Authorizations (BETA)

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Authorizations Overview (BETA)

Authorizations Overview

The Authorization screens are some of the longest-standing screens in the system, having kept the same look for over 15 years. The redesigned Authorization workflow modernizes these screens for usability and performance while keeping their core purpose: documenting, tracking, and assigning prior authorizations and referrals so claims and appointments validate correctly.

Where to find it: The Authorization screens can be opened from the Patient Setup screen, iScheduler, or the Claim screen.

Screens in this workflow

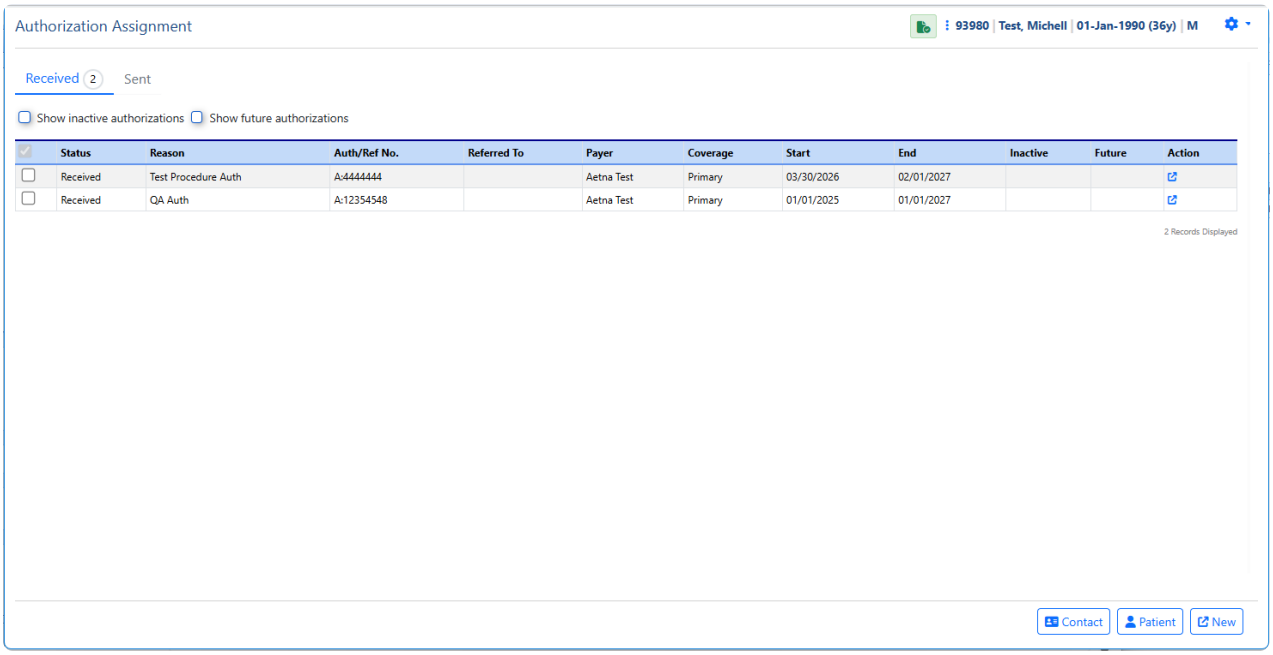
The redesigned workflow spans three screens:

- **Authorization Assignment** — view a patient's authorizations and assign one to an appointment or claim. See Assign an Authorization to an Appointment or Claim.
- **Patient Authorization** — document and track an authorization or referral for a patient. See Add an Authorization.
- **Authorization Search** — search all authorizations, or find appointments and claims with missing or invalid authorizations. See Search for Authorizations.

Automatic prompt in iScheduler

If an appointment is scheduled using an appointment type that requires an authorization and one isn't already on file, the Authorization Assignment screen opens automatically so you can assign or add one before continuing. See Assign an Authorization to an Appointment or Claim.
These prompts are controlled by the Authorization rules. See Authorization Setup for details on the Authorization rules

Authorization Assignment



The Authorization Assignment screen is organized into two tabs:

- **Received** — tracks authorizations/referrals that have been received for the patient.
- **Sent** — tracks authorizations/referrals that have been sent for the patient.

Below the tabs, two checkboxes filter the list:

- **Show Inactive Authorizations** — shows only inactive authorizations.
- **Show Future Authorizations** — shows only future authorizations.

*By default, only active and future authorizations are displayed.

Each tab contain the following columns:

- **Checkbox** — select an authorization to assign it to the appointment or claim (behaves like a radio button).
- **Status** — the authorization's status.
- **Reason** — the authorization's reason.
- **#** — the authorization number, prefixed with A or R based on the authorization's Type.
- **Referred To** — the referring provider on the authorization.
- **Payer** — the insurance selected on the authorization.
- **Coverage** — the coverage of that insurance.
- **Start / End** — the authorization's effective start and end dates.
- **Inactive** — flag denoting that the authorization is inactive.
- **Future** — flag denoting that the authorization is a future authorization.
- **Actions** — View Details opens the authorization; Delete removes it.

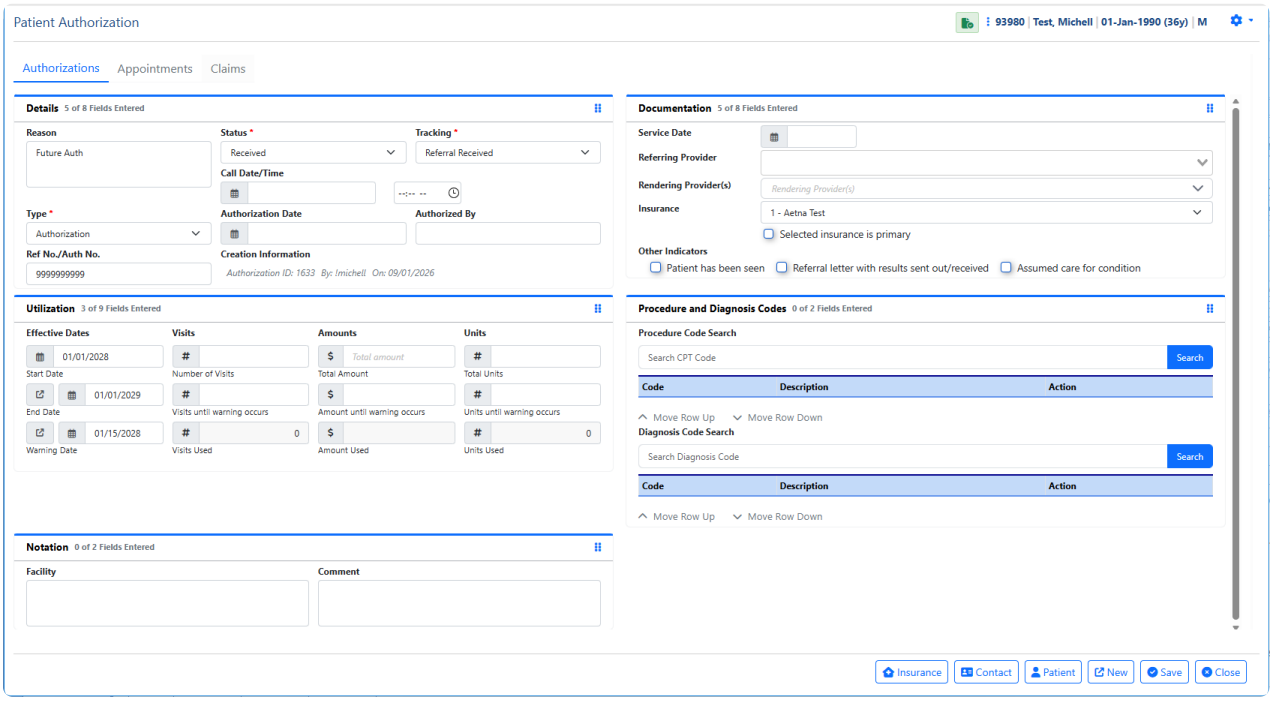
Bottom buttons

- **Contact** — opens a quick patient info screen with Patient Name, DOB, Age, Chart #, Address, City/State/Zip, Home/Work/Other phone numbers, Email, and the Primary, Secondary, and Tertiary insurance names and member IDs.
- **Patient** — opens the Patient Demographics screen.
- **New** — opens a blank Patient Authorization entry. See Add an Authorization.

Gear menu

- **Authorization Rules** — provides a menu selection of Authorization Rules. See Authorization Setup for details on the Authorization rules.

Patient Authorization



The **Patient Authorization** tab is broken into five sections:

Details

- **Reason** — free-text field for what the authorization is for.
- **Status** — Needs Review, Received, Auth Not Required, or External PA. Defaults to Received.
- **Tracking** — Referral Received or Referral Sent, depending on whether the authorization is for or from the practice. Defaults to Referral Received.
- **Type** — Authorization or Referral. Defaults to Authorization.
- **Auth Date** — the date the authorization or referral was acquired.
- **Ref # / Auth #** — the number provided for the referral or authorization.
- **Auth by** — the rep who provided the authorization.
- **Created / Created By** — the date, time, and user who created the authorization.
- **Call Date** — logs the time of the call, with an AM/PM selector.

Documentation

- **Service Date** — the date of service the authorization applies to.
- **Referring** — search field for the referring provider (all providers in the database).
- **Rendering** — multi-select search field for the rendering provider(s); the search only includes providers flagged as rendering. Selecting a provider here means the authorization can only be assigned to a claim where that provider is the rendering provider.

- **Indicators** — checkboxes for "Patient has been seen," "Referral letter with results sent out/received," and "Care for condition was assumed."
- **Insurance** — the payer the authorization applies to, from a list of active payers with payer name and coverage.
- **Selected insurance is Primary** — when checked, the selected insurance is listed as primary on any claim the authorization is assigned to.

Utilization

Fill in only the section that matches how the authorization was issued:

- **Effective Dates** — for authorizations issued over a date range. Includes Start Date, End Date (or a day-count calculator that fills End Date from Start Date), and a Warning Date for when warnings should start.
- **Visits** — for authorizations issued for a number of visits. Includes # Visits, Used (auto-tracked from linked claims), and a warning threshold after X visits.
- **Amount** — for authorizations issued for a dollar amount. Includes Amount, Used (auto-tracked from linked claims), and a warning threshold after $X.
- **Units** — for authorizations issued for a number of units. Includes # Units, Used (auto-tracked from linked claims), and a warning threshold after X units.

Procedure/DX

- **Procedure** — search and add the specific procedure codes the authorization applies to. Codes can be reordered or removed; the display shows the code and description.
- **Diagnosis** — search and add the specific diagnosis codes the authorization applies to. Codes can be reordered or removed; the display shows the code and description.

Notation

- **Facility** — free-text field for the service facility.
- **Comment** — free-text field for internal notes on the authorization.

Gear menu 

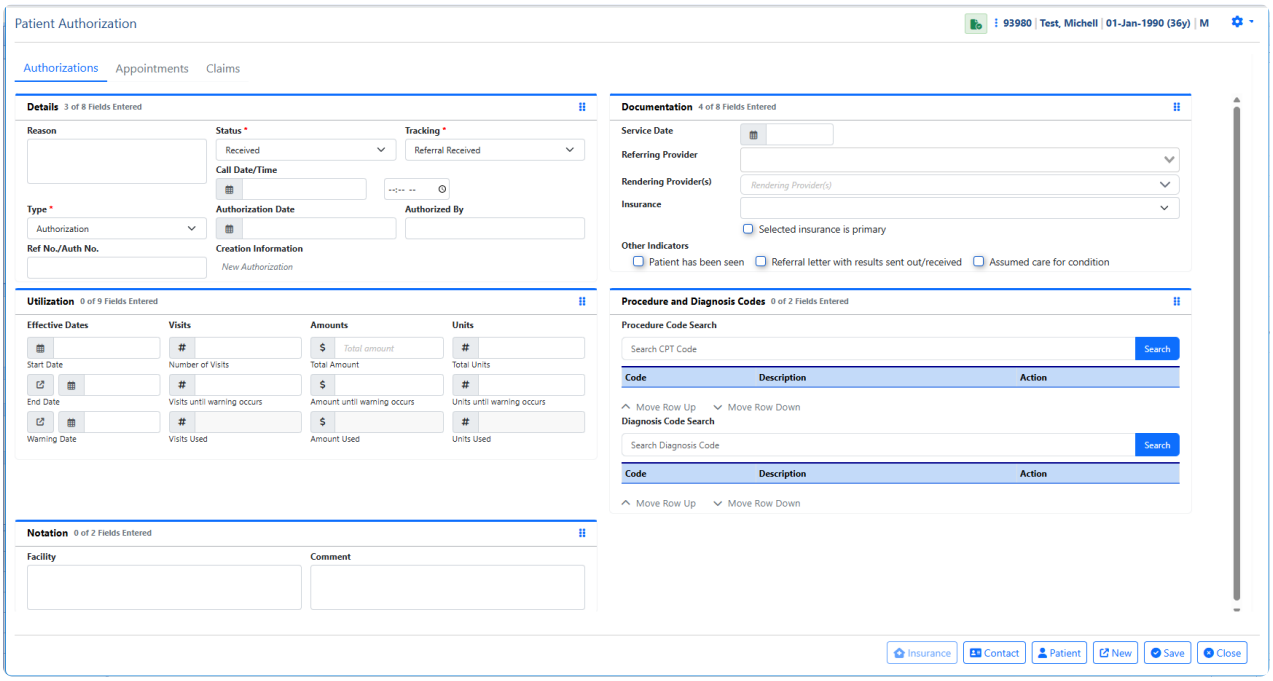
- **Audit** — opens the audit history for the authorization.
- **Authorization Rules** — provides a menu selection of Authorization Rules. See Authorization Setup for details on the Authorization rules.

Add an Authorization (BETA)

This article covers documenting a new authorization or referral on the redesigned Patient Authorization screen. For an overview of the whole workflow, see Authorizations (BETA).

Where to find it: Open the Patient Authorization screen from the Patient Setup screen, iScheduler, or the Claim screen, then click New.

How to add an authorization



1. From the Patient Authorization screen, click **New** to open a blank authorization.
2. In the **Details** section, enter the Reason, Status, Tracking, Type, Auth Date, Ref # / Auth #, and Auth by. Status defaults to Received, Tracking defaults to Referral Received, and Type defaults to Authorization — update any of these as needed.
3. In the **Documentation** section, enter the Service Date, Referring provider, and Rendering provider(s), select the Insurance the authorization applies to, and check any Indicators that apply. Check **Selected insurance is Primary** if the authorization should be listed as primary on any claim it's assigned to.
4. In the **Utilization** section, fill in only the subsection that matches how the authorization was issued — **Effective Dates**, **Visits**, **Amounts**, or **Units** — including the warning threshold for each.
5. In the **Procedure/DX** section, search for and add any specific procedure or diagnosis codes the authorization applies to.
6. In the **Notation** section you can notate the service Facility and any internal Comment.
7. Click **Save**.

Tracking used visits, amounts, and units: The Used field in the Utilization section updates automatically based on the claims linked to the authorization.

Once an authorization is saved, it becomes available to link to appointments and claims. See Assign an Authorization to an Appointment or Claim.

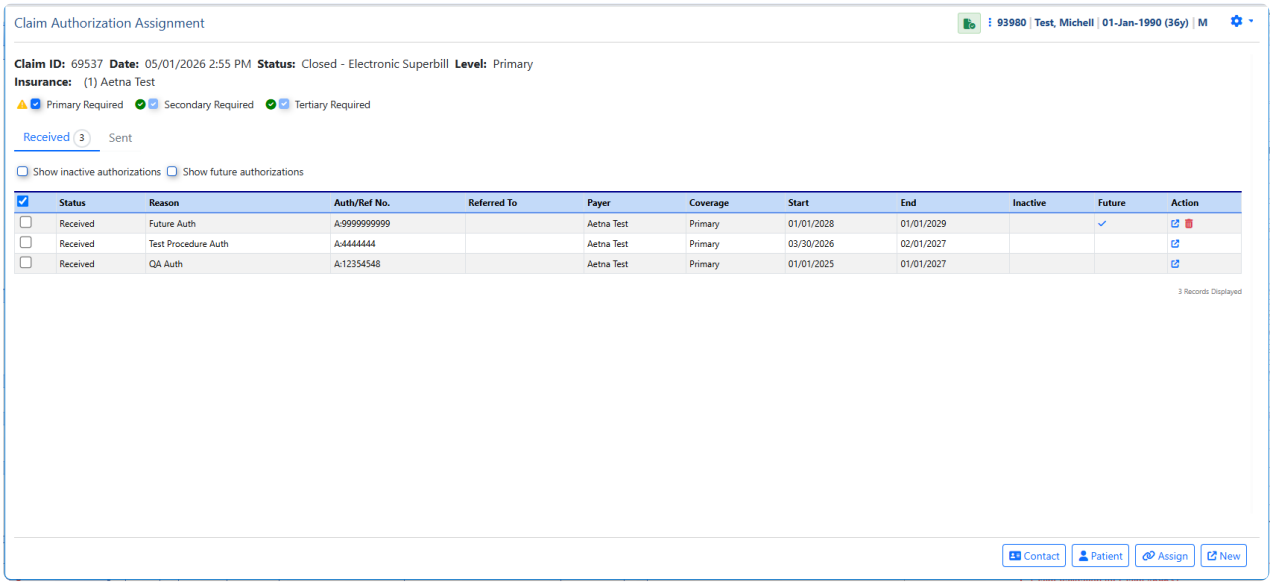
Assign an Authorization to an Appointment or Claim (BETA)

The Authorization Assign screen lets you view a patient's authorizations and link one to an appointment or claim. For an overview of the whole workflow, see Authorizations (BETA).

Where to find it: Open from an appointment in iScheduler or from the Authorization button on a claim. The patient's name and details appear in the header in the top-right corner.

Opens automatically when needed: Based on the authorization settings the Authorization Assign window will

open automatically from the iScheduler. For an overview see Authorization Setup.
If you schedule an appointment using an appointment type that requires an authorization, change the appointment status to a status that validates for an authorization, or the patient or the payer requires an authorization and an authorization is not already linked the Authorization Assign screen will open automatically, so you can assign or add one for the appointment.



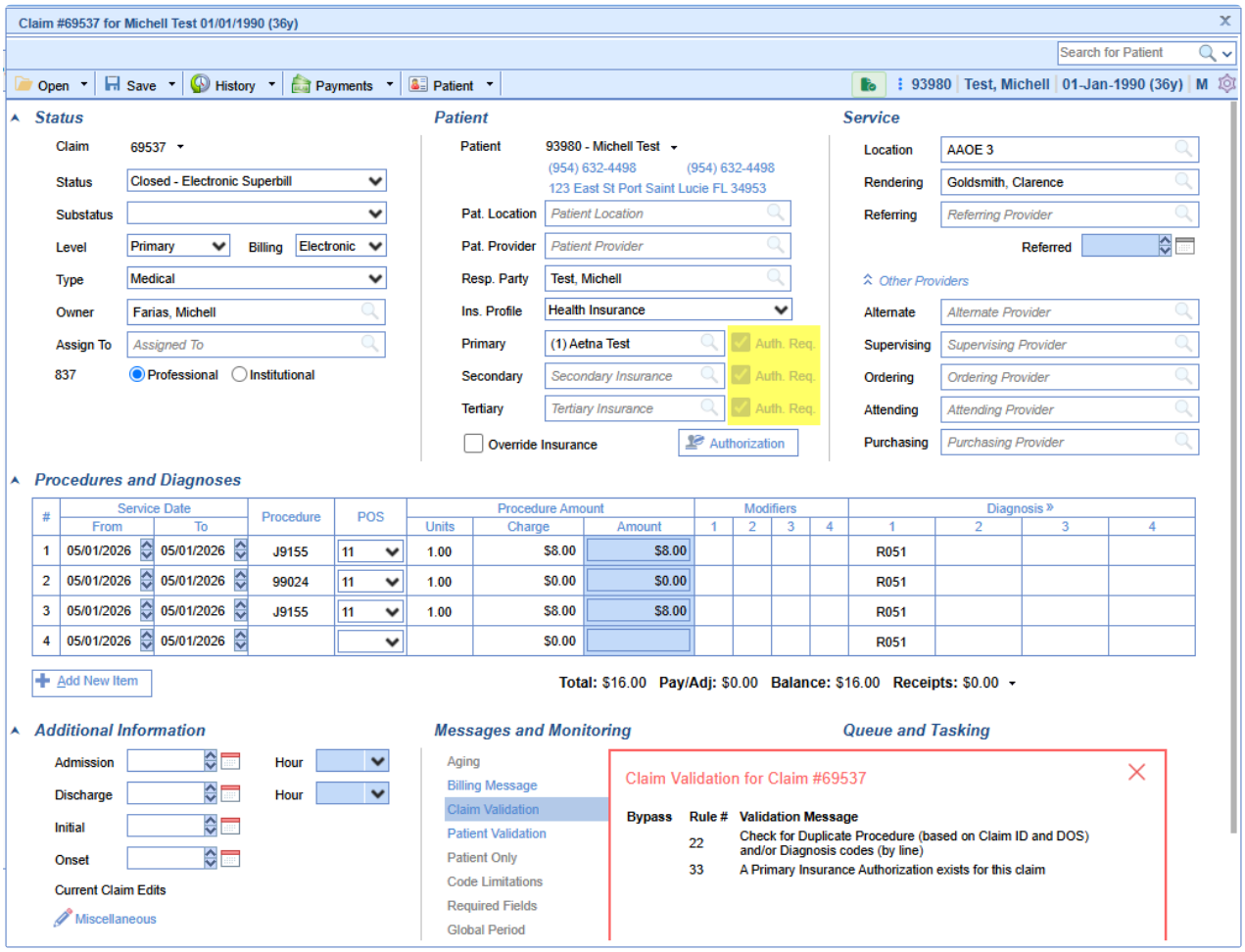
Required checkboxes

At the top of the screen are three checkboxes: **Primary Required**, **Secondary Required**, and **Tertiary Required**.

- Each checkbox is grayed out and checked if the authorization-required indicator isn't set for the payer (Payer Setup → Authorization tab) or the patient (Patient Setup → Insurance tab).
- If either the payer or the patient has the authorization-required indicator set, the checkbox is checked and editable.
- Unchecking a checkbox removes the authorization-required validation for that payer on the appointment or claim.

A message — "Appointment/Claim requires a (primary, secondary, or tertiary) authorization" — appears based on which payers on the appointment or claim require an authorization.

Bypassing without opening this screen: The Auth. Req. checkboxes on the Claim Entry screen mirrors these checkboxes and stays in sync with them, so you can bypass a requirement directly from the claim.



Authorization list

The list is split into two tabs, **Received** and **Sent**, each with the following columns:

- **Checkbox** — select an authorization to assign it to the appointment or claim (behaves like a radio button).
- **Status** — the authorization's status.
- **Reason** — the authorization's reason.
- **#** — the authorization number, prefixed with A or R based on the authorization's Type.
- **Referred To** — the referring provider on the authorization.
- **Payer** — the insurance selected on the authorization.
- **Coverage** — the coverage of that insurance.
- **Start / End** — the authorization's effective start and end dates.
- **Inactive** — flag denoting that the authorization is inactive.
- **Future** — flag denoting that the authorization is a future authorization.
- **Actions** — View Details opens the authorization; Delete removes it.

Below the tabs, two checkboxes filter the list:

- **Show Inactive Authorizations** — shows only inactive authorizations.
- **Show Future Authorizations** — shows only future authorizations.

By default, only active and future authorizations are shown.

Bottom buttons

- **Contact** — opens a quick patient info screen with Patient Name, DOB, Age, Chart #, Address, City/State/Zip, Home/Work/Other phone numbers, Email, and the Primary, Secondary, and Tertiary insurance names and member IDs.
- **Patient** — opens the Patient Demographics screen.
- **Assign** — assigns the checked authorization to the appointment or claim.
- **New** — opens a blank Patient Authorization entry. See Add an Authorization.

How to assign an authorization

1. Open the Authorization Assign screen from the appointment or claim.
2. Select the **Received** or **Sent** tab, and use the filters if you need to find an inactive or future authorization.
3. Check the box next to the authorization you want to link.
4. Click **Assign**.

Click **Cancel** at any time to close the window without assigning/modifying the authorization assignment.

Search for Authorizations (BETA)

Use Authorization Search to catch missing or invalid authorizations before they turn into denied claims. Also, allowing you to quickly answer questions like “which authorizations are expiring this month?” or “does this scheduled appointment already have an authorization on file?”

The screen has three tabs, each built around a specific use case:

- **Authorizations** — Search your full authorization list by reason, status, payer, provider, procedure, diagnosis, or date range. Use this to audit existing authorizations, track down a specific one, or find any that are running low on approved visits or dollar amount.
- **Appointments** — Find scheduled appointments whose insurance doesn't have a valid authorization yet. A red/yellow/green indicator flags each appointment's Primary, Secondary, and Tertiary insurance at a glance, so you can work the list before the patient's visit instead of after a claim gets rejected.
- **Claims** — Same idea, but for claims: instantly spot which submitted claims are missing an authorization or have an invalid one, so you can fix it before the payer denies the claim.

Where to find it: Open the Authorization Search screen from the Authorizations window in the Billing portal. For an overview of the whole workflow, see Authorizations (BETA).

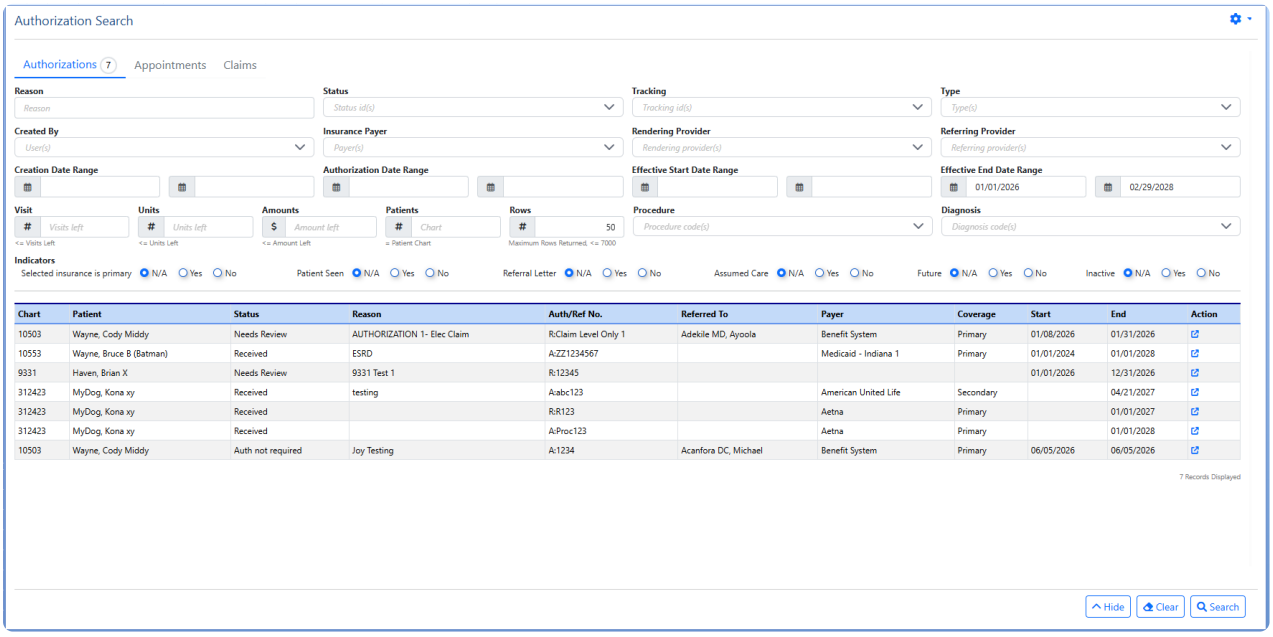
Authorizations tab

Search parameters:

- **Reason** — text search for the authorization reason.
- **Status, Tracking, Type** — multiselect; leave blank to include all.
- **Created By** — multiselect for who created the authorization; leave blank to include all.
- **Payer, Rendering, Referring** — multiselect; leave blank to include all.
- **Creation Date Range** — date range for when the authorization was created.
- **Authorization Date, Effective Start Date, Effective End Date** — date ranges.

- **Visits/Amounts** — filter to authorizations with less than X visits, units, or dollar amount left.
- **Chart** — patient chart number to filter for a specific patient.
- **Rows** — maximum number of results displayed.
- **Procedure, Diagnosis** — multiselect; leave blank to include all.

Results columns: Chart #, Patient, Status, Reason, Auth. No. (prefixed A or R based on Type), Referred To, Payer, Coverage, Start, End, and an Action column with View Authorization.



Appointments Missing/Invalid tab

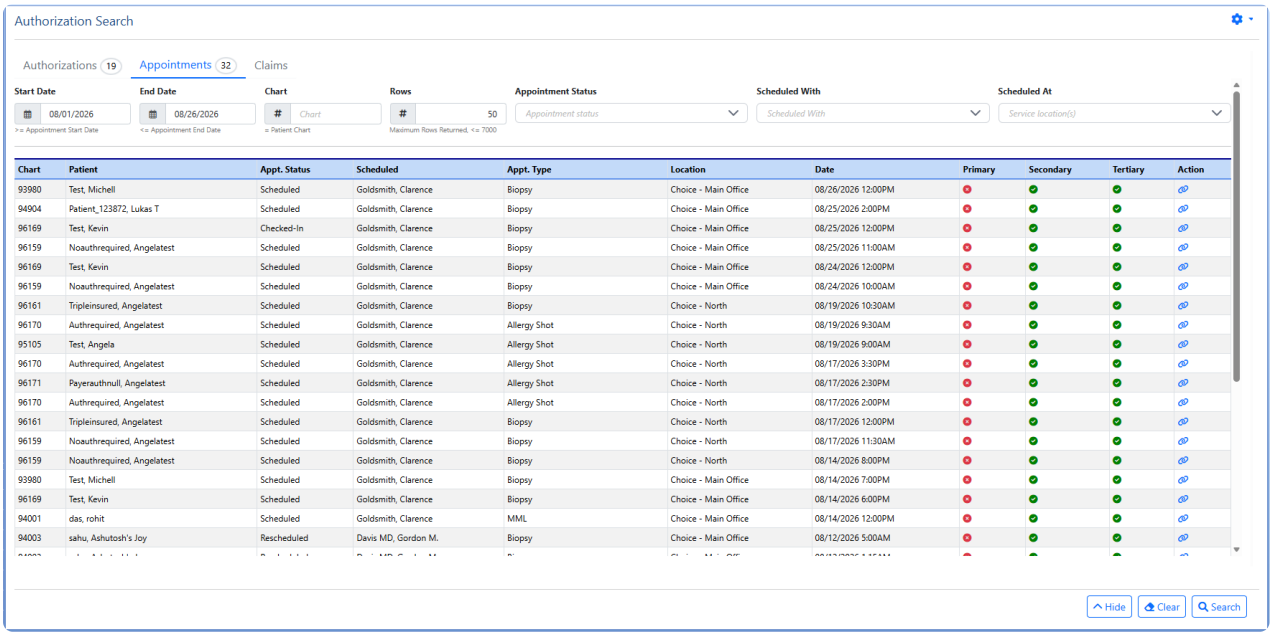
Search parameters:

- **Start Date, End Date** — appointment date range.
- **Chart** — patient chart number to filter for a specific patient.
- **Rows** — maximum number of results displayed.
- **Appointment Status** — multiselect; leave blank to include all.
- **Scheduled With** — multiselect resources; leave blank to include all.
- **Scheduled At** — multiselect locations; leave blank to include all.

Results columns: Chart #, Patient, Appt. Status, Scheduled, Appt. Type, Location, Appt. Date, and a Primary / Secondary / Tertiary indicator for each insurance:

- ❌ — authorization missing.
- ⚠ — authorization invalid.
- ✅ — authorization valid.

Click on the Link Action to open the Authorization Assign screen for that appointment. See Assign an Authorization to an Appointment or Claim.



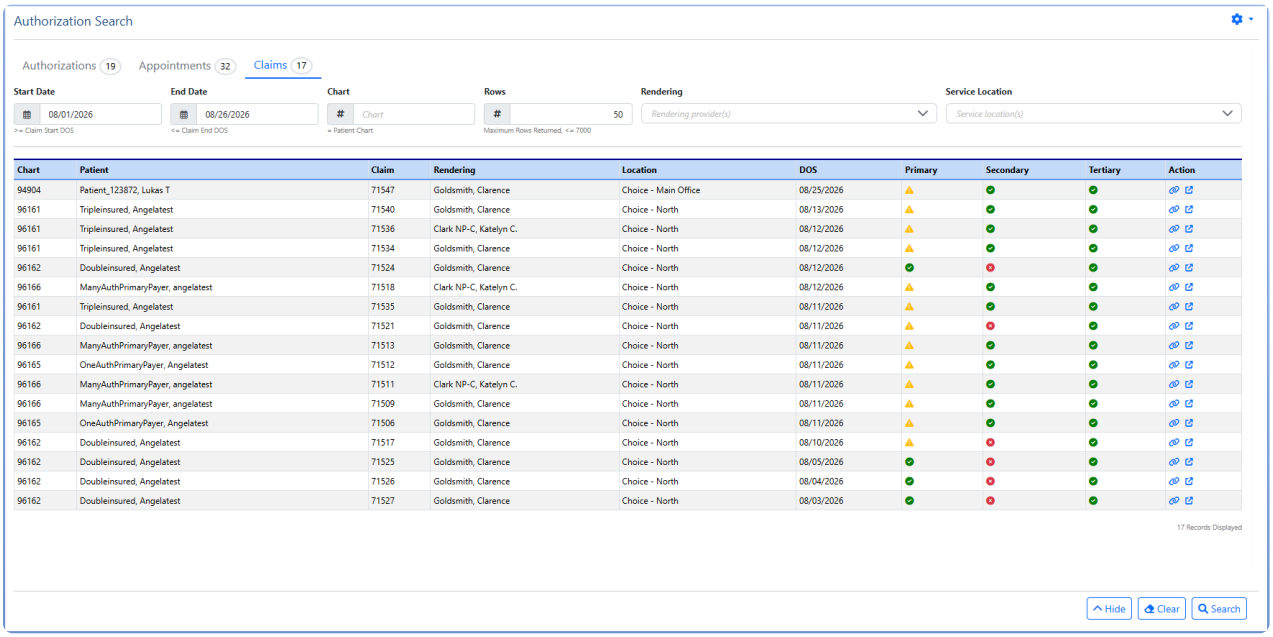
Claims Missing/Invalid tab

Search parameters:

- **Start Date, End Date** — claim date of service.
- **Chart** — patient chart number to filter for a specific patient.
- **Rows** — maximum number of results displayed.
- **Rendering** — multiselect providers; leave blank to include all.
- **Service Location** — multiselect; leave blank to include all.

Results columns: Chart #, Patient, Claim, Rendering, Location, Service Date, and the same Primary / Secondary / Tertiary indicators used on the Appointments tab.

Click on the Link Action to open the Authorization Assign screen for that claim or click the View Details Action to open the Claim Entry screen for that claim.



Authorization Auto Link Logic (BETA)

Authorization Auto Link Logic

When Authorization auto link is enabled, OfficeEMR automatically links an existing authorization to an appointment or claim based on the logic below. See Authorization Setup.
An authorization must be Active to be eligible for auto-linking (see the definition at the end of this section).

Appointment Auto-Link

Condition	Result
An active authorization exists for the primary payer on the appointment	Link the authorization to the appointment
Multiple active authorizations exist for the primary payer	Do not link
The authorization specifies a rendering provider and it matches the appointment's resource	Link the authorization
The authorization specifies a rendering provider and it does not match the appointment's resource	Do not link

Claim Auto-Link (Primary, Secondary, and Tertiary Payer)

Claims are evaluated independently for the primary, secondary, and tertiary payer. For the primary payer, this check runs only if an authorization was not already linked from the appointment.

Condition	Result
An active authorization exists for the payer level on the claim	Link the authorization, subject to the procedure and rendering provider checks below
The authorization specifies a procedure and that procedure is on the claim	Link the authorization
The authorization specifies a procedure and that procedure is not on the claim	Do not link
The authorization specifies a rendering provider and that provider is on the claim	Link the authorization
The authorization specifies a rendering provider and that provider is not on the claim	Do not link
Multiple active authorizations exist for the payer level and at least one has a matching procedure code	Link based on the procedure code match
Multiple active authorizations exist for the payer level and none has a matching procedure code	Do not link
Multiple active authorizations exist for the payer level and at least one has a matching rendering provider	Link based on the rendering provider match
Multiple active authorizations exist for the payer level and none has a matching rendering provider	Do not link

Authorization "Active" Definition

An authorization must be Active — based on its effective dates and remaining visit count — to be eligible for

auto-linking.

Criteria	Requirement
Effective Dates	The appointment date (or claim date of service) must fall between the authorization's start and end date
Visit Counts	Visits utilized must be less than the total number of authorized visits
Amounts	Dollar amount utilized must be less than the total dollar amount.