



Partners In Performance

Focusing Professional Encounters — Capturing the Visit

August 27, 2019

*Coverage for
every stage of life™*

Agenda

A light teal horizontal bar with rounded ends, containing the text 'Housekeeping'.

Housekeeping

A dark teal horizontal bar with rounded ends, containing the text 'Encounters Overview'.

Encounters Overview

A dark teal horizontal bar with rounded ends, containing the text 'Encounters Process'.

Encounters Process

A dark teal horizontal bar with rounded ends, containing the text 'Performance Reports'.

Performance Reports

A dark teal horizontal bar with rounded ends, containing the text 'Best Practices'.

Best Practices

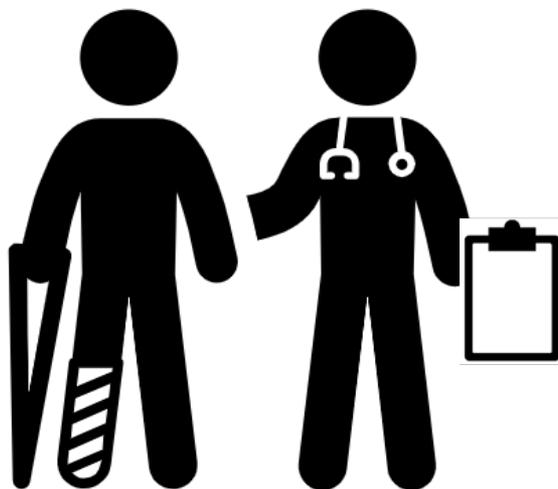
A dark teal horizontal bar with rounded ends, containing the text 'Q&A'.

Q&A



What is an Encounter?

Visit



Procedures (CPT)





How is an Encounter different than a claim?

Encounter = Capitated



Rate
\$\$\$
per member

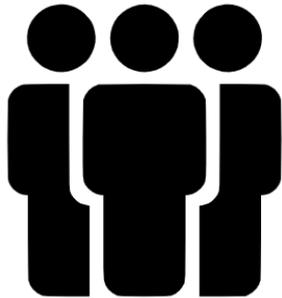
Claim = Fee-for-Service



Fee
\$\$\$
per service



Why are Encounters important?



Track Health Services Given to Our Members



Regulatory Reporting Requirement



HEDIS & STARS Performance Rating



What are the different types of Encounters?

Professional



Institutional



Encounter Type	CPT Codes	Examples
Evaluation & Management	99201–99499	99201 – Outpatient Visit for New Patients (10 mins)
Laboratory & Pathology	80000–89999	80050 – General Health Panel (Metabolic Panel and Blood Count)
Radiology	70000–79999	77053 – Mammography
Other	All other codes	97542 – Wheelchair

Knowledge Review

What is an encounter? Select the best answer

- Outpatient Visit
- Service Line
- Procedure
- Patient-Physician Visit
- All of the above



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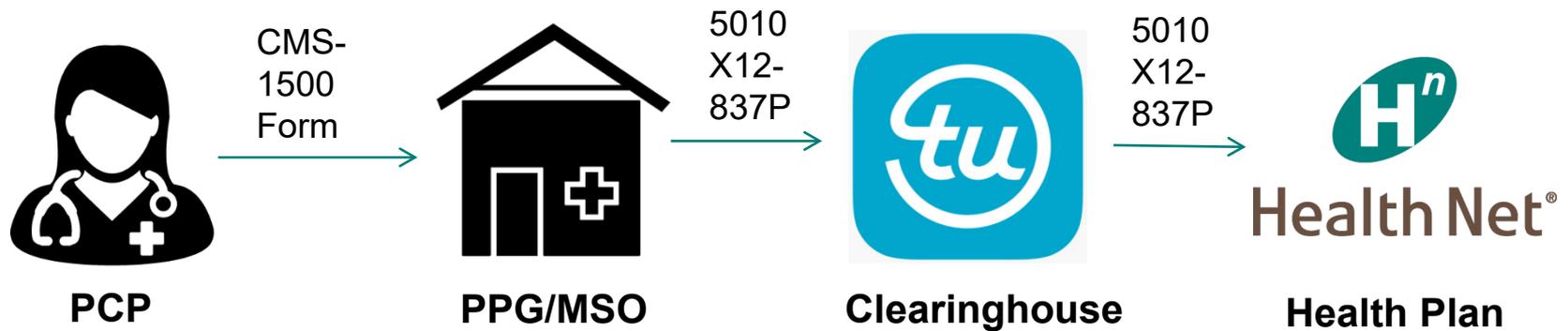
Best Practices

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Q&A



How are professional encounters sent to Health Net?





How can you tell if all the necessary data fields are being sent in the encounter data file?



WEDI SNIP Level Validation :

Health Net Validates up to SNIP Partial Level 5

1. **EDI Syntax Integrity**** *Header, segment, loop and file structure information is present*
2. **HIPAA Implementation Guide Requirement**** *Qualifiers or segments required by HIPAA*
3. **HIPAA Balance** *Example is that line amount must add up to billed amount*
4. **HIPAA Inter-Segment Situation** *If A occurs B must occur, example if address present, zip must be included*
5. **HIPAA External Code Set** *Validates diagnosis and procedure codes*

*Hard Edits

Front-end EFT File Level Edits

EDI Team SNIP Level II

Plan Specific Edits *e.g. submitter ID, Member eligibility, duplicate, void, adjustment and replacement logic, Medicare allowed amount & patient responsibility.*





What are common errors for rejecting an encounter and how do I correct an encounter that was rejected based on edits?



See Appendix C-D for screenshot of TU's Claims Dashboard that lists rejections

Error Code	Error Description	Correction Guidance
1459	HEALTH CARE DIAGNOSIS CODE(S) (XXXXX) IS INVALID. MUST BE A VALID DIAGNOSIS CODE FOR THE DATE ON WHICH THE SERVICE WAS PERFORMED	Provide the valid diagnosis and procedure code for the date of service, which can be obtained from CPT book or coding software
3529	PROCEDURE CODE (XXXX) IS INVALID. MUST BE A VALID PROCEDURE CODE FOR THE DATE OF SERVICE	
PDMB/001	(R) MEMBER NOT FOUND	Ensure member name is spelled correctly and exactly as displayed in the eligibility sent by HN

Note: If submitter does not utilize the portal as a means of correction, than submitter should correct and/or modify encounter data in the provider's internal system and resubmit.



What is Health Net's duplicate logic?



Professional Encounter Duplicate Logic

1. Member
2. Provider (*Billing provider or Rendering provider*)
3. Date of service
4. Procedure code
5. Modifier 1-4
6. Frequency code
7. Check / Processed date

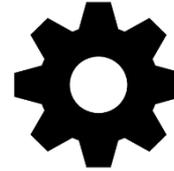
Error Code	Error Description	Correction Guidance
PLDU/006	(R) INTERNAL DUP FIRST RECORD	Submit the procedure on a separate encounter OR submit the encounter with a modifier: 59, 76, or 77*
PLDU/007	(R) INTERNAL DUP SUBSEQUENT RECORD	
PLDU/008	(R) INTERNAL DUP LAST RECORD	



Can I modify encounters that have been accepted?



Diagnosis Codes
(Up to 12!)



Procedure Codes!
(Up to 50!)

2 Step Process

1. Frequency code 7 (replacement) must be sent in the CLM segment
2. Ensure processing date in the DTP*573 segment is greater than the original DTP*573 date

Note: If ClearIQ is not used then submitter needs to make these changes on their internal 837 file to be submitted to TU

Knowledge Review

What are the three most common encounter errors? Select all that apply

- Invalid diagnosis code
- Member not found
- Paid amount blank
- Invalid procedure code
- Member not eligible for beginning service date



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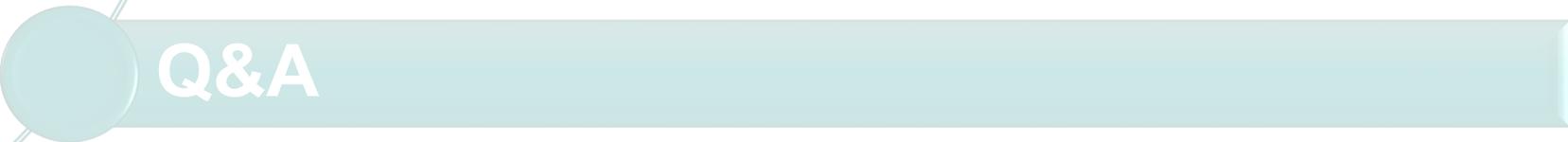
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Q&A



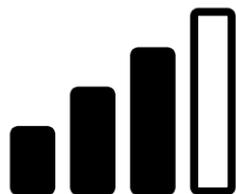
What are Key Performance Indicators for Encounters?



Rejection Rate

Definition: percentage of total encounters that are denied

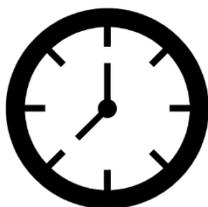
Performance Standard: < 5%



Volume

Definition: the number of service lines (CPT codes) rendered as Per Member Per Month (PMPM)

Performance Standard: ≥ 75th peer percentile



Timeliness

Definition: the number of days starting from the DOS to when the encounter was received by Health Net

Performance Standard: 75% within 75 days



Daily Encounter Batch Reports

KPI: Volume and Rejects

Health Net, Inc - DAILY Encounter Batch Reports

Submitter: FHC00000123

ENC122

Health Net - Balancing Summary Report (by Submitter id)

Run Date: 20190617

		<---PRE EDIT--->		<---MCAL SPLIT--->		<---ABS EDIT--->	
	DL	COUNTS	AMOUNT	COUNT	AMOUNT	COUNT	AMOUNT
TOTAL FOR JULIAN DATE = 2019168	DOC	1,433	1,744,253.79	0	0.00	1,433	1,744,253.79
TOTAL FOR SUBMITTER ID = FHC00000123	LINE	4,310	1,744,253.79	0	0.00	4,310	1,744,253.79

ENC420PS

Health Net Professional Reject Summary Report

Submitter Name: PPG A

SUBID: FHC00000123

Julian Date: 2019168

Error Code	Error Description	Error Count
PDMB/001	(R)MEMBER NOT FOUND	17
PDSE/001	(S)PAT PAID AMT BLANK/MISMATCH	1
PLDU/001	(R)DUP-SAME MBR, PRV, DT, PROC, M1-M4	13
PLDU/008	(R)INTERNAL DUP LAST RECORD	8
PLMB/001	(R)MBR NOT ELIG FOR BEG SERVICE DATE	5

Medi-Cal Professional Encounter Performance Status



KPI: Volume



MEDI-CAL PROFESSIONAL ENCOUNTER PERFORMANCE STATUS

TOTAL

ENCOUNTER RECEIPTS BY DATE OF SERVICE
ACCEPTED BY MAY 31 2019
All values in SERVICE LINES

RUN DATE:
6/18/2019

PEER RANKING

PMPY: **9.520**

A123 MEDICAL PROVIDERS GROUP

PARENT = A123 MEDICAL PROVIDERS GROUP
PROVIDER_IDS A123, B456, C789

	201901	201902	201903	201904	201905	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVG MBR MONTHS
2019 TTL MEMBERSHIP †	728	738	685	697	703	0	0	0	0	0	0	0	710
													ANNUALIZED
TOTAL													-PMPY-
ACCEPTED Encounters	793	588	618	556	262	-	-	-	-	-	-	-	563
BENCHMARK Encounters	1,124	1,022	992	874	576	-	-	-	-	-	-	-	918
ACCEPTED PMPM	1.089	0.797	0.902	0.798	0.373								9.520
BENCHMARK PMPM	1.544	1.385	1.448	1.254	0.819								15.480
% BENCHMARK	71%	58%	62%	64%	46%								61%
E & M CODES													
ACCEPTED Encounters	212	199	210	184	148	-	-	-	-	-	-	-	191
BENCHMARK Encounters	284	269	253	220	140	-	-	-	-	-	-	-	233
ACCEPTED PMPM	0.291	0.270	0.307	0.264	0.211								3.221
BENCHMARK PMPM	0.390	0.364	0.370	0.315	0.199								3.931
% BENCHMARK	75%	74%	83%	84%	106%								82%
LAB / PATHOLOGY													
ACCEPTED Encounters	360	206	163	188	7	-	-	-	-	-	-	-	185
BENCHMARK Encounters	414	356	357	318	211	-	-	-	-	-	-	-	331
ACCEPTED PMPM	0.495	0.279	0.238	0.270	0.010								3.123
BENCHMARK PMPM	0.569	0.483	0.521	0.456	0.300								5.590
% BENCHMARK	87%	58%	46%	59%	3%								56%
RADIOLOGY													
ACCEPTED Encounters	24	29	32	28	9	-	-	-	-	-	-	-	24
BENCHMARK Encounters	66	59	61	51	28	-	-	-	-	-	-	-	53
ACCEPTED PMPM	0.033	0.039	0.047	0.040	0.013								0.412
BENCHMARK PMPM	0.091	0.080	0.089	0.073	0.040								0.895
% BENCHMARK	36%	49%	52%	55%	32%								46%
OTHER													
ACCEPTED Encounters	197	154	213	156	98	-	-	-	-	-	-	-	164
BENCHMARK Encounters	384	359	327	301	196	-	-	-	-	-	-	-	314
ACCEPTED PMPM	0.271	0.209	0.311	0.224	0.139								2.764
BENCHMARK PMPM	0.528	0.487	0.478	0.432	0.279								5.290
% BENCHMARK	51%	43%	65%	52%	50%								52%

(Total accepted encounters ÷ total membership) × 12 (months) = PMPY

Medi-Cal Professional Encounter Performance Status

KPI: Timeliness



MEDI-CAL PROFESSIONAL ENCOUNTER PERFORMANCE STATUS

TIMELINESS

ENCOUNTER RECEIPTS
ACCEPTED BY MAY 31, 2019
by DATE of SERVICE

MEDICAL PROVIDERS GROUP % within 75 days: 98%

RUN DATE:
6/18/2019

A123 MEDICAL PROVIDERS GROUP
PROVIDER_IDS A123, B456, C789

2019	201901					201902					201903					201904					201905					AVG MBRs
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
MEMBERSHIP	728	738	685	697	703																				710	
ANNUALIZED																										563
% RECEIVED ENCOUNTER	793	588	618	556	262																				563	
RECEIVED 0 - 30 days of DoS	25%	30%	52%	49%	86%																				48%	
RECEIVED 0 - 60 days of DoS	76%	85%	91%	87%	100%																				88%	
RECEIVED 0 - 75 days of DoS	96%	97%	99%	100%																					98%	
RECEIVED 0 - 90 days of DoS	100%	100%	100%																						100%	
RECEIVED 0 - 120 days of DoS	100%	100%																							100%	
RECEIVED 0 - 150 days of DoS	100%																								100%	
RECEIVED 0 - 300 days of DoS																										
# RECEIVED ENCOUNTERS	793	588	618	556	262																				563	
RECEIVED 0 - 30 days of DoS	197	177	320	274	226																				239	
RECEIVED 0 - 60 days of DoS	599	501	563	481	262																				481	
RECEIVED 0 - 75 days of DoS	761	568	614	556																					625	
RECEIVED 0 - 90 days of DoS	790	588	618																						665	
RECEIVED 0 - 120 days of DoS	793	588																							691	
RECEIVED 0 - 150 days of DoS	793																								793	
RECEIVED 0 - 300 days of DoS																										
RECEIVED > 300 days of DoS																										

2018	201801					201802					201803					201804					201805					AVG MBRs
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC		
MEMBERSHIP	744	752	754	756	766	769	773	706	716	732	720	712													742	
ANNUALIZED																										568
% RECEIVED ENCOUNTER	565	560	603	484	574	396	661	521	537	853	478	581													568	
RECEIVED 0 - 30 days of DoS	45%	27%	51%	46%	38%	29%	22%	29%	19%	16%	34%	28%													32%	
RECEIVED 0 - 60 days of DoS	82%	88%	84%	71%	75%	70%	57%	73%	72%	56%	77%	62%													72%	
RECEIVED 0 - 75 days of DoS	96%	91%	90%	92%	94%	95%	85%	94%	89%	92%	87%	87%													91%	
RECEIVED 0 - 90 days of DoS	96%	94%	93%	98%	97%	96%	93%	96%	94%	95%	95%	98%													95%	
RECEIVED 0 - 120 days of DoS	97%	96%	94%	99%	97%	99%	94%	96%	94%	99%	99%	99%													97%	
RECEIVED 0 - 150 days of DoS	97%	99%	96%	99%	97%	100%	95%	97%	96%	99%	100%	100%													98%	
RECEIVED 0 - 300 days of DoS	100%	99%	99%	100%	97%	100%	100%	100%	100%	100%	100%	100%													100%	
RECEIVED > 300 days of DoS	0.4%	0.5%	0.8%	0.2%	2.6%	-	0.2%	-	-	-	-	-													0.78%	
# RECEIVED ENCOUNTERS	565	560	603	484	574	396	661	521	537	853	478	581													568	
RECEIVED 0 - 30 days of DoS	256	151	309	224	219	114	147	153	103	133	163	162													178	
RECEIVED 0 - 60 days of DoS	465	490	509	346	430	277	378	379	384	481	368	358													405	
RECEIVED 0 - 75 days of DoS	542	511	543	445	541	375	562	490	477	785	414	506													516	
RECEIVED 0 - 90 days of DoS	545	529	560	474	554	380	618	498	505	809	454	567													541	
RECEIVED 0 - 120 days of DoS	548	539	565	477	555	394	624	502	506	845	473	573													550	
RECEIVED 0 - 150 days of DoS	550	553	576	478	556	395	630	507	514	847	478	581													555	
RECEIVED 0 - 300 days of DoS	563	557	598	483	559	396	660	521	537	853	478	581													566	
RECEIVED > 300 days of DoS	2	3	5	1	15		1																		5	

(Total encounters received within 75 days of date of service) ÷ (Total received encounters) = (% of encounters received within 75 days of date of service)

Knowledge Review

What are Health Net's KPIs for encounter performance? Select all that apply

- Completeness
- Rejection Rate
- Volume
- Accuracy
- Timeliness



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Q&A



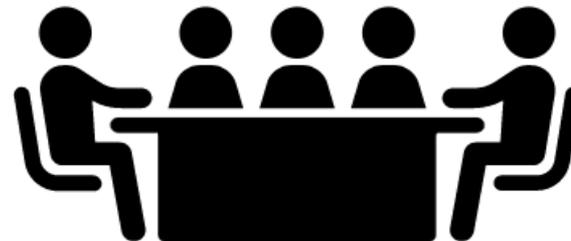
How can I get the Encounter reports?

Report	Run Frequency	Published When
Daily Encounter Batch Report	Upon submission	Upon submission
Volume Report	Monthly	Mid-Month
Timeliness Report	Monthly	Mid-Month

Automatically Emailed



Joint Operations Meeting (JOM)



*Email to ENC_group@healthnet.com



What are Encounter best practices?

General

- Develop your own reporting capabilities that monitor volume and timeliness at the individual practitioner level
- Incentivize office staff to submit encounters based on Health Net's performance standards

Volume

- Review Daily Encounter Batch reports to ensure data submitted through Transunion has reached Health Net
- Review monthly accepted data reports to identify deficiencies

Timeliness

- Submit encounters to TU/HN on a weekly basis

Rejections

- Develop a standard process whereby rejected encounters are corrected w/in 30-60 days in TU's ClearIQ portal
- Prioritize the common reasons for encounter rejections by group and train providers on the appropriate submission process



Thank you!

If you have any questions or require any encounter assistance, please contact enc_group@healthnet.com, we are always happy to assist.

Go Team! 😊

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Questions and Answers



Appendix

Appendix A: What does an encounter look like in a file?



An 837 professional or institutional encounter consists of the data fields contained in a HCFA 1500 or UB-94 837.

Example of a professional file with segment/field descriptions:

NM1*IL*1*WAYNE*BRUCE****MI*R01234567~ → MEMBER NAME AND ID
N3*1234 E AVENUE ~ → MEMBER ADDRESS
N4*HOLLYWOOD*CA*90210~
DMG*D8*20200231*F~ → MEMBER DATE OF BIRTH
NM1*PR*2*HEALTH NET*****PI*987654321~ → DATA RECEIVER
CLM*6HRY62W-1234567891011*100***49>B>1*Y*A*Y*Y~ → CLAIM#, BILLED AMT, FREQ CODE
REF*D9*2669453014~ → CLEARINGHOUSE TRACKING NUMBER
HI*ABK>A749~ → DIAGNOSIS CODE
NM1*82*1*KIRK*T*JAMES***XX*9876543210~ → RENDERING /ATTENDING PHYS
PRV*PE*PXC*515000000X~ → TAXONOMY CODE (*Rendering Provider specialty*)
NM1*77*2*SOUTH PAW HEALTH CENTER~ → SERVICING FACILITY
N3*564431 40TH ST E~ → SERVICING FACILITY ADDRESS
N4*HEALTHYTOWN*CA*05150~
LX*1~ → LINE 1 OF CLAIM
SV1*HC>Q0144*0*UN*2***1~ → PROCEDURE CODE, BILLED ON PROCEDURE, UNITS
DTP*472*D8*20180404~ → DATE OF SERVICE

Appendix B: In what instance is encounter data accepted via an ASM format and who is responsible for receiving this data?

For encounter reporting purposes the required method to submit encounters is via the X12-837 electronic encounter file. Some of the instances in which an ASM format is accepted are as follows:

- If the group is changing systems and unable to create a file for a period of time.
- If the group is having problems populating a segment in a file and the time to fix the issue will be substantial.
- If data is rejecting in large volumes and the issue is being looked into but not able to be fixed in an accepted timely manner.
- The ASM data is received by the HEDIS or RAF department for inclusion into their perspective reporting.



Appendix C: TransUnion's Claims Dashboard




 Domain: TU - TransUnion Users (85386) | Welcome, **Cherise Funakoshi** | [Log off](#)
 Account: Training Account- TransUnion (88160) | [What's New](#) | [Support and Training](#)

[MY WORK](#) | [CLAIMS PROCESSING](#) | [ACCOUNT](#)

Professional Claims

- [Dashboard](#)
- [Claims](#)
- [Batches](#)
- [Name Matching](#)
- [Providers](#)
- [Reports](#)
- [Exports](#)
- [Payers](#)
- [Coding Tools](#)
- [Settings](#)
- [Claim Status Inquiries](#)
- [Attachments](#)

Current Claims Rejections

[User Preferences](#)

Narrow Results

Group By: Rejection Message

Include Name Matching Rejections

Age of Oldest Rejected Claim: **642 Days**

338 claims remain rejected from 642 days ago on September 21, 2017

Qty	Total Charges	Rejection Message	Drill Down	Action
335	\$43,254.77	A3:109:03 CLAIM HAS BEEN REJECTED AS UNPROCESSABLE. ENTITY NOT ELIGIBLE. DEPENDENT	Batch Go	Resubmit Hide
5	\$3,400.16	CLAIM REJECTED BY FIRST EDITS BILLING PROVIDER NPI REQUIRED FOR THIS PAYER.	Batch Go	Resubmit Hide
4	\$392.01	A3:491:QC CLAIM HAS BEEN REJECTED AS UNPROCESSABLE. ENTITY NOT ELIGIBLE FOR ENCOUNTER SUBMISSION. PATIENT	Batch Go	Resubmit Hide
2	\$84.07	A3:33 CLAIM HAS BEEN REJECTED AS UNPROCESSABLE. SUBSCRIBER AND SUBSCRIBER ID NOT FOUND.	Batch Go	Resubmit Hide
1	\$0.00	A7:188 REJECTED FOR INVALID INFORMATION. STATEMENT FROM-THROUGH DATES. A7:508 REJECTED FOR INVALID INFORMATION. ICD9 NOTE: AT LEAST ONE OTHER STATUS CODE IS REQUIRED TO IDENTIFY THE RELATED PROCEDURE CODE OR DIAGNOSIS CODE.	Batch Go	Resubmit Hide
1	\$360.00	CLAIM REJECTED BY FIRST EDITS PAYER ID [TU121] IS NOT VALID FOR THIS ACCOUNT.	Batch Go	Resubmit Hide
1	\$140.00	CLAIM REJECTED BY SECOND EDITS UNABLE TO DETERMINE NORTH/SOUTH REGION FOR THIS PAYER FROM PO PPID (). BILLING PROVIDER LAST NAME IS REQUIRED TO BE PRESENT. [2010AA-NM103]. BILLING PROVIDER ADDRESS LINE IS REQUIRED TO BE PRESENT. [2010AA-N301]. BILLING PROVIDER CITY IS REQUIRED TO BE PRESENT. [2010AA-N401]. BILLING PROVIDER STATE IS REQUIRED TO BE PRESENT. [2010AA-N402]. BILLING PROVIDER ZIP IS REQUIRED TO BE PRESENT. [2010AA-N403]. BILLING PROVIDER TAX ID IS REQUIRED TO BE PRESENT. [2010AA-REF02].	Batch Go	Resubmit Hide
349	\$47,631.01			

Results do not include Hidden Claims



Appendix D: TransUnion's Correction

Patient: DOE
 Payer:
 Provider: Claim ID: 1062004762 Claim Number: 14155E03201
 Total Charges: \$3,400.16
 Seq: Primary (1)

Re-Apply Overrides

Rejection Messages (1) [Show Original Message](#)
 Billing Provider NPI is missing. [X12 Info: 2010AA-NM109]

Claim Overview
 Patient
 Insurance
Provider
 Claim
 Service Line
 CMS 1500

Billing | Pay To | Rendering | Facility | Referring | Primary Care | Supervising

Organization Individual (Last, First, Middle, Suffix)

PALMER PAM
 Last First
 888 WEST MAIN STREET
 Address Line 1
 Address Line 2
 LOUISVILLE KY 402022626
 City State Zip Country Subdivision
 NPI Tax ID 987654321 Type SSN EIN
 Taxonomy 208600000X Currency Code

Secondary Provider Identifiers
 State License Number Provider Number
 UPIN Location Number

Contact Information
 Name PAM PALMER Add Anot
 Phone+Ext 9005555555 Fax E-Mail 8005551212

Rejection Message Help: Billing Provider NPI is invalid or missing

Article Number: 000001613
Article Detail: Rejection Message Help: Billing Provider NPI is invalid or missing

Reason for the rejection message

A Billing Provider NPI is required by this payer and is not present on the claim. An NPI must be 10 digits and contain no alpha characters. It is made up of a 9-digit identifier and a check digit at position 10.

Common reason(s) and solution(s) for this rejection

Common Reason(s)	Solution(s)
Billing NPI was not sent and the payer requires it.	Begin submitting NPI <ul style="list-style-type: none"> Send the NPI from your practice management system. Use Waystar Provider screens to input the NPI you want to go on your claim.

Steps to correct, using Waystar Claim Editor

Claim Level

- In the **Claim Editor**, click the **Provider** view.
- Click the **Billing** tab.
- Insert/edit the **NPI** in the NPI field.
- Click the **Resubmit** button to save changes and resubmit the claim.

Claim Form References

- CMS 1500: Box 33A (unshaded area)
- UB04: Form Locator 56

4010 and 5010 Loop Ref

- Professional** (4010 and 5010)
 - 2010AA Segment NM109
- Institutional** (5010 only)
 - 2010AA Segment NM109

Additional Resources

NPI Registrv: <https://nppes.cms.hhs.gov/>.

Appendix E: How many diagnosis codes can be captured on 837?

Diagnosis - the 837 **professional** claim record can contain up to **12** codes. The 837 **institutional** claim records can contain up to **27** codes. This can potentially be a significant loss of volume of diagnosis codes per claim record if the encounter record is not received and accepted by Health Net.

In order to work around the 837 file limitation on the number of diagnosis codes that can be sent in one claim record, the same claim can be sent again with additional diagnoses codes. Health Net will reject the encounter as duplicate but accept the additional diagnoses and add them to the original claim record.

Kbase is capable of storing up to 80 diagnosis codes per encounter.

Procedures - the 837 service line procedure code volume limit that can be submitted per claim record is 50 for professional and 999 for institutional.

NOTE! If the record contains more procedure codes than the 837 allows, additional codes will need to be added to a new claim record, do not include previously submitted and accepted procedure codes in the new claim record.



Appendix F: Internal HN Rejection Report



Daily Commercial at a Glance

Monday, June 10, 2019 Julian Date

10:16:22 AM

2019158

Submitter ID	Submitter Name	Analyst	Prof Total Input Line Count	Prof 2%	Prof Total Rejects less Dups	Inst Total Doc Count	Inst 2%	Inst Total Rejects less dups
FHA000001	PPG A	Theresa	1	0				
FHA000003	PPG B	Marisela	518	10	444			
FHC000001	PPG C	Johnny	432	9		9	0	1
FHC000006	PPG D	Marisela	1,677	34	36			
FHC000009	PPG E	Johnny	3	0	3			
FHC000011	PPG F	Johnny	689	14	5	13	0	