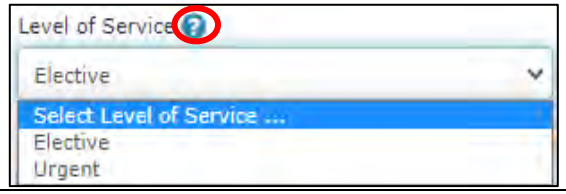
NaviNet Behavioral Health Authorization Management
Frequently Asked Questions

What are the first steps?

Question	Response
What web browsers are supported by NaviNet?	The following web browsers are supported: • Chrome • Edge • Firefox • Safari
What is the first step in creating a new authorization/request?	Select **Behavioral Health Authorization Management** under ***Workflows for this Plan*** on the Plan Central Page.
When creating a new authorization, how can you search for the patient?	The **Patient Search** screen allows the user to search by Member ID or by **Member** Name. **If searching by Member Name, the member's first name, last name and date of birth (DOB) are required**. If there are multiple matches based on the criteria entered, the user will get a search results screen. On the search results screen, the user selects the appropriate member from the list returned. If there is an exact match, the user is taken to the pre-screening questions.
What is the purpose/function of the pre-screening questions?	The pre-screening questions are a way to help the user verify that they are using the correct authorization process.
Why did I not advance to the pre-screening questions?	If a member is not active with the health plan, the user will not be advanced to the pre-screening questions.

Authorizations

Question	Response
If I am part of a large facility, how do I know which provider to choose?	• When choosing the requesting and servicing provider, users should choose the correct provider that aligns with the service that is being requested. For example, o The provider name to choose for TCM would be Provider ABC, Inc **TCM** o The provider name to choose for Psych Rehab would be Provider ABC, Inc **PSYCHREHAB** • Providers can review current authorizations to confirm which provider profile is linked to use for future authorizations.
What provider should providers use under the requesting provider field?	Providers should choose the provider in which the authorization should be issued to. For MH OP group and Music Therapy providers this should be the credentialed practitioner.
What provider should providers use under the servicing provider field?	This selection should always match the requesting provider field and list who the authorization should be issued to.
What is the difference between Elective, and Emergent?	• Outpatient requests include: o **Elective** – Services scheduled in advance that do not involve a medical emergency. o **Emergent**- Acute MH symptoms requiring treatment within an expedited timeframe. **Note:** Users can click the question mark next to the **Level of Service** field for Outpatient requests to display these guidelines. 

What happens if an incorrect procedure code is entered?	If an incorrect Procedure Code is entered the request may not be processed. Providers can find the correct procedure code to use on the LOC specific NaviNet Submission Forms found on the right side of the Plan Central page. ***Important Reminder:*** *The Procedure Code field is a free text field, not a lookup field. The user will not be prompted if an incorrect code is entered, so it is very important for users to enter the correct code.*
If the provider enters an incorrect procedure code, will the system notify them?	The NaviNet system does not inform the user that an incorrect procedure code has been entered. However, once submitted PerformCare may send an error code "Input errors, correct and resubmit." This error may or may not point to an issue with the procedure code.
What if the provider has more than 12 diagnosis codes or procedure codes?	EDI does not support more than 12 diagnosis codes or more than 15 procedure codes.
For Psychological and Neuropsychological authorizations does each code, ie. 96130, 96131, 96136, etc., need to be listed as a procedure code in NaviNet?	No, providers should authorize the base code of 96130 or 96132 for one unit. The NaviNet Submission form will outline how many units are needed, which will be updated by PerformCare staff when the Testing Results are sent.
How can Psychological and Neuropsychological testing results be sent to PerformCare?	Providers must continue to send testing results to PerformCare within 10 calendar days of completing the written results of testing for payment. Providers should find the current authorization in NaviNet and upload those results as a document following these instructions.
Can providers save the authorization into an Electronic Medical Record?	Yes, this can be done by clicking on the View/Print as PDF option within the Authorization Details screen.

Can NaviNet provide a report of authorizations that are about to expire that month?	Providers do have the capability to pull an excel spreadsheet of all authorizations issued to a profile by following these instructions.
Will a paper authorization letter still be mailed out to providers?	Yes, this will continue.
Since switching to NaviNet, I get 2 authorization letters in the mail. Is this normal?	Yes, this is normal. Since the new system requires that a Requesting and Servicing provider is chosen, each then also receive a mailed paper authorization.
What if I submit an authorization and then realize that I need to update the units or start/end date?	Providers should locate the approved authorization (following Section 5 of the participant guide), click amend, and then enter a note in the Notes section letting PerformCare staff know what needs corrected in the authorization.
What if I submit an authorization and then realize that I need to delete or cancel the authorization due to an error made?	Providers should locate the approved authorization (following Section 5 of the participant guide), click amend, and then enter a note in the Notes section letting PerformCare staff know that the authorization should be canceled or deleted.
What if "Criteria Not Met" is received when completing the InterQual Assessment for PSS, TCM, CRS, or Psych Rehab authorizations?	Providers should ensure that answers given to the assessment questions are correct by clicking "Review Summary". If any corrections need to be made, click "Cancel Review", and restart the assessment. If all answers are correct, provider should click "Complete". The authorization will be reviewed by our Clinical Care Managers and an approved or denied authorization will be issued in 2 business days.

Retroactive Request

Question	Response
Can the start date be retroactive?	The start date can be modified for **CRS, MH TCM, MPN, PSS, Psych Rehab, and SU IOP** authorizations, for specific timeframes please refer to page 15 of the NaviNet Participant Guide. The start date **cannot be modified** for **any other level of care** authorizations.

Overlapping Dates/ Services

Question	Response
What happens if the dates of services overlap?	The system will notify the user with the following message: *"Warning: Service line date ranges cannot overlap with the date range from another service line."*
When requesting an overlap of PSS and Psych Rehab how long should those auths be?	The authorizations should be 6 months.

Documents

Question	Response
What document types can be attached to a request?	Supported document types include the following: **pdf, docx, xml, csv, png, gif**. Up to 10 documents may be attached. **Note:** If the user is attaching a document, the appropriate document type must be selected.

Is adding an attachment optional?	No, adding attachments is ***not*** optional. Providers must attach the corresponding NaviNet Submission form for each authorization that can be found under the Forms menu on the right side of the NaviNet Plan Central page.
Where can providers find the NaviNet Authorization Submission forms that are required to be uploaded for every authorization?	These can be found on the right side of the NaviNet Plan Central page under the Forms section.

Searching for an Existing Authorization

Question	Response
How can I search for an existing authorization?	From the Plan Central Page, select **Behavioral Health Authorization Management** under ***Workflows for this Plan***. There is a box on the Authorizations screen that is titled **Search for Existing Authorization**. The user can search by requesting or servicing provider.
What if the authorization that I am trying to locate has an initial start date that is 3 or more years ago?	This authorization will not be able to be found on the NaviNet Provider Portal. The NaviNet Provider Portal has a look back limit of 3 years. If a re-authorization is needed, an initial authorization will need to be completed.
What should I do if I cannot find my existing authorization?	Providers should ensure that a search under requesting and servicing provider is completed. Group providers will also need to toggle between searching under the Provider and Group/Facility options.

Pending Request

Question	Response
Are providers notified that additional information is required for a pending authorization (i.e. medical records or additional clinical information)?	If the user is signed up to receive Notifications, they will receive a pop-up alert inside NaviNet with the ability to launch to the "Authorization Details" screen. Once the user launches the "Authorization Details" for that patient, they will be able to see and review the notes from the Health Plan. **Note:** The first time you access a Behavioral Health Authorizations, a pop-up window will display asking the user to turn on the notifications. If YES is selected, the "Settings" menu will appear. Select "Authorizations Status Updates" to modify the frequency of the pop-up. This field can also be accessed via the "Bell" icon followed by "Settings."
How long does the Pend process take?	Refer to the predetermined turnaround times for your health plan. Turnaround times vary based on the request type, urgency, and respective State guidelines.

Amending a Request

Question	Response
What does it mean to amend a request?	Amending a request is the process of extending existing services ***or*** re-authorizing a service. **Amending is NOT the process of changing a request that has already been submitted**. **Note:** Only requests that have been approved or partially approved can be amended.

Can changes be made to a request once it has been submitted?	The user is unable to make changes to a request that has already been submitted.
What is the maximum number of services that can be added to an authorization?	The maximum number of services that can be added to an authorization is 15.

Reauthorizations

Question	Response
How is a re-authorization done through NaviNet?	Providers should follow the Amending an Authorization section in the Participant Guide and add a new service line to an existing authorization.
What should I do if I receive the error message, "Amend Not Available"?	Providers should enter a new authorization.
If a provider needs to submit a re-authorization due to exhausting all units in the previous authorization how is that done in the NaviNet Provider Portal?	Since providers cannot edit the end-date of a previously approved authorization, providers will need to use the next day (ie. if the current authorization ends 6/30, provider should use 7/1) and enter a new service line. Providers should then include a note outlining the start date needed and PerformCare will edit the end-date for the previously approved authorization.

Do MH TCM services require a re-authorization?	As of 1/23/25, TCM authorizations ***do*** require re-authorizations. Please refer to AD 24 116 Requirement if Re-authorization for MH and SU TCM.

Provider Set-up

Question	Response
What provider types are included in an outpatient request?	In an outpatient request, there is a ***Requesting Provider*** (provider requesting the service) and a ***Servicing Provider*** (provider completing the service).
Will NON-PAR providers appear under Servicing Provider?	Yes.
What if the Servicing Provider/Facility is not found?	If the provider is credentialed with PerformCare, provider should outreach to the Account Executive. If the provider is not credentialed, the provider should default to fax submission.
Can the requesting and servicing provider be the same?	Yes, it will ***always*** be the same.
Can the user create a favorites list for diagnosis and providers?	No, this option is not available at this time.
How can a new provider be added to NaviNet?	Once a provider is credentialed with PerformCare, PerformCare sends that information to NaviNet on a weekly basis. The provider would then outreach to NaviNet to set-up an account or add PerformCare as a Health Plan under an existing NaviNet account.

How can a new practitioner that joined an existing group be added to NaviNet?	Once the new practitioner is credentialed with PerformCare, PerformCare sends that information to NaviNet on a weekly basis. Providers should see the new practitioner in NaviNet in a few weeks after credentialing is complete. Providers should send specific issues on this topic to their Account Executive.

Declaration Check Box

Question	Response
What is the declaration check box?	The declaration check box is an agreement from the provider in which they agree to notify the member of any services that are approved.

Notes & Notifications

Question	Response
Is there a character limit in the notes section?	Yes, there is a 264-character limit in the Notes section.
Will there be an alert when there is a note from the Health Plan?	If the user is signed up to receive notifications, they will receive a pop-up alert inside NaviNet with the ability to launch to the “Authorization Details” screen. Once the user launches the “Authorization Details” for that patient, they will be able to see and review the notes from the Health Plan
Is the contact information required to be entered by the user?	Yes, the user must submit their First Name, Last Name, and Phone Number. If they attempt to bypass this area, the system will remind them that this is a required field.

Will the communication between Providers and the Health Plan be instant?	No, communication may be slightly delayed.

Appeals

Question	Response
Can appeals be initiated in NaviNet?	Not at this time.

Behavioral Health Authorizations Log

Question	Response
Is there a way for providers to see all the authorizations that have been created in NaviNet?	Yes. In the **Behavioral Health Authorizations Log**, users have the ability to select a checkbox "***Authorizations Created by Me***" on the left side of the screen.
Under the Behavioral Health Authorizations Log, what does Required mean when listed as the authorization status?	This means that the user cancelled the authorization submission or received an error while entering the authorization, for example, if the authorization overlapped another authorization already entered.

What do the various statuses represent in the Behavioral Health Authorizations Log?

If the status is….	Then…
Approved	the request is Approved
Denied	the request is Denied
Pending	the request is Pending review from the health plan
Partially Approved	either some items were approved and others were not and/or items approved were of a lesser amount or frequency
No Authorization Required (NA)	the request does not require authorization
Duplicate	the request was identified as a duplicate request
Cancelled	the system has detected a possible duplicate episode and cancelled/voided the request

NaviNet Support

Question	Response
Is there a NaviNet Customer Service phone number?	Yes, the NaviNet Customer Service Support number is: 1-**888-482-8057.**