

# Chorus Community Health Plans Authorization Request Packet

Red asterisk

Auth Queue Auth Request

Disclaimers:  
 ICD-9 Procedure 35.50  
 o Your request requires documentation. Please select the Document button for  
 o Approval of this request does not guarantee payment of the claim.  
 o Payment for new member providers may be delayed.

on Request - Request Form

Code Type	Code	Code Description
ICD-9	086.0	Chagas' disease with heart involvement
ICD-9	086.0	Chagas' disease with heart involvement

Authorization Guideline Search - ICD9D (250.20)

Results for "250.20"  
 250.20 Diabetes with hyperosmolality, type II or unspecified type, not stated as uncontrolled

Guideline Code	Product	Type
R-0017	AC	Diabetes Mellitus - Referral Management
S-0103	AC	Exercise Treadmill Test (ETT) with ECG
A-0309	AC	Insulin Infusion Pump
S-0000	AC	Pharmacologic Stress Echocardiography
R-100	DC	Diabetes
R-148	DC	Diabetes, Pediatric
DC-014	DC	Diabetes: Observation Care

Code Lookup Results

Show 10 entries

Code Type	Code	Description
CPT/HCPCS	0051T	Implantation of (heart) with re...
CPT/HCPCS	0052T	Replacement or heart system (artificial heart)
CPT/HCPCS	0053T	Replacement or repair of implantable component or components of total replacement heart system (artificial heart), excluding thoracic unit

Showing 1 to 3 of 3 entries (filtered from 84 total entries)

- NoDecisionYet
- Pended
- Complete-Approved
- Complete-Rejected
- Complete-Partial
- Not Processed



HEARST HEALTH NETWORK

# CITE<sup>®</sup> PROVIDER USER'S GUIDE

Cite AutoAuth Module 7.0

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# 1 Welcome to your authorization request website

This authorization request website is a service of Cite AutoAuth Module that is provided by Chorus Community Health Plans (CCHP) to speed authorization of patient care.

Use this website to:

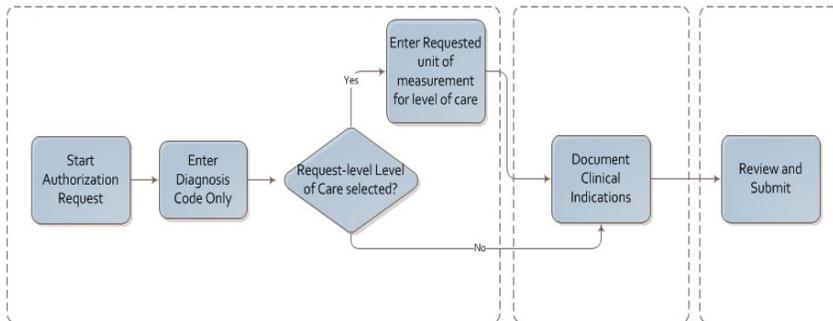
- Prepare and submit an authorization request electronically
- Receive immediate notification of whether the authorization request was approved, denied, or held for further review.

Use these general steps to create and submit an authorization request:

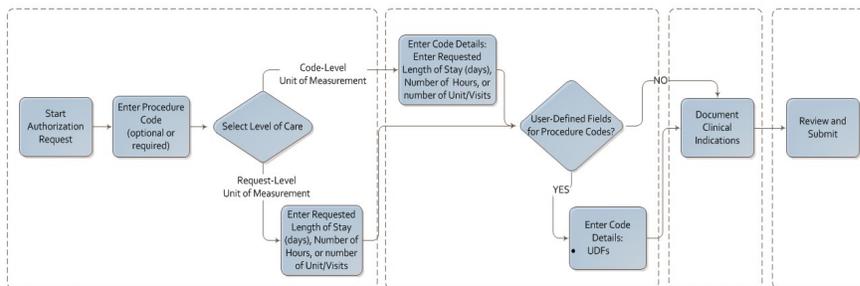
1. Create the core authorization request, in which you identify the request type, patient, providers, procedure and diagnosis codes, date and place of requested services, and so on.
2. Provide additional information as specified by CCHP, if required.
3. Document the clinical indications for each code to be authorized.
4. Review and then submit the authorization request. You will receive the initial response back from CCHP.

The following diagrams illustrate the general workflow for creating and submitting an authorization request.

## Authorization request workflow – diagnosis only



## Authorization request workflow – procedure code



On this website, you can perform the following actions:

- Request a new user account
- Start an authorization request
- Provide additional information
- Document clinical indications
- Submit a complete authorization request
- Manage the auto authorization queue
- Manage auto authorization messages
- Manage document attachments

## 1.1 Supported Web browsers

The following browsers in a Windows environment are supported:

- Microsoft® Internet Explorer® 8, 9, or 10
- Google® Chrome™ (certified on version 32)



If you are **not** using a compatible browser, a warning message will appear at the top of the page.

If you ignore the message, application functionality should be largely unaffected, but you may experience page layout irregularities.

To stop the error message from appearing on all pages, you must close it on two pages. Select the "Close" link on the message when it appears on the login page and on the main page of the application. After being closed for both instances, the message will remain closed for the duration of your session. The next time you log in, the message will reappear. Removing the message for a session does not change the fact that you are using a browser that is not supported. See your administrator about upgrading to a supported browser.

## 2 Request a new user account

1. CCHP providers will receive a provider portal registration packet via regular mail, which includes a unique registration code and a link to the CCHP provider portal for your Site Administrator.
2. Next, your Site Administrator will need to complete an online registration form located at: [provider.childrenscommunityhealthplan.org](http://provider.childrenscommunityhealthplan.org) (FIRST AVAILABLE ON 09/15/2015).  
**Note: the first person signing in will be deemed the Site Administrator.**
3. Complete the form. All fields on the form must be completed, and the facility's tax ID number is required.
4. After submitting the form, you'll receive a confirmation email of the submission.
5. Within 30 minutes of submitting the form, you'll receive an email to verify your email address. Click on the link to verify your email address is valid.
6. You will receive an "Email Verification Completed" email to the email address you provided.
7. In approximately three business days, you'll receive your user login information and password.
8. Site Administrators may register additional users for their facilities at any time after they have registered. An individual user will follow the above steps for email verification and login.



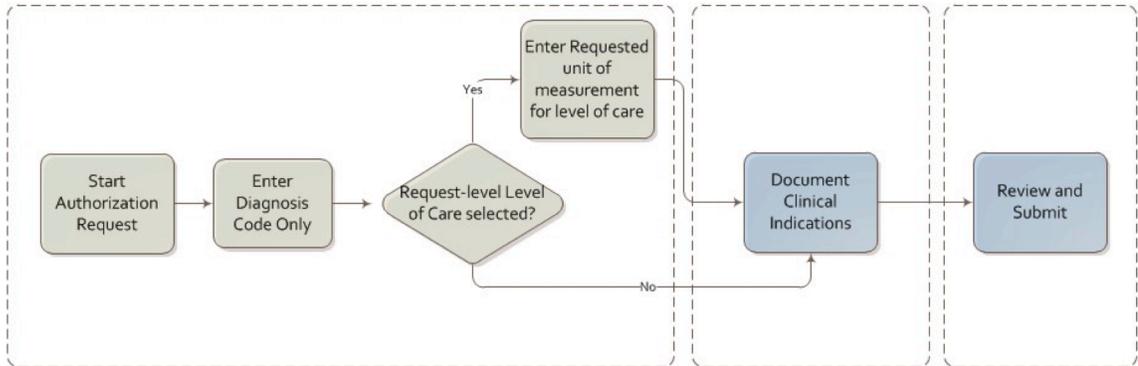
You may call CCHP at 414-266-5747 with any questions about the provider portal registration.

## 3 Start an authorization request

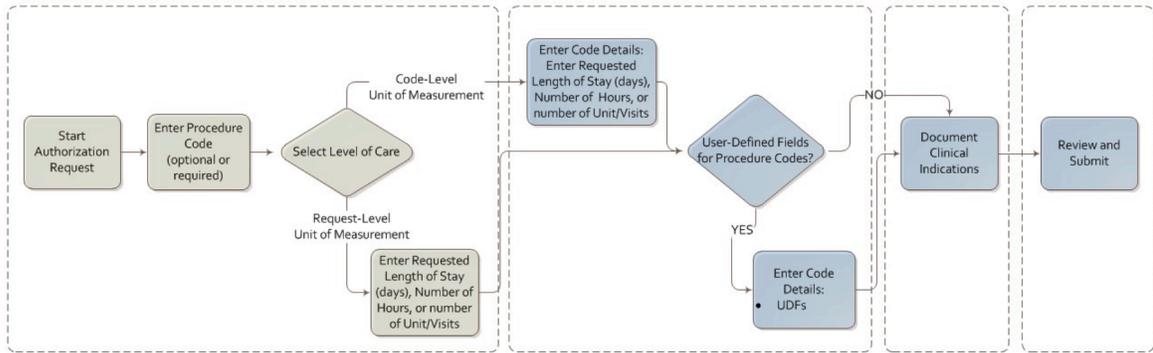
When you create an authorization request, you begin by specifying the core information of the request:

1. Requesting provider
2. Request type
3. Patient
4. Requested level of care
5. Codes for one or more diagnoses and/or procedures
6. Facility (if known)
7. And more

### Diagnosis code only workflow

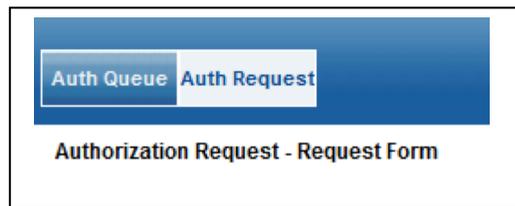


### Procedure code workflow



## 3.1 Start an authorization request

Select the **Auth Request** tab to open the first page of the Authorization Request.



### 1. Who is the provider requesting pre-authorization?

Type the name of the requesting **Provider or your unique ID number**. A dropdown listing of possible matches will appear. Select yours for it to populate the other fields.

If two records have the same name ...

Each provider has a unique ID number that may be entered in the Provider Search field. If you don't know the provider, you may enter "Pro-Unknown" in the field.

**If two records have the same name**, and you need more information to determine which record is the correct one, move your mouse over the information icon (i) located at the end of a record ID. A small information window appears, displaying the ID number, name, and address details for that record. Patient records also display the date of birth. Note that the "Patient Record Selector" window also lists the plan eligibility dates. To close the window, simply move the mouse away from the information icon. The i may not appear with some browsers; hover near the end of the unique provider number and the information will appear.

Tap the information icon to open the information window. Tap the window to close it.

## 2. What is the Request Type?

a. Select the **Request Type** from the list

Requesting a procedure or visit

b. **Pre-authorization, outpatient procedures**

Select this option when requesting a procedure that is noted on the Prior Authorization List for CCHP (childrenchp.com). A primary diagnosis code must be entered and all procedure codes that are being requested. The procedure codes will need to be documented.

c. **Medical inpatient admission**

Select this option when requesting an admission authorization. First, enter a primary diagnosis code, which need to be documented. There is the option to enter additional diagnosis codes, which you can (but are not required to) document. You also have the option to enter procedure codes, but you cannot document them.

d. **Surgical inpatient**

Select this option when an elective admission for a surgical procedure occurs. This request type is for the actual admission, not for authorizing the surgical procedure, if required. Refer to the CCHP Prior Authorization list on the website for those procedure requiring surgical authorization by the performing provider

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

It is recommended to use Medicaid ID numbers here

Type the patient **name or ID number**. The patient's date of birth (DOB), Eligibility and Address text boxes will populate.

4. What is the patient's diagnosis?

- a. Add one or more diagnosis codes. If a **red** asterisk is present, at least one diagnosis code is required. You can always add optional (non-required) diagnosis codes:
- b. Select the type of code from the **Code Type** list.

 Diagnosis codes may include ICD-9 Diagnosis (Only ICD-10 codes will be accepted for services after 9/30/2015).

Red asterisk

4 . What is the patient's diagnosis?

Code	Code Type	Description			
<input type="text"/>	ICD-9 Diagnosis	<input type="text"/>	<input type="button" value="Add"/>		
Primary	Code	Type	Description	Documentable	Action

Red asterisk

5 . What procedure(s) are requested in this Authorization?

Code	Code Type	Description			
T2040	CPT/HCPCS	<input type="text"/>	<input type="button" value="Add"/>		
Primary	Code	Type	Description	Documentable	Action
<input checked="" type="radio"/>	T2040	CPT/HCPCS	Financial management, self-directed, waiver; per 15 minutes	<input checked="" type="checkbox"/>	<a href="#">delete</a>

- c. Two options for entering a diagnosis code:
  - Type all or part of the diagnosis code in the **Code** text box.
  - Type all or part of the diagnosis code description in the **Description** text box.
- d. Select the **Add** button. One of the following things will happen:
  - **If a single, exact match is found for the code or description you provided**, the code and description are automatically added to your authorization request.
  - **If there is more than one possible match to the code or description you provided**, a window opens with a list of codes. Locate the code you want in the list and select the corresponding **Select** link to add it to your authorization request.
  - **If there is no match**, a message appears — indicating nothing was found and asking if you want the code to be used as entered. Click **OK** to save the code as entered.

 You can remove codes at any time by selecting the **Delete** link for the code. You can also select **Close** to leave the Search Results window without selecting a code.

1. You can start a new code or description search.
2. If your search was by code rather than by description, the code you just searched for will still be in the **Code** box. Select **Add** to add the code as you typed it to the authorization request or clear the code to start a new code search.

- e. If listing multiple diagnoses, select the **Primary** option for the code that is the primary reason for the authorization request.
- f. Clear the **Documentable** check box if you do not want to document a non-primary diagnosis.
  - If the **Documentable** check box for the primary diagnosis is automatically selected and is inactive, you cannot clear it. You must document the diagnosis code.
- g. Repeat these steps until you have added all of the diagnosis codes relevant to this request.

## 5. What procedure(s) are requested in this Authorization?

Add one or more procedure codes if the request type is Procedure Pre-authorization or a type that requires a procedure code. If a red asterisk is present, at least one procedure code is required. You must add all codes requested that require an authorization.



This question does not appear if you selected a request type (in question number 2) that does not allow entry of procedure codes.

- a. Select the type of code from the **Code Type** list.

5 . What procedure(s) are requested in this Authorization?

Code	Code Type	Description	
<input type="text" value="t2040"/>	<input type="text" value="CPT/HCPCS"/>	<input type="text"/>	<input type="button" value="Add"/>

Primary	Code	Type	Description	Documentable	Action
<input checked="" type="radio"/>	T2040	CPT/HCPCS	Financial management, self-directed, waiver; per 15 minutes	<input checked="" type="checkbox"/>	<a href="#">delete</a>



Procedure codes may include CPT/HCPCS, Revenue, or Other. For guidance on which codes to use with Revenue or Other, contact CCHP.

- b. Do one of the following:
- Type all or part of the procedure code in the **Code** text box.
  - Type all or part of the procedure code description in the **Description** text box.
- c. Select the **Add** button. One of the following things will happen:
- **If a single, exact match is found for the code or description you provided**, the code and description are automatically added to your authorization request.
  - **If there is more than one possible match to the code or description you provided**, a window opens with a list of codes. Locate the code you want in the list and select the corresponding **Select** link to add it to your authorization request.
  - **If there is no match**, a message appears, informing you that nothing was found and asking if you want the code to be used as entered. Click **OK** to save the code as entered.



You can remove codes at any time by selecting the **Delete** link for the code.

- d. Select the **Primary** option button if this code is the primary procedure for the authorization request. If you enter only a single code, the system automatically selects the Primary option.
- e. Clear the **Documentable** check box for non-primary procedure codes you do not want to document.
- f. **Repeat** these steps until you have added all of the procedure codes relevant to this request.
- ## 6. At which facility does the service need to be performed?
- a. Provide information about the place and date of the requested service: (Name and address auto-fill).
- b. Type or select the **Facility**. If facility is unknown, enter "Fac-Unknown".
- c. Type or select from the calendar the **Date of Service**.
- d. Select the **Requested Level of Care** from the list — Inpatient, Outpatient or Observation.

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

\* Facility:   Name:

\* Date of Service:   mm/dd/yyyy Address:

Requested Level of Care:

Requested Length of Stay:

Mark as Urgent:

- e. If the selected Requested Level of Care has a unit of measurement at the request level, type the requested length of care in the unit of measurement field that appears (number of hours, days, or units/visits). If it has a unit of measurement at the code level, the unit of measurement field appears on a different page.

**Details regarding "unit of measurements"**



The default **unit of measurement** for an Inpatient Requested Level of Care is Requested Length of Stay (number of days) and appears on the request page.

The default **unit of measurement** for an Outpatient Requested Level of Care is units or visits, and appears on a different page. For more information, see Provide additional information on page 13.

- f. Select the **Mark as Urgent** check box to indicate the authorization request needs immediate review.



An "Urgent Request" is defined as a service where the normal processing time of 15 days for routine and not life-threatening determinations could seriously jeopardize the life, health or safety of the member. The condition would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

You can change the **Mark as Urgent** setting (whether selected or cleared) prior to submitting the authorization request, but not after.

**7. Who is the servicing provider for the service?**

Type or select the servicing provider, using name or ID number.  
(Name and address auto-fill)

**7 . Who is the Servicing provider for the service?**

\* Provider:   Name:

Address:

**8. Are there any other details?**

In the text box, provide any nonclinical notes about the case that you think should be considered when making the authorization decision. The maximum allowed is 2500 characters.

**Only 2500 Characters are allowed for the "Note" section.**

**8 . Are there any other details?**

2500 Characters Left for Notes

	<p><i>Date format required: mm/dd/yyyy</i></p> <ul style="list-style-type: none"> <li>• mm: 2 digit month, with a leading zero</li> <li>• dd: 2 digit day, with a leading zero</li> <li>• yyyy: 4 digit year_</li> </ul>
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- When the page is complete, select Next. If additional information about procedure codes is required, the Authorization Code Detail page opens. Once the Authorization Request Review page opens, documentation for the patient's clinical indications for each required code from this page is allowed.

<p>Before proceeding to next page ...</p>	
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	<p>All required information needs to be entered prior to proceeding to next page, such as Requesting Provider ID, Request Type, Attending Provider ID, Patient ID, Facility ID, and Date of Service.</p>
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## 3.2 Find a provider, patient or facility ID

- Type the name in the text box on the request page, and then select the adjoining  button. The Record Selector window displays a list of potential matches.

	<p>If the feature that allows an unknown provider is active for your system, the Requesting Provider may default to an unknown provider (the "PRO-Unknown" provider record), which you can change. If two records have the same name, and you need more information to determine which record is the correct one, mouse over the information icon () located at the end of a record ID. A small information window appears, displaying the ID number, name, and address details for that record. Patient records also display the date of birth. Note that the Patient Record Selector window also lists the plan eligibility dates. To close the window, simply move the mouse away from the information icon.</p> <p>Tap the information icon to open the information window. Tap the window to close it.</p>
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- Scroll down the list of names and select the **Select** link for the one you want.

### 3.2.1 Tips for finding a provider, patient or facility ID

- If the full name of a provider, facility, or patient is unknown — you can look it up by typing a few characters of the first or last name (for a facility, the name or city where it is located) in the text box, and then selecting **Search and Select**.
- If unable to find the correct provider, patient or facility — contact CCHP for assistance at 414-266-5707.
- You can search for a different name while you're at the Record Selector page. Type all or part of the name in the text box and select **Search**.
- **In-Network** checkbox (that appears next to the **Search** button in the Record Selector window) to search for only in-network attending providers and facilities. Clear the checkbox to search all attending providers and facilities regardless of benefit plan name affiliation.

## 3.3 Tips for selecting procedure and diagnosis codes

- The Documentable option is automatically selected for each code you add — if the request type supports documentation of the respective code type. This option controls whether the code will go through the process of documenting clinical indications (pre-certification) or not. To exclude a code from documentation (and from appearing on the Authorization Request Review page), clear the Documentable checkbox (select the checkbox to clear it) for the code.
- This option is useful if you want to include a diagnosis or procedure code for reference, but do not want it to be considered for authorization.
- Each code you document will receive a separate authorization decision from CCHP.

### 3.3.1 Looking up codes

1. There is an automatic code lookup feature to help you add a diagnosis or procedure code to an authorization request. This feature gives you the option to enter an exact code or description, if you know it, or to look-up a code based on part of the code or one or more words in the code description.
2. To use the code look-up feature, type a value into either the Code or Description box on the Authorization Request page, and then press the **Add** button. The system automatically begins a search for codes or code descriptions matching the value you typed.
3. If a single exact match to the code or words you provided is found, the associated code and description is automatically added to your authorization request. Otherwise, you will have the option to select the code you want from a list of potential matches, begin a new code search without selecting a code or to add the code exactly as you typed it.
4. Remove any punctuation marks when searching for a code based on words in the description. For example, if you type, “infection unspecified” in the Description box, the system will not find any code matches; however, if you type “infection unspecified”, the system will find matches.
5. You can remove a code from your authorization request at any time by selecting the associated delete link. You cannot add the same code more than once to an authorization request.
6. You can search for ICD-9 and ICD-10 diagnosis codes, and for CPT/HCPCS, ICD-9, and ICD-10 procedure codes, whether or not they’re associated with an MCG guideline. ICD-10 codes will be required for any service provided after 09/30/2015. If your service request spans before and after 10/01/2015, an authorization for ICD-9 must be entered and another request with the ICD-10 code for dates of service after 10/01/2015.
7. You can select only one code from the Code Lookup Results page. If you want to select more than one, add any others as additional codes on the Authorization Request Review page.
8. The Code Lookup Results page displays a maximum of 200 potential code matches. If you do not see the code you are looking for in the list, return to the Authorization Request Review page and start a new search using a more specific code, or more of the words contained in the code description.
9. If you do not receive any entries on the Code Lookup Results page, return to the Authorization Request Review page and verify that the Code Type is set to the correct type.

## 3.3.2 Navigating the code results

1. If there are more entries than will display on a single page, you will see a page navigation bar at the lower right of the page.



2. To move between pages of entries, select one of the options in the navigation bar:
  - **First:** Return to the first page of the results.
  - **Next:** Proceed to the next page of results.
  - **Last:** Jump to the last page of results.
  - **Previous:** Back up one page in the results.
  - **Page numbers:** Select the number of the page to which you want to jump to.



If you want to jump to a page greater than shown, select the last page number in the list until you see the one you want. For example, if you want to jump to page 7 of the results using the sample shown above, you would select page number 5 first, then select page 7.

3. To change the number of entries displayed on the page, select one of the options in the **Show entries** menu at the top left of the page. The options are 10, 25, 50 and 100.
4. To further narrow your list of code match results, type another search term (code or word) in the **Search** box at the top right of the Code Lookup Results page. The list of results will be narrowed to only those codes in the list that match both your original search term on the Authorization Request page, and the term you provide on the Code Lookup Results page.
5. You can list the results in code or code description order. To do this, select either the Code or Code Description heading at the top of the page. Selecting the heading once causes the list to appear in ascending (1-10, and then A-Z) order. Selecting the column heading again causes the list to appear in descending (Z-A, and then 10-1) order.



The list of codes automatically adjusts as you type. Type as many characters of the code or word as you need until you see the code you want in the list.

## 4 Provide additional information

Depending on the requested level of care (inpatient or outpatient), and the procedure requested, additional information when creating an authorization request may be needed.

### 4.1 Update the number of requested units for a code-level Level of Care

	<p>If the <b>Requested Level of Care</b> selected for the authorization request has a code-level unit of measurement, the unit of measurement field (Requested Length of Stay (number of days), or Units/Visits) appears in the Code Attributes panel on the page that appears after the initial authorization request page.</p> <p>The default unit of measurement for an Outpatient <b>Requested Level of Care</b> has a code-level unit of measurement of units or visits.</p>
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1. Open the Authorization Code Detail page (*on the Authorization Request page, select the **Next** button*).
2. In the Code Attributes panel for the code's **Detail**, update the unit of measurement value (Requested Hours, Requested Length of Stay (number of days), or Units/Visits). A separate Code Attributes panel appears for each procedure code.
3. Select the **Next** button. The Auto Authorization Review page opens.

### 4.2 Update additional information for a procedure code

1. Open the Authorization Code Detail page (*on the Authorization Request page, select the **Next** button*).
2. If CCHP needs additional information at the procedure code level, these fields appear in an Additional Information panel for each procedure code. Enter the information as needed.
3. Select the **Next** button. The Auto Authorization Review page opens.

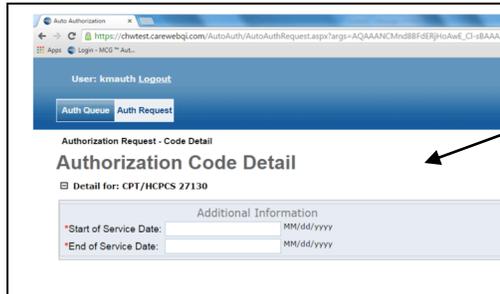
## 5 Document clinical indications

When you document the clinical indications in an authorization request, you provide clinical information that supports the codes that you've submitted for authorization. During this step, you may be asked to provide additional information about your patient's condition.

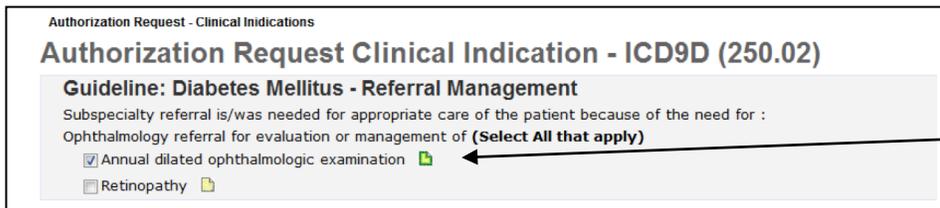
A list of the codes entered for authorization in the previous step will appear. You must document each of the listed codes before you can submit the authorization request to CCHP.

## 5.1 Document clinical indications for codes

1. Navigate to the Authorization Request Review page (open the Authorization Request page and select the **Next** button. (If the Authorization Code Detail page opens, select the **Next** button to continue.) The Authorization Request Review page opens.



Authorization code detail box will only open when a procedure code is required (for example: when entering DME or surgical information).

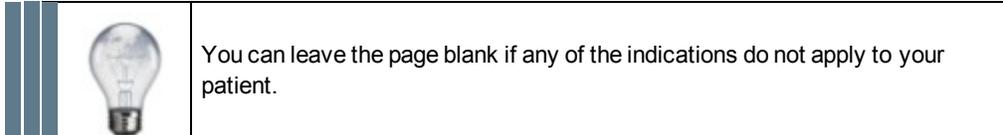


Yellow note pad icon requires additional information to be entered.

2. Review the information provided. If you want to update any of the information, select the **Back** button to return to the Authorization Request form.

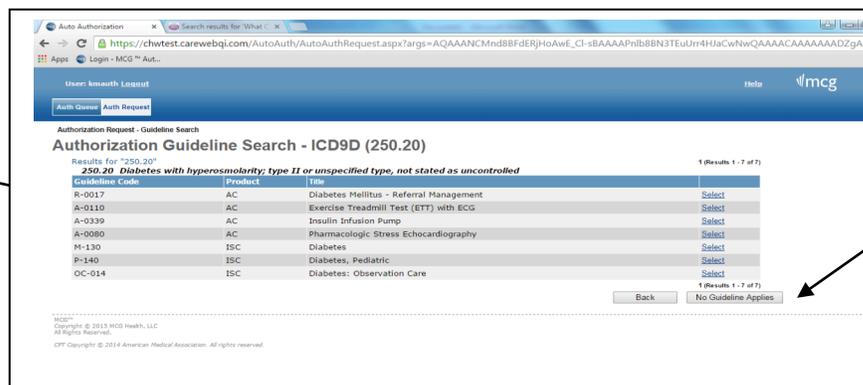
3. For each primary procedure and/or diagnosis code in the list, select **Document**. One of four things happens:

- If no additional documentation is needed, **Re-Document** and **Remove** buttons appear for the code. No further action is required for this code.
- The Authorization Request Clinical Indication page appears if CCHP has determined which guideline to use, and wants additional information about your request. You will be presented with a series of pages listing potential indications.
  - a. Select the indications that apply to your patient (add notes on the yellow notepad), and then select **Next**.



- b. Repeat this step until you see the Authorization Request Review page again.
- The Authorization Guideline Search page appears if you need to select the guideline to use for your request before proceeding.
    - a. Scroll through the list of guidelines until you find the one that best describes your authorization request.
    - b. Select the Select link for the guideline. The Authorization Request Clinical indication page appears with a list of indications.
    - c. Complete the clinical indication pages as described above.
    - d. If none of the guidelines on the Authorization Guideline Search page apply, select the **No Guideline Applies** button. Type the patient's clinical information in the No Guideline Applies box on the Applies page and then select the **Next** button. Use this box to note if there is no clinical information available at the time of entry of the authorization.
  - If no guidelines are found for the code, the Authorization Request No Guideline Applies page appears. Enter your clinical documentation text or select the **Back** button to delete the code.

Repeat Step 3 until all the listed codes have been documented. The request for authorization is ready to be submitted.



Select "Back" button or "No guideline applies" here.

## 5.2 Document OB clinical indications

OB Delivery Inpatient admissions require the entry of some specific information to meet the newborn reporting requirements for the state of Wisconsin. We have created fields for the required information to be added to the guideline.

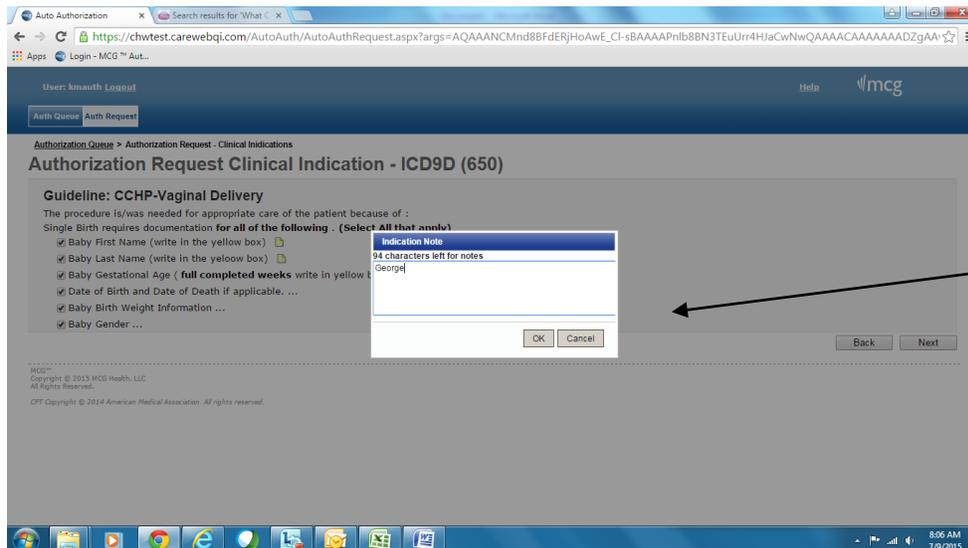
The required information includes:

- Baby first name
- Baby last name
- Baby gender
- Baby date of birth
- Baby gestational age
- Baby weight in grams
- Is baby low birth weight Y/N

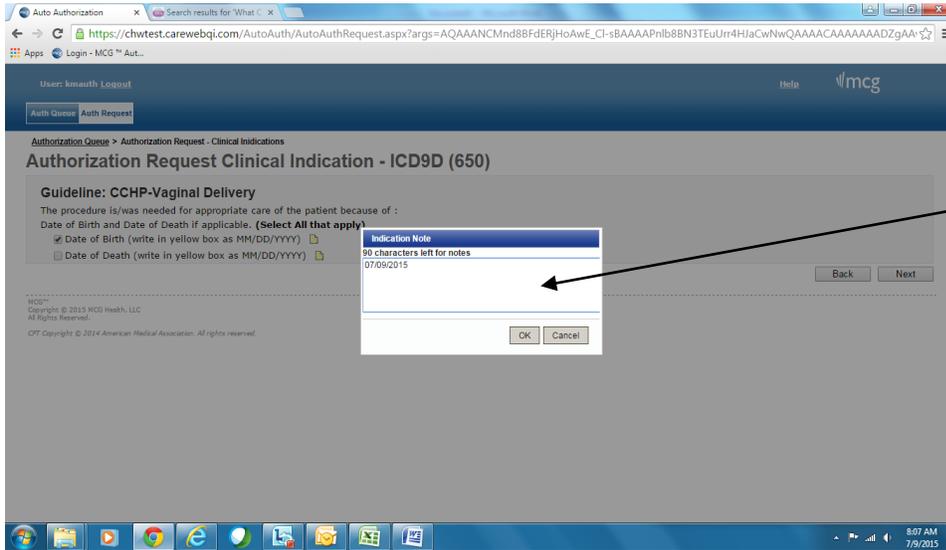
The information should be entered into the corresponding yellow notepads within the guideline. The fields for mother and infant discharge dates must also be completed.



All yellow notepad icons are requesting information in this section to be completed prior to proceeding.



This box appears after clicking on yellow notepad icon. This is where the first name of infant is entered. Next yellow icon produces a screen to enter last name of infant.



Select yellow icon here to enter gender information.



Add date of birth here — after selecting the yellow note pad icon



Enter why procedure was/ is needed for appropriate care of patient. Then select yellow note pad icon to enter discharge dates.

## 5.3 Tips for documenting clinical indications

- Depending on the diagnosis and/or procedure code or codes you submitted, you might be required to document the clinical indications for the patient's condition. This is done through a series of pages where you select the indications that apply to your patient's case.
- You can select as many of the indications that are relevant to your patient's situation. You do not need to select any of the indications that are displayed if they do not apply. However, you must continue through each page of questions by selecting Next until you see the Authorization Request Review page again.
- Only codes that were designated as "documentable" on the original request appear on the Authorization Request Review page. Any other codes are considered to be informational only. You must document
- The clinical indications for each of the codes listed on this page. The Submit button at the bottom of the page will remain unavailable until the clinical indications for all codes have been documented.
- You only need to attach a specific guideline to your request once. If other codes require the same guideline, you will have the opportunity to update any information you've already documented for the guideline.
- If you are asked to select a guideline for your request, you may see a guideline in the list in gray type that cannot be selected. This means that your request already uses that guideline, and you cannot select it a second time.

## 5.4 Attaching documents

When you first open the Authorization Request Review page and/or upon completion of documentation, one or more disclaimers from CCHP may appear for each procedure code. A disclaimer might provide information related to indicated codes, requesting that specific documents be attached to the request to expedite nursing review, or detail some other request-specific action

The screenshot displays the Authorization Request Review interface. At the top, it shows the Procedure Code as 35.50 (Primary), Code Type as ICD-9 Procedure, Requested Units as 0, and Approved Units as 0. There are buttons for Document and Remove Guideline. Below this, the Guideline is listed as No Guideline Documented, and the Clinical Indication field is empty. An Attach File button is present. A table with columns for Name, Description, and Date shows no files associated with this episode. There are buttons for Messages (0), Cancel Request, Back, and Submit. A red-bordered box highlights the Disclaimers section, which includes the text: "ICD-9 Procedure 35.50" followed by three bullet points: "Your request requires documentation. Please select the Document button for each code where it is active.", "Approval of this request does not guarantee payment of the claim.", and "Payment for new member providers may be delayed." The page is powered by CareWebQI.

## 5.5 Manage document attachments

An external document attachment is enabled by CCHP; you can attach documents to an auto authorization request at any time before and after submitting the request.

### 1. Attach a file in response to a message requesting additional information

1. Open the Auto Authorization Queue page (select the **Auth Queue** tab).
2. Select the authorization number link. The Authorization Request Review page appears if the request has been submitted.
3. Select the **Attach File** button. The Upload Episode Attachment window appears.
4. Select **Browse** to locate and select the file to upload.
5. Type a **File Description**. [Optional]
6. Select **Upload**. When the upload is complete, the window displays the file name and description. If you provided no file description, the file name is used as the file description.
7. Select the **Close** button. You return to the Authorization Request Review page, which displays the file name, description and time and date of the upload. Before submitting the file to CCHP, you can do the following:
  - Select the **Open** link to preview the file.
  - Select the **Remove** link to remove the file in order to upload a different file.
8. Repeat as needed to add additional files.
9. Select **Submit**.

### 2. Attach a file to a new authorization request

1. Create the request, then document each of the requested codes.
2. On the Authorization Request Review page, select the **Attach File** button. The Upload Episode Attachment window appears.
3. Type a **File Description**. [Optional]
4. Select **Upload**. When the upload is complete, the window displays the file name and description. If you provided no file description, the file name is used as the file description.
5. Select the **Close** button. You return to the Authorization Request Review page, which displays the file name, description and time and date of the upload. Before you submit the file to CCHP, you can do the following:
  - Select the **Open** link to preview the file.
  - Select the **Remove** link to remove the file in order to upload a different file.
6. Repeat as needed to add additional files.
7. Select **Submit**.

### 3. Tips for attaching files

- You can attach and review files of those types supported by the system and for which your computer has the supporting software. Supported file types include:
  - Microsoft Word documents (.doc and .docx)
  - Microsoft Excel files (.xls, .xlsx)
  - Adobe Reader files (.pdf)
  - Image files (jpg, .tiff, and .gif)
- Contact your system administrator if you need additional file types supported.
- You can use up to 100 characters in a file name.
- You can upload files up to 5 MB in size.
- After upload, you can **view or delete** but *not edit* an attached file. The system maintains a log of users who have viewed an attachment, including the date and time viewed.

Summary of Submitted Requests									
Authorization	Servicing Provider	Requesting Provider	Patient	Service Code	Facility Name	Date of Submission	Date of Service	Status	
EPS-00221954	Joe Who R	Appleseed, Johnny	DOE, JANE	ICD9-D (733.16), CPT(27727)	Aurora Sinai Medical Center of AHC Inc.	06/22/2015 08:53 AM CST	03/02/2015	Complete-Approved	

### 5.6 Add a clinical indication note

1. On an Authorization Request Clinical Indication page, select the note icon (📝) at the end of the indication. The Indication Note window appears.

**For Example:**

**Authorization Request Clinical Indication - ICD9D (250.02)**

**Guideline: Diabetes Mellitus - Referral Management**

Subspecialty referral is/was needed for appropriate care of the patient because of the need for :  
Ophthalmology referral for evaluation or management of (**Select All that apply**)

Annual dilated ophthalmologic examination 📝

**Indication Note**

100 characters left for notes

2. Type the note in the text box, and then select **OK**. The icon changes to a shaded green to indicate the presence of the new note (📝). The note is saved when you select **Next**.

## 5.7 Tips for clinical indication notes

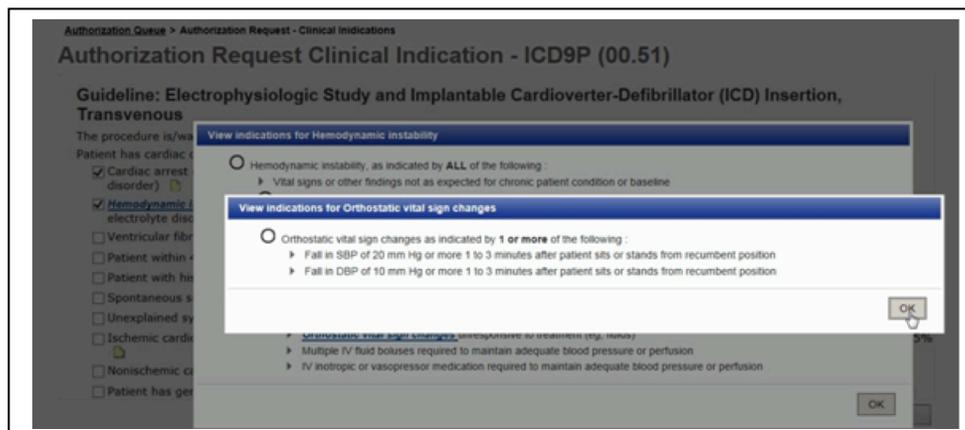
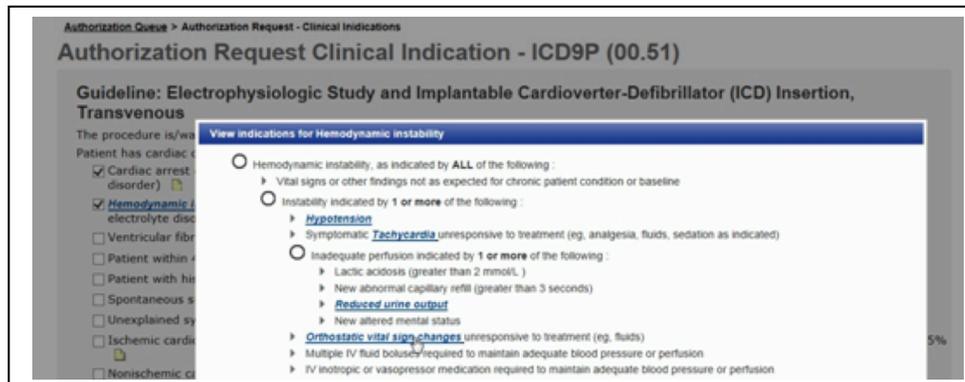
- You can return to a clinical indication on a previous page to add, update, or review a note by selecting **Back** on an Authorization Request Clinical Indication page, or by selecting **Re-Document** on the Authorization Request Review page. To view a note, place your mouse cursor over the saved note icon (📄). To add another note, select the icon.

## 5.8 About indication definitions

An indication definition is available for a term that appears as a blue underlined hyperlink. Select the term to view the definition, which opens in a separate window and consists of a series of indications.

- You can view indications within a definition (that is, an indication definition window may contain links to other definitions.)
- Each indication definition window remains open until you close it.
- The number of windows that can be open at one time is unlimited.

### Examples of an indication definition, and a definition within a definition



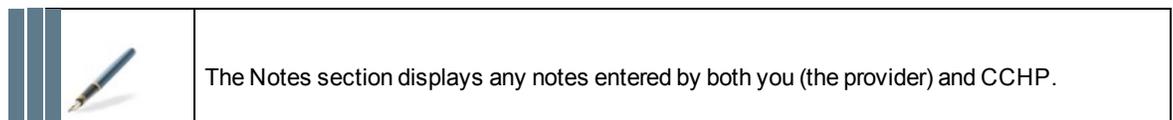
- If reference information is available for the definition, it appears as a number in parentheses at the end of the indication term. Select the number to view the reference, which appears in a separate window.
- You cannot add an indication note to an indication definition.

## 5.9 Re-document documented indications of a draft authorization request

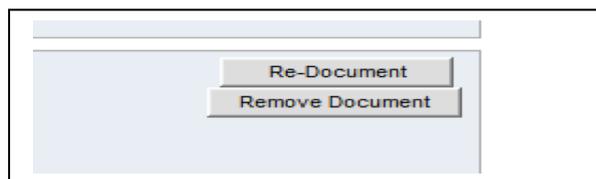
Open the Auto Authorization Queue page (select the **Auth Queue** tab).



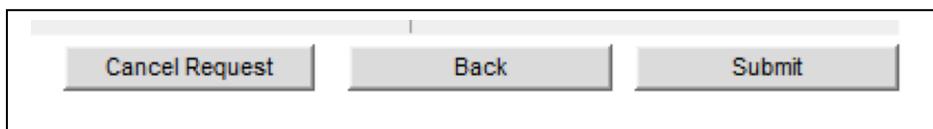
1. Set the Submission Status filter to Draft. The page displays all draft authorization requests. Select the authorization number link for the draft authorization request you want to re-evaluate. The Authorization Request page appears.
2. You can update the information on the Authorization Request Review page, if necessary, including adding more details that will be saved as notes.



3. Select the **Next** button. The Authorization Code Detail page opens.
4. You can update any additional information on this page if necessary.
5. Select the **Next** button. The Authorization Request Review page appears. The page displays a **Re-Document** button and a **Remove Document** button for each diagnosis or procedure code.



6. Select the **Re-Document** button for the diagnosis or procedure code that requires further annotation. The first Authorization Request Clinical Indication page appears.
7. Proceed through the pages to further annotate and document the authorization request as needed. When documentation is completed the Authorization Request Review page will appear.
8. Select the **Submit** button (on bottom right of screen).



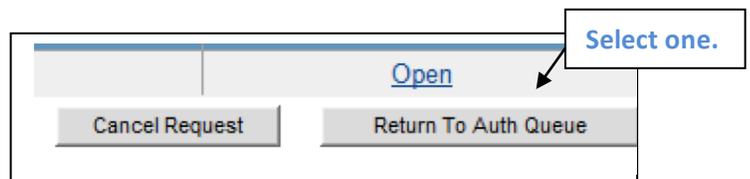


## 6 Submit a completed authorization request

Submitting your request to CCHP for evaluation is the final step in authorization request.

### 6.1 Submit a completed request for authorization

1. At the Authorization Request Review page (create the request, then document codes as required), select the **Submit** button. This submits the request to CCHP for review.
2. The page changes to Auto Authorization Response. The initial decision of CCHP appears in the Status column for each code.
3. Select **Return to Auth Queue**.



### 6.2 Cancel an authorization request

**For a draft** authorization request that has the requested codes documented:

1. On the Authorization Request Review page, select the **Cancel Request** button. A message appears, asking confirmation that you want to cancel the request and notifying you that this action will remove the request from the Auth Queue page.
2. Select **OK**, which will take you to the Auth Queue page, which does not display the request.

**For a submitted** authorization request:

1. On the Auto Authorization Response page, select the **Cancel Request** button. A message appears, asking confirmation that you want to cancel the request and notifying you that this action will remove the request from the Auth Queue page.
2. Select **OK**. You return to the Auth Queue page, which no longer displays the request.

## 6.3 Tips about submitting an authorization request

Once a request has been submitted:

- CCHP may automatically approve or deny the request based on the information you've provided
- CCHP may determine that your request requires additional review. In this case, you will see a status of **"Pended"** or **"No Decision Yet."** Contact CCHP with any questions about this type of request.
- May display one or more disclaimers, identified by the code submitted.



**Each code you have documented is evaluated separately, so you will receive an authorization decision for each of the codes submitted.**

- If CCHP has special code response fields, these appear on the Auto Authorization response page, in the Auto-Authorization panel and each procedure code panel, as applicable.

NoDecisionYet
Pended
Complete-Approved
Complete-Rejected
Complete-Partial
Not Processed

**"Not Processed" status may determine no authorization is required.**

# 7 Manage the authorization request queue

1. The Auto Authorization Queue shows you a history of all requests that are working drafts or have been submitted.

**Auto Authorization Queue**

Submission History

Filter By: NotFiltered

And: NotFiltered

Submission Status: Draft

1 (Results 1 - 49 of 49)

Summary of Draft Requests

Authorization	Servicing Provider	Requesting Provider	Patient	Service Code	Facility Name	Date of Submission	Date of Service	Status
EPS-00221790	Woods, Phillip N	Zernzack, Lance E	DOE, JANE	ICD9-D (765.15), CPT (90378)	Aurora Visiting Nurse Association of WI		11/03/2015	NoDecisionYet

2. From the Auto Authorization Queue page, you can:
  - See the current status of a request
  - See all requests you have submitted or are working drafts
  - View the information in the request
  - See which requests have messages (if secure messaging is enabled)
  - If external document attachment is enabled, manage external document attachments posted by CCHP.
3. You have the option to filter or limit your list, so that only certain requests are displayed.

**Authorization Queue**

**Auto Authorization Queue**

Submission History

Filter By: NotFiltered

And: NotFiltered

Submission Status: Draft

## 7.1 Find and review a request

1. Open the Auto Authorization Queue page (select the **Auth Queue** tab).
2. If wanted, set the filters so that you only see specific types of requests (draft or submitted).
3. From here, you can:
  - View the current status of the request in the Status column.
  - View the full authorization request by selecting the link in the Authorization column.
  - If the submission status is Draft, the Authorization Code Selection page opens.
  - If the submission status is Submitted, the Authorization Request Response page opens. This page displays the summary details of CCHP response, including the status for the authorization as a whole, and the status for each documented code.
  - Check if CCHP has sent a message regarding a request in the list.
  - Check if CCHP has attached external document regarding a request in the list.

## 7.2 Request status types

CCHP defines the request status types. The following table shows examples of common status types.

Status	Description
Pended	CCHP has received your request and determined that it requires further review.
No Decision Yet	A request that has been submitted for authorization, and has not yet received a decision from CCHP. It may be pending a review by CCHP. This status may also indicate that you have not yet submitted the request to CCHP.
Complete-Approved	CCHP has approved the authorization request.
Complete-Rejected	CCHP has denied the pre-authorization request.
Complete-Partial	CCHP has partially approved the pre-authorization request. One or more codes may not be approved or may not be approved for the quantities or time period requested.

## 7.3 About the authorization request ID number

The authorization request ID number identifies a specific authorization request. It is numbered according to CCHP's records, so the numbers that you see may not be sequential in your list. They are, however, unique and will not be used by any other CCHP providers. You can use this number to identify the request if you need to talk to CCHP about a request.

## 7.4 Filter the authorization request list

1. At the Auto Authorization Queue page (select the **Auth Queue** tab), select your first criteria in the **Filter by** list box. A blank text box appears.
2. Type or select the date, name, or status.
3. Select the next condition in the **And** list box, then provide the value you want to filter for.
4. Select the request status you want to filter for in the **Submission Status** list box, and then select **Filter**. The list of requests in the summary updates to reflect your filtering choices.

## 7.5 Tips for filtering your authorization request queue

- You have the option to filter or limit your queue so that only certain requests are displayed. You can select records with a specific:
  - Approval status
  - Requested date of service
  - Date the authorization request was submitted
  - Patient Name
  - Facility name
  - Request submission status (draft or submitted)
- You can filter by any three of the above conditions at the same time. For example, you can limit your request queue so that you can see only:
  - Draft requests for patients named Smith who are to be admitted to Mercy Hospital.
  - Requests submitted on 8/1/2010 that have been approved.
  - All requests with an anticipated admit date of 8/13/2010, whether approved or denied.

Authorization requests displayed in the queue must meet all of the conditions you specify in the filters. If you do not see the request you are looking for, try removing one or more of the filters, or make the filter more general. For example, rather than filtering for patients named "Smith," filter for patients named "Smi." Any patient whose name begins with "Smi" will be displayed - such as Smith, Smithe, or Smithey.

To see the entire list, select **"Unfiltered"** for each of the filter options.

The image shows two side-by-side screenshots of the 'Auto Authorization Queue' web interface. Both screenshots have a blue header with 'Auth Queue' and 'Auth Request' tabs. The main title is 'Authorization Queue' and 'Auto Authorization Queue'. Below the title is a 'Submission History' section with three filter options: 'Filter By', 'And', and 'Submission Status'. The left screenshot shows the 'Filter By' dropdown menu open, with 'NotFiltered' selected. The right screenshot shows the 'Submission Status' dropdown menu open, with 'Submitted' selected. Both screenshots show '1 (Results 1 - 188 of 188)' at the bottom.

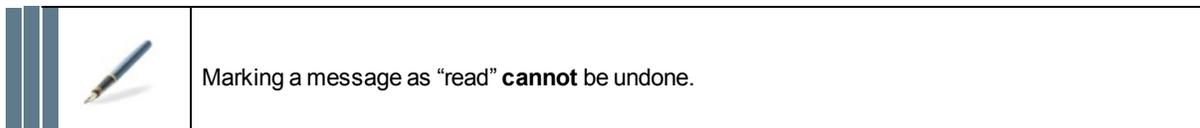
## 8 Manage authorization request messages

If secure messaging is enabled, you can manage messages sent to and received from CCHP, including requests for additional information. You can compose and send a message to CCHP at any time that you need to communicate about an authorization request, both before and after you submit the request.

Messages appear on the View Authorization Request Messages page in the order sent, with the most recent at the top.

## 8.1 View messages

1. In the Auto Authorization Queue, select the authorization number with a message icon. The Authorization Request Review page appears if the request has an unread message from CCHP that requests additional information. The Auto Authorization Response page appears if the request has no unread messages.
2. Select the **Messages** button, which displays the number of unread messages in parentheses. The View Authorization Request Messages window appears, displaying a list of messages.
3. Select the **Show all messages** option to display all messages for the authorization request, or select the **Show only Unread messages** option to view unread messages.
4. If necessary, use the scroll bar to view the text of a long message.
5. Select the **Mark as Read** link to indicate the message has been read.

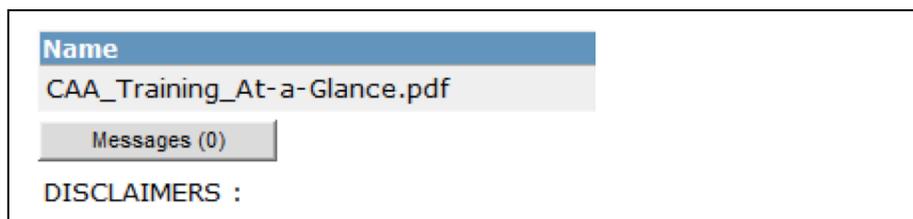


## 8.2 Reply to a message

1. On the Auto Authorization Queue page, select the authorization number with a message icon. The Authorization Request Review page appears if the request has an unread message from CCHP that requests additional information. The Auto Authorization Response page appears if the request has no unread messages.
2. Select the **Messages** button, which lists the number of unread messages in parentheses. The View Authorization Request Messages window appears, displaying a list of messages.
3. Select the Show all messages option to display all messages for the authorization request, or select the Show only Active messages option to view unread messages.
4. Select the Reply link for the message. The Message Composition window appears.
5. Type your reply and select the **Send** button. You return to the View Authorization Request Messages window, which displays your message at the top of the list.

## 8.3 Send a message

1. On the Auto Authorization Queue page, select the authorization number link. The Auto Authorization Response page appears.



2. Select the **Messages** button. The View Authorization Request Messages window appears.
3. Select the **Compose** button. The Message Composition window appears.
4. Type your message and select **Send**. You return to the View Authorization Request Messages window, which displays your message at the top of the list.

# Notes: