carolina complete health™

Secure Provider Portal Overview

Last updated: December 2023

Agenda

- Introduction
- Registration and Provider Resources
- Account Management Role and Tasks
- Account Details
- Portal Features and Benefits:
  - Member Eligibility
  - Patient List (only PCP / PCP Organizations)
  - Viewing and Submitting Authorizations
  - Viewing Claims Information
  - Claim Submission
- AMH Specific Information: Intro to Provider Analytics
- Q&A

Secure Provider Portal Introduction

Secure Provider Portal Introduction

The Provider Portal allows providers to:

- Check eligibility
- Submit, correct, and check claim status
- Submit and view prior authorizations
- View patient care gaps
- And much more

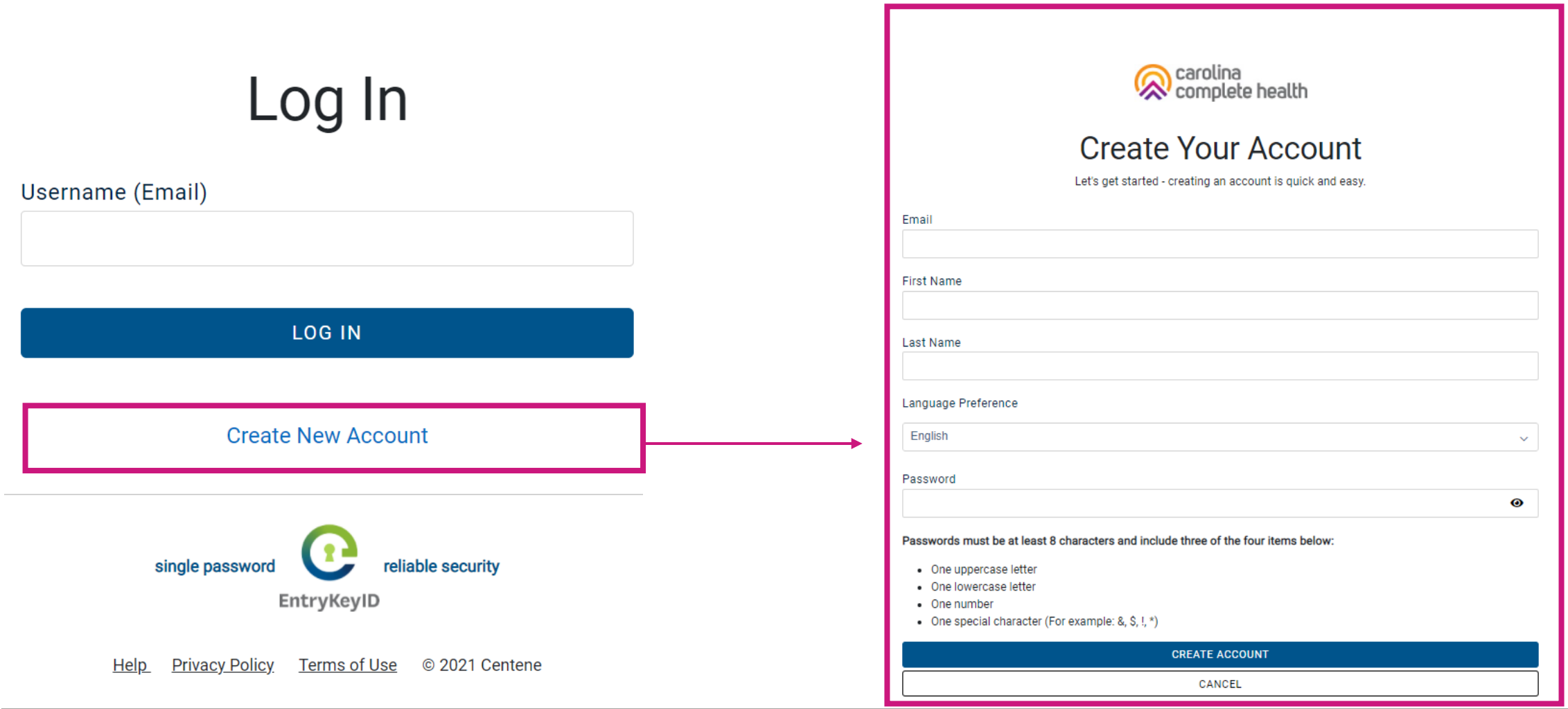
Secure Provider Portal General Information

- Driven by Tax ID Number (TIN)
- Performs best in the current version of Chrome
- Does ***not*** house member, provider, claim, or authorization data, it merely displays information from CCH back-end systems

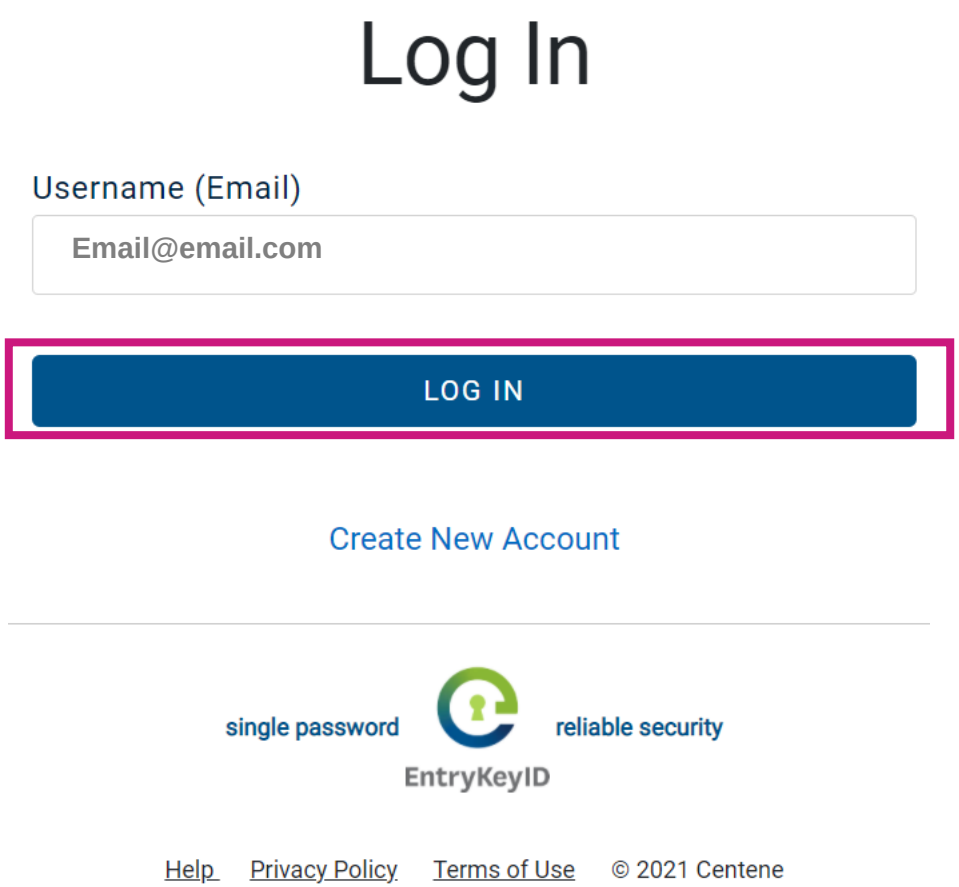
Provider Portal Registration & Login

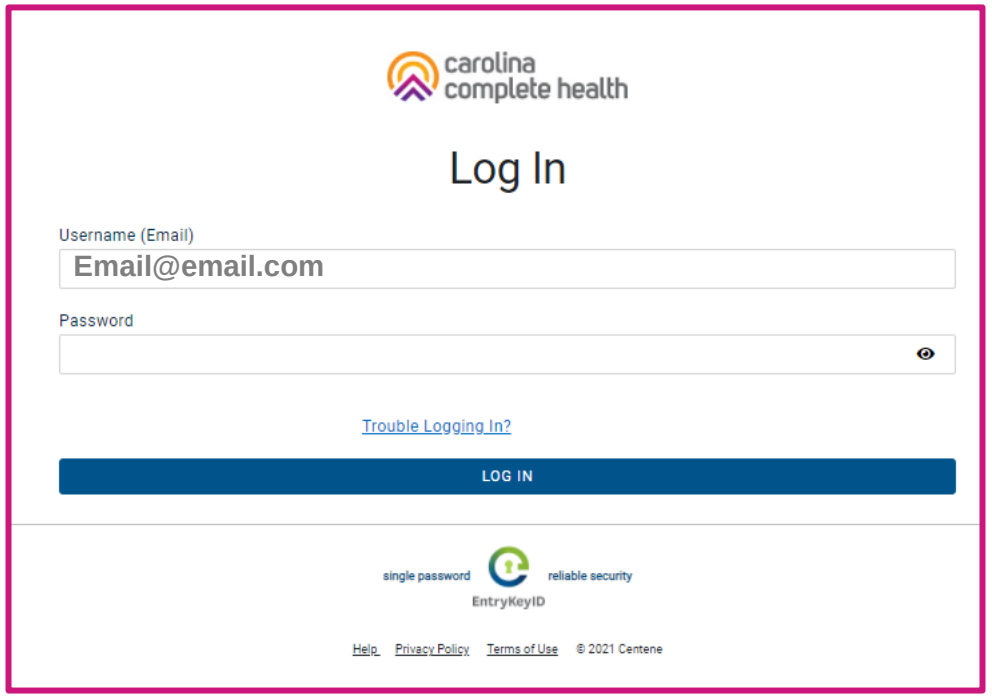
Portal Registration: provider.carolinacompletehealth.com

Tip: add no-reply@mail.entrykeyid.com to your email contacts

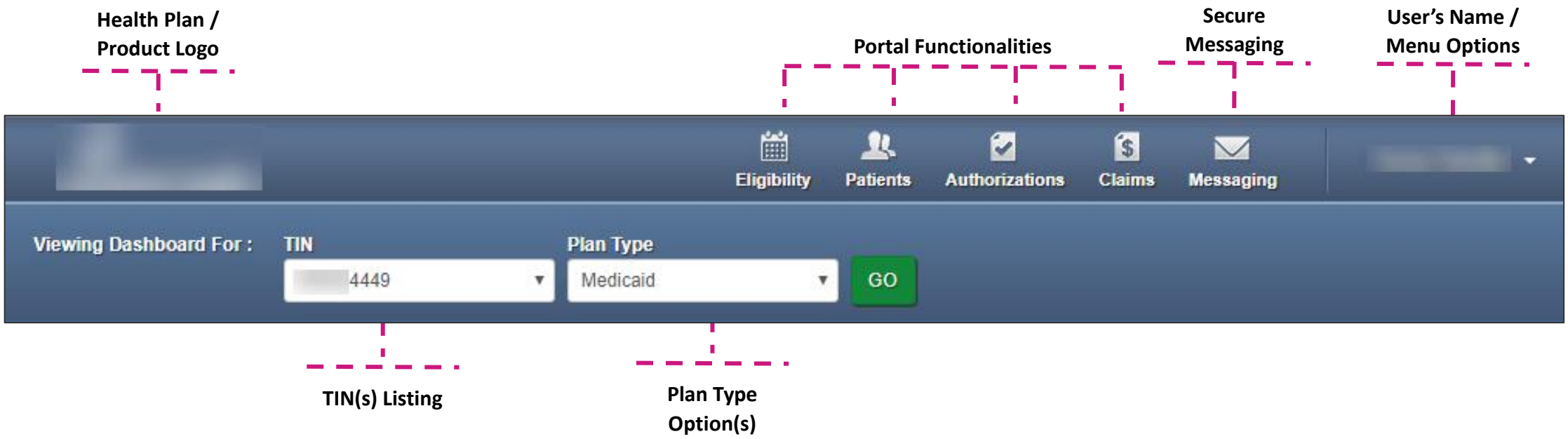


Portal Login





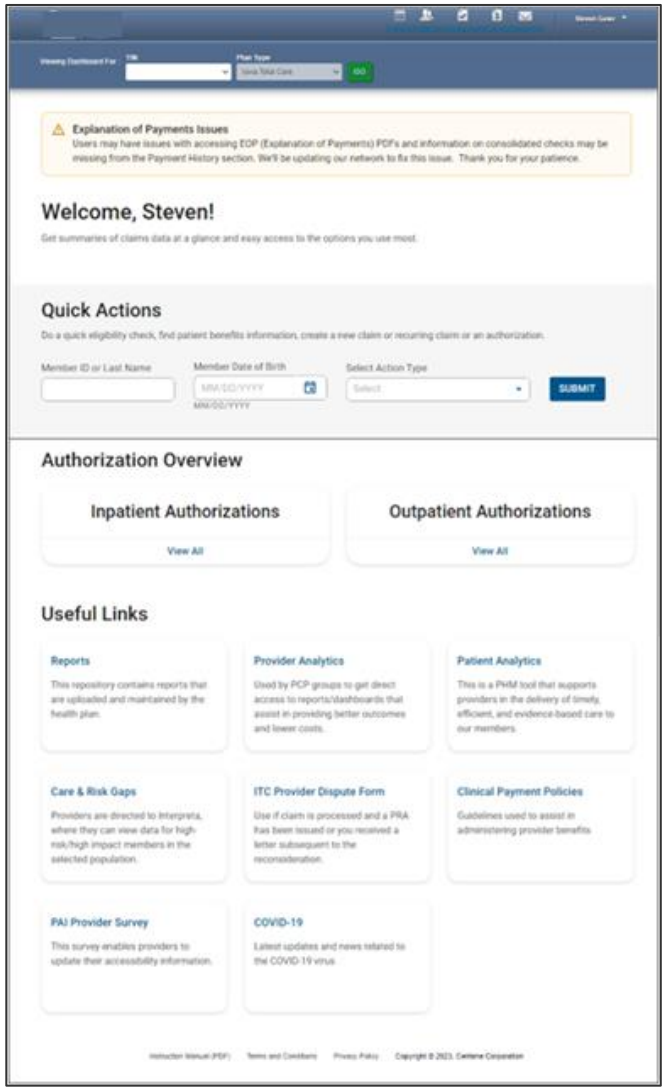
Portal Banner



Tips

- Portal functionality / access is based on the user's permissions
- **Plan Type** drop-down options are automatically assigned based on how the TIN is set-up in our systems, and the products offered by the Health Plan

Portal Home Page – Verified Portal Account



Portal Registration & Login Tips

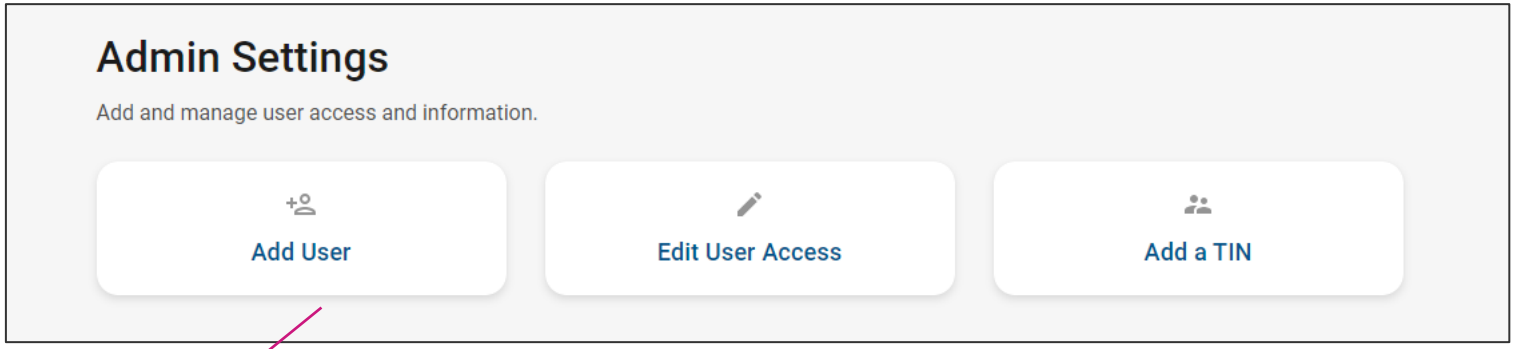
- Registration is required for access to the portal
  - Carolina Complete Health is responsible for verifying and setting up the original user/registrant for your TIN. This is your Account Manager. Reach out to your Provider Engagement Administrator for support setting up the Account Manager.
- Portal accounts cannot be shared
  - Each person within a provider organization who needs access to the portal, must compete the portal registration
- For a portal user to register, their TIN must be loaded in our systems
  - Allow at least two business days for portal to reflect updates in back-end systems
- There is no limit on the number of TINs a portal user can add to their portal account
- Portal users must log into the portal every 90 days to prevent their account from being locked due to inactivity
- The Forgot Password / Unlock Account link on the Secure Provider Portal login page, cannot be used to unlock a portal account, that is locked due to inactivity

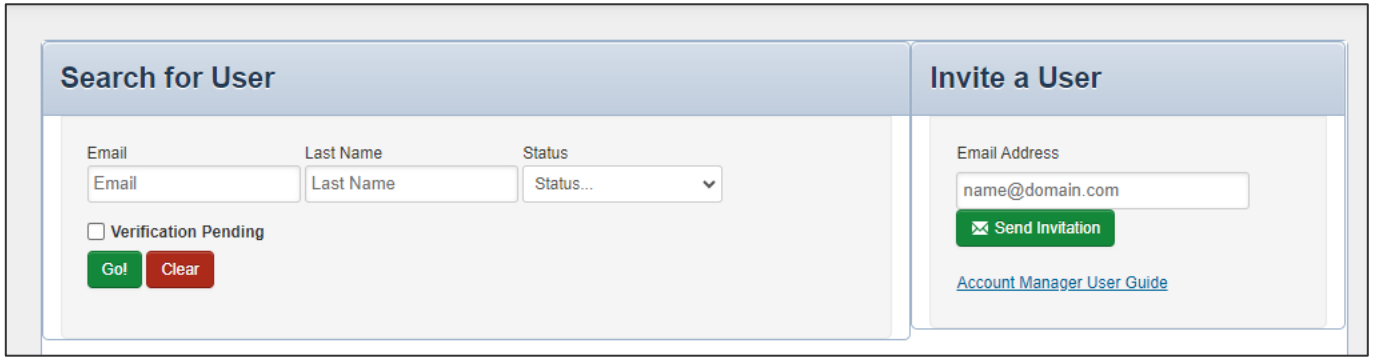
Portal Account Manager

Portal Account Manager

- A Portal Account Manager is a role assigned to a primary contact within a provider organization
- **The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same TIN**
- Email your Provider Engagement Administrator to establish the first account manager for your TIN

Portal User Management: User Access





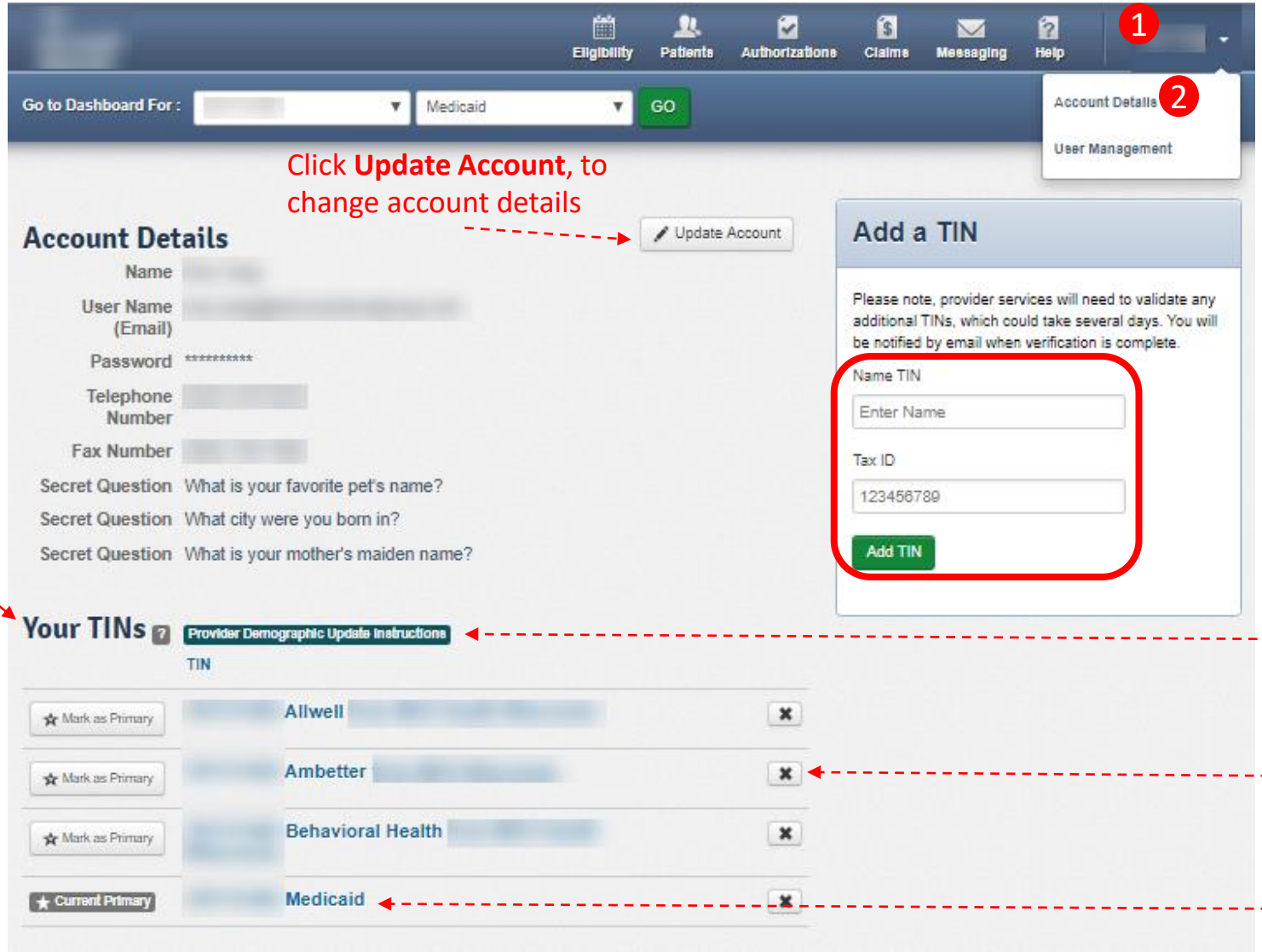
Portal Account Manager Tips

- Each TIN should have at least two Account Managers
  - For large organizations, it is recommended to have at least two Account Managers per department.
  - There is no limit on the number of Account Managers allowed under a TIN
- Account Managers should *regularly* log into the portal to:
  - Verify new portal registrations
  - Disable / Enable a user's portal access
  - Modify portal permissions based on the user's role within your organization
- Account Managers **cannot** manage their own portal account

Tip: Always disable portal users, who no longer need portal access, especially when they leave your company.

Portal Account Details

Portal Account Details



Use **Add a TIN**, to associate additional TIN(s) to your portal account

Your TINs, list the TIN(s) you added to your portal account

NOTE: Carolina Complete Health providers must update demographic information with NCTracks

Click **X** to remove a TIN

Click **Mark as Primary**, to change TIN and Product login default

Click **TIN / Product** to view / update Provider Demographics

Portal Account Details - Tips

- Under Account Details, portal users can:
  - Update account details (i.e. change email address, name, password, etc.)
  - Select TIN/Product login default
  - Add a TIN
  - Remove TIN(s) from portal account

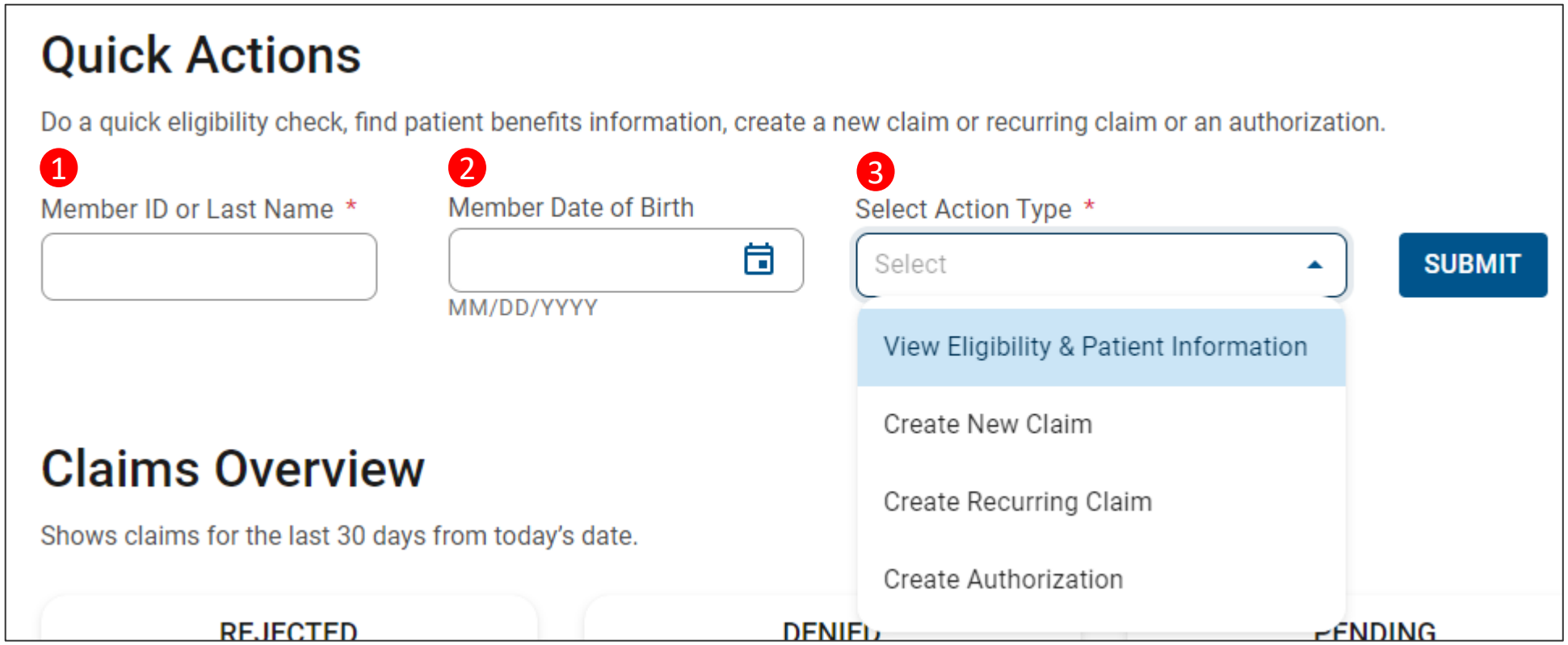
Tip: If an inactive TIN is removed from a portal account, it cannot be re-added.

Portal Functionality: Check Eligibility

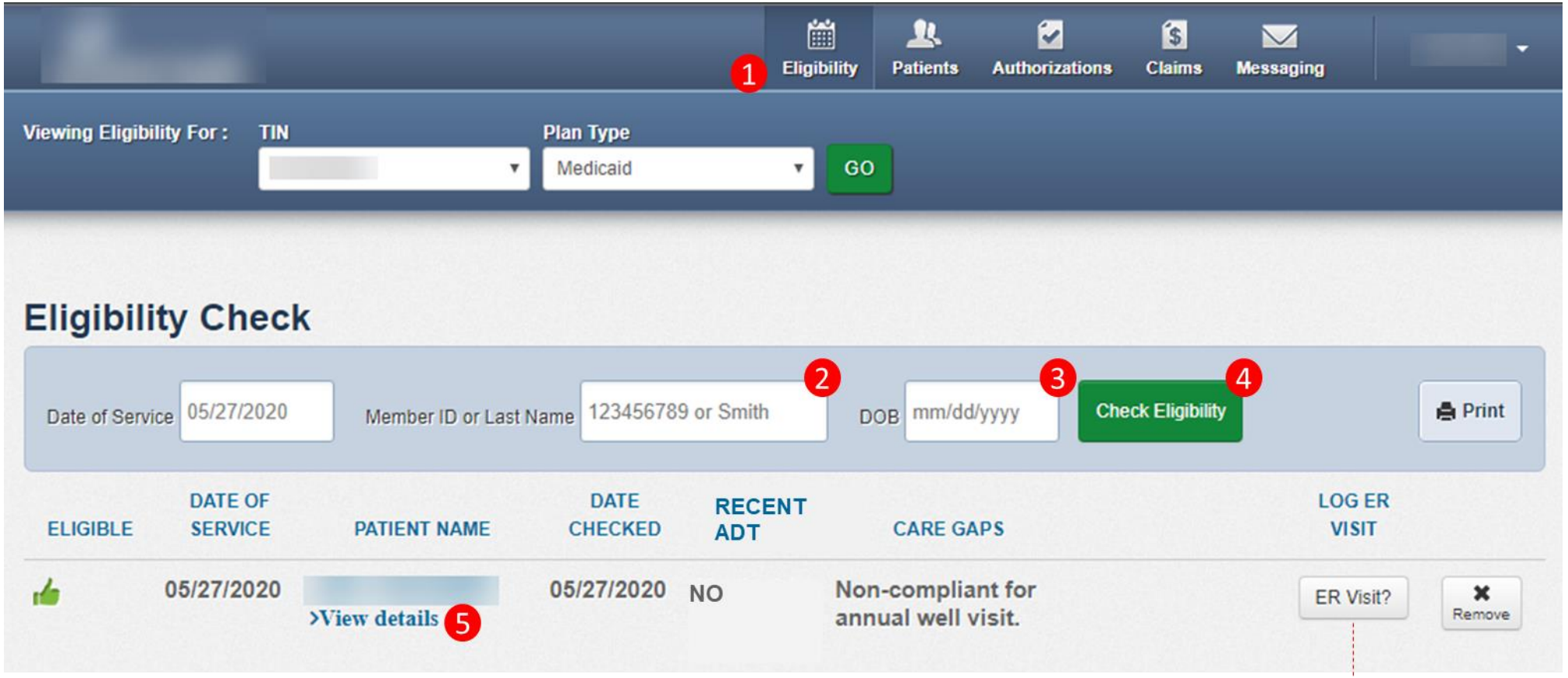
Eligibility Check

Within Eligibility Check results, the Patient Overview displays patient demographic, claims, authorizations and other pieces of information. It can be used to identify Care Gaps, view ER visits, and PCP history.

Quick Eligibility Check



Eligibility Check



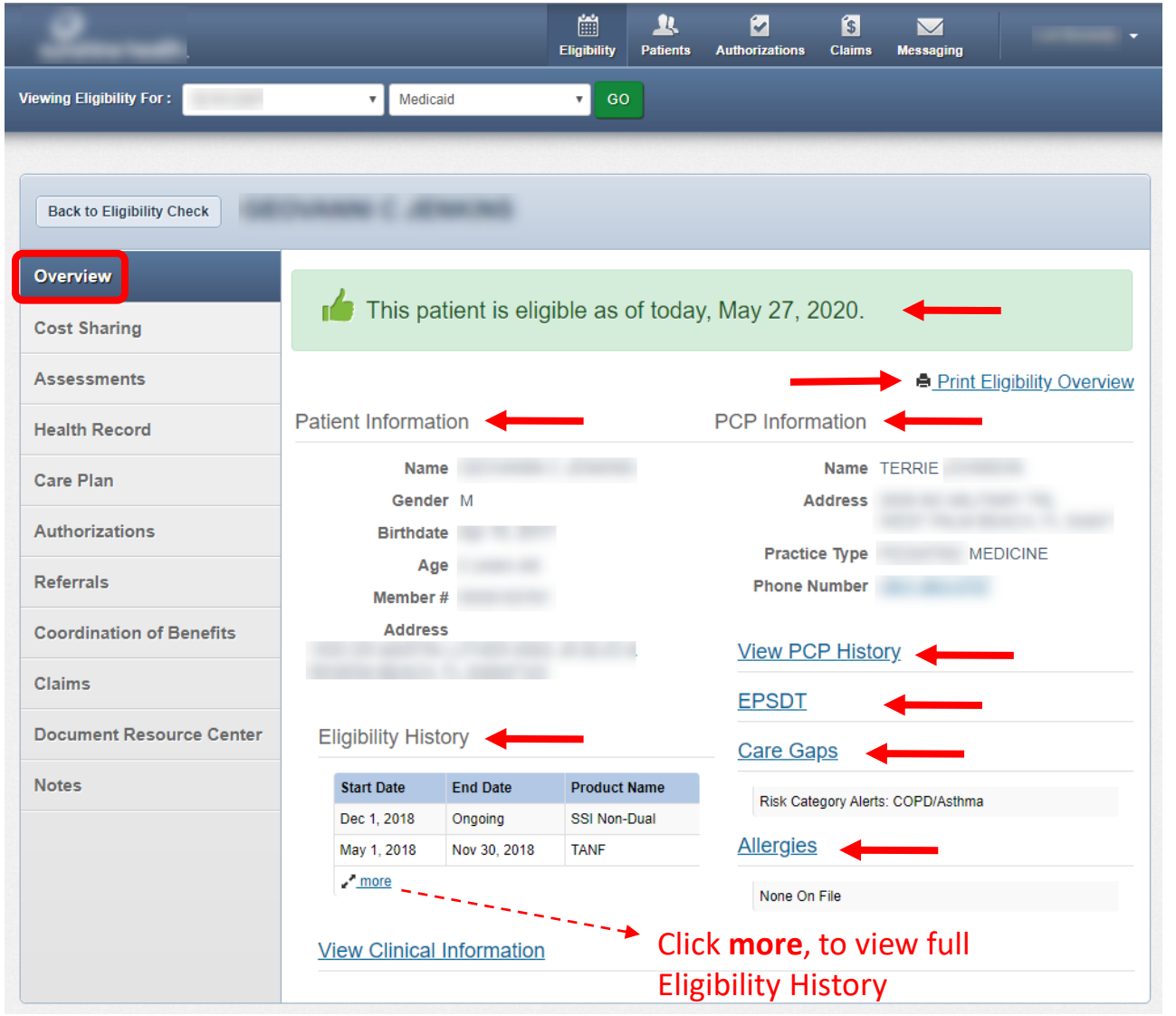
If Eligibility Check is for an ER visit, click **ER Visit?**

Eligibility Tips

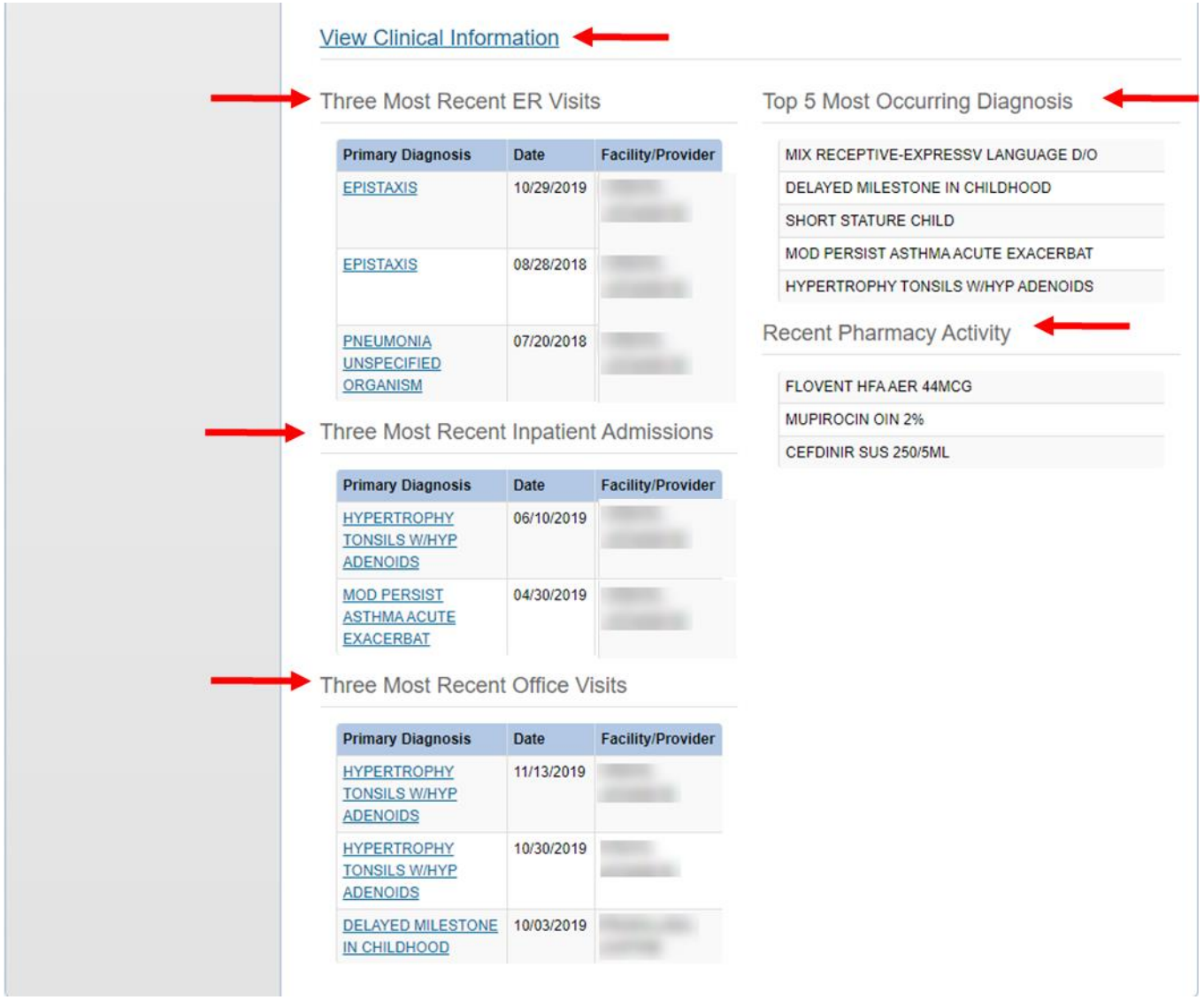
- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- As best practice, always check member eligibility before creating a web authorization or web claim

Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid.

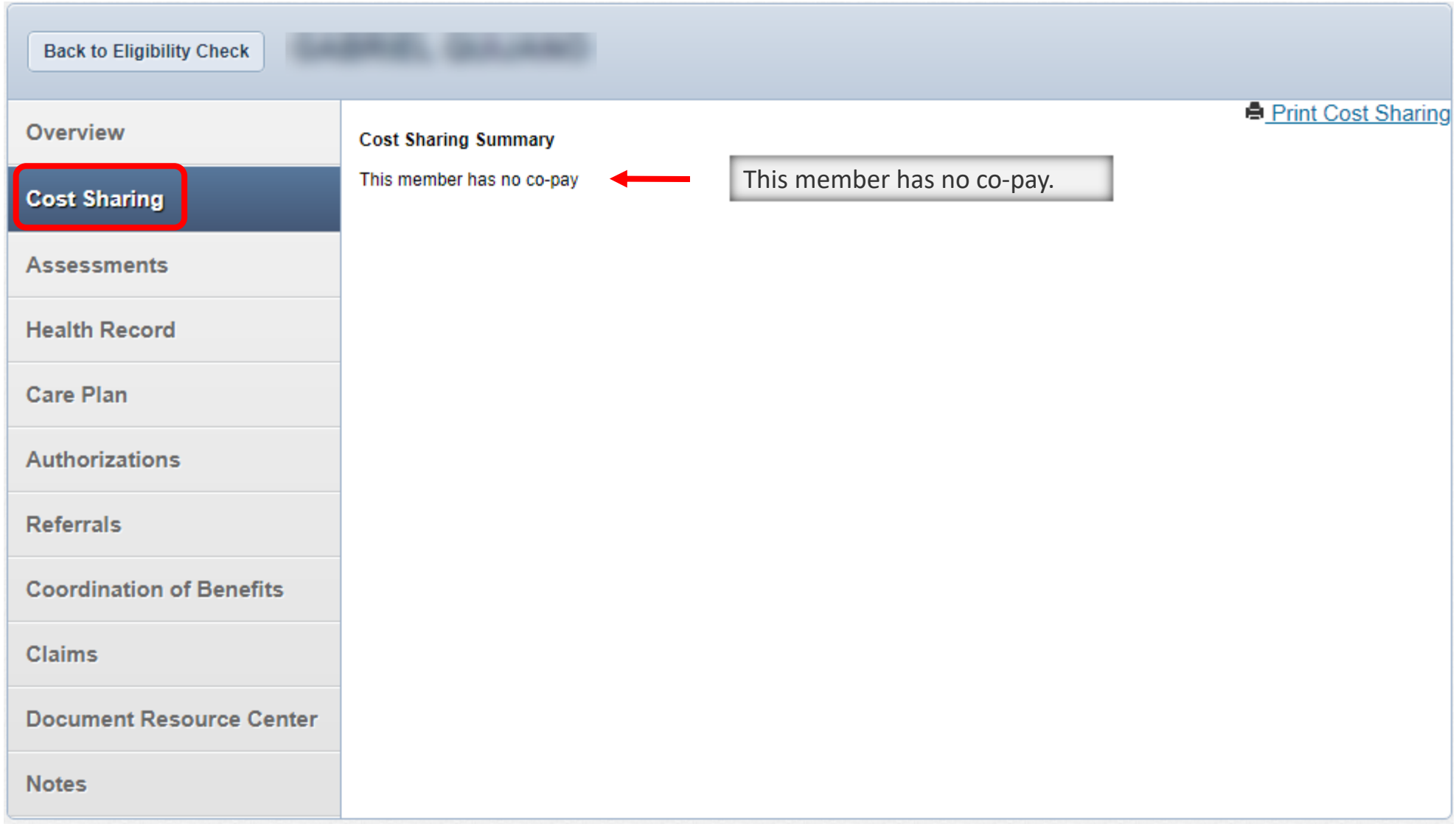
Patient Overview



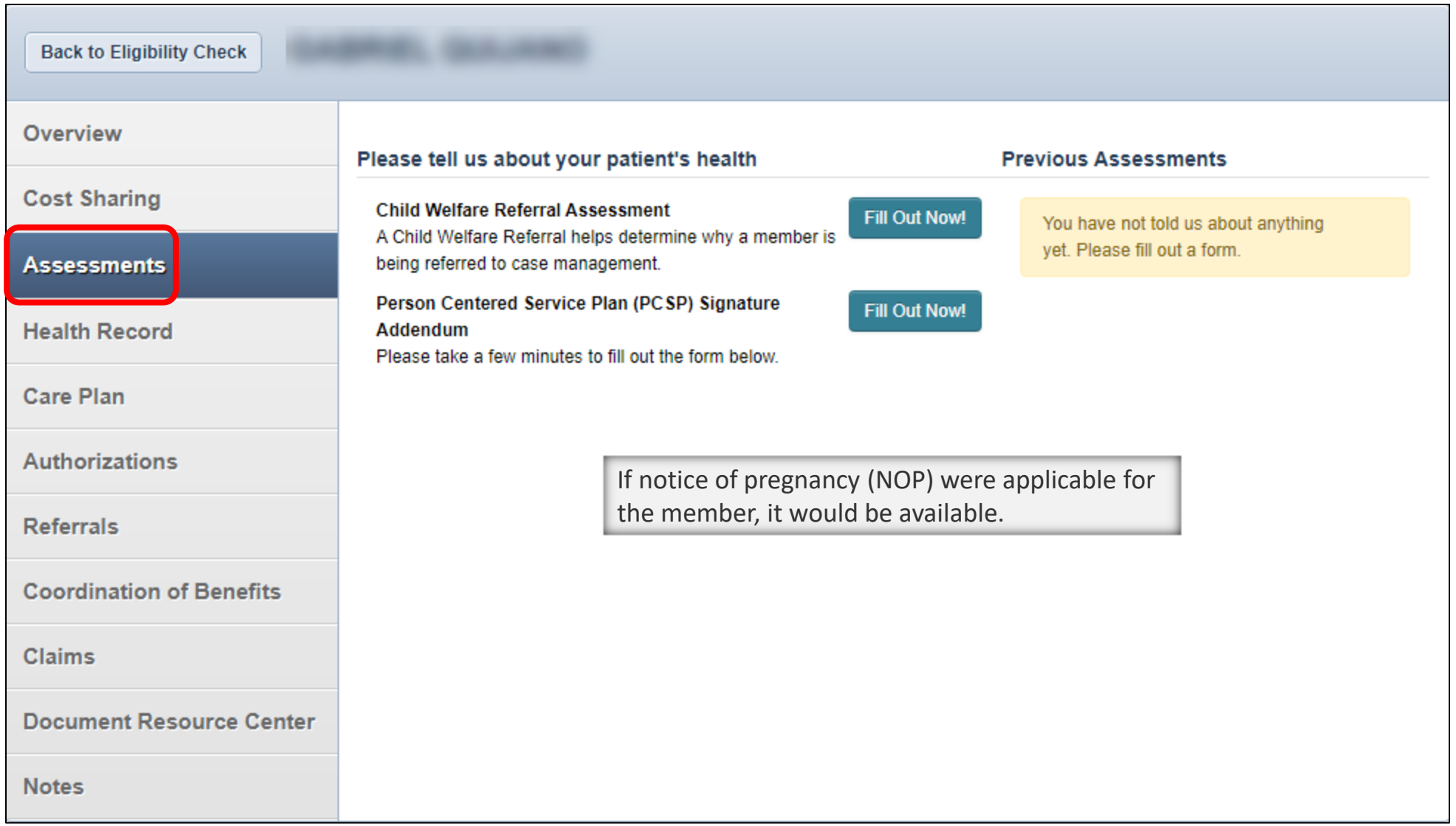
Patient Overview, cont.



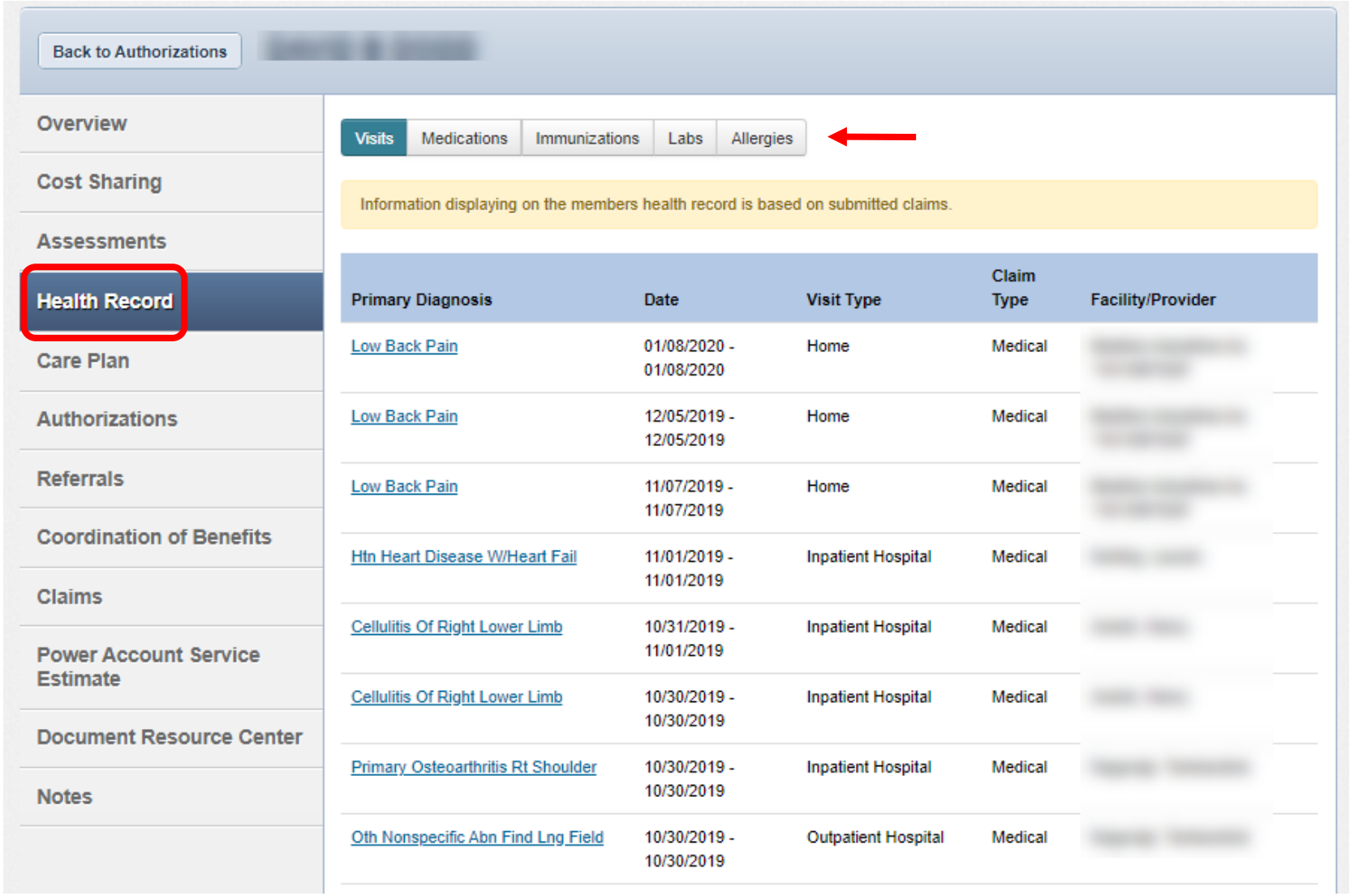
Patient Overview – Cost Sharing



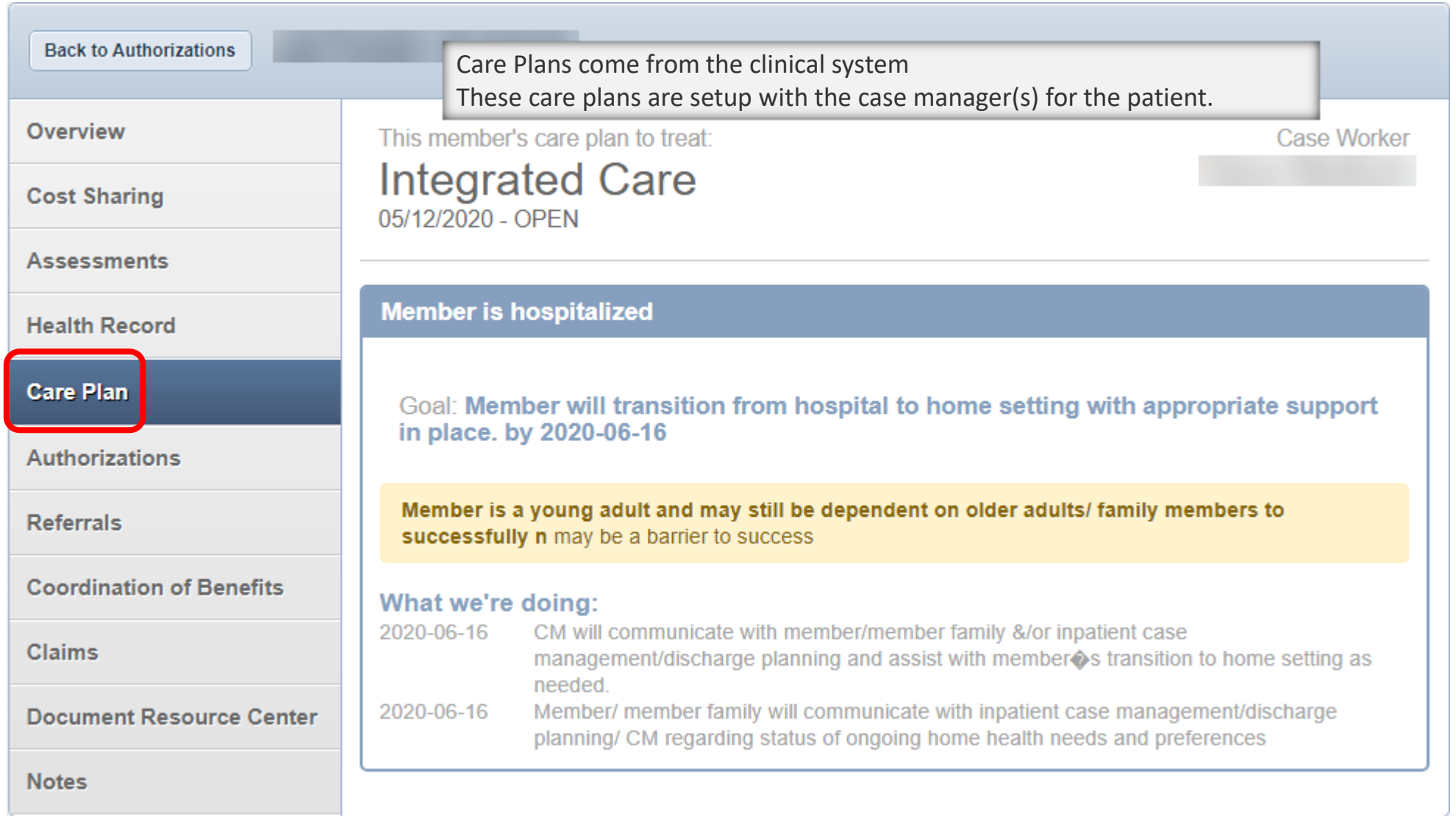
Patient Overview – Assessments



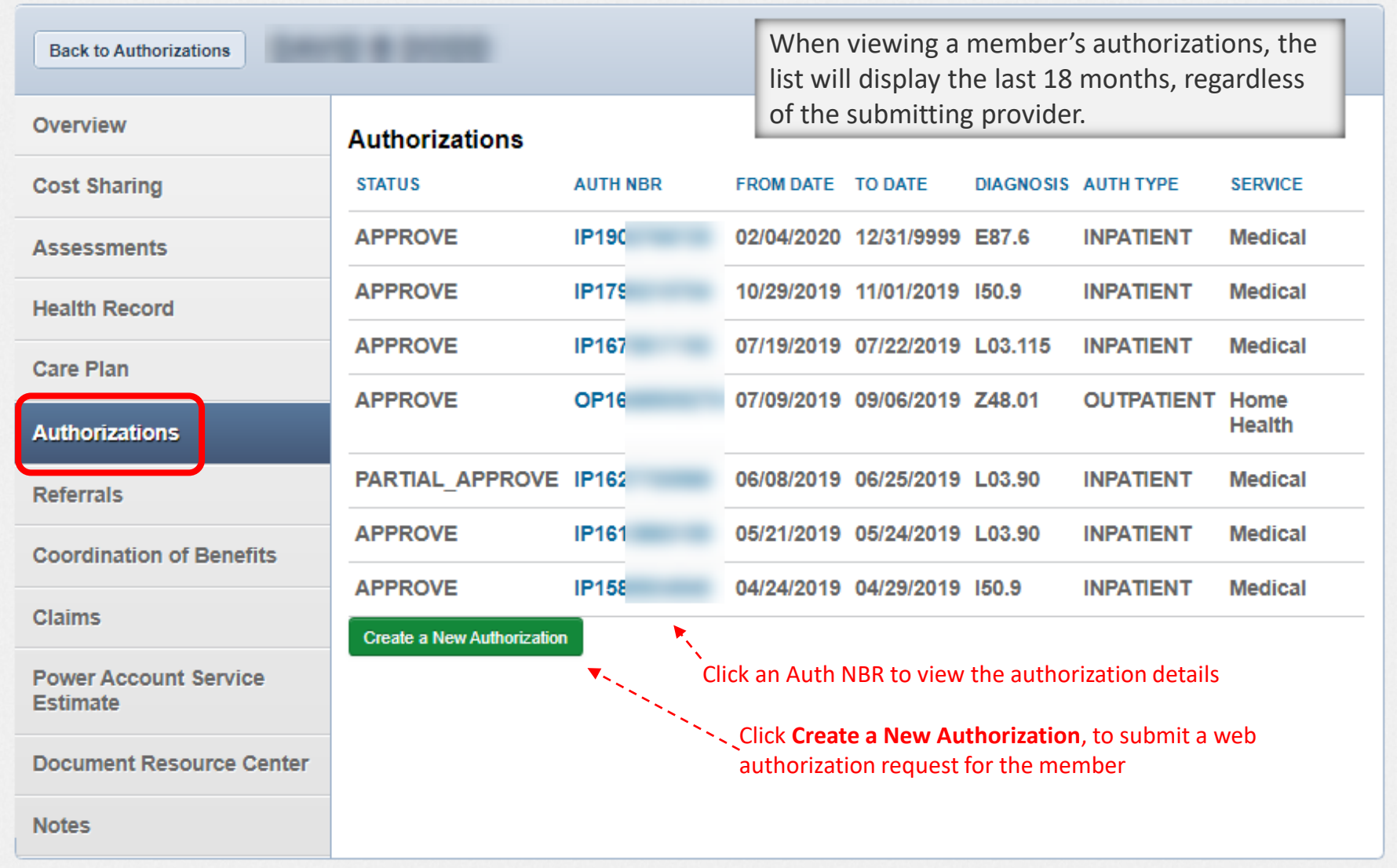
Patient Overview – Health Record



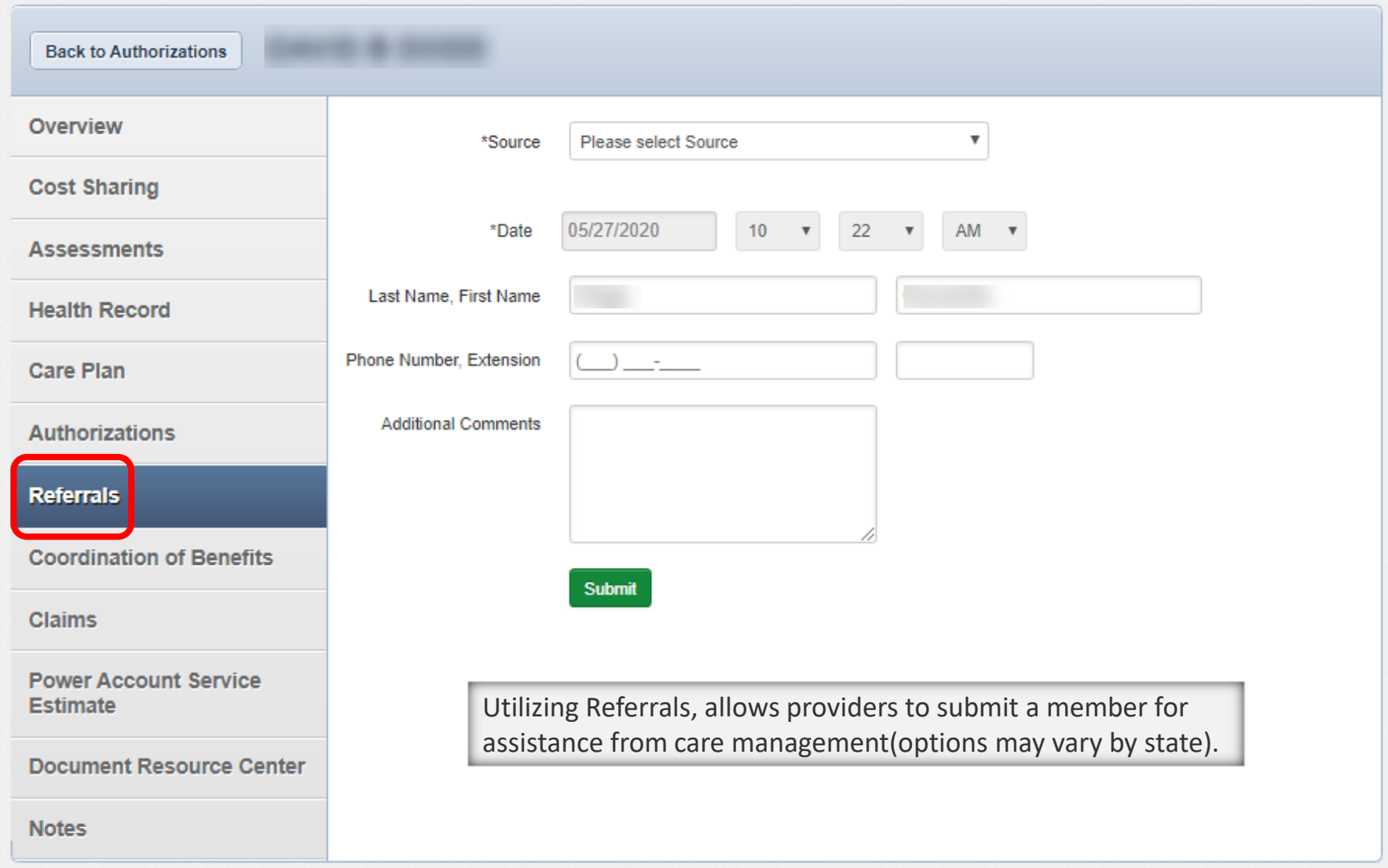
Patient Overview – Care Plan



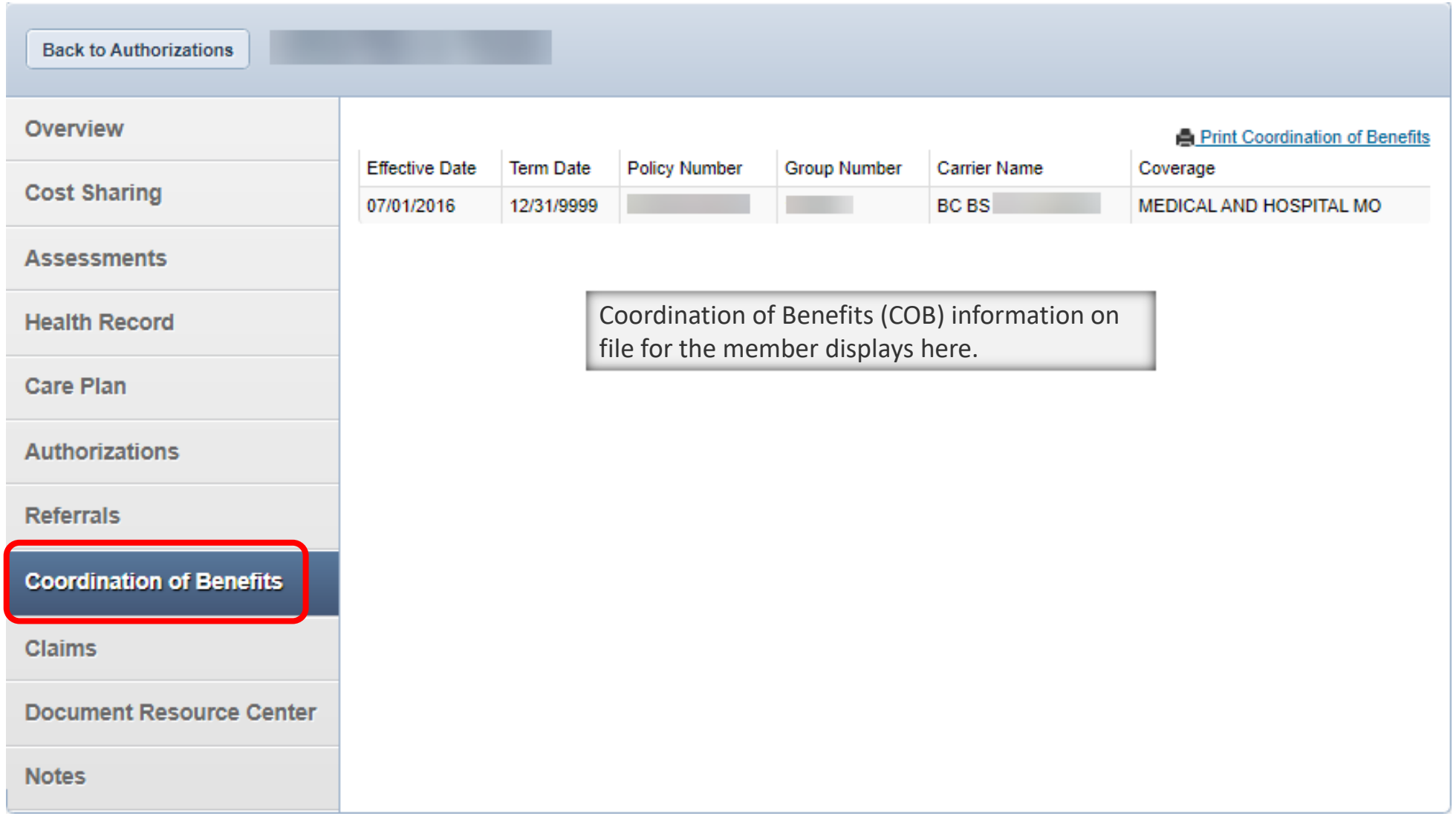
Patient Overview – Authorizations



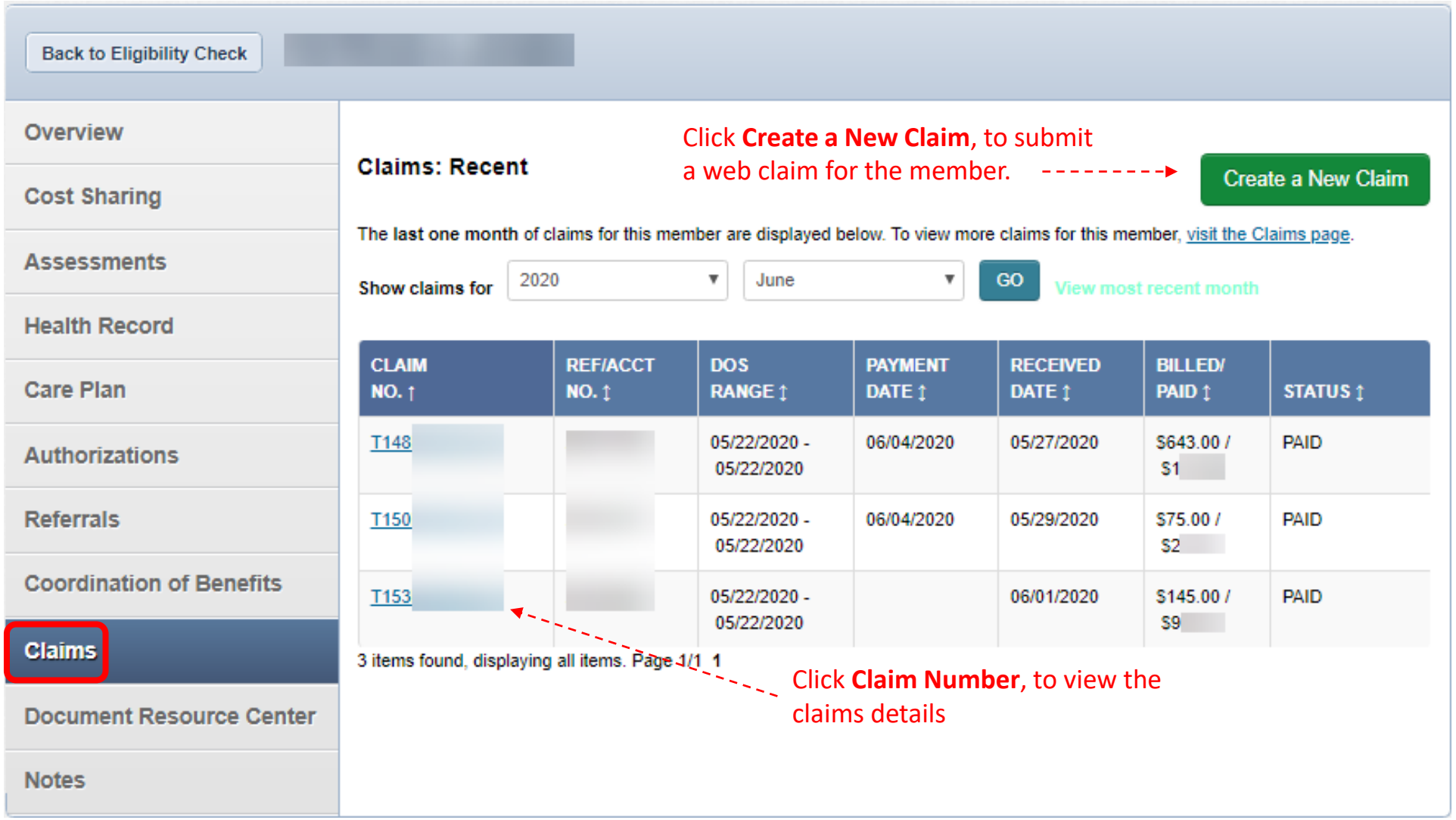
Patient Overview – Referrals



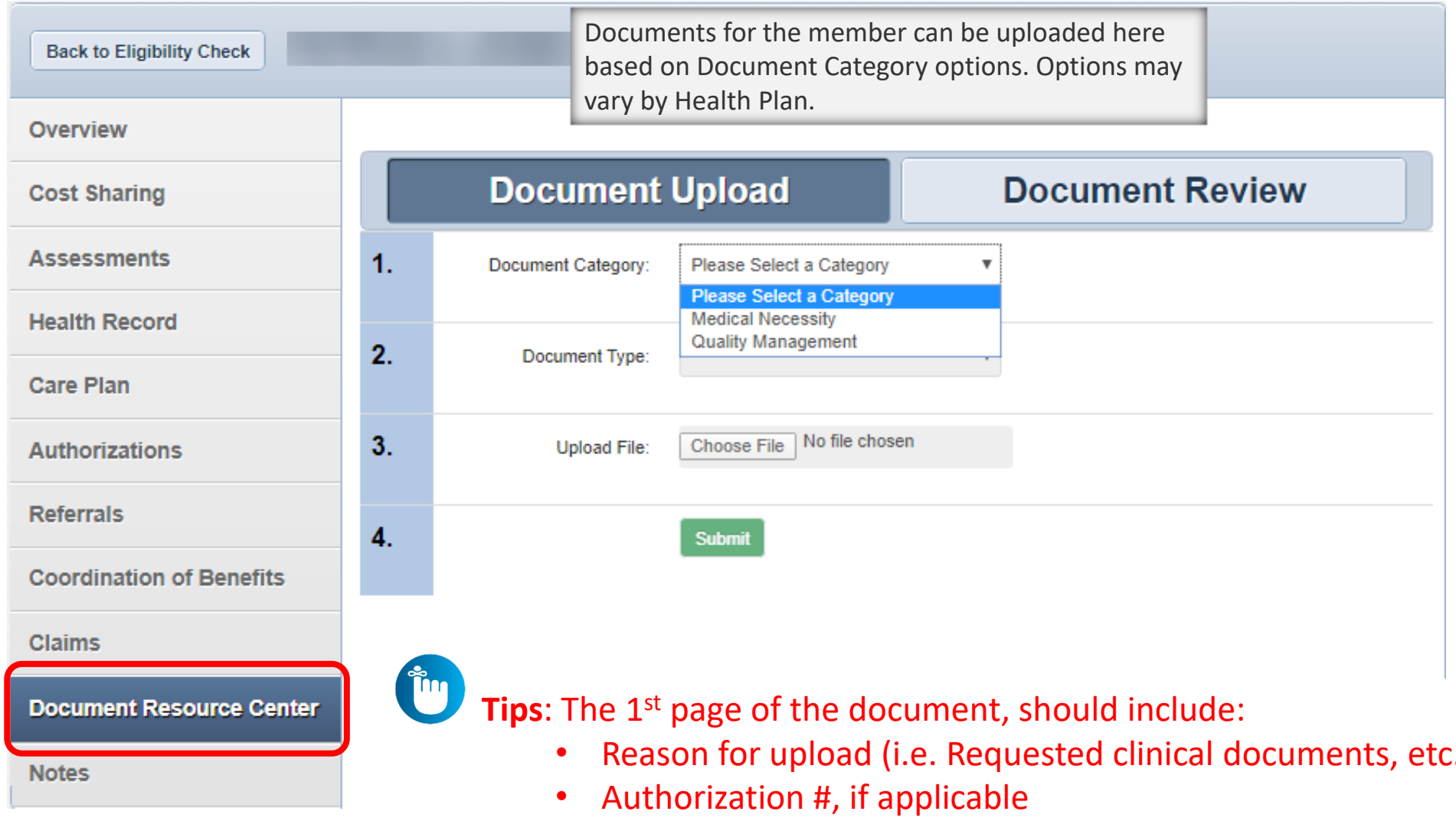
Patient Overview – Coordination of Benefits



Patient Overview – Claims



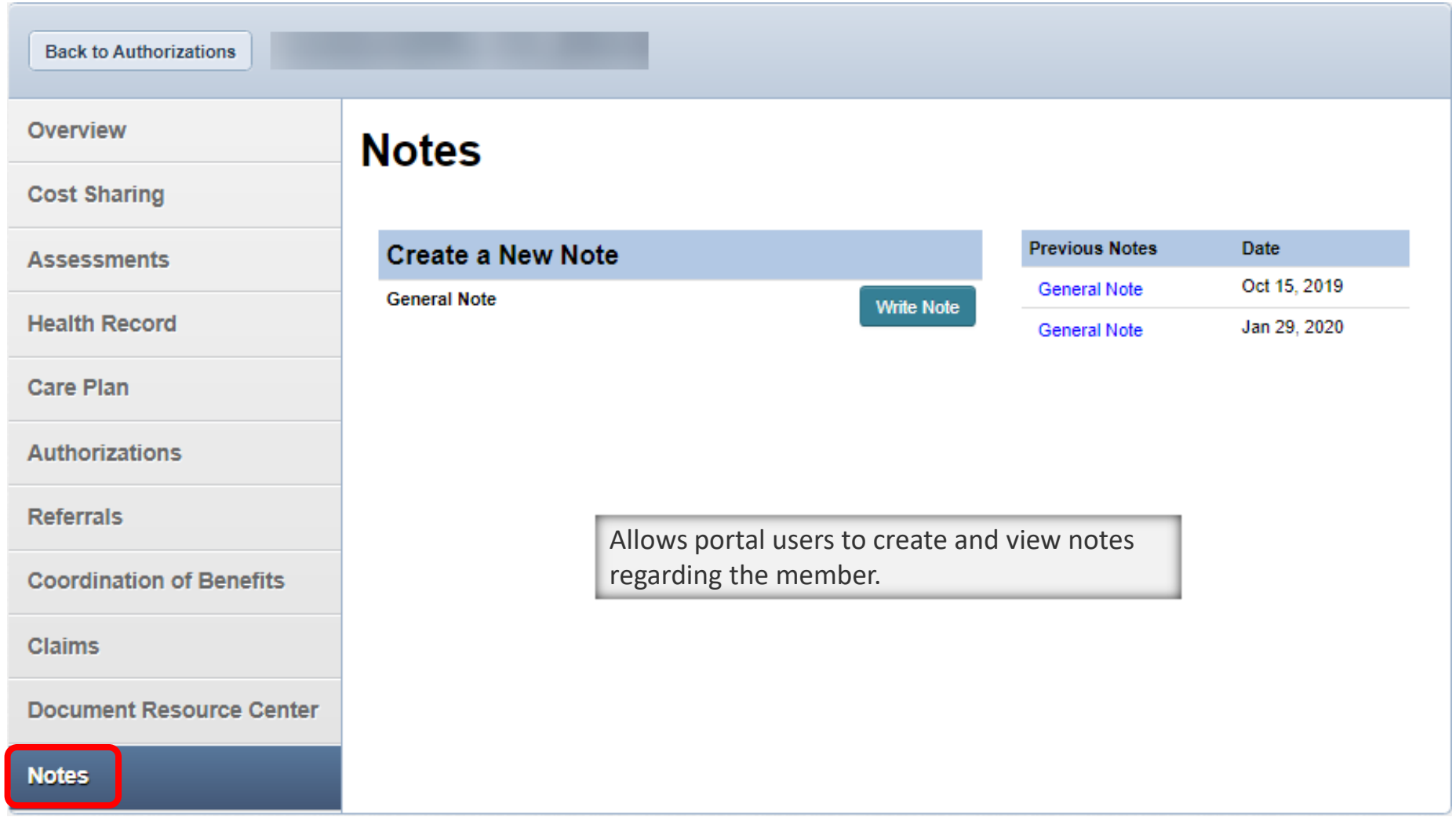
Patient Overview – Document Resource Center



Tips: The 1st page of the document, should include:

- Reason for upload (i.e. Requested clinical documents, etc.)
- Authorization #, if applicable
- The file size limit for the Document Resource Center is 10MB.

Patient Overview – Notes



Document Resource Center: Sterilization Consent Form Submission

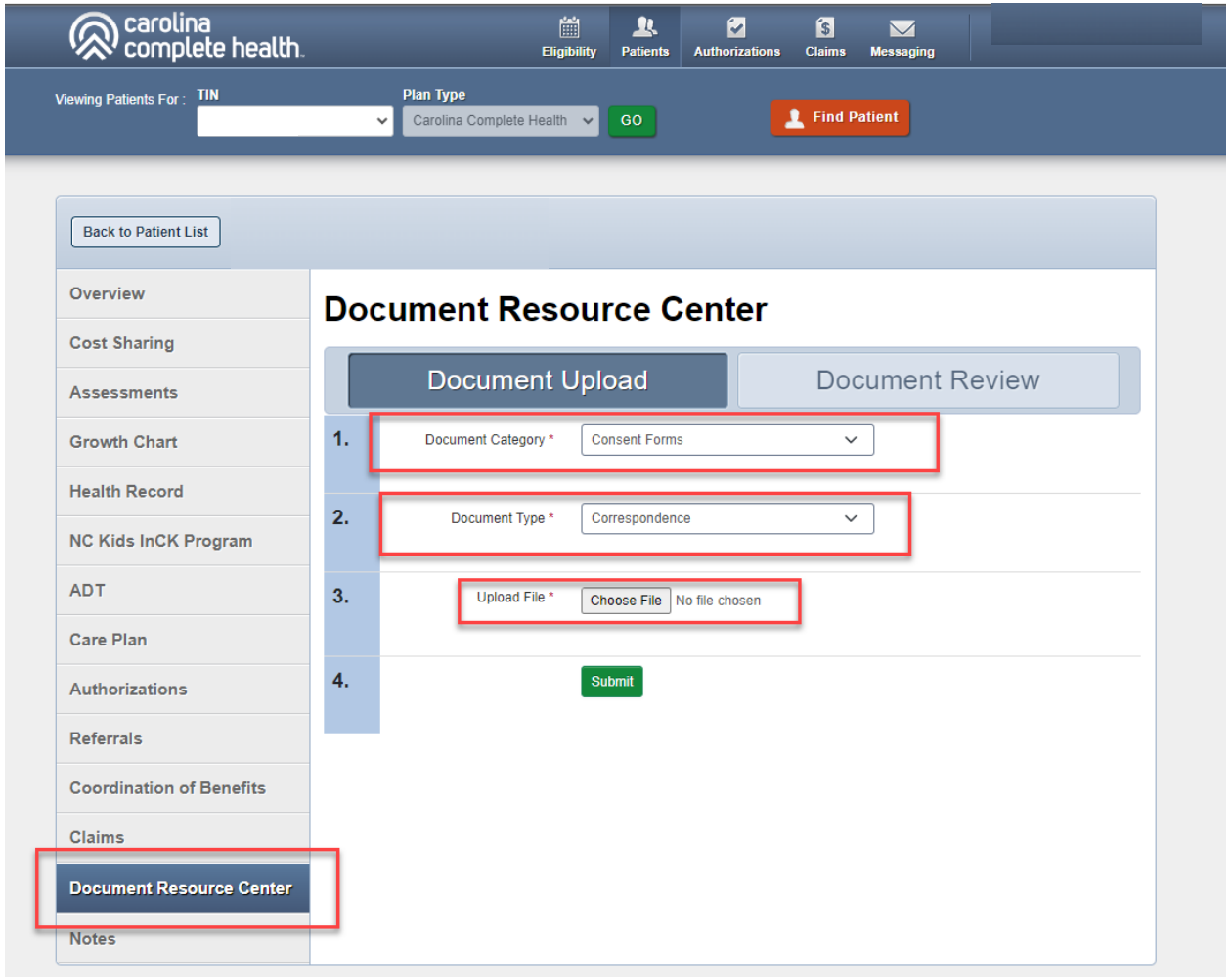
Secure Portal Submission Process for Sterilization Consent Forms

- Carolina Complete Health Providers can now submit Sterilization Consent Forms (SCFs) through the secure portal in advance of the claim submission.
- CCH providers can also view the status of SCF, both portal submitted and mail submitted, in the portal.
- Please refer to Medicaid Clinical Coverage Policy 1E-3 for additional details and guidance around Sterilization Procedures and Consent Forms.

Document Resource Center: Upload

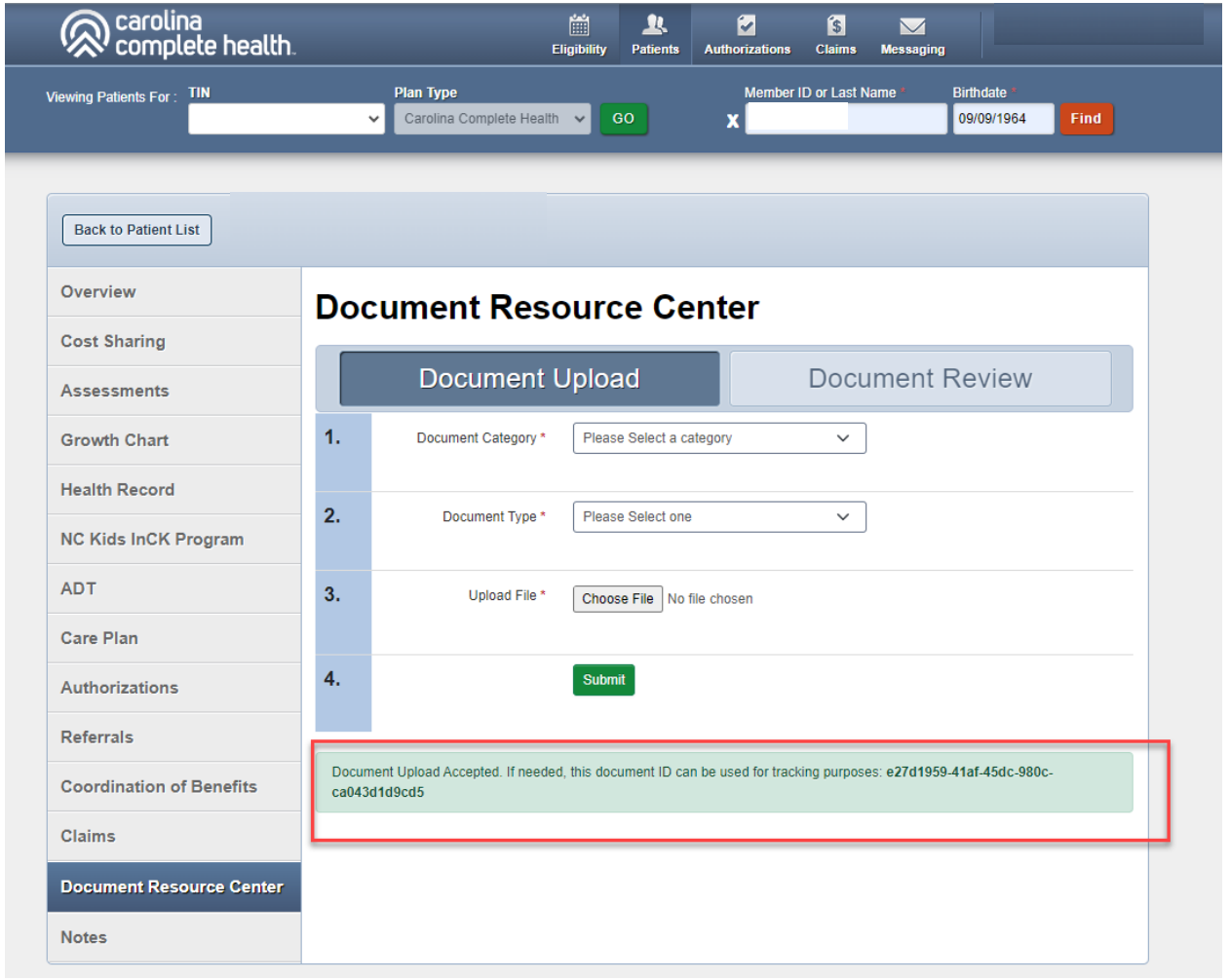
- Under Document Resource Center, under Document upload. Must have to choose Document Category as “Consent Forms” and Document Type as “Correspondence” and choose file within the size limit.

Tip: Prior to uploading, save the file to your computer with ‘Consent-Form’ in the naming convention.



Document Resource Center

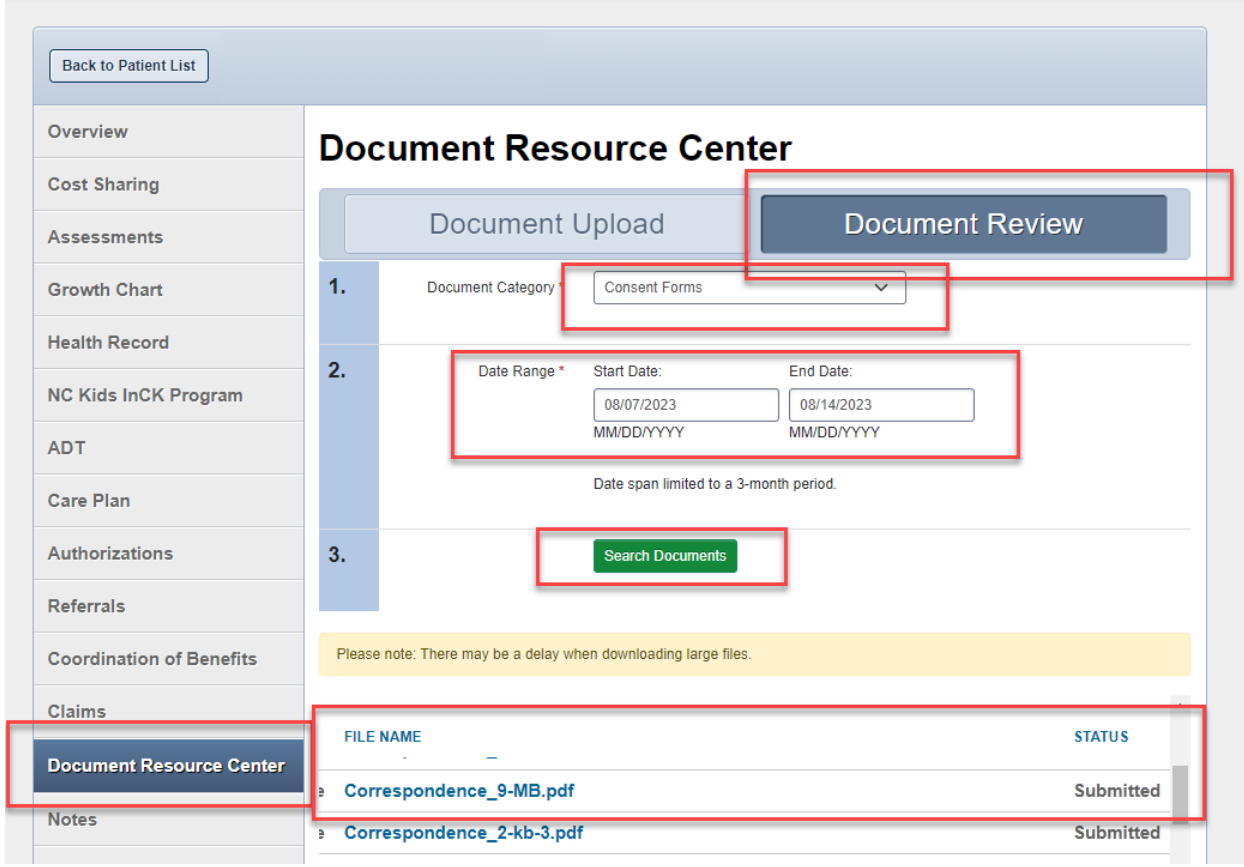
- After the file is successfully uploaded, you will see the message indicating ‘Document Upload Accepted.’



Document Review

- To view the uploaded documents, select Document Review
- Select Document Category “consent Forms” and Date Range “Start Date” & “End Date”
- This will display the files from the search criteria
- The File Name is listed as “Correspondence_{FileName}” with status indicated

Tip: The Document Review tab will also show the status of mailed Consent Forms



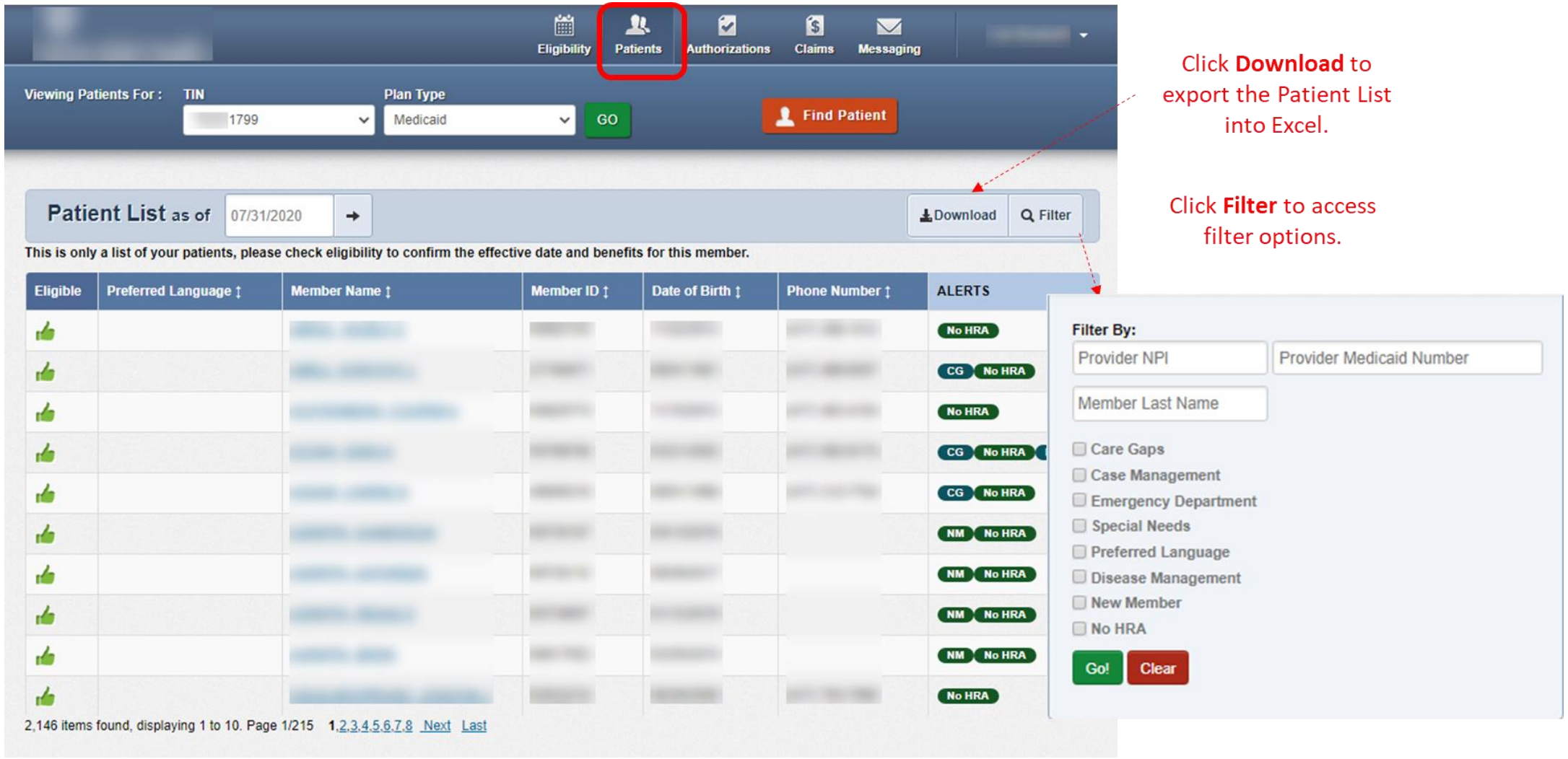
Portal Functionality: Patients

Patient List

Primary Care Providers are able to view and download a list of their assigned members. The Patient List displays:

- Member Name
- Member ID #
- DOB
- Preferred language
- Eligibility status
- Phone number
- Alerts

Patient List



Click **Download** to export the Patient List into Excel.

Click **Filter** to access filter options.

Patients Tips

- Patients tab is only applicable to AMHs / AMH organizations
- Click on a member’s name to access their eligibility, health record, etc. information
- Patients list can be exported to excel for more filtering options

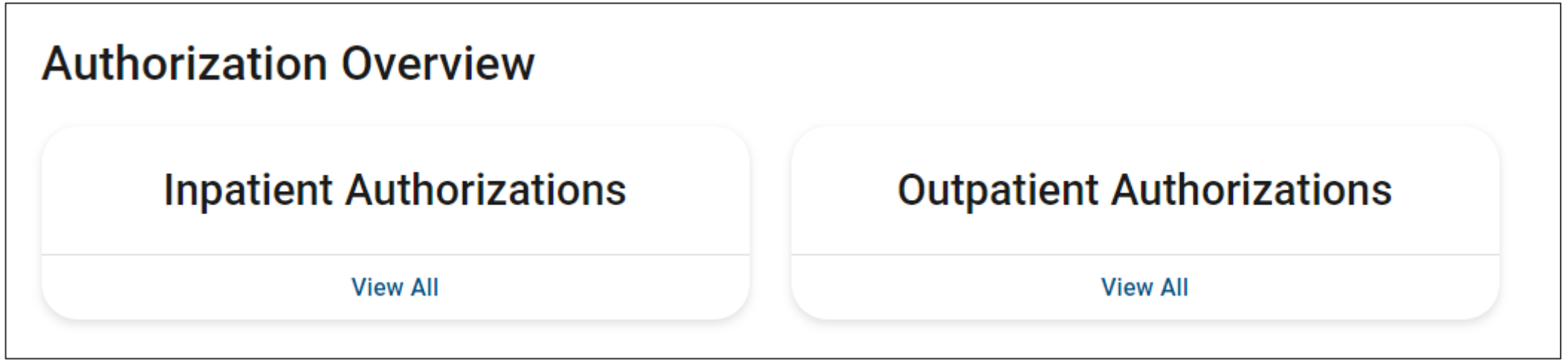
Portal Functionality: Authorizations

Authorizations

Providers are able to use the portal to submit web authorization requests and view 18 months of authorization history.

View Authorizations (Quick Actions)

On Landing Page, scroll down to Authorization Overview, and view Inpatient or Outpatient Authorizations

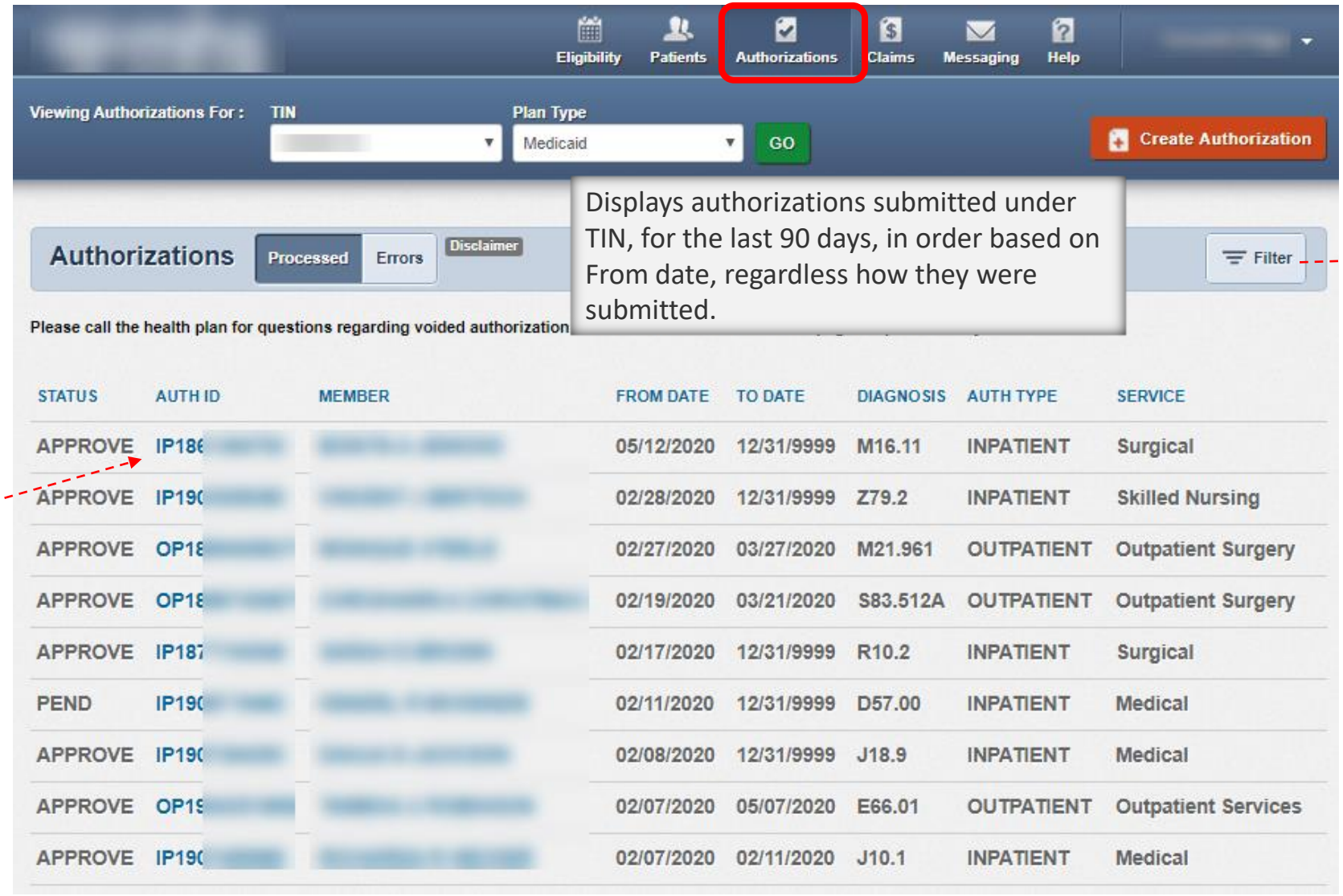


View Authorizations

To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.

Tip: The member drives Plan Type selection. For example, an Ambetter member will not pull up under Medicaid. To find an Ambetter member, the Plan Type must be 'Ambetter'.

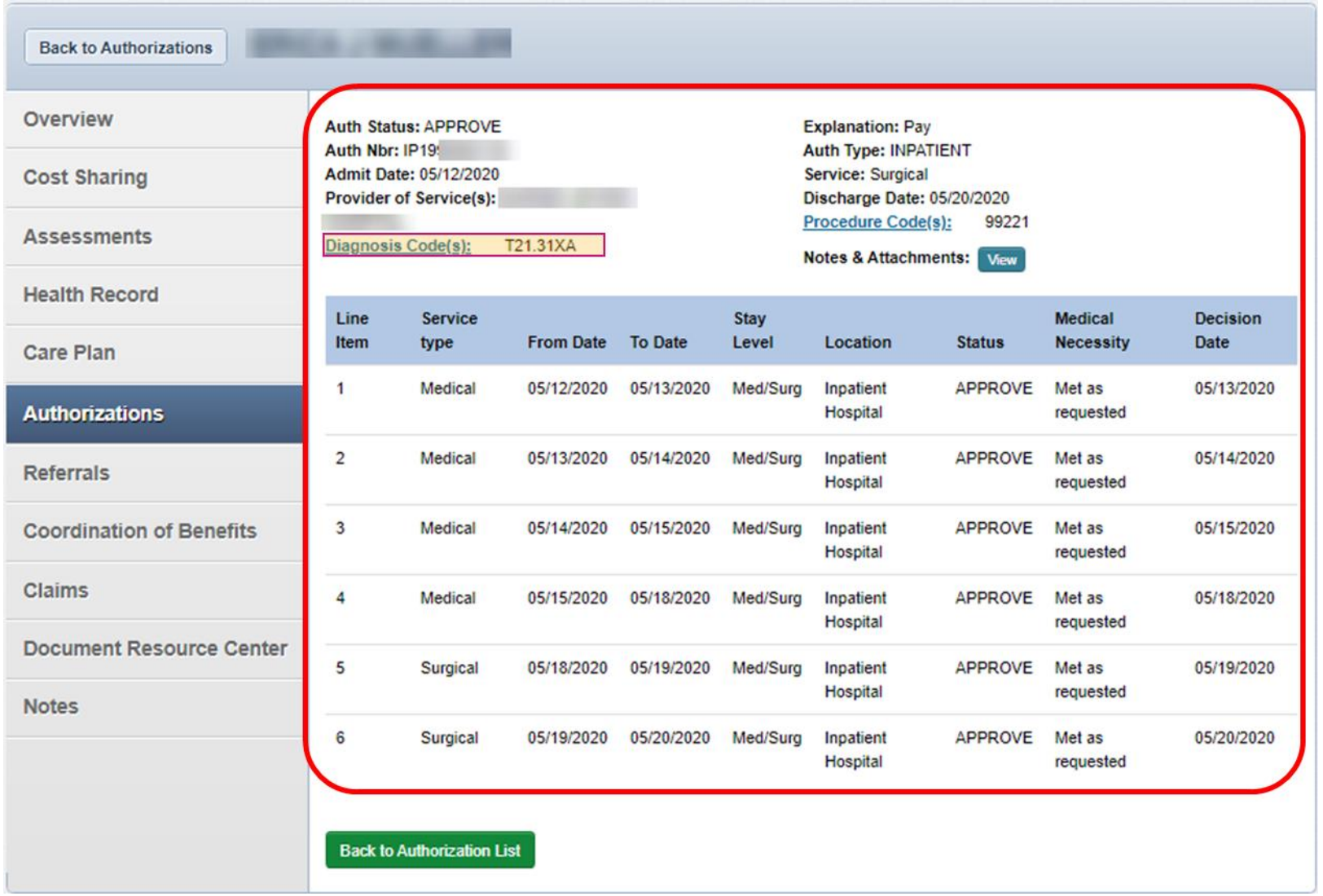
Authorizations Summary



Click **Filter** to access filter options

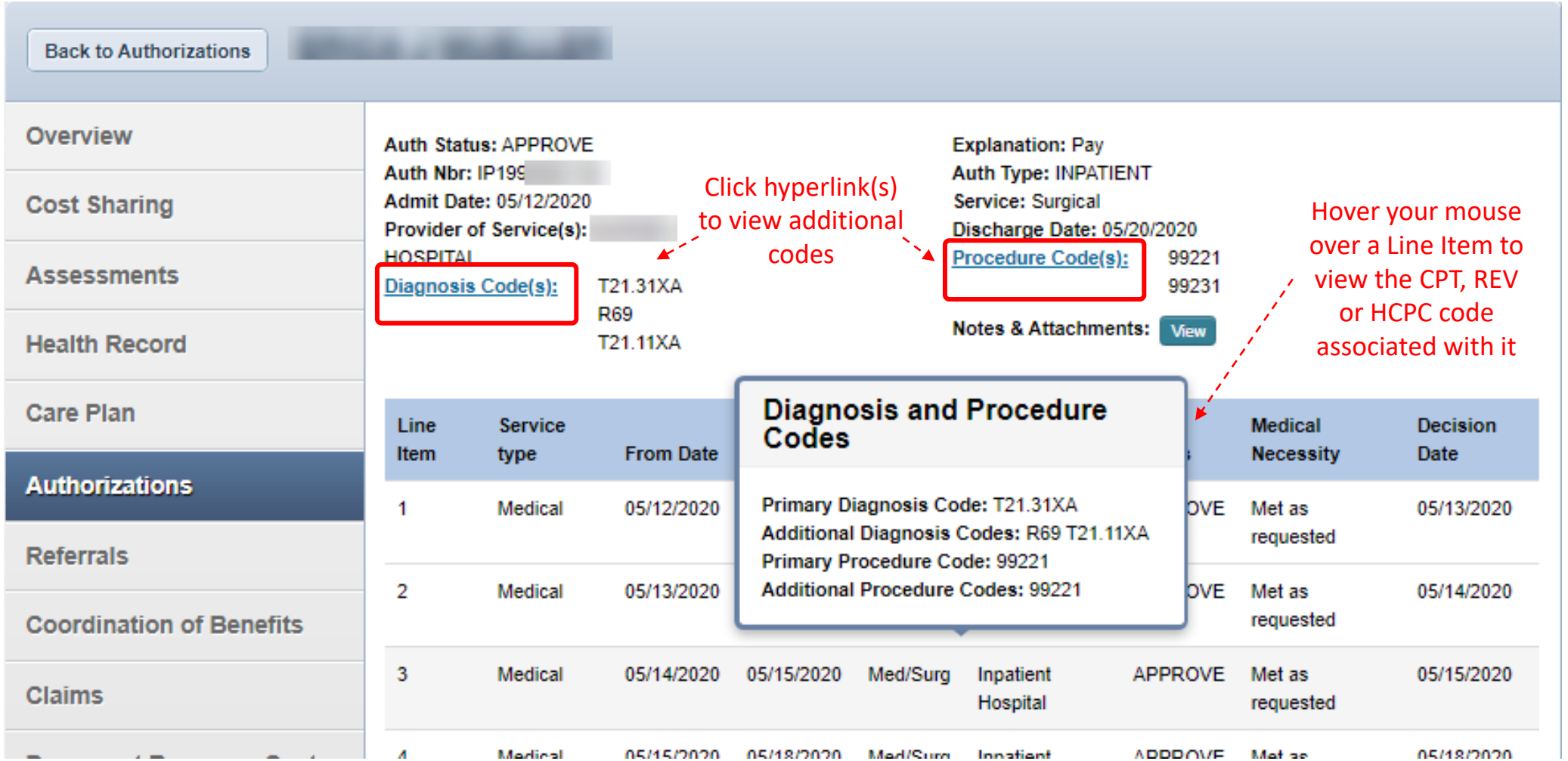
Click an **Auth ID** to view authorization details

Authorization Details



Line Item	Service type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	05/12/2020	05/13/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/13/2020
2	Medical	05/13/2020	05/14/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/18/2020
5	Surgical	05/18/2020	05/19/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/19/2020
6	Surgical	05/19/2020	05/20/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/20/2020

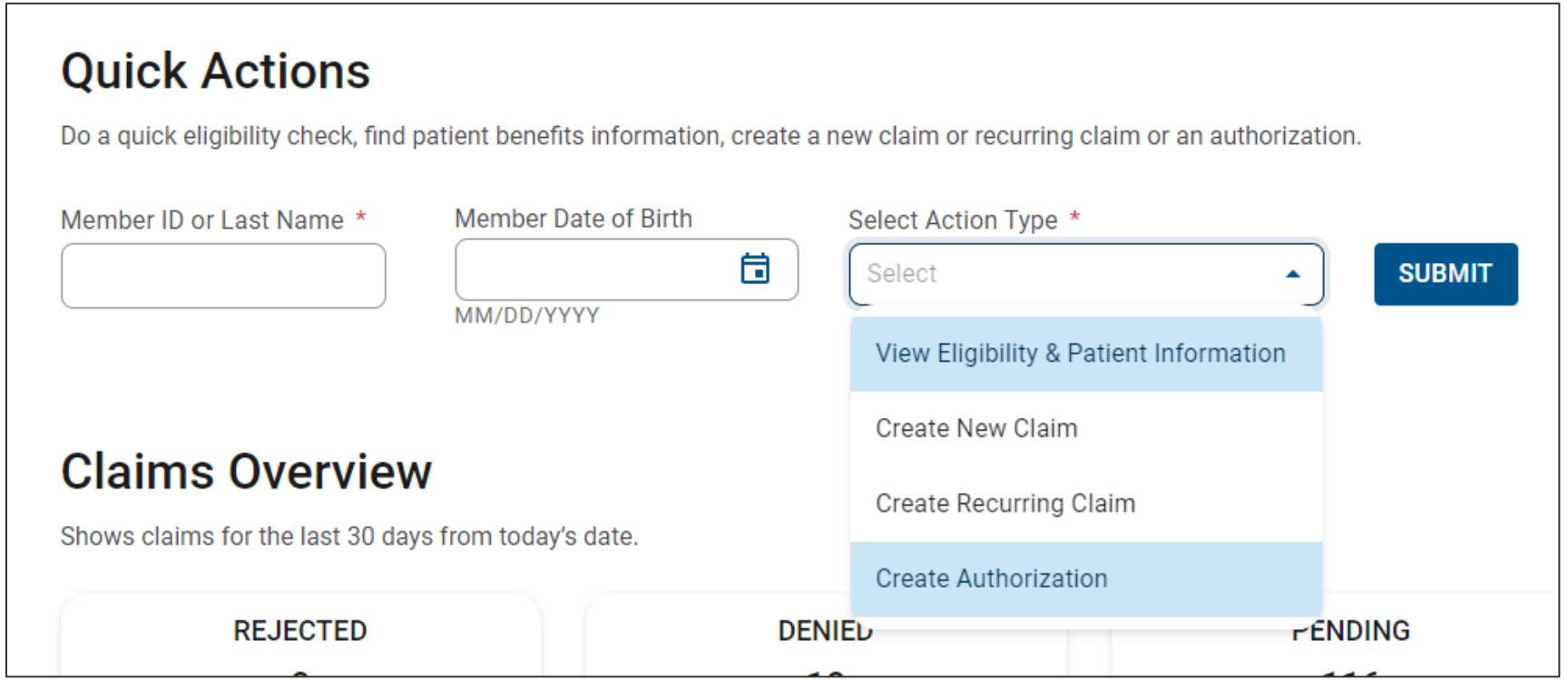
Authorization Details Links and Pop-Up



Create Authorization (Quick Actions)

From the portal landing page, under Quick Actions

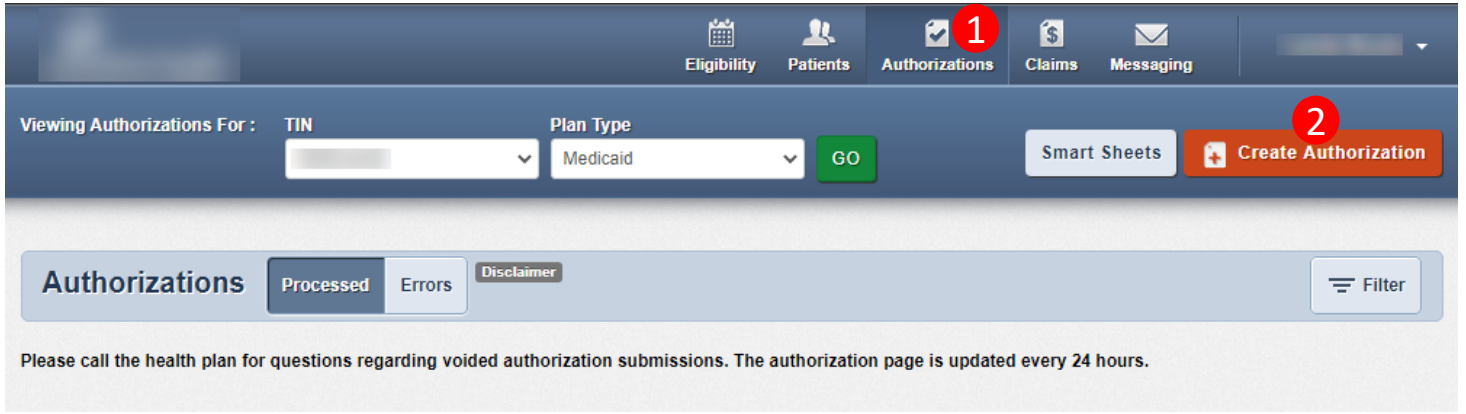
1. Enter Member ID or Last Name
2. Enter Member DOB
3. Select Create Authorization from the ‘Select Action Type’ menu and hit submit

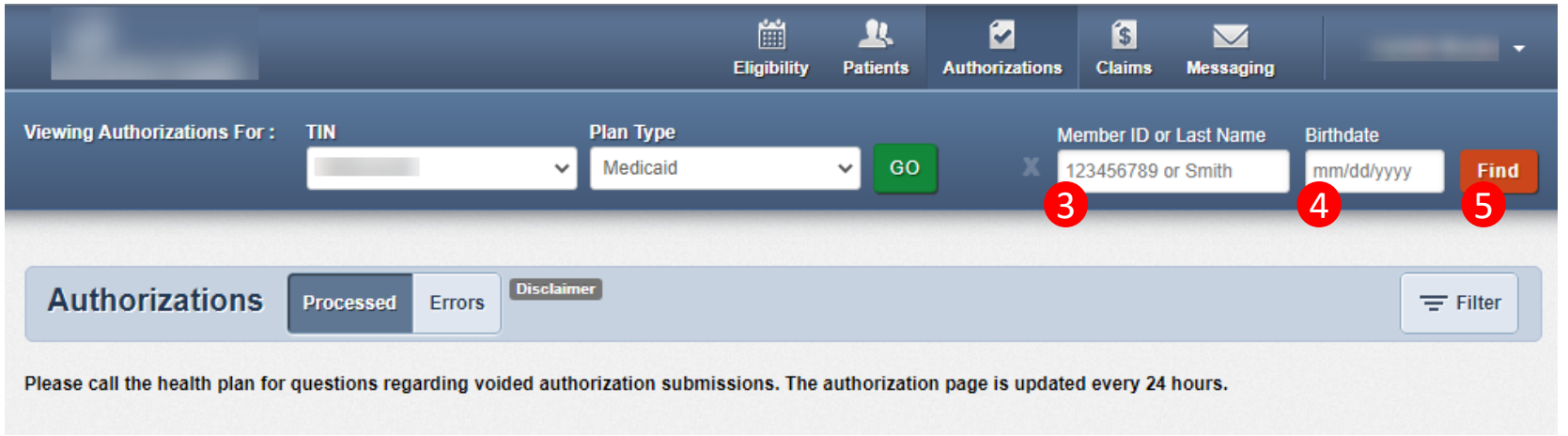


Create Authorization (Web Authorization Request)

To begin a web authorization request:

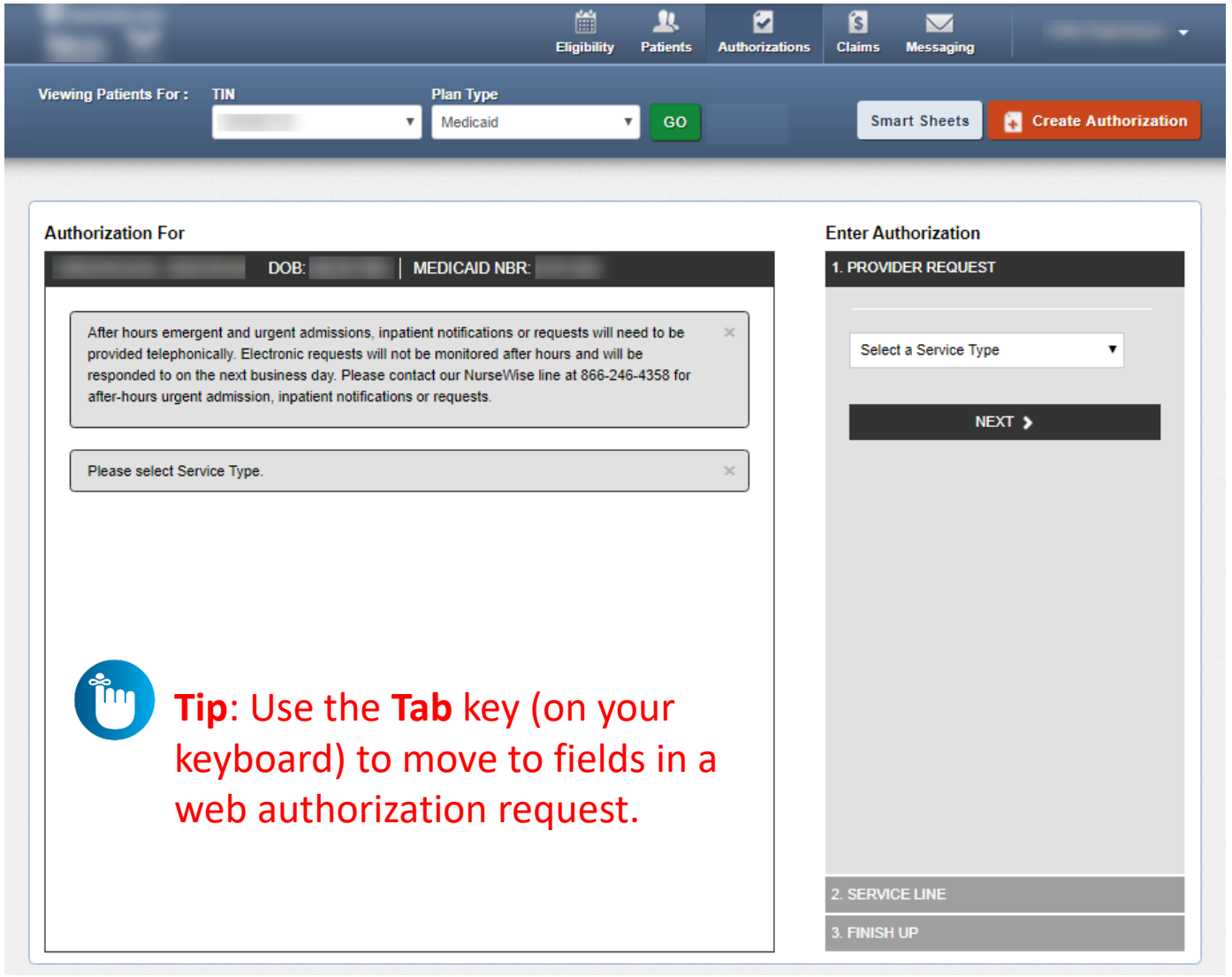
1. Click **Authorizations**.
2. **Create Authorization**.
3. Enter **Member ID or Last Name**.
4. Enter Member's **Birthdate**.
5. Click **Find**. The web authorization request displays.





Tip: You cannot create a web authorization on an ineligible member.

Create Authorization (Web Authorization Request)

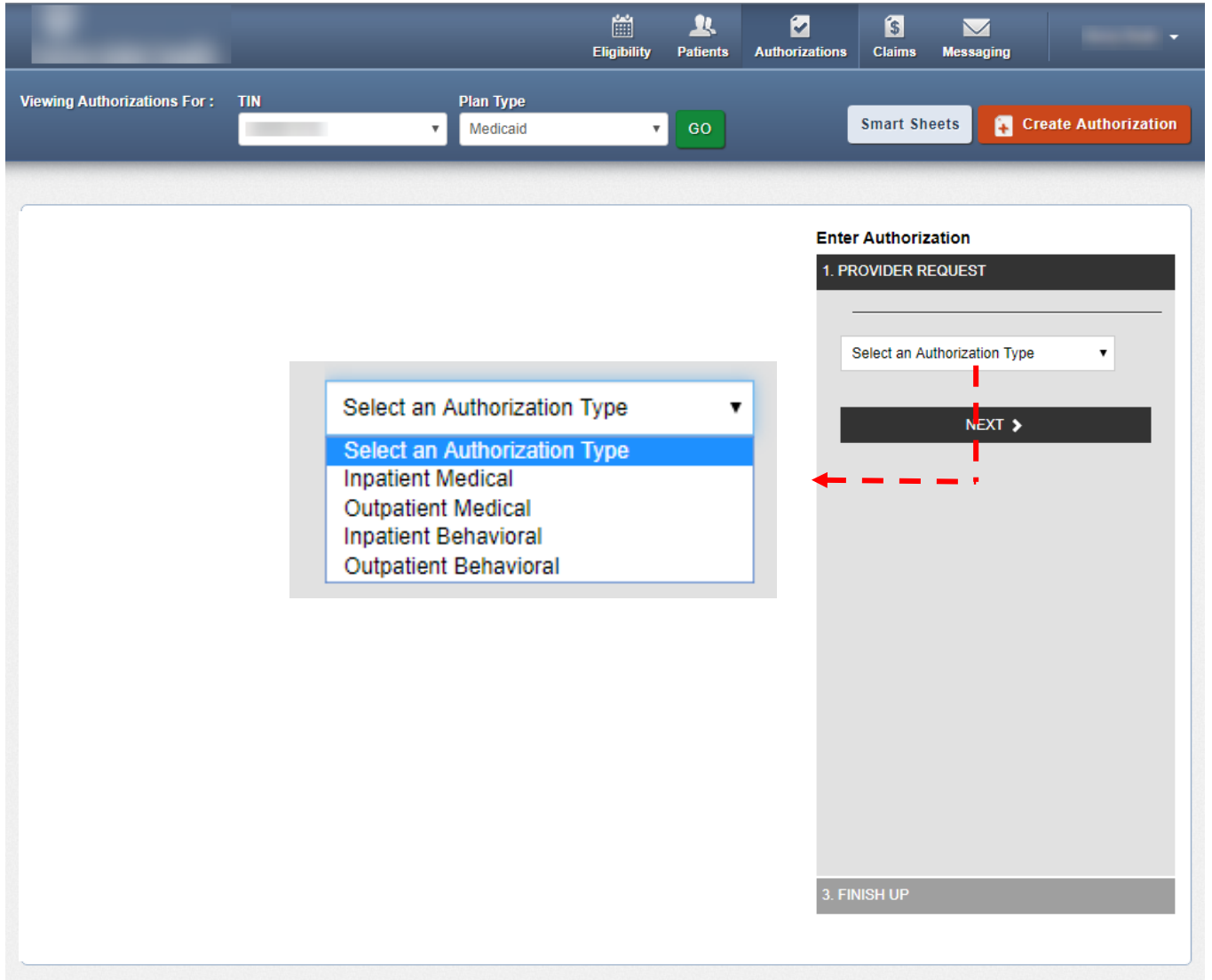


Tip: Use the **Tab** key (on your keyboard) to move to fields in a web authorization request.

Web Authorization

Web Authorization

- Authorization Type-driven
- Streamlined



Authorization Tips

- Always check the member's eligibility before submitting an authorization request
  - A web authorization **cannot** be submitted on an ineligible member
- **Web authorizations generally load in processing queue within seconds of submission**
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
  - This is the only way a portal user will see a web authorization error
  - Web authorization errors are uncommon, but when an error is encountered the web authorization request will not load, and thereby will not be processed
    - Please submit the authorization request by phone or fax
    - Notify the Health Plan and provide the web authorization confirmation number for research

Portal Functionality: Claims

Claims

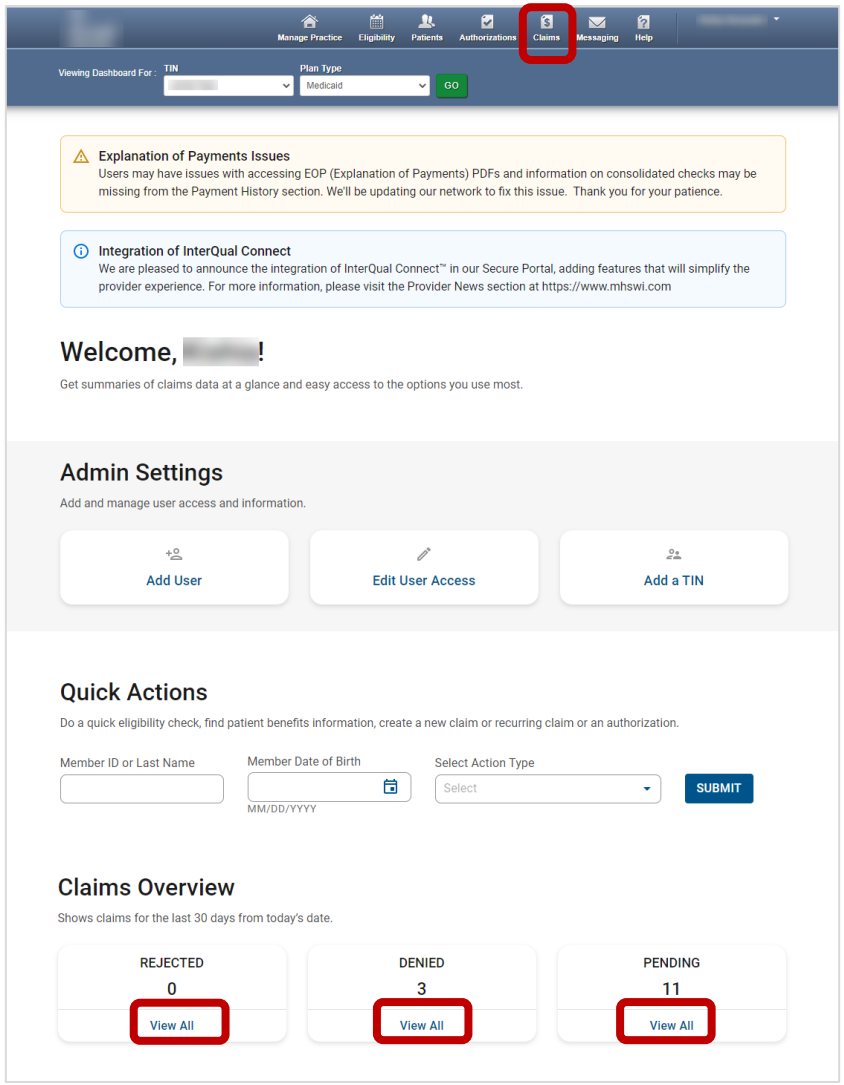
Providers are able to use the portal to:

- Access up to 24 months of claims-related history
- Submit new claim
- Correct claims
- Batch claims

Accessing Claims

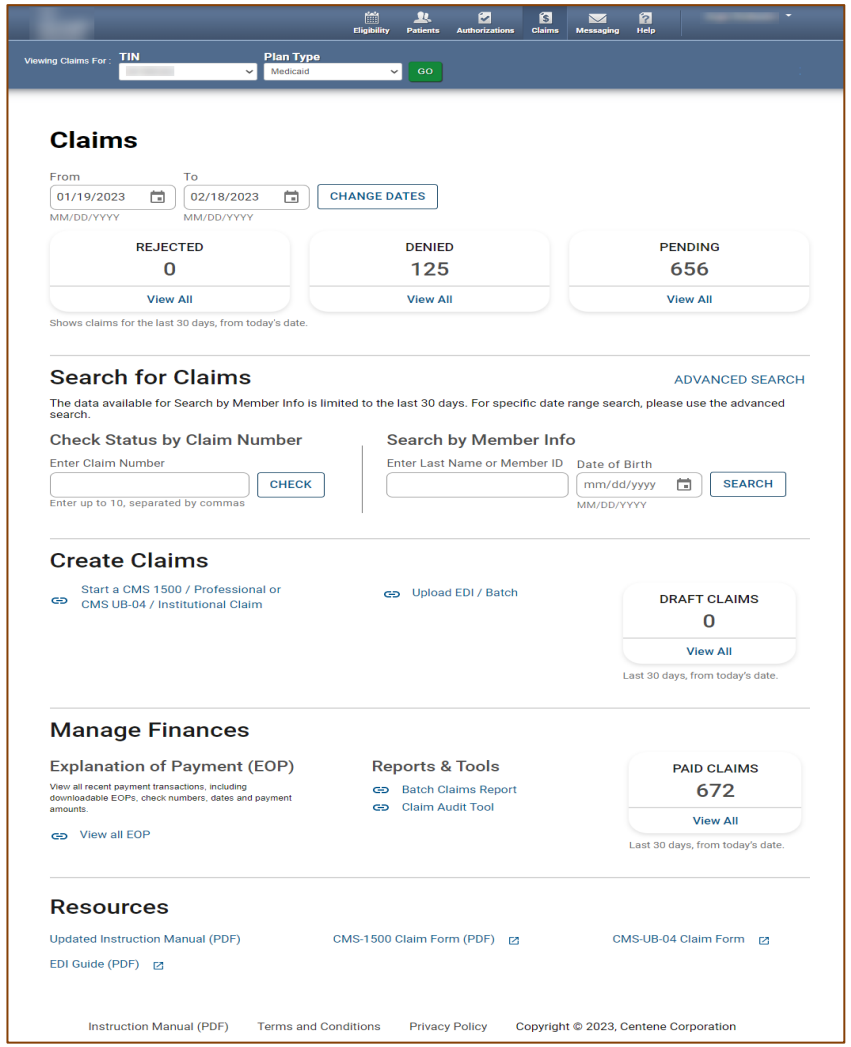
To access all claim-related information, click **Claims** in the portal toolbar.

Under Claims Overview, to access claims in the associated status count, click **View All**.



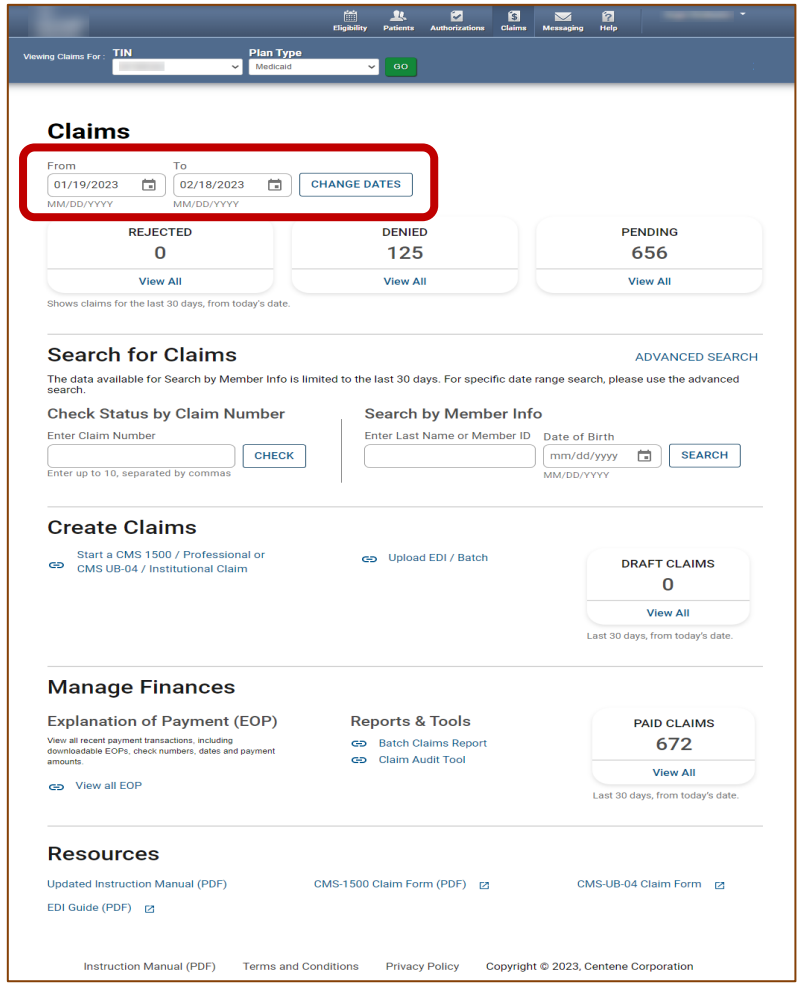
Tip: Navigating to Rejected, Denied, and/or Pending claims, [each] will open in a new tab or window. Once you are finished reviewing the selected information, close the tab or window to prevent system performance issues.

Claims Dashboard



- The new Claims Dashboard provides an easy view and access to claims / claims-related information:
  - Claims Tiles by status
  - Claim Search options
  - Claim Submission Methods
  - Managing Finances (i.e., EOPs, Paid Claims, etc.)
  - Claim Audit Tool, *where available*
  - Resources

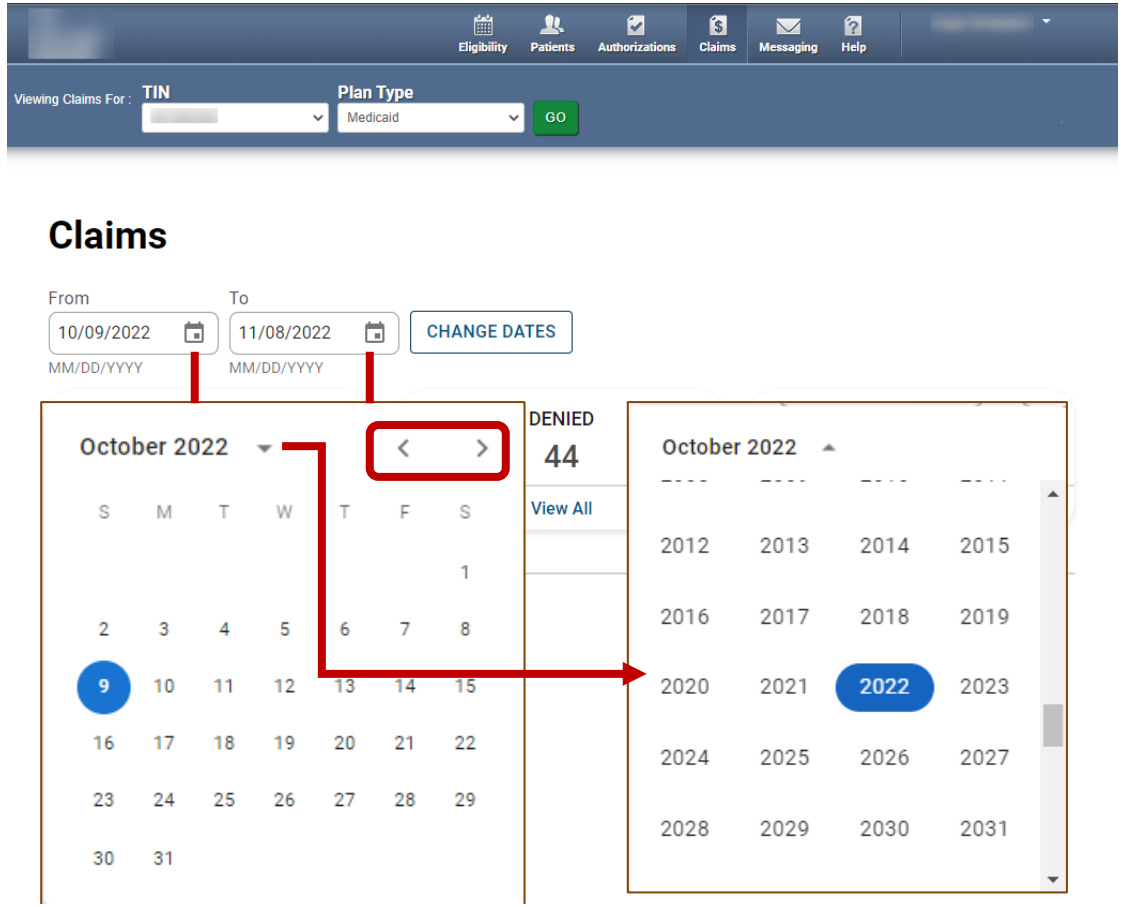
Claims Dashboard – Change Dates



- Informational text displays immediately under the date fields providing required date format.
- Dates can be manually entered or pasted in the From / To boxes.
- Calendar pop-up makes it easier to change dates.
- Once a date is selected, informational text displays in red to provide guidance.

Claims Dashboard – Change Dates Calendar Options

There are two ways to change the date range.



Manually

1. Type desired date range in **From** and **To** fields.
2. Click **CHANGE DATES**. The page will refresh to display Rejected, Denied, and Pending counts for the new date range.

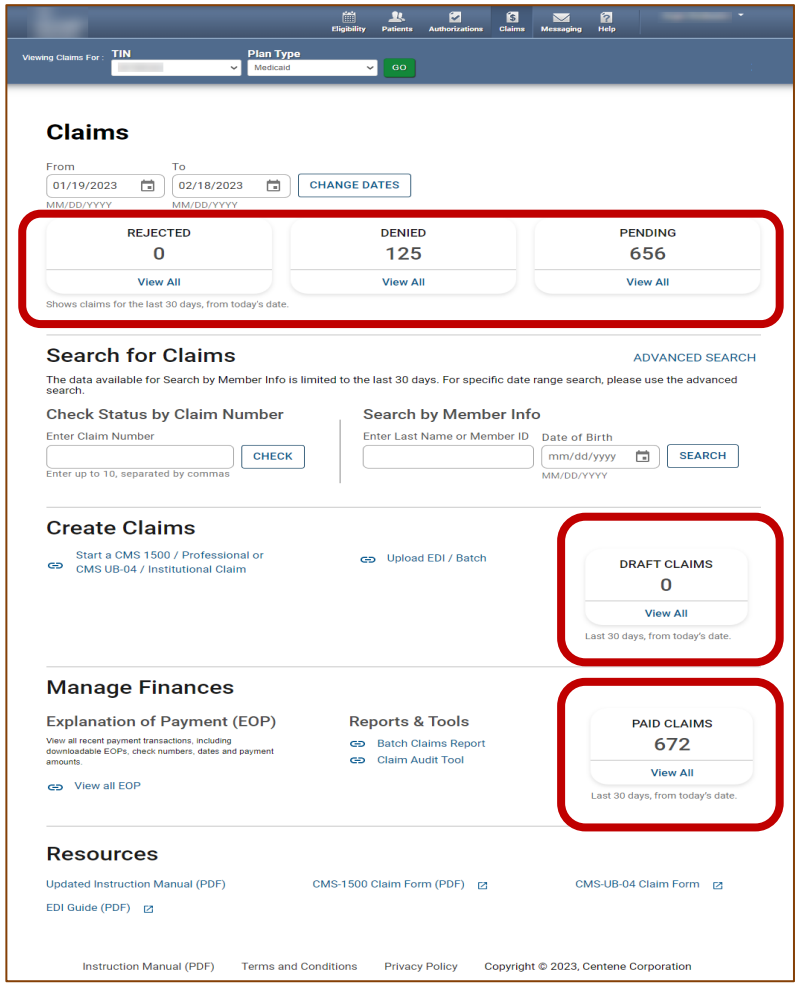
Calendar Pop-Up

1. Click Calendar icon. The calendar pop-up displays.
2. Use the arrows to view and select desired date in **From** and **To** fields.
3. Click **CHANGE DATES**. The page will refresh to display Rejected, Denied, and Pending counts for the new date range.

Tips:

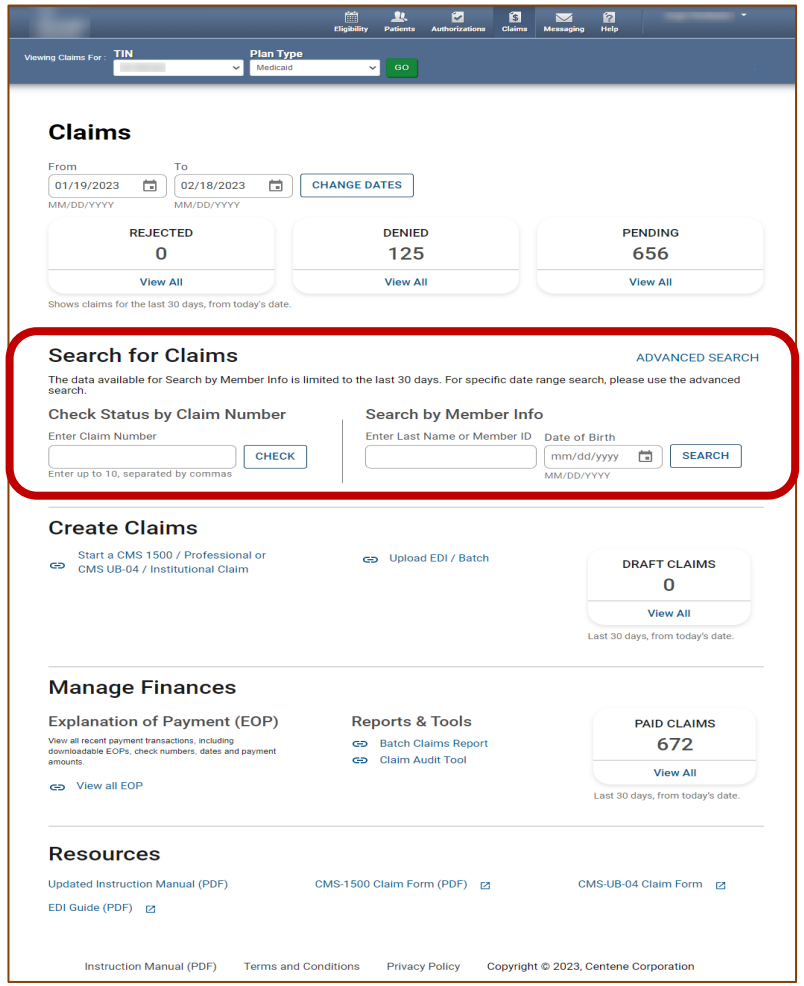
- Portal users can access up to 24 months of claim history. The key is the first DOS in the claim must be within the last 24 months from the current date.
- Date Range is limited to a 30-day span at a time.

Claims Dashboard – Claim Status Tiles



- The Claims Status Tiles displays the count for the respective status.
- Informational note displays advising 30-day default display.
- Portal users click **View All** to access claims based on status.

Claims Dashboard – Search for Claims

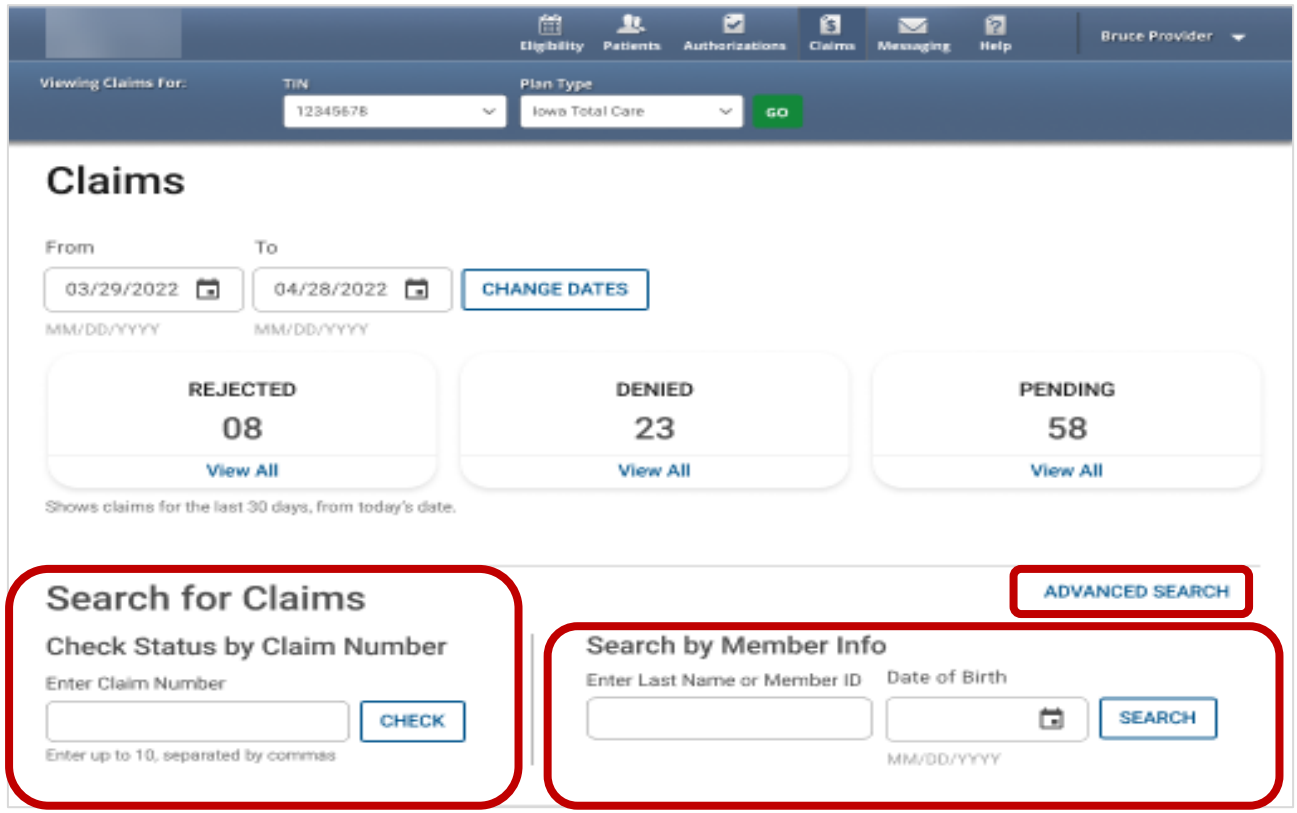


- Claims search options from the claims dashboard.
- Portal users can search up to 10 claims at once, by adding a comma, after each Claim Number, but no space following the comma(s).
- Search button, replaced with a hyperlink, and renamed Advanced Search.

Claims Dashboard – Claims Search Options

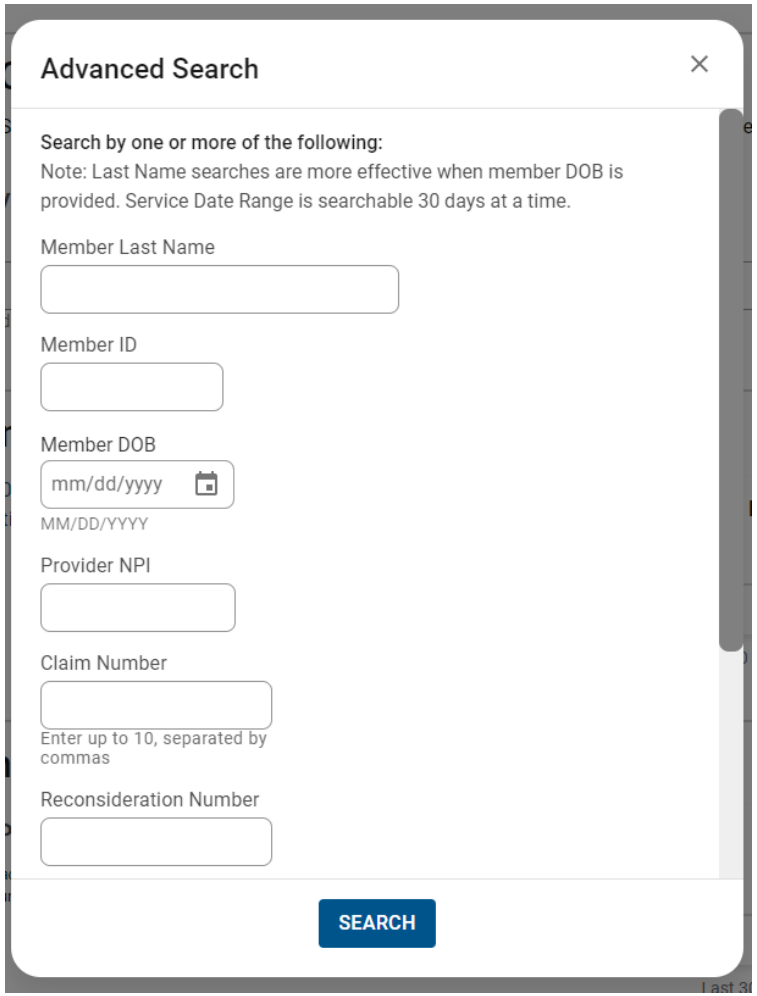
In the portal, there are three ways to search for claims:

1. Complete the **Check Status by Claim Number**
2. Complete the **Search by Member Info**, or
3. Use the **Advanced Search**



Tip: In the Check Status by Claim Number, enter up to 10 Claim Numbers separated by commas, but no spaces. For example, you would enter V290XXP00010,V300XXE07468,V305XXE01234 (no space after the comma and upper-case letters).

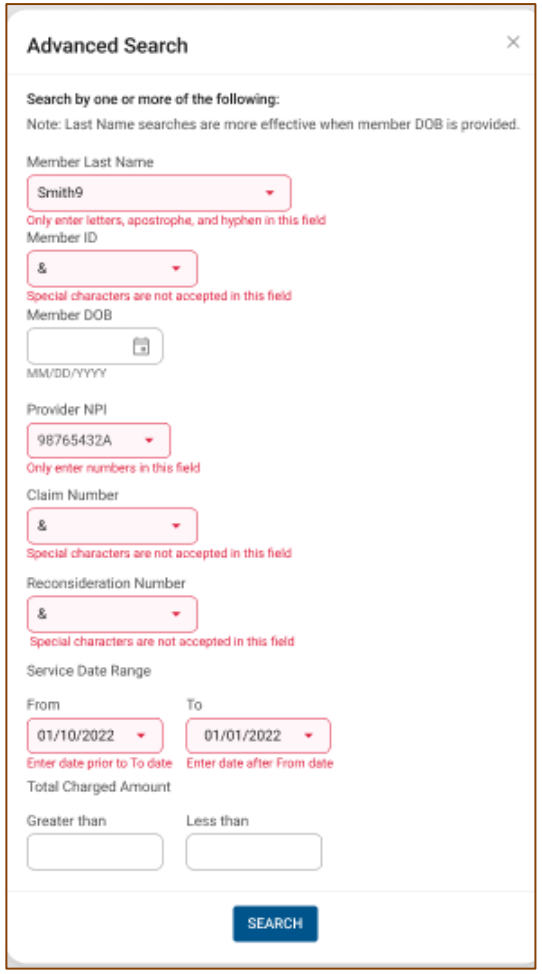
Claims Dashboard – Advanced Search

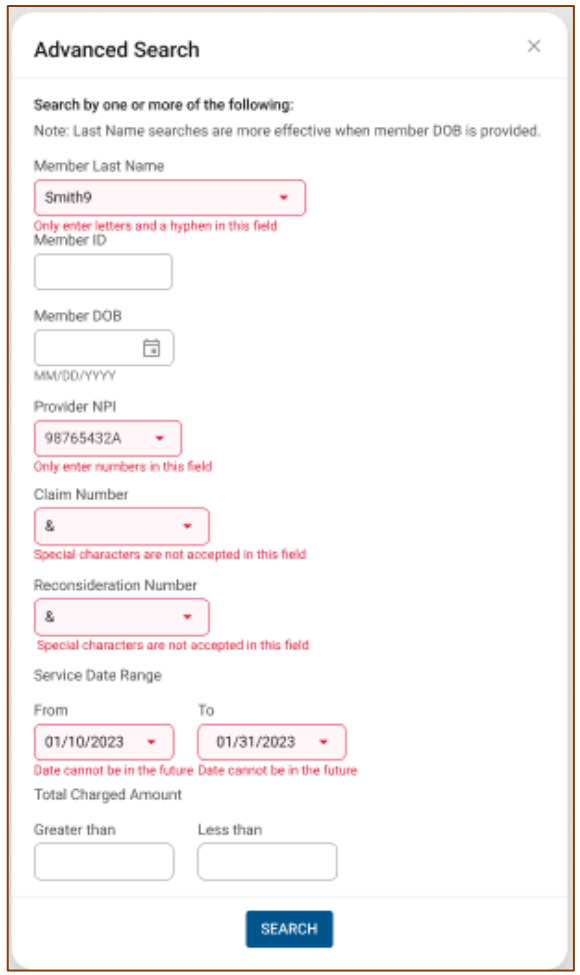


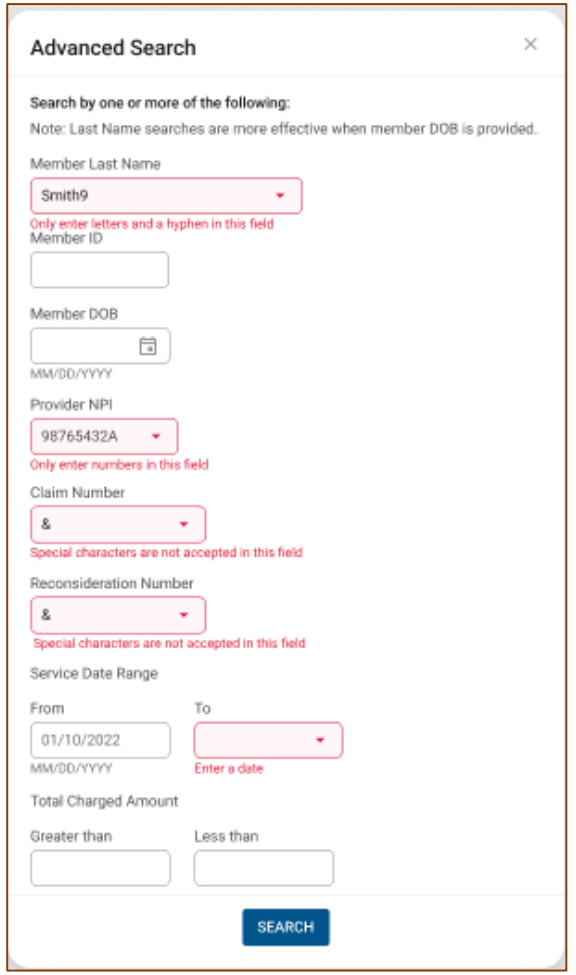
- Search pop-up renamed “Advanced Search”.
- Right scrollbar added, to view available options.
- Can search up to 10 Claim Numbers by separating them by a comma, but no spaces.
- Portal users can search by Total Charged Amount.
- Field errors provide data and/or format guidance.

Claims Dashboard – Advanced Search Onscreen Errors

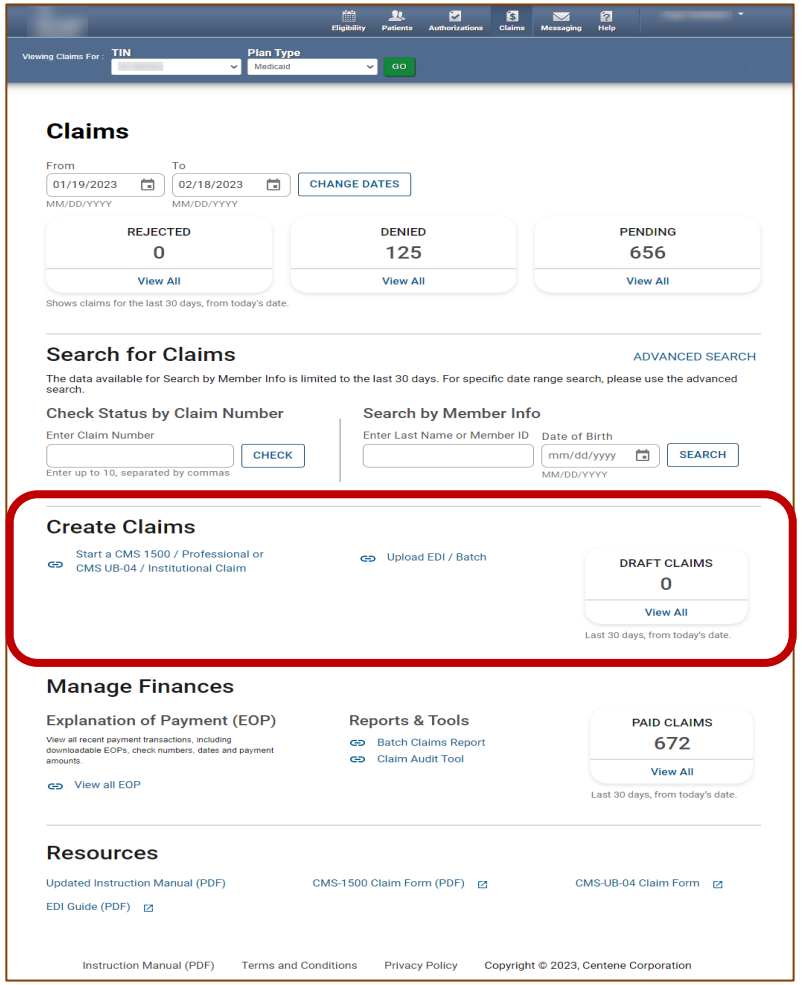
Onscreen errors provide guidance on acceptable format and/or data.





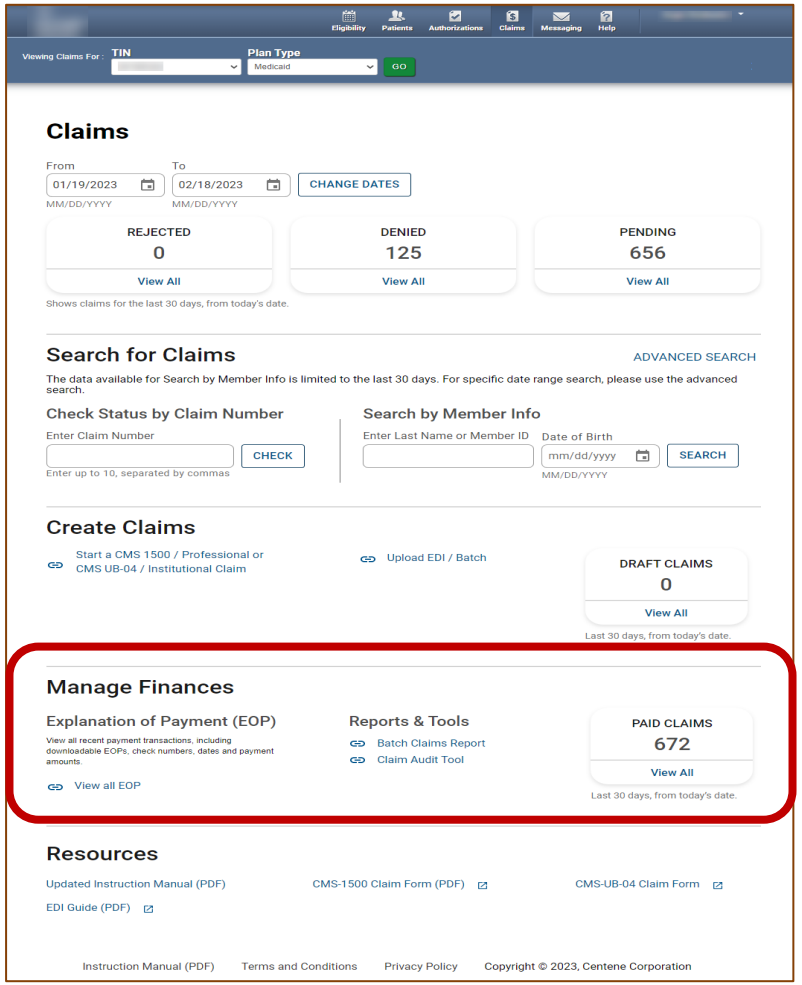


Claims Dashboard – Create Claims



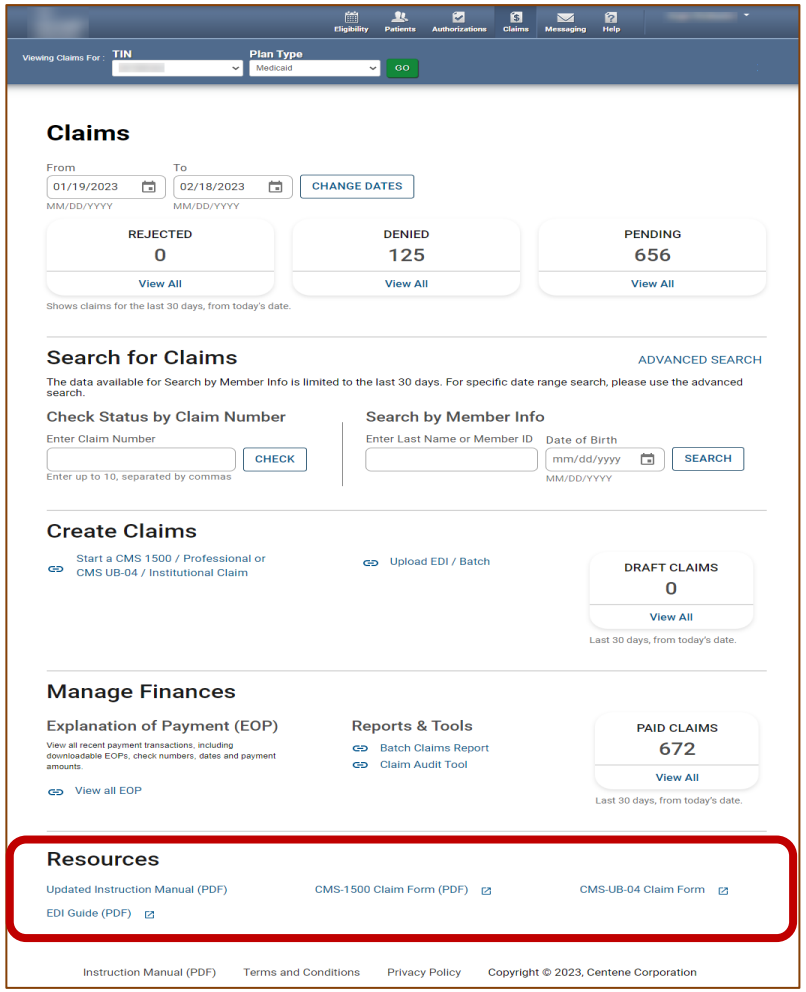
- From the landing page, scroll down to Create Claim options.
- Replaced Create Claim button, with “Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim”.
- Member Eligibility check added and required to create an Institutional or Professional claim.
- Easy access to Draft Claims, Recurring (*where available*), and Upload EDI / Batch.

Claims Dashboard – Manage Finances



- From Claims Dashboard, scroll to 'Manage Finances'
- "View all EOPs" links to existing Payment History tab and information
- Batch Claims Reports link provides quick access to EDI Response Report (i.e., 999, TA1, etc.).
- Claim Audit Tool (*where available*) changed from a tab to a link.

Claims Dashboard – Resources Links



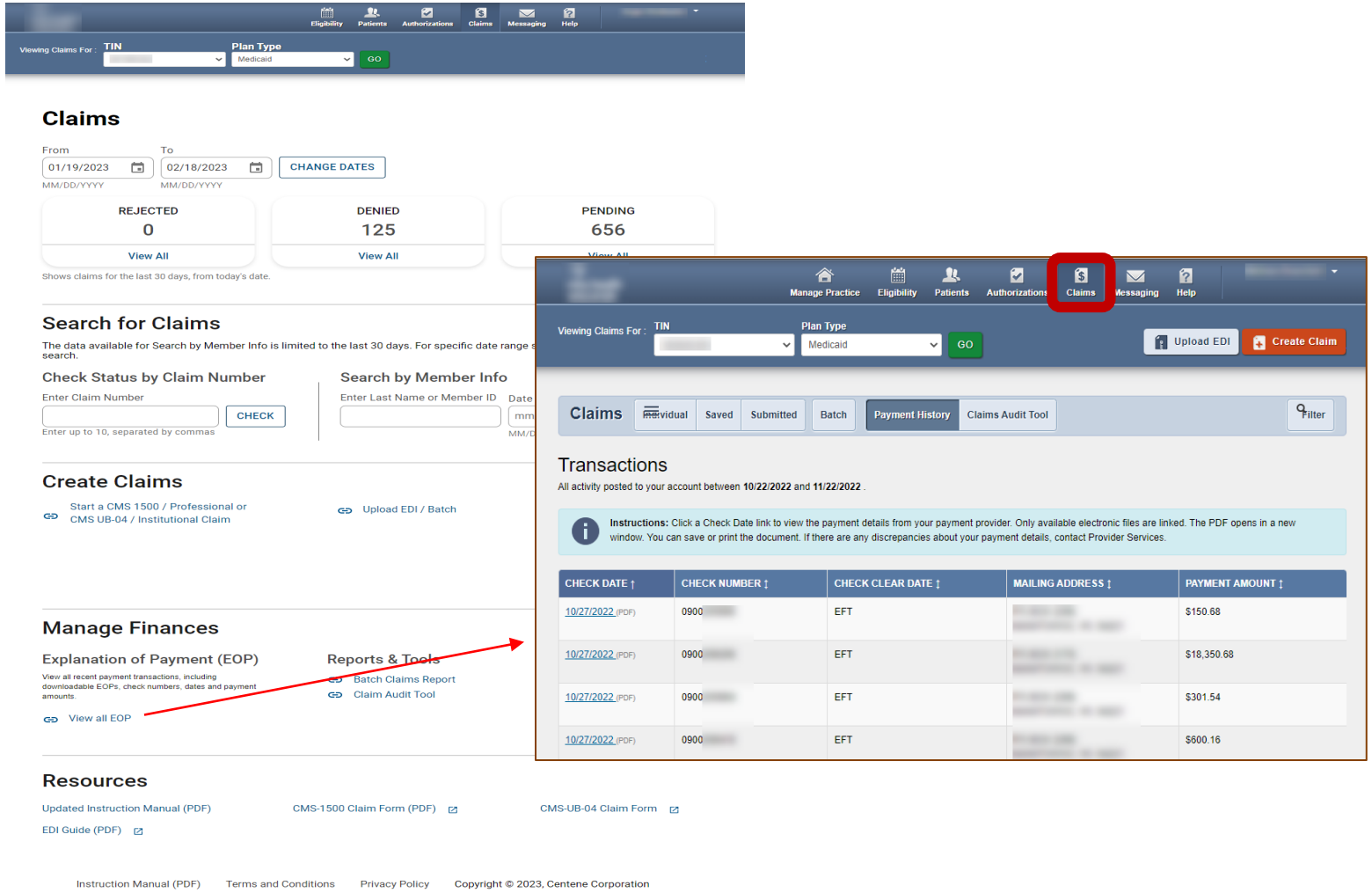
- From claims dashboard, scroll to Resources

Navigating Managing Finances

Claims Dashboard – Manage Finances: View all EOPs

To access Explanation of Payment (EOP) information, under Manage Finances, click **View all EOPs**. The legacy Payment History tab displays.

Click **Claims** at the top of any page to return to Claims Dashboard.

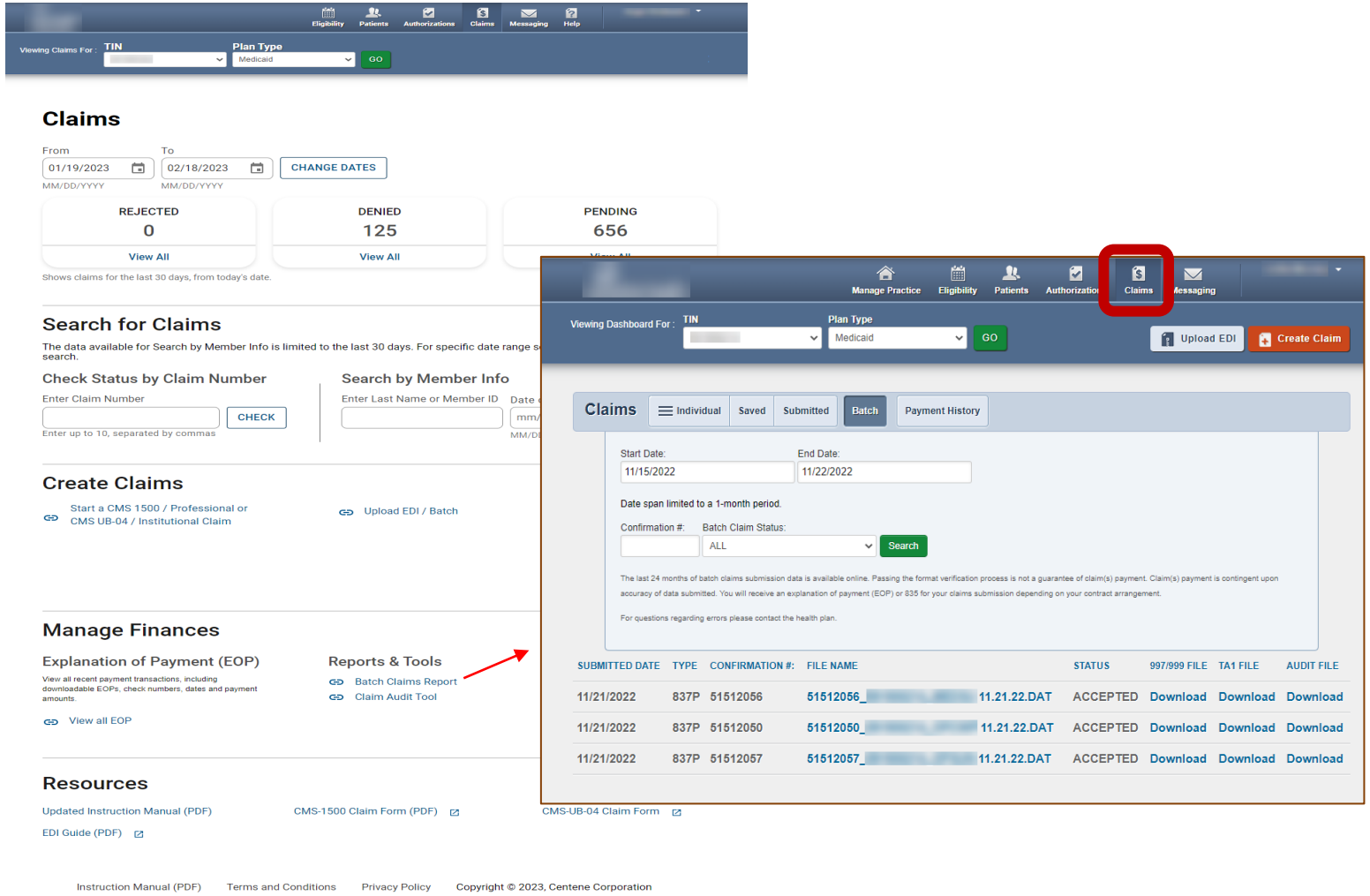


Tip: You can access up to 18 months of payment history. The key is the Check Date must be within the last 18 months from the current date.

Claims Dashboard – Manage Finances: Batch Claims Reports

To access EDI Batch Responses (i.e., 999, TA1, etc.), under Reports & Tools, click **Batch Claims Report**. The legacy Batch tab displays.

Click **Claims** at the top of any page to return to Claims Dashboard.

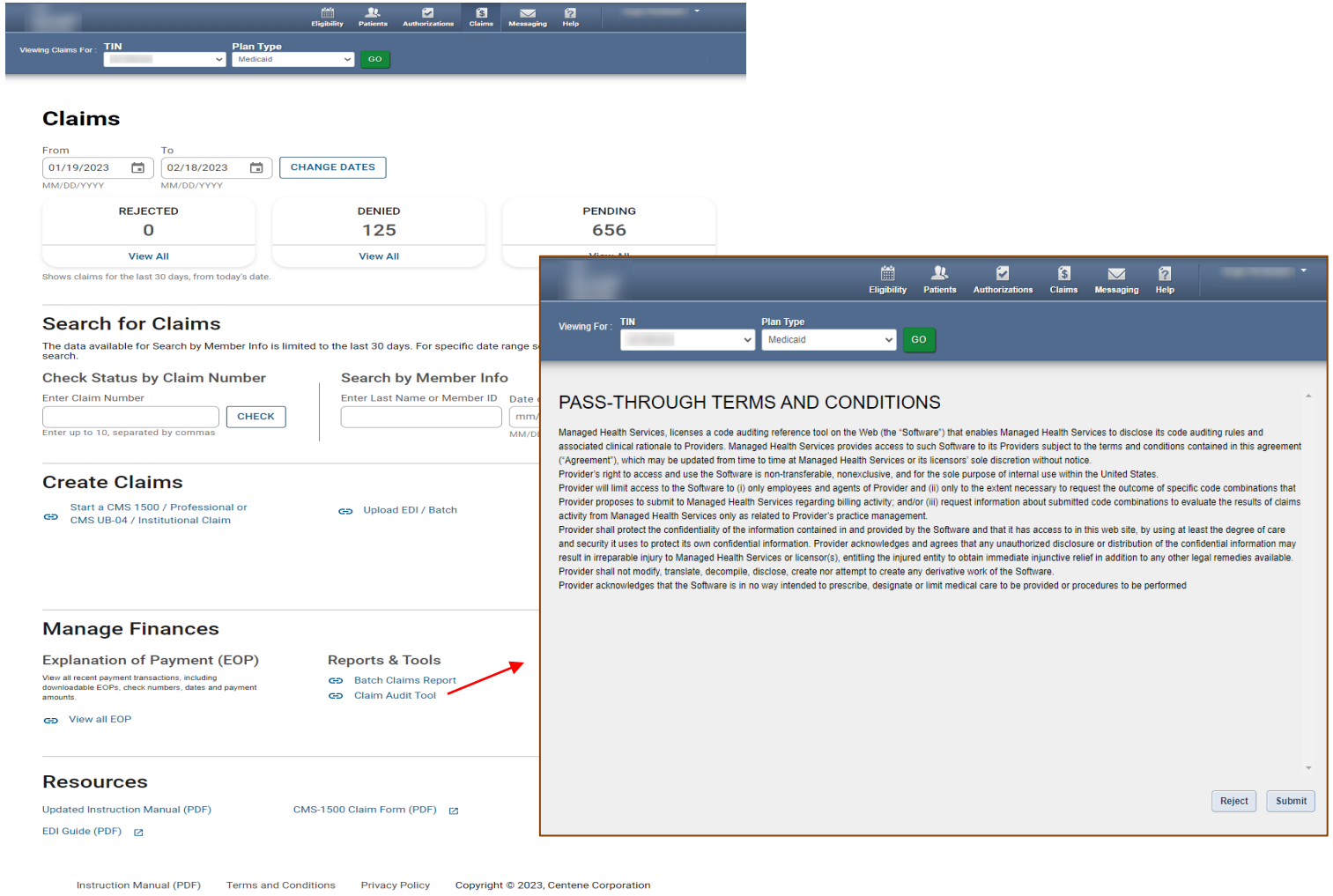


Tip: Batch Claims Reports are only applicable to organizations, who upload EDI Claim Batches (i.e., 837P / 837I) via the Secure Provider Portal.

Claims Dashboard – Manage Finances: Claim Audit Tool

To access the Claim Audit Tool *(where available)*, under Reports & Tools, click **Claim Audit Tool**. The legacy Pass-Through Terms and Conditions displays in a new tab or window.

Close the new tab or window to return to the Claim Dashboard.

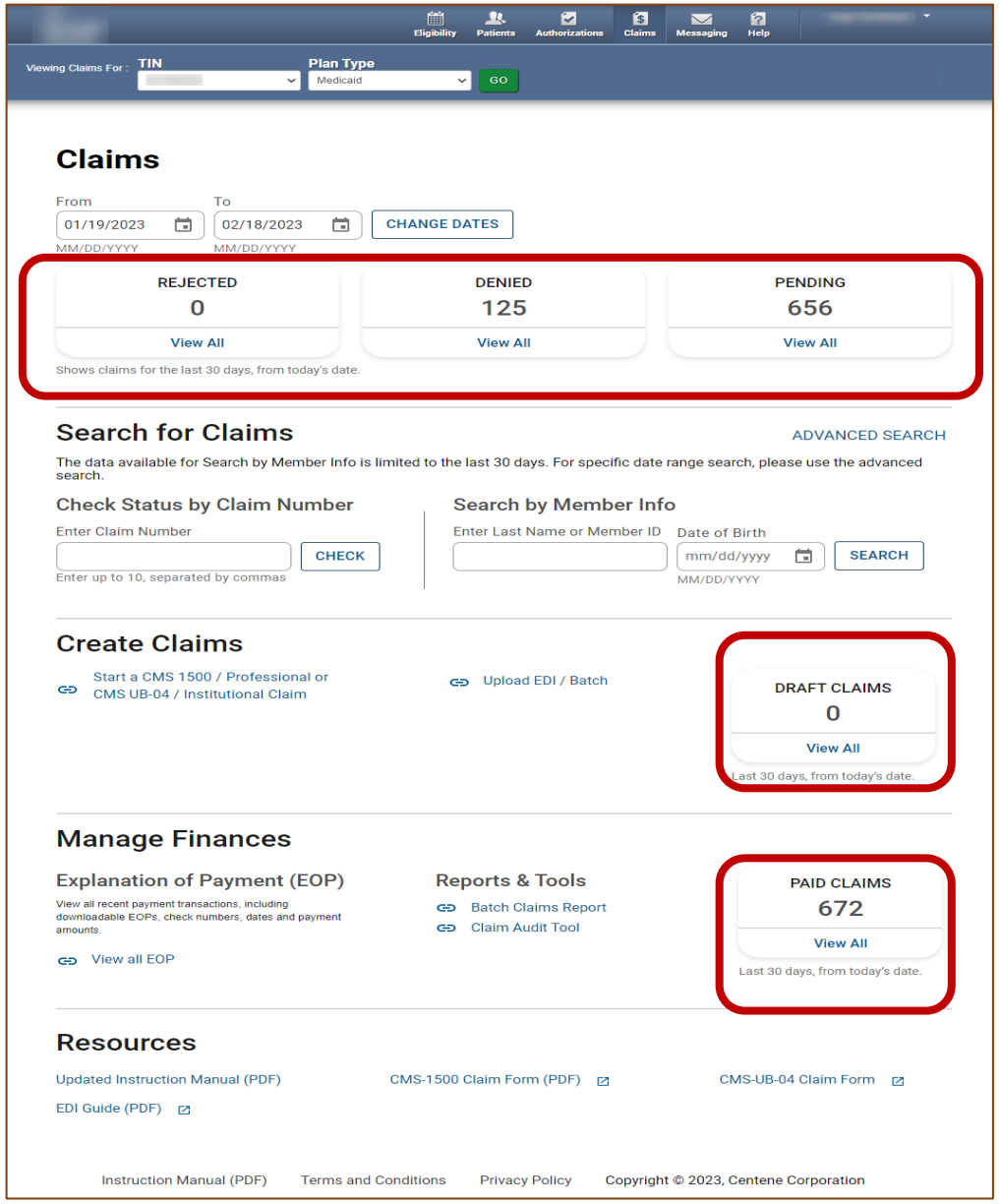


Claim Status Pages

Claim Status Tiles

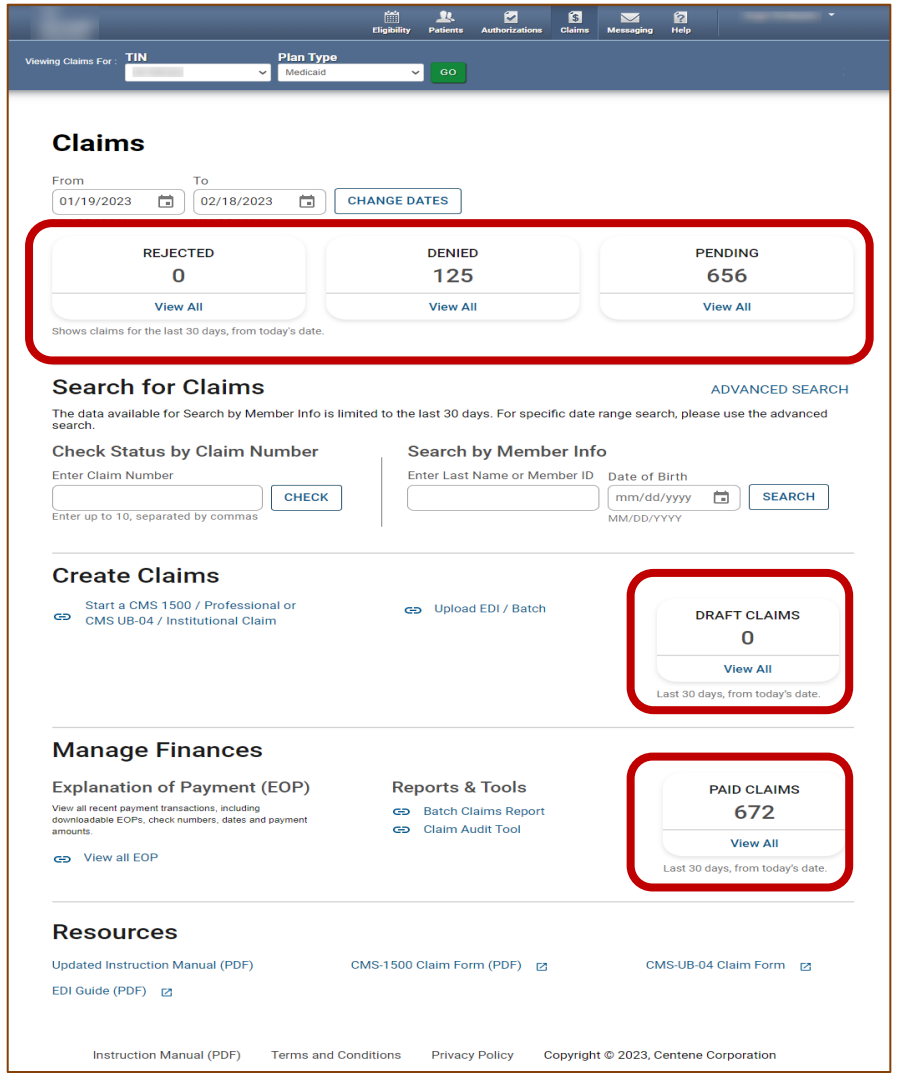
The Rejected, Denied, Pending, Draft Claims, and Paid Claim Status Tiles, display on the Claims Dashboard, and provides the claim count for each status. Please note:

- Initial default count for each status, are for claims where the first Date of Service (DOS) is within the last 30 days, from the current date.
- The Rejected tile, is only applicable to individual web claims submitted via the portal, which received a front-end EDI rejection. If your Provider organization does not submit individual web claims via the portal or does not have any rejected web claims, the Rejected tile, will be zero (0).
- The Draft Claims tile, is only applicable to individual web claims started in the portal, but not submitted.



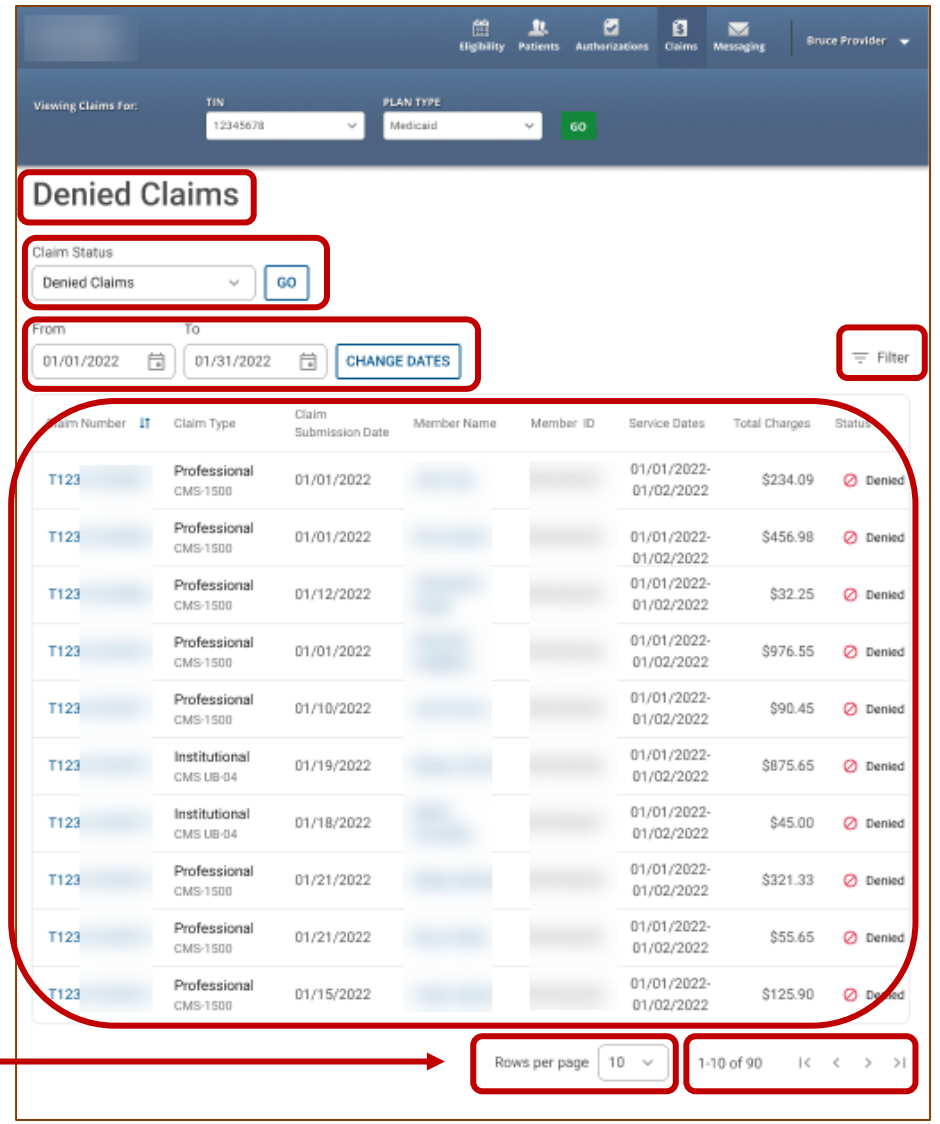
Accessing Claim Status Pages

To access a Claim Status page, click **View All**. The respective page displays.



Claim Status Pages – Layout

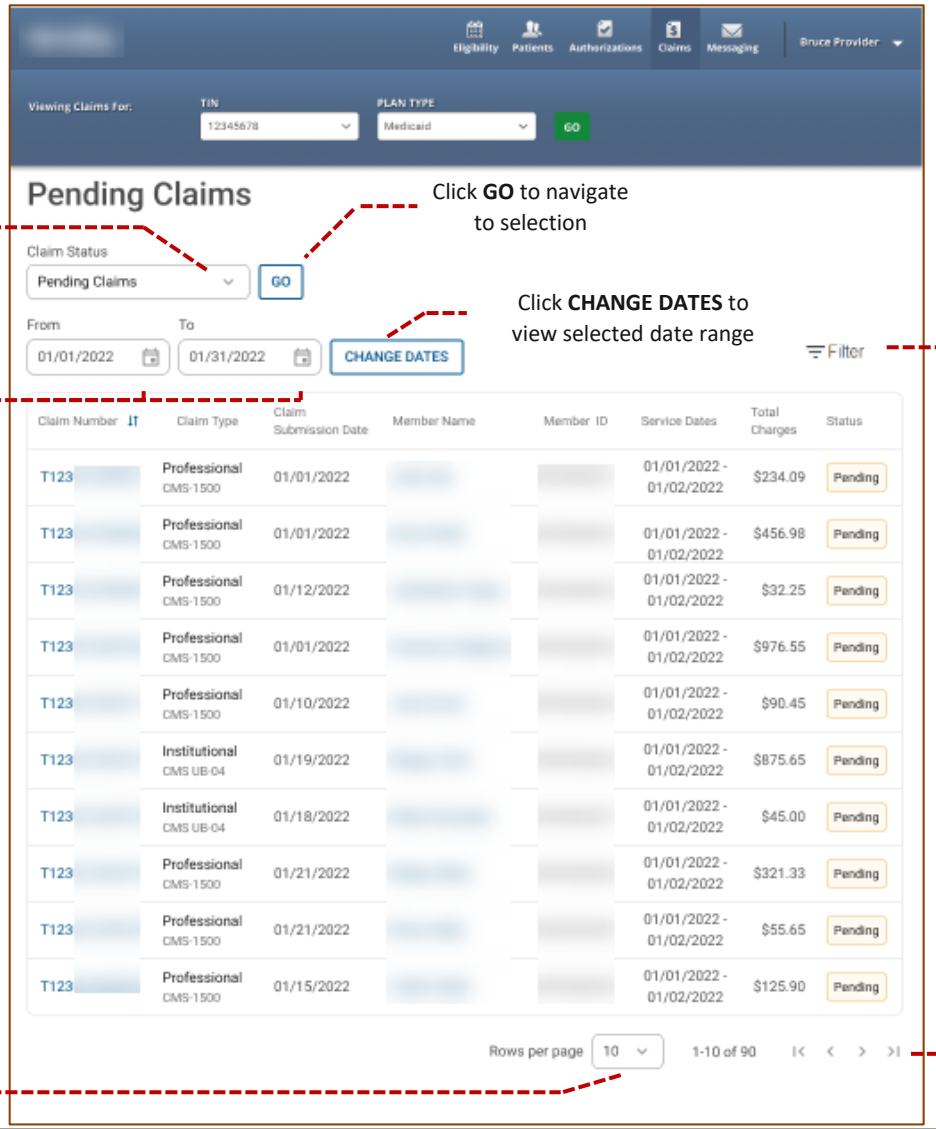
The Claim Status Pages layout are all the same. Please note, the Claims Display and Options may vary, based on the status of the claim.



Tip: Claims Display and Options may vary, based on the status of the claim.

Claim Status Pages – General Navigation

General navigation on the Rejected, Denied, Pending, Draft Claims, and Paid Claim Status pages is the same.



Click drop-down arrow to select/change status

Click Calendar icon, or manually type desired date(s)

Click **GO** to navigate to selection

Click **CHANGE DATES** to view selected date range

Click **Filter** to filter claims

Click to change row count

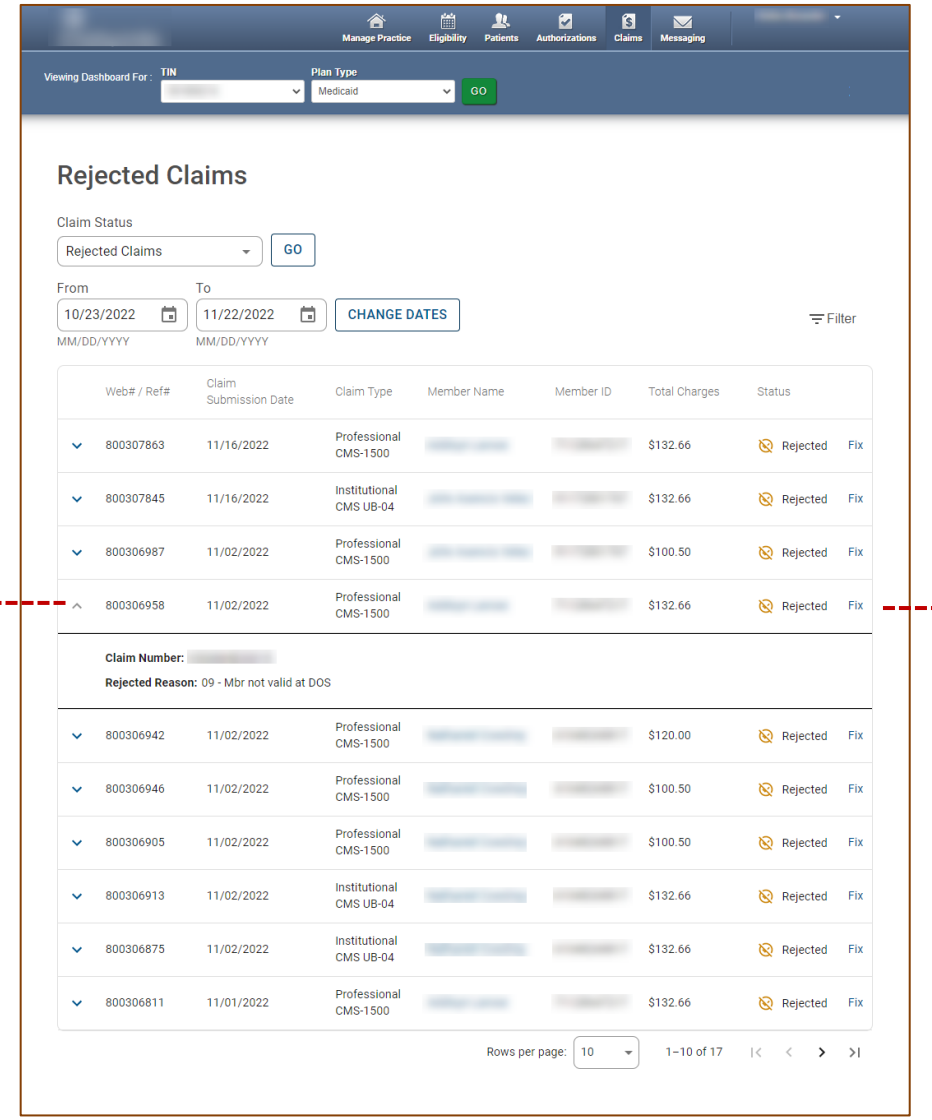
Use pagination to navigate list

Tips:

- You can access up to 24 months of claim history, but the first DOS in a claim must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

Claim Status Pages – Navigating Rejected Claims

Rejected Claims is only applicable to individual web claims (i.e., new, corrected, reconsider, etc.) submitted via the portal, which received a front-end EDI rejection.



Click arrow to view / hide reject reason

Click **Fix** to resolve the reason for the rejection and resubmit claim

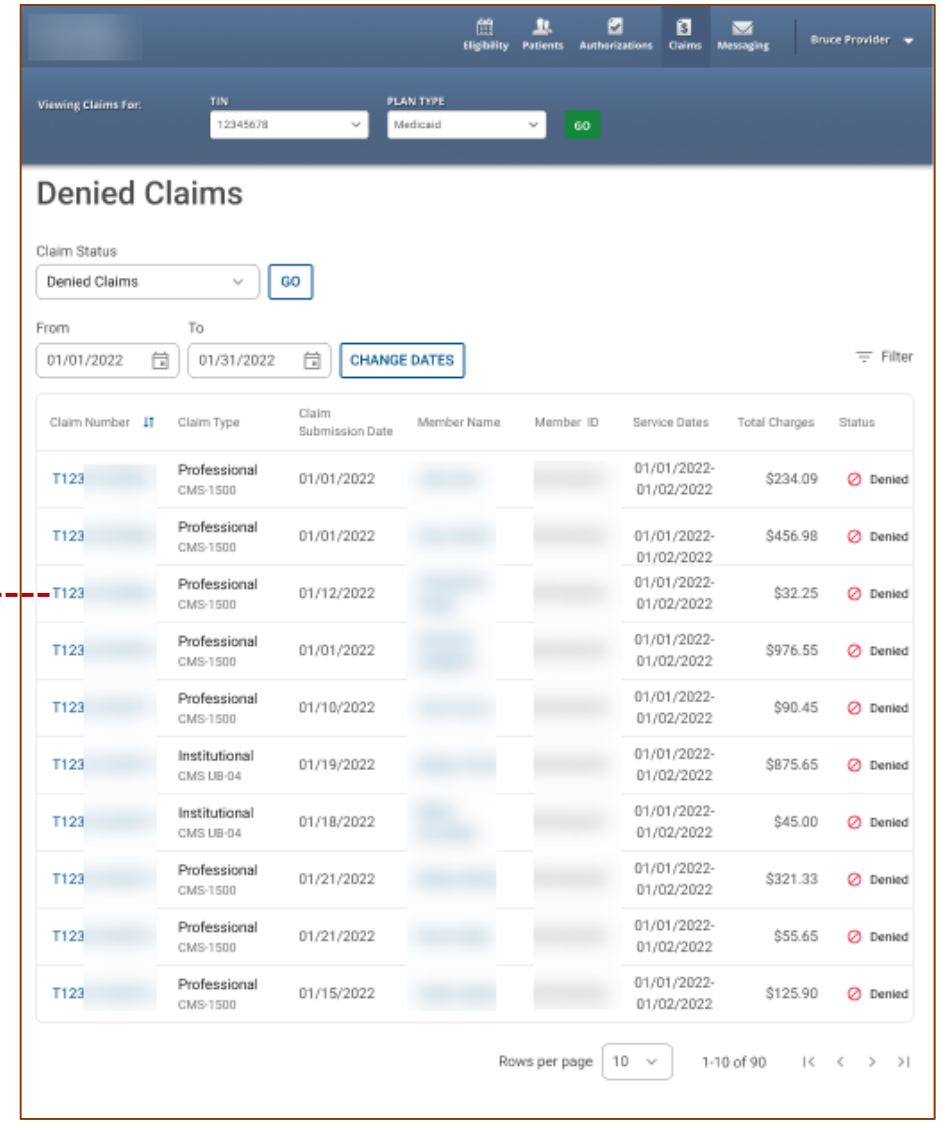
Tips:

- Front-end EDI rejections will not be processed any further, therefore, rejected claims will not be adjudicated.
- You can access up to 24 months of web claim rejection history, but the Submission Date must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

Claim Status Pages – Navigating Denied, Pending, and Paid Claims

Regardless of submission method, claims on file under the TIN in a denied, pending, or paid status, will display on the respective Claims Status Page.

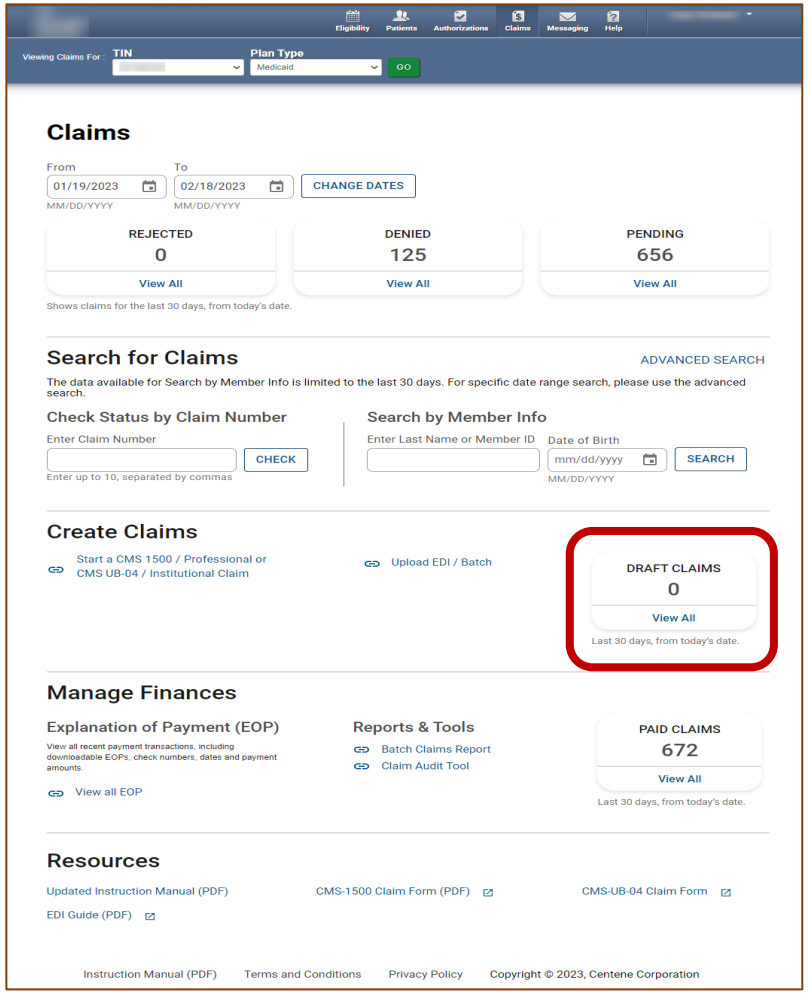
Click a **Claim Number** to view claim details



Tips:

- You can access up to 24 months of claim history, but the first DOS in a claim must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

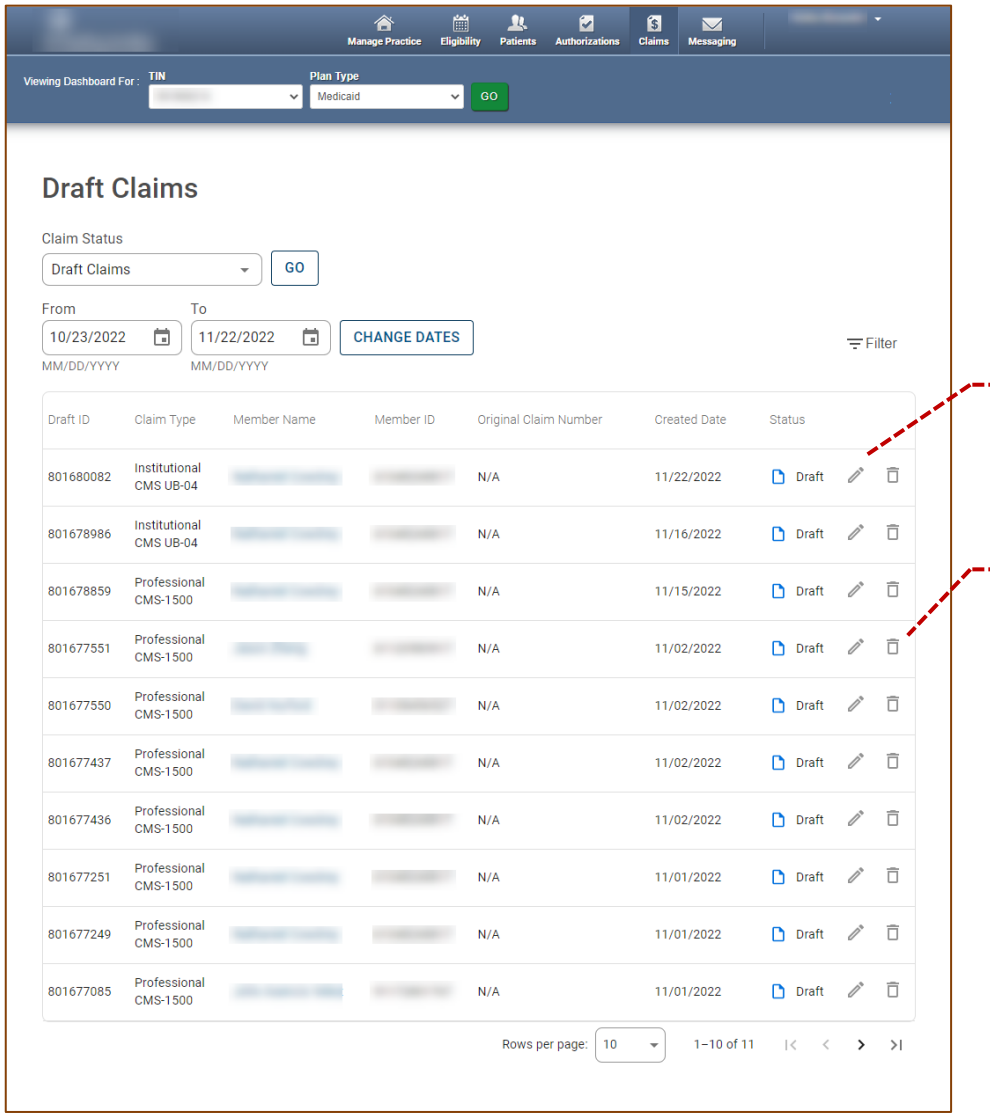
Claims Status – Draft Claims



- Saved tab changed to Draft Claims Tile.
- Claim drafts created in the last 30 days from current date, display regardless where the claim was exited without submitting it.

Claim Status Pages – Navigating Draft Claims

A claim draft is automatically created and saved, for any individual web claim started, but not submitted. This includes correct and reconsider claim drafts, and where available, void/recoup and/or appeal drafts.



Click Pencil icon to resume, complete, and submit web claim

Click Trashcan icon to delete the web claim draft

Tip: A Claim Number in the **Original Claim Number** column, identifies correct, reconsider, void/recoup, or appeal claim drafts.

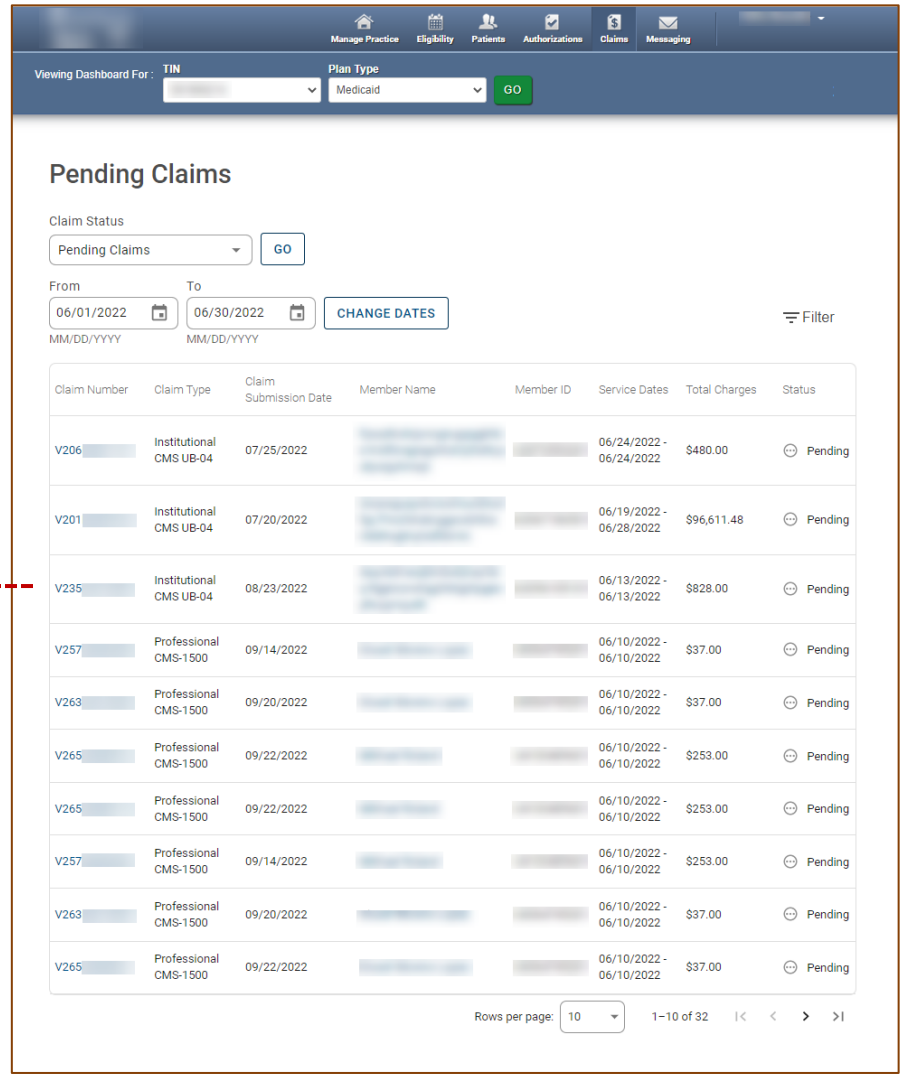
Claim Details

Accessing Claim Details – Denied, Pending, and Paid Claims

Regardless of claims submission method, claims on file under the TIN in a denied, pending, or paid status, will display on the respective Claims Status Page.

When you click a Claim Number, the Claim Details page displays.

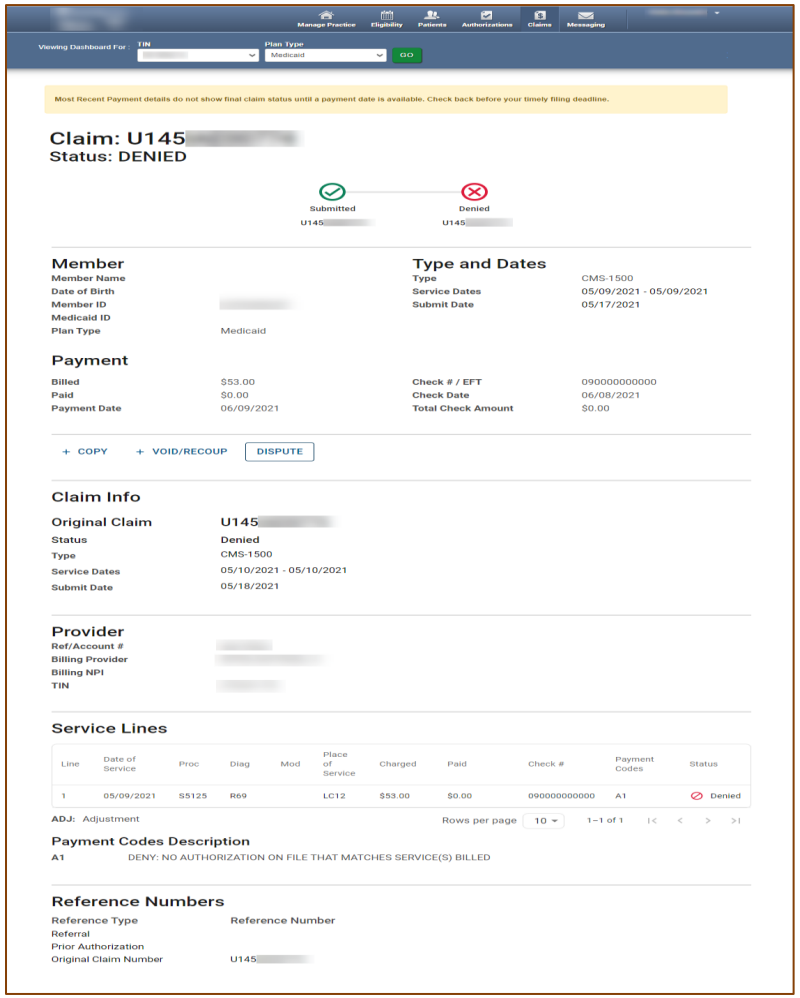
Click a **Claim Number** to view claim details



Tips:

- You can access up to 24 months of claim history, but the first DOS in a claim must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

Claims Details



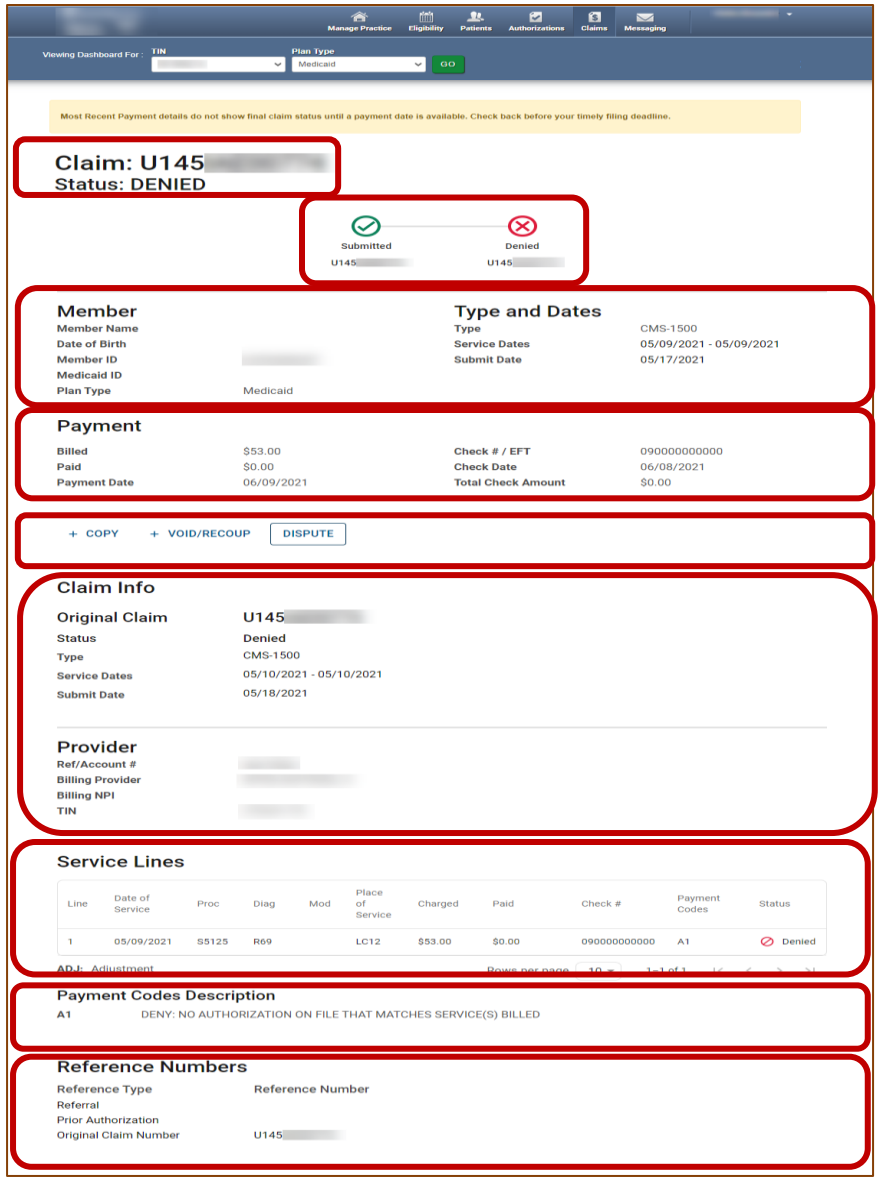
- Claim Status Tracker will display current claim status and include Reconsideration and Appeal information, when applicable.
- Member Name is a hyperlink for quick access to the Patient Record.
- Claim Type displays under Type and Dates.
- On finalized claims, in the Payment section, Billed [Claim Amount], Check # / EFT, and Total Check Amount displays.
- Copy Claim button replaced with link and renamed +Copy.
- Void/Recoup Claim button replaced with link and renamed +Void/Recoup.
- Dispute button added with additional claim action capabilities.
- Claim Info will display Claim # and additional information on associated submitted reconsideration and/or appeal requests.
- In the Reference Numbers section, on claims with submitted reconsideration and/or appeal requests, the associated reference number(s) display.

Claim Details Overview

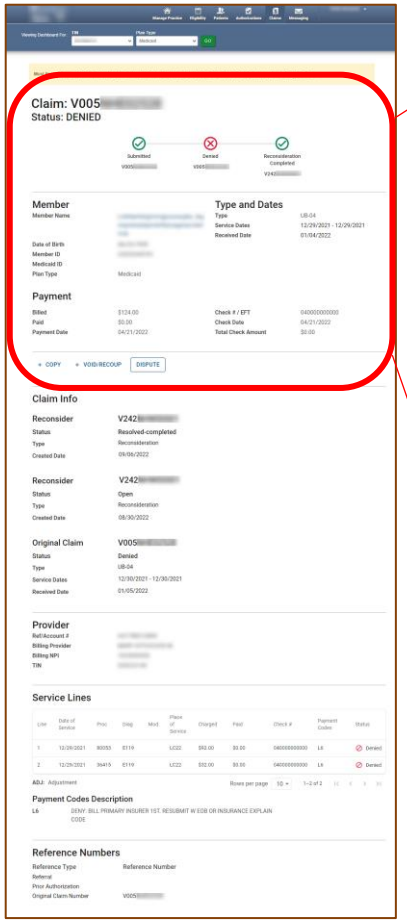
The Claim Details page provides a wholistic view of a claim.

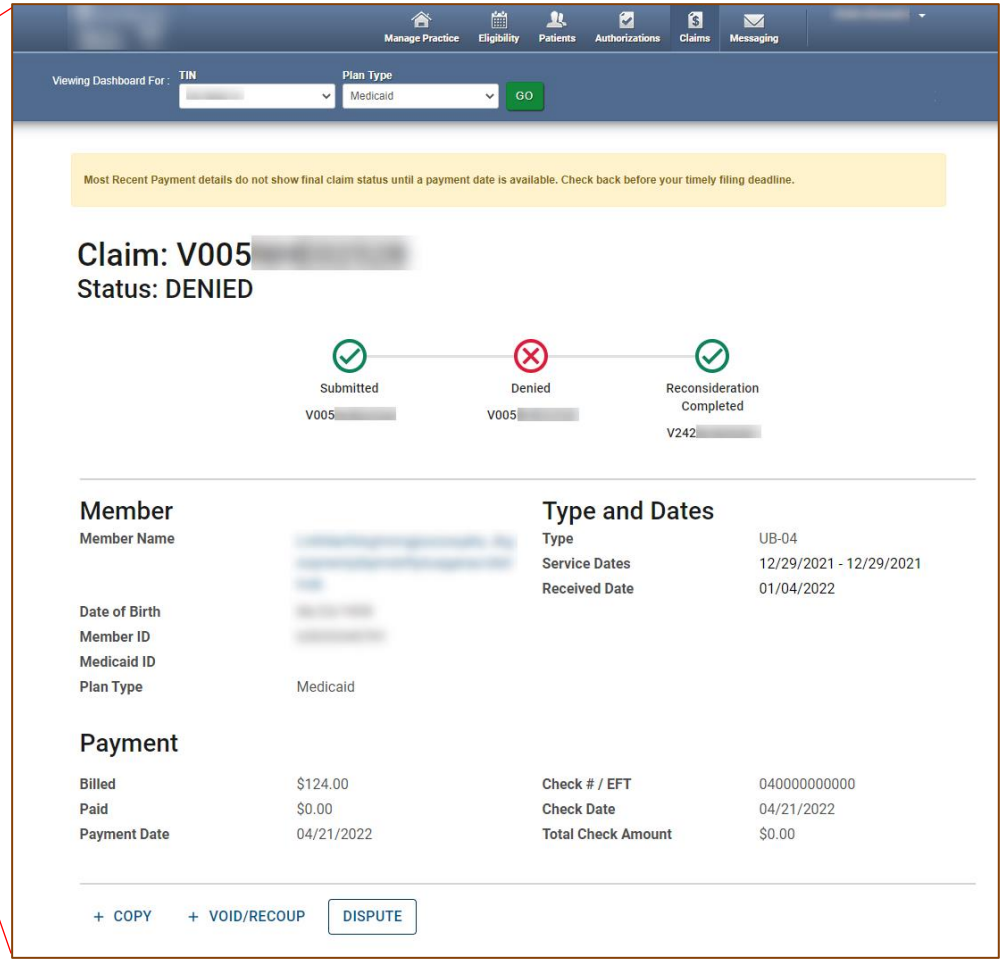
Please note, the following only displays on finalized claims (i.e., Paid, Denied, etc.):

- Payment Information
- Dispute Button
- Payment Codes & Description



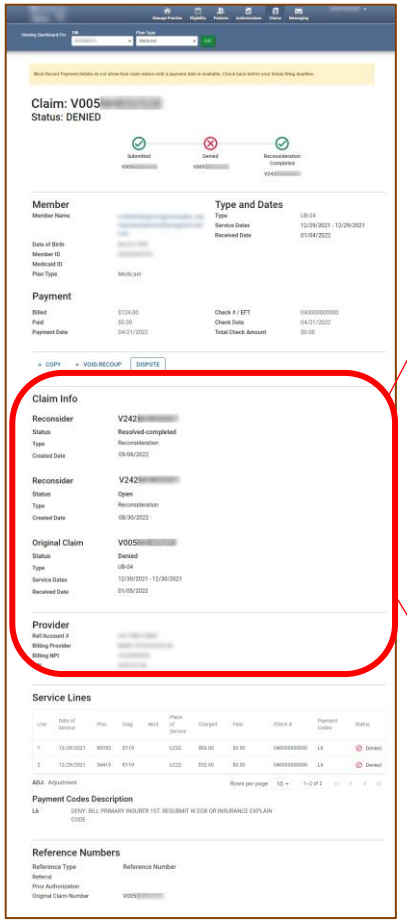
Claim Details

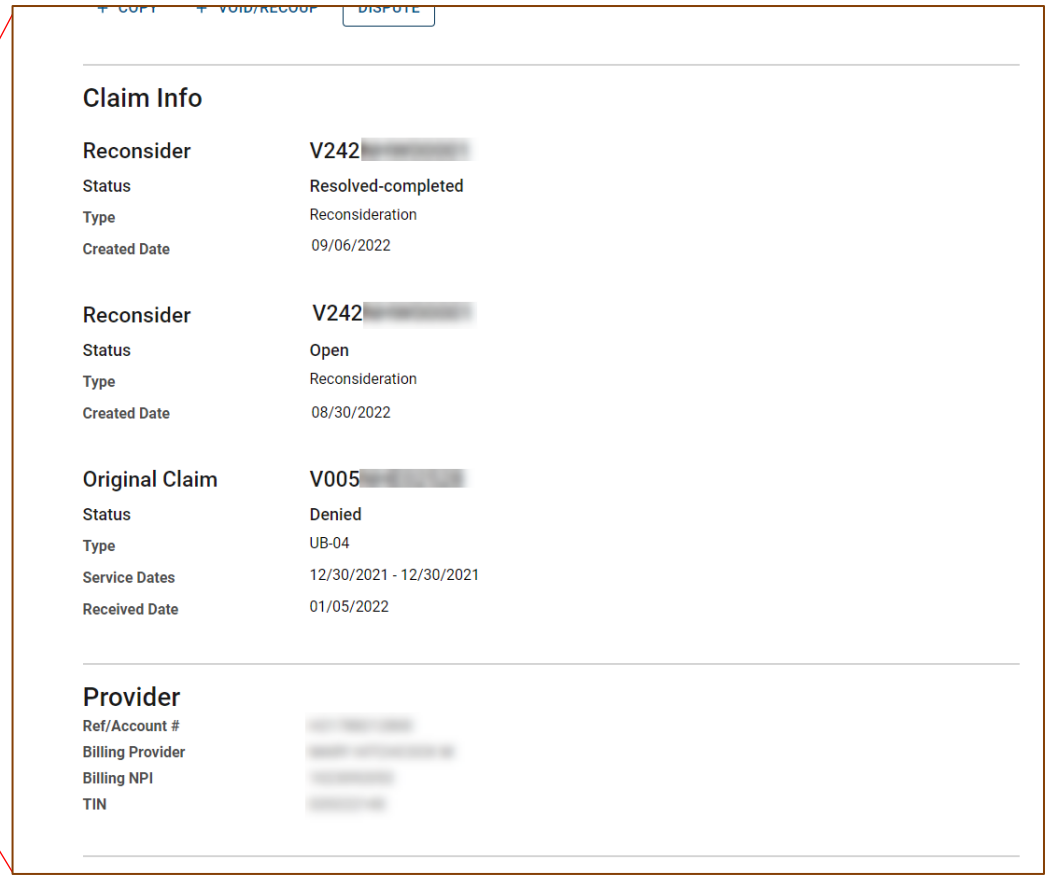




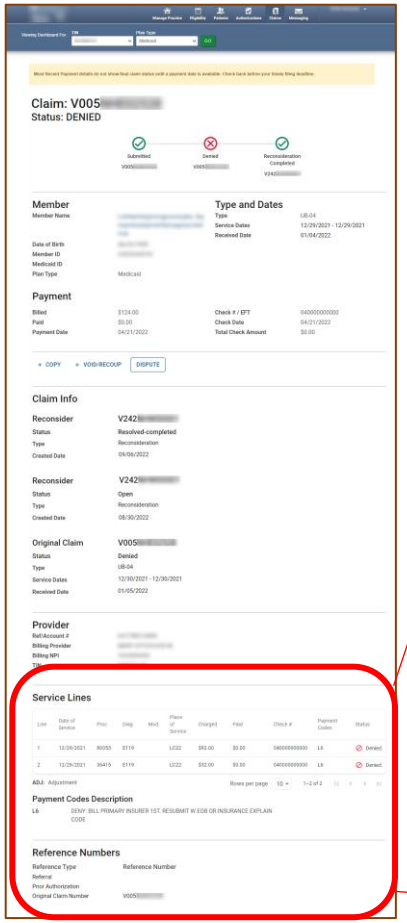
Tip: Payment information only displays on finalized claims.

Claim Details, *continued*





Claim Details, *continued*



Service Lines

Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	12/29/2021	80053	E119		LC22	$92.00	$0.00	040000000000	L6	Denied
2	12/29/2021	36415	E119		LC22	$32.00	$0.00	040000000000	L6	Denied

ADJ: Adjustment

Rows per page 10 1–2 of 2

Payment Codes Description

L6 DENY: BILL PRIMARY INSURER 1ST. RESUBMIT W EOB OR INSURANCE EXPLAIN CODE

Reference Numbers

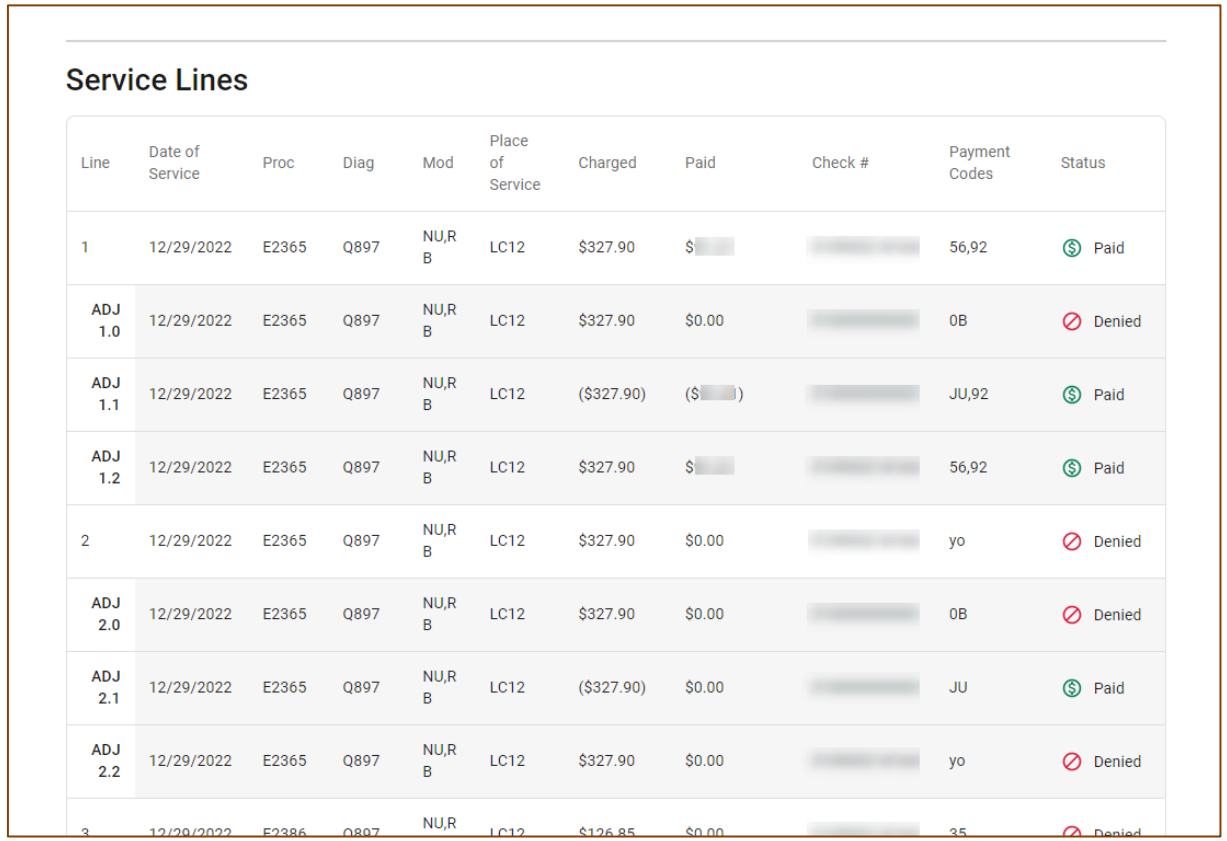
Reference Type	Reference Number
Referral	
Prior Authorization	
Original Claim Number	V005

Tip: Payment Codes and Payment Codes Description only display on finalized claims.

Claim Details: Service Lines With Adjustments

When an adjustment occurs on a claim or Service Line(s), the adjustment will appear as a child line item detailing the changes. The child line items are identified by ADJ, which means adjustment. Please note:

- On the lines without “ADJ” the Paid, Payment Codes, and Status columns reflect the finalized adjustment. However, the Check # is the original Check #.
- ADJ lines are read from the top, down.
- ADJ 1.1, 2.1 (i.e., X.1), contains the finalized adjustment Check #. This will be the Check # displayed in the Payment section of the Claim Details page.



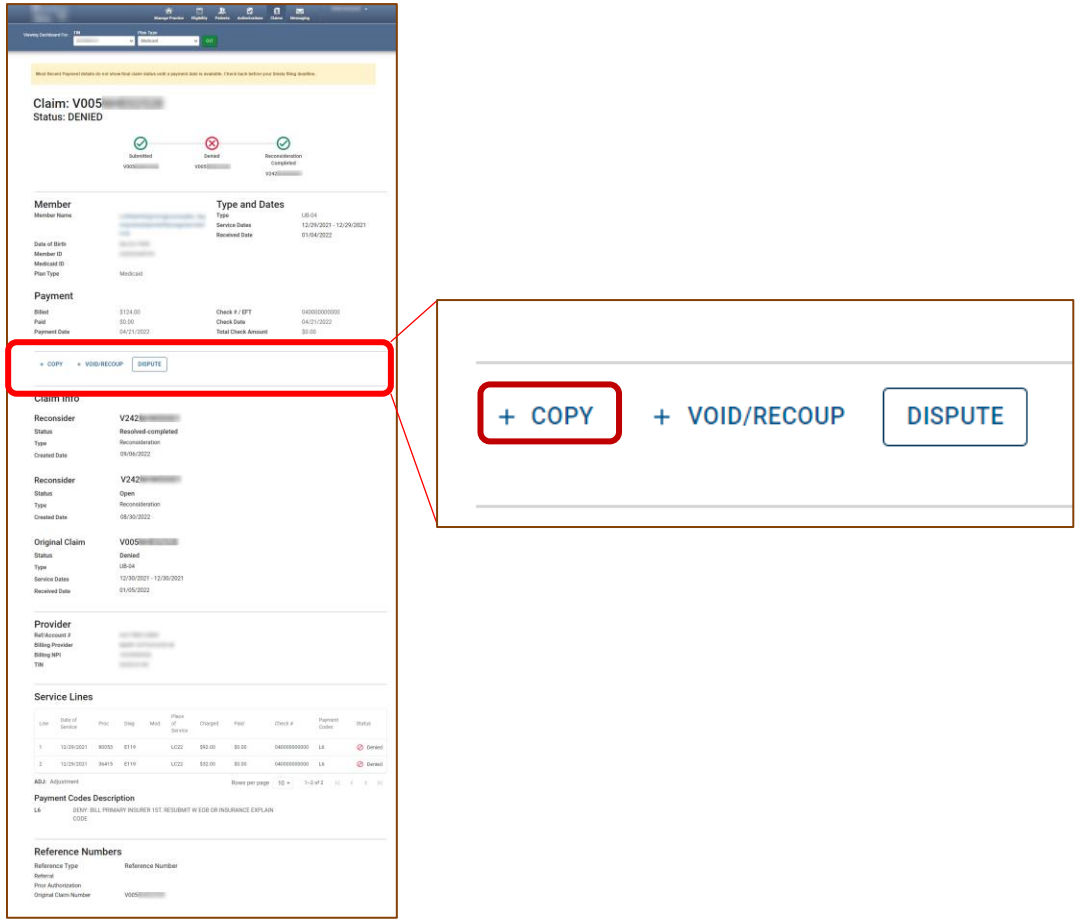
Service Lines

Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	12/29/2022	E2365	Q897	NU,RB	LC12	$327.90	$		56,92	Paid
ADJ 1.0	12/29/2022	E2365	Q897	NU,RB	LC12	$327.90	$0.00		0B	Denied
ADJ 1.1	12/29/2022	E2365	Q897	NU,RB	LC12	($327.90)	($)		JU,92	Paid
ADJ 1.2	12/29/2022	E2365	Q897	NU,RB	LC12	$327.90	$		56,92	Paid
2	12/29/2022	E2365	Q897	NU,RB	LC12	$327.90	$0.00		yo	Denied
ADJ 2.0	12/29/2022	E2365	Q897	NU,RB	LC12	$327.90	$0.00		0B	Denied
ADJ 2.1	12/29/2022	E2365	Q897	NU,RB	LC12	($327.90)	$0.00		JU	Paid
ADJ 2.2	12/29/2022	E2365	Q897	NU,RB	LC12	$327.90	$0.00		yo	Denied
3	12/29/2022	E2386	Q897	NU,R	LC12	$126.85	$0.00		35	Denied

Claim Details – Claim Action Buttons: + Copy

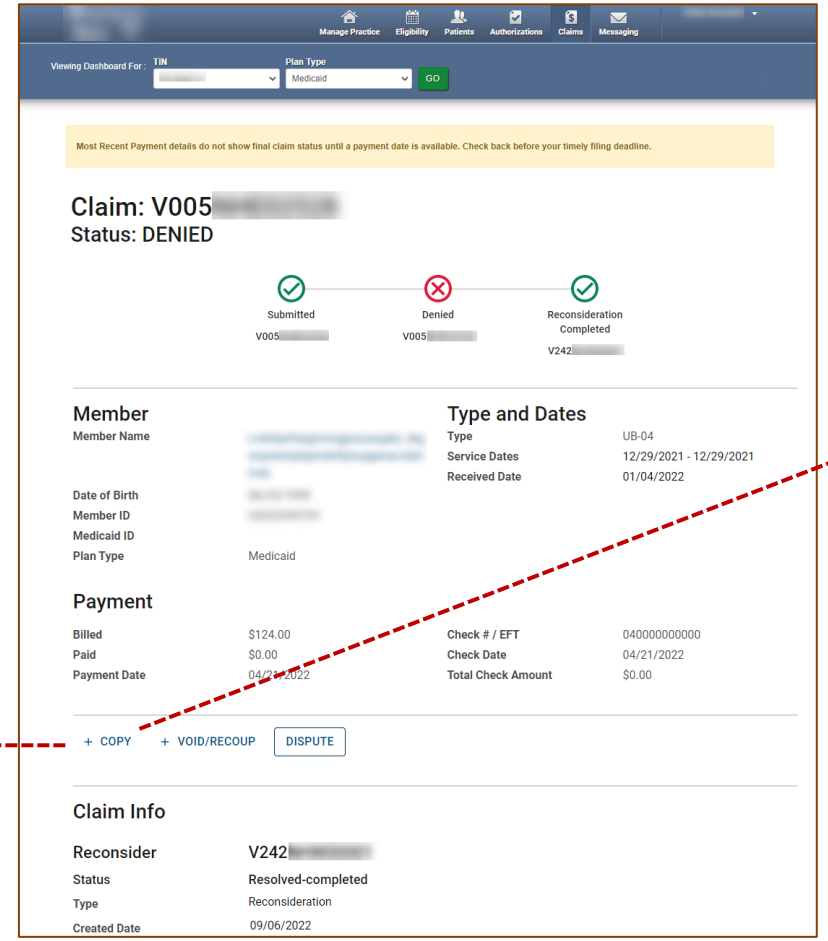
Click **+ Copy**, to create an exact duplicate of the claim. All the information within the claim can be edited, allowing you to simply change the needed information (i.e., Date(s) of Service, Diagnosis Code(s), Procedure Code(s), etc.) to submit a new claim.

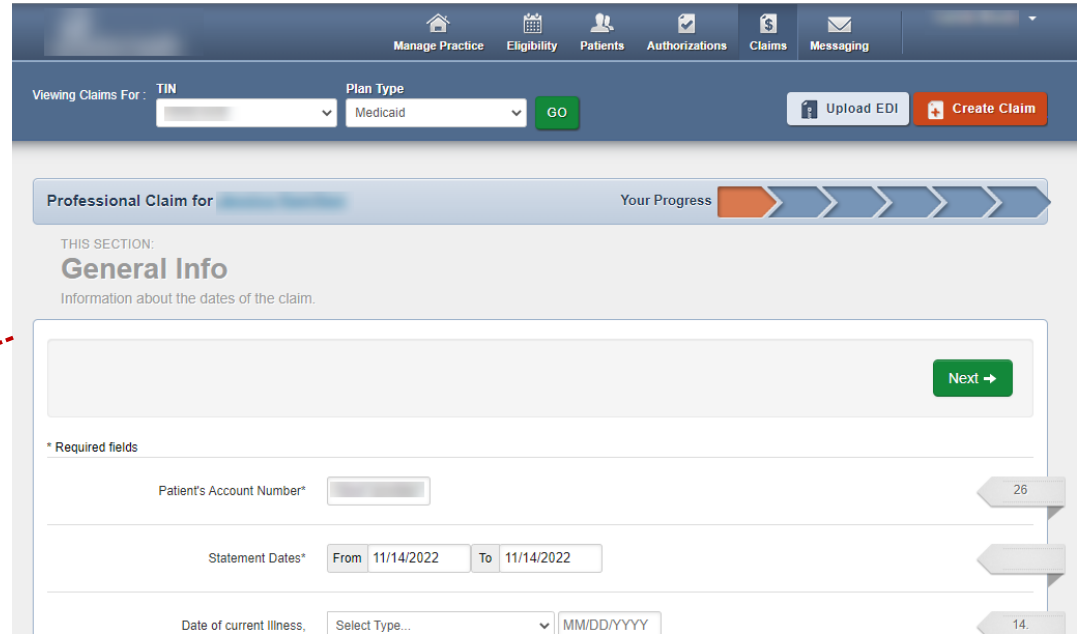
Once it is submitted, it is considered a new claim submission and will be processed as a first-time claim.



Claim Details – Claim Action Buttons: + Copy Workflow

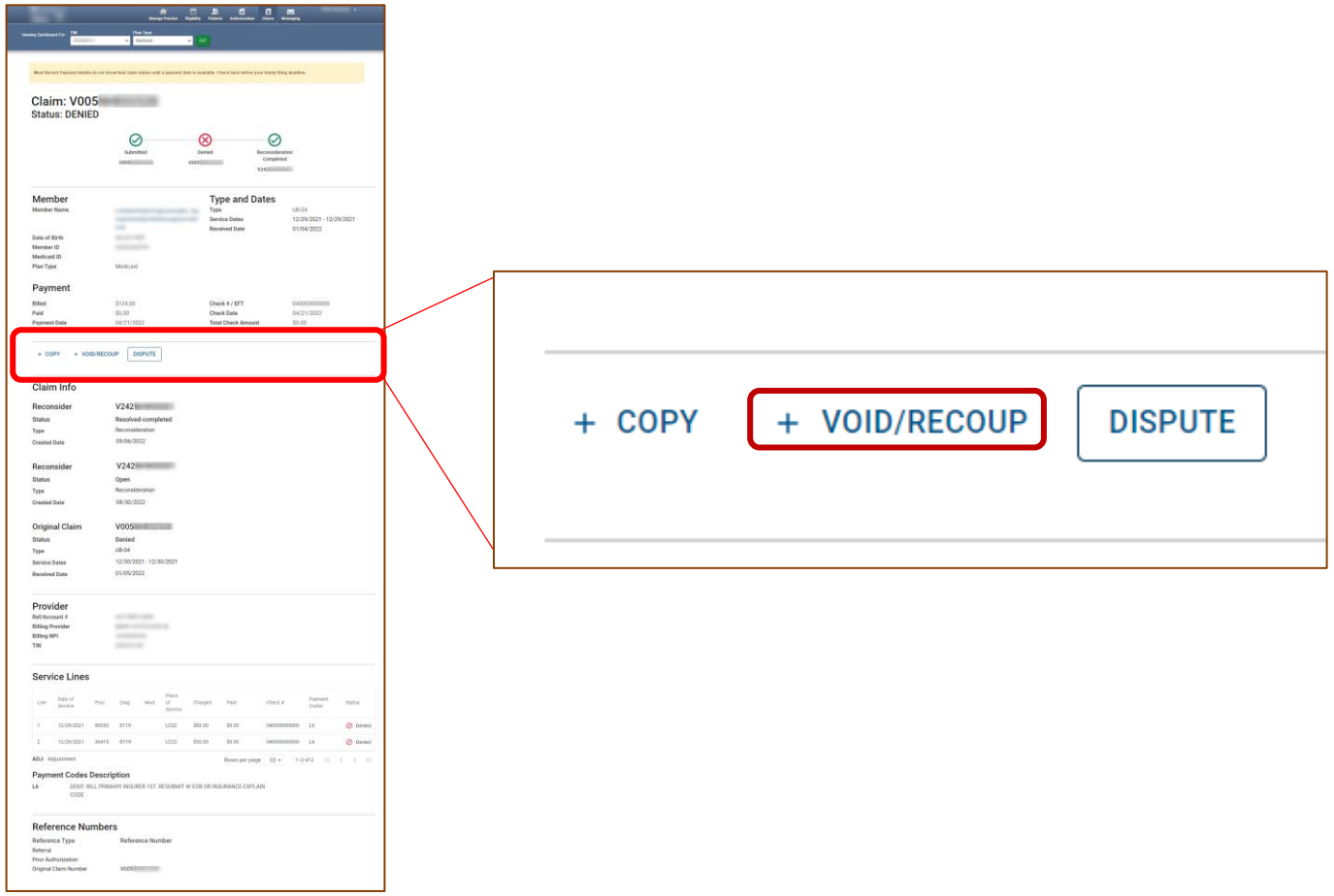
Click **+Copy** to create copied claim





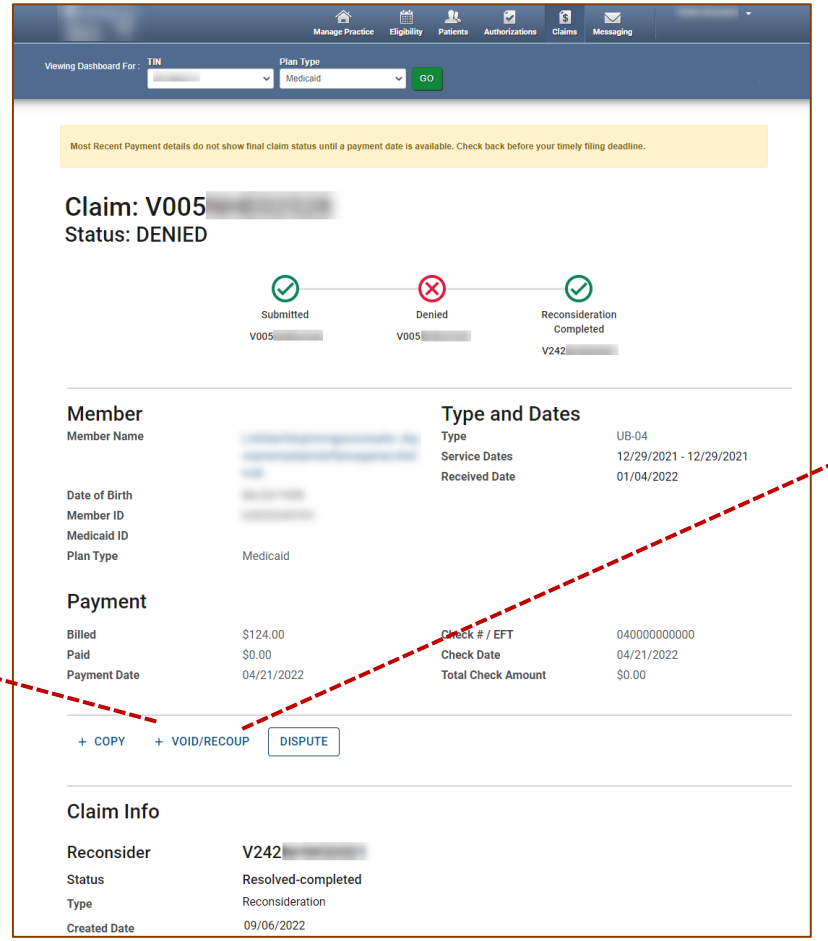
Claim Details – Claim Action Buttons: + Void/Recoup

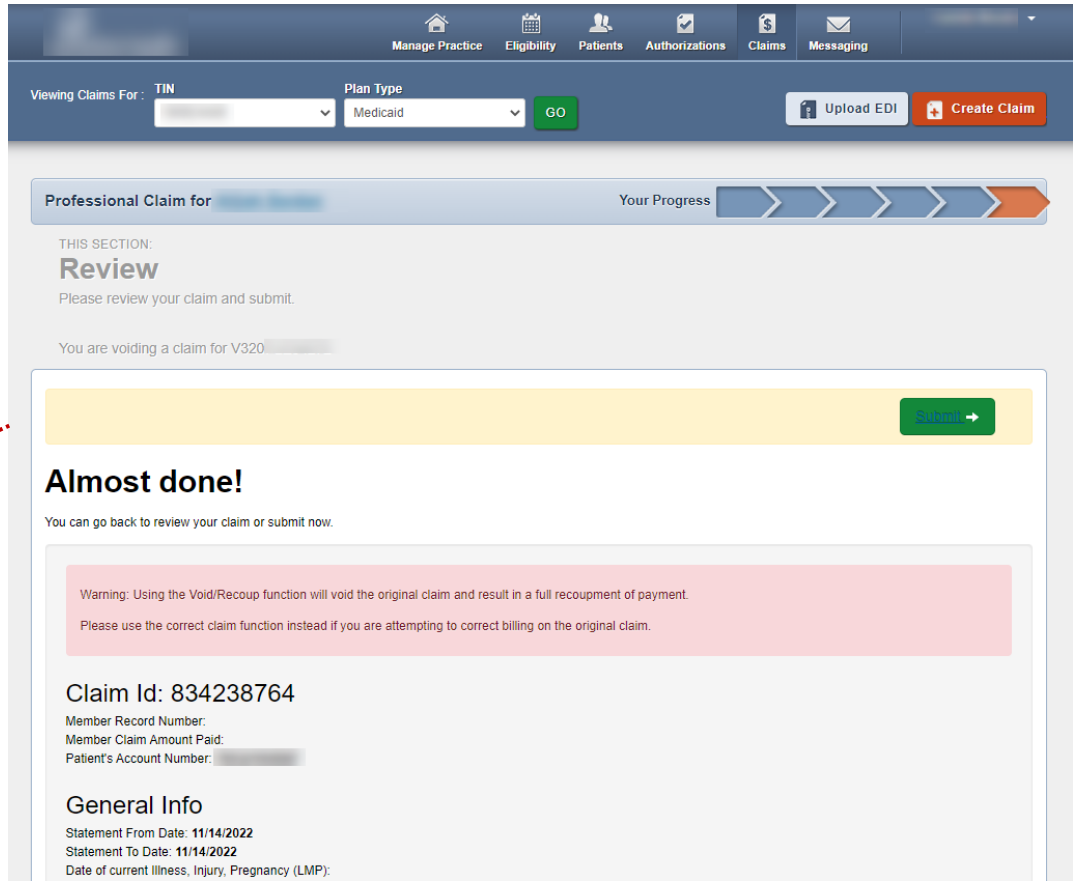
Where available, click + **Void/Recoup** to request to void claim, and full recoupment of payment, if applicable.



Claim Details – Claim Action Buttons: + Void/Recoup Workflow

Click **+Void/Recoup** to submit void/recoup claim request

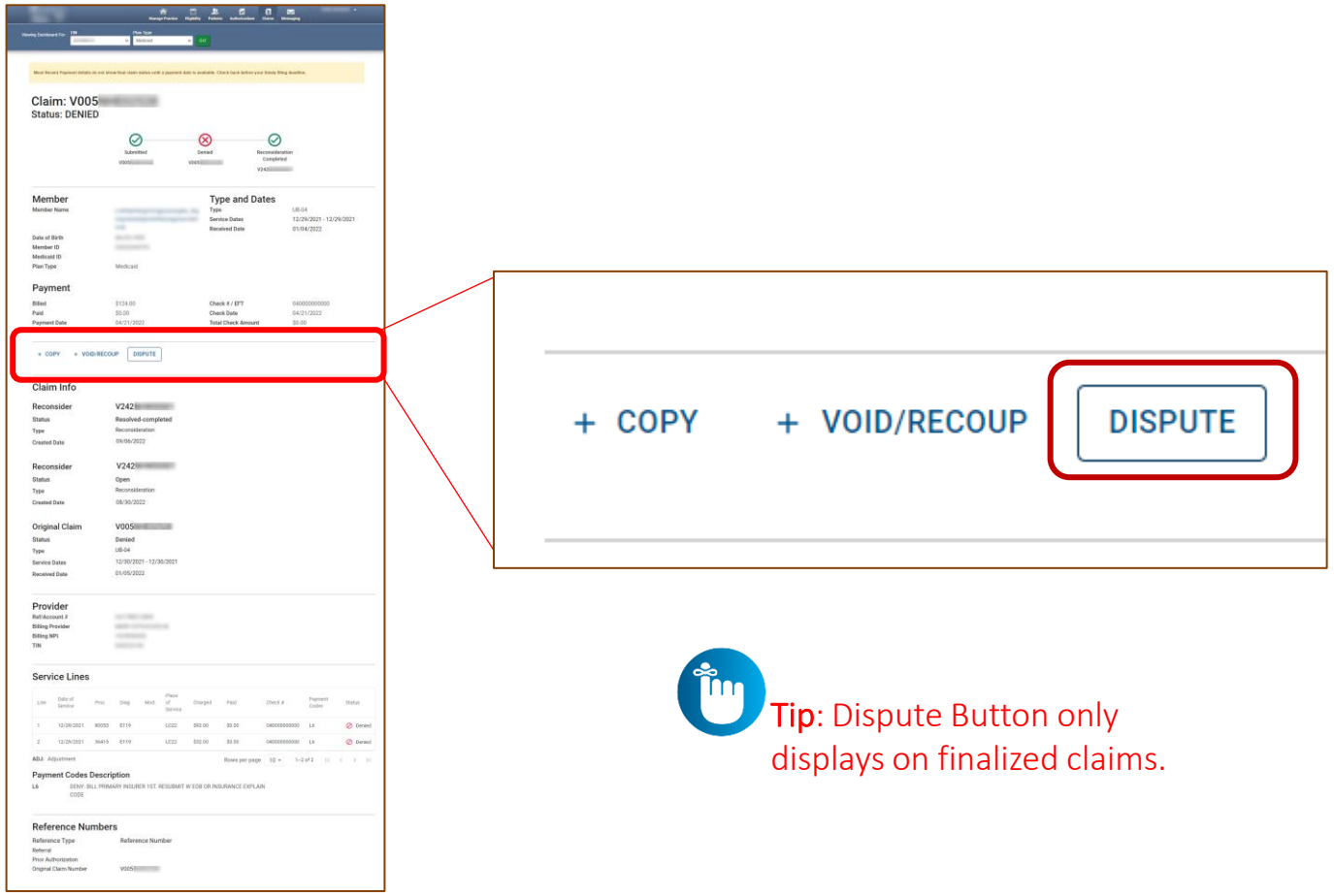




Claim Details – Claim Action Buttons: Dispute

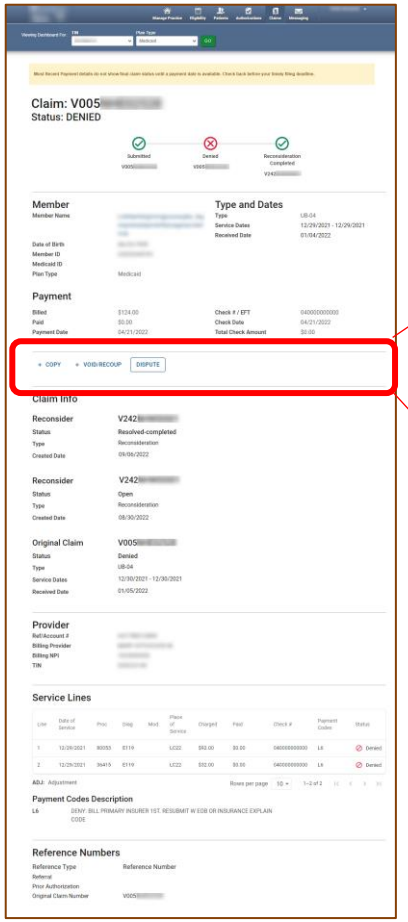
The Dispute button only displays on finalized claims (i.e., Paid, Denied, etc.).

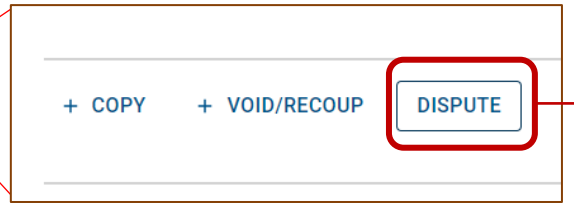
When applicable, click **Dispute** to view options.

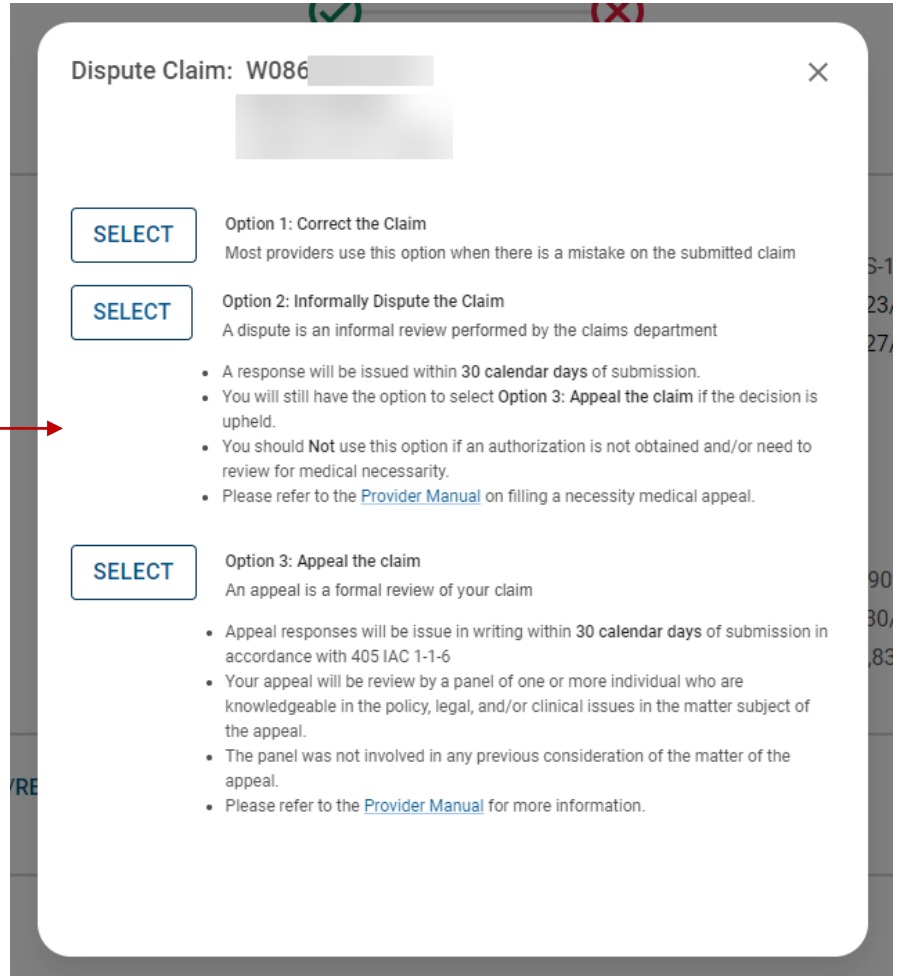


Tip: Dispute Button only displays on finalized claims.

Claim Details – Claim Action Buttons: Dispute, continued





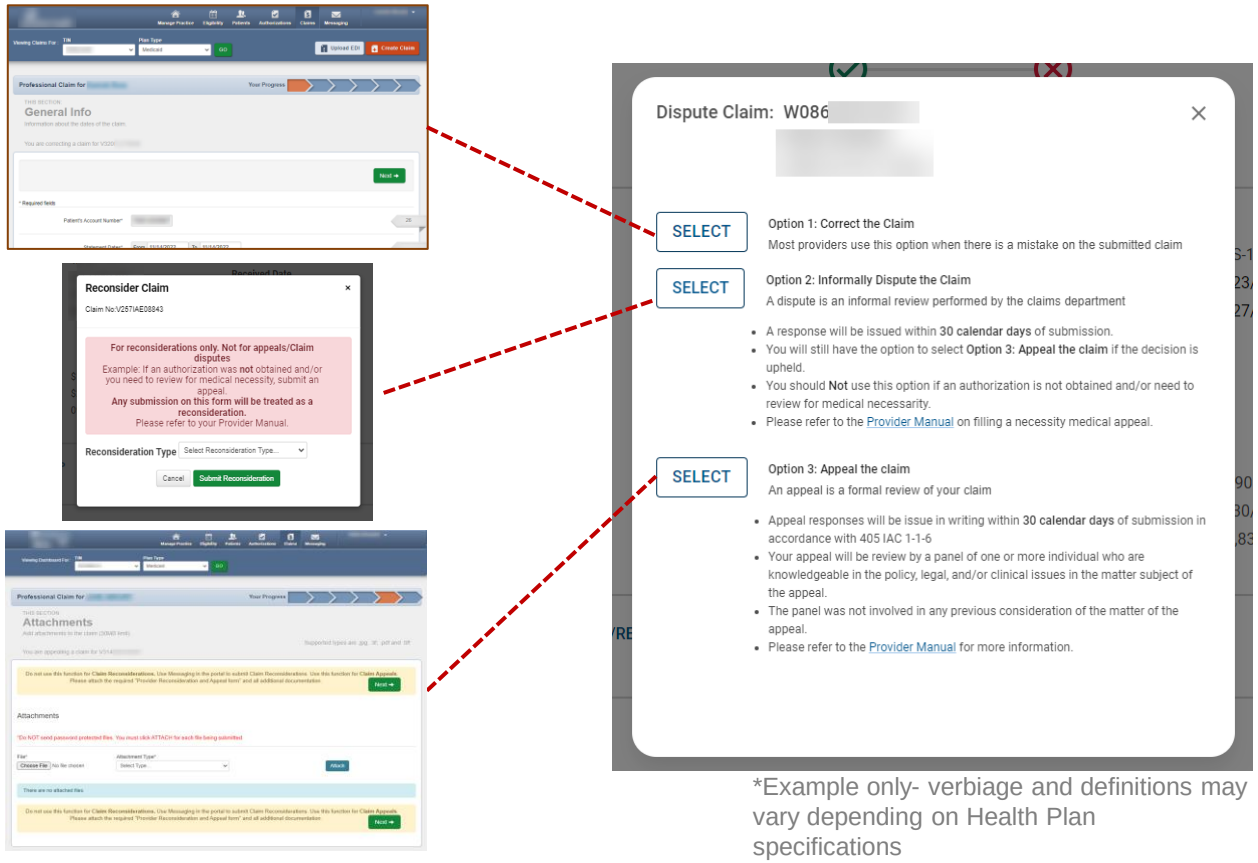


Tip: Follow onscreen instructions.

*Example only- verbiage and definitions may vary depending on Health Plan specifications

Claim Details – Claim Action Buttons: Dispute Workflows

When you click **Select**, if there are no errors, the applicable legacy screen displays.



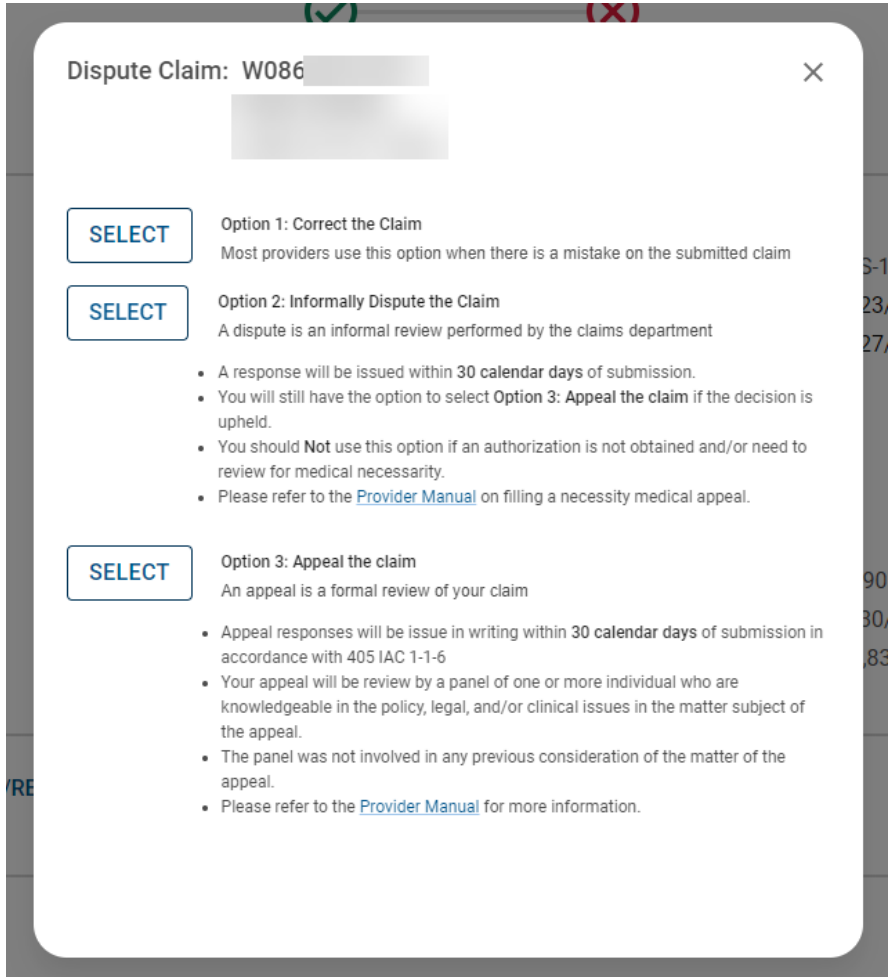
*Example only- verbiage and definitions may vary depending on Health Plan specifications

Tip: Dispute options may vary by Health Plan.

Claim Details – Claim Action Buttons: Dispute Claim Errors

When you click **Select**, and there is a dispute claim draft, the Claim Details page will display an error message, “This Claim has an Adjusted Claim that is not yet submitted.” To resolve:

1. Click **Claims** (at the top of any page). The Claims Dashboard displays.
2. Click **Draft Claims**. The Draft Claims Status Page displays. On the Draft Claims page, a Claim Number in the Original Claim Number column identifies correct, reconsider, claim drafts, and where available, void/recoup and/or appeal claim drafts.
3. Locate the claim, and click:
   a) **Pencil icon**, to resume claim, complete and submit, or
   b) **Trashcan icon** to delete claim draft.

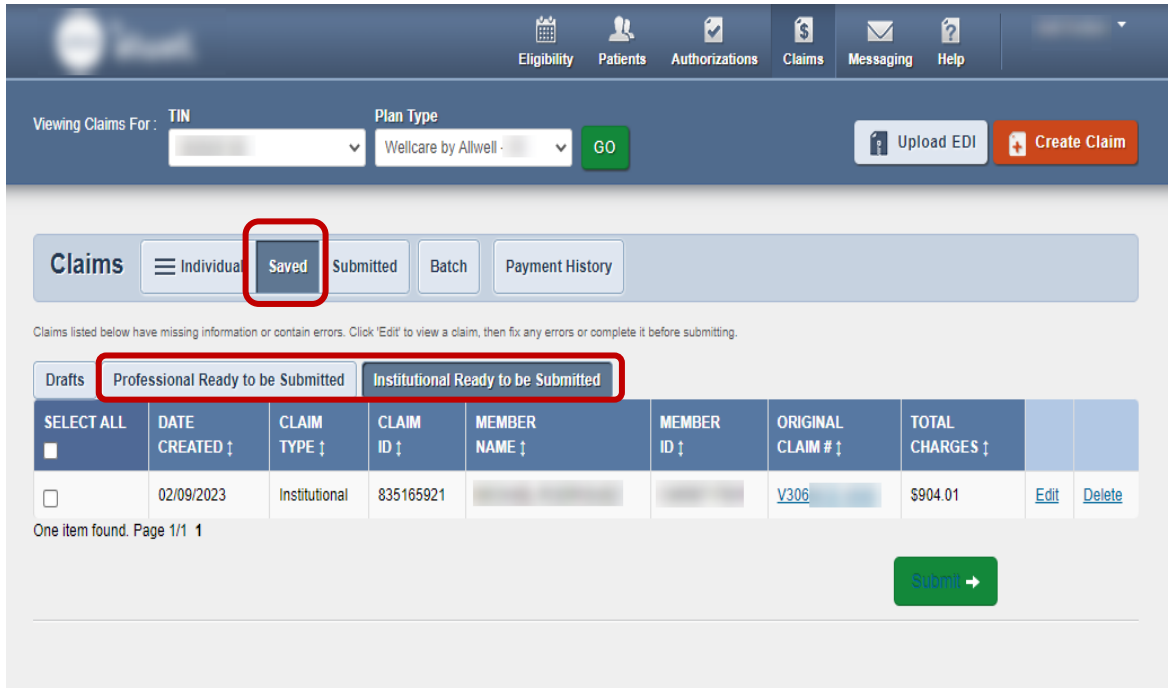


*Example only- verbiage and definitions may vary depending on Health Plan specifications

Claim Details – Claim Action Buttons: Dispute Claim Errors, continued

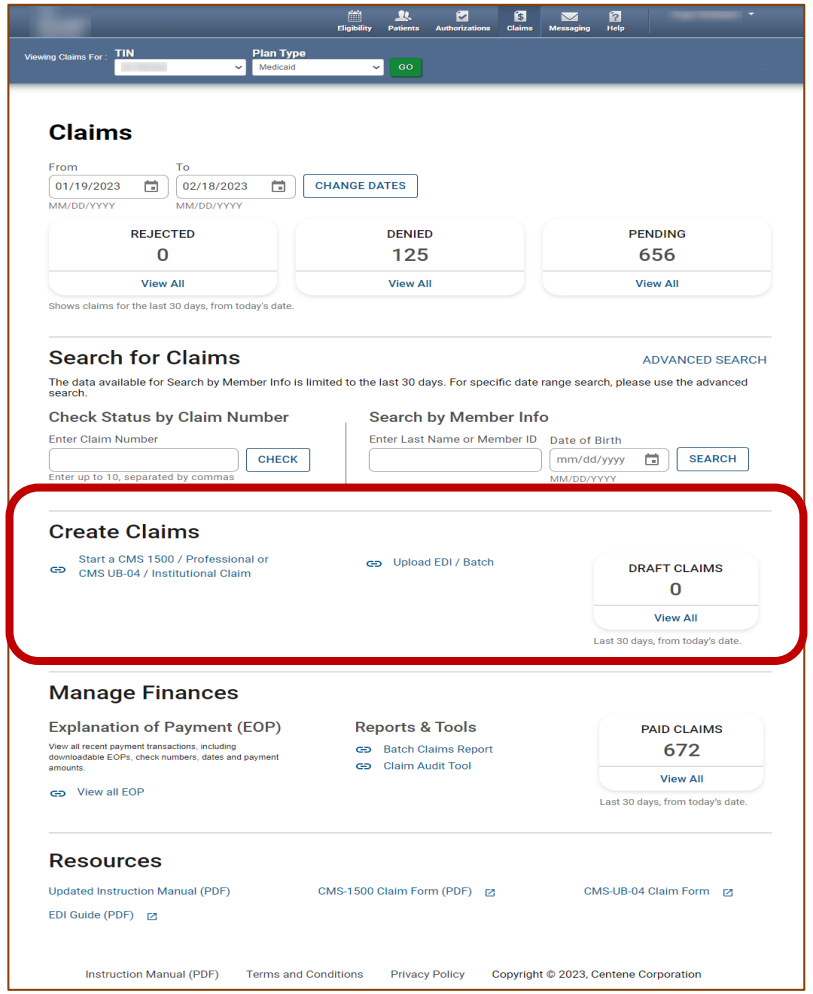
When a disputed web claim is exited from the **Review** page, without a submission, the claim draft is only accessible on the legacy **Professional Ready to be Submitted** or **Institutional Ready to be Submitted** tab. To access/resolve:

1. Click **Claims** (at the top of any page). The Claims Dashboard displays.
2. Under Manage Finances, click **View all EOPs**. The legacy Payment History [tab] displays.
3. Click Saved. The Saved tab displays.
4. Based on the claim draft, click Professional Ready to be Submitted or Institutional Ready to be Submitted.
5. Locate claim draft with the Claim Number (being disputed) in the Original Claim Number column.
6. Click:
   a) **Edit**, to resume claim, complete and submit, or
   b) **Delete** to delete claim draft.



Create Claim

Create Claim

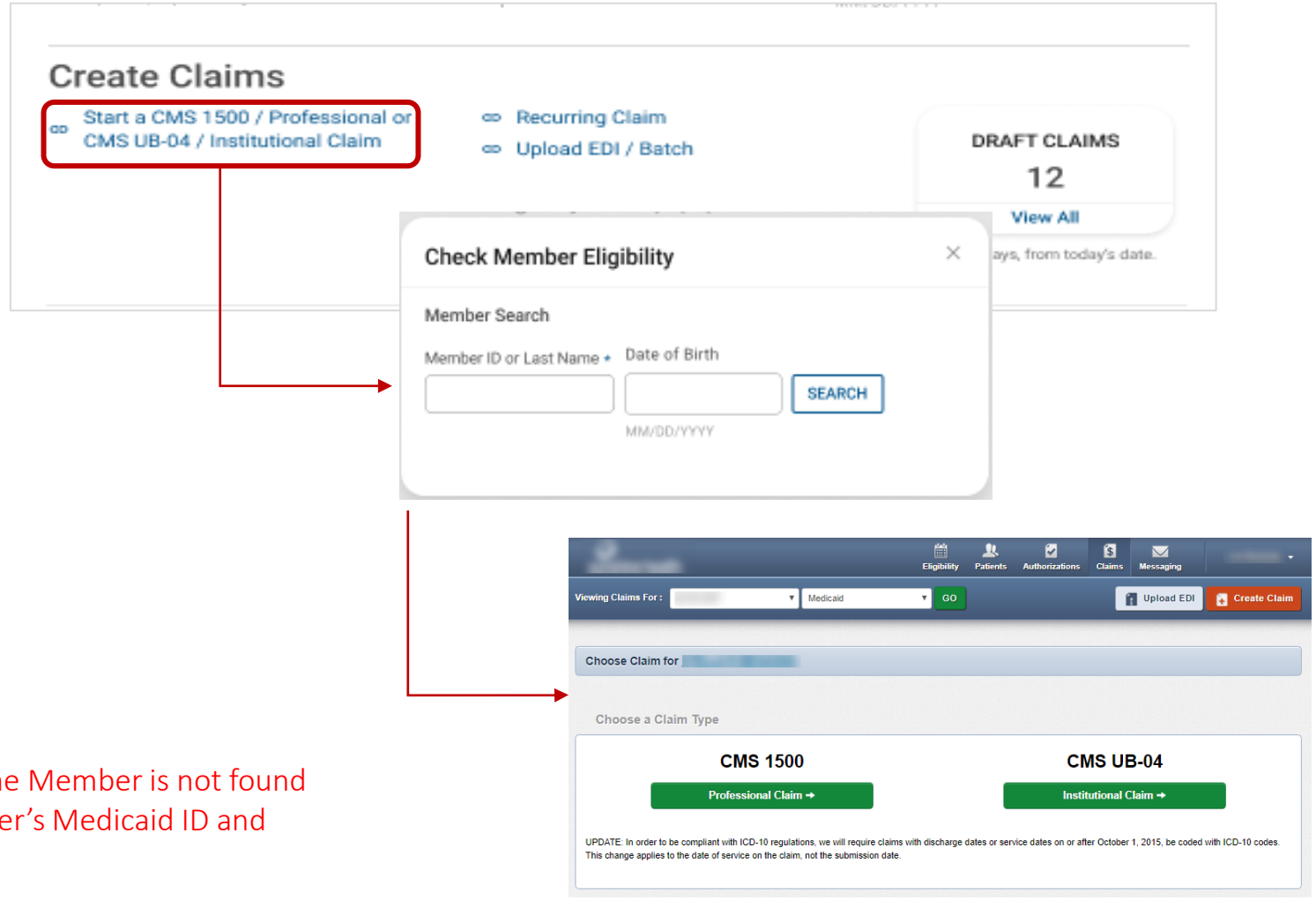


- On the Claims Dashboard, web claim creation options grouped in Create Claims section.
- Create Claim button replaced with a link and renamed, Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim.
- Recurring Claim link (*where available*), directs to legacy recurring claim creation page.
- Upload EDI button replaced with a link and renamed, Upload EDI / Batch.

Create Claim – Individual Web Claim

To begin an individual web claim:

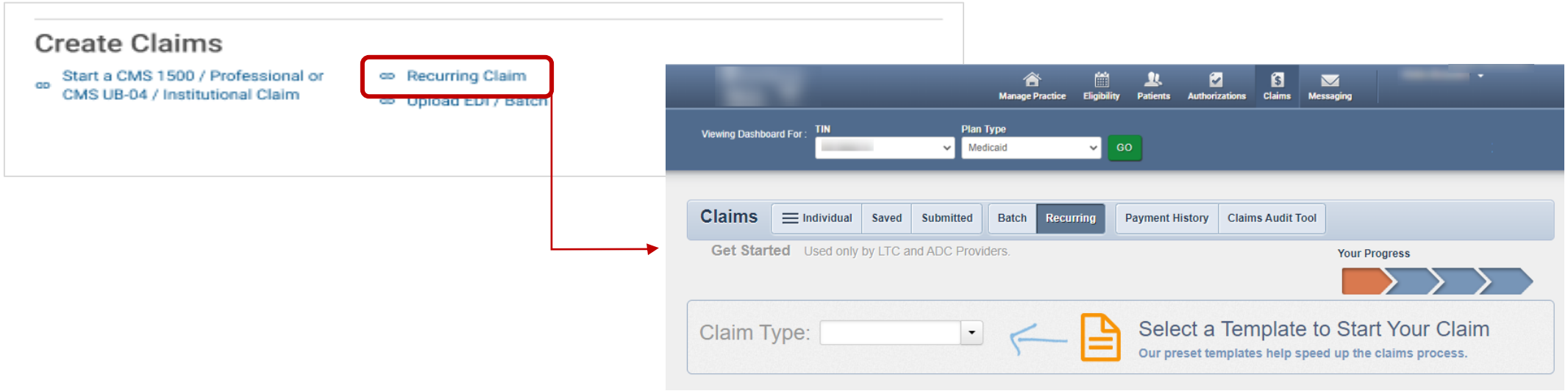
- Click **Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim.** The Check Member Eligibility pop-up displays.
- Enter **Member ID or Last Name**.
- Enter Member's **Date of Birth** (DOB).
- Click **Search**. If the Member is found, the legacy Choose Claim Type page displays.
- Click **Professional Claim** or **Institutional Claim**.



Tip: In the Check Member Eligibility pop-up, if the Member is not found by Member Last Name and DOB, use the Member's Medicaid ID and DOB.

Create Claim – Recurring Claim

Where available, to begin a Recurring Claim, click **Recurring Claim.** The legacy Recurring, Get Started page displays.



Create Claim – Upload EDI / Batch

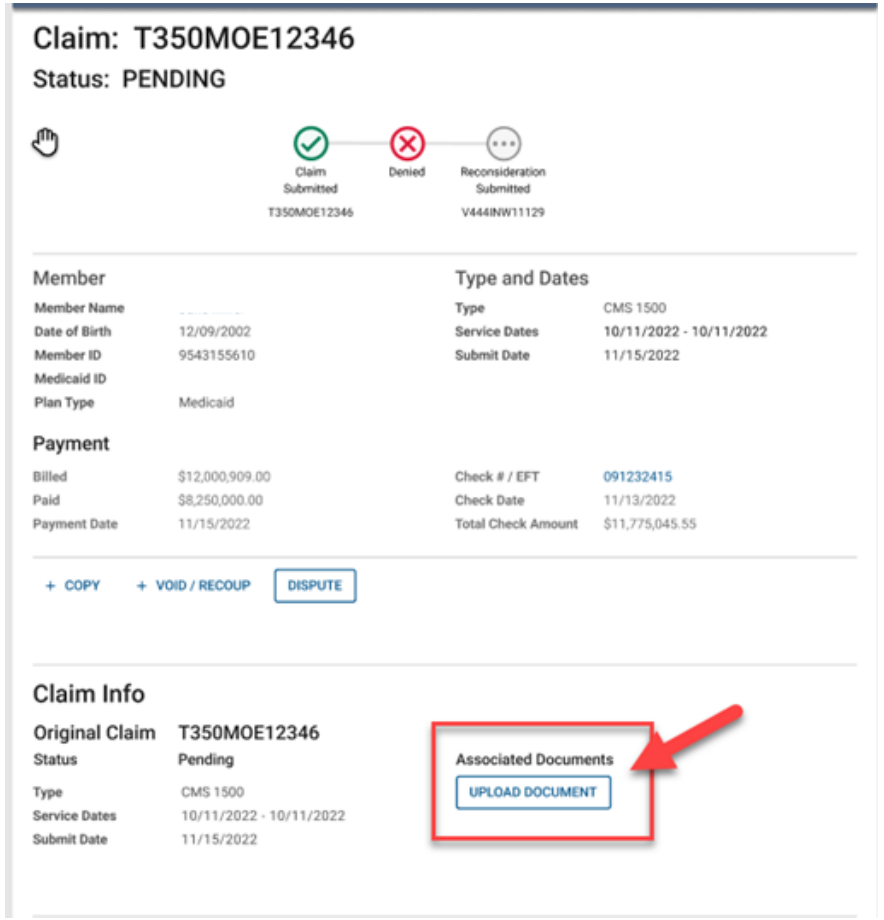
Click **Upload EDI / Batch** to upload an EDI Batch (837I / 837P). The legacy Batch Claims Upload page displays. Follow onscreen instructions.

Tip: Provider organization must have software to create HIPAA-compliant EDI Batch files.

Submitting Attachments to Pending Claims

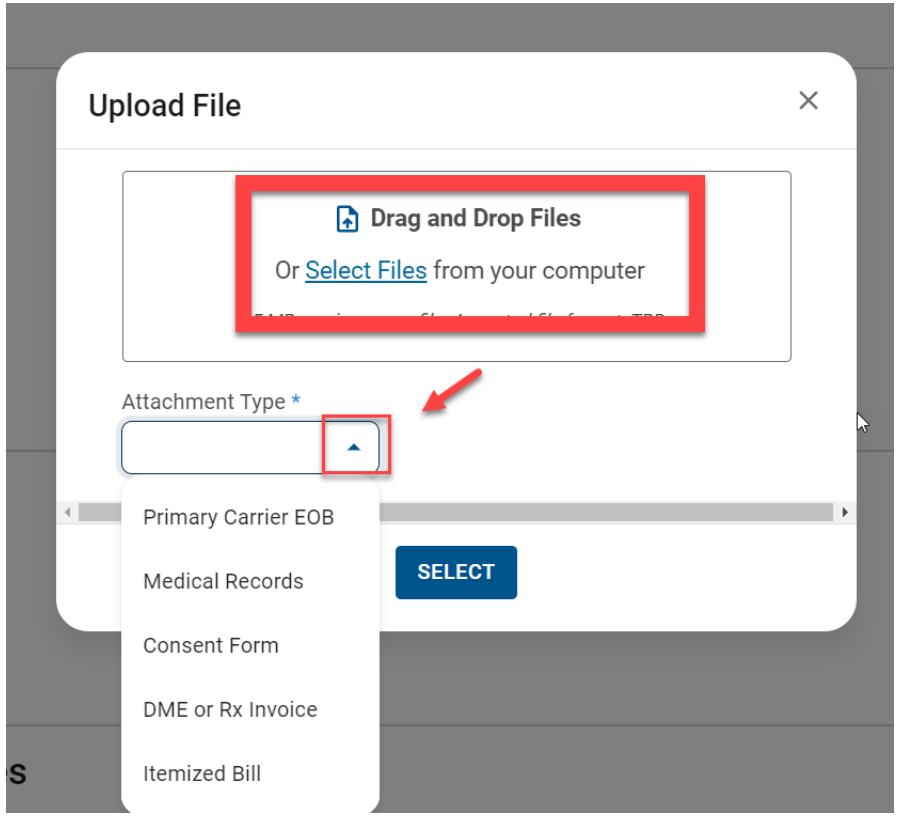
Claims Attachment (post claims submission)

Step 1: Locate the claim on the Claims Status Page
Step 2: Navigate to the Pending claim details and select upload document



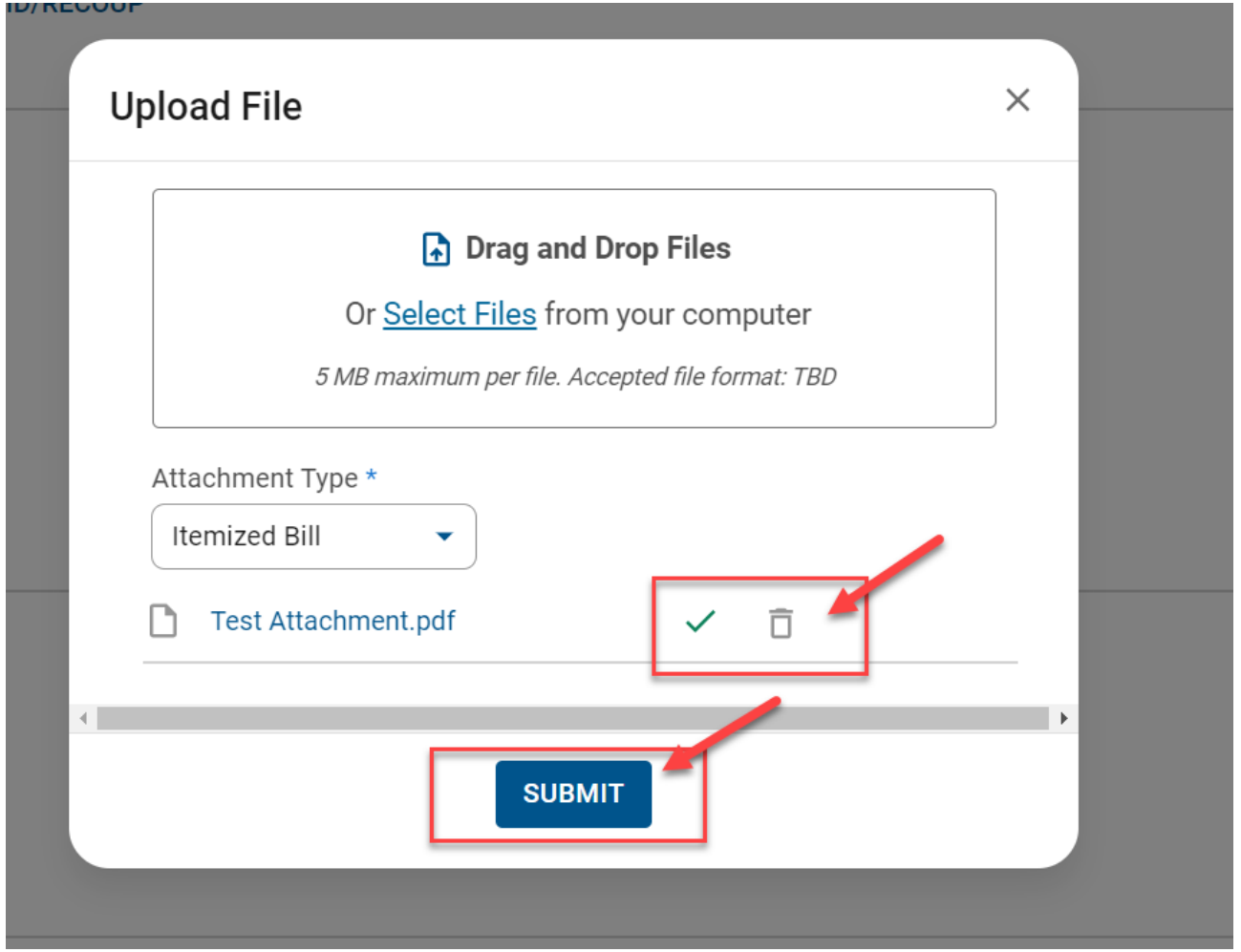
Claims Attachment (post claims submission)

Step 3: Add documents via drag and drop or by selecting a file.



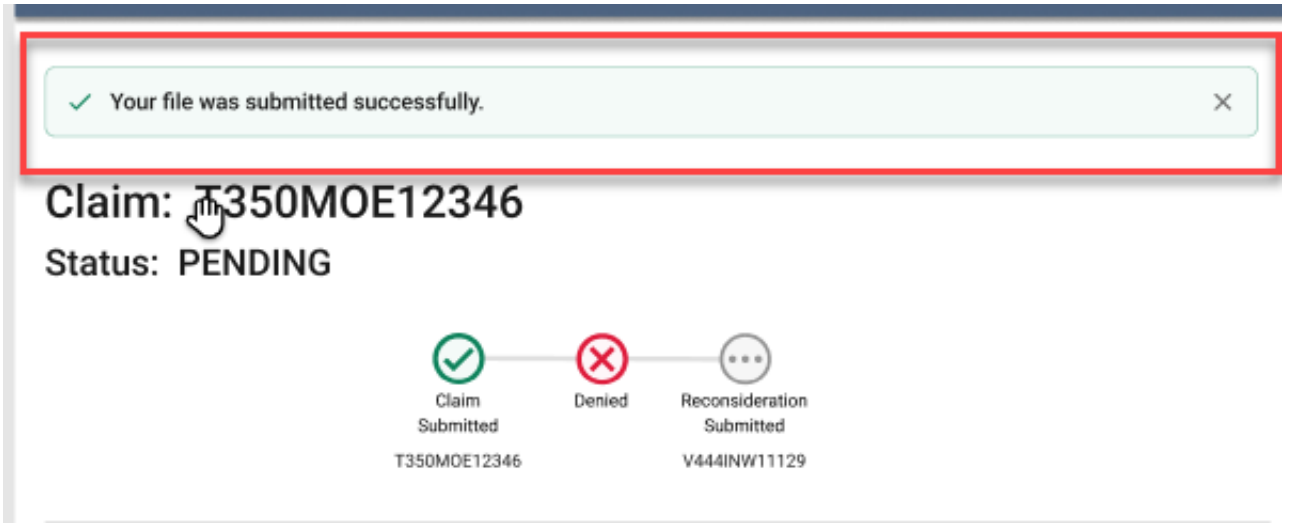
Claims Attachment (post claims submission)

Step 4: Use trash can to delete upload if needed or click submit.



Claims Attachment (post claims submission)

Step 5: Confirmation appears at the top of the screen; document is immediately available to see.



Portal Functionality:
Claim Tips

Claims – Submission Tips

- Always check the member's eligibility before submitting a claim
  - If a member is ineligible, claims can be submitted for DOS the member was eligible
- Hover mouse over tabs in the right margin for field-level help on web claims
- To submit a secondary web claim you must complete the Add Coordination of Benefits section on the Diagnosis Codes page and the Primary Insurance fields on the Service Lines page
- On the Service Lines page, always click Save/Update when creating or editing service line(s)
- NPI and Taxonomy should be entered on every claim, except some Atypical Providers
- Portal users can attach up to five (5) separate documents to their web claim submissions (first-time and corrected claims)

Claims – Submission Tips (Continued)

- Organizations that upload EDI Batches (i.e. 837P / 837I) via the portal, must monitor the **Claims → Batch** for EDI response reports (i.e. 999, Audit File, etc.)
- Regardless of submission method, all claims go through the EDI claims process, and are:
  - Accepted and loaded for adjudication, **or**
  - Rejected and will not be processed any further (i.e. front-end EDI rejection)
- Once a web claim goes through the EDI process, the claim number will display on the **Claims → Submitted**, under the Claim Number column (4th column from the left)
  - If the web claim was accepted, use the Claim # to track status on the Individual tab

Claims – Tracking / Status Tips

- Voided claims will not display in the portal
- When looking up a claim, the From Date must be on or before the first date of service (DOS) in the claim
- Portal users can access up to 24 months (from the current date) of claims history using the Filter buttons to change the date range
    - Date range is limited to one-month (at a time)

Claims – Date Range Criteria Tips

- The Date Range criteria varies by Claims tab:
  - **Individual** tab is by Date of Service
  - **Submitted** tab is by Date Submitted
  - **Batch** is by Submitted Date
  - **Payment History** is by Check Date

Benefits of Portal Utilization

- Portal available 24/7
- Cost savings, portal free to submit claims and authorizations
- Better management of patient's care, i.e. care gaps
- Efficiency of electronic authorizations and claim submissions
- Ability to view both patient and provider history/data
- Ability to correct claims

ADVANCED MEDICAL HOMES

Additional Portal Features

Portal Functionality:
PMPM Payment Reports

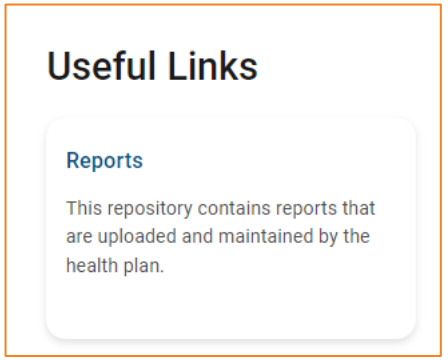
Portal Functionality:
PMPM Payment Reports

Portal Home Page – Reports

On the Home Screen, under the ‘Useful Links’ dashboard, click ‘Reports’.

View our How-to Guide for accessing Payment Reports for more information

The types of Capitation Reports found in this module have two different document endings .xlsx and .txt. For details on converting the .TXT file into an excel file that can be sorted and analyzed, view our how-to guide

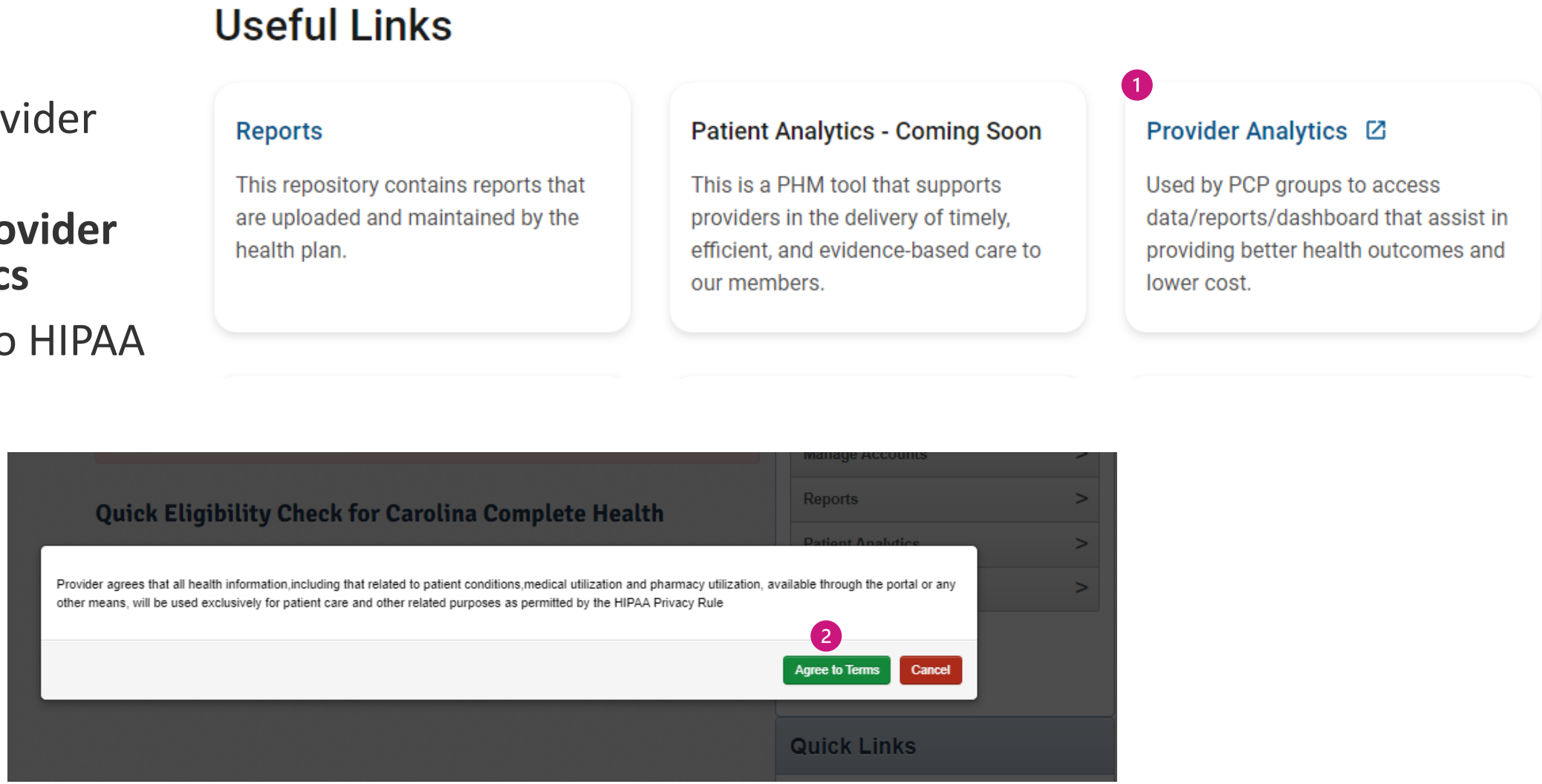


Portal Functionality: Provider Analytics

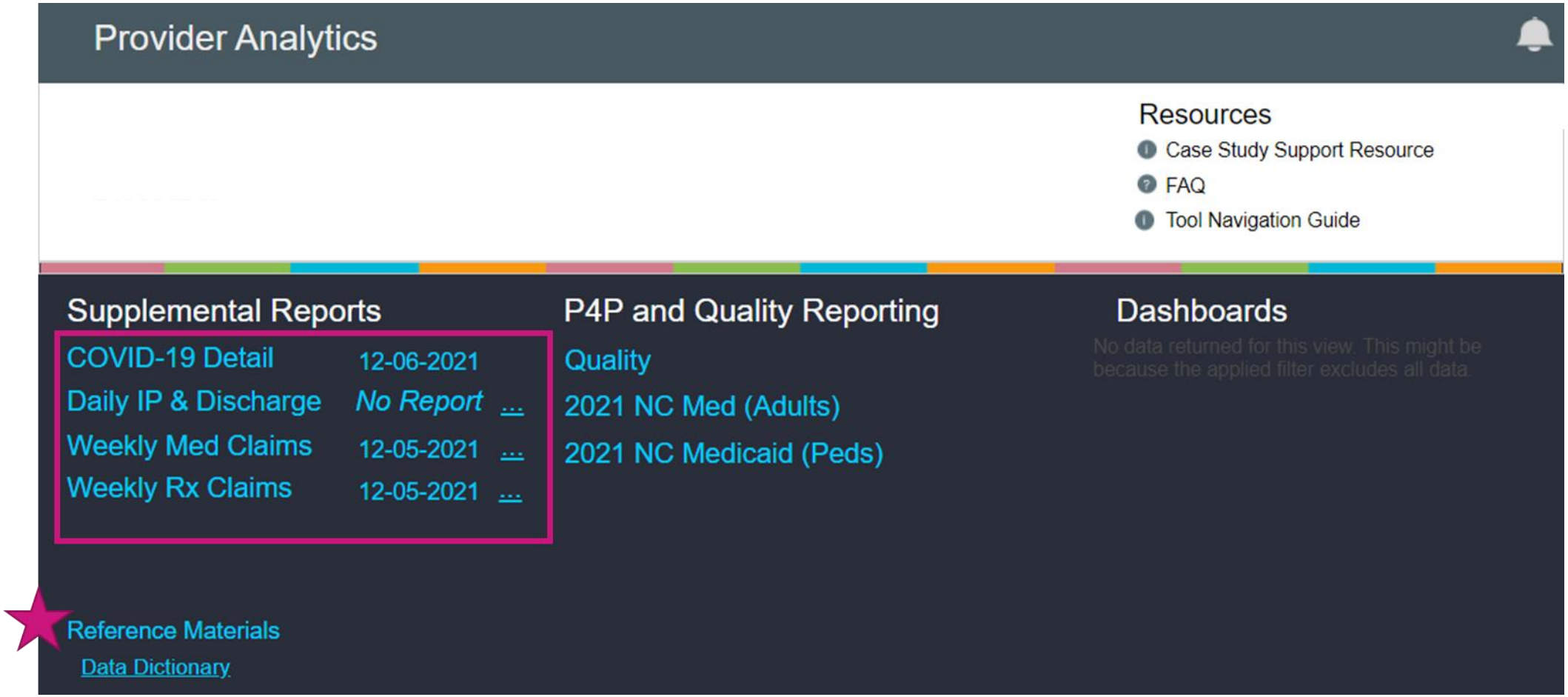
Provider Analytics

To view Provider Analytics

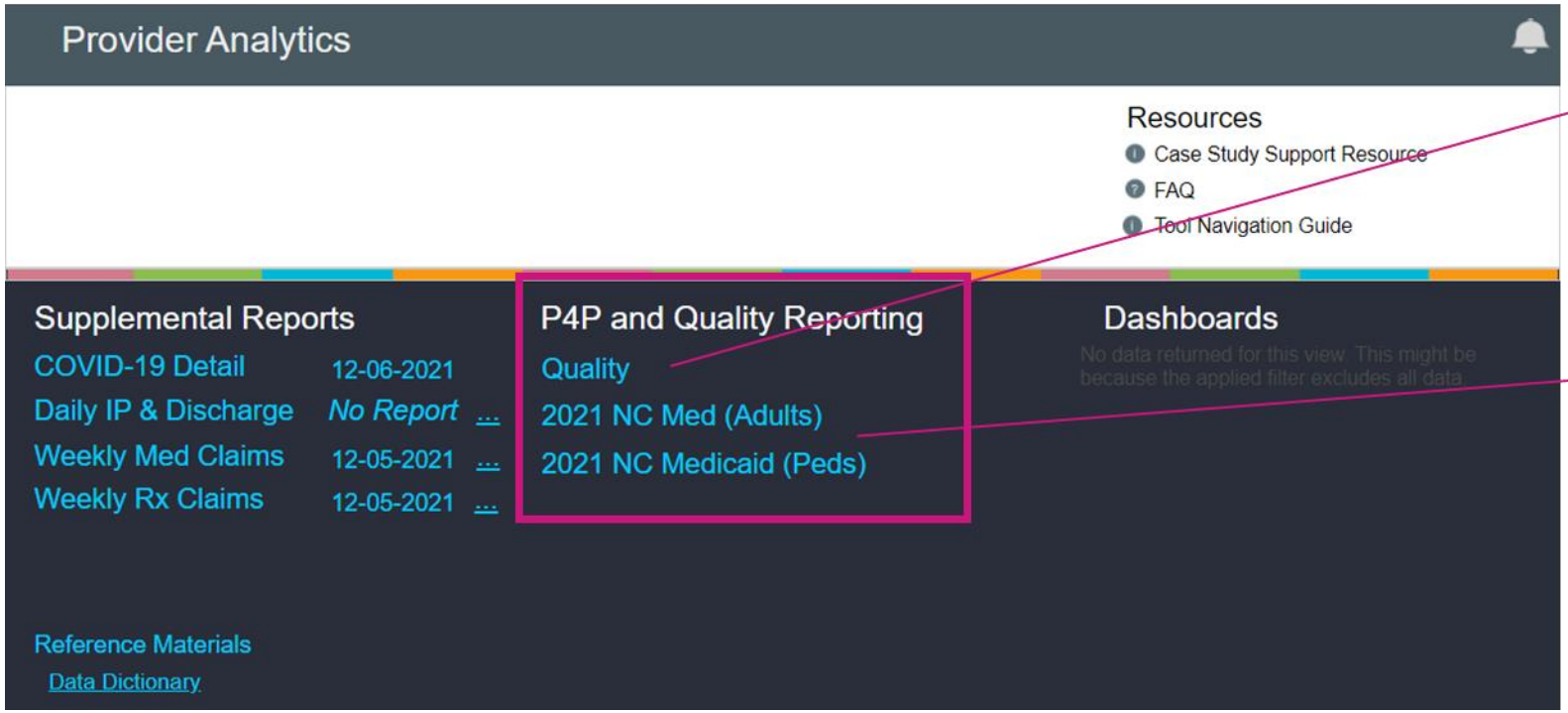
1. Click **Provider Analytics**
2. **Agree** to HIPAA terms



Supplemental Reports



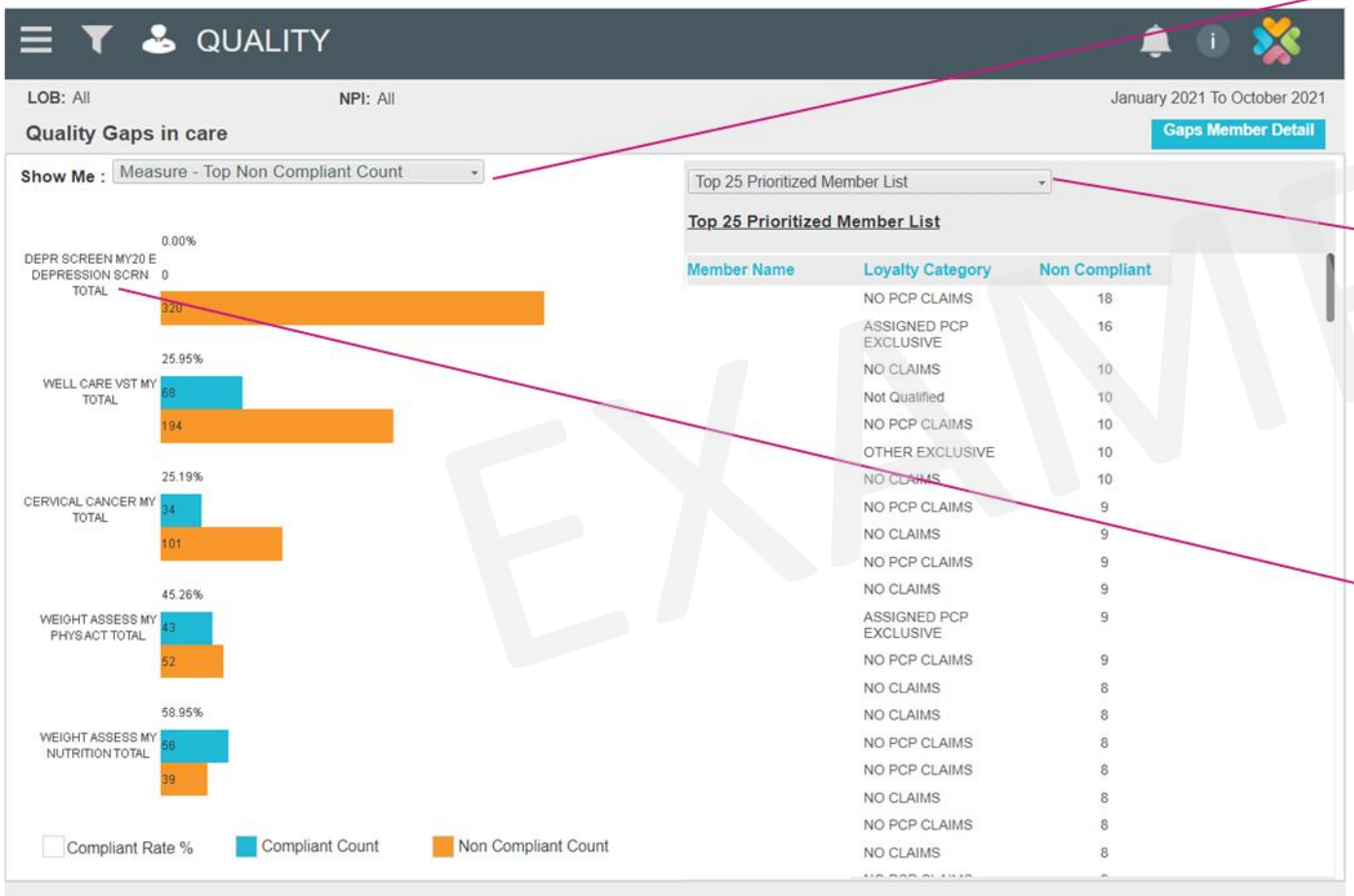
P4P and Quality Reporting

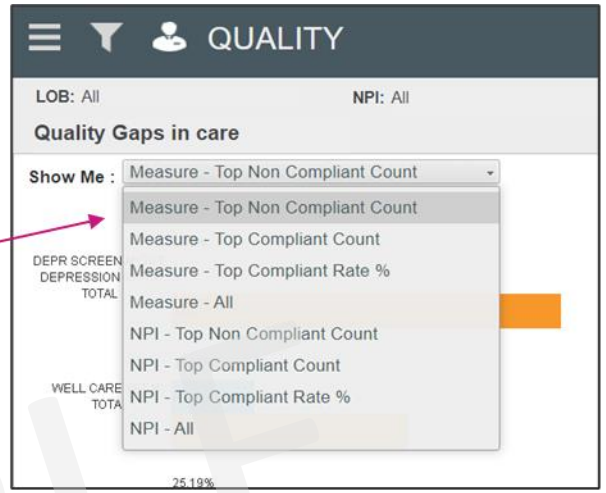


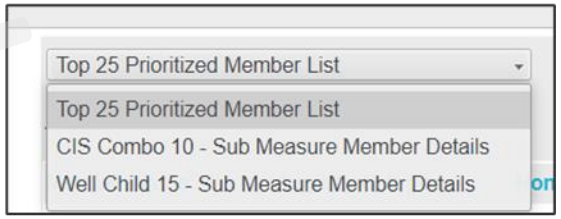
Quality: All AMHs have Quality care gap and measure report available that includes all priority measures.

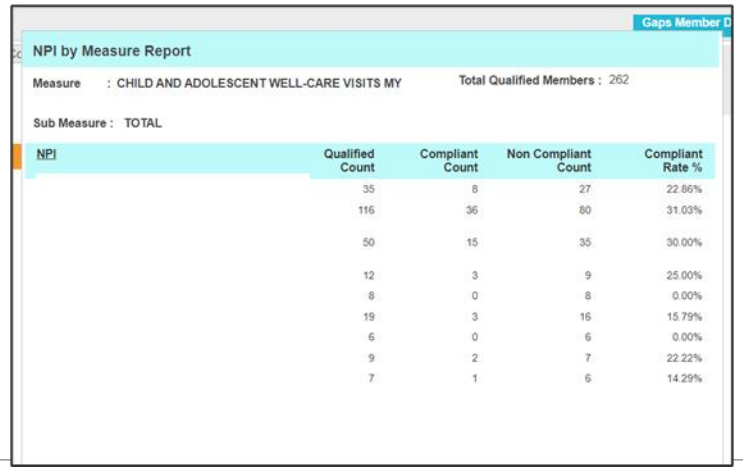
P4P: All AMHs have a standard P4P available except those within practice entities that are involved in a broad value-based payment arrangement.

Quality Measures

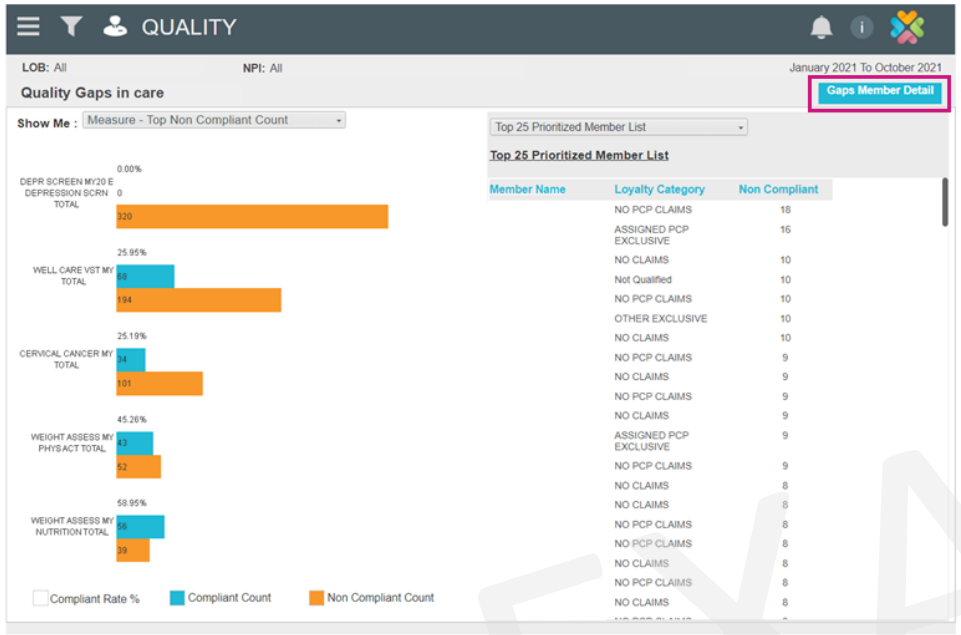








Quality Gaps- Member Detail



Portal Functionality: Pay-for-Performance Scorecards

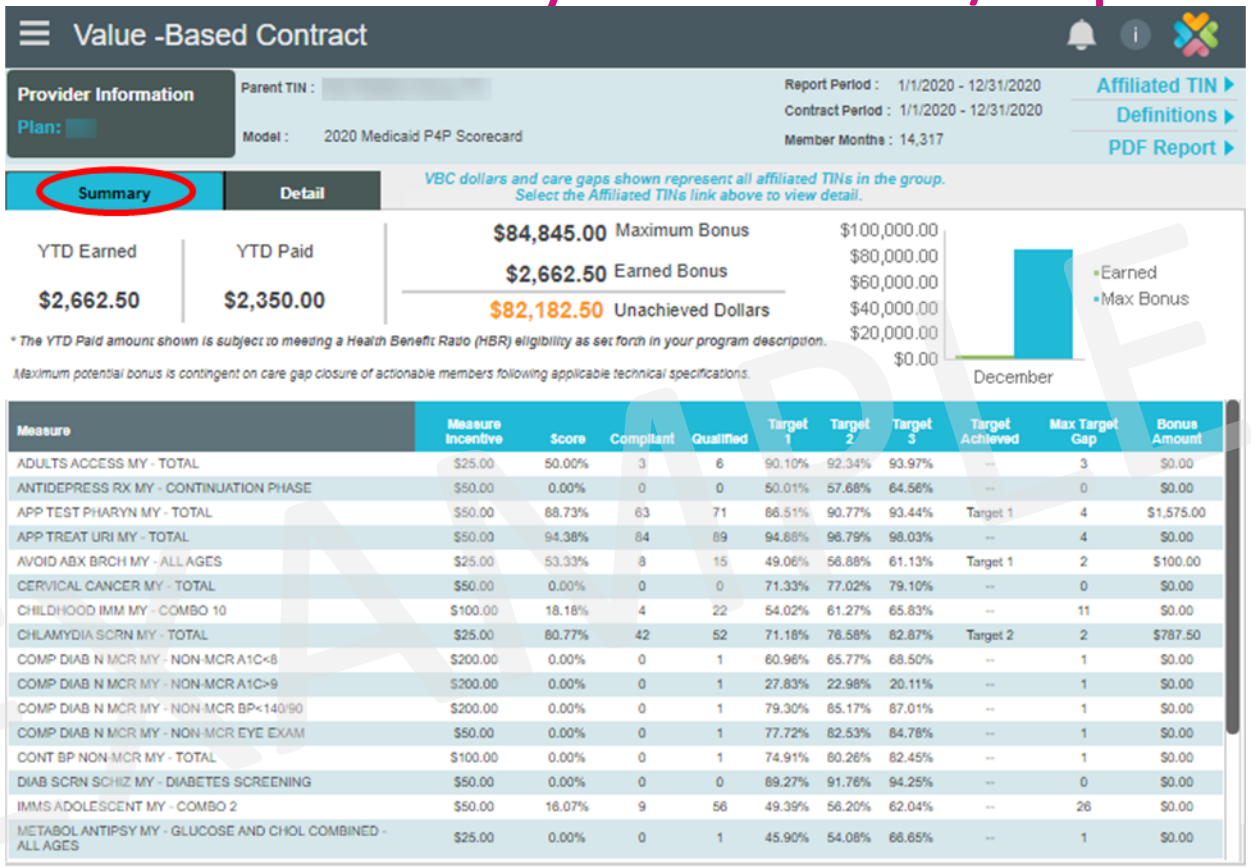
Value-Based Contract – Summary Scorecards/Reports

P4P and Quality Reporting

Quality

2021 NC Med (Adults)

2021 NC Medicaid (Peds)

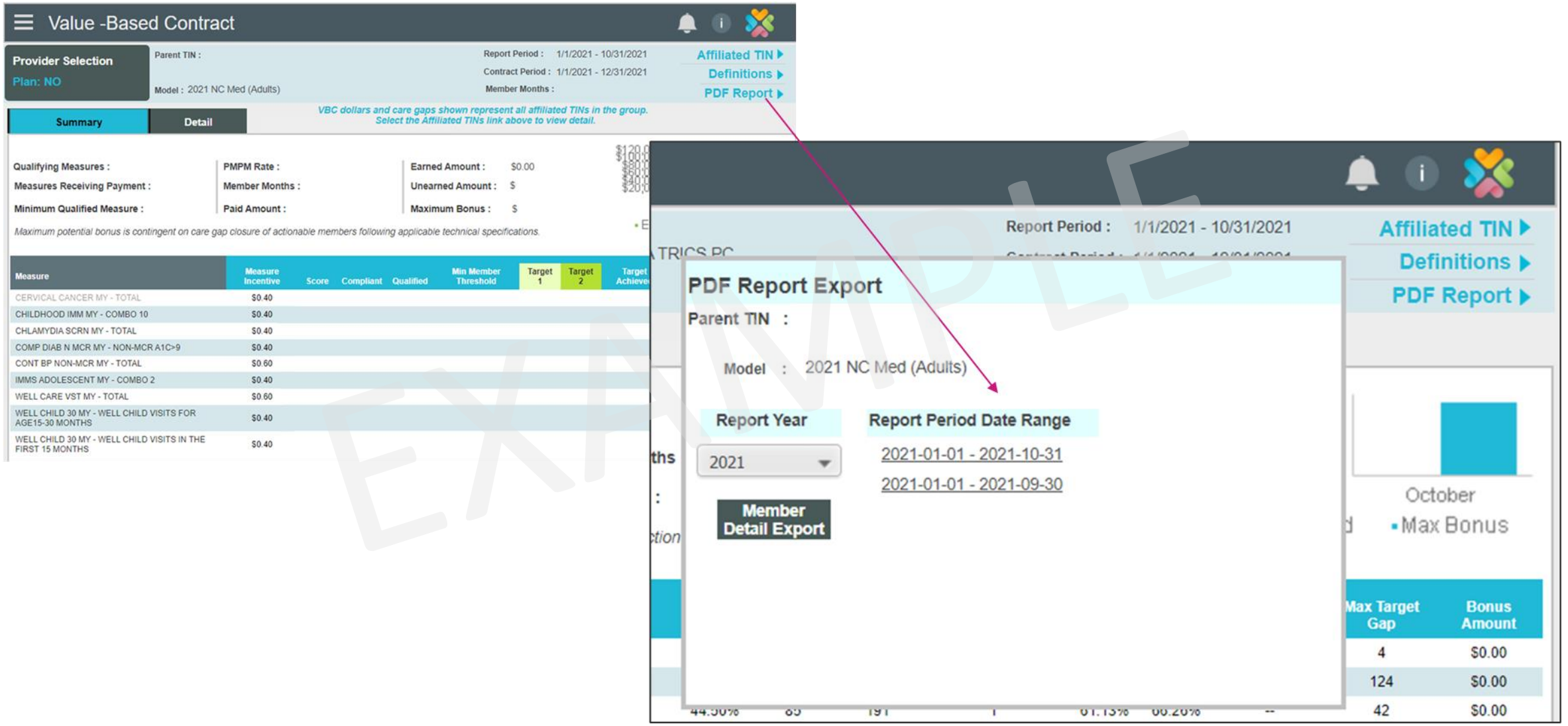


Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target 3	Target Achieved	Max Target Gap	Bonus Amount
ADULTS ACCESS MY - TOTAL	$25.00	50.00%	3	6	90.10%	92.34%	93.97%	--	3	$0.00
ANTIDEPRESS RX MY - CONTINUATION PHASE	$50.00	0.00%	0	0	50.01%	57.68%	64.56%	--	0	$0.00
APP TEST PHARYN MY - TOTAL	$50.00	88.73%	63	71	86.51%	90.77%	93.44%	Target 1	4	$1,575.00
APP TREAT URI MY - TOTAL	$50.00	94.38%	84	89	94.88%	96.79%	98.03%	--	4	$0.00
AVOID ABX BRCH MY - ALL AGES	$25.00	53.33%	8	15	49.06%	56.88%	61.13%	Target 1	2	$100.00
CERVICAL CANCER MY - TOTAL	$50.00	0.00%	0	0	71.33%	77.02%	79.10%	--	0	$0.00
CHILDHOOD IMM MY - COMBO 10	$100.00	18.18%	4	22	54.02%	61.27%	65.83%	--	11	$0.00
CHLAMYDIA SCRN MY - TOTAL	$25.00	80.77%	42	52	71.18%	76.58%	82.87%	Target 2	2	$787.50
COMP DIAB N MCR MY - NON-MCR A1C<8	$200.00	0.00%	0	1	60.96%	65.77%	68.50%	--	1	$0.00
COMP DIAB N MCR MY - NON-MCR A1C>9	$200.00	0.00%	0	1	27.83%	22.98%	20.11%	--	1	$0.00
COMP DIAB N MCR MY - NON-MCR BP<140/90	$200.00	0.00%	0	1	79.30%	85.17%	87.01%	--	1	$0.00
COMP DIAB N MCR MY - NON-MCR EYE EXAM	$50.00	0.00%	0	1	77.72%	82.53%	84.78%	--	1	$0.00
CONT BP NON-MCR MY - TOTAL	$100.00	0.00%	0	1	74.91%	80.26%	82.45%	--	1	$0.00
DIAB SCRN SCHIZ MY - DIABETES SCREENING	$50.00	0.00%	0	0	89.27%	91.76%	94.25%	--	0	$0.00
IMMS ADOLESCENT MY - COMBO 2	$50.00	16.07%	9	56	49.39%	56.20%	62.04%	--	26	$0.00
METABOL ANTIPSY MY - GLUCOSE AND CHOL COMBINED - ALL AGES	$25.00	0.00%	0	1	45.90%	54.08%	66.65%	--	1	$0.00

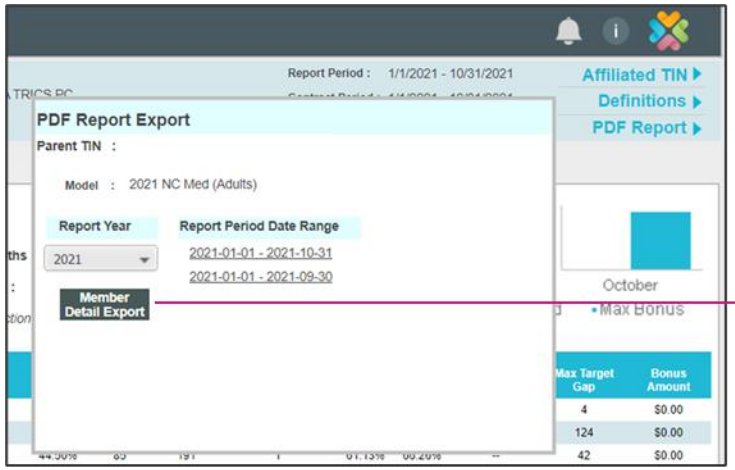
- Sub Measure = HEDIS measures in P4P
- Maximum Incentive = Payout for each compliant event
- Score = Compliant/Qualified (also known as rate)
- Targets = set by plan to earn payout
- Target Achieved = current performance
- Max Target Gap = # of additional compliant events needed to get to the highest target (max payout)
- Bonus Amount = earned through report date

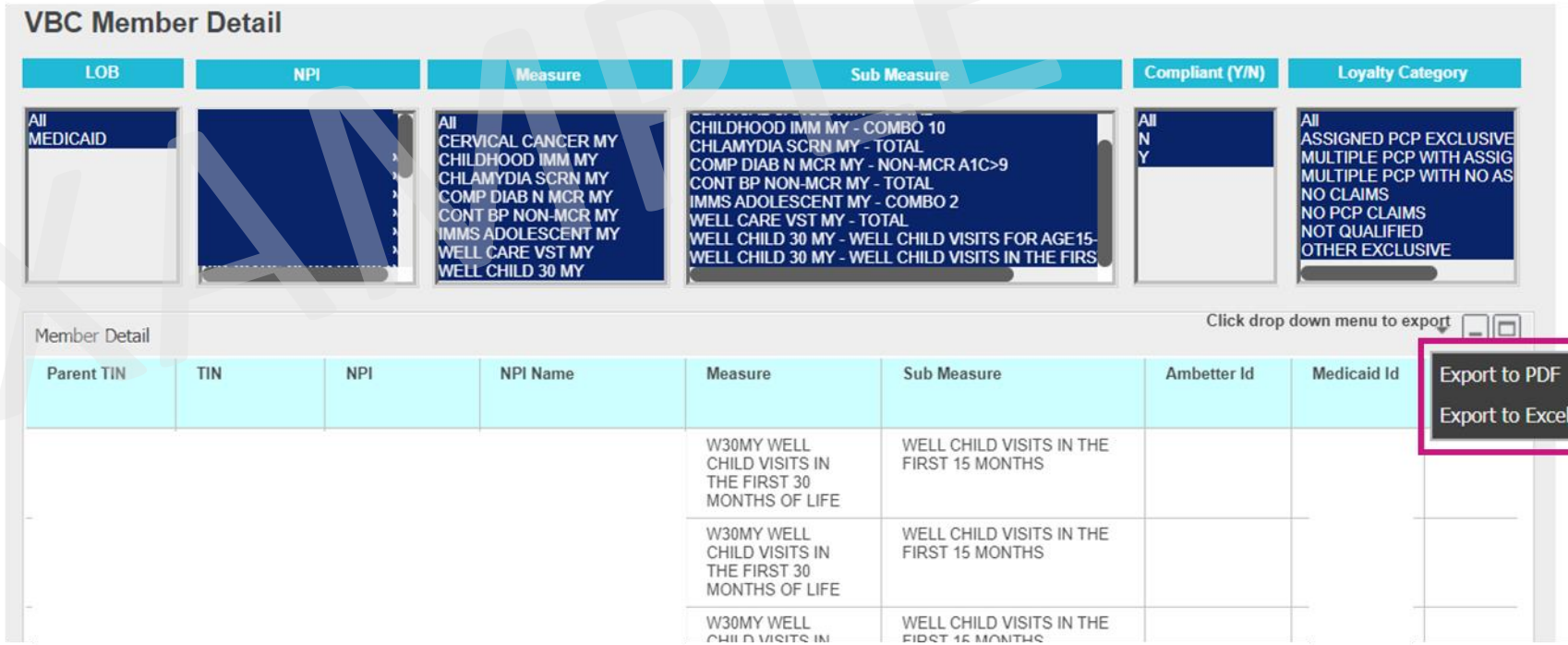
NOTE: *This is a summary report you can scroll through the measures and sort the columns but there is no drill down capabilities. For a hard copy to go the "PDF Report". For drill down capabilities go to the "Detail" tab*

P4P Scorecard



P4P Gaps- Member Detail





Thank you!