



MHK Portal User Guide

MHK Portal User Guide for: Tufts Health Plan Commercial, Connector, Medicaid and Medicare Plans (excluding Tufts Health One Care and Tufts Health Plan Senior Care Options Plans)

Note: We recently updated the MHK Portal User guide to include ALL products including Medicaid products for medical requests. For Behavioral Health and Substance Use request, please continue to use the [Behavioral Health MHK Portal User Guide](#).

Table of Contents

Overview	3
Portal Support and Trouble Shooting	3
Accessing the Portal	4
Logging In	4
Migrating to MHK Medical Management (formerly known as MedHOK) from within the Secure Provider Portal	5
Requesting a Prior Authorization or Submitting an Inpatient Notification	9
Member Search	9
Add Requesting Provider	11
Add Servicing/Facility Provider	16
Add Diagnosis Code	18
Add Primary Procedure Code	19
Add Medical/Clinical Documentation	21
Submitting Assessments (Commercial Plans)	24
Physical Therapy/Occupational Therapy/Speech Therapy	24
Inpatient Hospice and Respite	25
Submitting Assessments (Tufts Health Public Plans)	26
Physical Therapy/Occupational Therapy/Speech Therapy	26
Home Health Care for Tufts Health Together and RITogether	26
Inpatient Hospice and Respite	27
Viewing/Adding Updates to an Existing Inpatient Notification or Prior Authorization	28
Adding Medical/Clinical Notes to an Existing Authorization	34
Adding Discharge Date(s) to an Existing Authorization	36

Overview

Inpatient notifications and prior authorization requests for outpatient services for Tufts Health Commercial Plans including Connector Plans (Tufts Health Direct and Tufts Premier), Tufts Medicare Preferred Plans including Tufts Medicare Access, Tufts Health Plan Preferred HMO, Tufts Medicare Preferred Supplement, and other Tufts Health Plan Medicare Preferred Plans and Tufts Health Plan Medicaid Plans, including Tufts Health Together and Tufts Health RITogether should be entered into the MHK Medical Management system (formerly known as MedHOK) portal via [secure Provider portal](#).

Tufts Health Plan Senior Care Options (SCO) and Tufts Health One Care plans **do not** follow these processes. Please refer to “Authorization” in the [Forms](#) section of the Provider Resource Center for further direction on requests for these products.

Note: If you are using an outdated or unsupported browser, certain features on the secure Provider portal may not function properly. For an improved user experience, upgrade your browser to the latest version of Microsoft Edge, Mozilla Firefox, or Google Chrome.

For questions, please call [Tufts Health Plan Provider Services](#) contact center.

MHK PORTAL SUPPORT AND TROUBLESHOOTING

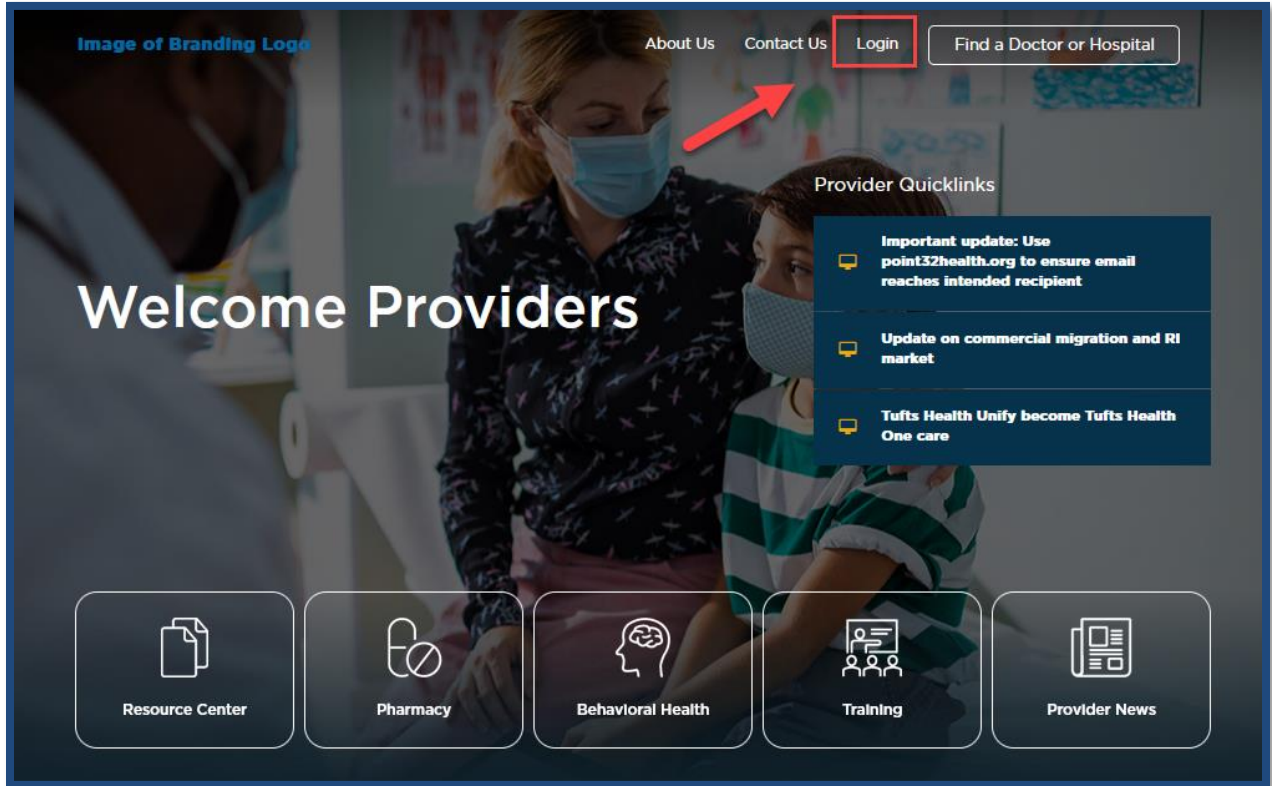
When contacting Provider Services, please be prepared to provide the following information:

- User ID
- First name, last name
- Contact phone number
- Web browser used
- Web browser version
- Is the issue constant or intermittent?
- Are multiple users at the same site experiencing the issue?
- When did the issue start? Is it still happening?
- Provide specifics on issue: Member ID, Reference Number, dropdowns, or fields, steps taken to create the issue.
- Have you spoken to anyone else about this issue at your organization (e.g., provider’s IT help desk)?
- Screenshots (please be sure to include any error messages).

Accessing the Portal

LOGGING IN

Step 1: Visit the Tufts Health Plan Provider [website](#) and click “Secure Provider Portal Login” to continue.



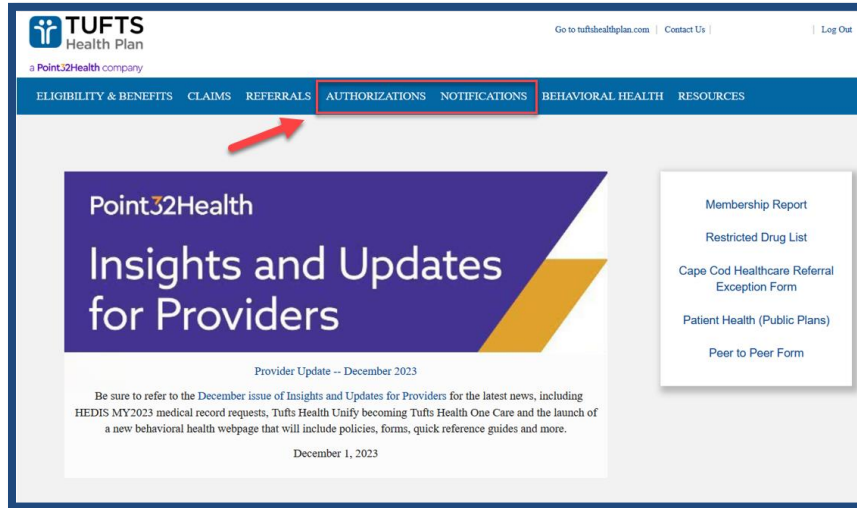
Step 2: Enter your *Username* and *Password* then click “Login.”

The screenshot shows the 'Provider Portal Account Login' page. At the top left is the Tufts Health Plan logo. At the top right are links for 'Contact Us' and 'Login'. The main heading is 'Provider Portal Account Login'. Below the heading are two input fields: 'Username' and 'Password'. Each input field has a 'Forgot?' link to its right. Below the input fields is a blue 'LOGIN' button with a right-pointing arrow. At the bottom, there is a link that says 'Don't have an account yet?' followed by a 'Register Here' button.

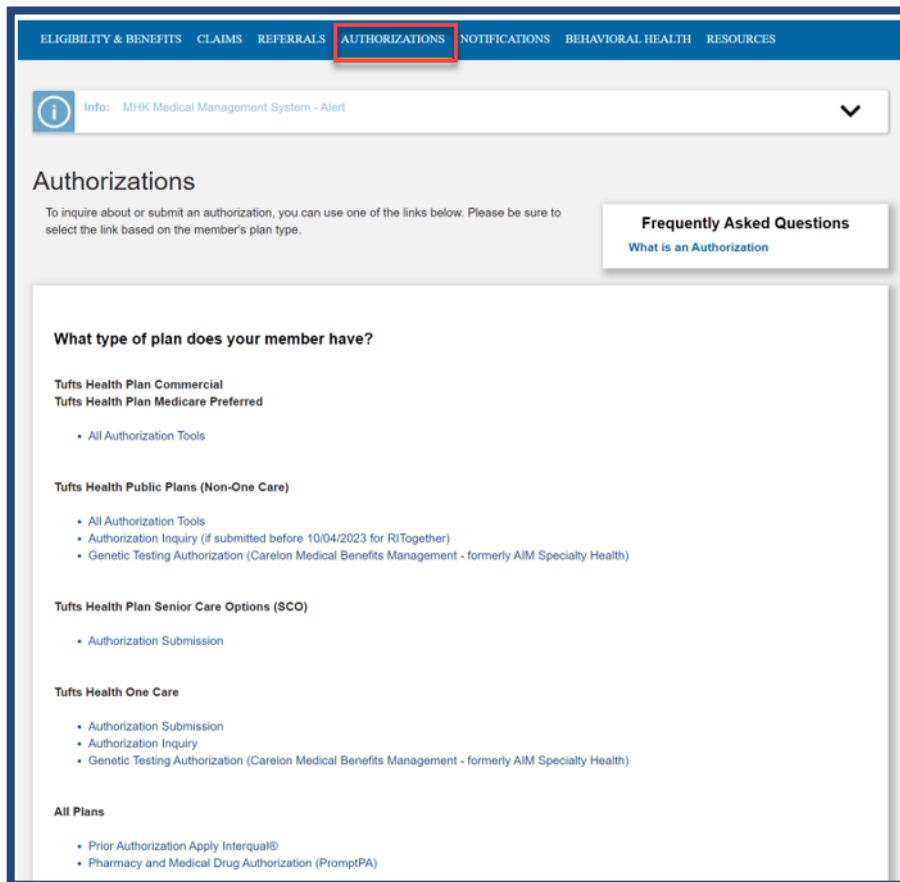
Accessing MHK Medical Management (formerly known as MedHOK) from within the Secure Provider Portal

MIGRATING TO MHK MEDICAL MANAGEMENT (FORMERLY KNOWN AS MEDHOK)

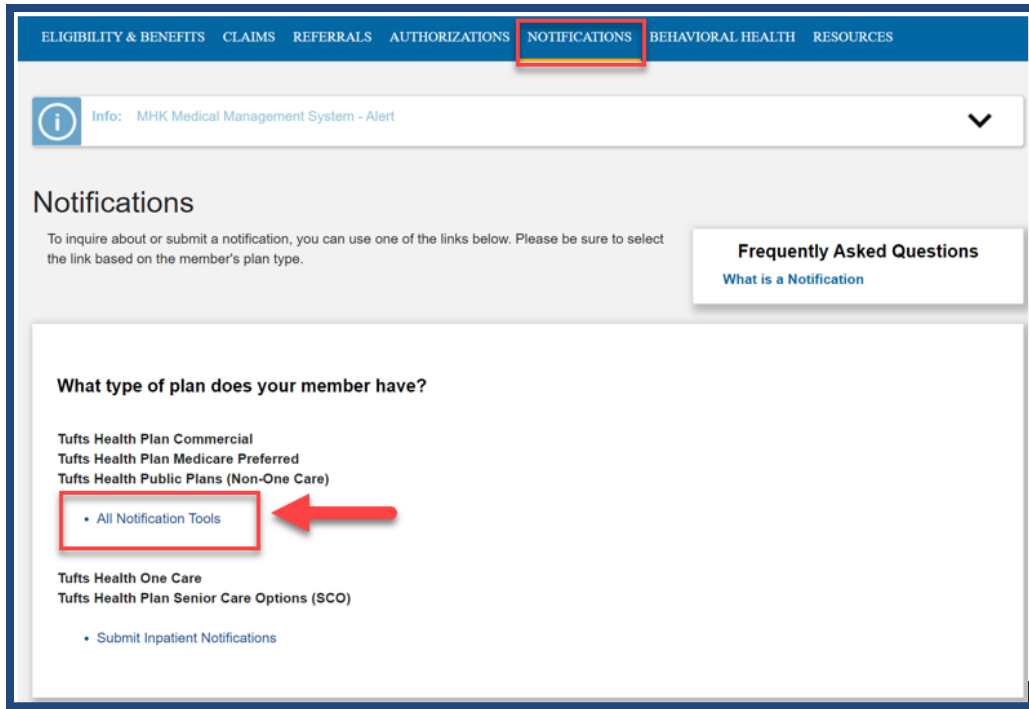
Step 1: To initiate a Prior Authorization, click the “Authorizations” tab or to initiate an Inpatient Notification, click the “Notifications” tab.



The following screen is displayed when selecting *Authorizations*:

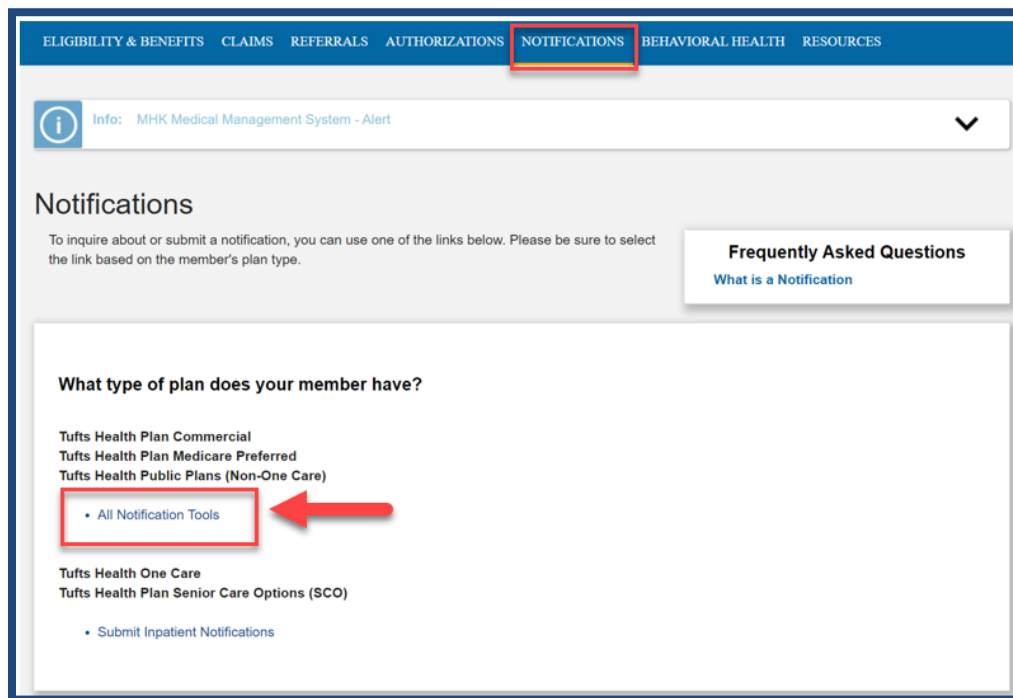


The following screen is displayed when selecting *Notifications*:

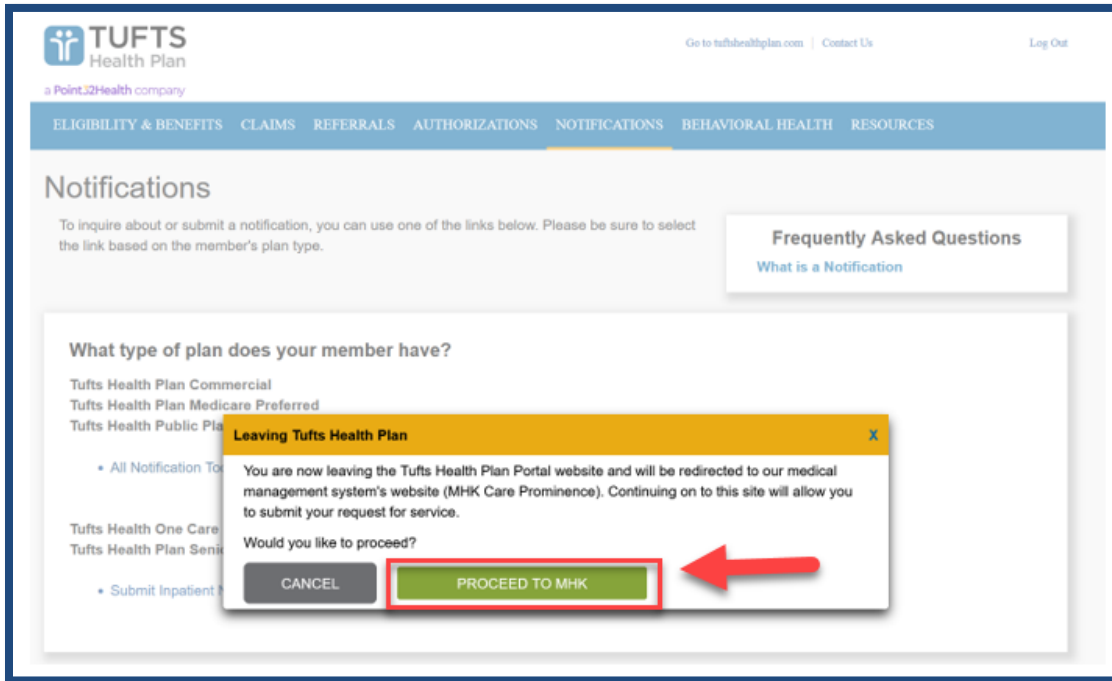


Step 2: Select the appropriate option under the member's plan:

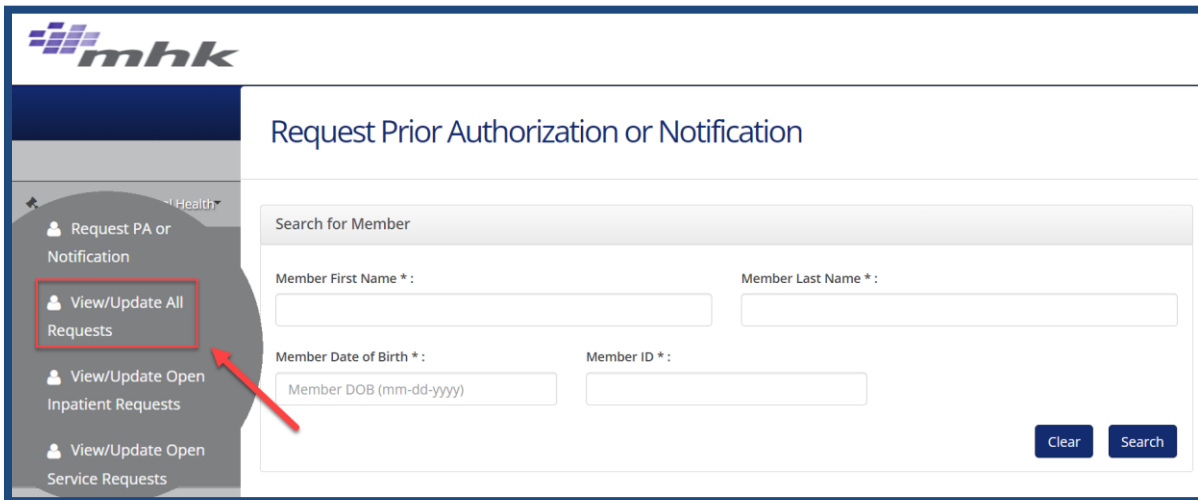
Example = All Notification Tools for Tufts Health Plan Commercial & Senior Products.



Step 3: Click “Proceed to MHK” to continue.



The following screen displays:



Option	Description
“Request PA or Notification”	Choose this option to initiate a request.
“View/Update All Requests”	Choose this option to view <u>all</u> inpatient, outpatient, medical, and behavioral health requests that are in progress or completed.
“View/Update Open Inpatient Requests”	This option is limited to medical and behavioral health inpatient events that are in progress.
“View/Update Open Service Requests”	This option is limited to medical or behavioral health service requests that are in progress.

Requesting a Prior Authorization or Submitting an Inpatient Notification

MEMBER SEARCH

Step 1: Click “Request PA or Notification” and then enter the *Member First Name*, *Member Last Name*, *Member Date of Birth* and *Member ID* and click “Search.”

The screenshot shows the MHK portal interface. On the left, a sidebar menu has 'Request PA or Notification' highlighted with a red box and a red arrow pointing to it. The main content area is titled 'Request Prior Authorization or Notification' and contains a search form. The form has four input fields: 'Member First Name *', 'Member Last Name *', 'Member Date of Birth *' (with a placeholder 'Member DOB (mm-dd-yyyy)'), and 'Member ID *'. There are 'Clear' and 'Search' buttons at the bottom right of the form. The 'Search' button is highlighted with a red box.

The *Member Search Results* screen displays.

Step 2: Click “Select” in the *Action* field once the appropriate member record is found.

Note: The member is not currently active if “Eligible” is not listed in the *Status* field.

The screenshot shows the 'Member Search Results' screen. At the top, there is a checkbox labeled 'Show all Eligibility Records' which is currently unchecked. Below this is a table with the following columns: ACTION, FIRST NAME, LAST NAME, DATE OF BIRTH, MEMBER ID, ADDRESS, STATUS, EFFECTIVE DATE, TERM DATE, PLAN CODE, PLAN DESCRIPTION, PCP, PCP NAME, IPA CODE, and IPA NAME. The first row of the table has a 'Select' button in the ACTION column, which is highlighted with a red box. A red arrow points to this button. The STATUS column for the first row contains the word 'Eligible'. The EFFECTIVE DATE column contains '11-12-2018' and the TERM DATE column contains '12-31-3999'. These three cells are highlighted with a red box. At the bottom of the screen, there is a 'Date:' field and 'Print' and 'Cancel' buttons.

Note: Click “Show all Eligibility Records” to view more member eligibility records.

The *Request Prior Authorization or Notification* screen displays:

The screenshot shows a form with the following fields:

- Name:** [Redacted]
- Member ID:** [Redacted]
- Plan Type/Group ID#:** [Redacted]
- Date Of Birth:** [Redacted]
- LOB:** [Redacted]
- Address:** [Redacted]
- IPA/MG:** [Redacted]
- Phone:** [Redacted]
- Effective:** 02-15-2019
- Term:** 12-31-2100
- Special Programs:** [Redacted]
- Case Manager:** [Redacted]

In the upper right-hand section, there is a green button labeled "Member Eligible" and a date "12-31-2100".

Note: Click "Member Eligible" in upper right-hand section of the screen to review member coverage details.

- If the "Member Eligible" button is red with a past eligibility date, you selected a record that is not eligible. The date denotes member's last date of coverage.

This close-up shows a red button labeled "Member Eligible" and a date "12-31-2019" next to it, indicating that the member is no longer eligible as of that date.

The following screen displays:

Patient Eligibility History

Click here to view eligibility history.

MEDICAID NUMBER	MEDICARE NUMBER	EFFECTIVE DATE	TERM DATE	TERM REASON	PLAN	COMPANY CODE	COMPANY DESCRIPTION	PRODUCT PLAN
		07-01-2015	12-31-3999			MAPOSSI	MA POS SELF INSURED	
		07-01-2006	06-30-2015			MAPPOSI	MA PPO SELF INSURED	

Cancel

Step 3: Select the appropriate urgency for the authorization request as indicated below:

- **Standard:** Default priority for all requests
- **Expedited:** For urgent requests due to medical necessity

Note: Select the "Expedited" radio button if the authorization requires an expedited review. If expedited, be sure to agree to the *Attestation Regarding Expedited Review*.

Select Authorization Urgency

Standard Expedited

Select Authorization Urgency

Standard Expedited

Attestation Regarding Expedited Review

By checking expedited, I certify that the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. Please refer to your provider manual for more information.

ADD REQUESTING PROVIDER

Step 1: Select the appropriate *Requesting Provider* and enter their contact information.

Note: If the user has less than or exactly 20 provider IDs affiliated with their account, the user must select the correct *Requesting Provider* from the dropdown menu.

Select 6 digit Provider IDs for Commercial and Medicare Preferred members.
Select 8 digit Provider IDs for Tufts Health Public Plans members.

*Requesting Provider

Specialty

Provider Status

Note: If the user has more than 20 provider IDs affiliated with their account, the Provider Search option is available, and the user must perform a "Search" using the Providers' NPI and participating status to select the appropriate *Requesting Provider*.

*Requesting Provider

Search

Unknown
Provider

Specialty

Provider Status

Note: If the *Requesting Provider* is out of network (OON), the user must select the “No” radio button under the *Participating* field, click search and select the appropriate record.

The screenshot shows the 'Provider Search' form with fields for Provider Id, NPI, Tax Id, First Name, Last Name, Facility/Organization, and Zip Code. A 'Participating' section has radio buttons for 'Yes' and 'No', with 'No' selected. A red box highlights the 'Participating' section, and a red arrow points to the 'No' radio button. Below the form is a 'Provider Search Results' table with columns: ACTION, PROVIDER ID, NPI, TAX ID, FIRST NAME, LAST NAME, FACILITY, and ADDRESS. The first row has a 'Select' button highlighted with a red box, and a red arrow points to it.

Note: Users may see duplicate records if providers are registered with multiple addresses.

Step 2: Fill out the *Requesting Phone Number*, *Requesting Fax Number*, and *Contact Name and Contact Phone Information* fields.

The screenshot shows the 'Select Authorization Urgency' form. It includes a 'Select Authorization Urgency' section with radio buttons for 'Standard' (selected) and 'Expedited'. Below this are fields for *Requesting Provider, Speciality (Addiction Medicine), and Provider Status. There are also fields for First Name, Last Name, Organization, Address1, Address2, City, and State. The *Requesting Phone Number field contains '617-555-1234' and the *Requesting Fax Number field contains '617-555-4567', both highlighted with a red box. Other fields include Zip, Contact Name, and Contact Phone.

Note: The *Specialty* and *Provider Status* fields will pre-populate based on the selected provider’s credentials. The provider status will populate once *Request Type* is selected (below).

Step 3: Select the “Yes” radio button in the *Requesting Provider Same as Servicing Provider* field if the servicing and requesting provider are the same.

Note: The *Requesting Provider Same as Servicing Provider* field defaults to “No.” If these are not the same, a *Servicing Provider* must be added to the request.

Requesting Provider Same as Servicing Provider

YES NO

Step 4: Select the appropriate *Request Type* option from the dropdown menu.

Request Type	Description
“Service Request”	Used for <u>all</u> medical prior authorization requests (e.g., Elective Surgeries, DME, etc.).
“Inpatient”	Used for <u>all</u> medical inpatient admissions.
“Behavioral Health Inpatient”	Used for <u>all</u> behavioral health inpatient admissions.
“Behavioral Health Service Request”	Used for <u>all</u> behavioral health prior authorization requests.

Note: To get instructions on how to submit a Behavioral Health Inpatient Admission or Service Request, click the [MHK Behavioral Health Portal User Guide](#).

*Request Type

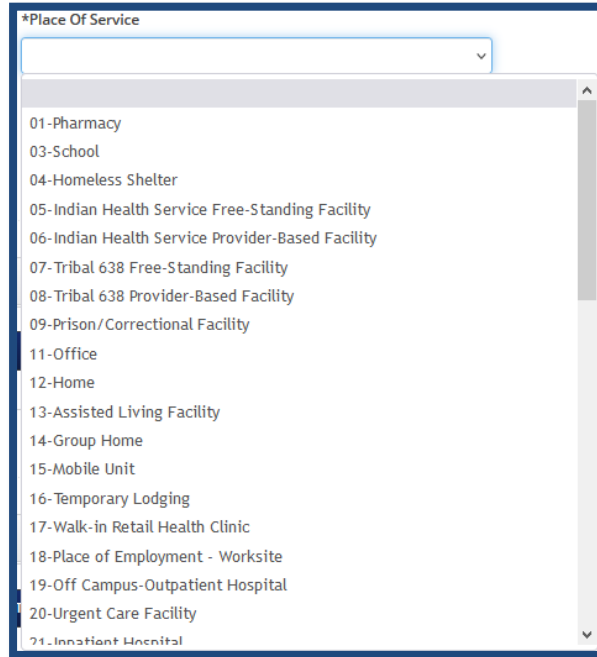
- Service Request
- Inpatient
- Behavioral Health Inpatient
- Behavioral Health Service Request

Note: After selecting the appropriate *Request Type* additional fields may display.

If request type is...	Then complete the following fields marked with an asterisk as required:
“Inpatient”	<ul style="list-style-type: none"> • “Bed Type” • “Request Admit Date” • “Admit Type” • “Review Type”
“Service Request”	<ul style="list-style-type: none"> • “Review Type”

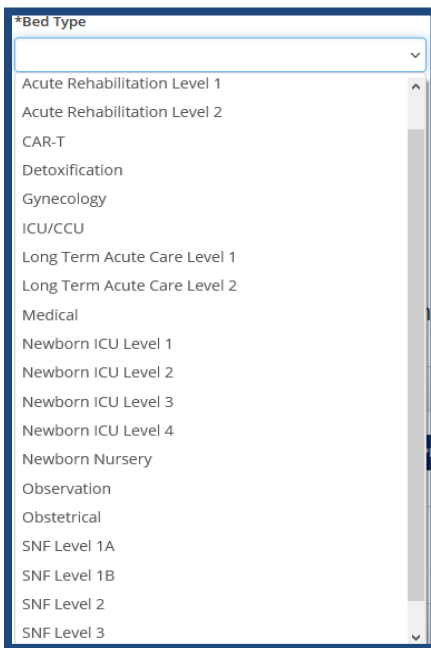
Step 5: Select the appropriate *Place of Service* from the dropdown menu (e.g., 21- Inpatient Hospital, 11-Office).

Note: Values in step 5 are based on the member’s coverage and values displayed maybe different.



Step 6: If *Request Type* is “Inpatient,” select the appropriate *Bed Type* from the options in the dropdown menu:

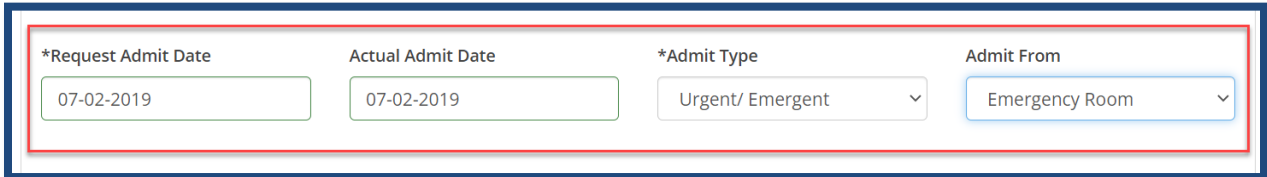
Note: Values in step 6 are based on the member’s coverage and values displayed maybe different.



Note: Tufts Health Plan may authorize medically necessary observation stays greater than 48 hours for Tufts Health Together and Tufts Health RITogether members **ONLY**. For more information, see the [Observation Services Facility Payment Policy](#).

Step 7: Enter the *Request Admit Date* (“MM-DD-YYYY”) and select the appropriate *Admit Type* and *Admit From* option from their respective dropdown menus.


Note: If *Admit Type* is “Urgent/Emergent,” enter the *Actual Admit Date* (“MM-DD-YYYY”). The *Actual Admit Date* cannot be dated in the future. Please leave this field blank for scheduled admissions (in the future).



The screenshot shows a form with four fields: *Request Admit Date (text input with value 07-02-2019), Actual Admit Date (text input with value 07-02-2019), *Admit Type (dropdown menu with value Urgent/ Emergent), and Admit From (dropdown menu with value Emergency Room).

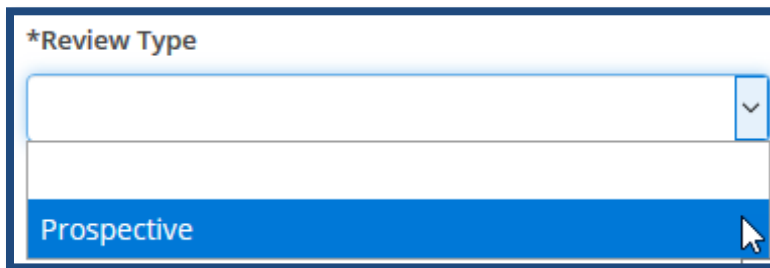
Step 8: Select the appropriate *Review Type* option from the dropdown menu (e.g., “Initial Review” for Inpatient Requests or “Prospective” for Service Requests).

Inpatient Requests:



The screenshot shows a dropdown menu titled *Review Type. The menu is open, and the option 'Initial Review' is highlighted in blue.

Service Requests:

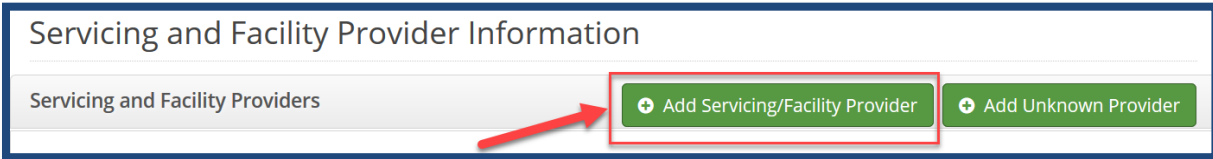


The screenshot shows a dropdown menu titled *Review Type. The menu is open, and the option 'Prospective' is highlighted in blue. A mouse cursor is visible over the 'Prospective' option.

ADD SERVICING/FACILITY PROVIDER

Step 1: Click “Add Servicing/Facility Provider” if different from the *Requesting Provider*.

Note: For Inpatient requests, a *Facility Provider* must be added in addition to the *Servicing Provider*.

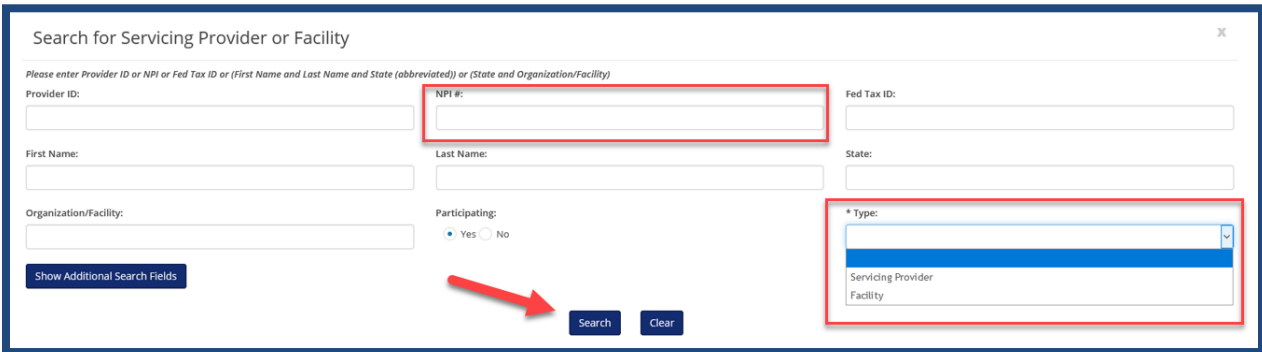


Step 2: Search for Servicing provider and/or Facility by entering the Servicing/Facility Provider ID, or NPI, or Tax ID, or Name and State, or Facility Name and State.

Step 3: Select the appropriate *Provider Type* from the *Provider Type* dropdown menu and click “Search.”

The search results display for *Servicing Provider* or *Facility*.

Note: If servicing provider/facility are out of network (OON), the user must select the “No” radio button under the *Participating* field.



Note: Multiple results may display (e.g., more than one address for the same NPI).

Step 4: Locate the appropriate provider record and click “Select.”

Search for Servicing Provider or Facility

Organization/Facility: Participating: Yes No * Type:

Show Additional Search Fields

Search Clear

Servicing Providers - Search Results

Show entries Search:

ACTION	PROVIDER NAME	NPI#	DEA#	SPECIALITY	ADDRESS	PROVIDER STATUS
Select	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
Select	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
Select	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

Cancel

Step 5: Enter the *Servicing and/or Facility Provider’s Fax Number* and click “Save.”

Note: For Inpatient requests, the facility provider fax number should always be the Utilization Review department’s fax number.

Servicing Provider Fax Number

*Fax Number :

Contact Name Contact Phone

Cancel Save

The *Servicing and Facility Providers* section will now be populated:

Servicing and Facility Providers Add Servicing/Facility Provider Add Unknown Provider

ACTION	PROVIDER NAME	NPI#	DEA#	SPECIALITY	NETWORK	ADDRESS	FAX NUMBER	PROVIDER TYPE	PROVIDER STATUS
Remove	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	Facility	Contracted
Remove	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	Servicing Provider	Contracted

ADD DIAGNOSIS CODE

Step 1: Click “Add Primary Diagnosis.”

*Diagnosis (*Denotes required field)

ICD - Search Results

+ Add Primary Diagnosis + Add Diagnosis

Step 2: Enter the *ICD Code* or *Diagnosis Description* and click “Search.”

ICD Search

ICD Codes: Diagnosis Description:

Search

ICD - Search Results

ACTION	ICD NUMBER	DESCRIPTION	ICD TYPE
Select	S42.296A	Other Nondisplaced Fracture Of Upper End Of Unspecified Humerus, Initial Encounter For Closed	ICD10 DX

Cancel

Note: All ICD Codes must be properly formatted (ex: E66.01, not E6601)

Step 3: In the *Action* field, click “Select” to add the diagnosis to the request.

ICD Search

ICD Codes: Diagnosis Description:

Search

ICD - Search Results

ACTION	ICD NUMBER	DESCRIPTION	ICD TYPE
Select	S42.296A	Other Nondisplaced Fracture Of Upper End Of Unspecified Humerus, Initial Encounter For Closed	ICD10 DX

Cancel

Note: If added in error, click “Remove” in the “Action” field to remove a diagnosis.

ACTION	ICD NUMBER	DESCRIPTION	ICD TYPE	PRIMARY DIAGNOSIS
Remove	H44.651	Retained (Old) Magnetic Foreign Body In Vitreous Body, Right Eye	ICD10 DX	YES

ADD PRIMARY PROCEDURE CODE

A CPT/HCPCS code is only required for scheduled surgical admissions or service requests. If submitting an urgent/emergent inpatient notification, this step is not required.

Step 1: Click “Add Primary Procedure” for inpatient requests or click “Add Procedure” for service requests.

*Procedure (*Denotes required field)

CPT/HCPCS - Search Results

+ Add Primary Procedure + Add Procedure

ACTION	CPT/HCPCS#	PLANNED PROCEDURE	QUANTITY	UNIT TYPE	FREQUENCY	MODIFIER 1	MODIFIER 2	START	END	STATUS	PRIMARY PROCEDURE
--------	------------	-------------------	----------	-----------	-----------	------------	------------	-------	-----	--------	-------------------

Step 2: Enter the procedure code or description in the *CPT/HCPCS Codes* field and click “Search.”

CPT/HCPCS Search

CPT/HCPCS Codes: 27446 Procedure Description:

Search

CPT/HCPCS - Search Results

ACTION	CPT/HCPCS#	PLANNED PROCEDURE
Select	27446	Revision Of Knee Joint

Cancel

Step 3: Click “Select” to add the procedure code to the request.

ACTION	CPT/HCPCS#	PLANNED PROCEDURE
Select	27446	Revision Of Knee Joint

Step 4: Enter *Modifier (if applicable), Quantity, Units, Start and End Date* then click “Submit” to continue.

CPT/HCPCS Information X

CPT/HCPCS CODE: Procedure Description:

PA Status
Under Review

Modifier 1 (if applicable): Modifier 1 Description (if applicable):

Modifier 2 (if applicable): Modifier 2 Description (if applicable):

*Quantity: *Units: Frequency:

*Start Date: End Date:

Short Description

Note: Click “Add Procedure” and repeat steps to add additional procedure codes.

Note: If added in error, click “Remove” in the “Action” field to remove a procedure code.

ACTION	CPT/HCPCS#	PLANNED PROCEDURE	QUANTITY	UNIT TYPE	FREQUENCY	MODIFIER 1	MODIFIER 2	START	END	STATUS	PRIMARY PROCEDURE
Remove	20100	Explore Wound, Neck	1	Procedure				08-24-2020	11-21-2020	Under Review	NO

Step 5: Click “Submit” to save and move to the next screen.

STATUS	PRIMARY PROCEDURE
Under Review	NO

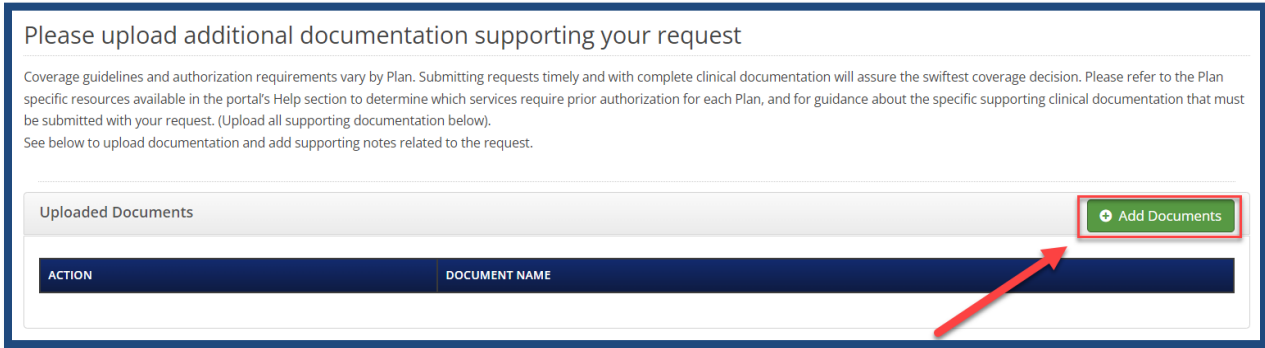
Note: If you are requesting an authorization for PT/OT/ST, Home Care or Inpatient Hospice and Respite, additional information may be required via an assessment. Refer to the section for Submitting Assessments.

ADD MEDICAL/CLINICAL DOCUMENTATION

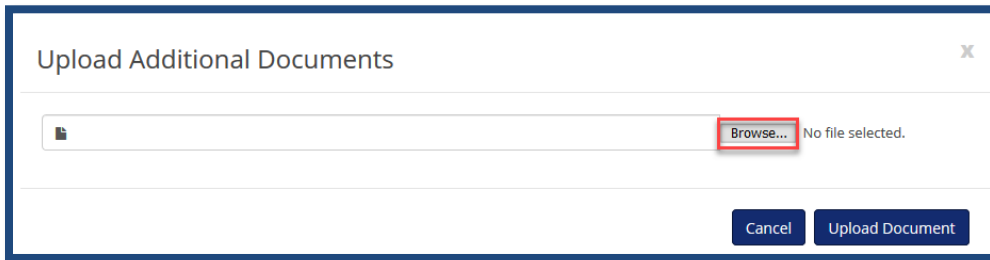
If your request auto cancels or auto approves, this screen will not display.

Step 1: Click “Add Documents” to add supporting clinical documentation.

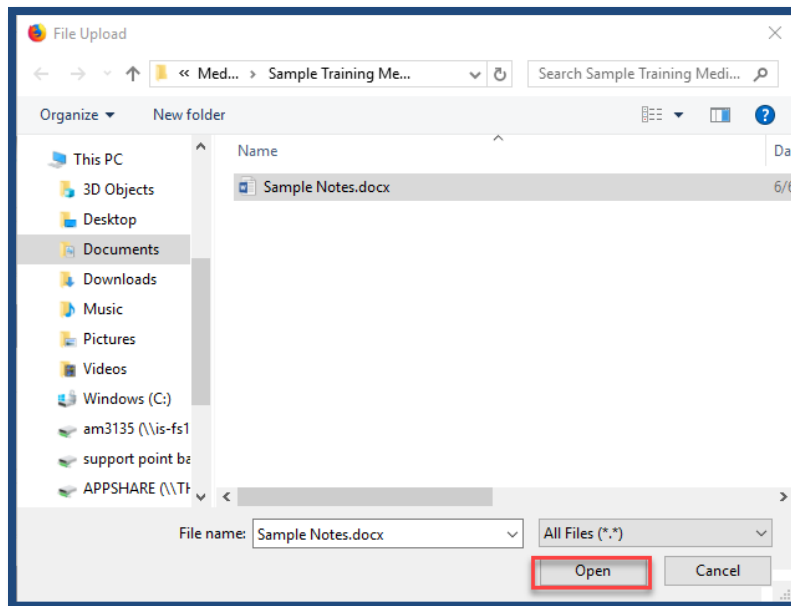
Note: In most circumstances, **clinical documentation is required to support the request.**



Step 2: Click “Browse.”



Step 3: Navigate to where the clinical documentation is saved on your computer and click “Open.”



Step 4: Click “Upload Document” to add the attachment.

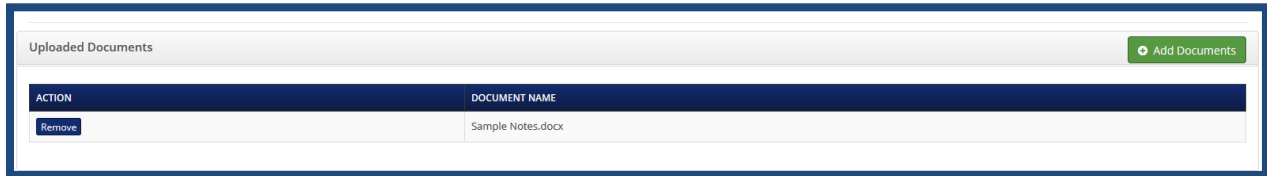


Upload Additional Documents

Sample Notes.docx Browse... Sample Notes.docx

Cancel Upload Document

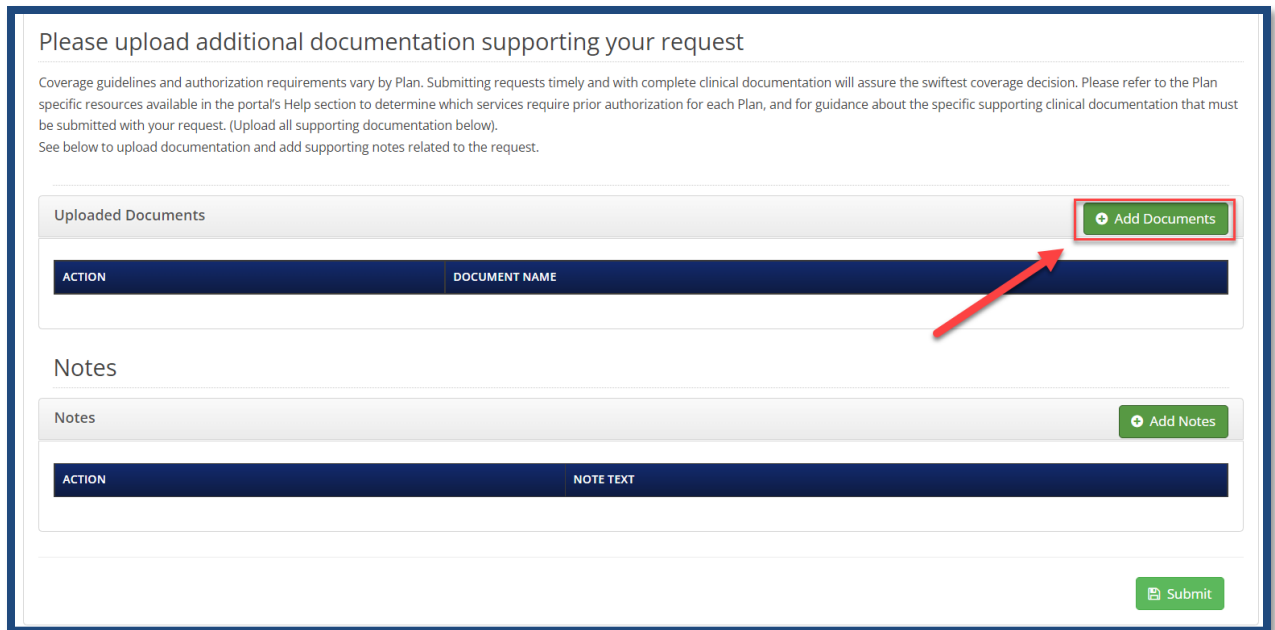
The *Uploaded Documents* screen is now populated:



Uploaded Documents Add Documents

ACTION	DOCUMENT NAME
Remove	Sample Notes.docx

Step 5: Click “Add Documents” and repeat steps to add additional attachments.



Please upload additional documentation supporting your request

Coverage guidelines and authorization requirements vary by Plan. Submitting requests timely and with complete clinical documentation will assure the swiftest coverage decision. Please refer to the Plan specific resources available in the portal's Help section to determine which services require prior authorization for each Plan, and for guidance about the specific supporting clinical documentation that must be submitted with your request. (Upload all supporting documentation below). See below to upload documentation and add supporting notes related to the request.

Uploaded Documents Add Documents

ACTION	DOCUMENT NAME
--------	---------------

Notes Add Notes

ACTION	NOTE TEXT
--------	-----------

Submit

Step 6: Click “Add Notes” to add a note to the request.

Please upload additional documentation supporting your request

Coverage guidelines and authorization requirements vary by Plan. Submitting requests timely and with complete clinical documentation will assure the swiftest coverage decision. Please refer to the Plan specific resources available in the portal's Help section to determine which services require prior authorization for each Plan, and for guidance about the specific supporting clinical documentation that must be submitted with your request. (Upload all supporting documentation below). See below to upload documentation and add supporting notes related to the request.

Uploaded Documents Add Documents

ACTION	DOCUMENT NAME
Remove	Testfax.pdf

Notes Add Notes

ACTION	NOTE TEXT
Remove	Enter information pertaining to your request not included within the clinical documentation you have attached.

Step 7: The Note Text field will display, enter your note here and click Add Notes when your note is completed.

Notes x

Note Text

[Add Notes](#) [Cancel](#)

Step 8: Click “Submit” to send the request.

The screenshot shows two sections: "Uploaded Documents" and "Notes".

Uploaded Documents: A table with columns "ACTION" and "DOCUMENT NAME". One row contains a "Remove" button and the text "Sample Notes.docx". A green "Add Documents" button is in the top right.

Notes: A section with a green "Add Notes" button in the top right. Below it is a table with columns "ACTION" and "NOTE TEXT".

A red arrow points to a green "Submit" button in the bottom right corner of the form.

The *Request Prior Authorization or Notification* screen displays the reference number and status of your request.

The screenshot shows the "Request Prior Authorization or Notification" screen. At the top right, there is a green "Member Eligible" button and a "12-31-3999" date.

Member details are displayed in a grid:

- Name: [Redacted]
- Date Of Birth: [Redacted]
- Address: [Redacted]
- Phone: [Redacted]
- Special Programs: [Redacted]
- Member ID: [Redacted]
- LOB: [Redacted]
- IPA/MG: [Redacted]
- Effective: [Redacted]
- Case Manager: [Redacted]
- Plan Type/Group ID#: [Redacted]
- Term: [Redacted]

A red arrow points to the "Term" field.

Request status is shown in a red-bordered box:

- Authorization Status: In Progress
- Reason: [Redacted]
- Decision: [Redacted]
- Reference#: [Redacted]
- Procedure Status: [Redacted] Not Decided

Buttons at the bottom: "Create Request for the Same Member" and "Create Request for Different Member".

Disclaimer text at the bottom: "It is the provider's responsibility to check eligibility for each date of service and to follow current payment policies. Benefits for this service are subject to the provisions of the member's plan, the member's eligibility on the dates of service, and the outcome of this determination. A determination is dependent on receiving complete clinical information and in a timely manner."

Submitting Assessments-Commercial Plans

PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH THERAPY

If a PT/OT or ST procedure code is submitted, the Commercial Physical Therapy Services assessment screen displays. Depending on the clinical information from these assessments, requests may auto void for authorization not required or pend for clinical review.

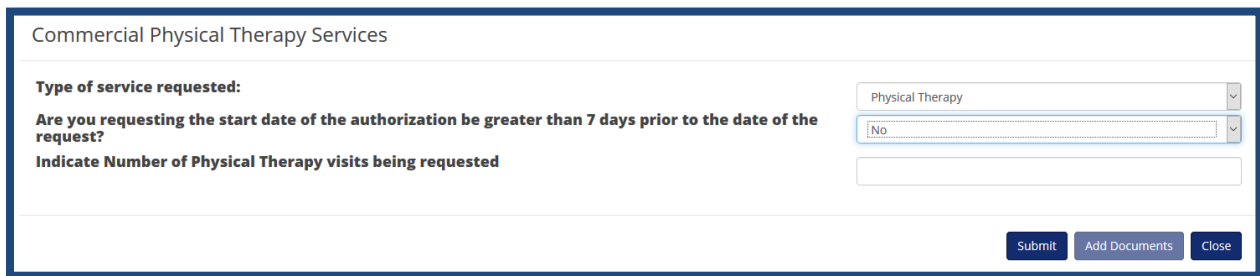
Step 1: Select “Physical Therapy,” “Occupational Therapy,” or “Speech Therapy” from the dropdown menu for the *Type of service requested* field.

Step 2: Complete any additional questions based on the type of service selected.

Step 3: Click “Submit” once assessment is completed.

Step 4: Click “Add Documents” to upload clinical documentation to support your request-Required.

Step 5: Click “Close” to close the assessment.



The screenshot shows a web form titled "Commercial Physical Therapy Services". It contains the following fields and controls:

- Type of service requested:** A dropdown menu with "Physical Therapy" selected.
- Are you requesting the start date of the authorization be greater than 7 days prior to the date of the request?** A dropdown menu with "No" selected.
- Indicate Number of Physical Therapy visits being requested:** An empty text input field.
- Buttons:** "Submit", "Add Documents", and "Close" buttons are located at the bottom right of the form.

Note: For additional information on coverage for PT/OT and ST services, refer to the applicable medical necessity guidelines for Commercial products:

- [Medical Necessity Guidelines: Rehabilitative Services: Occupational Therapy](#)
- [Medical Necessity Guidelines: Rehabilitative Services: Physical Therapy](#)
- [Medical Necessity Guidelines: Rehabilitative Services: Speech Therapy](#)
- [Medical Necessity Guidelines: Habilitative Services for Physical Therapy, Occupational Therapy and Speech Therapy](#)

INPATIENT HOSPICE AND RESPITE

If a Hospice or Respite procedure code is requested, the Comm Inpatient Hospice assessment screen displays. Depending on the clinical information from these assessments, requests may auto approve or pend for clinical review.

Step 1: Confirm if the member has previously received Inpatient Hospice or Respite Care with any provider.

Step 2: Click “Request Type” and select “Initial” or “Continued” services.

Step 3: Complete any additional questions based on the type of service selected.

Step 4: Click “Submit” once assessment is completed.

Step 5: Click “Add Documents” to upload clinical documentation to support your request.

Step 5: Click “Close” to close the assessment.

Inpatient Hospice

Has the member previously received Inpatient Hospice or Respite Care with any provider?

Tufts Health Plan may authorize coverage of Inpatient Hospice or Respite Care when the member meets the following criteria set. Please check all that apply.

Please select the Request Type

A. Inpatient Hospice- Initial

1. Has the member been diagnosed as being terminally ill? (An individual is considered to be terminally ill if the medical prognosis is that his or her life expectancy is 6 months or less if the illness runs its normal course.)
2. Is the sole reason for this request that the Member's caregiver support system has broken down?
3. Choose One
4. Does the member need pain control or symptom management that cannot feasibly be provided in other settings?
5. Does the member require frequent skilled nursing care intervention on all three shifts directed toward pain control and symptom management?

No

Inpatient Hospice- Initial

Inpatient Hospice- Continued

Inpatient Hospice- Initial

Inpatient Respite- Continued

Inpatient Respite- Initial

Yes

No

Submit Add Documents Close

Note: For more information, refer to the medical necessity guidelines for [Inpatient Hospice and Respite Services](#).

Submitting Assessments-Tufts Health Public Plans

PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH THERAPY

If a PT or OT procedure code is submitted, the Medicaid PT/OT assessment screen displays. Depending on the clinical information from these assessments, requests may auto void for authorization not required or pend for clinical review.

Step 1: Select “Physical Therapy” or “Occupational Therapy” from the dropdown menu for the *Type of service requested* field.

Step 2: Complete any additional questions based on the type of service selected.

Step 3: Click “Submit” once assessment is completed.

Step 4: Click “Add Documents” to upload clinical documentation to support your request.

Step 5: Click “Close” to close the assessment.

The screenshot shows a form titled "Medicaid PT/OT Auto Auth". It contains a dropdown menu for "Type of service requested" with "Physical Therapy" selected. Below it is a text field with the instruction "'Please confirm member has used one Evaluation and 11 visits'" and a dropdown menu with "No - Member has not used initial visits" selected. At the bottom right, there are three buttons: "Submit", "Add Documents", and "Close".

Note: For additional information on coverage for PT/OT services, please refer to the applicable medical necessity guidelines:

Medical Necessity Guidelines:

[Habilitative Services for Physical Therapy, Occupational Therapy, and Speech Therapy](#) for Tufts Health Direct.

[Medical Necessity Guidelines: Medical Necessity Guidelines: Outpatient Physical Therapy, Occupational Therapy and Speech Therapy for Tufts Health Together and Tufts Health RITogether.](#)

HOME HEALTH CARE FOR TUFTS HEALTH TOGETHER AND TUFTS HEALTH RITOGETHER

If a home health care procedure code is submitted for Tufts Health Together and Tufts Health RITogether, the *THPP Homecare Assessment* screen displays. Depending on the clinical information from these assessments, requests may auto void for authorization not required or pend for clinical review.

Step 1: Confirm if member requires daily visits for home health care.

Step 2: Confirm if the member has received continuous home care over the past 6 months.

Step 3: Click “Submit.”

Step 4: Click “Add Documents” to upload clinical documentation to support your request.

Step 5: Click “Close” to close the assessment.

The screenshot shows a form titled "THPP Homecare Assessment". It contains two questions with dropdown menus. The first question is "Do you require daily visits?" with "No" selected. The second question is "Has the member received homecare continuously over the past 6 months?" with "No" selected. Below the second question is a text field with the instruction "No authorization required for the initial 6 months." At the bottom right, there are three buttons: "Submit", "Add Documents", and "Close".

Note: For more information, refer to the medical necessity guidelines for Home Health Care Services Tufts Health Together.

INPATIENT HOSPICE AND RESPITE

If a Hospice or Respite bed type is requested, the Inpatient Hospice assessment screen displays. Depending on the clinical information from these assessments, requests may auto approve or pend for clinical review.

Step 1: Confirm if the member has previously received Inpatient Hospice or Respite Care with any provider.

Step 2: Click “Request Type” and select “Initial” or “Continued” services.

Step 3: Complete any additional questions based on the type of service selected.

Step 4: Click “Submit” once assessment is completed.

Step 5: Click “Add Documents” to upload clinical documentation to support your request.

Step 5: Click “Close” to close the assessment.

The screenshot shows the 'Inpatient Hospice' assessment form. At the top, it asks 'Has the member previously received Inpatient Hospice or Respite Care with any provider?' with a dropdown menu set to 'No'. Below this, it provides instructions and asks to 'Please select the Request Type'. A dropdown menu is open, showing options: 'Inpatient Hospice- Initial' (selected), 'Inpatient Hospice- Continued', 'Inpatient Respite- Continued', and 'Inpatient Respite- Initial'. Below the dropdown, there are five numbered questions with corresponding 'Yes' or 'No' dropdown menus. The first question is '1. Has the member been diagnosed as being terminally ill? (An individual is considered to be terminally ill if the medical prognosis is that his or her life expectancy is 6 months or less if the illness runs its normal course.)'. The second is '2. Is the sole reason for this request that the Member's caregiver support system has broken down?'. The third is '3. Choose One'. The fourth is '4. Does the member need pain control or symptom management that cannot feasibly be provided in other settings?'. The fifth is '5. Does the member require frequent skilled nursing care intervention on all three shifts directed toward pain control and symptom management?'. At the bottom right, there are three buttons: 'Submit', 'Add Documents', and 'Close'.

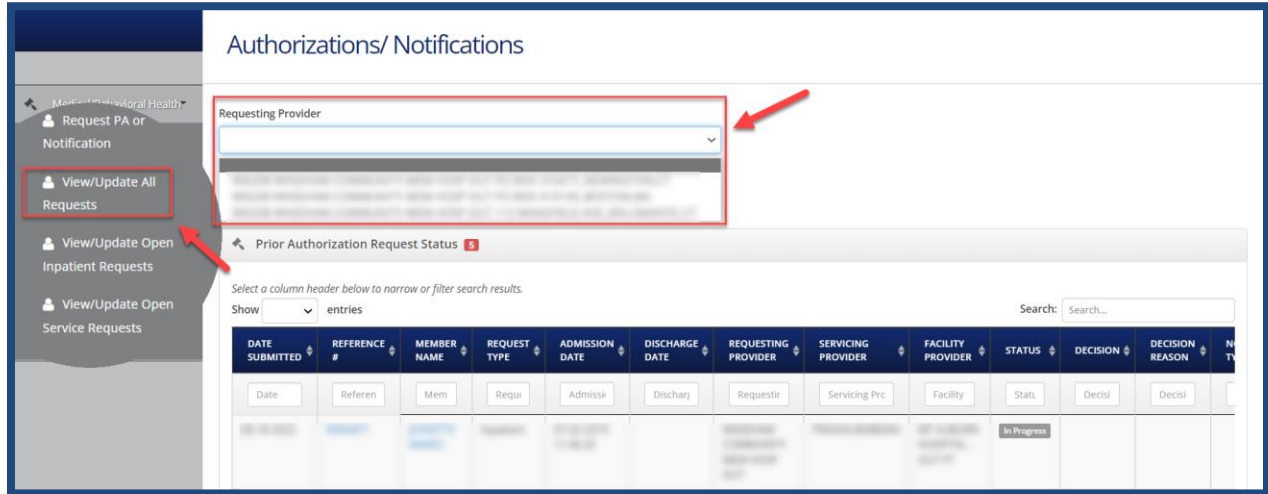
Note: For more information, refer to the medical necessity guidelines for [Inpatient Hospice and Respite Services for Tufts Health Direct and Tufts Health Together and RITogether.](#)

View/Add to Existing Inpatient Notifications or Prior Authorizations

VIEWING/ADDING UPDATES TO AN EXISTING INPATIENT NOTIFICATION OR PRIOR AUTHORIZATION

Step 1: From the *MHK home page*, select *View/Update All Requests* option on the left-hand navigation bar: (see table below for additional options and their descriptions)

Note: The last seven days of closed (completed/decisioned) cases and all Open events associated with the providers registered to the account will display. If the user has less than or exactly 20 provider IDs affiliated with their account, the user can further refine their search by selecting the appropriate *Requesting Provider* from the dropdown menu.



Option	Description
“Request PA or Notification”	Choose this option to initiate a request.
“View/Update All Requests”	Choose this option to view <u>all</u> inpatient, outpatient, medical, and behavioral health requests that are in progress or completed.
“View/Update Open Inpatient Requests”	This option is limited to medical and behavioral health inpatient events that are in progress.
“View/Update Open Service Requests”	This option is limited to medical or behavioral health service requests that are in progress.

Note: Although not mandatory, MHK users can narrow their search when by utilizing the *Requesting Provider* dropdown as illustrated in Step 1. If more the requesting provider has more than 20 affiliates, please follow the steps beginning with 1A below. The Provider Search option is available, and the user can further refine their search using the Providers’ NPI.

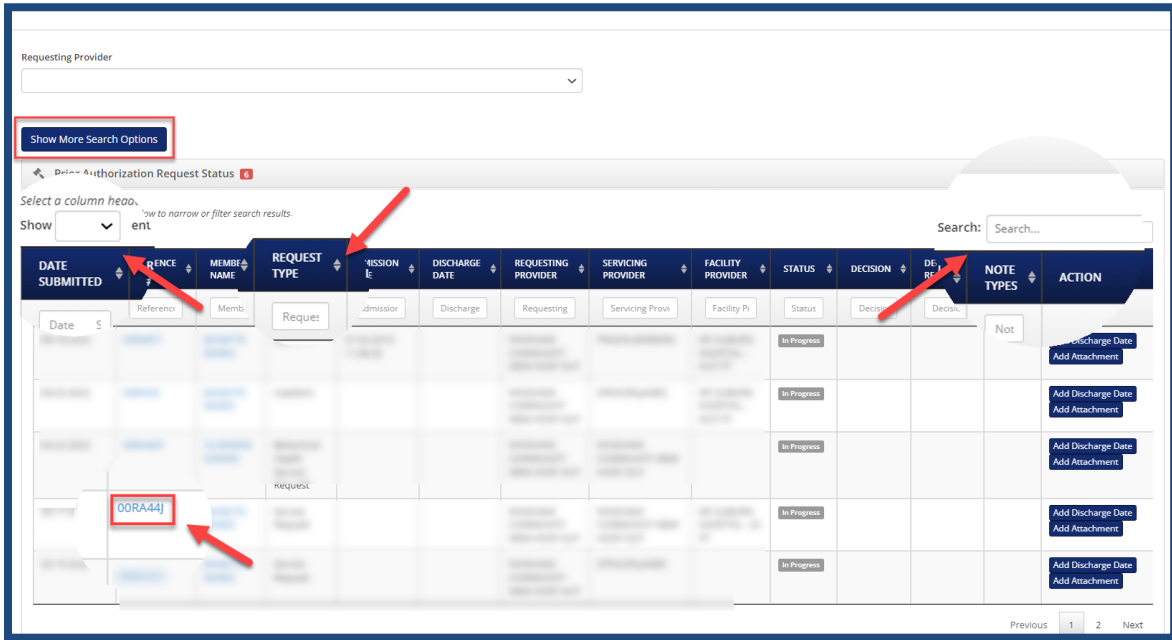
Step 1A (if applicable): Click the Search button next to the Requesting Provider field.

The screenshot shows the 'Authorizations/ Notifications' page. On the left is a navigation menu with 'Medical/Behavioral Health' selected. Underneath, there are several options: 'Request PA or Notification', 'View/Update All Requests' (highlighted with a red box), 'View/Update Open Inpatient Requests', and 'View/Update Open Service Requests'. The main content area has a 'Requesting Provider' search field with a green 'Search' button next to it, also highlighted with a red box. A red arrow points from the 'Search' button to the 'Requesting Provider' field. Below the search field is a 'Show More Search Options' button. Further down, there is a section for 'Prior Authorization Request Status' with a red '0' indicator. Below that, there is a text prompt 'Select a column header below to narrow or filter search results.' and a 'Show' dropdown menu set to 'entries'. At the bottom, there is a table header with columns: 'DATE SUBMITTED', 'REFERENCE #', 'ALTERNATE AUTH ID', 'MEMBER NAME', 'REQUEST TYPE', and 'ADMISSION DATE'.

Step 1B (if applicable): Enter the Provider NPI and choose the appropriate provider record under the Provider Search Results Section.

The screenshot shows the 'Provider Search' page. It has several input fields: 'Provider Id', 'NPI' (highlighted with a red box), 'Tax Id', 'First Name', 'Last Name', 'Facility/Organization', and 'Zip Code'. A red arrow points from the 'NPI' field to the 'Search' button. Another red arrow points from the 'Search' button to the 'NPI' field. Below the input fields are 'Search' and 'Clear' buttons. At the bottom, there is a section for 'Provider Search Results' with a table header containing columns: 'ACTION', 'PROVIDER ID', 'NPI', 'TAX ID', 'FIRST NAME', 'LAST NAME', 'FACILITY', and 'ADDRESS'.

Step 2: Utilize *Show More Search Options* below to enhance your search:



Click “Show More Search Options” to use advanced search features such as name, date of birth, authorization number, etc. to access older completed events or narrow down recent cases.

- “Show entries” can display up to 100 records at a time.
- Type in free text field to search for any information listed in columns below – date, request type, etc.
- Use down arrows in column headers to sort your search.
- Type in column filters to search by date, request type, etc.

The following screen displays if you click “Show More Search Options”:

Note: To return to the previous page, click “Hide Search Options.”

To search by authorization number, please enter the authorization number in the Auth # field then click search:

Hide Search Options

Member First Name :
Member Last Name :
Member DOB :
Member DOB (mm-dd-yyyy)
Member ID# :
Authorization Status :
Decision :
Auth # :
00RASY7
Alternative Auth ID :
Request Type :
Requesting Provider First Name :
Requesting Provider Last Name :
Servicing Provider First Name :
Servicing Provider Last Name :
Search by Date (Date Type) :
From Date :
From Date (mm-dd-yyyy)
To Date :
To Date (mm-dd-yyyy)
Search Clear

Prior Authorization Request Status

Select a column header below to narrow or filter search results.
Show entries

DATE SUBMITTED	REFERENCE #	MEMBER NAME	REQUEST TYPE	ADMISSION DATE	DISCHARGE DATE	REQUESTING PROVIDER	SERVICING PROVIDER	FACILITY PROVIDER	STATUS
Date Submitted	Reference #	Member Name	Request Type	Admission Date	Discharge Date	Requesting Provider	Servicing Provider	Facility Provider	Status
08-18-2022	00RASY7								In Progress

To search by date, please select the appropriate *Date Type*, enter start and end dates, then click search.

Hide Search Options

Member First Name :
Member Last Name :
Member DOB :
Member DOB (mm-dd-yyyy)
Member ID# :
Authorization Status :
Decision :
Auth # :
Alternative Auth ID :
Request Type :
Requesting Provider First Name :
Requesting Provider Last Name :
Servicing Provider First Name :
Servicing Provider Last Name :
Search by Date (Date Type) :
From Date :
08-28-2022
To Date :
09-01-2022
Search Clear

Prior Authorization Request Status

Step 3: Click the Reference # in the *Reference #* column to view additional details on the Prior Authorization or Inpatient Notification.

Prior Authorization Request Status 6

Select a column header below to narrow or filter search results.

Show [dropdown]

DATE SUBMIT	REFERENCE #	MEMBER #	REQUEST TYPE	ADMISSION DATE	DISCHARGE DATE	REQUESTING PROVIDER	SERVICING PROVIDER	FACILITY PROVIDER	STATUS
Da S	Reference	b	Request	Admission	Discharge	Requesting	Servicing Provi	Facility Pr	In Progress
	00RA8Y7								In Progress
									In Progress
									In Progress

Note: Click the hyperlink in the *Review Number* column to view details on the procedure, decision, etc.

Member Auth Details

Medical Authorization Review

REVIEW NUMBER	REVISION	REVIEW TYPE	PRIORITY	DECISION	REOPEN
H4613299	1	Initial Review	Concurrent		

The *Auth Review Details* screen displays:

Auth Review Details

Service Request

CODE	DESCRIPTION	MOD 1	MOD 2	FROM	THRU	REQUESTED	UNITS	DECISION	DECISION REASON	APPROVED
43235	Uppr GI Endoscopy, Diagnosis			07-18-2019	10-16-2019	3.0	Procedure			

Cancel

Note: Click “Cancel” to return to the Member Auth Details Screen.

Step 4: To view additional details such as diagnosis, CPT, or provider information and to view attachments or correspondence letters, scroll through the *Member Auth Details* page.

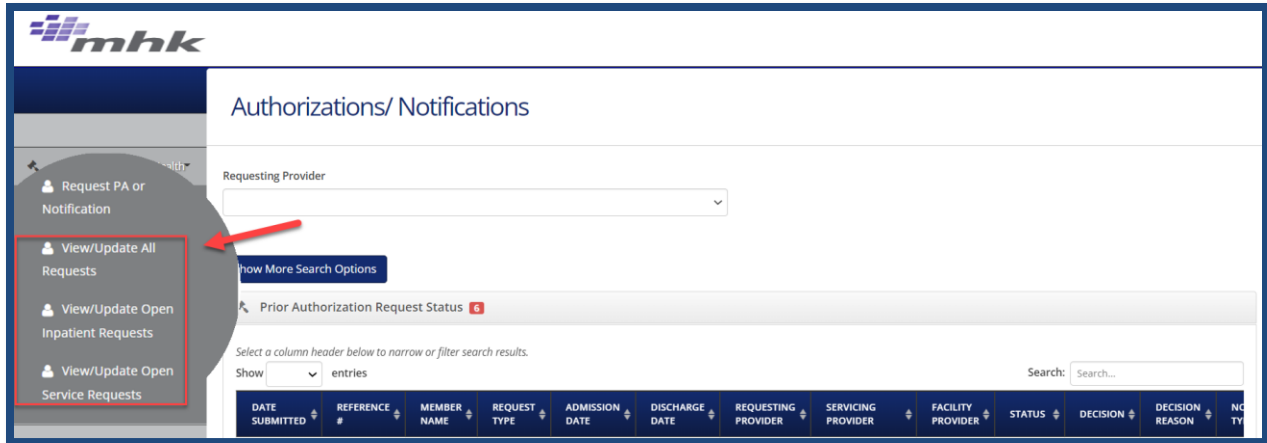
The screenshot displays the 'Member Auth Details' interface. It features two main sections: 'Uploaded Documents' and 'Correspondence'. The 'Uploaded Documents' section includes a table with columns for 'DOCUMENT NAME' and 'TYPE', showing a document named 'Clinical Attachment' of type 'Member Document'. The 'Correspondence' section includes a table with columns for 'NAME', 'CORRESPONDENCE TYPE', and 'RECEIVED DATE', listing two entries: 'Comm IP Initial RFMI' and 'CC Member'. At the bottom right, there are 'Print' and 'Cancel' buttons.

DOCUMENT NAME	TYPE
Clinical Attachment	Member Document

NAME	CORRESPONDENCE TYPE	RECEIVED DATE
Comm IP Initial RFMI	UM RFMI Facility Provider Fax	11-15-2020 20:49:23
CC Member	UM CC Member	11-15-2020 20:49:23

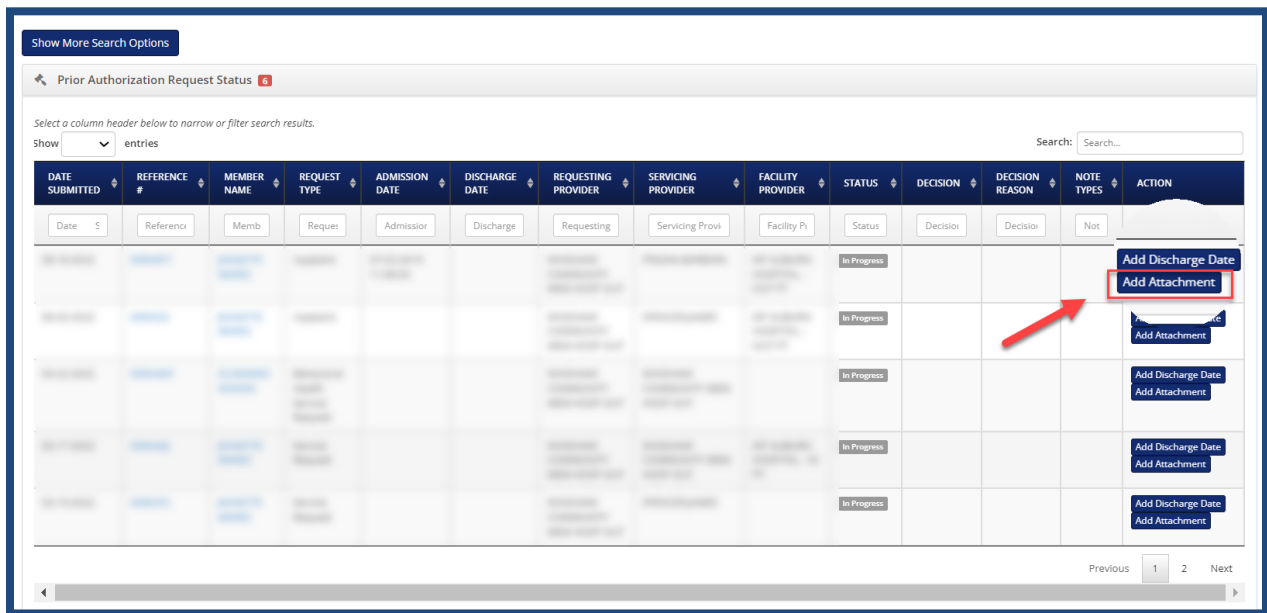
ADDING MEDICAL/CLINICAL NOTES TO AN EXISTING AUTHORIZATION

Step 1: From the *MHK home page*, select any one of the subsections to “View/Update All Requests” or “View/Update Open Inpatient or Service Requests” on the left-hand navigation bar.

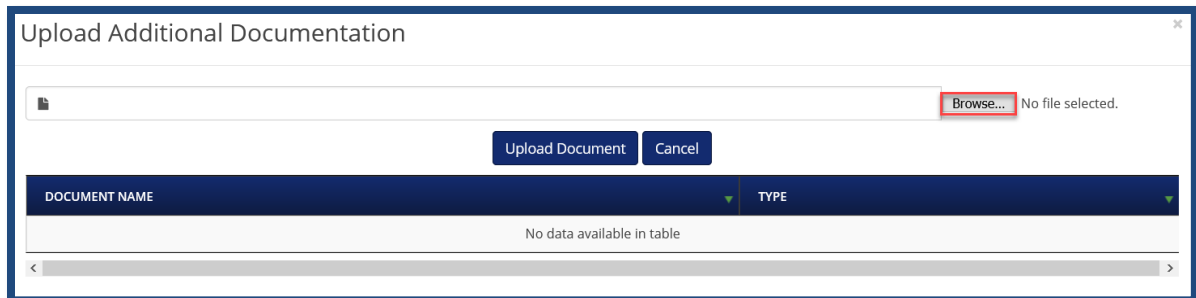


Step 2: After locating the existing request, click “Add Attachment” in the *Action* column.

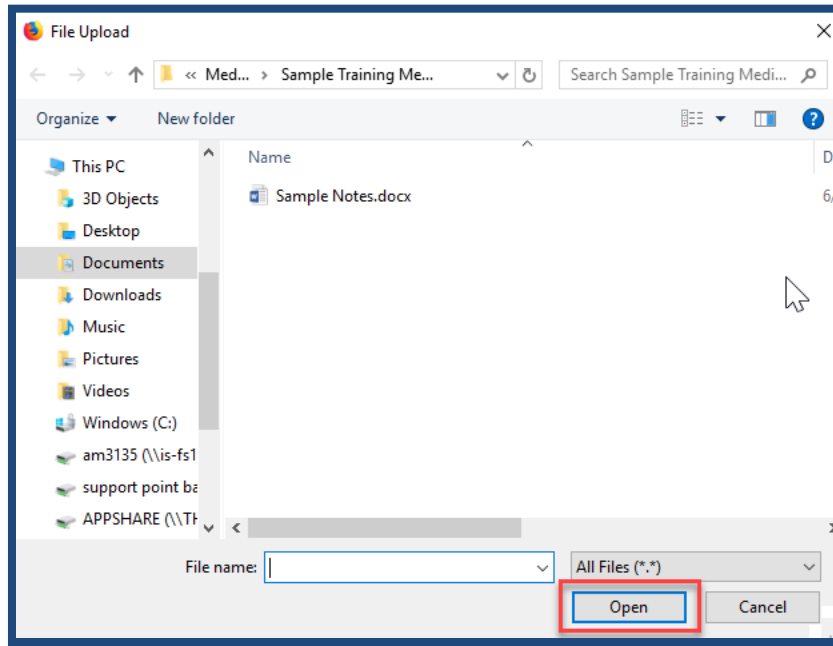
Note: Attachments should only be added to requests that are still In Progress



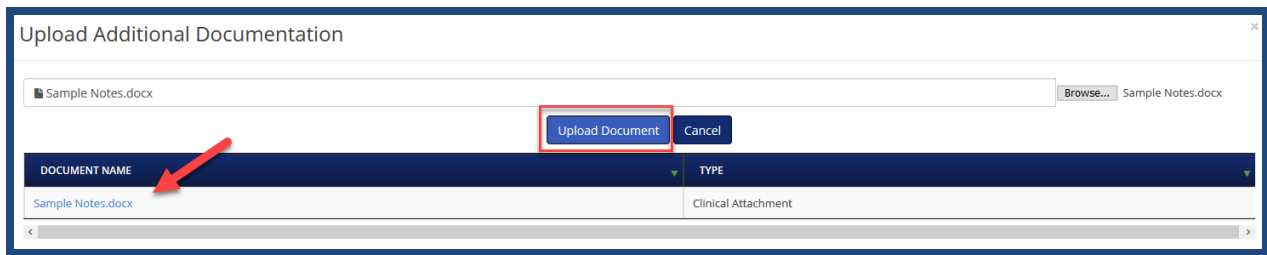
Step 3: Click “Browse.”



Step 4: Navigate to where the clinical documentation is saved on your computer and click “Open.”



Step 5: Click “Upload Document.”



ADDING DISCHARGE DATE(S) TO AN EXISTING AUTHORIZATION

Step 1: Discharge dates can be updated by selecting either the “View/Update Open Inpatient Requests” or “View/Update All Requests” subsections on the left-hand navigation bar.

Open Inpatient Requests

Medical/Behavioral Health

*Requesting Provider

Prior Authorization Request Status 3

Show [dropdown] entries

DATE SUBMITTED	REFERENCE #	MEMBER NAME	REQUEST TYPE	ADMISSION DATE	DISCHARGE DATE	REQUESTING PROVIDER	SERVICING PROVIDER
Date	Reference	Memb	Request	Admissior	Discharge	Requesting	Servicing Provi

Step 2: From the *View/Update Open Inpatient Requests* section, locate the appropriate reference number and click “Add Discharge Date” in the *Action* column.

Prior Authorization Request Status 6

Select a column header below to narrow or filter search results.

Show [dropdown] entries

Search: Search...

DATE SUBMITTED	REFERENCE #	MEMBER NAME	REQUEST TYPE	ADMISSION DATE	DISCHARGE DATE	REQUESTING PROVIDER	SERVICING PROVIDER	FACILITY PROVIDER	STATUS	DECISION	DECISION REASON	NOTE TYPES	ACTION
Date	Reference	Memb	Request	Admissior	Discharge	Requesting	Servicing Provi	Facility Pr	Status	Decision	Decision	Not	
									In Progress				Add Discharge Date Add Attachment
									In Progress				Add Attachment
									In Progress				Add Discharge Date Add Attachment

The *Discharge Date* screen displays:

Discharge Date

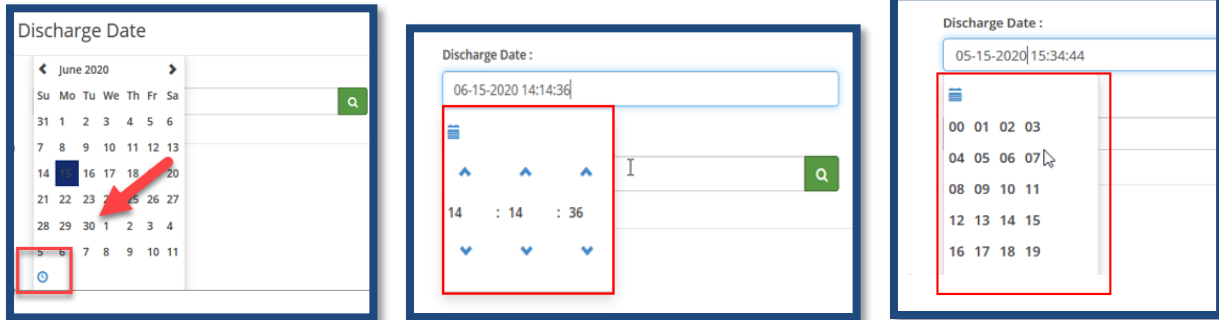
Discharge Date : 06-15-2020 14:14:36

Discharge Disposition :

Diagnosis Description :

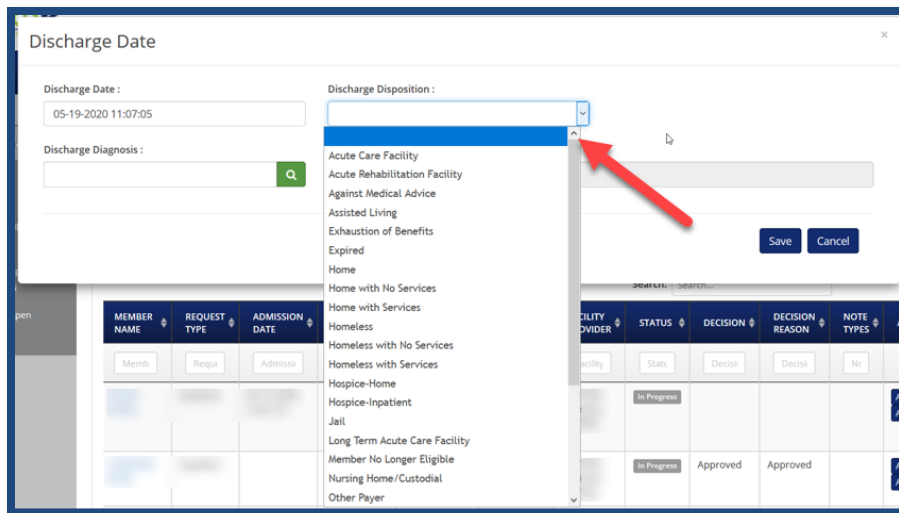
Save Cancel

Step 3: Choose the appropriate *Discharge Date* and click the “clock icon” to enter the time of discharge.

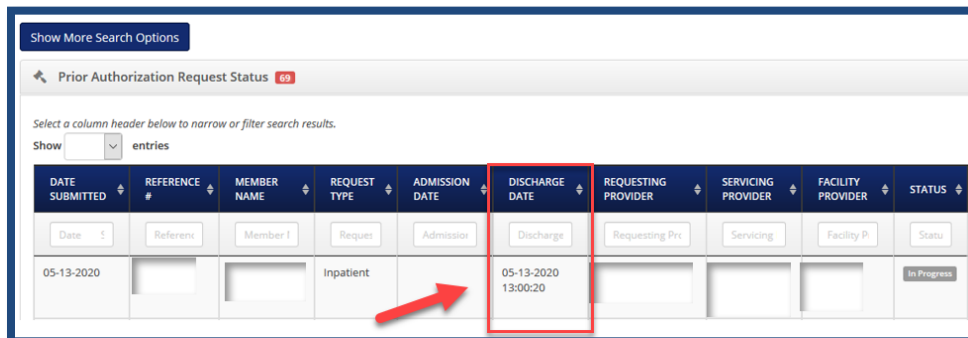


Note: The submitter can click or use the arrows for the hour, minute, or second fields and the discharge time will display in military time.

Step 4: Enter *Discharge Disposition* and *Discharge Diagnosis*, then click “Save.”



The following screen displays with the discharge date and time:



Note: When entering the discharge date, use the calendar to ensure the system captures the accurate discharge date and time.