MEDVISION SOLUTIONS

QUICK CAP™

Provider Portal Manual

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INTRODUCTION

The Provider Portal is a robust tool which allows providers to both submit and view data, as well as, communicate directly with the organization. Within the portal, providers can perform key tasks including entering and look up of authorization requests and claims. It also gives you a platform for performing eligibility verification of the patient.

The portal also allows providers to print EOBs on-demand. Each of these functions serve to make the provider staff happier and more efficient. To login to the Portal, go to https://prosource.quickcap.net using Mozilla FireFox.

❖ AUTHORIZATION/REFERRAL

From the **Authorization/Referral** module, users are able to submit a new authorization and referral and check the status of an existing authorization.

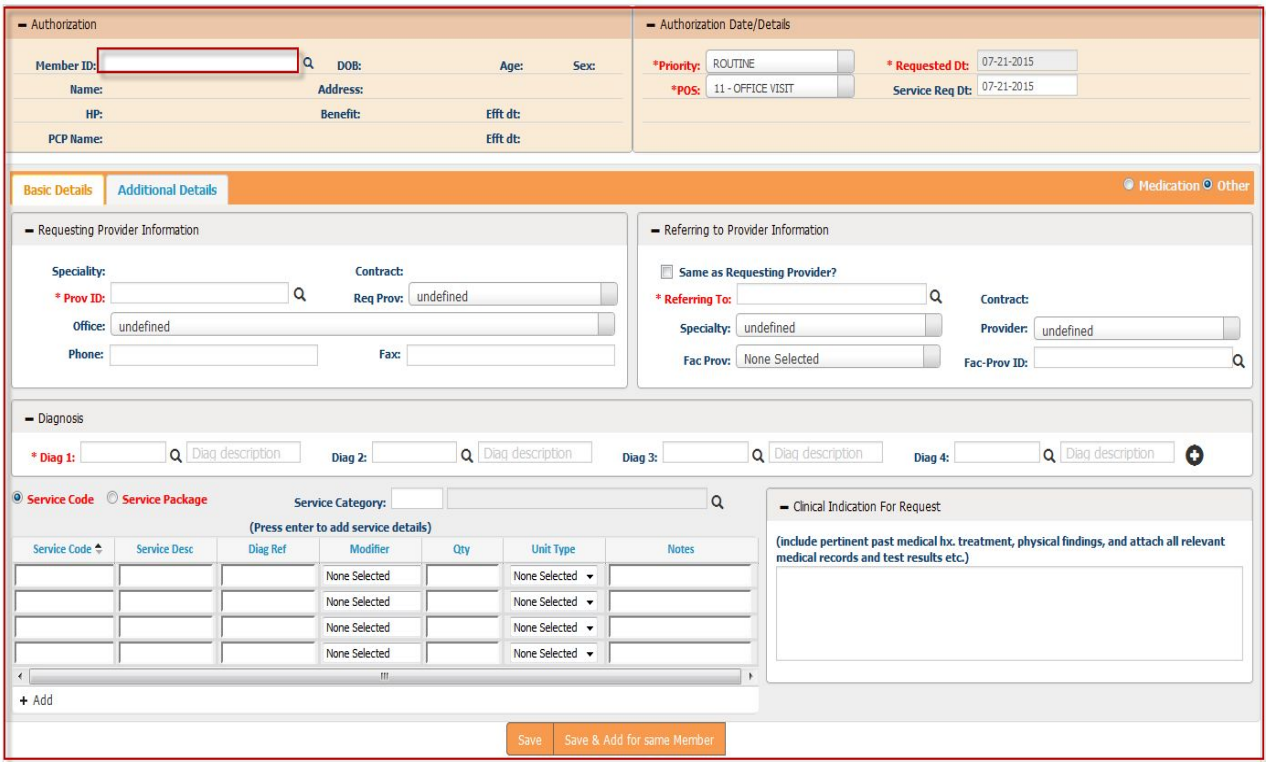
	The Authorization/Referral module

● SUBMITTING A NEW AUTHORIZATION

Step 1: From the **Authorization/Referral** list, select **New Auth Entry**.
To submit a new authorization, follow the steps below:

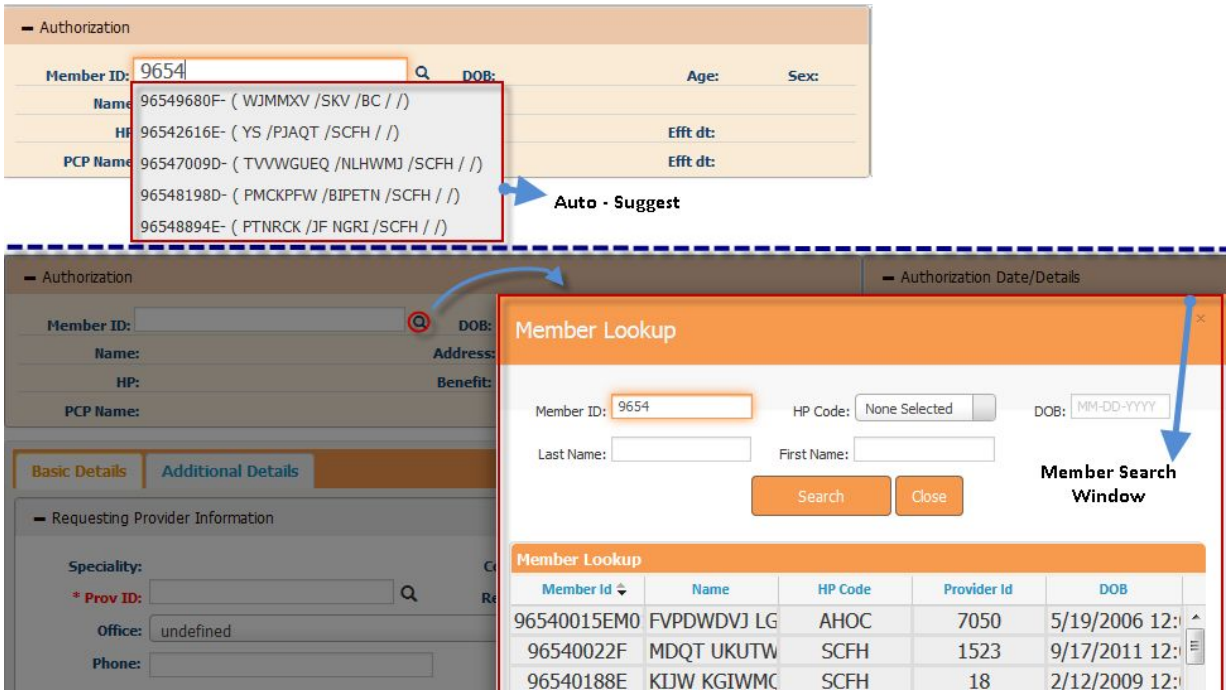
	The New Auth Entry submodule

Step 2: The screen will display as shown below. On this screen, there are three subsections to add an authorization.

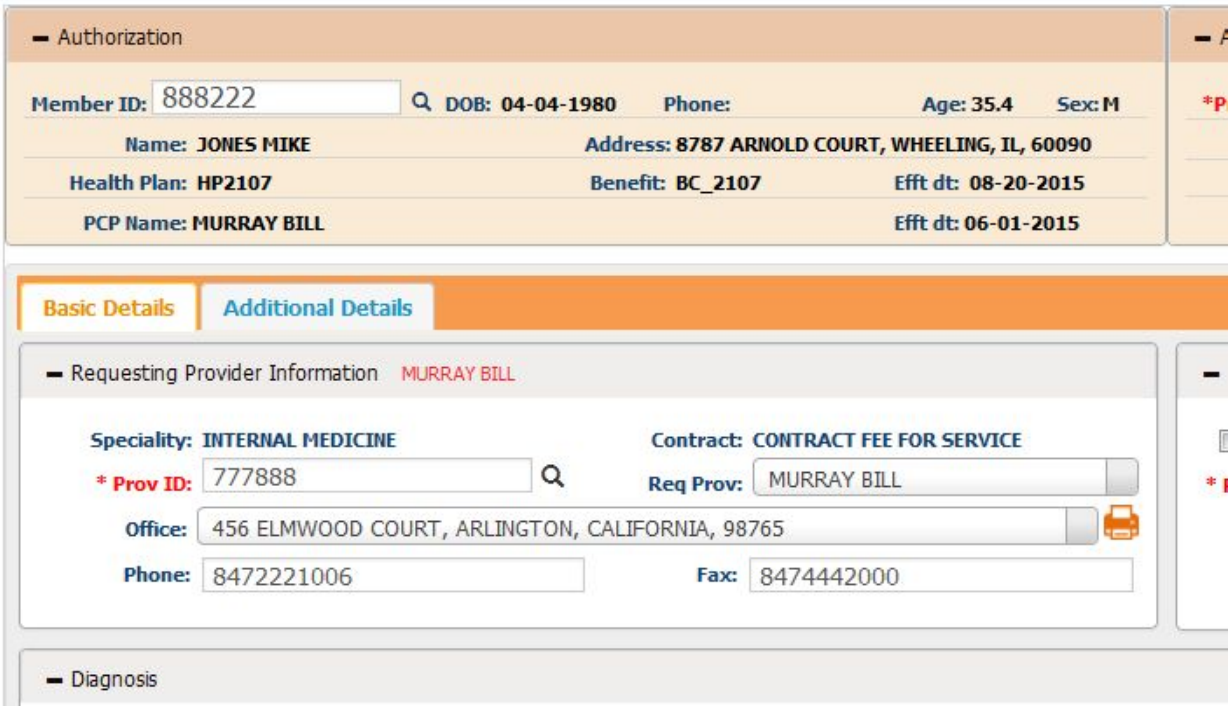


Step 3: The first section is the **Member Section.** Users can enter the member's information in one of two ways:

- Enter the **Member ID** for the specific member. The system will begin suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member's information to the screen.
- Users can click on the **Magnifying Glass** icon to search for the member. The **Member Lookup** screen will open. From this screen, users can search using a combination of **Member ID, Health Plan**, **Name,** and **DOB** to find the record. Double click the correct record to add it to the authorization request.



Step 4: The details for the selected member will be populated on the screen. The system will default the **Requesting Provider** information matching the organization and provider logged in.

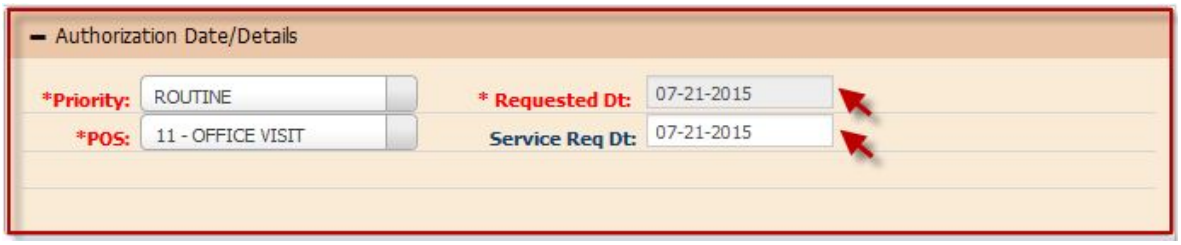


Step 5: The user can select the **Priority** and the **Place of Service** for the request.

- Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear or additional options.
  - **Urgent**: If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.

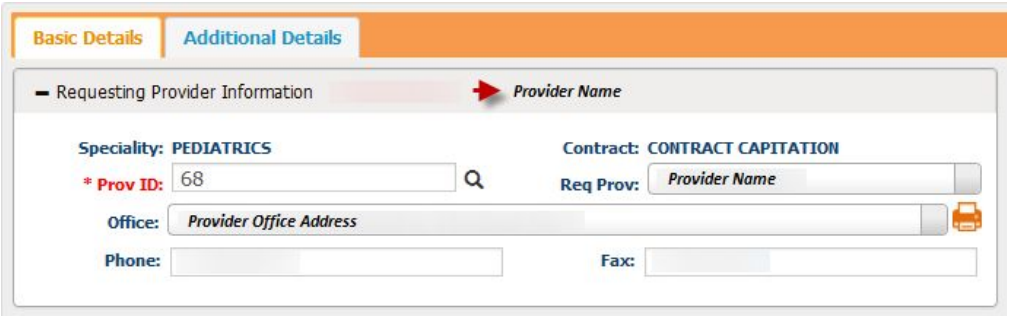
  - **Retro**: If the services have already been provided, users should select **Retro.** A new field, **Retro Date,** will appear and require date entry.

Step 6: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** is non-editable and will always default to the date of submission.

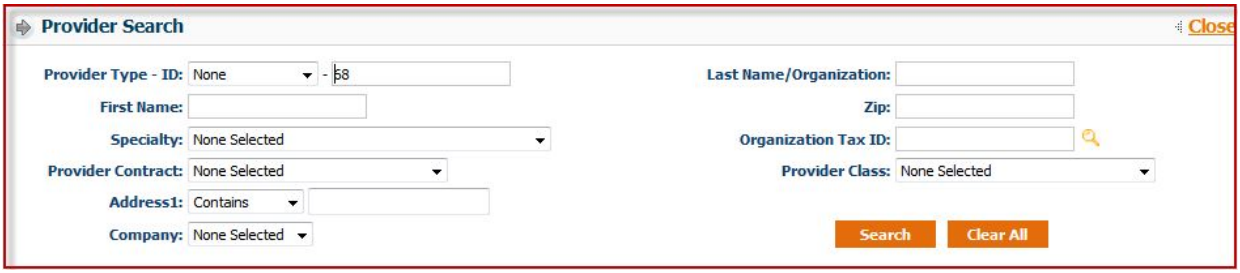


- The **Service Requested Date,** displayed in the **Service Req. Dt** field should be entered as the date that the service should be performed, scheduled for, or for the authorization to become effective. This date will be reviewed by Nivano Physicians internal staff and is subject to their discretion.

Step 7: The **Basic Details** tab displays the **Requesting Provider Information**. This will default for the provider that is logged into the system. This screen includes **the Specialty, Contract Type, Provider ID**, **Requesting Provider Name**, and the contact information.



- If the requesting provider needs to be changed, users can search for a new provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information.



- Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.
- If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 8: The next section, **Referring to Provider Information,** allows users to enter the information for the provider that member is being referred to.

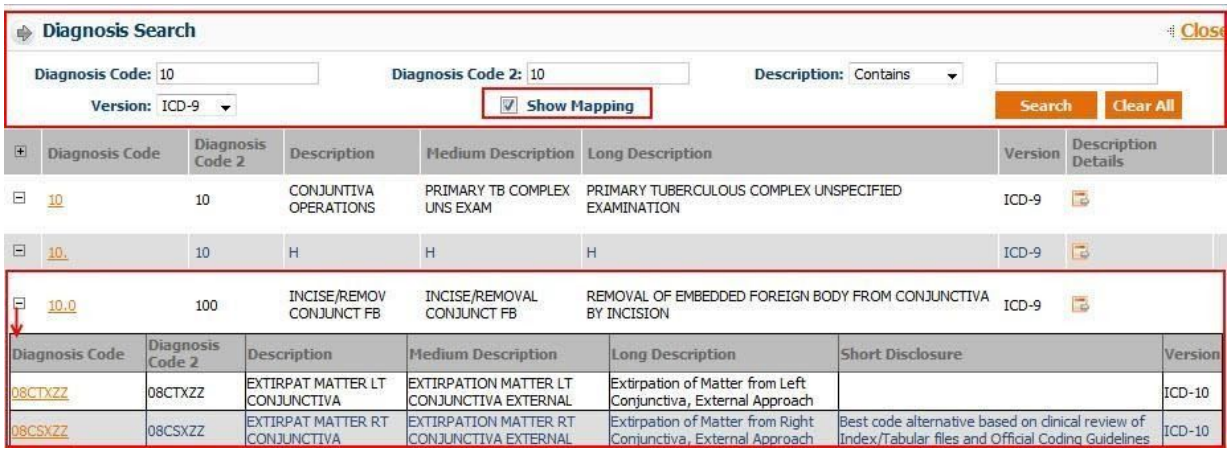
- For self-referrals, select the "**Same as Requesting Provider"** checkbox. This will auto-populate the information from the **Requesting Provider** screen.
- To search for a **Referring To Provider**, click the **Magnifying Glass** icon beside the **Referring To** field. The **Provider Search** screen will populate as shown in the above section. Users can search for the specific provider.
- Click the correct **Provider ID** to enter the details of the referring provider on the authorization request.

- Then, select the **Referring to Office** from the dropdown menu.

Step 9: This step is optional. Users can enter **Facility Provider Information** for the request, if needed.

Step 10: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.

- Enter all ICD codes related to the request in the **Diagnosis Code** field.
  - If the user knows the ICD code, they can enter it into the field and press **tab** on their keyboard. The system will populate the description to the right in the **Diag. Description** field. The system will auto suggest codes if they are partially entered.
  - To search for the diagnosis code, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.

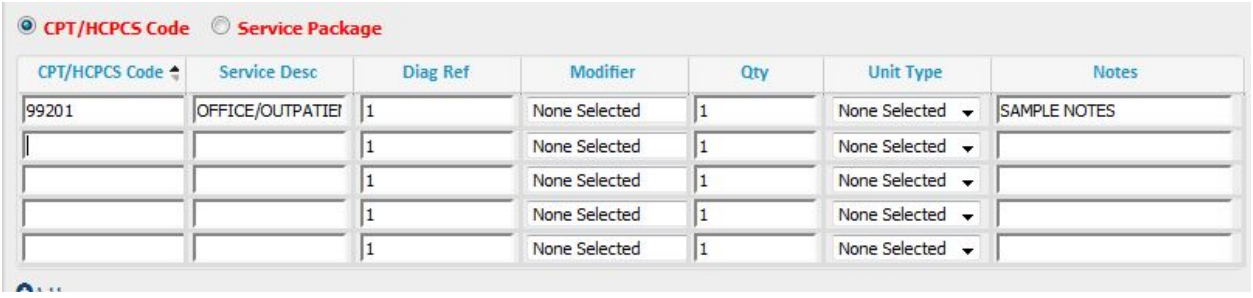


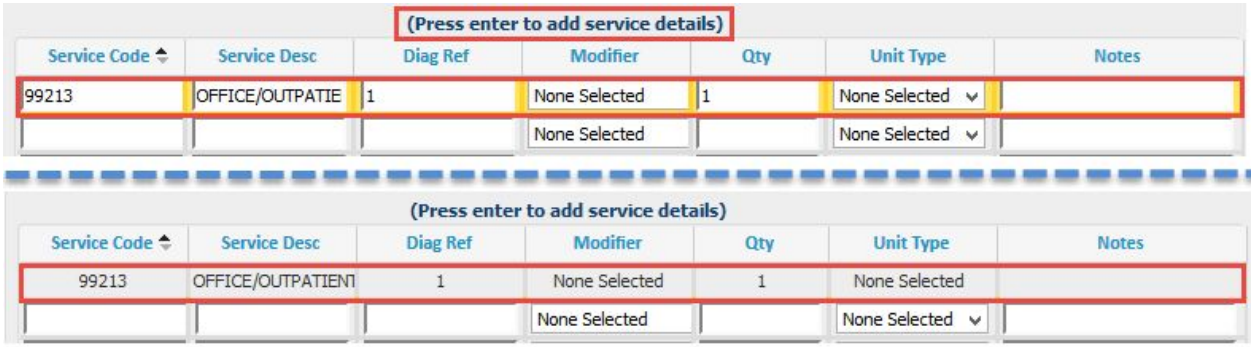
- From the **Diagnosis Search** screen:
  - Enter either the diagnosis code or description to search for the code.
  - Select the version of the code. ICD 9 codes will default. However, users can search for ICD 9, ICD 10, or for both codes.
  - Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
  - Click the **Search** button.

  - Click the **+** icon to the left of each code to view the mapping**.**
  - Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

Note: Users can add 12 distinct diagnosis codes.

Step 11: The next section is used to enter the CPT/HCPCS codes for the requested services.

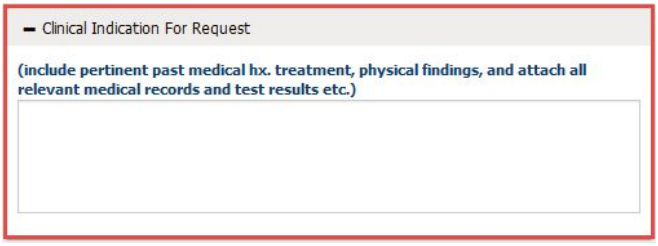




- The option for **CPT/HCPCS Code** defaults for entry; users can select **Service Package** if it is enabled. This will be described further below.
- To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard.
- If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated. This can be used to identify certain services such as Office Visits or Consultation visits.
- After the code is entered, the description will auto populate into the **Service Desc** field.
- Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.

- Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.
- Users can add any modifiers if needed. Modifiers can be selected from the dropdown menu or manually enter the code.
- Press **tab** on the keyboard to go to the next CPT (service) line.

Step 12: The next section is **Clinical Indication for Request**. In this section, users can add the member's past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.



Step 13: The second information tab is **Additional Details.** Within this tab, three more sections will appear.

Step 14: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

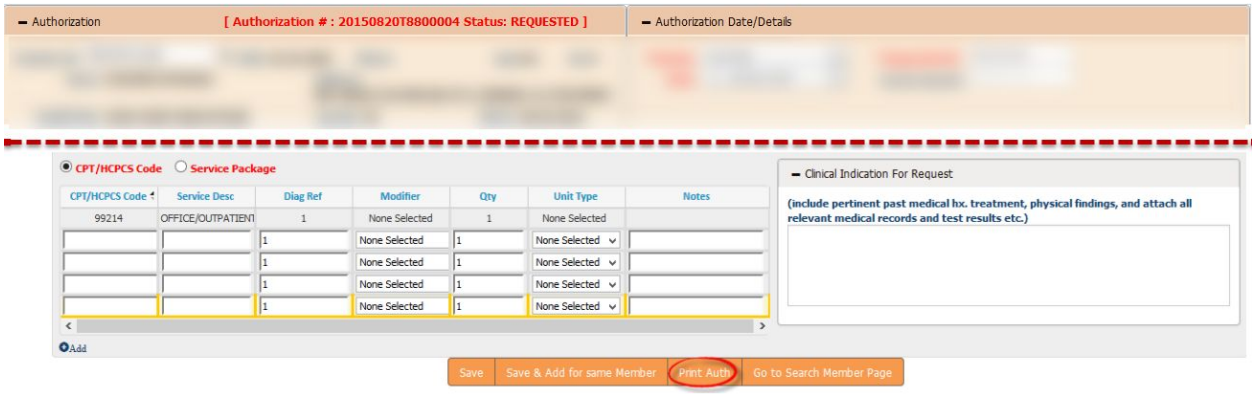
- Select the **Category** and **Priority** of the document.
- Click **Browse** to find the file from the computer directory
- Upload documents in the following formats: .doc, .docx, .xls, .xlsx, .pptx, .xps, .psd, .htm, .pdf, .tiff, .rtf, and text.
- Click the **Add Additional Documents** button to add multiple documents.
- Once users click **Save**, the document will send with the referral automatically.

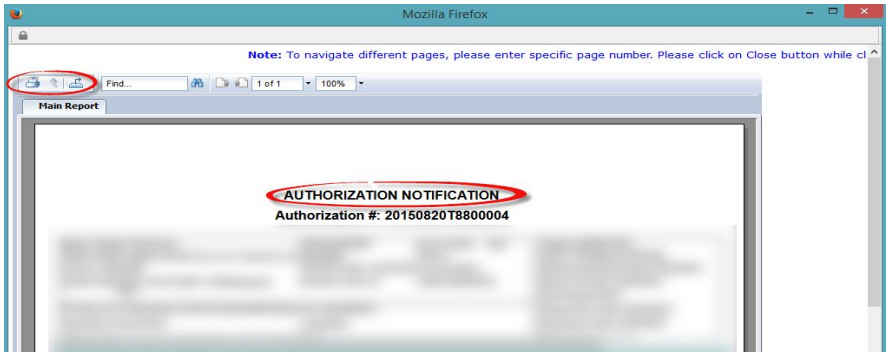
Step 15: After verifying the data entered, users can save the request.

- To submit the referral request, click **Save**.
- To submit the referral request and add another request for the same member, click **Save and Add for same Member**.

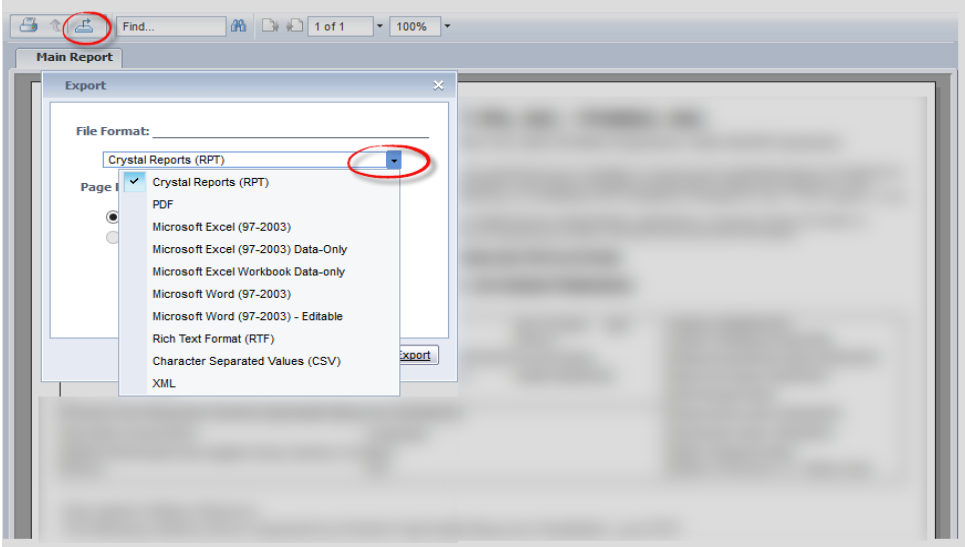
Note: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.

Step 16: Users have the option to **Print Auth** on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.





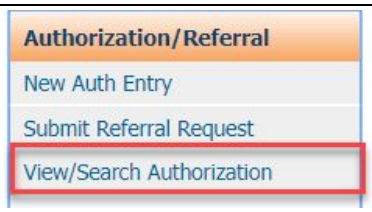
- **Export Options:** There are several options that the reports can be exported to:
  - Crystal Reports (RPT)
  - PDF
  - Excel 97 – 2003
  - Excel 97 – 2003 Data Only
  - Excel Workbook Data Only
  - Word 97 – 2003
  - Word 97 – 2003 Editable
  - Rich Text Format (RTF)
  - Character Separated Values (CSV)
  - XML



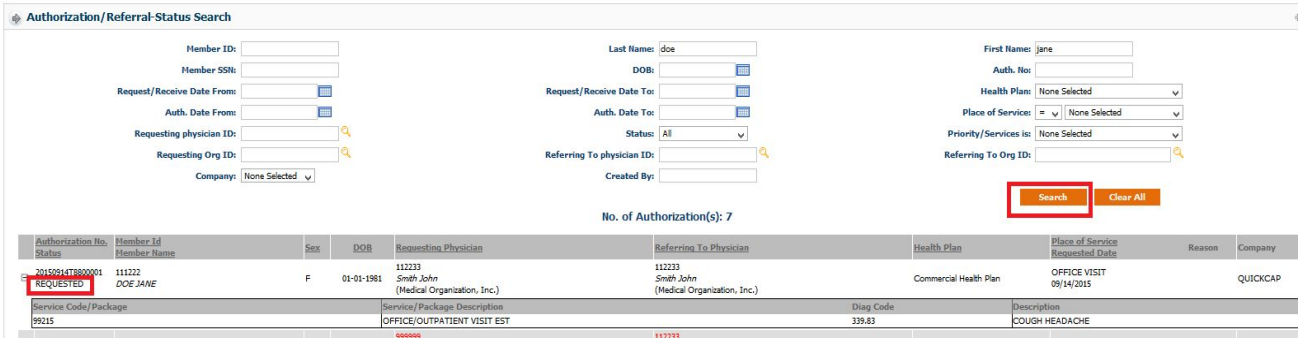
• CHECKING THE STATUS OF AN AUTHORIZATION

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

Step 1: From the **Authorization/Referral** list, select **View/Search Authorization**.

	The View/Search Authorization submodule

Step 2: The **Authorization/Referral Status Search** screen will display as shown below:



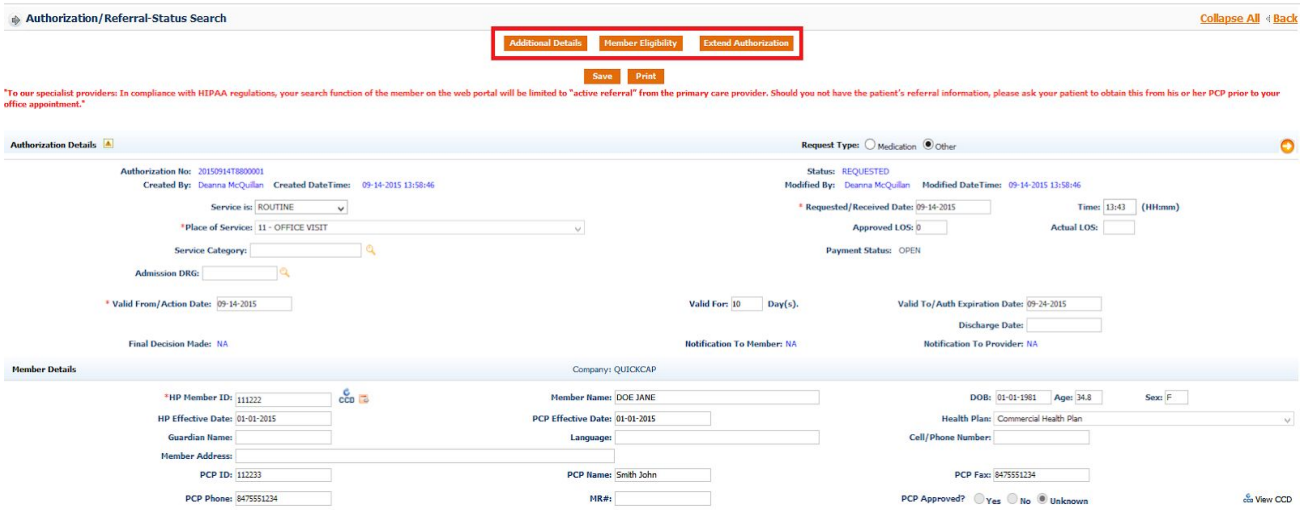
Step 3: The first section is where users search for authorizations. Enter search criteria in any of the available fields. The search results will display in the results section below.

Step 4: Click the (**+**) icon to view the services requested in the authorization. The service information will be visible.

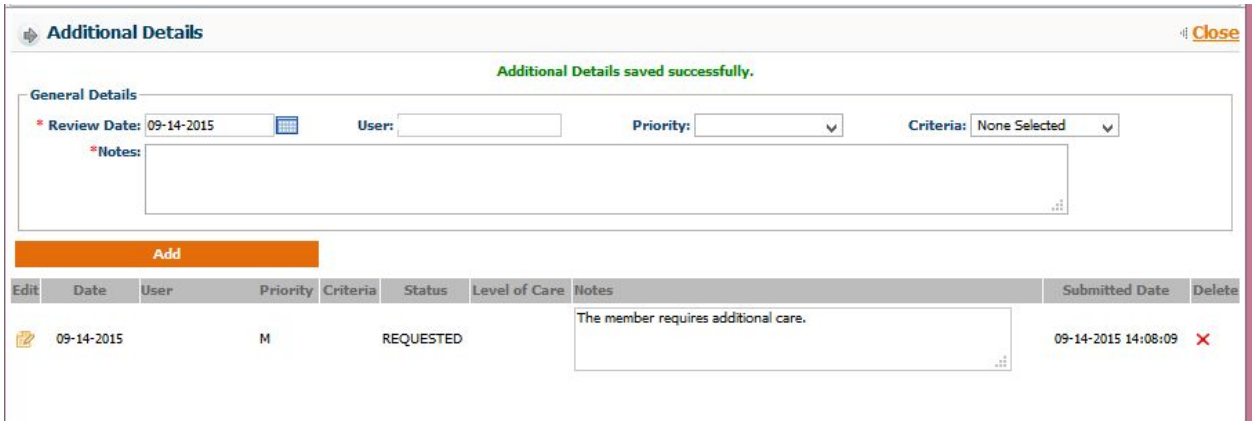
Step 5: The status of the authorization (requested, approved, denied) is displayed in the **Authorization No. Status** column.

Step 6: To view all of the information for a specific authorization, click on the row for the authorization. This will redirect users to the **Authorization/Referral Status Search** screen with all of the authorization details.

Note: This screen is only for viewing purposes. Only a few sections are enabled.

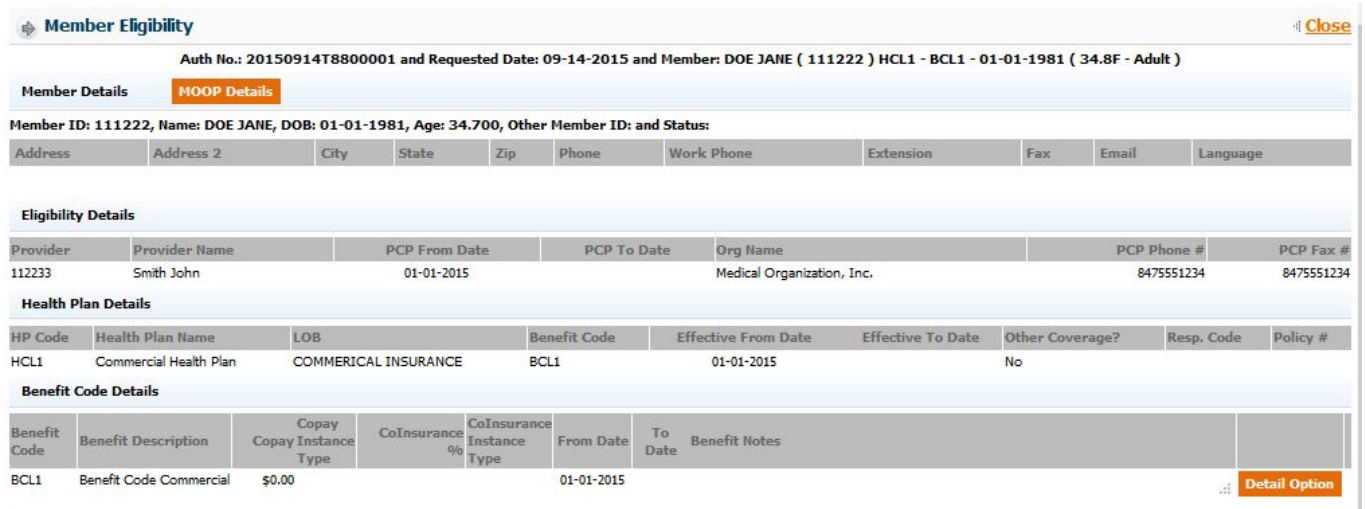


Step 7: To add additional details to the current authorization request, click the **Additional Details** button. The **Additional Details** screen will populate as shown below.

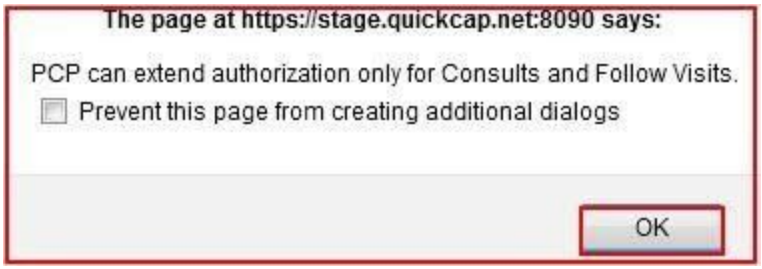


- In the **General Details** section, select the review date, priority of detail and criteria. Enter the information needed in the **Notes** field**.** Click the **Add** button to save the details.
- If you want to edit already added details, click the **Edit** icon.

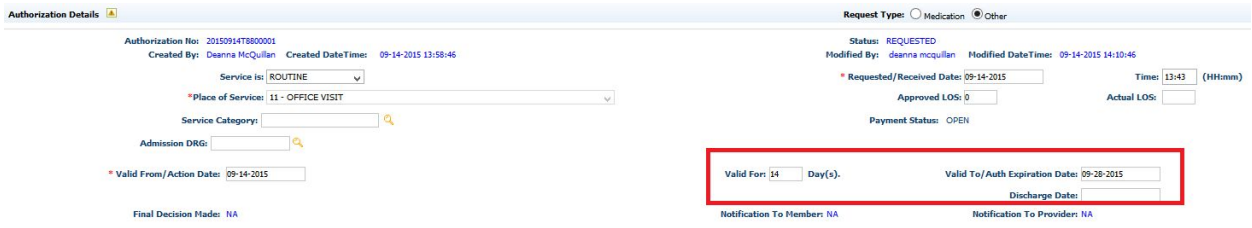
Step 8: To view the member's eligibility details, click the **Member Eligibility** button. The **Member Eligibility** screen will populate as shown below.



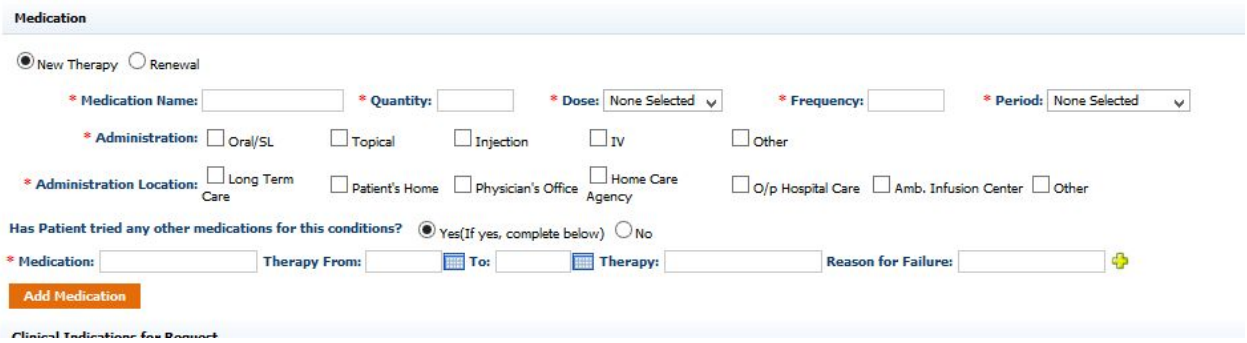
Step 9: If you want to extend the date of authorization, then click the **Extend Authorization** button. A message will pop up as follows.



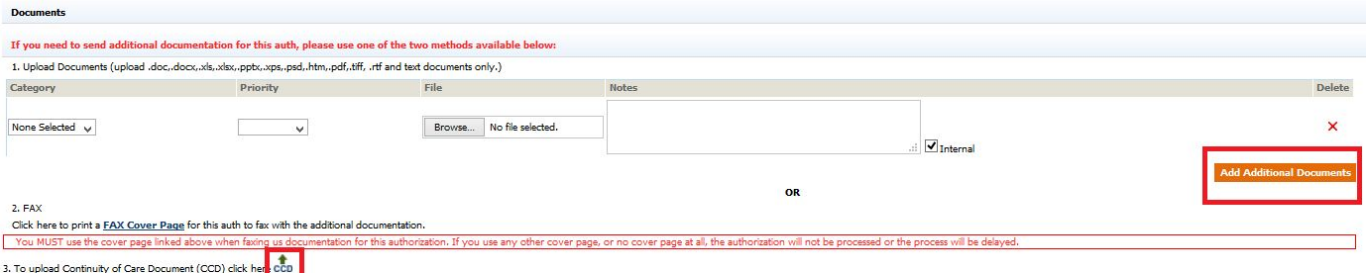
- Click the **OK** button. This will redirect the user to the **Auth Expiration Date** field. Users can extend by either entering the new authorization expiration date or by entering the number of days in **Valid For** field.



Step 10: Users can add medication details and edit existing medication details from the **Medication** section.



Step 11: Users can send additional documentation related to the referral by adding the attachments in the **Documents** section.



Step 12: Click the **Save** button to save the updated request.

❖ CLAIMS

From the **Claims** module, users are able to submit a new claim view and search for previously submitted claims.

• SUBMITTING A NEW CLAIM

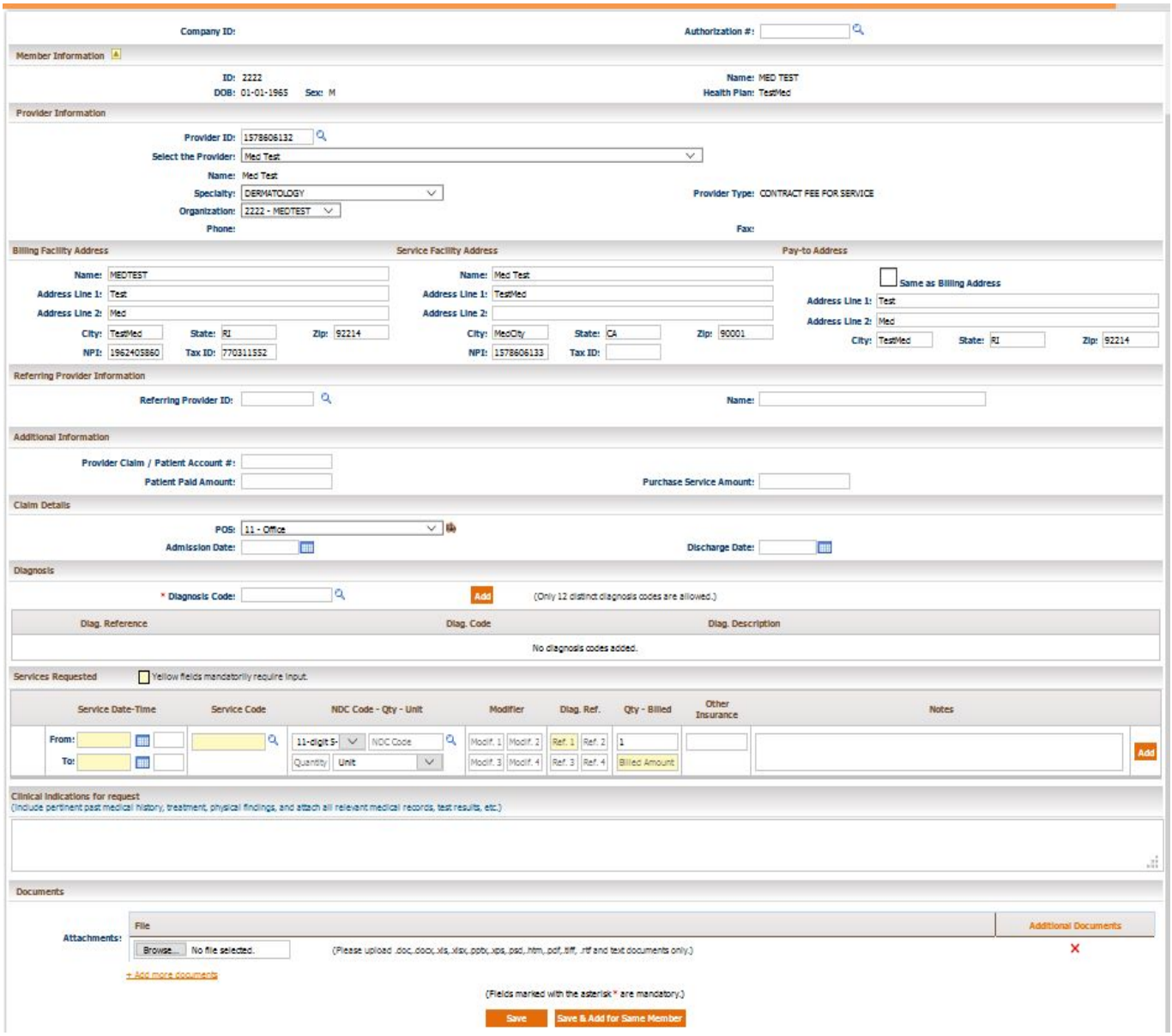
To submit a new claim, follow the below:

Step 1: From the **Claims** list, select **Provider – Direct Submission**.

Step 2: The screen will display as shown below. Look up the member for which you want to add claim for, using Member ID or Last Name, DOB and HealthPlan, by adding details in search and clicking on search icon.

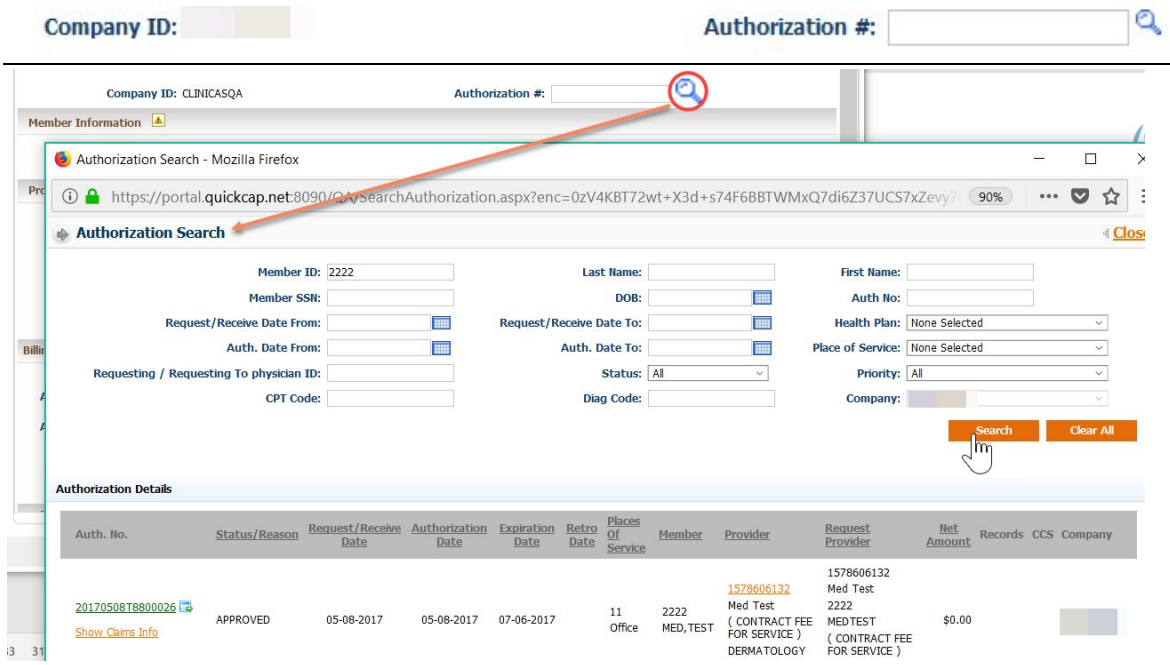
Step 3: Once you have the member record in result field, click on Submit claim button at the left-hand corner of the member record.

Step 4: Once the button is clicked, system will re-direct to the screen to add claims. Please refer to the image on next page of how the screen will look now. There is a total of 10 sections to fill the details.



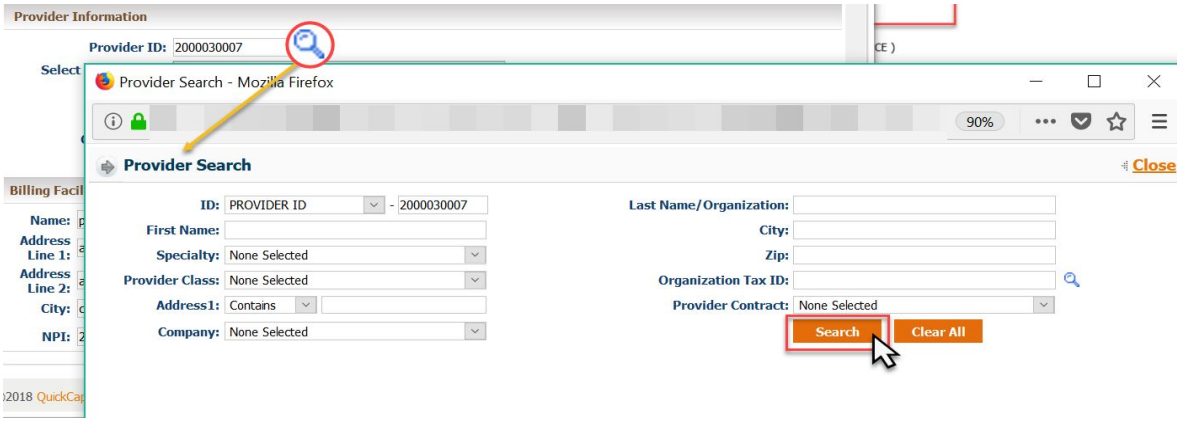
Step 5: Below are the steps to add details on the claim:

- Add **Authorization number** on the claim. You can click on the magnifying glass to look up an authorization from the system. Click on the Auth# to select the auth for this claim.

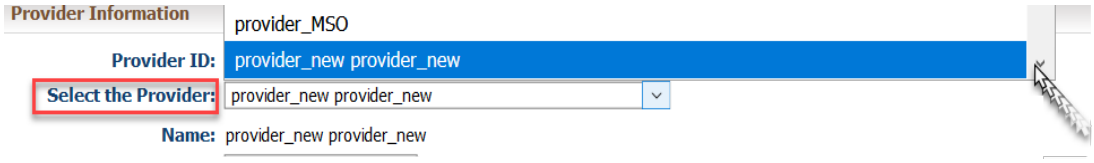


- Basic **member information** will automatically populate, based on the member we selected initially before we clicked **Submit Claim**

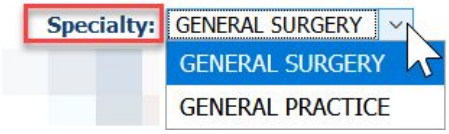
- Under **Provider Information** section, you can choose the rendering provider for the claim. Provider can be selected using two options
  - **Provider ID** search using magnifying glass, to look up provider using filters. Once you have the provider in result grid, click on the ID to select the provider.



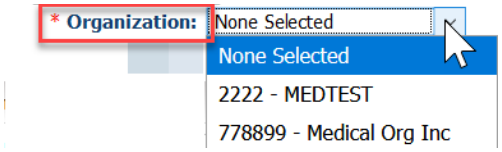
- Select the Provider drop down. which will show you all providers under your organization.



- Once you have selected the provider, all other details will be auto-populated.
- If you wish to change the specialty of the provider (In case the provider is multi-specialty), click on the specialty drop down.



- If you wish to change the organization (Billing entity) you can click on the drop down to choose from different organizations linked to this provider.



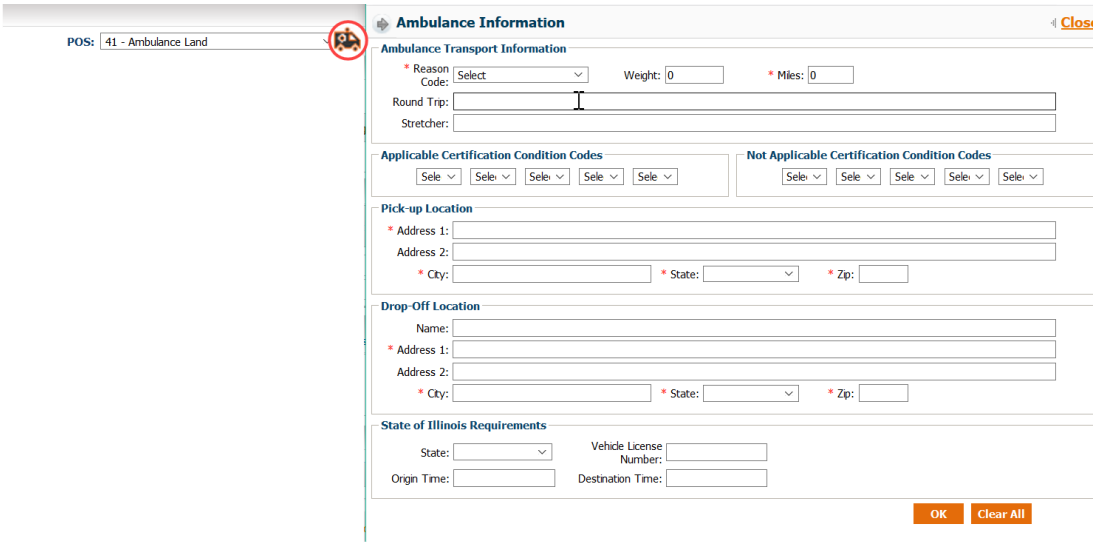
- Addresses – **Billing**, **Service** and **Pay to**
  - These addresses will auto-populate based on the provider and organization selected. However, if you wish to manually override it, you can.

- **Additional Information** section will let you add additional details on this claim like
  - **Patient Account #**
  - **Patient paid amount**
  - **Purchase service amount**

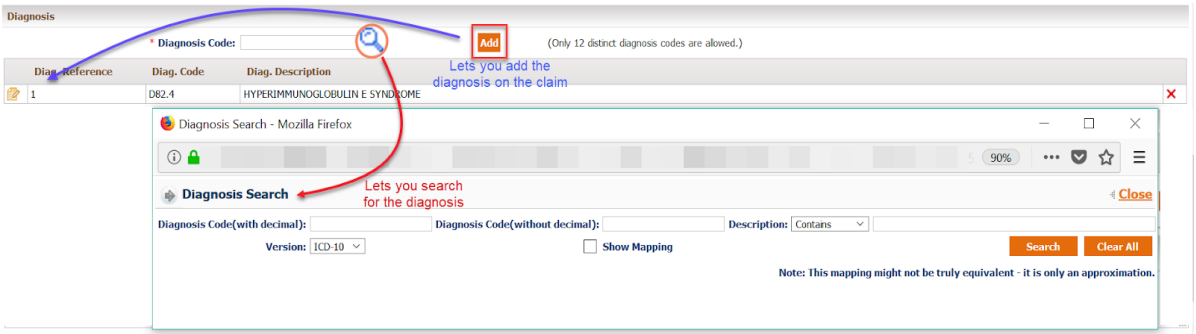
- **Claim Details** will let you enter the **POS** of this claim.
  - When the POS added is an inpatient POS, it lets you add the admit and discharge date.

Note: In case of inpatient claim, it is mandatory to add Admit date.

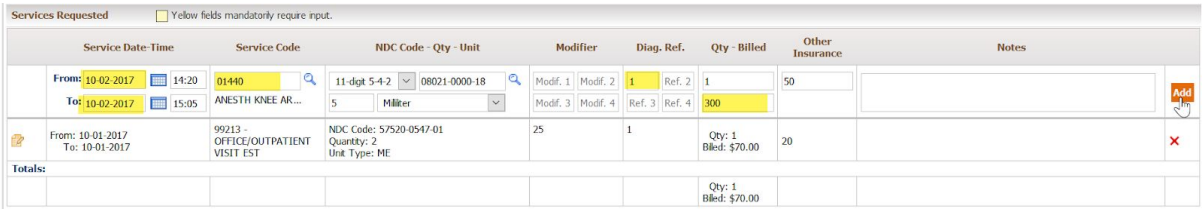
  - When the POS is Ambulance, the ambulance icon gives you pop up to add ambulance details. Fill in the details and click on OK to save the ambulance details.



- **Diagnosis** field lets you add 12 distinct diagnosis on the claim. You can either type in the diagnosis code (Tab Out) and hit add OR you can look up the diagnosis code using the magnifying glass.

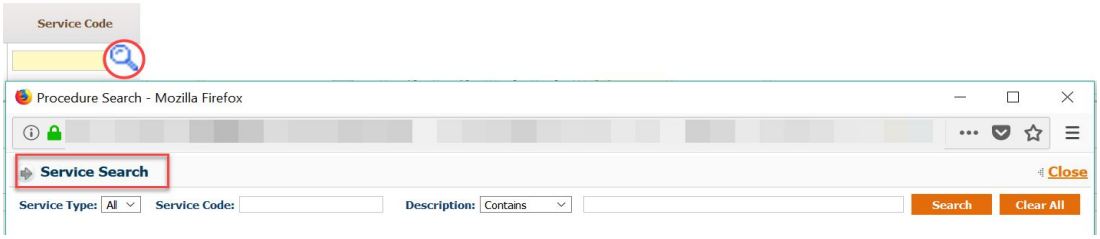


- **Services** lets you add all the details for procedures to be billed on this claim.



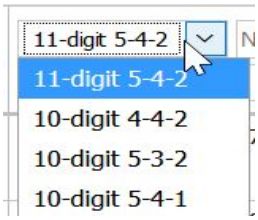
  - Below are the details you can add on the service line
    - **Service From** and **Service To** *date and time*. (Advised to add time for Anesthesia claims)

    - **Service code/Procedure code.** You can type in or look up from the magnifying glass icon. Click on the code to add on claim.

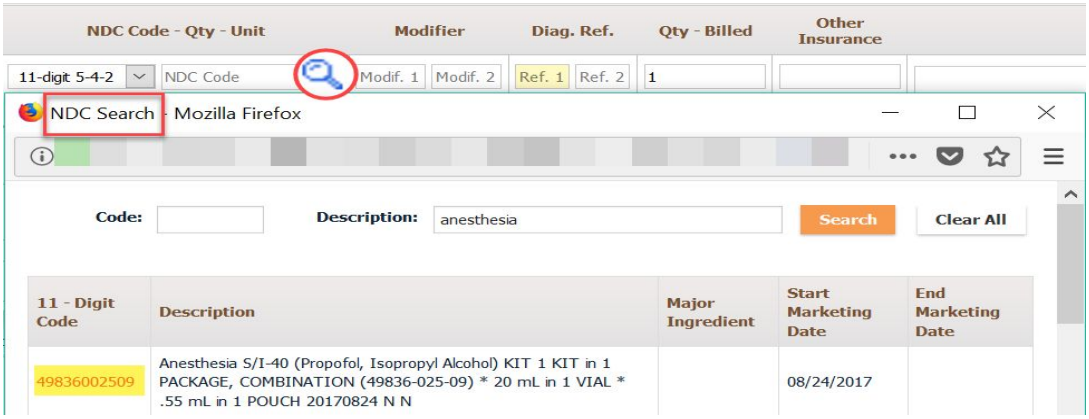


    - **NCD Code – QTY – Unit. (Mandatory to add for all J codes)**

- You can add NDC code in different formats. Format can be selected from the drop down.

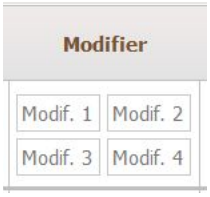


- Once you have selected the format, you can add your NDC code or look up using the magnifying glass.

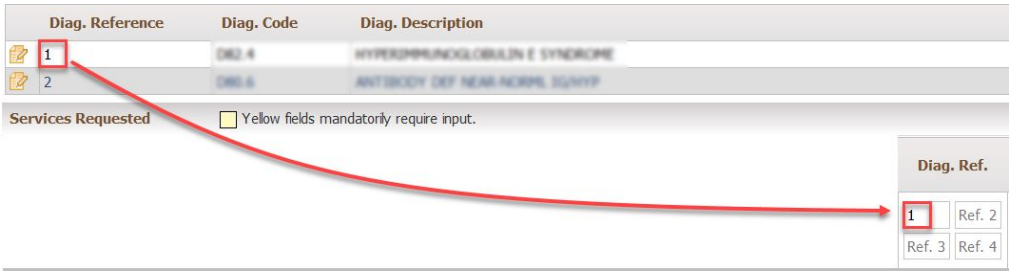


- QTY is the space provided to define the number of quantity for the drug specified on NDC code
- Unit, lets you choose the unit for the code

- **Modifier code** lets you add four modifiers on each service line



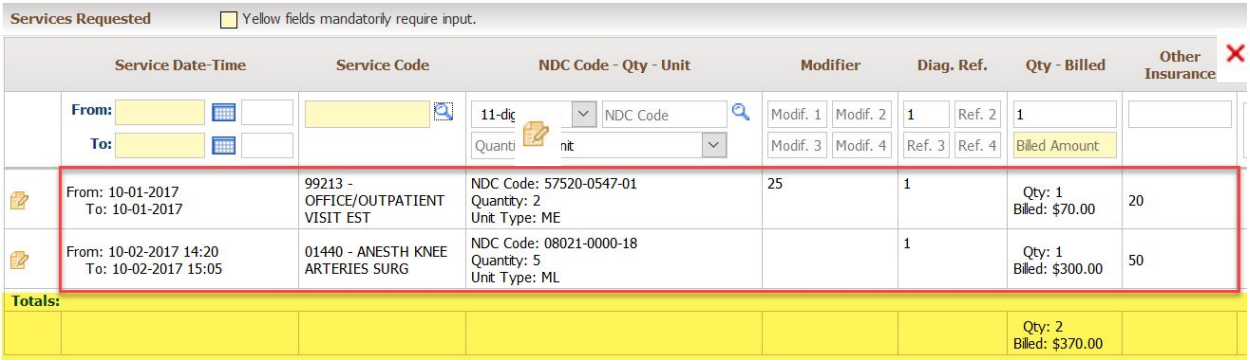
- **Diagnosis code ref,** lets you add the diagnosis code indicator for each service line. Please add numeric value in this to indicate the diagnosis code place value you would like to add.



- **QTY** is the quantity for the procedure code you want to bill.
- **Billed** is the billed amount for this procedure code
- **Other Insurance** is the amount received from Primary insurance if this is secondary claim, etc.
- **Notes** lets you add service level note if needed. Any significant detail for this line item can be sent here.

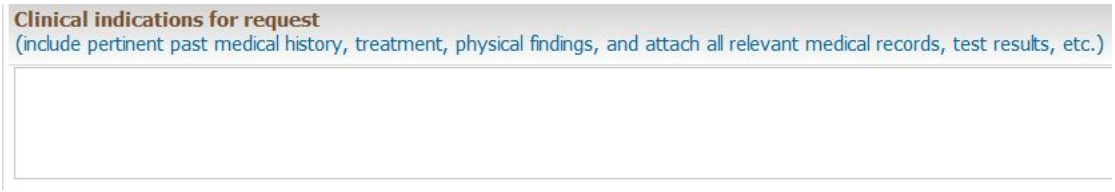
- **ADD** icon adds these details and makes these fields blank again for the next line item

o Once all details are added, you can see the detail lines added and their total below them.



***Note**: To delete a line item added in error please click on the Cross icon at the right end of each service line. To merely update the details, click on the edit the icon on extreme left of the service line.*

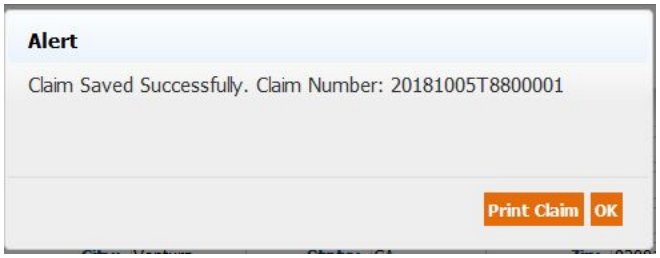
- **Clinical Indication** is a section where you can add additional details to be submitted on the claim. This can contain patient's history, medical findings or any relevant records.



- **Documents** let you attach any relevant document about the claim being submitted. You can attach files with the type as mentioned on the screen.
  - To add document, click on Browse, to select a file from your machine.
  - To add more than one document click on the link for **+add more document.**
  - To **delete** a document attached before submitting claim, you can hit the cross on the right.

Step 6: Once all the details are added**,** click on **Save to submit the claim** for processing**.** You can also use **Save & add for same member** if you wish to add another claim for the same member.

Note: Once the claim is saved it will give you a pop up with claim number, as shown below. You can click on **OK** to go back to the screen. If you wish to print the submitted claim as CMS 1500 click on **PRINT CLAIM**.



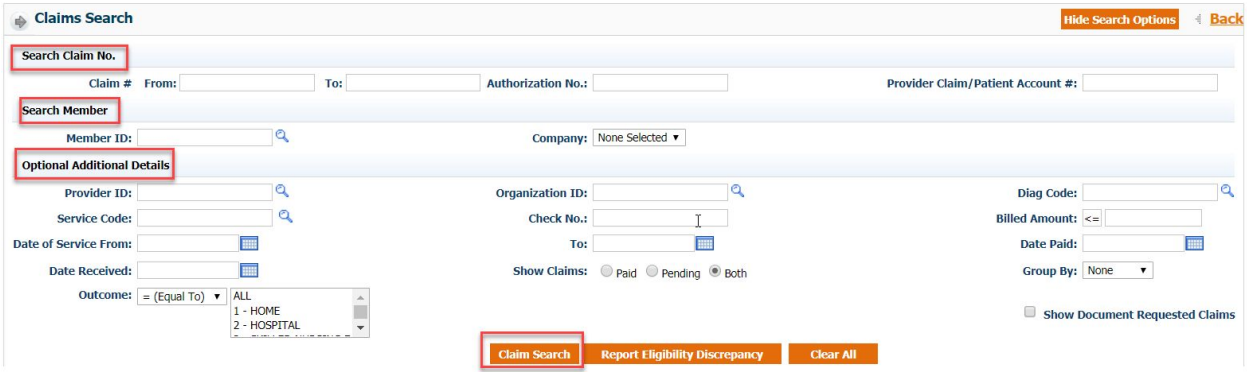
• CHECKING THE STATUS OF A CLAIM

To verify the status of a claim, follow these steps:

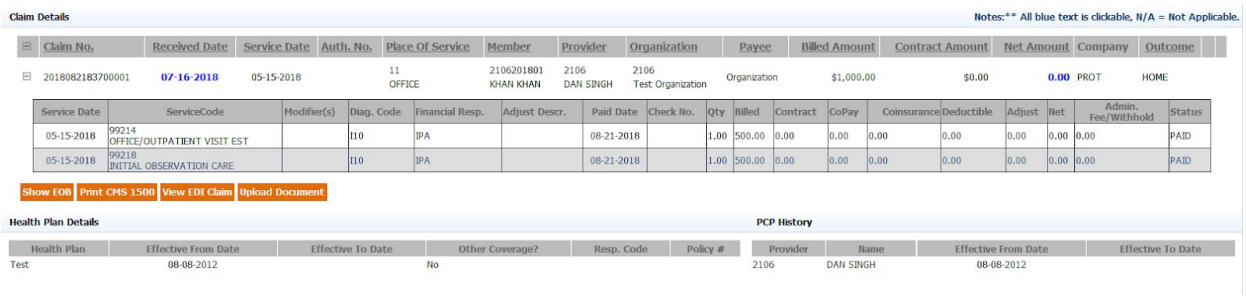
Step 1: From the **Claims** list, select **Claims Status/Search**.

	The Claims Search/Status submodule

Step 2: The screen will display as shown below. On this screen, there are three subsections to search claims by.



Step 3: Based on the criteria users have input, the search results will display in Claim Details section, as shown below.



- The **Status** can be found on the right side in the last box. The adjustment code and net amount on the claim is not finalized and is subject to change until the **Status** is **Paid.**

Step 4: To view and print the claim in CMS 1500 format, click the **Print CMS 1500** button.

Step 5: If the claim is in a **Paid** status, there will be an additional button for **Show EOB.**

❖ ELIGIBILITY

From the **Eligibility** module, users are able to verify a member's eligibility and report any discrepancies.

	The Eligibility module

• VERIFYING ELIGIBILITY

To verify Eligibility for a member, follow these steps:

Step 1: From the **Eligibility** list, select **Member Verification**.

The Member Verification submodule

Step 2: The screen will display as shown below.

Step 3: Users can search for members in two different ways:

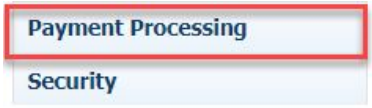
- Search by entering the **Member ID** for the specific person.
- Search by entering the **Last Name, Date of Birth,** and **Gender** of the member; all three fields must be completed.
    - Users can add the **Health Plan, First Name, SSN,** and **Service Date** for a more detailed search.

Step 4: Select **Verify Eligibility**. If the member exists in the system, their details will be displayed as shown below.

- To view additional details about the member's eligibility, click the **magnifying glass** (first icon) under **Details**.
- To print the member's eligibility, click the **Print** button (second icon) under **Details.**

❖ PAYMENT PROCESSING

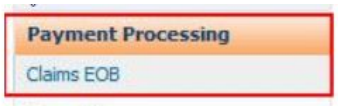
From the **Payment Processing** module, users are able to generate Explanation of Benefits (EOBs) for members that claims have been submitted and paid for.

	The Payment Processing module

• CLAIMS EOB

To print a claims EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Claims EOB**.

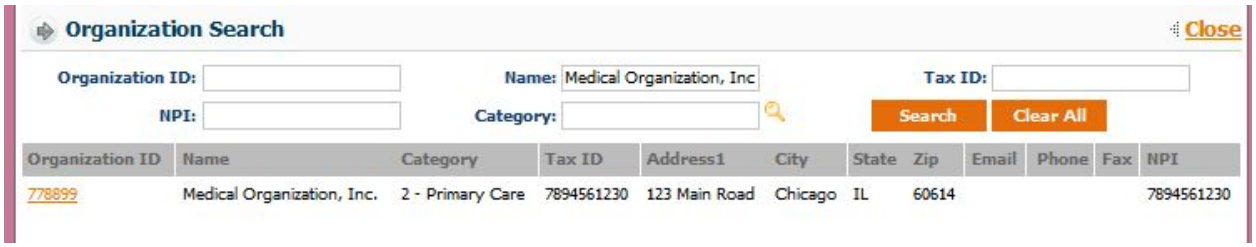
	The Claims EOB submodule

Step 2: The screen will display as shown below.

Step 3: Enter the specific member's name that you want to generate the EOB for**.**

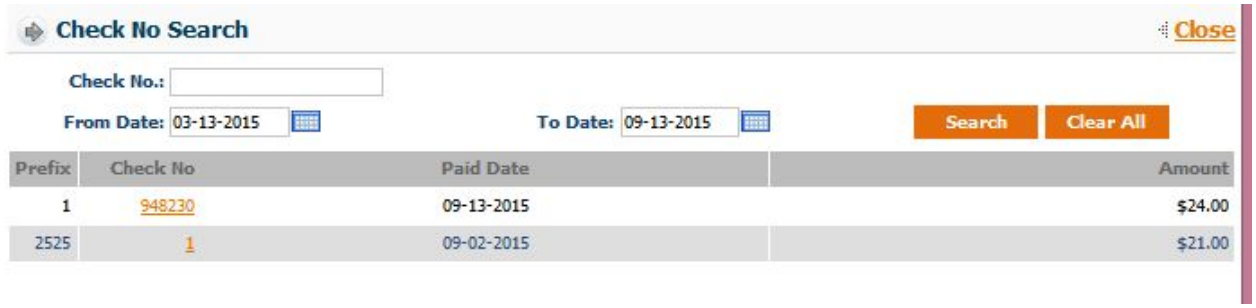
- ***Note*:** Users can skip this search criteria if they want to generate EOBs for multiple members from an organization.

Step 4: Enter the correct organization name or search the organization by clicking the magnifying glass icon. The **Organization Search** screen will be displayed as below. Only organizations that users are affiliated with will show in the search screen.



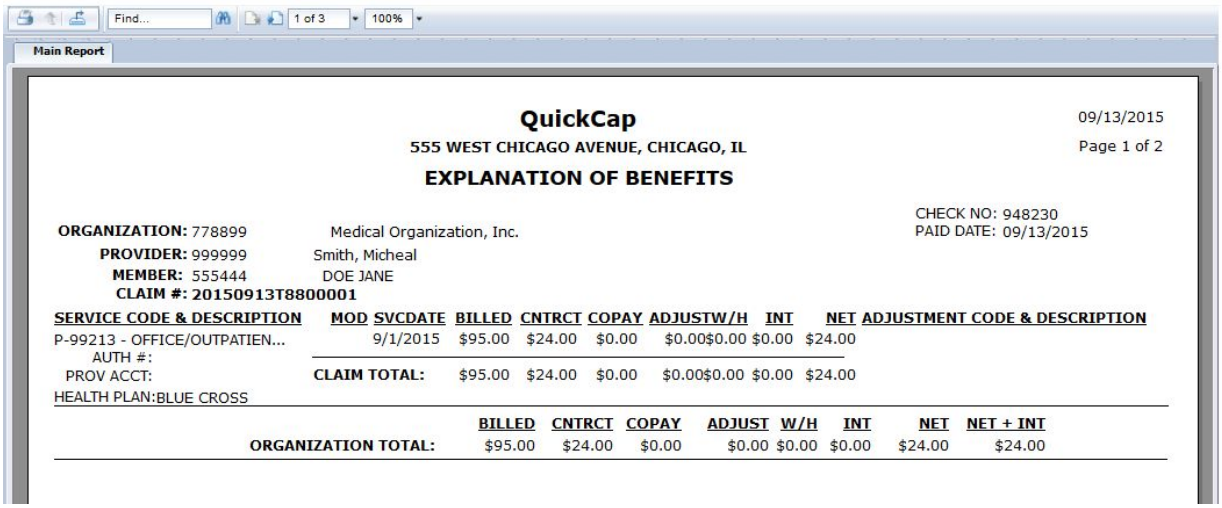
- Search the organization by entering any of the available information.
- Select the organization by clicking the **Organization ID.**

Step 5: Enter the check number that the EOB was paid with. If the user does not know the check number, they can search for the check by clicking the **Retrieve Check** button. The **Check No Search** screen will display as shown below.

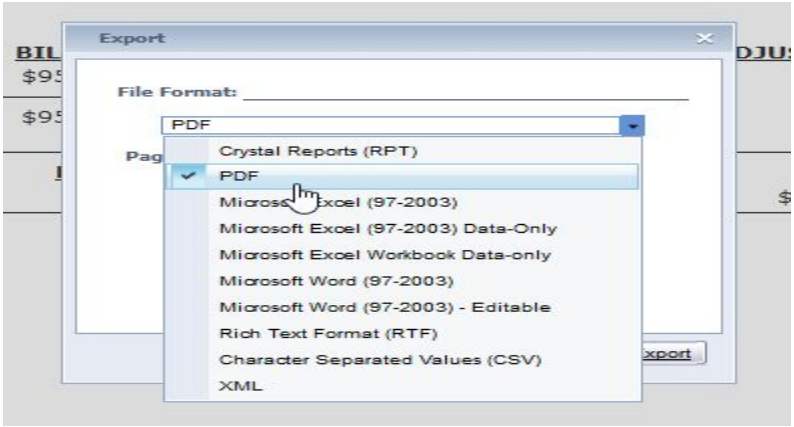


- Search the check by entering either the check number or by entering date ranges. To search for all checks ever paid, leave the fields blank and click the **Search** button.
- Select the check by clicking on the **Check No**.

Step 6: By entering the check number, the **Paid Date** field will be populated with the dates automatically. Click the **Display EOB** button and the EOBs will be generated as shown below.



- To print the report, click the **Print** icon.
- To export the report, click the **Export** icon. An **Export** dialogue box will be populated as shown below.

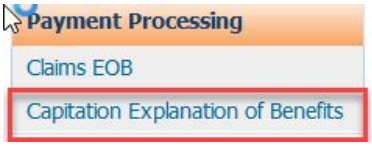


- Select which file format to save the report in.
- Click the **Export** button. The report will be exported in the selected file format.

• CAPITATION EOB

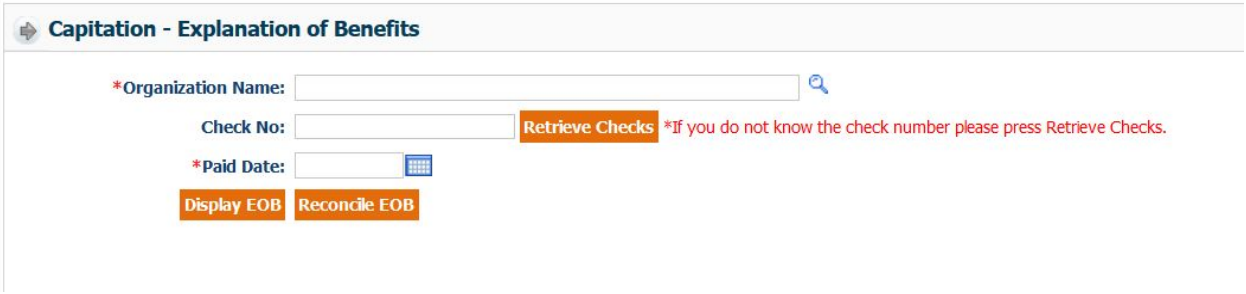
To print a capitation EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Capitation Explanation of Benefits**.



The Capitation Explanation of Benefits submodule

Step 2: The screen will display as shown below.



Step 3: The name of the **Organization** should populate automatically.

Step 4: Enter the **Check Number**, this is an optional field.

Step 5: Enter the **Paid Date**.

Step 6: Click **Display EOB**.

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