NETWORK HEALTH

CLAIMS EDITING SYSTEM

USER'S GUIDE

network health

Network Health Claims Editing Portal

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Any comments relating to the Network Health Claims Editing Portal should be directed to Network Health’s Customer Service at 920-720-1300 or 800-826-0940 and 920-720-1400 or 855-275-1400 for the Individual and Family Plan Customer Service.

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Introduction

The purpose of this guide is to provide users with an overview of the basic functions, definitions and use of the Network Health Claims Editing System.

The Network Health Claims Editing System Portal (herein referred to as the "Portal") is a web-based, easy-to-use application intended for users to submit hypothetical claims through the claims editing system to be able to view the results of clinical editing of that claim. Users can immediately view the results for each submitted claim through the Portal user interface. The Portal also provides the ability for users to look up previously submitted claims to view the clinical editing results.

Some of the key features of the Portal include:

- Test submissions for professional and facility claims ,as well as, lookup capability for previously submitted claims
- User friendly interface that facilitates claim entry
- Claim results displayed with line-by-line edits, edit rationale and detailed sourcing

It is important to note that the claims submitted through the Portal are considered "hypothetical claims" and will not guarantee payment or denial of similarly billed claims.

It is also important to note that the claim lookup results will only provide information on the coding edits that occurred on a given claim, but will not provide the final disposition of the adjudication of that claim.

The Portal is for commercial lines of business only.

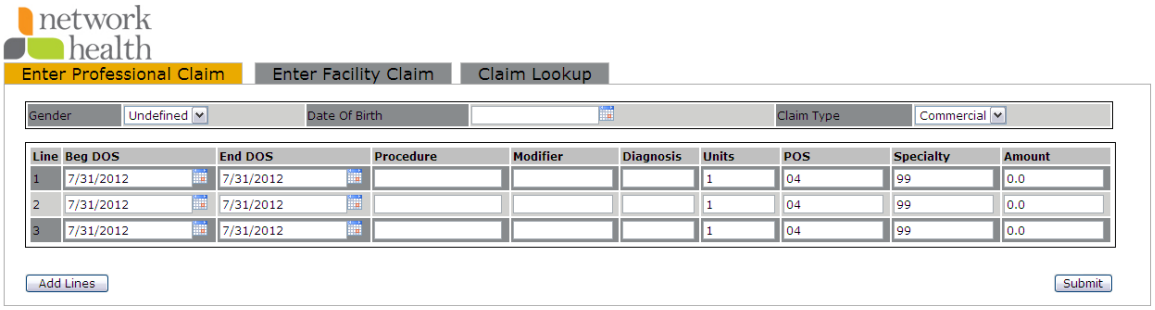
Claims Edit Portal – User Interface

The following are covered in this section:

1. Enter Professional Claim Function
2. Enter Facility Claim Function
3. Claim Lookup Function
4. Claim Analysis Results

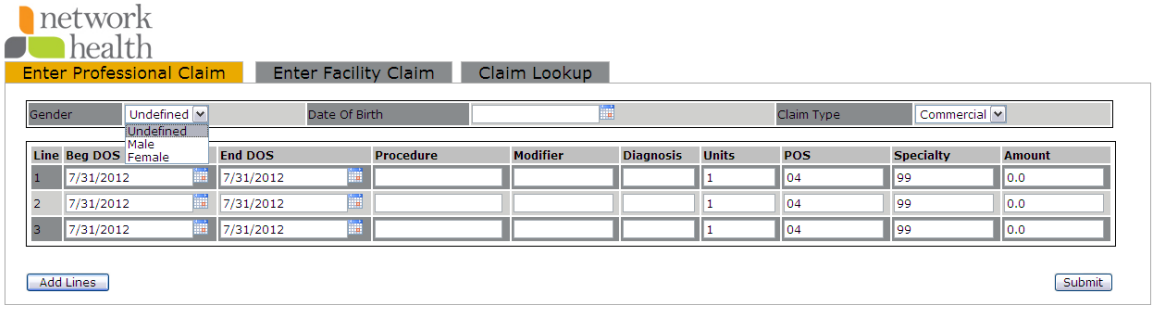
Enter Professional Claim Tab

This tab allows a user to enter a professional claim that will be analyzed by the claims editing system. The available fields on the tab and their acceptable values are listed below.

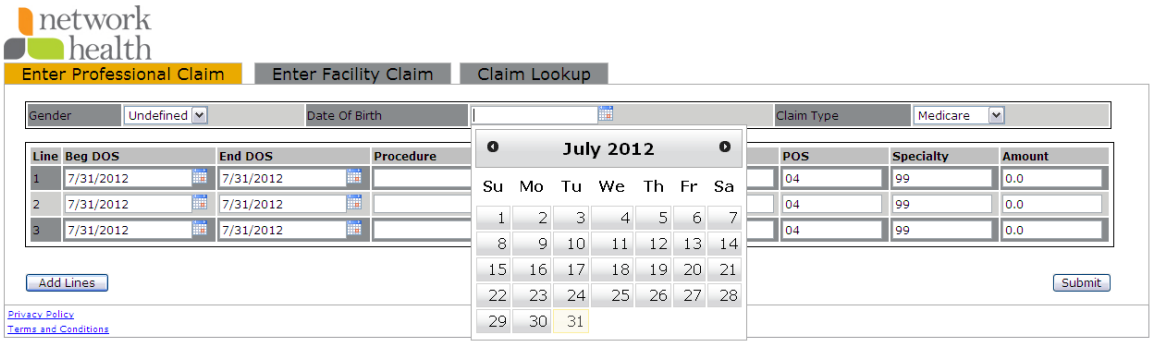


The first section of the tab is consistent with information found on the claim header.
The following fields make up the header section:

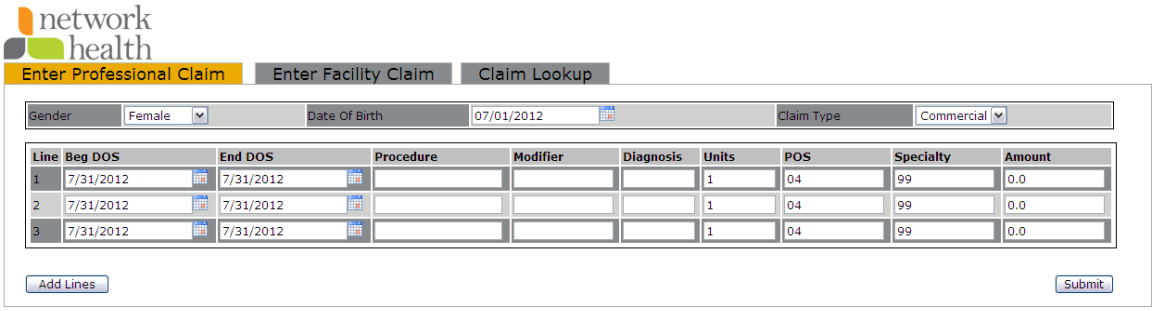
- **Gender** – User must select the gender of the patient. The acceptable values in the drop down list for the gender field are *Male* and *Female*. (This is a required field)



- **Date Of Birth** – User must enter the patient's date of birth in this field. The date format for this field is MM/DD/YYYY. E.g. 01/01/2011. The user can also click on the calendar icon to the right of the field to select the date of birth.

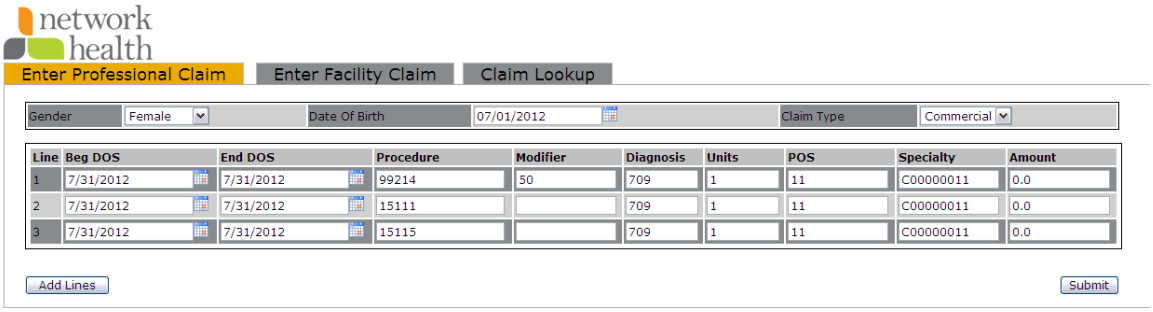


- **Claim Type** – The Claim Type field is commercial.



Entering Claim Line Details

When the header fields are populated, enter claim lines. All fields except modifiers are required.



The fields are:

- **Line** – This column shows the sequential number of claim lines on a claim.
- **Beg DOS** – Enter the *Beginning Date of Service* in this field. The acceptable format in this field is MM/DD/YYYY. You can manually enter the date in the field using this format, or select the date by clicking on the calendar icon to the right of the field.
- **End DOS** – Enter the *Ending Date of Service* in this field. Like the Beg DOS, the acceptable format is MM/DD/YYYY. You can either manually enter the date in the field using this format, or select the correct date by clicking on the calendar icon to the right of the field.

- **Procedure Code** – Enter a valid procedure code for this line.
- **Modifier** – If appropriate, enter a valid modifier for this claim line.
- **Diagnosis** – Enter a valid diagnosis code for this claim line.
    - Separate multiple diagnoses with comma
    - No spacing
    - No decimal point
    - Must be entered in the order of primary, secondary, etc.
- **Units** – This field defaults to one unit. Enter the number of units for this line.
- **POS** – Enter a valid place of service for this line.
- **Specialty** – Enter a valid specialty code for this line. The list of valid specialty codes is available online.

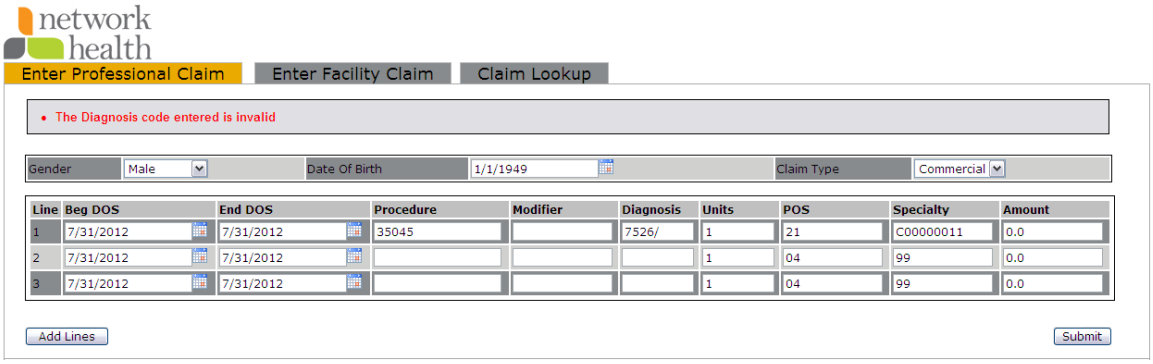
You may also enter additional claim lines simply by clicking on the **Add Lines** button.

Submitting the Claim

When all of the required information has been entered for the claim, click **Submit** to indicate that the claim is ready to be processed. After the Portal completes its review, the results will appear on the screen.

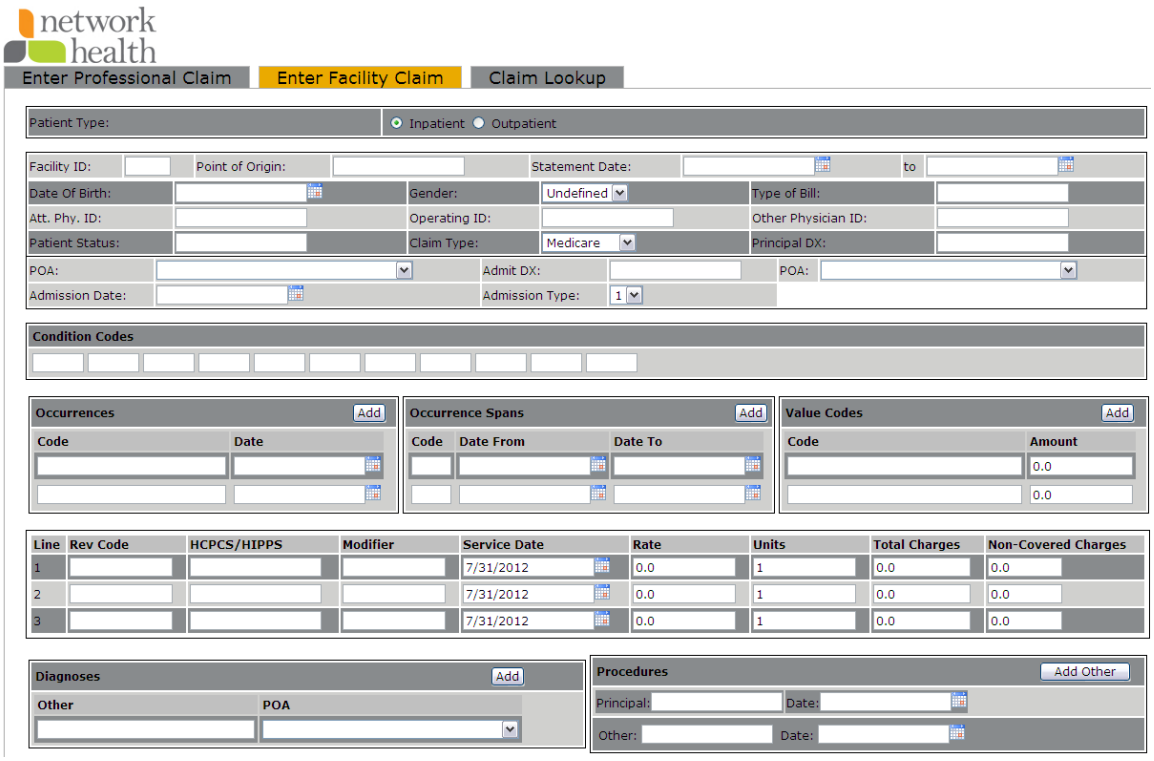
Data Entry Errors

The Portal will issue errors to inform users when there is invalid data entered in a field. In the example below, an invalid value was entered in the diagnosis code field. An error was issued to advise the user to verify and make changes to the data.



Enter Facility Claim Tab

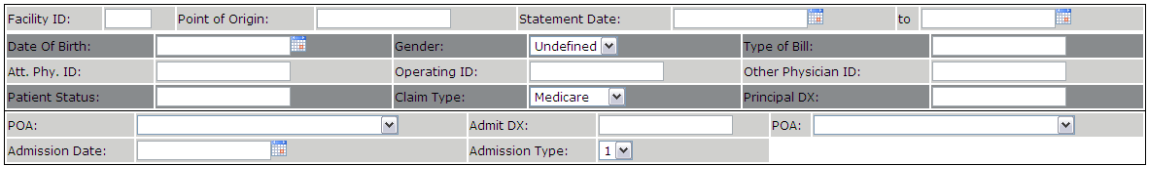
This tab allows users to enter claims for services that are performed in a hospital setting. The available fields and their acceptable values are listed below.



Patient Type – This field is required and the available options are inpatient or outpatient. This field defaults to *Inpatient*. Notice that all non-applicable fields are disabled and are no longer on the screen when a selection is made.

Facility and Patient Information

In this section of the Enter Facility Claim tab, you will need to enter demographic information for the facility, as well as, information for the patient.



The available fields on the Enter Facility Claim tab are:

Note: *User must populate all the required fields. Failure to complete all required fields may generate errors in the Portal.*

- **Facility ID (Required)** – Enter the identification number for the facility. The identification number is the provider NPI number.

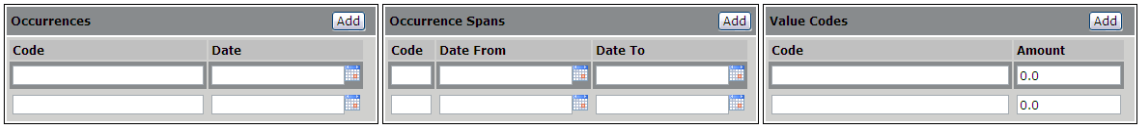
- **Code Type** – Use the drop-down box to indicate whether you are using ICD-9 or ICD-10 diagnosis code.
- **Point of Origin** – Enter a valid Point of Origin code in this field.
- **Statement Date (Required)** – Enter the beginning date of service. In the 'to' field, enter the last date of service.
- **Date of Birth (Required)** – Enter the patient's date of birth in this field.
- **Gender (Required)** – Select the patient's gender.
- **Type of Bill (Required)** – The valid entries for this field are the standard three-digit Type of Bill codes.
- **Att. Phy. ID.** – This field refers to the attending physician, and is not required. Enter a valid physician ID (NPI) in this field.
- **Operating ID** – This field is most commonly seen on a UB-04/CMS-1450 Form and is not a required field.
- **Other Physician ID** – The information for this optional field can be found in Box 83 of a UB92.
- **Patient Status** – If the patient's status is other than '01', enter a valid patient status. **This field is required for outpatient claims.**
- **Principal DX (Required)** – Enter a valid primary diagnosis code.
- **POA** – This field refers to the diagnosis and whether that diagnosis was present on admission. Select one of the valid values from the dropdown list.

Note: *The POA fields are only applicable in an inpatient setting. When the 'Outpatient' radio button is selected, the POA fields are no longer available.*

- Y – Yes
- N – No
- U – No information in the record
- W – Clinically undetermined
- 1 – Dx. Code is exempt from POA

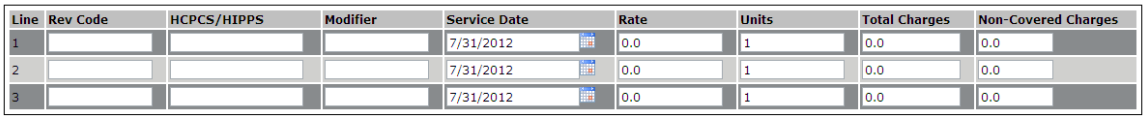
- **Admit DX** – This could be a diagnosis for a condition diagnosed prior to admission or a diagnosis the physician indicates as present upon admission.
- **Admission Date** – This is the date the patient was admitted.
- **Admission Type** – This field will accept the type of admission for the claim.
- **Condition Codes** – These fields are used to report conditions related to the claim.

- **Occurrences** – Like condition codes, occurrence codes relate to significant events that impact this claim. The occurrence codes may be related to an auto accident, an employment related accident, etc.
- **Occurrence Spans** – These fields are for reporting the specific dates that span the related event or occurrence.
- **Value Codes** – These codes and their related dollar amounts show the monetary or possible entitlement for processing a claim.



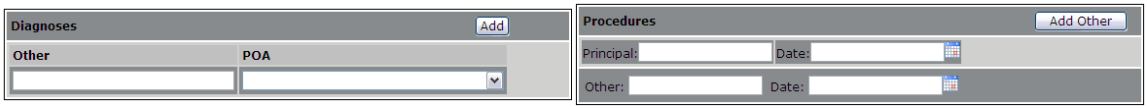
Claim Lines

The claim line fields provide information about the procedures that were performed.



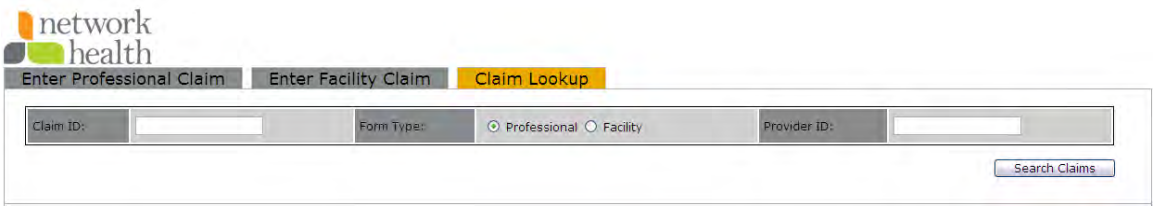
Click on **Add Lines** for additional claim lines.

- **Rev Code** – Enter an applicable revenue code.
- **HCPCS/HIPPS** – Enter, if applicable, the valid HCPCS or HIPPS code.
- **Modifier** – Enter, if applicable, any modifiers related to this claim line.
- **Service Date** – Enter the date of service. The format is MM/DD/YYYY or you may select the date by clicking on the calendar.
- **Units** – Enter the number of units.
- **Diagnoses** – Click the **Add** button if there are additional diagnoses at the time of admission.
- **Procedures** – In the Principal and Other fields, enter ICD procedures and the date the procedure was performed.



Claim Lookup

The Claim Lookup tab provides users with an option to search for claims that have already processed through the Portal.



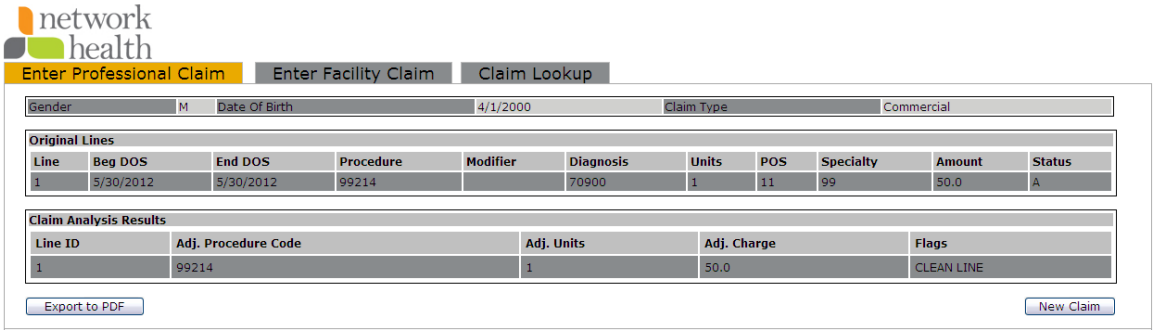
To search for claims, enter the **Claim ID, Provider ID** (NPI number), select **Form Type** and click on the **Search Claims** button.

If the Portal finds a match the claim will be displayed, otherwise a message will indicate no match was found.

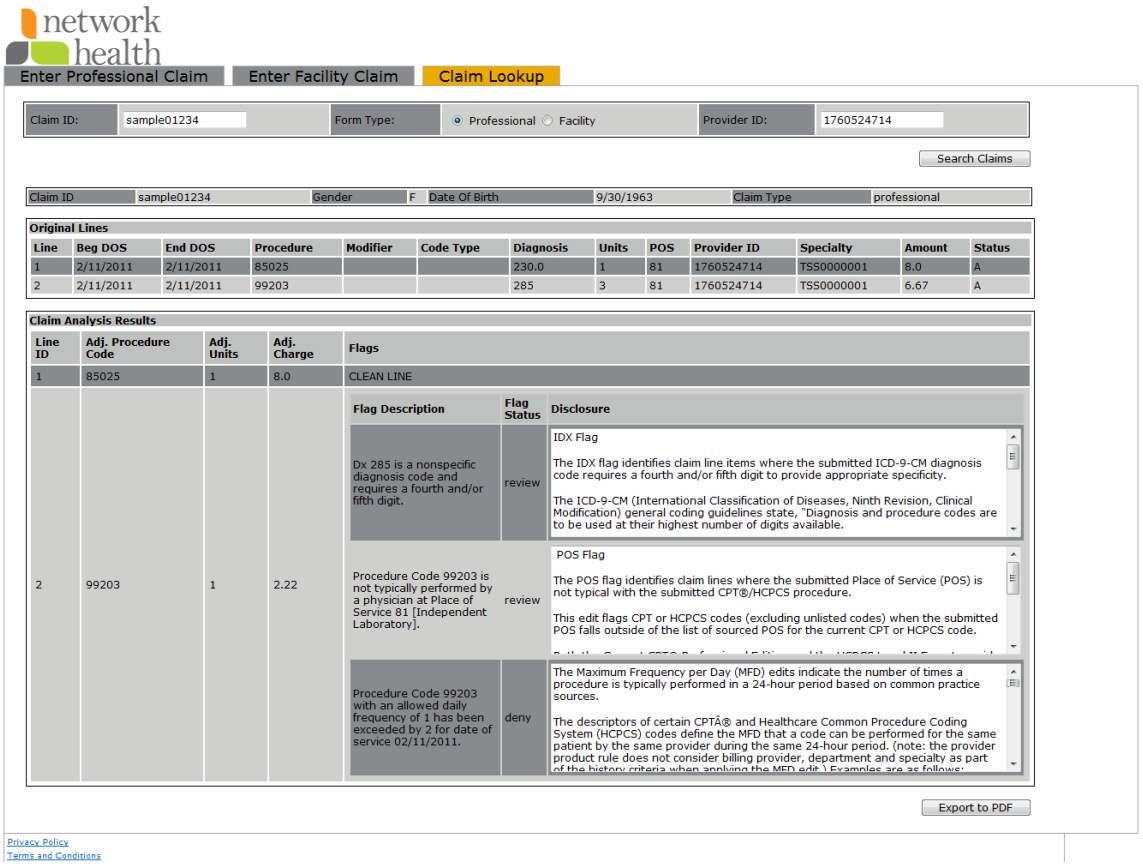
Claim Analysis Results

The **Claim Analysis Results** section of the screen indicates whether or not edits (also referred to as "flags") were issued on the claim. Any potential edits are issued on a line-by-line basis.

In the following example, one claim line was submitted and the result was a "clean" claim line. A "clean" claim line indicates to the user that no edits were issued and therefore no further action is required.



In the next example, a claim was entered and submitted and multiple flags were issued.



- **Line ID** – The Line ID shows which claim line received an edit.
- **Adj. Procedure Code** – This column will display the original procedure code on the line.
- **Adj. Units** – This column shows the number of units on the claim line.
- **Flags** – This section provides the following information:
    - **Flag Description** – This column gives a brief description of the flag that was issued on a given line.
    - **Flag Status** – This column provides a status or a recommendation on how to proceed with this edit.
    - **Disclosure** – The Portal uses a number of sources to provide the most accurate edits and results for a claim. The information contained in the disclosure provides further explanation on why the flag was issued.

- **Export to PDF** – This button allows the user to open and save the results in a printer friendly format. The PDF will include all information available from the Claim Analysis Results screen, including the full disclosure text.