



# Provider User Guide

Intensive Case Management Enhancements  
via NaviNet®

December 2017



**Provider Guide:  
Intensive Case Management Program**

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## About the Intensive Case Management (ICM) Program

### Background

Under its contract with the Pennsylvania Department of Human Services, AmeriHealth Caritas Pennsylvania and AmeriHealth Caritas Northeast (The Plan) are 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 Pennsylvania Department of Human Services.

Pennsylvania Department of Human Services 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 Pennsylvania and AmeriHealth Caritas Northeast, member-level information obtained through encounters allows Pennsylvania Department of Human Services to gain a more in-depth understanding of the factors driving cost and quality within the Pennsylvania Department of Human Services Medicaid program.

The Plan 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 Plan's 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 the Pennsylvania Department of Human Services regarding The Plan's 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

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

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 six 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 40 of this guide for a visual of this process flow.**

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

### Supplemental Reimbursement

- The Plan 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, The Plan offers PCPs an administrative payment for each record reviewed, in accordance with the following fee schedule:

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

### ICM Program Assistance

If you would like assistance with the review of your medical records The Plan’s Risk Adjustment Department can assist as follows:

- The Plan 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.
- The Plan 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, The Plan also performs a random review of claims submitted for adjustment through the ICM process. As part of the audit process, The Plan 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 coded for each date of service and the diagnosis actions indicated in NaviNet (e.g., Confirmed, Can’t Confirm, Resolved, Updated or Added) will be compared. Upon completion of the review, you will be notified of the audit results.

## 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

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

Username:

Password:

**Sign In**

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

Getting Started with NaviNet

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

**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**

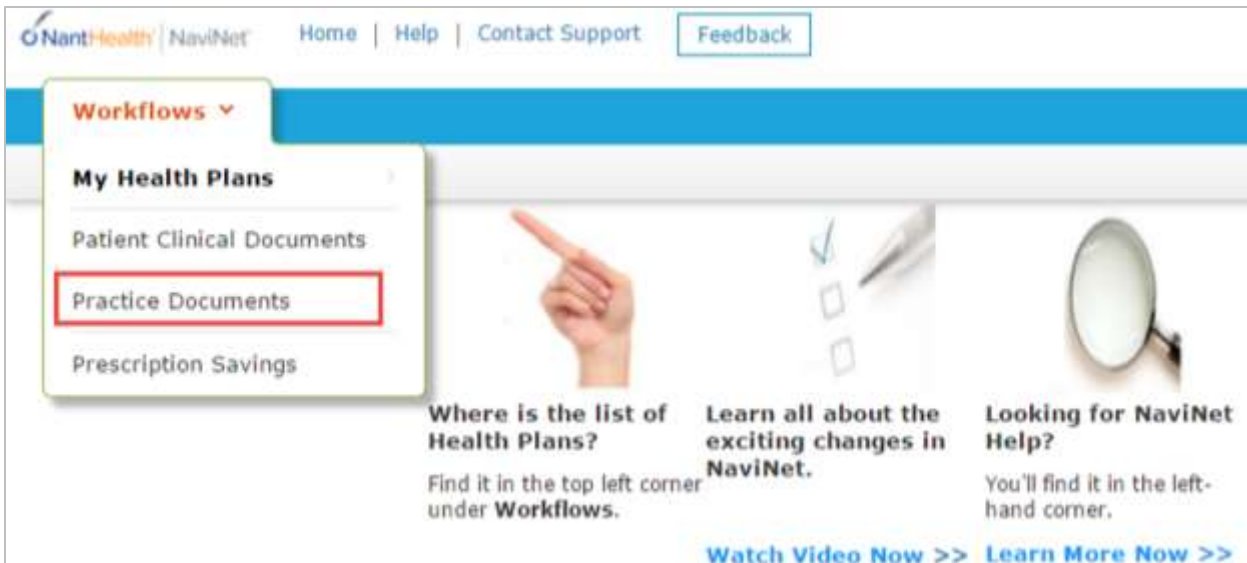
## Step 2. Access “Practice Documents” Workflow

### 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 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 'My Health Plans', 'Patient Clinical Documents', 'Practice Documents' (highlighted with a red box), 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 icon of a hand pointing and text that says 'Find it in the top left corner under **Workflows**.' The second card, titled 'Learn all about the exciting changes in NaviNet.', features an icon of a pen writing on a checklist and a 'Watch Video Now >>' link. The third card, titled 'Looking for NaviNet Help?', features an icon of a magnifying glass and text that says 'You'll find it in the left-hand corner,' with a 'Learn More Now >>' link.



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

- Use the enhanced filter and sorting options to look for specific records.
- To view ICM-related documents, filter for **Patient Roster Report** under “Document Category”. Or, type **Intensive Case Management** into the “Document Tags” field.
- 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 features:

- Filter Options:** A blue arrow points to the filter sidebar. A yellow callout box lists the following options:
  - Document Name
  - Date Received
  - Response Status
  - Health Plan
  - Document Category
  - Line of Business
  - Document Tags
- Sorting Options:** A blue arrow points to the 'Sort by' dropdown menu. A yellow callout box lists the following options:
  - Date Received
  - Document Title
  - Document Category

The document list shows several records, with the second record circled in red:

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

In the filter sidebar, the 'Document Category' dropdown is set to 'Patient Roster Report' and the 'Document Tags' field contains 'Intensive Case Management', both of which are circled in red.

## Step 4. Launch “Member Selection” for ICM Activities

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

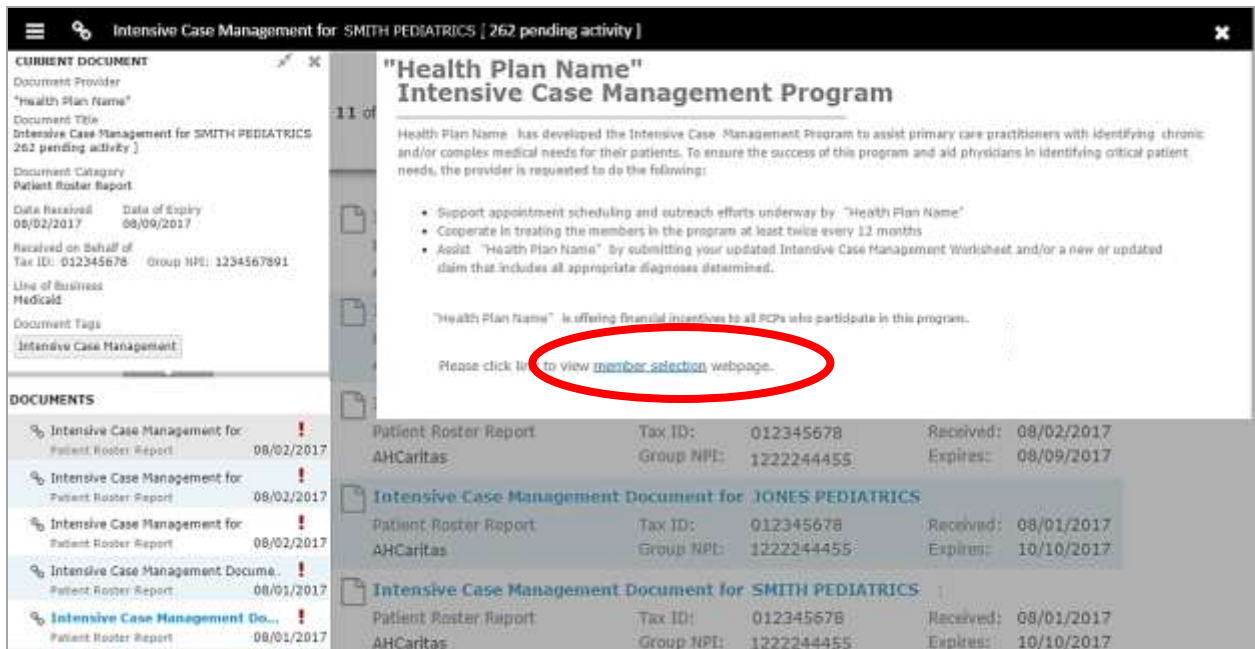


Document Title  
Document Category

**Intensive Case Management for SMITH FAMILYCARE [ 262 pending activity ]**

Patient Roster Report Tax ID: 012345678 Received: 08/02/2017  
Health Plan Name 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.



Intensive Case Management for SMITH PEDIATRICS [ 262 pending activity ]

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

**DOCUMENTS**

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

PLAN LOGO



<<Health Plan Name>>  
Intensive Case Management Program

Group: ST JOSEPH FAMILY AND WORKING CARE  
Service Rep: CHARLES PERTERSON  
Service Rep (Phone): 818-888-8889  
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 locating 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  Filter by Action  
Member Last Name   Adjust Claim(s)  
Member Date of Birth   Please Schedule Appointment  
Filter by Status  
 Incomplete  
 Pending

Search Reset Filters

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
12345666	GEORGE	SIMON	05/09/1999	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
77654332	QADAR	ABDUL	02/01/2006	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54343444	VELAZQUEZ	PEDRO	08/03/2003	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
87675455	JUSTICE	BARBARA	02/19/2007	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
67003341	TORRES	FERNANDO	04/23/2013	ADJUST CLAIM(S)	INCOMPLETE	
34421092	MATTHEW	SUSANNA	12/30/1997	ADJUST CLAIM(S)	PENDING	
54121233	SAMUELS	BOBY	03/31/2004	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

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

Member ID  Filter by Action  
 Adjust Claim(s)  
 Please Schedule Appointment  
 Member Last Name   
 Member Date of Birth  MM/DD/YYYY  
 Filter by Status  
 Incomplete  
 Pending

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
67003341	TORRES	FERNANDO	01/23/2013	ADJUST CLAIM(S)	INCOMPLETE	
34421092	MATTHEW	SUSANNA	12/30/1997	ADJUST CLAIM(S)	PENDING	

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

**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

Member ID  Filter by Action  
 Adjust Claim(s)  
 Please Schedule Appointment  
 Member Last Name   
 Member Date of Birth  MM/DD/YYYY  
 Filter by Status  
 Incomplete

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
12345666	GEORGE	SIMON	05/09/1999	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
77654332	QADAR	ABOUL	02/01/2005	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54343444	VELAZQUEZ	PEDRO	09/03/2003	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
87675455	JUSTICE	BARBARA	02/19/2007	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54121233	SAMUELS	BOBY	03/31/2004	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

From this screen, you can also click on a **Member ID number** to view additional member details.

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
12345666	GEORGE	SIMON	05/09/1999	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
77654332	QADAR	ABDUL	02/01/2005	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54343444	VELAZQUEZ	PEDRO	09/03/2003	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
87675455	JUSTICE	BARBARA	02/19/2007	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54121233	SAMUELS	BOBY	03/31/2004	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	

**Member Address:** 121 SPRUCE ST,  
PHILADELPHIA,  
PA, 19139,  
Philadelphia

**Member Phone:** 822-777-6767

**Diagnosis Code** K21.9  
**(s):**

**Case Manager:**

**Case Manager**  
**Phone:**

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
12345666	GEORGE	SIMON	05/09/1999	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
77654332	QADAR	ABDUL	02/01/2005	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54343444	VELAZQUEZ	PEDRO	09/03/2003	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
87675455	JUSTICE	BARBARA	02/19/2007	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
67003341	TORRES	FERNANDO	01/23/2013	ADJUST CLAIM(S)	INCOMPLETE	
34421092	MATTHEW	SUSANNA	12/30/1997	ADJUST CLAIM(S)	PENDING	
54121233	SAMUELS	BOBY	03/31/2004	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.

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 Fernando Torres (Date of Birth 01/23/2013)**

Claim ID	Date of Service	Claim Status	Adjust Claim
14281858900	05/31/2017	CLAIM ADJUSTED ON 06/12/2017	
142635194200	12/30/2016	INCOMPLETE	
142626231400	12/16/2016	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. At the top left, it says 'Provider Self-Service' and at the top right is the 'Appian' logo. Below the header, there is a 'PLAN LOGO' placeholder and a circular icon with a printer symbol. The main title is 'Intensive Case Management Claim Adjustment'. Below the title is an 'Instructions' section with a document icon. 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 Amerihealth 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**

<u>Patient Details</u>	<u>Provider Details</u>
Name: TORRES, FERNANDO	Billing Provider Name: NORTH EAST INTERNAL MEDICINE AND FAMILY PRACTICE
ID: 67003341	Billing Provider ID: 123456
Gender: Male	Servicing Provider Name: MATHEW, THOMAS
	Servicing Provider ID: 9834567

**Claim Details**

Claim Number: 142635194200	Status Date: 5/29/2017
Service Date Range: 05/04/2017 - 05/04/2017	Status Code: 107
Total Amount Billed: \$196.29	Category Code: F1
Total Amount Paid: \$196.29	Remark Code:
Paid Date: 05/29/2017	Check Number: 456734120
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.

[Type a quote from the document or the summary of an interesting point. You can position the text box anywhere in the document. Use the Drawing Tools tab to change the formatting of the pull quote text box.]

**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	<input type="text"/>

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
I69.990 ✕	Other sequelae following unspecified cerebrovascular disease	--Please Select--	
K21.9 ✕	Gastro-esophageal reflux disease without esophagitis	--Please Select--	
D89.89 ✕	Other specified disorders involving the immune mechanism, not elsewhere classified	--Please Select--	
Q66.7 ✕	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.

**Diagnosis Code Adjustment**

Diagnosis Code	Description	Status	Action
I50.9 ✕	Heart failure, unspecified	<div style="border: 1px solid black; padding: 2px;">           --Please Select--            CONFIRMED            RESOLVED            CANNOT CONFIRM         </div>	

[Add Diagnosis Code](#) 1 item

- 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 ✕	Berign neoplasia 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	Description	Status	Action
I50.9	Heart failure, unspecified	--Please Select--	
F33.1	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.”**

PLAN 10000



**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 the screen. Once you click "Submit" from this screen, claims will be waiting for their batch process to run. You may make additional corrections until the claim status changes from "Submitted, Waiting batch process" to "Claims Adjusted on MM(DDYYYY)".

**Patient and Provider Details**

<p><b>Patient Details</b></p> <p>Name: TORRES, ERNANDO          ID: 0700044          Gender: Male</p>	<p><b>Provider Details</b></p> <p>Billing Provider Name: NORTH EAST INTERNAL MEDICINE AND FAMILY PRACTICE          Billing Provider ID: 12400          Servicing Provider Name: gomez, rodrigo          Servicing Provider ID: 900007</p>
---	---

**Claim Details**

<p>Claim Number: 140035194000          Service Date Range: 05/04/2017 - 05/04/2017          Total Amount (Bill): \$195.25          Total Amount (Paid): \$195.25          Paid Date: 05/04/2017          Diagnosis Code: Z91.00</p>	<p>Issue Date: 05/03/17          Status Code: 01          Category Code: F1          Remark Code:          Check Number: 400794100</p>
---	--

**Service Line Detail**

	Date From/To	Claim Status	Units	Proc. Cd	Modifier	Billed Amt	POB	DRG CR Payment	Status CR	Line Status
1	05/04/2017 - 05/04/2017	01	1	71010	-	\$195.25	45	1		Confirmed
2	05/04/2017 - 05/04/2017	01	1	99212	-	\$0.00	45	1		Confirmed

[2 More](#)

**Additional Procedure Code**

Date From/To	Proc. Cd	Units	Billed Amt
05/04/2017 - 05/04/2017	99400	1	\$40.00

[1 More](#)

**Diagnosis Code Adjustment**

Diagnosis Code	Description	Status
R01.1	Belching, unspecified	CONFIRMED
Z91.0	Drug-induced dizziness	ADDED
N10	Tubulo-interstitial nephritis, not specified as acute or chronic	ADDED




[3 More](#)

**Contact Information**

Contact Name: agomez003  
 Phone Number: 212-945-3534

- 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.

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**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 90499 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 **Fernando Torres** (Date of Birth 01/23/2013)

Claim ID	Date of Service	Claim Status	Adjust Claim
142618858900	05/31/2017	CLAIM ADJUSTED ON 06/12/2017	
142635194200	12/30/2016	INCOMPLETE	
142626231400	12/16/2016	SUBMITTED;WAITING BATCH PROCESS	

3 items




**Back**

Member Listing screen:

Member ID:  Filter By:  Adjust Claims,  Member Details,  Pending/Incomplete Actions

Member Last Name:

Member Date of Birth:

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claims/Member Details
903432176	BOB	TEST	0715/1909	ADJUST CLAIM(S)	INCOMPLETE	
90343470	PERSON	TEST	0701/1979	ADJUST CLAIM(S)	INCOMPLETE	
903438415	TEST	ADAMS	0601/1967	PLEASE SCHEDULE APPOINTMENT	COMPLETED	

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.

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/Member Details
12345666	GEORGE	SIMON	05/09/1999	PLEASE SCHEDULE APPOINTMENT	INCOMPLETE	
77094332	QADAR	ABDUL	02/01/2005	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
54343444	VELAZQUEZ	PEDRO	09/03/2003	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
07675455	JUSTICE	BARBARA	02/19/2007	PLEASE SCHEDULE APPOINTMENT	COMPLETED	
07003741	TORRES	FERNANDO	01/23/2013	ADJUST CLAIM(S)	INCOMPLETE	
34421002	MATTHEW	SUSANNA	12/09/1997	ADJUST CLAIM(S)	PENDING	
54121233	SAMUELS	BOBY	03/01/2004	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"/>	

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

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
992432176	BOB	TEST	07/15/1908	ADJUST CLAIM(S)	INCOMPLETE	
992434792	PERSON	TEST	07/01/1979	ADJUST CLAIM(S)	INCOMPLETE	
992429415	TEST	ADAMS	08/01/1967	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**.

**User Search**

Search for a user. Then, if desired, select a user and click **Edit Access** to change transaction access for that user. [Tell me more...](#)

Last Name:  First Name:   
Username:  User Status:   
New User?:  Combined User Status: Able to Access NaviNet  [What is this?](#)

Hide Search Criteria After Search  
[Hide Search Criteria](#) Records 1-10 of 26, page: 1 2 3

<b>Edit Access</b>							
Name	Username	Status	Last Login	Status Change	Security Officer?	New User?	
Anderson, Julie	janderson01	Active	03/30/2016	Expires in 12 day(s)			
Berner, Rachel	rbernar01	Active	07/12/2016	Expires in 90+ days			



3. The next screen is titled “Transaction Management for User \_\_\_\_\_”. From this screen, select **NaviNet** in the Plan’s drop-down list and select **Document Exchange** 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.)

Plan/Service A	Name	Access?	Last Modified	Modified By	
NaviNet	<a href="#">Document Respond</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Document Viewer</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Document Download</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Document Preview</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Practice Document Respond</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Practice Document Viewer</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Practice Document Download</a>	Enabled			<input type="button" value="Disable"/>
NaviNet	<a href="#">Practice Document Preview</a>	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	<a href="#">Document Respond</a>	Enabled			Disable
NaviNet	<a href="#">Document Viewer</a>	Enabled			Disable
NaviNet	<a href="#">Document Download</a>	Enabled			Disable
NaviNet	<a href="#">Document Preview</a>	Enabled			Disable
NaviNet	<a href="#">Practice Document Respond</a>	Enabled			Disable
NaviNet	<a href="#">Practice Document Viewer</a>	Enabled			Disable
NaviNet	<a href="#">Practice Document Download</a>	Enabled			Disable
NaviNet	<a href="#">Practice Document Preview</a>	Enabled			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 Julie Anderson**

Username: janderson01    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	<a href="#">Clinical Summary</a>	Disabled			Enable
Aries Health Plan	<a href="#">Patient Consideration</a>	Disabled			Enable
Aries Health Plan	<a href="#">Program Enrollment</a>	Disabled			Enable
Aries Health Plan	<a href="#">Info Request</a>	Disabled			Enable

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	<a href="#">Clinical Summary</a>	Disabled			Enable
Aries Health Plan	<a href="#">Patient Consideration</a>	Disabled			Enable
Aries Health Plan	<a href="#">Program Enrollment</a>	Disabled			Enable
Aries Health Plan	<a href="#">Info Request</a>	Disabled			Enable

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

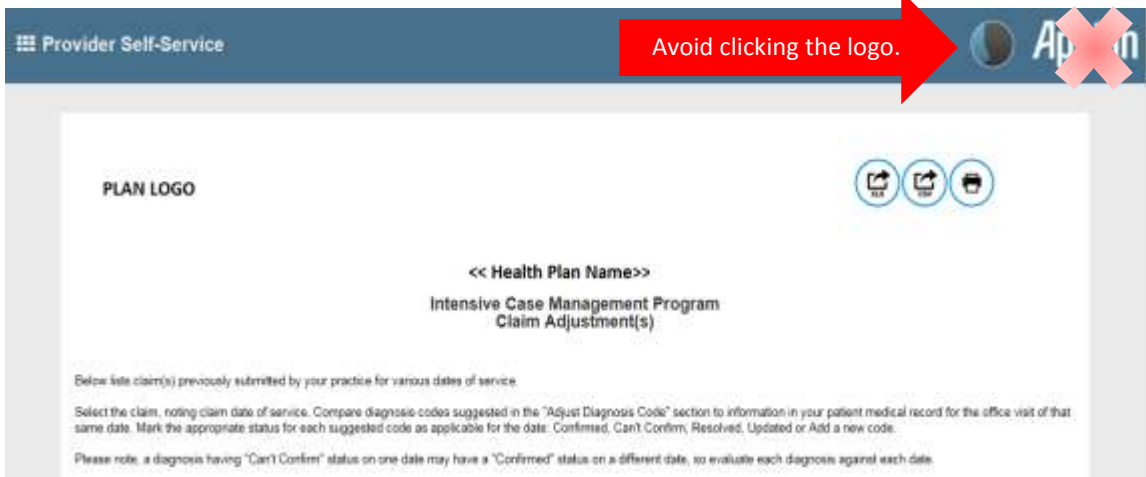
Aries Health Plan	<a href="#">Patient Transition Report</a>	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	<a href="#">Patient Roster Report</a>	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	<a href="#">Pharmacy Report</a>	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	<a href="#">Program Enrollment Report</a>	Disabled			<input type="button" value="Enable"/>
Aries Health Plan	<a href="#">Financial Report</a>	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 A	Name	Plan	Office	Access?	Last Modified	Modified By	
	<a href="#">Patient Roster Report</a>	Disabled	←	Disabled			<input type="button" value="Enable"/>
	<a href="#">Patient Consideration</a>	Disabled	←	Disabled			<input type="button" value="Enable"/>
	<a href="#">Patient Level Documents</a>	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.

A login form for AmeriHealth Caritas. At the top left, it says 'AmeriHealth Caritas Family of Companies'. Below this are two input fields: 'Username' and 'Password'. Under the password field is a checkbox labeled 'Remember me on this computer'. At the bottom right of the form is a green button labeled 'Sign In'.

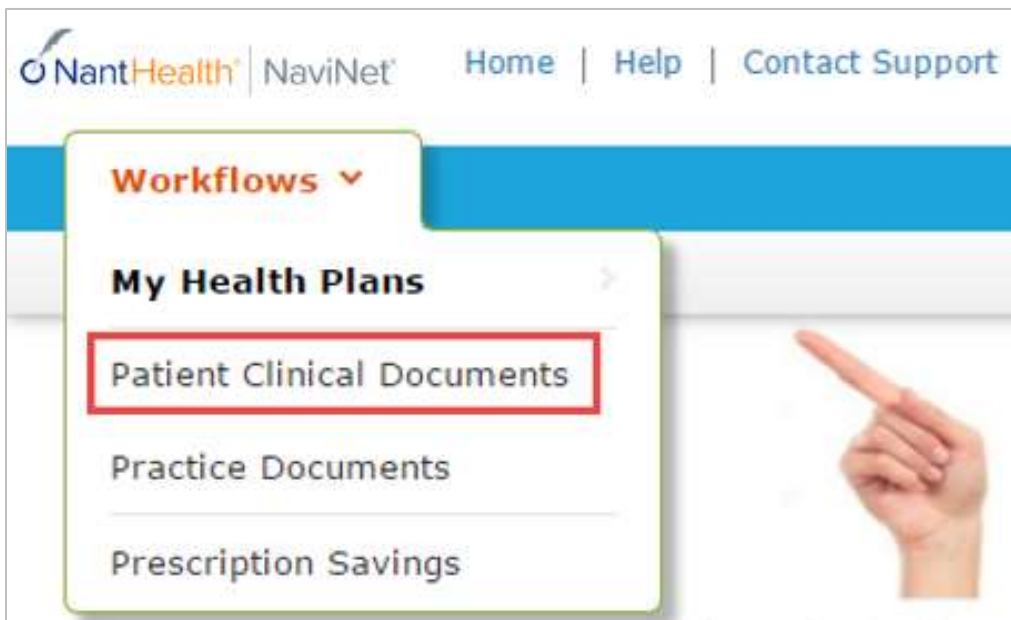
## Alternative Workflow – “Patient Clinical Documents”

### 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.

Showing 14 of 14 patients

Sort by: Patient Last Name

**Clinical Documents**

Exclamation Point	Patient Name	Count	Date
!	JACI SMITH Date of Birth: 1/01/2000 PCP: JAMES, TONI P.	2	Aug 02, 2017
!	SAM JONES Date of Birth: 5/01/1970 PCP: ROY, PAUL	1	Aug 02, 2017
!	CARLI SMITH Date of Birth: 1/07/1979 PCP: LARKIN, GREG	6	Aug 01, 2017
!	JENN MARKS Date of Birth: 7/16/1978 PCP: CLARK, RACHEL	2	Jul 28, 2017

Filter by:

Patient's last name

PCP

Date Received

Unread

Response Status

Health Plan

Document Category

Line of Business

Document Tags

View/Print List

F. Click on a member record to view. For example, "LACI SMITH."

Clinical Documents		Payer
		Last Document Received
<b>LACI SMITH</b>		
Date of Birth: 1/01/2000	2	Aug 02, 2017
PCP: JAMES, TONI P.		

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.

The screenshot displays the 'Intensive Case Management' interface. On the left, a sidebar shows document details for 'Health Plan Name' Intensive Case Management, including patient information for Laci Smith and primary care physician James, Toni P. The main content area shows the document title and a list of bullet points regarding the program's goals and requirements. At the bottom, a 'DOCUMENTS' list shows two entries for 'Intensive Case Management' with counts and dates. A red box highlights the link 'member complex case management worksheet' in the text below the document list.



## 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.

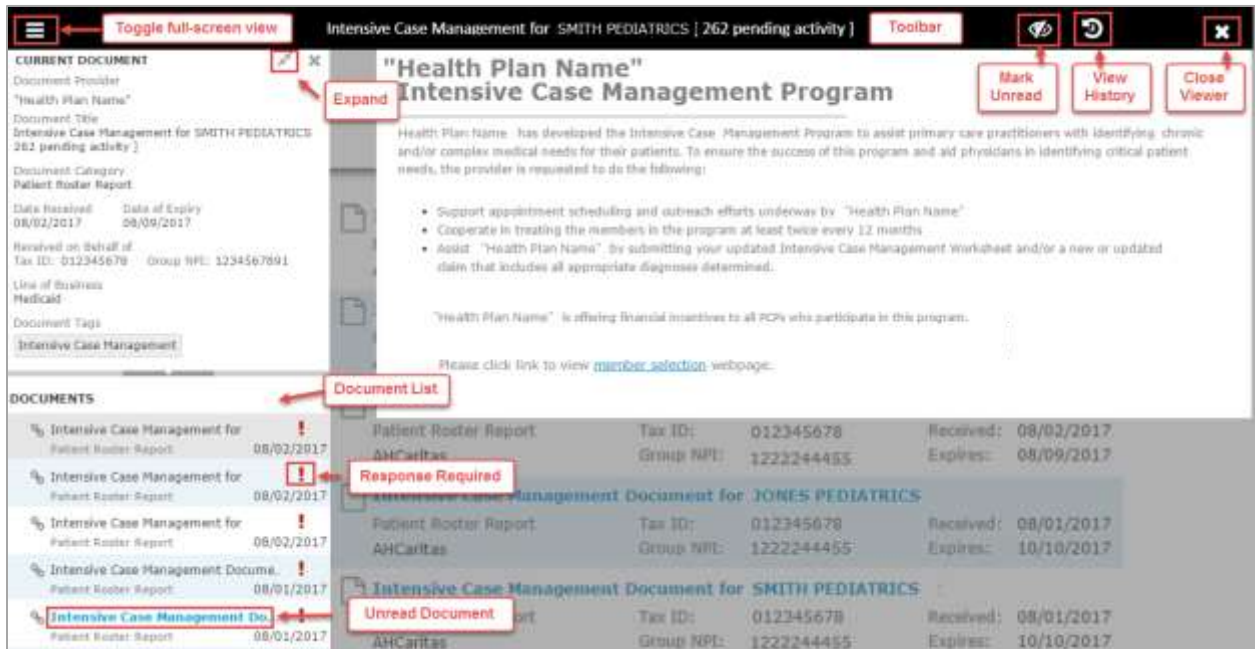
Users can select a number of documents in the list and then click View to open the selected documents in the Document Viewer.

The screenshot displays the 'Practice Documents' interface. On the left, there is a 'Filter by' sidebar with sections for Document Name, Date Received, Response Status, Health Plan, Document Category, Line Of Business, and Document Tags. The 'Document Category' section has 'Patient Roster Report' selected, with an 'ICM Filter' button. The main area shows a list of documents with columns for document title, Patient Roster Report, Tax ID, Group NPI, Received, and Expires. A 'Sort by: Date Received (Descending)' dropdown is at the top right. A 'View/Print List' link is in the top right corner. Red callout boxes with 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 dropdown menu; '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.

Document Title	Patient Roster Report	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.

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 'Patient Consideration' filter is selected. The main area displays a list of patients under the heading 'Clinical Documents'. Each patient entry includes their name, date of birth, PCP, a count of documents, and the date received. Annotations with red boxes and arrows point to specific features: 'Unread Document' points to a blue bar on the left of the patient list; 'Sorting Options' points to a dropdown menu set to 'Patient Last Name'; 'Filtering Options' points to the 'Patient Consideration' filter; 'Document for which a response is required' points to a red exclamation point icon; and 'Number of documents for this patient' points to the number '6' in the document count column.

Patient Name	Date of Birth	PCP	Number of Documents	Date Received
LACI SMITH	1/01/2000	JAMES, TONI P.	2	Aug 02, 2017
SAM JONES			1	Aug 02, 2017
CARLI SMITH	1/07/1979	LARKIN, GREG	6	Aug 01, 2017
JENN MARKS	7/16/1978	CLARK, RACHEL	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.

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 Fernando Torres (Date of Birth 01/23/2013)

Claim ID	Date of Service	Claim Status	Adjust Claim
142818858900	05/31/2017	CLAIM ADJUSTED ON 06/12/2017	
142635194200	12/00/2016	INCOMPLETE	
142626231400	12/16/2016	SUBMITTED;WAITING BATCH PROCESS	

3 items

Back

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

Provider Self-Service

Appian

PLAN LOGO

Please Press

## 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.

Workflows > Plan Name > Financial Reports Inquiry > Report Selection

PLAN NAME <<Health Plan Name>> Print page

Financial Report Inquiry

Select Report: Adjusted Claims Report Query

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:  
 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
30060276	DENSE WYNN-BAKER MD PEDIATRICS AT EINGSTEIN

Member ID	Member Name	Claim ID	DOB From - To	Code	Billed Amount	User ID	Updated Date	DX Code - Status	Paid Date	Paid Amount	Status
50543988	ABDULMALK UZAYR	2050143760	10/02/15 TO 10/02/15	99499	\$40.00	casenr48	05/20/2016	Z23-CONFIRMED R180-RESOLVED	05/23/2016	\$7.00	PROCESSED SUCCESSFULLY - 02
50543988	ABDULMALK UZAYR	205114352000	11/16/2015 TO 11/16/2015	99499	\$40.00	casenr48	05/20/2016	N040-CONFIRMED Z00129-CONFIRMED R180-RESOLVED	05/23/2016	\$7.00	PROCESSED SUCCESSFULLY - 02
50543988	ABDULMALK UZAYR	204642112500	06/29/2015 TO 06/29/2015	99499	\$40.00	casenr48	05/20/2016	S019-CONFIRMED I120-CONFIRMED 78961-RESOLVED	05/23/2016	\$40.00	PROCESSED SUCCESSFULLY - 02
51230598	ALLEN ANTHONY	205320203101	01/15/2016 TO 01/15/2016	99499	\$40.00	gubtel	11/26/2016	R0915-CONFIRMED J45909-CANNOT CONFIRM	11/03/2016	\$0.00	PROCESSED SUCCESSFULLY - 01
50914341	BADAL KHAN	205949705500	07/15/2016 TO 07/15/2016	99499	\$40.00	casenr75	11/04/2016	F840-CONFIRMED H9190-CONFIRMED F902-CONFIRMED F88-CONFIRMED Z00129-CONFIRMED Z23-CONFIRMED	11/07/2016	\$40.00	PROCESSED SUCCESSFULLY - 02
50329961	BANDY MARLAN	205267055400	12/02/2015 TO 12/02/2015	99499	\$40.00	casenr48	05/20/2016	J4520-CONFIRMED J301-CONFIRMED Z00129-CONFIRMED Z23-CONFIRMED J448-CONFIRMED	05/23/2016	\$40.00	PROCESSED SUCCESSFULLY - 02
50524117	BURNSIDE MAKAYLA	205964901100	06/30/2016 TO 06/30/2016	99499	\$40.00	talfer15	10/05/2016	Z00129-CONFIRMED J4520-CONFIRMED Z23-CONFIRMED H500-CONFIRMED 7410-CONFIRMED	10/10/2016	\$40.00	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

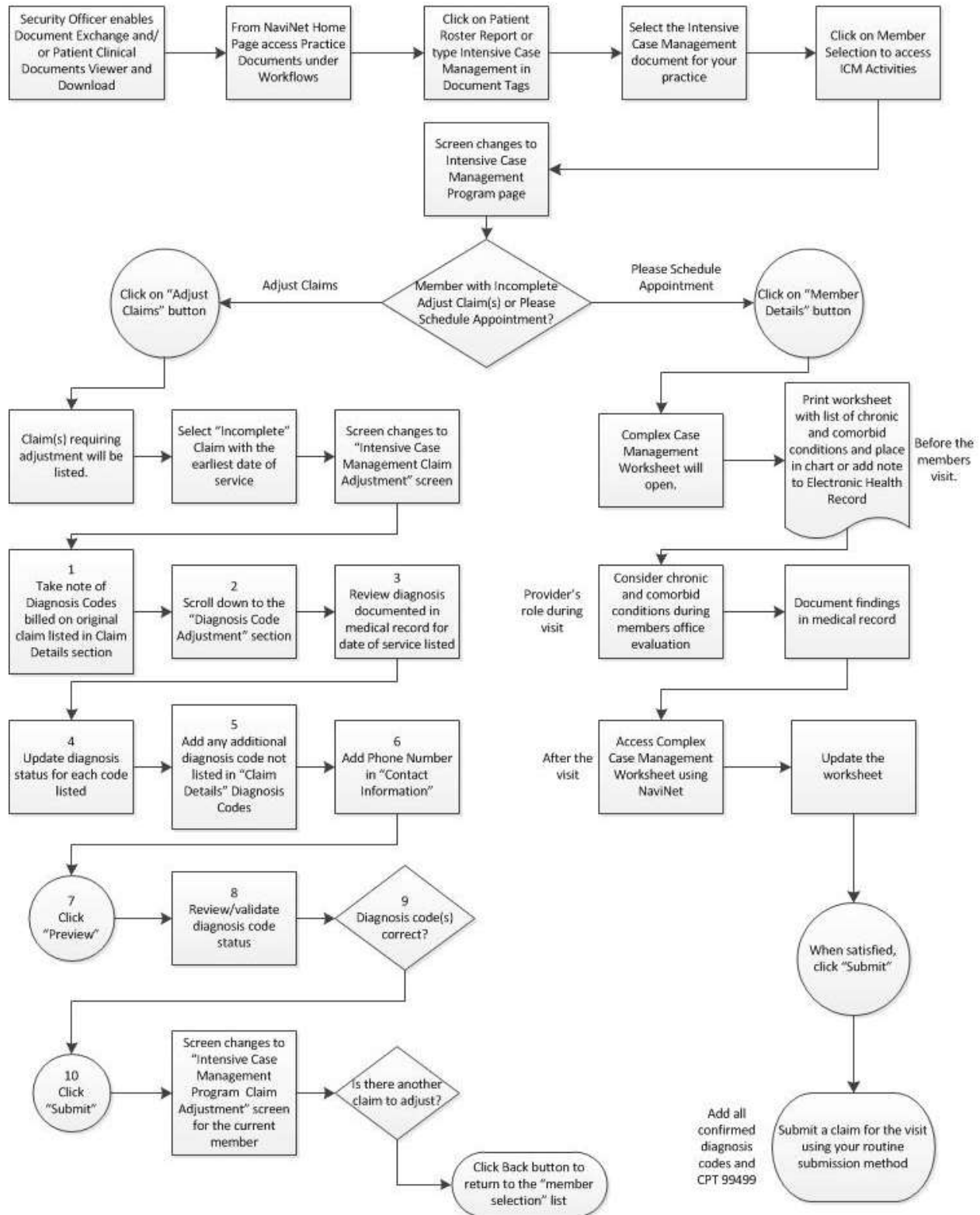
Provider ID	Provider Name
30000276	DENISE WYNN-BAKER MD PEDIATRICS AT EINSTEIN

Member ID	Member Name	Claim ID	DOS From - To	Code	Billed Amount	User ID	Updated Date	DX Code - Status	Paid Date	Paid Amount	Status
51393323	SUMMERVILLE EMMA	204793495001	07/02/2015 TO 07/02/2015	99499	\$40.00	slairnaco	06/27/2016	V202-CONFIRMED S6400-CONFIRMED V6081-CONFIRMED 7540-CANNOT CONFIRM	06/29/2016	\$40.00	PROCESSED SUCCESSFULLY - 01
51393323	SUMMERVILLE EMMA	209091796600	08/29/2016 TO 08/29/2016	99499	\$40.00	jcattelan	11/11/2016	Z134-CONFIRMED O672-CANNOT CONFIRM	11/16/2016	\$40.00	PROCESSED SUCCESSFULLY - 01

Total Number of Claim Adjustments: 28  
 Total Billed Amount: \$1,120.00  
 Total Paid Amount: \$684.00  
 Total Count by Claim Status:  
 Claim processed successfully : 28  
 Other Status : 0



## Attachment 1: Example Process Flow for Intensive Case Management Process





## Our mission

We help people get care, stay well, and build healthy communities.

We have a special concern for those who are poor.

## Our values

Advocacy

Dignity

Care of the poor

Diversity

Compassion

Hospitality

Competence

Stewardship



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