Aetna Better Health
Provider MCG-CWQI Auth Entry Guide

Dear Provider-

Thank you for choosing to submit electronic authorization requests through Aetna's Medicaid Web Portal. The following instructions will guide you through all the steps necessary to correctly submit an electronic authorization request.

Please note the following:

- Prior to submitting an auth request, use the *PA Requirement Search Tool* found as a link at the bottom of your *Provider Web Portal* screen.
  - o This leads to ProPat, an easy to use PA = Yes/No tool.
  - o If PA=No for the code you enter, there is no need to submit an auth request.
  - o We recommend using this tool before submitting an auth request to save time.
- If you are submitting an electronic auth request but the request is not completed correctly this will result in your request not processing in the MCG-CWQI system and will not reaching the Utilization Management Team for a decision review.
- If your request is not completed correctly the Plan staff are not permitted to correct your request. If this happens the Plan will reach out to you to inform you of the situation and request you resubmit the request correctly or cancel your request.
- The clock will not start on a decision until the Provider correctly submits the authorization request.
- MCG-CWQI is only intended as an initial authorization request tool.
- MCG-CWQI will not show you auth review status or claims payment information.
- Auth review status and claims payment information can be accessed on your *Provider Medicaid Web Portal* Home Screen.

Content

Logging into the *Provider Secure Web Portal*

To access the *CWQI Auth Submission Screen* you must log into the *Provider Secure Web Portal*:

- *User Name*
- *Password*
- *Click Sign-In* to access the *Provider Secure Web Portal*

Note: If you have not yet registered for the *Provider Secure Web Portal* follow the directions on the screen to register. You cannot access the MCG-*CWQI Auth Submission Screen* until you successfully complete the registration.

Provider Secure Web Portal **– Home Screen**

After logging in you will see the screen above.
Focus areas with regard to authorizations are noted above.

Tasks
- **Authorization Search**: This is to find authorization status/decision for previously submitted requests. This area is not to submit new authorization request.
- **Claim Search:** This is to find claims status on submitted claims
- **Other links**: For details on other links on this screen please see your Aetna Provider Manual.

Health Tools
- **PA Requirement Search Tool:** This leads to ProPat, an easy to use PA = Yes/No tool.
  - If PA = No based on the code you enter, there is no need to submit an auth request.
  - We recommend checking this tool first before submitting an auth request to save you time.
- **Submit Authorizations:** This leads to the MCG-*CWQI Auth Submission Screen*.
  - This is the area to submit new authorization requests.
  - This will be discussed in detail throughout the rest of this document.
- **Case Management:** This leads to the Dynamo Care Management view.

Important Links
- **Authorization Submission User Guide:** This leads back to this document.
- **Referral and Prior Authorizations:** General information about Plan PA requirements.

Authorization Search Reminder

If you click on the *Authorization Search* link from the Provider Home Screen you will get to the *Authorization Search* screen above.
This screen also contains the *Tasks* and *Health Tools* found on the Provider Home Screen (see left hand of the screen).

To create a new authorization request:
Click on *Submit Authorizations* link on the left side of this screen or on the bottom of the Provider Home Screen.

To find the status/decision for previously submitted authorization requests:
Use the search fields in the center of the *Authorization Search* screen above.

To edit an authorization request already submitted:
Please call the Health Plan to speak to someone on the Prior Auth or Concurrent Review team.

Note: This document includes detailed directions for new electronic authorization requests. For authorization and claims status searches, please see your Aetna Provider Manual for additional details on using the search screen above.

MCG-CWQI Authorization Queue

After you selected the *Submit Authorizations* link, you will see the *Auth Authorization Queue* screen above.

If this is your first time submitting an auth request through the Web Portal this Summary screen will be blank.

This screen will grow to display a history of what you submitted through this electronic request system.

Note:
If you submitted an auth request by Faxing in the auth request it will not be part of this system.
To find status of auth requests faxed in, you must use the Search Authorization feature previously noted.

To create a new electronic auth request:
- Click on *Auth Request* in the upper left corner of the screen

Authorization Requests

After clicking on Authorization Request button the screen above will appear.
There are 9 questions on this screen. The requirements for each question are covered in the following pages:

#1. Who is the provider requesting pre-autorization?
Provider Field:

- Enter the Provider who is <u>requesting</u> the services, not the Provider to perform the service.
- You can search by name or Provider ID*
- After entering the name or Provider ID click the Search icon to the right of the entry.
- All matching search results will appear in a pop up window that require you to select the appropriate match. See screen shot below.
- Find the correct Provider.
- Click on *Select* on the right side of the search screen.
- The requesting Provider Name and details should now fill in all fields.

Note: *To avoid errors, users must select a provider record that contains a Provider ID that is affiliated to the user's group. To view a list of acceptable provider ID's, visit the *Provider Details* tab within the *Provider Web Portal*. (See next page for screen shot).

Note: Searching by *Last, First* will yield results if entry <u>matches exactly</u> to Provider in system. If you cannot find using *Last, First* we recommend entering only the *Last* name to search.

Note: If there are several pages of Providers from which to select, click on one of the headers to sort by Alpha or Numeric order (increase or decreasing order).

Screen-shot of *Provider Medicaid Web Portal* / *Provider Details Screen*

For any corrections, updates, or changes to the list of affiliated providers, please reach out to Provider Relations/Services for assistance.

#2. What is the Request Type?
Request Type Field:
- Click on the *Request Type* drop down
- Search for a *Request Type* option that comes as close as possible to the service(s) you are requesting.
- Scroll down if needed to view all the *Request Type* options
- Double click on the *Request Type* option you want.
- The *Request Type* will fill in the Field as seen below.

Note: You will add the actual service code(s) in Step 5. Multiple service codes can be entered per auth type as described in Step 4 below.

Note: If you are requesting more than 1 *Request Type* then you must enter additional auth requests for each *Request Type.* (Examples: In-pt vs Out-pt or DME vs Surgery, etc)

#3. Who is the patient requiring the pre-authorization?
Patient Field:

- Enter the Member's information in one of the following ways:
  - Member's last name only and click the Search icon
  - Member's name Last, First and click the Search icon
  - Member's Medicaid ID # and click the Search icon
- For name searches a list of Member's with similar names will pop-up.
- For Medicaid ID # search, a single option exact match should pop-up.
- Find the correct Member
- Click on *Select* on the right side of the search screen
- The Members details should now fill in all fields.

#4. What is the patient's diagnosis?

- **Code:** Enter a specific Dx Code if you know it
- **Code Type:** Use drop down to select ICD-10
- **Description:** Leave blank if you entered a specific Dx Code
- Click *Add* to Search for this code
- If the system recognizes it, it will be added as seen below

If you do not know the specific Dx Code

- **Code:** Leave blank
- **Code Type:** Use drop down to select ICD-10
- **Description:** Type in the general word Ex: Pneumonia, Diabetes, Trauma etc.
- Click *Add* to Search for this code
- Find the correct Dx from the pop-up
- Click Select on the Dx you want to add

For multiple Dx/ Remove a Dx

- Repeat the steps above to add as many Dx as are needed for the auth
- The first Dx entered will default as the *Primary* Dx
- Select the Radio button to change the reassign the *Primary* Dx
- To remove a Dx, click the corresponding box to the right of the Dx and click Delete

#5. What procedures(s) are requested in this Authorization?
- **Code:** Enter a specific Service/Procedure Code if you know it
- **Code Type:** Use drop down to select CPT/HCPCS or Rev Codes
- **Description:** Leave blank if you entered a specific Service/Procedure Code
- Click *Add* to Search for this code
- If the system recognizes it, it will be added as seen above

If you do not know the specific Service/Procedure Code
- **Code:** Leave blank
- **Code Type:** Use drop down to select CPT/HCPCS or Rev Codes
- **Description:** Type in the general word Ex: Home Health, Hospice, Wheel Chair etc.
- Click *Add* to Search for a code that contains this word
- Find the correct Service/Procedure from the pop-up
- Click *Select* on the Service/Procedure you want to add

For multiple Service Codes/ Remove a Service Code

- Repeat the steps above to add as many Service/Procedure Codes as are needed for the auth
- The first Service/Procedure Codes entered will default as the *Primary* Code
- Select the *Radio button* to change the reassign the *Primary*Code
- To remove a Code, click the corresponding box to the right of the Code and click *Delete*

Note: For both the Dx Code (Step #4.) and the Procedure Code (Step #5.), if the item entered is not valid, the system will not add the information below the search fields.
- If the full description and the radio buttons do not display then the information was not valid or not added correctly.
- You must redo these steps until this information displays for the auth request to be correct.

#6. At which facility does the service need to be performed?

For outpatient auths
Facility: Enter "Not Applicable", Click Search, and Select.
Date of Service: Because it is a required field enter the first date that must match the start date of the request.
Requested Level of Care: Using the drop-down select Outpatient

Note: If Not Applicable does not appear in the Search pop-up, unclick the "In-Network" button in the Search pop-up and try the Search again.

For inpatient auths
Facility: Search for the Facility name the same way you previously completed the Provider search.
Date of Service: Enter the first date/admit date. It must match the start date of the request.
Requested Length of Stay: Leave blank
Requested Level of Care: Using the drop-down select Inpatient
Mark as Urgent: This box can be checked. However, it is recommended to call in Urgent requests to promote timely processing.

Note: For Date of Service use the calendar icon to ensure the date is selected in the correct format to prevent issues.

#7. Who is the Servicing (or Facility) provider for the service?
This is the name of the Provider that will be performing the service, sending in the claim and will appear on the claim to receive payment.

- Enter the Provider who is performing the service(s)
- You can search by name or Provider ID*
- After entering the name or Provider ID click the Search icon to the right of the entry.
- All matching search results will appear in a pop up window that require you to select the appropriate match. See screen shot below.
- Find the correct Provider.
- Click on *Select* on the right side of the search screen.
- The Provider Name and details should now fill in all fields.

Note: *To avoid errors, users must select a provider record that contains a Provider ID that is affiliated to the user's group. To view a list of acceptable provider ID's, visit the *Provider Details* tab within the *Provider Web Portal*.

Note: Searching by *Last, First* will yield results if entry matches exactly to Provider in system. If you cannot find using *Last, First* we recommend entering only the *Last* name to search.

Note: If there are several pages of Providers from which to select, click on one of the headers to sort by Alpha or Numeric order (increase or decreasing order).

#8. Are there any other details?
Enter the reason you are requesting the authorization this can include copy and paste of clinical notes. 2500 character limit.

Note: The sample above was for demonstration purposes only. The reason for the request should be detailed enough to show medical necessity.

#9. Please provide the following additional information
Acuity: Use the drop-down to select *Elective* or the other options if appropriate.
Authorization Start Date: This date should be on or before the date in Step 6. This should be today or future date and not date in the past.
Authorization End Date: Typically entered as a date 60 – 90 days in the future
Note: For Start and End Dates use the calendar icon to ensure the date is selected in the correct format to prevent issues.

Double Check & Next
- Review Questions 1-9
- Ensure everything with a * is filled in
- Ensure everything is filled in correctly
- Click *NEXT* in the lower right side of the screen.

Note: You will have one <u>final opportunity</u> to correct any item before you Submit the authorization.

Authorization Code Detail (Adding Units to a Code)

- Based on the number of Service/Procedure Codes entered on Question 5 the system will display those services separately on the sceen.
- For each Service enter the number of units you are requesting for the Patient.
- Click *NEXT* in the lower right of the screen.

Note: Units are not the same value for each Service/Procedure.
We strongly recommend you use your code look-up tool to determine the correct value for the specific request.

Examples:
E1090 Wheelchair 1 Unit = 1 chair
G0156 Home health/hospice aide in home health or hospice settings 1 Unit = 15 min
Revenue Codes 1 Unit = 1 day

Authorization Request Clinical Indication

Based on the Services/Procedures Selected the clinical review screen will be next.
- Read each indicator
- Select all indicators that accurately reflect the Patient's condition – All that apply
- Click on *NEXT* in the lower right of the screen

Authorization Request Review

Authorization Request - Request Review

Authorization Request Review

| Auto-Authorization : **EPS00000190** | *4* | Request Type : **OP-Home Health** | Request Status : **NoDecisionYet** | *1* |

⊞ *2*   Patient : HPZZ0000002759-ZKEN03389903   Name : **KRUM, VICTOR**   Date of Birth : **3/15/1989**

⊞   Auto-Authorization : EPS00000190

⊞   Requesting Provider : 145804FLIP   Name : **Bermudez, Roberto**

⊞   Servicing (Or Facility) MSC000001076   Name : **HOME BOUND CARE INC, .**
     Provider :

⊞   Place of Service : **Not Applicable**   Name : **Not Applicable**   Date of Service : **2/21/2017**

⊞   Procedure Code : G0156 *Primary*   Code Type : **CPT/HCPCS**   Requested Units : **36**   Edit Documentation Remove Documentation

⊞   Procedure Code : E1090   Code Type : **CPT/HCPCS**   Requested Units : **1**   Edit Documentation Remove Documentation

This system provides access to MCG evidence-based guidelines; however the determinations made using this system are directed by the health plan, based on a number of factors.

Attach File *5*   *3*

Name	Description	Date
No files associated with this episode		

6 **Submit** Cancel Request Back

#1 – Request Status: No DecisionYet = Not yet submitted to the Plan
#2 – Details: Review all the details of the auth to ensure they are correct
#3 – Edit: Click either of these links to make corrections if needed
#4 – Auto-Authorization: EPS#####.   This is your authorization reference number. However, at this point <u>you have not submitted your auth request</u>, it is not yet with the Plan.
#5 – Attach File: Click here to load any attachments /documents
#6 – Submit: Click Submit if you are ready to send the auth request to the Plan.

Auto Authorization Response

Authorization Request - Request Response

Auto Authorization Response

| Auto-Authorization : **EPS00000190** | *2* | Request Type : **OP-Home Health** | Request Status : **Pended** | *1* |

⊞   Patient : HPZZ0000002759-ZKEN03389903   Name : **KRUM, VICTOR**   Date of Birth : **3/15/1989**

⊞   Auto-Authorization : EPS00000190

⊞   Requesting Provider : 145804FLIP   Name : **Bermudez, Roberto**

⊞   Servicing (Or Facility) MSC000001076   Name : **HOME BOUND CARE INC, .**
     Provider :

⊞   Place of Service : **Not Applicable**   Name : **Not Applicable**   Date of Service : **2/21/2017**

⊞   Procedure Code : G0156 *Primary*   Code Type : **CPT/HCPCS** Requested Units : **36**   Status : **NoDecisionYet**

⊞   Procedure Code : E1090   Code Type : **CPT/HCPCS** Requested Units : **1**   Status : **NoDecisionYet**   *3*

Messages (0)   Cancel Request   Return To Auth Queue

#1 – Request Status: Pended = You successfully submitted this to the Plan
#2 – Auto-Authorization: EPS#####.   If you follow-up on your request you can use this number to track your request.
#3 – Return to Auth Queue: Click this to return to your Auth Queue.

Auto Authorization Queue (Review)

#1 – Authorization: Auth Reference numbers. Click the # to open the auth detail.

#2 – Status:
- **Pended** = Auth request completed correctly and moved to the Plan for review
- **Not Submitted** = Did not submit due to error on the auth request. Click on # to reopen auth and correct any issues.

#3 – Submission History: If you have several auths in queue use these filters to help specify your search.

#4 – Auth Request: Click this Tab to begin a new Authorization Request.

Reminder:
MCG-CWQI *Auth Request* is only the initial request tool.
To see the review, decisions, and other Plan activity around the authorization or claims go to next page.

Provider Web Portal – **Home Screen**

Auth Status / Plan Review Status

- To search for a status of authorization submitted to the Plan for review and decision Return to your *Provider Web Portal* main screen
- Click on the *Authorization Search* link under *Tasks*

If you have any questions regarding this user guide, the prior authorization request process or Care Web QI; please contact the health plan.

Cancel your Electronic Auth request

If you need to cancel your request for whatever reason:
- Click on the Auth #
- Find the *Cancel Request* in the lower right corner, a pop-up message will appear
- Click OK to confirm you want to cancel

Note: We recommend to only cancel requests that are *Not Submitted*. If you need to cancel a request already submitted, *Pended*, please contact the Health Plan.

Auto Approved Feature

Auto Authorization Response

Auto Queue | Auth Request

Auto-Authorization : EPS00000163   **Request Type : Outpatient Procedure**   **Request Status : Complete-Approved**

Patient : 9012753063   **Name : Treinen, Ebony**   **Date of Birth : 02/02/1965**
Gender : **Female**   Address : **11093 Banjo Circle**
Windsor Mill, Maryland 21244
Benefit Plan : **MPC - Upgrade - Health Choice**   Eligibility : **04/01/2009 - 12/31/2078**
Diagnosis Code : **ICD-9 Diagnosis (836.2)** *Primary*

Auto-Authorization : EPS00000163
Requested Level of Care : **Outpatient**
Approved Level of Care : **Outpatient**
Acuity : **Elective**   Authorization Start Date : **11/09/2013**
Authorization End Date : **01/21/2014**

Requesting Provider : QMXPR0013910   Name : **RICCIO, THOMAS**
Speciality :   Address : **1655 Woodbrooke Dr Ste 101**
Salisbury, Maryland 21804
Phone : **(410) 749-7491**   Fax :

Servicing (Or Facility) Provider : QMXPR0013910   Name : **RICCIO, THOMAS**
Speciality :   Address : **1655 Woodbrooke Dr Ste 101**
Salisbury, Maryland 21804
Phone : **(410) 749-7491**   Fax :

- The system is designed to Auto Approve auths based upon RULES previously defined.
- However, each Health Plan makes a decision to turn on this feature.
- If the Auto Approve is turned on you will see other *Request Status* terms (upper right).
- In this example the *Request Status* is listed as: *Completed – Approved*
- Auths will only auto-approve if all the criteria is met as part of the RULES previously defined.
- Auths will not auto-approve if criteria is not met according to the RULES previously defined.

Note: Please call your Plan UM department to confirm if this feature is turned on in your state.

If you have any questions regarding this user guide, the prior authorization request process or Care Web QI; please contact the Health Plan.