Provider User Guide

Condition Optimization Program

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Blue Cross complete of Michigan

Condition Optimization Program Provider User Guide

Table of Contents

About the Condition Optimization Program

Background

Under its contract with the Michigan Department of Health and Human Services, Blue Cross Complete 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 MDHHS.

MDHHS 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. For managed care plans such as Blue Cross Complete, member-level data obtained through encounters allows MDHHS to gain a more in-depth understanding of the factors driving cost and quality within the Medicaid program.

Blue Cross Complete has developed the **Condition Optimization Program** to compensate providers for completing the essential, administrative activities that help to validate encounter data and for encouraging our members to routinely visit their primary care provider.

Program purpose

The Blue Cross Complete Condition Optimization Program exists to:

- Help primary care providers identify members with chronic 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 MDHHS regarding Blue Cross Complete member diagnosis information.

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

Identifying members and informing providers

Condition Optimization Program 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 such as Blue Cross Complete, reveals chronic and comorbid diagnoses are often incorrectly reported on claims or not reported at all.

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

- No claims were submitted by the primary care provider for that member within the previous six months.
- Claims were submitted by the primary care provider within the previous six months, but claims didn't include all the chronic/comorbid diagnosis codes found in the member's claims history.

Validating claims/encounter data

Blue Cross Complete encourages providers to check their "Practice Documents" monthly via NaviNet to identify members who require action.

Overview – Retrospective Outreach Program is one of two components of the Condition Optimization Program that focuses on previously billed claims.

"Adjust Claim(s) – Provider Self-Review Medical Records," are activities completed by a provider, online, via NaviNet and include:

- 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 additional diagnosis findings of the review;
- Receiving an applicable administrative fee for completing the review.

"Adjust Claim(s) – Plan Medical Record Review," informs provider of diagnosis information identified through the retrieval, abstraction and coding of medical record documentation by dual-certified Professional and Risk Adjustment Coders (CPC, CRC) at Blue Cross Complete. Activities completed by a provider, online, via NaviNet include:

- Accessing claim details.
- Reviewing the results of the codes identified by Blue Cross Complete against relevant medical record documentation (treatment and plan for date of service corresponding to claim date of service) in order to confirm or not confirm diagnosis information.
- Receiving an applicable administrative fee for completing the review.

Claims reviewed in NaviNet as part of the **Retrospective Outreach Program** 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 for the **Retrospective Outreach Program** will fall into one of two categories:

- **Adjust Claim(s) - Provider Self-Review Medical Records** – 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, updated 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 evaluation and management visit(s), review the notes for the member's visit(s), and determine if the suspected diagnosis code(s) are confirmed, resolved, or can't be confirmed. If a suspected diagnosis code isn't coded to the greatest specificity, update the diagnosis with a more appropriate code. Or, if additional diagnosis codes are identified that should have been on the original claim, add the diagnosis code(s) in the *Diagnosis Code Adjustment* section.

- **Adjust Claim(s) – Plan Medical Records Review Results** – Medical records were recently received and reviewed by a dual-certified Professional and Risk Adjustment Coder. Chronic/comorbid diagnosis codes were identified within the medical record that weren't reported on the originally submitted claim. Potential claim adjustments were identified and may be completed in NaviNet.

  Provider action: In the *Diagnosis Code Adjustment* section are diagnosis code(s) that are supported in the medical record provided, but weren't reported on the original claim. Review the diagnosis code(s) listed and if agreed that the diagnosis code(s) should've been submitted on the claim, mark the code as "Confirmed." If in disagreement that the diagnosis code(s) was present, mark as "Cannot Confirm."

Overview – Prospective Outreach Program is the component of the Condition Optimization Program that focuses on engaging members to be seen regularly by their primary care provider.

"Please Schedule Appointment" and "Appointment Scheduled" are activities that are to be completed by a provider and must include:

- Outreach to a member to schedule an appointment.
- During visit, clinician evaluates and documents presence of possible chronic/comorbid conditions, treated conditions and newly identified conditions within the medical record.
- Submitting any findings of the review.
- Receiving an applicable administrative fee for completing the review.

All of the above actions items are documented in NaviNet as part of the **Prospective Outreach Program.** An administrative payment is available for the completion of all activities, including complete and accurate diagnoses billing.

- **Please Schedule Appointment - Prospective Outreach Program** – The member hasn't been seen within the last six months, but there are chronic/comorbid diagnosis codes found in the member's claims history. Outreach to the member is completed and an appointment is scheduled to evaluate for possible chronic/comorbid diagnoses the member may have.

  Provider action: Outreach to the member, schedule an appointment and complete the **Prospective Outreach Program Contact Worksheet**. If contact with the member can't be made

or the member isn't interested in scheduling an appointment, update the **Contact Worksheet** with this information.

- **Appointment Scheduled** – The member returns for their scheduled appointment (as documented in the **Please Schedule Appointment** action as described above).

  Provider action: After the member has been evaluated, review the relevant diagnosis codes during the evaluation and management visit. Complete the **Scheduled Appointment Worksheet** process in NaviNet and submit a claim using the standard claim submission process.

IMPORTANT AUDIT NOTE

Any diagnosis confirmed or identified during the visit must be reported:

- Within the medical record
- On the *Scheduled Appointment Worksheet*
- On the corresponding medical claim

To receive reimbursement for the administrative services:

1. Complete the **Scheduled Appointment Worksheet** and document all confirmed diagnoses and any additional conditions identified.
2. Submit a claim following the normal process and ensure that any previously confirmed or newly identified conditions are included in the diagnosis code(s) submitted.

- Program information is refreshed on a monthly basis as new information becomes available to Blue Cross Complete; therefore, it's important that providers check each month for new **"Practice Documents."**

Supplemental reimbursement

Blue Cross Complete recognizes the additional work involved in making medical records available to us, validating the results of medical record reviews, outreaching to members to schedule appointments, and completing the NaviNet worksheet(s). Accordingly, Blue Cross Complete offers primary care providers an administrative payment in accordance with the following fee schedule:

Retrospective Outreach – Adjust Claim(s)

- Original claim for any member – $75 per claim.
- All subsequent claims for the same member with service dates exceeding 180 days from the prior claim service date – $75 per claim.
- All subsequent claims for the same member with service dates within a 180 day period from the prior claim service date – $75 per claim.

The additional reimbursement is for your effort and participation in this program; it isn't dependent on Blue Cross Complete's receipt of updated or confirmed chronic diagnoses codes.

Prospective Outreach – Appointment Completed

- Payment is issued in January and July of each year.
- Administrative fee - $150.00 per completed visit, per member.

Audit of Condition Optimization Program - Prospective Outreach Program

When providers have opted to review medical records on their own or have completed a visit with a member identified in the COP *Prospective Outreach Program*, Blue Cross Complete also performs a random quality review of claims submitted or adjusted through the COP program process. As part of the quality audit process, Blue Cross Complete obtains medical records 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'll be notified of the audit results. Providers with low quality audit scores may be asked to participate in program training and repeat low quality audit scores will result in the rejection of previously-submitted adjustments that can't 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 the Condition Optimization Program activities. In this guide, you'll find information on how to:

- Access the "Practice Documents" workflow
- Review, search and filter pending activities in the workflow
- Launch "Member Selection" for COP activities
- Search for a member 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.
    - Scheduling an office visit, evaluating the member and submitting a *Scheduled Appointment Worksheet*.

Before you begin

1. NaviNet permissions

Check with your NaviNet security officer to confirm you have been granted the appropriate access to the workflows you need. If your NaviNet security officer hasn't enabled *Document Exchange,* ask your security officer to follow the steps outlined on pages 36 through 39 in the "Supplemental information" section of this guide.

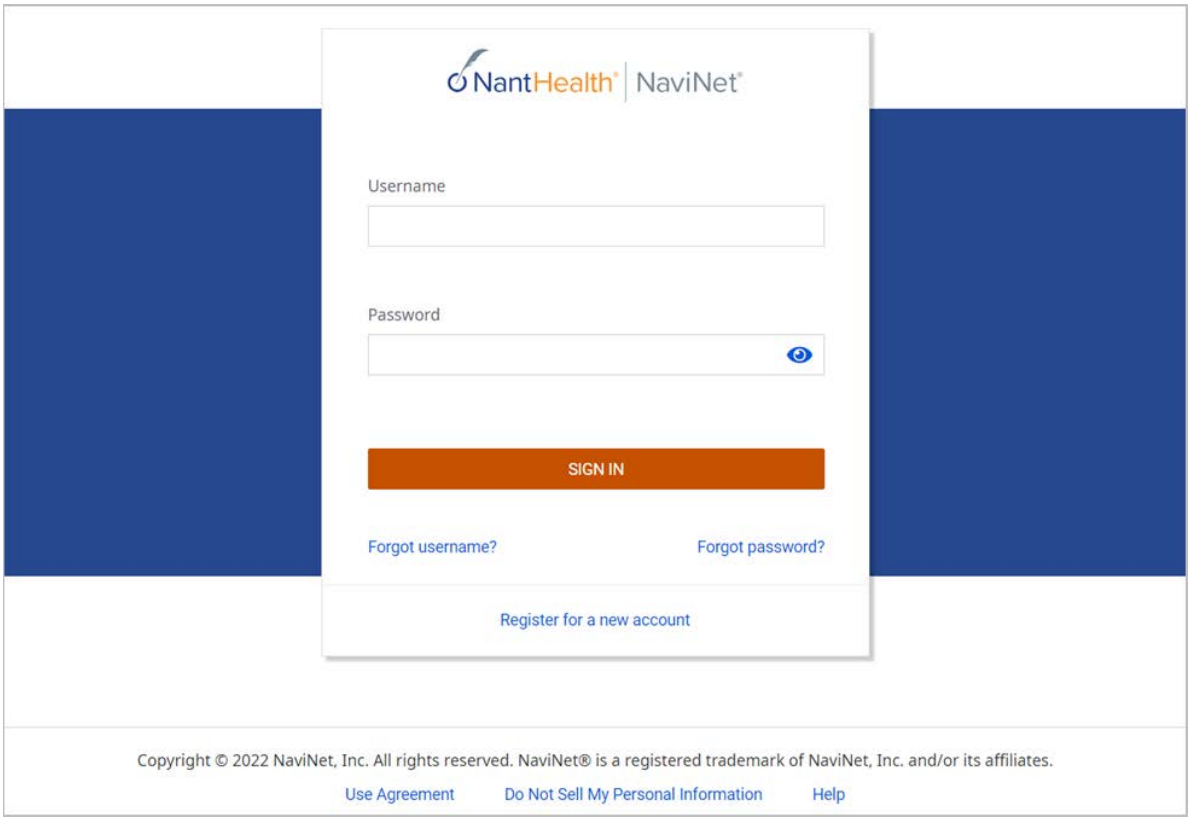
2. Consider filtering providers for optimum access

You can view and access documents submitted on behalf of all providers associated with your office. Additionally, you can specify a list of providers whose documents you prefer to see. You can save this list of providers to be shown by default anytime you access the Patient or Practice

Document dashboards. To learn more about your access options, please login to NaviNet and visit support.nanthealth.com/health-plans/navinet-open/user-guide/provider-filter.

Step 1. Login to NaviNet

A. Open your internet browser.
B. Go to NaviNet.net.
C. Login to NaviNet by entering your **Username** and **Password** and then clicking **Sign In**.

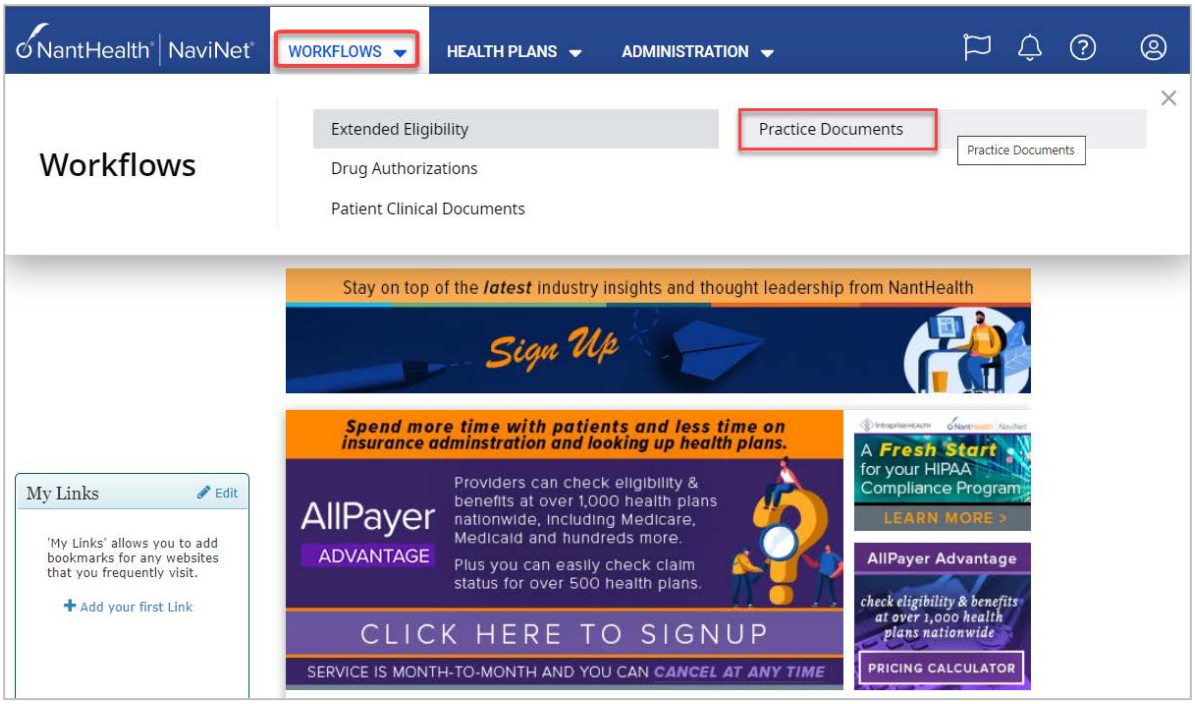


Step 2. Access “Practice Documents” workflow

About workflows – “Practice Documents”

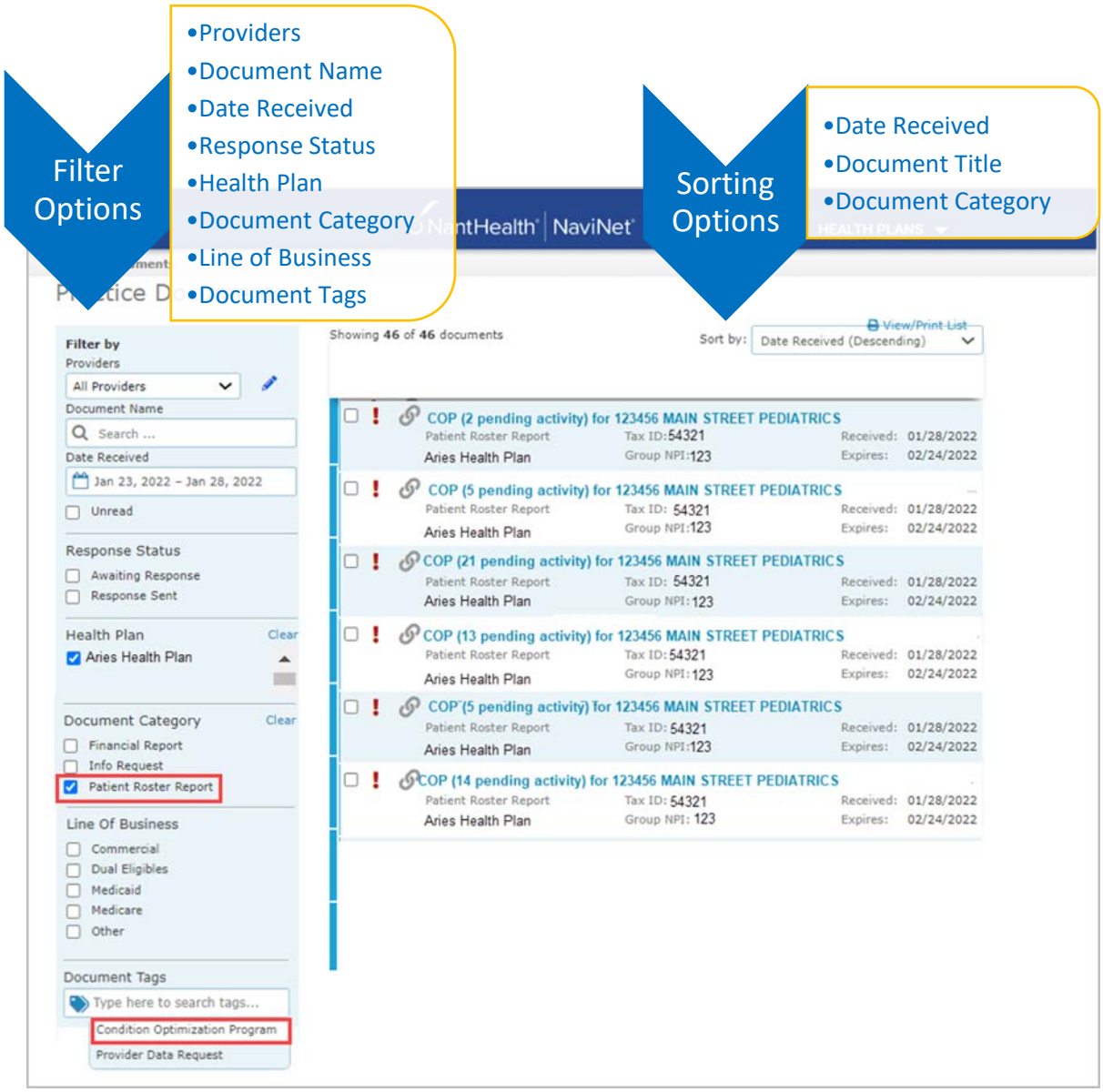
The most common way to access and complete Condition Optimization Program activities is the **“Practice Documents**” workflow, which allows users to see a list of all members on a patient roster for a particular health plan. The steps below provide access to the **“Practice Documents”** workflow.

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



Step 3. Review, search and filter pending activities in the workflow

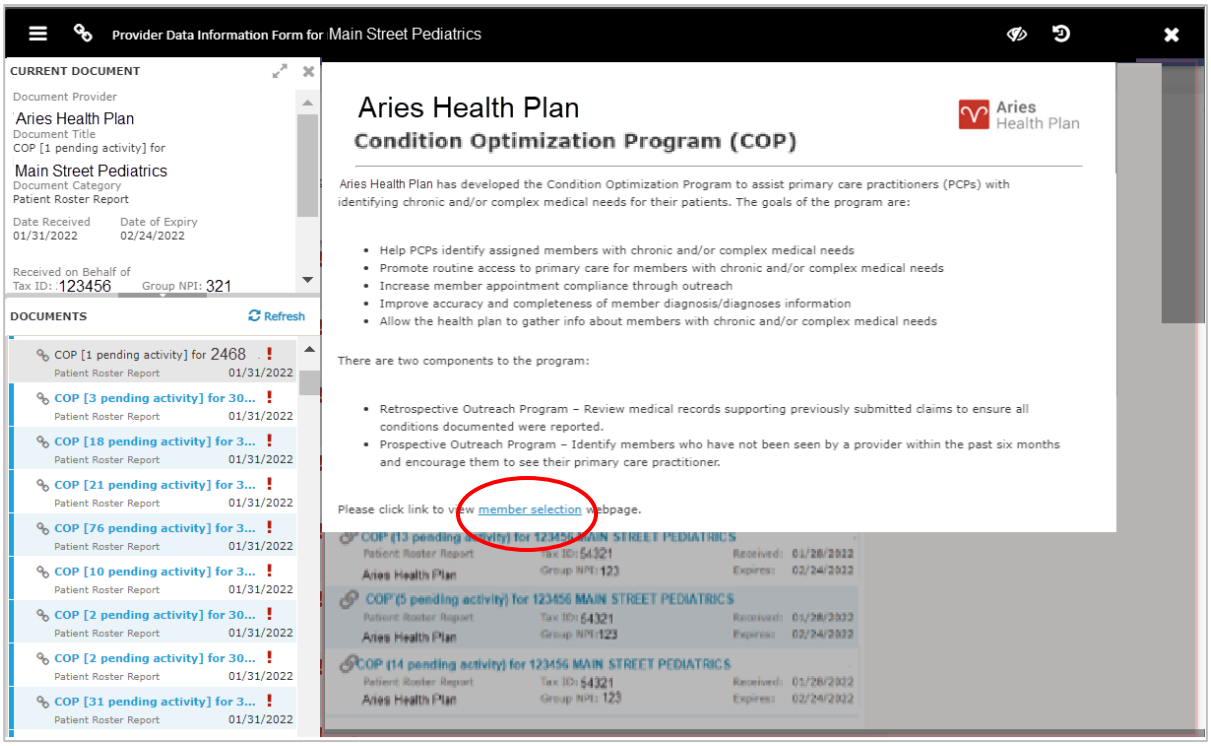
A. Use the enhanced filter and sorting options to look for specific records.
B. To view Condition Optimization Program documents, filter for **Patient Roster Report** under **"Document Category"** or type **Condition Optimization Program** into the "Document Tags" field.
C. Check for **Pending Activity**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



Step 4. Launch “Member Selection” for Condition Optimization Program activities

A. Click on a record to view. For example, “COP for 123456 MAIN STREET PEDIATRICS.”

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



Step 5. Search for a member or filter by needed actions

You're now in the Condition Optimization Program section of NaviNet. Here, the user will see the **Member Listing,** which contains all Condition Optimization Program members associated with the practice the user selected in Step 3.

Here, the user can choose to:

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

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

   - **Adjust Claim(s) - Plan Medical Records Review Results** will filter for members where medical records have been received, abstraction has been completed, and diagnosis codes were identified that were not originally reported on the claim (Retrospective Outreach Program). These diagnosis codes will require review to update the claim.

   - **Please Schedule Appointment – Prospective Outreach Program** will filter for members who may need to be seen by their primary care provider for overdue routine care. For these members, a ***Contact Worksheet*** will need to be submitted.

   - **Appointment Scheduled** – will filter for members who previously were updated in a **Please Schedule Appointment** action as scheduled for evaluation of suspected historical diagnoses. For these members, a ***Scheduled Appointment Worksheet*** will need to be submitted.

C. Filter by status:
   - **Incomplete** status will filter for all records regardless of action type that require review/adjustment.

   - **Pending** status will filter for records where at least one claim for the member is in "Submitted; Waiting Batch Process" status and no other claims are in an "Incomplete" status. This is applicable for Adjust Claim(s) scenarios only.

PLAN LOGO

Condition Optimization Program

If you have any questions about the Condition Optimization Program, please contact your Service Representative or Provider Services. For contact information, click here.

Group:
Publish Date:
Due Date:

Member ID
Member Last Name
Member Date of Birth MM/DD/YYYY

Filter by Action
- Adjust Claim(s) - Provider Self-Review Medical Records
- Adjust Claim(s) - Plan Medical Records Review Results
- Please Schedule Appointment - Prospective Outreach Program
- Appointment Scheduled

Filter by Status
- Incomplete
- Pending

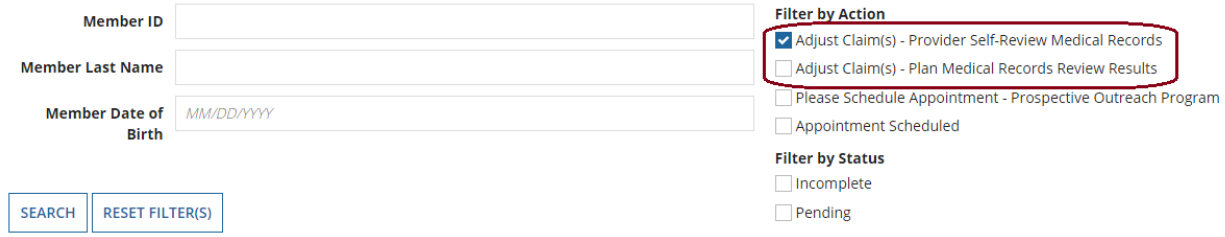
SEARCH | RESET FILTER(S)

Definition of each 'Filter by Action'

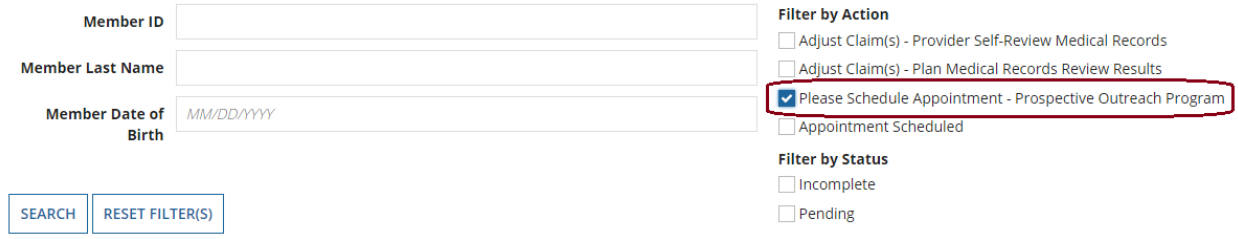
- Adjust Claim(s) - Provider Self-Review: Provider pulls medical record for date of service and evaluates presence/treatment of condition in question (Retrospective Outreach Program).
- Adjust Claim(s) - Plan Medical Record Review: Plan requested medical records from provider, completed abstraction and coding and identified diagnosis codes that were not originally reported on claim (Retrospective Outreach Program).
- Please Schedule Appointment: Member has not been treated by physician in at least six months. Schedule appointment, evaluate conditions identified and submit claim. Be sure to include all diagnosis codes treated during visit (Prospective Outreach Program).
- Appointment Scheduled: Outreach to member completed and Contact worksheet has been submitted. After member has been seen by the provider and evaluated for suspected chronic and/or complex conditions, Appointment Scheduled worksheet must be completed.

Member ID	Last Name	First Name	Date of Birth	Action	Status	Adjust Claim(s)/ Member Details
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT - PROSPECTIVE OUTREACH PROGRAM	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				PLEASE SCHEDULE APPOINTMENT - PROSPECTIVE OUTREACH PROGRAM	INCOMPLETE	
				ADJUST CLAIM(S) - PROVIDER SELF-REVIEW MEDICAL RECORDS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				ADJUST CLAIM(S) - PROVIDER SELF-REVIEW MEDICAL RECORDS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	
				ADJUST CLAIM(S) - PLAN MEDICAL RECORDS REVIEW RESULTS	INCOMPLETE	

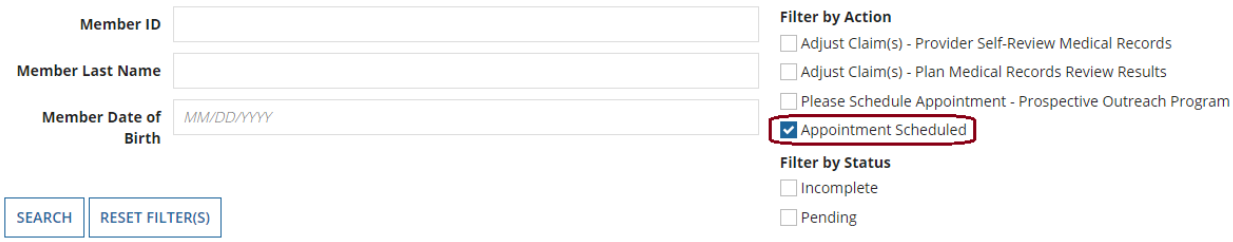
When a user selects **Filter by Action "Adjust claim(s),"** only members with that option will be displayed on the screen:



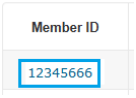
When a user selects **Filter by Action "Please Schedule Appointment,"** only members with that option will be displayed on the screen:



When a user selects **Filter by Action "Appointment Scheduled,"** only members with that option will be displayed on the screen:



From this screen, users can also click on **Member ID** to view additional member details, including address, telephone number and diagnosis code(s).



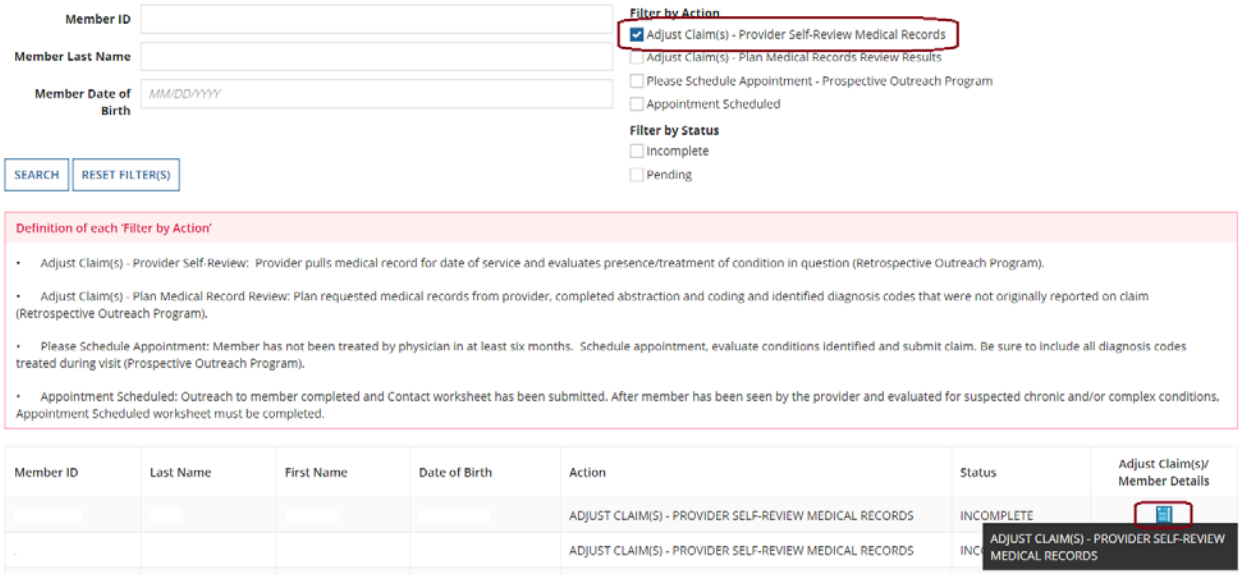
There are three possible statuses in the **Member Listing** screen:

1) **INCOMPLETE** - This status will be populated when at least one claim of a member has an "Incomplete" status.
2) **PENDING** - This status will be populated when at least one claim of a member has a "Submitted; Waiting batch process" status and no other claim is in "Incomplete" status.
3) **COMPLETED** - This status will be populated when all claims are in "Claim Adjusted on MM/DD/YYYY" status.

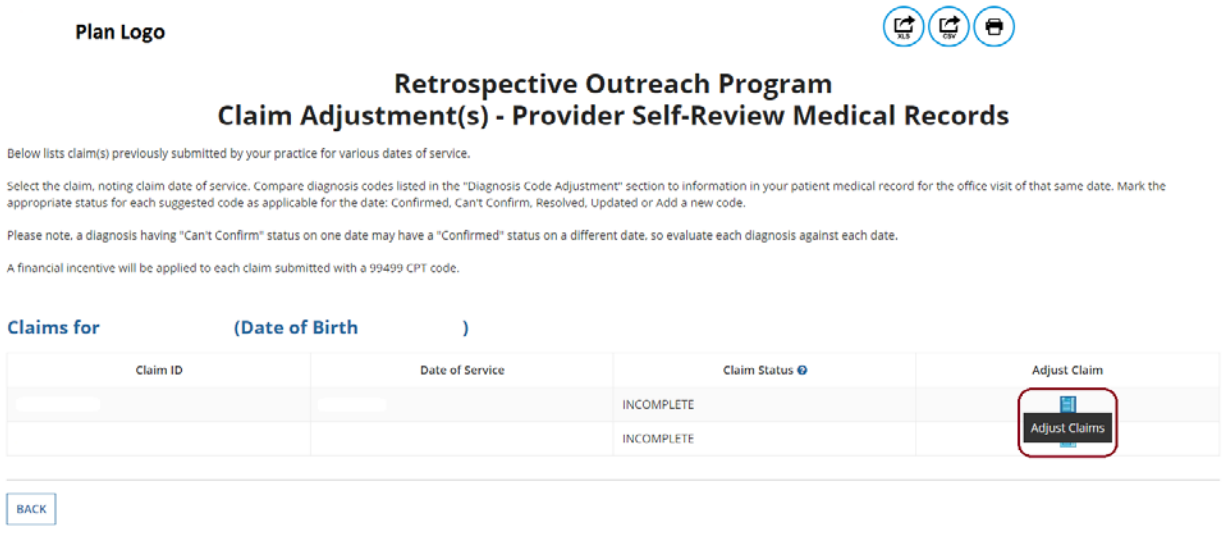
Step 6. Complete the needed actions

A. Adjust the action type "Adjust Claim(s) – Provider Self-Review Medical Records" to reflect diagnosis information from the member's medical record

I. Under **Filter by Action**, select "**Adjust Claim(s) – Provider Self-Review Medical Records**" to display all records of this type. Then, under **"Adjust Claim(s)/Member Details,"** click on the **Adjust Claim(s) – Provider Self-Review Medical Records Icon** to view the complete list of adjustable claims associated with that member.



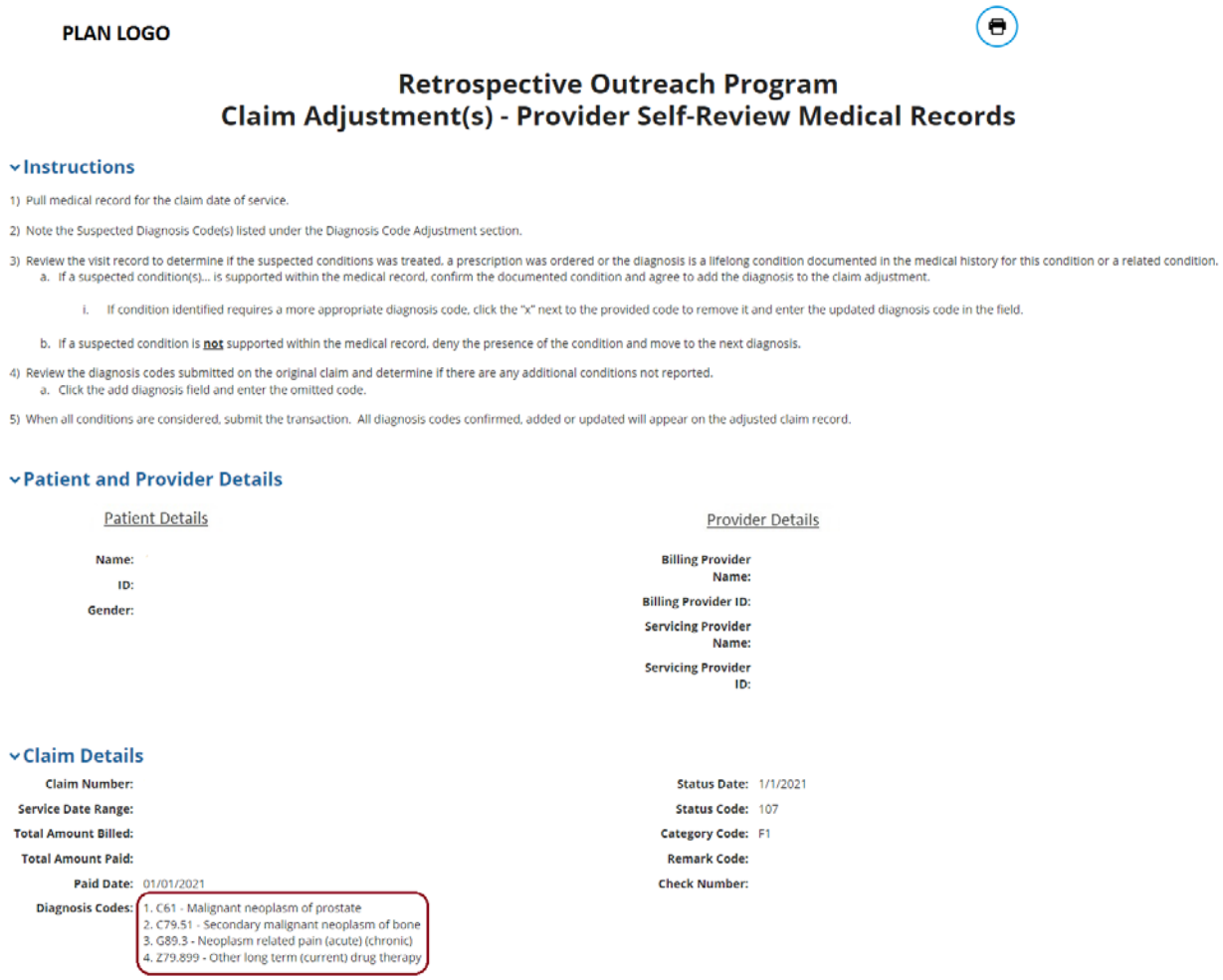
II. To view claims details and to make claim adjustments, select the **Adjust Claim(s)** icon on the right.



Three possible statuses in the **Claim Listing** screen include:

1) **INCOMPLETE** – The user 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 the user can re-adjust a claim in this status.
3) **Claim Adjusted on MM/DD/YYYY** - Status is populated when the user submitted an adjustment and the batch process is completed.

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



PLAN LOGO

Retrospective Outreach Program
Claim Adjustment(s) - Provider Self-Review Medical Records

Instructions

1) Pull medical record for the claim date of service.
2) Note the Suspected Diagnosis Code(s) listed under the Diagnosis Code Adjustment section.
3) Review the visit record to determine if the suspected conditions was treated, a prescription was ordered or the diagnosis is a lifelong condition documented in the medical history for this condition or a related condition.
   a. If a suspected condition(s)... is supported within the medical record, confirm the documented condition and agree to add the diagnosis to the claim adjustment.
      i. If condition identified requires a more appropriate diagnosis code, click the "x" next to the provided code to remove it and enter the updated diagnosis code in the field.
   b. If a suspected condition is **not** supported within the medical record, deny the presence of the condition and move to the next diagnosis.
4) Review the diagnosis codes submitted on the original claim and determine if there are any additional conditions not reported.
   a. Click the add diagnosis field and enter the omitted code.
5) When all conditions are considered, submit the transaction. All diagnosis codes confirmed, added or updated will appear on the adjusted claim record.

Patient and Provider Details

Patient Details

Name:
ID:
Gender:

Provider Details

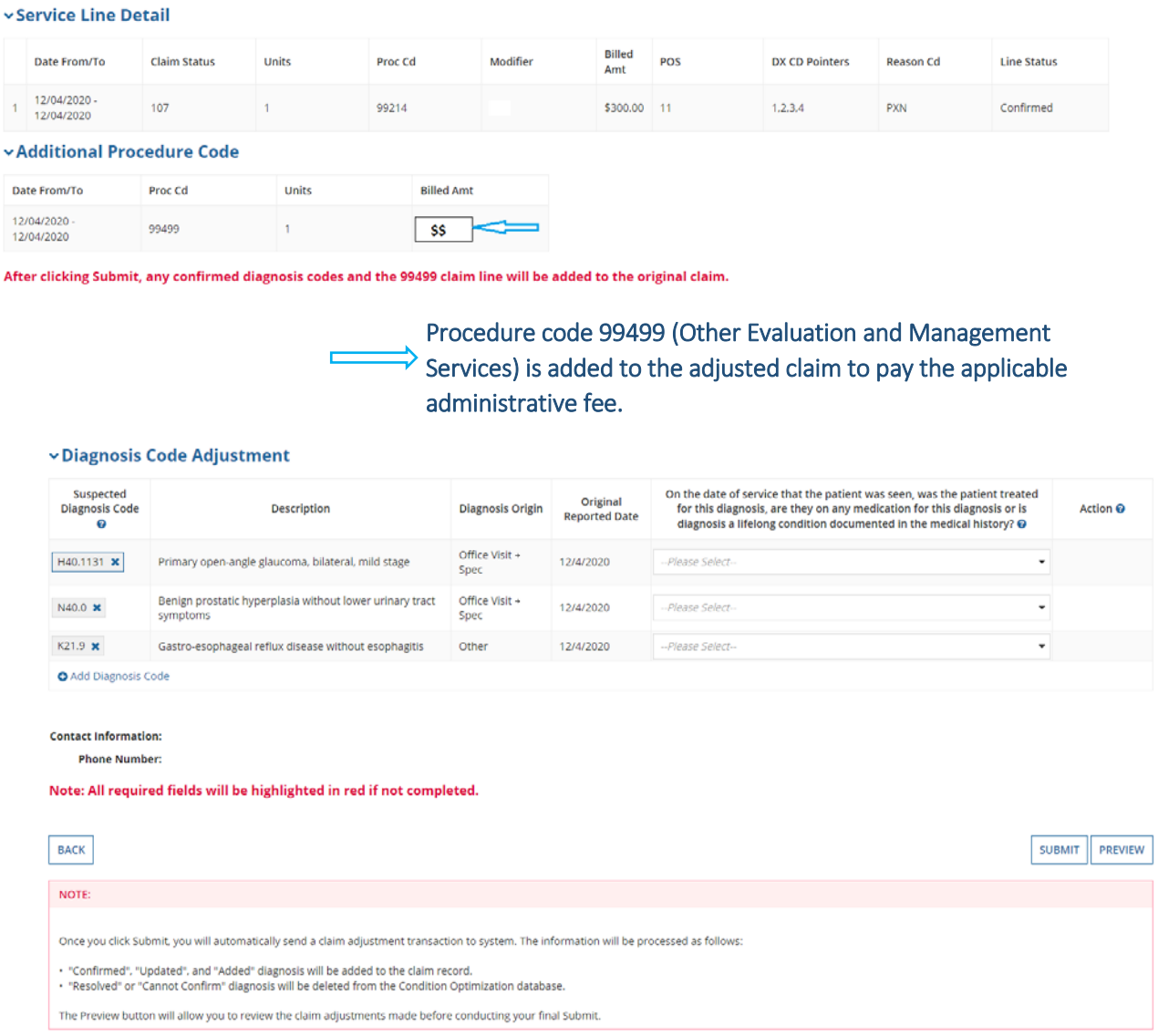
Billing Provider Name:
Billing Provider ID:
Servicing Provider Name:
Servicing Provider ID:

Claim Details

Claim Number:
Service Date Range:
Total Amount Billed:
Total Amount Paid:
Paid Date: 01/01/2021
Diagnosis Codes:
1. C61 - Malignant neoplasm of prostate
2. C79.51 - Secondary malignant neoplasm of bone
3. G89.3 - Neoplasm related pain (acute) (chronic)
4. Z79.899 - Other long term (current) drug therapy

Status Date: 1/1/2021
Status Code: 107
Category Code: F1
Remark Code:
Check Number:

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



Service Line Detail

	Date From/To	Claim Status	Units	Proc Cd	Modifier	Billed Amt	POS	DX CD Pointers	Reason Cd	Line Status
1	12/04/2020 - 12/04/2020	107	1	99214		$300.00	11	1,2,3,4	PXN	Confirmed

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
12/04/2020 - 12/04/2020	99499	1	$$

After clicking Submit, any confirmed diagnosis codes and the 99499 claim line will be added to the original claim.

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

Diagnosis Code Adjustment

Suspected Diagnosis Code	Description	Diagnosis Origin	Original Reported Date	On the date of service that the patient was seen, was the patient treated for this diagnosis, are they on any medication for this diagnosis or is diagnosis a lifelong condition documented in the medical history?	Action
H40.1131	Primary open-angle glaucoma, bilateral, mild stage	Office Visit + Spec	12/4/2020	--Please Select--	
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms	Office Visit + Spec	12/4/2020	--Please Select--	
K21.9	Gastro-esophageal reflux disease without esophagitis	Other	12/4/2020	--Please Select--	

Add Diagnosis Code

Contact Information:

Phone Number:

Note: All required fields will be highlighted in red if not completed.

BACK SUBMIT PREVIEW

NOTE:

Once you click Submit, you will automatically send a claim adjustment transaction to system. The information will be processed as follows:

- "Confirmed", "Updated", and "Added" diagnosis will be added to the claim record.
- "Resolved" or "Cannot Confirm" diagnosis will be deleted from the Condition Optimization database.

The Preview button will allow you to review the claim adjustments made before conducting your final Submit.

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

a. **Yes, diagnosis confirmed** – Attesting the user confirms the diagnosis is still present.

b. **Yes, but diagnosis updated** – If the diagnosis code listed isn't correct for the member's condition, the user 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.

c. **No, cannot confirm** – Attesting that the user doesn't have record(s) of this diagnosis; never present.

d. **No, diagnosis resolved** – Attesting that the diagnosis has been treated and is no longer present.

The diagnosis codes presented here may or may not have originated from claims that the provider submitted. In the **Diagnosis Code Adjustment** section, information is available under **Diagnosis Origin** and **Original Reported Date** that provides additional data pertaining to the diagnosis codes requiring review.

V. The user also has the option to **Add Diagnosis Code** should they 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.

VI. Select **Preview** at the bottom of the screen for an opportunity to review the "Verification" page. Here, a user can review all the information they provided/updated (see the next page, for example).

VII. Next:

a. Click **Edit** to return to the Claim Adjustment screen for additional changes.
b. Click **Submit** to complete claim adjustment activity. The user will see the Claim Listing screen with the status for adjusted claims now displaying as "**Submitted; Waiting batch process.**"

PLAN LOGO

Retrospective Outreach Program
Claim Adjustment(s) - Provider Self-Review Medical Records

Instructions

1) Pull medical record for the claim date of service.

2) Note the Suspected Diagnosis Code(s) listed under the Diagnosis Code Adjustment section.

3) Review the visit record to determine if the suspected conditions was treated, a prescription was ordered or the diagnosis is a lifelong condition documented in the medical history for this condition or a related condition.
   a. If a suspected condition(s)... is supported within the medical record, confirm the documented condition and agree to add the diagnosis to the claim adjustment.
      i. If condition identified requires a more appropriate diagnosis code, click the "x" next to the provided code to remove it and enter the updated diagnosis code in the field.
   b. If a suspected condition is **not** supported within the medical record, deny the presence of the condition and move to the next diagnosis.

4) Review the diagnosis codes submitted on the original claim and determine if there are any additional conditions not reported.
   a. Click the add diagnosis field and enter the omitted code.

5) When all conditions are considered, submit the transaction. All diagnosis codes confirmed, added or updated will appear on the adjusted claim record.

Patient and Provider Details

Patient Details		Provider Details	
Name:		**Billing Provider Name:**	
ID:		**Billing Provider ID:**	
Gender:		**Servicing Provider Name:**	
		Servicing Provider ID:	

Claim Details

Claim Number:		**Status Date:**	
Service Date Range:		**Status Code:**	
Total Amount Billed:		**Category Code:**	
Total Amount Paid:		**Remark Code:**	
Paid Date:		**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	99214		$300.00	11	1,2,3,4		Confirmed

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
12/04/2020 - 12/04/2020	99499	1	

Diagnosis Code Adjustment

Suspected Diagnosis Code	Description	Diagnosis Origin	Original Reported Date	On the date of service that the patient was seen, was the patient treated for this diagnosis, are they on any medication for this diagnosis or is diagnosis a lifelong condition documented in the medical history?
H40.1131	Primary open-angle glaucoma, bilateral, mild stage	Office Visit – Spec	12/4/2020	Yes, diagnosis confirmed
N40.0	Benign prostatic hyperplasia without lower urinary tract symptoms	Office Visit – Spec	12/4/2020	Yes, diagnosis confirmed
K21.9	Gastro-esophageal reflux disease without esophagitis	Other	12/4/2020	No, diagnosis resolved
J45.909	Unspecified asthma, uncomplicated			ADDED

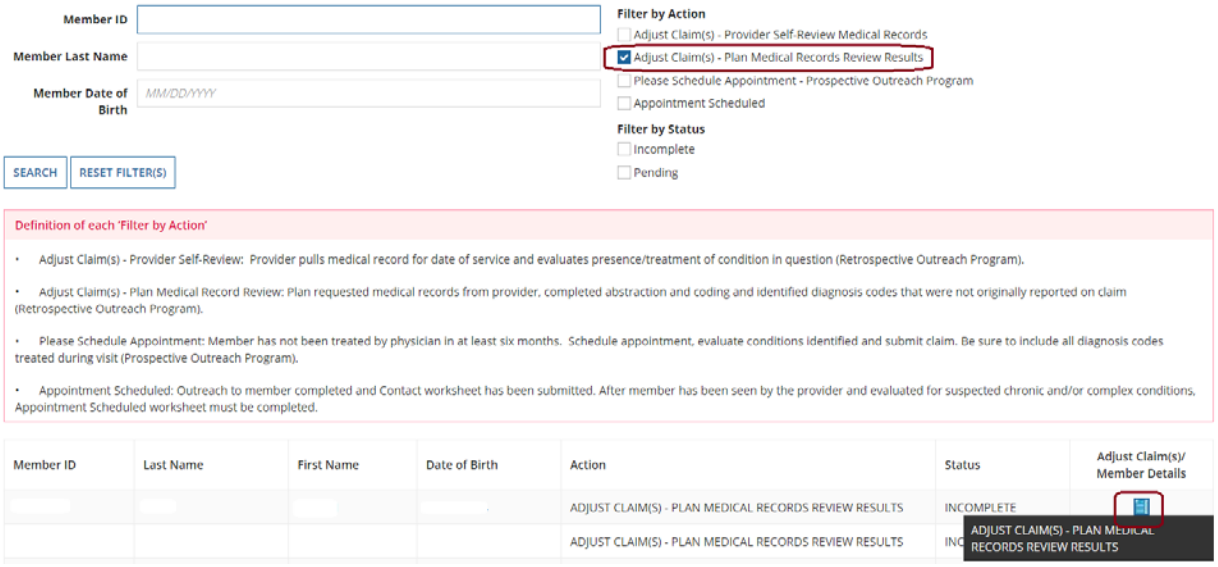
Contact Information:
Phone Number:

SUBMIT EDIT

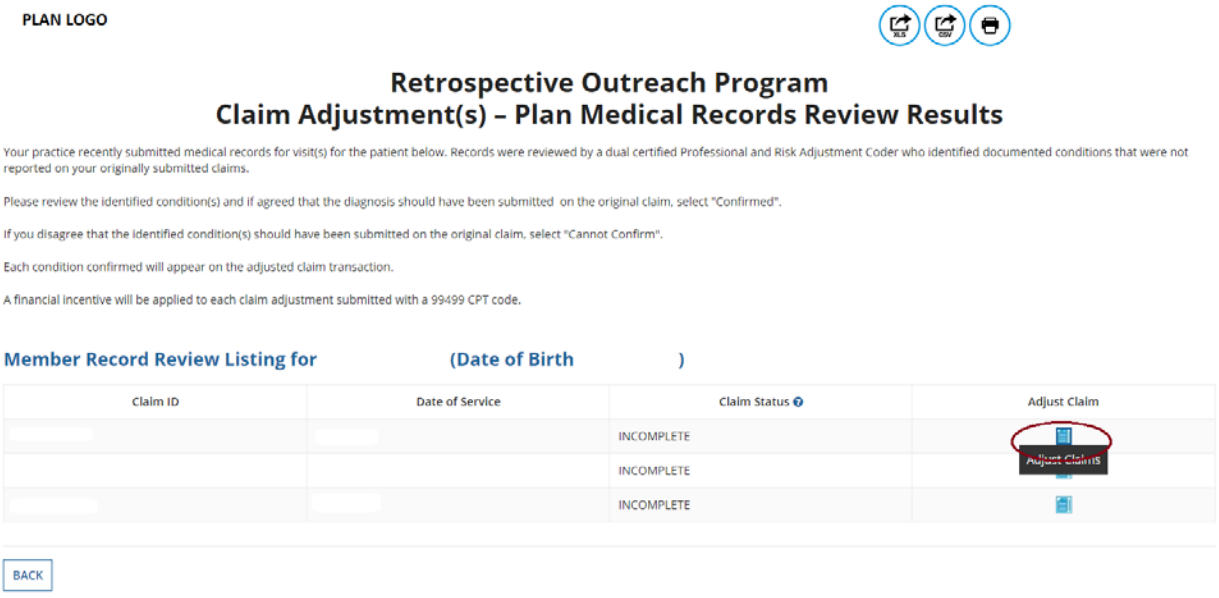
VIII. After submitting the adjustment, the user is returned to the **Claim Listing** screen. If there are additional claims to adjust, proceed to the next claim for adjustment or click the Back button to return to the Member Listing screen.

B. Adjust the action type "Adjust Claim(s) – Plan Medical Records Review Results" to review diagnosis information abstracted from the member's medical record

I. Under **Filter by Action**, select "**Adjust Claim(s) – Plan Medical Records Review Results**" to display all records of this type. Then, under **"Adjust Claim(s)/Member Details,"** click on the **Adjust Claim(s) – Plan Medical Records Review Results Icon** to view the complete list of adjustable claims associated with that member.



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

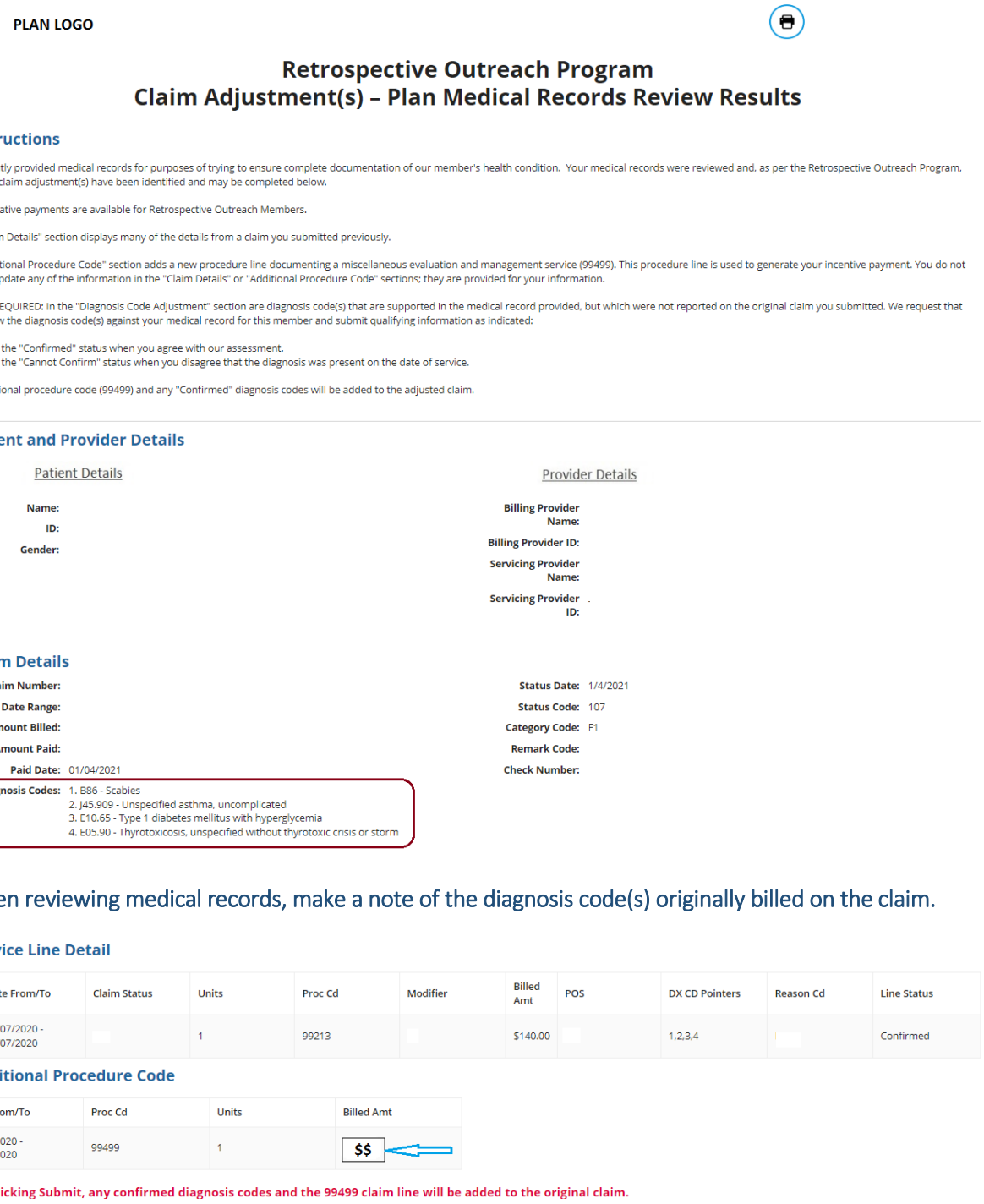


Three possible statuses in the **Claim Listing** screen include:

4) **INCOMPLETE** – The user can adjust claims which are in an "**incomplete"** status.

5) **SUBMITTED; WAITING BATCH PROCESS** - Status will be seen when you already submitted an adjustment, but the user can re-adjust a claim in this status.
6) **Claim Adjusted on MM/DD/YYYY** - Status is populated when the user submitted adjustment and batch process is completed.

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



PLAN LOGO

Retrospective Outreach Program
Claim Adjustment(s) – Plan Medical Records Review Results

Instructions

You recently provided medical records for purposes of trying to ensure complete documentation of our member's health condition. Your medical records were reviewed and, as per the Retrospective Outreach Program, potential claim adjustment(s) have been identified and may be completed below.

Administrative payments are available for Retrospective Outreach Members.

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 (99499). This procedure line is used to generate your incentive payment. 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.

ACTION REQUIRED: In the "Diagnosis Code Adjustment" section are diagnosis code(s) that are supported in the medical record provided, but which were not reported on the original claim you submitted. We request that you review the diagnosis code(s) against your medical record for this member and submit qualifying information as indicated:

- Click the "Confirmed" status when you agree with our assessment.
- Click the "Cannot Confirm" status when you disagree that the diagnosis was present on the date of service.

The Additional procedure code (99499) and any "Confirmed" diagnosis codes will be added to the 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:
Paid Date: 01/04/2021
Diagnosis Codes: 1. B86 - Scabies
2. J45.909 - Unspecified asthma, uncomplicated
3. E10.65 - Type 1 diabetes mellitus with hyperglycemia
4. E05.90 - Thyrotoxicosis, unspecified without thyrotoxic crisis or storm

Status Date: 1/4/2021
Status Code: 107
Category Code: F1
Remark Code:
Check Number:

When reviewing medical records, make a note of the diagnosis code(s) originally billed on the claim.

Service Line Detail

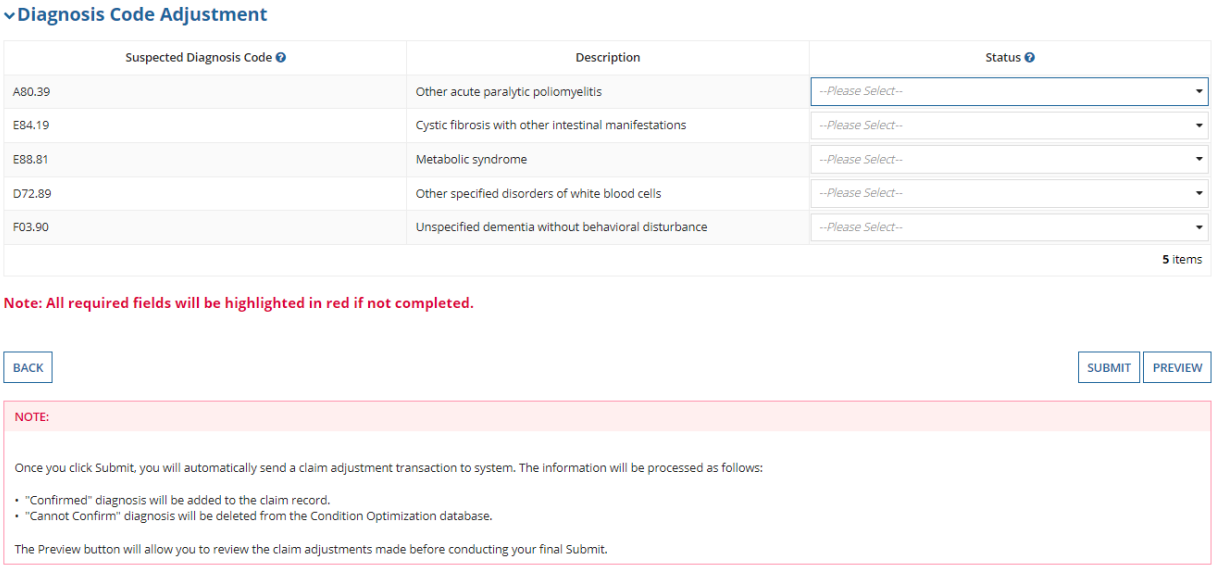
	Date From/To	Claim Status	Units	Proc Cd	Modifier	Billed Amt	POS	DX CD Pointers	Reason Cd	Line Status
1	12/07/2020 - 12/07/2020		1	99213		$140.00		1,2,3,4		Confirmed

Additional Procedure Code

Date From/To	Proc Cd	Units	Billed Amt
12/07/2020 - 12/07/2020	99499	1	$$

After clicking Submit, any confirmed diagnosis codes and the 99499 claim line will be added to the original claim.

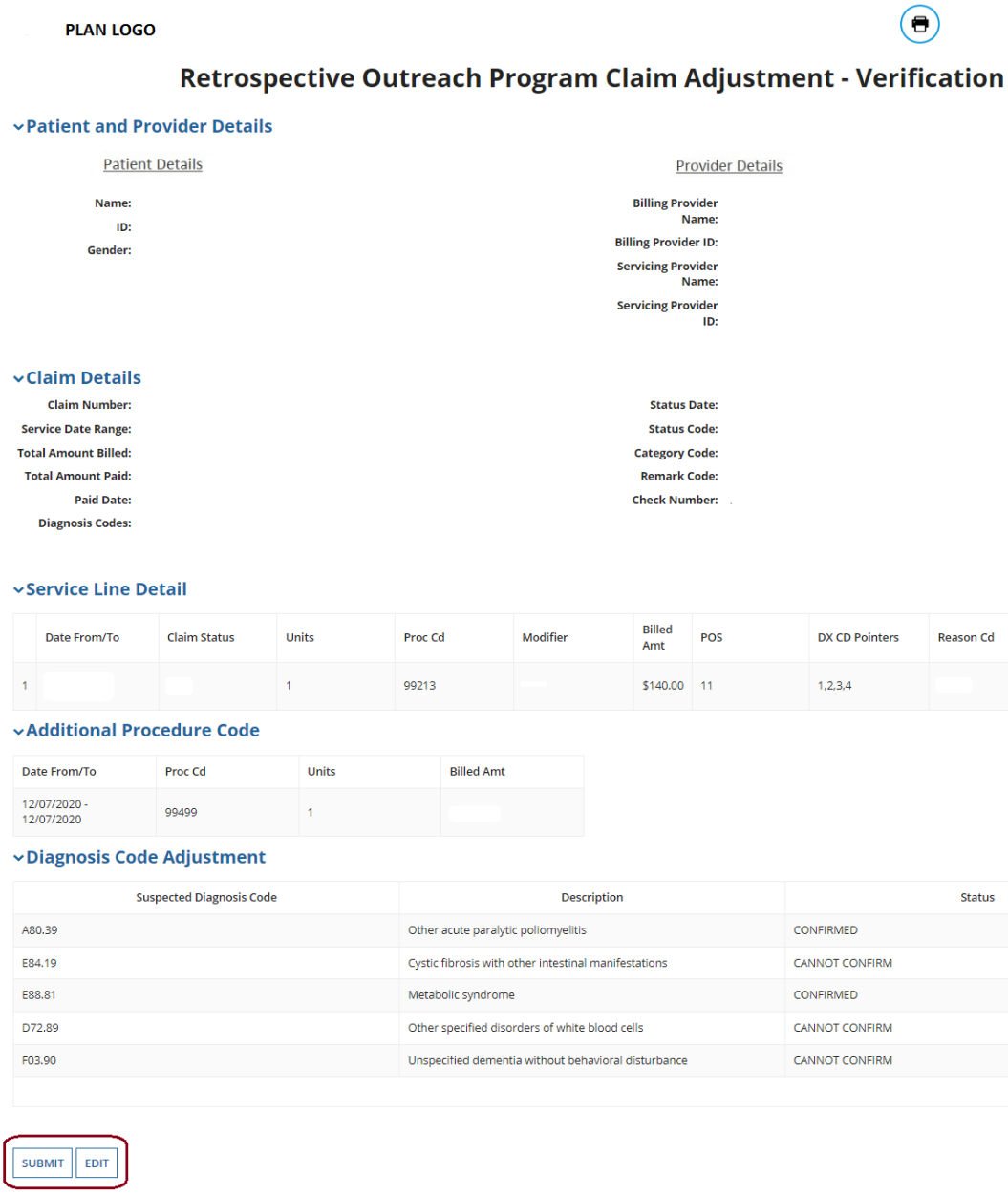
Procedure code 99499 (Other Evaluation and Management Services) is added to the adjusted claim to pay the applicable administrative fee.



IV. In the **Diagnosis Code Adjustment** section, we're requesting that you review the diagnosis codes listed against the medical record for this member and submit qualifying information as indicated:
   a. **Confirmed** – If the user agrees the diagnosis code should have been included on the original claim.
   b. **Cannot Confirm** – If the user disagrees that the diagnosis was present.

V. Select **Preview** at the bottom of the screen for an opportunity to review the "Verification" page. Here, a user can review all the information provided or updated (see next page for example).

VI. Next:
   a. Click **Edit** to return to the **Claim Adjustment** screen for additional changes.
   b. Click **Submit** to complete claim adjustment activity. The user will see the Claim Listing screen with the status for adjusted claims now displaying as "**Submitted; Waiting batch process.**"



VII. 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.

PLAN LOGO

Retrospective Outreach Program
Claim Adjustment(s) – Plan Medical Records Review Results

Your practice recently submitted medical records for visit(s) for the patient below. Records were reviewed by a dual certified Professional and Risk Adjustment Coder who identified documented conditions that were not reported on your originally submitted claims.

Please review the identified condition(s) and if agreed that the diagnosis should have been submitted on the original claim, select "Confirmed".

If you disagree that the identified condition(s) should have been submitted on the original claim, select "Cannot Confirm".

Each condition confirmed will appear on the adjusted claim transaction.

A financial incentive will be applied to each claim adjustment submitted with a 99499 CPT code.

Member Record Review Listing for (Date of Birth)

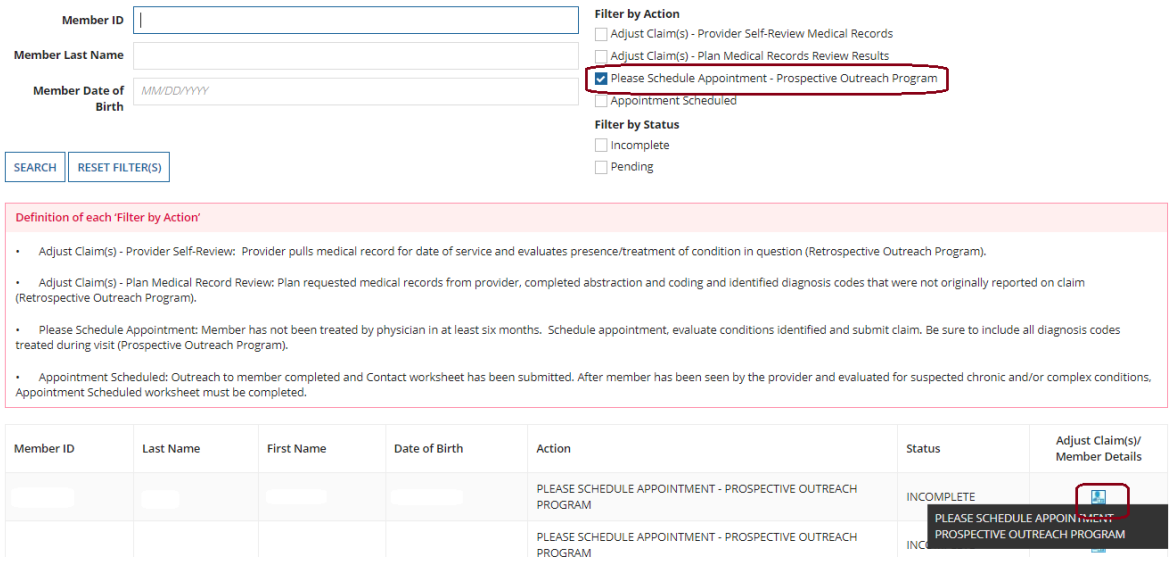
Claim ID	Date of Service	Claim Status	Adjust Claim
		SUBMITTED; WAITING BATCH PROCESS	

BACK

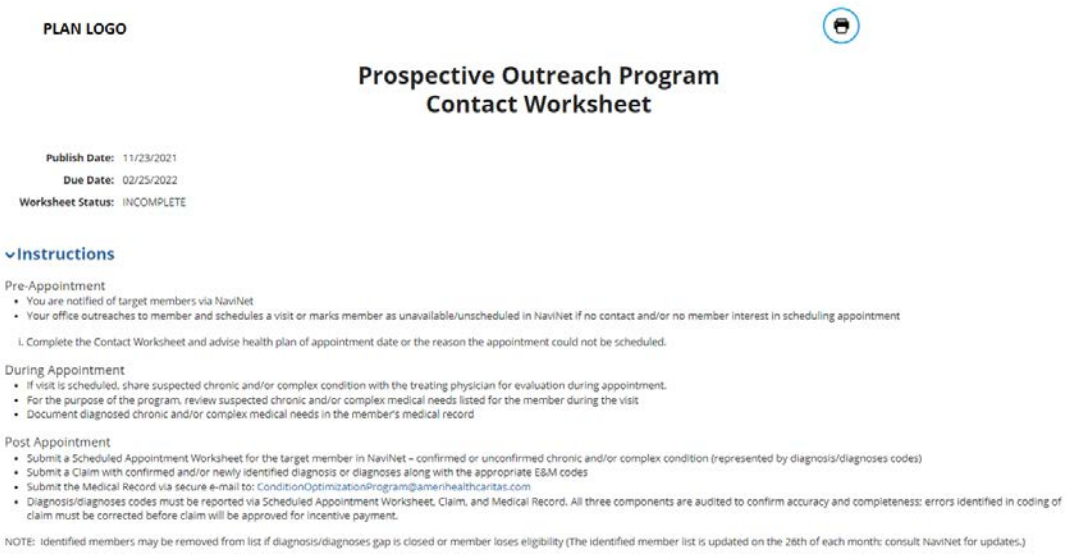
C. Schedule an office visit and complete a *Please Schedule Appointment* contact worksheet

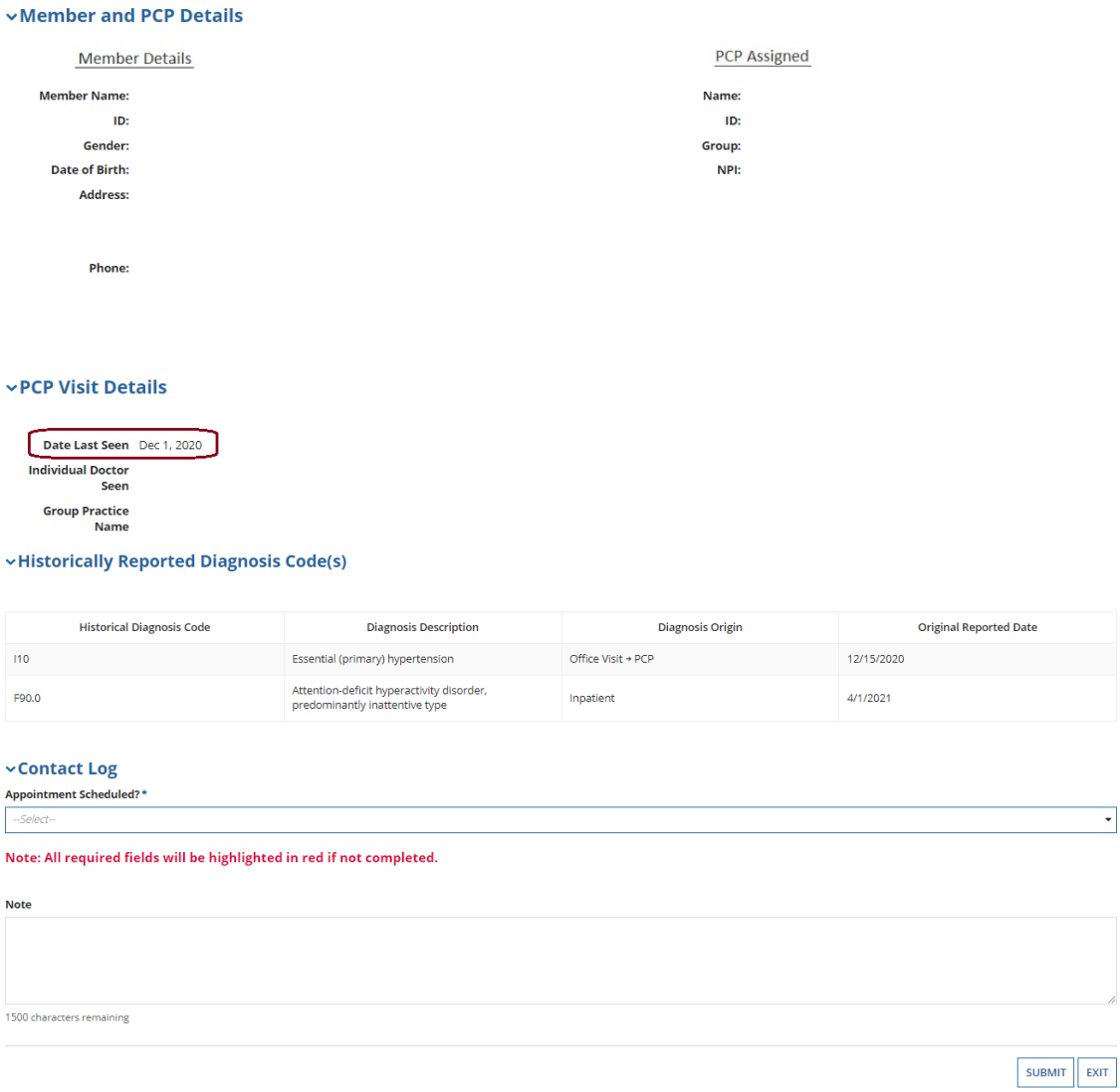
In terms of workflow, many providers prefer to complete all of the Adjust Claim(s) activities first, and then move on to the **Please Schedule Appointment** activities, which will require outreach to the member to schedule an appointment with the member.

I. Under **Filter by Action**, select "**Please Schedule Appointment – Prospective Outreach Program**" to display all records of this type. Then, under "**Adjust Claim(s)/Member Details,"** click on the **Please Schedule Appointment – Prospective Outreach Program** icon to view the complete list of adjustable claims associated with that member.



II. The **Contact Worksheet** will display.



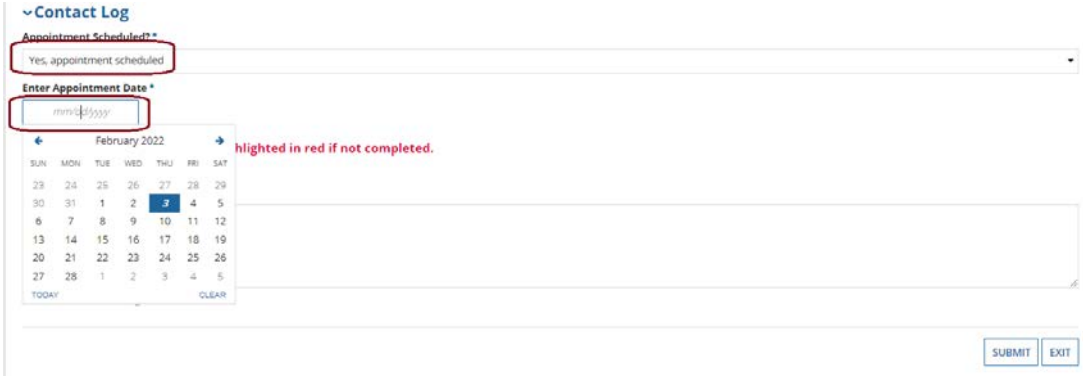


It is important to note that Blue Cross Complete has no record of these members being treated by a physician in the last six months. Additionally, these members may have **never** been seen at your office or haven't been seen in your office for more than a year. With this in mind, your office should outreach to these members and attempt to schedule a **new** visit.

Completing the **Contact Worksheet** allows you to advise Blue Cross Complete if your office was successful in scheduling an appointment and the new appointment date. If your office wasn't successful in scheduling a **new** appointment, you can still advise the health plan on what prevented the member from scheduling an appointment.

III. On the **Contact Worksheet**, in the **Contact Log** section, click on the drop-down box under **Appointment Scheduled** (this is a **required** field that must be completed before clicking on **Submit**).

a. If your office was **<u>successful</u>** in outreach to the member and was able to schedule a new appointment, select "**Yes, appointment scheduled**":



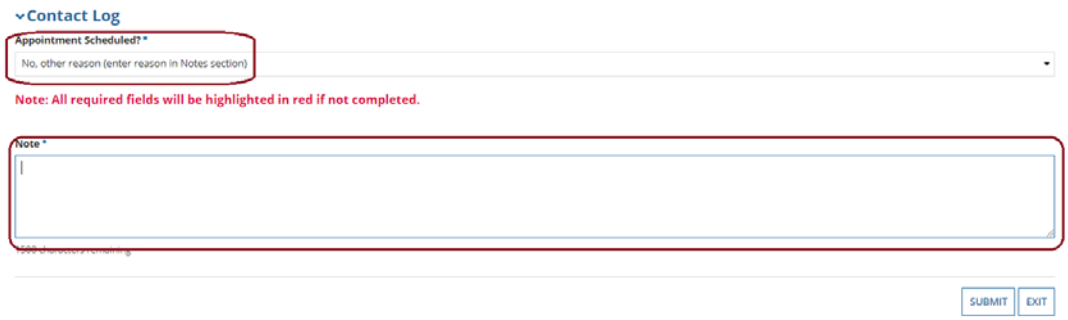
The user will then need to enter the date of the ***newly*** scheduled appointment for the member.

Note: The date the user enters can either be within six months **<u>before</u>** or **<u>after</u>** the current date.

b. If your office was **<u>unsuccessful</u>** in outreach attempts to the member, in the **"Appointment Scheduled"** drop down, select one of the six "**No**" options:

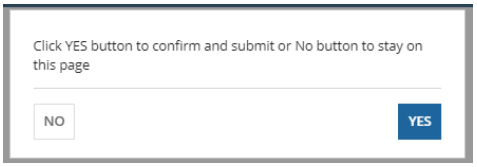
Note: When selecting one of the "**No**" options, the user can still enter any additional information about those outreach efforts in the **Notes** Section.

c. If selecting the option "**No, other reason (enter reason in Notes section),**" make sure to provide detailed information about that attempt in the **Notes** section.



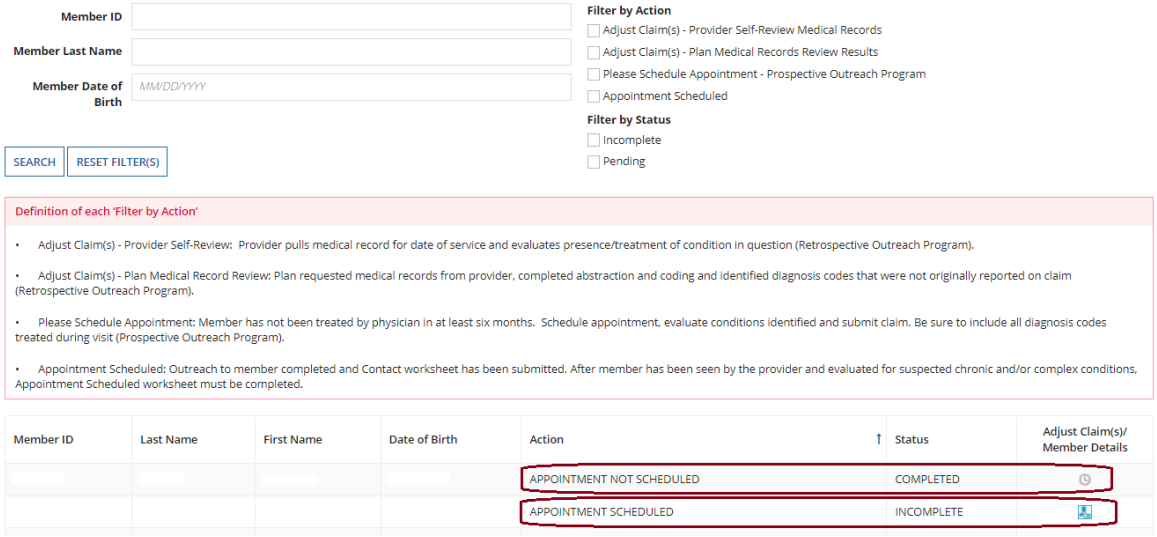
IV. After completing the required information in the **Contact Log** section, review the selections you made. There isn't a "Preview" button and the user can't go back and change their selections after the worksheet has been successfully submitted. Once the user is ready, click on the **Submit** button in the lower right section of the page.

A warning message will display:



This message is a reminder to review the selections made by the user. If the user needs to go back and change anything, click **NO**. If no changes need to be made, click **YES**.

V. Once successfully submitted, depending on whether an appointment was or wasn't able to be scheduled for the member, the record will ***change*** from the Action type of **"Please Schedule Appointment"** to the Action type **"Appointment Scheduled"** or "**Appointment Not Scheduled.**"



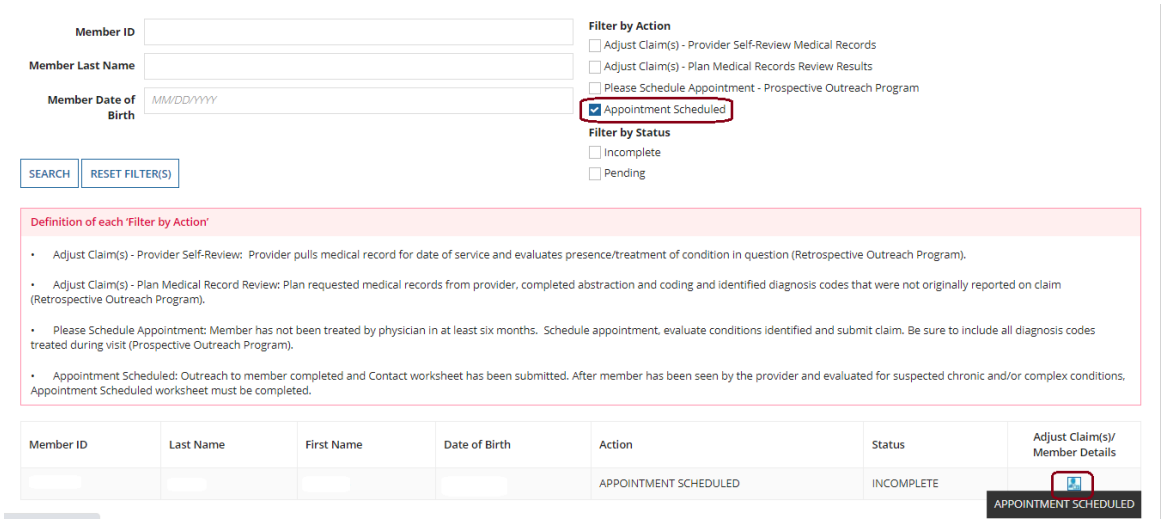
No further action is required for those records that are the Action type of **Appointment Not Scheduled**. The process for completing the Action type **Appointment Scheduled** is addressed in the next section.

D. Scheduled Appointment successful - complete the *Scheduled Appointment Worksheet*

If your office was successful in securing an appointment with the member, the member presented for the appointment and was able to be evaluated, the physician can now complete the **Scheduled Appointment Worksheet** to help Blue Cross Complete determine if the chronic condition(s)/diagnoses are still present, never present, or resolved. There is also an option to update the diagnosis with a more accurate diagnosis.

Remember 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 *Scheduled Appointment Worksheet*. Additionally, the medical record must be submitted via secure email to: ConditionOptimizationProgram@amerihealthcaritas.com.

I. Under **Filter by Action**, select "**Appointment Scheduled**" to display all records of this type. Then, under **"Adjust Claim(s)/Member Details,"** click on the **Appointment Scheduled** Icon to view the complete list of adjustable claims associated with that member.



Note: **Appointment Scheduled** actions will *only* appear as the result of a **Please Schedule Appointment** Action being completed where it was indicated that the member was successfully scheduled for a new appointment.

II. The **Scheduled Appointment Worksheet** will display.

PLAN LOGO

Prospective Outreach Program
Scheduled Appointment Worksheet

Publish Date: 11/23/2021
Due Date: 02/25/2022
Worksheet Status: INCOMPLETE

Instructions

After the provider has seen the member and evaluated the chronic conditions, there are three key activities to complete:

STEP 1
Complete the Scheduled Appointment Worksheet for the target member in NaviNet - confirmed or unconfirmed chronic and/or complex condition (represented by diagnosis/diagnoses codes)

STEP 2
Submit a Claim with confirmed and/or newly identified diagnosis or diagnoses along with the appropriate E&M codes

STEP 3
Submit the Medical Record via secure e-mail to: ConditionOptimizationProgram@amerihealthcaritas.com

NOTE: Diagnosis/diagnoses codes must be reported via Scheduled Appointment Worksheet, Claim, and Medical Record. All three components are audited to confirm accuracy and completeness; errors identified in coding of claim must be corrected before claim will be approved for incentive payment.

Member and PCP Details

Member Details		PCP Assigned	
Member Name:		**Name:**	
ID:		**ID:**	
Gender:		**Group:**	
Date of Birth:		**NPI:**	
Address:			
Phone:			

Contact Worksheet Appointment Scheduled Date

Date : 2/7/2022

Note: The **Scheduled Appointment Worksheet** will contain the Appointment Scheduled Date that was previously entered on the *Please Schedule Appointment Contact Worksheet*. However, if the member was seen and evaluated on a different date due to rescheduling or other issues, the date of the actual appointment can be entered on this **Scheduled Appointment Worksheet**.

Historically Reported Diagnosis Code(s)

*** Date Member Recently Evaluated** mm/dd/yyyy

Provider Name

Historical Diagnosis Code	Description	On the date the patient was recently evaluated, was the patient treated for this diagnosis, are they on any medication for this diagnosis or is diagnosis a lifelong condition documented in the medical history?	Action
I10 ✖	Essential (primary) hypertension	--Please Select--	
F90.0 ✖	Attention-deficit hyperactivity disorder, predominantly inattentive type	--Please Select--	

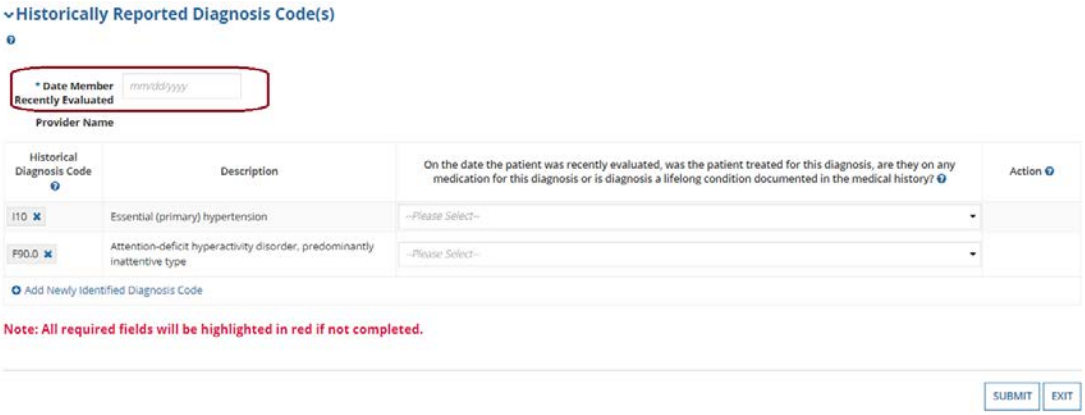
Add Newly Identified Diagnosis Code

Note: All required fields will be highlighted in red if not completed.

SUBMIT EXIT

III. On the **Scheduled Appointment Worksheet**, in the **Historically Reported Diagnosis Code(s)** section, enter the date that the member was recently seen and evaluated in the box labeled **Date Member Recently Evaluated** (this is a required field).

Only the current date or a date within the last six months can be entered.

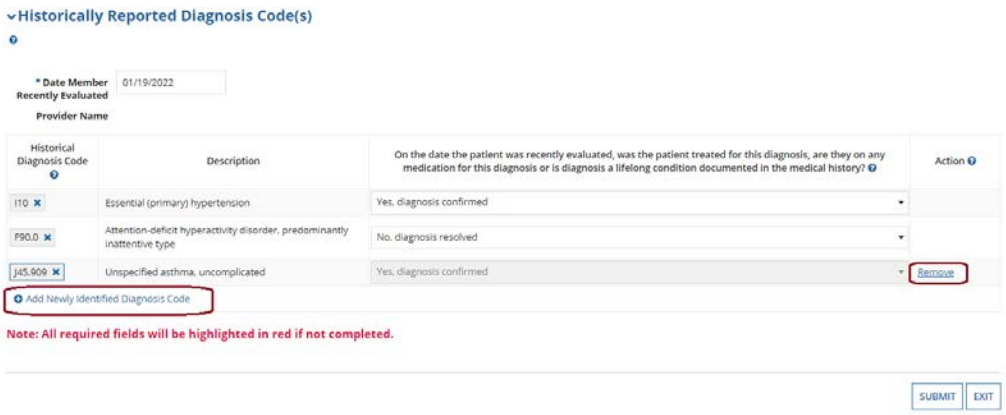


IV. Based on the recent evaluation of the member, select the appropriate status for each diagnosis code under **"Historically Reported Diagnosis Code(s)":**

a. **Yes, diagnosis confirmed** – Attesting the user confirms the diagnosis is still present.
b. **Yes, but diagnosis updated** – If the diagnosis code listed isn't correct for the member's condition, the user may update the form with the correct diagnosis by clicking the "x" and entering at least the first three characters of the updated diagnosis.
   Note: If the user erroneously click the "x," you can select **Undo Changes** under "**Action**" to revert to the original code.
c. **No, cannot confirm** – Attesting the user doesn't have record(s) of this diagnosis; never present.
d. **No, diagnosis resolved** – Attesting the diagnosis has been treated and is no longer present.

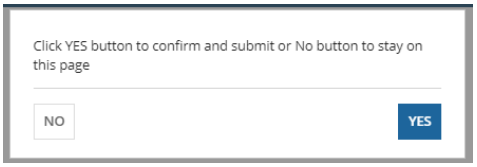
V. The user also has the option to **Add Newly Identified Diagnosis Code** should you identify a new diagnosis or diagnoses previously unlisted on the claim. To initiate entry of a new diagnosis, type at least **the first three characters** to populate this field.

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



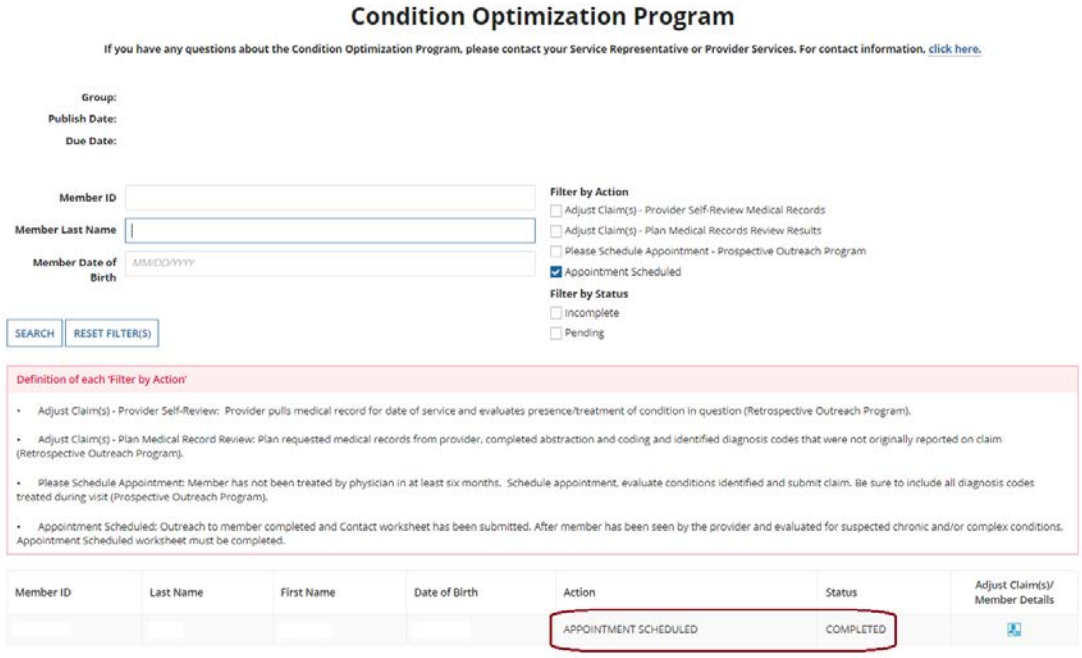
VI. After completing the required information in the **Historically Reported Diagnosis Code(s)** section, review the selections made. There isn't a "Preview" button and the user will be unable to go back and change selections after the worksheet has been successfully submitted. Once the user is ready, select the **Submit** button in the lower right bottom section of the page.

A warning message will display:



This message is a reminder to review the selections made. To go back and change anything, click **NO**. If no changes are needed, click **YES**.

VII. After submitting the adjustment, the user is returned to the main home page. The **Appointment Scheduled** record will show with the status of **Completed**.



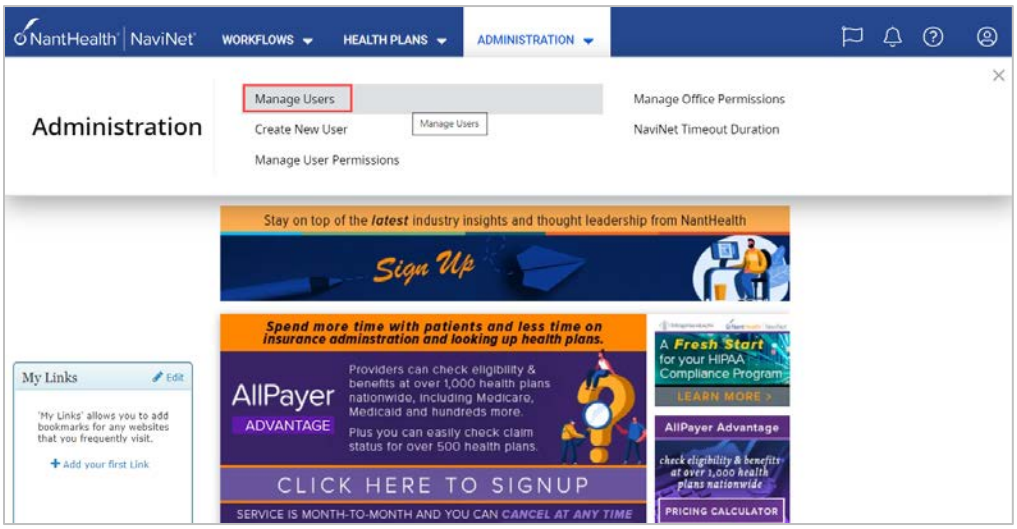
Keep in mind that the user can still click on the **Adjust Claim(s)/Member Details** icon and go back into the adjustment, but the user will be unable to make any changes at this point.

Supplemental Information

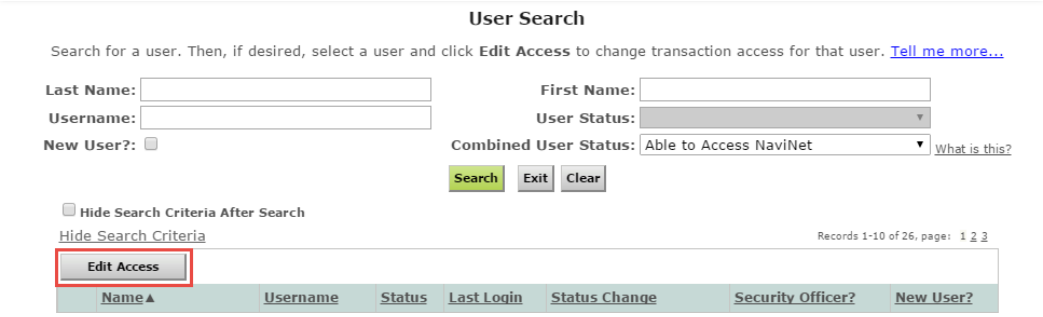
Enabling Document Exchange for a Plan Service User

A NaviNet security officer can follow the steps below to enable Document Exchange for a plan service user:

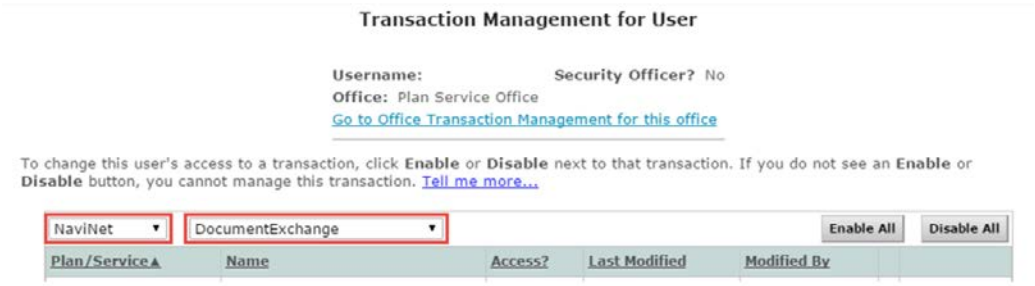
1. Click **Administration** from the NaviNet toolbar and then scroll down to select **Manage User Permissions**.



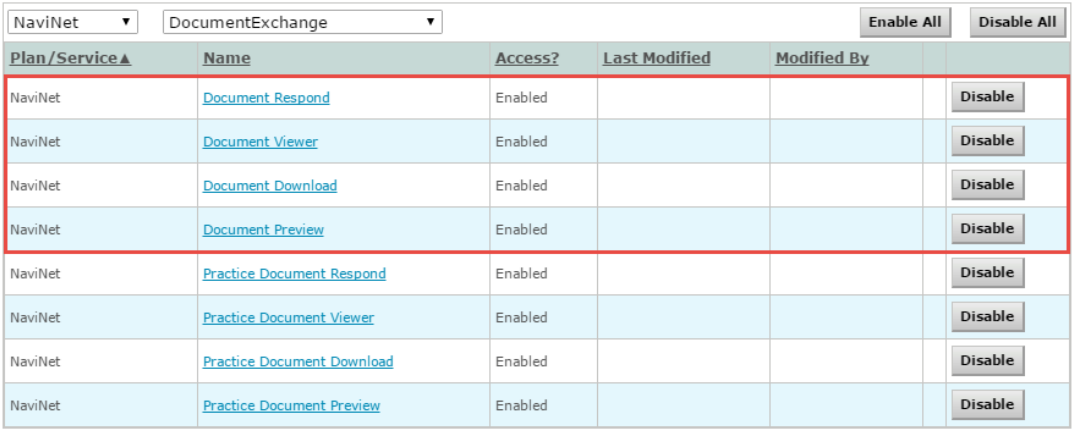
2. From the next screen, select the user whose permissions you want to adjust, and then select **Edit Access**.



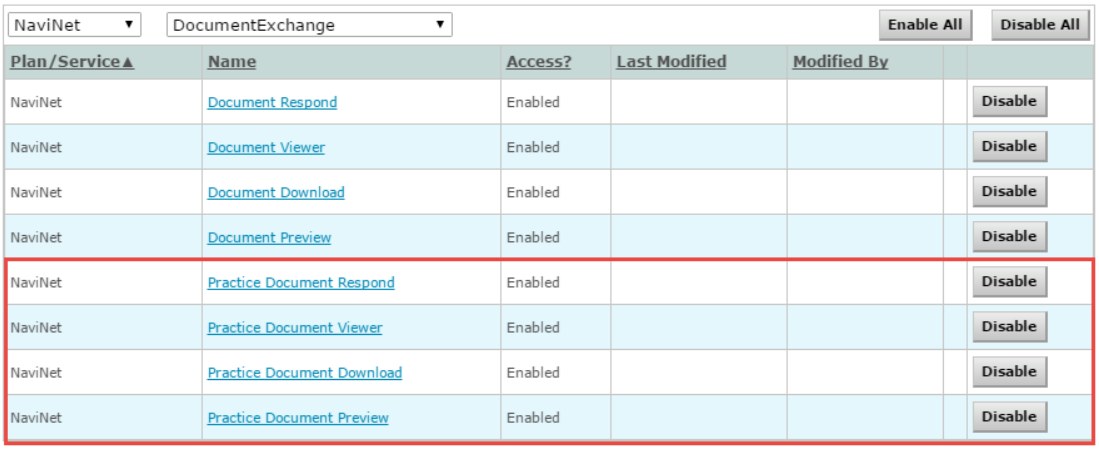
3. The next screen is titled "**Transaction Management for User _____.**" From this screen, select **NaviNet** in the Plan's drop-down list and select **DocumentExchange** in the Group's drop-down list.



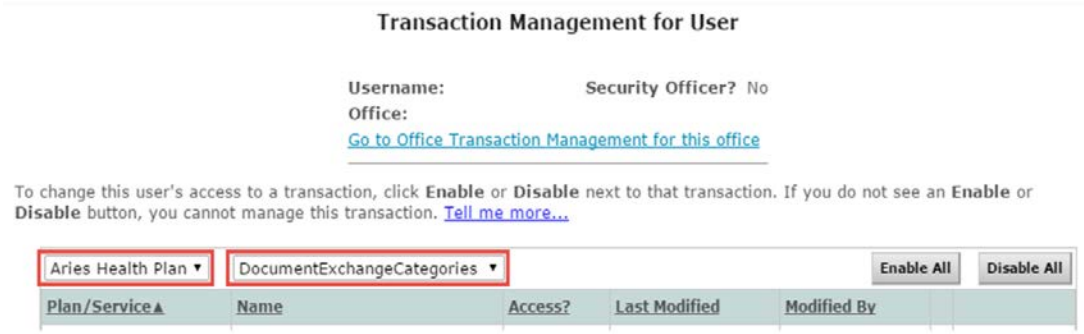
4. It's important to note **"Patient Clinical Documents"** are enabled for all users by default, but - you'll want to confirm the global permissions for **"Patient Clinical Documents"** are set appropriately.
    a. For a user to *view* Patient Clinical Documents, both **Document Viewer** and **Document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



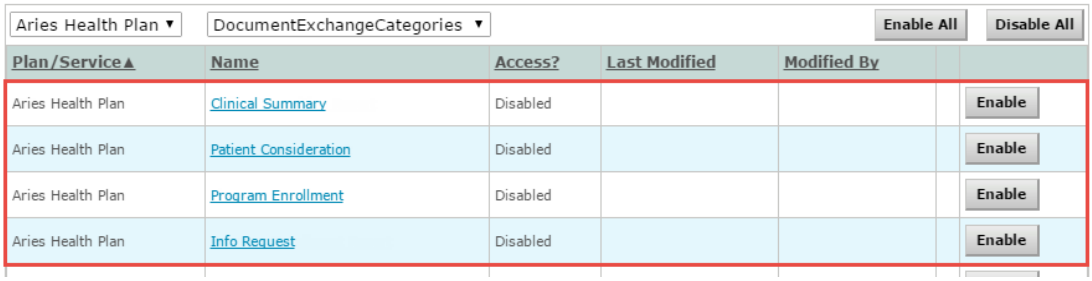
5. Similarly, **"Practice Documents"** are enabled for all users by default, but you'll want to confirm the global permissions are set appropriately.
    a. For a user to *view* Practice Documents, both **Practice Document Viewer** and **Practice Document Preview** must be enabled.
    b. For a user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



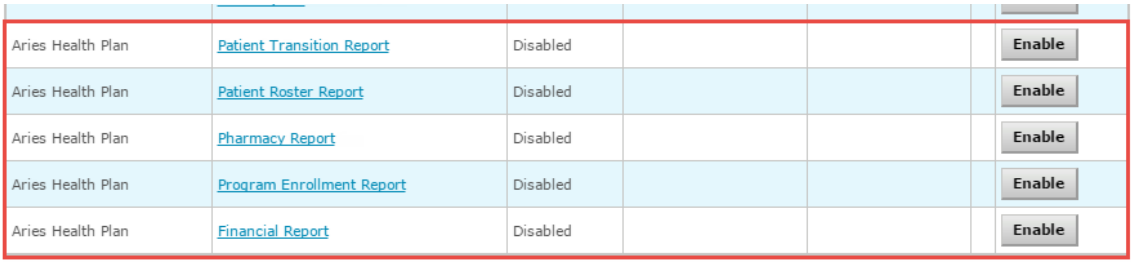
6. Now that you have confirmed the global permissions, you need to enable the specific permissions. First, select **Blue Cross Complete** from the plan's drop-down list and **DocumentExchangeCategories** in the Group's drop-down list.



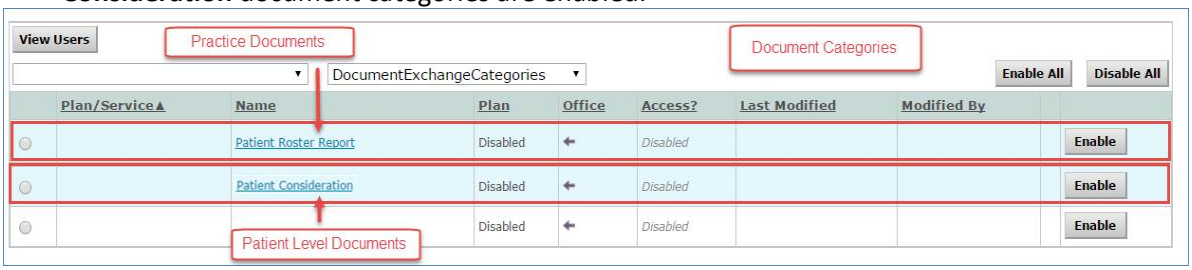
7. Click **Enable** next to any Patient Clinical Document categories you want available to this user for the selected health plan (Blue Cross Complete).



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

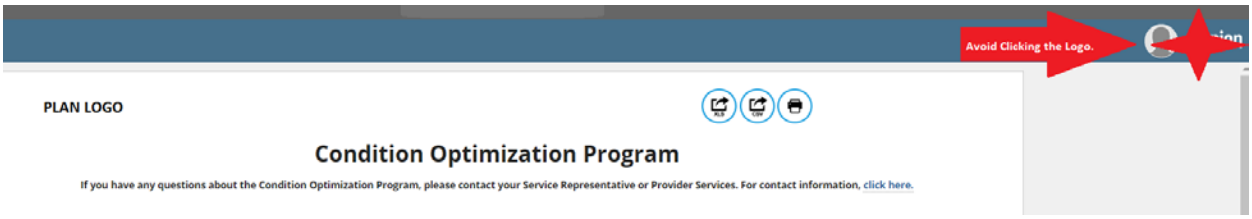


9. Finally, for access to all COP activities, make sure **Patient Roster Report** and **Patient Consideration** document categories are enabled.

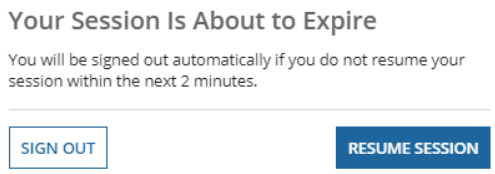


Important note: Time-out information

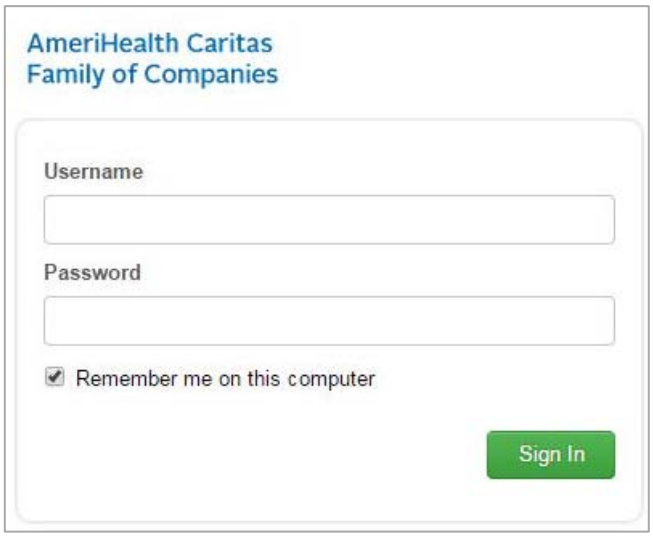
Avoid clicking on the Appian logo. If the user does so, the screen will auto-refresh.



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

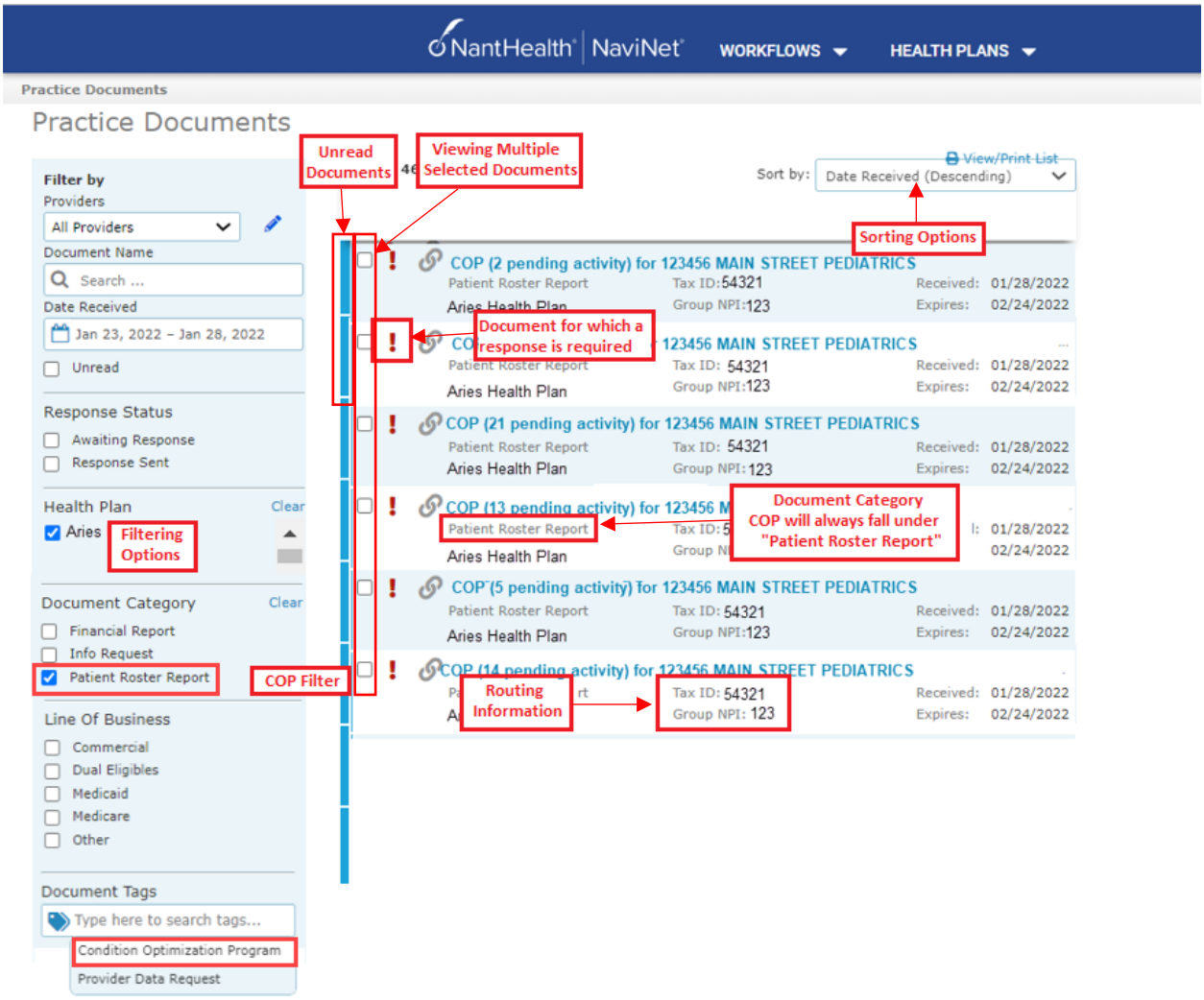


If you don't click **Resume** within five minutes, the form will time-out, and the user will see the login window pictured below. Please **don't** attempt to login through this pop-up window. Instead, close the window and login to NaviNet again.



Anatomy of the Workflow and Document Viewer screens

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



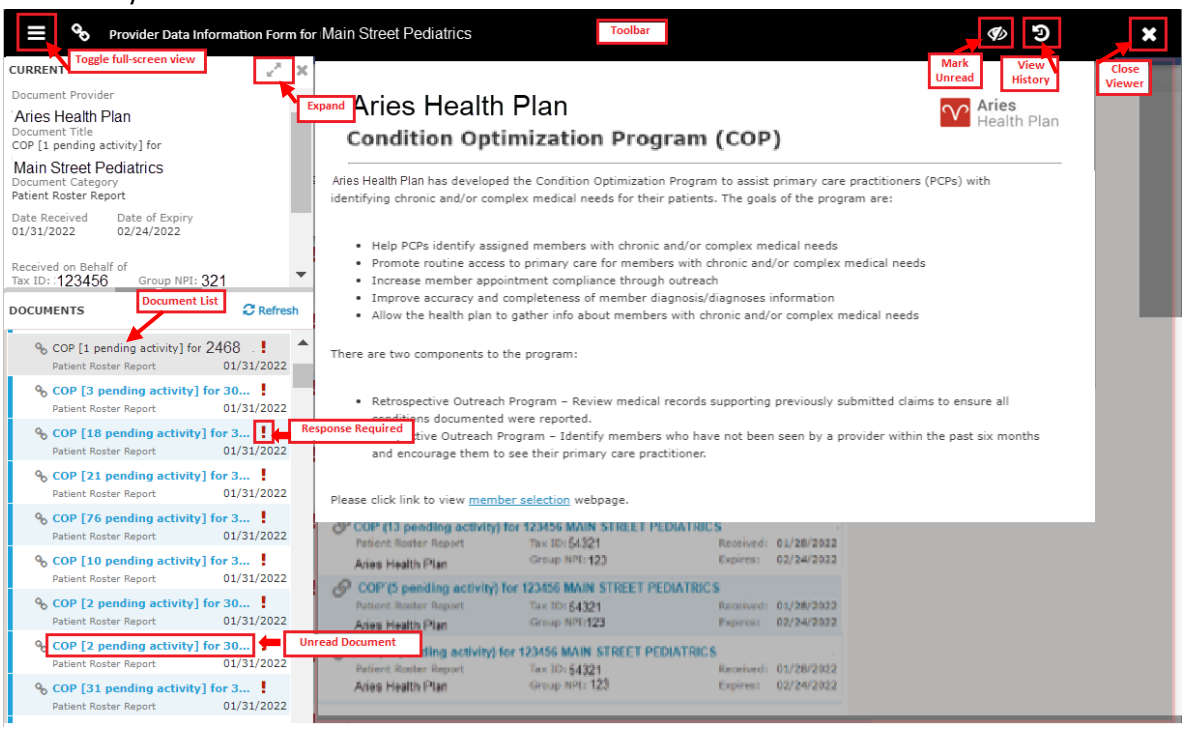
A blue bar and text indicates that a document is unread.

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

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

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

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



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

- Documents 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 expiration dates. Document routing and tag information is also displayed. Users can expand the window to see any hidden information.

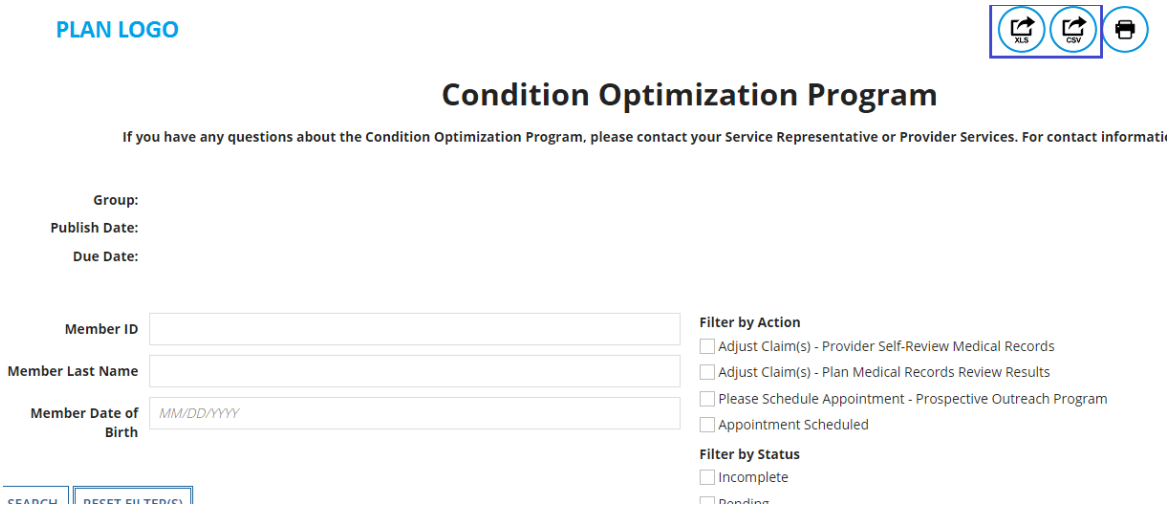
Pop-up blocker must be disabled

For the **COP - Prospective Outreach Program** to work properly, the internet browser's pop-up blocker must be disabled by the user.

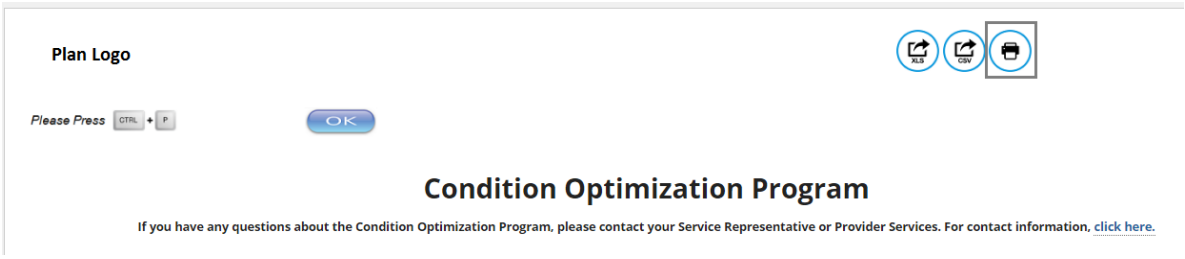
Downloading, saving and printing member information

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

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



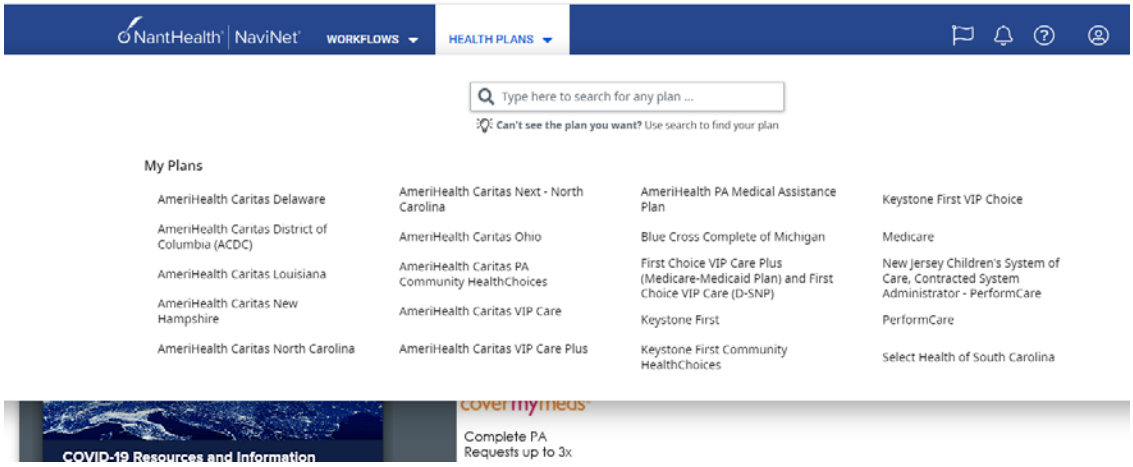
- The third icon displays instructions for printing (press CTRL + P).



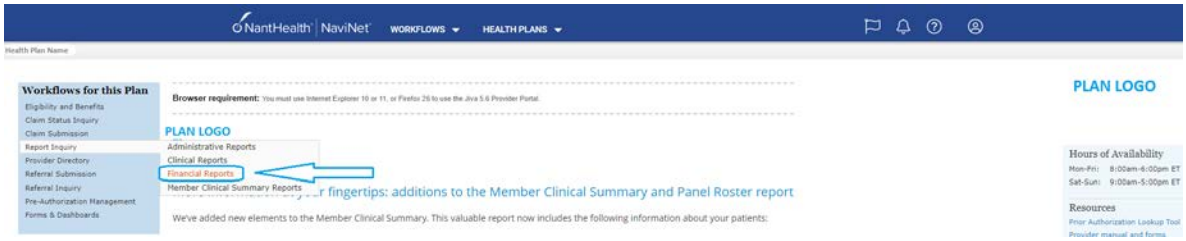
Report generation

A COP - Prospective Outreach Program Report can be generated in NaviNet to show the status of all adjusted claims. Follow the steps below to generate a report for your practice.

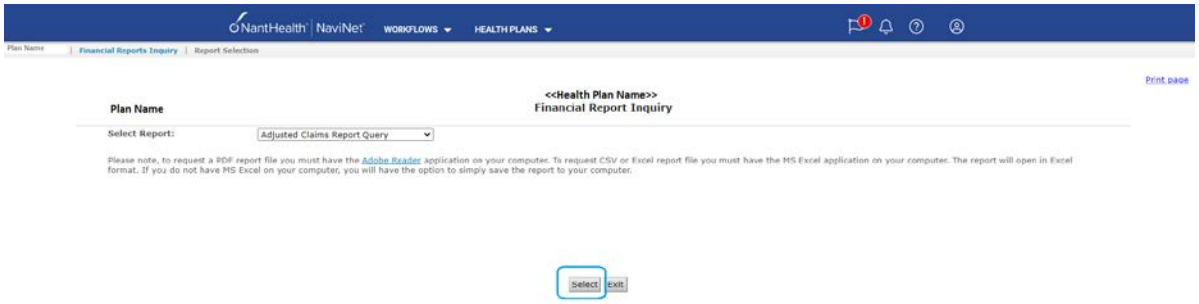
1. Select **Workflows** in the upper left of the NaviNet screen.
2. Drop-down and select **My Health Plans** from the list of workflows.
3. Choose the health plan for which the user wants to pull a report.



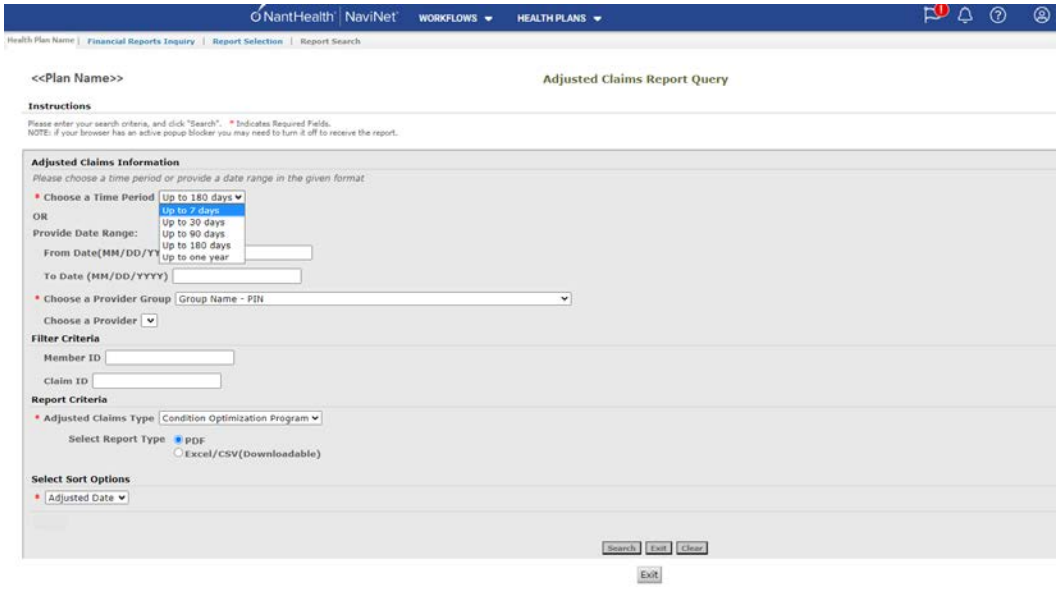
4. Next, select **Report Inquiry** and then **Financial Reports**.



5. For reviewing **Retrospective** Action Items completed (provider self-review medical records or plan medical records review results) that have been completed, select **Adjusted Claims Report Query** from the drop-down list and then click on **Select** at the bottom of the page.



6. Now, the user can set the parameters:
    i. **Time Period or Date Range**
        1. Time period defaults to “Up to 7 days,” but, the user can select 30, 90, 180 days, or up to one year. **This is a required field.**
        2. The user can choose a specific “Date Range” as selection criteria. When a date range is provided, these dates have precedence over **Time Period** from the drop-down. Report will be based on **date range**.
    ii. **Provider Group Selection**
        1. The user **must** choose a provider group. **This is a required field.**
        2. The user may also select a specific provider within the group and only claim records for that provider will be returned.
            a. It isn’t necessary to choose a specific provider under the group, but all providers will be returned in the report.
    iii. **Filter Criteria**
        1. If the user enters a specific member ID, the report will be member specific if the record exists.
        2. If the user enters a specific claim ID, report will be claim specific if the record exists.
    iv. **Report Criteria**
        1. Adjusted Claims Type defaults to Condition Optimization Program. **This is a required field.**
        2. Report type defaults to “PDF,” but user can also select “Excel/CSV” (Downloadable) option.
    v. **Select Sort Options**
        1. The user can select sort options by Member Name, Claim ID or Adjusted Date. **This is a required field.**



See next page for example reports.

<<PLAN LOGO>>

Provider Transaction Detail Report -COP

Date from: 08/04/2021 to 02/04/2022

Date of Report : 02/04/2022

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
	.		12/03/2020 TO 12/03/2020	99499			09/21/2021	M2550-CONFIRMED Q332-CONFIRMED R7401-CONFIRMED M329-CONFIRMED M3210-ADDED	10/08/2021		PROCESSED SUCCESSFULLY - 01
			05/03/2021 TO 05/03/2021	99499			10/05/2021	F3189-CONFIRMED F419-CONFIRMED E669-CONFIRMED E785-CONFIRMED I10-CONFIRMED J449-CONFIRMED K219-CONFIRMED M170-CONFIRMED R05-CONFIRMED R0609-CONFIRMED E119-CONFIRMED	10/08/2021		PROCESSED SUCCESSFULLY - 01
			04/02/2021 TO 04/02/2021	99499	$40.00		10/25/2021	Z0000-CONFIRMED E7800-CONFIRMED F419-CONFIRMED F909-CONFIRMED I493-CONFIRMED	11/11/2021		PROCESSED SUCCESSFULLY - 01
			03/18/2021 TO 03/18/2021	99499	$40.00		01/26/2022	R21-CONFIRMED M25511-CONFIRMED A8039-CONFIRMED E8419-CANNOT CONFIRM E8881-CONFIRMED D7289-CONFIRMED F0390-CANNOT CONFIRM	01/28/2022		PROCESSED SUCCESSFULLY - 01

Page 1 of 3

(Last page of report details)

								D7289-CONFIRMED F0390-CANNOT CONFIRM			

Total Number of Claim Adjustments: 8

Total Billed Amount:

Total Paid Amount:

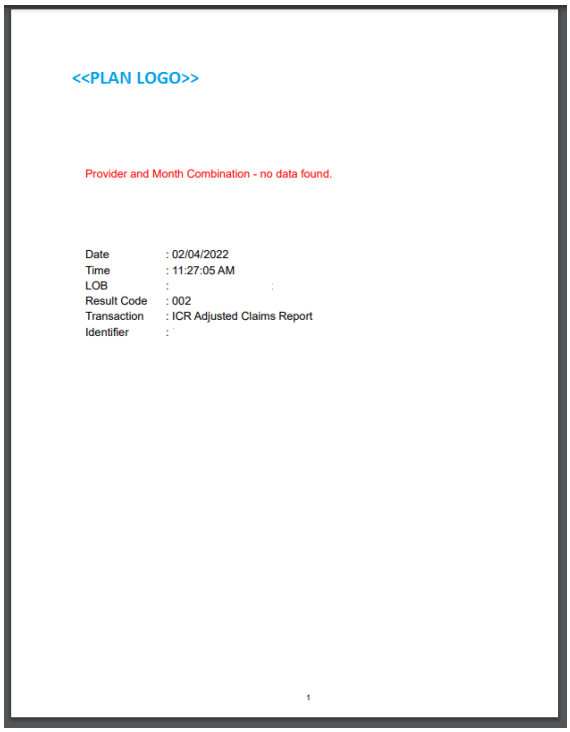
Total Count by Claim Status:

Claim processed successfully : 8

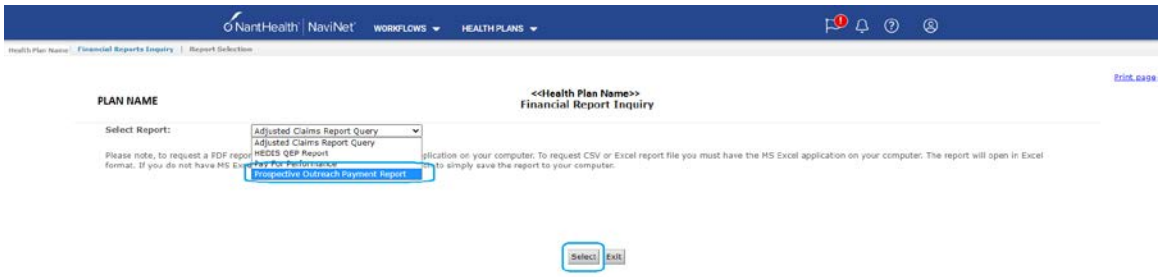
Other Status : 0

Page 3 of 3

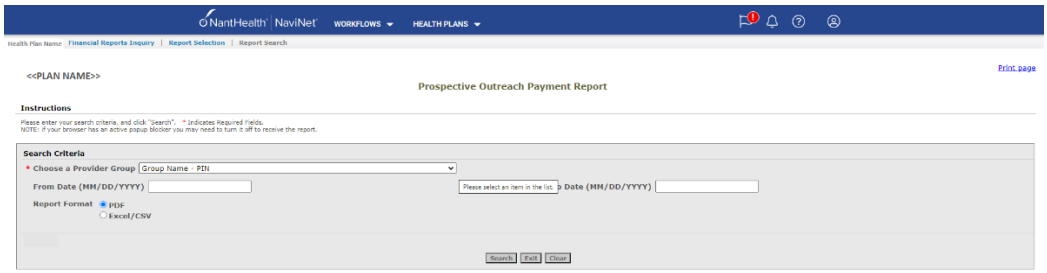
7. If parameters are selected and the search performed with no records to return, the screen will display with the following message:



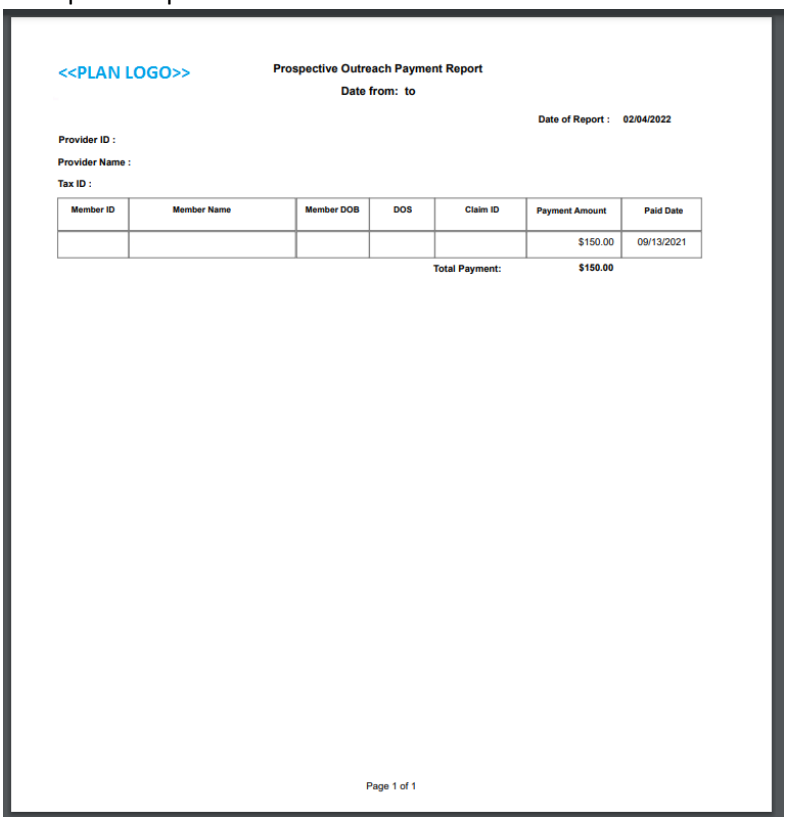
8. For reviewing the **Prospective Outreach Payment Report**, select this option from the drop-down list and then click on **Select** at the bottom of the page.



9. The only required field is the **Provider Group** field. Click the drop-down arrow and select the **Provider Group** for this report.
   Note: Users can also select a From/To date for running the report and choose a specific output (i.e. PDF, Excel, CSV); these fields are ***optional***. Once the provider group is selected, click **Search**.



Example of report:



<<PLAN LOGO>>

Prospective Outreach Payment Report

Date from: to

Date of Report : 02/04/2022

Provider ID :

Provider Name :

Tax ID :

Member ID	Member Name	Member DOB	DOS	Claim ID	Payment Amount	Paid Date
					$150.00	09/13/2021
				Total Payment:	**$150.00**	

Page 1 of 1