



NETWORK HEALTH

CLAIMS EDITING SYSTEM



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.

Line	Beg DOS	End DOS	Procedure	Modifier	Diagnosis	Units	POS	Specialty	Amount
1	7/31/2012	7/31/2012				1	04	99	0.0
2	7/31/2012	7/31/2012				1	04	99	0.0
3	7/31/2012	7/31/2012				1	04	99	0.0

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)

Line	Beg DOS	End DOS	Procedure	Modifier	Diagnosis	Units	POS	Specialty	Amount
1	7/31/2012	7/31/2012				1	04	99	0.0
2	7/31/2012	7/31/2012				1	04	99	0.0
3	7/31/2012	7/31/2012				1	04	99	0.0

- **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.

network health
Enter Professional Claim | Enter Facility Claim | Claim Lookup

Gender: Undefined | Date Of Birth: [Calendar: July 2012] | Claim Type: Medicare

Line	Beg DOS	End DOS	Procedure	POS	Specialty	Amount
1	7/31/2012	7/31/2012		04	99	0.0
2	7/31/2012	7/31/2012		04	99	0.0
3	7/31/2012	7/31/2012		04	99	0.0

Buttons: Add Lines, Submit, Privacy Policy, Terms and Conditions

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

network health
Enter Professional Claim | Enter Facility Claim | Claim Lookup

Gender: Female | Date Of Birth: 07/01/2012 | Claim Type: Commercial

Line	Beg DOS	End DOS	Procedure	Modifier	Diagnosis	Units	POS	Specialty	Amount
1	7/31/2012	7/31/2012				1	04	99	0.0
2	7/31/2012	7/31/2012				1	04	99	0.0
3	7/31/2012	7/31/2012				1	04	99	0.0

Buttons: Add Lines, Submit

Entering Claim Line Details

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

network health
Enter Professional Claim | Enter Facility Claim | Claim Lookup

Gender: Female | Date Of Birth: 07/01/2012 | Claim Type: Commercial

Line	Beg DOS	End DOS	Procedure	Modifier	Diagnosis	Units	POS	Specialty	Amount
1	7/31/2012	7/31/2012	99214	50	709	1	11	C00000011	0.0
2	7/31/2012	7/31/2012	15111		709	1	11	C00000011	0.0
3	7/31/2012	7/31/2012	15115		709	1	11	C00000011	0.0

Buttons: Add Lines, Submit

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.

The screenshot shows the 'network health' portal interface. At the top, there are three tabs: 'Enter Professional Claim' (highlighted in orange), 'Enter Facility Claim', and 'Claim Lookup'. Below the tabs, a red error message states: 'The Diagnosis code entered is invalid'. The form fields show 'Gender' as 'Male', 'Date Of Birth' as '1/1/1949', and 'Claim Type' as 'Commercial'. A table below contains three claim lines:

Line	Beg DOS	End DOS	Procedure	Modifier	Diagnosis	Units	POS	Specialty	Amount
1	7/31/2012	7/31/2012	35045		7526/	1	21	C0000011	0.0
2	7/31/2012	7/31/2012				1	04	99	0.0
3	7/31/2012	7/31/2012				1	04	99	0.0

At the bottom of the form, there are two buttons: 'Add Lines' and 'Submit'.

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.

Condition Codes							

- **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.

Occurrences		Occurrence Spans			Value Codes	
Code	Date	Code	Date From	Date To	Code	Amount
						0.0
						0.0

Claim Lines

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

Line	Rev Code	HCPCS/HIPPS	Modifier	Service Date	Rate	Units	Total Charges	Non-Covered Charges
1				7/31/2012	0.0	1	0.0	0.0
2				7/31/2012	0.0	1	0.0	0.0
3				7/31/2012	0.0	1	0.0	0.0

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.

Diagnoses		Procedures	
<input type="button" value="Add"/>		<input type="button" value="Add Other"/>	
Other	POA	Principal:	Date:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	Other:	Date:
		<input type="text"/>	<input type="text"/>

Claim Lookup

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

The screenshot shows the 'network health' logo at the top left. Below it are three tabs: 'Enter Professional Claim', 'Enter Facility Claim', and 'Claim Lookup' (which is highlighted). The 'Claim Lookup' tab contains a search form with the following fields: 'Claim ID:' with a text input, 'Form Type:' with radio buttons for 'Professional' and 'Facility', and 'Provider ID:' with a text input. A 'Search Claims' button is located at the bottom right of the form.

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.



Enter Professional Claim Enter Facility Claim Claim Lookup

Gender	M	Date Of Birth	4/1/2000	Claim Type	Commercial
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Line	Beg DOS	End DOS	Procedure	Modifier	Diagnosis	Units	POS	Specialty	Amount	Status
1	5/30/2012	5/30/2012	99214		70900	1	11	99	50.0	A

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	99214	1	50.0	CLEAN LINE

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



Enter Professional Claim Enter Facility Claim Claim Lookup

Claim ID:	sample01234	Form Type:	<input checked="" type="radio"/> Professional <input type="radio"/> Facility	Provider ID:	1760524714
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Search Claims

Claim ID	sample01234	Gender	F	Date Of Birth	9/30/1963	Claim Type	professional
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Line	Beg DOS	End DOS	Procedure	Modifier	Code Type	Diagnosis	Units	POS	Provider ID	Specialty	Amount	Status
1	2/11/2011	2/11/2011	85025			230.0	1	81	1760524714	TSS0000001	8.0	A
2	2/11/2011	2/11/2011	99203			285	3	81	1760524714	TSS0000001	6.67	A

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags												
1	85025	1	8.0	CLEAN LINE												
2	99203	1	2.22	<table border="1"> <thead> <tr> <th>Flag Description</th> <th>Flag Status</th> <th>Disclosure</th> </tr> </thead> <tbody> <tr> <td>Dx 285 is a nonspecific diagnosis code and requires a fourth and/or fifth digit.</td> <td>review</td> <td> <p>IDX Flag</p> <p>The IDX flag identifies claim line items where the submitted ICD-9-CM diagnosis code requires a fourth and/or fifth digit to provide appropriate specificity.</p> <p>The ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) general coding guidelines state, "Diagnosis and procedure codes are to be used at their highest number of digits available."</p> </td> </tr> <tr> <td>Procedure Code 99203 is not typically performed by a physician at Place of Service 81 [Independent Laboratory].</td> <td>review</td> <td> <p>POS Flag</p> <p>The POS flag identifies claim lines where the submitted Place of Service (POS) is not typical with the submitted CPT®/HCPCS procedure.</p> <p>This edit flags CPT or HCPCS codes (excluding unlisted codes) when the submitted POS falls outside of the list of sourced POS for the current CPT or HCPCS code.</p> </td> </tr> <tr> <td>Procedure Code 99203 with an allowed daily frequency of 1 has been exceeded by 2 for date of service 02/11/2011.</td> <td>deny</td> <td> <p>The Maximum Frequency per Day (MFD) edits indicate the number of times a procedure is typically performed in a 24-hour period based on common practice sources.</p> <p>The descriptors of certain CPT® and Healthcare Common Procedure Coding System (HCPCS) codes define the MFD that a code can be performed for the same patient by the same provider during the same 24-hour period. (note: the provider product rule does not consider billing provider, department and specialty as part of the history criteria when applying the MFD edit.) Examples are as follows:</p> </td> </tr> </tbody> </table>	Flag Description	Flag Status	Disclosure	Dx 285 is a nonspecific diagnosis code and requires a fourth and/or fifth digit.	review	<p>IDX Flag</p> <p>The IDX flag identifies claim line items where the submitted ICD-9-CM diagnosis code requires a fourth and/or fifth digit to provide appropriate specificity.</p> <p>The ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) general coding guidelines state, "Diagnosis and procedure codes are to be used at their highest number of digits available."</p>	Procedure Code 99203 is not typically performed by a physician at Place of Service 81 [Independent Laboratory].	review	<p>POS Flag</p> <p>The POS flag identifies claim lines where the submitted Place of Service (POS) is not typical with the submitted CPT®/HCPCS procedure.</p> <p>This edit flags CPT or HCPCS codes (excluding unlisted codes) when the submitted POS falls outside of the list of sourced POS for the current CPT or HCPCS code.</p>	Procedure Code 99203 with an allowed daily frequency of 1 has been exceeded by 2 for date of service 02/11/2011.	deny	<p>The Maximum Frequency per Day (MFD) edits indicate the number of times a procedure is typically performed in a 24-hour period based on common practice sources.</p> <p>The descriptors of certain CPT® and Healthcare Common Procedure Coding System (HCPCS) codes define the MFD that a code can be performed for the same patient by the same provider during the same 24-hour period. (note: the provider product rule does not consider billing provider, department and specialty as part of the history criteria when applying the MFD edit.) Examples are as follows:</p>
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Export to PDF

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- **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.