



**CARE IMPROVEMENT PLUS**

*Specialized Care for Medicare Beneficiaries*

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# Provider Portal User Guide

*For Eligibility and Provider users*

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# 1 Purpose

This User Guide is for Eligibility and Provider users of the Provider Portal web application, a secure web-based application, to access information provided by Care Improvement Plus.

This guide provides a detailed overview of the application's functionality, based on a menu-driven sequence as displayed in the Home Page, as well as an intuitive dashboard interface for all sections on the landing page for a more visual experience. It also provides a step-by-step process on how to use the application and all of its features effectively.

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## 2 Accessing the Portal

### 2.1 Login

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1. To access the Provider Portal click on the link below:

<https://providerportal.careimprovementplus.com/> . This log-in box will appear:



The screenshot shows the login page for the CARE IMPROVEMENT PLUS Provider Portal. At the top left is the logo and text: "CARE IMPROVEMENT PLUS Specialized Care for Medicare Beneficiaries". Below this is a "Login Information" section. On the left side of this section, there is a form with the following elements: "Please enter your username and password.", "Username:" with a text input field containing the placeholder "Enter username here", "Password:" with a text input field containing the placeholder "Enter password here", a "Log In" button, and a link for "Forgot/Reset Password". On the right side, there is a welcome message: "Welcome to the Care Improvement Plus **Provider Portal**. Whether you are a Participating or Non-Participating Provider, you can access the Provider Portal. If you want to register as a new user please click" followed by a "Self Register" button and a link for "View Self-Registration tutorial".

2. Key in your Username and Password.
3. If you forgot your password, click “Forgot Password?” and enter your Username and email address on file then click “Reset Password”. Your password reset link will be emailed to you on the email address we have on file.
4. If the User does not have an account, the user can click the “Self Register” button.
5. If the User clicks the Self Register button, the user will need to select one of the two options listed.
  - a. To view Member Eligibly only (Eligibility user):
    - Select radio button “I agree to use the Provider Portal to view Eligibility Only” > Click “I Agree”
    - Fill in all user Registration Information (red asterisk indicates information that is required” >

- Please note that the password must contain at least one digit, one upper case, one lower case, one special character, range between 8-15 characters and should not be a user name.
- Once you enter the entire user registration information click on 'Register'.



Eligibility User Registration

First Name:

Last Name:

Occupation/Title:

Facility Name:

Primary Phone:

Email Address:

Fax:

User Name:

Password:

Confirm Password:

Elig Only Active User

[Back To Login](#)

- The user will be brought back to the login screen when the a User Name and Password created on the User Registration screen

b. To view Claim Information (Provider user):

- Select radio button "I agree to use the Provider Portal to view Claim Information" > Click "I Agree"
- This user will need to call Provider Portal Support - **1-800-690-1916** to set up the account.
- This user will also be able to view the Eligibility Information.

6. Once you are able to logon, the user will arrive on the Home Page.

**Tutorial Videos:** The user can also access the Self-Registration *Tutorials* through the Log In page.



**Login Information**

Please enter your username and password.

**Username:**

**Password:**

[Forgot/Reset Password](#)

Welcome to the Care Improvement Plus **Provider Portal**.

Whether you are a Participating or Non-Participating Provider, you can access the Provider Portal.

If you want to register as a new user please click

[View Self-Registration tutorial](#)

## 3 Eligibility User Experience

### 3.1 Home


As an **Eligibility user**, the user will have limited access to the portal. The following menu will be available to the user:

- Home
- Member Inquiry
- Medicaid Info
- Provider News
- Forms and Guides
- FAQ's
- Contact Us



As a **Provider user**, the user will have access to more features (in addition to the features Eligibility users are able to access):

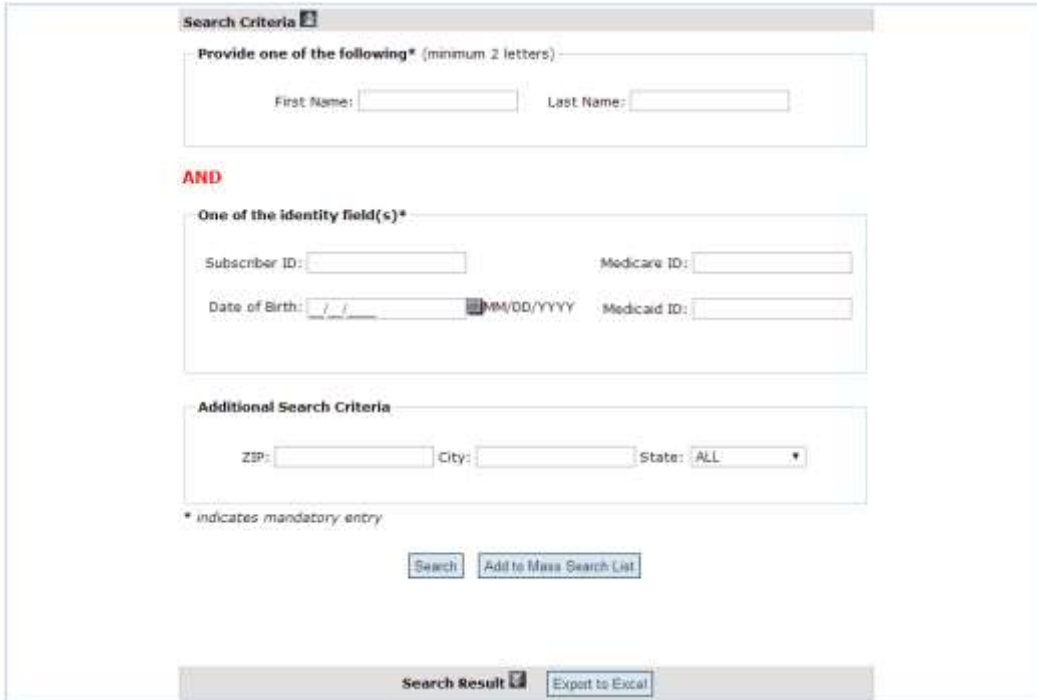
- Claim Center
- Document Upload
- Reports

<p>Home Member Inquiry Claim Center Medicaid Info Document Upload Provider News Forms &amp; Guide Reports FAQs Contact Us</p>		
<p><b>Provider Alert</b></p> <p>Please review report for <a href="#">462 patient(s)</a></p>	<p><b>What's New</b></p> <ul style="list-style-type: none"> <li>Upload up to five documents in electronic Medical Records (eMR) Upload.</li> <li>View Provider Alert in Home menu based on Patient Care Opportunity Report (PCOR) measures.</li> <li>Providers may now upload the Authorization of Representative (AOR).</li> <li>For formal appeals providers may now upload the Waiver of Liability (WOL).</li> </ul>	<p><b>Quick Links</b></p> <ul style="list-style-type: none"> <li><a href="#">Release Note V7.2.d</a></li> <li><a href="#">EMR Portal Guide</a></li> <li><a href="#">Sequestration Implementation</a></li> <li><a href="#">Provider Portal User Guide<sup>NEW</sup></a></li> </ul> <p><b>Featured Training :</b> <a href="#">How to verify member eligibility</a></p>
<p><b>Member Inquiry</b></p> <p>The section offers several options to retrieve member information, as well as verify the member eligibility and eligibility history.</p>	<p><b>Medicaid Info</b></p> <p>Provide Filing Claim information for State base Dual Advantage Plan Member.</p>	<p><b>Provider News</b></p> <ul style="list-style-type: none"> <li><a href="#">Provider Communication: PATH Medicare Advantage HEDIS Improvement Program (MA-HIP) FAQ's</a></li> <li><a href="#">Provider Communication: PATH Medicare Advantage HEDIS Improvement Program (MA-HIP) 2014 Terms and Conditions</a></li> <li><a href="#">Provider Communication: Wellness and Physical Examination Codes</a></li> <li><a href="#">Provider Communication: Gold Card</a></li> <li><a href="#">Provider Communication: ICD-10 Transitions Basics and FAQs</a></li> </ul>
<p><b>Claim Center</b></p> <ul style="list-style-type: none"> <li>To view detailed information on payment status and amount, claim amount, and charge code detail.</li> <li>See the copy of the remittance related to the specific claims.</li> <li>Review reports for "Medical Records Requests", "Audit Findings", and "Reconsideration &amp; Appeals Activity" related to the specific claims.</li> <li>Request Remittance Details.</li> <li>Send a Claim dispute.</li> </ul>	<p><b>Document Upload</b></p> <ol style="list-style-type: none"> <li>1. Medical Records Submit Medical Records electronically for Post Payment Audit Reviews.</li> <li>2. Appeal/Reconsideration Upload Submit missing medical records or additional documentation electronically for Appeal or Reconsideration request.</li> </ol>	<p><b>Contact Us</b></p> <p>Provide Health Plan contact information, for available e-mail, fax and phone numbers. Allow the user to send feedback on feature and functionality.</p>
<p><b>Forms and Guides</b></p> <p>Provide all forms and guides related to Prior Authorization, Claim &amp; Payment, Member &amp; Benefit Information, Part D Claim, Part D Coverage Determination and Redetermination, Part D Mail Order Form.</p>	<p><b>Reports</b></p> <ol style="list-style-type: none"> <li>1. Post Payment Audit <ul style="list-style-type: none"> <li>- Medical Records Request Provide status report of submitted medical records and/or additional documentation.</li> <li>- Audit Findings Provide status of a claim audit.</li> </ul> </li> <li>2. Reconsiderations and Appeals Activities Provide status of a Reconsideration and/or appeal.</li> <li>3. Payment Summary This report allows providers to review claims payments and/or recoveries processed on a remit.</li> <li>4. Stargazer Report This report displays list of members who are assigned to provider office and 'action required' on specific measures for them.</li> <li>5. PCOR-CIP Patient Care Opportunity Report for CIP members. This report provides information regarding members where screenings or tests are recommended.</li> </ol>	
<p><b>Video Tutorials</b></p> <ul style="list-style-type: none"> <li>Featured Video Tutorial : <a href="#">How to verify member eligibility</a></li> </ul> 		



## 3.2 Member Inquiry

This section offers several options to retrieve member information, as well as verify the member eligibility and eligibility history. When you click the “Member Inquiry” menu, you will get the following search screen:



The screenshot shows a search interface with the following sections:

- Search Criteria** (with a help icon):
  - Provide one of the following\* (minimum 2 letters):
    - First Name:
    - Last Name:
- AND** (in red text)
- One of the identity field(s)\***:
  - Subscriber ID:
  - Medicare ID:
  - Date of Birth:  MM/DD/YYYY
  - Medicaid ID:
- Additional Search Criteria**:
  - ZIP:
  - City:
  - State: ALL

\* indicates mandatory entry

Buttons: Search, Add to Mass Search List

Bottom bar: Search Result  Export to Excel

- Under *Search Parameters* you can enter any combination of the following
  - Member’s First Name or Last name (Minimum 2 letters)

**AND**

Any one of the following





- Subscriber ID;
- Medicare Number;

- Medicaid #;
- Date of Birth.


Enter the member information as per search parameters and click on *Search* and it will list the results associated with the search request.

You also have the option of narrowing down the search by adding any additional information in the *Additional Search Criteria* box, though this is not required.

- If you want to do **multiple searches** at one time, you can enter the same combination above and click on *Add to Mass Search List*. Once you have added all of the members that you were looking for into the *Mass Search List* you can then click on *Search* and it will pull all results for those names.

Mass Search List 										
Subscriber ID	Last Name	First Name	Medicare #	Medicaid #	DOB	City	State	Zip	Effective Date	Delete
	davis									
	smith									
	jones									

- Another feature under the Member Inquiry is *Export to Excel*. This button allows you to save and print an excel spreadsheet of members you received in your Search Results.

Search Result 				
Subscriber ID	Member	DOB	Effective Date	Eligible
	Smith			YES

- After you have located your Member, click on the Subscriber ID link to access the details of their record in the *Member Details* screen.

**Member Details** - Displays basic Member Information, such as, member name, subscriber ID, Date of Birth and Gender, Member's PCP as per Health Plan records, Eligibility History and Member Plan details.


**Member Information:**

Name: [Redacted]  
Subscriber ID: [Redacted]  
DOB: [Redacted]  
Gender: **Male**

**Primary Care Provider (PCPs)**

Member does not have a Primary Care Physician

**Claims**

 [View Recent Claims](#)

**Member Eligibility History**

**Eligibility: Medical Product**

As of 11/8/2013, [Redacted] is **Eligible** for coverage under [Arkansas Gold Rx \(Regional PPO\) Plan](#) plan for the period of 01/01/2009 to Present.


**Eligibility Report**

**Product Name:** Arkansas Gold Rx (Regional PPO) Plan  
**Eligible:** Eligible  
**Effective From:** 01/01/2009  
**Effective To:** Present

**Product Name:** Arkansas Gold Rx (Regional PPO) Plan  
**Eligible:** Eligible  
**Effective From:** 06/01/2007  
**Effective To:** 12/31/2008

To receive benefit information for any products other than available above, please contact Provider Services at 1-866-679-3119

**Primary Care Provider (PCPs)** – Displays the member’s Primary Care Physician as per Care Improvement Records.

- **Claims** – displays a link to the Claim Center search page. If the user is an Eligibility user, the user will see a message *“Currently your User account is for viewing Eligibility. If you would like to add Claims permission please call Web Portal Support 1-800-690-1916”*
- If the user has a Provider role that links to a specific Provider’s Tax ID or NPI listed in their User Account, the user will see the  [View Recent Claims](#) icon. By clicking on this icon, the user will be able to view the most recent claims submitted by that member.

**Claims**

 [View Recent Claims](#)

- The user may view the summary of a member’s healthcare benefits plan by clicking the coverage plan information link found in the Member Eligibility History section.

#### Member Eligibility History

##### Eligibility: Medical Product

As of 11/0/2013, [REDACTED] is Eligible for coverage under **Arkansas Gold Rx (Regional PPO) Plan** plan for the period of 01/01/2009 to Present.


## 3.3 Claims Center


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This page is accessible by any user that has provider role access to the application. Eligibility users will not be able to have the option. The Claim Center page is useful:


- To view detailed information on payment status and amount, claim amount, and charge code detail.
- To see the copy of the Remit related to the specific claims.
- To review reports for Post Payment Audit Report, such as "Reconsideration & Appeals Activity", "Medical Records Requests", and "Audit Findings" related to the specific claims.
- To request Remittance Details.
- To send a Claim dispute.


There are two ways to reach to the Claim Center page: On the Member Detail Page, click on the *View Recent Claims* icon or from the main menu by clicking the Claim Center tab. On this page:


- The user will see a Search Criteria Box.
- The user will have the option to search by **claim type** - Facility or Medical.
- The user may enter in **dates of service date range** (this defaults back to a 6 month span) or use the calendar to pick dates.
- By clicking on the drop down box next to the **Status** field you can choose from a list of options -- **Processing, Processed and Adjusted Claims**.
- The **Members First and Last Name** will be carried over from the Member Details screen if the user accesses this page from the Member Details page. Otherwise, the user can click the search icon  to find the member first.


**Claim Search Criteria** 


Advanced Search:

Claim Type:  

Date of Service From:   (mm/dd/yyyy)

Date of Service To:   (mm/dd/yyyy)

Claim Status:  


Member:  


Provider NPI:


Payment Ref. ID:


Member First Name:


Member Last Name:


Member Date of Birth:   (mm/dd/yyyy)


Tax ID/NPI: 

















































































































































































Claim ID Search:

Claim ID:

**Claim Search Results** 

Claim ID / Status	Provider ID	Services Date	Member	Service Provider (NPI)	Claim Description	TAX ID	CHECK AMOUNT	View Remit
PROCESSED		03/01/2014 to 03/03/2014					1251.92	
PROCESSED		05/28/2014 to 05/29/2014					612.25	

- After you have made your selection, click the Search button. A list of **Search results** should display at the bottom of the screen. By clicking on the column headers, you may sort the information in ascending or descending order.
- The user can hide the *Claim Search Criteria* or *Claim Search Results* by clicking on the adjacent  icon.
- Click the  icon in the **View Remit** column of the search results page to open a link to that claims' PDF Remit form, if one is available. For more information on Remits, see section 3.3.1 (Claim Details page).

If the Members Claim does not match to the NPI or Tax ID associated with this User Account and click Search, No Records should appear with "No Results found" message

- Under the Claim search results you will see an **Export to Excel** button. This will allow the option to save the Search Results into excel spreadsheet.
- By clicking on each Claim ID number, it will take you to a screen where you can view claim details which are generated from the database.

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All Member information will be protected unless the User has access to view the Claims information by NPI or Tax ID

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### 3.3.1 Claims Details page

Claim Summary		Remittance Information	
Claim ID:	[REDACTED]	Provider Name:	[REDACTED]
Member (ID):	[REDACTED]	Address:	[REDACTED]
Covered Under:	Care Improvement Plus- Silver Plan 100% Subsidy	NPI:	[REDACTED]
Patient Acct #:	[REDACTED]	Paid on this Claim:	[REDACTED]
Dates of Service:	05/10/2011 to 06/01/2011	<a href="#">Request Remittance Details</a>	
Servicing Provider:	[REDACTED]	<b>Payment Information</b>	
Received:	06/07/2011	Check Number#:	[REDACTED]
Status:	PROCESSED	Payment Ref ID:	[REDACTED]
Primary Diagnosis Code :	27803	Payment Date:	[REDACTED]
DRG Code :	208	Check Amount:	[REDACTED]
Place of Service :		Combined Check:	[REDACTED]
Note:		Check Status:	[REDACTED]
Reason:		<a href="#">All Post Payment Audit Reports</a> <a href="#">Dispute / Request</a>	

Post Payment Audit Reports		
<b>Medical Records Request</b>	<b>Audit Findings</b>	<b>Reconsiderations and Appeals Activity</b>
No pertinent data for this report.	Chart Received: <b>Yes</b> Audit Date: <b>11/13/2011</b> Determination: <b>Pass</b>	No pertinent data for this report.

Claim Items									
This claim has 22 Line item(s)									<a href="#">Export To Excel</a>
Item	Proc Code	Description	Charge	Allowed	Copay	Coinsurance	Deductible	Plan Paid	EXPL Code
1	0110	Room & Board - Private	\$19,431.20	\$22,549.21	\$0.00	\$0.00	\$1,132.00	\$21,417.21	PGR
2	0200	Intensive Care	\$18,025.50	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
3	0250	Pharmacy	\$29,962.80	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
4	0255	Pharmacy - Drugs Incident to Radiology	\$15.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
5	0258	Pharmacy - IV Solutions	\$2,668.15	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

On the Claim Details page, you will see six sections:

- Claim Summary
- Remittance Information
- Payment Information
- Post Payment Audit Reports
- Claim Items
- Claims bundled into same check (If any)

On claim summary page, you can find the claim and associated details to it such as claim id, Member ID, Patient account Number (If any), Coverage Type, Dates of service, Servicing

Provider, Claim received date, Claim Status, Primary Diagnosis Code (If any), Place of Service, Reason and Note for the given claim if any.

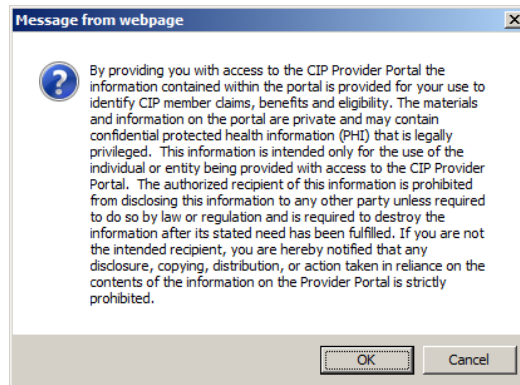
Beside this information on claim detail page, hovering the cursor on '**Servicing Provider Name**' will show the servicing provider address, while hovering the cursor on **EXPL Code** of Claim Items will show explanation/Note for that selected code.

There are three additional buttons available on this page.

- Request Remittance Details
- Dispute
- Export to Excel (To export claim line items and Bundled claims details)

**Post Payment Audit Reports** will display any relevant data for the claim. If there is no audit report data available, it will state 'no pertinent data for this report' as shown in the figure above.

Clicking the **Request Remittance Details** button will display an image of the Remit if the claim payment is **after July 1, 2009**. Prior to showing the available Remit file, a confidentiality disclaimer message will be displayed (see below).



Clicking OK will then display the PDF as shown below:





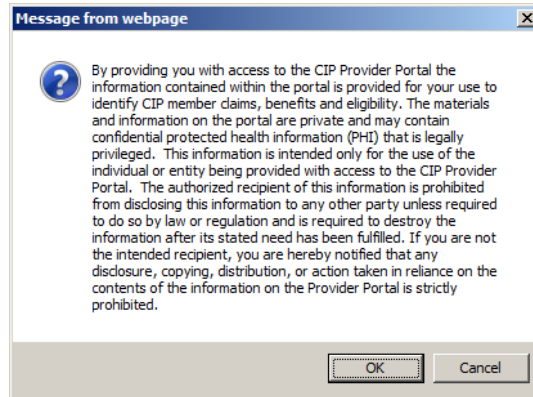
Your notification to Care Improvement Plus is ready to be sent. Please add any additional comments you feel would be pertinent. When finished click "Send Notification" or press "Cancel" to return to Claim Summary screen.

Email Address (Required):

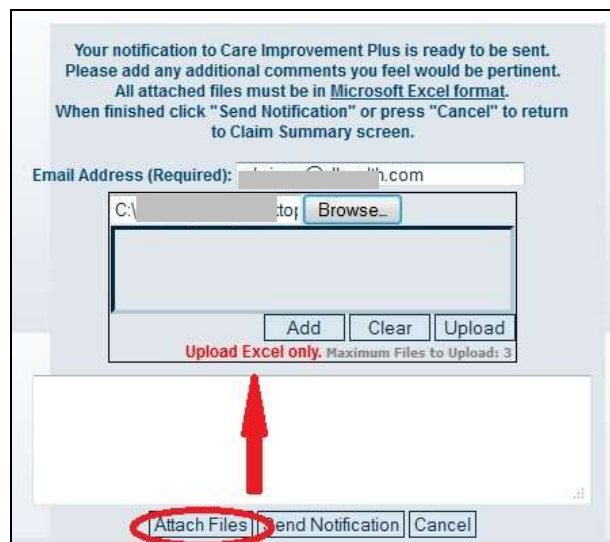
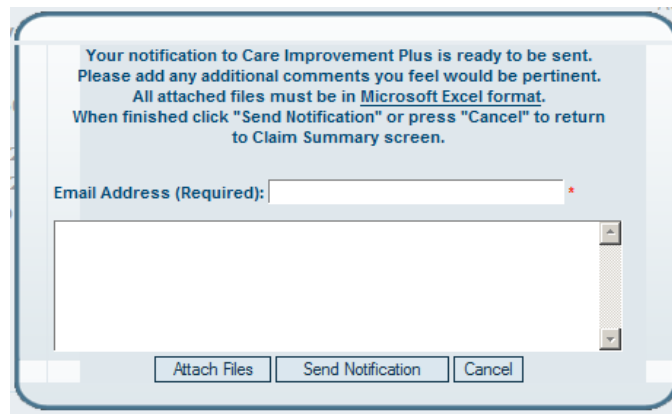
Requesting EQP document for member John Doe for Claim # 1234566789E34100

Claim Summary	Remittance Information
Claim ID: <input type="text"/>	Provider Name: <input type="text"/>
Member (ID): <input type="text"/>	Address: <input type="text"/>
Covered Under: <b>Care Improvement Plus- Silver Plan 100% Subsidy</b>	NPI: <input type="text"/>
Patient Acct #: <input type="text"/>	Paid on this Claim: <input type="text"/>
Dates of Service: <b>05/10/2011 to 06/01/2011</b>	<input type="button" value="Request Remittance Details"/>
Servicing Provider: <input type="text"/>	<b>Payment Information</b>
Received: <b>06/07/2011</b>	<input type="text" value="Check Number#"/>
Status: <b>PROCESSED</b>	Payment Ref ID: <input type="text"/>
Primary Diagnosis Code : <b>27803</b>	Payment Date: <input type="text"/>
DRG Code : <b>208</b>	Check Amount: <input type="text"/>
Place of Service : <input type="text"/>	Combined Check: <input type="text"/>
Note: <input type="text"/>	Check Status: <input type="text"/>
Reason: <input type="text"/>	<input type="button" value="All Post Payment Audit Reports"/> <input type="button" value="Dispute / Request"/>

Click the **Dispute/Request** button on the Claim Detail page to request an explanation about the claim. A dispute window will prompt the user to answer **OK** or **Cancel**.



Clicking *OK* will bring the user to the next step to enter the e-mail address, add a message and attach Excel-only files which are related to the claim.



- When attaching file(s), click the **Browse** button to search for a local Excel file to upload, then once selected click **Open** in the file selection window. The path to that file should now be listed in the field next to Browse. Click **Add** to add it to the queue of Excel documents to be uploaded. Once you've selected up to three documents that you wish to include, click **Upload** to send them to the database. Once the **Send Notification** button is clicked, the IT staff and vendor will receive an email with this information, including links to all the Excel documents that were attached.

Claim Summary	Remittance Information
Claim ID: [REDACTED]	Provider Name: [REDACTED]
Member (ID): [REDACTED]	Address: [REDACTED]
Covered Under: <b>Care Improvement Plus- Silver Plan 100% Subsidy</b>	NPI: [REDACTED]
Patient Acct #: [REDACTED]	Paid on this Claim: [REDACTED]
Dates of Service: <b>05/10/2011 to 06/01/2011</b>	<a href="#">Request Remittance Details</a>
Servicing Provider: [REDACTED]	<b>Payment Information</b>
Received: <b>06/07/2011</b>	Check Number#: [REDACTED]
Status: <b>PROCESSED</b>	Payment Ref ID: [REDACTED]
Primary Diagnosis Code : <b>27803</b>	Payment Date: [REDACTED]
DRG Code : <b>208</b>	Check Amount: [REDACTED]
Place of Service : [REDACTED]	Combined Check: [REDACTED]
Note: [REDACTED]	Check Status: [REDACTED]
Reason: [REDACTED]	<a href="#">All PostPayment Audit Reports</a>
	<a href="#">Dispute / Request</a>

### 3.4 Medicaid Info

This page provides claims filing information for Care Improvement Dual Advantage Plan Members in the following eligible states: **Arkansas, Georgia, Missouri, South Carolina, Texas and Wisconsin.**

### 3.5 Document Upload

This section allows the provider users to submit/upload the medical records, Appeal (Redetermination)/Reconsideration (Technical Denial) upload. Click on the *Document Upload* menu and go to the appropriate module to upload the intended documents.

## Document Upload

Medical Record Upload	Appeal/Reconsideration Request Upload
<p>Care Improvement Plus requests medical records according to the guidelines set forth by CMS for fee-for-service Medicare. The Plan provides 30 calendar days for providers to fulfill each medical record request.</p>	<p>Providers may file a formal Appeal following an adverse determination with Care Improvement Plus. If a denial was issued due to missing/insufficient medical records, a Reconsideration request may be submitted; providers may supply missing medical records or additional documentation for consideration by the Plan.</p>
<p><a href="#">Click here to upload a Medical Record by using Document ID</a> <a href="#">Click here to upload a Medical Record by using Claim ID</a></p>	<p><a href="#">Click here to upload an Appeal/Reconsideration Request</a></p>

### 3.5.1. Medical Record Upload

The Medical Records upload module allows the user to submit/upload electronic health records requested by Care Improvement Plus. It also allows the user to find the Medical Record Upload History by clicking on the *Expanded Upload History* button on the top right corner of the page.

To upload the Medical Record documents, click on “Medical Record Upload” or “Click here to upload a Medical Record by using Document ID” link if you have document ID (you may find this in Medical Record Request letter that you received) available for the claims you want to upload the documents. You may chose “Click here to upload a Medical Record by using Claim ID” if you do not know or do not have the Document ID available.

## Document Upload

Medical Record Upload	Appeal/Reconsideration Request Upload
<p>Care Improvement Plus requests medical records according to the guidelines set forth by CMS for fee-for-service Medicare. The Plan provides 30 calendar days for providers to fulfill each medical record request.</p>	<p>Providers may file a formal Appeal following an adverse determination with Care Improvement Plus. If a denial was issued due to missing/insufficient medical records, a Reconsideration request may be submitted; providers may supply missing medical records or additional documentation for consideration by the Plan.</p>
<p><a href="#">Click here to upload a Medical Record by using Document ID</a> <a href="#">Click here to upload a Medical Record by using Claim ID</a></p>	<p><a href="#">Click here to upload an Appeal/Reconsideration Request</a></p>

If user's account is associated with multiple Tax ID/NPIs then user should select the one from the Provider Tax ID/NPI drop downs menu.

<p><b>Facility/Provider</b></p> <p>To upload a Medical Record, please choose the Provider NPI from the menu. You may provide a different email address for receiving the confirmation.</p> <p>Provider/Facility Name: <input type="text"/></p> <p>Provider Name: <input type="text"/></p> <p>Provider Tax ID: <input type="text"/></p> <p>Provider Email: <input type="text"/></p> <p>Confirmation Email Address: <input type="text"/></p>	<p><b>Medical Record Upload History</b></p> <p>Click the "Expanded Upload History" button to see detailed Upload History</p> <p>2 Medical Records were uploaded.</p> <p><b>Most recent completed upload:</b></p> <p><b>Document ID:</b> 40910I</p> <p><b>Claim:</b> <input type="text"/></p> <p><b>Upload Date:</b> <input type="text"/></p> <p><a href="#">Expanded Upload History</a></p>
<p><b>Medical Record Request Letter</b></p> <p>Please choose a claim from the list below</p> <p>Document ID: <input type="text" value="40910I"/> <input type="button" value="Submit"/></p> <p><a href="#">Help/Document ID lookup</a></p> <p><a href="#">I don't have a document ID</a></p> <p>Claims: <input type="text"/></p>	
<p><b>Member</b></p> <p>Patient Account Number: <input type="text"/></p> <p>Subscriber ID: <input type="text"/></p> <p>Member Name: <input type="text"/></p> <p>Member Date of Birth: <input type="text"/></p> <p>Date of Service (From date): <input type="text"/></p> <p>Date of Service (Thru date): <input type="text"/></p>	
<p><b>Medical Record File</b></p> <p>Please choose the Medical Record File by clicking on 'browse' button. Then Click 'Submit' button.</p> <p><b>Note:</b> If a password restriction has been placed on the document, please remove the restriction prior to upload.</p> <p>Choose Medical Record File: <input type="text"/> <input type="button" value="Browse..."/></p> <p><input type="button" value="Add Another File"/></p> <p><input type="button" value="Submit"/></p>	

If you do not have the Document ID, you can click on **I don't have Document ID** and you will allow to enter a claim ID number. After entering the Claim ID, all associated document IDs will show up. User can select the appropriate document ID or choose 'I don't know document ID' in case does not know the associated document ID number. These steps will auto populate the Member information and allow user to submit Medical Records via Medical Record File section. User can click to 'Add Another File' button to upload additional button. Users are allowed to submit up to five documents via clicking on 'Submit' button.



**Note: User may upload PDF, JPEG, TIFF or XML type of file format and maximum size of the file should not exceed more than 60MB.**

User can view all the total numbers of Medical Records Upload and Most recent upload details via Medical Record Upload history. Clicking on 'Expand Upload History' will show all previously uploaded documents by the user.

### Medical Record Upload

**Facility/Provider**

To upload a Medical Record, please choose the Provider NPI from the menu. Please enter your email address to receive an email confirmation.

Provider/Facility Name:

Provider Name:

Provider Tax ID:

Provider Email:

Confirmation Email Address:

**Medical Record Upload History**

Click the "Expanded Upload History" button to see detailed Upload History

**20** Medical Records were uploaded.

**Most recent completed upload:**

**Document ID:**

**Claim:**

**Upload Date:**

[Expanded Upload History](#)

**Medical Record Request Letter**

Please type the Document ID that you have received in the Medical Record Letter, and then click the Submit button. If you cannot find the Document ID, please click on the 'Help/Document ID lookup' button below to open Medical Record Letter template.



### Medical Record Upload

Medical Record History									
Search by Upload Date: From: MM/DD/YYYY To : MM/DD/YYYY <input type="button" value="Search"/> <input type="button" value="Clear Search"/> <input type="button" value="Export to Excel"/>									
Doc ID	Claim ID	Member Name	Member DOB	Uploaded By	Total Uploads	Upload Date	Confirmation	Update	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1	10/16/2014 14:08	<input type="text"/>	<input type="button" value="Update"/>	
B1750R	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2	10/08/2014 11:41	<input type="text"/>	Medical Record File has been updated	
<input type="button" value="Back to Upload"/>									

You can filter the list by entering the upload "From" and "To" dates, then click on "Search". By clicking on 'Update' button, user can change/update the previously submitted document. You

can also export the Medical Upload History in excel document by clicking on “Export to Excel” button

For more information on how to use this specific feature, please go to Forms & Guides (by either clicking the main menu tab or the header tab on the dashboard landing page) and click the ‘EMR Portal Guide’ link found within the Manual and User Guide panel. Or simply click this link:

[https://providerportal.careimprovementplus.com/pdf/XLHealth\\_EMR\\_Guide.pdf](https://providerportal.careimprovementplus.com/pdf/XLHealth_EMR_Guide.pdf)

### 3.5.2. Appeal/Reconsideration Upload

The Appeal/Reconsideration Upload module allows the users to electronically upload the documents to support the appeal & reconsideration request. This module automatically identifies the provider details as a part of provider portal account and hence, makes the appeal submission easier and faster. User can upload supporting documentation, submit manual routing request, view and update previous request and export previous submission history to excel for Appeal & Reconsideration activities.

CIP Provider users can submit the following types of requests and supporting documentation:

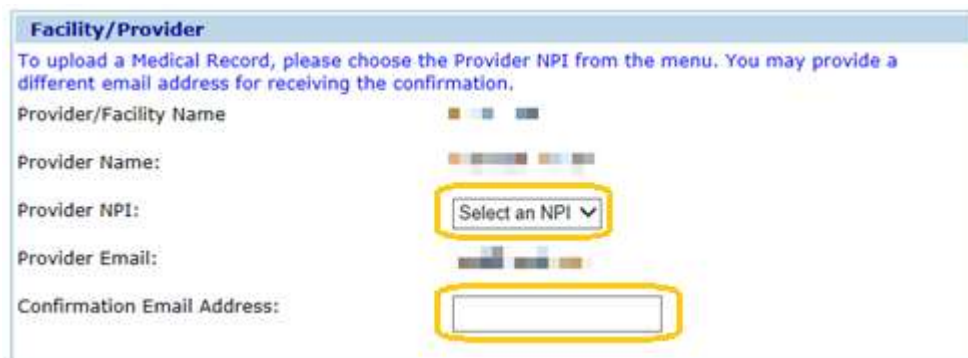
Requestor Type	Required Supporting Documents
Appeal	At least one of the following must be attached: Assignment of responsibility (AOR) Waiver of liability form (WOL) 1-5 additional documents
Reconsideration	1-5 additional documents (at least one document required)
Pre-Service	At least one of the following must be attached: Assignment of responsibility (AOR) Waiver of liability form (WOL) 1-5 additional documents



Clicking on Document Upload, you will see options for Medical Record Upload and Appeal/Reconsideration Request. To upload an Appeal and/or a Reconsideration documents, click on “Appeal/Reconsideration Request Upload” or “Click here to upload an Appeal/Reconsideration Request” link as shown in following figure.



Clicking on “Appeal/Reconsideration Request” will open up appeal/reconsideration document upload module with pre populated information such as provider/facility name, provider name and provider email address associated with the account. If user’s account is associated with multiple Tax ID/NPIs then user should select the one from the Provider Tax ID/NPI drop downs menu. After selecting the Tax ID or NPI from the drop down menu ‘*Provider/Facility*’ details and ‘*Appeal/Reconsideration History*’ will show up. User can type in confirmation email address if wants to receive confirmation email on other than displayed email address.



Type in the document ID number in the *Document ID* field and the member information will be populated. User can submit the related documents such as letter of appeal/reconsideration,

waiver of liability (For non-par provider only) and additional documents through the Appeal/Reconsideration Documents Field.

**Decision Type**

Please type the Document ID that you have received and then click the Submit button. If you received a letter but don't know the Document ID, please click 'Help/Document ID lookup'. If you did not receive a letter, please click 'I don't Have Document ID'.

Document ID:

[Help/Document ID lookup](#)  
[I don't have a document ID](#)

### Submit Documents

User can browse, select the Appeal/Reconsideration letter and other supporting documents and submit them by clicking on '*Confirm and Submit*' button.

## Appeal / Reconsideration Request

<p><b>Facility/Provider</b></p> <p>You may provide a different email address for receiving the confirmation email.</p> <p>Provider/Facility Name: <input style="width: 100%;" type="text"/></p> <p>Provider Name: <input style="width: 100%;" type="text"/></p> <p>Provider Tax ID: <input style="width: 100%;" type="text"/></p> <p>Provider Email: <input style="width: 100%;" type="text"/></p> <p>Provider Fax: <input style="width: 100%;" type="text"/></p> <p>Confirmation Email Address: <input style="width: 100%;" type="text"/></p>	<p><b>Appeal/Reconsideration History</b></p> <p>Click the "Appeal/Reconsideration History" button to see detailed Upload History</p> <p>3 Appeals/Reconsiderations were uploaded.</p> <p><b>Most recent completed upload:</b></p> <p><b>Document ID:</b> <input style="width: 100%;" type="text"/></p> <p><b>Claim:</b> <input style="width: 100%;" type="text"/></p> <p><b>Upload Date:</b> 04/16/2014 05:01 PM</p> <p style="text-align: center;"><a href="#">Appeal/Reconsideration History</a></p>
<p><b>Decision Type</b></p> <p>Please type the Document ID that you have received and then click the Submit button. If you received a letter but don't know the Document ID, please click 'Help/Document ID lookup'. If you did not receive a letter, please click 'I don't Have Document ID'.</p> <p>Document ID: <input style="width: 100%;" type="text"/></p> <p style="text-align: right;"><a href="#">Help/Document ID lookup</a> <a href="#">I don't have a document ID</a></p> <p style="text-align: center;"><input type="button" value="Submit"/></p>	
<p><b>Appeal and Reconsideration Upload</b></p> <p>This is an Appeal and Reconsideration Upload. Please attach the letter of appeal, waiver of liability form or any additional documentation necessary for your appeal and reconsideration upload.</p> <p>Upload Supporting Documentation: <input style="width: 100%;" type="text"/> <input type="button" value="Browse..."/></p> <p><a href="#">What constitutes a valid appeal?</a> <input type="button" value="Add Another File"/></p> <p>If you have already uploaded an AOR or a WOL form, or you are not required to submit either of those forms, you do not have to separately upload them below:</p> <p>Upload an AOR: <input style="width: 100%;" type="text"/> <input type="button" value="Browse..."/></p> <p><a href="#">What is an AOR?</a> <a href="#">Download AOR Form</a></p> <p>Upload a WOL: <input style="width: 100%;" type="text"/> <input type="button" value="Browse..."/></p> <p><a href="#">What is a WOL?</a> <a href="#">Download WOR Form</a></p> <p style="text-align: center;"><input type="button" value="Confirm and Submit"/></p>	

If you do not have the Document ID or the decision letter, you can click on **I don't have Document ID** and you will allow to enter a claim ID number. You can look up the document ID with the date of service plus one of the following.

1. HICN
2. Member Name and Date of Birth

### 3. Subscriber ID

Please enter the information below in support of your request.

**Please enter the following information**

Date of Service (From):	<input type="text" value="MM/DD/YYYY"/>
Date of Service (Thru):	<input type="text" value="MM/DD/YYYY"/>

**AND**

**Please enter the field(s) in one of the following sections.**

HICN (Beneficiary Medicare Number):	<input type="text"/>
-------------------------------------	----------------------

**OR**

Member First Name:	<input type="text"/>
Member Last Name:	<input type="text"/>
Member Date of Birth:	<input type="text" value="MM/DD/YYYY"/>

**OR**

Subscriber ID:	<input type="text"/>
----------------	----------------------

[Proceed to upload documentation](#)

**Note:** If you are unable to locate or look up the document ID number using other information, you can submit a manual routing request. For more information, see the “Submit a Manual Routing Request” procedure at end of this section.

After entering the document ID or proceeding through “I don’t have document ID”, you can proceed to document upload and browse for the document, select the Appeal/Reconsideration

letter and other supporting documents and submit them by clicking on 'Confirm and Submit' button.

**Note:** User may upload PDF, JPEG, TIFF or XML type of file format and maximum size of the file should not exceed more than 60MB.

### Submit a Manual Routing request

If your request was not found when you search for the document ID via "I don't have document ID" within two attempts, an option to submit a manual routing request will appear at the bottom of the page. Click on "Submit Manual Routing Request" to begin.

### Appeal / Reconsideration Request

**Enter HICN and date of service, member info and date of service information, or subscriber ID and date of service information**

Please enter the information below in support of your request.

**Please enter the following information**

Date of Service (From):	<input type="text" value="01/01/2001"/>
Date of Service (Thru):	<input type="text" value="01/01/2001"/>

AND

**Please enter the field(s) in one of the following sections.**

HICN (Beneficiary Medicare Number):	<input type="text"/>
-------------------------------------	----------------------

OR

Member First Name:	<input type="text"/>
Member Last Name:	<input type="text"/>
Member Date of Birth:	<input type="text" value="01/01/1921"/>

OR

Subscriber ID:	<input type="text"/>
----------------	----------------------

Request was not Found

Proceed to upload documentation

If your request was not found,  
you may enter it manually by clicking:  

Submit Manual Routing Request

Cancel

Click the “Submit Manual Routing Request” button and Manual Routing Request module will open up. Enter the information about the request type, member and date of service then click “Proceed to upload documentation”.

### Appeal / Reconsideration Request

**Manual Routing Request**

Please be advised that you are submitting manual Appeal/Reconsideration request. A team member will review your request within 72 hours if your request is Expedited-PreService appeal. Otherwise, you will receive a reply within 30 days. Please enter one of the following combinations below: a) HICN and dates of service, b) first name, last name, date of birth and dates of service, c) Subscriber ID and dates of service.

Request Type:

Doc\_ID:

Subscriber ID:

HICN (Beneficiary Medicare Number):

Member First Name:

Member Last Name:

Member Date of Birth:

Date of Service (From Date):

Date of Service (Thru Date):

Pre-Service Expedited Appeal

Upload documentation and submit. For more information, see the “Submit Documents” on previous section.

### Appeal/Reconsideration History

User can view all the total numbers of Appeal/Reconsideration document Upload and Most recent upload details via Appeal/Reconsideration history. Clicking on ‘*Appeal Reconsideration History*’ will show all previously uploaded documents by the user.

The Appeal/Reconsideration history section allows the user to update previously uploaded appeals or reconsideration documents. Once a document is uploaded, the provider is given a new confirmation number with a revised date for the date of submission for the appeal/reconsideration.

### Appeal / Reconsideration Upload

**Facility/Provider**

Provider/Facility Name:

Provider Name:

Provider Tax ID:

Provider Email:

Confirmation Email Address:

**Appeal/Reconsideration History**

Click the "Appeal/Reconsideration History" button to see detailed Upload History

**No** Appeals/Reconsiderations were uploaded.



**Appeal Submission History**

Search by Upload Date: From:  To:

Doc ID	Claims ID	Member Name	Member DOB	Uploaded By	Upload Date	Update
XXX	XXXXX	[Redacted]	[Redacted]	[Redacted]	11/04/2013 14:03	<input type="button" value="Update"/>
					11/04/2013 14:03	<input type="button" value="Update"/>
					11/04/2013 14:03	<input type="button" value="Update"/>
					11/04/2013 14:02	<input type="button" value="Update"/>

You can also export the "Appeal Submission History" to excel file by using 'Export to Excel' button.

### Appeal / Reconsideration Request

**Appeal/Reconsideration History**

Search by Upload Date: From:  To:

Doc ID	Claim ID	Member Name	Member DOB	Uploaded By	Upload Date	Type	Confirmation	Update
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	01/08/2014 14:09	RECONSIDERATION	1401080046	<input type="button" value="Update"/>
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	01/08/2014 14:03	APPEAL	1401080045	<input type="button" value="Update"/>
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	01/08/2014 13:55	APPEAL	1401080044	Claim Files have been updated
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	01/08/2014 13:50	APPEAL	1401080043	<input type="button" value="Update"/>
[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	01/08/2014 13:48	APPEAL	1401080042	Claim Files have been updated



## 3.6 Provider News

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The most recent updates/news items will display in this section. The Top 5 most recent news items will display in this panel, and clicking any of these will open the news detail as a PDF document. Clicking the header of the Provider News panel or the Provider News main menu tab will open the public Provider Portal News section in a new browser window and display all news items.

## 3.7 Forms & Guides

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Provides all forms and guides related to Manual & User Guide, Appeals & Reconsideration, Prior Authorization, Claims & Payments, Medical Record Reimbursement, Member & Benefit Information, Part D Claim, Part D Coverage Determination and Redetermination, and Part D Mail Order Form.




<p><b>Manual &amp; User Guide</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Approved Recovery Category</a> Audits can occur 4 years from the initial determination date.</li> <li>• <a href="#">Provider Manual</a> A guide to assist providers and their office staff with providing services to our members, your patients.</li> <li>• <a href="#">Provider Portal User Guide</a> An instructions to the secure provider portal.</li> <li>• <a href="#">EMR Portal Guide</a> How to Guide for navigation of the NEW Electronic Medical Record Submission Portal.</li> <li>• <a href="#">Provider Directory</a> Search providers within Care Improvement Plus provider network.</li> </ul>	<p><b>Prior Authorization</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Provider Preauthorization Form</a> Form to request preauthorization</li> <li>• <a href="#">Provider Authorization Requirements</a> Care Improvement Plus UM Provider Fact Sheet of Auth Rules</li> </ul>
<p><b>Appeals &amp; Reconsideration</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Waiver of Liability</a> Form for Waiver of Liability</li> <li>• <a href="#">Payment Dispute Process for Non-contracted Medicare Providers</a> Form for Claim Payment Dispute Request Form for Non-Participating Providers</li> <li>• <a href="#">Payment Dispute Resolution</a> A guide from Care Improvement Plus regarding the payment dispute resolution process for non-par providers.</li> </ul>	<p><b>Claim &amp; Payment</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Filing State Medicaid Claim</a> A state based instruction for filing claims with Care Improvement Plus for Dual Advantage Plan Members. <a href="#">Select a state</a> ▼</li> <li>• <a href="#">Remittance</a> Learn how to read a Care Improvement Plus Remittance statement.</li> <li>• <a href="#">Non-Contracted Provider Payment Guide</a> A guide from Care Improvement Plus regarding reimbursement for non-contracted providers.</li> <li>• <a href="#">Medicare Advantage Payment Guide</a> A guide from CMS regarding reimbursement by Medicare Advantage (MA) Plans for network and out of network providers.</li> <li>• <a href="#">Voluntary refund submission form</a> Claim to submit refund due to overpayment.</li> </ul>
<p><b>Member &amp; Benefit Information</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Appointment of Representative Form</a> Form to appoint the individual demonstrates legal authority.</li> <li>• <a href="#">Authorization to Release form</a> Form to delegated the authority by submitting to the plan a signed Authorization to release form.</li> <li>• <a href="#">Quick Reference Guide (State base)</a> A State base Benefit Overview information, ie. Copay and plan information. <a href="#">Select a state</a> ▼</li> <li>• <a href="#">Health Plan Benefit Summary</a> State based link to Benefit at a Glance. <a href="#">Select a state</a> ▼</li> </ul>	<p><b>Medical Record Reimbursement</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Medical Record Reimbursement</a> This form is for Post Payment Medical Necessity Medical Record reimbursement.</li> </ul>
<p><b>Part D Coverage Determination and Redetermination</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Coverage Determination Form</a> Form to request prescription drug coverage determinations and exception.</li> <li>• <a href="#">Coverage Determination Instruction</a> Instruction to request prescription drug coverage determinations and exception.</li> <li>• <a href="#">Rx Redetermination</a> Form to request for Medicare Prescription Drug Appeal.</li> </ul>	<p><b>Part D Claim</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Vaccine Claim Form</a> This claim form is for reimbursement of covered Part D vaccines and their administration (injection).</li> <li>• <a href="#">Rx Claim Paper Claim Form</a> Form for filing a claim to request payment.</li> </ul>
	<p><b>Part D Mail Order Form</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Mail Order Form</a> For obtaining prescription drugs by mail.</li> </ul>

- Selecting a state from the state drop-down boxes will display specific information relevant to those states.
- The Forms & Guide section has the new feature listed as *Approved Recovery Category* under the section “Manual and User Guide”.

Hours: 8:00 AM - 8:00 PM 7 days a week | Sales: 1-800-711-1656 | Members: 1-800-204-1002 | Providers: 1-888-879-3119 | TTY: 711

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**CARE IMPROVEMENT PLUS**  
Specialized Care for Medicare Beneficiaries

Hello, rama | [Log Out](#) | [Print](#) | [Help](#) | [V:6.2](#) | [Tutorials](#)

User Name: **ram ramram** | Facility Name: **developer** | TAX ID/NPI:

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[Home](#) | [Member Inquiry](#) | [Claim Center](#) | [Medicaid Info](#) | [Medical Records](#) | [Provider News](#) | **[Forms & Guide](#)** | [Reports](#) | [FAQs](#) | [Contact Us](#)

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**Manual & User Guide**

- [Approved Recovery Category](#)  
Audits can occur 4 years from the initial determination date.
- [Provider Manual](#)  
A guide to assist providers and their office staff with providing services to our members, your patients.
- [Provider Portal User Guide](#)  
An instructions to the secure provider portal.
- [EMR Portal Guide](#)  
How to Guide for navigation of the NEW Electronic Medical Record Submission Portal.
- [Provider Directory](#)  
Search providers within Care Improvement Plus provider network.

**Appeals & Reconsideration**

- [Waiver of Liability](#)  
Form for Waiver of Liability

**Prior Authorization**

- [Provider Preauthorization Form](#)  
Form to request preauthorization
- [Provider Authorization Requirements](#)  
Care Improvement Plus UM Provider Fact Sheet of Auth Rules

**Claim & Payment**

- [Filing State Medicaid Claim](#)  
A state based instruction for filing claims with Care Improvement Plus for Dual Advantage Plan Members. [Select a state](#)
- [Remittance](#)  
Learn how to read a Care Improvement Plus Remittance statement.
- [Non-Contracted Provider Payment Guide](#)  
A guide from Care Improvement Plus regarding reimbursement for non-contracted providers.

- This section provides the information about the Audit Concept, Recovery Type, Claim Type, Implementation Date and Description of the Audit. By using this link, the user can look back over 4 years of review data from the current date.
- The user can also sort the list alphabetically by clicking on a specific column title to change the default order of items listed by Audit Concept, and the *Implementation date* column can be sorted chronologically. To jump to another page, please click on the pagination on bottom of the table. Please refer to the following image.

**Approved Recovery Categories**

<a href="#">Audit Concept</a>	<a href="#">Recovery Type</a>	<a href="#">Claim Type</a>	<a href="#">Implemented On</a>
<a href="#">Acupuncture Paid Claims</a>	Automated	Professional	11/1/2011
<a href="#">Add On Codes for Same Physician</a>	Automated	Professional	12/1/2011
<a href="#">Age Inappropriate Services</a>	Automated	All	12/1/2011
<a href="#">Anesthesia Overpaid Claims</a>	Automated	Professional	10/1/2010
<a href="#">Annual Wellness Visit (AWV) Overpayments</a>	Automated	Professional	6/1/2013
<a href="#">Arthritis Kits</a>	Complex	Professional/DME	11/1/2009
<a href="#">Back Braces with Inappropriate Modifiers</a>	Automated	DME	10/1/2012
<a href="#">Bone Growth Stimulators</a>	Complex	DME	12/1/2011
<a href="#">Claims Billed on HCFA 1500 and UB04</a>	Automated	All	12/1/2011
<a href="#">Cosmetic Surgery Covered Services</a>	Complex	Outpatient/Inpatient/Professional	12/1/2011
<a href="#">CPAP Without Sleep Apnea Test or DX</a>	Complex	DME	12/1/2011
<a href="#">CT &amp; MRI Imaging Procedures With and Without Contrast</a>	Complex	Outpatient/Professional	12/1/2011
<a href="#">Diabetic Shoes</a>	Complex	DME	12/1/2011
<a href="#">Diagnostic Services with no Physician Visit</a>	Complex	Outpatient/Professional	12/1/2011
<a href="#">DME Unlisted Procedure</a>	Automated	DME	1/1/2012
<a href="#">Doctors Working Weekends</a>	Complex	Professional	12/1/2011
<a href="#">E &amp; M Upcoding</a>	Complex	Professional	12/1/2011
<a href="#">E&amp;M Crosswalk</a>	Automated	Professional	12/1/2011
<a href="#">E&amp;M Same Day as Debridement</a>	Complex	Professional	1/1/2013
<a href="#">Emergency Ambulance no Medical Claim</a>	Complex	Ambulance	5/1/2010

1 2 3 4 5

- Click on any of the Audit Concept list links and a new window will open up with the details of the recovery category, along with Policy Related Links (if any exist). To return back to the Approved Recovery Categories list view page, simply click on the close button or the 'X' icon located on the top-right corner of the box.

Approved Recovery Categories

Audit Concept	Recovery Type	Claim Type	Implemented On
<a href="#">Unna Boot</a>	Complex	DME	12/1/2011
<a href="#">Diabetic Shoes</a>	Complex	DME	12/1/2011
<a href="#">Back Braces with Inappropriate Modifiers</a>	Automated	DME	10/1/2012
<a href="#">ESRD Value Code 48 and 49</a>	Automated	ESRD	10/1/2012

**Approved Recovery Category Details** ✕

**Audit Concept** : Observation Billed in Inpatient Setting

**Recovery Type** : Automated

**Claim Type** : Inpatient

**Date Implemented** : 12/1/2011

**Description** : Review inpatient claims where observation charges are billed and paid. Observation charges should be denied when billed in an inpatient setting as the services are included in the inpatient stay.

**Policy Related Links** : <http://www.cms.gov/manuals/Downloads/bp102c08.pdf>  
Medicare Benefit Policy Manual, Section 20.5 - Outpatient Observation Services

[Close](#)

<a href="#">Inpatient Stay with DRG of CHF</a>	Complex	Inpatient	12/1/2011
<a href="#">Inpatient Acute Respiratory</a>	Complex	Inpatient	10/1/2012
<a href="#">Inpatient DRG Nervous System Disorders</a>	Complex	Inpatient	7/1/2012
<a href="#">Inpatient Kidney and Urinary Tract Disorders</a>	Complex	Inpatient	5/1/2012

1 2 3 4 5

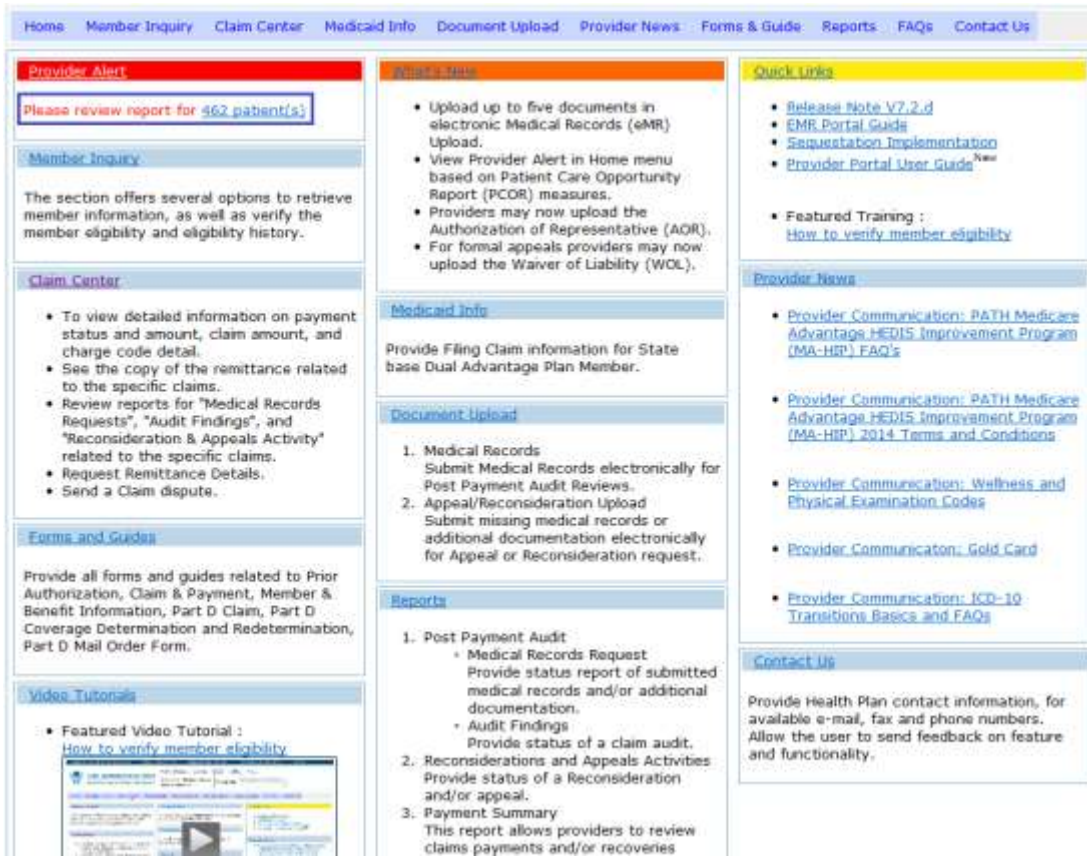
## 3.8 Reports

This page gives the user the ability to view five medical report types: **Medical Records Request, Audit Findings, Reconsiderations and Appeals Activity, Payment Summary and the Stargazer report**. If data is available for these reports, it will display in a lookup table once a report button is clicked.

This page can be accessed from the main menu by clicking the Reports tab, or from the Reports dashboard on the home page.



Providers can also access the **PCOR report** from the main menu by clicking on the patient numbers under the Provider Alert section on the home page. Please review the *Patient Care Opportunity Report (PCOR)* section for more details.



- To access either the Medical Requests or Audit Findings Reports, simply hover over the Post Payment Audit sub-menu field as shown in the picture above. You will then arrive on the Reports search page, with criteria in which to search for reports. A provider user must select one of the Tax ID or NPI numbers they are assigned to in the application first.

Payment Summary Reports

Date Range Search

Tax ID:

Patient Acct # :

Check Ref Id :

Date of Service Range 
  Paid Date Range

From :

To:

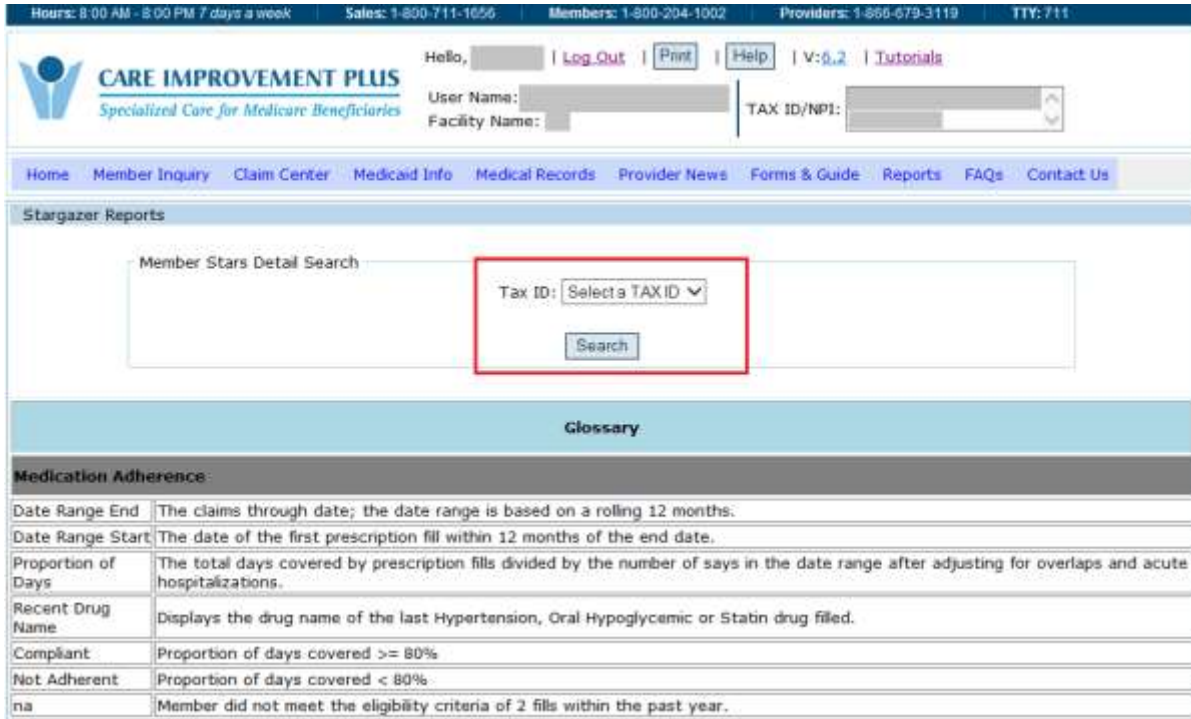
Payment Summary

Current Check Ref Id	Provider Tax Id	Current Patient Acct #	Check #	Gross Check Amount	Recovered This Check	Net Check Amount	Check Paid Date	Current Claim #	Current Member Id	Current Member Name	Current Patient #
				112.6500	0.0000	112.6500	04/02/2007				
				112.6500	0.0000	112.6500	04/02/2007				
				112.6500	0.0000	112.6500	04/02/2007				

- The Payment Summary Report is a unique report type that allows you to search by a specific Patient Account number or Check Reference ID, along with the Tax ID or NPI number. Users must also select a date range, either by the Date of Service or by date the check was processed and paid for.
- Users have the option to export and save the information into an Excel document. The data is displayed in the excel sheet by table column and in the same order as it appears within the application.



**Stargazer Report:** The Provider Portal will display any members which are assigned to their office, and each member will have a column for a specific measure. Based on the contents of each column will determine the action required for each member. Provider user can search the Member Stars Detail by selecting the associated TAX ID or NPI and then clicking on the *Search* button.



Hours: 8:00 AM - 8:00 PM 7 days a week | Sales: 1-800-711-1656 | Members: 1-800-204-1002 | Providers: 1-866-679-3119 | TTY: 711

Hello, [User] | [Log Out](#) | [Print](#) | [Help](#) | V: 0.2 | [Tutorials](#)

User Name: [User] | Facility Name: [User] | TAX ID/NPI: [User]

Home | Member Inquiry | Claim Center | Medicaid Info | Medical Records | Provider News | Forms & Guide | Reports | FAQs | Contact Us

**Stargazer Reports**

Member Stars Detail Search

Tax ID: Select a TAX ID ▼

**Glossary**

Medication Adherence	
Date Range End	The claims through date; the date range is based on a rolling 12 months.
Date Range Start	The date of the first prescription fill within 12 months of the end date.
Proportion of Days	The total days covered by prescription fills divided by the number of days in the date range after adjusting for overlaps and acute hospitalizations.
Recent Drug Name	Displays the drug name of the last Hypertension, Oral Hypoglycemic or Statin drug filled.
Compliant	Proportion of days covered $\geq$ 80%
Not Adherent	Proportion of days covered $<$ 80%
na	Member did not meet the eligibility criteria of 2 fills within the past year.

If a member is Non-Compliant that indicates the member has not received the required screening or test for that required measure. If a member is listed as Compliant, the member has met all requirements and requires no action. If a “-” or “na” is listed the member does not qualify for that measure and does not require and action. User can find the *Glossary* on bottom of the table for detailed explanation about the terms.

- User can scroll the report horizontally through the scrollbar and also jump to another page by clicking on the page number located below the table. Another feature under the *Stargazer Summary* is *Export to Excel*. This button allows you to save and print an excel spreadsheet of members you received in your Search Results.

**Stargazer Summary**


Member Details			Hypertension (RAS)				Diabet	
Subscriber ID	Member Name	DOB	Status	Proportion of Days Covered	Recent Drug Name	Status	Proportion of Days Covered	
			Not Adherent	59.26 %	Lisinopril Tab 20 MG	na		
			na			Adherent	99.65 %	
			na	100.00 %		na		
			na			na		
			na			na		
			Adherent	87.50 %	Fosinopril Sodium Tab 40 MG	na	100.00 %	
			Adherent	98.36 %	Losartan Potassium & Hydrochlorothiazide Tab 50-12.5 MG	na	9.84 %	
			Adherent	90.04 %	Lisinopril Tab 10 MG	na		
			Adherent	100.00 %	Benazepril HCl Tab 20 MG	Adherent	100.00 %	
			na			Adherent	95.05 %	
			na	13.16 %		na		
			Adherent	96.88 %	Lisinopril Tab 10 MG	na		
			Not Adherent	65.69 %	Lisinopril & Hydrochlorothiazide Tab 20-25 MG	Not Adherent	76.64 %	
			Adherent	96.53 %	Quinapril HCl Tab 40 MG	na		
			Adherent	93.75 %	Ramipril Cap 10 MG	Adherent	100.00 %	
			na			na		
			Adherent	95.24 %	Losartan Potassium Tab 50 MG	Not Adherent	70.45 %	
			Adherent	95.22 %	Benazepril & Hydrochlorothiazide Tab 20-25 MG	Adherent	85.20 %	
			na			na	9.80 %	
			Adherent	93.44 %	Benazepril HCl Tab 20 MG	Adherent	100.00 %	

1 2 3 4 5 6 7

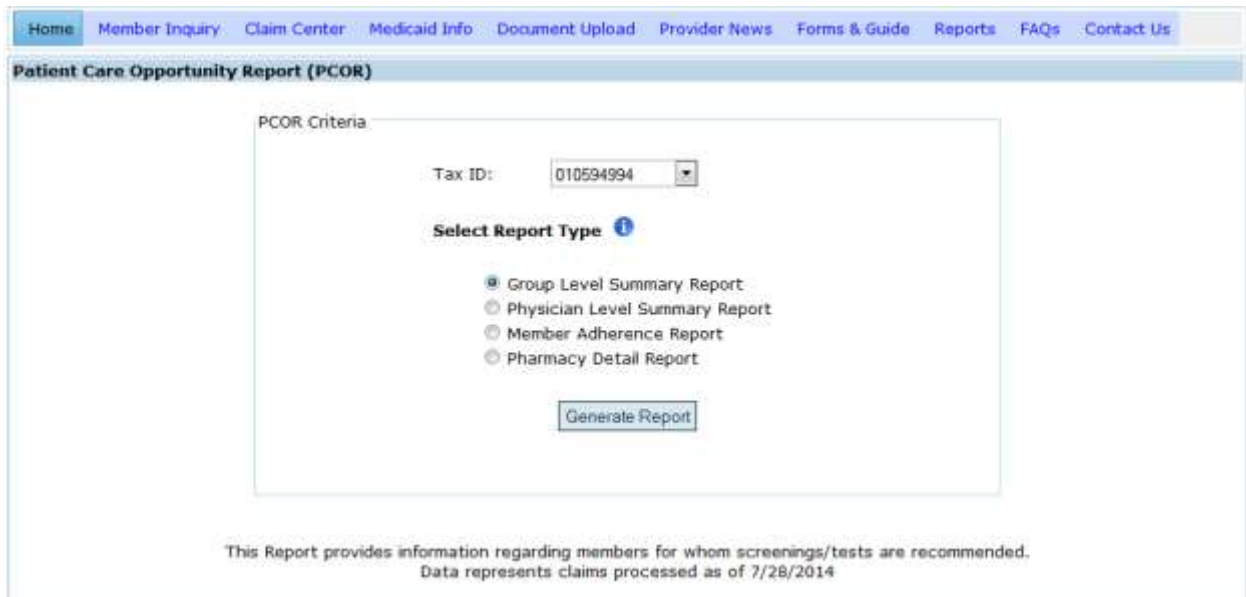
Glossary

**Patient Care Opportunity Report (PCOR):**

Patient Care Opportunity Report for CIP members provides information regarding members where screenings or tests are recommended. User can access four different types of reports under PCOR.

1. Group Level Summary Report
2. Physician Level Summary Report
3. Member Adherence Report
4. Pharmacy Detail Report





User can select the Tax ID and report type and click on generate report. These reports can be export to excel sheet by using 'Export to Excel' button located on top right corner of each report. This button allows you to save and print an excel spreadsheet of members you received in your Search Results. User can also view the High-Risk Medication Alternatives and glossary for this report, located at top left corner of the each report.

User can scroll the report horizontally through the scrollbar and also jump to another page by clicking on the page number located below the table.

- **Group Level Summary Report**

Summarizes by group (TIN) the number of members for each recommended HEDIS measure. Additionally, current and prior reporting period compliance as well as current STAR rating is provided. Quality Outcomes and Clinical Performance represent performance based on HEDIS and/or STAR specifications.

Group Level Summary

[HRM Rx Alternatives](#)  
[Glossary](#) [Export to Excel](#)

### Group Level Summary Report

Total Physicians: 2      Total Patients: 257      Total Open Care Opportunities: 114

The following data shows metrics for HEDIS measures that indicate a potential care opportunity.  
Metrics include Medicare members specific to [redacted].

Quality Measure	Relevant Patients	Open Care Opportunities	% Non-Adherent	% Adherent	% Adherent Prior Reporting Period	Adherence Trend	Quality Rating	% Adherence Target
C01-Breast Cancer Screening	7	3	42.86 %	57.14 %	100.00 %	↓	2	74.00 %
C02-Colorectal Cancer Screening	20	13	65.00 %	35.00 %	41.67 %	↓	1	58.00 %
C03-Cardiovascular Care - Cholesterol Screening	2	0	0.00 %	100.00 %	50.00 %	↑	5	85.00 %
C04-Diabetes Care - Cholesterol Screening	20	2	10.00 %	90.00 %	65.00 %	↑	4	85.00 %
C05-Glaucoma Testing	11	6	54.55 %	45.45 %	50.00 %	↓	2	70.00 %
C14-Osteoporosis Management in Women	1	1	100.00 %	0.00 %	0.00 %	→	1	60.00 %

This report displays important information about total number of physicians within the provider group assigned (or attributed) as the PCP for a member, and total number of members with an assigned PCP that is part of the provider group (Total Patients). This report also gives detail summary of number of Patients for relevant Quality Measures, open care opportunities, Non Adherent and Adherent percentage, Prior Adherent Reporting Period percentage, Adherent Trend, Quality Rating and Adherence Target percentage.

- **Physician Level Summary Report**

Summarizes by physician (MPIN) the number of members for each recommended HEDIS and Part D measure. Additionally, the number of members eligible for the screening as well as current and prior reporting period compliance is shown. Quality Outcomes and Clinical Performance represent performance based on HEDIS and/or STAR specifications.

Physician Level Summary

[HRM Bx Alternatives](#)  
[Glossary](#) Export to Excel

**Physician Level Summary Report**

Total Physicians: 2      Total Patients: 257      Total Open Care Opportunities: 114

The following data shows metrics for HEDIS measures that indicate a potential care opportunity.  
Metrics include Medicare members specific to [REDACTED]

Physician Name	Quality Measure	Relevant Patients	Open Care Opportunities	% Non-Adherent	% Adherent	% Adherent Prior Reporting Period	Adherence Trend	Quality Rating	% Adherence Target
[REDACTED]	C01-Breast Cancer Screening	7	3	42.86 %	57.14 %	100.00 %	↓	2	74.00 %
[REDACTED]	C02-Colorectal Cancer Screening	20	13	65.00 %	35.00 %	41.67 %	↓	1	58.00 %
[REDACTED]	C03-Cardiovascular Care - Cholesterol Screening	2	0	0.00 %	100.00 %	50.00 %	↑	5	85.00 %

This report displays following key fields:

**Relevant Patients:** All members assigned or attributed to a physician in the group that have at least one open or closed care opportunity for any of the HEDIS and Part D metrics identified on the Member Compliance Report.

**Quality Rating:** A calculated field showing current adherence for that metric for that group based on the 2012 CMS STAR Rating thresholds.

**Open Care Opportunities:** Displays the total of gaps in care for the HEDIS measures and Pharmacy current year gaps as defined by the alert levels on the Member Adherence Report where: R= Gap; Y=Gap; and G= No Gap.

Physician Level Summary Report also displays the detailed information for Physician Name, Quality Measures, Relevant Patients, Open Care Opportunities, Non Adherent and Adherent percentage, Prior Adherent Reporting Period percentage, Adherent Trend, Quality Rating and Adherence Target percentage.

- **Member Adherence Report**

Summarizes care opportunity data by physician (MPIN) each HEDIS and Part D measure.

Member Adherence

[HRM Rx Alternatives](#) Export to Excel  
[Glossary](#)

**Member Adherence Report**

According to our records, the following patients have been identified as having care opportunities for preventive services for selected quality indicators, based on the nationally recognized HEDIS performance measurement set. Please check your records to validate the information, and if the patient needs these or other services, we would appreciate you performing those services. We understand that some of the patients may require more than one visit to meet the required preventive care. We hope you find this information useful and appreciate the care you provide to your patients who are [redacted] members. This report includes patient care opportunities for [redacted] members who meet criteria for healthcare services specific to evidence-based quality indicators and include patients who may be soon due or overdue for care.

Blank	Not eligible for the measure.	GM	On track for adherence.
-	Adherent for the measure.	YM	At risk for being non-adherent.
X	Not adherent for the measure.	RM	Not adherent.

\*\*Part D measures only    \*\*\*Medication adherence measures only    99%\*\*\* PDC value is displayed for prior year adherence, red font indicates non-adherence.

Physician	New/ Existing Patient	Member First Name	Member Last Name	Member ID	Member DOB	Member Phone	Care Score	Last Wellness Exam	Seen by this Physician	C01- Breast Cancer Screening	C02- Colorectal Cancer Screening	C03- Cardiovascular Cholesterol Screening
[redacted]	E	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1 6	11/4/2013	Y		X	-
[redacted]	E	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3 6	7/2/2014	Y	X	-	-
[redacted]	E	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3 7	6/16/2014	Y		-	-
[redacted]	E	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1 0	5/21/2014	Y		-	-
[redacted]	E	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	4 4	6/9/2014	Y	-	-	-

This report has following key fields:

**Member ID:** The number found on the member's identification card. For some dual eligible members, the field may be blank.

**Care Score** is a Care Improvement Plus calculation which uses a combination of a measure's adherence status and the weight of the HEDIS and/or pharmacy measure for each relevant member. Its purpose is to quantify the care needed for each member based on CMS guidelines.

**Last Wellness Exam:** Displays date that this member had a wellness exam although not necessarily with the physician to which the member is currently assigned. Last Wellness Exam will be determined by the most recent claim with the following procedure codes:

- ICD-9-CM Diagnosis Codes: V70.0, V70.8, V70.9
- HCPCS codes: G0402, G0438, and G0439
- CPT Codes: 99385-99387 and 99395-99397

This report also displays the detailed information about Physician, Patient type (New/Existing), Member details, Care score, Last wellness Exam and different quality measures for that member.

- **Pharmacy Detail Report**

Provides objective member specific information including drug name(s), dates prescriptions were last filled, Prescriber and Pharmacy information. This report may be used to proactively close gaps.

Pharmacy Detail

[HRM Rx Alternatives](#) [Glossary](#) Export to Excel

Pharmacy Detail Report

According to our records, the following patients have been identified as having care opportunities for preventive services for selected quality indicators, based on the nationally recognized HEDIS performance measurement set. Please check your records to validate the information, and if the patient needs these or other services, we would appreciate you performing those services. We understand that some of the patients may require more than one visit to meet the required preventive care. We hope you find this information useful and appreciate the care you provide to your patients who are [REDACTED] members. This report includes patient care opportunities for [REDACTED] members who meet criteria for healthcare services specific to evidence-based quality indicators and include patients who may be soon due or overdue for care.

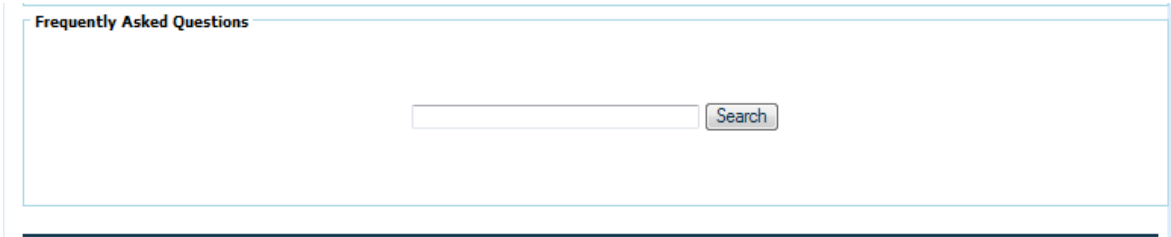
Blank	Not eligible for the measure	G <sup>SM</sup>	On track for adherence
-	Adherent for the measure	Y <sup>SM</sup>	At risk for being non-adherent
X	Not adherent for the measure	R <sup>SM</sup>	Not adherent

\*\*Part D measures only. \*\*\*Medication adherence measures only. SM\*\* PDC value is displayed for prior year adherence, red font indicates non-adherence.

Physician	Member First Name	Member Last Name	Member ID	Member DOB	Member Phone	Seen by this Physician	D11 - High Risk Medication Prior Year Result	D11 - High Risk Medication Current Year Status	D11 - Most Recent High Risk Medication (5) with Prescriber Information	D12 - Diabetes Treatment Prior Year Result
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	Y	X	Y	Drug Name: Digox 125 MCB Prescriber: [REDACTED] Prescriber Phone: [REDACTED] Last Fill Date: 3/20/2014	-
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	Y	X			
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	Y	X			-

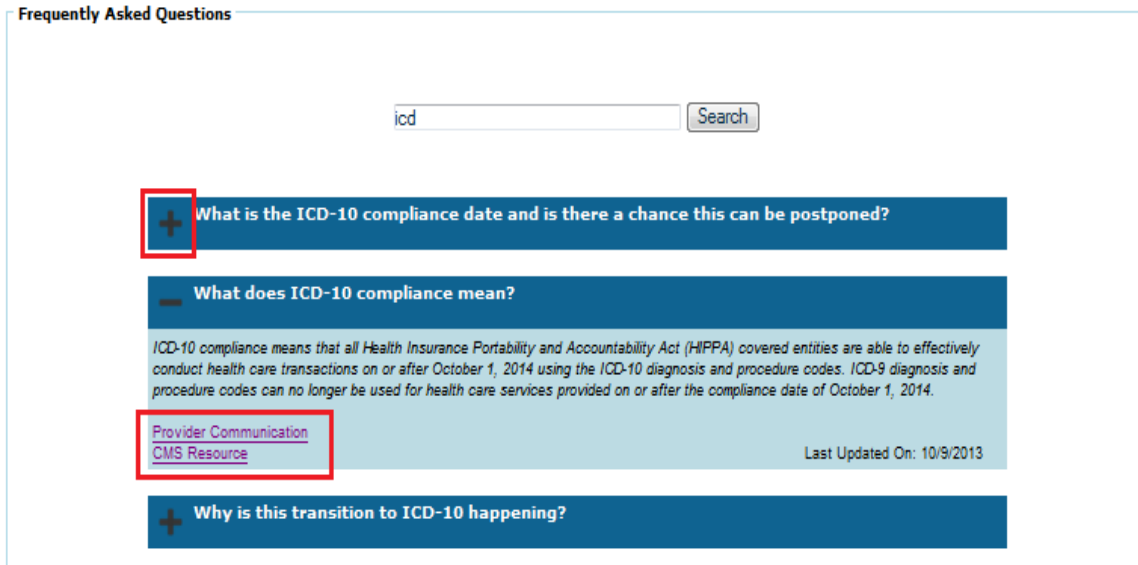
## 3.9 FAQs

This section provides information pertaining to any questions the user may have. This is a key-word-driven search engine.



Frequently Asked Questions

Type the question or keyword (Minimum 3 characters) in the search text box field and all the information related to search field will be shown under the search option. The question can be expanded by clicking on '+' icon to find the related answer. It also contains related links such as 'Provider Communication' and 'CMS Resource'. Related information can be found by clicking on any of this links. The user can also find the last updated information on bottom right corner of the answer.



Frequently Asked Questions

**+** What is the ICD-10 compliance date and is there a chance this can be postponed?

**-** What does ICD-10 compliance mean?

*ICD-10 compliance means that all Health Insurance Portability and Accountability Act (HIPPA) covered entities are able to effectively conduct health care transactions on or after October 1, 2014 using the ICD-10 diagnosis and procedure codes. ICD-9 diagnosis and procedure codes can no longer be used for health care services provided on or after the compliance date of October 1, 2014.*

[Provider Communication](#)  
[CMS Resource](#)

Last Updated On: 10/9/2013

**+** Why is this transition to ICD-10 happening?

## 3.10 Contact Us

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This page provides Health Plan contact information related to claims submission, Appeals, Inpatient Hospital Admission Authorization, Eligibility Inquiry and Web Portal Support such as e-mail, fax, TTY and phone numbers.



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## 4 Tutorials

This section provides the tutorial videos about the different functions of the portal and helps user to understand how to navigate the system and use its specific features. The tutorials section can be access through the *Tutorials* tab on upper right corner of the portal.



The user can find video tutorials on the following topics:

- How to self-register
- How to verify member eligibility
- How to search claims and viewing claim details
- How to dispute a claim
- Medical Records Upload
- How to request a remit if one is not immediately available
- How to view forms and guides
- How to view provider news
- How to verify post payment audit
- Appeal and Reconsideration Upload



The user can also access the Self-Registration *Tutorial* through the Log In page.



**Login Information**

Please enter your username and password.

**Username:**

**Password:**

Did you forget your password? [Click here](#)


Welcome to the Care Improvement Plus **Provider Portal**.

Whether you are a Participating or Non-Participating Provider, you can access the Provider Portal.

If you want to register as a new user please click

To access the tutorial videos, click on *Tutorial* link and the page with tutorial videos will open up.

Click on the video icon or the video topic to play the video. The video will be played in a new

window after clicking on the  icon.

User Tutorials

- [How to self register](#)



- [How to request a remit if one is not immediately available](#)



- [How to verify member eligibility](#)



- [How to view forms and guides](#)



- [How to search claims and viewing claim details](#)



- [How to view provider news](#)



- [How to dispute a claim](#)



- [How to verify post payment audit](#)



- [Medical Records Upload](#)



- [Appeal and Reconsideration Upload](#)



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## 5 Disclaimer

- Care Improvement Plus has made every effort to ensure that this User's Manual is accurate and up to date. Care Improvement Plus disclaims liability for any inaccuracies or omissions that may have occurred and makes no commitment to keep the information update or current.
- Information in this manual is subject to change without any prior notice. No part of this manual shall be assumes any liability to the users.
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----- **End of the Document** -----