Step-by-Step Guide

Medicare Authorization Requests in the JIVA Provider Portal

Please refer to the prior authorization list (PAL) Tool at pal.sentarahealthplans.com to view authorization requirements for in-network providers.

1. In Jiva, from the dashboard, select Menu.
2. Select New Request.
3. In Member ID Types, select Member ID.
4. Enter Member ID: XXXXXXXX.
5. If the member is present in the list or listed with multiple lines, select the line where Coverage End Date is blank. If multiple lines have blank Coverage End Dates, select Member Coverage in this order: Commercial, Medicare, Medicaid.
6. Under the Action dropdown, select Inpatient, Outpatient, Behavioral Health Inpatient, or Behavioral Health Outpatient.
7. For outpatient authorizations, continue to step 8. For inpatient authorizations, skip to step 13.
8. For outpatient Medicare authorizations
   - Request Type, select either:
     - Pre-Service – For services that have not been performed.
     - Post Service – For services that have already been performed.
   - Request Priority, select from the following:
     - Non-Urgent Pre-Service
     - Urgent Pre-Service
       - The Centers for Medicare & Medicaid Services (CMS) defines an expedited request as a request for a determination that must be made quickly because waiting for a standard decision could seriously jeopardize a member's health, life, or ability to regain maximum function.
     - Post Service
       - Used for post-service requests as described above
   - Reason for Request:
     - For all outpatient authorizations, select Outpatient Medical.

9. For Diagnosis(es), add ICD-10 (you may add multiple diagnosis codes).

10. Enter Service Type

    - The most common Service Types for outpatient Medicare authorizations:

Durable Med Equipment	All rental durable medical equipment (DME) and DME supplies (includes enterals)
OTPT-Procedures	All outpatient procedures (surgery, diagnostics, sleep studies, video EEG) include medication infusion in an outpatient setting or an office setting
Pharmacy	Medications

11. Add service codes

    - Outpatient authorizations:
        - CPT/HCPCS Codes
        - Start Date and End Date *(not to span greater than a year; example: 4/27/24 to 4/26/25)*
        - Units and Frequency Qualifiers
    - Click ADD and add the codes to the request. You may add multiple codes by adding other codes and clicking ADD.

12. There is a green ADD button that you must click before adding the providers.

    - Proceed to step 19 to complete the outpatient request

13. Inpatient Medicare authorizations
    - Request Type, select either:
      - Concurrent Service
        - Acute hospital admission
      - Pre-Service
        - Inpatient elective services
    - Request Priority, select from one of the following:
      - Urgent concurrent 72-hour government utilization management
      - Non-urgent Preservice
      - Urgent Preservice
        - CMS defines an expedited request as a request for a determination that must be made quickly because waiting for a standard decision could seriously jeopardize a member's health, life, or ability to regain maximum function.
    - Reason for Request, select either:
      - Inpatient Med/Surgery for inpatient electives
      - Inpatient Emergent for inpatient acute

14. For Diagnosis(es), add ICD 10 (you may add multiple diagnosis codes)

15. Service Types:
    - The most common Service Types for Inpatient Medicare authorizations:

INPT-IM-General Medicine	All inpatient hospital admissions
LTC-Rehab	Skilled nursing facility (SNF)
INPT-PHYSICAL MED & REHAB	Inpatient rehab (IPR)
LTC-INTERMEDIATE	Long-term acute care hospital (LTACH)

16. Enter Stay Line:
    - Start Date and End Date and all other required (*) information

    There is a green ADD button that you will need to click prior to adding the providers.

17. Enter Service Lines:
    - Only add service lines if requesting an inpatient procedure
    - Service type should be INPT-IM-General Medicine

18. Add Service Codes
    - Inpatient Authorizations:
      - No service line is needed for acute (through the emergency department) admissions
      - CPT/HCPCS codes
      - Start Date and End Date (should be the same date)
      - Units and Frequency Qualifiers

    Click ADD and add the codes to the request. You may add multiple codes by adding other codes and clicking ADD.

    There is a green ADD button that you must click before adding the providers.

19. Attach providers: Always use Multiple Attach to add providers as needed.
    - NPIN – Treating Provider
      - The facility or location where the procedure or service is being completed. - Do Multiple Attach using the widget.
    - NPIN – Requesting Provider
      - The provider performing the procedure or service – Do Multiple Attach using the widget.
    - NPIN – Submitting Provider
      - Completed by the provider submitting the request – Do Multiple Attach using the widget.

20. Add contact information – It must include your name and phone number. Fax number and email address are strongly recommended.

21. Hit Submit and click on the Action button above the CPT codes you added for requests. Click on the green Review button to get to the criteria sets. For inpatient requests, there will only be a review button to click in the Stay Area. Always look for the green Review button.

22. Clicking the Review button will take you to the criteria sets; if there are no criteria to review, type “No Criteria” in the document, click save, and then submit. After a few seconds, you will return to the main screen.

23. Now, you may add your documents to the request. Accepted document types include PDFs, Word, and Excel documents. For the document title, enter “Clinical Information.”

24. After attaching the documents, click Submit. You will see a summary of what was submitted. Return to the Dashboard and refresh the screen. Your submission will be in your My Episode folder. *Don’t forget to clear your Memory List.*

    In the My Episode folder, you can view previously submitted requests and see if they are pending for review or have been processed. Processed requests must be opened to view the final determination of approved or denied.

Step-by-Step Guide

Common Medicare Outpatient Portal Submissions Quick Guide

For Medicare Prior Authorizations for Oxygen

- Requesting, treating, and submitting provider roles should all be the DME provider.
- The date span for a year must subtract one day.
- Service Type: Durable Med Equipt
- Request amount: 1
- Units and Frequency Qualifiers Section
  - Frequency Qualifier: Month
  - Units Qualifier: Unit
  - Authorized Frequency: 1

For Medicare Prior Authorizations for Outpatient Physical and Occupational Therapies

- Authorization for 97110 will authorize all allowed treatment codes.
- Requesting, treating, and submitting provider roles should all be the therapy provider.
- Service Type: OTPT-Phys Therapy
- Request amount: The total number of visits x 4
- Units and Frequency Qualifiers Section
  - Frequency Qualifier: Episode
  - Units Qualifier: Unit
  - Authorized Frequency: 1

For Medicare Prior Authorizations for Outpatient Occupational Therapies

- Authorization for 97530 will authorize all allowed treatment codes.
- Requesting, treating, and submitting provider roles should all be the therapy provider.
- Service Type: OTPT-Occupa Therapy
- Request amount: The total number of visits x 4
- Units and Frequency Qualifiers Section
  - Frequency Qualifier: Episode
  - Units Qualifier: Unit
  - Authorized Frequency: 1

For Medicare Prior Authorizations for Outpatient Speech Therapy

- Authorization for 92507 will authorize all allowed treatment codes.
- Requesting, treating, and submitting provider roles should all be the therapy provider.
- Service Type: OTPT-Speech Therapy
- Request amount: the total number of visits being requested.
- Units and Frequency Qualifiers Section
  - Frequency Qualifier: Episode
  - Units Qualifier: Unit
  - Authorized Frequency: 1

For Medicare Prior Authorizations for Home Health Requests

- All home health services can be authorized on one authorization.
  - For example, skilled nursing, physical therapy, occupational therapy, speech therapy, and home health aide services can all be contained on one authorization.
- Requesting, treating, and submitting provider roles should all be the home health agency.
- Service Type: Home Health Homebound
- Request amount: the total number of visits being requested x 4
- Units and Frequency Qualifiers Section
  - Frequency Qualifier: Episode
  - Units Qualifier: Unit
  - Authorized Frequency: 1.