Provider TouCHPoint Training Guide

Feb 1, 2018

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Texas Children's Health Plan

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

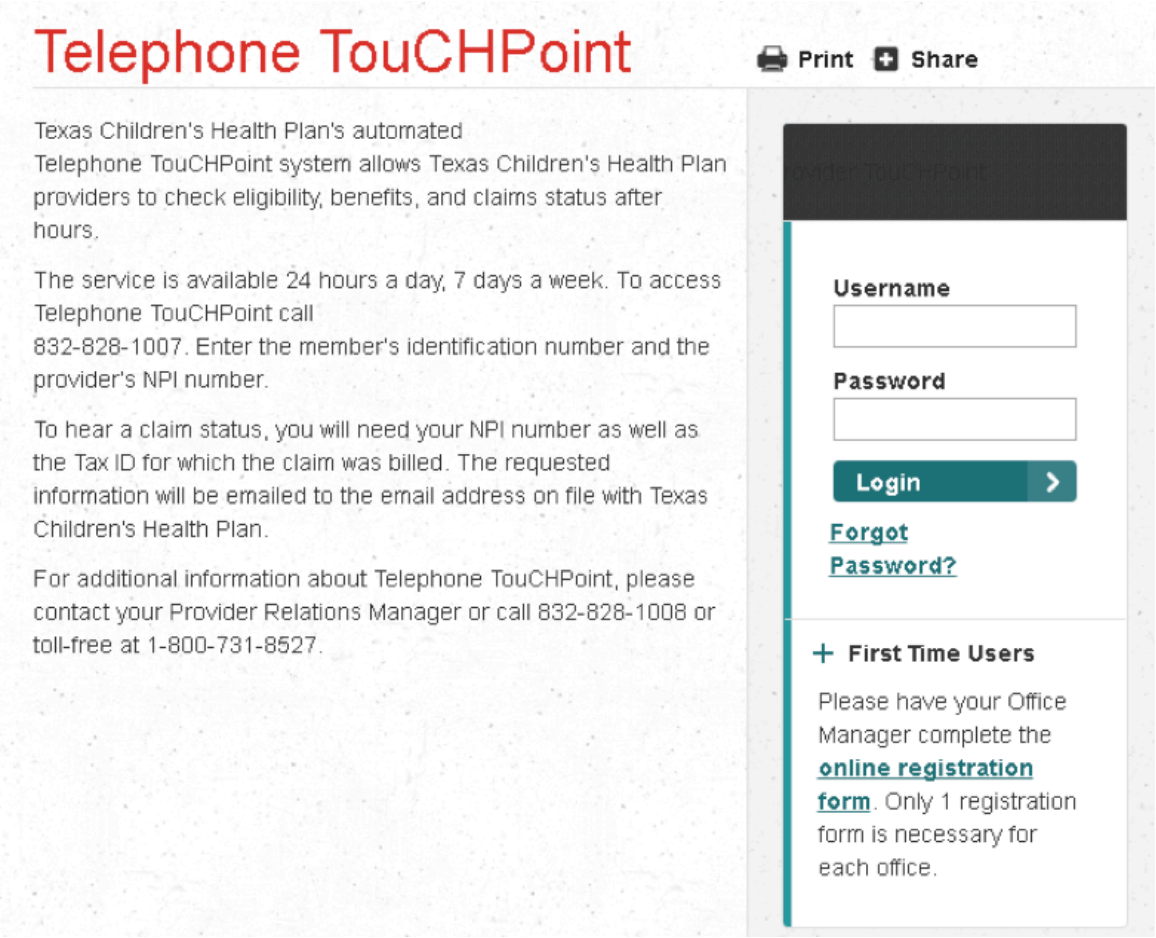
President, Texas Children's Health Plan

Registration

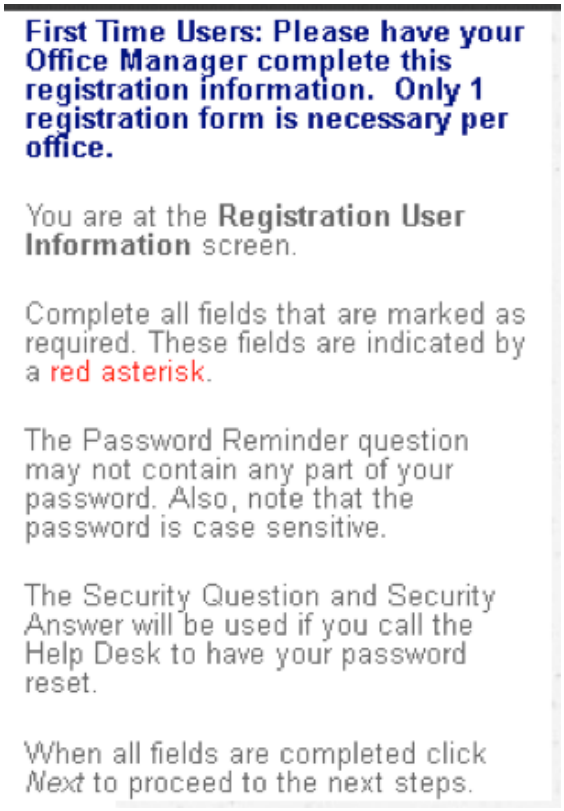
Registration

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. Click on the First Time Users link under the login box.



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 *

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.

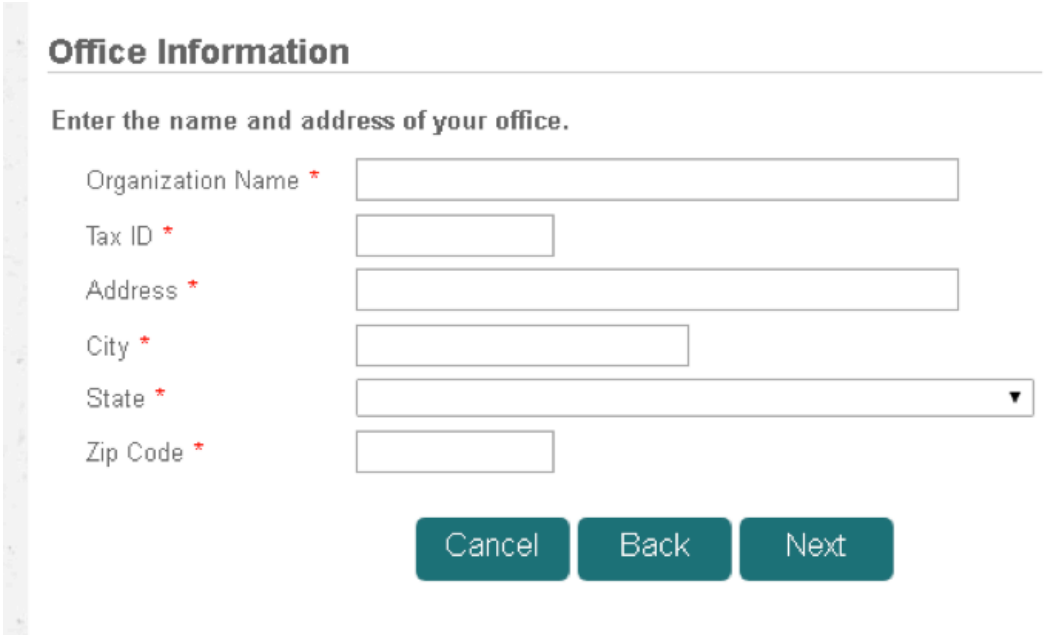
Security Question 3 *

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

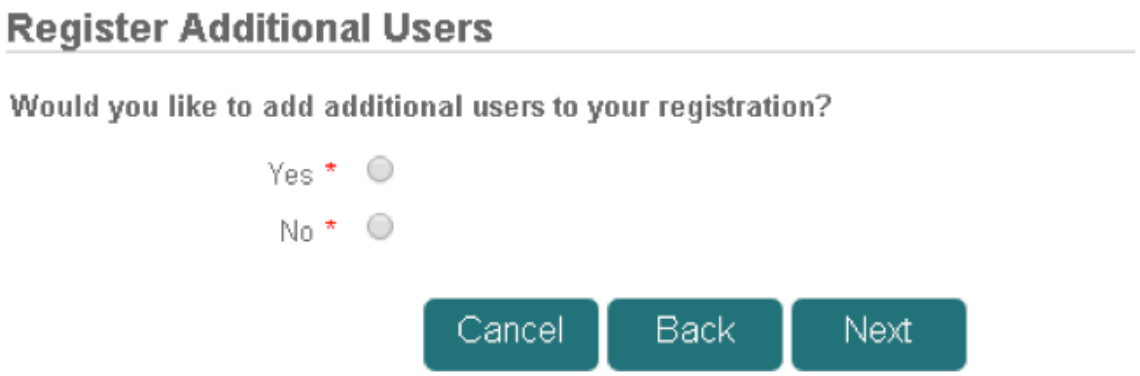
Step 3: Enter your office information. All fields are required.



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.

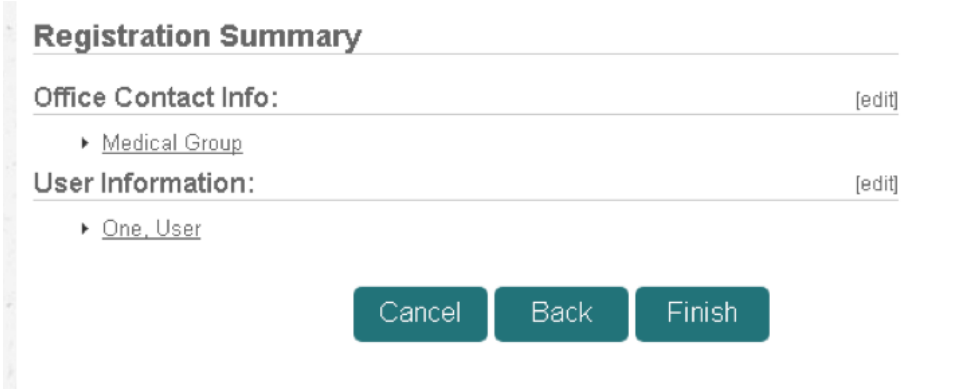


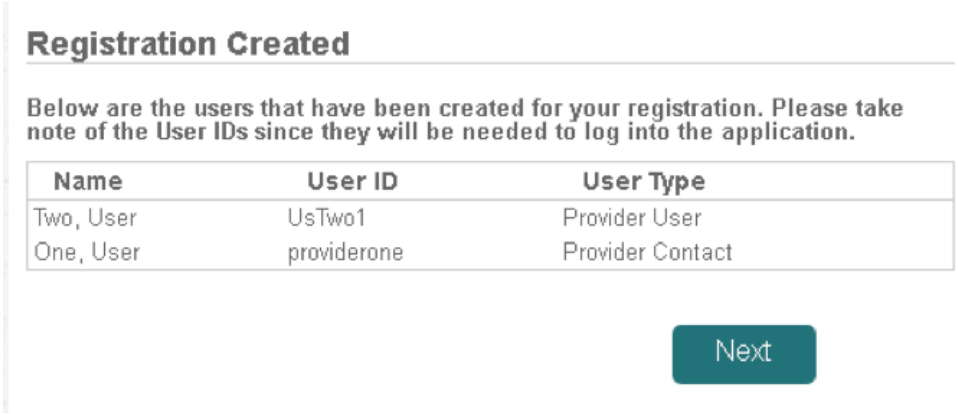
Step 2: Once you complete the form for additional users, click Local Admin if you want a user to have the same administrative rights to add or delete users and manage roles. Click Add User. If you want to continue to add users, repeat this step. Once you complete this process, click the Next button.

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.



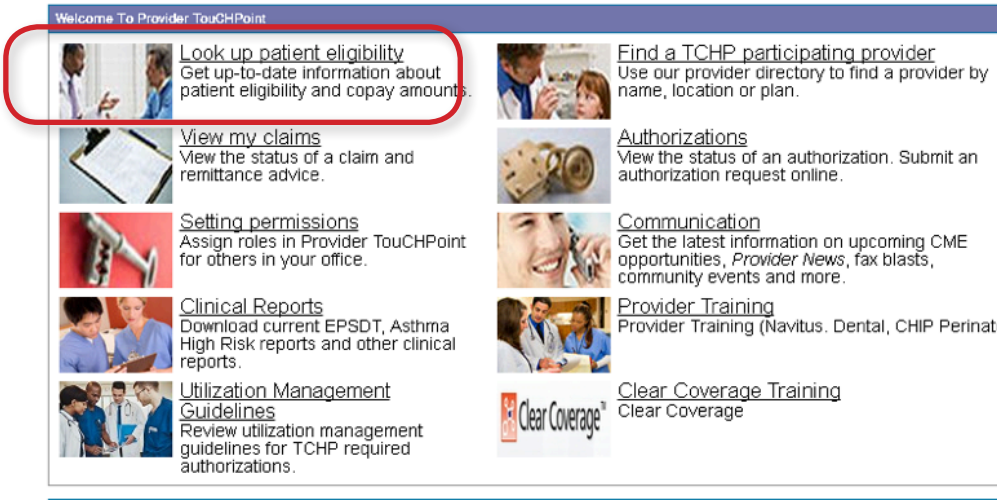


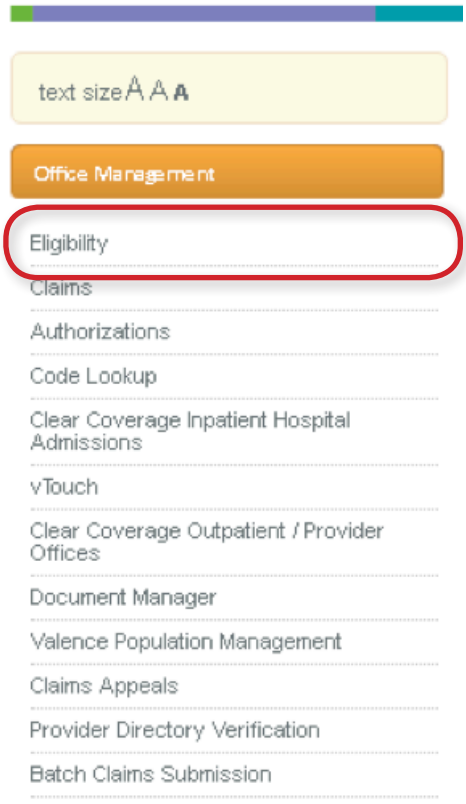
Once registration is complete, you will receive a confirmation e-mail. TCHP will approve registrations as soon as possible. You will then need to login to Provider TouCHPoint using your username and temporary password assigned by TCHP. You will be prompted to create a new password.

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.

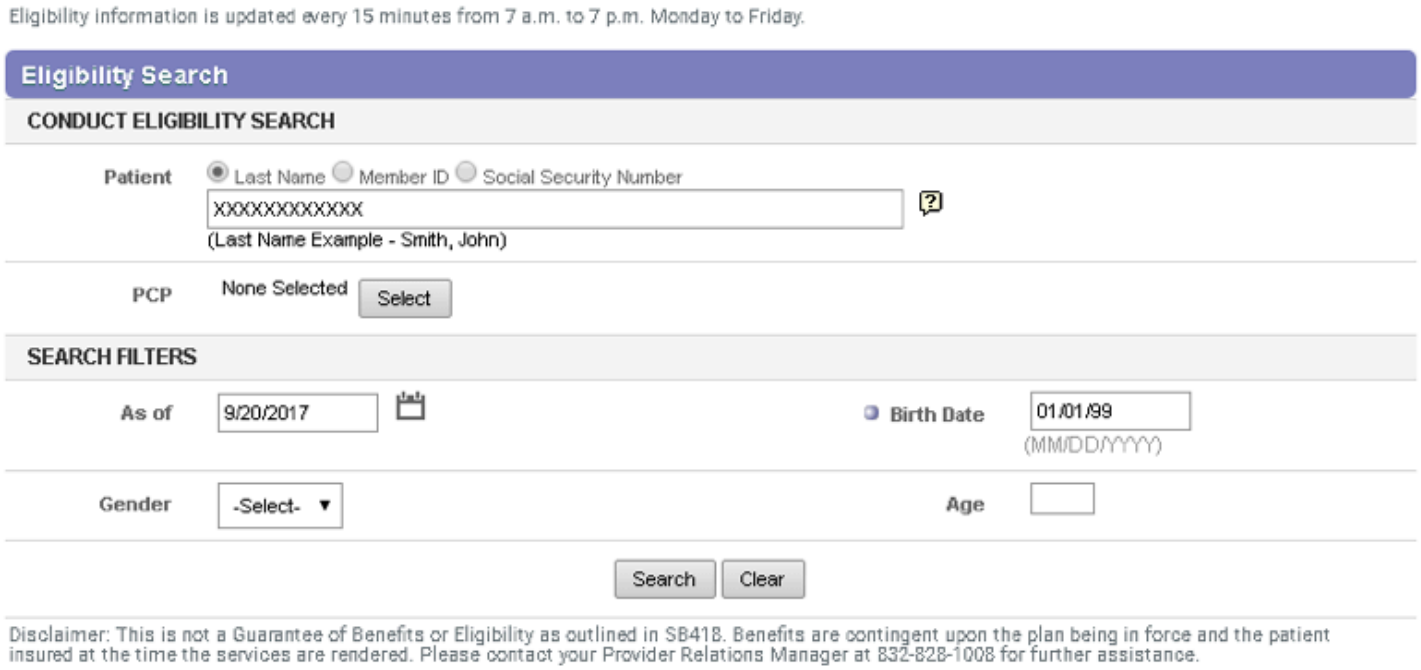




The eligibility search feature allows you to search for a patient by any of the following:

- 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)



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.

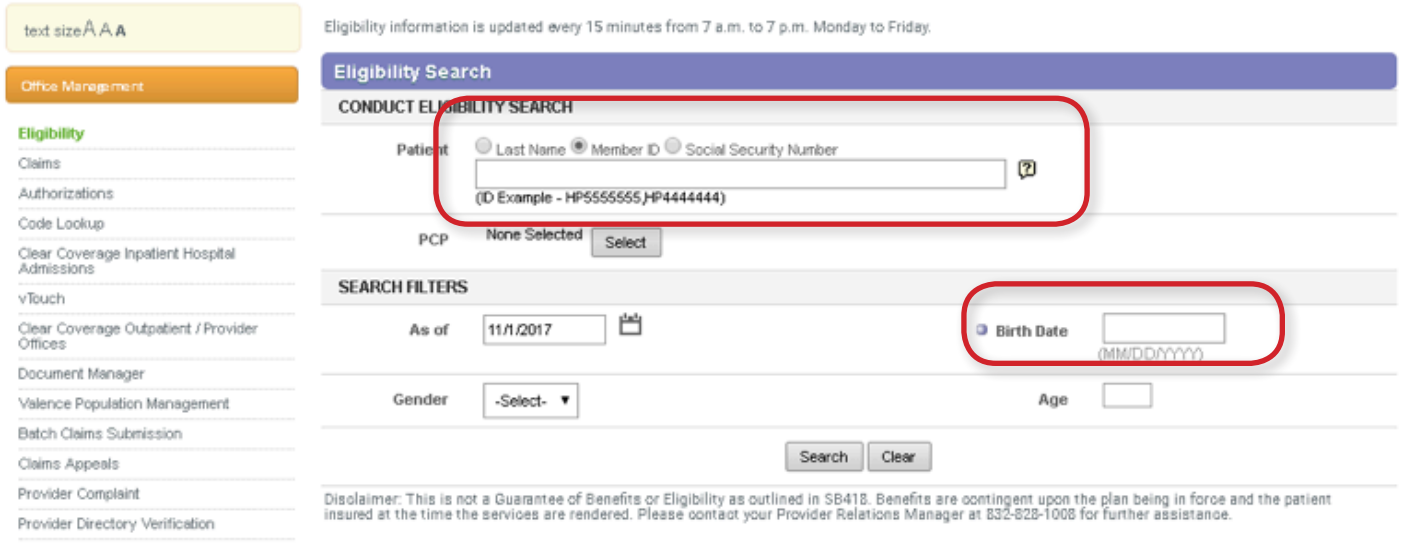
EPSDT visit alert

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.

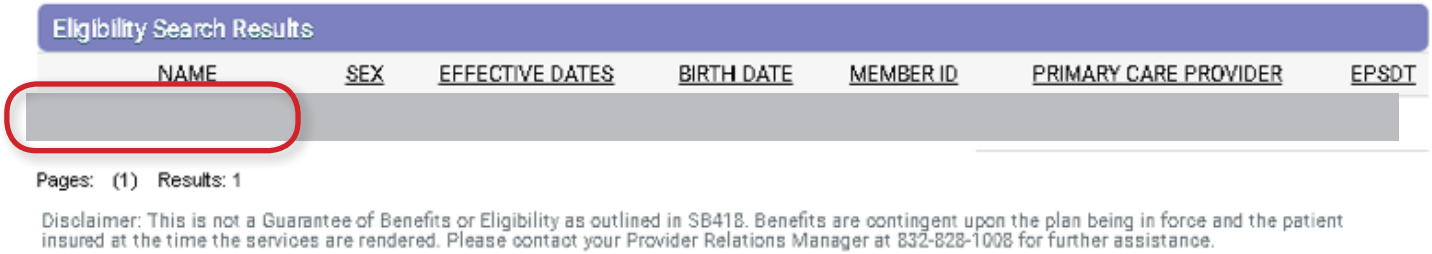
Locating a StarKids Service Coordinator

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.



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.

Claims/Code Lookup

Claims

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

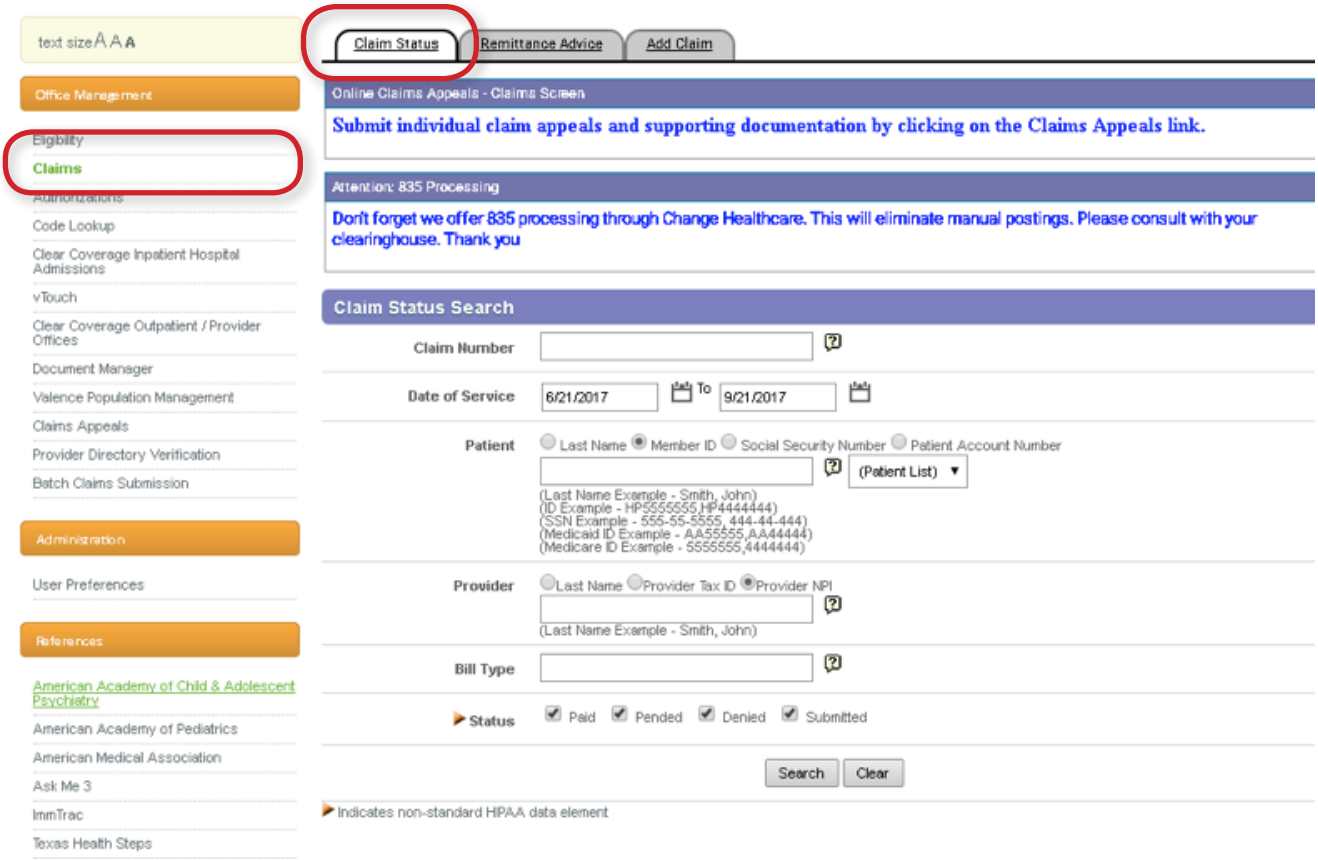
Step 1: Click on the Claims button under the Office Management section of Provider TouCHPoint or View My Claims link on the home page.

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:

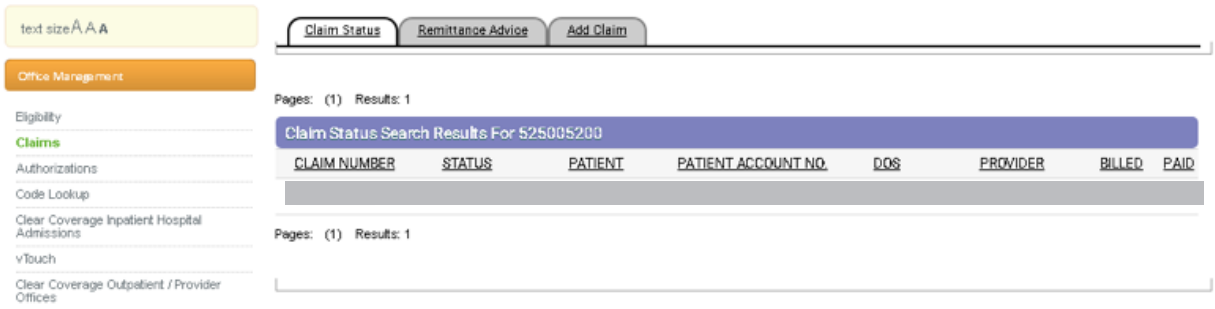
- Claim number (partial search)
- Date of service
- Patient information
  - Last name (partial search)
  - Member ID
  - SSN
  - Patient account number
- Provider information
  - Last name (partial search)
  - Tax ID
  - NPI
- Bill type
- Status (paid, pended, denied)

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

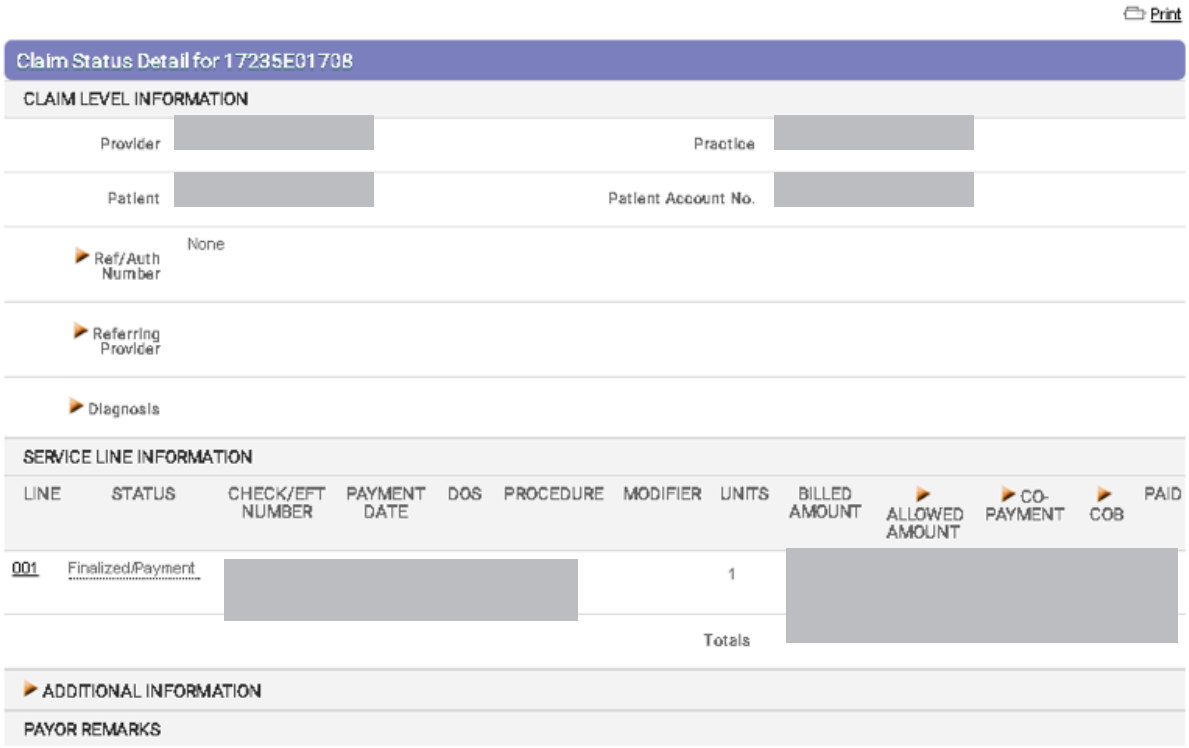


Step 2: Complete the form and click the search button.

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.



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
001	Finalized/Payment	[redacted]					1	[redacted]				
							Totals					

ADDITIONAL INFORMATION

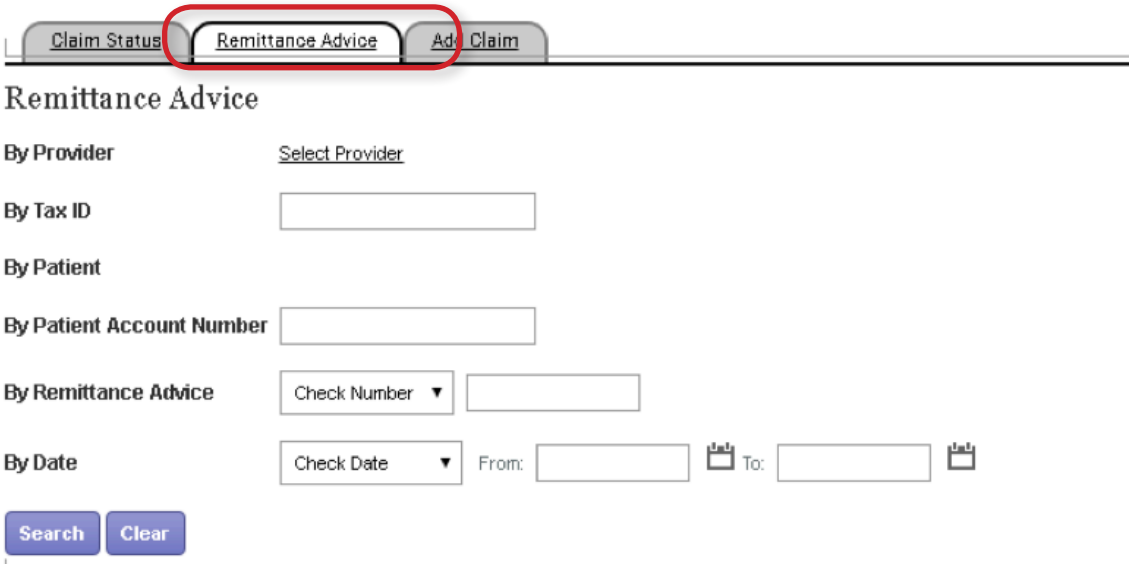
PAYOR REMARKS

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.

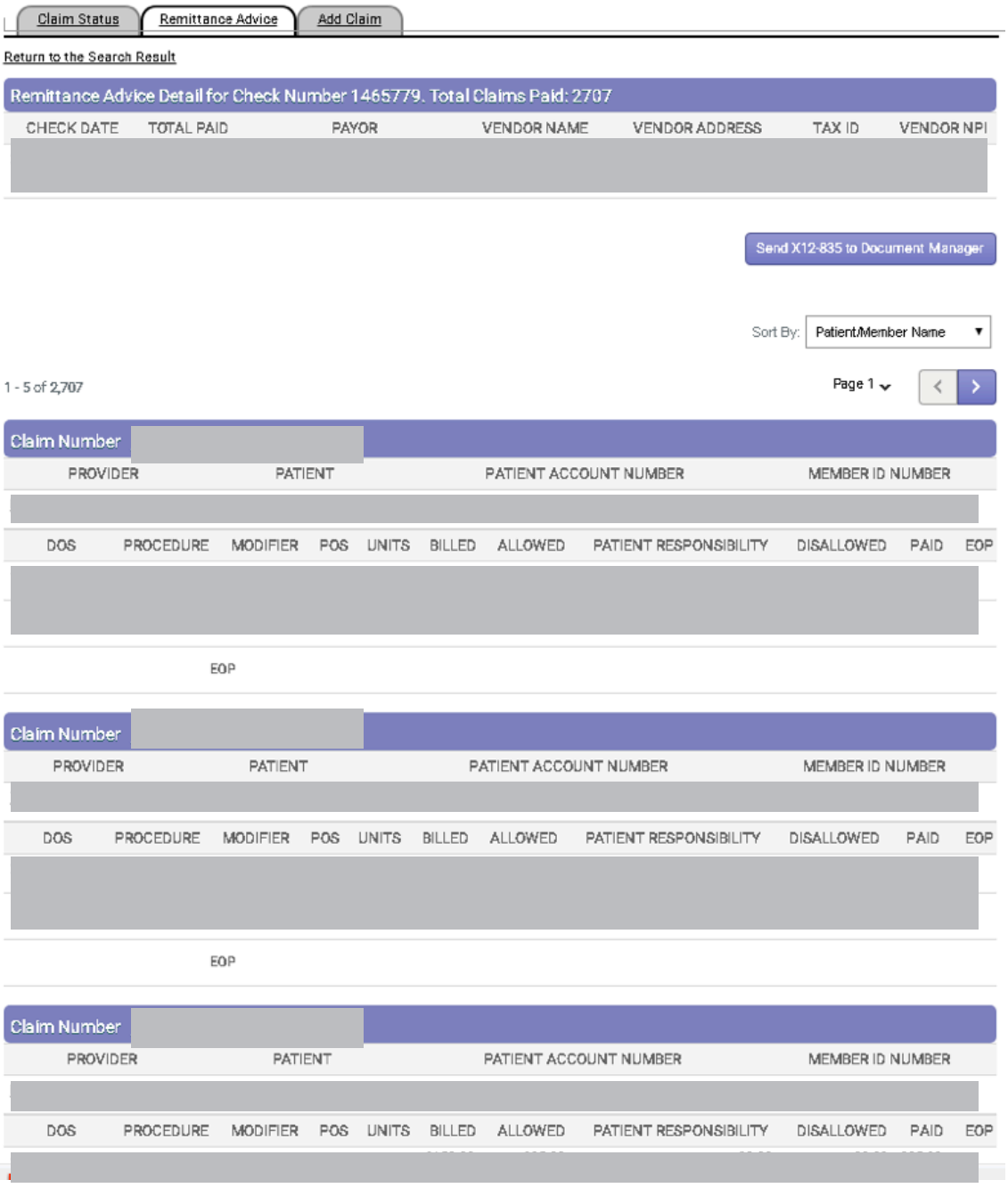


Under the Remittance Advice tab, you can search by any of the following:

- 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.

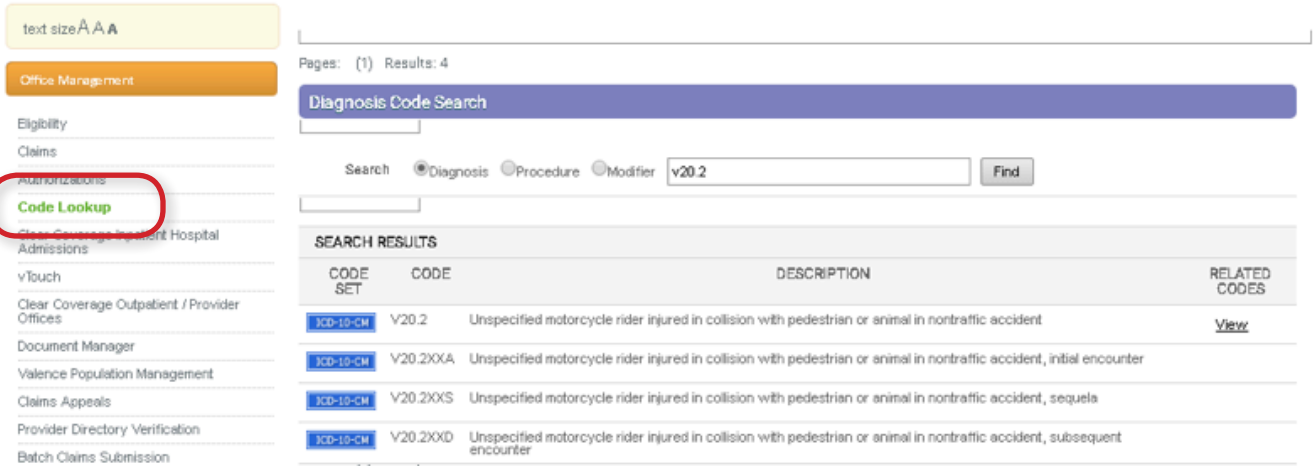


Code lookup

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

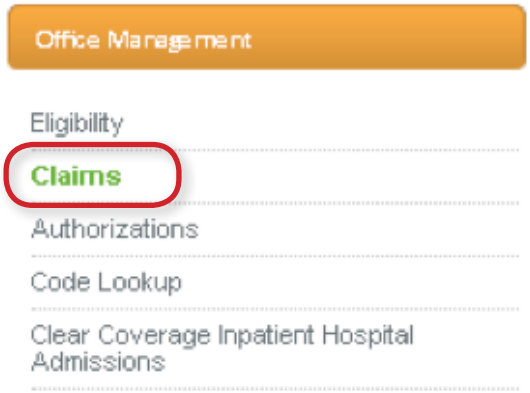
Step 1: Click on the Code Lookup button under the Office Management section.

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

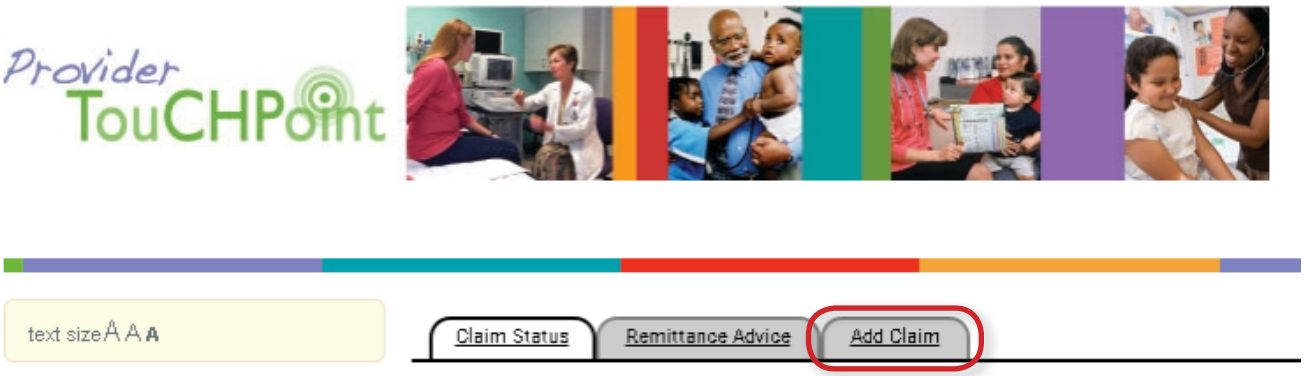


Individual Claim Submission

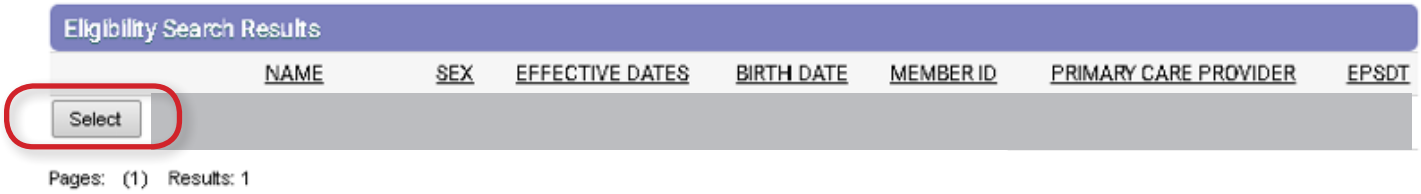
Step 1: Click on the Claims menu item on the left navigation (highlighted below in red) to enter a new single claim.



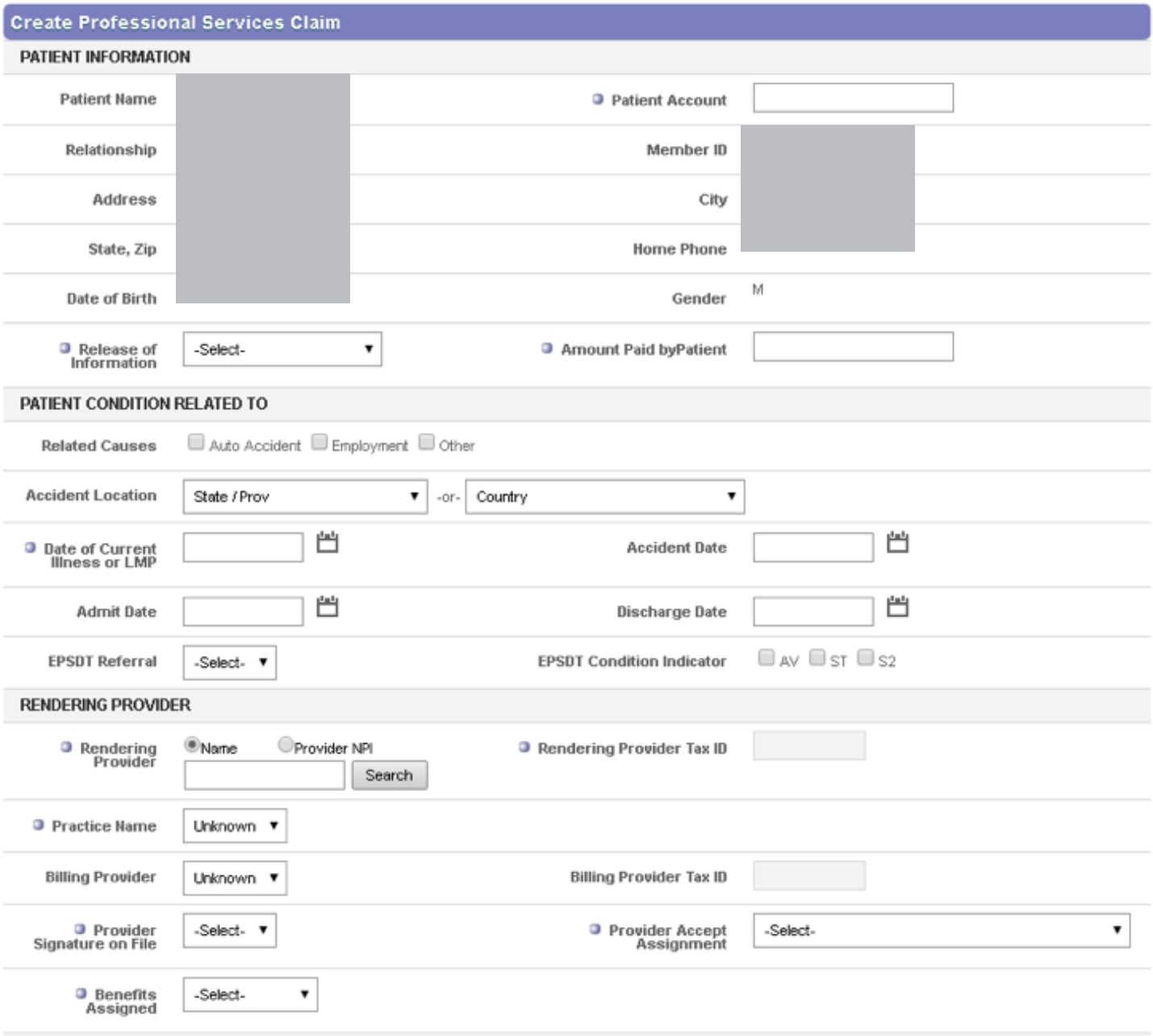
Step 2: Click on the Add Claim tab: (highlighted below in red) to enter a new individual claim.

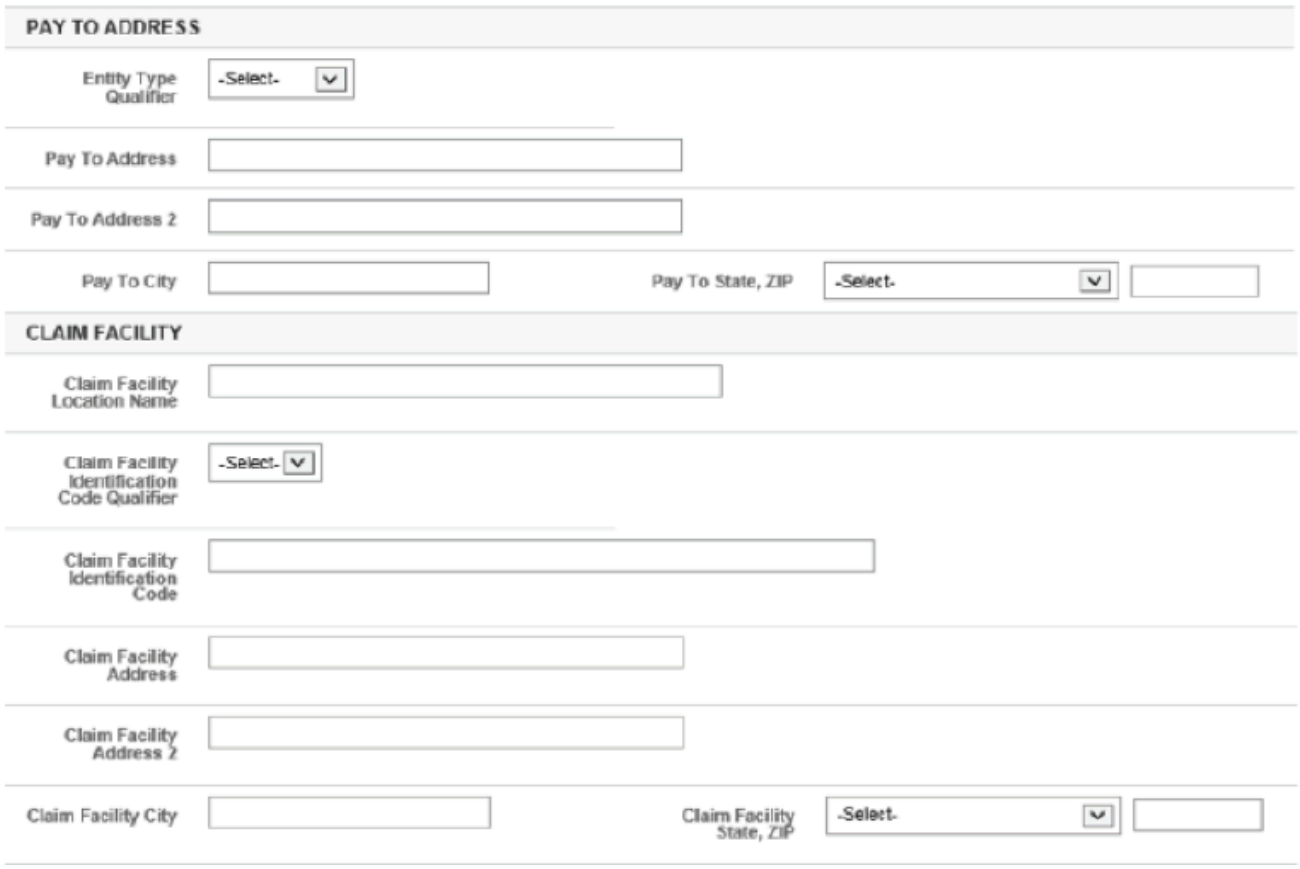


Step 3: Search for the patient by Last Name, Member ID, or Medicaid ID. Click the select button (highlighted below in red) to begin entering an individual claim.

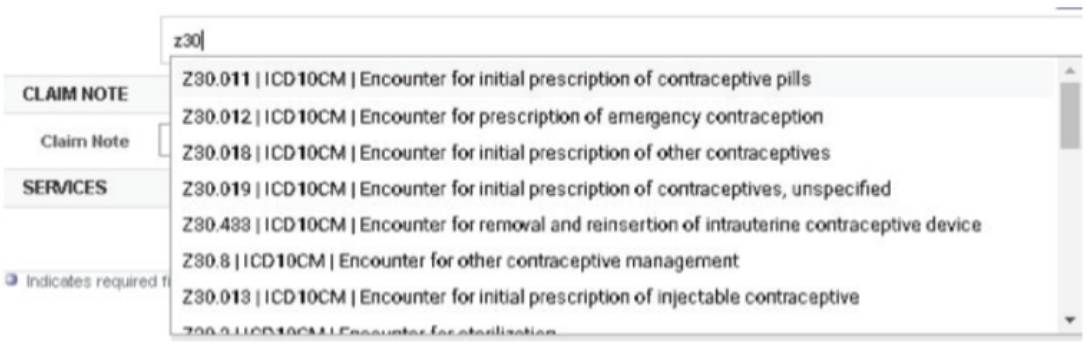


Step 4: Create Professional Services Claim: Enter information into all required fields.

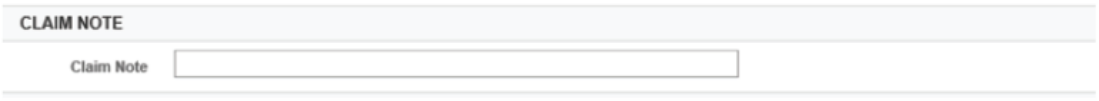




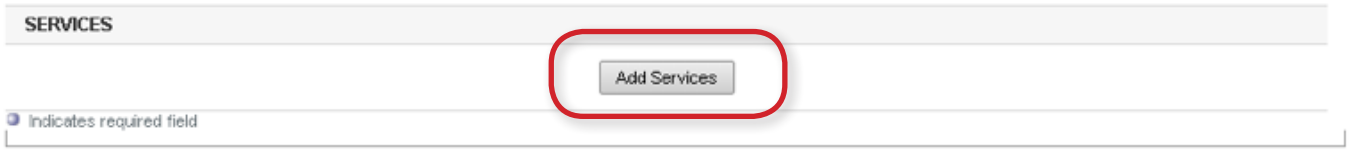
DIAGNOSIS: Enter at least two characters to populate a list of dx codes. Dx code format xxx.xxxx



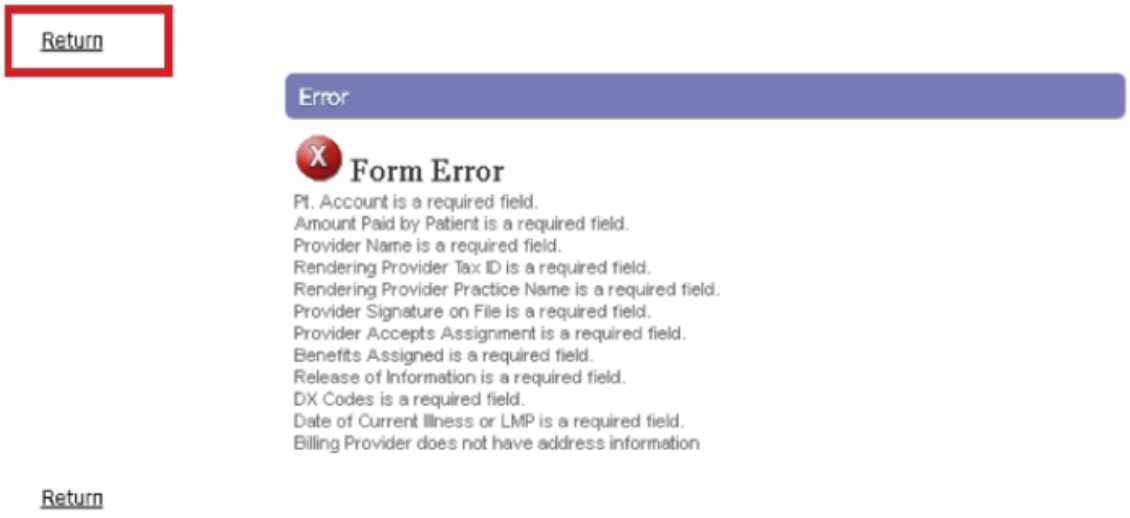
CLAIM NOTE: Provider can free text any claims information the health plan should be aware of.



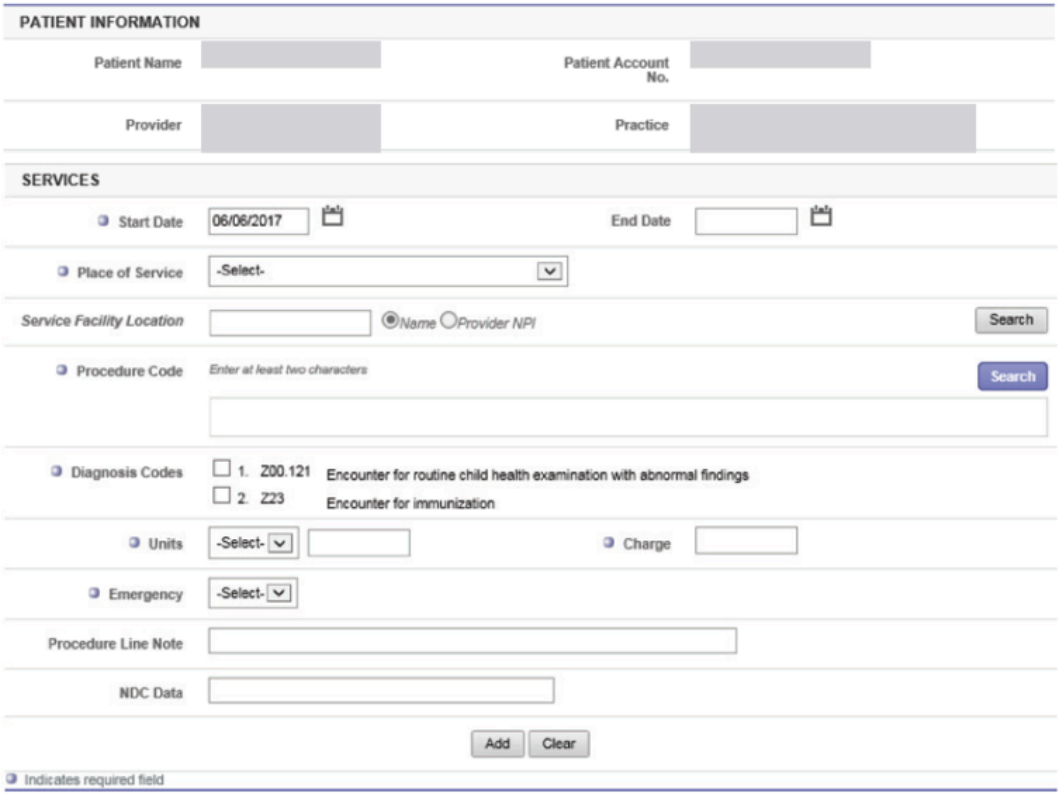
Step 5: Once all the required fields are entered, click Add Services (highlighted below in red).



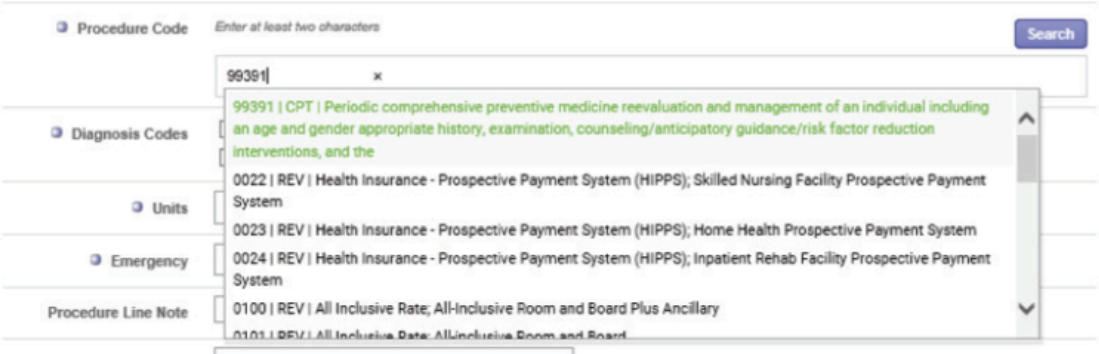
Step 6: If all required fields are not entered, you will get the following error message detailing the missing required fields. Select the Return button to restore to the previous page to add the missing required information.



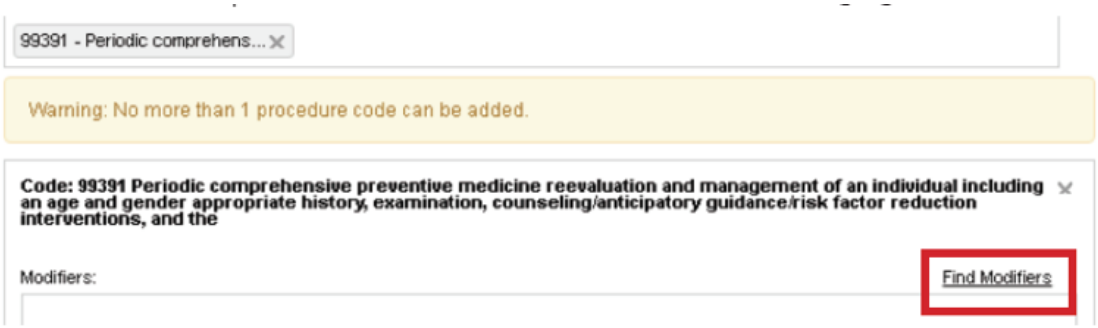
Step 7: You will now be allowed to proceed to the next step in single claim submission.



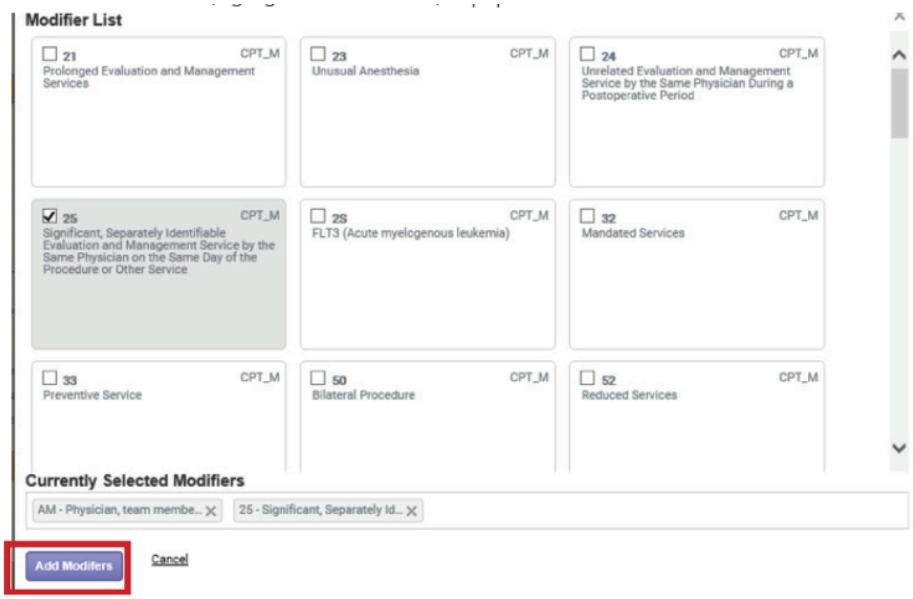
Step 8: Procedure Code Search: Enter at least two characters to populate a list of procedure codes.



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



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.



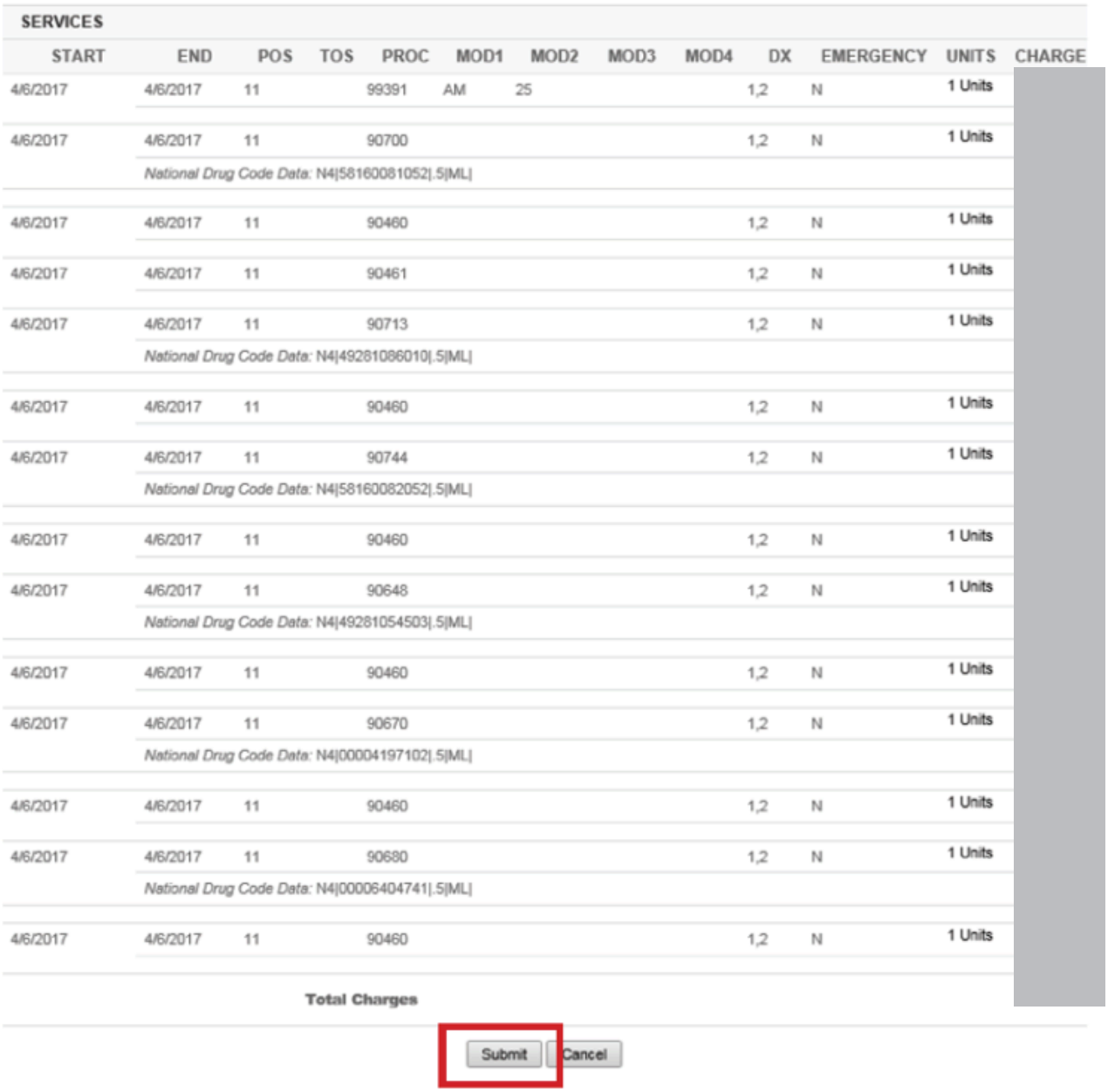
NDC DATA:

*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 Finish (highlighted below in red) to proceed.

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



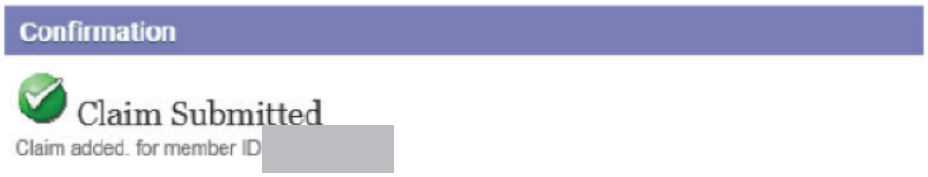
SERVICES

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	
	National Drug Code Data: N4|58160081052|.5|ML|											
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	
	National Drug Code Data: N4|49281086010|.5|ML|											
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	
	National Drug Code Data: N4|58160082052|.5|ML|											
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	
	National Drug Code Data: N4|49281054503|.5|ML|											
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	
	National Drug Code Data: N4|00004197102|.5|ML|											
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	
	National Drug Code Data: N4|00006404741|.5|ML|											
4/6/2017	4/6/2017	11		90460					1,2	N	1 Units	

Total Charges

Submit Cancel

Submitted:



Confirmation

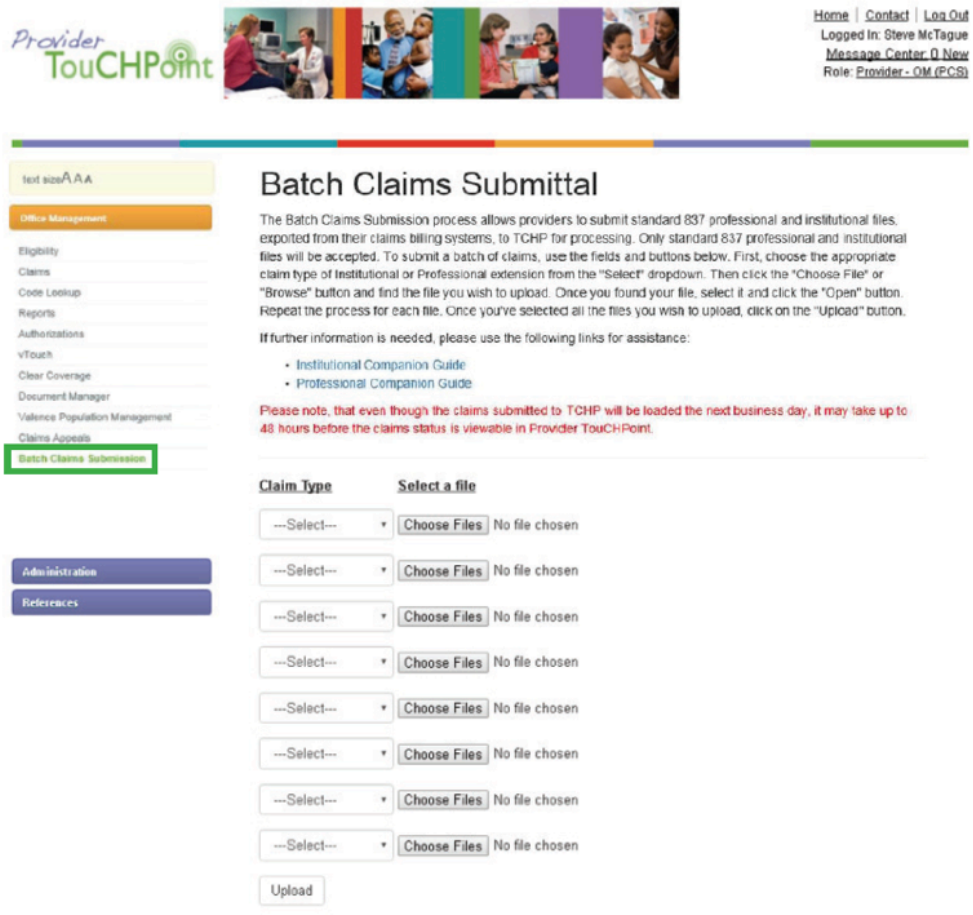
Claim Submitted

Claim added. for member ID

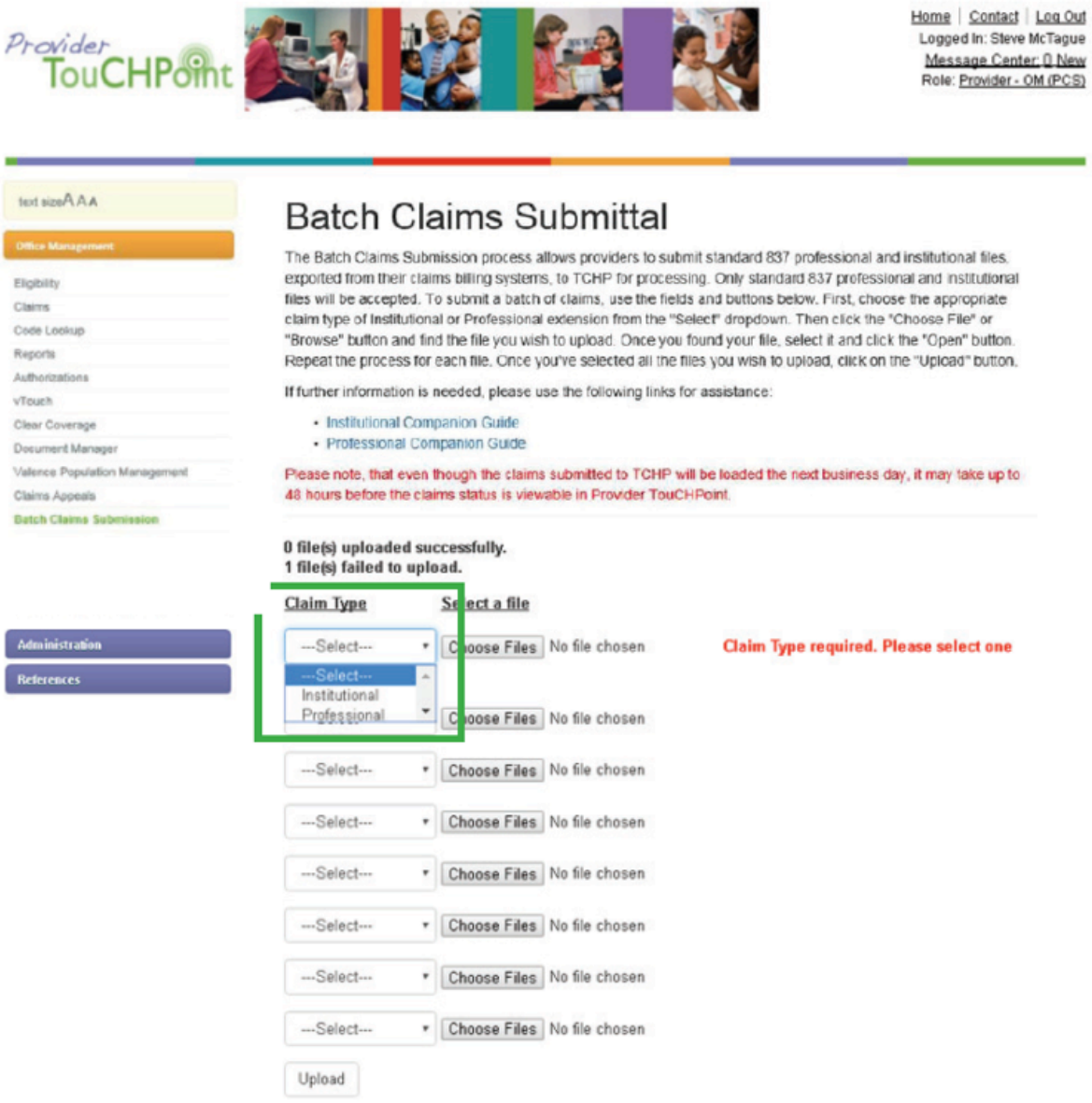
Batch Claims Submittal

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.

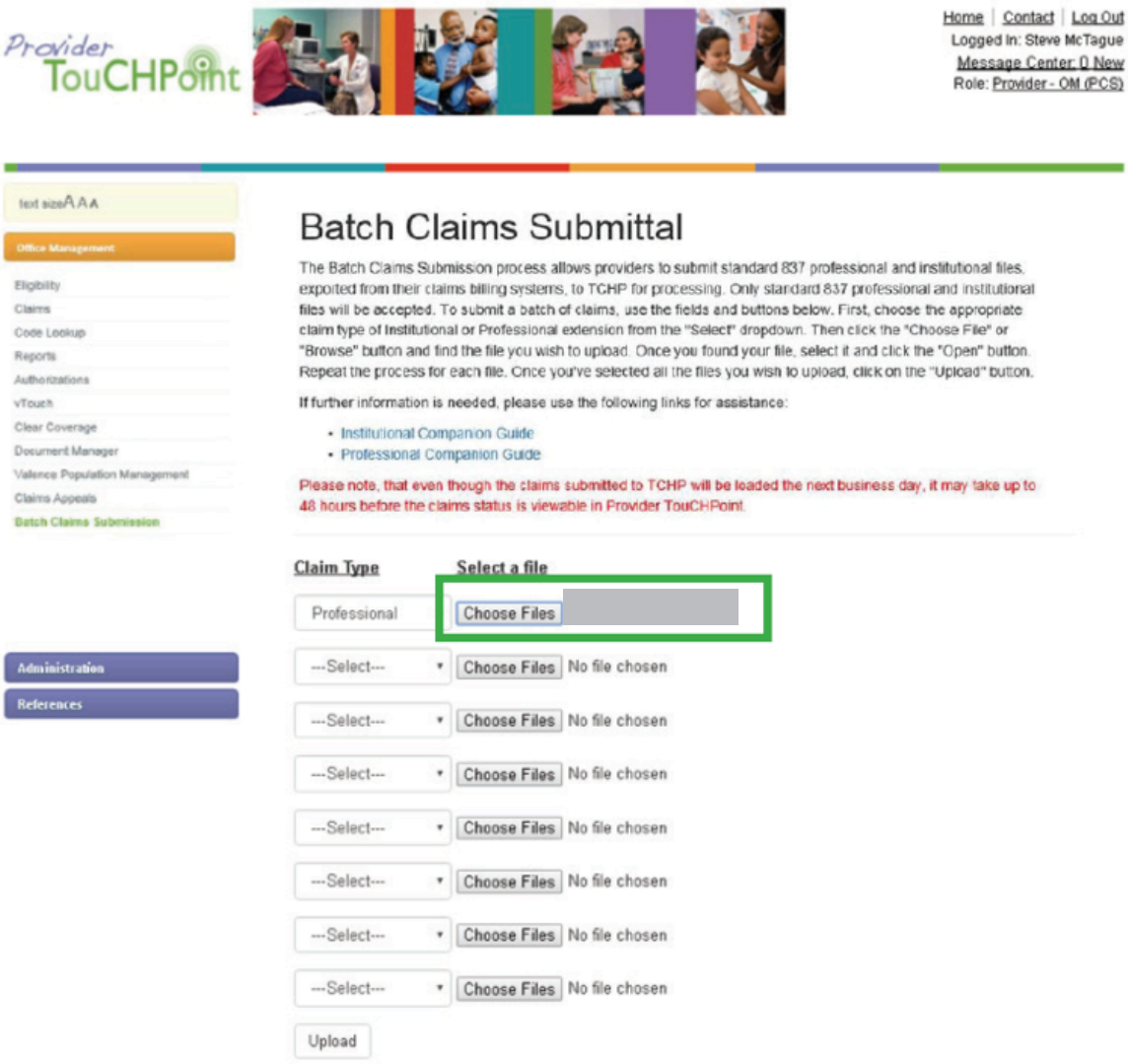
Step 2: Select the Batch Claims Submission menu option from the left navigation (highlighted in green):



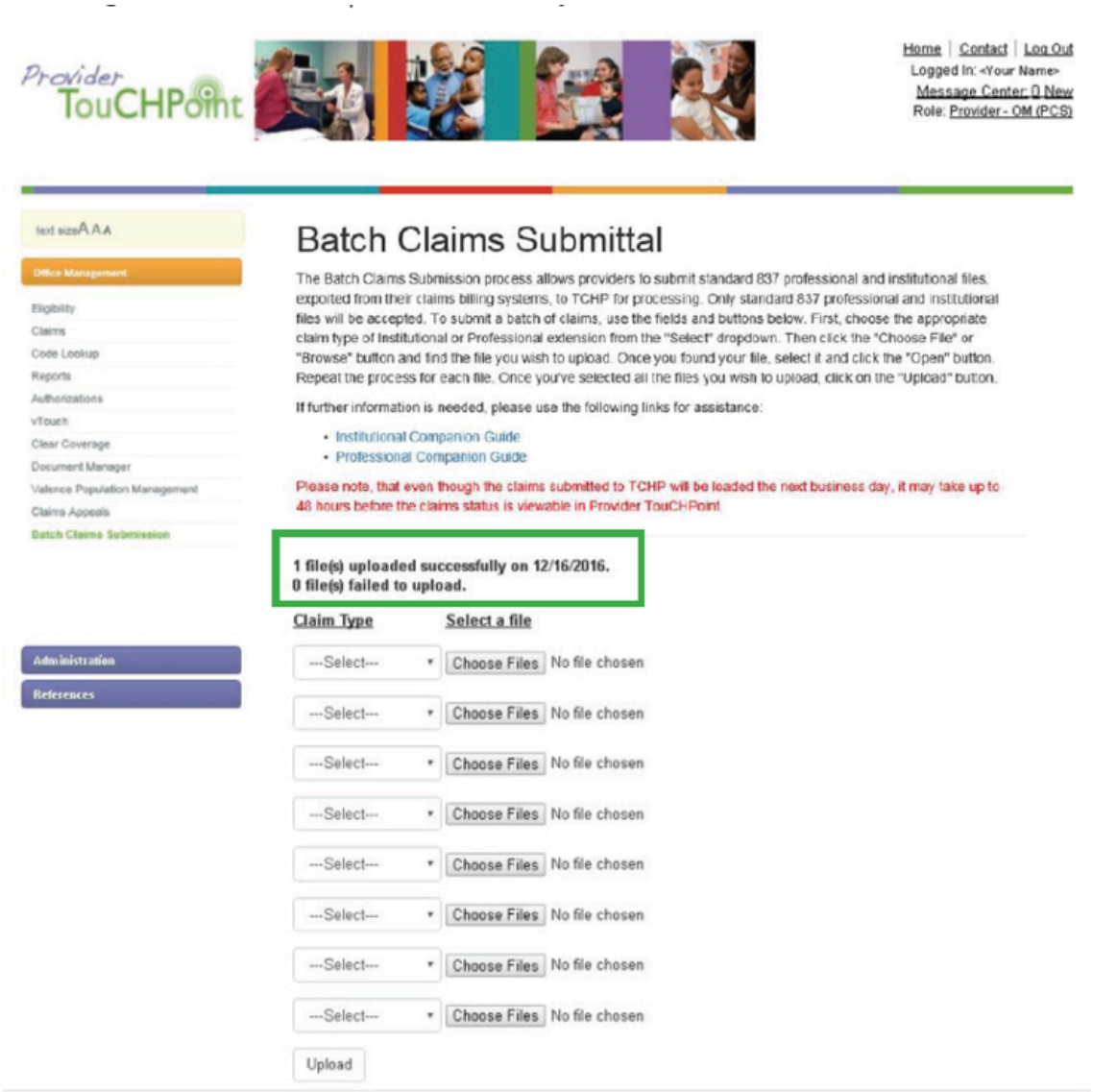
Step 3: Select the appropriate Claim Type for each file to be uploaded. Each file can only contain one type of claims.



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.

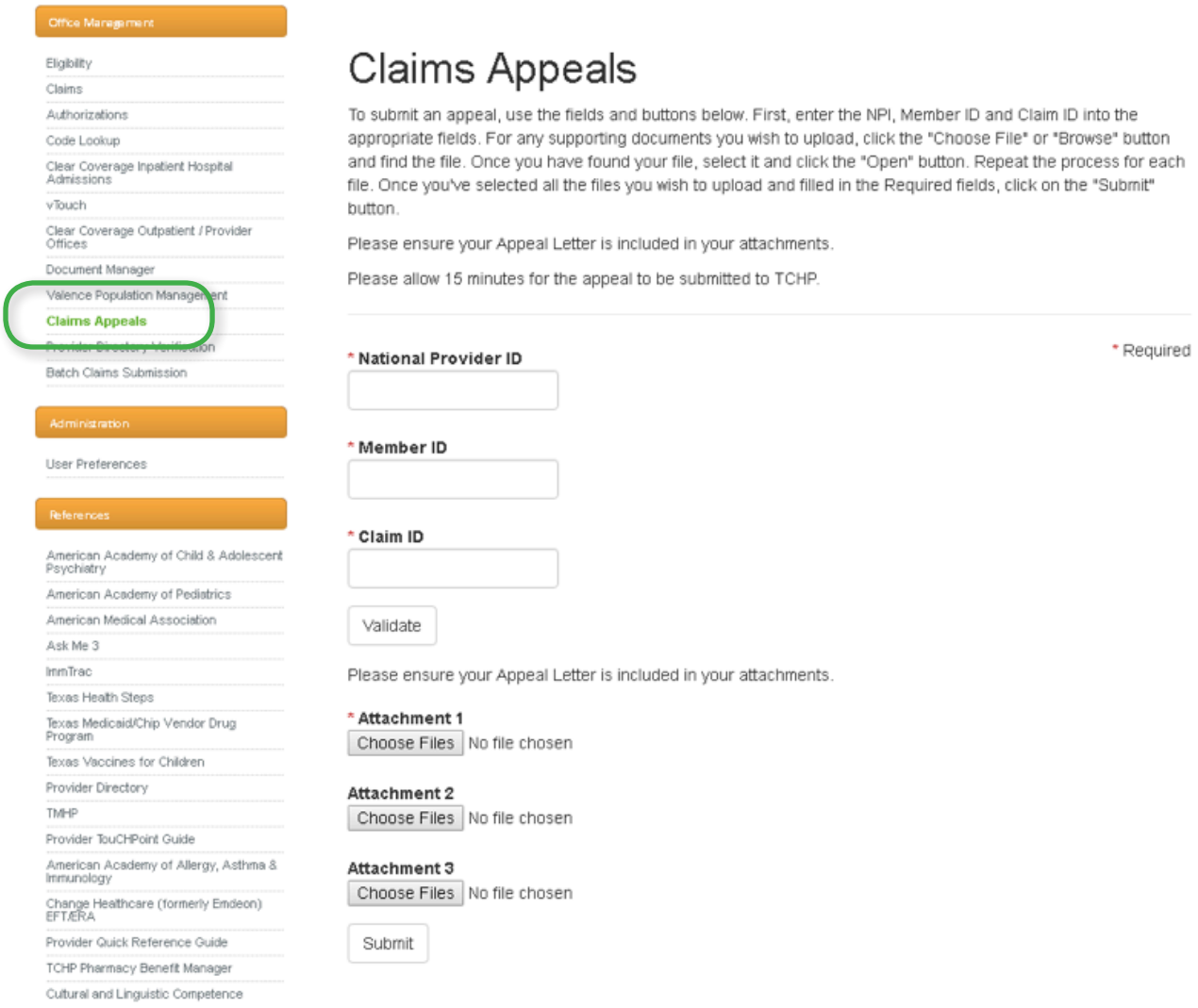


Step 5: Clicking the Upload button will upload the claims. Successful uploads will result in a message stating the number of files uploaded successfully, and the current date.

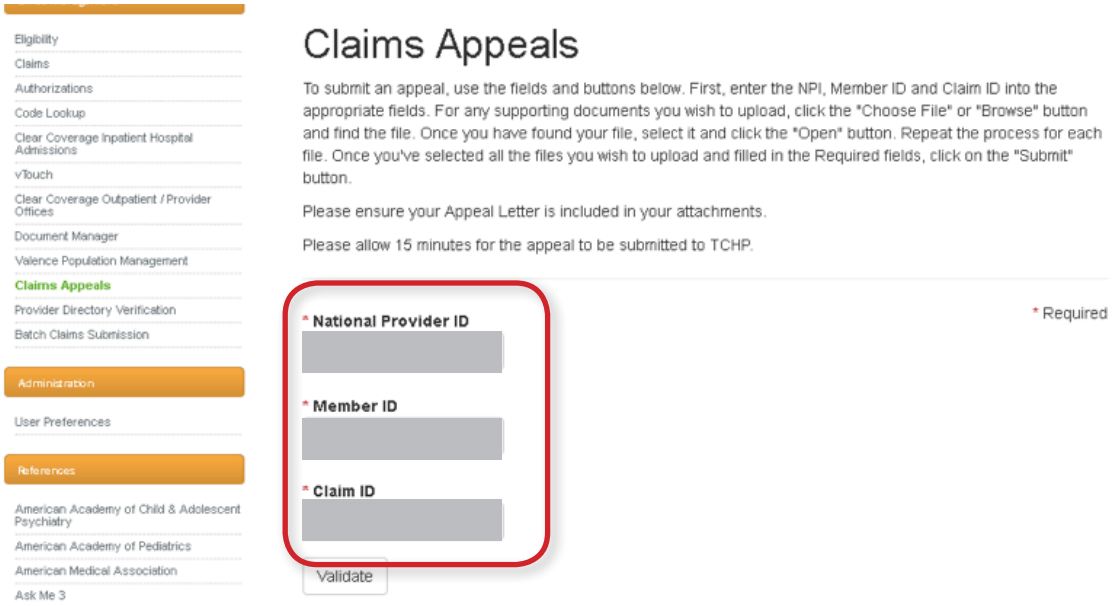


Claims appeals

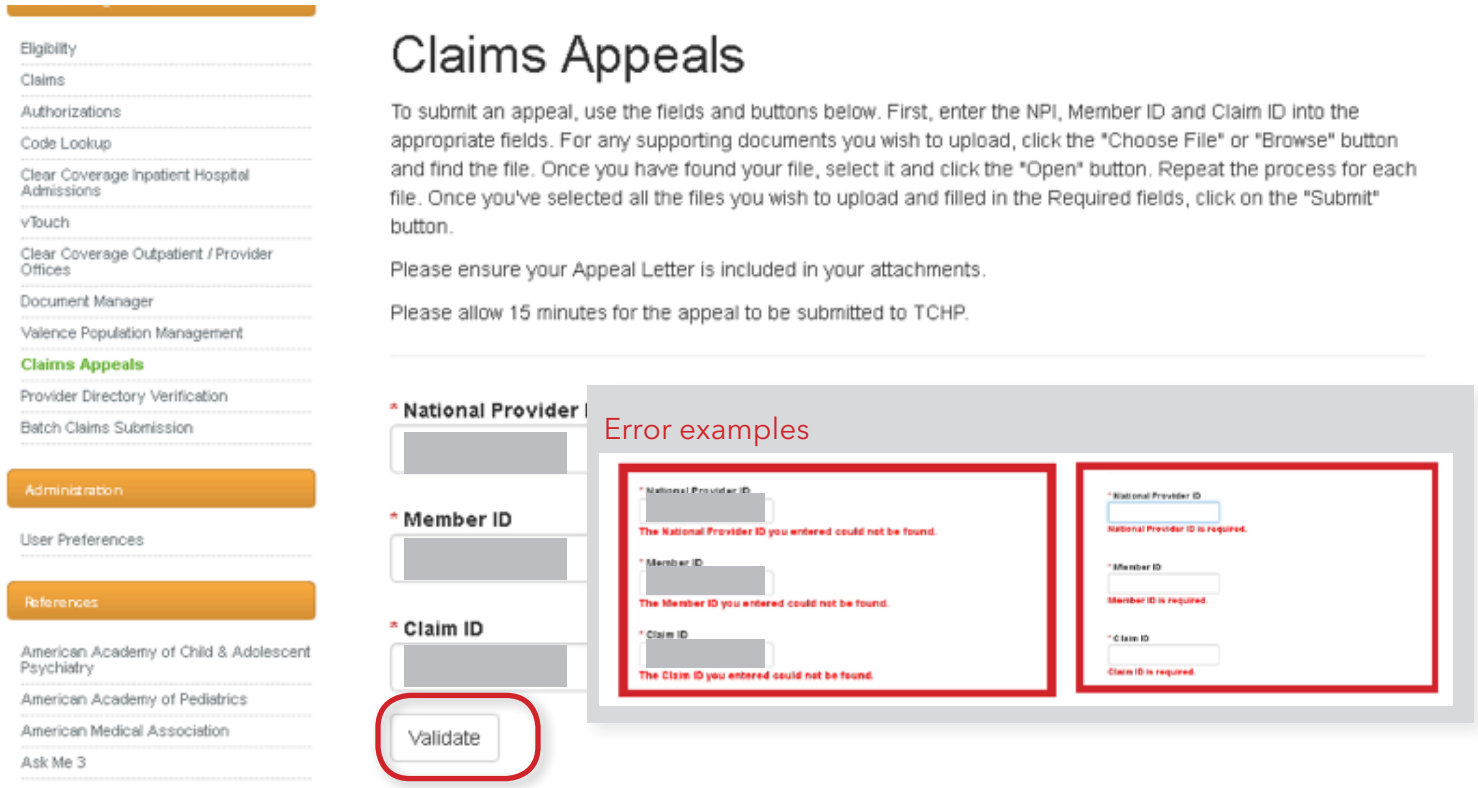
Step 1: Click on the Claims Appeals menu in the left navigation (highlighted in green below) to enter a Claims Appeal. Please ensure your Appeal Letter is included in your attachments.



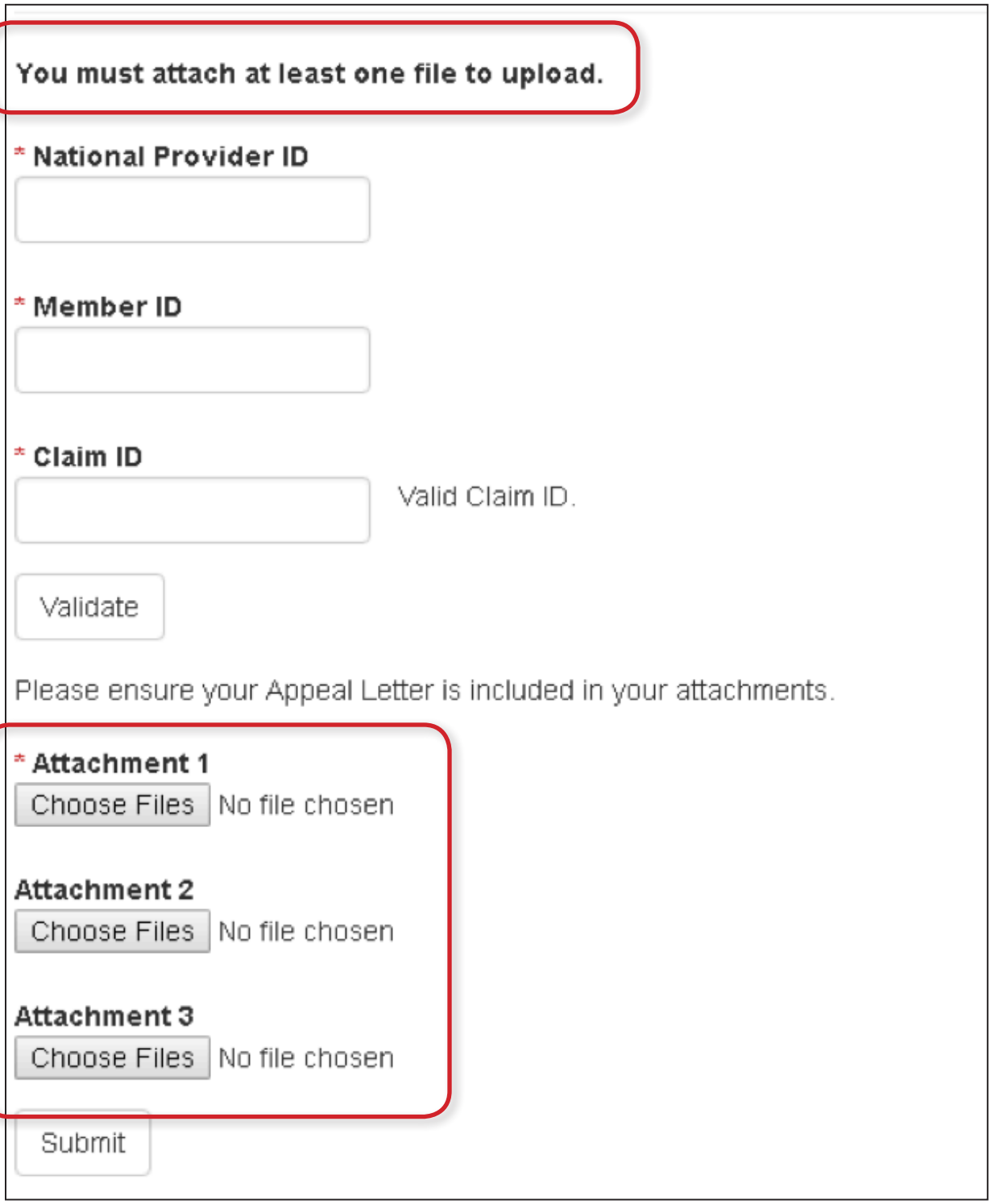
Step 2: Enter the National Provider ID, Member ID, and Claim ID associated with the claim being appealed.



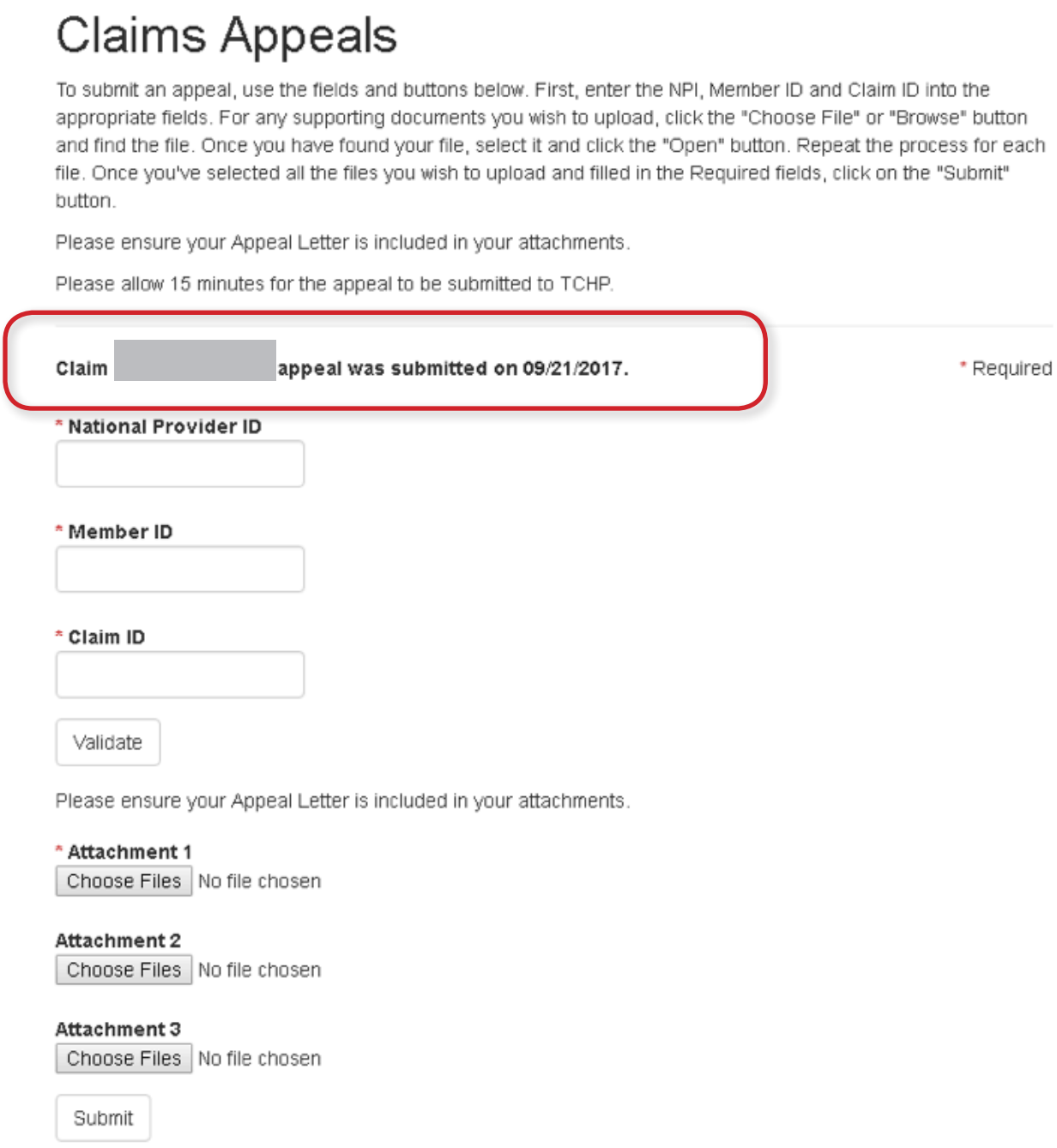
Step 3: Click the Validate button to display the provider name, member name, and date of birth.



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

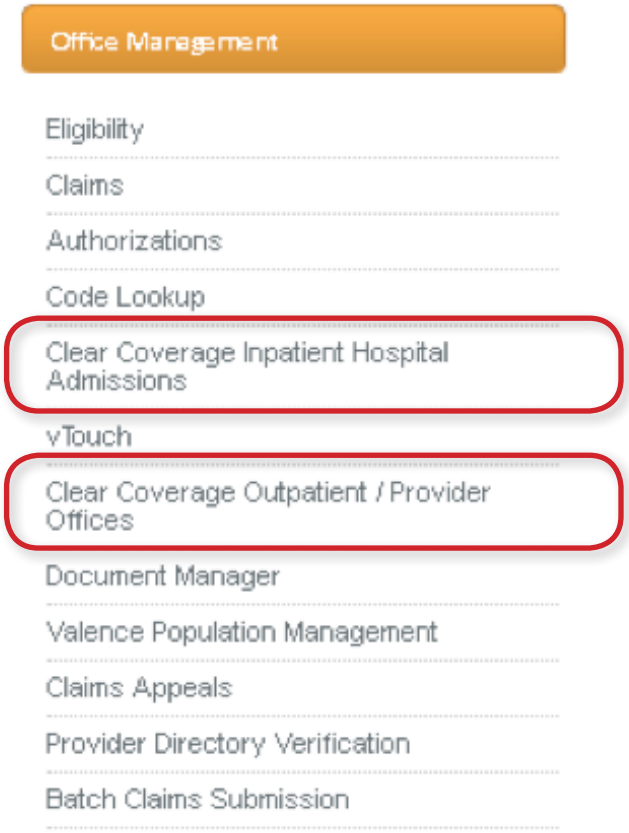


Step 5: Once all the required fields are entered, clicking the Submit button will confirm the Claim Appeal has been submitted on the current date. You may now proceed entering the next Claims Appeal.



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.



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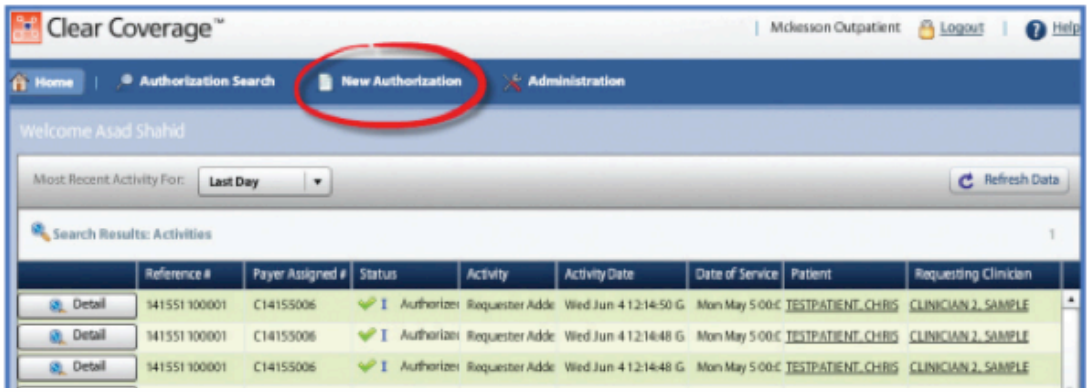
Clear Coverage™

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 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.



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Step 1: Find the Patient

Creating an Authorization Request starts with finding the patient.

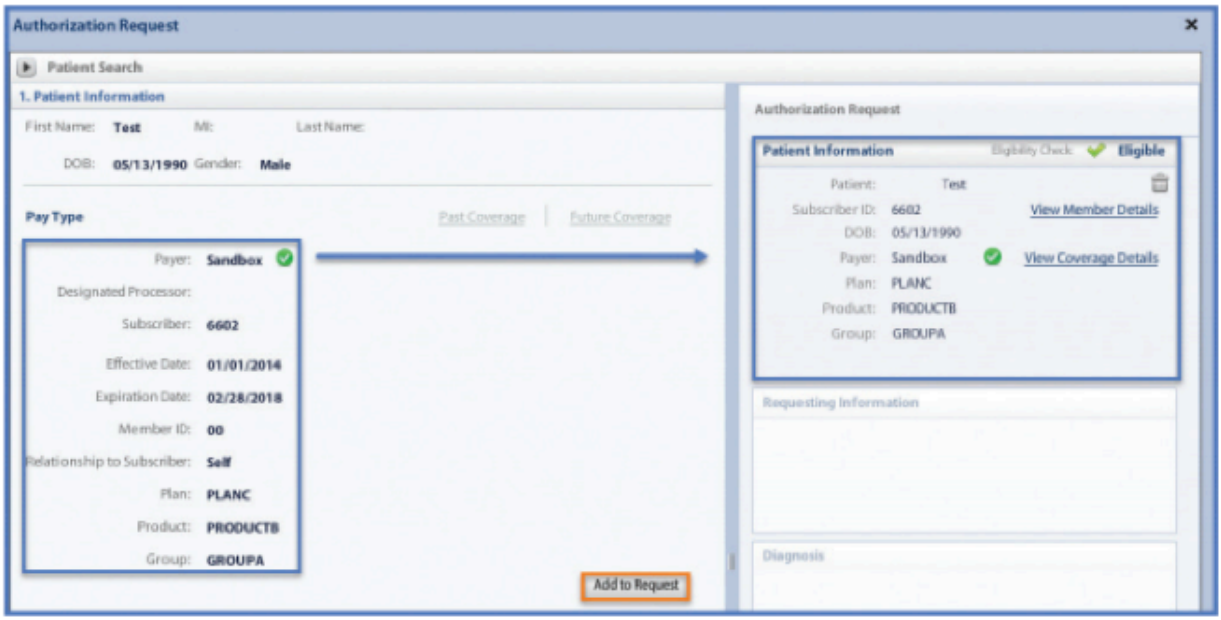
You find a patient by entering information such as the subscriber ID or the patient's first and last name in the search fields.

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**.

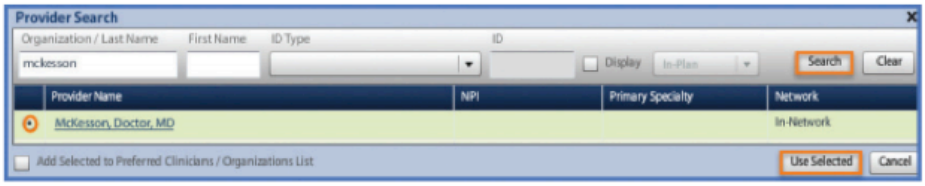
The Patient Information is added to the Authorization Request summary, and Clear Coverage advances to the Requesting Information accordion.



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 Othe 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.

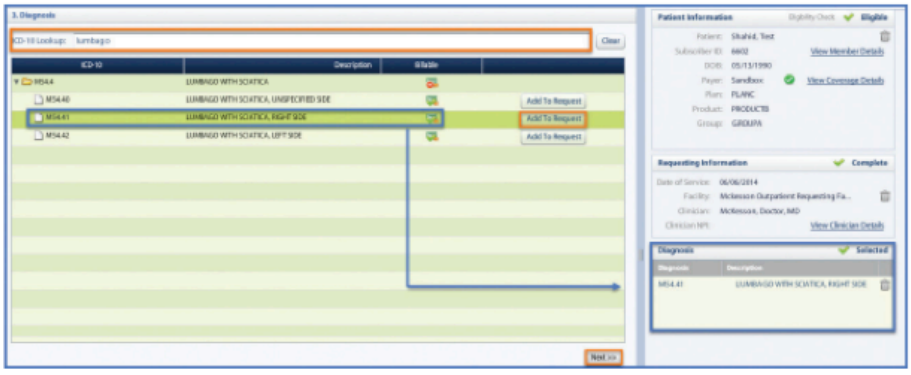
1. Search for the diagnosis by entering one of the following in the ICD Lookup:

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.



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Step 4: Select a Service

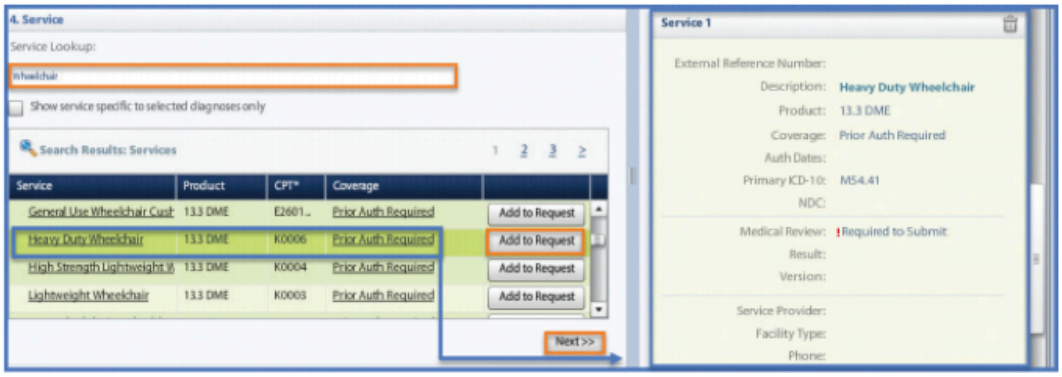
The Service accordion enables you to select the service for which you are requesting authorization.

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**.

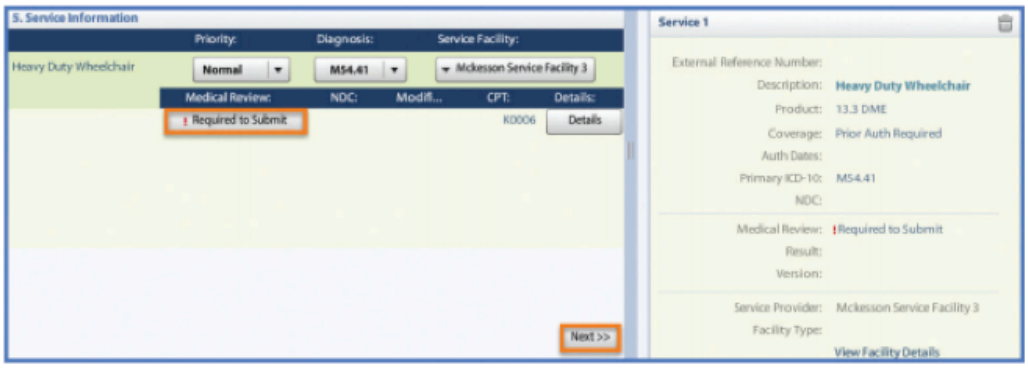


Step 5: Enter Service Information

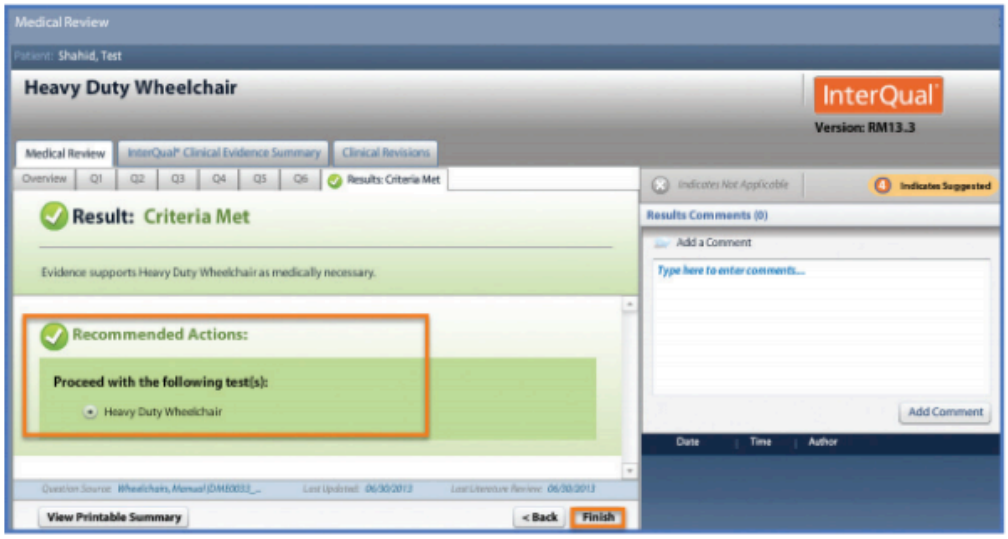
Clear Coverage uses a question and answer workflow to assess the medical necessity of the requested service. The Medical Review information is addressed below. Additional fields like Diagnosis, Service Facility, Modifiers, and on may be required to complete prior to submission. Required information will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



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 Completed 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.

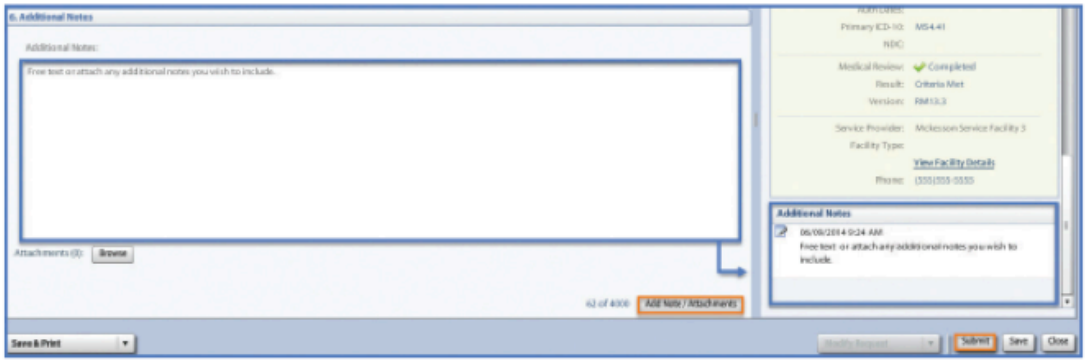
Note: You may copy and paste information from the EMR to support the request. There is a 4,000 character limit in this free text field.

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).

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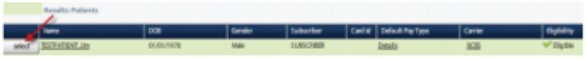
Quick Reference Guide

Clear Coverage™

Start by logging into Clear Coverage Outpatient / Provider Offices.

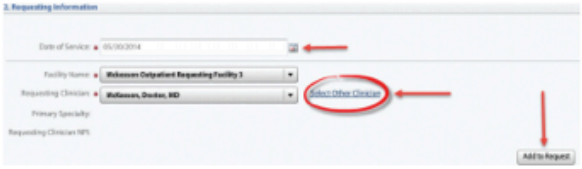
1. After logging in, click **New Authorization** at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**.

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



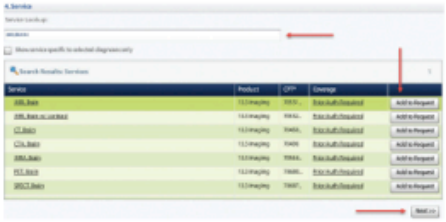
4. Verify the patient's information, and then click **Add to Request.**

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.**

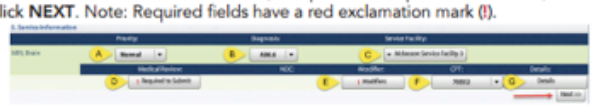


6. In the Diagnosis accordion, search for a specific billable diagnosis, click **Add to Request**, and then click **Next**. Search by entering a diagnosis description or ICD-10 may be entered.

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.

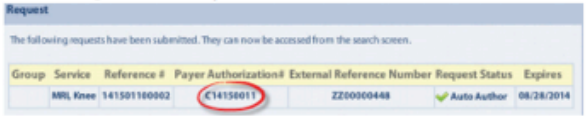


8. In the Service Information accordion, complete the required information, and then click **NEXT**. Note: Required fields have a red exclamation mark (!).



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.

Updated 5/14/17

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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.

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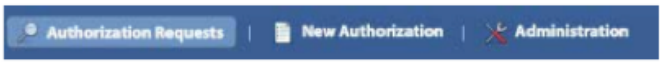
2

Clear Coverage Tabs

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

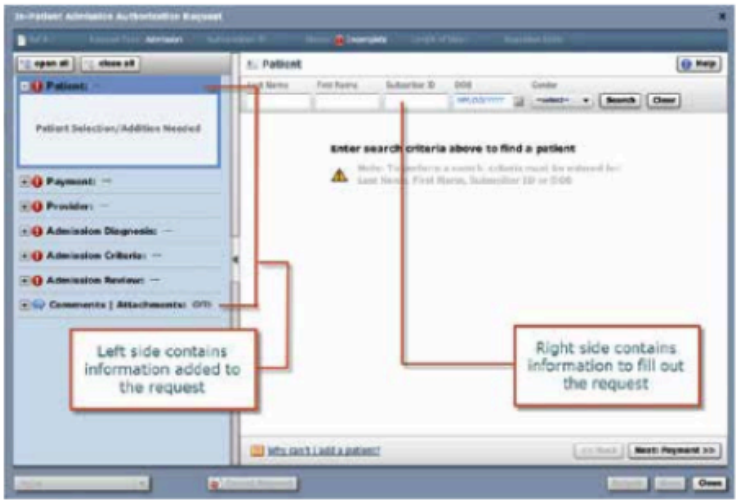


- Search Authorization Requests
- New Authorization Requests
- Administration

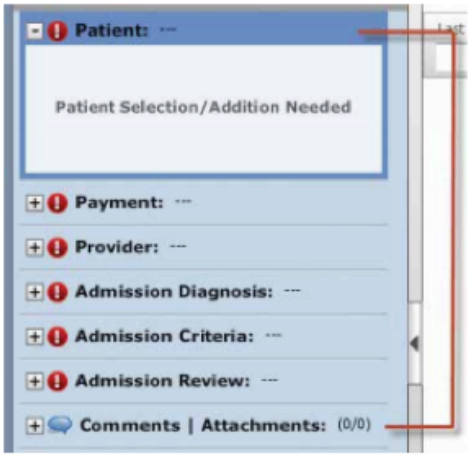
New Authorization Request Overview

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.

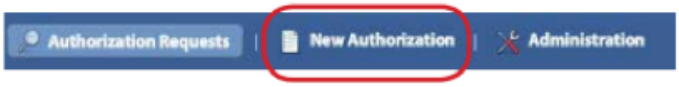


Click on the Accordion Headers on the left to switch from area to area.



Creating a New Authorization Request

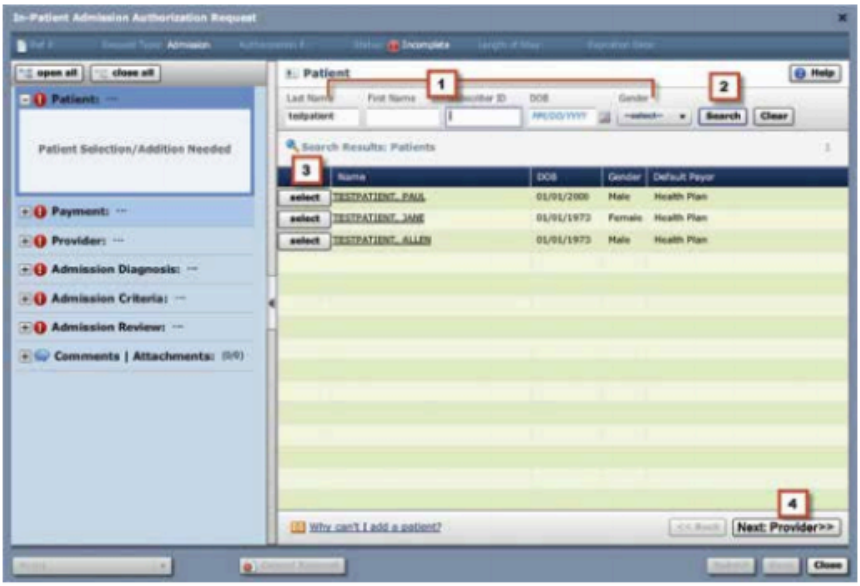
Click on the "**New Authorization**" tab to open the workflow available on this tab.



Step 1: Patient Search

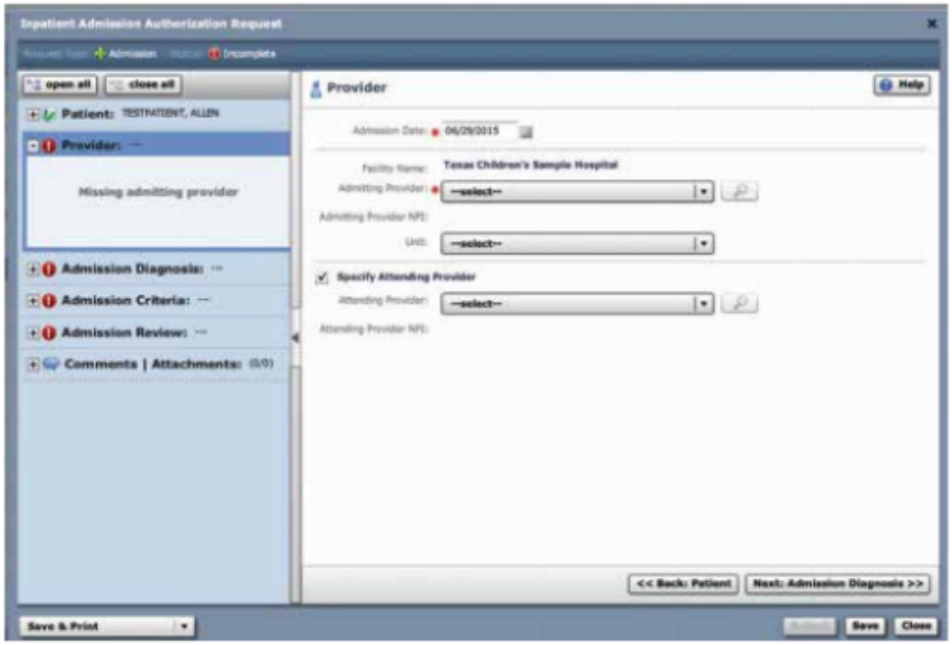
Creating an authorization request starts with selecting the Patient.
Using the Search function, a Patient can be found with a few letters of their first or last name. If you have the member or subscriber ID of the patient, you can use that as well. The same search criteria options that are used for Outpatient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



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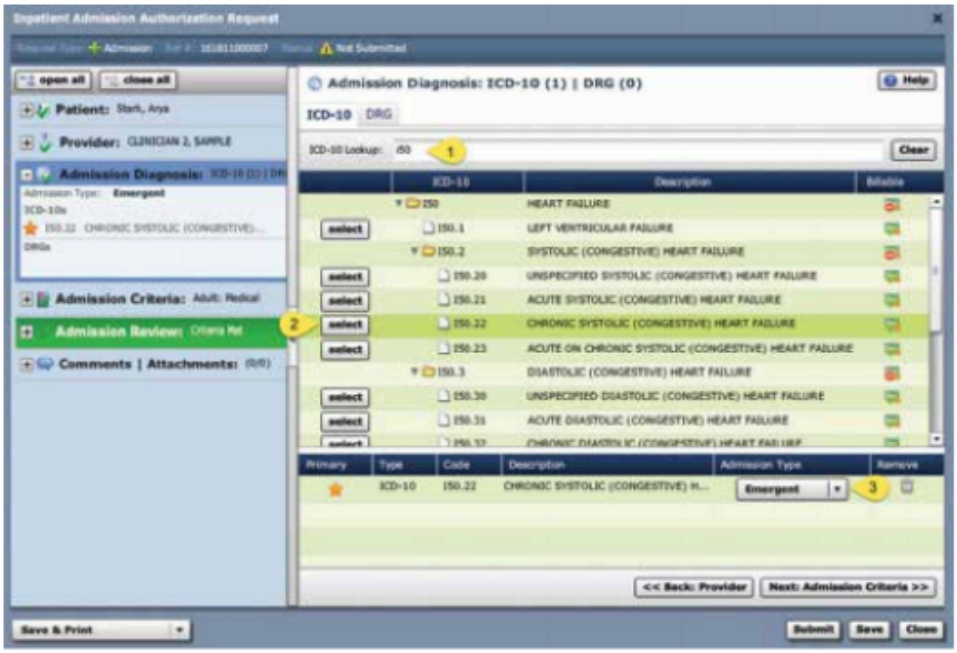
Step 3: Admission Diagnosis

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.

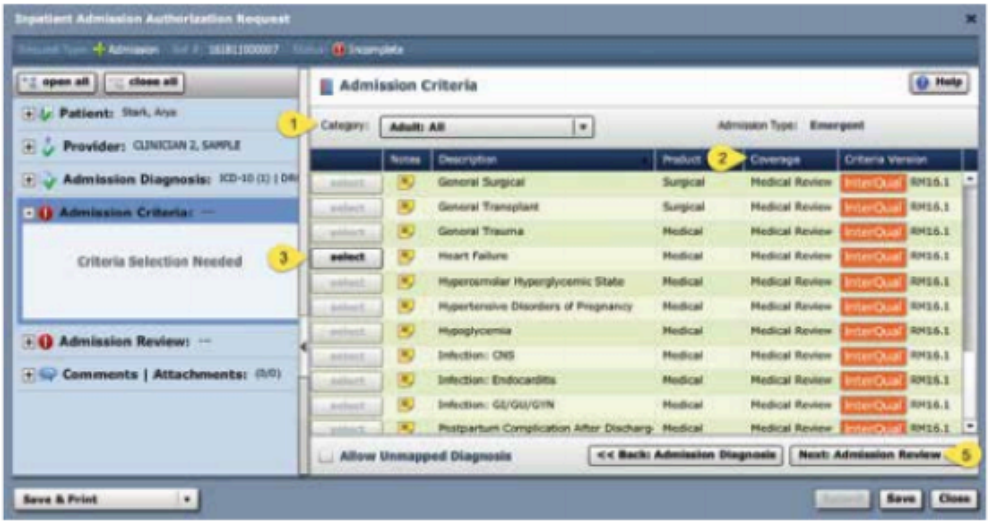
1. Search for the diagnosis using one of the following methods:
   a. Part of the clinical diagnosis description (e.g. "Heart Failure")
   b. ICD-10 or DRG code (e.g. "I50.22")
2. When you find the appropriate diagnosis code, click the "**select**" button next to the diagnosis. (The Diagnosis is added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



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

Texas Children's Health Plan

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.

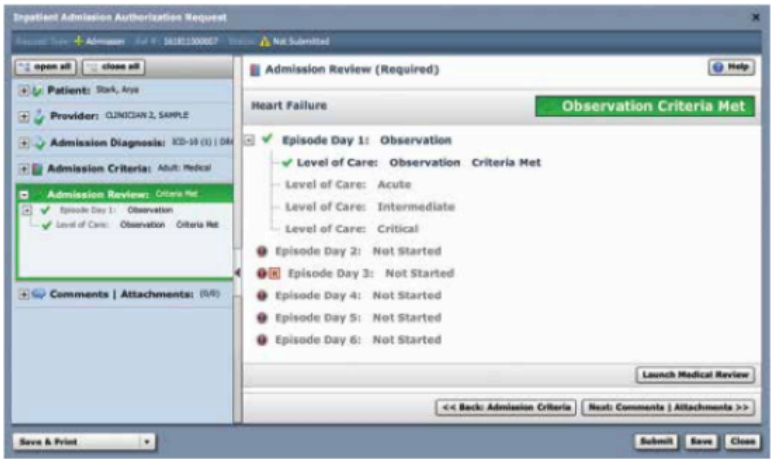
1. Click on the "**Launch Medical Review**" button to launch the Medical Review.
2. Provide the appropriate responses for your specific patient and clinical situation.
3. Upon completion of the Medical Review, you will receive a outcome on the medical appropriateness of the admission based upon the best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

MCKESSON

Clear Coverage™

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

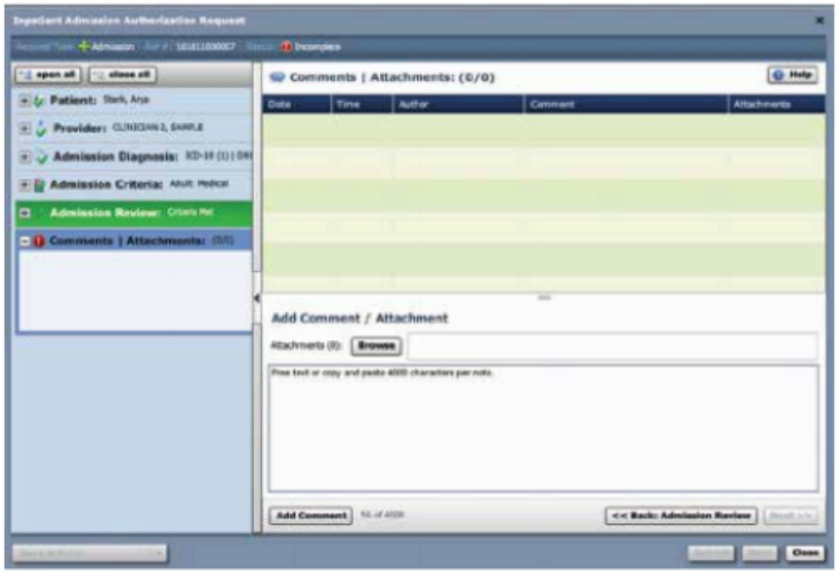
The **Comments I Atttachments** section allows you to provide any additional notes to support your Authorization Request.

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.



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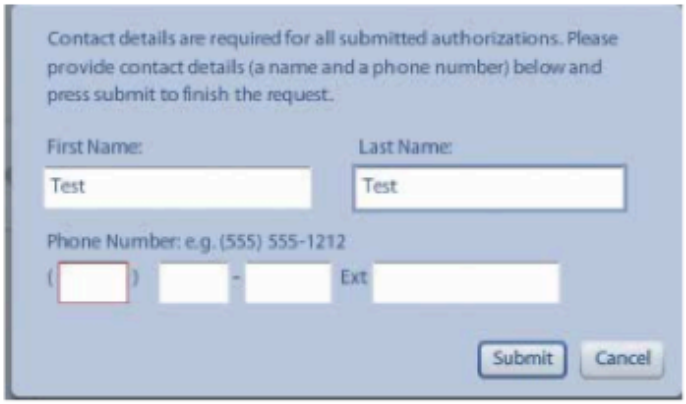
"Save" or "Submit" an Authorization

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).

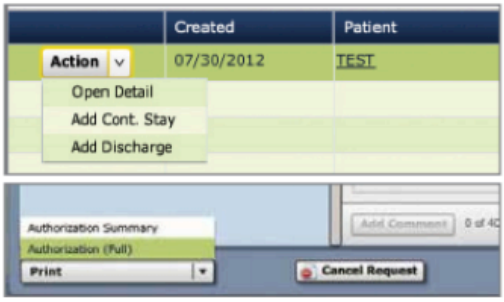
ii. Clear Coverage will record the Request with an **Internal Reference #**, a 12 digit number (Ex. "012345678901").

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 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.



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:

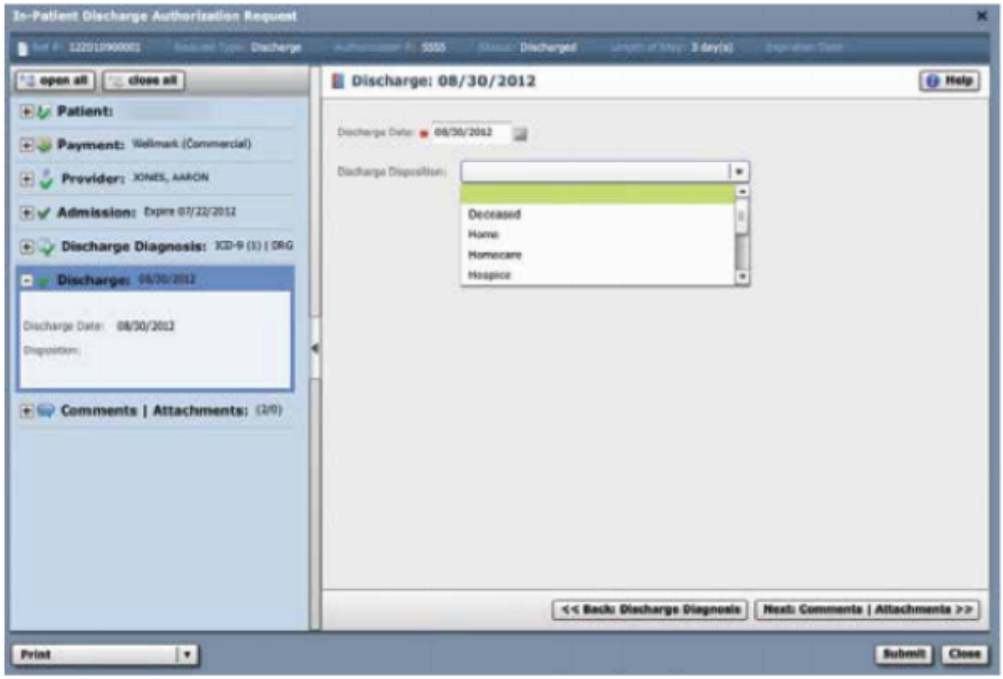
1. Locate the patient on the "**Authorization Request**" tab.
2. Click the "**Action**" button next to the patient and select "**Add Cont. Stay**" from the drop down menu.
3. Enter a new Diagnosis if different from the original, or continue on to the Cont. Stay Criteria.
4. You may or may not be required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



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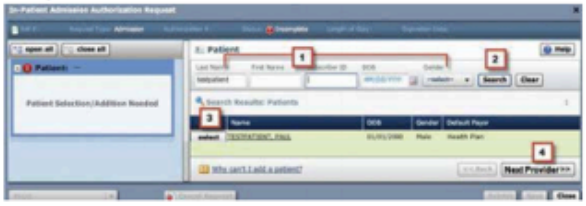
Quick Reference Guide

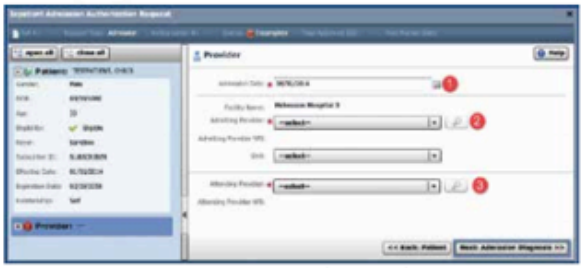
Clear Coverage™

Start by logging into Clear Coverage.

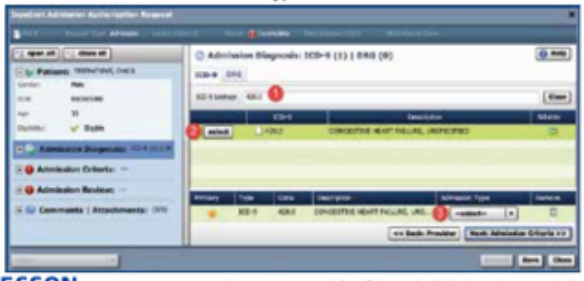
1. After logging in, click New Authorization at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**. Note that fields with a red asterisk (*), if noted, are required to search.
3. In the Search Results, click **select next**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



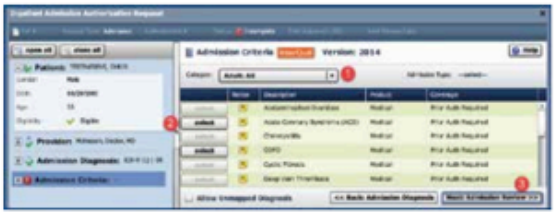
5. In the Provider accordion, select the **Admission Date** followed by the **Admitting Provider** (Facility) from your preferred clinician list. You may also choose a facility by clicking on the icon. **Click Next: Admission Diagnosis**



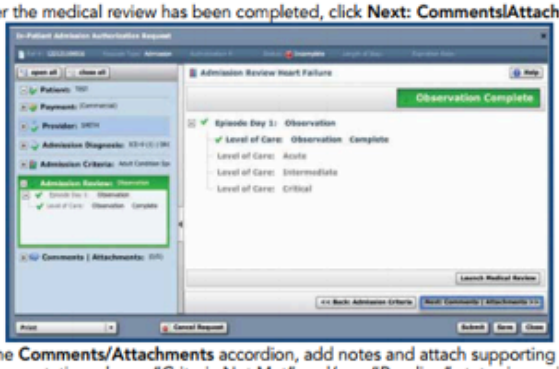
6. In the Admission Diagnosis accordion, search for a specific billable diagnosis, click **Select**, and then select an **Admission Type. Click Next: Admission Criteria**



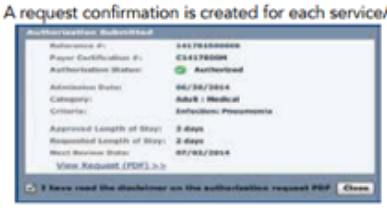
7. In the Admission Criteria accordion, start by selecting the category of your admission criteria. Click **Select** next to the appropriate service and then click **Next: Admission Review**



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.

 Updated 4/14/17

Additional Clear Coverage help is located on the home page.

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.

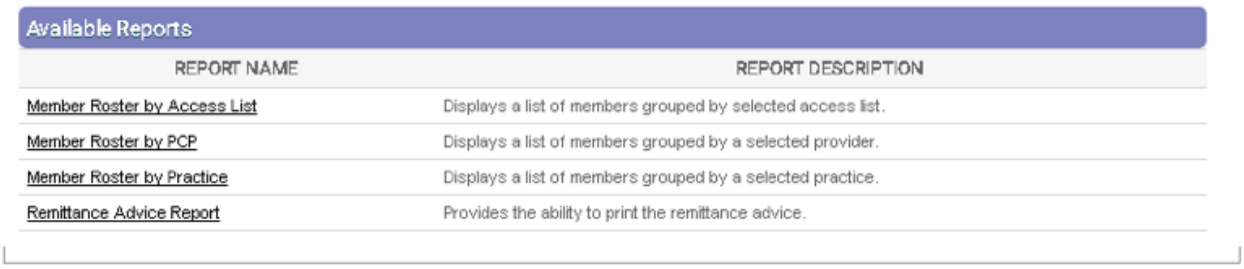
Step 5: Type in your subject and content. You can also attach documents and check the Mark Urgent box for your message. When finished, click the Send button.

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.



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.

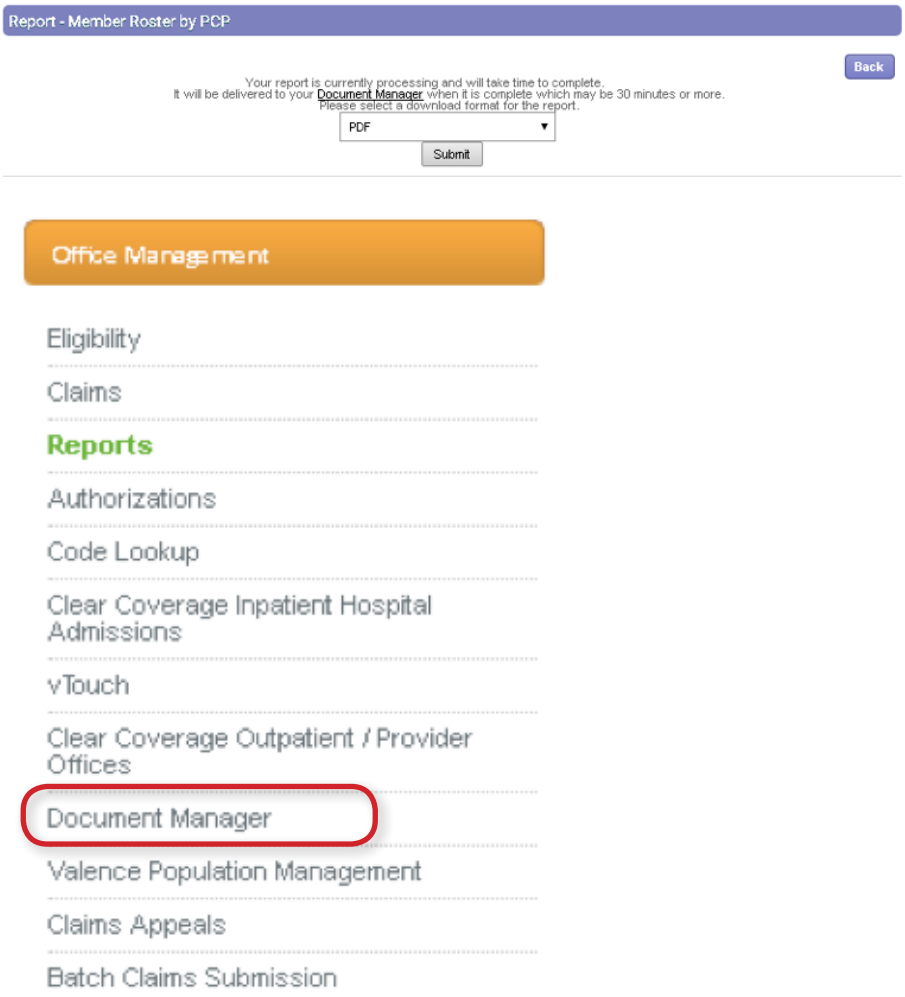
Step 5: Select the type of report format you want

- PDF
- Excel
- CVS

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

Step 6: Click the Submit button.

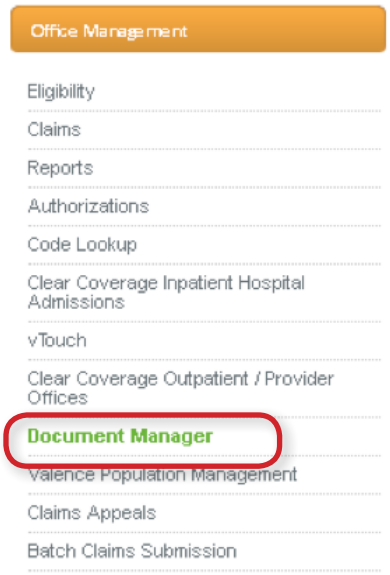
NOTE: If your panel report has more than 2,000 members, your report will be sent to the Document Manager.



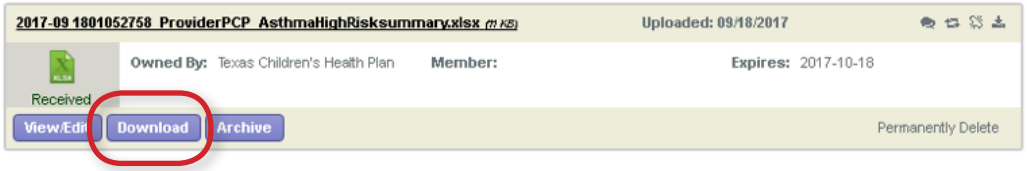
Document Manager

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.

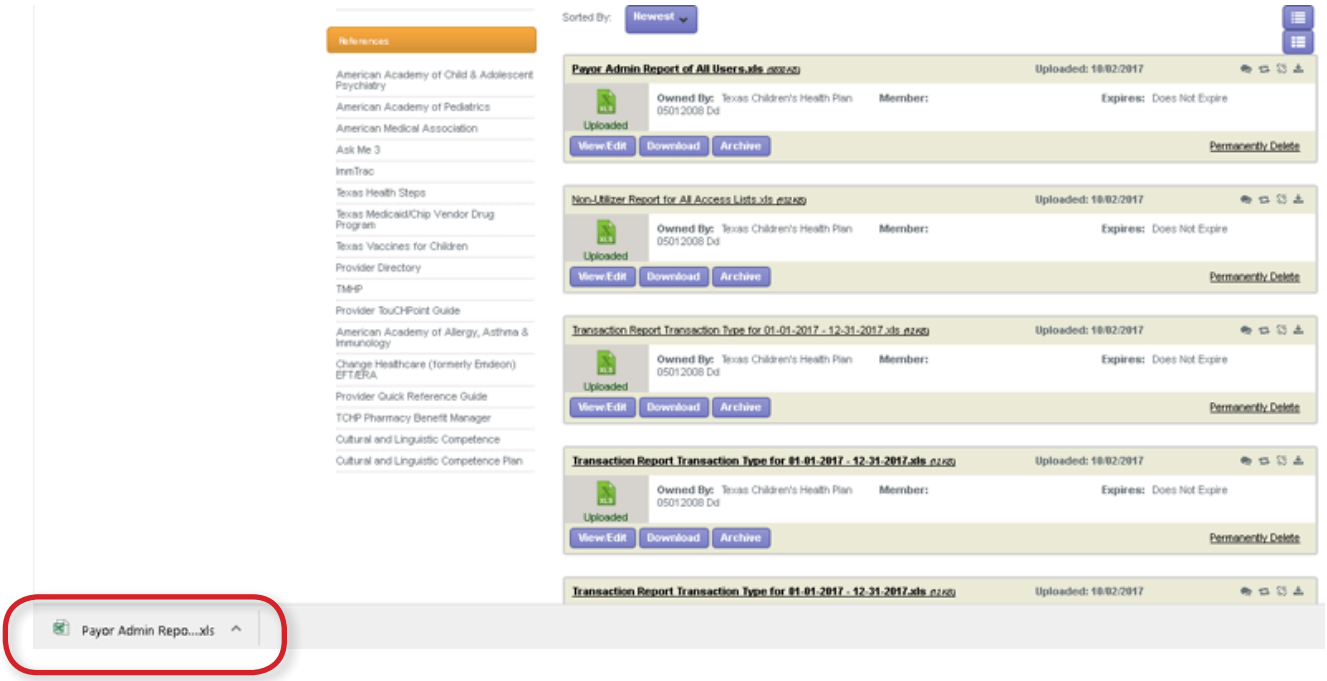
Step 1: Click on the Document Manager button under the Office Management section.



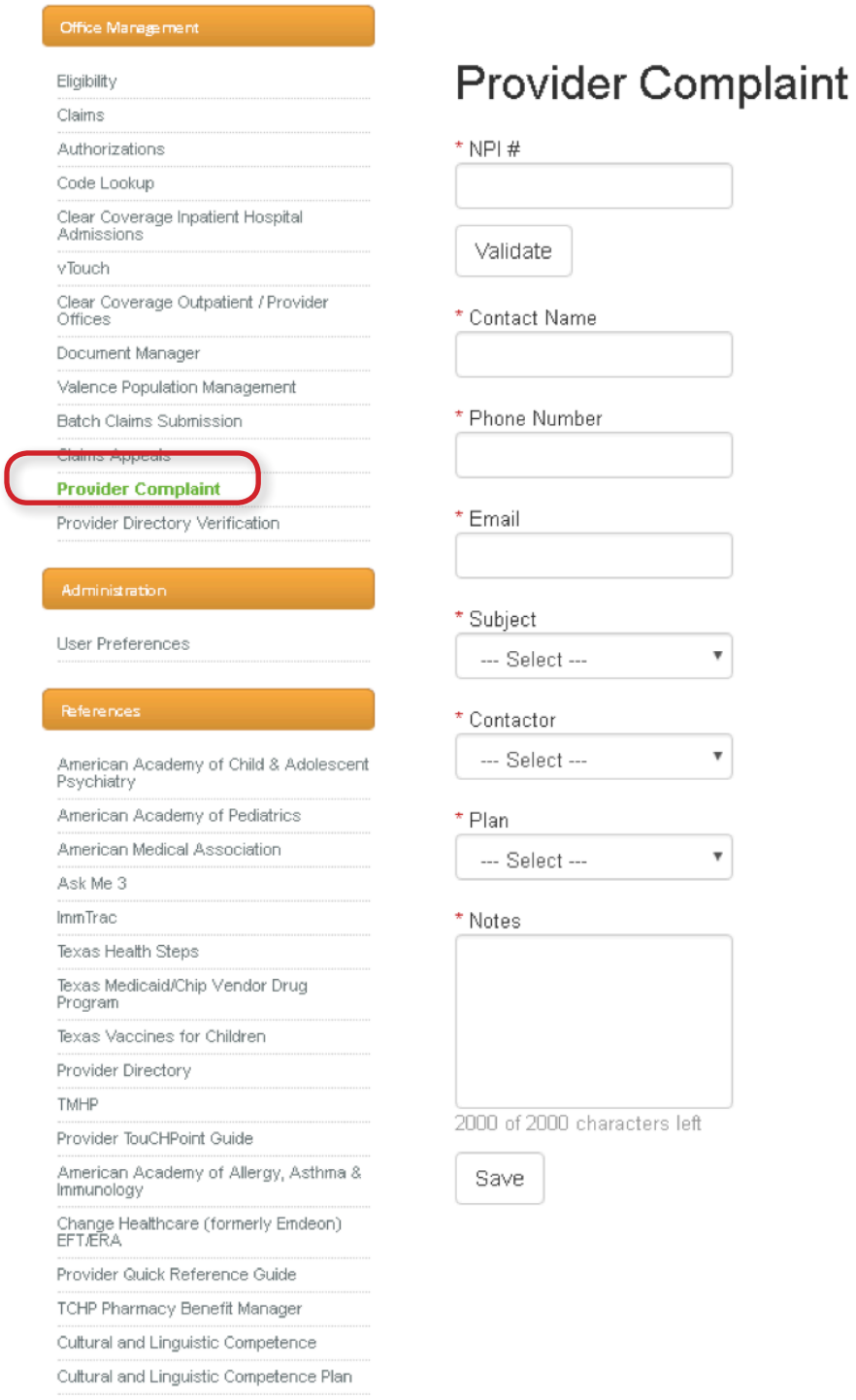
Step 2: Click on the Download link



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.



Provider Complaint



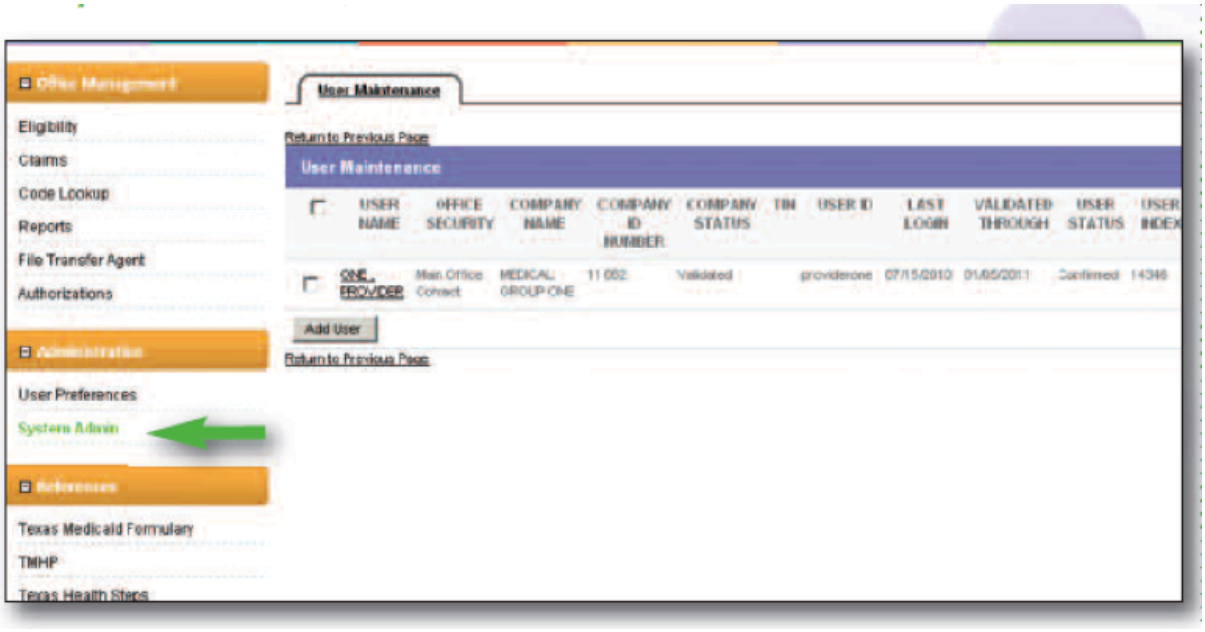
System Administration/User Maintenance

Adding an additional user

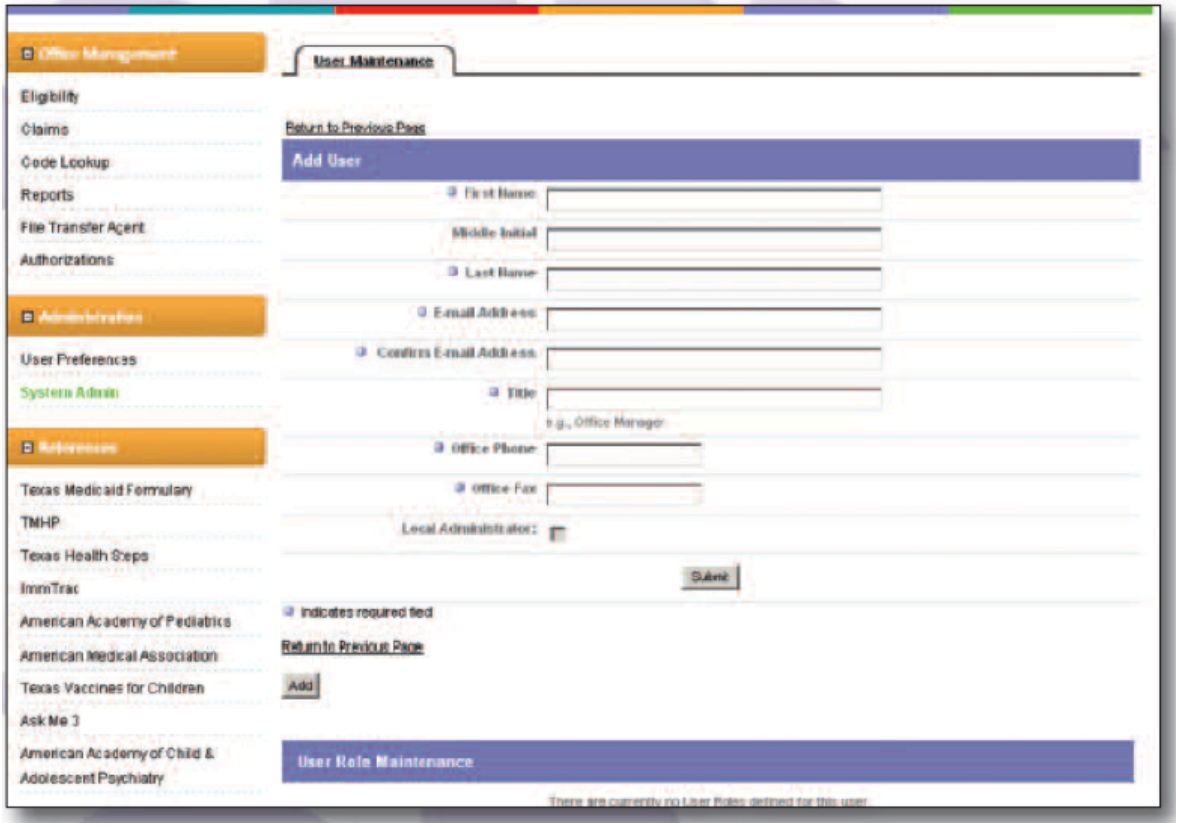
If you need to add or remove a user, you can use the system administration/user maintenance feature.

Step 1: Click on the System Admin link under the Administration section.

Step 2: To add a user, click the Add User button.

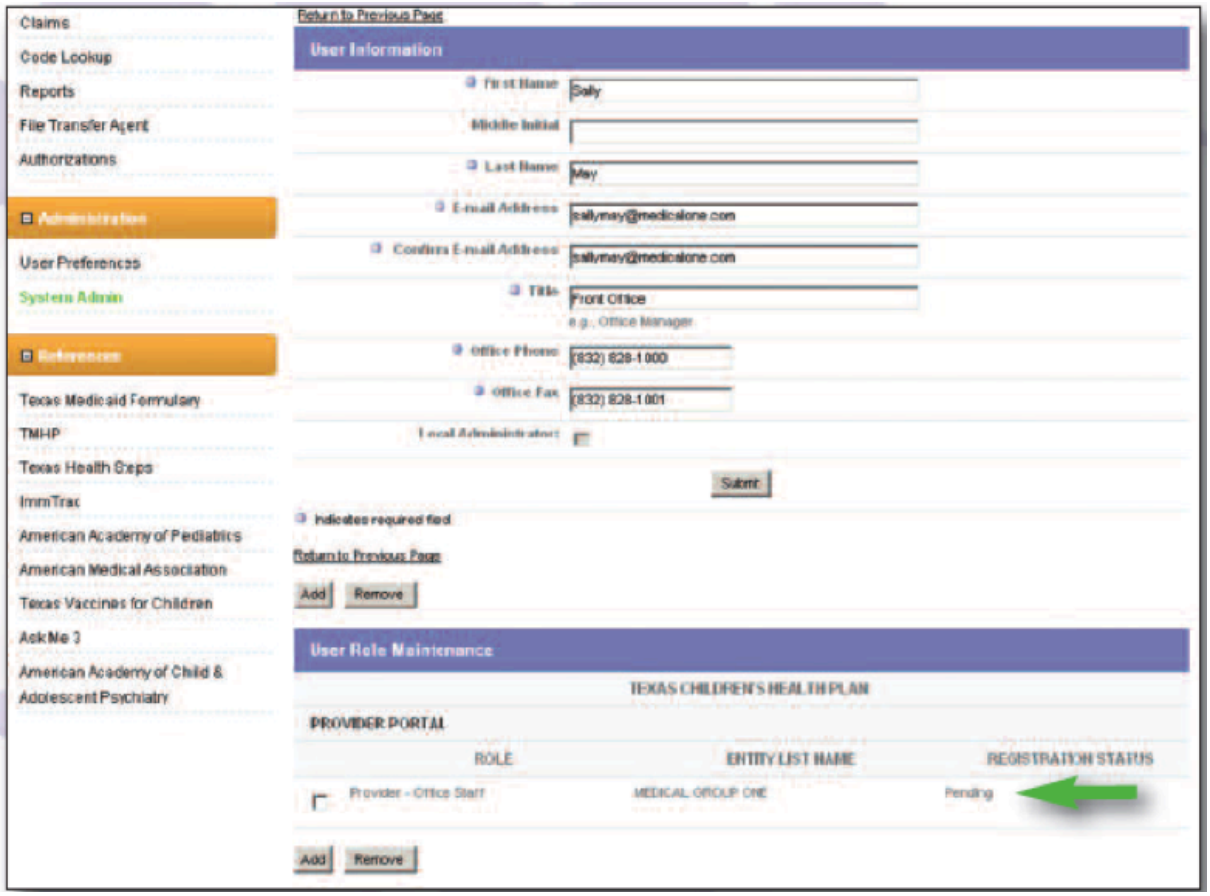


Step 3: Enter the new user information and click the Submit button.



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 Submit button.

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



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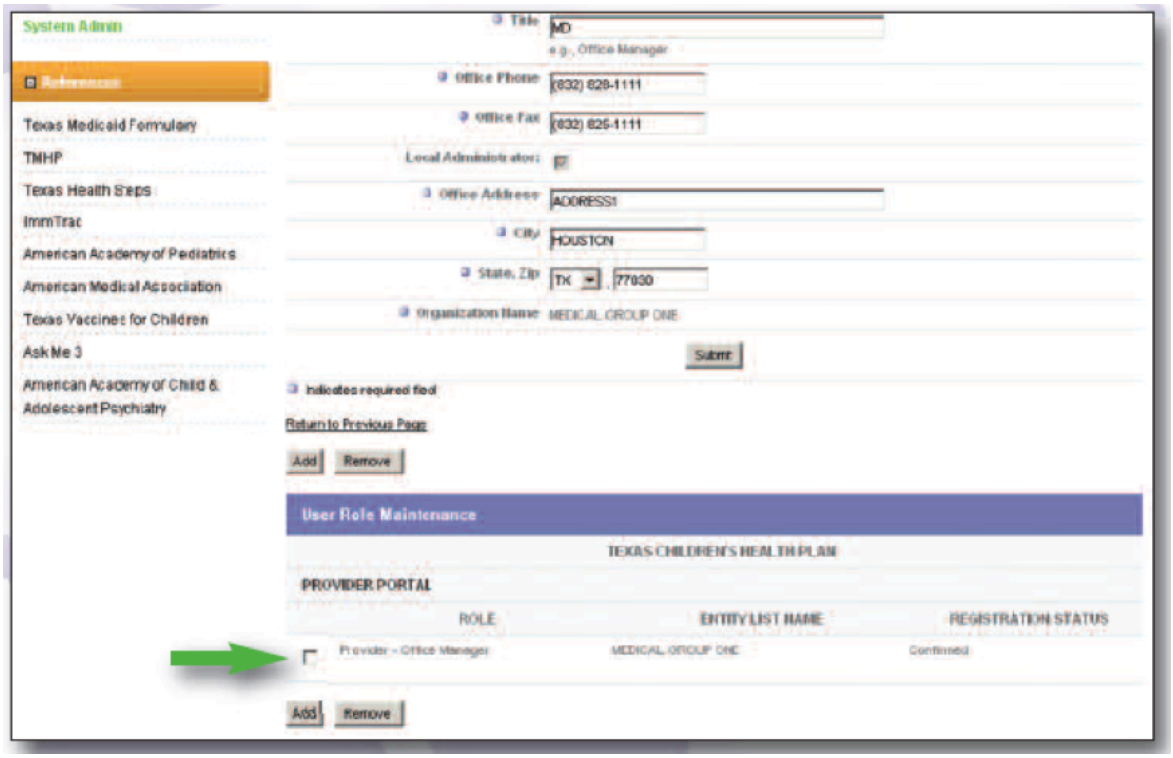
Once TCHP confirms, the user status will change from "pending" to "confirmed." The office administrator will receive an email with the user's temporary password. The office administrator must forward the user name (found in user maintenance) and temporary password for the initial login.

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 submit button.

Step 5: Click on the button next to the old role.

Step 6: Click on the Remove button

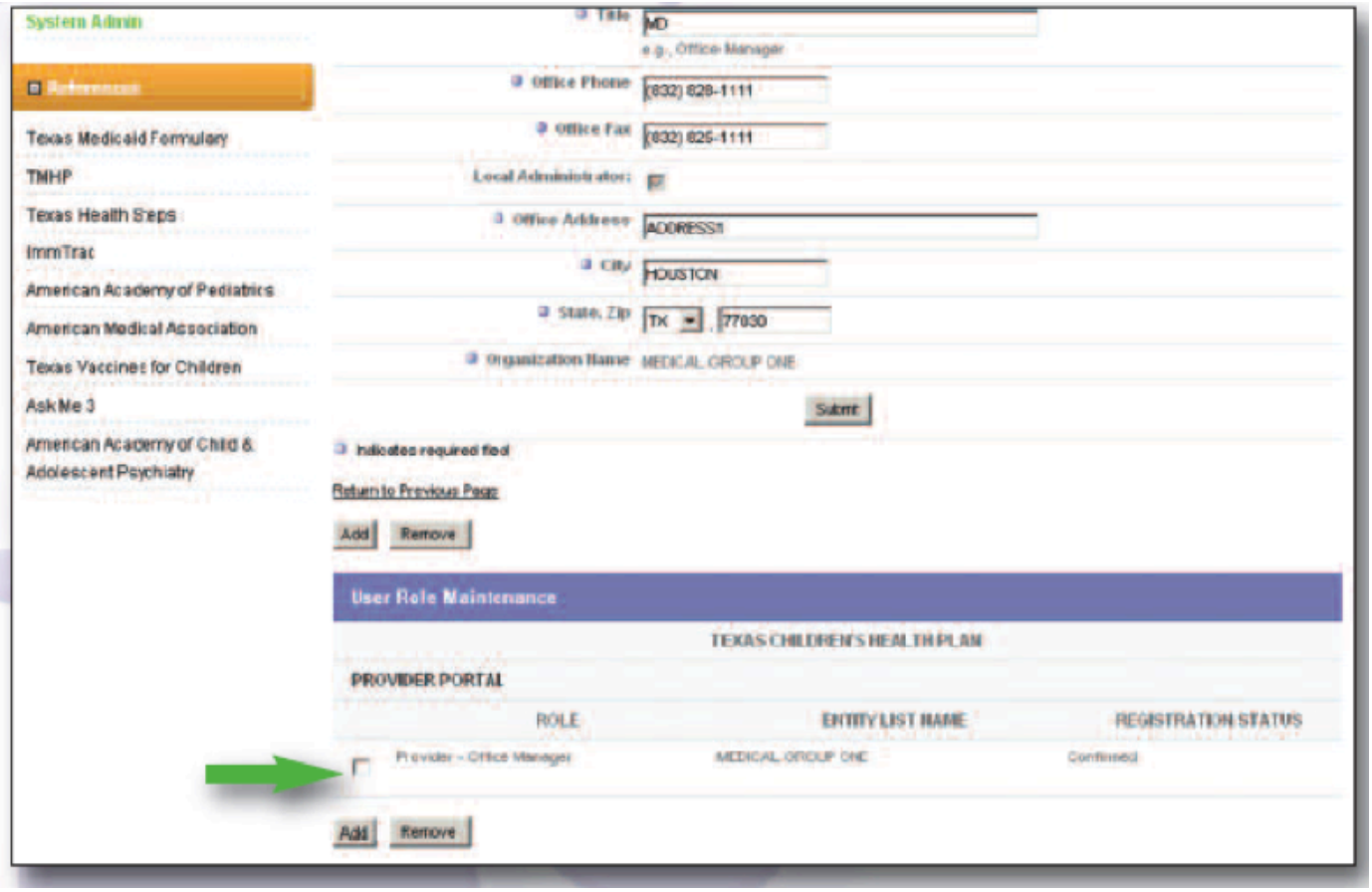
Under the User Role Maintenance section, you will see the user role change confirmed.

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 receive confirmation the user was removed.