Provider User Guide
Condition Optimization Program via NaviNet®
2022

Keystone First

Provider Guide:

Condition Optimization Program

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About the Condition Optimization Program (COP)

Background

Under its contract with the Pennsylvania Department of Human Services (DHS), Keystone First 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 DHS.

DHS 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 Keystone First, member-level data obtained through encounters allows DHS to gain a more in-depth understanding of the factors driving cost and quality within the Medicaid program.

Keystone First has developed the **Condition Optimization Program (COP)** 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 (PCP).

Program Purpose

The Keystone First Condition Optimization Program exists to:

- Help primary care providers (PCPs) identify members with chronic and/or complex medical needs.
- Promote routine access to primary care for chronically ill members.
- Increase member appointment compliance through outreach.
- Improve accuracy and completeness of reporting to DHS regarding Keystone First 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

COP members are identified as those with claims history indicating chronic and comorbid conditions. Review of program data from affiliated Plans within the AmeriHealth Caritas Family of Companies reveals chronic and comorbid diagnoses are often incorrectly reported on claims or not reported at all.

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

- No claims were submitted by the PCP for that member within the previous six months.
- Claims were submitted by the PCP within the previous six months, but claims did not include all the chronic/comorbid diagnosis codes found in the member's claims history.

Validating Claims/Encounter Data

Keystone First 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 COP 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 Keystone First. Activities completed by a provider, online, via NaviNet include:
> - Accessing claim details.
> - Reviewing the results of the codes identified by Keystone First 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, and/or additional diagnosis codes are added to the originally submitted claim along with procedure code 99499 (Other Evaluation and Management Services) to pay the applicable administrative fee.

Provider Action: Pull the member's medical record corresponding to the date of the 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 cannot be confirmed. If a suspected diagnosis code is not 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 were not 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 were not reported on the original claim. Review the diagnosis code(s) listed and if agreed that the diagnosis code(s) should have 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 COP that focuses on engaging members to be seen regularly by their primary care provider (PCP).

"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 has not 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 cannot be made or the member is not 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 Keystone First; therefore, it is important that providers check each month for new **"Practice Documents."**

Supplemental Reimbursement

Keystone First 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, Keystone First offers PCPs an administrative payment in accordance with the following fee schedule:

Retrospective Outreach – Adjust Claim(s)

- Original claim for any member – $40.00 per claim.
- All subsequent claims for the same member with service dates exceeding 180 days from the prior claim service date – $7.00 per claim.
- All subsequent claims for the same member with service dates within a 180 day period from the prior claim service date – $7.00 per claim.

The additional reimbursement is for your effort and participation in this program; it is not dependent on the health plan'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 (COP) - 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*, Keystone Firstalso performs a random quality review of claims submitted or adjusted through the COP program process. As part of the quality audit process, Keystone First 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 will 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 cannot be supported by medical record documentation.

How to Use this Guide

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

- Access the "Practice Documents" Workflow
- Review, Search, and Filter Pending Activities in the Workflow
- Launch "Member Selection" for COP Activities
- Search for a Member and/or Filter by Needed Actions
- Validate or Update the Member's Information by:
    - Completing a claims adjustment by reviewing your medical records and updating the member's diagnosis information based on documentation from the date of service. OR
    - Scheduling an office visit, evaluating the member, and submitting a *Scheduled Appointment Worksheet*.

Before You Begin

1. NaviNet Permissions

    Check with your NaviNet Security Officer to confirm that you have been granted the appropriate access to the workflows you need. If your NaviNet Security Officer has not enabled *Document Exchange,* please ask your Security Officer to follow the steps outlined on pages 35 through 38 in the "Supplemental Information" section of this guide.
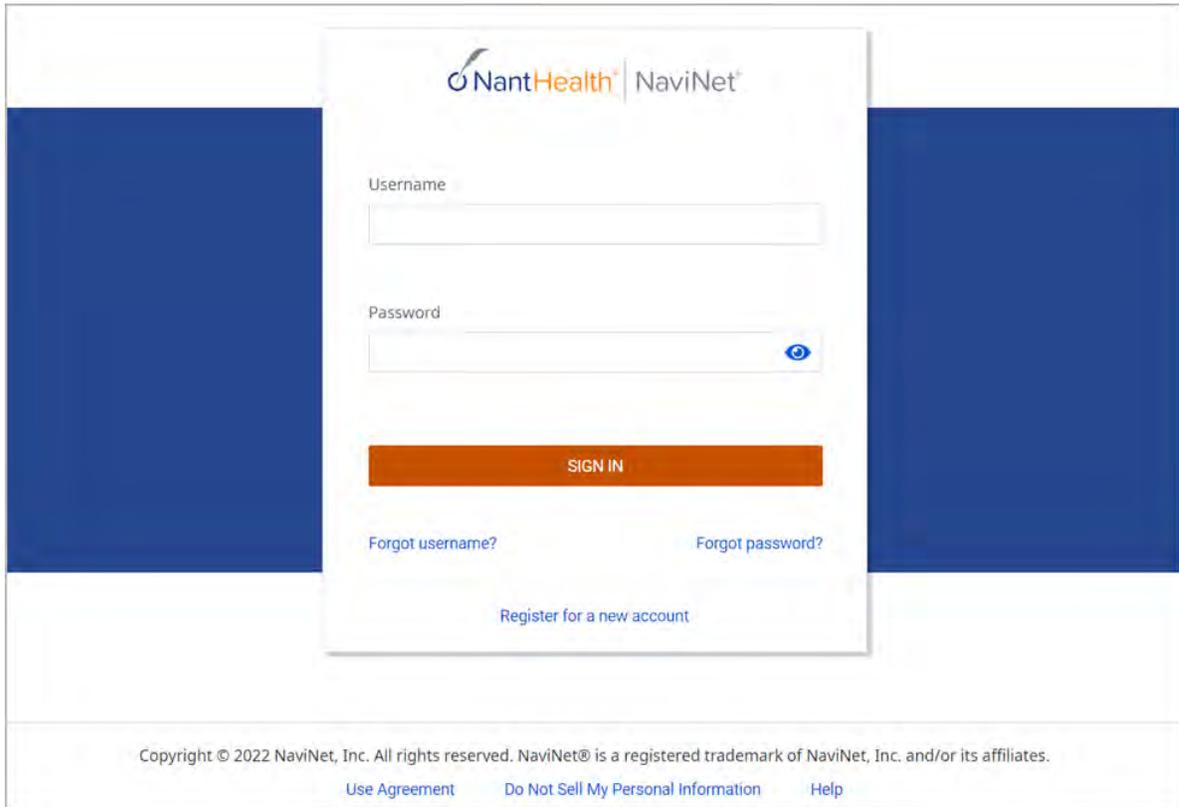
2. Consider Filtering Providers for Optimum Access

    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 log in to NaviNet and visit https://support.nanthealth.com/health-plans/navinet-open/user-guide/provider-filter.

Step 1. Log-In to NaviNet

A. Open your Internet browser.
B. Go to https://navinet.navimedix.com.
C. Log-in 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 COP activities is the **"Practice Documents**" workflow, which allows the user to see a list of all members on their patient roster for a particular health plan. The steps below provide access to the **"Practice Documents"** workflow.

    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 COP-related 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 COP Activities

A. Click on a record to view. For example, "COP for 123456 MAIN STREET PEDIATRICS."
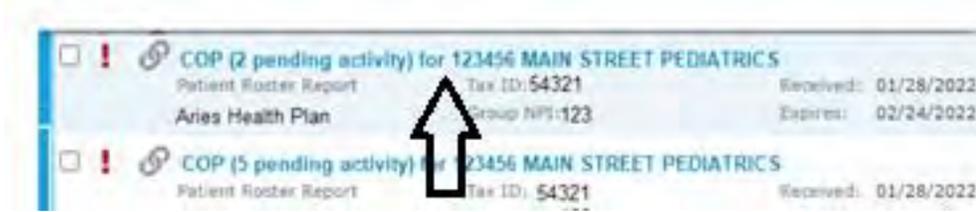
B. The screen below will display. Click on **Member Selection** at the bottom of this screen to access COP activities.

Step 5. Search for a Member and/or Filter by Needed Actions

You are now in the COP section of NaviNet. Here the user will see the **Member Listing,** which contains all COP 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 + Member Date of Birth.**

B. Filter by Action:
   o **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.

   o **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.

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

   o **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:
   o **Incomplete** status will filter for all records regardless of action type that require review/adjustment.

   o **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.

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

SEARCH   RESET FILTER(S)

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

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

Member ID

Member Last Name

Member Date of Birth: MM/DD/YYYY

SEARCH   RESET FILTER(S)

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

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

Member ID

Member Last Name

Member Date of Birth: MM/DD/YYYY

SEARCH   RESET FILTER(S)

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

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

Member ID

Member Last Name

Member Date of Birth: MM/DD/YYYY

SEARCH   RESET FILTER(S)

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

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

Member ID

12345666

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 once again.

There are three possible statuses in the Claim Listing screen are:

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 adjustment and 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	Provider Details
Name:	Billing Provider Name:
ID:	
Gender:	Billing Provider ID:
	Servicing Provider Name:
	Servicing Provider ID:

⌄ Claim Details

Claim Number:		Status Date:	1/1/2021
Service Date Range:		Status Code:	107
Total Amount Billed:		Category Code:	F1
Total Amount Paid:		Remark Code:	
Paid Date:	01/01/2021	Check Number:	

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

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.

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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 ❼	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? ❼	Action ❼
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 that the user confirms the diagnosis is still present.

   b. **Yes, but diagnosis updated** – If the diagnosis code listed is not correct for the member 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 does not have record(s) of this diagnosis; never present.

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

Please remember 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 the user can review all the information the user provided/updated (see the next page for example).

VII. Next:
a. Click **Edit** to return to the Claim Adjustment screen for additional changes. OR
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.

PLAN LOGO

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

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

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

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

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

Claims for   (Date of   )

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

BACK

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 once again.

There are three possible statuses in the Claim Listing screen are:

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

⌄Claim Details

Claim Number:	**Status Date:** 1/4/2021
Service Date Range:	**Status Code:** 107
Total Amount Billed:	**Category Code:** F1
Total Amount Paid:	**Remark Code:**
Paid Date: 01/04/2021	**Check Number:**

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

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.

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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	Status ❓
A80.39	Other acute paralytic poliomyelitis	--Please Select-- ▾
E84.19	Cystic fibrosis with other intestinal manifestations	--Please Select-- ▾
E88.81	Metabolic syndrome	--Please Select-- ▾
D72.89	Other specified disorders of white blood cells	--Please Select-- ▾
F03.90	Unspecified dementia without behavioral disturbance	--Please Select-- ▾
		5 items

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" diagnosis will be added to the claim record.
> • "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.   In the **Diagnosis Code Adjustment** section, we are 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 that 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 the user can review all the information provided and/or updated (see next page for example).

VI.   Next:

   a. Click **Edit** to return to the Claim Adjustment screen for additional changes.
       OR
       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 - Verification

⌄Patient and Provider Details

Patient Details   Provider Details

Name: Billing Provider
ID: Name:
Gender: Billing Provider ID:
                                   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	99213		$140.00	11	1,2,3,4		Confirmed

⌄Additional Procedure Code

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

⌄Diagnosis Code Adjustment

Suspected Diagnosis Code	Description	Status
A80.39	Other acute paralytic poliomyelitis	CONFIRMED
E84.19	Cystic fibrosis with other intestinal manifestations	CANNOT CONFIRM
E88.81	Metabolic syndrome	CONFIRMED
D72.89	Other specified disorders of white blood cells	CANNOT CONFIRM
F03.90	Unspecified dementia without behavioral disturbance	CANNOT CONFIRM
		5 items

[SUBMIT] [EDIT]

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.

Member and PCP Details

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

PCP Visit Details

Date Last Seen Dec 1, 2020

Individual Doctor Seen

Group Practice Name

Historically Reported Diagnosis Code(s)

Historical Diagnosis Code	Diagnosis Description	Diagnosis Origin	Original Reported Date
I10	Essential (primary) hypertension	Office Visit → PCP	12/15/2020
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type	Inpatient	4/1/2021

Contact Log

Appointment Scheduled? *

--Select--   ▼

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

Note

1500 characters remaining

SUBMIT   EXIT

It is important to note that Keystone First has no record of these members being treated by a physician in the last 6 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 the health plan if your office was successful in scheduling an appointment and the new appointment date. If your office was not 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 **successful** in outreach to the member and was able to schedule a new appointment, select the option "**Yes, appointment scheduled**":

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

<mark>Note</mark>: The date the user enters can either be within 6 months **before** or **after** the current date.

b. If your office was **unsuccessful** in outreach attempts to the member, in the "**Appointment Scheduled**" drop down, select one of the 6 "**No**" reasons available.

<mark>Note</mark>: 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, please double check the selections you have made. There is no "Preview" button available and the user will be unable to go back and change their selections after the worksheet has been successfully submitted. Once the use 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 double check the selections the user has made. 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 was not 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 completed - 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 the health plan 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 that you must also submit a claim following your normal claim submission process. Include all diagnosis codes identified during the office visit and any codes confirmed or updated on the *Scheduled Appointment Worksheet*. Additionally, the Medical Record must be submitted via secure e-mail 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)
❷

* Date Member Recently Evaluated   mm/dd/yyyy

Provider Name

Historical Diagnosis Code ❷	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? ❷	Action ❷
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 6 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 that the user confirms the diagnosis is still present.
b.   **Yes, but diagnosis updated** – If the diagnosis code listed is not 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.
       <mark>*NOTE*</mark>: 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 that the user does not have record(s) of this diagnosis; never present.
d.   **No, diagnosis resolved** – Attesting that 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.

Historically Reported Diagnosis Code(s)

| * Date Member Recently Evaluated | 01/19/2022 |
| 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	Yes, diagnosis confirmed	▾
F90.0 ✕	Attention-deficit hyperactivity disorder, predominantly inattentive type	No, diagnosis resolved	▾
J45.909 ✕	Unspecified asthma, uncomplicated	Yes, diagnosis confirmed	▾ Remove

⊕ Add Newly Identified Diagnosis Code

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

SUBMIT | EXIT

VI.   After completing the required information in the **Historically Reported Diagnosis Code(s)** section, please double check the selections made. There is no "Preview" button available and the user will be unable to go back and change selections after the worksheet has been successfully submitted. Once the user is ready, click on the **Submit** button in the lower right bottom section of the page.

A warning message will display:

Click YES button to confirm and submit or No button to stay on this page

NO   YES

This message is a reminder to double check the selections made. To go back and change anything, click **NO**. If no changes need to be made, click **YES**.

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

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		**Filter by Action**
Member Last Name		☐ Adjust Claim(s) - Provider Self-Review Medical Records
		☐ Adjust Claim(s) - Plan Medical Records Review Results
Member Date of Birth	MM/DD/YYYY	☐ 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
				APPOINTMENT SCHEDULED	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 (PSU)

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

1. Click **Administration** from the NaviNet toolbar and then scroll down to select **Manage User Permissions**.
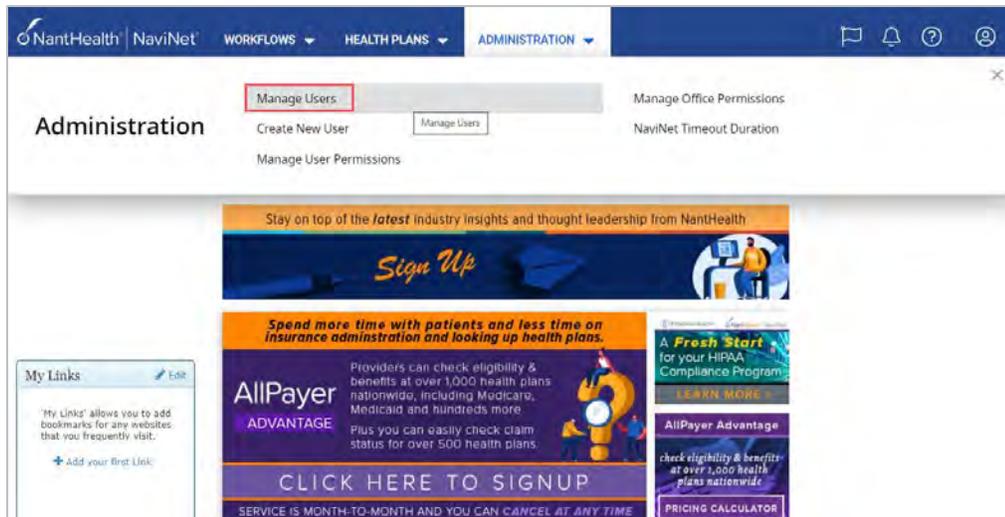
2. From the next screen, select the user whose permissions you want to adjust, and then select **Edit Access**.

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.

Transaction Management for User

Username: Security Officer? No
Office: Plan Service Office
Go to Office Transaction Management for this office

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

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

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

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
NaviNet	Document Respond	Enabled			Disable
NaviNet	Document Viewer	Enabled			Disable
NaviNet	Document Download	Enabled			Disable
NaviNet	Document Preview	Enabled			Disable
NaviNet	Practice Document Respond	Enabled			Disable
NaviNet	Practice Document Viewer	Enabled			Disable
NaviNet	Practice Document Download	Enabled			Disable
NaviNet	Practice Document Preview	Enabled			Disable

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

Transaction Management for User

Username: Security Officer? No
Office:
Go to Office Transaction Management for this office

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

Plan/Service ▲	Name	Access?	Last Modified	Modified By

7. Click **Enable** next to any Patient Clinical Document categories that you want to be available to this user for the selected health plan.

Plan/Service ▲	Name	Access?	Last Modified	Modified By	
Aries Health Plan	Clinical Summary	Disabled			Enable
Aries Health Plan	Patient Consideration	Disabled			Enable
Aries Health Plan	Program Enrollment	Disabled			Enable
Aries Health Plan	Info Request	Disabled			Enable

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

Aries Health Plan	Patient Transition Report	Disabled			Enable
Aries Health Plan	Patient Roster Report	Disabled			Enable
Aries Health Plan	Pharmacy Report	Disabled			Enable
Aries Health Plan	Program Enrollment Report	Disabled			Enable
Aries Health Plan	Financial Report	Disabled			Enable

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 will see the pop-up below warning you that your session is about to expire. If you click **Resume** within 5 minutes, the page will reload and you can continue entering information.

If you do not click **Resume** within 5 minutes, the form will time-out, and the user will see the log-in window pictured below. Please **do not** attempt to log-in via this pop-up. Instead, close the window and log-in to NaviNet again.

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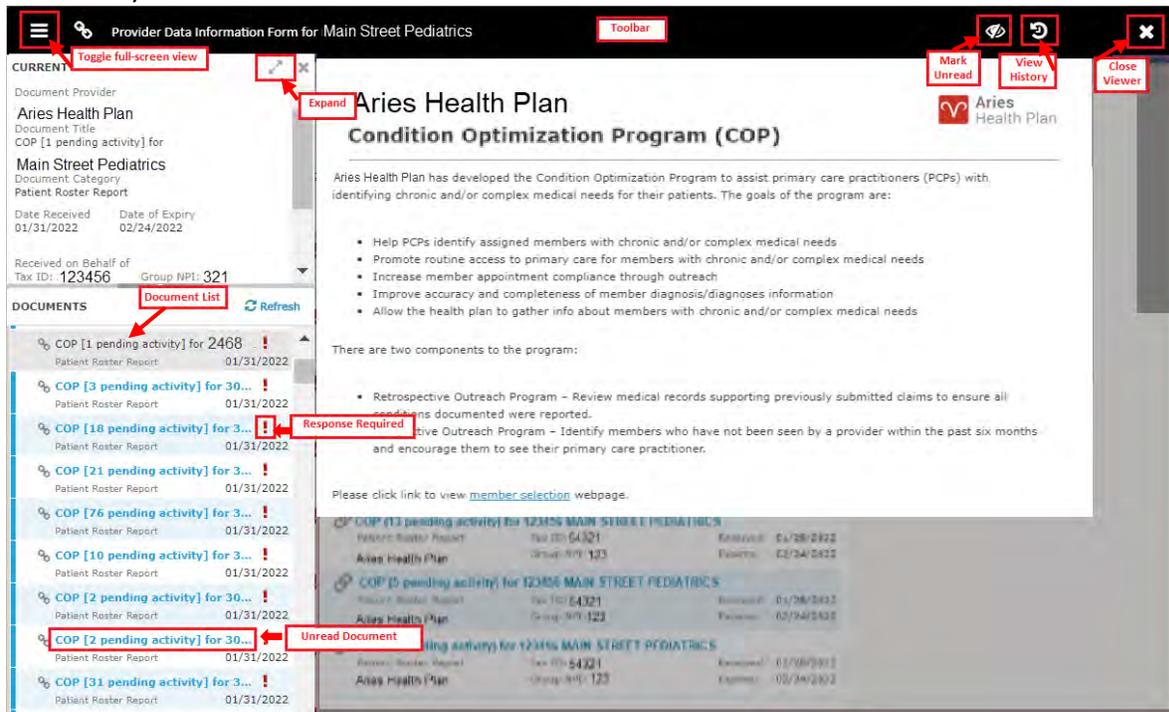
- Toolbar
    a. The left side of the toolbar lets the user toggle full screen view and shows the current document's file type and title. The right side lets the user mark the current document as unread.

- Document List
    a. Shows the documents you have selected. Clicking a document row displays the document in the document viewer.
    b. Unread documents are highlighted with a blue bar and text.
    c. Documents for which a response is requested are marked with a red exclamation point.

- Current Document Summary
    a. Gives information on the current document, such as the health plan that sent the document, the document category, line of business, document name, and received and expiry dates. Document routing and tag information is also displayed. Users can expand the window to see any hidden information.

Popup Blocker Must be Disabled

For the COP - Prospective Outreach Program to work properly, the user's Pop Up blocker must be disabled.

Downloading, Saving and Printing Member Information

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

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

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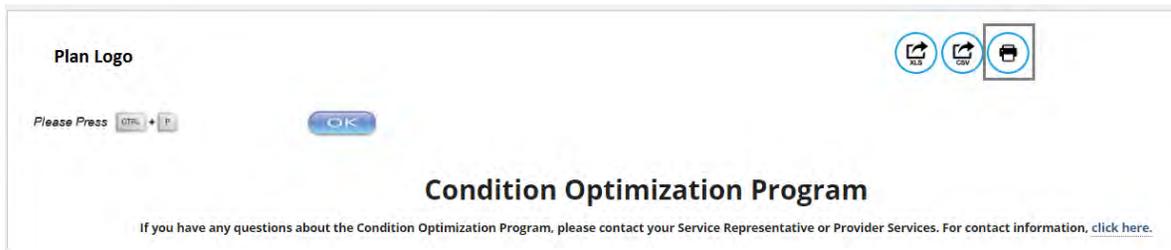
Report Generation

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.

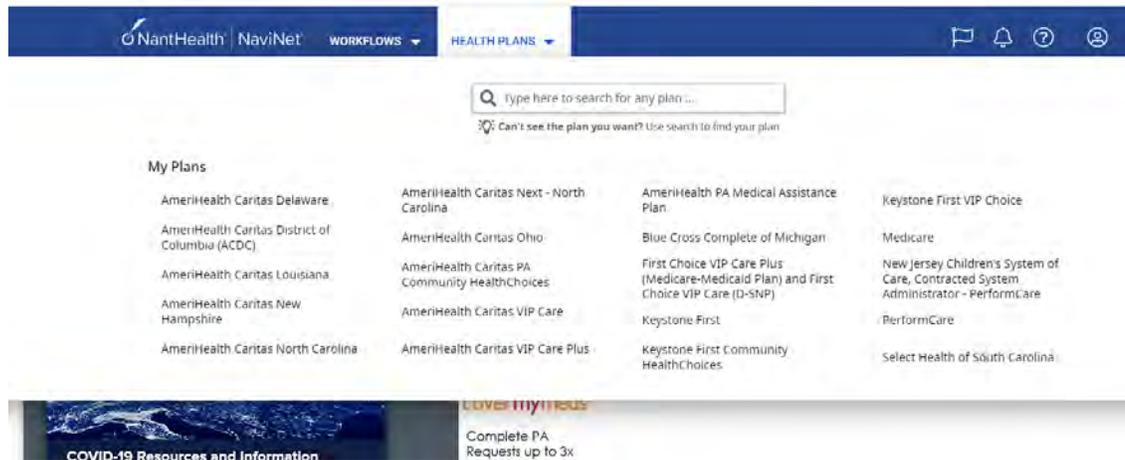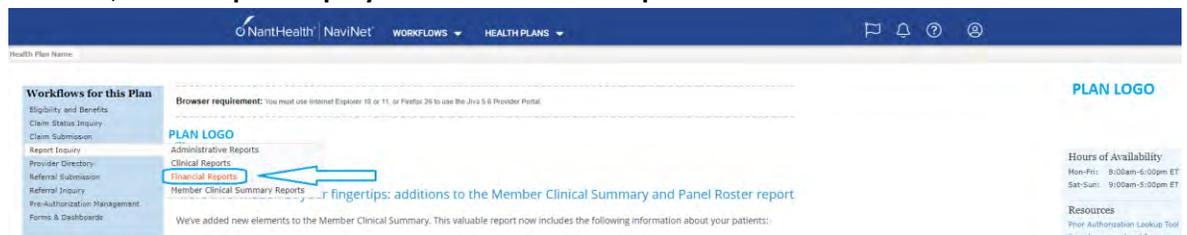4. Next, select **Report Inquiry** and then **Financial Reports**.

5. For reviewing **Retrospective** Action Items completed (Provider Self-Review Medical Records and/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.

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6. Now, the user can set the parameters:
   i. **Time Period or Date Range** –
      1. Time period defaults to "Up to 7 days", but user can select 30, 90, 180 days or up to one year. **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. **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 is not necessary to choose a specific provider under the group, but all providers will be returned in the report.
   iii. **Filter Criteria**
      1. If 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. **Required field.**
      2. Report type defaults to "PDF", but you 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. **Required field.**

<<Plan Name>>   **Adjusted Claims Report Query**

Instructions

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

Adjusted Claims Information

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

* Choose a Time Period   Up to 180 days ▾

OR
Up to 7 days
Up to 30 days
Provide Date Range: Up to 90 days
Up to 180 days
From Date(MM/DD/YY   Up to one year

To Date (MM/DD/YYYY)

* Choose a Provider Group   Group Name - PIN ▾

Choose a Provider ▾

Filter Criteria

Member ID

Claim ID

Report Criteria

* Adjusted Claims Type   Condition Optimization Program ▾

Select Report Type   ● PDF
○ Excel/CSV(Downloadable)

Select Sort Options

* Adjusted Date ▾

Search   Exit   Clear

Exit

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

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(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

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7. If parameters are selected and the search performed and there are no records to return, the screen will display with the following message:
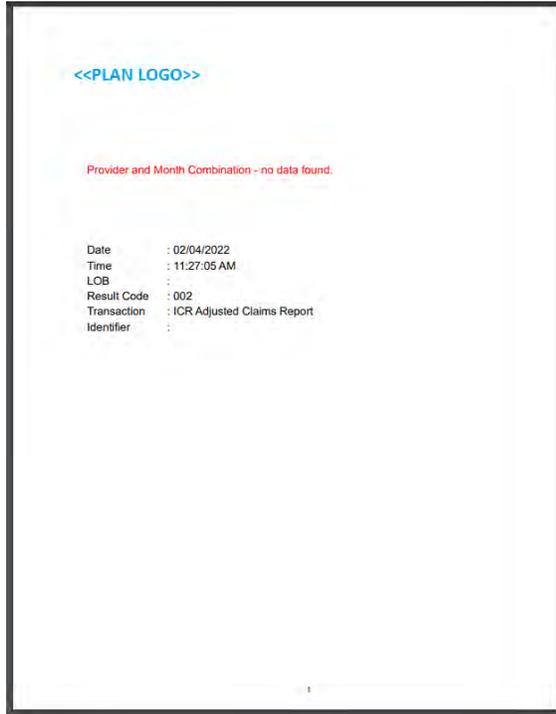
8. For reviewing the **Prospective Outreach Payment Report**, select this option from the drop-down list and then click on **Select** at the bottom of the page.

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

Example of Report: