

Access Express

UTILIZATION MANAGEMENT USER GUIDE

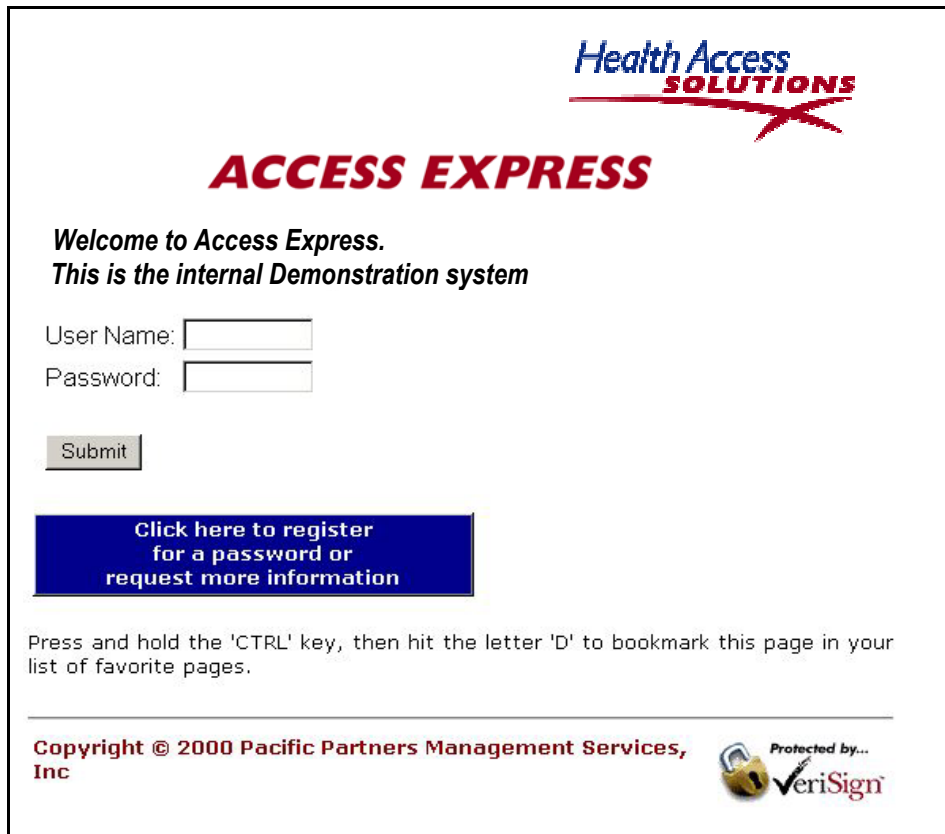


This User Guide includes information specific to Utilization Management functions.
Please refer to the Provider Office Guide for additional information about *Access Express*.

TABLE OF CONTENTS

1. Logging In to Access Express	3
2. The Main Menu.....	3
3. Look Up Eligibility	5
4. Select Member	6
5. Selected Member	7
6. Select Authorization.....	10
7. Select Provider	11
8. Find the Correct Diagnosis	12
9. Find the Correct Procedure	14
10. Referrals & Authorizations.....	15
A. How to Get Started with Authorizations	15
For Urgent Referrals to Specialists & Urgent Procedures/ Precertifications.....	15
B. Search Strategy for Authorizations	16
C. Authorization Guideline Questions.....	16
D. Referral Authorizations	17
E. Precertifications.....	18
F. Procedure Authorizations	20
G. Emergency Authorizations.....	21
11. Review Pending Requests	22
12. Review Specific Authorizations	23
13. Read and Record Authorization Notes.....	24
14. Send & Receive Email to Referring or Receiving Physicians	25
15. Request Supplemental Authorization Information.....	26
16. Add an Attachment to an Email about an Authorization.....	27
17. Search Authorizations	28
18. Perform Concurrent Review	28
19. Review Denied Authorizations	30
20. Maintain Authorization Tables	31
21. Manage Locked Authorization Tables	32
22. Add New Protocol Record and Update Protocol Table	33
23. Search/Update Protocol Table	33
24. Protocol Table Add Record/Update.....	34
25. Create New Authorization Guidelines	38
26. View Authorization Queues	Error! Bookmark not defined.
27. Maintain/ Edit Denial Reasons	40
28. Pay For Performance Quality Measures	40
29. Care Tips	45
30. Care Tip Maintenance	48

1. Logging In to Access Express



Health Access SOLUTIONS

ACCESS EXPRESS

Welcome to Access Express.
This is the internal Demonstration system

User Name:

Password:

[Click here to register for a password or request more information](#)

Press and hold the 'CTRL' key, then hit the letter 'D' to bookmark this page in your list of favorite pages.

Copyright © 2000 Pacific Partners Management Services, Inc

Protected by... VeriSign

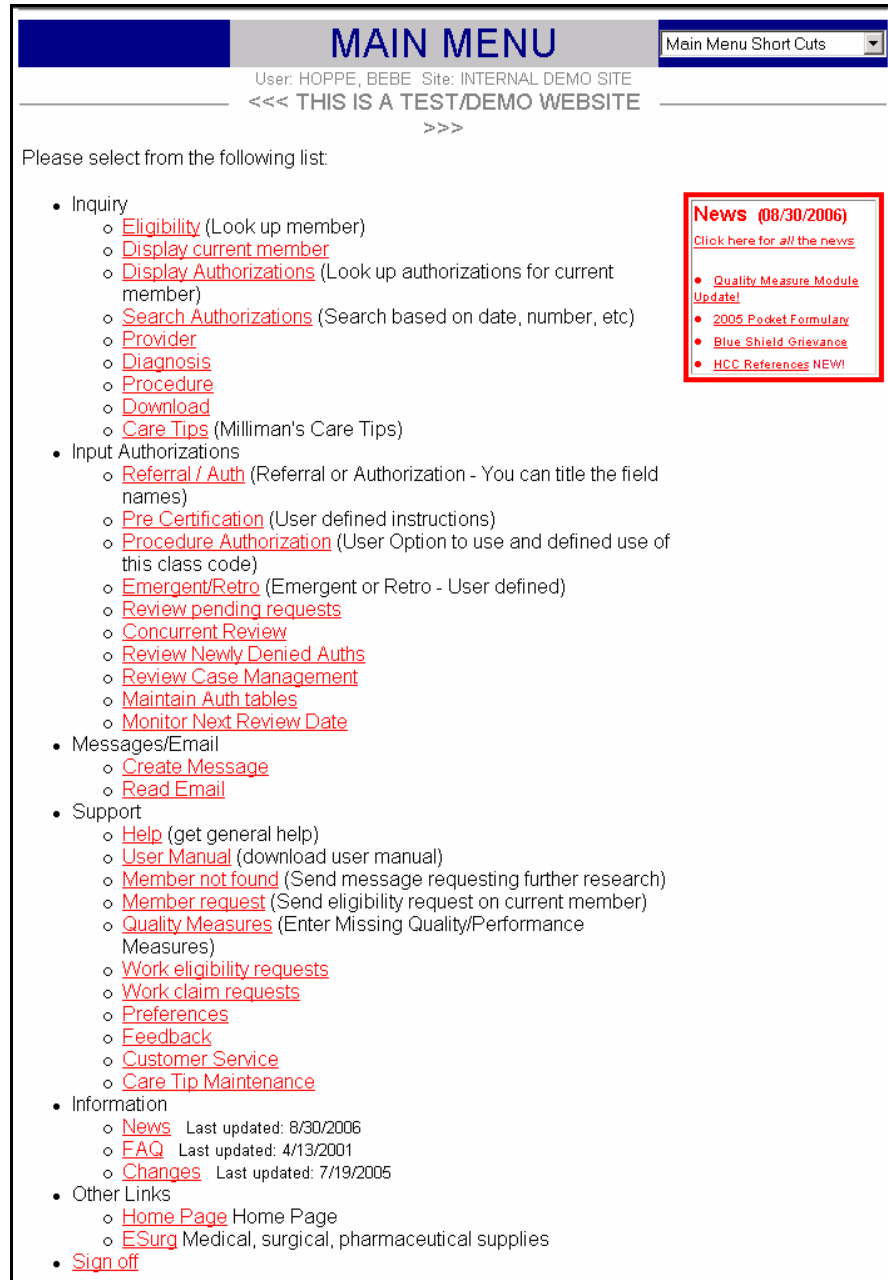
- Open the *Health Access Solutions* website at _____.
- **Make this your Home Page so it will show automatically every time you dial into the Internet:**
At the top Microsoft Internet Explorer Toolbar, select *Tools/Internet Options*, then highlight *Use Current*. Click *OK* at the bottom of the screen.
- **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.



MAIN MENU Main Menu Short Cuts

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Please select from the following list:

- Inquiry
 - [Eligibility](#) (Look up member)
 - [Display current member](#)
 - [Display Authorizations](#) (Look up authorizations for current member)
 - [Search Authorizations](#) (Search based on date, number, etc)
 - [Provider](#)
 - [Diagnosis](#)
 - [Procedure](#)
 - [Download](#)
 - [Care Tips](#) (Milliman's Care Tips)
- Input Authorizations
 - [Referral / Auth](#) (Referral or Authorization - You can title the field names)
 - [Pre Certification](#) (User defined instructions)
 - [Procedure Authorization](#) (User Option to use and defined use of this class code)
 - [Emergent/Retro](#) (Emergent or Retro - User defined)
 - [Review pending requests](#)
 - [Concurrent Review](#)
 - [Review Newly Denied Auths](#)
 - [Review Case Management](#)
 - [Maintain Auth tables](#)
 - [Monitor Next Review Date](#)
- Messages/Email
 - [Create Message](#)
 - [Read Email](#)
- Support
 - [Help](#) (get general help)
 - [User Manual](#) (download user manual)
 - [Member not found](#) (Send message requesting further research)
 - [Member request](#) (Send eligibility request on current member)
 - [Quality Measures](#) (Enter Missing Quality/Performance Measures)
 - [Work eligibility requests](#)
 - [Work claim requests](#)
 - [Preferences](#)
 - [Feedback](#)
 - [Customer Service](#)
 - [Care Tip Maintenance](#)
- Information
 - [News](#) Last updated: 8/30/2006
 - [FAQ](#) Last updated: 4/13/2001
 - [Changes](#) Last updated: 7/19/2005
- Other Links
 - [Home Page](#) Home Page
 - [ESurg](#) Medical, surgical, pharmaceutical supplies
- [Sign off](#)

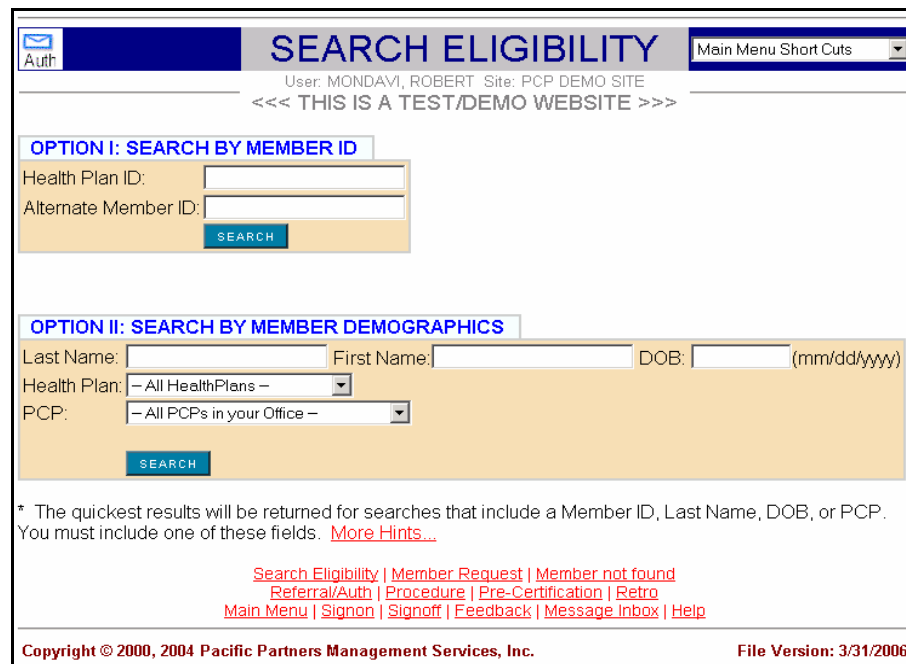
News (08/30/2006)
 Click here for [all the news](#)

- [Quality Measure Module Update!](#)
- [2005 Pocket Formulary](#)
- [Blue Shield Grievance](#)
- [HCC References NEW!](#)

- **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.

Member Name	DOB	Sex	HMO ID	Alternate Member ID	EffDate	TermDate
APPLESEED, JANE	5/27/1974	F	BW933HBB		8/1/2001	
ARBUCKLE, JON	7/31/1939	M	118508862		1/1/2002	
ARMSTRONG, LOUIS	5/27/1953	M	112328404		1/1/2001	
BAGGINS, BETTY	3/22/1960	F	66764101412		11/15/1996	
BEETHOVEN, MARY	4/9/1984	F	F124946426		12/1/2000	
BONAPARTE, NAPOLEAN	5/17/1980	M	70328861081		11/1/2001	
BRANDYBUCK, MERRIWEATHER	12/9/1977	F	24930168707		5/1/2001	
CEASER, JULIE	9/4/1964	F	1543868917		11/1/2000	
DEBUSSY, CHARLES	11/24/1937	M	119717822		1/1/2002	
DICKENS, CHERYL	12/6/1960	F	1114501356		1/1/2002	
EDISON, TAMMY	7/31/1947	F	116172805		1/1/2002	
EYRE, JANE	3/11/1932	F	360369838F		1/1/2001	
FERGUSON, MAYNARD	2/22/1942	M	522341347M		10/1/2001	
HITCHCOCK, ALFRED	3/13/1939	M	1140193856		1/1/2001	
KENOBI, OBI-WAN	4/3/1960	M	118222666		2/1/2001	

<< FIRST < PREV NEXT > LAST >> (Page: 1 of 2. Total Records: 25)

[\[New Search \]](#) [\[Modify Search \]](#)

[Search Eligibility](#) | [Member Request](#) | [Member not found](#)
[Referral/Auth](#) | [Procedure](#) | [Pre-Certification](#) | [Retro](#)
[Main Menu](#) | [Signon](#) | [Signoff](#) | [Feedback](#) | [Message Inbox](#) | [Help](#)

- 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.**

SELECTED MEMBER	
User: MONDAVI, ROBERT Site: PCP DEMO SITE	
<<< THIS IS A TEST/DEMO WEBSITE >>>	
[View authorizations] [Search authorizations] [Submit request to eligibility dept] [View eligibility history]	
[View PCP capitation payments] [View claims]	
Name	APPLESEED, JANE
DOB	5/27/1974
Sex	F
HMO ID	BW933HBB
Alternate Member ID	
Effective Date	8/1/2001
Termination Date	
PCP	JORGE V. CONTRERAS, MD, INC.
PCP Eff Date	9/1/2000
Address / Phone	123 MAIN ST SAN JOSE, CA 95122 4085551212
Plan	04306603
Plan Copay / Coinsurance	PCP Office Visits - \$10.00 Specialist Office Visits - \$10.00 Urgent Office Visits - \$35.00
Health Plan Name	AETNA US HEALTHCARE
IPA	Region 1
Quality Measure Data	PAP TEST
[Search for another member] [Send Email about this member]	

- **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.

Auth		ELIGIBILITY REQUEST SUBMITTED		Main Menu Short Cuts	
User: MONDAVI, ROBERT Site: PCP DEMO SITE <<< THIS IS A TEST/DEMO WEBSITE >>>					
<p>Eligibility request has been submitted for processing. Look for the eligibility notification envelope in the upper-left corner of the screen that indicates our research department has sent you a reply.</p>					
Member:	MARION SMITH				
Date of Birth:	03/12/1947				
Sex:	F				
Notes:	PATIENT NEEDS URGENT REFERRAL TO CARDIOLOGIST				

- **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.

SELECTED MEMBER	
User: MONDAVI, ROBERT Site: PCP DEMO SITE	
<<< THIS IS A TEST/DEMO WEBSITE >>>	
View authorizations Search authorizations Submit request to eligibility dept View eligibility history View PCP capitation payments View claims	
Name	APPLESEED, JANE
DOB	5/27/1974
Sex	F
HMO ID	BVW933HBB
Alternate Member ID	
Effective Date	8/1/2001
Termination Date	
PCP	JORGE V CONTRERAS MD, INC.
PCP Eff Date	9/1/2000
Address / Phone	123 MAIN ST SAN JOSE, CA 95122 4086551212
Plan	04306603
Plan Copay / Coinsurance	PCP Office Visits - \$10.00 Specialist Office Visits - \$10.00 Urgent Office Visits - \$35.00
Health Plan Name	AETNA US HEALTHCARE
IPA	Region 1
Quality Measure Data	PAP TEST
Search for another member Send Email about this member	

- 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.

SEARCH AUTHORIZATIONS	
User: MONDAVI, ROBERT Site: PCP DEMO SITE	
<<< THIS IS A TEST/DEMO WEBSITE >>>	
Current member: APPLESEED, JANE PCP: JORGE V CONTRERAS MD, INC.	
Authorization Class:	<input type="text" value="- All Classes -"/>
From Date:	<input type="text" value="8/3/2004"/>
To Date:	<input type="text" value="8/3/2006"/>
Diagnosis Code:	<input type="text"/>
Procedure Code:	<input type="text"/>
Reason (Exact Phrase):	<input type="text" value="heart"/>
<input type="button" value="Search"/> <input type="button" value="Reset"/>	
Back to selected member	

- 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

SELECT AUTHORIZATION					
Date	Number	Type	Referred From	Referred To	Status
<u>5/18/2006</u>	10000489	Referral/Auth	JIMMY J LIN MD	JACQUELINE CHENG MD	Approved by system - autologic
<u>8/18/2005</u>	10000368A	Referral	JIMMY J LIN MD	KURT N BAUSBACK MD	Pended by system - autologic
<u>7/21/2005</u>	10000368	Referral	JIMMY J LIN MD	KURT N BAUSBACK MD	Approved by system - autologic
<u>3/21/2005</u>	10000337	Pre-Certification	JIMMY J LIN MD	ROBERT D DAIGLE MD	Pended by system - autologic
<u>11/21/2004</u>	10000306	Referral	JIMMY J LIN MD	PATRICK H BITTER SR MD	Approved by system - autologic
<u>9/23/2004</u>	10000283	Referral	JOE L MORGENSEN MD	PATRICK H BITTER SR MD	Cancel Authorization
<u>7/15/2004</u>	10000265	Referral	JIMMY J LIN MD	ARTHUR A BIEDERMANN MD	Approved by system - autologic
<u>9/5/2003</u>	10000180	Referral	JIMMY J LIN MD	KENT S CARSON MD	Cancel Authorization
<u>8/7/2003</u>	10000166	Referral	JIMMY J LIN MD	RUSSELL ANDREWS MD	Approved by Medical Director
<u>7/29/2003</u>	10000145	Referral	JOE L MORGENSEN MD	D THOMAS URBAN MD	Approved by system - autologic
<u>7/29/2003</u>	10000153	Referral	JOE L MORGENSEN MD	D THOMAS URBAN MD	Approved by system - autologic
<u>7/22/2003</u>	10000123	Pre-Certification	D THOMAS URBAN MD	DARYL K HOFFMAN MD	Denied - Modified
<u>5/13/2003</u>	10000105	Referral	JIMMY J LIN MD	ROGER M HAYASHI MD	Approved by system - autologic
<u>5/13/2003</u>	10000106	Referral	JIMMY J LIN MD	ROGER M HAYASHI MD	Cancel Authorization
<u>4/23/2003</u>	10000097	Referral	JIMMY J LIN MD	MARWAN BALAA MD	Approved by system - autologic

[Back to selected member](#) | [Search for another member](#)

- 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.

SELECTED AUTHORIZATION	
Member:	DICKENS, CHERYL 123 MAIN ST / SAN JOSE, CA 95122 / 4085551212
Plan / HMO ID:	HealthNet Commercial / 1114501356
Date of Birth:	12/6/1960
PCP:	JIMMY J LIN MD / REGION 1 / (408) 983-1012
Date / Number:	8/18/2005-10000368A
Expiration Date:	8/18/2006
Patient Requested?:	No
Category:	
Referred From:	JIMMY J LIN MD 2419 FOREST AVE / SAN JOSE, CA 95128 / (408) 983-1012
Referred To:	KURT N BAUSBACK MD Cardiology 15100 LOS GATOS BLVD #4 / LOS GATOS, CA 95032 / (408) 358-3939
Place of Service:	Office
Diagnosis:	(1) 786.5 - CHEST PAIN
Protocol:	CARDIOLOGY
Requested Service (s):	CHEST PAIN
Latest Note:	
Status:	Pended by system - autologic
Received Date:	8/18/2005
Decision Date:	
Type:	Referral
Active Case Management: CHF	
Back	

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.

Auth
SELECTED PROVIDER
Main Menu Short Cuts

User: MONDAVI, ROBERT Site: PCP DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Name	CONSTANTINO GALLO, MD.
Office/Facility	COSTANTINO GALLO MD

Region 1

Specialty	Plan type	Address	Phone
Cardiology	Commercial	173 N MORRISON AVE #D SAN JOSE, CA 95126	(408) 293-1992 Fax: (408) 293-0213
Cardiology	Commercial	18500 ST LOUISE DR, #201 MORGAN HILL, CA 95037	(408) 779-0113 Fax: (408) 776-5687
Cardiology	Commercial	700 W 6TH ST #K GILROY, CA 95020	(408) 848-2008 Fax: (408) 848-2064
Cardiology	Commercial	941 SUNSET DR HOLLISTER, CA 95023	(408) 637-1120
Cardiology	Senior	173 N MORRISON AVE #D SAN JOSE, CA 95126	(408) 293-1992 Fax: (408) 293-0213
Cardiology	Senior	18500 ST LOUISE DR, #201 MORGAN HILL, CA 95037	(408) 779-0113 Fax: (408) 776-5687
Cardiology	Senior	700 W 6TH ST #K GILROY, CA 95020	(408) 848-2008 Fax: (408) 848-2064
Cardiology	Senior	941 SUNSET DR HOLLISTER, CA 95023	(408) 637-1120

[[Search again](#)] [[Search again same provider](#)]

- 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

Auth
SELECT DIAGNOSIS
Main Menu Short Cuts

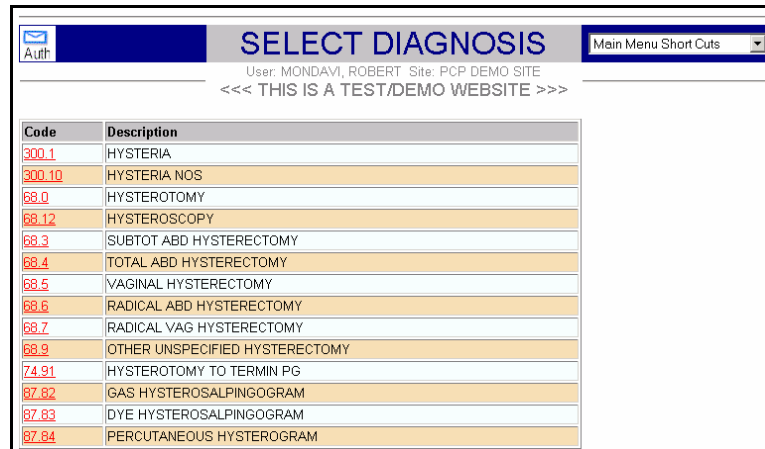
User: MONDAVI, ROBERT Site: PCP DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Diagnosis Code:

Description:

- *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*.

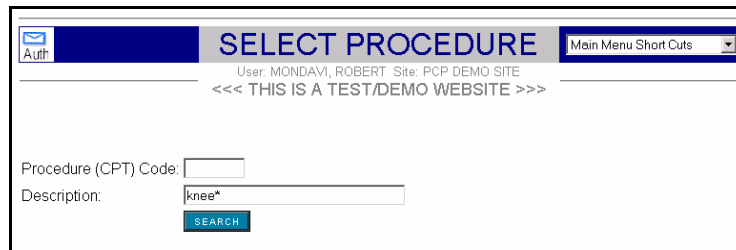
- **The Asterisk (*) can be used in place of part of a number field to find all occurrences that match.** For example, V68* will not only find codes equal to V68, but also codes beginning with V68, like V68.7.
- Cancer diagnoses are often listed under *neoplasm* or *mal neo* depending on their listing 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.



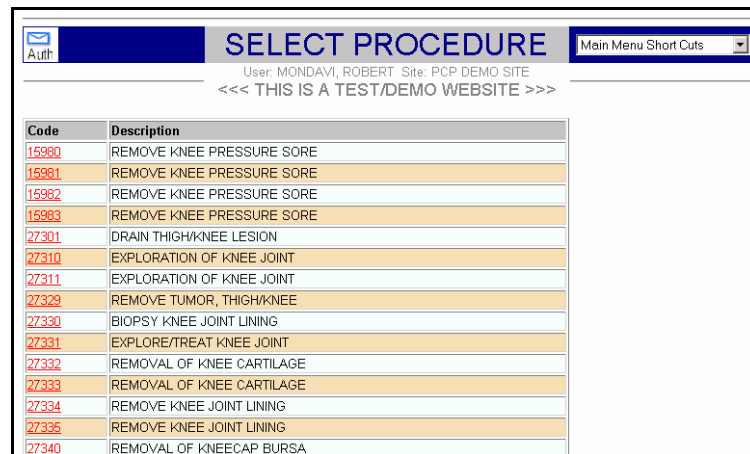
Code	Description
300.1	HYSTERIA
300.10	HYSTERIA NOS
68.0	HYSTEROTOMY
68.12	HYSTEROSCOPY
68.3	SUBTOT ABD HYSTERECTOMY
68.4	TOTAL ABD HYSTERECTOMY
68.5	VAGINAL HYSTERECTOMY
68.6	RADICAL ABD HYSTERECTOMY
68.7	RADICAL VAG HYSTERECTOMY
68.9	OTHER UNSPECIFIED HYSTERECTOMY
74.91	HYSTEROTOMY TO TERMIN PG
87.82	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
27323	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

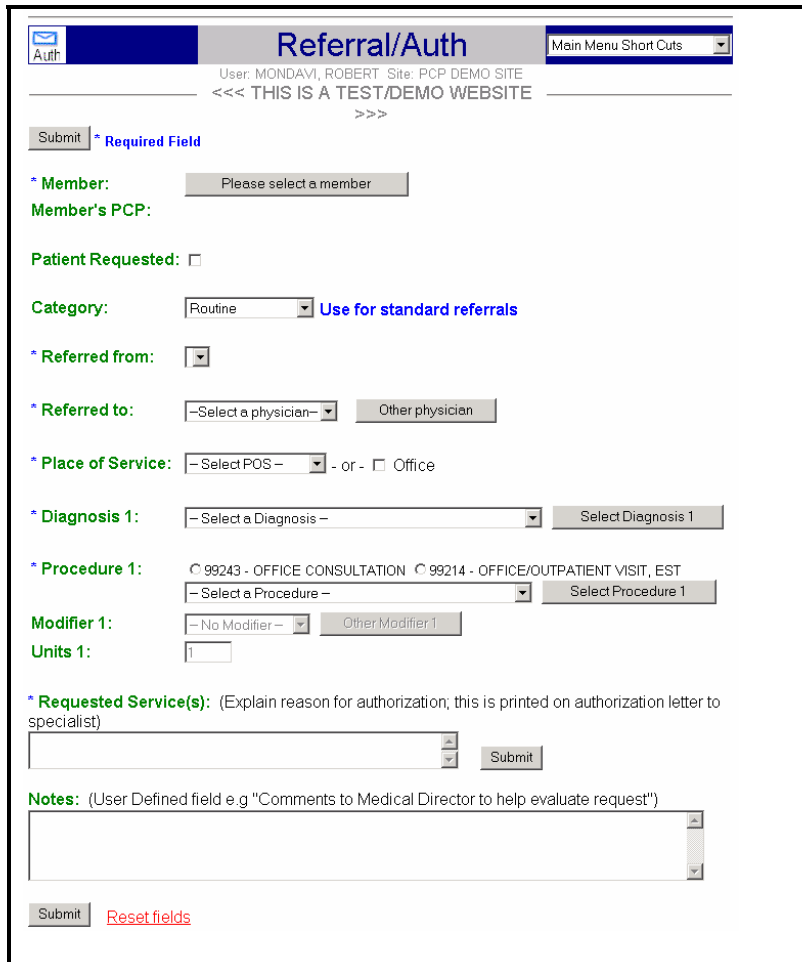
Access Express users who request referrals and authorizations will often be required to answer additional questions about their requests. These questions were developed to expedite referral and authorization requests by making sure requestors include the information required for an appropriate decision.

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.

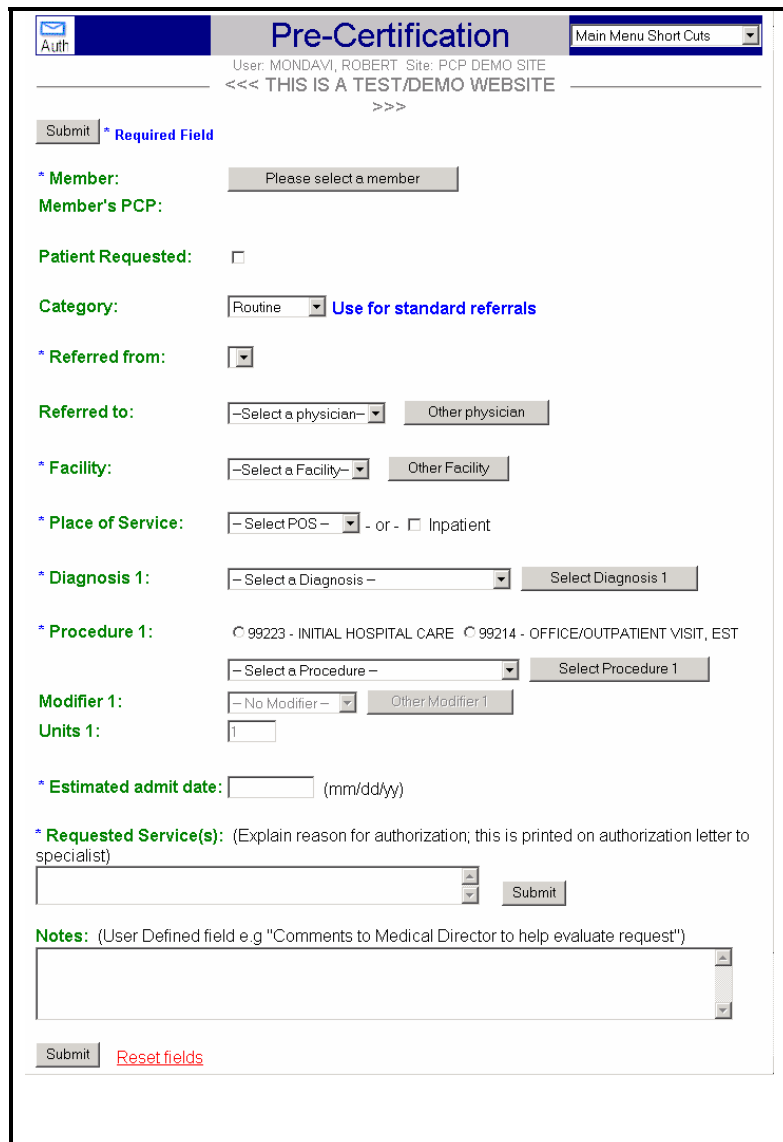
D. Referral Authorizations



- 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 click on the icon, they will be able to view/print any authorizations they have received.

E. Precertifications



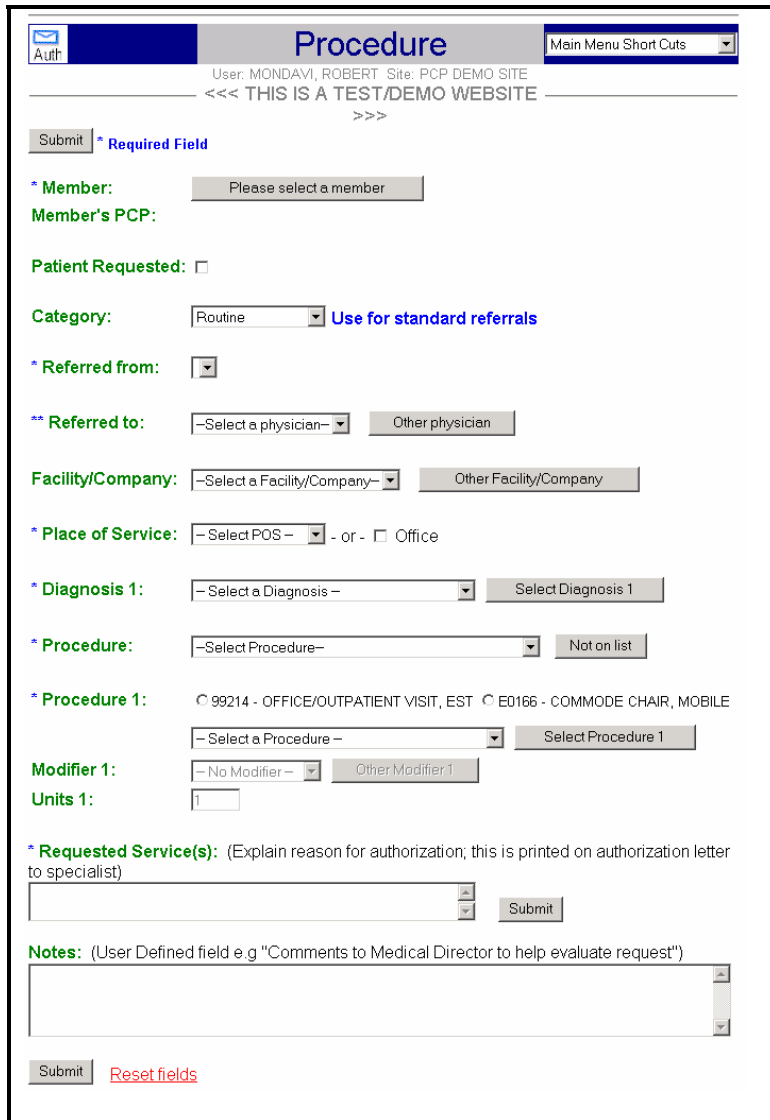
The screenshot shows a web form titled "Pre-Certification" with a user header "User: MONDAVI, ROBERT Site: PCP DEMO SITE" and a warning "THIS IS A TEST/DEMO WEBSITE". The form includes several required fields marked with an asterisk: Member (a dropdown menu), Member's PCP, Patient Requested (checkbox), Category (dropdown menu with "Use for standard referrals" link), Referred from (dropdown menu), Referred to (dropdown menu and "Other physician" button), Facility (dropdown menu and "Other Facility" button), Place of Service (dropdown menu and "Inpatient" checkbox), Diagnosis 1 (dropdown menu and "Select Diagnosis 1" button), Procedure 1 (dropdown menu and "Select Procedure 1" button), Modifier 1 (dropdown menu and "Other Modifier 1" button), Units 1 (text input), Estimated admit date (text input with "(mm/dd/yy)" placeholder), and Requested Service(s) (text area with "Submit" button). A "Notes" field is also present at the bottom. The form has "Submit" and "Reset fields" buttons at the bottom left.

- 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 procedure 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

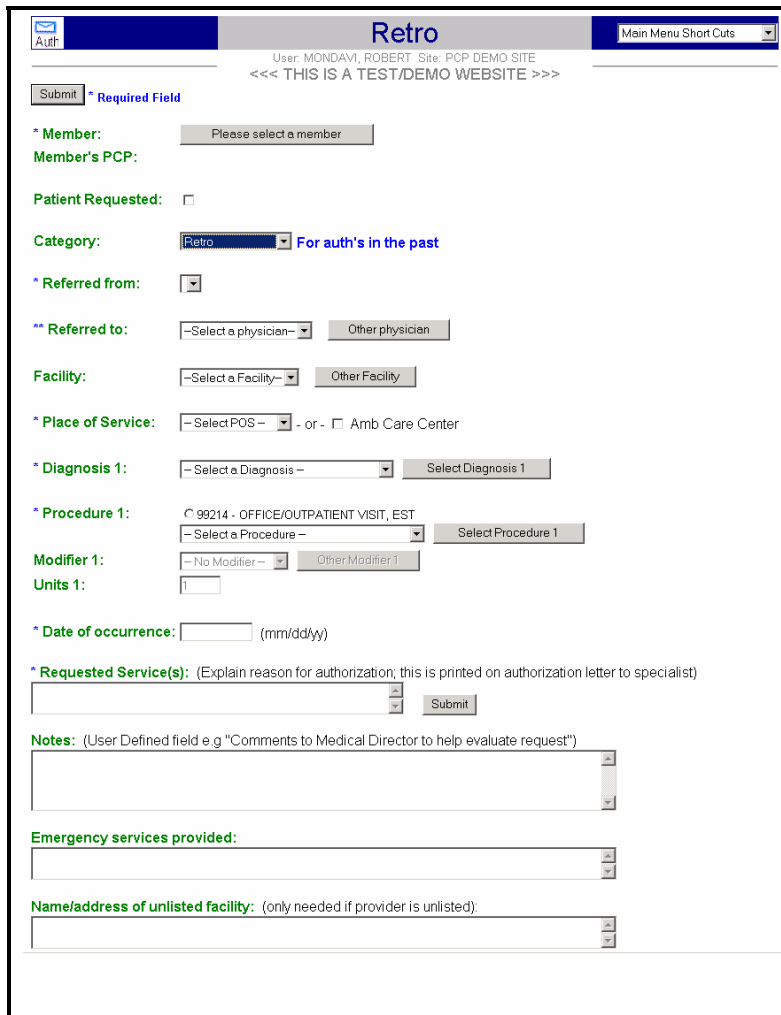


- Fill in *Referred From* and *To* spaces as described under *Referral* and in the Search Strategy in Sections 7 & 10B.
- Check the box provided if the Patient requested the Procedure.
- Select the Category—Urgent, Emergency, Routine, Appeal, Retro
- The *Facility* is the site where this procedure will 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

REVIEW PENDING REQUESTS

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

To quickly view all authorizations in a particular queue, click the corresponding button in the Queue column.

Queue	Name	# Authorizations
CM1	Case Manager	59
A01	Auth Rep	9
MD1	MEDICAL DIRECTOR	9
N01	NURSE	7
G01	General Queue	6
C01	Care Coordinator	2
A02	Case Coordinator	1
DME	DME	1
MD2	Appeals	1
All	All Queues	95

To view filtered results, select your search parameters from the drop-down lists below.

Class: --All Classes--
 IPA: --All Classes--
 Emergency/Retro
 Pre Certification
 Procedure
 Referral/Auth

[Search Eligibility](#) | [Member Request](#)
[Ref/Auto](#) | [Procedure](#) | [Pre Certification](#) | [Emergency/Retro](#)
[Main Menu](#) | [Signoff](#) | [Feedback](#) | [Message/Inbox](#) | [Help](#)

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).

REVIEW PENDING REQUESTS

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Category	NRD	Class	Received Date	Auth Date	Auth Number	Member	Plan Type	Referred To	Facility	Diagnosis 1	Worker
Routine	3/21/2005	Referral/Auth	3/21/2005	3/21/2005	10000335	ARMSTRONG, LOUIS	Commercial	PATRICK H BITTER SR MD		ABDOMINAL PAIN	
Routine	7/11/2005	Referral/Auth	7/11/2005	7/11/2005	10000362	DEBUSSY, CHARLES	Commercial	PATRICK H BITTER SR MD		OTHER MYCOSES	
Routine	8/11/2005	Referral/Auth	8/11/2005	8/11/2005	10000372	ARMSTRONG, LOUIS	Commercial	PATRICK H BITTER SR MD		ASTHMA	
Routine	10/11/2005	Referral/Auth	10/11/2005	10/11/2005	10000383	BONAPARTE, NAPOLEAN	Commercial	A, JUDITH PICKERSGILL MD		ABN FIND-STOOL CONTENTS	
Routine	11/28/2005	Referral	11/28/2005	11/28/2005	10000402	ARMSTRONG, LOUIS	Commercial	ROBERT L DALE MD		DIABETES W CIRCULAT DIS	
Routine	1/22/2006	Procedure	12/8/2005	12/8/2005	10000408	ZANE, JANE	Commercial	KURT N BAUSBACK MD		ANGINA PECTORIS	
Routine	3/25/2006	Procedure	2/8/2006	2/8/2006	10000418	KENOBI, OBI-WAN	Commercial	KURT N BAUSBACK MD		ANGINA PECTORIS	BEBE

<< First < Prev Next > Last >> (Page: 1 of 1. Total Records: 7)

[Search again]

- 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.

Input Date	User	Comment
5/26/2006 1:20:34 PM	DHIGGASO	ADHOC LETTER CREATED (Delay / Pre-service Extension (Commercial))
5/26/2006 1:21:03 PM	DHIGGASO	Set to review in 10 days
6/6/2006 11:24:19 AM	TSCHULZE	ADHOC LETTER CREATED (Notice of Medicare Non-Coverage (NOMNC)(Senior))

To add new note, put in note and click 'Add New Note'.

Buttons: Add New Note, Return

[View Change History](#)

Status	Message	Date	User	Program
T	ADD DIAGNOSIS 1: 413	2/8/2006 4:43:42 PM	PCPSITE	AUTHSUB.ASP
T	PEND	2/8/2006 4:43:43 PM	PCPSITE	AUTOAUTH.ASP
T	INITIAL QUEUE: N01	2/8/2006 4:43:43 PM	PCPSITE	AUTOAUTH.ASP

Navigation: << First, < Prev, Next >, Last >> (Page: 1 of 1, Total Records: 3)

Button: Return

14. Send & Receive Email to Referring or Receiving Physicians

- An Email function is available on the *Review Pending* screen to facilitate sending pending 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 screenshot shows a web form titled "SUPPLEMENTAL AUTH INFORMATION". At the top right, there is a "Main Menu Short Cuts" dropdown menu. Below the title, it displays "User: HOPPE, BEBE Site: INTERNAL DEMO SITE" and " <<< THIS IS A TEST/DEMO WEBSITE >>> ". The form contains the following fields:

- Auth Number:** A text input field containing "0000372".
- Admit Type:** A dropdown menu with "No Value" selected.
- Information Source:** A text input field.
- Intensity of Service / Severity of Illness:** A text input field.
- User Defined Field:** A large text area with a scroll bar.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.
- User Defined Field:** A text input field.

At the bottom of the form are "Submit" and "Cancel" buttons.

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

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.

The ID number for this Attachment is:	67
Your batch description:	Mary Poppins caught flying
Auth Key:	2005071110000361
FileName:	mary_poppins_pdf.pdf
File Extension:	pdf
Verified File Size in bytes:	88475

[Back](#)

- 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.

Action	InputDateTime	File Name	Description
<input checked="" type="checkbox"/>	7/11/2006 1:49:00 PM	<u>mary_poppins_pdf.pdf</u>	
<input checked="" type="checkbox"/>	7/11/2006 4:22:00 PM	<u>mary_poppins_pdf.pdf</u>	Mary Poppins caught flying

[Back](#) [Add Attachment](#)

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.

CONCURRENT REVIEW											
User: HOPPE, BEBE Site: INTERNAL DEMO SITE <<< THIS IS A TEST/DEMO WEBSITE >>>											
Category	NRD	Auth #	Est Admit	Admit	Member	DOB	Plan	Plan ID	PCP	Facility	Diagnosis 1
Routine	4/23/2003	10000097A	4/23/2003	4/23/2003	DICKENS, CHERYL	12/6/1960	NETCOM	1114501356	JIMMY J LIN MD	GOOD SAMARITAN HOS INPATIENT	REG ENTERITIS, SM INTEST
Retro	12/9/2003	10000219	12/11/2003	12/1/2003	HITCHCOCK, ALFRED	3/13/1939	NETCOM	1140193856	NAYLOR FITZHUGH JR MD	EL CAMINO HOSPITAL INPATIENT	CONGESTIVE HEART FAILURE
Routine	9/29/2004	10000285	9/30/2004	9/29/2004	KENOBI, OB'WAN	4/3/1950	NETCOM	118222666	EMIRO BURBANO MD	EL CAMINO HOSPITAL INPATIENT	CHEST PAIN
	12/20/2004	10000311	12/20/2004	1/2/2006	SOPRANO, TINA	2/23/1977	AETCOM	853306853	ALBERT PANGLOSS MD	GOOD SAMARITAN HOS INPATIENT	AC ALCOHOL INTOXICATION

<< First < Prev Next > Last >> (Page: 1 of 1. Total Records: 4)

[Print Entire List](#)
 (List only includes precerts ready to be reviewed based on NRD)
 (List shows only approved)
 (List shows only admits)
 (List shows only inpatient facilities)
 (List does not show SNF)
[Search again](#)

- 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.)

AUTHORIZATION NOTES				
User: HOPPE, BEBE Site: INTERNAL DEMO SITE <<< THIS IS A TEST/DEMO WEBSITE >>>				
Click to display authorization summary for screen prints.				
Input Date	User	Comment	LOC	Effective Date
4/23/2003 12:42:56 PM	MONTANEZ	SW JOANNE/BALAA 408-402-9990		
4/23/2003 12:43:17 PM	MONTANEZ	DIRECT ADMIT BY GI TEAM, DR. BALAA ADN HOSPITALIST DR. YIEH FOR CROHN'S DS MANAGEMENT, NOW WITH ABDOMINAL PAIN, INC. TENDERNESS IN ABD. DIARRHEA BLDY,WBC=13.9, ON NPO, PPN, IVF, BLD CULTURE X2, ON IV ABX.	MED	4/23/2003

Level of Care: -- Select a Level of Care --

Effective Date: -- Select a Level of Care --

To add: A

- BURN U - Burn Unit
- CCU - Critical Care Unit or Cardiac Care Unit
- CUST - Custodial
- DETOX - Detox
- HOS - Hospice
- ICU - Intensive Care Unit
- MED - Medical
- MEDS - Medical/Surgical (use when combined floor in hospital)
- MH - Mental Health / Psych
- NICU I - Neonatal Intensive Care, Level 1

[Referral/Auth](#) | [Procedure](#) | [Pre Certification](#) | [Emergency/Retro](#)
[Main Menu](#) | [Signoff](#) | [Feedback](#) | [Message Inbox](#) | [Help](#)

19. Review Denied Authorizations

CDU DENIAL REVIEW										
Category	Auth Date	Decision Date	Auth Number	Member	Plan Type	Referred To	Last Note	Denial Reason Code	Diagnosis 1	Worker
Emergency	5/3/2006	9/19/2006	10000473	SOPRANO, TINA	Commercial	JOANNE M CHAO MD	CHAR 1-20 of LatestNote	M14	BACK DISORDER NEC	
Emergency	5/22/2006	10/4/2006	10000491	APPLESEED, JANE	Commercial	DWAIN L COGGINS MD	CHAR 1-20 of LatestNote	M24	AMI ANTEROLATERAL WALL	
Routine	4/27/2006	8/31/2006	10000468	KIPLING, RUDYARD	Commercial	ARTHUR A BIEDERMANN MD	CHAR 1-20 of LatestNote	M24	PULMONARY VALVE DISORDER	
Routine	8/14/2006	9/7/2006	10000540	APPLESEED, JANE	Commercial	KHANH K NGUYEN MD	CHAR 1-20 of LatestNote	M24	ROUTINE MEDICAL EXAM	

<< First < Prev Next >> Last >> (Page: 1 of 1. Total Records: 4)

[Print Entire List](#)

- 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.

Main Menu Short Cuts

REVIEW DENIED AUTHORIZATION

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
<<< THIS IS A TEST/DEMO WEBSITE >>>

<< Prev Next >> Submit [Back to Auth WorkList](#)

Auth #: 10000473 (Make Copy)	Entered By: Tim Schulte	Phone: (650) 358-5800	Received: 5/2/2006	Submitted: 5/3/2006	Exp: 1/17/2007
Class: Referral/Auth	REVIEW COMPLETED	Category: Emergency	Patient Requested: <input type="checkbox"/>		

Member: SOPRANO, TINA (DOB: 02/23/1977 Sex: F)	Health Plan: AETNA US HEALTHCARE	Plan Code: 04306603
IPA: Region 1	Eff Date: 01/01/2001	Term Date:
Other Cov: COVERED UNDER SPOUSE ALSO	PCP: ALBERT PANGLOSS MD	
Referring Physician: ALBERT PANGLOSS MD (Family Practice)	Phone: (408) 630-7000	Prov Status: PAR
Referred To Physician: JOANNE M CHAO MD (Orthopedic Surgery)	Phone: (408) 998-2688	Prov Status: PAR
Place of Service: Office	Diagnosis 1: 724 - BACK DISORDER NEC	
Add New Diagnosis:	Procedure 1: 99213 - OFFICE/OUTPATIENT VISIT, EST	Modifier: --No Modifier-- Units: 1
Reason for Request: TEST WITH CARE TIPS	Latest Note: COPY OF AUTHORIZATION: 10000321	

Change Reason Code: M14

Denial Reason:

We have received the request for service from the above provider/physician. This notice is to inform you the service is being denied. This determination was made based upon our review of your health condition in relation to AETNA US HEALTHCARE medical necessity criteria or guidelines and in accordance with the terms and conditions of your evidence of coverage (EOC) or your Federal Brochure.

Based on the information provided by the requesting provider/physician, you do not meet the established medical necessity criteria or guidelines for the above noted service(s) at this time.

CDU Review Complete:

Status to assign: Denied Medical Necessity

Submit Notes Supplemental Data [View Letter History](#) [View Change History](#)

<< Prev Next >> Upload Attachments [Back to Work List](#)

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*.

[Main Menu Short Cuts](#)

REVIEW PENDING
User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

<< Prev
Next >>
Submit
[Back to Auth Work List](#)

Auth #:	10000418 [Make Copy]	Entered By:	Robert Mondavi	Phone: 444-444-4444	Received:	2/8/2006	Submitted:	2/6/2006	Exp:	2/27/2007
Class:	Procedure	Next Review Date:	3/25/2006		Category:	Routine		Patient Requested:	<input type="checkbox"/>	

Member:	KENOBI, OBLWAN <small>(DOB: 04/03/1950 Sex: M)</small>	Health Plan:	HEALTH NET	Plan Code:	HOA
IPA:	Region 1	Eff Date:	02/01/2001	Term Date:	
PCP:	EMIRO BURBANO MD				
Referring Physician:	EMIRO BURBANO MD (Internal Medicine)	Phone:	(408) 258-5864	Prov Status:	NON
Referred To Physician:	KURT N BAUSBACK MD (cardiology) <input checked="" type="checkbox"/>	Phone:	(408) 358-3939	Prov Status:	PAR
Facility:		Phone:		Prov Status:	

Place of Service:

Diagnosis 1: 413 - ANGINA PECTORIS

Add New Diagnosis:

Specific Procedure:

Add New Procedure:

Reason for Request: Latest Note:

Status to assign:

Assign to Queue:

Submit
Notes
Supplemental Data
[\[View Letter History \]](#)
[\[View Change History \]](#)

<< Prev
Next >>
Upload Attachments
[\[Back to Work List \]](#)

[Search Eligibility](#) | [Member Request](#)
[Referral/Auth](#) | [Procedure](#) | [Pre Certification](#) | [Emergent/Retro](#)
[Main Menu](#) | [Signoff](#) | [Feedback](#) | [Message Inbox](#) | [Help](#)

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

[Main Menu Short Cuts](#)

MONITOR NEXT REVIEW DATE
User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

To quickly view all authorizations in a particular queue, click the corresponding button in the Queue column.

Queue	Name	# Authorizations
CM1	Case Manager	56
MD1	MEDICAL DIRECTOR	15
N01	NURSE	11
A01	Auth Rep	9
G01	General Queue	7
DME	DME	3
C01	Care Coordinator	2
A02	Case Coordinator	2
MD2	Appeals	2
N02	Region 1	1
All	All Queues	108

To view filtered results, select your search parameters from the drop-down lists below.

Class:

IPA:

NRD:

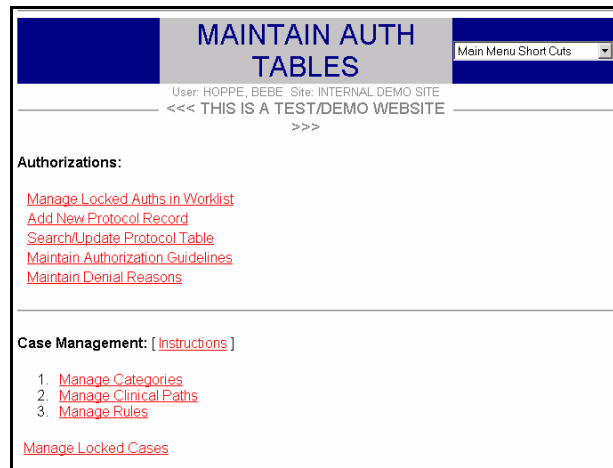
[Main Menu Short Cuts](#)

MONITOR NEXT REVIEW DATE
User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Category	NRD	Class	Auth Date	Auth Number	Exp Date	Member	Plan Type	Referred To	Facility	Diagnosis 1	Worker
	4/22/2003	Referral/Auth	4/22/2003	10000091	8/20/2003	CEASER, JULIE	Commercial			REG ENTERITIS, SM INTEST	
	3/21/2005	Referral	3/21/2005	10000335	7/19/2005	ARMSTRONG, LOUIS	Commercial	PATRICK H BITTER SR MD		ABDOMINAL PAIN	
	7/11/2005	Referral	7/11/2005	10000362	11/8/2005	DEBUSSY, CHARLES	Commercial	PATRICK H BITTER SR MD		OTHER MYCOSES	
	10/11/2005	Referral	10/11/2005	10000393	2/6/2006	BONAPARTE, NAPOLEAN	Commercial	A JUDITH PICKERSGILL MD		ABN FIND-STOOL CONTENTS	
	11/28/2005	Referral	11/28/2005	10000402	3/28/2006	ARMSTRONG, LOUIS	Commercial	ROBERT L DALE MD		DIABETES W CIRCULAT DIS	
	1/22/2006	Procedure	12/6/2005	10000408	4/7/2006	ZANE, JANE	Commercial	KURT N BAUSBACK MD		ANGINA PECTORIS	
	3/25/2006	Procedure	2/8/2006	10000418	6/8/2006	KENOBI, OBLWAN	Commercial	KURT N BAUSBACK MD		ANGINA PECTORIS	
Emergency	3/21/2005	Referral/Auth	3/21/2005	10000336	8/31/2006	ARMSTRONG, LOUIS	Commercial	PATRICK H BITTER SR MD		ABDOMINAL PAIN	
Routine	6/8/2006	Procedure	3/24/2006	10000461	9/23/2006	EYRE, JANE	Commercial	ROSE GARDEN DIALYSIS CENTER	ROSE GARDEN DIALYSIS CENTER	AFTERCARE, DIALYSIS NEC	
Routine	8/3/2006	Referral/Auth	6/19/2006	10000500	10/17/2006	APPLESEED, JANE	Commercial	PATRICK H BITTER SR MD		ACNE NEC	
Routine	8/5/2006	Referral/Auth	6/21/2006	10000503	10/19/2006	BAGGINS, FRAN	Commercial	VALLEY RADIOLOGY		ALLERGIC RHINITIS NEC	

<< First < Prev Next > Last >> (Page: 1 of 1. Total Records: 11)

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

Class	IPA Code	Carrier	Priority	Description	Guideline	Diagnosis	Procedure
REFER	01	ALL	4720	CARDIOLOGY			
REFER	04	ALL	4740	PREGNANCY		V22.V23.9.V27.0.V27.9.650.669.9.763...	
REFER	01	ALL	4760	PREGNANCY		V22.V23.9.V27.0.V27.9.650.669.9.763...	
REFER	01	ALL	4780	PREGNANCY (DUPLICATE REQUEST)		V22.V23.9.V27.V27.9.650.669.9.763.7...	
REFER	04	ALL	4800	PREGNANCY (DUPLICATE REQUEST)		V22.V23.9.V27.V27.9.650.669.9.763.7...	
REFER	04	ALL	4820	OB/GYN REFERRALS		001.627.9.629.999.9	
REFER	01	ALL	4840	OB/GYN REFERRALS		001.627.9.629.999.9	
REFER	01	ALL	4860	AUDIOLOGY REFERRAL		365.365.9,	
REFER	01	ALL	4900	GLAUCOMA CARE		365.365.9,	
REFER	04	ALL	4920	GLAUCOMA CARE		365.365.9,	
REFER	ALL	ALL	99999	DEFAULT			

<< First < Prev Next > Last >> (Page: 1 of 41. Total Records: 611)
[\[New Search \]](#) [\[Modify Search \]](#)

- 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

ADD PROTOCOL
 User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Class: Emergen/Retro
 Region: - All IPAs -
 Carrier: - All Carriers -
 Protocol Priority: 50
 Description: Referral for Backache

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

ADD PROTOCOL RECORD
 User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

ID:

Class: Referral/Auth

Priority: 50

Description: REFERRAL FOR BACKACHE

Effective Date: 10/30/2006

Termination Date: 12/31/9999

IPAs:

Plan Type: - All PlanTypes -

Carrier: - All Carriers -

RFRPV must be a PCP?

Patient Requested?

Category: Routine

Place of Service: ALL

Primary Diagnosis: 724.5

Primary Procedures:

Authorized Units: 4

Check For Duplicates?

Duplicate on Procedures only?

Duplicate Days:

Status to Assign: Approved by system - autologic

Expiration Days: 120

Days Until First Review: 0

Pend Queue: General Queue

Authorization Guidelines: referral to orthopedist for backache

MEMBER

Minimum Age: 19

Maximum Age: 105

Gender: BOTH

Member Alert Code: - None -

Member Alert Code: - None -

Internal Plan Code:

External Plan Code:

REFERRED FROM

RFRPV Specialty 1: - None -

RFRPV Specialty 2: - None -

RFRPV Specialty 3: - None -

RFRPV Specialty 4: - None -

RFRPV Specialty 5: - None -

RFRPV Par Status: PAR - Par and preferred

GoldStar Required?

REFERRED TO

RTRPV Specialty 1: Orthopedic Surgery

RTRPV Specialty 2: Neurological Surgery

RTRPV Specialty 3: Neurology

RTRPV Specialty 4: - None -

RTRPV Specialty 5: - None -

RTRPV Par Status: - None -

GoldStar Required?

GOLD CARD PROVIDERS

Referred From 1:

Referred From 2:

Referred From 3:

Referred From 4:

Referred From 5:

Referred To 1:

Referred To 2:

Referred To 3:

Referred To 4:

Referred To 5:

- 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 osteogenesis 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.

Edit Auth Guidelines Main Menu Short Cuts

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Use this screen to maintain the question tree for authorization guidelines. You can create new authorization guidelines or edit existing guidelines. The entries below appear as selections for the "Authorization Guidelines" field on the "Add New Protocol" screen.

Select the 'Create New Authorization Guideline' button to build a new guideline.

*c=CurrentVersion, **Locked**=Responses already recorded, **Mc**=Make this version Current

Action	Ver	Description
Locked View	1	Acupuncture
Edit Del View	2c	Acupuncture
Edit Del View	1c	Aetna Admission to Los Gatos Community Hosp
Edit Del View	1c	Aetna Corn Foot Orthotics
Locked View	1	allergist referrals
Locked View	2c	allergist referrals
Edit Del View	1c	anorexia care
Edit Del View	1c	asymptomatic or cosmetic
Del View	1	Autism guideline
Edit Del View	2c	Autism guideline
Locked View	1c	Back Pain
Locked View	1c	Bariatric surgery

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

Edit Auth Guidelines Main Menu Short Cuts

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Enter a descriptive title that describes this authorization guideline. It will be displayed on a selection list sorted alphabetically. After saving, add questions to this guideline by clicking on 'Edit' which will be displayed on the next screen.
 You may also create a newer version of an existing Guideline. In this case, you can alter the questions but still keep the same title. After editing, you can activate this new version by making it 'current'.

New Authorization Guideline Title

- OR -

Create another version of an existing Guideline

- 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).

Edit Auth Guidelines Main Menu Short Cuts

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Press the 'Add Question' button to add a new question. If there is more than one question listed, use the arrow buttons to adjust the order.

Back Pain2						
Order	Action	Question	Correct Answer	Default Answer	ErrorMessage	Queue Code
↓	ⓧ	Has the patient experienced this pain for longer than 2 weeks?	Yes	No	Primary Care providers should try and treat acute back pain with physical therapy before sending to a Orthopedic Specialist.	C01
	ⓧ	Was the patient condition caused by an accident or injury?	No	Yes	Possible third party liability or even workers compensation must be investigated before approval can be given.	C01

- 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*.

Edit Auth Guidelines Main Menu Short Cuts

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
 <<< THIS IS A TEST/DEMO WEBSITE >>>

Add or edit questions associated with this Authorization Guideline. They will be displayed before an authorization matching a certain criteria is submitted to the system.

Back Pain

Question Text: Was the patient condition caused by an accident or injury?

Correct Answer: No

Default Answer: Yes

Error Message Text: Possible third party liability or even workers compensation must be investigated before approval can be given.

Queue Code: Care Coordinator

- 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

Manage Denial Reasons
Main Menu Short Cuts ▾

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
<<< THIS IS A TEST/DEMO WEBSITE >>>

PLNTP Group Filter:

Show Prefix and Suffix Text

Action	PLNTP Group	Code	Denial Reason <small>NOTE: Text in brackets [...] denotes dynamic text that must be valued during the denial process.</small>
LOCKED	Commercial	B01	We have received the request for service from the above provider/physician. This notice is to inform you the service is being denied. This determination was made based upon our review of your health condition in relation to [HealthPlan] conditions of coverage and in accordance with the terms and conditions of your evidence of coverage (EOC) or your Federal Brochure. The above noted service(s) is/are not a benefit covered under your health plan. As stated in your EOC or your Federal Brochure exclusions and limitations section, [Requested Service] is/are excluded from coverage. Please refer to your EOC or your Federal Brochure for additional benefit coverage information.
LOCKED	Commercial	B03	We have received the request for service from the above provider/physician. This notice is to inform you the service is being denied. This determination was made based upon our review of your health condition in relation to [HealthPlan] conditions of coverage and in accordance with the terms and conditions of your evidence of coverage (EOC) or your Federal Brochure. The above noted services are not a benefit covered under your health plan. As stated in your EOC or your Federal Brochure exclusions and limitations section, vaccines required for employment due to exposure risk of employment, or for travel are not a covered benefit under your health plan benefit. Please refer to your EOC/brochure for additional information regarding your health plan's immunization coverage. For additional information and your future health care needs, please contact your primary care physician.

- 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.

Manage Denial Reasons
Main Menu Short Cuts ▾

User: HOPPE, BEBE Site: INTERNAL DEMO SITE
<<< THIS IS A TEST/DEMO WEBSITE >>>

PLNTP Group	Denial Code	Denial Reason
Commercial	B04	Specifically, service(s) after the effective date of eligibility with your Health Plan ends is/are not covered under your Health Plan. Your evidence of coverage/brochure, states that services rendered after the member's effective date of disenrollment are not covered. Please contact your Health Plan's customer service/member service department for further assistance.

Suppress 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.

Quality Measure dates and values have been extracted from claims, prescriptions, and encounters received as of **01/15/2006**. Please add in missing data from **2005** if care was given but not reflected below.

Please select a member to edit.

Member	DOB	Age	PCP	Measure
ARMSTRONG, LOUIS	5/27/1953	53	MICHAEL E KAN MD	HBA1C, LDLC
BEETHOVEN, MARY	4/9/1984	22	WILLIAM G BROAD MD	CHLAMYDIA, Pap-Test
BRANDYBUCK, MERRIWEATHER	12/9/1977	29	HIEN V NGUYEN MD	PAP TEST
CEASER, JULIE	9/4/1964	42	ANN TO MD	Mammogram, PAP TEST
FERGUSON, MAYNARD	2/22/1942	64	ROBERT NORMAN MD	ASTHMA RX
KENDRI, ORLWAN	4/3/1950	56	EMIRO BURBANO MD	LDLC
KIPLING, RUDYARD	10/10/1946	60	DIANA F FINK MD	HBA1C, LDLC
SCROOGE, EBENEZER	3/8/1948	58	JAMES PELLEGRIN MD	LDLC
VAN GOGH, LORIE	6/15/1948	58	ALBERT PANGLOSS MD	Mammogram, PAP TEST

Filter section (highlighted in blue dots):

- Measure Name: Pap Test
- Measure Status: Measures Missing Data
- Member Last Name: [Empty]
- Provider Name: ANN TO MD

Member	DOB	Age	PCP	Measure
CEASER, JULIE	9/4/1964	42	AN N TO MD	Mammogram, 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.

Mammogram - Breast Cancer Screening

Please get a mammogram on this person or record the date of the most recent mammogram in the box below. The only official reason for not obtaining a mammogram is a history of bilateral mastectomy. This exclusion reason needs to be recorded.

Mammogram	Excluded: 76092 REMOVAL OF BREAST with mod code 09950 (Bilateral)	Exclusion Note:	RESET
-----------	---	-----------------	-------

Pap Test - Cervical Cancer Screening

Please record date of most recent Pap test. Enter date of known Pap test even if you were not the one that obtained this Pap. Previous hysterectomy is an obvious valid reason for not doing this test which needs to be documented as a selected exclusion. Should be done at least every 3 years.

Pap Test Date(s): **EXCLUDE**

- **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.

**Quality Measure
Collection Exclusion**

Member Demographics	
Member Name:	CEASER, JULIE
DOB:	9/4/1964
HMO ID:	1543986917

In rare situations a member can be excluded from measure collection. Please select the proper exclusion for this member.

Measure / Exclusion	
Cervical Cancer Screening: Pap Test	
- Select Exclusion - - Select Exclusion - 58150 Total Hysterectomy *Temporarily turn off notification	<input type="checkbox"/>

**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.

SELECTED MEMBER	
User: MONDAVI, ROBERT Site: PCP DEMO SITE <<< THIS IS A TEST/DEMO WEBSITE >>>	
View authorizations Search authorizations Submit request to eligibility dept View eligibility history View PCP capitation payments View claims	
Name	CEASER, JULIE
DOB	9/4/1964
Sex	F
HMO ID	1543986917
Medical ID number	
Effective Date	11/1/2000
Termination Date	
PCP	AN N TO MD
PCP Eff Date	12/1/1996
Address / Phone	123 MAIN ST SAN JOSE, CA 95132 4085551212
Plan	04306603
Plan Copay / Coinsurance	PCP Office Visits - \$10.00 Specialist Office Visits - \$10.00 Urgent Office Visits - \$10.00
Health Plan Name	AETNA LIS HEALTH CARE
IPA	Region 1
Quality Measure Data	Mammogram, PAP TEST
Search for another member Send Email about this member	

- 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.

Quality Measure Reminder

Member Demographics	
Member Name:	CEASER, JULIE
DOB:	9/4/1964
HMO ID:	1543986917

Quality Measures require your attention!

PAP TEST

[REVIEW/UPDATE](#) [IGNORE](#)


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

SELECTED AUTHORIZATION	
User: HOPPE, BEBE Site: INTERNAL DEMO SITE <<< THIS IS A TEST/DEMO WEBSITE >>>	
Back Printer version	
Member:	SILVER, LONG JANE 123 MAIN ST / SAN JOSE, CA 95135 / 4085551212
Plan / HMO ID:	HealthNet Commercial / 1177301205
Date of Birth:	1/22/1948
PCP:	GEORGE P KENT MD / REGION 1
Date / Number:	12/20/2004-10000312
Expiration Date:	4/19/2005
Patient Requested?:	No
Category:	
Referred From:	GEORGE P KENT MD 25 N. 14TH STREET, SUITE 1020 / SAN JOSE, CA 95112 / (408) 977-4677
Referred To:	ROBERT D DAIGLE MD Chemical Dependency 1425 Fruitdale Avenue / SAN JOSE, CA 95138 / (408) 568-7004
Facility:	GOOD SAMARITAN HOS INPATIENT Hospital, Inpatient 2425 SAMARITAN DRIVE / SAN JOSE, CA 95124 / (408) 559-2011
Place of Service:	Office
Estimated Admit Date:	12/20/2004
Admit Date:	
Discharge Date:	
Diagnosis:	1) 303.01 - AC ALCOHOL INTOX-CONTIN 
Protocol:	DEFAULT
Requested Service(s):	RUM DRINKER- NEEDS ACUTE DETOXIFICATION. KEEPS CALLING DARBY MCGUIRE FOR RUM AND SEES HIM IN HALLUCINATIONS
Latest Note:	
Status:	Approved by Medical Director
Received Date:	12/20/2004
Decision Date:	12/20/2004 2:50:31 PM
Type:	Pre-Certification

Click to find the Milliman Care Guidelines listed below.

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



Access Express Care Tips

Today's date: 7/10/2006

[Close](#)

Please review the following Care Tips from HealthNet.

Care Tip Context	MbrNo	Health Plan	ReferredTo Specialty
SILVER, LONG JANE (Female: 58)	00003664001	HealthNet Commercial	Chemical Dependency
Diagnosis: 303.01 AC ALCOHOL INTOX-CONTIN			

Care Tip For: Alcohol Abuse, Health Net HMO

HEALTHNET COMMERCIAL Diagnosis 303.00;305.02 v2 12/14/2005 4:25:32 PM

Acute detoxification from alcohol is a medical group financial responsibility. However, once the acute in-patient detoxification has been rendered, all further care must be provided by the health plan mental health providers, not the medical group. If the patient was or is hospitalized for acute detox, once detoxification has occurred, the patient must be discharged from the Access Express system. Please contact the special Plan mental health provider network at (888)426-0030 for Managed Health Network for substance abuse care once the acute detoxification episode has resolved.

Milliman's Care Guidelines are also available for your review.

Eliq
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 - 10th Edition


Search Results for alcohol:

Description	Codes	Keywords	GLOS
Acute Delirium, Not Associated with Alcohol or Drugs	(Search phrase found in ORG title)	N/A	3
Alcohol Dependence	(Search phrase found in ORG title)	N/A	3
Alcohol Withdrawal	(Search phrase found in ORG title)	N/A	3
Alcohol Withdrawal and Dependence	N/A	Annotation/Annotated Bibliography	N/A
Acute Delirium, Not Associated with Alcohol or Drugs	ORG: MH-110 HSIM: 15-43-95-0a ICD-9 Diagnosis: 293.0, 293.1, 780.09; DSM-IV: 293.0, 780.09;	Cognitive Disorder; Dementia; Disturbance in Consciousness; Hallucinations; Impaired Mental Status	3
Alcohol Dependence	ORG: PS-60 HSIM: 15-63-31-0b ICD-9 Diagnosis: 303.00, 303.01, 303.02, 303.90, 303.91, 303.92; ICD-9 Procedure: 94.61, 94.62, 94.63, 94.67, 94.68, 94.69; DSM-IV: 303.00, 303.90;	Addiction; Alcohol Hallucinations; Alcohol Intoxication; Alcohol Withdrawal; Delirium tremens	3
Alcohol Withdrawal	ORG: PS-410 HSIM: 15-63-41-0b ICD-9 Diagnosis: 291.0, 291.3, 291.5, 291.81, 303.00, 303.01, 303.02, 303.03, 303.90, 303.91, 303.92, 303.93, 305.00, 305.01, 305.02, 305.03; ICD-9 Procedure: 94.62, 94.68; DSM-IV: 291.0, 291.3, 291.5, 291.81, 303.00, 303.90, 305.00;	Addiction; Alcohol Hallucinations; Alcohol Intoxication; Alcohol Withdrawal; Delirium tremens	3

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

	<h1 style="margin: 0;">CARE GUIDELINES</h1>	Main Menu Short Cuts
User: HOPPE, BEBE Site: INTERNAL DEMO SITE <<< THIS IS A TEST/DEMO WEBSITE >>>		
Select Milliman Content: <input type="text" value="Inpatient and Surgical Care"/>		
<p>Milliman Care Guidelines® <i>Inpatient and Surgical Care</i> 10th Edition</p> <p>EDITED BY JAMES M. SCHIBANOFF, M.D.</p>	<p>Use of these <i>Care Guidelines®</i> 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.</p> <p>Copyright 1990 - 2006 Milliman Care Guidelines LLC All Rights Reserved</p>	
Search for: <input type="text"/> <input type="button" value="Go"/> <input type="button" value="Reset"/>		
<ul style="list-style-type: none"> • User Guide • Index: Optimal Recovery Guidelines 		
Table of Contents		
<ul style="list-style-type: none"> • Milliman Care Guidelines Editorial Staff • Important Notices 		
<ul style="list-style-type: none"> • Introduction <ul style="list-style-type: none"> ◦ Preface ◦ Introduction: How to Use the Inpatient and Surgical Care Guidelines ◦ 10th Edition Optimal Recovery Guidelines Comparison Tables 		
<ul style="list-style-type: none"> • Care Guidelines for Inpatient Care <ul style="list-style-type: none"> ◦ Medical and Surgical Optimal Recovery Guidelines and Annotated Bibliographies ◦ Pediatric Optimal Recovery Guidelines and Annotated Bibliographies ◦ Behavioral Health Optimal Recovery Guidelines and Annotated Bibliographies ◦ Common Complications and Conditions ◦ Intensive, Intermediate, and Telemetry Care Guidelines ◦ Observation Care Guidelines 		
<ul style="list-style-type: none"> • Case Management Guidelines <ul style="list-style-type: none"> ◦ Medical and Surgical Case Management Guidelines ◦ Pediatric Case Management Guidelines ◦ Behavioral Health Case Management Guidelines 		
<ul style="list-style-type: none"> • Length of Stay Tables <ul style="list-style-type: none"> ◦ Introduction to Length of Stay Tables ◦ Length of Stay Tables - Surgical (by CPT® Code) ◦ Length of Stay Tables - Surgical (by ICD-9 Procedure Code) ◦ Length of Stay Tables - ORG (by ICD-9 Diagnosis Code), Behavioral Health (by ICD-9 Code and DSM-IV Code) 		
<ul style="list-style-type: none"> • Assistant Surgeon Guidelines <ul style="list-style-type: none"> ◦ Introduction to Assistant Surgeon Guidelines ◦ Assistant Surgeon Guidelines 		
<ul style="list-style-type: none"> • Inpatient Care Utilization Models <ul style="list-style-type: none"> ◦ Introduction to Inpatient Care Utilization Models ◦ Commercial Models <ul style="list-style-type: none"> ■ Model A - Loosely Managed Delivery System, Summary by Service Category ■ Model A - Loosely Managed Delivery System, Summary by Diagnostic Groups ■ Model B - Moderately Managed Delivery System, Summary by Service Category ■ Model B - Moderately Managed Delivery System, Summary by Diagnostic Groups ■ Model C - Well Managed Delivery System, Summary by Service Category ■ Model C - Well Managed Delivery System, Summary by Diagnostic Groups 		

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.

Care Tip Maintenance										Main Menu Short Cuts		
User: HOPPE, BEBE Site: INTERNAL DEMO SITE										<<< THIS IS A TEST/DEMO WEBSITE >>>		
This is the Care Tips Maintenance page. Click on the Add New Care Tip link 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.										Care Tip published. Care Tip published and a new version is being edited. First version being edited, no published version.		
Add New Care Tip												
View All Care Tips	Active	Internal Use Only	Date Added	Description	Filter Type			Filter Value	DEMO CUSTOMER	AETNA COMM	HEALTHNET COMM	PACIFICARE COMM
					Diagnosis	Procedure	Referred To Specialty					
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/27/04	ACNE VULGARIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	706.1		-	-	-
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/16/04	ACUTE IN-PATIENT REHABILITATION AFTER STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	430.438		-	-	-
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/16/04	ALCOHOL ABUSE, HEALTH NET HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	303.00.305.02	-	-		-
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/27/04	ALLERGIC RHINITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	477.0.477.9		-	-	-
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/16/04	ASTHMA MANAGEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	493.493.92		-	-	-
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12/16/04	BACKACHE AND RELATED COMPLAINTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	724.724.5		-	-	-

- 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.

Care Tip Filter Edit			Main Menu Short Cuts
User: HOPPE, BEBE Site: INTERNAL DEMO SITE			<<< THIS IS A TEST/DEMO WEBSITE >>>
			Edit Care Tip. (Please note that that all related care tips are affected by this change.)
Filter Type	<input checked="" type="radio"/> Diagnosis <input type="radio"/> Procedure <input type="radio"/> [Referred To Specialty]	What should this Care Tip filter on?	
Filter value or range	<input type="text" value="303.00.305.02"/>	For diagnosis and procedure filters, use a semicolon to separate multiple entries and a colon to specify an inclusive range. For example: 410.1;420.10;429.99.	
Care Tip Description	<input type="text" value="Alcohol Abuse, Health Net HMO"/>	The Care Tip Maintenance page sorts on this field.	
<input type="button" value="Update Care Tip"/>		<input type="button" value="Cancel"/>	<input type="button" value="Delete 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.