NaviNet Medical Authorizations Participant Guide

Population Health Training

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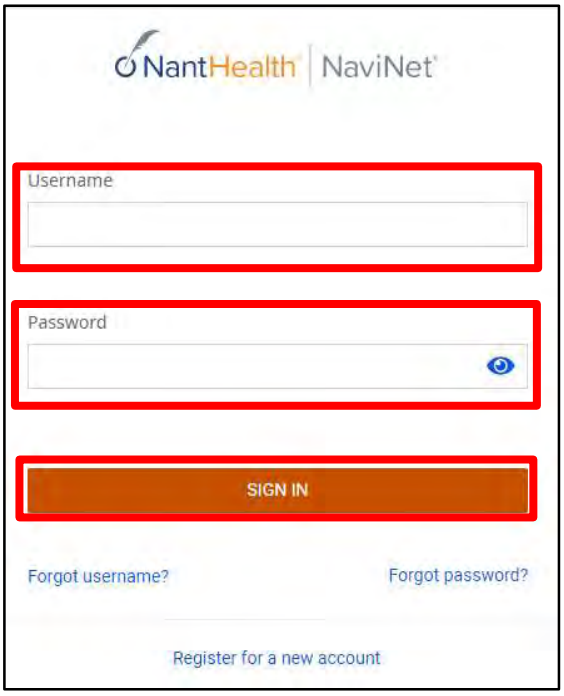
1

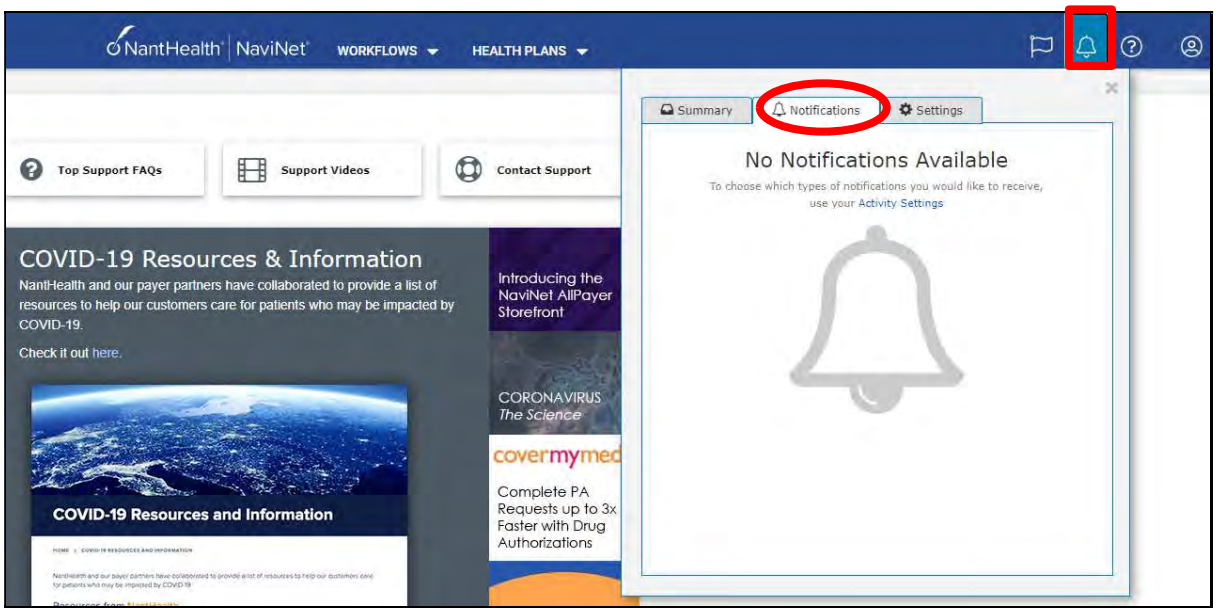
1 LOGGING IN TO NAVINET

Logging in to NaviNet

Step	Action
1.	Access NaviNet using the following address: **https://navinet.navimedix.com.** The following web browsers are supported: Chrome, Firefox, Safari, and Edge. 
2.	Enter your **Username**
3.	Enter your **Password**
4.	Click **Sign In** ***Result*** *The NaviNet Home screen will be displayed*

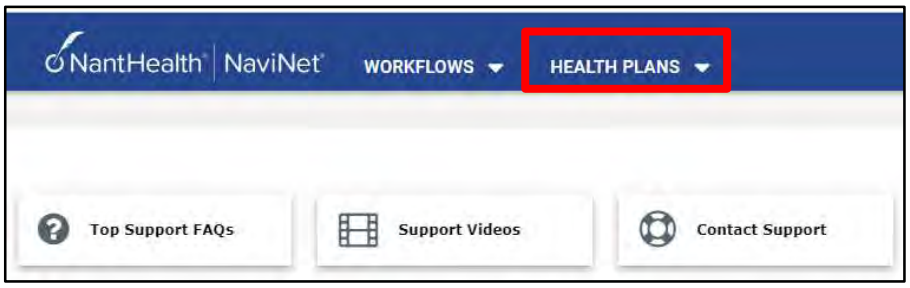
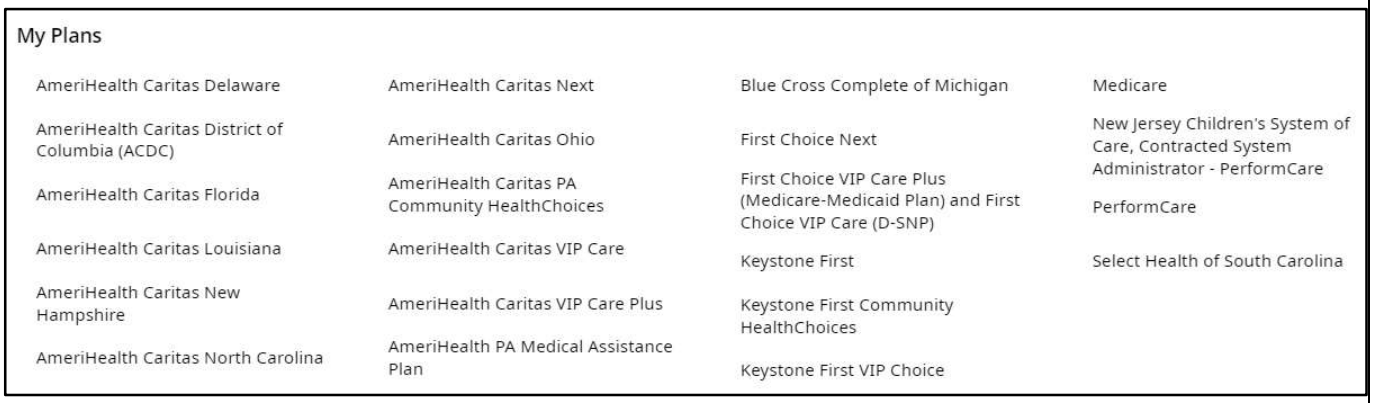
Logging in to NaviNet (cont.)

Notifications are an important part of the communication process between the health plan and the provider. Users can opt to receive notifications whenever a request is sent from the health plan to the provider. Notifications can be managed from the bell icon in the top right banner on the home page. Additional information regarding notification settings can be found in the Request For More Information (RFMI) chapter.



Logging in to NaviNet (cont.)

The NaviNet Home Page is not health plan specific. To locate a health plan, follow the steps below:

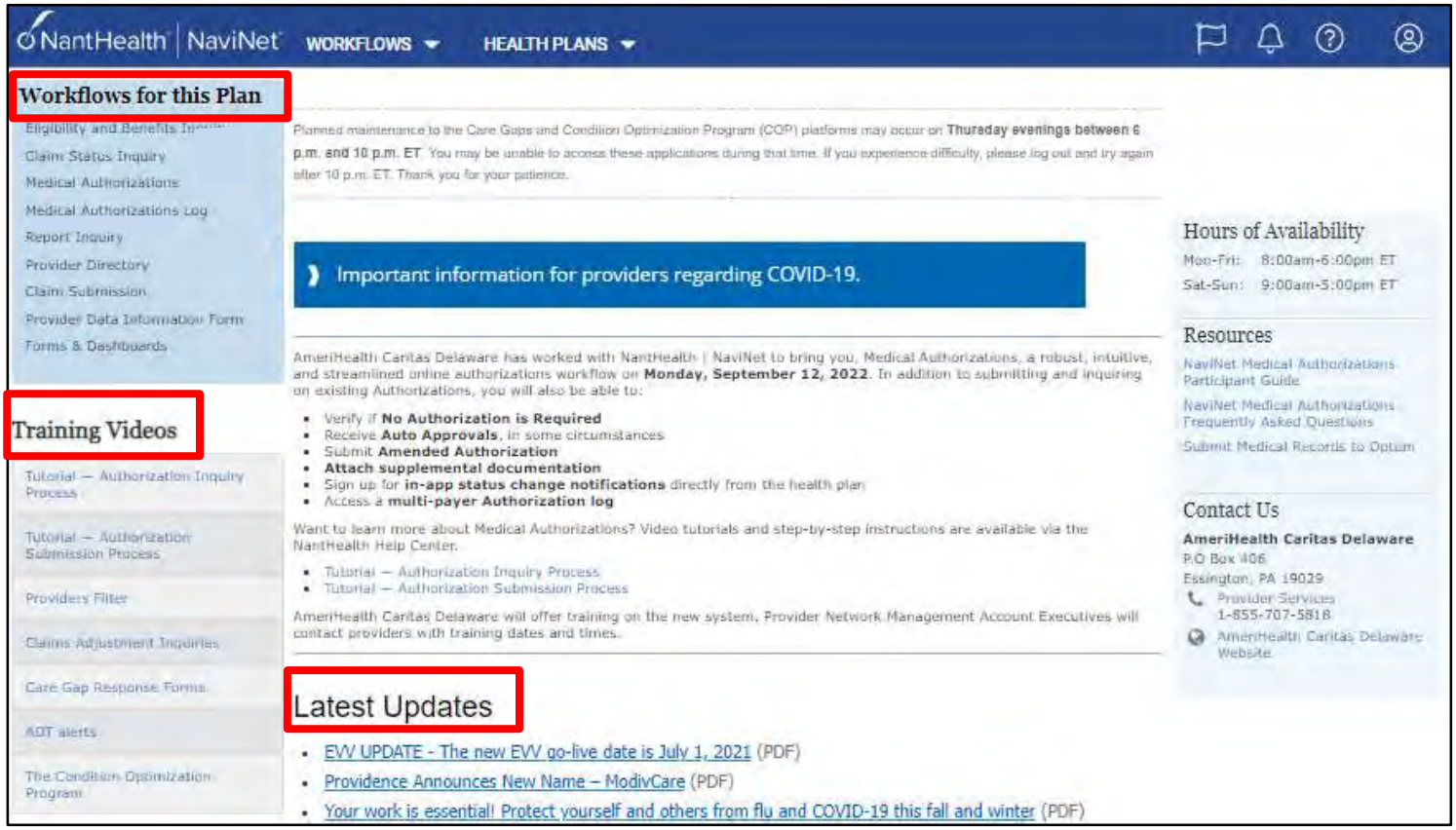
Step	Action
1.	Click on **HEALTH PLANS** in the top menu. 
2.	Select the appropriate health plan from the displayed list. Once the appropriate health plan is selected, the user will be directed to Plan Central, see the next chapter for additional details. 

2

2 PLAN CENTRAL

Plan Central Overview

Plan Central is the health plan specific homepage.



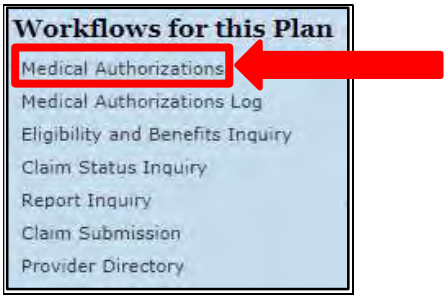
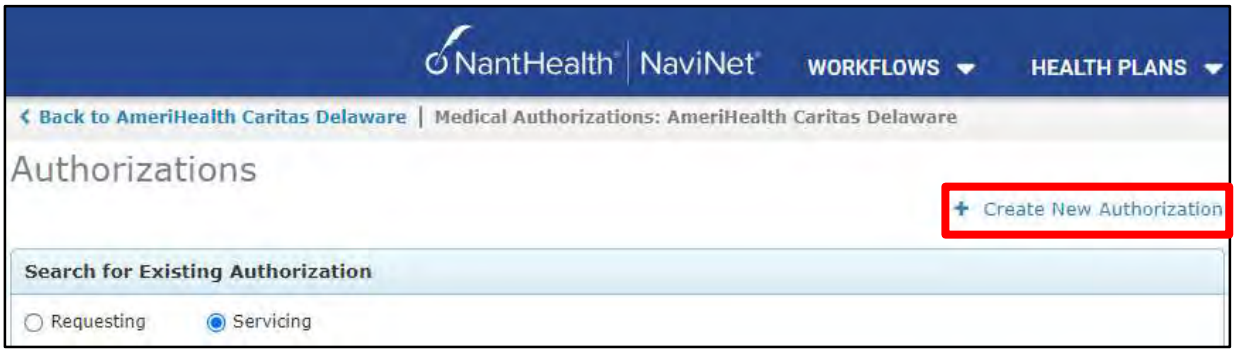
Plan Central	Topic	Description
Workflows for this Plan	Plan specific options	• Various functionalities are available to include initiating medical authorizations, inquiries, etc.
Training Videos	Training Videos	• Instructional videos on system usage.
Latest Updates	Latest News and Updates	• New functionalities to make your experience more efficient.

3

3 CREATING A NEW AUTHORIZATION

Creating a New Authorization

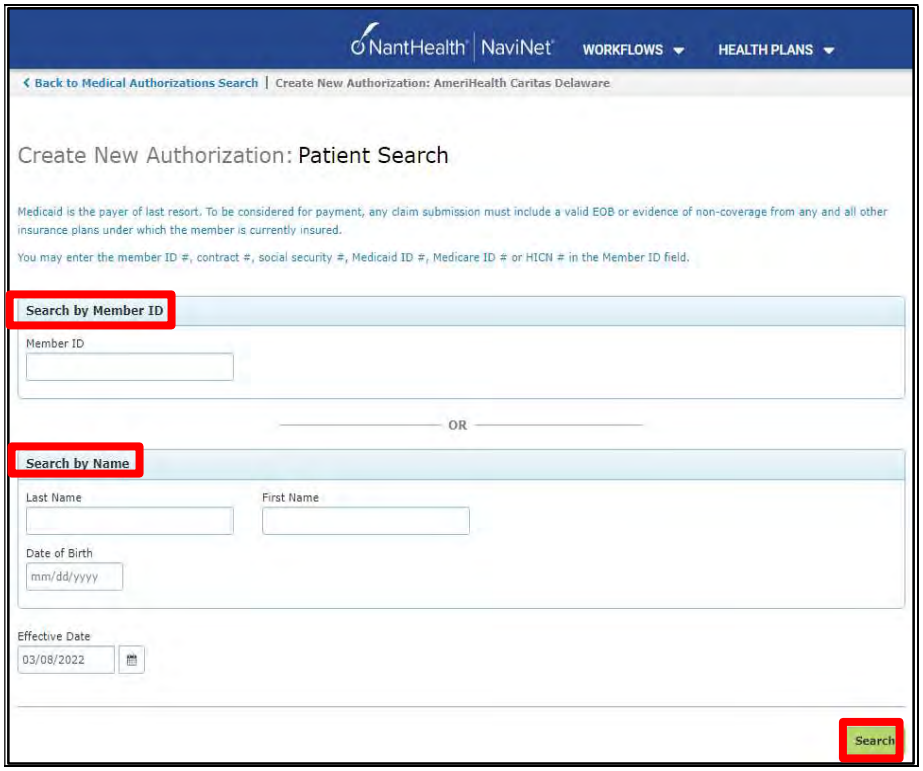
To create a new authorization:

Step	Action
1.	Launch **Medical Authorizations** under Workflows for this Plan**.** 
2.	Click **Create New Authorization** 

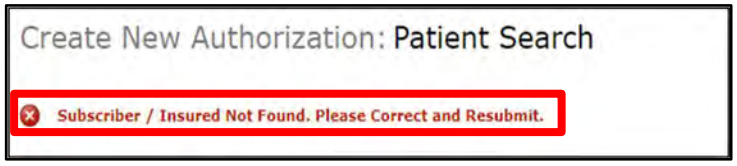
Creating a New Authorization (cont.)

Step	Action
3.	Enter patient search criteria information then select **Search**. The patient search screen allows the user to search by Member ID or Search by Name. If searching by name, the member's first name, last name, and date of birth (DOB) are required.

If there are multiple matches based on criteria entered, the user will get a search results screen. On the search results screen, the user selects the appropriate member from the list returned. If there is an exact match, the user is taken to the pre-screening questions.



Note: If you enter an incorrect/invalid member ID you will receive the following:



Step	Action
4.	Address the pre-screening questions pop up box and select **Continue**. **Note**: If a member is not active with the health plan, you will not be advanced to the pre-screening questions.

If…	Then…
The member has active coverage	The provider will be advanced to the New Authorization Pre-Screening Questions The purpose of the New Authorization Pre-Screening Questions is to ensure that the user is following the correct authorization process. It is important to scroll through the questions to ensure that there is not a more appropriate avenue for your specific request. These questions are specific based on the health plan.
The member is ineligible	The provider will receive the authorization cannot be created message.

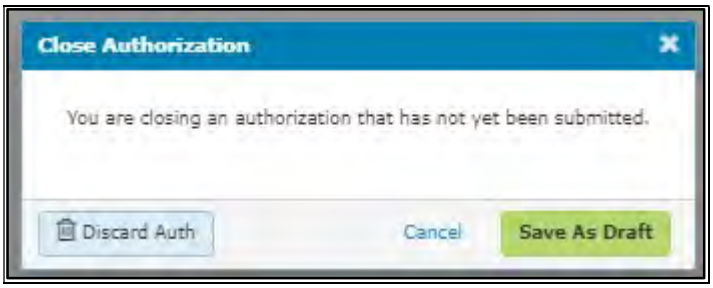
Step	Action
5.	Enter service type and place of service, then select **Next**

View Eligibility & Benefits is available to view under the member's demographic information.

Service Type – Select the appropriate service type. Based on the service type selected the user may or may not be prompted to enter the place of service. For example, if the request is for home health care the user will not be prompted to select a place of service because the place of service is in the home. If the service type is physical therapy the user will be prompted to specify a place of service (comprehensive outpatient rehabilitation facility, home, independent clinic, off campus-outpatient hospital, office). If an inpatient service type is selected the user will not be prompted to enter a place of service on this screen.

If…	Then…
Creating an outpatient episode	Continue to the next step (step 6)
Creating an inpatient episode	Continue to step 7

Note: At any time while creating an authorization if you wish to close or save the request select ✖ Close/Save which will enable the following pop up and allows the user to discard auth, cancel, and save as draft.

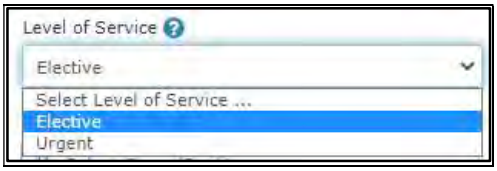


Discard Auth – deletes the request

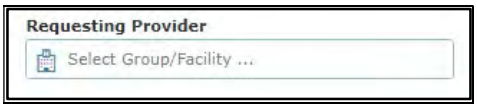
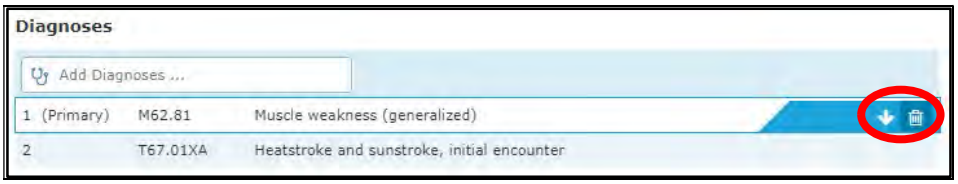
Cancel – allows the user to continue

Save As Draft – allows the user to come back and complete the request later

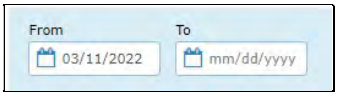
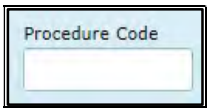
Step	Action
6.	Complete information in the required fields following the guidelines outlined below for an Outpatient Request. Outpatient request can be entered up to 365 days in advance.

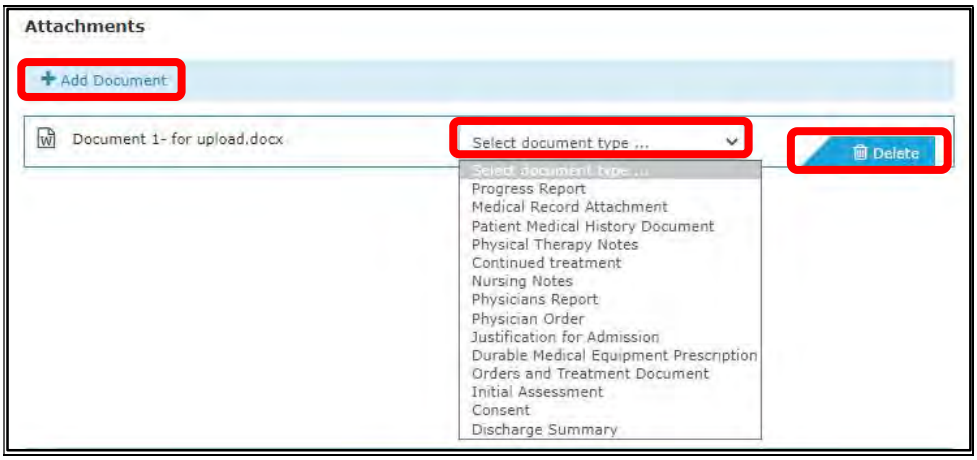
Date of Service	This defaults to the current date and is not available to be changed.
Level of Service	Choose the appropriate selection from the drop-down list – elective or urgent. 

If	Then
Elective	Services scheduled in advance that do not involve a medical emergency
Urgent	Unscheduled admission of patient. An unexpected illness or injury that needs prompt medical attention.

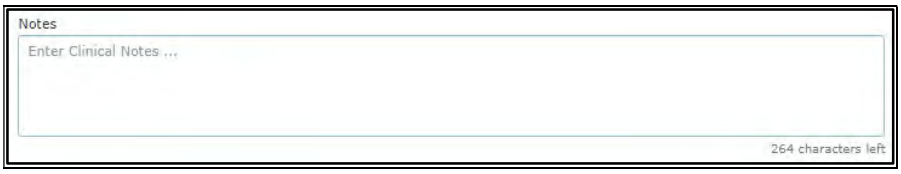
Requesting Provider	Choose the appropriate selection from the drop-down list. Requesting provider is the provider that is requesting the service. 
Servicing Provider	Choose the appropriate selection from the drop-down list. Servicing provider is the provider completing the service.
Diagnoses	This is a look up field (max number of diagnosis codes that can be attached is 12). **Note**: The user can change the primary diagnosis if more than 1 diagnosis exists and there is also the ability to delete diagnosis that may have been entered in error. The user can hover over the row to reorder (arrow) and or delete (trashcan) the diagnosis. 

Step	Action
6.	**Services**

From / To	**From** (start date) **/ To** (end date)  **Note:** The user will not be able to submit requests for identical service codes for the same dates. The error message below will be received when the system detects a duplication of services for the same date range. If InterQual is applicable the error message will appear after InterQual is completed. If InterQual is not applicable, the error message will appear when the user clicks **Submit.**
Procedure Code	Free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free text and not a lookup field. The user will not be notified if an incorrect code is entered so it is very important for the user to enter the correct code. 
Modifiers	Free text field. This is not a mandatory field.
Units	Free text numeric value.
Add New Service Line	The user must add new service line for the system to recognize the request even if only adding 1 request or 1 service. The **Add New Service Line** will also be utilized when adding additional service requests.

Step	Action	
6.	**Attachments**	
	+ Add Document	Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). The user may attach up to 10 documents. The user can identify the document type based on the drop down list. If the user attaches a document, the document type is mandatory. Select document type drop down. The user also has the ability to delete any document attached in error. 

Step	Action
6.	**Notes**

Notes	Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters. 
Contact Information	Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete. **Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future.

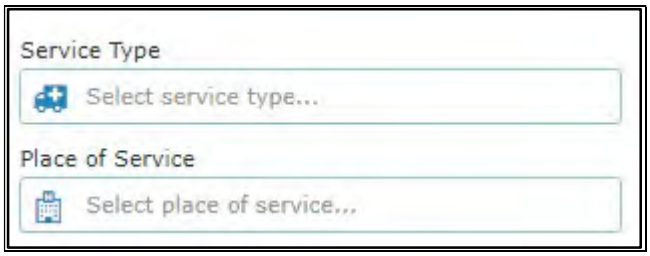
*****Proceed to Step 8 for InterQual instructions*****

Creating a New Authorization – Inpatient Request

Step	Action
7.	Complete information following the guidelines outlined below for an inpatient request:

Service Type

Select the appropriate service type and place of service according to the request.



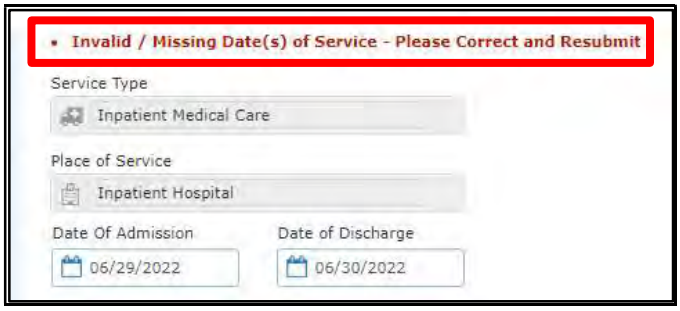
Service Type	Type of service to be provided to the member. (Based on the service type, the system will request for the user to enter the place of service.)
Place of Service	Location in which services will be rendered.

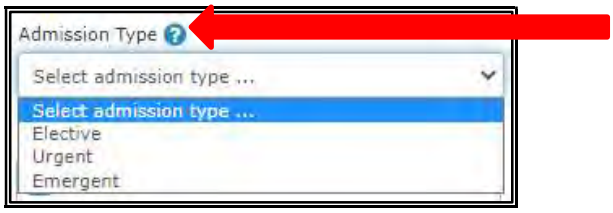
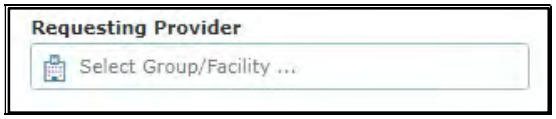
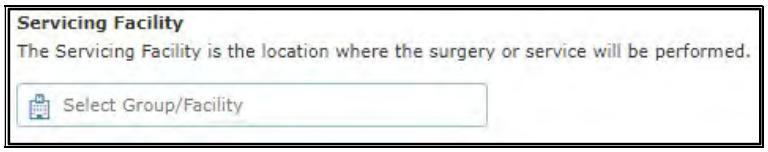
Once service type is select, click **Next** to continue.

Date of Admission/ Date of Discharge

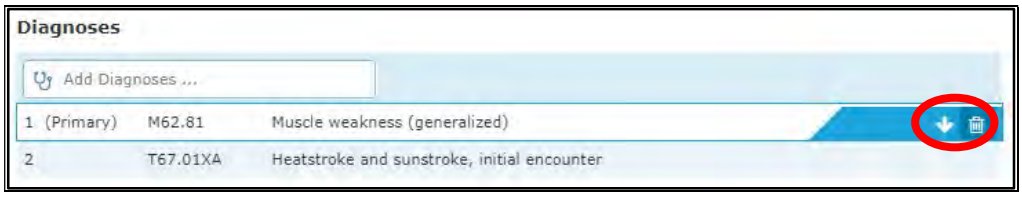
Date of admission is a mandatory field. Date of discharge is optional because it may not be known at the time the request is initiated. However, providers can record the members discharge date by amending the inpatient authorization request (refer to Amending an Authorization chapter).

Note: The user will receive the message below if the dates of service overlap in the same case.

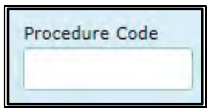
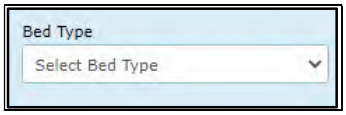


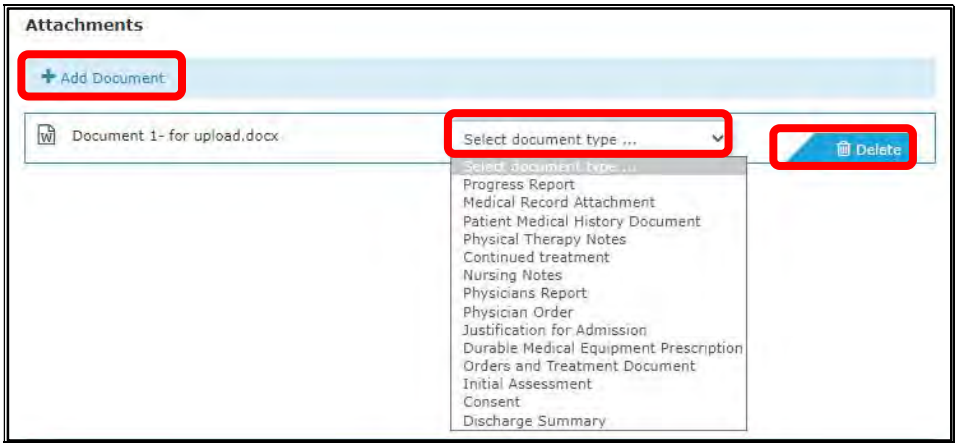
Step	Action	
7.	**Admission Type**	Select the appropriate admission type from the drop-down list – Elective, Urgent, or Emergent.  The question mark beside admission type provides information regarding the types of admissions. **If** / **Then** **Elective**: Potential admission for illness/injury enrollee not currently admitted **Urgent**: Potential admission for illness/injury that can be treated in a 24-hour period and if left untreated could rapidly become a crisis or emergency, enrollee not currently admitted **Emergent**: Concurrent review, enrollee is currently admitted
	Requesting Provider	Select the appropriate provider from the drop-down list. Requesting provider is the provider that is requesting the service. 
	Servicing Provider	Select the appropriate servicing provider from the drop-down list. Servicing provider is the provider completing the service (also known as the attending provider).
	Servicing Facility	The servicing facility is the location where the service will be performed. 

Step	Action
7.	**Diagnoses**

Diagnoses	Look up field (max number of diagnosis codes that can be attached is 12). **Note:** The user can change the primary diagnosis if more than 1 diagnosis exists and there is also the ability to delete a diagnosis that may have been entered in error. The user can hover over the row to reorder using the arrow icon and or delete the diagnosis by selecting the trash icon. 

Step	Action
7.	**Services**

From / To	From (start date) / To (end date). From and To dates are mandatory. If the To date is unknown, advance it by 1 day from the From date.
Procedure Code	Free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free text and not a lookup field. The user will not be notified if an incorrect code is entered so it is very important for the user to enter the correct code. If this is an inpatient only request and there is no procedure code do not place anything in the procedure code field. 
Modifiers	This is a free text field and is not mandatory.
Units	Free text numeric value. For the inpatient request, units are equivalent to days.
Bed Type	Select the appropriate bed type from the drop down list. This is a mandatory field. 
+ Add New Service Line	The user must add new service line for the system to recognize the request. The **Add New Service Line** will also be utilized when adding additional service requests.

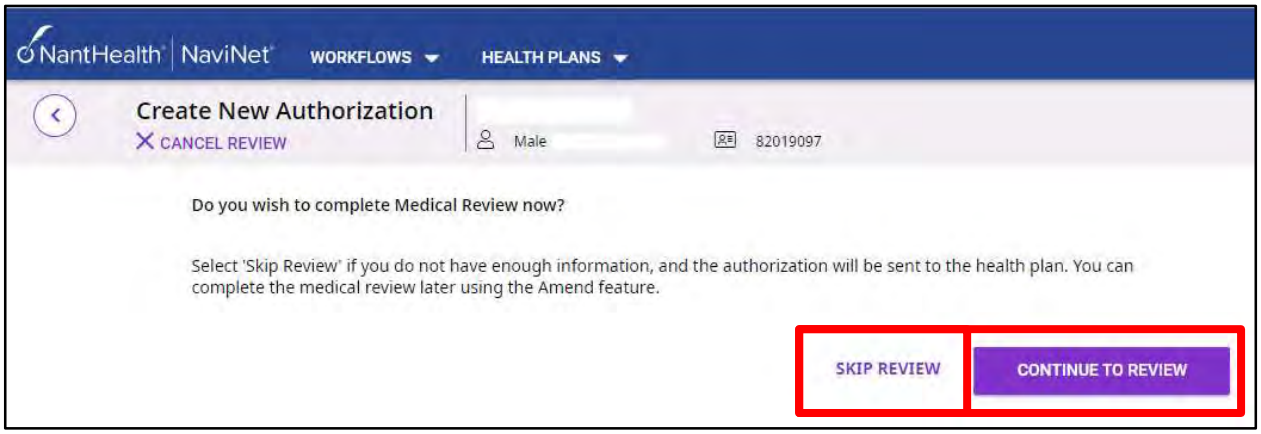
Step	Action	
7.	**Attachments**	
	Add Document	Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). The user may attach up to 10 documents. If the user attaches a document, the document type is mandatory. The user also has the ability to delete any document attached in error. 

Step	Action
7.	**Notes**

Notes	Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters.
Contact Information	Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete. **Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future.

Creating a New Authorization – InterQual – Outpatient and Inpatient

If you need training or have questions regarding the use of InterQual criteria, please contact Change Healthcare.

Step	Action
8.	After completion of the previous steps, when the user selects **Submit**, InterQual criteria may or may not launch. InterQual criteria is launched based on the diagnosis code and or the service code and if there are criteria to launch for the diagnosis code and or service code that is identified in the episode. If InterQual criteria is not launched after the user submits the request, the user may receive a status of pending or an automatic approval.
9.	The message below will populate indicating the InterQual page is loading.
10.	Once routed to InterQual, users will have two options 'Skip Review' or 'Continue to Review.' 

If….	Then…
Skip Review	The user will return to the authorization details page and will be provided with a summary of the request along with the status and the pending authorization number. ***Note:*** *If the InterQual medical review is skipped, the medical review is completed by the health plan. If additional information is needed to complete the medical review, a Request For More Information (RFMI) will be sent to the provider through the NaviNet Provider Portal.*
Continue to Review	The user will be presented with the appropriate InterQual Subset and should complete the clinical questions/medical review prior to submission. ***Note:*** *If the InterQual medical review is completed and the InterQual criteria is met, there is the possibility of an automatic approval.*

Creating a New Authorization - InterQual (cont.)

Step	Action
11.	

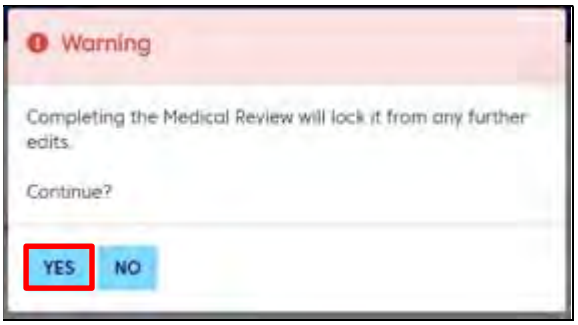
If…	Then…
Outpatient	The system will determine the criteria set and subset based on the diagnosis code and the procedure code (if applicable). To begin the review, click on medical review at the bottom of the screen. Answer the questions as they relate to the patient/member.
Inpatient	The system will direct the user to a guideline selection page. Select the most appropriate guideline then click on medical review. Select the day on which you wish to complete the medical review then select the pertinent findings/interventions.

Creating a New Authorization - InterQual (cont.)

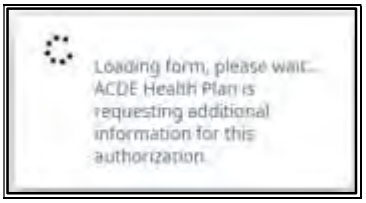
Step	Action
12.	At the end of the InterQual review…

If….	Then….
Q&A criteria is used (outpatient)	After all questions have been answered the no remaining questions message will display: Click view recommendations to continue.
Decision tree is used (inpatient)	Address all pertinent findings/interventions based on the day selected for the review. At the end of the review the user will receive criteria met or criteria not met. Regardless of if the criteria meet or does not meet, the user should continue.

13. When the review is complete, click **Complete**, then select **YES** to continue.



14. The following notice which indicates that the user is being sent back to NaviNet from InterQual.



Creating a New Authorization - InterQual (cont.)

Step	Action
15.	Once the user arrives back in NaviNet, it defaults to the authorization details screen.

Authorization Details FRANKIE MOCHRIE

AmeriHealth Caritas Delaware

+ Create New | History | Authorization Search | View/Print as PDF

Pending

Authorization #: 92204002349

Disposition pending review

FRANKIE MOCHRIE

PATIENT'S INSURANCE

PRIMARY CARE PHYSICIAN
HEATHER BITTNER-FAGAN
NPI:

View Eligibility & Benefits

Requesting Provider
Ahmed, Mohamed F.

379 Walmart Dr Ste 101
Camden Wyoming , DE 19934--1365
(302) 698-4441

Servicing Facility
Alfred I Dupont Hospital

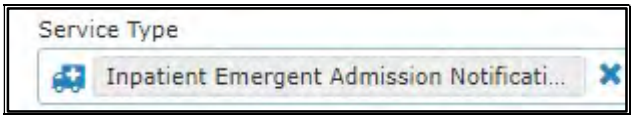
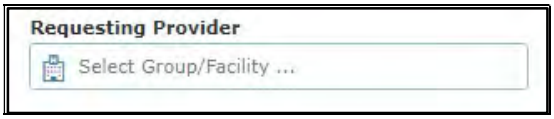
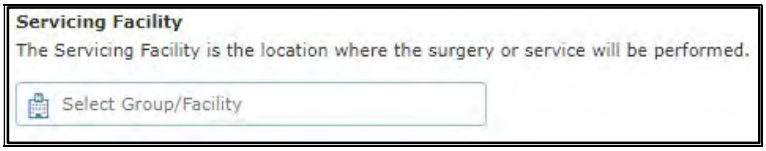
1600 Rockland Rd
Wilmington, DE 19803--3607

Servicing Provider
Alfred I Dupont Hospital

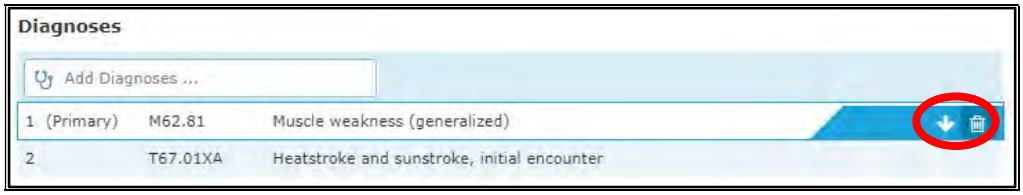
1600 Rockland Rd
Wilmington , DE 19803--3607
Date of Admission: 04/13/2022
Admission Type: Emergent
Service Type: Inpatient Medical Care
Place of Service: Inpatient Hospital

Creating a New Authorization – Inpatient Emergent Admission Notification

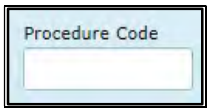
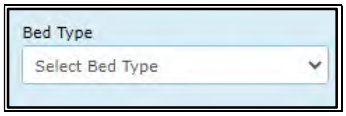
Step	Action
6.	Refer to steps 1-5 above under the heading Creating a New Authorization. Complete information following the guidelines outlined below for an Inpatient Emergent Admission Notification. If the user is identified as non-clinical, the user may report an Emergency Admission utilizing the steps below.

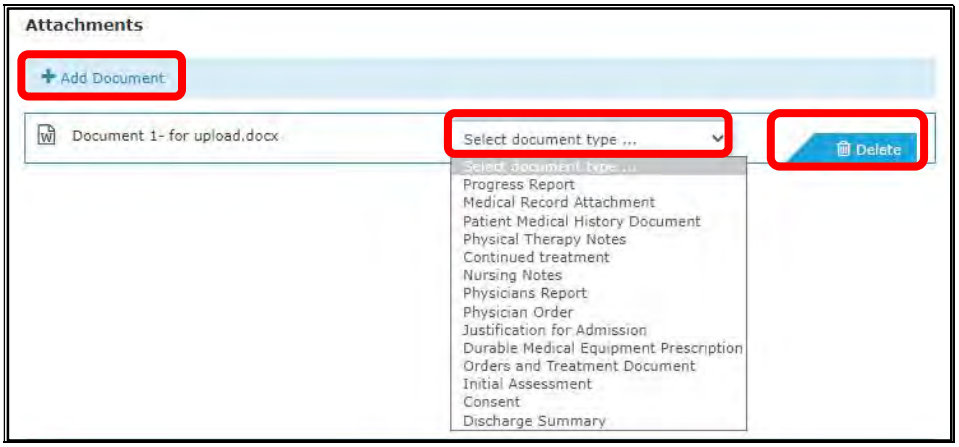
Service Type	Select the Service Type (users should select Inpatient Emergent Admission Notification as their service type).  Click **Next** to continue.
Date of Admission/ Date of Discharge	Date of Admission is a mandatory field. Date of Discharge is optional because it may not be known at the time the request is initiated.
Admission Type	Select the appropriate admission type– Elective, Urgent, or Emergent. The question mark provides information regarding the types of admissions.
Requesting Provider	Requesting provider is the provider that is requesting the service. 
Servicing Provider	Servicing provider is the provider completing the service, also known as the attending provider.
Servicing Facility	Servicing Facility is where the service will be performed. 

Step	Action
6.	**Diagnoses**

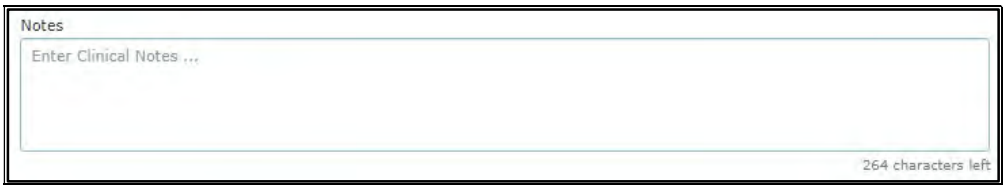
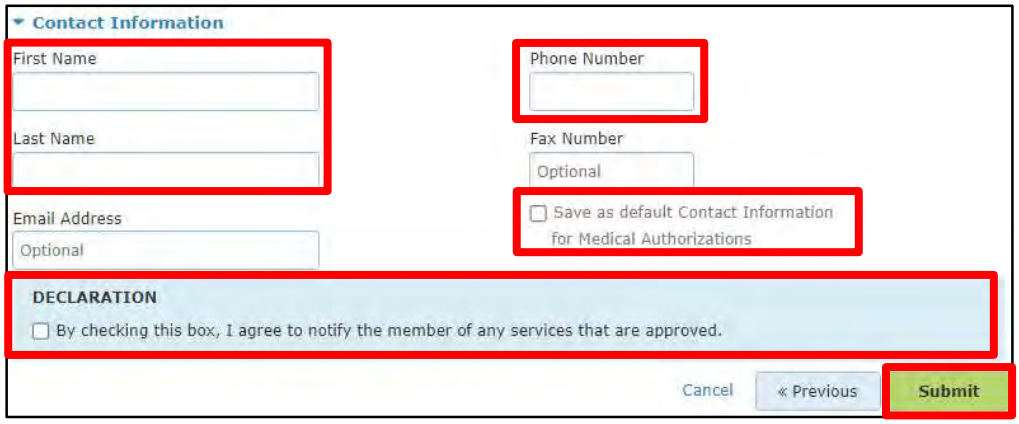
Diagnoses	Diagnoses is a look up field (max number of diagnosis codes that can be attached is 12). **Note:** The user can change the primary diagnosis if more than 1 diagnosis exists and there is also the ability to delete a diagnosis that may have been entered in error. The user can hover over the row to reorder (arrow icon) and or delete (trash icon) the diagnosis. 

Step	Action
6.	**Services**

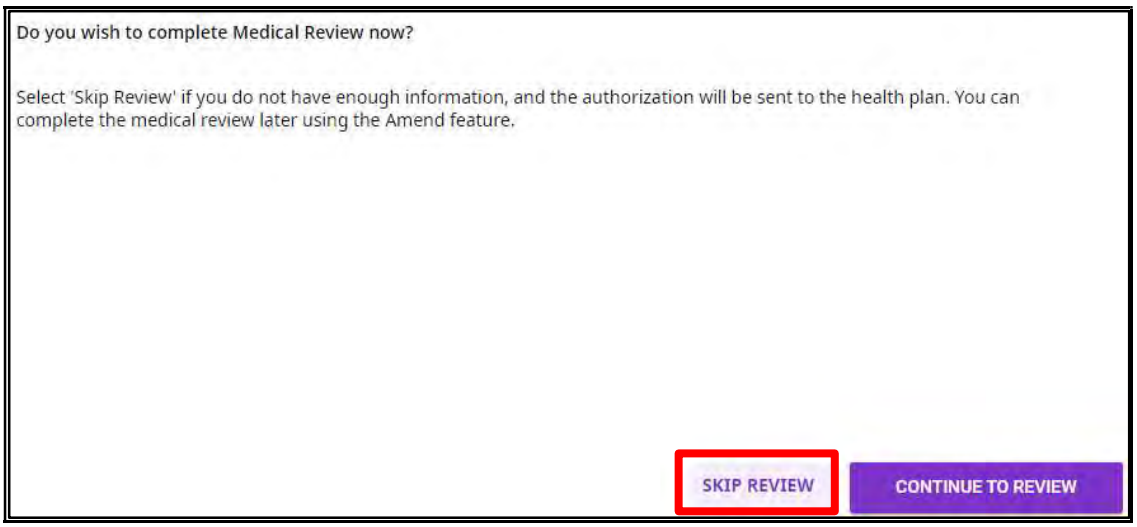
From / To	From (start date) / To (end date). From and To dates are mandatory. If unsure of the To date, advance it by 1 day from the From date.
Procedure Code	This is a free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free text and not a lookup field. The user will **not** be notified if an incorrect code is entered so it is very important that the correct code is entered. If this is an inpatient (IP) only request and there is no procedure code do not enter anything in the procedure code field. 
Modifiers	This is a free text field and is not a mandatory field.
Units	Free text numeric value. For the inpatient request, units are equivalent to days.
Bed Type	Select bed type from the drop down list. This is a mandatory field. 
+ Add New Service Line	Click on **Add New Service Line** for the system to recognize the request. **Add New Service Line** will also be utilized when adding additional service requests.

Step	Action	
6.	**Attachments**	
	Add Document	Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). Up to 10 documents may be attached. If a document is attached, the document type is mandatory. Documents attached in error may be deleted. 

Step	Action
6.	**Notes**

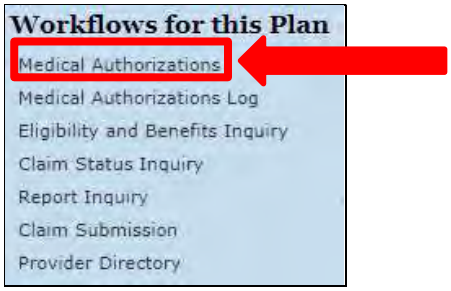
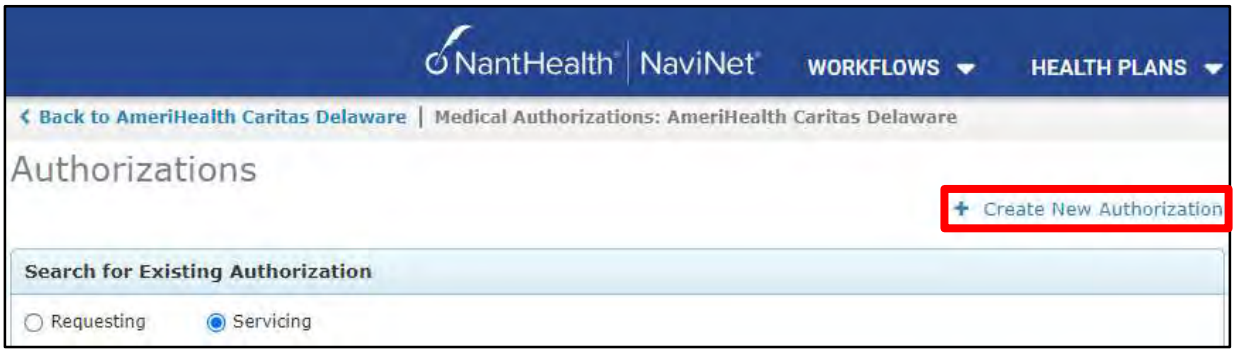
Notes	Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters. 
Contact Information	Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete. **Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future. 

Note: Non-clinical users may follow the steps below to bypass the InterQual Review.

Step	Action
7.	The message below will populate indicating the InterQual page is loading.
8.	The system will offer non-clinical users the option to by-pass InterQual Medical Review. To bypass the InterQual review, select “Skip Review.  **Note:** After selecting Skip Review, the user will be routed back to the authorization page notifying them of the status.

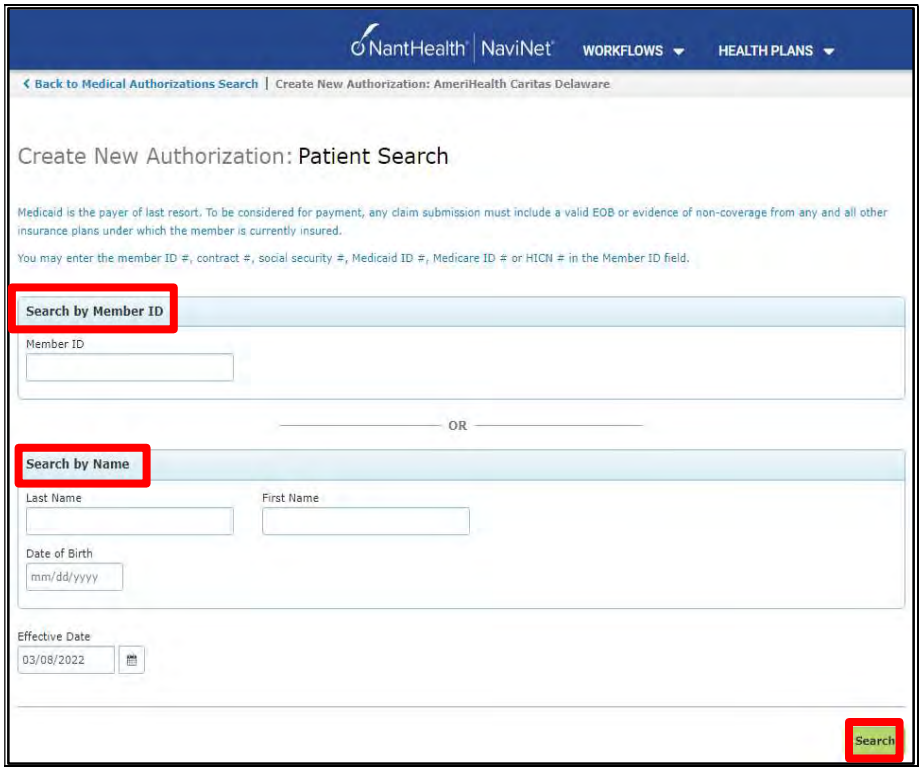
Creating a New Authorization – Inpatient Delivery Notification

To create an Inpatient Delivery Notification:

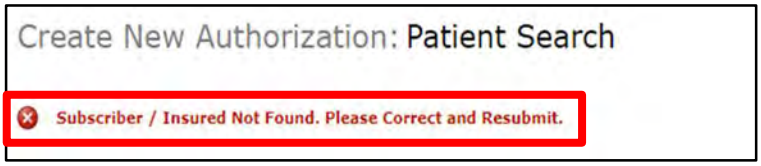
Step	Action
1.	Launch **Medical Authorizations** under Workflows for this Plan**.** 
2.	Click **Create New Authorization** 

Step	Action
3.	Enter patient search criteria information then select **Search**. The patient search screen allows the user to search by Member ID or Search by Name. If searching by name, the member's first name, last name, and date of birth (DOB) are required.

	If there are multiple matches based on criteria entered, the user will get a search results screen. On the search results screen, select the appropriate member from the list returned. If there is an exact match, the user is taken to the pre-screening questions.



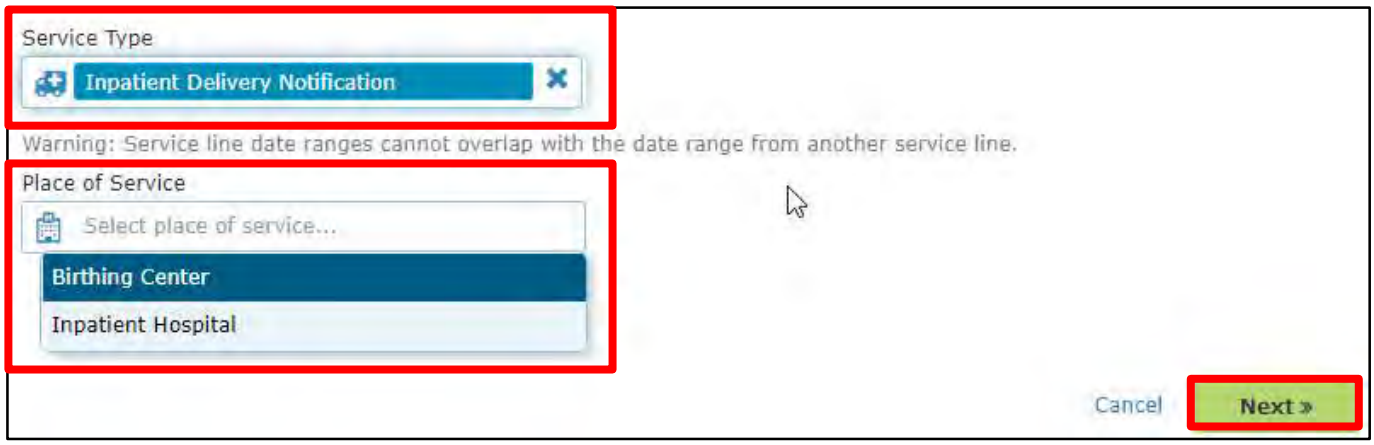
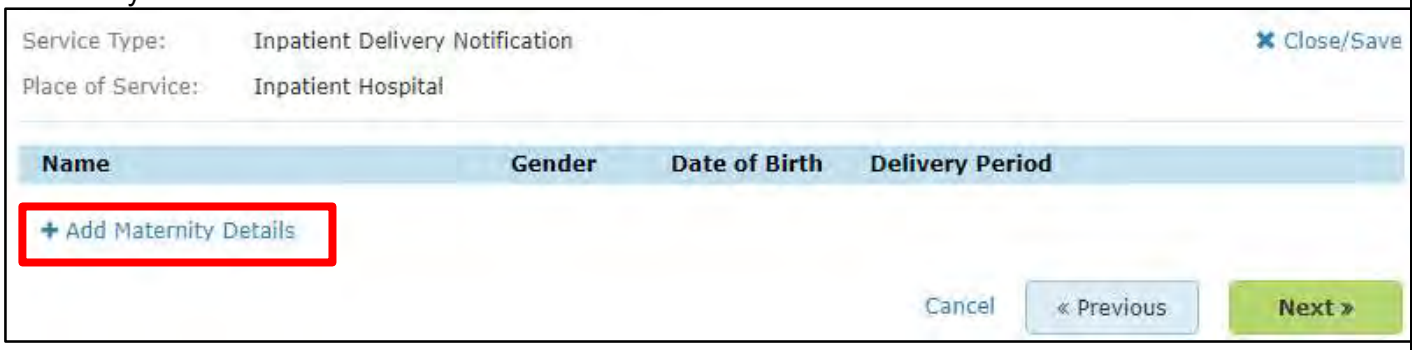
Note: If an incorrect/invalid member ID is entered, the message below appears:



Step	Action
4.	Address the pre-screening questions pop up box then select **Continue**. **Note**: If a member is not active with the health plan, the user will not be advanced to the pre-screening questions.

If…	Then…
The member has active coverage	The provider will be advanced to the New Authorization Pre-Screening Questions The purpose of the New Authorization Pre-Screening Questions is to ensure that the correct authorization process is being followed. It is important to scroll through the questions to ensure that there is not a more appropriate avenue for the request. These questions are specific based on the health plan.
The member is ineligible	The provider will receive the authorization cannot be created message.

Creating a New Authorization – Inpatient Delivery Notification (cont.)

Step	Action
5.	Complete the required fields following the guidelines below for an Inpatient Delivery Notification: Service Type: **Inpatient Delivery Notification** Place of Service: **Birthing Center** or **Inpatient Hospital** Select **Next**  Service Type Inpatient Delivery Notification Warning: Service line date ranges cannot overlap with the date range from another service line. Place of Service Select place of service... Birthing Center Inpatient Hospital Cancel Next »
6.	Click **+ Add Maternity Details** to populate the Add Maternity Details pop out box. The fields in this box are mandatory. 

Creating a New Authorization – Inpatient Delivery Notification (cont.)

Step	Action
6.	**Add Maternity Details** Baby's Last Name: Baby's First Name: Gender: Select Date Of Birth: MM/DD/YYYY Weight in Grams: 1 Minute Apgar: Select 5 Minute Apgar: Select **Delivery** Delivery Outcome: Select Delivery Method: Select Delivery Period: Select Estimated Gestational Age : Select weeks 0 days Estimated Confinement Date: MM/DD/YYYY Nursery type: Select Cancel Save

Step	Action	
6.	**Baby's Last Name**	Free text field. Enter the baby's last name. Baby's Last Name:
	Baby's First Name	Free text field. Enter the baby's first name. Baby's First Name:
	Gender	Drop down field. The options are Male, Female, Unknown Gender: Select
	Date Of Birth	Select a date from the calendar Date Of Birth: MM/DD/YYYY
	Weight in Grams	Free text field. Enter the weight in grams Weight in Grams:
	1 Minute Apgar	Drop down field - select 1-10. Click on the question mark for clarification. 1 Minute Apgar Select 1 Minute Apgar: The Apgar score measures five things to check a baby's health. Each is scored on a scale of 0 to 2, with 2 being the best score. 1. Appearance (skin color) 2. Pulse (heart rate) 3. Grimace response (reflexes) 4. Activity (muscle tone) 5. Respiration (breathing rate and effort)

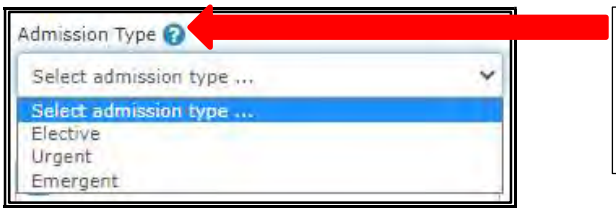
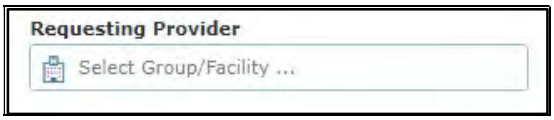
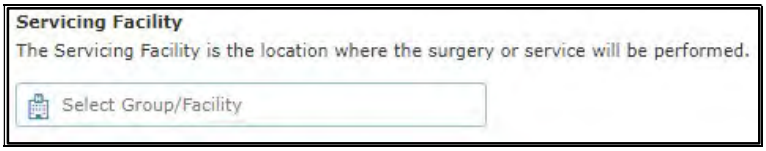
Step	Action	
6.	**5 Minute Apgar**	Drop down field - select 1-10. 5 Minute Apgar: Select
	Delivery Outcome	Drop down field – select live birth or non live birth. Delivery Outcome: Select
	Delivery Method	Drop down field – select c-section or normal vaginal delivery. Delivery Method: Select
	Delivery Period	Drop down field – select day of admission, day after admission, or 2 or more days after admission. Delivery Period: Select
	Estimated Gestational Age	Select the appriopriate values from the drop down fields. Estimated Gestational Age : Select weeks 0 days
	Estimated Confinement Date	Type the date or use the calendar to select the appropriate date. Estimated Confinement Date: MM/DD/YYYY
	Nursery type	Drop down field – select well baby or NICU. Nursery type: Select
7.	Select **Save** when the Add Maternity Details are complete. If this is a multiple gestation pregnancy and additional births should be reported, select **+ Add Maternity Details** to complete the additional details, then select **Next.**	

Name	Gender	Date of Birth	Delivery Period
JESSICA BODLEY	Female	09/29/2022	Day of admission

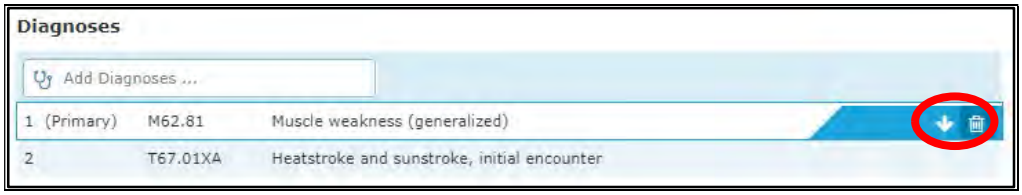
+ Add Maternity Details

Cancel « Previous **Next »**

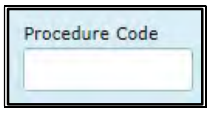
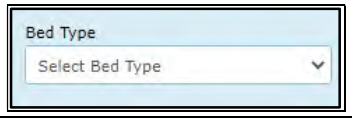
Step	Action	
8.	**Date of Admission/ Date of Discharge**	Date of admission is a mandatory field. Date of discharge is optional because it may not be known at the time the request is initiated. Providers can add the date of discharge by amending an authorization (see Amending an Authorization chapter). Date Of Admission: 03/09/2022 Date of Discharge: Optional **Note:** If the dates of service overlap in the same case, the message below will display. • Invalid / Missing Date(s) of Service - Please Correct and Resubmit

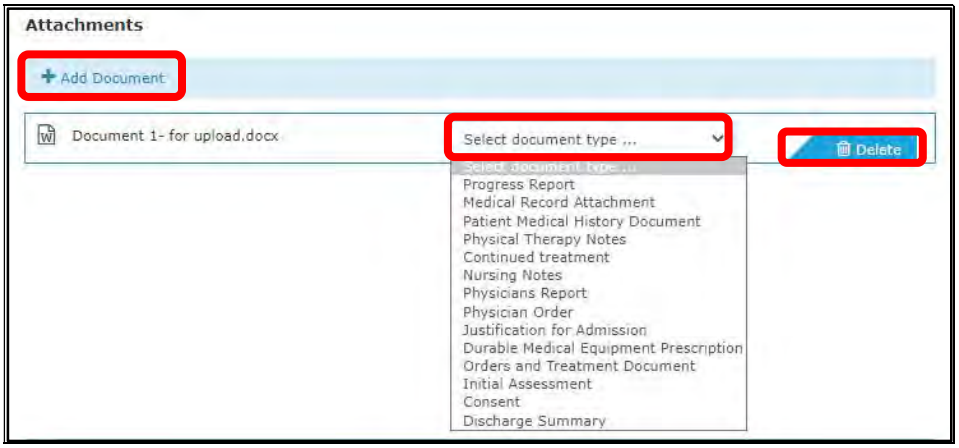
Step	Action	
9.	**Admission Type**	Select the admission type – Elective, Urgent, or Emergent  The question mark beside admission type provides information regarding the types of admissions. **If** / **Then** **Elective** – Potential admission for illness/injury enrollee not currently admitted **Urgent** – Potential admission for illness/injury that can be treated in a 24-hour period and if left untreated could rapidly become a crisis or emergency, enrollee not currently admitted **Emergent** – Concurrent review, enrollee is currently admitted
	Requesting Provider	Select the requesting provider. Requesting provider is the provider that is requesting the service. 
	Servicing Provider	Choose the appropriate selection from the drop-down list. Servicing provider is the provider completing the service (also known as the attending provider).
	Servicing Facility	The servicing facility is the location where the service will be performed. 

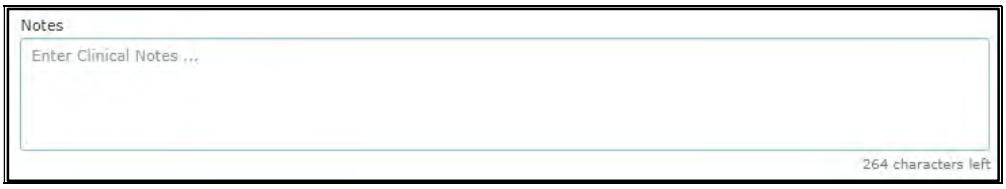
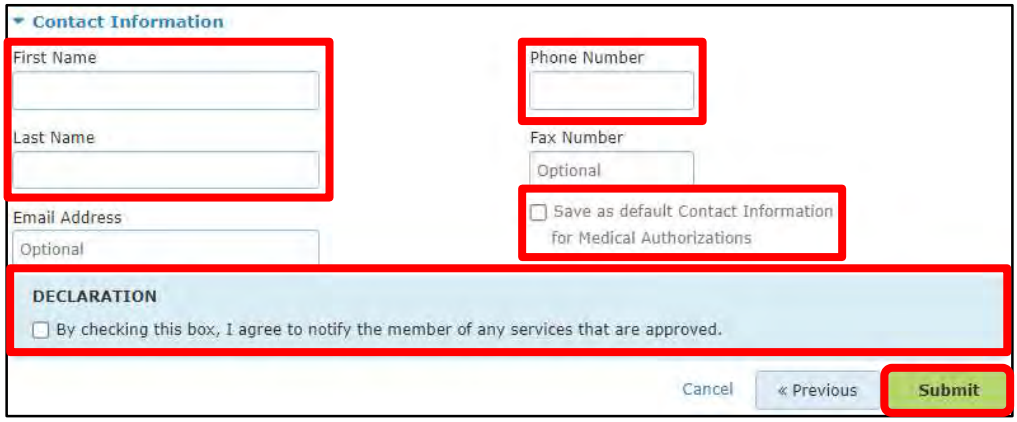
Step	Action
9.	**Diagnoses**

Diagnoses	Diagnoses is a look up field (max number of diagnosis codes that can be attached is 12). **Note:** The primary diagnosis can be changed if more than 1 diagnosis exists. There is also the ability to delete a diagnosis that may have been entered in error. The user can hover over the row to reorder (arrow icon) and or delete (trash icon) the diagnosis. 

Step	Action
9.	**Services**

From / To	From (start date) / To (end date). The From and To dates are mandatory. If the To date is unknown, advance it by 1 day from the From date.
Procedure Code	This is a free text field and is not mandatory. If an incorrect procedure code is entered the request may not be processed. The user will **not** be notified if an incorrect code is entered so it is important for the user to enter the correct code. If this is an inpatient only request and there is no procedure code, do not place anything in the procedure code field. 
Modifiers	This is a free text field and is not mandatory.
Units	Free text numeric value. For the inpatient request, units are equivalent to days.
Bed Type	Select the appropriate bed type from the drop down list. This is a mandatory field. 
+ Add New Service Line	The user must add new service line for the system to recognize the request. The **Add New Service Line** will also be utilized when adding additional service requests.

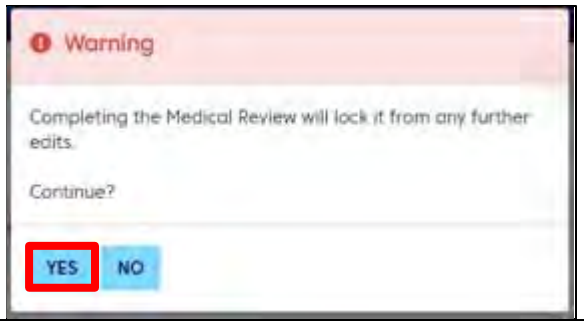
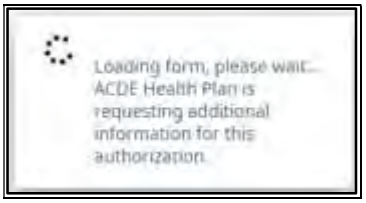
Step	Action	
9.	**Attachments**	
	Add Document	Attach supporting clinical documentation (supported document types: pdf, docx, xml, csv, png, gif). Up to 10 documents may be attached. If a document is attached, the document type is mandatory. Documents attached in error can be deleted. 

Step	Action
9.	**Notes**
	Notes — Add pertinent notes. There is a 264 character limit. Once the max character limit is reached, the box will turn red and the user will be unable to add additional characters. 
	Contact Information — Enter your contact information. First name, last name and phone number are required fields. Fax number and email address are optional fields. The Declaration check box is mandatory and must be checked to submit the request. Select **Submit** when the request is complete. **Note**: Check Save as default Contact Information for Medical Authorizations to save time in the future. 
9.	Selecting **Submit** may or may not launch InterQual criteria. InterQual criteria is launched based on the diagnosis code and or the service code and if there are criteria to launch for the diagnosis code and or service code that is identified in the episode. If InterQual criteria is not launched after the user submits the request, the user may receive a status of pending or an automatic approval.
10.	If InterQual is launched, the message below will populate indicating the InterQual page is loading.

Creating a New Authorization – Inpatient Delivery Notification(cont.)

Step	Action
11.	The system will direct the user to a guideline selection page. Select the most appropriate guideline then click on medical review. Select the day on which you wish to complete the medical review then select the pertinent findings/interventions.

Creating a New Authorization – Inpatient Delivery Notification (cont.)

Step	Action
12.	Address all pertinent findings/interventions based on the day selected for the review. At the end of the review the user will receive criteria met or criteria not met. Regardless of if it meets or does not meet, the user should continue.
13.	When the review is complete, click **Complete** at the bottom**,** then select **YES** to continue. 
14.	The following notice which indicates that the system is going back to NaviNet from InterQual. 

Step	Action
15.	Once the user arrives back in NaviNet, they will arrive on the authorization details screen.

Authorization Details FRANKIE MOCHRIE

AmeriHealth Caritas Delaware

+ Create New History Authorization Search View/Print as PDF

Pending Authorization #: 92204002349

Disposition pending review

FRANKIE MOCHRIE

PATIENT'S INSURANCE

PRIMARY CARE PHYSICIAN
HEATHER BITTNER-FAGAN
NPI

View Eligibility & Benefits

Requesting Provider
Ahmed, Mohamed F.
379 Walmart Dr Ste 101
Camden Wyoming , DE 19934--1365
(302) 698-4441

Servicing Facility
Alfred I Dupont Hospital
1600 Rockland Rd
Wilmington, DE 19803--3607

Servicing Provider
Alfred I Dupont Hospital
1600 Rockland Rd
Wilmington , DE 19803--3607
Date of Admission: 04/13/2022
Admission Type: Emergent
Service Type: Inpatient Medical Care
Place of Service: Inpatient Hospital

Authorization Status – Approved and Pending

The episode will be approved or be in a pending status when the request has been submitted to the health plan.

Note: Denials are not processed automatically, pending status submissions will require medical review by the health plan. If a denial is processed by the plan, a telephone call/letter will be made/sent to the provider.

<table>
<tr><th>If…</th><th>Then it will look like this…</th></tr>
<tr><td>Approved</td><td>

Note: Approved and partially approved requests can be amended (see chapter on Amending).

The following actions can be taken on an approved request from the authorization status page:
<table>
<tr><td>Amend</td><td>Extending existing services or requesting another service on the same authorization</td></tr>
<tr><td>Create New</td><td>Creating a new request</td></tr>
<tr><td>Attach</td><td>Attaching a document</td></tr>
<tr><td>Authorization Search</td><td>Searching for an authorization</td></tr>
<tr><td>View/Print as PDF</td><td>View and print authorization status request as PDF</td></tr>
</table>
</td></tr>
<tr><td>Pending</td><td>

Note: Submissions with a pending status will require medical review by the health plan. Requests with a pending status cannot be amended.

The following actions can be taken on an approved request from the authorization status page:
<table>
<tr><td>Create New</td><td>Creating a new request</td></tr>
<tr><td>History</td><td>Detailed history of the request</td></tr>
<tr><td>Authorization Search</td><td>Searching for an authorization</td></tr>
<tr><td>View/Print as PDF</td><td>View and print authorization status request as PDF</td></tr>
</table>
</td></tr>
</table>

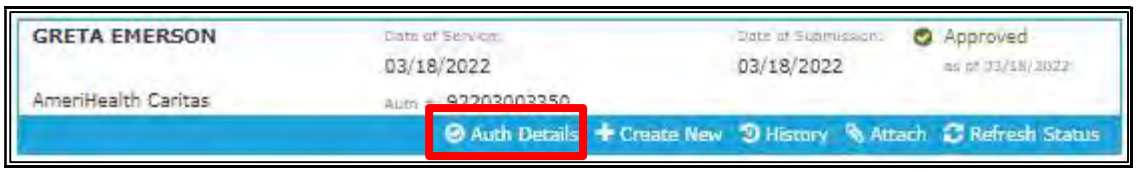
4

4 AMENDING AN AUTHORIZATION

Amending an Authorization Request

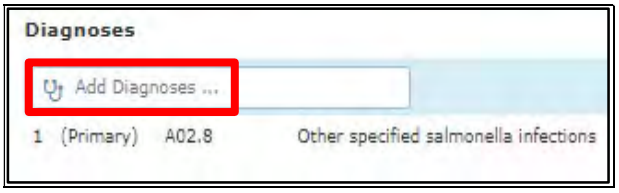
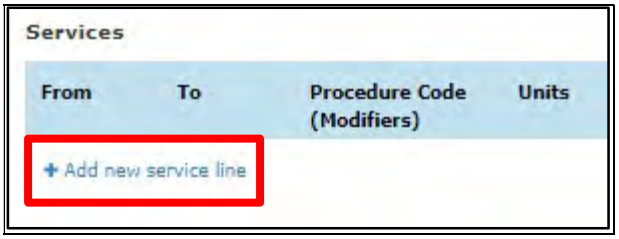
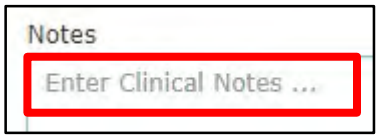
Amending a request is the process of extending existing services **or** requesting another service on the same authorization. Each time an amendment is made the note character limit will be reduced. Amending is only available to requests that have been approved or partially approved by the health plan. The maximum number of services that can be added to an authorization is 15.

	When making an amendment the user can add diagnoses, add services, add notes (if the maximum character limit has not been exceeded) and add documents.

Step	Action
1.	Locate the existing request under **Workflows for this Plan**. **If…** / **Then…** The request was created in NaviNet — Select **Medical Authorizations Log** The request was not created in NaviNet (for example if the request was faxed, phoned, or submitted via Jiva) — Select **Medical Authorizations** and then **Search for Existing Authorization** (also referred to as Authorization Inquiry by NaviNet)
2.	Select **Auth Details** on the request that needs to be amended. 
3.	Select **Amend.**

Step	Action
4.	

If…	Then….
Amending an outpatient request	The following items can be addressed: date of service, diagnosis, add new service line, add document, notes and contact information.

Address the Date of Service	
Add additional diagnoses if applicable	
Add new service line	
Add attachments if applicable	
Add notes if applicable	

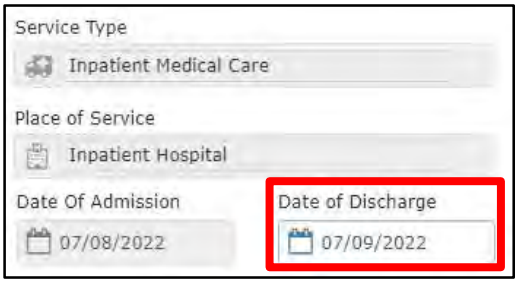
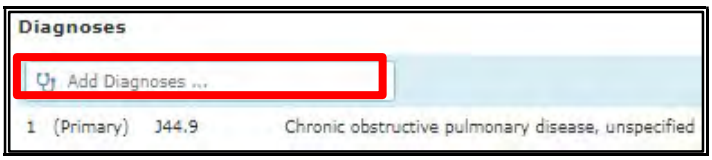
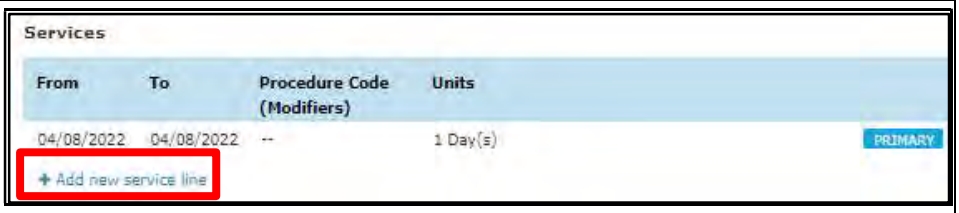
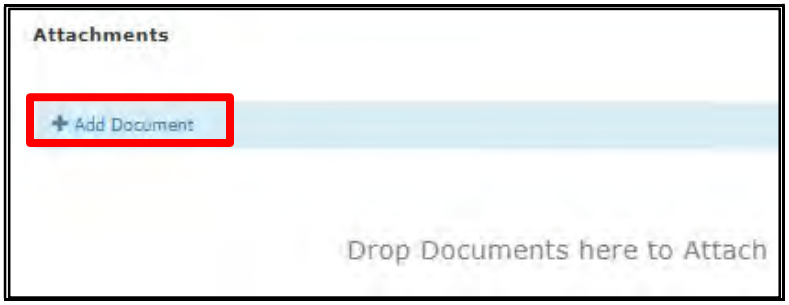
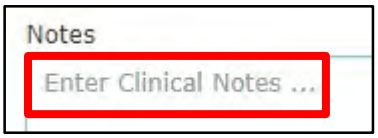
Amending an Authorization Request (cont.)

Step	Action
4. **(cont.)**	Amending an outpatient request
	Enter contact information, check the Declaration box, and **Submit.**

Contact Information
First Name
Beth
Last Name
Williams
Email Address
Optional
Phone Number
(843) 999-9999
Fax Number
Optional
Save as default Contact Information for Medical Authorizations
DECLARATION
By checking this box, I agree to notify the member of any services that are approved.
Cancel
« Previous
Submit

Step	Action
5.	Amending an inpatient request

If…	Then….
Amending an inpatient request	The following items can be addressed: date of date of discharge, diagnosis, add new service line, add document, notes and contact information

Providers can enter the date of discharge for members that have discharged.	
Add additional diagnoses if applicable	
Add new service line	
Add attachments if applicable	
Add notes if applicable	

Amending an Authorization Request (cont.)

Step	Action
5. (cont.)	Amending an inpatient request
	Enter contact information, check the Declaration box, and **Submit**

Contact Information

First Name: Beth

Last Name: Williams

Email Address: Optional

Phone Number: (843) 999-9999

Fax Number: Optional

☑ Save as default Contact Information for Medical Authorizations

DECLARATION

☑ By checking this box, I agree to notify the member of any services that are approved.

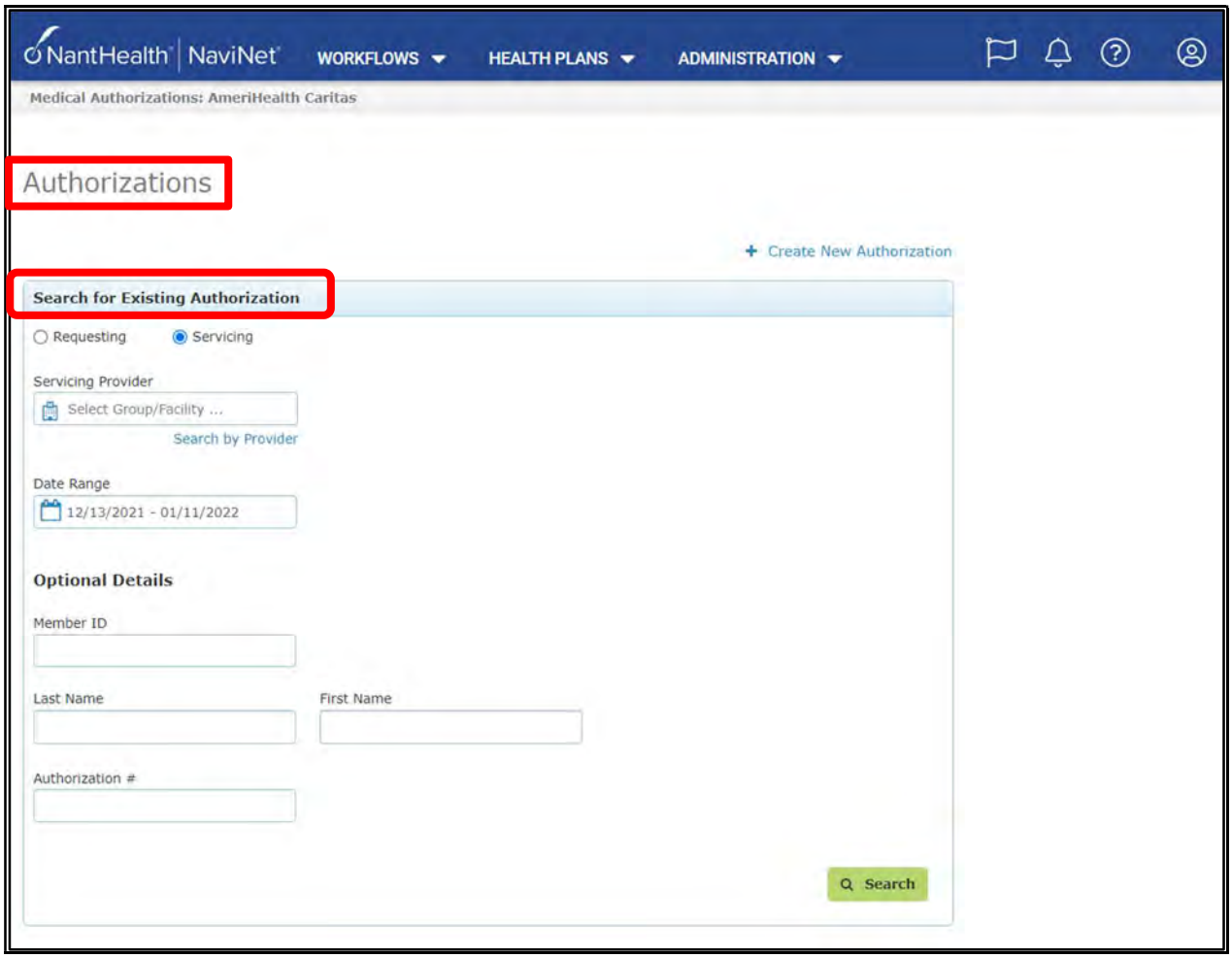
Cancel | « Previous | Submit

5

5 SEARCH FOR AN EXISTING AUTHORIZATION

Search for an Existing Authorization

Search for an Existing Authorization (also known as Authorization Inquiry) is a way to search for authorizations that may not have been initiated in NaviNet, for example they may have phoned, faxed, or created in Jiva.

Step	Action
1.	Providers will only see authorizations/requests for members that are under their care. To search for an existing authorization select **Medical Authorizations** under Workflows for this Plan. 

Search: Search for an Existing Authorization (cont.)

Step	Action
2.	Select Servicing or Requesting Provider and adjust the date range then select **Search**.
3.	Select the authorization that you wish to view.

Search: Search for an Existing Authorization (cont.)

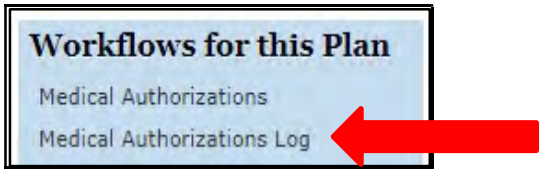
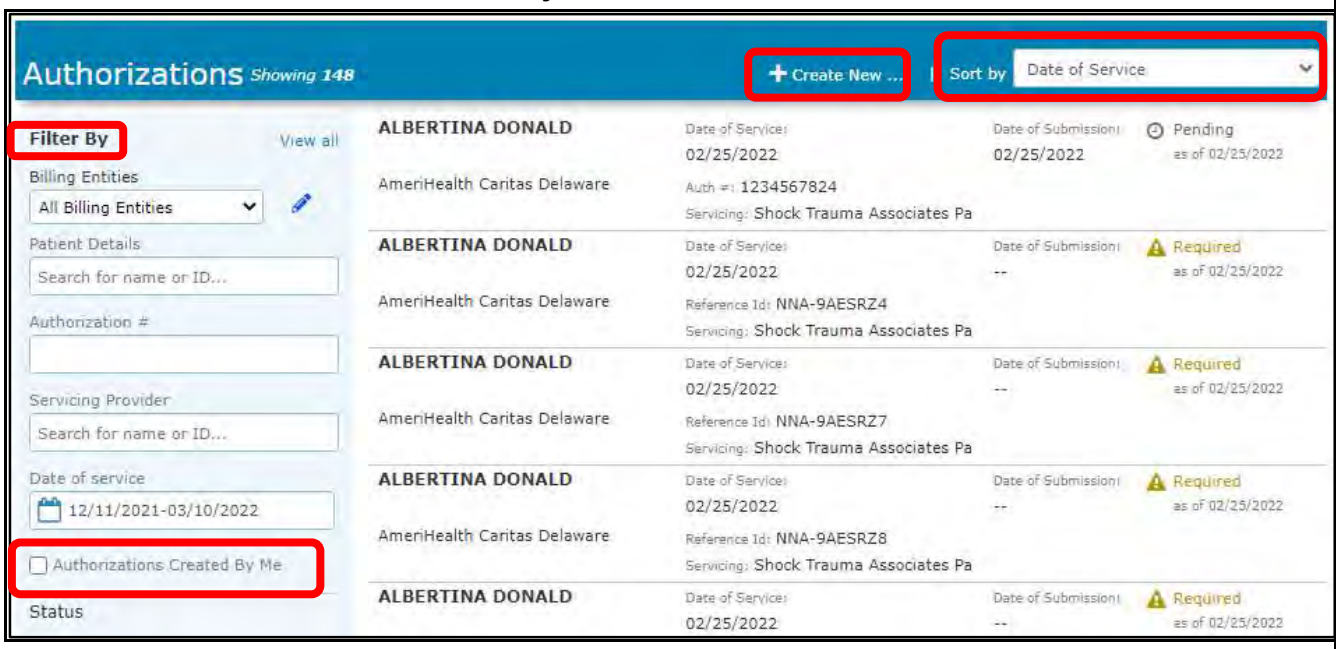
Step	Action
4.	The user will be directed to the authorization details of the authorization that was selected in the previous step. **Note:** Additional actions may be accessed from the authorization details to include amending (only available for approved or partially approved requests), create new, attach, authorization search, and view/print as PDF. **Amend** — Extending existing services or requesting another service on the same authorization **Create New** — Creating a new request **Attach** — Attaching a document **Authorization Search** — Searching for an authorization **View/Print as PDF** — View and print authorization status request as PDF

6

6 MEDICAL AUTHORIZATION LOG

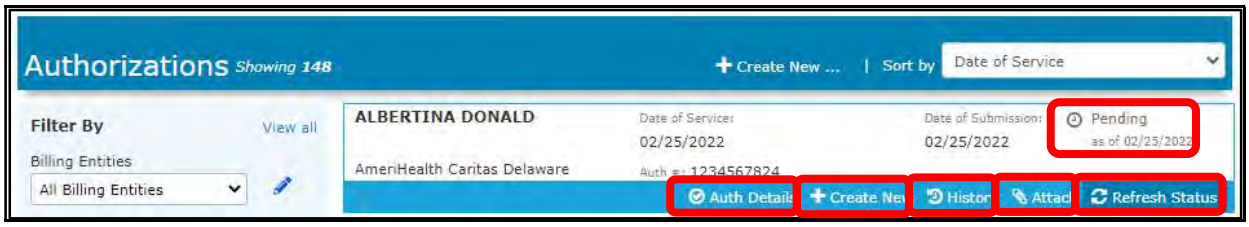
Search: Medical Authorization Log

Only requests that have been submitted via NaviNet Open Medical Authorizations will appear in the Authorization Log. To see cases that were initiated outside of NaviNet, use Search for an Existing Authorization (sometimes referred to as Authorization Inquiry).

Step	Action
1.	Select **Medical Authorization Log** under Workflows for this Plan. Result: All requests submitted by your office/facility via NaviNet can be found here. 
2.	The user can +Create New, Sort by and Filter By. To see Authorizations created by you, check the box in front of **Authorizations Created By Me.** 

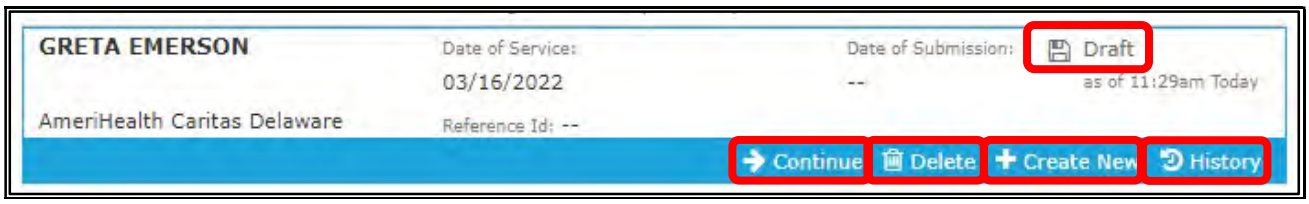
Search: Medical Authorization Log (cont.)

Step	Action
3.	Once the user selects the desired authorization for review they have the ability to view the following if the request is in pending status: **Auth Details, +Create New, History, Attach, and Refresh Status**.



Field	Function
Auth Details	Details related to the authorization
Create New	Create New Authorization for the member
History	Provides detailed history of the request
Attach	Ability to attach documents
Refresh Status	Allows the user to refresh the status for any updates.

Step	Action
3. (cont.)	If the request is in draft status different fields are available. **Continue, Delete, Create New,** and **History**



Field	Function
Continue	Allows the user to continue working on the request
Delete	Allows the user to delete the request
Create New	Allows the user to create a new authorization for the member
History	Provides detailed history of the request

7

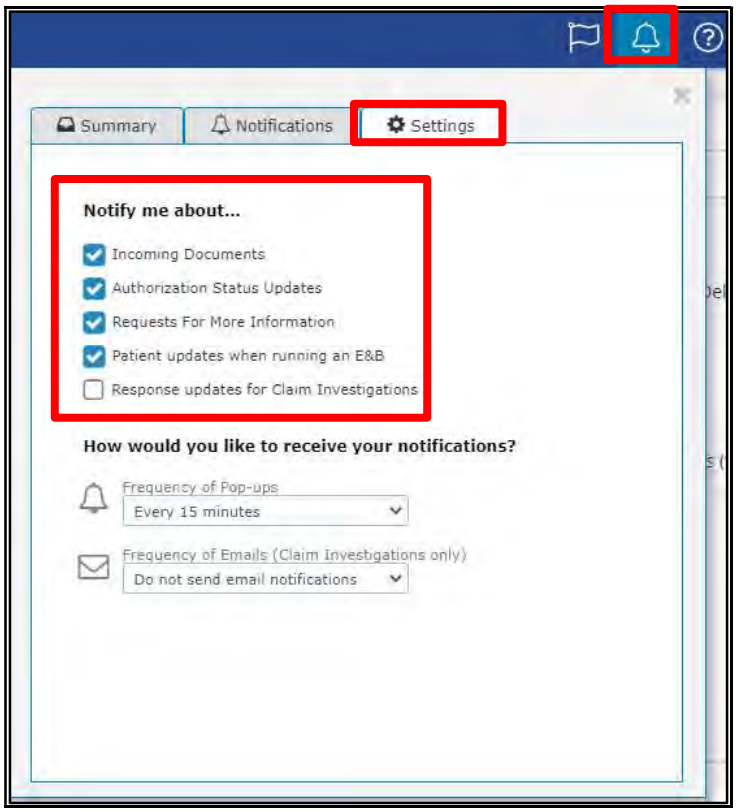
7 REQUEST FOR MORE INFORMATION (RFMI)

Request for More Information (RFMI)

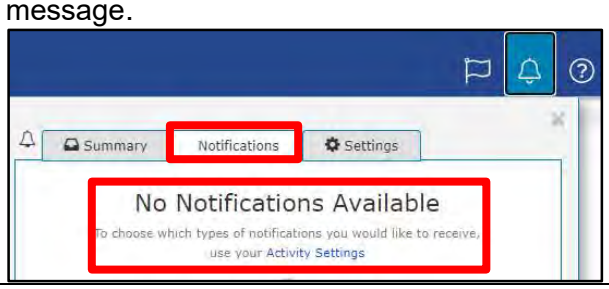
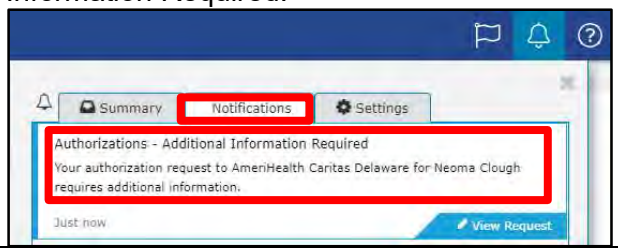
Request for More Information (RFMI) is a feature that allows the health plan to request specific additional information to the provider if needed. Providers will only be able to have the RFMI ability for authorization requests that are pended or approved that are created in the NaviNet Provider Portal. Providers will be able to add notes and/or upload the documents in NaviNet Provider Portal for the pended authorization requests via the 'more information required' screen.

	Notifications are an important part of the communication process between the health plan and the provider. Users can opt to receive notifications whenever a request is sent from the health plan to the provider. Notifications can be managed from the bell icon in the top right banner on the home page. It is important to note that notifications related to RFMI is not an immediate process. There is a slight delay as information travels from system to system.

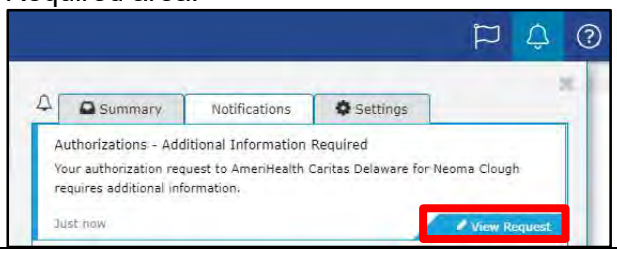
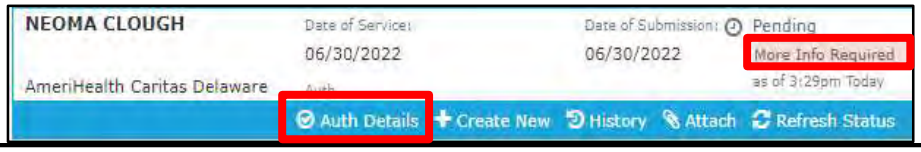
In NaviNet, users can opt to receive notifications whenever a request for additional information is requested from the health plan. Notifications can be managed under settings which is found when the bell icon is selected.

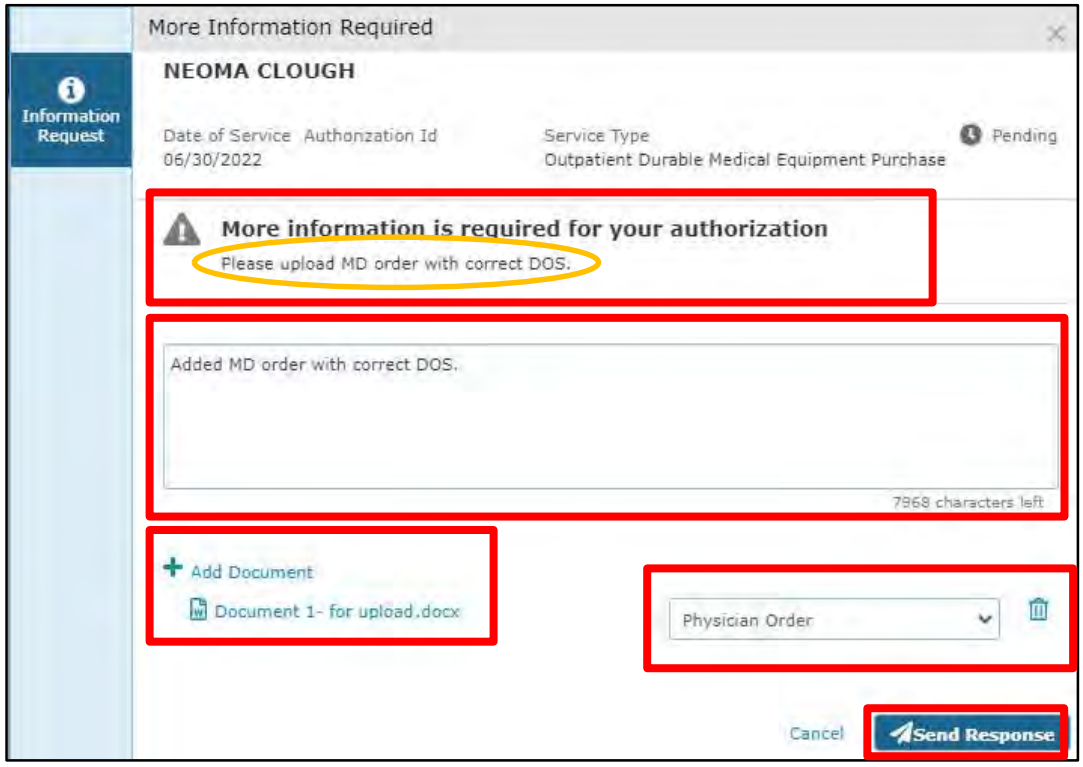
Step	Action
1.	Select the bell icon in the top right corner in NaviNet, then frome the Settings tab, specify the notifications you would like to receive. 

Step	Action
2.	To view notifications, select **Notifications**.

If…	Then…
No notifications exist	The user will see No Notifications Available message. 
Notifications are available	The user will see Authorizations – Additional Information Required. 

3. There are 3 ways for the user to see RFMI from the health plan.

1.	From Notifications the user will select View Request which activates the More Information Required area. 
2.	From the Medical Auth Log if More Info Required is listed the user will select Auth Details then select More Information Required to activate the More Information Requried area. 

Step	Action
3. (cont.)	**3.** From Auth Inquiry if More Information Required is listed, click on it to activate the the More Information Required area.
4.	Complete the more information required information request. The requested information will be listed under More information is required for your authorization. You may add notes (up to 8000 characters) and upload documents. If a document is uploaded, the document type will need to be specified from the drop down list (supported document types: pdf, docx, xml, csv, png, gif). To send the response back to the health plan select **Send Response**. 

Request for More Information (RFMI) (cont.)

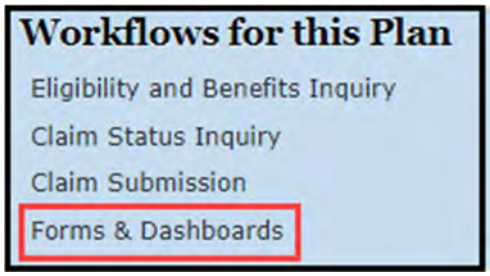
Step	Action
5.	To see that the requested information has been sent back to the health plan, select **History**.

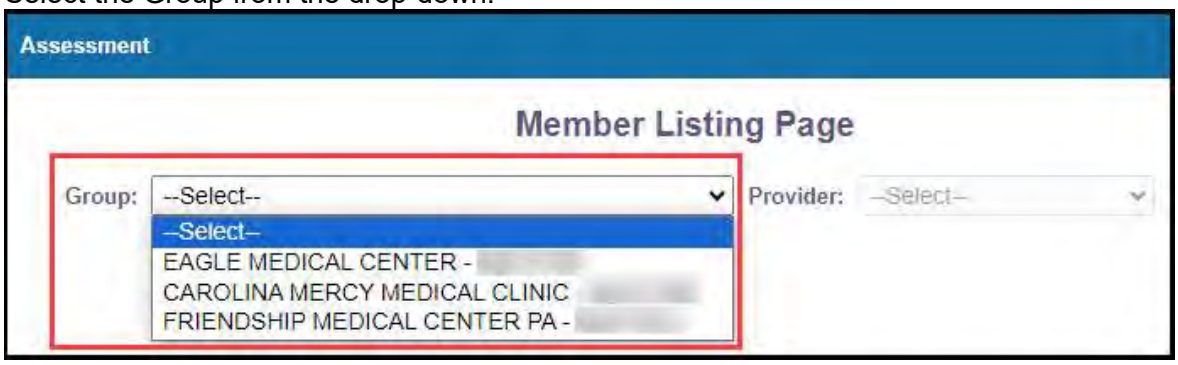
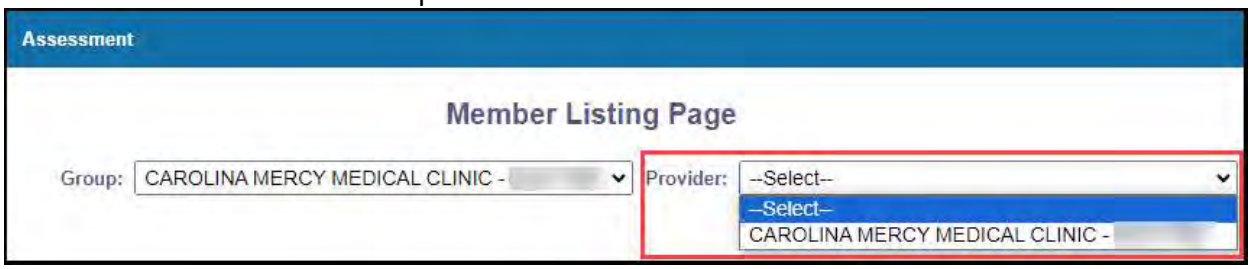
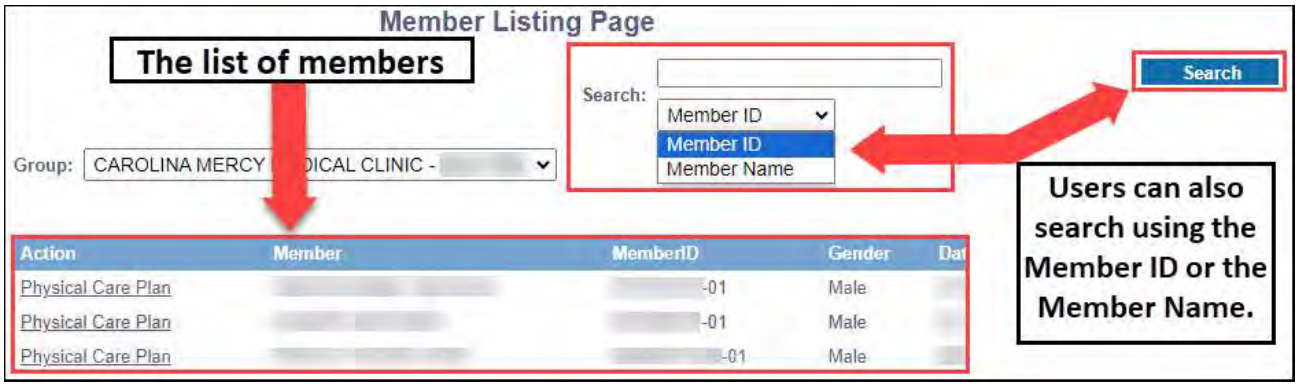
8

8 LOCATING ASSESSMENTS IN NAVINET

Locating Assessments in NaviNet

Providers may want to view assessments for their patients.

Step	Action
From the health plan specific homepage…	
1.	Select **Forms & Dashboards** under Workflows for this Plan. 
2.	Select **View Health Risk Assessment Form** under Health Risk Assessment.
3.	Select **Assessment**. ***Result:*** The Member Listing page will display.

Step	Action
4.	Select the Group from the drop-down. 
5.	Select the Provider from the drop-down.  ***Result:*** After the Group and the Provider are selected, users will also be able to search for members.
6.	Members are listed, but users can also search for members by Member ID or Member Name. Select Member ID or Member Name from the drop-down, enter the Member ID or Member Name in the search box, and then select **Search**. 

Step	Action
7.	Once the member is located, select **Physical Care Plan** under Action.

Action	Member	MemberID	Gender	Date Of Birth
Physical Care Plan		-01	Male	

Note	If the Assessment Summary does not display after selecting Physical Care Plan, ensure that the popup blocker is disabled.

8. The Assessment Summary is displayed. Users can select the assessment they wish to view.

Assessment Summary

Assessment	Date
Initial Assessment-PEDS	02/28/2024
Initial Assessment-PEDS	02/28/2024
Initial Assessment - Adult	02/28/2024
Initial Assessment - Adult	02/28/2024

Result: The assessment questions and answers will be displayed.

Note	If the Assessment Summary does not display after selecting the assessment, ensure that the popup blocker is disabled.

9

9 RESOURCES

Plan Contact Information

Health Plan	UM Phone Number	UM Fax Number
AmeriHealth Caritas Delaware	855-396-5770	866-423-0946
AmeriHealth Caritas District of Columbia	800-408-7510	877-759-6216
AmeriHealth Caritas Florida	855-371-8074	855-236-9285
AmeriHealth Caritas Louisiana	888-913-0350	866-397-4522
AmeriHealth Caritas New Hampshire	833-472-2264	833-469-2264
AmeriHealth Caritas North Carolina	833-900-2262	833-893-2262
AmeriHealth Caritas Northeast	888-498-0504	888-743-5551
AmeriHealth Caritas Pennsylvania	800-521-6622	866-755-9949
Blue Cross Complete of Michigan	888-312-5713	888-989-0019
Keystone First	800-521-6622	215-937-5322
Select Health of South Carolina	888-559-1010	888-824-7788
AmeriHealth Caritas Next	833-702-2262	844-412-7890
AmeriHealth Caritas VIP Care Plus	888-978-0862	866-263-9036
First Choice VIP Care Plus	888-996-0499	855-236-9284
AmeriHealth Caritas VIP Care	866-533-5490	855-707-0847
First Choice VIP Care	888-996-0499	855-236-9284
Keystone First VIP Choice	800-450-1166	855-707-0847
AmeriHealth Caritas Pennsylvania Community HealthChoices	800-521-6007	855-332-0115
Keystone First Community HealthChoices	800-521-6622	855-540-7066

Escalation Process and Training Requests – Account Executives and Providers

If…	Then contact…
Access Issues and/or Technical Issues related to NaviNet and InterQual	DL-ACFC: Jiva and Client Letter Support (ACFC_JivaCLSupport@amerihealthcaritas.com)
Account Executive Training Requests	Corporate Provider Network Management Training (CPNMT@amerihealthcaritas.com)
Provider Training Requests	Contact your designated Account Executive (AE)
Provider is not listed in NaviNet	Submit an online case in NaviNet via My Account>Customer Support>Open a Case Online
InterQual training or instruction is needed	Reach out to your internal point of contact as this is an internal process

Revision History

Date	Revisions
1/14/25	Updated disclaimer language to state: "*Please note, the information depicted as member information within this document is fictitious and intended solely for testing and demonstration purposes.*"