Secure Provider Portal Overview

Agenda

- Introduction
- Registration and Provider Resources
- Account Management Role and Tasks
- Account Details
- Portal Features and Benefits:
  - Member Eligibility
  - Patient List (only PCP / PCP Organizations)
  - Viewing and Submitting Authorizations
  - Viewing Claims Information
  - Claim Submission

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Secure Provider Portal Introduction

Secure Provider Portal Introduction

The Provider Portal allows providers to:

- Check eligibility
- Submit, correct, and check claim status
- Submit and view prior authorizations
- View patient care gaps
- And much more

All at no charge….***FREE!***

Secure Provider Portal General Information

- Driven by Tax ID Number (TIN)
- Performs best in the current version of Chrome
- Does ***not*** house member, provider, claim, or authorization data, it merely displays information from our back-end systems

Tip: Generally, when there is an issue, if the portal matches the back-end system, it is not a portal issue.

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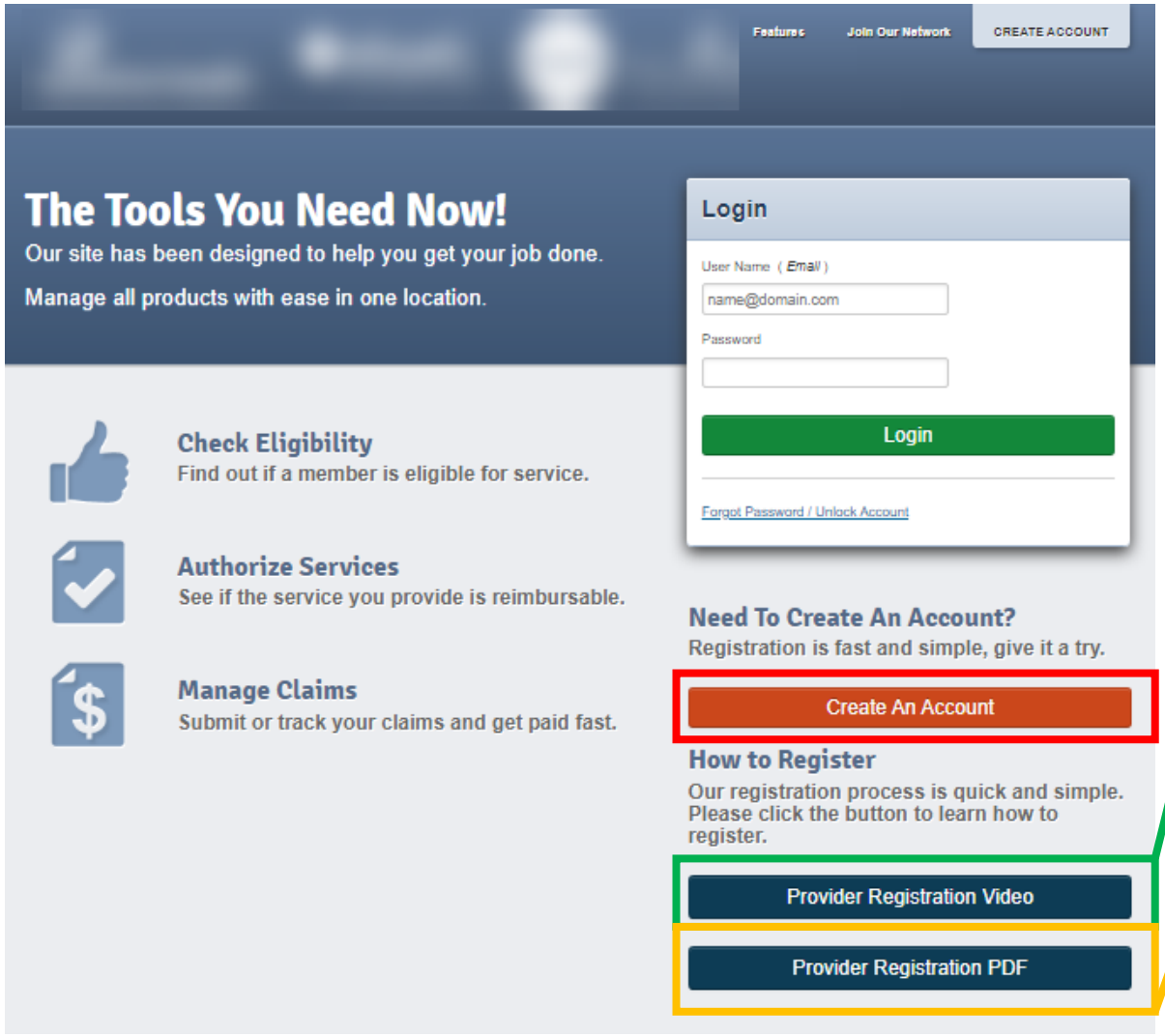
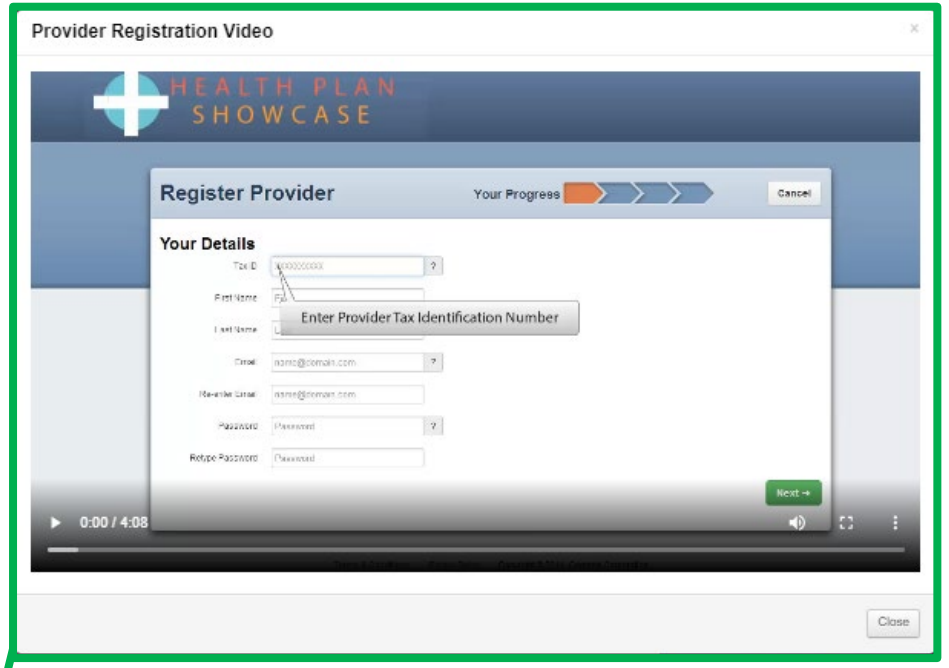
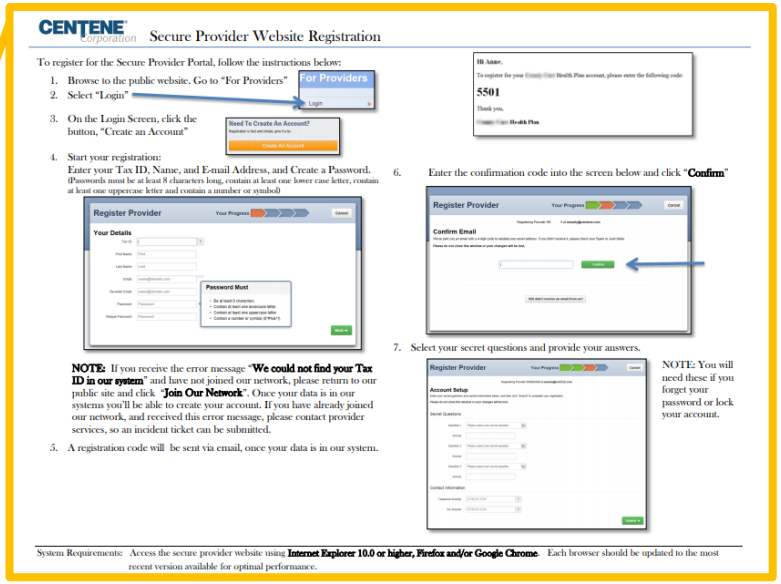
Provider Portal Registration & Login

Portal Registration

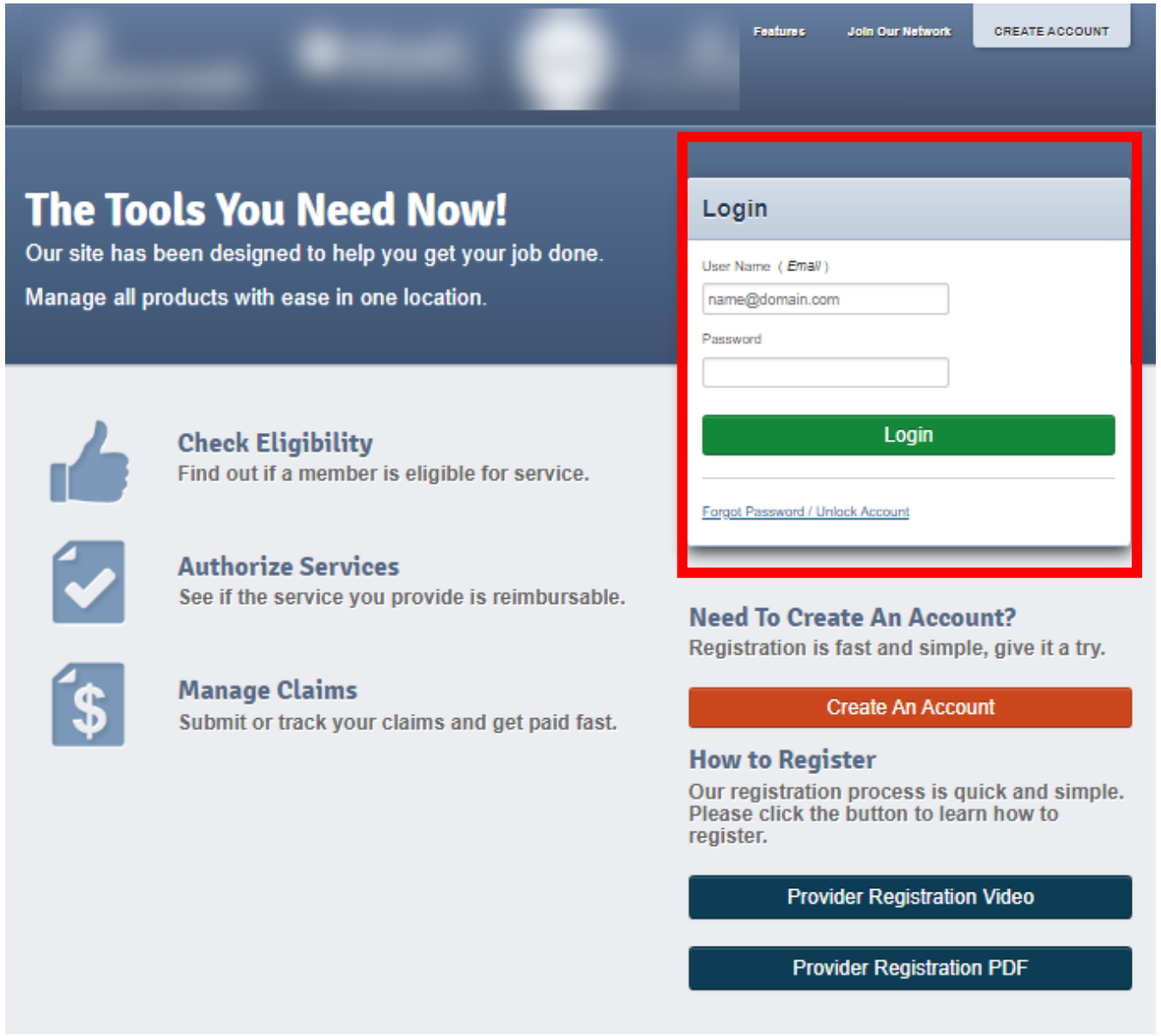




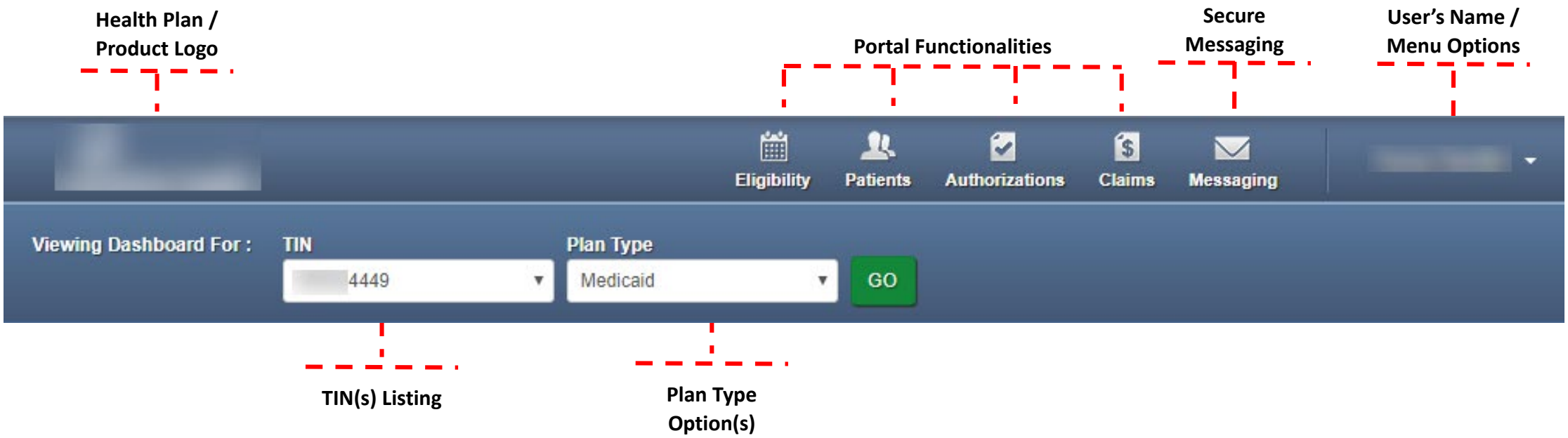


Portal Login

Tip: When a TIN operates in more than one state, the portal user can register for each health plan's portal with the same user name (e-mail) and password.



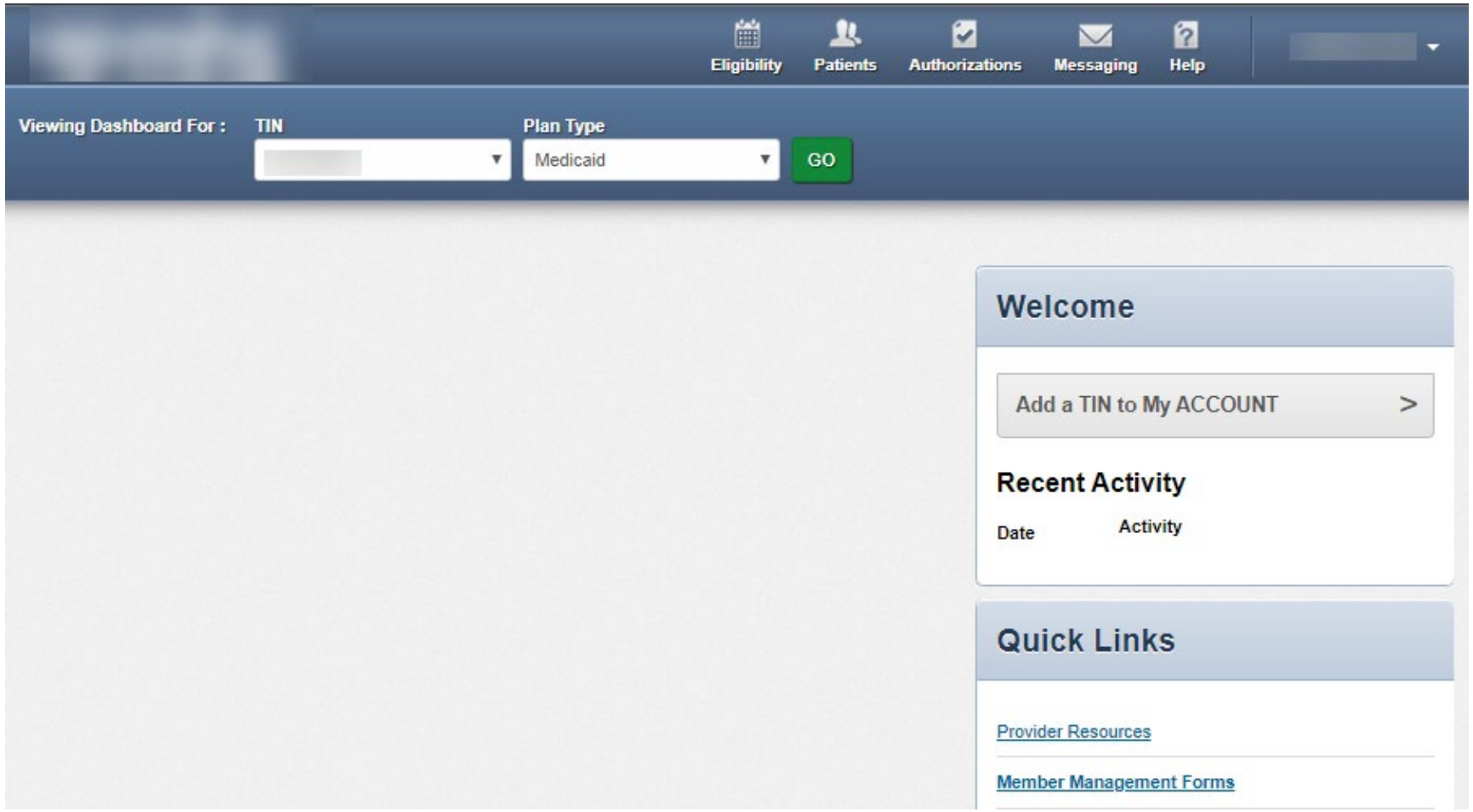
Portal Banner



Tips

- Portal functionality / access is based on the user's permissions
- **Plan Type** drop-down options are automatically assigned based on how the TIN is set-up in our systems

Portal Landing Page – Unverified Portal Account



Tip: Once a portal account is registered, the portal user will only have access to Secure Messaging and Account Details, until their portal account is verified.

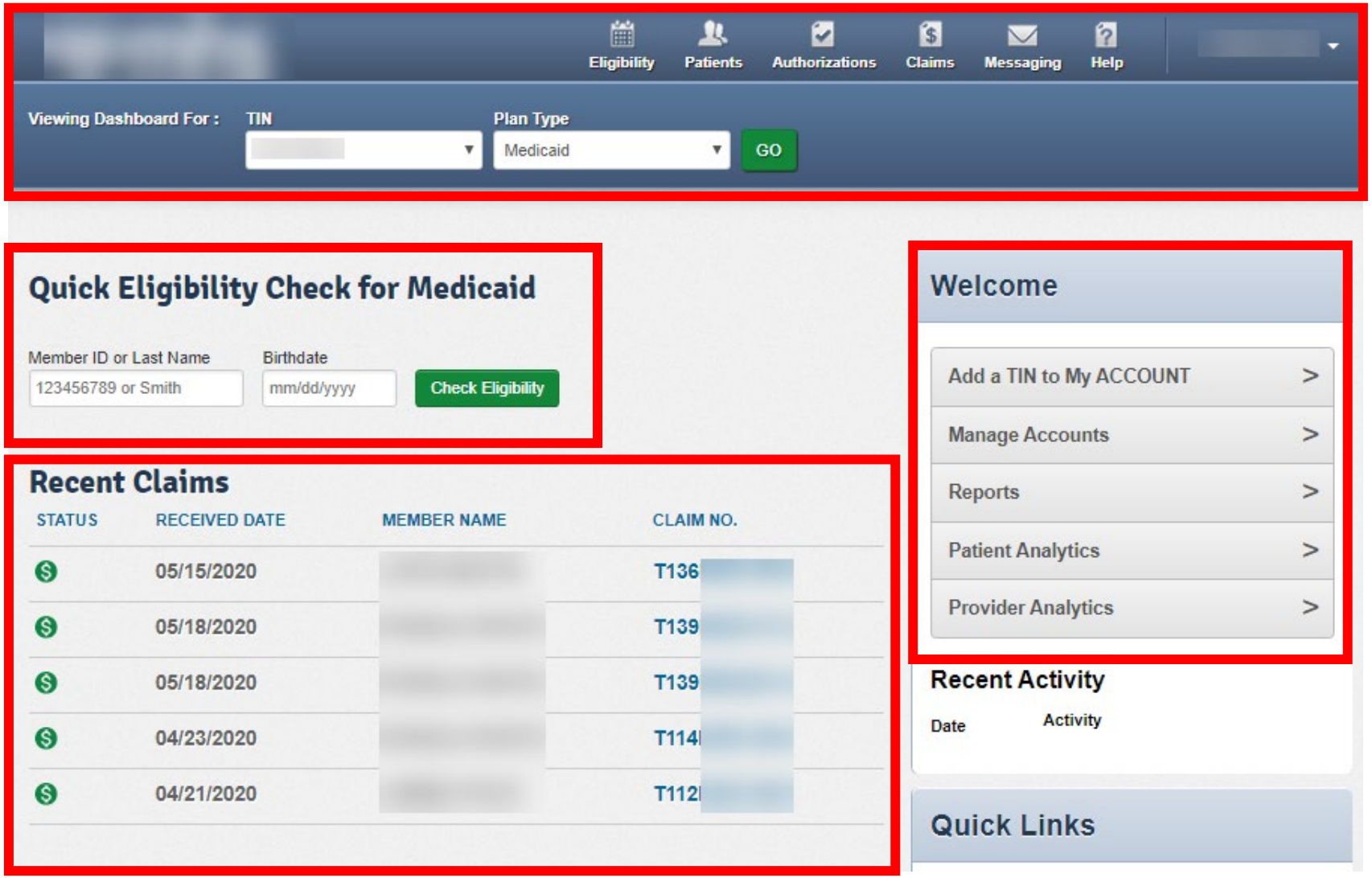
Portal Home Page – Verified Portal Account

Portal Banner

Quick Eligibility Check

Last Five Received Claims

Welcome Center



Portal Registration & Login Tips

- Registration is required for access to the portal
- Portal accounts cannot be shared
  - Each person within a provider organization who needs access to the portal, must compete the portal registration
- For a portal user to register, their TIN must be loaded in our systems
  - Allow at least two business days for portal to reflect updates in back-end systems
- There is no limit on the number of TINs a portal user can add to their portal account
- Portal users must log into the portal every 90 days to prevent their account from being locked due to inactivity
- The Forgot Password / Unlock Account link on the Secure Provider Portal login page, cannot be used to unlock a portal account, that is locked due to inactivity
- Options in the portal Plan Type drop-down are automatically assigned based on how the TIN is set-up in our back-end systems

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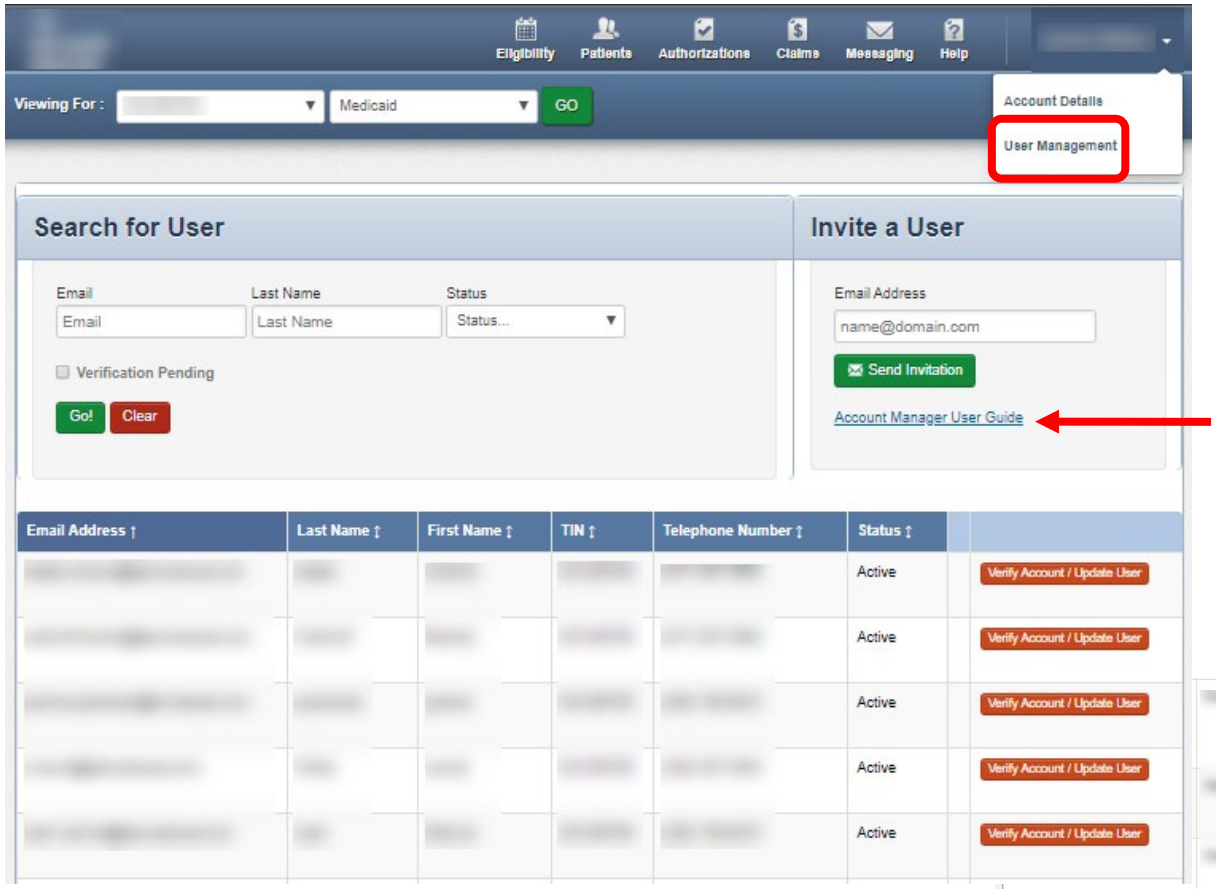
Portal Account Manager

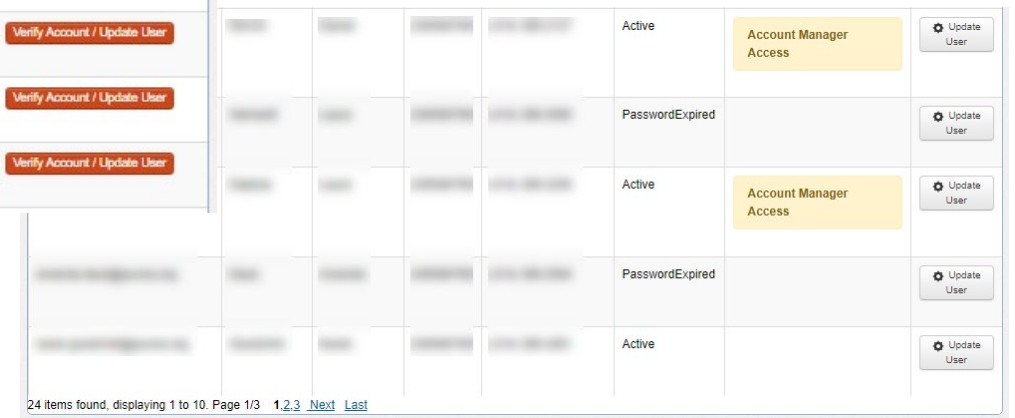
Portal Account Manager

- A Portal Account Manager is a role assigned to a primary contact within a provider organization
- The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same TIN

Portal User Management



Portal Account Managers, can click here to access the **Account Manager User Guide**



Portal Account Manager

SECURE PORTAL ACCOUNT MANAGER

WHAT YOU NEED TO KNOW

Your health plan is responsible for verifying and setting up the original user/registrant for your TIN. Please contact your Provider Relations rep or Provider Services to get set up.

What is an Account Manager?

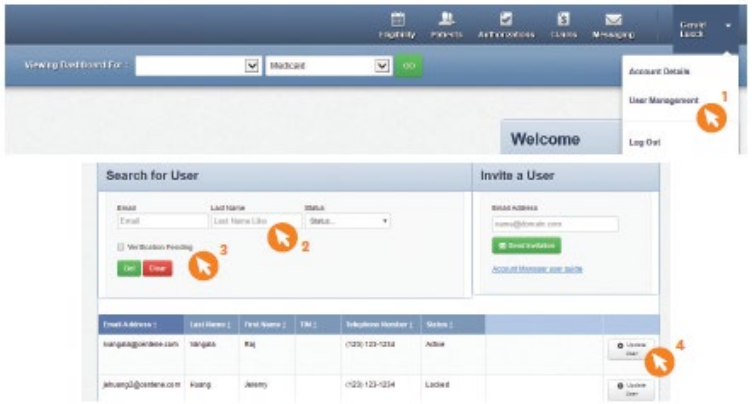
Account Manager is a role within the Secure Portal that is assigned to your health plan's primary contact within your practice. The purpose of this role is to help us maintain the safety and integrity of patient data.

The Account Manager is responsible for day-to-day support of all Secure Portal user accounts that are registered under the same Tax Identification Number (TIN). These responsibilities include:

- Approving access for new Secure Portal users
- Assigning permissions for users based on their job responsibilities
- Regularly adjusting the permissions of users whose roles may have changed
- Terminating users who no longer work at the practice.

Accessing Account Manager Tasks

1) Click the **User Management** dropdown in order to complete Account Manager actions.
2) Search for a specific user by entering their name and email address, or view a list of all users in your practice.
3) For new user accounts that need to be verified, select the **Verification Pending** box, click the Verify Account button, and follow instructions on the back page.
4) To view and edit details of existing accounts, click the **Update User** button and follow instructions on the back page.



Account Manager Tasks

Within the Update User Status and Permissions screen as shown below, the Account Manager has three tasks:

1) Enabling and Disabling Users

- Account Managers will receive an email when a user from their practice creates a new user account. The Account Manager will click **Enable User** to grant access to the user.
- User accounts are disabled after 90 days of inactivity. Account Managers can use this button to re-enable these users.
- If a user leaves the practice or no longer needs access to the Secure Portal information for that specific TIN, the Account Manager will click **Disable User.**

2) Send email to verify user accounts and to reset passwords

- Once a user is enabled, their status will change to "Unverified." The Account Manager can click **Send Registration Email** for the user to be notified that they must complete their registration.
- If a user has forgotten their password, the account manager can click **Send Password Reset Email.**

3) Selecting/modifying access levels for users

- Account Managers are responsible for selecting and managing the appropriate access for each user in their practice.
- Access levels include:

Health Records: View a patient's health records for number and type of visits, medications, immunizations and labs, care gaps, etc.

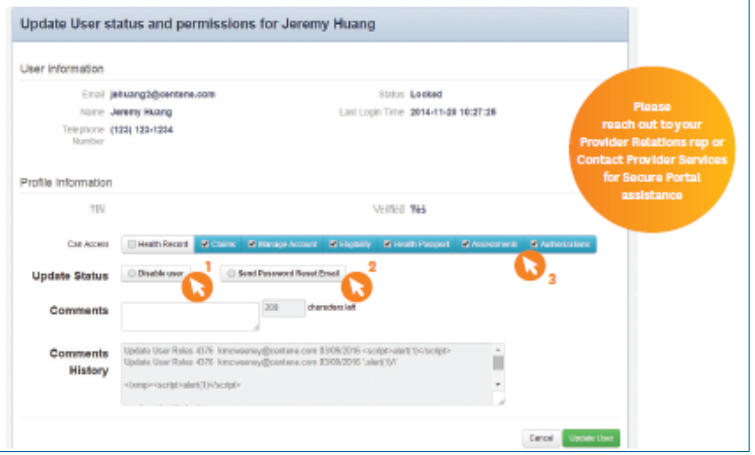
Claims: View and submit claims.

Manage Account: Enable, disable, modify permissions for a specific TIN, and invite users to set up an account.

Eligibility: View and check eligibility for a specific patient.

Assessments: Complete or view a Health Risk Assessment (HRA) or Notification of Pregnancy (NOP) for a patient.

Authorizations: View and submit authorizations.



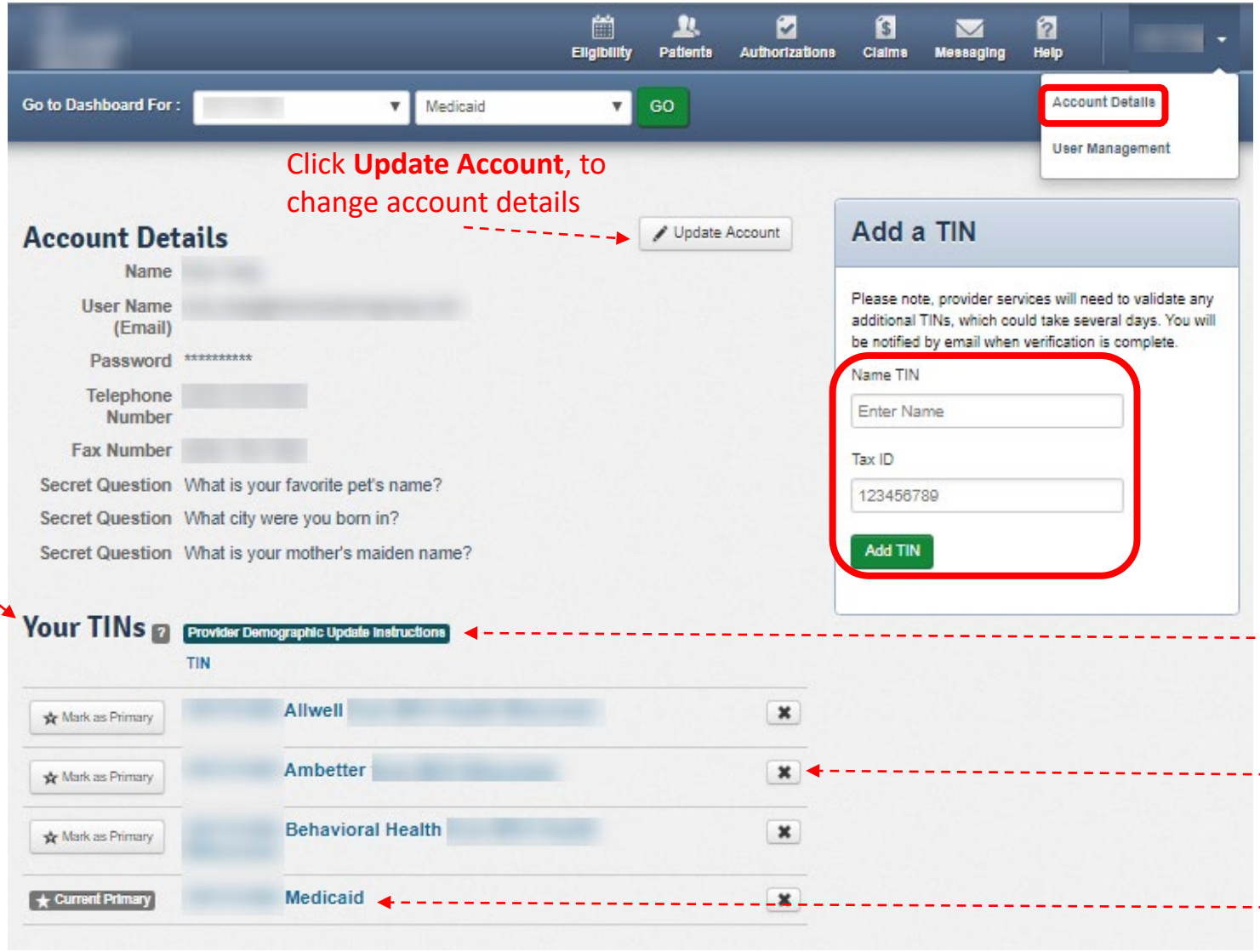
Portal Account Manager Tips

- Each TIN should have at least two Account Managers
  - For large organizations, it is recommend to have at least two Account Managers per department.
  - There is no limit on the number of Account Managers allowed under a TIN
- Account Managers should *regularly* log into the portal to:
  - Verify new portal registrations
  - Send password reset email to users whose portal account is locked due to inactivity
  - Disable / Enable a user's portal access
  - Modify portal permissions based on the user's role within your organization
- Account Managers **cannot** manage their own portal account

Tip: Always disable portal users, who no longer need portal access, especially when they leave your company.

Portal Account Details

Portal Account Details



Your TINs, list the TIN(s) you added to your portal account

Use **Add a TIN**, to associate additional TIN(s) to your portal account

Click **Provider Demographic Update Instructions** to access instructions

Click **X** to remove a TIN

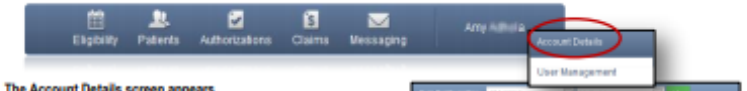
Click **Mark as Primary**, to change TIN and Product login default

Click **TIN / Product** to view / update Provider Demographics

Update Provider Demographic Information Instructions

Update Provider Demographic Information

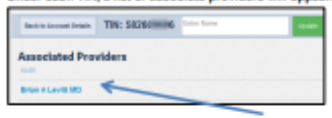
1. From the Main Tool Bar - select **Account Details** under the Users Name.



The Account Details screen appears.

2. To modify information about the Specific TIN, click on the individual TIN to update.

Under each TIN, a list of associate providers will appear.



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

A list of possible Service Locations will appear.

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

5. Click Edit Location to update the provider information – This information will update the Find A Provider website.

6. The following Transaction attributes will be available for edits - ***only one update within a transaction set is allowed per day.***
(If any additional updates are necessary – please contact your provider relations representative)

Transaction Set #1 - Provider Location Address
- Address1
- Address2
- City

Transaction Set #2 - Provider Location Phone
- Phone
- Fax

Transaction Set #3 - Provider Location Accessibility
- Accessibility (Yes or No)

Transaction Set #4 - Provider Office Hours
- Monday- Sunday (7 Data Attributes for each day)

Transaction Set #5 - Practitioner Gender
- Gender

Transaction Set #6 - Practitioner Office Hours
- Monday- Sunday (7 Data Attributes for each day).

For example: Changing the phone number and saving will cause a wait time of 24-36 hours in order to change the fax number. However, changing information in a different transaction set will not be limited to an additional wait time.

7. Save changes by clicking on the Save Location button at the bottom of the screen.

ATTENTION: All Delegated Providers, please contact your delegate for any changes. All demographic updates for Delegated Providers must be routed through the delegate for submission to your health plan.

Portal Account Details and Demographic Update Tips

- Under Account Details, portal users can:
  - Update account details (i.e. change email address, name, password, etc.)
  - Select TIN/Product login default
  - Update specific demographic information for their organization(s)
    - The Provider Demographic Update is **not** available for Behavioral Health
  - Add a TIN
  - Remove TIN(s) from portal account

Tip: If an inactive TIN is removed from a portal account, it cannot be re-added.

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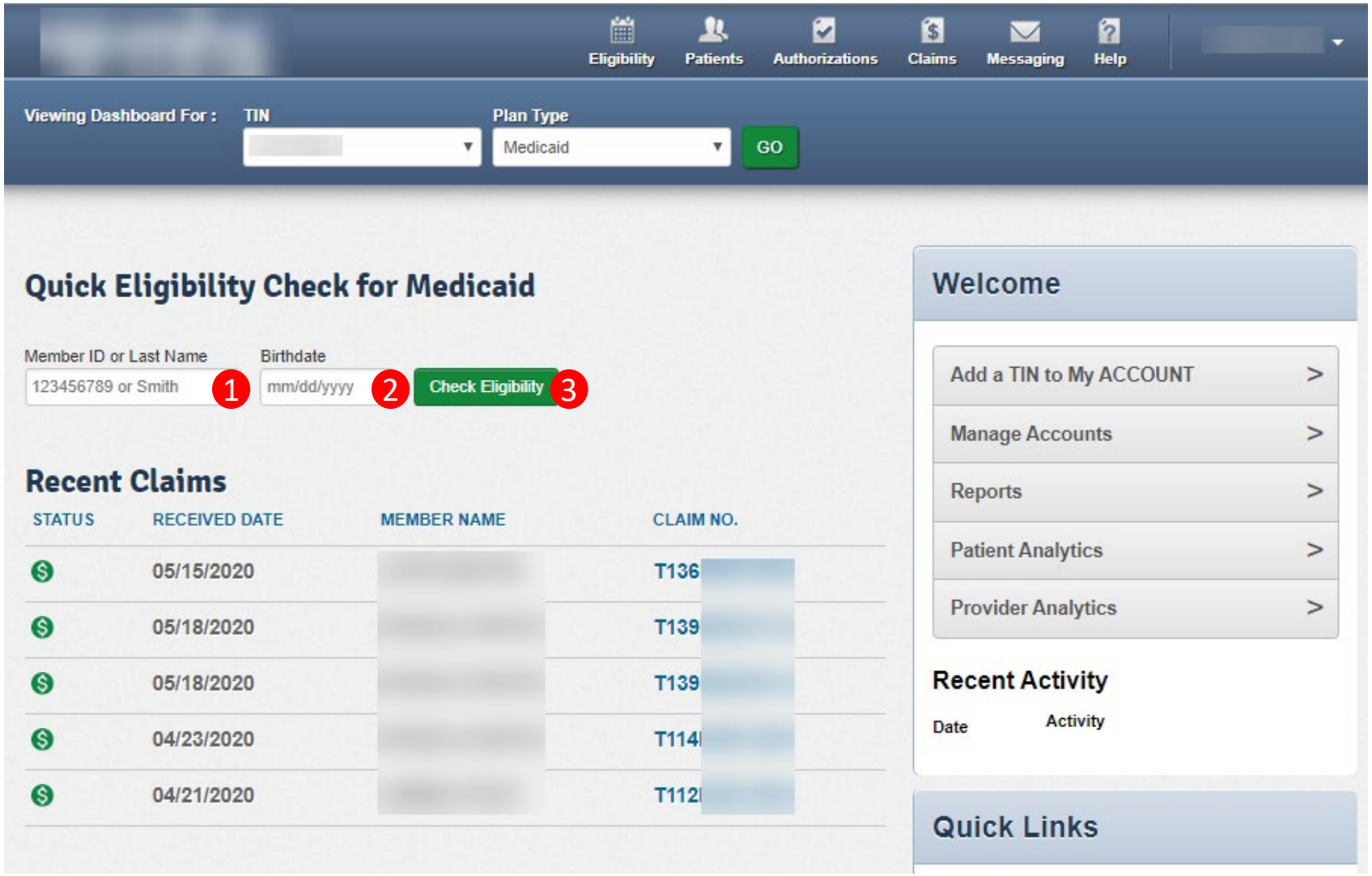
Portal Functionality: Check Eligibility

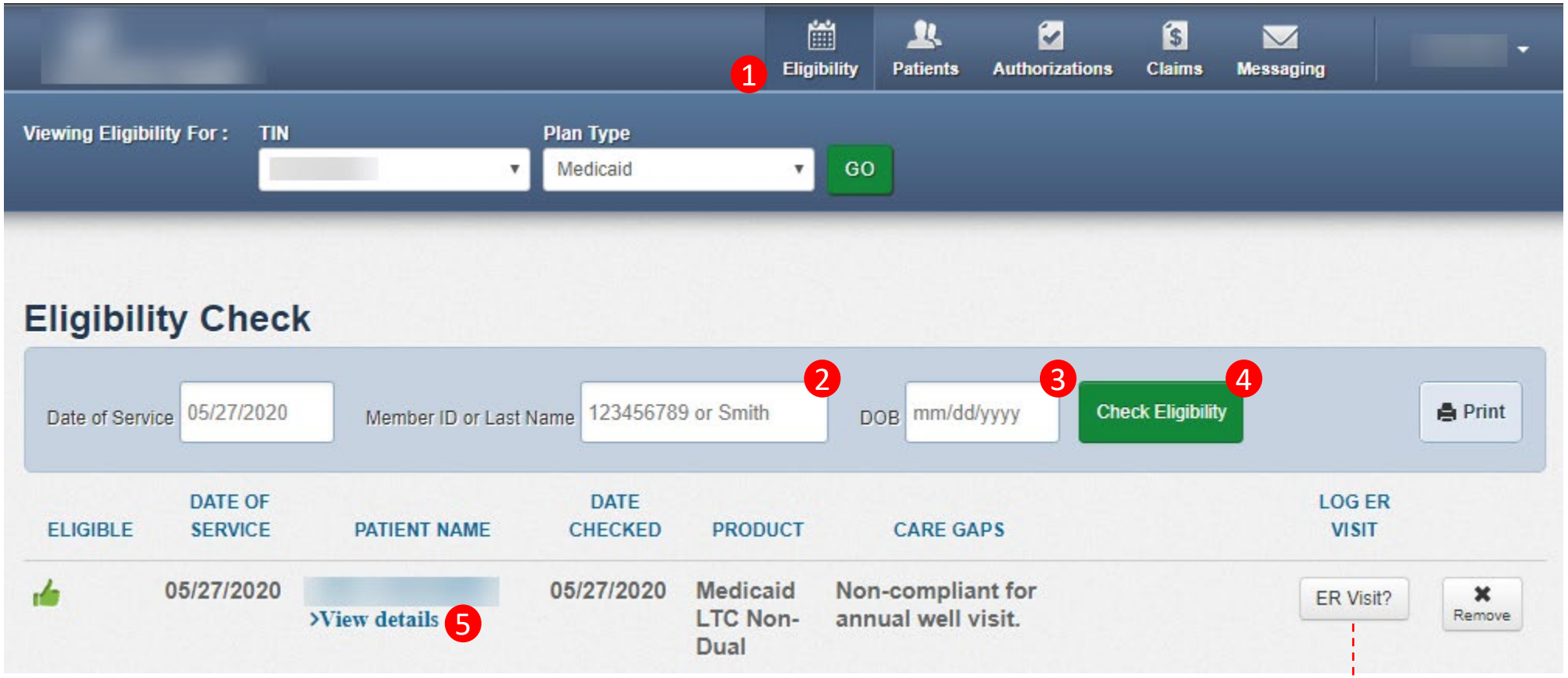
Eligibility Check

Within Eligibility Check results, the Patient Overview displays patient demographic, claims, authorizations and other pieces of information. It can be used to identify Care Gaps, view ER visits, and PCP history.

Quick Eligibility Check

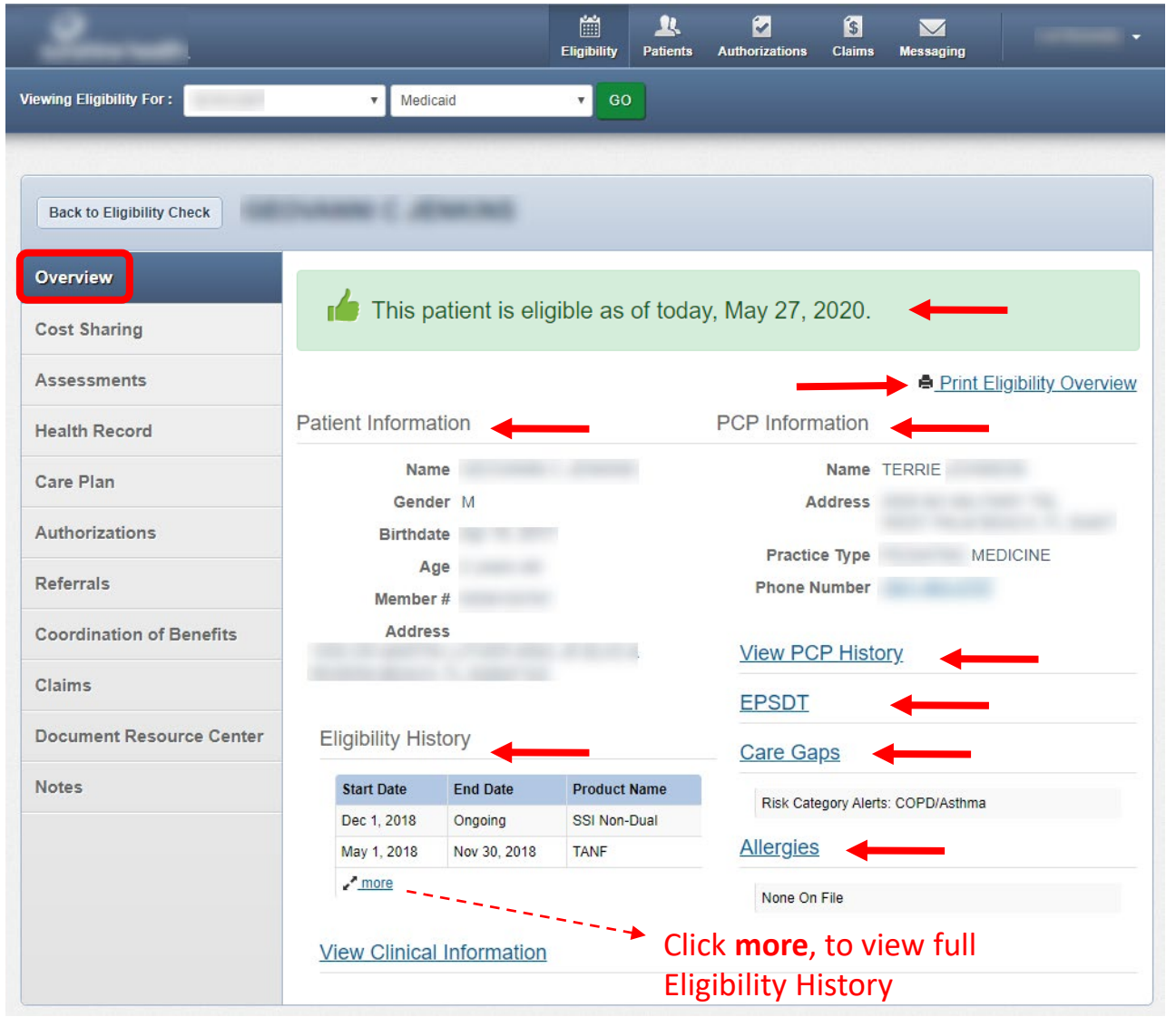


Eligibility Check

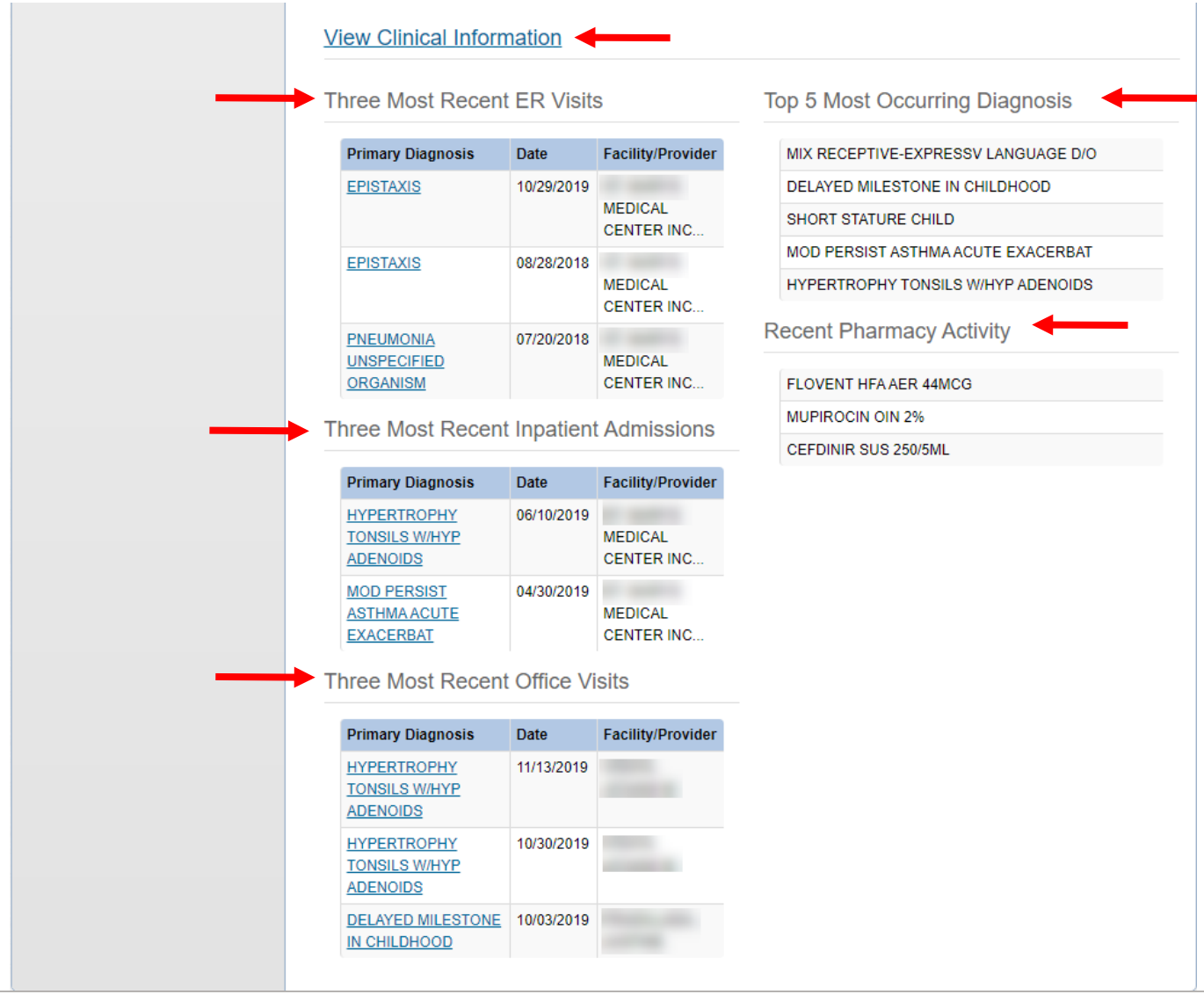


If Eligibility Check is for an ER visit, click **ER Visit?**

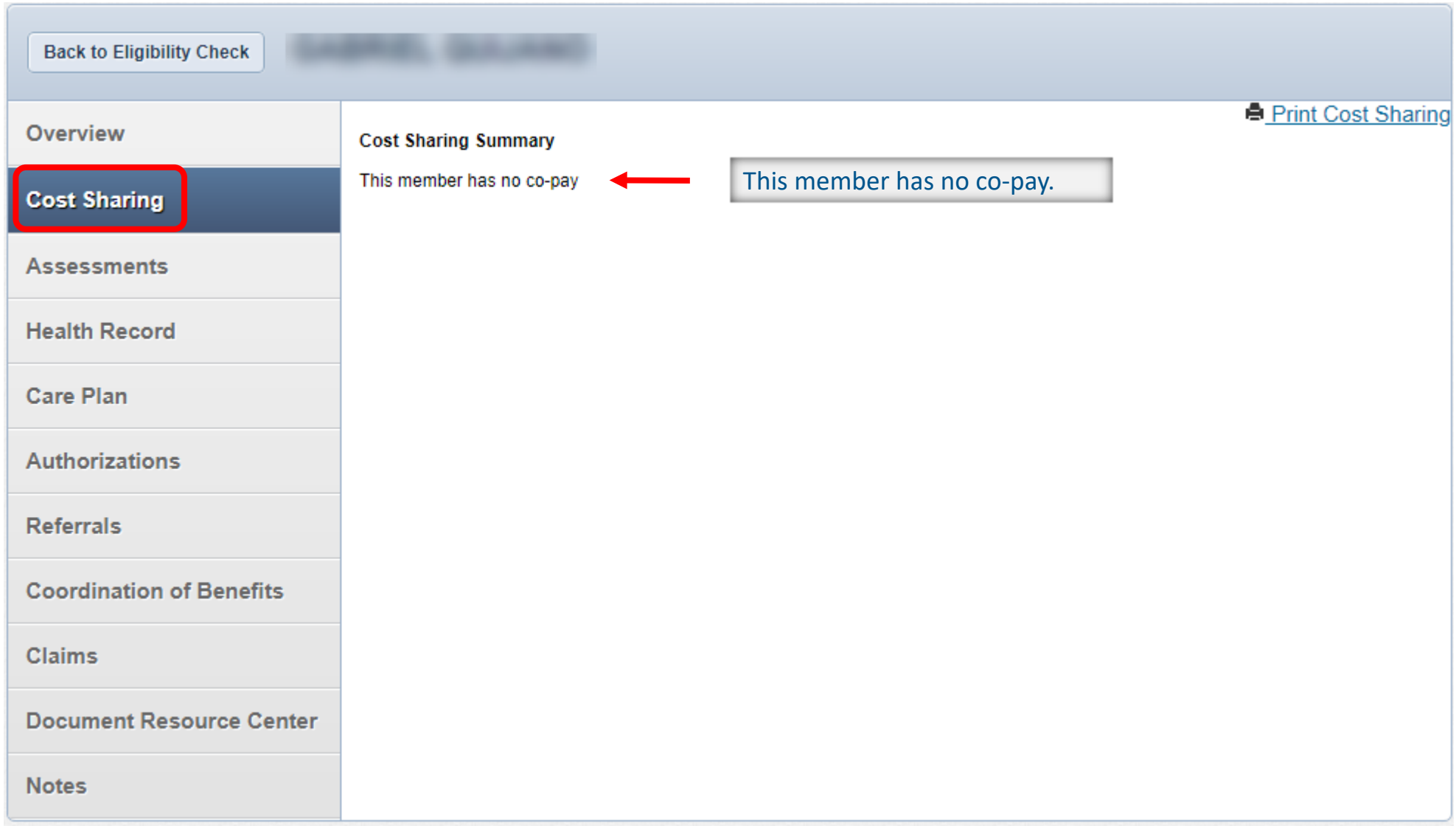
Patient Overview



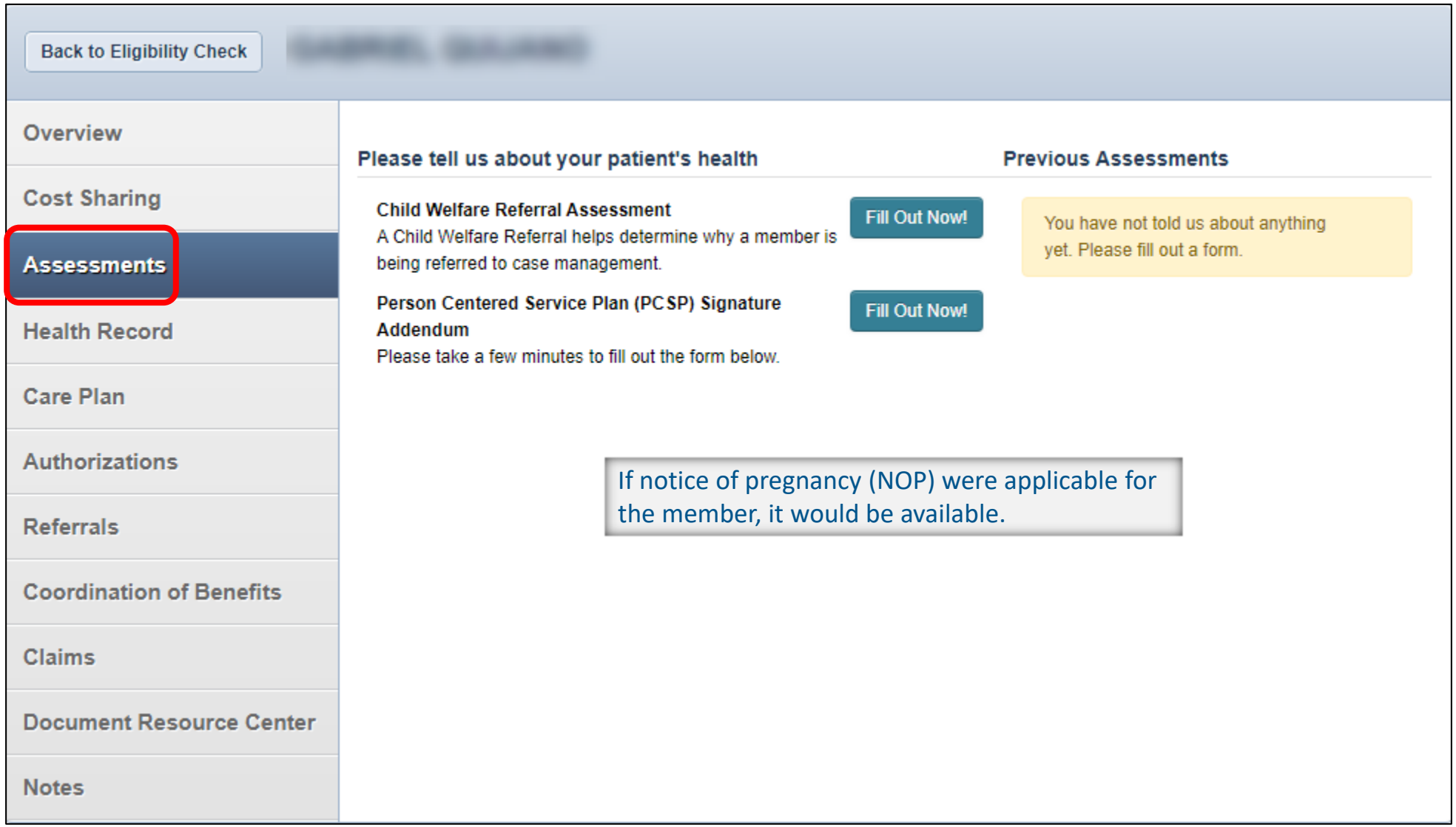
Patient Overview, cont.



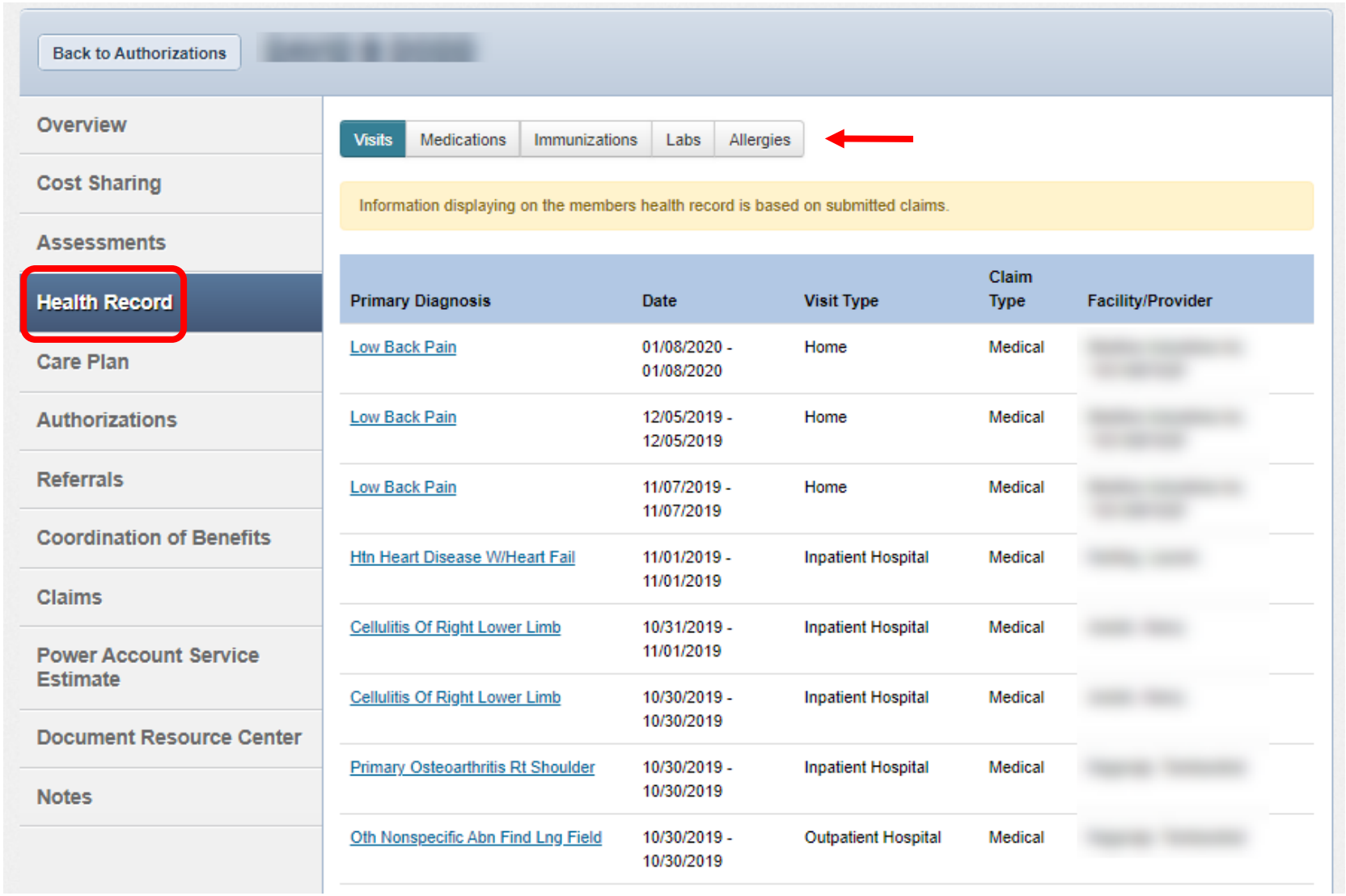
Patient Overview – Cost Sharing



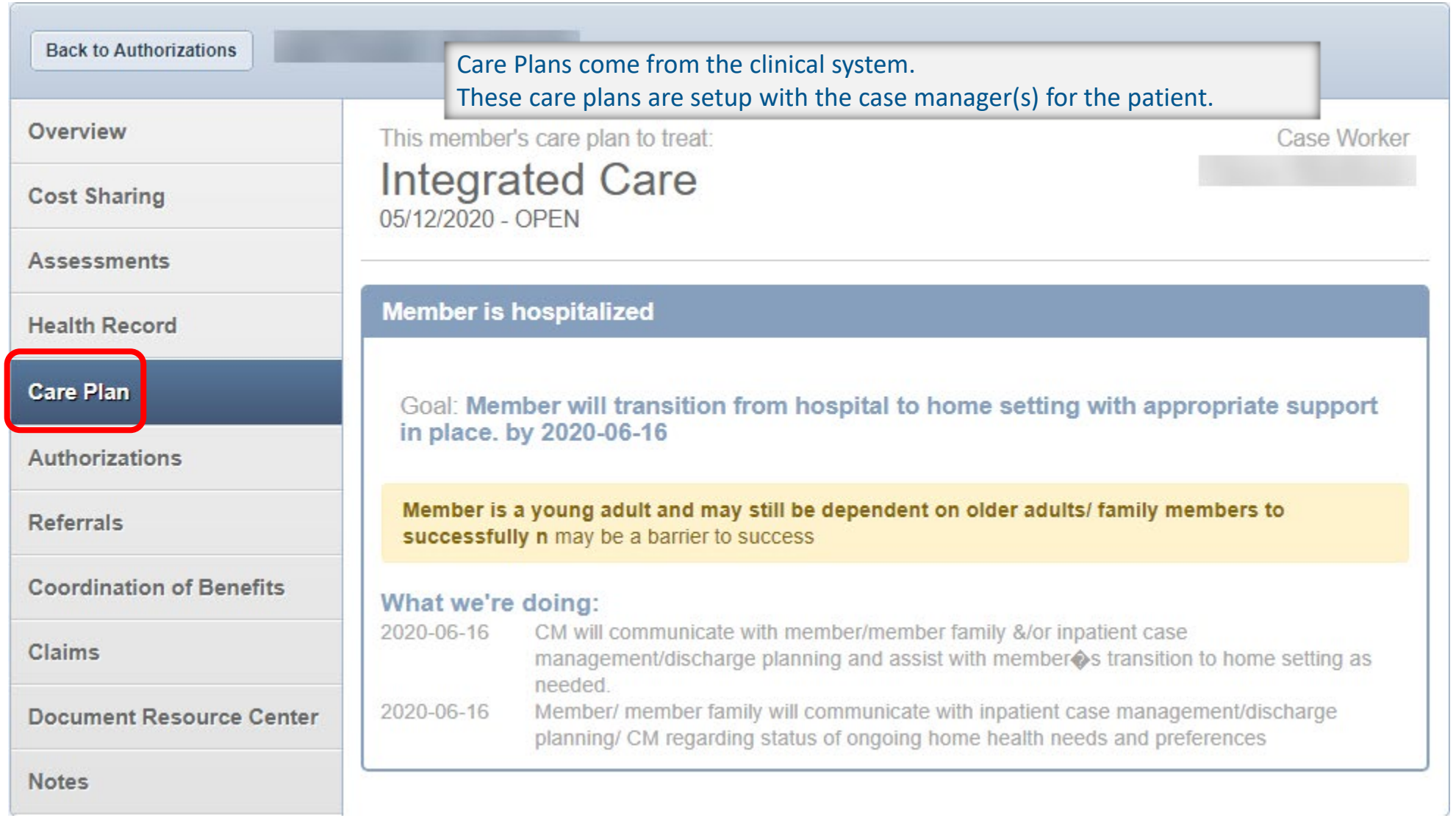
Patient Overview – Assessments



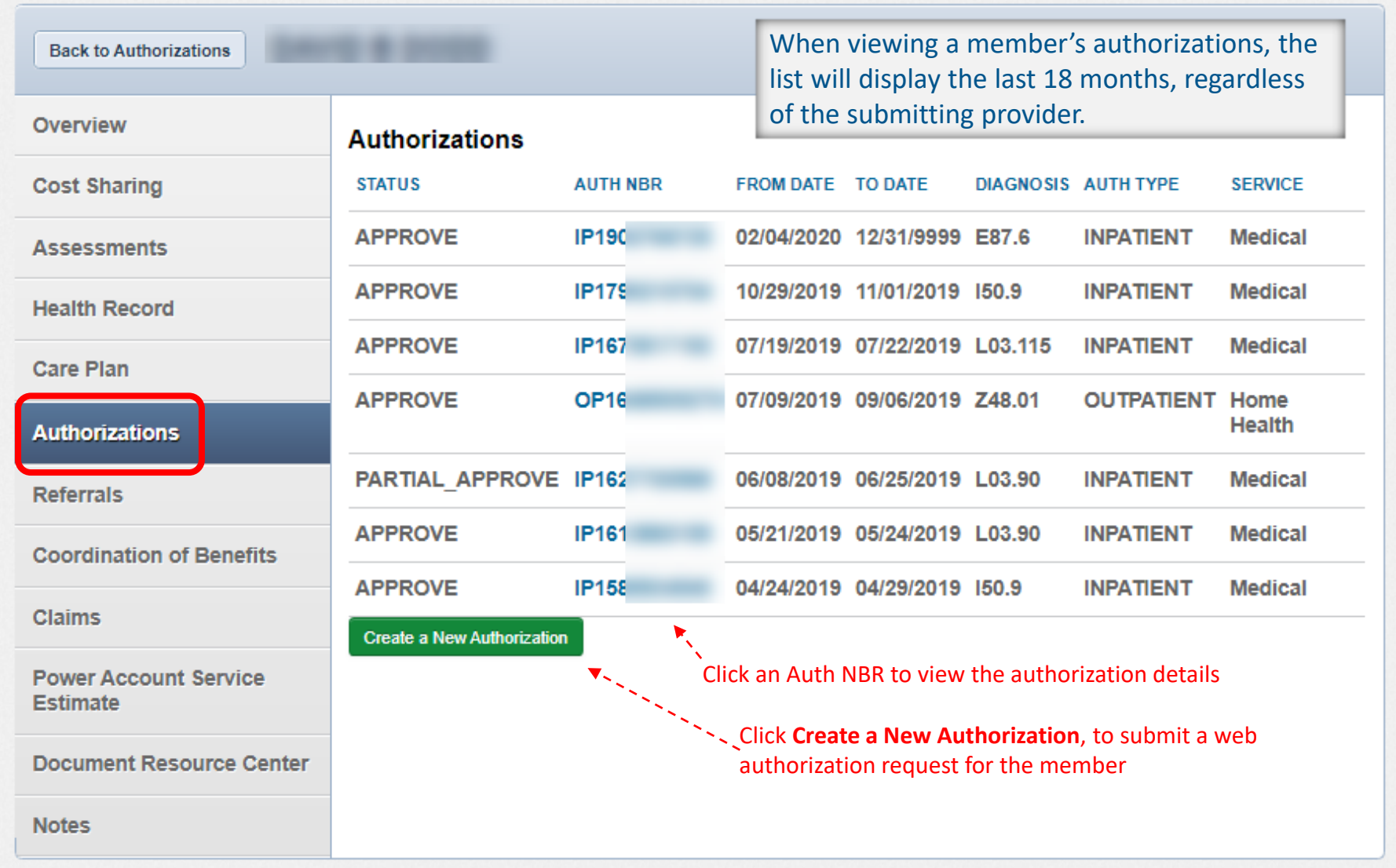
Patient Overview – Health Record



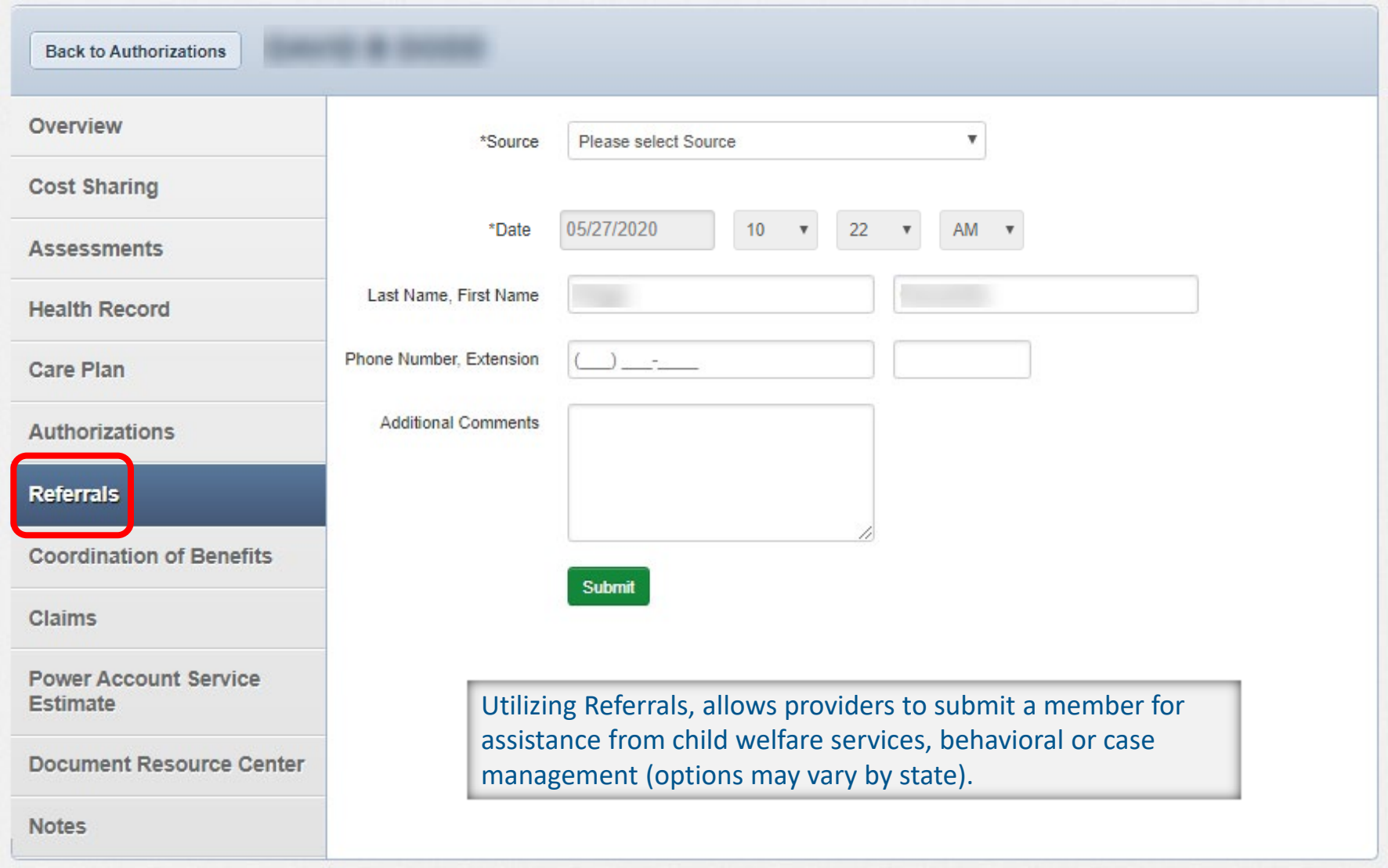
Patient Overview – Care Plan



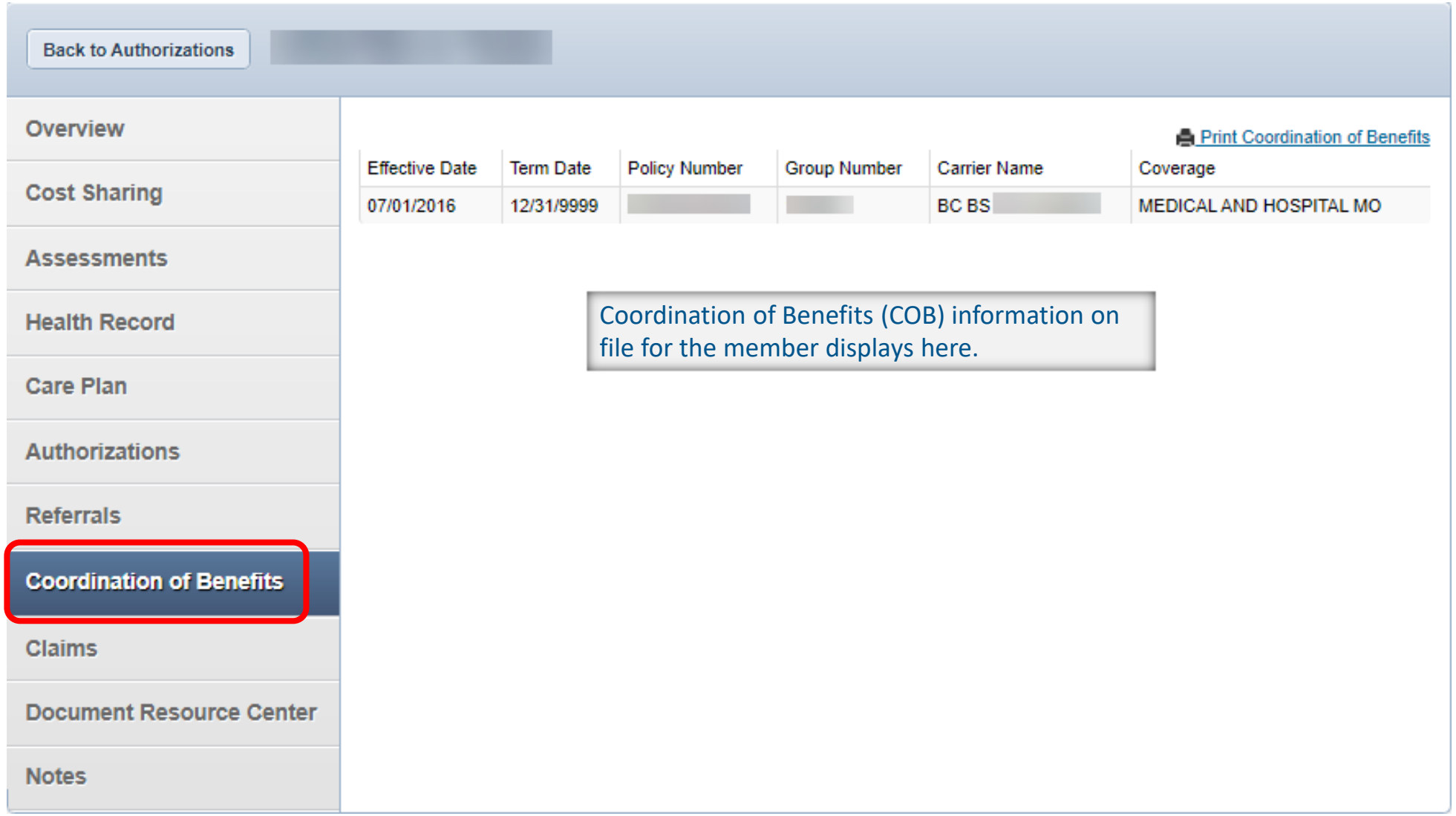
Patient Overview – Authorizations



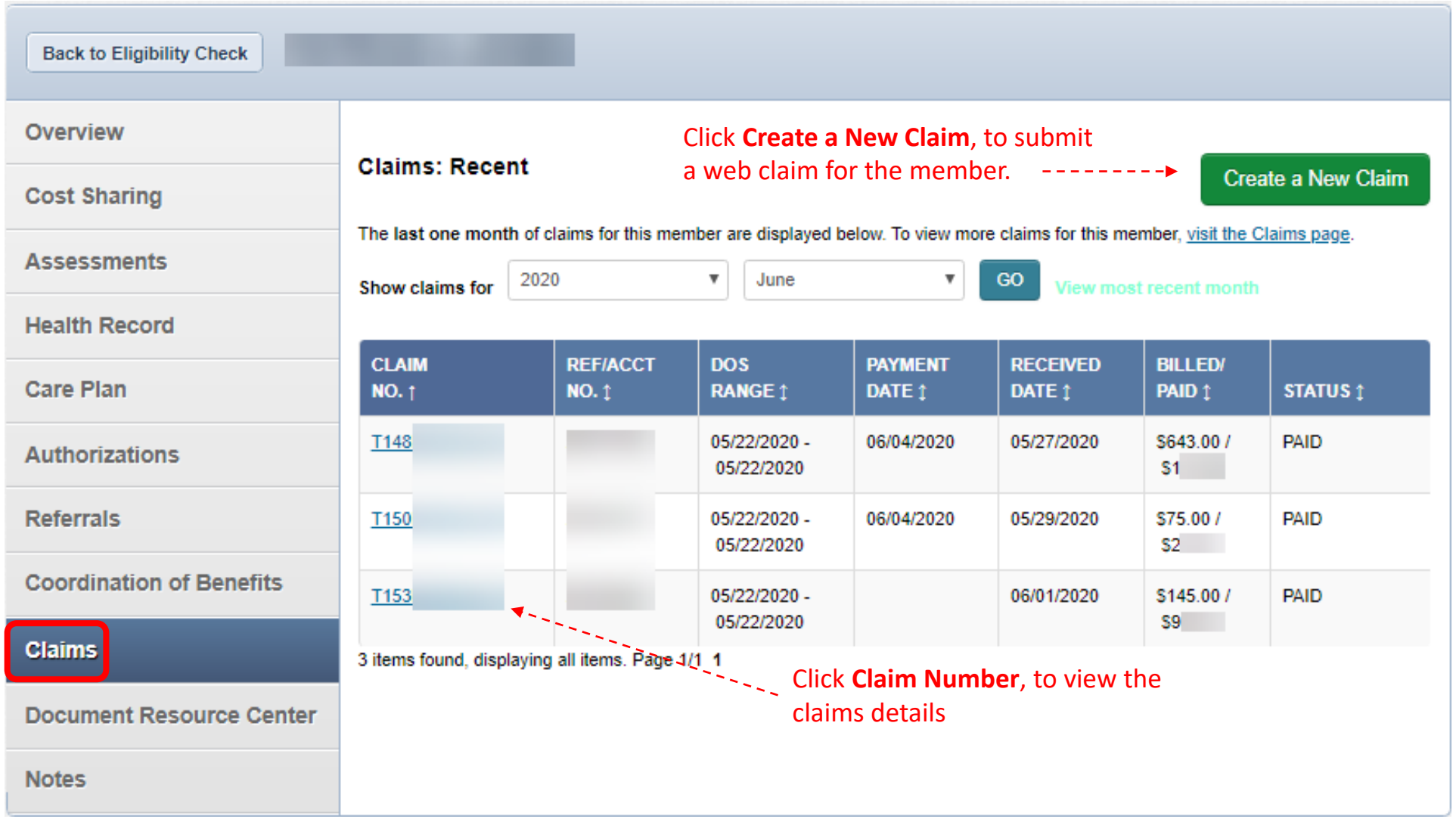
Patient Overview – Referrals



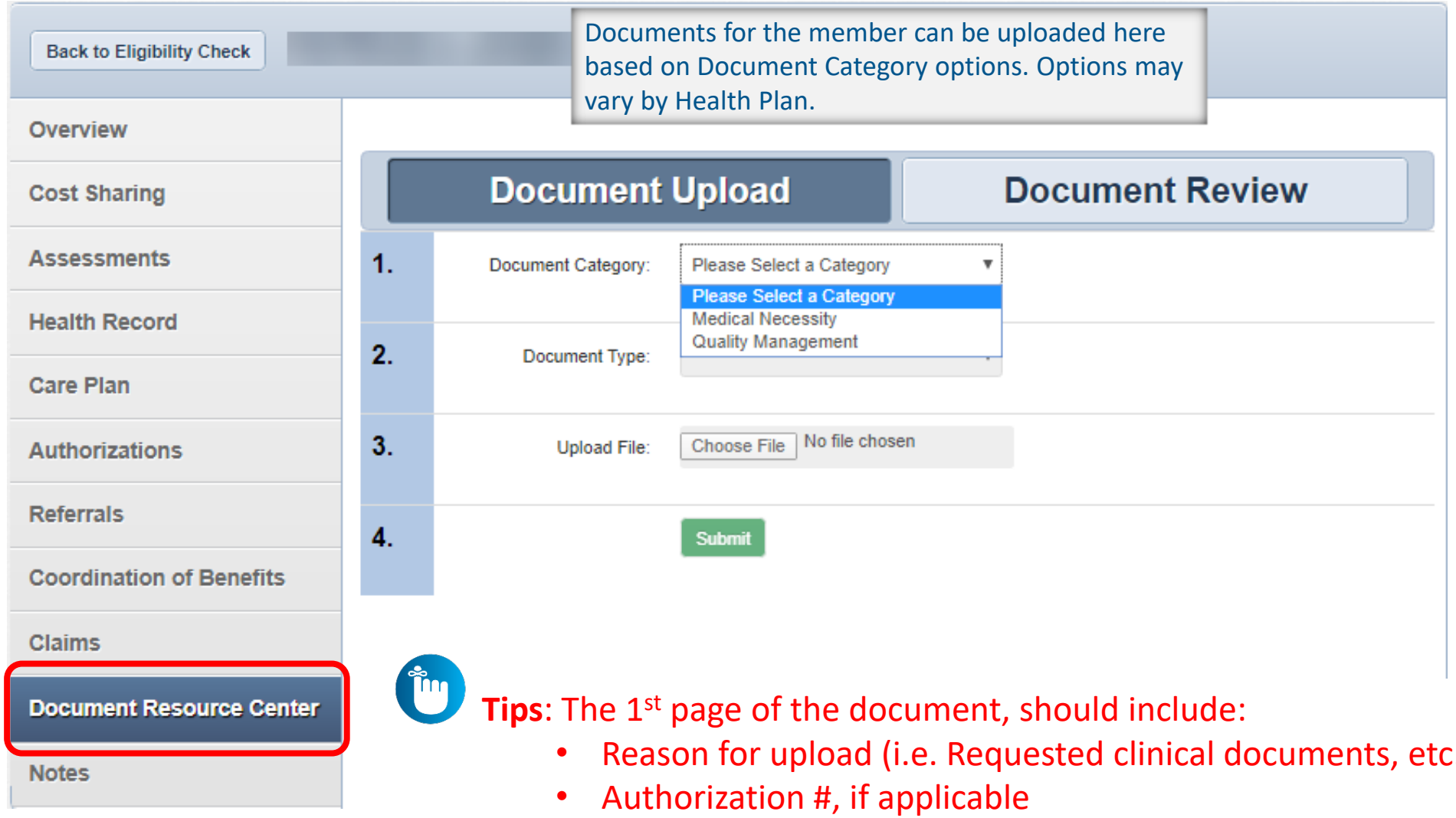
Patient Overview – Coordination of Benefits



Patient Overview – Claims



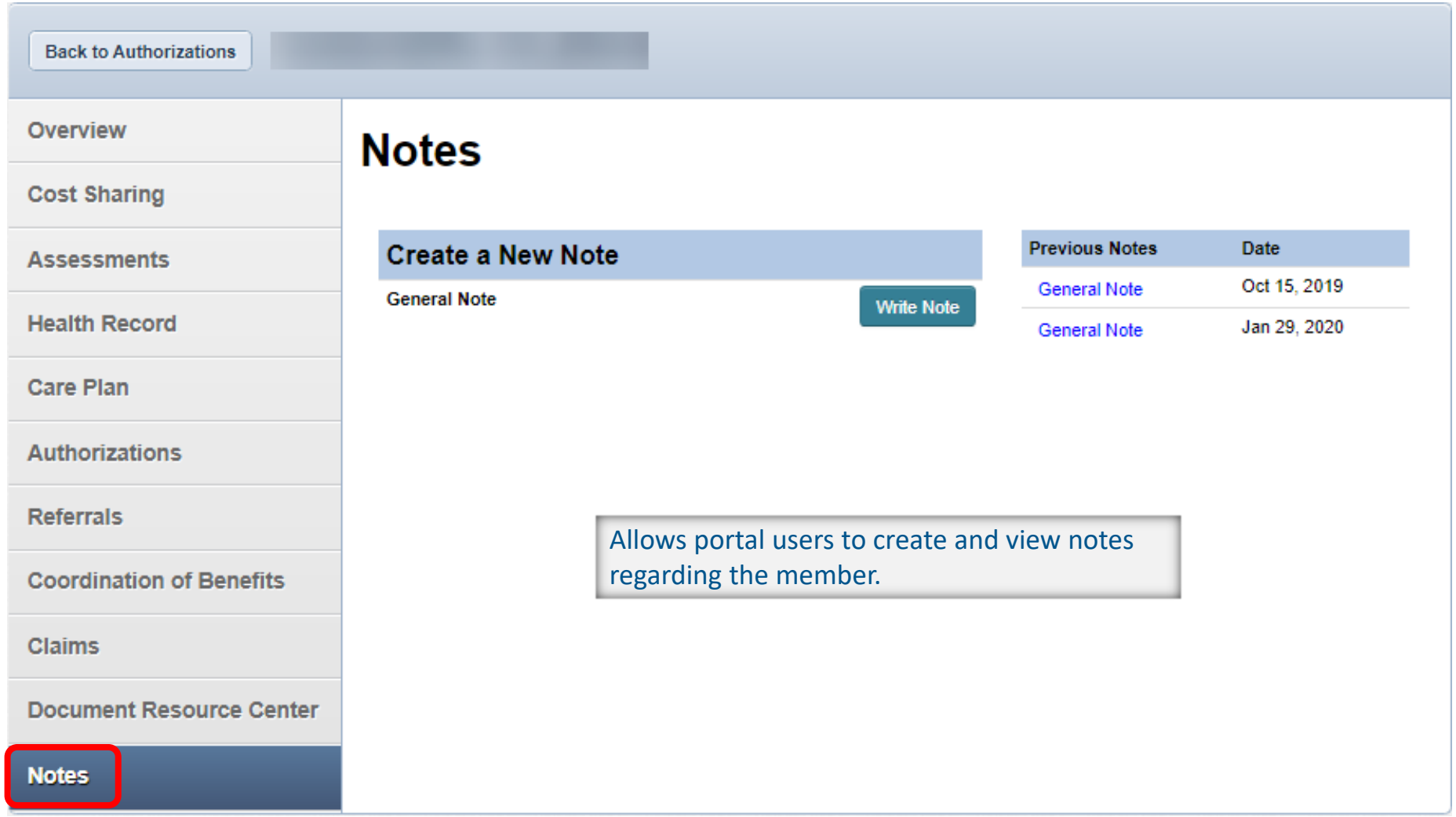
Patient Overview – Document Resource Center



Tips: The 1st page of the document, should include:

- Reason for upload (i.e. Requested clinical documents, etc.)
- Authorization #, if applicable

Patient Overview – Document Resource Center



Eligibility Tips

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- As best practice, always check member eligibility before creating a web authorization or web claim

Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid.

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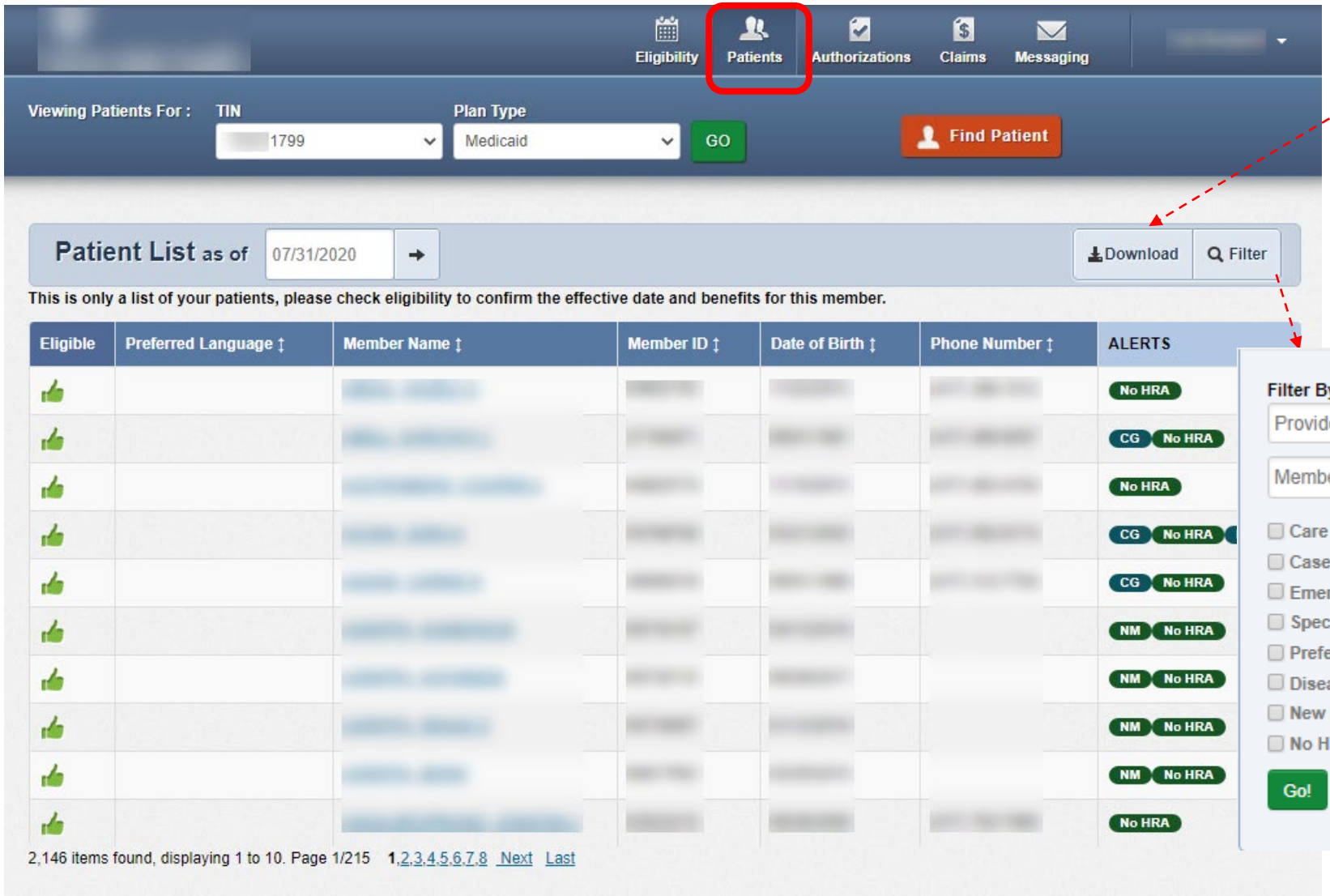
Portal Functionality: Patients

Patient List

Primary Care Providers are able to view and download a list of their assigned members. The Patient List displays:

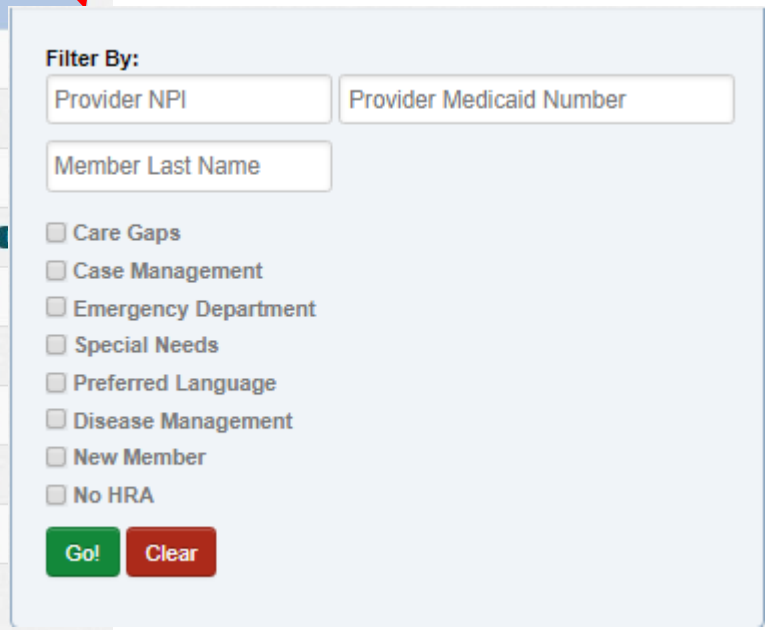
- Member Name
- Member ID #
- DOB
- Preferred language
- Eligibility status
- Phone number
- Alerts

Patient List



Click **Download** to export the Patient List into Excel.

Click **Filter** to access filter options.



Patients Tips

- Patients tab is only applicable to PCPs / PCP organizations
- Click on a member's name to access their eligibility, health record, etc. information
- Patients list can be exported to excel for more filtering options

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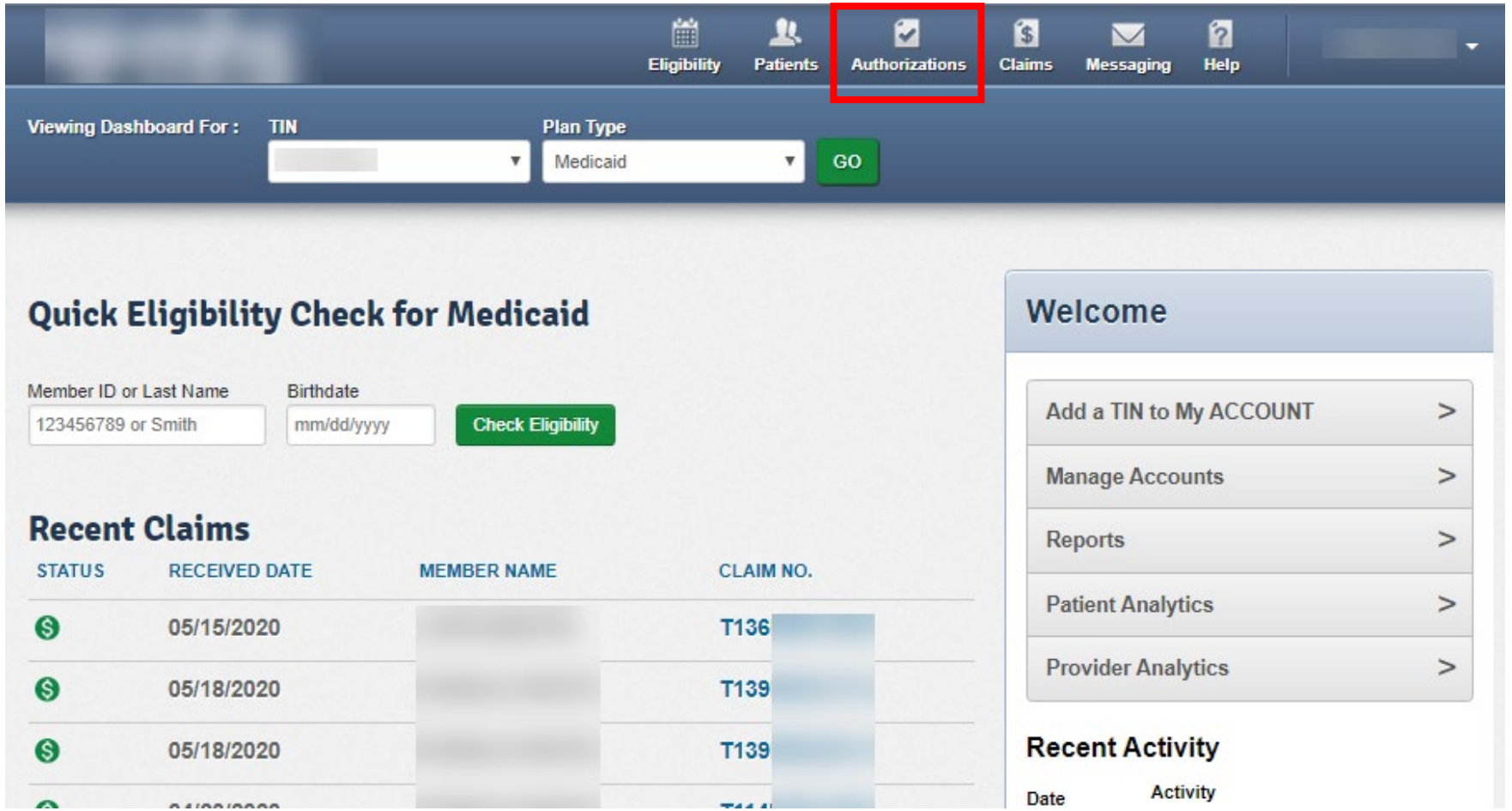
Portal Functionality: Authorizations

Authorizations

Providers are able to use the portal to submit web authorization requests and view 18 months of authorization history.

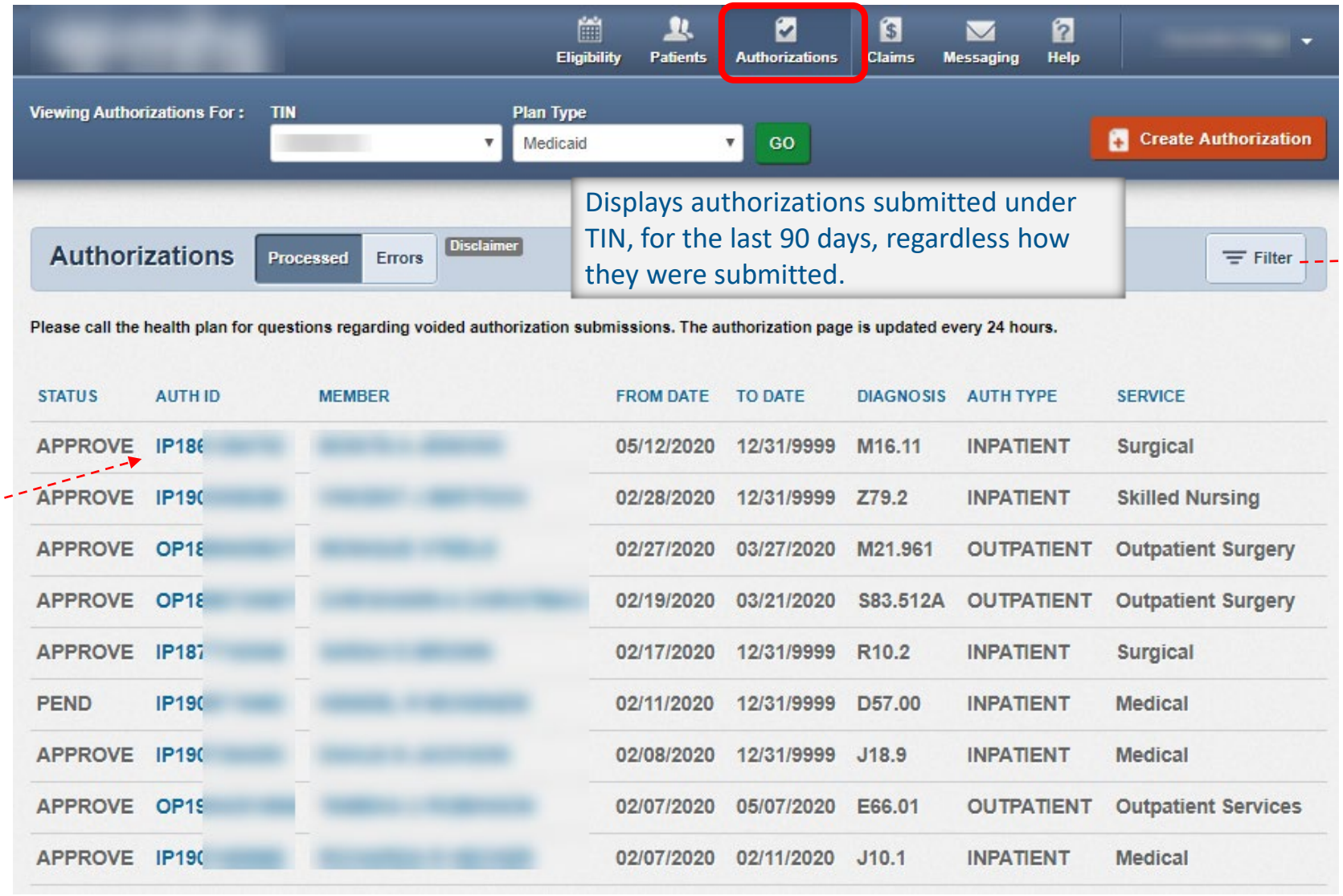
Accessing Authorizations

To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.



Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid. To find an Ambetter member, the Plan Type must be 'Ambetter'.

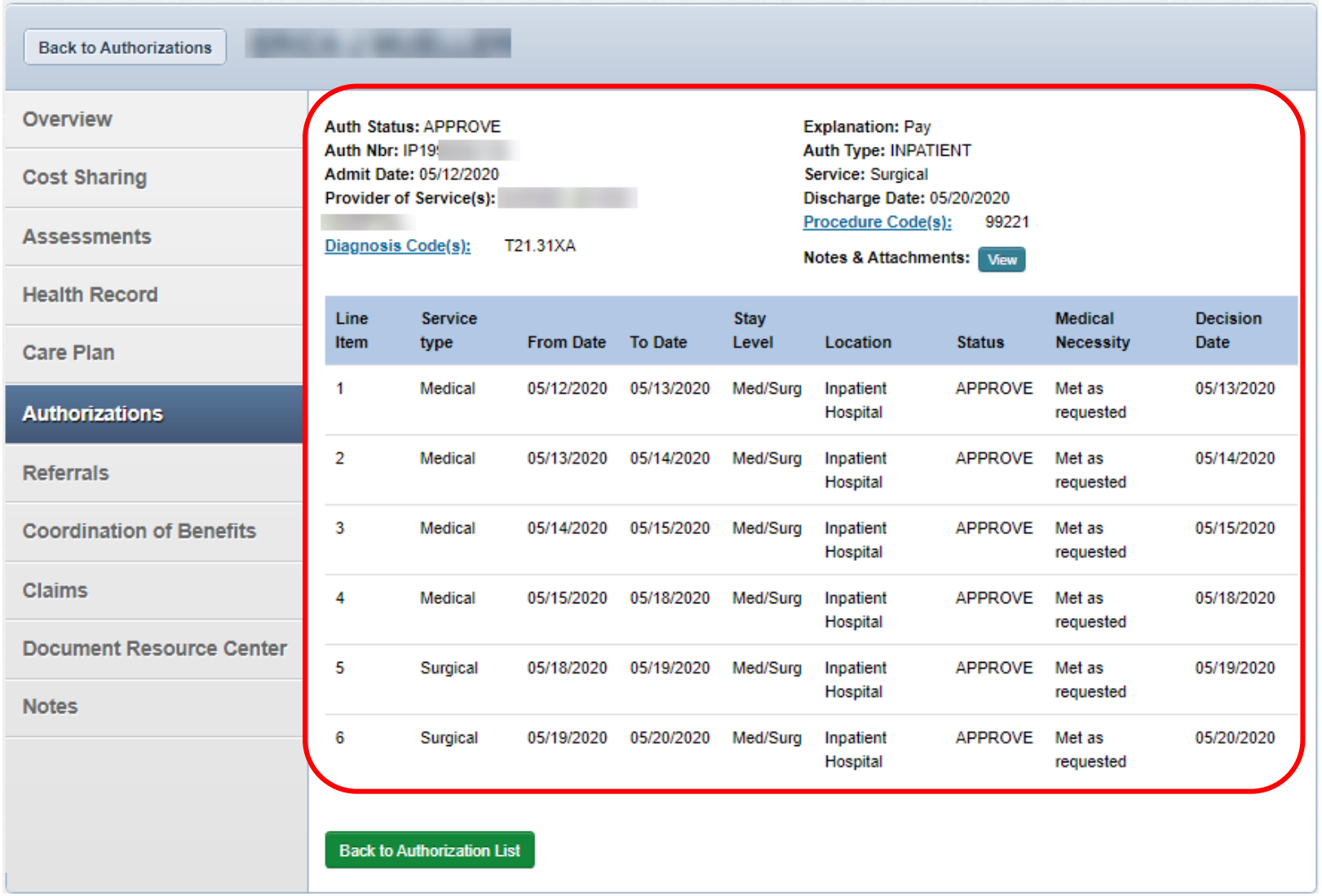
Authorizations Summary



Click an **Auth ID** to view authorization details

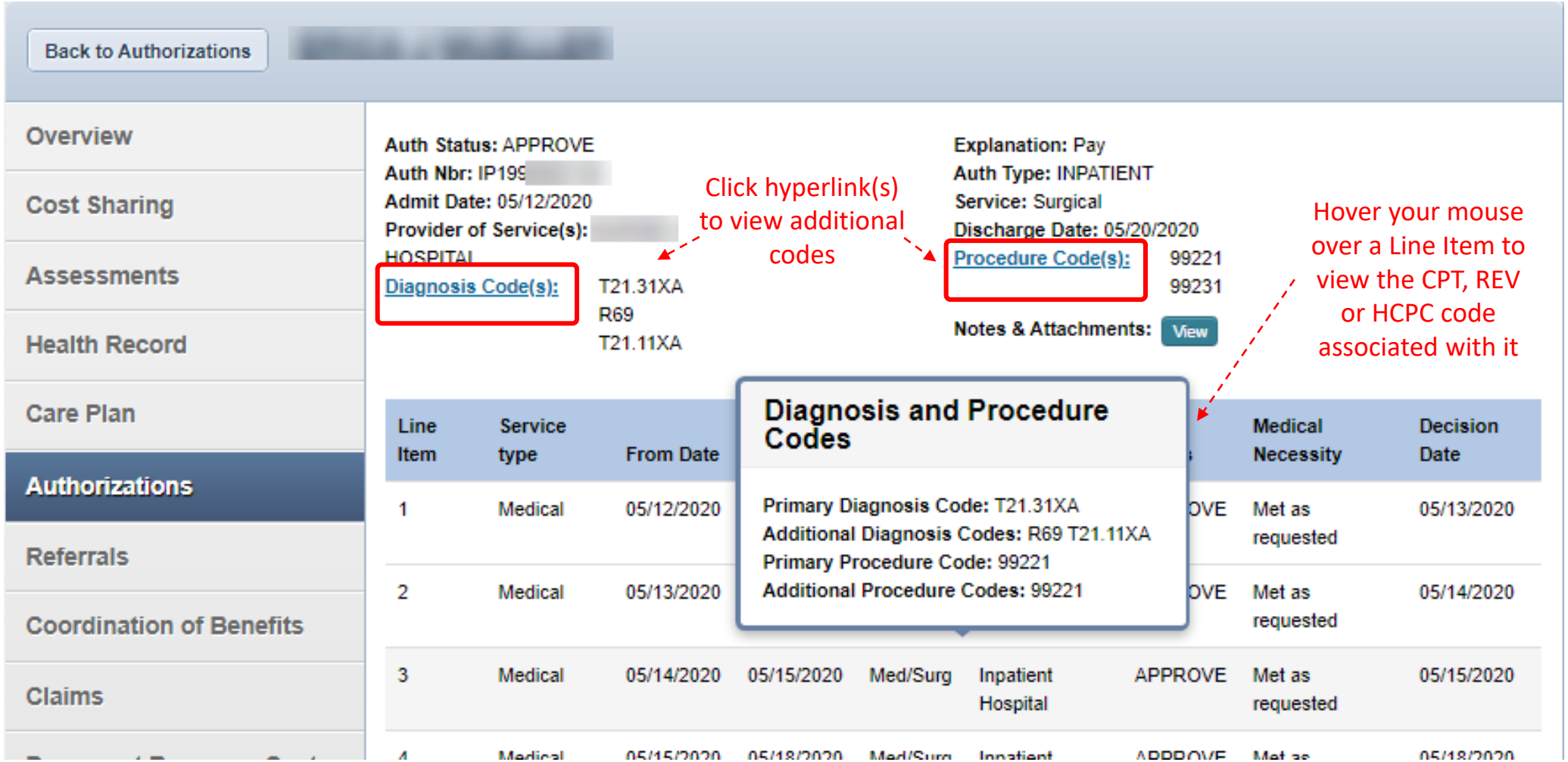
Click **Filter** to access filter options

Authorization Details



Line Item	Service type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	05/12/2020	05/13/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/13/2020
2	Medical	05/13/2020	05/14/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/18/2020
5	Surgical	05/18/2020	05/19/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/19/2020
6	Surgical	05/19/2020	05/20/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/20/2020

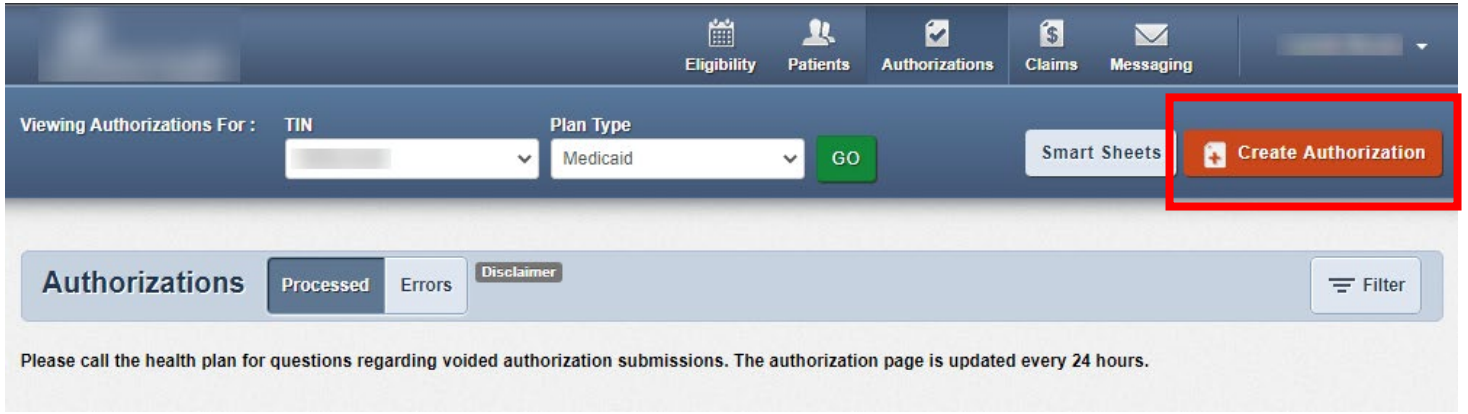
Authorization Details Links and Pop-Up

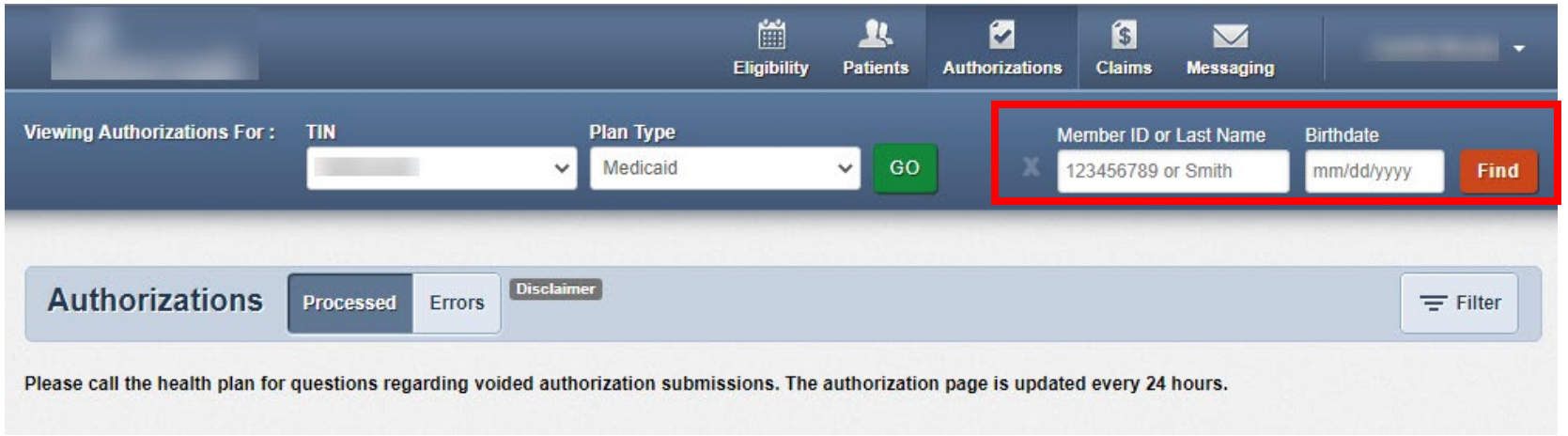


Create Authorization (Web Authorization Request)

To begin a web authorization request:

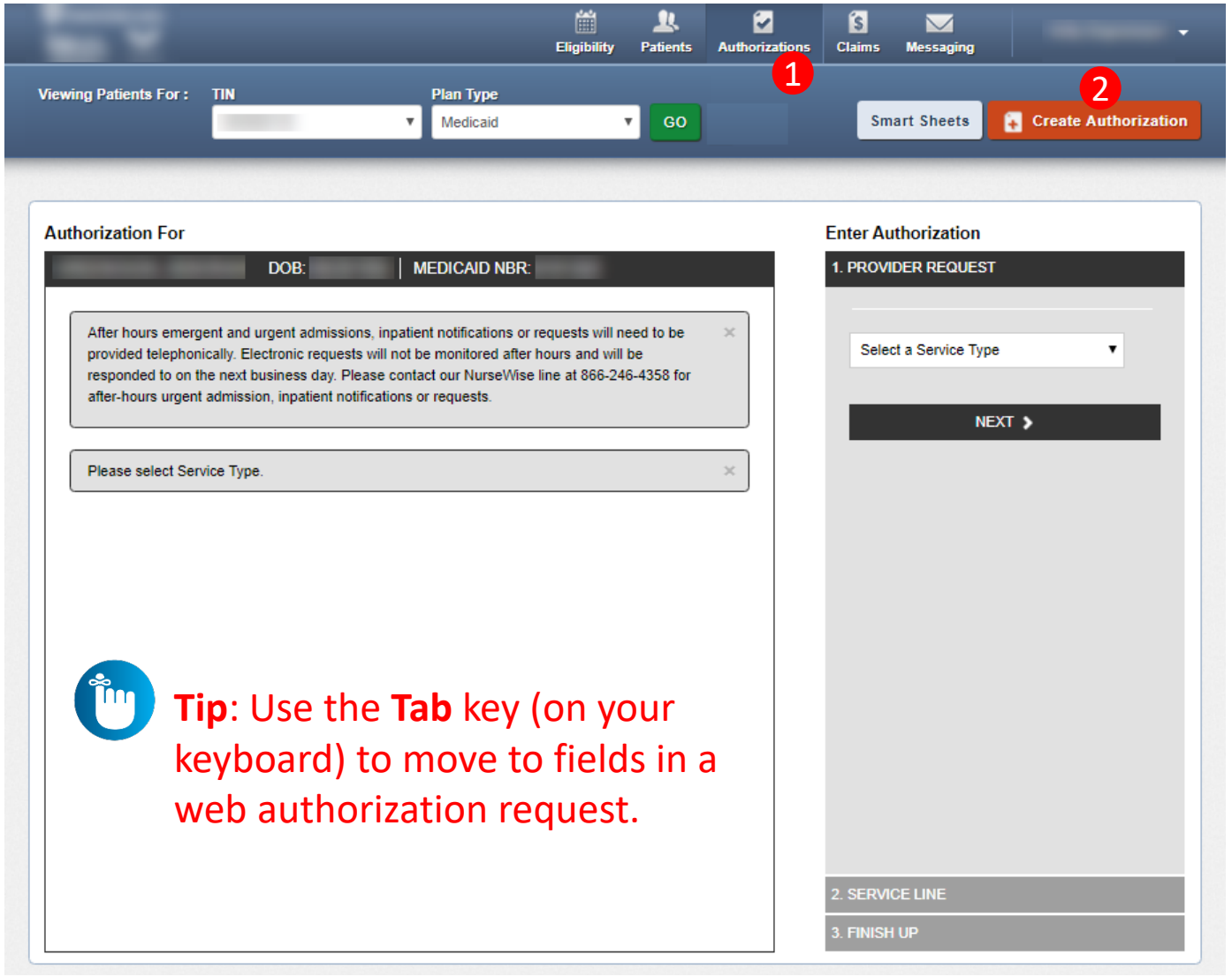
1. Click **Create Authorization**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**





Tip: You cannot create a web authorization on an ineligible member.

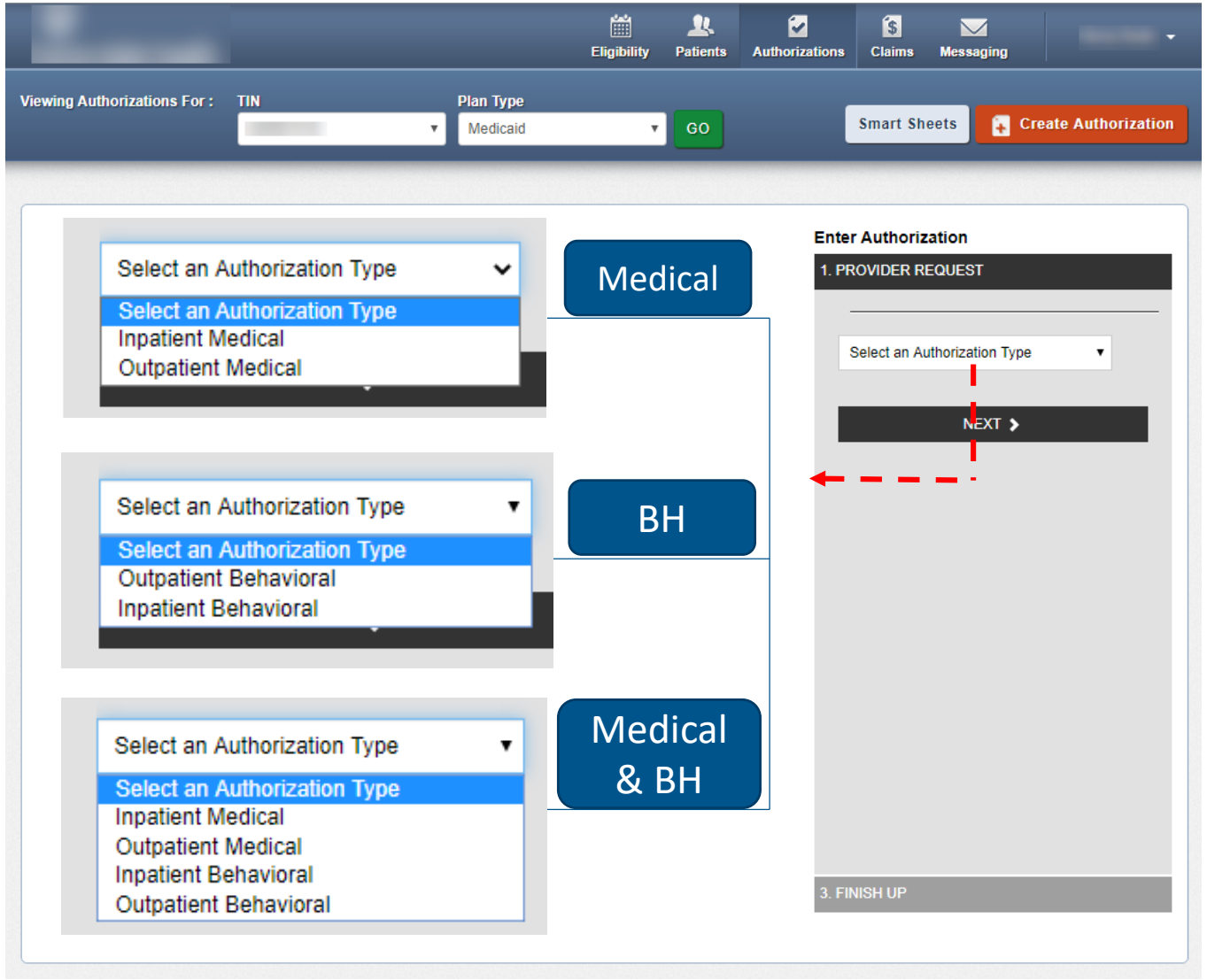
Create Authorization (Web Authorization Request)



Web Authorization Redesign

Web Authorization Redesign

- Authorization Type-driven
- Streamlined
- All Plan Types
  - Medicaid
  - Behavioral Health (BH) Medicaid
  - Allwell
  - Ambetter



Authorization Tips

- Always check the member's eligibility before submitting an authorization request
  - A web authorization **cannot** be submitted on an ineligible member
- Web authorizations generally load in processing queue within seconds of submission
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
  - This is the only way a portal user will see a web authorization error
  - Web authorization errors are uncommon, but when an error is encountered the web authorization request, will not load, and thereby will not be processed
    - Please submit the authorization request by phone or fax
    - Notify the Health Plan and provide the web authorization confirmation number for research

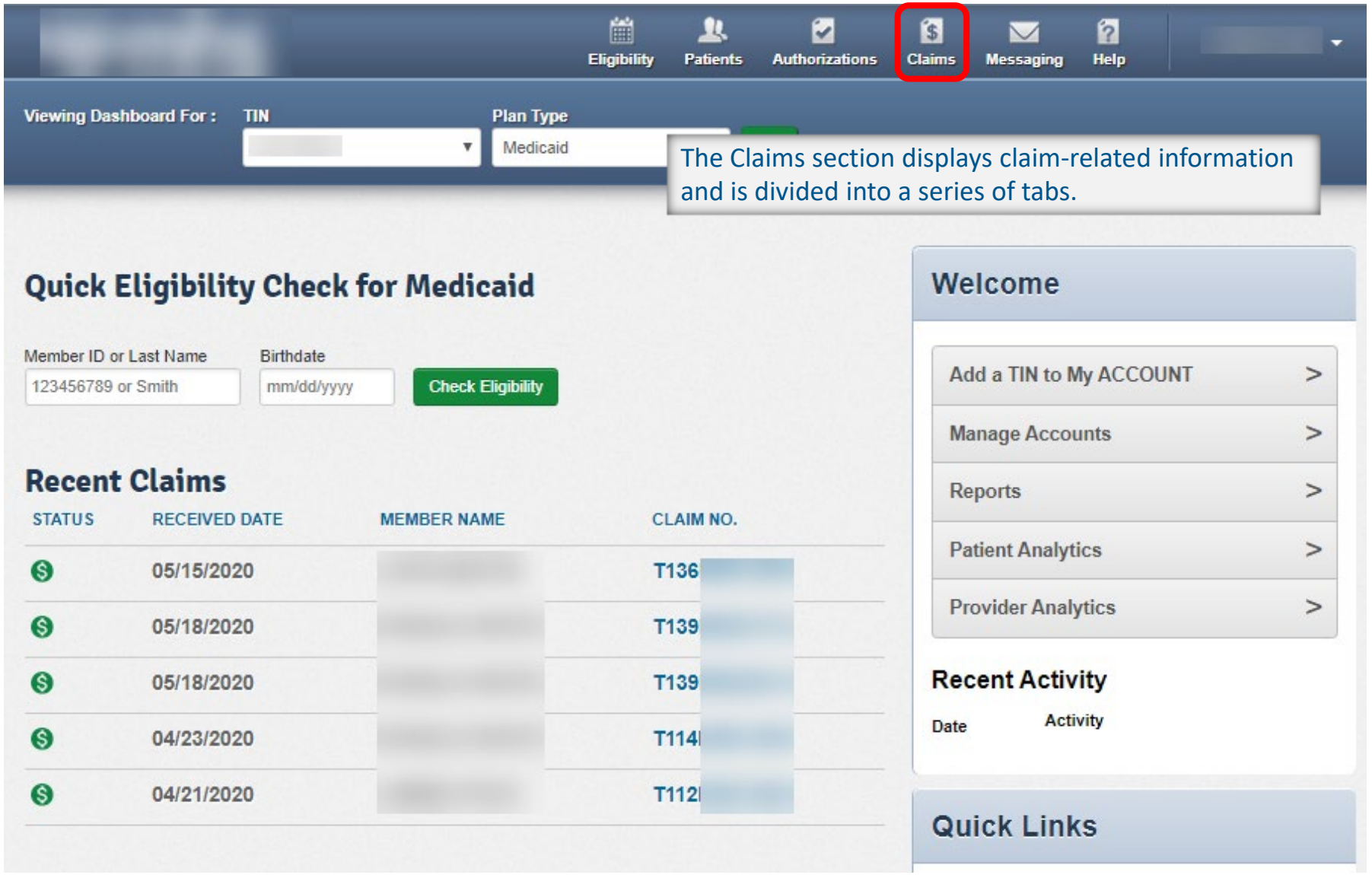
Portal Functionality: Claims

Claims

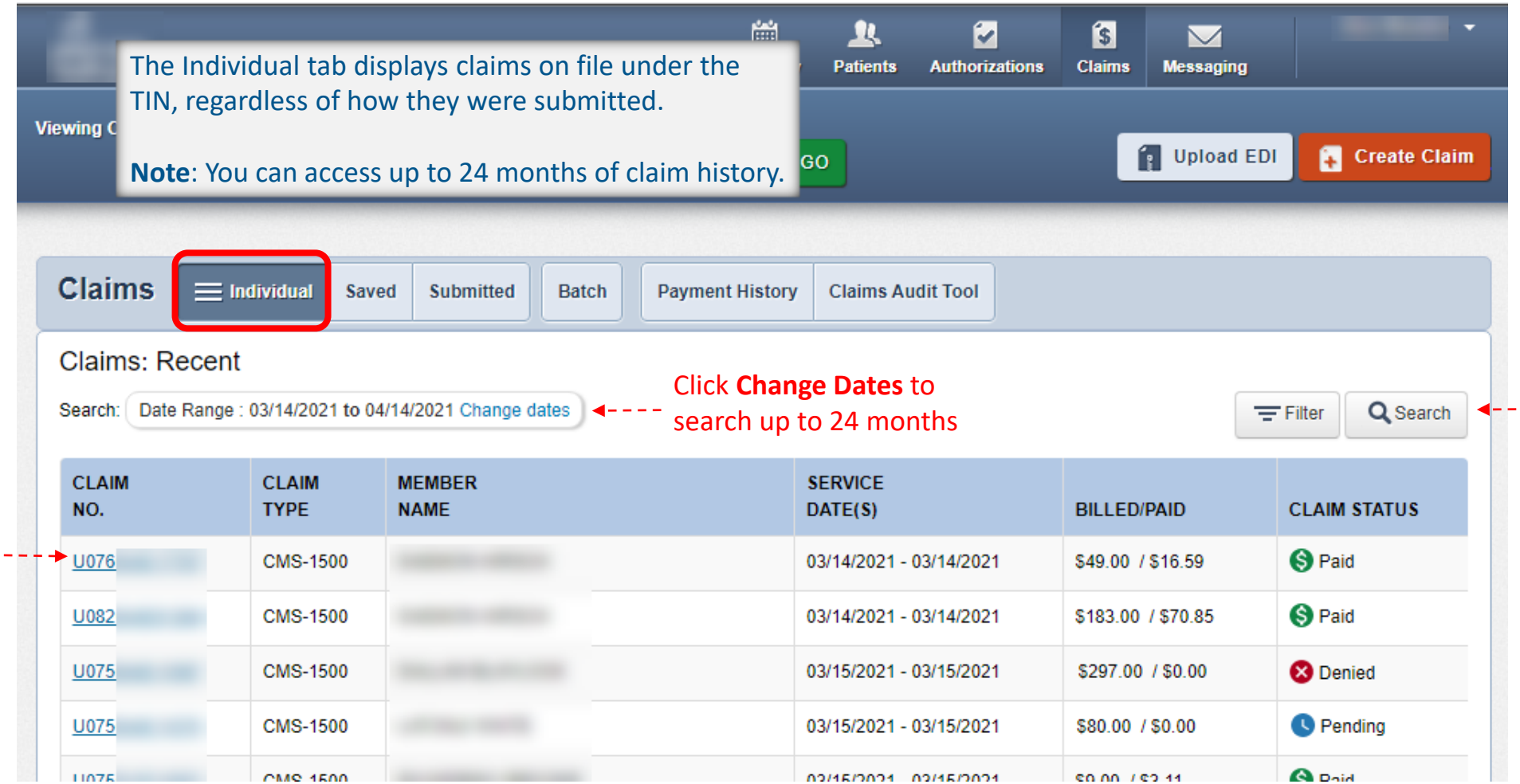
Providers are able to use the portal to:

- Access up to 24 months of claims-related history
- Submit new claim
- Correct claims
- Batch claims

Claims


Eligibility
Patients
Authorizations
Claims
Messaging
Help
Viewing Dashboard For :
TIN
Plan Type
Medicaid
The Claims section displays claim-related information and is divided into a series of tabs.
Quick Eligibility Check for Medicaid
Member ID or Last Name
123456789 or Smith
Birthdate
mm/dd/yyyy
Check Eligibility
Recent Claims
STATUS
RECEIVED DATE
MEMBER NAME
CLAIM NO.
05/15/2020
T136
05/18/2020
T139
05/18/2020
T139
04/23/2020
T114
04/21/2020
T112
Welcome
Add a TIN to My ACCOUNT
Manage Accounts
Reports
Patient Analytics
Provider Analytics
Recent Activity
Date
Activity
Quick Links

Claims – Individual



Click **Change Dates** to search up to 24 months

Click **Filter** and/or **Search** for additional options

Click Claim Number to view claim details

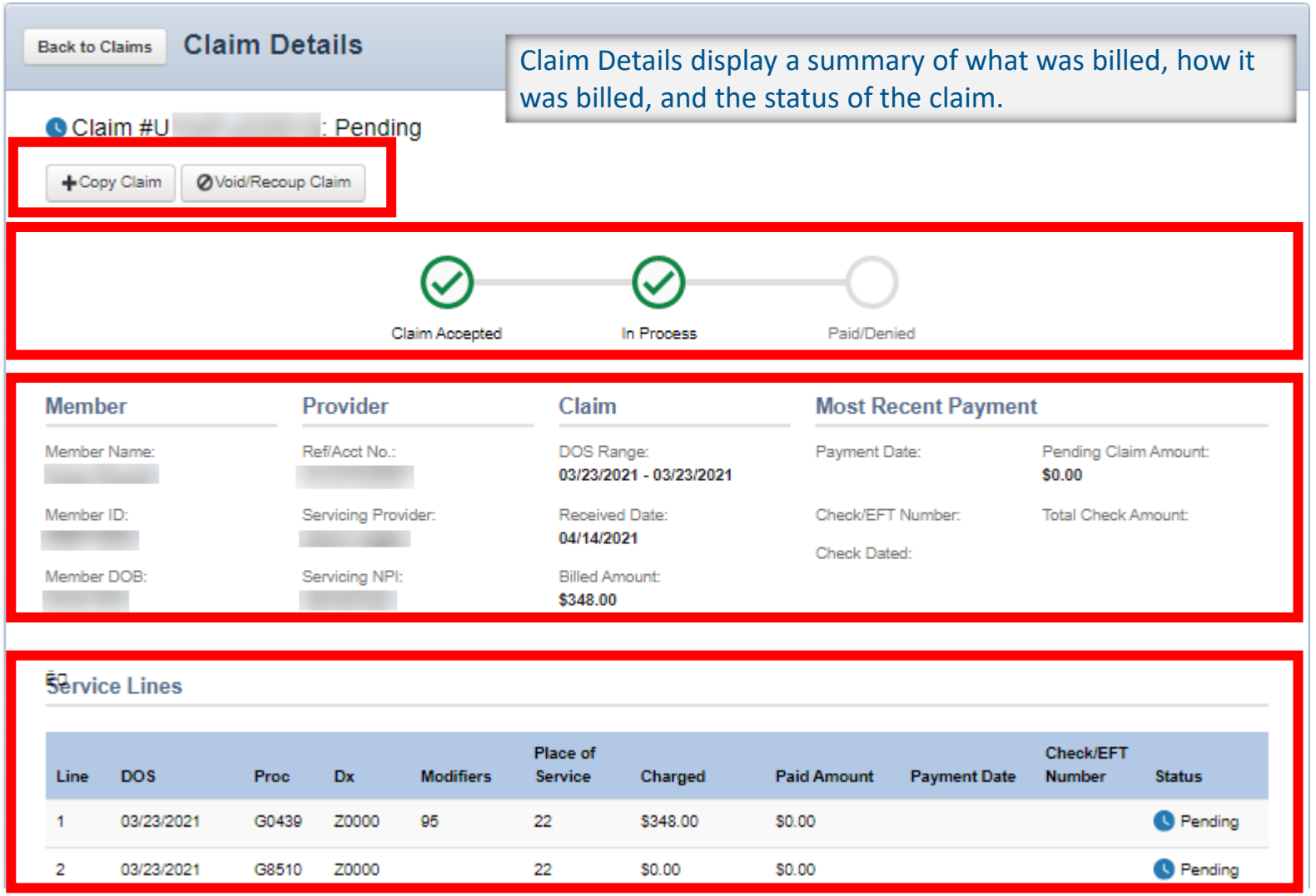
Claim Details

Claim Action Buttons

Claim Information

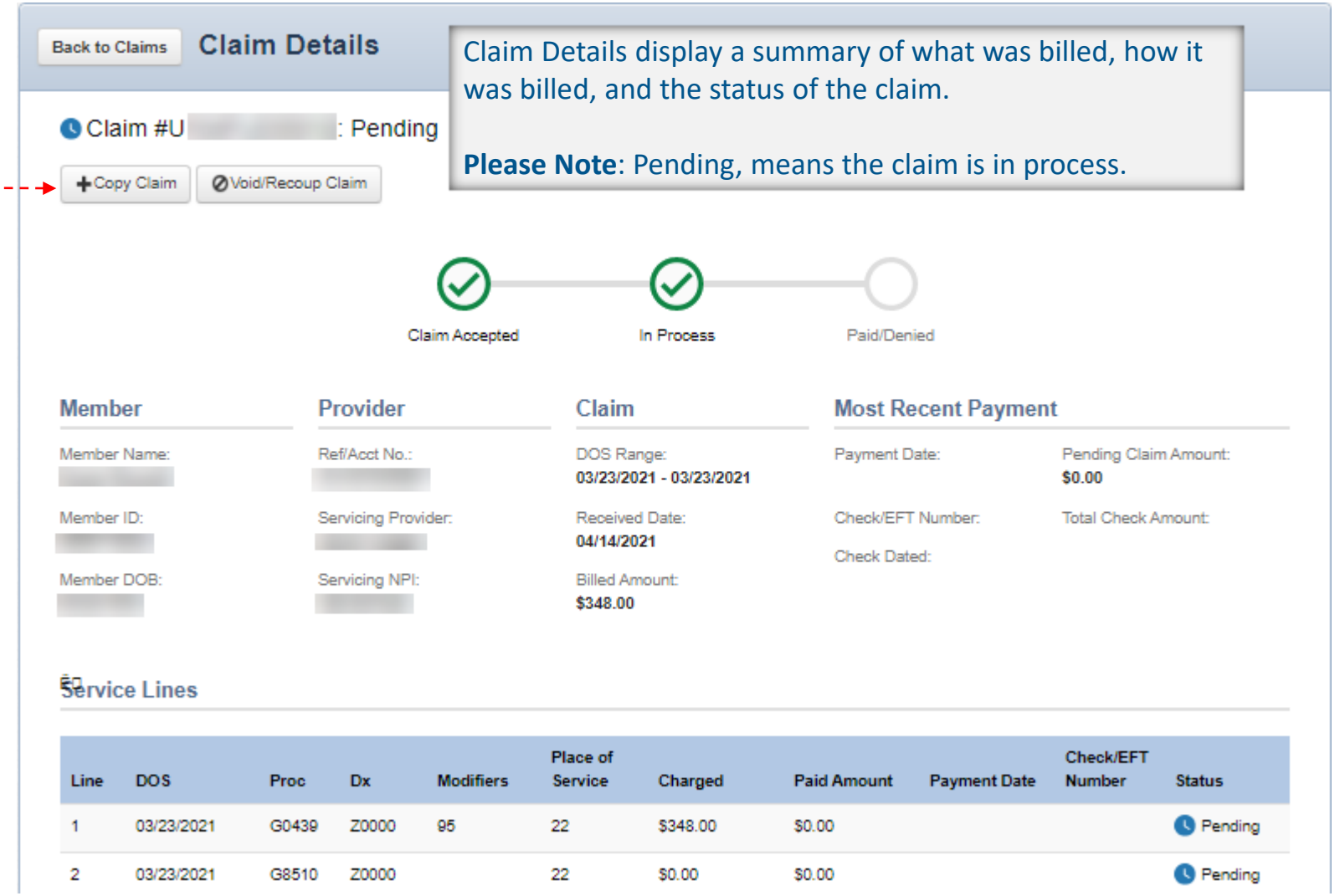
Claim Status Tracking

Claim Service Line(s)



Claim Details – Pending

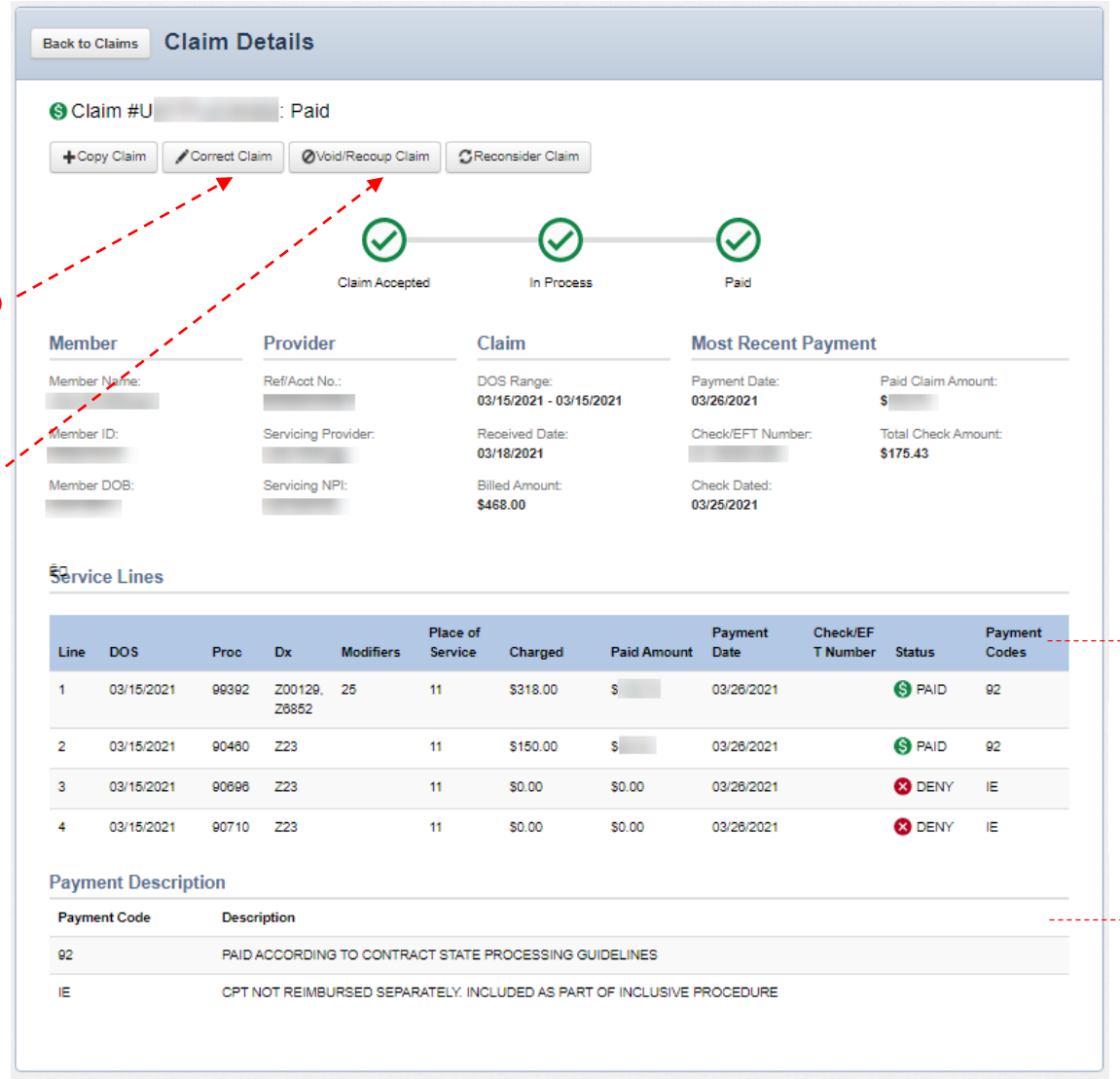
Click **Copy Claim** to create an exact copy of this claim, as a shortcut. It is considered a new claim submission and will be processed as a 1st time claim



Claim Details – Finalized

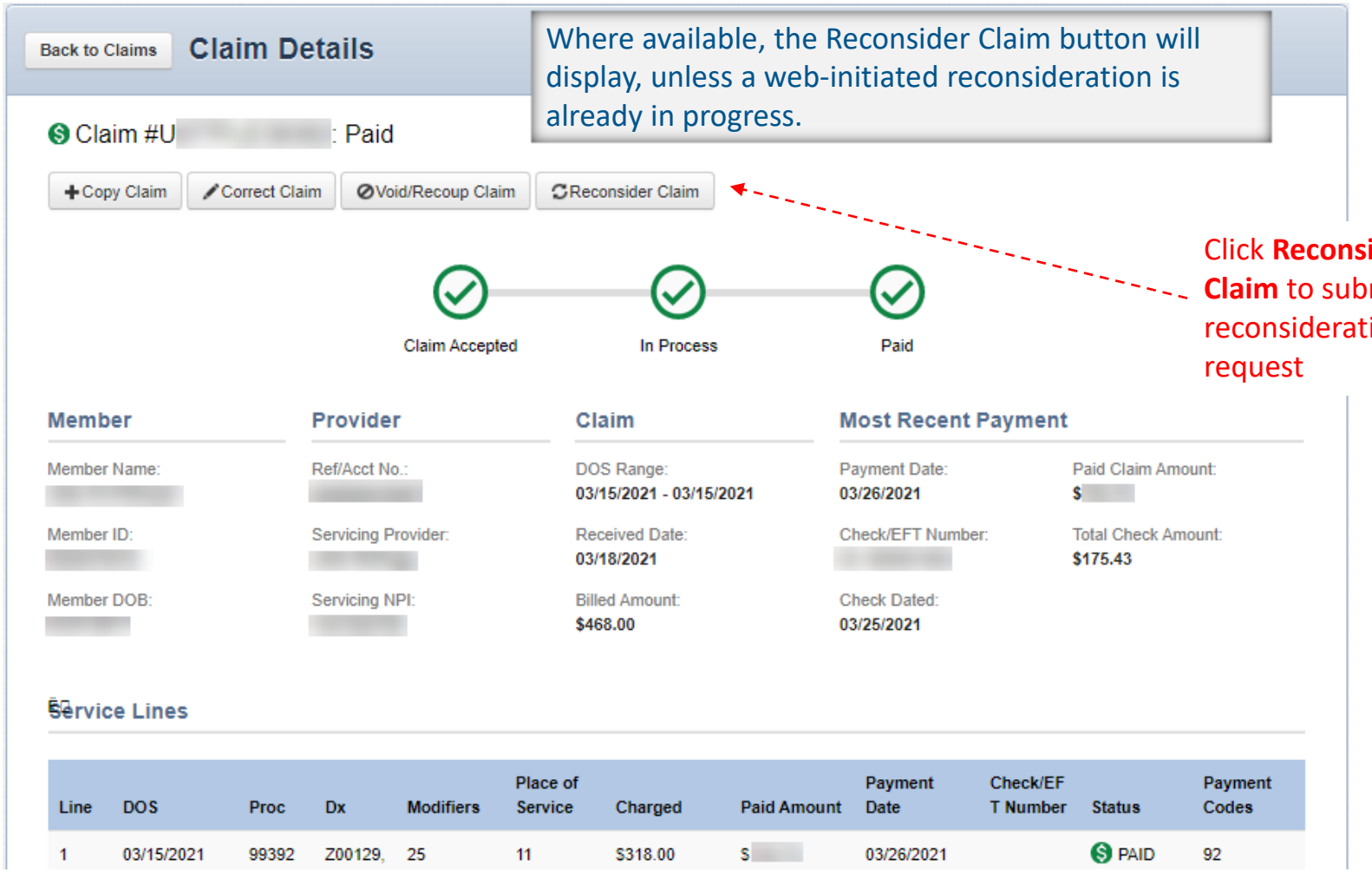
Click **Correct Claim** to correct a finalized claim

Where available, click **Void/Recoup Claim** void an original claim that has already been processed, and request a full recoupment of payment



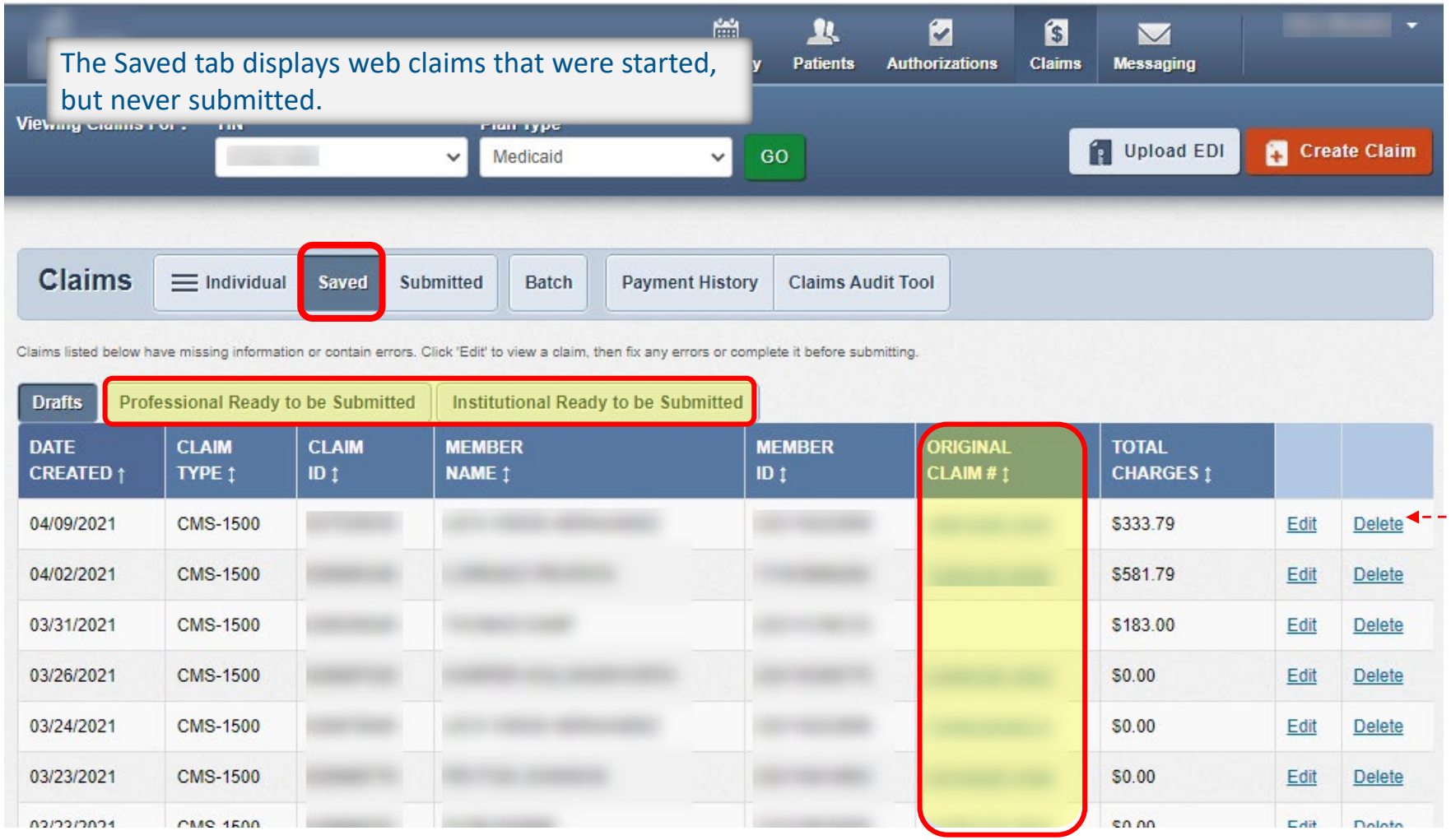
Payment Codes and **Payment Description** display on finalized claims

Reconsider Claim



Tip: **Reconsider Claim** is for reconsiderations only. It cannot be used for Appeals/Claim Disputes.

Claims – Saved

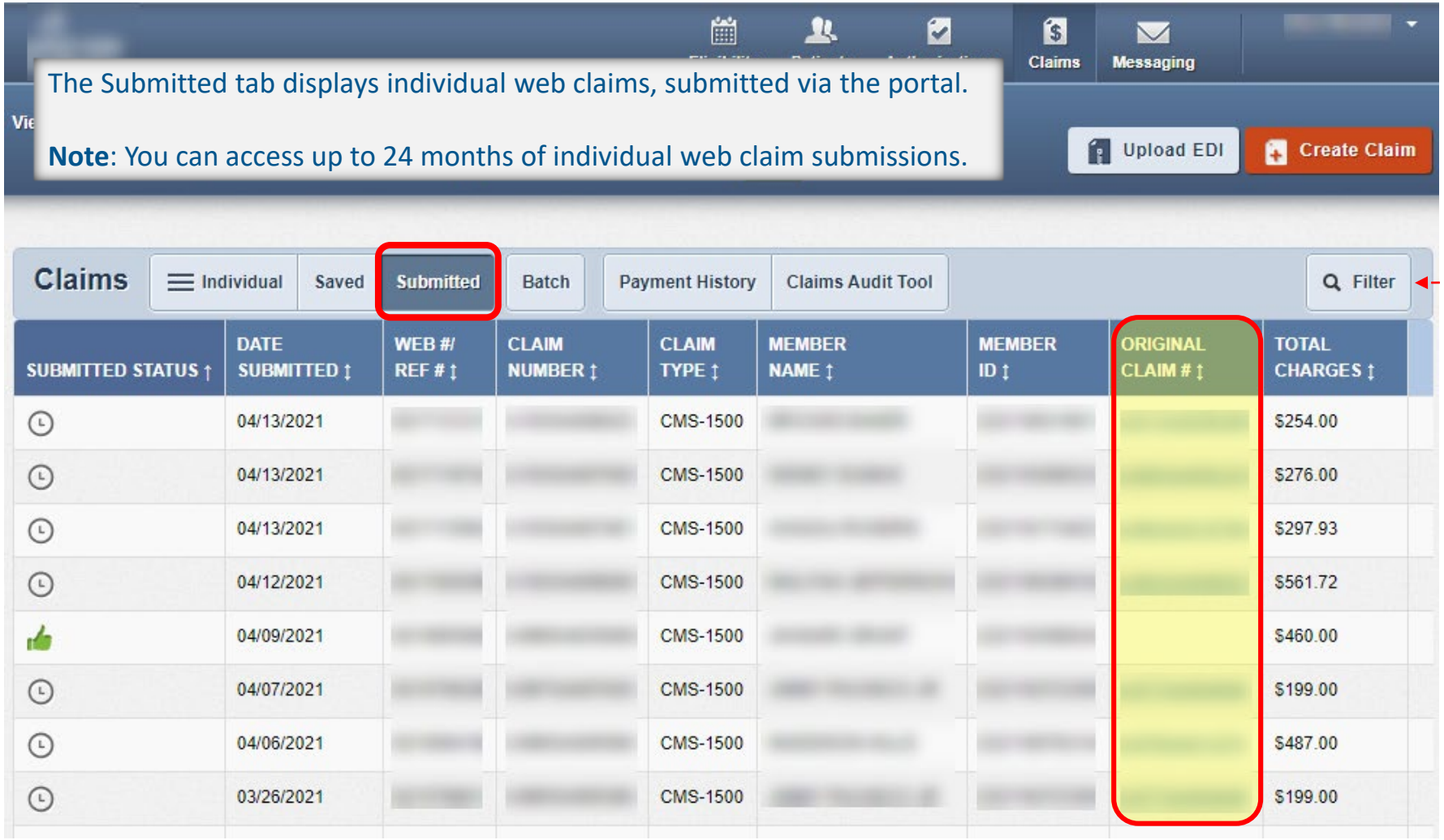


Click **Edit** to resume, complete, and submit web claim

Click **Delete** to delete the web claim draft

Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim draft.

Claims – Submitted



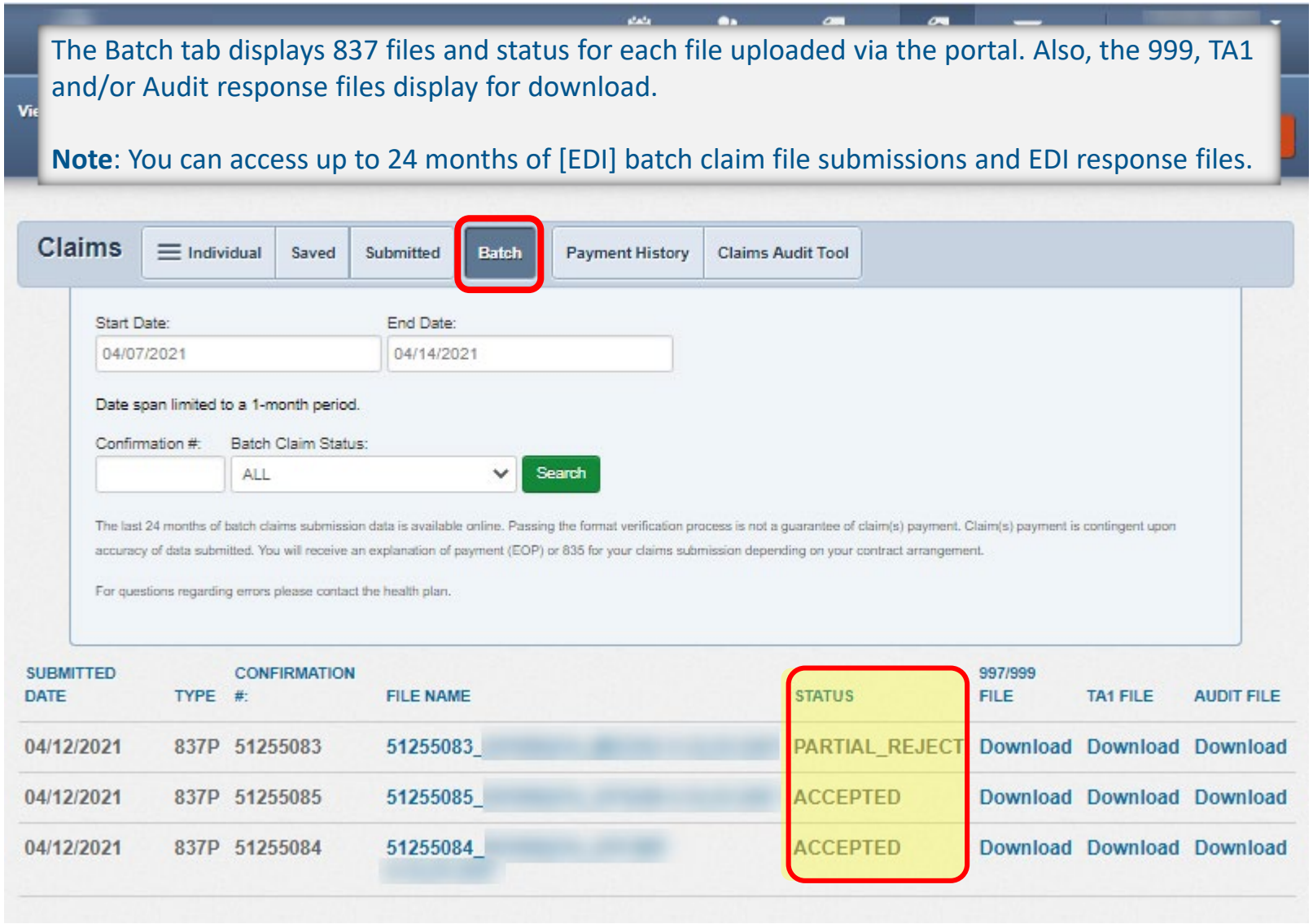
Click **Filter** for additional search options

Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim submission.

Claims – Batch

The Batch tab displays 837 files and status for each file uploaded via the portal. Also, the 999, TA1 and/or Audit response files display for download.

Note: You can access up to 24 months of [EDI] batch claim file submissions and EDI response files.



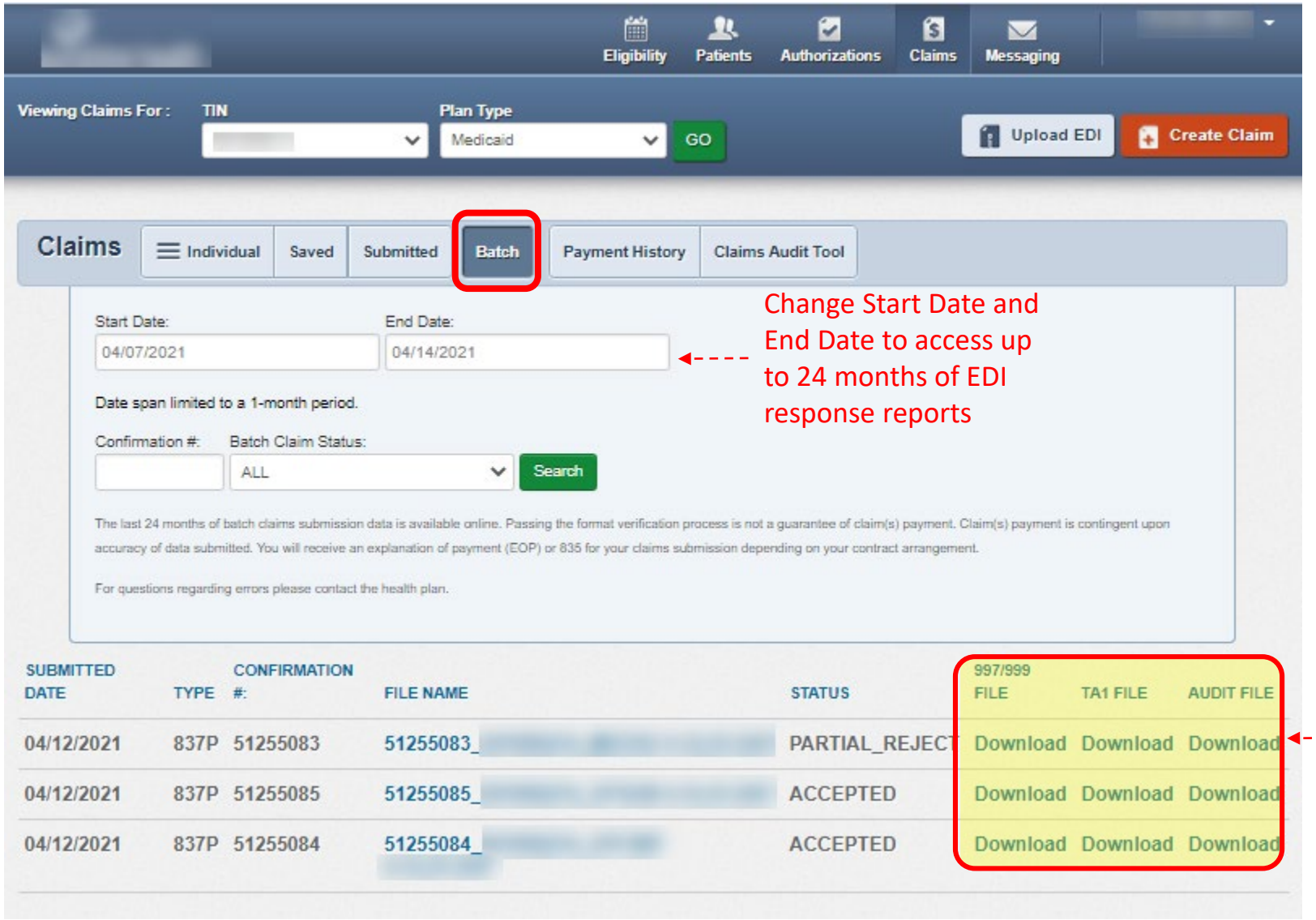
The File status displays in Status. File status Rejected or Partial_Rejected indicates file-level EDI front-end rejections.

Action required to resolve file-level rejections:

- The errors must be corrected in your system
- Re-batch claims
- Resubmit (i.e. upload)

Note: Front-end EDI rejections will not be processed any further, therefore, the claims will never load for adjudication.

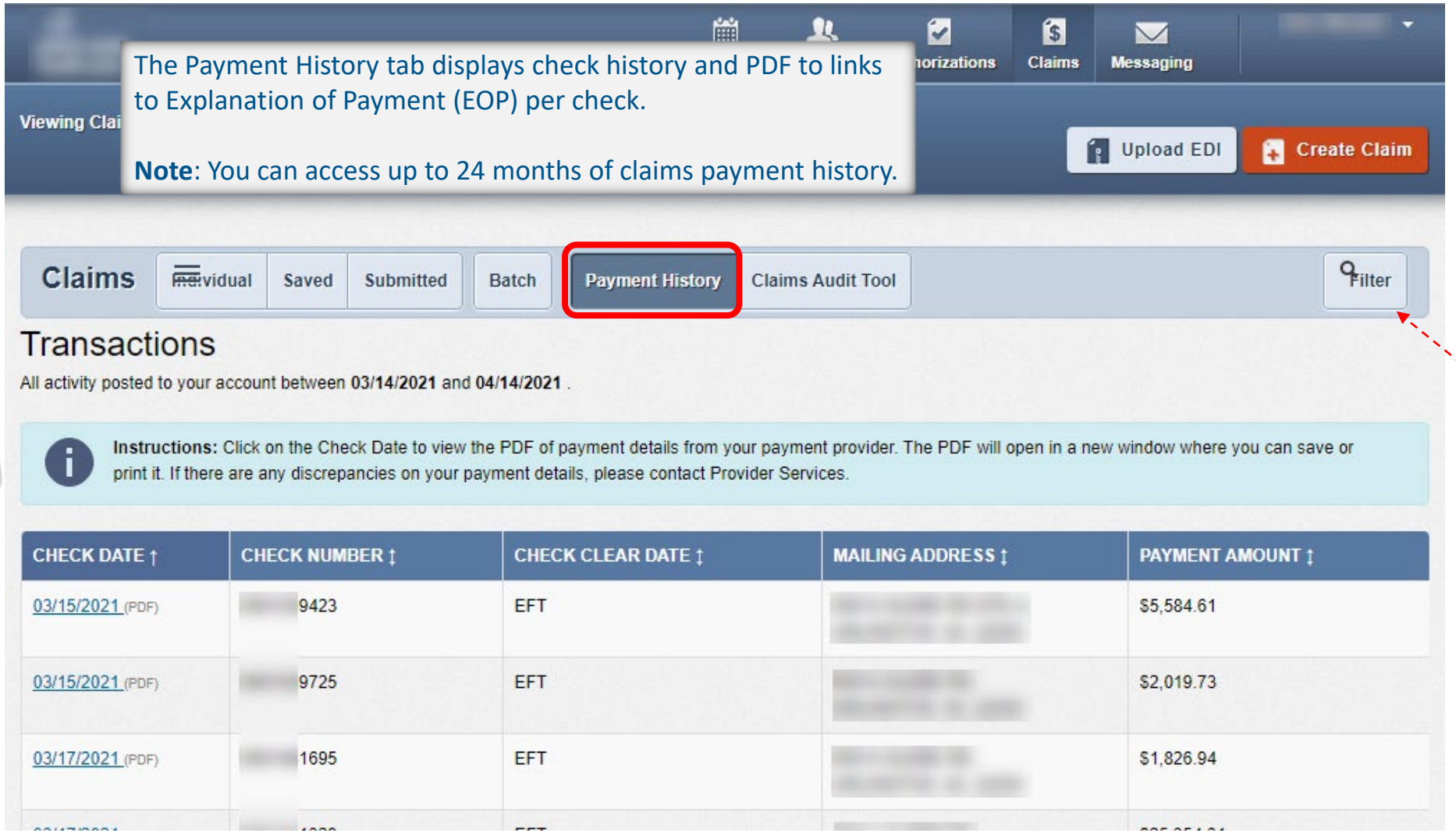
Claims – Batch, continued



Claims – Payment History

The Payment History tab displays check history and PDF to links to Explanation of Payment (EOP) per check.

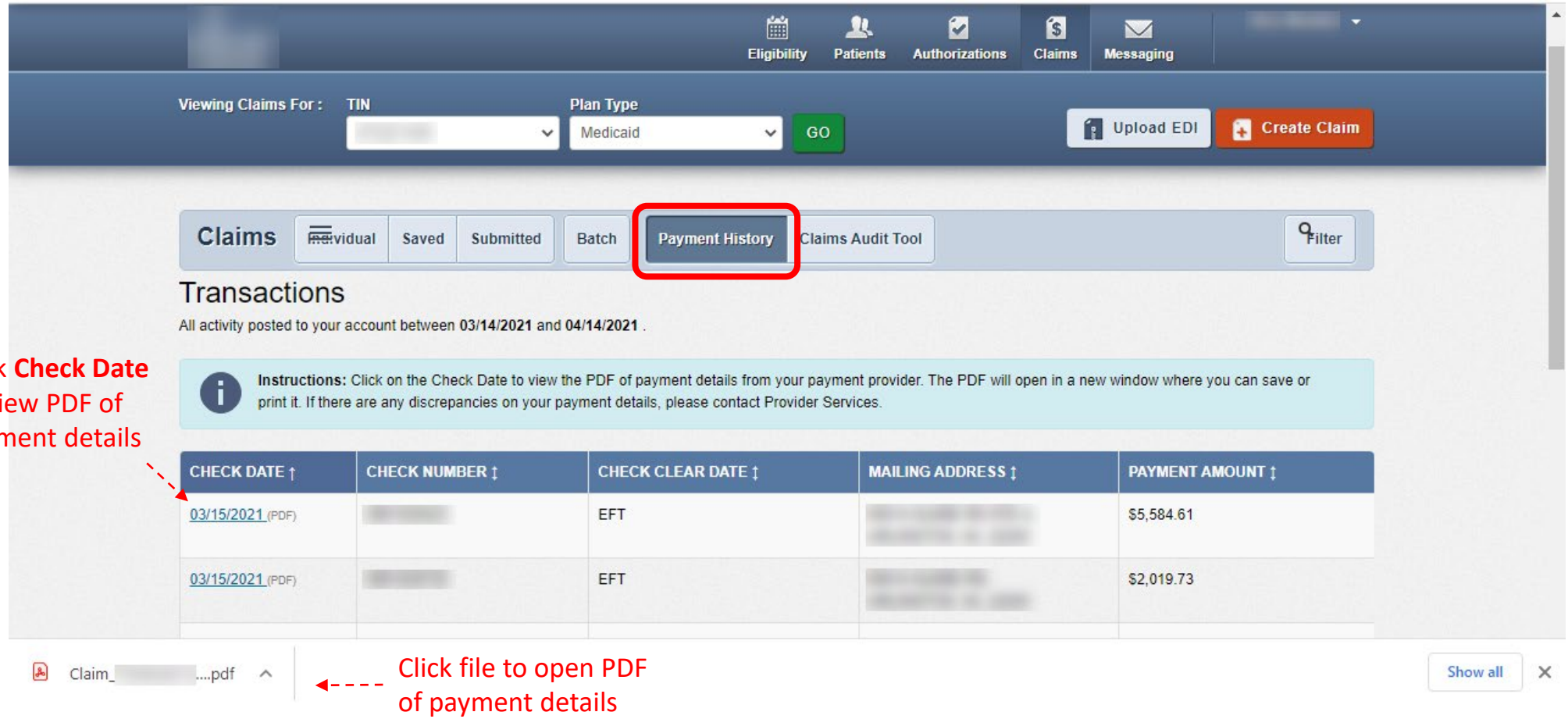
Note: You can access up to 24 months of claims payment history.



NEW

Click **Filter** for additional search options

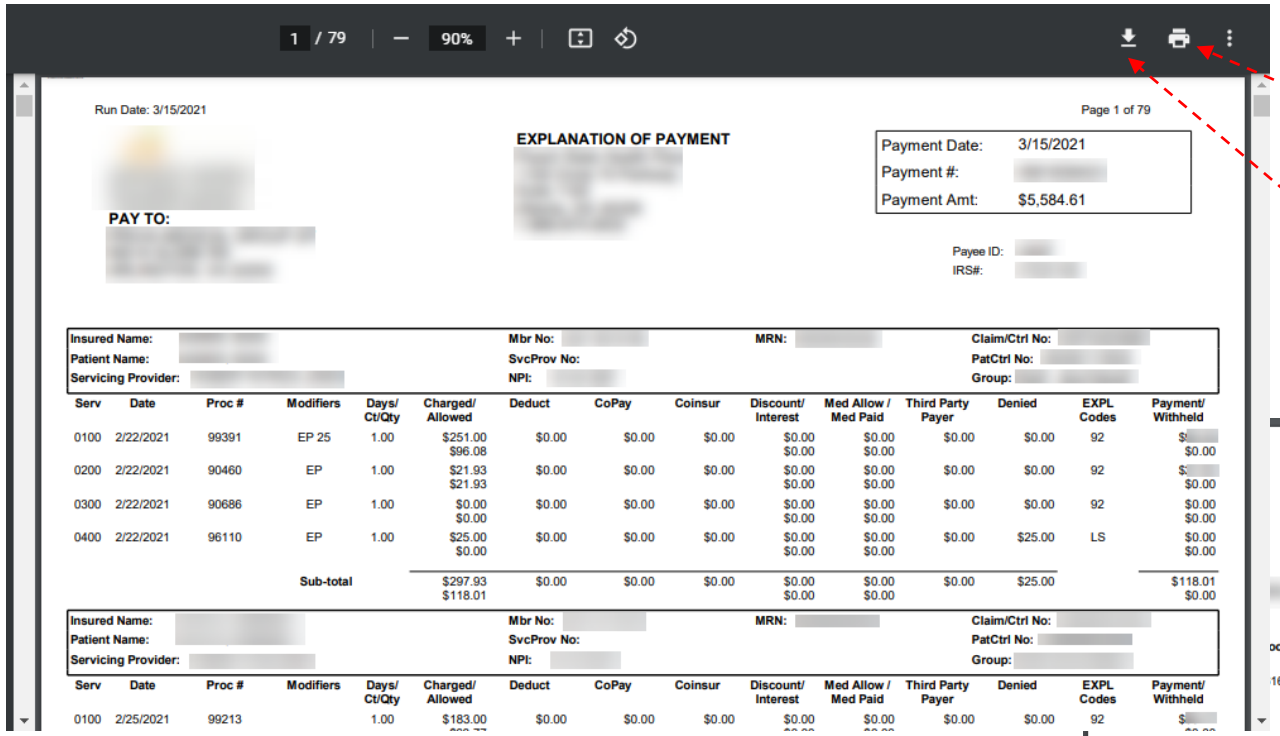
Claims – Payment History, continued



Click **Check Date** to view PDF of payment details

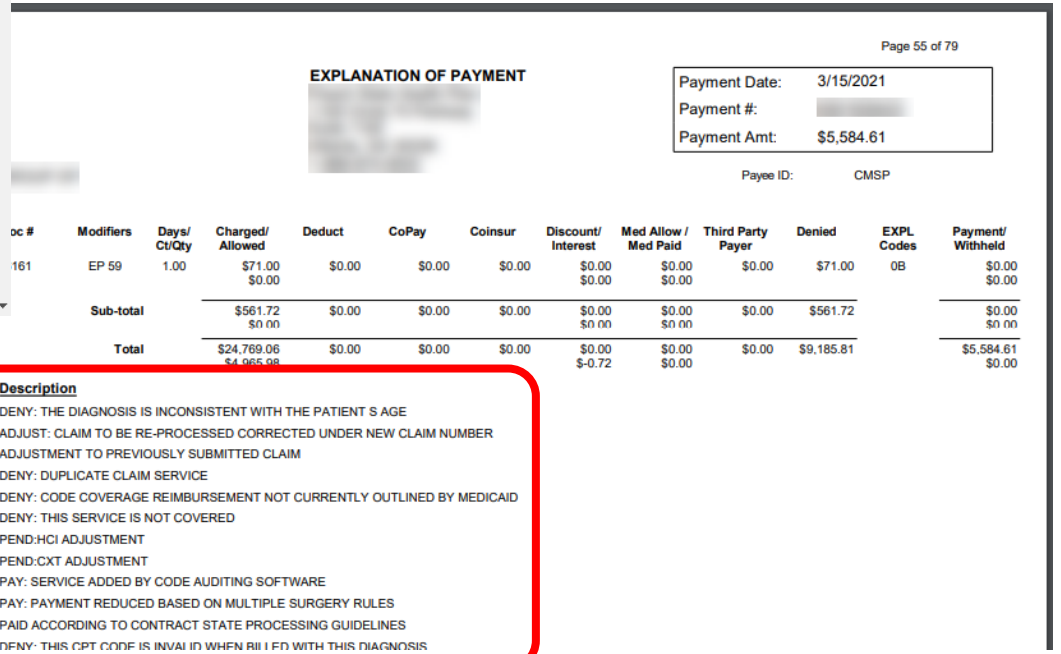
Click file to open PDF of payment details

Claims – Explanation of Payment PDF



Click to print EOP

Click to download and save a copy of EOP



Tip: The **Explanation Code** and **Description**, displays after the last claim in the EOP.

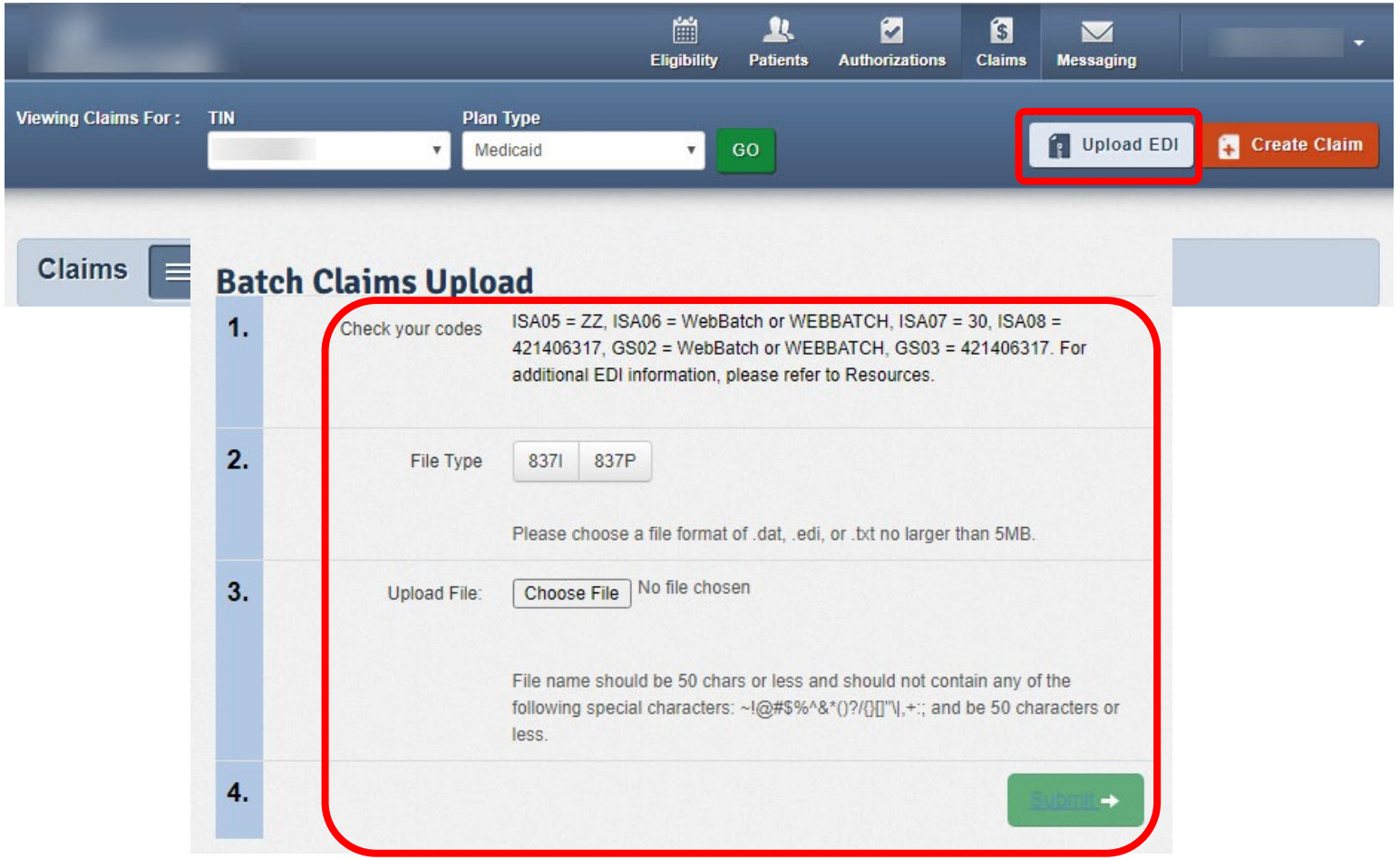
CENTENE Corporation

Portal Functionality: Claim Submission

Claim Submission – Upload EDI

Click **Upload EDI** to upload an EDI Batch (837I / 837P).

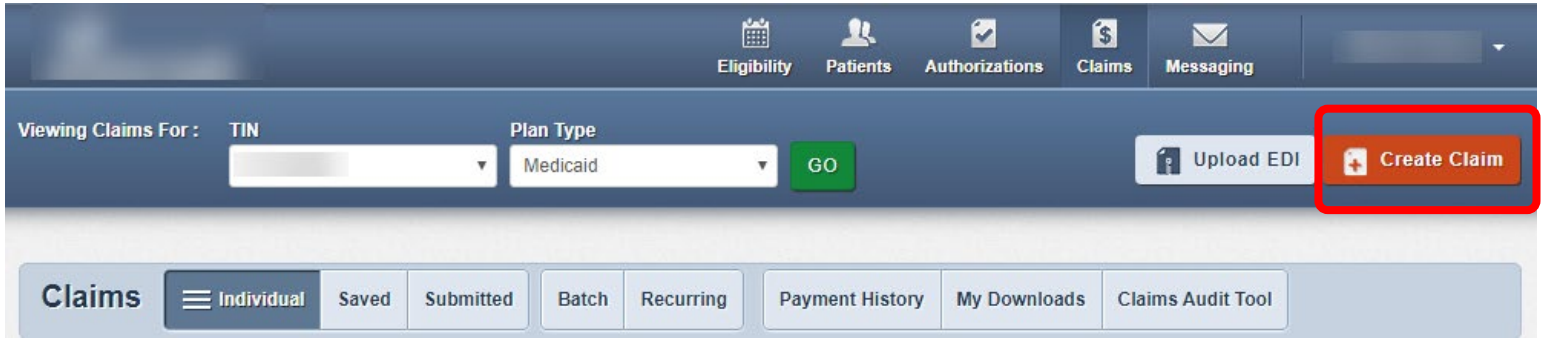
1. Check the codes in your file.
   - Ensure file name is less than 50 characters and does not contain special characters
2. Select **File Type**.
3. Click **Choose File**. A separate window will display.
4. Select file from your computer directory.
5. Click **Open**.
6. Click **Submit**.

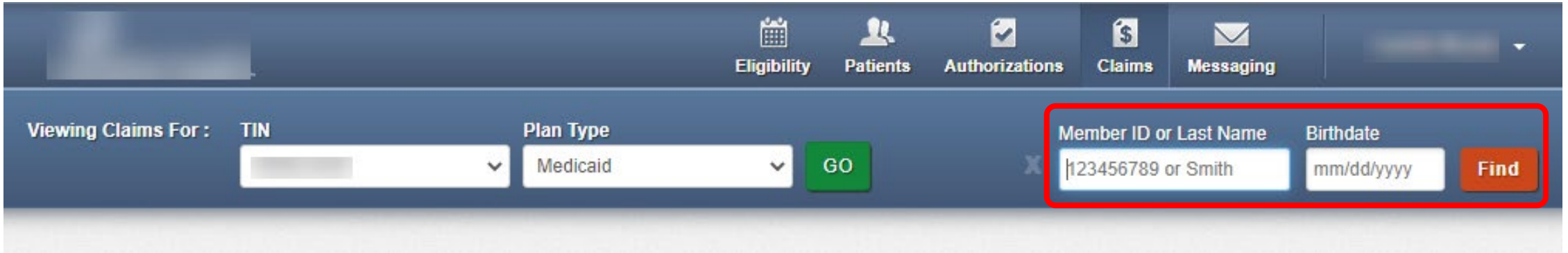


Claim Submission – Create Claim (Individual Web Claim)

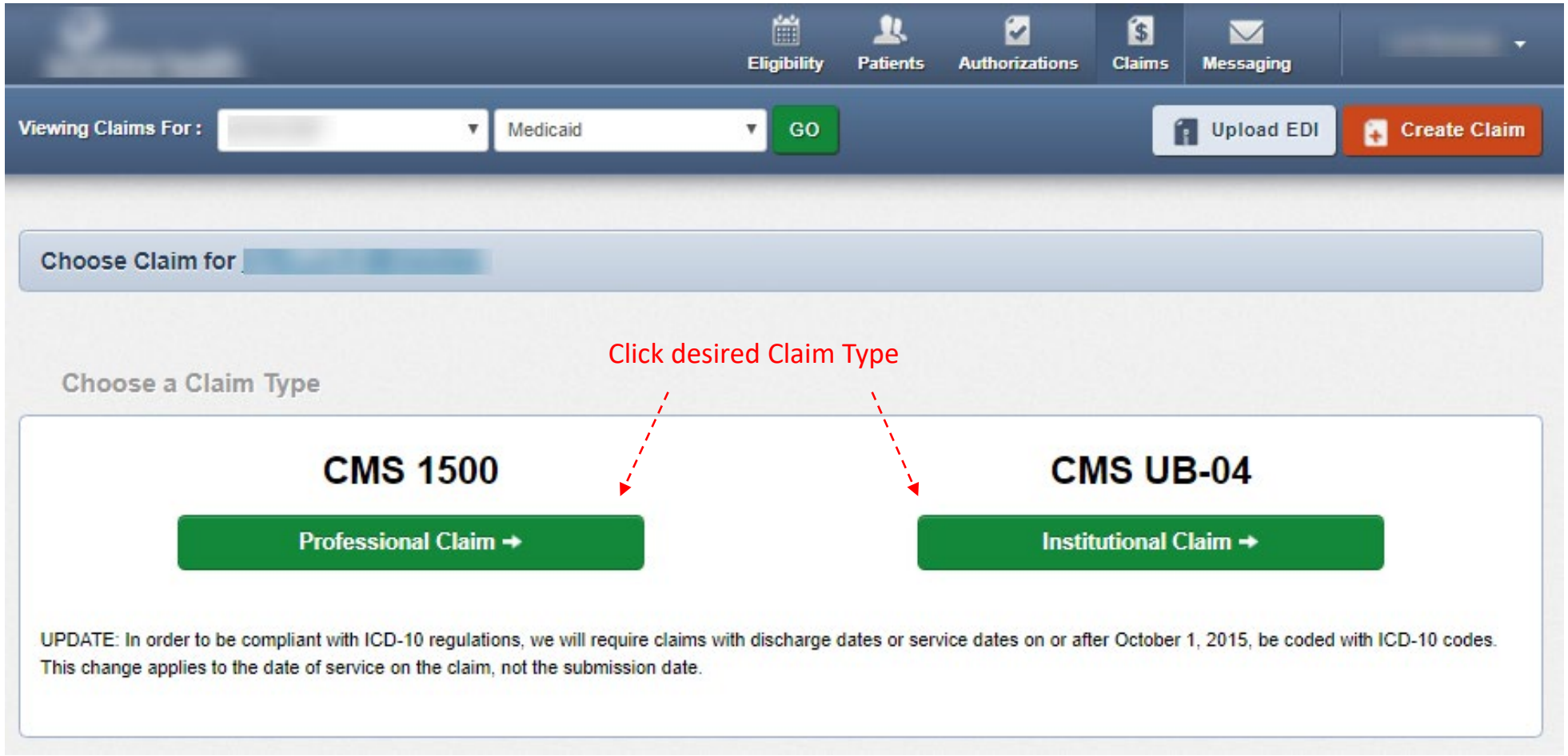
To begin an individual web claim:

1. Click **Create Claim**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**

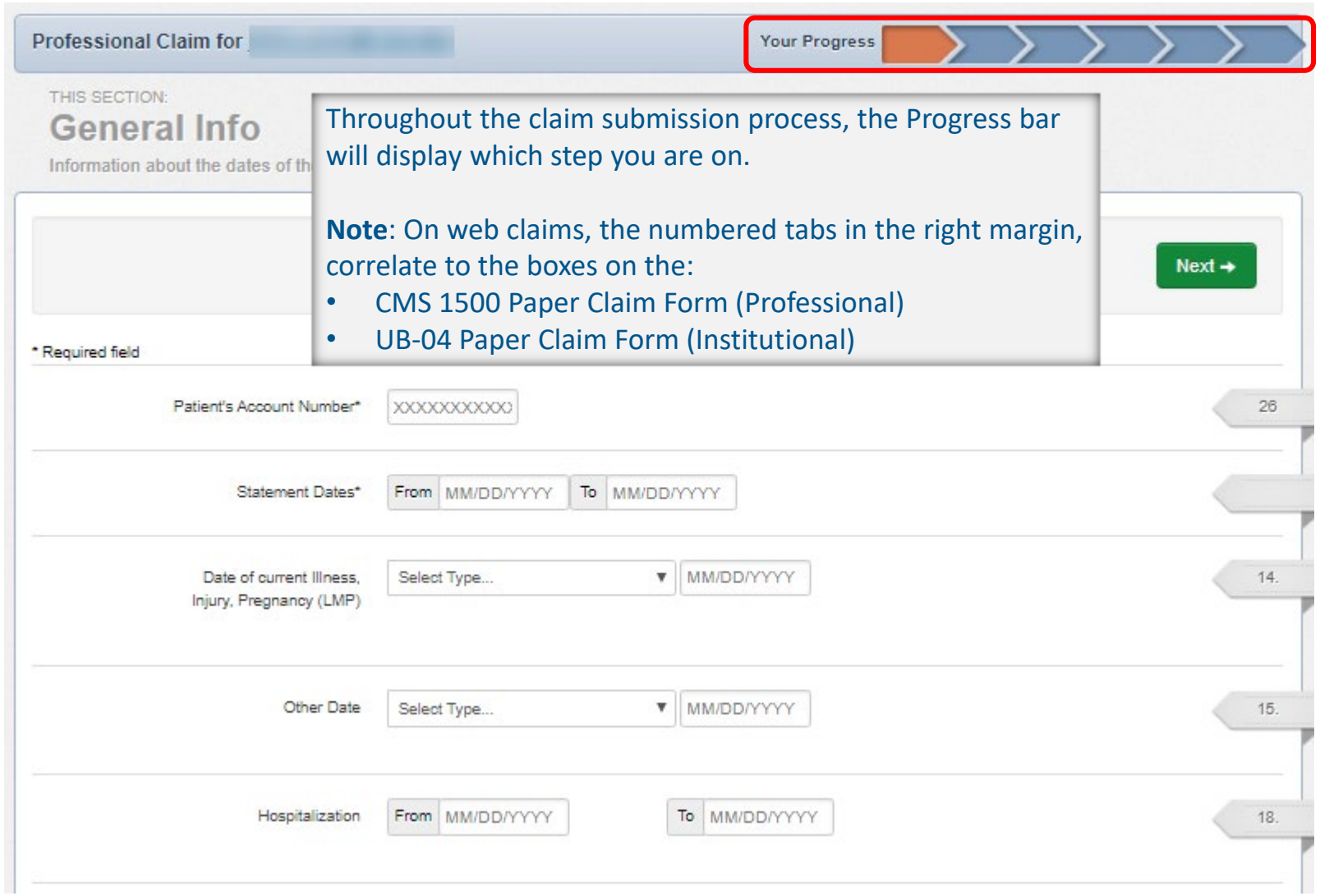




Create Claim – Claim Type Selection

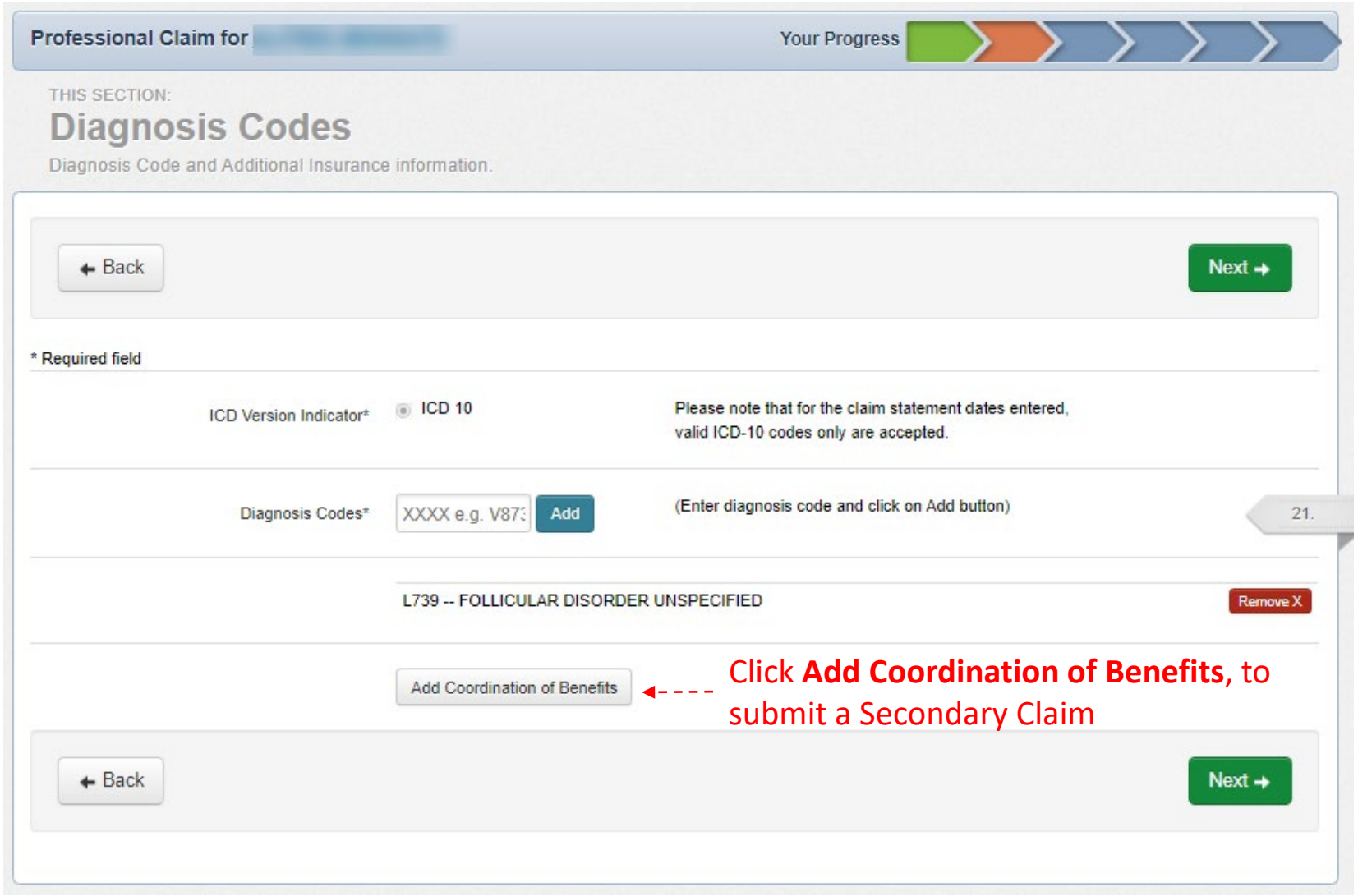


Create Claim – General Information



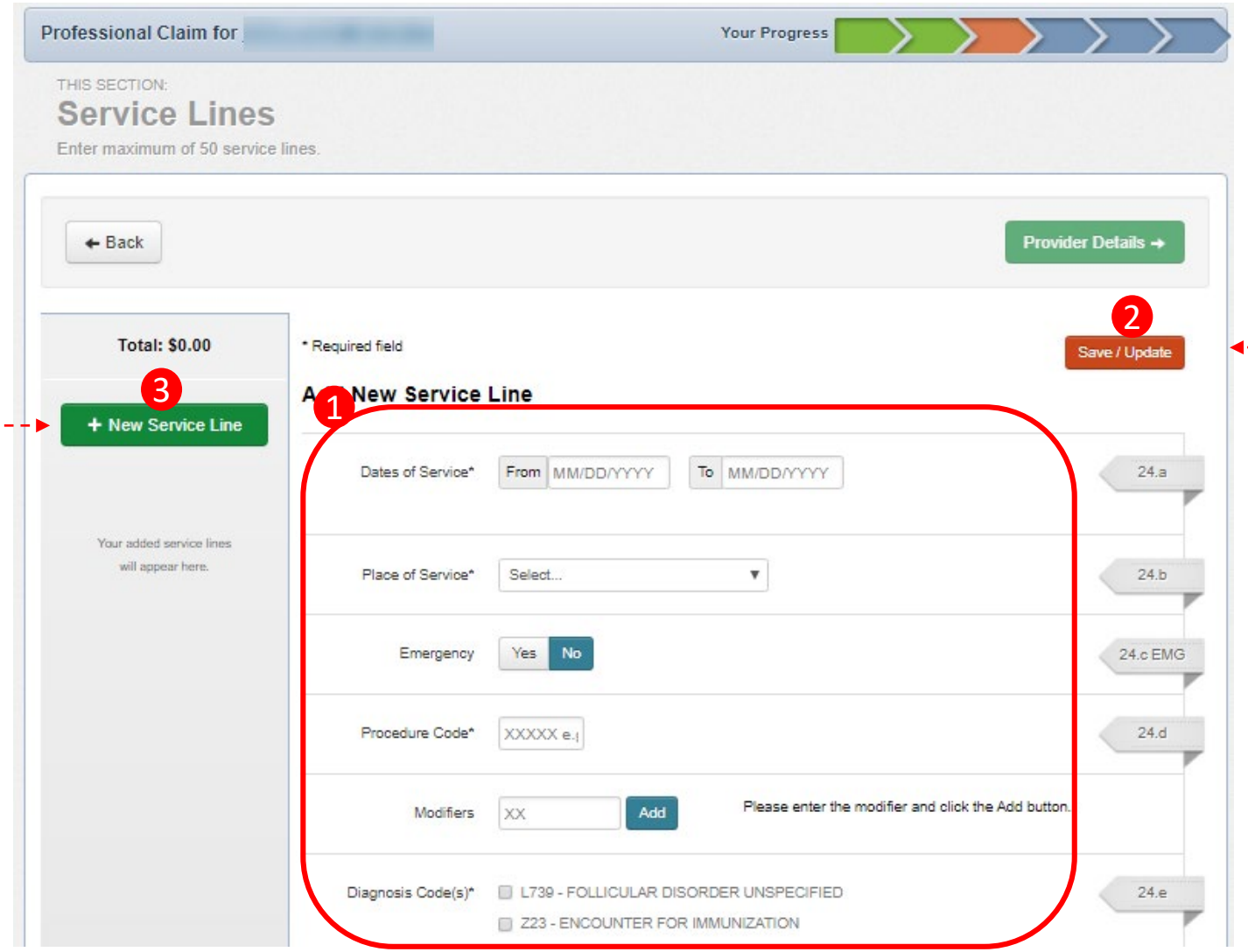
Hover mouse over tabs for additional information

Create Claim – Diagnosis Codes



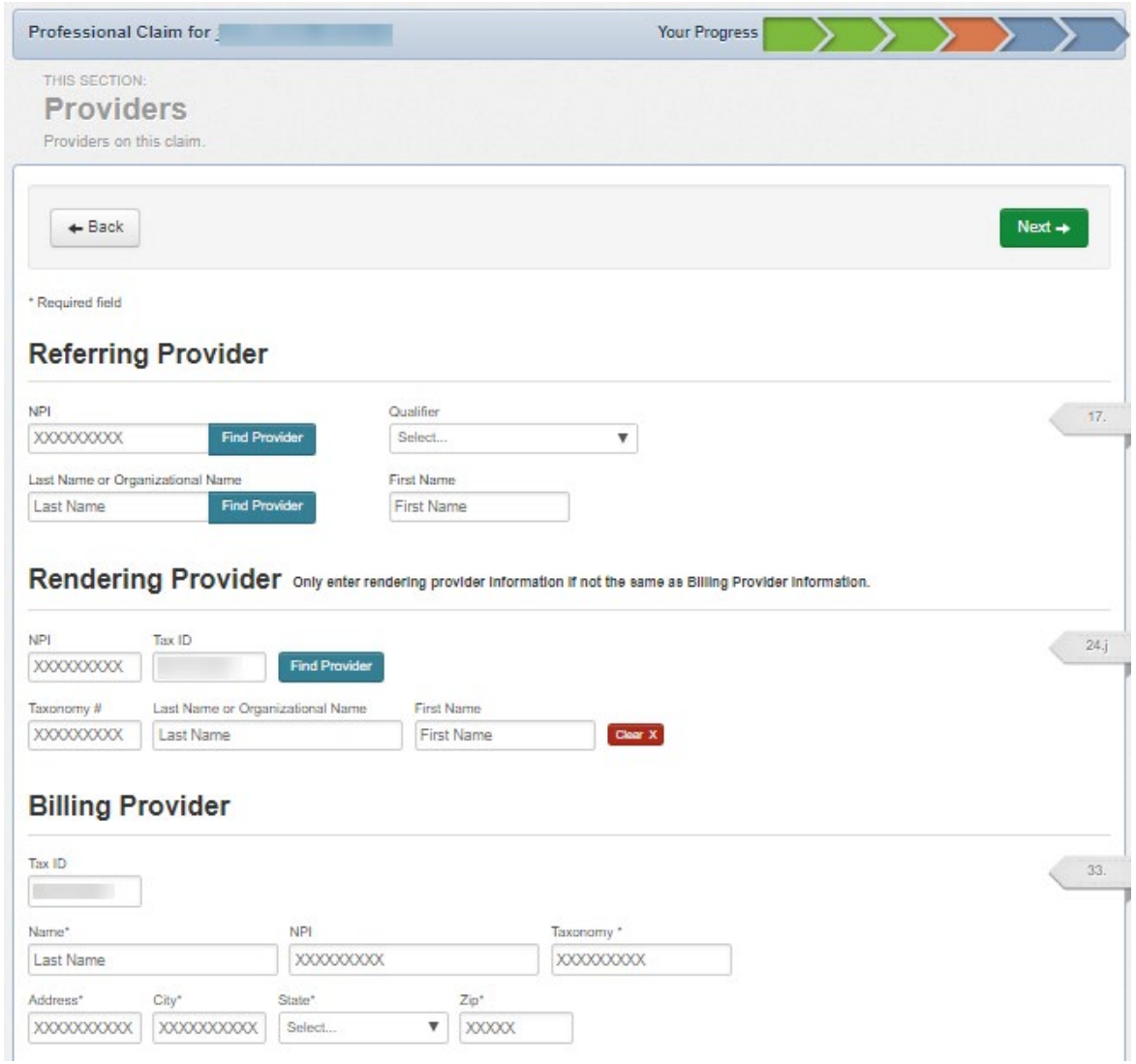
Create Claim – Service Lines

Click **+ New Service Line** to enter additional Service Line(s).

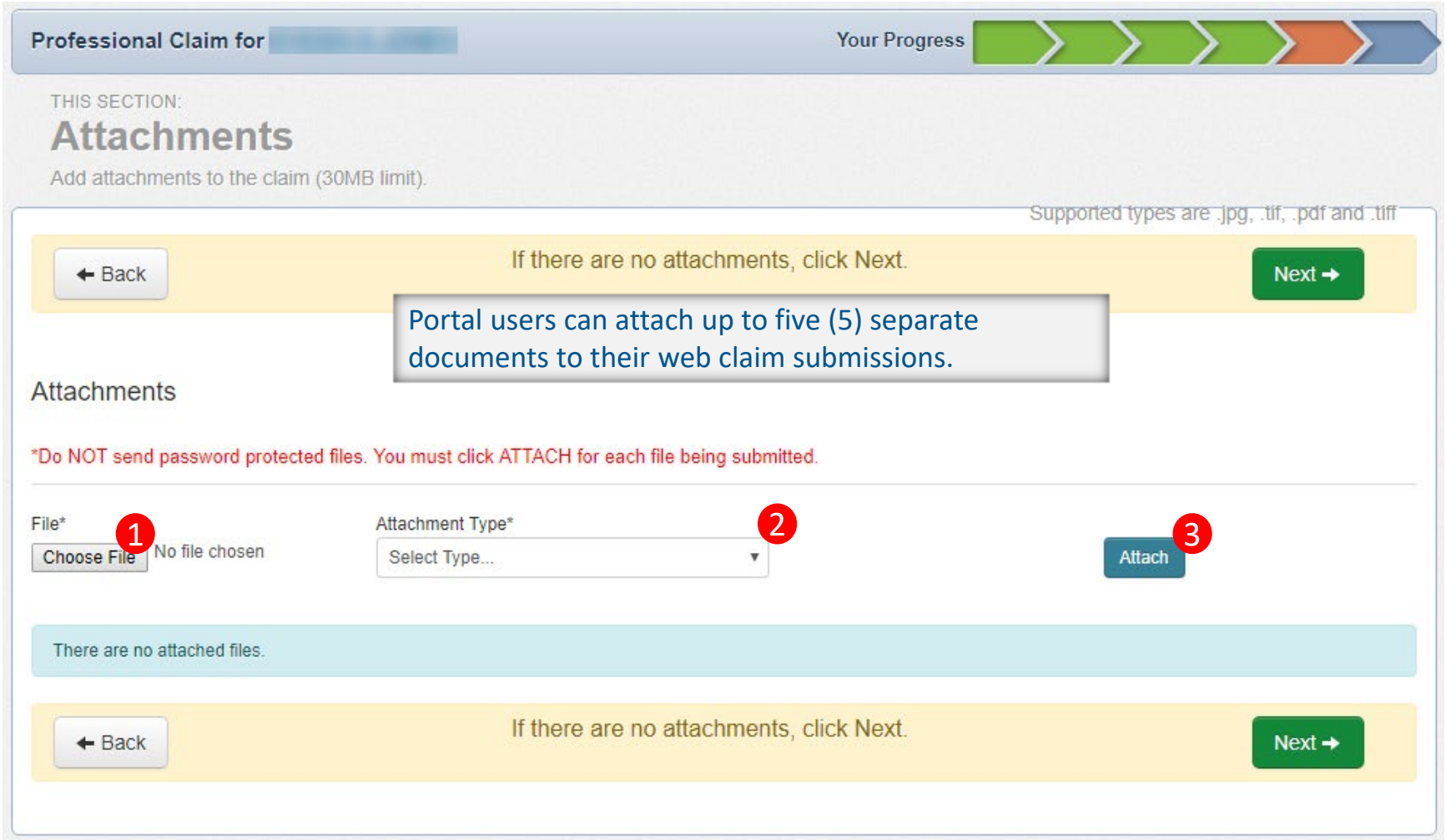


After entering or editing a Service Line, click **Save/Update**.

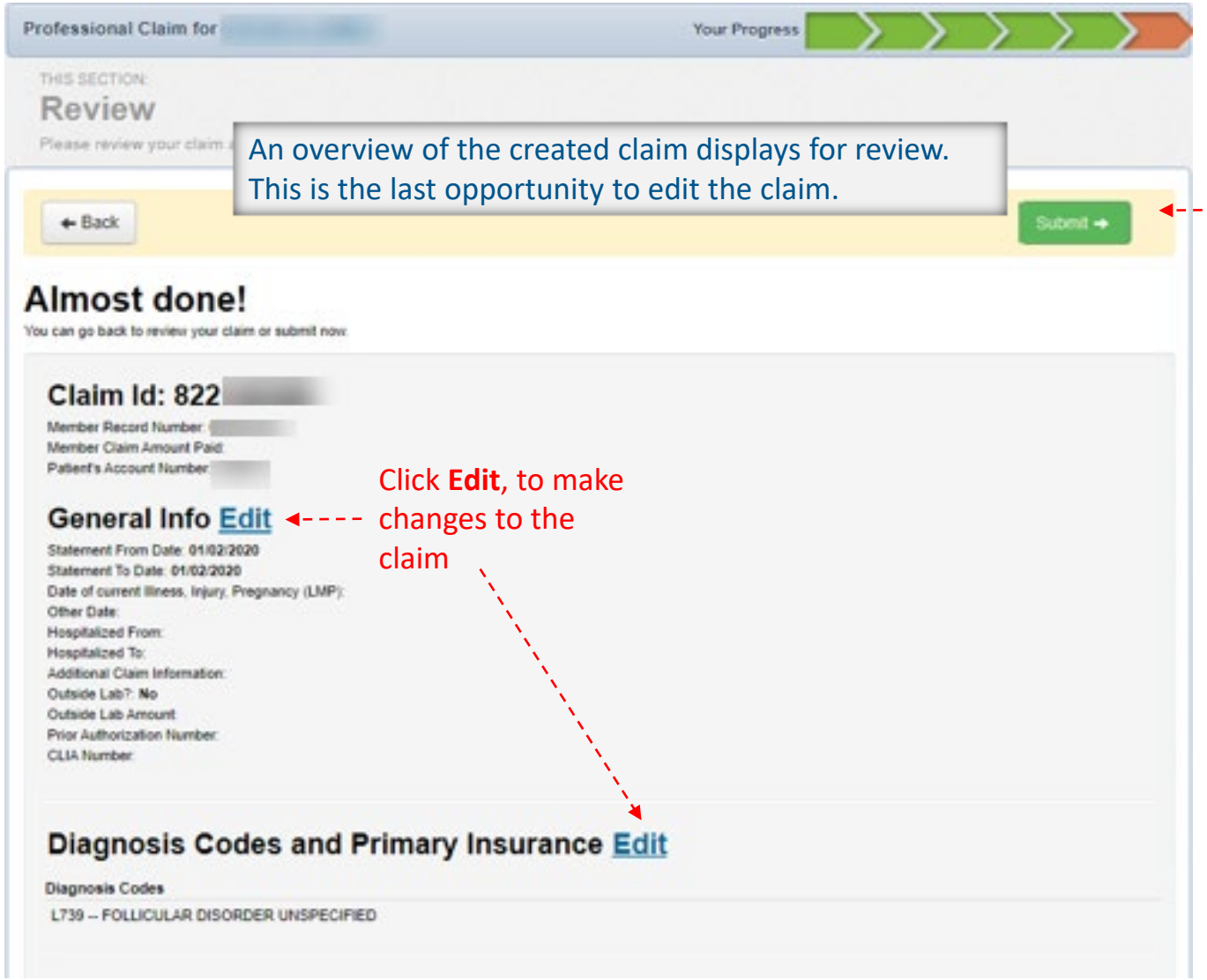
Create Claim – Providers



Create Claim – Attachments



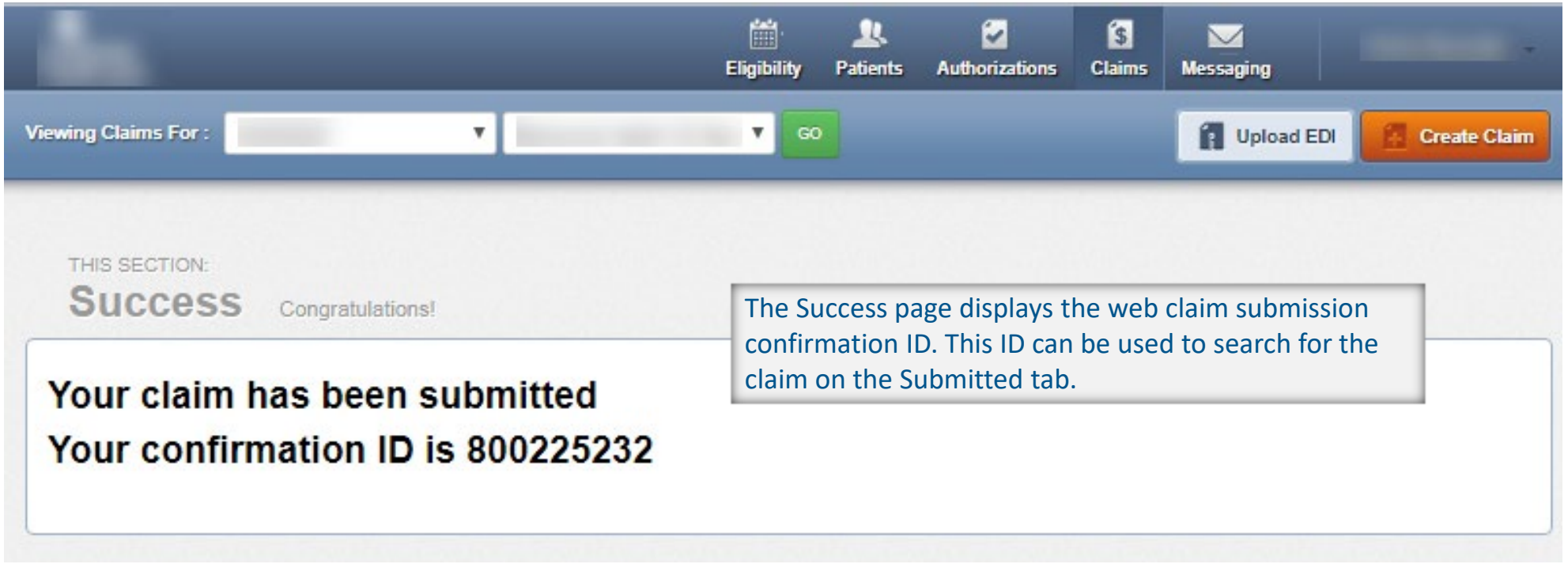
Create Claim – Review and Submit



Click **Submit** to complete claim submission

Click **Edit**, to make changes to the claim

Create Claim – Submission Confirmation



The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.

CENTENE Corporation

Portal Functionality: Claim Tips

Claims – Submission Tips

- Always check the member's eligibility before submitting a claim
  - If a member is ineligible, claims can be submitted for DOS the member was eligible
- Hover mouse over tabs in the right margin for field-level help on web claims
- To submit a secondary web claim you must complete the Add Coordination of Benefits section on the Diagnosis Codes page and the Primary Insurance fields on the Service Lines page
- On the Service Lines page, always click Save/Update when creating or editing service line(s)
- NPI and Taxonomy should be entered on every claim, except some Atypical Providers
- Portal users can attach up to five (5) separate documents to their web claim submissions (first-time and corrected claims)

Claims – Submission Tips (Continued)

- Organizations that upload EDI Batches (i.e. 837P / 837I) via the portal, must monitor the **Claims → Batch** for EDI response reports (i.e. 999, Audit File, etc.)
- Regardless of submission method, all claims go through the EDI claims process, and are:
  - Accepted and loaded for adjudication, **or**
  - Rejected and will not be processed any further (i.e. front-end EDI rejection)
- Once a web claim goes through the EDI process, the claim number will display on the **Claims → Submitted**, under the Claim Number column (4th column from the left)
  - If the web claim was accepted, use the Claim # to track status on the Individual tab

Claims – Tracking / Status Tips

- Voided claims will not display in the portal
- When looking up a claim, the From Date must be on or before the first date of service (DOS) in the claim
- Portal users can access up to *24 months (from the current date) of claims history using the Filter buttons to change the date range
    - Date range is limited to one-month (at a time)

*** For TINs who contracted with the Health Plan less than 24 months (from current date), portal users should be able to access claim history back to initial claim submission.**

Claims – Date Range Criteria Tips

- The Date Range criteria varies by Claims tab:
  - **Individual** tab is by DOS
  - **Submitted** tab is by Date Submitted
  - **Batch** is by Submitted Date
  - **Payment History** is by Check Date

Benefits of Portal Utilization

- Portal available 24/7
- Cost savings, portal free to submit claims and authorizations
- Better management of patient's care, i.e. care gaps
- Efficiency of electronic authorizations and claim submissions
- Ability to view both patient and provider history/data
- Ability to correct claims

Thank you!