IDAHO DEPARTMENT OF
HEALTH & WELFARE

Trading Partner Account (TPA) User Guide

for

State of Idaho MMIS

gainwell

Date of Publication: 09/20/2024
Document Number: RF019
Version: 21.0

Table of Contents

Table of Figures

1. Trading Partner Account (TPA) Introduction

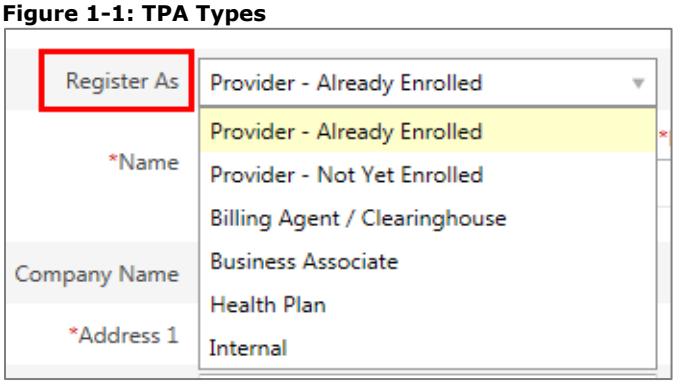
This user guide is to assist providers with using the secure portion of the Idaho Gainwell Technologies Medicaid website.

1.1. TPA Types

Each TPA type has access to different parts of the secure website based on how the account was registered (Figure 1-1). For more information about registering for a TPA and account maintenance, see the *Trading Partner Account Registration and Maintenance User Guide* on www.idmedicaid.com.

- **Provider – Already Enrolled**: Providers who are already enrolled with Idaho Medicaid.
- **Provider – Not Yet Enrolled**: Providers who are not yet enrolled with Idaho Medicaid. TPA registration is required before completing the Idaho Provider Enrollment Application.
- **Billing Agents**: Entities contracted by providers to create and manage the submission of the claims and related transactions for the providers.
- **Clearinghouse:** Entities who contract with providers to aggregate Electronic Data Interchange (EDI) transactions from multiple providers.
- **Health Plan**: Organizations that only need to verify or exchange Electronic Protected Health Information (EPHI) using EDI/X12 transactions.
- **Business Associate**: Non-medical providers, such as transportation services, that only need to exchange Electronic Protected Health Information (EPHI) using EDI/X12 transactions.
- **Internal**: Internal TPA types are not available for use by providers.

Figure 1-1: TPA Types



1.2. TPA Type Access

Each type of TPA account will have designated access levels to the TPA Idaho Gainwell Technologies Medicaid website (Figure 1-2).

Figure 1-2: TPA Access

Secure Menu Item	Provider Already Enrolled	Provider Not Yet Enrolled	Billing Agent	Clearing-house	Health Plan	Business Associate
Manage Users	X	X	X	X	X	X
Reset Password	X	X	X	X	X	X
User Status	X	X	X	X	X	X
Manage Providers	X	X	X	X		

Secure Menu Item	Provider Already Enrolled	Provider Not Yet Enrolled	Billing Agent	Clearing-house	Health Plan	Business Associate
Manage Billing Agents	X					
Account Information	X		X	X	X	X
EDI Certification Status	X		X	X	X	X
Provider Enrollment	X	X				
X12 Upload	X		X	X	X	X
X12 Archive Search	X		X	X	X	X
X12 Responses	X		X	X	X	X
Claim (837)	X		X	X	X	X
Claim Status (276)	X		X	X	X	X
Eligibility (270)	X		X	X	X	X
Finance (835, 820)	X		X	X	X	X
Services Review (278)	X		X	X	X	X
Reports	X		X	X	X	X
Remittance Advice (pdf)	X				X	X
Claims in Process	X		X	X	X	X
Healthy Connections Roster	X		X	X	X	X
View Authorizations	X		X			
View & Submit Claims	X		X			
Verify Member Eligibility	X		X		X	
View Patient Roster	X		X			
View & Submit LTC Case	X		X			
View PCP Roster	X		X			
View Payment Detail	X		X			
View & Submit Referrals Submission	X		X			

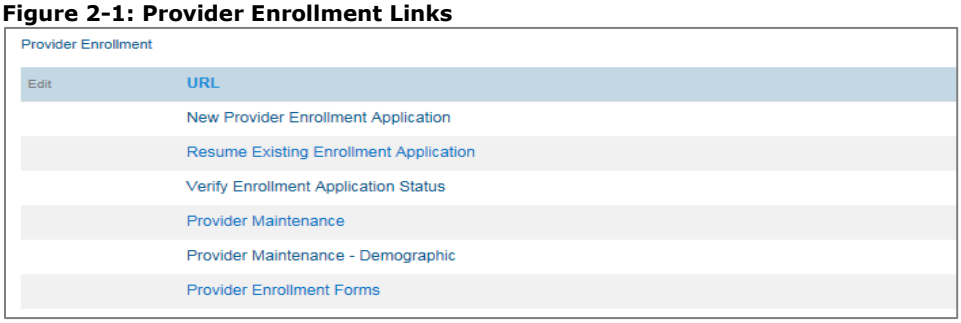
2. Registering a New TPA

See the *Trading Partner Account Registration and Maintenance User Guide* located on www.idmedicaid.com.

2.1. Provider Enrollment

The **Provider Enrollment** link is available **only** to users registered as a *Provider – Already Enrolled* or a *Provider – Not Yet Enrolled*. The *Provider Enrollment* screen displays a list of links to the Provider Enrollment application and the Provider Maintenance Forms. For more information on submitting provider enrollment and maintenance, refer to the Provider Enrollment User Guides at the **User Guides** link under **Reference Material**.

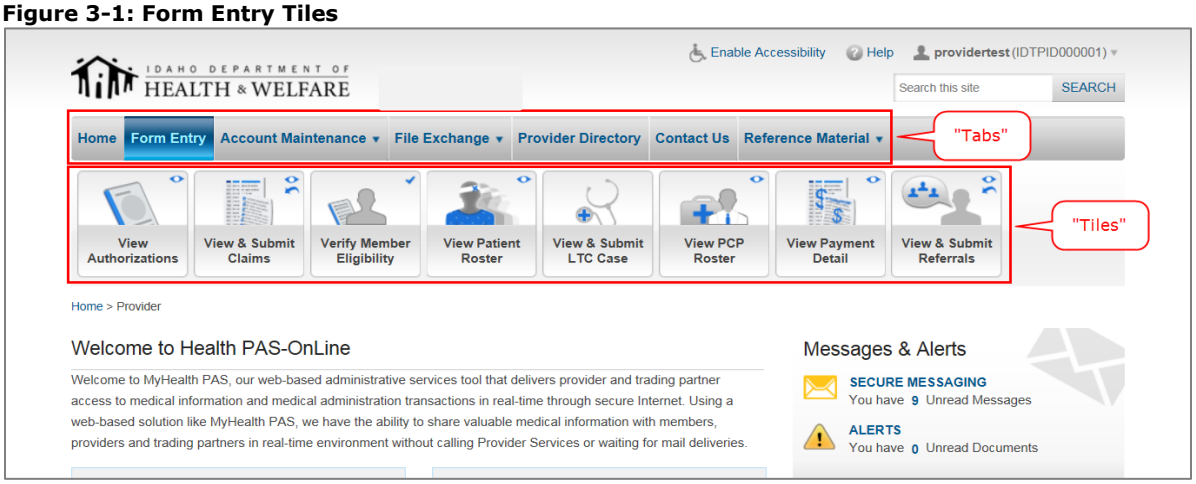
Figure 2-1: Provider Enrollment Links



3. Form Entry

The Form Entry tiles allow you to verify eligibility, submit and edit claims, maintain patient rosters, submit referrals, submit LTC cases, and view the status of authorizations, referrals, claims, and LTC cases. These functions are discussed in detail in this user guide.
Note: Please ensure pop-ups are enabled for this site.

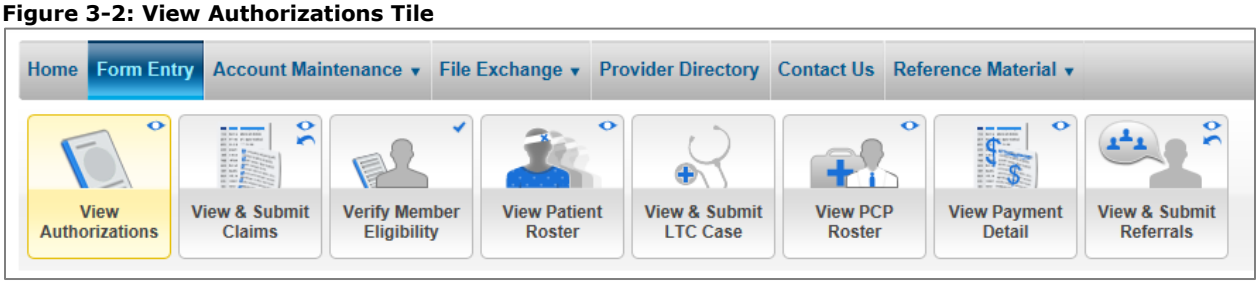
Figure 3-1: Form Entry Tiles



3.1. View Authorization Status

Access the **View Authorizations** tile under the **Form Entry** tab.

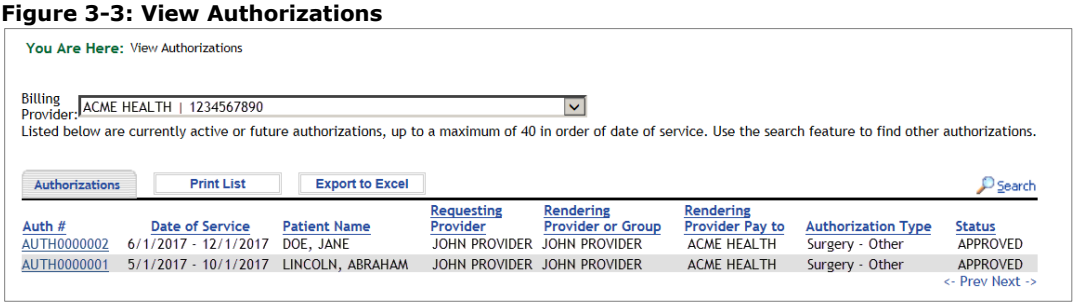
Figure 3-2: View Authorizations Tile



This screen displays the most recent 40 authorizations. To view additional authorizations, the user may search for authorizations by billing provider (Figure 3-3). Select the billing provider from the drop-down. This information will be auto-populated if there is only one billing provider associated to the TPA.

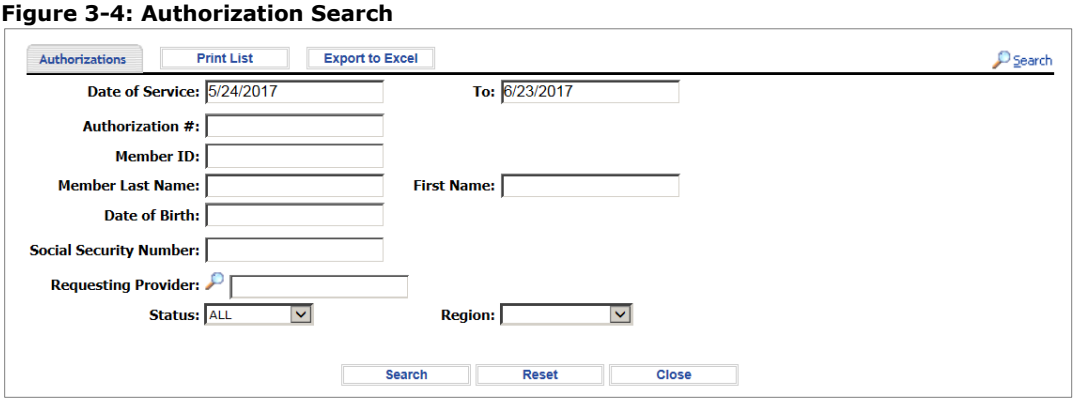
To change the order of the items displayed, select the heading of any of the columns to re-sort using that parameter. If the list of authorizations is more than one screen long, use the **Prev**/**Next** buttons located in the bottom right corner of the screen.

Figure 3-3: View Authorizations



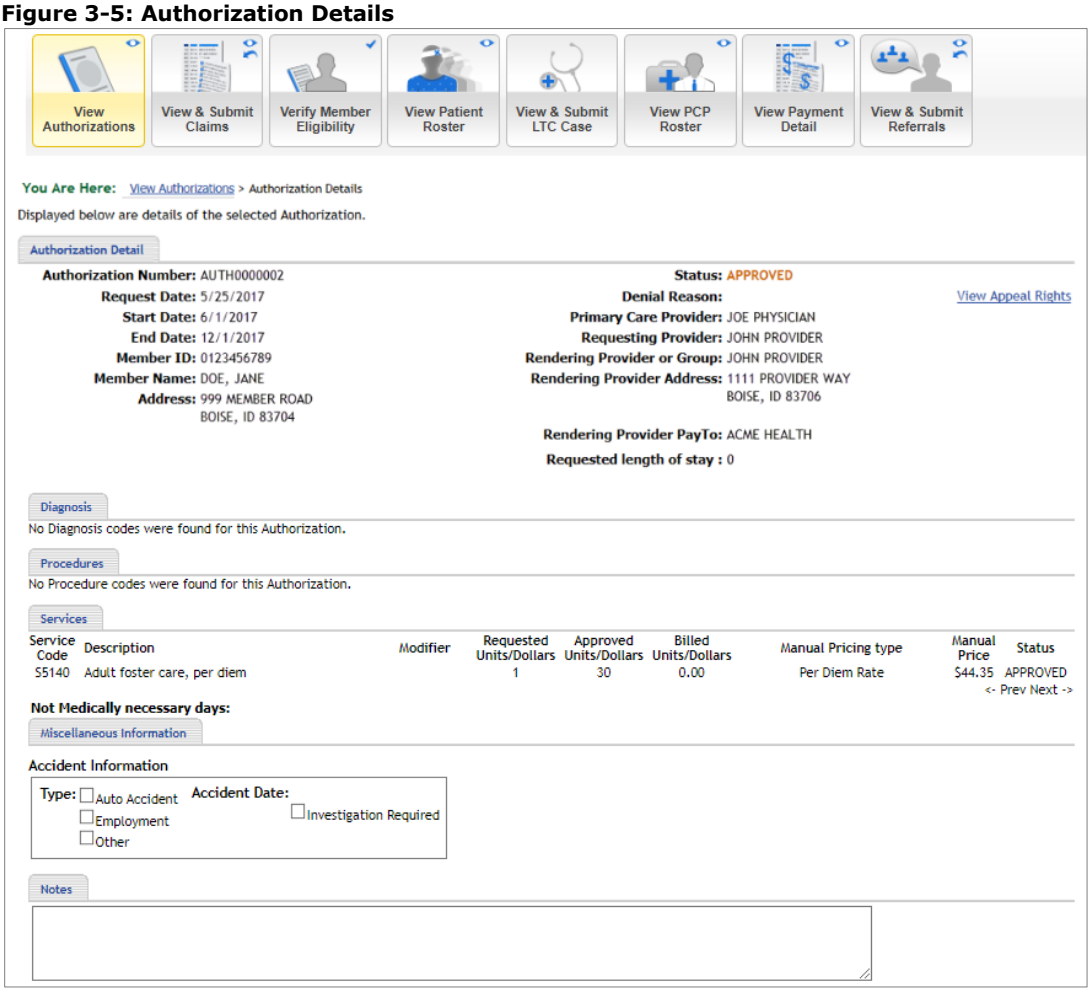
The system will default the search time frame to the last 30 days. If no current authorizations are found during that time frame, no authorizations will be listed. To search for a specific authorization, select the **Search** icon above the Status column to open the search window (Figure 3-4). To view all authorizations, clear the information in the **Date of Service** fields and select the **Search** button.

Figure 3-4: Authorization Search



To view an authorization in greater detail, select the **Auth #**. The complete authorization will be displayed in a new window (Figure 3-5). When an authorization is for a specific service code, number of units or a specific dollar amount the details can be seen under the Services header section.

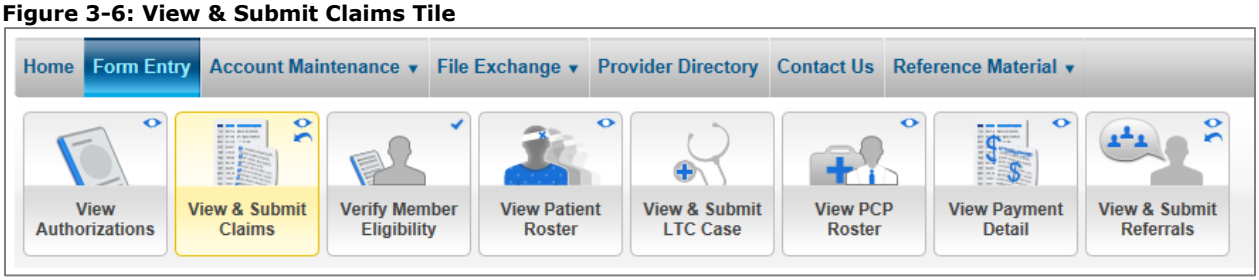
Figure 3-5: Authorization Details



3.2. Claim Submission

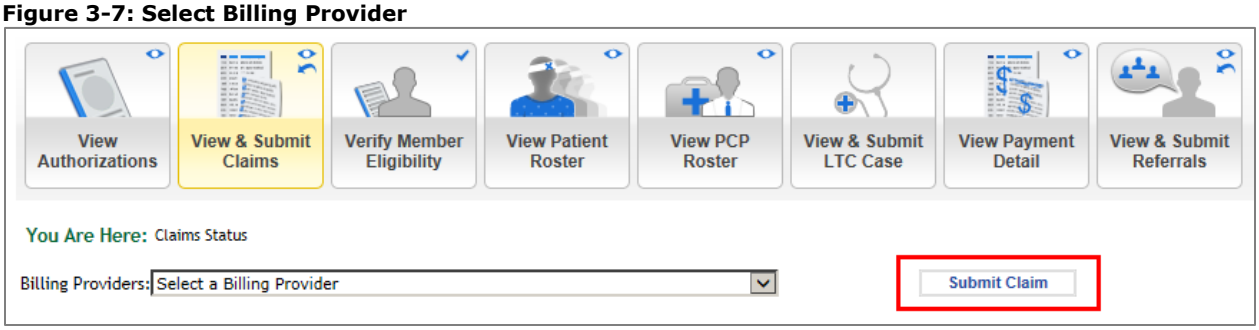
To access claim entry, select the **View & Submit Claims** tile under the **Form Entry** tab.

Figure 3-6: View & Submit Claims Tile



On the first screen (Figure 3-7), select the billing provider from the drop-down and select the **Submit Claim** button. This information will be auto-populated if there is only one billing provider associated to the TPA.

Figure 3-7: Select Billing Provider

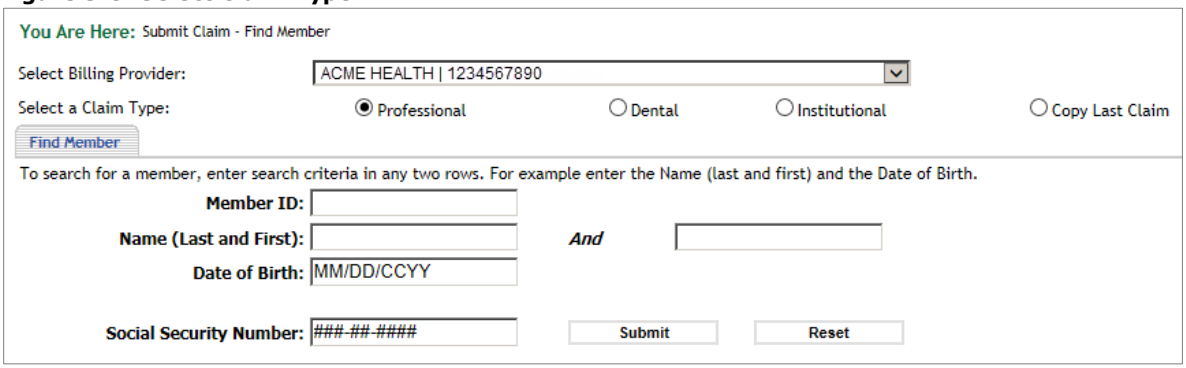


Choose the appropriate radio button next to Select a Claim Type (Figure 3-8):

- Professional – CMS-1500
- Institutional – UB-04
- Dental – **should not be used**. Dental claims are processed through our dental vendor. Dentists enrolled with Gainwell Technologies may only bill for interpretation services.
- Copy Last Claim is not a claim type – please see *Section 3.2.3 Copy Last Claim* below to learn more about this feature.

Under *Find Member* enter at least two search criteria to locate the appropriate participant. Once the member is found, select the radio button next to the member's name and select **Continue**.

Figure 3-8: Select Claim Type



3.2.1. Professional Claim

A professional claim is used for providers who bill with the CMS-1500 claim form.

All dollar amounts on the professional claim can be entered without the dollar sign in the following formats:

- For $100 even, enter 100, the field will display 100.00
- For $54.35, enter 54.35, the field will display 54.35
- For $45.10, enter 45.1, the field will display 45.10

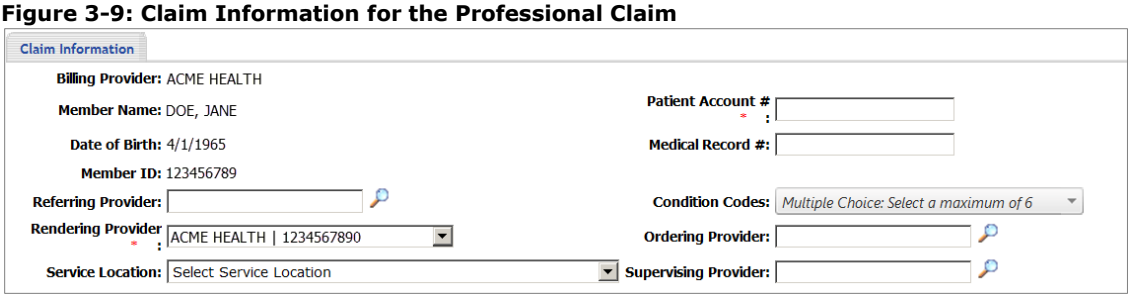
Reminder: Any fields with a red asterisk (*) are required unless inactive (grayed out). An error message will be displayed if these values are left blank at time of submission.

3.2.1.1. Claim Information for Professional Claim

The participant information (Figure 3-9) will auto-populate based on the participant selected.

- **Patient Account #**, the number assigned to the patient in your billing system, is a required field.
- **Medical Record #** (as used by your office) is optional.
- Enter **Referring Provider**, **Ordering** (Prescribing) **Provider**, or **Supervising Provider** by selecting the **Search** icon. Do not manually enter data into these fields; it will not populate on your claim.
- Select **Rendering Provider** and **Service Location** from the drop-down menu.
- The **Condition Codes** field will be used in the future, but is not required at this time and does not affect claims processing. A maximum of six condition codes may be selected.

Figure 3-9: Claim Information for the Professional Claim



3.2.1.2. Diagnosis Codes

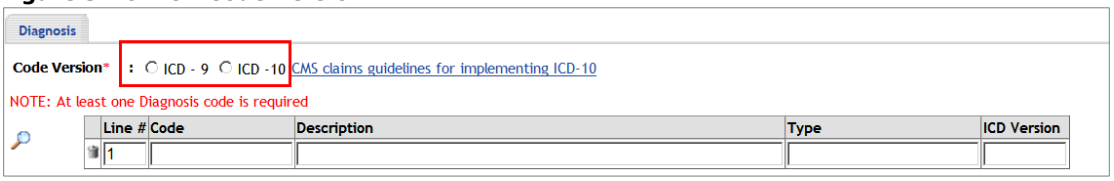
ICD Code Version

Diagnosis codes and the correct ICD code sets for the date of service are required on all claim types (Figure 3-10).

- For dates of service prior to October 1, 2015, use the ICD-9 code.
- For dates of service on or after October 1, 2015, use the appropriate ICD-10 code.

Only one ICD version may be used per claim. If a claim is submitted with both ICD-9 and ICD-10 codes, you will receive an error message and the claim must be corrected before it can be submitted. The diagnosis codes entered must match the ICD version selected; if they do not match, the code description will read "Code Not Found."

Figure 3-10: ICD Code Version



Diagnosis Code Search

To search for a diagnosis code, select the **Code** field on the claim and then select the **Search** icon near the **Line #** and a search window will open.

In the search window, enter a diagnosis description in the Description field and select Search (Figure 3-11).

Figure 3-11: Diagnosis Code Search

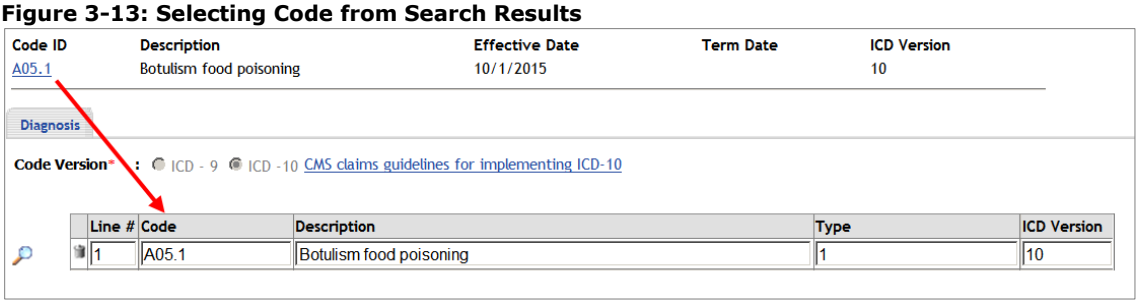
A list of results will display at the bottom of the window (Figure 3-12). Search results will ONLY yield codes for the ICD version selected. Select the blue **Code ID** to add the diagnosis to the claim.

Figure 3-12: Diagnosis Code Search Results

Adding Diagnosis Codes

The only field you can edit is **Code**. Once you have selected a code from the search results, or entered the code manually, press the Tab key on your keyboard or select in the **Description** field. The **Description**, **Type**, and **ICD Version** fields will be loaded into your form. If the code cannot currently be used for billing, an error message will display in the description field.

Figure 3-13: Selecting Code from Search Results



To add a new line, press the Tab key on your keyboard at the end of the last line and a new line will display. The **Line #** will increase automatically as each line is added. The first line entered will be assigned as the primary diagnosis. All lines entered after that will be considered secondary diagnoses.

To delete a line from the list, select the **Recycle Bin** icon next to the **Line #** field.

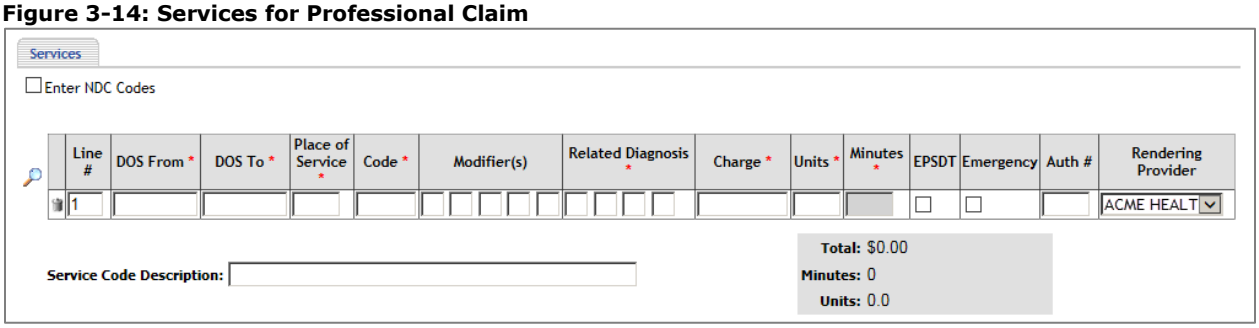
3.2.1.3. Services for the Professional Claim

The fields for entering Services are as follows (Figure 3-14).

Special Instructions:

- Date of Service: **DOS From** and **DOS To**
  - Date format: MM/DD/YYYY
- **Place of Service**: Two-digit numeric number
- **Code**: CPT or HCPCS billing code
- **Modifiers**: One two-digit modifier in each box as appropriate
- **Related Diagnosis**: Refers back to the line # used under the *Diagnosis* heading
- **Charge**: Enter total charges for this service
- **Units**: Enter total number of units delivered for this code on this date of service
- **Minutes**: This field is only active if it is required on your claim
- **EPSDT**: Check to indicate Early Periodic Screening, Diagnosis and Treatment
- **Emergency**: Check if related to emergency
- **Auth #**:
  - Enter the prior authorization (PA) number in the **Auth #** field if a service requires a PA.
  - Enter the entire PA number *including the preceding "AUTH."* (Pas from the QIO vendor do not contain or require text to be entered before the number.)
  - Search for the PA number under **View Authorizations** on the **Form Entry** tab. For more information, refer to *3.1 View Authorization* Status.
- **Rendering Provider** defaults to the rendering provider listed in the Claim Information section at the top of the screen. If this service line was provided by another rendering, use the drop-down to select the correct rendering provider.
- Pressing the Tab key on your keyboard through all these fields without entering data will result in some of the fields automatically filling with the following information:
  - Dates of Service (From and To): Current date
  - Place of Service: 11
  - Charge: $0.00
  - Units: 1
- If the service code entered cannot be used for billing, an error message will display in the description field
- To add more service lines, press the Tab key on your keyboard at the end of the last line and a new line will display. Up to 99 service lines are available for entry.
- The system will calculate total charges and total units and will display them in the gray box next to the **Service Code Description** box.

Figure 3-14: Services for Professional Claim



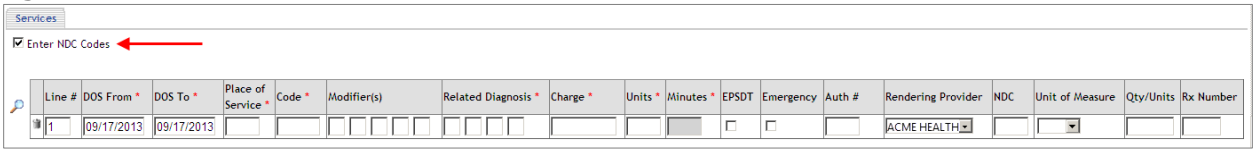
3.2.1.4. National Drug Code (NDC) for Professional Claim

If the services is (Figure 3-15) or a drug product, select the **Enter NDC Codes** checkbox directly under the *Services* tab. The applicable fields will be available for entry at the right end of the array.

The **NDC** is an 11-digit number with no dashes. **Unit of Measure** needs to be selected from the drop-down box. **Qty/Units** must be entered.

The **Rx Number** field is used when a provider administers a compound drug and is billing multiple service lines with the individual NDCs that make up the compound. The Rx Number should be the same for each service line containing the components of a single compound to link the service lines together.

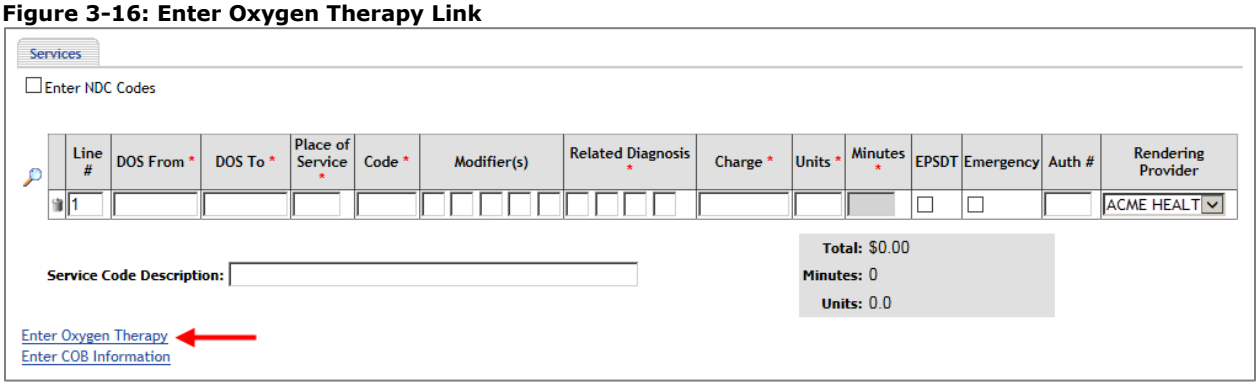
Figure 3-15: Enter NDC Codes



3.2.1.5. Oxygen Service Information

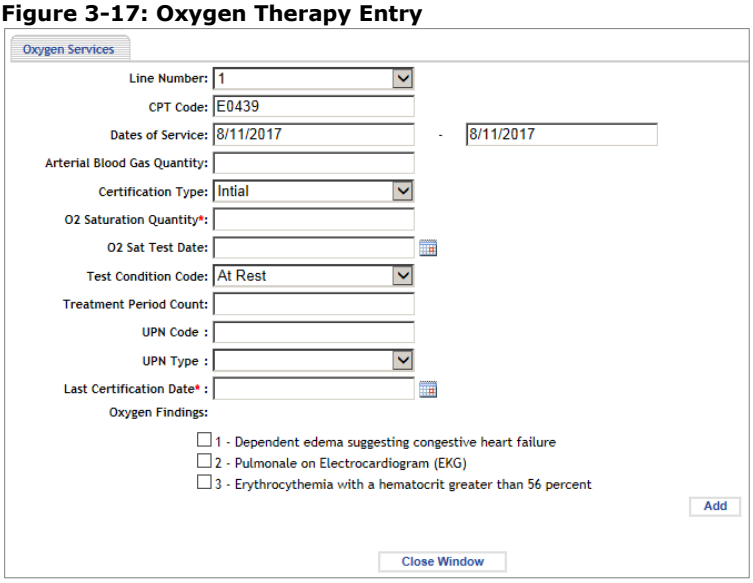
To enter Oxygen Services information, select the **Enter Oxygen Therapy** link (Figure 3-16) to open the Oxygen Services window.

Figure 3-16: Enter Oxygen Therapy Link



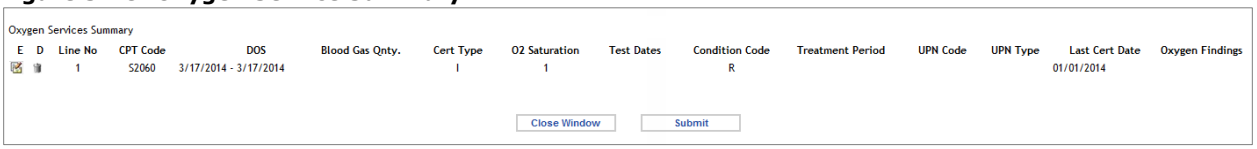
Enter the information in the fields provided (Figure 3-17). Select the **Add** button and a summary screen will display.

Figure 3-17: Oxygen Therapy Entry



The Oxygen Services Summary will display (Figure 3-18). To edit a value, select the **Edit** icon on the left, modify the line, and then select the **Save** button. Select the **Submit** button on this window to keep the information and add it to the claim.

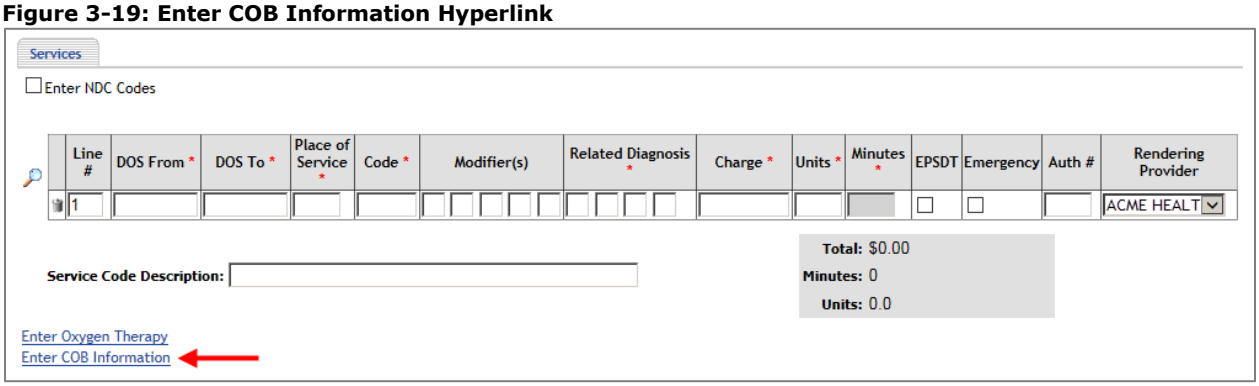
Figure 3-18: Oxygen Service Summary



3.2.1.6. Coordination of Benefits (COB) Information

Select the Enter COB Information link (Figure 3-19) to access the COB Information screen.

Figure 3-19: Enter COB Information Hyperlink



The COB Information screen will allow the user to enter COB information in order for Idaho Medicaid to coordinate payment. For information related to COB calculation methods, refer to the General Billing Instructions in the Provider Handbook.

On the COBInfo section of the screen, required fields are marked with a red asterisks (*). If directed below, optional fields can be completed.

When the primary payer was a TPL or Commercial payer, provide the following information:

- **Filing Indicator***: Choose from the drop-down **Commercial**
- **Payer Name***: Enter the name of the primary payer
- **Payer Sequence***: Choose from the drop-down; **Primary**, **Secondary**, **Unknown** based on how payment was coordinated. If the participant had only one TPL or Commercial payer on the DOS, choose Primary. If there were two or more other payers, select the sequence based on who the primary and secondary payer was.
- **Policy Number**: Enter the Policy Number associated to the other payer's plan

When the primary payer was a Medicare Advantage payer, provide all of the following information:

- **Filing Indicator***: Choose from the drop-down **Commercial**
- **Payer Name***: Enter the name of the Medicare Advantage payer
- **Payer Sequence***: Choose from the drop-down; **Primary**, **Secondary**, **Unknown** based on how payment was coordinated. If the participant had only the Medicare Advantage payer on the DOS, choose Primary. If there were two or more other payers, select the sequence based on who the primary and secondary payer was.
- **Policy Number**: Enter the Policy Number associated to the Medicare Advantage plan

When the primary payer was Medicare A/B, provide the following information:

- **Filing Indicator***: Choose from the drop-down **Medicare A** or **Medicare B**
- **Payer Name***: Auto-filled with *Medicare*
- **Payer Sequence***: Choose from the drop-down; **Primary**, **Secondary**, **Unknown** based on how payment was coordinated. If the participant had only Medicare as a payer on the DOS, choose Primary. If there were two or more other payers, select the sequence based on who the primary and secondary payer was.
- **Policy Number**: Enter the Policy Number associated to the Medicare plan

Note: In all instances, if there was more than one other payer on the DOS, select the **+Add Payer** link and provide the required details.

After providing the information into the COBInfo fields, select the **Document Icon** to provide the COB Details from the primary payer's Explanation of Benefits (EOB). If only one service line is billed on the claim, choose the radio button to enter the details **By Claim.** If two or more service lines are billed on the claim, choose the radio button to enter the details **By Service Line**.

All of the following fields must be completed, even if the other payer did not make payment. All information provided in the fields below should be reported as shown on the primary payer's EOB. The amount allowed by the primary payer will be calculated based on the amounts provided in the following fields:

- **Paid Amt**: Enter the paid amount, if any
- **Deductible Amt**: Enter the deductible amount, if any
- **Coinsurance Amt**: Enter the coinsurance amount, if any
- **CopayAmt**: Enter the copayment amount, if any
- **Adjustment Reason Code**: Enter the Adjustment Reason Code when the primary payer is a Medicare Advantage Plan or Medicare A/B. Do not use the Adjustment Reason Code when reporting TPL or Commercial remits/remarks.

Note: Only the numeric Medicare remit/remarks should be provided. Do not include remarks such as "PR"

- **PaidDate**: Enter the paid date

Note: If the claim was denied, enter zeroes in each amount field. An EOB attachment, including the summary page, will be required; see *3.2.4.1 Upload Attachments*.

Select **Submit** at the bottom of the page to save this information. You will be returned to the claim screen, where you can submit the claim for processing or add additional information (shown below).

Note: We do not suggest providers adjudicate secondary claims.

Figure 3-20: COB Information – TPL/Commercial

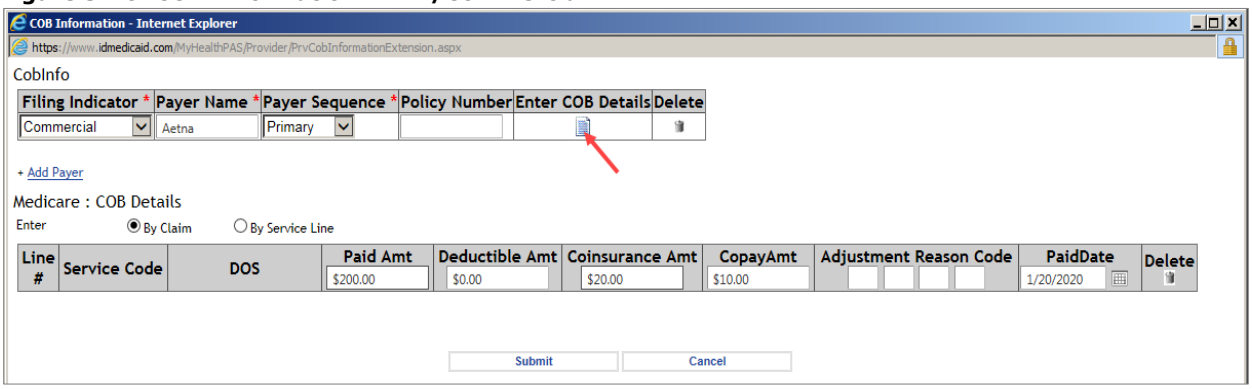


Figure 3-21: COB Information – Medicare Advantage

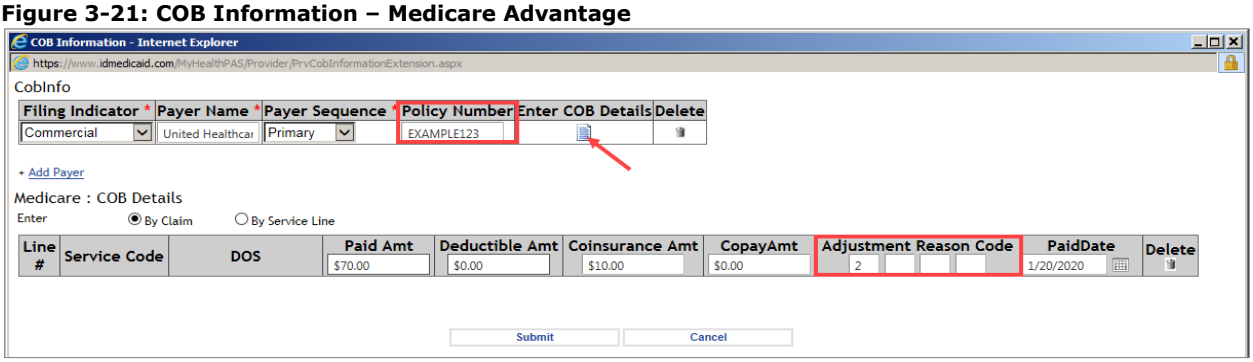
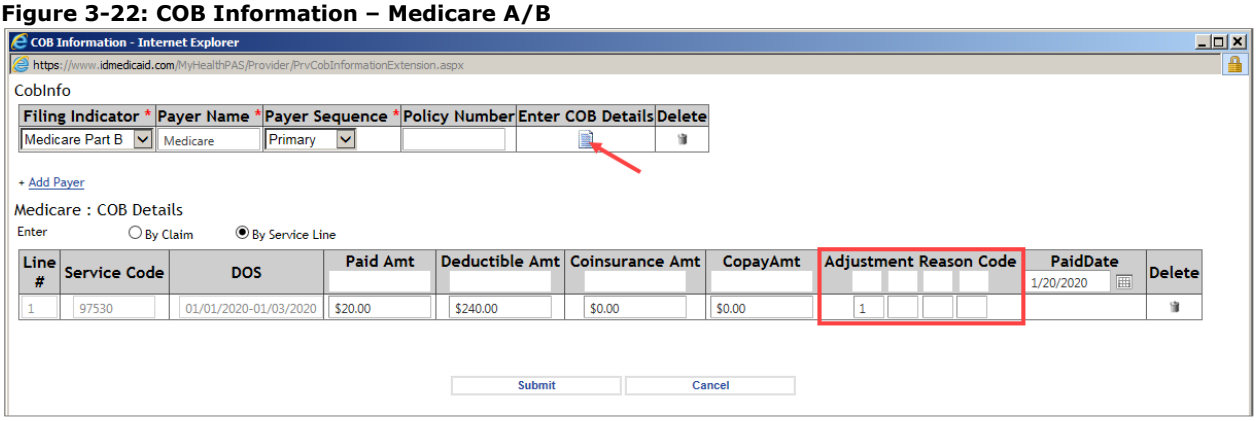


Figure 3-22: COB Information – Medicare A/B

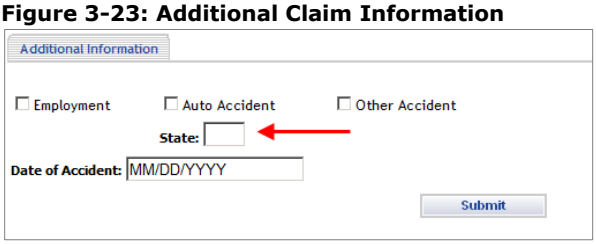


3.2.1.7. Additional Information for the Professional Claim

The *Additional Information* section contains information about whether these services are related to an employment, auto, or other kind of accident.

Enter the Date of Accident in MM/DD/YYYY format. If the claim relates to an Auto Accident, enter the two-digit State abbreviation in which the accident occurred in the field just below Auto Accident (Figure 3-23).

Figure 3-23: Additional Claim Information



3.2.1.8. Submit the Professional Claim

When all the information has been entered, review your entries for accuracy, and select the **Submit** button to submit the claim. Any error messages will display in red at the top of the page and must be corrected before the claim will be submitted.

Once submitted, a confirmation message will display. Here you will have the option to edit the claim or to upload any attachments that need to be submitted with the claim. For more information on adding attachments, see *3.2.4.1 Upload Attachments*.

3.2.2. Institutional Claim

This claim, comparable to the paper UB-04, is used for all providers billing institutional claims.

All dollar amounts on the institutional claim can be entered without the dollar sign. Whole dollars can be entered without the decimal and the additional zeroes. For example, the following entry conventions apply:

- For $100 even, enter 100, the field will display 100.00
- For $54.35, enter 54.35, the field will display 54.35
- For $45.10, enter 45.1, the field will display 45.10

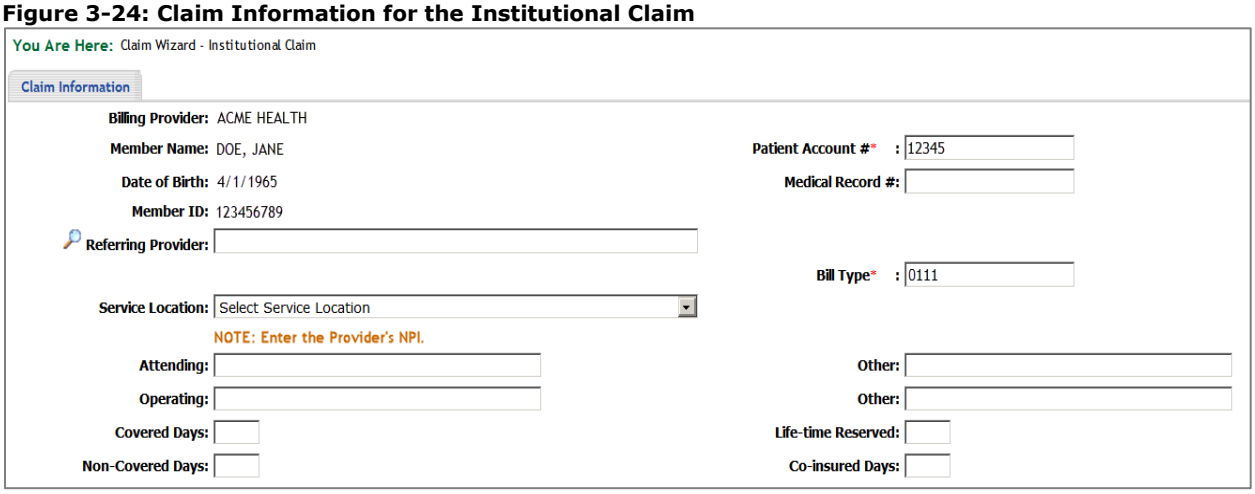
Reminder: Any fields with a red asterisk (*) are required unless inactive (grayed out). An error message will be displayed if these values are left blank at time of submission.

3.2.2.1. Claim Information for the Institutional Claim

For Claim Information for the institutional claim, see Figure 3-24 below. The participant information will auto-populate based on the participant identified.

- **Patient Account #**, the number assigned to the patient in your billing system, is a required field.
- **Medical Record #** (as used by your office) is optional.
- Enter **Referring Provider** by selecting the **Search** icon. Do not manually enter data into this field; it will not populate on your claim.
- Select **Service Location** from the drop-down menu (if applicable).
- **Bill Type** is required.
- **Attending** provider's NPI is required.
- **Operating** provider's NPI may be required depending on the service codes entered.
- **Other** is used for ordering or prescribing providers. Enter the provider's NPI.
- Enter **Covered Days, Non-Covered Days, Life-time Reserve**, and **Co-insured Days** as needed.

Figure 3-24: Claim Information for the Institutional Claim



3.2.2.2. *Bill Type on the Institutional Claim*

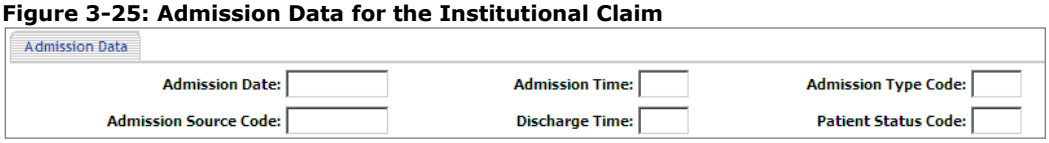
Bill type requires four digits, with "0" as the first digit. When entering a bill type, the third digit determines whether the claim is considered inpatient or outpatient. If the third digit of the bill type is a "1" or a "2," the claim is considered inpatient and Admission Data will be required on the claim. If an admitting diagnosis is not entered, an error message will display.

3.2.2.3. *Admission Data for the Institutional Claim*

On this section of the claim form, times should be entered using the 24-hour format. Enter the first two digits of the closest hour to the admission/discharge time. For example:

- 8:00 am would be entered as 08
- 7:00 pm would be entered as 19 (note that 12 + 7 = 19)

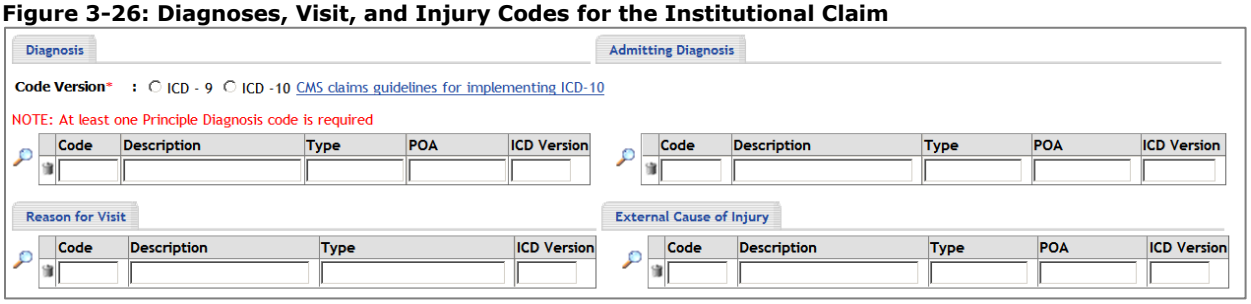
Figure 3-25: Admission Data for the Institutional Claim



3.2.2.4. *Diagnosis, Visit, and Injury Codes for the Institutional Claim*

This section of entry for the institutional claim has four sets of fields (Figure 3-26).

Figure 3-26: Diagnoses, Visit, and Injury Codes for the Institutional Claim



3.2.2.5. Diagnosis Codes

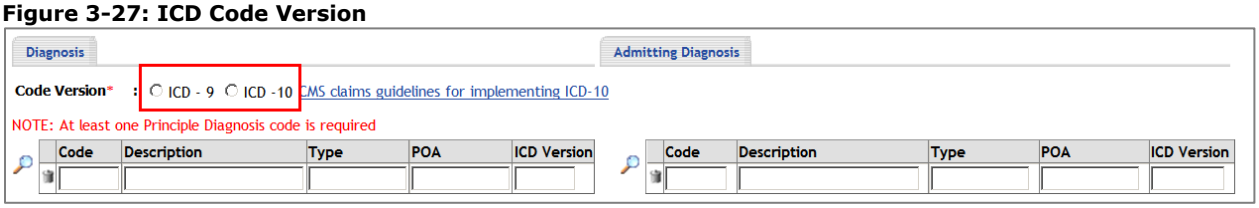
ICD Code Version

Diagnosis codes and the correct ICD code sets for the date of service are required on all claim types (Figure 3-27).

- For dates of service prior to October 1, 2015, use the ICD-9 code.
- For dates of service on or after October 1, 2015, use the appropriate ICD-10 code.

Only one ICD version may be used per claim. If a claim is submitted with both ICD-9 and ICD-10 codes, you will receive an error message and must correct before the claim can be submitted. The diagnosis codes entered must match the ICD version selected; if they do not match, the code description will read "Code Not Found."

Figure 3-27: ICD Code Version

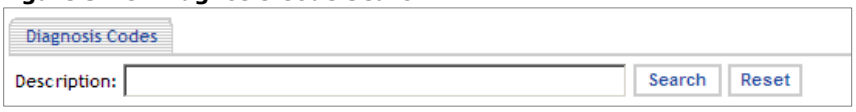


Diagnosis Code Search

To search for a diagnosis code, select the **Code** field on the claim and then select the **Search** icon near the **Line #** and a search window will open.

In the search window, enter a diagnosis description in the Description field and select Search (Figure 3-28).

Figure 3-28: Diagnosis Code Search



A list of results will display at the bottom of the window (Figure 3-29). Search results will ONLY yield codes for the ICD version selected. Select the blue **Code ID** to add the diagnosis to the claim.

Figure 3-29: Diagnosis Code Search Results

Adding Diagnosis Codes

Once you have selected a code from the search results, or entered the code manually, press the Tab key on your keyboard or select the **Description** field. The **Description**, **Type**, and

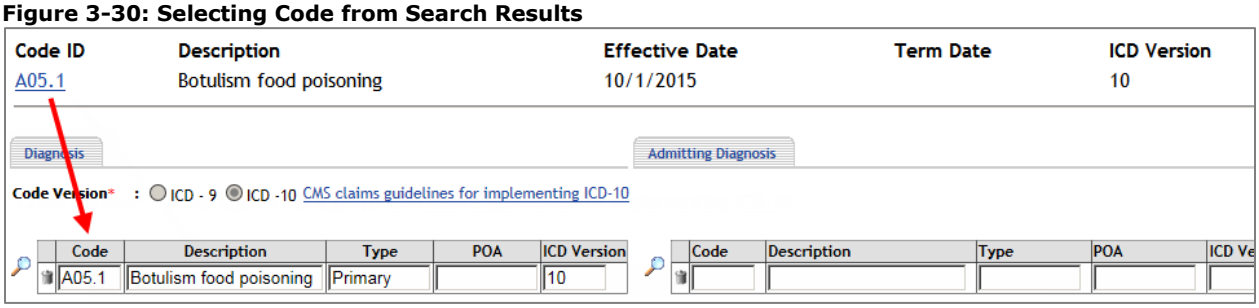
ICD Version fields will be loaded into your form. If the code cannot currently be used for billing, an error message will display in the description field.

In the **POA** (Present on Admission) field, use one of the following:

- Y for Yes
- N for No
- U for Unknown/Undetermined

Note: Although not marked with an asterisk (*), this field is required for **inpatient** claims.

Figure 3-30: Selecting Code from Search Results



To add a new line, press the Tab key on your keyboard at the end of the last line and a new line will display. The **Line #** will increase automatically as each line is added. The first line entered will be assigned as the primary diagnosis. All lines entered after that will be considered secondary diagnoses.

To delete a line from the list, select the **Recycle Bin** icon next to the **Line #** field.

Reminder: An **Admitting Diagnosis** is required if the third digit of the bill type entered on the claim is a "1" or a "2." For more information, see *3.2.2.2 Bill Type on the Institutional Claim*.

3.2.2.6. Procedures for the Institutional Claim

The fields for entering the **Principle Procedure** and **Other Procedures** codes are shown below.

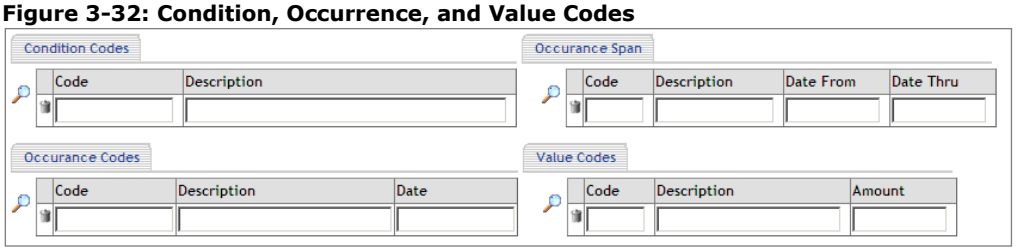
For all procedure codes, the **Code** and the **Date of Service** can be entered or edited. The **Description**, **Type**, and **ICD Version** will fill automatically. The Principle Procedure entered will be assigned as the Primary procedure for the claim. All following lines entered will be secondary.

Figure 3-31: Procedure Codes for the Institutional Claim

3.2.2.7. Condition, Occurrence, and Value Codes for the Institutional Claim

Condition, Occurrence, and **Value Codes** (Figure 3-32) provide additional information used in adjudicating an institutional claim.

Figure 3-32: Condition, Occurrence, and Value Codes



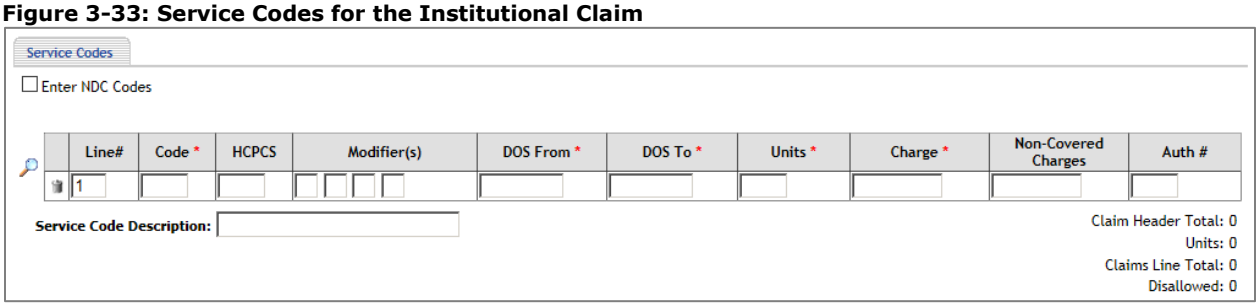
3.2.2.8. Service Codes for the Institutional Claim

The fields for entering **Services** are as follows (Figure 3-33).

Special Instructions for Institutional Claims:

- Up to 99 lines of service codes may be entered. After each code has been entered, the total price and total units will be displayed next to the **Service Code Description** box.
- Dates of Service (**DOS From** and **DOS To**) format: MM/DD/YYYY
- In the **Auth #** field:
  - Enter the prior authorization (PA) number in the **Auth #** field if a service requires a PA.
  - Enter the entire PA number *including the preceding "AUTH."* (Pas from the QIO vendor do not contain or require text to be entered before the number.)
  - Search for the PA number under **View Authorizations** on the **Form Entry** tab. For more information, refer to *3.1 View Authorization* Status. (**Note**: QIO vendor authorizations do not display in the View Authorizations module. Contact the QIO vendor if you need to locate a specific authorization number.)
- Pressing the Tab key on your keyboard through all these fields without entering data will result in some of the fields automatically filling with the following information:
  - DOS From and DOS To: The current date
  - Units: 1
  - Charge: $0.00
  - Non-Covered Charges: $0.00

Figure 3-33: Service Codes for the Institutional Claim



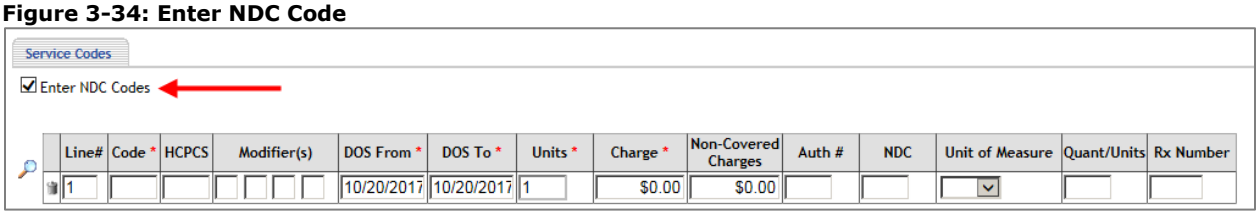
3.2.2.9. National Drug Code (NDC) for Institutional Claim

If the service is for a drug product, select the Enter NDC Codes checkbox directly under the *Services* tab (Figure 3-34). The applicable fields will be available for entry at the right end of the array.

The **NDC** is an 11-digit number with no dashes. **Unit of Measure** needs to be selected from the drop-down box. **Qty/Units** must be entered.

The **Rx Number** field is used when a provider administers a compound drug and is billing multiple service lines with the individual NDCs that make up the compound. The Rx Number should be the same for each service line containing the components of a single compound to link the service lines together.

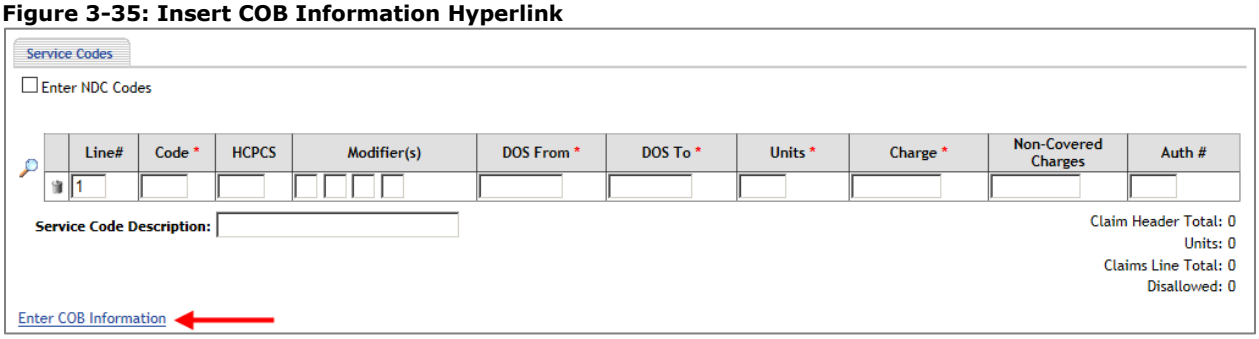
Figure 3-34: Enter NDC Code



3.2.2.10. Coordination of Benefits (COB) Information

Select the **Enter COB Information** link (Figure 3-35) to access the appropriate screen.

Figure 3-35: Insert COB Information Hyperlink



Please refer to section *3.1.1.6* for COB Information.

Select **Submit** at the bottom of the page to save this information. You will be returned to the claim screen where you can submit the claim for processing. For more information on entering third party benefit information, see the General Billing Instructions section of the provider handbook.

3.2.2.11. Submit the Institutional Claim

When all the information has been entered, review your entries for accuracy and select the Submit button to submit the claim. Any errors will display at the top of the page in red and must be corrected before the claim will be submitted.

Once submitted, a confirmation message will display. Here, you will have the option to edit the claim or to upload any attachments that need to be submitted with the claim. For more information on adding attachments, see *3.2.4.1 Upload Attachments.*

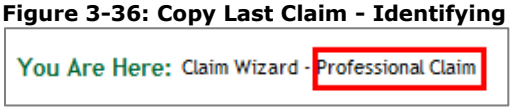
3.2.3. Copy Last Claim

This feature allows the provider to select the most recent claim by date of service for the Member ID entered. Identify the Billing Provider and choose **Copy Last Claim** from the claim type options.

Special Instructions:

- The claim type is identified at the top of the screen (Figure 3-36).
- If there is more than one claim with the same DOS, the system will select the most recent claim submitted based on time stamp.
- If there is no previously billed claim for the member entered, the provider will get a message *No Claim Found* and the provider must submit the claim without using the *Copy Last Claim* feature.
- Use the Find Member screen to identify the participant.
- The **Patient Account #** and **Claim DOS** fields will not be copied over to the new screen.
- At least one diagnosis code is required to submit the claim. The diagnosis code from the copied claim is displayed on the screen. The provider can update or modify the diagnosis code if needed, but the ICD version cannot be changed.
- The **DOS From** and **DOS To** fields must be entered to submit the claim. Use the MM/DD/YYYY format for the dates.
- Tab through the claim to ensure the information entered is correct for the date of service. Information returned in the *Diagnosis* and *Service* tabs can be modified.
- Enter COB information, if applicable.

Figure 3-36: Copy Last Claim - Identifying Claim Type



Reminder: Any fields with a red asterisk (*) are required unless inactive (grayed out). An error message will be displayed if these values are left blank at time of submission.

3.2.3.1. Submit the Claim

All fields on the *Claim Detail* screen must be reviewed and completed before selecting the **Submit** button. Any errors will display at the top of the page in red and must be corrected before the claim will be submitted.

Once submitted, a confirmation message will display. Here, you will have the option to edit the claim or to upload any attachments that need to be submitted with the claim. For more information on adding attachments, see *3.2.4.1 Upload Attachments.*

3.2.4. Submit and Process a Claim

Once you have submitted a claim, the *Claim Confirmation* will be displayed (Figure 3-37). The **Claim ID** is in the upper left corner. The confirmation message displays the following options.

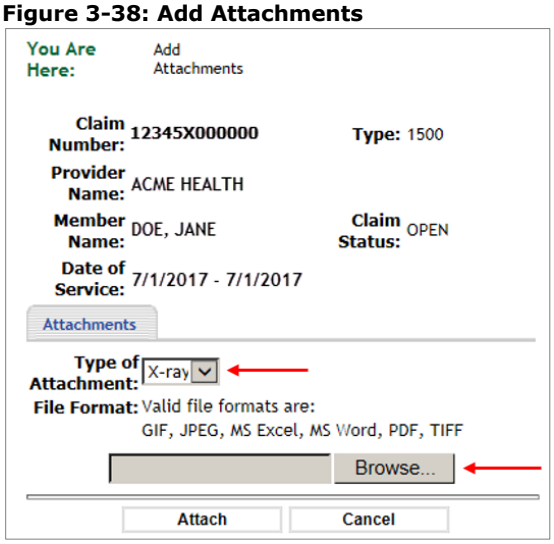
Figure 3-37: Claim Confirmation

3.2.4.1. Upload Attachments

When your claim submission confirmation displays, you will have the option to **Upload Attachments** that are needed to process the claim.

The *Add Attachments* screen will display (Figure 3-38). Select the **Type of Attachment** from the drop-down; the type will default to X-ray. Select the **Browse** button to search for the file(s) that need attached.

Figure 3-38: Add Attachments

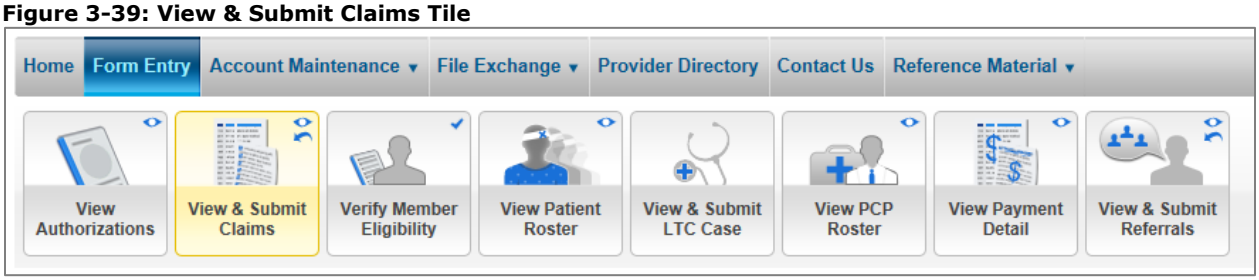


Note: Files must be in .pdf, .gif, .tiff, .jpeg, MS Word, or MS Excel formats. Once you have selected the appropriate file(s), select the **Attach** button. A confirmation message that the attachment submitted to the queue successfully will display in the upper portion of the screen.

3.3. Claim Status

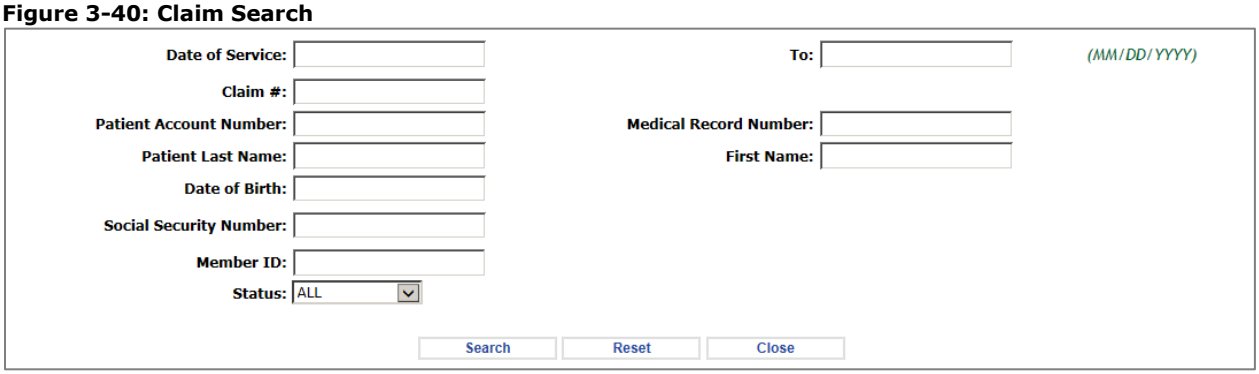
To check the status of a claim, select the **View & Submit Claims** tile under the **Form Entry** tab.

Figure 3-39: View & Submit Claims Tile



This screen displays the most 40 recent claims with date of service in the last 30 days. To view additional claims, the user may search by selecting the appropriate billing provider from the drop-down menu. This will be auto-populated if there is only one billing provider associated to the TPA. Select the **Search** button and enter additional search criteria to narrow your search.

Figure 3-40: Claim Search



You may also print the list displayed or export to Excel.

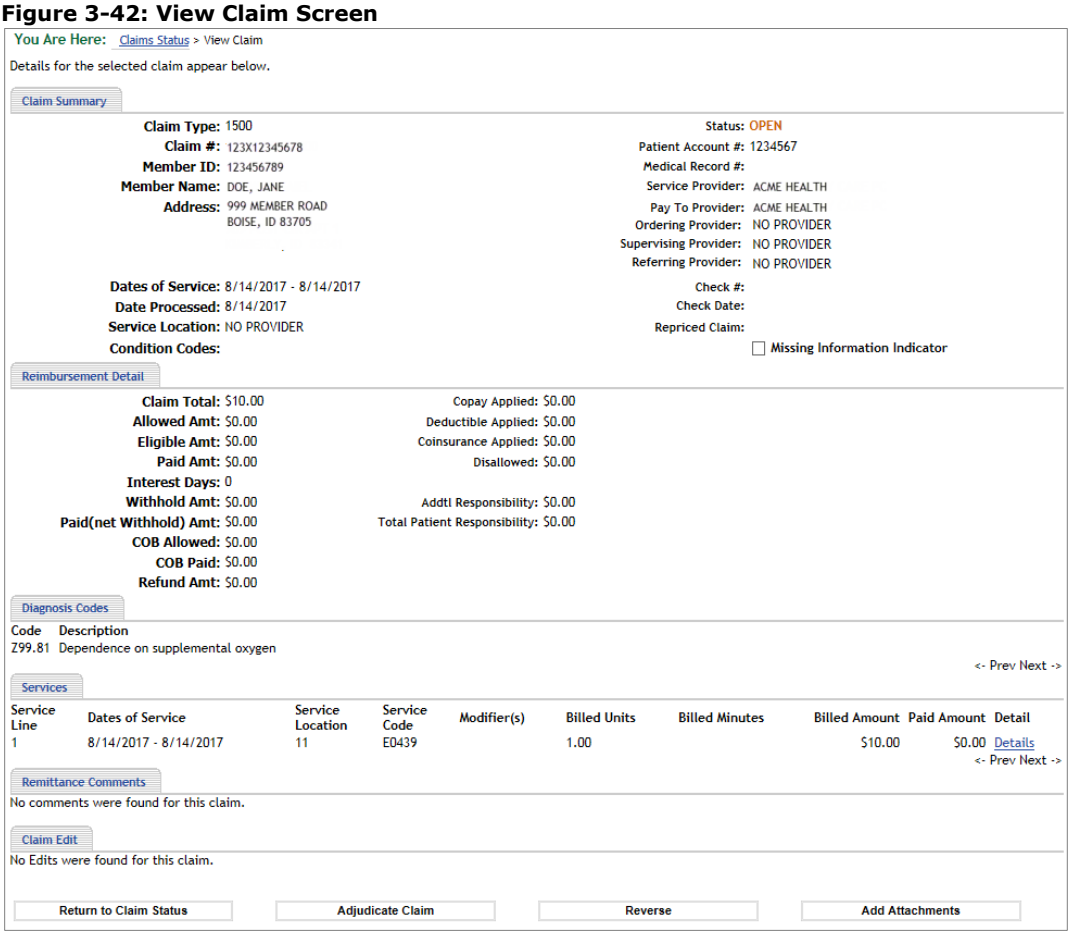
Figure 3-41: Print and Export Options

Select any column header to sort the information by that column.

Use the **Prev/Next** links to move backward or forward if there are multiple pages of claims.

To view a claim in more detail, select the claim number from the claims status screen (Figure 3-42).

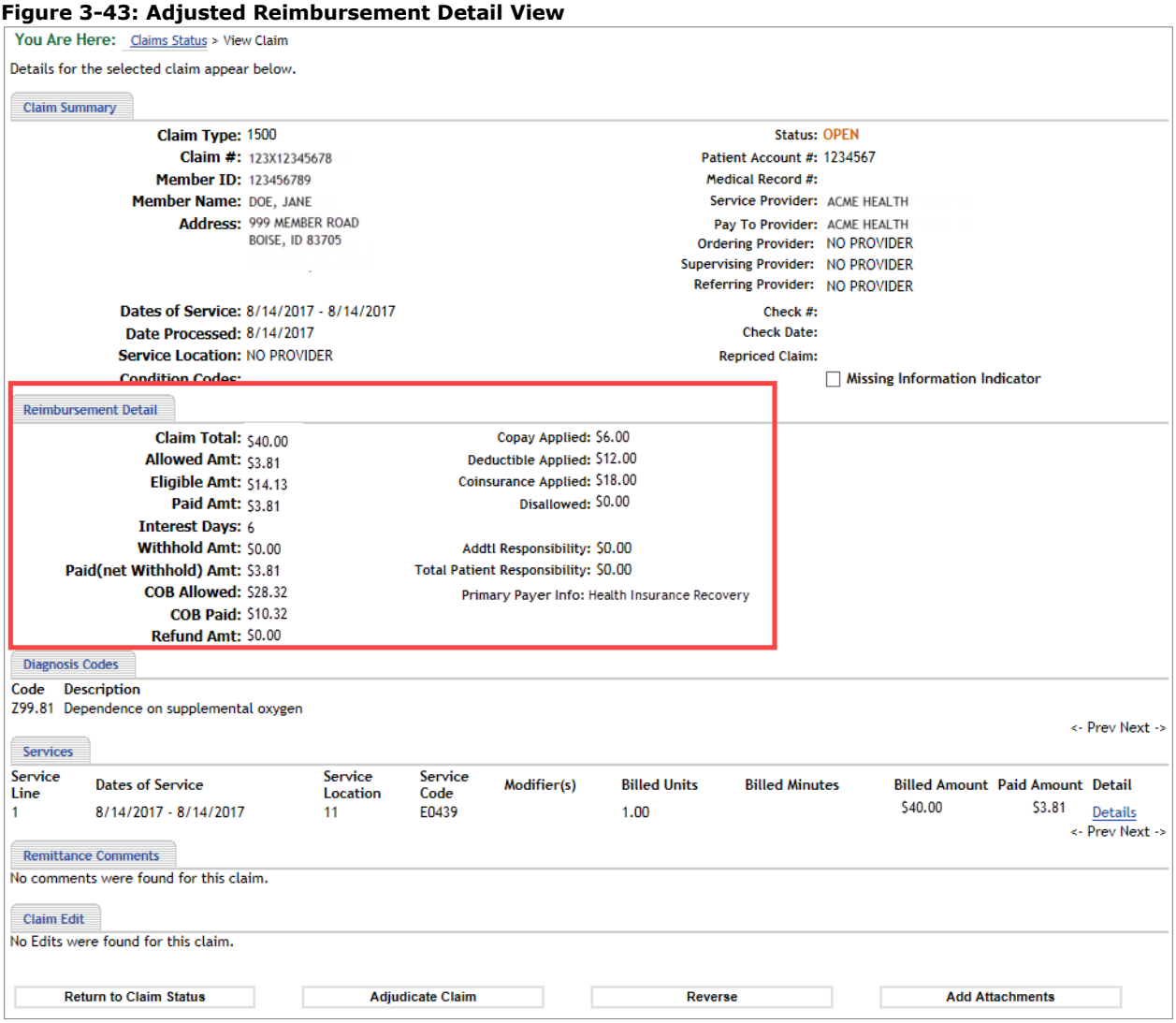
Figure 3-42: View Claim Screen



Note: If a participant is subject to a Medicaid copay and/or a Share of Cost, and the amount is applied to the claim, the amount will be totaled and reflected on the View Claim Screen in the **Total Patient Responsibility** field.

If a claim has been adjusted on behalf of a provider due to a recovery, the recovery payment details will be displayed, along with the Primary Payer Info, in the Reimbursement Detail section of the Claim Status.

Figure 3-43: Adjusted Reimbursement Detail View



To change or process a claim, select the radio button to the left of the claim number on the *Claims Status* screen (Figure 3-41). One or more of the following options become available, depending on the status of the claim (Figure 3-44):

- **Edit**: For claims in a Pay, Deny, Open, Adjudicated, or Pend status
- **Adjudicate**: Processes the claim and displays any initial edits
- **Add Attachments** (see *3.2.4.1 Upload Attachments*)
- **Print**: Opens a dialog box to print the claim detail
- **Reverse**: For claims in a Paid or Denied status
- **Print Attachment Cover Sheet**

Figure 3-44: Buttons to Access Claim

Claims in a Wait status cannot be adjusted or edited. No action should be taken on these claims until they are in a finalized (Paid or Denied) status.

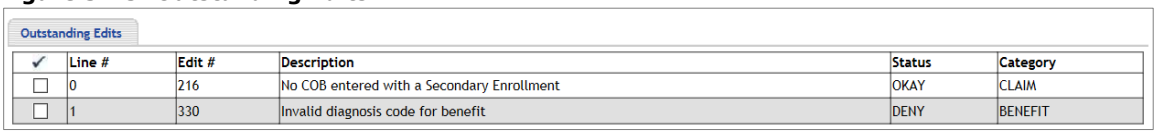
3.3.1. Edit Claim

Claims that are not in a finalized status can be edited.

Selecting the Edit Claim button displays the list of outstanding edits (Figure 3-45).

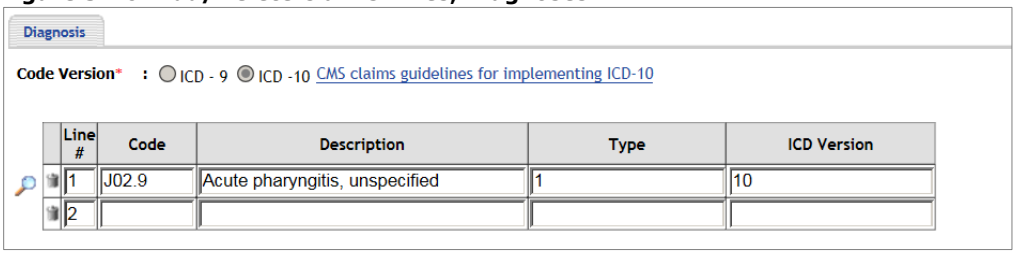
A checkbox displays in front of each edit. You may use these boxes to track claim changes you make. **Claim Type**, **Billing Provider**, **Member**, and **Code Version** are the only fields that cannot be changed when editing a claim. A diagnosis can only be deleted after you remove the Related Diagnosis under the *Services* tab.

Figure 3-45: Outstanding Edits


Outstanding Edits

✓	Line #	Edit #	Description	Status	Category
☐	0	216	No COB entered with a Secondary Enrollment	OKAY	CLAIM
☐	1	330	Invalid diagnosis code for benefit	DENY	BENEFIT

Figure 3-46: Add/Delete Claims Lines, Diagnoses



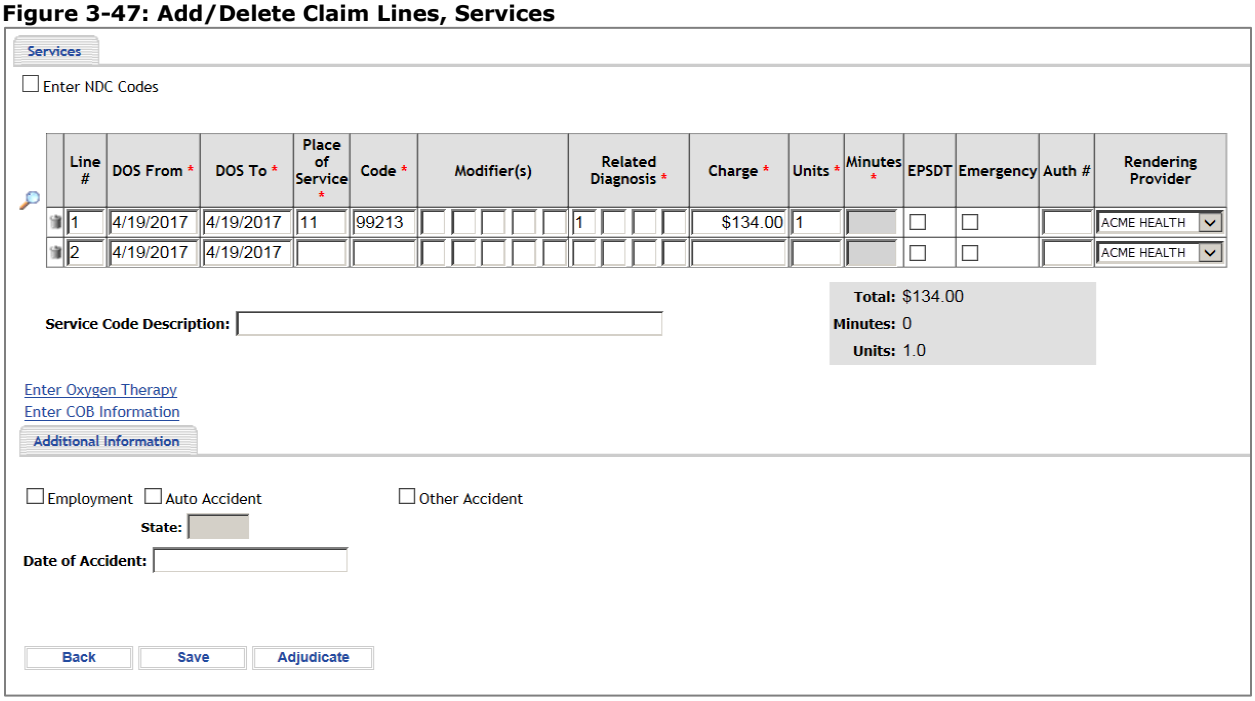
Services lines can also be added or deleted.

After entering all corrections, there are three options.

- **Back**: Select the Back button to return to the previous screen. **Note**: By selecting this button, any data you have entered or changed will not be saved.
- **Save**: Select the Save button to save the changes made so far.
- **Adjudicate**: Select the Adjudicate button to adjudicate the edited claim.

WARNING: If you do not save before adjudicating, you could lose your changes.

Figure 3-47: Add/Delete Claim Lines, Services

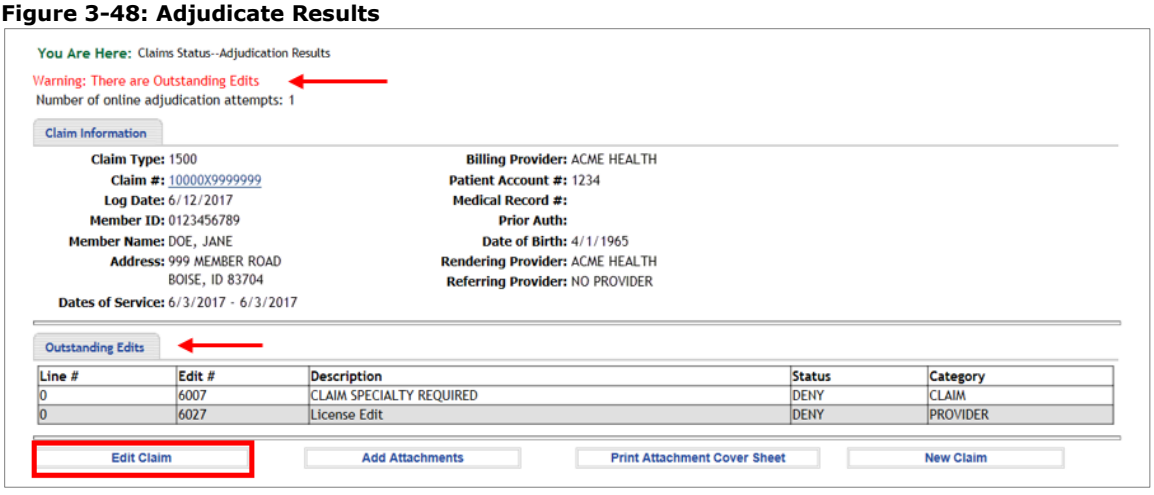


3.3.2. Adjudicate Claim

Adjudication processes the claim and displays any initial edits. If the claim cannot be adjudicated, the screen will show the error message, "Warning: There are Outstanding Edits." Select the **Edit Claim** button at the bottom of the section to correct these edits in order to adjudicate the claim again (Figure 3-48).

- Edits with status of "OKAY" are informational only.
- Edits with status of "WARN" are informational and require no action but may indicate future changes.

Figure 3-48: Adjudicate Results

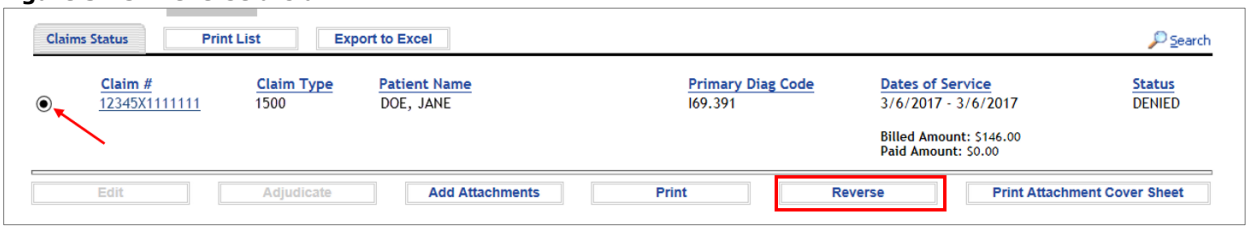


Note: You can adjudicate up to nine times and correct any errors. However, if you need to adjudicate a tenth time, then you must let the claim be processed.

3.4. Reverse or Adjust a Claim

Any finalized claim that has been processed through a payment cycle and has a denied or paid status may be reversed and replaced by selecting on the **Reverse** button on the claim status screen.

Figure 3-49: Reverse a Claim

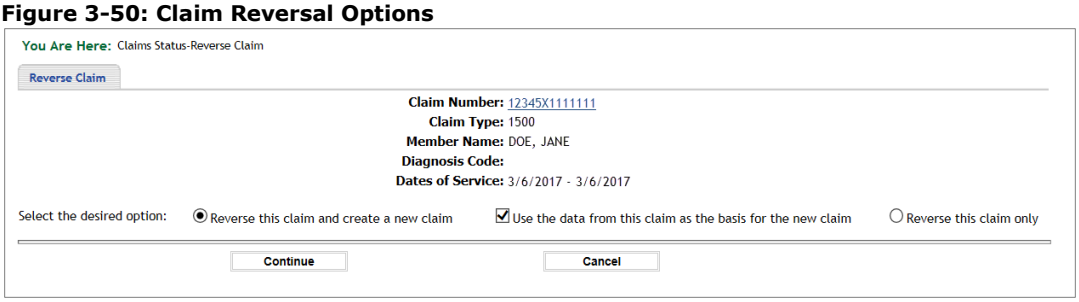


On the *Reverse Claim* screen, choose the appropriate action (Figure 3-50).

- **Reverse this claim and create a new claim (default)**: If you do not want to preserve existing data, uncheck the box *Use the data from this claim as the basis for the new claim.* The new claim can be edited and submitted using updated data
- **Reverse this claim only**: Use only on a paid claim. This will return the payment and prevent the claim from further modification. You will receive a reversal confirmation that will display the Reversal ClaimId.

Once you have chosen an option, select the **Continue** button.

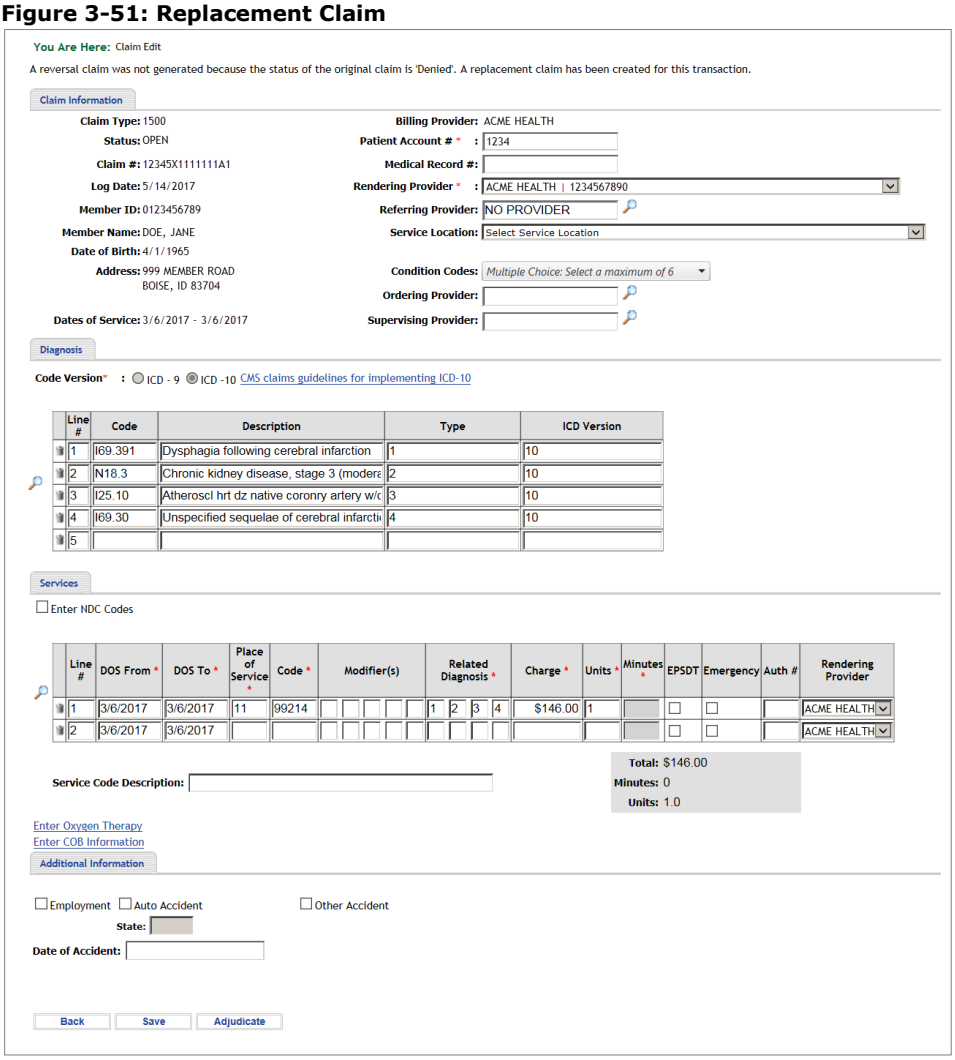
Figure 3-50: Claim Reversal Options



Note: You must tab to the next field from the field(s) you changed. Without tabbing to the next field, the altered information will not be retained when you submit the replacement claim.

When you are finished updating the information on the replacement claim, select **Save**.

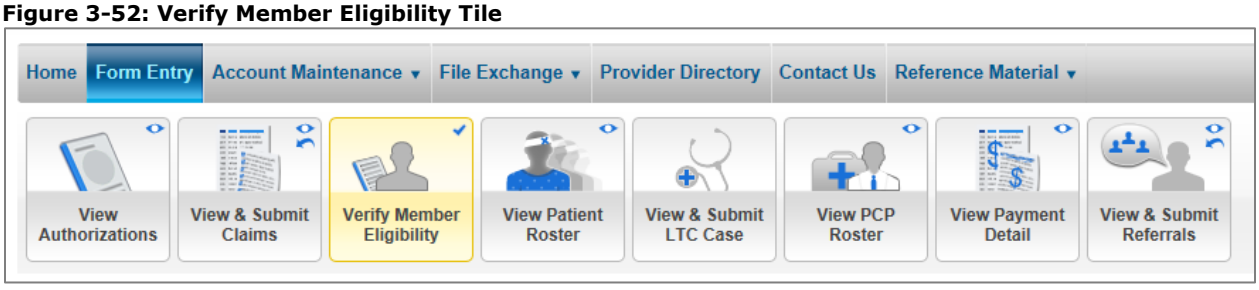
Figure 3-51: Replacement Claim



3.5. Eligibility Verification

To check participant eligibility, select the **Verify Member Eligibility** tile under the **Form Entry** tab.

Figure 3-52: Verify Member Eligibility Tile



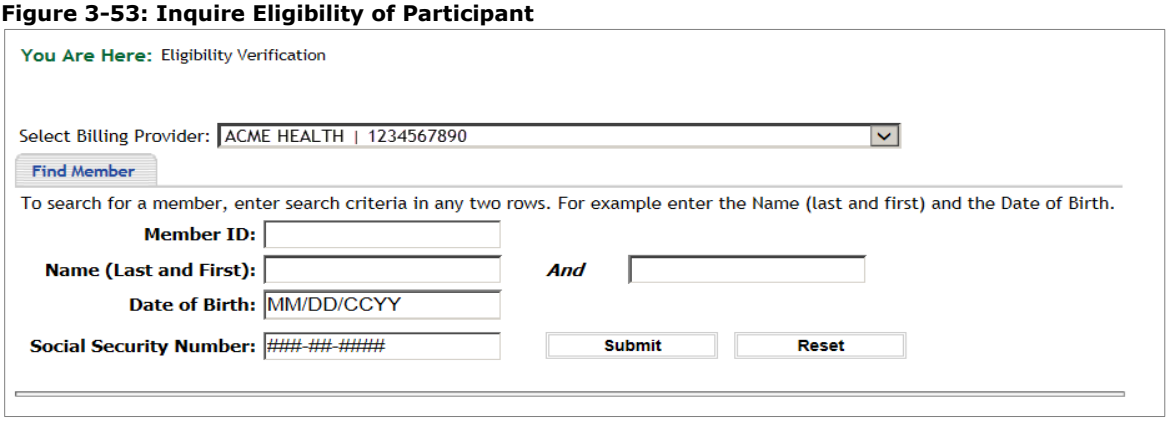
To locate a participant and verify eligibility, you need at least two of the following search criteria (Figure 3-53).

- Member ID

- Name (Last and First)
- Date of Birth
- Social Security Number

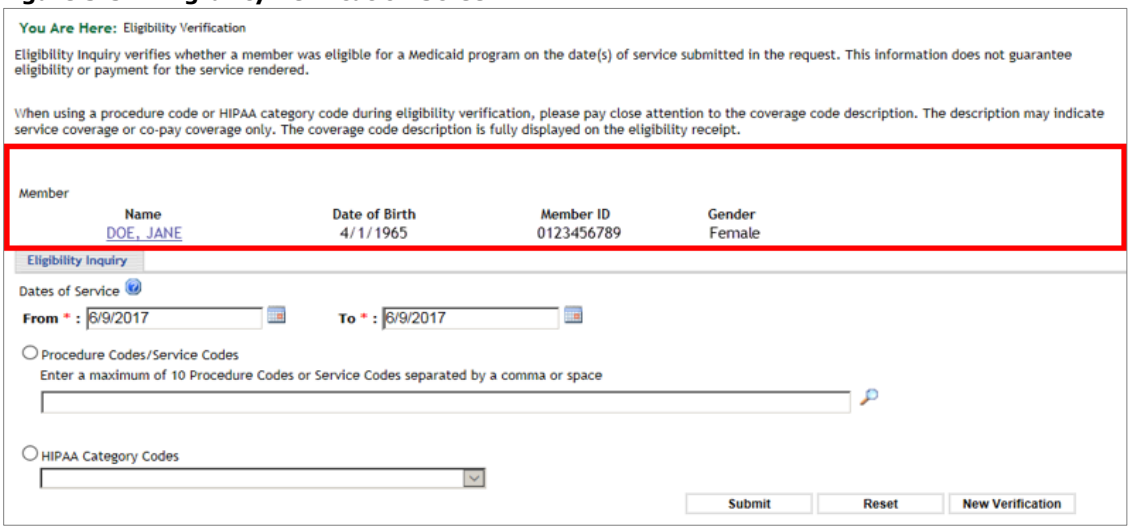
Note: It is important to verify eligibility for all Medicaid participants on the day the services are to be provided.

Figure 3-53: Inquire Eligibility of Participant



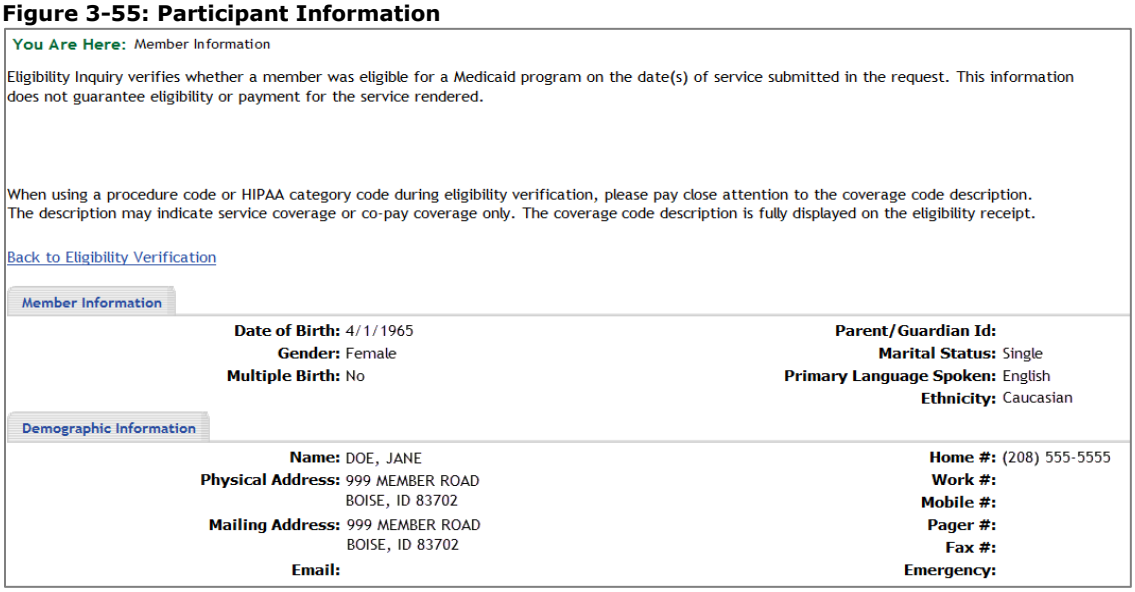
After the search criteria have been submitted, the Eligibility Verification screen will display (Figure 3-54) and the Name, Date of Birth, Medicaid ID, and Gender. This information cannot be edited.

Figure 3-54: Eligibility Verification Screen



To see additional information about the participant, including demographics, select the participant name. A window showing the participant information will open.

Figure 3-55: Participant Information



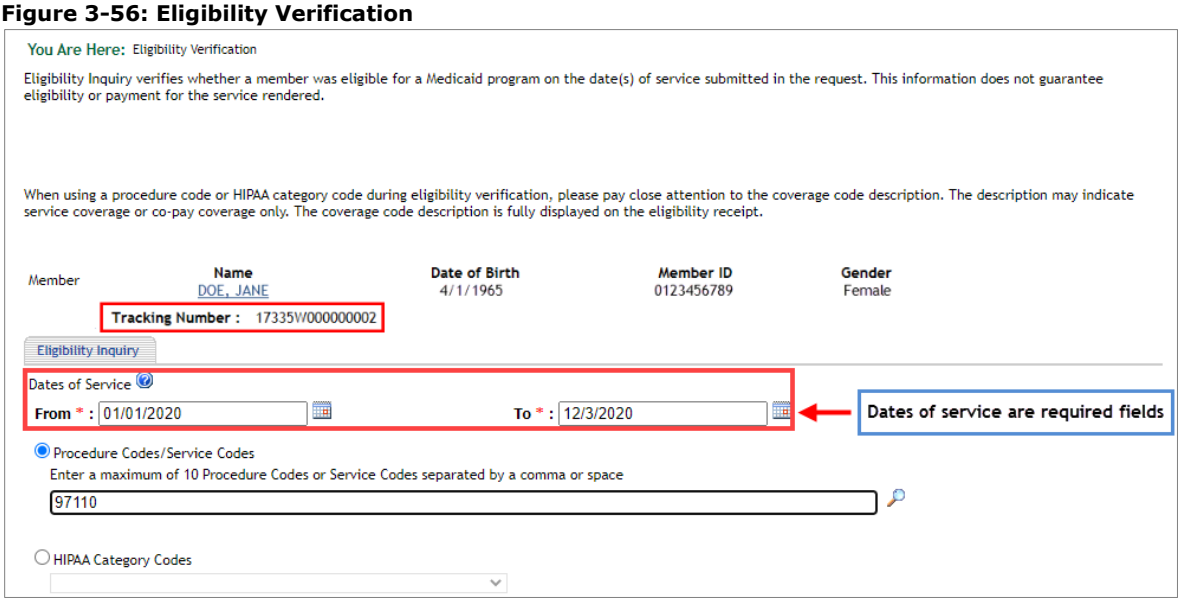
To go back to the *Eligibility Inquiry* screen, select the **Back to Eligibility Verification** link.

The Tracking Number (Figure 3-56) is used to provide proof (when requested) that the eligibility for the participant was verified; however, it does **not** provide the specific details that were returned. It is important to print and retain this, as this will contain the specific information returned in the eligibility verification. The *Eligibility Verification Response* screen can be printed by selecting the **Print Receipt** button found at the bottom of the screen. A new window displays the entire Eligibility Response with a **Print** button at the bottom.

The **Dates of Service**, both **From** and **To**, are required fields for this form. The dates can be entered manually using the format MM/DD/YYYY, or you can use the calendar at the end of each field.

- From Date
  - Automatically fills with current date
  - Date can be changed, but not for more than one year in the past
- To Date
  - Automatically fills with current date
  - Date can be changed, but cannot be a future date

Figure 3-56: Eligibility Verification



To receive the most accurate eligibility, enter the specific procedure or service codes to be billed.

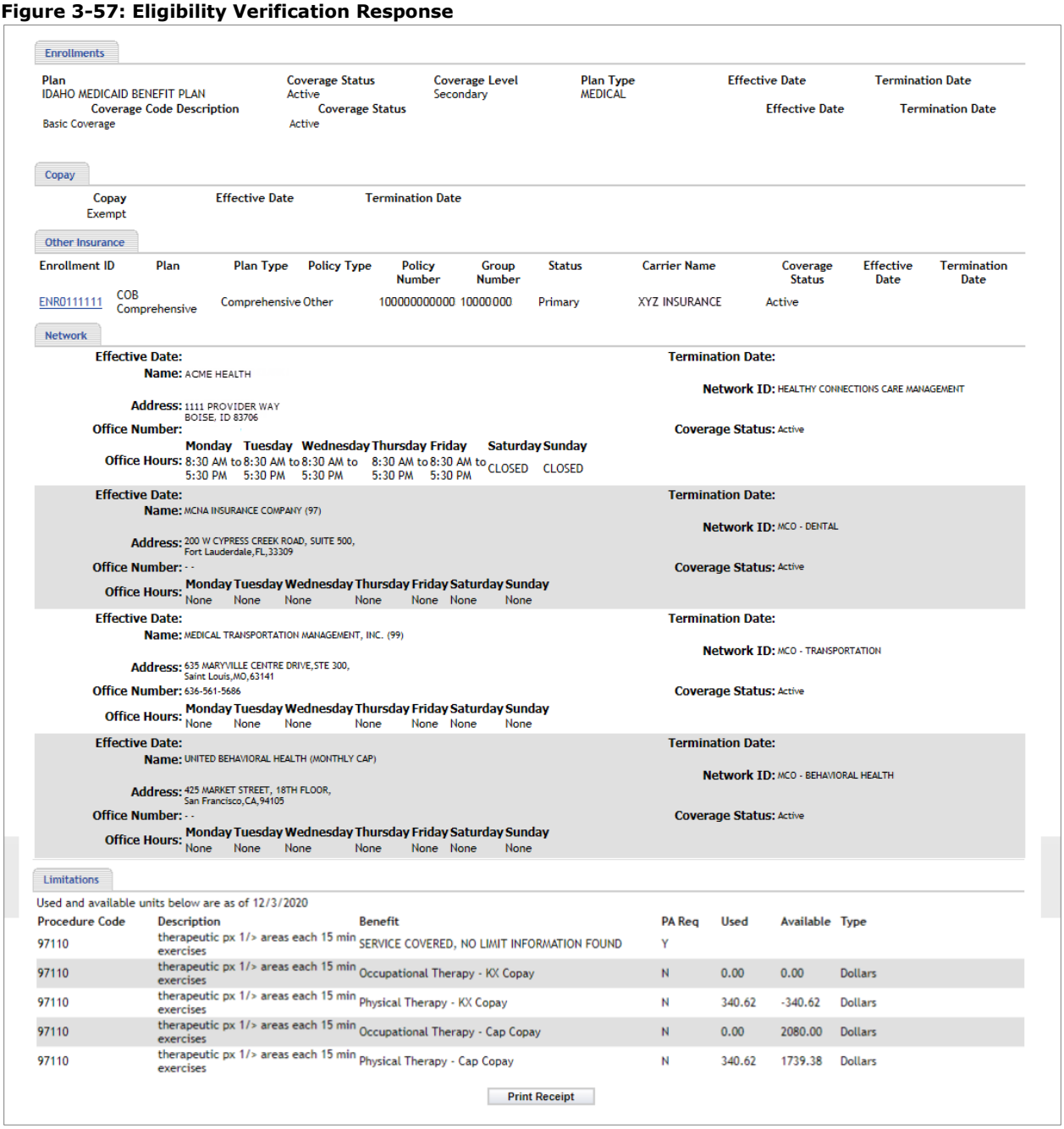
Using HIPAA Category Codes is not recommended. If a HIPAA Category Code shows eligible, that does not mean every service is eligibly. The information does not guarantee payment for services rendered. Please pay close attention to the details of the coverage code listed (Figure 3-57).

If further clarification is needed, call Provider Services Monday through Friday between 7 A.M. and 7 P.M. MT at 1 (866) 686-4272.

Selecting on the **Reset** button at any time clears all the values.

Select the **Submit** button to enter the request. After the request is submitted, the response will display (Figure 3-57).

Figure 3-57: Eligibility Verification Response



Enrollments

Plan	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date
IDAHO MEDICAID BENEFIT PLAN	Active	Secondary	MEDICAL		

Coverage Code Description	Coverage Status	Effective Date	Termination Date
Basic Coverage	Active		

Copay

Copay	Effective Date	Termination Date
Exempt		

Other Insurance

Enrollment ID	Plan	Plan Type	Policy Type	Policy Number	Group Number	Status	Carrier Name	Coverage Status	Effective Date	Termination Date
ENR0111111	COB Comprehensive	Comprehensive	Other	100000000000	10000000	Primary	XYZ INSURANCE	Active		

Network

Effective Date: **Termination Date:**
Name: ACME HEALTH
Network ID: HEALTHY CONNECTIONS CARE MANAGEMENT
Address: 1111 PROVIDER WAY BOISE, ID 83706
Office Number: **Coverage Status:** Active

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	8:30 AM to 5:30 PM	8:30 AM to 5:30 PM	8:30 AM to 5:30 PM	8:30 AM to 5:30 PM	8:30 AM to 5:30 PM	CLOSED	CLOSED

Effective Date: **Termination Date:**
Name: MCNA INSURANCE COMPANY (97)
Network ID: MCO - DENTAL
Address: 200 W CYPRESS CREEK ROAD, SUITE 500, Fort Lauderdale,FL,33309
Office Number: - - **Coverage Status:** Active

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	None	None	None	None	None	None	None

Effective Date: **Termination Date:**
Name: MEDICAL TRANSPORTATION MANAGEMENT, INC. (99)
Network ID: MCO - TRANSPORTATION
Address: 635 MARYVILLE CENTRE DRIVE,STE 300, Saint Louis,MO,63141
Office Number: 636-561-5686 **Coverage Status:** Active

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	None	None	None	None	None	None	None

Effective Date: **Termination Date:**
Name: UNITED BEHAVIORAL HEALTH (MONTHLY CAP)
Network ID: MCO - BEHAVIORAL HEALTH
Address: 425 MARKET STREET, 18TH FLOOR, San Francisco,CA,94105
Office Number: - - **Coverage Status:** Active

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	None	None	None	None	None	None	None

Limitations

Used and available units below are as of 12/3/2020

Procedure Code	Description	Benefit	PA Req	Used	Available	Type
97110	therapeutic px 1/> areas each 15 min exercises	SERVICE COVERED, NO LIMIT INFORMATION FOUND	Y			
97110	therapeutic px 1/> areas each 15 min exercises	Occupational Therapy - KX Copay	N	0.00	0.00	Dollars
97110	therapeutic px 1/> areas each 15 min exercises	Physical Therapy - KX Copay	N	340.62	-340.62	Dollars
97110	therapeutic px 1/> areas each 15 min exercises	Occupational Therapy - Cap Copay	N	0.00	2080.00	Dollars
97110	therapeutic px 1/> areas each 15 min exercises	Physical Therapy - Cap Copay	N	340.62	1739.38	Dollars

Print Receipt

The participant's plans are listed under the **Enrollments** tab. Each plan heading will display the **Coverage Code Descriptions** for that particular plan. This section displays the types of coverage for which the participant is eligible. It will also show if a participant has any conditions that may impact their services.

Effective 1/31/2017, the Idaho Smiles and Idaho Behavioral Health coverage segments will no longer display under the **Enrollments** tab. Beginning 1/1/2018, dental and behavioral health coverage can be verified if a Managed Care Organization (MCO) for these coverages is listed under the **Network** tab.

If a participant has MMCP or Idaho Medicaid Plus coverage, refer to the Network tab to determine whether the coverage is through Blue Cross of Idaho or Molina Healthcare (Figure 3-58) or (Figure 3-59).

If a participant is an incarcerated inmate, and qualifies for Medicaid, their eligibility will reflect **INPATIENT ONLY** (Figure 3-60).

Figure 3-58: MMCP Eligibility

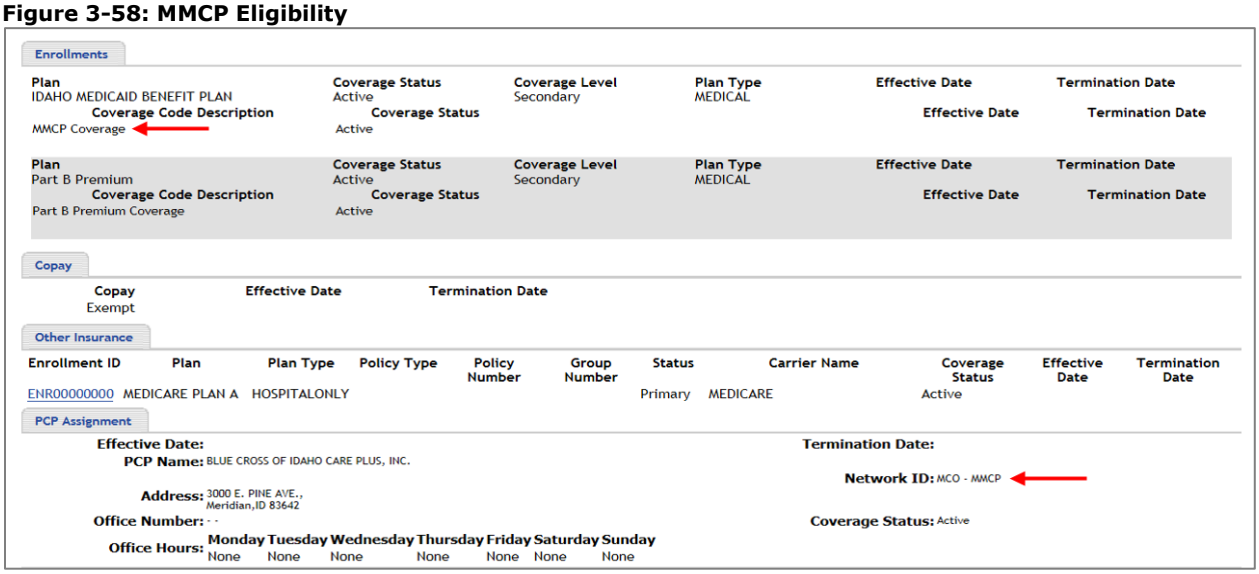


Figure 3-59: Idaho Medicaid Plus Eligibility

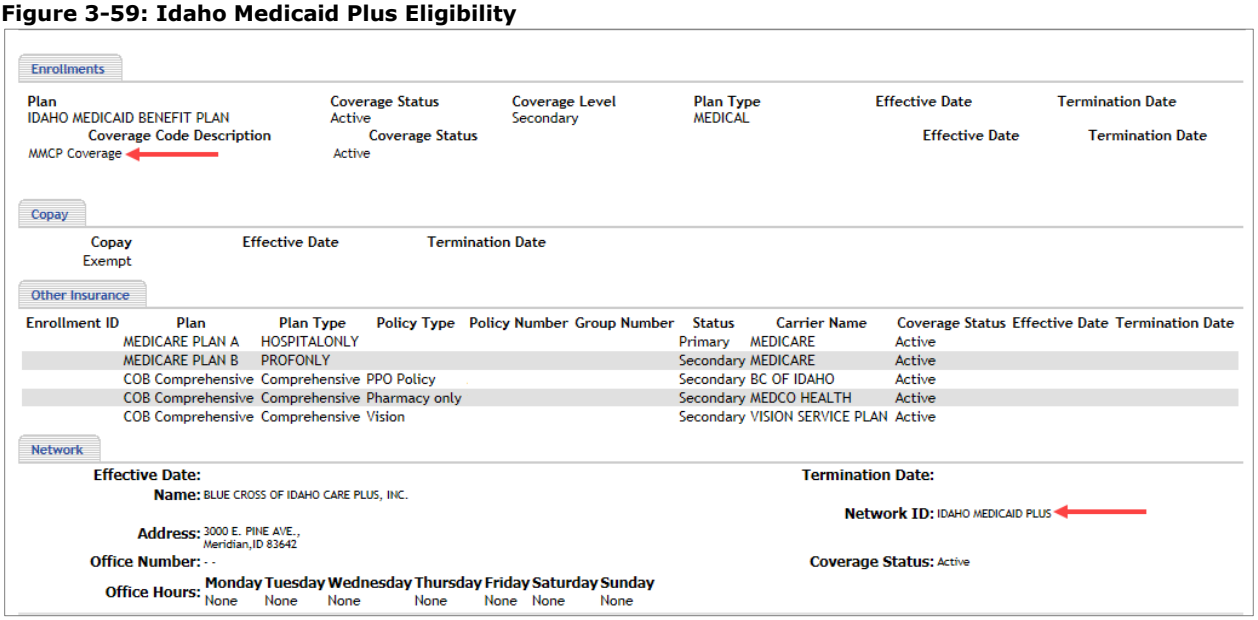


Figure 3-60: Inpatient Only

The *Coverage Status* column populates as either *Active* or *Partial*. The effective/termination dates are populated only when coverage is partial. See the following example.

When the enrollment is active for the entire inquiry period, the coverage status is displayed as *Active*. Otherwise, the coverage status is displayed as *Partial* and either the effective date, or termination date, or both are populated. The table below shows the enrollment information that would display for a member with enrollment active from 1/1/2017 to 12/31/2017.

Note: The Share of Cost tab is not available unless the provider is one that can verify Share of Cost (SOC) amounts. For providers that verify SOC amounts, it is important to enter the first day of the month in the eligibility verification query.

Coverage Status for Enrollment of 1/1/2017 to 10/31/2017			
Inquiry Period	**Coverage Status**	**Effective Date**	**Termination Date**
3/1/2017 – 10/31/2017	Active	Blank	Blank
10/1/2016 – 10/31/2017	Partial	1/1/2017	Blank
3/1/2017 – 10/31/2017	Partial	Blank	9/30/2017

Reminder: Print the *Eligibility Verification Response* screen by selecting the **Print Receipt** button.

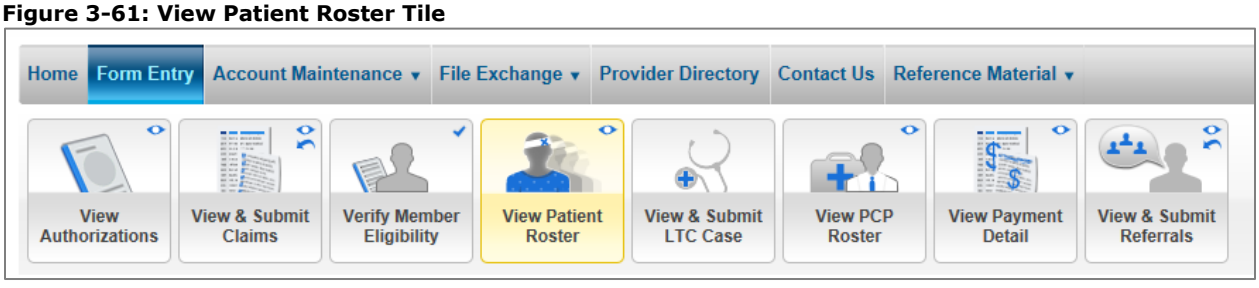
After printing the response, you can select the **New Verification** button (above the Eligibility Verification Response) to search for a different participant's eligibility.

3.6. Patient Roster

A patient roster allows you to verify eligibility and submit a claim or referral directly from the *Patient Roster* screen. You can create a custom roster or a list of participants (members) associated with a particular billing provider. To access the patient roster, select the **View Patient Roster** tile under the **Form Entry** tab.

Note: The Patient Roster is different than the Primary Care Provider (PCP) Roster.

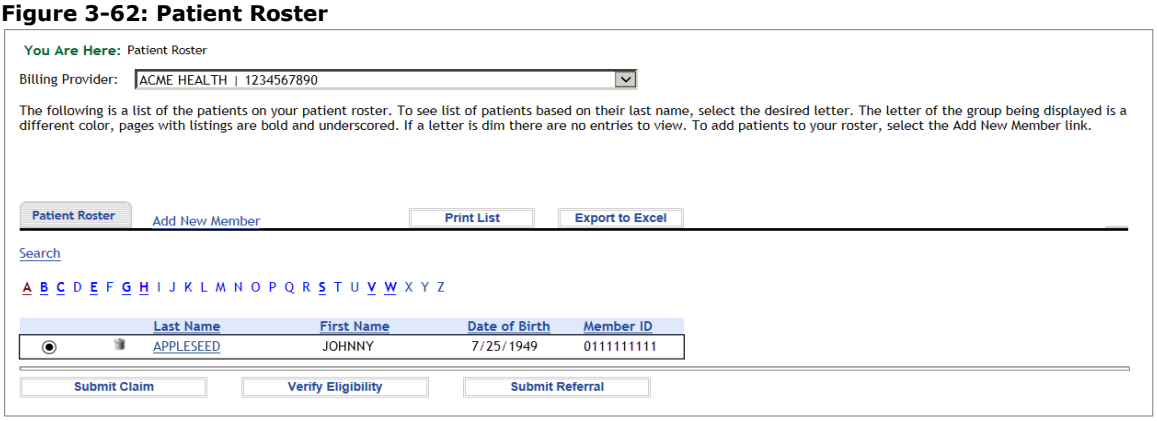
Figure 3-61: View Patient Roster Tile



The *Patient Roster* screen displays alphabetically by last name (Figure 3-62).

Select the appropriate billing provider. This information will be auto-populated if there is only one billing provider associated to the TPA. The patient roster will display with participants sorted alphabetically by last name.

Figure 3-62: Patient Roster



To view the participant's demographic information, select their **Last Name**.

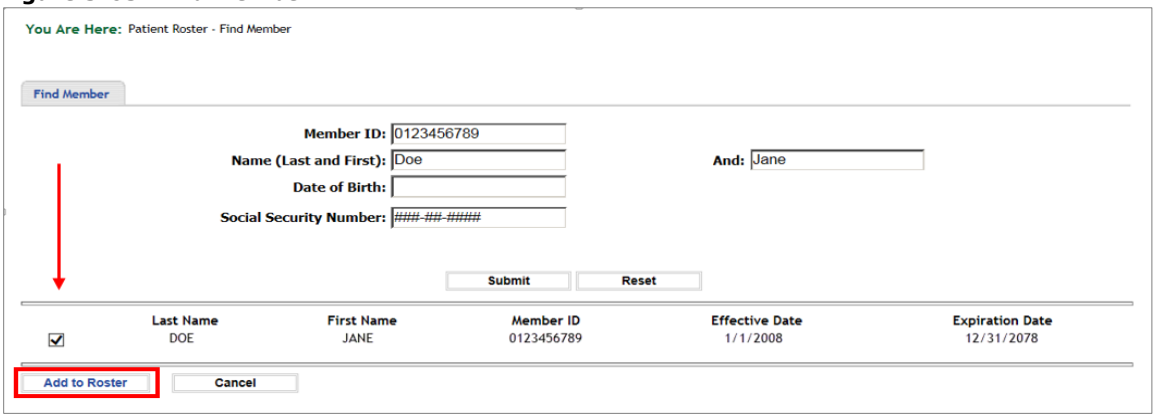
To search your patient roster for a specific participant, select on the **Search** link or select one of the highlighted letters below the link to browse by last name.

Note: Select **Print List** to print the roster of all members or **Export to Excel** to send the roster to an excel spreadsheet.

3.6.1. Add or Remove a Member from your Patient Roster

To add a participant (member) to the patient roster, select the **Add New Member** link. The **Find Member** fields display. Fill in at least two search fields and select the **Submit** button, and the participant's information displays. Select the checkbox in front of the participant's name and then select the **Add to Roster** button to add the patient to your roster.

Figure 3-63: Find Member



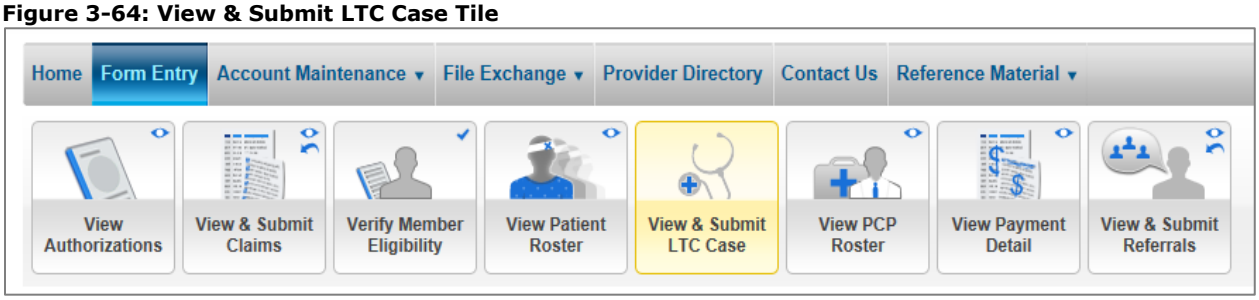
If you want to remove a participant from your roster, select the recycle bin icon next to the last name of the participant on the *Patient Roster* screen (Figure 3-62).

To verify eligibility, submit a claim, or submit a referral, first select the radio button in front of the name of the participant. Then select one of the buttons at the bottom of the screen to initiate the desired form.

- Verify Eligibility – See *Eligibility Verification*
- Submit Claim – See *Submit and Process a Claim*
- Submit Referral – See *Referrals*

3.7. Long Term Care Case Submission and Status

Figure 3-64: View & Submit LTC Case Tile

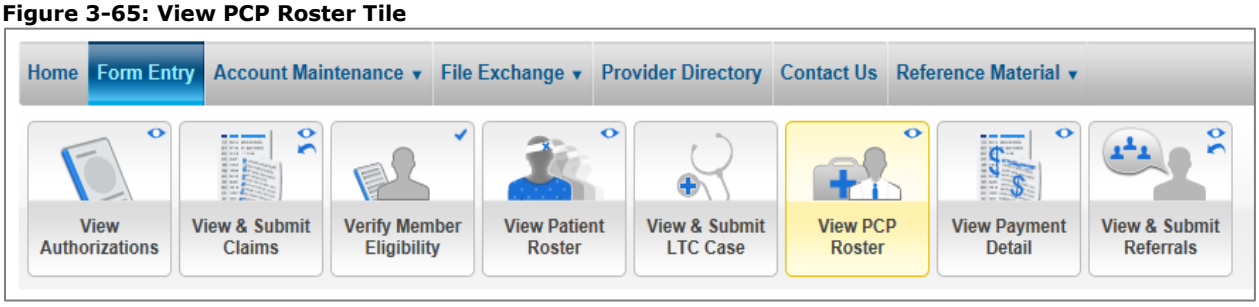


For more information on submitting and reviewing LTC cases, please refer to the Trading Partner Account LTC User Guide.

3.8. Primary Care Provider (PCP) Roster

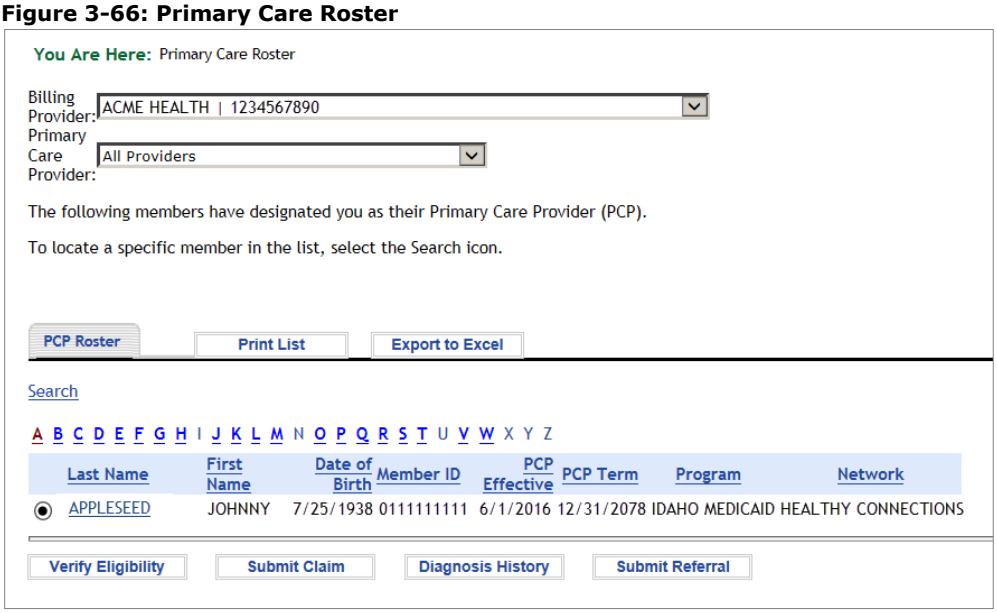
The PCP Roster is a system-generated list of participants that are assigned to a service location, and it displays only for Healthy Connections providers. Select the **View PCP Roster** tile under the **Form Entry** tab to access the PCP Roster.

Figure 3-65: View PCP Roster Tile



The *Primary Care Roster* screen will display (Figure 3-66). Select the appropriate billing provider from the first drop-down menu and the appropriate service location (PCP) from the second drop-down menu. The PCP roster will display the current participants assigned to that service location (PCP) as of the day it is viewed.

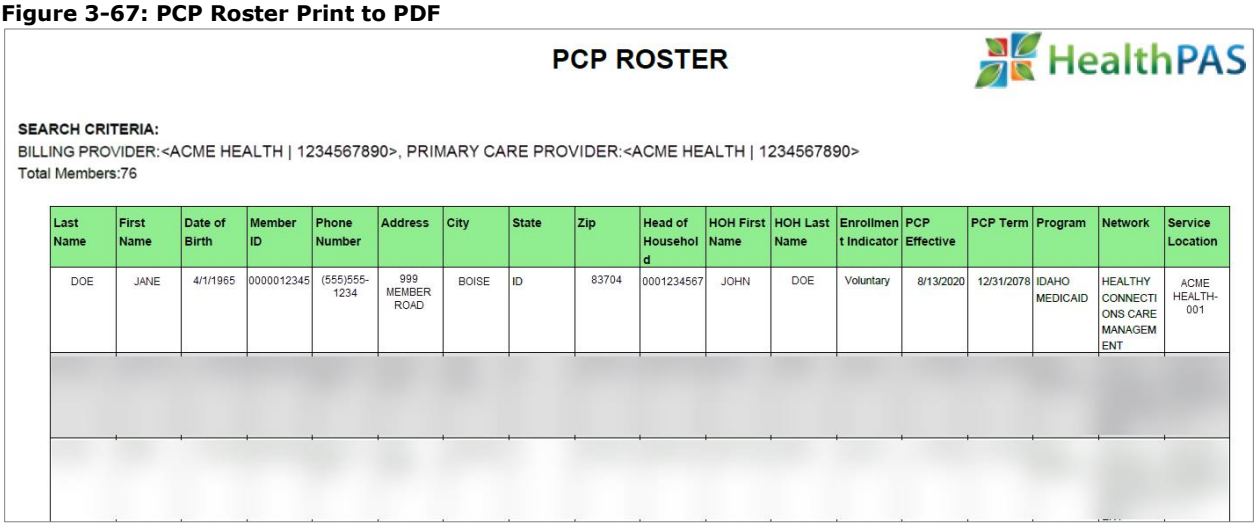
Figure 3-66: Primary Care Roster



The dynamic PCP Roster can be exported to Excel or PDF by selecting **Print List** or **Export to Excel**. The following pieces of information are available on the exported version of the roster (Figure 3-67):

- Participant's Last and First Name
- Participant's Date of Birth
- Participant's Member ID
- Participant's Phone Number
- Participant's Address, including City, State, and Zip Code
- The Head of Household's (HOH) Member ID
- HOH First and Last Name
- Participant's Enrollment Indicator (Voluntary or Mandatory)
- PCP Effective and Term Date
- Participant's Program assignment
- Participant's Network
- Service location

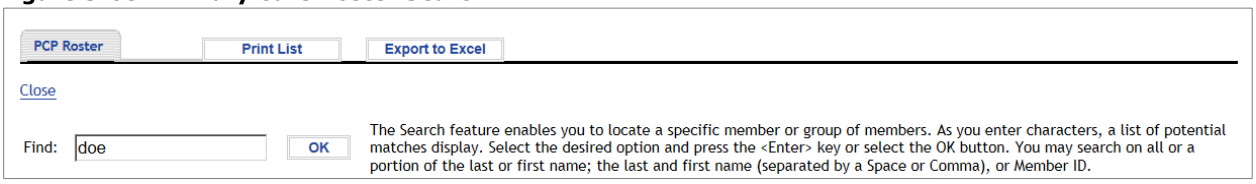
Figure 3-67: PCP Roster Print to PDF



To view the participant's demographic information, select their **Last Name.**

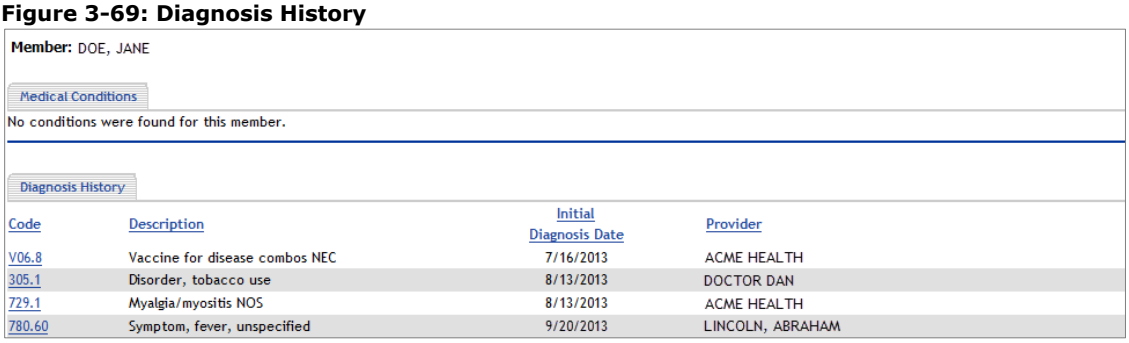
To search your PCP roster for a specific participant, select the **Search** link or select one of the highlighted letters below the link to browse by last name.

Figure 3-68: Primary Care Roster Search



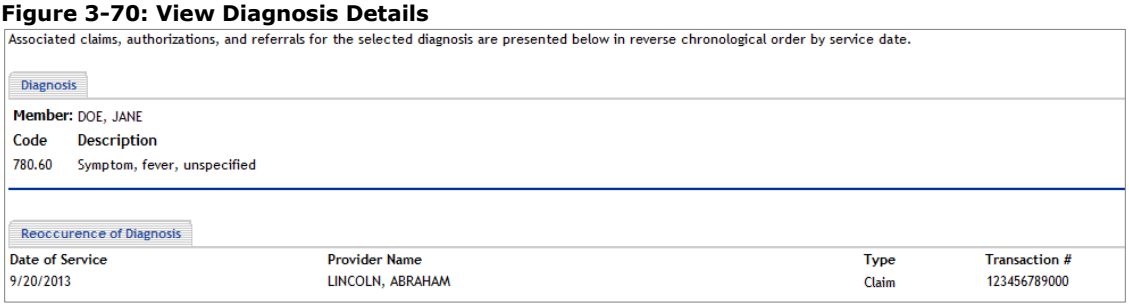
Diagnosis History is at the bottom of the screen. Select this button to display the *Medical Conditions* and *Diagnosis History* for the selected participant (Figure 3-69). The diagnoses are listed in chronological order with the oldest diagnosis first. You can sort this list by diagnosis code, description, initial diagnosis date, and provider by selecting the column heading.

Figure 3-69: Diagnosis History



Select Next-> or <-Prev in the lower right to see other pages in the list of the Diagnosis History. Select a diagnosis code to see a list in date order of the Medicaid visits associated with that diagnosis (Figure 3-70).

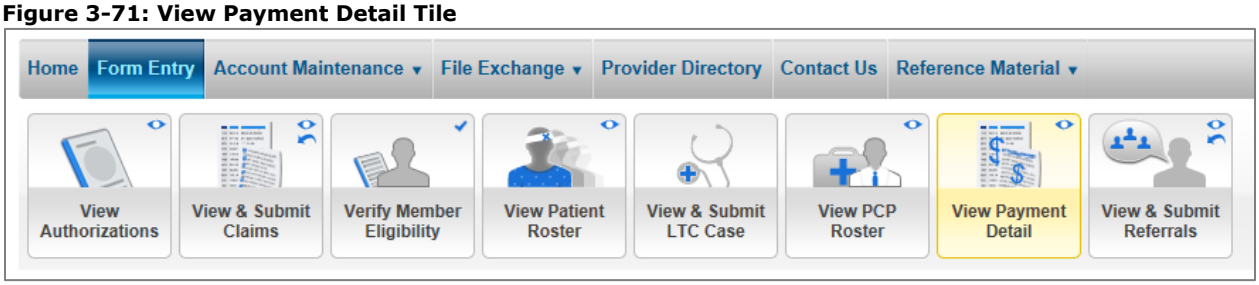
Figure 3-70: View Diagnosis Details



3.9. Payment Detail

Access provider payments by selecting **View Payment Detail** under the **Form Entry** tab.

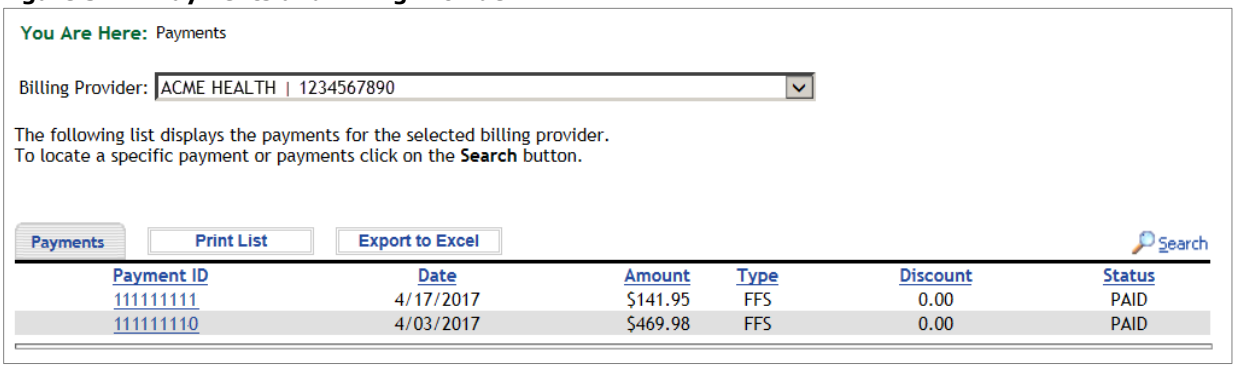
Figure 3-71: View Payment Detail Tile



Payments made to billing providers, and the claims associated with these payments, can be viewed in this window (Figure 3-72).

This screen displays the 40 most recent payments. To view additional payments, the user may search by selecting the appropriate billing provider from the drop-down menu. This information will be auto-populated if there is only one billing provider associated to the TPA. Select the **Search** button and enter additional search criteria to narrow your search. You can also print the list or export to Excel.

Figure 3-72: Payments and Billing Provider



Select a **Payment ID** in the first column to see additional information about that payment. The ***Payment Detail Screen*** will display (Figure 3-73).

To return to the payment list, select the **Back to Payments** button at the bottom of Payment Detail screen.

To view a claim included in a payment, select the **Claim #**. The *View Claim* screen displays (Figure 3-74).

Figure 3-73: Payment Detail

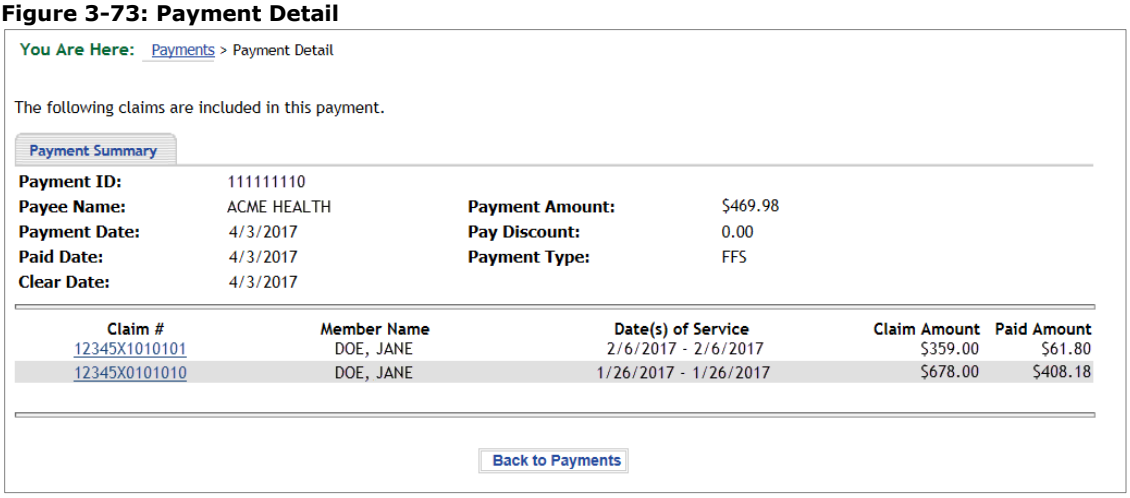
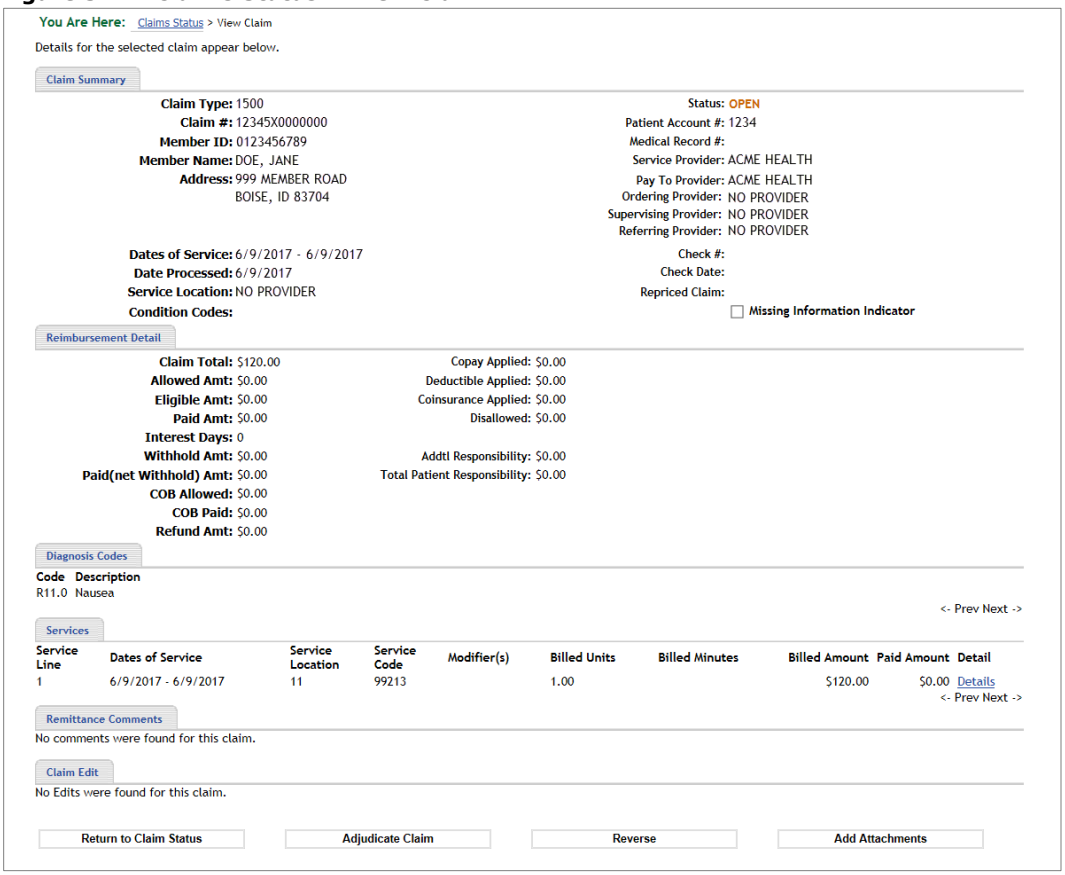


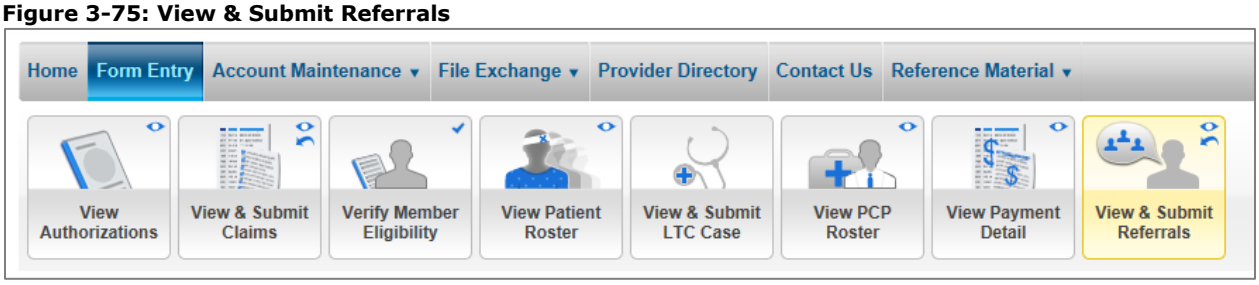
Figure 3-74: Claims Status > View Claim



3.10. Referrals

Referrals and authorizations are handled separately. To submit a new referral or view a referral status, select the **View & Submit Referrals** tile under **Form Entry**.

Figure 3-75: View & Submit Referrals



Referrals can only be entered online by a member's current PCP organization.

- Paper referrals should not be faxed to Gainwell Technologies and will not be entered in the system.
- For instructions to retrieve a referral, see *View a Referral* below.
- To make sure the referred-to providers can successfully retrieve referrals online, it is important that they provide the PCP with their correct organization pay-to NPI.
- Make sure that all of the information is correct before submitting the referral. If the referral is found to be incorrect, it cannot be changed and a new referral will need to be entered.

Note: To submit or retrieve a referral, the user must have R5 R8 Utilization Management access via the **Manage Users** link under the **Account Maintenance** tab (for more information on managing users, see the *Trading Partner Account Registration and Account Maintenance User Guide* on www.idmedicaid.com).

3.10.1. View a Referral

From your TPA, select the **View & Submit Referrals** title under the Form Entry (Figure 3-75) to retrieve referrals as either the refer-from or refer-to provider. The screen displays the most recent 40 referrals. To view additional referrals, follow the steps below.

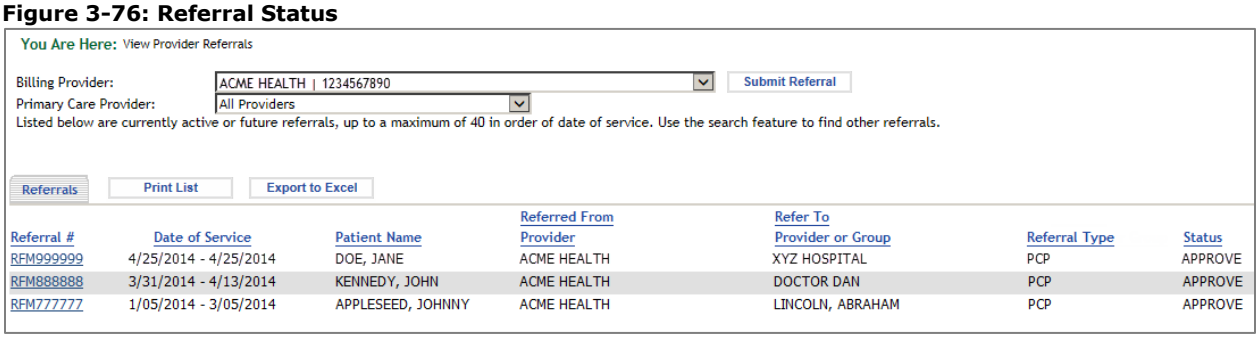
Note: To ensure referred-to providers can successfully retrieve referrals online, it is important they provide the PCP with their correct pay-to organization NPI.

3.10.1.1. View/Search Provider Referrals

The View Provider Referrals window is organized by provider and displays active referrals and the status.

1) Select the appropriate billing provider. This information will be auto-populated if there is only one billing provider associated to the TPA.
2) **Primary Care Provider**: Select *All Providers* from the drop-down menu or choose a service location associated to that billing provider.
3) After selecting the PCP, any referral active during the last 30 days will be displayed. This includes referrals issued or received (Figure 3-76).
4) Sort the columns by selecting any heading.

Figure 3-76: Referral Status



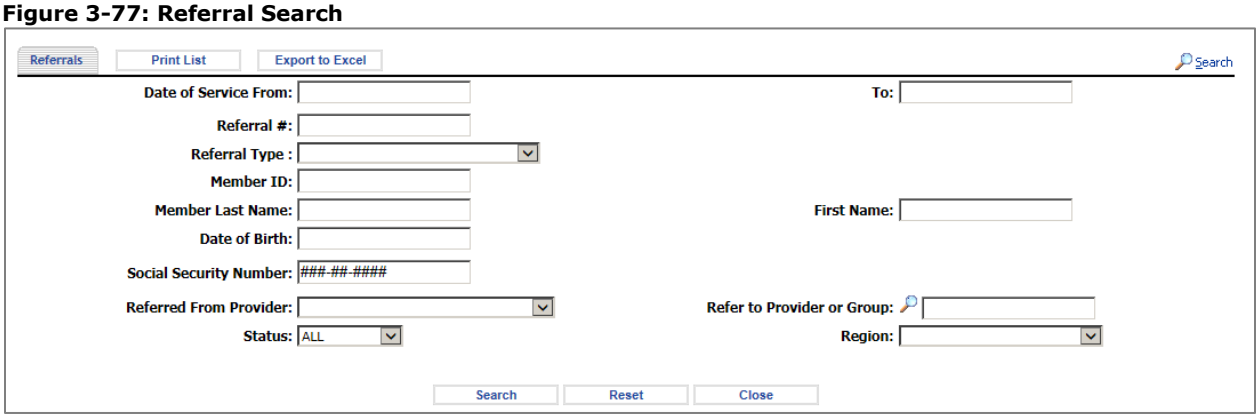
5) To view additional referrals, select the **Search** icon and enter search criteria (Figure 3-77).

6) To view "all," clear the **Date of Service** fields. Then select the **Search** button. To move between multiple pages, use the next or previous option located at the lower right of the page.
    a. If a referral is not viewable and the organization has multiple NPIs, try choosing a different billing provider's NPI to search for the referral.

7) Select a Referral # link to display the details (Figure 3-76).
8) Select the **Print List** button to print, or select the **Export to Excel** button to export to an Excel spreadsheet.

Note: The service location and address associated to a referral can be viewed after exporting the list to excel.

Figure 3-77: Referral Search

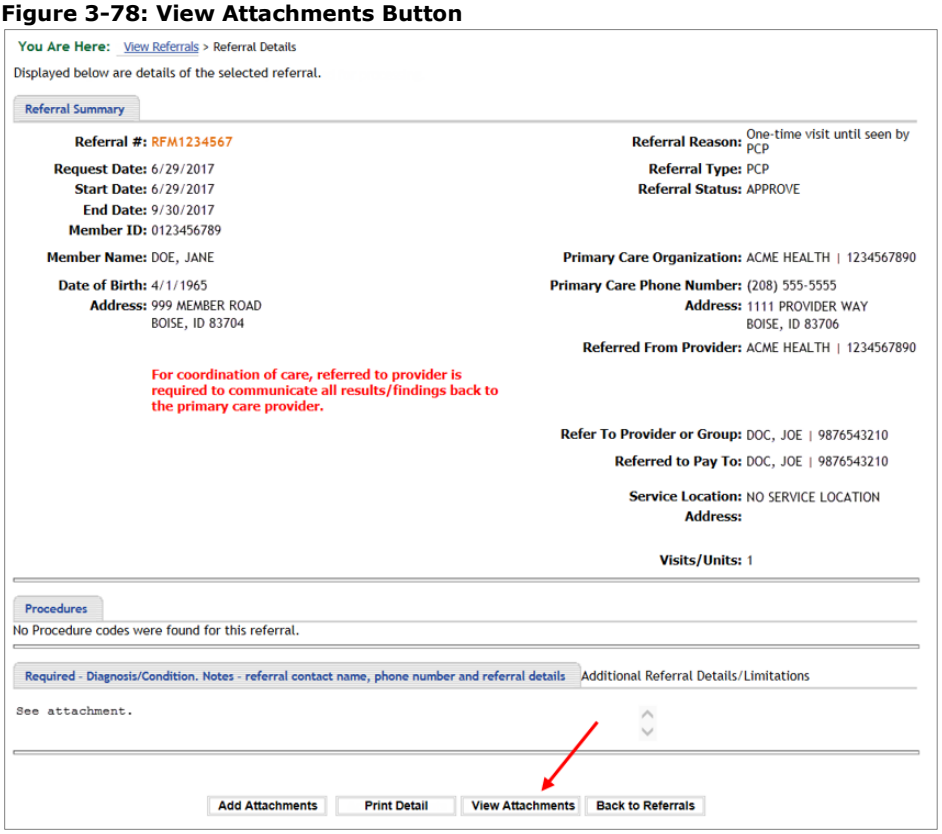


Viewing an Attachment

To view attachments that have been sent with the referral, use the following steps.

1) Select the specific Referral # link. The Referral Details window displays.
2) Select the **View Attachments** button (Figure 3-78).
3) The *View Attachment* window opens.

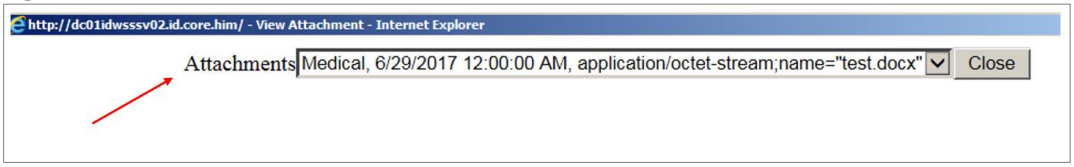
Figure 3-78: View Attachments Button



4) Select the **Attachments** field to show a list of attachments (Figure 3-79).

5) Select the attachment to download. The *File Download* box displays, allowing the ability to open and save the attachment(s).

Figure 3-79: File Attachment



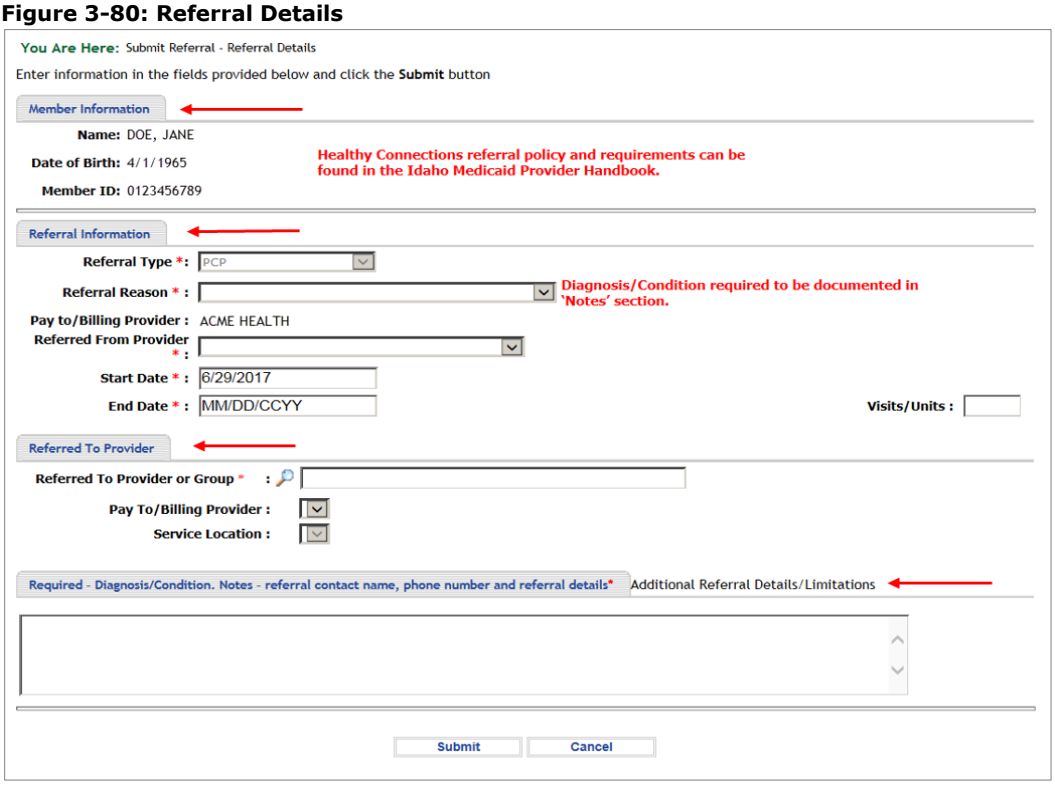
3.10.2. Submit a Referral

To submit a referral, access your PCP Roster and locate the member. Select the **Submit Referral** button to continue.

3.10.3. Referral Details

The *Referral Details* screen displays (Figure 3-80). There are four sections to the *Referral Details* screen, each requiring specific information explained in the subsections below.

Figure 3-80: Referral Details



3.10.3.1. Member Information

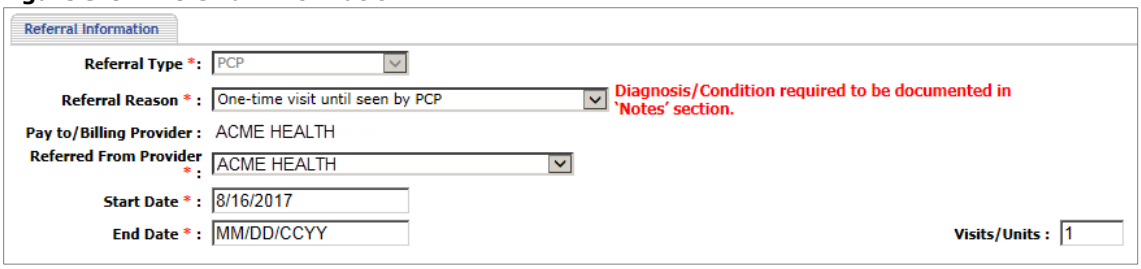
Confirm that the correct member was selected. If not, select the **Cancel** button and start the search again.

3.10.3.2. Referral Information

The pay-to/billing provider information will auto-populate from the previous screen.

Required fields are noted with a red asterisk (*).

Figure 3-81: Referral Information

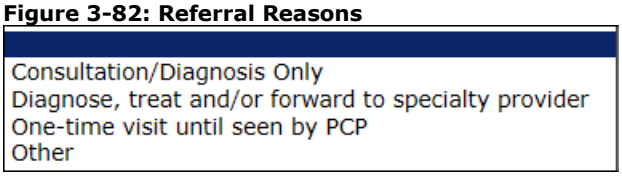


Referral Information Fields

The referral information fields are described as follows:

- **Referral Type** *: The referral type auto-populates with *PCP*.
- **Referral Reasons** *: Select an applicable reason from the drop down list of options (Figure 3-82).

Figure 3-82: Referral Reasons



Diagnosis/Condition required to be documented in 'Notes' section.

Note: ALL referral reasons require information about the diagnosis/condition to be documented in the *Notes* section at the bottom of the *Referral Details* screen.

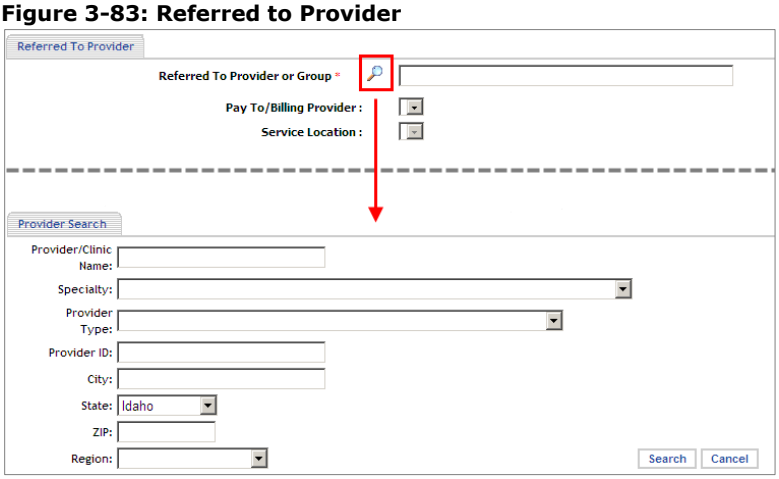
For additional instructions on notes, see *3.10.3.4 Notes*.

- **Referred From Provider** *: Displays a list of ALL service locations.
  Note: If there is only one primary care affiliation, the field will auto-populate.
- **Start Date***: Enter the start date that the referral is effective. (This defaults to the current date.)
- **End Date***: Enter the date that the referral should terminate.
  - If the End Date is not entered, it defaults to 365 days from the Start Date. *It is important that the appropriate end date be modified if referral intent is less than 365 days.*
- **Visits/Units**: Enter the number of visits/units. Visits must be greater than 0 and less than 9999.
  Note: If the Referral Reason selected is *One-time visit until seen by PCP,* the *Visits/Units* field defaults to "1." If the value is more than 1, the error message "Maximum Number of Visits/Units for this Referral Reason is 1" will display at the top of the screen.

3.10.3.3. Referred To Provider

1) Select the search icon to find a Referred To Provider or Group (Figure 3-83).
2) *Provider Search* criteria includes:
   - **Provider/Clinic Name**: Enter a partial or full name of a provider or clinic (service location).
   - **Specialty**: Choose from the alphabetical drop-down list.
   - **Provider Type:** Choose from the alphabetical drop-down list.
   - **Provider ID**, enter the NPI number, if known.
     Note: Searching by NPI brings back all providers affiliated to that NPI.
   - **City**: Enter a partial or full name of the city.
   - **State:** Defaults to the state of Idaho; however this can be changed by making a selection from the drop-down list.
   - **Zip**: Enter the provider's service location zip code.
   - **Region**: Select from the drop-down list.

Figure 3-83: Referred to Provider



In Figure 3-84, the search results display providers that met the entered search criteria.

Note: The search results can display up to 300 providers. If more than 300 providers are found with the criteria entered, you will be prompted to refine your search.

1) Select the radio button next to the identified provider/group. Be cautious to review all information for each provider to confirm the correct refer to individual provider or group is chosen at the correct service location.

Note: In determining the correct Referred To Provider, the PCP can choose to issue a referral to a medical group or to a specific rendering provider within a medical group.

2) Scroll to the bottom of the *Search Results* screen and select the **Continue** button.

Figure 3-84: Provider Selection

The *Referred To Provider* tab populates with the provider or group that was selected in the search screen.

The **Pay To/Billing Provider** displays a drop-down list of Pay-To providers affiliated with the referred to provider/group selected.

Note: If there is only one Pay-To/Billing Provider associated with the selected provider/ group, the system will default to the Pay-To/Billing Provider. If multiple results are available in the drop-down, select the applicable provider.

The **Service Location** displays a drop-down list based on the selection of the Pay-To/Billing Provider. If multiple service locations exist, select the location from the available options in the drop-down. The Service Location is not a required field, however it is recommended for the service location information to display on the referral summary.

3.10.3.4. Notes

The **Notes** tab is required for all referral reasons. Information about the diagnosis/condition should be entered into this field, including additional referral details/limitations.

Notes entered on the referral can be read by the referring provider and the referred-to provider.

3.10.3.5. Submitting the Referral

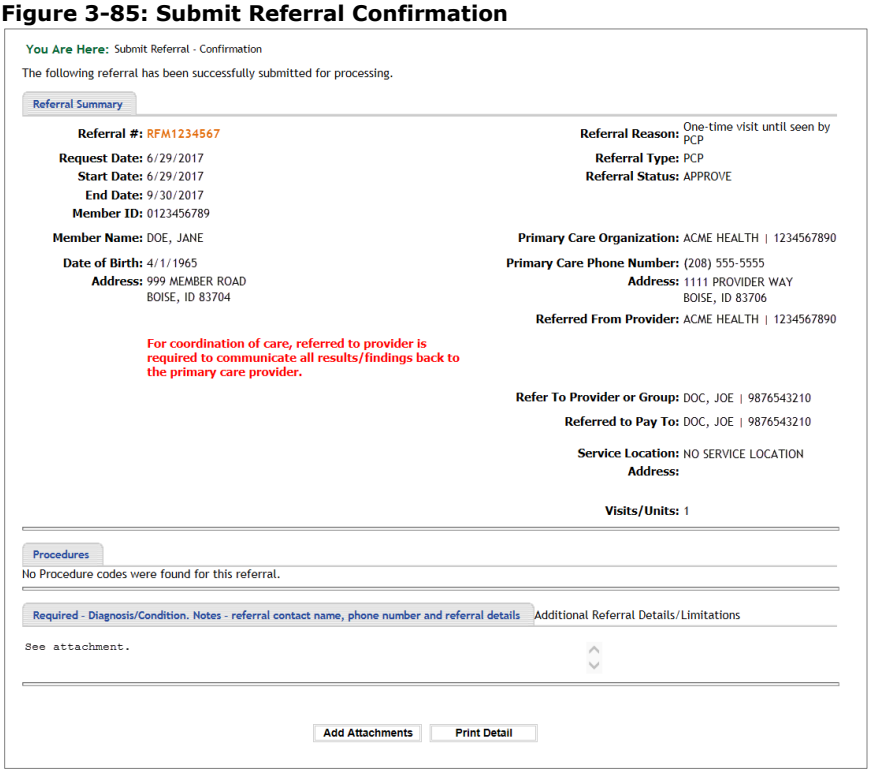
1) Select the **Submit** button. The message "Do you want to submit the referral? Once you select Submit, you cannot change the "referral" displays.
2) Select **OK**, if NO changes need to be made.
3) Select **Cancel**, if changes need to be made.

Once a referral is submitted, changes ***CANNOT*** be made. *A new referral* must be entered.

After submitting the referral, the system generates a confirmation with the referral information and a confirmation number. This confirmation referral number should not be entered on any claim. It is the responsibility of the billing provider to ensure the referral is in place prior to rendering care.

The system provides the options to **Print Detail** or **Add Attachments**. For more information on adding attachments, see *3.2.4.1 Upload Attachments*.

Figure 3-85: Submit Referral Confirmation



3.10.3.6. No Active Internal Enrollment Error Message

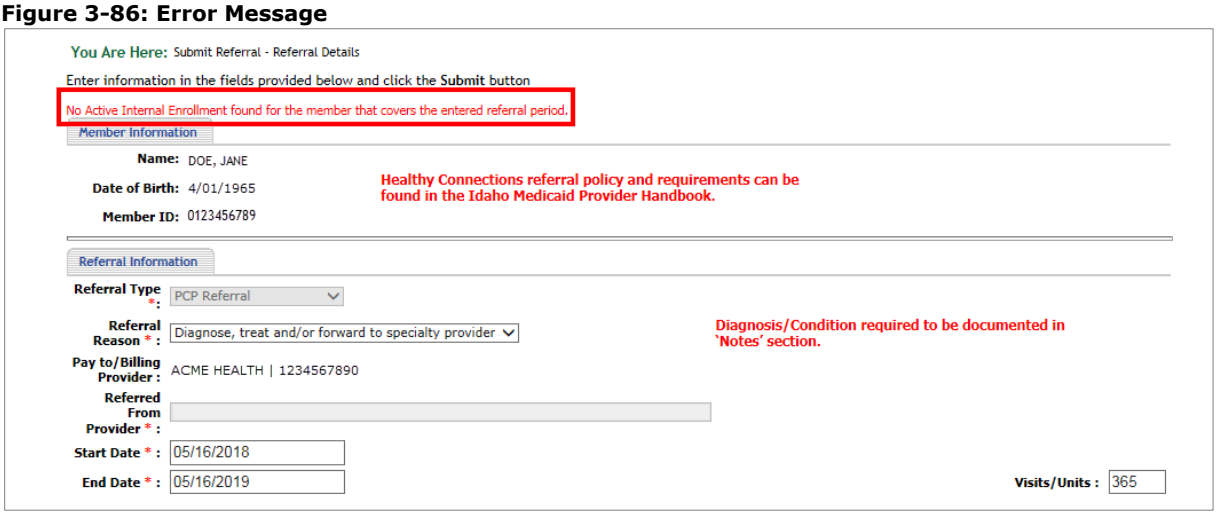
If the member becomes prospectively eligible for Medicare during the date span of the referral, their Medicaid eligibility will become secondary. This will cause their primary Medicaid coverage to terminate on the last day of the month, before their Medicare takes effect as the primary insurance, and their secondary Medicaid coverage to begin the first of the following month.

Even though there is not gap in their Medicaid coverage, the system does not look beyond the termination date of the primary Medicaid coverage, and will not allow a referral to be submitted with a date span that extends beyond the Medicaid termination date. In this case you'll receive the error message shown below (Figure 3-86).

In order to complete the referral it will need to be done in two segments. One effective the first day of the referral and ending the same date as the primary Medicaid coverage. The second segment beginning the first of the next month and ending when the referral ends.

If further assistance is needed to confirm the start and end dates needed for the referral, call Provider Services Monday through Friday between 7 A.M. and 7 P.M. MT at 1 (866) 686-4272.

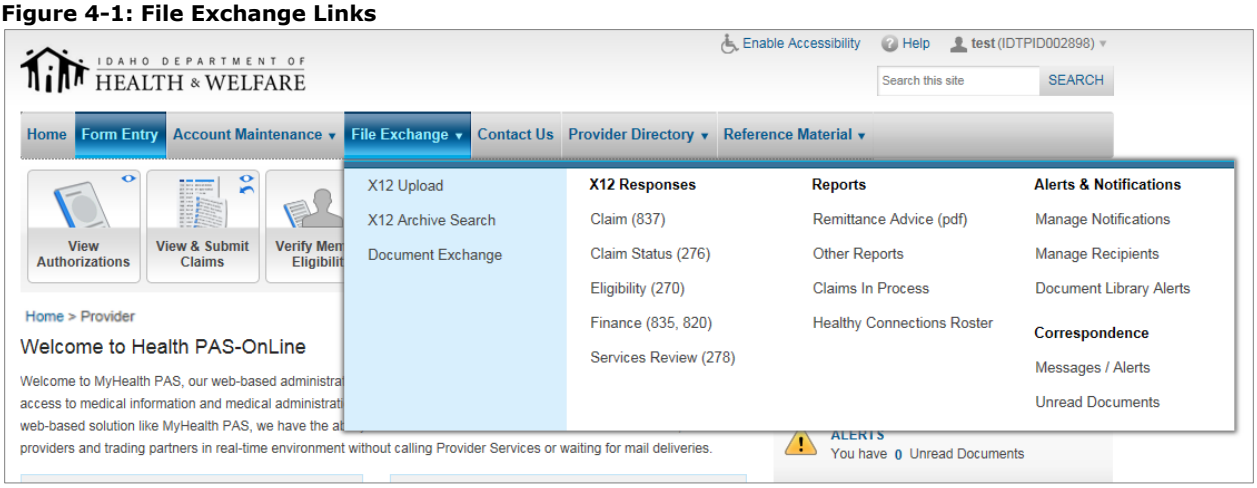
Figure 3-86: Error Message



4. File Exchange

These links allow for X12 Upload, Archive Search, Document Exchange and viewing of Responses, Reports, and alerts, notifications, and Secure Messaging.

Figure 4-1: File Exchange Links



4.1. X12 Upload

All trading partners must be individually certified to submit production EDI transactions. Please refer to the respective **Companion Guide** link under the **Reference Material** tab.

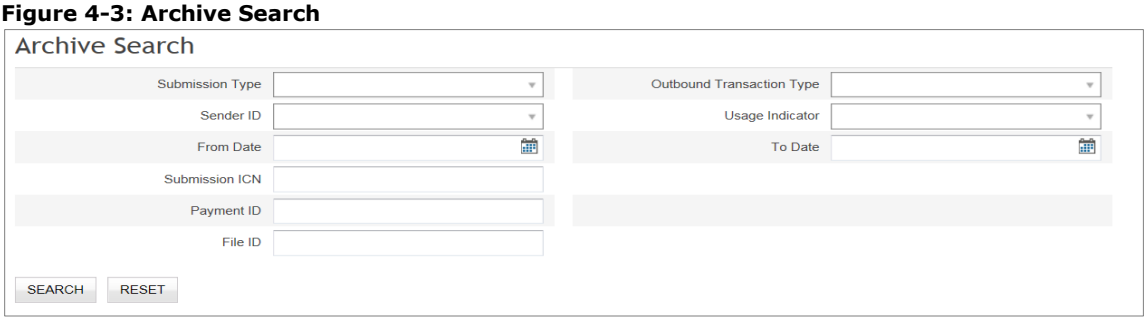
Figure 4-2: X12 Upload

4.2. X12 Archive Search

Use the **X12 Archive Search** to search and display both inbound and outbound X12 files. Transactions are maintained online for two years and then moved to offline storage. Transactions will be archived in offline storage for ten years. Requests for offline storage items may be made through the Technical Services Help Desk. Offline storage items will be supplied by posting the requested items to a secured document library.

The Archive Search screen will display (Figure 4-3). Enter as many criteria as possible. The search is limited to a three-month window using the **From Date** and **To Date** to reduce the impact on various systems.

Figure 4-3: Archive Search



If you need clarification on these fields, refer to the respective **Companion Guide** link under the **Reference Material** tab.

4.3. Document Exchange

The **Document Exchange** link can be used to transmit documents to various entities for processing, rather than sending the sensitive material via fax. This feature ensures proper routing and it allows all documents to be encrypted for security.

From the **File type** drop-down, select the destination for the document. The following options are presented:

- Bureau of Long-Term Care
- BLTC Annual Review
- Durable Medical Equipment and Supplies Pre-Authorization
- Transportation
- Healthy Connections
- Medicaid Care Unit Prior Authorization
- Preventative Health Assistance (PHA)
- Pre-Admission Screening and Resident Review (PASRR)
- Provider Services

Note: The Provider Services file type should **only** be used to transmit material related to a new provider enrollment case, or to transmit maintenance documentation to Gainwell Technologies Provider Enrollment department.

Select the **Browse/Choose** button to locate the file(s) that need to be exchanged for processing. Once you have selected the appropriate file(s), select the **Open** button on the **Choose File to Upload** dialog window. Select the **Upload** button. A confirmation message that the *File has been uploaded successfully* will display in the upper left portion of the screen, once the document has been transmitted.

Figure 4-4: File Upload Screen Confirmation

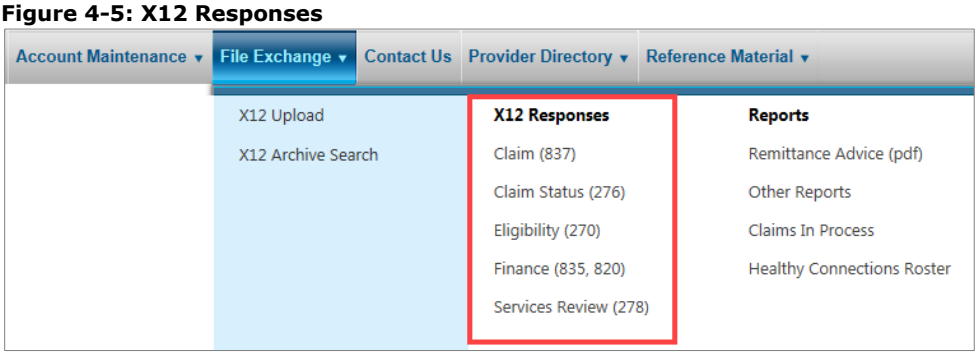
Note: Files must be in GIF, JPEG, MS Excel, MS Word, PDF, TIFF formats, and cannot exceed the file upload limit of 50 MB.

4.4. X12 Responses

Select the applicable X12 Response link to view a list of files (Figure 4-5).

Note: The 820 Transaction is not currently supported by Idaho Medicaid.

Figure 4-5: X12 Responses



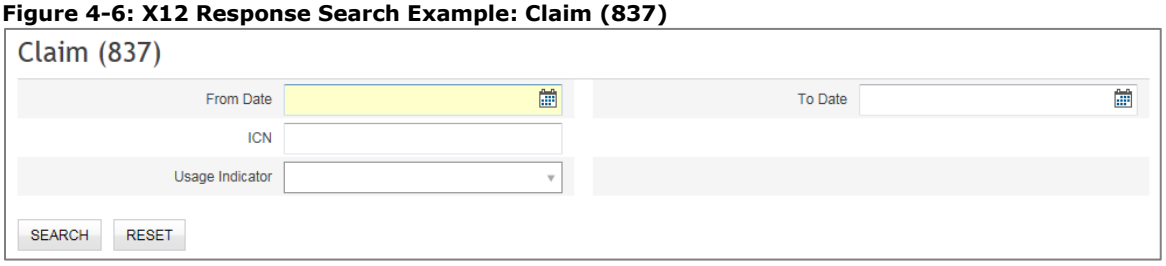
4.4.1. Claim (837)

Selecting on the header of a column will sort the records by that particular value.

If there are multiple files in one row, a **DOWNLOAD ALL** button will be available. Otherwise, select the individual file number to download a single file.

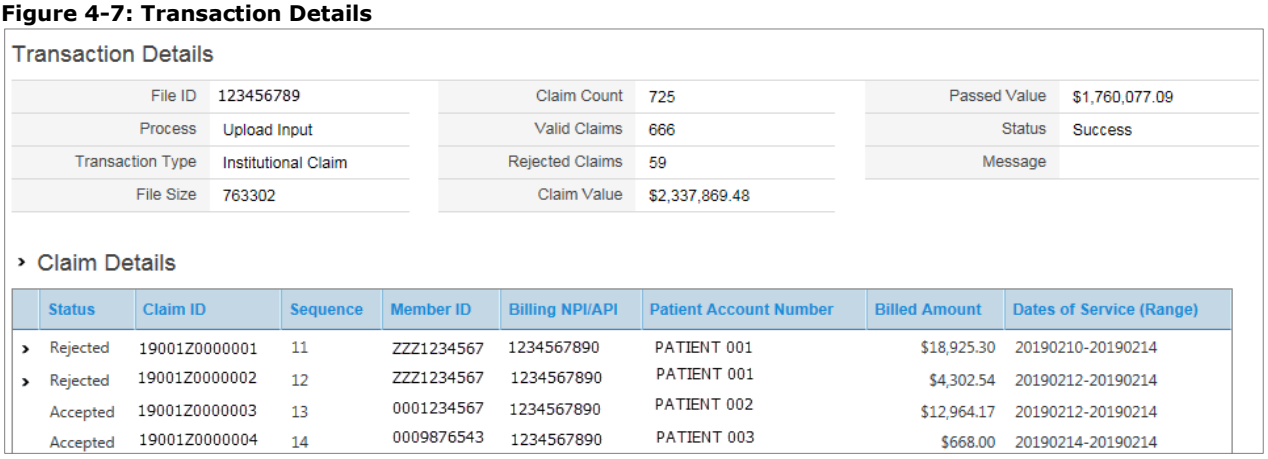
To view additional files, select the **SEARCH** button and enter search criteria (Figure 4-6).

Figure 4-6: X12 Response Search Example: Claim (837)



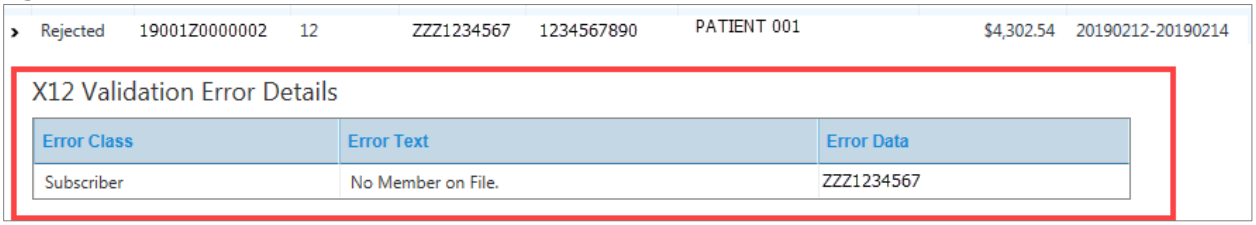
To view the detail that was submitted in a Submission File, select the blue link in the **Submission File Name** column. The **Transaction Details** screen will display, containing various details about the file, including the status of the file, and the status of each claim submitted (Figure 4-7).

Figure 4-7: Transaction Details



To view the rejection details at a claim level, select the arrow to left of the claim. This will provide the **X12 Validation Error Details** (Figure 4-8).

Figure 4-8: X12 Validation Error Details



If you need clarification on these fields, refer to the respective **Companion Guide** link under the **Reference Material** tab.

4.5. Reports

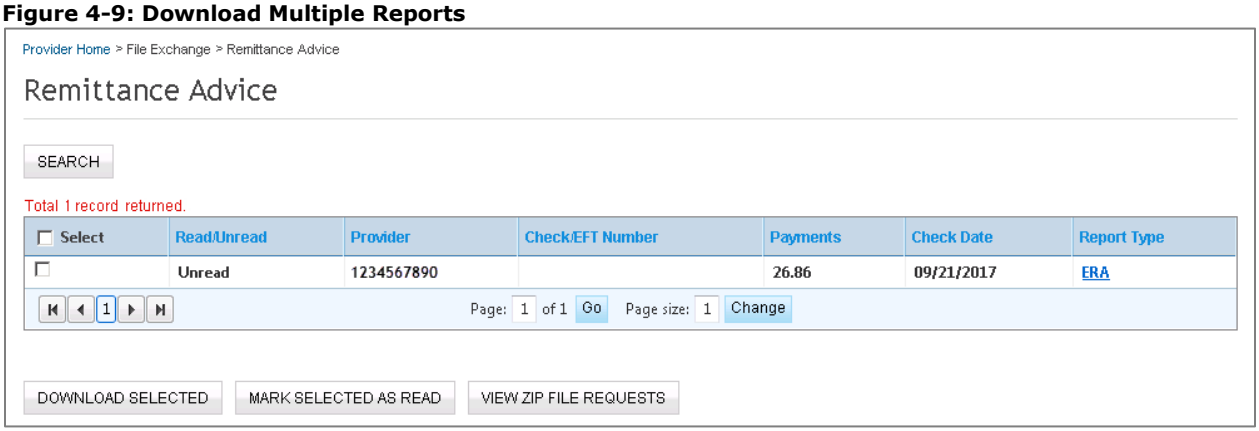
Select the applicable **Reports** link to view the file (Figure 4-1).

4.5.1. Remittance Advice (RAs)

The Remittance Advice Report is a PDF copy for the file (Figure 4-9).

To download an electronic RA file select the **ERA** link under the **Report Type** column header. You may also download multiple reports by selecting two or more checkboxes and selecting the **DOWNLOAD SELECTED** button.

Figure 4-9: Download Multiple Reports



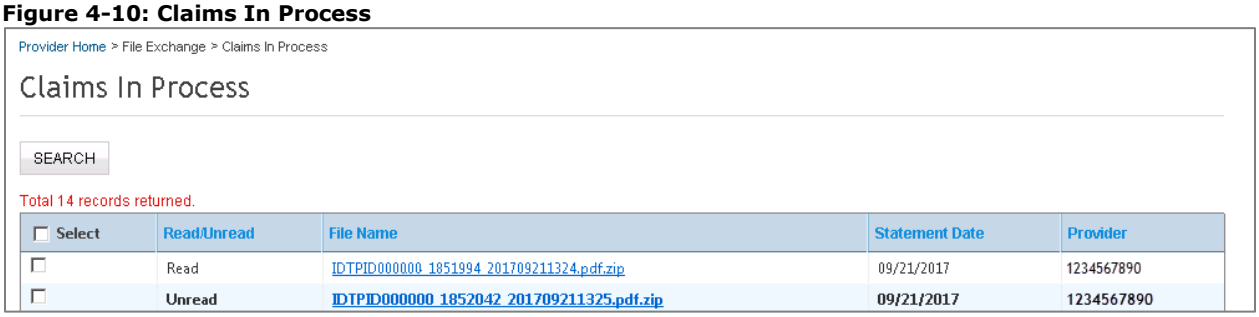
A dialog box will prompt you to either **Open** the file or **Save** it to your computer.

If you wish to have a paper copy of your RA mailed to you, refer to the *Trading Partner Account Registration and Maintenance Guide*.

4.5.2. Claims in Process

This is a companion report for the Remittance Advice (RA). It pulls weekly claims that have not been finalized and indicates where claims are in the adjudication process. The RA and an in-process claim report together equal all claims submitted and processed by the system. Select the file name to download the report.

Figure 4-10: Claims In Process



4.5.3. Healthy Connections Rosters

This is a static monthly report which lists the following:

- New members enrolled to the service location
- Ongoing members who are currently enrolled to the service location
- Members who are no longer enrolled to the service location
- Members who are no longer eligible for Idaho Medicaid

Select the file name to download the report.

Figure 4-11: Healthy Connections Rosters

Additionally, the static Healthy Connections Roster will contain the following details:

- Medicaid ID of the member
- Member's full name
- Member's birth date
- Reimbursement amount for the member
- Type of enrollment
  - B: Basic coverage
  - E: Enhanced coverage
- Healthy Connections start date
- Healthy Connections end date (when applicable)

See *3.8 Primary Care Provider (PCP) Roster*, which provides similar information and has direct access to eligibility verification, claims submission, referral submission, authorization submission, and diagnosis history for those members on the roster.

4.6. Alerts & Notifications

4.6.1. Manage Notifications

You have the option to receive e-mail alerts whenever new responses and reports under **File Exchange** become available. You must log into your TPA to view these reports.

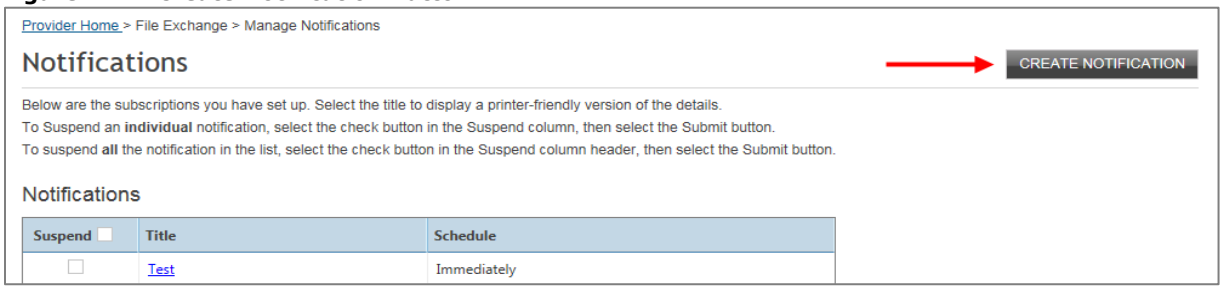
To set up notifications, you must have the role of R9 – Alerts and Subscriptions.

4.6.1.1. Adding Notifications

To set up notifications on your TPA, follow the steps below. It is recommended you set up an individual notification for each report you wish to receive.

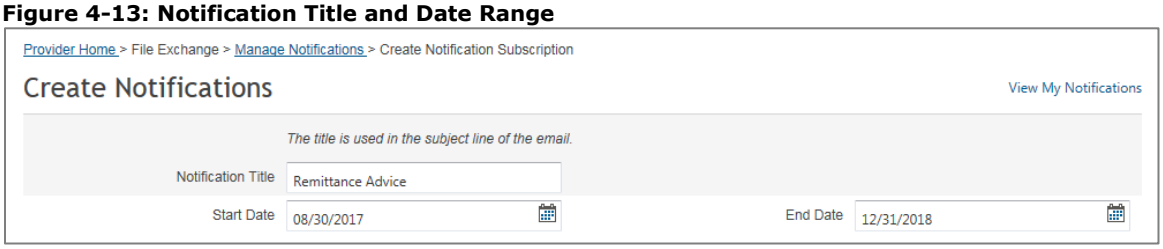
1) Select **Manage Notifications** under *Alerts & Notifications*. A list of current notifications displays.
2) Select the **Create Notification** button (Figure 4-12). The *Create Notification* screen displays.

Figure 4-12: Create Notification Button



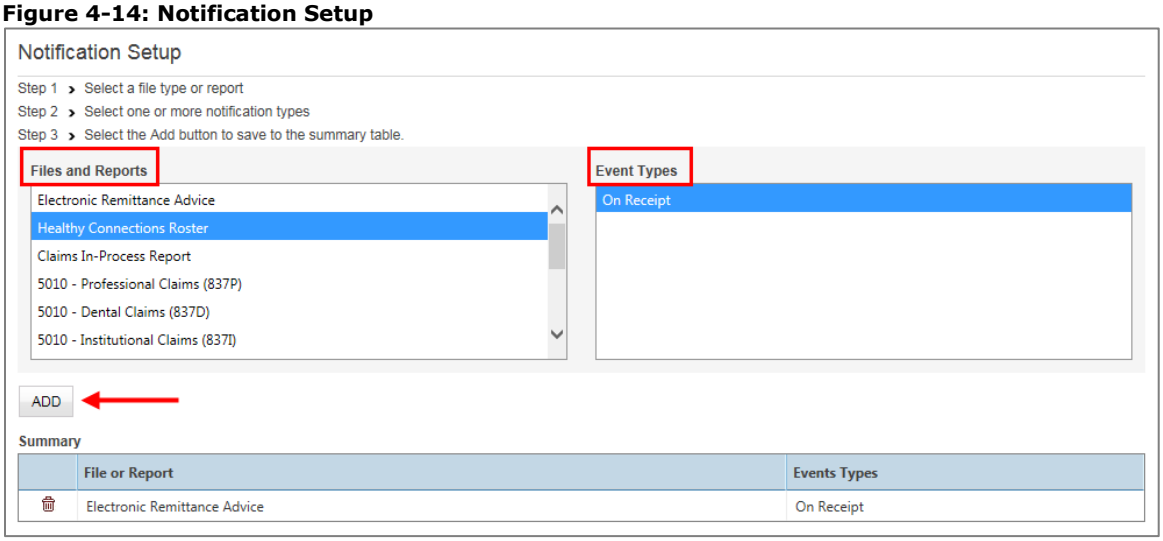
3) **Notification Title**: Enter free-form text, which will show as the subject line of the e-mail
4) **Start Date**: Choose when you would like to start receiving notifications. This must be a current or future date.
5) **End Date**: Choose when you would like to stop receiving notifications, or leave blank to receive indefinitely.

Figure 4-13: Notification Title and Date Range



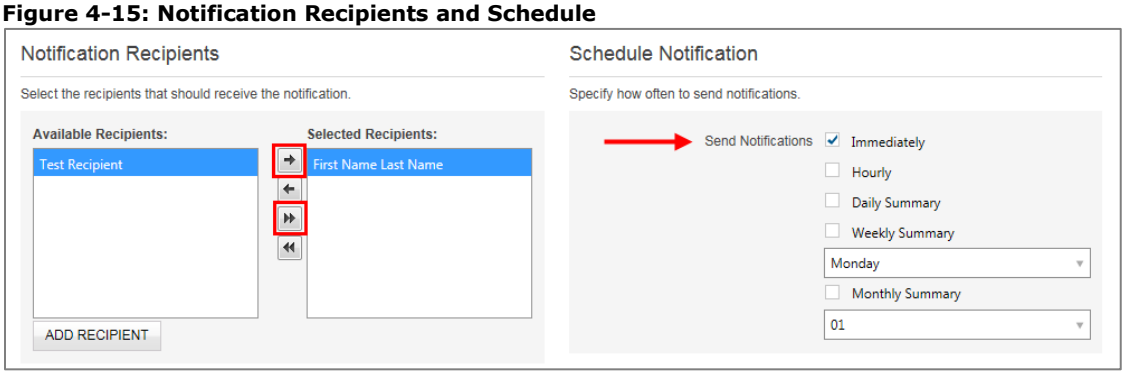
6) Under *Files* and *Reports,* choose the report or response for which you want to receive notifications (Figure 4-14).
7) If multiple EDI/X12 *Event Types* display for the report or responses chosen, choose the desired type (Figure 4-14).
8) Select the **ADD** button. The report or response name and the event type will display in the *Summary* box below Notification Setup.

Figure 4-14: Notification Setup



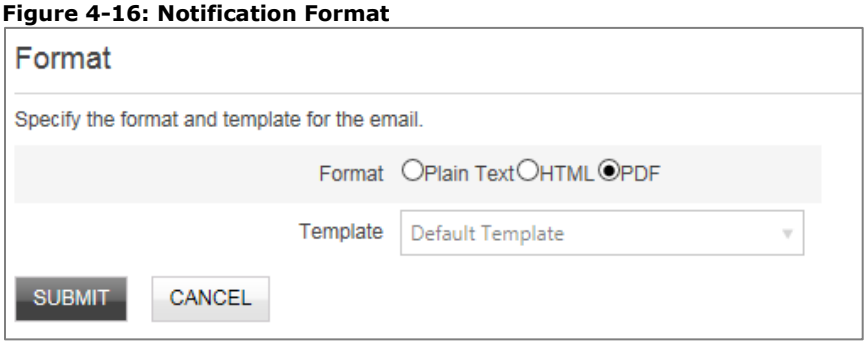
9) Under *Notification Recipients*, choose one or more recipient names and select the right arrow to move them into the *Selected Recipients* box. To choose all recipients, select the double arrow button (Figure 4-15). If the desired recipient does not show in the list, select the **ADD RECIPIENT** button. See *4.6.2 Manage Recipients* for more information.
10) Under *Schedule Notification*, choose from the available options to specify how often you wish to receive notifications (Figure 4-15).

Figure 4-15: Notification Recipients and Schedule



11) Under *format*, specify how you wish to view the report or response (Figure 4-16).
12) Select the **SUBMIT** button. A confirmation screen will display with a summary of the notification created.

Figure 4-16: Notification Format

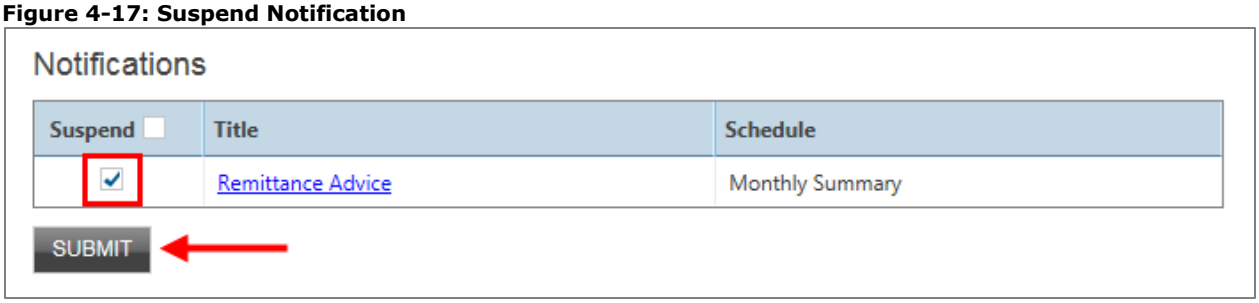


4.6.1.2. Suspending Notifications

To suspend notifications on your TPA, follow the steps below.

1) Select **Manage Notifications** under *Alerts & Notifications*. A list of current notifications displays.
2) Check the box to the left of the notifications you wish to suspend.
3) Select the Submit button (Figure 4-17).
4) A confirmation message will display below the list of notifications.

Figure 4-17: Suspend Notification



4.6.2. Manage Recipients

Under this option, you can manage the list of recipients available to receive notifications.

- To edit a recipient's information, select the edit icon in the *E* column.
- To delete a recipient, select the recycle bin icon in the *D* column.

- To add a new recipient, select the ADD RECIPIENT button (Figure 4-18). The *Manage Recipient* box will display; enter the recipient's First Name, Last Name, and Email and select the Save button (Figure 4-19).
  Note: The e-mail address entered must be in all lowercase.

Figure 4-18: Manage Recipients

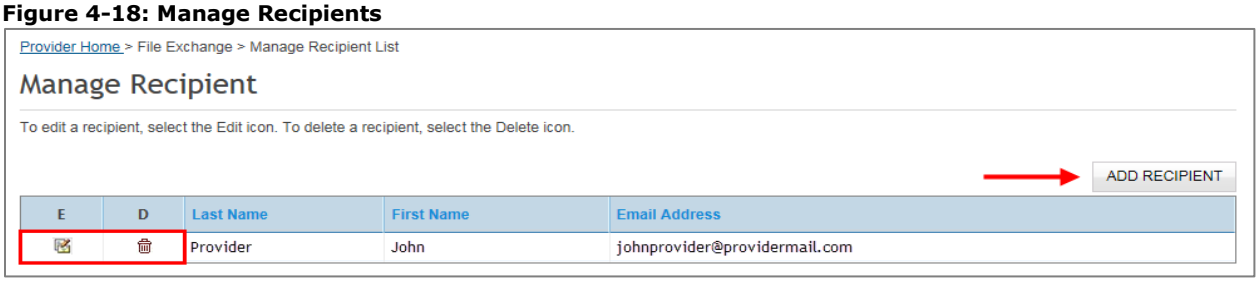
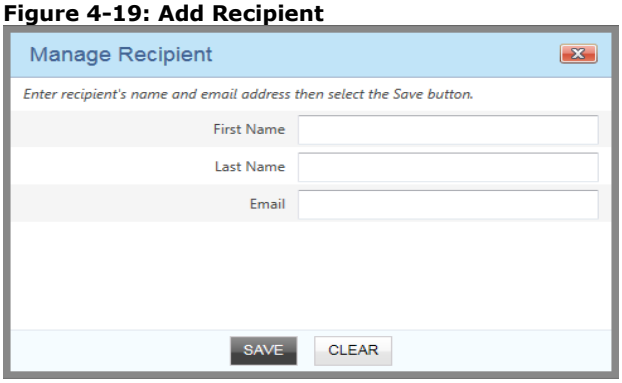


Figure 4-19: Add Recipient



4.6.3. Managing Alerts

You can opt to receive e-mail alerts whenever certain content on the Idaho Gainwell Technologies Medicaid website is added, removed, or changed. Alerts are for public information such as the MedicAide newsletters, announcements, Information Releases, etc.

To set up alerts, you must have the role of R9 – Alerts and Subscriptions.

4.6.3.1. Adding Alerts

To set up alerts on your TPA, follow the steps below. **Note**: Alerts must be added one at a time.

1) Select **Document Library Alerts** under *Alerts & Notifications*. A list of current alerts displays.
2) Select **Add Alert** (Figure 4-20).
3) Site lists and libraries will display (Figure 4-21).
4) Select the radio button for the list or library for which you would like to receive alerts.

Figure 4-20: Add Alert

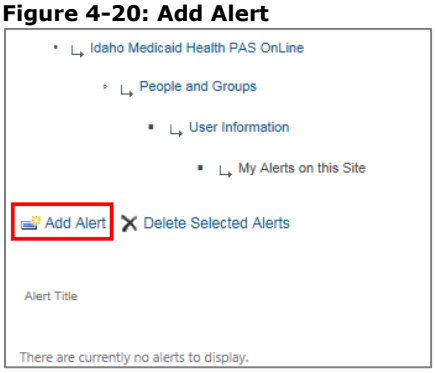
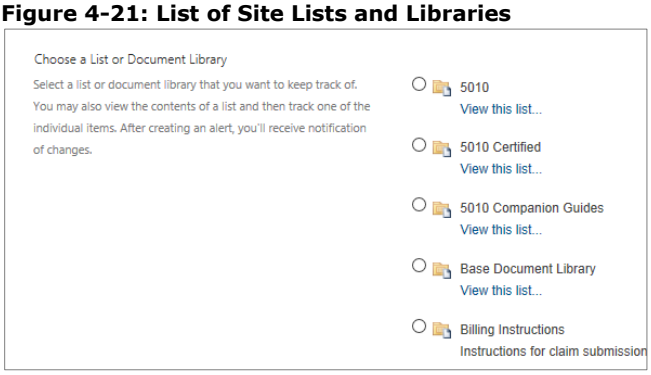
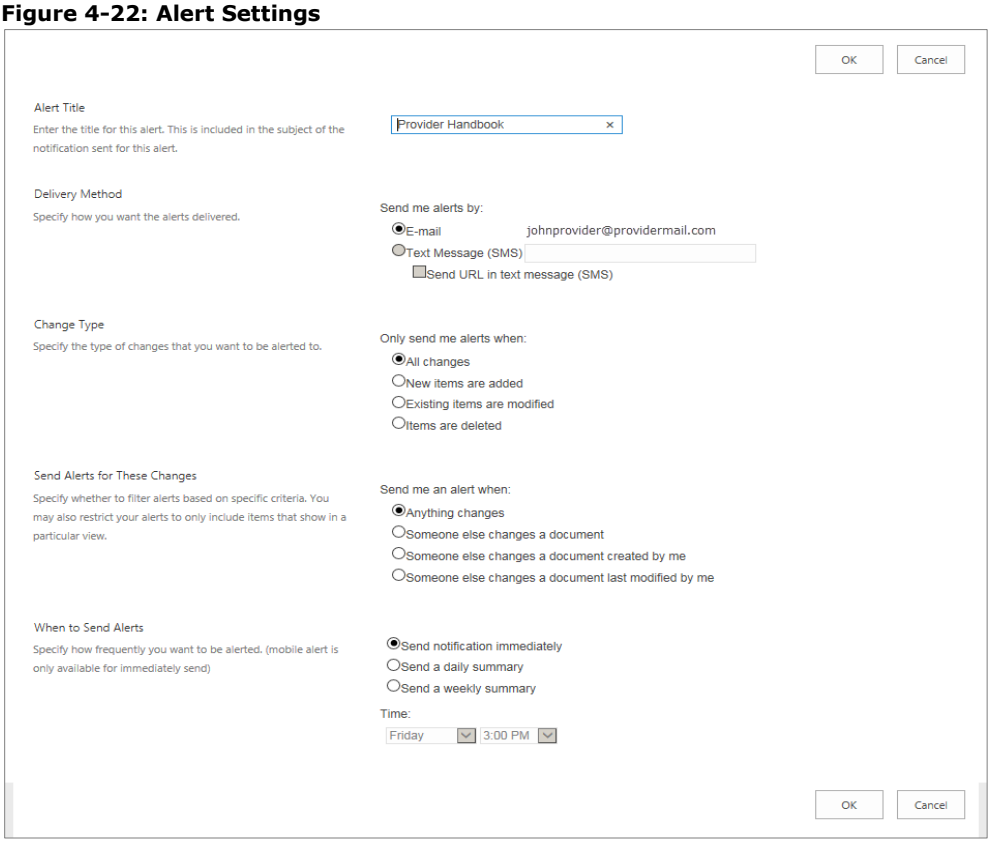


Figure 4-21: List of Site Lists and Libraries



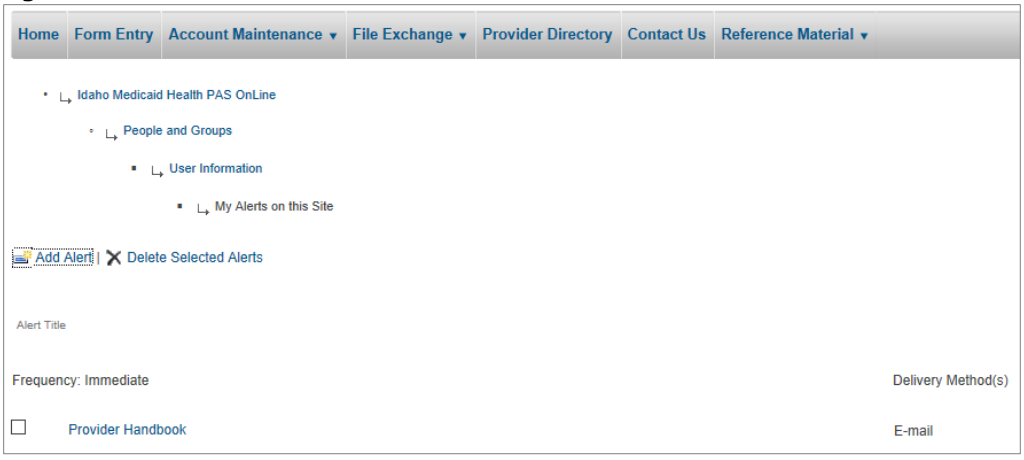
5) Select the **Next** button at the bottom of the screen.
6) Verify the e-mail address the alerts will be sent to.
7) Select the **Change Type** for which you want to receive alerts.
8) Select alert frequency under **When to Send Alerts**.

Figure 4-22: Alert Settings



9) Select **Ok.** A list of your alerts will display (Figure 4-23).
10) A confirmation of new alerts will be sent via e-mail.

Figure 4-23: New Alert Added



4.6.3.2. Editing Alerts

To edit the setup of an alert, follow the steps below.

1) Select **Document Library Alerts** under *Alerts & Notifications*.
2) Select the title of the alert you wish to edit. The *Edit Alert* screen will display.
3) Make any desired changes, and then select the **OK** button.

4.6.3.3. Deleting Alerts

To delete an alert, follow the steps below.

1) Select **Document Library Alerts** under *Alerts & Notifications*.
2) Select the checkbox next to the alerts you would like to delete.
3) Select **Delete Selected Alerts**.
4) Select **OK** to confirm.

4.7. Secure Messaging

Secure Messaging is a feature that allows users to exchange messages with Gainwell Technologies from within their secure Trading Partner Accounts. Access Secure Messaging from the **Form Entry** page or from the **File Exchange** menu.

Our Gainwell Technologies representatives are eager to resolve your secure message inquiries in a timely and informative manner. To save you time and energy we would like to ask for your support in eliminating unnecessary interactions when working to resolve issues for claims, eligibility, or EDI inquiries.
Here is how you can help:

- Review the responses that are returned and in your Inbox from your Secure Message. Messages will appear in near-real time from the time our team has responded. All messages are responded to in one to two business days.
- Limit inquiries. If you have multiple claims for the same participant, include them all in one Secure Message rather than sending one message for each claim. Please provide no more than five claims numbers per inquiry.
- Provide your claim number(s). You can look up a claim number by navigating to your View & Submit Claims tile by using the Search button and entering search criteria.
- Provide enough information for us to assist and resolve the question in the first secure message that is sent to us. Each message should include your pay-to or billing NPI or atypical provider ID and name of the provider and your question or concern. Include the following, based on the type of message you are sending:
- Claims
    - Claim number or
    - Pay-to or billing NPI and name of the provider, participant's Medicaid ID number and full name, the date of service and billed amount
- Eligibility
    - Participant's Medicaid ID number and name, the date of service(s), and service codes (CPT, HCPCS, and/or Revenue)
    - For Prior Authorization (PA): Participant's Medicaid ID number and name, the PA request date, date of service(s) the PA was requested for, and service codes
- EDI
    - Claim submission date, claim number(s) (if on file), participant's Medicaid ID number and full name, the date of service and billed amount.

Figure 4-24: Secure Messaging – Form Entry Access

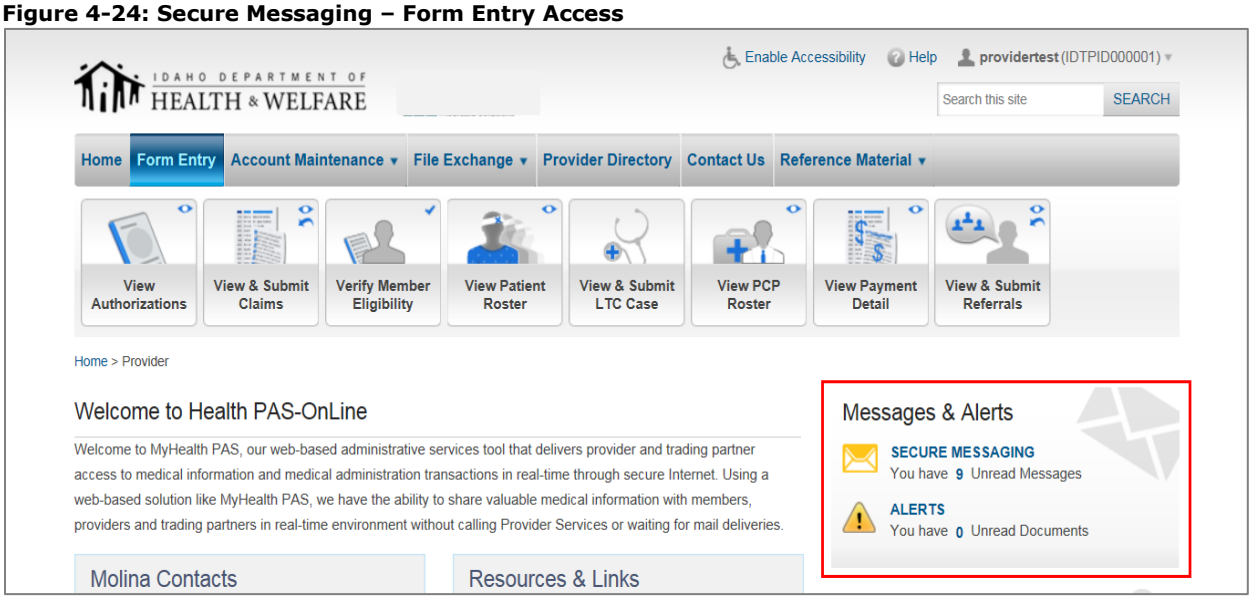
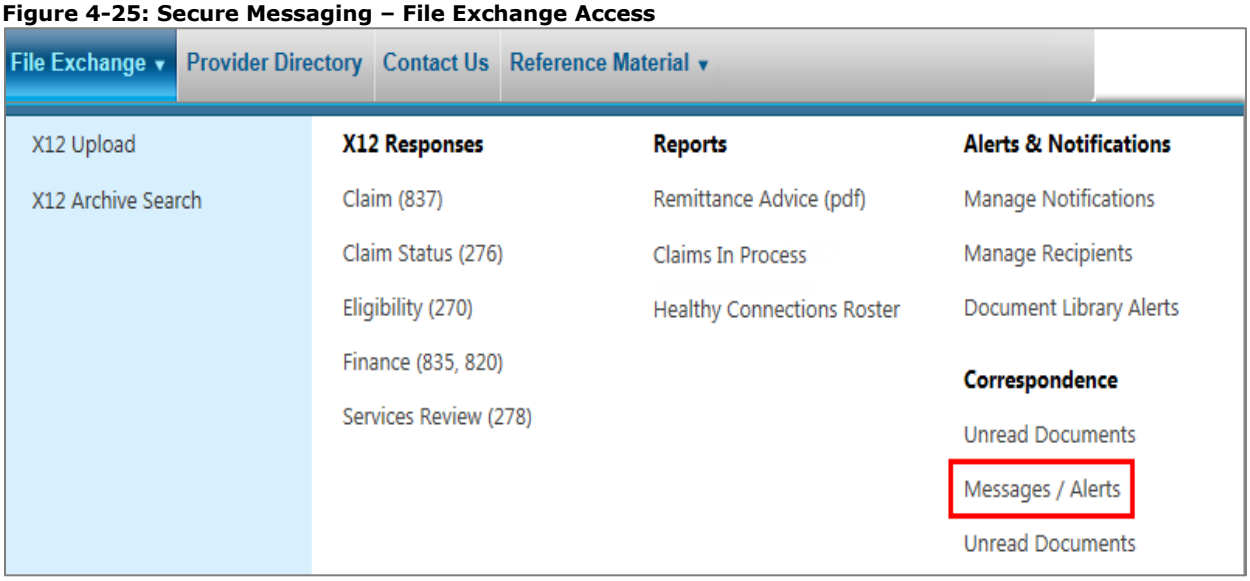


Figure 4-25: Secure Messaging – File Exchange Access



4.7.1. Secure Messaging Interface

Secure Messaging functions similar to e-mail with the following folders:

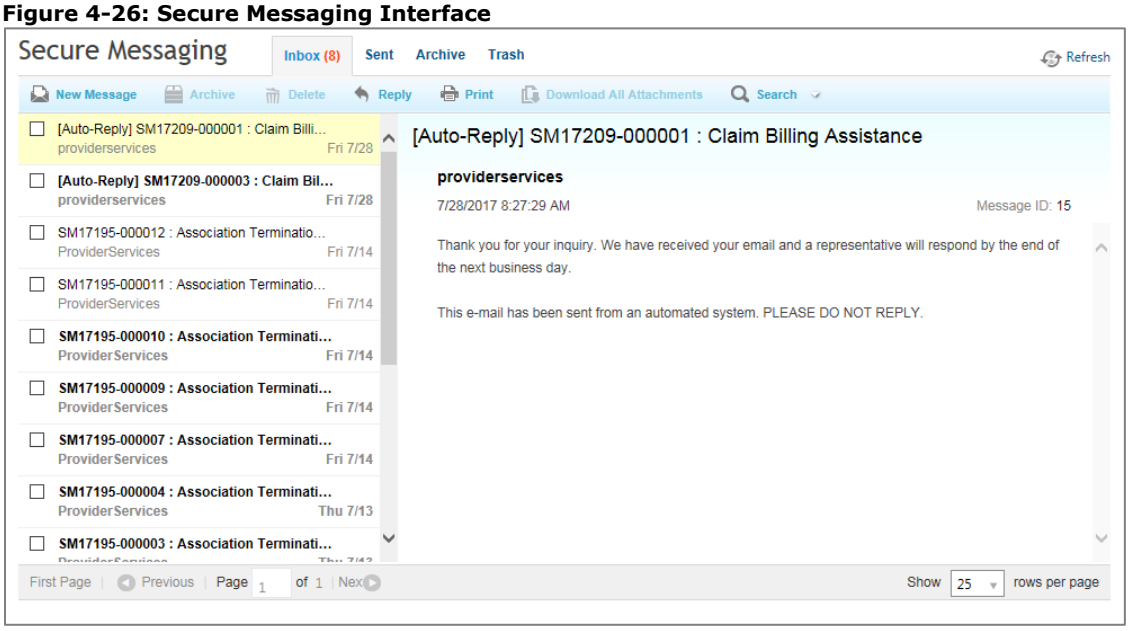
Folder Name	Use
Inbox	Contains current messages that have not been deleted or saved to the Archive folder
Sent	Contains messages the user has sent to Gainwell Technologies
Archive	Contains saved messages marked as "Archive" by the user; archived messages remain here permanently unless later deleted by the user
Trash	Contains messages deleted by the user; messages in this folder auto-delete after 30 days

When you open **Secure Messaging** or the **Messages/Alerts** link, the **Inbox** will display a list of current messages. Messages in bold text are unread. When you select an item in this list, the full message appears in the left pane.

Above the message pane is a toolbar of actions that can be taken.

- **New Message**: Opens a window for the user to draft a new message.
- **Archive**: Removes the selected message from your inbox, but saves it in the **Archive** folder for future use.
- **Delete**: Removes the selected message from your inbox and moves it to the **Trash** folder.
- **Reply**: Opens a draft message window for you to respond to the sender of the selected message.
- **Print**: Opens a dialog box so you can print the selected message.
- **Download All Attachments**: Downloads any attachments included in the selected message.
- **Search**: Searches for keywords in the current folder.

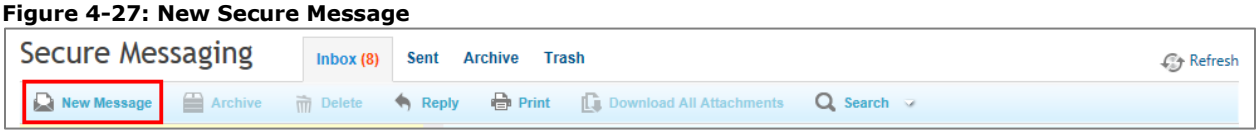
Figure 4-26: Secure Messaging Interface



4.7.2. Composing a New Message

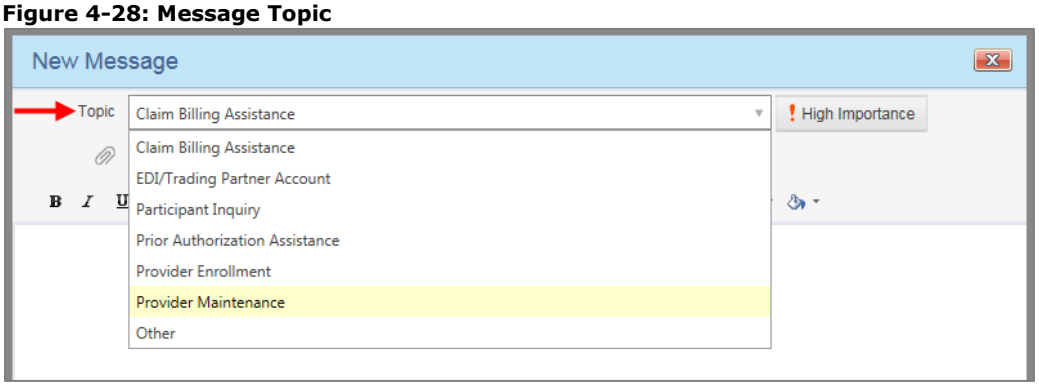
Select the **New Message** button and the *New Message* window will display.

Figure 4-27: New Secure Message



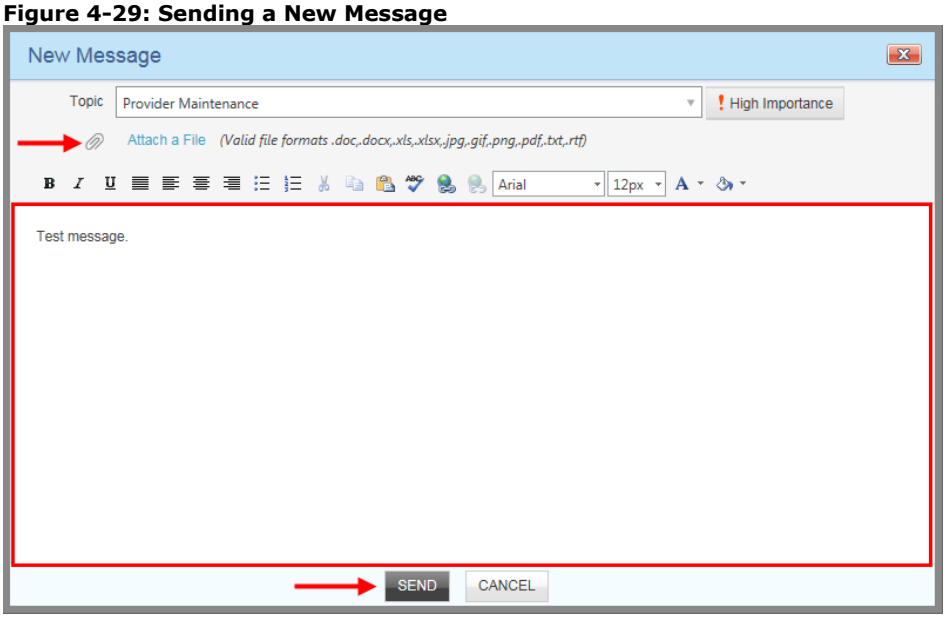
Choose a topic for your message to ensure it is routed to the most appropriate individual for review.

Figure 4-28: Message Topic



Type your message in the body field of the *New Message* window. To add an attachment, select the **Attach a File** link under the topic drop-down. When you have finished, select the **SEND** button. A copy will be stored in the **Sent** folder.

Figure 4-29: Sending a New Message

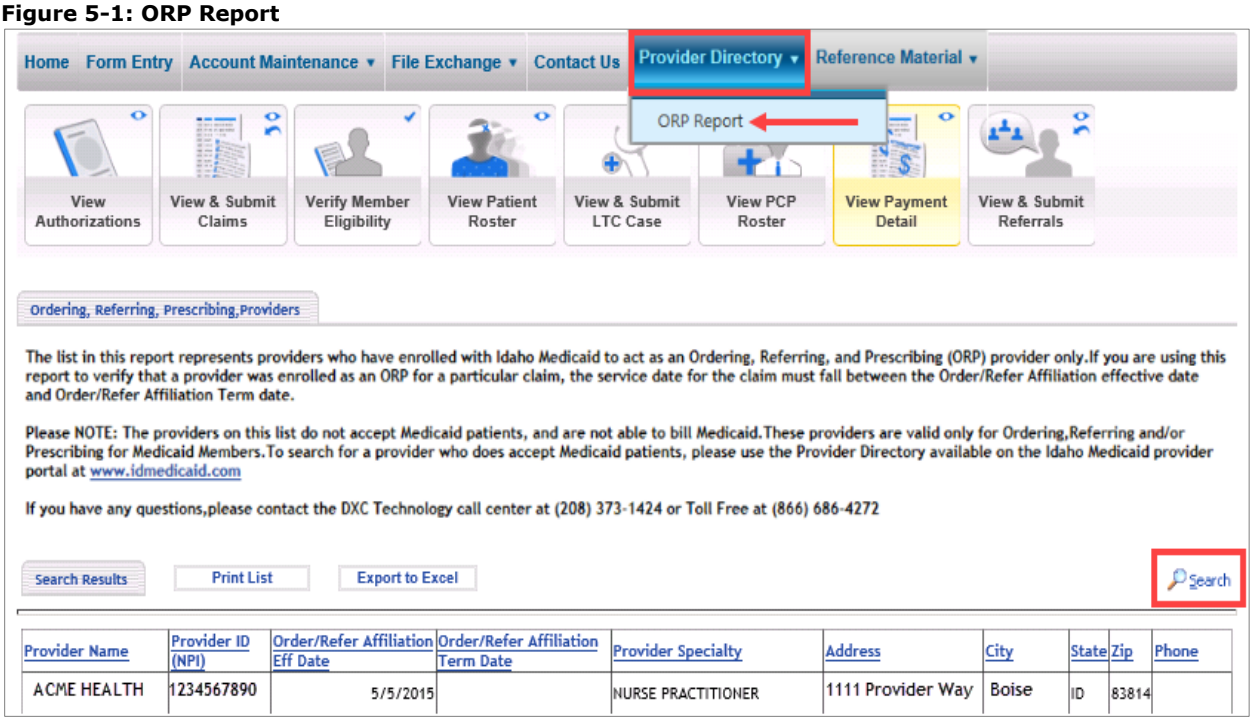


5. Provider Directory

The Provider Directory tab will display an OPR Report link. The report represents providers who are enrolled with Idaho Medicaid to act as an Ordering, Referring, and Prescribing (ORP) provider. The report can be searched, viewed, printed, or exported.

To search the report and narrow the displayed results, select the **Search** icon displayed on the right side, and enter the NPI number of the OPR into the **NPI** field and select the **Search** button. The respective provider information will be returned. To search the report by other criteria, enter a minimum of two characters into the search criteria field(s). All results matching the criteria entered will be returned.

Figure 5-1: ORP Report



Revision History

Version	Date	Author	Action/Summary of Changes
1.0	11/10/2017	Molina, Jacquie Kennedy-King, Tara Humpherys, Kim Duke	New document for TPA upgrade – to replace previous *Trading Partner Account (TPA) User Guide*
2.0	12/1/2017	TQD	DHW approved via UB01899B. Finalized and promoted to next whole version.
2.1	12/1/2017	Hope McCain	Updated Eligibility information for CCFs 10819 and 10823.
3.0	12/6/2017	TQD	DHW validated changes 12/6/2017.
3.1	2/22/2018	Hope McCain	Updated Eligibility Response Verification screenshot for new transportation vendor. Updated to include additional detail regarding searches for authorizations, claims, payments, and referrals.
4.0	3/8/2018	TQD	DHW validated changes 3/7/2018.
4.1	3/9/2018	Hope McCain	Updated Eligibility Verification section to reflect change from "PCP Assignment" tab to "Network" tab.
5.0	4/25/2018	TQD	DHW validated changes 3/16/2018.
5.1	7/30/2018	Sandra Knigge Myranda Payne	Incorporated "No Active Internal Enrollment Error Message".
5.2	07/31/2018	Madasyn Zampierin	Reviewed and QA'd the document
6.0	09/04/2018	TQD	Finalized per DHW 30 day notification agreement.
6.1	9/28/2018	Myranda Payne	Updated Eligibility information for CCF 10823B2.
7.0	10/17/2018	TQD	Finalized per DHW validated changes 10/16/18.
7.0	11/16/2018	M Zampierin	Removed Molina references and replaced logo.
7.1	11/21/2018	Myranda Payne	Added ORP report content per CR56293.
7.2	11/26/2018	Myranda Payne	Updated per comments returned by the State on 11/23/2018.
7.3	11/29/2018	Myranda Payne	Additional clarification added per State review on 11/29/2018.
8.0	12/5/2018	TQD	Finalized per validation by DHW 11/30/18.
8.0	1/11/2019	M Zampierin	Updated Copyright statement to DXC
8.1	3/1/2109	Myranda Payne	Added dynamic PCP Roster details to support CCFs 10828B1 and 10831B1
8.2	3/7/2019	Myranda Payne	Added static PCP Roster details to support PROD CR 57981
9.0	3/11/2019	TQD	Finalized per validation by DHW 3/8/2019
9.1	4/3/2019	Myranda Payne	Added Medicaid copay/Share of Cost claim detail per TR58073.
10.0	4/10/2019	TQD	Finalized per DHW 4/8/19
10.1	5/15/2019	Myranda Payne	Updated the TPA Type access table to reflect Health Plan access to Eligibility Verification per CR 57915 and TPA Release 4.17.0.0. Added detail to the X12 Responses for Claim (837) to support TPA Release 17865.

Version	Date	Author	Action/Summary of Changes
11.0	6/18/2019	TQD	Validated per DHW 30 day notification agreement.
11.1	8/23/2019	Myranda Payne	Added detail regarding recovery claim to Claim Status section per CCF 10760B3.
12.0	09/09/2019	TQD	Finalized per DHW validated changes 09/06/19.
12.1	10/28/2019	Myranda Payne	Added detail to section 3.1.1.6. to support Coordination of Benefits (COB) Information entry.
12.2	11/06/2019	B. Oliverez	Updated per DHW comments.
13.0	11/07/2019	TQD	Finalized per DHW validated changes 11/07/19.
13.1	12/03/2019	Myranda Payne	Added section 4.3 Document Exchange to support CCF 10855.
13.2	12/11/2019	Myranda Payne	Clarified detail added in section 4.3 Document Exchange to support CCF 10855.
14.0	12/20/2019	TQD	Finalized per DHW validated changes 12/19/19.
14.1	12/16/2019	Myranda Payne	Added INPATIENT Only detail to Eligibility section to support CCF 10852B1
15.0	01/29/2020	TQD	Finalized per DHW validated changes 01/28/2020
15.1	04/21/2020	Myranda Payne	Reviewed for Semi-Annual review; updated details in section 3.1.1.6 to support MHP V.56.22.5 and V.56.23 releases.
15.2	04/22/2020	Myranda Payne	Updated figure 3-24 to reflect a new screen shot to support TR502173. Updated figure 5-1 for TR56923. Added a note to section 3.8.1.1 to specify the export details that are displayed, service location and address. All changes to support MHP 56.24 release.
16.0	11/01/2020	TQD	Finalized per DHW notification agreement
16.0	11/16/2020	Myranda Payne	Reviewed for Semi-Annual; no updates necessary
16.1	12/03/2020	Myranda Payne	Updated section 3.6. Primary Care Provider (PCP) Roster and figure 3-67 to include Service Location per CRs 61619/62466.
17.0	01/15/2021	TQD	Finalized per DHW notification agreement
17.1	06/16/2021	Myranda Payne	Semi-annual review. Rebranded throughout from DXC to Gainwell. Email approval granted by DHW.
18.0	07/08/2021	TQD	Finalized per rebranding approval granted.
18.0	12/03/2021	Myranda Payne	Semi-annual review. No updates necessary.
18.1	03/18/2022	Myranda Payne	Added BLTC Annual Review to the Document Exchange section, per CR 65622.
19.0	05/02/2022	TQD	Finalized per DHW validated changes
19.1	06/29/2022	Myranda Payne	Semi-annual review; per end-user request, updated screenshot and text in section 3.1 View Authorization Status. No other changes necessary.
20.0	11/15/2022	TQD	Finalized per DHW validated changes.
20.0	05/25/2023	Myranda Payne	Semi-annual review; no changes necessary.
20.0	12/06/2023	Myranda Payne	Semi-annual review; no changes necessary.
20.1	06/30/2024	Myrand Payne	Semi-annual review; updated figure 1-2 to bring current. Updated section 4.7 with information for provider use of the secure messaging functionality.
21.0	09/20/2024	TQD	Finalized per DHW notification agreement.