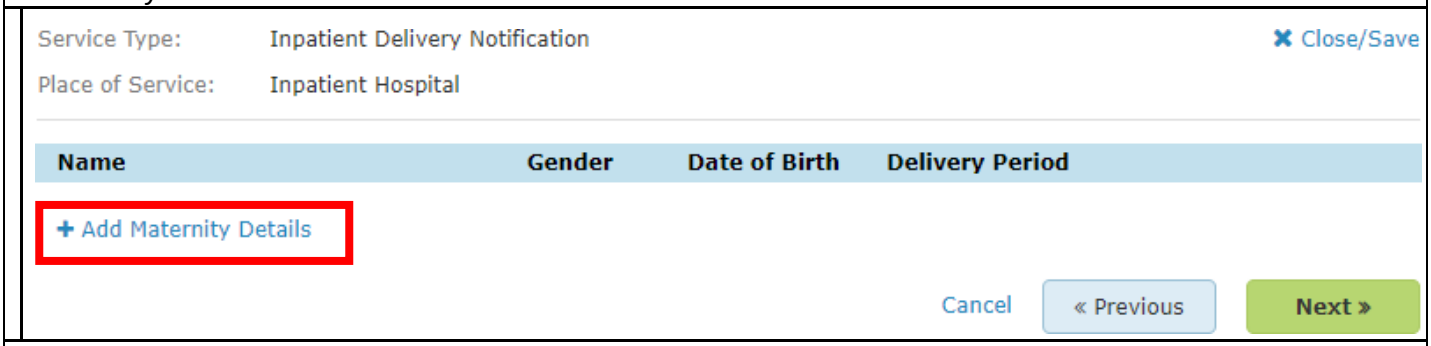


## Creating a New Authorization – Inpatient Delivery Notification (cont'd)

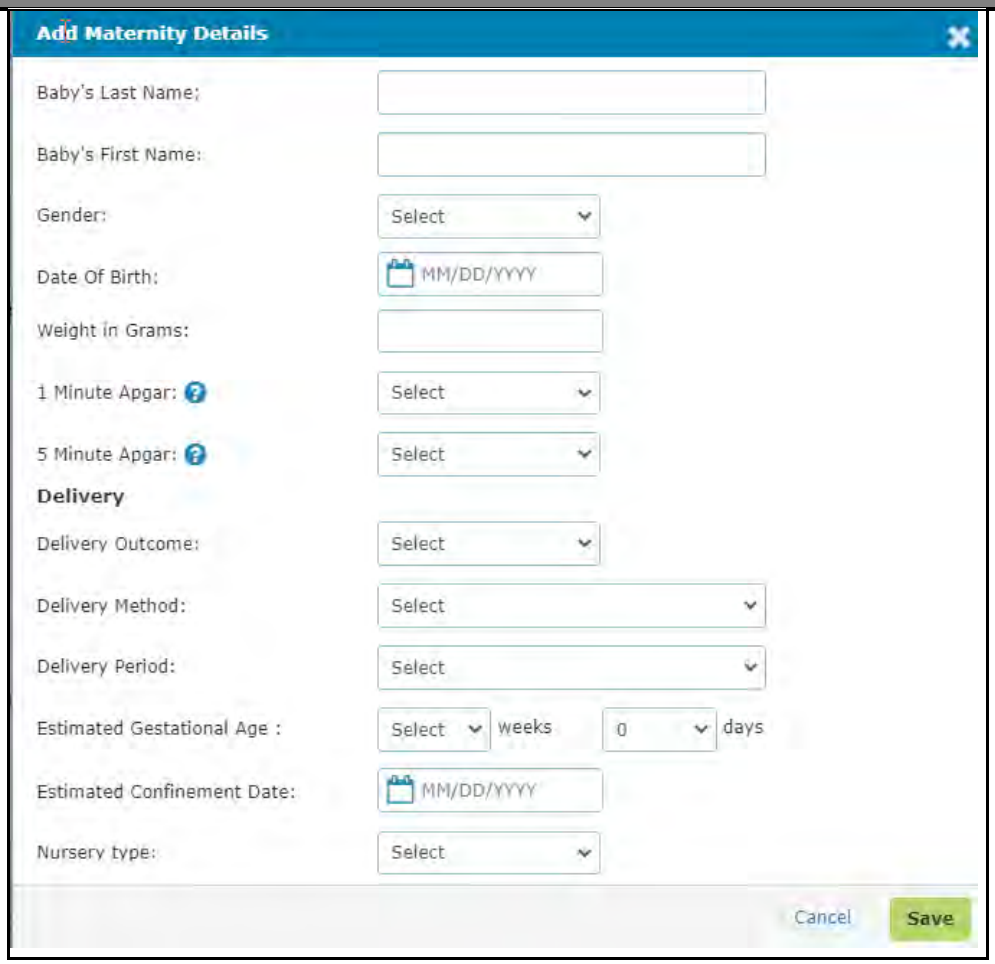
| Step | Action |
|---|---|
| **4.** | Address the pre-screening questions pop up box then select **Continue**.<br>**Note**: If a member is not active with the health plan, the user will not be advanced to the pre-screening questions. |

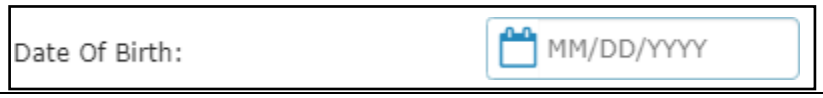
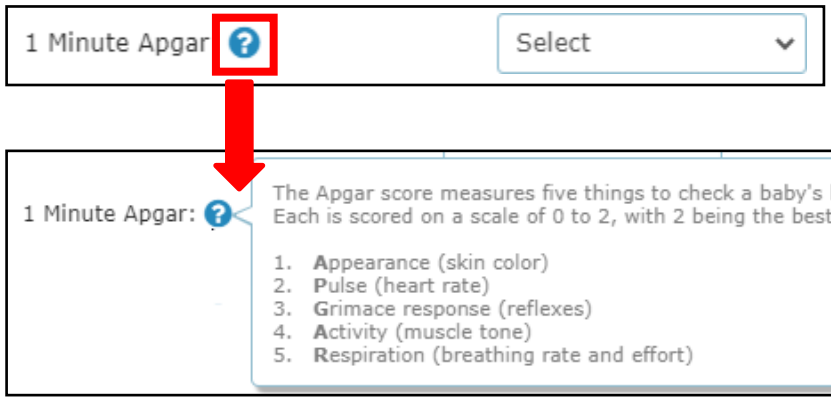
| If… | Then… |
|---|---|
| The member has active coverage | The provider will be advanced to the New Authorization Pre-Screening Questions<br>  <br>The purpose of the New Authorization Pre-Screening Questions is to ensure that the correct authorization process is being followed. It is important to scroll through the questions to ensure that there is not a more appropriate avenue for the request. These questions are specific based on the health plan. |
| The member is ineligible | The provider will receive the authorization cannot be created message.<br> |

## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

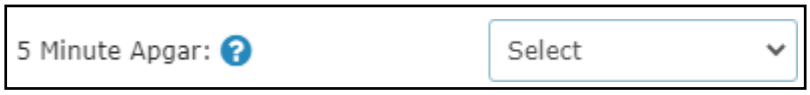
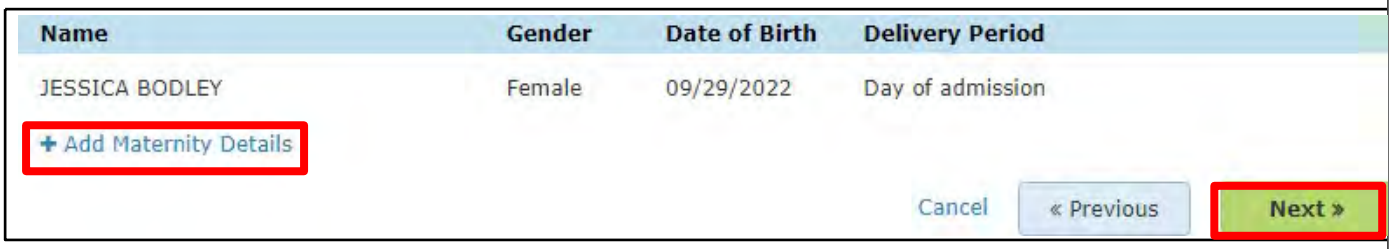
| Step | Action |
|---|---|
| **5.** | Complete the required fields following the guidelines below for an Inpatient Delivery Notification:<br><br>Service Type: **Inpatient Delivery Notification**<br>Place of Service: **Birthing Center** or **Inpatient Hospital**<br>Select **Next**<br><br>  Service Type<br>Inpatient Delivery Notification<br>Warning: Service line date ranges cannot overlap with the date range from another service line.<br>Place of Service<br>Select place of service...<br>Birthing Center<br>Inpatient Hospital<br>Cancel<br>Next » |
| **6.** | Click **+ Add Maternity Details** to populate the Add Maternity Details pop out box. The fields in this box are mandatory.<br><br>  Service Type: Inpatient Delivery Notification<br>Close/Save<br>Place of Service: Inpatient Hospital<br>Name<br>Gender<br>Date of Birth<br>Delivery Period<br>+ Add Maternity Details<br>Cancel<br>« Previous<br>Next » |

## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

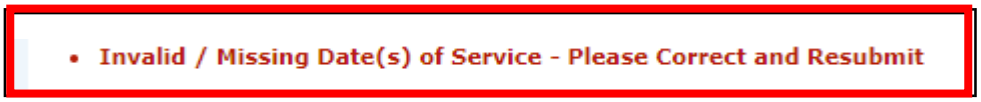
| Step | Action |
|---|---|
| 6. |  |

| Step | Action | |
|---|---|---|
| 6. | **Baby's Last Name** | Free text field. Enter the baby's last name.<br> |
| | **Baby's First Name** | Free text field. Enter the baby's first name.<br> |
| | **Gender** | Drop down field. The options are Male, Female, Unknown<br> |
| | **Date Of Birth** | Select a date from the calendar<br>  |
| | **Weight in Grams** | Free text field. Enter the weight in grams<br> |
| | **1 Minute Apgar** | Drop down field - select 1-10. Click on the question mark for clarification.<br>  |

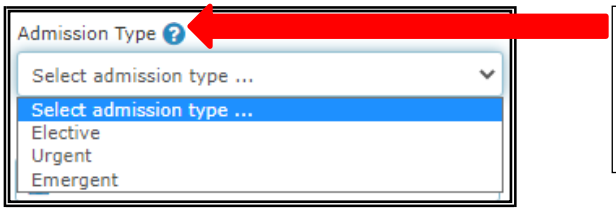
## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

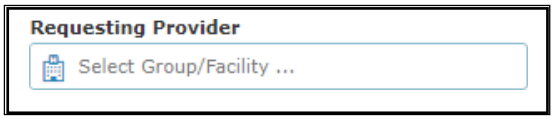
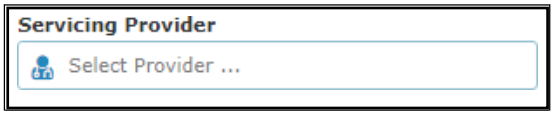
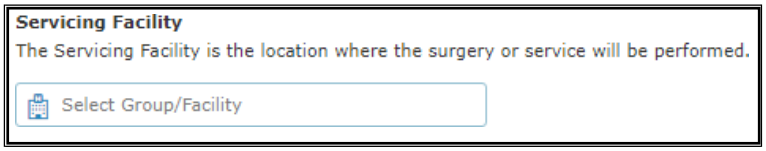
| Step | Action | |
|---|---|---|
| 6. | **5 Minute Apgar** | Drop down field - select 1-10.<br>  |
| | **Delivery Outcome** | Drop down field – select live birth or non live birth.<br> |
| | **Delivery Method** | Drop down field – select c-section or normal vaginal delivery.<br> |
| | **Delivery Period** | Drop down field – select day of admission, day after admission, or 2 or more days after admission.<br> |
| | **Estimated Gestational Age** | Select the appriopriate values from the drop down fields.<br> |
| | **Estimated Confinement Date** | Type the date or use the calendar to select the appropriate date.<br> |
| | **Nursery type** | Drop down field – select well baby or NICU.<br> |
| 7. | Select **Save** when the Add Maternity Details are complete.<br>If this is a multiple gestation pregnancy and additional births should be reported, select **+ Add Maternity Details** to complete the additional details, then select **Next.**<br>  | |

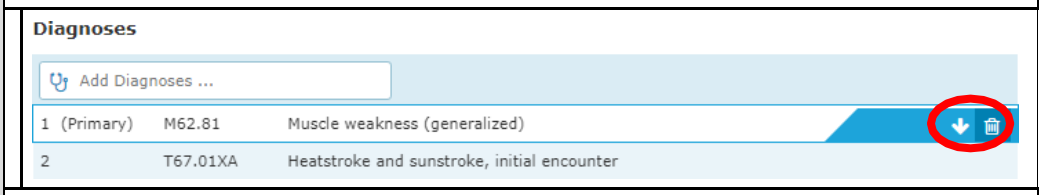
## Creating a New Authorization – Inpatient Delivery Notification (cont'd)

| Step | Action | |
|---|---|---|
| 8. | **Date of Admission/ Date of Discharge** | Date of admission is a mandatory field. Date of discharge is optional because it may not be known at the time the request is initiated. Providers can add the date of discharge by amending an authorization (see Amending an Authorization chapter).<br> <br><br>**Note:** If the dates of service overlap in the same case, the message below will display.<br>  <br> |

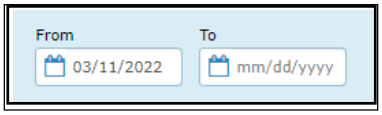
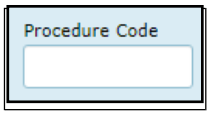
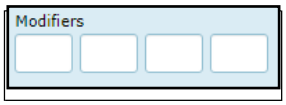
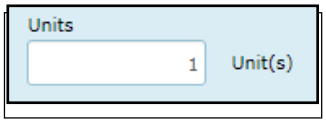
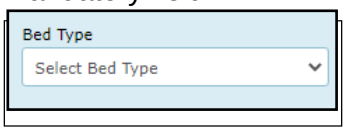
## Creating a New Authorization – Inpatient Delivery Notification

<table>
<tr><th>Step</th><th colspan="2">Action</th></tr>
<tr><td>9.</td><td>Admission Type</td><td>Select the admission type – Elective, Urgent, or Emergent<br> 

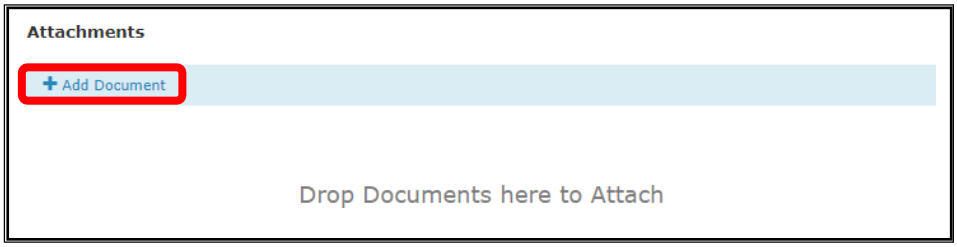
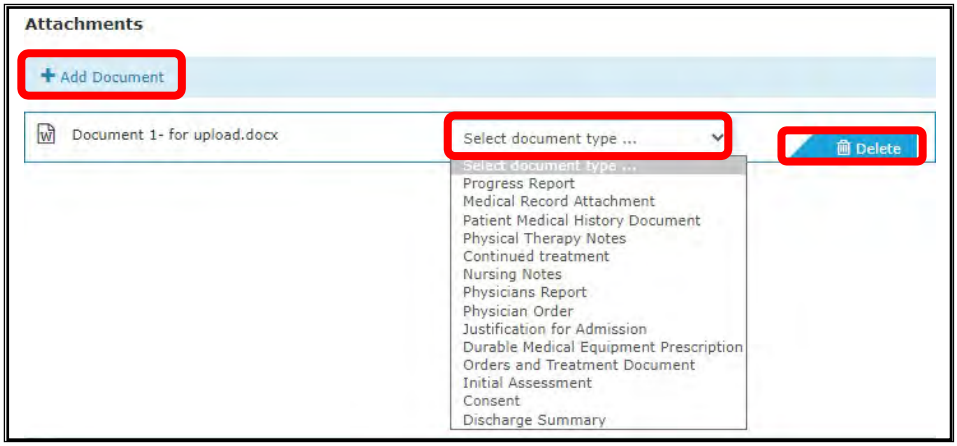
The question mark beside admission type provides information regarding the types of admissions.<br><br>
<table>
<tr><th>If</th><th>Then</th></tr>
<tr><td>Elective</td><td>Potential admission for illness/injury enrollee not currently admitted</td></tr>
<tr><td>Urgent</td><td>Potential admission for illness/injury that can be treated in a 24-hour period and if left untreated could rapidly become a crisis or emergency, enrollee not currently admitted</td></tr>
<tr><td>Emergent</td><td>Concurrent review, enrollee is currently admitted</td></tr>
</table></td></tr>
<tr><td></td><td>Requesting Provider</td><td>Select the requesting provider. Requesting provider is the provider that is requesting the service.<br> 
</td></tr>
<tr><td></td><td>Servicing Provider</td><td>Choose the appropriate selection from the drop-down list. Servicing provider is the provider completing the service (also known as the attending provider).<br> 
</td></tr>
<tr><td></td><td>Servicing Facility</td><td>The servicing facility is the location where the service will be performed.<br> 
</td></tr>
</table>

| Step | Action |
|---|---|
| 9. | **Diagnoses**<br>**Diagnoses**<br>Diagnoses is a look up field (max number of diagnosis codes that can be attached is 12).<br> <br><br>**Note:** The primary diagnosis can be changed if more than 1 diagnosis exists. There is also the ability to delete a diagnosis that may have been entered in error. The user can hover over the row to reorder (arrow icon) and or delete (trash icon) the diagnosis.<br>  <br> |

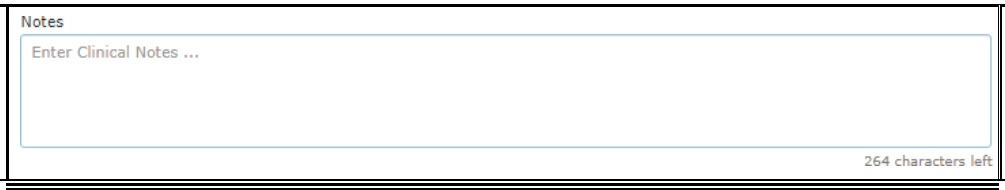
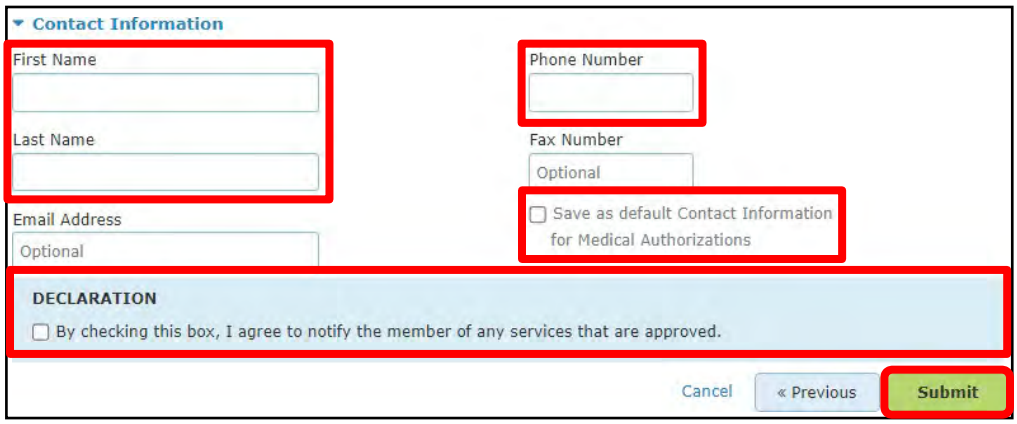
## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

| Step | Action | |
|---|---|---|
| 9. | **Services** | |
| | **From / To** | From (start date) / To (end date). The From and To dates are mandatory. If the To date is unknown, advance it by 1 day from the From date.<br>  |
| | **Procedure Code** | This is a free text field and is not mandatory. If an incorrect procedure code is entered the request may not be processed. The user will **not** be notified if an incorrect code is entered so it is important for the user to enter the correct code. If this is an inpatient only request and there is no procedure code, do not place anything in the procedure code field.<br>  |
| | **Modifiers** | This is a free text field and is not mandatory.<br>  |
| | **Units** | Free text numeric value. For the inpatient request, units are equivalent to days.<br>  |
| | **Bed Type** | Select the appropriate bed type from the drop down list. This is a mandatory field.<br>  |
| | **+ Add New Service Line** | The user must add new service line for the system to recognize the request. The **Add New Service Line** will also be utilized when adding additional service requests.<br> |

# Creating a New Authorization – Inpatient Delivery Notification(cont'd)

| Step | Action | |
|---|---|---|
| 9. | **Attachments** | |
| | **Add Document** | Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). Up to 10 documents may be attached. If a document is attached, the document type is mandatory. Documents attached in error can be deleted.<br>  <br><br>  <br> |

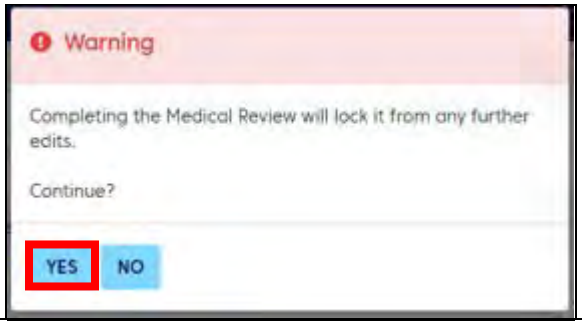
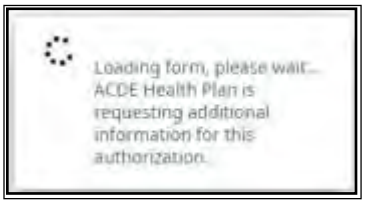
## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>9.</td><td>Notes
<table>
<tr><td>Notes</td><td>Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters.<br> 
</td></tr>
<tr><td>Contact Information</td><td>Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select Submit when the request is complete.<br>Note: Check Save as default Contact Information for Medical Authorizations to save time in the future.<br> 
</td></tr>
</table></td></tr>
<tr><td>9.</td><td>Selecting Submit may or may not launch InterQual criteria. InterQual criteria is launched based on the diagnosis code and or the service code and if there are criteria to launch for the diagnosis code and or service code that is identified in the episode. If InterQual criteria is not launched after the user submits the request, the user may receive a status of pending or an automatic approval.</td></tr>
<tr><td>10.</td><td>If InterQual is launched, the message below will populate indicating the InterQual page is loading.<br>
</td></tr>
</table>

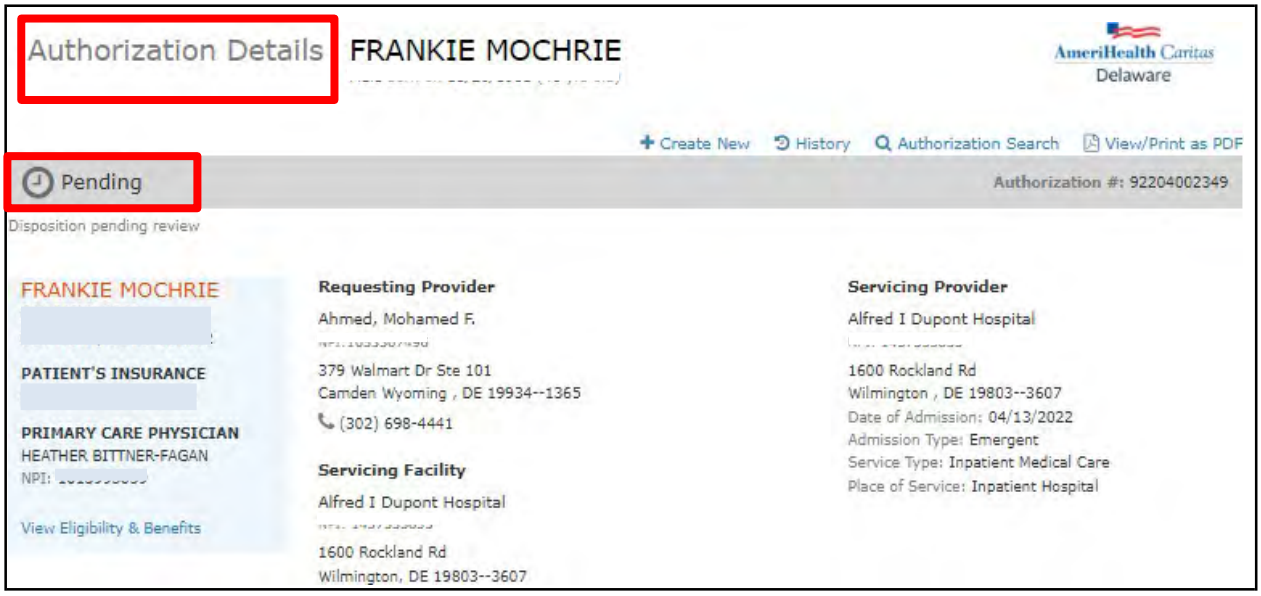
## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

| Step | Action |
|---|---|
| **11.** | The system will direct the user to a guideline selection page. Select the most appropriate guideline then click on medical review.<br> <br>Select the day on which you wish to complete the medical review then select the pertinent findings/interventions. |

## Creating a New Authorization – Inpatient Delivery Notification(cont'd)

| Step | Action |
|---|---|
| **12.** | Address all pertinent findings/interventions based on the day selected for the review. At the end of the review the user will receive criteria met or criteria not met. Regardless of if it meets or does not meet, the user should continue. |
| **13.** | When the review is complete, click **Complete** at the bottom**,** then select **YES** to continue.<br>  |
| **14.** | The following notice which indicates that the system is going back to NaviNet from InterQual.<br>  |

## Creating a New Authorization - Inpatient Delivery Notification (cont'd)

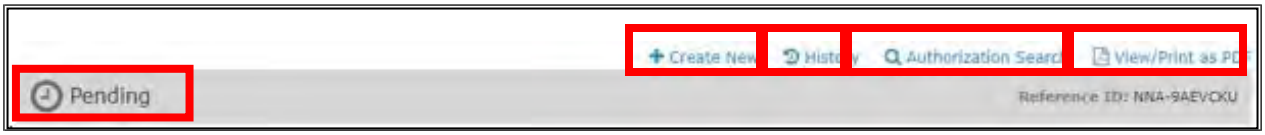
| Step | Action |
|---|---|
| **15.** | Once the user arrives back in NaviNet, they will arrive on the authorization details screen.   |

## Authorization Status – Approved and Pending

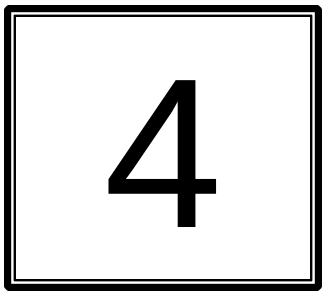
The episode will be approved or be in a pending status when the request has been submitted to the health plan.

**Note**: Denials are not processed automatically, pending status submissions will require medical review by the health plan. If a denial is processed by the plan, a telephone call/letter will be made/sent to the provider.

<table>
<tr><th>If…</th><th>Then it will look like this…</th></tr>
<tr><td>Approved</td><td>

Note: Approved and partially approved requests can be amended (see chapter on Amending).<br><br>
The following actions can be taken on an approved request from the authorization status page:
<table>
<tr><td>Amend</td><td>Extending existing services or requesting another service on the same authorization</td></tr>
<tr><td>Create New</td><td>Creating a new request</td></tr>
<tr><td>Attach</td><td>Attaching a document</td></tr>
<tr><td>Authorization Search</td><td>Searching for an authorization</td></tr>
<tr><td>View/Print as PDF</td><td>View and print authorization status request as PDF</td></tr>
</table>
</td></tr>
<tr><td>Pending</td><td>


Note: Pended status submissions will require medical review by the health plan. Requests that have a pending status cannot be amended.<br><br>
The following actions can be taken on an approved request from the authorization status page:
<table>
<tr><td>Create New</td><td>Creating a new request</td></tr>
<tr><td>History</td><td>Detailed history of the request</td></tr>
<tr><td>Authorization Search</td><td>Searching for an authorization</td></tr>
<tr><td>View/Print as PDF</td><td>View and print authorization status request as PDF</td></tr>
</table>
</td></tr>
</table>



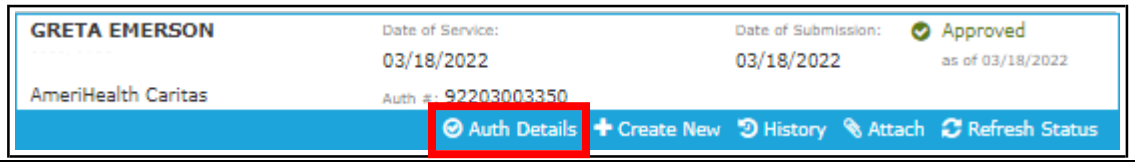

# 4 AMENDING AN AUTHORIZATION

## Amending an Authorization Request

Amending a request is the process of extending existing services **or** requesting another service on the same authorization. Each time an amendment is made the note character limit will be reduced. Amending is only available to requests that have been approved or partially approved by the health plan. The maximum number of services that can be added to an authorization is 15.

When making an amendment the user can add diagnoses, add services, add notes (if the maximum character limit has not been exceeded) and add documents.

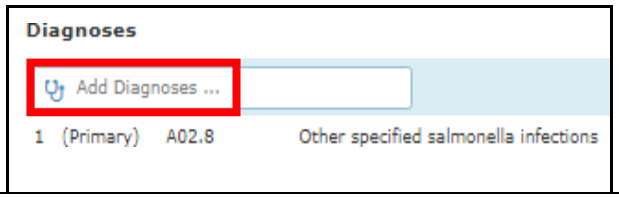
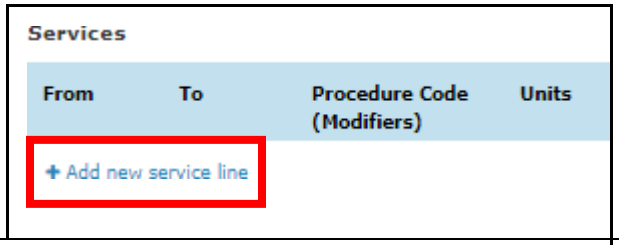
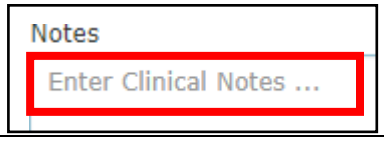
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1.</td><td>Locate the existing request under Workflows for this Plan.<br>

<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>The request was created in NaviNet</td><td>Select Medical Authorizations Log</td></tr>
<tr><td>The request was not created in NaviNet (for example if the request was faxed, phoned, or submitted via Jiva)</td><td>Select Medical Authorizations and then Search for Existing Authorization (also referred to as Authorization Inquiry by NaviNet)</td></tr>
</table></td></tr>
<tr><td>2.</td><td>Select Auth Details on the request that needs to be amended.<br> 
</td></tr>
<tr><td>3.</td><td>Select Amend.<br>
</td></tr>
</table>

## Amending an Authorization Request (cont'd)

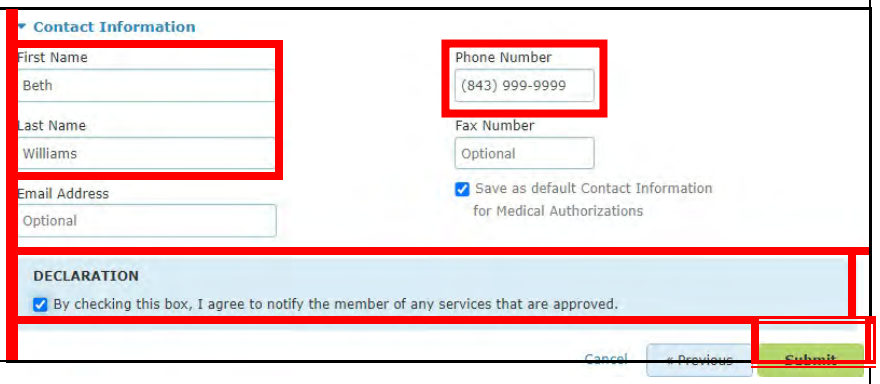
| Step | Action |
|---|---|
| **4.** | |

| | |
|---|---|
| Amending an outpatient request | The following items can be addressed: date of service, diagnosis, add new service line, add document, notes and contact information. |

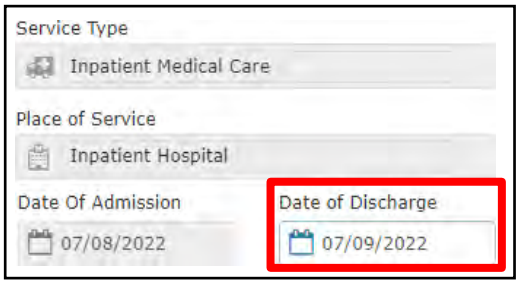
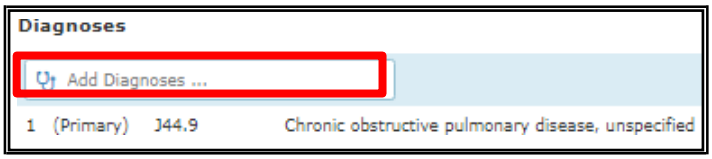
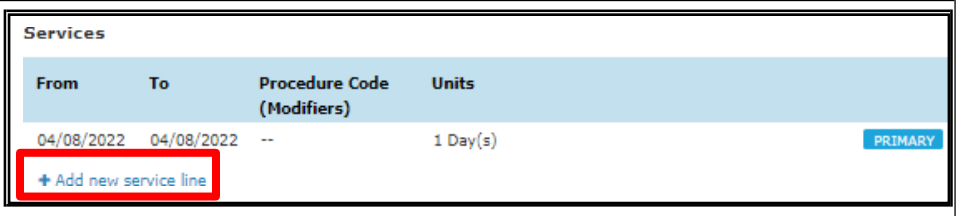
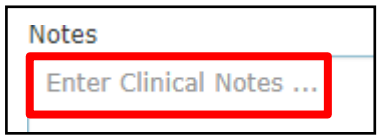
| | |
|---|---|
| Address the Date of Service | |
| Add additional diagnoses if applicable |  |
| Add new service line |  |
| Add attachments if applicable | |
| Add notes if applicable |  |

## Amending an Authorization Request (cont'd)

| Step | Action |
|---|---|
| **4.** **(cont.)** | Amending an outpatient request |
| | Enter contact information, check the Declaration box, and **Submit.** |

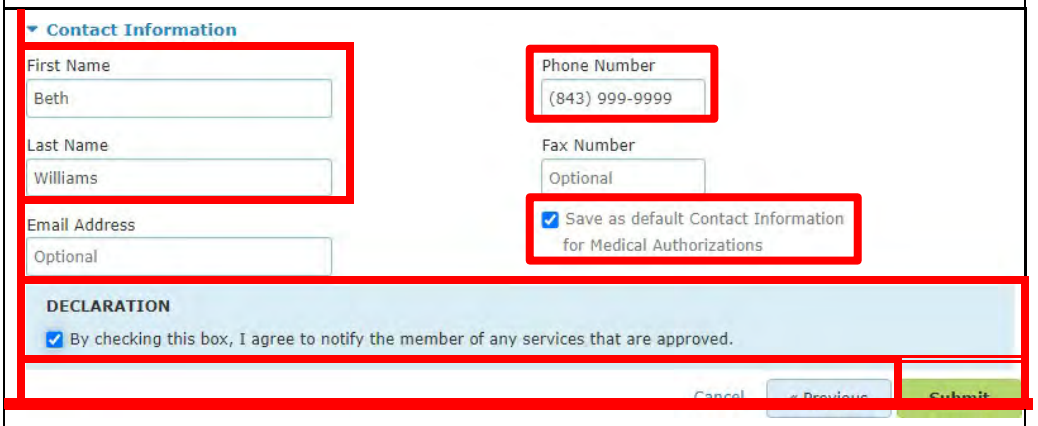


## Amending an Authorization Request (cont'd)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>5.</td><td>Amending an inpatient request
<table>
<tr><th>If…</th><th>Then….</th></tr>
<tr><td>Amending an inpatient request</td><td>The following items can be addressed: date of date of discharge, diagnosis, add new service line, add document, notes and contact information</td></tr>
</table>
<table>
<tr><td>Providers can enter the date of discharge for members that have discharged.</td><td> 
</td></tr>
<tr><td>Add additional diagnoses if applicable</td><td> 
</td></tr>
<tr><td>Add new service line</td><td> 
</td></tr>
<tr><td>Add attachments if applicable</td><td>
</td></tr>
<tr><td>Add notes if applicable</td><td> 
</td></tr>
</table></td></tr>
</table>

## Amending an Authorization Request (cont'd)

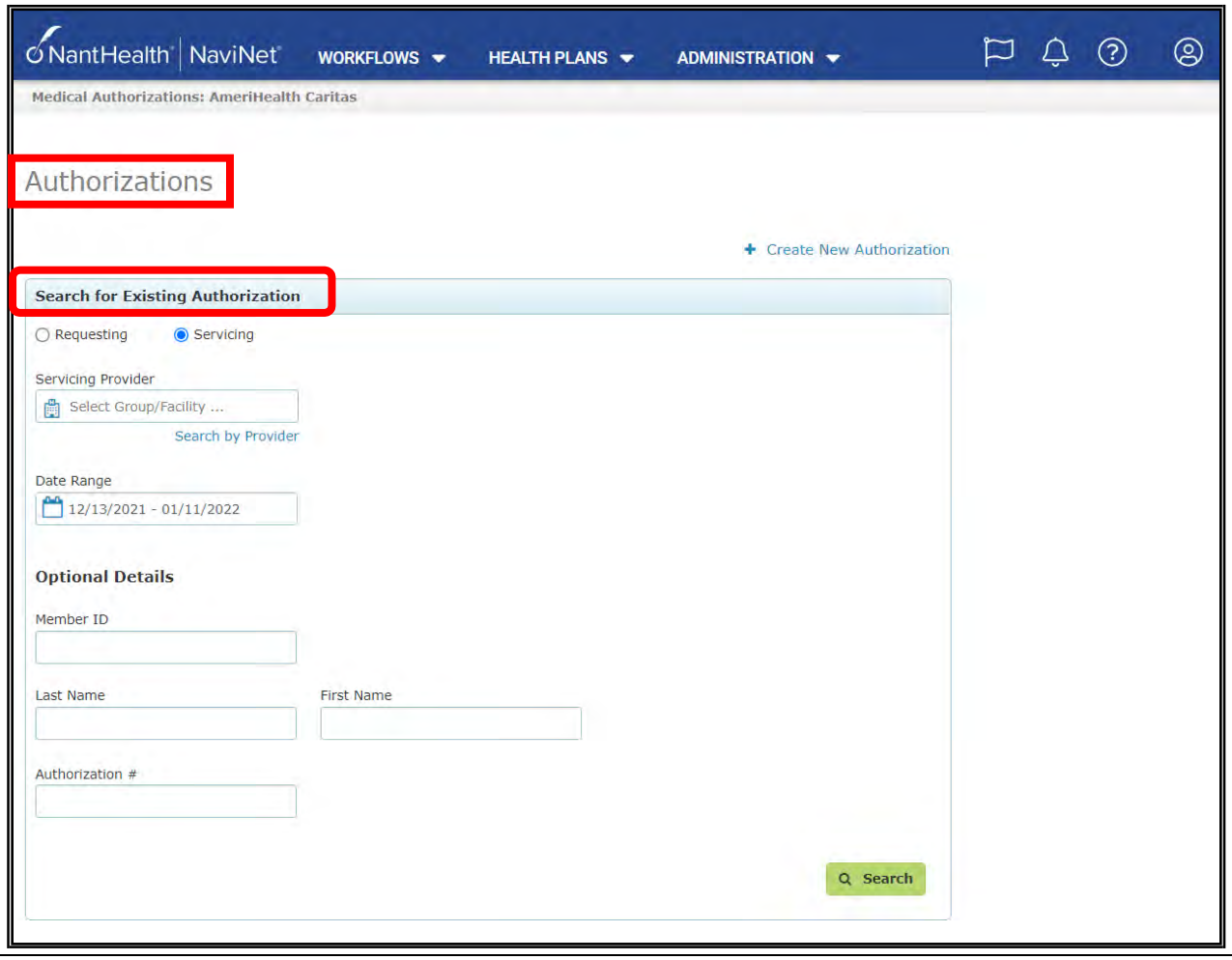
| Step | Action |
|---|---|
| **5. (cont.)** | Amending an inpatient request |
| | Enter contact information, check the Declaration box, and **Submit** |



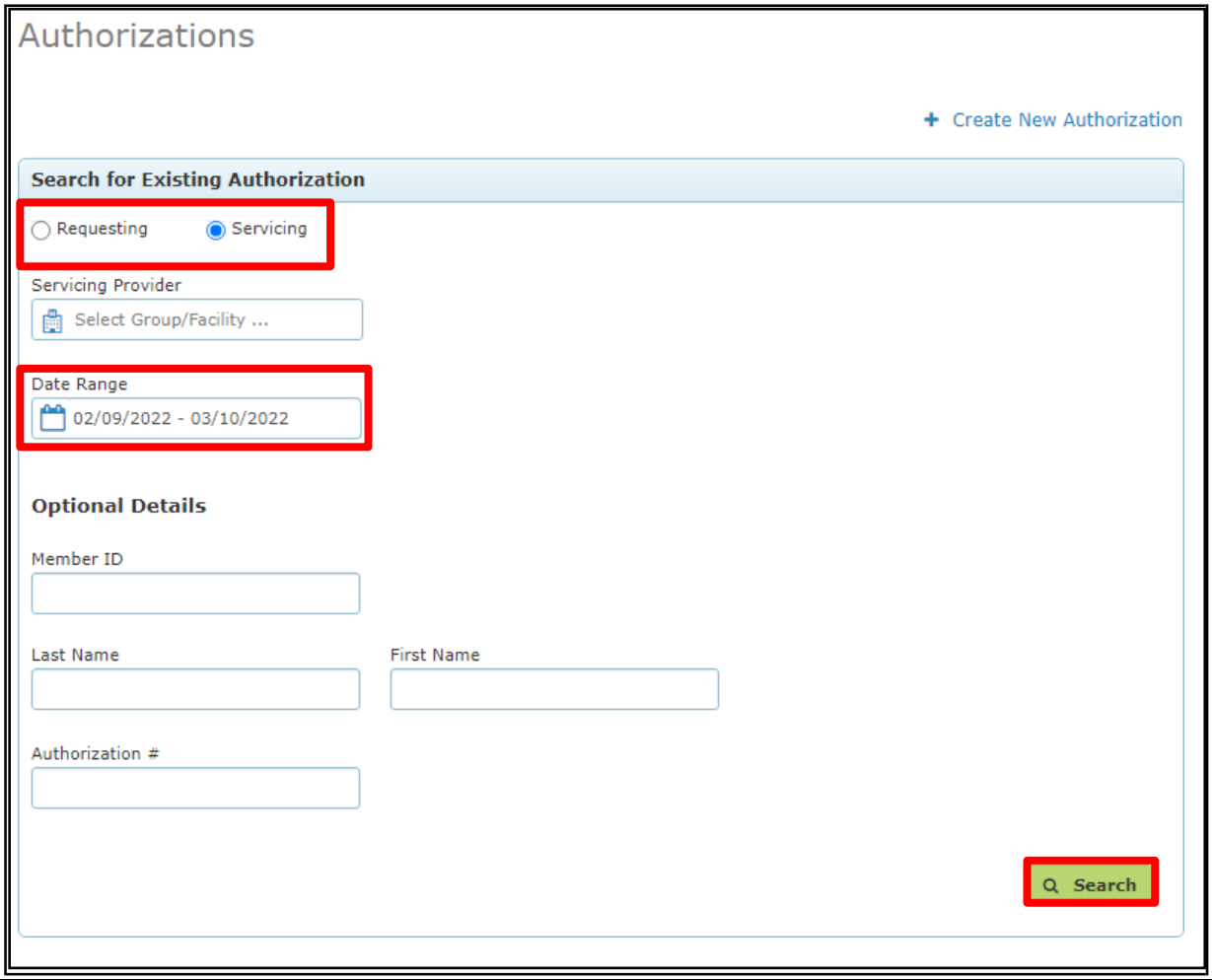
# 5 SEARCH FOR AN EXISTING AUTHORIZATION

## Search for an Existing Authorization

Search for an Existing Authorization (also known as Authorization Inquiry) is a way to search for authorizations that may not have been initiated in NaviNet, for example they may have phoned, faxed, or created in Jiva.

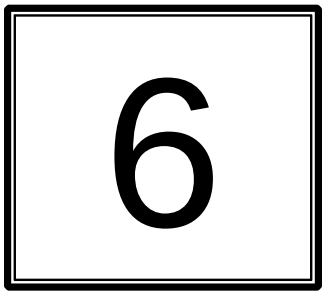
| Step | Action |
|---|---|
| **1.** | Providers will only see authorizations/requests for members that are under their care. To search for an existing authorization select **Medical Authorizations** under Workflows for this Plan.   |

## Search: Search for an Existing Authorization (cont'd)

| Step | Action |
|---|---|
| **2.** | Select Servicing or Requesting Provider and adjust the date range then select **Search**.<br>  |
| **3.** | Click the authorization that you wish to view.<br> |

## Search: Search for an Existing Authorization (cont'd)

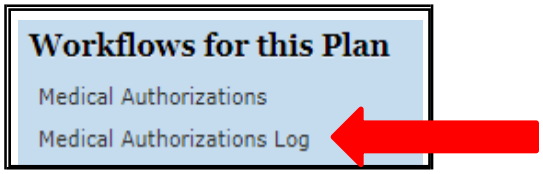
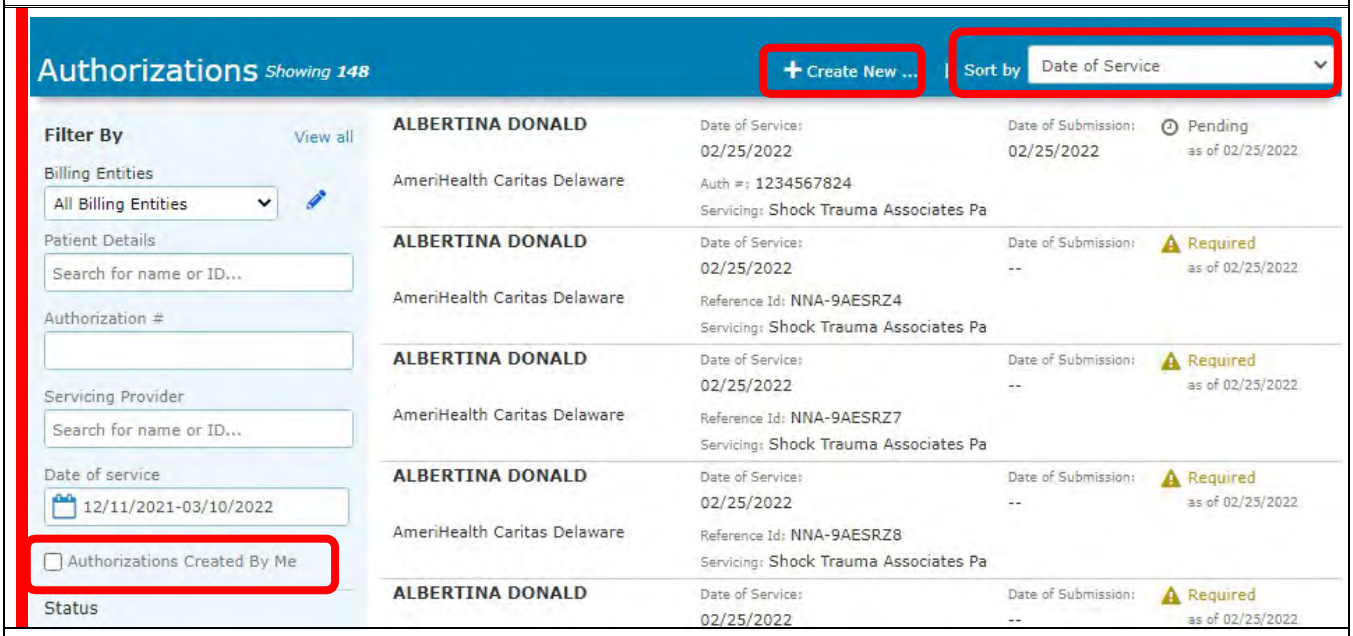
| Step | Action |
|---|---|
| **4.** | The user will be directed to the authorization details of the authorization that was selected in the previous step.<br> <br>**Note:** Additional actions may be accessed from the authorization details to include amending (only available for approved or partially approved requests), create new, attach, authorization search, and view/print as PDF.<br>**Amend** — Extending existing services or requesting another service on the same authorization<br>**Create New** — Creating a new request<br>**Attach** — Attaching a document<br>**Authorization Search** — Searching for an authorization<br>**View/Print as PDF** — View and print authorization status request as PDF |




# 6 MEDICAL AUTHORIZATION LOG

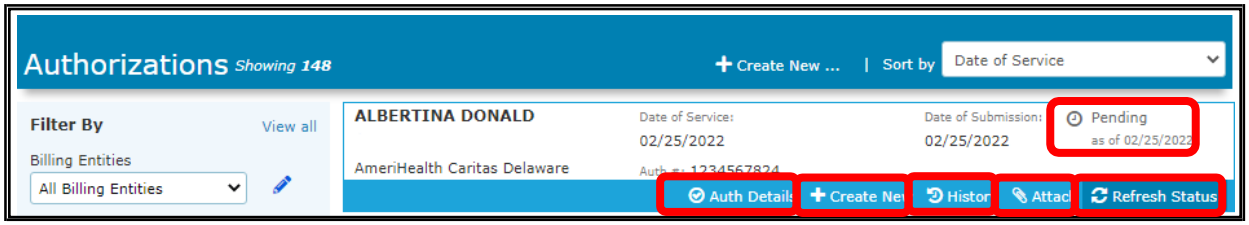
## Search: Medical Authorization Log

Only requests that have been submitted via NaviNet Open Medical Authorizations will appear in the Authorization Log. To see cases that were initiated outside of NaviNet, use Search for an Existing Authorization (sometimes referred to as Authorization Inquiry).

| Step | Action |
|---|---|
| **1.** | Select **Medical Authorization Log** under Workflows for this Plan.<br>Result: All requests submitted by your office/facility via NaviNet can be found here.<br>  |
| **2.** | The user can +Create New, Sort by and Filter By. To see Authorizations created by you, check the box in front of **Authorizations Created By Me.**<br>  |

# Search: Medical Authorization Log (cont'd)

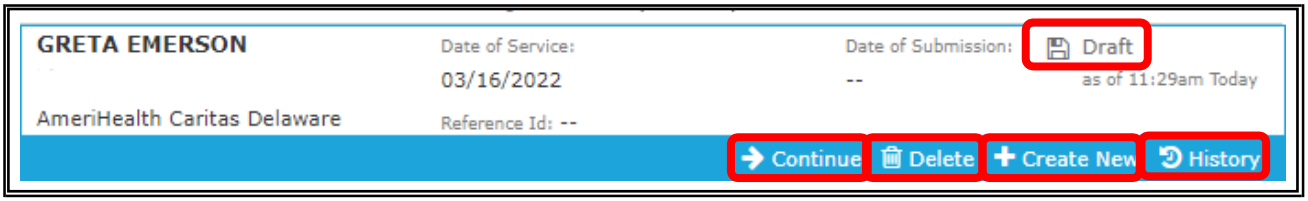
| Step | Action |
|---|---|
| **3.** | Once the user selects the desired authorization for review they have the ability to view the following if the request is in pending status: **Auth Details, +Create New, History, Attach, and Refresh Status**. |




| Field | Function |
|---|---|
| Auth Details | Details related to the authorization |
| + Create New | Create New Authorization for the member |
| History | Provides detailed history of the request |
| Attach | Ability to attach documents |
| Refresh Status | Allows the user to refresh the status for any updates. |

## Search: Medical Authorization Log (cont'd)

| Step | Action |
|---|---|
| **3. (cont.)** | If the request is in draft status different fields are available.<br>**Continue, Delete, Create New,** and **History** |




| Field | Function |
|---|---|
| Continue | Allows the user to continue working on the request |
| Delete | Allows the user to delete the request |
| Create New | Allows the user to create a new authorization for the member |
| History | Provides detailed history of the request |

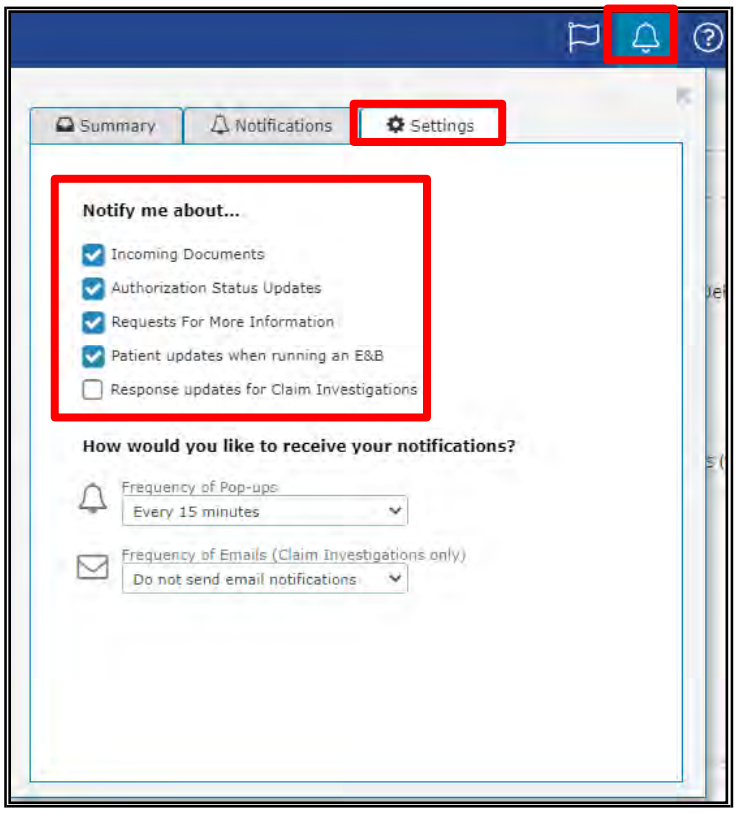
# 7 REQUEST FOR MORE INFORMATION (RFMI)

## Request for More Information (RFMI)

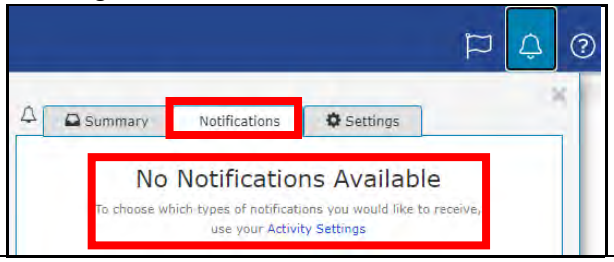
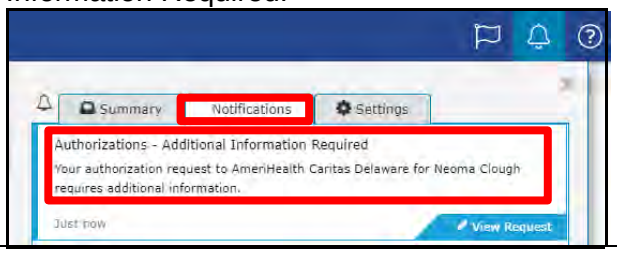
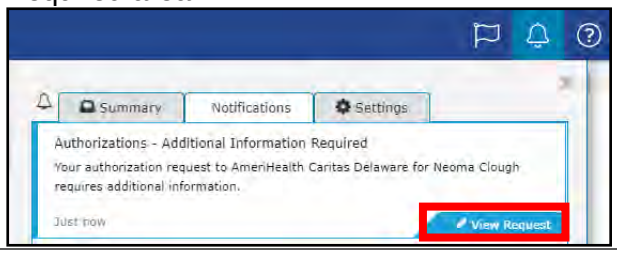
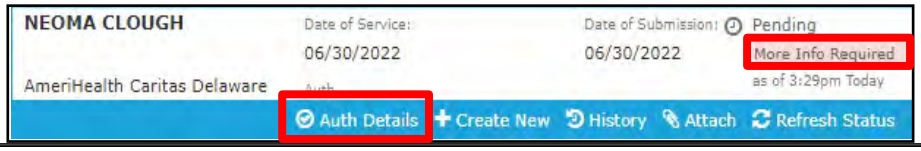
Request for More Information (RFMI) is a feature that allows the health plan to request specific additional information to the provider if needed. Providers will only be able to have the RFMI ability for authorization requests that are pended or approved that are created in the NaviNet Provider Portal. Providers will be able to add notes and/or upload the documents in NaviNet Provider Portal for the pended authorization requests via the 'more information required' screen.

Notifications are an important part of the communication process between the health plan and the provider. Users can opt to receive notifications whenever a request is sent from the health plan to the provider. Notifications can be managed from the bell icon in the top right banner on the home page. It is important to note that notifications related to RFMI is not an immediate process. There is a slight delay as information travels from system to system.

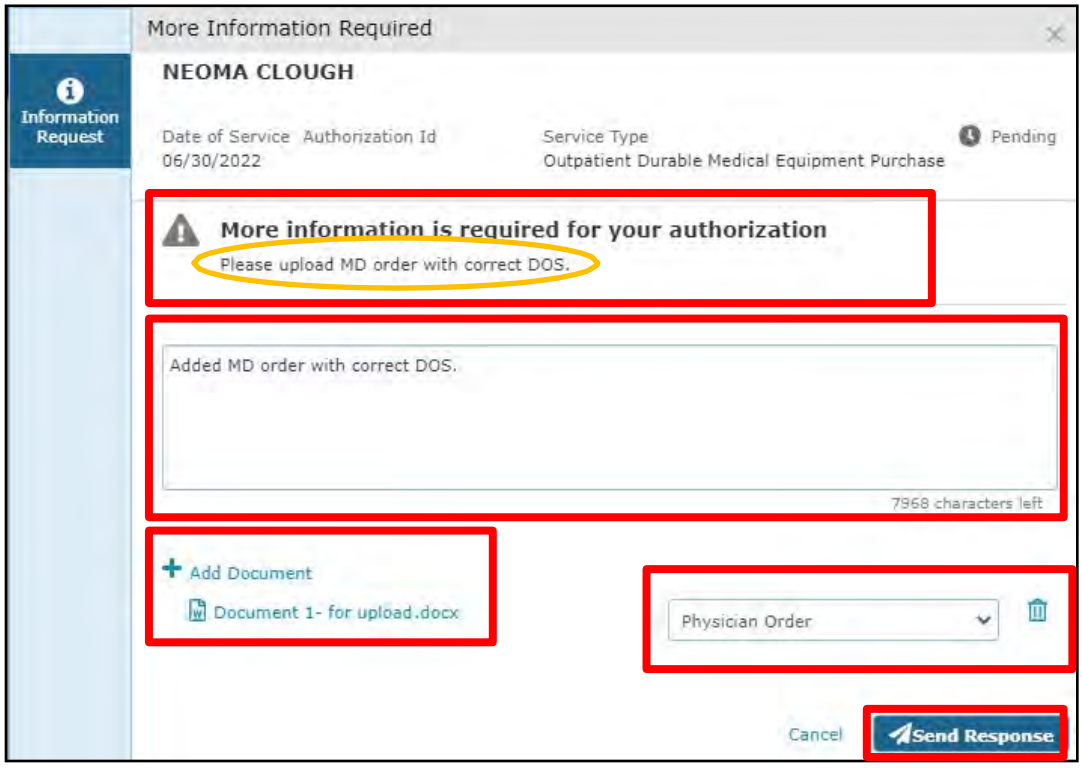
In NaviNet, users can opt to receive notifications whenever a request for additional information is requested from the health plan. Notifications can be managed under settings which is found when the bell icon is selected.

| Step | Action |
|---|---|
| **1.** | Select the bell icon in the top right corner in NaviNet, then frome the Settings tab, specify the notifications you would like to receive.<br>  |

## Request for More Information (RFMI) (cont'd)

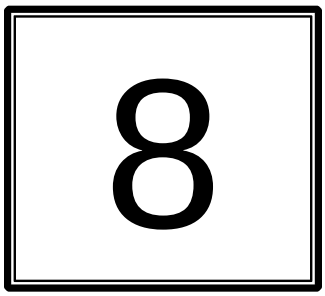
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>2.</td><td>To view notifications, select Notifications.
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>No notifications exist</td><td>The user will see No Notifications Available message.<br> 
</td></tr>
<tr><td>Notifications are available</td><td>The user will see Authorizations – Additional Information Required.<br> 
</td></tr>
</table></td></tr>
<tr><td>3.</td><td>There are 3 ways for the user to see RFMI from the health plan.
<table>
<tr><td>1.</td><td>From Notifications the user will select View Request which activates the More Information Required area.<br> 
</td></tr>
<tr><td>2.</td><td>From the Medical Auth Log if More Info Required is listed the user will select Auth Details then select More Information Required to activate the More Information Requried area.<br> 
</td></tr>
</table></td></tr>
</table>

## Request for More Information (RFMI) (cont'd)

| Step | Action |
|---|---|
| **3. (cont'd)** | **3.** From Auth Inquiry if More Information Required is listed, click on it to activate the the More Information Required area.<br> |
| **4.** | Complete the more information required information request. The requested information will be listed under More information is required for your authorization. You may add notes (up to 8000 characters) and upload documents. If a document is uploaded, the document type will need to be specified from the drop down list (supported document types: pdf, docx, xml, csv, png, gif). To send the response back to the health plan select **Send Response**.<br>  |

## Request for More Information (RFMI) (cont'd)

| Step | Action |
|---|---|
| **5.** | To see that the requested information has been sent back to the health plan, select **History**.<br> |




# 8 RESOURCES

## Plan Contact Information

| Health Plan | UM Phone Number | UM Fax Number |
|---|---|---|
| **AmeriHealth Caritas Delaware** | 855-396-5770 | 866-423-0946 |
| **AmeriHealth Caritas District of Columbia** | 800-408-7510 | 877-759-6216 |
| **AmeriHealth Caritas Florida** | 855-371-8074 | 855-236-9285 |
| **AmeriHealth Caritas Louisiana** | 888-913-0350 | 866-397-4522 |
| **AmeriHealth Caritas New Hampshire** | 833-472-2264 | 833-469-2264 |
| **AmeriHealth Caritas North Carolina** | 833-900-2262 | 833-893-2262 |
| **AmeriHealth Caritas Northeast** | 888-498-0504 | 888-743-5551 |
| **AmeriHealth Caritas Pennsylvania** | 800-521-6622 | 866-755-9949 |
| **Blue Cross Complete of Michigan** | 888-312-5713 | 888-989-0019 |
| **Keystone First** | 800-521-6622 | 215-937-5322 |
| **Select Health of South Carolina** | 888-559-1010 | 888-824-7788 |
| **AmeriHealth Caritas Next** | 833-702-2262 | 844-412-7890 |
| **AmeriHealth Caritas VIP Care Plus** | 888-978-0862 | 866-263-9036 |
| **First Choice VIP Care Plus** | 888-996-0499 | 855-236-9284 |
| **AmeriHealth Caritas VIP Care** | 866-533-5490 | 855-707-0847 |
| **First Choice VIP Care** | 888-996-0499 | 855-236-9284 |
| **Keystone First VIP Choice** | 800-450-1166 | 855-707-0847 |
| **AmeriHealth Caritas Pennsylvania Community HealthChoices** | 800-521-6007 | 855-332-0115 |
| **Keystone First Community HealthChoices** | 800-521-6622 | 855-540-7066 |

## Escalation Process and Training Requests – Account Executives and Providers

| If… | Then contact… |
|---|---|
| **Access Issues and/or Technical Issues related to NaviNet and InterQual** | DL-ACFC: Jiva and Client Letter Support (ACFC_JivaCLSupport@amerihealthcaritas.com) |
| **Account Executive Training Requests** | Corporate Provider Network Management Training (CPNMT@amerihealthcaritas.com) |
| **Provider Training Requests** | Contact your designated Account Executive (AE) |
| **Provider is not listed in NaviNet** | Submit an online case in NaviNet via My Account>Customer Support>Open a Case Online |
| **InterQual training or instruction is needed** | Reach out to your internal point of contact as this is an internal process |