



Provider User Guide

Intensive Case Management via NaviNet[®]

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AmeriHealth Caritas[™]

District of Columbia

Provider Guide:

Intensive Case Management Program

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About the Intensive Case Management (ICM) Program

Background

Under its contract with the Delaware Department of Health and Social Services (DHSS), AmeriHealth Caritas Delaware is responsible for collecting and submitting complete and accurate encounter data for all services furnished to its members. One of the key components to ensuring that our encounter data is complete and accurate is validation of the diagnoses reflected in the encounters that we submit to Delaware's DHSS.

Delaware's DHSS uses the encounter data from its managed care plans in a number of ways, including to more accurately gauge the disease acuity within our member population, which helps to predict expenditures for delivery of care. *Risk Adjustment* refers to the adjustments that are made to reflect the health status of a population. For managed care plans such as AmeriHealth Caritas Delaware, member-level information obtained through encounters allows Delaware's DHSS to gain a more in-depth understanding of the factors driving cost and quality within Medicaid program.

AmeriHealth Caritas Delaware has developed the **Intensive Case Management (ICM) Reimbursement Program** to compensate providers for completing the essential, administrative activities that help to validate encounter data.

Program Purpose

The AmeriHealth Caritas Delaware ICM Reimbursement Program exists to:

- Help primary care providers (PCPs) identify members with chronic and/or complex medical needs.
- Promote routine access to primary care for chronically-ill members.
- Increase member appointment compliance through outreach.
- Improve accuracy and completeness of reporting to Delaware's DHSS regarding AmeriHealth Caritas Delaware membership.

To help the health plan accurately represent our membership, this program facilitates provider submission of complete and accurate member diagnoses and disease acuity information.

Identifying Members and Informing Providers

ICM members are identified as those with claims history indicating chronic and comorbid conditions. Review of program data from affiliated Plans within the AmeriHealth Caritas Family of Companies reveals chronic and comorbid diagnoses are often incorrectly reported on claims or not reported at all.

Providers are informed about ICM members via pending activities in the *Patient Roster* under the "Practice Documents" workflow in NaviNet. A pending activity appears for an ICM member when one of the following occurs:

- No claims were submitted by the PCP for that member within the previous six months.
- Claims were submitted by the PCP within the previous six months, but claims did not include all the chronic/comorbid diagnosis codes found in the member’s claims history.

Validating Claims/Encounter Data

AmeriHealth Caritas Delaware encourages providers to check their “Practice Documents” (or the alternate “Patient Clinical Documents”) monthly via NaviNet to identify members who require action.

Definition – “Adjust a Claim” is an ICM program activity that can be completed by a provider, online, via NaviNet. The activity includes:

- Accessing claim details;
- Reviewing the claim against relevant medical record documentation (treatment and plan for date of service corresponding to claim date of service) in order to confirm, not confirm, resolve, update, or add diagnosis information;
- Submitting any findings of the review;
- Receiving an applicable administrative fee for completing the review.

All claims reviewed in NaviNet for ICM program purposes are adjusted to include the procedure code 99499; this indicates completion of the review and results in the applicable administrative fee. Procedure code 99499 is added to the claim even if the diagnosis cannot be confirmed and no new diagnosis information is submitted.

Actions to be completed will fall into one of two categories:

- **Adjust a Claim** – The member was seen within the last six months, but submitted claims may not include all the chronic/comorbid diagnosis codes found in the member’s claims history. The medical record for each date of service is reviewed and the corresponding claim is adjusted through NaviNet. As each claim is adjusted in NaviNet, confirmed and/or additional diagnosis codes are added to the originally submitted claim along with procedure code 99499 (Other Evaluation and Management Services) to pay the applicable administrative fee.

Provider Action: Pull the member’s medical record corresponding to the date of the face-to-face visit, review the notes for the member’s visit, and determine if the potential diagnosis code(s) are confirmed, resolved, or cannot be confirmed. If additional diagnosis codes are identified that should have been on the original claim, add the diagnosis code(s) in the ICM Claim Adjustment screen.

- **Schedule an Appointment** – The member has not been seen within the last several months but there are chronic/comorbid diagnosis codes found in the member’s claims history.

Provider Action: Outreach to member, schedule an appointment; review the relevant diagnosis codes during the face-to-face visit; complete the *Complex Case Management Worksheet* process in NaviNet and; submit a claim using your standard claim submission process. To receive reimbursement for the administrative services, add procedure code 99499 (Other Evaluation and Management Services) to the claim.

See Attachment 1 on page 41 of this guide for a visual of this process flow.

- Program information is refreshed on a monthly basis as new information becomes available to AmeriHealth Caritas Delaware; therefore it is important that providers check each month for new “Practice Documents” (or “Patient Clinical Documents”).

Supplemental Reimbursement

AmeriHealth Caritas Delaware recognizes the additional work involved in making medical records available to us and in validating the results of medical record reviews or outreaching to members to schedule appointments. Accordingly,

AmeriHealth Caritas Delaware offers PCPs an administrative payment for each record reviewed, in accordance with the following fee schedule:

- Original claim for any member – \$25.00 per claim.
- All subsequent claims for the same member with service dates exceeding 180 days from the prior claim service date – \$7.00 per claim.
- All subsequent claims for the same member with service dates within a 180 day period from the prior claim service date – \$7.00 per claim.

The additional reimbursement is for your effort and participation with this program; it is not dependent on the health plan’s receipt of updated or confirmed chronic diagnoses codes.

ICM Program Assistance

If you would like assistance with the review of your medical records, AmeriHealth Caritas Delaware’s Risk Adjustment Department can assist as follows:

- AmeriHealth Caritas Delaware will obtain medical records of identified members from you, the PCP. Record requests may be made using a chart retrieval vendor contracted by the Plan.
- AmeriHealth Caritas Delaware will review the medical records, and re-abstract/code diagnoses based on the face-to-face office visits documented in the medical record. The results will be compiled into a Claim Attestation Summary report that is provided to the PCP.
 - *See Attachment 2 on page 42 of this guide for an example of this report.*
- You, the PCP, will review the Claim Attestation Summary report, determine if the new/updated diagnoses identified as a result of the re-abstractation are accurate and complete, and follow the *Claims Adjustment* process in NaviNet.

For assistance with the review of your medical records, please contact the Risk Adjustment Program Department at 215-863-5435.

Audit of Intensive Case Management Program

When providers have opted to review medical records on their own, AmeriHealth Caritas Delaware also performs a random quality review of claims submitted for adjustment through the ICM process. As part of the quality audit process, AmeriHealth Caritas Delaware obtains medical records from you, the PCP, for members who have been selected for audit. (Medical records may be requested through a chart retrieval vendor). The medical record will be re-abstracted and reviewed to identify appropriate diagnosis codes for each date of service based on the documentation. The results will be compared to diagnosis actions indicated in NaviNet (e.g., Confirmed, Can't Confirm, Resolved, Updated or Added). Upon completion of the review, you will be notified of the audit results. Providers with low quality audit scores may be asked to participate in program training; repeat low quality audit scores will result in the rejection of previously-submitted adjustments that cannot be supported by medical record documentation.

How to Use this Guide

This guide offers step-by-step instructions on how to use NaviNet to complete ICM Reimbursement Program activities. In this guide, you will find information on how to:

- Access the “Practice Documents” Workflow (or the alternate “Patient Clinical Documents” Workflow)
- Review, Search, and Filter Pending Activities in the Workflow
- Launch “Member Selection” for ICM Activities
- Search for a Member and/or Filter by Needed Actions
- Validate or Update the Member’s Information by:
 - Completing a claims adjustment by reviewing your medical records and updating the member’s diagnosis information based on documentation from the date of service.
 - OR
 - Scheduling an office visit and submitting an ICM Member Worksheet.

Before You Begin

1. NaviNet Permissions

Check with your NaviNet Security Officer to confirm that you have been granted the appropriate access to the workflows you need. If your NaviNet Security Officer has not enabled Document Exchange, please ask your Security Officer to follow the steps outlined on pages 24 through 27 in the “Supplemental Information” section of this guide.

2. Attest to Access the Workflows

If this is your first time launching the “Practice Documents” or “Patient Clinical Documents” workflows, you will be asked to complete the attestation process. Follow the prompts to complete this process for the billing entities and clinicians you support. You can also complete

this process by using the **My Organization** feature, accessed from the **Welcome** menu in NaviNet. From **My Organization** you can perform or view your attestations.

Note: NaviNet will only show Practice Documents or Patient Clinical Documents sent to billing entities that you have attested to support.

Step 1. Log-In to NaviNet

- A. Open your Internet browser.
We recommended the use of Internet Explorer browser for ICM functionality. Some of the functionality might not work as expected in Chrome browser versions 61 and higher.
- B. Go to <https://navinet.navimedix.com>.
- C. Log-in to NaviNet by entering your **User ID** and **Password** and then clicking **Sign In**.

NantHealth | NaviNet

Sign In

Username:

Password:

Sign In

[Forgot your password?](#)
[Forgot your username?](#)

Getting Started with NaviNet

[Trouble Logging In?](#)
[Sign Up](#)
[What Plans Participate?](#)

All-Payer Access: 750+ Plans Now Available | [Re-Save Bookmarks](#) | [New IVR Message](#) | [Discontinued Support of Windows Vista](#)

ALLPAYER ACCESS

**750+ Plans,
At Your Fingertips.**

Get Started >

ICD-10 READY

NaviNet is ICD-10 compliant. For information regarding plan-specific implementation of this federal mandate, please refer to plan-supplied documentation or visit the plan's website for details.

Are You In The Loop?

Make sure you don't miss out on our important updates. Update your email address today by logging in and going to **My Account** and clicking **About Me** to receive important updates and information.

Are You Sharing Login Credentials?

HIPAA guidelines prohibit users from sharing login information. If you are sharing login credentials, please contact your NaviNet Security Officer to be added as a user. Don't know the name of your Security Officer? Log in and go to **My Account** and click **My**

Step 2. Access “Practice Documents” Workflow

About Workflows – “Practice Documents” vs. “Patient Clinical Documents”

The most common way to access and complete ICM activities is the “Practice Documents” workflow, which allows a user to see a list of all members on their patient roster for a particular health plan. The steps below provide access to the “Practice Documents” workflow.

For an alternative workflow, focused on individual member information, please refer to steps for accessing the “Patient Clinical Documents” workflow on page 29 of this guide.

- A. Select **Workflows** in the upper left of the NaviNet screen.
- B. Drop down and select **Practice Documents** from the list of workflows.

The screenshot shows the NaviNet interface. At the top, there is a navigation bar with the NantHealth logo, 'NaviNet', and links for 'Home', 'Help', 'Contact Support', and a 'Feedback' button. A blue header bar contains the 'Workflows' dropdown menu, which is open to show a list of options: 'My Health Plans', 'Patient Clinical Documents', 'Practice Documents' (highlighted with a red box), and 'Prescription Savings'. Below the header bar, there are three informational cards. The first card, titled 'Where is the list of Health Plans?', features an image of a hand pointing and text stating 'Find it in the top left corner under **Workflows**.' The second card, titled 'Learn all about the exciting changes in NaviNet.', features an image of a pen and checkboxes and text stating 'Watch Video Now >>'. The third card, titled 'Looking for NaviNet Help?', features an image of a magnifying glass and text stating 'Learn More Now >>'. At the bottom of the cards, there are two blue links: 'Watch Video Now >>' and 'Learn More Now >>'.

Step 3. Review, Search, and Filter Pending Activities in the Workflow

- A. Use the enhanced filter and sorting options to look for specific records.
- B. To view ICM-related documents, filter for **Patient Roster Report** under “Document Category”. Or, type **Intensive Case Management** into the “Document Tags” field.
- C. Check for **Pending Activity** by looking for the indicator at the end of a document title.

The screenshot displays the 'Practice Documents' interface. On the left, a 'Filter by' sidebar includes sections for Document Name, Date Received, Unread, Response Status, Healthy Plan, Document Category (with 'Patient Roster Report' selected), Line Of Business, and Document Tags (with 'Intensive Case Management' selected). The main area shows 'Showing 11 of 11 documents' sorted by 'Date Received (Descending)'. A list of documents is displayed, each with a red exclamation mark icon and a title indicating pending activity. The second document, 'Intensive Case Management [262 pending activity] for CORE FAMILYCARE', has its title circled in red. Below the list, a table provides details for each document.

Document Title	Tax ID	Group NPI	Received	Expires
Intensive Case Management [262 pending activity] for SMITH FAMILYCARE	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management [262 pending activity] for CORE FAMILYCARE	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management [264 pending activity] for SMITH FAMILYCARE	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for JONES PEDIATRICS	012345678	1222244455	08/01/2017	10/10/2017
Intensive Case Management Document for SMITH PEDIATRICS	012345678	1222244455	08/01/2017	10/10/2017

Step 4. Launch “Member Selection” for ICM Activities

A. Click on a record to view. For example, “Intensive Case Management for SMITH FAMILYCARE.”

This screenshot shows the header of a document. On the left, there is a document icon, a red exclamation mark, and a file icon. The main title is "Intensive Case Management for SMITH FAMILYCARE [262 pending activity]". Below this, it says "Patient Roster Report" and "Health Plan Name". To the right, there is a table with document details:

Document Title	Document Category
Intensive Case Management for SMITH FAMILYCARE [262 pending activity]	Patient Roster Report
Tax ID: 012345678	Received: 08/02/2017
Group NPI: 1222244455	Expires: 08/09/2017

A hand cursor icon is pointing to the "Group NPI" field.

B. The screen below will display. Click on **Member Selection** at the bottom of this screen to access ICM activities.

This screenshot shows the full document view. The title bar reads "Intensive Case Management for SMITH PEDIATRICS [262 pending activity]". The main content area is titled "Health Plan Name" and "Intensive Case Management Program".

Health Plan Name" Intensive Case Management Program

Health Plan Name has developed the Intensive Case Management Program to assist primary care practitioners with identifying chronic and/or complex medical needs for their patients. To ensure the success of this program and aid physicians in identifying critical patient needs, the provider is requested to do the following:

- Support appointment scheduling and outreach efforts underway by "Health Plan Name"
- Cooperate in treating the members in the program at least twice every 12 months
- Assist "Health Plan Name" by submitting your updated Intensive Case Management Worksheet and/or a new or updated claim that includes all appropriate diagnoses determined.

"Health Plan Name" is offering financial incentives to all PCPs who participate in this program.

Please click link to view [member selection](#) webpage.

At the bottom, there is a table of documents:

Document Title	Tax ID	Group NPI	Received	Expires
Patient Roster Report: AHC Caritas	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for JONES PEDIATRICS				
Patient Roster Report: AHC Caritas	012345678	1222244455	08/01/2017	10/10/2017
Intensive Case Management Document for SMITH PEDIATRICS				
Patient Roster Report: AHC Caritas	012345678	1222244455	08/01/2017	10/10/2017

On the left side, there is a sidebar with "CURRENT DOCUMENT" and "DOCUMENTS" sections. The "CURRENT DOCUMENT" section shows details for the current document, including "Document Provider: Health Plan Name", "Document Title: Intensive Case Management for SMITH PEDIATRICS", "Document Category: Patient Roster Report", "Date Received: 08/02/2017", "Date of Expiry: 08/09/2017", "Received on Behalf of: Tax ID: 012345678 Group NPI: 1234567891", "Line of Business: Medicaid", and "Document Tags: Intensive Case Management". The "DOCUMENTS" section lists several other documents with their respective dates and status indicators.

Step 5. Search for a Member and/or Filter by Needed Actions

You are now in the Intensive Case Management (ICM) part of the application. Here you will see the **Member Listing** which contains all ICM members associated with the practice you selected in Step 3.

Here you can choose to...

- A. Search for a specific member using **Member ID**, **Member Last Name**, or **Member Last Name + Member Date of Birth**.

- B. Filter by Action:
 - **Adjust Claim(s)** will filter for members attached to a claim or to claim(s) that have been adjusted or may need adjustment in order to reflect complete and accurate diagnosis data for that member.
 - **Please Schedule Appointment** will filter for members who may need to be seen by their PCP for overdue routine care. For these members, an ICM Member Worksheet may have been submitted or may need to be submitted.

- C. Filter by Status:
 - **Incomplete** status will filter for all incomplete actions for Case Management Worksheet or Claim Adjustment

Pending status will filter when at least one claim of member is in “Submitted; Waiting batch process” status and no other claims in “incomplete” status. This is applicable for Claim adjustment scenarios only.

Note: When user selects “Please Select Appointment” filter, “Pending” status filter option will disappear since this status is not applicable for Case Management worksheet



**<<Health Plan Name>>
Intensive Case Management Program**

Group:
 Service Rep:
 Service Rep
 Phone:
 Publish Date: 09/06/2017
 Due Date: 03/01/2018

<<Plan Name>> has developed the Intensive Case Management Program to assist primary care practitioners with identifying chronic and/or complex medical needs for their patients. To ensure the success of this program and aid physicians in identifying critical patient needs, the provider is requested to do the following:

- Support appointment scheduling and outreach efforts underway by <<Health Plan Name>>
- Cooperate in treating the members in the program at least twice every 12 months.
- Assist <Plan Name> by submitting your updated Intensive Case Management Worksheet and/or a new or updated claim that includes all appropriate diagnoses determined.

<Plan Name> is offering financial incentives to all PCPs who participate in this program.

Detailed information and instructions can be accessed on the <Plan Name> website.

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				ADJUST CLAIM(S)	INCOMPLETE	
				ADJUST CLAIM(S)	PENDING	
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

When user selects Filter by Action “Adjust claim(s)”:

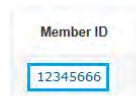
The screenshot shows a filter interface with three input fields: Member ID, Member Last Name, and Member Date of Birth (with a date format MM/DD/YYYY). To the right, there are two filter sections: 'Filter by Action' and 'Filter by Status'. In the 'Filter by Action' section, the checkbox for 'Adjust Claim(s)' is checked and circled in red, while 'Please Schedule Appointment' is unchecked. In the 'Filter by Status' section, both 'Incomplete' and 'Pending' checkboxes are unchecked. Below the filters are 'Search' and 'Reset Filter(s)' buttons. At the bottom, a table header is visible with columns: Member ID, Last Name (with an upward arrow), First Name, Date of Birth, Action, Status, and Adjust Claim(s)/Member Details.

When user selects Filter by Action “Please Schedule Appointment”, only members with that option will be displayed in screen

Note: When user selects “Please Schedule Appointment” filter, “Pending” status filter option will disappear since this status is not applicable for Case Management work sheet

The screenshot shows the same filter interface as above. In the 'Filter by Action' section, the checkbox for 'Please Schedule Appointment' is checked and circled in red, while 'Adjust Claim(s)' is unchecked. In the 'Filter by Status' section, only the 'Incomplete' checkbox is visible and unchecked; the 'Pending' option is no longer present. The 'Search' and 'Reset Filter(s)' buttons are still visible. The table header at the bottom is the same as in the previous screenshot.

From this screen, you can also click on a **Member ID number** to view additional member details including address, telephone number, diagnosis code(s), Case Manager, and Case Manager’s Telephone.








There are three possible statuses in the Member Listing screen:

- 1) INCOMPLETE: This status will be populated when at least one claim of a member is in an “Incomplete” status or the member has an incomplete Complex Case Management Worksheet.
- 2) PENDING: This status will be populated when at least one claim of a member is in “Submitted; Waiting batch process” status and no other claim is in “Incomplete” status.
- 3) COMPLETE: This status will be populated when all claims are in “Claim Adjusted on MM/DD/YYYY” status.

Step 6. Complete the Needed Actions

A. Adjust a Claim to Reflect Diagnosis Information from the Member's Medical Record

- I. Under "Adjust Claim(s)/Member Details," click on the **Adjust Claim(s) Icon** to view the complete list of adjustable claims associated with that member.

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/Member Details
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				ADJUST CLAIM(S)	INCOMPLETE	
				ADJUST CLAIM(S)	PENDING	
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

- II. To view claims details and to make claim adjustments, select the **Adjust Claim(s) Icon** on the right once again.

PLAN LOGO



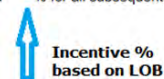
<< Health Plan Name >>
**Intensive Case Management Program
 Claim Adjustment(s)**

Below lists claim(s) previously submitted by your practice for various dates of service.



Select the claim, noting claim date of service. Compare diagnosis codes suggested in the "Adjust Diagnosis Code" section to information in your patient medical record for the office visit of that same date. Mark the appropriate status for each suggested code as applicable for the date: Confirmed, Can't Confirm, Resolved, Updated or Add a new code.

Please note, a diagnosis having "Can't Confirm" status on one date may have a "Confirmed" status on a different date, so evaluate each diagnosis against each date.

A financial incentive will be applied to each claim submitted with a 99499 CPT code at 100% of the allowed amount for the first claim and % for all subsequent claims submitted within 180 days from a previous date of service.



Claims for

Claim ID	Date of Service	Claim Status	Adjust Claim
		CLAIM ADJUSTED ON 06/12/2017	
		INCOMPLETE	
		SUBMITTED;WAITING BATCH PROCESS	

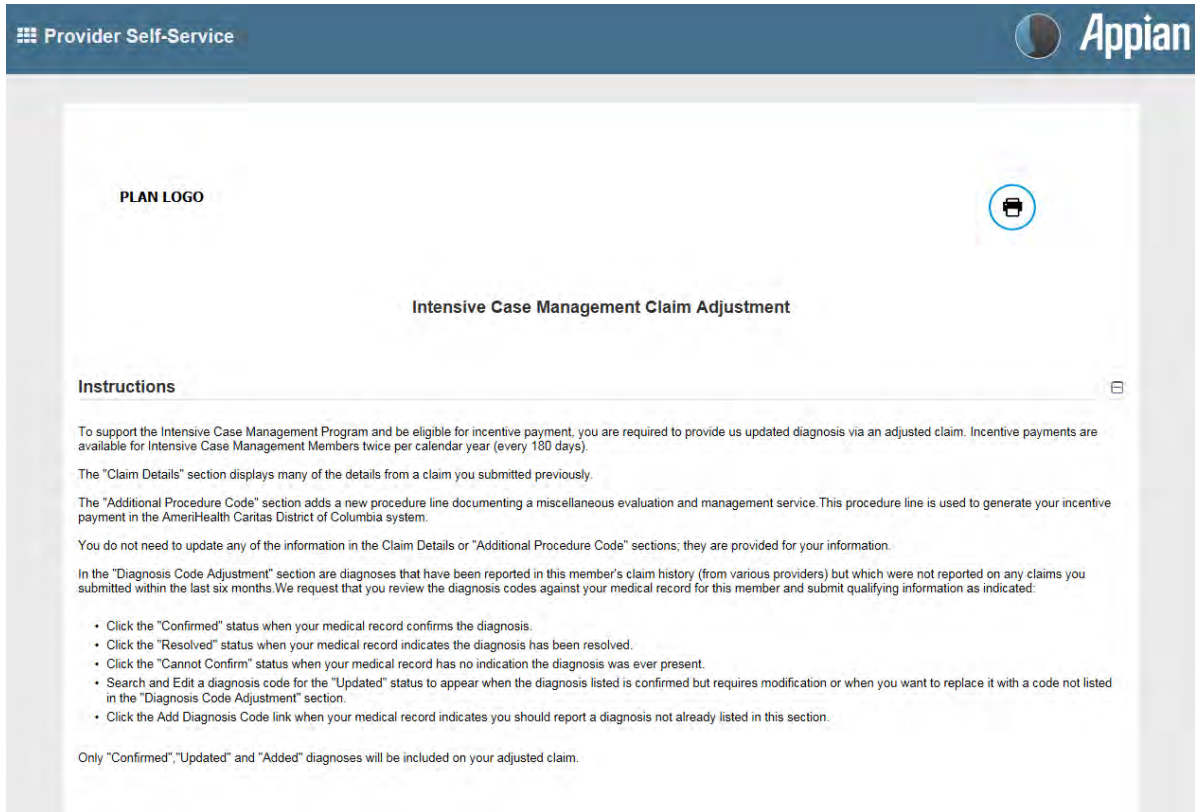
3 items

Back

There are three possible statuses in the Claim Listing screen:

- 1) INCOMPLETE: You can adjust claims which are in an INCOMPLETE status.
- 2) SUBMITTED; WAITING BATCH PROCESS: Status will be seen when you already submitted an adjustment, but you can re-adjust a claim in this status.
- 3) Claim Adjusted on MM/DD/YYYY - Status is populated when user submitted adjustment and batch process is completed.

III. The **Claim Adjustment Screen** will display.



The screenshot shows the 'Intensive Case Management Claim Adjustment' screen in the Appian Provider Self-Service portal. The header includes the 'Provider Self-Service' logo and the Appian logo. The main content area features a 'PLAN LOGO' placeholder, a printer icon, and the title 'Intensive Case Management Claim Adjustment'. Below the title is an 'Instructions' section with a close button. The instructions text reads: 'To support the Intensive Case Management Program and be eligible for incentive payment, you are required to provide us updated diagnosis via an adjusted claim. Incentive payments are available for Intensive Case Management Members twice per calendar year (every 180 days). The "Claim Details" section displays many of the details from a claim you submitted previously. The "Additional Procedure Code" section adds a new procedure line documenting a miscellaneous evaluation and management service. This procedure line is used to generate your incentive payment in the AmenHealth Caritas District of Columbia system. You do not need to update any of the information in the Claim Details or "Additional Procedure Code" sections; they are provided for your information. In the "Diagnosis Code Adjustment" section are diagnoses that have been reported in this member's claim history (from various providers) but which were not reported on any claims you submitted within the last six months. We request that you review the diagnosis codes against your medical record for this member and submit qualifying information as indicated:'. A bulleted list follows: '• Click the "Confirmed" status when your medical record confirms the diagnosis. • Click the "Resolved" status when your medical record indicates the diagnosis has been resolved. • Click the "Cannot Confirm" status when your medical record has no indication the diagnosis was ever present. • Search and Edit a diagnosis code for the "Updated" status to appear when the diagnosis listed is confirmed but requires modification or when you want to replace it with a code not listed in the "Diagnosis Code Adjustment" section. • Click the Add Diagnosis Code link when your medical record indicates you should report a diagnosis not already listed in this section.' The final line states: 'Only "Confirmed", "Updated" and "Added" diagnoses will be included on your adjusted claim.'

Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:

Status Date: 5/29/2017
Status Code: 107
Category Code: F1
Remark Code:
Check Number:

Paid Date: 05/29/2017
Diagnosis Codes: Z91.09

When reviewing medical records, make a note of the diagnosis code(s) originally billed on the claim. Add any applicable diagnosis code(s) during the adjustment process.

Service Line Detail

	Date From/To	Claim Status	Units	Proc Cd	Modifier	Billed Amt	POS	DX CD Pointers	Reason Cd	Line Status
1	12/30/2016 - 12/30/2016	107	1	99213	-	\$125.66	11	1,2	PAI	Confirmed
1 item										

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
12/30/2016 - 12/30/2016	99499	1	\$250
1 item			

Procedure Code 99499 (Other Evaluation and Management Services) is added to the adjusted claim to pay the applicable administrative fee.

Diagnosis Code Adjustment

Diagnosis Code	Description	Status	Action
I69.998 x	Other sequelae following unspecified cerebrovascular disease	--Please Select--	
K21.9 x	Gastro-esophageal reflux disease without esophagitis	--Please Select--	
D89.89 x	Other specified disorders involving the immune mechanism, not elsewhere classified	--Please Select--	
Q66.7 x	Congenital pes cavus	--Please Select--	

[Add Diagnosis Code](#) 4 items

- IV. Based on your review of the member’s medial record for the date of service listed on the claim, select the appropriate status for each diagnosis code under “Diagnosis Code Adjustment”:
- Confirmed** – Attesting that you confirm the diagnosis is still present.
 - Resolved** – Attesting that the diagnosis has been treated and is no longer present.
 - Cannot Confirm** – Attesting that you do not have record(s) of this diagnosis; never present.
 - Updated** – If the diagnosis code listed is not correct for the member condition, you may update with the correct diagnosis by clicking the “x” and entering at least the first three characters of the updated diagnosis.
NOTE: If you erroneously click the “x”, you can select **Undo Changes** under “action” to revert to the original code

Please remember, the diagnosis codes presented here may or may not have originated from claims that you submitted. The member may have been treated in the ER or Urgent Care, or by another provider type, and may have been diagnosed by a provider not associated with your practice.

- V. Once you’ve made an adjustment, you will see **Updated** will appear in the “Status” column. To undo your update, select **Undo Changes** under “Action”.

Diagnosis Code Adjustment

Diagnosis Code	Description	Status	Action
D11 x	Benign neoplasm of major salivary glands	UPDATED	Undo Changes

- VI. You also have the option to **Add Diagnosis Code** should you identify a new diagnosis or diagnoses previously unlisted on the claim. To initiate entry of a new diagnosis, type **at least the first three characters** to populate this field.

Use the **Remove** option under “Action” to remove the new diagnosis, if needed.

Diagnosis Code Adjustment

Diagnosis Code	Description	Status	Action
I50.9 x	Heart failure, unspecified	--Please Select--	
F33.1 x	Major depressive disorder, recurrent, moderate	ADDED	Remove

Add Diagnosis Code 2 Items

- VII. Next, in the **Phone Number** field under “Contact Information,” enter your **10-digit telephone number** with no spaces and no characters between digits. (Example: 8185557777.)

Contact Information: GEORGE, WILLIAM

* Phone Number:

* Required Fields

- VIII. Select **Preview** at the bottom of the screen for an opportunity to review a “Verification” page. Here you can review all the information you provided/updated. See next page for example.

- IX. Next:
- Click **Edit** to return to the Claim Adjustment screen for additional changes.
OR
 - Click **Submit** to complete your claim adjustment activity. You will see the Claim Listing screen with the status for adjusted claims now displaying as “**Submitted; Waiting batch process.**”



Intensive Case Management Claim Adjustment - Verification

Instructions

Please review all of the "Diagnosis Code Adjustment" section information you entered and make corrections as necessary, then click the "submit" button on this screen. Once you click "submit" from this screen, claim will be waiting for next batch process to run. You may make additional corrections until the claim status changes from "Submitted, Waiting batch process" to "Claim adjusted on MM/DD/YYYY".

Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:
Paid Date:
Diagnosis Codes:

Status Date:
Status Code:
Category Code:
Remark Code:
Check Number:

Service Line Detail

	Date From/To	Claim Status	Units	Proc Cd	Modifier	Billed Amt	POS	DX CD Pointers	Reason Cd	Line Status
1			1	T1015	-		11	1		Confirmed
2			1	99212	-	\$0.00	11	1		Confirmed

2 items

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
	99499	1	

1 item

Diagnosis Code Adjustment

Diagnosis Code	Description	Status
R00.1	Bradycardia, unspecified	CONFIRMED
E66.1	Drug-induced obesity	ADDED
N12	Tubulo-interstitial nephritis, not specified as acute or chronic	ADDED


3 items

Contact Information




Contact Name:
Phone Number:

- X. After submitting the adjustment, the user is returned to the Claim Listing screen if there are additional claims to adjust. Proceed to the next claim for adjustment or click the Back button to return to the Member Listing screen.

Provider Self-Service



PLAN LOGO


<< Health Plan Name >>
Intensive Case Management Program
Claim Adjustment(s)

Below lists claim(s) previously submitted by your practice for various dates of service.



Select the claim, noting claim date of service. Compare diagnosis codes suggested in the "Adjust Diagnosis Code" section to information in your patient medical record for the office visit of that same date. Mark the appropriate status for each suggested code as applicable for the date: Confirmed, Can't Confirm, Resolved, Updated or Add a new code.

Please note, a diagnosis having "Can't Confirm" status on one date may have a "Confirmed" status on a different date, so evaluate each diagnosis against each date.

A financial incentive will be applied to each claim submitted with a 99499 CPT code at 100% of the allowed amount for the first claim and % for all subsequent claims submitted within 180 days from a previous date of service.


Incentive % based on LOB

Claims for

Claim ID	Date of Service	Claim Status	Adjust Claim
		CLAIM ADJUSTED ON 06/12/2017	
		INCOMPLETE	
		SUBMITTED;WAITING BATCH PROCESS	

3 items

Back

B. Schedule an Office Visit and Complete an ICM Member Worksheet

In terms of workflow, many providers prefer to complete all of the Adjust Claim(s) activities first, and then move on to the Member Detail activities, which may require outreach to the member to obtain an appointment with the member.

- I. Under “Adjust Claim(s)/Member Details,” click on the **Member Details Icon** to view the member worksheet. The worksheet is there to help track your efforts in outreach and appointment scheduling for the member. Once the member presents for an appointment, you can also use this worksheet to report the member’s diagnosis or diagnoses.

The screenshot shows a search interface with the following elements:

- Search filters: Member ID, Member Last Name, Member Date of Birth (MM/DD/YYYY).
- Filter by Action:
 - Adjust Claim(s)
 - Please Schedule Appointment
- Filter by Status:
 - Incomplete
 - Pending
- Buttons: Search, Reset Filter(s)

The table below displays the results of the search:

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/Member Details
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				ADJUST CLAIM(S)	INCOMPLETE	
				ADJUST CLAIM(S)	PENDING	
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

Note: The member detail screen does not offer a “save” option. You can print out the Member Detail screen to keep track of your attempt(s) to schedule an appointment with the member. Do not complete the electronic Member Detail screen until you are prepared to submit the information.

- II. If you secure an appointment with the member, and he/she presents for the appointment, the physician can perform an examination to help determine if the chronic condition(s)/diagnosis is still present, never present, or resolved. There is also an option to update the diagnosis with a more accurate diagnosis.

Remember that you must also submit a claim following your normal claim submission process. Include all diagnosis codes identified during the office visit and any codes confirmed or updated on the Complex Case Management Worksheet. Be sure to include procedure code 99499 (Other Evaluation and Management Services) to receive the administrative fee.

Clinical Detail ⊞

* Date Member Seen: 9/6/2017

Diagnosis Code	Diagnosis Description	Dx Never Present	Dx Resolved	Dx Confirmed	Updated Dx
M41.115	Juvenile idiopathic scoliosis, thoracolumbar region	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="text"/>

1 item

- III. If you are unable to secure an appointment, and/or the member does not keep a scheduled appointment, there are options to report this information as well. Please choose one of the following three options, as appropriate for each case:
- Could not contact member.
 - Member did not keep scheduled appointment.
 - Member transferred to another Primary Care Practitioner.

Contact Log



Could not contact member	<input checked="" type="checkbox"/>	
Member did not keep scheduled appointment	<input type="checkbox"/>	
Member transferred to another PCP	<input type="checkbox"/>	<input type="text" value="PCP Name"/>

3 items

- IV. Once the diagnosis or member outreach information has been logged on the worksheet, simply select **Submit**. The user will be returned to the Member Listing screen to select the next member.

Member ID

Member Last Name

Member Date of Birth

Filter By

Adjust Claim(s)

Member Details

Pending/Incomplete Actions

Search
Reset Filter(s)

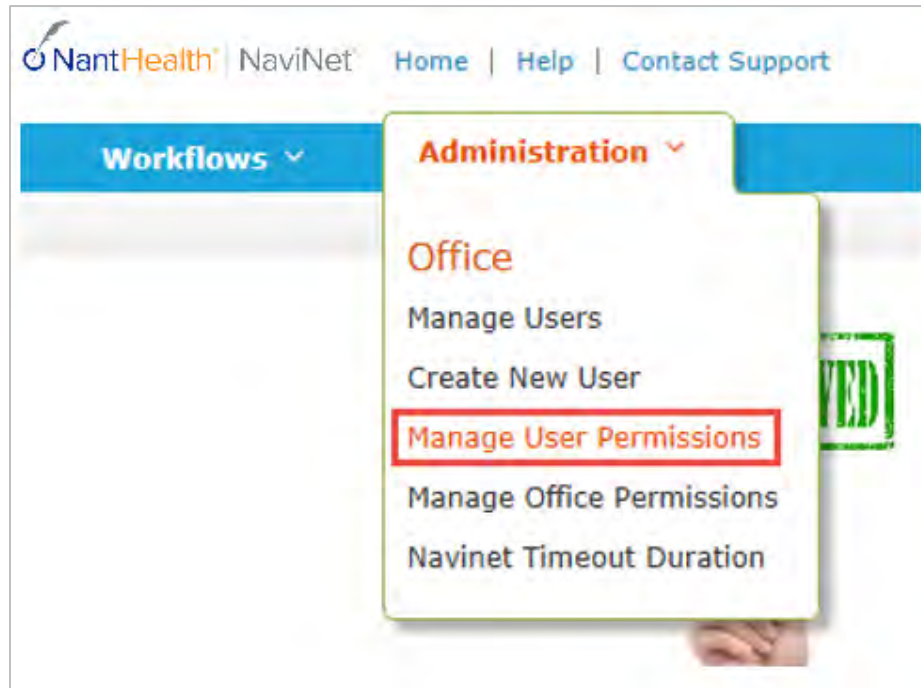
Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
				ADJUST CLAIM(S)	INCOMPLETE	
				ADJUST CLAIM(S)	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	

Supplemental Information

Enabling Document Exchange for a Plan Service User (PSU)

A NaviNet Security Office can follow the steps below to enable Document Exchange for a Plan Service User (PSU):

1. Click **Administration** from the NaviNet toolbar and then scroll down to select **Manage User Permissions**.



2. From the next screen, select the user whose permissions you want to adjust, then select **Edit Access**.

A screenshot of the 'User Search' interface. The title is 'User Search'. Below the title is a search instruction: 'Search for a user. Then, if desired, select a user and click **Edit Access** to change transaction access for that user. [Tell me more...](#)'. The search form includes fields for 'Last Name', 'First Name', 'Username', and 'User Status'. There is a 'New User?' checkbox and a 'Combined User Status' dropdown menu set to 'Able to Access NaviNet'. Below the search fields are 'Search', 'Exit', and 'Clear' buttons. A checkbox for 'Hide Search Criteria After Search' is also present. At the bottom, there is a table with columns: 'Name', 'Username', 'Status', 'Last Login', 'Status Change', 'Security Officer?', and 'New User?'. The 'Edit Access' button is highlighted with a red box.

3. The next screen is titled “Transaction Management for User _____”. From this screen, select **NaviNet** in the Plan’s drop-down list and select **DocumentExchange** in the Group’s drop-down list.

Transaction Management for User

Username: _____ Security Officer? No
 Office: Plan Service Office
[Go to Office Transaction Management for this office](#)

To change this user's access to a transaction, click **Enable** or **Disable** next to that transaction. If you do not see an **Enable** or **Disable** button, you cannot manage this transaction. [Tell me more...](#)

NaviNet ▾

DocumentExchange ▾

Plan/Service ▲	Name	Access?	Last Modified	Modified By
NaviNet	DocumentExchange			

4. It’s important to note, “Patient Clinical Documents” are enabled for all users by default. But you will want to confirm that the global permissions for “Patient Clinical Documents” are set appropriately:
 - a. For a user to view Patient Clinical Documents, both **Document Viewer** and **Document Preview** must be enabled.
 - b. For a user to download Patient Clinical Documents, **Document Download** must also be enabled. (This permission affects only documents that allow downloads.)
 - c. For a user to respond to Patient Clinical Documents, **Document Respond** must also be enabled. (This permission affects only documents that allow responses.)

NaviNet ▾

DocumentExchange ▾

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
NaviNet	Document Respond	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Viewer	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Download	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Preview	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Respond	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Viewer	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Download	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Preview	Enabled			<input type="button" value="Disable"/>

5. Similarly, "Practice Documents" are enabled for all users by default. But you will want to confirm that the global permissions are set appropriately:
 - a. For a user to view Practice Documents, both **Practice Document Viewer** and **Practice Document Preview** must be enabled.
 - b. For a user to download Practice Documents, **Practice Document Download** must also be enabled. (This permission affects only documents that allow downloads.)
 - c. For a user to respond to Practice Documents, **Practice Document Respond** must also be enabled. (This permission affects only documents that allow responses.)

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
NaviNet	Document Respond	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Viewer	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Download	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Preview	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Respond	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Viewer	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Download	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Preview	Enabled			<input type="button" value="Disable"/>

6. Now that you have confirmed the global permissions, you need to enable the specific permissions. First, select the **appropriate health plan** in the Plan's drop-down list and **DocumentExchangeCategories** in the Group's drop-down list.

Transaction Management for User

Username: Security Officer? No

Office:

[Go to Office Transaction Management for this office](#)

To change this user's access to a transaction, click **Enable** or **Disable** next to that transaction. If you do not see an **Enable** or **Disable** button, you cannot manage this transaction. [Tell me more...](#)

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
Aries Health Plan ▼	DocumentExchangeCategories ▼				<input type="button" value="Enable All"/> <input type="button" value="Disable All"/>

7. Click **Enable** next to any Patient Clinical Document categories that you want to be available to this user for the selected health plan.

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
Aries Health Plan	Clinical Summary	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Patient Consideration	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Program Enrollment	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Info Request	Disabled			<input type="button" value="Enable"/>

- Click **Enable** any Practice Document categories that you want to be available to this user for the selected health plan.

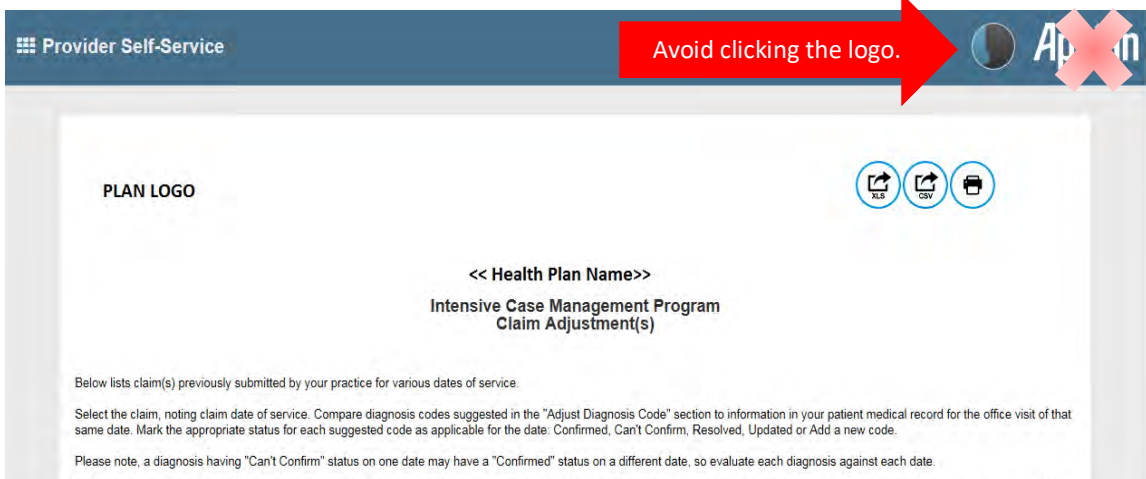
Aries Health Plan	Patient Transition Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Patient Roster Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Pharmacy Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Program Enrollment Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Financial Report	Disabled			<input type="button" value="Enable"/>

- Finally, for access to all ICM activities, make sure **Patient Roster Report** and **Patient Consideration** document categories are enabled.

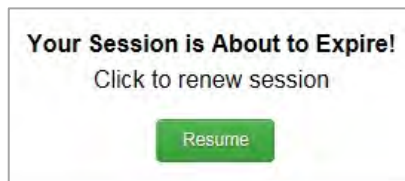
Plan/Service ▲	Name	Plan	Office	Access?	Last Modified	Modified By	
	Patient Roster Report	Disabled	←	Disabled			<input type="button" value="Enable"/>
	Patient Consideration	Disabled	←	Disabled			<input type="button" value="Enable"/>
	Patient Level Documents	Disabled	←	Disabled			<input type="button" value="Enable"/>

Important Note: Time-Out Information

Avoid clicking on the Appian logo. If you do so, the screen will auto-refresh.



If you are inactive for more than 60 minutes, you will see the pop-up below warning you that your session is about to expire. If you click **Resume** within 5 minutes, the page will reload and you can continue entering information.



If you do not click **Resume** within 5 minutes, the form will time-out, and you will see the log-in window pictured below. Please **do not** attempt to log-in via this pop-up. Instead, close the window and log-in to NaviNet again.

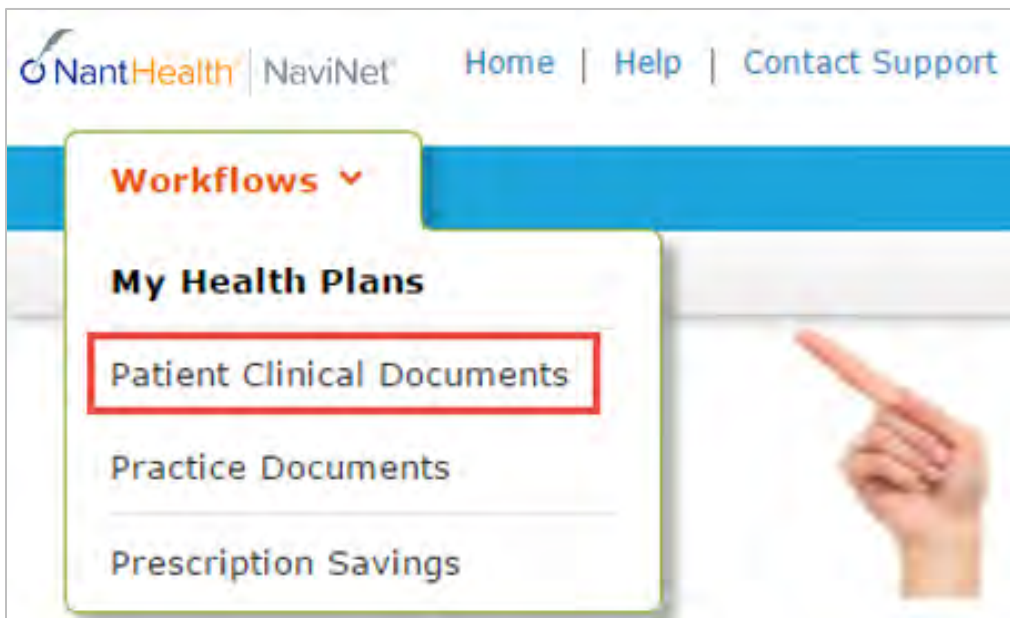
Alternative Workflow – “Patient Clinical Documents”

About Workflows – “Practice Documents” vs. “Patient Clinical Documents”

The steps below describe the “Patient Clinical Documents” workflow, which is focused on individual member information and is particularly helpful for accessing “need to schedule” member information.

*Note, for instructions on using the “Practice Documents” workflow, please refer to **Step 2** on page 8 of this guide.*

- A. Select **Workflows** in the upper left of the NaviNet screen.
- B. Drop down and select **Patient Clinical Documents** from the list of workflows.



- C. Use the enhanced filter and sorting options to look for specific records.
- D. To view ICM-related documents, filter for **Patient Consideration** under “Document Category”.
Or, type **Intensive Case Management** into the “Document Tags” field.
- E. Check for a **Red Exclamation Point** to indicate that a response is requested.

Filter
Options

- Patients Last Name
- PCP
- Date Received
- Response Status
- Health Plan
- Document Category
- Line of Business
- Document Tags

Sorting
Options

- Patient Last Name
- Payer
- Last Document Received

Patient Clinical Documents

These documents are provided by the patient's health plan. Many of them are questionnaires or forms that require an uploaded response. Depending on the contracts that your providers have in place, they may be eligible for incentives when these documents are completed and returned.

Filter by

Patient's last name

PCP

Date Received

Unread

Response Status
 Awaiting Response
 Response Sent

Health Plan

Document Category
 Clinical Summary
 Patient Consideration

Line of Business
 Commercial
 Dual Eligibles
 Medicaid
 Medicare
 Other

Document Tags

No tags selected

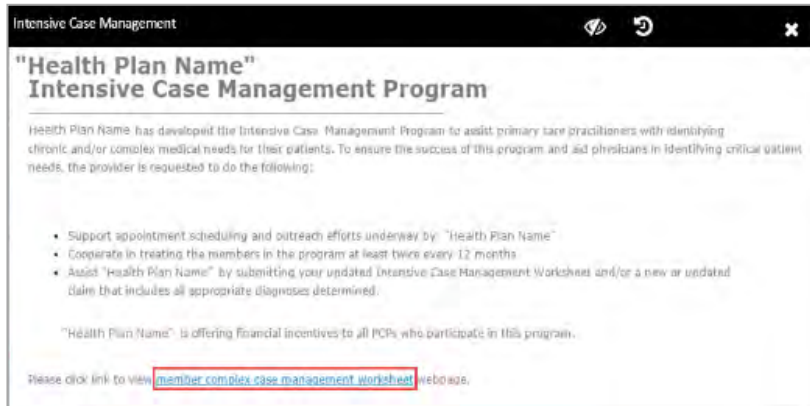
Showing 14 of 14 patients

Sort by: Patient Last Name

	Clinical Documents	
<div style="text-align: center; font-size: 24px; margin-bottom: 5px;">!</div> <p>Date of Birth: [redacted] PCP: [redacted]</p>	2	Aug 02, 2017
<div style="text-align: center; font-size: 24px; margin-bottom: 5px;">!</div> <p>Date of Birth: [redacted] PCP: [redacted]</p>	1	Aug 02, 2017
<div style="text-align: center; font-size: 24px; margin-bottom: 5px;">!</div> <p>Date of Birth: [redacted] PCP: [redacted]</p>	6	Aug 01, 2017
<div style="text-align: center; font-size: 24px; margin-bottom: 5px;">!</div> <p>Date of Birth: [redacted] PCP: [redacted]</p>	2	Jul 28, 2017

[View/Print List](#)

- F. Click on a member record to view.
- G. The screen below will display. Click on **Member Complex Case Management Worksheet** at the bottom of this screen to access ICM activities. Continue completing the worksheet by following **Step 6-B** on page 22 of this guide.



Anatomy of the Workflow & Document Viewer Screens

1. Anatomy of the starting screen for the **Practice Documents** workflow:

A blue bar and text indicates that a document is unread.

A red exclamation point indicates that a response is requested for this document.

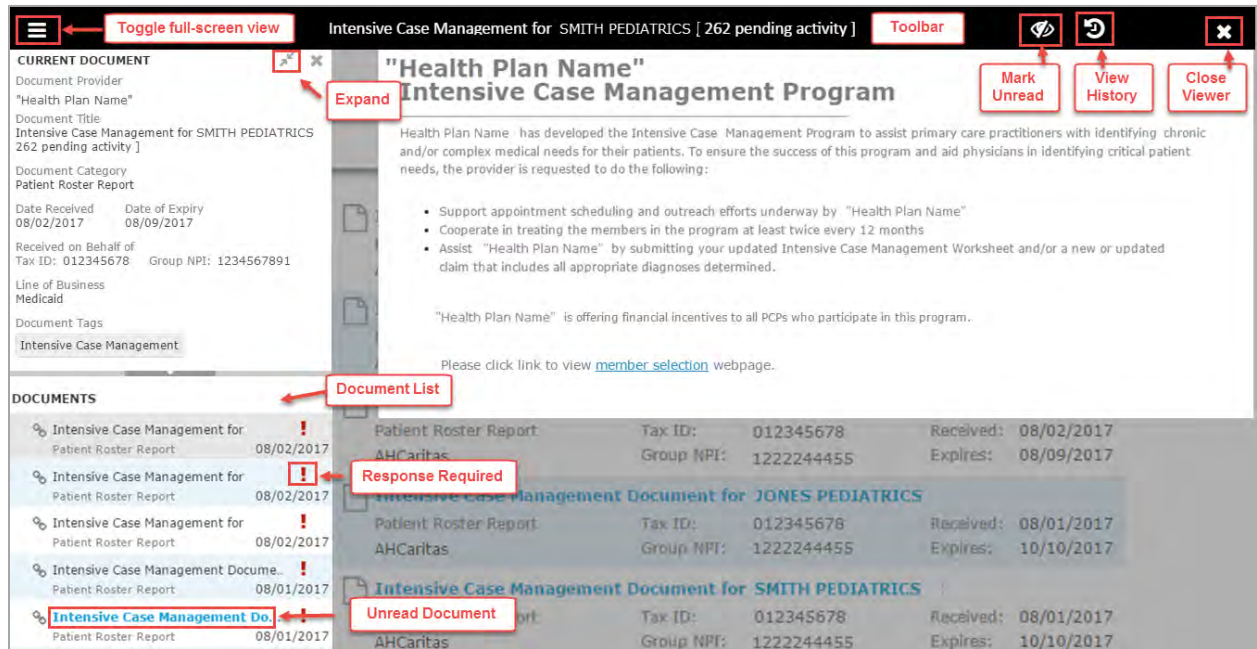
The exclamation point will not be displayed if a response has already been submitted for this document.

Users can select a number of documents in the list and then click View to open the selected documents in the Document Viewer.

The screenshot displays the 'Practice Documents' interface. On the left, a 'Filter by' sidebar includes sections for Document Name (with a search box), Date Received (with a date range selector), Response Status (with checkboxes for 'Awaiting Response' and 'Response Sent'), Health Plan, Document Category (with 'Patient Roster Report' selected and an 'ICM Filter' button), Line Of Business (with checkboxes for 'Commercial', 'Dual Eligibles', 'Medicaid', 'Medicare', and 'Other'), and Document Tags (with a search box and a tag 'Intensive Case Management'). The main area shows a list of documents with columns for document title, Patient Roster Report, Tax ID, Group NPI, Received date, and Expires date. A 'Sort by' dropdown is set to 'Date Received (Descending)'. Annotations with red boxes and arrows point to various elements: 'Unread Document' points to a blue bar on the left; 'Viewing Multiple Selected Documents' points to a blue bar on the left; 'Sorting Options' points to the 'Sort by' dropdown; 'Document for which a response is required' points to a red exclamation point icon; 'Document Category ICM will always fall under "Patient Roster Report"' points to the 'Patient Roster Report' text in the document title; and 'Routing Information' points to the 'Tax ID' and 'Group NPI' fields in the document details.

Document Title	Patient Roster Report	Tax ID	Group NPI	Received	Expires
Intensive Case Management for SMITH FAMILYCARE [262 pending activity]	Intensive Case Management for SMITH FAMILYCARE [262 pending activity]	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for CORE FAMILYCARE [262 pending activity]	Intensive Case Management Document for CORE FAMILYCARE [262 pending activity]	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for JONES PEDIATRICS [264 pending activity]	Intensive Case Management Document for JONES PEDIATRICS [264 pending activity]	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for JONES PEDIATRICS	Intensive Case Management Document for JONES PEDIATRICS	012345678	1222244455	08/01/2017	10/10/2017
Intensive Case Management Document for SMITH PEDIATRICS	Intensive Case Management Document for SMITH PEDIATRICS	012345678	1222244455	08/01/2017	10/10/2017

2. Anatomy of the document viewer screen for the **Practice Documents** workflow:



- **Toolbar**
 - The left side of the toolbar lets the user toggle full screen view and shows the current document's file type and title. The right side lets the user mark the current document as unread.
- **Document List**
 - Shows the documents you have selected. Clicking a document row displays the document in the document viewer.
 - Unread documents are highlighted with a blue bar and text.
 - Documents for which a response is requested are marked with a red exclamation point.
- **Current Document Summary**
 - Gives information on the current document, such as the health plan that sent the document, the document category, line of business, document name, and received and expiry dates. Document routing and tag information is also displayed. Users can expand the window to see any hidden information.

3. Anatomy of the starting screen of for the **Patient Clinical Documents** workflow:

Document Category for ICMs: Patient Consideration

A red exclamation point indicates that there are one or more documents for this member where a response is requested and has not yet been submitted for this document by a NaviNet user in the same Recipient Office Group.

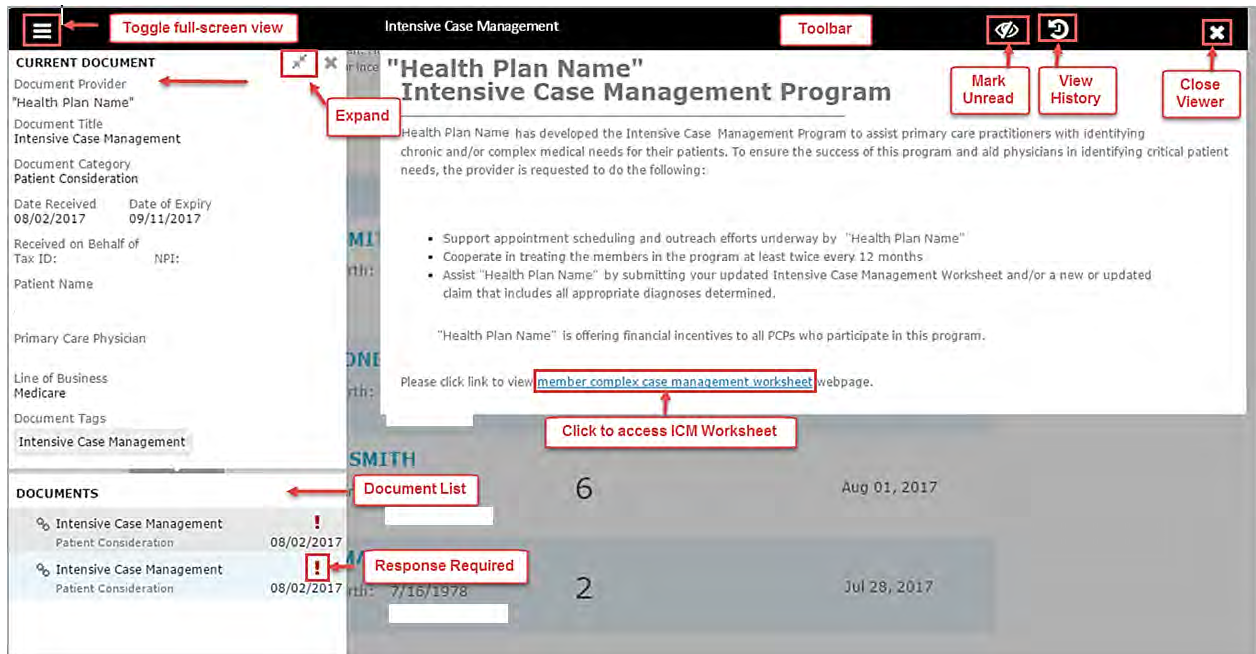
The exclamation point will not be displayed if a response has already been submitted for this document.

A blue bar and text indicates that there are one or more unread documents for this member.

The screenshot shows the 'Patient Clinical Documents' interface. On the left is a filter sidebar with sections for 'Filter by Patient's last name', 'PCP', 'Date Received', 'Response Status', 'Health Plan', 'Document Category', 'Line Of Business', and 'Document Tags'. The 'Document Category' section has 'Patient Consideration' selected, marked with a red 'X' and labeled 'ICM Filter'. The main area shows a list of documents for 14 patients, sorted by 'Patient Last Name'. Annotations include: 'Unread Document' pointing to a blue bar on the left; 'Sorting Options' pointing to the 'Sort by' dropdown; 'Filtering Options' pointing to the filter sidebar; 'Document for which a response is required' pointing to a red exclamation point; and 'Number of documents for this patient' pointing to the number '6' in a document row.

Document Category	Date of Birth:	PCP:	Count	Date
Clinical Documents			2	Aug 02, 2017
Clinical Documents			1	Aug 02, 2017
Clinical Documents			6	Aug 01, 2017
Clinical Documents			2	Jul 28, 2017

4. Anatomy of the document viewer screen for the **Patient Clinical Documents** workflow:



- **Toolbar**
 - a. The left side of the toolbar lets the user toggle full screen view and shows the current document's file type and title. The right side lets the user mark the current document as unread.
- **Document List**
 - a. Shows the documents you have selected. Clicking a document row displays the document in the document viewer.
 - b. Unread documents are highlighted with a blue bar and text.
 - c. Documents for which a response is requested are marked with a red exclamation point.
- **Current Document Summary**
 - a. Gives information on the current document, such as the health plan that sent the document, the document category, line of business, document name, and received and expiry dates. Document routing and tag information is also displayed. Users can expand the window to see any hidden information.

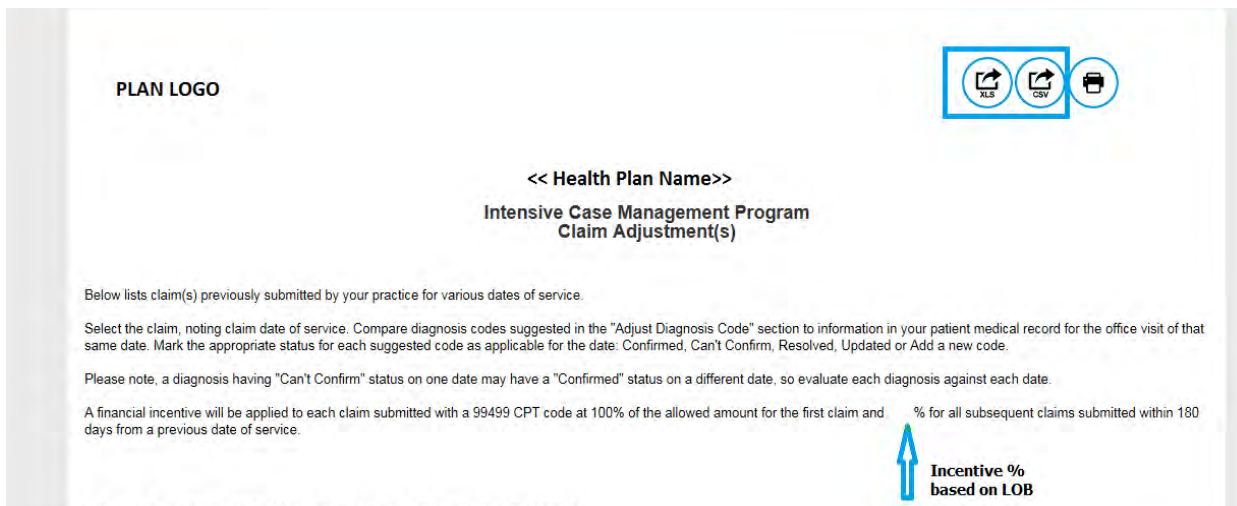
Popup Blocker Must be Disabled

For the Intensive Case Management function to work properly, your Pop Up blocker must be disabled.

Downloading, Saving, and Printing Member Information

From the Claim Adjustment(s) page, there are two options for downloading and one option for printing a member's information. The icons in the upper right corner provide these options.

- The first icon produces an .XLS file.
- The second icon produces a .CSV file.



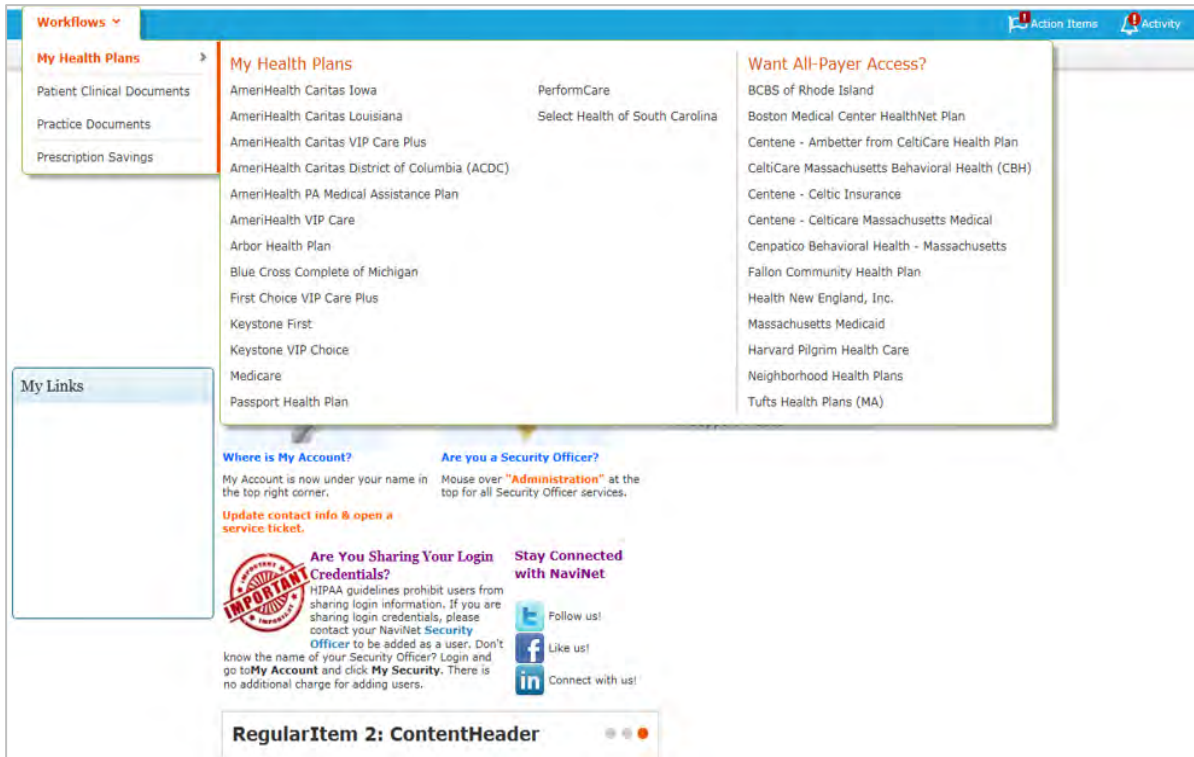
- The third icon displays instructions for printing (press CTRL + P).



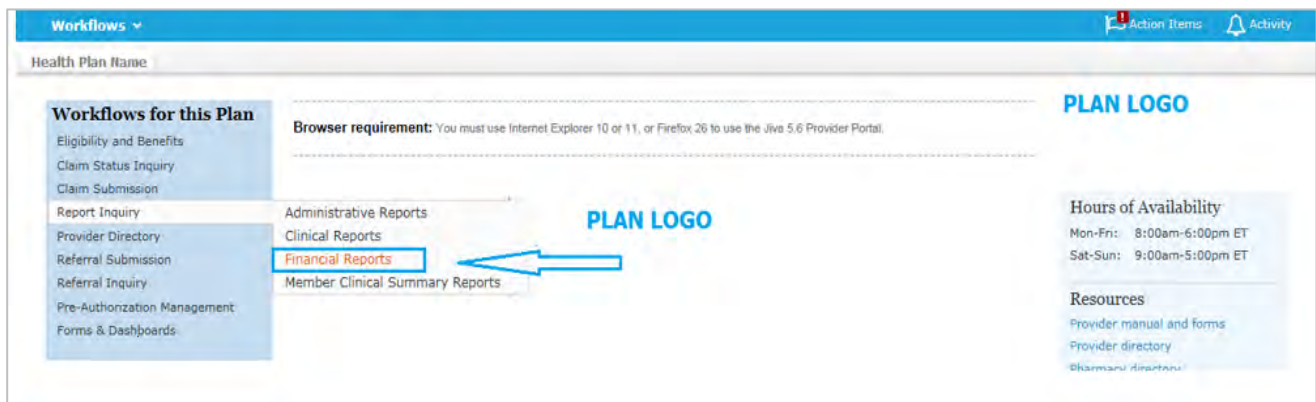
Report Generation

Intensive Case Management Report (ICR) can be generated in NaviNet to show the status of ICM adjusted claims. Follow the steps below to generate a report for your practice.

1. Select **Workflows** in the upper left of the NaviNet screen.
2. Drop down and select **My Health Plans** from the list of workflows.
3. Choose the health plan for which you want to pull a report.



4. Next, select **Report Inquiry** and then **Financial Reports**.



5. Finally, select **Adjusted Claims Report Query** from the drop-down list.

The screenshot shows a web application interface for 'Financial Report Inquiry'. At the top, there is a blue navigation bar with 'Workflows' and 'Action Items' (with a notification icon). Below this is a breadcrumb trail: 'Plan Name > Financial Reports Inquiry > Report Selection'. The main content area has a header 'PLAN NAME' on the left and '<<Health Plan Name>>' on the right. Below the header is the title 'Financial Report Inquiry' and a 'Print page' link. A 'Select Report:' dropdown menu is set to 'Adjusted Claims Report Query'. Below the dropdown is a note: 'Please note, to request a PDF report file you must have the Adobe Reader application on your computer. To request CSV or Excel report file you must have the MS Excel application on your computer. The report will open in Excel format. If you do not have MS Excel on your computer, you will have the option to simply save the report to your computer.'

6. Now you can set the parameters
 - i. **Time Period or Date Range** –
 1. Time period defaults to “Up to 7 days”, but user can select 30, 90, 180 or up to one year.
 2. You can choose a specific “Date Range” as selection criteria. When a date range is provided, these dates have precedence over Time Period from drop down. Report will be based on **date range**.
 - ii. **Provider Group Selection**
 1. You **must** choose a Provider Group.
 2. You may also select a specific provider within the group and only claim records for that provider will be returned.
 - a. It is not necessary to choose a specific provider under the group, but all providers will be returned in the report.
 - iii. **Filter Criteria**
 1. If you enter a specific Member ID, report will be member specific if the record exists.
 2. If you enter a specific Claim ID, report will be Claim specific if the record exists.
 - iv. **Report Criteria**
 1. Report type defaults to “PDF”, but you can also select “Excel/CSV (Downloadable)” option.

See next page for example reports.

<<PLAN NAME>>

[Print page](#)

Adjusted Claims Report Query v. 1.1.7

Instructions

Please enter your search criteria, and click "Search". * Indicates Required Fields.
 NOTE: if your browser has an active popup blocker you may need to turn it off to receive the report.

Adjusted Claims Information

Please choose a time period or provide a date range in the given format

* Choose a Time Period Up to 7 days

OR

Provide Date Range:

Up to 30 days
 Up to 90 days
 Up to 180 days
 Up to one year

From Date(MM/DD/YYYY)

To Date (MM/DD/YYYY)

* Choose a Provider Group

Choose a Provider

Filter Criteria

Member ID

Claim ID

Report Criteria

* Adjusted Claims Type

Select Report Type PDF
 Excel/CSV(Downloadable)

Select Sort Options

* Member Name

Last Update: 08/21/2017 v.1.1.7

<<PLAN LOGO>>

Provider Transaction Detail Report - ICM

Date from: 01/01/2016 to 09/11/2017

Date of Report : 09/11/2017

Provider ID	Provider Name

Member ID	Member Name	Claim ID	DOS From - To	Code	Billed Amount	User ID	Updated Date	DX Code - Status	Paid Date	Paid Amount	Status
			10/20/2015 TO 10/20/2015	99499			05/20/2016	Z23-CONFIRMED R180-RESOLVED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			11/16/2015 TO 11/16/2015	99499			05/20/2016	N040-CONFIRMED Z00129-CONFIRMED R180-RESOLVED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			06/29/2015 TO 06/29/2015	99499			05/20/2016	5819-CONFIRMED 1120-CONFIRMED 78951-RESOLVED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			01/15/2016 TO 01/15/2016	99499			11/28/2016	R3915-CONFIRMED J45909-CANNOT CONFIRM	11/30/2016		PROCESSED SUCCESSFULLY - 01
			07/15/2016 TO 07/15/2016	99499			11/04/2016	F840-CONFIRMED H9190-CONFIRMED F902-CONFIRMED F88-CONFIRMED Z00129-CONFIRMED Z23-CONFIRMED	11/07/2016		PROCESSED SUCCESSFULLY - 02
			12/22/2015 TO 12/22/2015	99499			05/20/2016	J4520-CONFIRMED J301-CONFIRMED Z00129-CONFIRMED Z23-CONFIRMED J449-CONFIRMED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			06/30/2016 TO 06/30/2016	99499			10/05/2016	Z00129-CONFIRMED J4520-CONFIRMED Z23-CONFIRMED H5000-CONFIRMED 7418-CONFIRMED	10/10/2016		PROCESSED SUCCESSFULLY - 01

PLAN LOGO

Provider Transaction Detail Report - ICM

Date from: 01/01/2016 to 09/11/2017

Date of Report : 09/11/2017

Provider ID	Provider Name

Member ID	Member Name	Claim ID	DOS From - To	Code	Billed Amount	User ID	Updated Date	DX Code - Status	Paid Date	Paid Amount	Status
			07/02/2015 TO 07/02/2015	99499			06/27/2016	V202-CONFIRMED 56400-CONFIRMED V6081-CONFIRMED 7540-CANNOT CONFIRM	06/29/2016		PROCESSED SUCCESSFULLY - 01
			08/29/2016 TO 08/29/2016	99499			11/11/2016	Z134-CONFIRMED Q672-CANNOT CONFIRM	11/16/2016		PROCESSED SUCCESSFULLY - 01

Total Number of Claim Adjustments:

Total Billed Amount:

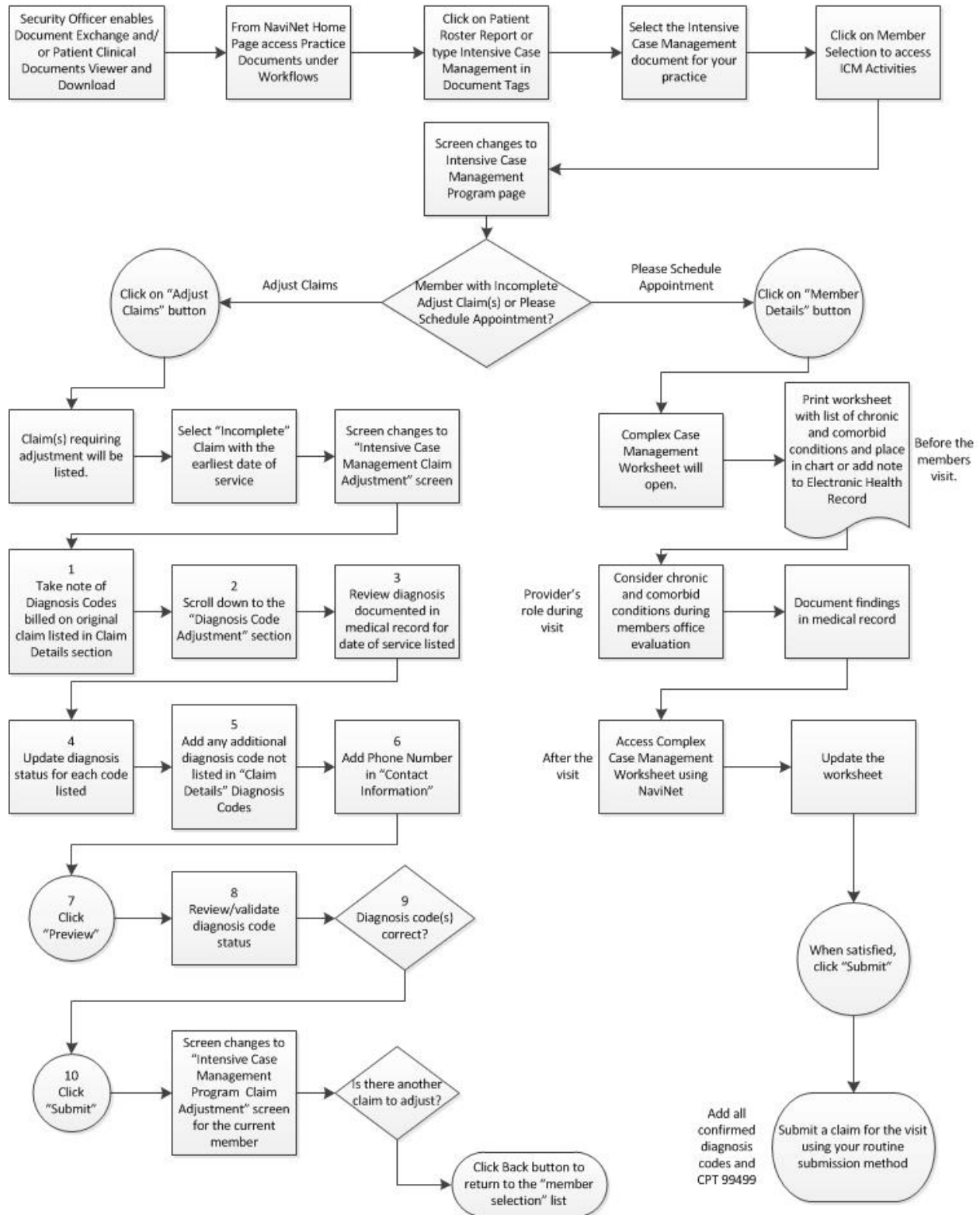
Total Paid Amount:

Total Count by Claim Status:

Claim processed successfully :

Other Status :

Attachment 1: Example Process Flow for Intensive Case Management Process





AmeriHealth Caritas[™]

District of Columbia

www.amerihealthcaritasdc.com



Provider Guide:

Intensive Case Management Program

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About the Intensive Case Management (ICM) Program

Background

Under its contract with the District of Columbia Department of Health Care Finance (DHCF), AmeriHealth Caritas District of Columbia is responsible for collecting and submitting complete and accurate encounter data for all services furnished to its members. One of the key components to ensuring that our encounter data is complete and accurate is validation of the diagnoses reflected in the encounters that we submit to the District's DHCF.

The District's DHCF uses the encounter data from its managed care plans in a number of ways, including to more accurately gauge the disease acuity within our member population, which helps to predict expenditures for delivery of care. *Risk Adjustment* refers to the adjustments that are made to reflect the health status of a population. For managed care plans such as AmeriHealth Caritas District of Columbia, member-level information obtained through encounters allows the District's DHCF to gain a more in-depth understanding of the factors driving cost and quality within the Medicaid program.

AmeriHealth Caritas District of Columbia has developed the **Intensive Case Management (ICM) Reimbursement Program** to compensate providers for completing the essential, administrative activities that help to validate encounter data.

Program Purpose

The AmeriHealth Caritas District of Columbia ICM Reimbursement Program exists to:

- Help primary care providers (PCPs) identify members with chronic and/or complex medical needs.
- Improve accuracy and completeness of reporting to the District's DHCF regarding AmeriHealth Caritas District of Columbia membership.

To help the health plan accurately represent our membership, this program facilitates provider submission of complete and accurate member diagnoses and disease acuity information.

Identifying Members and Informing Providers

ICM members are identified as those with claims history indicating chronic and comorbid conditions. Review of program data from affiliated Plans within the AmeriHealth Caritas Family of Companies reveals chronic and comorbid diagnoses are often incorrectly reported on claims or not reported at all.

Providers are informed about ICM members via pending activities in the *Patient Roster* under the "Practice Documents" workflow in NaviNet. A pending activity appears for an ICM member when the following occurs:

- Claims were submitted by the PCP within the previous six months, but claims did not include all the chronic/comorbid diagnosis codes found in the member's claims history.

Validating Claims/Encounter Data

AmeriHealth Caritas District of Columbia encourages providers to check their “Practice Documents” monthly via NaviNet to identify members who require action.

Definition – “Adjust a Claim” is an ICM program activity that can be completed by a provider, online, via NaviNet. The activity includes:

- Accessing claim details;
- Reviewing the claim against relevant medical record documentation (treatment and plan for date of service corresponding to claim date of service) in order to confirm, not confirm, resolve, update, or add diagnosis information;
- Submitting any findings of the review;
- Receiving an applicable administrative fee for completing the review.

All claims reviewed in NaviNet for ICM program purposes are adjusted to include the procedure code 99499; this indicates completion of the review and results in the applicable administrative fee. Procedure code 99499 is added to the claim even if the diagnosis cannot be confirmed and no new diagnosis information is submitted.

Actions to be completed:

- **Adjust a Claim** – The member was seen within the last six months, but submitted claims may not include all the chronic/comorbid diagnosis codes found in the member’s claims history. The medical record for each date of service is reviewed and the corresponding claim is adjusted through NaviNet. As each claim is adjusted in NaviNet, confirmed and/or additional diagnosis codes are added to the originally submitted claim along with procedure code 99499 (Other Evaluation and Management Services) to pay the applicable administrative fee.

Provider Action: Pull the member’s medical record corresponding to the date of the face-to-face visit, review the notes for the member’s visit, and determine if the potential diagnosis code(s) are confirmed, resolved, or cannot be confirmed. If additional diagnosis codes are identified that should have been on the original claim, add the diagnosis code(s) in the ICM Claim Adjustment screen.

See Attachment 1 on page 33 of this guide for a visual of this process flow.

Program information is refreshed on a monthly basis as new information becomes available to AmeriHealth Caritas District of Columbia; therefore it is important that providers check each month for new “Practice Documents”.

Supplemental Reimbursement

AmeriHealth Caritas District of Columbia recognizes the additional work involved in making medical records available to us and in validating the results of medical record reviews or outreaching to members to schedule appointments. Accordingly, AmeriHealth Caritas District of Columbia offers PCPs an administrative payment for each record reviewed, in accordance with the following fee schedule:

- Original claim for any member – \$25.00 per claim.

- All subsequent claims for the same member with service dates exceeding 180 days from the prior claim service date – \$25.00 per claim.
- All subsequent claims for the same member with service dates within a 180 day period from the prior claim service date – \$7.00 per claim.

The additional reimbursement is for your effort and participation with this program; it is not dependent on the health plan's receipt of updated or confirmed chronic diagnoses codes.

ICM Program Assistance

If you would like assistance with the review of your medical records, AmeriHealth Caritas District of Columbia's Risk Adjustment Department can assist as follows:

- AmeriHealth Caritas District of Columbia will obtain medical records of identified members from you, the PCP. Record requests may be made using a chart retrieval vendor contracted by the Plan.
- AmeriHealth Caritas District of Columbia will review the medical records, and re-abstract/code diagnoses based on the face-to-face office visits documented in the medical record. The results will be compiled into a Claim Attestation Summary report that is provided to the PCP.
 - *See Attachment 2 on page 34 of this guide for an example of this report.*
- You, the PCP, will review the Claim Attestation Summary report, determine if the new/updated diagnoses identified as a result of the re-abstracting are accurate and complete, and follow the *Claims Adjustment* process in NaviNet.

For assistance with the review of your medical records, please contact the Risk Adjustment Program Department at 215-863-5435.

Audit of Intensive Case Management Program

When providers have opted to review medical records on their own, AmeriHealth Caritas District of Columbia also performs a random quality review of claims submitted for adjustment through the ICM process. As part of the quality audit process, AmeriHealth Caritas District of Columbia obtains medical records from you, the PCP, for members who have been selected for audit. (Medical records may be requested through a chart retrieval vendor). The medical record will be re-abstracted and reviewed to identify appropriate diagnosis codes for each date of service based on the documentation. The results will be compared to diagnosis actions indicated in NaviNet (e.g., Confirmed, Can't Confirm, Resolved, Updated or Added). Upon completion of the review, you will be notified of the audit results. Providers with low quality audit scores may be asked to participate in program training; repeat low quality audit scores will result in the rejection of previously-submitted adjustments that cannot be supported by medical record documentation.

How to Use this Guide

This guide offers step-by-step instructions on how to use NaviNet to complete ICM Reimbursement Program activities. In this guide, you will find information on how to:

- Access the “Practice Documents” Workflow
- Review, Search, and Filter Pending Activities in the Workflow
- Launch “Member Selection” for ICM Activities
- Search for a Member and/or Filter by Needed Actions
- Validate or Update the Member’s Information by:
 - Completing a claims adjustment by reviewing your medical records and updating the member’s diagnosis information based on documentation from the date of service.

Before You Begin

1. NaviNet Permissions

Check with your NaviNet Security Officer to confirm that you have been granted the appropriate access to the workflows you need. If your NaviNet Security Officer has not enabled Document Exchange, please ask your Security Officer to follow the steps outlined on pages 20 through 23 in the “Supplemental Information” section of this guide.

2. Consider Filtering Providers for Optimum Access

You can view and access documents submitted on behalf of all providers associated with your office. However, you can also specify a list of providers whose documents you prefer to see. You can save this list of providers to be used by default anytime you access the Patient or Practice Document dashboards. To learn more about your access options, please log in to NaviNet and visit <https://support.nanthealth.com/health-plans/navinet-open/user-guide/provider-filter>.

Step 1. Log-In to NaviNet

- A. Open your Internet browser.
We recommended the use of Internet Explorer browser for ICM functionality. Some of the functionality might not work as expected in Chrome browser versions 61 and higher.
- B. Go to <https://navinet.navimedix.com>.
- C. Log-in to NaviNet by entering your **User ID** and **Password** and then clicking **Sign In**.

NantHealth | NaviNet

Sign In

Username:

Password:

Sign In

[Forgot your password?](#)
[Forgot your username?](#)

Getting Started with NaviNet

[Trouble Logging In?](#)
[Sign Up](#)
[What Plans Participate?](#)

All-Payer Access: 750+ Plans Now Available | [Re-Save Bookmarks](#) | [New IVR Message](#) | [Discontinued Support of Windows Vista](#)

ALLPAYER ACCESS

**750+ Plans,
At Your Fingertips.**

Get Started >

ICD-10 READY

NaviNet is ICD-10 compliant. For information regarding plan-specific implementation of this federal mandate, please refer to plan-supplied documentation or visit the plan's website for details.

Are You In The Loop?

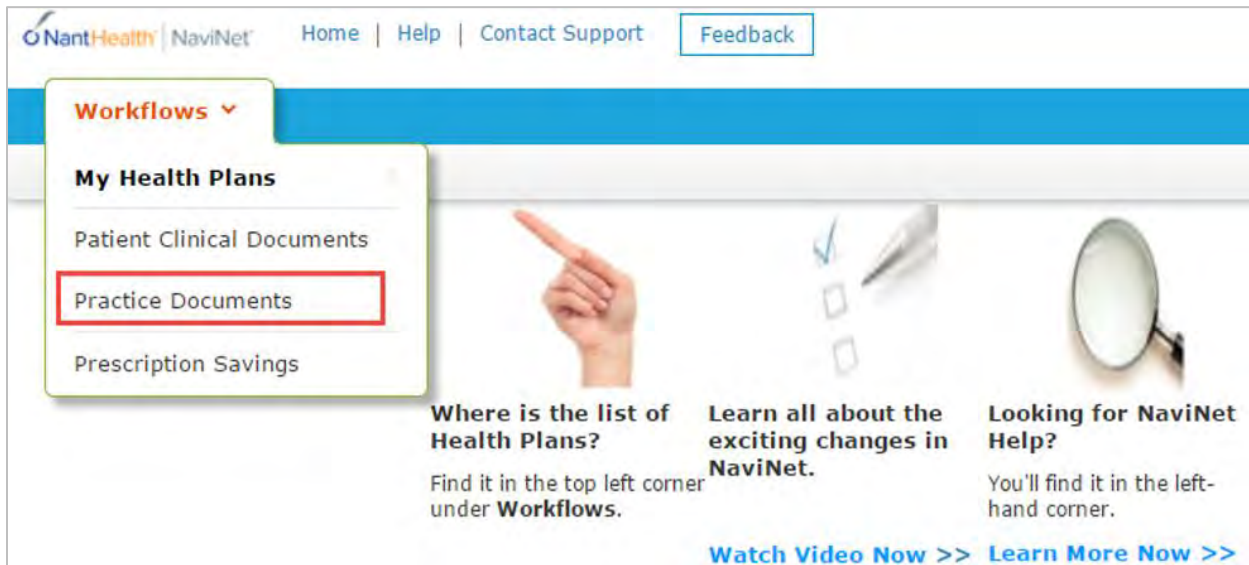
Make sure you don't miss out on our important updates. Update your email address today by logging in and going to **My Account** and clicking **About Me** to receive important updates and information.

Are You Sharing Login Credentials?

HIPAA guidelines prohibit users from sharing login information. If you are sharing login credentials, please contact your NaviNet Security Officer to be added as a user. Don't know the name of your Security Officer? Log in and go to **My Account** and click **My**

Step 2. Access “Practice Documents” Workflow

- A. Select **Workflows** in the upper left of the NaviNet screen.
- B. Drop down and select **Practice Documents** from the list of workflows.



The screenshot shows the NantHealth NaviNet interface. At the top, there is a navigation bar with the NantHealth logo, 'NaviNet', and links for 'Home', 'Help', 'Contact Support', and a 'Feedback' button. Below the navigation bar, a blue header contains the 'Workflows' dropdown menu, which is expanded to show a list of options: 'My Health Plans', 'Patient Clinical Documents', 'Practice Documents' (highlighted with a red border), and 'Prescription Savings'. To the right of the dropdown menu, there are three promotional cards. The first card, titled 'Where is the list of Health Plans?', features an image of a hand pointing and text stating 'Find it in the top left corner under **Workflows**.' The second card, titled 'Learn all about the exciting changes in NaviNet.', features an image of a pen and checklist and a link 'Watch Video Now >>'. The third card, titled 'Looking for NaviNet Help?', features an image of a magnifying glass and text stating 'You'll find it in the left-hand corner.' and a link 'Learn More Now >>'.

Step 3. Review, Search, and Filter Pending Activities in the Workflow

- A. Use the enhanced filter and sorting options to look for specific records.
- B. To view ICM-related documents, filter for **Patient Roster Report** under “Document Category”. Or, type **Intensive Case Management** into the “Document Tags” field.
- C. Check for **Pending Activity** by looking for the indicator at the end of a document title.

The screenshot shows a document management interface with a left-hand filter sidebar and a main document list. Two callout boxes highlight specific options:

- Filter Options:** Document Name, Date Received, Response Status, Health Plan, Document Category, Line of Business, Document Tags.
- Sorting Options:** Date Received, Document Title, Document Category.

The document list contains several entries, each with a red exclamation mark icon and a red circle around the text "[262 pending activity]". The entries are:

- Intensive Case Management [262 pending activity] for SMITH FAMILYCARE
- Intensive Case Management [262 pending activity] for CORE FAMILYCARE
- Intensive Case Management [264 pending activity] for SMITH FAMILYCARE
- Intensive Case Management Document for JONES PEDIATRICS
- Intensive Case Management Document for SMITH PEDIATRICS

Each entry includes fields for Patient Roster Report, Health Plan Name, Tax ID, Group NPI, Received date, and Expires date.

Step 4. Launch "Member Selection" for ICM Activities

A. Click on a record to view. For example, "Intensive Case Management for SMITH FAMILYCARE."

This screenshot shows the header of a document titled "Intensive Case Management for SMITH FAMILYCARE [262 pending activity]". The document is categorized as a "Patient Roster Report". A hand cursor icon points to the document title. To the right, a table provides key information:

Document Title	Document Category
Intensive Case Management for SMITH FAMILYCARE [262 pending activity]	Patient Roster Report
Tax ID: 012345678	Received: 08/02/2017
Group NPI: 1222244455	Expires: 08/09/2017

B. The screen below will display. Click on **Member Selection** at the bottom of this screen to access ICM activities.

This screenshot shows the main content of the document titled "Intensive Case Management Program" for "Health Plan Name". The document text includes:

Health Plan Name has developed the Intensive Case Management Program to assist primary care practitioners with identifying chronic and/or complex medical needs for their patients. To ensure the success of this program and aid physicians in identifying critical patient needs, the provider is requested to do the following:

- Support appointment scheduling and outreach efforts underway by "Health Plan Name"
- Cooperate in treating the members in the program at least twice every 12 months
- Assist "Health Plan Name" by submitting your updated Intensive Case Management Worksheet and/or a new or updated claim that includes all appropriate diagnoses determined.

"Health Plan Name" is offering financial incentives to all PCPs who participate in this program.

Please click [here](#) to view **member selection** webpage.

The screenshot also shows a sidebar with document metadata and a list of other documents. The document metadata includes:

CURRENT DOCUMENT
Document Provider: "Health Plan Name"
Document Title: Intensive Case Management for SMITH PEDIATRICS [262 pending activity]
Document Category: Patient Roster Report
Date Received: 08/02/2017, Date of Expiry: 08/09/2017
Received on Behalf of: Tax ID: 012345678, Group NPI: 1234567891
Line of Business: Medicaid
Document Tags: Intensive Case Management

DOCUMENTS

Document Title	Document Category	Tax ID	Group NPI	Received	Expires
Intensive Case Management for Patient Roster Report	Patient Roster Report	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for JONES PEDIATRICS	Patient Roster Report	012345678	1222244455	08/01/2017	10/10/2017
Intensive Case Management Document for SMITH PEDIATRICS	Patient Roster Report	012345678	1222244455	08/01/2017	10/10/2017

Step 5. Search for a Member and/or Filter by Needed Actions

You are now in the Intensive Case Management (ICM) part of the application. Here you will see the **Member Listing** which contains all ICM members associated with the practice you selected in Step 3.

Here you can choose to...

- A. Search for a specific member using **Member ID**, **Member Last Name**, or **Member Last Name + Member Date of Birth**.

- B. Filter by Action:
 - **Adjust Claim(s)** will filter for members attached to a claim or to claim(s) that have been adjusted or may need adjustment in order to reflect complete and accurate diagnosis data for that member.

- C. Filter by Status:
 - **Incomplete** status will filter for all incomplete actions for Case Management Worksheet or Claim Adjustment

 - **Pending** status will filter when at least one claim of member is in “Submitted; Waiting batch process” status and no other claims in “incomplete” status. This is applicable for Claim adjustment scenarios only.



**<<Health Plan Name>>
Intensive Case Management Program**

Group:
 Service Rep:
 Service Rep
 Phone:
 Publish Date: 09/06/2017
 Due Date: 03/01/2018

<<Plan Name>> has developed the Intensive Case Management Program to assist primary care practitioners with identifying chronic and/or complex medical needs for their patients. To ensure the success of this program and aid physicians in identifying critical patient needs, the provider is requested to do the following:

- Support appointment scheduling and outreach efforts underway by <<Health Plan Name>>
- Cooperate in treating the members in the program at least twice every 12 months.
- Assist <Plan Name> by submitting your updated Intensive Case Management Worksheet and/or a new or updated claim that includes all appropriate diagnoses determined.

<Plan Name> is offering financial incentives to all PCPs who participate in this program.

Detailed information and instructions can be accessed on the <Plan Name> website.

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				ADJUST CLAIM(S)	INCOMPLETE	
				ADJUST CLAIM(S)	PENDING	
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

When user selects Filter by Action “Adjust claim(s)”:

The screenshot shows a web interface for filtering members. On the left, there are three input fields: "Member ID", "Member Last Name", and "Member Date of Birth" (with a date format hint "MM/DD/YYYY"). To the right of these fields are two filter sections. The "Filter by Action" section has a red circle around its title and contains two checkboxes: "Adjust Claim(s)" (checked) and "Please Schedule Appointment" (unchecked). The "Filter by Status" section contains two checkboxes: "Incomplete" and "Pending", both unchecked. Below the filters are two buttons: "Search" and "Reset Filter(s)". At the bottom, a table header is visible with columns: "Member ID", "Last Name" (with an upward arrow), "First Name", "Date of Birth", "Action", "Status", and "Adjust Claim(s)/ Member Details".

From this screen, you can also click on a **Member ID number** to view additional member details including address, telephone number, diagnosis code(s), Case Manager, and Case Manager’s Telephone.

Member ID
12345666

There are three possible statuses in the Member Listing screen:

- 1) **INCOMPLETE:** This status will be populated when at least one claim of a member is in an “Incomplete” status or the member has an incomplete Complex Case Management Worksheet.
- 2) **PENDING:** This status will be populated when at least one claim of a member is in “Submitted; Waiting batch process” status and no other claim is in “Incomplete” status.
- 3) **COMPLETE:** This status will be populated when all claims are in “Claim Adjusted on MM/DD/YYYY” status.

Step 6. Complete the Needed Actions

A. Adjust a Claim to Reflect Diagnosis Information from the Member's Medical Record

- I. Under "Adjust Claim(s)/Member Details," click on the **Adjust Claim(s) Icon** to view the complete list of adjustable claims associated with that member.

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/Member Details
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				PLEASE SCHEDULE APPOINTMENT	COMPLETED	
				ADJUST CLAIM(S)	INCOMPLETE	
				ADJUST CLAIM(S)	PENDING	
				PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

- II. To view claims details and to make claim adjustments, select the **Adjust Claim(s) Icon** on the right once again.

PLAN LOGO



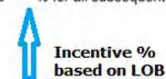
<< Health Plan Name >>
**Intensive Case Management Program
 Claim Adjustment(s)**

Below lists claim(s) previously submitted by your practice for various dates of service.

Select the claim, noting claim date of service. Compare diagnosis codes suggested in the "Adjust Diagnosis Code" section to information in your patient medical record for the office visit of that same date. Mark the appropriate status for each suggested code as applicable for the date: Confirmed, Can't Confirm, Resolved, Updated or Add a new code.

Please note, a diagnosis having "Can't Confirm" status on one date may have a "Confirmed" status on a different date, so evaluate each diagnosis against each date.

A financial incentive will be applied to each claim submitted with a 99499 CPT code at 100% of the allowed amount for the first claim and % for all subsequent claims submitted within 180 days from a previous date of service.



Claims for

Claim ID	Date of Service	Claim Status ⓘ	Adjust Claim
		CLAIM ADJUSTED ON 06/12/2017	
		INCOMPLETE	
		SUBMITTED;WAITING BATCH PROCESS	


3 items


Back

There are three possible statuses in the Claim Listing screen:


- 1) INCOMPLETE: You can adjust claims which are in an INCOMPLETE status.
- 2) SUBMITTED; WAITING BATCH PROCESS: Status will be seen when you already submitted an adjustment, but you can re-adjust a claim in this status.
- 3) Claim Adjusted on MM/DD/YYYY - Status is populated when user submitted adjustment and batch process is completed.

III. The **Claim Adjustment Screen** will display.

Provider Self-Service 

PLAN LOGO 

Intensive Case Management Claim Adjustment

Instructions 

To support the Intensive Case Management Program and be eligible for incentive payment, you are required to provide us updated diagnosis via an adjusted claim. Incentive payments are available for Intensive Case Management Members twice per calendar year (every 180 days).

The "Claim Details" section displays many of the details from a claim you submitted previously.

The "Additional Procedure Code" section adds a new procedure line documenting a miscellaneous evaluation and management service. This procedure line is used to generate your incentive payment in the AmenHealth Caritas District of Columbia system.

You do not need to update any of the information in the Claim Details or "Additional Procedure Code" sections; they are provided for your information.

In the "Diagnosis Code Adjustment" section are diagnoses that have been reported in this member's claim history (from various providers) but which were not reported on any claims you submitted within the last six months. We request that you review the diagnosis codes against your medical record for this member and submit qualifying information as indicated:

- Click the "Confirmed" status when your medical record confirms the diagnosis.
- Click the "Resolved" status when your medical record indicates the diagnosis has been resolved.
- Click the "Cannot Confirm" status when your medical record has no indication the diagnosis was ever present.
- Search and Edit a diagnosis code for the "Updated" status to appear when the diagnosis listed is confirmed but requires modification or when you want to replace it with a code not listed in the "Diagnosis Code Adjustment" section.
- Click the Add Diagnosis Code link when your medical record indicates you should report a diagnosis not already listed in this section.

Only "Confirmed", "Updated" and "Added" diagnoses will be included on your adjusted claim.

Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:

Status Date: 5/29/2017
Status Code: 107
Category Code: F1
Remark Code:
Check Number:

Paid Date: 05/29/2017
Diagnosis Codes: Z91.09

When reviewing medical records, make a note of the diagnosis code(s) originally billed on the claim. Add any applicable diagnosis code(s) during the adjustment process.

Service Line Detail

	Date From/To	Claim Status	Units	Proc Cd	Modifier	Billed Amt	POS	DX CD Pointers	Reason Cd	Line Status
1	12/30/2016 - 12/30/2016	107	1	99213	-	\$125.66	11	1,2	PAI	Confirmed

1 item

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
12/30/2016 - 12/30/2016	99499	1	\$

1 item

Procedure Code 99499 (Other Evaluation and Management Services) is added to the adjusted claim to pay the applicable administrative fee.

Diagnosis Code Adjustment

Diagnosis Code	Description	Status	Action
I69.998 x	Other sequelae following unspecified cerebrovascular disease	--Please Select--	
K21.9 x	Gastro-esophageal reflux disease without esophagitis	--Please Select--	
D89.89 x	Other specified disorders involving the immune mechanism, not elsewhere classified	--Please Select--	
Q66.7 x	Congenital pes cavus	--Please Select--	

[Add Diagnosis Code](#) 4 items

- IV. Based on your review of the member’s medial record for the date of service listed on the claim, select the appropriate status for each diagnosis code under “Diagnosis Code Adjustment”:
- Confirmed** – Attesting that you confirm the diagnosis is still present.
 - Resolved** – Attesting that the diagnosis has been treated and is no longer present.
 - Cannot Confirm** – Attesting that you do not have record(s) of this diagnosis; never present.
 - Updated** – If the diagnosis code listed is not correct for the member condition, you may update with the correct diagnosis by clicking the “x” and entering at least the first three characters of the updated diagnosis.
- NOTE:** If you erroneously click the “x”, you can select **Undo Changes** under “action” to revert to the original code

Please remember, the diagnosis codes presented here may or may not have originated from claims that you submitted. The member may have been treated in the ER or Urgent Care, or by another provider type, and may have been diagnosed by a provider not associated with your practice.

- V. Once you’ve made an adjustment, you will see **Updated** will appear in the “Status” column. To undo your update, select **Undo Changes** under “Action”.

Diagnosis Code Adjustment

Diagnosis Code	Description	Status	Action
D11 x	Benign neoplasm of major salivary gland	UPDATED	Undo Changes

- VI. You also have the option to **Add Diagnosis Code** should you identify a new diagnosis or diagnoses previously unlisted on the claim. To initiate entry of a new diagnosis, type **at least the first three characters** to populate this field.

Use the **Remove** option under “Action” to remove the new diagnosis, if needed.

Diagnosis Code Adjustment

Diagnosis Code	Description	Status	Action
I50.9 x	Heart failure, unspecified	--Please Select--	
F33.1 x	Major depressive disorder, recurrent, moderate	ADDED	Remove

Add Diagnosis Code 2 Items

- VII. Next, in the **Phone Number** field under “Contact Information,” enter your **10-digit telephone number** with no spaces and no characters between digits. (Example: 8185557777.)

Contact Information: GEORGE, WILLIAM

* **Phone Number:**

* **Required Fields**

- VIII. Select **Preview** at the bottom of the screen for an opportunity to review a “Verification” page. Here you can review all the information you provided/updated. See next page for example.
- IX. Next:
- a. Click **Edit** to return to the Claim Adjustment screen for additional changes.
 - OR
 - b. Click **Submit** to complete your claim adjustment activity. You will see the Claim Listing screen with the status for adjusted claims now displaying as “**Submitted; Waiting batch process.**”



Intensive Case Management Claim Adjustment - Verification

Instructions

Please review all of the "Diagnosis Code Adjustment" section information you entered and make corrections as necessary, then click the "submit" button on this screen. Once you click "submit" from this screen, claim will be waiting for next batch process to run. You may make additional corrections until the claim status changes from "Submitted, Waiting batch process" to "Claim adjusted on MM/DD/YYYY".

Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:
Paid Date:
Diagnosis Codes:

Status Date:
Status Code:
Category Code:
Remark Code:
Check Number:

Service Line Detail

	Date From/To	Claim Status	Units	Proc Cd	Modifier	Billed Amt	POS	DX CD Pointers	Reason Cd	Line Status
1			1	T1015	-		11	1		Confirmed
2			1	99212	-	\$0.00	11	1		Confirmed

2 items

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
	99499	1	

1 item

Diagnosis Code Adjustment

Diagnosis Code	Description	Status
R00.1	Bradycardia, unspecified	CONFIRMED
E66.1	Drug-induced obesity	ADDED
N12	Tubulo-interstitial nephritis, not specified as acute or chronic	ADDED


3 items

Contact Information




Contact Name:
Phone Number:

- X. After submitting the adjustment, the user is returned to the Claim Listing screen if there are additional claims to adjust. Proceed to the next claim for adjustment or click the Back button to return to the Member Listing screen.

Provider Self-Service




PLAN LOGO







<< Health Plan Name >>
Intensive Case Management Program
Claim Adjustment(s)

Below lists claim(s) previously submitted by your practice for various dates of service.
 Select the claim, noting claim date of service. Compare diagnosis codes suggested in the "Adjust Diagnosis Code" section to information in your patient medical record for the office visit of that same date. Mark the appropriate status for each suggested code as applicable for the date: Confirmed, Can't Confirm, Resolved, Updated or Add a new code.
 Please note, a diagnosis having "Can't Confirm" status on one date may have a "Confirmed" status on a different date, so evaluate each diagnosis against each date.
 A financial incentive will be applied to each claim submitted with a 99499 CPT code at 100% of the allowed amount for the first claim and % for all subsequent claims submitted within 180 days from a previous date of service.


Incentive % based on LOB

Claims for

Claim ID	Date of Service	Claim Status	Adjust Claim
		CLAIM ADJUSTED ON 06/12/2017	
		INCOMPLETE	
		SUBMITTED;WAITING BATCH PROCESS	

3 items

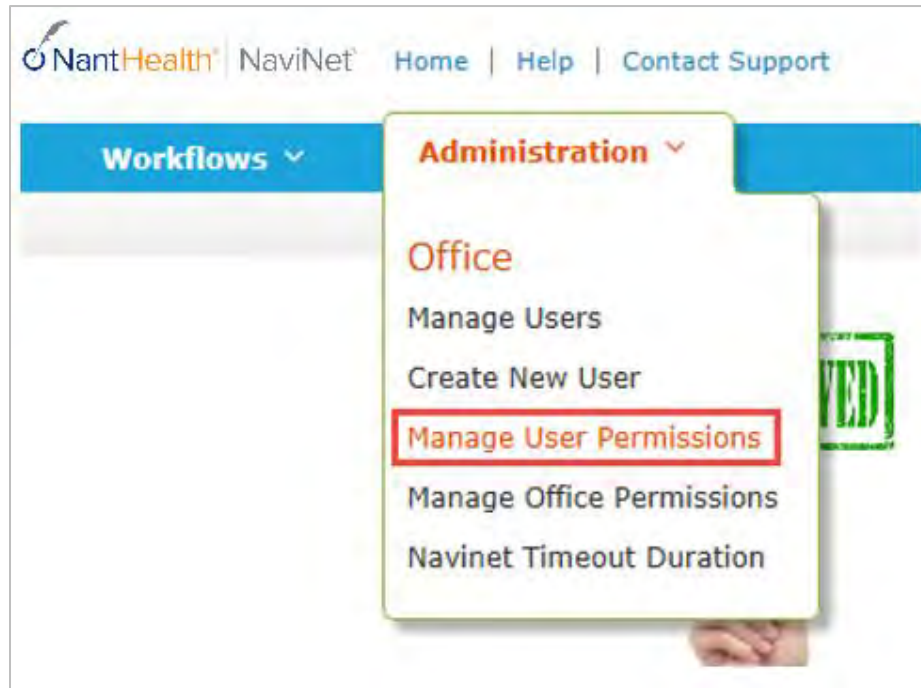
Back

Supplemental Information

Enabling Document Exchange for a Plan Service User (PSU)

A NaviNet Security Office can follow the steps below to enable Document Exchange for a Plan Service User (PSU):

1. Click **Administration** from the NaviNet toolbar and then scroll down to select **Manage User Permissions**.



2. From the next screen, select the user whose permissions you want to adjust, and then select **Edit Access**.

A screenshot of the 'User Search' interface. It features search fields for 'Last Name', 'First Name', and 'Username', along with a 'User Status' dropdown menu and a 'Combined User Status' dropdown menu. There are 'Search', 'Exit', and 'Clear' buttons. Below the search fields, there is a checkbox for 'Hide Search Criteria After Search' and a 'Hide Search Criteria' link. At the bottom, there is a table with columns: 'Name', 'Username', 'Status', 'Last Login', 'Status Change', 'Security Officer?', and 'New User?'. The 'Edit Access' button is highlighted with a red box.

- The next screen is titled “Transaction Management for User _____”. From this screen, select **NaviNet** in the Plan’s drop-down list and select **DocumentExchange** in the Group’s drop-down list.

Transaction Management for User

Username: _____ Security Officer? No
 Office: Plan Service Office
[Go to Office Transaction Management for this office](#)

To change this user's access to a transaction, click **Enable** or **Disable** next to that transaction. If you do not see an **Enable** or **Disable** button, you cannot manage this transaction. [Tell me more...](#)

NaviNet ▾
DocumentExchange ▾
Enable All
Disable All

Plan/Service ▲	Name	Access?	Last Modified	Modified By
NaviNet	Document Respond	Enabled		
NaviNet	Document Viewer	Enabled		
NaviNet	Document Download	Enabled		
NaviNet	Document Preview	Enabled		
NaviNet	Practice Document Respond	Enabled		
NaviNet	Practice Document Viewer	Enabled		
NaviNet	Practice Document Download	Enabled		
NaviNet	Practice Document Preview	Enabled		

- It’s important to note, “Patient Clinical Documents” are enabled for all users by default. But you will want to confirm that the global permissions for “Patient Clinical Documents” are set appropriately:
 - For a user to view Patient Clinical Documents, both **Document Viewer** and **Document Preview** must be enabled.
 - For a user to download Patient Clinical Documents, **Document Download** must also be enabled. (This permission affects only documents that allow downloads.)
 - For a user to respond to Patient Clinical Documents, **Document Respond** must also be enabled. (This permission affects only documents that allow responses.)

NaviNet ▾
DocumentExchange ▾
Enable All
Disable All

Plan/Service ▲	Name	Access?	Last Modified	Modified By
NaviNet	Document Respond	Enabled		
NaviNet	Document Viewer	Enabled		
NaviNet	Document Download	Enabled		
NaviNet	Document Preview	Enabled		
NaviNet	Practice Document Respond	Enabled		
NaviNet	Practice Document Viewer	Enabled		
NaviNet	Practice Document Download	Enabled		
NaviNet	Practice Document Preview	Enabled		

5. Similarly, “Practice Documents” are enabled for all users by default. But you will want to confirm that the global permissions are set appropriately:
 - a. For a user to view Practice Documents, both **Practice Document Viewer** and **Practice Document Preview** must be enabled.
 - b. For a user to download Practice Documents, **Practice Document Download** must also be enabled. (This permission affects only documents that allow downloads.)
 - c. For a user to respond to Practice Documents, **Practice Document Respond** must also be enabled. (This permission affects only documents that allow responses.)

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
NaviNet	Document Respond	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Viewer	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Download	Enabled			<input type="button" value="Disable"/>
NaviNet	Document Preview	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Respond	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Viewer	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Download	Enabled			<input type="button" value="Disable"/>
NaviNet	Practice Document Preview	Enabled			<input type="button" value="Disable"/>

6. Now that you have confirmed the global permissions, you need to enable the specific permissions. First, select the **appropriate health plan** in the Plan’s drop-down list and **DocumentExchangeCategories** in the Group’s drop-down list.

Transaction Management for User

Username: Security Officer? No

Office:

[Go to Office Transaction Management for this office](#)

To change this user's access to a transaction, click **Enable** or **Disable** next to that transaction. If you do not see an **Enable** or **Disable** button, you cannot manage this transaction. [Tell me more...](#)

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
Aries Health Plan ▼	DocumentExchangeCategories ▼				<input type="button" value="Enable All"/> <input type="button" value="Disable All"/>

7. Click **Enable** next to any Patient Clinical Document categories that you want to be available to this user for the selected health plan.

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
Aries Health Plan	Clinical Summary	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Patient Consideration	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Program Enrollment	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Info Request	Disabled			<input type="button" value="Enable"/>

- Click **Enable** any Practice Document categories that you want to be available to this user for the selected health plan.

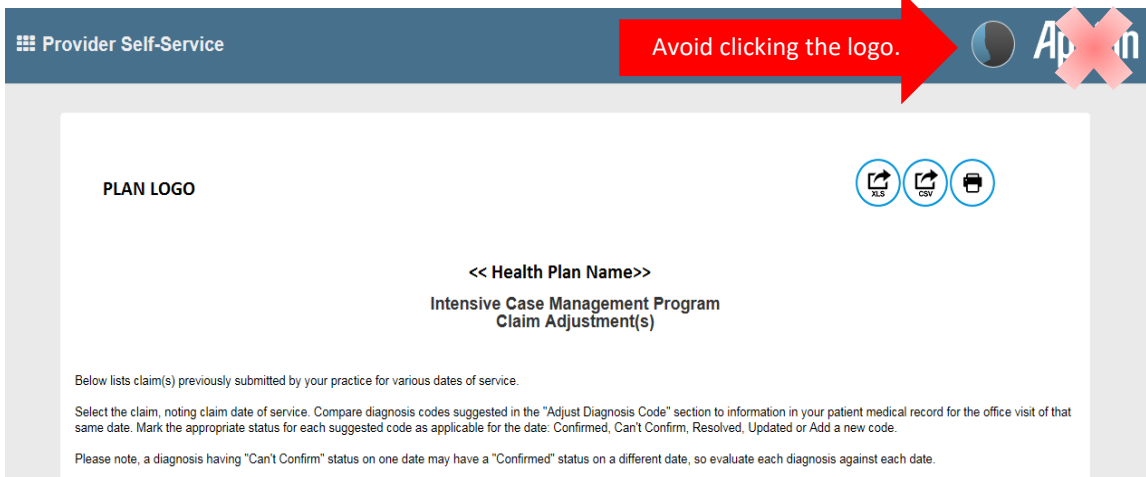
Aries Health Plan	Patient Transition Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Patient Roster Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Pharmacy Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Program Enrollment Report	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	Financial Report	Disabled			<input type="button" value="Enable"/>

- Finally, for access to all ICM activities, make sure **Patient Roster Report** and **Patient Consideration** document categories are enabled.

Plan/Service ▲	Name	Plan	Office	Access?	Last Modified	Modified By	
	Patient Roster Report	Disabled	←	Disabled			<input type="button" value="Enable"/>
	Patient Consideration	Disabled	←	Disabled			<input type="button" value="Enable"/>
	Patient Level Documents	Disabled	←	Disabled			<input type="button" value="Enable"/>

Important Note: Time-Out Information

Avoid clicking on the Appian logo. If you do so, the screen will auto-refresh.



If you are inactive for more than 60 minutes, you will see the pop-up below warning you that your session is about to expire. If you click **Resume** within 5 minutes, the page will reload and you can continue entering information.



If you do not click **Resume** within 5 minutes, the form will time-out, and you will see the log-in window pictured below. Please **do not** attempt to log-in via this pop-up. Instead, close the window and log-in to NaviNet again.

Anatomy of the Workflow & Document Viewer Screens

1. Anatomy of the starting screen for the **Practice Documents** workflow:

A blue bar and text indicates that a document is unread.

A red exclamation point indicates that a response is requested for this document.

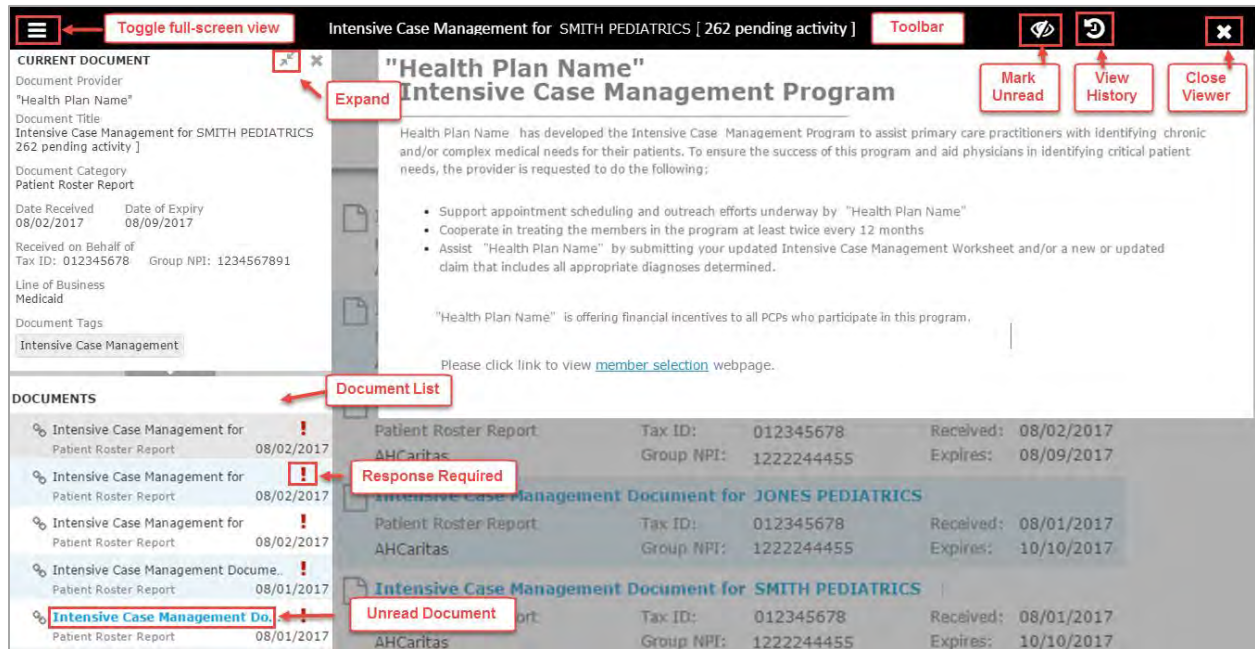
The exclamation point will not be displayed if a response has already been submitted for this document.

Users can select a number of documents in the list and then click View to open the selected documents in the Document Viewer.

The screenshot displays the 'Practice Documents' interface. On the left, a 'Filter by' sidebar includes sections for Document Name (with a search box), Date Received (with a date range selector), Response Status (with checkboxes for 'Awaiting Response' and 'Response Sent'), Health Plan, Document Category (with 'Patient Roster Report' selected and an 'ICM Filter' button), Line Of Business (with checkboxes for 'Commercial', 'Dual Eligibles', 'Medicaid', 'Medicare', and 'Other'), and Document Tags (with a search box and a tag 'Intensive Case Management'). The main area shows a list of documents sorted by 'Date Received (Descending)'. Each document entry includes a document icon, a title, 'Patient Roster Report', 'Tax ID', 'Group NPI', 'Received' date, and 'Expires' date. Annotations with red boxes and arrows point to various elements: 'Unread Document' points to a blue bar on the left; 'Viewing Multiple Selected Documents' points to a blue bar on the left; 'Sorting Options' points to the 'Sort by' dropdown; 'Document for which a response is required' points to a red exclamation point icon; 'Document Category ICM will always fall under "Patient Roster Report"' points to the 'Patient Roster Report' text; and 'Routing Information' points to the 'Tax ID' and 'Group NPI' fields.

Document Title	Tax ID	Group NPI	Received	Expires
Intensive Case Management for SMITH FAMILYCARE [262 pending activity] Patient Roster Report	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for CORE FAMILYCARE [262 pending activity] Patient Roster Report	012345678	1222244455	08/02/2017	08/09/2017
Intensive Case Management Document for JONES PEDIATRICS Patient Roster Report	012345678	1222244455	08/01/2017	10/10/2017
Intensive Case Management Document for SMITH PEDIATRICS Patient Roster Report	012345678	1222244455	08/01/2017	10/10/2017

2. Anatomy of the document viewer screen for the Practice Documents workflow:



- **Toolbar**
 - a. The left side of the toolbar lets the user toggle full screen view and shows the current document's file type and title. The right side lets the user mark the current document as unread.
- **Document List**
 - a. Shows the documents you have selected. Clicking a document row displays the document in the document viewer.
 - b. Unread documents are highlighted with a blue bar and text.
 - c. Documents for which a response is requested are marked with a red exclamation point.
- **Current Document Summary**
 - a. Gives information on the current document, such as the health plan that sent the document, the document category, line of business, document name, and received and expiry dates. Document routing and tag information is also displayed. Users can expand the window to see any hidden information.

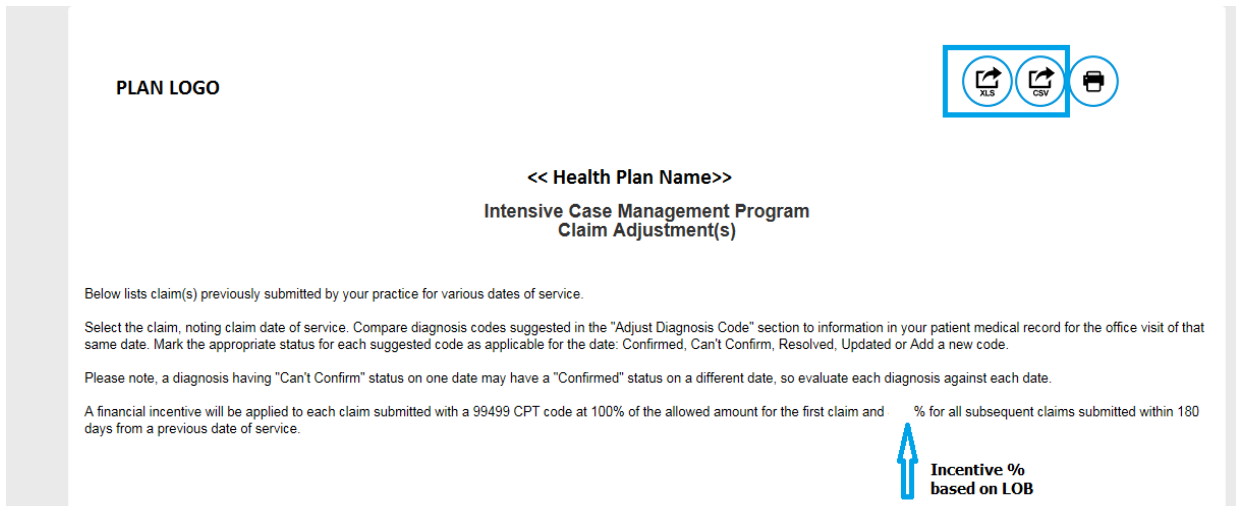
Popup Blocker Must be Disabled

For the Intensive Case Management function to work properly, your Pop Up blocker must be disabled.

Downloading, Saving, and Printing Member Information

From the Claim Adjustment(s) page, there are two options for downloading and one option for printing a member's information. The icons in the upper right corner provide these options.

- The first icon produces an .XLS file.
- The second icon produces a .CSV file.



The screenshot shows a web interface for "Intensive Case Management Program Claim Adjustment(s)". In the top right corner, three icons are visible: a blue-bordered box containing an XLS icon and a CSV icon, and a separate print icon. Below the icons, the text reads: "PLAN LOGO", "<< Health Plan Name >>", "Intensive Case Management Program Claim Adjustment(s)", "Below lists claim(s) previously submitted by your practice for various dates of service.", "Select the claim, noting claim date of service. Compare diagnosis codes suggested in the 'Adjust Diagnosis Code' section to information in your patient medical record for the office visit of that same date. Mark the appropriate status for each suggested code as applicable for the date: Confirmed, Can't Confirm, Resolved, Updated or Add a new code.", "Please note, a diagnosis having 'Can't Confirm' status on one date may have a 'Confirmed' status on a different date, so evaluate each diagnosis against each date.", "A financial incentive will be applied to each claim submitted with a 99499 CPT code at 100% of the allowed amount for the first claim and % for all subsequent claims submitted within 180 days from a previous date of service." A blue arrow points to the blank space before the percentage sign, with the text "Incentive % based on LOB" below it.

- The third icon displays instructions for printing (press CTRL + P).

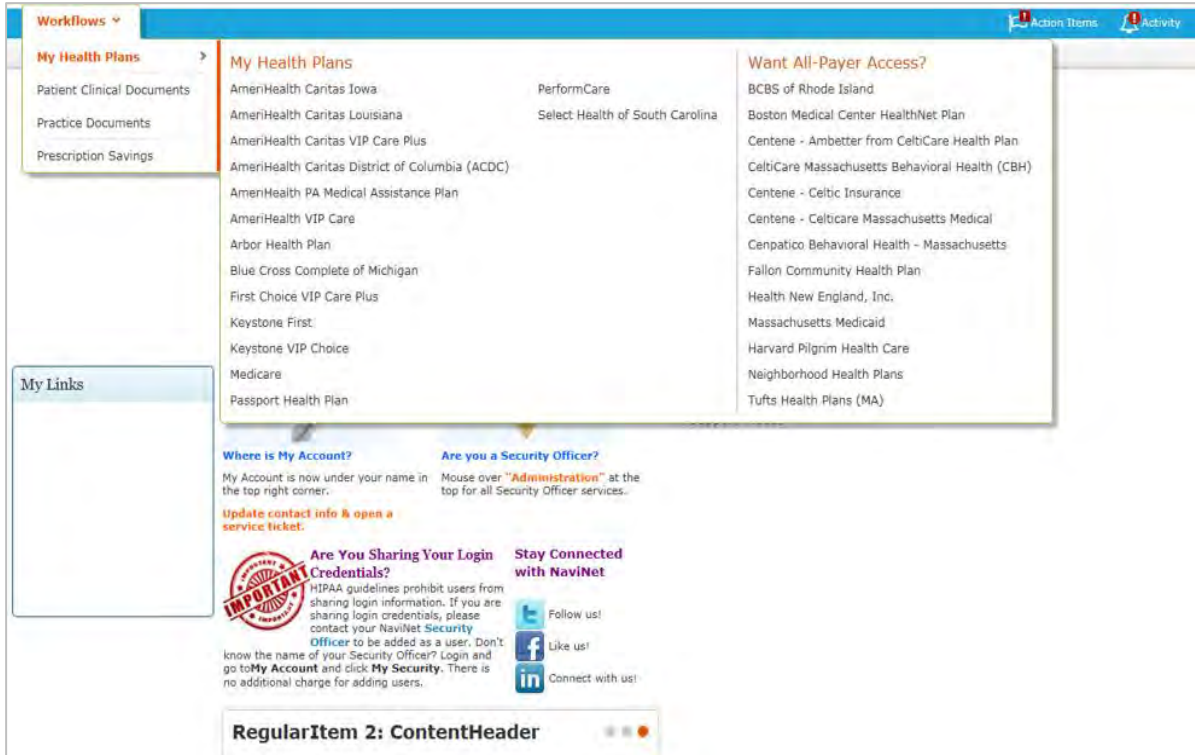


The screenshot shows the same web interface as above, but with a modal overlay. The overlay contains the text "Please Press" followed by a "CTRL + P" button icon and an "OK" button. The background content is dimmed. The top navigation bar shows "Provider Self-Service" and the "Appian" logo.

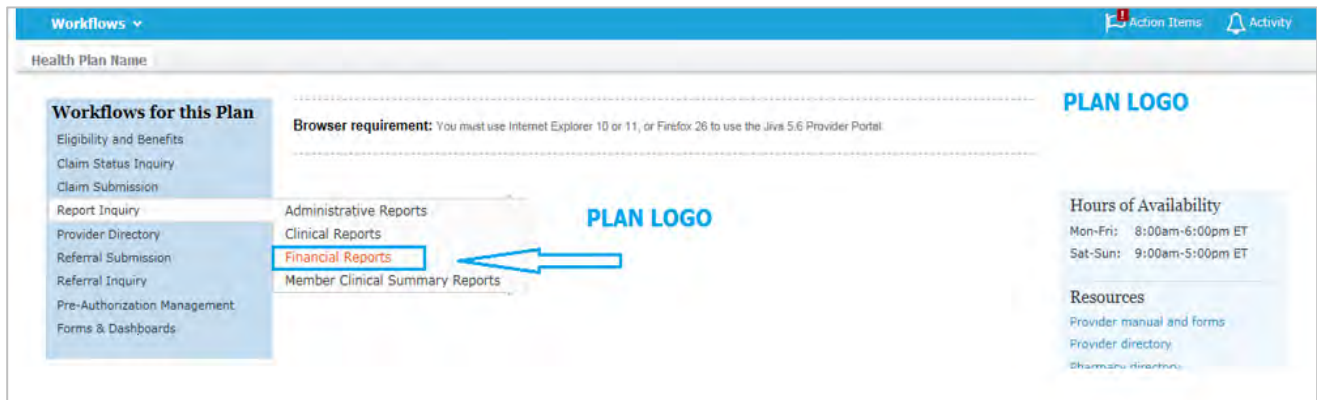
Report Generation

Intensive Case Management Report (ICR) can be generated in NaviNet to show the status of ICM adjusted claims. Follow the steps below to generate a report for your practice.

1. Select **Workflows** in the upper left of the NaviNet screen.
2. Drop down and select **My Health Plans** from the list of workflows.
3. Choose the health plan for which you want to pull a report.



4. Next, select **Report Inquiry** and then **Financial Reports**.



5. Finally, select **Adjusted Claims Report Query** from the drop-down list.

The screenshot shows a web application interface for 'Financial Reports Inquiry'. At the top, there is a blue navigation bar with 'Workflows' and 'Action Items' (with a notification icon). Below this is a breadcrumb trail: 'Plan Name | Financial Reports Inquiry | Report Selection'. The main content area has a header 'PLAN NAME' on the left and '<<Health Plan Name>>' on the right. Below the header is the title 'Financial Report Inquiry' and a 'Print page' link. A 'Select Report:' dropdown menu is set to 'Adjusted Claims Report Query'. Below the dropdown is a note: 'Please note, to request a PDF report file you must have the Adobe Reader application on your computer. To request CSV or Excel report file you must have the MS Excel application on your computer. The report will open in Excel format. If you do not have MS Excel on your computer, you will have the option to simply save the report to your computer.'

6. Now you can set the parameters
 - i. **Time Period or Date Range** –
 1. Time period defaults to “Up to 7 days”, but user can select 30, 90, 180 or up to one year.
 2. You can choose a specific “Date Range” as selection criteria. When a date range is provided, these dates have precedence over Time Period from drop down. Report will be based on **date range**.
 - ii. **Provider Group Selection**
 1. You **must** choose a Provider Group.
 2. You may also select a specific provider within the group and only claim records for that provider will be returned.
 - a. It is not necessary to choose a specific provider under the group, but all providers will be returned in the report.
 - iii. **Filter Criteria**
 1. If you enter a specific Member ID, report will be member specific if the record exists.
 2. If you enter a specific Claim ID, report will be Claim specific if the record exists.
 - iv. **Report Criteria**
 1. Report type defaults to “PDF”, but you can also select “Excel/CSV (Downloadable)” option.

See next page for example reports.

<<PLAN NAME>>

[Print page](#)

Adjusted Claims Report Query v. 1.1.7

Instructions

Please enter your search criteria, and click "Search". * Indicates Required Fields.
 NOTE: if your browser has an active popup blocker you may need to turn it off to receive the report.

Adjusted Claims Information

Please choose a time period or provide a date range in the given format

* Choose a Time Period Up to 7 days

OR

Provide Date Range:

Up to 30 days
 Up to 90 days
 Up to 180 days
 Up to one year

From Date(MM/DD/YYYY)

To Date (MM/DD/YYYY)

* Choose a Provider Group

Choose a Provider

Filter Criteria

Member ID

Claim ID

Report Criteria

* Adjusted Claims Type

Select Report Type PDF
 Excel/CSV(Downloadable)

Select Sort Options

*

Last Update: 08/21/2017 v.1.1.7

<<PLAN LOGO>>

Provider Transaction Detail Report - ICM

Date from: 01/01/2016 to 09/11/2017

Date of Report : 09/11/2017

Provider ID	Provider Name

Member ID	Member Name	Claim ID	DOS From - To	Code	Billed Amount	User ID	Updated Date	DX Code - Status	Paid Date	Paid Amount	Status
			10/20/2015 TO 10/20/2015	99499			05/20/2016	Z23-CONFIRMED R180-RESOLVED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			11/16/2015 TO 11/16/2015	99499			05/20/2016	N040-CONFIRMED Z00129-CONFIRMED R180-RESOLVED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			06/29/2015 TO 06/29/2015	99499			05/20/2016	5819-CONFIRMED 1120-CONFIRMED 78951-RESOLVED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			01/15/2016 TO 01/15/2016	99499			11/28/2016	R3915-CONFIRMED J45909-CANNOT CONFIRM	11/30/2016		PROCESSED SUCCESSFULLY - 01
			07/15/2016 TO 07/15/2016	99499			11/04/2016	F840-CONFIRMED H9190-CONFIRMED F902-CONFIRMED F88-CONFIRMED Z00129-CONFIRMED Z23-CONFIRMED	11/07/2016		PROCESSED SUCCESSFULLY - 02
			12/22/2015 TO 12/22/2015	99499			05/20/2016	J4520-CONFIRMED J301-CONFIRMED Z00129-CONFIRMED Z23-CONFIRMED J449-CONFIRMED	05/23/2016		PROCESSED SUCCESSFULLY - 02
			06/30/2016 TO 06/30/2016	99499			10/05/2016	Z00129-CONFIRMED J4520-CONFIRMED Z23-CONFIRMED H5000-CONFIRMED 7418-CONFIRMED	10/10/2016		PROCESSED SUCCESSFULLY - 01

PLAN LOGO

Provider Transaction Detail Report - ICM

Date from: 01/01/2016 to 09/11/2017

Date of Report : 09/11/2017

Provider ID	Provider Name

Member ID	Member Name	Claim ID	DOS From - To	Code	Billed Amount	User ID	Updated Date	DX Code - Status	Paid Date	Paid Amount	Status
			07/02/2015 TO 07/02/2015	99499			06/27/2016	V202-CONFIRMED 56400-CONFIRMED V6081-CONFIRMED 7540-CANNOT CONFIRM	06/29/2016		PROCESSED SUCCESSFULLY - 01
			08/29/2016 TO 08/29/2016	99499			11/11/2016	Z134-CONFIRMED Q672-CANNOT CONFIRM	11/16/2016		PROCESSED SUCCESSFULLY - 01

Total Number of Claim Adjustments:

Total Billed Amount:

Total Paid Amount:

Total Count by Claim Status:

Claim processed successfully :

Other Status :

Attachment 1: Example Process Flow for Intensive Case Management Process

Attachment 1: Example Process Flow for Intensive Case Management Process
Revised 3/2/2020

