Health Access SOLUTIONS

Access Express

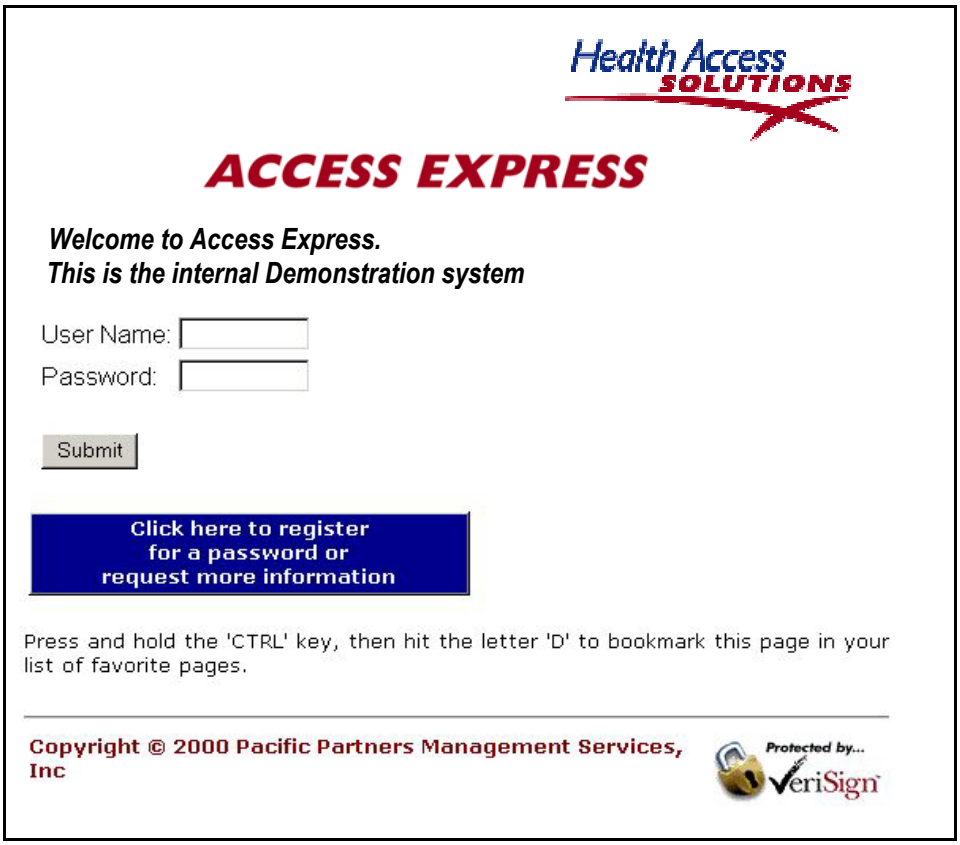
UTILIZATION MANAGEMENT USER GUIDE

This User Guide includes information specific to Utilization Management functions.
Please refer to the Provider Office Guide for additional information about *Access Express*.

© 2002-2005 Pacific Partners Management Services, Inc.

TABLE OF CONTENTS

1. Logging In to Access Express



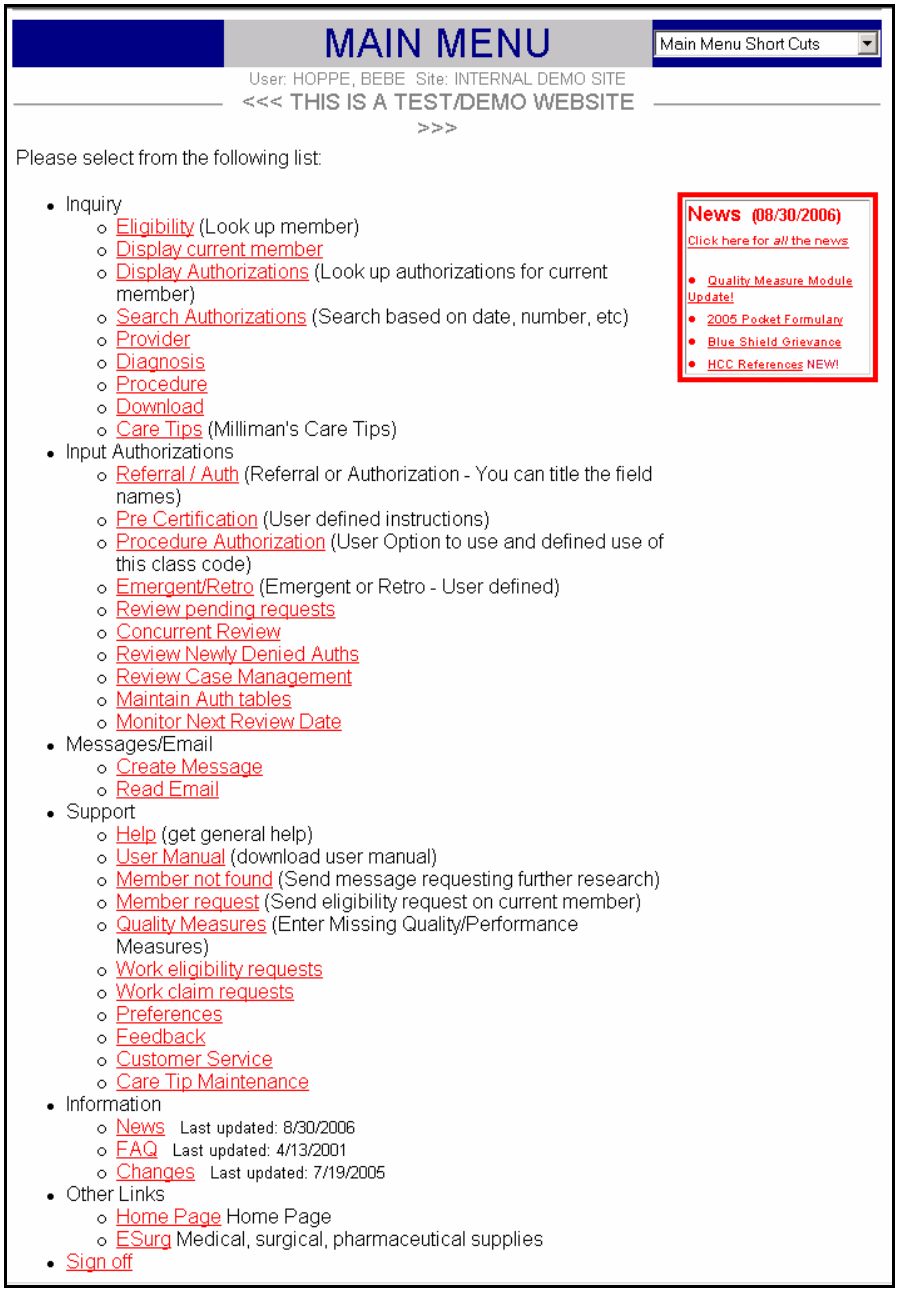
- **Open the *Health Access Solutions* website at _____.**
- **Make this your Home Page so it will show automatically every time you dial into the Internet:** At the top Microsoft Internet Explorer Toolbar, select *Tools/Internet Options,* then highlight *Use Current.* Click *OK* at the bottom of the screen.
- **OR You can add this page to your Favorites:** On the top Toolbar, click *Favorites,* then *Add to Favorites,* then fill in *Access Express.* Click *OK.* You can now find the LogIn page under *Favorites.*
- **Use the Forward and Back Arrows** in Microsoft Internet Explorer to navigate between screens.
- **To complete your Log In:** fill in *User Name* and *Password* provided, click *Submit*.
- **Accept the HIPAA Privacy agreement.**
- **You are now at the *Main Menu.***

2. The Main Menu

- The *Main Menu* lists functions available to each user through *Access Express.* Functions are listed *selectively* on the Main Menu depending on the system functions that are defined for each user at Setup. Medical

Directors and Nurse Reviewers have access to different screens and different functionality than physician office staff or MSO claims or eligibility staff.

- There are six functional groupings--Inquiry, Input Authorization, Claims, Messages/ Email, Support and Information.

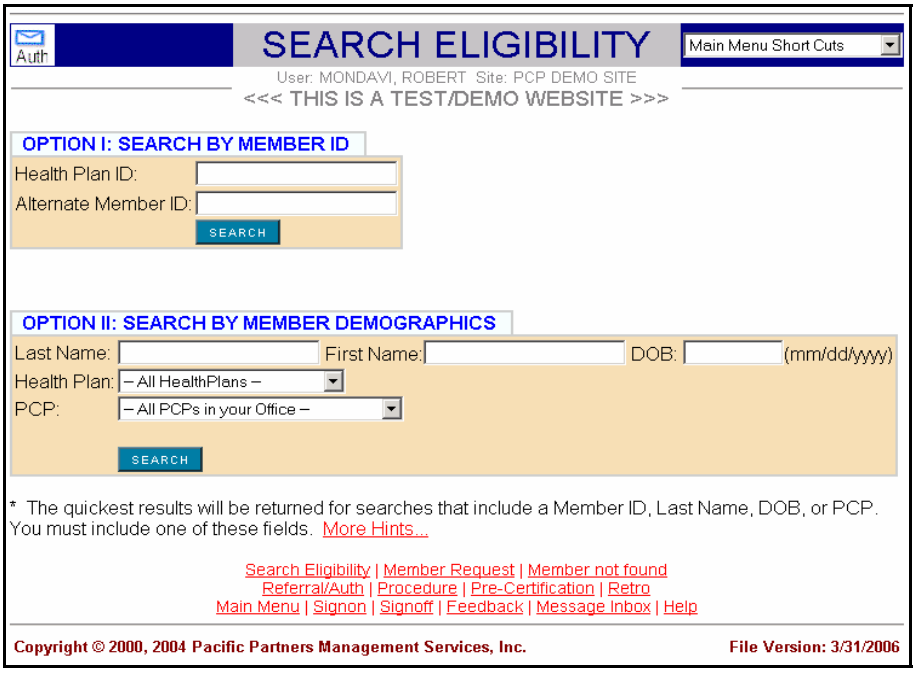


- **Inquiry** functions allow users to look up Eligibility, Authorizations or Lab results by member, or search a Provider, Diagnosis or Procedure codes, inputting minimal information.
- **Input Authorization** functions allow physician offices and UM staff to input requests for Specialist referrals; Emergency authorizations; Precertifications for care involving a facility, a special procedure, home health or durable medical equipment. Remaining functions are available to authorized Medical Directors and Nurse Reviewers --

- *Review Pending Authorization Requests*
- *Perform Concurrent Review*
- *Review Newly Denied Authorizations*
- *Set up or Modify Protocols and Authorization Guidelines*

- **Claims** functions allow physician offices to submit electronic claims (ECS) or to look up ECS batches to check for errors and/or rejected claims. These functions are omitted from the Main Menus of UM staff and therefore are not included in the UM User Guide.
- **Messages/Email** functions allow users to create messages to UM staff, participating physicians and other *Access Express* users and to read email from *Access Express* users.
- **Support** functions allow users to change their online preferences; to provide feedback; to research eligibility information for members who are not found on the system; or to get timely answers to eligibility questions about members who are listed in the system with old or invalid information. Most of these functions are omitted from the Main Menus of UM staff and they are not included in this User Manual.
- **Information** functions allow users to check the latest information and newest features of *Access Express*, and to read answers to the most frequently asked questions.
- **Main Menu Short Cuts** (top right of all screens) allow you to quickly move between screens for key functions.
- **Email** (icon visible at top left of Main Menu above) indicates pending email replies from other *Access Express* users.

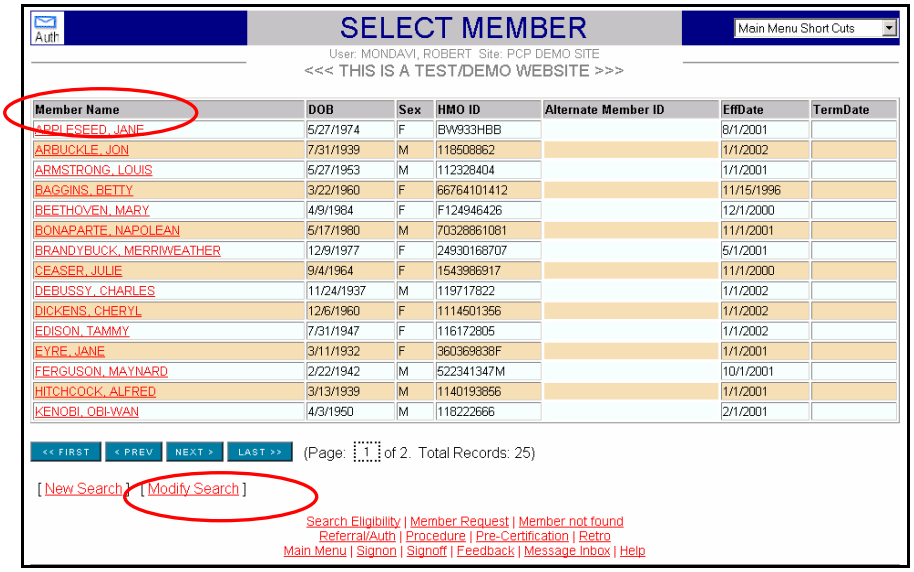
3. Look Up Eligibility



- The *Eligibility* function is used to look up health plan members. It can be accessed from the Inquiry option on the Main Menu, from the drop down Short Cuts, and from the link at the bottom of most screens.
- **Option I allows you to search by Member ID number** which is usually the fastest way to check member eligibility. Then, select the member's name from a list of family members with the same ID number.
- **Option II uses demographic criteria. You can search with full name or partial name to find all occurrences that match your search.** To check member eligibility, you can input a full name, e.g. *Apple*, to generate a list of medical group members named *Apple.* Users can also input 'Ap' or 'App' to generate a list of members with last names beginning with Ap or App.
- Most users input the fewest number of letters or numbers to generate a list of choices. Then choose the correct entry from the list. This technique minimizes errors due to misspellings and typos.
- **DROP-DOWN MENUS with arrows on the right are created to speed user input. Clicking on an arrow with the left mouse button will yield a list of possible selections. Click the selection that is most appropriate for your search.**
- Words that appear red and underlined like those listed at the bottom of the page above indicate links to other windows that allow users to view additional information.

4. Select Member

- If the member's name was misspelled during data entry, or if a nickname is provided rather than a legal name, there may not be a direct online match through eligibility. Once a list of potential members is created, *DOB (date of birth)* and *Sex* may be used to narrow the selection.



- Once a member or a list of members is identified as a possible match, the user can click on the red Member Name to view more information and to verify the patient information matches the Eligibility data for a specific member.

- Information that can be accessed is shown in RED. Notice in the above screen shot, you see the Members Names in RED, you see [New Search] in RED, Modify Search is in RED. You also see the system functions at the bottom of the page in RED. Click any link to continue. (The example in Section 4 selects the member, Jane Appleseed, from the list above.)

- The member *Effective Date* will reflect the most current information for the member that your organization has received from the health plan. Since your administrator receives fresh regular membership downloads from every plan, long term member information changes should always be made by the member directly contacting the health plan.

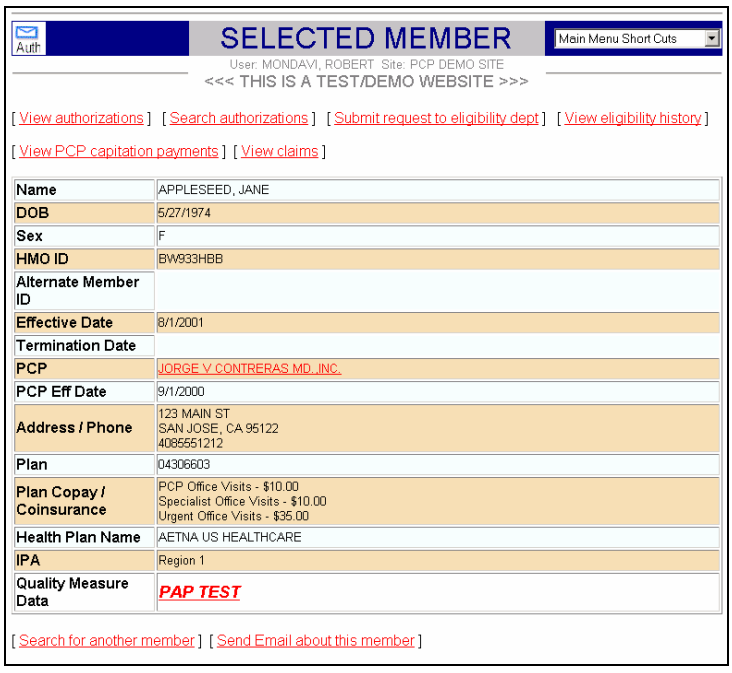
- If your patient is not listed on the roster, click on the link for *Member Not Found* at the bottom right of the screen, and proceed to the next section for further information.

5. Selected Member

The *Selected Member* screen provides information about each member including *PCP, Member demographics, Health Plan, HMO ID, Effective & Termination Dates, Plan Code* and if configured *Copay.* It also provides direct links to more information about a Member, including authorizations, eligibility research requests, optionally claims and capitation payments information. The links are shown in RED. You can use the drop down ***Main Menu Short Cuts*** or the links at the bottom of the screen to select an action for this member.

- ***Use the back arrow at the top left of the Internet Explorer screen (not shown) to return to the prior screen.***

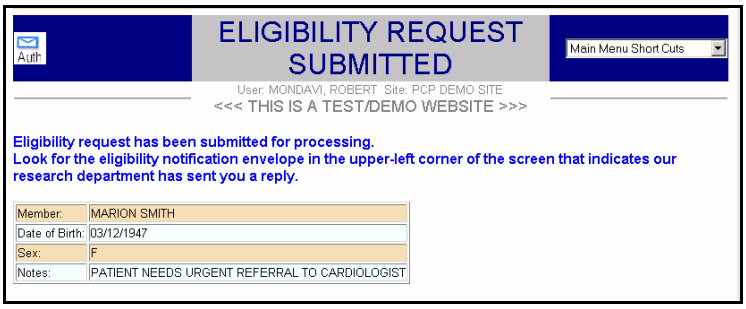
- **To *Search for another member*, select Search for another member at the bottom left of this screen. To send a secure Email about the member, click that option at the bottom of the screen.**



- **If the information in the above screen is incorrect, the member should call the health plan to make a change.** The member's name or address may have been entered incorrectly, or the member may have changed his or her name or address without notifying the health plan. Sometimes there are data input errors or mismatches caused by nicknames given to the physician office. Alternatively, the office may decide to update office records to assure a continuing match with the name that shows up in the online record.

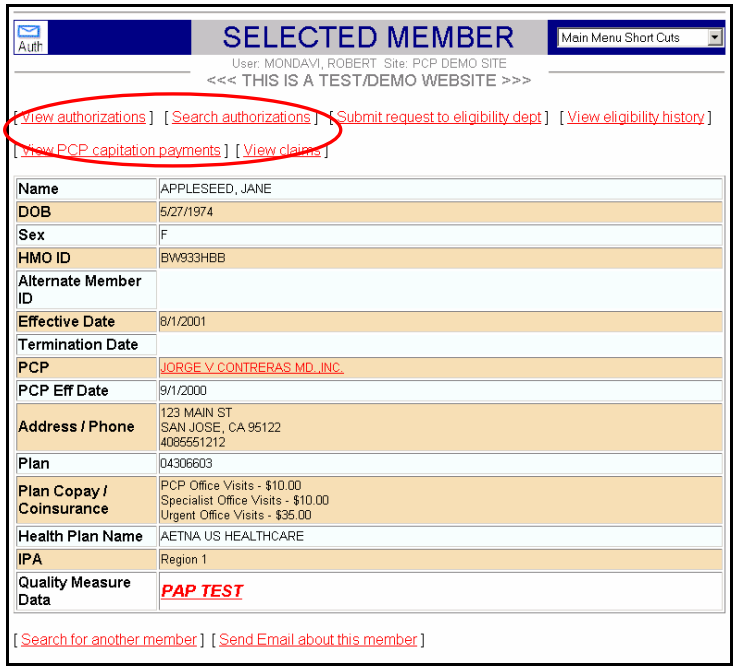
- When users select Submit Request to eligibility dept at the top, your organization's eligibility group will contact the health plan, research the question, and get back to users with answers. However, it will still be necessary for the member to call the health plan to assure long term continuing changes.

- The *Member Not Found* function can be accessed from the Support option on the *Main Menu*, the *Short Cuts,* and other Eligibility screens. Patients may be listed incorrectly in the Eligibility database, or may be terminated from one health plan and not yet registered for another. Completed Member Request information can be submitted to the eligibility dept by the physician office. The user will receive an *Eligibility Request Submitted* confirmation, and will be notified by email when the eligibility group receives an answer from the health plan. Patients should also contact their health plans with the correct information. In the meantime, without correct Eligibility information, Authorization Requests will not be accepted by the system.

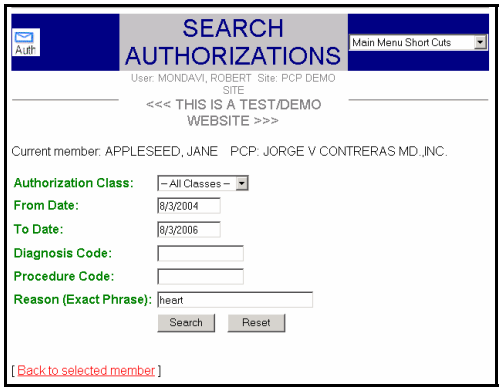


- ***Use the back arrow at the top left of the Internet Explorer screen if necessary to return to the prior screen. There is also a forward arrow that can be used to navigate throughout the online system.***

- Several other information options are available from the screen below. Email is explained later in this Guide.



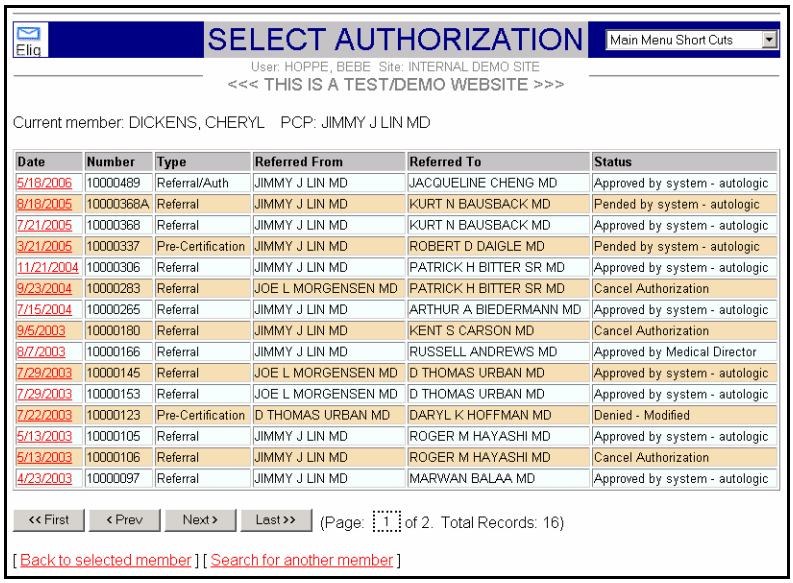
- Once the member is identified, the user can select Search Authorizations for this member (for a specific date range, diagnosis or procedure code or based on specific words in the *Reasons* fields on the original Authorization Request) by selecting the link at the top of the *Select Member* screen.



- Or, the user can select View Authorizations for member in the *Selected Member* screen by clicking the underlined selection at the top left of the *Selected Member* screen or selecting the *Display Authorizations* function from Shortcuts.

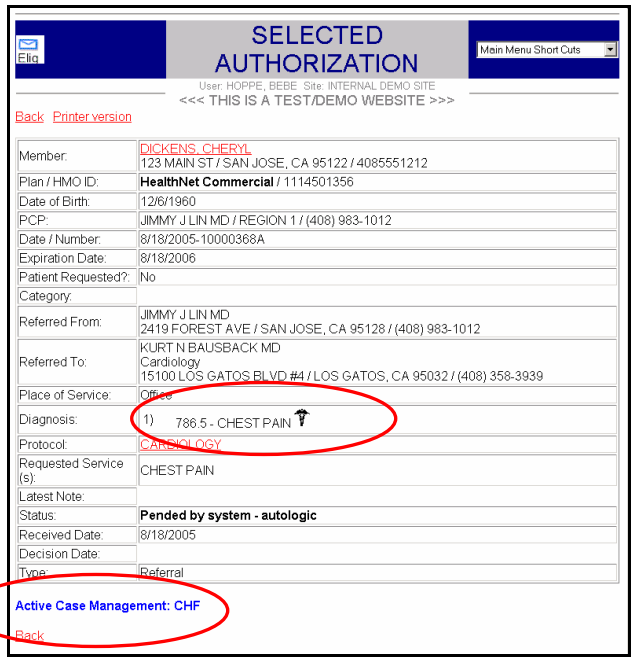
- Either way, the user will see a list of authorizations like the one below.
  Hold the cursor over underlined text to find out the reason for a referred visit.

6. Select Authorization

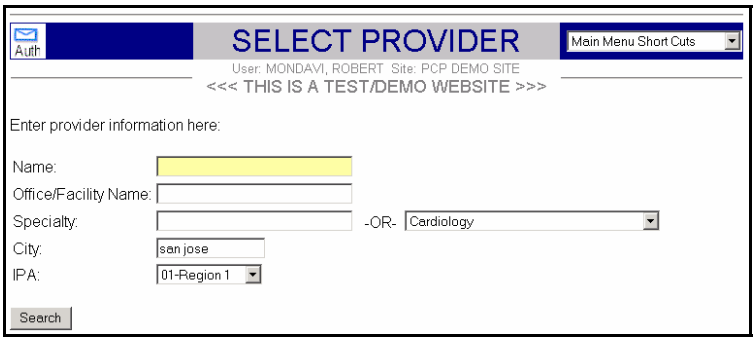


- To view a specific authorization, either click on a particular authorization date and number underlined in red in the *Date* column for information, or *Search* for another Member. ***Hold the cursor over underlined text to find out the reason for a referred visit.***

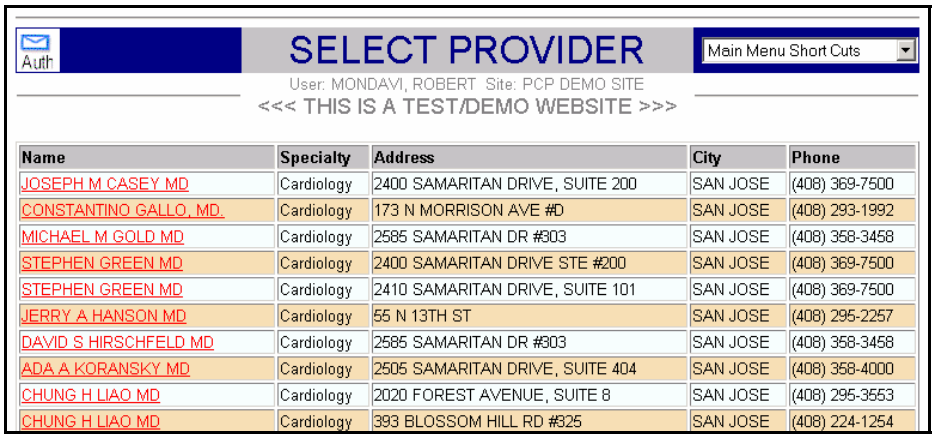
- This screen provides basic information about a specific authorization, as well as several links at the bottom of the page (not pictured) to (a) send an e-mail or upload attachments about the authorization, (b) view/change history, notes, or supplemental information, and (c) cancel the authorization. Specific information about these functions is provided later in this guide.
- Note: This screen also indicates that the authorization has been pended by the system, that the
- Member is in Active Case Management, and the caduceus insignia indicates there is a relevant Care Tip for this patient. These functions are reviewed later in this guide.



7. Select A Provider



- The *Select Provider* screen is used to identify your network providers. It can be accessed—(a) from the *Main Menu*, (b) from a Referral or Authorization screen, or (c) using the links at the bottom of some screens.
- To search for a provider, enter the last name or part of the last name with an asterisk. Users who input *B* and *Search,* get a screen listing all names beginning with B. Users who select *Search*, get an alpha list of preferred providers.
- Alternatively, the user may select *Specialty* from the drop-down menu to generate a shorter list. The user can input *Cardiology* from the pull-down menu or *car* ***--the use of partial words eliminates many unmatched entries.***

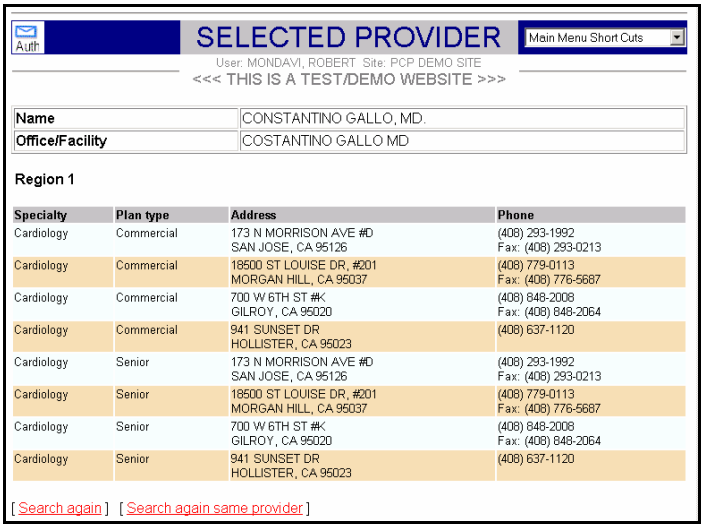


Name	Specialty	Address	City	Phone
JOSEPH M CASEY MD	Cardiology	2400 SAMARITAN DRIVE, SUITE 200	SAN JOSE	(408) 369-7500
CONSTANTINO GALLO, MD.	Cardiology	173 N MORRISON AVE #D	SAN JOSE	(408) 293-1992
MICHAEL M GOLD MD	Cardiology	2585 SAMARITAN DR #303	SAN JOSE	(408) 358-3458
STEPHEN GREEN MD	Cardiology	2400 SAMARITAN DRIVE STE #200	SAN JOSE	(408) 369-7500
STEPHEN GREEN MD	Cardiology	2410 SAMARITAN DRIVE, SUITE 101	SAN JOSE	(408) 369-7500
JERRY A HANSON MD	Cardiology	55 N 13TH ST	SAN JOSE	(408) 295-2257
DAVID S HIRSCHFELD MD	Cardiology	2585 SAMARITAN DR #303	SAN JOSE	(408) 358-3458
ADA A KORANSKY MD	Cardiology	2505 SAMARITAN DRIVE, SUITE 404	SAN JOSE	(408) 358-4000
CHUNG H LIAO MD	Cardiology	2020 FOREST AVENUE, SUITE 8	SAN JOSE	(408) 295-3553
CHUNG H LIAO MD	Cardiology	393 BLOSSOM HILL RD #325	SAN JOSE	(408) 224-1254

Region and Patient Site information for the search are summarized at the top of the screen.

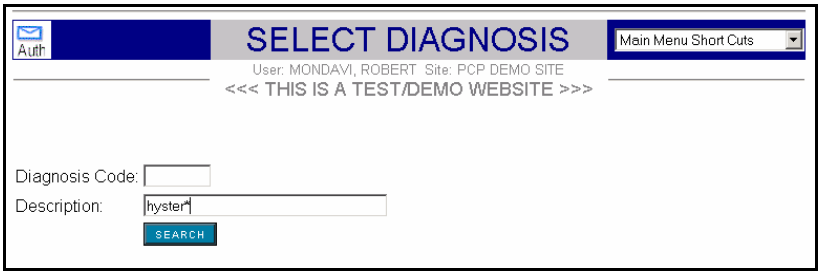
Select the red Provider Name to the left, to see a third *Selected Provider* screen with more information (including street address) about the selected provider.

If the user is researching providers for a Referral or Authorization, the Provider selected will automatically be transferred to the Referral or Authorization that is being completed.



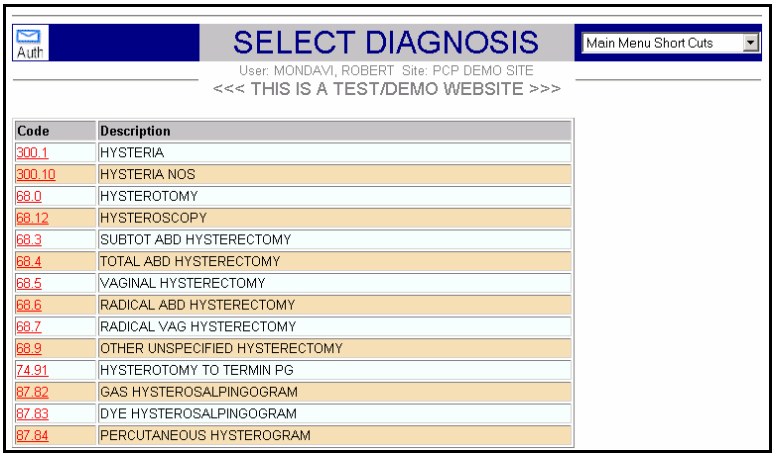
- If the user selects a provider that is not a preferred provider for a Referral or Authorization, you will be asked to make another provider selection.
- Since all preferred contracting providers are listed online, use of a non-Plan or unlisted provider will only be authorized if needed care is unavailable from a preferred provider.
- ***If a provider is not listed in the medical group database, use 'Provider Not Listed'(under P) as provider of choice for the authorization. Two essential facts must always accompany a Provider Not Listed request in the Notes field--***
  - ***--Name and telephone number of the unlisted provider, and***
  - ***--Explanation of why a listed provider could not be used***
- See Section 10 for information about Authorizations.

8. Find the Correct Diagnosis



- *Access Express* helps the user select appropriate diagnosis codes when completing Referrals and Authorizations. Access the *Select Diagnosis* screen from the *Main Menu* or from one of the Referral or Authorization screens.
- If the user inputs a partial word general description like *hyster,* a second screen will come up with a list of diagnosis codes and descriptions for the full range of problems that include *hyster.*

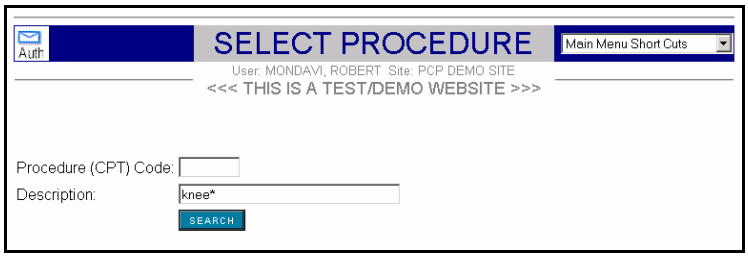
- ***The Asterisk (*) can be used in place of part of a number field to find all occurrences that match.*** For example, V68* will not only find codes equal to V68, but also codes beginning with V68, like V68.7.
- Cancer diagnoses are often listed under *neoplasm* or *mal neo* depending on their listing in the ICD-9 tables.
- ***Access Express will accept multiple diagnoses.*** For Authorizations, a second blank diagnosis input line will appear once the first diagnosis is completely filled out. The third diagnosis input line will appear once the second diagnosis is filled out, and so on.



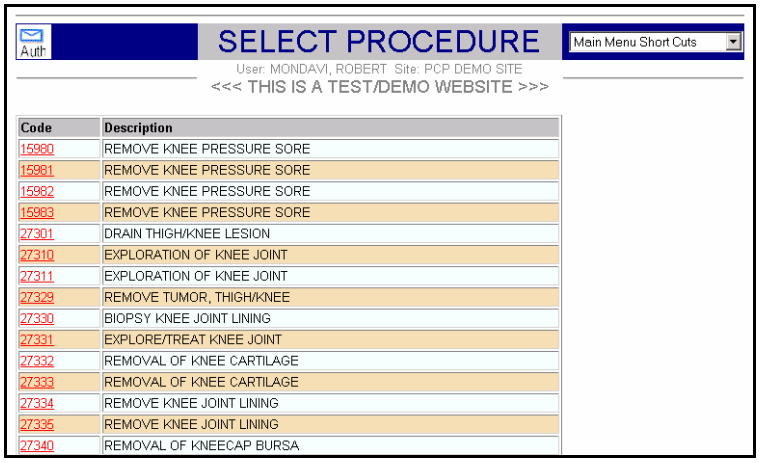
Code	Description
300.1	HYSTERIA
300.10	HYSTERIA NOS
68.0	HYSTEROTOMY
68.12	HYSTEROSCOPY
68.3	SUBTOT ABD HYSTERECTOMY
68.4	TOTAL ABD HYSTERECTOMY
68.5	VAGINAL HYSTERECTOMY
68.6	RADICAL ABD HYSTERECTOMY
68.7	RADICAL VAG HYSTERECTOMY
68.9	OTHER UNSPECIFIED HYSTERECTOMY
74.91	HYSTEROTOMY TO TERMIN PG
87.82	GAS HYSTEROSALPINGOGRAM
87.83	DYE HYSTEROSALPINGOGRAM
87.84	PERCUTANEOUS HYSTEROGRAM

- When directed to the *Diagnosis* screen from a Referral or Authorization, users can select the appropriate red code at the left on the second screen. Both code and description will automatically be transferred to the Referral or Authorization in process. When researching a Diagnosis with no associated Referral or Authorization, a new screen will come up with the information selected from the listing above.

9. Find the Correct Procedure



- The *Select Procedure* screen can be accessed from the *Main Menu* or from one of the Referral or Authorization screens.
- ***A general description like 'knee', will generate a second screen with a list of codes and descriptions for the full range of procedures associated with the knee.*** If 'Biopsy' is input, the user will get a list of biopsy codes. Check the last section for information about how to use the Asterisk (*) character for number fields to select a range of procedure codes.



Code	Description
15980	REMOVE KNEE PRESSURE SORE
15981	REMOVE KNEE PRESSURE SORE
15982	REMOVE KNEE PRESSURE SORE
15983	REMOVE KNEE PRESSURE SORE
27301	DRAIN THIGH/KNEE LESION
27310	EXPLORATION OF KNEE JOINT
27311	EXPLORATION OF KNEE JOINT
27329	REMOVE TUMOR, THIGH/KNEE
27330	BIOPSY KNEE JOINT LINING
27331	EXPLORE/TREAT KNEE JOINT
27332	REMOVAL OF KNEE CARTILAGE
27333	REMOVAL OF KNEE CARTILAGE
27334	REMOVE KNEE JOINT LINING
27335	REMOVE KNEE JOINT LINING
27340	REMOVAL OF KNEECAP BURSA

- When directed to the *Select Procedure* screen from a Referral or Authorization, users can select the appropriate red code on the second *Procedure* screen. Both code and description will automatically be transferred to the Referral or Authorization in process.
- When researching a Procedure with no associated Referral or Authorization, users will see a new screen with the information selected from the listing above.

10. Referrals & Authorizations

There are four types of Authorizations that can be entered by the UM and provider office staff—

- **Referrals** completed by PCP offices to request visits to Specialists and by Specialist offices to request additional visits/followups through PCPs.
- **Precertifications** for all services performed in a facility (hospital, surgicenter or hospital outpatient surgical suite) with the exception of Special Procedure Authorizations (below).
- **Special Procedure Authorizations** involve special procedures & medical equipment your administrator wants to review before care is rendered (listed in the drop-down list of the online input form.
- **Emergency Authorizations** are required for urgent care already taken place that has not been authorized in advance due to specific clinical circumstances.

A. How to Get Started with Authorizations

- The first step in every Authorization is to identify the Member using the Member Eligibility inquiry screens described in the section on *Eligibility.* Select *Eligibility* from the *Short Cut* drop-down menu or from the *Inquiry* section of the *Main Menu.* Enter the *Health Plan ID* number without prefix from the card. Alternatively, you can input any data you know (*Member Last Name-First Name* or *Initial, Date of Birth* or *Health Plan)* to help identify the member. Once the member has been identified as a possible match, click the red Member Name to view more information.

- Once the *Selected Member* screen is displayed and the user has verified the correct member, click on the *Main Menu Short Cut* drop-down menu. Select the type of authorization and the correct screen will be displayed with the *Selected Member* and *PCP* data filled in.

- Check the box to indicate if the Referral or Authorization was requested by the Patient.

- Fill in the *Category* which will determine the priority with which the request will be reviewed—*Emergency, Urgent, Routine or Retro (retroactive). Categories are not used for Emergency authorizations.* From this point, each type of authorization has specific requirements which are listed in this section.

For Urgent Referrals to Specialists & Urgent Procedures/ Precertifications

- ***If care has not yet taken place:***
  Fill out a Referral, Precertification or Procedure Authorization Request explaining why the care is Urgent in the Note Section.

- ***If care has already been provided on an Emergency basis:***
  Fill out an Emergency Request explaining why the care was required as Urgent or Emergency care without advance authorization.

B. Search Strategy for Authorizations

With *Access Express,* users can complete the entire request while connected to the Internet system. All Authorizations use the search strategy described in prior sections to identify members, specialists, facilities, diagnoses and procedures.

As users click on each search tab, the screen shifts to the individual screens described in prior sections.

When the search is complete, the user's selection is added to the original *Authorization Request* screen.

When the request has been completed and submitted, the user sees the message--*Authorization Submitted.* The provider's office will receive an email or online response once the request is reviewed.

Assuming Authorization letters are used by your administrator:

- An Auth letter will be sent to the patient and also to specialists/facilities that don't use *Access Express*
- The specialist and/or facility will also receive an online response if the office is an *Access Express* user.

C. Authorization Guideline Questions

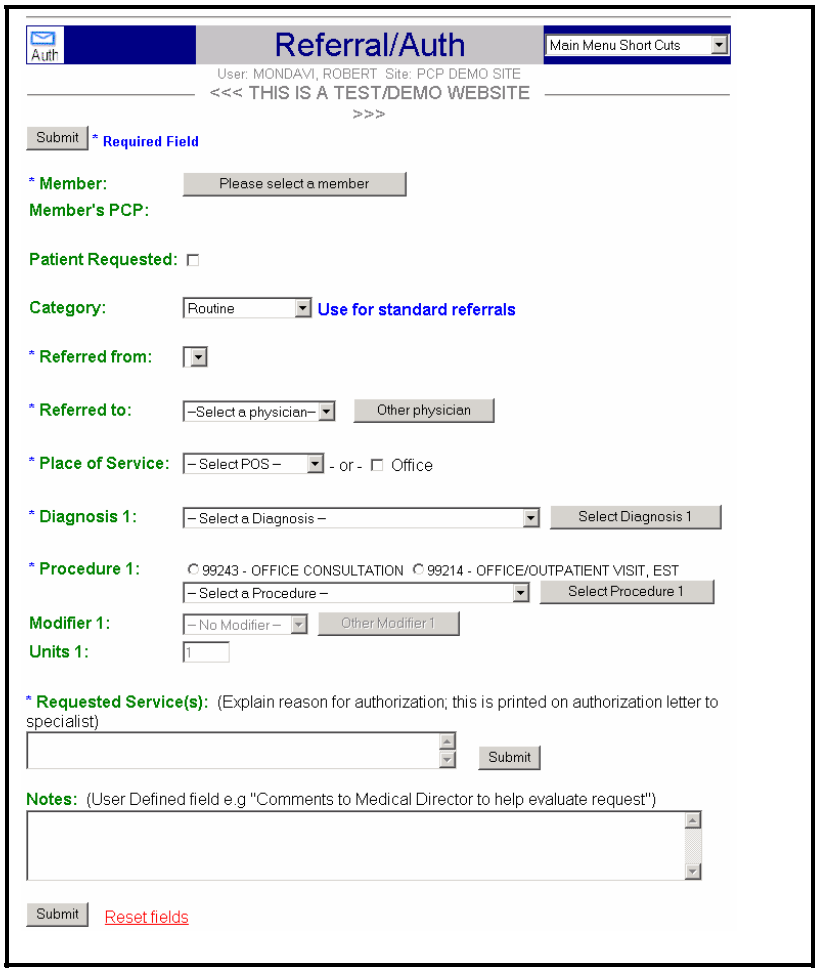
Access Express users who request referrals and authorizations will often be required to answer additional questions about their requests. These questions were developed to expedite referral and authorization requests by making sure requestors include the information required for an appropriate decision.

For example, your organization may have decided that all referrals to otolaryngologists for chronic or recurrent otitis media should be made only after two trials of antibiotics and sinus films or CAT scans. For these types of referrals, requesters will be asked to answer two questions—

1. Has patient failed at least 2 courses of antibiotics?
2. Has patient had sinus films or CAT scan of sinuses?

The answers to these questions will be factored in when the referral decision is made.

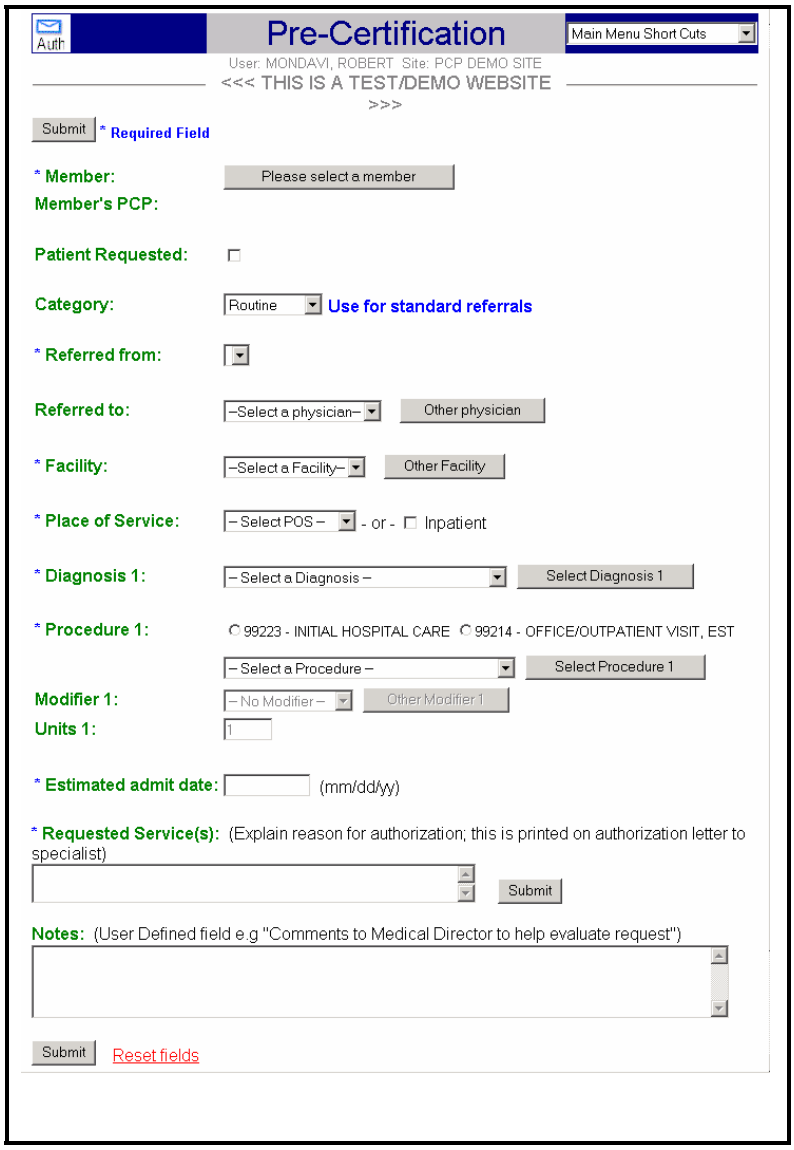
D. Referral Authorizations



- The system will recognize the user once the user signs in and it will automatically fill in the *Referred from* field.
- Check the box provided if the Patient requested the Referral.
- Select the Referral Category—Urgent, Emergency, Routine, Appeal, Retro.
- The *Referred to Select a Physician* drop-down list will populate with the user's most common choices as it is used.
- Until your list develops, click the *Other Physician* button to bring up the *Select Provider* screen (see *Select Provider* Section 7 and *Search Strategy* Section B). In the *Name* field, create a specialty list by clicking *Pick A Specialty* or enter last name (or partial last name) of the physician to generate a screen with a list of physicians with that name. Select the desired name, and return to the *Referral Authorization* screen with the *Referred to* physician filled in.

- For Diagnosis, the *Select a Diagnosis* drop-down list will populate as more referrals are completed. To begin, enter the diagnosis code in the *Code* box and click the *Other Diagnosis* button. If it is a valid code, the Code and Description will appear in the *Diagnosis* field. If not, use the Asterisk* and the Other Diagnosis button to search for the right code.
- Enter the number of visits. Default is one (1) visit. If needed, adjust the number of visits, then proceed.
- *Explain the Reason for this Authorization* is a description of why the Referral is requested--either the patient's symptoms or the doctor's diagnosis. ***Avoid using codes or unique specialty abbreviations; depending on the policy of your organization, this is the only information the specialist or facility will receive to explain the patient's problem. This field is printed exactly as entered in letters to facility and specialist but does not display on the patient's letter.***
- The *Notes* field is an optional entry only viewed by the Requester and Medical Director. This information *will not show* in letters to patients or specialists. The entry might include the reasons for urgency of the referral.
- When all information has been entered for this Referral, click *Submit*, and expect to see the *Authorization Submitted* screen as your confirmation. Once the Referral is reviewed, the physician office will see the AUTH E-mail icon displayed at the top left of the screen. If they clck on the icon, they will be able to view/print any authorizations they have received.

E. Precertifications

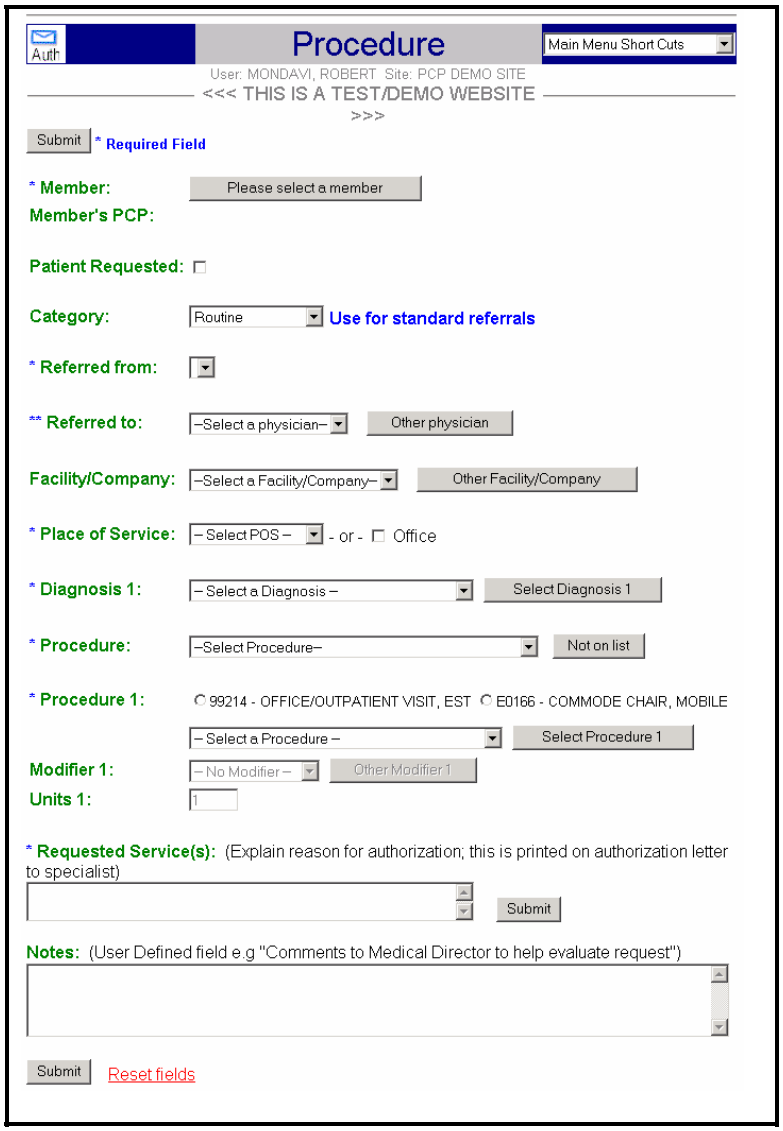


- Fill in *Referred From* and *To* spaces as described under *Referral* and in the Search Strategy on Sections 7 & 10B. *Referred To* is usually the admitting physician.
- Check the box provided if the Patient requested the Precert.
- Select the Category—Urgent, Emergency, Routine, Appeal, Retro.
- The *Facility* is the site where the pro-cedure will be performed--either a surgery center or hospital. The *Select a Facility* drop-down list will populate with the user's choices as more precert requests are entered. Until your list develops,, click the *Other Facility* button to bring up the *Select Provider* screen. In the *Name* or *Facility* field, enter the name or type of facility, bringing up a list that matches the request. Select the desired facility and you will return to the *Precertification* screen with the *Facility* filled in. Partial words can also be used to research facilities.
- The *Diagnosis* code for this *Precertification* is filled out like the *Referral Authorization* on the prior page. However, the *Precertification* allows for an optional *Secondary Diagnosis.* Fill in the *Units* and *Modifier* for professional or technical services, where they apply.

- *Estimated admit date* should be filled in using 2 digits each for month, day and year—09/12/05.
- *Explain the Reason* is a description of the doctor's diagnosis or why the Precert is requested for the procedure to be performed. ***Avoid using codes or unique specialty abbreviations;*** *depending on the policy of your organization, this is the only information the specialist or facility will receive to explain the patient's problem. This field is printed exactly as entered in letters to facility and specialist but does not display on the patient's letter.*
- The *Notes* field is an optional entry only viewed by the Requester and Medical Director. This information *will not show* in letters to patients or specialists. The entry might include the reasons for urgency of the precert.
- When all information for this Precert has been entered, click the *Submit* button, and expect to see the *Authorization Submitted* screen as your confirmation. Once the Precert is reviewed, the physician office will see the AUTH E-mail icon displayed at the top left of the screen. If they click on the AUTH E-mail icon they will be able to view/print any

authorization they have received as either a response to their own request or one by another *Access Express* physician office.

F. Procedure Authorizations

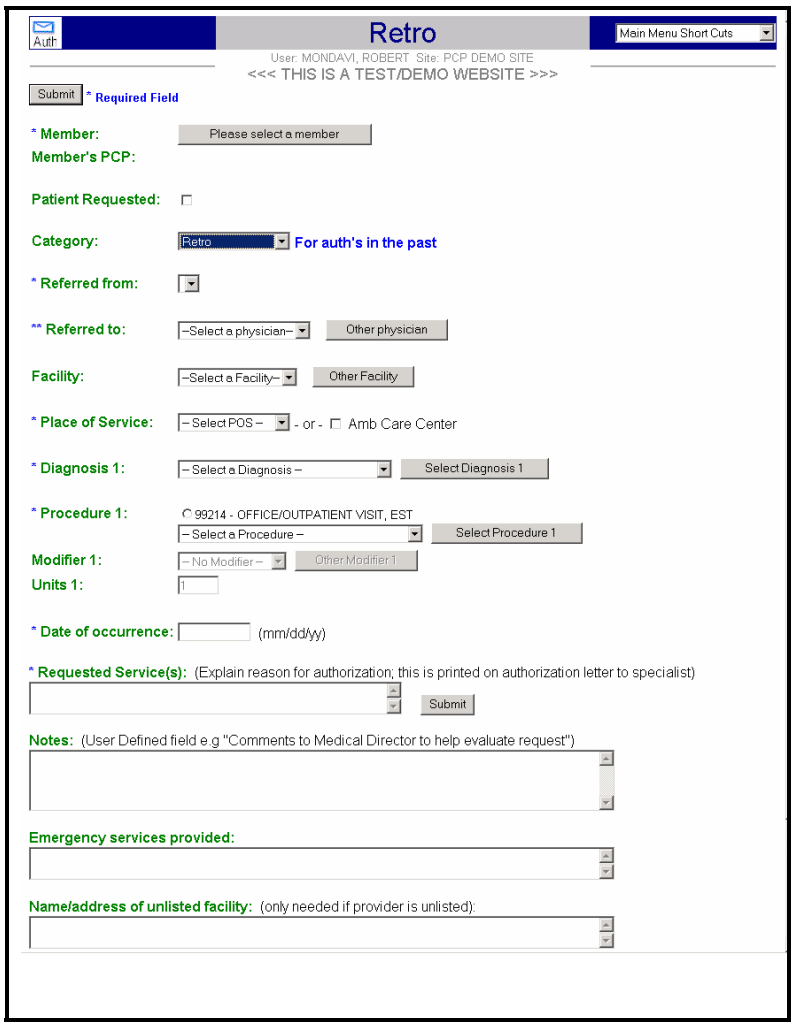


- Fill in *Referred From* and *To* spaces as described under *Referral* and in the Search Strategy in Sections 7 & 10B.
- Check the box provided if the Patient requested the Procedure.
- Select the Category—Urgent, Emergency, Routine, Appeal, Retro
- The *Facility* is the site where this procedure will be performed. The *Select a Facility* drop-down list will populate with the user's own choices as more procedure requests are entered. Until your list develops, click the *Other Facility* button to bring up the *Select Provider* screen. In the *Name* or *Facility* field, enter the name or type of facility, bringing up a list that matches the request. Select the desired facility and you will return to the *Procedure* screen with *Facility* filled in. Partial words can also be used to research facilities.
- *Diagnosis* codes are filled out using the Search Strategy described earlier.
- Fill in the number of *Visits Requested.*

- Use the drop-down menu to select the *Special Procedure* for this authorization. If the procedure to be reviewed is not included in this menu, it is not designated by your organization as a *Special Procedure*, and should be requested as a *Referral,* a *Precertification* or *Emergency*. Select *Not on list* for further information about authorizations. Each Special Procedure includes all related services (e.g. Home Health includes all services possible in a single day).
- *Explain the Reason for this Procedure* is a description, up to 100 characters, of why the Procedure is being requested. ***Avoid using codes or unique specialty abbreviations;*** *depending on the policy of your organization, this is the only information the specialist or facility will receive to explain the patient's problem. This field is printed exactly as entered in letters to facility and specialist but does not display on the patient's letter.*
- The *Notes* field is an optional entry that is only viewable to the Requester and the Medical Director. This information will never show in letters to patient or specialist. This entry might include reasons for the urgency of the procedure or specific injectables to be administered. When the information has been entered, click *Submit*, and you will see the *Authorization Submitted* screen confirmation. Providers who click on the AUTH E-mail icon can view/print any authorization they received as either a response to their own request or one by another *Access Express* physician office.

G. Emergency Authorizations

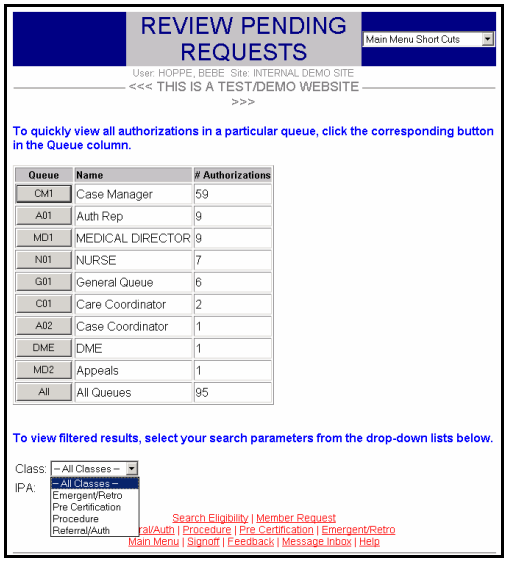
Emergency Authorizations are required for urgent care that has already taken place that has not been authorized in advance due to specific clinical circumstances. This allows past unauthorized emergent care to be described for possible retroactive approval. Be sure to note WHY the problem was not reported until after the care was rendered. Select the Emergency option from the *Main Menu* under *Input Authorizations.* The Emergency Authorization is the only Authorization that cannot be accessed from *Short Cuts*.



- Fill in *Referred From* and *To* spaces as described under *Referral* and in the Search Strategy in Sections 7 & 10B.
- Check the box provided if the Patient requested the Emergency Room visit.
- Fill in the *Facility* as described in the *Precertification* and *Procedure* instructions. Partial words can be used to research facilities.
- Complete the *Diagnosis* section as indicated in the *Procedure* and *Precert Authorization* sections.
- Enter the *Date of Occurrence*, using MM/DD/YY format (for the January 5, 2005 you would enter 01/05/05).
- *Requested Services* is the reason for the services, up to 100 characters, including patient symptoms and/or diagnosis. ***Avoid using codes or abbreviations.*** *Depending on the policy of your organization, this field is printed exactly as entered in letters to facility and specialist but does not display on the patient's letter.*

- Fill in the *Notes,* an optional entry that is only viewable to the Requester and the Medical Director. This information will *never show* in letters to patient or specialist. This entry should include reasons for the urgency of the procedure.
- Enter the *Emergency Services Provided* to this member.
- If services were rendered at an *Unlisted Facility,* enter the name and address of that facility in the field provided.
- Click the *Submit* button and expect to see the *Authorization Submitted* screen displayed to confirm your submission. When the Emergency Authorization has been reviewed, physician office personnel will see the AUTH E-mail icon displayed at the top left of the screen. They can click on the icon to view/print any authorization received as either a response to their own request or one initiated by another *Access Express* physician office.

11. Review Pending Requests



- The Review Pending Requests screen is used by each Reviewer to access his/her work queue from the Input Authorizations section of the Main Menu.
- The Reviewer can preview the number of authorizations to be reviewed in each queue and can select a queue from accessible choices including General, Denial, Medical Director and Nurse.

jj

- Alternatively, depending on the time available to review authorizations, the Reviewer can be more specific in limiting requests selected for review from queues, classes and regions listed below or sort by Next Review Date (NRD). For example, the Reviewer may select *Emergency Referrals in Region 4* to begin working:

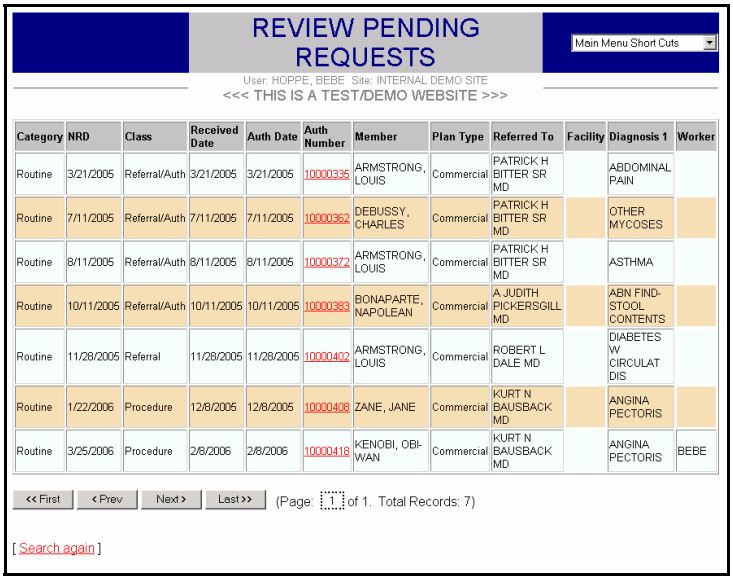
  Queues: Auth Rep, Denial, General, Medical Director, Nurse, etc.

  Classes: Precert, Procedure, Referral, Emergency

  Region: Specific Region or All Regions

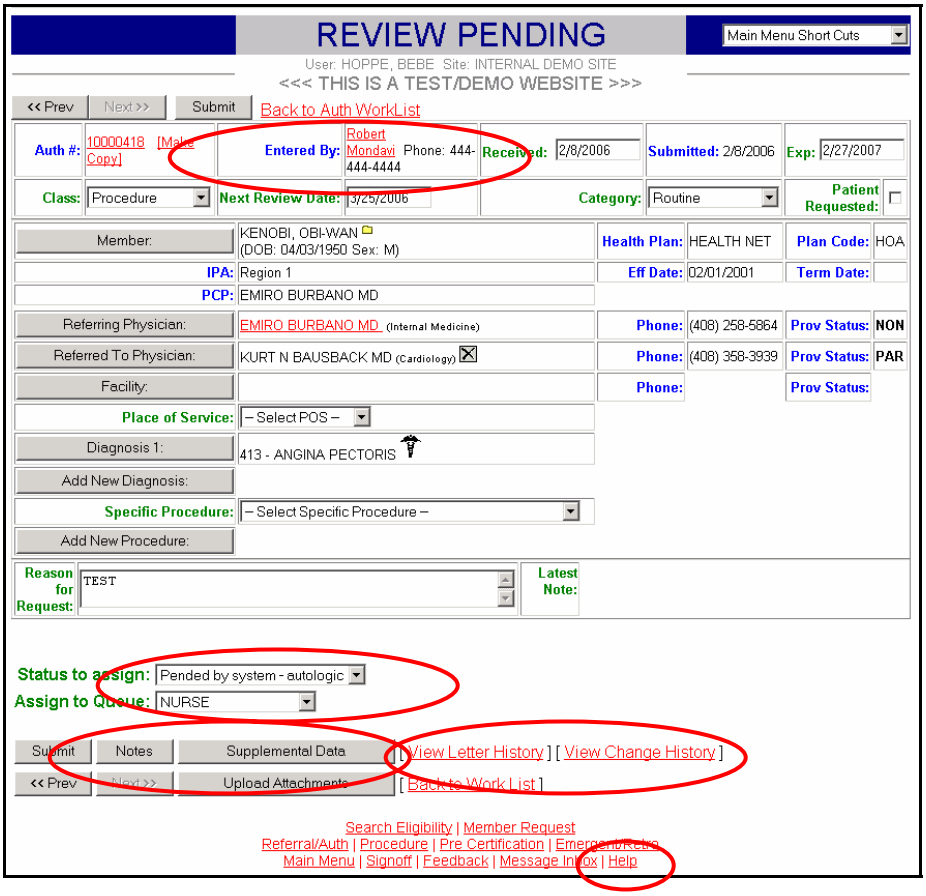
  Sites: Specific Site or All Regions

- The *Review Pending Requests* screen shows the results of your selection.
- To facilitate identification of high priority requests for immediate attention, the *Review Pending Requests* list is sorted by category and, within each category, ascending order of authorization dates (beginning with the oldest.)
- The *Emergent* category has the highest priority, then *Urgent,* followed by *Routine* and finally *Retro* (retroactive authorizations for services that have already been performed).



- Pended authorizations can be selected from the worklist for modification in *Review Pending,* which is the main screen used by reviewers to review pended authorization requests.

12. Review Specific Authorizations



- The *Review Pending* screen is used to review referral and authorization requests that have been pended by the system. The system pends all requests that are not managed by the protocol tables.

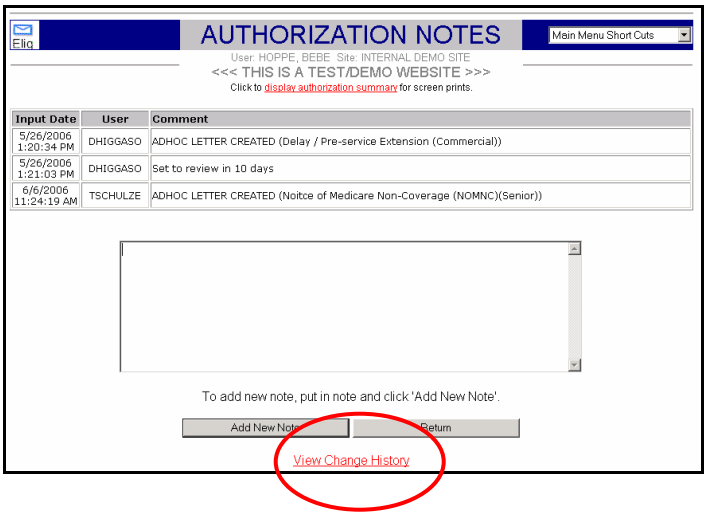
- Using this screen, the Reviewer assigns a *Status* to each request (toward the bottom of the screen), which varies depending on whether the request is approved or denied or pended to obtain additional information. The complete *Status* list is: (a) *Pended by System – autologic; (b) Approved by Medical Director; (c) Denied by Medical Director; (d) Denial letter in progress; (e) Pend by Medical Director; (f) Cancel Authorization; (g) Approval – refraction not covered; (h) Override Approved, Denied or Pended.*

- Prior to actual authorization, the *Authorization Number* is viewable to UM staff on both summary and detail levels, but NOT to requesting or performing providers. The authorization number on *approved* authorizations is viewable to all users.

- If additional information is required, the Reviewer may click on a number of options:
  - Pend the authorization and assign it to a queue
  - Read or create an authorization note (see next section 13)
  - Click one of the names underlined in red to send an email message to a referring or receiving physician's office (see section 14 on email)
  - Request supplemental information (see section 15)
  - Upload attachments to one of the above communications (see section 16)

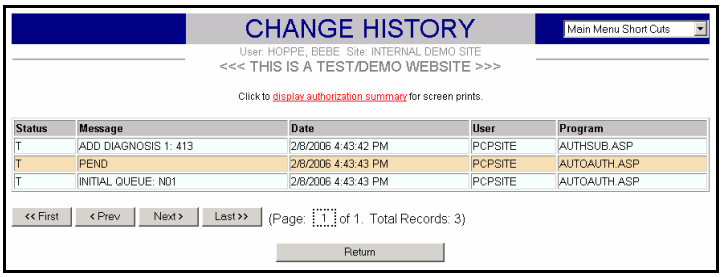
13. Read and Record Authorization Notes

- The *Authorization Notes* screen is used to add information to the Member's online medical record or to forward authorizations to the Medical Director or other internal case manager or reviewer. It is also used during Concurrent Review to approve ongoing care based on the level of care provided in the past. For example, if a patient's level of care changes from CCU to MEDS (medsurg), a note is entered with the new *location* and *effective date* for the change in care.



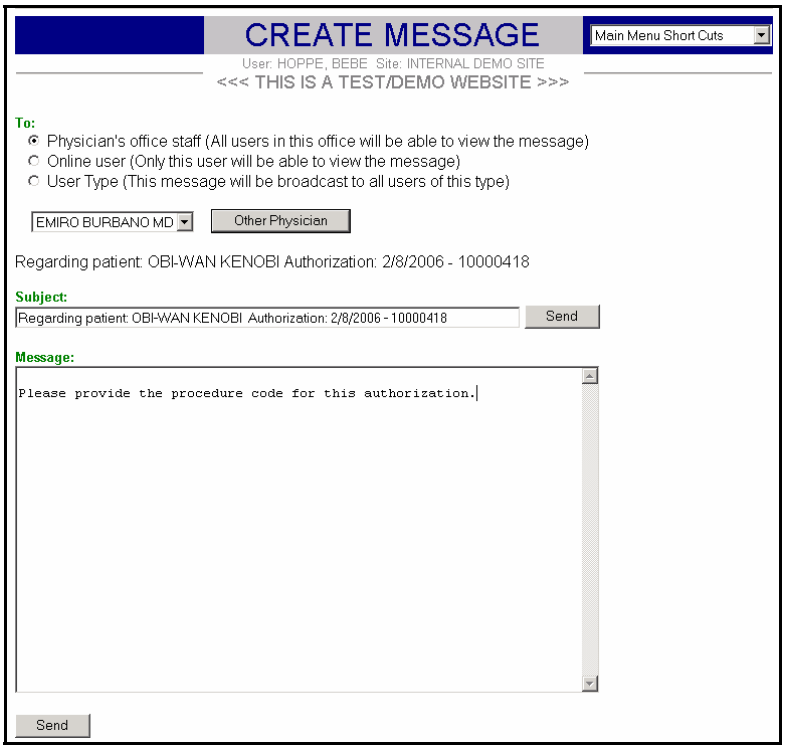
- The Auth Notes are a very important part of each Member's online medical record. They are available to UM staff, reviewed by case managers on a daily basis, and also used to document decisions in the event of a Member Appeal or Grievance.

- Click View Change History to review prior additions to the authorization or to see an 'audit trail' of past individual or electronic system actions.

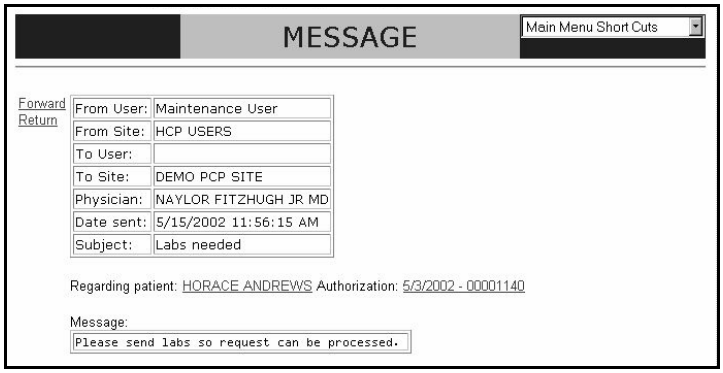


14. Send & Receive Email to Referring or Receiving Physicians

- An Email function is available on the *Review Pending* screen to facilitate sending pended authorizations back to a referring physician or the physician's office to obtain more information.
- A *Create Message* screen with physician and patient information is displayed by clicking *Referring Physician* on the *Review Pending* screen. From this screen a message can be created for either an individual user or a physician's office. If a physician's office is selected, all users in that office with authority to view email will be able to view the message. Physicians and other system users can be selected from drop down lists.



- When authorizations are submitted with information that is confusing, incomplete or conflicting, email messages can be used to educate providers about the process or the system without cluttering permanent member documentation.
- The body of your message can be as long as several pages. Use the *Enter* key for spacing to make the email more readable. When the message is complete, click the *Send* button at the bottom of the screen. NOTE: there is no spell check or grammar check.



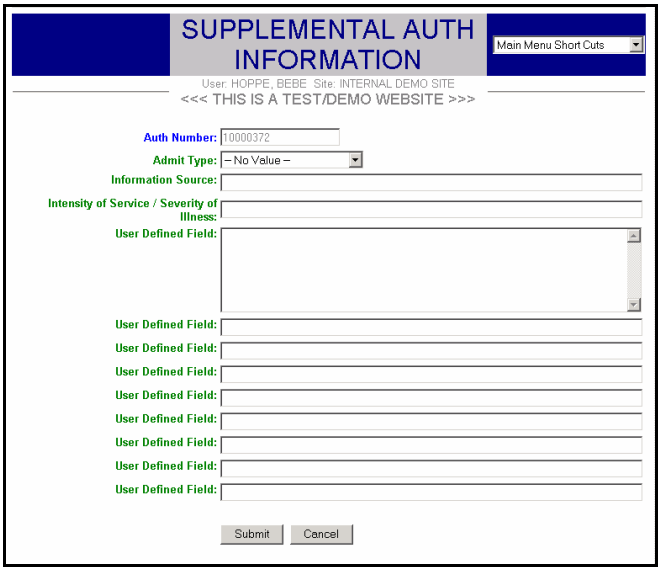
- Incoming email is most easily accessed through the letter icon found at the top left of the screen when email is received. Clicking on the icon displays a summary list of the mail sent to that recipient.
- By selecting a summary line the Message screen displays complete message information like the screen at left. From the Message screen the user can also display the relevant authorization and the member's eligibility information which is underlined in red toward the center of the screen.

- **To view the message,** click the underlined name. **To delete a message**, click the 'X' box before the senders name.

- **To open & view saved, deleted or sent items** click the underlined item in the list.

- **Email can also be accessed** from the ***Main Menu*** under Messages/Email and by clicking ***Help*** *at the* bottom right of the *Review Pending* page, which gives you the opportunity to send an email to the correct contact for this patient in Administration, Provider Services or Information Technology.

15. Request Supplemental Authorization Information



- The *Supplemental Auth Information* screen is a user-defined screen for supplemental data. It is accessible from *Search Authorizations, Display Authorizations* and *Review Pending Authorizations* functions.

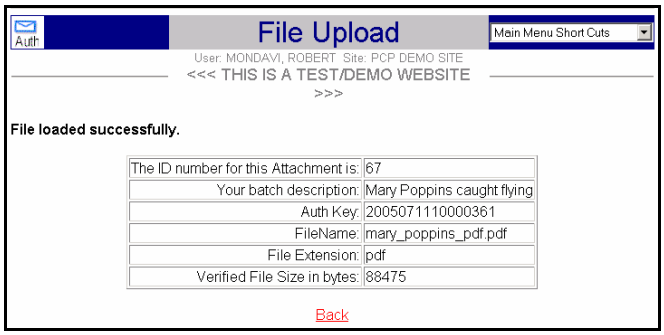
- The fields on the screen can be used by Medical Directors to request additional authorization information. Up to twelve user-defined fields are available, each of which can be defined as a number, a date, a text field or field with a drop down box with set selection options. These fields can be given user-defined names or labels that appear on the screen with the associated field. In the example above, the Supplemental data screen is set up to demonstrate the different types of field types (text, date, numeric and drop down box selections) and edits (date and numeric).

- PPMSI currently uses this screen to collect inpatient information with the following fields:

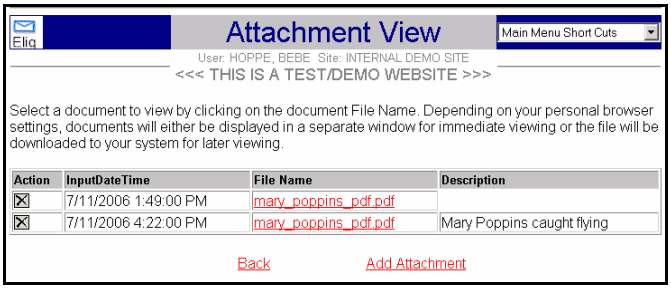
  Auth Number
  Admit Type
  Information Source
  Intensity of Service/ Severity of Illness
  Intensive Care Unit
  Disposition
  Maximum Temperature
  Inpatient Psychiatric Care
  Transplant
  Place of Service
  Medical Director Approval
  Managing Doctor
  Managing Doctor Phone Number

16. Add an Attachment to an Authorization

- *Upload/View Attachments* is accessed from the *Search Authorizations, Display Authorizations* and *Review Pending Authorizations* options on the Main Menu and from the Modify Authorizations screen. When a specific authorization is selected, a link on the *Selected Authorization* screen displays the link to *Upload/View Attachments.* The user can browse all files on the system for a new file to attach or the user can enter the path and the new file name. A message is issued indicating whether the upload was successful. The Attachment continues to be part of the Member file.

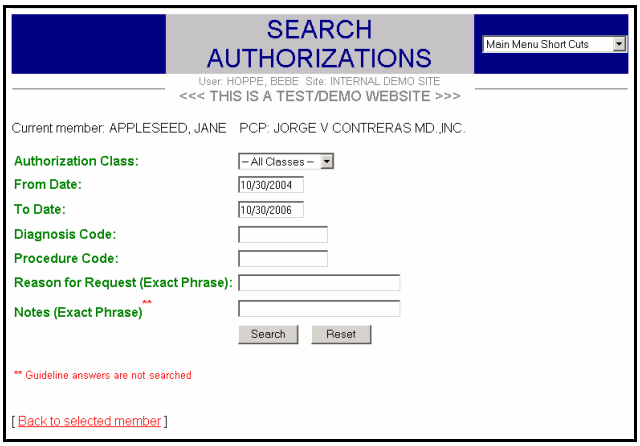


- Once files have been attached to the authorization, a summary line appears on the attachment screen. The attached files may be selected and viewed by selecting the appropriate file name underlined in red.

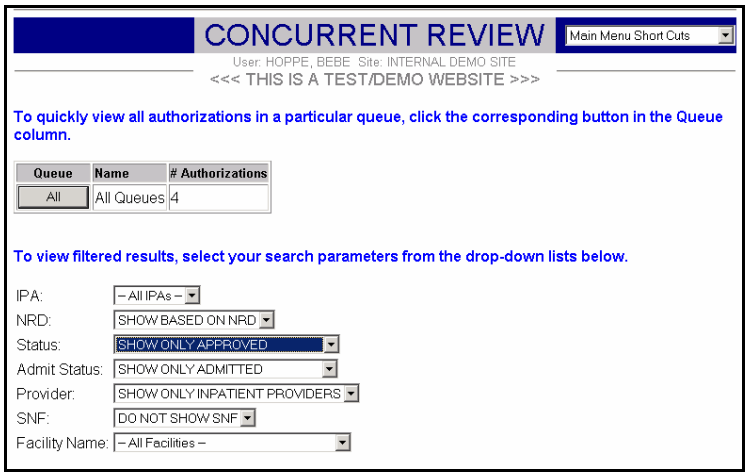


17. Search Authorizations

- Material in the authorization system can also be easily searched using medical and lay terminology, diagnostic or procedural codes.
- Click *Search Authorizations* under *Inquiry* in the **Main Menu** or find this function at the top left of the Selected Member screen.
- To search for people, services and agreements with providers, and health plans, just insert the name or reference to search the Notes and/or Reason section of Authorization or case management notes. Click **Search**. If you choose this function from the Selected Member screen, the member and PCP will be populated by the system.

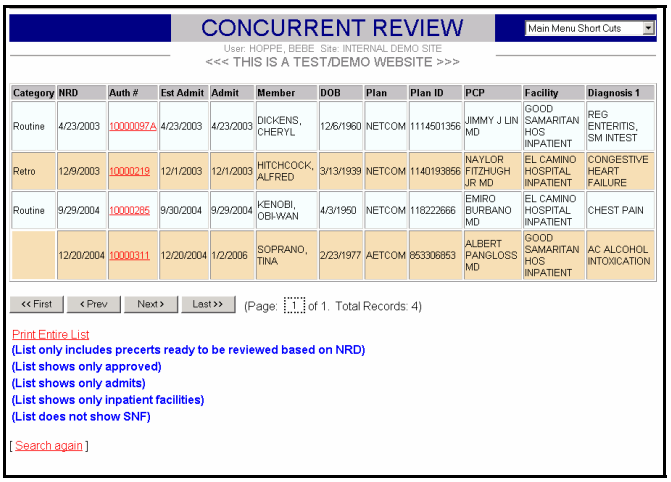


18. Perform Concurrent Review

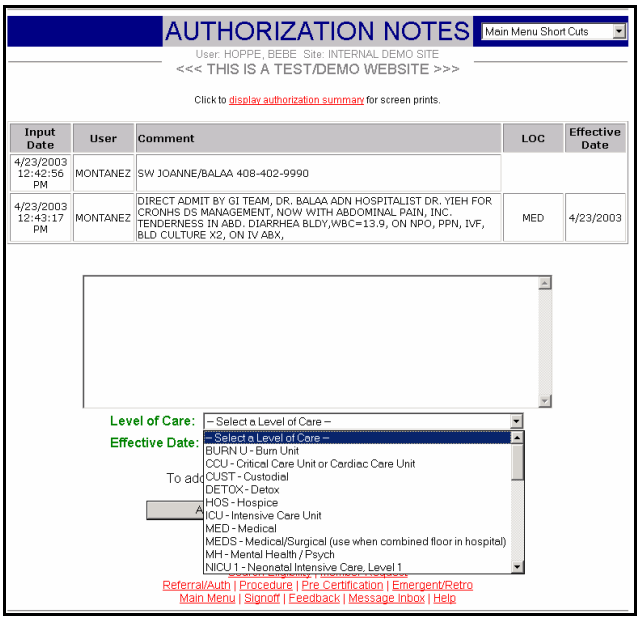


- The *Concurrent Review* screen is accessed from the *Main Menu*.
- The drop-down menus are used to focus the Reviewer on specific IPAs, NRDs (next review dates), specific queues, approval/admit status, provider, facilities. The options allow the Reviewer to further prioritize Concurrent Review by eliminating Pending Precerts, Preadmits and Outpatient admissions from their Worklists.

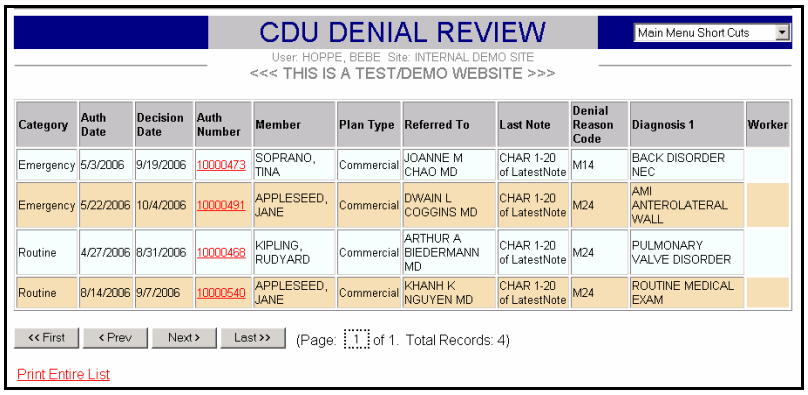
- Output is a list of patients to review. The Default view lists ALL queues, ALL regions, ALL sites. Default listings include pending precerts, admits and preadmits, and all provider types.



- *Once the patient is selected, Authorization Notes* are used to enter comments and to authorize admission to a higher or lower level of care. Notations for Level of Care and Effective dates are added when updating the Notes (see page 23 for additional information.)



19. Review Denied Authorizations

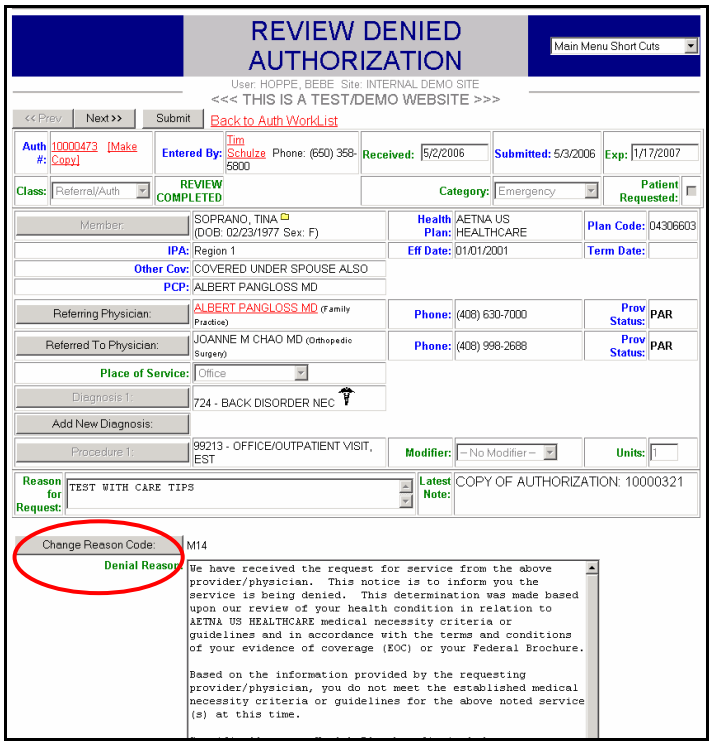


- A list of *Newly Denied Authorizations* can be accessed through the *Main Menu* and used by the Medical Director to word the denial reason printed in the denial letter. Once the Medical Director denies the authorization, selects and finalizes the denial reason, the authorization is officially denied. At that time, the denied authorization is routed to a CDU Denial queue, so a denial letter can be printed manually by staff.

- When an authorization number in the above screen is selected, it will create an Authorization Screen with the *Reason for Denial* and the *Status*, with *Notes* and *Attachments* that have been added during the authorization process. This screen can be used to reference the primary Authorization screens.

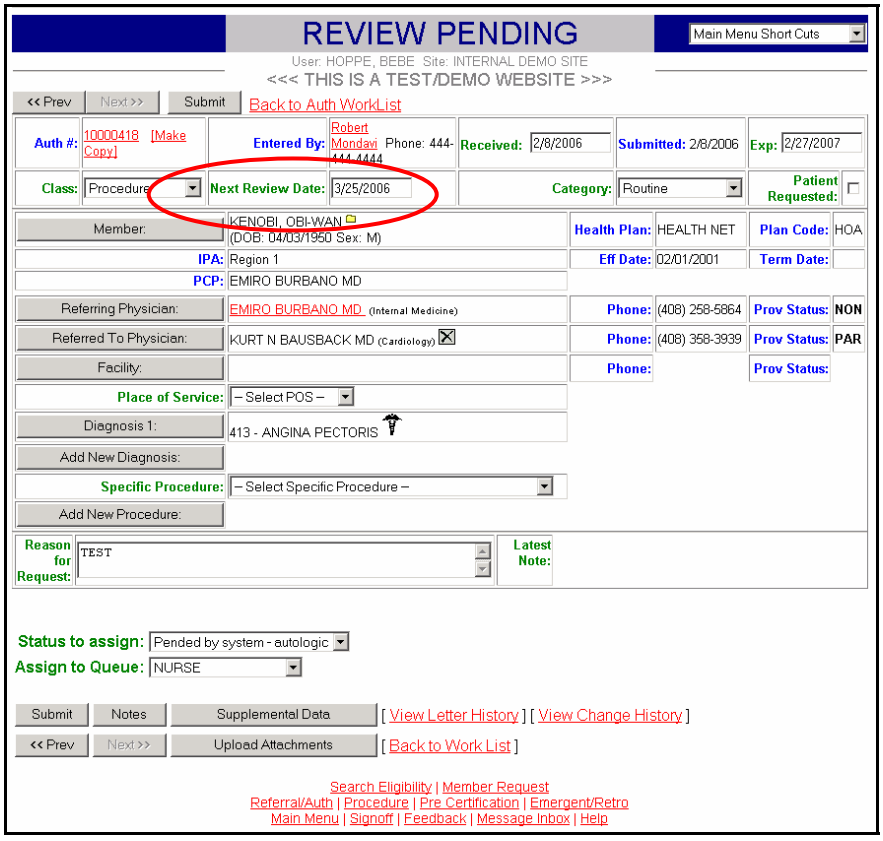
- Click on Change Reason Code if you would like to change the reason listed for the

- Authorization Denial before any letters are printed.

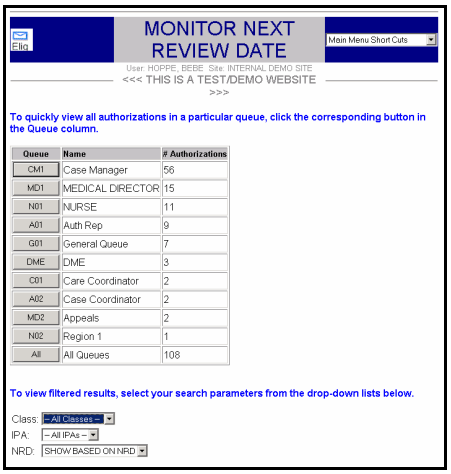


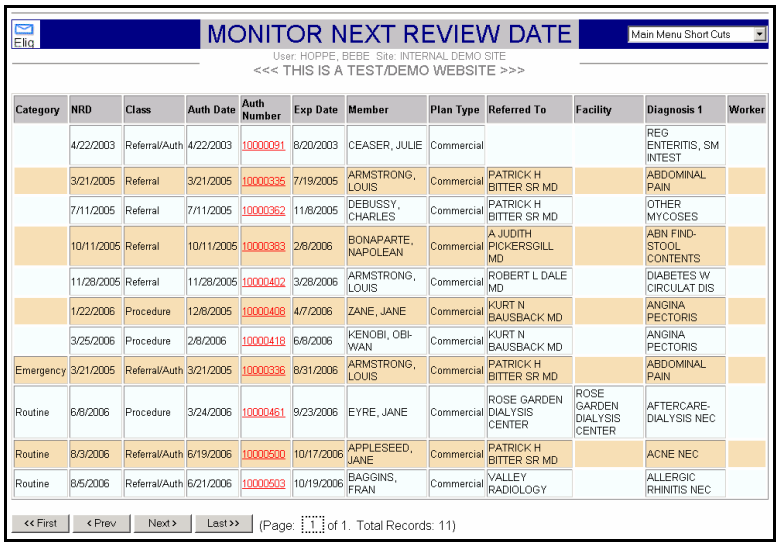
20. Monitor Next Review Date

This function allows the reviewer to assign the NRD (Next Review Date) to follow up on reviews with information that is incomplete. Once the NRD is assigned, the Reviewer can access the list of pending reviews under *Input Authorizations* from the *Main Menu.*



The actual screens (pictured below) are similar to the screens used to Review Pending Requests.

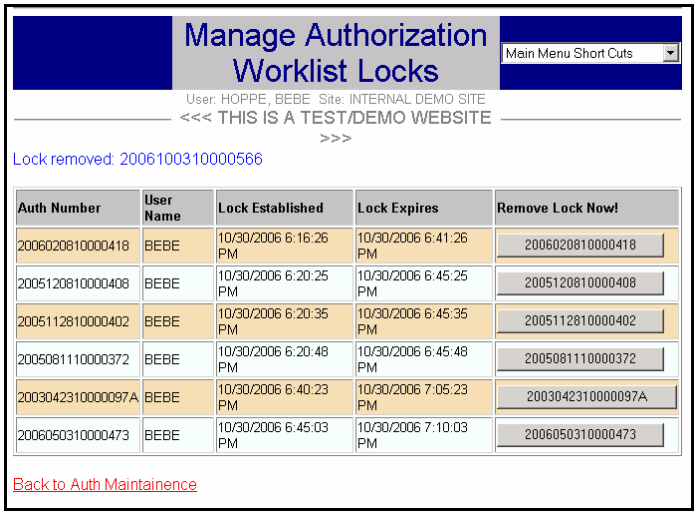




21. Maintain Authorization Tables

The *Maintain Authorization Table* screen can be accessed from the *Main Menu.* Authorization Maintenance functions are listed on this screen and can be selected from the list.

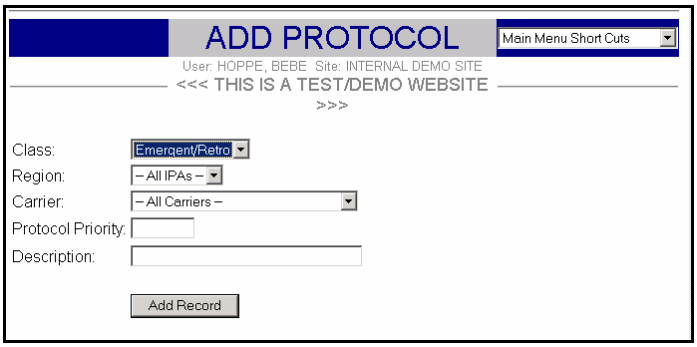
22. Manage Locked Authorization Tables



Auth Number	User Name	Lock Established	Lock Expires	Remove Lock Now!
2006020810000418	BEBE	10/30/2006 6:16:26 PM	10/30/2006 6:41:26 PM	2006020810000418
2005120810000408	BEBE	10/30/2006 6:20:25 PM	10/30/2006 6:45:25 PM	2005120810000408
2005112810000402	BEBE	10/30/2006 6:20:35 PM	10/30/2006 6:45:35 PM	2005112810000402
2005081110000372	BEBE	10/30/2006 6:20:48 PM	10/30/2006 6:45:48 PM	2005081110000372
2003042310000097A	BEBE	10/30/2006 6:40:23 PM	10/30/2006 7:05:23 PM	2003042310000097A
2006050310000473	BEBE	10/30/2006 6:45:03 PM	10/30/2006 7:10:03 PM	2006050310000473

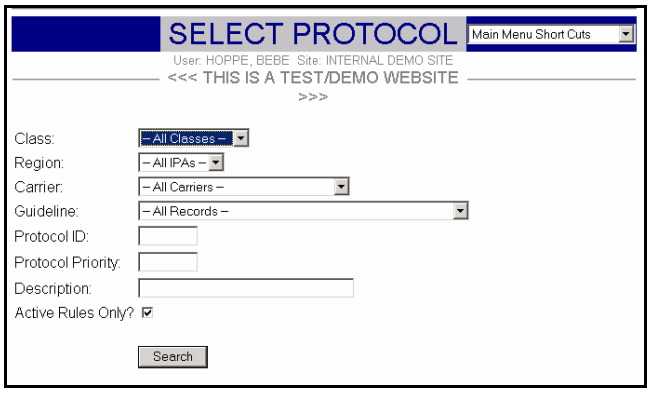
- This function can be accessed from the *Maintain Auth Tables* screen—which is a choice on the *Main Menu.*
- The Locking function prevents two Reviewers from working on the same request at the same time. The system typically locks out the second person to access a record that has already been accessed by another reviewer.
- The *Manage Locked Authorization Tables* function allows the Medical Director to unlock specific Authorization Requests, in the event a Reviewer has left the computer without finalizing a review. Just click on the correct authorization number in the *Remove Lock Now!* column, and the removed lock will appear at the top of the screen with the authorization number.

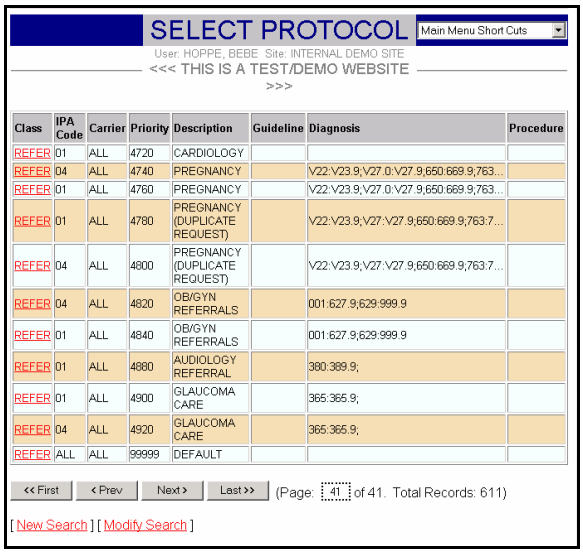
23. Add New Protocol Record and Update Protocol Table



- Select *Maintain Auth Tables* from the *Main Menu*, then select *Add New Protocol Record.* On the *Add Protocol Screen,* select the *Class, Region, Patient Site* and *Carrier* to which the new Protocol will apply.
- Fill in the *Description* and *Priority number (1-999)* for the new protocol. For the most reliable results, use each Protocol Priority number only once. If a Protocol Priority number is already assigned, the system will suggest the closest priority number available to complete that protocol screen.
- If the new Protocol requires *Authorization Guidelines,* follow the instructions in *Section 21* to create the *Authorization Guidelines*. Then return to *Sections 19 & 20* to update the Protocol Table with all the required information including the guidelines.

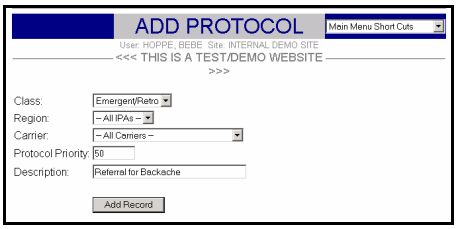
24. Search/Update Protocol Table



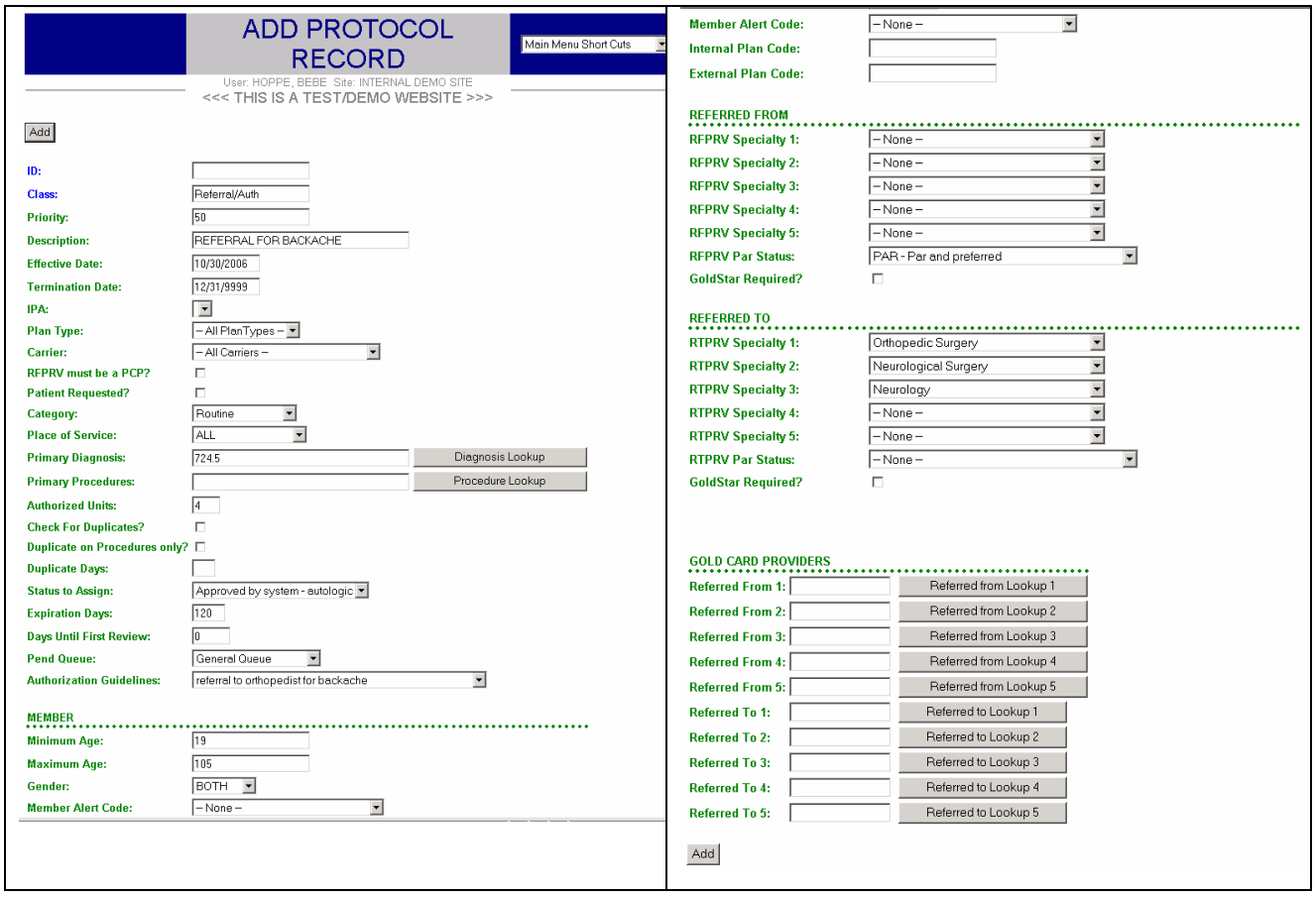


- To Search the Protocol Table or update an existing protocol, select *Search/Update Protocol Table* from the *Maintain Auth Tables* menu. Then select the appropriate Protocol from the list.

25. Protocol Table Add Record/Update



Select Add New Protocol Record under Maintain Auth Tables. Then fill in the Protocol Record screen below.



- The screen above illustrates a protocol for *Backache.* Details of the *Referral to Orthopedist Authorization Guidelines* included above can be found later in this guide.
- When creating a protocol, a blank field means the protocol applies to ALL possible entries in this category.
- When an authorization is submitted, the matching functionality attempts to locate a protocol record that matches ALL fields that are required for a protocol. If a field on the protocol is left blank, the matching continues to other records.

Definitions of Data Fields used in the Authorization Protocol Tables

CLASS: defines the *type* of authorization requested. Valid authorization types used by the medical group are--

- EMERG for emergent services
- REFER for referrals from one doctor to another
- PROC for a special set of outpatient services the group wants to approve in advance, such as MRIs
- PRECERT for precertification of care provided in a facility, e.g. a hospital admission
- MISC for a variety of services such as home care provided by a licensed home care agency

There is a new class in development for Case Management

REGION & PATIENT SITE: defines the region or sub-region this protocol will affect. If no region code is entered for a particular protocol, this rule applies to all regions.

CARRIER: defines the particular HMO affected by the rule.

PRIORITY: prioritizes the protocol to apply when Authorization Protocols conflict with one another. Lower number protocols take precedence over higher number protocols. If Protocol #1 states all patients with orthopedic problems go to any Plan orthopedist, and Protocol #2 states referrals for treatment of osteogenisis imperfecta go to a particular orthopedist. Protocol #2 would be given a lower number priority than the first rule so it would take precedence and the member would be directed only to the single specified specialist for this rare disease.

DESCRIPTION: a brief description of the Authorization Protocol.

EFFECTIVE DATE: the starting date for the time period for which the Authorization Protocol is in effect. When no start date is given, the protocol is effective until an end date is entered.

TERMINATION DATE: the date this protocol ends. If no date is present, the protocol is effective indefinitely.

PRIMARY DIAGNOSIS: the ICD9 codes to which the protocol applies. Either single codes, ranges of codes, or mixtures of single code and ranges can be used. Blanks in the Diagnosis field indicate that all diagnoses are allowed.

PRIMARY PROCEDURES: determine which particular CPT procedure codes or specified sets of such codes are affected by the protocol. Blanks in the Procedure field on the protocol record indicate that ALL procedures are allowed.

Both Diagnosis and Procedure must match on an authorization and protocol record. The procedure field is matched only against the first procedure listed for the authorization so subsequent procedures DO NOT NEED to be indicated in the procedure field on the protocol record for that protocol record to be matched with the authorization. With Procedure Authorizations, the procedure match is performed using the Special Procedure on the authorization. For all other authorizations, Procedure 1 is used to perform the match.

PLACE OF SERVICE: specifies a particular place of service for this protocol.

PROVIDER (SUB) TYPE (1-5): 5 fields describe provider specialty type, like a physician who is a general orthopedist

MEMBER AGE FROM: minimum age of a member that a particular Authorization Protocol affects.
MEMBER AGE THRU: maximum age of a member that a particular Authorization Protocol affects.

Either or both of these fields can be left blank to indicate an "open age limit", or integers can be entered.

GENDER: gender of the member a particular Authorization Protocol affects.

PAR STATUS: the contracting status (level of preferred use) assigned to the 'Referred to' participating provider. Medical group provider 'par' (participating) Status can be PPL, EPL, NLL, UNA) or it may be left blank.

CATEGORY: classification assigned to protocols to identify high priority requests for immediate attention by the UM staff. *Emergent* has the highest priority, then *Urgent,* followed by *Routine* and *Retro* (retroactive authorizations for services that have already been performed). *All* can be assigned to allow all categories to be accepted for the protocol.

PATIENT REQUESTED: indicates whether the initiating request was made by the patient.

PCP INDICATOR: indicates whether the initiating request was made by the PCP. If the PCP indicator is selected, the protocol record is applied when the Referred From Provider is a PCP. A protocol record with the PCP indicator not selected, is applied when the Referred From Physician is either a PCP or some other kind of provider (i.e. a specialist).

These features allow the medical group to identify different Authorization Protocols for initial and subsequent requests made during a specific time interval:

DUPLICATE FLAG: describes the duplicate situation to which this rule applies

Y where the request **is** a duplicate of an earlier request
N where the request **is not** a duplicate of an earlier request
Field left blank where duplicate status is not an issue

DUPLICATE AUTH DAYS: time interval used to determine whether an auth request qualifies as new or a duplicate.

STATUS TO ASSIGN: an action code the system assigns to requests that meet Authorization Protocol criteria--(a) to approve the request & note it was approved by electronic logic, or (b) to deny the request & note it was denied by electronic logic, or (c) to forward the request to a particular review queue or reviewer. This can also be used to generate a particular type of letter to the member &/or providers.

AUTHORIZED VISITS: the number of visits or days the Authorization Protocol will authorize. If a Referral or Procedure Authorization has an approved status, authorized visits are limited by the number of visits designated in the protocol record. If an Authorization has a pended status, the authorized visits entered by the requestor are used. Visits on Precertification and Emergency Authorizations are always set to 1, whether the authorization is approved or pended and regardless of the number of visits in the associated protocol record.

EXPIRATION DAYS: the number of days from the date of the request entry into the system that the Authorization remains valid.

PEND QUEUE: the queue used by particular individuals or groups of individuals who will review specific authorization requests. For example, DME requests can be routed to a DME or Regional queue.

AUTHORIZATION GUIDELINES: the user may enter an Authorization Guideline Description to use the guideline in a particular protocol. Only available guidelines display in the drop-down window. When Authorization Guidelines are used as part of an Authorization Protocol, questions with yes/no answers are generated as part of the online form that is filled in by the requesting provider. If all the questions are answered correctly, the protocol will take effect. If the answers are incorrect, the requesting provider will view a screen with information about medical group policy and will be given an opportunity to either cancel the request or send it on for medical review. See next section for an example.

GOLD CARD PROVIDERS (**REFERRED FROM 1-5 & REFERRED TO 1-5):** *Referred From* or *Referred to Physicians* who require special handling that is either more liberal or more restricted. For example, an Authorization Protocol developed for a specific physician (or group of up to five physicians) who requires additional vigilance will use a specific protocol to differentiate referral handling from that of his/her peers. Additional protocols are required for more than five Gold Card Providers. Authorization Protocols may also be applied to specific specialist groups in the medical group.

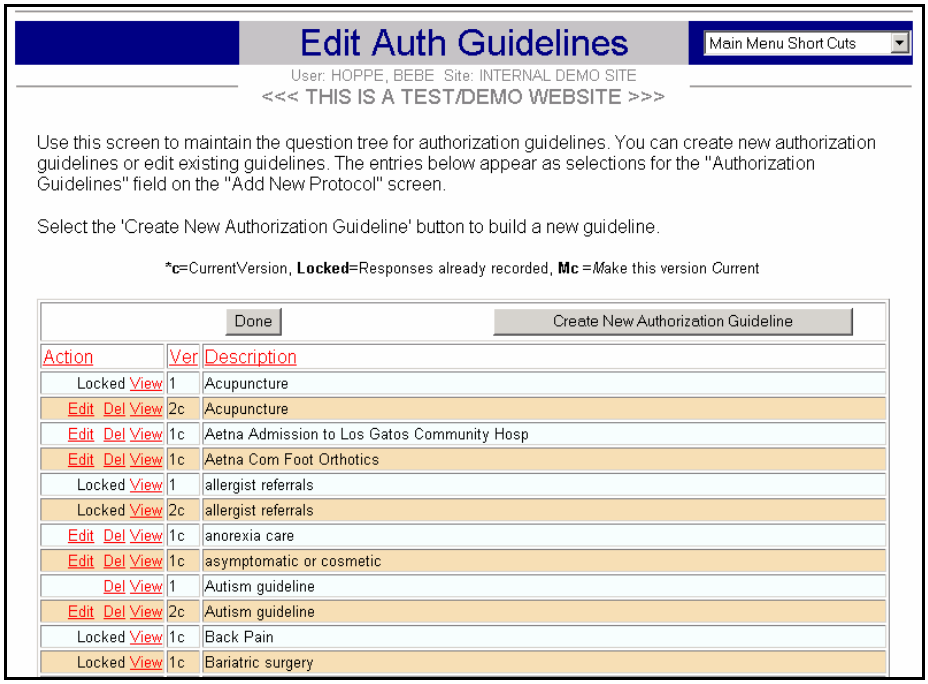
An authorization and a protocol record must match on all specified parameters (diagnosis, procedure, par status, category etc.) for Gold Card functions to be applied. If specific parameters are not entered, the protocol disregards that category in its logic. The protocol and authorization must then match on the Refer From and Refer To providers when designated on the protocol.

For a matching authorization and protocol record where visits apply (i.e. auto-approved Referrals and Procedures) and Gold Card providers are designated, the Gold Card Visits take precedence over the protocol's base Visits field. If Gold Card Visits are zero, the protocol base Visits field is used. A maximum number of Gold Card Visits may also be designated (but is not required). For example, if a protocol record designates a Gold Card provider who allows 3 visits for an asthma diagnosis, a matching authorization with 1, 2 or 3 visits would be allowed. If the authorization has 4 visits, then the authorization visits are adjusted to 3.

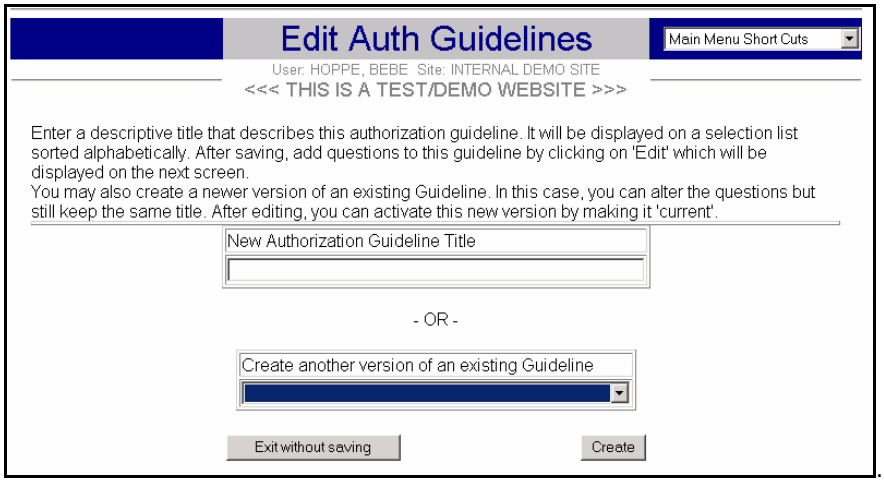
REFERRED TO VISIT: number of visits approved for Gold Card Providers (subject of this Authorization Protocol.

26. Create or Edit Authorization Guidelines

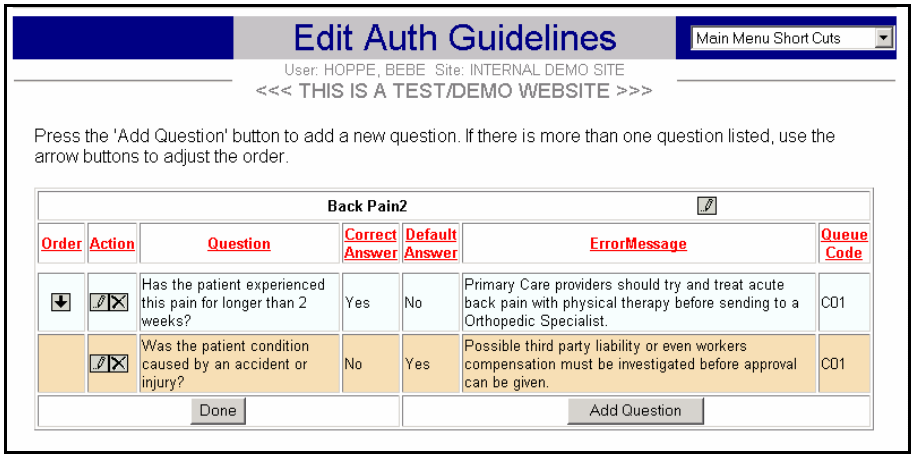
- To create or edit an existing guideline, click *Maintain Auth Guidelines* on the *Maintain Authorization Tables* screen that is accessible from the *Main Menu.* You will find a list of existing guidelines like the ones below.



- Click the Create tab and follow the directions to create new Authorization Guidelines or to set up new guidelines that build on existing guidelines.

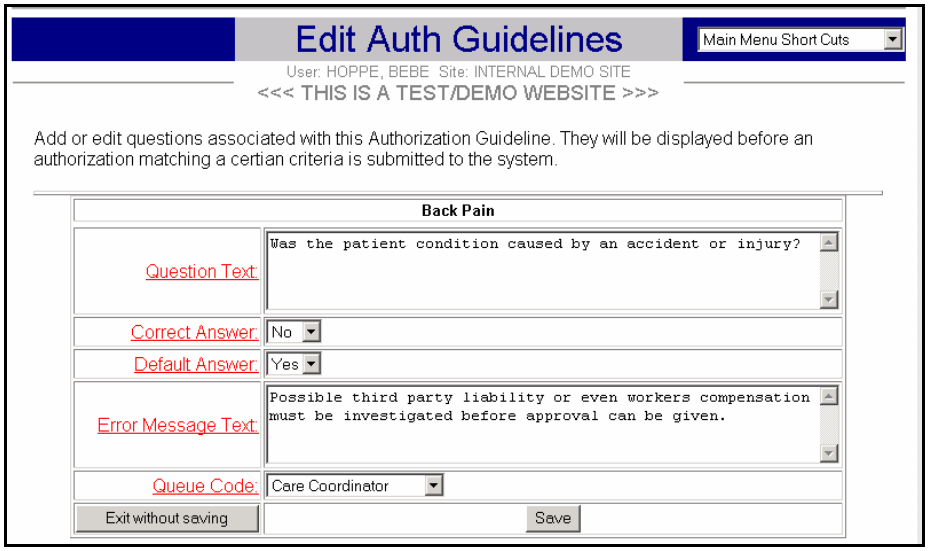


- To *Edit* an existing guideline, in the first *Edit Auth Guidelines* screen of this section, select the guideline and click *Edit to pull up the screen below. Use the* pencil *before* the guideline to pull up the next screen. (Click the X to delete a guideline).



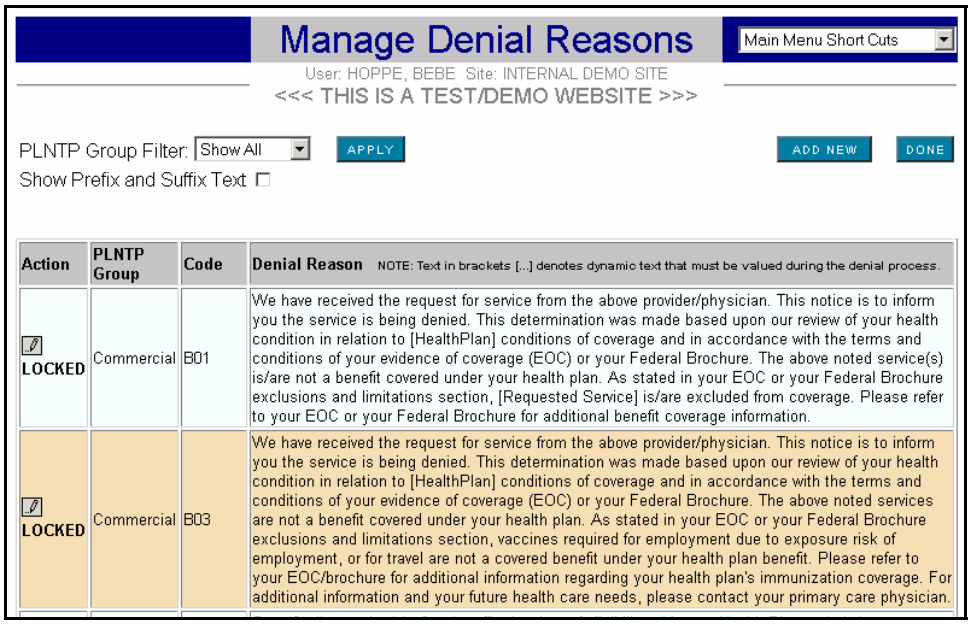
- The *Edit Auth Guidelines* screen will allow the user to add questions by clicking *Add Questions* at the bottom of the screen or delete existing questions using the X before each question. When complete click *Done.*

- Use the screen below to add or change questions associated with each guideline. Click *Save.*

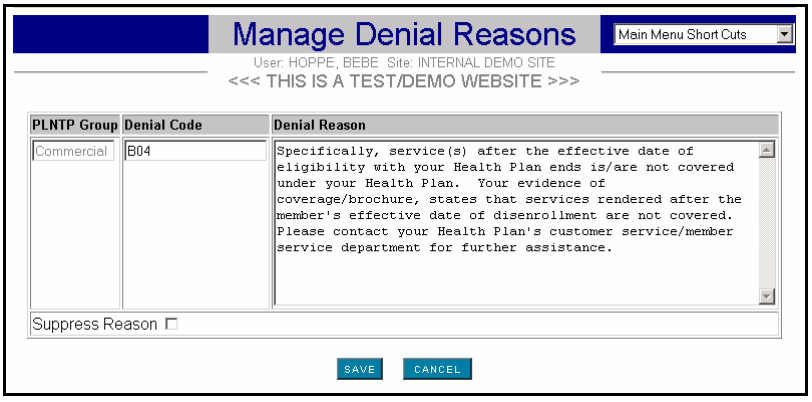


- To link the new Authorization Guidelines to a Protocol, return to *Maintain Auth Tables* on the *Main Menu*, select *Search/Update Protocol Table*, and follow the instructions in Section 25 to finish setting up the Protocol.

27. Maintain/ Edit Denial Reasons



- Select *Maintain Authorization Guidelines* on the *Maintain Auth Tables* screen that is accessible from the *Main Menu.* Click on the column labels for information.
- To Edit Denial Reasons, click the pencil icon. Then Click on New Denial Reason to add a denial reason.
- To Add New Denial Reasons, click the tab at the top of the screen and click Save when you are finished. You will have access to existing denial reasons, should you want to cut and paste existing information into the new reason.



28. Pay For Performance Quality Measures

Pay for Performance (P4P) is an employer initiative that requires health plans and physician organizations to demonstrate their patients are getting appropriate care based on specific standard quality measures like immunizations for children under age 2, Pap & mammogram screenings for women, Glycohemoglobin tests for diabetics, and suppressor drug treatment for asthmatics.

Access Express helps maximize your physician's P4P score by insuring the most current administrative data is recorded and submitted for your office. Measurement is based on claims and encounters from your office and on data submitted by pharmacy and lab providers. ***Neither your physicians nor your managed care organization get P4P credit for needed care, unless the data is recorded in the Access Express administrative records.***

- Since each HMO member is linked to a specific Primary Care Physician, most organizations rely on their PCPs to gather and input all P4P information.
- Access Express functions use PCP office staff time efficiently to enter missing information so your office can meet P4P goals.

How to Update P4P Quality Measures to Add Missing Information & Conditions Excluded from Quality Measures

Once a health plan member is qualified for a P4P measure, the Access Express system views each measure as either—Passed, Missing or Excluded (based on valid P4P criteria).

- **Select Quality Measures** in the **Main Menu/ Support** section**,** to find the list of patients who lack specific P4P measures according to your medical group records.
- **Use the information below to enter missing Quality Measures online for each patient listed for your office.**

The Quality Measures screen shows the cutoff date (01/15/06) for data extracted from claims, prescriptions & encounter data.

Select the right filter from the Filter section in blue dots. You can choose to—

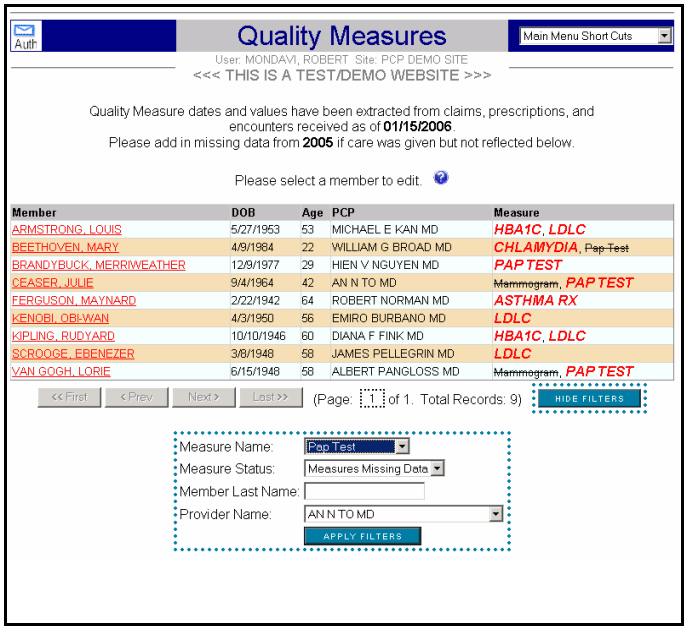
-Show ONLY measures that need action

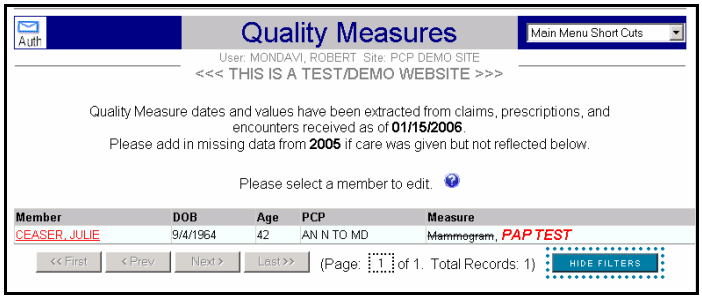
-List patients for EACH physician OR for ALL physicians in the practice

-Show patients who require a specific Quality Measure for a SPECIFIC disease OR

-Show ALL Quality Measures

This example filters only patients of Dr. To with no specific last name, who need a Pap Test.





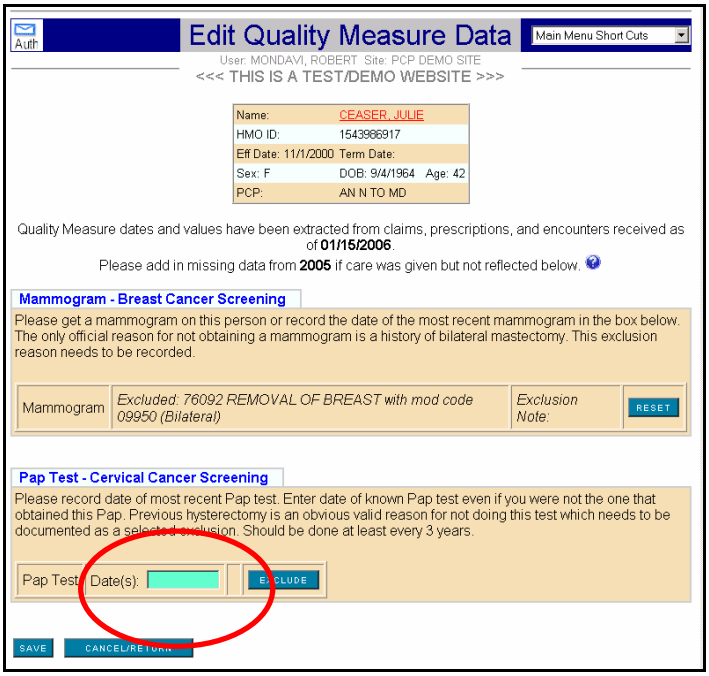
Click one of the names to see a summary of the measures on record & the measures required for that patient.

For each member, you will see a list of Quality Measures still missing from the P4P database.

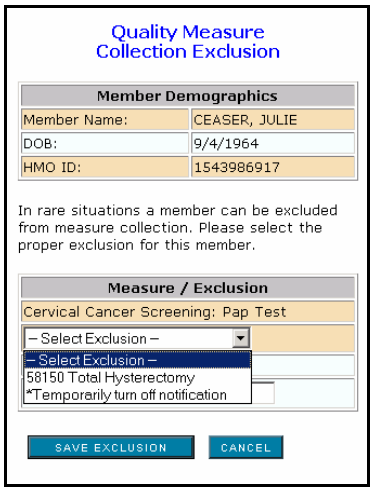
In this case, Julie Ceaser has an acceptable mammogram exclusion, but still requires a Pap.

If historical data is included in your organization's database, the DATE OF THE LAST EXAM will be listed.

- **FILL IN the missing data, if there has been a more recent test.** Because of the lag time, your data will usually be more timely than the database.
- **If the member is due** for a new test, leave it blank for now, but place a note in the patient chart to order the missing test at the next visit.



- **Click *Exclude*** to enter the appropriate reason your patient should be excluded from the measure. Only valid exclusions will remove a member from a physician's P4P score. For example, a Bilateral Mastectomy is an official exclusion for the Breast Cancer Screening measure. The next screen will pop up with a list of valid exclusions.
- After entering a valid exclusion (see below), click ***Save*** to save the data added to the database.



To Enter A Valid Exclusion,
Click on the exclusion, then click SAVE EXCLUSION at the bottom of the window to update the database.

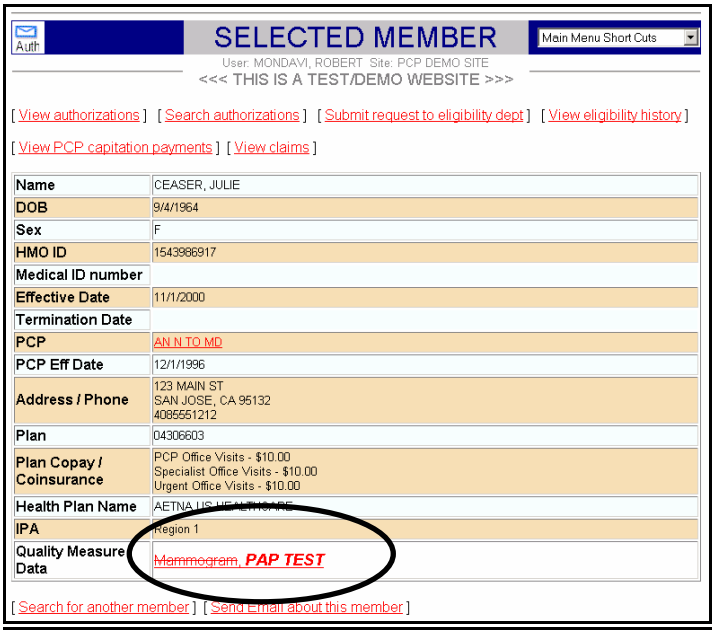
- The Exclusion screen at the right shows ***Bilateral Mastectomy*** is the only acceptable exclusion for a mammogram.

- Although ***Patient declined test*** is not an approved exclusion under P4P, it should be filled in where appropriate.

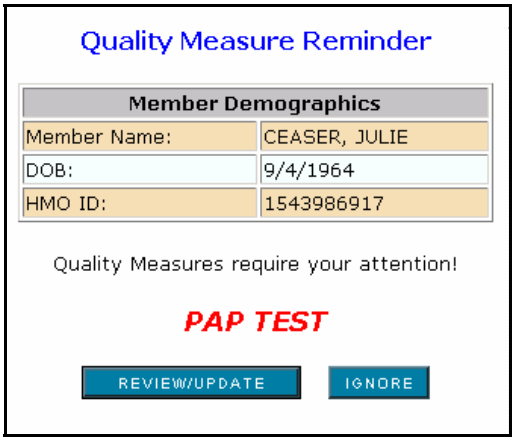
- Quality Measures required for a specific member are also referenced on the **Member Eligibility** Screen.
  - **If the Measure is listed in *BOLD RED*** P4P data is still required—either there is no date or no value entered or the data does not satisfy P4P.
  - **If the Measure is listed in** regular type, P4P data is up-to-date.
  - **If the Measure is** ~~crossed out,~~ it is excluded for that patient.

  In this example, the Mammogram is excluded but the PAP TEST is still required.

- Click on the Quality Measure listed at the bottom of the screen to link with the *Edit Quality Measure* screen pictured on the previous page.



- To the right is the POP-UP Quality Measure Reminder that shows up when the PCP office checks this Member's eligibility or requests an Authorization.



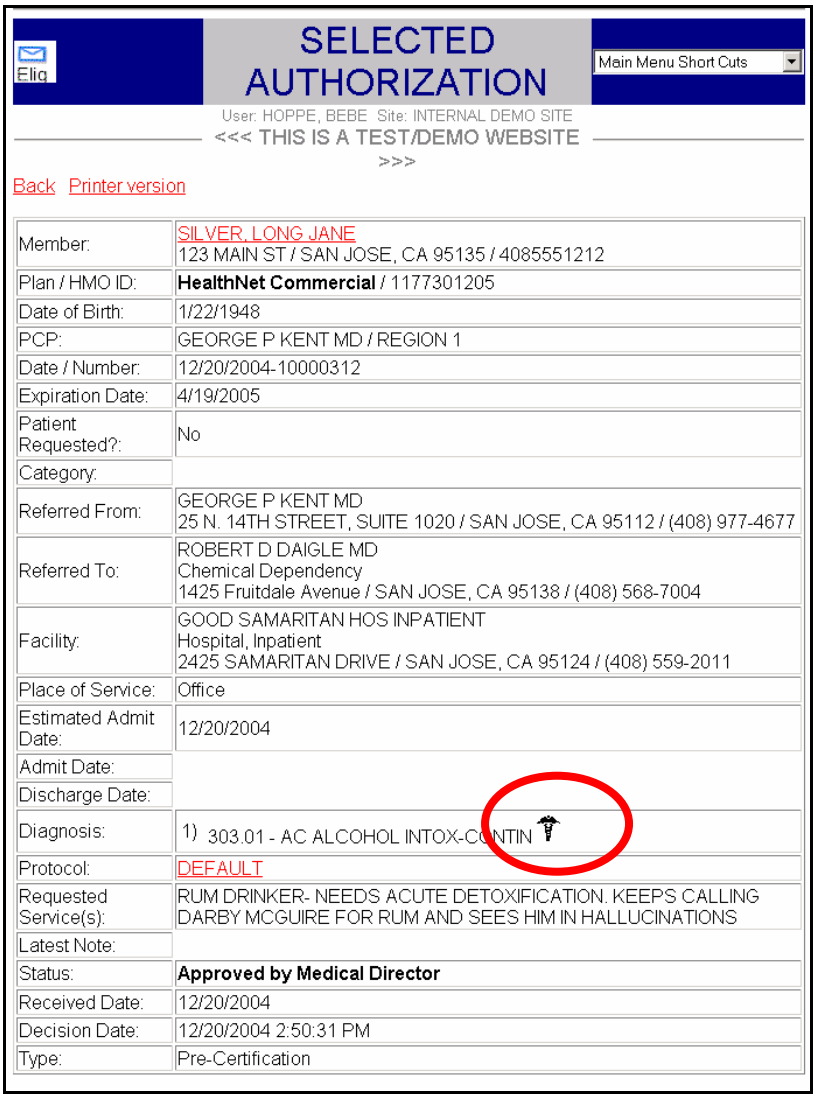
29. Care Tips

Care Tips brings health plan guidelines and clinical information directly to the doctor or nurse at the point of service where it can do the most good. It provides the providers in your organization (and, where appropriate, patients) with detailed clinical information and recognized medical source data to facilitate care. It distributes health plan and medical group treatment guidelines to providers in a timely, efficient manner.

Care Tips may be used for guidelines that are specific to a particular health plan. For example, for a Health Net Substance Abuse carveout that applies to Medicare members, Care Tips reminds the provider staff that, following acute detoxification, care should be arranged by Health Net's subsidiary, MHN.

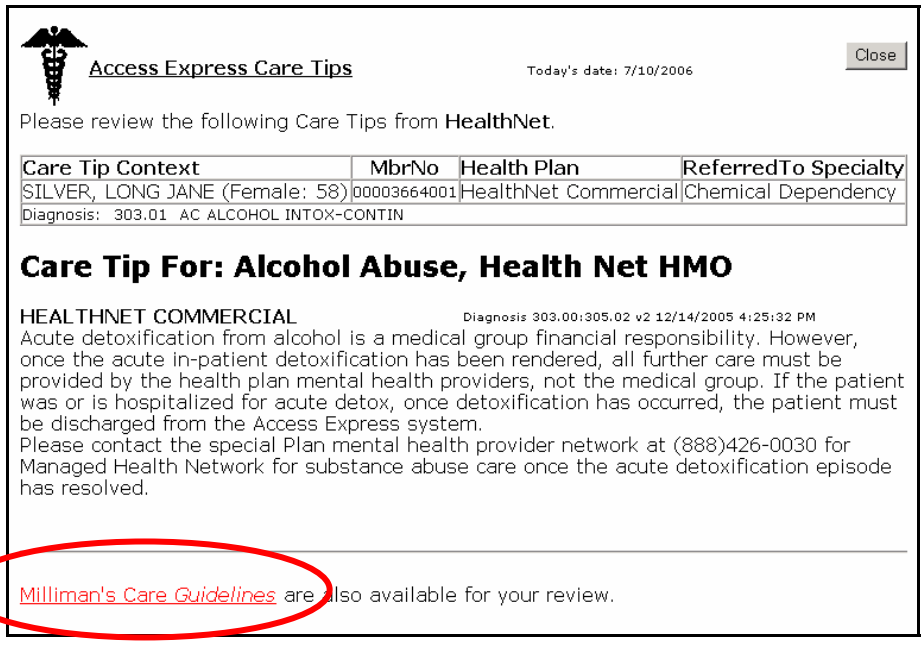
Care Tips will also be used for medical group guidelines that apply to specific diagnoses like asthma, diabetes and coagulation problems that have been reviewed and accepted by UM and Quality Committees. Physician offices will also have access to Milliman Care Guidelines from the appropriate the Care Tip.

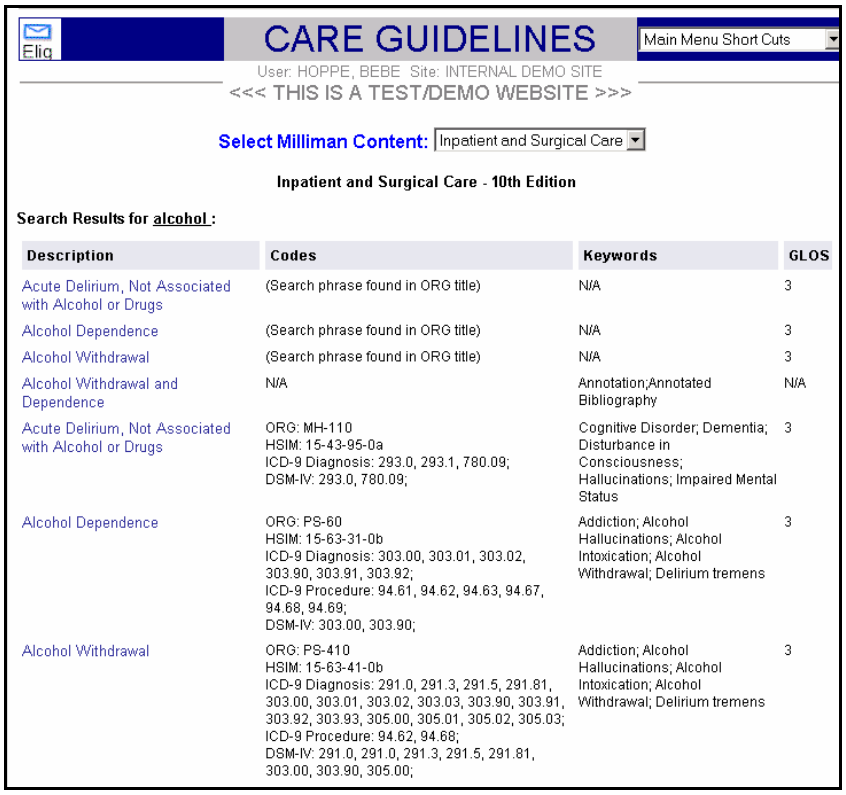
To find Care Tips: Click the Caduceus symbol



Click to find the Milliman Care Guidelines listed below.

Then Search "Alcohol" to find the related Milliman Care Guidelines.

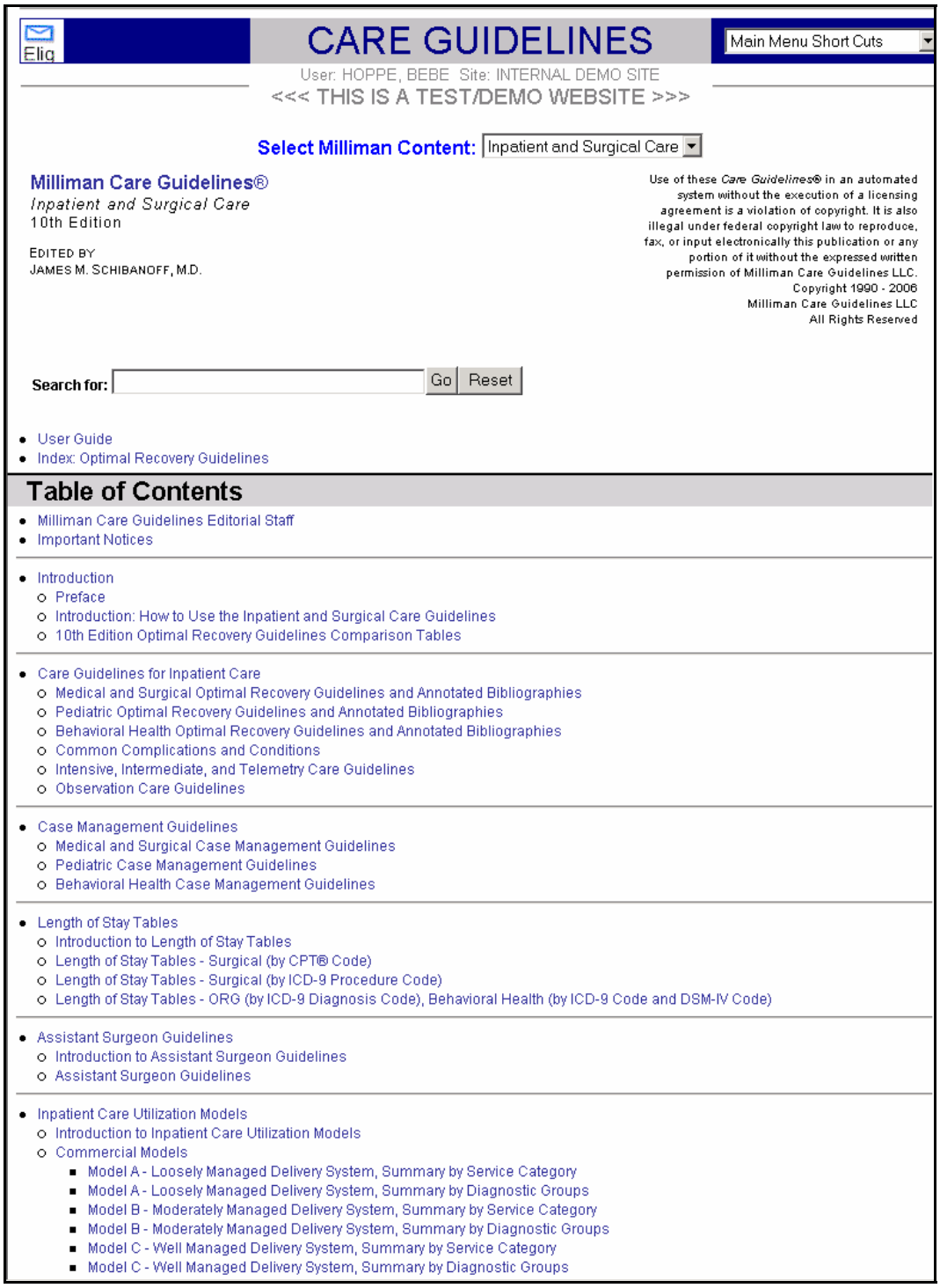




Select the appropriate Milliman Care Guideline from the list at the left.

A sample Milliman Care Guideline is pictured on the next page.

Sample Milliman Care Guideline



Elig

CARE GUIDELINES

Main Menu Short Cuts

User: HOPPE, BEBE Site: INTERNAL DEMO SITE

<<< THIS IS A TEST/DEMO WEBSITE >>>

Select Milliman Content: Inpatient and Surgical Care

Milliman Care Guidelines®

Inpatient and Surgical Care

10th Edition

EDITED BY
JAMES M. SCHIBANOFF, M.D.

Use of these *Care Guidelines®* in an automated system without the execution of a licensing agreement is a violation of copyright. It is also illegal under federal copyright law to reproduce, fax, or input electronically this publication or any portion of it without the expressed written permission of Milliman Care Guidelines LLC.
Copyright 1990 - 2006
Milliman Care Guidelines LLC
All Rights Reserved

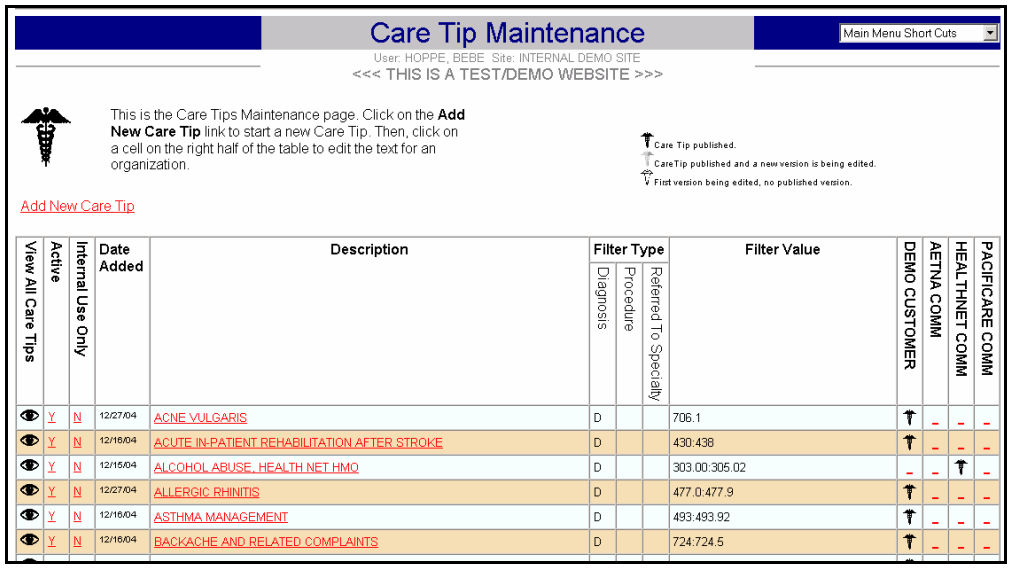
Search for: Go Reset

- User Guide
- Index: Optimal Recovery Guidelines

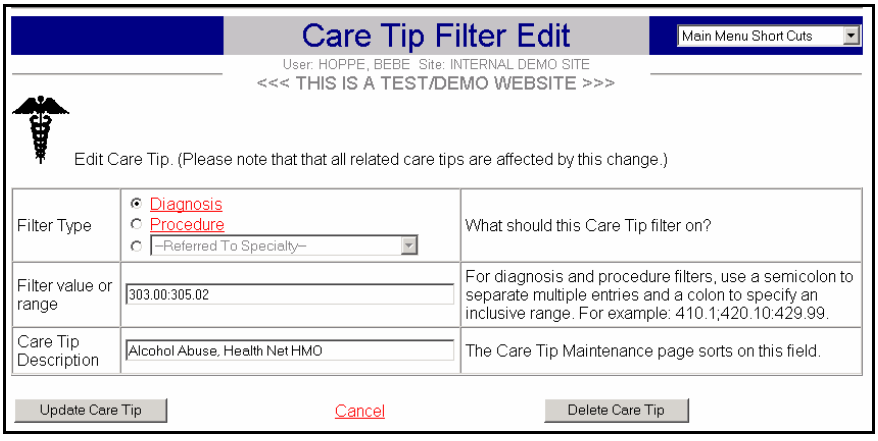
Table of Contents

30. Care Tip Maintenance

- Select *Care Tip Maintenance* from the *Support* section of the *Main Menu, and you will find the Care Tip Maintenance Page* shown below.
- Care Tips can vary by health plan or medical group. Care Tips may be created in draft form and finalized after review. Note the 3 different caduceus symbols at the top right of the page that designate DRAFT vs. FINAL Care Tips.



- Click on the *Add New Care Tip* link at the top or bottom left of the page to start a new Care Tip. Then, click on a cell on the right half of the table to edit the text for an organization.
- To update or delete an existing Care Tip, click on the specific Description in Column 4, change the filter information as appropriate, and click on either the UPDATE or DELETE button for the Care Tip.



- Click ADD NEW CARE TIP to pull up a blank screen like the one above, then click CREATE NEW CARE TIP to make the new Care Tip operational.