



Provider User Guide

# Intensive Case Management Via NaviNet

[www.amerihealthcaritasde.com](http://www.amerihealthcaritasde.com)

  
**AmeriHealth Caritas**<sup>™</sup>  
Delaware

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.
- 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 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 Delaware 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 32 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”.

## 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 – \$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 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 33 of this guide for an example of this report.*
- You, the PCP, will review the Claim Attestation Summary report, determine if the new/updated diagnoses identified as a result of the re-abstracting are accurate and complete, and follow the *Claims Adjustment* process in NaviNet.

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

### Audit of Intensive Case Management Program

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

rejection of previously-submitted adjustments that cannot be supported by medical record documentation.

## How to Use this Guide

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

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

## Before You Begin

### 1. NaviNet Permissions

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

### 2. Consider Filtering Providers for Optimum Access

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

## Step 1. Log-In to NaviNet

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

NantHealth | NaviNet

Sign In

Username:

Password:

**Sign In**

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

Getting Started with NaviNet

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

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

**ALL PAYER ACCESS**

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

**Get Started >**

**ICD-10 READY**

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

**Are You In The Loop?**

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

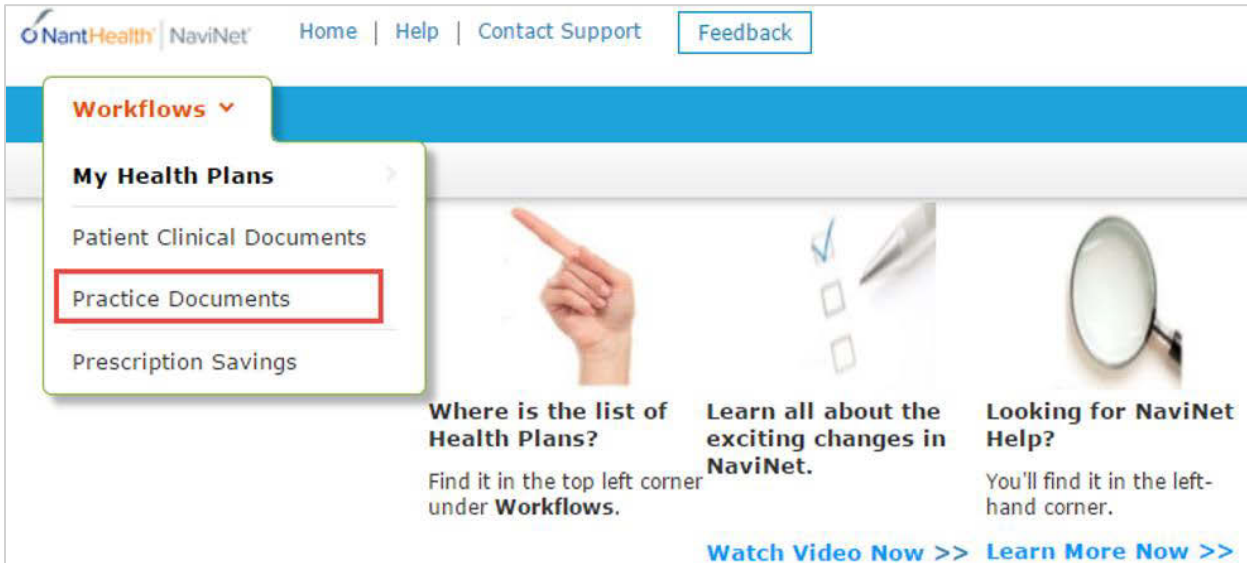
**Are You Sharing Login Credentials?**

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



## Step 2. Access “Practice Documents” Workflow

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



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

Filter Options

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

Sorting Options

- Date Received
- Document Title
- Document Category

Practice Documents View/Print List

Filter by: Document Name Sort by: Date Received (Descending)

Showing 11 of 11 documents

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

## Step 4. Launch "Member Selection" for ICM Activities

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

This screenshot shows the top portion of a document interface. On the left, there are navigation icons (a square, an exclamation mark, and a document icon) followed by the document title "Intensive Case Management for SMITH FAMILYCARE [ 262 pending activity ]". Below the title, it says "Patient Roster Report" and "Health Plan Name". To the right, a hand cursor points to the "Tax ID: 012345678" and "Group NPI: 122244455". Further right, it displays "Received: 08/02/2017" and "Expires: 08/09/2017". A table-like structure is partially visible with columns for "Document Title" and "Document Category".

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

This screenshot shows the full document content. The title is "Health Plan Name" Intensive Case Management Program. The text describes the program's purpose: "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:" followed by a bulleted list of requirements. Below the list, it states: "Health Plan Name" is offering financial incentives to all PCPs who participate in this program. At the bottom, there is a red circle around the text "Please click link to view member selection webpage." The left sidebar shows a "CURRENT DOCUMENT" section with details like "Document Provider: Health Plan Name", "Document Title: Intensive Case Management for SMITH PEDIATRICS", and "Document Category: Patient Roster Report". Below that is a "DOCUMENTS" list with several entries for "Intensive Case Management for Patient Roster Report" with dates and status icons. The right sidebar shows a table of document details for "Patient Roster Report" for "AHC Caritas", including Tax ID, Group NPI, Received date, and Expires date.

## 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.



**<<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)”:

Member ID

Member Last Name

Member Date of Birth

Filter by Action

- Adjust Claim(s)
- Please Schedule Appointment

Filter by Status

- Incomplete
- Pending

Member ID	Last Name ↑	First Name	Date of Birth	Action	Status	Adjust Claim(s)/Member Details
-----------	-------------	------------	---------------	--------	--------	--------------------------------

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

Member ID

There are three possible statuses in the Member Listing screen:

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

## Step 6. Complete the Needed Actions

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

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

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

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

PLAN LOGO



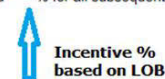
<< Health Plan Name >>  
**Intensive Case Management Program  
 Claim Adjustment(s)**

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

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

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

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



**Claims for**

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

3 items

Back

There are three possible statuses in the Claim Listing screen:

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

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

The screenshot shows the Appian Provider Self-Service interface. At the top left, it says "Provider Self-Service" with a grid icon. At the top right is the Appian logo. The main content area has a header "PLAN LOGO" on the left and a circular icon with a printer symbol on the right. Below this is the title "Intensive Case Management Claim Adjustment". A section titled "Instructions" with a blue icon on the right contains the following text:

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

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

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

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

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

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

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



**Patient and Provider Details**

Patient Details

Name:  
ID:  
Gender:

Provider Details

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

**Claim Details**

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

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

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

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

**Service Line Detail**

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

1 item

**Additional Procedure Code**

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

1 item

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

**Diagnosis Code Adjustment**

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

[Add Diagnosis Code](#) 4 items

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

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

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

**Diagnosis Code Adjustment**

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

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

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

**Diagnosis Code Adjustment**

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

**Add Diagnosis Code** 2 Items

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

**Contact Information:** GEORGE, WILLIAM

\* **Phone Number:**

\* **Required Fields**

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



### Intensive Case Management Claim Adjustment - Verification

#### Instructions

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

#### Patient and Provider Details

##### Patient Details

Name:  
ID:  
Gender:

##### Provider Details

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

#### Claim Details

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

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

Diagnosis Codes:

#### Service Line Detail

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

#### Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
	99499	1	
1 item			

#### Diagnosis Code Adjustment


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

#### Contact Information




Contact Name:  
Phone Number:

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

Provider Self-Service



**PLAN LOGO**


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

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



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

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

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


**Incentive % based on LOB**

**Claims for**

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

3 items

Back

## Supplemental Information

### Enabling Document Exchange for a Plan Service User (PSU)

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

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



2. From the next screen, select the user whose permissions you want to adjust, 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:  [What is this?](#)

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

Name ▲	Username	Status	Last Login	Status Change	Security Officer?	New User?
<input type="button" value="Edit Access"/>						

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

**Transaction Management for User**

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

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

NaviNet ▾

DocumentExchange ▾

Enable All

Disable All

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
NaviNet	Document Exchange				

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

NaviNet ▾

DocumentExchange ▾

Enable All

Disable All

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



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			<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"/>

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

**Transaction Management for User**

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

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

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

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

Aries Health Plan	<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.

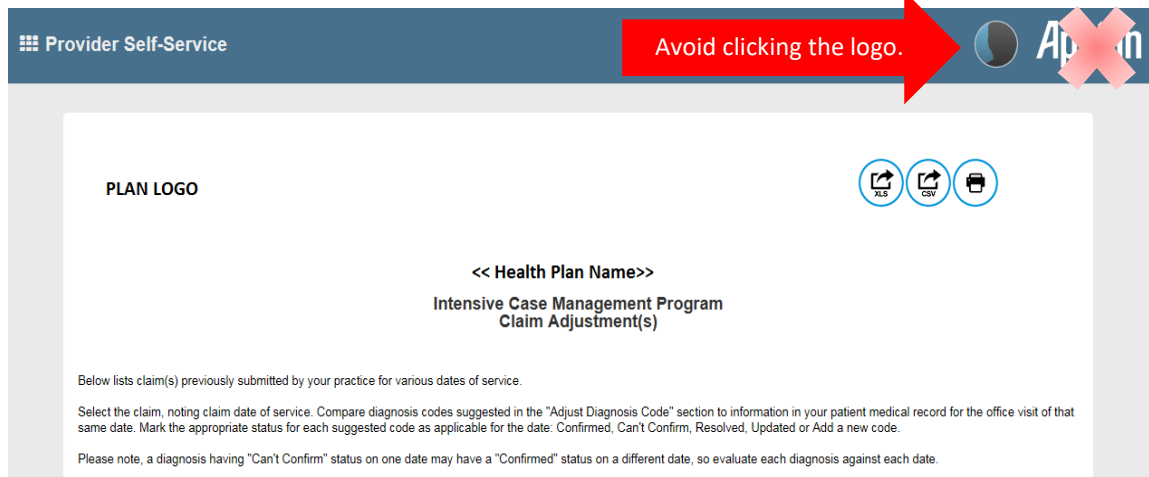
Practice Documents

Document Categories

Plan/Service ▲	Name	Plan	Office	Access?	Last Modified	Modified By	
<input type="radio"/>	<a href="#">Patient Roster Report</a>	Disabled	←	Disabled			<input type="button" value="Enable"/>
<input type="radio"/>	<a href="#">Patient Consideration</a>	Disabled	←	Disabled			<input type="button" value="Enable"/>
<input type="radio"/>	<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.

## Anatomy of the Workflow & Document Viewer Screens

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

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

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

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

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

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

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

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

**CURRENT DOCUMENT**

Document Provider  
"Health Plan Name"

Document Title  
Intensive Case Management for SMITH PEDIATRICS  
262 pending activity ]

Document Category  
Patient Roster Report

Date Received 08/02/2017 Date of Expiry 08/09/2017

Received on Behalf of  
Tax ID: 012345678 Group NPI: 1234567891

Line of Business  
Medicaid

Document Tags  
Intensive Case Management

**"Health Plan Name" Intensive Case Management Program**

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

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

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

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

**DOCUMENTS**

Document Name	Date Received	Expiration Date
Intensive Case Management for Patient Roster Report	08/02/2017	08/09/2017
Intensive Case Management for Patient Roster Report	08/02/2017	08/09/2017
Intensive Case Management for Patient Roster Report	08/02/2017	10/10/2017
Intensive Case Management Document for SMITH PEDIATRICS	08/01/2017	10/10/2017

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

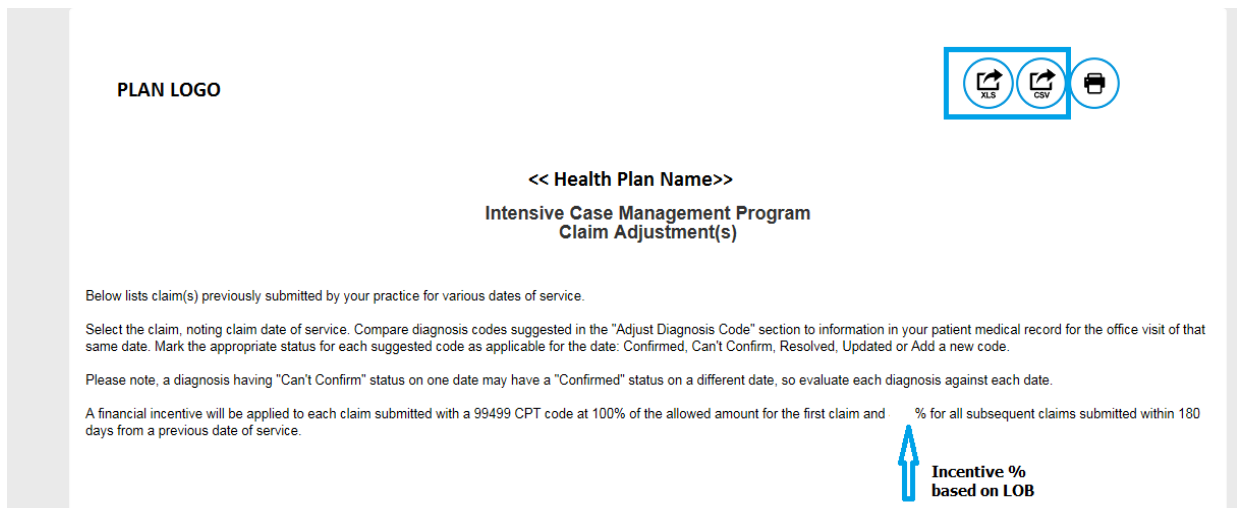
## Popup Blocker Must be Disabled

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

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



Provider Self-Service Appian

PLAN LOGO

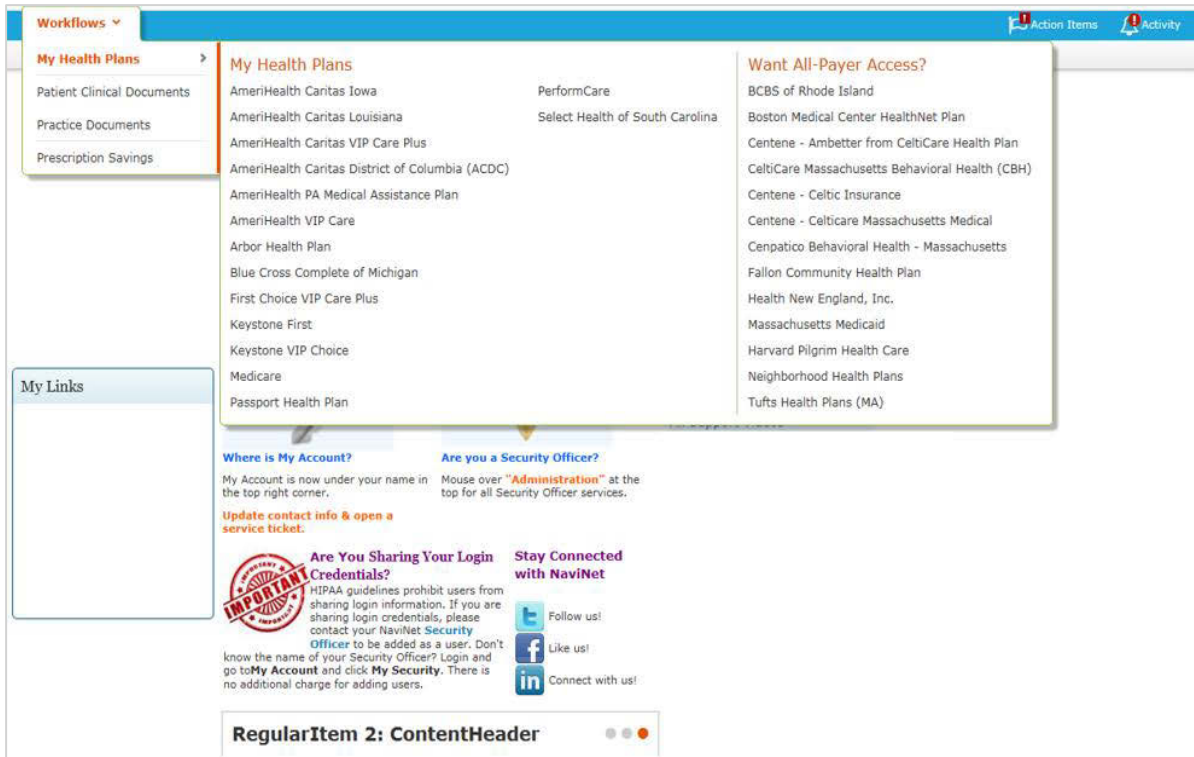
  

Please Press  

## 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.

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

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

See next page for example reports.

<<PLAN NAME>>

[Print page](#)

### Adjusted Claims Report Query v. 1.1.7

**Instructions**

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

**Adjusted Claims Information**

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

\* Choose a Time Period Up to 7 days

OR

Provide Date Range:

From Date(MM/DD/YYYY)  To Date (MM/DD/YYYY)

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

\* Choose a Provider Group Group Name - PIN ▼

Choose a Provider Provider Name - PIN ▼

**Filter Criteria**

Member ID

Claim ID

**Report Criteria**

\* Adjusted Claims Type Intensive Case Management ▼

Select Report Type  PDF  
 Excel/CSV(Downloadable)

**Select Sort Options**

\* Member Name ▼

Last Update: 08/21/2017 v.1.1.7

<<PLAN LOGO>>

### Provider Transaction Detail Report - ICM

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

Date of Report : 09/11/2017

Provider ID	Provider Name

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

PLAN LOGO

Provider Transaction Detail Report - ICM

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

Date of Report : 09/11/2017

Provider ID	Provider Name

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

Total Number of Claim Adjustments:

Total Billed Amount:

Total Paid Amount:

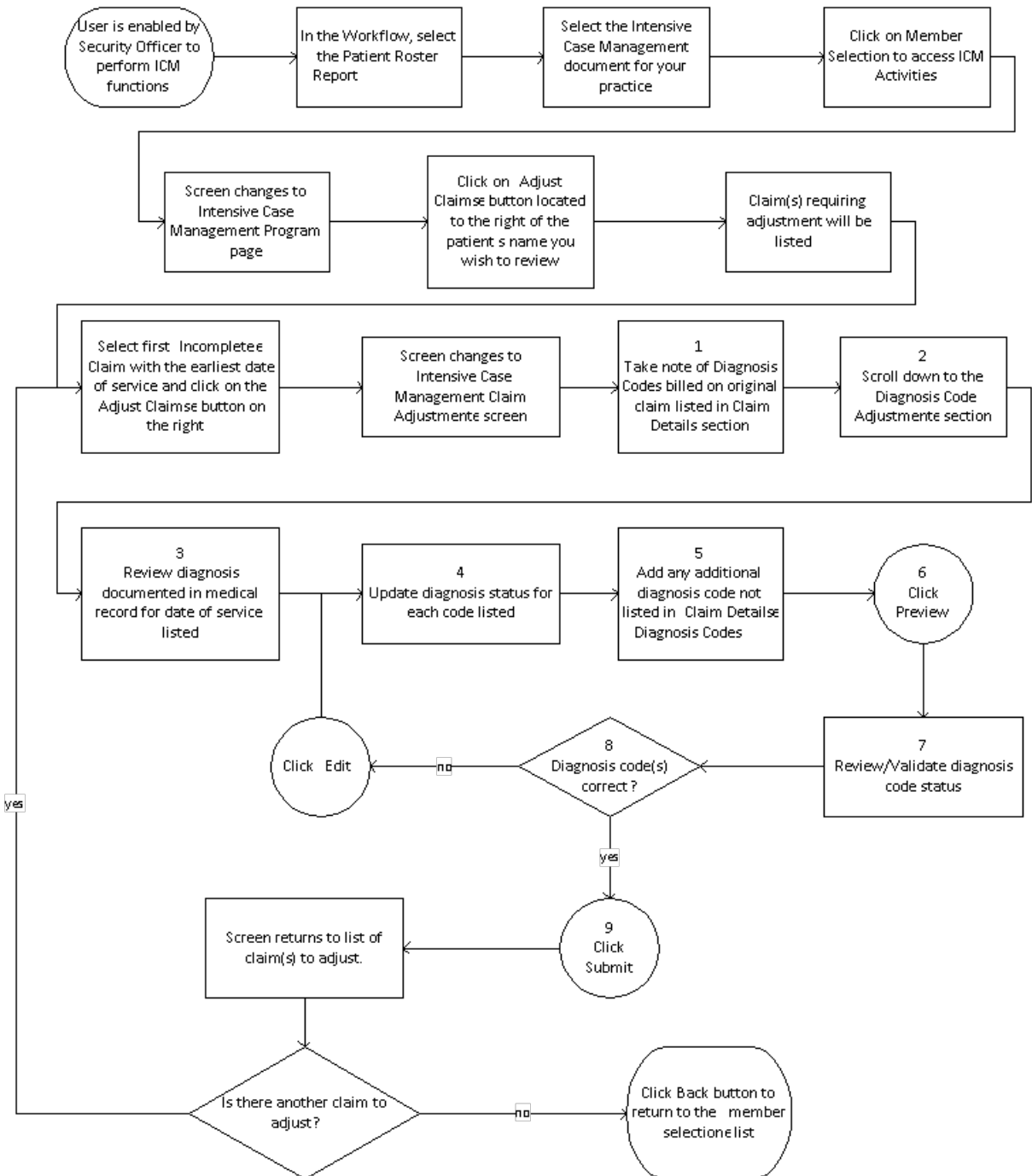
Total Count by Claim Status:

Claim processed successfully :

Other Status :

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

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



**AmeriHealth Caritas**<sup>™</sup>

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Delaware

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