Leading America in Health Care
Solutions for the Underserved
and Chronically Ill.

NaviNet Behavioral Health User Guide

Corporate Clinical Systems Training Department

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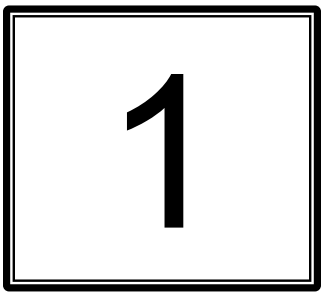
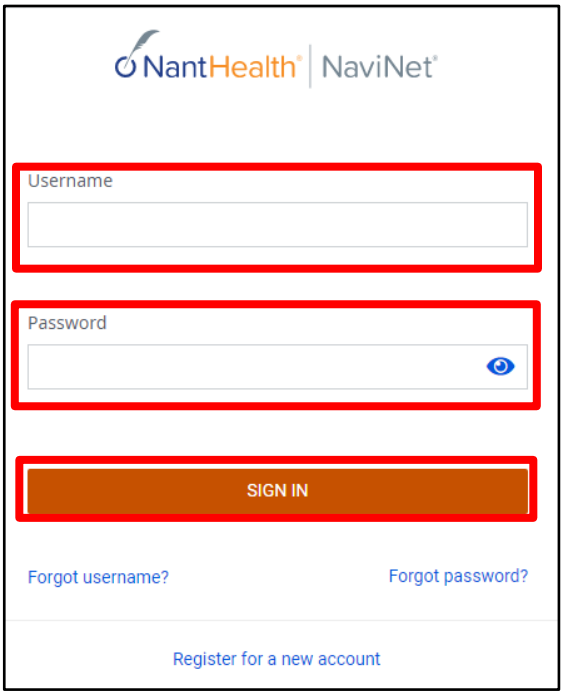
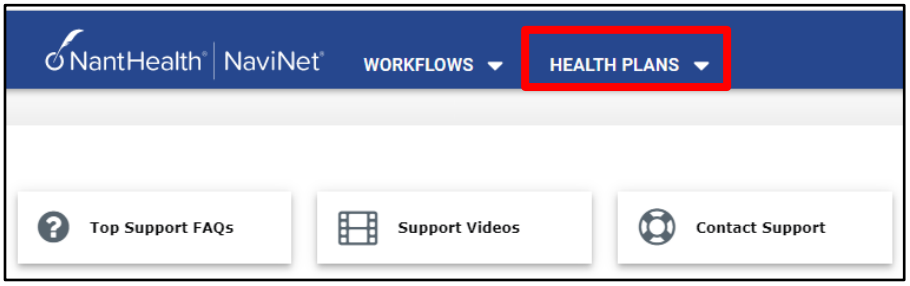
Review Cycle:	Annually

TABLE OF CONTENTS

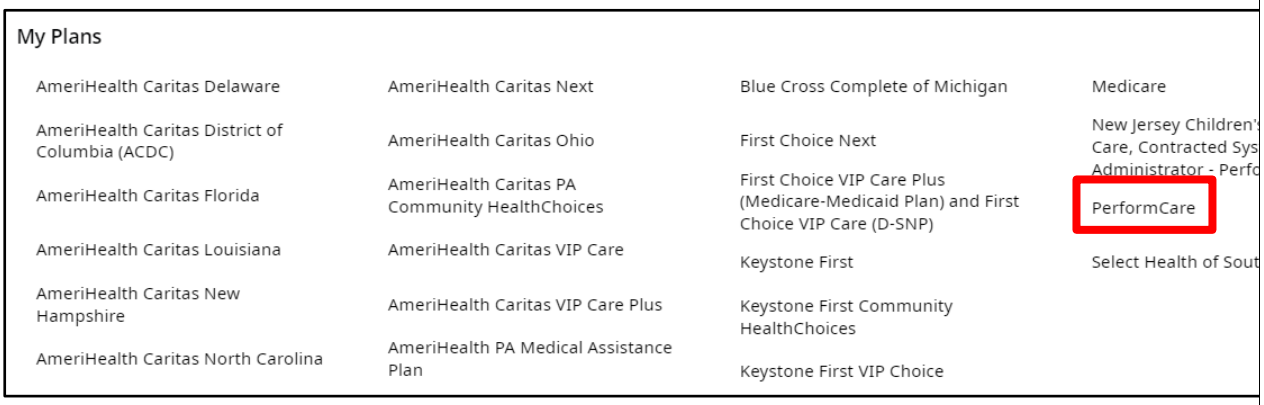


1 LOGGING IN TO NAVINET

Logging in to NaviNet

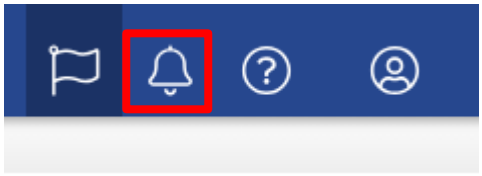
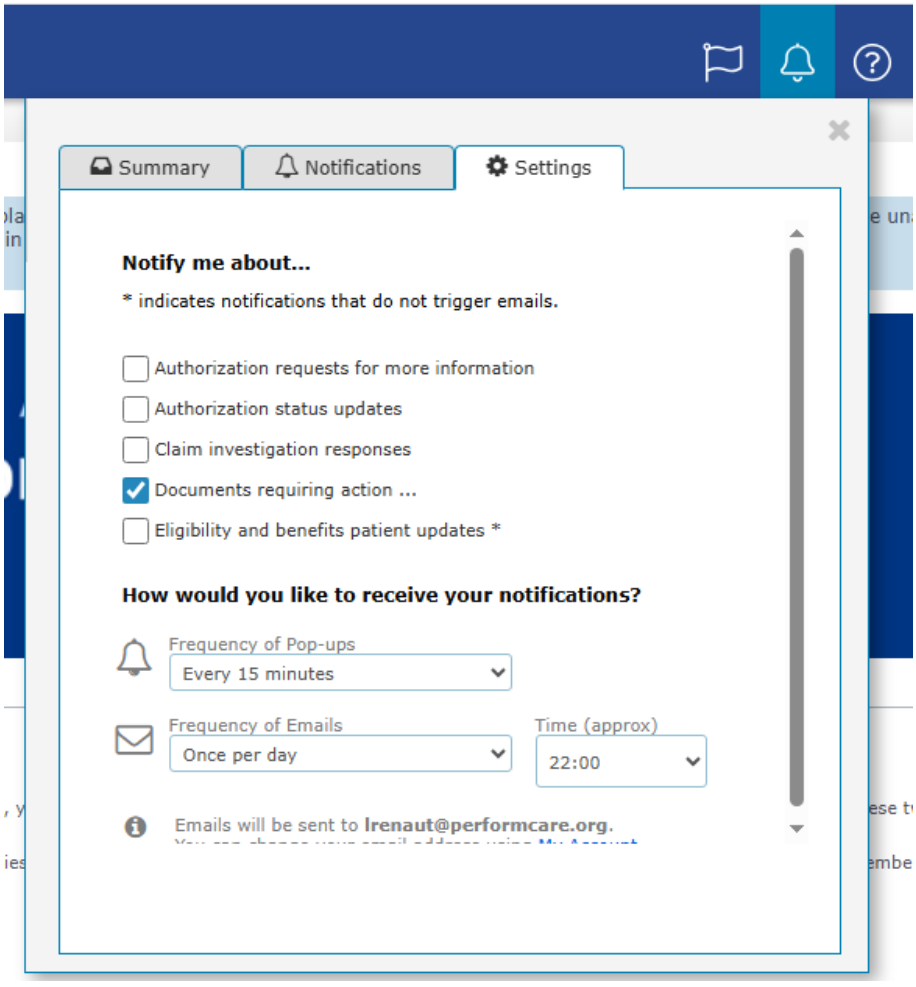
Step	Action
1.	Access NaviNet using the following address: **https://navinet.navimedix.com.**  **Note:** It is recommended that you use the Google Chrome browser for NaviNet.
2.	Enter your **Username**
3.	Enter your **Password**
4.	Click **Sign In** ***Result*** *The NaviNet Home screen will be displayed*
5.	Click on **HEALTH PLANS** in the top menu. 

Logging in to NaviNet (cont'd)

6.	Select **PerformCare**. 

Notifications via the Activity Tab

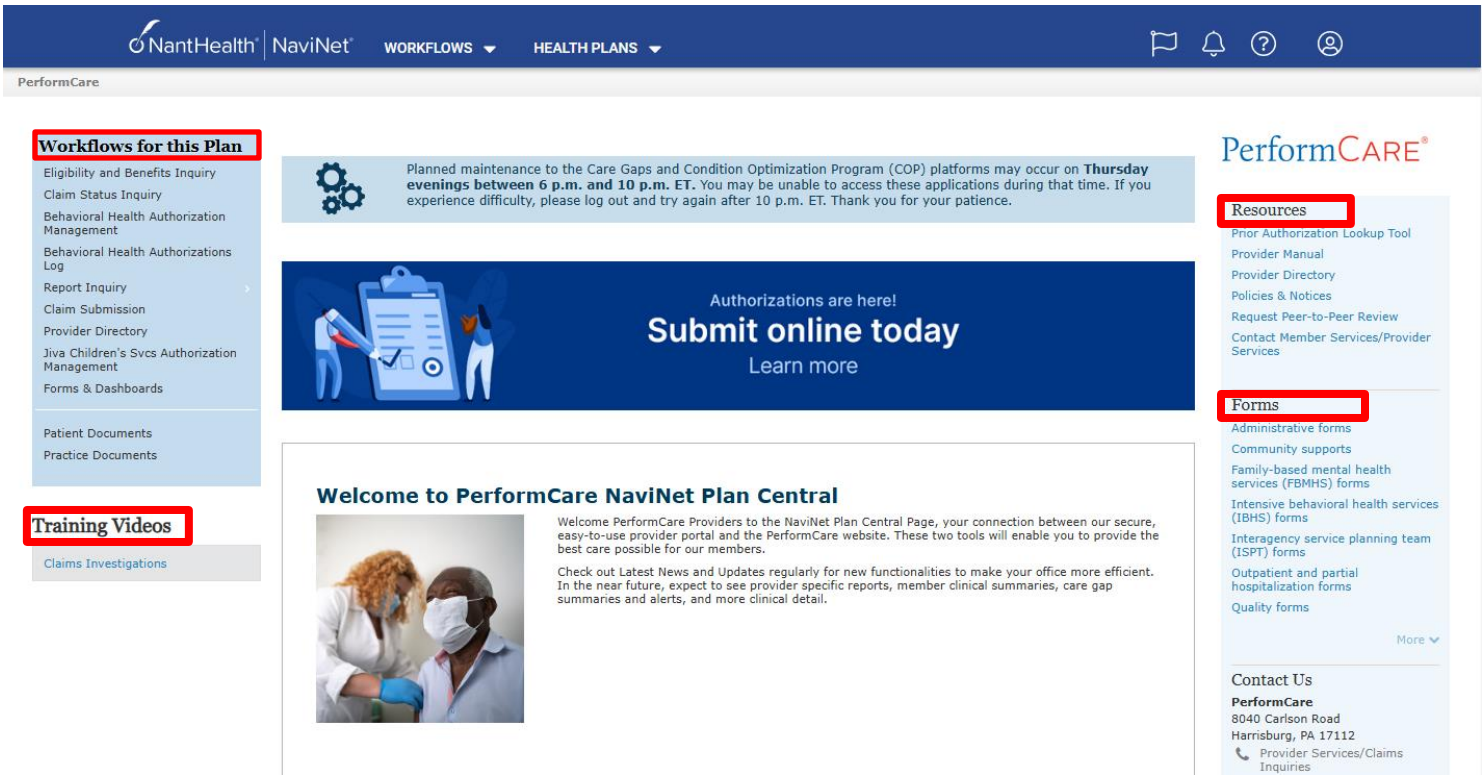
Notifications are an important part of the communication process between the health plan and the provider. Users can opt to receive notifications whenever a request is sent from the health plan to the provider.

Step	Action
1.	Click on the **Activity icon** in the upper right corner of the screen (bell icon) 
2.	Click the **Settings Tab** to select the notifications you want to receive. • Checking the "Documents requiring action" box means you will receive notifications for Overpayment requests, Requests for More Information (RFMIs) and Integrated Care Plans. • You can also select the frequency of notifications and whether or not you want to receive pop-ups.  **Note:** Providers must provide their e-mail in the NaviNet settings to receive the notifications.

2 PLAN CENTRAL

Plan Central Overview for PerformCare

The Plan Central displayed below is the health plan specific homepage for PerformCare.

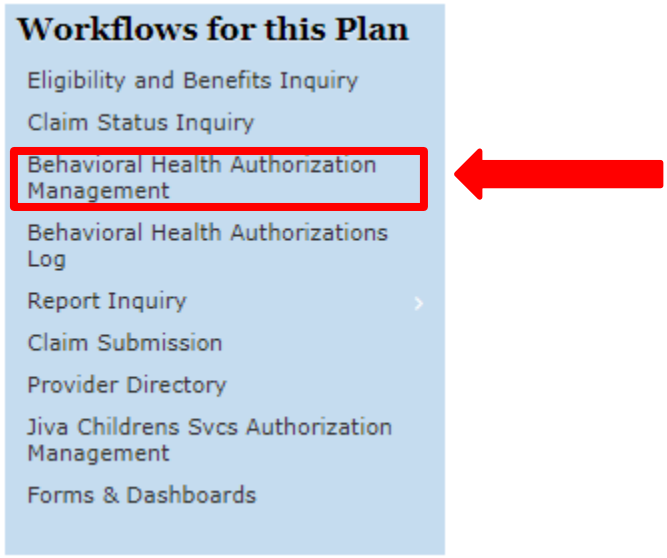
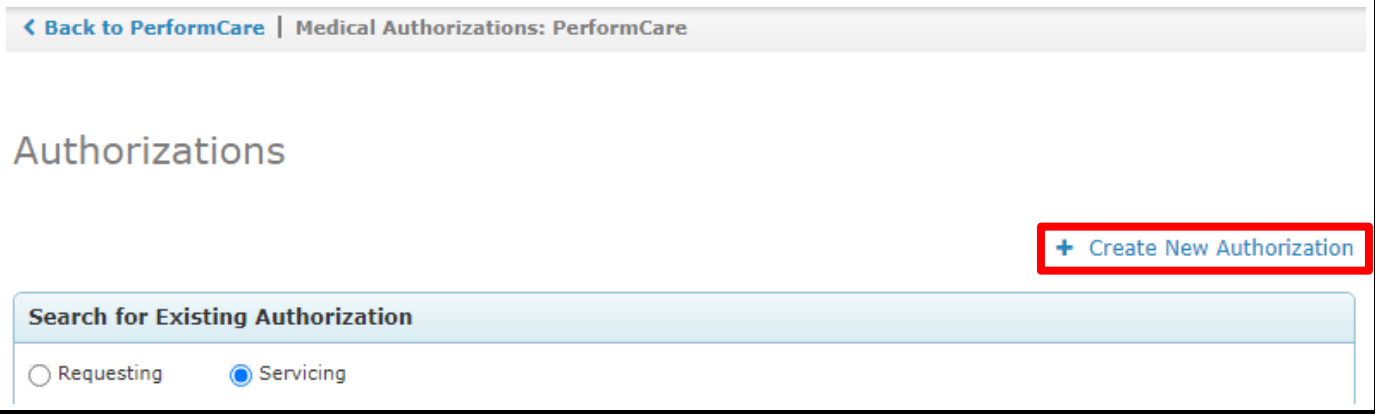


Plan Central	Topic	Description
Workflows for this Plan	Plan specific options	• Various functionalities are available to include initiating Behavioral Health authorizations, inquiries, etc.
Training Videos	Training Videos	• Instructional videos on system usage.
Resources	Website Resource Links	• Quick links for resources found on the PerformCare website.
Forms	Forms	• Forms to submit for authorizations can be found under this link.

3 CREATING A NEW AUTHORIZATION

Creating a New Authorization

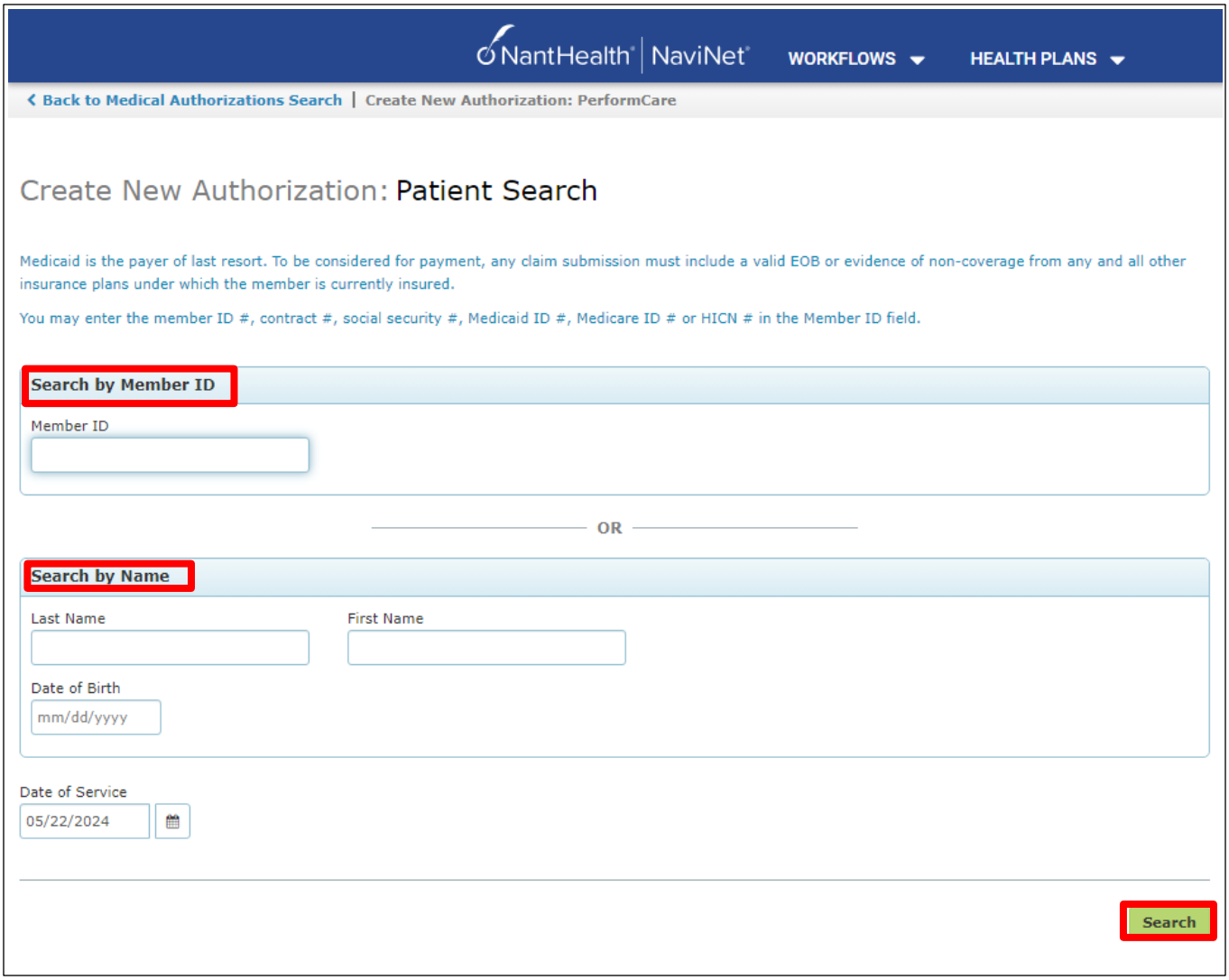
To create a new authorization:

Step	Action
1.	Launch **Behavioral Health Authorization Management** under Workflows for this Plan. 
2.	Click **Create New Authorization** 

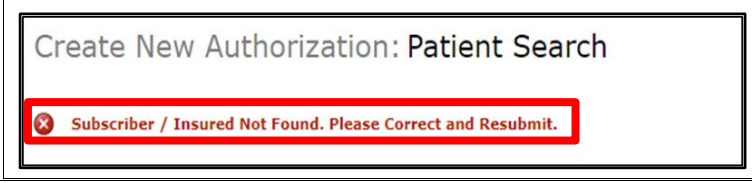
Creating a New Authorization (cont'd)

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.

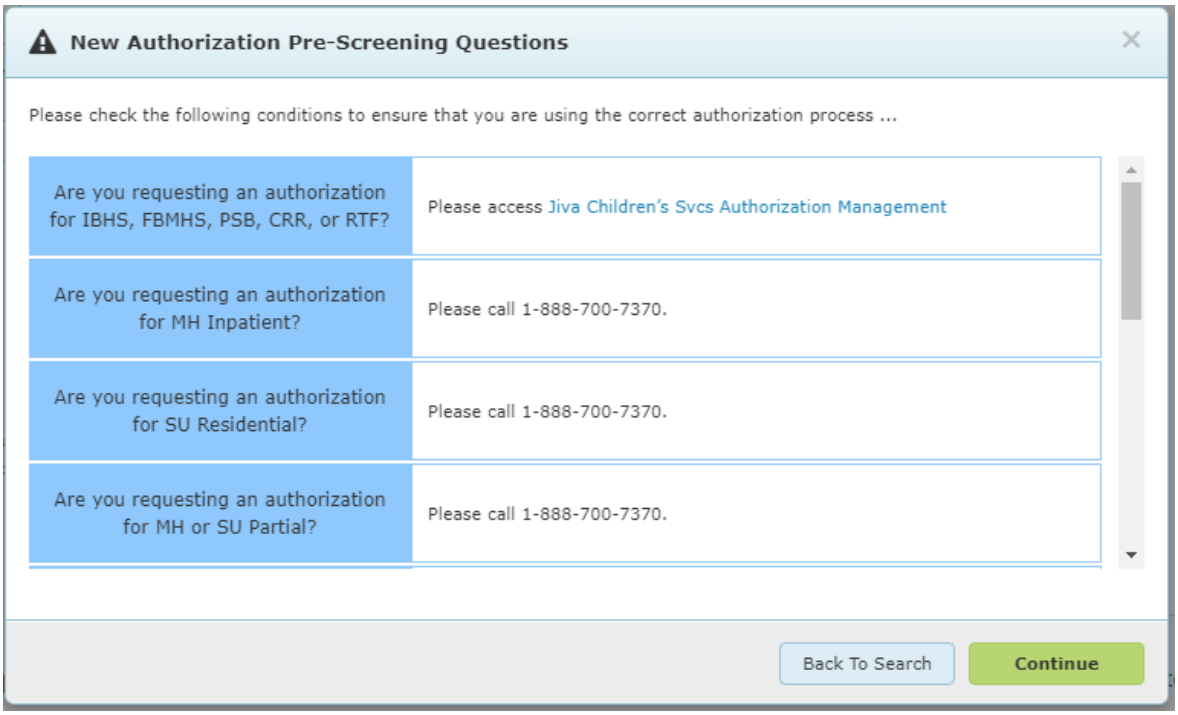
	If there are multiple matches based on criteria entered, the user will get a search results screen. On the search results screen, the user selects the appropriate member from the list returned. If there is an exact match, the user is taken to the pre-screening questions.



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. Once the questions have been review, please click Continue to advance.
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 Service Type Outpatient Case Management is chosen the user will not be prompted to select a place of service because the only place of service is in the home. If the service type chosen is Outpatient Psychiatric the user will be prompted to specify a place of service (office or home).

Providers should choose the service type and place of service that corresponds to the level of care listed below,

Level of Care	Service Type	Place of Service
ACT/CTT	Outpatient Serious Mental Health	Home
Crisis*	Outpatient Emergency Services	Other Place of Service
CRS	Outpatient Substance Abuse	Outreach Site/Street
ECT/ TMS	Outpatient Mental Health	On Campus-Outpatient Hospital
Methadone*	Outpatient Drug Addiction	Other Place of Service
Mobile Psych Nursing	Outpatient Skilled Nursing Care	Other Place of Service
Mobile MH/ID	Outpatient Psychotherapy	Home
Music Therapy	Outpatient Psychotherapy	Other Place of Service
Outpatient Eval/ Med Mmgt (Adjunct/OON) +	Outpatient Psychiatric	Office
Outpatient Therapy (Adjunct/OON) ^	Outpatient Psychotherapy	Office

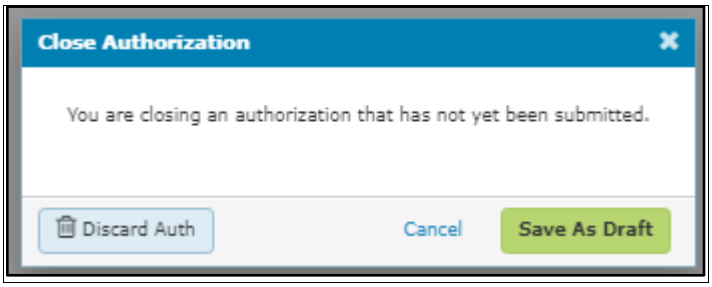
Peer Support	Outpatient Mental Health	Other Place of Service
Psych Rehab/Clubhouse	Outpatient Rehabilitation	Other Place of Service
Psych/NeuroPsych Testing	Outpatient Diagnostic Medical	Other Place of Service
MH Targeted Case Management	Outpatient Case Management	Home
SU IOP	Outpatient Drug Addiction	Non-residential Substance Abuse Treatment Facility
SU Level of Care Assessment*	Outpatient Substance Abuse	Other Place of Service
SU OP*	Outpatient Substance Abuse	Office
SU TCM	Outpatient Substance Abuse	Home

*Authorizations for these levels of care should only be entered for out-of-network purposes.

+If requesting Therapy and Eval/Med Mgmt submit using the Outpatient Therapy (Adjunct/OON) Service Type

^If requesting Therapy and Eval/Med Mgmt submit all codes following Outpatient Therapy (Adjunct/OON) Service Type

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



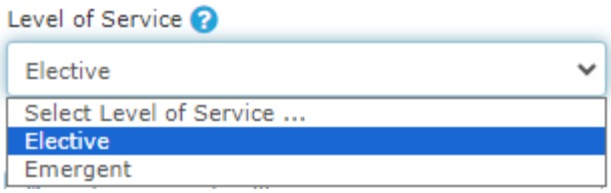
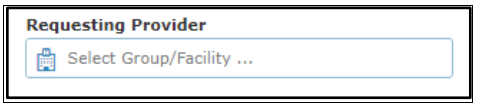
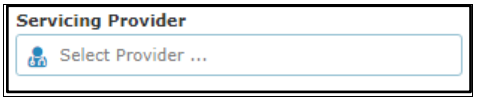
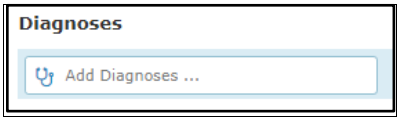
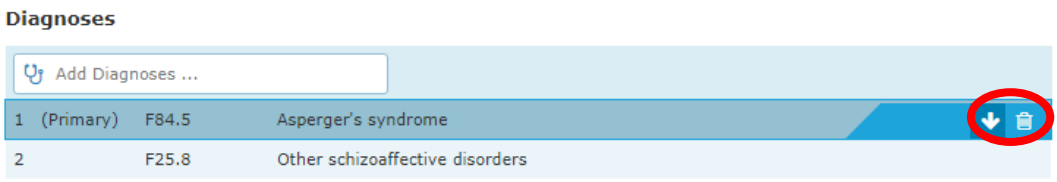
Discard Auth – deletes the request

Cancel – allows the user to continue

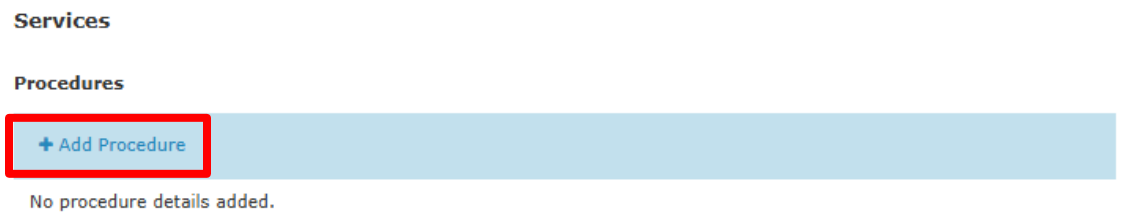
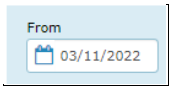
Save As Draft – allows the user to come back and complete the request later

Creating a New Authorization - Outpatient Request

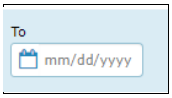
Step	Action
6.	Complete information in the required fields following the guidelines outlined below for an Outpatient Request. Outpatient request can be entered up to 90 days in advance.

Date of Service	This defaults to the current date and is not available to be changed. 
Level of Service	Choose **Elective** from the drop-down list 
Requesting Provider	Choose the appropriate selection from the drop-down list. Requesting provider is the provider that is requesting the service and who the authorization should be entered under.  **Note:** Outpatient and Music Therapy groups should choose the individual credentialed practitioner that the authorization should be entered under.
Servicing Provider	Choose the appropriate selection from the drop-down list. Servicing provider is the provider completing the service and ***should match*** the requesting provider. 
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. 

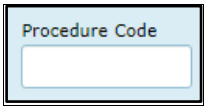
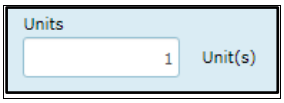
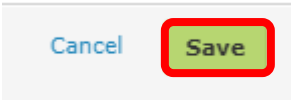
Creating a New Authorization - Outpatient (cont'd)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>6.</td><td>
Services
<table>
<tr><td>Add Procedure</td><td>Click Add Procedure. This will bring up a pop-up box to continue with the authorization.
 
</td></tr>
<tr><td>From (Start Date)</td><td>From (start 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.
 

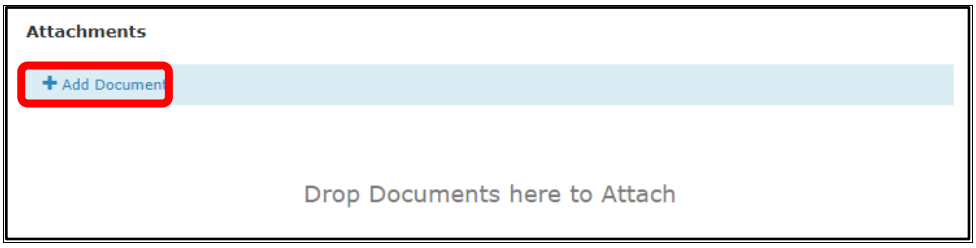
<table>
<tr><th>LOC</th><th>Can be backdated to…</th></tr>
<tr><td>PSS</td><td>6 months from the date request received</td></tr>
<tr><td>CRS, MPN, Psych Rehab, SU IOP, TCM</td><td>30 days from the date request received</td></tr>
<tr><td>OON</td><td>30 days from the date request received</td></tr>
</table>
Note: All other LOC's should use the date that the request is being submitted or a future start date. Authorization end date must be a future date and must not be equal to a start date.</td></tr>
<tr><td>To (End Date)</td><td>To (end date)
 

<table>
<tr><th>Length of Auth</th><th>Level of Care</th></tr>
<tr><td>6 sessions</td><td>ECT</td></tr>
<tr><td>12 weeks</td><td>Initial TMS</td></tr>
<tr><td>6 Months</td><td>Music Therapy, Psychological Testing/ Neuropsychological Testing, Mobile Psych Nursing</td></tr>
</table></td></tr>
</table>
</td></tr>
</table>

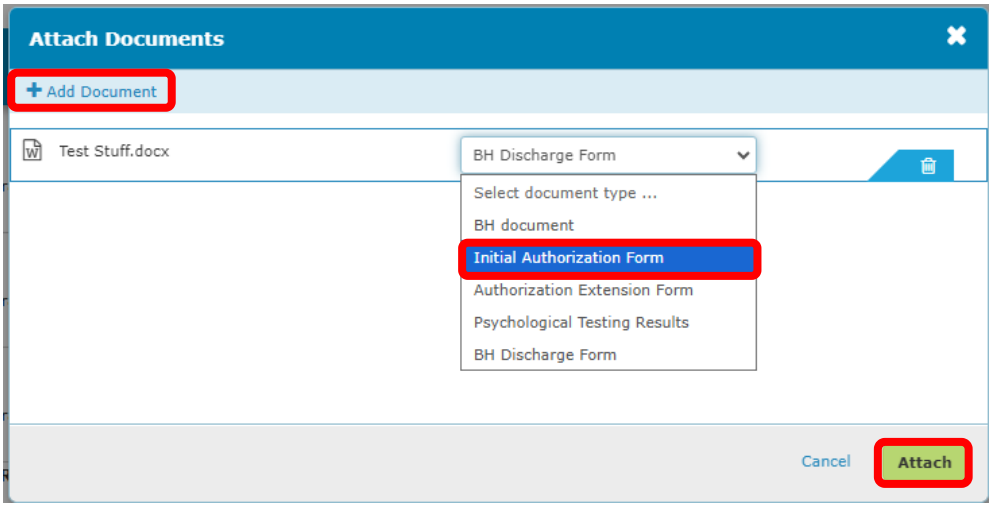
	1 Year: ACT/ CTT, Adjunct Requests, Certified Recovery Services, Mobile MH/ID, OON Requests, Peer Support, Psych Rehab/Clubhouse, SU IOP, TCM and TMS Maintenance
Procedure Code	Free text field. If an incorrect procedure code is entered the request may not be processed. The procedure code field is free 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	Click **Save** to add the service line. 

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. The user also has the ability to delete any document attached in error.

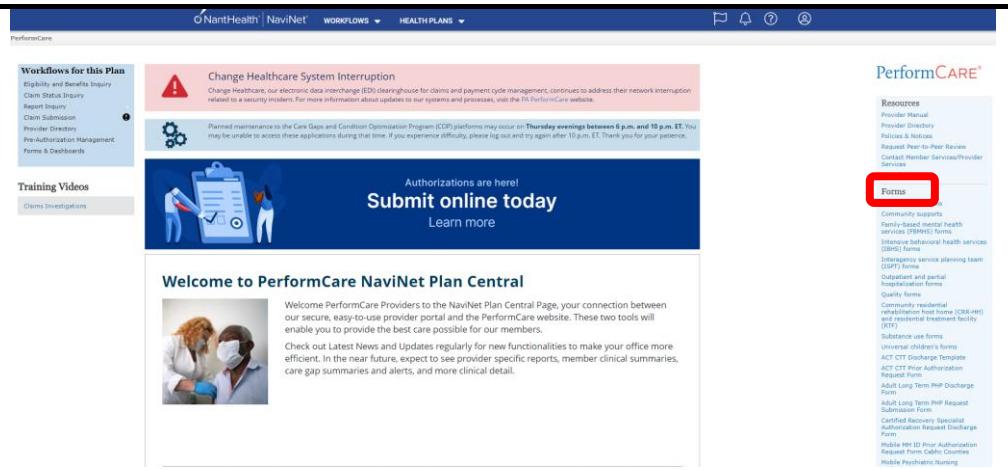


Select **Initial Authorization Form** in the document type drop down. If any other documents need to be uploaded for the authorization, providers should choose **BH document.**

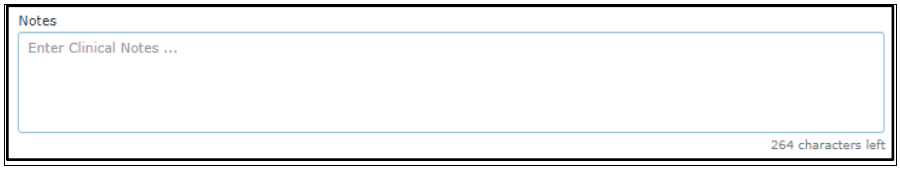
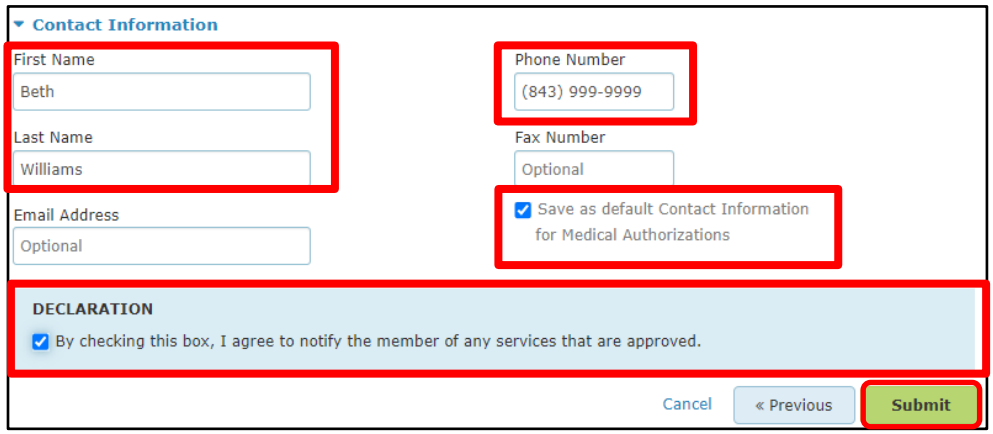
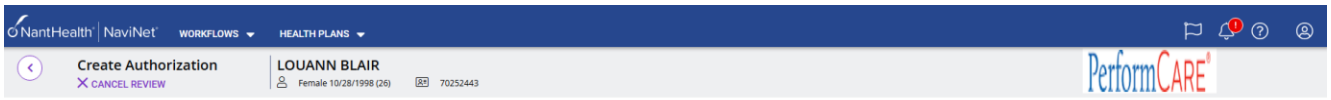


Note: Providers must attach the corresponding NaviNet Submission Form for the level of care requested, for example if entering a SU IOP authorization, the Substance Use Disorder IOP Program Prior Authorization Request/Discharge Form *for NaviNet Submission Only* will need to be submitted as an attachment.

These level of care specific forms can be found on the right side of NaviNet Plan Central page, under Forms.


NantHealth | NaviNet
WORKFLOWS
HEALTH PLANS
PerformCare
Workflows for this Plan
Eligibility and Benefits Inquiry
Claim Status Inquiry
Report Inquiry
Claim Submission
Provider Directory
Pre-Authorization Management
Forms & Dashboards
Training Videos
Claims Investigations
Change Healthcare System Interruption
Change Healthcare, our electronic data interchange (EDI) clearinghouse for claims and payment cycle management, continues to address their network interruption related to a security incident. For more information about updates to our systems and processes, visit the PA PerformCare website.
Planned maintenance to the Care Gaps and Condition Optimization Program (CCIP) platforms may occur on Thursday evenings between 6 p.m. and 10 p.m. ET. You may be unable to access these applications during that time. If you experience difficulty, please log out and try again after 10 p.m. ET. Thank you for your patience.
Authorizations are here!
Submit online today
Learn more
Welcome to PerformCare NaviNet Plan Central
Welcome PerformCare Providers to the NaviNet Plan Central Page, your connection between our secure, easy-to-use provider portal and the PerformCare website. These two tools will enable you to provide the best care possible for our members.
Check out Latest News and Updates regularly for new functionalities to make your office more efficient. In the near future, expect to see provider specific reports, member clinical summaries, care gap summaries and alerts, and more clinical detail.
PerformCARE
Resources
Provider Manual
Provider Directory
Policies & Notices
Request Peer-to-Peer Review
Contact Member Services/Provider Services
Forms
Community supports
Family-based mental health services (FBMHS) forms
Intensive behavioral health services (IBHS) forms
Interagency service planning team (ISPT) forms
Outpatient and partial hospitalization forms
Quality forms
Community residential rehabilitation host home (CRR-HH) and residential treatment facility (RTF)
Substance use forms
Universal children's forms
ACT CTT Discharge Template
ACT CTT Prior Authorization Request Form
Adult Long Term PHP Discharge Form
Adult Long Term PHP Request Submission Form
Certified Recovery Specialist Authorization Request Discharge Form
Mobile MH ID Prior Authorization Request Form Cabbi Counties
Mobile Psychiatric Nursing

Creating a New Authorization – Outpatient (cont'd)

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. 
7.	**For CRS, Peer Support, Psych Rehab, MH TCM and SU TCM authorizations providers will be taken to the InterQual Assessment to finish the authorization.**  **Providers can refer to the corresponding IQ assessment guide under the Authorization portal guidelines section for more assistance.**

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.

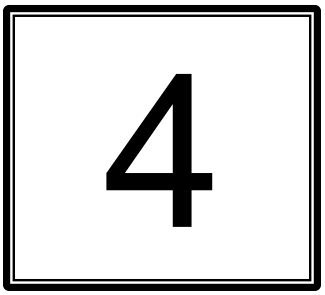
<table>
<tr><th>If…</th><th>Then it will look like this…</th></tr>
<tr><td>Approved</td><td>


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</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: Pended status submissions will require medical review by the health plan. Requests that have 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>

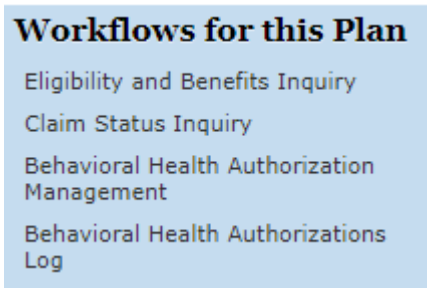
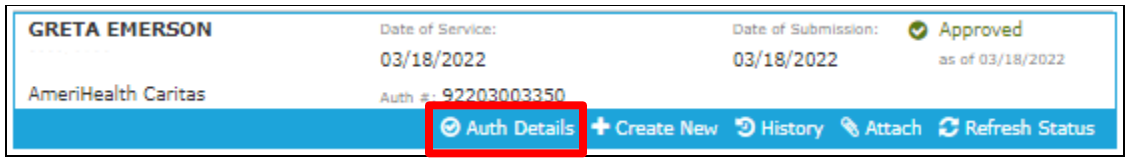
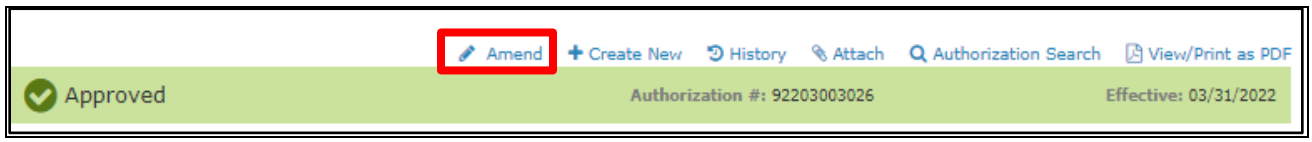


4 AMENDING AN AUTHORIZATION

Amending an Authorization Request

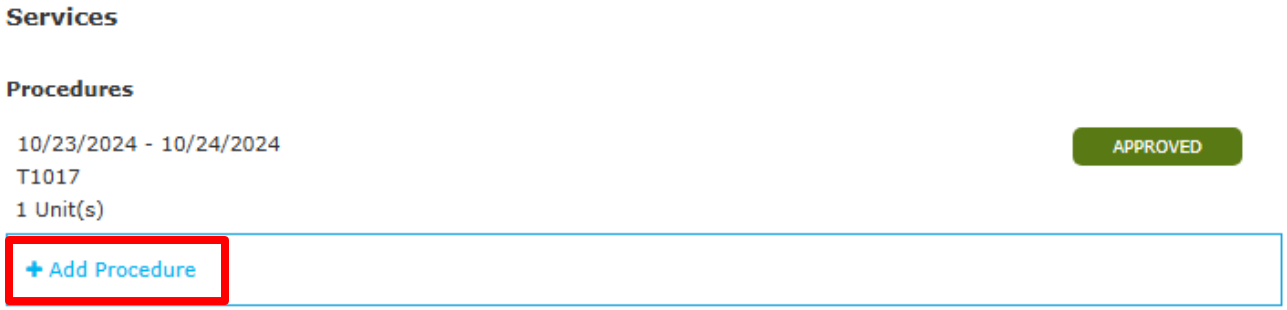
Amending a request is the process of extending existing services, ie. requesting a reauthorization. Each time an amendment is made the note character limit will be reduced. Amending is only available to requests that have been approved or partially approved by the health plan. The maximum number of services that can be added to an authorization is 30.

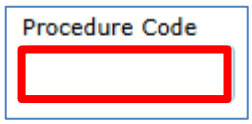
	When making an amendment the user can add diagnoses, add notes (if the maximum character limit has not been exceeded) and add documents.

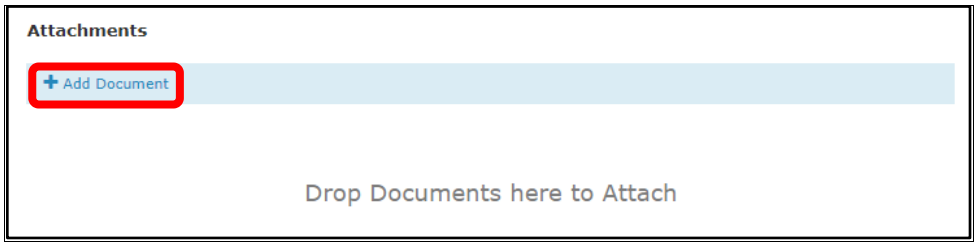
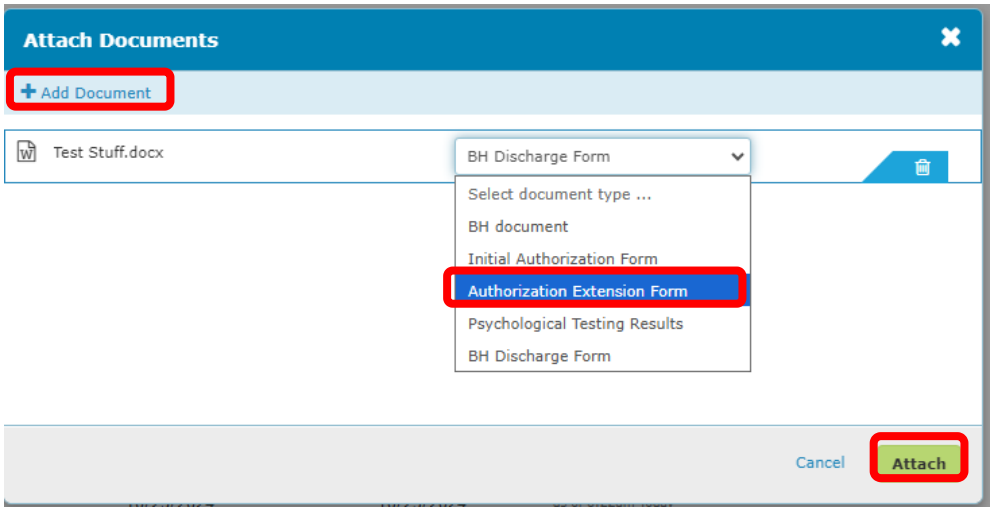
Step	Action
1.	Locate the existing request under **Workflows for this Plan**.  **If…** / **Then…** The request was created in NaviNet → Select **Behavioral Health Authorizations Log** The request was not created in NaviNet (for example if the request was faxed, phoned, or submitted via Jiva) → Select **Behavioral Health Authorizations Management** 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.** 

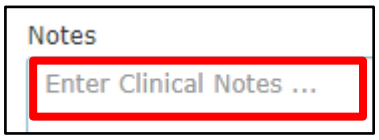
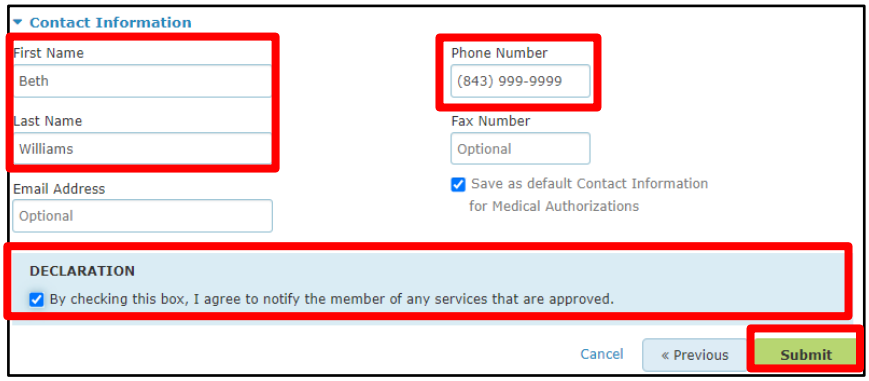
Amending an Authorization Request (cont'd)

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>4.</td><td>Click Add Procedure under the already approved service line.

This will bring up a pop-up box to complete the rest of the information.</td></tr>
<tr><td>5.</td><td>
<table>
<tr><td>Add the Date of Service</td><td> 
</td></tr>
<tr><td>Add the Procedure Code</td><td> 
</td></tr>
<tr><td>Add Modifiers (if applicable)</td><td> 
</td></tr>
<tr><td>Add Units</td><td> 
</td></tr>
</table>
</td></tr>
<tr><td>6.</td><td>Click Save.
 
</td></tr>
</table>

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. The user can identify the document type based on the drop down list. If the user attaches a document, the document type is mandatory. The user also has the ability to delete any document attached in error.  Select **Authorization Extension Form** in the document type drop down. If any other documents need to be uploaded for the authorization, providers should choose **BH document.**  **Note:** Providers must attach the corresponding NaviNet Submission Form for the level of care requested, for example if entering a SU IOP authorization, the Substance Use Disorder IOP Program Prior Authorization Request/Discharge Form *for NaviNet Submission Only* will need to be submitted as an attachment. These level of care specific forms can be found on the right side of NaviNet Plan Central page, under Forms.

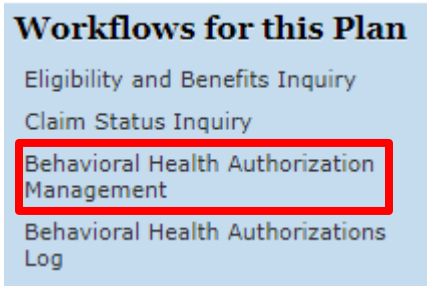
8.	**Notes**	Add pertinent notes as applicable. 
9.	**Contact Information**	Enter contact information, check the Declaration box, and **Submit.** 

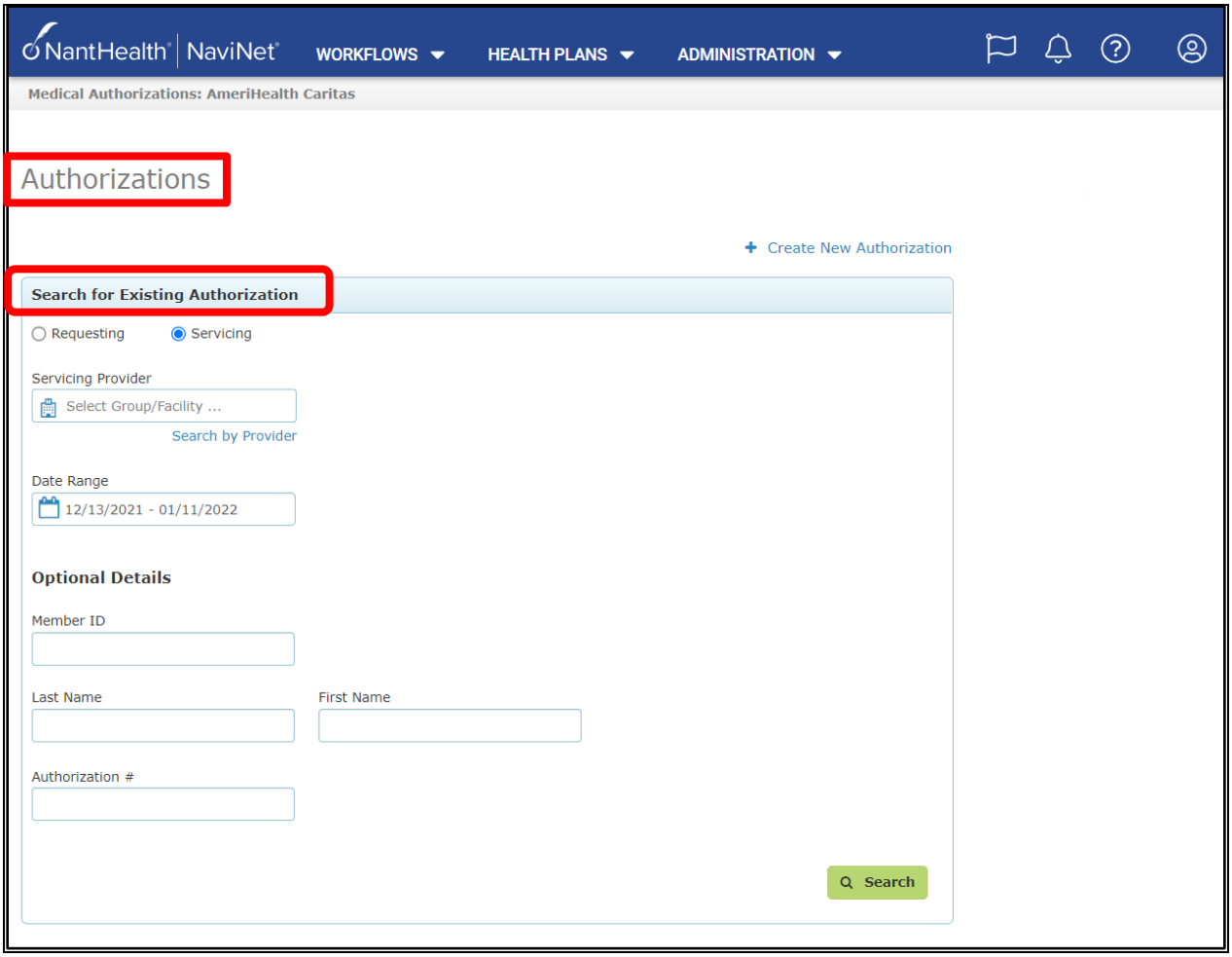
5 SEARCH FOR AN EXISTING AUTHORIZATION

Search for an Existing Authorization

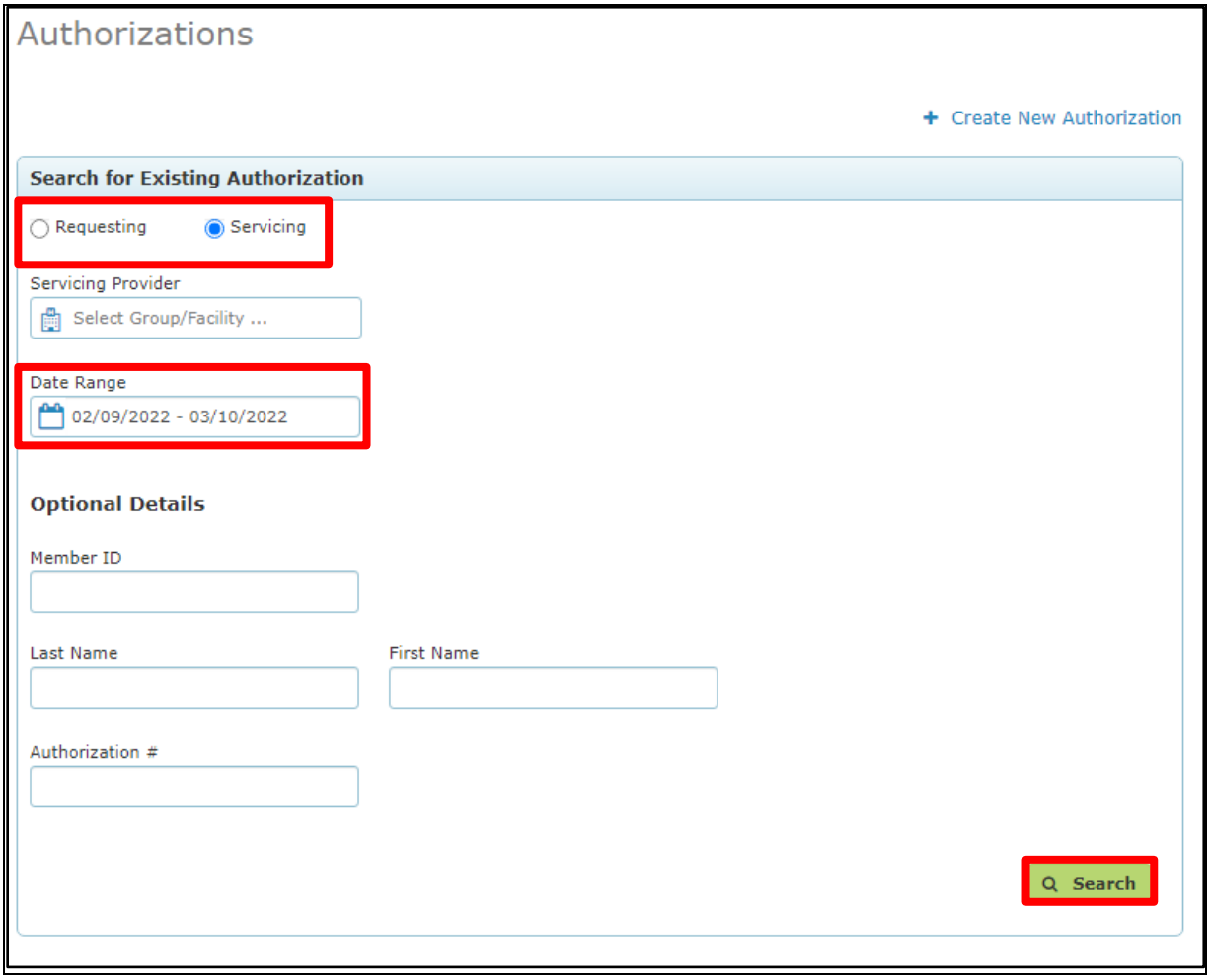
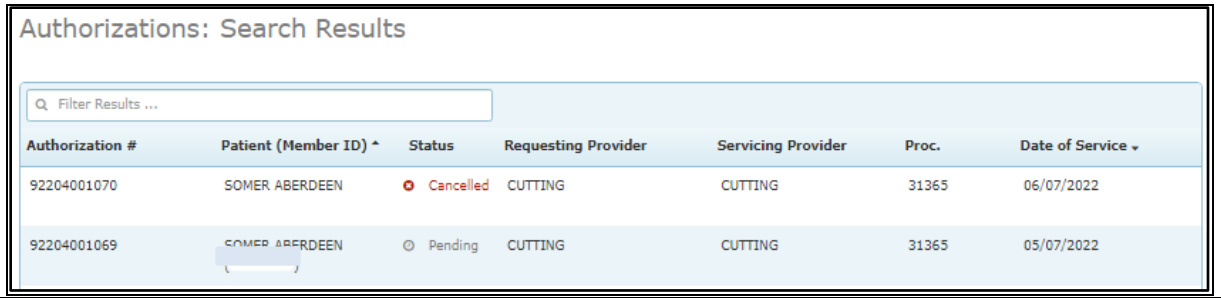
Search for an Existing Authorization (also known as Authorization Inquiry) is a way to search for authorizations that may not have been initiated in NaviNet, for example they may have phoned, faxed, or created in Jiva.

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

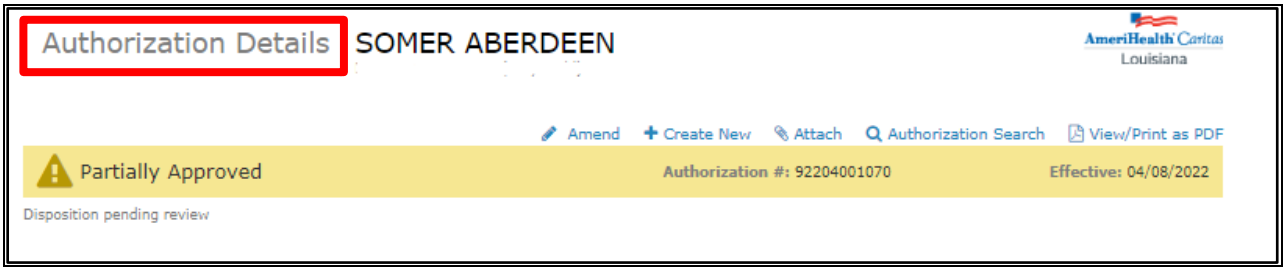




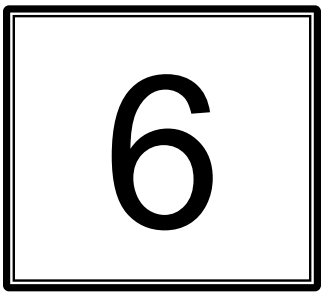
Search: Search for an Existing Authorization (cont'd)

Step	Action
2.	Select Servicing or Requesting Provider and adjust the date range then select **Search**. The Date Range must include the start date of the authorization that is being searched for. The current limit on the look back period is 3 years if the authorization started more than 3 years ago the authorization will not show on the search screen. 
3.	Click the authorization that you wish to view. 

Search: Search for an Existing Authorization (cont'd)

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.

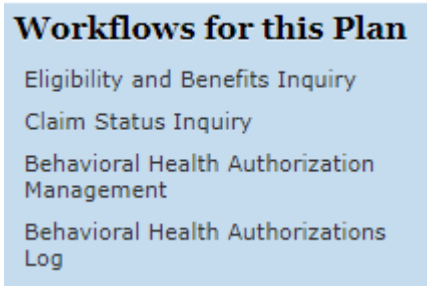
Amend	Extending existing services or requesting another service on the same authorization
Create New	Creating a new request
Attach	Attaching a document
Authorization Search	Searching for an authorization
View/Print as PDF	View and print authorization status request as PDF

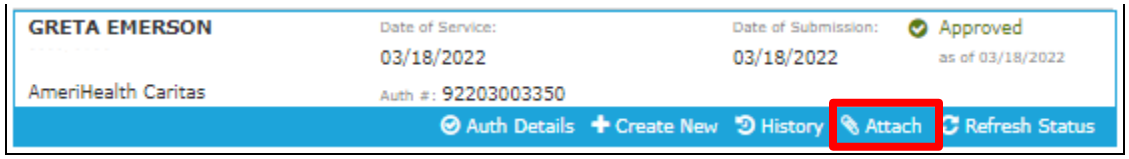
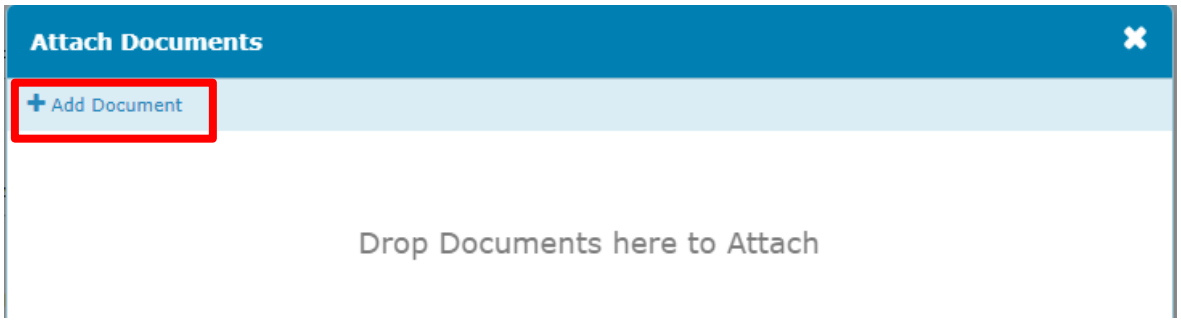


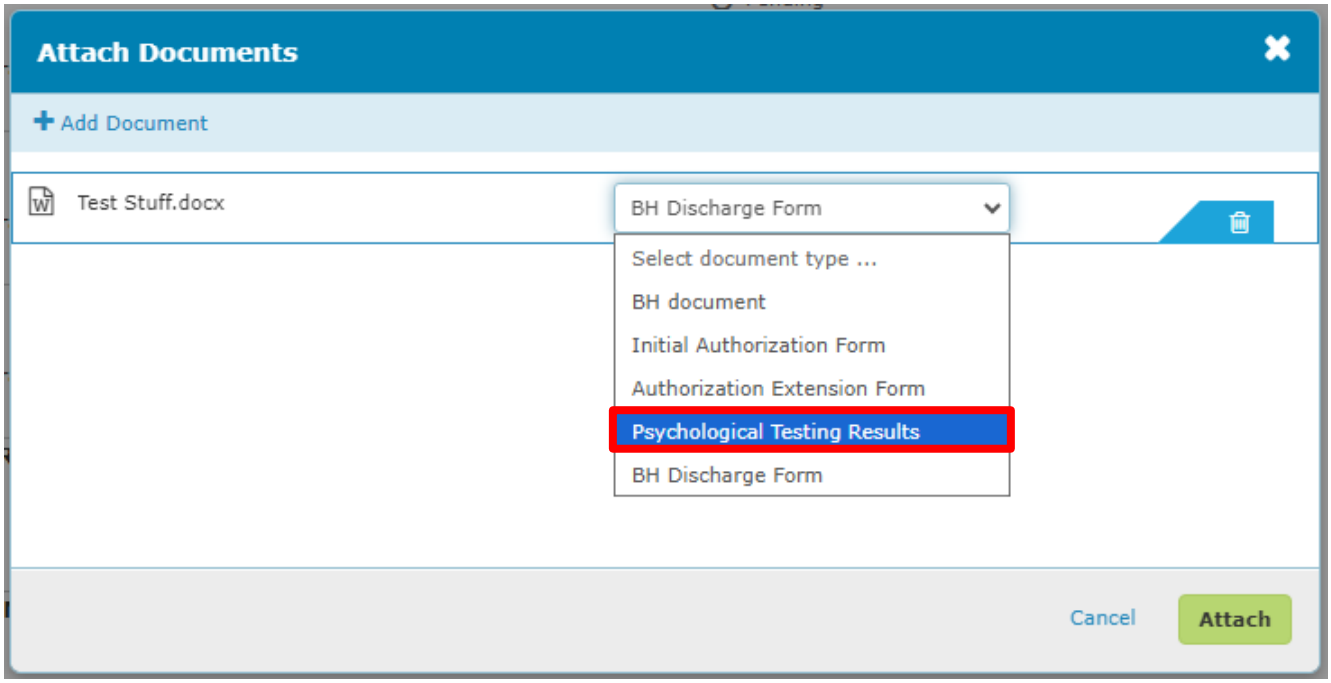
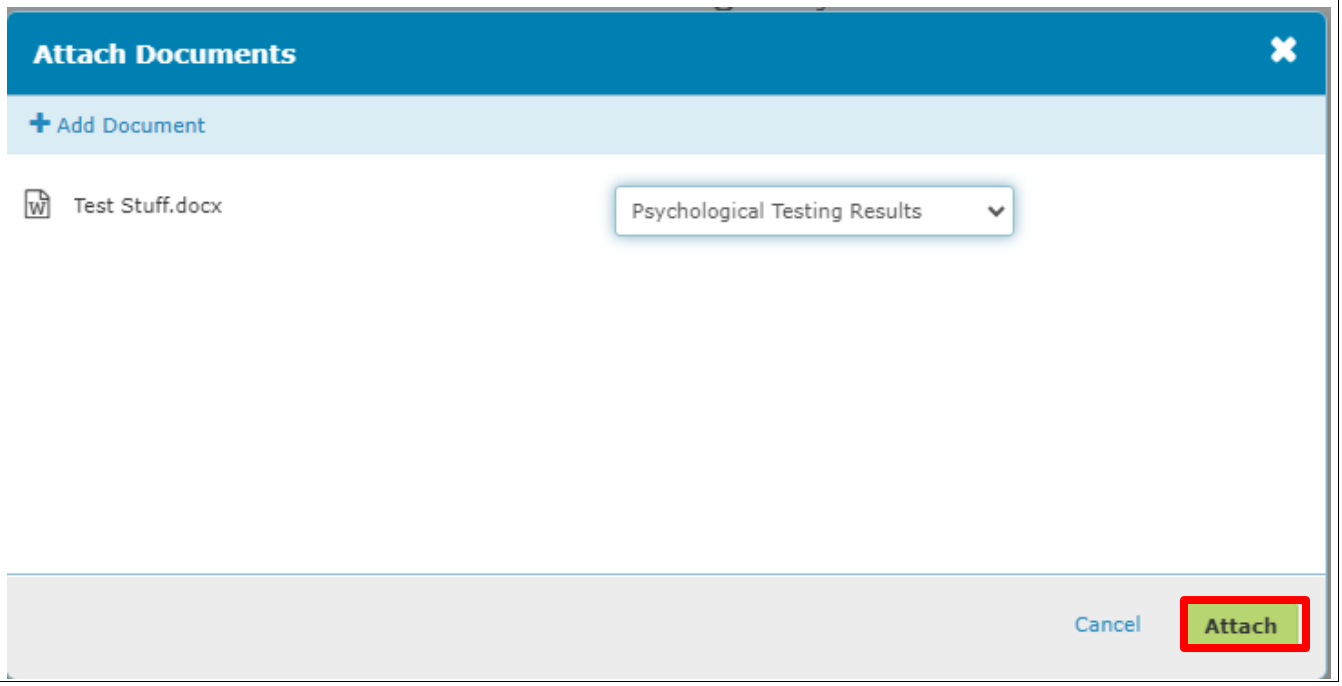
6 SUBMISSION OF PSYCHOLOGICAL/ NEUROPSYCHOLOGICAL TESTING RESULTS

Submission of Psychological/Neuropsychological Testing Results

Per PerformCare policy CM-012, Psychological and Neuropsychological providers are required to submit completed testing results to PerformCare ***within 10 calendar days of completing the written results of testing*** for payment. With the implementation of the NaviNet Provider Portal, providers are able to follow these instructions to submit those results instead of faxing or mailing.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1.</td><td>Locate the existing request under Workflows for this Plan.
 

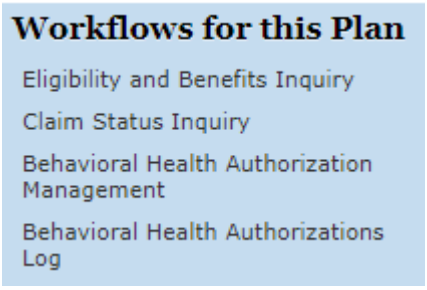
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>The request was created in NaviNet</td><td>Select Behavioral Health Authorizations Log</td></tr>
<tr><td>The request was not created in NaviNet (for example if the request was faxed, phoned, or submitted via Jiva)</td><td>Select Behavioral Health Authorizations Management and then Search for Existing Authorization (also referred to as Authorization Inquiry by NaviNet)</td></tr>
</table></td></tr>
<tr><td>2.</td><td>Select Attach on the request that needs to be amended.
 
</td></tr>
<tr><td>3.</td><td>Select Add Document.
 
</td></tr>
<tr><td>4.</td><td>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. The user also has the ability to delete any document attached in error.</td></tr>
</table>

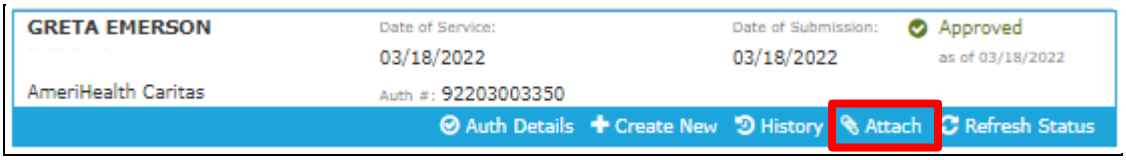
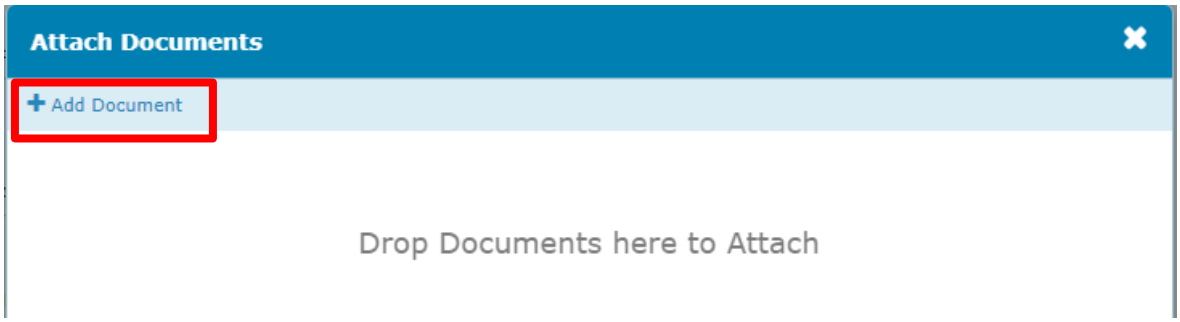
	Select **Psychological Testing Results** in document type drop down. 
5.	Select **Attach** when the request is complete. 

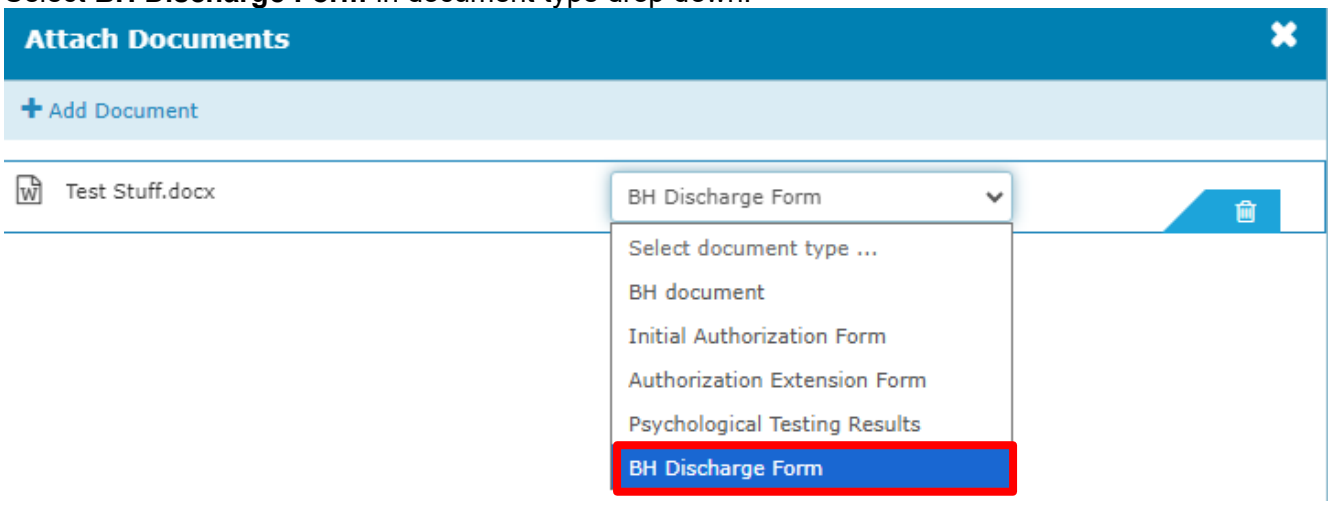
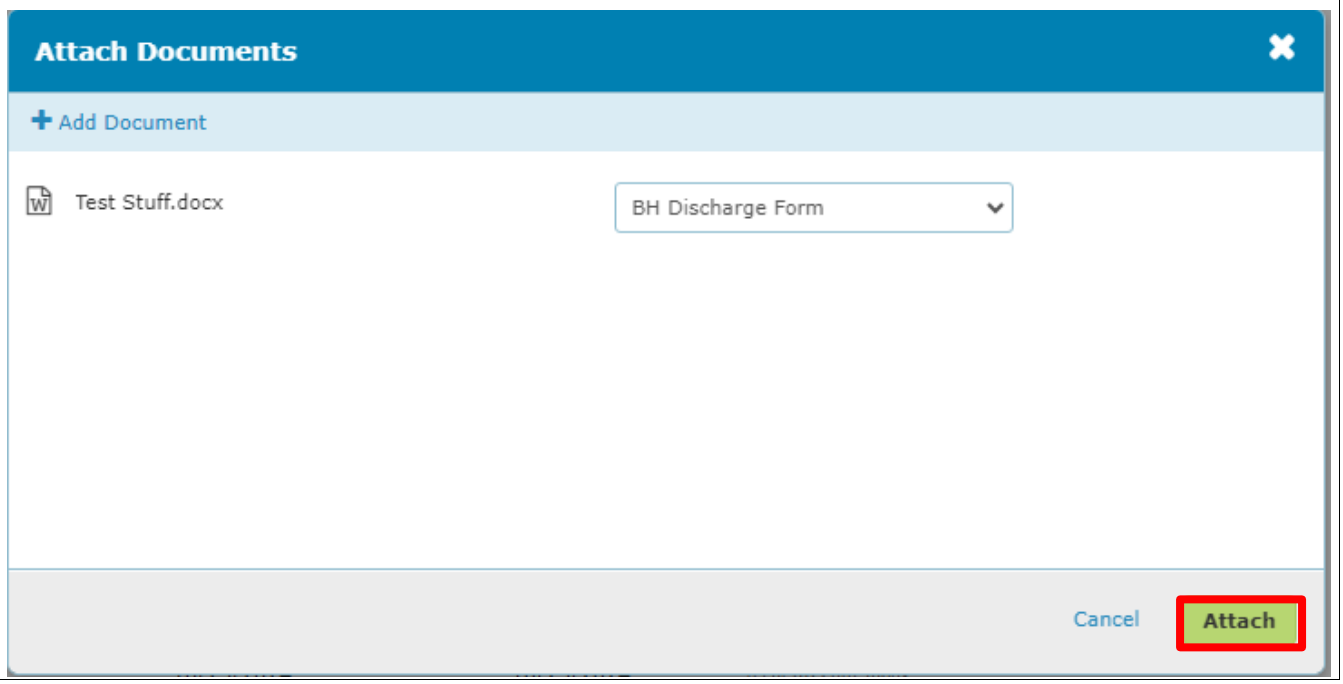
7 DISCHARGING AN AUTHORIZATION

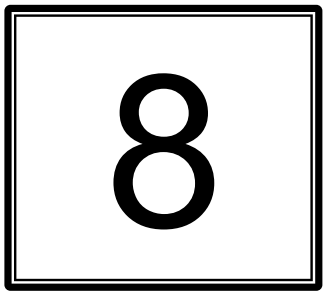
Discharging an Authorization

Discharging a request is the process of ending an existing authorization in the system, providers should follow the below instructions to complete this process. This step is required for ACT/ CTT, Certified Recovery Specialists, Mobile MH/ID, Psychiatric Rehabilitation Services, and Targeted Case Management providers.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1.</td><td>Locate the existing request under Workflows for this Plan.
 

<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>The request was created in NaviNet</td><td>Select Behavioral Health Authorizations Log</td></tr>
<tr><td>The request was not created in NaviNet (for example if the request was faxed, phoned, or submitted via Jiva)</td><td>Select Behavioral Health Authorizations Management and then Search for Existing Authorization (also referred to as Authorization Inquiry by NaviNet)</td></tr>
</table></td></tr>
<tr><td>2.</td><td>Select Attach on the request that needs to be amended.
 
</td></tr>
<tr><td>3.</td><td>Select Add Document.
 
</td></tr>
<tr><td>4.</td><td>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. The user also has the ability to delete any document attached in error.</td></tr>
</table>

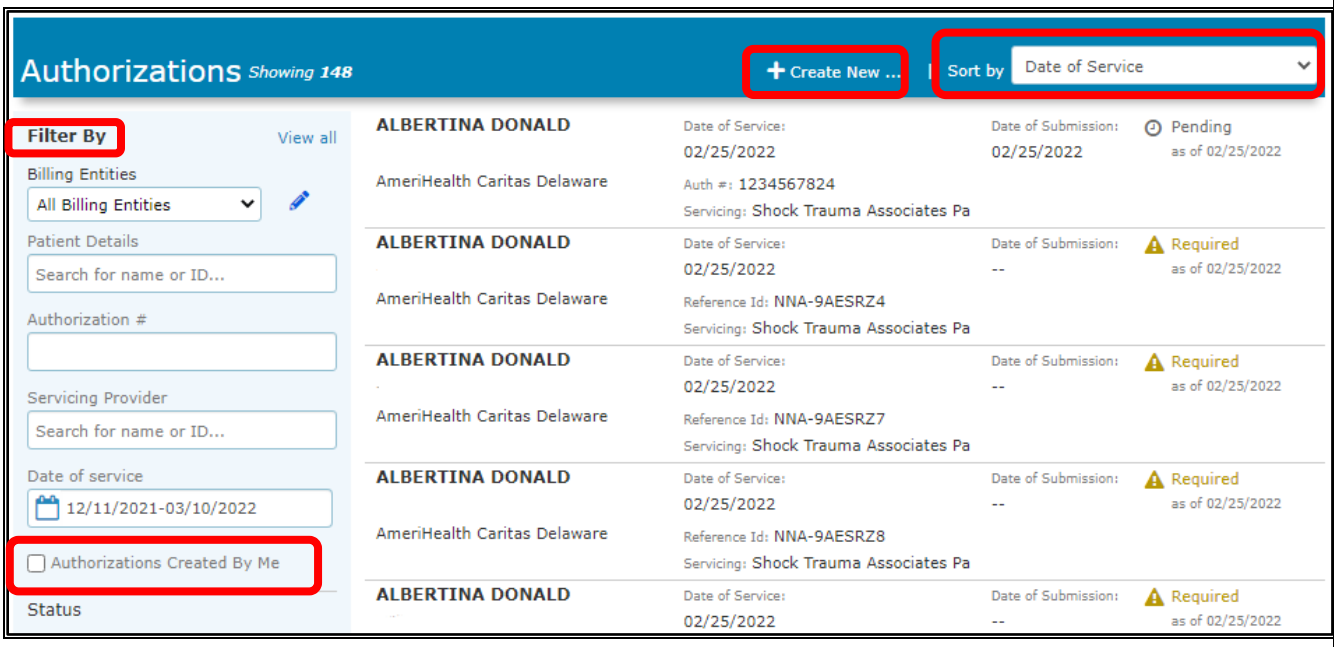
	Select **BH Discharge Form** in document type drop down. 
5.	Select **Attach** when the request is complete. 



8 BEHAVIORAL HEALTH AUTHORIZATIONS LOG

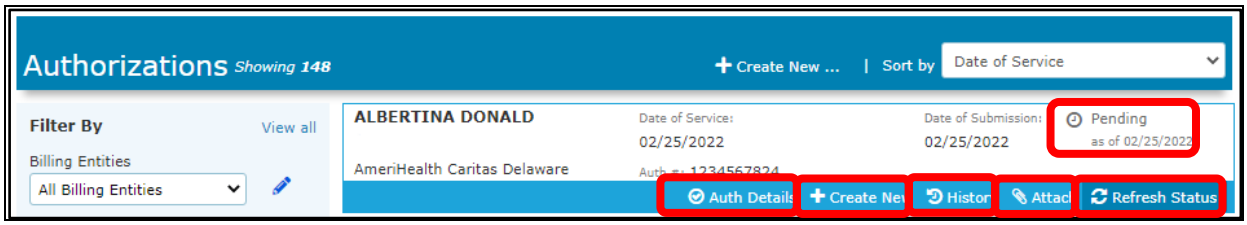
Search: Behavioral Health Authorizations Log

Only requests that have been submitted via NaviNet Open Behavioral Health Authorization Management 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 **Behavioral Health 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: Behavioral Health Authorizations Log (cont'd)

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**.

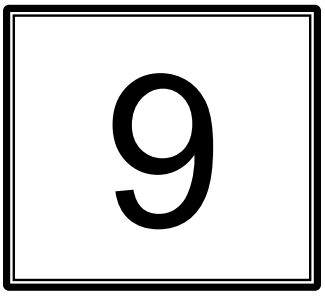


Field	Function
Auth Details	Details related to the authorization
+ Create New	Create New Authorization for the member
History	Provides detailed history of the request
Attach	Ability to attach documents
Refresh Status	Allows the user to refresh the status for any updates.

Search: Behavioral Health Authorizations Log (cont'd)

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



9 REQUEST FOR MORE INFORMATION (RFMI)

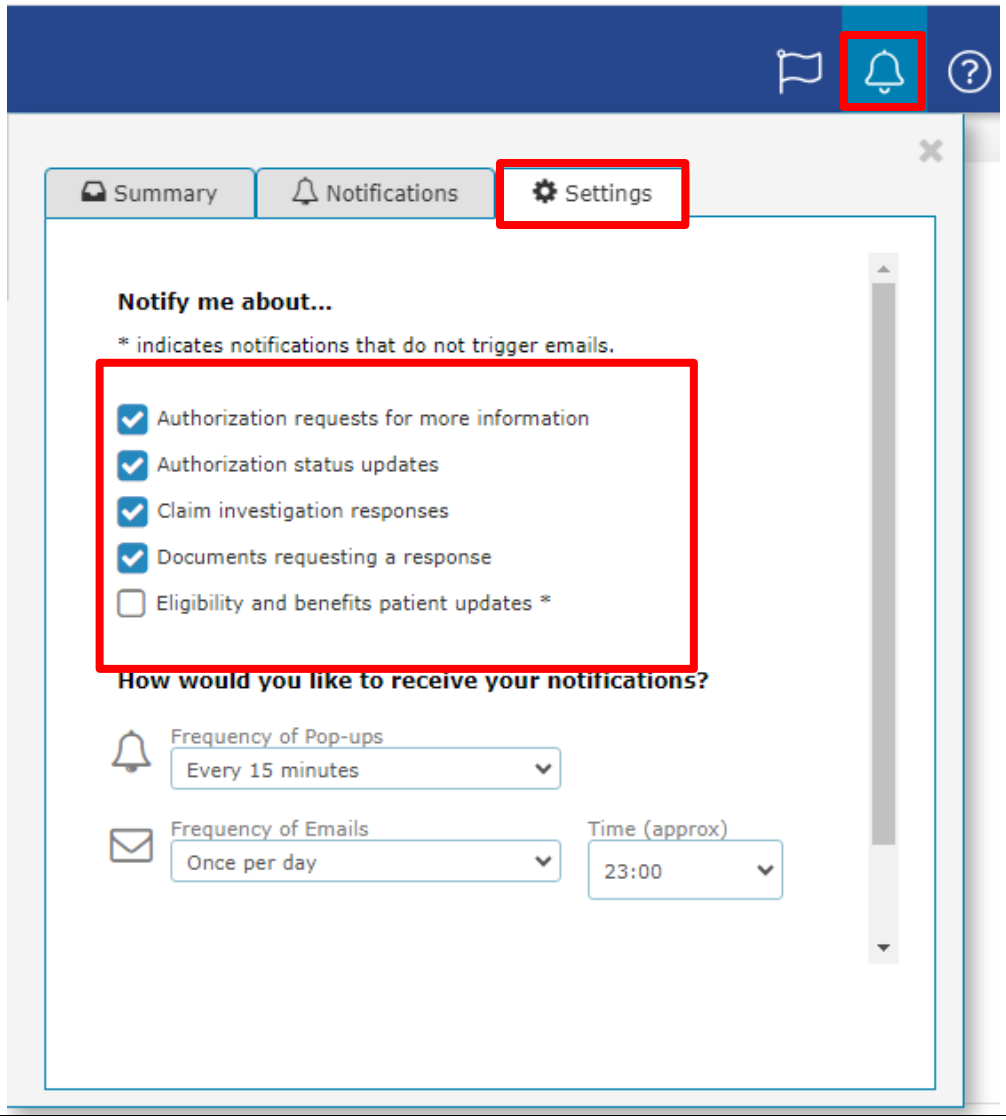
Request for More Information (RFMI)

Request for More Information (RFMI) is a feature that allows the health plan to request specific additional information from the provider if needed. The RFMI ability for authorization requests is limited to those authorizations that are created in the NaviNet Portal, this feature is not available for authorizations requested outside of 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.

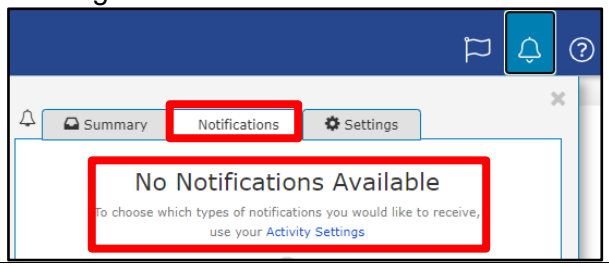
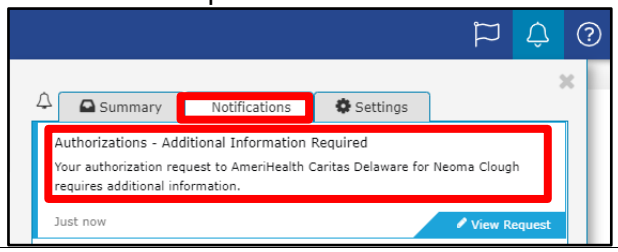
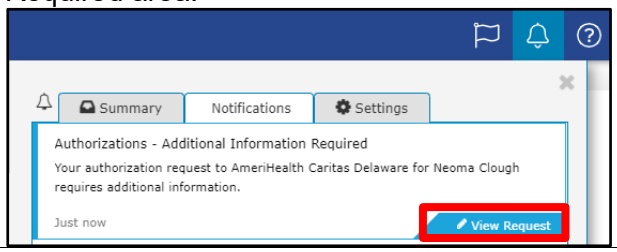
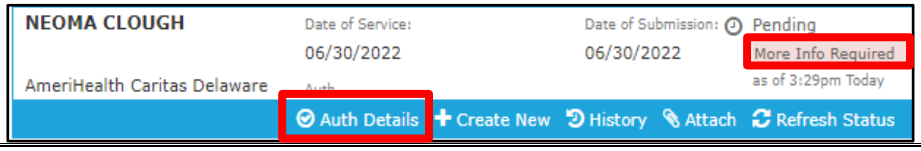
	Notifications are an important part of the communication process between the health plan and the provider. Users can opt to receive notifications whenever a request is sent from the health plan to the provider. Notifications can be managed from the bell icon in the top right banner on the home page. 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.

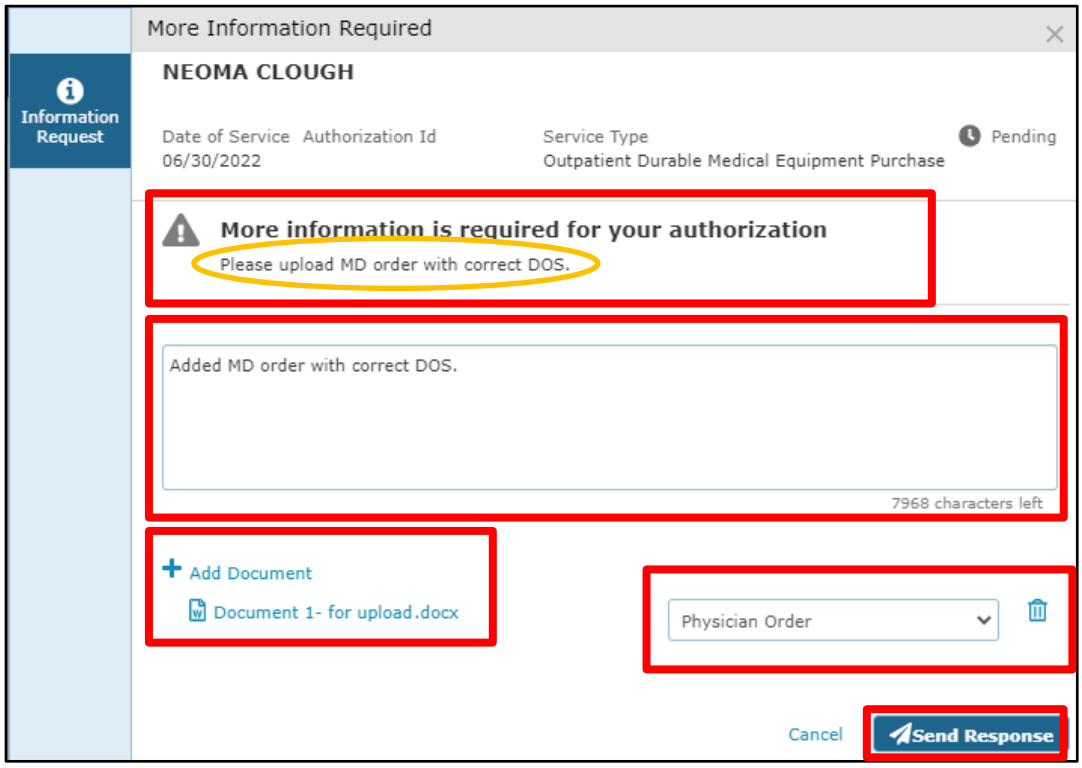
Step	Action
1.	Select the bell icon in the top right corner in NaviNet, then frome the Settings tab, specify the notifications you would like to receive.



Request for More Information (RFMI) (cont'd)

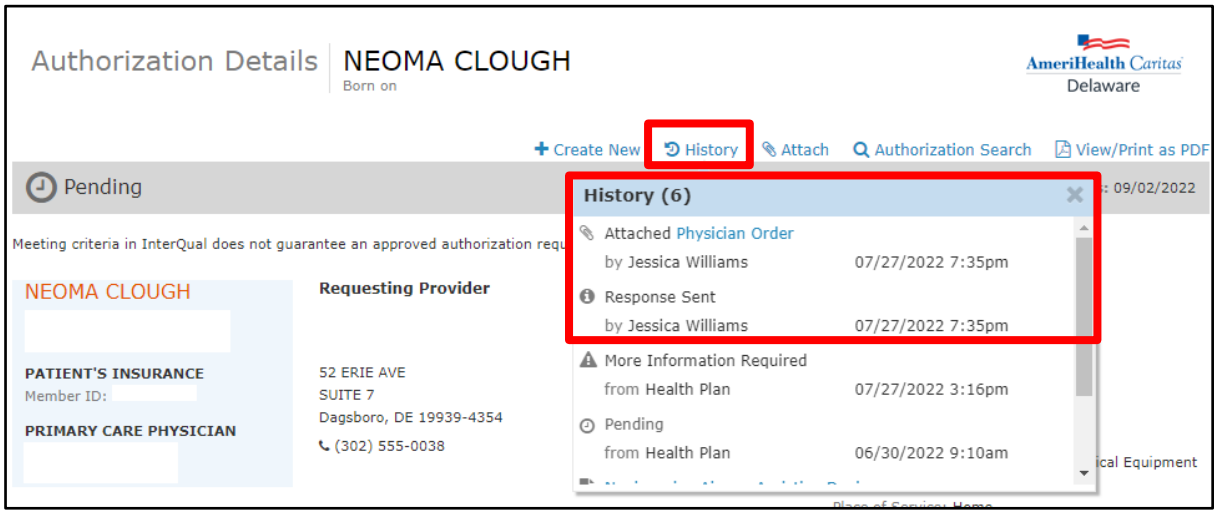
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>2.</td><td>To view notifications, select Notifications.
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>No notifications exist</td><td>The user will see No Notifications Available message.
 
</td></tr>
<tr><td>Notifications are available</td><td>The user will see Authorizations – Additional Information Required.
 
</td></tr>
</table></td></tr>
<tr><td>3.</td><td>There are 3 ways for the user to see RFMI from the health plan.
<table>
<tr><td>1.</td><td>From Notifications the user will select View Request which activates the More Information Required area.
 
</td></tr>
<tr><td>2.</td><td>From the Behavioral Health 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.
 
</td></tr>
</table></td></tr>
</table>

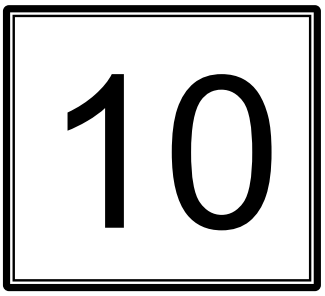
Request for More Information (RFMI) (cont'd)

Step	Action
3. (cont'd)	**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**. ***Please note: Providers have 5 business days to response to a request for more information. If a response is not received within this timeframe, the request will be denied.*** 

Request for More Information (RFMI) (cont'd)

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



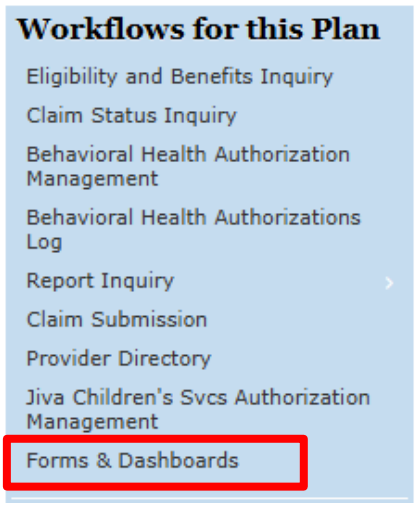
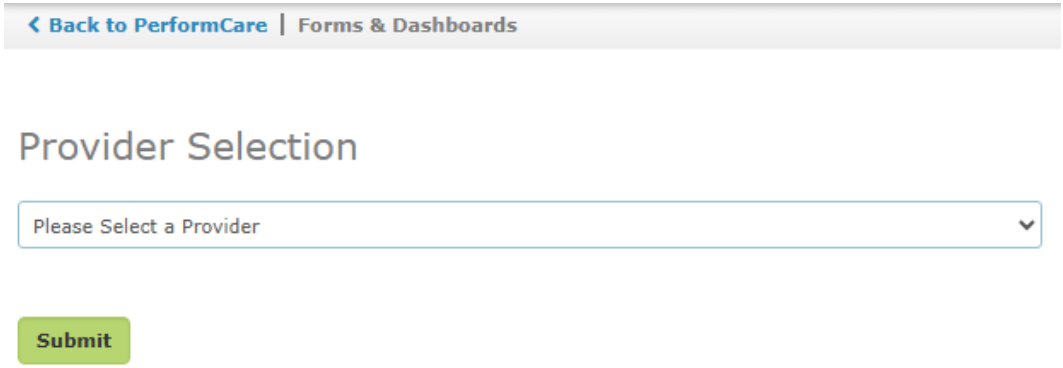
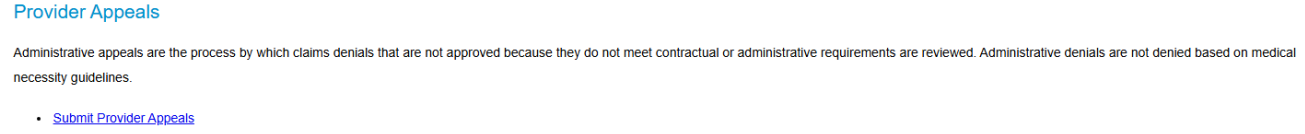


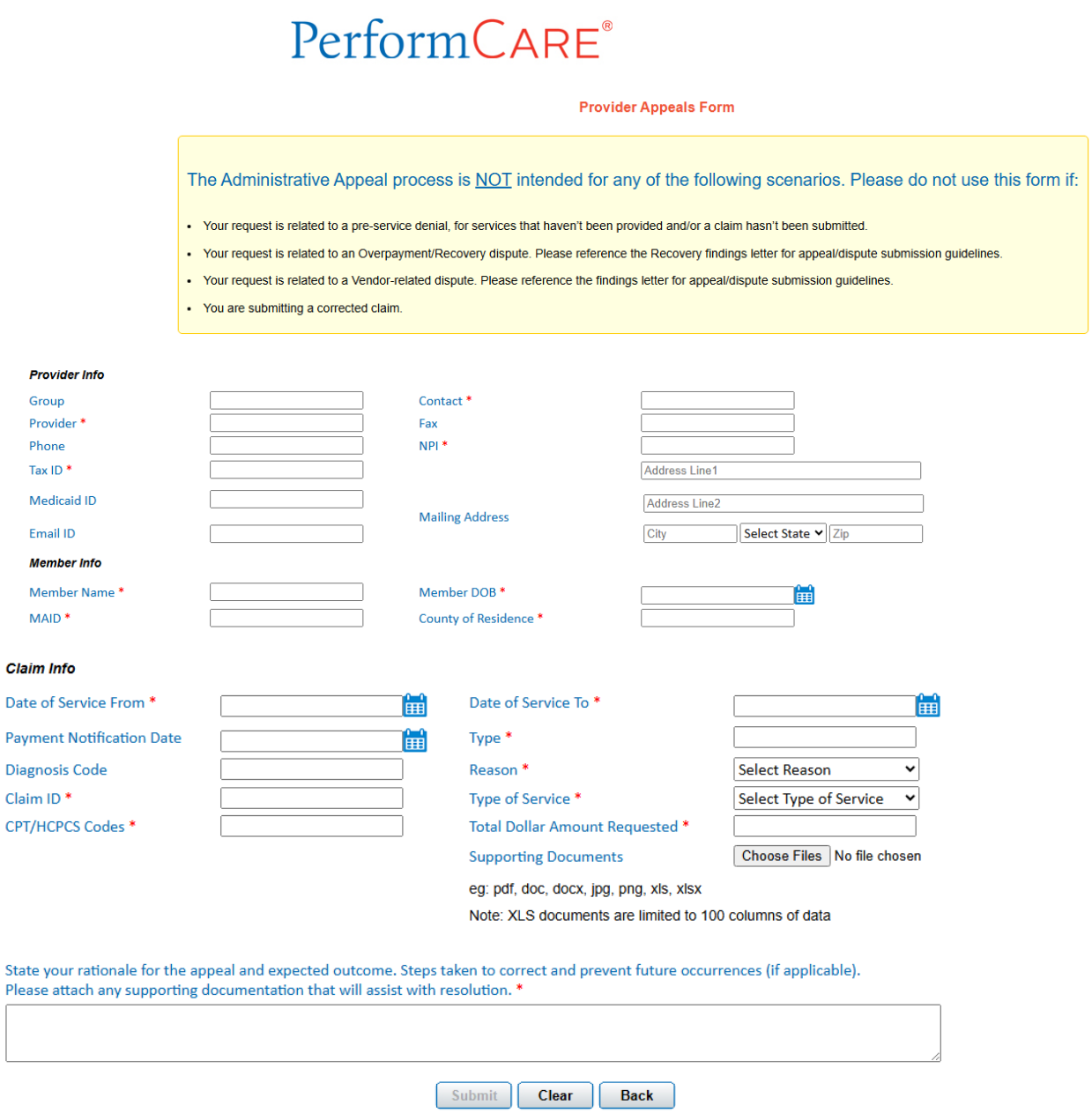
10 FORMS AND DASHBOARDS

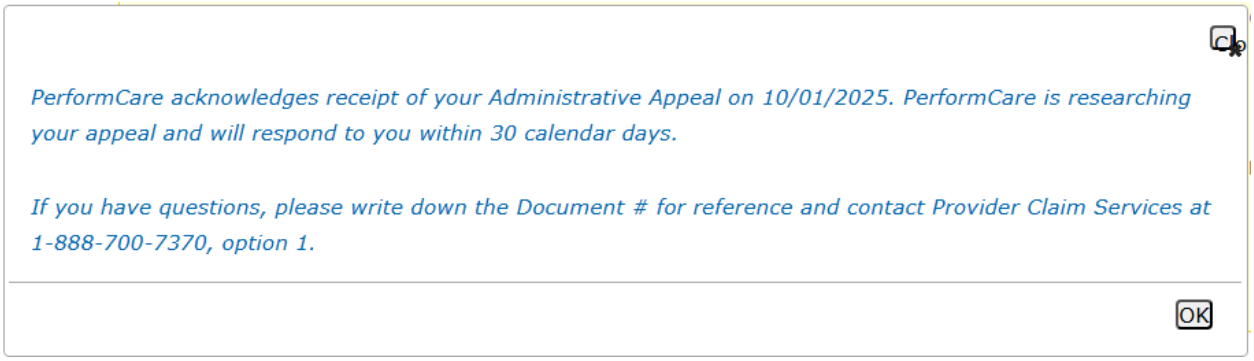
Administrative Appeal Submission

Providers are permitted to submit Administrative Appeals via NaviNet rather than mailing. Each document must be 32MB or smaller and in the following file types: .docx, .gif, .pdf, and .png.

Providers should refer to our Claims and Billing Page for full instructions on Administrative Appeals.

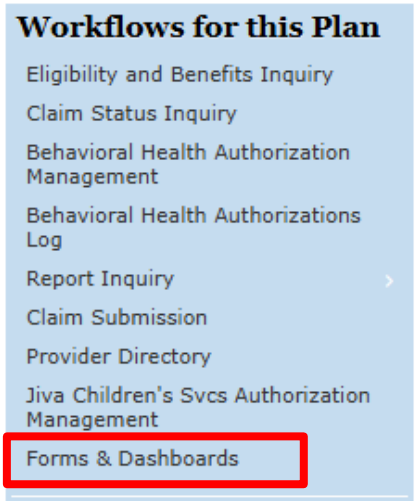
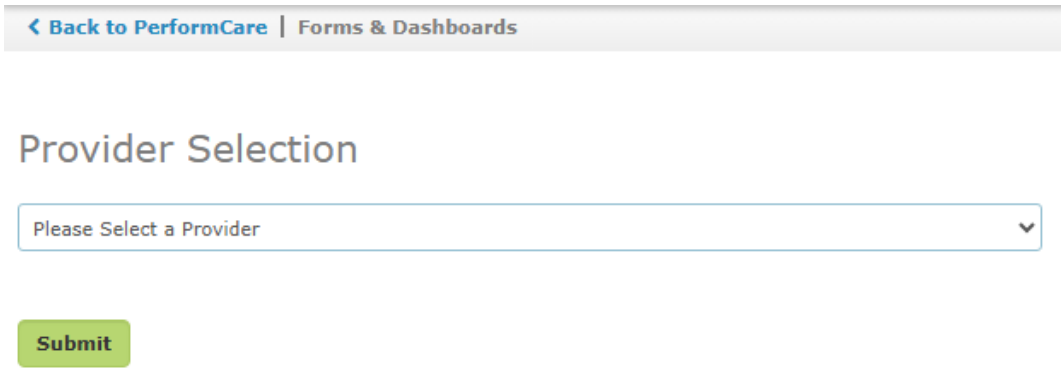
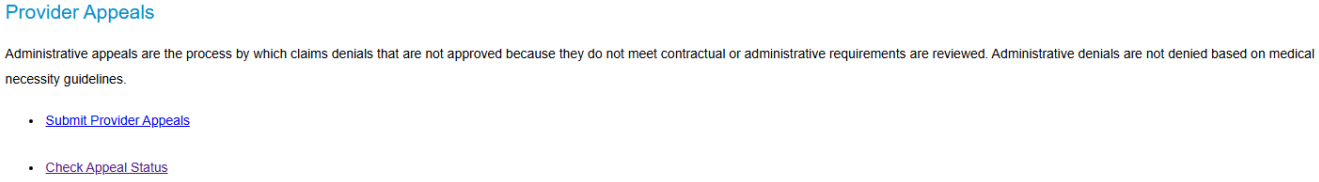
Step	Action
1.	From the NaviNet Plan Central Page, click **Forms & Dashboards** under Workflows for this Plan. 
2.	In the drop-down, select the provider in which the Administrative Appeal applies to (if submitting a multiple appeals spreadsheet where multiple contracts are included, providers can select either provider/contract combination in the drop-down). 
3.	NaviNet will then take the user to the Forms page. User should scroll down to the **Provider Appeals** menu. Click **Submit Provider Appeals**, 

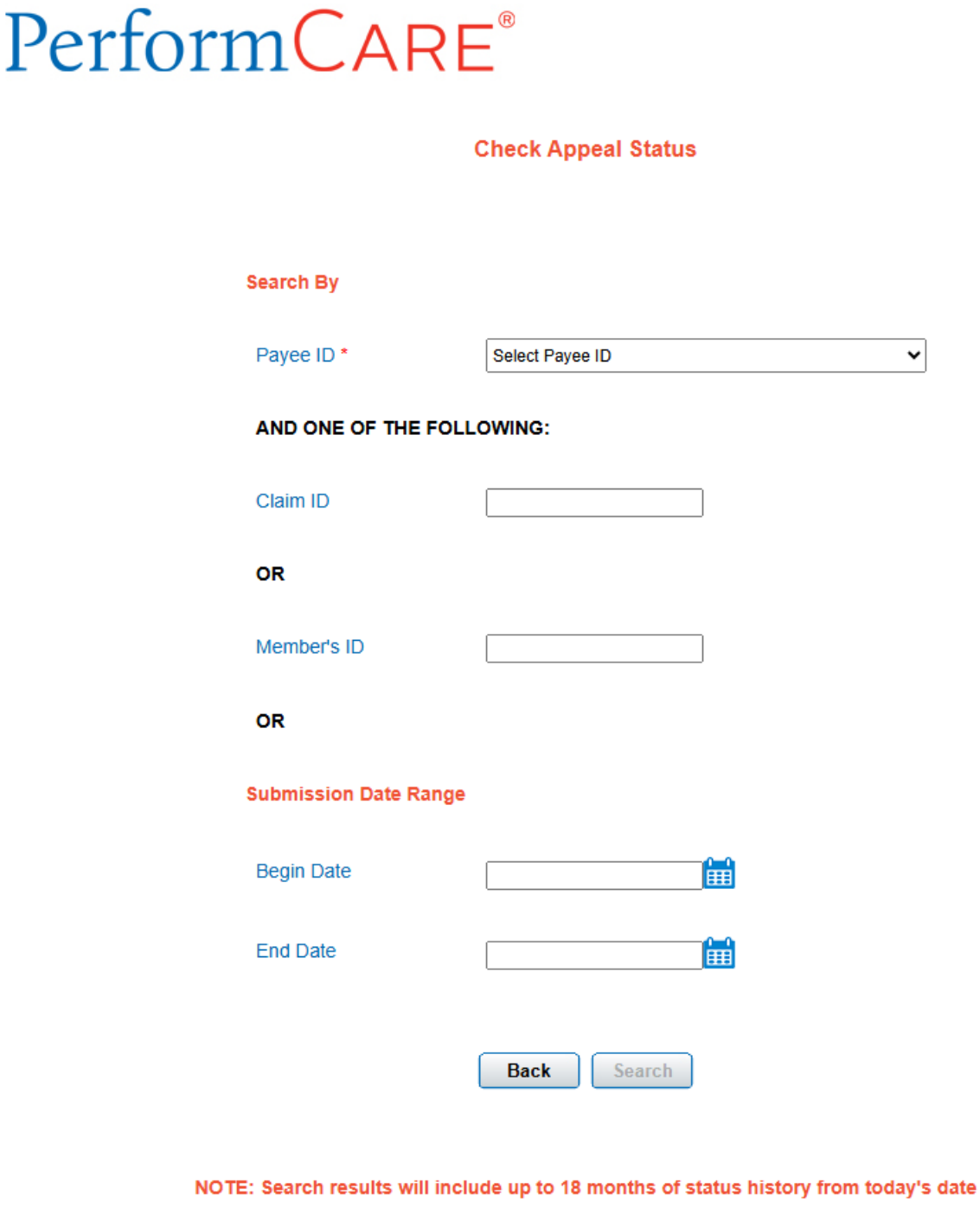
4.	Provider will be taken to the Provider Appeals form. All fields with a * must be completed. When finished with the form and required documents, click **Complete.** Providers are reminded that the Administrative Appeal process is **not** intended for the situations highlighted in the yellow box below and further explained here, • The request is related to a pre-service denial. If providers need to appeal an Medical Necessity Criteria (MNC) denial, providers should follow the Grievance process. • The request is related to an Overpayment/Recovery dispute. Providers receive a letter in the mail and should follow the instructions outlined in the letter. • The request is related to a Vendor-related dispute. Providers should work with the vendor on any disputes. • A corrected claim is needed. Providers should refer to PerformCare's Claim Submission Instructions on how to complete a corrected claim.  PerformCARE® Provider Appeals Form The Administrative Appeal process is NOT intended for any of the following scenarios. Please do not use this form if: • Your request is related to a pre-service denial, for services that haven't been provided and/or a claim hasn't been submitted. • Your request is related to an Overpayment/Recovery dispute. Please reference the Recovery findings letter for appeal/dispute submission guidelines. • Your request is related to a Vendor-related dispute. Please reference the findings letter for appeal/dispute submission guidelines. • You are submitting a corrected claim. Provider Info Group Provider * Phone Tax ID * Medicaid ID Email ID Contact * Fax NPI * Mailing Address Address Line1 Address Line2 City Select State Zip Member Info Member Name * MAID * Member DOB * County of Residence * Claim Info Date of Service From * Payment Notification Date Diagnosis Code Claim ID * CPT/HCPCS Codes * Date of Service To * Type * Reason * Select Reason Type of Service * Select Type of Service Total Dollar Amount Requested * Supporting Documents Choose Files No file chosen eg: pdf, doc, docx, jpg, png, xls, xlsx Note: XLS documents are limited to 100 columns of data State your rationale for the appeal and expected outcome. Steps taken to correct and prevent future occurrences (if applicable). Please attach any supporting documentation that will assist with resolution. * Submit Clear Back Providers should complete the fields above completely. Additional instructions for each field are as follows,

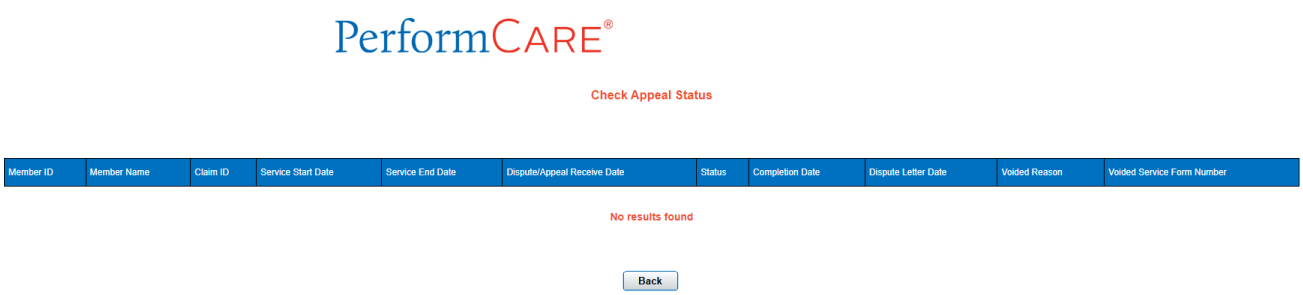
	Group- This would only need to be completed if the Payee name is different than the provider who the claim was billed under. **Provider-** This should match the provider that the claim was billed under. **Tax ID-** This should match the provider that the claim was billed under. **Contact-** This is the person that PerformCare would contact should there be any questions on the appeal. Contact's phone number and email address should also be included. **NPI-** This should match the provider that the claim was billed under. **Mailing address-** Providers should list the billing provider's address listed in PerformCare's system. **Member Info-** All information must be completed and match what is in PerformCare's system. **Date of Service From/Date of Service To-** These dates must match what was billed on the claim. If the dates do not match, the appeal could be rejected. **Payment Notification Date-** The date of the EOB from PerformCare should be listed. **Type-** Providers should enter Provider Appeal. **Diagnosis Code-** Must match what was billed on the claim. **Reason-** Provider must choose the reason for the appeal from the dropdown box. **Claim ID-** Provider must bill the claim and receive the denial before submitting the appeal. **Type of Service-** Provider should choose the level of care that the claim is in relation to. **CPT/HCPCS Codes-** Provider should list the code billed on the claim that is reimbursable by PerformCare. **Total $ Amount Requested-** Provider should list the dollar amount that is expected from PerformCare. **Supporting Documents-** Provider should attach any documents that support the appeal. Providers are reminded that if the service requires prior authorization, providers should include the member's record. Each document must be 32MB or smaller and in the following file types: .docx, .gif, .pdf, and .png. **State your rationale for the appeal and expected outcome-** Providers should outline why the appeal is being submitted, and what outcome the provider is seeking. **NOTE: When submitting a Multiple Administrative Appeal Spreadsheet fields above should represent one member and one claim's information. All other members and claim information would then be listed in the spreadsheet.**
5.	For Administrative Appeals affecting 10 or more claims, a Multiple Administrative Appeal Spreadsheet, must be added to the submission. Providers can submit more than one member on the spreadsheet.
6.	Provider will then see a confirmation pop-up box. 
7.	Once a decision has been rendered on the Administrative Appeal a response letter will be mailed out and uploaded under **Practice Documents** within 30 days. Providers should allow some time for mailing time.

Check Administrative Appeal Status

Providers are able to check or view the status of a previously submitted Administrative Appeal.

Step	Action
1.	From the NaviNet Plan Central Page, click **Forms & Dashboards** under Workflows for this Plan. 
2.	In the drop-down, select the provider in which the Administrative Appeal submitted applies to. 
3.	NaviNet will then take the user to the Forms page. User should scroll down to the **Provider Appeals** menu. Click **Check Appeal Status**, 

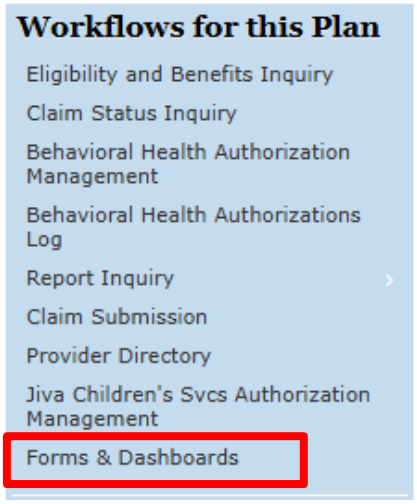
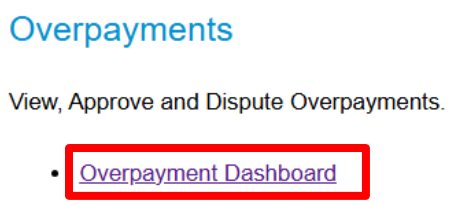
4.	The **Check Appeal Status** form will display. The search criteria will be based on the provider's NaviNet login information. Perform a search by using the **Payee ID** and one of the following data elements: • Claim ID or • Member ID or • Submission Date Range- Begin Date and End Date Click the Search button.  **Note:** Providers will be able to view 18 months of status history based on the date the Administrative Appeal is received.

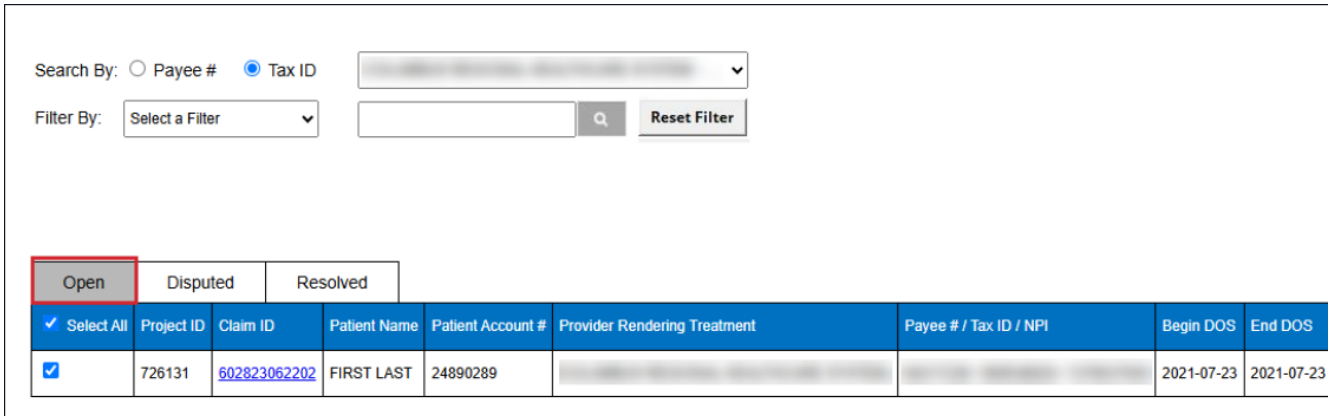
3.	The search will return one of the following statuses: **In Progress, Rejected, Approved, Denied, or Voided** and will include the date the determination letter was uploaded into the system. A copy of the determination letter will be available under **Patient Documents.** 

Claims Overpayment (Retro TPL Process)

Providers are able to use NaviNet to review, approve, or dispute claims overpayments and submit supporting documentation electronically in real-time.

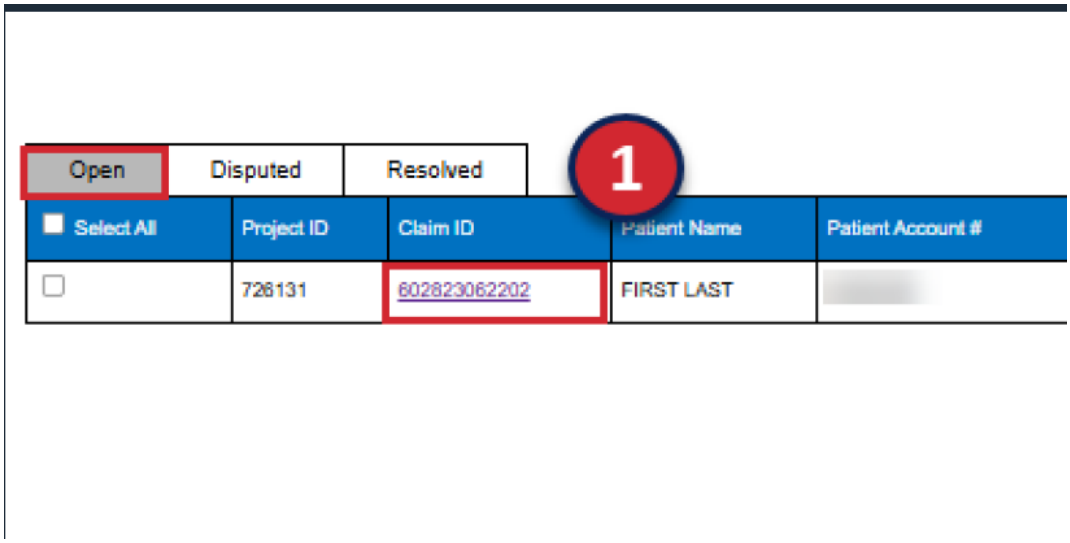
This functionality allows providers a more efficient way to respond to overpayment letters. It will help reduce the need to mail written correspondence and minimize response times.

Step	Action
1.	From the NaviNet Plan Central Page, click **Forms & Dashboards** under Workflows for this Plan. 
2.	The Forms and Dashboards **Home Page** appears. Click the **Overpayment Dashboard** link under the Overpayments section. 

3.	Select the search criteria. • Payee (displays the Provider Group name and ID) • Tax ID (displays the Tax entity name and ID) The Payee or TIN results will appear based on the search performed. 
4.	Search results based on the criteria selected will be displayed in the **Open tab** on the Overpayment dashboard.  **Note:** Users can use the Filter By option to search for a specific overpayment by Project ID, Claim ID, or Patient Account #.

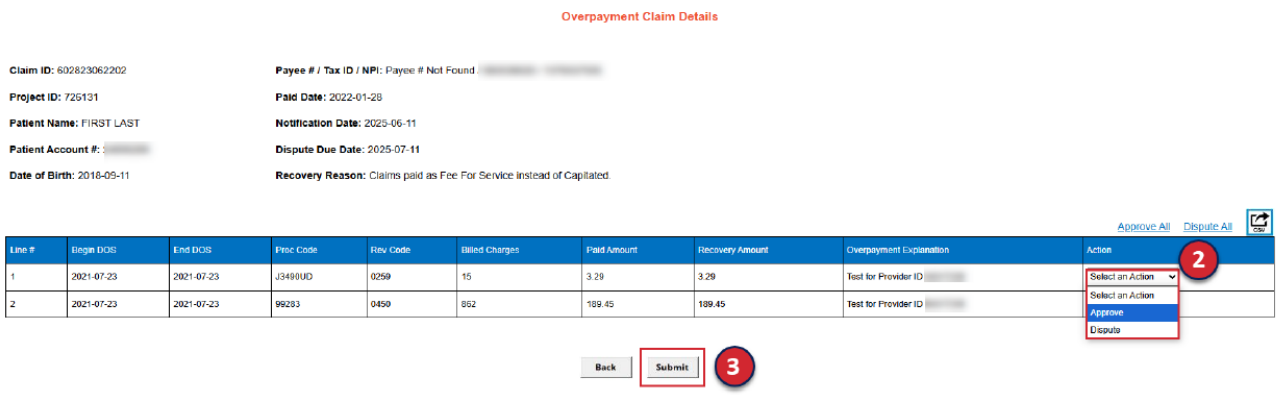
5.

From the Open tab, users will click the **Claim ID link** to open the Claims Details page and resolve by claim line. Each claim line of the selected claim will be displayed.



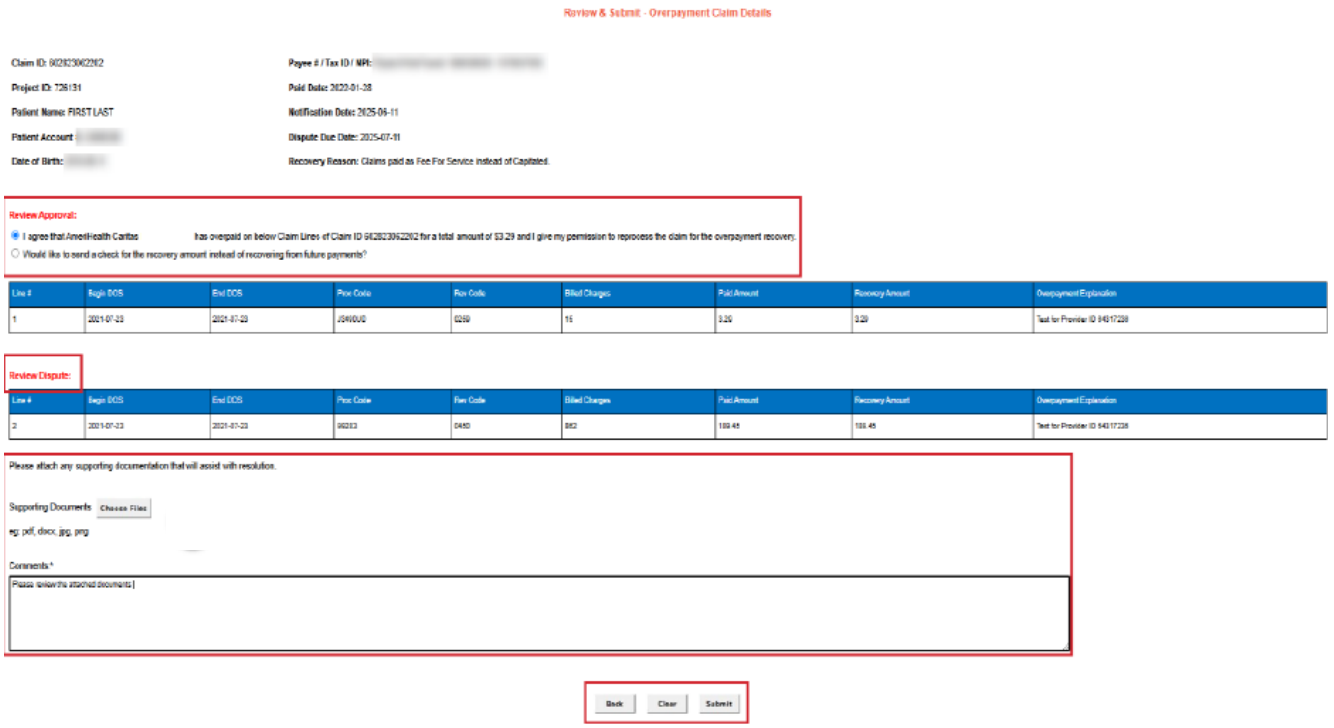
6.

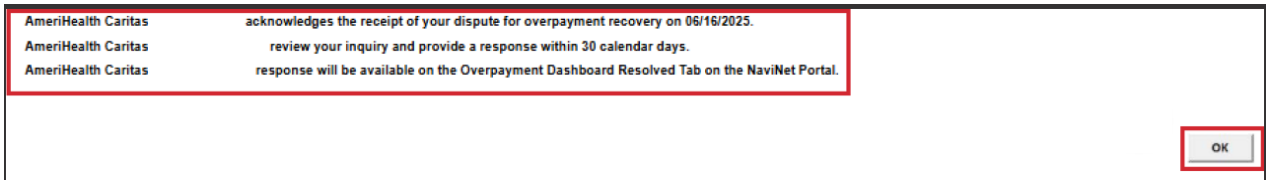
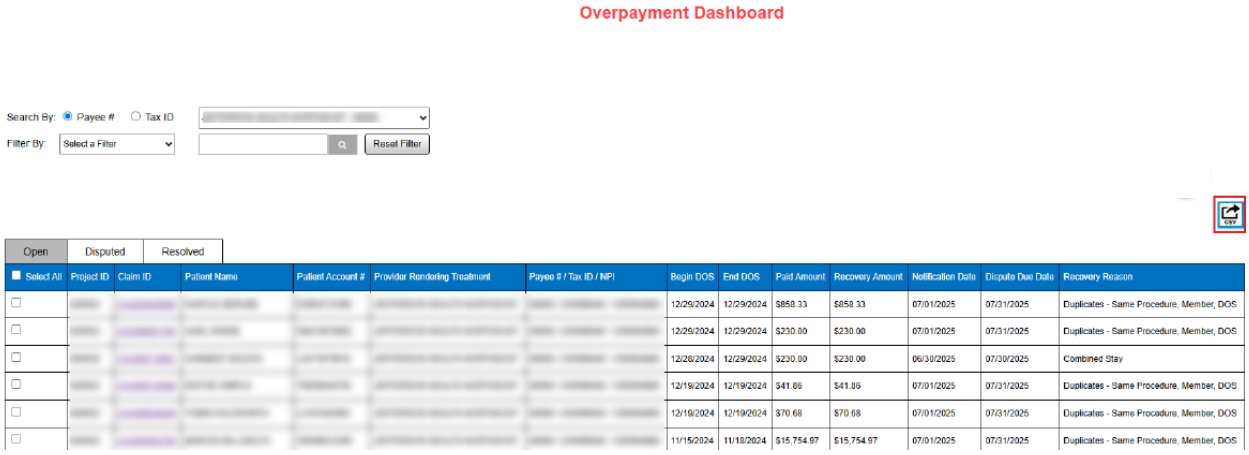
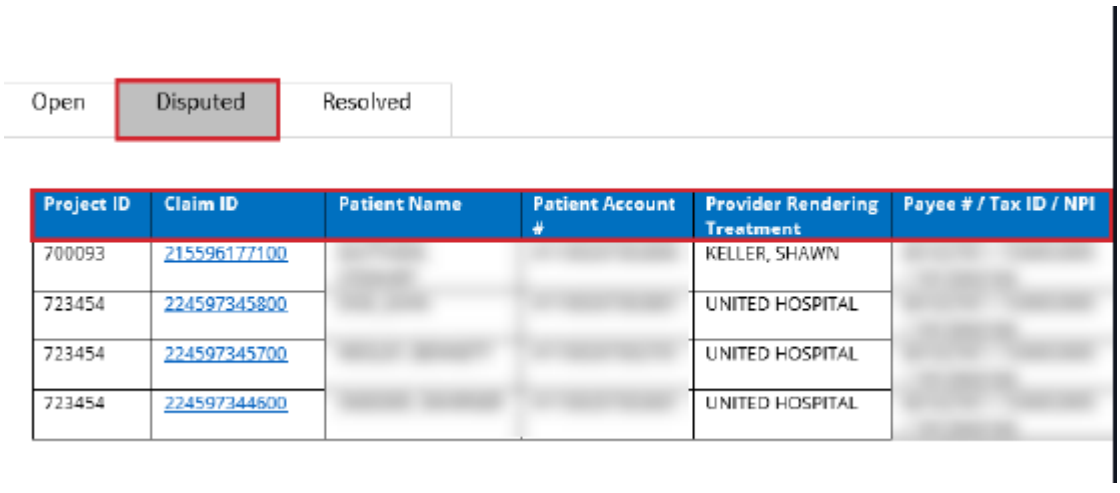
Select an **Action** "Approve or Dispute" from the drop-down menu. Once an action has been chosen click **Submit.**

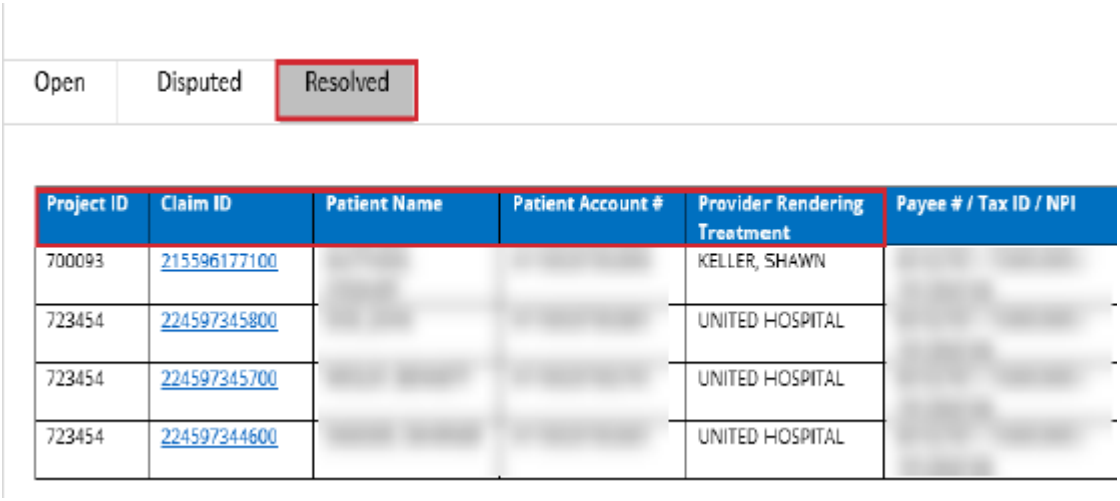


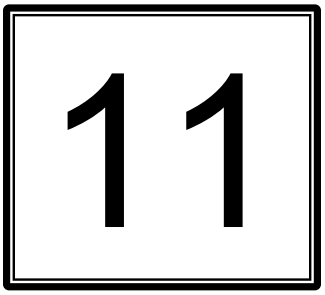
By choosing "**Approve"** providers are agreeing that the claim was an overpayment. If a provider chooses "**Approve"** the claim will be recouped in a future check run.

By choosing "**Dispute"** providers are noting that an overpayment has not been made. Provider must then attach supporting documentation showing why an overpayment was not made. Examples of acceptable documentation include TPL termination notices, eligibility checks showing that the primary insurance is not valid or is no longer valid, etc.

7.	The user will be taken to the **Review & Submit Overpayment Details** screen. The **Approve** and or **Dispute** summary will be displayed. When the provider chooses Dispute in Step 6, supporting documents must be uploaded. This option will not show if Approve is chosen in Step 6. Click **Submit** or the Back button to make changes. 

8.	The acknowledgement of reciept message will display. Click **Ok.** 
9.	Providers are able to run Reports from the Overpayment Dashboard. To run a report from the Overpayment Dashboard, Click the **CSV** icon on the Overpayment Dashboard page and hit Enter.  The system can generate **Excel spreadsheets** for each of the three overpayment categories. • Open • Dispute • Resolved
10.	Previously disputed claims will appear in the **Disputed tab** with a Determination Due date. The plan will respond within the stated time noted in the confirmation message. 

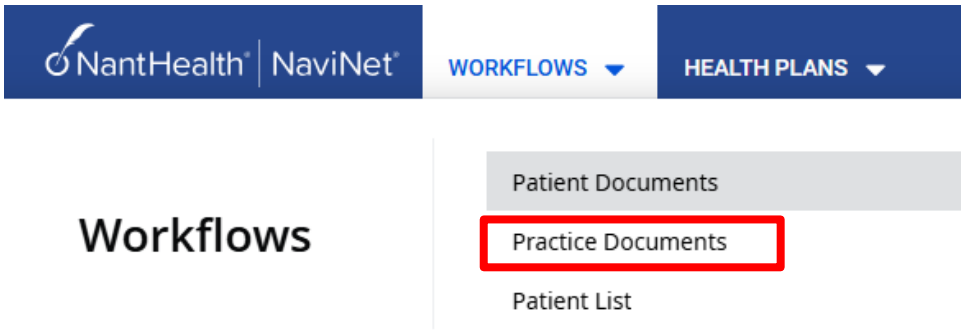
11.	The **Resolved tab** will show multiple Resolution statuses based on the action taken. • Overpayments submitted from the Open tab will appear in the Resolved tab • If no action is taken in Open tabs and the due date has expired, records will be moved to the Resolved tab, and the recovery of overpayments will begin.  Open Disputed Resolved | Project ID	Claim ID	Patient Name	Patient Account #	Provider Rendering Treatment	Payee # / Tax ID / NPI
---	---	---	---	---	---
700093	215596177100			KELLER, SHAWN	
723454	224597345800			UNITED HOSPITAL	
723454	224597345700			UNITED HOSPITAL	
723454	224597344600			UNITED HOSPITAL	

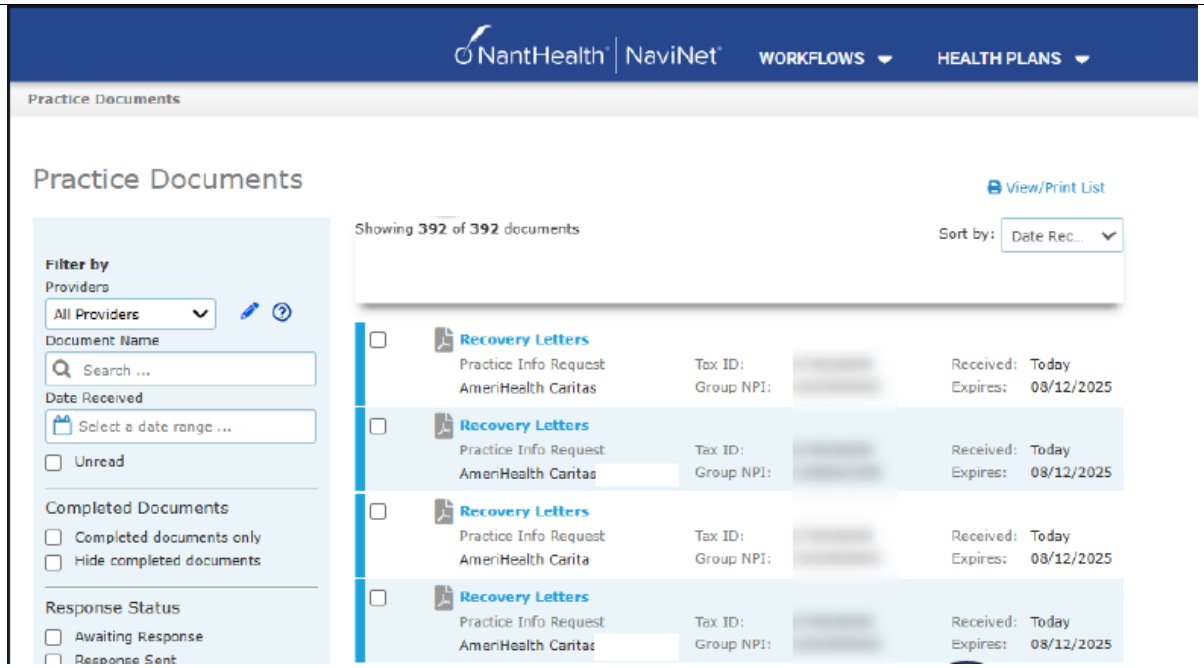


11 DOCUMENTS

Practice Documents

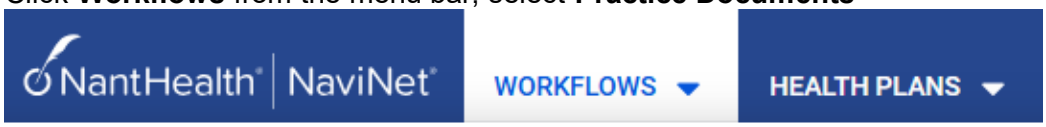
Providers can access Overpayment Letters and Administrative Appeal decision letters via the Practice Documents in 2 ways.

Step	Action
1.	To access the documents via the Practice Documents workflow: Click **Workflows** from the menu bar, select **Practice Documents** 
2.	To access the documents via the Plan Central Page: Click **the Practice Document** link on the left side Navigation panel, 
3.	The **Practice Documents** page will appear.

	
4.	Check the box to select the appropriate letter from the list.

Patient Documents

Providers can access Integrated Care Plans (ICPs) via the Patient Documents in 2 ways.

Step	Action
1.	To access the documents via the Patient Documents workflow: Click **Workflows** from the menu bar, select **Practice Documents**  

2.	**To access the documents via the Plan Central Page:** **Click** the Patient Document **link on the left side Navigation panel,** 
3.	The **Patient Documents** page will appear.

12 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
PerformCare	888-700-7370	888-987-5828

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)
Provider Training Requests	Contact your designated Account Executive (AE) https://pa.performcare.org/assets/pdf/providers/resources-information/account-execs.pdf
Provider is not listed in NaviNet	Submit an online case in NaviNet via My Account>Customer Support>Open a Case Online