Jiva Provider Portal Questions and Answers

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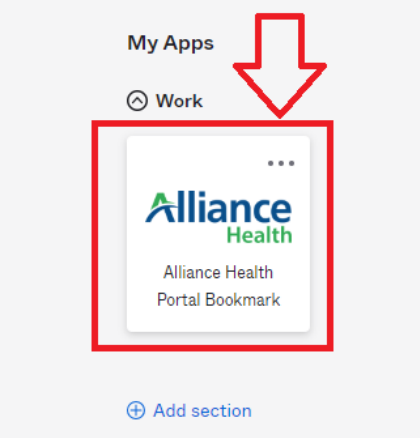
HOW DO I LOGIN TO JIVA PROVIDER PORTAL?

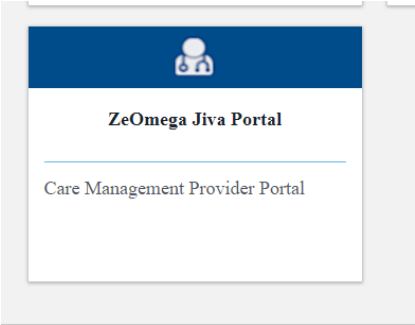
In order to access Jiva Provider Portal, you will log in to the Okta Single Sign On at the link below:

https://alliancehealth.okta.com/

If you have already has a login to Okta, you will log in and select the Alliance Health Portal Bookmark



Select the ZeOmega Jiva Portal tile and Jiva Provider Portal will open on your screen.



If you did not already have access to Okta, you would have received an auto generated e-mail from Okta with instructions on how to log in. Please check your Spam/Junk folder

WHEN WILL I GET ACCESS TO JIVA?

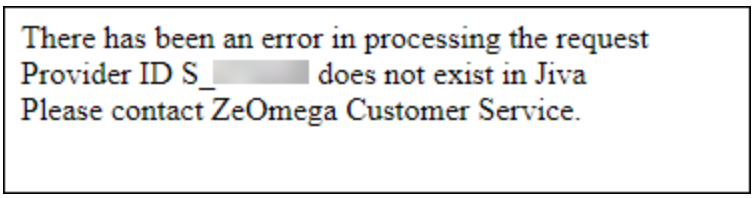
Have you submitted the necessary forms?

If no, then please go to the following link to complete the Jiva Provider Portal Service Agreement.
You can also reference the Jiva Provider Portal Service Agreement Instructions.
https://www.alliancehealthplan.org/providers/network/um-jiva-provider-portal-forms-and-instructions/
The completed forms need to be submitted to privacysecurity@alliancehealthplan.org.
Please allow 2-3 business days for access to Jiva to be granted.

If yes, you have submitted a signed Jiva Provider Portal Service Agreement and Attachment A to privacysecurity@alliancehealthplan.org:

- Please send an email to privacysecurity@alliancehealthplan.org with the following information:
    - Agency Name
    - Staff name who does not have access to Jiva
    - Email contact for the provider staff member

ERROR MESSAGE WHEN LOGGING IN TO JIVA



If you receive the error shown above when logging in to Jiva please Contact the Provider Helpdesk at 855-759-9700 or providerhelpdesk@alliancehealthplan.org to report this error.

Please include the following in the email:

Name

Email

Phone Number

Provider Name

Provider ID noted in the error message

WHEN WE BEGIN SUBMITTING PRIOR AUTHORIZATIONS FOR THE FIRST TIME, WHAT START DATE SHOULD WE USE?

Providers can submit an authorization request as of 7/1/2024, but they are not required until 10/1/2024. When providers do submit a request, please indicate the start date needed for that member/service.

WILL CURRENT AUTHORIZATIONS ROLL OVER FROM PREVIOUS INSURANCE?

Current authorizations will not roll over. Alliance Health does not require prior authorization until 10/1/2024, so if a member's current authorization expires before then, it is suggested that the provider submit a new request as that one ends.

IF AN OUT OF NETWORK PROVIDER REQUESTS ACCESS TO JIVA

Out of Network (OON) providers will not have access to the Jiva Provider Portal for authorization requests. OON providers will continue or begin using the OON process by submitting the PA Request at:
https://www.alliancehealthplan.org/document-library/89018/
The completed form should be sent to UMOutofNetwork@AllianceHealthPlan.org.

QUESTIONS REGARDING TRAINING MATERIALS AND USER GUIDE

Training is not required for providers; however, strongly recommended.

You can access Jiva Provider Portal forms, Use Guides, and videos on our website at https://www.alliancehealthplan.org/providers/network/um-jiva-provider-portal-forms-and-instructions/.

You can also access the User Guides, recorded training, and live training sessions in KnowledgePoint at https://alliancehealthplan.docebosaas.com/.

A quick reference guide is located here: KnowledgePoint Quick Reference Guide.
Questions regarding KnowledgePoint can be sent to knowledgepoint@alliancehealthplan.org

The following User Guides are available on our website and in the Content tab of the corresponding course in KnowledgePoint:

- Behavioral Health - Inpatient
- Behavioral Health - Outpatient
- Physical Health – Inpatient
- Physical Health – Outpatient

For Physical Health Providers: Live virtual trainings are ongoing. There are two separate training types:

- Jiva: Physical Health (Inpatient)
- Jiva: Physical Health (Outpatient)

For Behavioral Health Providers: The recorded training video is located in the course titled Jiva Provider Portal Training: Behavioral Health.

HOW DO I KNOW WHICH PROVIDER SITE TO ATTACH TO A REQUEST?

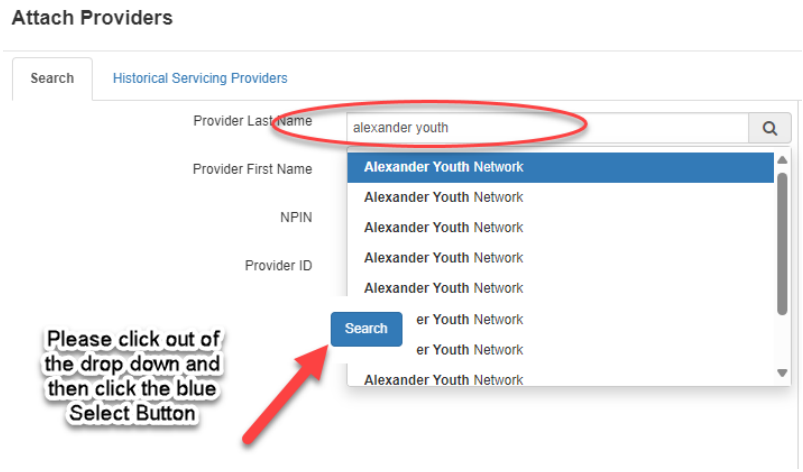
Effective May 1, 2024, authorizations will no longer be site-specific and will be authorized at the provider level. Therefore, please search by the Provider Name (this is the provider name that matches how you are enrolled in NCTracks) or Tax ID (in Advanced Search). This will bring up a limited number of provider IDs, from which you will select your agency/practice.

More information can be found in the Provider News Update here: https://www.alliancehealthplan.org/provider-updates/important-information-regarding-jiva-and-authorizationprocess-for-in-network-providers/

Select the main site for your provider in Jiva.

If you have trouble locating your provider site in Jiva, please search for your agency name in the Provider Last Name/Agency Name field.
Click out of the dropdown box and click the blue Search button.

Note: Do not click in the dropdown menu.



If you still cannot locate your provider site, please contact your assigned Network Relations Specialist.

Please include the following information:

Name
Email
Phone Number
Provider Name
Site ID

Find your Network Relations Specialist here: https://www.alliancehealthplan.org/providers/network/assignments/

ARE SIGNED DOCTOR'S ORDERS REQUIRED TO BE UPLOADED?

If you have a signed doctor's order, it is recommended that it is uploaded. Whether it is a requirement is dependent on the clinical coverage policy for the service you are requesting.

You can access more information here: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies

IF I ATTACH AN EVALUATION DOCUMENT THAT SHOWS MEDICAL NECESSITY AND ALL INFORMATION REQUIRED, HOW DETAILED DOES THE NOTE SECTION NEED TO BE?

The UM Service Request Note section can be brief since attached documents include information to demonstrate medical necessity.

At minimum, please include the submitter's name, email, and contact phone number.

IS THE MCG REVIEW STEP REQUIRED FOR EVERY AUTHORIZATION REQUEST?

The MCG Review is required for each authorization request.

If you have administrative staff that are entering your requests, our guidance is to provide them with this information for submission. You can decide on an internal process that would be best to accomplish this.

I RECEIVED A POP-UP/ERROR WHEN I TRY TO SUBMIT A REQUEST

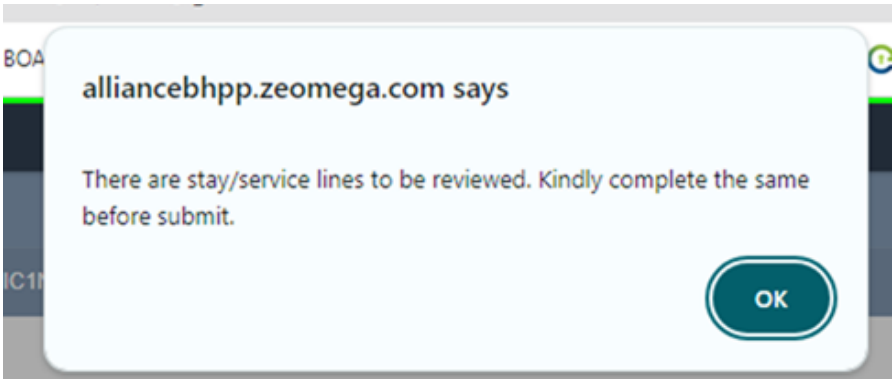
There are a few different pop-up/error messages that can appear when a provider tries to submit a new request.

Please see examples and solutions below.

POP-UP STATES "THERE ARE STAY/SERVICE LINES TO BE REVIEWED…"

When you click Submit on a request, you will receive the pop-up stating "there are stay/service lines to be reviewed, kindly complete before moving forward".

Click "Ok."



You will then click the check box next to the Service Code and click the green "Review" button to proceed into the MCG guidelines for review.

This is covered in the Jiva Provider Portal User Guide in the "Performing MCG Reviews" section.

Below is a screenshot of the beginning of those instructions.

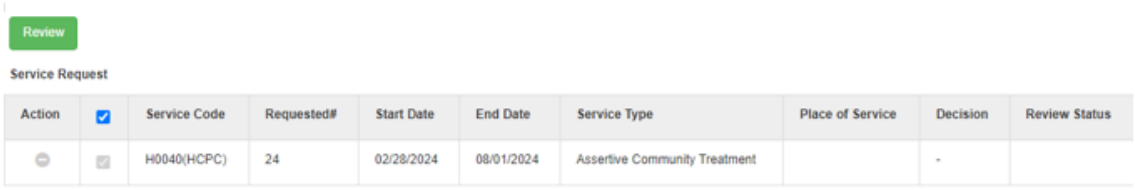
1. When creating an Episode after you click Submit, a pop-up message will appear.



2. Click OK.

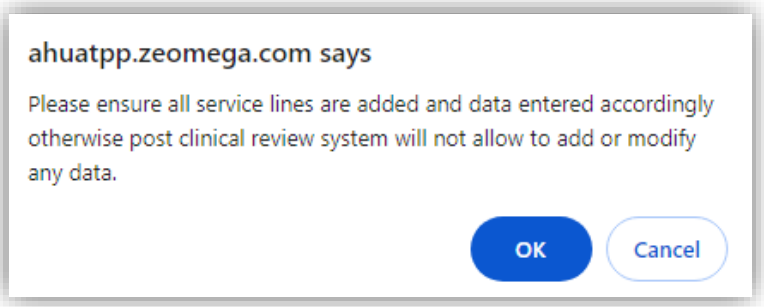
For BH-OP: The green Review button will now appear in the Service Request section. Select the checkbox in the Service Request header.

Note: You cannot select individual request lines/service codes as Jiva groups all of the request lines/service codes for review. Each line should reflect a decision (Pending or Approved). If any lines do not have a decision after completing the review process, select the header checkbox again to repeat the review for those lines.



After you click Review, you will receive the pop-up message below. You will click OK and a new browser tab should open for MCG.

Note: If a new browser tab does not open, check if you are using a pop-up blocker.
If so, you will need to click to allow pop-ups from that site. Then you will go back to click Review and click OK in the pop-up again and MCG should open in a new browser tab.



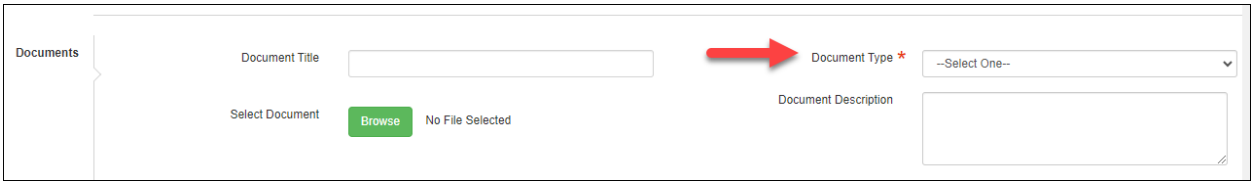
POP-UP STATES “PLEASE LOOK INTO THE HIGHLIGHTED FIELDS”

You may receive a pop-up stating “Please look into the highlighted fields” when you click to Submit your request.



Currently the Document Type is required, even when not attaching a new document.
You must select an option from the dropdown menu in order to click Submit.

Please note: This does not attach another document nor is a document required.

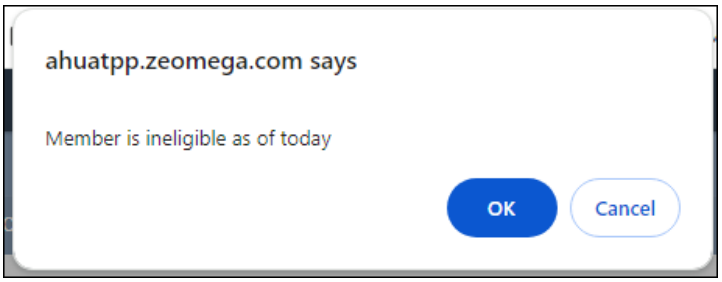


Alliance is aware of this glitch and is working with our vendor to correct it.

POP-UP STATES “MEMBER IS INELIGIBLE AS OF TODAY”

In the Service Request section, when a provider enters the desired Service Code and clicks Add, you may receive a pop-up stating “Member is Ineligible as of Today”. This will appear if the date range you have selected extends beyond the current coverage end date in Jiva.

You can click OK and proceed with submitting your request.



HOW LONG DOES THE AUTHORIZATION USUALLY TAKE TO GET APPROVED?

Expedited – Turn-around time will be within 72 hours. This should only be used in instances where a member's health/safety are at risk in accessing a service.

Please note that should a request not meet expedited guidelines, Alliance Health staff may remove the request from expedited status, and it will be reviewed within Standard timeframes.

Standard – Turn-around time will be within 14 calendar days to complete an episode, unless this is a retrospective, in which case the turn-around time is 30 calendar days.

WILL ALLIANCE HEALTH FAX A COPY OF THE APPROVED AUTHORIZATION?

Alliance Health does not fax a copy of the authorization letter.

Providers can view the authorization number and authorization letter in the Alliance Claims System (ACS) portal.

HOW LONG DOES IT TAKE FOR AN AUTHORIZATION TO SHOW UP IN ACS AFTER A REQUEST IS APPROVED IN JIVA?

Typically, authorizations populate in ACS within one hour of a decision being rendered in Jiva.

Should you see an approval in Jiva and not in ACS, please send an email to UMSupervisors@alliancehealthplan.org including the following:

- Episode ID
- Alpha ID
- Member Name
- Member DOB
- Service/Procedure Code Requested
- Provider Name

WHEN AN AUTHORIZATION REQUEST IS APPROVED, IS THE AUTHORIZATION START DATE THE DATE I ENTERED ON THE REQUEST OR THE DATE THE DECISION WAS FINALIZED?

The Authorization Start Date is typically the requested service Start Date the provider entered when submitting the request.

For example, if you submit a request on 7/1/2024 with a requested start date of 7/8/2024, the authorization start date would be 7/8/2024.

For Inpatient (IP Episodes), the Authorization Start Date is typically the Expected/Actual Admission Date the provider entered when submitting the request.

QUESTIONS ABOUT HOW TO FILE CLAIMS

Alliance Health Claims Department does a detailed training on ACS and billing information on Tuesdays at 9-10am.

Further information can be found at https://www.alliancehealthplan.org/provider-updates/claims-enrollment-provider-training/.

Claims questions can be directed to claims@alliancehealthplan.org