CMSI Provider Portal Frequently Asked Questions

User Access

- Multiple logins are not necessary. If you work with several providers at a location, you will be able to enter the details for each authorization request on the submission page. Use your primary MD's information to create your account.
- Do not use spaces in your username. Please note that usernames and passwords are case-sensitive.
- The password will require upper and lowercase, as well as a special character and a minimum of 10 digits.
- After 30 days of inactivity, your portal access may move to inactive status. Please contact the CMSI intake team to have your account refreshed. There is no need to create a new account.
- Co-workers / business units that are responsible for the same block of patients can have their accounts linked. Please reach out to CMSI for assistance.

General Issues Logging in to the CMSI Provider Portal

- Make sure you click 'Sign in with Username/Password' when logging in.
  - Do not use the 'Single Sign-On (SSO)' button, as it will result in a log-in error.
  - Staff outside of CMSI must log in using their username and password.
- If your password has been reset and errors continue to occur, clear your browser history / cache and try logging in again.
- Contact the CMSI intake team at 262-369-8750 or 800-861-8744 for assistance logging in to your account or to reset your password.

How to Choose a Case Type: Inpatient vs Service Procedure

- Inpatient Authorization requests include:
  - All inpatient cases
  - Observation stays
  - Behavioral health
    - Inpatient treatment
    - Partial hospitalization program (PHP)
    - Residential treatment
- Service Procedure Authorization requests include:
  - All outpatient procedures
  - Behavioral health IOP treatment
  - Diagnostics
  - Home care*
  - Therapies*
  - Injections / infusions
  - Anything else that does not fall under the inpatient category

**Physical, occupational, speech therapies and skilled nursing need to be entered as separate authorization requests.*

Multiple CPT or Diagnosis Codes on the Same Authorization Request

- Click the + icon to add additional lines and codes to the same authorization request.

- Do not submit the authorization request until all required information is available. Entering a question mark or '0' in a field will result in a call or follow-up from our team for clarification.

Case Turnaround Times

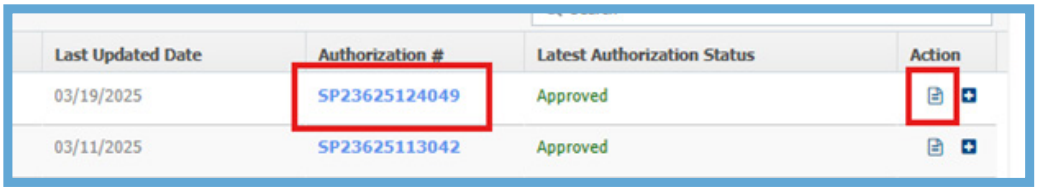
- Several factors can affect case turnaround time. Cases may require physician review, additional records, or during periods of high-volume prioritization of cases may occur.
- Cases are reviewed at three levels: Expedited, Standard, and Retro.
- Please review the CMSI Criteria for Expedited Status document for additional details.

Authorization Outcome Descriptions

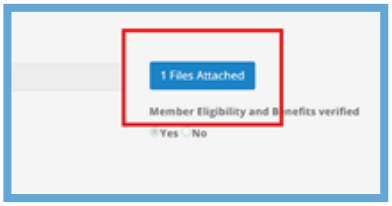
- **Approval:** The case has been approved as medically appropriate. Per the member's health plan, they may have navigation or care requirements. Please refer to determination letter for specifics.
- **Partial Approval:** The case has been partially approved as medically appropriate. Refer to determination letter for specifics.
- **Denial:** The case has been denied and determined not medically appropriate, a plan exclusion, or there is insufficient information. Refer to determination letter for specifics.

Determination Letters

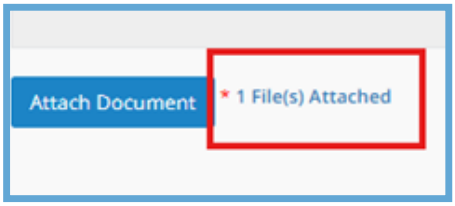
- Letters and reports can be viewed by clicking on the Authorization Number or the paper icon.



- View the attached files for the determination letter:

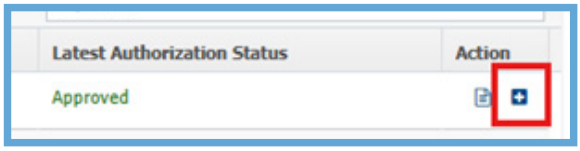


OR



Adding Records or an Authorization Extension Request

- To modify or add an extension request to a case that is already open in the portal, click on the case via the + icon.



- Review the information, add any additional notes or details, attach the necessary records, and submit.
- All determinations for the case will continue to flow to the provider portal.
- Subsequent extension requests can be added to the same case, following the same procedure.

CMSI provides medical necessity review for the account / TPA. What does this mean?

- Per our authorization / determination letters, a disclaimer is noted that indicates:

  Final determination of benefits is based on in-network or out-of-network status, eligibility, deductibles, plan limits, and overall plan language. Benefits can be verified with the plan administrator or health fund directly. This form does not guarantee payment of benefits.

- Providers are responsible for verifying benefits, eligibility, and any navigation needs with the plan administrator.

For general questions or assistance, please contact the CMSI intake team:

262-369-8750 or 800-861-8744

Monday to Friday, 8:00 AM to 4:30 PM CST