QUICK START GUIDE

PROVIDER PORTAL
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INTRODUCTION

The Provider Portal is a robust tool which allows providers to submit and view data, as well as communicate directly with the organization. Within the portal, providers can perform key tasks including entering authorization requests, printing EOBs and performing eligibility verification. The portal also allows providers to create their own customer service requests, submit documentation, generate membership utilization reports, and communicate directly with their organization using a secure channel. Each of these functions serve to make your provider staff happier and more efficient, while reducing their need to make phone calls to the organization.
ELIGIBILITY

From the Eligibility module, users are able to verify member eligibility that is present in the IPA/medical group system. This may be useful if you are unable to find your member and wish to see if they exist in the system. From this module, you may at this point also notify the IPA/medical group of any eligibility discrepancies if you believe the member is in fact eligible.

MEMBER VERIFICATION SCREEN

From this screen, users are able to verify member eligibility.

Step 1: QuickCap Portal -> Left Panel -> Eligibility -> Member Verification

Step 2: The Eligibility - Member Verification 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 search by the **Health Plan or Service Date** if they want to be more specific. Regardless, it is mandatory to enter the member’s last name, date of birth, and gender.

**Step 4:** Click the **Verify Eligibility** button. If the member exists in the system, their details will be displayed as shown below. You will be able to see demographics, plus benefit, eligibility, PCP and family information.

- To view additional details about the member, click the **Details** icon. More member information will be visible as shown in the figure above.

**ELIGIBILITY DISCREPANCY**

From this screen, users are able to add eligibility discrepancies for members and search for existing member eligibility discrepancies. The **Eligibility Discrepancy** screen is where providers can communicate regarding any member eligibility matters. Providers can easily add member information for those who do not exist in the system along with Proof of Eligibility or update current eligibility. Once it is reviewed by the IPA/medical group, they will send a determination back to you notifying you if they’ve added the member to the system, or have determined the member is still ineligible.

**Step 1:** **QuickCap Portal** -> **Left Panel** -> **Eligibility** -> **Eligibility Discrepancy**

**Step 2:** The **Eligibility Discrepancy** screen will display as shown below.
Step 3: The first section in this screen is **Add/Edit Eligibility Discrepancy**. Users add eligibility discrepancies for members in this area.

- Select the type of discrepancy being reported (Member not Exists, Update Eligibility) in the **Type** field.
- Enter all of the details of the member. Any field with a red asterisk is required to save the discrepancy.
- Any supporting documentation that needs to be submitted as proof of eligibility can be uploaded in the **Proof of Eligibility** field. Click the **Browse** icon to search for the file on your computer. **Note:** The document size should not be more than 120 MB.
- Click the **Save** button to add the Eligibility Discrepancy.

Step 4: On the right of the screen is **Search Eligibility Discrepancy**. From this section, users are able to search for any existing eligibility discrepancies for their members.

- Complete any of the available search fields based on the needed criteria and click the **Search** button. The search results will be displayed as shown below.

![Search Results](image)

Step 5: Users can export the search results in Excel by clicking the **Export** icon.

Step 6: To edit an existing Eligibility Discrepancy, click the **Edit** icon and update the information. Click the **Update** button to save the updated Eligibility Discrepancy.
AUTHORIZATION/REFERRAL

From the **Authorization/Referral** module, users are able to submit referral requests, as well as view and search for requested authorizations.
**AUTHORIZATION REQUEST SUBMISSIONS**

This module will allow you to submit your own referral requests electronically and directly to your IPA/medical group. Please follow the steps below to accomplish this task.

**Step 1: QuickCap portal -> Authorization/Referral -> New Auth Entry.** The New Auth Entry screen will open as below.
Step 2: The first section is on the top-left and contains member information. Users can enter the member’s information in one of two ways:

1. Enter the Member ID for the specific member. The system will be 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.

2. 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 either exact parameters or a combination of Member ID, Health Plan, First Name, Last Name, and DOB to find the record. This section will also show you all members in the system that fit the criteria specified. Double click the correct record to add it to the authorization request.

Note: Some health plans or IPA/medical groups use a prefix and/or suffix for Member IDs mostly with commercial plans. If you are unable to pull up the member using their ID, please try again without the prefix or suffix. For example, if XOH00001 fails, try entering 00001 instead.
**Step 3:** The details for the selected member will be populated on the screen as pictured below. 

NOTE: the system will default the **Requesting Provider** information field to match your organization’s.

![Member Details](image1)

**Step 4:** The section to the right of the **Member Details** is the **Authorization Date/Details**. The **Requested Date** field is non-editable and will always default to the date of submission.

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

![Authorization Date/Details](image2)
Step 5: The user is then can select the **Priority** and the **Place of Service** for the request.

<table>
<thead>
<tr>
<th>Authorization Date/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>*<strong>Priority:</strong></td>
</tr>
<tr>
<td><strong>POS:</strong></td>
</tr>
<tr>
<td>ROUTINE</td>
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<tr>
<td>APPEAL</td>
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</tr>
</tbody>
</table>

- Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear.
  - **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.

  ![Required information for urgent requests](image)

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

  ![Authorization Date/Details](image)
Step 6: 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.

1. 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.

2. If the provider has multiple offices, users can select the correct office from the dropdown menu.
Step 7: The next section, Referring to Provider Information, allows users to enter the information for the provider that member is being referred to.

There are multiple options for selecting a Referring to Provider. Please read and understand each selection below for optimal use and understanding of the system:

1. For self-referrals, select the “Same as Requesting Provider” checkbox. This will auto-populate the information from the Requesting Provider screen.

2. If you are referring to a specialty only, meaning you do not have a provider name, please select the specialty from the Specialty field. Then, the system will populate all providers in the IPA/medical group’s system into the Provider pull-down menu to the right of it. You may then either select a provider from that list, or may always select Unassigned Provider, which defaults at the top of each specialty.

3. To search for a Referring To Provider using information such as city, first name, last name, organization name or other, 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.

Once your provider is selected, the information will appear in the section such as below:

- Then, select the Referring Office from the dropdown menu.
Step 8: Optional. Users can enter **Facility Provider Information** for the request, if needed. You may either search by selecting from the pull-down menu **Fac Prov**, or may search using the magnifying glass to the right of the **Fac-Prov ID** field.

Step 9: 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 to move to the next diagnosis code. The system will populate the description to the right in the **Diag. Description** field. The system will also auto suggest codes if codes are only partially entered.
  - To search for the diagnosis code by part of the code or a descriptive word, 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 10: 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 to search by part of a code or by word description.
- If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated or groups of codes that would all be acceptable for approval. 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 11: 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.

![Clinical Indication For Request](image)

Step 12: The second information tab is **Additional Details**. Within this tab, three more sections will appear.

Step 13: 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.
- The **FAX (Fax Cover Page)** allows users to fax the documents.

**Note:** This may not be enabled for all organizations. Please contact the **Systems Administrator** at the group for more information.

- To properly link the documentation to the request, the cover page must be submitted with the authorization request. If not, it will cause delay or the documentation not to be processed.

Step 14: This section is optional. Users have the ability to upload the **Continuity of Care Document (CCD)**. Click the icon and the **CCD Data Upload** screen will open.
On this screen, the member’s name will auto populate. Users can also search the member by clicking the Magnifying Glass icon.

Select the CCD Data type. Users can upload the XML file or paste in the XML Data.

To upload the file, click Browse. To manually enter the XML data, paste the XML data in the text field.

Click the Save button.

Note: Users can upload or enter XML data only.

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 1: 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.

Note 2: Users will also be unable to modify any authorization once it has been submitted to the IPA/medical group. If you wish to request a change, you must do one of three things:

1. Use the communication link that is provided on the authorization itself. This button is pictured below and is the envelope next to the word Authorization. This opens up an internal communication tool which looks similar to an email. This is secure and you may send information to and from the IPA/medical group using any sensitive information needed. To send to the UM department, simply begin typing “UM Department” and this entry will appear for you. You only need to click on it to be sent.
2. Use the customer service module described in another section, or
3. Call the IPA/medical group.
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
REVIEWING A REFERRAL / AUTHORIZATION AFTER SUBMISSION

After submitting the authorization, users are able to view the request by clicking back on the left module panel and selecting the View/Search Authorization module.

Step 1: Use any of the search criteria fields available to search for the specific referral or authorization request. Click on the Search button to populate the results.

Step 2: After the referral/authorization request populates, click on the link to view the request.

Step 3: The user will be redirected to the Authorization Detail screen. Users can review the request; internal users can update the statuses.
CLAIMS

From the Claims module, users are able to submit claims for payment. Users can also view and search for previously submitted claims.

CLAIMS SEARCH / STATUS SCREEN

From this screen, users are able to view and search for submitted claims. You will as a default see all of your organization’s claims listed at the bottom. You may further use any of the filters available to see only the claims you are searching for.

Note: For sections with ID, you may click on the magnifying glass to pull up other options to search for those specific entities.

Step 1: QuickCap Portal -> Left Panel -> Claims -> Claims Search/Status

Step 2: The Claim Search screen will display. 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.

Step 4: To view the service details of the claim, click the (+) icon. The details of the service will open.

Step 5: To view more details about the claim, click anywhere on the row. The Claim Details screen will display as shown below.

Step 6: If there is an associated authorization, the number will populate in the Claim Details. To view more information for the authorization, click on the Authorization Number. The Authorizations screen will display as shown below.
Step 7: To view the provider details, click on the Provider ID. The Provider Details screen will display as shown below.

Step 8: To view and print the claim in CMS 1500 format, click the Print CMS 1500 button.
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.

CLAIM EOB

From this screen, users are able to generate EOBs for paid claims.

Step 1: QuickCap Portal -> Left Panel -> Payment Processing -> Claims EOB

Step 2: The Claims - Explanation of Benefits 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 5: 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.
CUSTOMER SERVICE

From the Customer Service module, users are able to add and view existing customer service requests for their organization. This module provides a request tracking system without the back and forth of telephone calls. You may log information requests or complaints regarding claims, authorizations, provider services, member services, and IT services, among other options. The customer Service Request link will be found under the Customer Service Module link, as pictured below.

ADDING CUSTOMER SERVICE REQUESTS

From this screen, users are able to add customer service request into the portal. Once an external user submits a request, internal users will then be able to review and process as needed.


Step 2: Click the Add button shown to the left in the below screenshot.

Step 3: The Customer Service Request – Add screen will populate. Users can fill in the information below to submit a request. The fields with asterisks are required.

- **Call Regarding:** This dropdown menu allows users to select the purpose of the call. For example, the call could in regards to claims or authorizations.
- **Priority:** This allows users to select the severity between low, medium, and high.
- **Pref. Comm:** This field represents the best way to contact back incase follow up is needed. The selection includes Fax, Email, and Phone.
- **Reason:** This field indicates what the user was calling in regards to. Depending on the field selected above from the Call Regarding field, the Reasons will change.
- **Problem/Description:** Users can add a description to explain further the purpose of this request. This information will assist the representative reviewing the request.
- **Attachment:** Users can attach any documents that would aid the representative in completing the request.
Step 4: Press **Save** to submit the request. A customer service request reference number will be given upon saving the request. This can be used later to check for updates.

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**SEARCHING CUSTOMER SERVICE REQUESTS**

External users can check in the portal to view statuses of previously submitted requests.

**Step 1:** QuickCap Portal → **Customer Service** → **Customer Service Request.** The **Customer Service Request** screen will open.

**Step 2:** Enter information in any of the below fields to populate the search results specific to your organization.

**Step 3:** Press **Search** to show the results. Click the **Reference Number** associated to the request to open the entire request. Users can update or add information to an existing request at this time.
INFORMATION

From the Information module, users are able to search and view the code references for ICD codes, CPT codes, and modifiers. This provides you with a quick and easy way to see if these codes exist within the IPA/medical group, and to help you potentially during your authorization submission or claim submission purposes.

CODE REFERENCE - CPT

From this screen, users are able to search and view CPT codes.

Step 1: QuickCap Portal -> Information -> Code Reference-CPT

Step 2: The CPT Search screen will display as shown below.
Step 3: Users can search for codes either by entering the CPT Code or by entering the Description.

Note: It is necessary to enter data in at least one field. It is better to search with less specific descriptions as the search function will find more possible matches.

Step 4: Click the Find CPT button. The search results will display as shown below.

- To view more details regarding the CPT code, click the CPT Description Details icon. The CPT Description screen will populate as shown below.

- To view the NCCI Edits, click the View link for the specific row. The NCCI Edits screen will be populated in a separate screen.

CODE REFERENCE - ICD

From this screen, users are able to search and view ICD codes.

Step 1: QuickCap Portal -> Left Panel -> Information -> Code Reference-ICD

Step 2: The ICD Search screen will display as shown below.
**Step 3:** Users can search for codes either by entering the ICD Code (ICD-9 or ICD-10) or by entering the description.

*Note:* It is necessary to enter data in at least one field. It is better to search with less specific descriptions as the search function will find more possible matches.

**Step 4:** Users are able to select an ICD-version in the Version field. This allows the system to search by ICD-9, ICD-10, or include both in the search results.

**Step 5:** User should select the **Show Mapping** button if they would like to have the comparable ICD code map between ICD-9 and ICD-10.

**Step 6:** Click the **Find ICD** button. The search results will display as shown below.

**Step 7:** Click the (+) icon to view the mapping details.

**Step 8:** To view more details about the ICD code, click the **ICD Description Details** icon. The **ICD Description** screen will populate as shown below.

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**CODE REFERENCE - MODIFIER**

From this screen, users are able to search and view modifier codes.

**Step 1:** **QuickCap Portal** -> **Left Panel** -> **Information** -> **Code Reference-Modifier**

**Step 2:** The **Modifier Search** screen will display as shown below.
• Users can search either by entering the Modifier Code or by entering the description. Users can also search by directly clicking the **Find Modifier** button.
ABOUT MEDVISION

MedVision creates innovative, cost-effective, and intuitive software systems that enable organizations to operate efficiently in care coordination and population health management business processes. QuickCap™ v7.0, is a complete health benefits software solution that leverages advanced technology to automate workflow, enable superior analytics, integrate business processes and improve patient outcomes, while reducing operating costs.

About This QuickStart Guide

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