# Provider Secure Web Portal Navigation Guide

Quick Reference
Guide

# Provider Secure Web Portal Overview

The Provider Secure Web Portal allows providers to communicate health care service information directly with the health plan. Users can perform a variety of tasks, such as verifying eligibility, checking prior authorizations, checking billing status and more.

## Welcome Screen

The Welcome Screen is the first screen the provider will see after logging into the portal. The Welcome Screen will list Health News, Highlights, and useful links. This screen will also allow the provider to access their My Account, Tasks, Administration, Health Tools, Important Links, and Health Plan Contacts screens. The "**Help"** function located on the top right hand corner of each page outlines the step by steps instructions a user must follow in order to successfully navigate throughout the secure portal.

## My Account

The **My Account** screen allows the provider to view their details, change their password, and view their inbox.

**My User Details**– Page displays information associated with the currently logged-in user and permits the user to make cell phone number and email changes. The provider also has the options to have text messages sent to their cell phone as well.

**Provider Details** – Page displays the providers information including their specialty, any certifications, network affiliation, and provider affiliations.

**Change Password** – Page permits the user to change their password. User must enter their new password and then confirm the same way by re-entering it again.

**Change Security Question**– Page permits the user to change their security question and answer.

**Inbox** – Page displays emails to the user.

**Posts and Notifications**– Page includes important messages or information from the health plan in the form of a file attachment. The message and files are directed to a specific member, provider or provider group and are not general or broadcast communication.

## Tasks

**Search Authorizations** – Page allows the user to search for authorizations. You should refine your search by providing search criteria such as

**Search Authorizations Cont.**
Authorization Status, Authorization Date Range, etc.. The Authorization Date Range is the authorization effective date range. When an authorization is created, the requester submits a date range for which the authorization should be effective. The procedure Date of Service falls within the authorization effective date range.

**Search Claims**– Page allows the user to search for claims. You should refine your search by providing search criteria such as Claim Status, Claim Type, Date Range, etc.

**Search Remittance**– Page allows user to obtain and display remittance advice detail based upon a paid claim. This page allows you to search for (and generate) a list of paid claims.

**Search Member**– Page allows users to search for a member. You may search Last Name and Date of Birth or by Member ID. If searching by Member ID you may search for up to (5) members at a time.

**Panel Roster**– Page allows the user to generate a list of members who have designated the provider to be their primary care physician (PCP).

**Search Provider**– Page allows user to search for a provider based upon various criteria. You may search by Name, Provider Type, Provider Specialty, City, Zip Code or by Provider ID. You may also search the provider search tool located on our public website. (additional values will appears in this web search) http://www.aetnabetterhealth.com/ohio/find-provider

## Administration

**User List**– Page allows user to search for a portal user within your organization. You may also search

**Add Users**– Page allows user to manually create a new portal user, if the self-registration process cannot be followed.

The following are the basic steps for Add User:

Select a User Type. Depending on the user type, one of the following displays:

- For an Health Plan User, only the ID field will be shown. Enter the Aetna ID (A/N) and click Verify for validating the user. Once validated accept the declaration form and proceed with user registration.

- For a Provider, Provider ID, TIN/SSN and NPI fields will be displayed. Enter at least the provider ID and click Verify for validating the User. Once validated accept the declaration form and proceed with registration.

- For a Member, Carrier Member ID and Last Name fields will be displayed. Enter at least the Carrier Member ID and click Verify for validating the user. Once validated accept the declaration form and proceed with registration.

# Health Tools

**Submit Authorizations**– Page allows user to look up and request authorizations. Please review the Authorization Submission User Guide (Care QI) under Important Links for step by step instruction on how to use the authorization portal. The guide will cover the following:

- **Request Queue** – Displays the users submitted prior authorizations. You're able to filter by submission status, draft authorizations, and submitted authorizations. To review details about the specific authorization, select the authorization number.
- **Request Detail** – Messages can be associated to an auth. To view any messages either placed by the user or the Health Plan, click on the "Message" button. You may also add a message by clicking the same button.
- **New Prior Authorization Request** – Asterisk (*) must be completed. Requesting providers and members an be searched by last name or provider ID. Request types include Outpatient Procedure, Inpatient – Medical, Inpatient – Surgical or Inpatient – Behavioral. Submit & Auto Approved Patient's diagnosis code may be searched by code or description or a portion of either. More than one code may be added or deleted.

- **New Prior Authorization Request Cont. –** When a procedure is added, the 'documentable' checkbox is checked. *The box should remain checked if you want the health plan to evaluate and authorize the procedure.* The Facility can be searched by last name or provider ID or a portion of either. You may also select NA or Not Applicable. Enter the Date of Service (or your estimate of the DOS). Select the Level of Care and mark Urgent (if applicable). The Servicing Provider can be searched by last name or provider ID or a portion of either. Add any notes/detail. Acuity Types include: Elective, Urgent or Emergency The 'Authorization Start Date' should be entered as the current date or a date in the future BUT not a date in the past. The 'Authorization End Date' is typically entered as a date 60 – 90 days in the future. The actual procedure 'Date of Service' should fall within the Authorization Start Date and the Authorization End Date in order for the claim to adjudicate properly. For Requester Type, providers should always select 'Provider'. Select NEXT to advance the authorization request OR select CANCEL.
- **Validate / Update Units –** Validate or update units requested for each procedure submitted. Select the NEXT button or select BACK to correct or update the previous entries.
- **Review Request –** Review the request for accuracy and add any file attachments as support. Note that the Request Status is 'NoDecisionYet' – the request may be corrected or canceled if necessary. If the request is ready to be advanced, select the DOCUMENT button to apply a guideline/clinical criteria to the requested procedure (s). Each procedure code is subject to being 'documented' if a guideline exist. Example: If a request has (2) procedures, each one will be evaluated.
- **Document Procedures–** Complete the statements by selecting all that apply. Depending upon the procedure and/or diagnosis additional statements will be presented for completion. After completing each statement, select NEXT or BACK to revisit previous pages.
- **Final Review -** The request summary is presented again for final review and it now includes the guidelines and clinical indications as declared. Note that the request is still in a status of 'NoDecisionYet'. You have the option to 'Re-Document' the procedure. Note the disclaimer at the bottom of the page. There are three actions that can be taken: 1) Select the SUBMIT button 2) Select the BACK button to review or correct previous work or 3) Select CANCEL REQUEST. Select SUBMIT
- **Submitted & Auto Approved -** Based upon RULES previously defined, this example prior authorization request is automatically approved. Note that the Request Status is: Completed – Approved. The requester's next step is to return to the Auth Queue or select Cancel. *We recommend that the requester contact the health plan if they desire to cancel a request that has been submitted.*

**Care Management** – Page allows user to access the "Member Care Portal". Providers are able to do the following via the Member Care Web Portal:

- For their Practice:
    - Providers can view their own demographics, addresses, phone, and fax numbers for accuracy.
    - Provider can update their own fax number and email address.
- For their Patients:
    - View and print member's care plan[*] and provide feedback to Care Manager via secure messaging.
    - View a members profile which contains:
        - Member's contact information
        - Member's demographic information
        - Member's Clinical Summary
        - Member's Gaps in Care (individual enrollee)
        - Member's Care Plan
        - Member's Service Plans
        - Member's Assessments responses[*]
        - Member's Care Team: List of member's TCMT team and contact information (e.g., specialists, caregivers)[*], including names/ relationship
        - Detailed member clinical profile: Detailed member information (claims-based data) for conditions, medications, and utilization data with the ability to drill-down to the claim level[*]
        - High-risk indicator[*] (based on existing information, past utilization, and enrollee rank)
        - Conditions and Medications reported through claims
        - Member reported conditions and medications[*] (including Over The Counter (OTC), herbals, and supplements)
    - View and provide updates and feedback on "HEDIS Gaps in Care" and "Care Consideration" alerts for their member panel[*]

**Care Management Cont.** –
- Secure messaging between provider and Care Manager
- Provider can look up enrollees not on their panel (provider required to certify treatment purpose as justification for accessing records)

**Prior Authorization (PA) Search Tool** – This page allows user to search Aetna Better Health's authorization search tool.

**Contact Health Plan:**
Our Provider Services Department is here to answer any questions you may have about our Provider Secure Web Portal. Please call our toll free number at 1-855-364-0974 between the hours of 8 a.m. and 5 p.m. E.S.T., Monday through Friday to be connected to a representative.