CareAffiliate®

User Guide Version 5.1.0

Client Support Contact Information

Client Community Website: https://login.salesforce.com

Call us at: 1-800-669-4629

Available between 5:00 AM and 5:30 PM PST

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Preface

About This Guide

This *CareAffiliate User Guide* is a comprehensive, module-oriented guide that describes how to use EXL Healthcare's provider portal. CareAffiliate is a part of the CareRadius suite of products. CareAffiliate integrates member data and connects remote providers to clinical staff for care collaboration and coordination.

This guide is organized by chapters that focus on a specific module within CareAffiliate. Each chapter contains a combination of conceptual and task-based topics.

The EXL Healthcare Documentation team strives to ensure that the technical documentation accurately reflects the functionality of your CareAffiliate version. Please call Client Support at 1-800-669-4629 with any documentation-related comments or questions.

Audience

This user guide is designed for managed care staff and providers to submit authorization and referral requests for services on behalf of a member and to manage member care.

This user guide is also for trainers, implementation staff, project managers, and business application analysts who are working with CareAffiliate user teams.

Assumptions

This user guide makes the following assumptions:

Prior Knowledge

You are familiar with the roles, responsibilities, and standard practices of your business area.

Security Profile

You have security privileges for all applicable modules and features.

System Configuration

Your system has all modules and features configured, including access to third-party programs and reports that have been specifically defined by your organization to support the health plan in meeting their business goals.

Online Help

This user guide is available in HTML-based online help within CareAffiliate. You can access online help from various areas of CareAffiliate in full and context-sensitive modes by clicking the question mark icon.

Full mode provides access to all help topics, and context-sensitive mode provides help topics specific to your current location in CareAffiliate.

EXL Healthcare Documentation

EXL Healthcare delivers, or provides on request, the following documentation with each CareRadius suite release:

CareRadius Install Guide

Describes CareRadius system architecture and hardware specifications for implementing CareRadius, including database set up, application-tier installation, presentation-tier installation, CareRadius utilities, and third-party installations.

CareConfig Application Configuration Guide

Describes how to configure CareRadius using CareConfig, with primary focus on custom features such as standard care plan, user-defined windows, surveys, note template assessments, Job Control System and XAct.

CareManage Application Configuration Guide

Describes how to configure CareRadius using CareManage covering a broad range of areas including all workflows in CareRadius, Job Engine, Client Subsystem, and Request Profiles.

CareRadius Mover Guide

Describes the process for moving several types of CareRadius configuration data from one environment to another, with consistent record conflict handling and the ability to initiate multiple movers simultaneously.

CareRadius User Guide

Describes how to use the workflows and features within CareRadius, such as authorizations and referrals, appeals and grievances, case and disease management, and more. This guide is also included within CareRadius as HTML-based online help.

CareRadius Reporting Guide

Includes information related to reporting including installation of tools, report processing and configuration, standard reports and letters, government-specific reports and letters, and dashboards.

CareRadius Dashboards Guide

Includes information related to dashboards including installation of tools and dashboard configuration, access, and usage.

CareRadius Developer Integration Guide

Includes information for outside developers to implement extensions to the CareRadius business logic.

CareRadius Batch Guide

Includes installation, developer integration, job queue management, and interface information for both batch and job processing. CareRadius Batch is a support tool for moving large data sets in and out of a CareRadius database and is an alternative to CareRadius XAct.

CareRadius Interface Guide

Includes installation instructions and information for the interface component options available for the CareRadius suite, with a focus on 278 processing using raw X12, X12 with extensions, and XML.

CareRadius Connect Guide

Describes how to set up and configure the CareRadius Connect add-on module in order to automate member outreach messages based on business objectives. This guide includes checklists, sample business objectives, and both custom and auto-messaging information.

CareRadius Direct Guide

Describes how to set up and use the CareRadius Direct add-on mobile application in order to perform surveys from a mobile device. See your EXL Healthcare representative for information about the CareRadius Direct application.

CareAffiliate Install Guide

Describes CareAffiliate system architecture and hardware specifications for implementing CareAffiliate including instructions for installing and configuring the CareAffiliate web application and supporting server environment.

CareAffiliate User Guide

Describes how to use the modules and features within CareAffiliate such as authorization submissions, program enrollment and care plan reviews, provider and member surveys, and more. This guide is also included within CareAffiliate as HTML-based online help.

CareAdvise Guide

Includes examples of ten standard disease state evidence-based and accreditation-compliant surveys and care plans along with information for importing surveys, care plans, and database queries. A bibliography for each disease state is also available in a separate document. See your EXL Healthcare representative for information about implementing CareAdvise.

JCS Guides

Administrative and Rules guides are available for the Job Control System (JCS) that runs rules and triggers events for CareRadius and CareAffiliate.

Job Engine Guides

Administrative and Rules guides are available for the Job Engine that runs rules and triggers events for CareRadius and CareAffiliate.

XAct Guides

An administrative guide is available for the XAct application that moves large data sets in and out of the CareRadius database.

Release Notes

A combination of Excel files that describe new features, technical changes, and corrected issues.

NOTE: Guides for CareRadius utilities are also included in each CareRadius release.

Getting Started

CareAffiliate Overview

CareAffiliate is a web-based care management solution that allows managed care staff and providers to interact over the Internet by providing direct access to specific information in the database for the member's health plan or Managed Care Organization (MCO).

CareAffiliate includes the following features:

- Authorization Submissions
- Referral Submissions
- Eligibility and Benefits Verification
- Appeals
- Program Enrollment and Member Care Plan Reviews
- Clinical Criteria Assessments
- Member Surveys
- Inquiry and Reporting

Logging on to CareAffiliate

The CareAffiliate logon process can vary by site, depending on your organization's business needs. If your logon process differs from the one below, see your System Administrator.

1) Use your organization's Internet browser to open CareAffiliate.

   NOTE: The link or icon used to access CareAffiliate may vary for each organization.

   Major upgrades in supported third-party products can occasionally cause compatibility issues with other applications. Before implementing full version product upgrades, please contact EXL Healthcare to ensure compatibility with CareAffiliate.

2) Enter your user name and password.

   User names and passwords are assigned by the MCO with which you are associated and uniquely identify you as an authorized user of CareAffiliate. Passwords are case sensitive.

3) Click **Log In**.

If you are not identified as an authorized CareAffiliate user, an error message appears.

The following conditions may prevent access to CareAffiliate:

- Your account has time restrictions based on the day or week.
- Your account has expired.
- Your account is locked, either due to specific lock out or by too many failed logon attempts.
- Your account has insufficient security privileges.

After a period of inactivity, your CareAffiliate session time outs and you are automatically logged out of CareAffiliate. You need to log back on to Care-Affiliate to continue working. Information entered prior to submitting an authorization or referral may be lost.

Contact the administrative provider for your facility, organization, or office for further help with logging on or session timeouts.

Opening and logging on to CareAffiliate in tabbed browsers is treated as a single log on by CareAffiliate. When you open a new browser instance and log on, it is viewed as a new CareAffiliate session. The total number of simultaneous CareAffiliate sessions you can have open at one time is configured for your system. When you exceed the maximum number sessions allowed for your account, a dialog box appears with the Login Time values for your account's open sessions.

When the Too Many Sessions Open dialog box appears, choose one of the following actions:

- Select the check box(es) to the left of the Login Time column or select the **Login Time** check box to select all check boxes, and then click **Close Selected Session(s)**.

  —OR—

- Click **Cancel** to end the current logon attempt and automatically return to the Log In window. Close the current browser instance and return to your previous CareAffiliate session in the original browser instance.

If you close a current CareAffiliate session by closing the browser window or using the browser's **Back** button, the session only closes when it reaches the configured time-out limit. To immediately close a current session, use one of the two methods described above.

CareAffiliate Home Page

The Home page opens after you log on to CareAffiliate.

The Home page includes the following features:

Toolbar

Displays links to each module in CareAffiliate. If you do not have security privileges to view a module, the module link does not appear on the toolbar. The toolbar also includes a **Help** link.

Member Search

Allows you to search for and retrieve member records.

Image Carousel

Displays images as configured by your site.

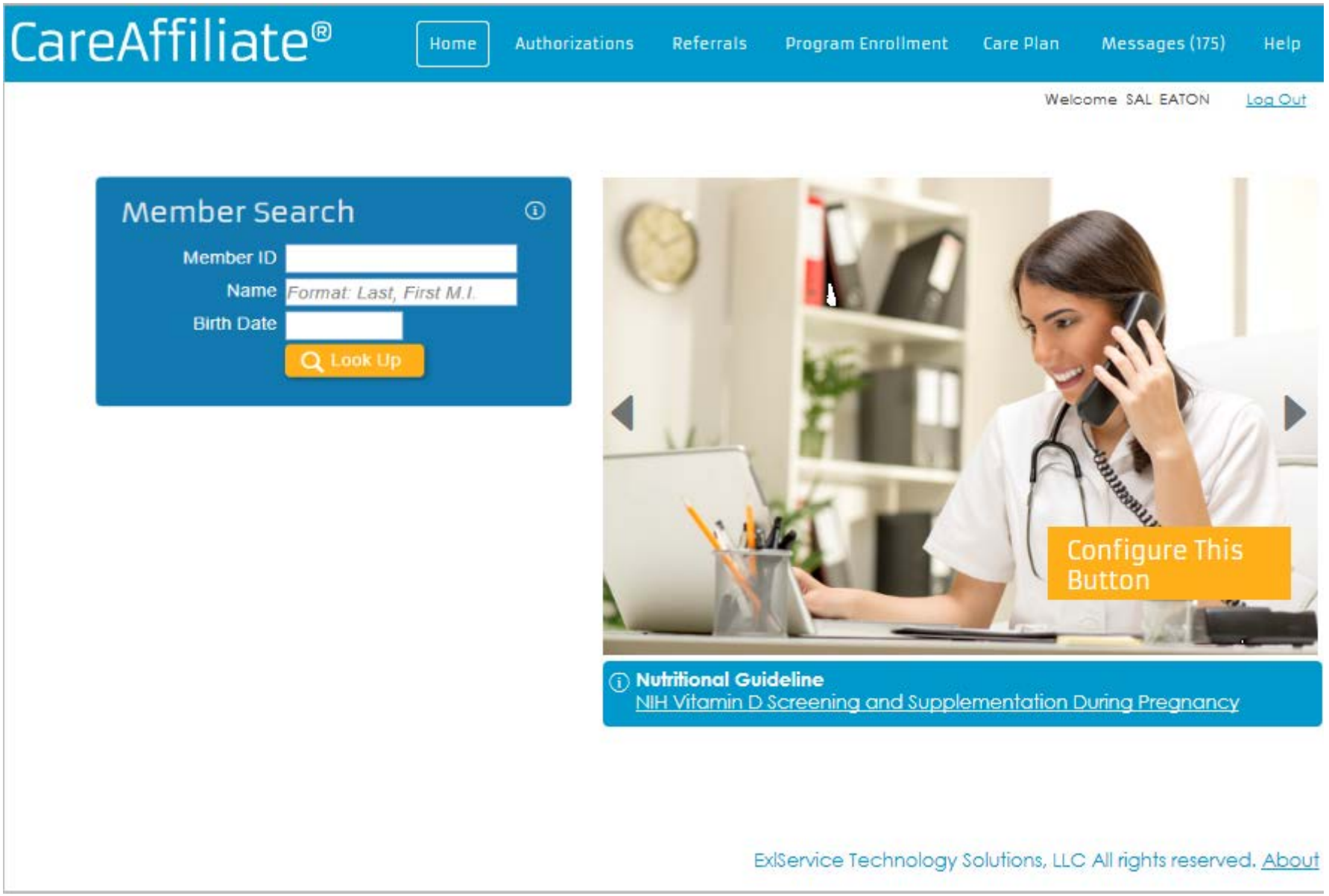
Information Icon

Displays help information configured by your site.

In-line Help

Displays in-line help information configured by your site.

The following image shows an example Home page:



The following logic and validation rules apply to member searches on the Home page, workflow record searches, and when creating new workflow records:

- If you perform a search on the Member ID field only, and multiple matches are identified, then the Member Name value must be included in the search.
- If you perform a search on the Member ID and Member Name fields only, and a member record is not identified, then the Birth Date value must be included in the search.
- If you perform a search on the Member ID, Member Name, and Birth Date, and a member is not identified, then the Member Search dialog box automatically opens so you can further refine your search criteria.

NOTE: The member record displays for all one-to-one matches. For example, if you enter a Member ID and it identifies a single member, then the member record is retrieved and displays the member's name and date of birth.

CareAffiliate Documentation

CareAffiliate contains online help and comes with a user guide in a Portable Document Format (PDF).

- Click the **Help** link on the toolbar to open the context-sensitive online help specific to your location in CareAffiliate.

  NOTE: If you choose to print an online help page, ensure that your print settings are set to fit to page.
- Navigate to your CareAffiliate directory to open the *CareAffiliate User Guide*.

Custom Help

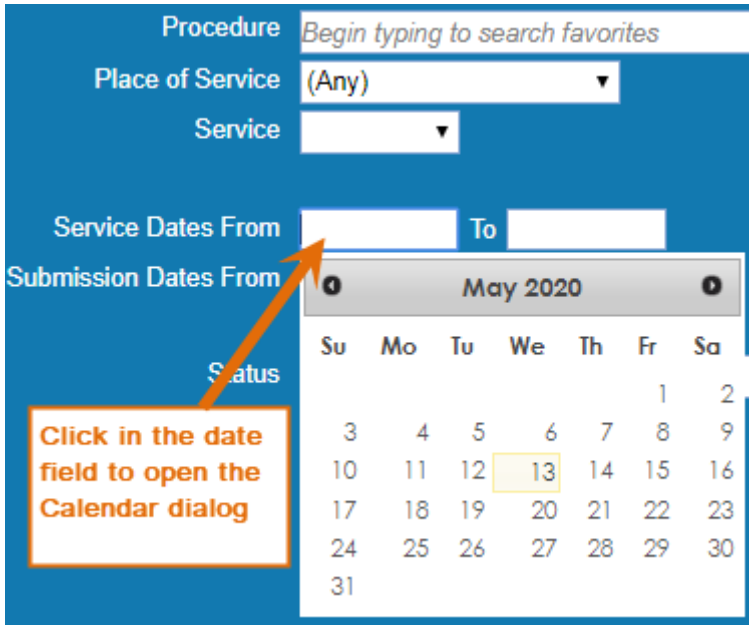
Custom help information may appear as in-line text next to a field, or as an Information icon ( ) next to various notes and other fields on the Home page and in the Authorizations, Referrals, or Appeals modules, depending on your configuration. Custom help conveys information that helps you complete your work and it may include links to websites that contain additional information.

When you click an Information icon for non-in-line Custom Help, a Custom Help dialog box displays below the Information icon with the custom text configured by your organization.

Calendar Dialog Boxes

When you click inside most date fields, a calendar automatically opens so you can select a date. Areas of CareAffiliate that do not automatically open a calendar have a standard Calendar icon for selecting dates.

The following image shows the calendar dialog box:



RELATED LINKS:

Entering Dates

Entering Time

Entering Dates

You can enter dates with keyboard shortcuts.

- Type **t**or **T** in the date field, and then press the **Tab** key to automatically enter the current month, day, and year.
- Use numbers in conjunction with **t** to indicate previous or future dates.

- Use the minus sign (-) to indicate a date in the past and a plus (+) sign to indicate a date in the future.
- Use the letters **w, m,** and **y** to represent week, month, and year.

The following table contains example of keyboard shortcuts for entering dates:

Date	Keyboard Shortcut
One week ago.	Type **t-7** and press the **Tab** key. or Type **t-1w**and press **Tab** key.
One week from today.	Type **t+7** or **t7** and press the **Tab** key. or Type **t+1w** and press the Tab key.
Three months from today.	Type **t+3m** or **t3m** and press the **Tab** key.

Date fields accept one or two-digit numbers, slashes or dashes, periods, and spaces as delimiters. If the year is omitted, the current year is assumed and all dates are validated for month and day of month correctness. Leap years are also taken into account.

You can enter months using three-digit abbreviations. For example, 7/5/02, 07-05-2002, JUL/5, and 7.5 would all be interpreted as July 5, 2002 if entered any time in the year 2002.

Entering Time

Dates and times are represented by the logged-on user's time zone when you create, display, and update data.

- Type **n** or **N** in the **Time** field and press the **Tab** key to enter the current time.

The letter **n** represents **Now** and automatically enters the current time.

Time appears as a 12 hour or 24-hour value (3:00pm and 15:00) as configured in CareManage.

You can enter a time value using any of the following formats: 1500, 15:00, 3p, 3pm.

Type-Ahead Functionality

You can enter text directly in the drop-down list and provider fields automatically display a list of values that match the text.

NOTE: Fields with type-ahead functionality include a watermark that says, "Begin typing to search for favorites."

For example, if you type "adm" in the **Place of Service** drop-down list, **Admission Review** displays as a possible value. Type-ahead text is not case sensitive and can display up to 10 text matches.

When you enter text in a keyword search field, each space between the text entered indicates a new keyword. For example, if you enter "davis, a" into the field, the search looks for two keyword matches: "davis" and "a". A wildcard is always added to the last keyword, so the "a" that was entered searches for records that include an "a" in them.

Entering text in a keyword search field and then pressing the **Tab** key automatically opens a search dialog box, allowing you to enter values to refine your search.

Type-ahead-enabled **Provider** fields display separate results lists for the following provider types:

- Requesting Providers (self-affiliated person providers or facility providers and person providers affiliated to groups)
- Requesting Group (self-affiliated groups)
- Requested (Service) Provider (self-affiliated person providers and providers affiliated to groups)
- Requested (Service) Group (self-affiliated groups)
- Requested (Service) Facility (self-affiliated facilities/vendor)
- Requesting Provider/Facility
- Provider (for the Service)
- Procedure
- Specialty

NOTE: Available values appear in the drop-down display for values that have been selected on previously-submitted records.

Search Dialog Boxes

Use Search dialog boxes to search for specific data. Search-enabled fields have linked field labels or a Lookup icon to the right of the field.

The following list explains CareAffiliate search features and functions:

- Click a linked field label that has a value to view information about the field value.
- Click a Lookup icon to open a Search dialog box with available fields for searches.
- When you select a value from Search dialog box results, the Search dialog box closes and the value you selected automatically appears in the field that initiated the search.
- Searches are not case sensitive.
- A wildcard is a symbol that represents one or more characters and is used to supply partial information in a field.
  - Acceptable wildcards are typically the asterisk (*) or percent symbol (%) and are determined by your MCO.
  - You can use wildcards in any search with a configurable required minimum number (the default is five) characters.
- You can begin a search by entering either full or partial text and pressing the **Tab** key to automatically open a Search dialog box that initiates a search for an exact match.
  - You must enter a configurable minimum number of characters, excluding wildcards, to perform a search with partial text.
- You can click a Lookup icon next to a field to open a Search dialog box.
- When you enter partial text in a type-ahead-enabled field and then press the **Tab** key, the associated Search dialog box opens but does not display the partial text as it does for non-type-ahead-enabled fields.
- Searches automatically perform under an assumed wildcard function for the following lookup-enabled fields:
  - Member ID
  - Provider/Group
  - Specialty
  - Diagnosis
  - Procedure
  - Facility ID

    For example, entering a Member ID value of “12345” and pressing the **Tab** key performs a search for a Member ID that exactly matches “12345.” If no results are found that match “12345,” then a search begins for Member IDs that match a double wildcard entry, such as “*12345*”, where * is the wildcard character.
- Searches using the **Reference #** field must include an exact match, or you must manually enter a wildcard to perform a wildcard search.

- For code/ID fields and other fields, CareAffiliate searches for an exact match for the numeric values first, and if that is not found, CareAffiliate searches for records that include the numeric value followed by a wildcard.

  For example, entering “12” in the **Other ID** field in the Provider/Group Affiliation Selection dialog box results in a search for member IDs that are exactly “12”, and if that exact match is not found, the search continues to look for member IDs with “12*”.

- Description field searches automatically include the double wildcard search, such as when you enter “an”, if an exact match is not found, the system searches for “*an*”.
- To perform a search from a **Name** field using wildcard functionality, you must manually enter the wildcard character.
- To perform a search from a **Birth Date** field provide the correct value in the field. The Birth Date field narrows the search results and helps you retrieve member records faster.

  NOTE: An Exact match cannot be identified by just the Birth Date field. All three fields must be correctly filled for an exact match to be identified.

RELATED LINKS:

Member Search Dialog Box

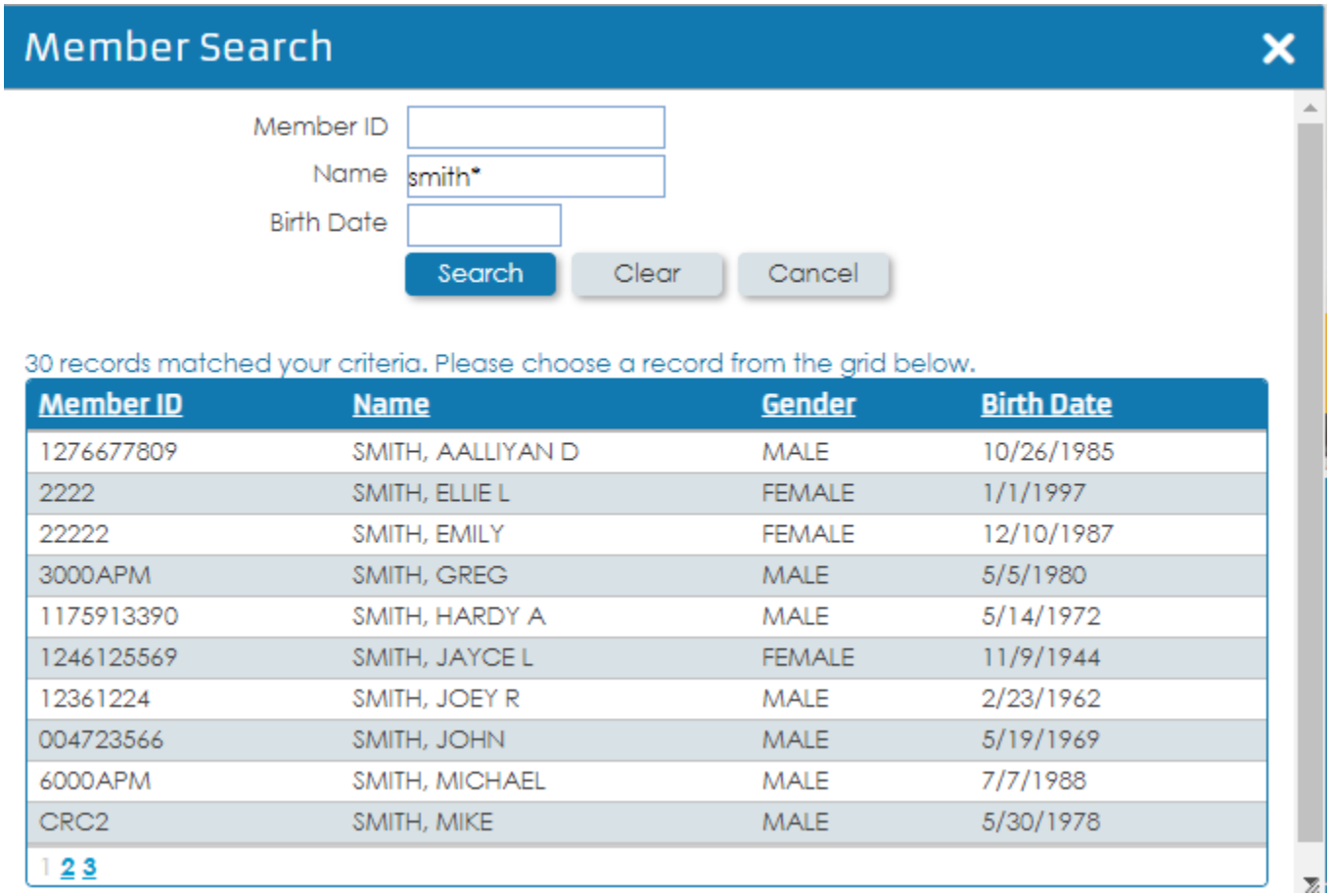
Provider Search Dialog Box

Member Search Dialog Box

Use the Member Search dialog box to search for a member.

Member ID values that appear in the search results and in the **Member ID** fields throughout CareAffiliate might display as ID Unavailable if CareAffiliate is configured to limit certain member ID types or if those member ID types are not populated for the member record.

The following image shows the Member Search dialog box:



For a successful search, you must provide correct values in the Member ID, Name and Birth Date fields. If any two fields, out of the Member ID, Name, and Birth Date fields, are correctly entered and a direct match is found, then the empty field is auto-populated and the Search Results multirow displays.

NOTE: An Exact match cannot be identified by just the Birth Date field. All three fields must be correctly filled for an exact match to be identified.

Provider Search Dialog Box

You can use provider search dialog boxes to retrieve search results for providers, provider groups, and facilities. Use the Lookup icon next to a provider field to open a provider search dialog box.

You can use a variety of criteria to perform a search. For example, in the *Provider Location Search* dialog box, you can search by provider type, provider ID, name, other ID, and more. Usually, a search requires at least two values. Depending on the provider field, provider search results may vary to include different types of providers.

Selecting a Provider Network

You can include a Network field value as part of your provider location search criteria to limit your search results to include in-network providers.

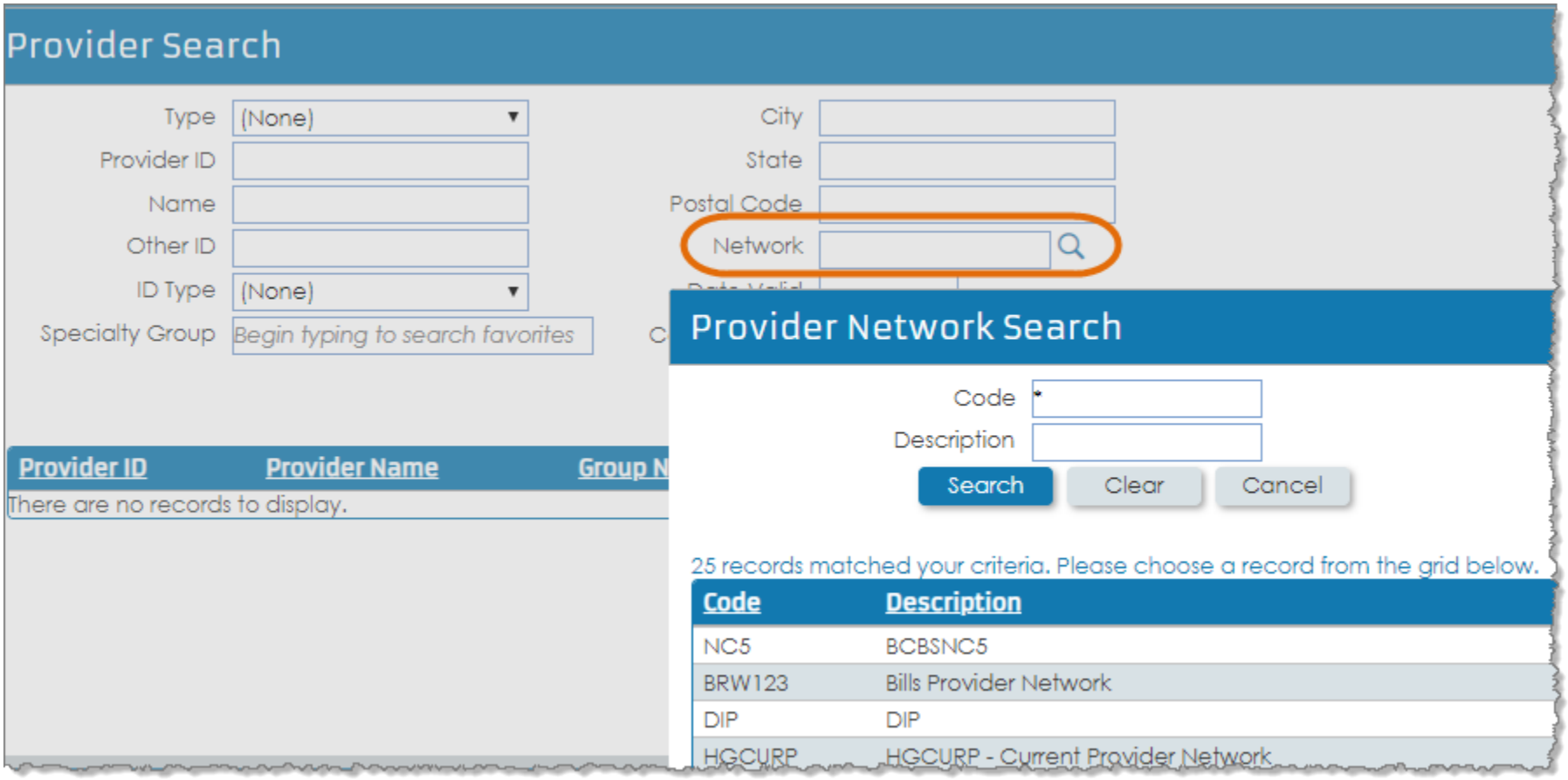
NOTE: Depending on your system configuration, the **Network** field might automatically populate with the network associated with the member's default plan. The **Network** field might also be disabled.

1) From the Provider Location Search dialog box, click the Lookup icon next to the **Network** field.

   The Provider Network Search dialog box opens.

2) Enter values in the **Code** and/or **Description** fields.

3) Click **Search**.



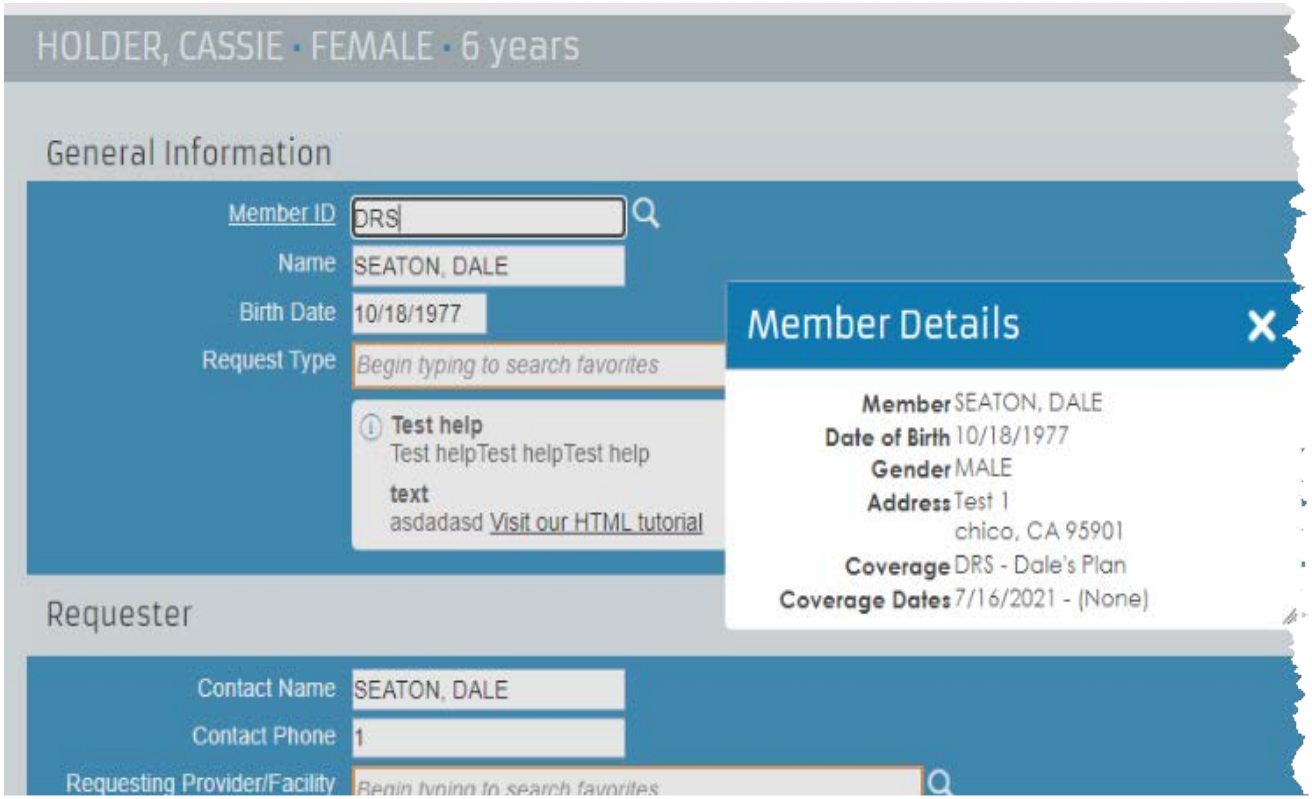
4) Click a search result.

The Provider Network Search dialog box automatically closes and CareAffiliate populates the **Network** field in the Provider Location Search dialog box.

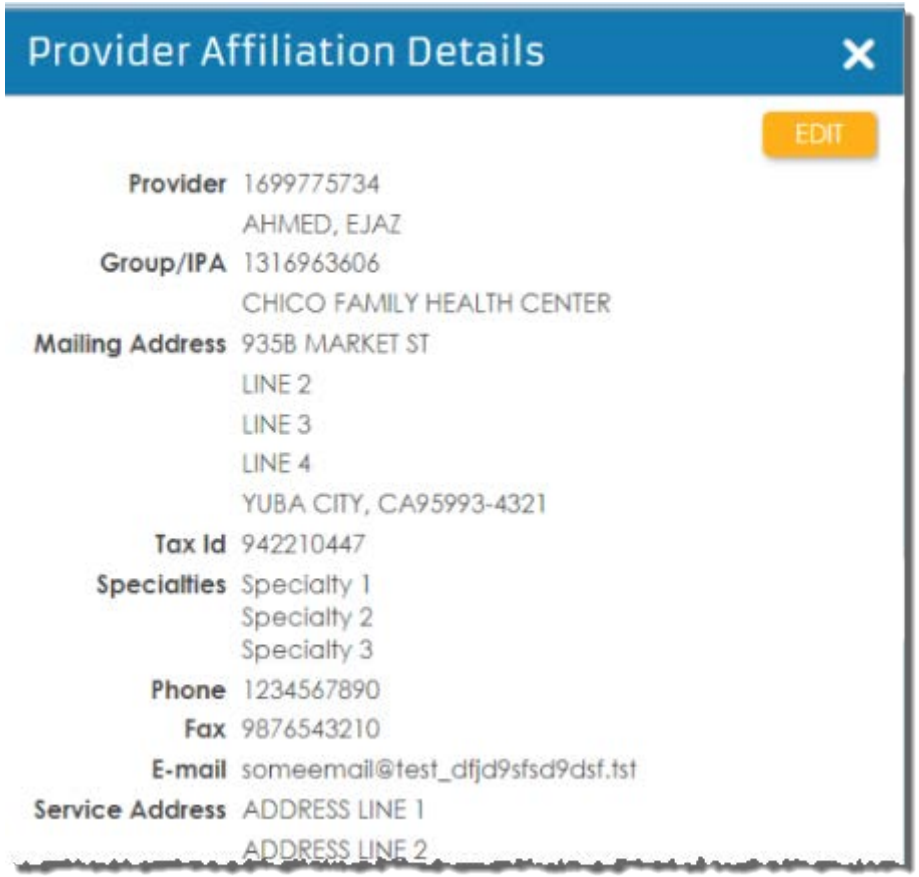
Detail Dialog Boxes

Linked field labels open details dialog boxes with information about the associated field.

- Click the **Member ID** link to open the Member Details dialog box.



- Click the **Requesting Provider/Facility** or **Requesting Group** link to open the Provider Affiliation Details dialog box.



- When accessed from the Authorizations, Referrals, or Appeals modules, and Edit button is available which allows you to open the Provider Affiliation Details dialog box in Edit mode.
- In Edit mode, you can modify the Phone, Fax, E-mail, Cell and Address values.
- In Edit mode, the Provider Affiliate Details dialog box displays additional fields for Cell, Fax, E-mail and Address field (Line 2), City, State and Postal Code.
- You can hover over the Requesting Provider/Facility field label to display a tooltip that indicates whether you can view or edit and view provider details.

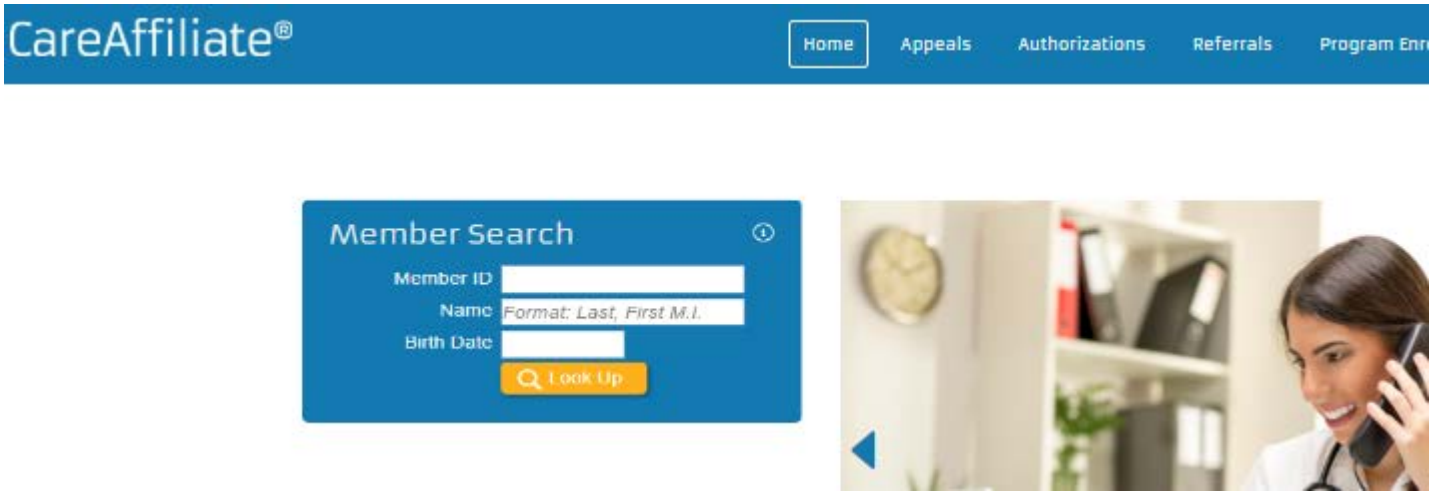
NOTE: The provider's Tax ID displays, but when other provider ID types are configured to be included in Tax ID searches, a row for each of those provider ID types displays beneath the Tax ID value.

Diagnosis Details dialog boxes include the diagnosis Code, Type, Description, Gender, and Age Range, if available.

Member Search Portlet

Use the Member Search portlet on the Home page to search and retrieve all records and messages associated with a member record for which you have the appropriate level of security.

The following image shows the Member Search portlet:



When CareAffiliate retrieves a member record, all authorization, referral, care plan, and survey records associated with the member appear as links to the specified module.

Searching for a Member Record

You can search for and retrieve a member record from the Member Search portlet.

1) Enter the Member ID, Name or Birth Date in the **Member ID**, **Name** or **Birth Date** field.

   You can also enter a partial value, enter a partial value with a wildcard, or click **Look Up** to search for a member.

2) Click **Look Up**.

   Search results appear in a multirow.

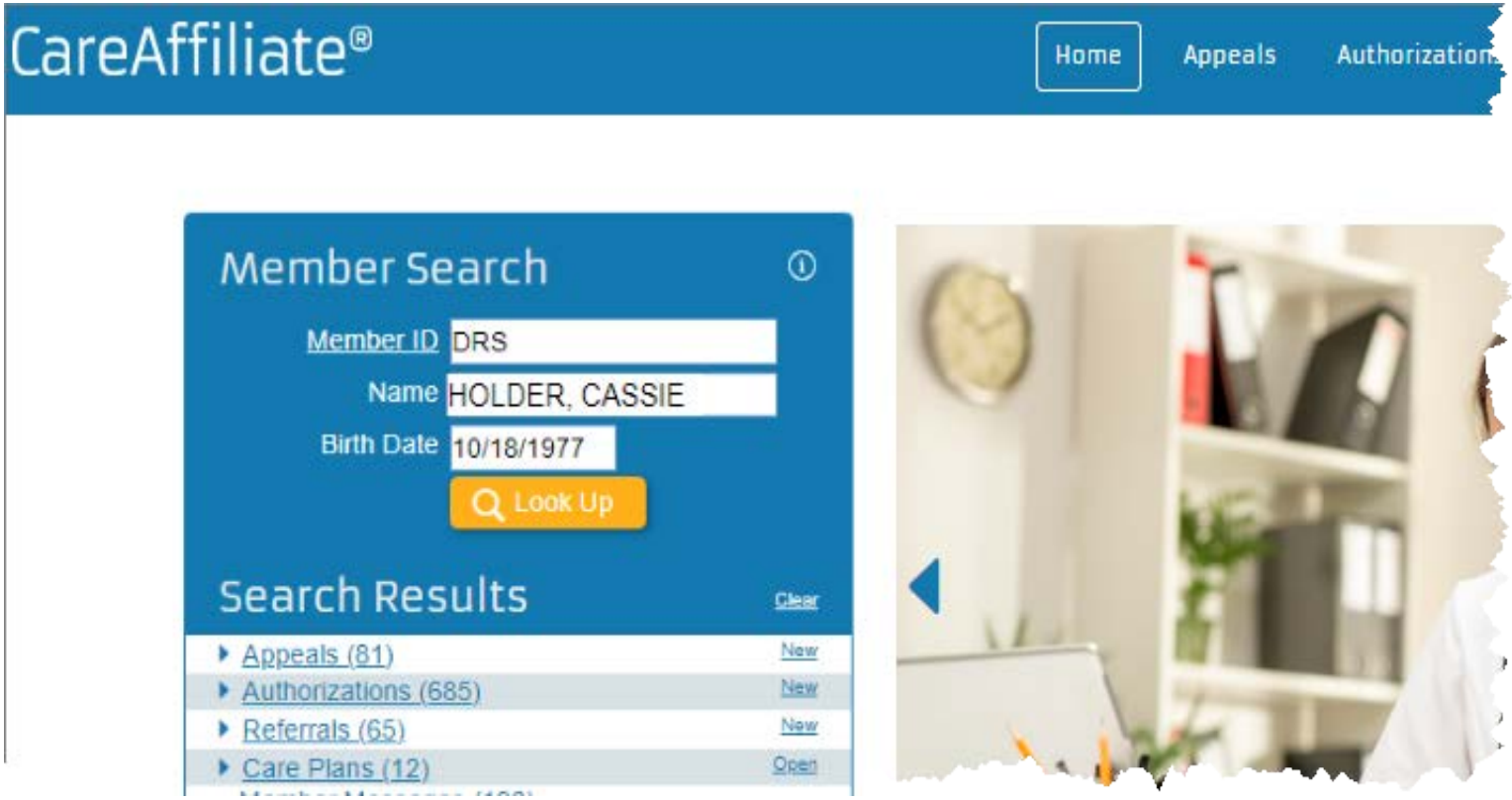
Member Search Results

When you perform a search, the Member Search portlet displays all records for the selected member, organized by module, in the Search Results multirow. Each module label is followed by a number that indicates the number of records within the module.

You can perform the following tasks in the Search Results multirow:

- Click the Expand arrow to view active links to the member's record within each module.
- Click **Clear** to clear search results and enter new information in the member search fields.
- Click **New** to open the module and create a new record.

The following image shows the Search Results multirow:



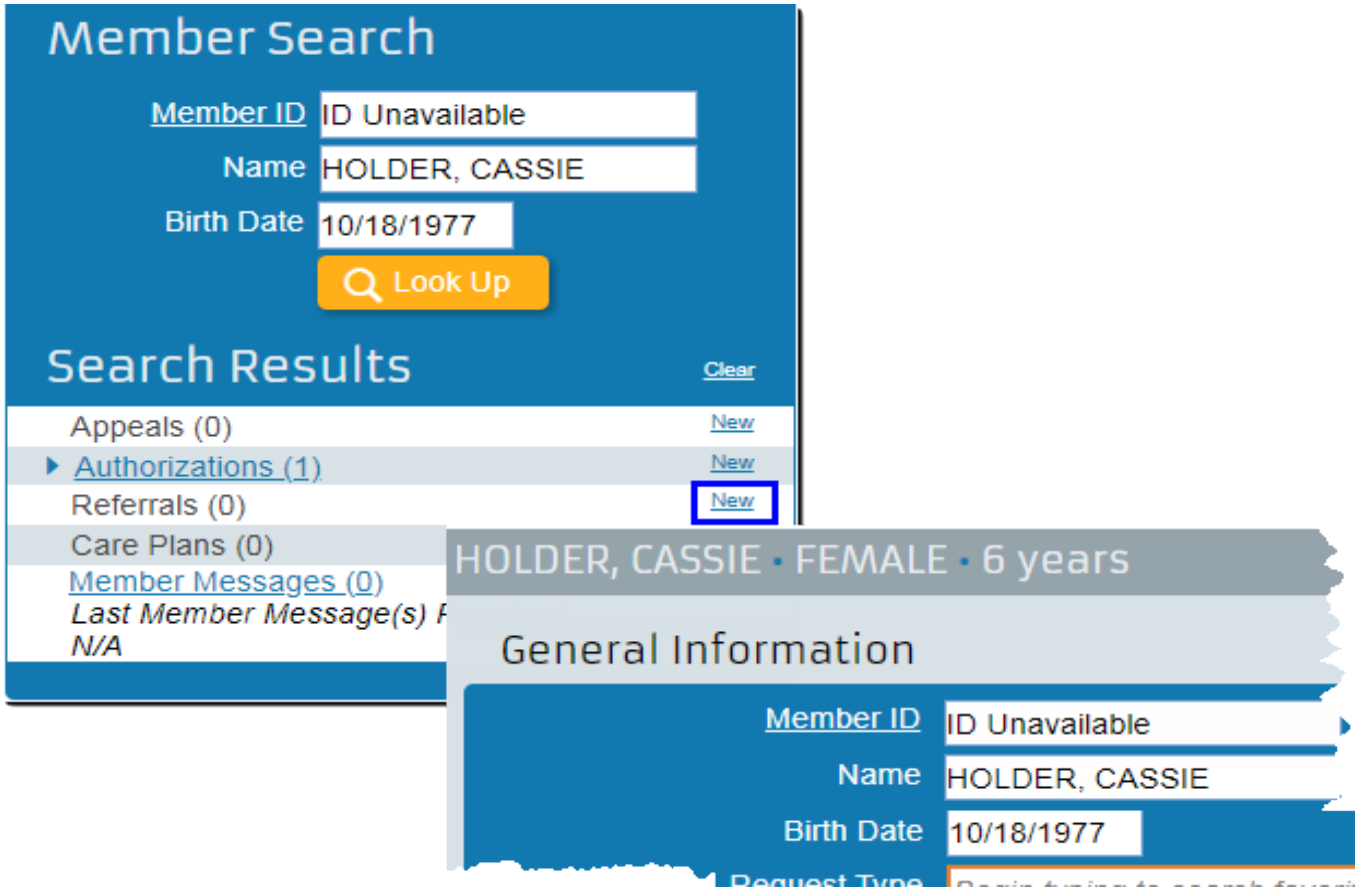
Adding a New Record from the Member Search Portlet

Each module label in the Search Results multirow has a **New** link that allows you to initiate a new record for the specific module with the member's information defaulted in the new record.

- Click a **New** link to open the module and begin creating a new record.

For example, click **New** next to the **Referrals** link to open the Referrals module and initiate a new referral request.

The following image shows the Referrals page that opens with the Member's ID, Name and Birth Date defaulted:



NOTE: You cannot initiate a new care plan from the Member Search portlet. An **Open** link is available for opening the Care Plan module where you can review and edit all care plans associated with the selected member record.

Messages

Messages

Messages are the primary means of receiving communication within CareAffiliate. Your MCO may send you messages and statuses for members. Messages can be for multiple members and all messages appear on the Messages page.

The Messages page contains the following features:

Inbox

Contains member messages and indicates the number of unread messages.

Archive

Archives messages and indicates the number of unread messages that have been archived. Archived messages cannot be reinstated.

Include Member Messages

Displays member-related messages in the inbox.

Mark as unread

Marks the selected messages as unread.

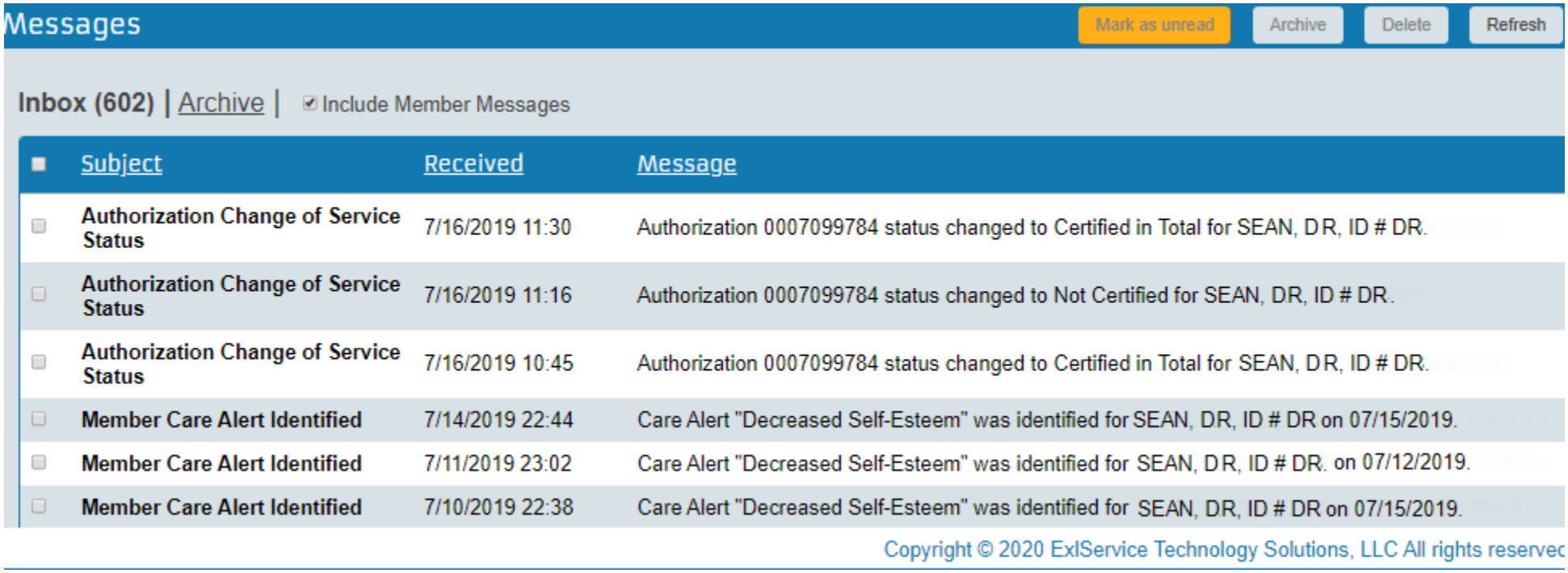
Delete

Deletes the selected message.

Refresh

Refreshes the Inbox messages list.

The following image shows the Messages page with the Inbox open:



Your Messages page receives secure communications from your MCO only. You cannot receive communication from regular e-mail accounts, and you are not able to send messages from CareAffiliate.

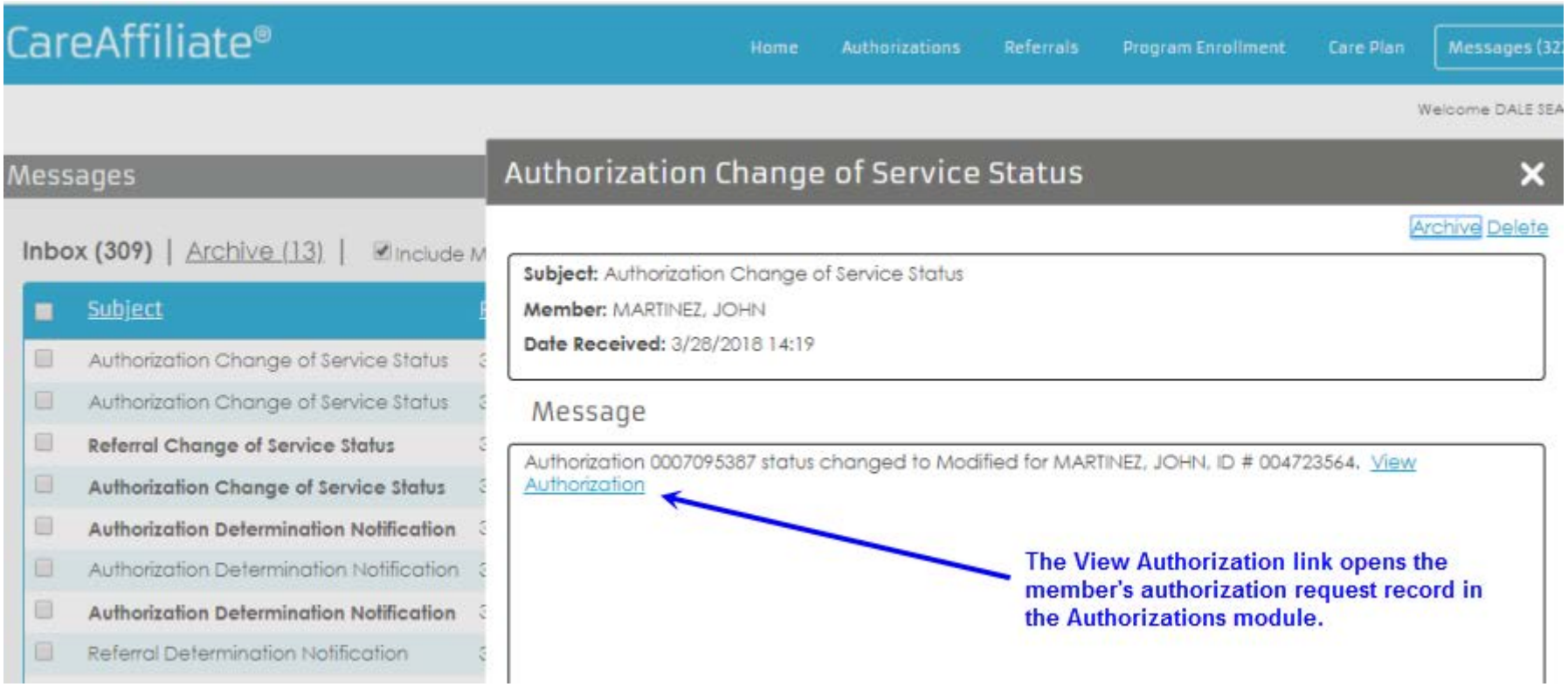
Accessing Member Messages

You can access member messages from the toolbar or the Member Search portlet.

- From the toolbar, click **Messages**.
- From the Member Search portlet, click the **Member Messages** link after you have retrieved a member record.

Each item in the Messages page is sorted in descending order by date and time and displays the first few words of the message. If a message is unread, the Subject appears in bold.

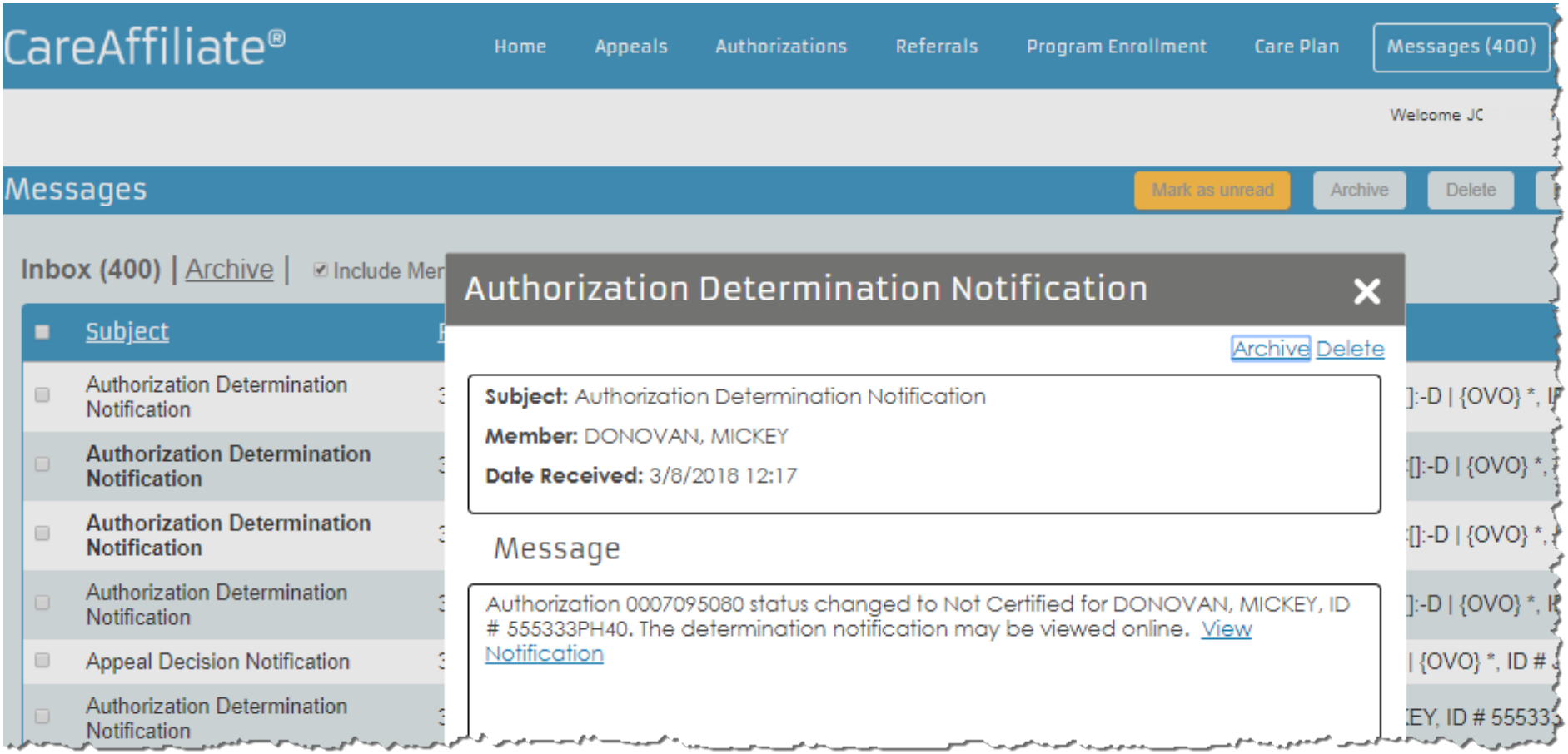
NOTE: Messages can also contain links that open modules that are relevant to the e-mail message.



Decision Letters and Notifications

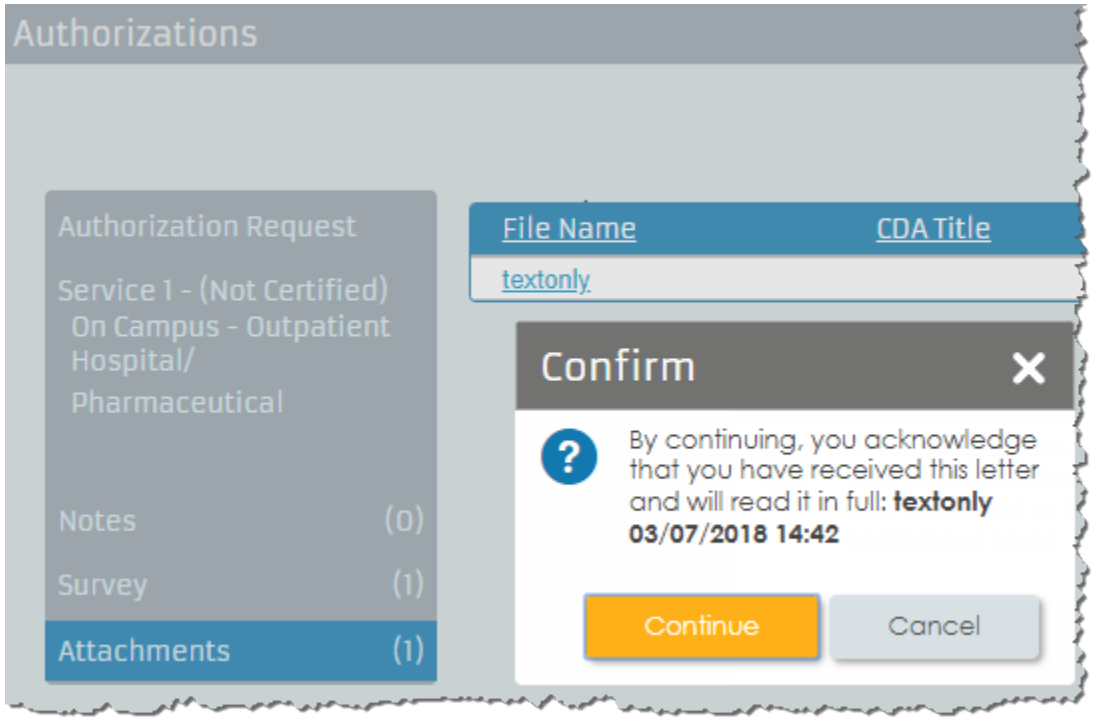
Decision or determination notifications are presented in the Messages queue when the MCO or health plan in CareRadius makes a determination or about an authorization, referral, or appeal request record.

The notification dialog box includes a View Notification link that opens the notification/decision letter on the Attachments page of the appropriate module.



The following features and actions are available for Appeal Decision and Authorization/Referral notifications:

- Click the File Name link on the Attachments page to display a confirmation dialog box that forces an acknowledgment of receipt of the notification.



- Click **Continue** in the Confirm dialog box, a pdf file is generated and available for viewing and printing.

Authorizations and Referrals Modules

Authorizations and Referrals Modules Overview

CareAffiliate allows primary care providers (PCP) to submit and respond to authorization and referral requests using the Authorizations and Referrals modules. Your MCO predetermines the necessary fields for you to complete each type of request.

IMPORTANT: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

The following diagram shows the CareAffiliate workflow for authorization and referral requests:

You can perform the following tasks in the Authorizations and Referrals modules:

- Create an authorization or referral request.
- Perform a pre-authorization check to determine if a request is required.
- Check for potential duplicate authorization or referral request records.
- Search for authorization or referral request records.
- Edit authorization or referral request records.

Authorization Requests

Authorization requests are submitted on behalf of a member in need of services.

For example, an admitting physician in a hospital might request an authorization for bypass surgery and follow-up care. For some plans, the PCP must submit an authorization request in order for the health plan or MCO to provide payment for the service.

Referral Requests

Referral requests are submitted on behalf of a member in need of services from a specialist provider, such as a dermatologist.

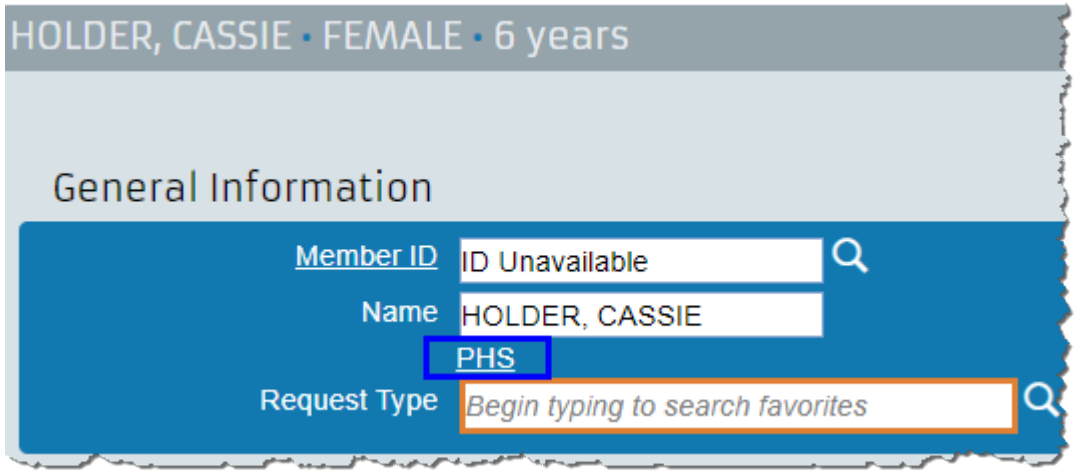
When a PCP (Primary Care Physician) makes a referral, the referring PCP is informing the MCO that the referred provider has permission to submit authorization requests for the member. In most cases, the MCO keeps the referral only for future reference.

Patient Health Summary Report

The Patient Health Summary (PHS) report provides a summary of health information based on the data available for the member and your site's configuration of the report.

NOTE: The name of this report is configurable and determined by the MCO.

- To open the PHS report, click the **PHS** link that appears after you enter a member's name in the **Name** field of the General Information field group or in the Member Search portlet.



The report opens as a PDF in a separate browser window.

Depending on the member and your security privileges, multiple member health reports might be available and appear as links below the **Name** field.

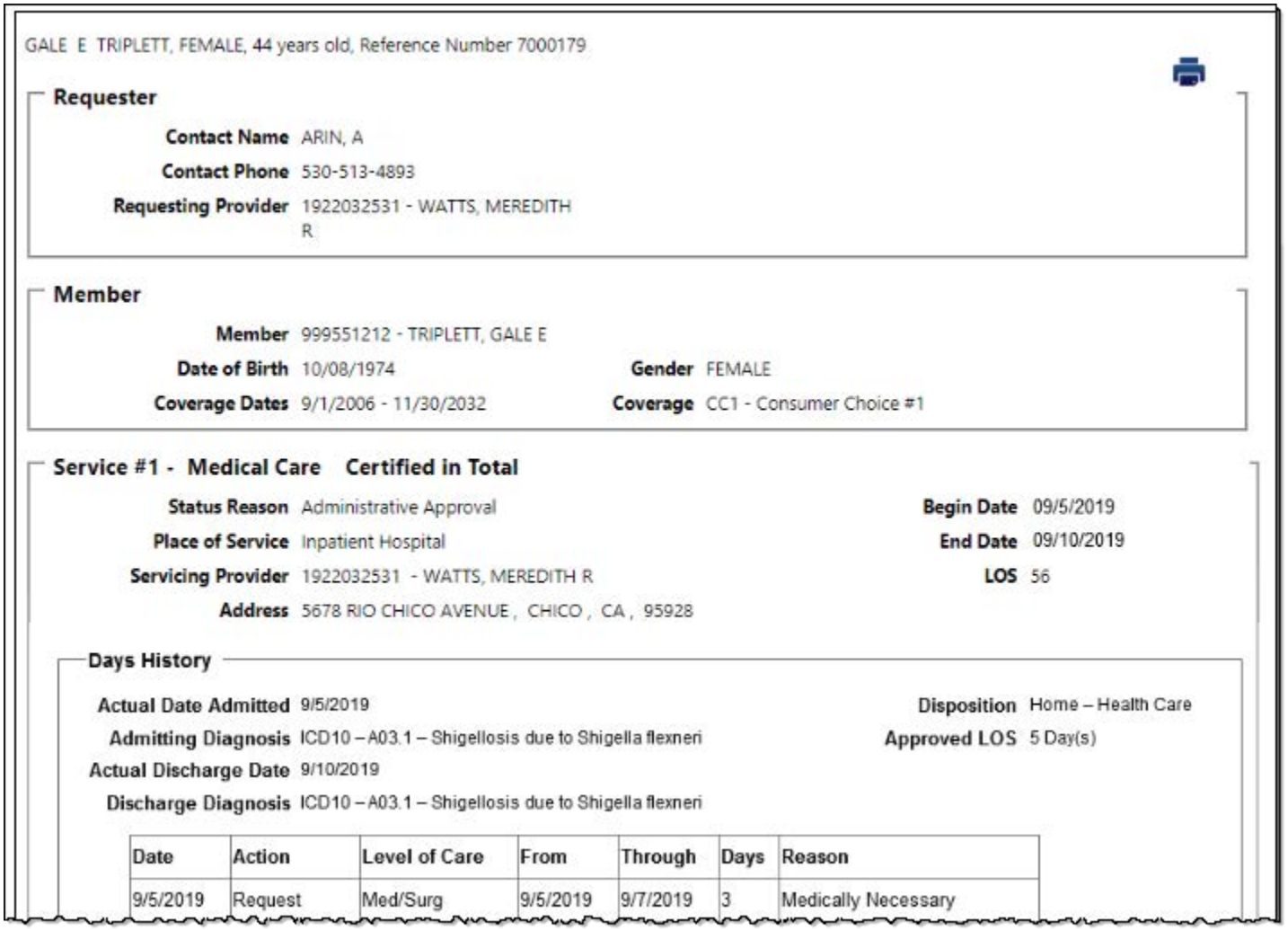
Standard information includes a patient demographics section with the member's ID, name, date of birth, gender, contact information, the date the report was generated, and the earliest date from which the report's data has been provided.

NOTE: You must have Adobe® Acrobat® Reader version 8.2 or higher installed on your machine to view the PHS report PDF. Also, if your browser has a disable pop-up window function, you might need to enable pop-ups in order to display the PHS report in a new browser window.

Printing an Authorization Request

You can display and print a report of an authorization or referral request in a new browser window, by clicking the Print button on the main toolbar.

NOTE: Inpatient and Outpatient Details information are not included in the report for referrals. The following image is an example of an authorization request report:



GALE E TRIPLETT, FEMALE, 44 years old, Reference Number 7000179

Requester

Contact Name ARIN, A
Contact Phone 530-513-4893
Requesting Provider 1922032531 - WATTS, MEREDITH R

Member

Member 999551212 - TRIPLETT, GALE E
Date of Birth 10/08/1974 **Gender** FEMALE
Coverage Dates 9/1/2006 - 11/30/2032 **Coverage** CC1 - Consumer Choice #1

Service #1 - Medical Care Certified in Total

Status Reason Administrative Approval **Begin Date** 09/5/2019
Place of Service Inpatient Hospital **End Date** 09/10/2019
Servicing Provider 1922032531 - WATTS, MEREDITH R **LOS** 56
Address 5678 RIO CHICO AVENUE , CHICO , CA , 95928

Days History

Actual Date Admitted 9/5/2019 **Disposition** Home – Health Care
Admitting Diagnosis ICD10 – A03.1 – Shigellosis due to Shigella flexneri **Approved LOS** 5 Day(s)
Actual Discharge Date 9/10/2019
Discharge Diagnosis ICD10 – A03.1 – Shigellosis due to Shigella flexneri

Date	Action	Level of Care	From	Through	Days	Reason
9/5/2019	Request	Med/Surg	9/5/2019	9/7/2019	3	Medically Necessary

Searching for an Authorization/Referral Request

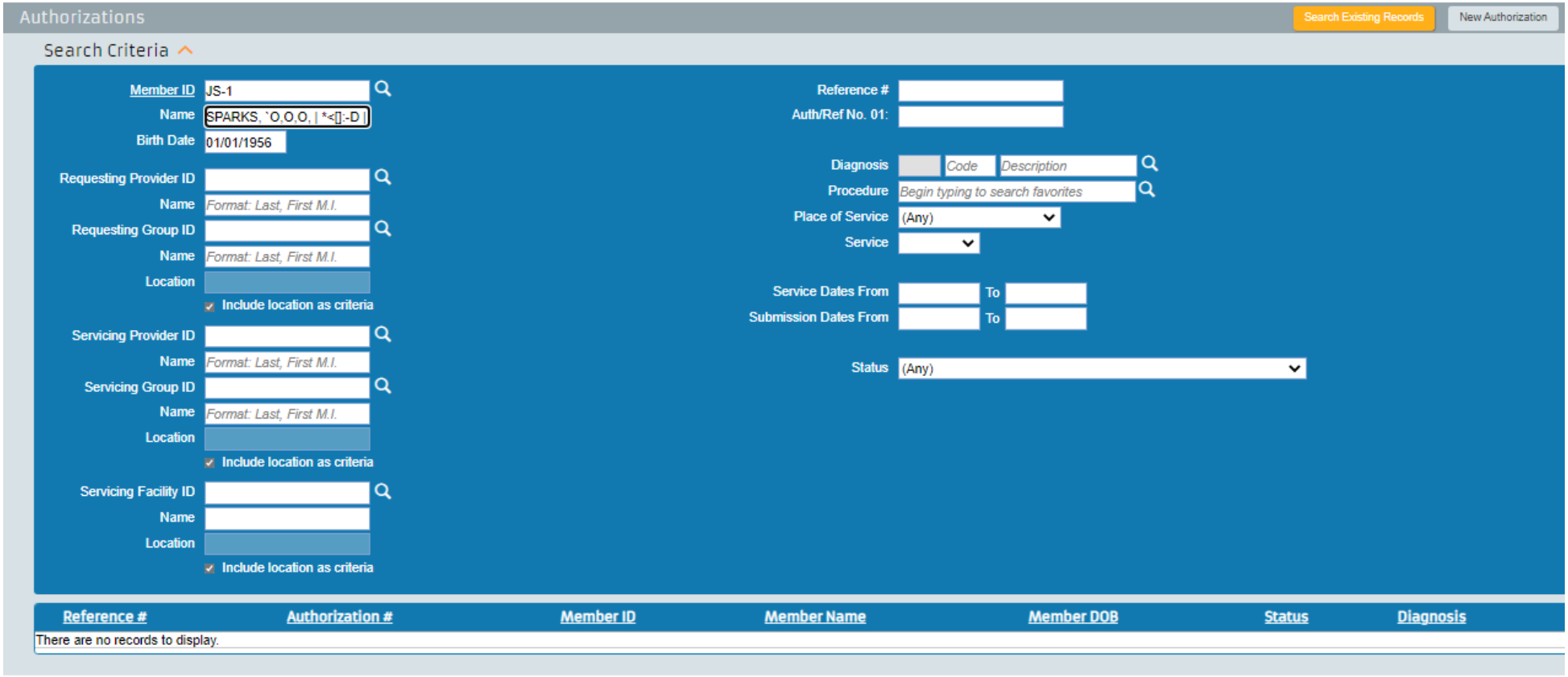
Search for and retrieve existing authorization request records by performing a search on the Authorizations search page.

NOTE: EXL Healthcare recommends clearing the browser cache, following an upgrade and prior to any member or authorization/referral record search, to avoid search-related errors.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

1) On the toolbar, click **Authorizations**.

   The Authorizations search page opens and displays a set of search fields.



2) Enter any known criteria.

   The minimum fields required to initiate a search are either the **Reference #**, **Authorization #**, **Member ID**, **Name**, **Birth Date**, **Submission Date** or **Service Date Range** fields. If you enter the submission or service dates, you also need to enter the servicing provider ID, servicing facility ID, or requesting provider ID.

   You can use the Lookup icon next to certain fields to search for and select a value.

NOTE: The **Authorization #**field may have a different label depending on your site's configuration.

3) Click **Search Existing Records**.

   Search results that match your criteria appear in a multirow at the bottom of the page. CareAffiliate displays only the records that you have security to access.

   You can sort request records by clicking the column headers.

4) Click a request record from the Reference # column or expand the row and select the Service Reference # to open the record.

   NOTE: You might not be able to retrieve all authorization records for a member. Only authorization records that reference the provider, primary care physician, healthcare facility, facility, or surgeon are retrieved.

5) Click **Edit** to add Contact Name and Contact Phone values, or to modify the requesting provider/facility or group values.

6) Add services, notes, and attachments.

7) Click **Submit**.

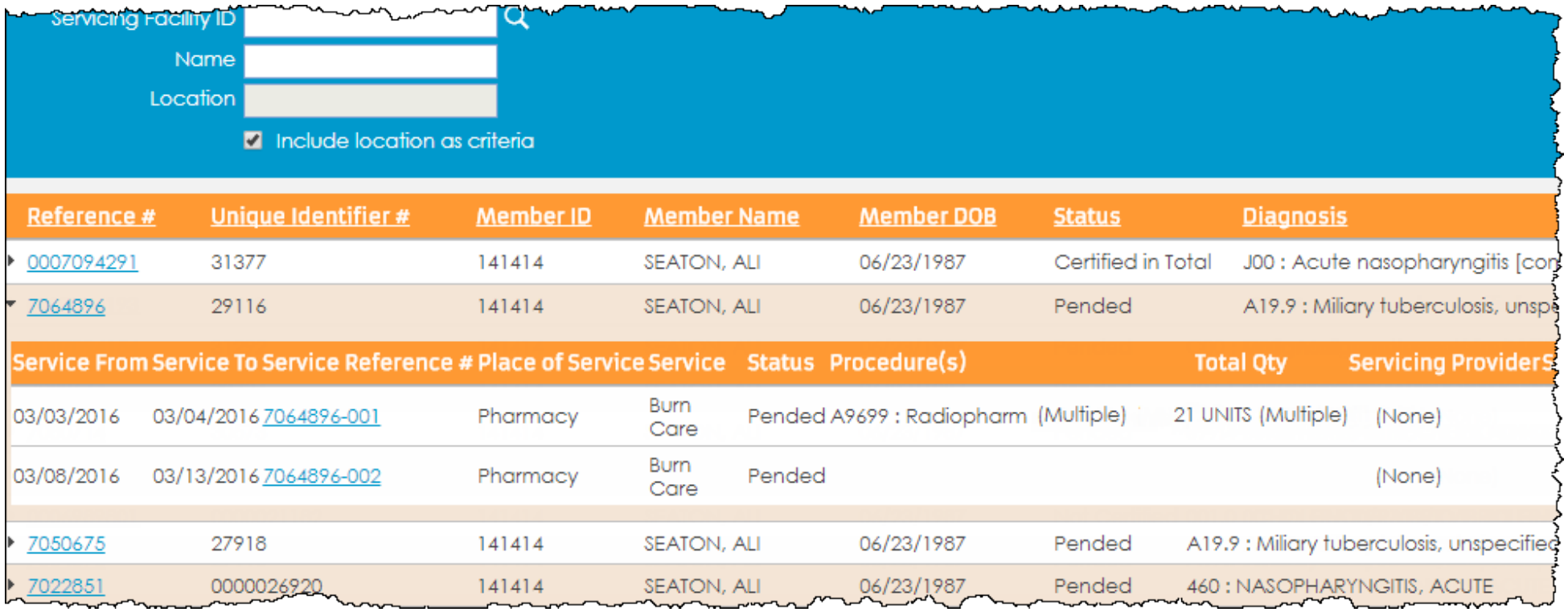
Authorization/Referral Search Results

Search results that display when you enter specific criteria and click Search Existing Records appear in a multirow at the bottom of the Authorizations page.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

Information is based on an existing authorization record and includes information about the member's requested service or services.

The following image shows retrieved authorization records for a member.



Consider the following information related to the authorization retrieved results multirow:

- Click the toggle icon to the left of the Reference # to expand the row and display one or more services associated with the authorization request.
- The authorization and service **Reference #** values are links that open the authorization request.
- If there is more than one procedure requested for a service, the word (Multiple) appears next to the **Procedure** value.
- If there is more than one service item for the requested service, then (Multiple) displays next to the **Total Qty** value, but the total quantity and qualifier is for the first service item.
- The Unique Identifier # is configured by your System Administrator and may be labeled differently.

Authorization/Referral Statuses

Authorization and referral statuses are determined by the MCO.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

The following table provides an overview of some of the statuses that you might see in CareAffiliate and their highlighted color:

Service	Status
Any Contact Payer services.	Contact Payer (orange)
No Contact Payer services, and at least one Pended service.	Pended (orange)
No Contact Payer or Pended services, and at least one Modified service. - OR - Both Certified in Total and Not Certified services.	Modified (green)
No Contact Payer, Pended, Modified, or Not Certified services, and there are Certified in Total services.	Certified in Total (green)
No Contact Payer, Pended, Modified, or Certified in Total services, and there are Not Certified services.	Not Certified (red)
Any No Action services.	No Action Required (red)
Zero No Action services, and at least one Canceled service.	Canceled (red)

NOTE: In the retrieved results rows for an authorization search, displayed data depends on the status of the service. When the service is Authorized (Certified or Approved) then the authorized data displays. If the status is Modified or Pended, then the requested data displays.

Submitting Modified Authorization/Referral Requests

You can add services, procedures, notes, and attachments to an existing authorization record.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

1) Click a request record from the Reference # column to open the record.

NOTE: Only authorization records that reference the provider, primary care physician, healthcare facility, facility, or surgeon are retrieved.

2) Click **Edit** to add Contact Name and Contact Phone values, or to modify the requesting provider/facility or group values.

3) Add services, notes, and attachments.

4) Click **Submit**.

After you submit a request, the **Place of Service, Service, Status Reason**, and **Length of Stay** fields are not editable. You can edit requester information for requests with a Pended status.

NOTE: Extension requests for Inpatient Services with a status of Pended, Certified, or Modified are limited to the Inpatient Details field group for the selected service.

Creating an Authorization/Referral Request

Create authorization requests in the Authorizations module.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

The following steps describe the basic process for creating an authorization request:

1) Initiate the authorization request.
2) Select a request type.
3) Enter service details.
4) Add relevant notes, attachments, and/or assessments.
5) Submit the authorization request.

Initiating an Authorization/Referral Request

Initiate an authorization request from the Authorizations search page.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

NOTE: You can also initiate an authorization request from the Member Search portlet by retrieving a member record and clicking **New** next to the **Authorizations** link.

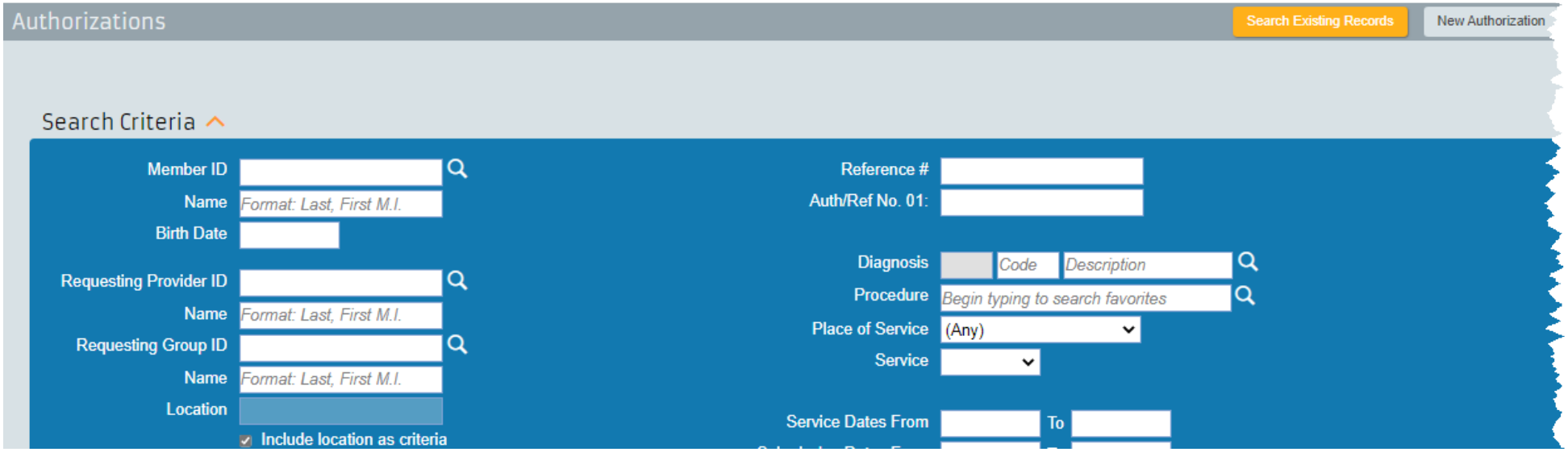
If configured, CareAffiliate performs a pre-authorization check based on your search criteria to determine if a request is required. CareAffiliate also performs a duplicate record check, if configured, to see if the authorization request already exists. This guide assumes that pre-authorization and duplicate record checking is enabled.

1) On the toolbar, click **Authorizations**.

   The Authorizations search page opens.

   NOTE: If you do not have security to view this page, CareAffiliate opens the Authorization submission page and you can continue to the "Selecting a Request Type" topic.

2) Click **New Authorization**.



CareAffiliate performs a pre-authorization and duplicate record check based on your site's pre-authorization configuration.

One or more messages may appear at the top of the page indicating the results.

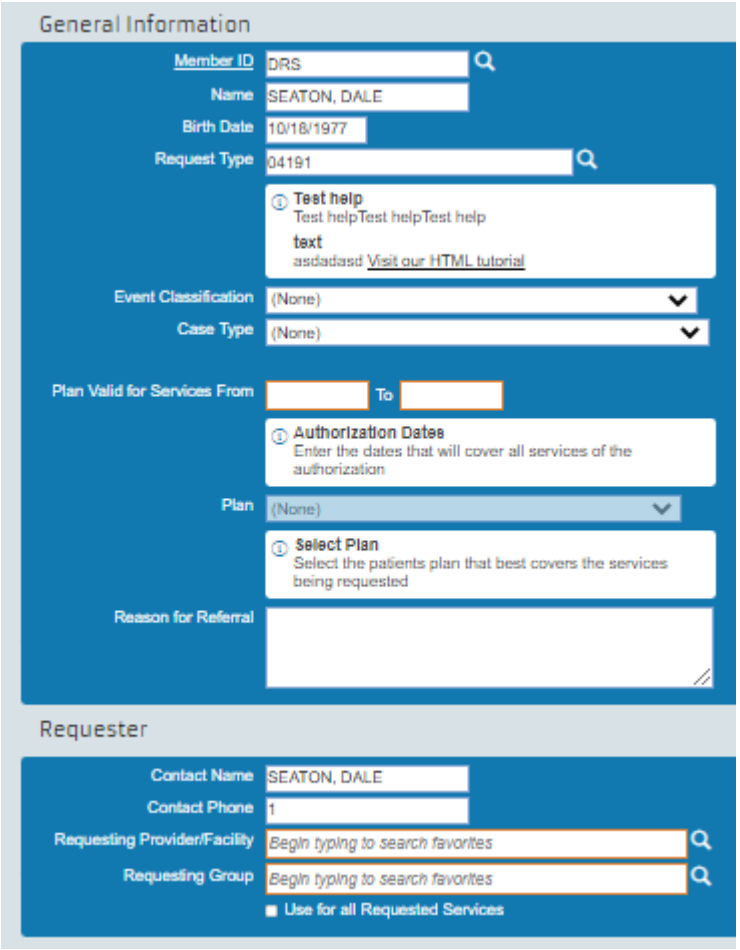
NOTE: If a potential duplicate record exists, click the authorization link to view the record and determine whether you continue with the request or move on to the next case.

3) Enter member and requester values in the appropriate fields.

4) Enter or search for a request type.

Consider the following options that appear once you enter a request type:

- The **Service** panel and **Diagnosis** fields appear. Available fields and options are also based on the request type selected.
- The **Reason for Referral** field is a freeform text field that may default guidance information based on the selected request type. You can overwrite the defaulted text, using up to 800 characters.
- The **Plan Valid From** and **To** date fields and the **Plan** field appear for users with appropriate security privileges.



5) If an authorization request is required, click **Continue Authorization**.

The Authorizations submission page opens.

Selecting a Plan

The Plan Valid From and To fields appear after you select a Request Type value and if you have appropriate security privileges to access the member plan fields. CareAffiliate providers can select a plan in the Authorization and Referral modules to accommodate members who have dual eligibility.

Consider the following options and features associated with the Plan fields:

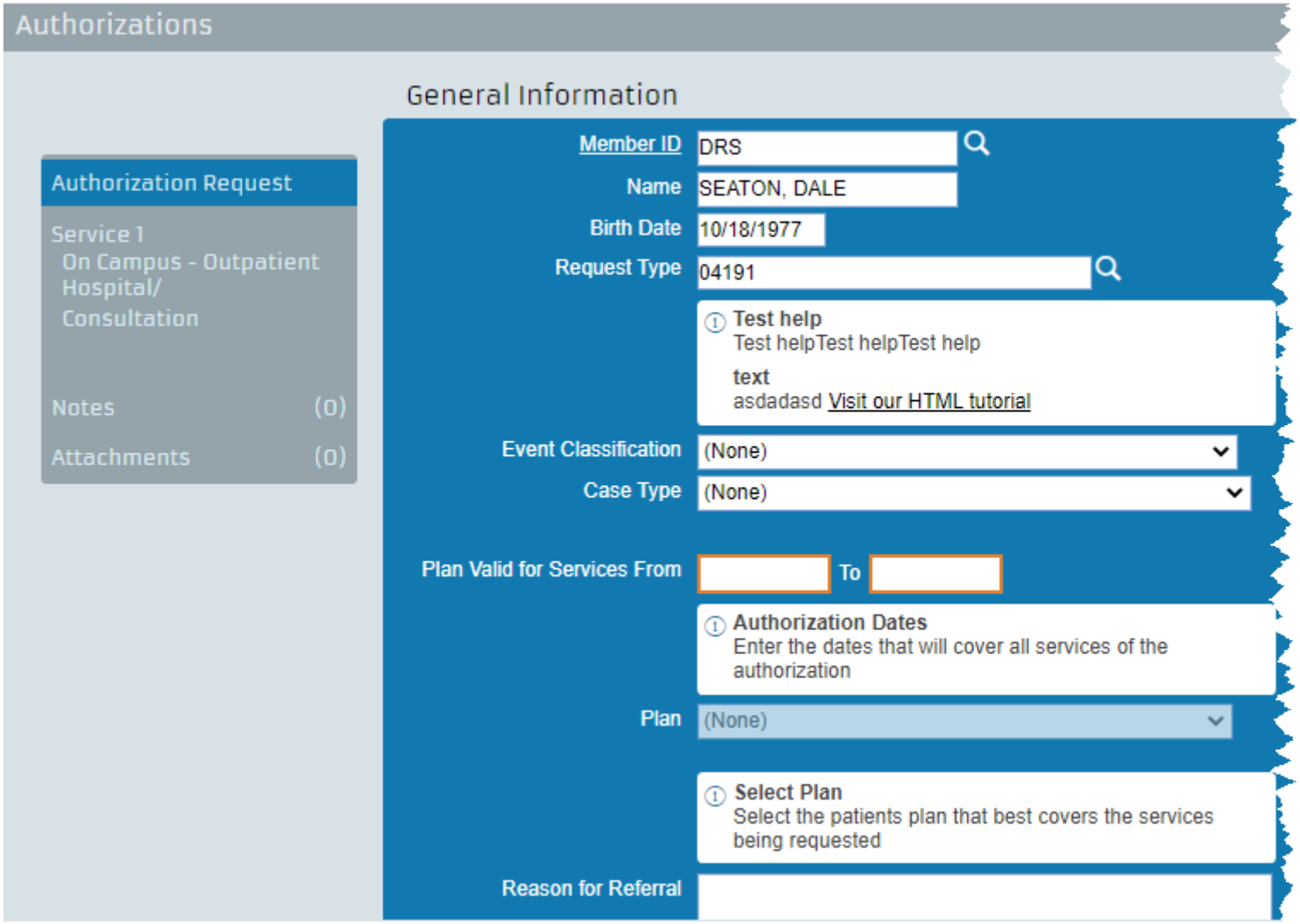
- If the selected request profile includes dates, then the **From** and **To** date range fields populate with those dates and enable the **Plan** drop-down list.
- Service dates and plan priority determine which plan defaults in the **Plan** drop-down list.
- The **Plan** drop-down list is only enabled and required when the Plan Valid From and To date fields are both populated.
- If you edit the **Plan Valid From/To** dates, then CareAffiliate selects a new **Plan** based on those dates. If there are no plans available then the drop-down list displays (None).
- If a user submits an Authorization/Referral and the selected plan is not valid for the dates of service, then an error message displays with the option to either keep the dates and select new coverage, or keep the coverage and select new dates.

Selecting a Request Type

Select a request type for the authorization request on the Authorizations submission page.

NOTE: Information that you entered in some search fields on the Authorizations search page automatically populate on the submission page.

1) In the General Information field group, enter the Member ID, Name or Birth Date in the **Member ID**, **Name** or **Birth Date** field, if not populated from the Authorizations search page.
2) In the **Request Type** field, enter a request type or click the Lookup icon to select a request type.
    - Additional required fields may appear in the General Information field group depending on the request type that you select, such as the **Request Category**, **Case Type**, and **Reason for Referral** fields.
    - The **Reason for Referral** field is a freeform text field that may default guidance information. You can overwrite the defaulted text, using up to 800 characters.
    - You can submit reason for referral information, visible to CareRadius users, when the profile is associated with an authorization request that includes a request profile with a **Reason for Referral** field.
    - Copy/paste functionality is available for the **Reason for Referral** value, even if the field is disabled.
    - The **Reason for Referral** field is also available in the Referrals workflow.
    - A panel appears on the left side of the page where you can view services and add notes, assessments, and attachments, depending on your site's configuration.
    - CareAffiliate can default one or multiple services based on the request type.



3) In the Requester field group, enter the contact person's name who handles authorization requests in the **Contact Name** field.

4) In the **Contact Phone** field, enter the phone number of the person who handles requests for your office.

5) In the **Requesting Provider/Facility** field, enter the provider/facility or click the Lookup icon to select a provider/facility.

   If you click the Lookup icon, the Provider Location Search dialog box appears. If the provider has more than one office, make sure you select the appropriate provider location for the requested service.

6) In the **Requesting Group** field, enter the group or click the Lookup icon to select a group.

7) Optionally, click the **Use for all Requested Services** check box if you want to use the same contact and provider information for all services associated with the request.

NOTE: You can modify provider information for services even when the **Use for all Requested Services** check box is selected.

8) Enter details in any remaining fields that default for the authorization request.

Depending on the request type, CareAffiliate can default the following field groups for the authorization request:

- Diagnoses
- Request Details
- Related Causes
- Related Conditions

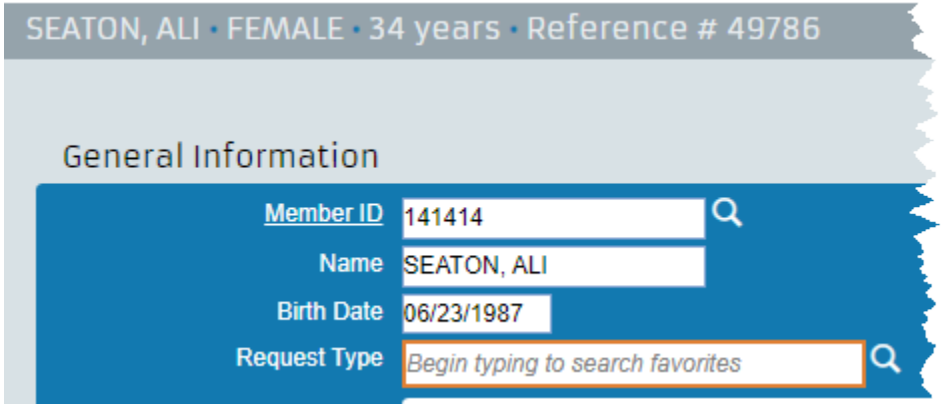
RELATED LINKS:

Request Types

Request Types

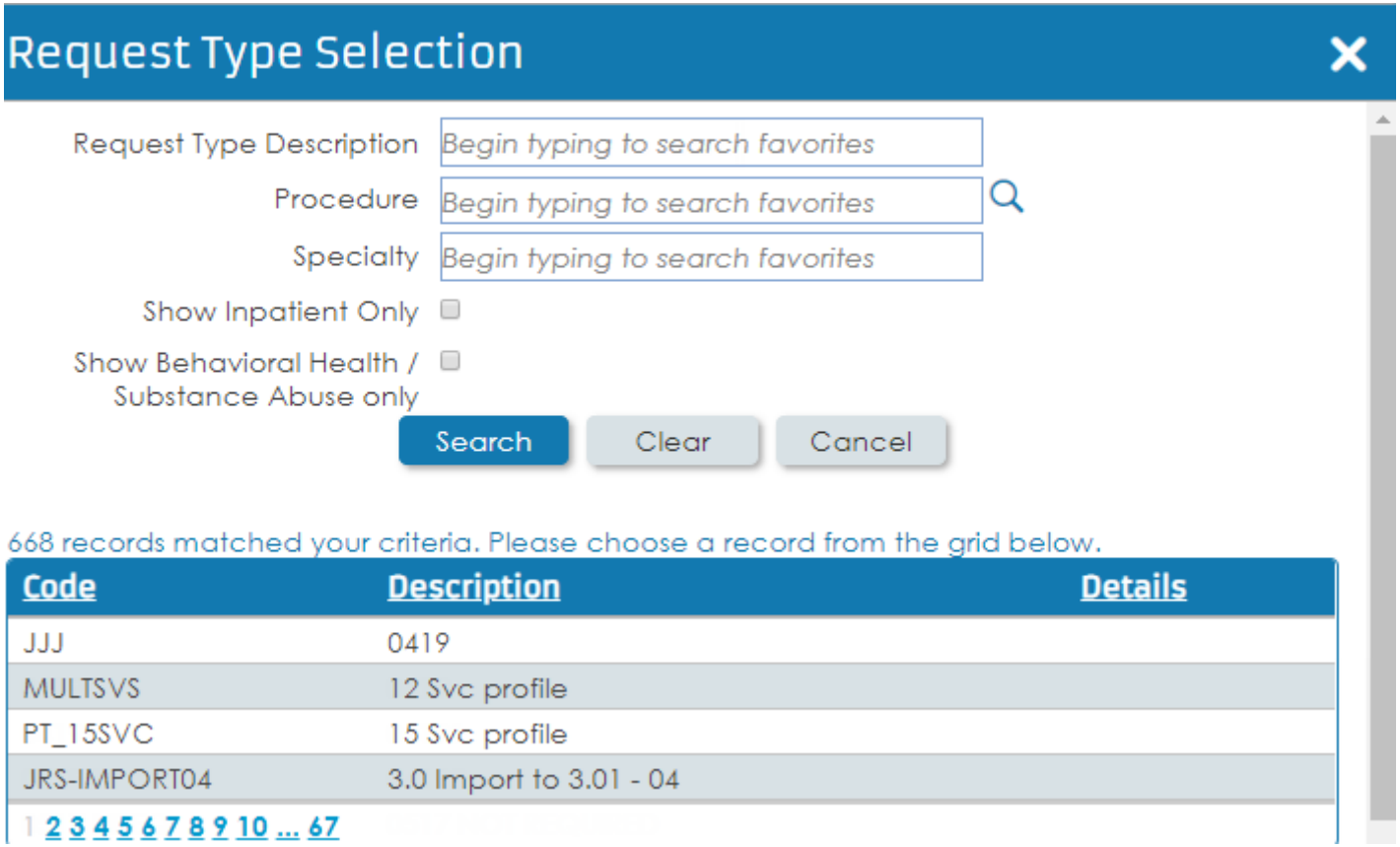
Request types are based on request profiles configured by your MCO and determine the available and required fields for an authorization request.

The following image shows the General Information field group before you select a request type:



You can click the Lookup icon next to the **Request Type** field to open the Request Type Selection dialog box to search for and select a request type. Results for all available request types, including the default request types designated for your organization, appear in the search results.

The following image shows the Request Type Selection dialog box:



You can narrow request type searches by description, procedure, specialty, inpatient, and behavioral health/substance abuse criteria. Only request profiles meeting all the criteria entered are returned.

- If a procedure is entered on the Authorizations search page then that procedure is added as a standard procedure (not as a medication procedure) in the Procedure Information field group for the first service in the new authorization.
- If the request type profile does not include procedures, then the procedure from the Authorizations search page is used as the primary procedure in the Procedure Information field group for the first service on the new Authorizations submission page.
- If the request type profile has fewer procedures than the configured maximum number of procedures allowed, then the procedure entered on the Authorizations search page is used as the primary procedure in the Procedure Information field group for the first service on the new Authorizations submission page, and the primary procedure from the selected request type profile is set to non-primary.

- If the Request Type profile includes the maximum number of procedures allowed, then the procedure entered on the Authorizations search page is added as the primary procedure in the Procedure Information multirow for the first service on the new Authorizations submission page, and the primary procedure from the request type profile is removed.

NOTE: CareAffiliate might display service-level alerts, procedure alerts, and diagnosis alerts that appear as an Alert icon next to critical fields.

The following image shows the General Information field group after you select a request type that is configured to display all possible fields:

Procedures and Request Types

CareAffiliate limits available procedure types based on the configured request profile for the selected request type.

Click the Lookup icon next to the **Request Type** field to open the Request Type Selection dialog box to search for request type by procedure.

Available procedure code sets include CPT, HCPCS, ICD-9-CM, ICD-10-CM, NDC, NUBC, and Site-Defined. CareAffiliate validates procedure types and ranges based on the request type (request profile).

Procedure search results are based on the Procedure High and Procedure Low values configured for the profile.

- If there is more than one service profile, and the search matches any of those service profiles, then the entire request profile is used for the search.
  - If the service profile is valid for CareRadius, and is searchable, then CareRadius service profiles are used for the procedure search.
  - If the service profile is valid for CareAffiliate, then the CareAffiliate service profile is used for the procedure search.
- A match for the service profile occurs if the procedure search criteria falls between the Procedure High and Procedure Low default values.

  NOTE: A service profile match, based on procedure criteria, will not return results if any other procedure criteria options are used.
- Request and Service profile searches that are based on procedure code criteria only return results for procedure codes that fall within the procedure code range indicated in any of the Procedure Default: Low and High fields.
- When you replace a previously-selected request profile with a different profile all previously defaulted profile values for the authorization and associated services, are replaced with values for the new one.
- When you change a standalone service profile (Service/Place of Service values), then selected procedures are not replaced by the defaults for that service profile if there are already procedures entered or defaulted from the previous profile.

  If there are not procedures in the multirow, then the selected procedures still default.

The Request Type Selection dialog box contains the following fields and check boxes:

- Procedure
- Specialty
  - Search results include request type records that match the first four digits of the Specialty value.
- Show Inpatient only
- Show Behavioral Health/Substance Abuse only

NOTE: Request profiles for previously saved authorization records cannot be changed.

RELATED LINKS:

Request Types

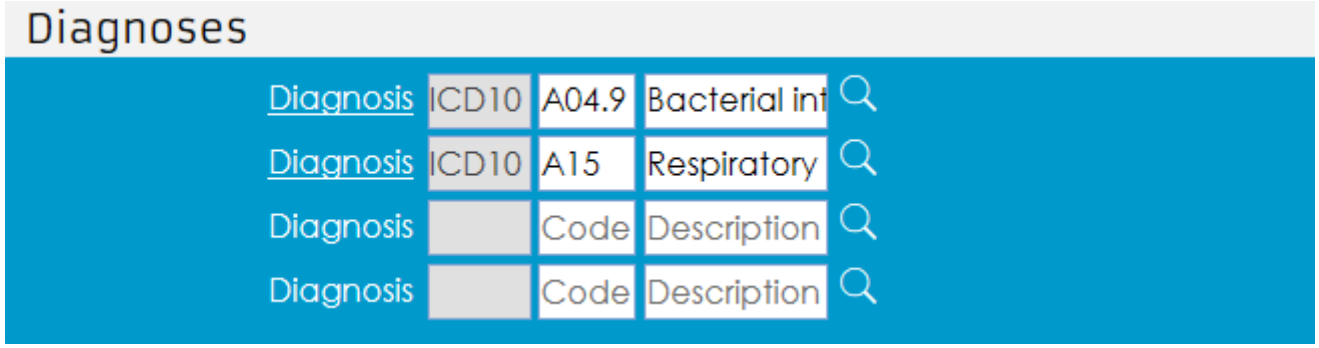
Diagnoses Field Group

Use the Diagnosis field group to enter diagnosis information related to the authorization request. The Diagnosis field group contains four rows of diagnosis fields with the code and description.

Enter the diagnosis code in the second available field, or click the Lookup icon to search for and select a code.

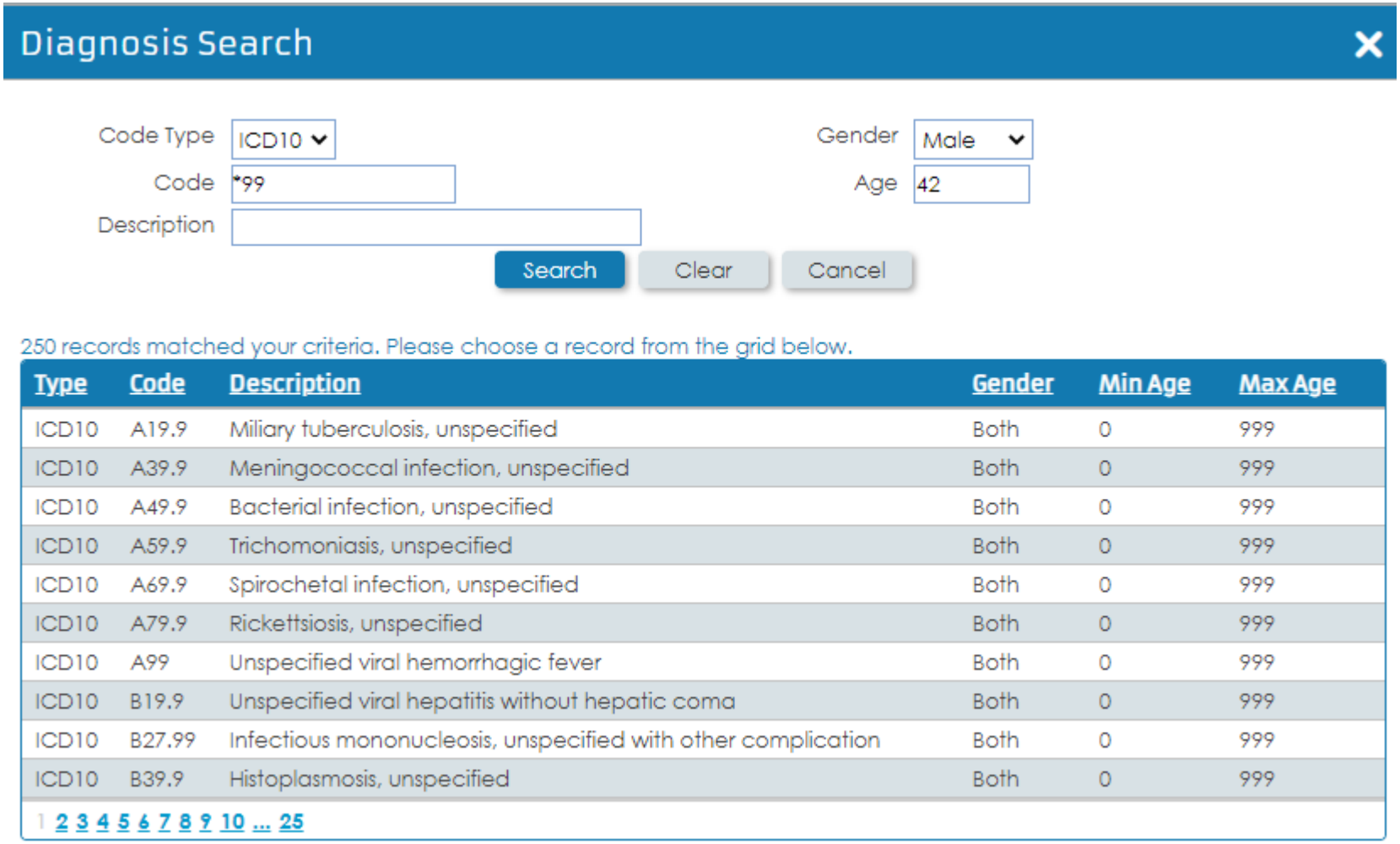
NOTE: Diagnosis fields may automatically populate depending on the selected request type or from an authorization record selected from the Authorization Search page.

The following image shows the Diagnoses field group with diagnosis codes and descriptions:

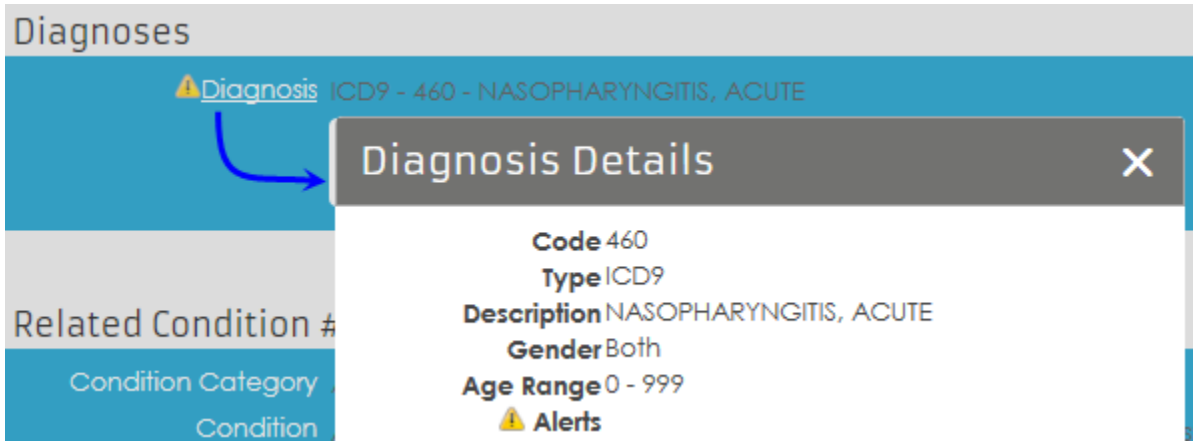


When you enter a valid diagnosis code in the second available field, and then press the **Tab** key, the diagnosis description automatically populates the third field.

When you enter a partial diagnosis code in the second available field, and then press the **Tab** key, the Diagnosis Search dialog box automatically opens and performs a search based on the partial text.



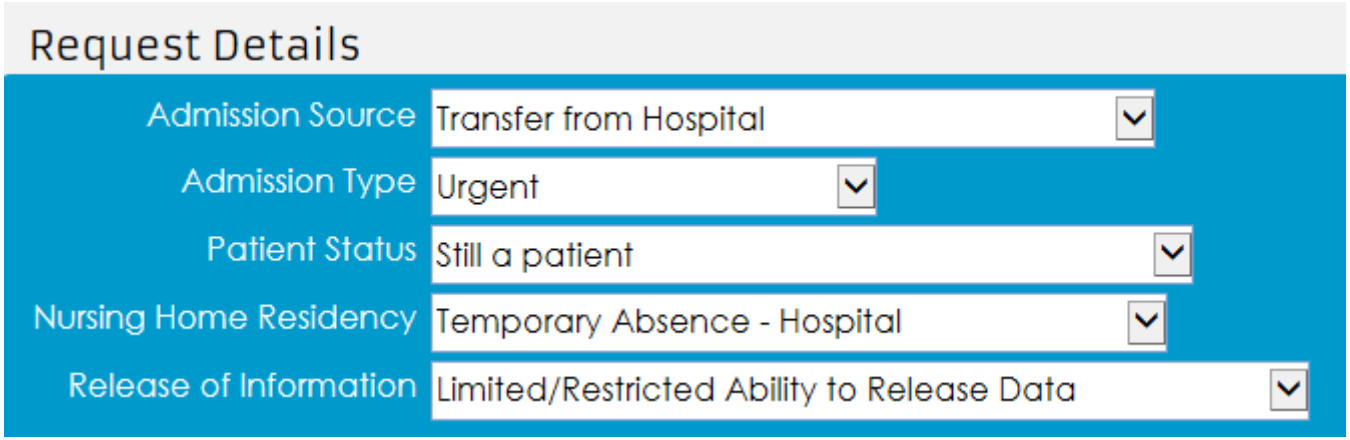
NOTE: An Alert icon appears next to the **Diagnosis** field when the field value has been configured to display an Alert message. You can also click the **Diagnosis** link to open the Diagnosis Details dialog box.



Request Details Field Group

The Request Details field group appears on the Authorizations submission page when you select inpatient admission as the request type for the authorization request. Use the Request Details field group to enter additional information about the inpatient admission request.

The following image shows the Request Details field group:



The Request Details field group contains the following information:

Admission Source

Describes the source of the inpatient admission. This information only applies to inpatient admissions and should be recorded if it could affect the decision of an authorization request.

Admission Type

Describes the type of admission, such as Emergency or Urgent.

Patient Status

Describes the current status of the patient admitted for inpatient treatment.

Nursing Home Residency

Describes the member's relationship to a nursing home. This information only applies if the member is or has recently been a nursing home resident.

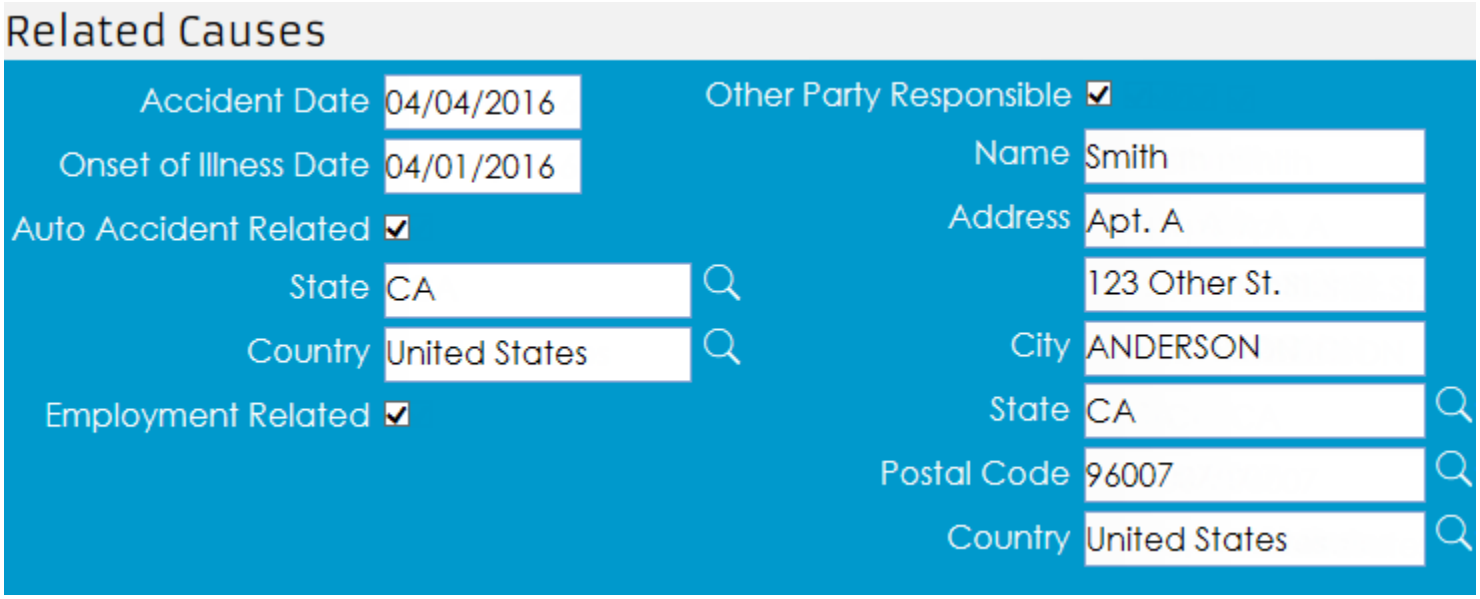
Release of Information

Indicates the authority of the requester to request information.

Related Causes Field Group

The Related Causes field group might appear on the Authorizations submission page depending on the request type selected for the authorization request. Use the Related Causes field group to enter pertinent dates and information related to an accident associated with the request.

The following image shows the Related Causes field group:



The Related Causes field group contains the following information:

Accident Date

The date of the accident that led to the member's condition and request for service.

Onset of Illness Date

The date that symptoms of the illness that led to the member's condition and request for service was first reported, if known.

Auto Accident Related

Indicates whether the authorization request is related to an automobile accident.

State and Country

Indicates the state and country in which the accident occurred. This information only applies to automobile-related accidents.

Employment Related

Indicates whether the accident was related to the member's employment.

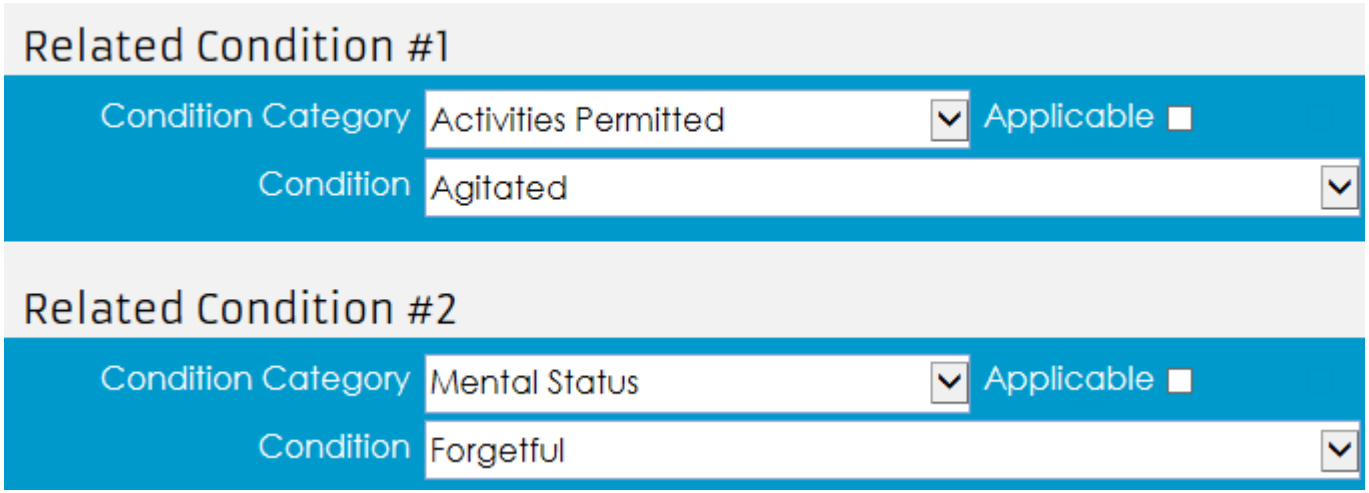
Other Party Responsible

Indicates whether someone other than the member is financially responsible for the member's authorization request. Additional name and address fields, related to the responsible party, appear when you select the **Other Party Responsible** check box.

Related Condition Field Group

The Related Condition field group might appear on the Authorizations submission page depending on the request type selected for the authorization request. Use the Related Condition field group(s) to enter information on conditions the member has that might be applicable to the request.

The following image shows two Related Condition field groups:



The Related Conditions field group contains the following information:

Condition Category

Describes the condition category.

Applicable

Indicates whether the condition(s) listed are applicable to the current authorization request. You can enter conditions that are not applicable to better understand the member's current condition.

Condition

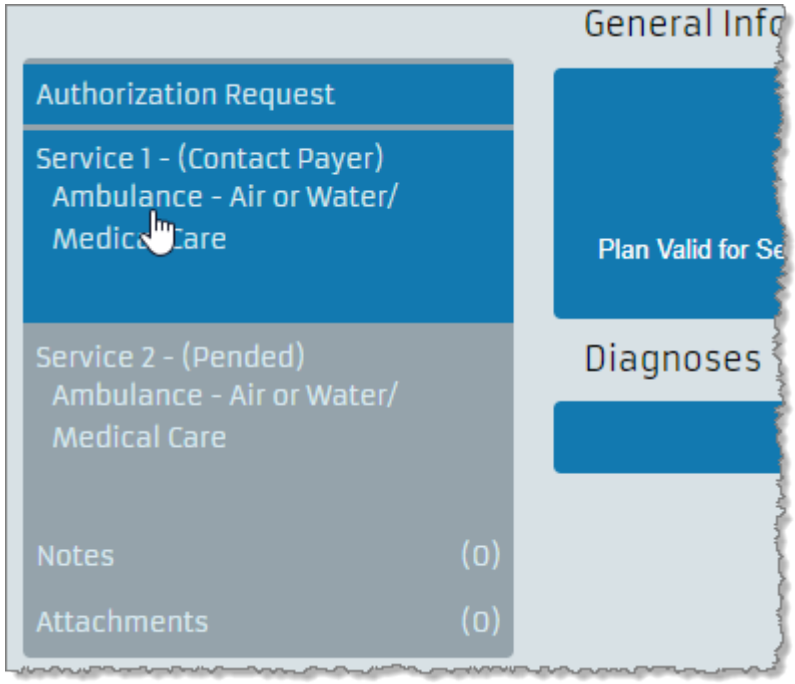
Describes conditions associated with the condition category that affects the member's health. You can enter up to five conditions for each condition category.

NOTE: You must provide a Condition Category value and at least one Condition value. You can use a Condition Category value more than once for a single authorization for a maximum of six times.

Entering Service Details

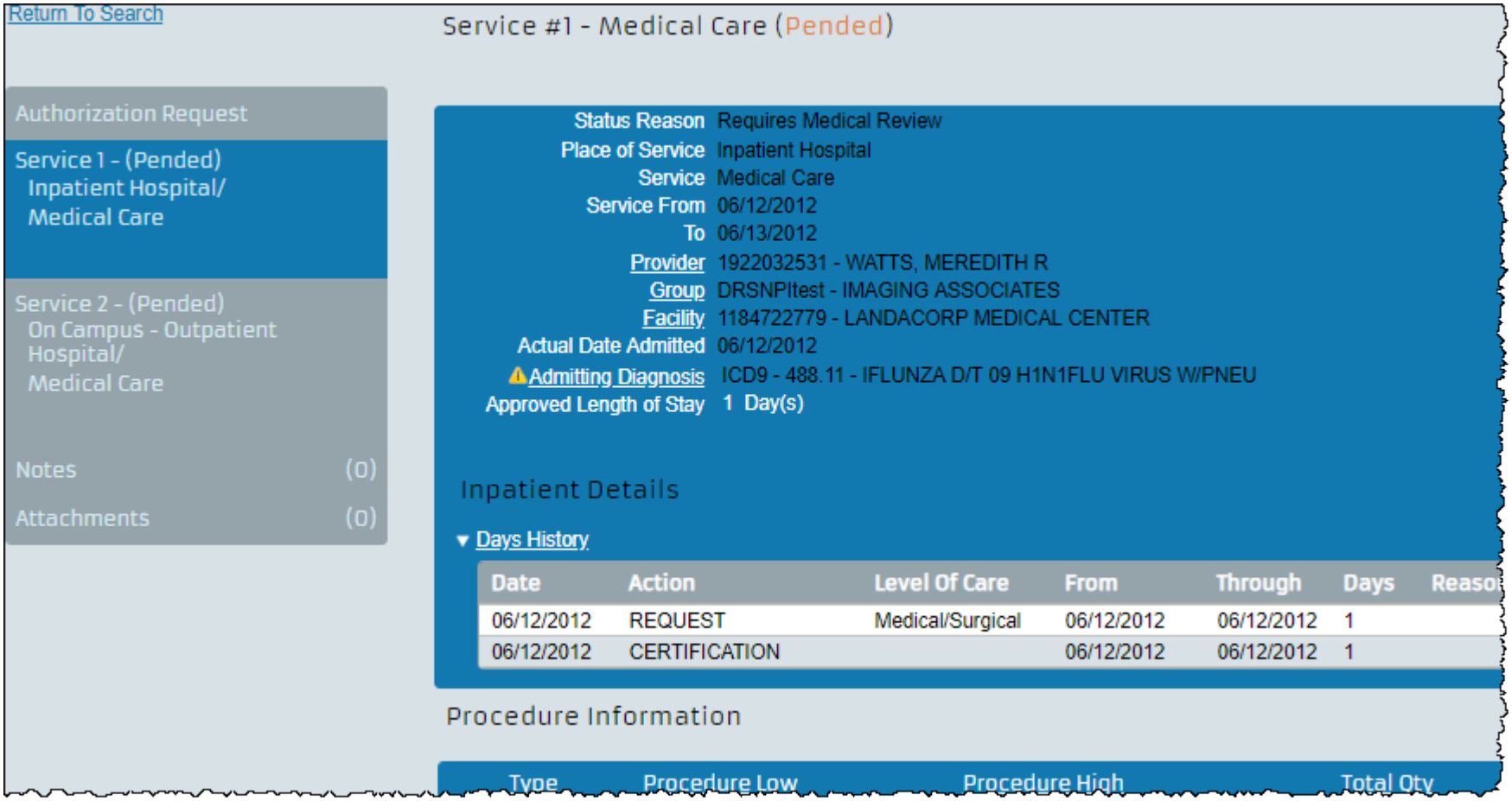
Enter details for the service on the Authorizations submission page. Services appear in numerical order in a panel on the left side of the page. CareAffiliate may default one or multiple services based on the request type.

1) In the panel on the left side of the Authorizations submission page, click **Service 1**.



NOTE: The ability to add a service using the **+ Add** feature depends on the request (profile) type selected. Some profiles do not allow services to be added.

Defaulted information for the service and any associated field groups, such as Inpatient Details and Extended Service Information, appear.



2) Enter information in all required fields.

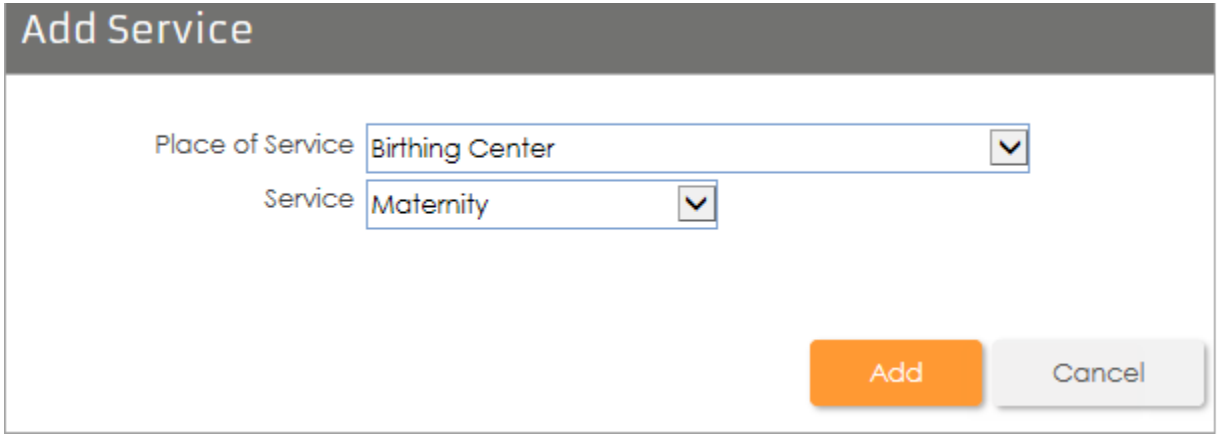
You can click the Lookup icon, when available, to search for a value.

Adding a Service

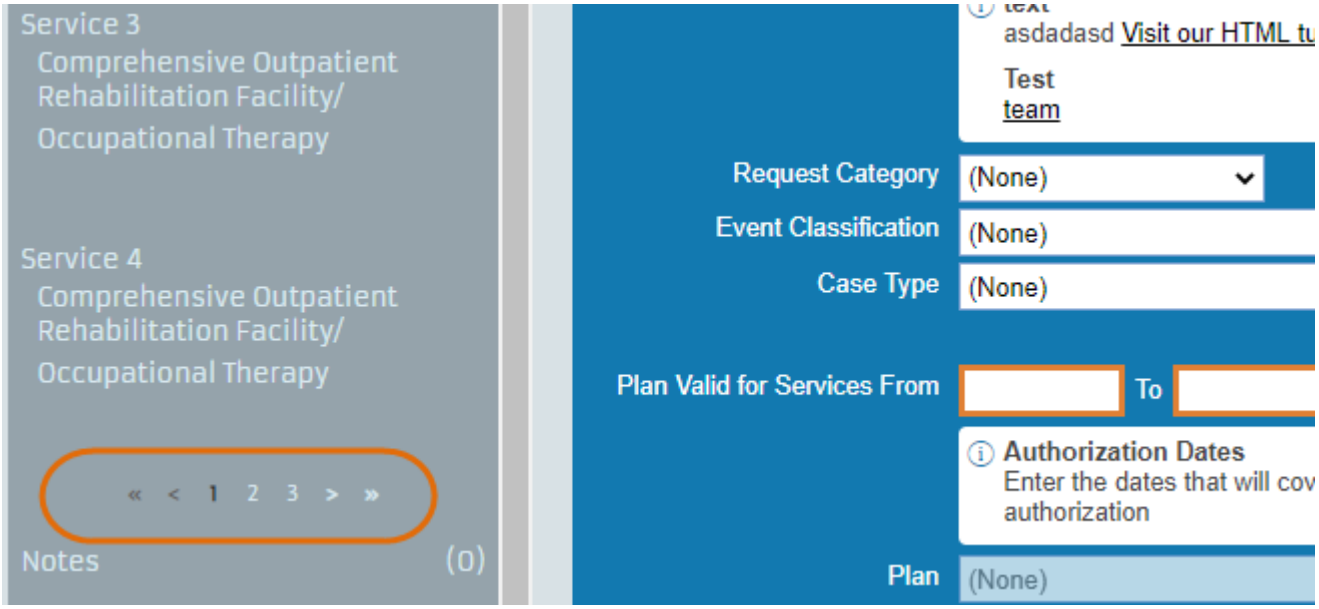
You can add a service to a new authorization request if the request type that you select allows services to be added. You can also add a service to an existing authorization when the Authorizations submission page is in Edit mode.

1) At the top of the Service page, click **Add New Service Line**.

   The Add Service dialog box opens.



NOTE: When more than four services are added, then a number scroll appears below displayed services in the Navigation Panel. Additionally, navigation arrow icons (double-arrows and arrows) display when there are multiple service records, which allow you to navigate to the first, next, previous, and last service record.



2) Click the **Place of Service** drop-down list and select a place.

3) Click the **Service** drop-down list and select a service.

4) Click **Add**.

   Defaulted information for the service and any associated field groups, such as Inpatient Details, Procedures, and Extended Service Information, appear.

5) Enter information as appropriate for the new service.

6) Click **Submit** when you are finished adding services for the authorization request.

RELATED LINKS:

Procedure Information Field Group

Extended Service Information Field Group

Ambulance Transport Field Group

Home Oxygen Therapy Field Group

Home Health Care Field Group

Spinal Manipulation Field Group

Dental Information Field Group

Copying a Service

You can copy a service to create an identical service record below the original service record by clicking the **Copy** button at the top of the Service page in the Authorizations or Referrals modules.

NOTE: The **Copy** button does not appear when you retrieve an authorization or referral request record that was created in CareRadius and includes services with CareRadius-only request profile data or no request profile data at all.

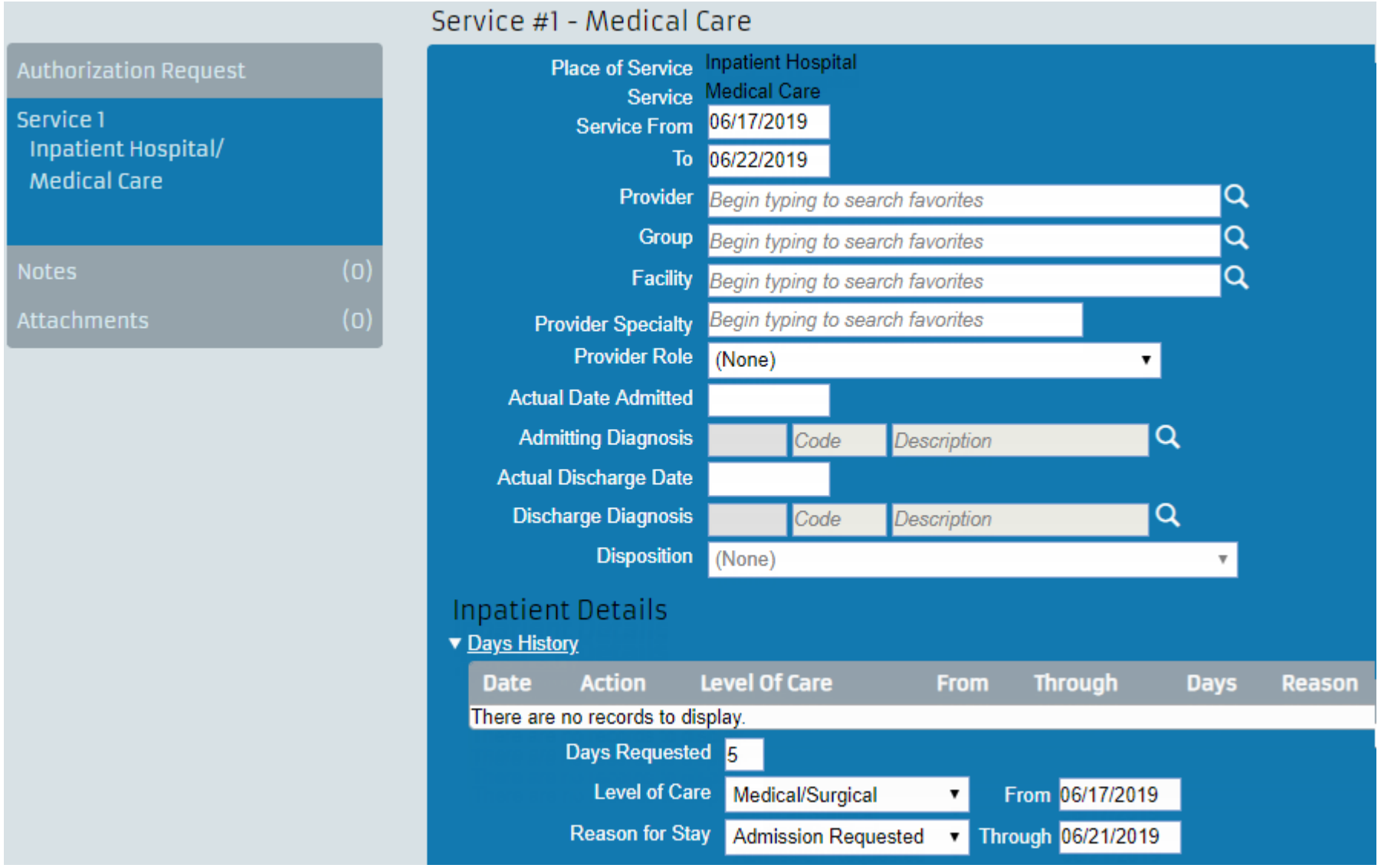
When you copy a service, the service profile is the same type of service profile (linked or stand-alone) as the current service and uses the same defaults.

The Place of Service/Service combination cannot be modified. You must add a new service to enter new Place of Service/Service values.

Inpatient Details

Inpatient Details appear in the Services section when you select an inpatient request type for the authorization/referral request. Inpatient requests notify a member's MCO about inpatient admission updates, discharges, extensions, level of care, inpatient stay reasons, and discharge dispositions.

The following image shows an initial inpatient request with inpatient detail fields on the Service page, above the Inpatient Details field group:



Inpatient detail fields that are not directly tied to Days Details for the Request Type, display above the Inpatient Details section of the Service page and include the following fields for certified requests:

Actual Date Admitted

The date the member is admitted to the facility.

Admitting Diagnosis

The diagnosis code and description associated with the member's admission to the facility.

Actual Discharge Date

The date the member is discharged from the facility.

Discharge Diagnosis

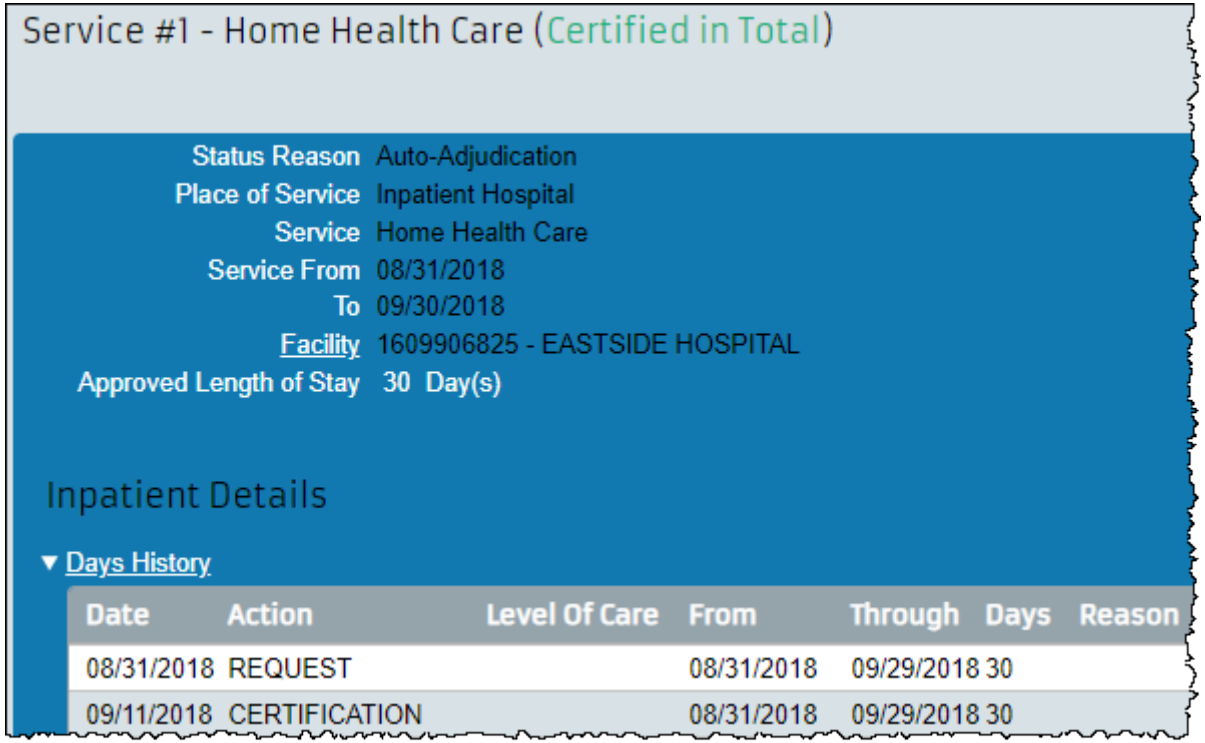
The diagnosis code and description associated with the member's discharge.

Disposition

The disposition or status of the member at the time of discharge.

Approved Length of Stay

The Approved Length of Stay field displays for approved inpatient requests and is calculated based on the certified number of days requested.



The Inpatient Details field group contains the following information:

Days Requested

When you complete the **From** and **Through** date fields, CareAffiliate automatically populates the **Days Requested** field with the **From** value minus the **Through** value. For example, if you entered 4/11/2015 in the **From** field and 4/12/2015 in the **Through** field, then the value in the **Days Requested** field would be 1.

Existing inpatient authorization records with only an initial request row in the inpatient days details record in CareRadius defaults the **Days Requested** field from that row in the **Days Requested** field in CareAffiliate.

When the edited authorization request for inpatient days is submitted, the values entered in the CareAffiliate fields override the corresponding values on the initial request row in CareRadius if the inpatient days details record has only an initial request with one row.

If the requested inpatient detail record includes more than one inpatient service request, then in CareRadius, the values submitted are used to create a new inpatient days detail record.

From

The requested date for when you want the inpatient service to start.

Through

The date of the final service date of the inpatient authorization request.

Level of Care

Indicates the level of care that the member will require during their inpatient stay, such as Hospice or Skilled Care.

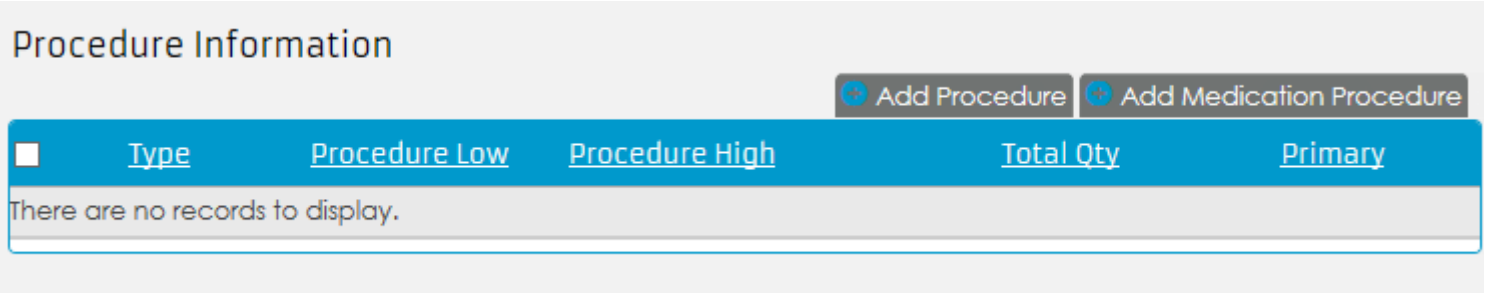
Reason for Stay

Describes the reason for the inpatient request, such as Extension Requested or Targeted Medical Management.

Procedure Information Field Group

The Procedures field group is a multirow that allows you to add one or more procedures to a single service, depending on configuration. Procedure values may be defaulted based on the selected request type.

The following image displays the Procedure Information field group for a new authorization request:

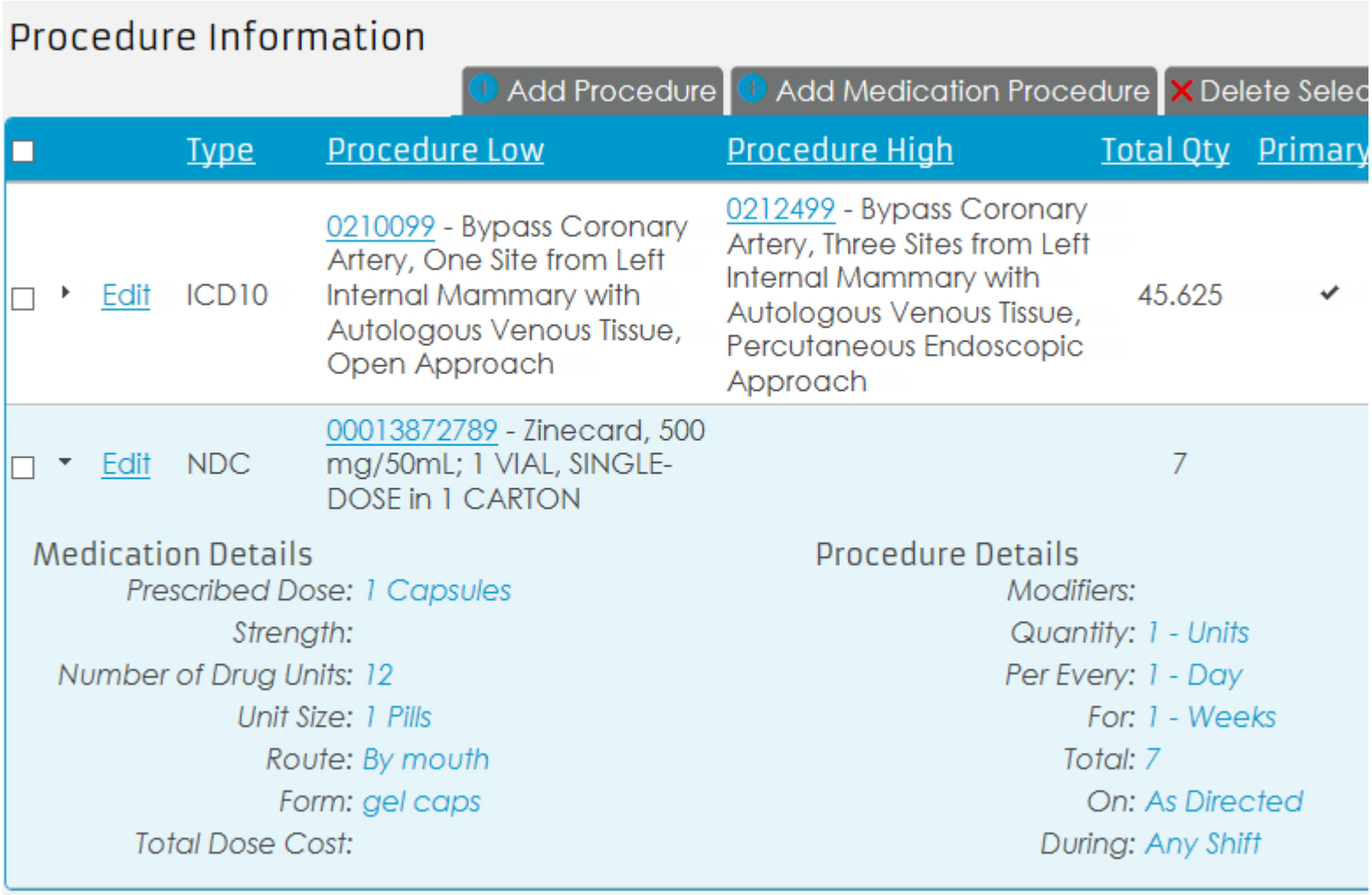


The selected request type allows you to add both standard procedures and medication procedures.

Click **Add Procedure** or **Add Medication Procedure** to open the Add Procedure or Add Medication Procedure dialog box.

NOTE: The **Add Medication Procedure** button conditionally displays based on the selected Request Type or standalone Service Profile (Service/Place of Service combination).

The following image displays the Procedure Information field group with both a procedure and a medication procedure:



The medication procedure row on the bottom is expanded to display medication and procedure details.

Procedure (Low) Procedure (High) Fields

The following logic applies to the Procedure fields when editing a new or saved authorization in CareAffiliate.

Entering values in either Procedure field (Low or High) will cause the other Procedure field to be auto-populated with the same value, as long as it was unpopulated prior to entering the value.

For example:

- If the **Procedure (Low)** and the **Procedure (High)** fields are both unpopulated, then entering CPT 99201 into the **Procedure (Low)** field will cause the **Procedure (High)** field to also populate with CPT 99201.
- If the **Procedure (High)** field was populated with CPT 99241, then entering CPT 99201 into the **Procedure (Low)** field would have no effect on the **Procedure (High)** field.

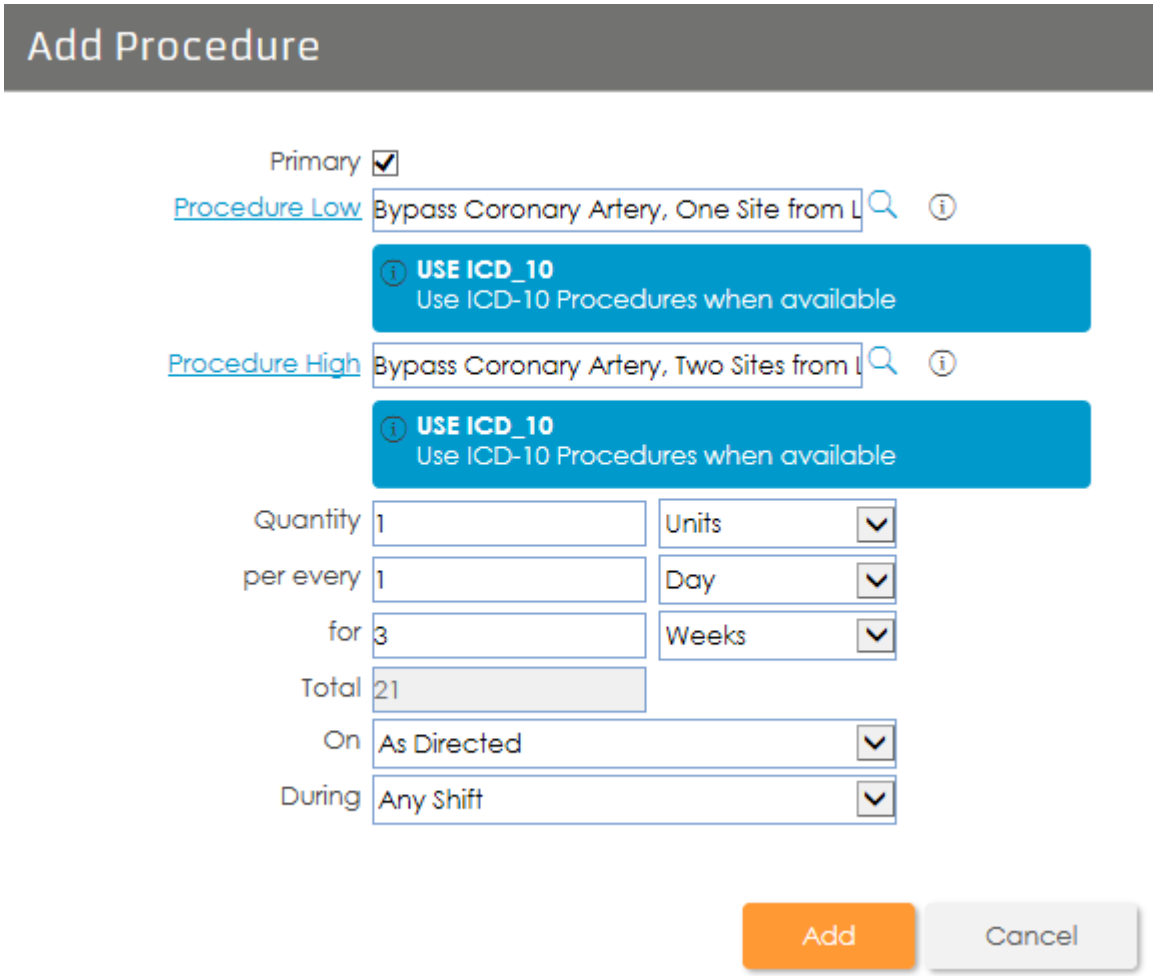
When only the **Procedure (Low)** code is configured to display or is enabled, CareAffiliate will update the hidden or disabled **Procedure (High)** code automatically to keep it in sync with the **Procedure (Low)** code values entered.

Adding a Procedure

Add procedures and medication procedures to an existing or new service using the **Add Procedure** button at the top of the Procedure Information field group.

NOTE: When you add a procedure to a service using the Add Procedure dialog box, CareAffiliate uses the service-level settings for hidden, disabled, and required fields, in addition to the default value setting for standard procedures, for the selected profile.

Click the **Add Procedure** button to open the Add Procedure dialog box.



Primary

Select the **Primary** check box if the procedure is the primary procedure for the service. There can only be one primary procedure per service.

Procedure (Low)

Enter the lowest procedure code for the procedure type.

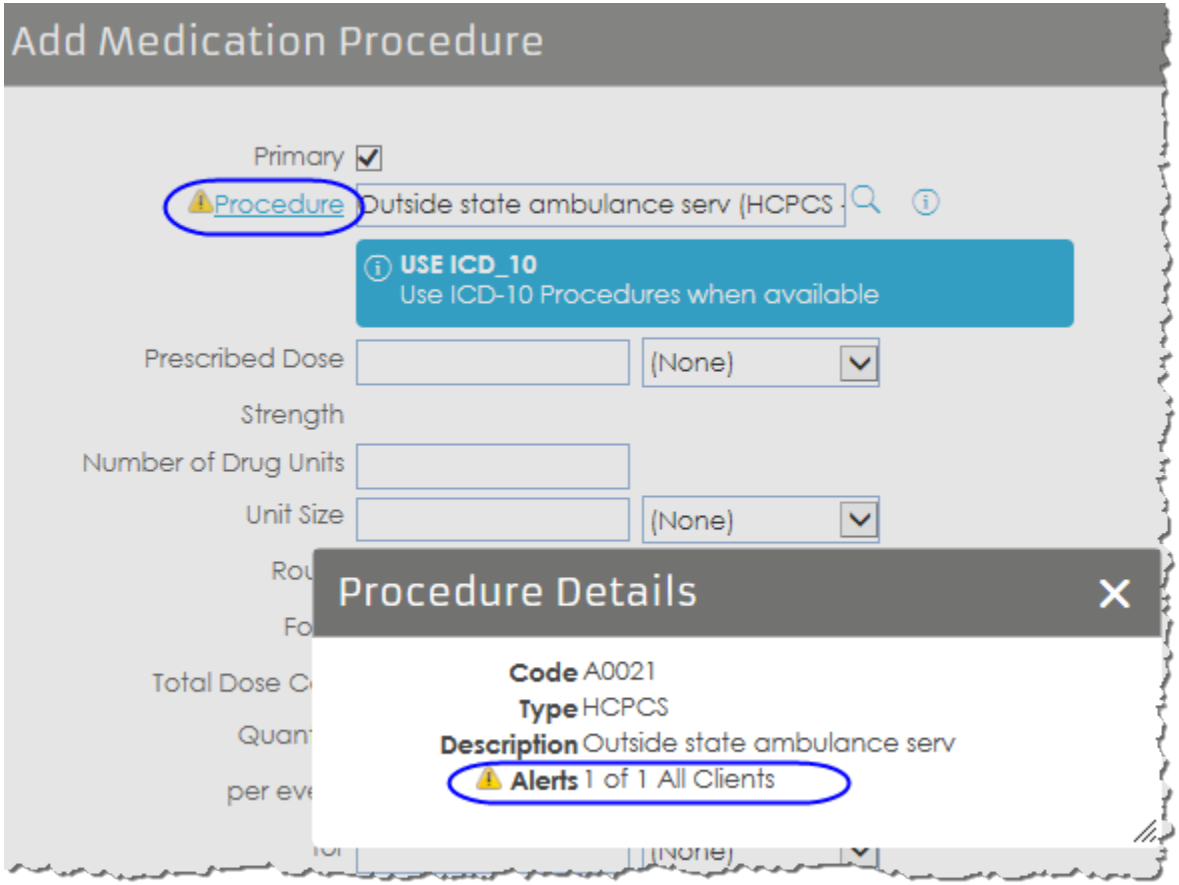
Type-ahead functionality automatically displays options based on the values you enter.

If you enter a valid procedure code, its corresponding description automatically appears.

If you enter an invalid code, the Procedure Search dialog box opens so you can select a valid procedure code and description.

The **Procedure (Low)** code must be lower than the **Procedure (High)** code.

If the code you select for the **Procedure (Low)** value is configured to display alert information, an exclamation icon appears in a Procedure Details dialog box with the alert information.



NOTE: Procedure alerts are reevaluated if you change the service dates for the current service.

Procedure (High)

Enter the highest procedure code for the procedure type, or click the Lookup icon to select a procedure code.

If you enter a valid procedure code, its corresponding description automatically appears.

If you enter an invalid code, the Procedure Search dialog box opens so you can select a valid procedure code and description.

Modifiers

The **Modifier** fields only appear when you enter a CPT or HCPCS procedure code type in the **Procedure (Low)** fields. You can type the two-character code for the procedure modifier, or click the Lookup icon to select a modifier. CareAffiliate allows a maximum of five modifier values.

Quantity

The appearance of **Quantity** fields depends on the service profile configured for the selected authorization request.

Enter the number of requested services and select a unit of measure from the corresponding drop-down list. Decimal values are allowed in any of the **Quantity** fields if necessary.

For example, you can enter 1.5 days instead of entering 36 hours. Up to 30 characters are allowed.

If the **Quantity** field has a value, its associated qualifier drop-down list requires a value.

Validation ensures that numerical field values such as day, week, or month, are equal to or greater than the preceding field value.

For example, if the **Quantity** field has a value of Months, then the **per every** field allows a value of Month, but not Day or Week, and the **for** field allows a value of Months or Years, not Hours, Days, or Weeks.

per every

Enter a numerical value up to 6 characters and select the frequency of the service, such as **per every: Week, Month**, or **Day**, from the corresponding drop-down list.

You must enter a numeric value of 1 or higher in the **per every** field.

When the **per every** field has a value, its associated qualifier drop-down list requires you to select a value.

for

Enter a numerical value up to 3 characters for the duration of the requested service and a unit of measure from the corresponding drop-down list. You must enter a numeric value of 1 or higher in the **for** field. When the **for** field has a value, its associated qualifier drop-down list requires you to select a value.

Total

The view-only total is calculated based on the Quantity, per every, and for field values. For example, if a **Quantity** = 2, **per every** = Day, **for** = 10 days, then the **Total** value is 20.

When a calculation cannot be correctly made for any reason, CareAffiliate clears the **Total** field. This behavior encompasses situations is which the **Quantity** and **per every** fields have a value, but the **for** field does not have a value or has a partial value.

On

Type a pattern of delivery based on a calendar year, month, or week in the **On** field, or click the Lookup icon to select a value.

During

Enter a pattern of delivery within a day, such as A.M. You can click the Lookup icon next to the **During** field to select a service delivery time.

RELATED LINKS:

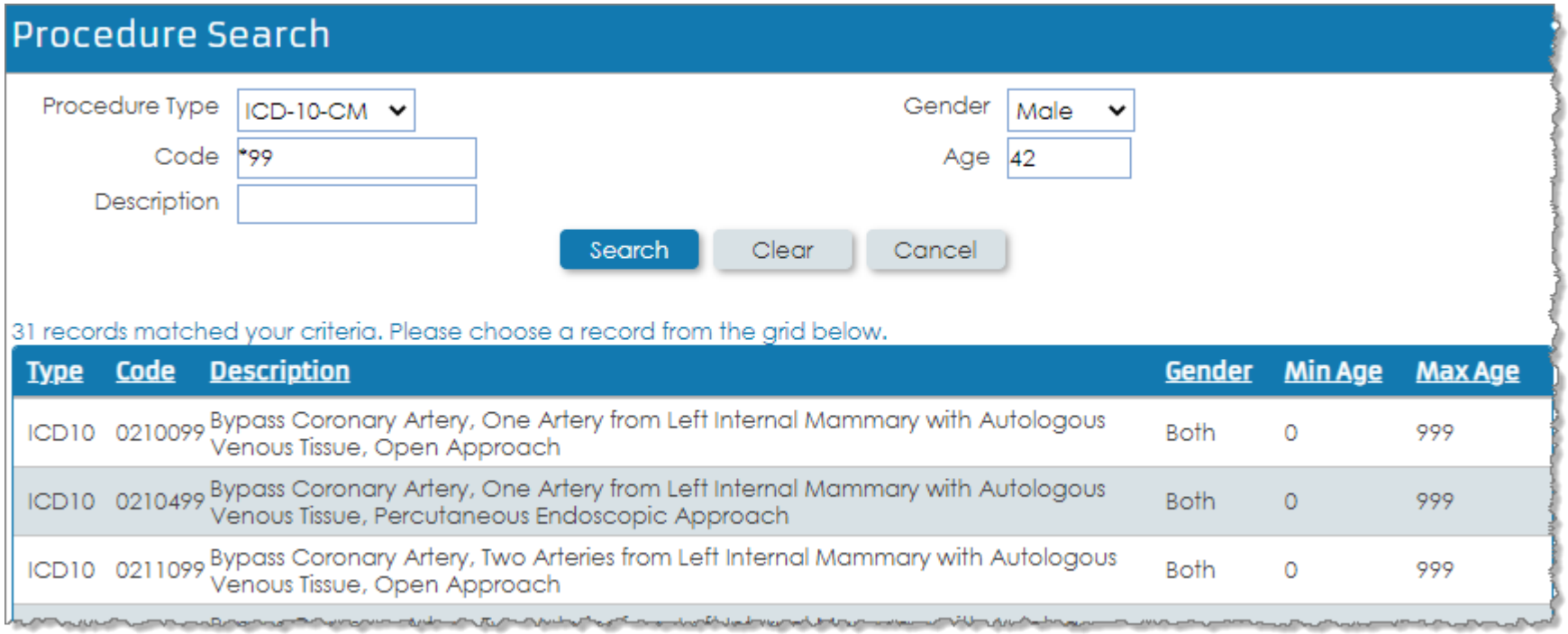
Type-Ahead Functionality

Searching for a Procedure

You can search for procedures in the Procedure Search dialog box. The Procedure Search dialog box automatically opens if you enter an invalid procedure in the **Procedure (Low)** or **Procedure (High)** fields.

1) Click the Lookup icon next to the **Procedure (Low)** or **Procedure (High)** fields in the Add Procedure dialog box.

   The Procedure Search dialog box opens.



2) Click the **Procedure Type** drop-down list and select a type of procedure.

   If the selected request type or service profile (Service/Place of Service combination) does not have specific procedure types defined, then available selections are CPT, HCPCS, ICD-9-CM, ICD-10-CM, NDC, and Site-Defined.

   If you do not select a value from the **Procedure Type** drop-down list, a value that matches the procedure code selected in the **Procedure (Low)** and **Procedure (High)** fields automatically appears, read only, in the **Procedure Type** field. The default **Procedure Type** field value is **All**.

3) You can restrict the number of procedures CareAffiliate retrieves using age and gender validation options defined by your organization's business needs.

4) Click **Search** to retrieve procedure results.

5) Select a procedure to default that value in the **Procedure (Low)** or **Procedure (High)** field and return to the Add Procedure dialog box.

Editing a Procedure

You can edit procedures in the Edit Procedure dialog box. The Edit Procedure dialog box includes the same fields, behaviors, and options as the Add Procedure dialog box.

Click **Edit** in any procedure row to open the Edit Procedure dialog box.

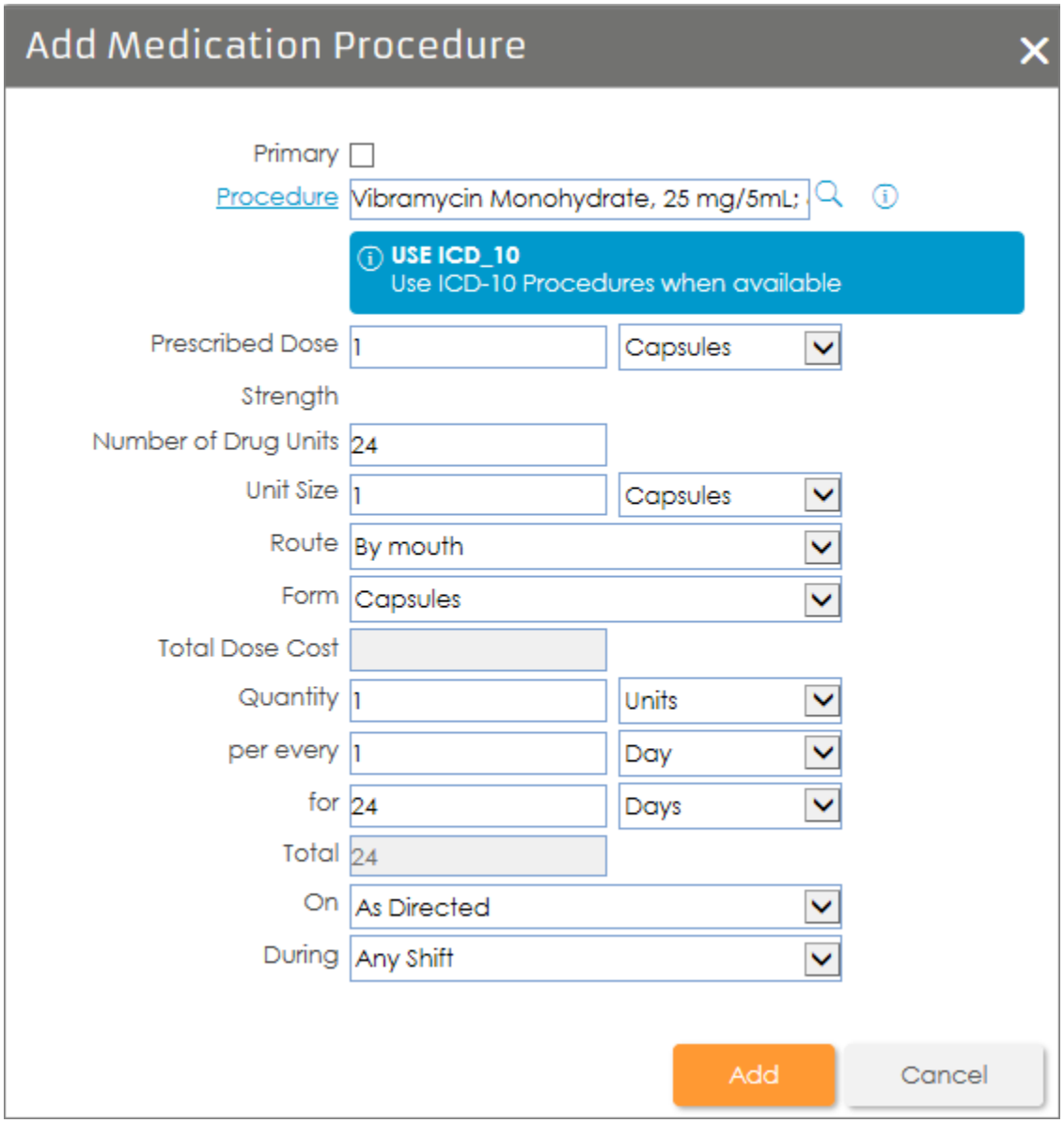
NOTE: Procedures for authorizations with a status of **Certified in Total** are not available for editing.

Adding a Medication Procedure

You can add a medication procedure in the Add Medication Procedure dialog box. The Add Medication Procedure dialog box is for associating one or more medication procedures with a service.

NOTE: When you add a procedure to a service using the Add Medication Procedure dialog box, CareAffiliate uses the service-level settings for hidden, disabled, and required fields, in addition to the default value setting for medication procedures, for the selected profile.

Click **Add Medication Procedure** at the top of the Procedure Information multirow.


Add Medication Procedure
Primary
Procedure
Vibramycin Monohydrate, 25 mg/5mL;
USE ICD_10
Use ICD-10 Procedures when available
Prescribed Dose
1
Capsules
Strength
Number of Drug Units
24
Unit Size
1
Capsules
Route
By mouth
Form
Capsules
Total Dose Cost
Quantity
1
Units
per every
1
Day
for
24
Days
Total
24
On
As Directed
During
Any Shift
Add
Cancel

Primary

Select the **Primary** check box if the medication procedure is the primary procedure for the service. There can only be one primary procedure, either standard medical or medication, per service.

Procedure

There are no procedure ranges, **Procedure (Low)** and **Procedure (High)**, for medication procedures.

Click the Lookup icon to select a procedure from the Procedure Search dialog box.

Only **NDC**, **HCPCS, or Site-Defined** procedures are available from the **Procedure Type** drop-down list in the Procedure Search dialog box.

Prescribed Dose

Indicates the specific medication dose for the member.

Strength

The read-only **Strength** field may automatically display NDC code set information, provided by a third-party vendor, that can help determine the value to enter in the **Number of Drug Units** field. The **Strength** field is blank if there is no associated NDC code set.

Number of Drug Units

The drug unit value in the **Number of Drug Units** field is used to calculate the **Total Dose Cost** field value. If this field does not have a value, then the **Total Dose Cost** field will not have a value. The **Number of Drug Units** field appears in conjunction with the **Total Dose Cost** field.

Unit Size

Indicates the medication unit of measure, for example, ounces, cc's, or milligrams. Values may display as defaulted and read-only for NDC information if your organization uses a third-party drug data set.

Route

Indicates the medication route of administration, for example, by mouth, injection, or inhalation. A drop-down list value may display by default, but is modifiable, if your organization purchased and uses a third-party drug data set.

Form

Indicates the form of the medication dosage, for example, liquid, gel caps, or powder. A value may display as defaulted and read-only for NDC information if your organization uses a third-party drug data set.

Total Dose Cost

The read-only, auto-calculated **Total Dose Cost** field displays the cost of the total medication dosage when your organization has purchased and uses a third-party NDC drug data set and the **Number of Drug Units** field has a value (both fields display or don't display based on the selected Place of Service/Service field values). The **Total Dose Cost** is calculated as follows:

Total Dose Cost = Number of Drug Units * NDC Average Wholesale Unit Price

NOTE: The NDC Average Wholesale Unit Price can only be obtained if the Procedure is an NDC code.

Quantity

The appearance of **Quantity** fields depends on the service profile configured for the selected authorization request.

Enter the number of requested medication items and select a unit of measure from the corresponding drop-down list.

Decimal values are allowed in any of the **Quantity** fields if necessary.

For example, you can enter 1.5 days instead of entering 36 hours. Up to 30 characters are allowed. Additionally, if the **Quantity** field has a value, its associated qualifier drop-down list requires a value to be selected.

Validation ensures that numerical field values (i.e. a measure of time, such a day/week/month) are equal to or greater than the preceding field value.

For example, if the **Quantity** field has a value of **Months**, then the **per every** field allows a value of **Month**, but not **Day** or **Week**, and the **for** field allows a value of **Months** or **Years**, not **Hours, Days**, or **Weeks**. Accurate **Total** calculations for cost savings features are dependent on the **Quantity** field(s).

per every

Enter a numerical value up to 6 characters and select the frequency of the service, such as **per every: Week, Month**, or **Day**, from the corresponding drop-down list. You must enter a numeric value of 1 or higher in the per every field. When the **per every** field has a value, its associated qualifier drop-down list requires you to select a value.

for

Enter a numerical value up to 3 characters for the duration of the requested service and a unit of measure from the corresponding drop-down list. You must enter a numeric value of 1 or higher in the **for** field. When the **for** field has a value, its associated qualifier is required.

Total

The view-only total value is calculated based on the **Quantity**, **per every**, and **for** field values.

For example, if a **Quantity** = 2, **per every** = Day, **for** = 10 days, then the **Total** value is 20.

When a calculation cannot be correctly made for any reason, CareAffiliate clears the **Total** field. This behavior encompasses situations in which the **Quantity** and **per every** fields have a value, but the **for** field does not have a value or has a partial value.

On

Type a pattern of delivery based on a calendar years, month, or week in the **On** field, or click the Lookup icon to select a value.

During

Enter a pattern of delivery within a day, such as A.M. You can click the Lookup icon next to the **During** field to select a service delivery time.

Editing a Medication Procedure

Edit a medication procedure in the Edit Medication Procedure dialog box. The Edit Medication Procedure dialog box includes the same fields, behaviors, and options as the Add Medication Procedure dialog box.

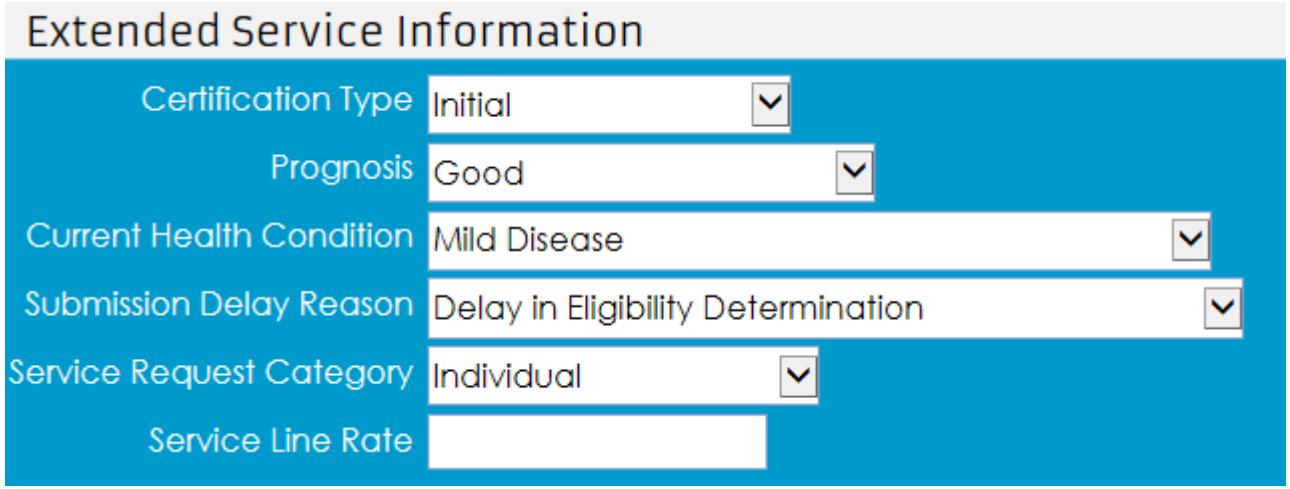
Click **Edit** in any procedure row to open the Edit Medication Procedure dialog box.

NOTE: Procedures for authorizations with a status of **Certified in Total** are not available for editing.

Extended Service Information Field Group

The Extended Service Information field group appears in the Services section when you select a service that requires additional member health information and typically includes information that could affect the MCO's decision to authorize services.

The following image shows the Extended Service Information field group:



The Extended Service Information field group contains the following information:

Certification Type

Describes the type of certification you are submitting for the authorization request. The certification type you select should be the same as the certification type selected for the Home Health Care field group.

Prognosis

Describes the probable course or outcome for the member's condition, such as Good or Terminal.

Current Health Condition

Describes the member's current health condition, such as Chronic or Excellent.

Submission Delay Reason

Describes the reason the submission was delayed if the authorization request is not made during the timelines allowed by the MCO.

Service Request Category

The Service Request Category value may be different at the authorization level than at the service level. For example, an authorization record that contains both inpatient and home follow-up components may require a different service-request category than the authorization-level category.

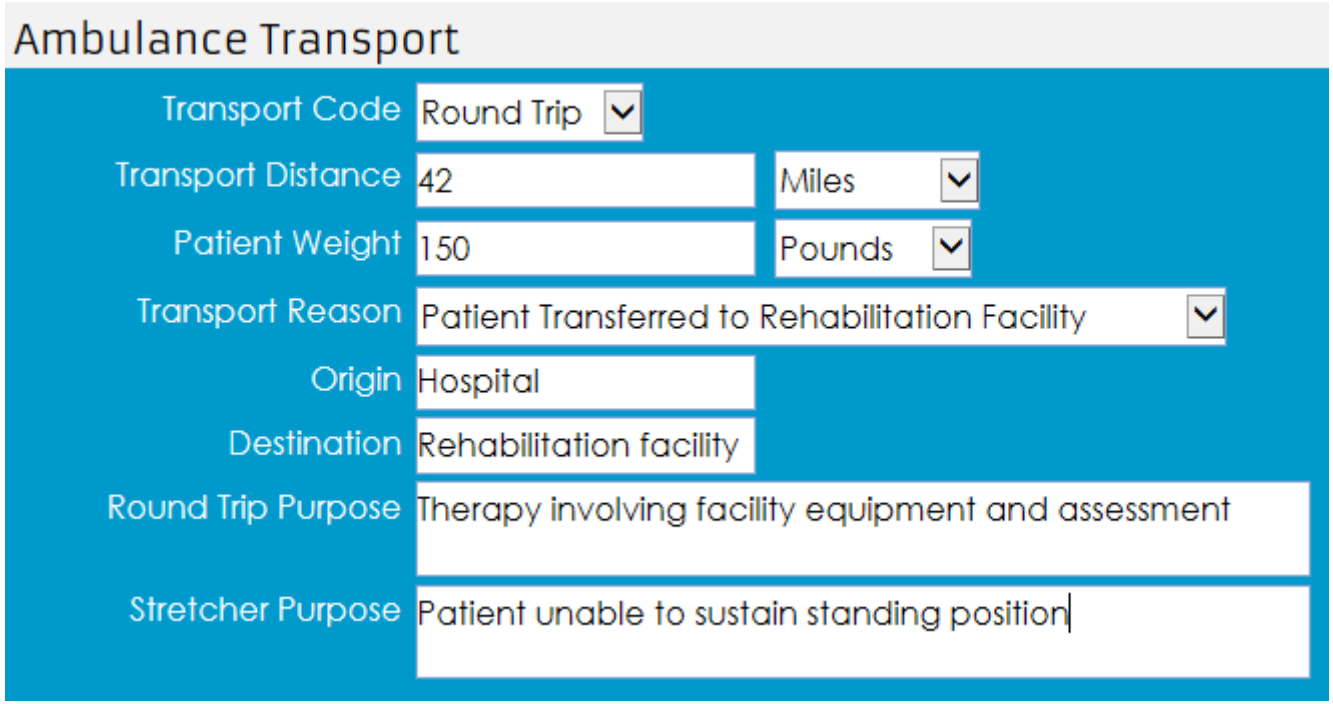
Service Line Rate

Describes the payment rate that applies to the service.

Ambulance Transport Field Group

The Ambulance Transport field group might appear in the Services section when you select ambulance transport as one of the requested services if configured by the request profile.

The following image shows the Ambulance Transport field group:



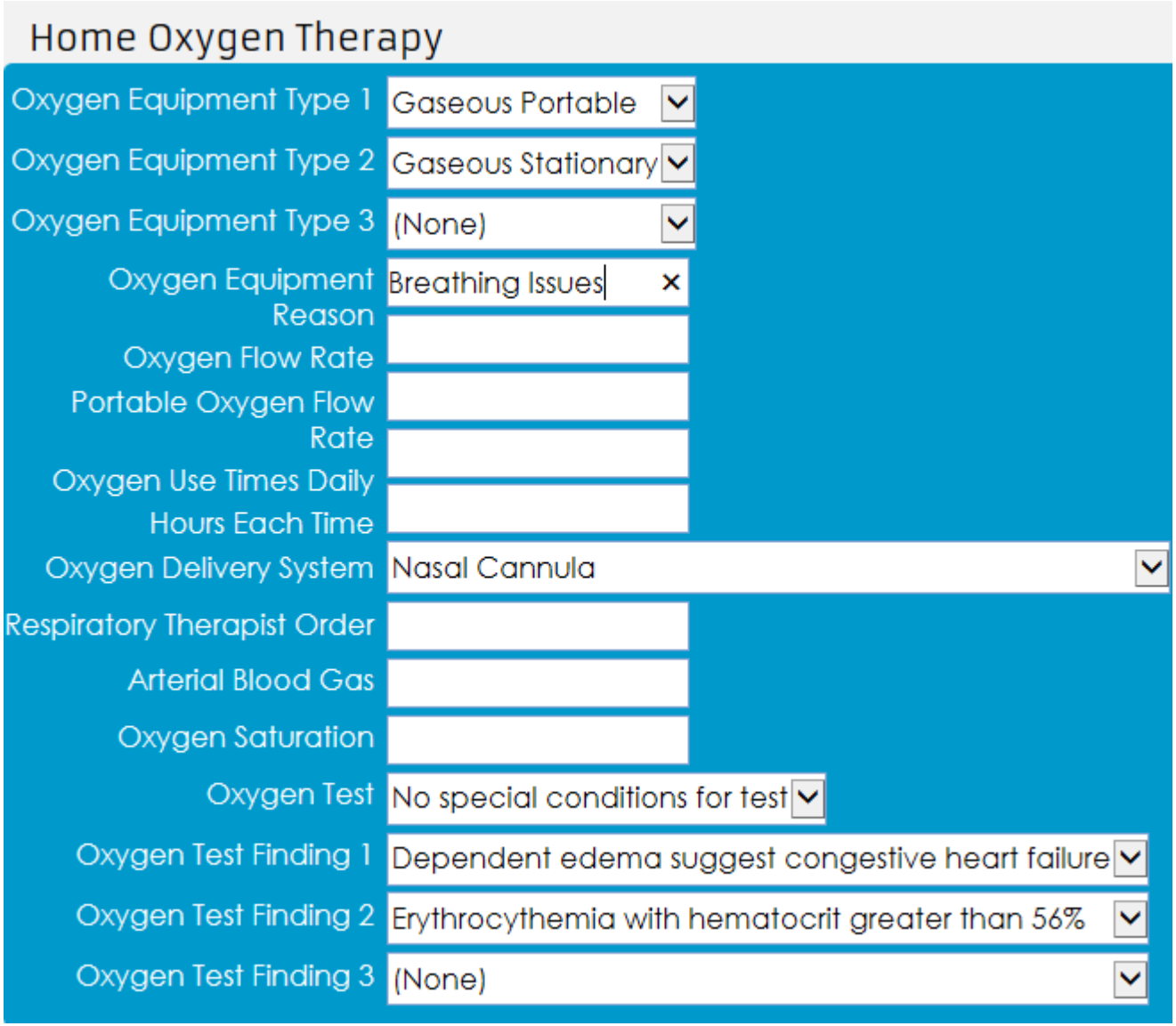
The Ambulance Transport field group contains the following information:

- Transport Code
- Transport Distance
- Transport Distance Qualifier
- Patient Weight
- Patient Weight Qualifier
- Transport Reason
- Origin
- Destination
- Round Trip Purpose
- Stretcher Purpose

Home Oxygen Therapy Field Group

The Home Oxygen Therapy field group might appear in the Services section when you select home oxygen therapy as the request type if configured by the request profile

The following image shows the Home Oxygen Therapy field group:



The Home Oxygen Therapy field group contains the following information:

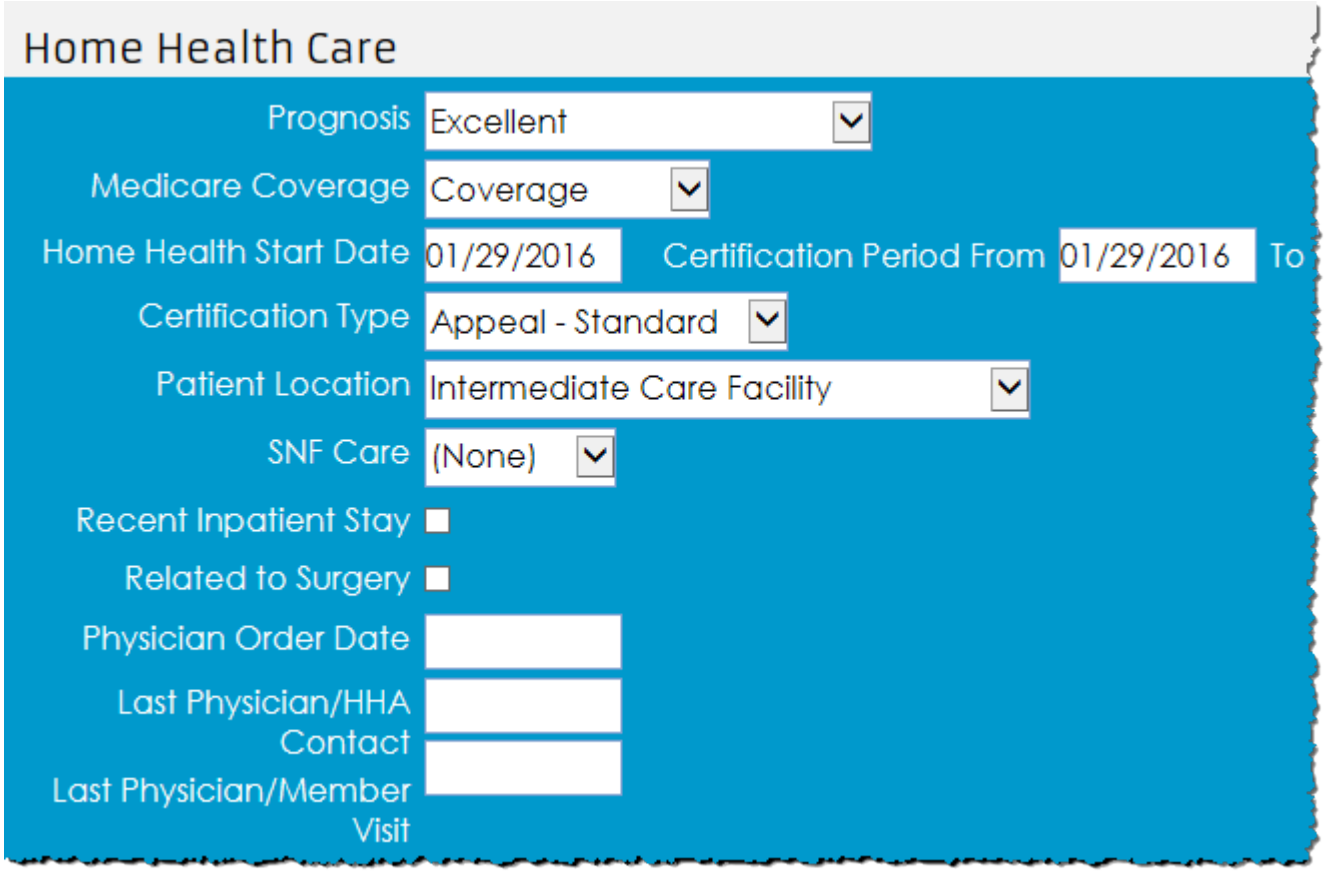
- Oxygen Equipment Type 1, 2, 3
- Oxygen Equipment Reason

- Oxygen Flow Rate
- Portable Oxygen Flow Rate
- Oxygen Use Times Daily
- Hours Each Time
- Oxygen Delivery System
- Respiratory Therapist Order
- Arterial Blood Gas
- Oxygen Saturation
- Oxygen Test
- Oxygen Finding 1, 2, 3

Home Health Care Field Group

The Home Health Care field group might appear in the Services section when you select a qualified home health service.

The following image shows the Home Health Care field group:



The Home Health Care field group contains the following information:

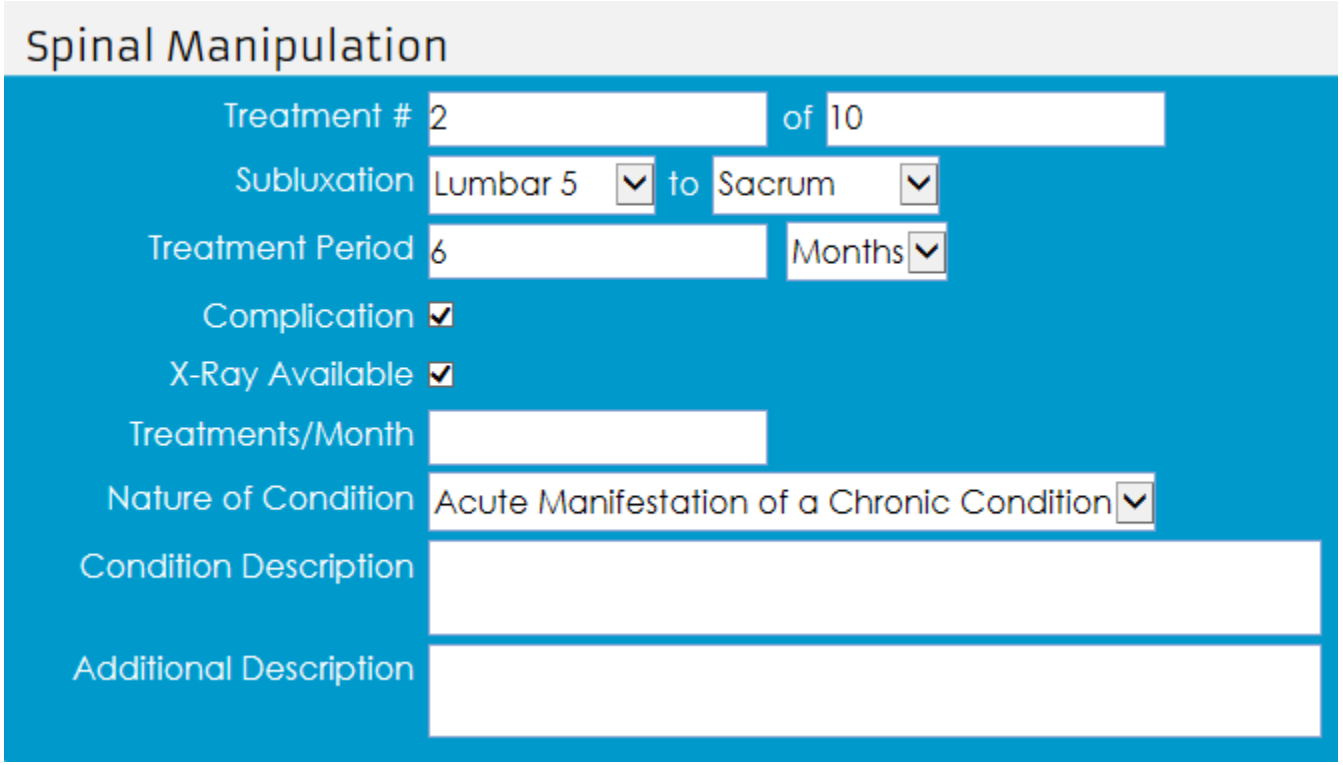
- Prognosis
- Medicare Coverage
- Home Health Start Date
- Certification Period From (date)
- Certification Period To (date)
- Certification Type
  - The certification type that you select should be the same as the certification type selected in the Extended Service Information field group.

- Patient Location
- SNF Care
- Recent Inpatient Stay
- Related To Surgery
  - When you click the **Related To Surgery** check box, the **Related Surgery Date** and **Procedure** fields appear.
- Physician Order Date
- Last Physician/HHA Contact
- Last Physician/Member Visit

Spinal Manipulation Field Group

The Spinal Manipulation field group might appear in the Services section when you select spinal manipulation as the request type for the authorization request.

The following image shows the Spinal Manipulation field group:



The Spinal Manipulation field group contains the following fields and check boxes:

- Treatment #/of (total)
- Subluxation
- Treatment Period
- Complication
  - A complication is considered a concurrent or aggravating condition that makes treatment difficult or a condition that requires precautions. For example, pregnancy might complicate spinal manipulation of the lumbar spine.
- X-Ray Available
- Treatments/Month
- Nature of Condition
- Condition Description

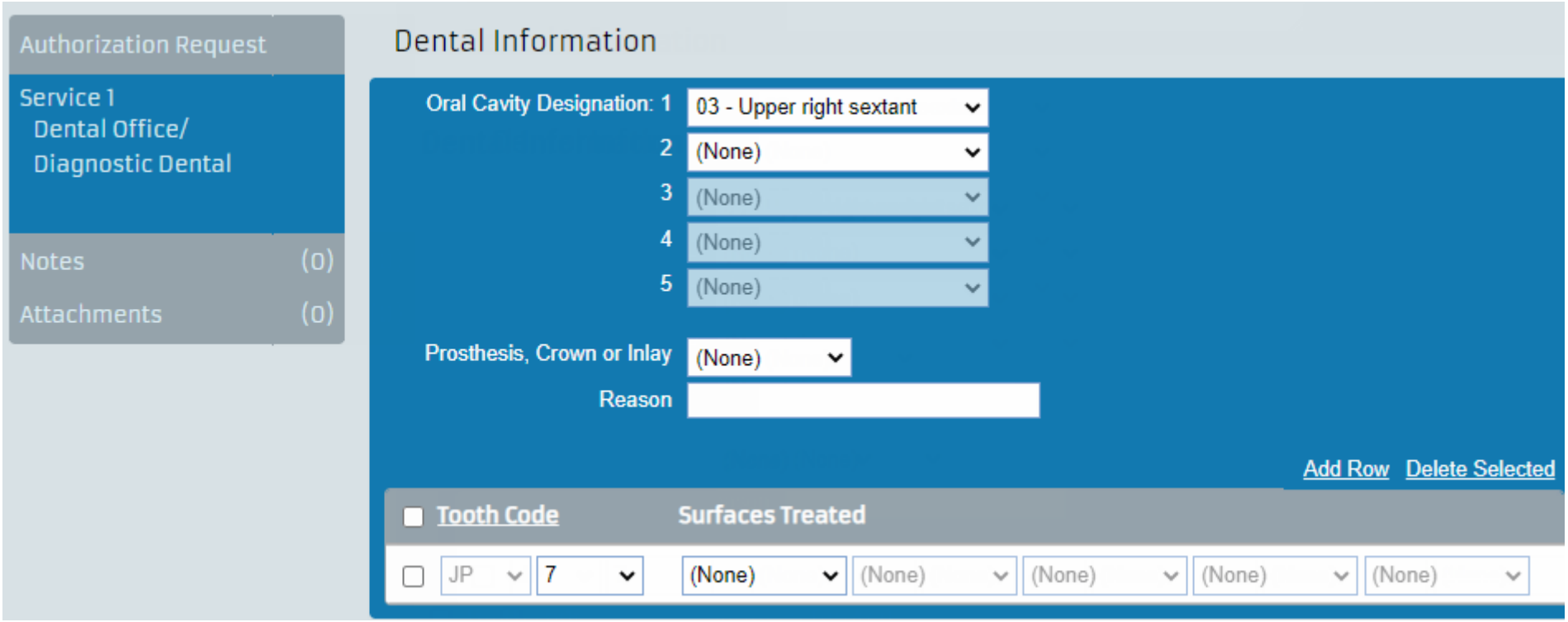
- Additional Description

Dental Information Field Group

The Dental Information field group might appear in the Services section when you select dental as the request type for the authorization request.

NOTE: The Dental Information field group accommodates 278/5010 transaction requirements.

The following image shows the Dental Information field group:



The Dental Information field group contains the following information:

- Oral Cavity Designation
- Prosthesis, Crown or Inlay
- Reason

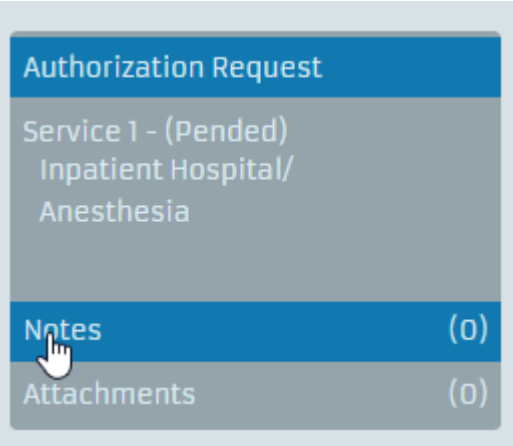
  - The **Reason** field only displays when the **Prosthesis, Crown or Inlay** drop-down list has a value of Replacement.
- Tooth Identification

Adding a Note to an Authorization/Referral

Add notes to the Notes section that can assist the MCO in the decision-making process. You can add notes to authorization requests after they have been submitted. Previous notes are view-only and appear with a date/time stamp and the name of the staff member who entered the note.

Available options in the Notes section are based on the request type for the request record and your user privileges. The Notes section also displays when the authorization request record has a status of Pended, Certified in Total, Contact Payer, or Modified, even if the request type is configured to hide the Notes section.

- To open the Notes section, click **Notes** from the panel on the left side of the Authorizations submission page.



Adding a File Attachment to an Authorization/Referral

Add file attachments that are relevant for a member's authorization request in the Attachments section.

NOTE: Files attached to components of an authorization request in CareRadius, such as service or inpatient days details records, are not available in CareAffiliate. CareRadius files must be attached at the authorization or referral level in order to appear in CareAffiliate.

1) In the panel on the left side of the Authorizations submission page, click **Attachments**.

   The Attachments section appears.

2) Click **Add File**.

   If you are working with an existing authorization request, click **Edit**, then click **Add File**.

   A file browser window opens.

3) Select the file that you want to upload and click **Open**.

   The file appears in the Attachments section.

4) Optionally, click the arrow next to the file name and enter details about the attachment in the **Description** field.

   NOTE: After you upload a CDA document, the Description no longer displays.

5) Click **Upload File(s)**.

   CareAffiliate adds the attached file to the request record and makes the files available in CareRadius.

   CareAffiliate displays file attachments in the Attachments multirow based on the order they were uploaded, with the most recent file attachments at the top of the multirow.

6) Click **Submit**.

   You cannot delete file attachments from an authorization request record after you submit the record.

Attaching a CDA Document to an Authorization/Referral

Clinical Document Architecture (CDA) is an XML-based markup standard that defines the structure of certain medical records and includes numerous template types.

You can attach CDA documents to an authorization or referral request in the Attachments section in order to provide additional clinical information to the health plan.

To attach a CDA document, the CDA document and any referenced file attachments must be contained in a zip file.

When you upload the zip file, CareAffiliate displays the CDA document in an attachment row. If the zip file contains multiple CDA documents, CareAffiliate displays an attachment row for each CDA document.

The following image shows a CDA document in an attachment row:

File Name	CDA Title	Date/Time Attached	File Size	Status
CCD_Document.xml	Good Health Health Summary	11/02/2016 10:13	91 KB	Attached

To open a CDA document's referenced file attachments, you must open the CDA document and click the attachment links within the CDA document.

CDA documents attached to authorization or referral requests in CareAffiliate appear in CareRadius on the All Documentation tab and on the workflow Documentation tab for the associated authorization or referral request.

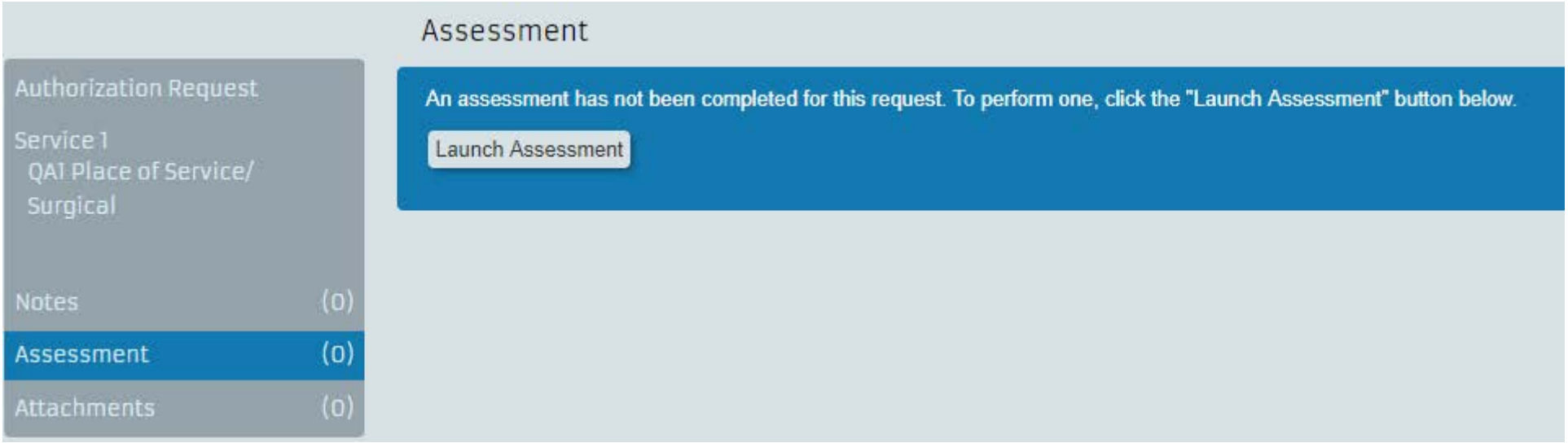
Adding an Assessment

Add an assessment to an authorization request that applies clinical guidelines (criteria assessments) to a request, gathers standard information, or includes more specific or comprehensive member notes.

An assessment's outcome does not definitively determine whether a request is approved or denied.

NOTE: Assessments are only available when the selected request type has been configured for an assessment. If you do not have security privileges for the assessment type associated with the selected request type (profile), then you cannot submit the authorization, regardless of whether it is a new or existing authorization, or whether the assessment is complete or incomplete.

1) In the panel on the left side of the Authorizations submission page, click **Assessment**.



The Assessment page opens.

2) Click **Launch Assessment**.

- If the assessment associated with the selected request type is for a Change Healthcare InterQual® Review Manager, and your system does not meet the minimum system requirements, then an alert message appears.
- If the assessment associated with the selected request type is system-defined, then the Assessment dialog box opens.

When possible, member information, diagnoses codes, and procedure codes specified in the original authorization or referral request automatically populate in the assessment.

NOTE: The Met/Not Met criteria indicators may or may not display depending on configuration settings for the assessment.

3) If the assessment is configured to allow multiple responses, click **Add Response** after the item to add a field for the additional response.

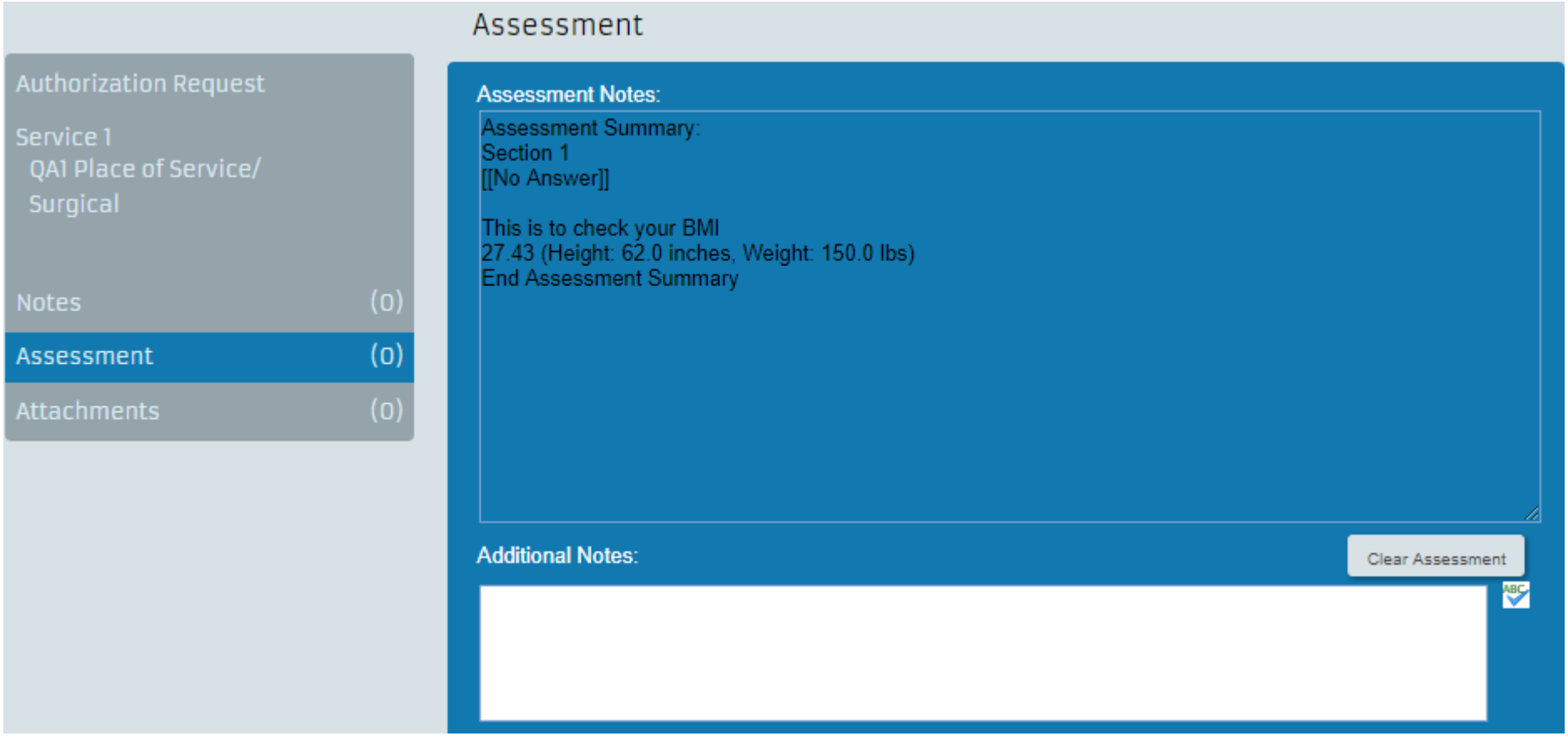
4) Click **Complete** when you are finished with the assessment.

You can also click **Clear Assessment** to remove the assessment from the request.

When you complete an assessment, the read-only **Assessment Notes** field displays assessment results.

NOTE: CareAffiliate truncates assessment entries that exceed the 2000 character limit and displays an informational message indicating that the entry was shortened to meet the maximum character limits.

After you submit an authorization request record and its associated assessment, you can only edit the assessment notes, and only then if the record's status is **Pended**.



Only the MCO can add an assessment after an authorization request is submitted.

InterQual Connect Medical Review Services Assessment

Change Healthcare is replacing its legacy InterQual® Review with the new Cloud-based InterQual Connect Medical Review Service (MRS). Once the new MRS application is enabled, you will no longer be able to create new assessments with the standard InterQual Review application. You can, however, continue to work with existing reviews until the transition to the new InterQual Connect MRS application is complete.

NOTE: Assessments or reviews based on InterQual® criteria open a proprietary notice message within CareAffiliate, and includes an option to agree or not agree before you begin creating the assessment. If this is the first time running InterQual Connect MRS, a Copyright window appears. Click **OK** to continue.

Consider the following information about InterQual Connect Medical Review Service assessments:

- You can append InterQual® assessments performed with InterQual Connect MRS, but completed InterQual assessments are not available for editing, regardless of user privilege settings.
- If the InterQual product in which the review was initiated is not enabled, then the user is not presented with a functional link to open the review in the InterQual product.
- CareRadius and CareAffiliate users can review the formatted Review Summary saved in the assessment record MNO_MEM_NOTE).
- If a review has been saved, but not completed, then the CareAffiliate user can reopen the review for editing.
- If a review has been completed, then the CareAffiliate user can reopen the review for viewing only.
- When InterQual Connect MRS is enabled, and the authorization request is in Edit mode, then a reopen link, either Saved or Completed, is visible and active.
- The reopen link text displays Saved when the status of a review is "In Primary".
- The reopen link text displays Completed when status of a review is "Completed".
- InterQual reviews created in CareRadius are neither visible nor accessible in CareAffiliate.
- InterQual reviews created in CareAffiliate are visible and accessible in CareRadius.
- CareAffiliate InterQual Assessments on the CareRadius Documentation tab have a status of Completed, and can only be viewed, not edited.
- The Assessment is displayed, on the CareRadius Documentation tab, at the Authorization Service level, not at the Authorization level.

Adding a Survey

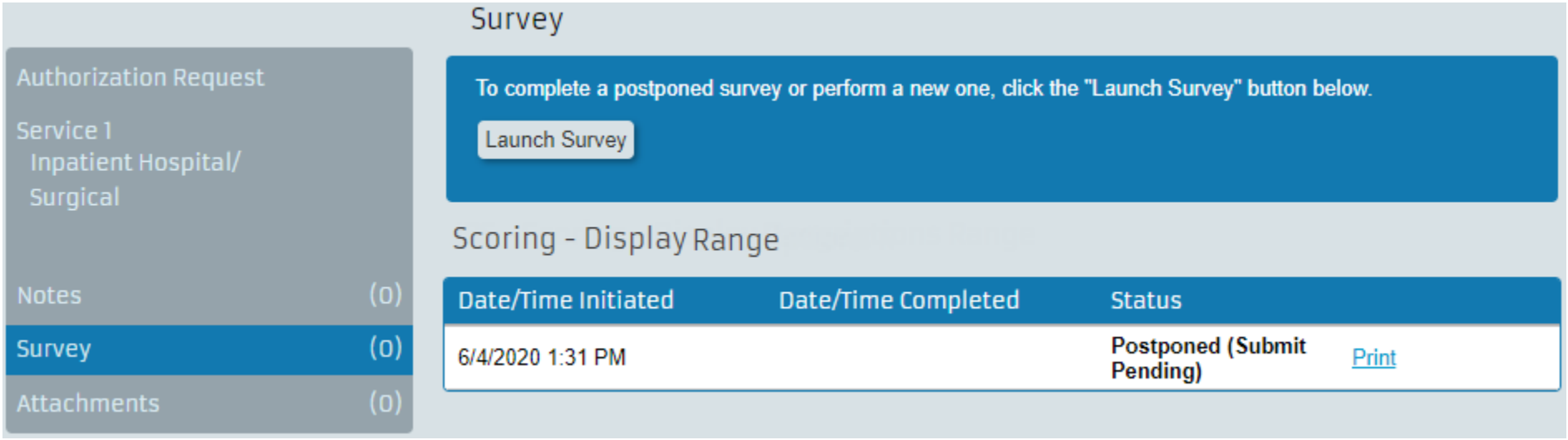
Add a survey to an authorization request that allows you to assess pre-certification for a specific service, identify preferences based on a member's situation, and collect other information relevant to the member and the member's authorization request.

A survey outcome does not definitively determine whether a request is approved or denied.

NOTE: Surveys are only available in the Authorizations or Referrals modules and only when the selected request type has been configured for a survey. If you do not have security privileges configured for surveys, then you cannot submit the authorization if you are submitting a new authorization or an existing authorization with an incomplete survey. You can submit an authorization with a completed survey.

1) In the panel on the left side of the Authorizations submission page, click **Survey**.

   The Survey page opens.



2) Click **Launch Survey**.

   The Surveys page opens for the survey associated with the selected request type.

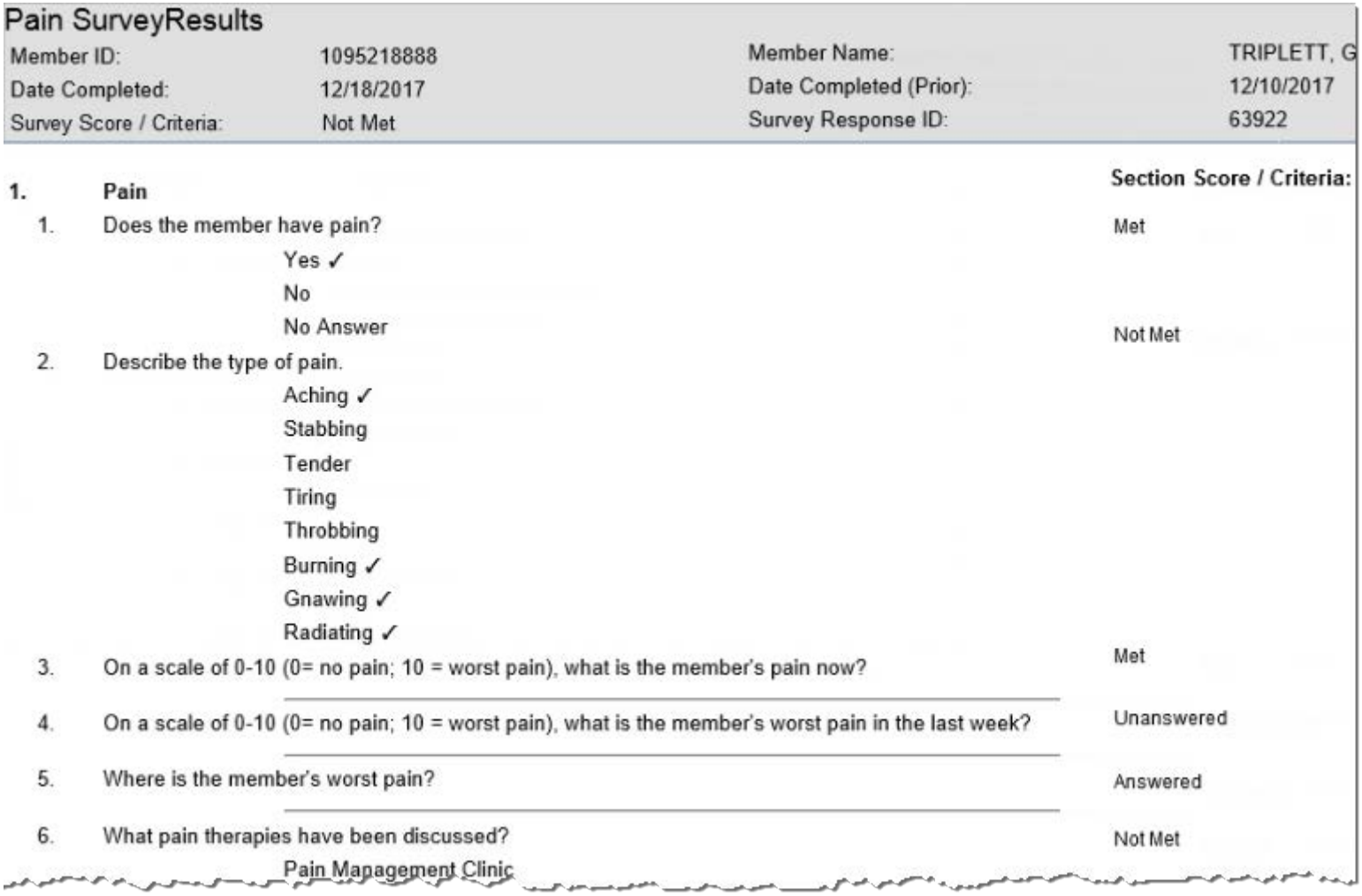
NOTE: Upon scrolling, a Back To Top button displays at the bottom of the page. Click the **Back to Top** button to return to the beginning of the survey.

3) Click **Done** when you are finished with the survey.

4) On the Survey page, click **Print** in any survey row to preview that survey in a separate browser window.

NOTE: Survey items on the Survey page are the same items displayed in the survey print preview. Survey items that are filtered out, or otherwise configured to be hidden, are not displayed.

The following image is an example of the survey preview page that opens when you click **Print** in a Survey row.



Pain SurveyResults

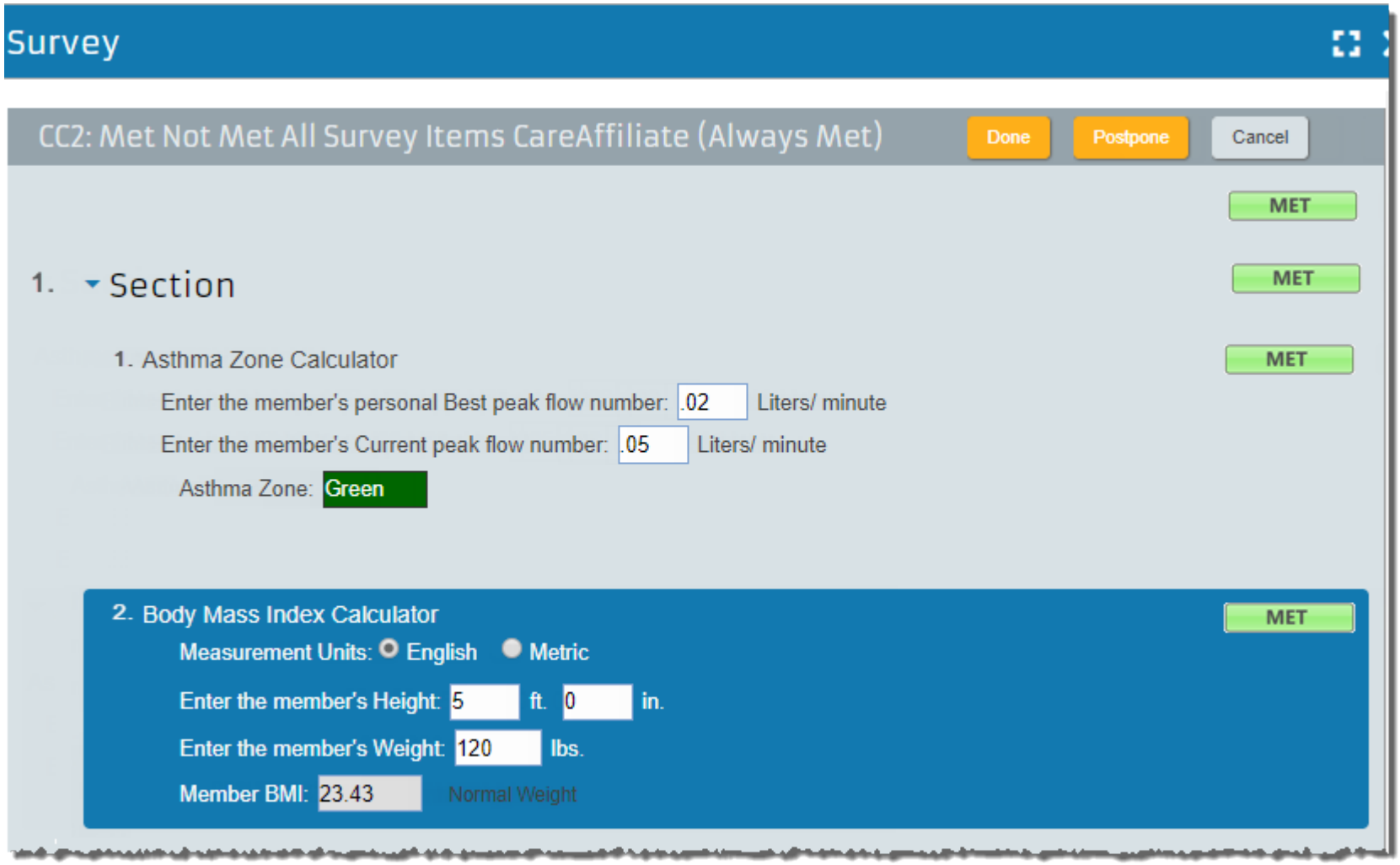
Member ID:	1095218888	Member Name:	TRIPLETT, G
Date Completed:	12/18/2017	Date Completed (Prior):	12/10/2017
Survey Score / Criteria:	Not Met	Survey Response ID:	63922

		Section Score / Criteria:
1.	**Pain**	
1.	Does the member have pain?	Met
	Yes ✓	
	No	
	No Answer	Not Met
2.	Describe the type of pain.	
	Aching ✓	
	Stabbing	
	Tender	
	Tiring	
	Throbbing	
	Burning ✓	
	Gnawing ✓	
	Radiating ✓	
3.	On a scale of 0-10 (0= no pain; 10 = worst pain), what is the member's pain now? _____	Met
4.	On a scale of 0-10 (0= no pain; 10 = worst pain), what is the member's worst pain in the last week? _____	Unanswered
5.	Where is the member's worst pain? _____	Answered
6.	What pain therapies have been discussed?	Not Met
	Pain Management Clinic	

NOTE: You can only administer one open survey, per survey type, for a single member. Open surveys include surveys with a suspended, postponed, or pending care plan. All other surveys of the same type for the member must be closed in order to initiate a new instance of the same survey.

Surveys with Met/Not Met Criteria

Surveys configured to use Met/Not Met criteria display green (Met) or red (Not Met) indicators beside each survey item and a Met or Not Met indicator for the entire survey at the top of the survey page.



NOTE: Depending on configuration for the survey, the Met/Not Met criteria indicators may not display at all.

User Benefits for Surveys with Authorization Requests

The following examples provide examples for how surveys launched from the Authorizations or Referrals modules can assist staff with authorization request submissions.

NOTE: Survey availability and authorization association depend on the request type (profile) entered in the Request Type field on the Authorizations submission page and your security privileges for surveys in CareAffiliate.

Submitting an Authorization/Referral Request

After you select a request type, enter service details, and add applicable notes, attachments, and/or assessments to an authorization request, click **Submit**. CareAffiliate sends the authorization request to the MCO.

NOTE: All concepts and tasks for the Authorizations module as described in this guide also apply to the Referrals module.

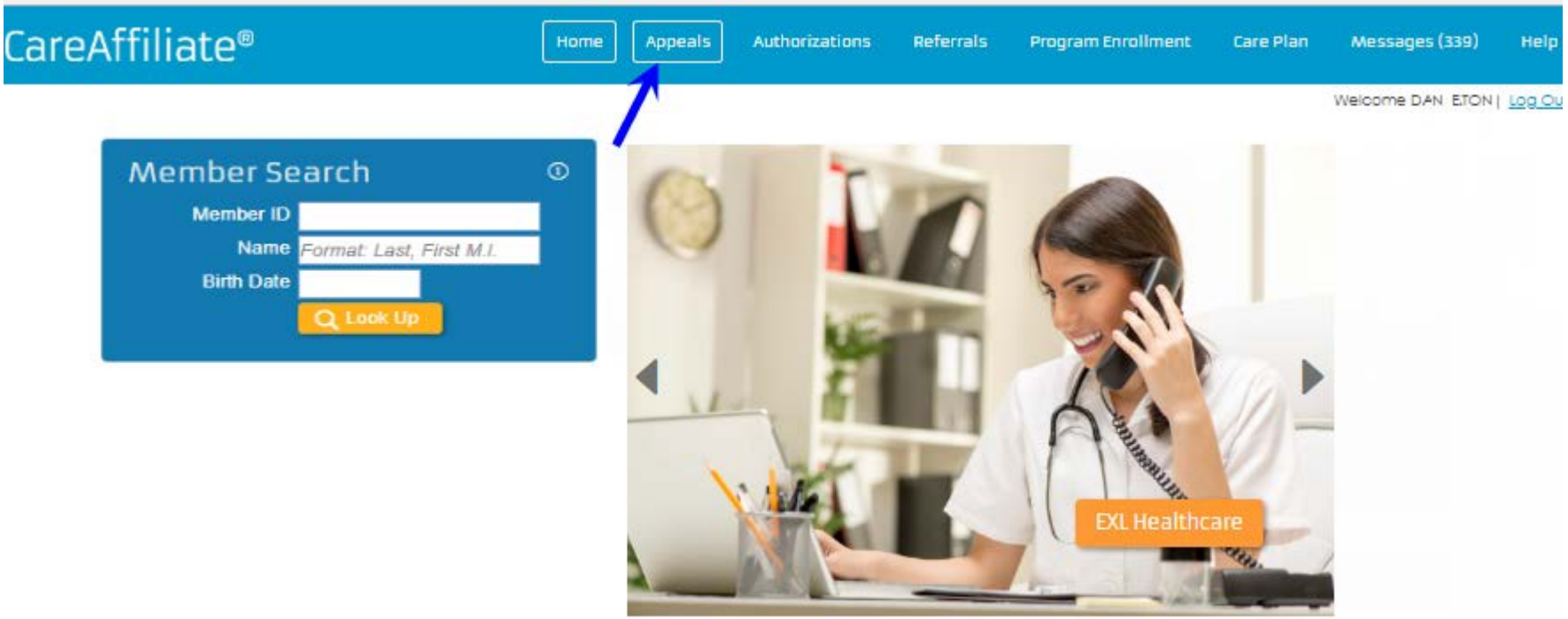
You can view and edit authorization request records after they have been submitted.

Appeals

Appeals Overview

Use the Appeals module to initiate an appeal for denied authorization or referral requests. You can also review the disposition of submitted appeals and receive automatic notifications of appeal dispositions.

You can access the Appeals module from the toolbar on the CareAffiliate Home page.



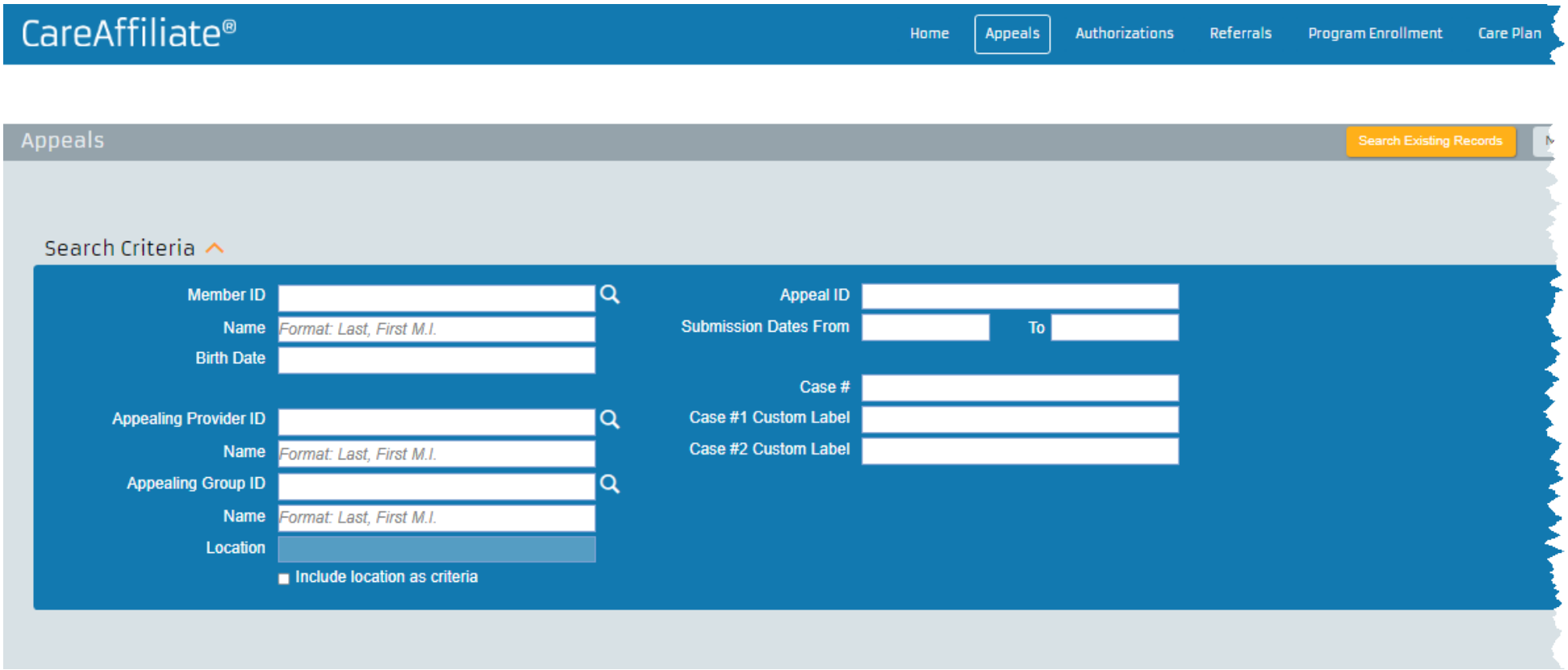
You can also access the Appeals module from the Authorizations and Referrals modules by clicking the Create Appeal button that conditionally displays in the Member stripe for authorization or referral records with a status of Modified or Not Certified.

Initiating an Appeal from the Appeals Module

You can initiate a new appeal from the Appeals module.

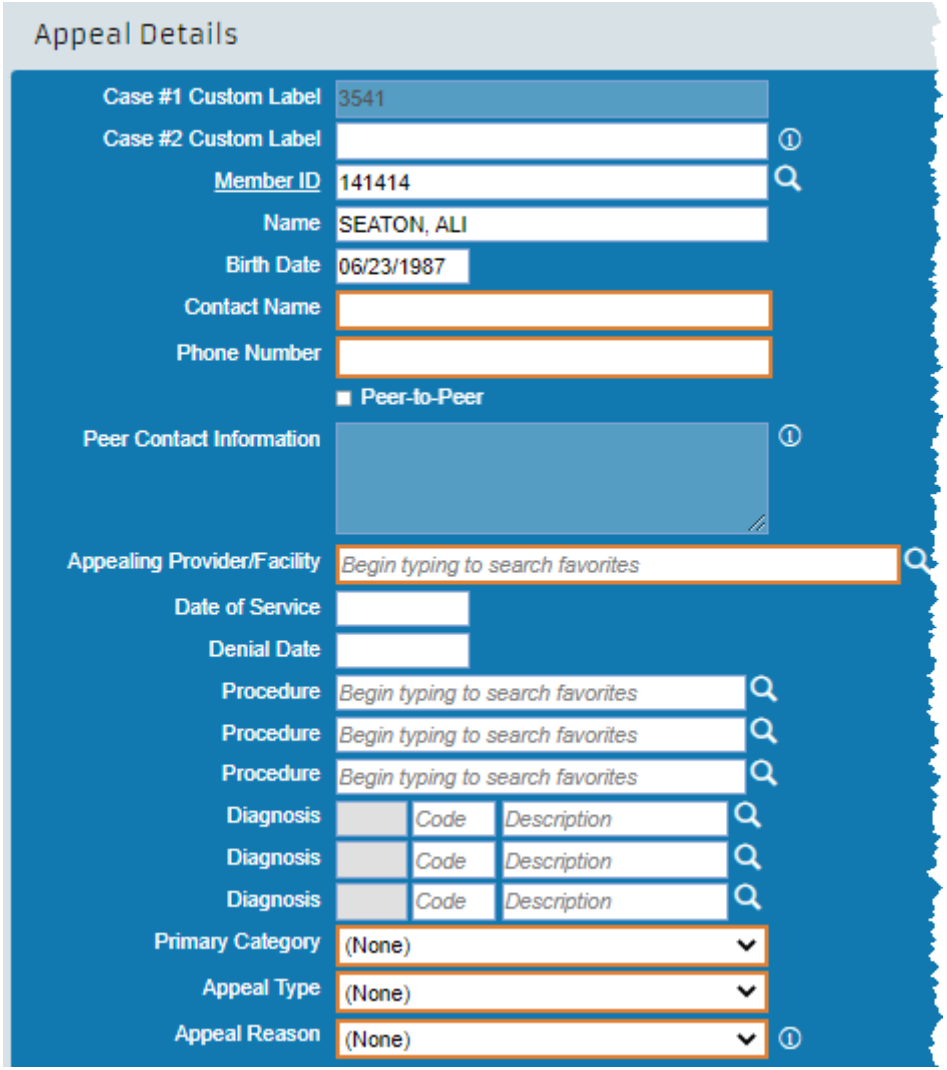
1) Click the Appeals module button on the CareAffiliate main toolbar.

   The Appeals page appears.



2) Click **New Appeal**.

The Appeal Details page appears.

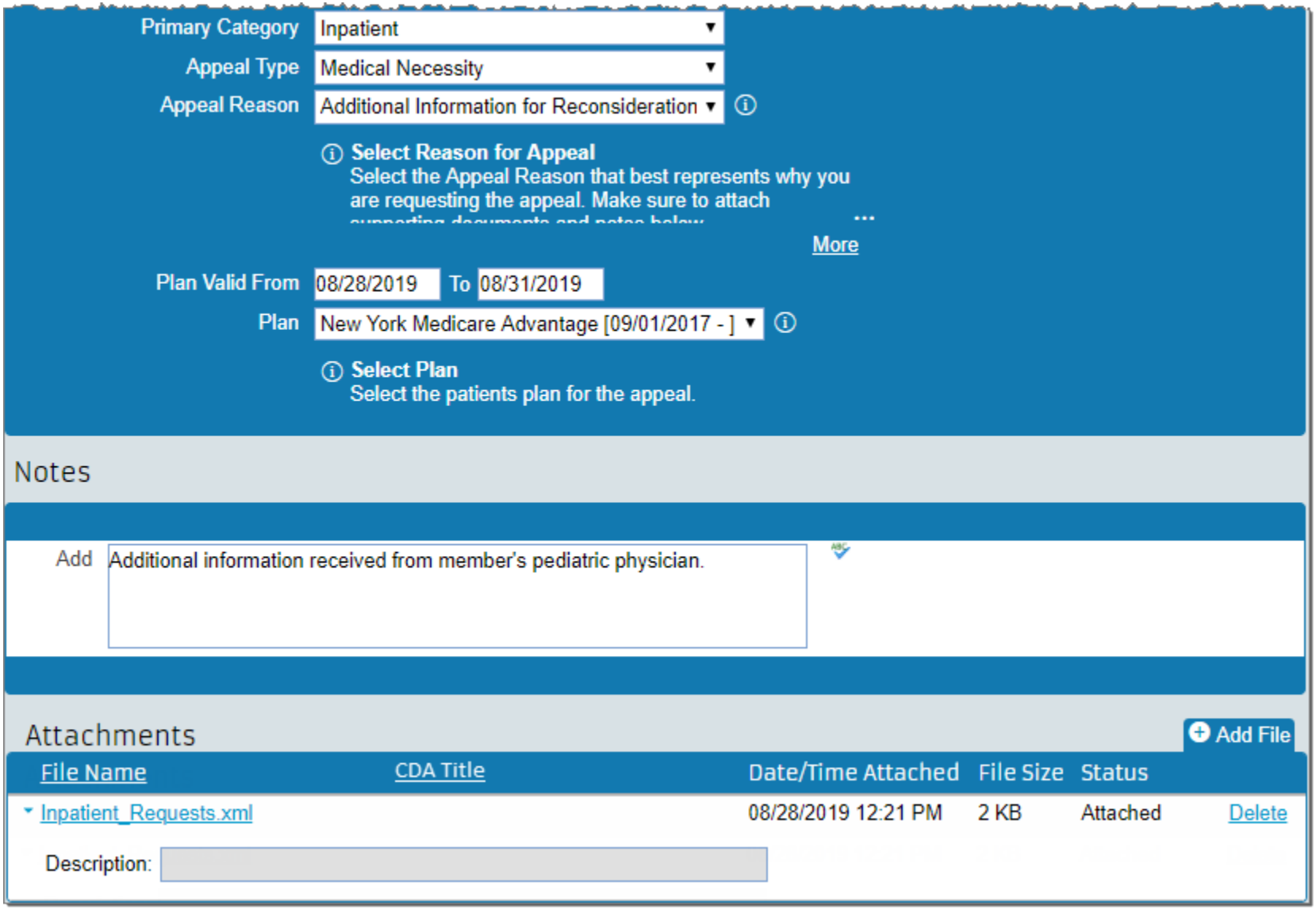


3) Enter member, provider, Service and Denial Dates, Procedures, Diagnoses, and all other appeal information in the required fields.

NOTE: The availability of the Peer-to-Peer check box and Peer Contact Information field is based on your security privileges.

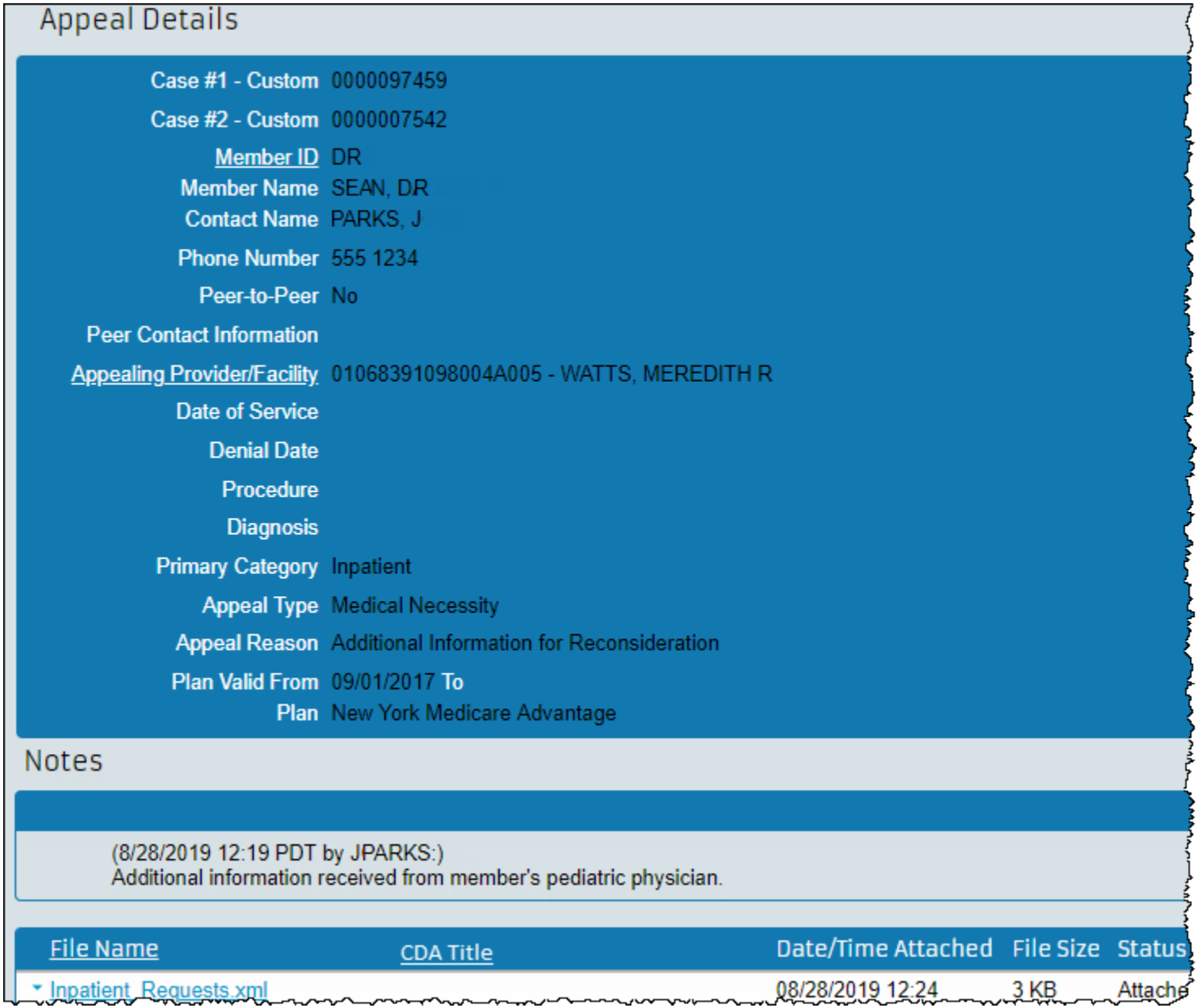
4) In the Notes section, add any additional supporting information in the Add field.

5) Under Attachments, click **Add File** to add supporting information as an attachment.



6) Click **Submit**.

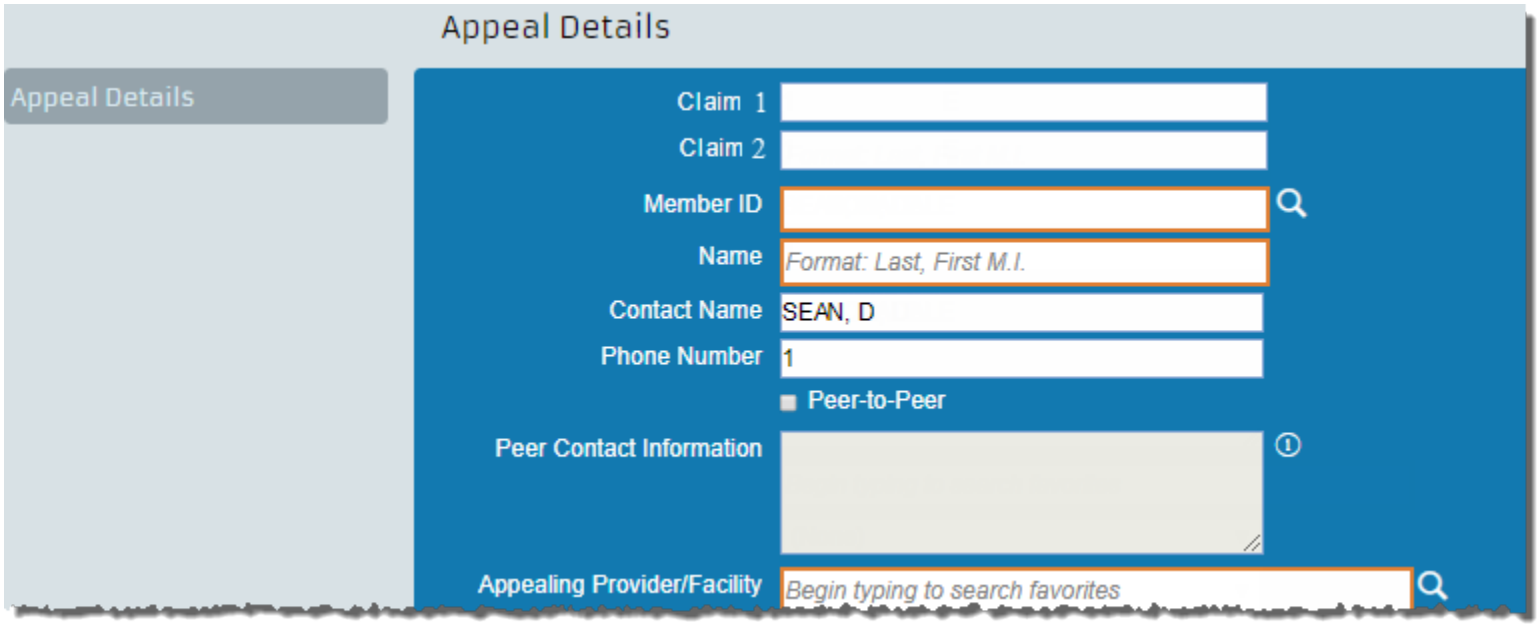
The Appeal Details page displays view-only information for the submitted appeal record.



7) Click **Edit** in the Appeals toolbar to make limited modifications to the submitted appeal record.

Appeal Claim ID Fields

If your organization has opted to display Claim ID information for appeal records, then either one or two Claim ID fields are displayed above the Member ID field.



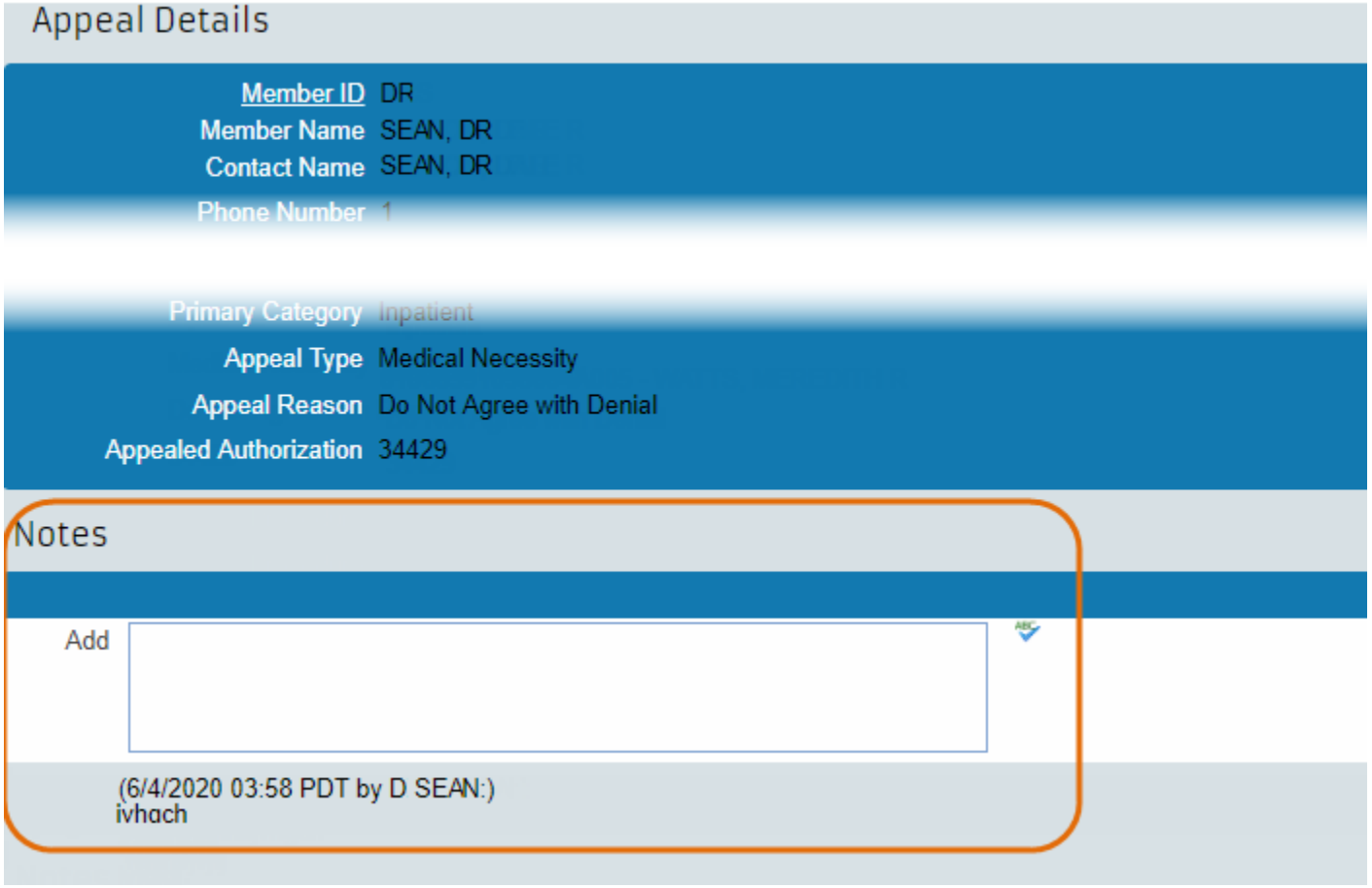
Consider the following information associated with the Appeal Claim ID fields:

- The Claim ID field labels are configurable and determined by your organization's system administrator.
- Whether the fields display, are visible but not enterable, or visible and enterable is determined by your organization's system administrator.
- Claim ID fields may present a custom help "i" icon which you can click to open a dialog box with information associated with the claim ID or Case #. Information may also appear inline, on the page. Whether the custom help set is available, and the content within the custom help, is determined by your organization.
- When the Appeal record is submitted, the Claim ID fields are disabled.
- Appeal Claim ID values may be editable if the appeal is reopened.

Adding a Note

You can add notes to a new or existing Appeal record. Previous notes are view-only, but can be appended. Notes for a submitted appeal appear with a date/time stamp and the name of the staff member who entered the note.

The Notes section displays on the Appeal Details page.



Adding a File Attachment

Add file attachments that are relevant for a member's appeal record in the Attachments section.

1) Click **Add File**.

   If you are working with an existing appeal record, click **Edit**, then click **Add File**.

   A file browser window opens.

2) Select the file that you want to upload and click **Open**.

   The file appears in the Attachments section.

3) Optionally, click the arrow next to the file name and enter details about the attachment in the **Description** field.

   NOTE: After you upload a CDA document, the Description no longer displays.

4) Click **Upload File(s)**.

   CareAffiliate adds the attached file to the appeal record and makes the files available in CareRadius.

   CareAffiliate displays file attachments in the Attachments multirow based on the order they were uploaded, with the most recent file attachments at the top of the multirow.

5) Click **Submit**.

   You cannot delete file attachments from an appeal record after you submit the record.

Attaching a CDA Document

Clinical Document Architecture (CDA) is an XML-based markup standard that defines the structure of certain medical records and includes numerous template types.

You can attach CDA documents to an appeal record in the Attachments section of the Appeal Details page in order to provide additional clinical information to the health plan.

To attach a CDA document, the CDA document and any referenced file attachments must be contained in a zip file.

When you upload the zip file, CareAffiliate displays the CDA document in an attachment row. If the zip file contains multiple CDA documents, CareAffiliate displays an attachment row for each CDA document.

The following image shows a CDA document in an attachment row:

File Name	CDA Title	Date/Time Attached	File Size	Status
CCD_Document.xml	Good Health Health Summary	11/02/2016 10:13	91 KB	Attached

To open a CDA document's referenced file attachments, you must open the CDA document and click the attachment links within the CDA document.

CDA documents attached to an appeal record in CareAffiliate are available in CareRadius on the All Documentation tab.

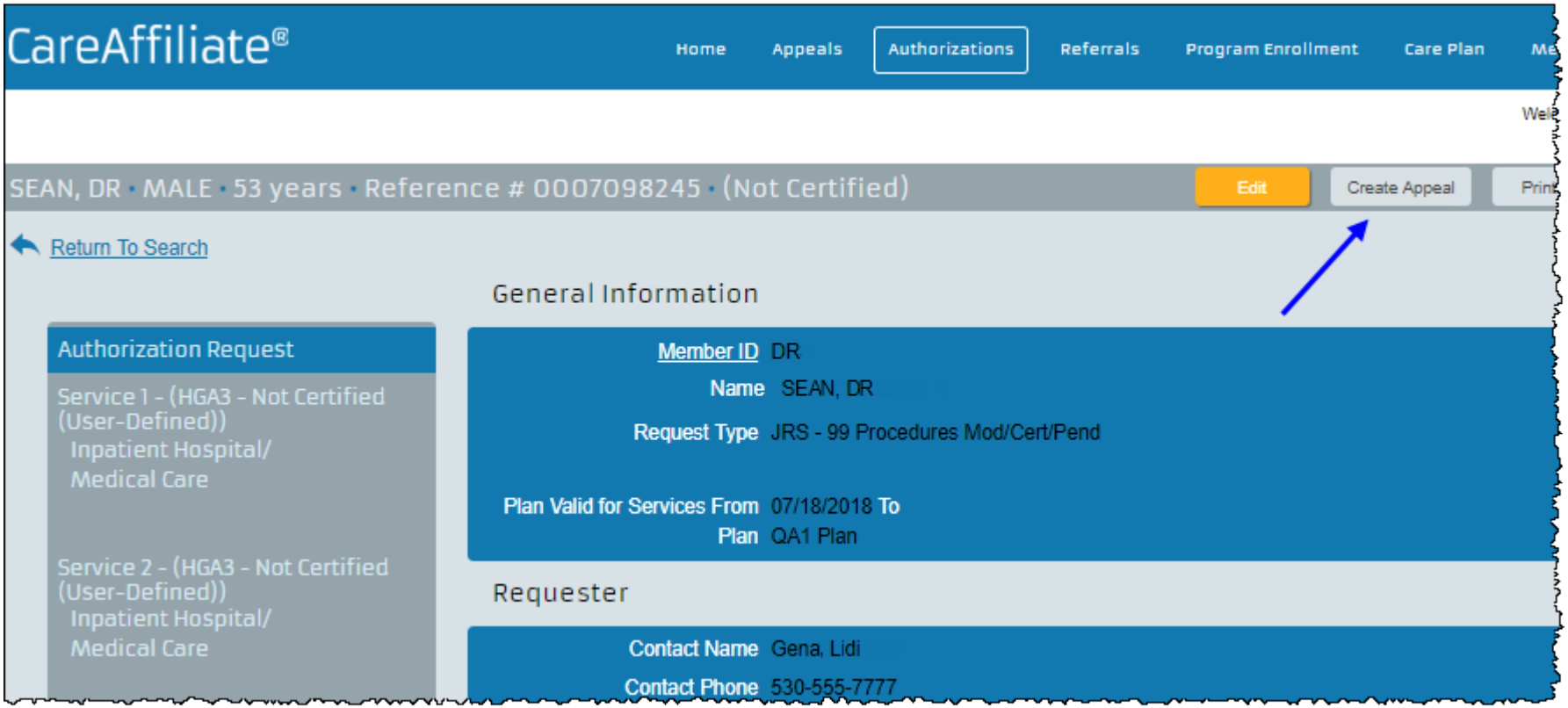
Initiating Appeals from Authorizations/Referrals Modules

You can initiate an appeal from the Authorizations or Referrals modules for records with a status of Modified or Non-Certified, provided you have security to access the **Create Appeal** button on the Authorizations/Referrals stripe.

The **Create Appeal** button is available for Inpatient Authorization requests with a Certified status when any of the Days History Response rows are in a Non-Certified status.

NOTE: For example, users with security for just the **Create Appeal** button can appeal denied requests for additional days on an authorization request that was approved for the initial hospital days.

The **Create Appeal** button is available for Certified authorizations when the user has security for the **Create Appeal** button, and the user's security profile includes the Can Appeal Certified Authorizations security privilege.



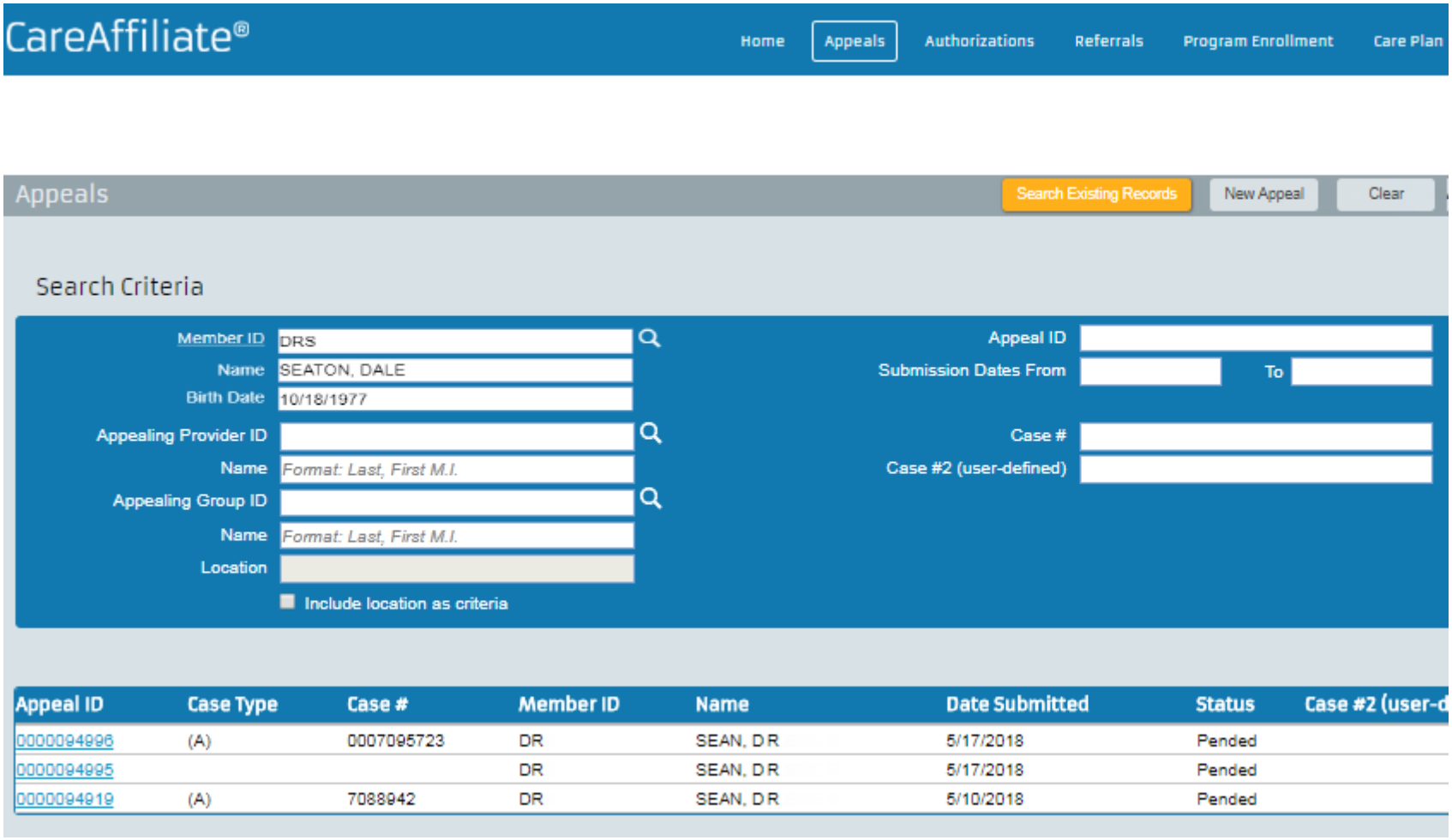
The **Create Appeal** button opens the Appeals module with the member's information defaulted.

The **Create Appeal** button is disabled when the authorization or referral record is in **Edit** mode.

Retrieving Existing Appeal Records

You can search for an existing appeal using specific values in the Search Criteria fields.

NOTE: Case #1 and Case #2 field labels for additional case criteria are configured by your organization and may or may not display.



1) Enter values in at least the Member ID and Name fields, and in the Case fields if available.

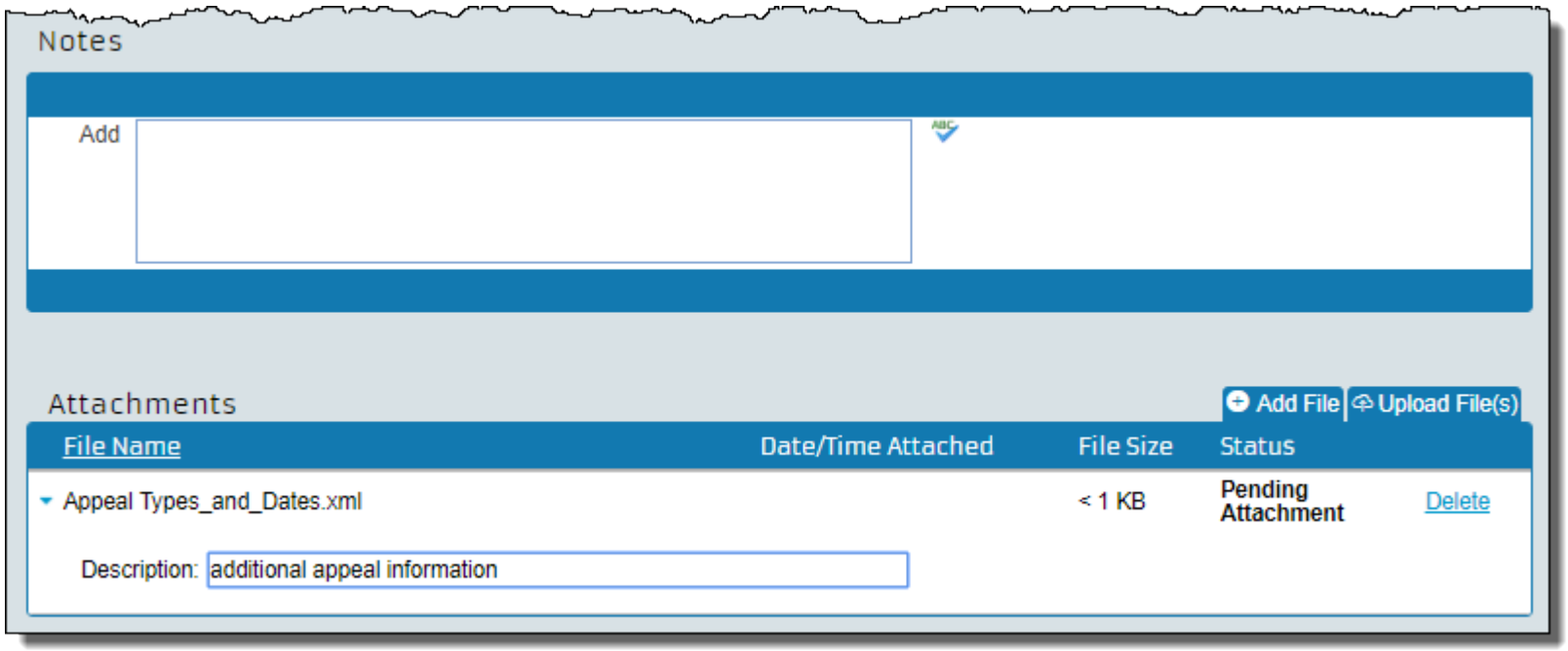
2) Click **Search Existing Records**.

3) In the Results section, click the **Appeal ID** link to open the appeal record in the Appeals module.


old · DR
Edit
ded)
Appeal Details
Case #1 - Custom 0000097449
Case #2 - Custom 0000007422
Member ID DR
Member Name SEAN, D R
Contact Name ATON, DAN
Phone Number 3672137660
Peer-to-Peer No
Peer Contact Information
Appealing Provider/Facility 62103672137660B003 - STON, ANTHONY D
Date of Service
Denial Date
Procedure
Diagnosis
Primary Category Dental
Appeal Type Medical Necessity
Appeal Reason Additional Information for Reconsideration
Plan Valid From 09/01/2017 To
Plan New York Medicare Advantage
File Name
Date/Time Attached
File Size
There are no records to display.

NOTE: Appeal Details are view-only and cannot be modified. Notes and File Attachment features are unavailable until you click **Edit**.

4) Click **Edit** to enable the Notes and File Attachment sections.



5) Enter notes in the **Add** field in the Notes section if applicable.

6) Click **Add File** and browse for attachments you want to associate with the appeal record.

7) Expand the row and enter a description of the attached file in the **Description** field.

8) Click **Upload File** in the Attachments section.

9) Click **Submit**.

Program Enrollment Module

Program Enrollment Module Overview

Use the Program Enrollment module to request health programs for members. Health programs are proactive health management solutions to improve members' overall health and quality of life.

Case Management (CM) and Disease Management (DM) are the two main types of health programs.

Case management involves interaction between an MCO's staff and plan members who require guidance and direction in order to overcome specific conditions or to generally improve their health and well being. Case management can include social work and lifestyle counseling in addition to health care direction and planning.

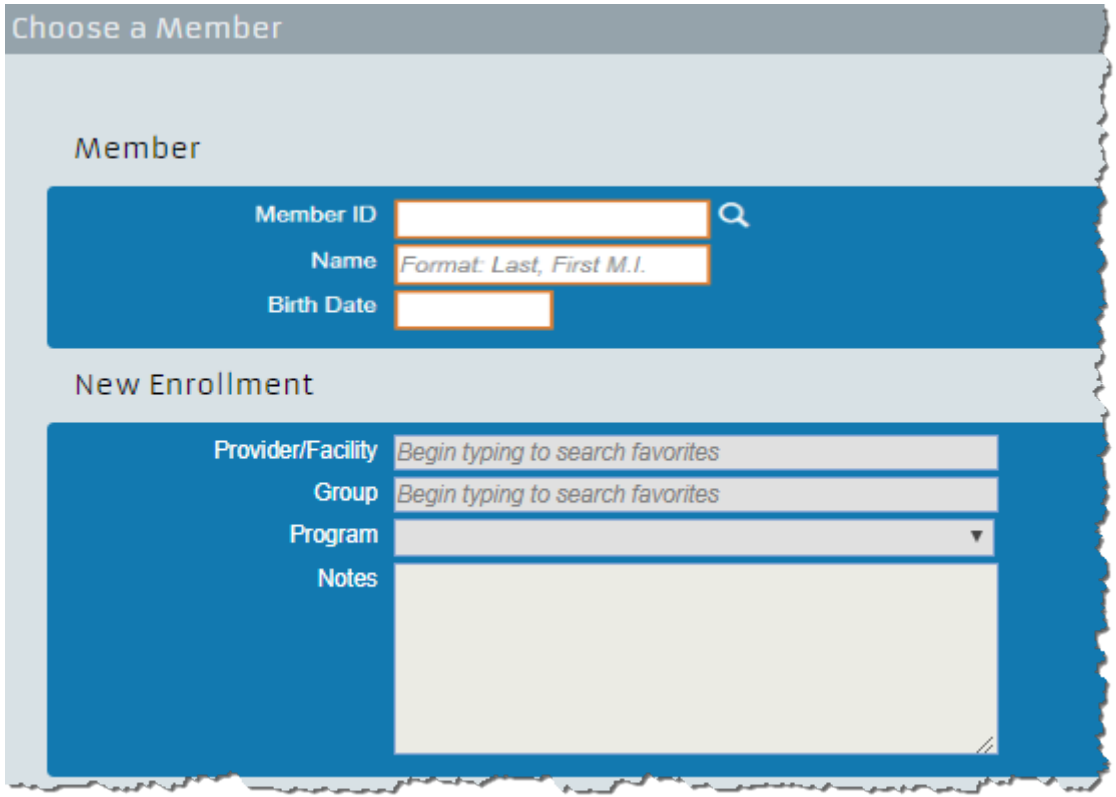
Disease management involves the delivery of education and health care services to members who have been diagnosed with specific conditions. Common disease management programs cover diabetes care, HIV, and cancer treatment.

Enrolling a Member

Search for and enroll a member in a new program. Member searches are limited to currently-enrolled members.

1) On the home page, click **Program Enrollment**.

   The Choose a Member page opens.

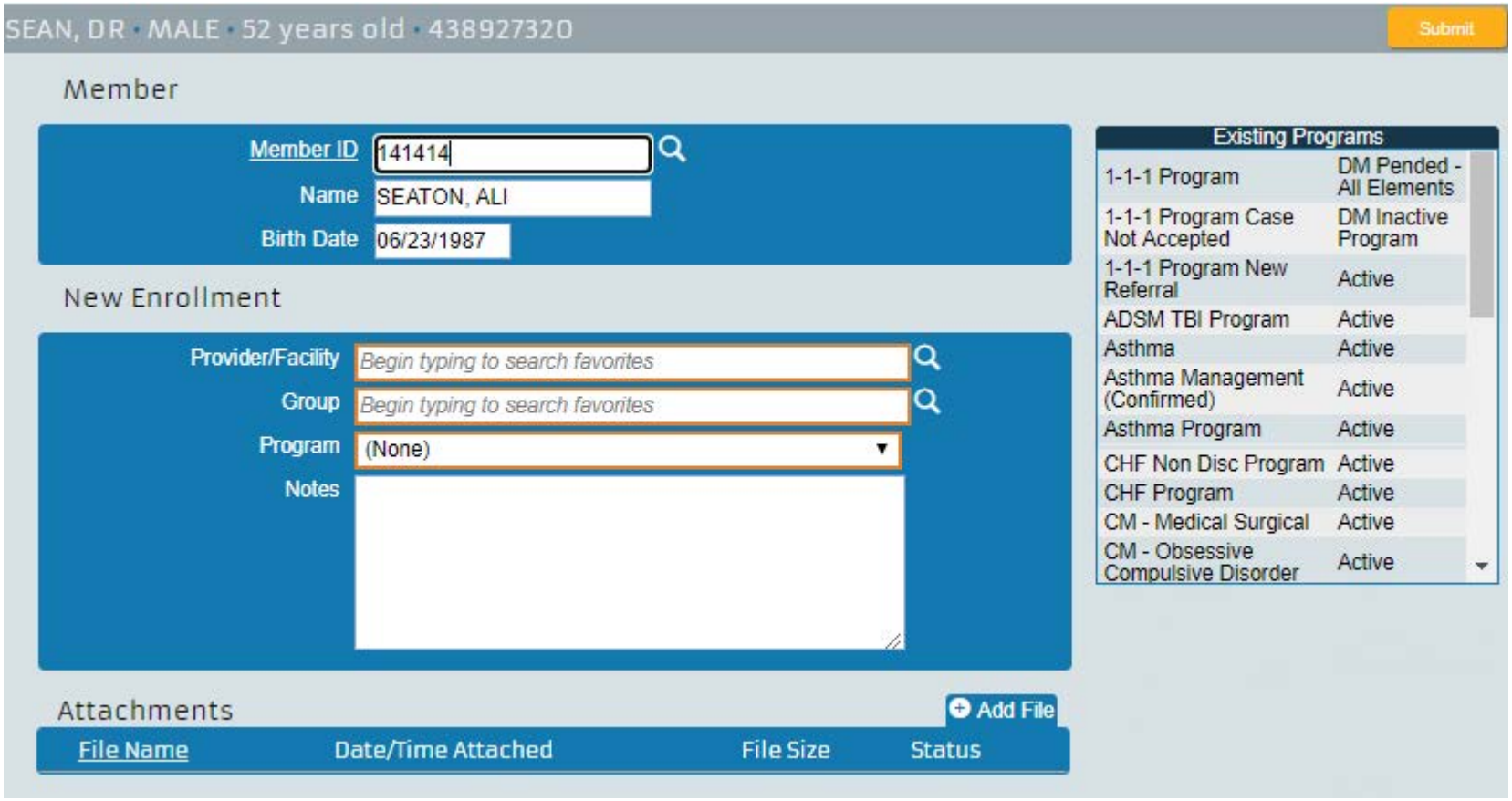


2) Enter the Member ID, Name or Birth Date in the **Member ID**, **Name** or **Birth Date** fields and press the **Tab** key.

NOTE: You can enter up to 25 characters, partial names, and wildcards in the **Name** field, but wildcards cannot be within the first two characters.

The Member Search dialog box automatically opens when the value you enter matches multiple members. Select the member you are searching for.

A list of programs in which the selected member is currently enrolled in appears.



3) In the New Enrollment section, perform one of the following actions, depending on your system's configuration:

- If the **Provider/Facility** field appears as a drop-down list, click the drop-down list and select the provider/facility ID.

  The Provider Location Search dialog box automatically opens when the value you enter matches multiple providers. Select the provider you are searching for.

- If the **Provider/Facility** field appears as a freeform field, enter the provider/facility ID.
- Click the Lookup icon to search for a provider/facility.

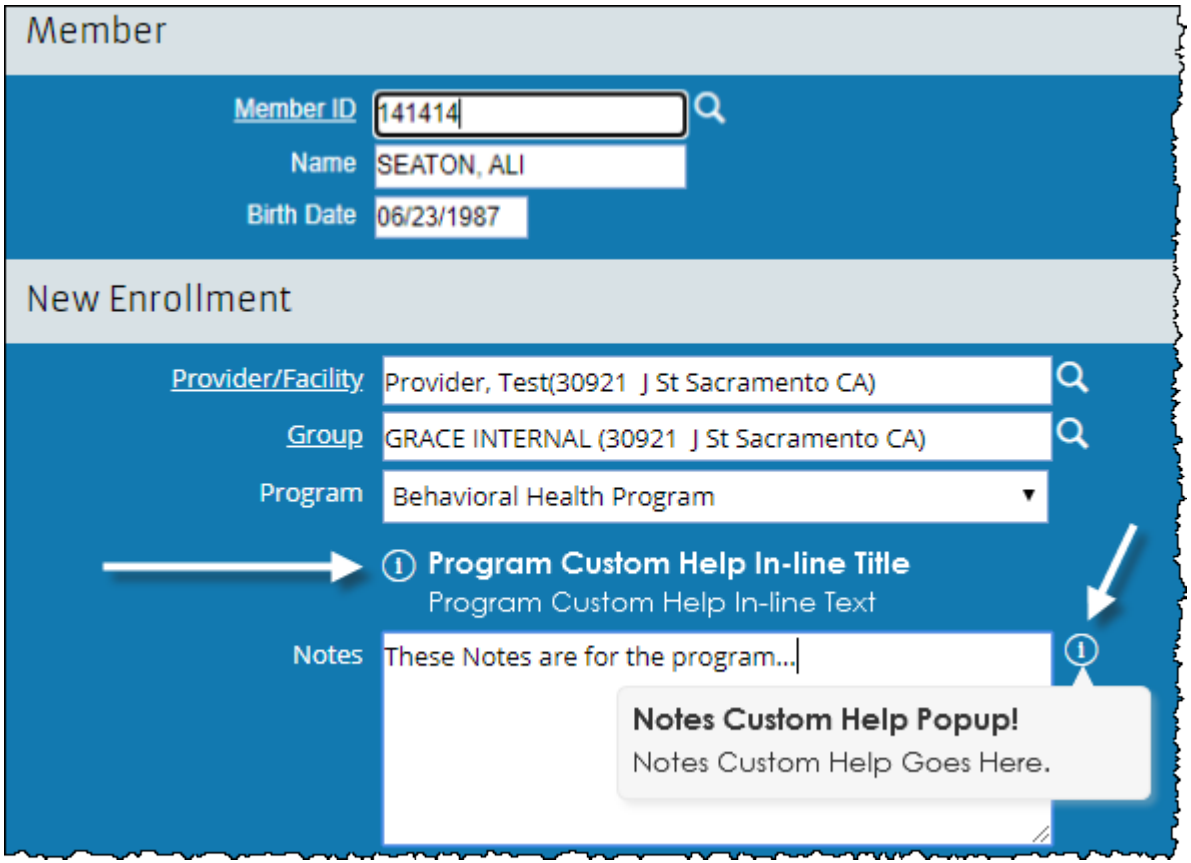
4) In the **Group** field, enter a group name.

5) Click the **Program** drop-down list and select a health management program.

Programs are not available for members with a Program Enrollment program status of Pending or Active or a status of Pending for a Program Enrollment Request.

6) Optionally, in the **Notes** field, enter notes for the member's request for program enrollment.

NOTE: Depending on your organization's configured settings, custom help information may be available in-line or in a pop-up window that provides instructions for the Program and/or Notes fields.



7) Click **Submit**.

CareAffiliate sends a Program Enrollment Request record to the MCO.

A confirmation message that the Program Enrollment Request record has been successfully submitted appears above the Member section.

Adding Attachments

Attach files that are relevant for a member's program enrollment request in the Attachments section.

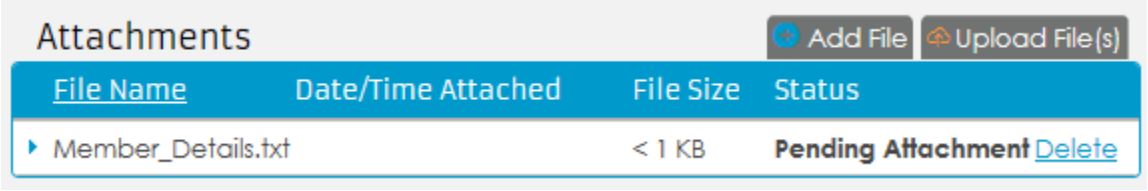
Attachments stay with the request, and you can access attachments in the Program Enrollment Queue in CareRadius. If the member is enrolled in a case or disease management program, then the attachments are also available from the Case Management or Disease Management workflows.

1) After you have selected am member, click **Add File** in the Attachments section.

   A browser window opens.

2) Select the file that you want to upload and click **Open**.

   The file appears in the Attachments section.



3) Optionally, click the arrow next to the file name and enter details about the attachment in the **Description** field.

4) Click **Upload File(s)**.

   CareAffiliate adds the attached file to the request record.

5) Click **Submit** to submit the request record.

You cannot remove file attachments from a request record after you submit the record.

NOTE: You can attach up to five files, up to a maximum of 100MB total. If you attempt to attach a file larger than 100MB, an error appears. Depending on the Internet settings for your organization, smaller file sizes may also trigger this error.

Care Plan Module

Care Plan Module Overview

The Care Plan module provides a collaborative view of specific areas of a member's care plan. Use the Care Plan module to edit care plans and add issues, interventions, and goals.

Case and disease managers working in CareRadius determine whether to share care plans with the member's CareAffiliate care team. The case and disease managers determine which issues are shared so that the CareAffiliate care team is not inundated with large care plans and collaborate with the team on specific care plan elements.

When a change is made to an issue or intervention, CareAffiliate sends a notification to the CareRadius case and disease managers associated with the member's care plan. Changes that prompt notification can include adding an issue or intervention, adding a provider note, or changing/adding a Target/Adjusted/Resolved Date.

CareAffiliate users must be associated with the providers or primary care providers designated as part of the care team and have appropriate security privileges to view a member's care plan. Contact your health plan representative for information about accessing a member's care plan in CareAffiliate.

Viewing a Care Plan

View and edit care plans in the Care Plan module.

1) On the Home page, click **Care Plan**.

   The Care Plan Search section appears.

2) Enter the Member ID, Name or Birth Date in the **Member ID**, **Name** or **Birth Date** fields and press the **Tab** key.

   The member's record opens. The member's name, gender, age, and ID appear in the title bar.

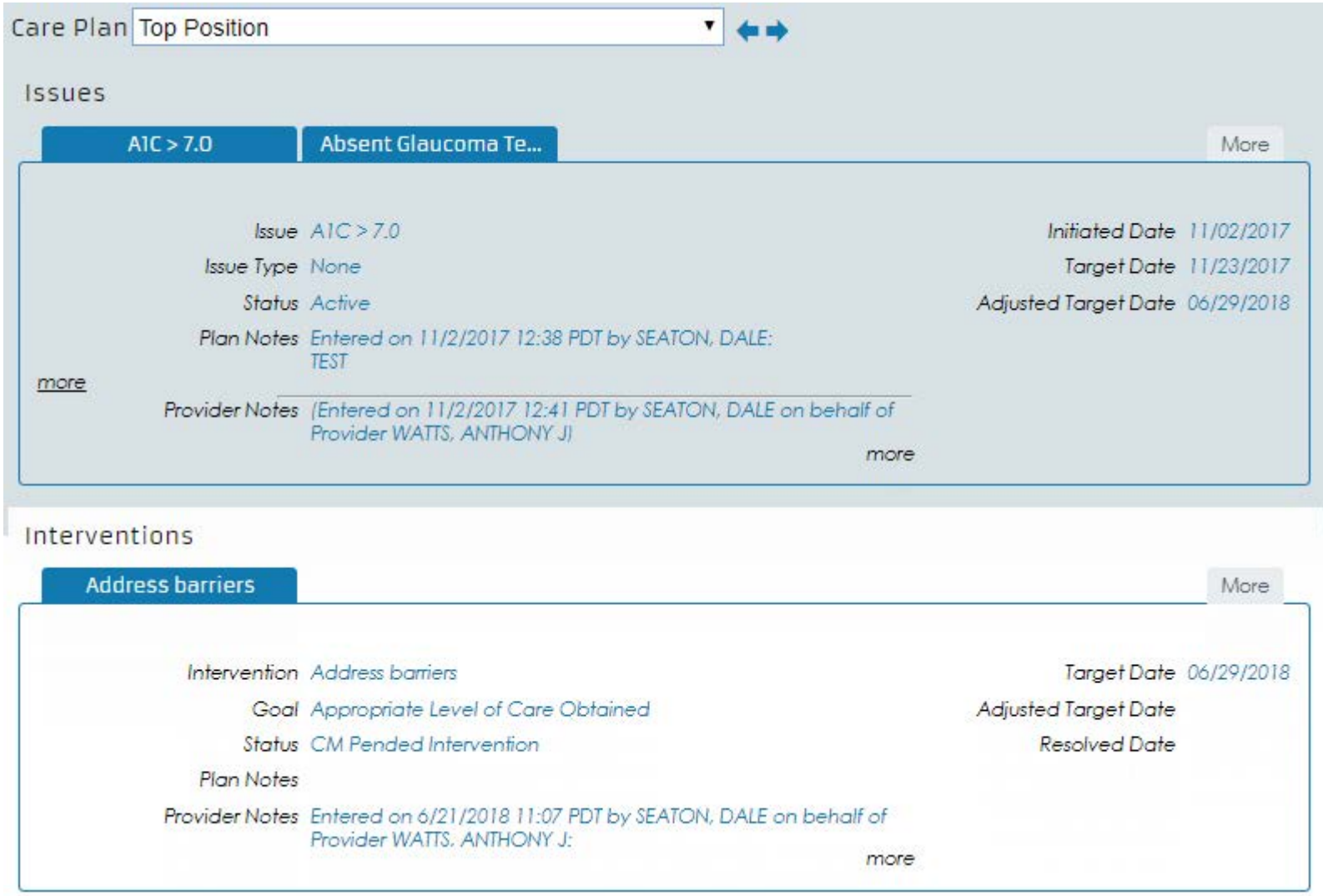
   NOTE: If the selected member has more than one associated care plan, the following logic is applied in selecting the plan:

   - The highest priority plan (the plan in CareRadius assigned the highest priority number).

- Plans with the most recent add or create date.
- Alphabetically by plan description

3) Click the **Care Plan** drop-down list and select the member's care plan that you want to view or edit.

The care plan opens and displays Issues and Interventions sections, if available, for the care plan.



4) To edit the care plan, click **Edit**, and then click **Submit** when you are finished editing.

When you are finished reviewing or editing the care plan, you can click the **Find Member** link to return to the initial Care Plan Search section and select a different member record.

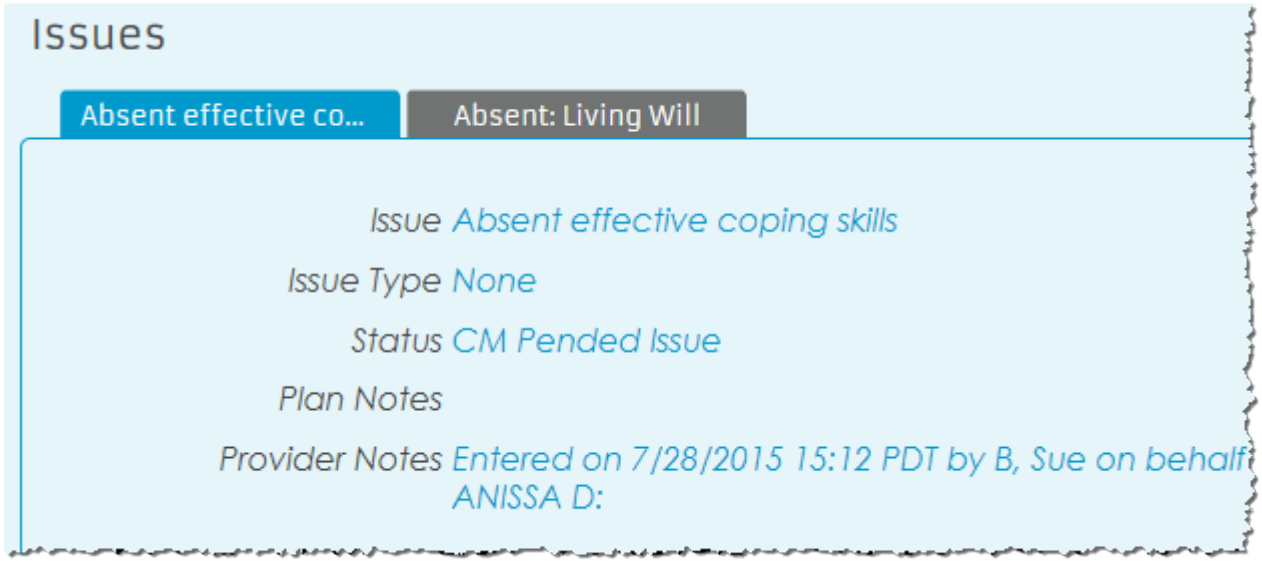
Issues

Issues provide a more complete picture of a member's case management or disease management needs.

Issues appear as tabs in the Issues section of the care plan. Each tab displays information about the issue's type, status, initiated date, target date, and associated notes from the health plan.

- To access all issues, click the left and right arrows at each end of the Issues section, or click the **More** button.

The following image shows the Issues section of a care plan:



RELATED LINKS:

Adding an Issue

Adding an Issue

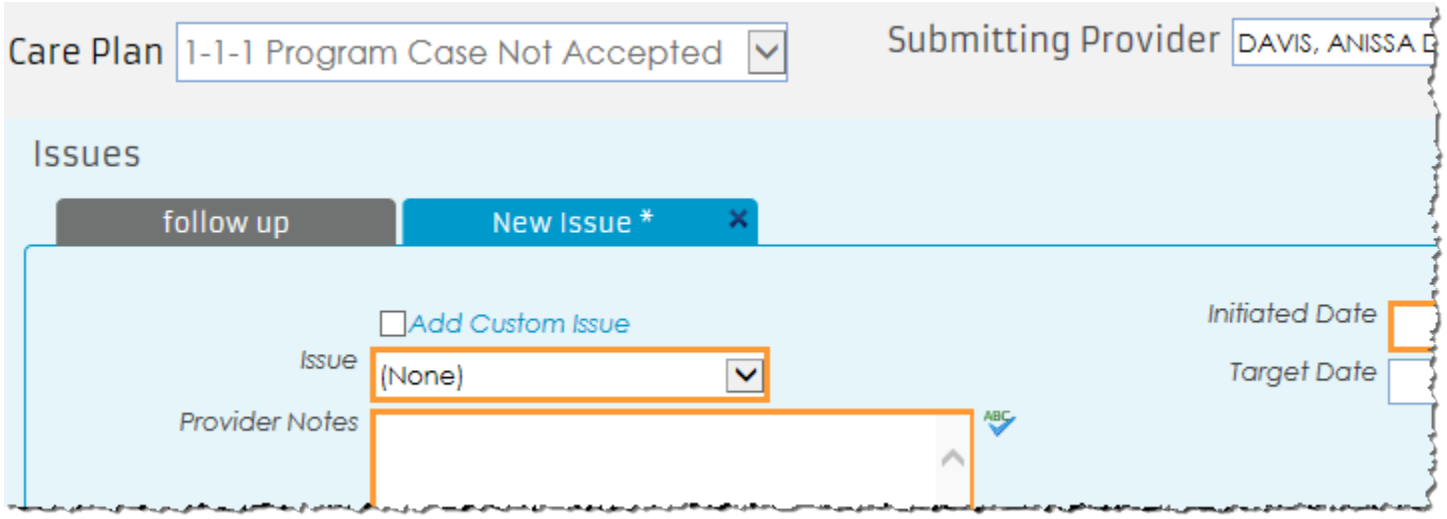
You can add issues to a member's care plan. You can add a new issue independently, or you can associate it with an intervention and goal in the Interventions section.

1) On the member's record in the Care Plan module, click **Edit**.

2) Click the **Submitting Provider** drop-down list and select the provider responsible for changes or additional notes to the care plan.

3) Click **Add Issue**.

   A New Issue tab opens.



   CareAffiliate hides the **Add Issue** button after you select it.

4) Click the **Issue** drop-down list and select an issue.

   NOTE: Available issues are determined by the health plan or MCO.

   - OR -

   Select the **Add Custom Issue** check box if you do not want to use an existing issue, and enter the custom issue name in the **Issue** field.

5) In the **Initiated Date** field, enter the initiated date for the issue.

   The initiated date is when the provider or case/disease manager wants the member to begin addressing the issue.

6) In the **Target Date** field, enter a target date for the issue, if appropriate.

7) In the **Provider Notes** field, enter notes that you want communicated to the case or disease manager at the health plan.

8) Optionally, click the **Add Intervention** link to enter intervention details and associate the new issue with an intervention.

9) Click **Submit**.

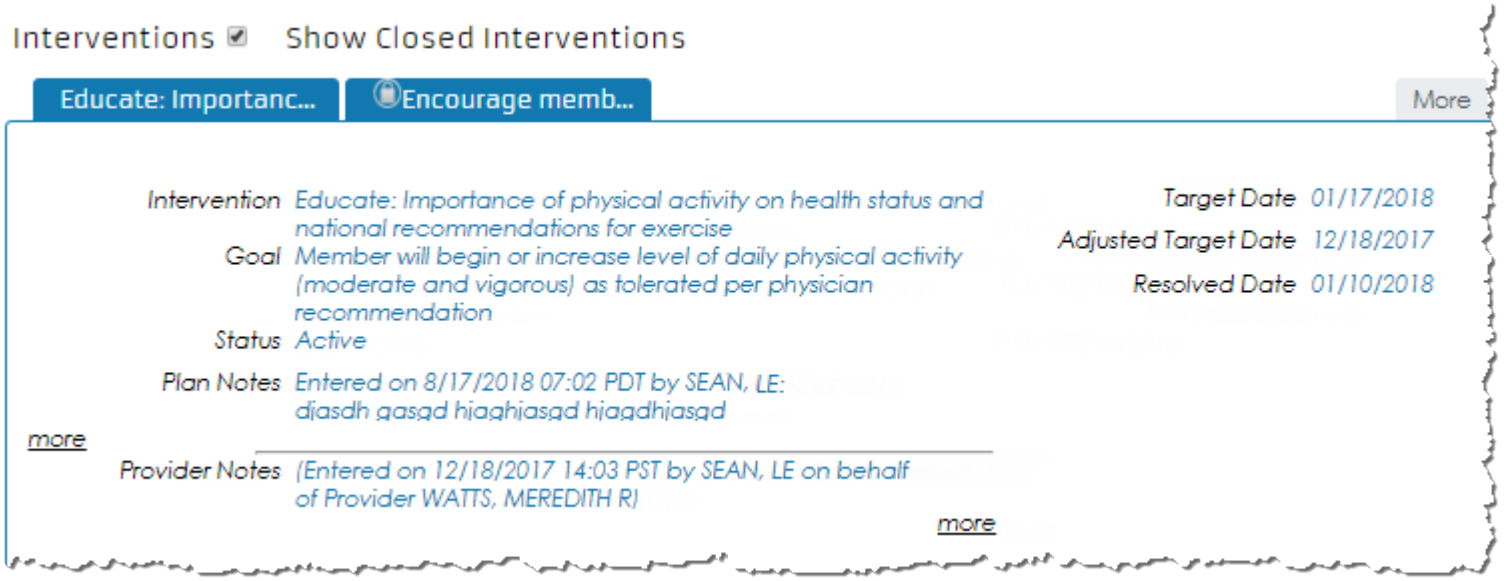
Interventions

Interventions appear as tabs in the Interventions section. Each tab displays information about the intervention's associated goal, the intervention's status, target date, adjusted target date, resolved target date, and associated notes from the health plan and provider.

NOTE: The Interventions section does not appear if the issue does not have associated interventions.

- To access all interventions, click the left and right arrows at each end of the Interventions section, or click the **More** button.

The following image shows the Interventions section of a care plan:



RELATED LINKS:

Adding an Intervention

Adding an Intervention

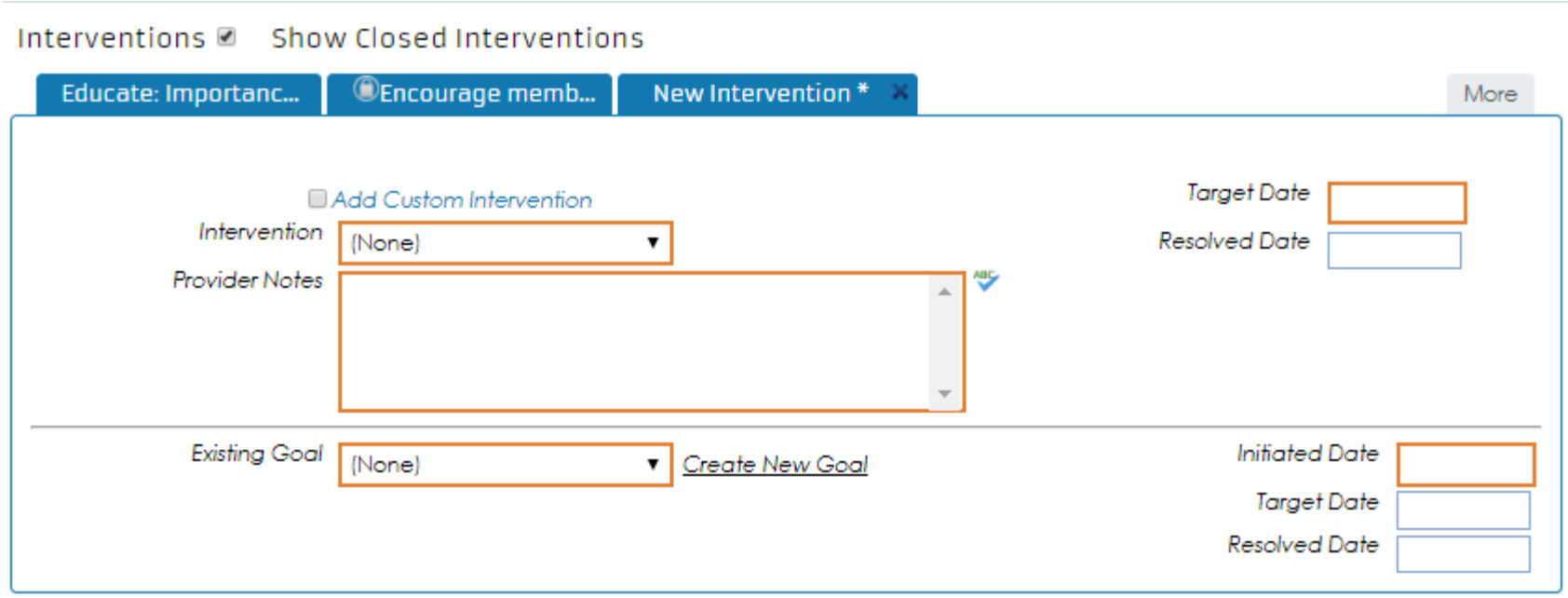
You can add interventions to a member's care plan. You can add a new intervention independently or for an existing issue.

1) On the member's record in the Care Plan module, click **Edit**.

   After you click **Edit**, you can modify the Adjusted Target Date and Resolved Date values, and add notes in the **Add Provider Notes** field in the Interventions section for existing interventions.

2) Click **Add Intervention**.

   A New Intervention tab opens.



3) Click the **Intervention** drop-down list and select an intervention.

   NOTE: Available interventions are determined by the health plan or MCO.

   - OR -

   Select the **Add Custom Intervention** check box if you do not want to use an existing intervention, and enter the custom intervention name in the **Intervention** field.

4) In the **Target Date** field, enter a target date for the intervention.

5) In the **Resolved Date** field, enter an intervention resolution date, if appropriate.

6) In the **Provider Notes** field, enter notes associated with the new intervention that you want communicated to the case or disease manager at the health plan.

7) Click the **New Goal** drop-down list and select a goal.

   - OR -

   Select the **Add Custom Goal** check box if you do not want to use an existing goal, and enter the custom goal name in the **New Goal** field.

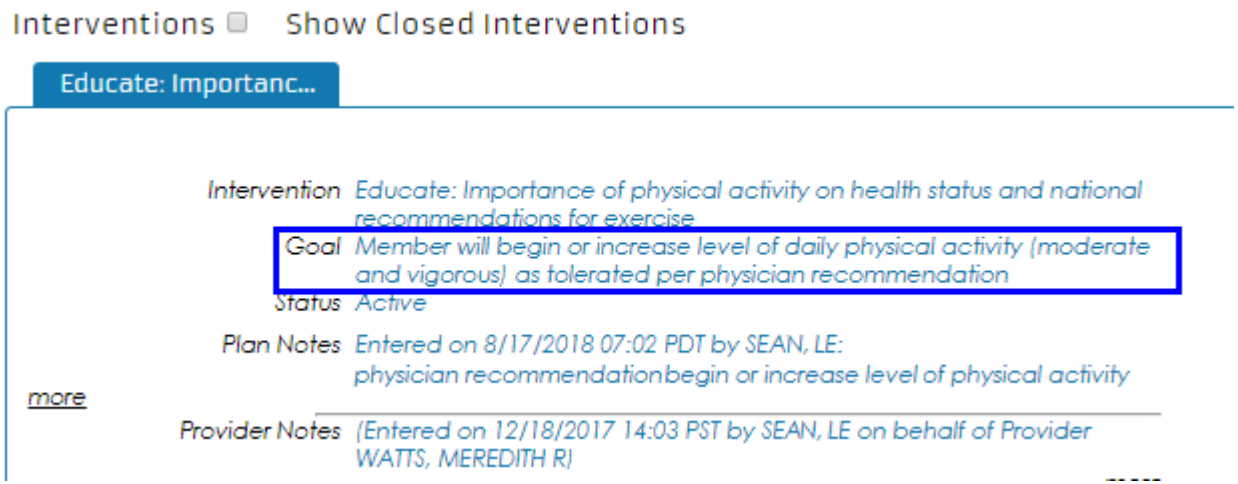
8) In the **Initiated Date** field, enter the initiated date for the goal.

9) Click **Submit**.

Goals

Goals appear in the Interventions section and are associated with interventions. For example, if an intervention to assess a member's non-adherence to medication is added to a member's care plan, a goal would be that the member demonstrates adherence to their medication regimen.

The following image shows a goal in the Interventions section:



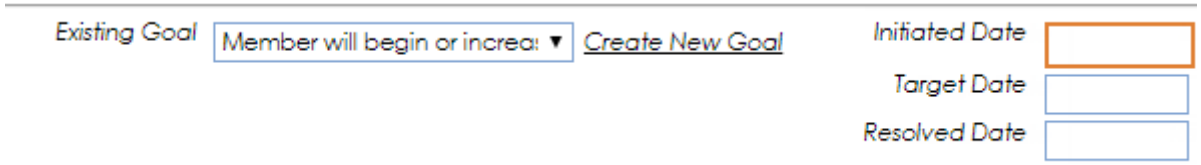
RELATED LINKS:

Creating Goals for New Interventions

Creating Goals for New Interventions

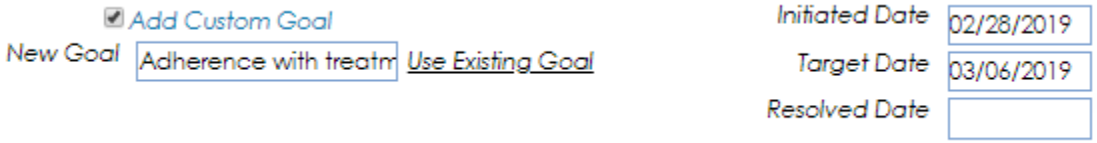
Create goals to associate with new interventions in the Interventions section.

1) In the New Intervention tab, click the Existing drop-down list and select a goal.



- OR -

Click the **Create New Goal** link, and then click the **New Goal** drop-down list and select a goal.



NOTE: Available goals are determined by the health plan or MCO.

Provider Notes Fields for Issues and Interventions

Medical service providers write provider notes for issues and interventions associated with a member's care plan.

Information in the **Plan Notes** field is read-only and displays notes entered by the member's case or disease manager. All provider notes appear with a date/time stamp along with the CareAffiliate user name and the provider's name on whose behalf the user is entering notes.

When the care plan is in Edit mode, provider note fields have the following availability:

Issues

- The **Add Provider Notes** field is available for entering additional information about the member's care plan issue.
- The **Provider Notes** field is view-only.

Interventions

- Provider note fields are not available for appending if the intervention has a status of Closed or there is a value in the **Resolved Date** field.
- Provider note fields that have reached the maximum number of characters are not available for appending.

Printing a Care Plan

You can preview and print a report of the current care plan when the care plan is not in Edit mode.

Care plan information appears in text only and includes the member's name and ID, the current issue, type of issue, status, plan issue notes, provider issue notes, relevant dates, plan intervention notes, provider intervention notes, goals, and goal status. Care plans with multiple interventions are printed in the order that they appear in preview mode.

1) On a member's care plan, click **Print**.

   The care plan report opens in preview mode in a new browser window, and the Print dialog box opens.

2) Select a printer and click **Print**.

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