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).

All Prior Authorizations can be submitted online, except the following:

Must be submitted via the appropriate fax line or by phone at 1-888-FIDELIS (1-888-343-3547):
- Urgent Requests
  - Initial Inpatient Rehabilitation can now be submitted online via provider portal
  - Inpatient Emergency Room Admission Requests will soon be available to submit online via provider portal
- Concurrent Requests
- Pharmacy Medication Requests should be faxed using the prior authorization forms available here: Pharmacy Services

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

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.

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After logging into PAO, the **Home Page** will be displayed, see *illustration i.*

*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 Name** hyperlink to open the **Patient Details** screen.

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

*illustration iii.*

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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. (refer to Page 2 for exceptions)

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...
Concurrent Request
A request for coverage of medical care or services made while the member is in the process of receiving the requested medical care or services. An ongoing course of care.

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.

If you need to refer to the Fidelis Care authorization grids, a hyperlink is provided:

Fidelis Care Authorization Grids
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.*

*illustration viii.*

**Type of Service** = Behavioral Health:

- **Multiple** Service Sub-Category:

**Type of Service** = Durable Medical Equipment:

- **Single** 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.

*For Essential Plan members* the plan year is defined as the member’s annual effective date each year.

*For all other Fidelis Care members* (besides the Essential Plan) the plan year follows the calendar year.
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](image)

**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 (**ie. Inpatient**) 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.

![Requesting Provider Form]

**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.

![Servicing Provider Form]

**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.

“Password-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 to Fidelis’, 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 for Later, or Submit to Fidelis.

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 for Later – To save the authorization data that has been keyed in so far. Once an
authorization is Saved for Later, it’s assigned an **Authorization Number**. This is still considered in "**Draft**" format until the authorization is Submitted to Fidelis.

A ‘Saved for Later’ authorization can be modified as long as it has not yet been “Submitted to Fidelis”.

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

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

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

A “Submit to Fidelis” 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:**

1. The **Authorization Number** will be assigned when the authorization is ‘**Saved for Later**’.

2. A **Saved for Later** authorization is assigned an Authorization Number, however, it is still considered to be in **Draft** format until it has been **Submitted to Fidelis**.

3. The **Submission Date** will be assigned when the authorization has been **Submitted to Fidelis**.

4. A ‘**Submitted to Fidelis**’ 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.

5. **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.
Authorization #:
A 9-digit authorization number that is automatically assigned by the system when a user ‘Saves for Later’ an authorization. Use the authorization number hyperlink to view the authorization details for one specific authorization.

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

- **Under Review** – a Saved for Later authorization, but, not yet submitted. (can still be deleted)
  A saved (Draft) even with an authorization number assigned still needs to be “Submitted to Fidelis” in order to obtain a decision by Fidelis Care’s QHCM Team.
  Note: A Draft authorization that is Deleted, will be gone forever.
- **Waiting Review** – An inpatient confinement that is under review.
- **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.
- **Cancelled** – a Saved for Later authorization that ended up being cancelled, rather than submitted.

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 to Fidelis yet.

Type:
This field indicates an abbreviation of the type of service that the authorization was entered under. Hover over the ‘information button’ to view a list of the Types.

IP/OP:
This field indicates OP (outpatient) or IP (inpatient) based on the site of service the authorization was entered under. Hover over the ‘information button’ to view a list of the two Types.

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”. Hover over the ‘information button’ to view that “Only authorizations not submitted 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.

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

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

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

After clicking the Authorization # hyperlink, the **Authorization Details** screen is displayed. You can scroll down and view all the details of the authorization you have clicked on.