Zyter TruCare

Nextgen Population Health for a Value-Based System

TruCare ProAuth

Release 10.1.1
User Guide

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Document revision history

Release	Date	Description
10.1.1.0.0	August 2023	Initial release

Contents

1

Introduction

TruCare ProAuth™ is an interactive digital authorization management tool that streamlines the authorization process for providers and payer organizations. Providers submit authorization requests using a simple online process. Real-time responses and updates increase efficiency in the authorization process.

TruCare ProAuth key features enable you to:

- Search for members to retrieve demographic and eligibility information
- Submit inpatient or service/procedure authorizations
- View service requests entered by a member's care team
- Receive real-time status determinations
- Add notes and clinical criteria, as well as upload supporting documentation as part of the authorization process
- Access comprehensive views of authorizations for your associated providers

The payer organization determines your user role and the features enabled for your use in TruCare ProAuth.

For administrative information about using the TruCare ProAuth Configuration areas, refer to the *TruCare ProAuth Configuration Guide*.

Topics in this section

Before you begin

Review this information, check that your computer meets system requirements, and that you have proper credentials to log on to TruCare ProAuth.

Web browser requirements

These browsers have been certified for use with TruCare ProAuth.

- Internet Explorer 11
- Google Chrome 112 (Recommended)
- Mozilla Firefox 111
- Microsoft Edge 112
- Apple Safari 13 (Mac OS)

If you are using Safari as your browser, make sure that scroll bars are enabled. Refer to the online support for your browser.

All application activity must occur on a single browser tab. Zyter|TruCare does not recommend using multiple tabs.

For the best user experience, maximize your browser window.

Note: Pop-ups must be enabled in the browser. Pop-ups are required for the login screen to open. Refer to the online support for your browser if you need help managing pop-ups.

If you are using the Chrome browser in an Apache Windows non-SSL deployment, you must disable the **SameSite by default cookies** setting.

1. Go to this URL in your Chrome browser: `chrome://flags/#same-site-by-default-cookies`.
2. Change the **SameSite by default cookies** setting to **Disabled**.

Private mode

Do not use browsers in private mode (also called incognito) when using InterQual Connect™ or Cite AutoAuth in TruCare ProAuth. They do not work in browsers using private mode.

Display resolution

The recommended resolution for your display screen is 1280x1024. Maximum resolution is 1920x1080; minimum resolution, 1280x800.

If you are using InterQual Connect™ with TruCare ProAuth, use the following screen resolution settings for InterQual Connect™ to correctly display.

- The minimum vertical display resolution should be 960 pixels or greater.
- The minimum horizontal resolution depends on the display aspect ratio, as in the following examples.

Display Aspect Ratio	Resolution Settings
4:3	1280 x 960
16:10	1680x1050
16:9	1920 x 1080

Note: If your display is set to the correct resolution and InterQual Connect™ is still not displaying properly, verify that the screen scaling is set to 100%.

Signing on

The payee provides all information related to your user account and logon credentials. Check with your administrator for details.

System connectivity

If your connection to TruCare ProAuth times out, log back into TruCare ProAuth.

Use of TruCare ProAuth requires connectivity to other systems. On rare occasions, one of these systems may be temporarily unavailable, perhaps for maintenance or because of a power outage. If the system is not restored in what you consider to be a reasonable amount of time, contact the system administrator for more information.

TruCare ProAuth notes

As you work in TruCare ProAuth, keep the following key pieces of information in mind.

- This version of TruCare ProAuth does not support medication searches on structured notes.
- This version of TruCare ProAuth does not support the National Drug Code (NDC).
- This version of TruCare ProAuth does not support the following features:
  - Home & Community Services (Note: Viewing Service Requests is an available feature.)
  - Rx Authorizations

2

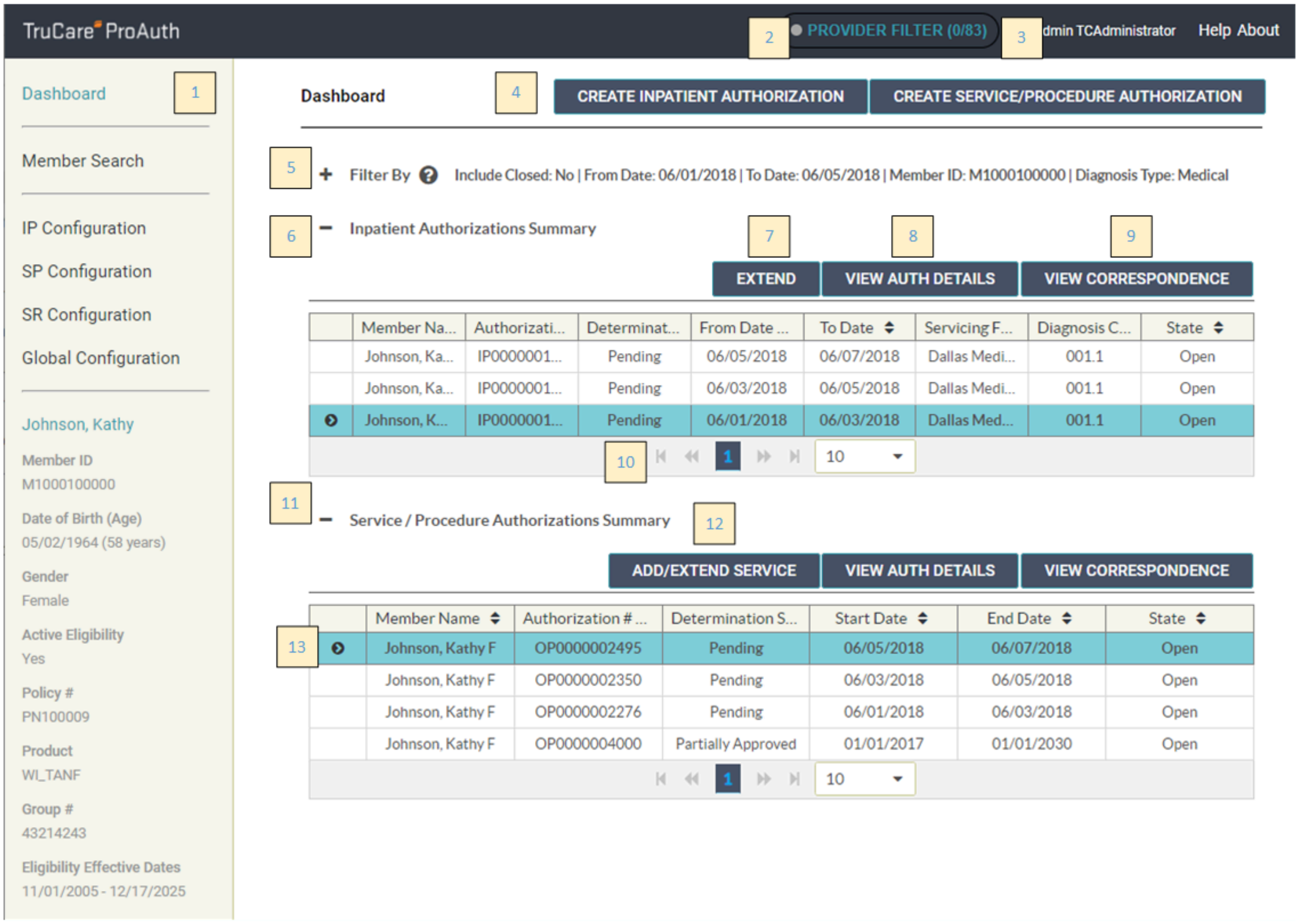
Touring the dashboard

TruCare ProAuth opens to the dashboard where you can locate members and work with authorizations.

On the dashboard you can start a member search, begin the workflow for an authorization request, and view or filter an authorization summary or a list of providers. You can also continue work on authorizations, such as extending authorizations or adding services.

As you move through the application, you can return to the main dashboard page by selecting **Dashboard** in the upper left.

Match the numbers on this illustration with the numbers in the table that follows for an explanation of the functional areas of the dashboard. The member in this example is fictional.



1

Functional areas of the dashboard

This table describes the functional areas of the dashboard.

Number	Function	Description
1	Navigation Pane	A designated space for links to other web pages and for data on a selected member. Select **Dashboard** to restore the default page. Select **Member Search** to find a member. For more information about finding a member, see Finding a member on page 19.

Number	Function	Description
2	Provider Filter	A tool for searching and filtering providers associated with your user account. For more information about using the provider filter, see Applying a filter to your provider list on page 111.
3	References	Name of the user currently signed in. Select **Help** to download the User Guide. Select **About** to display the ProAuth version.
4	Create authorization request buttons/ menus	Use the buttons or menus to begin creating an inpatient or service/ procedure authorization request. If behavioral health is enabled for IP or SP authorizations, there is a dropdown instead of the button. For more information, see Creating an IP authorization request on page 30 or Creating an SP authorization request on page 60.
5	Filter (Filter By)	A tool that controls what displays in the dashboard summary tables. For more information, see Populating the dashboard on page 15. For this example the Filter By tool is compressed.
6	Inpatient Authorizations Summary	A table of inpatient authorizations for providers associated with your user account. You use the dashboard's Filter to populate the summary table with authorization requests. For more information, see Viewing authorization summary tables on page 92.
7	Extend	Use to extend an open IP authorization request. This workflow starts at the dashboard with the selection of the authorization to be amended. For more information, see Extending an IP authorization on page 54.
8	View Auth Details	Use to access to the Authorization Details page. Select an authorization, then select **View Auth Details**. For more information, see Viewing authorization details on page 99.

Number	Function	Description
9	View Correspondence	Use to view the Correspndence Summary. From there you can open Letter History to view, share, or print letters sent to the member. Select an authorization, then select **View Correspondence**. For more information see Viewing correspondence on page 107.
10	Page controls	Displays the current page on view and the controls for moving to first, previous, next, or last page and for setting the number of table rows to view on each page.
11	Service/Procedure Authorizations Summary	A table of service/procedure authorizations for providers associated with your user account. You use the dashboard's Filter to populate the summary table with authorization requests. For more information, see Viewing authorization summary tables on page 92.
12	Add/Extend Service	Use to add a service to or extend a service on an existing SP authorization request. This workflow starts at the dashboard with the selection of the authorization to be amended. For more information, see Adding or extending an SP service on page 73.
13	Line Item	By member, each distinct service request that is submitted for authorization. The line item comprises parameters such as service date range, primary diagnosis and procedure codes, place of service, servicing provider, stay level or service type, and authorization status.
Not shown	Service Request Authorizations Summary	A table of service request authorizations for providers associated with your account. You use the dashboard's Filter to populate the summary table with service requests. Your organization controls the display of this table. For more information, see Viewing authorization summary tables on page 92.

3

Populating the dashboard

You can populate the TruCare ProAuth dashboard with authorizations related to a specific member or providers.

When you launch the application, all dashboard fields are blank except the Date of Service From Date in the Filter By section. The value in this field defaults to seven days prior to the current date.

You can display authorizations in summary tables on the dashboard. There is more than one way to display authorization requests and you can use filters to narrow the search for authorizations.

To populate a dashboard summary table with authorizations, use one of the following options:

- Provide a Member ID or Authorization Number in one of those fields and select **Filter**.

  This search process checks all of your associated providers and displays all matching authorizations in a summary table.

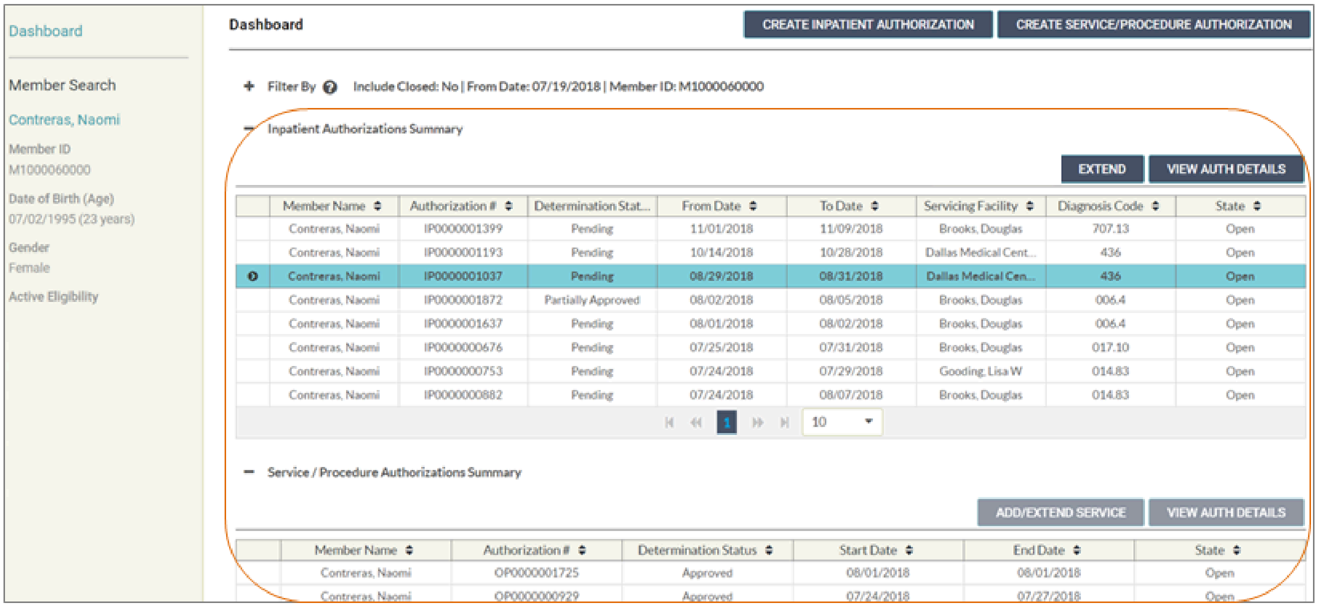
  You can narrow the search results using the following additional filtering options in the Filter By area:

  - Select providers from the Provider Filter.
  - Use the filtering options in Filter By.
- Select at least one provider from the Provider Filter and provide values in the Date Range, Service Type, and Diagnosis Type (if available) fields.

  This search process displays all matching authorizations associated with the provider in a summary table.

  Your filter can also include closed authorizations (Include Closed check box) or authorizations that only you have requested (Requested By Me check box). These options are in the Filter By area.

Any authorizations matching your search are displayed in summary tables.



Selecting **Reset** removes all values and entries on the dashboard. The value of the Date of Service From Date field is restored to the default.

Topics in this section

Filtering options on page 16
You can use filtering options to display authorizations of interest.

Related concepts

Applying a filter to your provider list on page 111
Using filtering is one of the best ways to make your work activities more efficient.

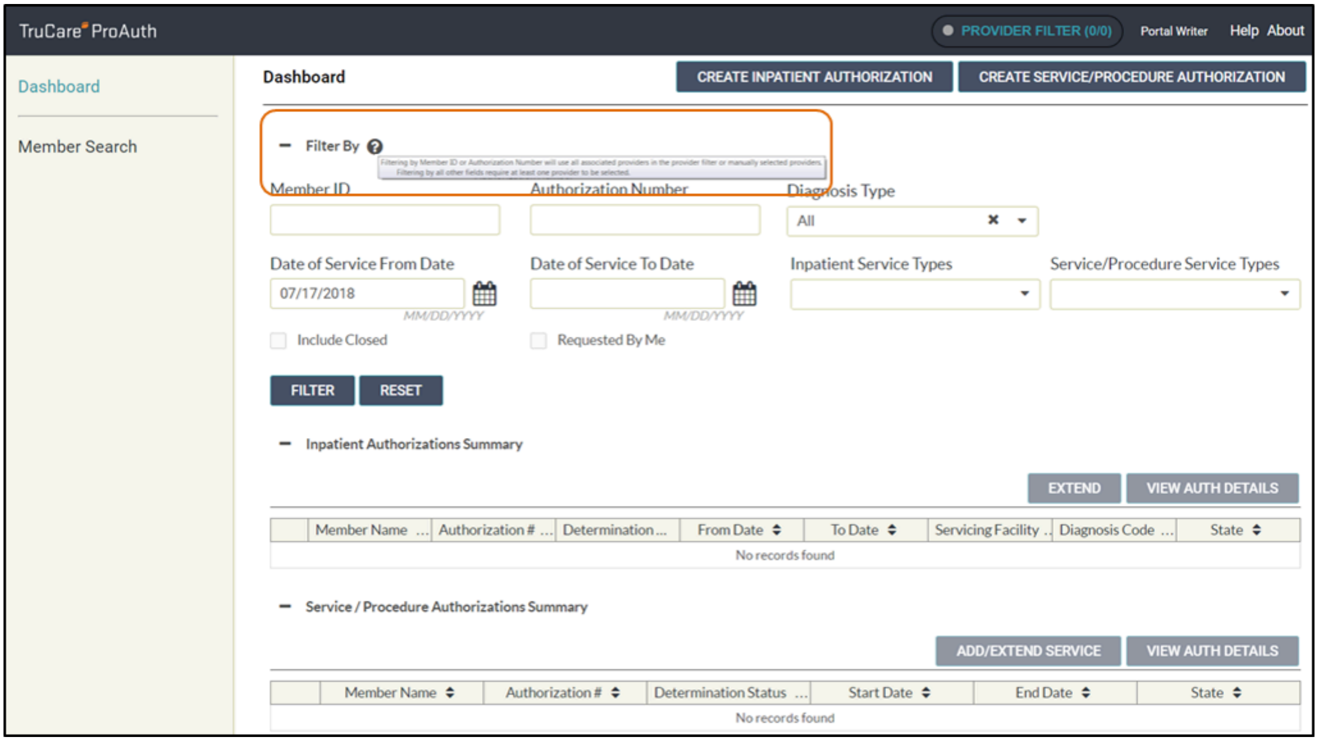
Viewing authorization summary tables on page 92
You can view authorizations linked to your user account in summary tables on the dashboard.

Filtering options

You can use filtering options to display authorizations of interest.

In addition to using a provider list filter, you can use the filters in **Filter By** area of the dashboard to narrow the authorization search results.

A tool tip in the Filter By area explains your filtering options.



Use the following filters to control the authorizations displayed in summary tables on the dashboard.

Filter	Description
Member ID	Enter the number of characters specified onscreen. Specification for this field is identical to the Member ID field of Member Search.
Authorization Number	Enter the exact number.
Diagnosis Type	Select the diagnosis type from the menu. **Note:** This menu is available only if behavioral health authorization requests are enabled inTruCare ProAuth.

Filter	Description
Inpatient Service Types	Select the IP service type from the menu.
Service/Procedure Service Types	Select the SP service type from the menu.
Date of Service From Date	Use this with Date of Service To Date to specify the date of service range. This date defaults to seven days before the current date. Modify the date if needed. Input the date in format mm/dd/yyyy or use the date picker to complete the entry.
Date of Service To Date	Enter an end date for the date of service range. Input the date in format mm/dd/yyyy or use the date picker to complete the entry.
Include Closed	Select this option to add closed authorizations to the filter.
Requested By Me	Select this option to limit the filter to authorizations that your filtered list of providers requested.

Related concepts

Applying a filter to your provider list on page 111
Using filtering is one of the best ways to make your work activities more efficient.

Viewing authorization summary tables on page 92
You can view authorizations linked to your user account in summary tables on the dashboard.

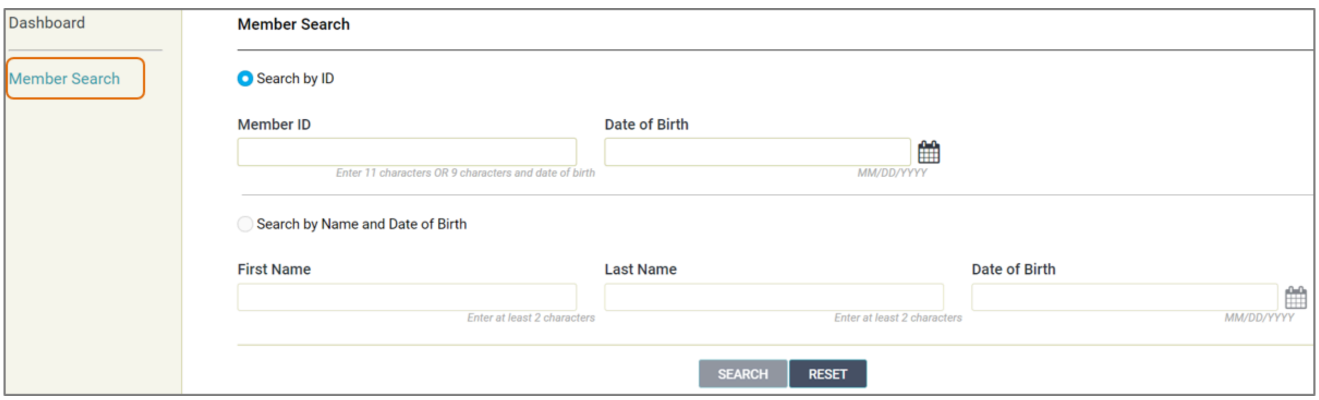
4

Finding a member

You can search for a member to work on member-specific tasks, such as viewing member authorization requests or creating a new authorization request for a member.

You can perform the member search using one of two methods: by member ID or by name and date of birth.

> **Note:** Search by Name and Date of Birth is an option that the payer (health plan) chooses to enable or not. This option is displayed only when the payer has chosen to configure its use.



In general, you search for a member before you begin the workflow for creating an authorization request. But if you select the button for creating an authorization first, the member search comes next. Once the Member Search screen is open, the steps for finding a member are the same.

> **Note:** You cannot see members for whom access is restricted. Under this limitation, functions for viewing member details and creating authorizations are inaccessible.

Topics in this section

Searching by member ID

Use the member ID to locate the member in TruCare ProAuth.

When searching by member ID, you need to provide the member ID required by your organization.

Your organization might allow you to provide the member's date of birth with part of the member ID. If so, the Date of Birth field appears with the Member ID field.

At any point during a member search you can use Reset to clear the fields and start new search.

To search by member ID, use the following steps.

1. Select **Member Search** on the navigation pane.

   The Member Search page opens.

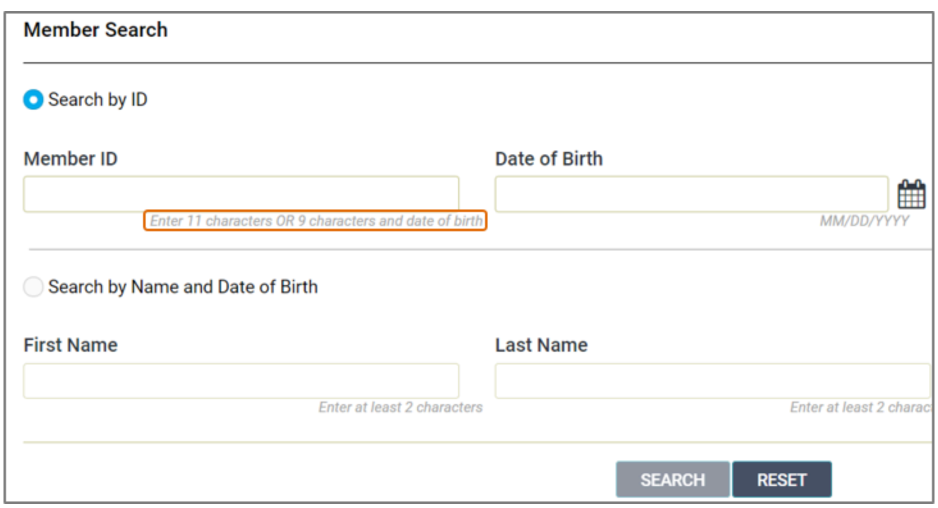
2. Select **Search by ID**.

   If search by Member ID is the only search option, Search by ID is not displayed and you can skip this step.

3. Enter the member's ID in the Member ID field, using the instructions specified on the screen.

   In this example, follow the specification to enter the 11-character member ID or the first 9 characters of the member ID and the member's date of birth.

   The instructions used by your organization might be different. You might be prompted to enter a member ID that is within a specified numeric range (for example, an ID with a length between 5–9 characters) or from a list of specified numbers (for example, an ID with a length that is 5, 7, 9, or 11 characters).

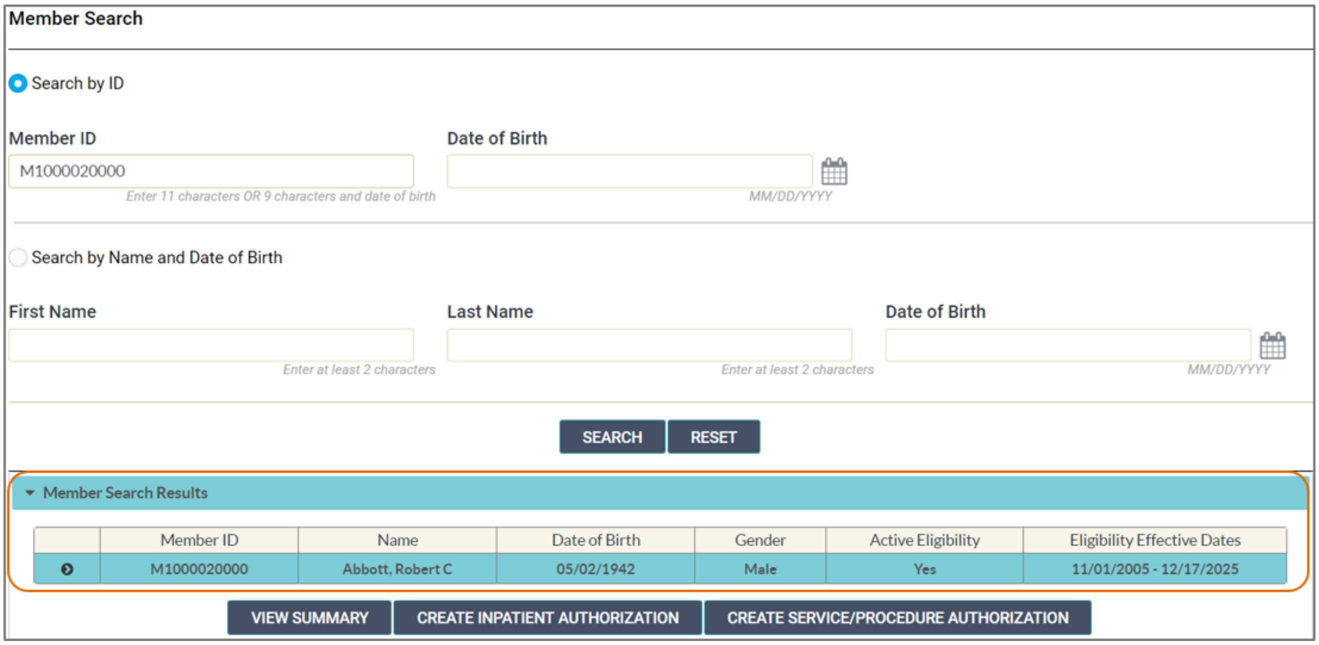


4. If using date of birth, enter the member's date of birth.

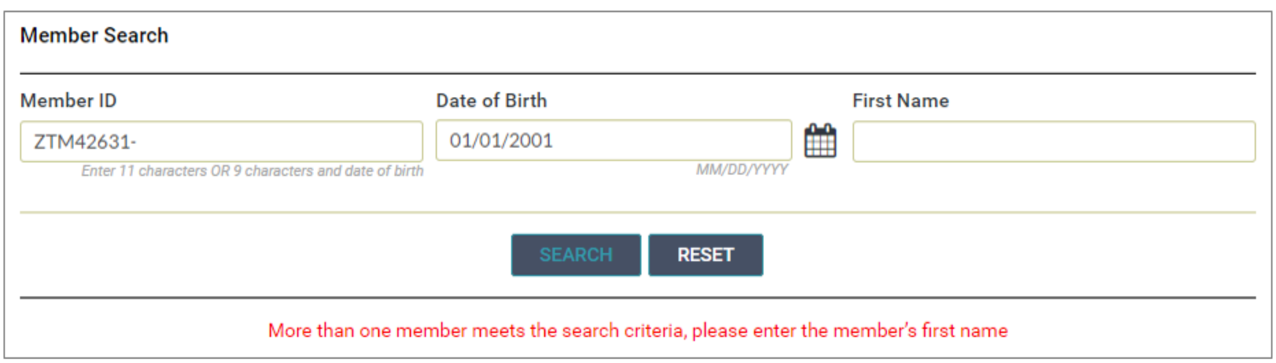
   Use the mm/dd/yyyy format. You must include the forward slash symbol (/). Or, you can use the date picker to complete the entry.

5. Select **Search**.

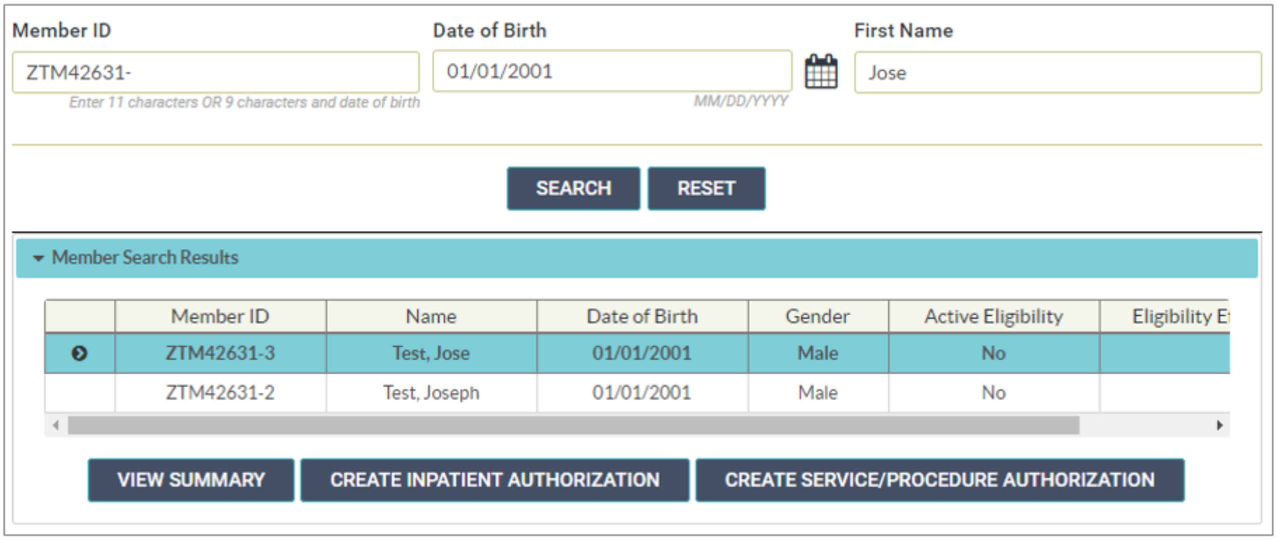
If the search results include only one member, the results appear below the search area.



Sometimes the results include more than one match. This could happen if you are searching a family that had a multiple birth event. The page updates to include the First Name field and a message informs you of what to do next.



Enter the first name and select the correct member on the results table.



Related procedures

Viewing a member summary on page 27
You can view details of a selected member in order to take further actions for that member.

Searching by name and date of birth

Use the member name and date of birth to locate the member in TruCare ProAuth.

Searching for a member by name and date of birth must have been configured for your organization's use for it to appear in the dashboard.

Search for member's by first name, last name, and date of birth. All three fields are mandatory.

Use at least two characters in the two name fields. You can use wildcards in first and last names for searches. The date of birth is still required in a wildcard search. For example, you can search for mi*, b*, 05/02/1954.

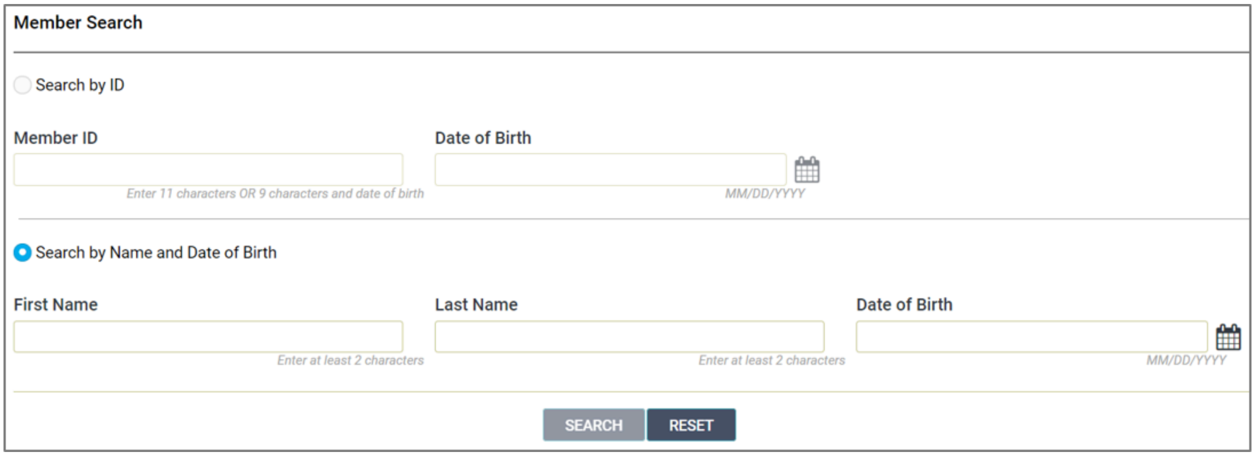
> **Note:** The recommended search method is the use of full first name and last name.

At any point during a member search you can use Reset to clear the fields and start new search.

To search for a member by name and date of birth, use the following steps.

1. Select **Member Search** on the navigation pane.

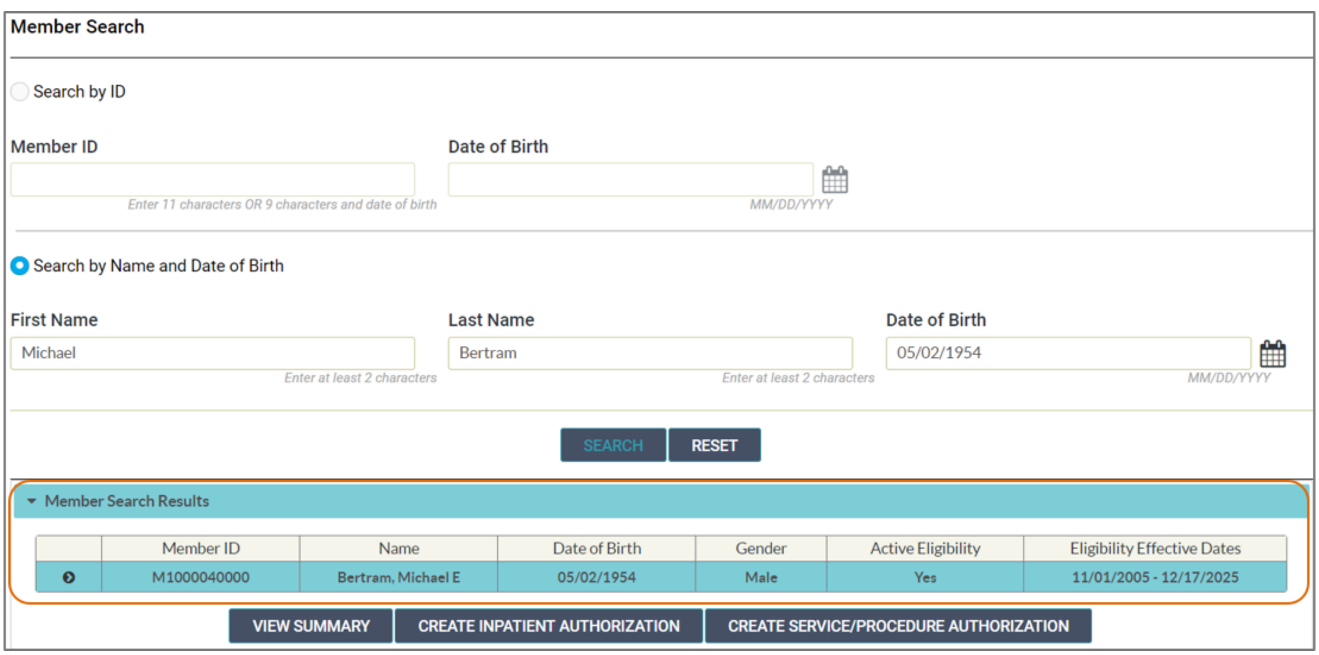
   The Member Search page opens.



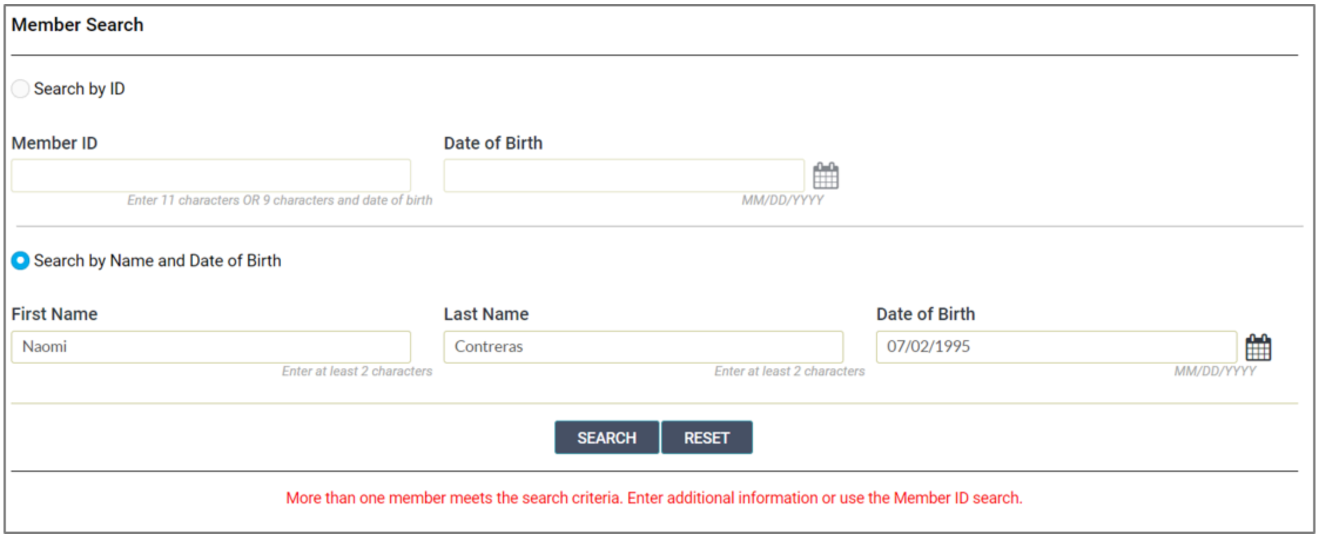
2. Select **Search by Name and Date of Birth**.
3. Enter the member's first name in the **First Name** field.
4. Enter the member's last name in the **Last Name** field.
5. Enter the member's date of birth.

   Use the mm/dd/yyyy format. You must include the forward slash symbol (/). Or, you can use the date picker to complete the entry.
6. Select **Search**.

If the search results include only one member, the results appear below the search area.



Sometimes the results include more than one match. A message informs you of what to do next.



Enter the requested information or use the Member ID to search for an exact match. Select the correct member in the search results.

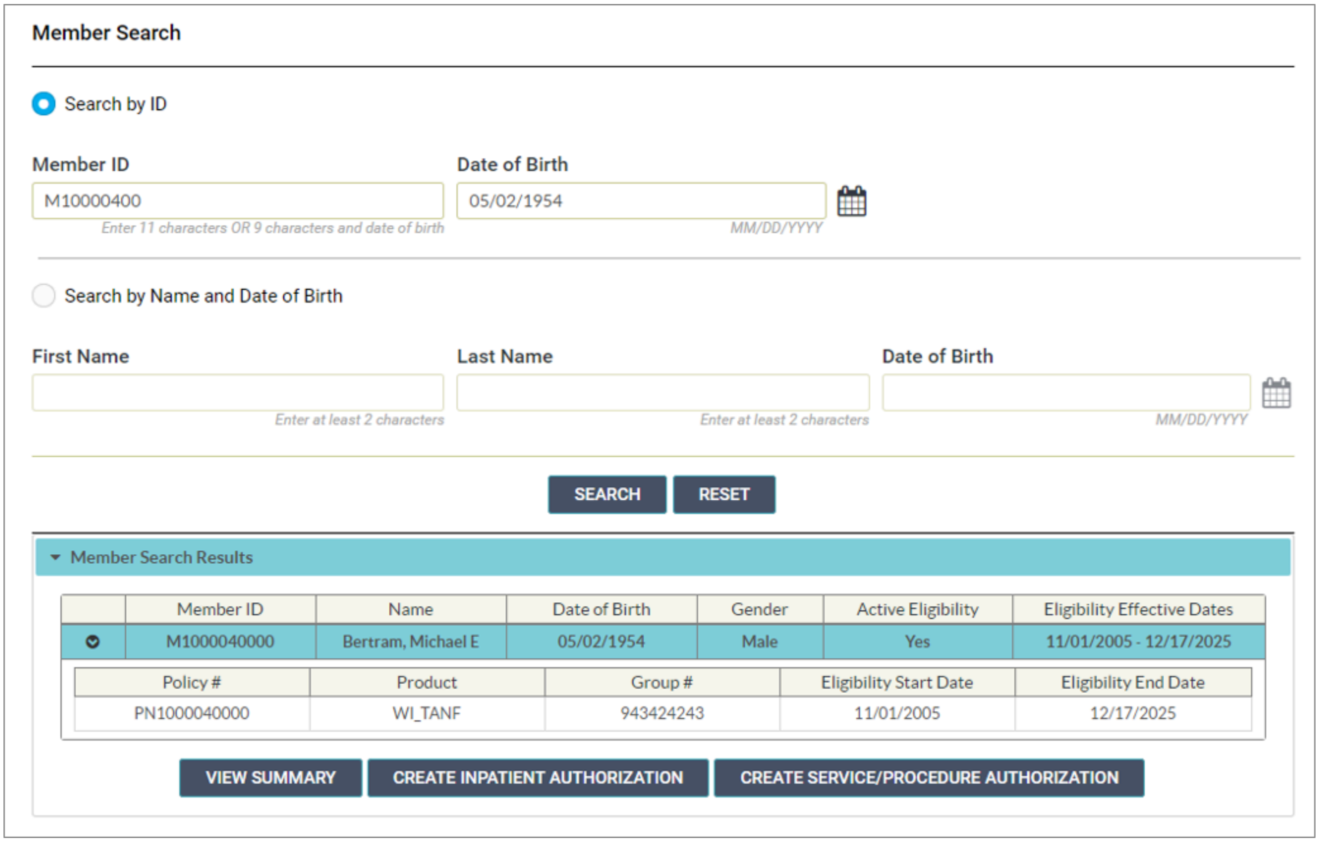
Related procedures

Viewing a member summary on page 27
You can view details of a selected member in order to take further actions for that member.

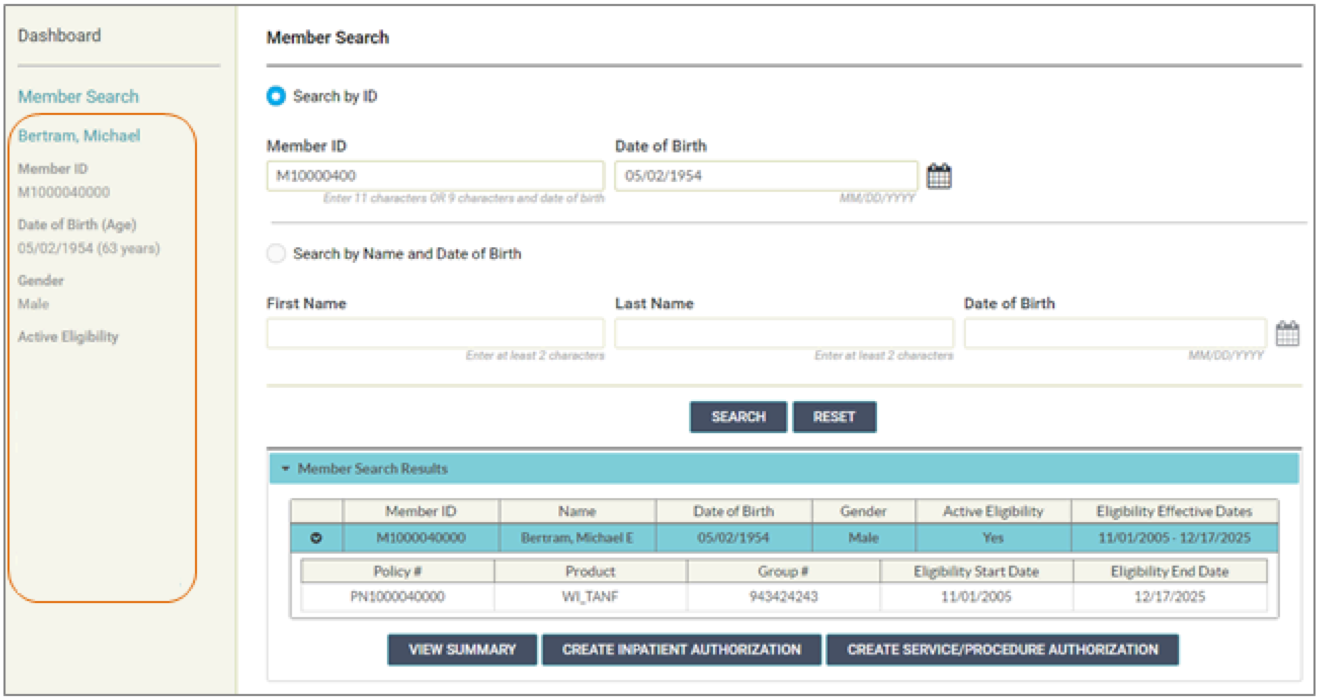
Member search results

A successful member search returns key information about a member.

The member search returns the member ID, member name, date of birth, gender, active eligibility, and eligibility effective dates.



As long as you have the current member active (or selected), the data on this member displays as the point of focus in the navigation pane. Any authorization requests that are created and submitted relate to this specific member. When you need to create an authorization request for a different member, start by selecting Member Search in the navigation pane.


Dashboard
Member Search
Bertram, Michael
Member ID
M1000040000
Date of Birth (Age)
05/02/1954 (63 years)
Gender
Male
Active Eligibility
Member Search
Search by ID
Member ID
M10000400
Enter 11 characters OR 9 characters and date of birth
Date of Birth
05/02/1954
MM/DD/YYYY
Search by Name and Date of Birth
First Name
Enter at least 2 characters
Last Name
Enter at least 2 characters
Date of Birth
MM/DD/YYYY
SEARCH
RESET
Member Search Results
Member ID
Name
Date of Birth
Gender
Active Eligibility
Eligibility Effective Dates
M1000040000
Bertram, Michael E
05/02/1954
Male
Yes
11/01/2005 - 12/17/2025
Policy #
Product
Group #
Eligibility Start Date
Eligibility End Date
PN1000040000
WI_TANF
943424243
11/01/2005
12/17/2025
VIEW SUMMARY
CREATE INPATIENT AUTHORIZATION
CREATE SERVICE/PROCEDURE AUTHORIZATION

5

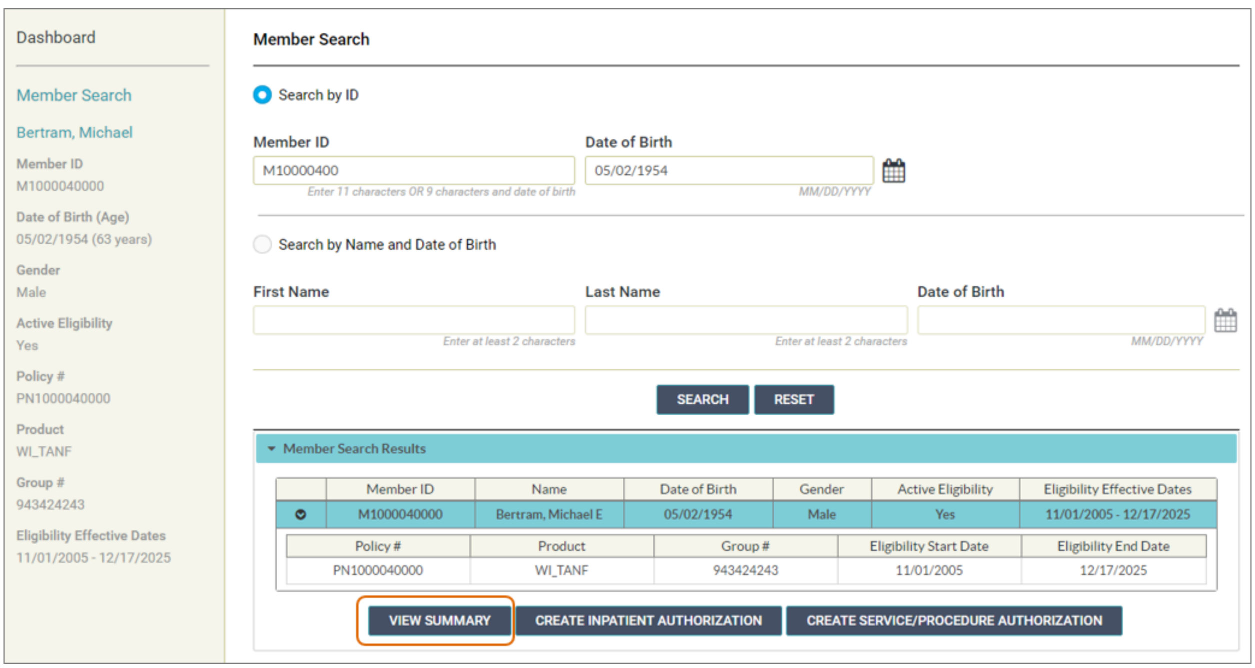
Viewing a member summary

You can view details of a selected member in order to take further actions for that member.

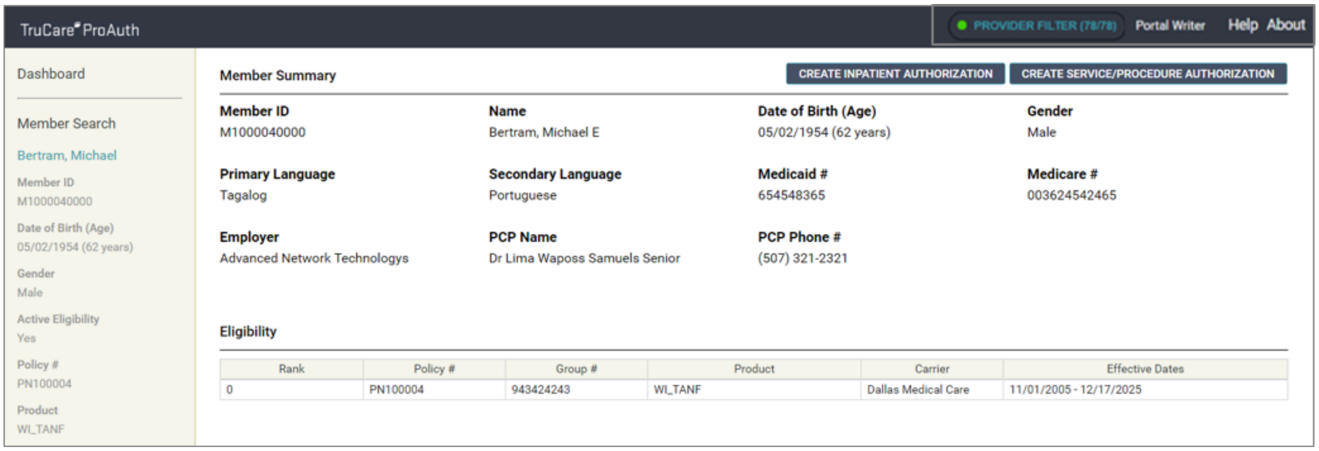
After a member search, you can access more details about the member.

To see a member summary:

1. If you have more than one member in the search results, select the member you want to work with (otherwise, skip to the next step).
2. At the bottom of the Member Search page, select **View Summary**.



The Member Summary page opens.



Note:

Rank is to distinguish between primary, secondary and tertiary client coverages TruCare Rankings numbering starts as 1 and can go up to the number of coverage entities a company may have. Primary coverage will come in as a 1 on the member feed as 1, secondary as a 2, and continue on. A member can have more than one primary (example one for medical and one for behavioral) so in this example the user would have to choose which to use for eligibility when entering authorization.

Related procedures

Searching by member ID on page 20
Use the member ID to locate the member in TruCare ProAuth.

Searching by name and date of birth on page 22
Use the member name and date of birth to locate the member in TruCare ProAuth.

6

Creating and updating authorization requests

Use these instructions to create and update IP and SP authorization requests.

Topics in this section

Creating an IP authorization request

You can create inpatient (IP) authorization requests in the TruCare ProAuth dashboard.

You can create two types of IP authorization requests: medical or behavioral health. The authorization request workflow is the same for both types of requests. If your organization does not support creation of behavioral health authorizations, they are not enabled in TruCare ProAuth.

You must complete all mandatory fields and customized User Defined Fields (UDFs) that are marked with an asterisk * when submitting an authorization request. For more information about UDFs, see UDF guidelines on page 119.

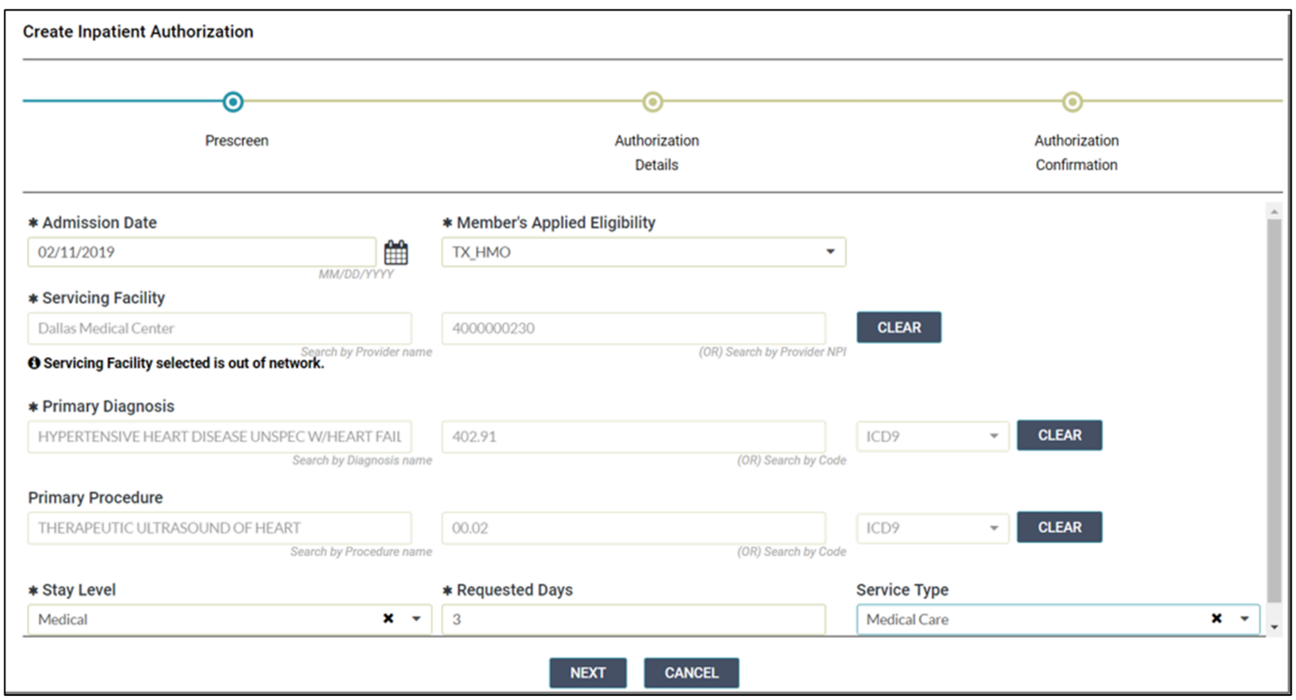
As you proceed through the workflow, the header on the screens reflects the type of authorization request you are creating.

- Select **Create Inpatient Authorization** for medical IP authorization requests.
- Select **Create Inpatient Behavioral Health Authorization** for behavioral health IP authorization requests.

There are two types of workflows for Inpatient Authorizations: standard and comprehensive. Your payer organization determines the workflows for Inpatient medical and Inpatient behavioral authorizations.

The visual header at the top of the screen indicates where you are in the main parts of standard IP Authorization workflow: Prescreen, Authorization Details, or Authorization Confirmation.

The standard IP Authorization workflow (see image below) follows these high-level tasks:



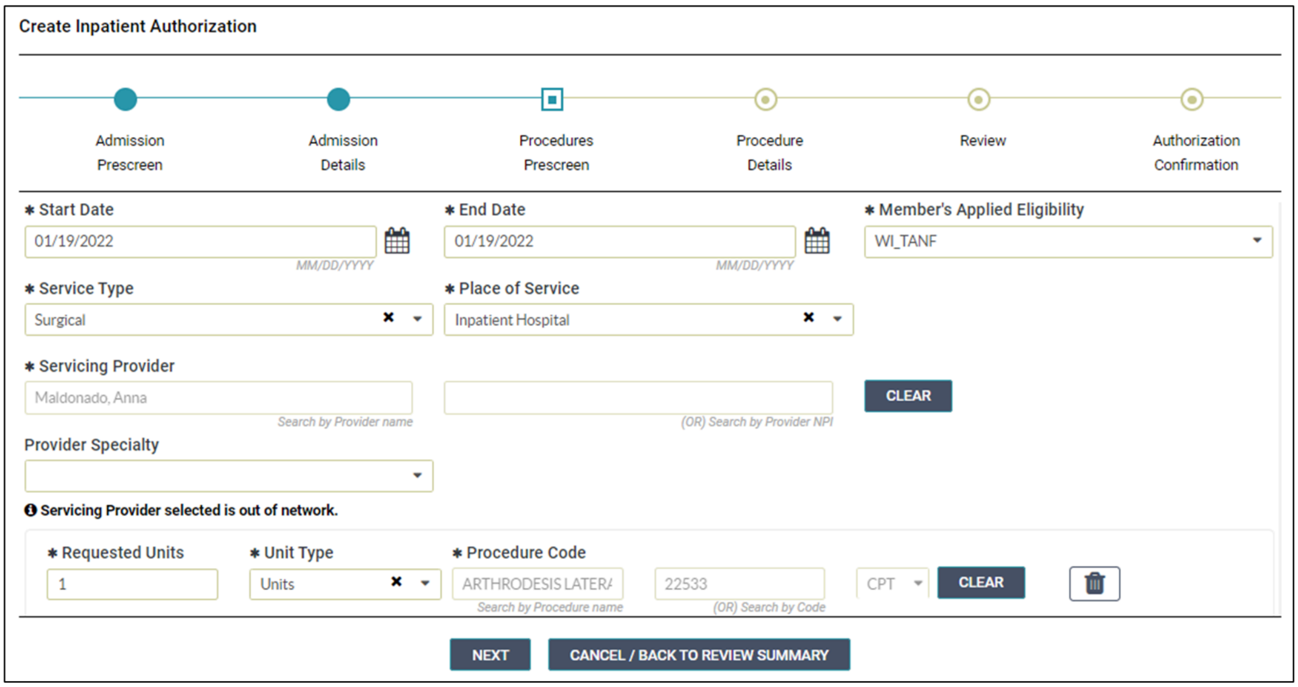
1. Start an authorization request.

2. Complete the IP authorization Prescreen.

3. Complete the Authorization Details section of the request and then submit it.

For organizations that utilize the comprehensive Inpatient Authorization workflow, the visual header at the top of the screen indicates where you are in the main parts of this workflow: Admission Prescreen, Admission Details, Procedure Prescreen, Procedure Details, Review or Authorization Confirmation.

The comprehensive Authorization workflow (see image below) involves the following high-level tasks:



1. Start an authorization request.

2. Complete the IP Admission Prescreen.

3. Complete the Authorization Details.

4. Complete Procedure Prescreen (if needed or click **Next** to go to Review).

5. Complete Procedure Details (if procedure prescreen was completed).

6. Review Inpatient admission and Inpatient procedure(s) and modify them as needed, then submit the authorization.

> **Note:** The option values shown in the workflow topics in this section are only illustrative.

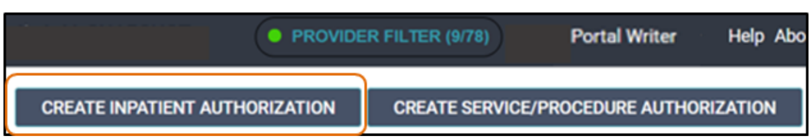
Topics in this section

Starting an IP authorization request

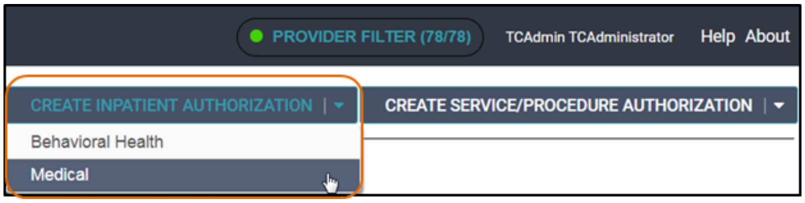
Initiate an IP authorization request on the dashboard.

Use one of the following actions on the dashboard to start creating an IP Authorization request. The available actions depend on whether behavioral health is enabled in TruCare ProAuth.

- If behavioral health is not enabled, select **Create Inpatient Authorization** (to create a medical authorization).



- If behavioral health is enabled, from the **Create Inpatient Authorization** menu, choose Behavioral Health or Medical.



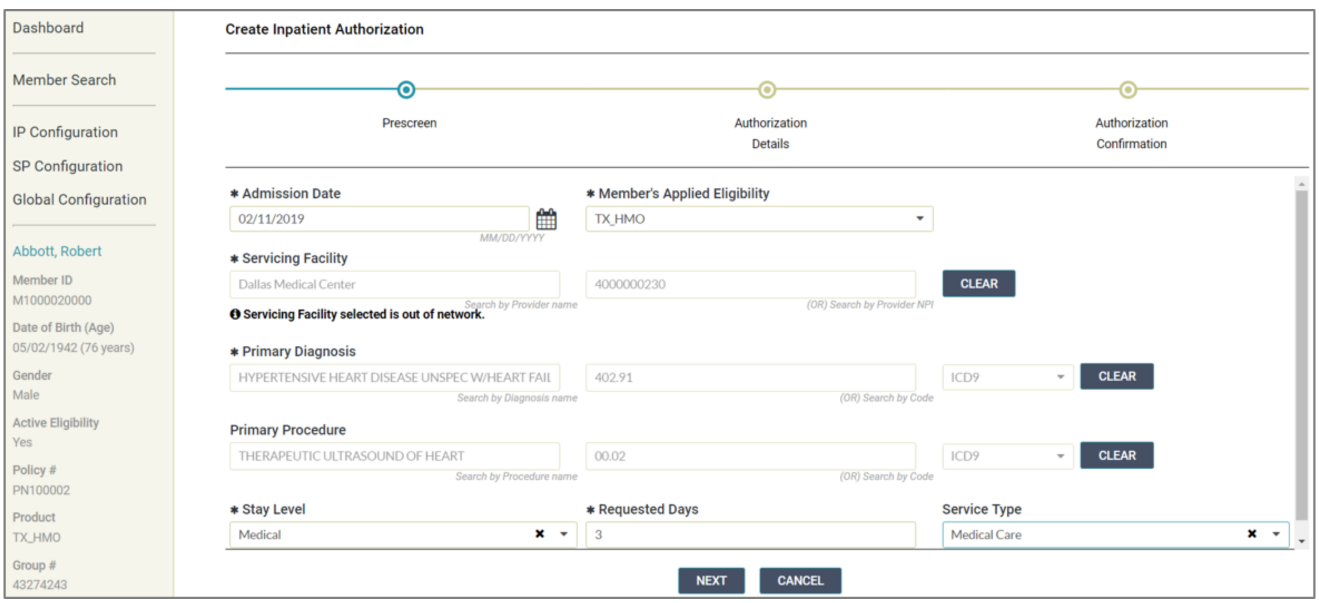
The Prescreen page opens. Now you can add information for preliminary evaluation.

Completing the IP authorization prescreening

Complete the Prescreen page fields to learn the classification of an IP authorization request immediately. This is part of the standard Inpatient workflow.

In the first part of the authorization request process, you provide prescreen information.

> **Note:** Depending on your organization's workflow, prescreen may be labeled as Admission prescreen or Prescreen. Both workflows will follow the same prescreen evaluation.



The prescreen functionality immediately provides the classification of an Inpatient authorization request. If authorization is required, you can proceed with the workflow. If authorization is not required, or if another business evaluation occurs, TruCare ProAuth displays a message to inform you of the action to follow.

You might see messages while completing the Prescreen section. For more information about the messages, see Prescreen messages on page 36.

To complete the Prescreen section:

1. Enter the admission date in the format mm/dd/yyyy or use the date picker.
2. From the **Member's Applied Eligibility** menu, make a selection.

   This field auto-completes when the member's eligibility is on record. There is only one active eligibility for the date of service.

3. Specify the servicing facility:

   a. Enter a minimum of two characters in the **Search by Provider name** or **Search by Provider NPI** and select **Search**.

      If the characters you enter have a unique match, the fields are filled in automatically.

   b. Select the facility from the list.

   This search is checked against the full TruCare provider database. If you search using the dashboard provider filter, you are limited to only those facilities associated with your user account.

   If necessary, select **Clear** to start over.

4. Specify the primary diagnosis:

   a. Enter a minimum of two characters in **Search by Diagnosis name** or **Search by Code**, optionally choose a code set from the drop-down menu, and select **Search**.

      Use precise criteria to get the best search results; only 50 data entries are shown per search.

      If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

      If your search did not result in a match, a slider opens with search results. To refine your search, select **Name contains** or **Name starts with**, enter your new search term in **Search by Diagnosis name** or **Search by Code**, optionally select a code set, and select **Search**.

   b. Choose the correct record (diagnosis name, code, code set) in the search results, scrolling through the list if needed.

   The code set includes the diagnosis coding schemes defined in TruCare.

   If necessary, select **Clear** to start over.

   You might see a message about a diagnosis code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

5. Specify the primary procedure:

   Note: This entry is required only if the payer has set the field to mandatory or this entry may be suppressed from this page.

   a. Enter a minimum of two characters in the **Search by Procedure name** or **Search by Code**, optionally choose a code set from the drop-down menu, and select **Search**.

      Use precise criteria to get the best search results; only 50 data entries are shown per search.

      If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

      If your search did not result in a match, a slider opens with search results. To refine your search, select **Name contains** or **Name starts with**, enter your new search term in **Search by Procedure name** or **Search by Code**, optionally select a code set, and select **Search**.

   b. Choose the correct record (procedure name, code, code set) in the search results, scrolling through the list if needed.

   The code set includes the procedure coding schemes defined in TruCare.

   If necessary, select **Clear** to start over.

   You might see a message about a procedure code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

6. From the **Stay Level** menu, make a selection.
7. In the **Requested Days** field, type the number of requested days or use the scroll arrows to enter requested days.

   Note: This field is displayed only when the payer has chosen to configure its use.

8. From the **Service Type** menu, make a selection.
9. Select **Next**.

The prescreen information is processed. If you can proceed with the authorization request, you automatically continue to the Authorization Details page, where you can add more details.

You might see a message with additional information about the request. Click **Next** again to continue to the Authorization Details page.

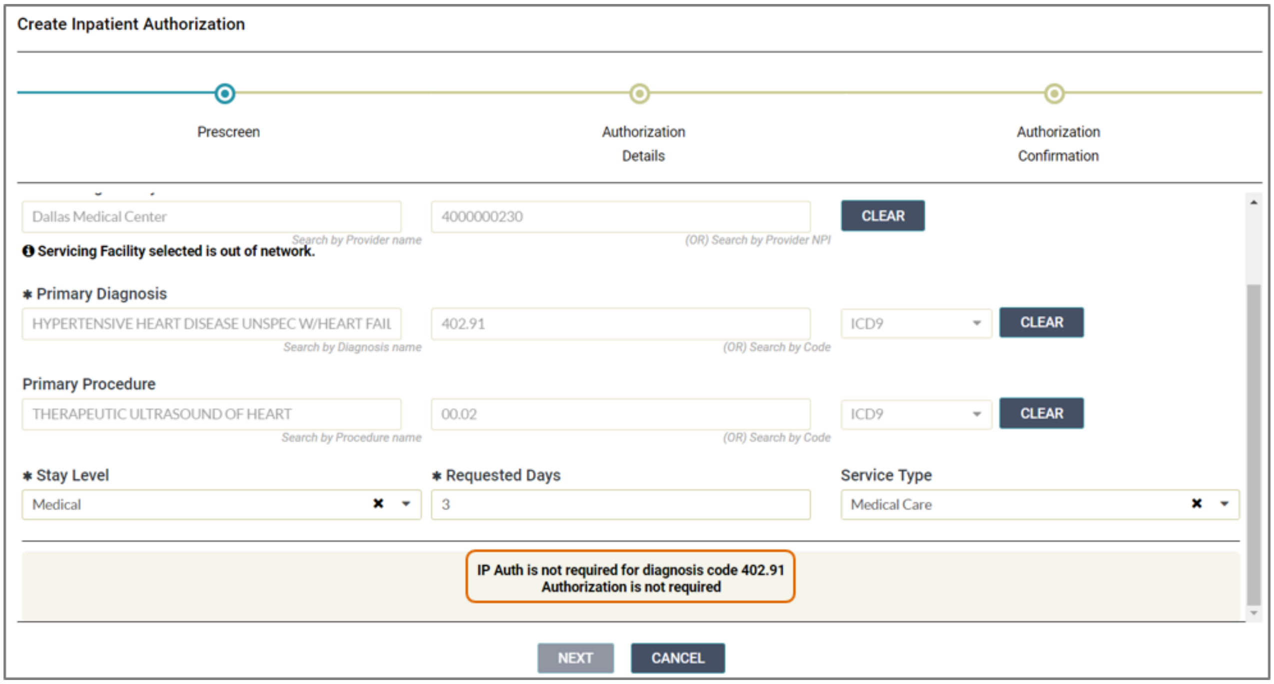
Sometimes the results of the prescreen evaluation prevent you from continuing with the authorization request, for one of the following reasons:

- Authorization is not required
- Duplicate request
- Review needed by a third party

- Member ineligibility

Select **Cancel** and then respond to the prompt to discard changes. Select **Yes** to return to the dashboard; select **No** to stay in the Prescreen page.

In the example below, the prescreen evaluation reports that “authorization is not required” and provides the reason why there is no requirement. You cannot proceed.



Topics in this section

Prescreen messages

When working on the prescreen part of an authorization request, you might see one of these messages.

Prescreen results are controlled by rules set up by the payee. The messages that appear during the prescreen process could include default messages or custom messages. The following table includes some of the possible messages you might see.

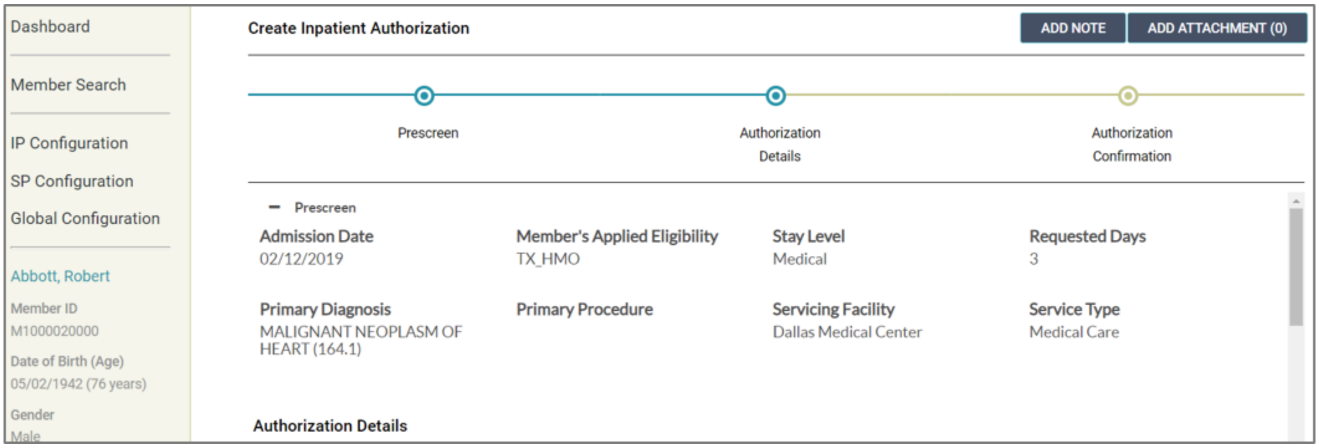
Possible prescreen message	Description
Authorization - Not Required	Approval might not be required for some standard or routine service.
Authorization - Duplicate Request	The same authorization has been submitted previously. You need to contact the payer for resolution.

Possible prescreen message	Description
Authorization - Third Party Vendor	You cannot submit a required authorization that a third-party vendor reviews.
Eligibility - Member Ineligible	The member is not eligible for treatment.
Servicing Facility - Out of Network	Servicing facility selected is out of network. **Note:** This message is informational only. You can continue with the authorization request and IP authorizations with the comprehensive workflow enabled.
Section Guidelines	A specification for the authorization to be requested. **Note:** This message might appear when creating SP authorization requests and the IP comprehensive workflow on procedure prescreen.
Authorization required reason	The reason that an authorization is required might be specified by the payee.
Authorization auto-approval reason	The reason that an authorization is automatically approved might be specified by the payee.
Recommended number of LOS-Units reason	The reason for the recommended number of LOS-Units might be specified by the payee.
Review notes	Authorization review notes might be specified by the payee.

Providing the IP authorization details

After completing the prescreen evaluation, provide IP authorization request details on the Authorization Details page.

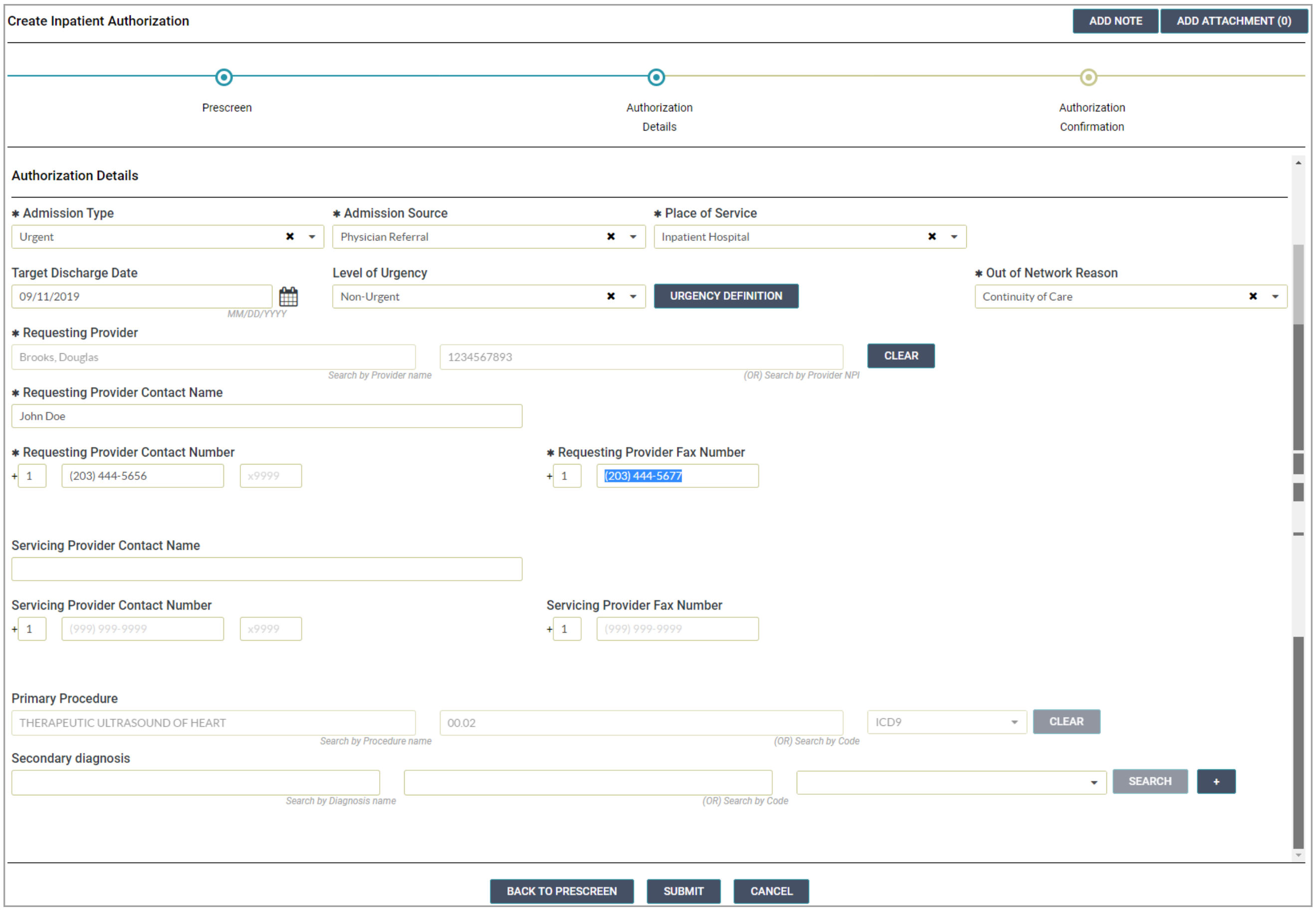
When the Authorization Details page opens, you see the prescreen section where there is a collapsible dash indicating entries to view (see image below). You might see an entry for Requested Days that you did not make. This entry is configured by the payee and is displayed automatically when criteria are met.



If you need to edit something in the Prescreen section, you have to go back to the Prescreen page to enter the change. Select **Back to Prescreen**. After any change, prescreen runs again when you select **Next** to determine whether authorization is required.

Complete the authorization details fields in the rest of the Authorization Details page.

> **Note:** All the fields on the Authorization Details screen are required or optional based on the configuration settings entered by the payer. The exception is for requesting provider contact information; namely, name, phone, and fax. Entry into these fields is always required. Required fields are marked with an asterisk.



While filling in the authorization details, if you return to the Prescreen page before you select Submit, but make no changes to the entries, you can return to Authorization Details without any loss of data. The entries you made remain intact.

To provide authorization details:

1. From the **Admission Type** menu, select the type of admission being requested.
2. From the **Admission Source** menu, select the admission source.
3. From the **Place of Service** menu, select the type of facility in which the service will be performed.
4. Enter the target discharge date in the format mm/dd/yyyy or use the date picker.
   Depending on the configuration set by the payer, this field may be required or optional.
5. From the **Level of Urgency** list, select the urgency level.
   If **Urgency Definition** is available, select it to see your organization's guidance on choosing urgency levels.

   Your organization may require an attestation (acknowledgement that the selection is in compliance with the urgency definition). If so, an attestation window will display. Select **Yes** to attest. If you select No, TruCare ProAuth will revert your selection to your organization's configured value or back to blank.

6. From the **Out of Network Reason** menu, select the reason for requesting a facility that is out of network.

   > **Note:** This entry displays as required only when an out-of-network facility has been entered in prescreen.

7. Specify the requesting provider:

   a. Enter a minimum of two non-wildcard characters in the **Search by Provider name** or **Search by Provider NPI**.
      The requesting provider is the entity that is requesting/ordering the service or admission for a member.

      By default, searches include only providers associated with your user account. You might have the option to search all available providers by selecting **Search All Providers**. When using the **Search All Providers** option, use precise criteria to get the best search results; only 50 data entries are shown per search.

      > **Note:** When authorization requests are created, searches for requesting providers use all providers associated with your account (or all providers if you have the option to search all providers and select it), not solely the providers selected in the Provider Filter at a given time. For more information about providers and the Provider Filter, see Applying a filter to your provider list on page 111.

   b. Select **Search**.
      If the characters you enter have a unique match, the fields are filled in automatically and you can skip the next step. Do an advanced search, if necessary.

   c. Select the provider from the list.

8. In the **Requesting Provider Contact Name** field, enter the contact name specified by the provider.
9. Enter the requesting provider contact number for the authorization, including the country code and extension, if any.
10. Enter the requesting provider fax number, including the country code.
11. In the **Servicing Provider Contact Name** field, enter the contact name specified by the provider.
12. Enter the servicing provider contact number for the authorization, including the country code and extension, if any.
13. Enter the servicing provider fax number, including the country code.

14. Specify the primary procedure using the following steps:

> **Note:** These fields might already be populated, if the information was supplied in prescreen.

   a. Enter a minimum of two characters in the **Search by Procedure name** or **Search by Code** and select **Search**.
   Use precise criteria to get the best search results; only 50 data entries are shown per search.

   To refine your search, select **Name contains** or **Name starts with**, enter your new search term, then select **Search**.

   If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

   b. Choose the correct record (procedure name, code, code set) in the search results, scrolling through the list if needed.

The code set includes the procedure coding schemes defined in TruCare.

If necessary, select **Clear** to start over.

You might see a message about a procedure code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

15. Specify a secondary procedure (or more than one) if needed, using the following steps:

    a. Enter a minimum of two characters in the **Search by Procedure name** or **Search by Code** and select **Search**.
    Use precise criteria to get the best search results; only 50 data entries are shown per search.

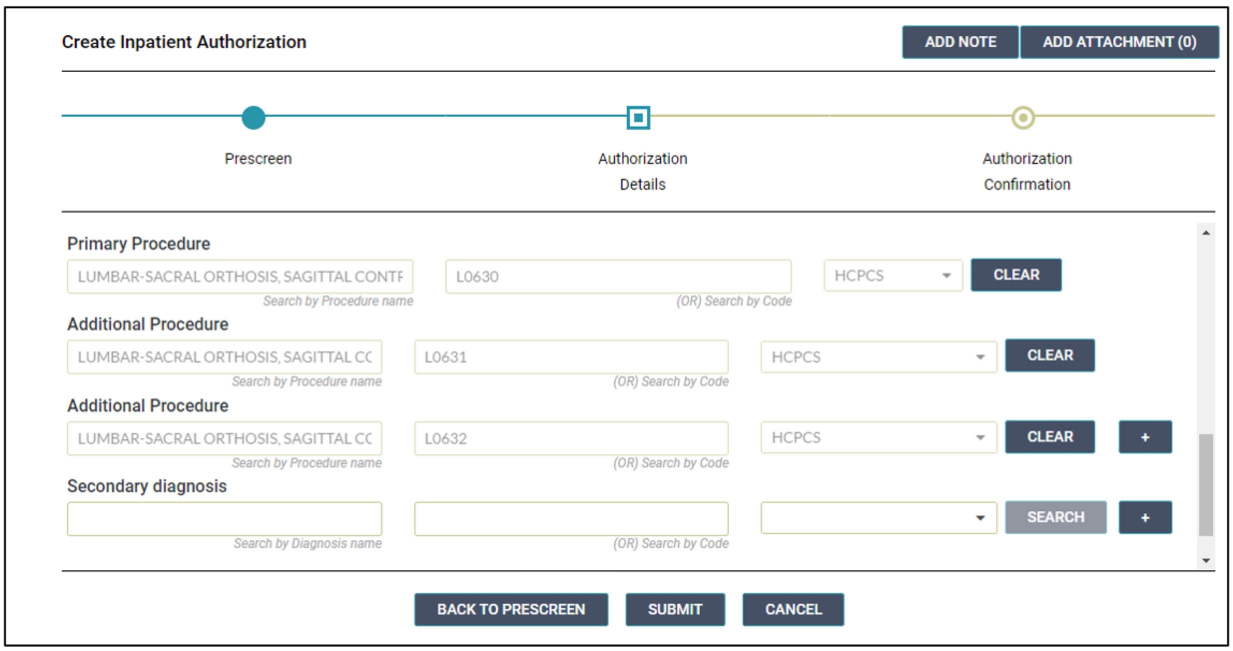
    To refine your search, select **Name contains** or **Name starts with**, enter your new search term, then select **Search**.

    If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

    b. Choose the correct record (procedure name, code, code set) in the search results, scrolling through the list if needed.

    The code set includes the procedure coding schemes defined in TruCare.

    If necessary, select **Clear** to start over (see image below).



You might see a message about a procedure code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

> **Note:** Select **+** to add another secondary procedure.

16. If you need to add a note or attachment, do so now.
    See Adding notes and attachments to authorization requests on page 85 for details.

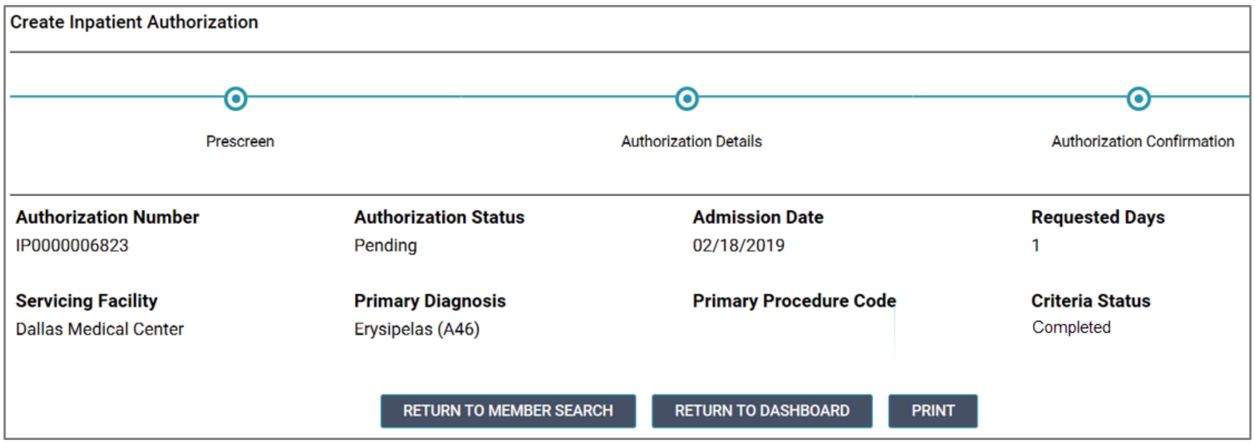
    If you try to submit the request without adding a required note or attachment, a message that a note or attachment is required appears on the screen.

17. If you need to add clinical criteria, do so now.
    See Adding clinical criteria to authorization requests on page 87 for details.

    If you try to submit the request or navigate to the next page without adding required clinical criteria, messages that clinical criteria are required or optional appear on the screen.

18. Depending on your organization's workflow, the standard inpatient workflow will allow **Submit**. Select **Submit** when you are ready to submit the authorization request. When configured, a message informs you that the authorization request has been submitted successfully. If the authorization has clinical criteria, a pop-up indicates that the authorization is being submitted.

    It will close when the submission is complete. An authorization summary is displayed and includes the authorization number and status.



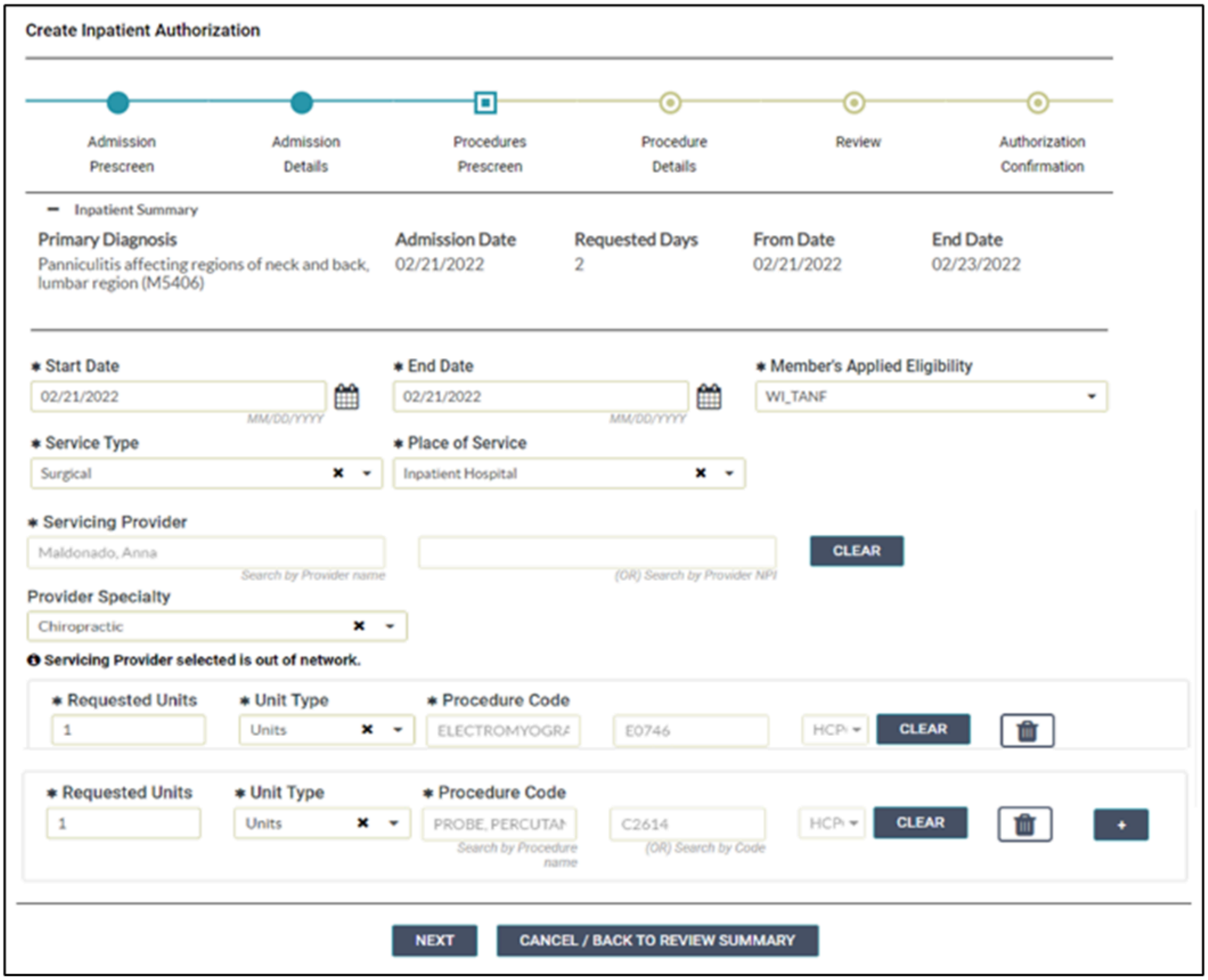
    The criteria status field appears only if clinical criteria are created for the authorization.

    You can print a copy of the confirmation for your records. The confirmation prints to PDF using the browser print function. Return to member search or to the dashboard.

If your organization is using the inpatient comprehensive workflow, you can use the Procedure Prescreen when the inpatient admission includes procedures that will be performed during the inpatient stay. You can also click **Next**, which will navigate the workflow directly to the Review page if no procedures are planned or known.

Completing the IP procedure prescreening

Complete the Procedure Prescreen immediately to learn the classification of IP procedure(s) request. This is part of the comprehensive Inpatient workflow.



The procedure prescreen functionality immediately provides the classification of an inpatient procedure. If required, you can proceed with the workflow. If not required, or if another business evaluation occurs, a message informs you of the next action to take.

You might see messages while completing the Procedure Prescreen section. For more information about the messages, see Prescreen messages on page 36.

To complete the Procedure Prescreen section:

1. Enter the **Service start date** in the format mm/dd/yyyy or use the date picker. The procedure start date will automatically default to the admission date entered on Admission prescreen. This date may be edited with the inpatient length of stay time frame From and End dates labeled in the Inpatient Summary section.
2. Enter the **Service end date** in the format mm/dd/yyyy or use the date picker. The procedure end date will automatically default to the admission date entered on Admission prescreen. This date may be edited with the inpatient length of stay time frame From and End dates labeled in the Inpatient Summary section.

3. From the **Member's Applied Eligibility** menu, make a selection.

   This field auto-completes when the member’s eligibility is on record.

4. Select the service type from the **Service Type** menu.
5. Select the place of service from the **Place of Service** menu.
6. Specify the information for the **Servicing Provider** search box using the following steps:
   a. Enter a minimum of two characters in the **Search by Provider name** or **Search by Provider NPI** and select **Search**.
   b. If the characters you enter have a unique match, the fields are filled in automatically and you can skip the next step.

      This search is checked against the full TruCare provider database. If you search using the dashboard provider filter, you are limited to only those facilities associated with your user account.

7. Select the provider specialty fro m the **Provider Specialty** menu (optional).

   If the provider does not have a speciality, this field is not displayed. If the provider has only one specialty, the field is automatically populated with it.

8. If necessary, select **Clear** to start over.
9. In the **Requested Units** field, type the number of requested units or use the scroll arrows to enter requested days.

   The count must be at least 1 (one).

10. From the **Unit Type** menu, make a selection.

11. Specify the procedure:

    a. Enter a minimum of two characters in the **Search by Procedure name** or **Search by Code**, optionally choose a code set from the drop-down menu, and select **Search**.

       Use precise criteria to get the best search results; only 50 data entries are shown for each search.

       If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

       If your search did not result in a match, a slider opens with search results. To refine your search, select **Name contains** or **Name starts with**, enter your new search term in **Search by Procedure name** or **Search by Code**, optionally select a code set, and select **Search**.

    b. Choose the correct record (procedure name, code, code set) in the search results, scrolling through the list if needed.

    The code set includes the procedure coding schemes defined in TruCare.

    If necessary, select **Clear** to start over.

    You might see a message about a procedure code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

    > **Note:** Select **+** to add another inpatient procedure that has the same dates of service, service type, and servicing provider. If there is a different date of service, service type, or servicing provider, you can add another service from the review page. For additional information, see *Adding an IP Service*.

12. Select **Next**.

The Procedure prescreen information is processed. If you can proceed with the Inpatient procedure(s) requested, you automatically continue to the Procedure Details page where you can add more details.

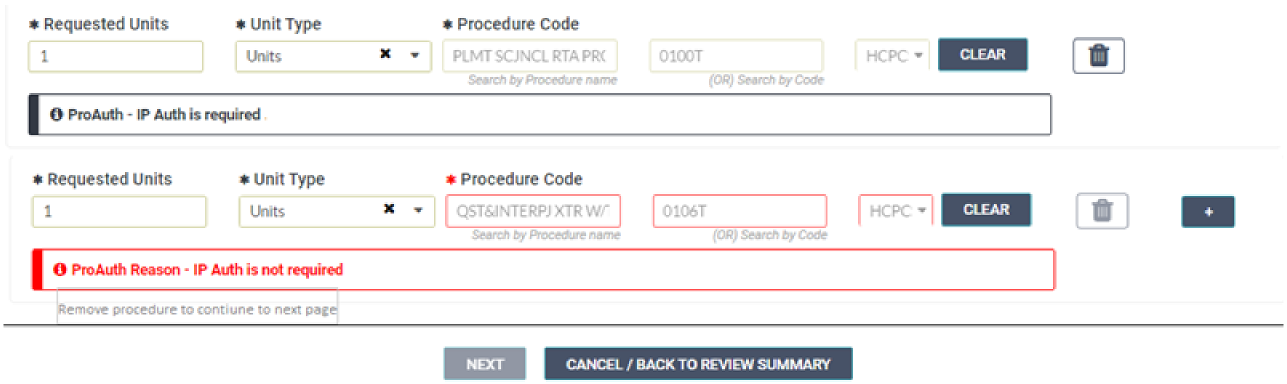
You might see a message with additional information about the Inpatient Procedure requested. Click **Next** again to continue to the Authorization Details page.

Sometimes the results of the prescreen evaluation prevent you from continuing with the Inpatient Procedure requested, for one of the following reasons and the message will display with a red font:

- Authorization is not required
- Duplicate request
- Review needed by a third party
- Member ineligibility

When one inpatient procedure is requested and results with one of the above results, Select **Cancel/Back to Review Summary** so that you may continue with the Inpatient Authorization request.

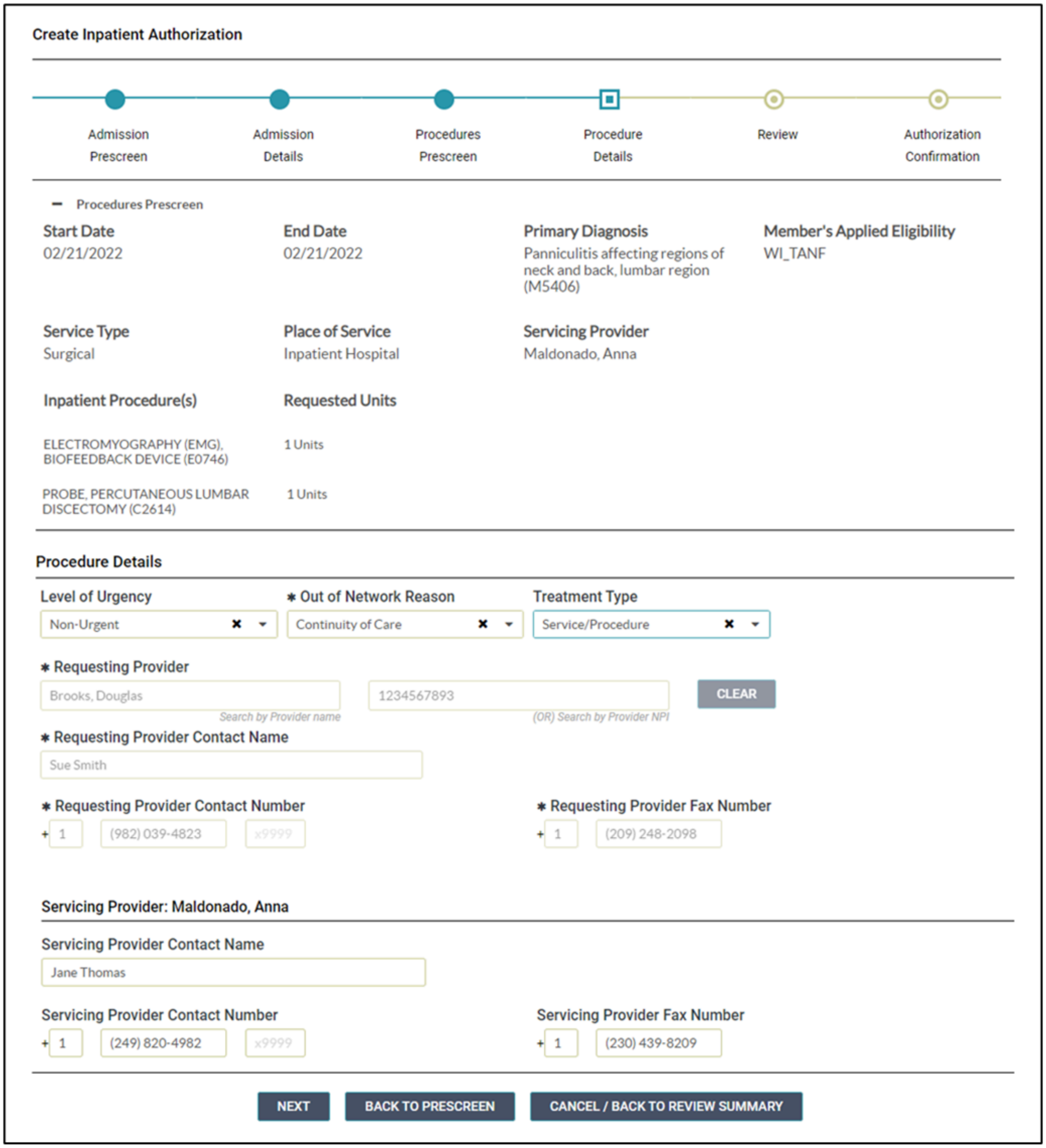
In the example below, there are multiple prescreen results where one result is "IP Auth is required" (dark gray text) and the other result is "IP Auth is not required" (red text). In order to proceed with the authorization, you need to remove the "IP Auth is not required" procedure. Hint text appears when you hover over the information icon or any part of the message. The **Next** button is disabled until you remove the procedure that is not required. Click the trashcan icon to remove the procedure not requiring authorization. The **Next** button is then enabled.



Providing the IP procedure details

After completing the Procedure Prescreen evaluation, provide IP procedure details on the Authorization Details page.

You will see the prescreen entries displayed as view only in the Procedure Prescreen section when the Procedure Details page opens.



If you need to edit something in the Procedure Prescreen section, you have to go back to the Prescreen page to enter the change. Select **Back to Prescreen**. After any change, prescreen runs again when you select **Next** to determine whether procedure is required.

To provide procedure details:

1. From the **Level of Urgency** list, select the urgency level.

   If **Urgency Definition** is available, select it to see your organization's guidance on choosing urgency levels.

   Your organization may require an attestation (acknowledgement that the selection is in compliance with the urgency definition). If so, an attestation window will display. Select **Yes** to attest. If you select No, TruCare ProAuth will revert your selection to your organization's configured value or back to blank.

2. From the **Out of Network Reason** menu, select the reason for requesting a facility that is out of network.

   > **Note:** This entry displays as required only when an out-of-network provider has been entered in prescreen.

3. From the **Treatment Type** menu, select the type of treatment being requested.
4. View the Requesting Provider and contact information that are carried forward from the Admission details page. This information displays in view only mode.
5. In the **Servicing Provider Contact Name** field, enter the contact name specified by the provider.
6. Enter the servicing provider contact number for the authorization, including the country code and extension, if any.
7. Enter the servicing provider fax number, including the country code.
8. Specify a secondary diagnosis (or more than one) if needed, using the following steps:

   a. Enter a minimum of two characters in the **Search by Diagnosis name** or **Search by Code** and select **Search**.

      Use precise criteria to get the best search results; only 50 data entries are shown per search.

      To refine your search, select **Name contains** or **Name starts with**, enter your new search term, then select **Search**.

      If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

   b. Choose the correct record (diagnosis name, code, code set) in the search results, scrolling through the list if needed.

   The code set includes the diagnosis coding schemes defined in TruCare.

   If necessary, select **Clear** to start over.

   You might see a message about a diagnosis code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

   > **Note:** Select **+** to add another secondary diagnosis.

9. If you need to add a note or attachment, do so now.

   See Adding notes and attachments to authorization requests on page 85 for details.

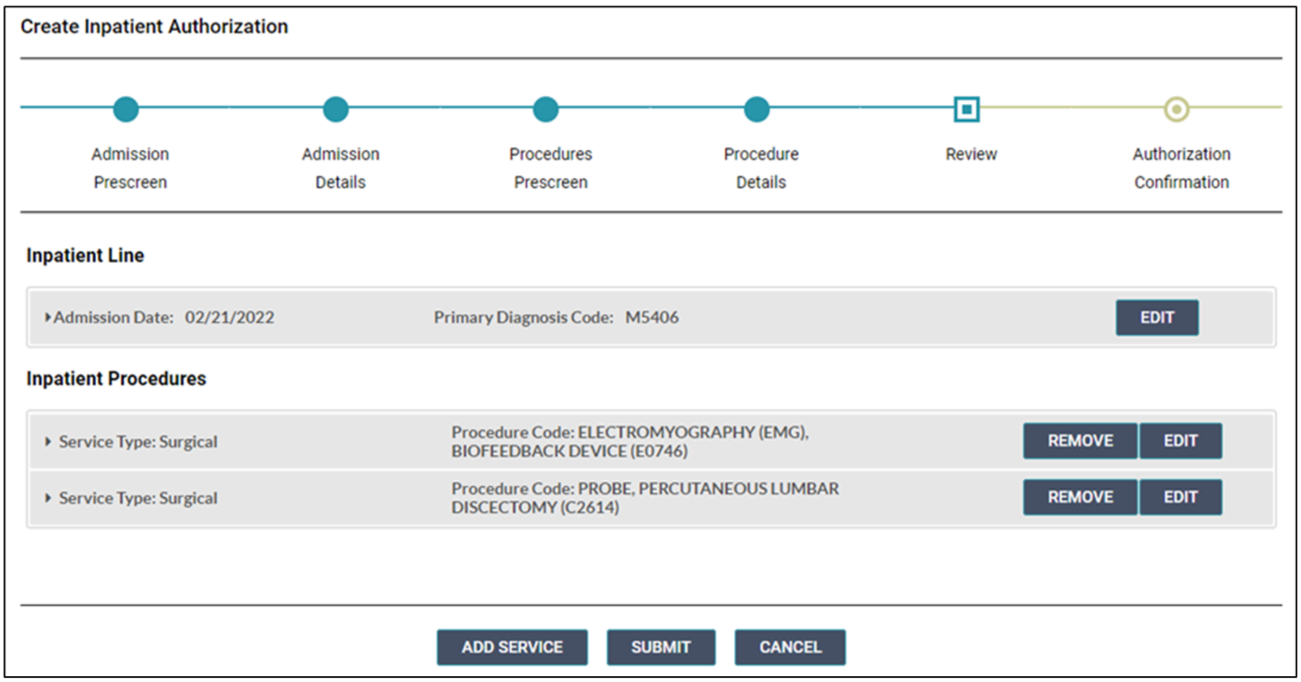
   If you try to submit the request without adding a required note or attachment, a message that a note or attachment is required appears on the screen.

10. Select **Next** and you are moved to the Review page to review inpatient admission and inpatient services.

Reviewing the IP authorization

After providing IP procedure details, you can review and make any needed changes.

The Review page provides Admission details and Inpatient procedure details. This page contains edit and remove (when there are inpatient procedures) functions to help you ensure the accuracy of an authorization before submission..



To review/make changes to services and submit the authorization request:

1. Review the Inpatient admission and any inpatient procedures that are entered on the page.

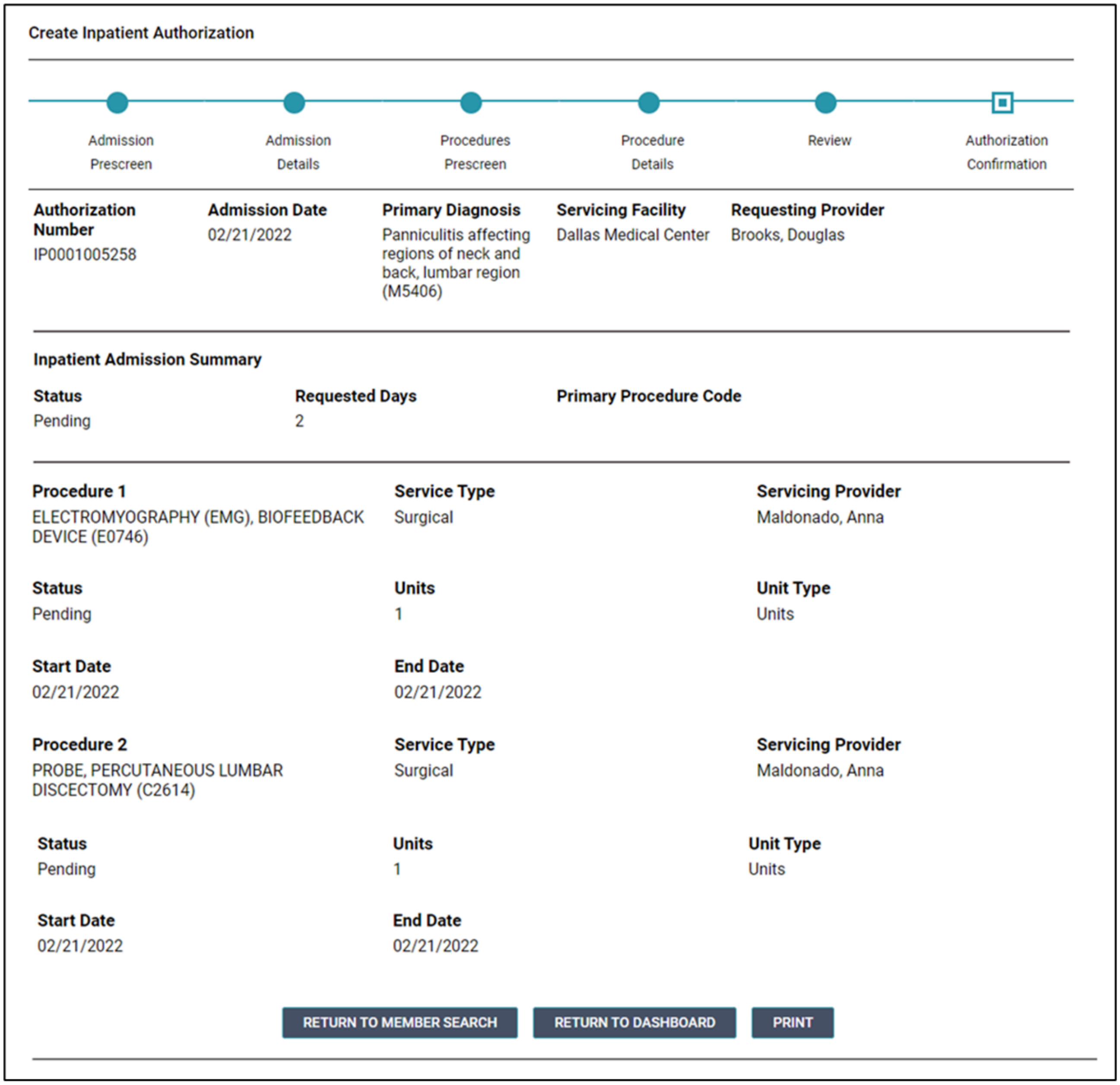
   > **Note:** Make sure that your entries are accurate. You cannot edit an authorization request after you submit it.

2. If any of the following changes are needed, use the appropriate instructions.

Select this option...	To do this...
Edit	To edit an inpatient procedure on the page. See the instructions in Editing an IP procedure or service on page 53.
Remove	To remove an inpatient procedure on the page. This button is available if there is more than one service listed. See the instructions in Removing an IP procedure or service on page 53.
Add Service	Add an inpatient procedure or service to the request. See the instructions in Adding an IP procedure or service on page 52.

3. When you are done reviewing services and ready to submit the authorization request, select **Submit**.

When configured, a custom message from your organization will display at the top of the page. An authorization summary is displayed and includes the authorization number for the admission and a status for each inpatient procedure included on the authorization..



You can print a copy of the confirmation for your records. The confirmation prints to PDF using the browser print function.

Return to member search or to the dashboard.

Adding an IP procedure or service

You can add an inpatient procedure or service when creating or extending an IP authorization request from the Review page.

When adding a procedure or service from the Review page, you are returned to the Procedure Prescreen page.

See these topics to complete this workflow:

- Completing the IP procedure prescreening on page 43
- Providing the IP procedure details on page 47
- Reviewing the IP authorization on page 50

Removing an IP procedure or service

You can remove an inpatient procedure or service from the Review page.

1. To remove, select the **Remove** button on the inpatient procedure you want to remove.
2. Select **Yes** in the confirmation prompt. The inpatient procedure is removed from the Review page, where you can finish reviewing and submit the authorization.

Editing an IP procedure or service

You can edit an inpatient procedure or service from the Review page.

When editing from the Review page, you are returned to the Procedure Prescreen page. Edits are subject to prescreen evaluation. Complete the entries and, if authorization is required, advance to the Procedure Details page.

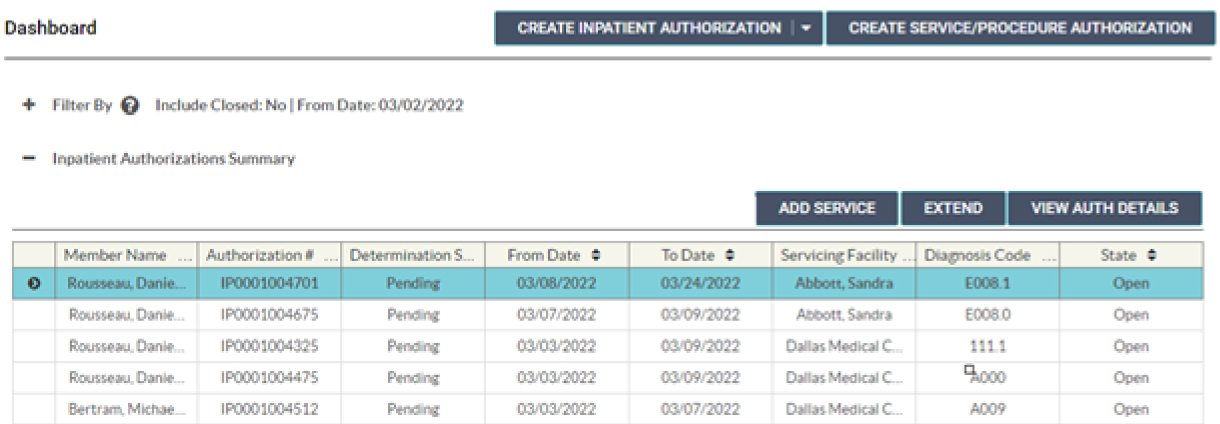
You can edit specific information on the Procedure details page (Requesting provider and contact information are not editable on this page). When you are done, click **Next** to advance to the Review page.

Adding an IP procedure

If the inpatient comprehensive workflow is supported, you can add inpatient procedure(s) or service(s) to an open IP authorization request. This workflow offers convenience and work/time efficiencies.

In the Add Service workflow, you can only add procedure(s) that are occurring during the inpatient hospital stay.

From the inpatient summary table on the dashboard, select the authorization.



Click **Add Service**, the form navigates directly to the **Procedure Prescreen** page.

See the following sections to complete this workflow:

- Completing the IP procedure prescreening
- Providing the IP procedure details
- Reviewing the IP authorization

Extending an IP authorization

You can extend an open IP authorization request. The extend function includes standard or comprehensive workflow that offers convenience and work/time efficiencies.

In the Extend workflow, you can only extend a stay as related to the existing authorization. Not all fields of the authorization request form can be edited, because some fields default from the initial authorization. For example, you cannot change the primary diagnosis. For any new episode of care, create another IP authorization request.

All IP authorizations that you extend require prescreen evaluation.

When extending IP authorization requests, you might need to submit detailed notes or upload more attachments to justify the specific request. Specification is set by the payer. In such instances, text messages are displayed in the workflow to inform you of the exact requirements. Look for these directions on the Authorization Details page.

Note: Review the following information.

- Before submitting an authorization request, you can extend an existing stay only once, but you can make multiple extensions on a single authorization. Each extend submission creates a distinct line item on the authorization request.
- You can edit information added during the extend workflow only before you submit the request.

As you proceed through the workflow, the header on the screens reflects the type of authorization request you are creating: Extend Inpatient Authorization for medical IP Authorization requests or Extend Inpatient

Behavioral Health Authorization for behavioral health IP Authorization requests. You can also see where you are in the main parts of the workflow: Prescreen, Authorization Details, or Authorization Confirmation.

The standard authorization extension workflow involves the following high-level tasks:

1. Start an authorization request extension.
2. Complete the Prescreen section of the extension.
3. Complete the Authorization Details section of the extension and submit it.

> **Note:** The option values shown in the workflow topics in this section are illustrative only.

The comprehensive authorization extension workflow involves the following high-level tasks:

1. Start an authorization request extension.
2. Complete the Admission Prescreen section of the extension.
3. Complete the Admission Details section of the extension.
4. Complete the Procedure Prescreen section if an Inpatient Procedure is needed or click **Next** to go the Review page.
5. Click **Submit**.

Topics in this section

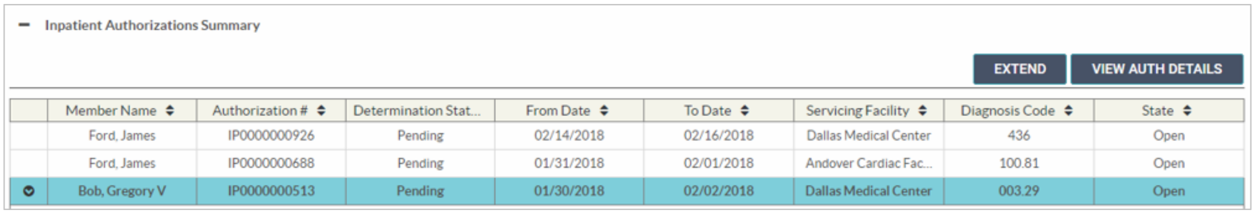
Starting an IP authorization extension

Initiate an IP authorization extension from the dashboard summary table.

The IP authorizations that you can extend appear in the IP Authorizations Summary table on the dashboard.

To start an authorization extension:

1. Go to the IP Authorizations Summary on the dashboard and select the authorization on which you are extending a stay.



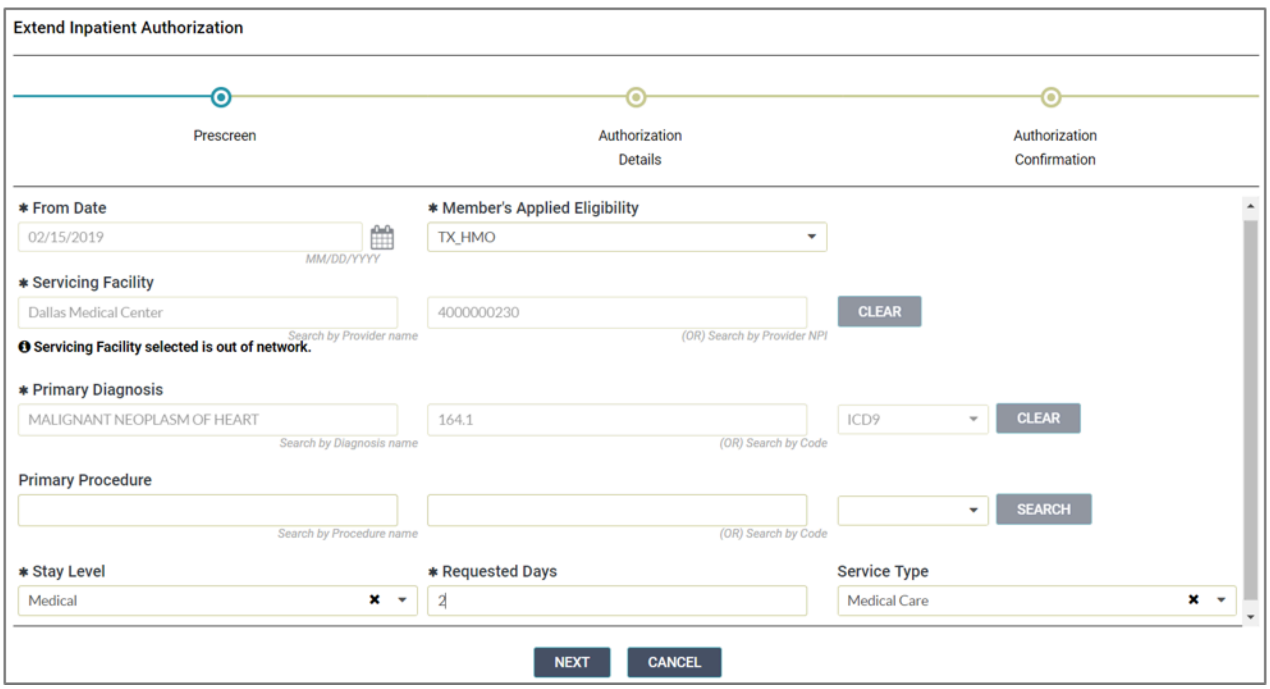
2. Select **Extend**.

You advance to the Prescreen page to enter data for the preliminary evaluation.

Completing the extend IP authorization prescreening

Complete the Prescreen page to determine if you can proceed with the IP authorization extension.

You can request continued stay for a patient in an inpatient treatment setting so that the payer is notified and has all the clinical information needed to make a determination.



To provide prescreen information for an authorization extension:

1. Complete the required fields on the Prescreen page.

   For more information about working in this page, refer to the instructions in Completing the IP authorization prescreening on page 33.

2. Select **Next**.

You advance to the Authorization Details page if authorization is required. Provide additional details on that page.

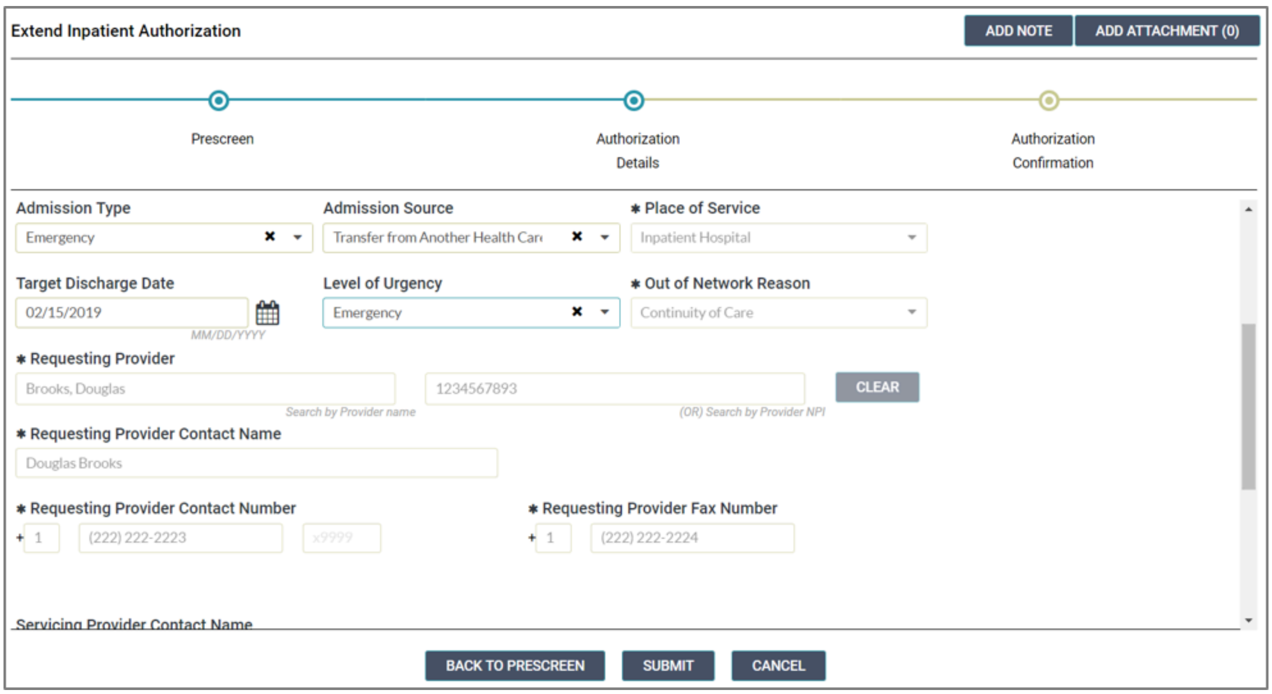
When no authorization is required, an explanation appears. Additional comments might follow the reason if the payer has more information on the specific authorization request.

You cannot proceed if the member is ineligible or if the authorization request is identified as a duplicate.

Completing the extend IP authorization details

When extending an IP authorization, after completing the prescreen evaluation, provide additional information on the Authorization Details page.

The editable fields on the Authorization Details page are optional. You might be required to add a note, attachment, or both.



To complete the authorization details section:

1. Complete fields on the page as needed.

   For more information about working in this page, refer to the instructions in Providing the IP authorization details on page 37.

2. Add any notes or attachments that are required.

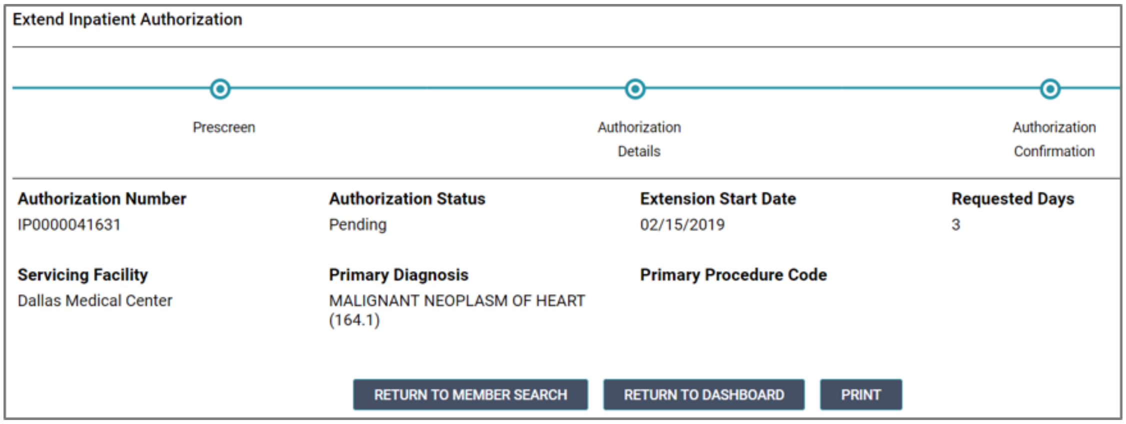
   For more information, see Adding notes and attachments to authorization requests on page 85.

3. Add clinical criteria if required.

   For more information, see Adding clinical criteria to authorization requests on page 87.

4. Select **Submit**.

You move to the Authorization Confirmation page. This page displays the authorization status of the IP Extension. In this example, the status is Pending.



You can print the authorization request for the new line item from the Authorization Confirmation page. A printed copy of the authorization request includes authorization summary, authorization details, and details of each line item. The member in focus prints on each page.

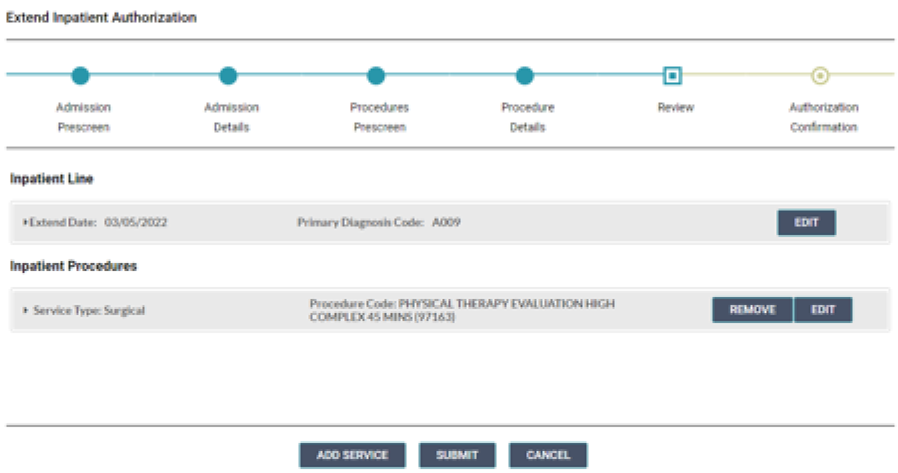
Adding IP procedure(s) during Extend workflow

For the inpatient comprehensive workflow, you can add inpatient procedure(s) performed during the inpatient stay. After admission details, follow the steps for Completing the IP procedure prescreening on page 43 and Providing the IP procedure details on page 47.

You can also click **Next**, which will navigate the workflow directly to the Review page, if no procedures are planned or known.

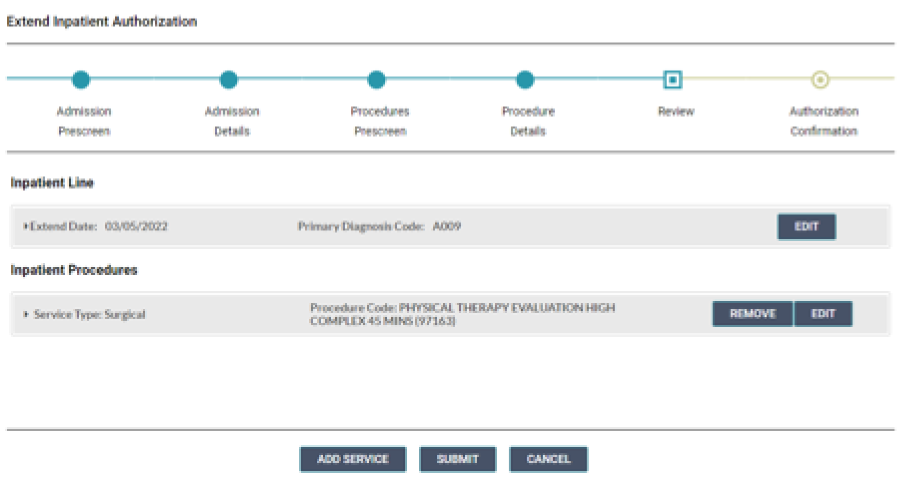
Topics in this section

The Review page provides inpatient extension details, including any inpatient procedure added. This page contains edit and remove functions (when there are one or more inpatient procedure) to help you ensure the accuracy of an authorization before submission.



Reviewing the IP authorization extension

The Review page provides inpatient extension details, including any inpatient procedure added. This page contains edit and remove functions (when there are one or more inpatient procedure) to help you ensure the accuracy of an authorization before submission.



To review or make changes to services and submit the authorization request:

1. Review the inpatient extension and any inpatient procedures.
2. To change an inpatient line procedure, select **Edit**.
3. To delete a procedure, select **Remove**.
4. If another inpatient procedure is needed, select **Add Service**.
5. When your review is complete, select **Submit** to submit the authorization request.

   When configured, a custom message from your organization appears at the top of the page. An authorization summary appears than includes the authorization number for the admission and a status for each inpatient procedure included in the authorization. Using the browser print function, you can print a copy of the confirmation for your records to PDF.

6. Return to member search or to the dashboard.

Creating an SP authorization request

You can create service/procedure (SP) authorization requests in the TruCare ProAuth dashboard.

You can create two types of service/procedure (SP) authorization requests: medical or behavioral health. If your organization does not support creation of behavioral health authorization requests, they are not enabled in TruCare ProAuth. The authorization request workflow is the same for both types of requests.

Throughout the workflow for submitting an SP authorization request, you must complete all mandatory fields marked with an asterisk. Authorizations might include User Defined Fields (UDFs). For more information about UDFs, see UDF guidelines on page 119.

As you proceed through the workflow, the header on the screens reflects the type of authorization request you are creating: Create Service/Procedure Authorization for medical SP authorization requests or Create Service/ Procedure Behavioral Health Authorization for behavioral health SP authorization requests. You can also see where you are in the main parts of the workflow: Prescreen, Authorization Details, Services, or Confirmation.

The authorization creation workflow involves the following high-level tasks:

1. Start an authorization request.
2. Complete the SP authorization prescreen.
3. Complete the Authorization Details section of the request.
4. Review services and modify them as needed, then submit the authorization.

> **Note:** The option values shown in the workflow topics in this section are illustrative only.

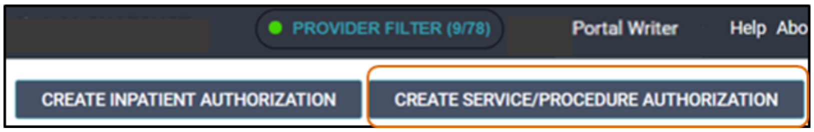
Topics in this section

Starting an SP authorization request

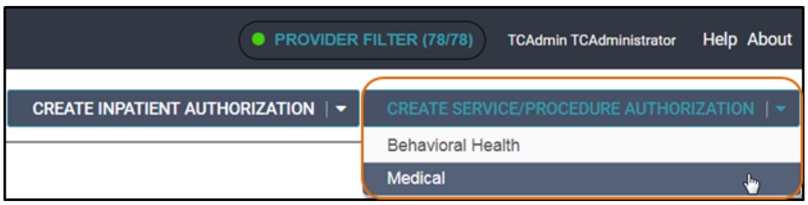
Initiate an SP authorization request on the dashboard.

Use one of the following actions on the dashboard to start creating an SP Authorization request. The available actions depend on whether behavioral health is enabled in TruCare ProAuth.

- If behavioral health is not enabled, select **Create Service/Procedure Authorization** (to create a medical authorization).



- If behavioral health is enabled, from the **Create Service/Procedure Authorization** menu, choose Behavioral Health or Medical.

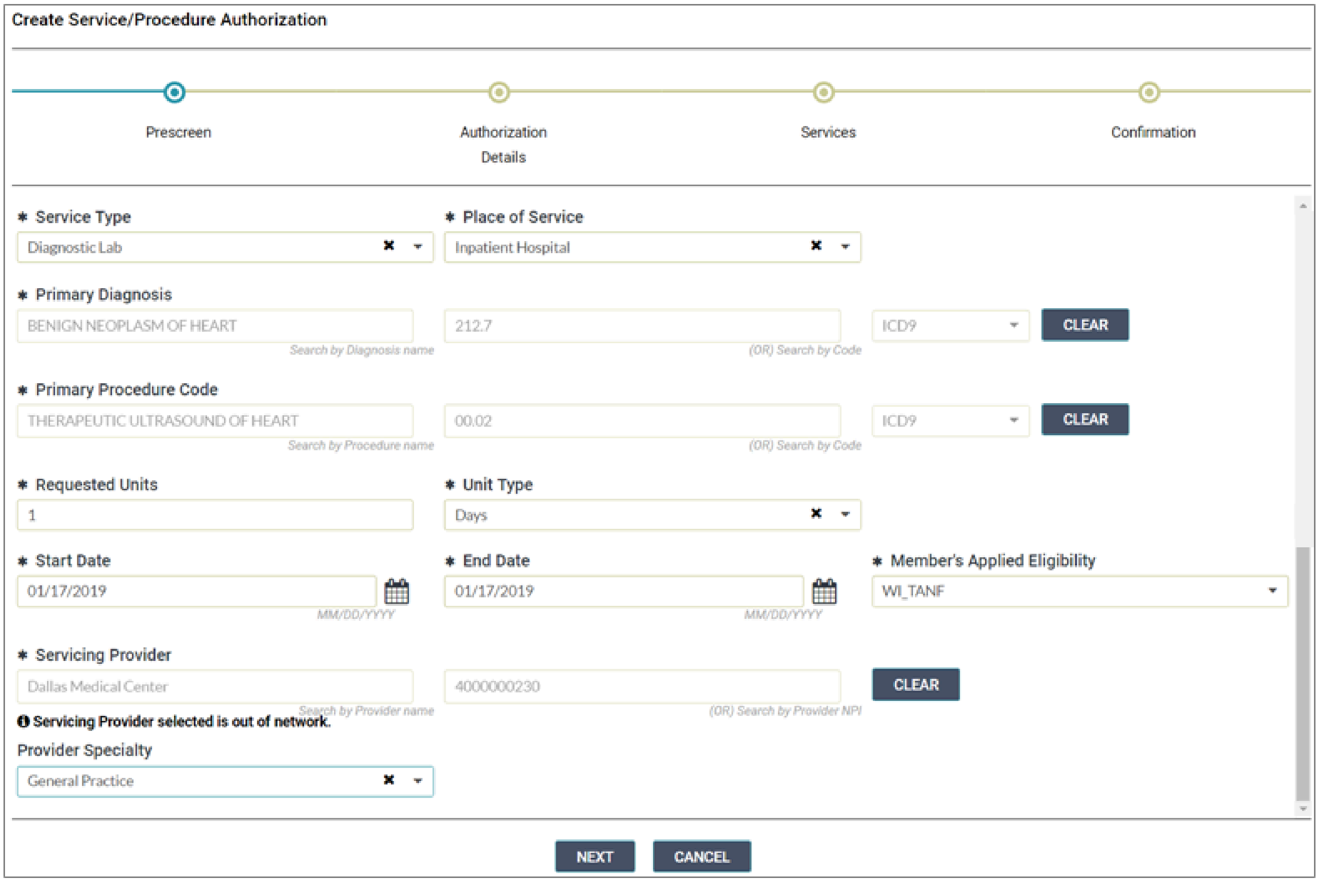


The Prescreen page opens. Now you can add information for preliminary evaluation.

Completing the SP authorization prescreening

Complete the prescreening to learn the classification of an SP authorization request immediately.

In the first part of the authorization request process you provide prescreen information.



The prescreen evaluation can immediately provide you with the classification of an authorization request. If authorization is required, you can proceed with the workflow. If authorization is not required, or if another business evaluation occurs, a message informs you of the next action to take.

You might see messages while completing the Prescreen section. For more information about the messages, see Prescreen messages on page 36.

To complete the Prescreen section:

1. Select the service type from the **Service Type** menu.
2. Select the place of service from the **Place of Service** menu.

3. Specify the primary diagnosis using the following steps:

   a. Enter a minimum of two characters in the **Search by Diagnosis name** or **Search by Code**, optionally choose a code set from the drop-down menu, and select **Search**.

      Use precise criteria to get the best search results; only 50 data entries are shown per search.

      If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

      If your search did not result in a match, a slider opens with search results. To refine your search, select **Name contains** or **Name starts with**, enter your new search term in **Search by Diagnosis name** or **Search by Code**, optionally select a code set, and select **Search**.

   b. Choose the correct record (diagnosis name, code, code set) in the search results, scrolling through the list if needed.

   The code set includes the diagnosis coding schemes defined in TruCare.

   If necessary, select **Clear** to start over.

   You might see a message about a diagnosis code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

4. Specify the primary procedure using the following steps:

   > **Note:** The fields may already include a default procedure code specified by your administrator for the selected service type. If you need to change the default procedure code, use these steps.

   a. Enter a minimum of two characters in the **Search by Procedure name** or **Search by Code**, optionally choose a code set from the drop-down menu, and select **Search**.

      Use precise criteria to get the best search results; only 50 data entries are shown per search.

      If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

      If your search did not result in a match, a slider opens with search results. To refine your search, select **Name contains** or **Name starts with**, enter your new search term in **Search by Procedure name** or **Search by Code**, optionally select a code set, and select **Search**.

   b. Choose the correct record (procedure name, code, code set) in the search results, scrolling through the list if needed.

   The code set includes the procedure coding schemes defined in TruCare.

   If necessary, select **Clear** to start over.

   You might see a message about a procedure code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

5. In the **Requested Units** field, type the number of requested units or use the scroll arrows to enter requested days.

   The count must be at least 1 (one).

6. From the **Unit Type** menu, make a selection.
7. Enter the service start date in the format mm/dd/yyyy or use the date picker.
8. Enter the service end date in the format mm/dd/yyyy or use the date picker.
9. From the **Member's Applied Eligibility** menu, make a selection.

   This field auto-completes when the member’s eligibility is on record.

10. Specify the servicing provider using the following steps:
    a. Enter a minimum of two characters in the **Search by Provider name** or **Search by Provider NPI** and select **Search**.

       If the characters you enter have a unique match, the fields are filled in automatically and you can skip the next step.

       This search is checked against the full TruCare provider database. If you search using the dashboard provider filter, you are limited to only those facilities associated with your user account.

    b. Select the provider from the list.
    c. Select the provider specialty from the drop-down list (optional).

       If the provider does not have a specialty, this field is not displayed. If the provider has only one specialty, the field is automatically populated with it.

    If necessary, select **Clear** to start over.

11. Select **Next**.

The prescreen information is processed. If you can proceed with the authorization request, you automatically continue to the Authorization Details page, where you can add more details.

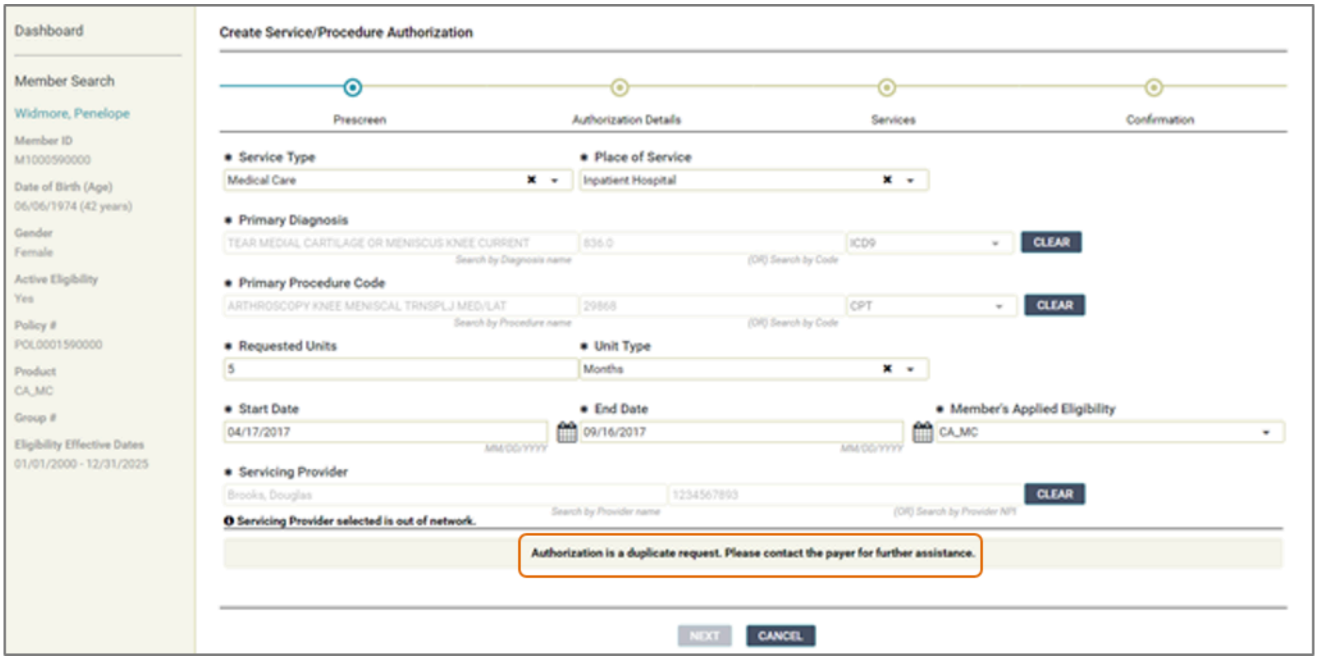
You might see a message with additional information about the request. Click **Next** again to continue to the Authorization Details page.

Sometimes the results of the prescreen evaluation prevent you from continuing with the authorization request, for one of the following reasons:

- Authorization is not required
- Duplicate request
- Review needed by a third party
- Member ineligibility

Select **Cancel** and then respond to the prompt to discard changes. Select **Yes** to return to the dashboard; select **No** to stay in the Prescreen page.

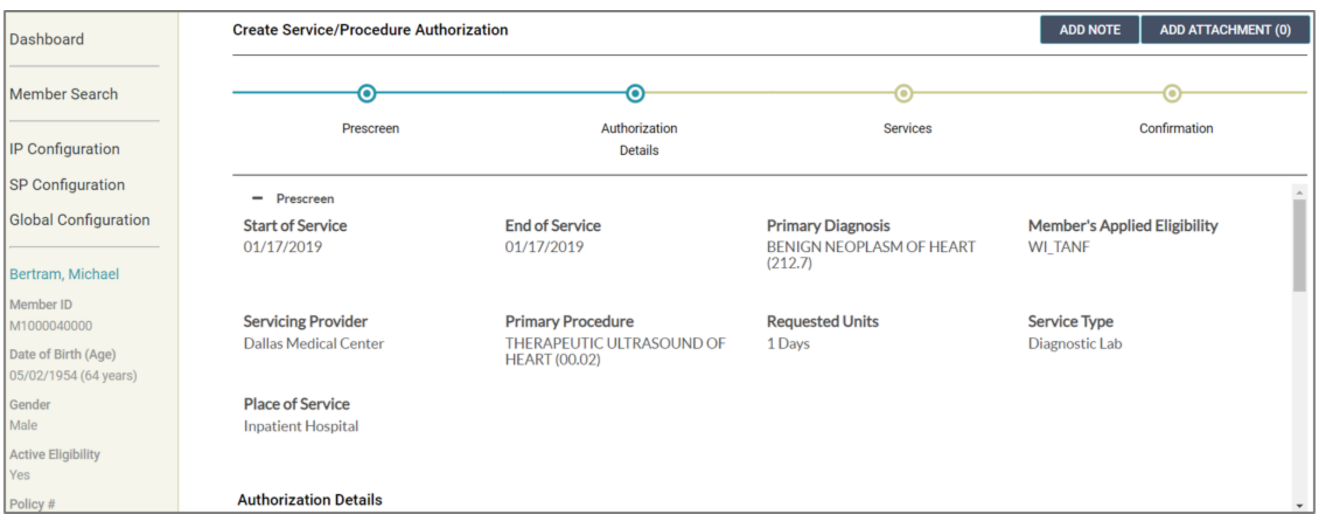
In the example below, the prescreen evaluation reports that “authorization is a duplicate” and instructs you to contact the payer. You cannot proceed.



Providing the SP authorization details

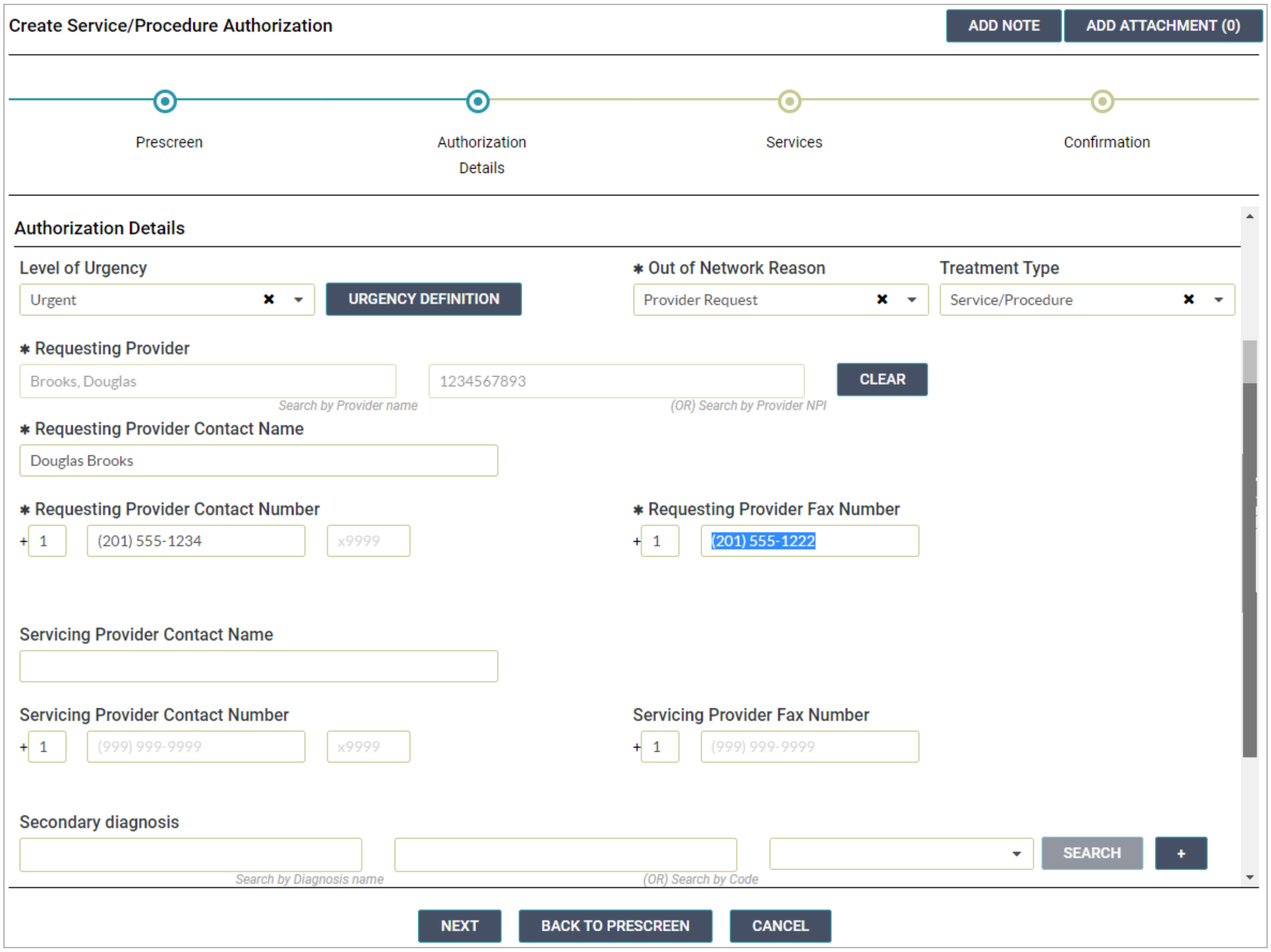
After completing the prescreen evaluation, provide SP authorization request details on the Authorization Details page.

When the Authorization Details page opens, you will see the prescreen entries displayed as view only near the top.



If you need to edit something in the Prescreen section, you have to go back to the Prescreen page to enter the change. Select **Back to Prescreen**. After any change, prescreen runs again when you select **Next** to determine whether authorization is required.

Complete the authorization details fields in the rest of the Authorization Details page.



To provide authorization details:

1. From the **Level of Urgency** list, select the urgency level.

   If **Urgency Definition** is available, select it to see your organization's guidance on choosing urgency levels.

   Your organization may require an attestation (acknowledgement that the selection is in compliance with the urgency definition). If so, an attestation window will display. Select **Yes** to attest. If you select No, TruCare ProAuth will revert your selection to your organization's configured value or back to blank.

2. From the **Out of Network Reason** menu, select the reason for requesting a facility that is out of network.

   > **Note:** This entry displays as required only when an out-of-network facility has been entered in prescreen.

3. From the **Treatment Type** menu, select the type of treatment being requested.

4. Specify the requesting provider using the following steps:

   a. Enter a minimum of two non-wildcard characters in the **Search by Provider name** or **Search by Provider NPI**.

      The requesting provider is the entity that is requesting/ordering the service or admission for a member.

      By default searches include only providers associated with your user account. You may have the option to search all available providers by selecting **Search All Providers**. When using the **Search All Providers** option, use precise criteria to get the best search results; only 50 data entries are shown per search.

      > **Note:** When authorization requests are created, searches for requesting providers use all providers associated with your account (or all providers if you have the option to search all providers and select it), not solely the providers selected in the Provider Filter at a given time. For more information about providers and the Provider Filter, see Applying a filter to your provider list on page 111.

   b. Select **Search**.

      If the characters you enter have a unique match, the fields are filled in automatically and you can skip the next step. Do an advanced search, if necessary.

   c. Select the provider from the list.

5. In the **Requesting Provider Contact Name** field, enter the contact name specified by the provider.
6. Enter the requesting provider contact number for the authorization, including the country code and extension, if any.
7. Enter the requesting provider fax number, including the country code.
8. In the **Servicing Provider Contact Name** field, enter the contact name specified by the provider.
9. Enter the servicing provider contact number for the authorization, including the country code and extension, if any.
10. Enter the servicing provider fax number, including the country code.

11. Specify a secondary diagnosis (or more than one) if needed, using the following steps:

    a. Enter a minimum of two characters in the **Search by Diagnosis name** or **Search by Code** and select **Search**.

       Use precise criteria to get the best search results; only 50 data entries are shown per search.

       To refine your search, select **Name contains** or **Name starts with**, enter your new search term, then select **Search**.

       If the characters you enter match a single record, the fields are filled in automatically and you can skip the next step.

    b. Choose the correct record (diagnosis name, code, code set) in the search results, scrolling through the list if needed.

    The code set includes the diagnosis coding schemes defined in TruCare.

    If necessary, select **Clear** to start over.

    You might see a message about a diagnosis code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

    Note: Select **+** to add another secondary diagnosis.

12. If you need to add a note or attachment, do so now.

    See Adding notes and attachments to authorization requests on page 85 for details.

    If you try to submit the request without adding a required note or attachment, a message that a note or attachment is required appears on the screen.

13. If you need to add clinical criteria, do so now.

    See Adding clinical criteria to authorization requests on page 87 for details.

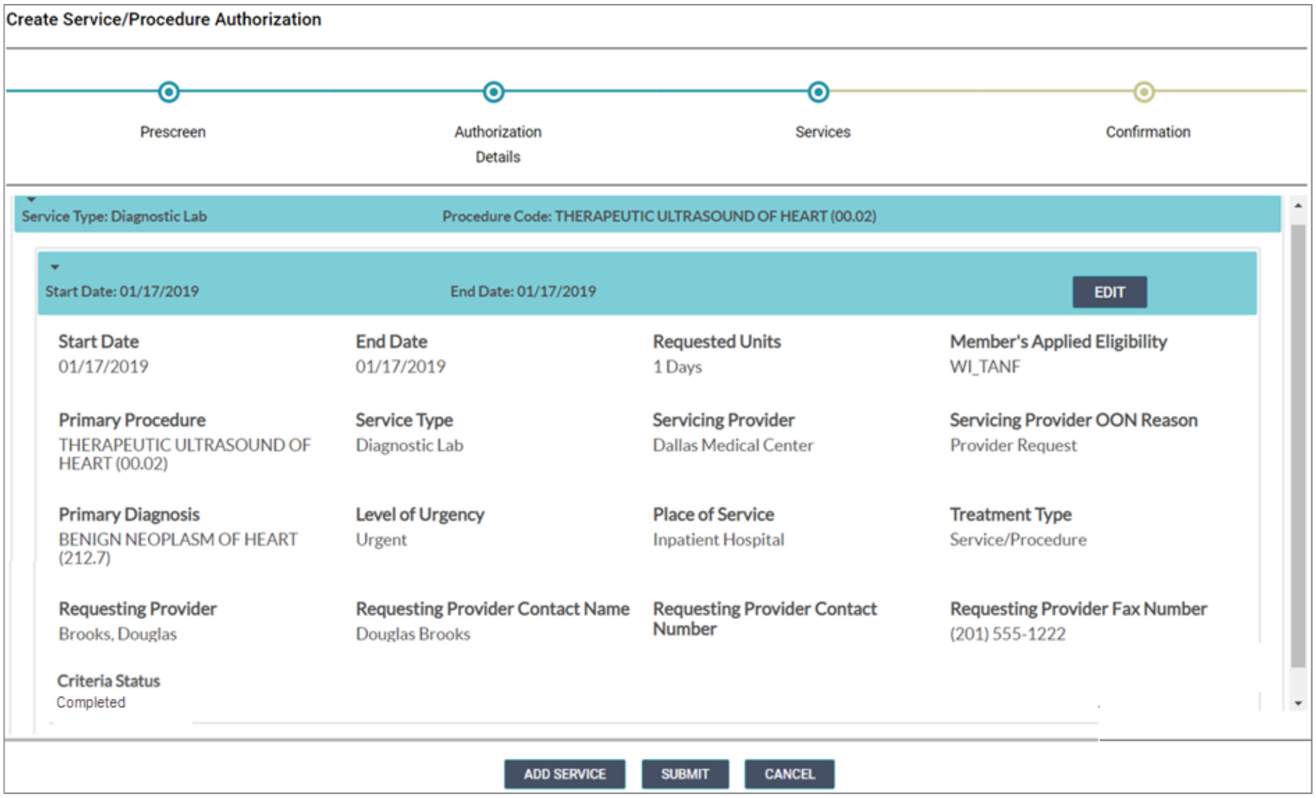
    If you try to submit the request without adding required clinical criteria, messages that clinical criteria are required appear on the screen.

14. Select **Next** and you are moved to the Services page to review services.

Reviewing the SP authorization services

After providing SP authorization details, you can review the services and make any needed changes on the Services page.

The Services page contains add, edit, and remove (when there are multiple services) functions to help you ensure the accuracy of an authorization request before submission. The procedure details that you entered on the Authorization Details page display under a header that includes service type and procedure code. You can edit this primary service but not remove (discard) it. The criteria status field appears per line item only if clinical criteria are created for it.



To review/make changes to services and submit the authorization request:

1. Review the services on the page.

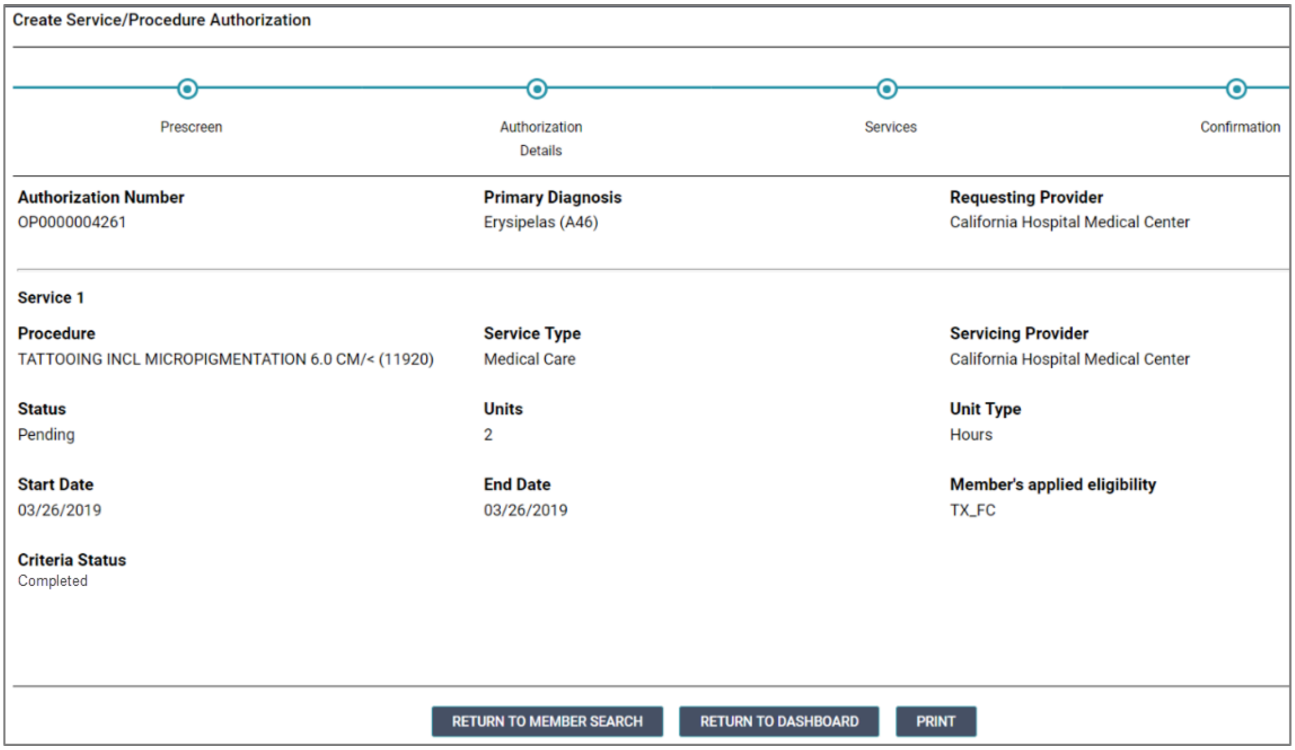
> **Note:** Make sure that your entries are accurate. You cannot edit an authorization request after you submit it.

2. If any of the following changes are needed, use the appropriate instructions.

Select this option...	To do this...
Add Service	Add a service to the request. See the instructions in Adding or editing a service on page 70.
Edit	To edit a service on the page. See the instructions in Adding or editing a service on page 70.
Remove	To remove a service on the page. This button is available if there is more than one service listed. See the instructions in Removing a service on page 72.

3. When you are done reviewing services and ready to submit the authorization request, select **Submit**.

When configured, a message informs you that the authorization request has been submitted successfully. If the authorization has clinical criteria, a popup displays indicating that the authorization is being submitted. It will close when the submission is complete. An authorization summary is displayed and includes the authorization number and status. Criteria status fields appear for services in the authorization that have clinical reviews associated with them.



You can print a copy of the confirmation for your records. (The confirmation prints to PDF using the browser print function.)

Return to member search or to the dashboard.

Topics in this section

Adding or editing a service on page 70
You can add a new service or edit a prescreened service when creating an SP authorization request.

Removing a service on page 72
You can remove a service if you have at least two services associated with the SP authorization request.

Adding or editing a service

You can add a new service or edit a prescreened service when creating an SP authorization request.

When adding or editing a service from the Services page, you are returned to the Prescreen page. The additional service or change to a prescreened service is subject to evaluation to determine if authorization is required. Complete the entries and, if authorization is required, advance to the Authorization Details page.

To add or edit a service:

1. On the Services page, select **Add Service** or **Edit**.

   You may have already done this and are on the Prescreen page, in which case you can ignore this step.

   The Prescreen page opens.

2. Complete the required fields.

   > **Note:** You can edit all fields in prescreen with the possible exception of primary diagnosis. If the request includes more than one service, the primary diagnosis is read-only. If the request includes only one service, you can edit the primary diagnosis.

   The Procedure fields may already include a default procedure code specified by your administrator for the selected service type. You can edit them and change the code. You might see a message about a procedure code being expired. For more information about expired codes, see Expired diagnosis or procedure codes on page 121.

   For more information about the fields, see Completing the SP authorization prescreening on page 61.

3. Select **Next**.

   If authorization is required, you proceed to Authorization Details.

   If authorization is not required, select **Cancel/Back to Services Summary** to complete the authorization request. See Reviewing the SP authorization services on page 68 for the final step.

4. On the Authorization Details page, provide details as follows:

   a. From the **Level of Urgency** list, select a value.

      If **Urgency Definition** is available, select it to see your organization's guidance on choosing urgency levels.

      Your organization may require an attestation (acknowledgement that the selection is in compliance with the urgency definition). If so, an attestation window will display. Select **Yes** to attest. If you select No, TruCare ProAuth will revert your selection to your organization's configured value or back to blank.

   b. From the **Treatment Type** menu, select a value.

   c. If required, from the **Out of Network Reason** menu, select a value.

      This is required if an out-of-network servicing provider was originally selected.

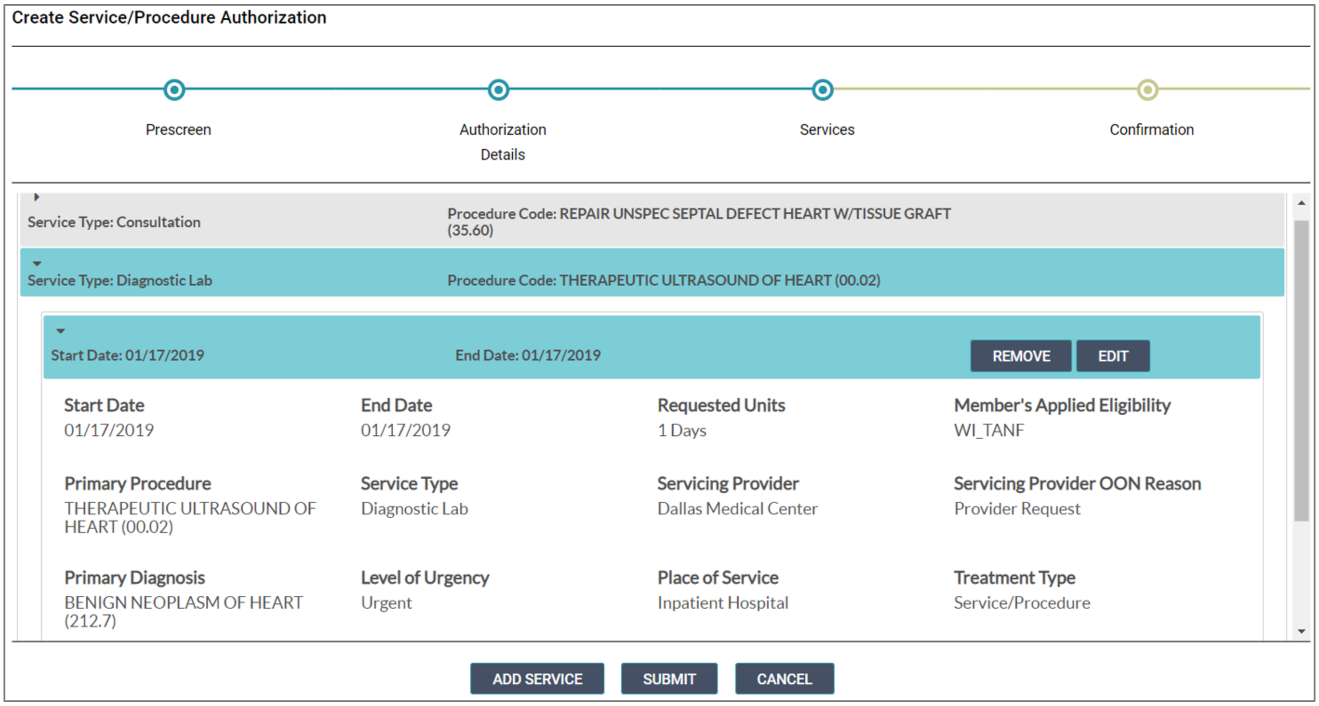
   > **Note:** The requesting provider and requesting provider name, number, and fax number are automatically entered.

   For more information about the fields, see Providing the SP authorization details on page 65.

5. When you are done, select **Next**.

You proceed to the Services page, where you can review the services and submit the authorization. See Reviewing the SP authorization services on page 68 for details.

In this example, a second service has been added. (Note that only one service can be expanded at a time.) After you add one or more services, you can edit all of the services and remove all but one service.



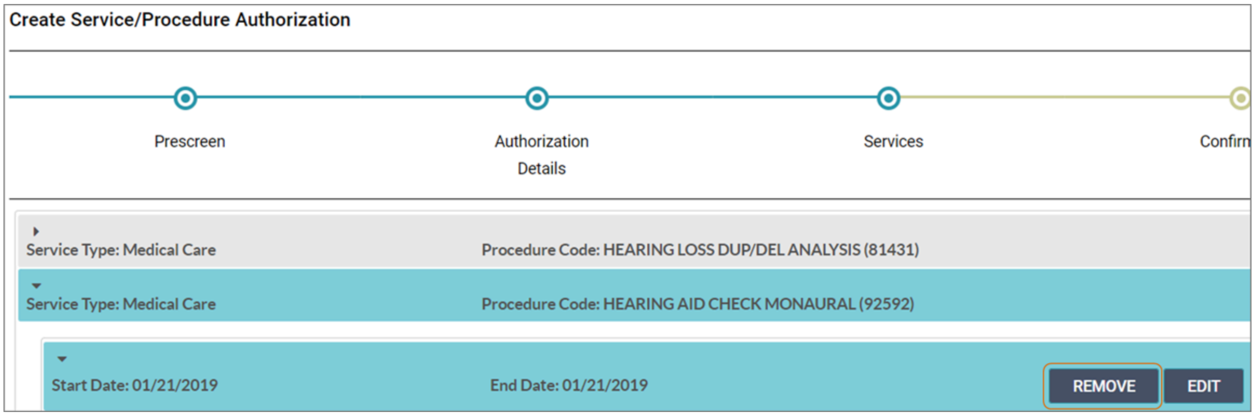
Removing a service

You can remove a service if you have at least two services associated with the SP authorization request.

At least two services are required for the Remove function to be activated. When you have multiple services listed on the Services page, you can remove all services except one. The service that remains can be edited, but not removed.

To remove a service:

1. On the Services page, select the service you want to remove, then select **Remove**.



2. Select **Yes** in the confirmation prompt.

The service is removed from the Services page, where you can finish reviewing services and submit the authorization. See Reviewing the SP authorization services on page 68 for details.

Adding or extending an SP service

You can add a service or extend an existing service on an open SP authorization request. These workflows offer convenience and work/time efficiencies.

In the Add Service and the Extend workflows, you can only add or extend a service as related to the existing authorization. Not all fields of the authorization request form can be edited, because some fields default from the initial authorization. For example, you are unable to change the primary diagnosis. For any new episode of care, create another SP authorization.

All services that you add or extend require prescreen evaluation.

Note: Keep the following information in mind.

- Before submitting an authorization request, you can extend an existing service only once.
- Only services that you add or extend in a workflow can be edited (and possibly) removed before submitting the authorization request.
- An added or extended service must be created before the Remove function is activated on the Services page. (If you have only one added or extended service and you want to modify it, you can edit the line item. If you want to discard it, you can cancel the authorization.)

As you proceed through the workflow for adding or extending a service, the header on the screens reflects the type of authorization request you are creating: Extend Service/Procedure Authorization for medical SP Authorization requests or Extend Service/Procedure Behavioral Health Authorization for behavioral health SP Authorization requests. You can also see where you are in the main parts of the workflow: Prescreen, Authorization Details, Services, or Confirmation.

Note: The option values shown in the workflow topics in this section are illustrative only.

Topics in this section

Adding a service to an existing SP authorization

You can add a service to an SP authorization that has already been submitted.

The workflow to add a service involves the following high-level tasks:

1. Start adding a service to the authorization.
2. Complete the Prescreen section.
3. Complete the Authorization Details section.
4. Review the services and submit the request.

Topics in this section

Start adding a service to an SP authorization

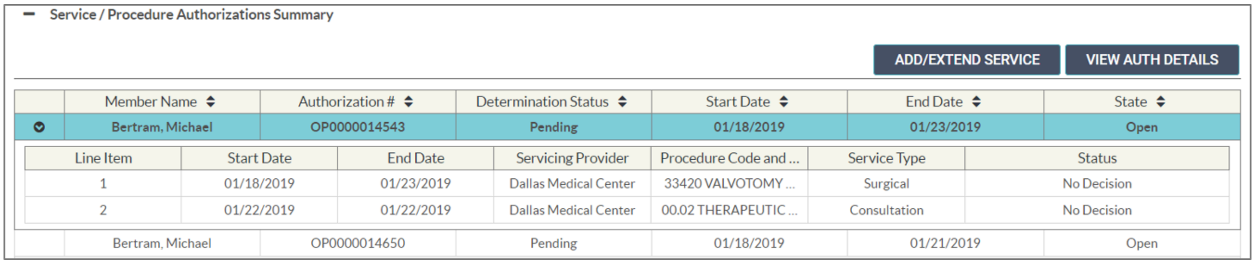
Initiate adding a service from the SP summary table on the dashboard.

You must select a service in the summary table for the Add/Extend Service function to be active.

To start adding a service to the authorization:

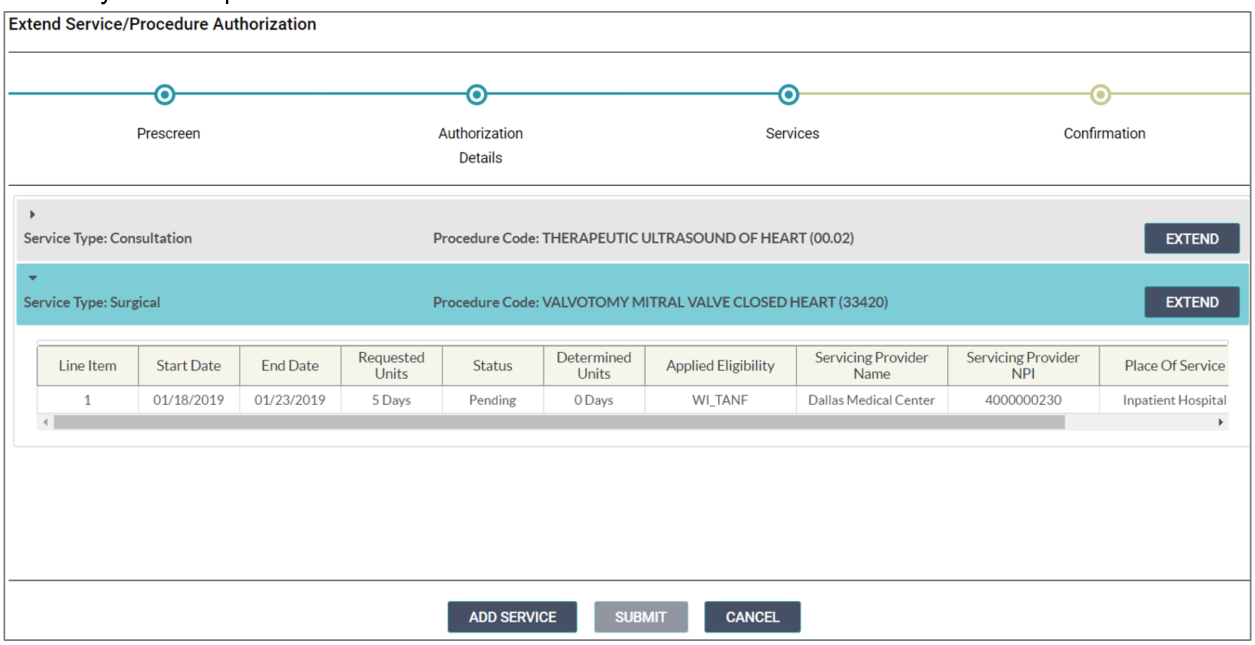
1. Go to the SP Authorizations Summary on the dashboard and select the authorization to which you want to add a service.

   In this example, the authorization request includes two services (line items 1 and 2).



2. Select **Add/Extend Service**.

   You are directed to the Services page. All line items for the authorization are displayed when the summary line is expanded.



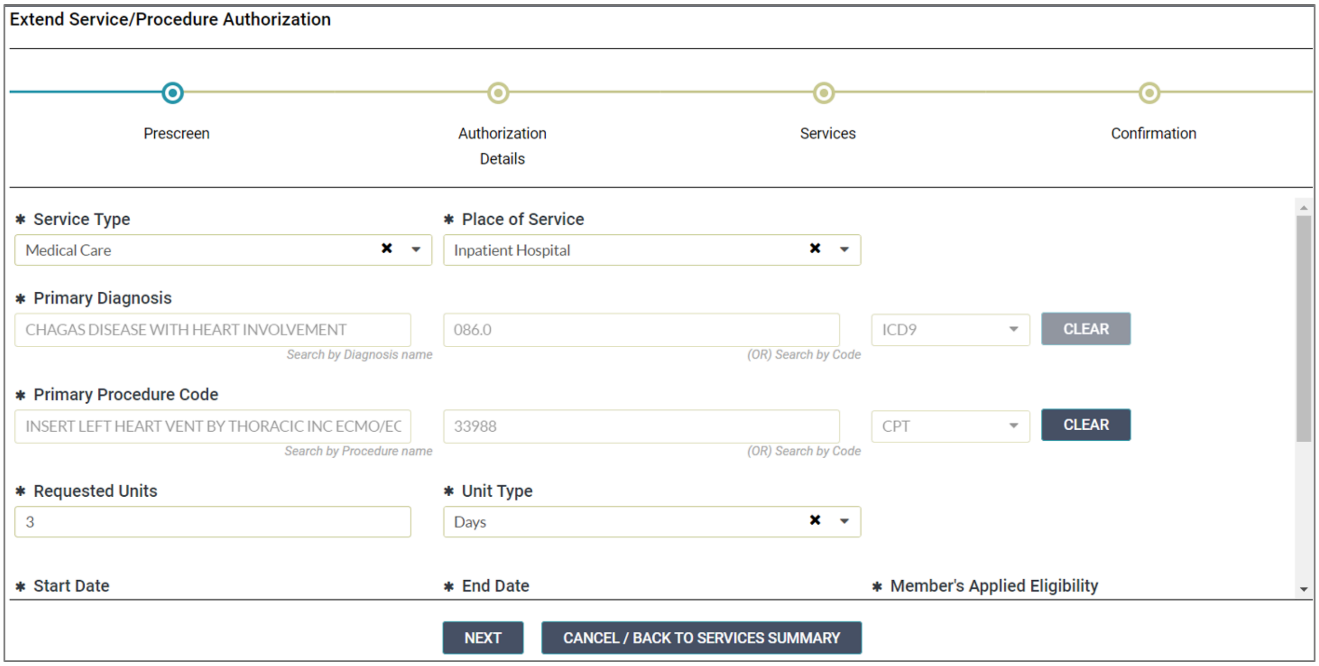
3. Select **Add Service**.

You advance to the Prescreen page to enter data for the preliminary evaluation of the new service request.

Completing the add service prescreening

Complete the Prescreen page to determine if you can continue to add a service.

Add required information in the prescreen fields to create a distinct service line item.



To complete the prescreen section:

1. Provide values in all of the required fields on the page.

   For more information about providing information in these fields or messages you might see on the page, see Completing the SP authorization prescreening on page 61.

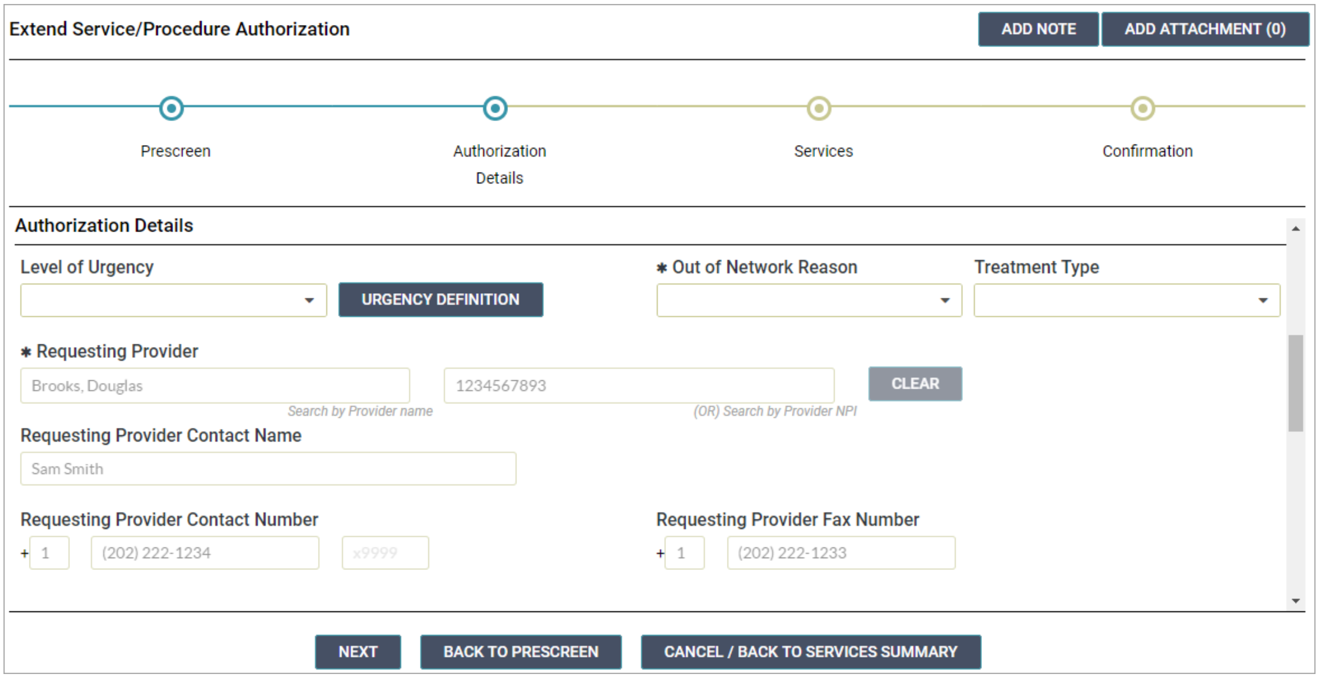
2. Select **Next**.

You advance to the Authorization Details page if authorization is required. Provide additional details on that page.

Completing the add service authorization details

When adding a service to an SP authorization, after completing the prescreen evaluation, provide additional information on the Authorization Details page.

Provide details in the fields on the page.



To complete the authorization details section:

1. Enter values in the required fields and in any of the optional fields that you want to use.

   For more information about providing information in these fields or messages you might see on the page, see Providing the SP authorization details on page 65.

   > **Note:** If the authorization was created in TruCare and any of the fields are empty, you can add a value.

2. Add any notes or attachments that are required.

   For more information, see Adding notes and attachments to authorization requests on page 85.

3. Add clinical criteria if required.

   For more information, see Adding clinical criteria to authorization requests on page 87.

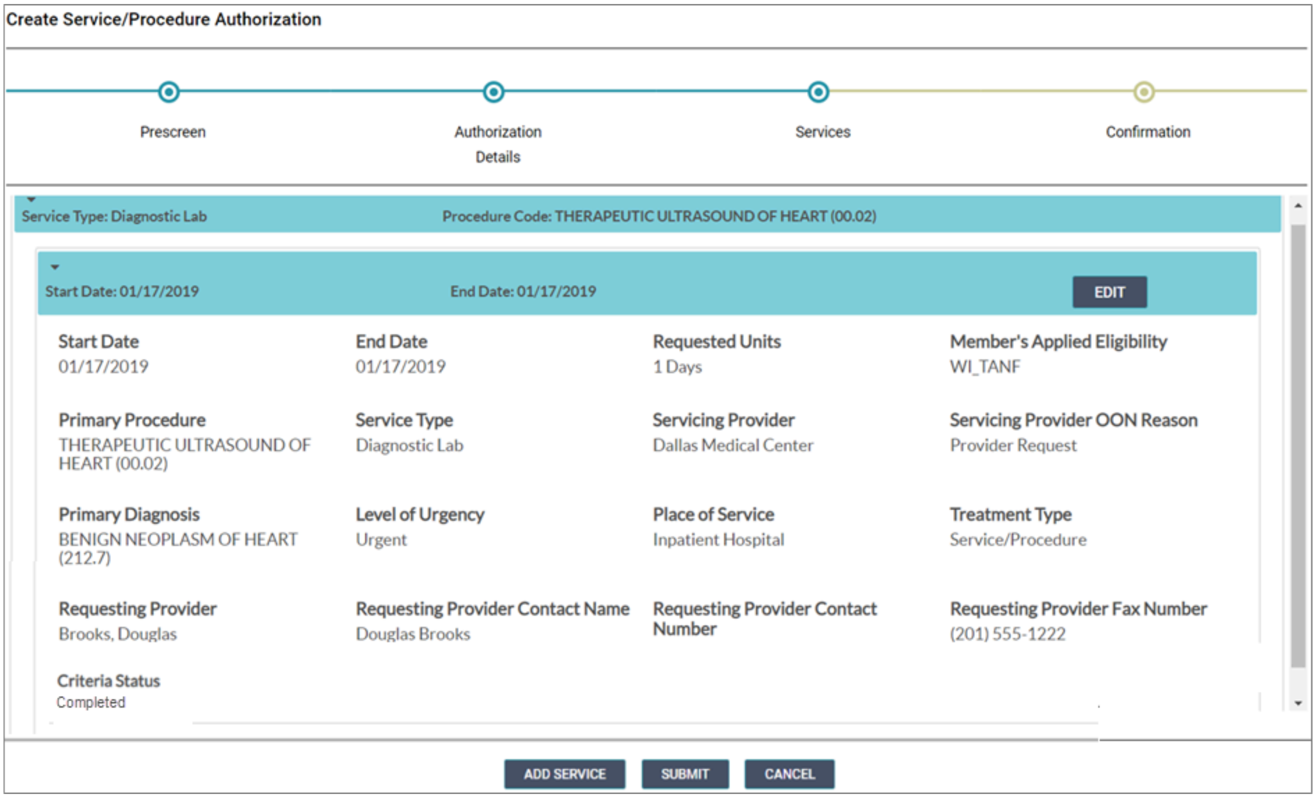
4. Select **Next**.

You move on to the Services page, where you can review services.

Reviewing services when adding a service

Review services and edit them if needed.

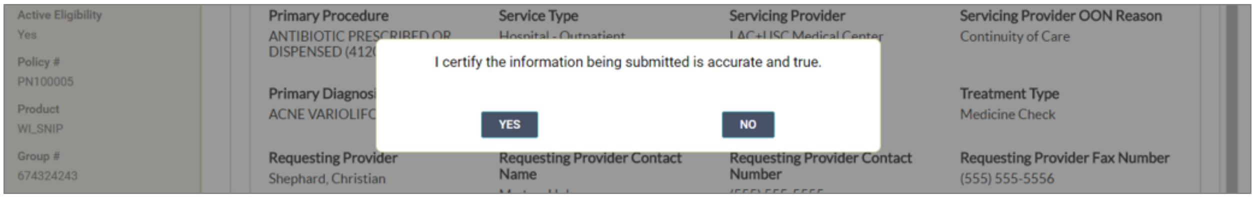
On the Services page, review your entries to ensure that you are submitting accurate information.



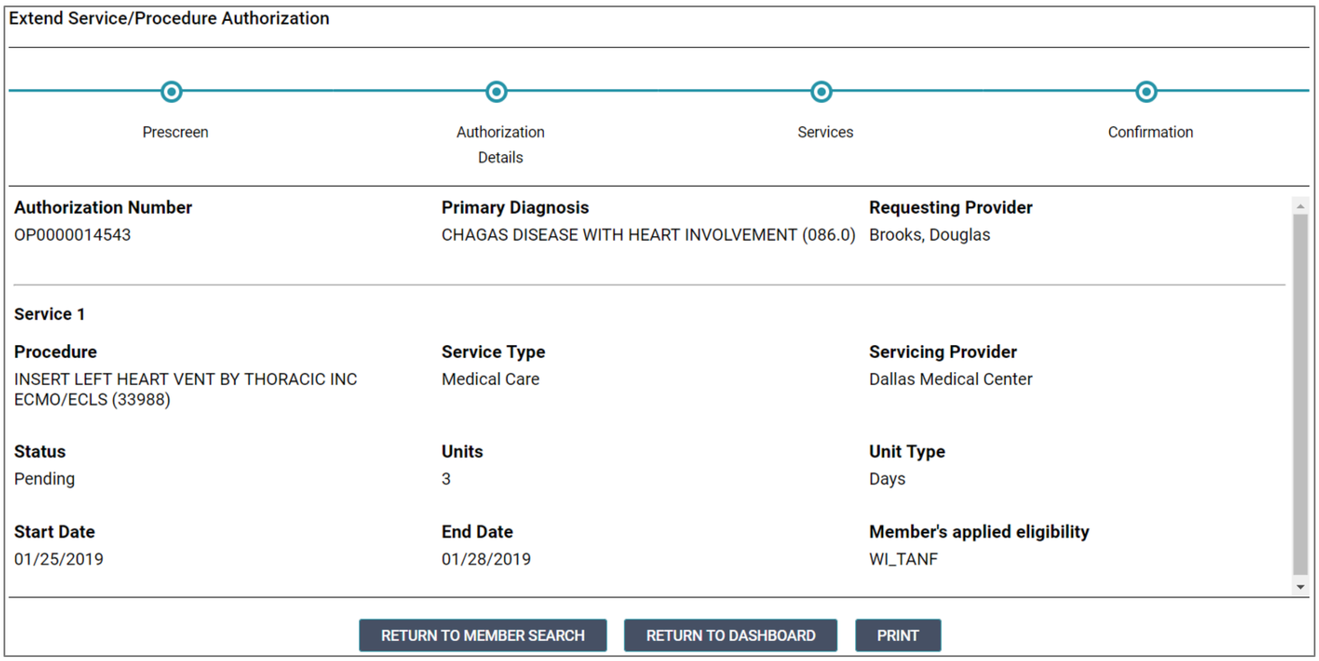
To review services, edit if needed, and submit the request:

1. Review the services on the page.
2. If you need to modify a service, take appropriate action. If you do not need to make changes, continue to the next step.
   - If you need to edit a service you just added, select **Edit** and complete the following steps.
     a. In the Prescreen page, you can edit all fields except service type, primary diagnosis, unit type, and servicing provider. When you finish, select **Next**.
     b. You can edit any fields in Authorization Details. When you are done, select **Next** to return to the Services page.
   - You can remove a service that you just added only after you have created at least two additional services and the Remove button is displayed on each service line. Select **Remove** to discard any newly added service if it is not needed.
3. After reviewing services, select **Submit** to submit your request.

4. You may need to respond to an attestation which requires the information to be accurate and true. If accurate and true, select **Yes** to proceed. If not, select **No**, then select **Edit** to correct the entries before you attempt to submit the authorization request again.



The Confirmation page displays the status of any new service that has been added and any existing service that has been extended.



You can print the authorization request for the new line item from the Confirmation page. A printed copy of the authorization request includes authorization summary, authorization details, and details of each line item. The member in focus prints on each page.

Return to member search or to the dashboard.

Extending a service on an existing SP authorization

You can extend a service on an SP authorization that has already been submitted.

Note: You can extend any service on an authorization only once before submission.

The workflow to extend a service involves the following high-level tasks:

1. Start extending a service on the authorization.
2. Complete the Prescreen section.
3. Complete the Authorization Details section.
4. Review the services and submit the request.

Topics in this section

Start extending a service on an SP authorization

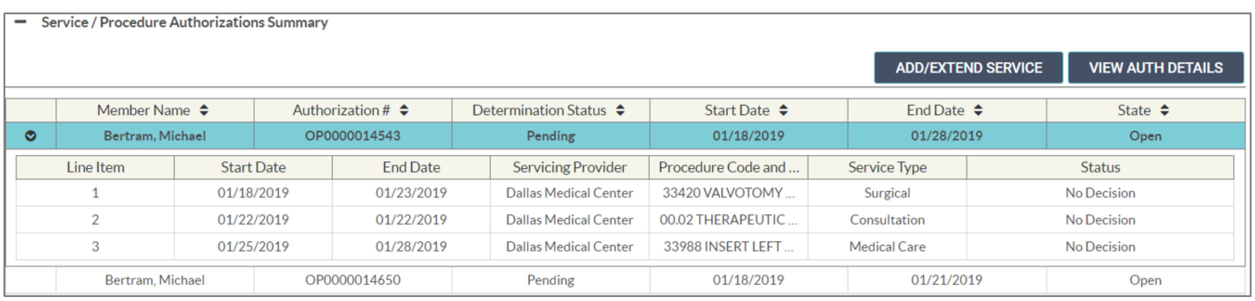
Initiate extending a service from the SP summary table on the dashboard.

You must select a service in the summary table for the Add/Extend Service function to be active.

To start extending a service on an authorization:

1. Go to the SP Authorizations Summary on the dashboard and select the authorization on which you are extending a service.

   This example continues from the adding a service example on page 74. The authorization request includes two original services (line items 1 and 2) and the added service (line item 3).


Service / Procedure Authorizations Summary

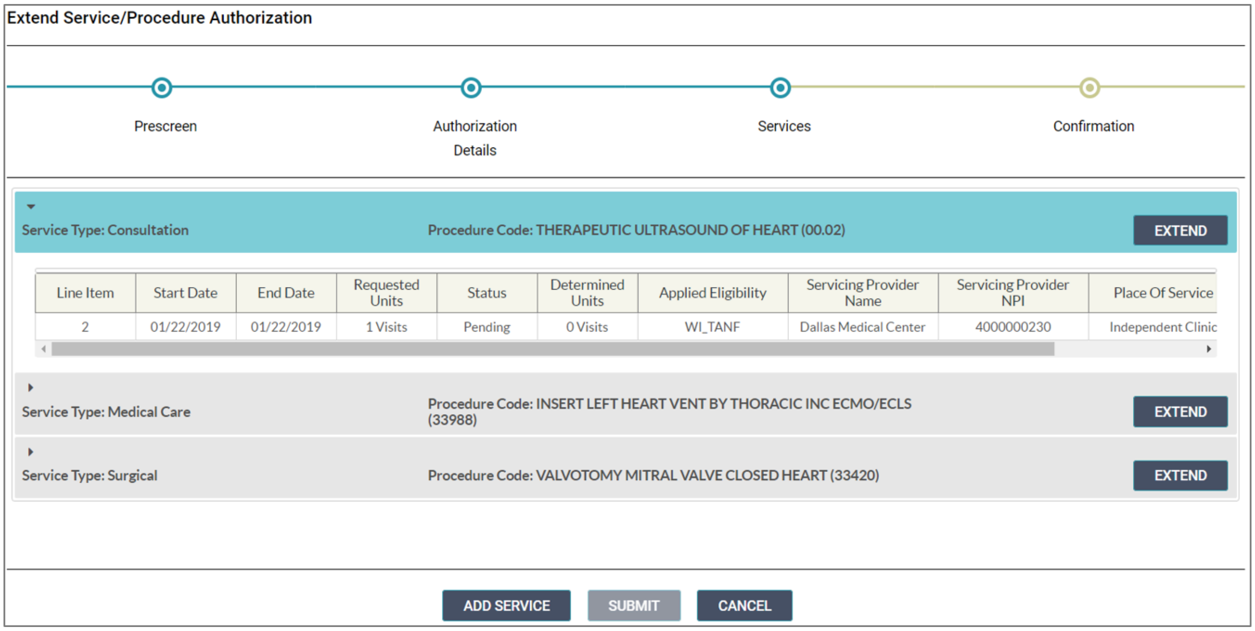
ADD/EXTEND SERVICE | VIEW AUTH DETAILS

	Member Name	Authorization #	Determination Status	Start Date	End Date	State
⌄	Bertram, Michael	OP0000014543	Pending	01/18/2019	01/28/2019	Open
	Bertram, Michael	OP0000014650	Pending	01/18/2019	01/21/2019	Open

Line Item	Start Date	End Date	Servicing Provider	Procedure Code and ...	Service Type	Status
1	01/18/2019	01/23/2019	Dallas Medical Center	33420 VALVOTOMY ...	Surgical	No Decision
2	01/22/2019	01/22/2019	Dallas Medical Center	00.02 THERAPEUTIC ...	Consultation	No Decision
3	01/25/2019	01/28/2019	Dallas Medical Center	33988 INSERT LEFT ...	Medical Care	No Decision

2. Select **Add/Extend Service**.

   You are directed to the Services page.



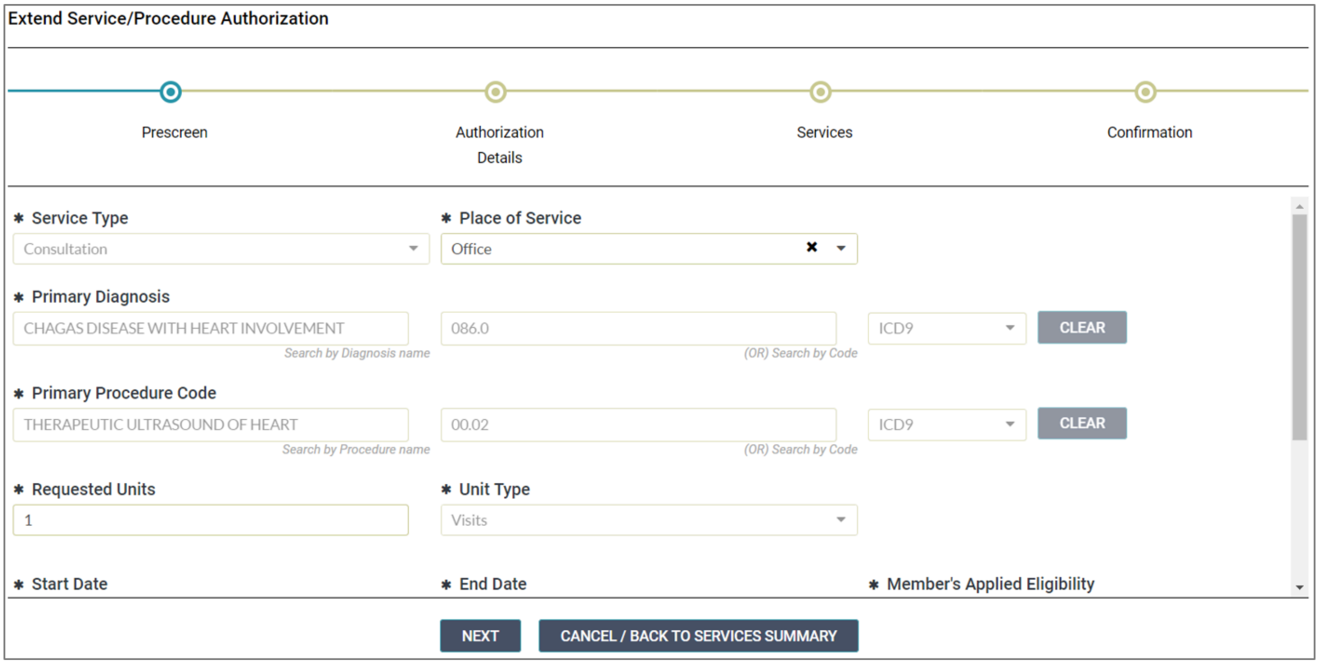
3. Select the service and select **Extend**.

You advance to the Prescreen page to enter data for the preliminary evaluation of the service extension request.

Complete the extend service prescreening

Complete the Prescreen page to determine if you can continue to extend a service.

On the Extend SP Authorization prescreen, complete the required fields to create a distinct service line item.



To complete the prescreen section:

1. Provide values in all of the required fields on the page.

   For more information about providing information in these fields or messages you might see on the page, see Completing the SP authorization prescreening on page 61.

2. Select **Next**.

You advance to the Authorization Details page if authorization is required. Provide additional details on that page.

Complete the extend service authorization details

When extending a service to an SP authorization, provide additional information on the Authorization Details page.

Provide details in the fields on the page.

To complete the authorization details section:

1. Enter values in the required fields and in any of the optional fields that you want to use.

   For more information about providing information in these fields or messages you might see on the page, see Providing the SP authorization details on page 65.

   > **Note:** If the authorization was created in TruCare and any of the fields are empty, you can add a value.

2. Add any notes or attachments that are required.

   For more information, see Adding notes and attachments to authorization requests on page 85.

3. Add clinical criteria if required.

   If clinical criteria are required, a message `Clinical Criteria Required` appears om the top right corner of the screen. For more information, see Adding clinical criteria to authorization requests on page 87.

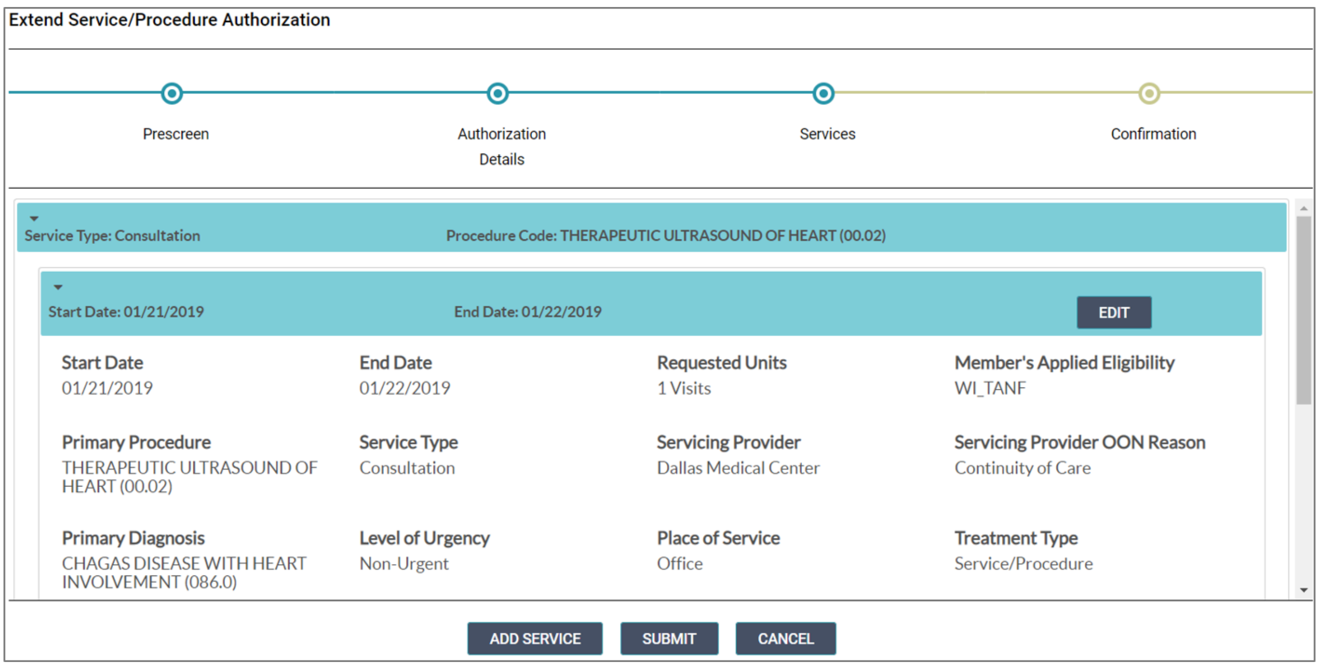
4. Select **Next**.

You move on to the Services page, where you can review services.

Reviewing services when extending a service

Review services and edit them if needed.

On the Services page, review your entries to ensure that you are submitting accurate information.



To review services, edit if needed, and submit the request:

1. Review the services on the page.

2. If you need to modify a service, take appropriate action. If you do not need to make changes, continue to the next step.

   -
   - If you need to edit a service you just added, select **Edit** and complete the following steps.
     - In the Prescreen page, you can edit all fields except service type, primary diagnosis, unit type, and servicing provider. When you finish, select **Next**.
       - If you make changes to admission date, primary diagnosis, requesting provider (only Cite AA) or procedure code (only when BRE rule is configured), it will impact the clinical criteria of the SP line.

         > **Note:** The clinical criteria may also be affected if the user modifies these fields in the Admissions Details screen.

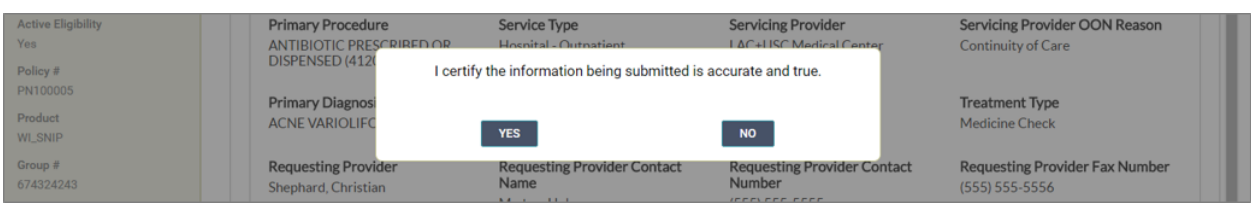
         When you make changes on the Prescreen page that impact clinical criteria, the message appears:

         ```
         You have made changes to this page. A clinical criteria
          submission is either in progress of completed and will be
          discarded. Would you like to proceed?
         ```

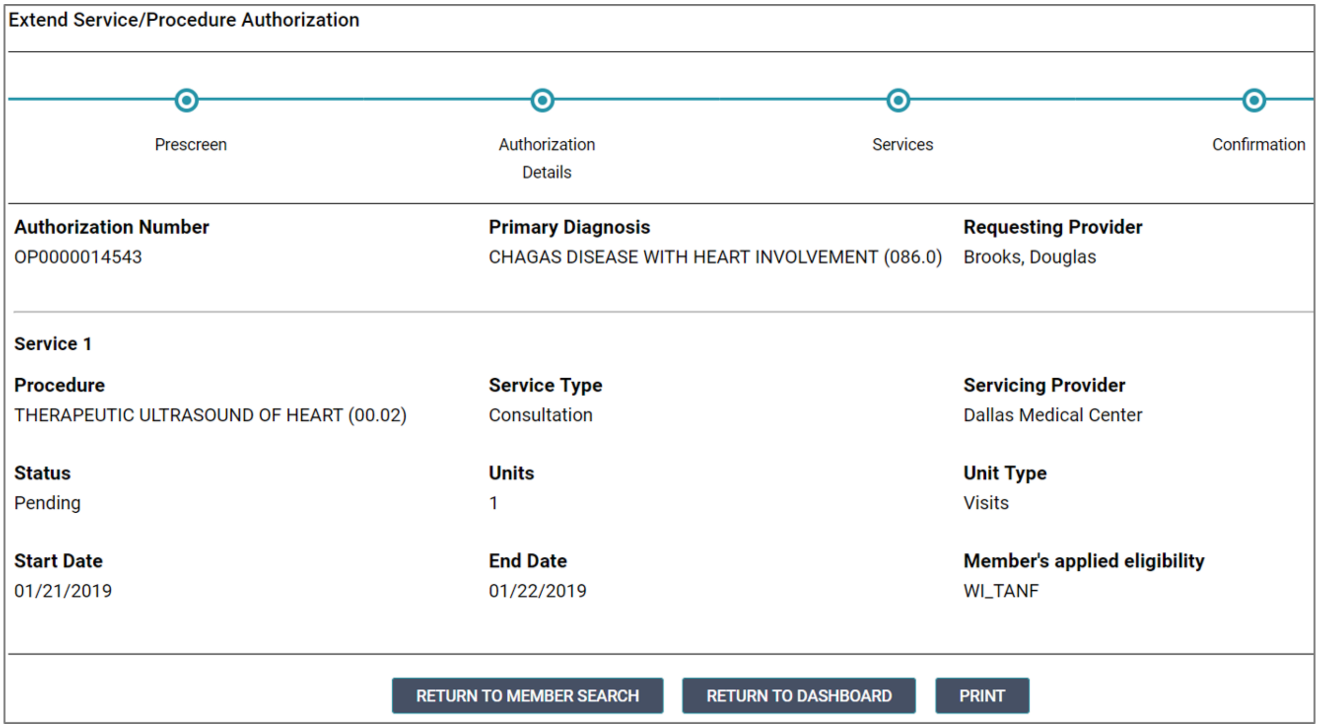
         Select **Yes** to discard the existing clinical review and go to the Review screen when you click **Next**. Select **No** to retain the user on the Admission Prescreen and not discard the changes.
       - You can edit any fields in Authorization Details. When you are done, select **Next** to return to the Services page.
   - You can remove a service that you just added only after you have created at least two additional services and the Remove button is displayed on each service line. Select **Remove** to discard any newly added service if it is not needed.

3. After reviewing services, select **Submit** to submit your request.

4. You may need to respond to an attestation which requires the information to be accurate and true. If accurate and true, select **Yes** to proceed. If not, select **No**, then select **Edit** to correct the entries before you attempt to submit the authorization request again.



The Confirmation page displays the status of any new service that has been added and any existing service that has been extended.



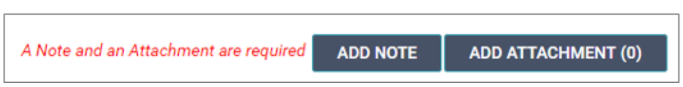
You can print the authorization request for the new line item from the Confirmation page. A printed copy of the authorization request includes authorization summary, authorization details, and details of each line item. The member in focus prints on each page.

Return to member search or to the dashboard.

Adding notes and attachments to authorization requests

Sometimes you need to add a note or an attachment to an authorization request.

If configured by the payer for the selected stay level (for IP authorization requests) or selected service type (for SP authorization requests), the text "A note is required" or "An authorization is required" (there might be a custom message) is displayed in red to the left of the Add Note button. If an attachment is also required, the text for both note and attachment is combined.



You cannot advance to the next page if you do not add the required note or attachment.

Topics in this section

Adding a note

You can add a note on the Authorization Details page.

You might be informed that a note is required for the authorization request that you are creating. Add it on the Authorization Details page before submitting the request.

To add a note, use the following steps.

1. Select **Add Note**.

   The Add Note dialog opens.

2. Enter content in the text box.
3. Select **Save**.

Adding an attachment

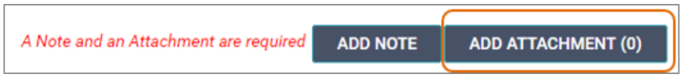
You can add an attachment on the Authorization Details page.

You might be informed that a note is required for the authorization request that you are creating. Add it on the Authorization Details page before submitting the request.

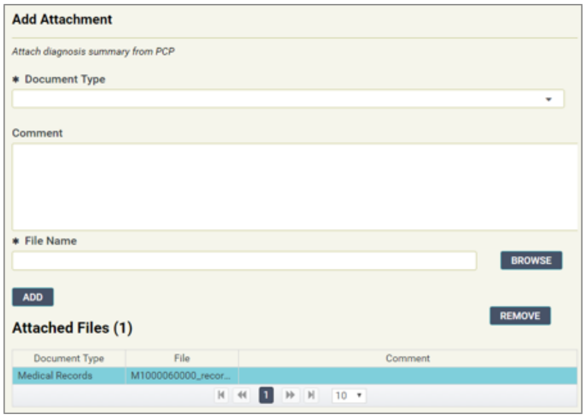
On the Add Attachment button, the count (in parenthesis) indicates the number of documents attached.

To add an attachment, use the following steps.

1. Select **Add Attachment** to add an attachment.

   The Add Attachment slider opens.

2. Select a document type.

3. Enter a comment if needed.

4. Select **Browse** to navigate to the file location, select the file, and select **Open**.

5. Select **Add**.

   The file is listed in the Attached Files section. The document type that you chose is displayed on the line item after the file is attached.

   To discard the file, select the line item and select **Remove**.

   > **Note:** If the attachment cannot be uploaded, a message informs you of the problem. The attachment might not load due to a file type or size that is not supported in TruCare. Consult your administrator for assistance.

6. When you are done, select **Close**.

The count on the Add Attachment button is updated for the new attachment.

Adding clinical criteria to authorization requests

Sometimes you need to add clinical criteria to an authorization request.

If clinical criteria requirements are configured by your administrator, a Clinical Criteria button appears on the Authorization Details page. For standard IP and SP authorizations, when clinical criteria are required, the text "Clinical Criteria Required" appears in red to the left of the Add Note button.

The Clinical Criteria button is also available if clinical criteria are optional. The text "Clinical Criteria Optional" appears in gray. If clinical criteria are required, you cannot proceed without selecting the **Clinical Criteria**.

For IP authorizations using the comprehensive workflow, the **Clinical Criteria** button appears on the IP admission details page, next to notes and attachments and/or on the procedure details page in the prescreen summary section of the page.

Topics in this section

Add InterQual Connect clinical criteria on page 88
When configured by your administrator, the Clinical Criteria button opens the Change Healthcare InterQual Connect™ application to add clinical criteria to authorization requests.

Add Cite AutoAuth clinical criteria on page 89
When configured by your administrator, the Clinical Criteria button opens an MCG Health Cite AutoAuth window to add clinical criteria to authorization requests.

Add InterQual Connect™ clinical criteria

When configured by your administrator, the Clinical Criteria button opens the Change Healthcare InterQual Connect™ application to add clinical criteria to authorization requests.

> **Note:** Do not use browsers in private mode (also called incognito) when using InterQual Connect™ in TruCare ProAuth. It does not work in browsers using private mode.

1. In the Authorization Details screen, select **Clinical Criteria**.

   Information from the prescreen fields is passed to the InterQual® system to identify a guideline that is appropriate for those field values. The next steps depend on the results of this guideline search.
   - If no guidelines are found, and a Clinical Review BRE rule is configured for it, an error message informs you that no clinical criteria guidelines were identified for the authorization request and to contact the administrator to correct the issue. You can skip the rest of these steps and continue the authorization request workflow.
   - If a single guideline is identified, InterQual® opens directly to the appropriate guideline for the authorization request. You can skip the next step.
   - If multiple guidelines apply, the Select Guideline for Clinical Criteria dialog opens. Complete the next step.

2. Select a guideline.

   You are connected to the InterQual Connect™ application.

3. Select **Medical Review** to add clinical criteria.

   The Medical Review window opens.

4. Provide required criteria.

   For information about using the InterQual Connect™ application, select **Help** in the application.

   While you are completing the clinical criteria, you can select **Save Review** to save the information for later. The status of the review displays near the top of the page. To complete the clinical review, select **Clinical Criteria** on the Authorization Details page.

5. Select **Complete** to complete the clinical criteria.

   A warning informs you that completing the medical review will lock it from further edits. If you need to return to the review to make changes or check it, select **No**. Otherwise, continue to the next step.

6. If your review is complete, select **Yes**.

Clinical criteria are linked to the authorization in TruCare when you complete the request and submit it. After completing clinical criteria, going back to the Prescreen page and changing values might invalidate the clinical criteria. When you select **Next** on prescreen, you will see the following message: "A clinical criteria submission is either in progress or completed and will be discarded. Would you like to proceed?"

- Selecting **Yes** discards the clinical review and you may need to provide clinical criteria again as you navigate through the authorization workflow. For the IP Comprehensive workflow, you may see a clinical review message on the Review page for one or more IP procedures due to an edit made. Click the Edit form on the IP procedure to get to the IP procedure details page.
- Selecting **No** keeps the clinical criteria. You can change the field values back to their original values and continue.

Add Cite AutoAuth clinical criteria

When configured by your administrator, the Clinical Criteria button opens an MCG Health Cite AutoAuth window to add clinical criteria to authorization requests.

> **Note:** Do not use browsers in private mode (also called incognito) when using Cite AutoAuth in TruCare ProAuth. It does not work in browsers using private mode.

When providing clinical criteria, you can add one guideline.

For more information about providing Cite AutoAuth guidelines, consult your MCG Health representative.

1. In the Authorization Details screen, select **Clinical Criteria**.

   The Clinical Criteria button is not enabled until you specify Requesting Provider details in the Authorization Details page.

   The **Clinical Criteria** button only appears if the clinical criteria in BRE configuration is set as "Required" or "Optional." It does not appear if the clinical criteria is set to "Suppressed."

   After selecting **Clinical Criteria**, the Authorization Request Review window opens and you are connected to the Cite AutoAuth application. Cite AutoAuth uses information that you added in the prescreen fields to filter the guidelines that are available for you to select.

2. Select **Document Clinical** to add guidelines.
3. Select **add** for the appropriate guideline.

   If none of the displayed guidelines apply, select **No Guideline Applies**.

4. In the next window, document the guideline indications by selecting the appropriate indications (adding indication notes if needed).

   While you are completing the clinical review, you can save the in-progress review. Select **Save**, and then select **Back** and return to the Authorization Details page. The status of the review displays near the top of the page. To complete the clinical review, select **Clinical Criteria** on the Authorization Details page.

5. When you are done, select **Save**.
6. Select **Submit Request** to complete the clinical criteria.

Clinical criteria are linked to the authorization in TruCare when you complete the request and submit it.

Going back to the Prescreen page and changing values, invalidates the clinical criteria. When you select **Next** on the Prescreen page, you see the following message: "You have made changes on this page. A clinical criteria submission is either in progress or completed and will be discarded. Would you like to proceed?"

- Selecting **Yes** discards the clinical review and you may need to provide clinical criteria again as you navigate through the authorization workflow. For IP Comprehensive workflow, you may see a clinical review message on the Review page for one or more IP procedures due to an edit made. Click the Edit form on the IP procedure to get to the IP procedure details page.
- Selecting **No** keeps the clinical criteria. You can change the field values back to their original values and continue.

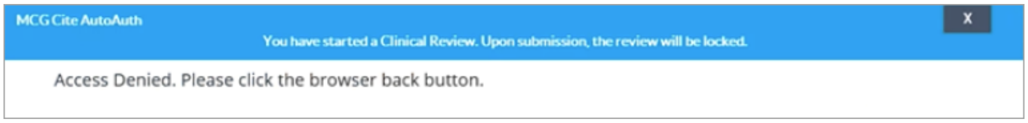
Changing the Requesting Provider information in the Authorization Details page invalidates the clinical criteria. If you clear the Requesting Provider Name or NPI fields, you see the following message: "You are about to make Requesting Provider changes. A clinical criteria submission is either in progress or completed and will be discarded if you continue. Would you like to proceed?"

- Selecting **Yes** discards the clinical review and you may need to provide clinical criteria again. Even if you revert the requesting provider values back to the original values after clicking Yes, you must provide clinical criteria again.
- Selecting **No** keeps the clinical criteria and the original requesting provider values remain.

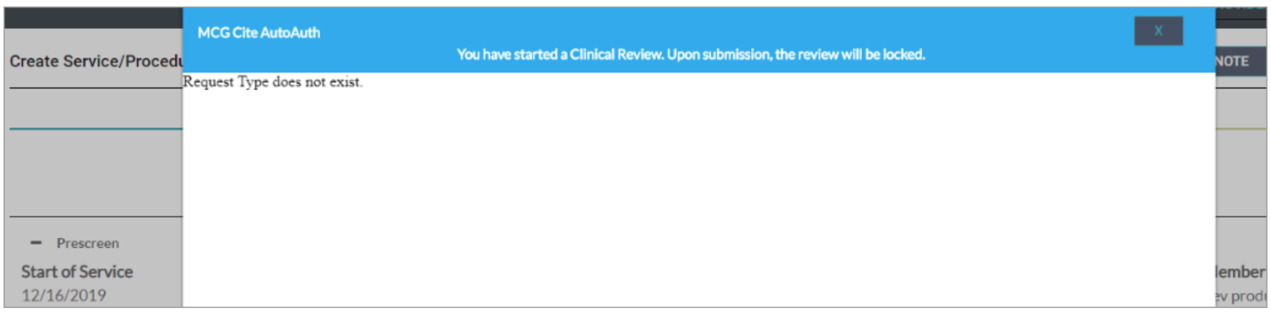
Use the following information to troubleshoot unexpected behavior or messages while adding clinical criteria.

- When saving or submitting a clinical review, a Cite AutoAuth login window appears.

  Response: Close the login window and select **Clinical Criteria** again on the Authorization Details page.
- When submitting a clinical review, an Access Denied message (or similar message) appears, instructing you to click the browser back button.



  Response: Ignore the message. There are no issues with access and the message should disappear quickly.
- When you select the Clinical Criteria button, if the Cite AutoAuth modal screen opens and displays a message that the request type does not exist (or something similar), there is an issue with the request type configuration.



  Response: Contact your system administrator.

7

Viewing authorization summary tables

You can view authorizations linked to your user account in summary tables on the dashboard.

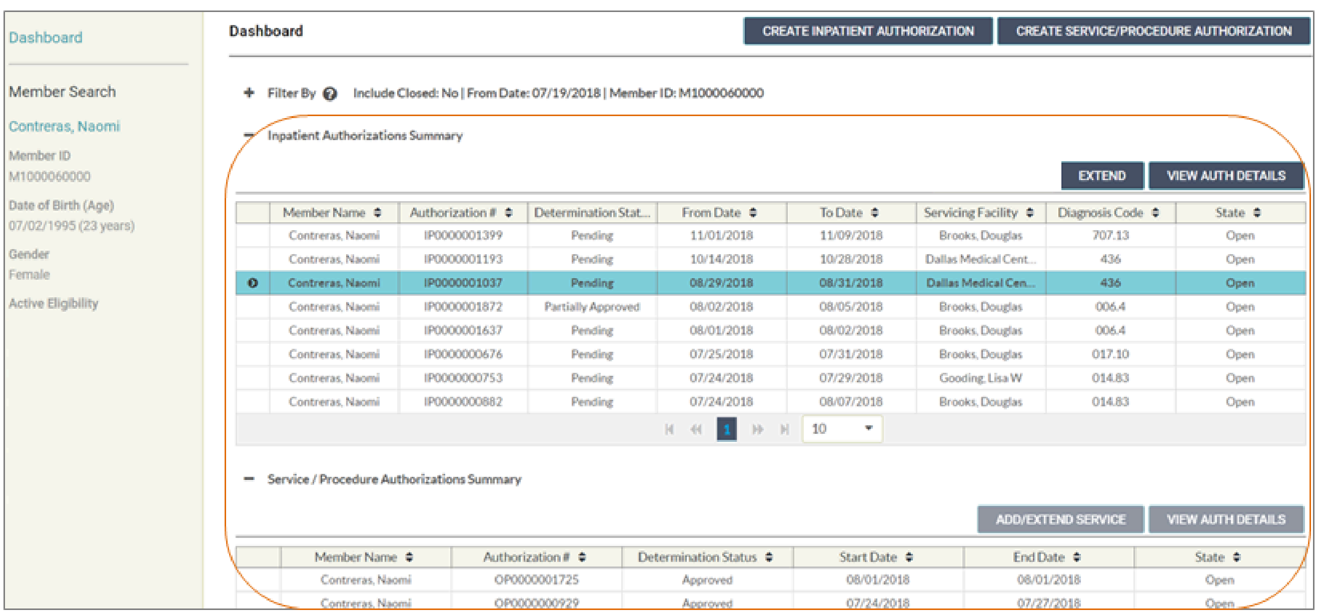
Authorization summaries are view-only. In the summary tables, you can view information on all the authorizations linked to your user account for any or all members. To view existing authorizations, you must populate the summary tables, as described in Populating the dashboard on page 15.

The following summary tables appear on the dashboard.

- Inpatient Authorization Summary
- Service/Procedure Authorization Summary
- Service Request Summary (if your organization configures this to display)

Each row of a table represents one authorization. Expand a row to view line items.

This example shows the IP and SP Summary tables expanded.



Use case

The provider user (such as an administrative assistant) who is responsible for managing authorization requests for the provider group logs on to TruCare ProAuth to review the status of authorization requests. The user can check on all IP authorizations that have been requested by providers in the group, specifically reviewing requests by chronological order or monitoring the status of each request posted.

The user can expand the authorization on the dashboard. The line item details provide policy number, product, group number, eligibility start date, and eligibility end date at a glance.

The user can select an authorization in the table and take another action, such as view details or extend the authorization.

About Summary tables

Keep in mind the following information about viewing summary tables.

- You can display 10, 20, 50, or 100 rows of data on each page.
- Select the down arrow on the bottom of the table to set your preference for the number of records per page.
- Select the double-right or double-left arrows to move one page forward or one page back.
- Select the bar-left or bar-right arrow to jump to the first or the last page.
- Sorting is supported for every column based on data type.
- Sorting applies to overall data, not just the visible set of rows.
- Default sorting via the From Date function yields the most recent authorizations first.
- By default, only open and non-voided authorizations are displayed. When filtering authorizations, you can expand the results by selecting the **Include Closed** check box in the Filter By section.
- The default view sets the “request date” filter to seven days before the current date.

Topics in this section

Related procedures

Viewing authorization details on page 99
You can view more authorization details from the summary table, using **View Auth Details**.

View Inpatient Authorizations Summary table

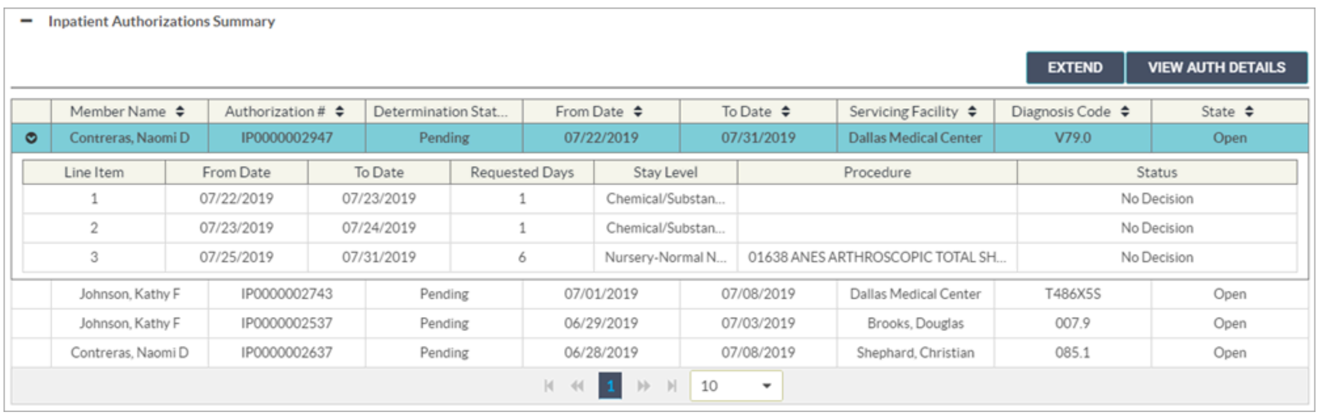
The Inpatient Authorizations Summary table provides access to authorizations for which facilities or providers associated with your user account are either the servicing or requesting facility or the requesting provider.

You can view data for the parameters displayed in the columns of the summary table (as shown in the example in this topic). You can sort each column of data in alphabetical or numerical order. Each line (or row) of data applies to a specific member.

When you select and expand an IP authorization, one or more line items each display line item number, from date, to date, requested days, stay level, and status.

The summary table updates each time an authorization request is submitted.

In this example, the expanded authorization contains three line items.



Inpatient Authorizations Summary

EXTEND VIEW AUTH DETAILS

Member Name	Authorization #	Determination Stat...	From Date	To Date	Servicing Facility	Diagnosis Code	State
Contreras, Naomi D	IP0000002947	Pending	07/22/2019	07/31/2019	Dallas Medical Center	V79.0	Open

Line Item	From Date	To Date	Requested Days	Stay Level	Procedure	Status
1	07/22/2019	07/23/2019	1	Chemical/Substan...		No Decision
2	07/23/2019	07/24/2019	1	Chemical/Substan...		No Decision
3	07/25/2019	07/31/2019	6	Nursery-Normal N...	01638 ANES ARTHROSCOPIC TOTAL SH...	No Decision

Member Name	Authorization #	Determination Stat...	From Date	To Date	Servicing Facility	Diagnosis Code	State
Johnson, Kathy F	IP0000002743	Pending	07/01/2019	07/08/2019	Dallas Medical Center	T486X5S	Open
Johnson, Kathy F	IP0000002537	Pending	06/29/2019	07/03/2019	Brooks, Douglas	007.9	Open
Contreras, Naomi D	IP0000002637	Pending	06/28/2019	07/08/2019	Shephard, Christian	085.1	Open

1 10

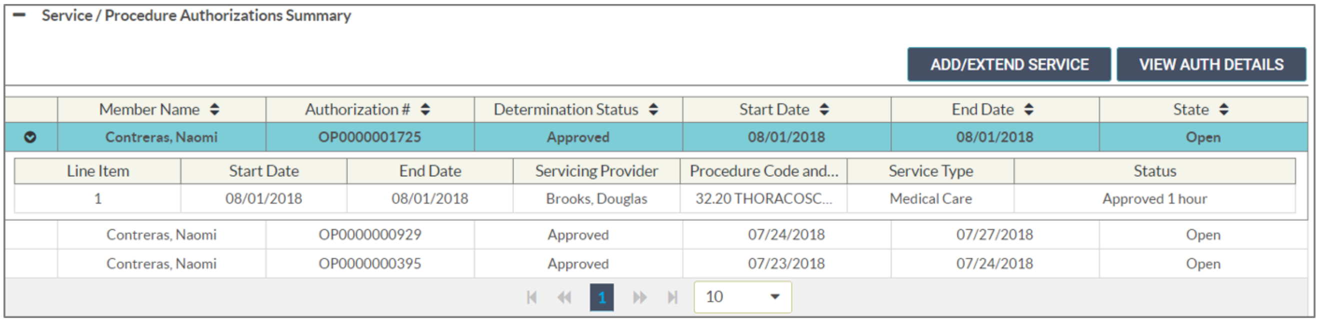
View Service/Procedure Authorizations Summary table

The Service/Procedure Authorizations Summary table provides access to authorizations for which facilities or providers associated with your user account are either the servicing or requesting facility or the requesting provider.

You can view data for the parameters displayed in the columns of the summary table (as shown in the example in this topic). You can sort each column of data in alphabetical or numerical order. Each line (or row) of data applies to a specific member.

When an authorization is selected and expanded, the row expands to list authorization line items. These include line item number, from date, to date, requested units, servicing provider, procedure code and description, service type, and status.

The summary table updates each time an authorization request is submitted. This example shows the summary of an authorization submitted with one line item.


Service / Procedure Authorizations Summary

ADD/EXTEND SERVICE | VIEW AUTH DETAILS

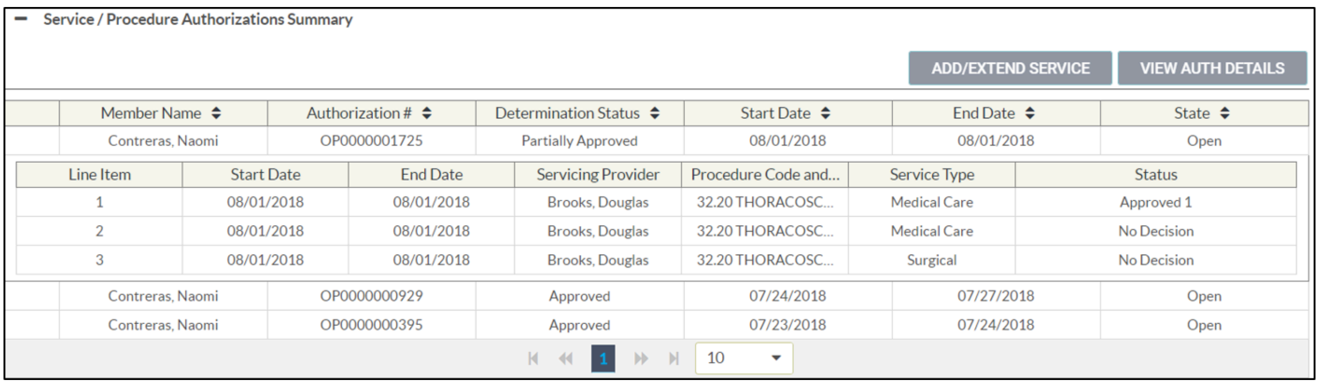
Member Name	Authorization #	Determination Status	Start Date	End Date	State
Contreras, Naomi	OP0000001725	Approved	08/01/2018	08/01/2018	Open

Line Item	Start Date	End Date	Servicing Provider	Procedure Code and...	Service Type	Status
1	08/01/2018	08/01/2018	Brooks, Douglas	32.20 THORACOSC...	Medical Care	Approved 1 hour

Member Name	Authorization #	Determination Status	Start Date	End Date	State
Contreras, Naomi	OP0000000929	Approved	07/24/2018	07/27/2018	Open
Contreras, Naomi	OP0000000395	Approved	07/23/2018	07/24/2018	Open

1 10

This example shows two line items have been added to the same authorization by Add/Extend Service.


Service / Procedure Authorizations Summary

ADD/EXTEND SERVICE | VIEW AUTH DETAILS

Member Name	Authorization #	Determination Status	Start Date	End Date	State
Contreras, Naomi	OP0000001725	Partially Approved	08/01/2018	08/01/2018	Open

Line Item	Start Date	End Date	Servicing Provider	Procedure Code and...	Service Type	Status
1	08/01/2018	08/01/2018	Brooks, Douglas	32.20 THORACOSC...	Medical Care	Approved 1
2	08/01/2018	08/01/2018	Brooks, Douglas	32.20 THORACOSC...	Medical Care	No Decision
3	08/01/2018	08/01/2018	Brooks, Douglas	32.20 THORACOSC...	Surgical	No Decision

Member Name	Authorization #	Determination Status	Start Date	End Date	State
Contreras, Naomi	OP0000000929	Approved	07/24/2018	07/27/2018	Open
Contreras, Naomi	OP0000000395	Approved	07/23/2018	07/24/2018	Open

1 10

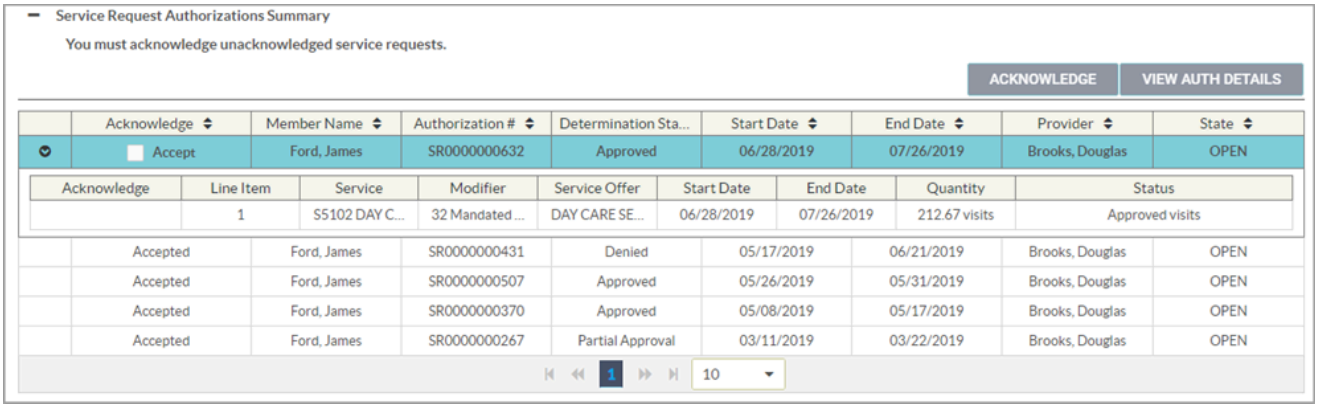
View Service Request Authorizations Summary table

The Service Request Summary table provides access to service requests for which providers associated with your user account are the servicing provider. This table is available if configured by your organization.

You can view data for the parameters displayed in the columns of the summary table (as shown in the example in this topic). You can sort each column of data in alphabetical or numerical order. Each line (or row) of data applies to a specific member.

When you select and expand a service request, the row expands to list authorization line items. These include line item number, service code, modifier, service offer, start date, end date, servicing provider, quantity, and status. The summary table updates each time a service request is submitted.

If your organization requires you to acknowledge service requests, the summary table includes an Acknowledge column and you must accept and acknowledge service requests before you can view authorization details. For more information, see Acknowledging service requests on page 97.



	Acknowledge	Member Name	Authorization #	Determination Sta...	Start Date	End Date	Provider	State
	Accept	Ford, James	SR0000000632	Approved	06/28/2019	07/26/2019	Brooks, Douglas	OPEN

Acknowledge	Line Item	Service	Modifier	Service Offer	Start Date	End Date	Quantity	Status
	1	S5102 DAY C...	32 Mandated ...	DAY CARE SE...	06/28/2019	07/26/2019	212.67 visits	Approved visits

	Acknowledge	Member Name	Authorization #	Determination Sta...	Start Date	End Date	Provider	State
	Accepted	Ford, James	SR0000000431	Denied	05/17/2019	06/21/2019	Brooks, Douglas	OPEN
	Accepted	Ford, James	SR0000000507	Approved	05/26/2019	05/31/2019	Brooks, Douglas	OPEN
	Accepted	Ford, James	SR0000000370	Approved	05/08/2019	05/17/2019	Brooks, Douglas	OPEN
	Accepted	Ford, James	SR0000000267	Partial Approval	03/11/2019	03/22/2019	Brooks, Douglas	OPEN

8

Acknowledging service requests

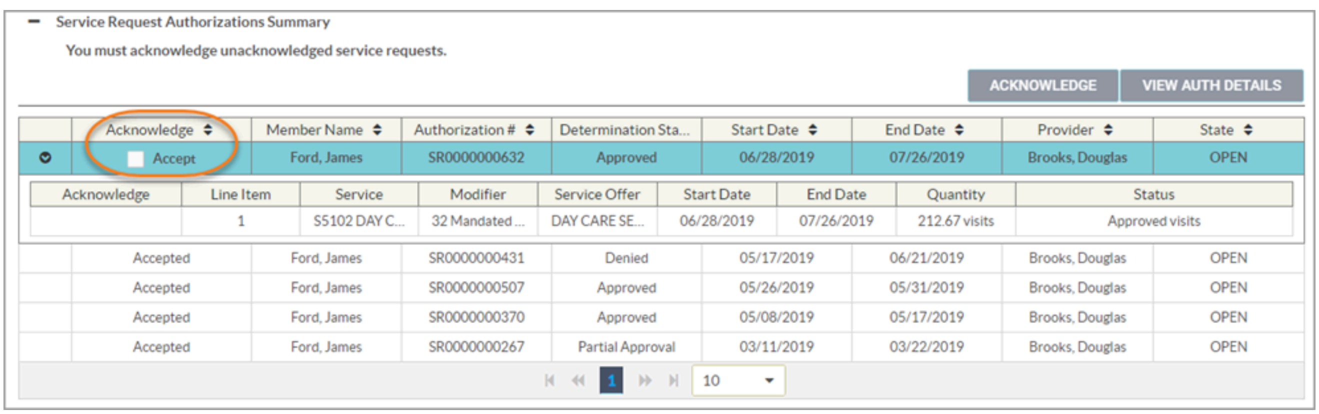
Your organization might require you to acknowledge service requests in the Service Request Authorizations Summary table.

When you need to acknowledge a service request, the Acknowledge column in the Service Request Summary table includes an **Accept** check box.

You must acknowledge service requests in the following cases:

- There is a new service request in TruCare ProAuth.
- A previously acknowledged service request is modified in TruCare, for example a new line item is added or an already acknowledged line item is changed.

In this example, the first service request needs to be accepted and acknowledged.



You cannot view a service request's details until you acknowledge it.

To acknowledge service requests in the summary table:

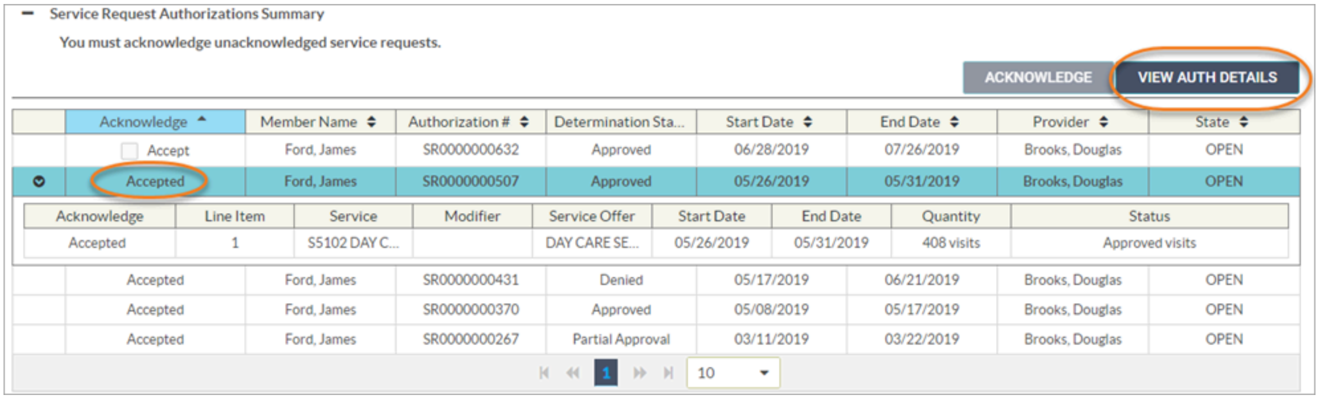
1. Select the **Accept** check box for the service request.

   The service request expands and the service request line items are visible. The **Acknowledge** button is enabled.

   If you want to acknowledge multiple service requests, select the **Accept** check box for all service requests you want to acknowledge. You can acknowledge up to 100 service requests at a time.

2. Select **Acknowledge**.

Acknowledged service requests display **Accepted** in the **Acknowledge** column. The **View Auth Details** button is enabled.



9

Viewing authorization details

You can view more authorization details from the summary table, using **View Auth Details**.

You can access more authorization details from the dashboard summary tables.

If service request authorizations require acknowledgement, you must acknowledge them before you can view authorization details. After you acknowledge service requests, the **View Auth Details** button is enabled.

To view authorization details:

1. In the authorization summary table on the dashboard, select the authorization you want to view.
2. Select **View Auth Details**.

The IP, SP, or SR Authorization Summary page opens. You can view or print (to a PDF file) the authorization's details.

Topics in this section

IP authorization details on page 99
You can view an IP authorization's details on the Inpatient Authorization Summary page.

SP authorization details on page 102
You can view an SP authorization's details on the Service/Procedure Authorization Summary page.

SR authorization details on page 105
You can view an SR authorization's details on the Service Request Authorization Summary page.

Related concepts

Viewing authorization summary tables on page 92
You can view authorizations linked to your user account in summary tables on the dashboard.

IP authorization details

You can view an IP authorization's details on the Inpatient Authorization Summary page.

An IP authorization request summary includes three parts:

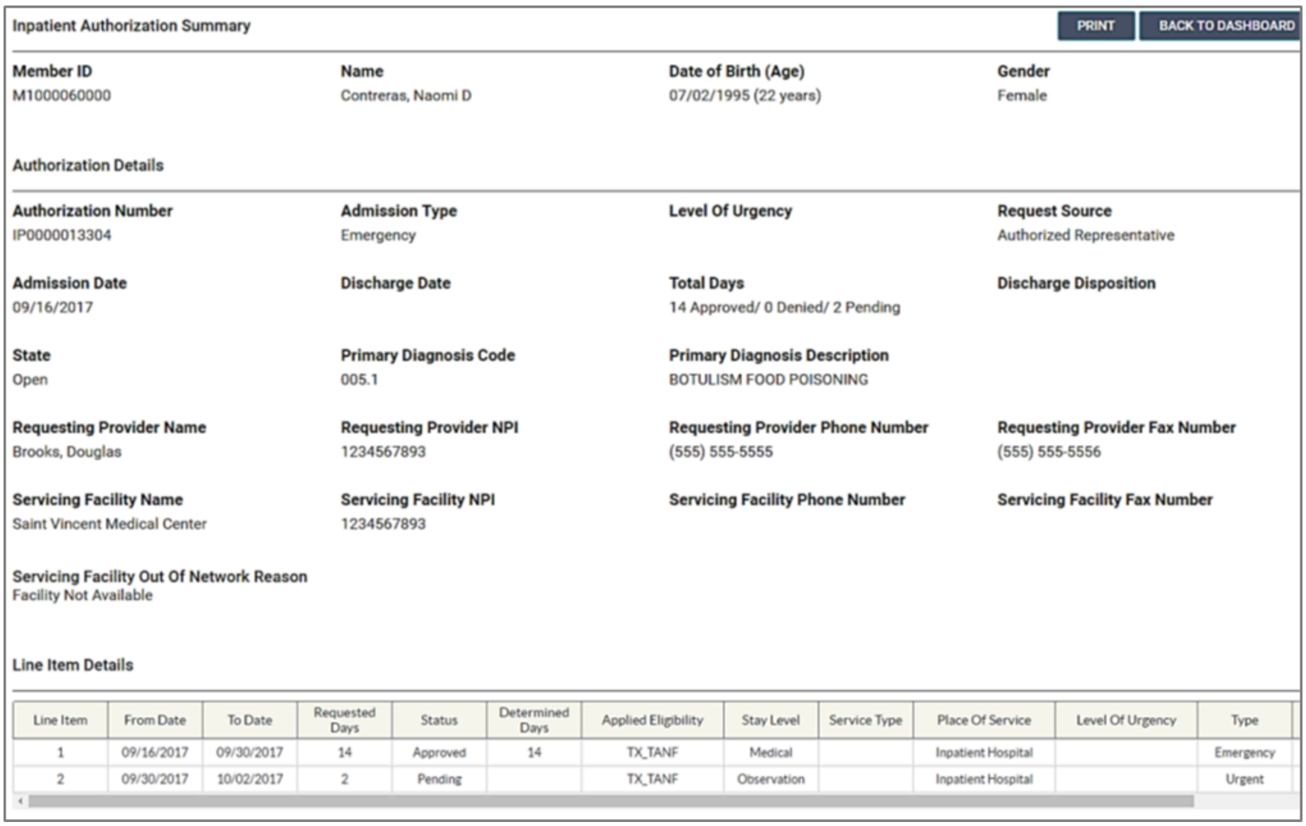
- Member ID
- Authorization Details
- Line Item Details

Member ID

Member ID includes the member identification number, member name, date of birth/age, and gender.

Authorization Details

Authorization Details shows all the data entered for the authorization request. Fields without data indicate that the entry was optional and the user chose not to exercise the option.


Inpatient Authorization Summary

PRINT | BACK TO DASHBOARD

Member ID	Name	Date of Birth (Age)	Gender
M1000060000	Contreras, Naomi D	07/02/1995 (22 years)	Female

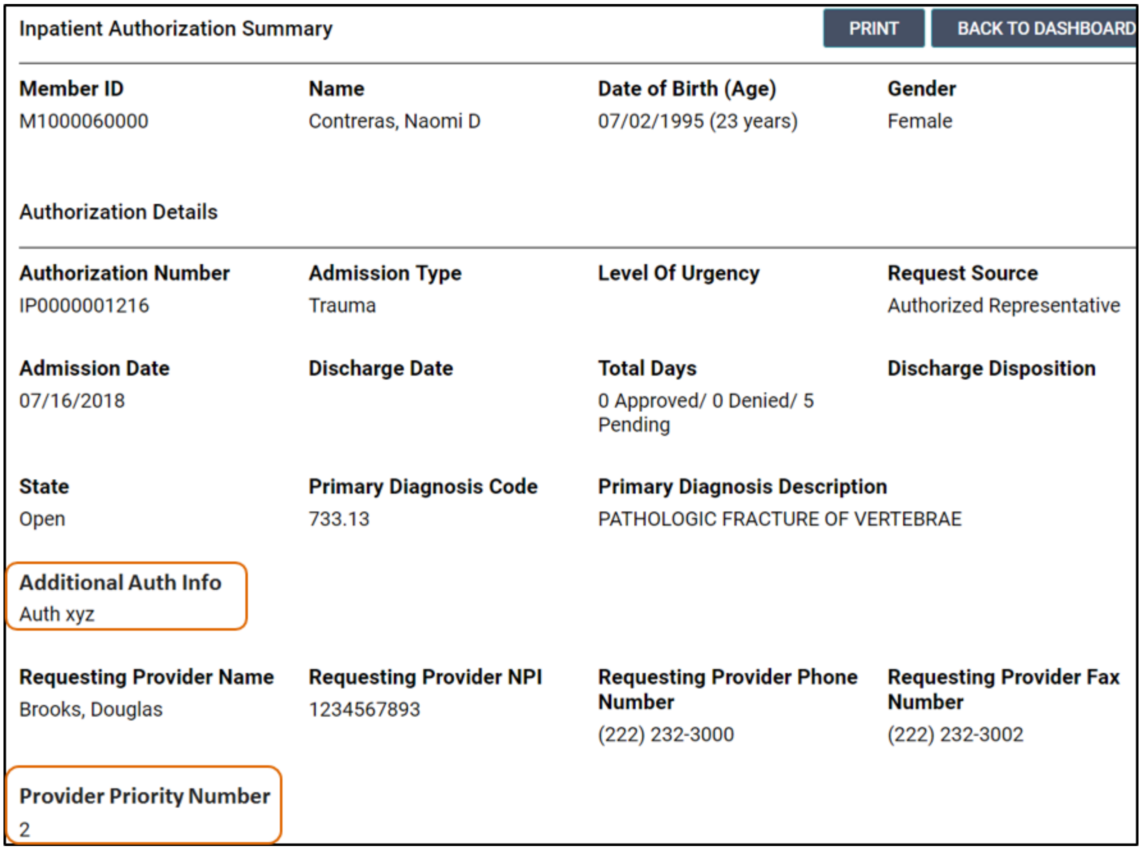
Authorization Details

Authorization Number	Admission Type	Level Of Urgency	Request Source
IP0000013304	Emergency		Authorized Representative
Admission Date	**Discharge Date**	**Total Days**	**Discharge Disposition**
09/16/2017		14 Approved/ 0 Denied/ 2 Pending	
State	**Primary Diagnosis Code**	**Primary Diagnosis Description**	
Open	005.1	BOTULISM FOOD POISONING	
Requesting Provider Name	**Requesting Provider NPI**	**Requesting Provider Phone Number**	**Requesting Provider Fax Number**
Brooks, Douglas	1234567893	(555) 555-5555	(555) 555-5556
Servicing Facility Name	**Servicing Facility NPI**	**Servicing Facility Phone Number**	**Servicing Facility Fax Number**
Saint Vincent Medical Center	1234567893		
Servicing Facility Out Of Network Reason			
Facility Not Available			

Line Item Details

Line Item	From Date	To Date	Requested Days	Status	Determined Days	Applied Eligibility	Stay Level	Service Type	Place Of Service	Level Of Urgency	Type
1	09/16/2017	09/30/2017	14	Approved	14	TX_TANF	Medical		Inpatient Hospital		Emergency
2	09/30/2017	10/02/2017	2	Pending		TX_TANF	Observation		Inpatient Hospital		Urgent

If there are User Defined Fields (UDFs) in the Authorization Details, they will appear in their associated sections, as shown in the following example.



Inpatient Authorization Summary

PRINT | BACK TO DASHBOARD

Member ID	Name	Date of Birth (Age)	Gender
M1000060000	Contreras, Naomi D	07/02/1995 (23 years)	Female

Authorization Details

Authorization Number	Admission Type	Level Of Urgency	Request Source
IP0000001216	Trauma		Authorized Representative
Admission Date	**Discharge Date**	**Total Days**	**Discharge Disposition**
07/16/2018		0 Approved/ 0 Denied/ 5 Pending	
State	**Primary Diagnosis Code**	**Primary Diagnosis Description**	
Open	733.13	PATHOLOGIC FRACTURE OF VERTEBRAE	
Additional Auth Info			
Auth xyz			
Requesting Provider Name	**Requesting Provider NPI**	**Requesting Provider Phone Number**	**Requesting Provider Fax Number**
Brooks, Douglas	1234567893	(222) 232-3000	(222) 232-3002
Provider Priority Number			
2			

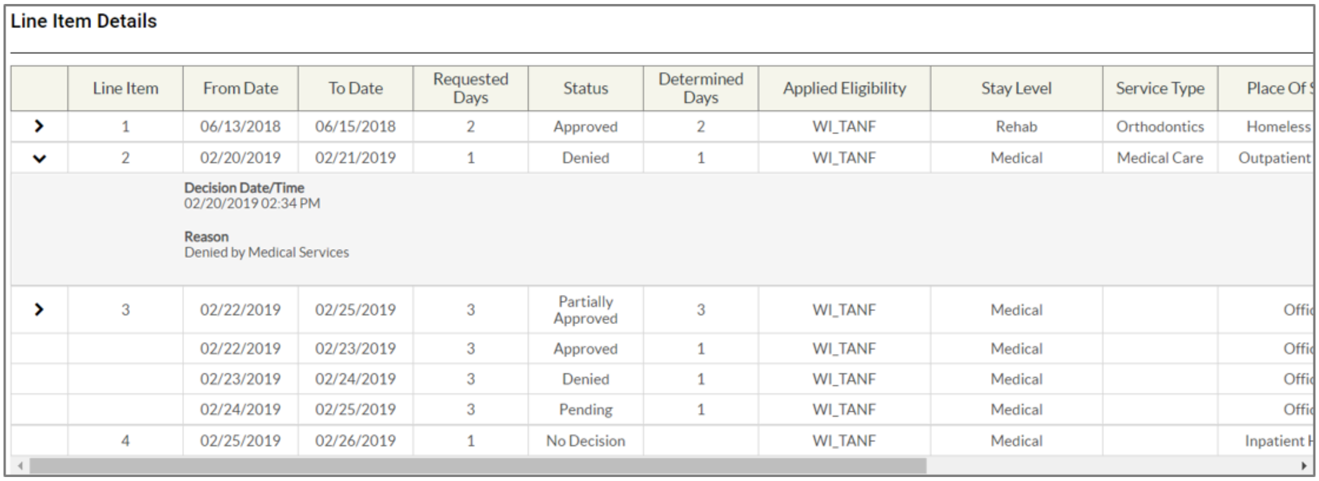
Line Item Details

Line Item Details includes a breakdown of items in the original request and extensions, such as date range, requested days, determination status, and stay level. The number of requested days and determined days are listed before and after the status. In the first example in this topic, Line item 1 includes Requested Days – 14; Status – Approved; Determined Days – 14. Any UDFs are included.

If the line items include UDFs, the UDFs are listed in columns on the right side of the line items, as in the following example, in which Additional Detail is a UDF.

Level Of Urgency	Type	Primary Px Code	Additional Detail
Urgent	Emergency		v3
Urgent	Emergency		v1
Urgent	Emergency		v1

The page includes line item determination reasons if the TruCare ProAuth administrator configures their display. Expand a line item to see the reason. Administrators can display reasons for all determination types or limit the display to specific determination types. For example, the reason for Denied determinations might appear, but not for Partially Approved determinations, as in this example for Line Item 2.



Line Item Details

	Line Item	From Date	To Date	Requested Days	Status	Determined Days	Applied Eligibility	Stay Level	Service Type	Place Of S
>	1	06/13/2018	06/15/2018	2	Approved	2	WI_TANF	Rehab	Orthodontics	Homeless
v	2	02/20/2019	02/21/2019	1	Denied	1	WI_TANF	Medical	Medical Care	Outpatient
		Decision Date/Time 02/20/2019 02:34 PM **Reason** Denied by Medical Services								
>	3	02/22/2019	02/25/2019	3	Partially Approved	3	WI_TANF	Medical		Offi
		02/22/2019	02/23/2019	3	Approved	1	WI_TANF	Medical		Offi
		02/23/2019	02/24/2019	3	Denied	1	WI_TANF	Medical		Offi
		02/24/2019	02/25/2019	3	Pending	1	WI_TANF	Medical		Offi
	4	02/25/2019	02/26/2019	1	No Decision		WI_TANF	Medical		Inpatient H

SP authorization details

You can view an SP authorization's details on the Service/Procedure Authorization Summary page.

An SP authorization request summary includes three parts:

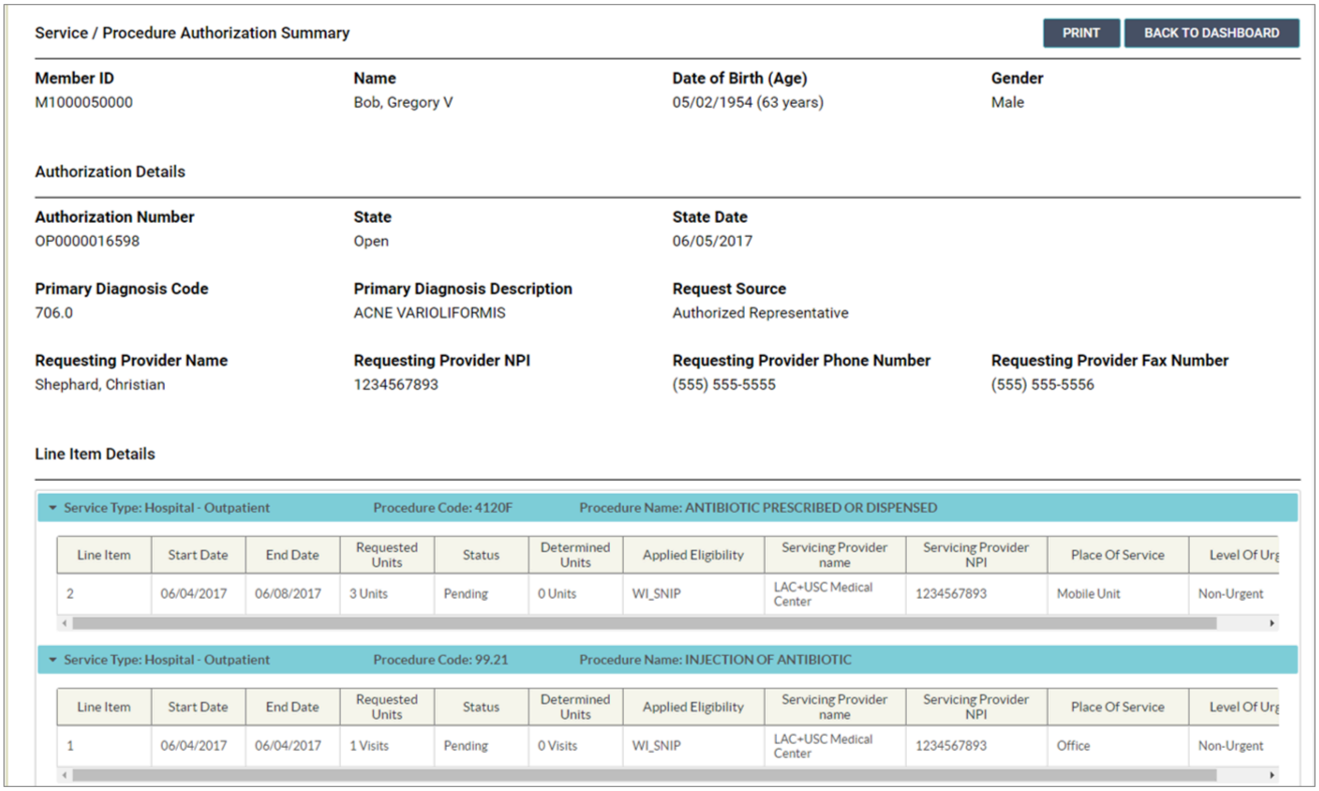
- Member ID
- Authorization Details
- Line Item Details

Member ID

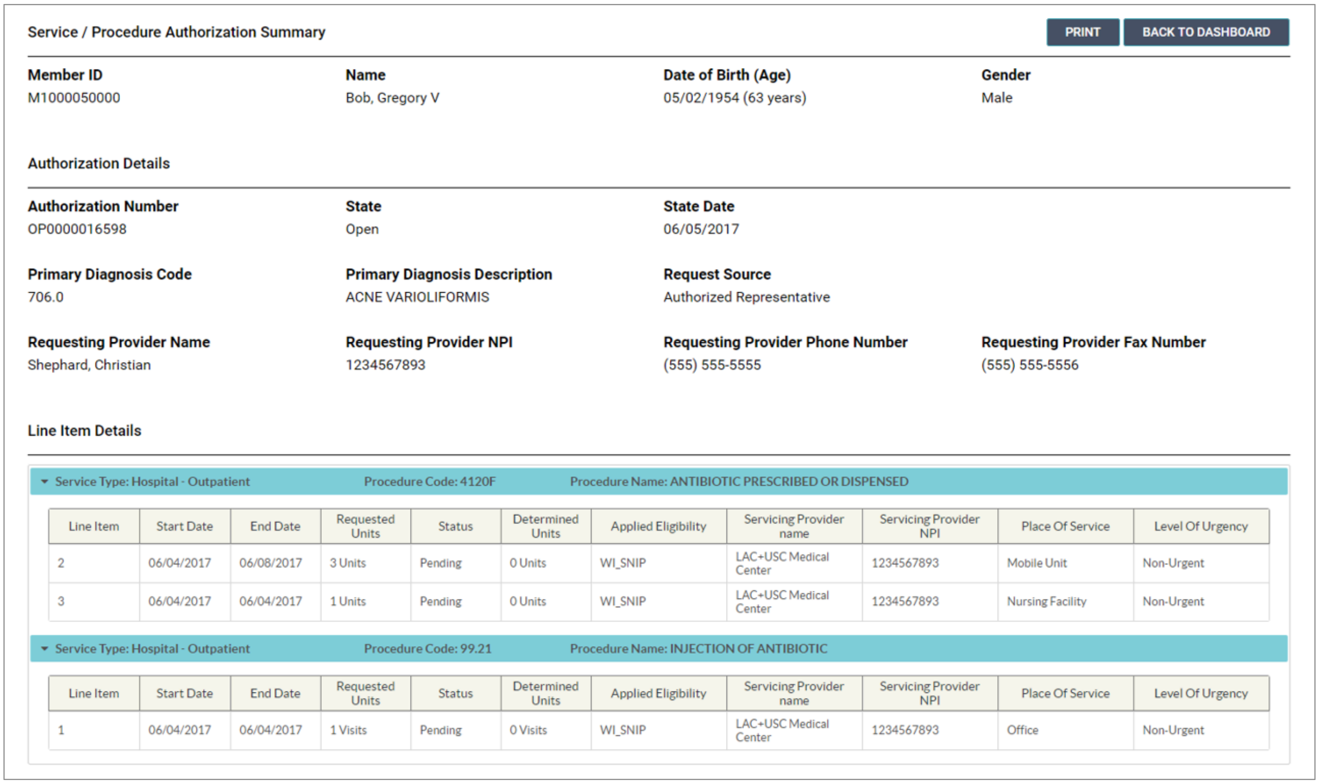
Member ID includes the member identification number, member name, date of birth/age, and gender.

Authorization Details

Authorization Details show all the data entered for the authorization request, as shown in the following example.



Authorization details are updated immediately when an authorization request is modified. Continuing from the preceding example, the line item details now show that Service 2 was modified with an extension. The extended service differs from the original service by requested units and place of service.



Service / Procedure Authorization Summary PRINT BACK TO DASHBOARD

Member ID	Name	Date of Birth (Age)	Gender
M1000050000	Bob, Gregory V	05/02/1954 (63 years)	Male

Authorization Details

Authorization Number	**State**	**State Date**	
OP0000016598	Open	06/05/2017	
Primary Diagnosis Code	**Primary Diagnosis Description**	**Request Source**	
706.0	ACNE VARIOLIFORMIS	Authorized Representative	
Requesting Provider Name	**Requesting Provider NPI**	**Requesting Provider Phone Number**	**Requesting Provider Fax Number**
Shephard, Christian	1234567893	(555) 555-5555	(555) 555-5556

Line Item Details

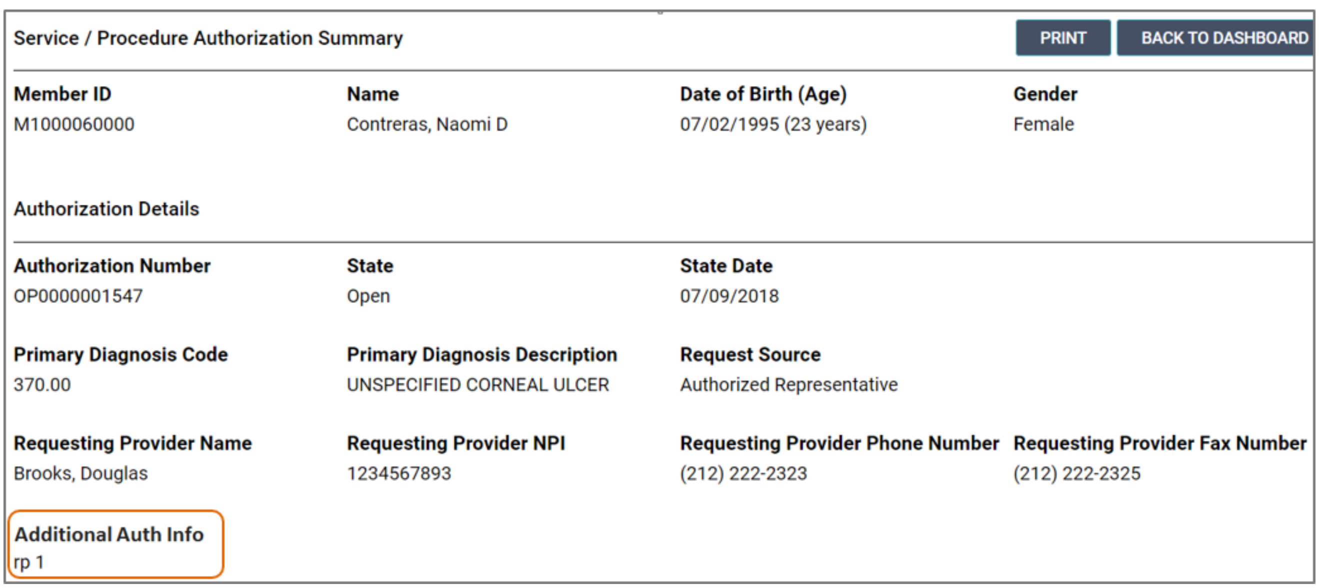
Service Type: Hospital - Outpatient Procedure Code: 4120F Procedure Name: ANTIBIOTIC PRESCRIBED OR DISPENSED

Line Item	Start Date	End Date	Requested Units	Status	Determined Units	Applied Eligibility	Servicing Provider name	Servicing Provider NPI	Place Of Service	Level Of Urgency
2	06/04/2017	06/08/2017	3 Units	Pending	0 Units	WI_SNIP	LAC+USC Medical Center	1234567893	Mobile Unit	Non-Urgent
3	06/04/2017	06/04/2017	1 Units	Pending	0 Units	WI_SNIP	LAC+USC Medical Center	1234567893	Nursing Facility	Non-Urgent

Service Type: Hospital - Outpatient Procedure Code: 99.21 Procedure Name: INJECTION OF ANTIBIOTIC

Line Item	Start Date	End Date	Requested Units	Status	Determined Units	Applied Eligibility	Servicing Provider name	Servicing Provider NPI	Place Of Service	Level Of Urgency
1	06/04/2017	06/04/2017	1 Visits	Pending	0 Visits	WI_SNIP	LAC+USC Medical Center	1234567893	Office	Non-Urgent

If there are User Defined Fields (UDFs), they will appear in their associated sections. The following example shows a UDF in the SP Authorization Details area.



Service / Procedure Authorization Summary PRINT BACK TO DASHBOARD

Member ID	Name	Date of Birth (Age)	Gender
M1000060000	Contreras, Naomi D	07/02/1995 (23 years)	Female

Authorization Details

Authorization Number	**State**	**State Date**	
OP0000001547	Open	07/09/2018	
Primary Diagnosis Code	**Primary Diagnosis Description**	**Request Source**	
370.00	UNSPECIFIED CORNEAL ULCER	Authorized Representative	
Requesting Provider Name	**Requesting Provider NPI**	**Requesting Provider Phone Number**	**Requesting Provider Fax Number**
Brooks, Douglas	1234567893	(212) 222-2323	(212) 222-2325
Additional Auth Info			
rp 1			

Line Item Details

Line Item Details includes a breakdown of items in the original request, extensions, and added services. These are shown in the first example in this topic.

If the line items include UDFs, the UDFs are listed in columns on the right side of the line items, as in the following example, in which Additional Detail is a UDF.

Level Of Urgency	Type	Primary Px Code	Additional Detail
Urgent	Emergency		v3
Urgent	Emergency		v1
Urgent	Emergency		v1

The page includes line item determination reasons if the TruCare ProAuth administrator configures their display. Expand a line item to see the reason. Administrators can display reasons for all determination types or limit the display to specific determination types. For example, the reason for Partially Denied determinations might appear, but not for Approved determinations, as in this example for Line Item 8.

Line Item Details

Service Type: Anesthesia	Procedure Code: 00.70	Procedure Name: REV HIP REPLACEMENT BOTH ACETAB & FEMORAL CMPNTS
Service Type: Consultation	Procedure Code: 00300	Procedure Name: ANES INTEG MUSC & NRV HEAD NECK&POSTERIOR TRUNK
Service Type: Diagnostic Lab	Procedure Code: 00.50	Procedure Name: IMPL CARD RESYNCHRNIZAT PACEMKR W/O DFIB TOT SYS
Service Type: Diagnostic X-Ray	Procedure Code: 00.40	Procedure Name: PROCEDURE ON SINGLE VESSEL
Service Type: Durable Medical Equipment Rental	Procedure Code: 1190	Procedure Name: ANESTHESIA OBTURATOR NEURECTOMY INTRAPELVIC
Service Type: Medical Care	Procedure Code: 00.28	Procedure Name: INTRAVASCULAR IMAGING OTHER SPECIFIED VESSEL(S)
Service Type: Radiation Therapy	Procedure Code: 00600	Procedure Name: ANESTHESIA CERVICAL SPINE & CORD NOS
Service Type: Surgical	Procedure Code: 0200T	Procedure Name: PERQ SACRAL AUGMENT UNI +-BALLOON/DEVICE 1+NDL
Service Type: Surgical Assistance	Procedure Code: 00.80	Procedure Name: REVISION KNEE REPLACEMENT TOTAL ALL COMPONENTS

	Line Item	Start Date	End Date	Requested Units	Status	Determined Units	Applied Eligibility	Servicing Provider Name	Servicing Provider NPI
	8	02/06/2017	02/11/2017	5 Visits	Partially Denied	5 Visits	WI_TANF	Brooks, Douglas	1234567893
		02/06/2017	02/11/2017	5 Visits	Denied	3 Visits	WI_TANF	Brooks, Douglas	1234567893
		02/06/2017	02/11/2017	5 Visits	Pending	2 Visits	WI_TANF	Brooks, Douglas	1234567893

Decision Date/Time
01/09/2019 06:42 PM

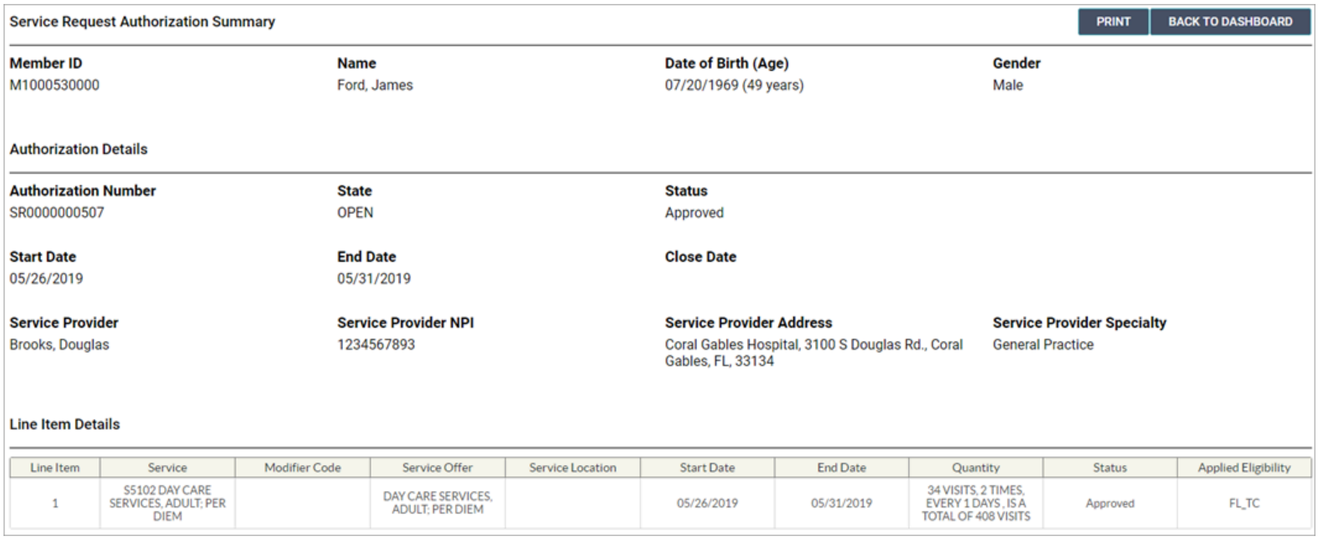
Reason
Authorization/Access Restrictions

SR authorization details

You can view an SR authorization's details on the Service Request Authorization Summary page.

An SR authorization request summary includes the following parts:

- Member ID
- Authorization Details
- Line Item Details



Service Request Authorization Summary

PRINT | BACK TO DASHBOARD

Member ID	Name	Date of Birth (Age)	Gender
M1000530000	Ford, James	07/20/1969 (49 years)	Male

Authorization Details

Authorization Number	State	Status	
SR0000000507	OPEN	Approved	
Start Date	**End Date**	**Close Date**	
05/26/2019	05/31/2019		
Service Provider	**Service Provider NPI**	**Service Provider Address**	**Service Provider Specialty**
Brooks, Douglas	1234567893	Coral Gables Hospital, 3100 S Douglas Rd., Coral Gables, FL, 33134	General Practice

Line Item Details

Line Item	Service	Modifier Code	Service Offer	Service Location	Start Date	End Date	Quantity	Status	Applied Eligibility
1	S5102 DAY CARE SERVICES, ADULT; PER DIEM		DAY CARE SERVICES, ADULT; PER DIEM		05/26/2019	05/31/2019	34 VISITS, 2 TIMES, EVERY 1 DAYS , IS A TOTAL OF 408 VISITS	Approved	FL_TC

Member ID

Member ID includes the member identification number, member name, date of birth/age, and gender.

Authorization Details

Authorization Details show all the data entered for the authorization request, such as the request's start date (earliest start date), end date (latest end date), and closed date, and the service provider's name, NPI, specialties, and address. Fields without data indicate that the entry was optional and the user chose not to exercise the option.

Line Item Details

Line Item Details includes line item number, service code/description, modifier code, service offer, service location, quantity, start date, end date, determination status, and applied eligibility. Rate information is included if configured by your organization.

10

Viewing correspondence

You can view correspondence relating to UM authorizations from the IP or SP summary dashboard, using **View Correspondence**.

To view correspondence:

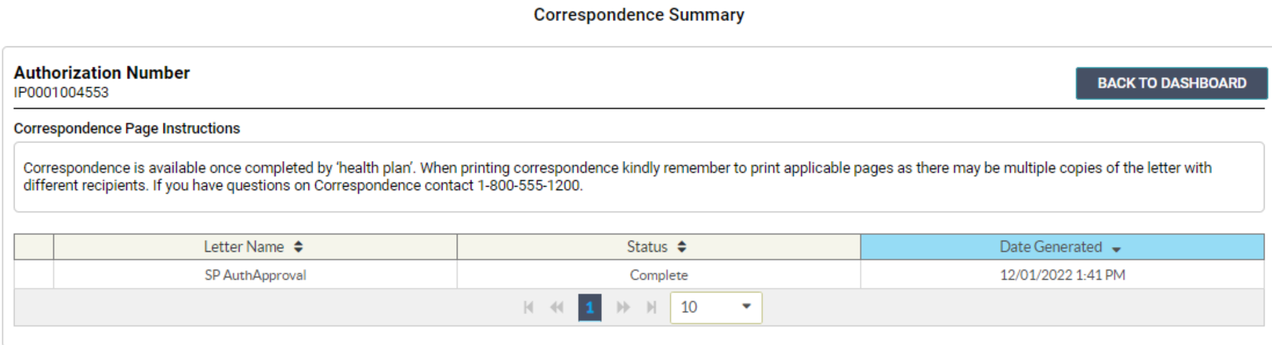
1. In the authorization summary table on the dashboard, select the authorization for which you wish to view correspondence.
2. Select **View Correspondence**.

The Correspondence Summary page for the selected authorization opens. You can view the letter history for any letter in Complete status.

Topics in this section

Correspondence summary

The Correspondence Summary appears when you select an authorization on the member dashboard and select **View Correspondence**. On the summary you can select correspondence to view details about or return to the member dashboard by selecting **Back to Dashboard**.



Functional areas of the Correspondence Summary

This table describes the functional areas of the Correspondence Summary.

Function	Description
Authorization Number	Shows the number identifying the authorization for which correspondence is being displayed.
Back to Dashboard	Returns you to the member dashboard.
Correspondence Page Instructions	This field provides any specific instructions for your payer organization. The instructions for your payer organization were entered in **Global Configuration** > **Miscellaneous** > **Correspondence** > **Correspondence Page Instructions**.

Function	Description
Letters	Correspondence Summary is updated in real-time when a payer initiates the letter to any of the recipients. This column lists letters concerning the authorization that have been initiated to designated recipients. To select a letter click on it. The line turns blue and a chevron appears on the first column of the list. Clicking on the chevron displays the letter history. Summary information columns for correspondence are: • **Letter Name** - a name indicating the content of the letter. • **Status** - Complete, indicating that the letter has been generated by TruCare, or Voided, indicating that the letter has been voided. You cannot view or print a void letter. If the letter status is Void, the void reason displays next to the status. • **Date Generated** - The date and time stamp from when the letter was generated. By default, letters are sorted using most recent to earliest date generated information, but you can adjust the sort on any or the columns using the arrows in any of the columns. Sorting applies to overall data and not just to the visible set of rows.
Page and Items per page	A display indicating page being viewed (highlighted in black) and the number of items that can display on a page (in the drop-down box). To increase the number of items displayed in the summary grid, select the down-arrow in the drop-down box and then select 10, 20, 50, or 100.

View letter history

Letter history provides additional information on a letter. It also allows you to view a PDF of the letter, from which you can download or print the letter.

To view letter history from the Correspondence Summary:

1. Select the letter in the Correspondence Summary grid by clicking on the corresponding line. The line turns blue and a chevron appears in the first column.
2. Select the chevron. The Letter History appears within the Correspondence Summary.

Topics in this section

The Letter History shows the status of a letter and the date and time the letter was generated. Using the Letter History grid, you can open a PDF of the letter and, from the PDF, print or download the letter.

Open PDF on page 110
From the Letter History grid, you can open a letter in PDF if its status is Complete. The PDF opens in a separate tab on your browser or in a PDF viewer, depending on your configuration. From that PDF, you can download, share, or print the letter. Each browser or PDF viewer differs in exactly how you download or print a file.

Viewing Letter History

The Letter History shows the status of a letter and the date and time the letter was generated. Using the Letter History grid, you can open a PDF of the letter and, from the PDF, print or download the letter.

The Letter History grid contains two columns:

- **Status** - The current state of the letter. SUCCESS indicates the letter was successfully printed. or faxed from TruCare. It does not indicate that the letter recipient received the correspondence.
- **Date Generated** - The date and time stamp indicating when the letter was printed or faxed.

The gird also contains the **Open PDF** button, which allows you to view the PDF of a letter.

Open PDF

From the Letter History grid, you can open a letter in PDF if its status is Complete. The PDF opens in a separate tab on your browser or in a PDF viewer, depending on your configuration. From that PDF, you can download, share, or print the letter. Each browser or PDF viewer differs in exactly how you download or print a file.

To view a PDF of a letter from the Letter History grid, select the letter and then click **Open PDF**. The letter opens in a separate tab on the browser or in a PDF viewer.

A

Applying a filter to your provider list

Using filtering is one of the best ways to make your work activities more efficient.

Filtering allows you to create a subset of just the entities you need to see at one time. For example, you can use filtering to narrow your provider list for a work session.

> **Note:** Any filters that you create last only for as long as you maintain your work session. Filters cannot be saved.

Requesting provider

The requesting provider is the entity that is requesting/ordering the service or admission for a member.

For authorization requests created and submitted, only the providers associated with your user account qualify as requesting providers, unless your configuration allows you to search for all available providers. If you have that option and you select **Search All Providers**, all available providers are returned by the search. Any providers returned by your provider search can be entered into the Requesting Provider field.

> **Note:** When authorization requests are created, searches for requesting providers use all providers associated with your account (or all providers if your configuration allows you to search for all available providers and you select that option), not solely the providers selected on the Provider Filter at a given time.

Default provider list

By default, none of the providers associated with your user account are selected at the start of a work session. You can select all by selecting the **Provider List** check box or filter the list by creating a subset of providers to use for a specific purpose.

> **Note:** The Provider List check box is only available if the number of providers associated with your account is less than or equal to the provider threshold configured by the TruCare ProAuth administrator. See About selecting providers in the Provider Filter on page 113 for more information.

To restore the default provider list, clear the **Provider List** check box. The indicator changes from green to gray, as no entries are active. All providers linked to your account are displayed. Select the **Provider List** check box then select **Apply Filter** to make all entries active again.

Topics in this section

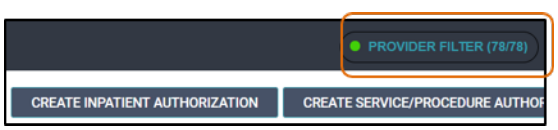
Provider Filter indicators

Provider Filter indicators show whether the filter is applied and information about your providers.

When you start TruCare ProAuth none of the providers linked to your user account are active.

The indicator on the Provider Filter button is gray, meaning no providers have been selected.

After you have selected providers, the indicator turns to green.



The numbers to the right of the Provider Filter button indicate the number of applied providers to the left of the diagonal line (/) and the number of providers associated with your account on the right. In the first example, 0/78 means that no providers are applied to the filter and 78 providers are associated with the user's account. In the second example, all 78 providers are applied to the filter.

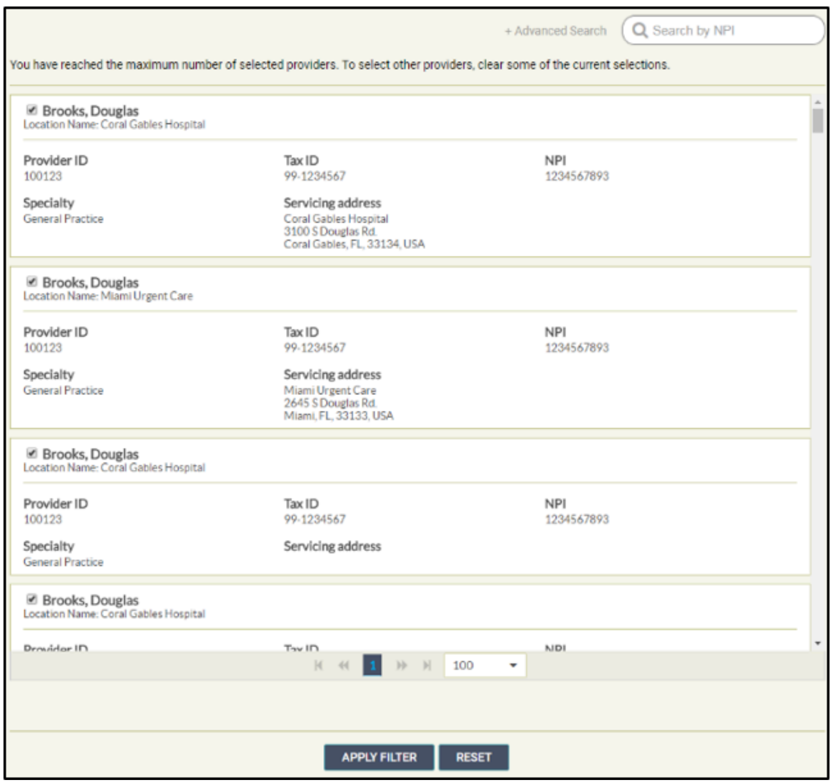
About selecting providers in the Provider Filter

In the Provider Filter, the maximum number of providers (provider threshold) that you can select is configured by the TruCare ProAuth administrator.

The display of the Provider List check box in the Provider Filter depends on the number of providers associated with your account and the configured provider threshold.

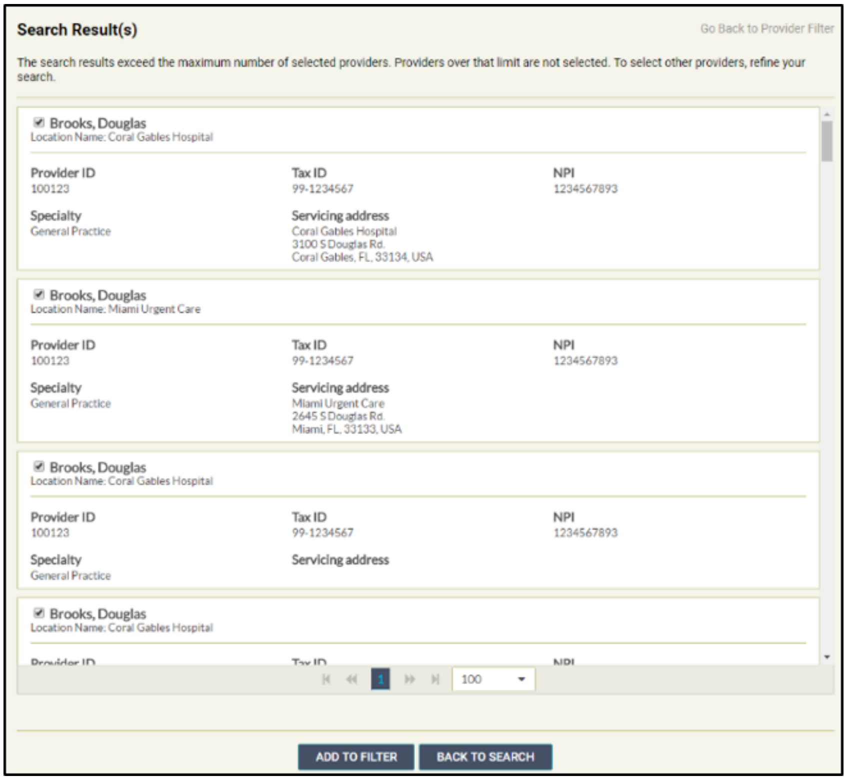
- If the number of providers associated with your account is less than or equal to the configured provider threshold, the Provider List check box is available in the Provider Filter. You can use that check box to select all providers. When using the Advanced Search, the results are automatically selected.
- If the number of providers associated with your account exceeds the configured provider threshold, the Provider List check box is not available in the Provider Filter.

You cannot manually select more providers than the configured provider threshold. If your selections reach the provider threshold, the remaining provider check boxes are disabled. A message informs you that the limit has been reached and to select other providers you must deselect some providers (as shown in the next example).



If the number of providers returned in advanced search results is less than or equal to the configured provider threshold, the results are automatically selected.

If the number of providers returned in advanced search results exceeds the configured provider threshold, the first x (where x is the provider threshold) number of providers are automatically selected. A message informs you that the limit has been reached and to select other providers, you must deselect some providers (as shown in the next example).



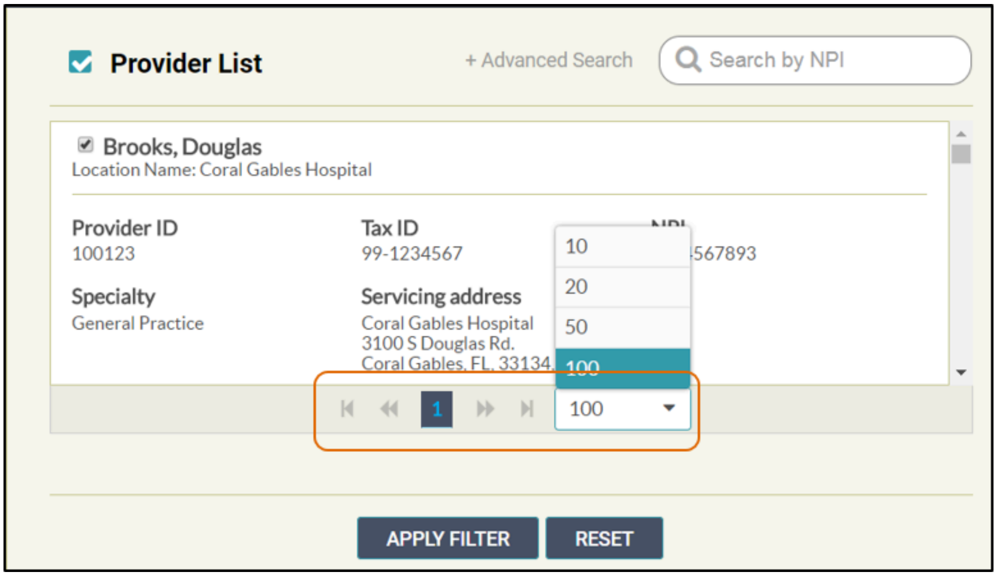
Applying a filter

Apply a filter to your provider list to create a list of providers that you need for your current work session.

Any filters that you create last only for as long as you maintain your work session. Filters cannot be saved.

When working in the filter, keep the following in mind:

- Use the bottom controls to page through the list and to set the number of entries per page.

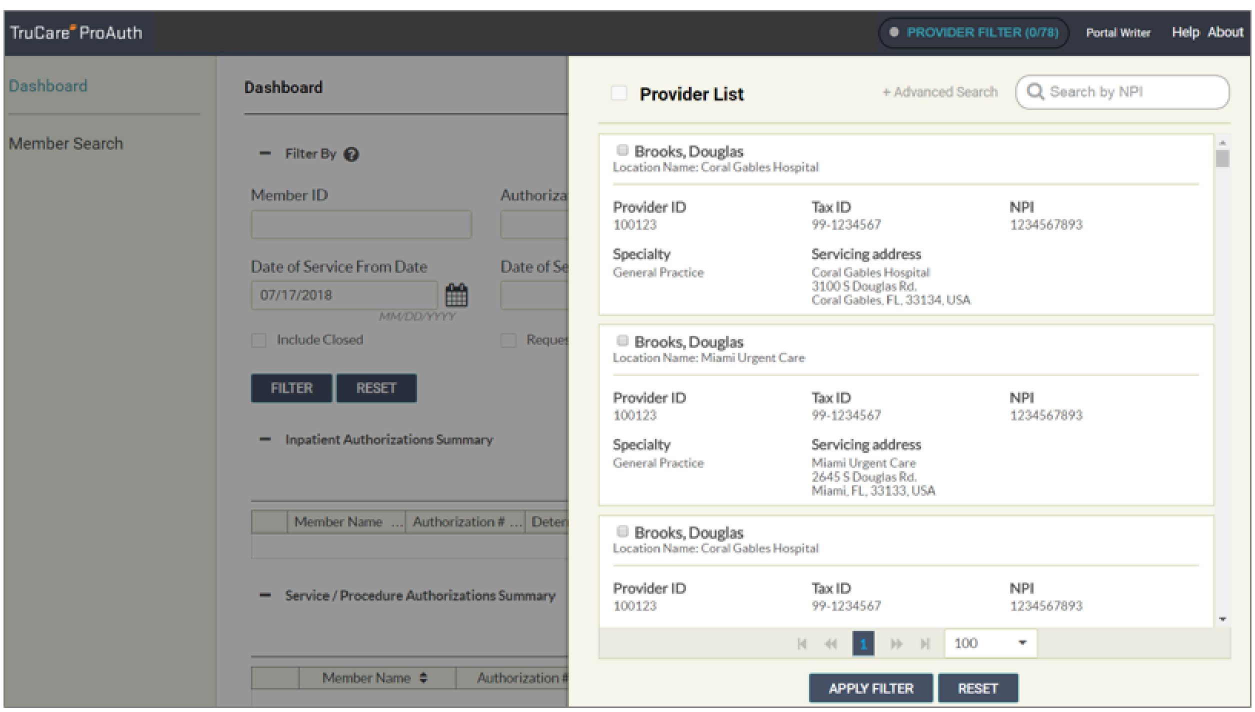


- To close the filter slider, select the Provider Filter button or click anywhere else on the page. Ensure that your selections are active before closing it.

To apply a filter to your provider list, use the following steps.

1. Select **Provider Filter** in the upper right area of the dashboard to open the filter slider.

   When the filter slider opens, by default, none of the providers associated with your user account are selected. The indicator is gray.



2. In the filter slider, select the providers you want active in your filter using one of the following methods.

   - Select all providers.

     a. Select the **Provider List** check box in the upper left of the slider.

        > **Note:** The Provider List check box is available if the number of providers associated with your account is less than or equal to the configured provider threshold. For information about the provider threshold and provider selections, see About selecting providers in the Provider Filter on page 113.

     b. When you are done, select **Apply Filter** to add the providers to the filter and close the slider.

   - Select providers individually.

     a. If you have a short list of providers, scroll through the list and check any provider you want to add to the filter.

     b. When you are done, select **Apply Filter** to add the providers to the filter and close the slider.

   - Search by NPI.

     a. Type the 10-digit ID number of the provider in the Search box. (You must enter at least two characters.)

        One or more matching provider entries are displayed. For example, a provider may work at multiple facilities.

        Providers are already selected if results do not exceed the provider threshold, as described in About selecting providers in the Provider Filter on page 113). If the threshold is exceeded, follow the instructions to select providers.

     b. If necessary, deselect entries you do not want.

     c. Select **Add to Filter** to add the selected provider(s) to the filter and close the slider.

   - Advanced Search.

     a. Select **Advanced Search** then fill in one or more of the fields. (You must enter at least two characters for the provider name, provider ID, or city. Select the state from the drop-down list.) When you are done, select **Search**.

        One or more matching provider entries are displayed. For example, a provider may work at multiple facilities.

        Providers are already selected if results do not exceed the provider threshold, as described in About selecting providers in the Provider Filter on page 113). If the threshold is exceeded, follow the instructions to select providers.

     b. If necessary, deselect entries you do not want.

     c. Select **Add to Filter** to add the selected provider(s) to the filter and close the slider.

The Provider Filter status indicator turns to green. The count on the Provider Filter button indicates the number of providers you applied to the filter.

Adding to a filter

After you activate a filter, you can add other providers to it.

If you need to add another provider to your filter after creating it, you can easily do so.

To add a provider to your filter:

1. Select **Provider Filter** in the upper right area of the dashboard to open the filter slider.

   To close the filter slider at any time during this process, select Provider Filter or click anywhere else on the page. Ensure that your new selections are active before closing it.

2. In the filter slider, select the providers you want active in your filter using one of the following methods.

   - Search by NPI.

     a. Type the 10-digit ID number of the provider in the Search box. (You must enter at least two characters.)

        One or more matching provider entries are displayed. For example, a provider may work at multiple facilities.

        Providers are already selected if results do not exceed the provider threshold, as described in About selecting providers in the Provider Filter on page 113). If the threshold is exceeded, follow the instructions to select providers.

     b. If necessary, deselect entries you do not want.

     c. Select **Apply Filter**.

   - Advanced Search.

     a. Select **Advanced Search** then fill in one or more of the fields. (You must enter at least two characters for the provider name, provider ID, or city. Select the state from the drop-down list.) When you are done, select **Search**.

        One or more matching provider entries are displayed. For example, a provider may work at multiple facilities.

        Providers are already selected if results do not exceed the provider threshold, as described in About selecting providers in the Provider Filter on page 113). If the threshold is exceeded, follow the instructions to select providers.

     b. If necessary, deselect entries you do not want.

     c. Select **Add to Filter** to add the selected provider to the filter and close the slider.

The count on the Provider Filter button increases by the number of providers you add to the filter.

Removing the filter

You can clear the provider filter, so that no providers are selected.

You can return to the default provider state, in which no providers are selected.

To remove the provider filter, use one of the following options:

- Clear (uncheck) the **Provider List** check box.

> **Note:** The Provider List check box is available if the number of providers associated with your account is less than or equal to the configured provider threshold. For information about the provider threshold and provider selections, see About selecting providers in the Provider Filter on page 113.

- Select **Reset**.

The Provider Filter status indicator turns to gray. The selected provider count on the Provider Filter button returns to zero (0).

B

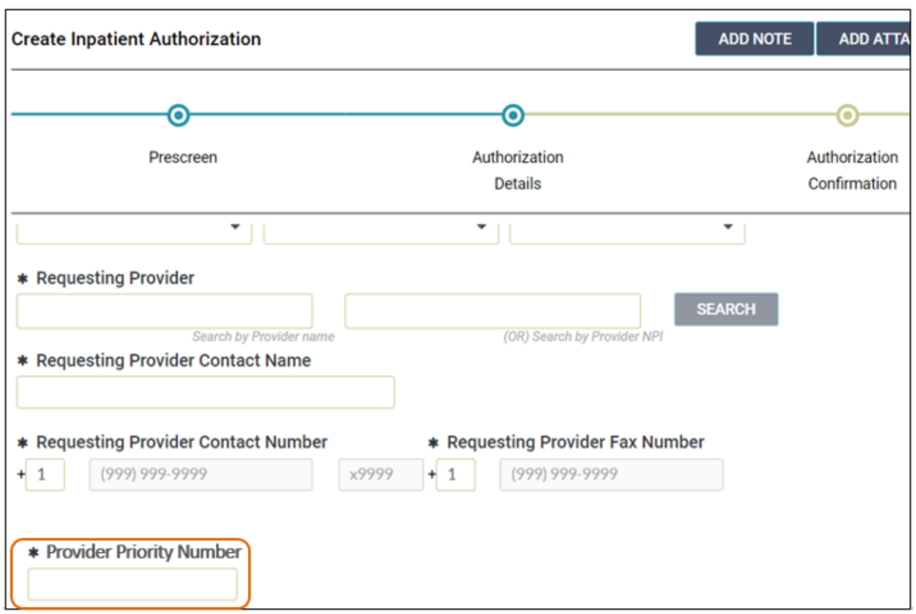
UDF guidelines

Use these guidelines when working with User Defined Fields (UDFs) in authorizations.

When you are creating an authorization request, it might include UDFs. The names and locations of UDFs vary based on your administrator's UDF configurations.

UDFs that require a value are marked with an asterisk. You must provide a value to continue creating the authorization (move to the next screen or submit an authorization).

The following example, shows an IP authorization with a required UDF.



Topics in this section

UDF types

There are four User Defined Fields (UDFs) types in TruCare authorizations that may be available in TruCare ProAuth.

- Date: Displays a text field and calendar. In the text field, only numbers and forward slashes (/) are allowed.
- Numeric: Display a field in which users can enter whole numbers. Negative numbers and decimals are not allowed.
- String: Displays a text field. Special characters are allowed.
- Drop-down: Displays a drop-down menu with values.

C

Expired diagnosis or procedure codes

TruCare ProAuth applies the TruCare Code Expiration Date Settings that were configured by the TruCare administrator.

When you create or extend authorizations, TruCare ProAuth applies the TruCare Code Expiration Date Settings to the specified diagnosis and procedure codes.

Expired codes in IP and SP authorizations

This section describes the circumstances in which a diagnosis or procedure code is expired.

In an IP authorization:

- A code is expired if its termination date is before (<) the authorization's Admission Date or its effective date is after (>) the authorization's Admission Date.
- A code is valid if its effective date is equal to or before (=<) the authorization's Admission Date and there is no code termination date or the termination date is equal to or after (=>) the authorization's Admission Date.

In an SP authorization:

- A code is expired if its termination date is before (<) the authorization's Start Date or its effective date is after (>) the authorization's Start Date.
- A code is valid if its effective date is equal to or before (=<) the authorization's Start Date and there is no code termination date or the termination date is equal to or after (=>) the authorization's Start Date.

Topics in this section

How TruCare ProAuth treats expired codes

When an authorization includes an expired diagnosis or procedure, TruCare Code Expiration Date Settings control the behavior in authorizations.

There are three TruCare Code Expiration Date Settings:

- **Do not check dates**
- **Warn when dates are invalid**
- **Disallow invalid dates**

The following sections describe how TruCare ProAuth handles expired diagnoses or procedures based on these TruCare settings.

Topics in this section

Do not check dates setting

When the TruCare Code Expiration Date Setting is **Do not check dates**, TruCare ProAuth handles expired diagnoses or procedures as described in this section.

In TruCare ProAuth, procedure and diagnosis codes are not checked for expiration dates. You can submit authorizations that have an expired procedure or diagnosis.

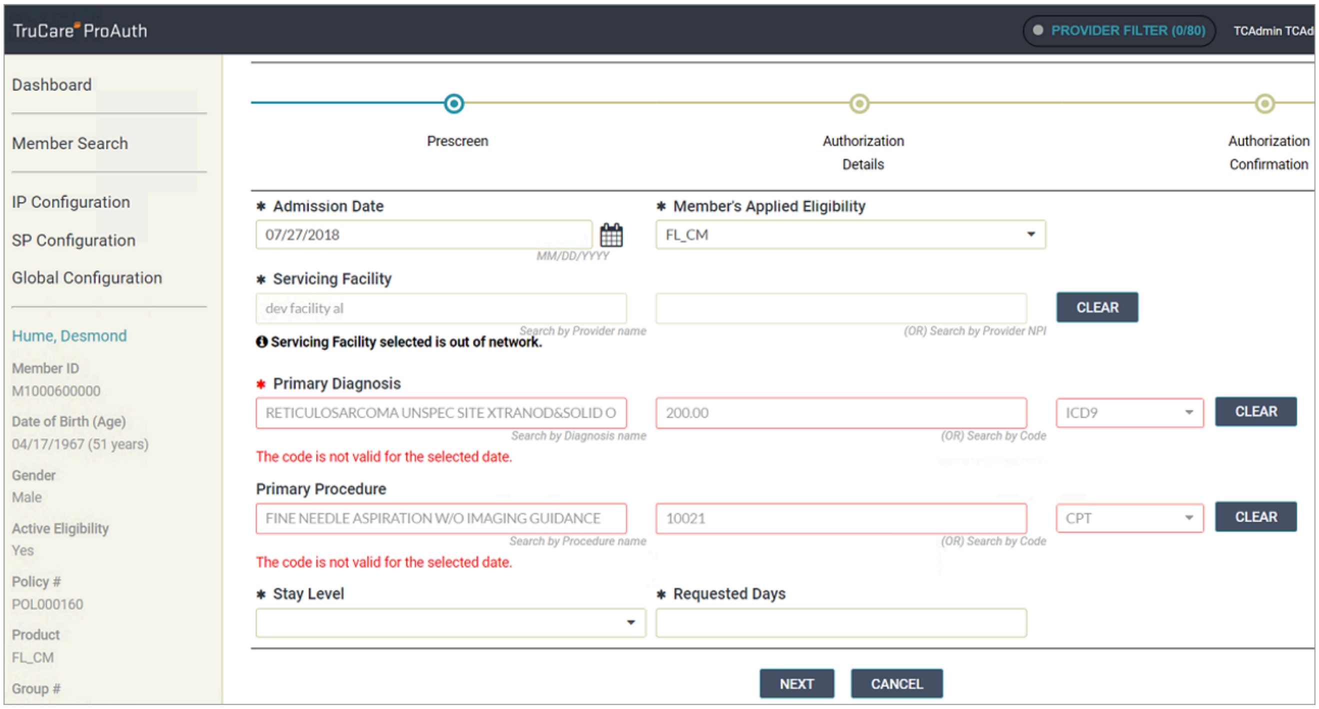
Warn when dates are invalid setting

When the TruCare Code Expiration Date Setting is **Warn when dates are invalid**, TruCare ProAuth handles expired diagnoses or procedures as described in this section.

In TruCare ProAuth, when you are creating or extending an authorization, you are informed when procedures or diagnoses are expired, but you can still create or extend the authorization. TruCare ProAuth informs you of expired codes in several ways.

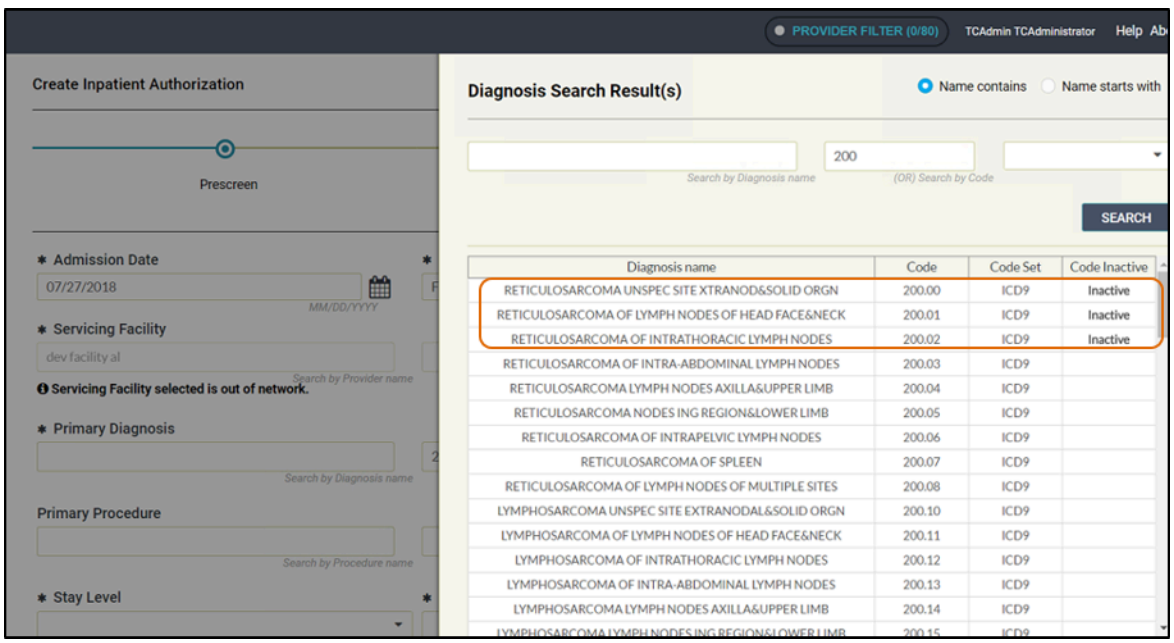
If an authorization includes an expired diagnosis or procedure, it is highlighted in red and a message informs you that the code is not valid for the selected date.

In the following example, the procedure and diagnosis codes are expired.

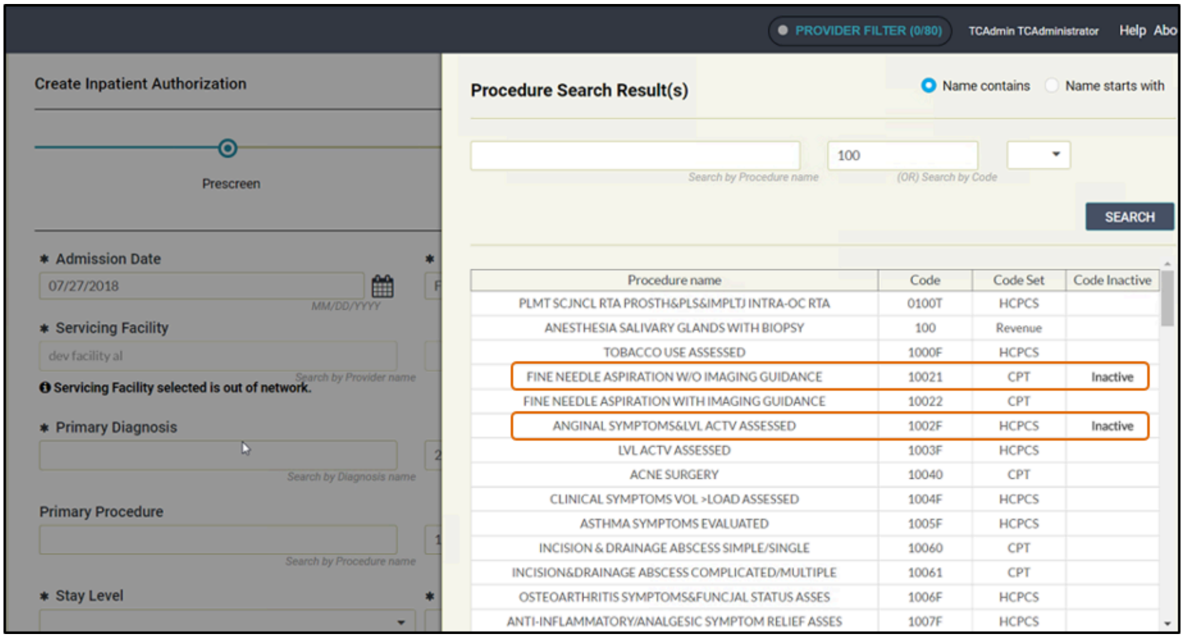


If you search for a diagnosis or procedure and the code is expired, the search results show the code as Inactive.

The following example shows diagnosis search results that include expired diagnosis codes:

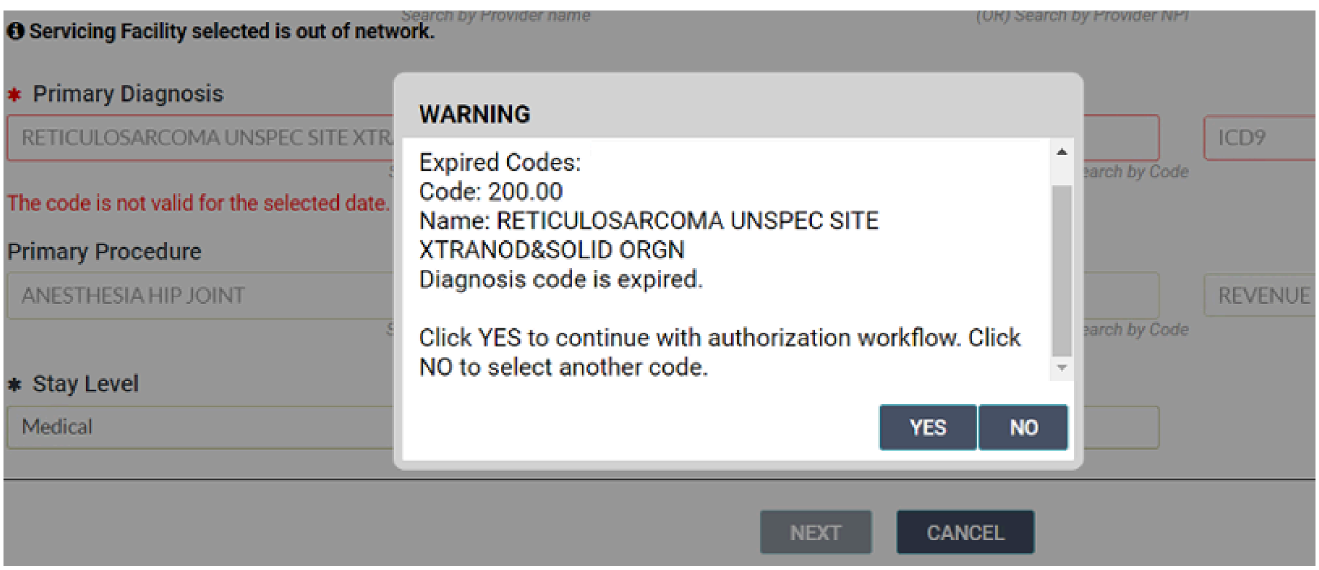


The next example shows procedure search results with expired procedure codes:

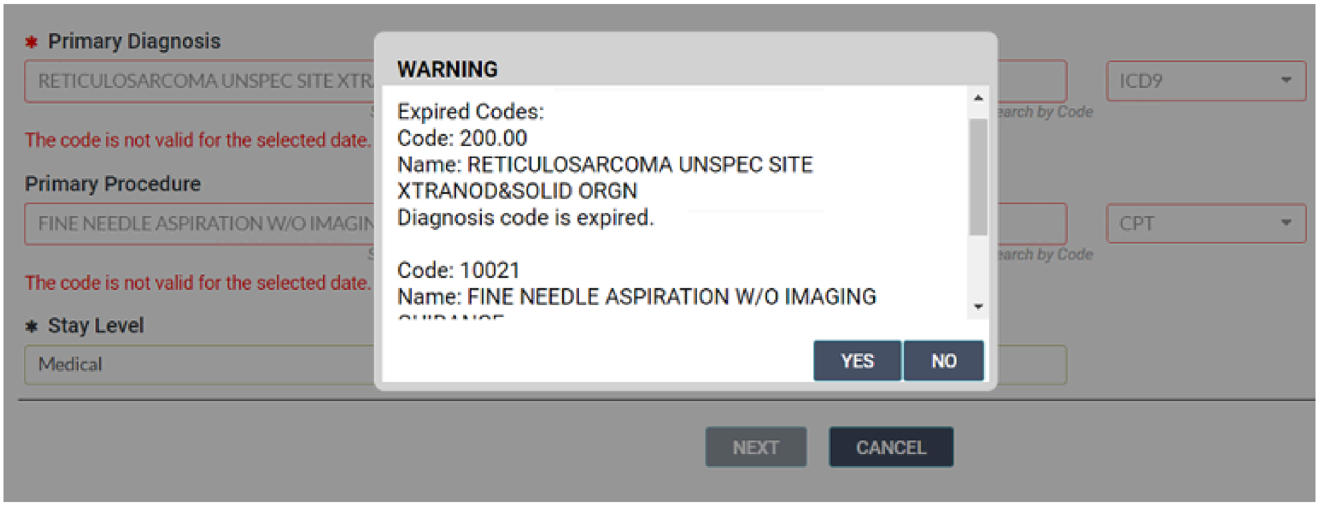


If you continue with the authorization workflow, for example by selecting **Next** or **Submit**, a Warning message informs you that there are expired codes. All expired codes are listed in the message.

In the following example, the diagnosis code is expired. A similar message appears for expired procedure codes.



In the next example, multiple codes are expired.



You can select **YES** to continue with the authorization workflow or select **NO** to go back and choose a different procedure or diagnosis.

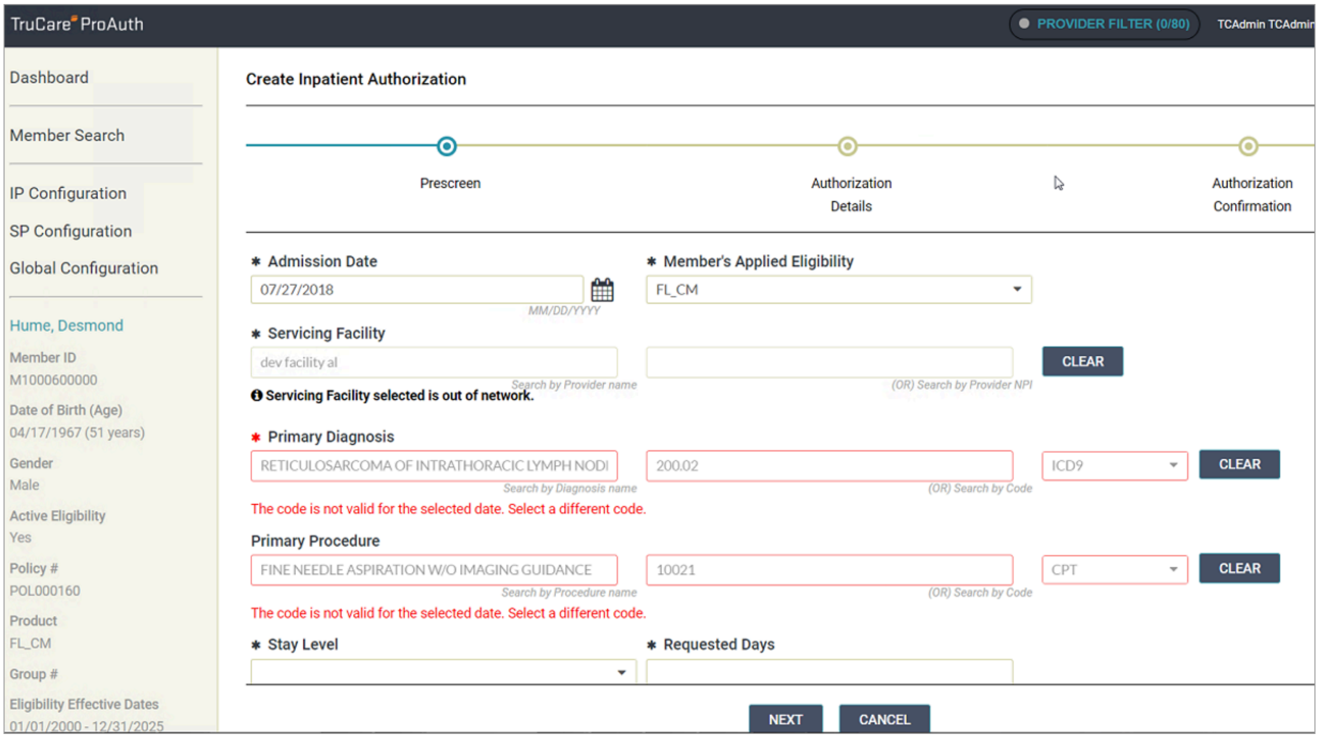
Disallow invalid dates setting

When the TruCare Code Expiration Date Setting is **Disallow invalid dates**, TruCare ProAuth handles expired diagnoses or procedures as described in this section.

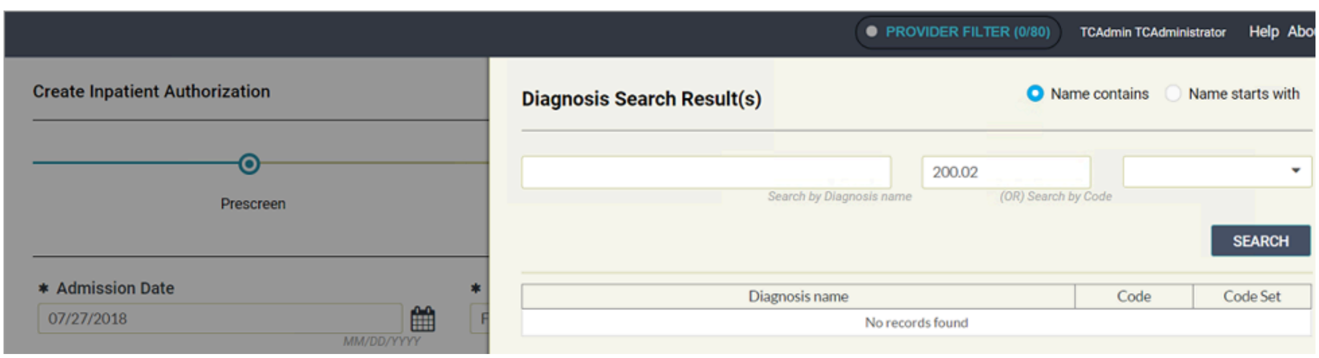
In TruCare ProAuth, you cannot create or extend an authorization that includes expired procedures or diagnoses. TruCare ProAuth informs you of expired codes in several ways.

If a diagnosis or procedure in an authorization is expired, it is highlighted in red and a message informs you that the code is not valid for the selected date and to select a different code.

In the following example, the procedure and diagnosis codes are expired.

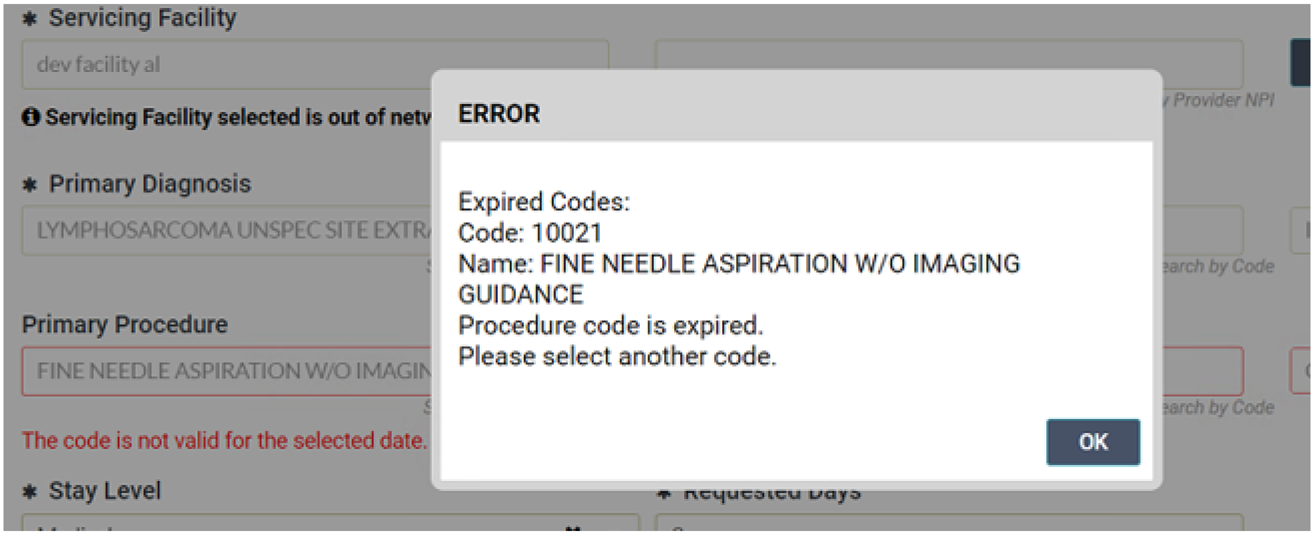


Searches for diagnosis or procedure codes do not include expired codes. If you search for a specific diagnosis or procedure and the code is expired, the search results do not display the code, as shown in the following example of a diagnosis code search. The same thing happens with an expired procedure search.



If you attempt to continue with the authorization workflow, for example by selecting **Next**, an Error message informs you that there are expired codes and to select another code. All expired codes are listed in the message.

In the following example, the procedure code is expired. A similar message appears for expired diagnosis codes.



You cannot continue with the authorization workflow. You must choose a valid (non-expired) diagnosis or procedure code.

When extending or adding a service to a service procedure authorization, if you specify dates that make the codes expired, you will get an error message telling you that the code is expired and that you cannot continue and to contact your health plan.

This can happen in the following service procedure authorization scenarios:

- When you extend an SP authorization and specify dates that make a diagnosis code or procedure code expired.
- When you add a service to an SP authorization and specify dates that make the procedure code expired.

D

TruCare ProAuth access from a member search in your parent portal

Some organizations configure their connection to TruCare ProAuth so that a member used in your parent portal can be passed directly to TruCare ProAuth, eliminating the need to search for the same member.

After successfully authenticating user access, TruCare ProAuth performs a member search, using the member ID that is transferred via a URL from your organization.

When you access TruCare ProAuth, one of the following scenarios will occur:

- If the member is found, TruCare ProAuth opens at the dashboard with the member in focus in the left navigation pane. Existing authorizations for this member for the past seven days are displayed (the Date of service From date defaults to seven days before current day). You can work with existing authorizations for the member or create new authorizations for the member.
- If the member is not found, TruCare ProAuth opens at the Member Search page. A message informs you that no member was found. You can try searching for a member on that page.
- If the URL from your organization does not include a member ID, TruCare ProAuth opens at the dashboard with no member in focus. You can search for a member or work with authorizations as needed.