

# Provider TouCHPoint Training Guide

Feb 1, 2018

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Dear Provider,

Texas Children's Health Plan (TCHP) is thankful for your continued support and commitment to our members. As our membership continues to grow to over 350,000 and we embark on new initiatives, we want to continue to find ways to enhance our ability to serve you. Our continued improvements and additions can be a vital resource for you and your staff.

Provider TouCHPoint has several enhanced features and capabilities that will quickly provide access to patient information. One of these great features is the ability to view patient copays and primary care assignments on a single page. We are confident that this enhanced version of Provider TouCHPoint will also offer you better access to:

- Claims information
- Claim submission
- Appeal submission
- Referrals and authorizations
- Provider directory search tools
- Self-generated reports

In this guide you will find information on how to register, search and view patient eligibility, view claims status, view and submit authorizations, generate reports, and send secure messages. If you have any questions regarding this new system, please call Provider Relations at 832-828-1008.

Your continued support is valuable to us throughout this process. We hope you will be pleased with these changes, and we would love to hear your feedback.

Sincerely,

Lucio Fragoso

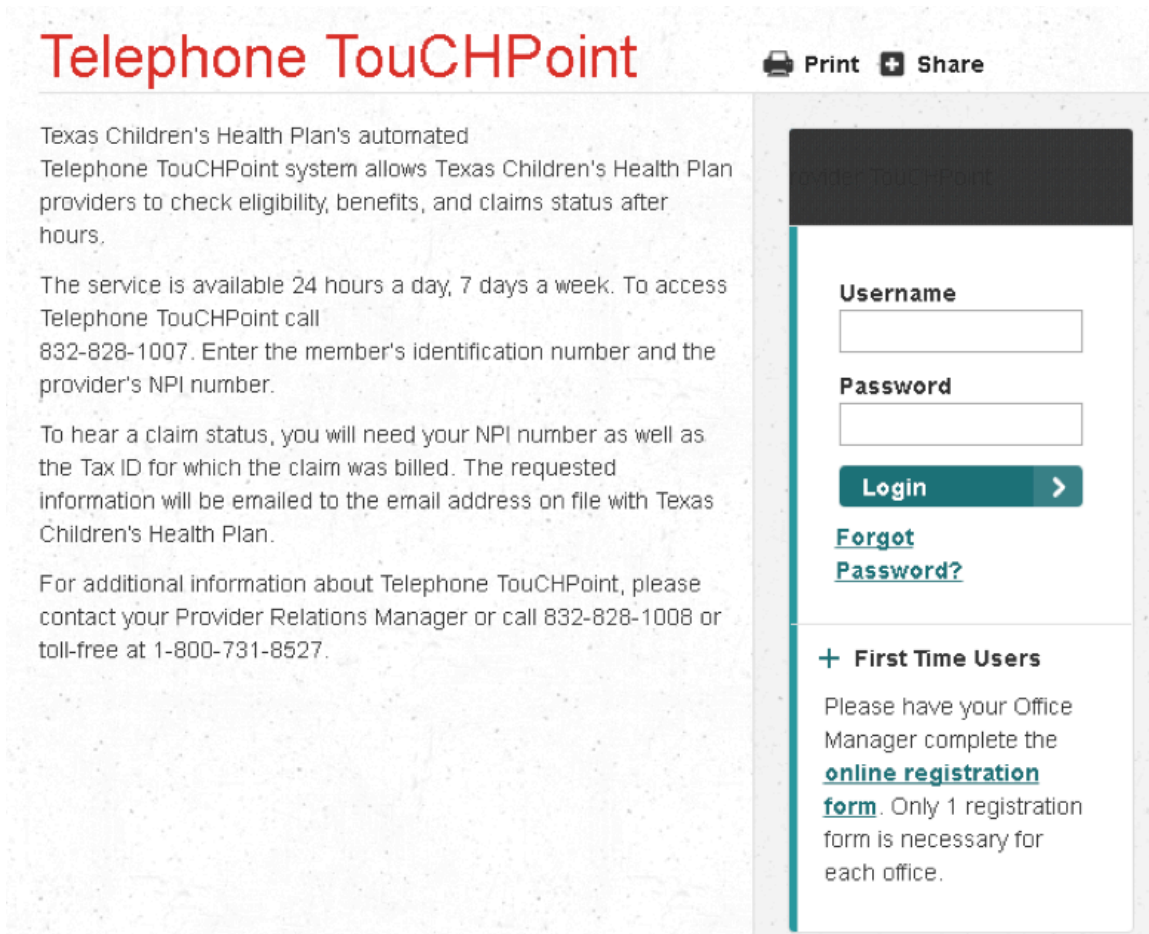
President, Texas Children's Health Plan

# Registration

## Registration

Registering for Provider TouCHPoint is fast and easy. New physicians, office manager, or administrators can register online by following these simple steps.

**Step 1:** Go to [tchp.us/for-providers/telephone-touchpoint](http://tchp.us/for-providers/telephone-touchpoint). Click on the [First Time Users](#) link under the login box.



The screenshot shows the 'Telephone TouCHPoint' login page. On the left, there is a text area with the following content:

**Telephone TouCHPoint**

Texas Children's Health Plan's automated Telephone TouCHPoint system allows Texas Children's Health Plan providers to check eligibility, benefits, and claims status after hours.

The service is available 24 hours a day, 7 days a week. To access Telephone TouCHPoint call 832-828-1007. Enter the member's identification number and the provider's NPI number.

To hear a claim status, you will need your NPI number as well as the Tax ID for which the claim was billed. The requested information will be emailed to the email address on file with Texas Children's Health Plan.

For additional information about Telephone TouCHPoint, please contact your Provider Relations Manager or call 832-828-1008 or toll-free at 1-800-731-8527.

On the right, there is a login form with the following elements:

- Print and Share icons
- Username field
- Password field
- Login button with a right arrow
- [Forgot Password?](#) link
- + First Time Users** section with the text: "Please have your Office Manager complete the [online registration form](#). Only 1 registration form is necessary for each office."

**Step 2:** Enter your user information. Fields with a red asterisk are required. Click the Next button.

**First Time Users: Please have your Office Manager complete this registration information. Only 1 registration form is necessary per office.**

You are at the **Registration User Information** screen.

Complete all fields that are marked as required. These fields are indicated by a **red asterisk**.

The Password Reminder question may not contain any part of your password. Also, note that the password is case sensitive.

The Security Question and Security Answer will be used if you call the Help Desk to have your password reset.

When all fields are completed click *Next* to proceed to the next steps.

## User Information

---

If you are an existing user of the Connect system please login [Click here to start your session.](#)

First Name *	<input type="text"/>
Middle Initial	<input type="text"/>
Last Name *	<input type="text"/>
Title *	<input type="text"/>
E-Mail *	<input type="text"/>
Confirm E-Mail *	<input type="text"/>
Office Phone *	<input type="text"/> Example: (555) 555-5555
Extension #	<input type="text"/> Example: 123456
Office Fax *	<input type="text"/> Example: (555) 555-5555
User Name *	<input type="text"/>
Password *	<input type="password"/>
Confirm Password *	<input type="password"/>
Security Question 1 *	<input type="text"/>
Security Answer 1 *	<input type="text"/> Your answer may not contain your username.
Security Question 2 *	<input type="text"/>
Security Answer 2 *	<input type="text"/> Your answer may not contain your username.
Security Question 3 *	<input type="text"/>
Security Answer 3 *	<input type="text"/> Your answer may not contain your username.
Local Admin	<input checked="" type="checkbox"/> As the primary registrant, you are automatically a local admin

Cancel

Back

Next

**Step 3:** Enter your office information. All fields are required.

**Office Information**

---

Enter the name and address of your office.

Organization Name \*

Tax ID \*

Address \*

City \*

State \*

Zip Code \*

Click the [Next](#) button.

## Adding additional users

**Step 1:** Once you complete your registration, you can register additional users. If you are going to add additional users, click [Yes](#), then click the [Next](#) button. If not, click [No](#) and click the [Next](#) button.

### Register Additional Users

---

Would you like to add additional users to your registration?

Yes \*

No \*

Cancel

Back

Next

**Step 2:** Once you complete the form for additional users, click [Local Admin](#) if you want a user to have the same administrative rights to add or delete users and manage roles. Click [Add User](#). If you want to continue to add users, repeat this step. Once you complete this process, click the Next button.

After adding additional users, the registration process confirms the additional users by displaying their names under the Additional Users section.

**NOTE:** Local administrators can select their username/password. All other users are assigned system-generated usernames and temporary passwords.

**Step 3:** Once you have completed entering additional users, you will receive a registration summary. If any information is incorrect, click the [Back](#) or [Cancel](#) button. If all the information is correct, click the [Finish](#) button. You will receive user IDs and user types for each added user. Click the [Next](#) button.

**Registration Summary**

---

**Office Contact Info:** [edit]

▶ [Medical Group](#)

**User Information:** [edit]

▶ [One, User](#)

Cancel
Back
Finish

---

**Registration Created**

Below are the users that have been created for your registration. Please take note of the User IDs since they will be needed to log into the application.

Name	User ID	User Type
Two, User	UsTwo1	Provider User
One, User	providerone	Provider Contact

Next

Once registration is complete, you will receive a confirmation e-mail. TCHP will approve registrations as soon as possible. You will then need to login to Provider TouCHPoint using your username and temporary password assigned by TCHP. You will be prompted to create a new password.













# Eligibility

Provider TouCHPoint allows you to verify eligibility and copay information for your TCHP patients. Below are some simple steps to get you started.

**Step 1:** Click on the [Eligibility](#) button under the [Office Management](#) section of Provider TouCHPoint or the [Look Up Patient Eligibility](#) link on the homepage.



Welcome To Provider TouCHPoint

	<a href="#">Look up patient eligibility</a> Get up-to-date information about patient eligibility and copay amounts.		<a href="#">Find a TCHP participating provider</a> Use our provider directory to find a provider by name, location or plan.
	<a href="#">View my claims</a> View the status of a claim and remittance advice.		<a href="#">Authorizations</a> View the status of an authorization. Submit an authorization request online.
	<a href="#">Setting permissions</a> Assign roles in Provider TouCHPoint for others in your office.		<a href="#">Communication</a> Get the latest information on upcoming CME opportunities, <i>Provider News</i> , fax blasts, community events and more.
	<a href="#">Clinical Reports</a> Download current EPSDT, Asthma High Risk reports and other clinical reports.		<a href="#">Provider Training</a> Provider Training (Navitus, Dental, CHIP Perinat
	<a href="#">Utilization Management Guidelines</a> Review utilization management guidelines for TCHP required authorizations.		<a href="#">Clear Coverage Training</a> Clear Coverage

text size **A A A**

Office Management

**Eligibility**

Claims

Authorizations

Code Lookup

Clear Coverage Inpatient Hospital Admissions

vTouch

Clear Coverage Outpatient / Provider Offices

Document Manager

Valence Population Management

Claims Appeals

Provider Directory Verification

Batch Claims Submission

The eligibility search feature allows you to search for a patient by any of the following:

- Last name, member ID or SSN (required)
- Date of birth (required)
- PCP
- Effective "as of"
- Gender
- Age

**Step 2:** Complete the form and then click the Search button. The eligibility search results screen displays the member name, gender, effective dates, date of birth, member ID and PCP. (For best results, use only the patient information and the date of birth)

Eligibility information is updated every 15 minutes from 7 a.m. to 7 p.m. Monday to Friday.

Eligibility Search

**CONDUCT ELIGIBILITY SEARCH**

Patient  Last Name  Member ID  Social Security Number

XXXXXXXXXXXX ?

(Last Name Example - Smith, John)

---

PCP None Selected

---

**SEARCH FILTERS**

As of    Birth Date   
(MM/DD/YYYY)

Gender   Age

---

Disclaimer: This is not a Guarantee of Benefits or Eligibility as outlined in SB418. Benefits are contingent upon the plan being in force and the patient insured at the time the services are rendered. Please contact your Provider Relations Manager at 832-828-1008 for further assistance.

**NOTE:** You must enter a date of birth using one of the following examples: 052508, 05252008, 05/25/2008, or 05/25/08

Last name search can be partial (at least first 2 letters of last name), while the SSN and member ID must be exact

To view newborn eligibility, enter the member’s ID number and type “NB” after the number

**Step 3:** For eligibility detail, click on the member name.

The [Eligibility Detail](#) screen will display TCHP member information including name, date of birth, sex, member ID, PCP, and address. Benefit copay information will also be displayed. If the effective date is red, the member is inactive.

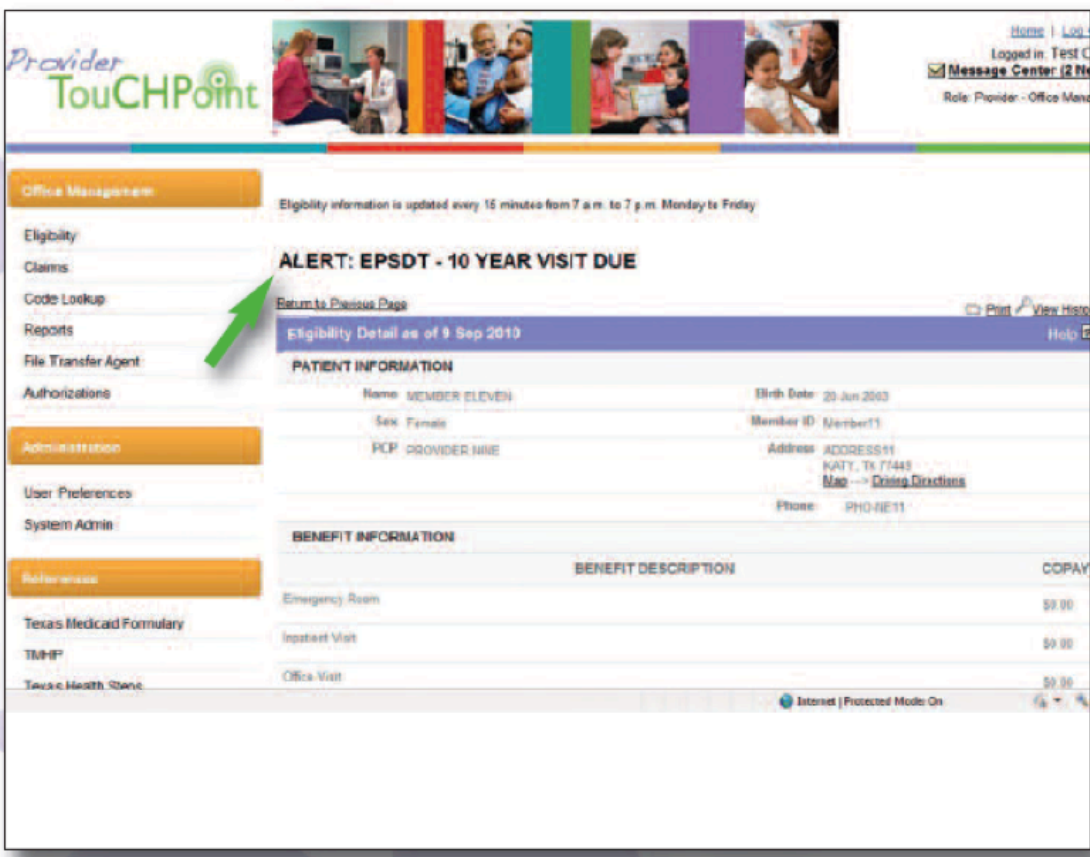
You can click on the [Print](#) icon to print the eligibility detail on 1 page. Benefit information will display copays. The Coordination of Benefits (COB) will be listed under the [Additional Information](#) link.

Click [Return to Previous Page](#) to return to the [Eligibility Detail](#) page.

You can click on the [View History icon](#) to see all previous eligibility segments.

### EPSDT visit alert

We have added a new feature that alerts you when a member's EPSDT visit is due. The EPSDT alert is shown on the [Eligibility Detail](#) page.



The screenshot shows the Provider TouCHPoint interface. At the top, there is a navigation bar with the logo and user information. The main content area is divided into a left sidebar with navigation options and a main panel. The main panel displays an alert: **ALERT: EPSDT - 10 YEAR VISIT DUE**. Below the alert, there is a section for **PATIENT INFORMATION** with fields for Name, Sex, PCP, Birth Date, Member ID, Address, and Phone. A **BENEFIT INFORMATION** table is also visible, listing various services and their associated copay amounts. A green arrow points to the **Return to Previous Page** link in the alert area.

Office Management

Eligibility

Claims

Code Lookup

Reports

File Transfer Agent

Authorizations

Administration

User Preferences

System Admin

Reference

Texas Medicaid Formulary

TIMFP

Texas Health Stone

Eligibility information is updated every 15 minutes from 7 a.m. to 7 p.m. Monday to Friday

**ALERT: EPSDT - 10 YEAR VISIT DUE**

[Return to Previous Page](#)

Eligibility Detail as of 9 Sep 2010

**PATIENT INFORMATION**

Name:	MEMBER ELEVEN	Birth Date:	20 Jun 2003
Sex:	Female	Member ID:	Member11
PCP:	PROVIDER NINE	Address:	ADDRESS11 KATY, TX 77449
		Phone:	PHO-1E11

**BENEFIT INFORMATION**

	BENEFIT DESCRIPTION	COPAY
	Emergency Room	\$9.00
	Inpatient Visit	\$9.00
	Office Visit	\$9.00

Internet | Protected Mode: On

## Locating a StarKids Service Coordinator

StarKids members are assigned a Service Coordinator to assist in coordination of care. To locate the Service Coordinator, begin by clicking on the [Eligibility](#) screen.

**Step 1:** Enter the [Member ID](#) and the [Birth Date](#) using a format of MM/DD/YYYY.

text size A A A

Office Management

Eligibility

Claims

Authorizations

Code Lookup

Clear Coverage Inpatient Hospital Admissions

vTouch

Clear Coverage Outpatient / Provider Offices

Document Manager

Valence Population Management

Batch Claims Submission

Claims Appeals

Provider Complaint

Provider Directory Verification

Eligibility information is updated every 15 minutes from 7 a.m. to 7 p.m. Monday to Friday.

### Eligibility Search

CONDUCT ELIGIBILITY SEARCH

Patient  Last Name  Member ID  Social Security Number

(ID Example - HP555555,HP444444)

PCP None Selected

#### SEARCH FILTERS

As of

Birth Date

(MM/DD/YYYY)

Gender

Age

Disclaimer: This is not a Guarantee of Benefits or Eligibility as outlined in SB418. Benefits are contingent upon the plan being in force and the patient insured at the time the services are rendered. Please contact your Provider Relations Manager at 832-828-1008 for further assistance.

The member eligibility will be shown. Click on the [member name](#).

### Eligibility Search Results

NAME	SEX	EFFECTIVE DATES	BIRTH DATE	MEMBER ID	PRIMARY CARE PROVIDER	EPSDT
<input type="text" value=""/>						

Pages: (1) Results: 1

Disclaimer: This is not a Guarantee of Benefits or Eligibility as outlined in SB418. Benefits are contingent upon the plan being in force and the patient insured at the time the services are rendered. Please contact your Provider Relations Manager at 832-828-1008 for further assistance.

**Step 2:** Scroll to the bottom of the eligibility information. Under [Additional Information](#), the Service Coordinator's name and phone number will be listed.

### ADDITIONAL INFORMATION

Service Coordinator Name:  MSW Phone Number:  ..... is the alternate insurance carrier on record.

# Claims/Code Lookup

## Claims

Checking the status of a claim has never been easier. Follow the steps below to get started.

**Step 1:** Click on the [Claims](#) button under the [Office Management](#) section of Provider TouCHPoint or [View My Claims](#) link on the home page.

You will see two tabs on the [Claims](#) screen: one for a claims status search and one for a remittance advice search.

Under the [Claims Status](#) tab, you can search for a claim by any of the following:

- Claim number (partial search)
- Date of service
- Patient information
  - Last name (partial search)
  - Member ID
  - SSN
  - Patient account number
- Provider information
  - Last name (partial search)
  - Tax ID
  - NPI
- Bill type
- Status (paid, pending, denied)

**NOTE:** A patient's account number will only be searchable if submitted on the claim.

text size A A A

Office Management

Eligibility

**Claims**

Authorizations

Code Lookup

Clear Coverage Inpatient Hospital Admissions

vTouch

Clear Coverage Outpatient / Provider Offices

Document Manager

Valence Population Management

Claims Appeals

Provider Directory Verification

Batch Claims Submission

Administration

User Preferences

References

[American Academy of Child & Adolescent Psychiatry](#)

American Academy of Pediatrics

American Medical Association

Ask Me 3

ImmTrac

Texas Health Steps

**Claim Status** Remittance Advice Add Claim

Online Claims Appeals - Claims Screen

Submit individual claim appeals and supporting documentation by clicking on the Claims Appeals link.

Attention: 835 Processing

Don't forget we offer 835 processing through Change Healthcare. This will eliminate manual postings. Please consult with your clearinghouse. Thank you

**Claim Status Search**

Claim Number

Date of Service  To

Patient  Last Name  Member ID  Social Security Number  Patient Account Number

(Patient List) ▼

(Last Name Example - Smith, John)  
(ID Example - HP5555555,HP4444444)  
(SSN Example - 555-55-5555, 444-44-444)  
(Medicaid ID Example - AA55555,AA44444)  
(Medicare ID Example - 555555,4444444)

Provider  Last Name  Provider Tax ID  Provider NPI

(Last Name Example - Smith, John)

Bill Type

Status  Paid  Pending  Denied  Submitted

Indicates non-standard HIPAA data element

**Step 2:** Complete the form and click the search button.

A [Claim Status Search Results](#) screen will appear. You will see a link for the claim numbers, status, patient name, patient account number, DOS, provider name, total charged, and total paid.

text size A A A

Office Management

Eligibility

**Claims**

Authorizations

Code Lookup

Clear Coverage Inpatient Hospital Admissions

vTouch

Clear Coverage Outpatient / Provider Offices

**Claim Status** Remittance Advice Add Claim


Pages: (1) Results: 1

**Claim Status Search Results For 525005200**

CLAIM NUMBER	STATUS	PATIENT	PATIENT ACCOUNT NO.	DOS	PROVIDER	BILLED	PAID

Pages: (1) Results: 1

**Step 3:** Click on the claim number to see the claim status details.

 [Print](#)

**Claim Status Detail for 17235E01708**

**CLAIM LEVEL INFORMATION**

Provider	[REDACTED]	Practice	[REDACTED]
Patient	[REDACTED]	Patient Account No.	[REDACTED]
▶ Ref/Auth Number	None		
▶ Referring Provider			
▶ Diagnosis			

**SERVICE LINE INFORMATION**

LINE	STATUS	CHECK/EFT NUMBER	PAYMENT DATE	DOS	PROCEDURE	MODIFIER	UNITS	BILLED AMOUNT	▶ ALLOWED AMOUNT	▶ CO-PAYMENT	▶ COB	PAID
<u>001</u>	Finalized Payment	[REDACTED]	[REDACTED]				1	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
							Totals	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

▶ **ADDITIONAL INFORMATION**

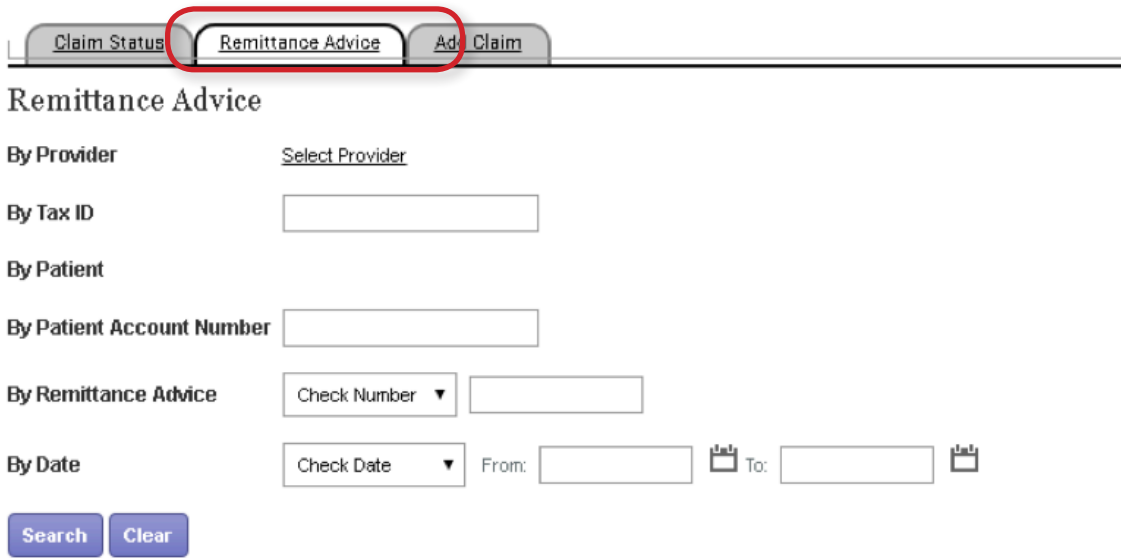
**PAYOR REMARKS**

**NOTE:** Clicking on the check number will open the [Remittance Advice](#) tab.

## Claims remittance

**Step 1:** To search for a claim remittance, click on the [Claims](#) button under the [Office Management](#) section of Provider TouCHPoint or [View My Claims](#) link on the homepage.

You will see two tabs on the [Claims](#) screen: 1 for claims status search and 1 for remittance advice search.



Claim Status **Remittance Advice** Ad Claim

### Remittance Advice



By Provider [Select Provider](#)

By Tax ID

By Patient

By Patient Account Number

By Remittance Advice Check Number ▼

By Date Check Date ▼ From:   To:  

Under the [Remittance Advice](#) tab, you can search by any of the following:

- Provider information
  - Last name (partial search)
  - Tax ID/TIN
  - NPI
- Patient information
  - Last name (partial search)
  - SSN
  - Member ID
  - Patient account number
- Check number
- Claim number
- Check date
- Date of service





**Step 2:** Complete the form and then click the [Search](#) button. The [Remittance Advice Search Results](#) screen will appear.

**Step 3:** Click on the check. The [Remittance Advice Detail](#) screen will appear. This screen consists of 2 sections: the check detail section and the claims detail section.

Claim Status Remittance Advice Add Claim

[Return to the Search Result](#)

Remittance Advice Detail for Check Number 1465779. Total Claims Paid: 2707

CHECK DATE	TOTAL PAID	PAYOR	VENDOR NAME	VENDOR ADDRESS	TAX ID	VENDOR NPI
[Redacted]						

[Send X12-835 to Document Manager](#)

Sort By: Patient/Member Name

1 - 5 of 2,707 Page 1

Claim Number	PROVIDER	PATIENT	PATIENT ACCOUNT NUMBER	MEMBER ID NUMBER						
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]						
DOS	PROCEDURE	MODIFIER	POS	UNITS	BILLED	ALLOWED	PATIENT RESPONSIBILITY	DISALLOWED	PAID	EOP
[Redacted]										
EOP										

Claim Number	PROVIDER	PATIENT	PATIENT ACCOUNT NUMBER	MEMBER ID NUMBER						
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]						
DOS	PROCEDURE	MODIFIER	POS	UNITS	BILLED	ALLOWED	PATIENT RESPONSIBILITY	DISALLOWED	PAID	EOP
[Redacted]										
EOP										

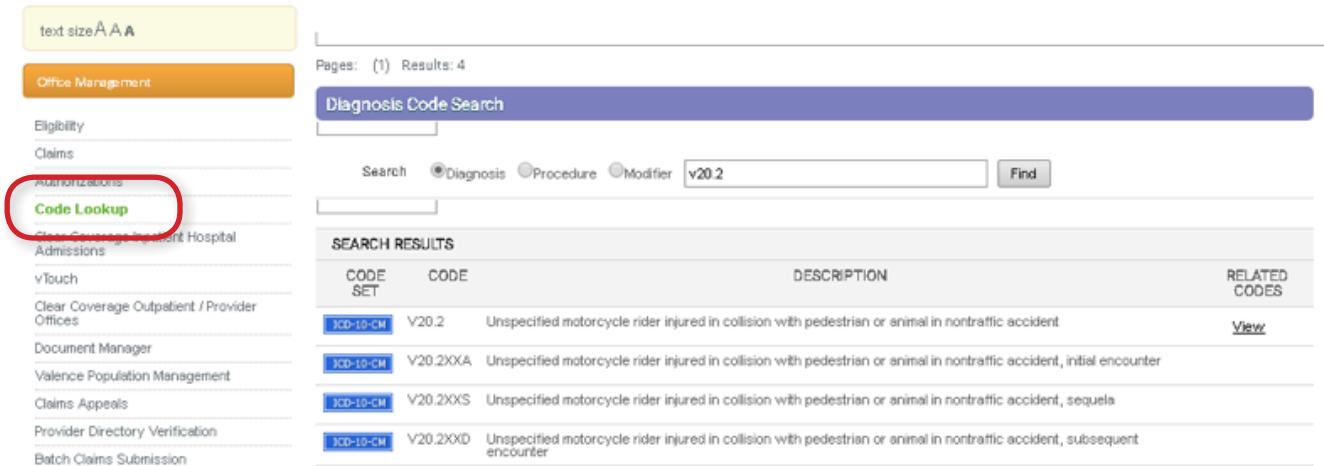
Claim Number	PROVIDER	PATIENT	PATIENT ACCOUNT NUMBER	MEMBER ID NUMBER						
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]						
DOS	PROCEDURE	MODIFIER	POS	UNITS	BILLED	ALLOWED	PATIENT RESPONSIBILITY	DISALLOWED	PAID	EOP
[Redacted]										

## Code lookup

The code lookup feature allows you to enter and view code explanations.

**Step 1:** Click on the [Code Lookup](#) button under the [Office Management](#) section.

**Step 2:** Enter a diagnosis code, procedure code, or modifier code. You will receive an explanation for the code you entered.



text size A A A

Office Management

Eligibility

Claims

Authorizations

**Code Lookup**

Clear Coverage Request Hospital Admissions

vTouch

Clear Coverage Outpatient / Provider Offices

Document Manager

Valence Population Management

Claims Appeals

Provider Directory Verification

Batch Claims Submission

Pages: (1) Results: 4

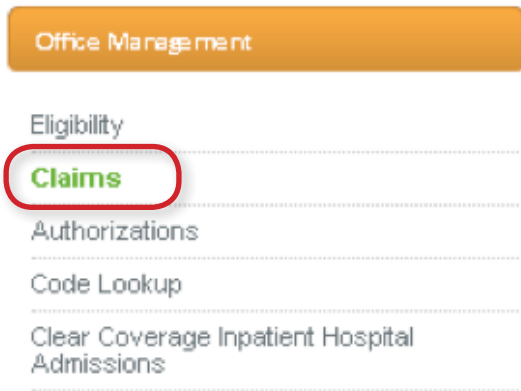
Diagnosis Code Search

Search  Diagnosis  Procedure  Modifier

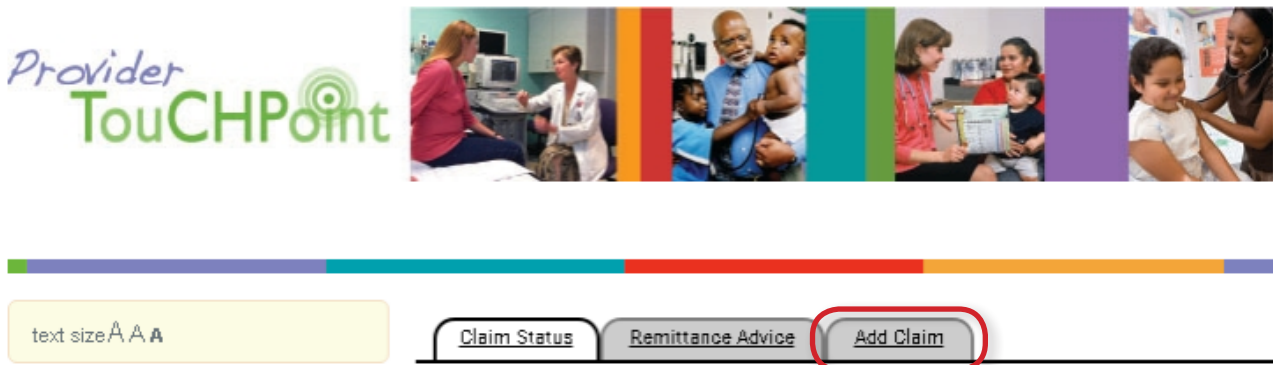
SEARCH RESULTS			
CODE SET	CODE	DESCRIPTION	RELATED CODES
<a href="#">ICD-10-CM</a>	V20.2	Unspecified motorcycle rider injured in collision with pedestrian or animal in nontraffic accident	<a href="#">View</a>
<a href="#">ICD-10-CM</a>	V20.2XXA	Unspecified motorcycle rider injured in collision with pedestrian or animal in nontraffic accident, initial encounter	
<a href="#">ICD-10-CM</a>	V20.2XXS	Unspecified motorcycle rider injured in collision with pedestrian or animal in nontraffic accident, sequela	
<a href="#">ICD-10-CM</a>	V20.2XXD	Unspecified motorcycle rider injured in collision with pedestrian or animal in nontraffic accident, subsequent encounter	

## Individual Claim Submission

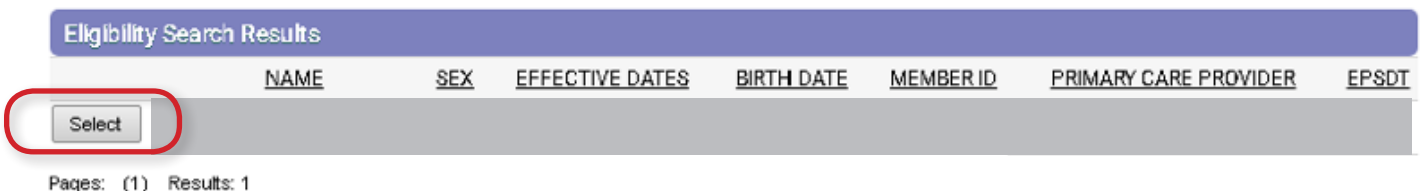
**Step 1:** Click on the Claims menu item on the left navigation (highlighted below in red) to enter a new single claim.



**Step 2:** Click on the Add Claim tab: (highlighted below in red) to enter a new individual claim.



**Step 3:** Search for the patient by Last Name, Member ID, or Medicaid ID. Click the select button (highlighted below in red) to begin entering an individual claim.



**Step 4:** Create Professional Services Claim: Enter information into all required fields.

**Create Professional Services Claim**

**PATIENT INFORMATION**

Patient Name		<input checked="" type="checkbox"/> Patient Account	<input type="text"/>
Relationship		Member ID	<input type="text"/>
Address		City	<input type="text"/>
State, Zip		Home Phone	<input type="text"/>
Date of Birth		Gender	M

Release of Information 
 Amount Paid by Patient

**PATIENT CONDITION RELATED TO**

Related Causes  Auto Accident  Employment  Other

Accident Location  -or-

Date of Current Illness or LMP

Accident Date

Admit Date

Discharge Date

EPSDT Referral

EPSDT Condition Indicator  AV  ST  S2

**RENDERING PROVIDER**

Rendering Provider  Name  Provider NPI  Rendering Provider Tax ID

Practice Name

Billing Provider  Billing Provider Tax ID

Provider Signature on File   Provider Accept Assignment

Benefits Assigned

PAY TO ADDRESS	
Entity Type Qualifier	<input type="text" value="-Select-"/>
Pay To Address	<input type="text"/>
Pay To Address 2	<input type="text"/>
Pay To City	<input type="text"/>
Pay To State, ZIP	<input type="text" value="-Select-"/> <input type="text"/>
CLAIM FACILITY	
Claim Facility Location Name	<input type="text"/>
Claim Facility Identification Code Qualifier	<input type="text" value="-Select-"/>
Claim Facility Identification Code	<input type="text"/>
Claim Facility Address	<input type="text"/>
Claim Facility Address 2	<input type="text"/>
Claim Facility City	<input type="text"/>
Claim Facility State, ZIP	<input type="text" value="-Select-"/> <input type="text"/>

DIAGNOSIS: Enter at least two characters to populate a list of dx codes. Dx code format [xxx.xxxx](#)

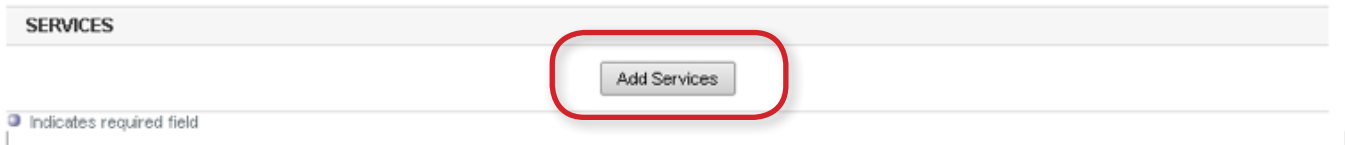
CLAIM NOTE	SERVICES
Claim Note	<input type="text" value="z30"/> <ul style="list-style-type: none"> <li>Z30.011   ICD10CM   Encounter for initial prescription of contraceptive pills</li> <li>Z30.012   ICD10CM   Encounter for prescription of emergency contraception</li> <li>Z30.018   ICD10CM   Encounter for initial prescription of other contraceptives</li> <li>Z30.019   ICD10CM   Encounter for initial prescription of contraceptives, unspecified</li> <li>Z30.488   ICD10CM   Encounter for removal and reinsertion of intrauterine contraceptive device</li> <li>Z30.8   ICD10CM   Encounter for other contraceptive management</li> <li>Z30.013   ICD10CM   Encounter for initial prescription of injectable contraceptive</li> <li>Z30.9   ICD10CM   Encounter for sterilization</li> </ul>

Indicates required field

CLAIM NOTE: Provider can free text any claims information the health plan should be aware of.

CLAIM NOTE
Claim Note

**Step 5:** Once all the required fields are entered, click [Add Services](#) (highlighted below in red).



SERVICES

Add Services

Indicates required field

**Step 6:** If all required fields are not entered, you will get the following error message detailing the missing required fields. Select the [Return](#) button to restore to the previous page to add the missing required information.

[Return](#)

Error



### Form Error

Pt. Account is a required field.  
Amount Paid by Patient is a required field.  
Provider Name is a required field.  
Rendering Provider Tax ID is a required field.  
Rendering Provider Practice Name is a required field.  
Provider Signature on File is a required field.  
Provider Accepts Assignment is a required field.  
Benefits Assigned is a required field.  
Release of Information is a required field.  
DX Codes is a required field.  
Date of Current Illness or LMP is a required field.  
Billing Provider does not have address information

[Return](#)

**Step 7:** You will now be allowed to proceed to the next step in single claim submission.

PATIENT INFORMATION	
Patient Name	<input type="text"/>
Patient Account No.	<input type="text"/>
Provider	<input type="text"/>
Practice	<input type="text"/>
SERVICES	
Start Date	<input type="text" value="06/08/2017"/> <input type="button" value="calendar"/>
End Date	<input type="text"/> <input type="button" value="calendar"/>
Place of Service	<input type="text" value="-Select-"/>
Service Facility Location	<input type="text"/> <input checked="" type="radio"/> Name <input type="radio"/> Provider NPI <input type="button" value="Search"/>
Procedure Code	<input type="text"/> <input type="button" value="Search"/> <small>Enter at least two characters</small>
Diagnosis Codes	<input type="checkbox"/> 1. Z00.121 Encounter for routine child health examination with abnormal findings <input type="checkbox"/> 2. Z23 Encounter for immunization
Units	<input type="text" value="-Select-"/> <input type="text"/> <input checked="" type="radio"/> Charge <input type="text"/>
Emergency	<input type="text" value="-Select-"/>
Procedure Line Note	<input type="text"/>
NDC Data	<input type="text"/>
<input type="button" value="Add"/> <input type="button" value="Clear"/>	
<small><input checked="" type="radio"/> Indicates required field</small>	

**Step 8:** Procedure Code Search: Enter at least two characters to populate a list of procedure codes.

Procedure Code	<input type="text" value="99391"/> <input type="button" value="Search"/> <small>Enter at least two characters</small>
Diagnosis Codes	<input type="checkbox"/> 99391   CPT   Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the
Units	0022   REV   Health Insurance - Prospective Payment System (HIPPS); Skilled Nursing Facility Prospective Payment System
Emergency	0023   REV   Health Insurance - Prospective Payment System (HIPPS); Home Health Prospective Payment System
Procedure Line Note	0024   REV   Health Insurance - Prospective Payment System (HIPPS); Inpatient Rehab Facility Prospective Payment System
	0100   REV   All Inclusive Rate; All-Inclusive Room and Board Plus Ancillary
	0101   REV   All Inclusive Rate; All-Inclusive Room and Board

**Step 9:** After selection of procedure code, click on the [Find Modifiers](#) button (highlighted below in red).

99391 - Periodic comprehens... X

Warning: No more than 1 procedure code can be added.

Code: 99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the X

Modifiers: Find Modifiers

**Step 10:** Select from the list of appropriate modifiers. There can be a maximum of 4 modifiers per line item. Please select modifiers in the correct order for the line item being billed. Click the [Add Modifiers](#) button (highlighted below in red) to populate modifiers.

**Modifier List**

<input type="checkbox"/> 21 Prolonged Evaluation and Management Services CPT_M	<input type="checkbox"/> 23 Unusual Anesthesia CPT_M	<input type="checkbox"/> 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period CPT_M
<input checked="" type="checkbox"/> 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service CPT_M	<input type="checkbox"/> 28 FLT3 (Acute myelogenous leukemia) CPT_M	<input type="checkbox"/> 32 Mandated Services CPT_M
<input type="checkbox"/> 33 Preventive Service CPT_M	<input type="checkbox"/> 50 Bilateral Procedure CPT_M	<input type="checkbox"/> 52 Reduced Services CPT_M

**Currently Selected Modifiers**

AM - Physician, team membe... X 25 - Significant, Separately Id... X

Add Modifiers Cancel

NDC DATA:

\*Must be submitted in the following format:

N4 I <NDC Code> I <Quantity> I <2 digit unit of measure code> I

NDC Data



**Step 11:** Review claims detail for final submission. Click **Finish** (highlighted below in red) to proceed.

Services													
	Start	END	POS	TOS	PROC	MOD1	MOD2	MOD3	MOD4	DX	EMERGENCY	UNITS	CHAR
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		99391	AM	25			1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90700					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90461					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90713					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90744					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90648					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90670					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90680					1,2	N	1 Units	
<input type="button" value="Remove"/>													
<input type="button" value="Edit"/>	4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<input type="button" value="Remove"/>													

**Step 12:** Submit claim by clicking the **Submit** button (highlighted below in red).

SERVICES												
START	END	POS	TOS	PROC	MOD1	MOD2	MOD3	MOD4	DX	EMERGENCY	UNITS	CHARGE
4/6/2017	4/6/2017	11		99391	AM	25			1,2	N	1 Units	
4/6/2017	4/6/2017	11		90700					1,2	N	1 Units	
<i>National Drug Code Data: N4[58160081052].5[ML]</i>												
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
4/6/2017	4/6/2017	11		90461					1,2	N	1 Units	
4/6/2017	4/6/2017	11		90713					1,2	N	1 Units	
<i>National Drug Code Data: N4[49281086010].5[ML]</i>												
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
4/6/2017	4/6/2017	11		90744					1,2	N	1 Units	
<i>National Drug Code Data: N4[58160082052].5[ML]</i>												
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
4/6/2017	4/6/2017	11		90648					1,2	N	1 Units	
<i>National Drug Code Data: N4[49281054503].5[ML]</i>												
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
4/6/2017	4/6/2017	11		90670					1,2	N	1 Units	
<i>National Drug Code Data: N4[00004197102].5[ML]</i>												
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
4/6/2017	4/6/2017	11		90680					1,2	N	1 Units	
<i>National Drug Code Data: N4[00006404741].5[ML]</i>												
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	
<b>Total Charges</b>												
<input type="button" value="Submit"/> <input type="button" value="Cancel"/>												

Submitted:

**Confirmation**



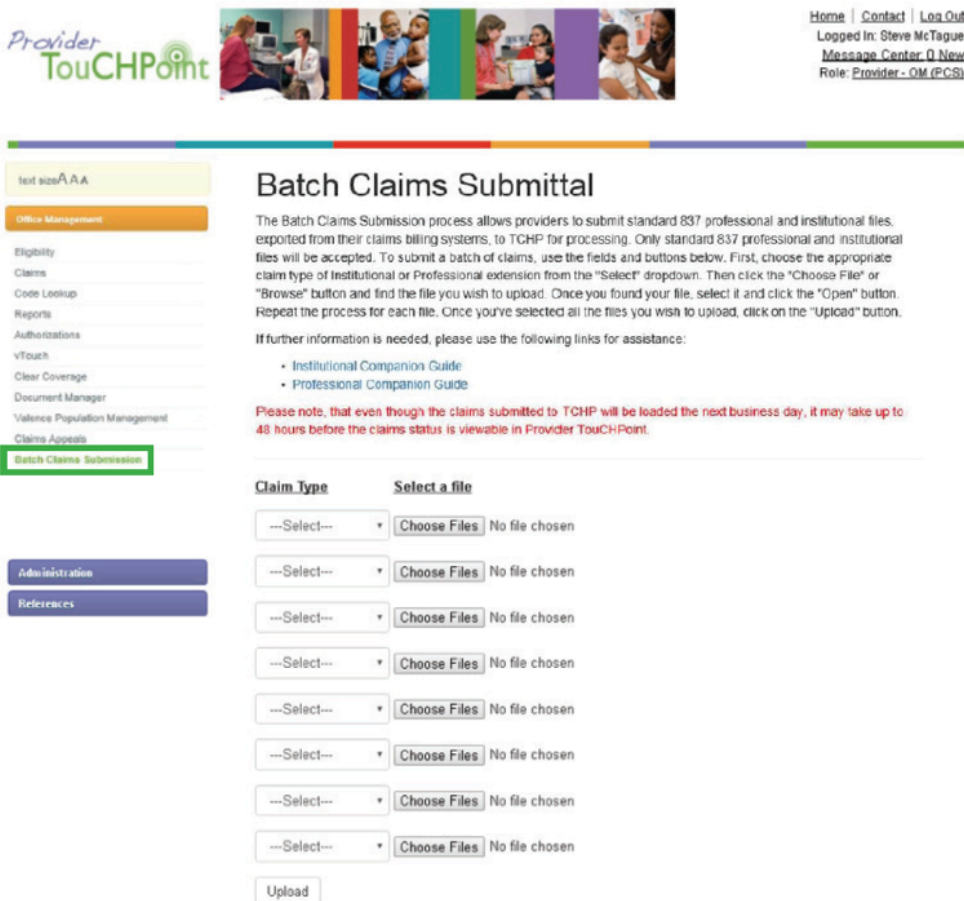
**Claim Submitted**

Claim added. for member ID [REDACTED]

## Batch Claims Submittal

**Step 1:** Perform an export of the claims to be submitted from your CLAIMS BILLING SYSTEM. The accepted file formats are "837 Institutional" or "837 Professional". Please save the file to your computer or on your computer network. The file name and its location is required for step 4.

**Step 2:** Select the [Batch Claims Submission](#) menu option from the left navigation (highlighted in green):



The screenshot shows the Provider TouCHPoint interface. At the top left is the logo and a navigation menu with items like Office Management, Eligibility, Claims, Code Lookup, Reports, Authorizations, vTouch, Clear Coverage, Document Manager, Valence Population Management, Claims Appeals, and Batch Claims Submission (highlighted in green). At the top right are links for Home, Contact, Log Out, and user information (Logged In: Steve McTague, Message Center: 0 New, Role: Provider - OM (PCS)).

### Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TCHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of Institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouCHPoint.

Claim Type	Select a file
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
<input type="button" value="Upload"/>	

**Step 3:** Select the appropriate **Claim Type** for each file to be uploaded. Each file can only contain one type of claims.



- text sizeAAA
- Office Management
- Eligibility
- Claims
- Code Lookup
- Reports
- Authorizations
- vTouch
- Clear Coverage
- Document Manager
- Valence Population Management
- Claims Appeals
- Batch Claims Submission**

## Batch Claims Submittal

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- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouCHPoint.

0 file(s) uploaded successfully.  
1 file(s) failed to upload.

Claim Type	Select a file
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
Institutional	<input type="button" value="Choose Files"/> No file chosen
Professional	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
<input type="button" value="Upload"/>	

**Claim Type required. Please select one**

**Step 4:** Click the [Choose File](#) or [Browse](#) button (depending on your browser), and browse out to the location of where the exported claim files were saved (from step #1). Institutional and professional claims can be uploaded in separate files, but as part of the same upload.



text sizeAAA

Office Management

- Eligibility
- Claims
- Code Lookup
- Reports
- Authorizations
- vTouch
- Clear Coverage
- Document Manager
- Valence Population Management
- Claims Appeals
- Batch Claims Submission**

## Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TGHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of Institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

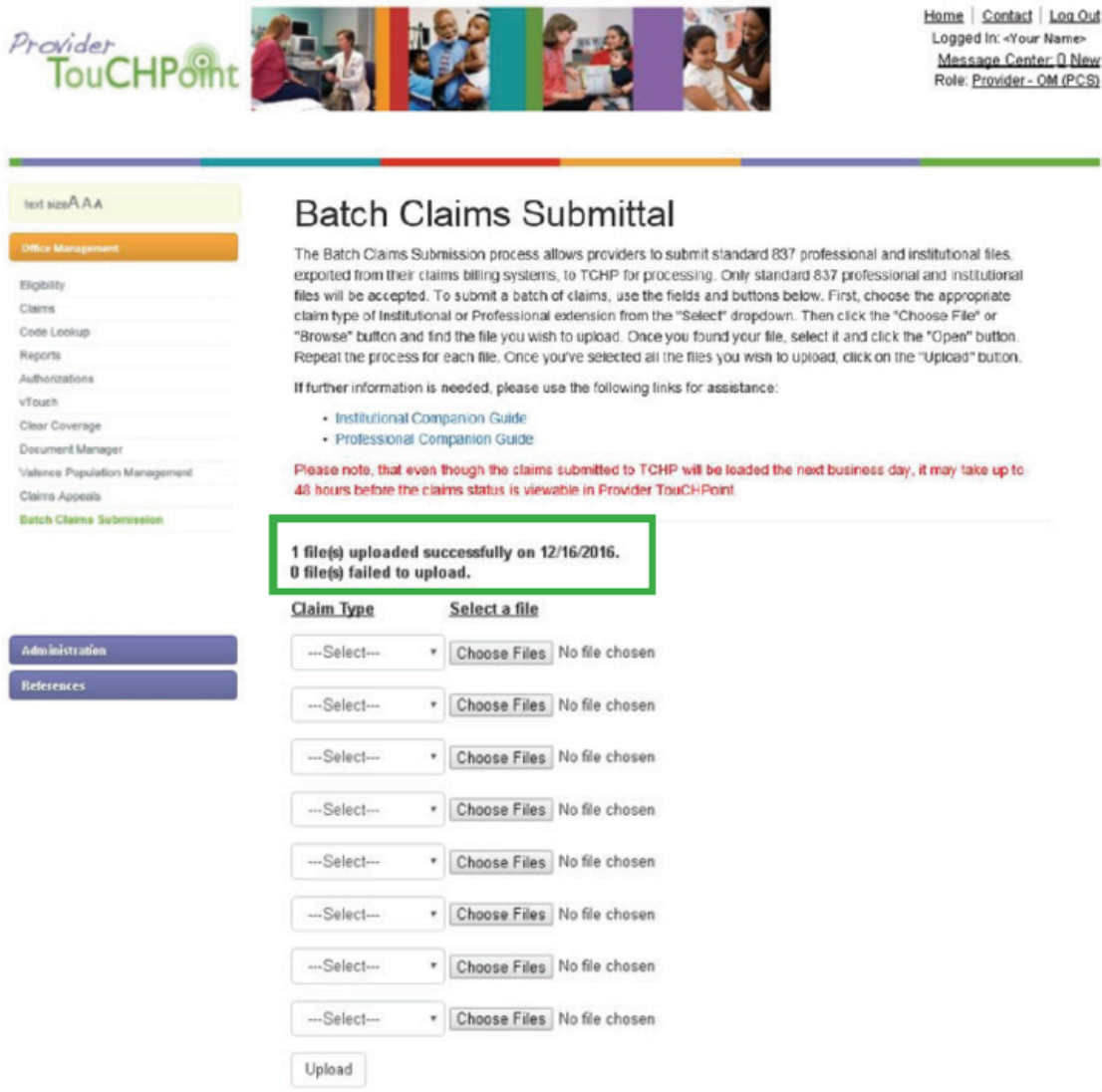
**Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouCHPoint.**

Claim Type	Select a file
Professional	<input type="button" value="Choose Files"/>
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
<input type="button" value="Upload"/>	

Administrations

References

**Step 5:** Clicking the [Upload](#) button will upload the claims. Successful uploads will result in a message stating the number of files uploaded successfully, and the current date.



**Provider TouCHPoint**

Home | Contact | Log Out  
 Logged In: <Your Name>  
 Message Center: 0 New  
 Role: Provider - QM (PCS)

text size AAA

**Office Management**

- Eligibility
- Claims
- Code Lookup
- Reports
- Authorizations
- vTouch
- Clear Coverage
- Document Manager
- Valence Population Management
- Claims Appeals
- Batch Claims Submission**

**Administration**

**References**

## Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TCHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of Institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouCHPoint.

**1 file(s) uploaded successfully on 12/16/2016.**  
**0 file(s) failed to upload.**

Claim Type	Select a file
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen
---Select---	<input type="button" value="Choose Files"/> No file chosen

# Claims appeals

**Step 1:** Click on the [Claims Appeals](#) menu in the left navigation (highlighted in green below) to enter a Claims Appeal. Please ensure your Appeal Letter is included in your attachments.

- Office Management
  - Eligibility
  - Claims
  - Authorizations
  - Code Lookup
  - Clear Coverage Inpatient Hospital Admissions
  - vTouch
  - Clear Coverage Outpatient / Provider Offices
  - Document Manager
  - Valence Population Management
  - Claims Appeals**
  - Provider Directory Maintenance
  - Batch Claims Submission
- Administration
  - User Preferences
- References
  - American Academy of Child & Adolescent Psychiatry
  - American Academy of Pediatrics
  - American Medical Association
  - Ask Me 3
  - InmTrac
  - Texas Health Steps
  - Texas Medicaid/Chip Vendor Drug Program
  - Texas Vaccines for Children
  - Provider Directory
  - TMHP
  - Provider TouchPoint Guide
  - American Academy of Allergy, Asthma & Immunology
  - Change Healthcare (formerly Emdeon) EFT/ERA
  - Provider Quick Reference Guide
  - TCHP Pharmacy Benefit Manager
  - Cultural and Linguistic Competence

## Claims Appeals

To submit an appeal, use the fields and buttons below. First, enter the NPI, Member ID and Claim ID into the appropriate fields. For any supporting documents you wish to upload, click the "Choose File" or "Browse" button and find the file. Once you have found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload and filled in the Required fields, click on the "Submit" button.

Please ensure your Appeal Letter is included in your attachments.  
Please allow 15 minutes for the appeal to be submitted to TCHP.

**\* National Provider ID** \* Required

**\* Member ID**

**\* Claim ID**

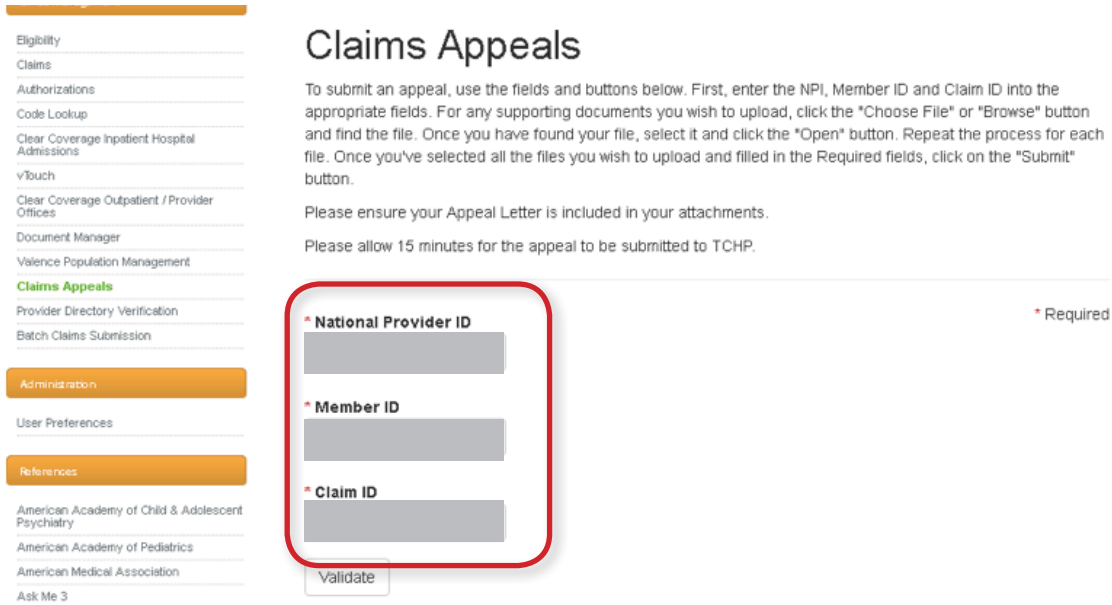
Please ensure your Appeal Letter is included in your attachments.

**\* Attachment 1**  
 No file chosen

**Attachment 2**  
 No file chosen

**Attachment 3**  
 No file chosen

**Step 2:** Enter the National Provider ID, Member ID, and Claim ID associated with the claim being appealed.



**Claims Appeals**

To submit an appeal, use the fields and buttons below. First, enter the NPI, Member ID and Claim ID into the appropriate fields. For any supporting documents you wish to upload, click the "Choose File" or "Browse" button and find the file. Once you have found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload and filled in the Required fields, click on the "Submit" button.

Please ensure your Appeal Letter is included in your attachments.

Please allow 15 minutes for the appeal to be submitted to TCHP.

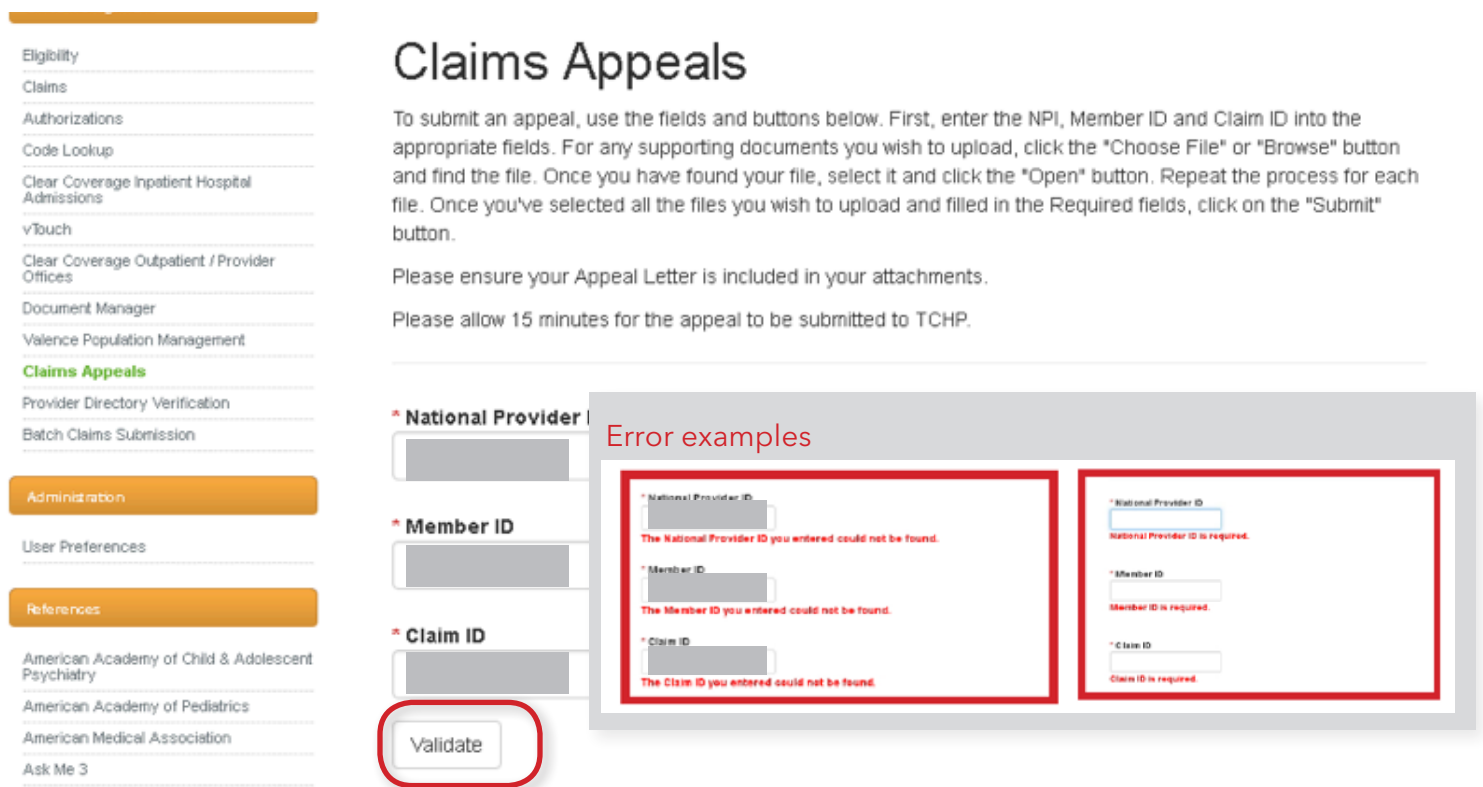
\* National Provider ID \* Required

\* Member ID

\* Claim ID

Validate

**Step 3:** Click the [Validate](#) button to display the provider name, member name, and date of birth.



**Claims Appeals**

To submit an appeal, use the fields and buttons below. First, enter the NPI, Member ID and Claim ID into the appropriate fields. For any supporting documents you wish to upload, click the "Choose File" or "Browse" button and find the file. Once you have found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload and filled in the Required fields, click on the "Submit" button.

Please ensure your Appeal Letter is included in your attachments.

Please allow 15 minutes for the appeal to be submitted to TCHP.

\* National Provider ID

\* Member ID

\* Claim ID

Validate

**Error examples**

The National Provider ID you entered could not be found.

The Member ID you entered could not be found.

The Claim ID you entered could not be found.

National Provider ID is required.

Member ID is required.

Claim ID is required.



**Step 4:** At least one attachment is required, including your Appeal Letter.

**You must attach at least one file to upload.**

**\* National Provider ID**

**\* Member ID**

**\* Claim ID**

Valid Claim ID.

Validate

Please ensure your Appeal Letter is included in your attachments.

**\* Attachment 1**

Choose Files No file chosen

**Attachment 2**

Choose Files No file chosen

**Attachment 3**

Choose Files No file chosen

Submit

**Step 5:** Once all the required fields are entered, clicking the [Submit](#) button will confirm the Claim Appeal has been submitted on the current date. You may now proceed entering the next Claims Appeal.

## Claims Appeals

To submit an appeal, use the fields and buttons below. First, enter the NPI, Member ID and Claim ID into the appropriate fields. For any supporting documents you wish to upload, click the "Choose File" or "Browse" button and find the file. Once you have found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload and filled in the Required fields, click on the "Submit" button.

Please ensure your Appeal Letter is included in your attachments.

Please allow 15 minutes for the appeal to be submitted to TCHP.

Claim [REDACTED] appeal was submitted on 09/21/2017.

\* Required

\* National Provider ID

\* Member ID

\* Claim ID

Validate

Please ensure your Appeal Letter is included in your attachments.

\* Attachment 1

Choose Files No file chosen

Attachment 2

Choose Files No file chosen

Attachment 3

Choose Files No file chosen

Submit

# Authorizations

Authorizations may now be requested by Clear Coverage, which is located under the [Office Management](#) tab. Inpatient Hospital Admissions and Outpatient/Provider offices are listed separately.

## Office Management

Eligibility

---

Claims

---

Authorizations

---

Code Lookup

---

Clear Coverage Inpatient Hospital  
Admissions

---

vTouch

---

Clear Coverage Outpatient / Provider  
Offices

---

Document Manager

---

Valence Population Management

---

Claims Appeals

---

Provider Directory Verification

---

Batch Claims Submission

---

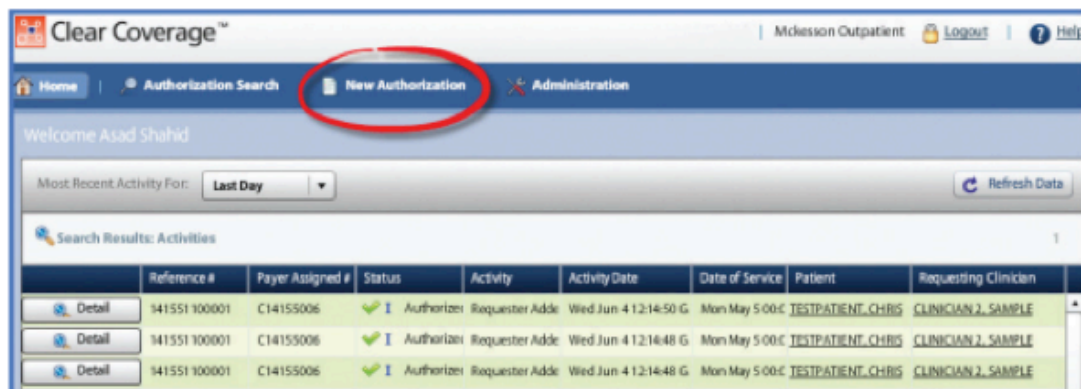


## Creating an Outpatient Authorization Request

### Authorization Request Workflow

Steps	Description
1. Find the Patient	Identifies the patient that requires this service.
2. Select the Requesting Clinician	Identifies the provider requesting this service.
3. Add Diagnosis (ICD-10) code(s)	Indicates the primary diagnoses for this service for this patient.
4. Select the procedure or service	Indicates which service(s) the patient needs (for example, Genetic Testing, Bariatric Surgery, Wheelchair).
5. Add Service Information	Provides information such as answers to questions that determine medical necessity of the service and indicates the facility where this service will be performed.
6. Add Additional Notes	Provides additional information about the case.

Click **New Authorization** to access the authorization workflow.



	Reference #	Payer Assigned #	Status	Activity	Activity Date	Date of Service	Patient	Requesting Clinician
<a href="#">Detail</a>	141551 100001	C14155006	✓ I	Authorizer Requester Adde	Wed Jun 4 12:14:50 G	Mon May 5 00C	TESTPATIENT_CHRS	CLINICIAN2_SAMPLE
<a href="#">Detail</a>	141551 100001	C14155006	✓ I	Authorizer Requester Adde	Wed Jun 4 12:14:48 G	Mon May 5 00C	TESTPATIENT_CHRS	CLINICIAN2_SAMPLE
<a href="#">Detail</a>	141551 100001	C14155006	✓ I	Authorizer Requester Adde	Wed Jun 4 12:14:48 G	Mon May 5 00C	TESTPATIENT_CHRS	CLINICIAN2_SAMPLE

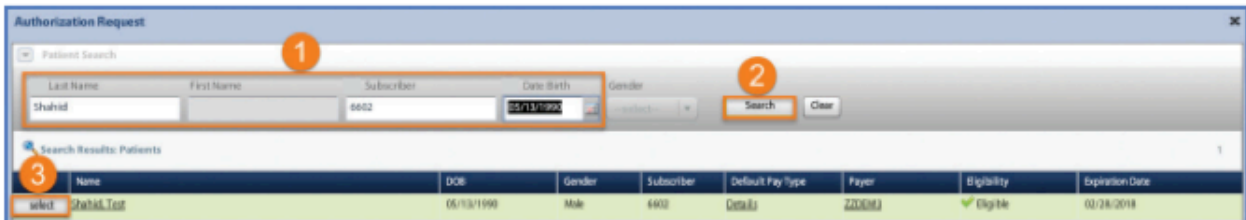
**MCKESSON**

## Step 1: Find the Patient

Creating an Authorization Request starts with finding the patient.

You find a patient by entering information such as the subscriber ID or the patient's first and last name in the search fields.

1. Enter search criteria in the required fields.
2. Click **Search** or press the Enter key.
3. Click **Select** next to the patient name.

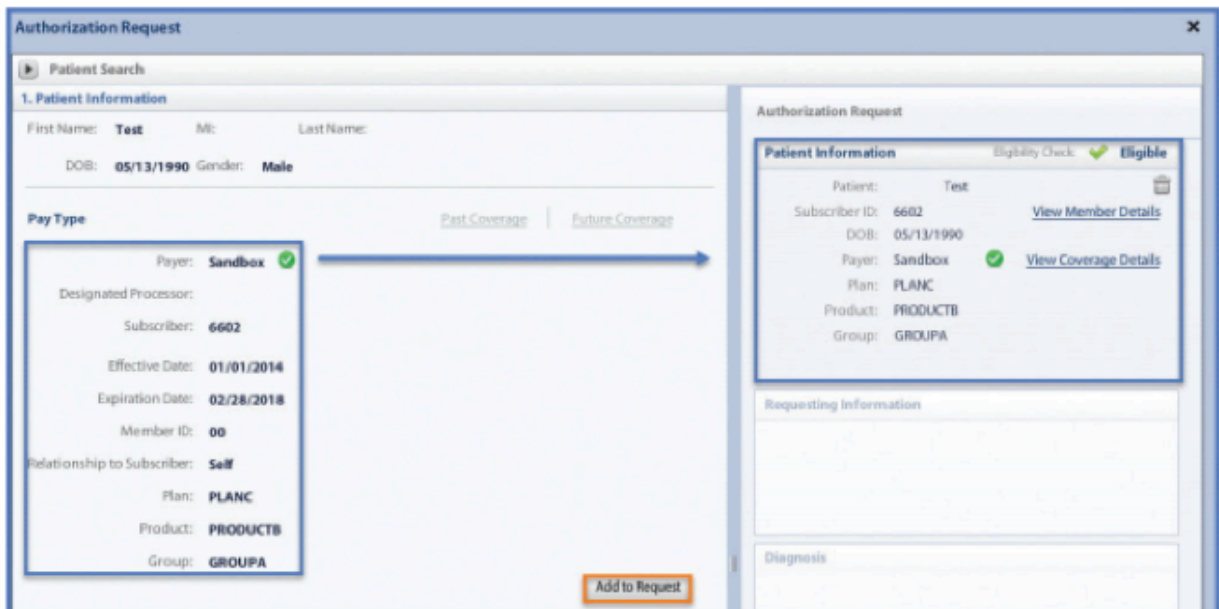


Name	DOB	Gender	Subscriber	Default Pay Type	Payer	Eligibility	Expiration Date
Shahid, Test	05/13/1990	Male	6602	Details	ZOOBJ	✓ Eligible	02/28/2018

## Verify the Patient Information

1. Verify the patient's health plan information, then click **Add to Request**.

The Patient Information is added to the Authorization Request summary, and Clear Coverage advances to the Requesting Information accordion.



**1. Patient Information**

First Name: **Test** MI: Last Name:

DOB: **05/13/1990** Gender: **Male**

**Pay Type** Past Coverage | Future Coverage

Payer: **Sandbox** ✓

Designated Processor:

Subscriber: **6602**

Effective Date: **01/01/2014**

Expiration Date: **02/28/2018**

Member ID: **00**

Relationship to Subscriber: **Self**

Plan: **PLANC**

Product: **PRODUCTB**

Group: **GROUPA**

**Add to Request**

**Authorization Request**

**Patient Information** Eligibility Check: ✓ **Eligible**

Patient: **Test**

Subscriber ID: **6602** [View Member Details](#)

DOB: **05/13/1990**

Payer: **Sandbox** ✓ [View Coverage Details](#)

Plan: **PLANC**

Product: **PRODUCTB**

Group: **GROUPA**

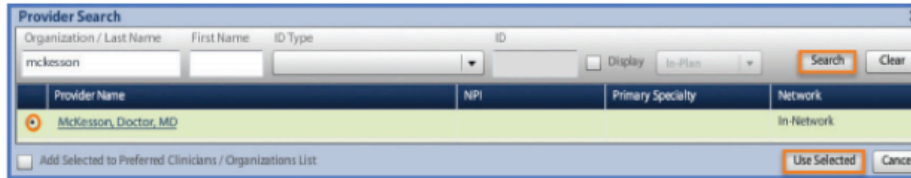
Requesting Information

Diagnosis

## Step 2: Select a Requesting Provider/PCP

1. Enter the **Date of Service** by clicking the calendar icon and selecting a date.
2. The **Facility Name** automatically defaults to the facility you are logged into.
3. Click the **Requesting Clinician** drop-down list and select the provider requesting the Authorization.
  - a. If the Requesting Clinician drop-down list is blank or if you want to select a different provider, click **Select Other Clinician**. In the Provider Search, enter a name in the Last Name field and click **Search**. Once you locate the provider, click **Use Selected** (as shown below).
  - b. You have the option to select the Add Selected to Preferred Clinicians/Organizations List check box to add the selected provider to the Requesting Clinician drop-down list for future authorizations.
4. Click **Add to Request**.

The Requesting Information is added to the Authorization Request summary and Clear Coverage advances to the Diagnosis accordion.

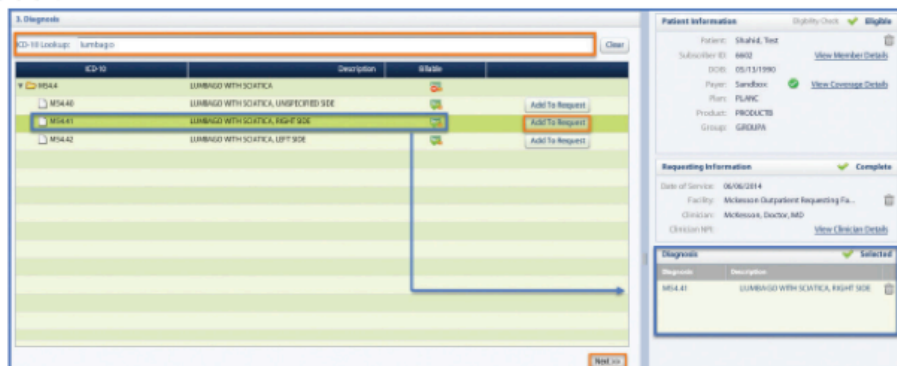


## Step 3: Select a Diagnosis

The Diagnosis accordion enables you to choose one or more diagnoses that are appropriate for the service for which you are requesting authorization.

1. Search for the diagnosis by entering one of the following in the ICD Lookup:
  - a. Part of the clinical diagnosis description (for example, "lumbago")
  - b. ICD-10 code (for example, "M54.41" for lumbago)
2. When you find the appropriate diagnosis code, click **Add to Request** next to the diagnosis.
3. Repeat steps 1-2 to include additional diagnoses, if necessary.
4. Click **Next**.

The Diagnosis(es) is added to the Authorization Request summary and Clear Coverage advances to the Service accordion.



### Step 4: Select a Service

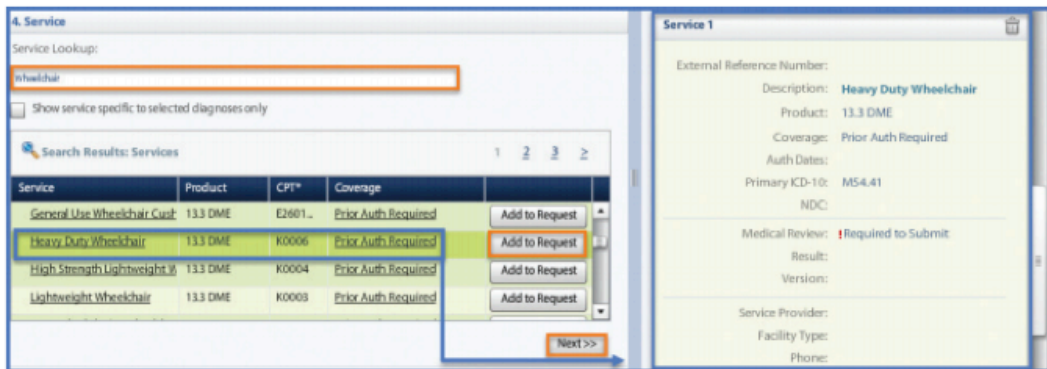
The Service accordion enables you to select the service for which you are requesting authorization.

1. Search for a service by entering one of the following in the Service Lookup:
  - a. Enter a complete CPT®/HCPCS code (for example, "K0006")
  - b. Enter a portion of the service name (for example, "Wheelchair")

The **Coverage** column in the list of services indicates whether a certain procedure or service can be auto-authorized. The coverage labels can be customized by the payer.

If you select the wrong service, click the trash can icon next to the service to delete it from your list and then choose again.

2. Repeat steps 1-2 until you have added all of the services you need authorized for this patient.
3. Click **Next**.



### Step 5: Enter Service Information

Clear Coverage uses a question and answer workflow to assess the medical necessity of the requested service. The Medical Review information is addressed below. Additional fields like Diagnosis, Service Facility, Modifiers, and on may be required to complete prior to submission. Required information will be marked with a red exclamation point (!).

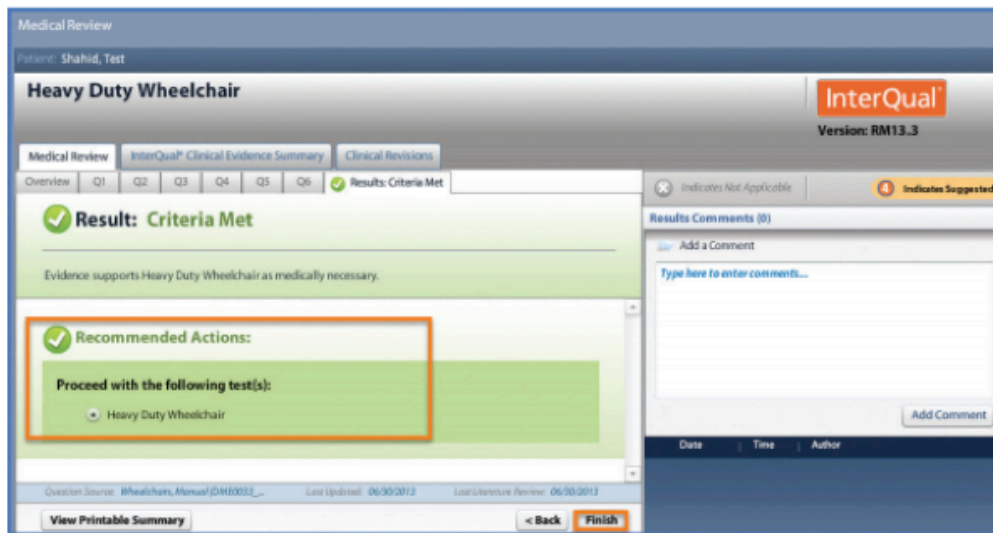
**Note:** Not all services will require a Medical Review, but those that do will have the red exclamation point icon (!) when required, then:

1. Click **Required to Submit** in the Service Information accordion.



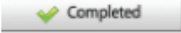
### Creating an Outpatient Authorization Request

2. Answer each question, as appropriate, for the patient and their medical condition. Upon completion of the Medical Review Q&A, you will receive a recommendation on the medical appropriateness of the service based upon the best current evidence available.



There may be alternate actions suggested, such as switching to a more appropriate service or removing the service you requested.

3. Click **Finish**.

Notice that under Medical Review in the Authorization Request the Required to Submit label has changed to  with the result of the Medical Review.

**Note:** If a Medical Review is not required or if the Medical Review result was "Criteria Not Met," then attach clinicals for nurse review.

### Step 6: Adding a Note or Attaching a Document

The Additional Notes accordion enables you to provide additional notes to support your Authorization Request.

1. Click in the Additional Notes text field and type any additional information that supports the request. Add the Requesting PCP/Provider's fax number as a note.

**Note:** You may copy and paste information from the EMR to support the request. There is a 4,000 character limit in this free text field.

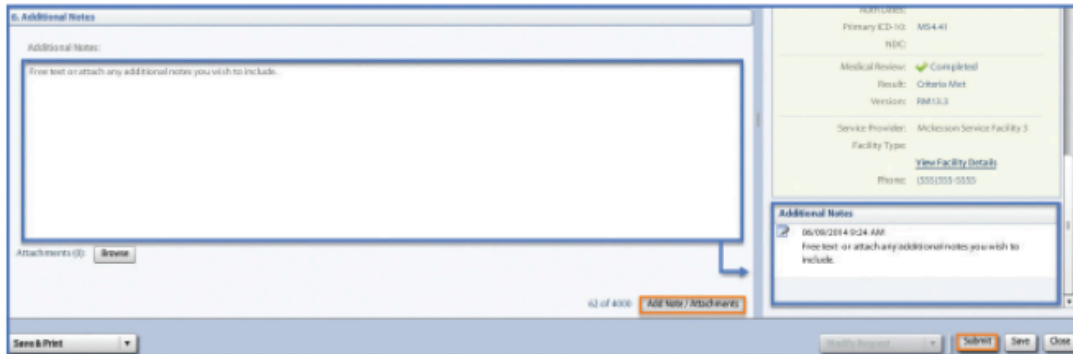
2. Click **Browse** to locate a document that you would like to attach.

**Note:** You may attach one or more files up to 5MB in size.

3. Click the **Add Note/Attachments** to add the notes to the request.



4. If necessary, review the request to be sure that you have added all information, then click **Submit**.

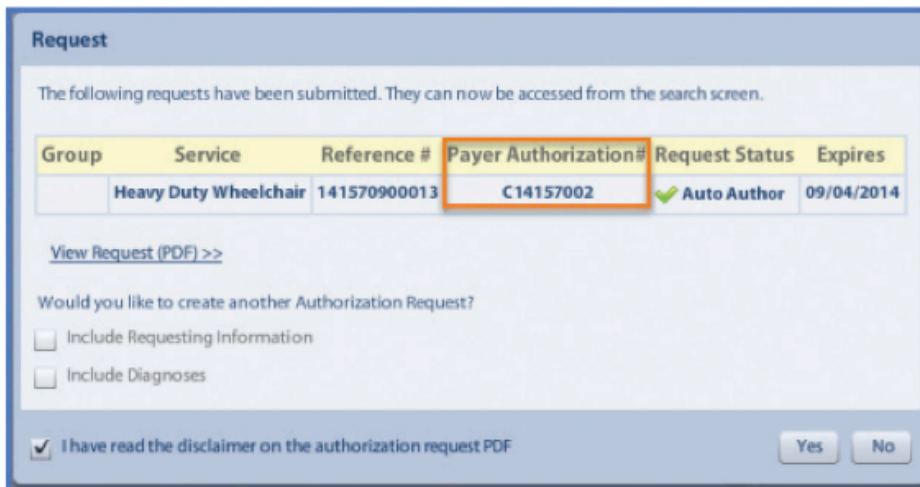


After submission, you will receive an immediate response to the request with the following information:

- Service: Name of the service
- Reference #:
- Payer Authorization:
- Request Status:
- Expires:

If approved, you will also receive a **Payer Authorization** number. This is your **Authorization**.

5. Create another authorization request.
  - a. Click **No** to return to the Authorization Search.
  - b. Click **Yes** to create another authorization request for the same patient, provider, and diagnosis (if you leave those check boxes selected).



Group	Service	Reference #	Payer Authorization #	Request Status	Expires
	Heavy Duty Wheelchair	141570900013	C14157002	✓ Auto Author	09/04/2014

View Request (PDF) >>

Would you like to create another Authorization Request?

Include Requesting Information

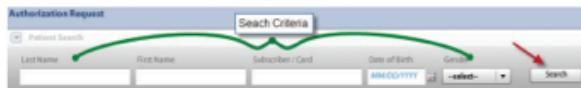
Include Diagnoses

I have read the disclaimer on the authorization request PDF

Yes No

Start by logging into **Clear Coverage Outpatient / Provider Offices**.

1. After logging in, click **New Authorization** at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**.



3. In the Search Results, click **select** next to the patient's name.

Name	DOB	Gender	Subscriber	Card#	Default Pay Type	Center	Eligible
select   20251212123	04/01/1976	Male	116521669	20855	SLP	SLP	✓ Eligible

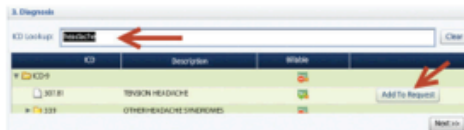
4. Verify the patient's information, and then click **Add to Request**.



5. In the Requesting Information accordion, select the **Date of Service** and then select the **Requesting Clinician** from your preferred clinician list. Alternatively, choose a provider from the **Select Other Clinician** link. Click **Add to Request**.

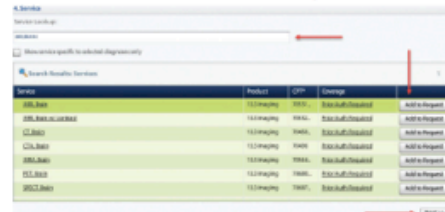


6. In the Diagnosis accordion, search for a specific billable diagnosis, click **Add to Request**, and then click **Next**. Search by entering a diagnosis description or ICD-10 may be entered.



ICD	Description	Billable	Action
G43.91	TENSION HEADACHE	Yes	Add to Request
G43.99	OTHER HEADACHE DISORDERS	Yes	Add to Request

7. In the Service accordion, search for the **Service/Test**, click **Add to Request**, and then click **Next**. Search by entering a service/test description or CPT®/HCPCS code.



Service	Product	CPT	Coverage	Action
SPEECH	10000000	92234	State Self-Insured	Add to Request
SPEECH	10000000	92234	State Self-Insured	Add to Request
SPEECH	10000000	92234	State Self-Insured	Add to Request
SPEECH	10000000	92234	State Self-Insured	Add to Request
SPEECH	10000000	92234	State Self-Insured	Add to Request
SPEECH	10000000	92234	State Self-Insured	Add to Request
SPEECH	10000000	92234	State Self-Insured	Add to Request

8. In the Service Information accordion, complete the required information, and then click **NEXT**. Note: Required fields have a red exclamation mark (!).



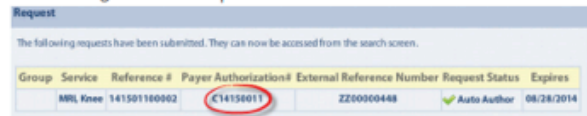
- A. **Priority** – Defaults to Normal.
- B. **Diagnosis** – If you selected multiple diagnosis codes, you should select the primary diagnosis from this drop down list.
- C. **Service Facility** – Select the appropriate servicing facility or Provider.
- D. **Medical Review** – An (!) appears only if a Medical Review is required.
- E. **Modifiers** – Appears only if a modifier is required. Click to select a modifier.
- F. **CPT** – You may be required to select a primary CPT code.
- G. **Details** – Enables you to specify details such as: Pay-To-Provider, Place of Service, Units/Duration. Enter this information as required.

9. In the **Additional Notes** accordion, attach a clinical document file to the authorization request if a Medical Review is not required or if the Medical Review result is "Criteria Not Met" and service is "Not Recommended" or "Requires Health Plan Review".

10. Verify the **Authorization Request** details are correct in the right pane.

11. Click **Submit** in the lower right pane. If **Submit** is not active, move the pointer over it to see the information that's missing.

12. Clear Coverage creates a request confirmation for each service/test.



Group	Service	Reference #	Payer Authorization#	External Reference Number	Request Status	Expires
MHI, Knee	141501100002	C14150011	ZZ0000448	Auto Author	08/28/2014	

13. **Print** the authorization request by selecting the **View Request PDF** link. Then, click **YES** to create another authorization for the same patient or **NO** to go back to the main screen to create an authorization for a new patient.

You can find more detailed information and reference guides in the Help section by clicking the **Help** button in the top right hand corner of the screen.

## Inpatient Hospital Admissions

The Inpatient Authorization Request through Clear Coverage connects payors and hospitals to improve the efficiency of conducting an Authorization. There are three (3) functions within the Authorization Service:

- Search Authorization Requests
- Create a New Authorization Request
- Administration

## What is Auto Authorization?

Clear Coverage offers the ability to submit an Authorization Request for a hospital admission, as well as receive an immediate, real-time response to that request. The Clear-Coverage Auto-Authorization Service combines critical components required to carry-out an Authorization: an Eligibility check and a Medical Appropriateness check.

Additional Clear Coverage help is located on the home page.

### New Authorization Request Workflow

There are **6 steps** in creating a new Authorization Request:

Steps/Accordion	Information
1. Select the Patient	Who is the patient who requires this admission?
2. Select the Admitting Physician/ Facility	Who is the facility requesting the admission?
3. Select Diagnosis (ICD-10) code(s)	What are the primary diagnoses for this admission for this patient?
4. Select the Admission Criteria	Which admission criteria is applicable?
5. Perform the Medical Review	Provide answers to questions to determine medical necessity of the admission.
6. Add Additional Notes/Documentation	Additional information about the admission.

## Clear Coverage Tabs

Once logged on, various tabs will appear on the top window. Below is a sample of tabs that will appear:

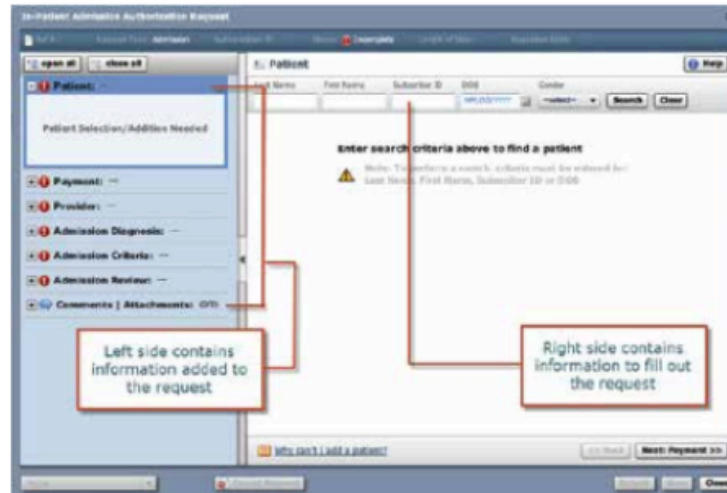


- Search Authorization Requests
- New Authorization Requests
- Administration

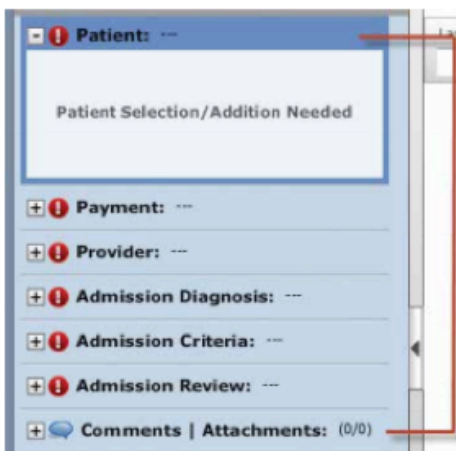
## New Authorization Request Overview

The "New Authorization" Tab consists of 2 sides:

- The **left side** contains the information that has been added to the authorization request.
- The **right side** contains information to search for patients, providers, and diagnoses.

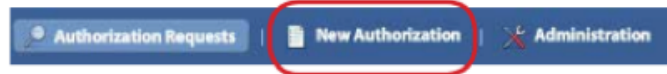


Click on the Accordion Headers on the left to switch from area to area.



## Creating a New Authorization Request

Click on the "New Authorization" tab to open the workflow available on this tab.

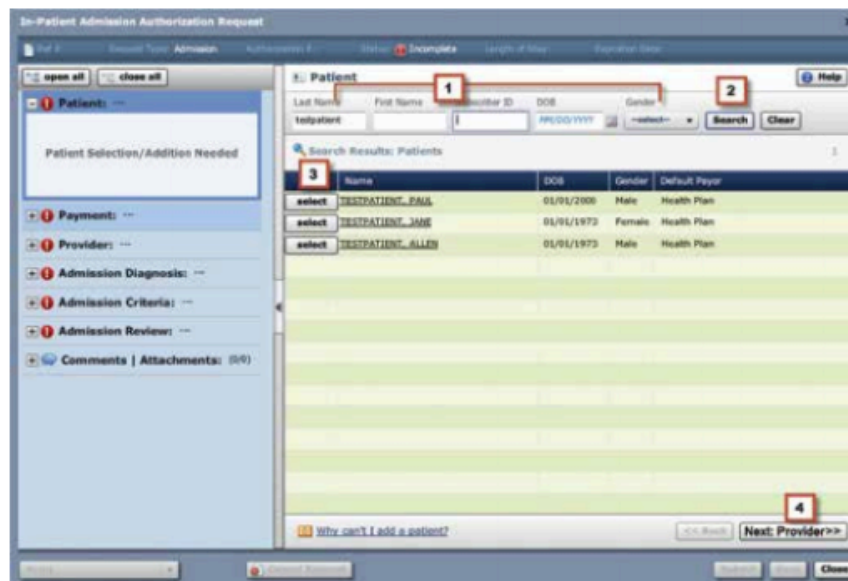


### Step 1: Patient Search

Creating an authorization request starts with selecting the Patient.

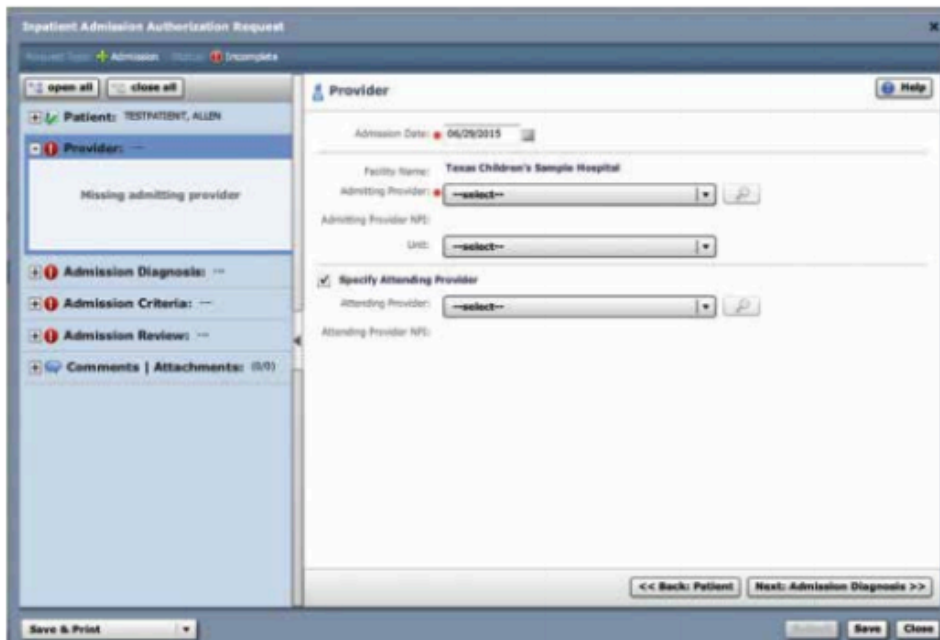
Using the Search function, a Patient can be found with a few letters of their first or last name. If you have the member or subscriber ID of the patient, you can use that as well. The same search criteria options that are used for Outpatient also apply to Inpatient.

1. Enter search criteria.
2. Click on the "Search" button.
3. Click the "select" button on the patient for whom the admission being requested.
  - a. The selected patient's information is added to the authorization request on the left side of the window.
  - b. Verify the patient information, eligibility, or search for another patient.
4. Click on the "Next: Provider" button.



## Step 2: Provider Information

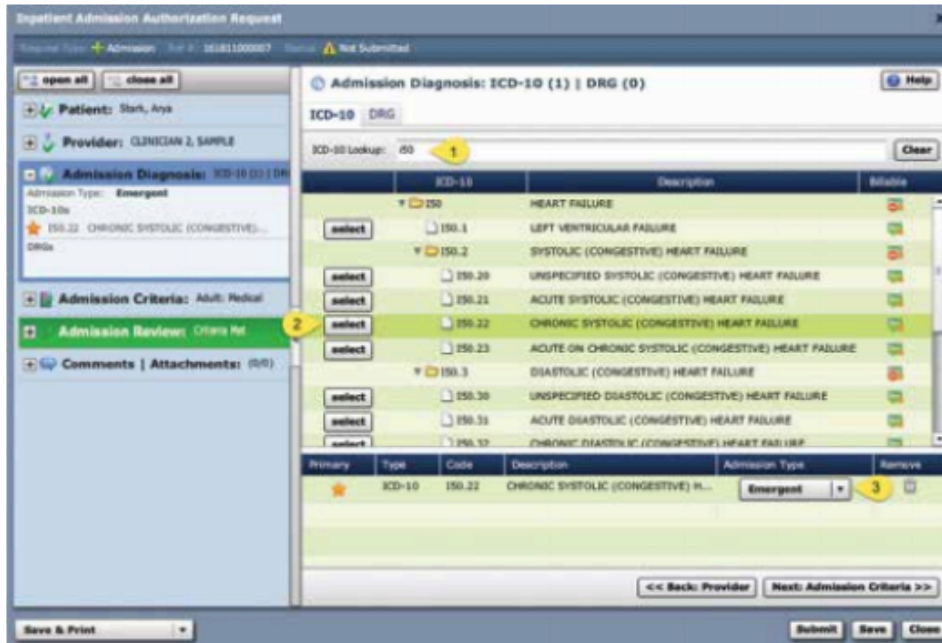
1. Enter the **Admission Date** - **Note:** You can click on the Calendar icon adjacent to the field and click on a date, or enter the date in the form MM/DD/YYYY, e.g. 09/15/2010.
2. The **Facility Name** will automatically default to the facility the user is assigned too.
3. Click on the **Admitting Provider** drop down menu and select the Facility requesting the Authorization. (The "**Admitting Provider ID**" will automatically populate once the "**Admitting Provider**" is selected).
4. If Admitting Provider drop down is blank or to add another Facility click the **search icon**. In the Provider Search enter Facility Name or an ID Type, click **Search** and once located you can "**Add Selected to Preferred Clinician List**".
5. Select the unit from the Unit dropdown, if applicable.
6. Click the "**Specify Attending Provider**" check box to select an attending provider, if applicable.
7. Select the Attending Provider from the drop down or use the search button to search.
8. Click on the "**Next: Admission Diagnosis**" button.
9. (This moves the Provider Information into the Authorization Request, and moves you to the next accordion — Admission Diagnosis).



### Step 3: Admission Diagnosis

The **Diagnosis** accordion allows you to choose one or more admission diagnoses for the requesting Authorization. The diagnosis can be identified by searching in the **"Diagnosis Lookup"** field, listing any results matching the keywords.

1. Search for the diagnosis using one of the following methods:
  - a. Part of the clinical diagnosis description (e.g. "Heart Failure")
  - b. ICD-10 or DRG code (e.g. "I50.22")
2. When you find the appropriate diagnosis code, click the **"select"** button next to the diagnosis. (The Diagnosis is added into the Authorization Request on the left-hand side).
3. Select the Admission Type by using the **"Admission Type"** drop down.
4. Repeat Procedure steps 1-3 to include additional diagnoses if desired.
5. Click the **"Next: Admission Criteria"** button to move to the next accordion.



The screenshot displays the 'Inpatient Admission Authorization Request' window. On the left, there are sections for Patient (Stark, Arys), Provider (CLINICIAN 2, SAMPLE), Admission Diagnosis (ICD-10 (1) | DRG (0)), Admission Type (Emergent), Admission Criteria (Adult, Pediatric), Admission Review (OT/PA Mt), and Comments | Attachments (0/0). The main area shows a search for ICD-10 codes. The search box contains 'I50' and a dropdown shows '1'. Below the search box is a table of results:

ICD-10	Description	Reliable
I50	HEART FAILURE	
I50.1	LEFT VENTRICULAR FAILURE	
I50.2	SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.20	UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.21	ACUTE SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.22	CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.23	ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.3	DIASTOLIC (CONGESTIVE) HEART FAILURE	
I50.30	UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE	
I50.31	ACUTE DIASTOLIC (CONGESTIVE) HEART FAILURE	
I50.32	CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE	

Below the table, a summary row shows: Primary: ICD-10, Code: I50.22, Description: CHRONIC SYSTOLIC (CONGESTIVE) H..., Admission Type: Emergent. At the bottom, there are buttons for '<< Back: Provider', 'Next: Admission Criteria >>', 'Save & Print', 'Submit', 'Save', and 'Close'.

## Step 4: Admission Criteria

The **Admission Criteria** accordion allows you to select the criteria for the admission event for which you are submitting an Authorization Request.

1. Select the criteria for your review. **Note:** If the criteria are not mapped to the diagnosis code, it may not be able to be selected for use.
  - a. You can select the category if you want to use condition-specific, acute, critical, or intermediate level of care criteria.
2. The **"Coverage"** column displays whether a certain admission criteria can be auto-authorized.
3. Click **"Select"** next to the admission criteria to add it to the Authorization Request.
  - a. If you select the wrong admission criteria, click **"Change Selected Criteria"** to delete the selection from your request and choose again.



4. The Coverage column for your admission criteria will determine what the next step is to take.

	Notes	Description	Product	Coverage
select	N	Cardiovascular / Peripheral Vascul	Acute	Medical Review Required
select	N	CNS / Musculoskeletal (Acute)	Acute	Medical Review Required
select	N	Endocrine / Metabolic (Acute)	Acute	Medical Review Required



5. Information about the selected admission criteria will be displayed. Click **"Next: Admission Review"** to begin the medical review.

Coverage	Meaning/Action to take
"Covered"	This admission does not require pre-authorization and cannot be added to an Authorization Request. <b>ACTION: You do not need to submit an authorization request and can stop this process.</b>
"Not Covered"	This admission is not a covered service. <b>ACTION: You do not need to submit an authorization request and can stop this process.</b>
"Medical Review Required"	This admission can be auto-authorized if the admission is recommended based on Medical Review. <b>ACTION: Select the Criteria and Perform Medical Review.</b>
"Authorized Instantly"	This admission will be auto-authorized regardless of the outcome of the Medical Review. <b>ACTION: Select the Criteria and Perform Medical Review.</b>
"Authorization Required"	This admission cannot be auto-authorized, but Medical Review is required. The request will be evaluated by the Payer's Utilization Management team. Proceed with the authorization. <b>ACTION: Select the criteria and Perform Medical Review.</b>
"Notification Required"	This admission indicates that the patient's health plan must be notified of the admission. <b>ACTION: Select the criteria and Perform Medical Review.</b>

## Step 5: Perform Medical Review

Clear Coverage will access the Medical Necessity of the Authorization Request.

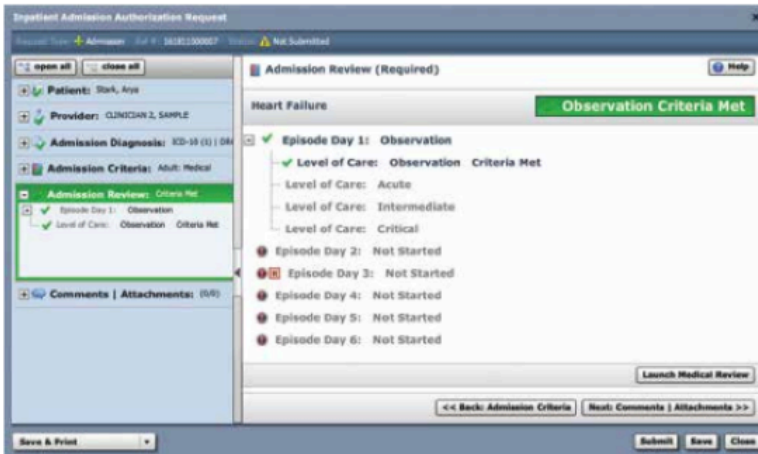
If in the previous step, the **"Coverage"** of your test was either **"Medical Review Required"**, **Authorized Instantly**, or **"Authorization Required"**, you need to perform Medical Review in order for the request to Auto-Authorize and give you an immediate authorization. If you do not perform medical review in those cases, you will NOT be eligible to receive an auto authorization, and the case will require manual review.

1. Click on the **"Launch Medical Review"** button to launch the Medical Review.
2. Provide the appropriate responses for your specific patient and clinical situation.
3. Upon completion of the Medical Review, you will receive a outcome on the medical appropriateness of the admission based upon the best current evidence available.



4. Click **Save**.

- i. Notice that under Medical Review in the Authorization Request the **"Not Started"** status has changed to **"Complete"** or **"Incomplete"** based on the result of the Medical Review.



### Step 6: Adding a Comment or Document

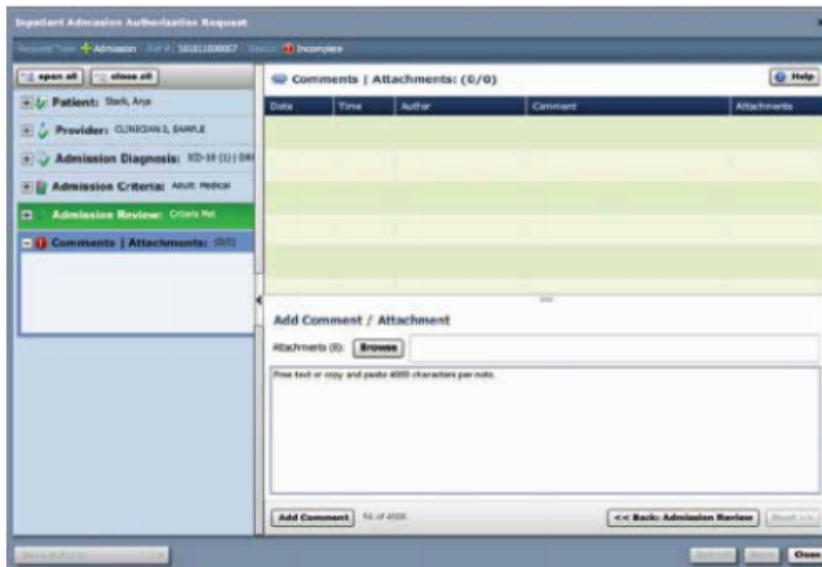
The **Comments | Attachments** section allows you to provide any additional notes to support your Authorization Request.

1. Add any additional notes to support the request (additional medical evidence, etc)

**Note:** You may copy and paste areas from your EMR to support your request in this area if needed.

2. Click the **"Add Comment"** button to attach the comments to the authorization request.
3. Click the **"Browse"** button to attach a file.

**Note:** Add notes and attach supporting clinical documentation when a "Criteria Not Met" and/or a "Pending" status is received.



## "Save" or "Submit" an Authorization

1. Verify all **6 Sections/Accordions** of the Authorization Request are filled out and complete.
2. Is **Medical Review** complete? Make sure you have performed the Medical Review questions if your admission coverage was "Medical Review Required", "Authorized Instantly", or "Authorization Required".
3. If you need to come back to Medical Review or if you are not sure about information within the authorization Click on the "**Save**" button.
4. If you are confident in the authorization information Click on the "**Submit**" button.
  - a. You will be asked to enter your contact information if this option is turned on.

Contact details are required for all submitted authorizations. Please provide contact details (a name and a phone number) below and press submit to finish the request.

First Name:  Last Name:

Phone Number: e.g. (555) 555-1212  
 (  )  -  Ext.

- b. You will then be asked to input an estimated length of stay if you have this option turned on.

**Estimated Length Of Stay**

Payor requires all in-patient authorization requests to have an estimated length of stay from the requesting office. Please provide the estimated length of stay for this request.

Estimated Length Of Stay in days

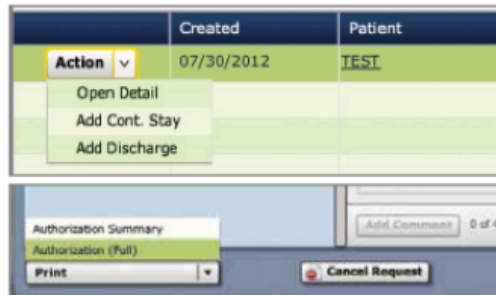
- c. Click "**Submit**".

- d. You will then receive an Automatic response to the request:
- i. Your request will be **Approved** (Auto-Authorized).
  - ii. Clear Coverage will record the Request with an **Internal Reference #**, a 12 digit number (Ex. "012345678901").
  - iii. If approved, you will also receive a certification number, a 10 character code starting with a "C" (Ex. "C12345ABCD"). This is your **Authorization Number**.
  - iv. If the authorization status is "Pending", find the member from the home page, click on "Action" button next to desired patient, select "Open Detail", then add the clinical attachment and notes. Refer to Step/ Accordion 6 for instructions on adding notes and attachments

**Note:** If the Submit button is not enabled, hover over the submit button to determine what information is missing from your request.



5. To review authorization submitted by the provider you are logged into click the Search Authorization Requests tab. For a copy of the authorization, click the "Open Detail" button, then click **Print Authorization** Full or Summary. This will open a pdf that can be printed or saved.



Search Results: Authorization Results

	Created	Patient	Payer	Admit Date
<b>Action</b> ▾	10/21/2013	TESTPATIENT, ALLEN	Sandbox	10/21/2013
Open Detail	11/20/2013	TESTPATIENT, ALLEN	Sandbox	11/20/2013
Add Cont. Stay	10/11/2013	TESTPATIENT, ALLEN	Sandbox	10/11/2013
Add Discharge	10/11/2013	TESTPATIENT, ALLEN	Sandbox	10/11/2013
<b>Action</b> ▾	10/11/2013	TESTPATIENT, ALLEN	Sandbox	10/11/2013
<b>Action</b> ▾	10/10/2013	TESTPATIENT, ALLEN	Sandbox	10/10/2013

The **Action** drop down will allow you to:

- View the request: "Open Detail"
- Add a Continued Stay
- Add a Discharge

## Creating a Continued Stay Review

To create a Continued Stay:

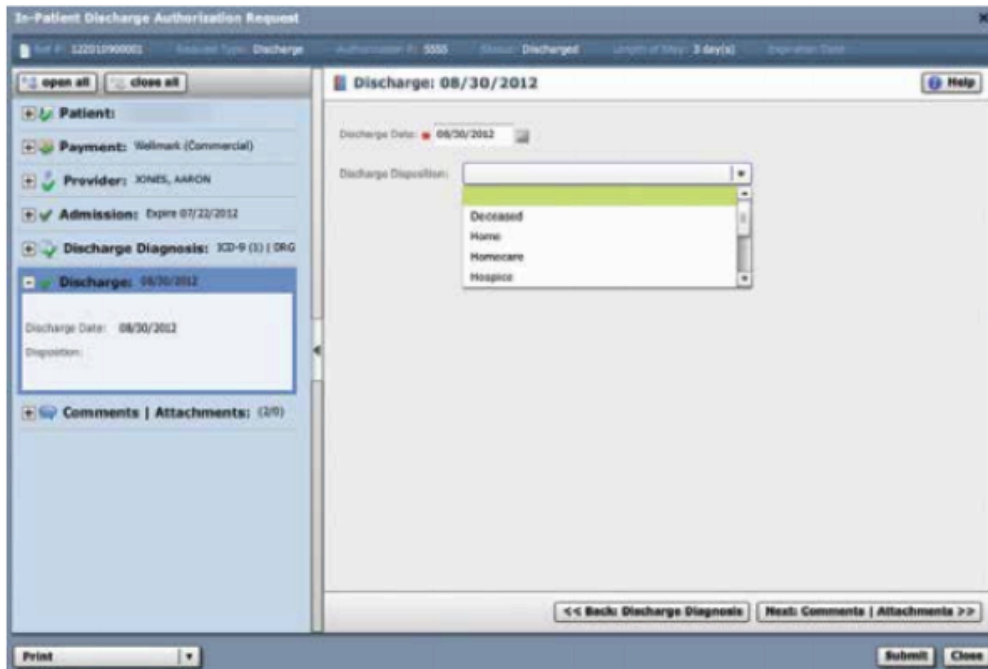
1. Locate the patient on the **"Authorization Request"** tab.
2. Click the **"Action"** button next to the patient and select **"Add Cont. Stay"** from the drop down menu.
3. Enter a new Diagnosis if different from the original, or continue on to the Cont. Stay Criteria.
4. You may or may not be required to complete the Continued Stay review.
5. Add any comments/attachments.
6. Click **"Submit"**.

Multiple Continued Stays can be performed.

## Creating a Discharge

To create a Discharge:

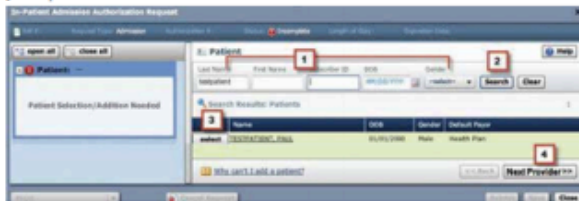
1. Locate the patient on the **"Authorization Request"** tab.
2. Click the **"Action"** button next to the patient and select **"Add Discharge"** from the drop-down menu.
3. Enter the **"Discharge Date"**.
4. Use the drop-down menu to select the **"Discharge Deposition"** if this option is turned on.
5. Click **"Submit"**.



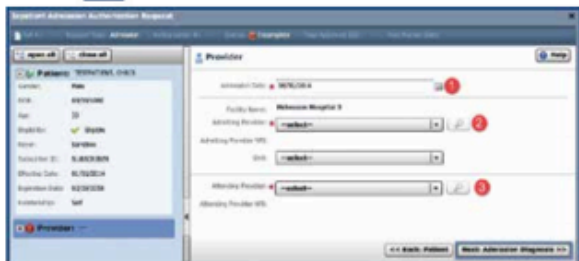
The screenshot displays the 'In-Patient Discharge Authorization Request' form. The top header includes the patient ID (1220190002), Request Type (Discharge), Authorization # (5555), Status (Discharged), Length of Stay (3 day(s)), and Disposition Code. The left sidebar contains expandable sections for Patient, Payment (Wellmark (Commercial)), Provider (JONES, AARON), Admission (Expires 07/22/2012), Discharge Diagnosis (ICD-9 (3) (DRG)), Discharge (08/30/2012), and Comments | Attachments (2/0). The main content area shows the Discharge Date as 08/30/2012 and a Discharge Disposition dropdown menu with options: Deceased, Home, Homecare, and Hospice. Navigation buttons at the bottom include '<< Back: Discharge Diagnosis', 'Next: Comments | Attachments >>', 'Print', 'Submit', and 'Close'.

## Start by logging into Clear Coverage.

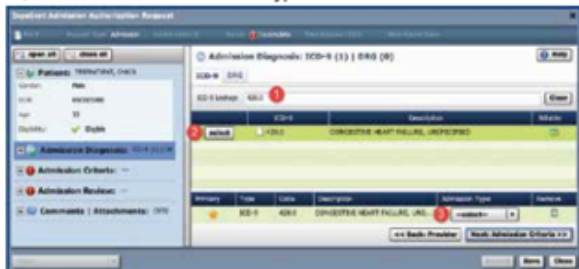
1. After logging in, click **New Authorization** at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**. Note that fields with a red asterisk (\*), if noted, are required to search.
3. In the Search Results, click **select next** to the patient's name.
4. Verify the patient's information, click **Next: Provider**



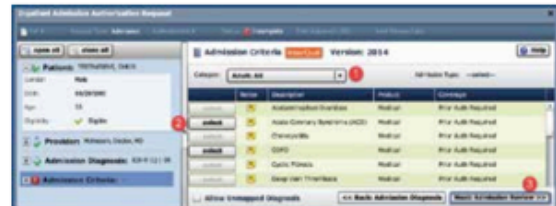
5. In the Provider accordion, select the **Admission Date** followed by the **Admitting Provider (Facility)** from your preferred clinician list. You may also choose a facility by clicking on the icon. Click **Next: Admission Diagnosis**



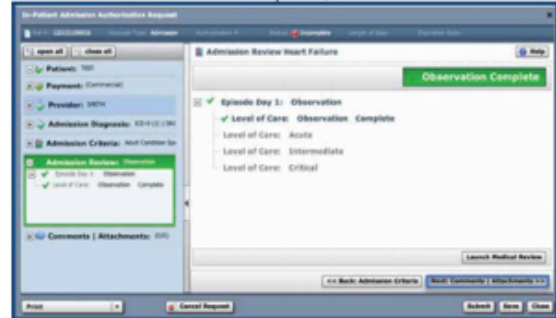
6. In the Admission Diagnosis accordion, search for a specific billable diagnosis, click **Select**, and then select an **Admission Type**. Click **Next: Admission Criteria**



7. In the Admission Criteria accordion, start by selecting the category of your admission criteria. Click **Select** next to the appropriate service and then click **Next: Admission Review**



8. After the medical review has been completed, click **Next: Comments/Attachments**



9. In the **Comments/Attachments** accordion, add notes and attach supporting clinical documentation when a "Criteria Not Met" and/or a "Pending" status is received. Reference page 11, "iv. If authorization status is "Pending"...from the Clear Coverage Inpatient Training Guide.
10. Verify the **Authorization Request** details are correct in the right pane.
11. Click **Submit** in the lower right pane. If **Submit** is not active, move the pointer over it to see the information that's missing.
12. A request confirmation is created for each service/test.




You can find more detailed information and reference guides in the Help section by clicking the **Help** button in the top right hand corner of the screen.

13. Print the authorization request by selecting the **View Request (PDF)** link.

Additional Clear Coverage help is located on the home page.

Welcome To Provider TouCHPoint

	<p><u><a href="#">Look up patient eligibility</a></u> Get up-to-date information about patient eligibility and copay amounts.</p>		<p><u><a href="#">Find a TCHP participating provider</a></u> Use our provider directory to find a provider by name, location or plan.</p>
	<p><u><a href="#">View my claims</a></u> View the status of a claim and remittance advice.</p>		<p><u><a href="#">Authorizations</a></u> View the status of an authorization. Submit an authorization request online.</p>
	<p><u><a href="#">Setting permissions</a></u> Assign roles in Provider TouCHPoint for others in your office.</p>		<p><u><a href="#">Communication</a></u> Get the latest information on upcoming CME opportunities, <i>Provider News</i>, fax blasts, community events and more.</p>
	<p><u><a href="#">Clinical Reports</a></u> Download current EPSDT, Asthma High Risk reports and other clinical reports.</p>		<p><u><a href="#">Provider Training</a></u> Provider Training (Navitus, Dental, CHIP Perinate)</p>
	<p><u><a href="#">Utilization Management Guidelines</a></u> Review utilization management guidelines for TCHP required authorizations.</p>	 <p><u><a href="#">Clear Coverage Training</a></u> Clear Coverage</p>	

## Secure Messaging

Every Provider TouCHPoint user receives a secure messaging e-mail account. Your message box is located in the upper right of the banner at the top of the screen. Using the [Message Center](#), you can:

- Add and edit mailboxes
- Send messages to TCHP staff
- Receive and manage messages
- Add or send documents



To send a message, follow the steps below:

**Step 1:** Click on the [NEW](#) button. The [Compose Message](#) form will appear.

**Step 2:** Select a recipient for your message by clicking on the [To](#) button. The [Select Recipient](#) screen will open.

**Step 3:** Select a recipient type from the list below:

- Provider relations - general comments
- Provider relations - claims questions
- Provider relations - issues with portal
- Authorization questions
- Eligibility questions

Click the [Search](#) button.



**Step 4:** To send a message, click on the [Select](#) button next to the mailbox.

**Step 5:** Type in your subject and content. You can also attach documents and check the Mark Urgent box for your message. When finished, click the [Send](#) button.

You will receive a confirmation that your message was sent. You can return to your inbox or do another task. You will be able to see your sent mail by clicking on the [Sent Items](#) tab.

# Reports

You can now access reports online through Provider TouCHPoint. This feature allows you to generate your own PCP panel reports.



**Step 1:** Click on the Reports link under the [Office Management](#) section of Provider TouCHPoint. A list of available reports will appear.

Available Reports	
REPORT NAME	REPORT DESCRIPTION
<a href="#">Member Roster by Access List</a>	Displays a list of members grouped by selected access list.
<a href="#">Member Roster by PCP</a>	Displays a list of members grouped by a selected provider.
<a href="#">Member Roster by Practice</a>	Displays a list of members grouped by a selected practice.
<a href="#">Remittance Advice Report</a>	Provides the ability to print the remittance advice.

**Step 2:** Click on the report name you would like to generate.

**Step 3:** Search and select your name or your provider ID

**Step 4:** Click on the available fields you would like to appear in each column.  
Click the [Add](#) button and the fields will appear under your column selections.

**Step 5:** Select the type of report format you want

- PDF
- Excel
- CVS

If a selection is not made, the report will be viewed on screen.

**Step 6:** Click the [Submit](#) button.

**NOTE:** If your panel report has more than 2,000 members, your report will be sent to the Document Manager.

Report - Member Roster by PCP

Your report is currently processing and will take time to complete. It will be delivered to your **Document Manager** when it is complete, which may be 30 minutes or more. Please select a download format for the report.

PDF

Submit

Back

## Office Management

Eligibility

Claims

### Reports

Authorizations

Code Lookup

Clear Coverage Inpatient Hospital Admissions

vTouch

Clear Coverage Outpatient / Provider Offices

Document Manager

Valence Population Management

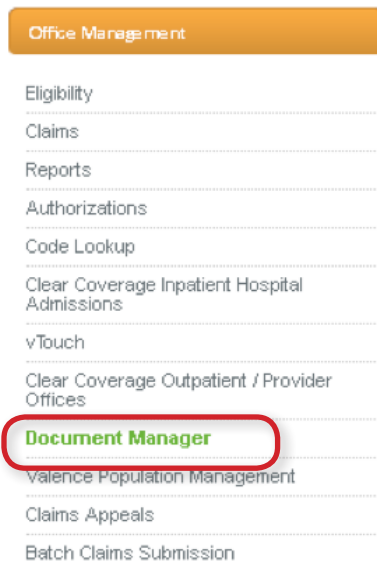
Claims Appeals

Batch Claims Submission

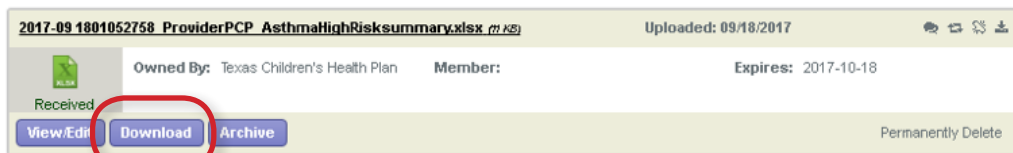
# Document Manager

TCHP will send reports and documents to providers using the [Document Manager](#). You will receive files in your message center inbox. When the file is downloaded, it will move from the message center inbox to the [Inbox](#) tab in Document Manager. To access the Document Manager, follow the steps below.

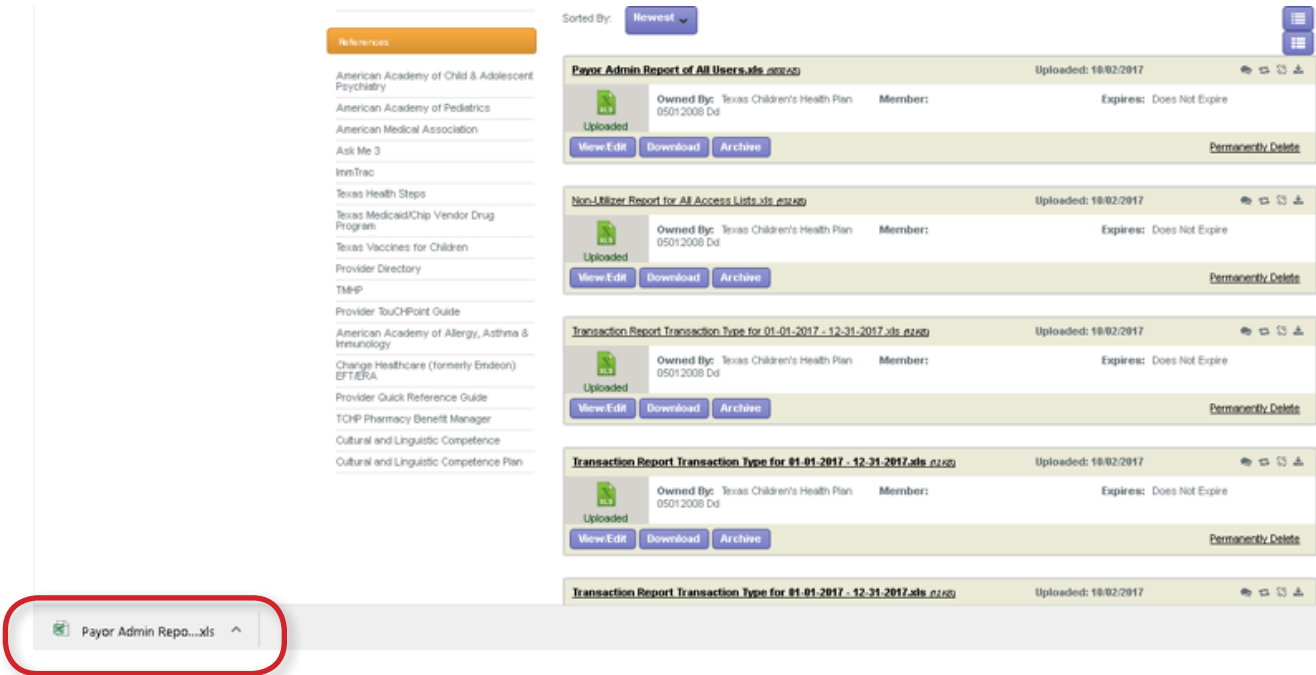
**Step 1:** Click on the Document Manager button under the [Office Management](#) section.



**Step 2:** Click on the [Download](#) link



**Step 3:** Click on the [Open](#) or [Save](#) button. The document will move from your Inbox tab to the Downloaded tab of the Document Manager. The selected format will open in the bottom left side of your screen.



The screenshot displays a Document Manager interface. On the left is a 'References' sidebar with a list of links including 'American Academy of Child & Adolescent Psychiatry', 'American Academy of Pediatrics', and 'Texas Vaccines for Children'. The main area shows a list of documents sorted by 'Newest'. Each document entry includes a file icon, title, upload date, ownership information, and action buttons like 'View/Edit', 'Download', and 'Archive'. A red circle highlights the download bar at the bottom left, which contains the file 'Payor Admin Repo...xls'.

Document Title	Upload Date	Owned By	Member	Expires
Payor Admin Report of All Users.xls	10/02/2017	Texas Children's Health Plan	05012008 Dd	Does Not Expire
Non-Utilizer Report for All Access Lists.xls	10/02/2017	Texas Children's Health Plan	05012008 Dd	Does Not Expire
Transaction Report Transaction Type for 01-01-2017 - 12-31-2017.xls	10/02/2017	Texas Children's Health Plan	05012008 Dd	Does Not Expire
Transaction Report Transaction Type for 01-01-2017 - 12-31-2017.xls	10/02/2017	Texas Children's Health Plan	05012008 Dd	Does Not Expire
Transaction Report Transaction Type for 01-01-2017 - 12-31-2017.xls	10/02/2017	Texas Children's Health Plan	05012008 Dd	Does Not Expire

Downloaded: Payor Admin Repo...xls

# Provider Complaint

## Office Management

- Eligibility
- Claims
- Authorizations
- Code Lookup
- Clear Coverage Inpatient Hospital Admissions
- vTouch
- Clear Coverage Outpatient / Provider Offices
- Document Manager
- Valence Population Management
- Batch Claims Submission
- Claims Appeals
- Provider Complaint**
- Provider Directory Verification

## Administration

- User Preferences

## References

- American Academy of Child & Adolescent Psychiatry
- American Academy of Pediatrics
- American Medical Association
- Ask Me 3
- ImmTrac
- Texas Health Steps
- Texas Medicaid/CHIP Vendor Drug Program
- Texas Vaccines for Children
- Provider Directory
- TMHP
- Provider TouCHPoint Guide
- American Academy of Allergy, Asthma & Immunology
- Change Healthcare (formerly Emdeon) EFT/ERA
- Provider Quick Reference Guide
- TCHP Pharmacy Benefit Manager
- Cultural and Linguistic Competence
- Cultural and Linguistic Competence Plan

## Provider Complaint

\* NPI #

Validate

\* Contact Name

\* Phone Number

\* Email

\* Subject

--- Select --- ▼

\* Contactor

--- Select --- ▼

\* Plan

--- Select --- ▼

\* Notes

2000 of 2000 characters left

Save

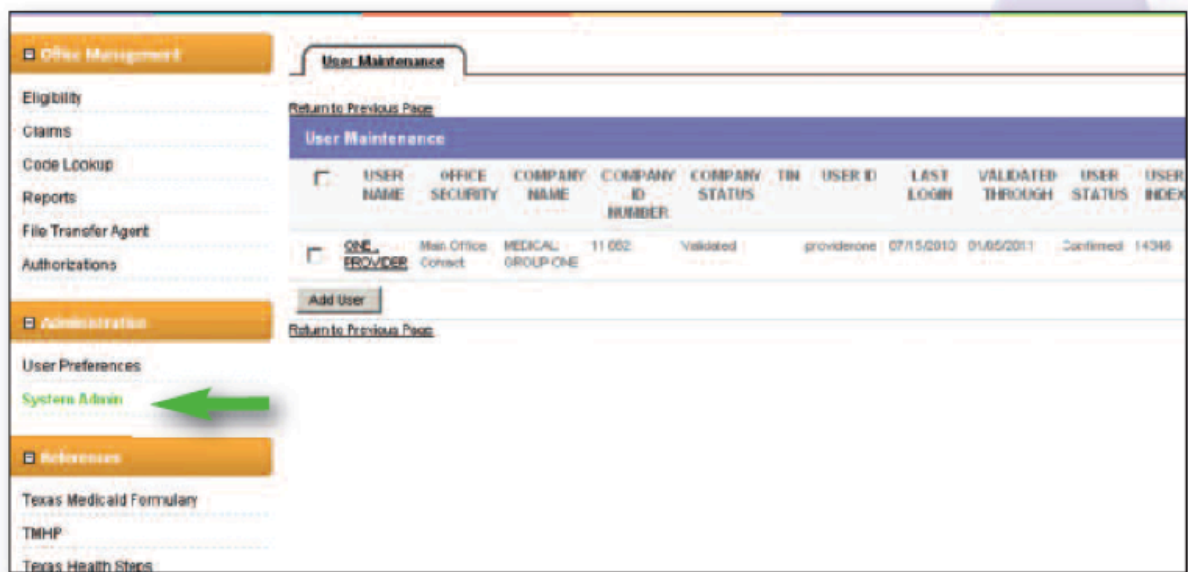
# System Administration/User Maintenance

## Adding an additional user

If you need to add or remove a user, you can use the system administration/user maintenance feature.

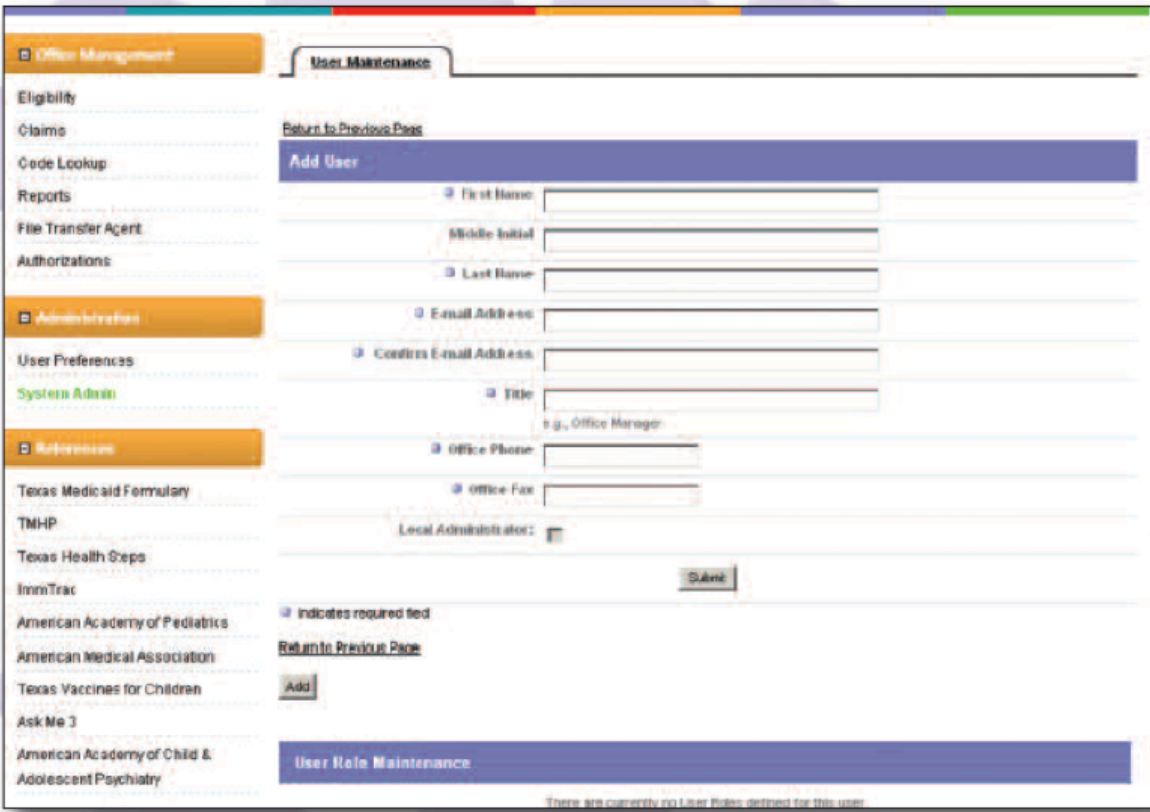
**Step 1:** Click on the [System Admin](#) link under the [Administration](#) section.

**Step 2:** To add a user, click the [Add User](#) button.



The screenshot displays the 'User Maintenance' interface. On the left, a navigation menu is visible with sections: Office Management, Administration, and References. Under 'Administration', 'System Admin' is highlighted with a green arrow. The main content area shows a 'User Maintenance' tab with a 'Return to Previous Page' link. Below this is a table with the following columns: USER NAME, OFFICE SECURITY, COMPANY NAME, COMPANY ID NUMBER, COMPANY TIN STATUS, USER ID, LAST LOGIN, VALIDATED THROUGH, USER STATUS, and USER INDEX. A single user entry is shown with the following details:  ONE PROVIDER, Min. Office Contact, MEDICAL GROUP ONE, 11 052, Validated, providerone, 07/15/2010, 01/05/2011, Confirmed, 14386. Below the table is an 'Add User' button and another 'Return to Previous Page' link.

**Step 3:** Enter the new user information and click the [Submit](#) button.



**Office Management**

**User Maintenance**

[Return to Previous Page](#)

**Add User**

First Name  
 Middle Initial  
 Last Name  
 Email Address  
 Confirm Email Address  
 Title  
e.g., Office Manager  
 Office Phone  
 Office Fax

Local Administrator:

Indicates required field

[Return to Previous Page](#)

**User Role Maintenance**

There are currently no User Roles defined for this user.

**Administration**

User Preferences

**System Admin**

**References**

Texas Medicaid Formulary

TMHP

Texas Health Steps

InnTrac

American Academy of Pediatrics

American Medical Association

Texas Vaccines for Children

Ask Me 3

American Academy of Child & Adolescent Psychiatry



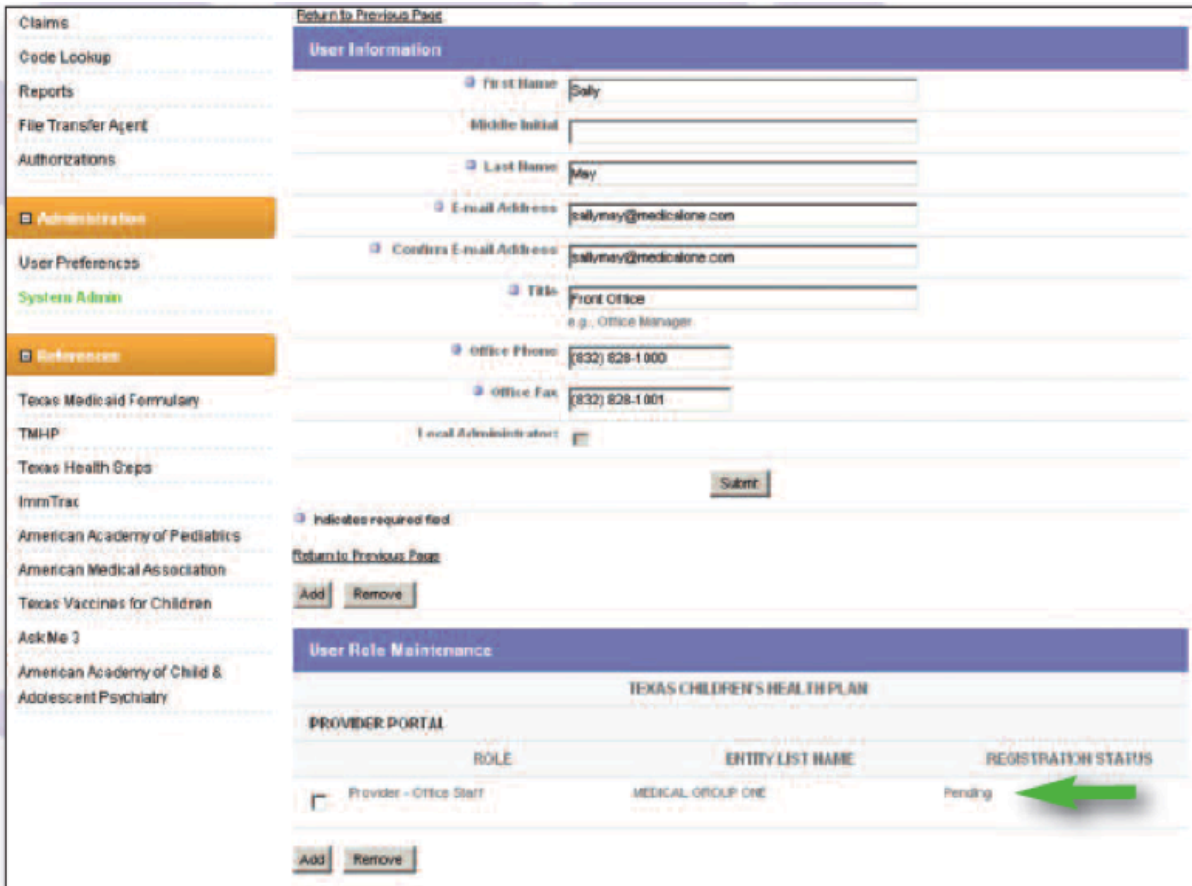
**Step 4:** You can then select a user role and access list from the pull down menu. Once you complete your user selections, click the **Submit** button.



The screenshot shows the 'Provider TouCHPoint' interface. In the top right corner, it indicates 'Logged In: Provider One', 'Message Center (0 New)', and 'Role: Provider - Office Manager'. On the left, there is a navigation menu with 'Office Management' highlighted. The main content area features a 'User Role Selection' form with the following fields:

- Roles:** A dropdown menu currently showing 'Provider - Provider - Office Staff'.
- Entity Lists:** A dropdown menu currently showing 'MEDICAL GROUP ONE - TCHP'.
- Buttons:** 'Submit' and 'Cancel' buttons are located below the dropdowns.
- Link:** A 'Return to Previous Page' link is positioned below the form.

The user status will show "pending" until TCHP confirms the user change.



This screenshot displays the 'User Information' and 'User Role Maintenance' sections of the Provider Portal. The 'User Information' section contains the following details:

- First Name:** Polly
- Middle Initial:** (empty)
- Last Name:** May
- E-mail Address:** pollymay@medication.com
- Confirm E-mail Address:** pollymay@medication.com
- Title:** Front Office (e.g., Office Manager)
- Office Phone:** (832) 828-1000
- Office Fax:** (832) 828-1001
- Local Administrator:**

Below the form is a 'Submit' button and a note: 'Indicates required field.' A 'Return to Previous Page' link and 'Add'/'Remove' buttons are also present.

The 'User Role Maintenance' section shows a table for 'PROVIDER PORTAL' under the heading 'TEXAS CHILDREN'S HEALTH PLAN':

ROLE	ENTITY LIST NAME	REGISTRATION STATUS
Provider - Office Staff	MEDICAL GROUP ONE	Pending

A green arrow points to the 'Pending' status in the table. Below the table are 'Add' and 'Remove' buttons.

Once TCHP confirms, the user status will change from "pending" to "confirmed." The office administrator will receive an email with the user's temporary password. The office administrator must forward the user name (found in user maintenance) and temporary password for the initial login.



Provider TouCHPoint

Home | Log Out  
Logged In: Provider One  
Message Center (0 New)  
Role: Provider - Office Manager

Office Management

User Maintenance

Return to Previous Page

<input type="checkbox"/>	USER NAME	OFFICE SECURITY	COMPANY NAME	COMPANY ID NUMBER	COMPANY STATUS	TN	USER ID	LAST LOGIN	VALIDATED THROUGH	USER STATUS	USER ID#
<input type="checkbox"/>	MINY, Sally	Use	MEDICAL GROUP ONE	11052	Validated		Sally1		01/05/2011	Confirmed	14377
<input type="checkbox"/>	ONE, PROVIDER	Max Office Contact	MEDICAL GROUP ONE	11052	Validated		providerone	07/15/2010	01/05/2011	Confirmed	14386

Add User

Return to Previous Page

Administrative

User Preferences

System Admin

## Changing a user role or access list

**Step 1:** To change a user's role or access list, click on the user's name.

**Step 2:** Click the [Add](#) button.



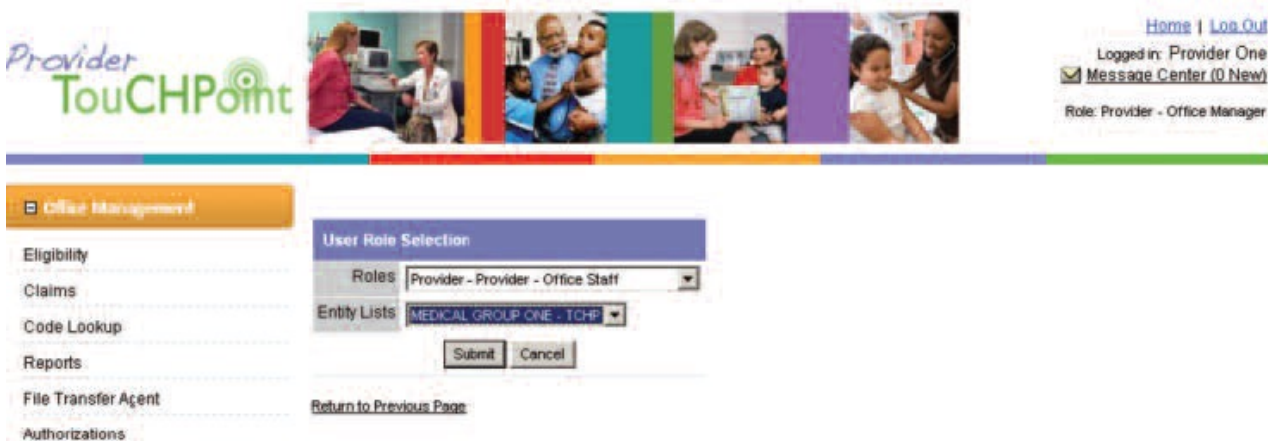
The screenshot shows a user profile page for 'MEDICAL GROUP ONE'. The 'User Role Maintenance' section contains a table with the following data:

PROVIDER PORTAL	ROLE	ENTITY LIST NAME	REGISTRATION STATUS
<input type="checkbox"/>	Provider - Office Manager	MEDICAL GROUP ONE	Confirmed

Below the table are 'Add' and 'Remove' buttons. A green arrow points to the 'Add' button.

**Step 3:** Select a different role or access list.

**Step 4:** Click the [submit](#) button.



The screenshot shows the 'Provider TouCHPoint' interface. The 'User Role Selection' dialog box is open, showing the following configuration:

- Roles: Provider - Provider - Office Staff
- Entity Lists: MEDICAL GROUP ONE - TCHP

Buttons for 'Submit' and 'Cancel' are visible. The user is logged in as 'Provider One' with the role 'Provider - Office Manager'.

**Step 5:** Click on the [button next to the old role](#).

**Step 6:** Click on the [Remove](#) button

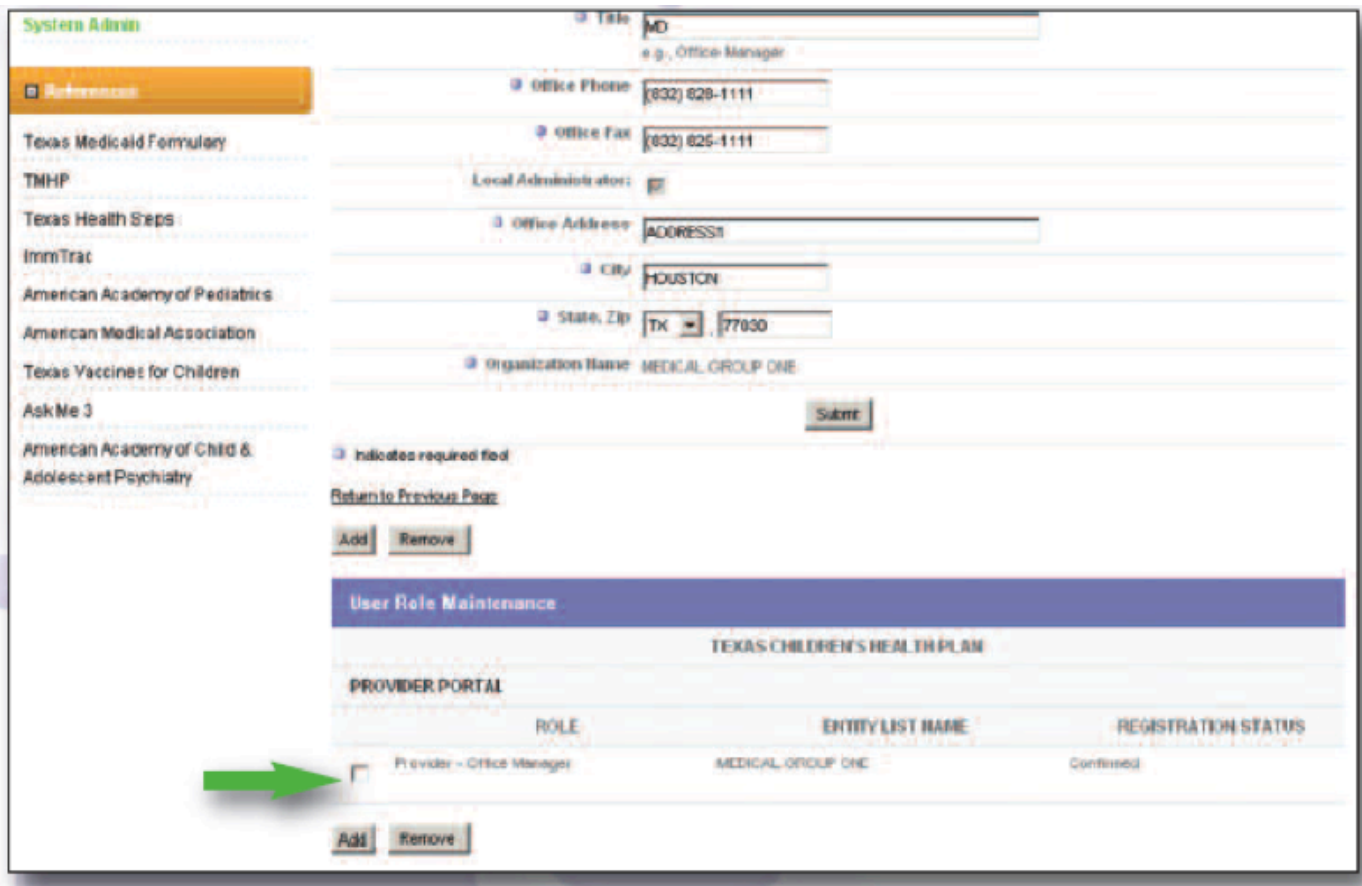
Under the [User Role Maintenance](#) section, you will see the user role change confirmed.

## Removing a User Role

**Step 1:** To change a user's role, click on the [user's name](#).

**Step 2:** Click on the [box next to the role](#)

**Step 3:** Click the [Remove](#) button.



The screenshot shows the 'System Admin' interface. On the left is a navigation menu with items like 'Texas Medicaid Formulary', 'TMHP', 'Texas Health Steps', 'InnTrac', 'American Academy of Pediatrics', 'American Medical Association', 'Texas Vaccines for Children', 'Ask Me 3', and 'American Academy of Child & Adolescent Psychiatry'. The main area contains a form for user details with fields for Title (MD), Office Phone, Office Fax, Local Administrator, Office Address, City (HOUSTON), State, Zip (TX 77030), and Organization Name (MEDICAL GROUP ONE). Below the form is a 'User Role Maintenance' section with a table for 'PROVIDER PORTAL'. The table has columns for 'ROLE', 'ENTRY LIST NAME', and 'REGISTRATION STATUS'. One row is visible: 'Provider - Office Manager' with 'MEDICAL GROUP ONE' and 'Confirmed'. A green arrow points to the checkbox in the 'ROLE' column for this entry. Below the table are 'Add' and 'Remove' buttons.

**NOTE:** You must have one role for the user or the user will be deleted.

**Step 4:** Enter the reason for removing user.

**Step 5:** Click the [Yes](#) button.



You will receive confirmation the user was removed.

