Texas Children's® Health Plan

Provider Portal Training Guide

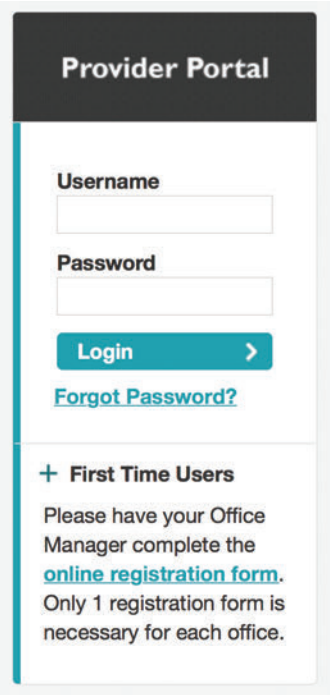
Summer 2019

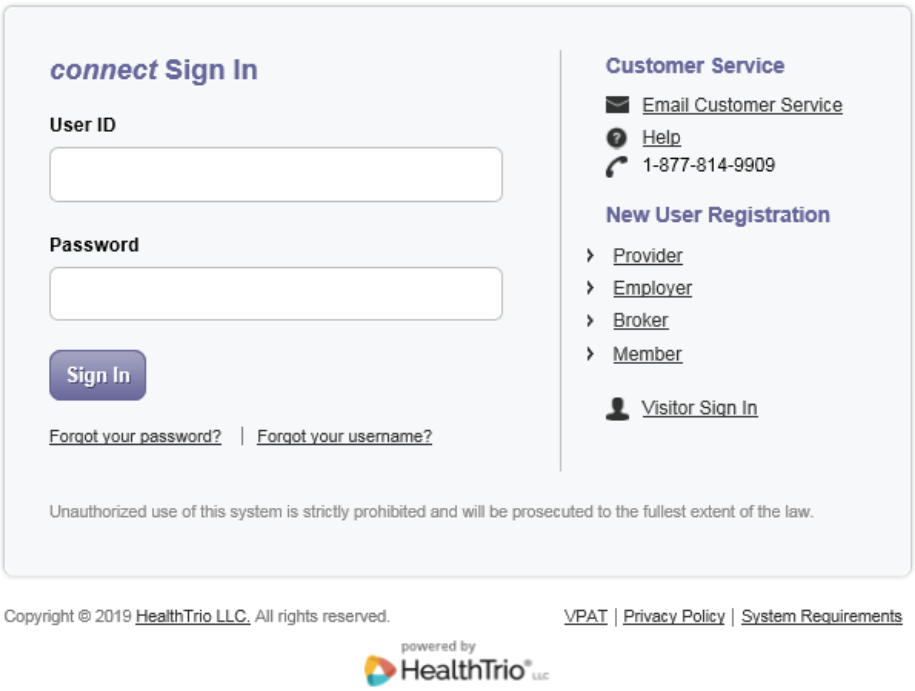
Registration

Registering for the Texas Children's® Health Plan (The Health Plan) Provider Portal is convenient. New physicians, office managers, or administrators can **register online** by following these simple steps.

Step 1

Go to **https://www.texaschildrenshealthplan.org/for-providers**.
Click on the **First Time Users** link under the Login box.





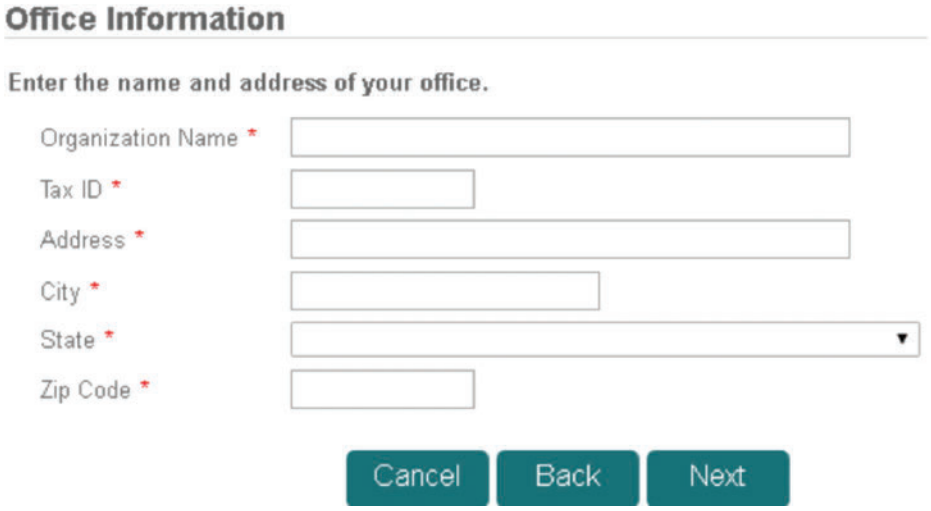
Step 2

Before you enter your **User Information**, please check to see if your office is already registered. They can simply add you with their access. Fields with a red asterisk are required.

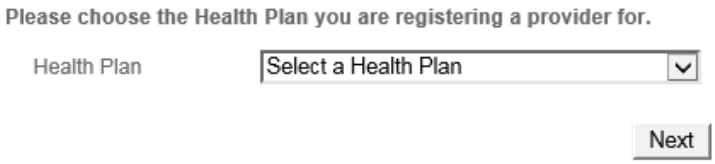
Click the **Next** button.

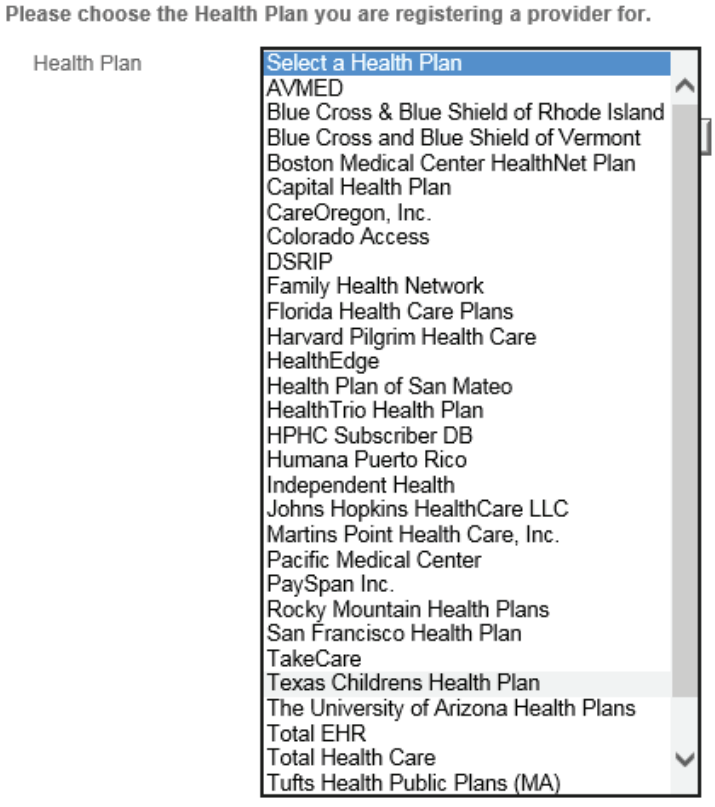
Step 3

Enter your Office Information. All fields are required.



Click the **Next** button.





Texas Children's Health Plan

Registration

Please choose the Health Plan you are registering a provider for.

Health Plan: Texas Childrens Health Plan

Next

User Information

If you are an existing user of the Connect system please login Click here to start your session.

First Name *

Middle Initial

Last Name *

Title *

E-Mail *

Confirm E-Mail *

Office Phone *
Example: (555) 555-5555

Extension #
Example: 123456

Office Fax *
Example: (555) 555-5555

User Name *

Password *

Confirm Password *

Security Question 1 *

Security Answer 1 *
Your answer may not contain your username.

Security Question 2 *

Security Answer 2 *
Your answer may not contain your username.

Security Question 3 *

Security Answer 3 *
Your answer may not contain your username.

Local Admin ☑ As the primary registrant, you are automatically a local admin

Cancel Back Next

Search for your provider office

Search For

Search By

Search Text

Search

Cancel Back Next

Search for your provider office

Search For: Practice

Search By: Name

Search Text: TCP

Search

Provider Office Search Results

Name	Office Address
TCP - After Hours The Woodlands	1011 Medical Plaza Dr #220, The Woodlands, TX 77380
TCP - Barker Cypress	9925 Barker Cypress Road, Ste. 200, None, Cypress, TX 77433
TCP - Barker Cypress	9925 Barker Cypress Road, Ste. 200, None, Cypress, TX 77433
TCP - Behavioral Wellness	7515 S Main St #220, None, Houston, TX 77030
TCP - Cypress	13203 Fry Rd #600, None, Cypress, TX 77433
TCP - Cypress	13203 Fry Rd #600, None, Cypress, TX 77433
TCP - Dr. Leass	1011 Medical Plaza Drive, Ste. 100, None, Spring, TX 77380
TCP - Dr. Leass	1011 Medical Plaza Drive, Ste. 100, None, Spring, TX 77380
TCP - East	13018 Woodforest Blvd., Ste. A, None, Houston, TX 77015
TCP - East	13018 Woodforest Blvd., Ste. A, None, Houston, TX 77015

1 - 10 of 209 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 >

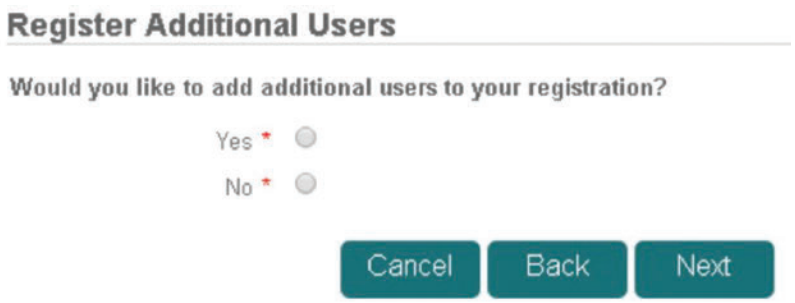
My office is not listed *

Cancel Back Next

Adding additional users

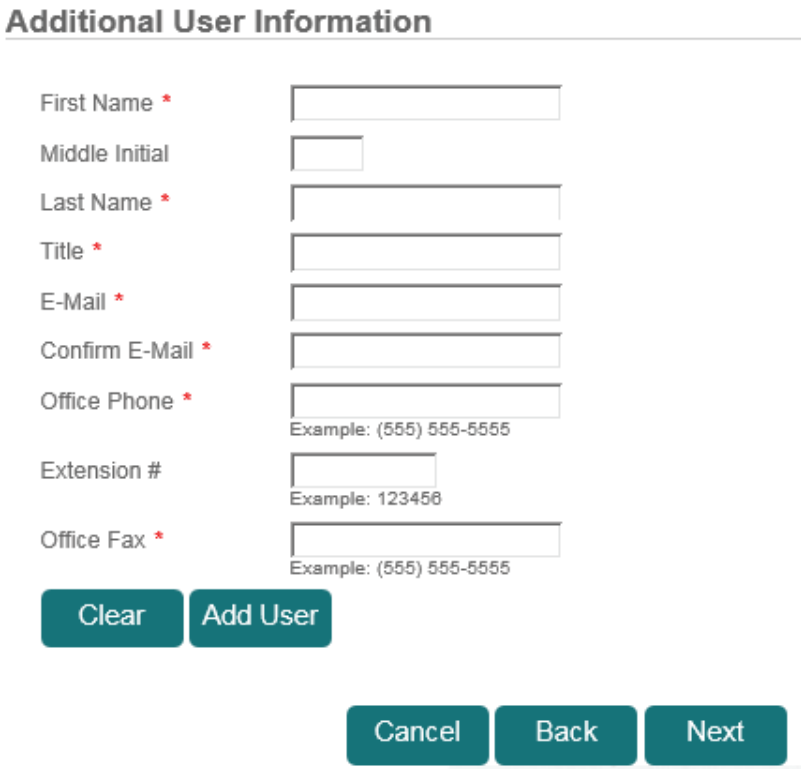
Step 1

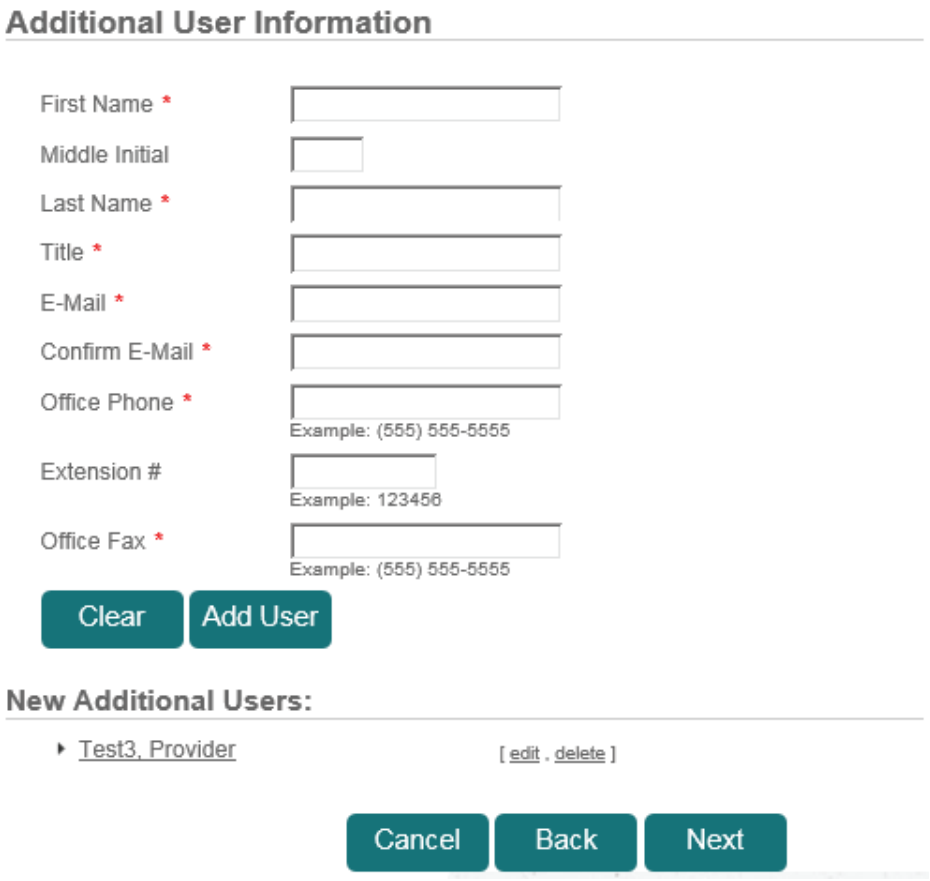
Once you complete your registration, you can register additional users. If you are going to add additional users, click **Yes**, then click the **Next** button. If not, click **No** and click the **Next** button.



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 have added all additional users, click the **Next** button.



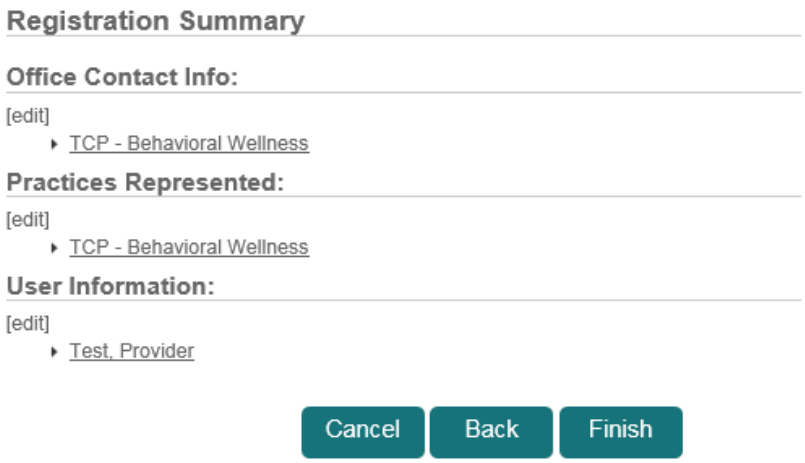


After adding additional users, the registration process confirms the additional users by displaying their names under the Additional Users section.

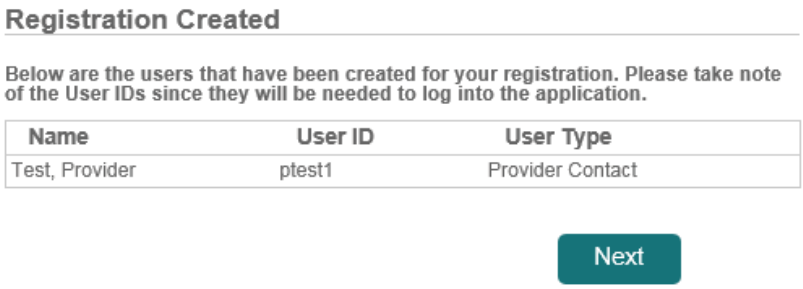
NOTE: Local administrators can select their username/password.
All other users are assigned system-generated usernames and temporary passwords.

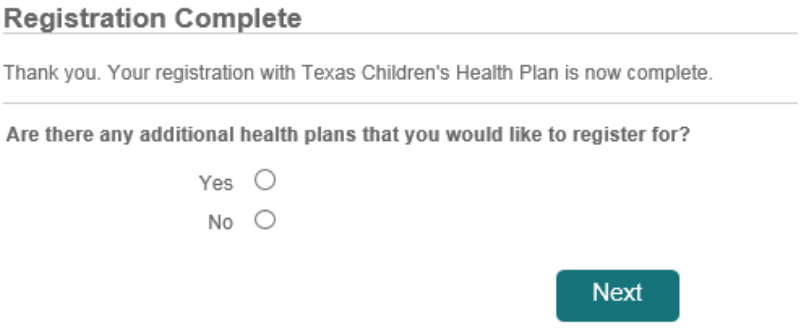
Step 3

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 **Next**.





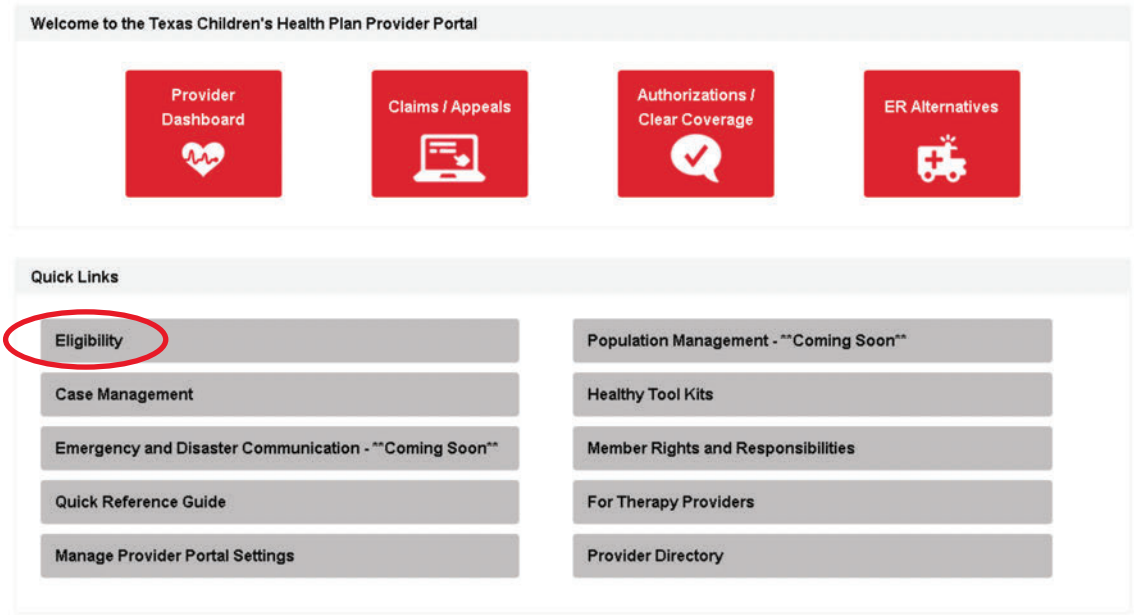
Once registration is complete, you will receive a confirmation e-mail. The Health Plan will approve registrations as soon as possible. You will then need to login to the Provider Portal using your username and temporary password assigned by The Health Plan. You will be prompted to create a new password.

Eligibility

The Provider Portal allows you to verify eligibility and copay information for your Texas Children's Health Plan patients. Below are some simple steps to get you started.

Step 1

Click on the **Eligibility** button under the *Quick Links* section of Provider Portal Homepage.

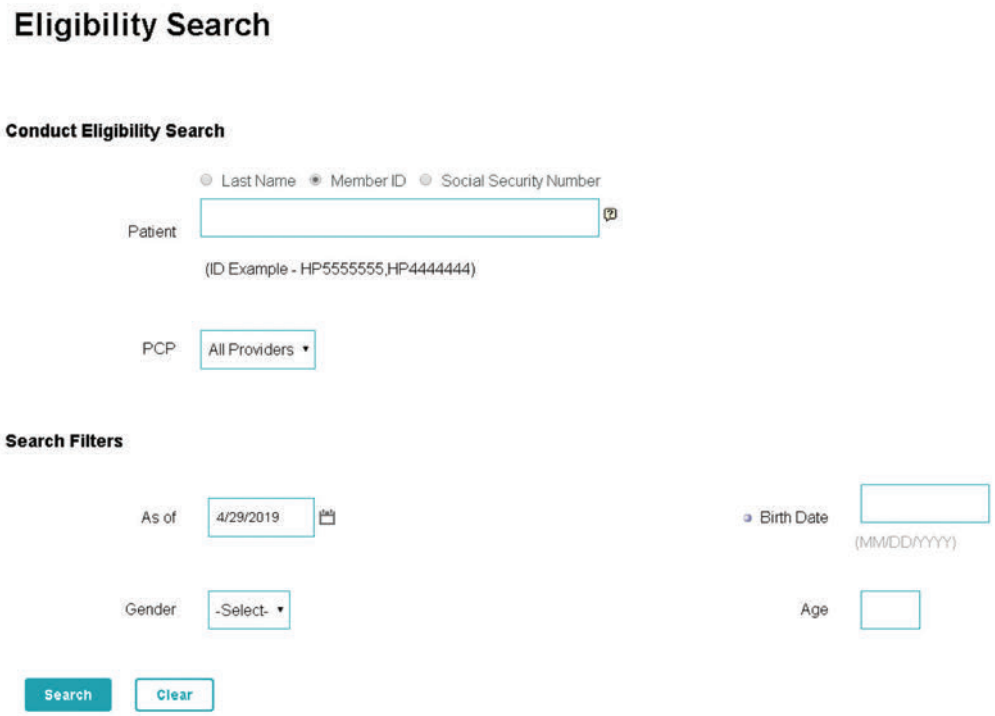


The eligibility search feature allows you to search for a patient by any of the following:

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

Step 2

Complete the fields and then click the **Search** button. The eligibility search results screen displays the member name, gender, effective dates, date of birth, member ID, if an EPSDT is needed, and PCP. (For best results, use only the Last Name, Member ID or Social Security Number and the Birth Date).



NOTE: You must enter a date of birth using one of the following examples: 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 The Health Plan member information including name, date of birth, sex, member ID, PCP, address, and phone number. Benefit copay information will also be displayed. If the effective date is red, the member is inactive.

STAR Kids members also have their MDCP waiver information populated when you click on the members name to display the eligibility detail. MDCP waiver information is located under Benefit Plan Information.

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

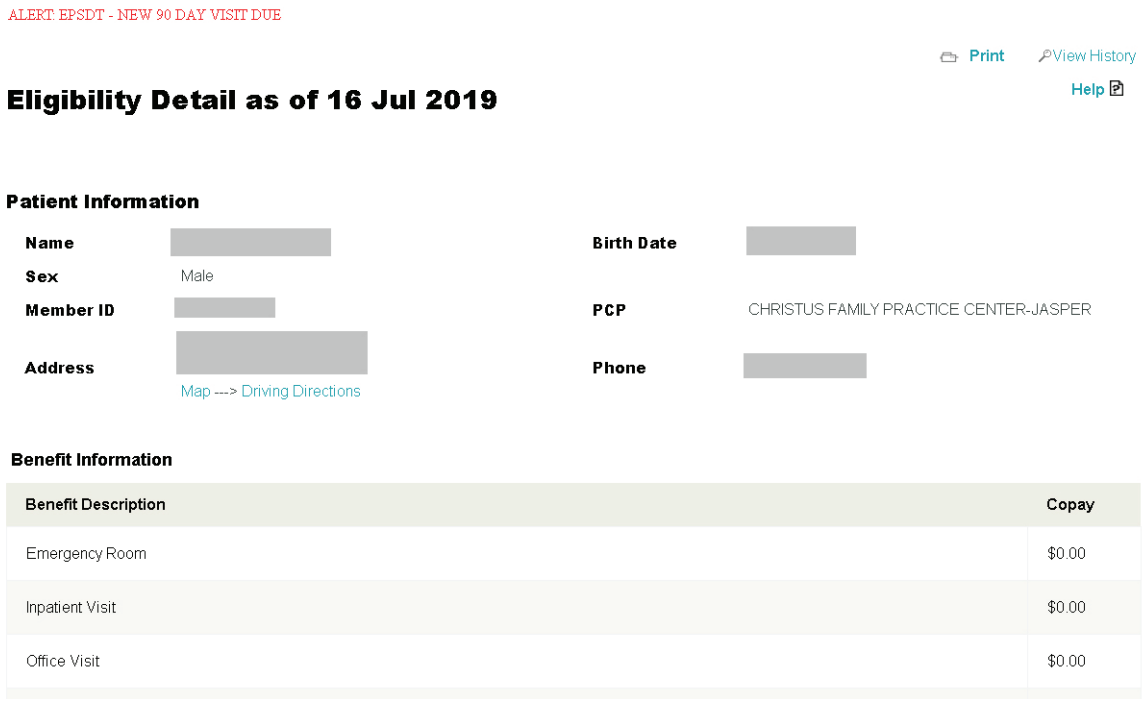
Click **Back to Search** to return to the **Eligibility Detail** page.
You can click on the **View History** icon to see all previous eligibility segments.

Eligibility History For [redacted] ([redacted])

Effective Dates	PCP	Product
01 Nov 2018 - 31 Dec 2078	[redacted]	CHIP
01 Nov 2017 - 30 Sep 2018	[redacted]	STAR
01 Jan 2017 - 30 Sep 2017	[redacted]	CHIP
01 May 2015 - 29 Feb 2016	[redacted]	STAR
01 Dec 2011 - 28 Feb 2013	[redacted]	STAR
01 Nov 2010 - 31 Aug 2011	[redacted]	STAR
01 Jun 2009 - 31 Aug 2010	[redacted]	STAR
01 Dec 2008 - 28 Feb 2009	[redacted]	STAR

EPSDT visit alert

We have a feature that alerts you when a member's EPSDT visit is due. The EPSDT alert is shown on the **Eligibility Detail** page.



ALERT: EPSDT - NEW 90 DAY VISIT DUE

Print View History

Help

Eligibility Detail as of 16 Jul 2019

Patient Information

Name	[redacted]	**Birth Date**	[redacted]
Sex	Male		
Member ID	[redacted]	**PCP**	CHRISTUS FAMILY PRACTICE CENTER-JASPER
Address	[redacted] Map ---> Driving Directions	**Phone**	[redacted]

Benefit Information

Benefit Description	Copay
Emergency Room	$0.00
Inpatient Visit	$0.00
Office Visit	$0.00

Locating a STAR Kids Service Coordinator

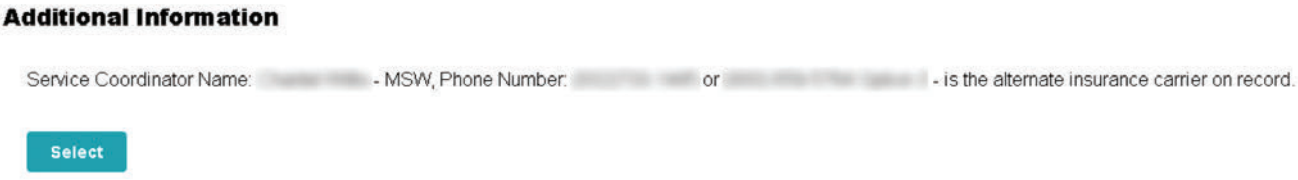
STAR Kids members are assigned a Service Coordinator to assist in coordination of care. To locate the Service Coordinator, begin by clicking on the **Eligibility** screen.

Step 1

Enter the **Member ID** and the **Birth Date** using the format of MM/DD/YYYY. The member eligibility will be shown. Click on the **Member Name**.

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: [redacted] - MSW, Phone Number: [redacted] or [redacted] - is the alternate insurance carrier on record.

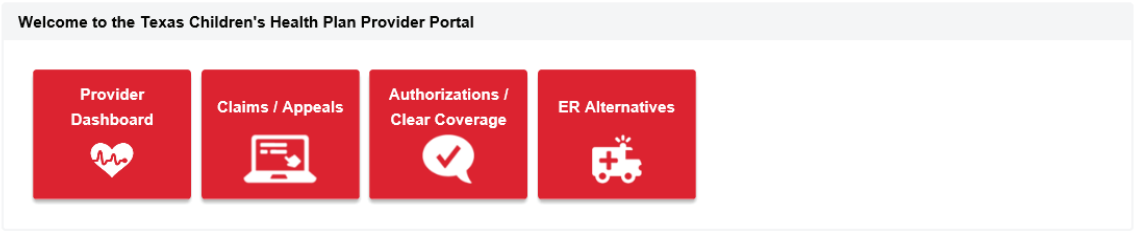
Select

Claims

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

Step 1

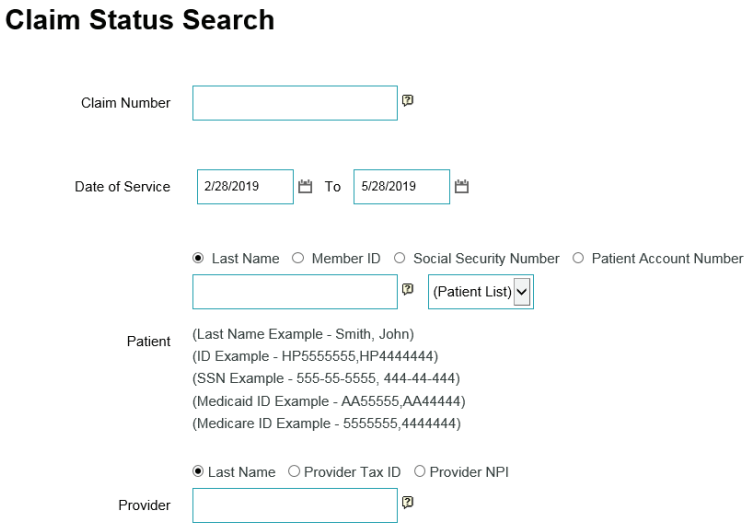
Click on the **Claims/Appeals** button.



You will see three tabs on the Claims/Appeals screen: **Claims Status Search, Remittance Advice Search** and **Add Claim for Single Claim Submission**.

Under the **Claims Status** tab, you can search for a claim by any of the following:

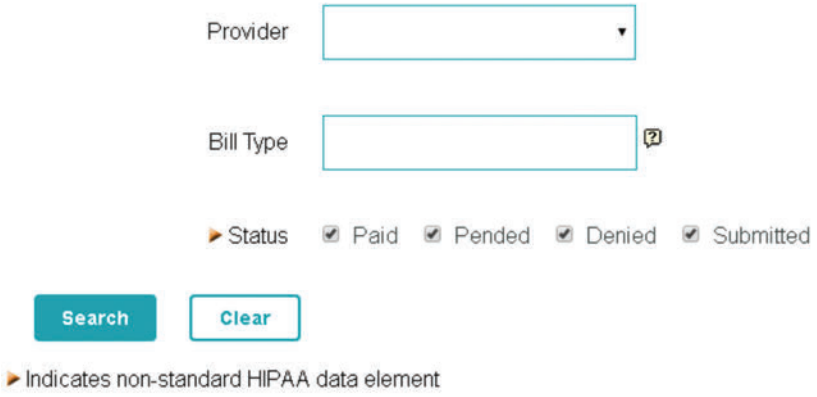
- Claim number (partial search)
- Date of service
- Patient information
  - Last name (partial search)
  - Member ID
  - SSN
  - Patient account number
- Provider information
  - Last name (partial search)
  - Tax ID
  - NPI
- Bill type
- Status (Paid, Pending, Denied)



NOTE: A patient's account number will only be searchable if submitted on the claim. User can only view claims for providers associated with the Tax ID based on the user's access list.

Step 2

Complete the fields 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.



Step 3

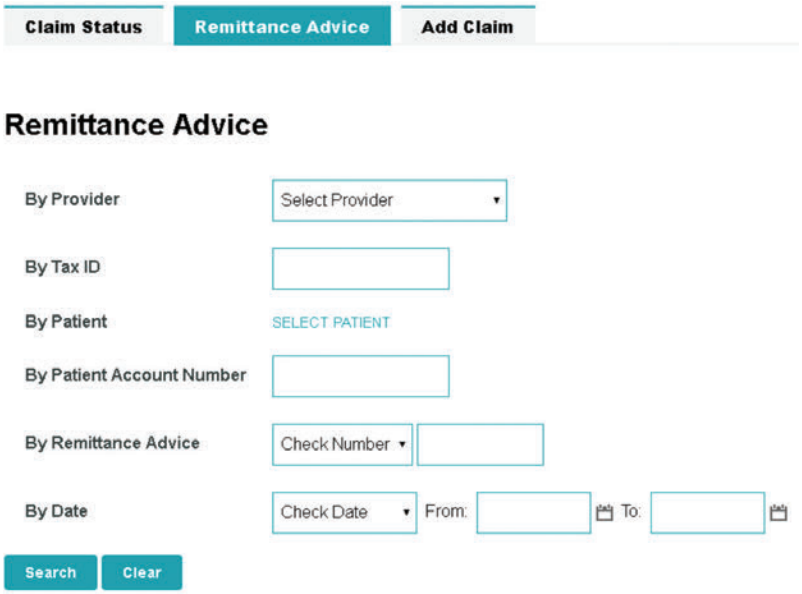
Click on the claim number to see the Claim Status details.

NOTE: Clicking on the Check/EFT 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 the Provider Portal or the **View My Claims** link on the homepage. You will see two tabs on the **Claims** screen: one for **Claims Status** search and one for **Remittance Advice** search.



Under the **Remittance Advice** tab, you can search by any of the following:

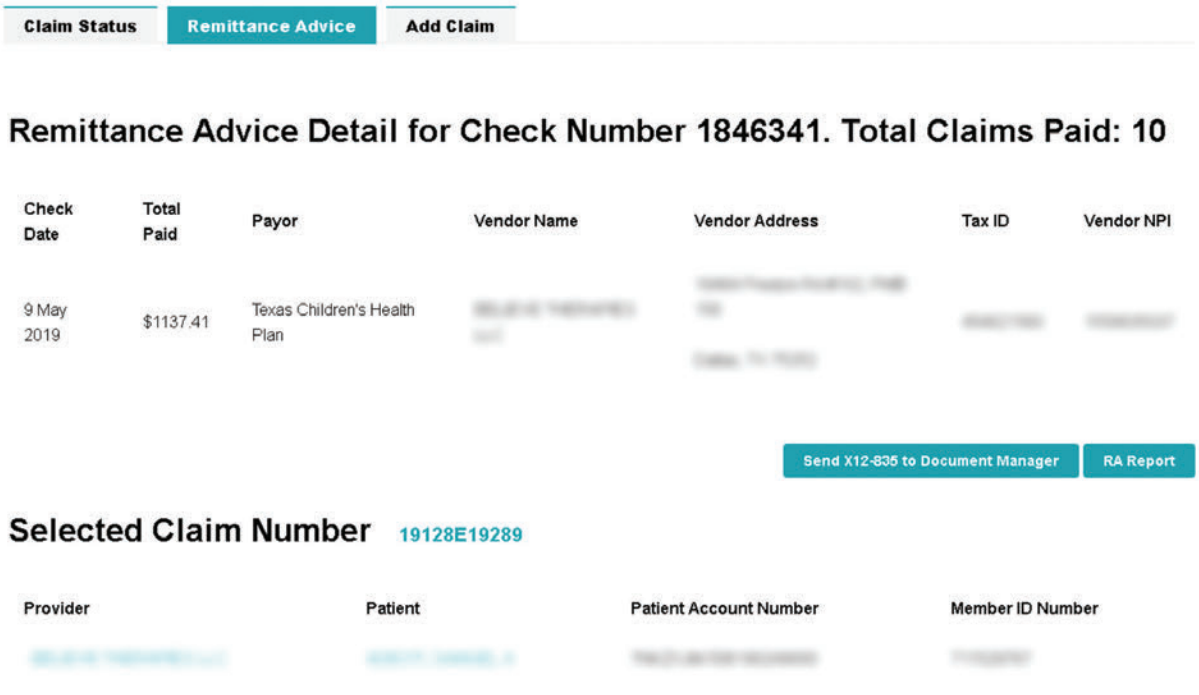
- Provider information
  - Last name (partial search)
  - Tax ID/TIN
  - NPI
- Patient information
  - Last name (partial search)
  - SSN
  - Member ID
  - Patient account number
- Check number
- Claim number
- Check date
- Date of service

Step 2

Complete the fields 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 two sections: the **Check Detail** section and the **Claims Detail** section.



Code Lookup

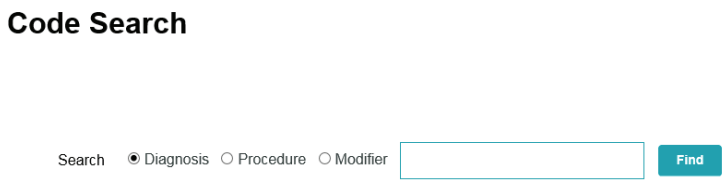
The Code Lookup feature allows you to enter a code and view code explanations.

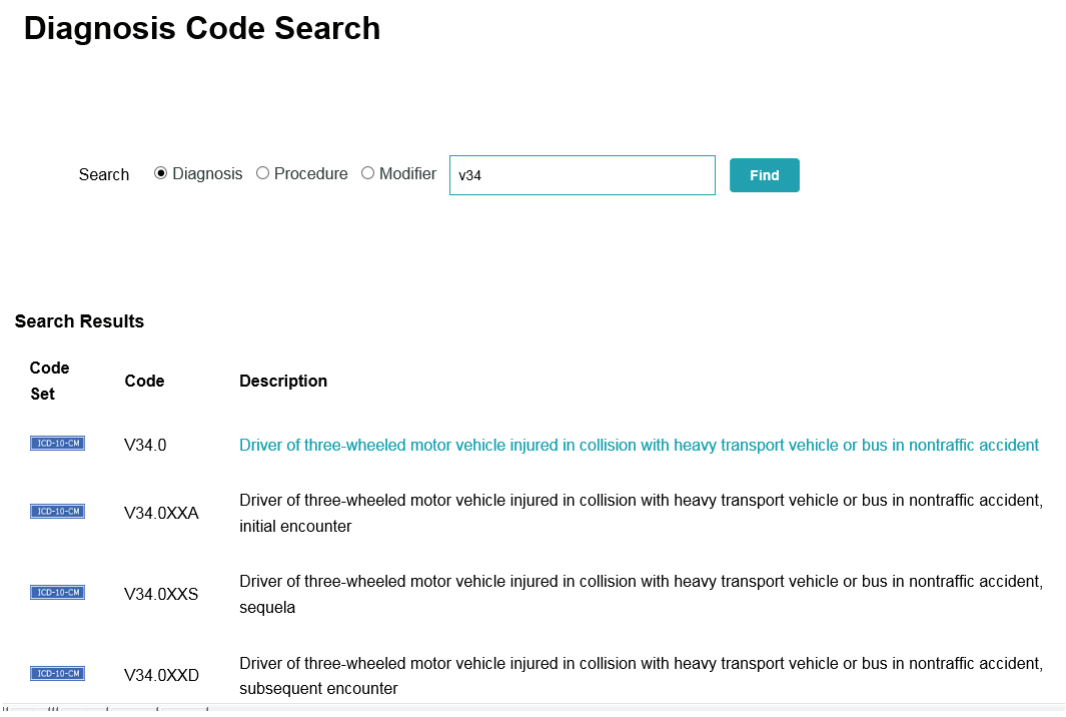
Step 1

Click on the **Claims/Appeals** button then **Code Lookup** button.

Step 2

Enter a Diagnosis Code, Procedure Code, or Modifier Code. You will receive an explanation for the code you entered.

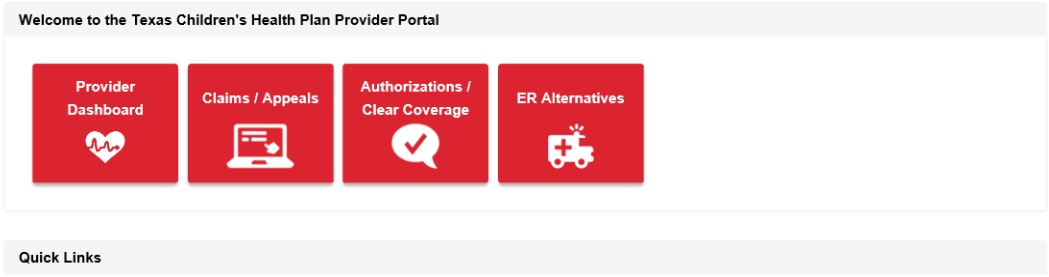




Individual Claim Submission

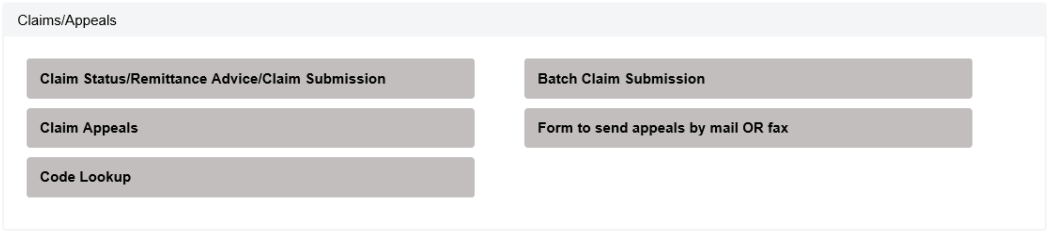
Step 1

Click on the **Claims/Appeals** menu under the *Quick Links* menu.



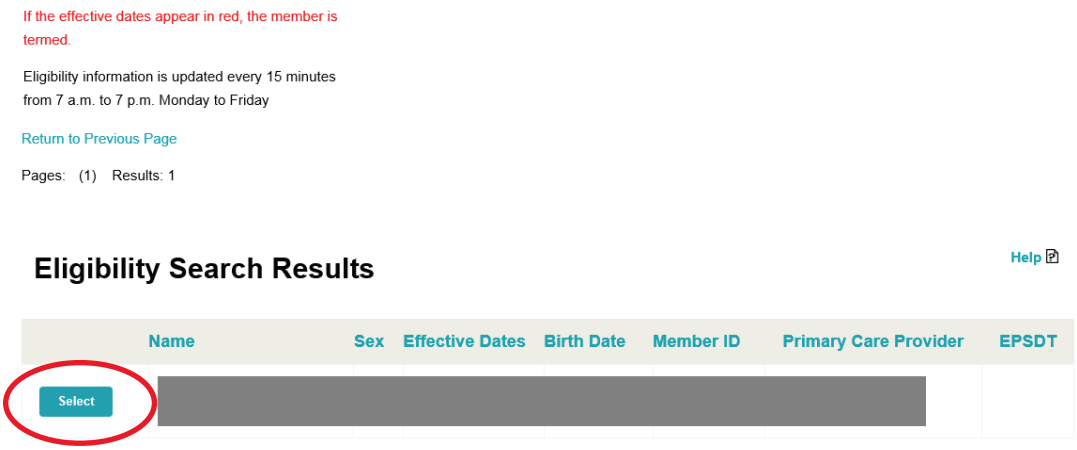
Step 2

To enter a new individual claim, click on the **Claim Status/Remittance Advice/ Claim Submission** button. Select **Claim Submission**.



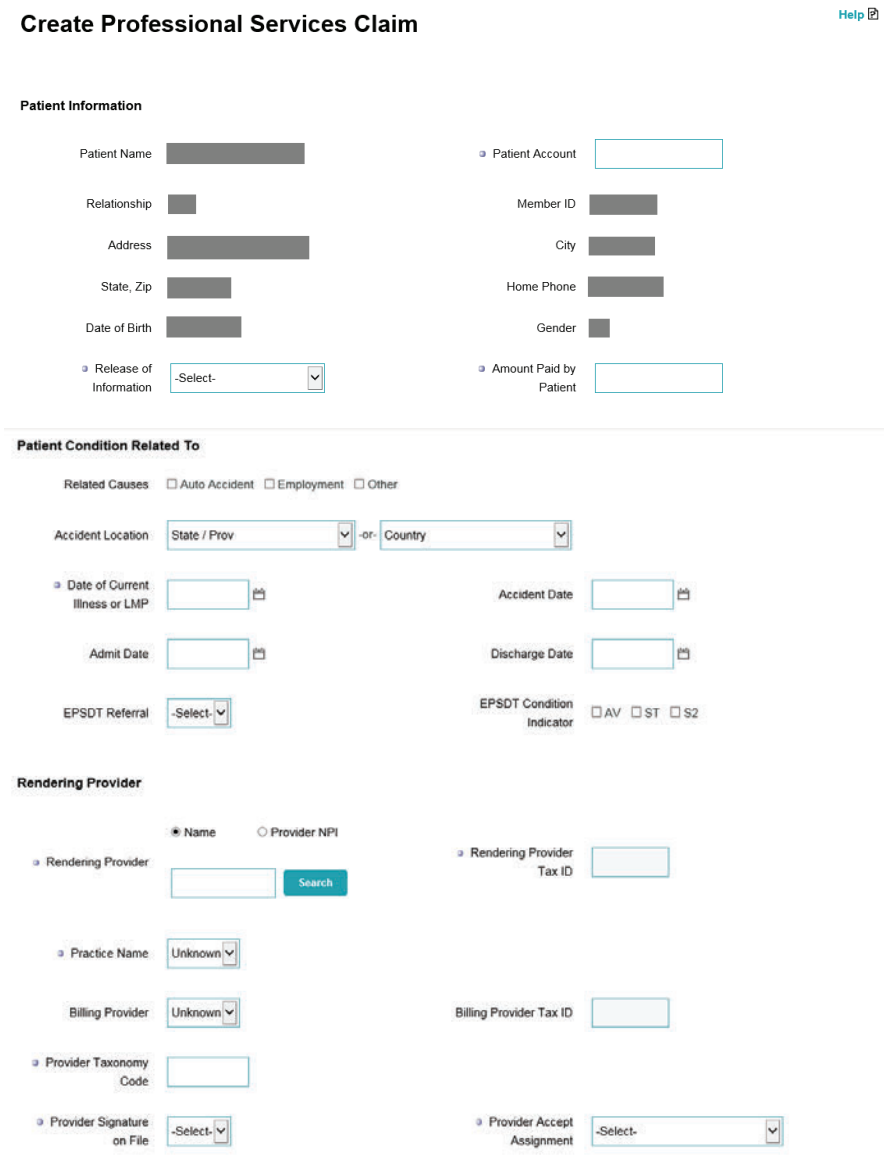
Step 3

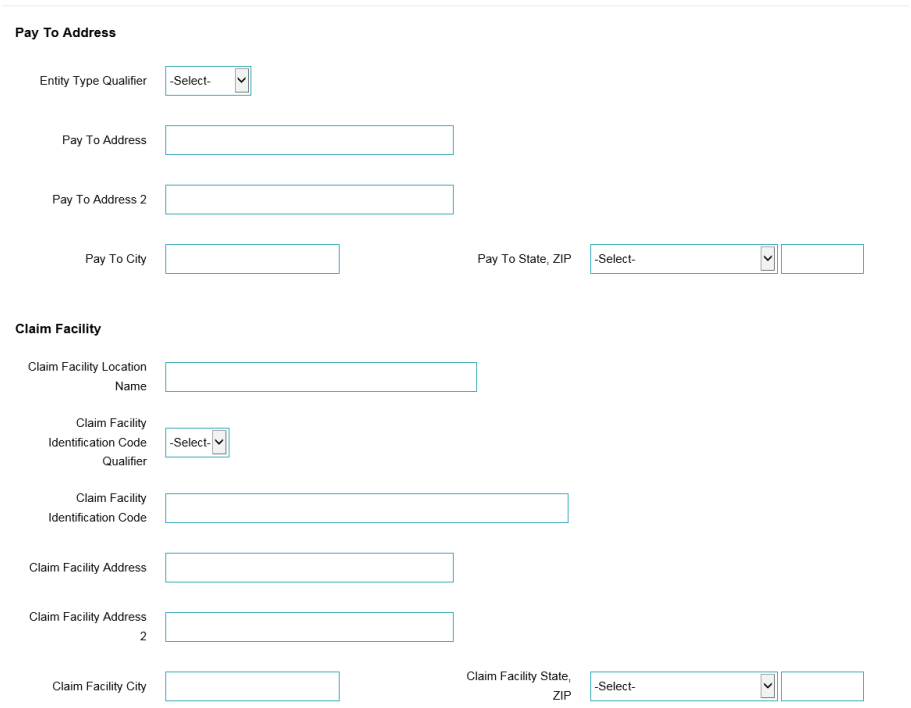
Search for the patient by Last Name, Member ID, or Medicaid ID. Click the **Select** button (circled below in red) to begin entering an individual claim.



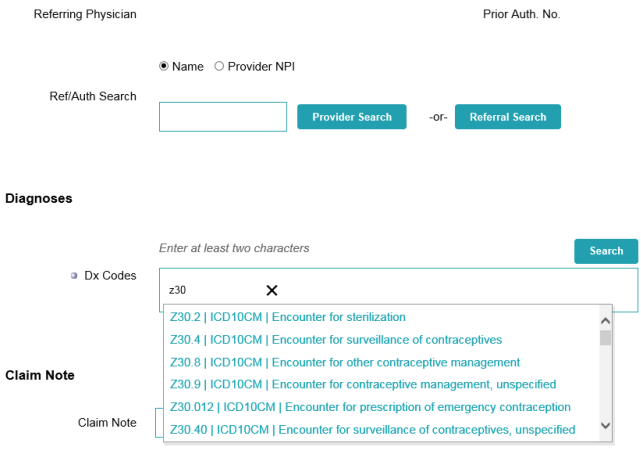
Step 4

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





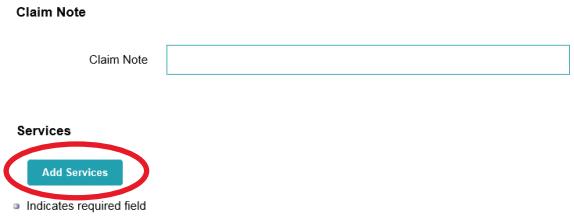
DIAGNOSIS: Enter at least two characters to populate a list of DX Codes. Dx Code format: **xxx.xxxx**.



CLAIM NOTE: Any claims information The Health Plan should be aware of can be entered by the Provider.

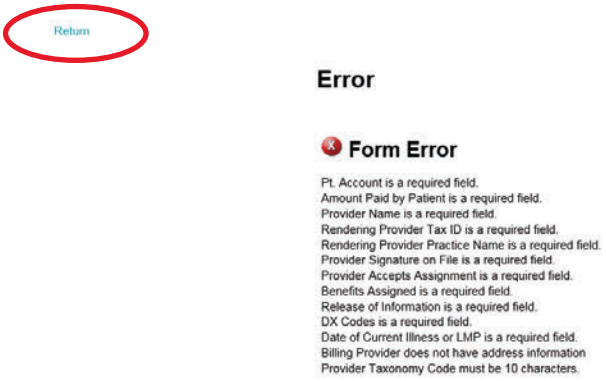
Step 5

Once all the required fields are entered, click **Add Services** (circled below in red).



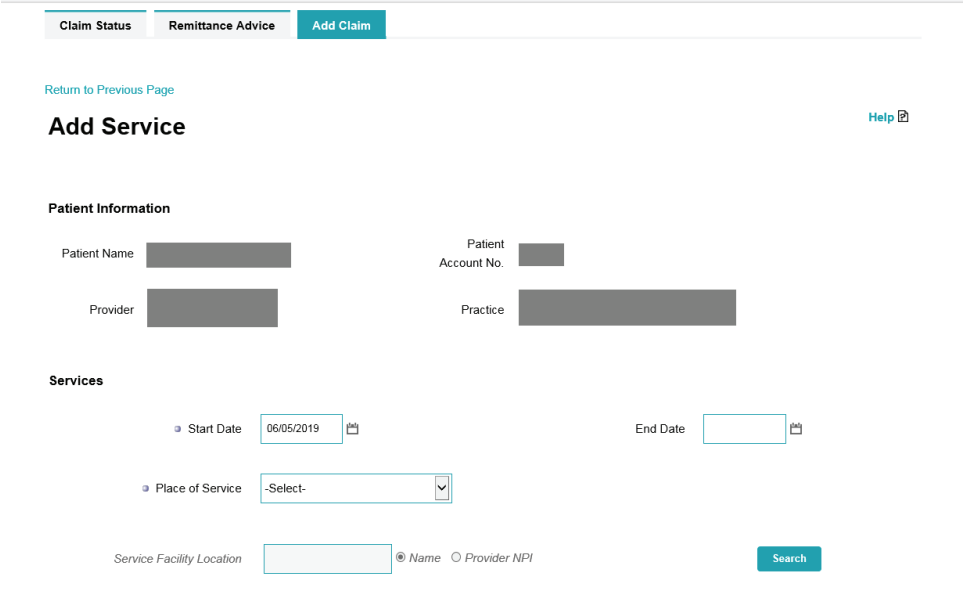
Step 6

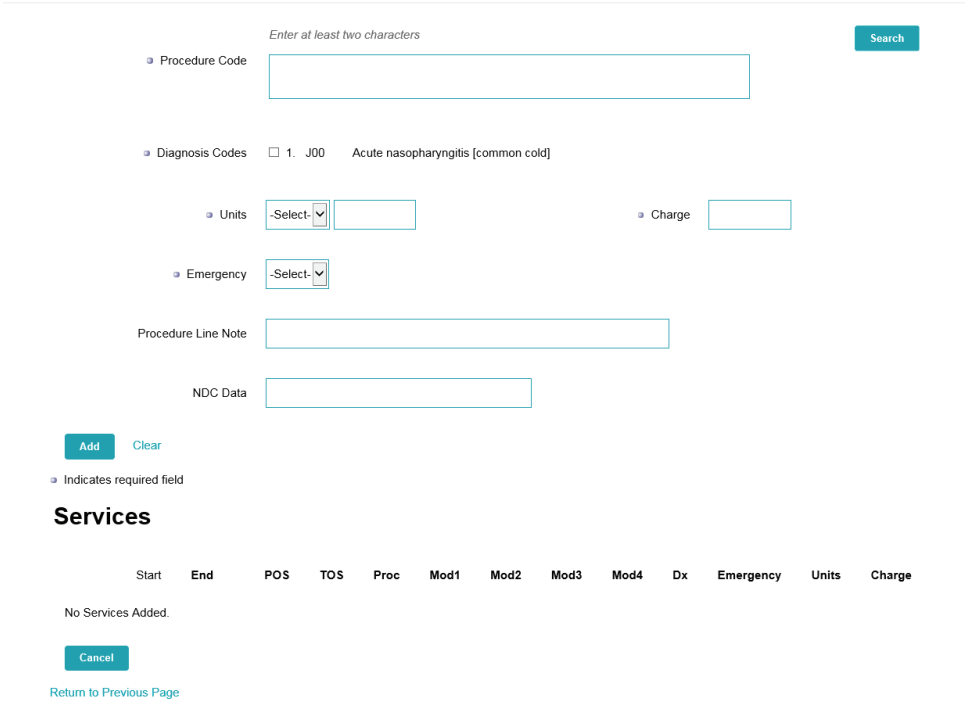
If all required fields are not entered, you will get the following error message detailing the missing fields. Select the **Return** button to return to the previous page to add the missing required information.



Step 7

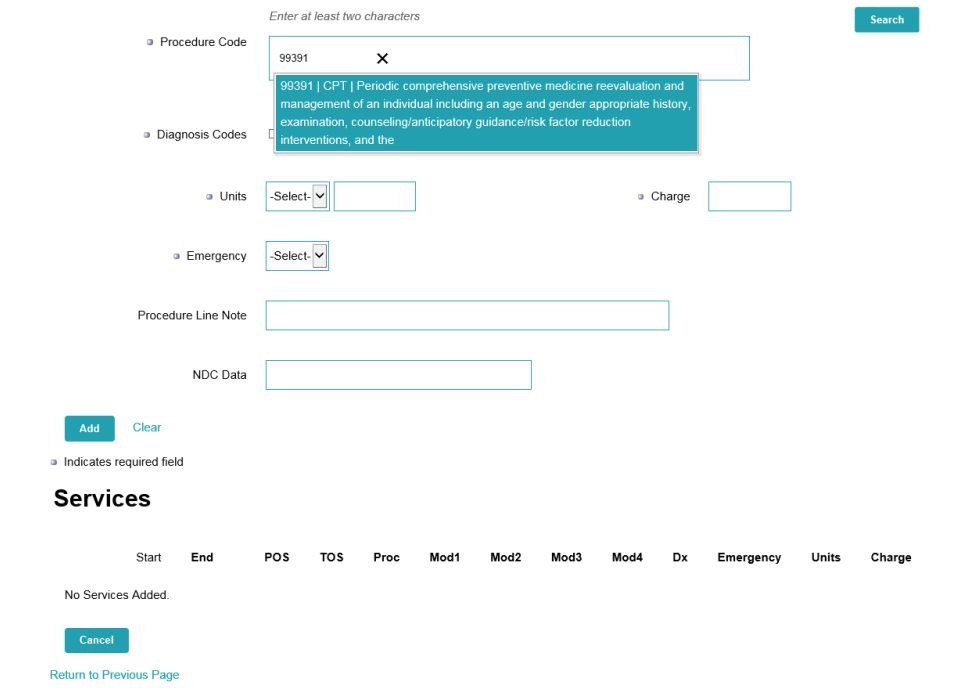
You will now be allowed to proceed to the next step in Single Claim Submission.





Step 8

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

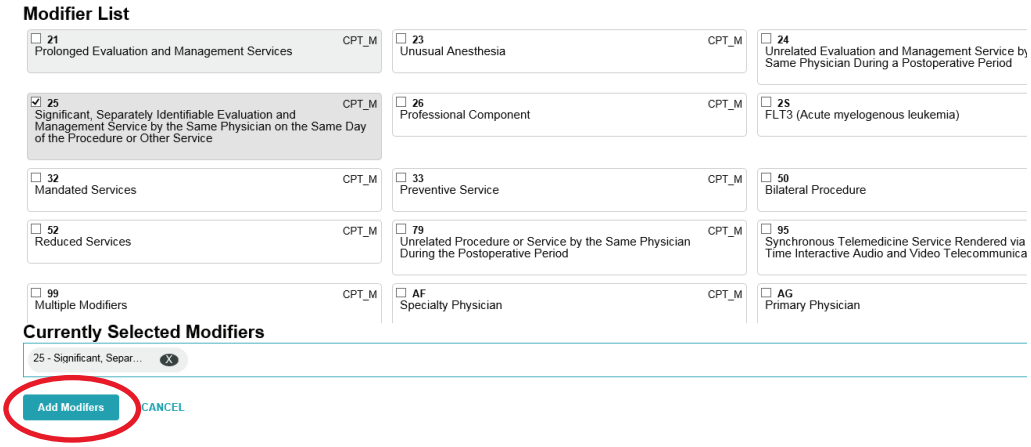


Step 9

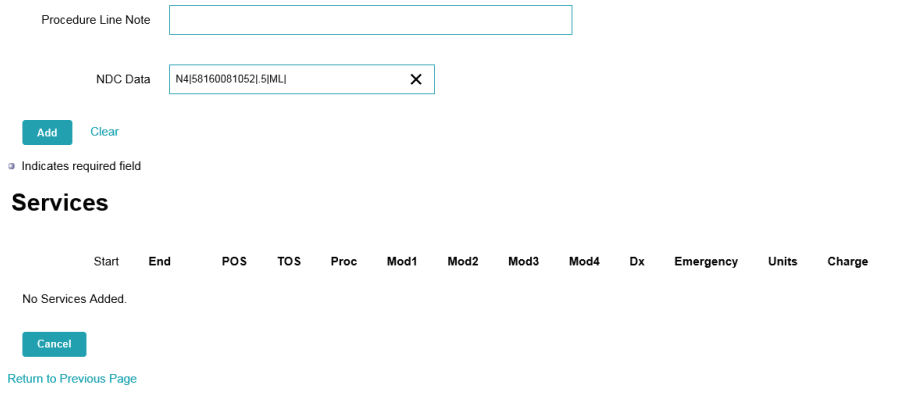
After selection of **Procedure Code**, click on the **Find Modifiers** button.

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 (circled below in red) to populate modifiers.

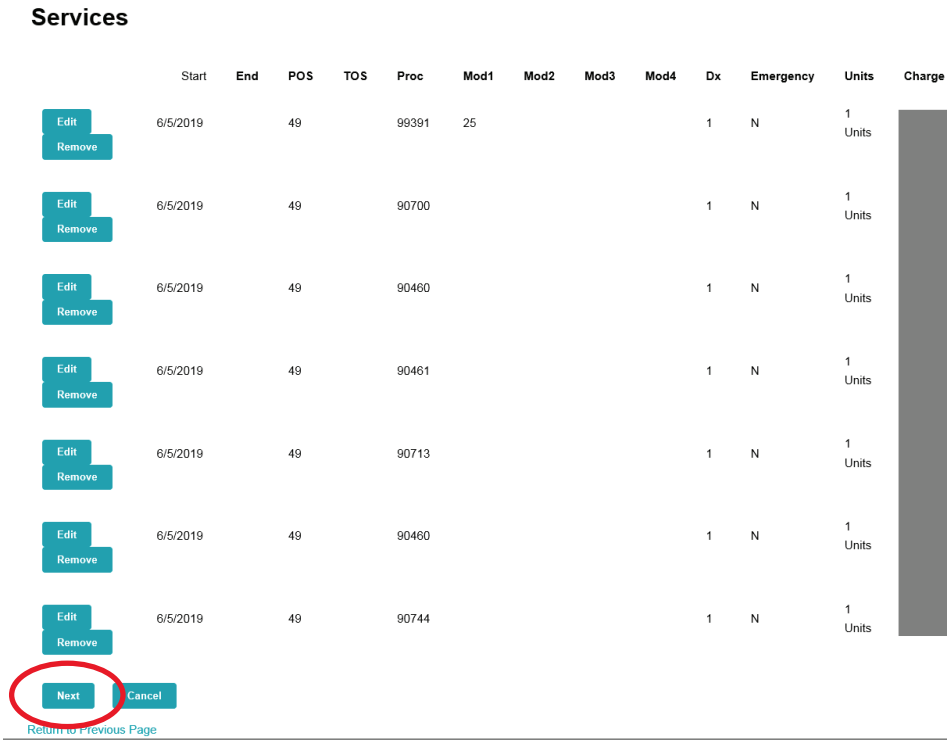


NDC DATA: Must be submitted in the following format:
N4 I <NDC Code> I <Quantity> I <2 digit unit of measure code> I



Step 11

Review Claims Detail for final submission. Click **Next** (circled below in red) to proceed.



Services

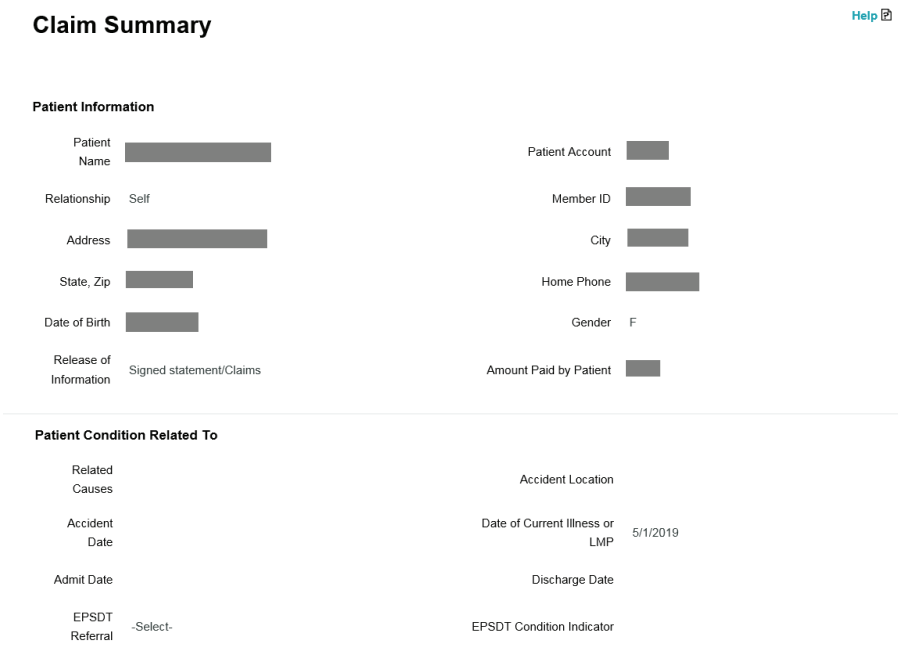
	Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
Edit Remove	6/5/2019		49		99391	25				1	N	1 Units	
Edit Remove	6/5/2019		49		90700					1	N	1 Units	
Edit Remove	6/5/2019		49		90460					1	N	1 Units	
Edit Remove	6/5/2019		49		90461					1	N	1 Units	
Edit Remove	6/5/2019		49		90713					1	N	1 Units	
Edit Remove	6/5/2019		49		90460					1	N	1 Units	
Edit Remove	6/5/2019		49		90744					1	N	1 Units	

Next Cancel

Return to Previous Page

Step 12

Enter **Patient Information**.



Claim Summary

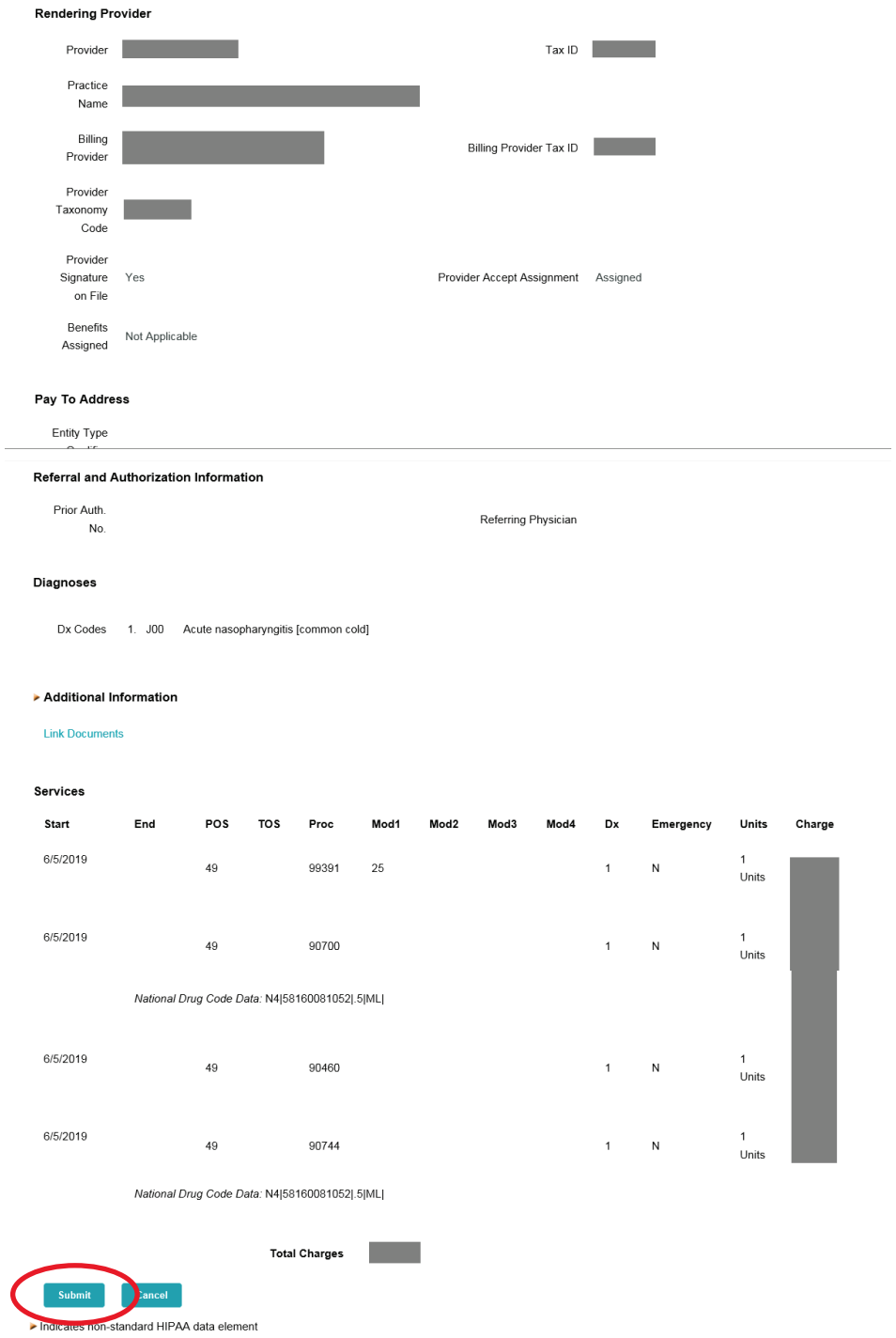
Help

Patient Information

Patient Name	[redacted]	Patient Account	[redacted]
Relationship	Self	Member ID	[redacted]
Address	[redacted]	City	[redacted]
State, Zip	[redacted]	Home Phone	[redacted]
Date of Birth	[redacted]	Gender	F
Release of Information	Signed statement/Claims	Amount Paid by Patient	[redacted]

Patient Condition Related To

Related Causes		Accident Location	
Accident Date		Date of Current Illness or LMP	5/1/2019
Admit Date		Discharge Date	
EPSDT Referral	-Select-	EPSDT Condition Indicator	



Rendering Provider

Provider [redacted] Tax ID [redacted]

Practice Name [redacted]

Billing Provider [redacted] Billing Provider Tax ID [redacted]

Provider Taxonomy Code [redacted]

Provider Signature on File Yes Provider Accept Assignment Assigned

Benefits Assigned Not Applicable

Pay To Address

Entity Type

Referral and Authorization Information

Prior Auth. No.

Referring Physician

Diagnoses

Dx Codes 1. J00 Acute nasopharyngitis [common cold]

Additional Information

Link Documents

Services

Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
6/5/2019		49		99391	25				1	N	1 Units	[redacted]
6/5/2019		49		90700					1	N	1 Units	
	National Drug Code Data: N4|58160081052|.5|ML|											
6/5/2019		49		90460					1	N	1 Units	
6/5/2019		49		90744					1	N	1 Units	
	National Drug Code Data: N4|58160081052|.5|ML|											

Total Charges [redacted]

Submit Cancel

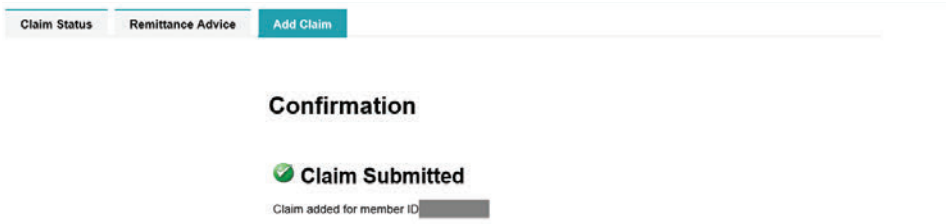
Indicates non-standard HIPAA data element

Step 12

Submit claim by clicking the **Submit** button.

Step 13

The **Claim Submitted Confirmation** screen will be displayed.



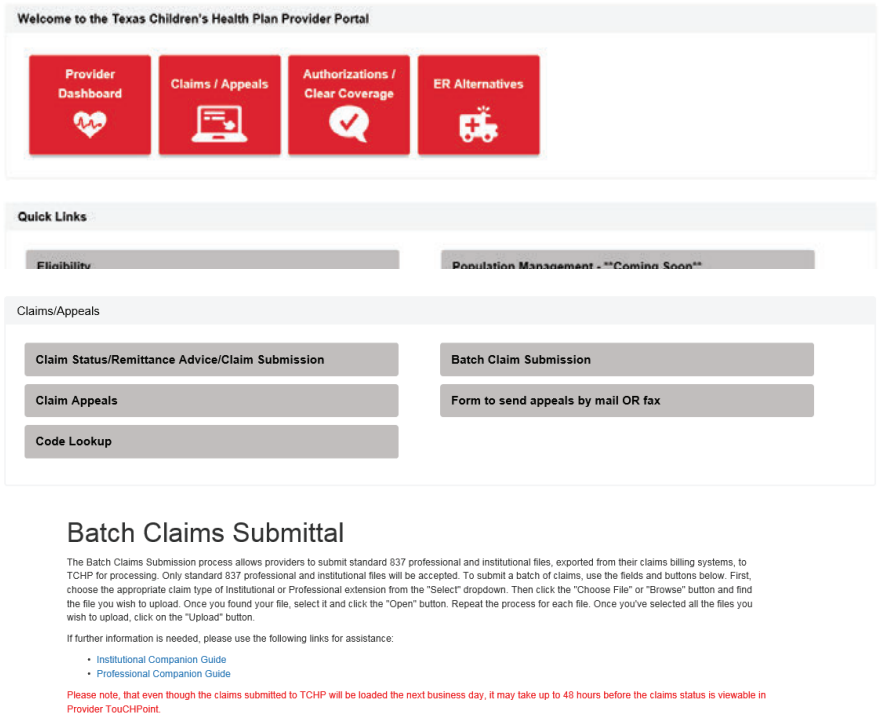
Batch Claims Submittal

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.

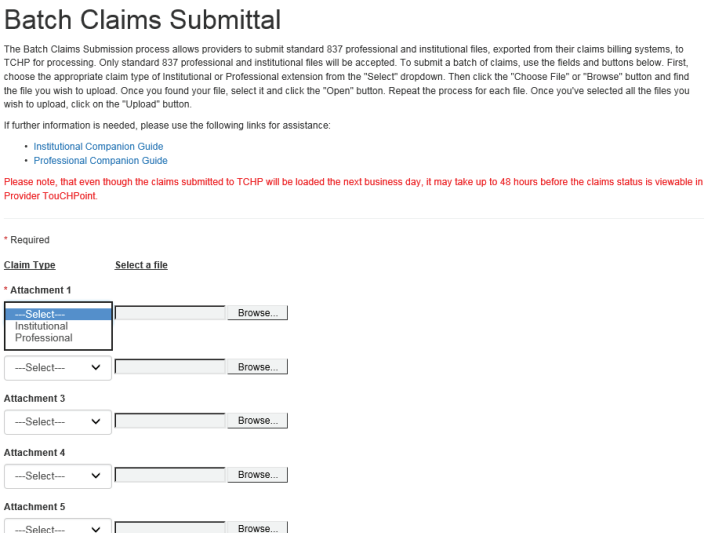
Step 2

Select the **Batch Claims Submission** menu option from the **Claims/Appeals** menu.



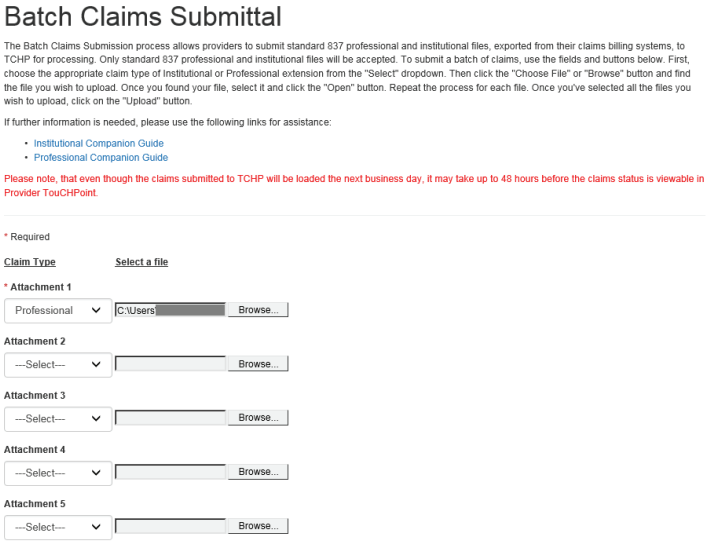
Step 3

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



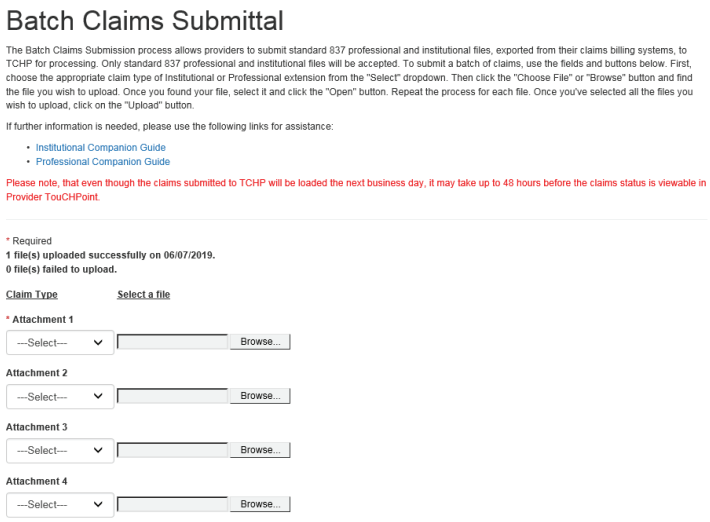
Step 4

Click the **Choose File** or **Browse** button (depending on your browser), and browse 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.



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.



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.

* Required
1 file(s) uploaded successfully on 06/07/2019.
0 file(s) failed to upload.

Claim Type | Select a file

* Attachment 1 ---Select--- Browse...

Attachment 2 ---Select--- Browse...

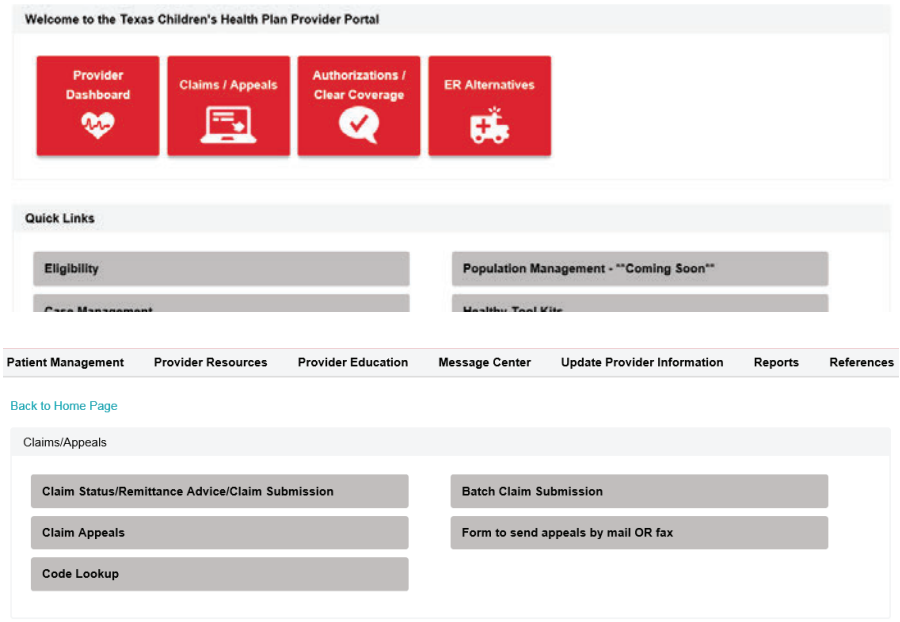
Attachment 3 ---Select--- Browse...

Attachment 4 ---Select--- Browse...

Claim Appeals

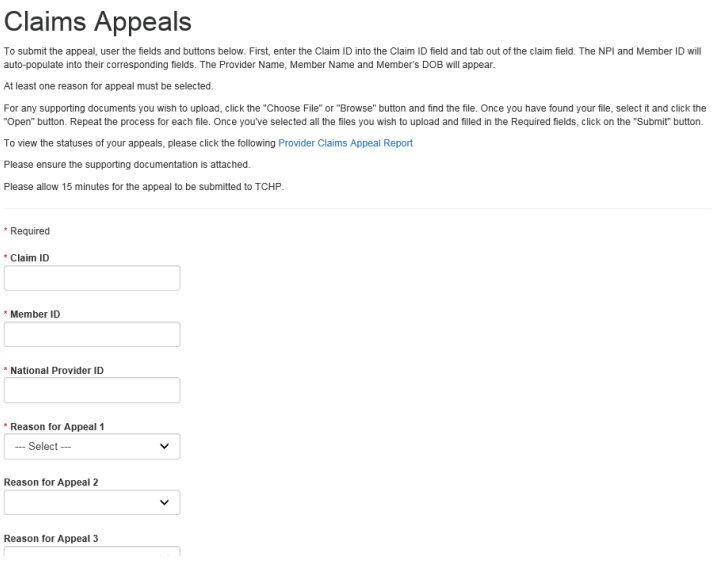
Step 1

Click on the **Claims/Appeals** menu to enter a Claim Appeal.



Step 2

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



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

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

--- Select ---

Reason for Appeal 2

Reason for Appeal 3

Please ensure the supporting documentation is attached.

Attachment 1

Browse...

Attachment 2

Browse...

Attachment 3

Browse...

Comment

300 character(s) left.

Submit

* Required

* Claim ID

Valid Claim ID.

* Member ID

* National Provider ID

* Reason for Appeal 1

No Authorization Denials

Reason for Appeal 2

Reason for Appeal 3

Please ensure the supporting documentation is attached.

Attachment 1

Browse...

Attachment 2

Browse...

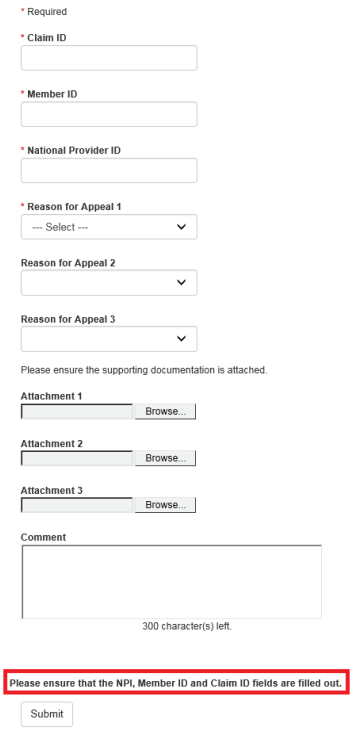
Attachment 3

Browse...

Comment

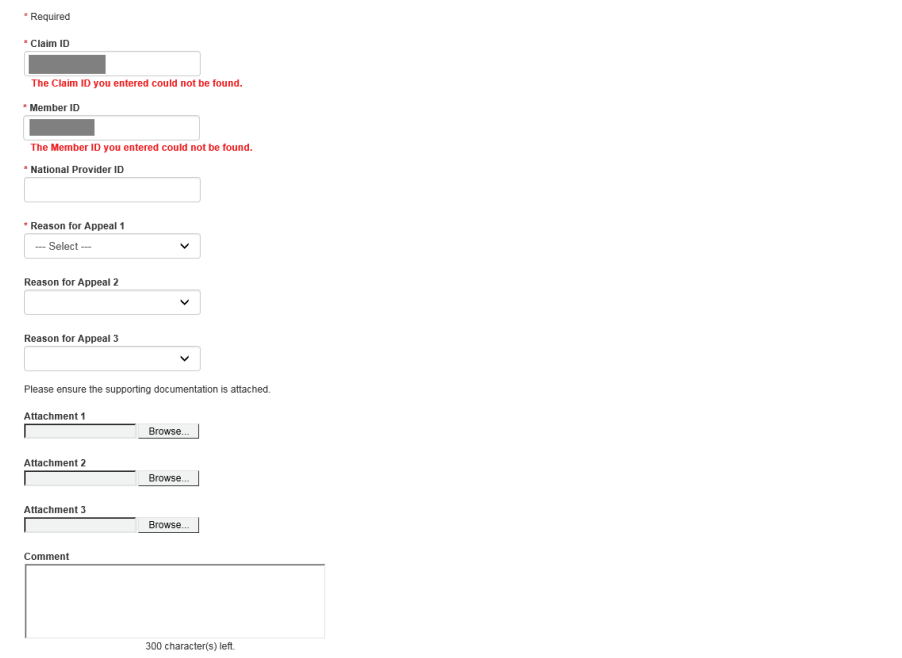
300 character(s) left.

Submit



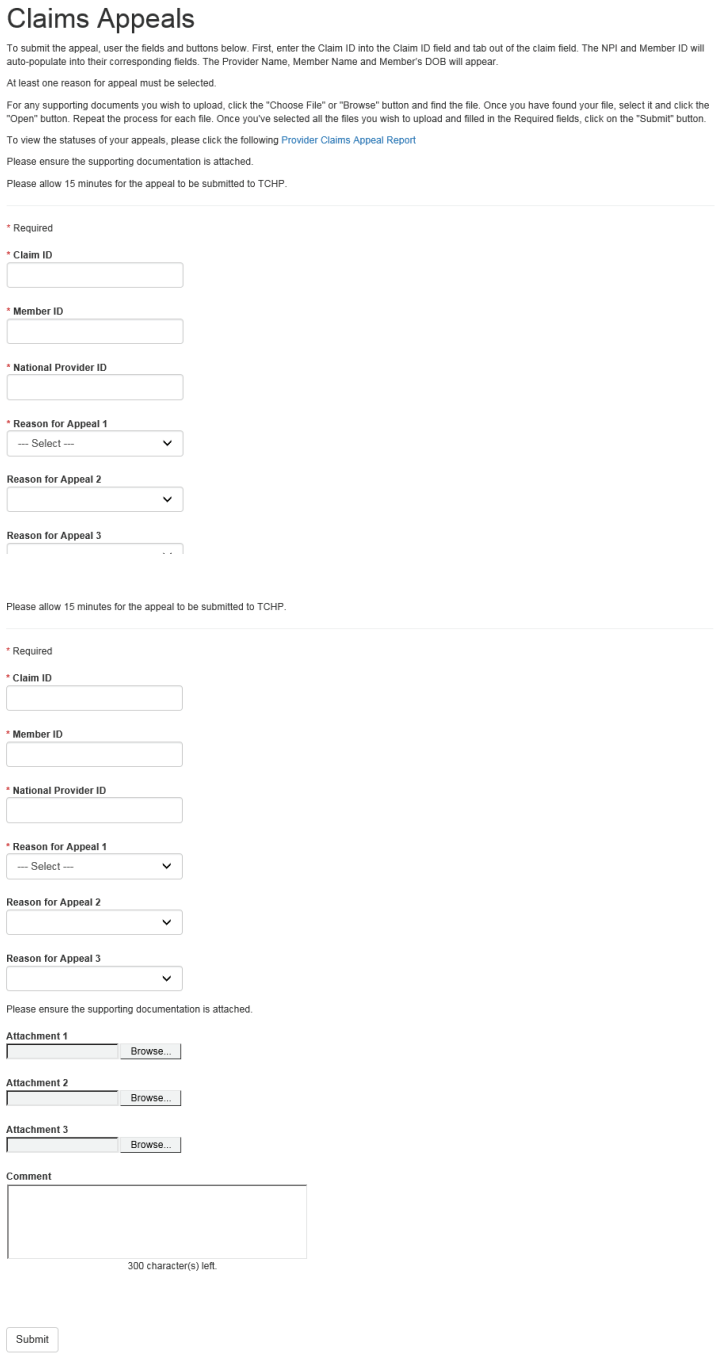
Step 3

Click the **Validate** button to display the Provider Name, Member Name, and date of birth.



Step 4

User can add an attachment or include information related to the appeal in the comment field. There is a 300 character limit. An attachment is not required to submit an appeal.



Claims Appeals

To submit the appeal, user the fields and buttons below. First, enter the Claim ID into the Claim ID field and tab out of the claim field. The NPI and Member ID will auto-populate into their corresponding fields. The Provider Name, Member Name and Member's DOB will appear.

At least one reason for appeal must be selected.

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.

To view the statuses of your appeals, please click the following Provider Claims Appeal Report

Please ensure the supporting documentation is attached.

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

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

--- Select ---

Reason for Appeal 2

Reason for Appeal 3

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

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

--- Select ---

Reason for Appeal 2

Reason for Appeal 3

Please ensure the supporting documentation is attached.

Attachment 1

Browse...

Attachment 2

Browse...

Attachment 3

Browse...

Comment

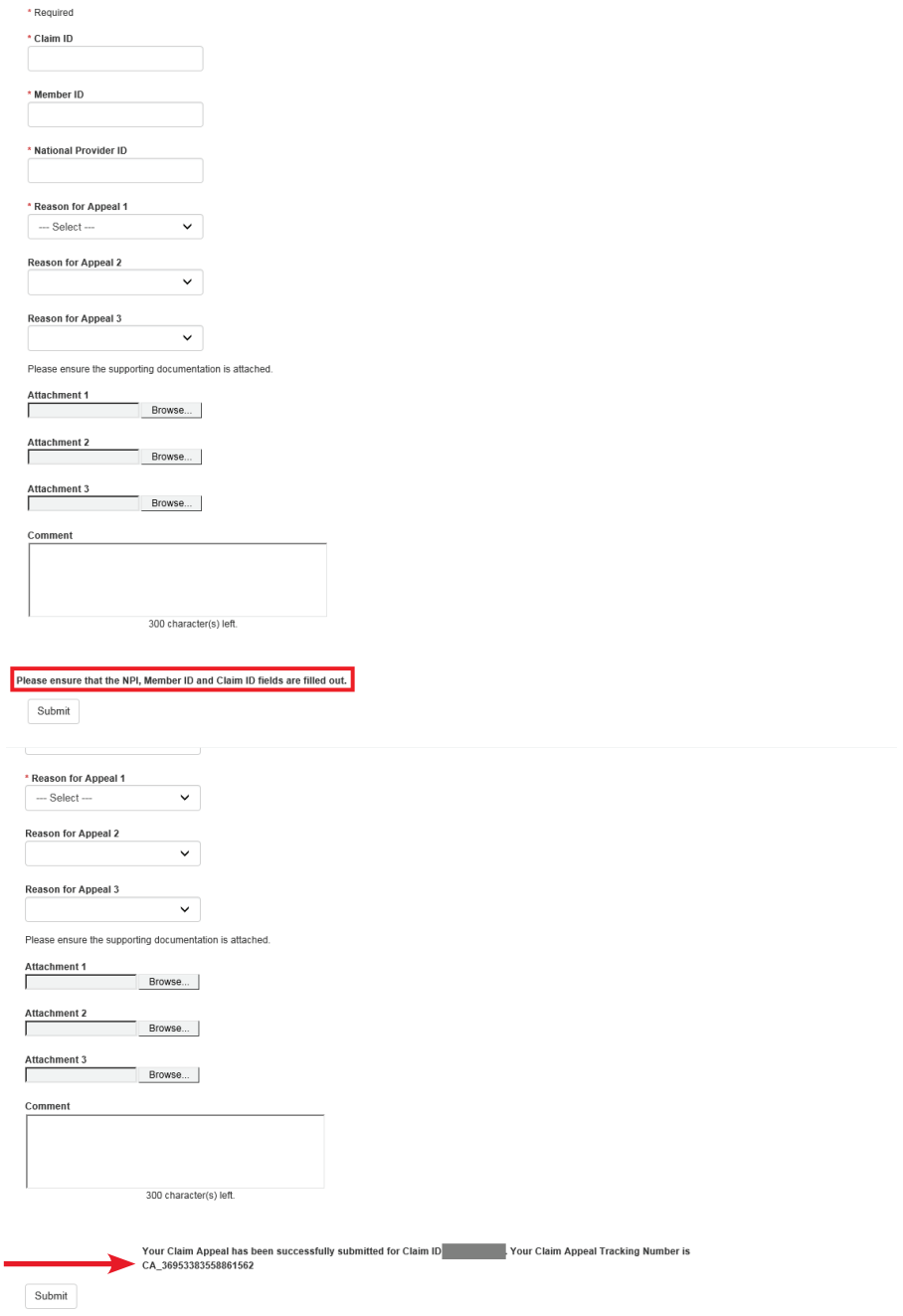
300 character(s) left.

Submit

Step 5

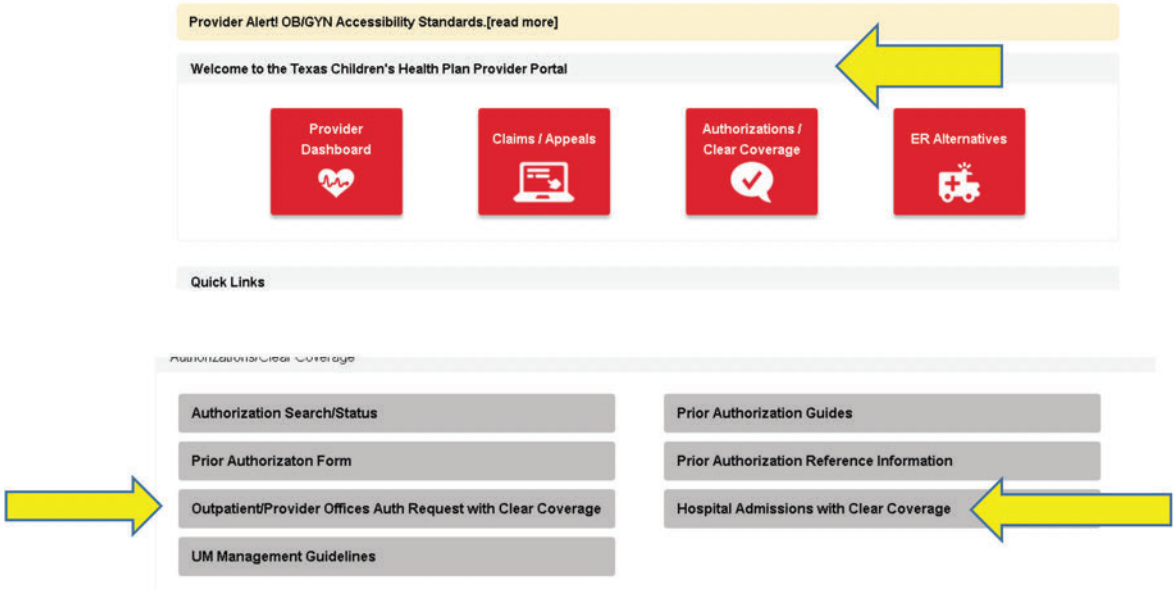
Once all the required fields are entered, clicking the **Submit** button will confirm the Claim Appeal has been submitted and you will receive a Claim Appeal tracking number that begins with the prefix CA_.

You may now enter the next Claim Appeal.



Authorizations

Authorizations may be requested by Clear Coverage™, which is located in the **Authorizations/Clear Coverage** menu. **Inpatient Hospital Admissions** and **Outpatient/Provider** offices are listed separately.



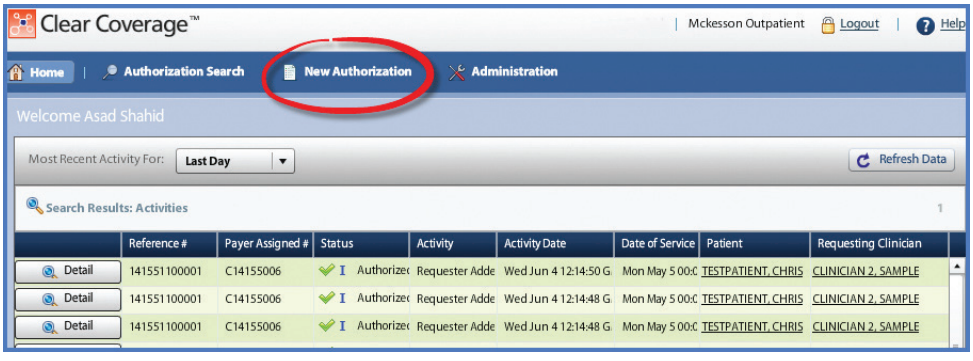
Clear Coverage™

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 diagnosis(ses) 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.



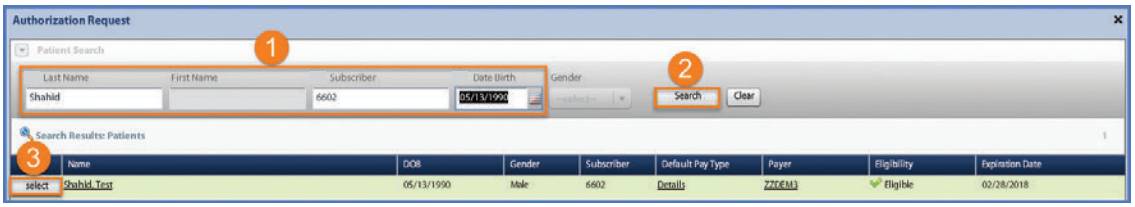
MCKESSON

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.

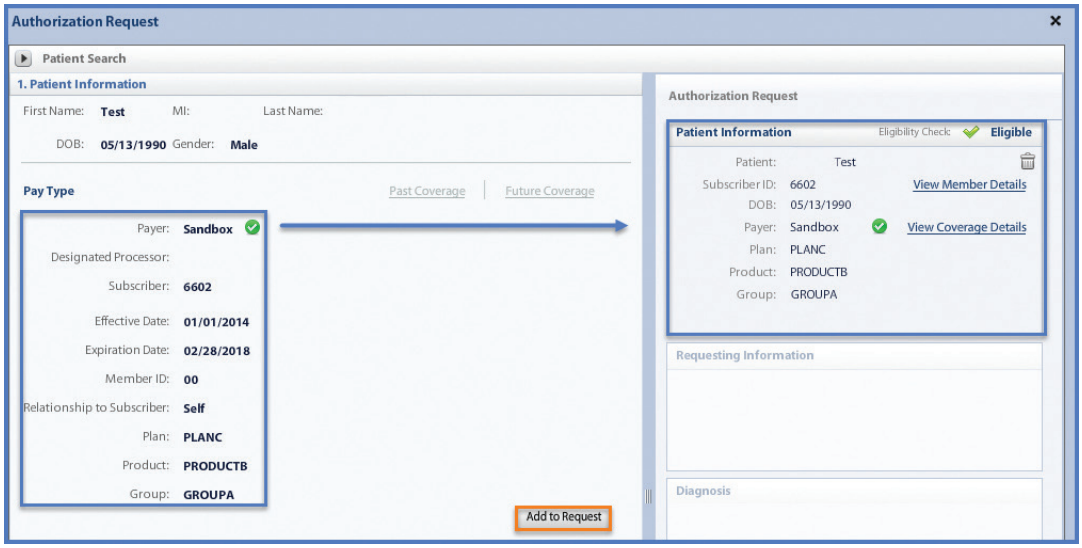
1. Enter search criteria in the required fields.
2. Click **Search** or press the Enter key.
3. Click **Select** next to the patient name.



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.



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**.

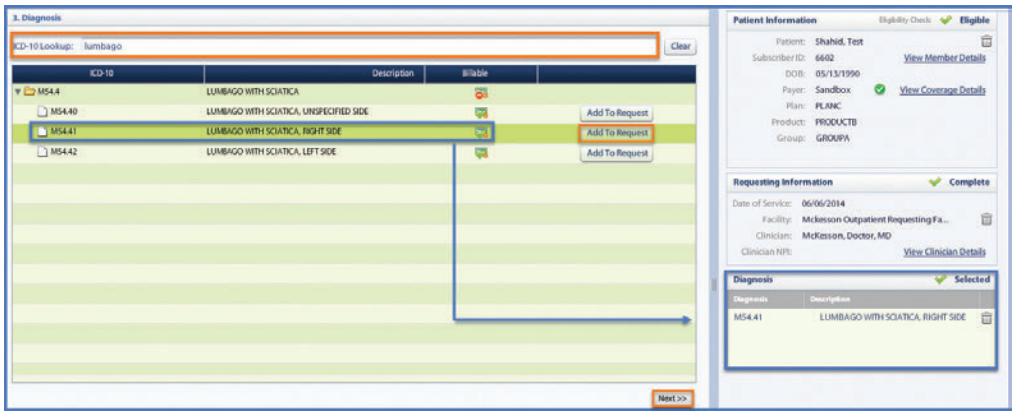
The Requesting Information is added to the Authorization Request summary and Clear Coverage advances to the Diagnosis accordion.

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

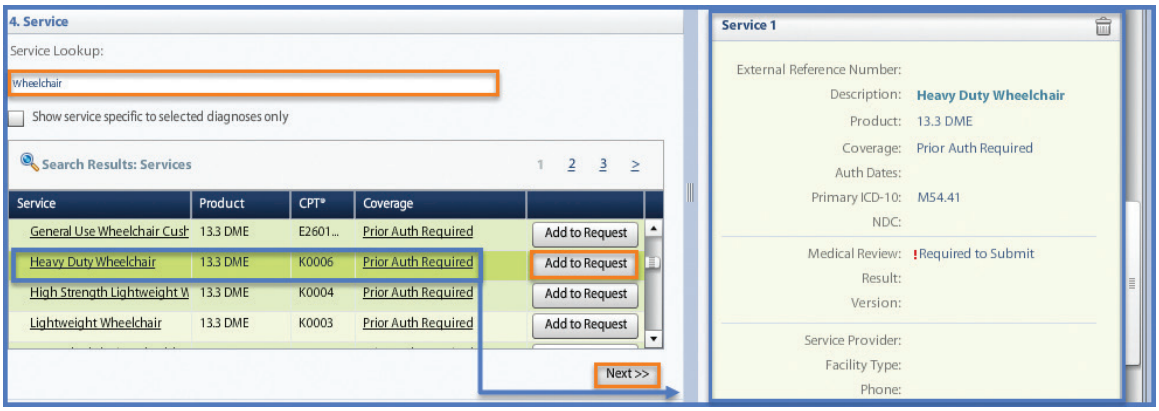
The Service accordion enables you to select the service for which you are requesting authorization.

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**.

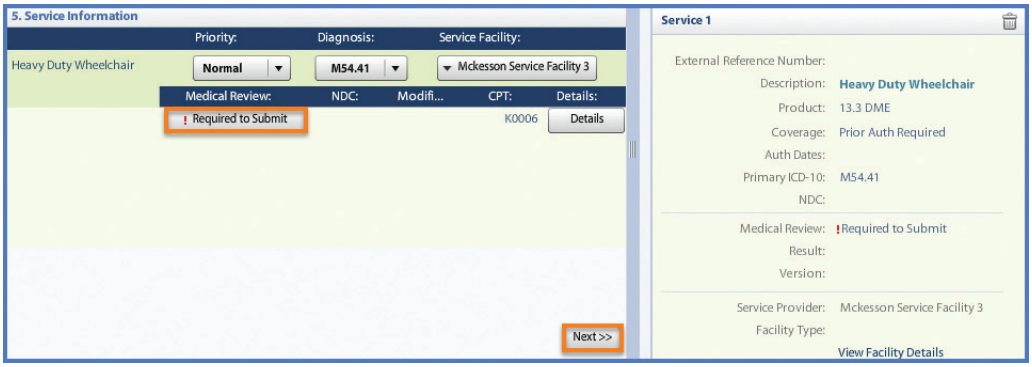


Step 5: Enter Service Information

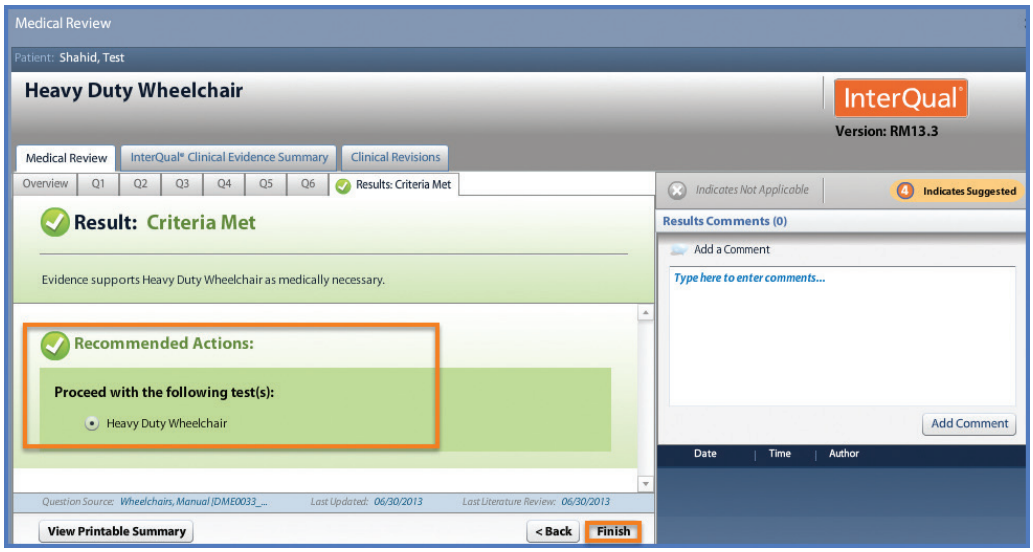
Clear Coverage uses a question and answer workflow to assess the medical necessity of the requested service. The Medical Review information is addressed below. Additional fields like Diagnosis, Service Facility, Modifiers, and so on may be required to complete prior to submission. Required information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

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



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 on 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.

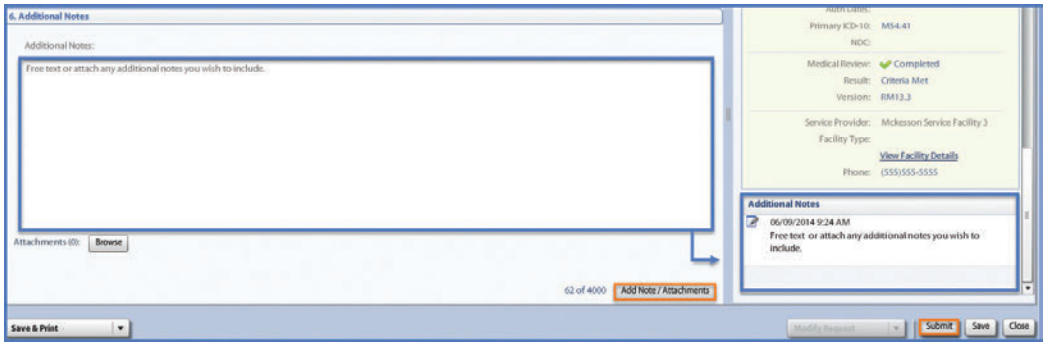
Note: You may copy and paste information from the EMR to support the request. There is a 4,000 character limit in this text field.

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**.

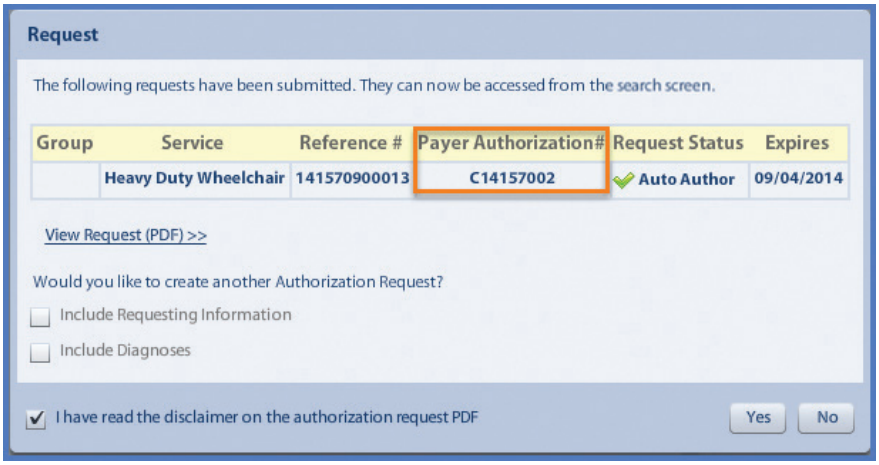


After submission, you will receive an immediate response to the request with the following information:

- 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).



Texas Children's Health Plan

Quick Reference Guide

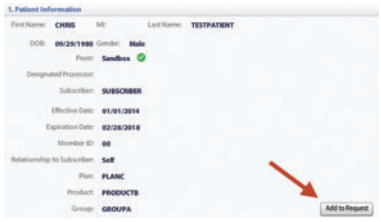
Clear Coverage™

Start by logging into Clear Coverage Outpatient / Provider Offices.

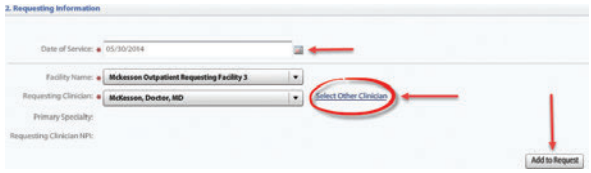
1. After logging in, click **New Authorization** at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**.

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

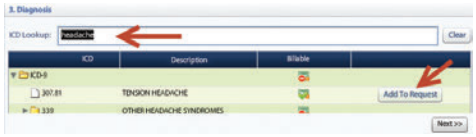
4. Verify the patient's information, and then click **Add to Request.**



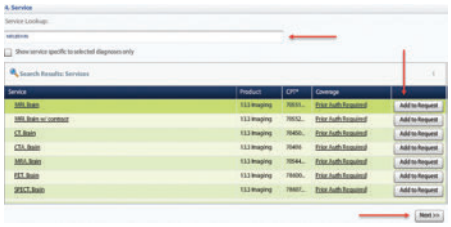
5. In the Requesting Information accordion, select the **Date of Service** and then select the **Requesting Clinician** from your preferred clinician list. Alternatively, choose a provider from the **Select Other Clinician** link. Click **Add to Request.**



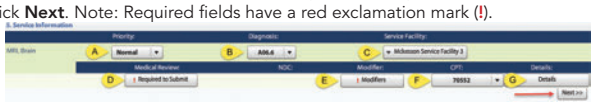
6. In the Diagnosis accordion, search for a specific billable diagnosis, click **Add to Request**, and then click **Next**. Search by entering a diagnosis description or ICD-10 may be entered.



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.

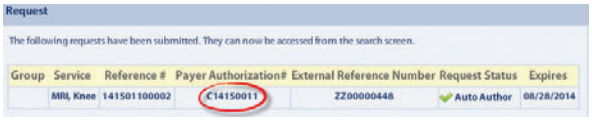


8. In the Service Information accordion, complete the required information, and then click **Next**. Note: Required fields have a red exclamation mark (**!**).



   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.



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.

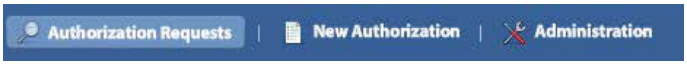
New Authorization Request Workflow

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/Which is the physician/facility requesting the admission?
3. Select Diagnosis (ICD-10) code(s)	What are the primary diagnosis(ses) 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:

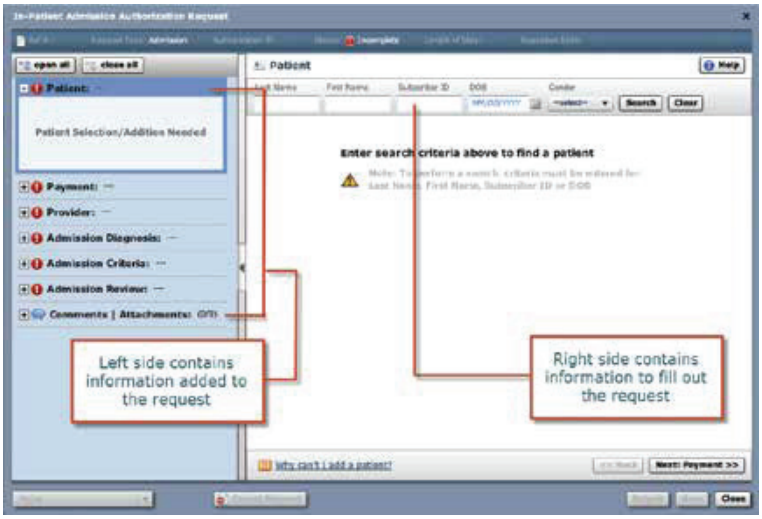


- Search Authorization Requests
- New Authorization Requests
- Administration

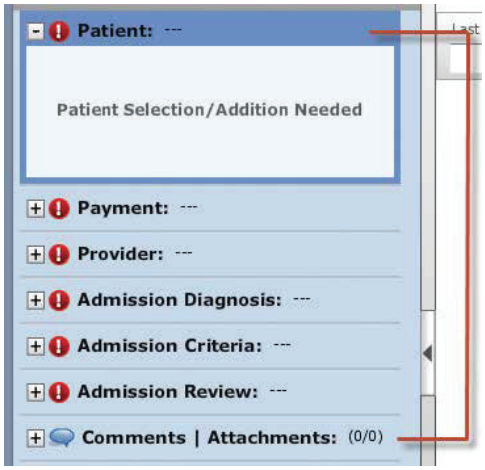
New Authorization Request Overview

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.

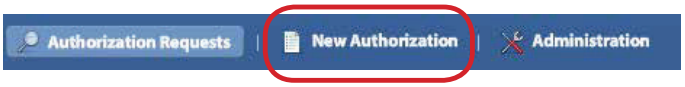


Click on the Accordion Headers on the left to switch from area to area.



Creating a New Authorization Request

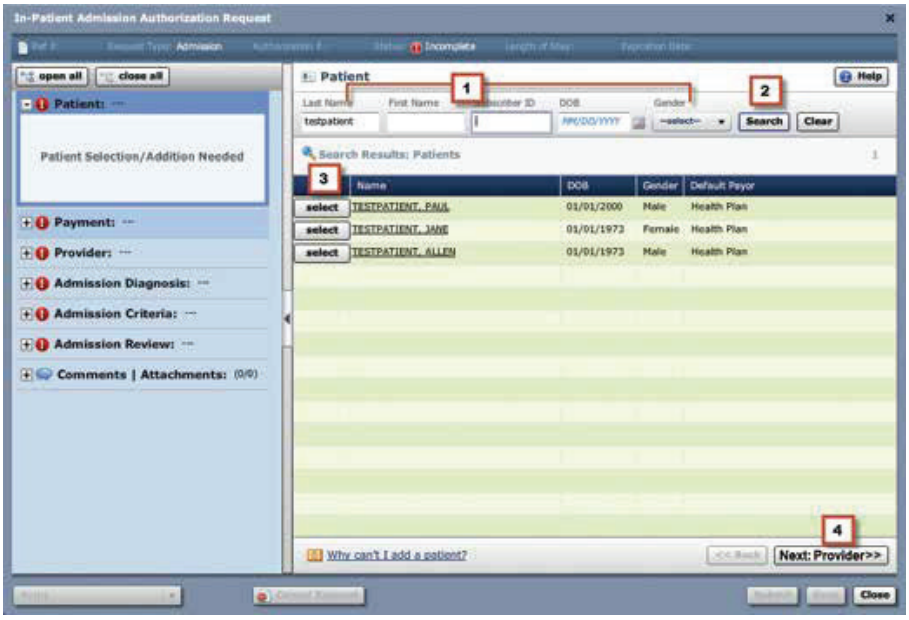
Click on the "**New Authorization**" tab to open the workflow available on this tab.



Step 1: Patient Search

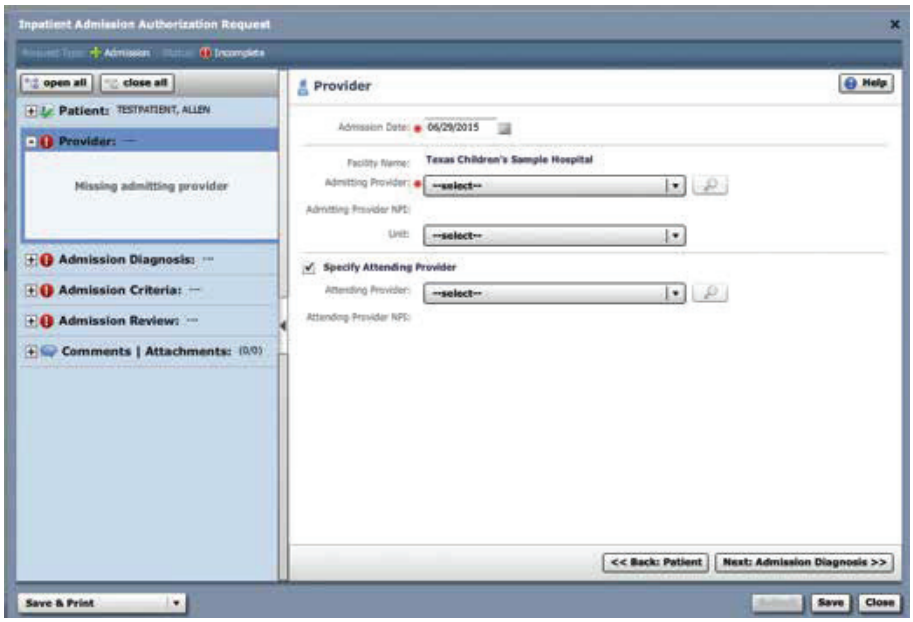
Creating an authorization request starts with selecting the Patient.
Using the Search function, a Patient can be found with a few letters of their first or last name. If you have the member or subscriber ID of the patient, you can use that as well. The same search criteria options that are used for Outpatient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

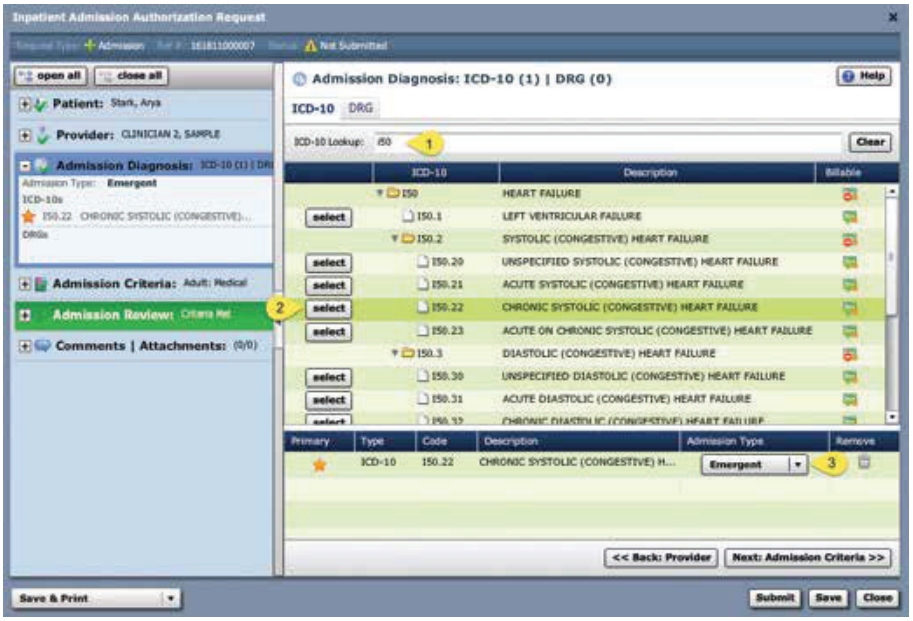
1. Enter the **Admission Date** - **Note**: You can click on the Calendar icon adjacent to the field and click on a date or enter the date in the format MM/DD/YYYY, e.g. 09/15/2010.
2. The **Facility Name** will automatically default to the facility the user is assigned too.
3. Click on the **Admitting 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** drop-down, 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.

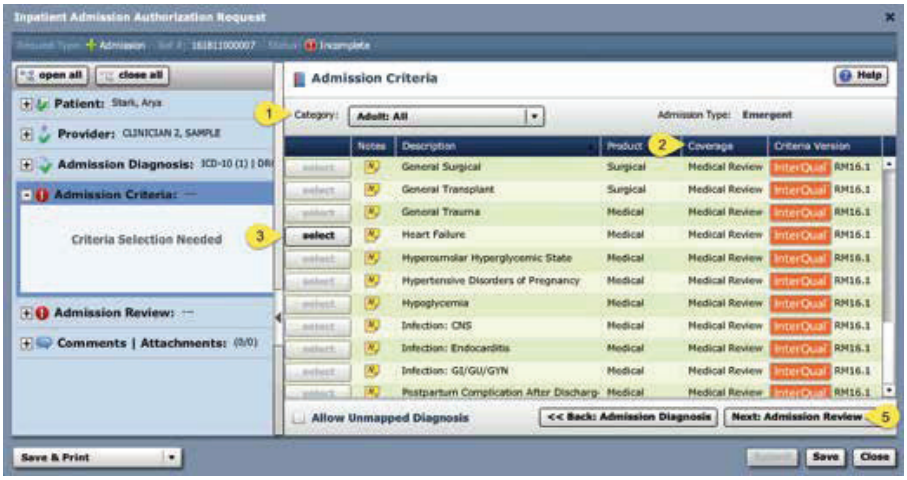
1. Search for the diagnosis using one of the following methods:
   a. Part of the clinical diagnosis description (e.g. "Heart Failure")
   b. ICD-10 or DRG code (e.g. "I50.22")
2. When you find the appropriate diagnosis code, click the "**Select**" button next to the diagnosis. (The Diagnosis is added 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.



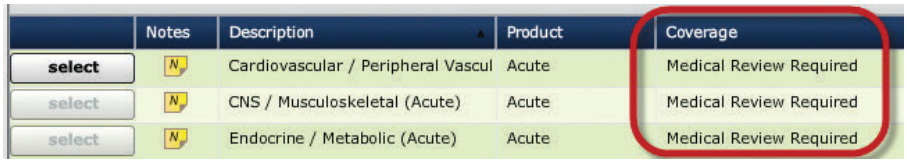
Step 4: Admission Criteria

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.



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. **ACTION: You do not need to submit an authorization request and can stop this process.**
"Not Covered"	This admission is not a covered service. **ACTION: You do not need to submit an authorization request and can stop this process.**
"Medical Review Required"	This admission can be Auto-Authorized if the admission is recommended based on Medical Review. **ACTION: Select the Criteria and Perform Medical Review.**
"Authorized Instantly"	This admission will be Auto-Authorized regardless of the outcome of the Medical Review. **ACTION: Select the Criteria and Perform Medical Review.**
"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. **ACTION: Select the criteria and Perform Medical Review.**
"Notification Required"	This admission indicates that the patient's health plan must be notified of the admission. **ACTION: Select the criteria and Perform Medical Review.**

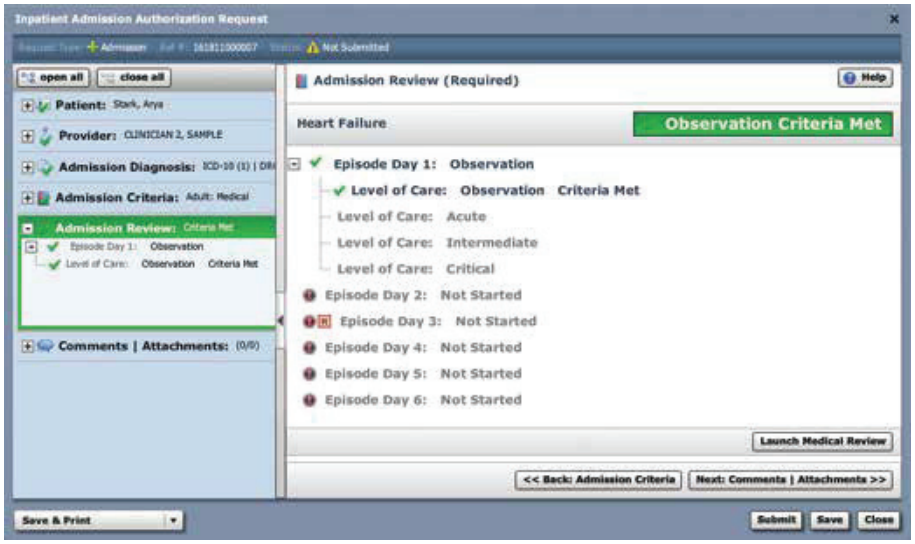
Step 5: Perform Medical Review

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 an outcome on the medical appropriateness of the admission based on the best current evidence available.

4. Click **Save**.
   a. 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

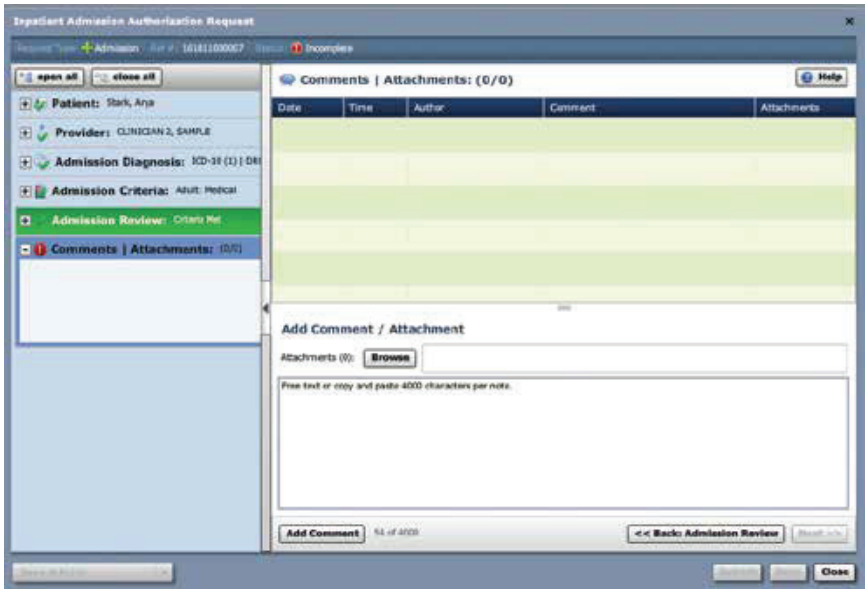
The **Comments | Attachments** section allows you to provide any additional notes to support your Authorization Request.

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.

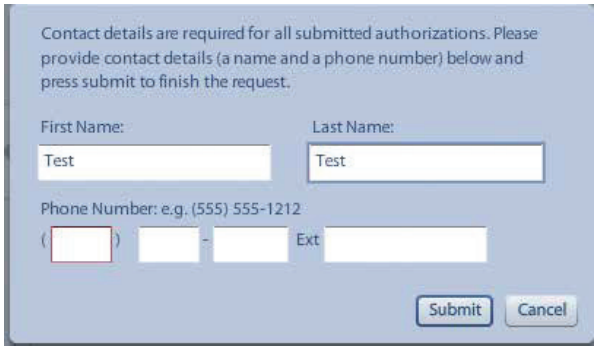
2. Click the "**Add Comment**" button to attach comments to the authorization request.
3. Click the "**Browse**" button to attach a file.

   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.



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

    c. Click "**Submit**".

d. You will then receive an Automatic response to the request:

i. Your request will be **Approved** (Auto-Authorized).

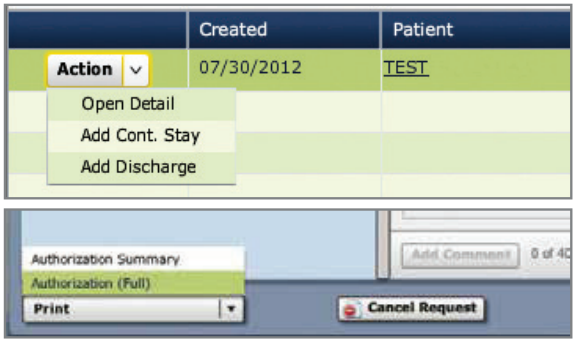
ii. Clear Coverage will record the Request with an **Internal Reference** #, a 12 digit number (Ex. "012345678901").

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 in as, 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.



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:

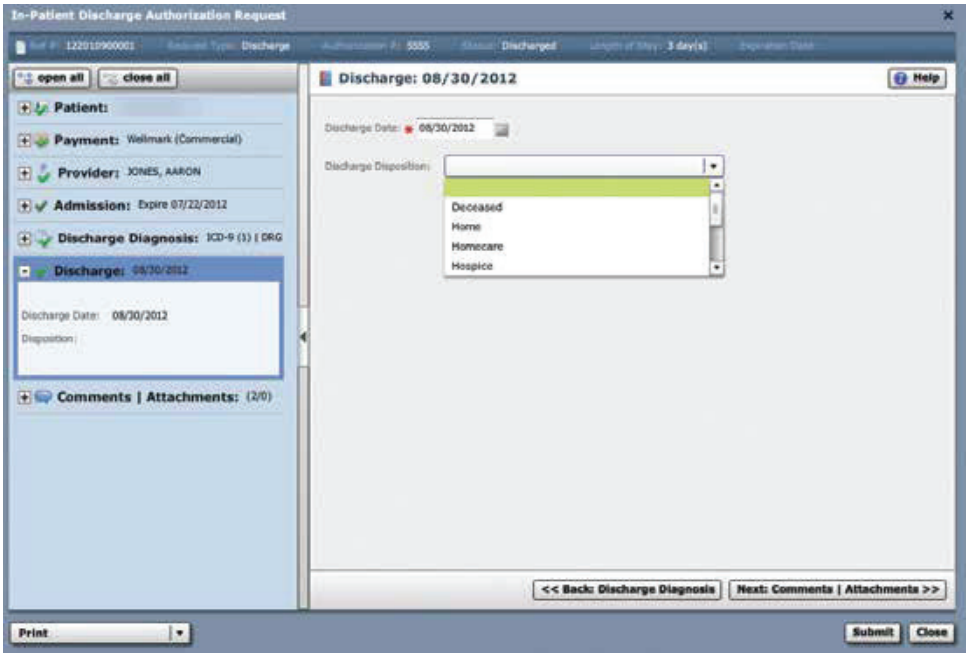
1. Locate the patient on the "**Authorization Request**" tab.
2. Click the "**Action**" button next to the patient and select "**Add Cont. Stay**" from the drop-down menu.
3. Enter a new Diagnosis if different from the original or continue on to the Cont. Stay Criteria.
4. You may or may not be required 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**".



Texas Children's Health Plan

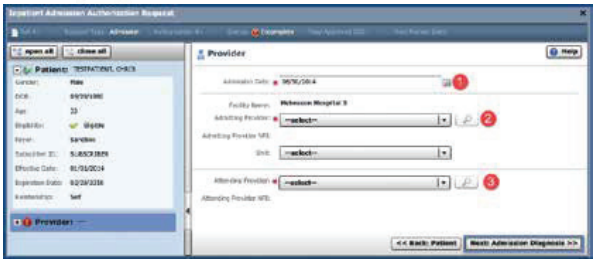
Quick Reference Guide

Clear Coverage™

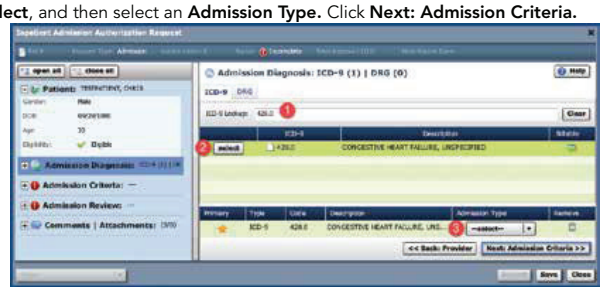
Start by logging into Clear Coverage.

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.
3. In the Search Results, click Select Next to the patient's name.
4. Verify the patient's information, click Next: Provider.

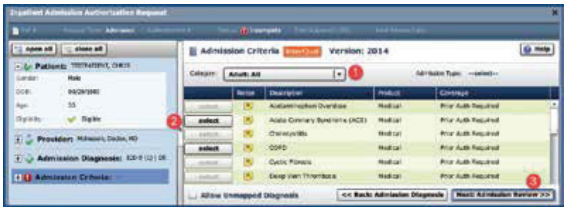
5. In the Provider accordion, select the **Admission Date** followed by the **Admitting Provider** (Facility) from your preferred clinician list. You may also choose a facility by clicking on the icon. Click **Next: Admission Diagnosis.**



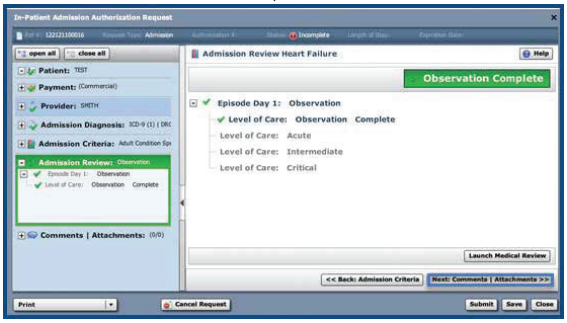
6. In the Admission Diagnosis accordion, search for a specific billable diagnosis, click **Select**, and then select an **Admission Type.** Click **Next: Admission Criteria.**



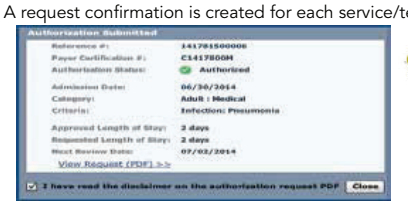
7. In the Admission Criteria accordion, start by selecting the category of your admission criteria. Click **Select** next to the appropriate service and then click **Next: Admission Review**



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.

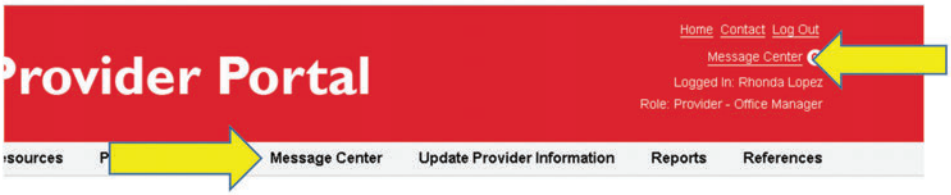
13. Print the authorization request by selecting the **View Request (PDF)** link.

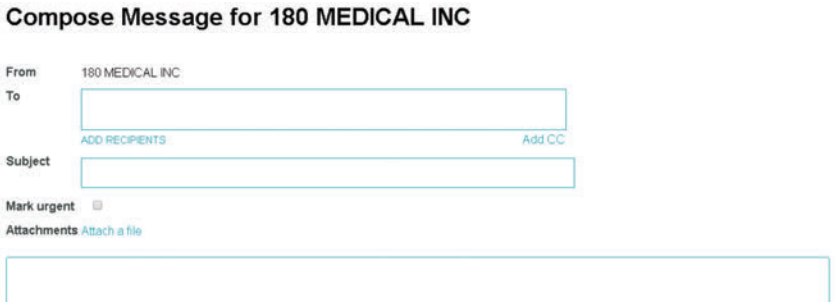
Additional Clear Coverage help is located under the **Provider Education** menu.

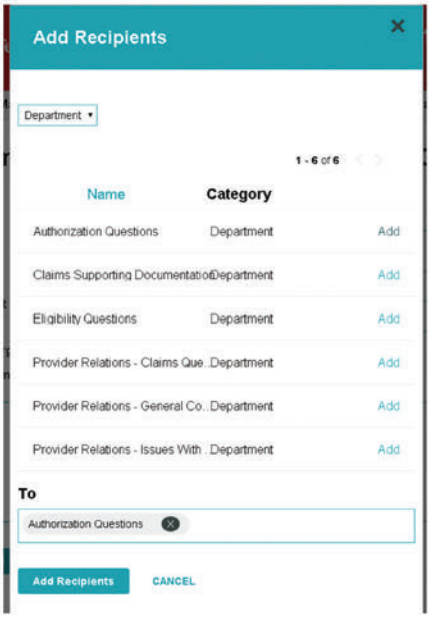
Secure Messaging

Every Provider Portal user receives a secure messaging e-mail account. Your **Message Center** is located in the top menu and just below the red banner. Using the Message Center, you can:

- Add and edit mailboxes
- Send messages to The Health Plan staff
- Receive and manage messages
- Add or send documents







Secure Messaging

To send a message, follow the steps below:

Step 1

Click on the **New Message** button. The **Compose Message** form will appear.

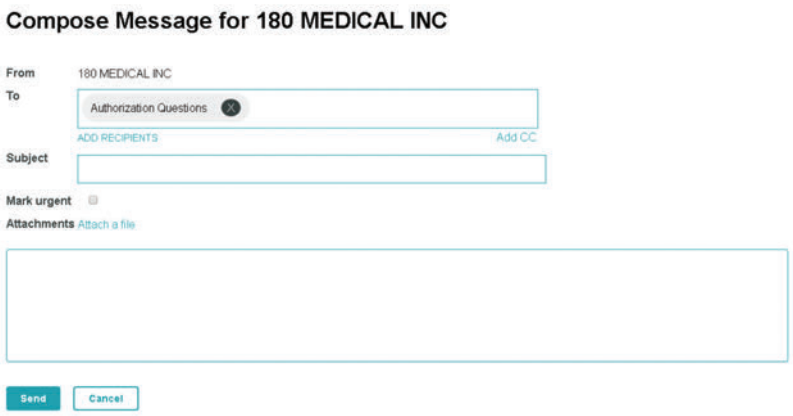
Step 2

Select **Add Recipient(s)**.

Step 3

Select a recipient from the list below by clicking the **Add** button to the right, then clicking **Add Recipients** at the bottom:

- Provider Relations – General comments
- Provider Relations – Claims questions
- Provider Relations – Issues with portal
- Utilization Management – Authorization questions
- Member Services – Eligibility questions



Step 4

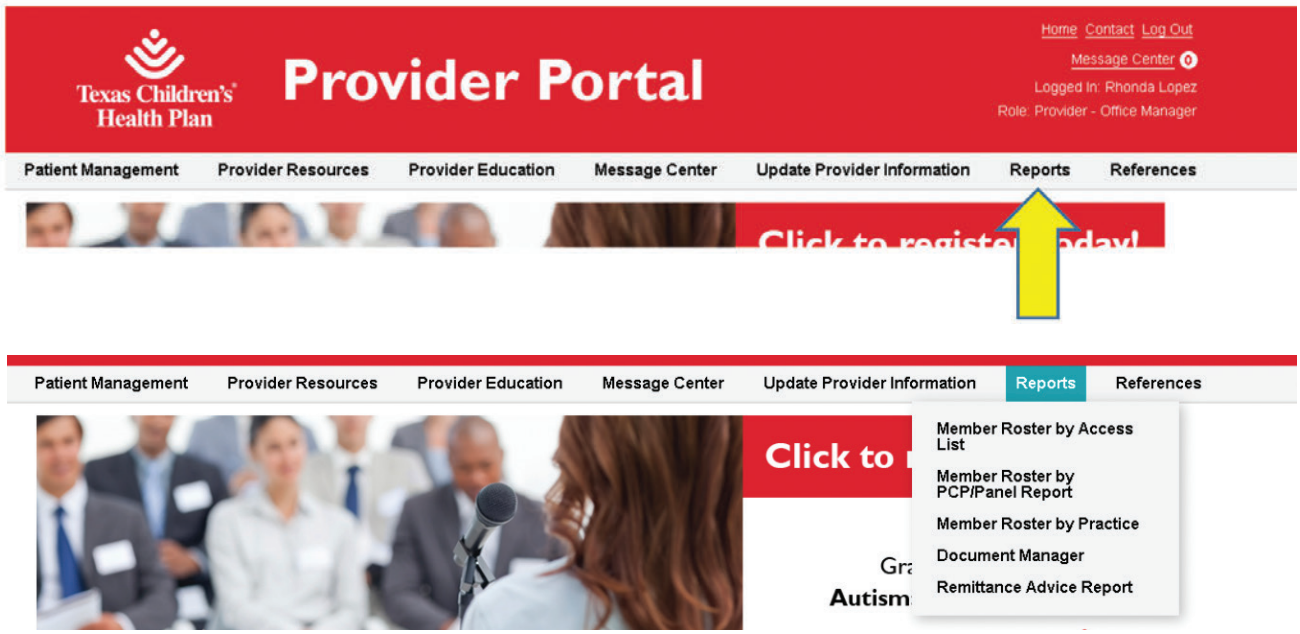
Type in your subject and content. You can also attach documents and check the **Mark Urgent** box for your message. When finished, click the **Send** button. You will receive a confirmation that your message was sent. You can return to your inbox or do another task. You will be able to see your sent mail by clicking on the **Sent Items** tab. When a response is received, the **Message Center** in the top right of the Portal Homepage will display the number of items in your inbox.

Reports

You can access reports online through **The Provider Portal**. This feature allows you to generate your own PCP panel reports.

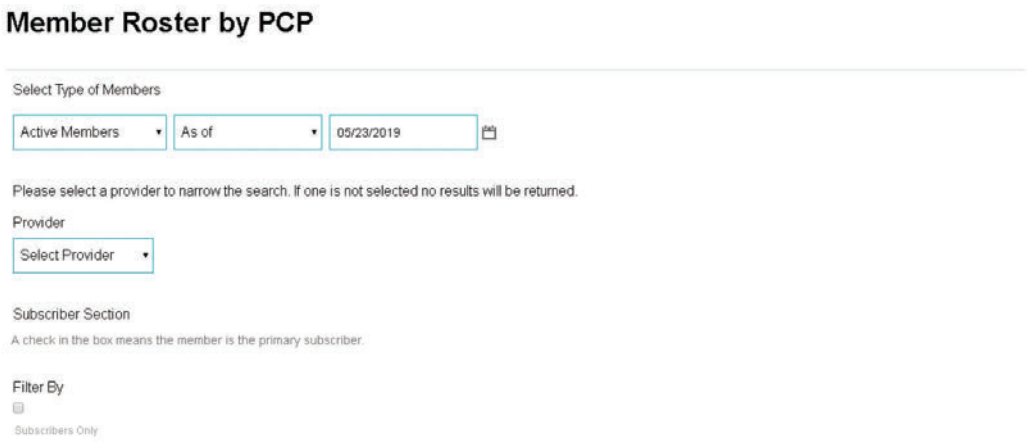
Step 1

Click on the **Reports** button at the top of the portal home page. A list of available reports will appear.



Step 2

Click on the report name you would like to generate.



Step 3

Select your Provider Name or your Provider ID and click **Search**.

Step 4

Select provider by clicking the **Add** link to the right then click **Continue**.

Step 5

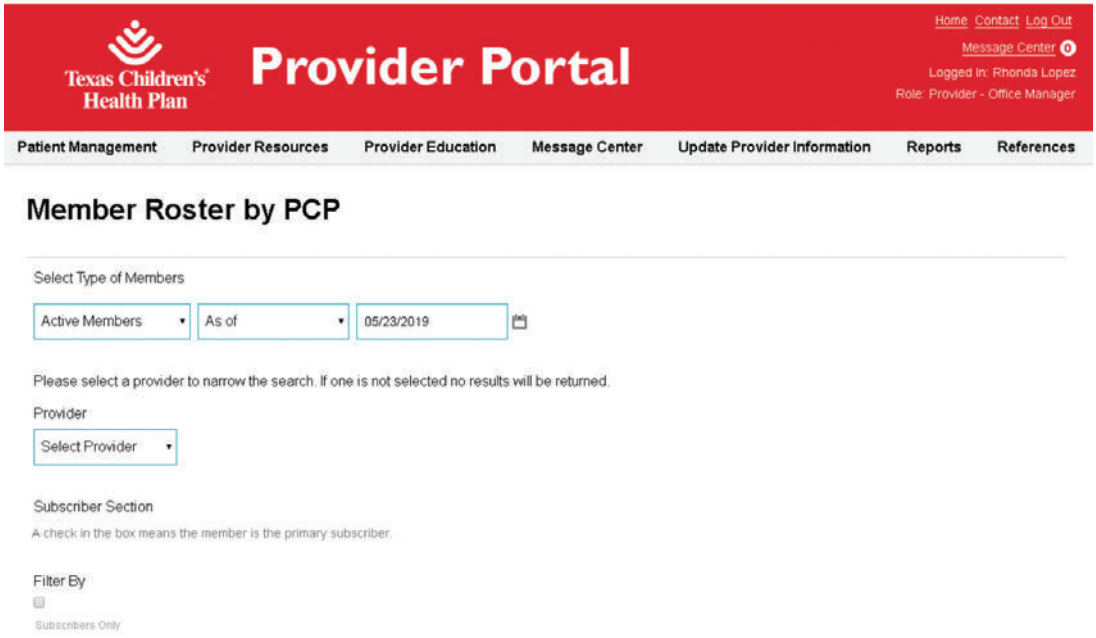
Select the type of report format you want:

- CVSPDF
- Excel
- CVS

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.

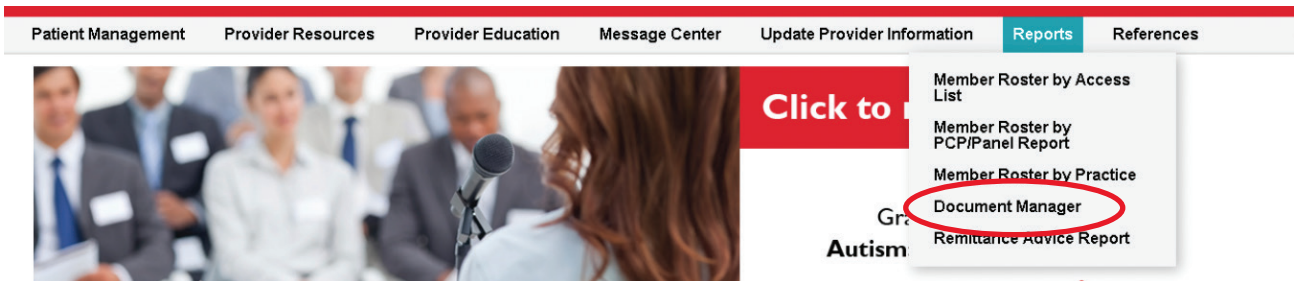


Document Manager

The Health Plan 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.

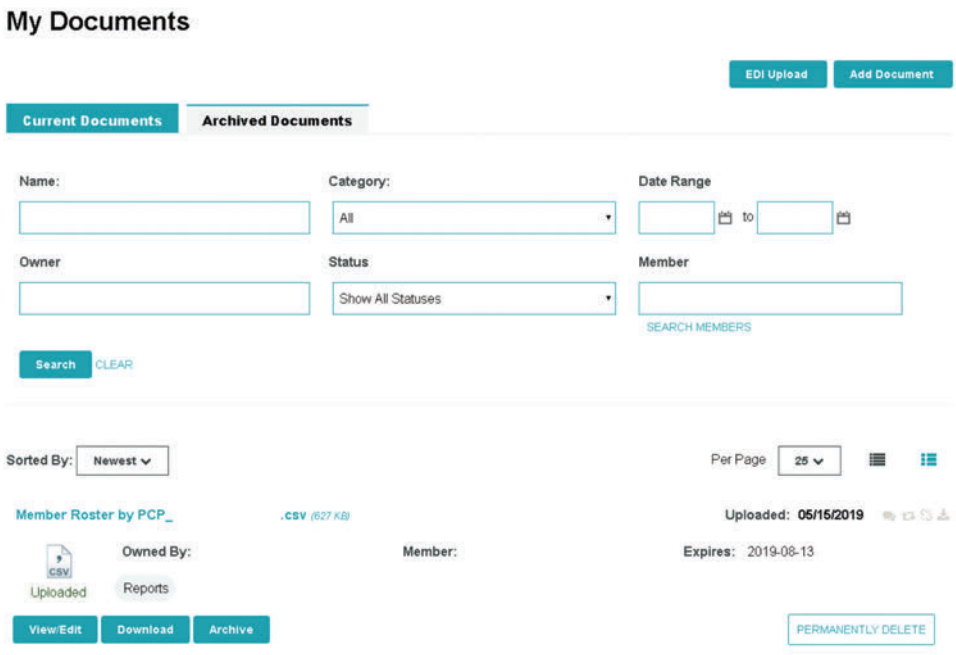
Step 1

Click on the **Document Manager** link under the **Reports Menu** on the top right of the home page.



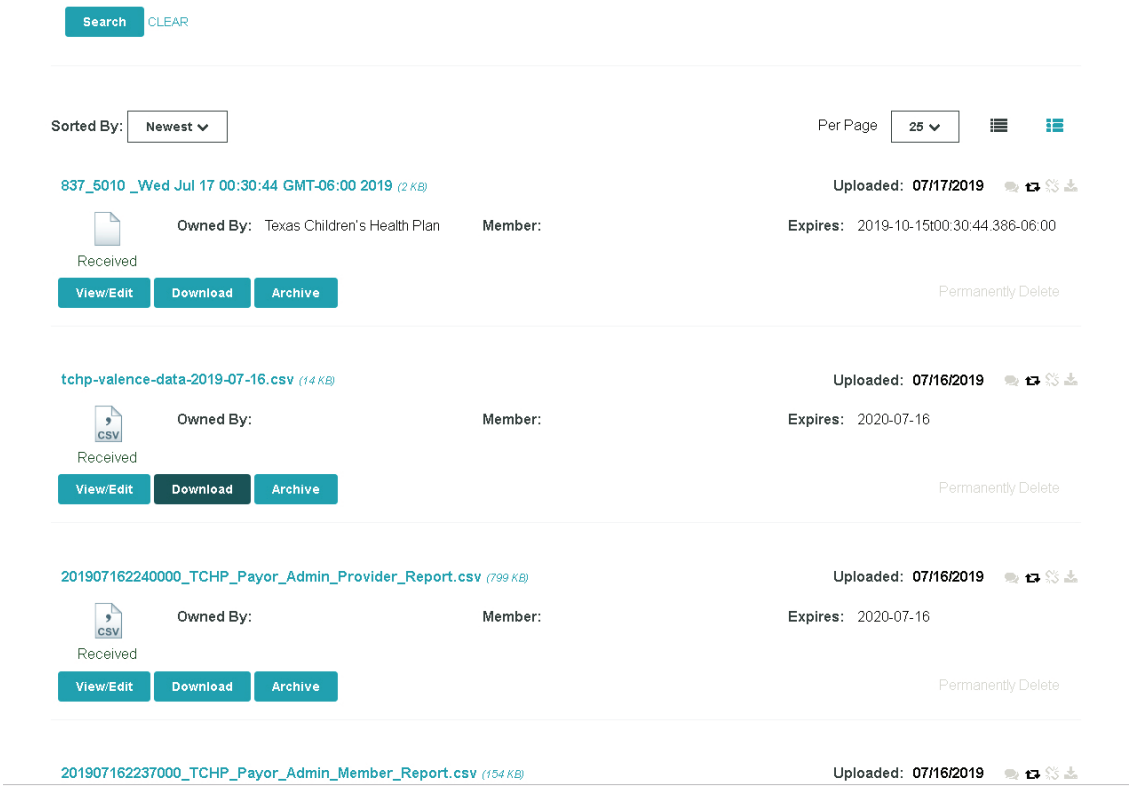
Step 2

Click on the **Download** link and save the report to your computer.



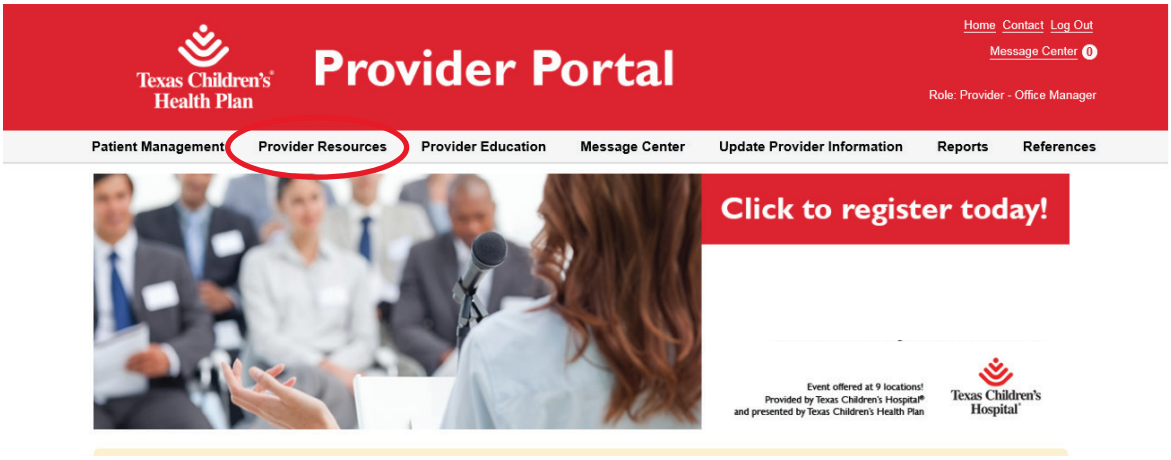
Step 3

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.



Provider Complaint

The **Provider Complaint** form is available under the **Provider Resources** menu on the portal homepage. Complete the form and provide details in the Note section. When complete click **Save**. A Texas Children's Health Plan employee will be in contact with you or the practice in an effort to resolve the complaint.

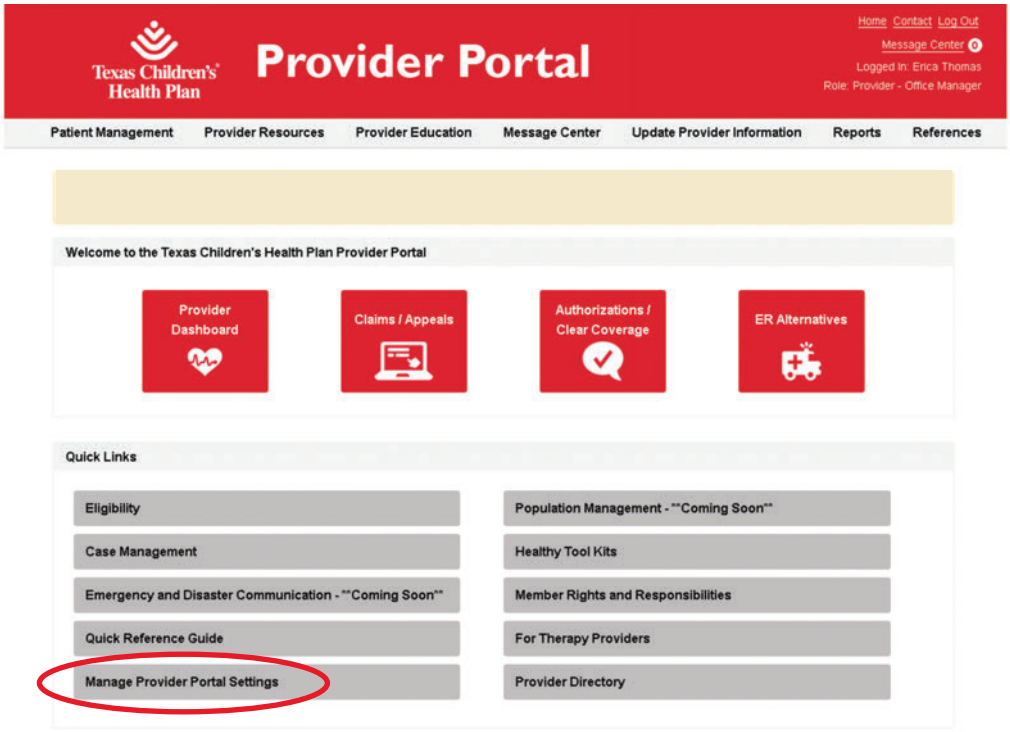


Adding or Removing a User

If you need to add or remove a user, you can use the **System Administration/ User Maintenance** feature.

Step 1

Click on the **Manage Provider Portal Settings**.

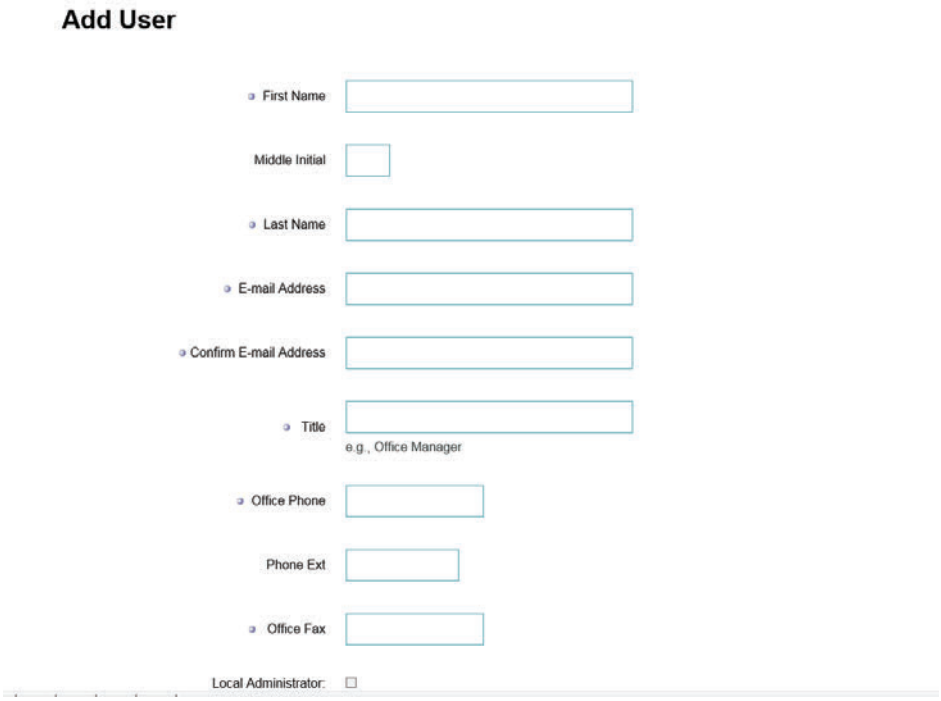


Step 2

To add a user, click the **Add User** button.

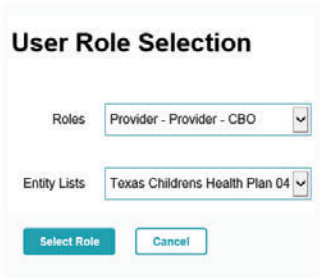
Step 3

Enter the new user information and click the **Submit** button.

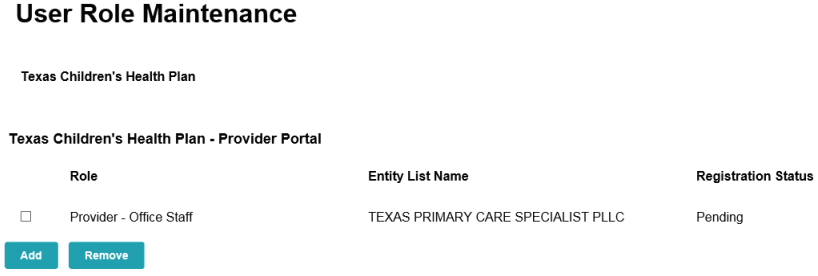


Step 4

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



The user status will show "Pending" until The Health Plan confirms the user change.



Step 5

Once The Health Plan 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.

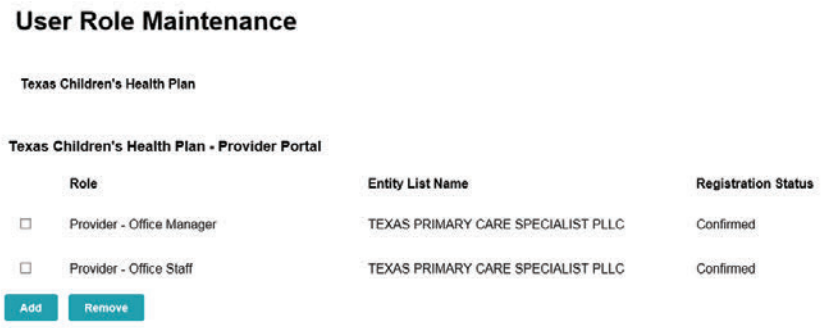
Changing a user role or access list

Step 1

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

Step 2

Click the **Add** button.

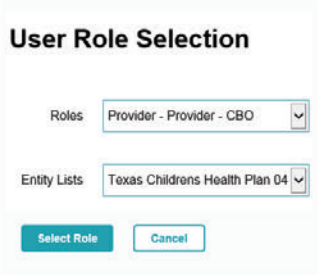


Step 3

Select a different role or access list.

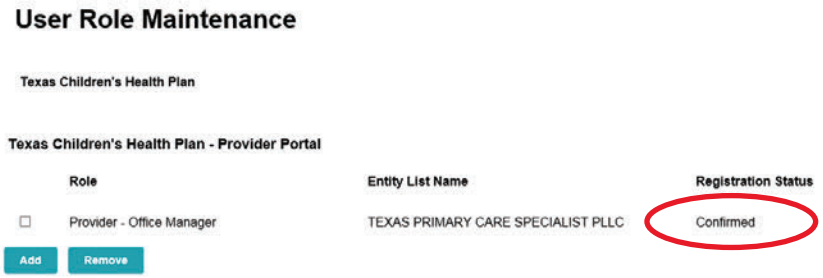
Step 4

Click the **Select Role** button.



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.

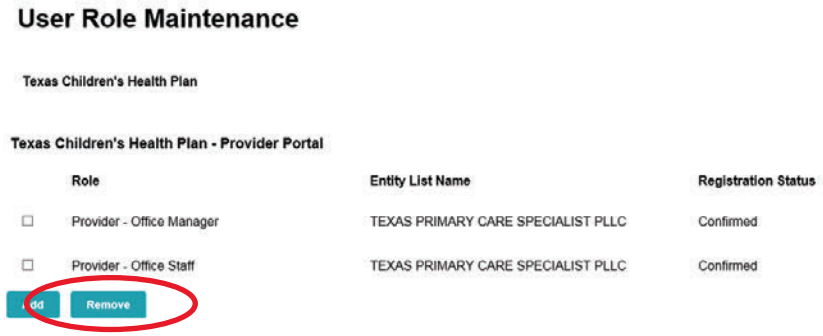


Removing a User Role

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.



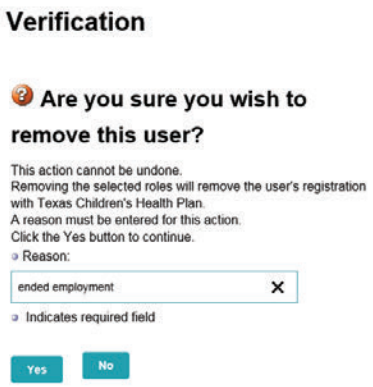
NOTE: You must have one role for the user or the user will be deleted.

Step 4

Enter the reason for removing user.

Step 5

Click the **Yes** button.



You will then return to the **User Maintenance** screen.