MedHOK®
Provider Portal
User Guide

Submitting inpatient
notifications and
prior authorization
requests for:
*Tufts Health Together* and
*Tufts Health Direct*
Background

On August 21, 2017, inpatient notifications and prior authorization requests for outpatient services, for Tufts Health Direct and Tufts Health Together plan members, should be entered in the MedHOK online tool through Tufts Health Provider Connect. Inpatient notifications and prior authorization requests for Tufts Health Unify plan members should be entered in the Tufts Health Provider Connect website.

For medications covered under the member’s pharmacy benefit, providers should continue to submit prior authorization requests through the current channels.

The MedHOK tool is best viewed in Mozilla Firefox or Google Chrome and might not display or function properly with other web browsers (e.g., Internet Explorer). We recommend upgrading your browser to the latest version of Firefox or Chrome.

For questions about using the MedHOK online tool, call Tufts Health Public Plans Provider Services at 888.257.1985.

More information about notification and prior authorization requirements

Refer to Chapter 4D of the Tufts Health Public Plans Massachusetts Provider Manual for prior authorization and notification requirements for hospital admissions, outpatient procedures, and ancillary and other services.
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Access the MedHOK Provider Portal through Tufts Health Provider Connect

Enter your User ID and password to login
Next, choose Submit Inpatient/Outpatient Authorization Requests for *Tufts Health Together & Tufts Health Direct Members*

Click on **Search Providers** to access the search input screen

The requesting provider field is mandatory in order to complete an inpatient admission or outpatient precertification. This field will auto-populate the requesting provider name in the THP medical management system's website, MedHOK.

Tips:
1. Only Name OR NPI/Provider ID/UPIN is required.
2. In the name search, please search by last name only.

Click on "Search Providers" below:
You will be prompted to enter the requesting provider’s name or NPI, provider ID, or UPIN to access the MedHOK medical management system.
The selected provider will be added to the **Requesting Provider** screen. Click **Submit** to continue.

Once you click **Submit**, a new screen will inform you that you are being redirected to the MedHOK medical management website. Click **Yes** to continue.
Access the member’s information

In the Search for Member screen, enter the member’s first name, last name, date of birth and member ID number. (All fields are required.) Then click Search.

In the Member Search Results screen, locate the member’s Eligible status line and click Select in the Action column of that line.
The next screen will display the member’s information at the top.

If the Member Eligible button at the top right-hand side of the member information screen is red with a past date next to it, you selected an Action with Not Eligible in the Status field.

You can view the Member’s Eligibility History by clicking on the Member Eligible button, regardless of the color (red or green).
To submit an inpatient notification or a request for prior authorization

Begin by entering information in the fields below the member information banner. All fields marked with an asterisk (*) are mandatory and must be completed to submit your request.

General Request Information

- **Select Authorization Urgency** defaults to Standard. Click the Expedited radio button only if your authorization requires expedited review.

- The **Requesting Provider, Specialty** and **Provider Status** fields will automatically populate based on the credentials the provider used to log in.

- Enter the **Contact Name, Phone Number** and **Fax Number** for the requesting provider. (These fields are required.) Phone and fax numbers should be entered in the format xxxxxxxxxx (no hyphens).

- **Requesting Provider Same as Servicing Provider** defaults to No. Select Yes only if the servicing and requesting provider are the same.

- Select a **Request Type** (Inpatient or Service Request).

- Select a **Place of Service**.
Inpatient notifications

- For an inpatient notification request, select Inpatient in the Request Type field.
- For Place of Service, select 21-Inpatient Hospital.

Several additional fields will appear. Note that Bed Type, Request Admit Date, Admit Type and Review Type fields are marked with an asterisk and are required:

- Select a Bed Type from the options in the drop-down list:
  - If the Admit Type is scheduled, select Surgical bed type.
  - If the Admit Type is urgent/emergent, select Medical bed type.

- In the Request Admit Date field, enter the requested admission date (in mm-dd-yyyy format).
- In the Admit Type field, select whether the admission is Scheduled or Urgent/Emergent.
- For Review Type, select either Initial Review or Observation:

Tufts Health Public Plans requires prior authorization for in-network observation services exceeding 48 hours, and for all non-preferred in-network and out-of-network observation services. For more information, see the Tufts Health Public Plans Observation Services Payment Policy.
Prior authorization requests

For a prior authorization request, select Service Request in the Request Type field.

- For Review Type, select Prospective or Retrospective.
- Select a Place of Service (either 11-Office or 22–On campus–Outpatient Hospital).

Enter servicing and facility provider information

- Click the Add Servicing/Facility Provider button

The Search for Servicing Provider or Facility screen will appear
• Enter the provider or facility information in this screen. One of the following is required in a search for a servicing provider or facility:
  • NPI or
  • Provider ID or
  • Federal Tax ID or
  • First name, last name and state or
  • Organization and state
(Although not mandatory, other fields can be used to further narrow your search.)
• **Type** is also required. Select **Servicing Provider, Facility** or **Additional Provider** from the drop-down list:

![Type dropdown list](image)

• When the provider/facility information has been entered, click the **Search** button.
• If multiple search results are obtained (e.g., more than one practice address for the same NPI), click **Select** in the **Action** column for the appropriate provider. For example, to choose the contracted provider in the following results, click **Select** in that line:

![Search results table](image)
• Once selected, a pop-up will appear that will ask you for the fax number of the Servicing Provider or Facility. The acceptable formats are ###-###-#### or #######-####.

The selected provider’s information will be added to the request:

To change the servicing provider, click Remove in the Action column and then click Add Servicing/Facility Provider to begin another search.

Enter diagnosis information
As indicated by the asterisk, a diagnosis is required in order to submit a request.

• To add a diagnosis to the request, click the Add Primary Diagnosis button:
- The **ICD Search** screen will appear. Enter a complete or partial ICD-10 diagnosis code or a partial code description and click **Search**:

![ICD Search Screen]

- If multiple search results are obtained (e.g., a partial code search returns more than one code), click **Select** in the **Action** column for the appropriate code. In the example below, a search for ICD-10 code “G03” returned multiple codes beginning with “G03.” To add code G03.2 to the service request, click **Select** in the **Action** column next to that code:

![ICD Search Results Screen]

- To change the diagnosis, click **Remove** and then click the **Add Primary Diagnosis** button to begin another search.

- To add an additional diagnosis to the request, click the **Add Diagnosis** button.
Enter procedure information

- In the **Procedure** section, click the **Add Procedure** button:

  ![Add Procedure button](image)

- The **CPT/HCPCS Search** screen will appear. Enter a complete or partial CPT, HCPCS, or ICD-10 procedure code or a partial procedure description, and click **Search**. In the **CPT/HCPCS – Search Results** section, click **Select** in the **Action** column next to the appropriate code. In the example below, a search for code 34830 returned one result. Click **Select** in the **Action** column to add that code to the request:

  ![Select button](image)

- Selecting a procedure code opens a screen for entering additional information about the requested procedure. Both **Quantity** and **Units** are required.
  - Enter a **Quantity** in that field.
  - Select the appropriate **Units** from the drop-down list. Then click **Submit**:  
    ![Submit button](image)
## CPT/HCPCS Information

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34830</td>
<td>Open Acetabular Prosth Respr</td>
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</table>

<table>
<thead>
<tr>
<th>Short Description</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Quantity:</th>
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<th>Frequency</th>
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<table>
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<th>End Date</th>
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</thead>
<tbody>
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<td>06-19-2017</td>
<td>09-17-2017</td>
</tr>
</tbody>
</table>

Modifier 1 Description (if applicable)

Modifier 2 Description (if applicable)

[Submit]
Submitting the request

After entering servicing provider, diagnosis and procedure information (and any additional information for PT, GI/endoscopy or home health care services), click Submit.

Clinical documentation is needed in most circumstances. Please attach your clinical information here.

Additional documentation

The next screen will offer the option to upload additional documentation to support your request, if necessary.

- To include additional documents, click Add Documents.

- Click the Browse button and navigate to and select the document to be included in your request. Then click Upload Document.

- If no additional documentation will be included with your request, click Submit.
Once you have submitted your authorization request, a screen will display the status of the submitted authorization.

This screen also includes buttons to begin creating another authorization for the same member or an authorization for a different member.
Assessments for PT/OT, GI/endoscopy and home health care services

If authorization is requested for certain physical therapy/occupational therapy, GI/endoscopy or home health care services, additional information will be requested when a code for those services is submitted.

Physical therapy/occupational therapy

- If a PT or OT procedure code is submitted, the Medicaid PT/OT screen will appear. For Type of service requested, select either Physical Therapy or Occupational Therapy from the drop-down list. Then confirm whether the member has used 11 visits and click the Submit button to submit the request.

- For more information on coverage for PT/OT services, refer to the Tufts Health Public Plans Medical Necessity Guidelines: Habilitative Services for Physical Therapy, Occupational Therapy and Speech Therapy.

If the member has used 11 visits, the screen below will be displayed when the request is submitted.

If the member has not used 11 visits, prior authorization is not required. When the request is submitted, the status screen will show that the authorization request has been voided and that prior authorization is not required.
GI/endoscopy

If prior authorization is requested for a GI/endoscopy procedure code, the **Upper GI/Endoscopy Assessment** screen will appear.

In this assessment, you will be asked to select the member’s clinical scenario. More than one option can be selected by holding the Ctrl key down. You will then be asked to provide information specific to the selected scenario(s).

Clinical information requested for each scenario corresponds to the coverage criteria described in the [Medical Necessity Guidelines: Upper GI Endoscopy: Certain Elective Procedures](#).

When the member’s clinical scenario has been selected and the appropriate information has been entered, click **Submit**.

The status screen will show that the authorization request is complete, and that the request for coverage of the procedure has been approved.
Home health care

If a procedure code for home health care services is submitted, the THPP Homecare Assessment screen will appear. Questions in this assessment correspond with the coverage criteria described in the Tufts Health Public Plans Medical Necessity Guidelines: Home Health Care Services.

You will first be asked if daily visits are required, and then whether the member has received home care services for the previous six months.

If daily home care visits are not required and the member has not received home care services continuously for the past 6 months, the screen will show that no authorization is required.

When the request is submitted, the status screen will show that the authorization request has been voided and that prior authorization is not required.
**Viewing authorizations**

There are two options to view authorizations by a provider:

- From the *Tufts Health Provider Connect* portal, log in with the provider’s username and password
- If completing an authorization request, click on **Create Auth for different** member.

In the **Search for Member** screen, click **View Authorizations** in the left menu.

The next screen will display all submitted authorizations for the provider and summary information for each authorization.

- Click on any column heading that has an up/down arrow (e.g., date submitted, authorization number, patient name, etc.) to order authorizations by that heading.
- Use the **Show** drop-down list to select the number of entries to display.
• Click a blue authorization number link in the **AUTH#** column to display details of that authorization.

The **Member Auth Details** screen will display a summary of the authorization review at the top and the following information:

- The requesting provider
- Diagnosis
- Servicing provider
- Requested procedure(s)
- Any submitted supporting documentation, and
- Any correspondence related to the request
If prior authorization is not required, the **Authorization Review** screen will show that the request was voided and the reason: