Provider User Guide

Intensive Case Management via NaviNet®

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 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-abstraction 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 support 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

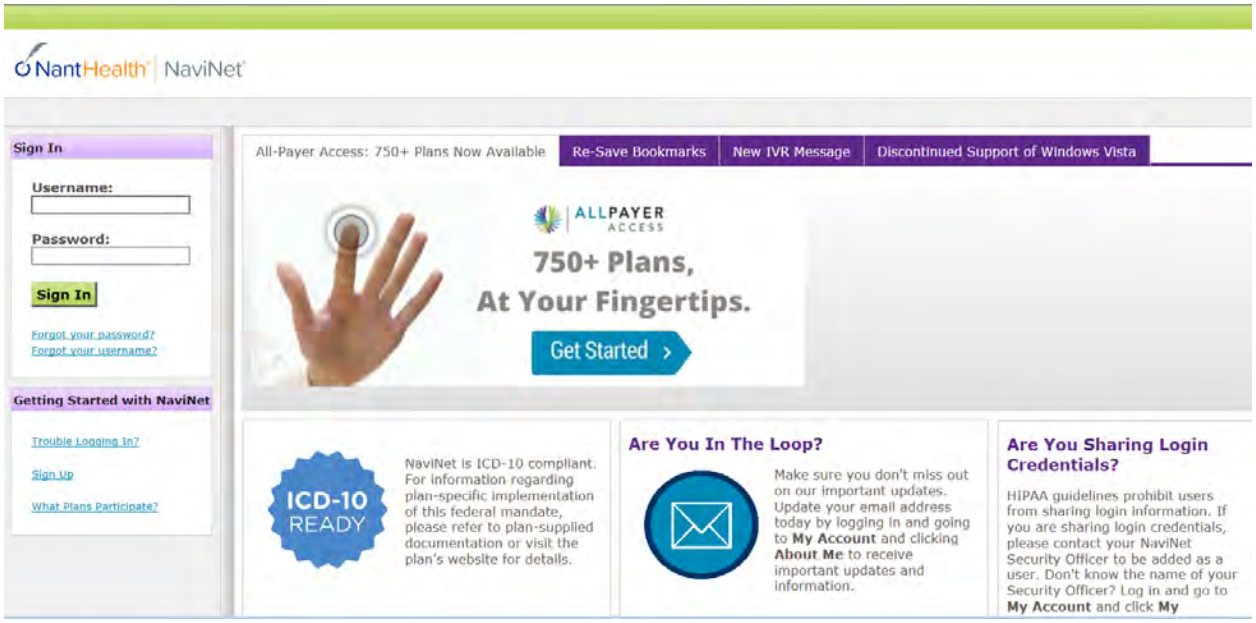
If this is your first time launching the "Practice Documents" or "Patient Clinical Documents" workflows, you will be asked to complete the attestation process. Follow the prompts to complete this process for the billing entities and clinicians you support. You can also complete

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**.



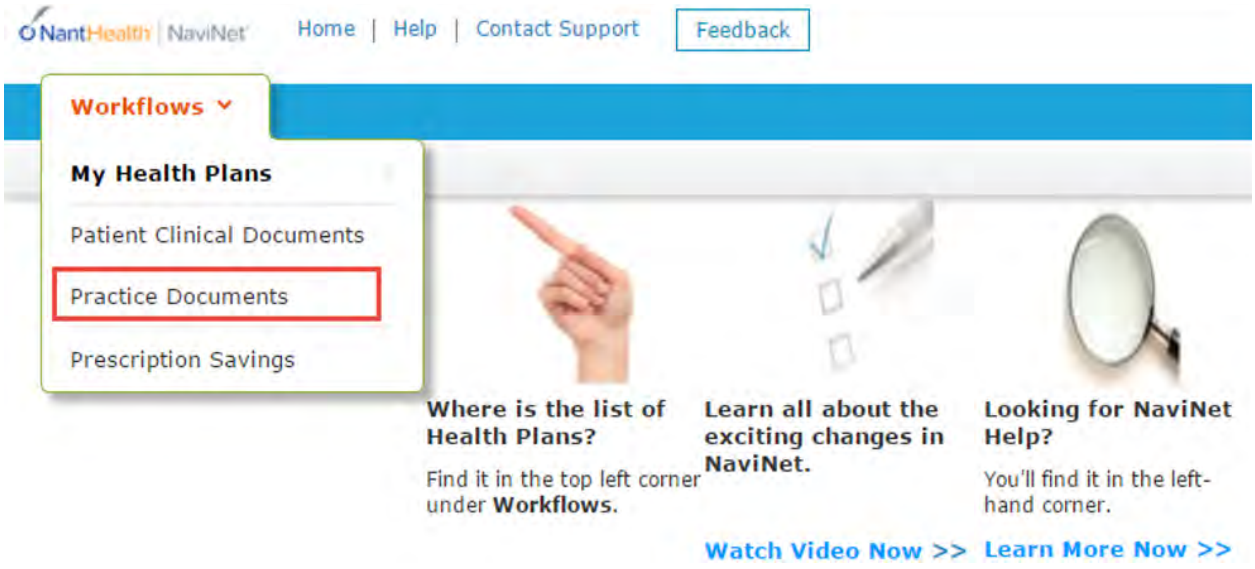
Step 2. Access “Practice Documents” Workflow

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.

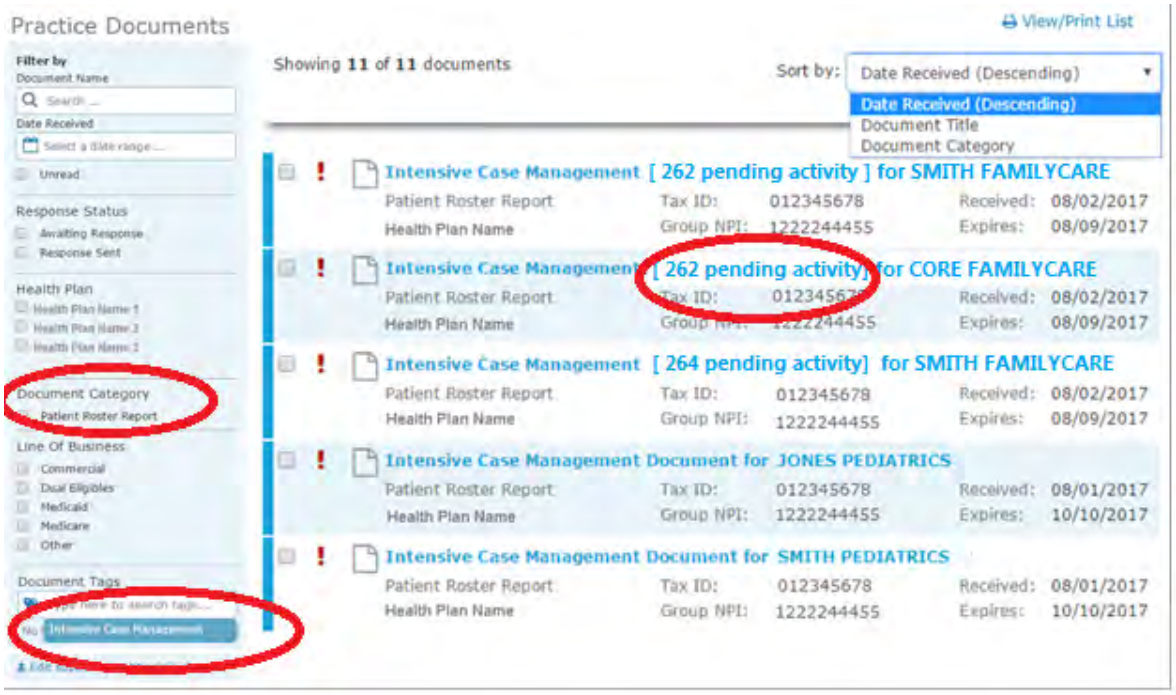
For an alternative workflow, focused on individual member information, please refer to steps for accessing the “Patient Clinical Documents” workflow on page 29 of this guide.

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



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

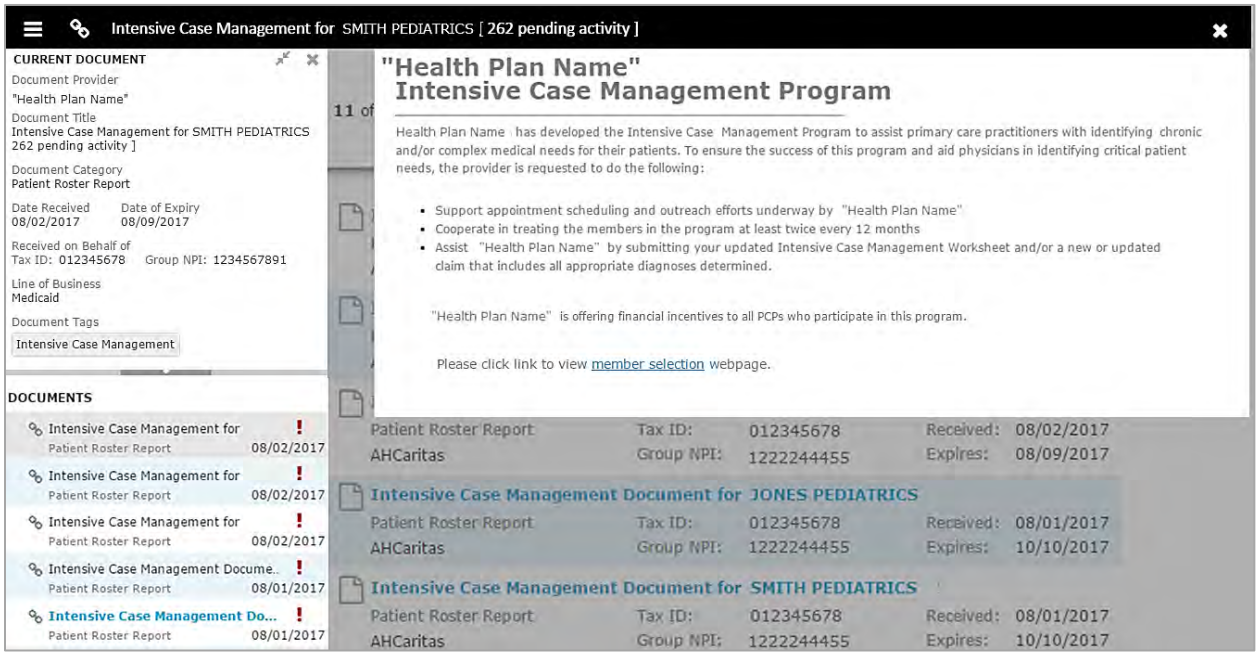
A. Use the enhanced filter and sorting options to look for specific records.
B. To view ICM-related documents, filter for **Patient Roster Report** under “Document Category”. Or, type **Intensive Case Management** into the “Document Tags” field.
C. Check for **Pending Activity** by looking for the indicator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



Step 4. Launch “Member Selection” for ICM Activities

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

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



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 Work sheet 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 work sheet

PLAN LOGO

<<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:

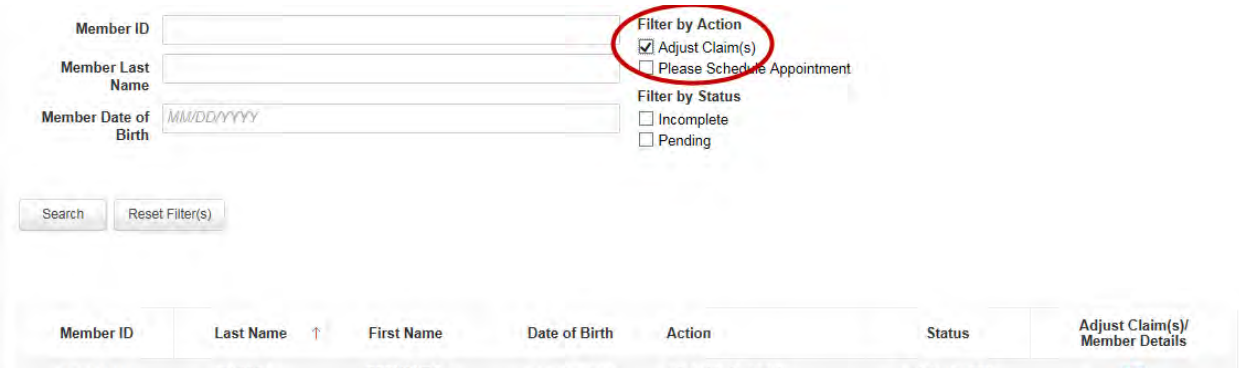
- Support appointment scheduling and outreach efforts underway by <<Health Plan Name>>
- Cooperate in treating the members in the program at least twice every 12 months.
- Assist <Plan Name> by submitting your updated Intensive Case Management Worksheet and/or a new or updated claim that includes all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

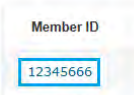
When user selects Filter by Action “Adjust claim(s)”:



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

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.

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	

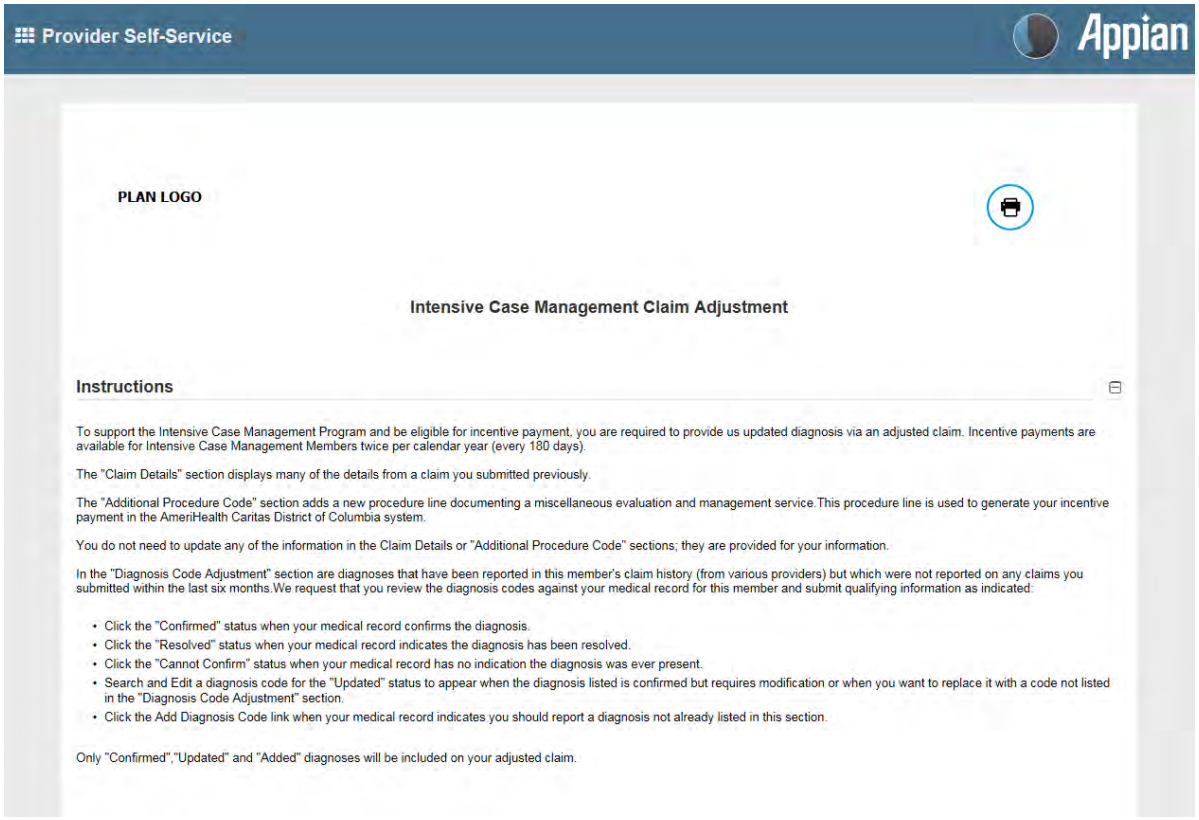
3 items

Back

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.



Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

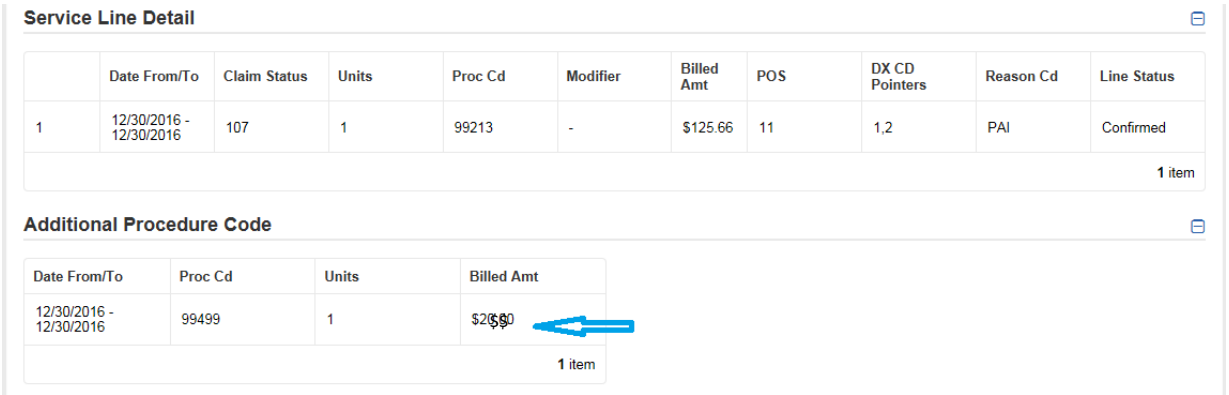
Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:
Paid Date: 05/29/2017
Diagnosis Codes: Z91.09

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

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

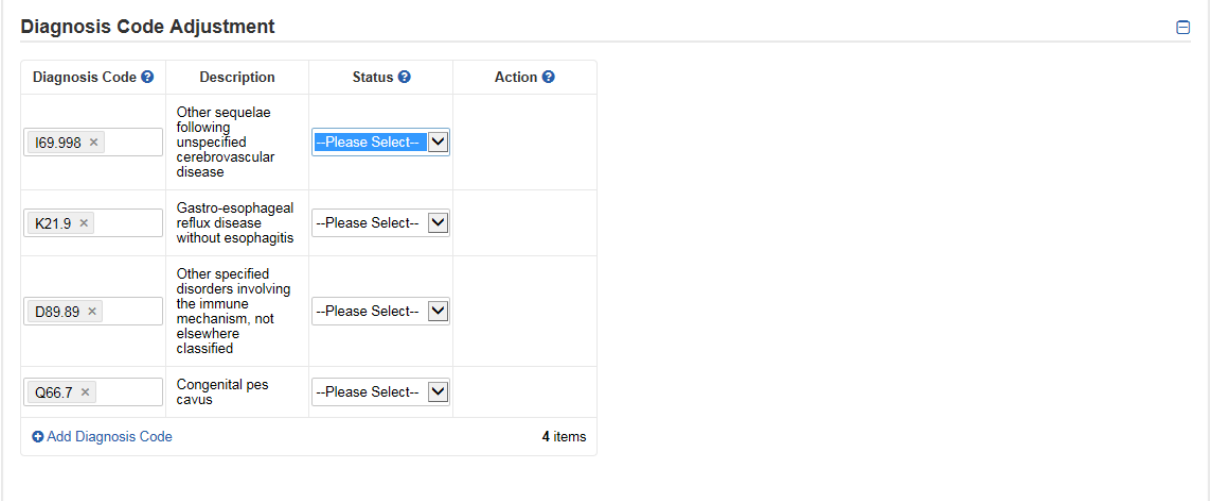
1 item

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
12/30/2016 - 12/30/2016	99499	1	$20.00

1 item

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

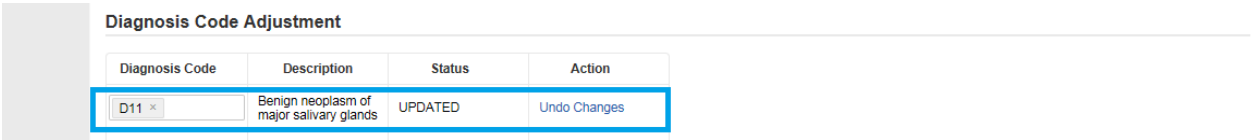


IV. Based on your review of the member's medial record for the date of service listed on the claim, select the appropriate status for each diagnosis code under "Diagnosis Code Adjustment":

a. **Confirmed** – Attesting that you confirm the diagnosis is still present.
b. **Resolved** – Attesting that the diagnosis has been treated and is no longer present.
c. **Cannot Confirm** – Attesting that you do not have record(s) of this diagnosis; never present.
d. **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

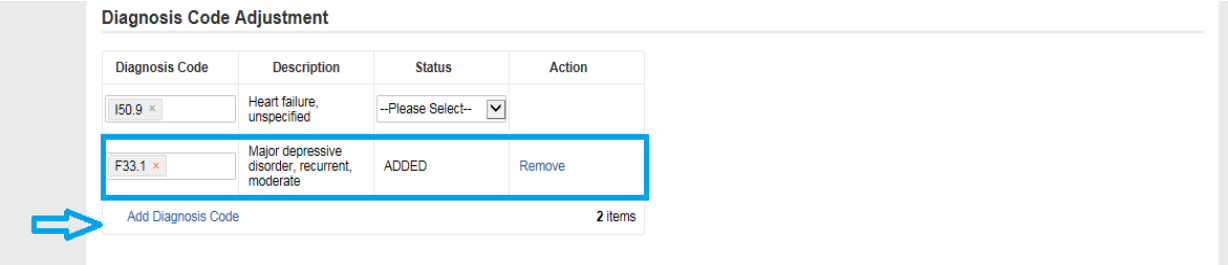
Please remember, the diagnosis codes presented here may or may not have originated from claims that you submitted. The member may have been treated in the ER or Urgent Care, or by another provider type, and may have been diagnosed by a provider not associated with your practice.

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".



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.



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.)

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.**"

PLAN LOGO

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

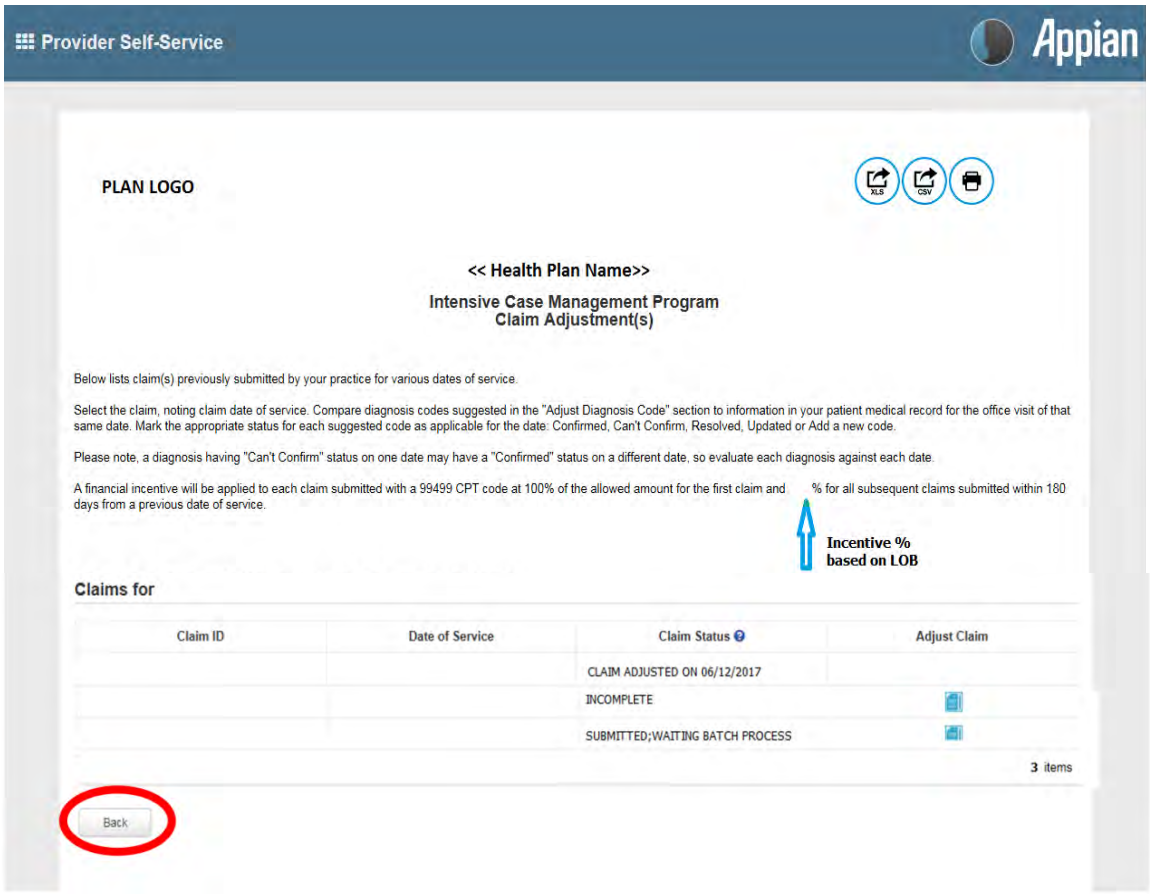
3 items

Contact Information

Contact Name:
Phone Number:

Submit Edit

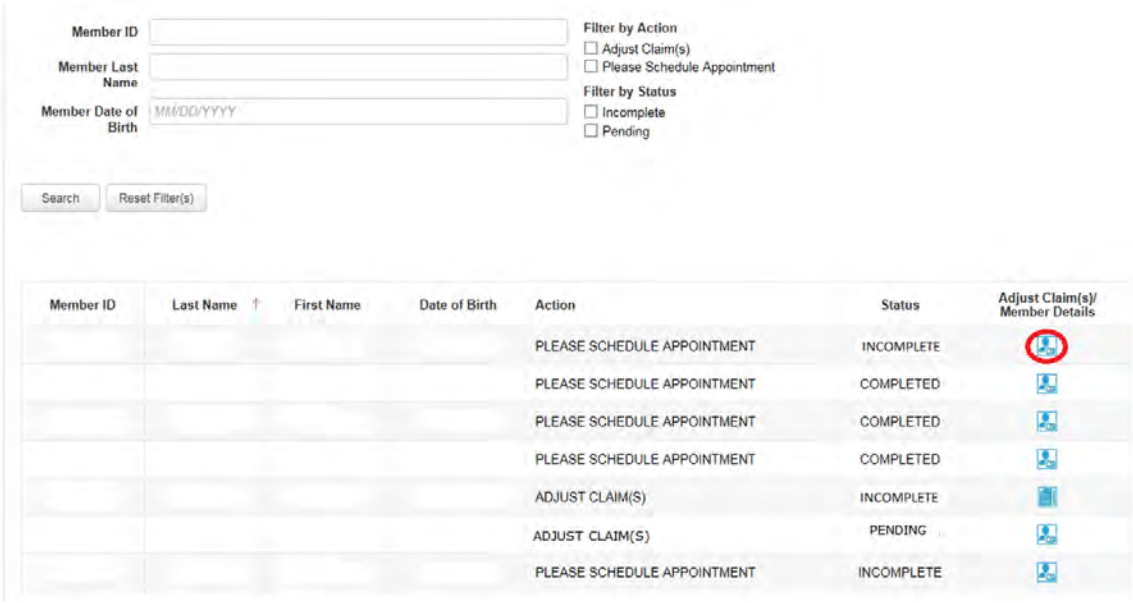
X. After submitting the adjustment, the user is returned to the Claim Listing screen if there are additional claims to adjust. Proceed to the next claim for adjustment or click the Back button to return to the Member Listing screen.



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.

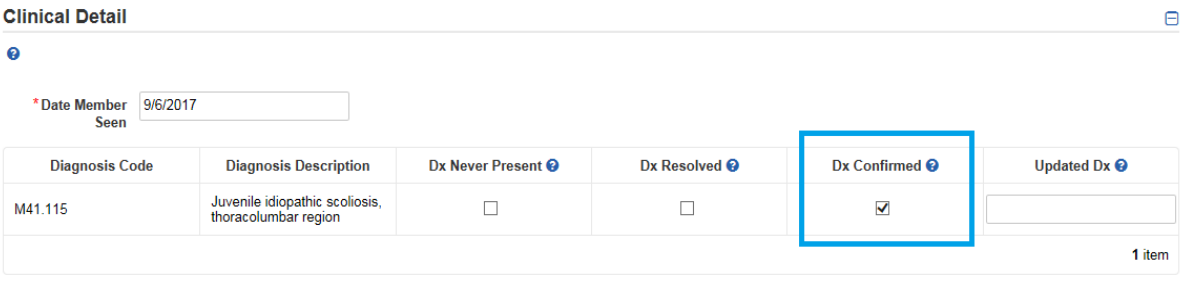
I. Under "Adjust Claim(s)/Member Details," click on the **Member Details Icon** to view the member worksheet. The worksheet is there to help track your efforts in outreach and appointment scheduling for the member. Once the member presents for an appointment, you can also use this worksheet to report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



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.

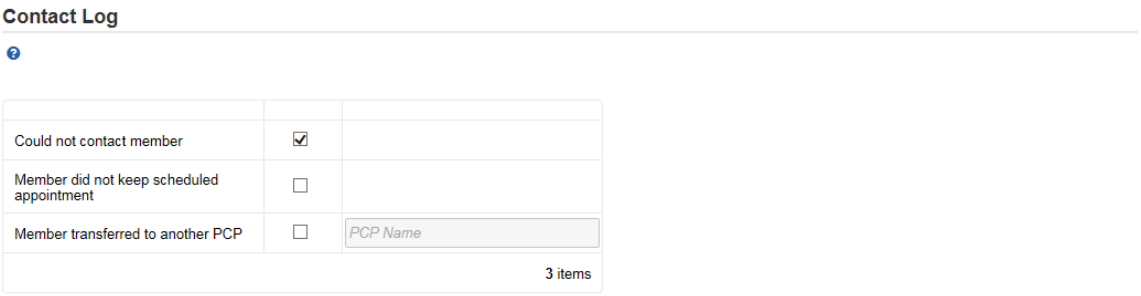
II. If you secure an appointment with the member, and he/she presents for the appointment, the physician can perform an examination to help determine if the chronic condition(s)/diagnosis is still present, never present, or resolved. There is also an option to update the diagnosis with a more accurate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

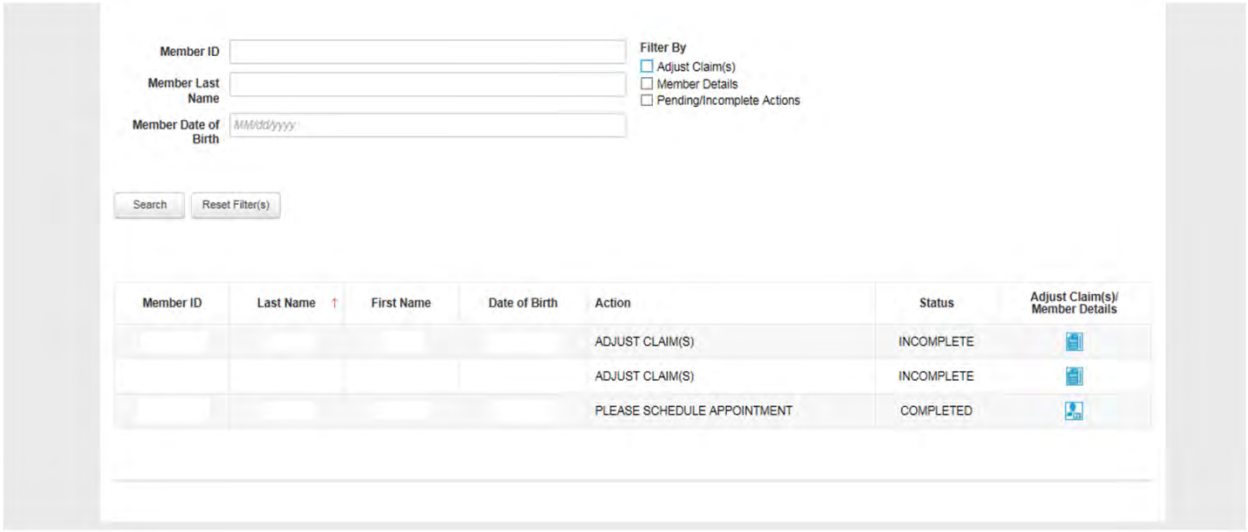


III. If you are unable to secure an appointment, and/or the member does not keep a scheduled appointment, there are options to report this information as well. Please choose one of the following three options, as appropriate for each case:

- Could not contact member.
- Member did not keep scheduled appointment.
- Member transferred to another Primary Care Practitioner.



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.

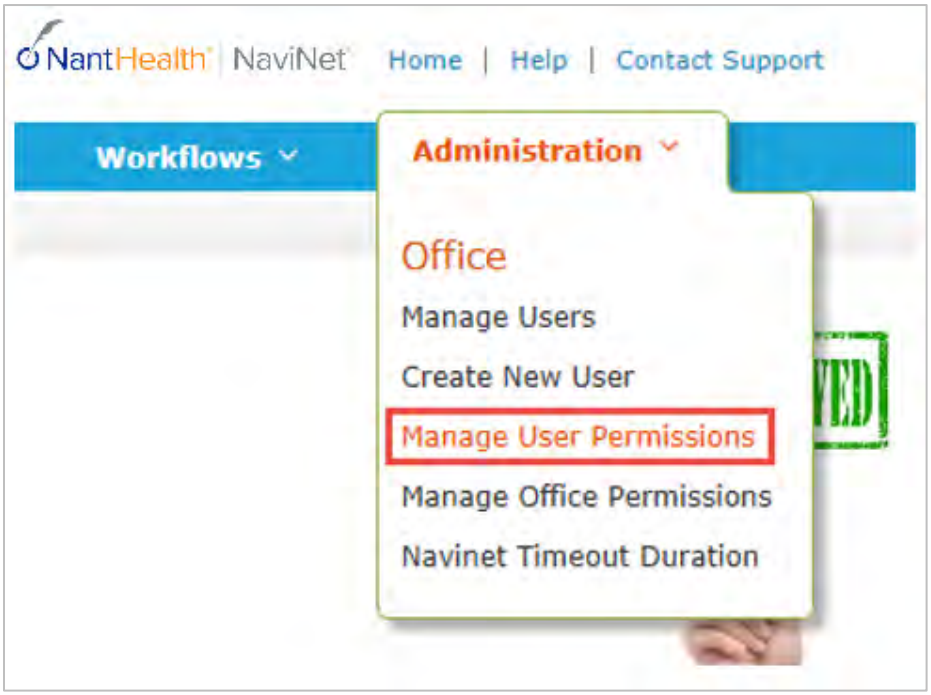


Supplemental Information

Enabling Document Exchange for a Plan Service User (PSU)

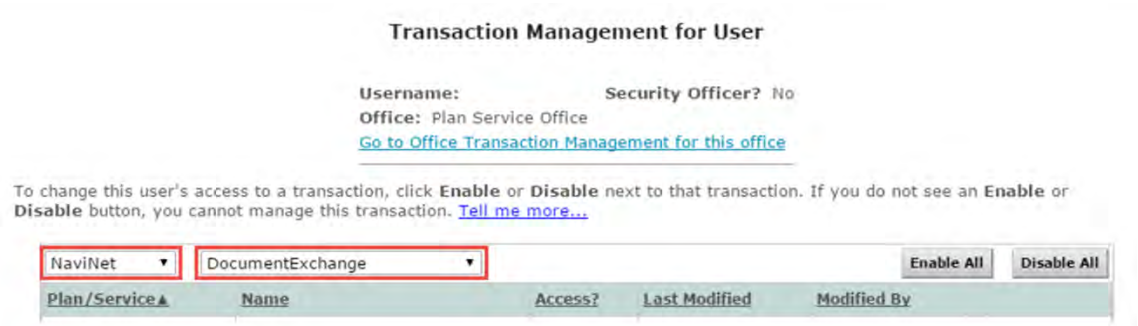
A NaviNet Security Office can follow the steps below to enable Document Exchange for a Plan Service User (PSU):

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

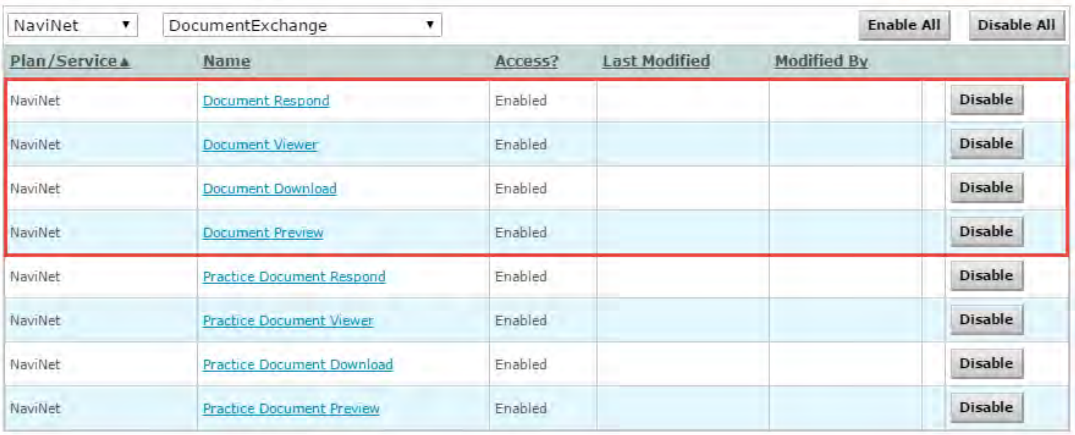


2. From the next screen, select the user whose permissions you want to adjust, then select **Edit Access**.

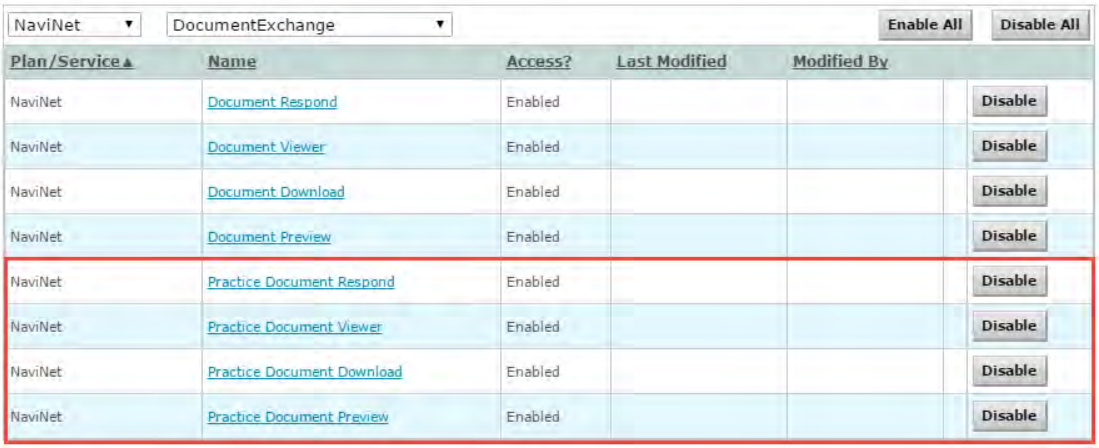
3. The next screen is titled “Transaction Management for User _____”. From this screen, select **NaviNet** in the Plan’s drop-down list and select **DocumentExchange** in the Group’s drop-down list.



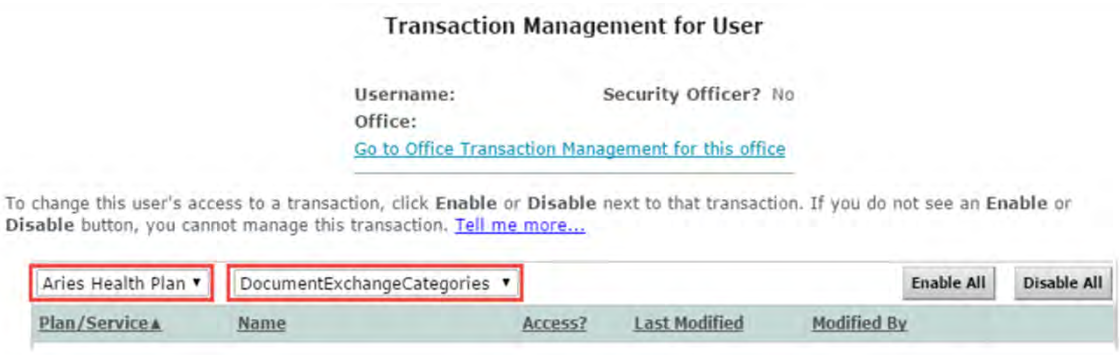
4. It’s important to note, “Patient Clinical Documents” are enabled for all users by default. But you will want to confirm that the global permissions for “Patient Clinical Documents” are set appropriately:
    a. For a user to *view* Patient Clinical Documents, both **Document Viewer** and **Document 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.)



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.)

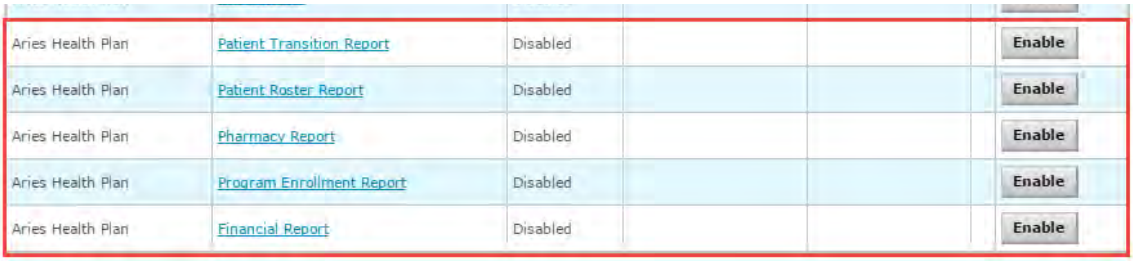


6. Now that you have confirmed the global permissions, you need to enable the specific permissions. First, select the **appropriate health plan** in the Plan’s drop-down list and **DocumentExchangeCategories** in the Group’s drop-down list.



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

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

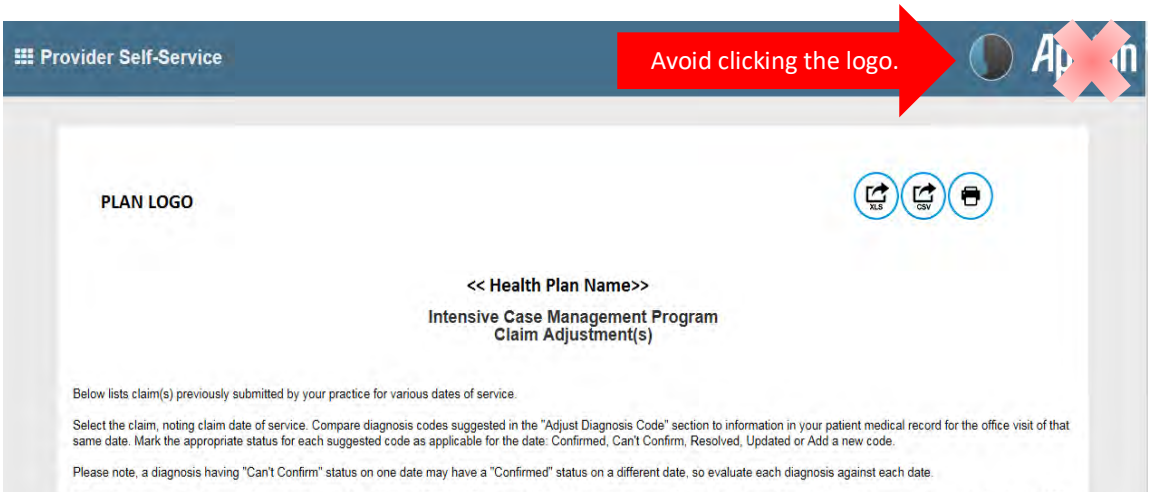


Aries Health Plan	Patient Transition Report	Disabled			Enable
Aries Health Plan	Patient Roster Report	Disabled			Enable
Aries Health Plan	Pharmacy Report	Disabled			Enable
Aries Health Plan	Program Enrollment Report	Disabled			Enable
Aries Health Plan	Financial Report	Disabled			Enable

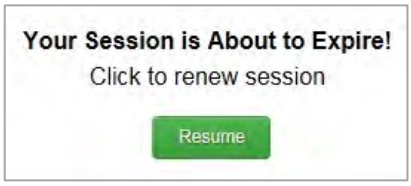
9. Finally, for access to all ICM activities, make sure **Patient Roaster Report** and **Patient Consideration** document categories are enabled.

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.

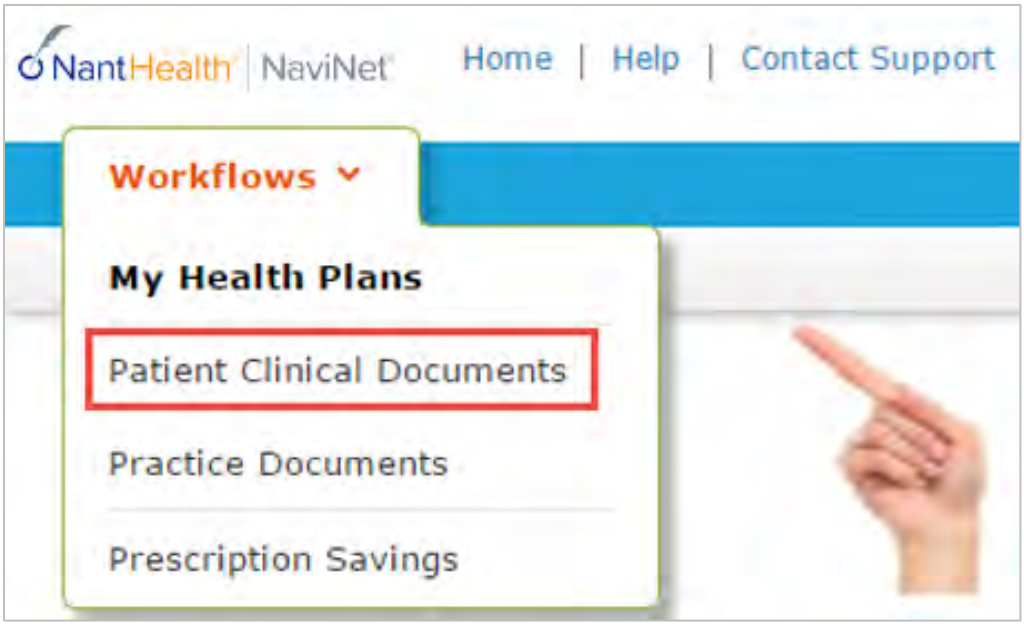
Alternative Workflow – "Patient Clinical Documents"

About Workflows – "Practice Documents" vs. "Patient Clinical Documents"

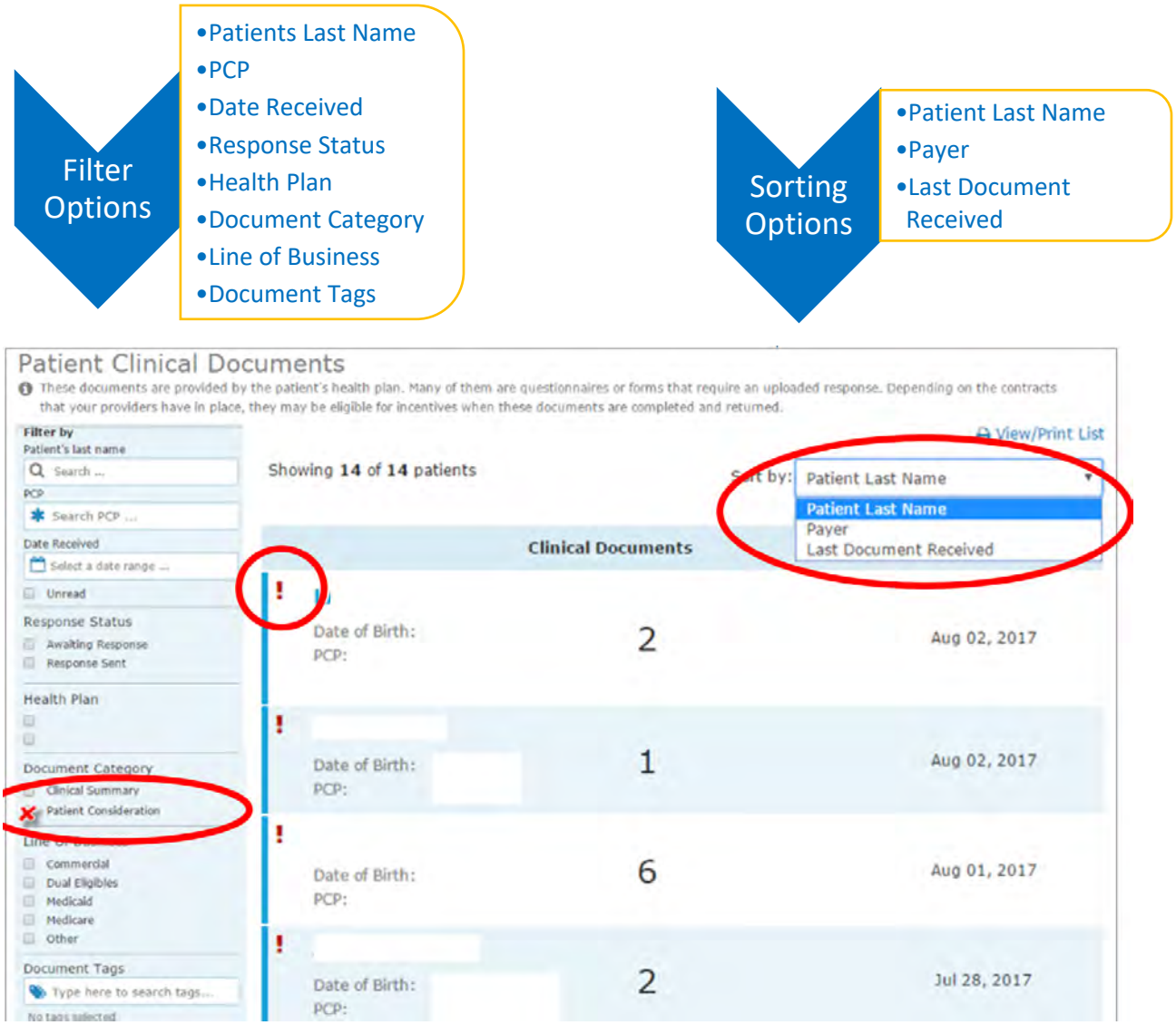
The steps below describe the "Patient Clinical Documents" workflow, which is focused on individual member information and is particularly helpful for accessing "need to schedule" member information.

*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.

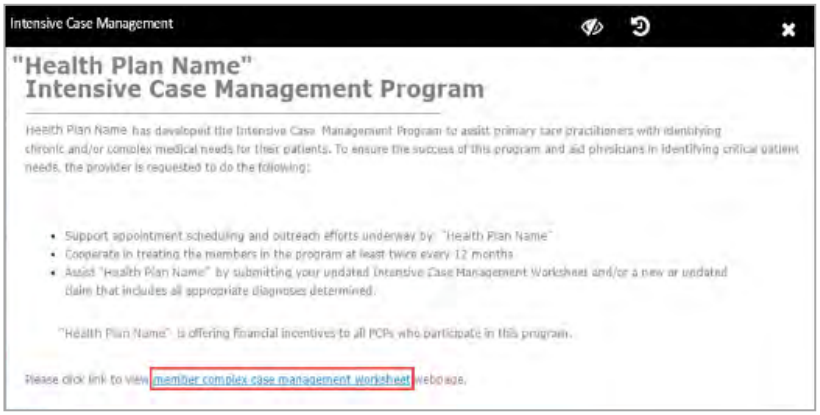


C. Use the enhanced filter and sorting options to look for specific records.
D. To view ICM-related documents, filter for **Patient Consideration** under "Document Category". Or, type **Intensive Case Management** into the "Document Tags" field.
E. Check for **a Red Exclamation Point** to indicate that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



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

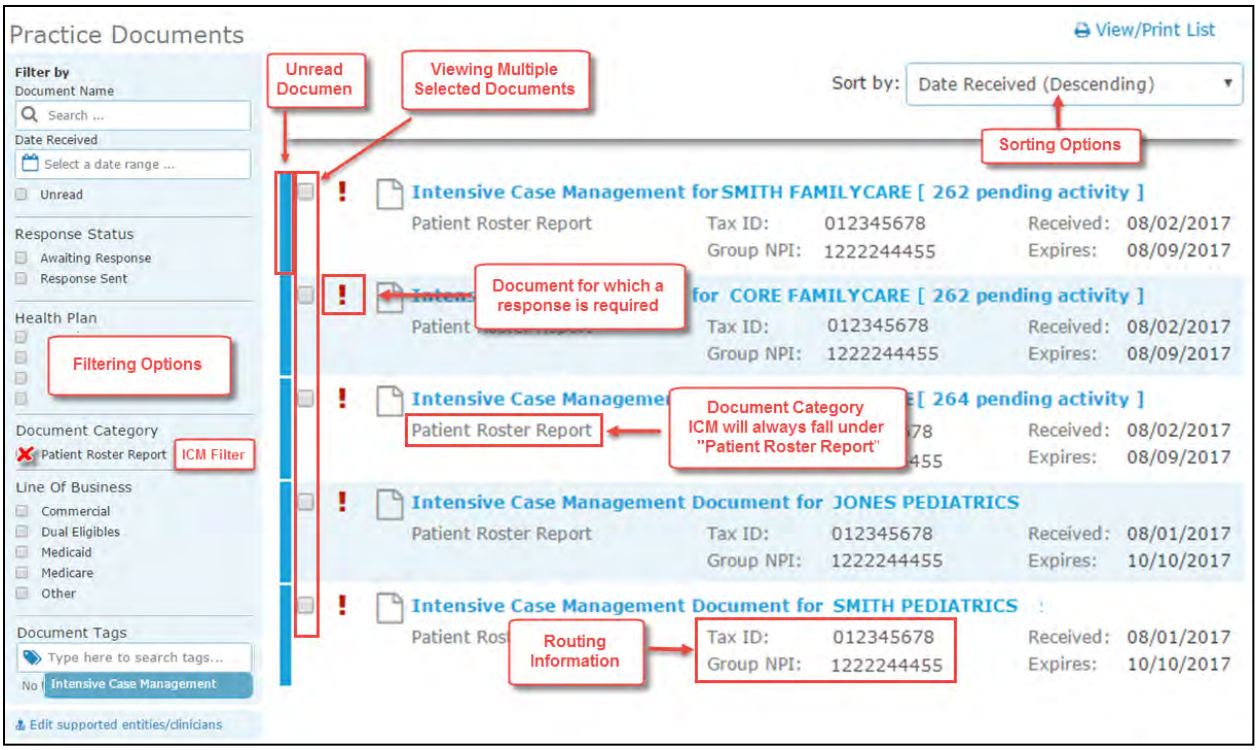
1. Anatomy of the starting screen for the **Practice Documents** workflow:

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

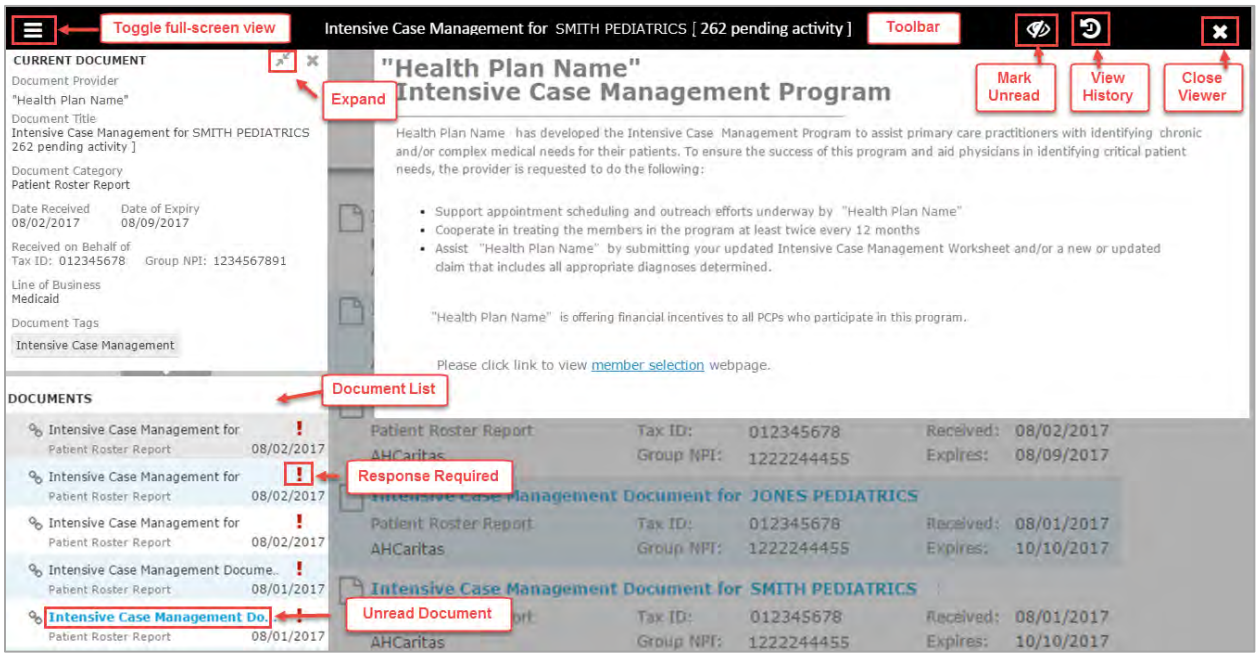
A red exclamation point indicates that a response is requested for this document.

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.



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



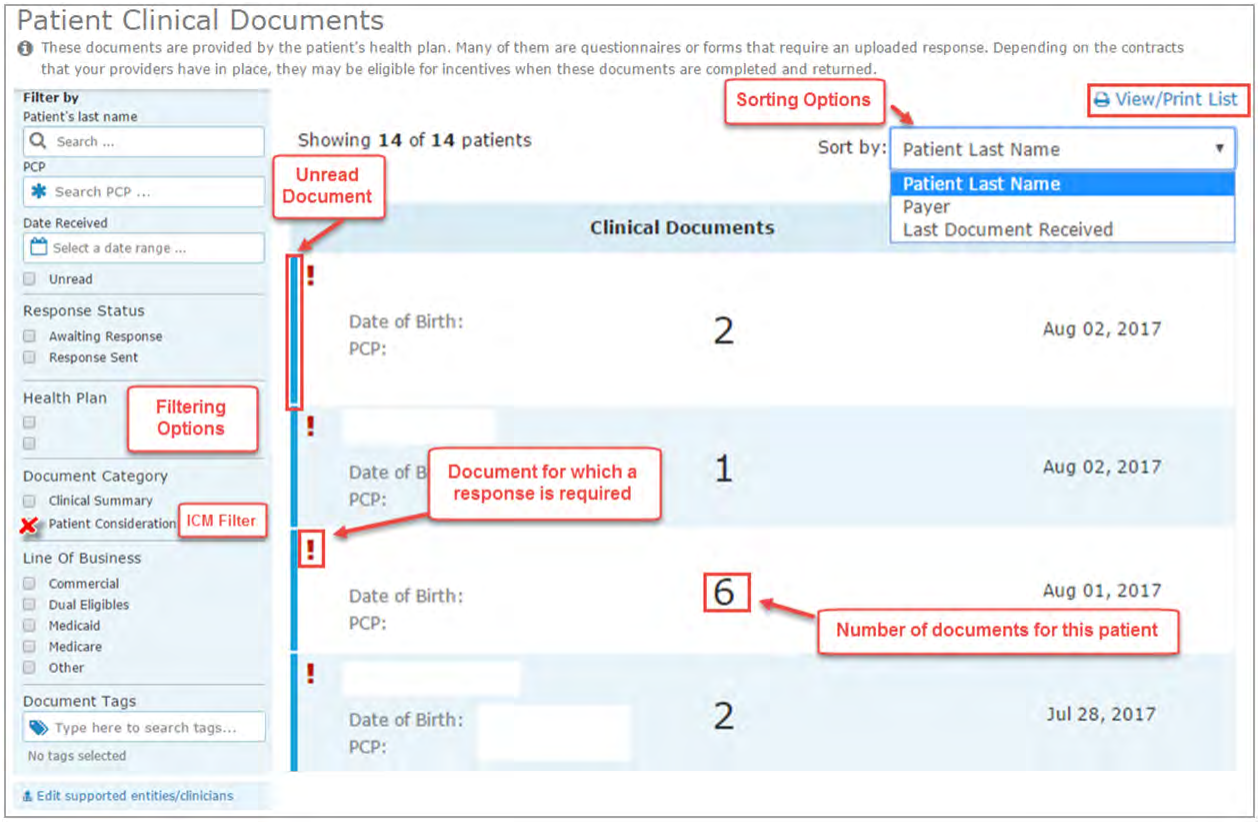
- Toolbar
    a. The left side of the toolbar lets the user toggle full screen view and shows the current document's file type and title. The right side lets the user mark the current document as unread.

- 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.

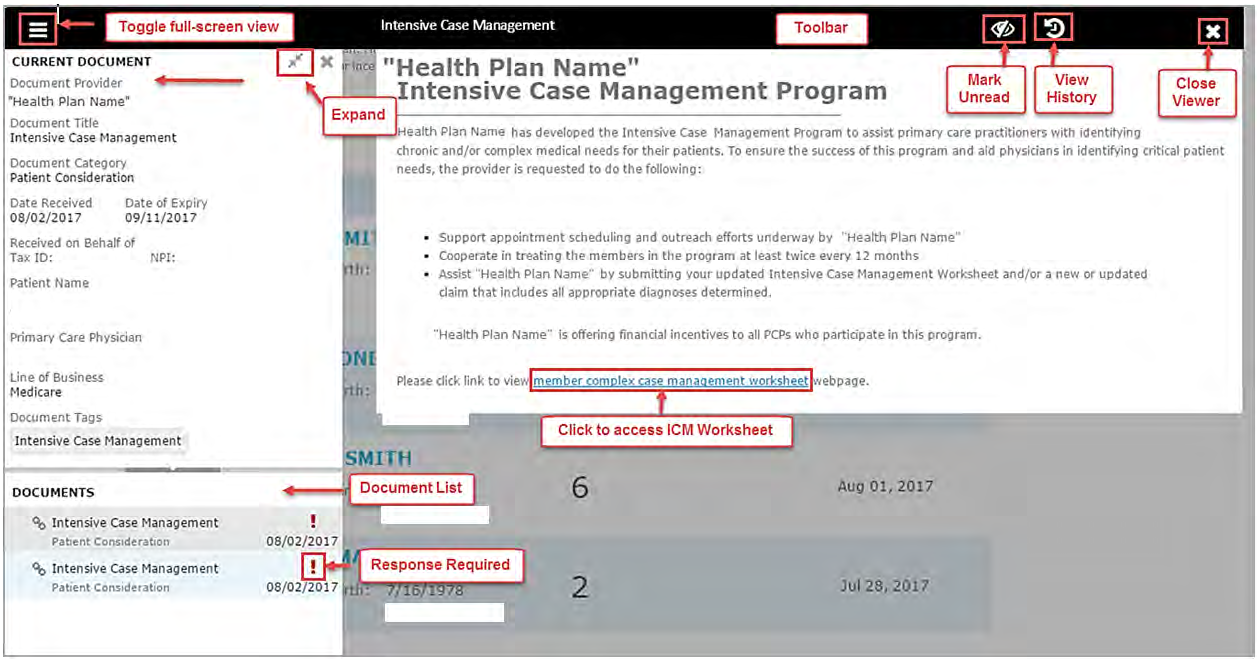
- Current Document Summary
    a. Gives information on the current document, such as the health plan that sent the document, the document category, line of business, document name, and received and expiry dates. Document routing and tag information is also displayed. Users can expand the window to see any hidden information.

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.



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.

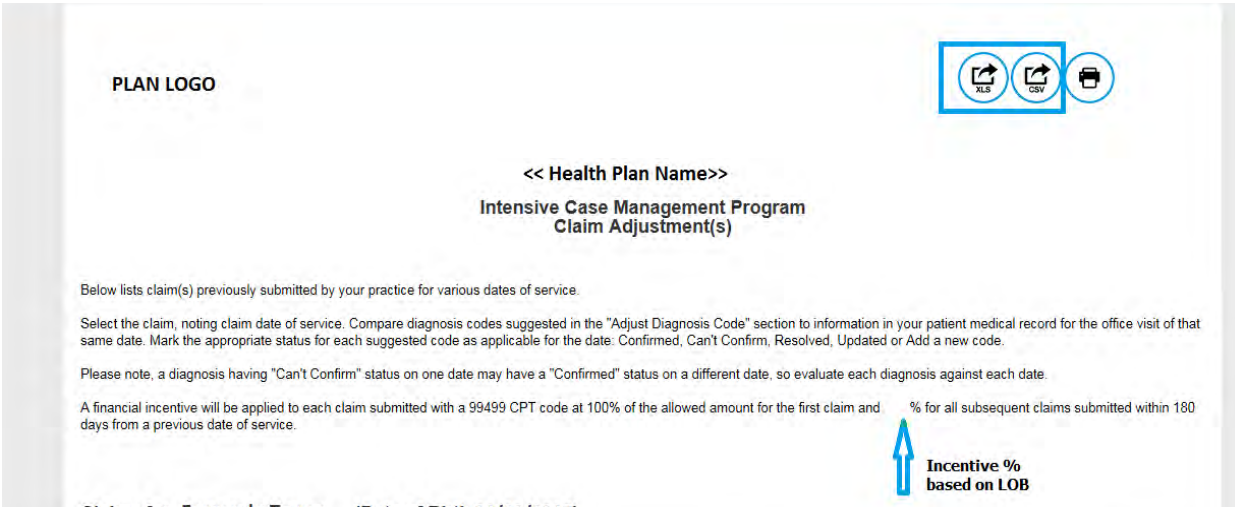
Popup Blocker Must be Disabled

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.

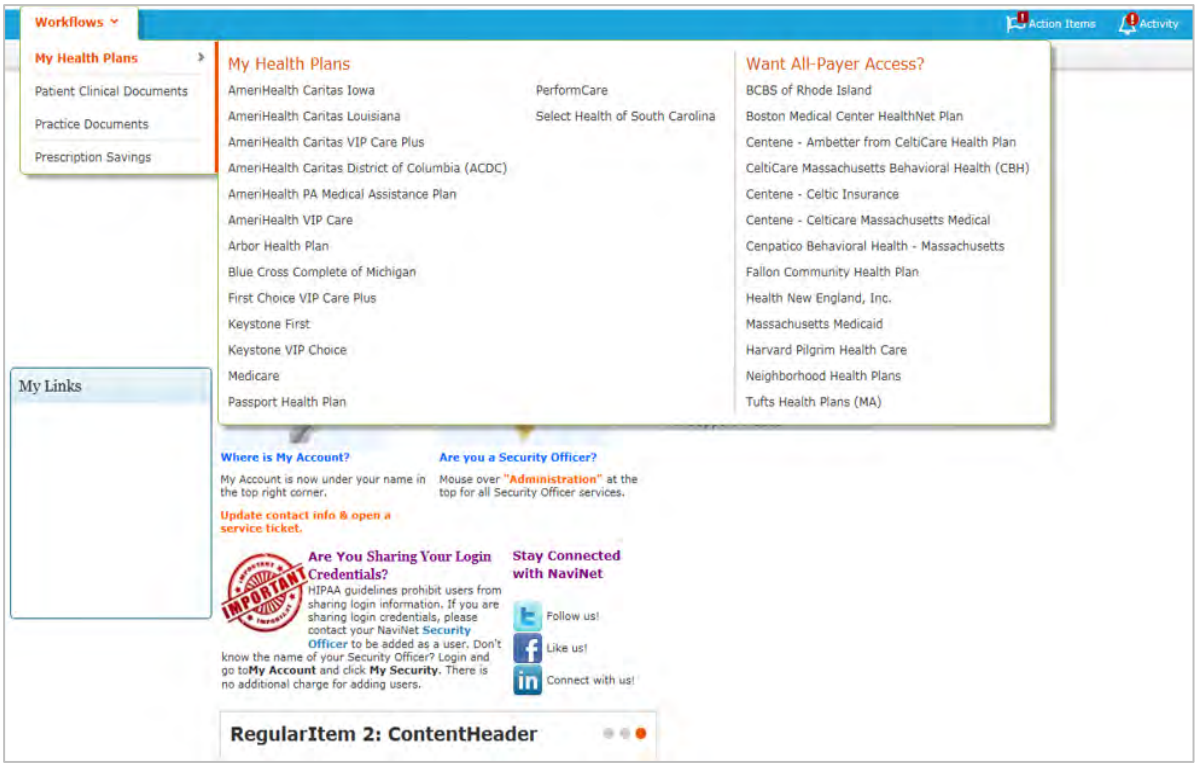


- The third icon displays instructions for printing (press CTRL + P).

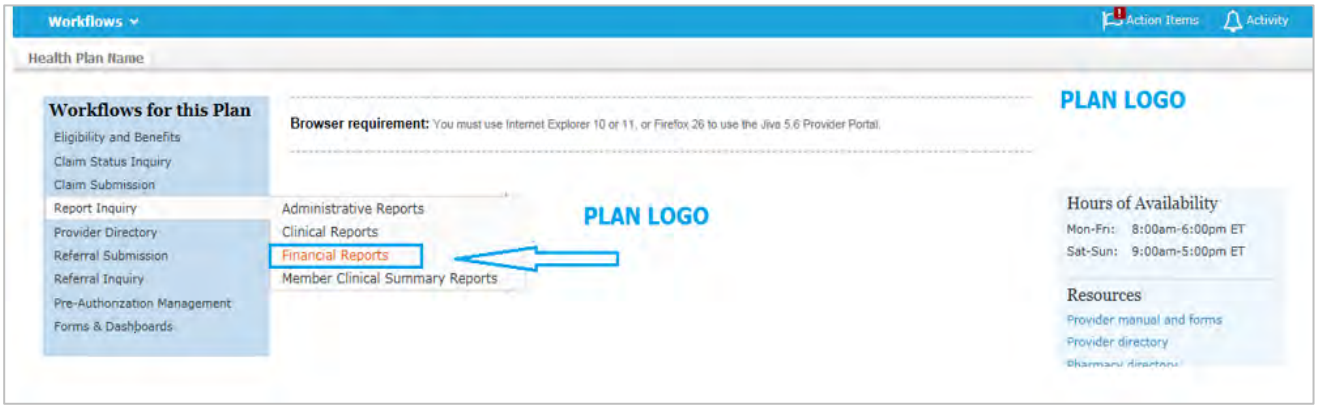
Report Generation

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.

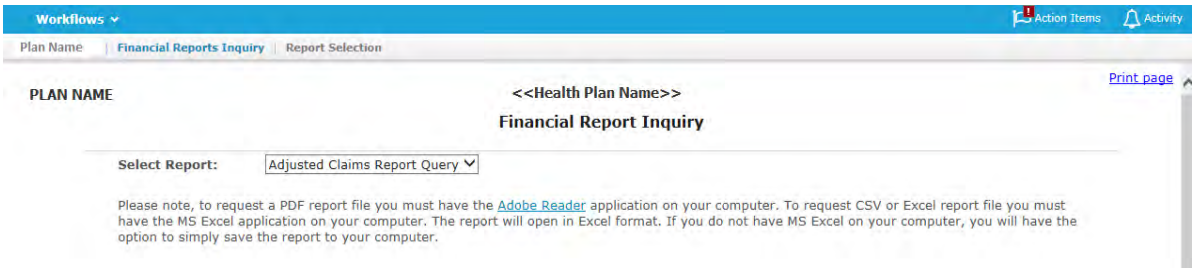
1. Select **Workflows** in the upper left of the NaviNet screen.
2. Drop down and select **My Health Plans** from the list of workflows.
3. Choose the health plan for which you want to pull a report.



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

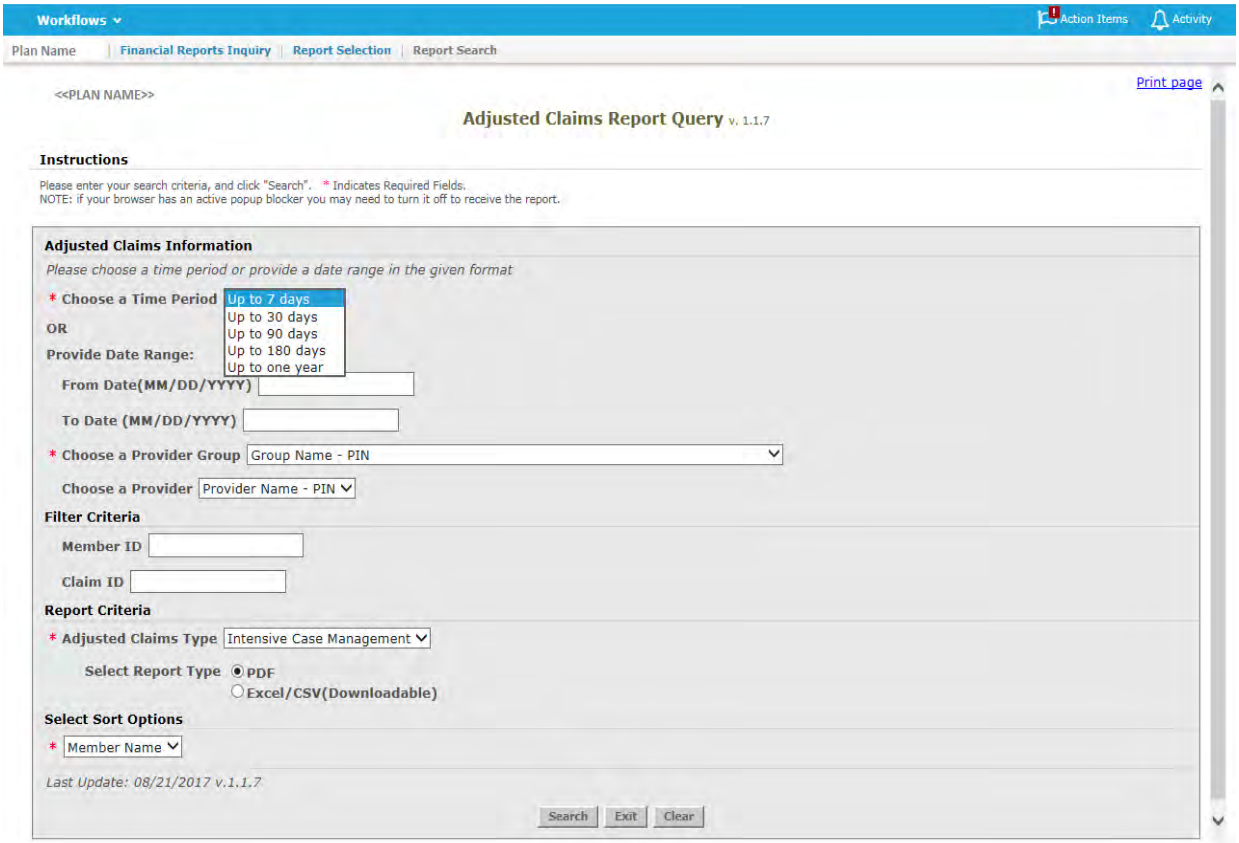


5. Finally, select **Adjusted Claims Report Query** from the drop-down list.



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 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 Z418-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:

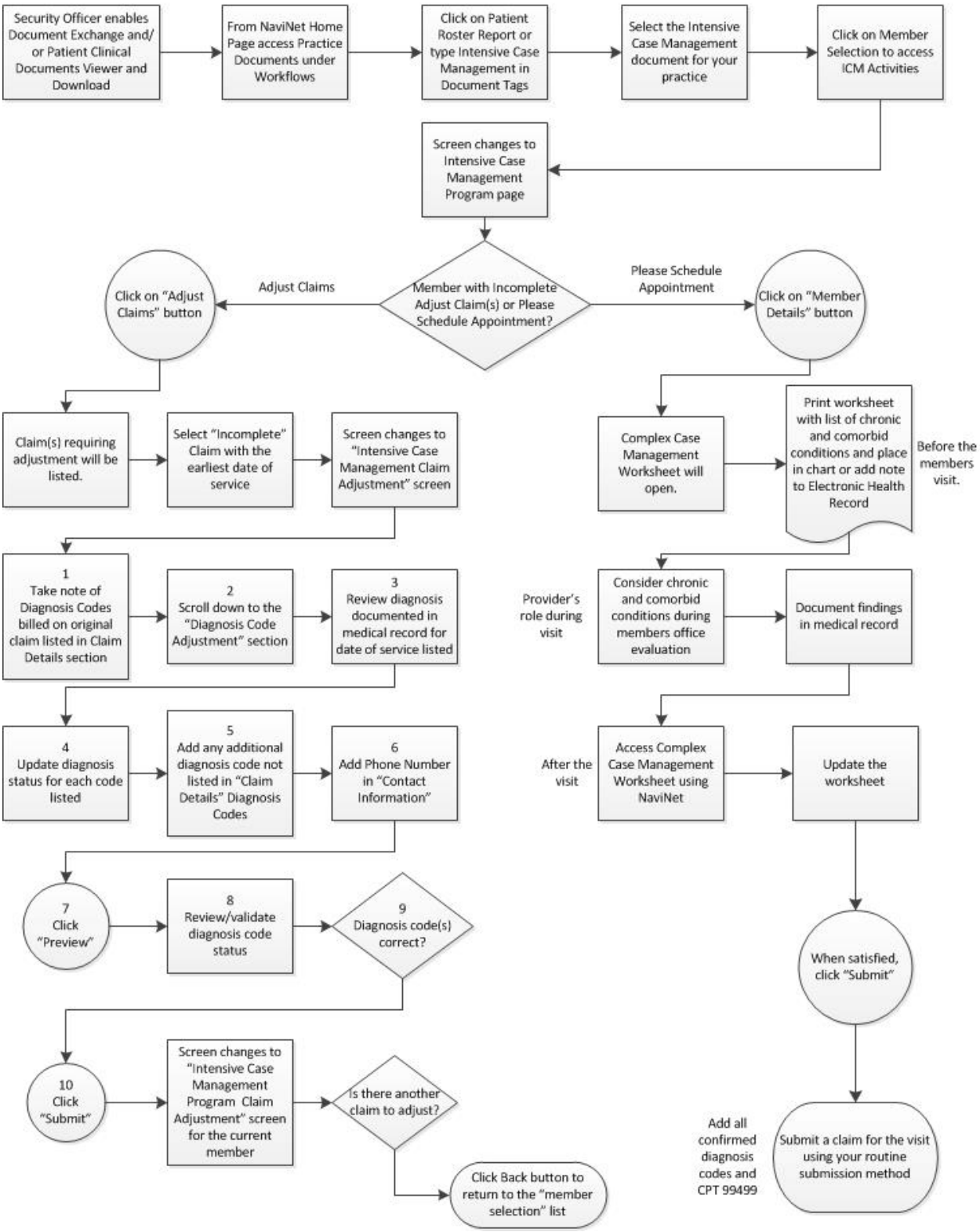
Total Paid Amount:

Total Count by Claim Status:

Claim processed successfully :

Other Status :

Attachment 1: Example Process Flow for Intensive Case Management Process



Attachment 2: Example Claim Attestation Report

Claim Attestation Summary Report

Group Name:

Group ID:

Service Provider ID:
Service Provider Name:
Service Representative:
Service Representative Phone:

Patient ID	Patient First Name	Patient Last Name	Patient DOB	Date of Service	Claim ID	Submitted Diagnosis Code(s)	Additional Diagnosis Code(s)

Signature below indicates provider/provider office staff agrees that the claim identified for the patient on the noted date of service should be adjusted with any additional diagnosis codes identified and the procedure code 99499 (unlisted evaluation and management service.)

Name / Title

Signature and Date

AmeriHealth Caritas™

District of Columbia

www.amerihealthcaritasdc.com

ACDC-19671400-1

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Any individual depicted is a model.

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Provider Guide:

Intensive Case Management Program

Table of Contents

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-abstraction 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 support 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

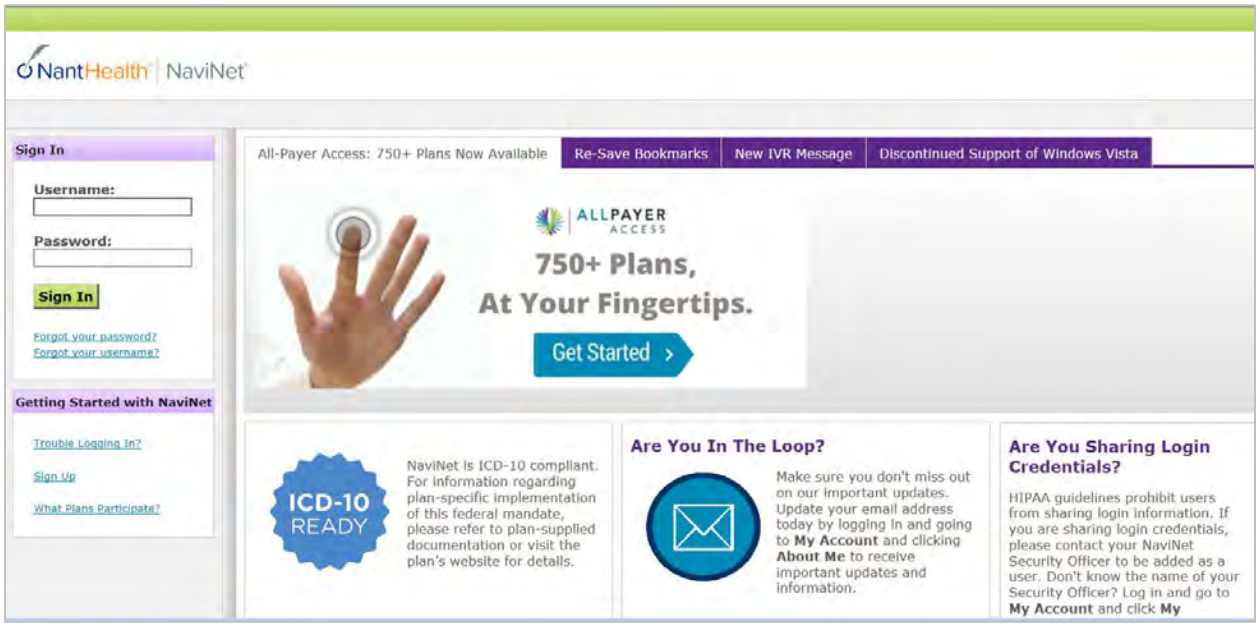
Check with your NaviNet Security Officer to confirm that you have been granted the appropriate access to the workflows you need. If your NaviNet Security Officer has not enabled Document Exchange, please ask your Security Officer to follow the steps outlined on pages 20 through 23 in the "Supplemental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

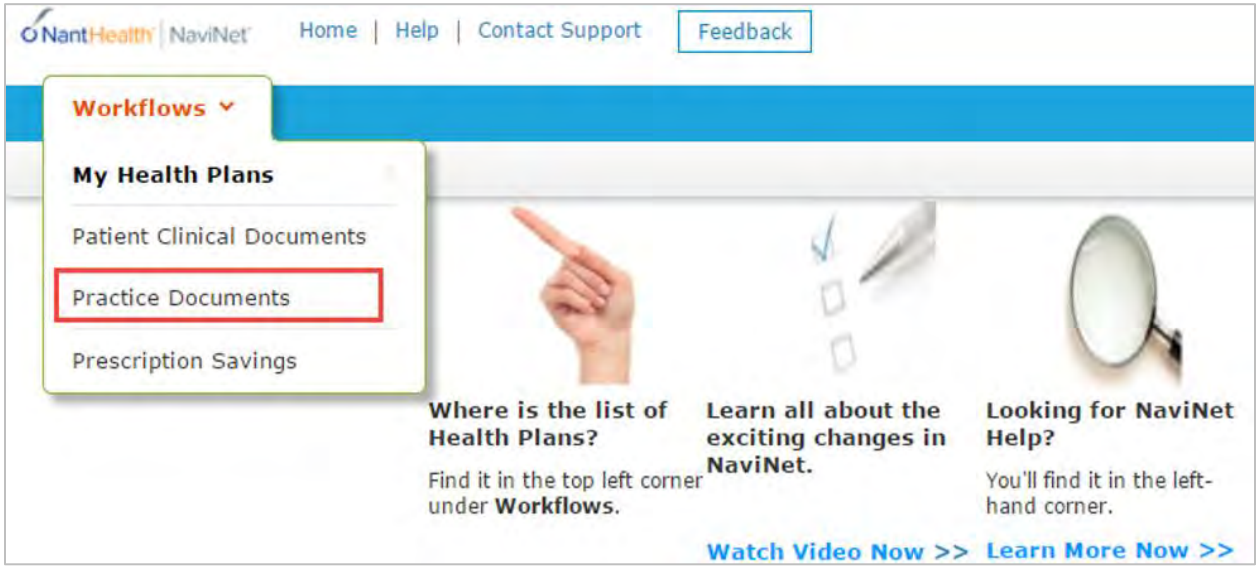
Step 1. Log-In to NaviNet

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**.



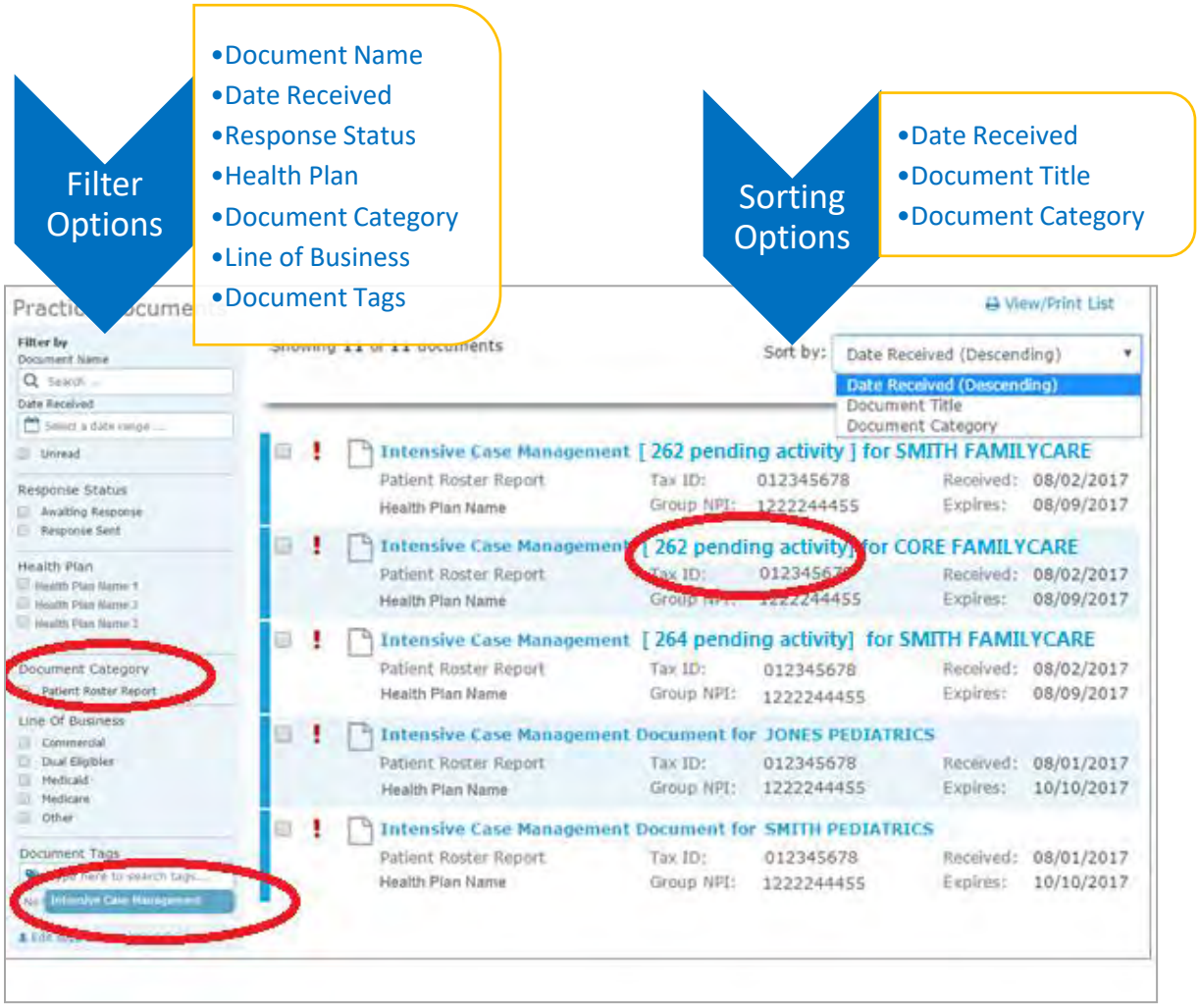
Step 2. Access “Practice Documents” Workflow

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



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

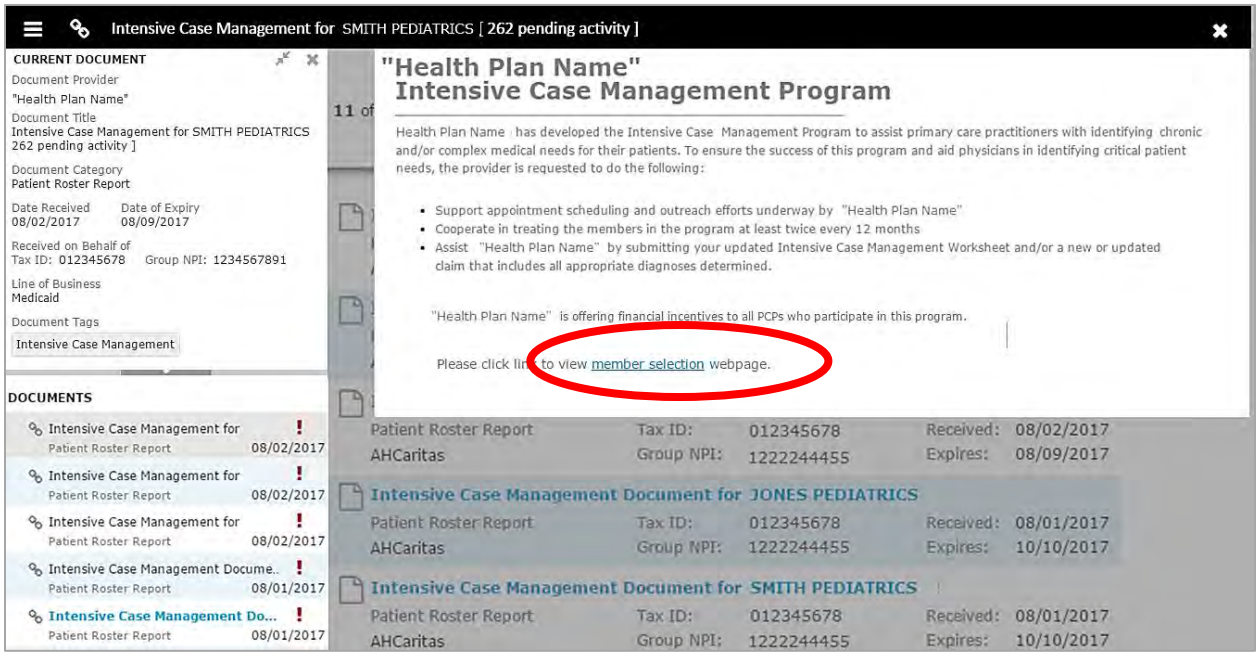
A. Use the enhanced filter and sorting options to look for specific records.
B. To view ICM-related documents, filter for **Patient Roster Report** under "Document Category". Or, type **Intensive Case Management** into the "Document Tags" field.
C. Check for **Pending Activity** by looking for the indicator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



Step 4. Launch "Member Selection" for ICM Activities

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

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



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 Work sheet 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.

PLAN LOGO

<<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:

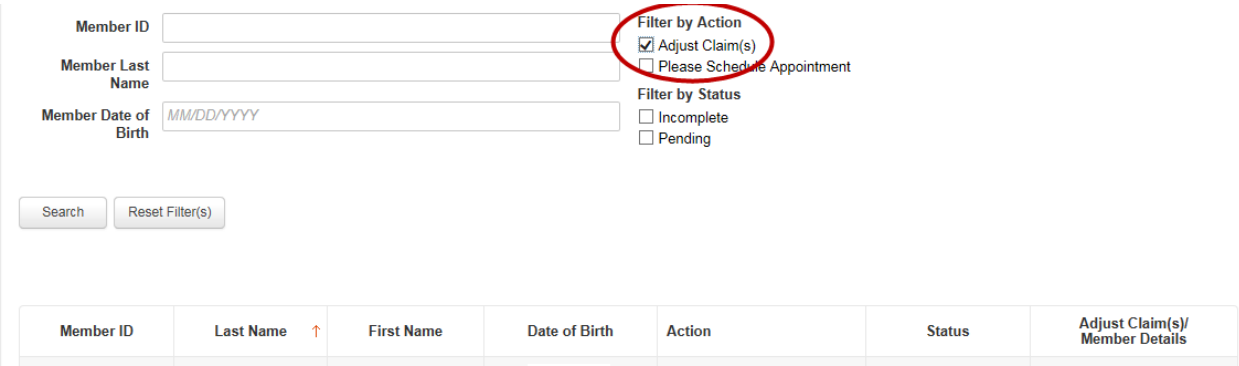
- Support appointment scheduling and outreach efforts underway by <<Health Plan Name>>
- Cooperate in treating the members in the program at least twice every 12 months.
- Assist <Plan Name> by submitting your updated Intensive Case Management Worksheet and/or a new or updated claim that includes all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

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

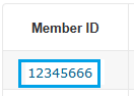
Detailed information and instructions can be accessed on the <Plan Name> website.

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)”:



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.

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	

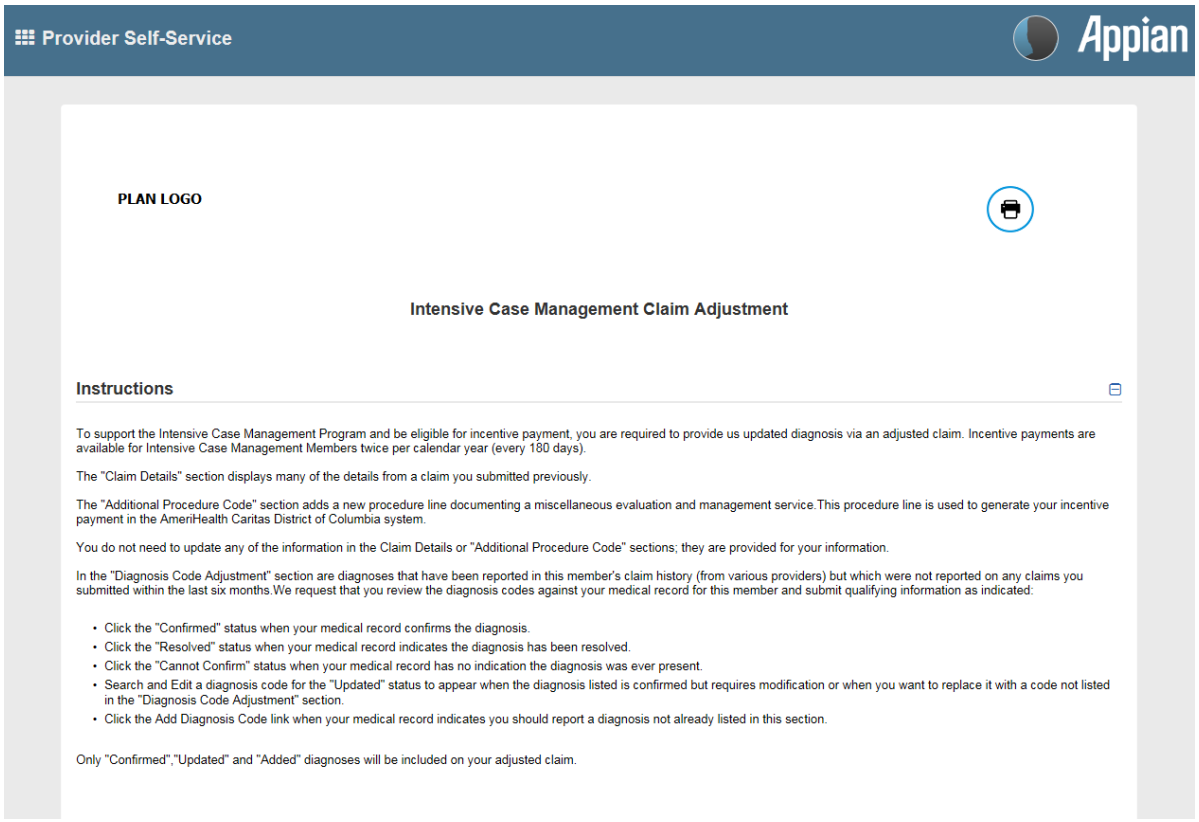
3 items

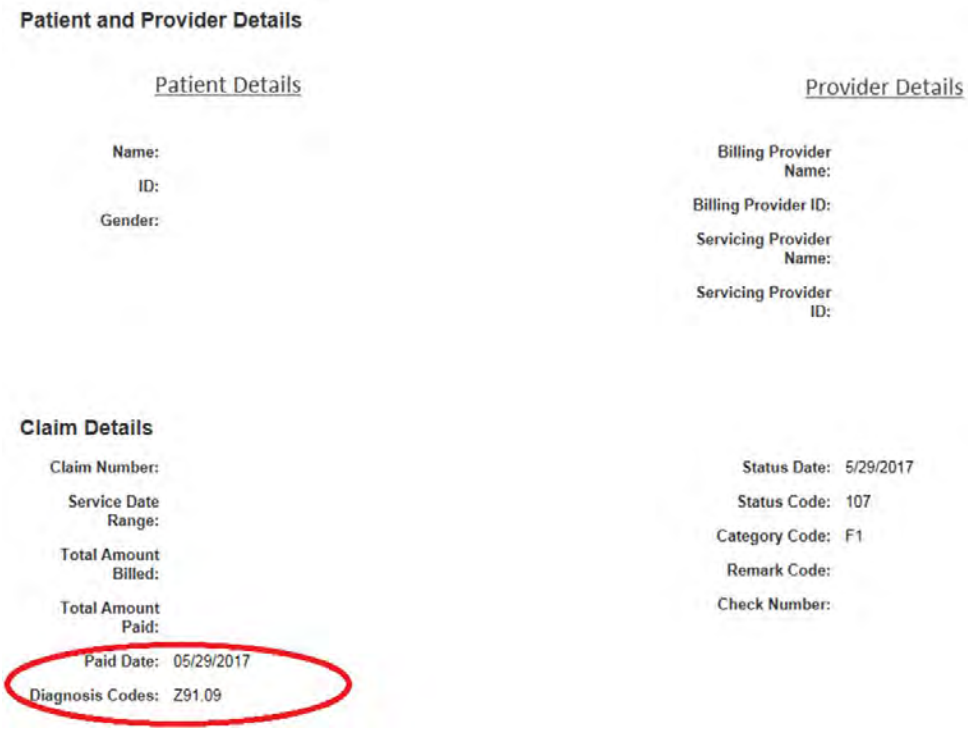
Back

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.





Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

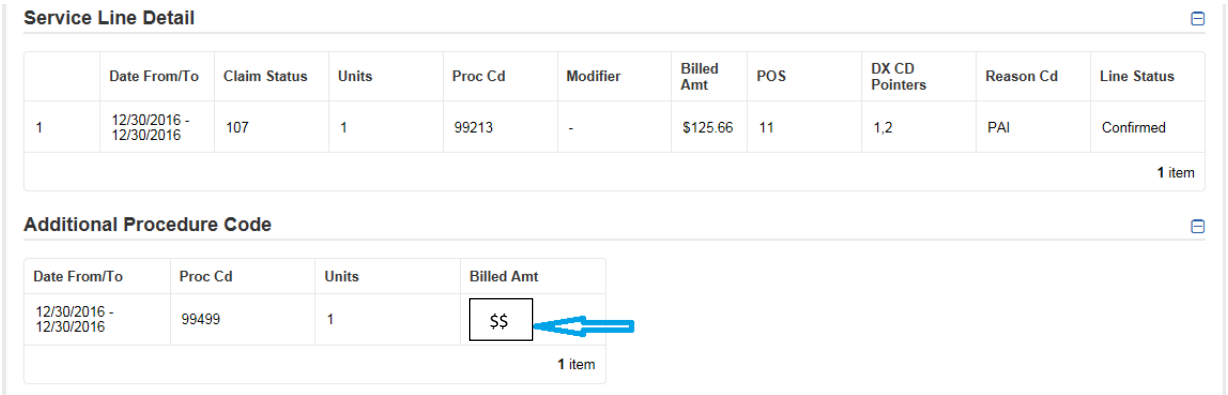
Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:
Paid Date: 05/29/2017
Diagnosis Codes: Z91.09

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

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

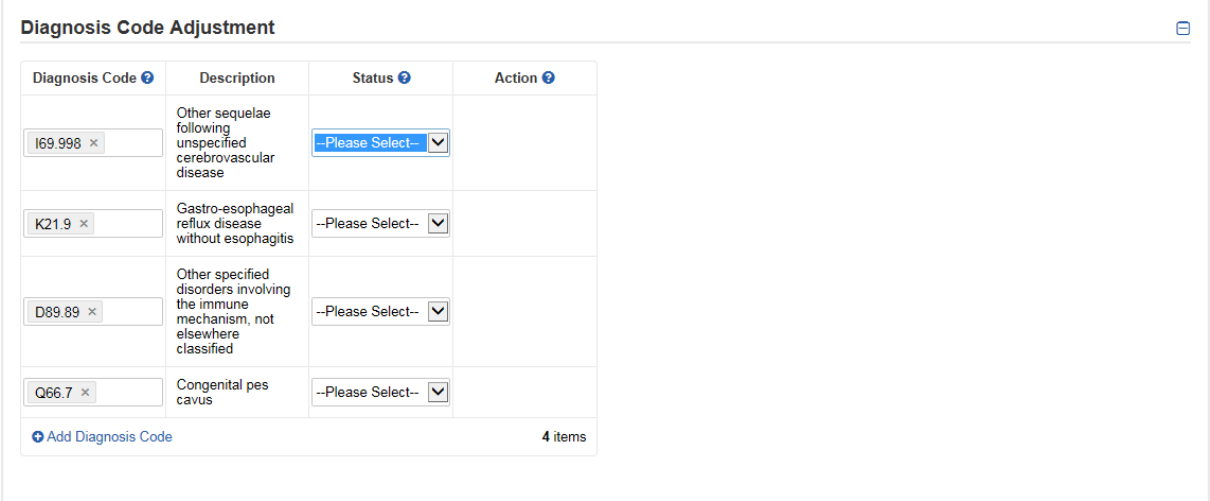
1 item

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.

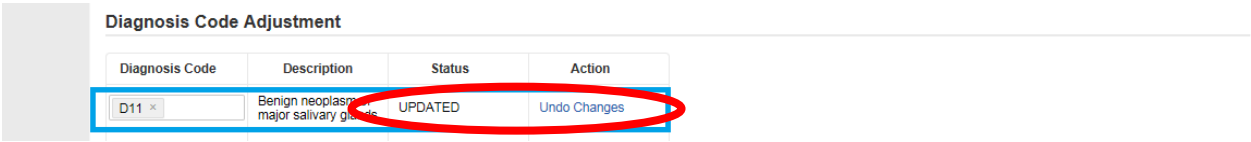


IV. Based on your review of the member's medial record for the date of service listed on the claim, select the appropriate status for each diagnosis code under "Diagnosis Code Adjustment":

a. **Confirmed** – Attesting that you confirm the diagnosis is still present.
b. **Resolved** – Attesting that the diagnosis has been treated and is no longer present.
c. **Cannot Confirm** – Attesting that you do not have record(s) of this diagnosis; never present.
d. **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

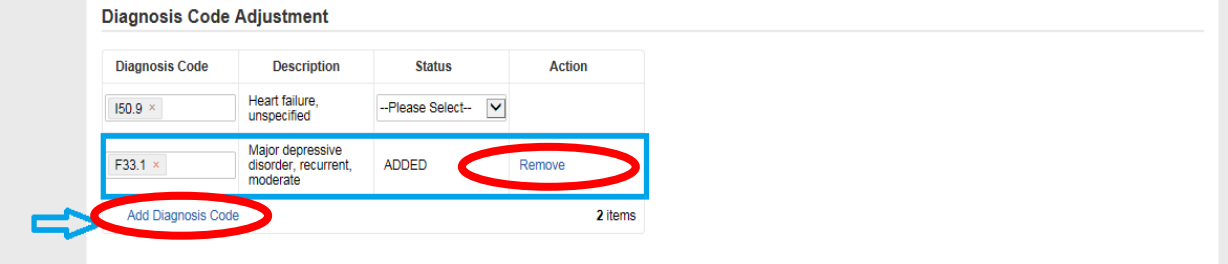
Please remember, the diagnosis codes presented here may or may not have originated from claims that you submitted. The member may have been treated in the ER or Urgent Care, or by another provider type, and may have been diagnosed by a provider not associated with your practice.

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".



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.



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.)

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.**"

PLAN LOGO

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

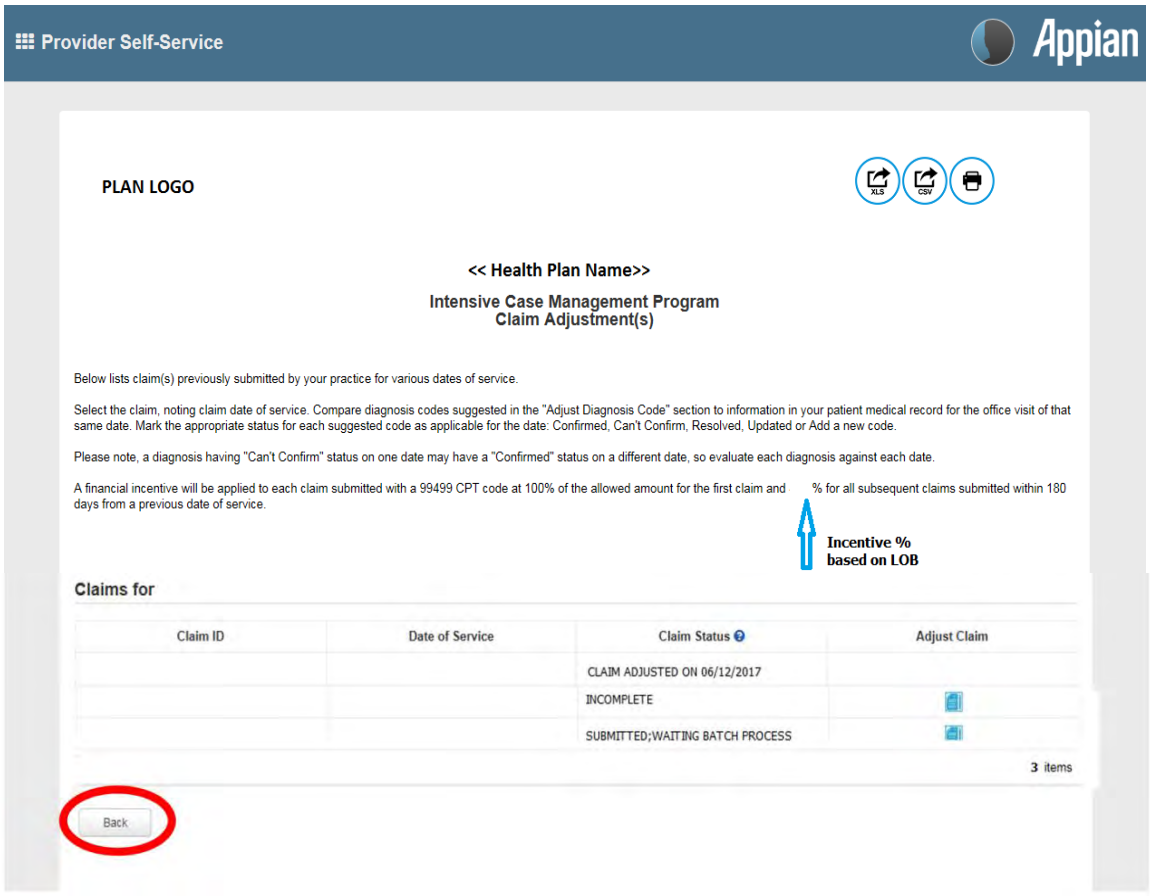
3 items

Contact Information

Contact Name:
Phone Number:

Submit Edit

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.

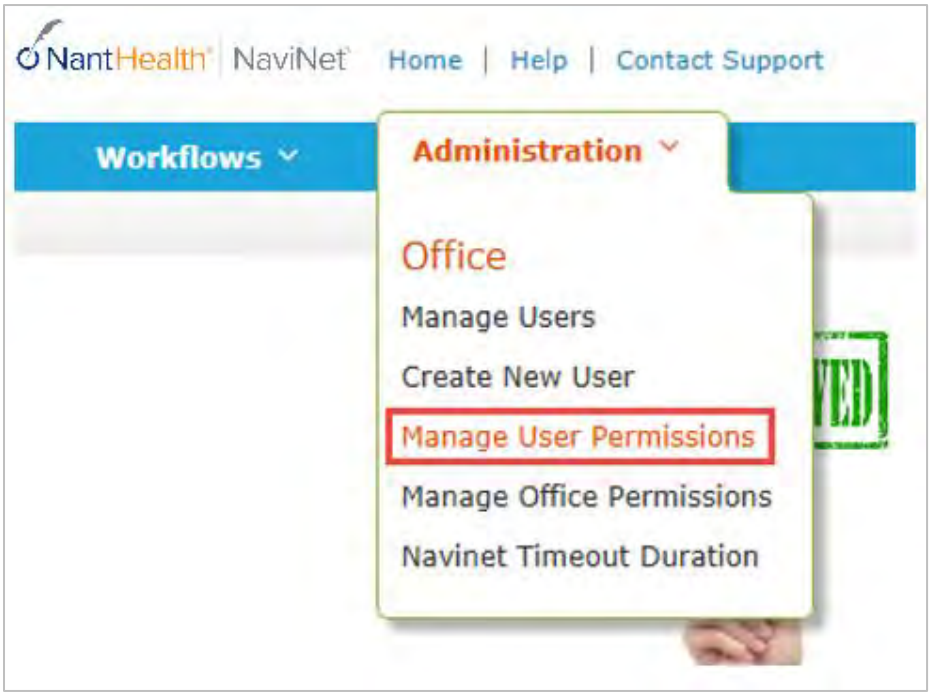


Supplemental Information

Enabling Document Exchange for a Plan Service User (PSU)

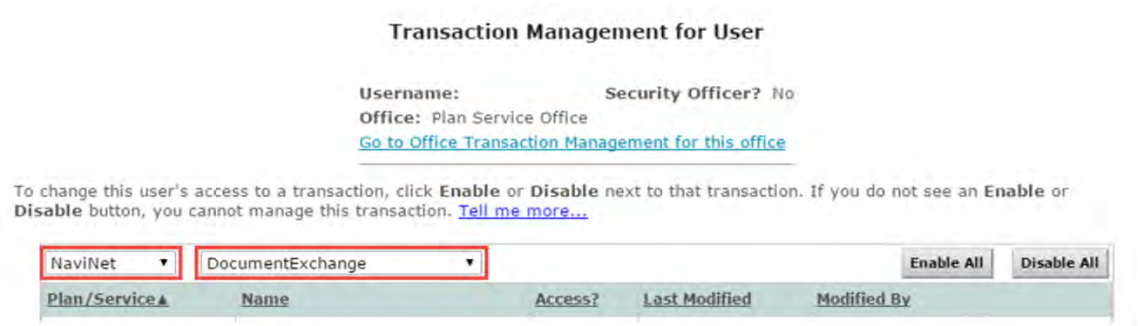
A NaviNet Security Office can follow the steps below to enable Document Exchange for a Plan Service User (PSU):

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

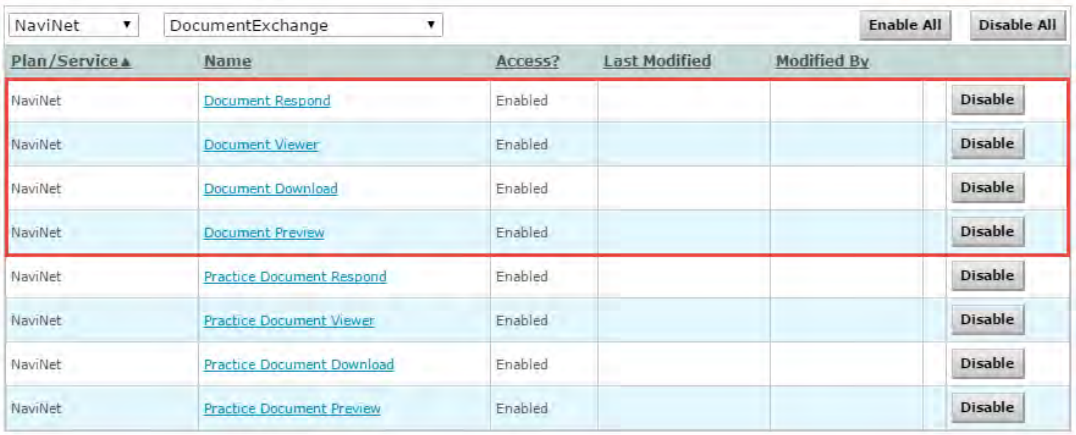


2. From the next screen, select the user whose permissions you want to adjust, and then select **Edit Access**.

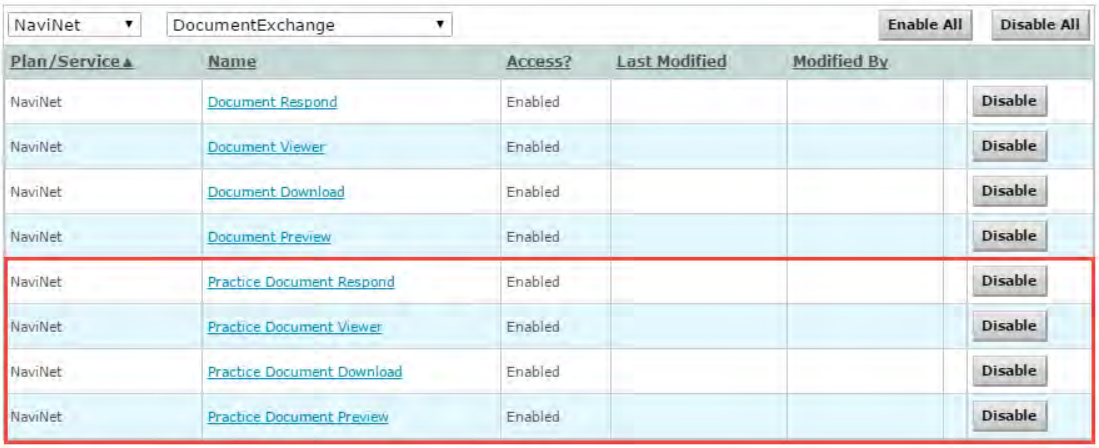
3. The next screen is titled “Transaction Management for User _____”. From this screen, select **NaviNet** in the Plan’s drop-down list and select **DocumentExchange** in the Group’s drop-down list.



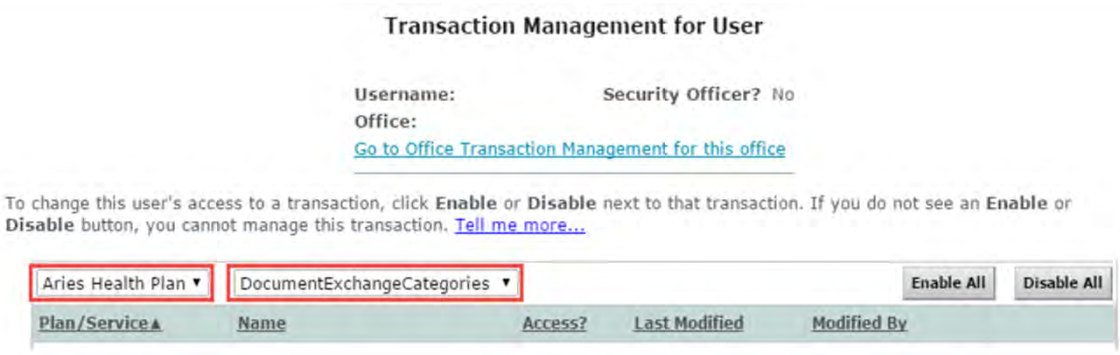
4. It’s important to note, “Patient Clinical Documents” are enabled for all users by default. But you will want to confirm that the global permissions for “Patient Clinical Documents” are set appropriately:
    a. For a user to *view* Patient Clinical Documents, both **Document Viewer** and **Document 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.)



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.)

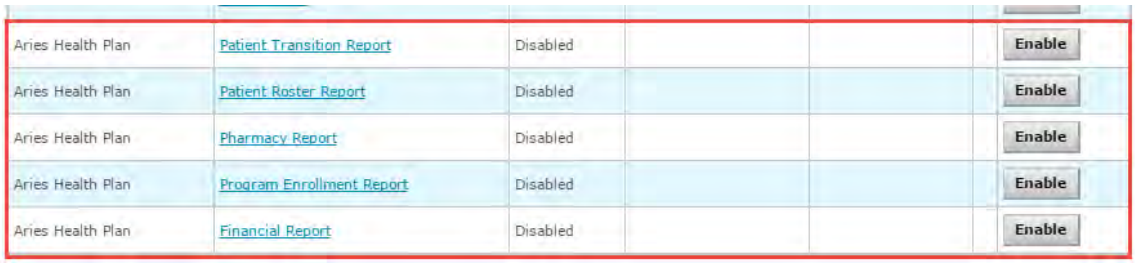


6. Now that you have confirmed the global permissions, you need to enable the specific permissions. First, select the **appropriate health plan** in the Plan’s drop-down list and **DocumentExchangeCategories** in the Group’s drop-down list.

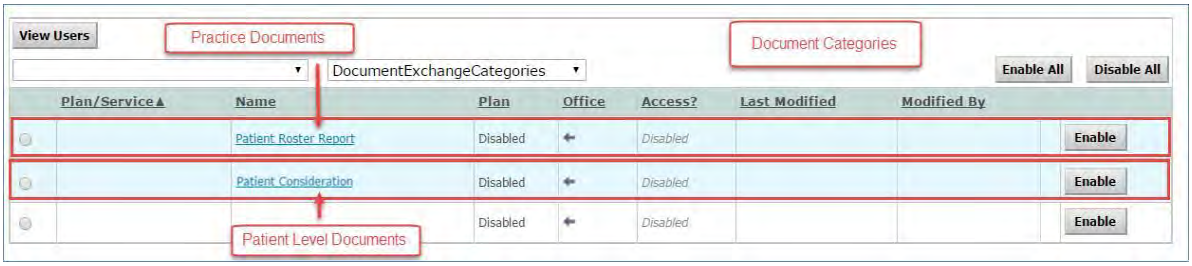


7. Click **Enable** next to any Patient Clinical Document categories that you want to be available to this user for the selected health plan.

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

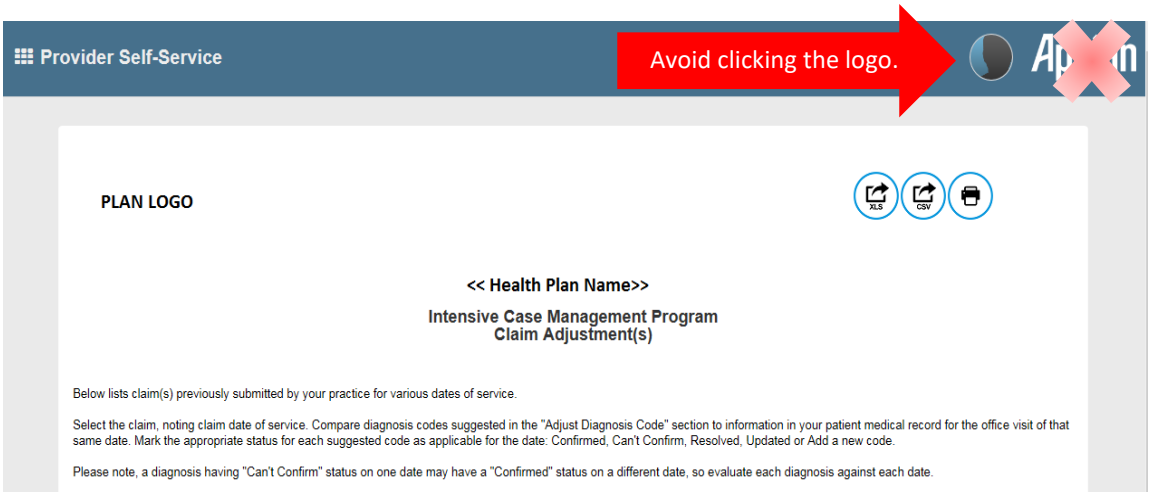


9. Finally, for access to all ICM activities, make sure **Patient Roster Report** and **Patient Consideration** document categories are enabled.



Important Note: Time-Out Information

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



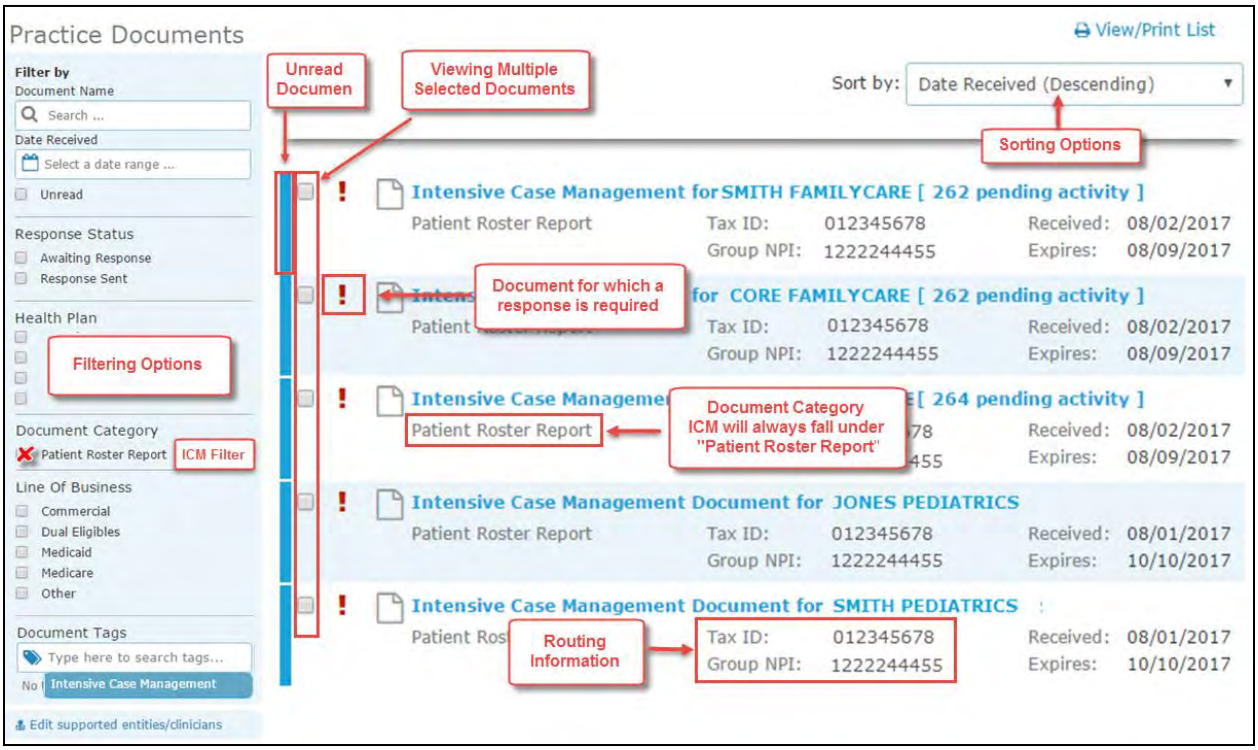
If you are inactive for more than 60 minutes,you will see the pop-up below warning you that your session is about to expire. If you click **Resume** within 5 minutes, the page will reload and you can continue entering information.

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.

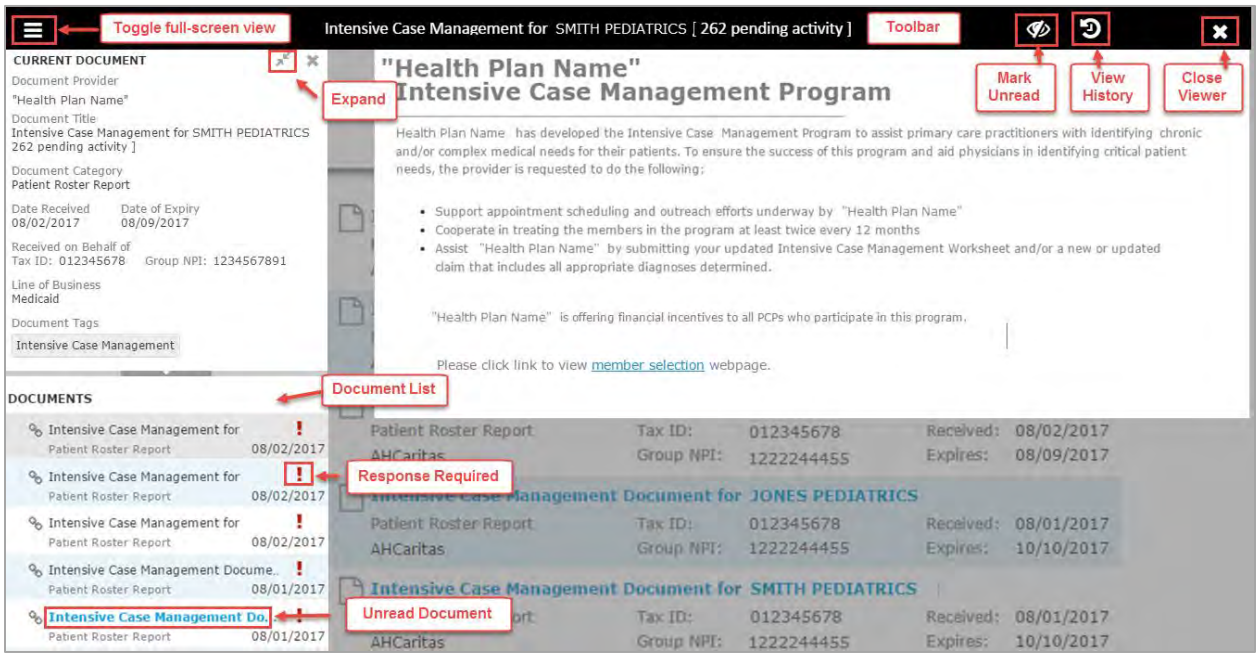
Anatomy of the Workflow & Document Viewer Screens

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.



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.

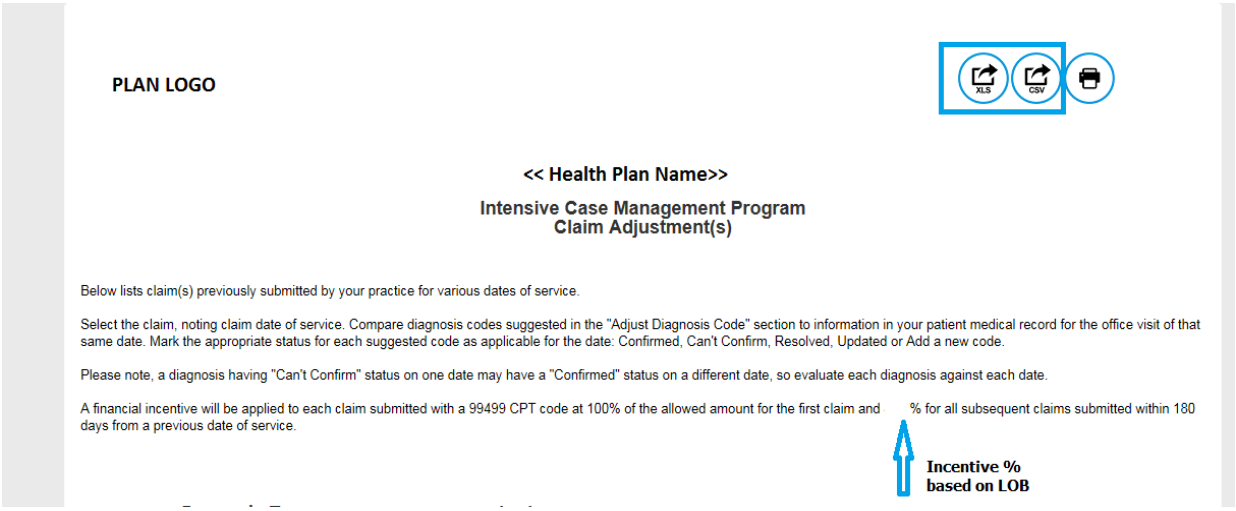
Popup Blocker Must be Disabled

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.

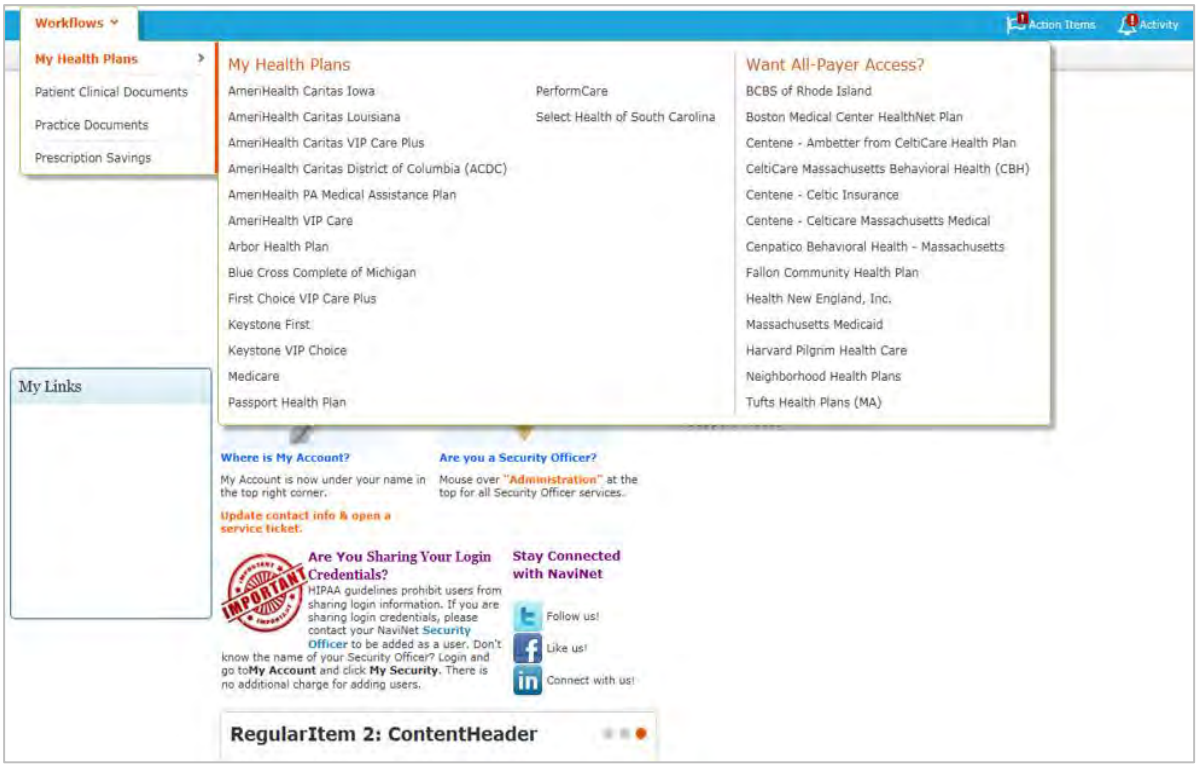


- The third icon displays instructions for printing (press CTRL + P).

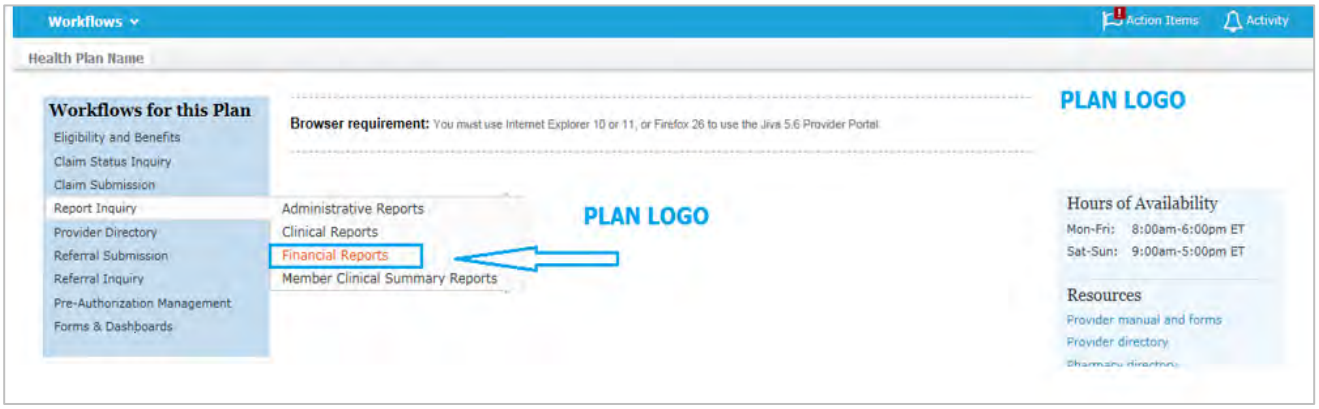
Report Generation

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.

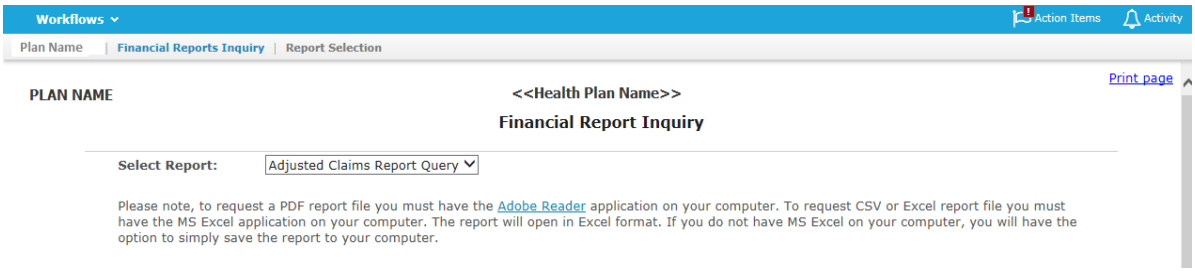
1. Select **Workflows** in the upper left of the NaviNet screen.
2. Drop down and select **My Health Plans** from the list of workflows.
3. Choose the health plan for which you want to pull a report.



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

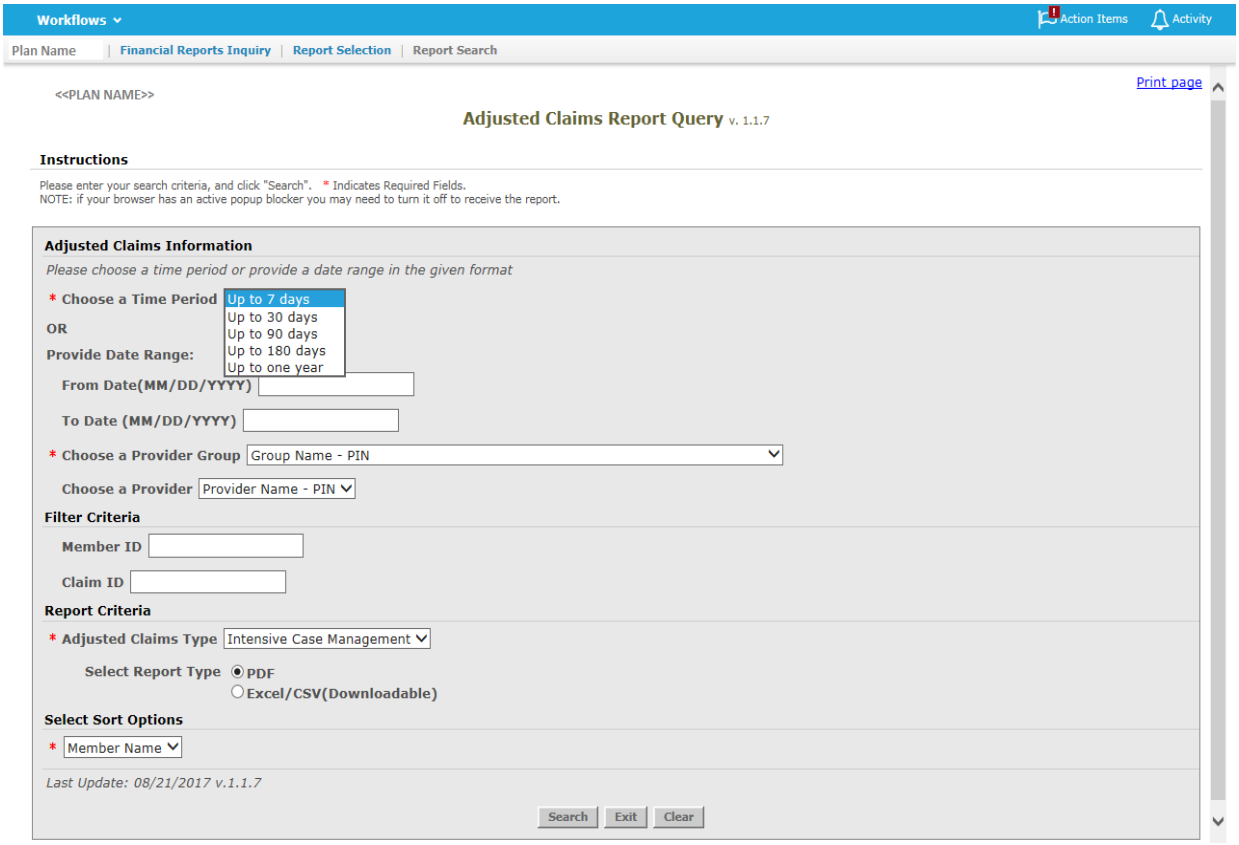


5. Finally, select **Adjusted Claims Report Query** from the drop-down list.



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 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 Z418-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:

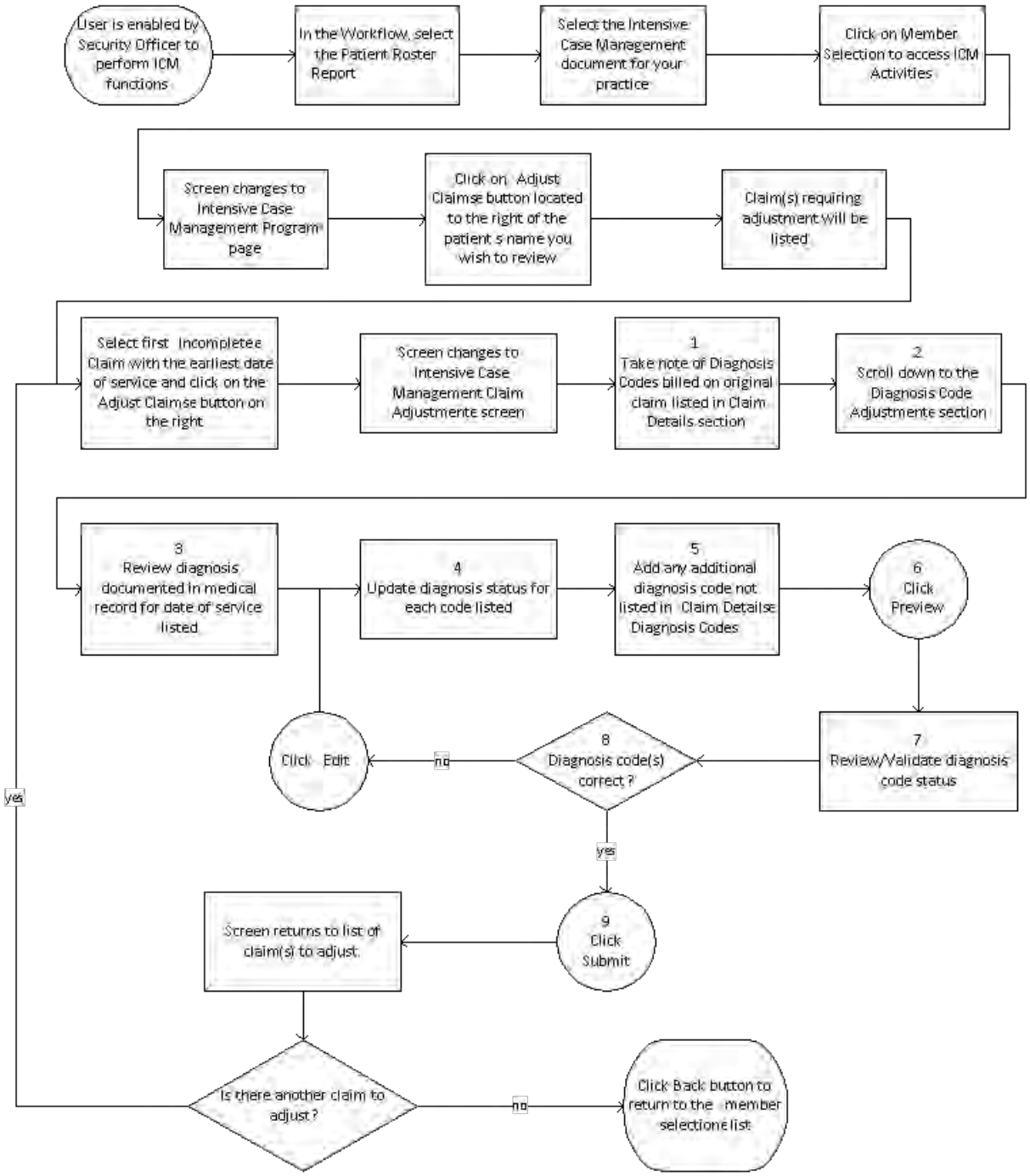
Total Count by Claim Status:

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



Attachment 2: Example Claim Attestation Report

Claim Attestation Summary Report

Group Name:

Group ID:

Service Provider ID:
Service Provider Name:
Service Representative:
Service Representative Phone:

Patient ID	Patient First Name	Patient Last Name	Patient DOB	Date of Service	Claim ID	Submitted Diagnosis Code(s)	Additional Diagnosis Code(s)

Signature below indicates provider/provider office staff agrees that the claim identified for the patient on the noted date of service should be adjusted with any additional diagnosis codes identified and the procedure code 99499 (unlisted evaluation and management service.)

Name / Title

Signature and Date