Provider User Guide: Provider Access Online – How to Request Online Authorizations:
This provider user guide provides step-by-step instructions for the field requirements necessary for requesting online authorizations for inpatient and outpatient services that require prior authorization with Fidelis Care. Checking Authorizations Status is explained starting on Page 14.

Prerequisites / Requirements:
Providers will need to establish a separate and unique Provider Access Online (PAO), provider portal, user account for each user's login access (login credentials) to the provider portal. The Account Administrator for the provider/group has the ability to create the necessary user accounts and must assign the role of 'Authorizations Viewer' to users who need to request prior authorizations online via the provider portal.

Important requirement! Each account user of PAO is required to have their own, separate and unique, login credentials to access the provider portal.

Sharing of account user login names/passwords is strictly prohibited.

If additional assistance is needed with user account maintenance, please contact the Fidelis Care Provider Call Center at 1-888-FIDELIS (1-888-343-3547).

Requesting Prior Authorizations – Inpatient and Outpatient*: Provider Access Online (PAO) can be used by providers to request online prior authorizations for inpatient and outpatient authorizations, including “after-hours” urgent inpatient mental health authorizations requested “after-hours”.
(“after-hours” are: Mon-Fri: 5 PM – 8:29 AM. Sat, Sun and Holidays 24 hours).

Exceptions: The following services cannot be submitted online via PAO:

- Urgent; concurrent; and inpatient ER admission requests must be submitted by fax at 1-800-860-8720 or by phone at 1-888-FIDELIS (1-888-343-3547)

- Outpatient high-technology Radiology services, Non-Obstetrical Ultrasounds, diagnostic Cardiology services, and Radiation therapy services must be requested and viewed through eviCore Provider Portal.

Follow the steps below to create an inpatient or outpatient authorization* online via PAO:

Step1: Login to Provider Access Online (PAO), provider portal.

Each account user accessing the provider portal will need separate and unique login credentials. Sharing of login user names/passwords is strictly prohibited.

After logging into PAO, the Home Page will be displayed, see illustration i.
Step 2: Select **Patient** from the menu list, type the Subscriber ID# in the **Subscriber ID** field and click the **Search** button to locate the member.

The **Patients** window is displayed. See **illustration ii**.

**illustration ii.**

Step 3: Click on the **Member's Name** hyperlink to open the **Patient Details** screen.

The **Patient Details** window is displayed. See **illustration iii**.

**illustration iii.**
Once you have located the correct member, you are ready to begin creating the prior authorization request.

**Step 4:** Using the right-side, vertical scroll bar, scroll all the way down to the bottom of the Patient Details page to view the **Authorizations** section.

The **Authorizations** window is displayed. See *illustration iv*.

**Step 5:** Click on the **Create Authorization** button. **Note!** *Urgent, Concurrent, and ER admission* requests cannot be submitted online, they must be faxed or phoned in.

The **Fidelis Provider Authorizations** window is displayed. See *illustration v*.

Additional information is available to you by hovering over the **information icons** throughout the authorization form.

*Urgent Request*

A request for medical care or services where application of the time-frame for making routine or non-life threatening care determinations could:

(a) Seriously jeopardize the life, health or safety of the member or others, due to the member’s psychological state or,

(b) In the opinion of a practitioner with knowledge of the member’s medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

*Concurrent Request* *continued below...*
The ‘After Hours Urgent inpatient Mental Health’ option only displays when the time of the request is “after hours” (M-F 5pm – 8:29am; Sat, Sun & Holidays 24 hrs.)

**Step 6: Type of Request:**
Choose the type of request you would like to submit by clicking the appropriate button.

- Pre-Service (Standard Non-Urgent)
- Post-Service (Standard non-Urgent)

Choosing Pre-Service or Post-Service will then display the **Inpatient or Outpatient** window. *See illustration vi.*

**Step 7: Inpatient or Outpatient:**

Is this an Inpatient or outpatient treatment? Click the appropriate button.

- Inpatient
- Outpatient

Choosing Inpatient or Outpatient will then display the **Type of Service** window with a drop-down menu to choose the type of service. You will notice that the drop-down menu lists will be different depending on your choice of inpatient or outpatient. *See illustration vii.*
After choosing the type of service, an additional window will open, Service Sub-Category. Note, that some types of services will have multiple sub-categories to choose from, while others will not. Those that do not, will have the type of service repeated in the Service Sub-Category field, such as “DME”. See illustration viii.

Type of Service = Behavioral Health:

- Multiple Service Sub-Category:
Type of Service = Durable Medical Equipment:

- Single Service Sub-Category:

![Service Sub-Category](image)

- Confirmation and/or authorization does not guarantee that services will be paid. Payment of claims is subject to member eligibility and adherence to correct coding standards.
- All requests for services require additional clinical evidence to support the requested service(s) including but not limited to: History & Physical, previous diagnostic tests, and consultation reports.
- To clarify any authorization requirements, please visit our Authorizations page.

**Step 8: Service Sub-Category:**
Choose the appropriate service sub-category using the drop down menu list.

When type of service and service sub-category = Physical therapy/Occupational therapy/Speech Therapy, an additional Treatment Information window will open.

Be sure to read the important notes beneath the Service Sub-Category section.

See illustration ix.

*illustration ix.*

**Physical Therapy/Occupational Therapy/Speech Therapy only:**
Choose the option for your authorization request by clicking on the appropriate button.
Step 9: Click the Next button in the lower, right-hand corner of screen.

After clicking the Next button, the Authorizations Details screen is displayed and some of the detail sections will be prepopulated based on information you have already filled in on the previous screens, such as: Request Info and Member information. See illustration x.

Illustration x.

Authorization Number will be assigned when the authorization is “Saved”.

Submission Date will not be filled in until the authorization form is completed and has been “Submitted”

Step 10. Outpatient Details or Inpatient Details:

Fill in the Requested Start Date of the authorization by keying the date in the format: MM/DD/YYYY or by choosing the date using the calendar icon.

Some authorizations may require an End Date as well.

Key in the number of units/visits being requested.
Step 11: Diagnosis & Procedure:

Diagnosis Codes

Key in the **diagnosis code**, *without decimals*, in the Diagnosis Codes box and click the **Add button**.

Alpha characters can be keyed in either upper/lower case.
Multiple diagnosis codes can be keyed one at a time.
A message will display to alert you when a diagnosis code is invalid.
To remove a diagnosis code, click on the code and click the **Remove** button.

Procedure Codes

Key in the **procedure code** with **modifier (if applicable)** immediately following, no spaces.

Alpha characters can be keyed in either upper/lower case.
Multiple procedure codes can be keyed one at a time.
A message will display to alert you when a procedure code is invalid.
To remove a procedure code, click on the code and click the **Remove** button.

Step 12: Requesting Provider

The Requesting Provider’s Name, Phone#, Address, Fax#, Tax ID (*last 4-digits*), and NPI# will automatically prefill based on the user that is logged in.
**Alternative Contact Information (optional)**

This (optional) field can be used for miscellaneous information that will help Fidelis Care staff process the prior authorization. The Requestor can indicate their direct contact information so that Fidelis Care staff can effectively outreach for additional information/clarification when needed.

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**Step 13: Servicing Provider**

To search for a **Provider**, fill in **at least one** of the following fields:

**First Name, Last Name, Tax ID**, and, or **NPI#** and then click the **Search** button.

- The more specific detail you key in, the better your results will be.

Select your provider.
Step 14: Facility

Will the services be rendered in a **Facility**? Choose Yes/No by clicking the appropriate button.

- If **No** is checked, continue on to **Step 15**.
- If **Yes** is checked, a window will open for you to search and select the **Facility**.

To search for a **Facility**, fill in at least one of the following fields:

- **Name**, **Tax ID**, and, or **NPI#** and then click the **Search** button and select your provider.
- The more specific detail you key in, the better your results will be.

Step 15: Additional Information:

The **Additional Information** field can be used for keying miscellaneous information and can include up to 500 characters.
Step 16: Supporting Clinical Documentation

The Supporting Clinical Documentation section is where you can upload and attach clinical documentation files, *up to 20 MB per each file.*

.setPassword-protected documents should not be attached.

In the Choose a Category drop-down box, choose the category that best fits the document you are attaching. Then click on Choose a file to search for each file you would like to attach to the authorization.

Double-click or click Open to attach your file and click the Save button.

At this point, all of the required fields should be filled in. You can scroll up or use the ‘up-arrow’ to go back and review any fields you’d like to review or change.

When you click Submit, if you are missing any required fields, a message will be displayed that tells you how many errors are found. A hyperlink will be provided to quickly return to the invalid/missing entries for your correction.

Step 17: Cancel, Save or Submit your Authorization.

The authorization can be cancelled, saved or submitted. Click the appropriate button:
Cancel - To close the current authorization that is on the screen.

If the user never saved the authorization, it will be gone forever. If the user saved the authorization, and cancel is clicked, the authorization will not be deleted, it will just be closed and not saved.

Contact the QHCM Department for further help with a submitted authorization.

Save – To save the authorization data that has been keyed in so far. Once an authorization is Saved, it’s assigned an Authorization Number. This is still considered in “Draft” format until the authorization is Submitted.

A saved authorization can be modified as long as it has not yet been “Submitted”.

An authorization can be deleted at any point after it has been saved, until it has been submitted.

Contact the QHCM Department for further help with a submitted authorization.

Submit – To submit the authorization data that has been keyed.

A “Submitted” authorization is “locked-down” from further editing or deleting via the Provider Portal. The authorization is transferred to Fidelis Care’s Quality Healthcare Management (QHCM) Team for review.

Contact the QHCM Department for further help with a submitted authorization.

Reminders:

- The Authorization Number will be assigned when the authorization is ‘Saved’.

- A Saved authorization is assigned an Authorization Number, however, it is still considered to be in Draft format until it has been Submitted.

- The Submission Date will be assigned when the authorization has been Submitted.

- A ‘Submitted’ authorization request will be sent to Fidelis Care’s Quality Healthcare Management (QHCM) Team for review. You will be notified of the decision. A new “Submitted” tab is created for detailed information.

- Authorization Status Tab – Providers can view the status of the authorization by using the ‘Authorization Status’ Tab.
Authorizations Status

To check the status of an authorization, follow these steps:

Step 1: On the Provider Access Online Home page, select ‘Authorizations Status’ from the menu list.

The Authorization Search screen is displayed. Authorizations that you have created and saved in the last 90 days, will be displayed in the ‘Our latest Authorization (90 days)’ view. See illustration xi.

illustration xi.

Click on any column heading to resort the list A-Z or Z-A.

Use Authorization # hyperlink to open a specific authorization for further details.

Use Previous & Next buttons to advance screen display to see more authorizations.

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Authorization #:
A 9-digit authorization number that is automatically assigned by the system when a user ‘Saves’ an authorization. Use the authorization number hyperlink to view the authorization details for one specific authorization.

Member Name:
First and Last name of the member on the authorization.

Date of Birth:
Member’s date of birth MM/DD/YYYY.

Created Date:
The date the authorization was created, which may or may not have a Submission Date if authorization hasn’t been submitted yet.

Type:
This field indicates an abbreviation of the type of service that the authorization was entered under.

IP/OP:
This field indicates OP (outpatient) or IP (inpatient) based on the site of service the authorization was entered under.

Status:
The status of the authorization. The values are:

- Draft – a saved authorization, but, not yet submitted. (can still be deleted)
  A saved (Draft) even with an authorization number assigned still needs to be “Submitted” in order to obtain a decision by Fidelis Care’s QHCM Team.
  Note: A Draft authorization that is Deleted, will be gone forever.
- Submitted – An authorization that has been Submitted to our QHCM Team for review and decision. (cannot be deleted)
- Approved – A Submitted authorization that has been reviewed/approved by our QHCM Team. Providers are notified of the decision via letter.
- Denied – A Submitted authorization that has been reviewed/denied by our QHCM Team.
- Partially Approved - A Submitted authorization that has some of the requested services reviewed and approved by our QHCM Team.

User Name:
The Provider Portal logged-in user.

Delete:
A red X will be present in this column for the authorizations that have a status of “Draft”. Only draft authorizations can be deleted.

If your authorization was created more than 90 days ago, it will not be listed in the “90-Day” view, continue on to step 2.
Step 2: Authorization Not Listed?

If your authorization was created more than 90 days ago, you will need to search for it. Click the Search your other Authorizations hyperlink to begin your search. See illustration xii.

illustration xii.

Step 3: Key the member’s Subscriber ID number in the Subscriber ID field and click the Search button. See illustration xiii.

illustration xiii.

After clicking the Search button, the Authorizations window will be displayed. See illustration xiv.

illustration xiv.
Step 4: Click the Authorization # hyperlink to open the Authorization Form for more detail.

After clicking the Authorization # hyperlink, the Authorization Form is displayed. See illustration xv.

Illustration xiv.

Illustration xv.
Step 5. For additional detail at the procedure code level, click the “plus-sign” to the left of the procedure code. After clicking the “plus-sign”, additional details will be displayed. See illustration xvi.

illustration xvi.

Note: the plus-sign, turns to a red, minus-sign. Click this button to open & close the procedure detail level.