Patient Estimates (PE) for eCare NEXT®

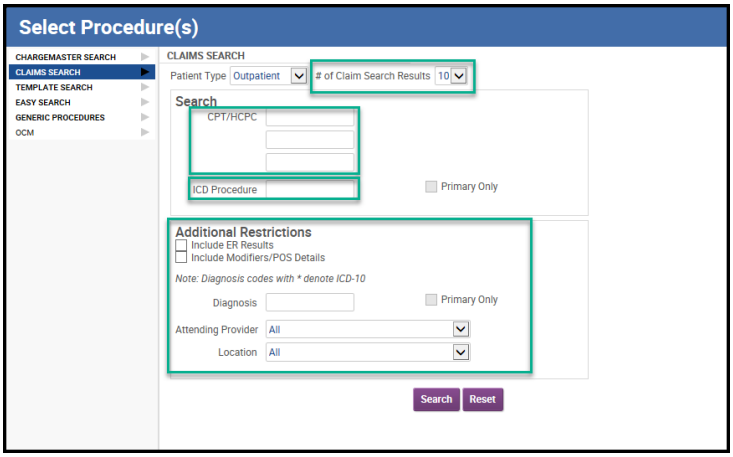
Claims History Search

The Claims History Search (Claims Search) tool is designed to produce a more detailed and accurate estimate of the line item procedures that are included in an estimate. It leverages client specific 837 claims data to determine the typical procedures included on a client's claims and the average price of each of those procedures when searching for the main procedure. Also, additional restrictions have been enabled to refine the search process. It was recommended to use the previous version of claims search for only outpatient surgical procedures or inpatient procedures. The Claims History Search can be used for outpatient surgical procedures, inpatient procedures as well as items that previously needed to be built in the template such as CTs, MRIs, Nuclear Medicine, Ultrasounds, and X-ray procedures. Searching by Patient Type a user can produce an estimate for an Outpatient, Inpatient or Professional services. For both Inpatient and Outpatient searches if the Combined Professional option is turned on we can also display the most common professional line items related to these claims.

Outpatient Search Options

# of Claim Search Results

The end user can limit the number of claims groupings that will be displayed during the search. The default value is 10 but this can be changed, in increments of 5 to be as low as 5 or as high as 50. It is important to note that selecting a higher number does not guarantee groupings will return that value. For example, if 50 is selected but only 34 groupings exist, only 34 will be returned.



CPT/HCPC

An end user can search up to 3 CPT/HCPC codes at the same time. If multiple codes are entered, the search will be limited to use claims that have all listed codes present. An example of this situation would be if a patient was getting a Colonoscopy and an EGD on the same visit. The end user can type in both procedure codes and the results would be limited to only use claims where both codes were present.

ICD Procedure

An ICD procedure code can be searched for instead of a CPT/HCP. The search can look for claims with the ICD procedure code present anywhere on the claim, or only if the code is the primary procedure if 'Primary Only' is selected.

All criteria boxes have the ability to accept a typed description of the code or the actual numeric code to determine the code to be searched.

Additional Restrictions

In addition to entering specific codes, the end user can choose to add restrictions. All of these are optional but will affect the results that re returned.

Include ER Results

When this is unchecked, all claims that have an ER revenue code (450) are excluded from the search. If this box is checked, all claims including the ones with ER revenue codes (450) are displayed.

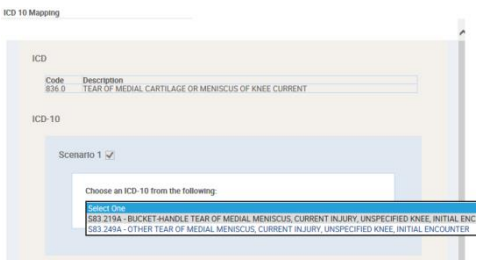
Include Modifiers/Place of Service (POS) Details

When this is unchecked, all common CPTs/Revenue Codes are group together even if the Modifiers/POS are different. If this is checked, All CPT/Revenue codes including the modifiers/POS are list separately.

Diagnosis

The user can enter either an ICD-9 diagnosis or ICD10 diagnosis code. When the primary check box is checked, it will bring up claims that have only this diagnosis code as the primary diagnosis. If the box is unchecked the results will bring up claims that have this diagnosis in any position on the claim.

If the 'Enable ICD10 Mapping' is turned on when the user enters an ICD-9 diagnosis code, the system will automatically prompt the user to select an ICD-10 diagnosis code from a list if there are multiple ICD-10 diagnosis codes. If there is one to one mapping, the system will utilize the ICD-10 value without any user intervention. The search will be performed on both the ICD-9 and the ICD-10 diagnosis code.



Attending Provider

The selection of this criterion will limit the claims only to the selected provider.

Location

The drop down lists the "Billing" address for all the claims for this account.

Claims Search Results

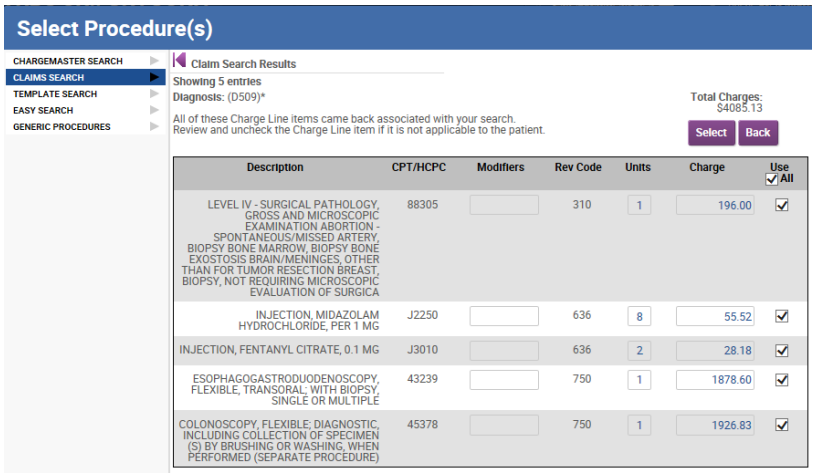
After entering criteria and any additional restrictions into the search fields, all claims matching the criteria are returned. All matching claims are used to create a claim group. If no diagnosis is specified all matching claims are split

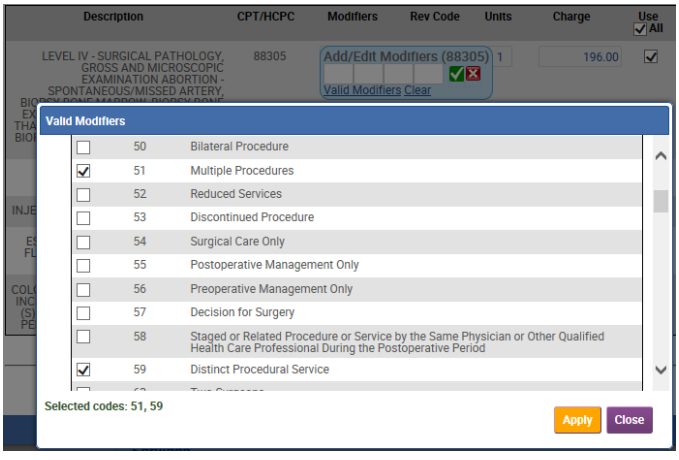
into claim groups based on Primary Diagnosis. If an Additional restriction Diagnosis value is included in the search, the groups are limited to those claims that match both the primary search criteria and the diagnosis. If the user knows the primary search data and utilizes secondary search data (i.e. a diagnosis code), there will be fewer groups of claims displayed after the search completes. Often this will limit the results to only one group.

Once the groupings of claims have been created, each line item that is displayed must be on 70% (default setting) of the claims to be displayed. For example: if we have 10 matching institutional claims, a line item must have been on 7 or more of the claims in order to be displayed. The 70% value is an Account Setting that that can be changed to match the client's needs. If this value is set to 25%, more line items will be displayed for each grouping but may also produce less accurate results with a significant variation in line items. It is recommended that these settings be discussed with your account manager before being changed from the default value. It is also important to note that this setting is specific to institutional claims.

The results will display according to the greatest number of claims found. If you know the primary diagnosis code that will be used, you can select that grouping that corresponds to that diagnosis code, if not it is recommended you select the grouping with the most number of claims.

After selecting the first grouping the user can change units, add modifiers or remove any specific line item(s) that may not be performed during this encounter. To remove a specific line item the user needs to remove the check mark in the box located to the right of the line item charge by clicking on it. To change the number of units type edit the number in the 'Units' box. The values that are displayed in the Units box are based on the average number of times a specific line item has been used on the claims that comprised the group result that was selected. In order to update the modifiers the user needs to click on the Modifiers block to enable a pop-up box. On the pop up box click on the Valid Modifiers link to get a list of modifiers. The user can check the modifier that they would like to add to this line item by



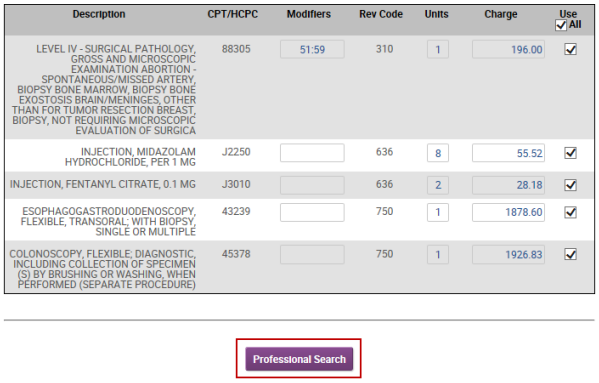


selecting it and then clicking on 'Apply'. This will return you to the modifiers pop-up box; clicking on Green arrow applies the modifier and closes the pop-up box.

At this point, the user is done choosing line items for institutional outpatient services. If the facility does not produce combined estimates, or does not wish to add professional line items, the user should click on the 'Select' button and all checked line items will be added as Selected Procedures. The user can now produce the institutional outpatient only estimate.

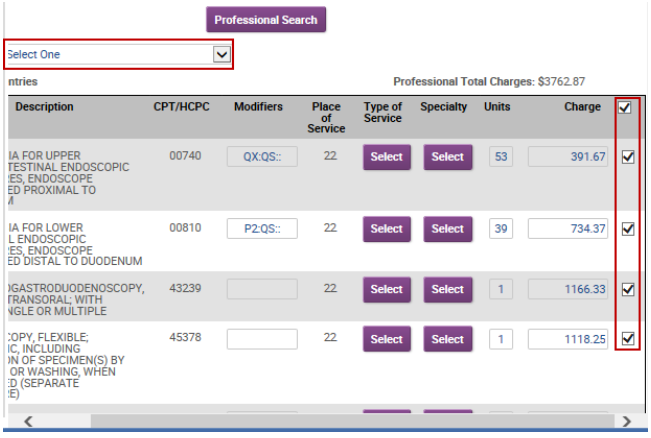
Combined Estimates

If the facility produces combined estimates the user should now click on the 'Professional Search' button to create the estimate for Professional charges.



If the Combined Professional option is turned on, the user can obtain estimates for professional line items. These items are determined by mapping the professional claims to institutional claims by claims grouping and displaying the professional line items of these claims. The line items that are displayed are based on the frequency in which these professional charges occur in relation to the original claims grouping that was selected. This can be changed based on the client's preference via an account setting. The default is set at a 0% match return rate. This means all professional line items that appear on any of the claims will be returned. Depending on your client's preference this can be change to produce more granular results.

All professional line items are checked by Default. At this time the user should verify if all of the professional line items are needed for this encounter and remove the check mark from those line times that should not be included in the estimate. There is an account setting that will disable this behavior if the facility would prefer to not have each line item automatically checked.

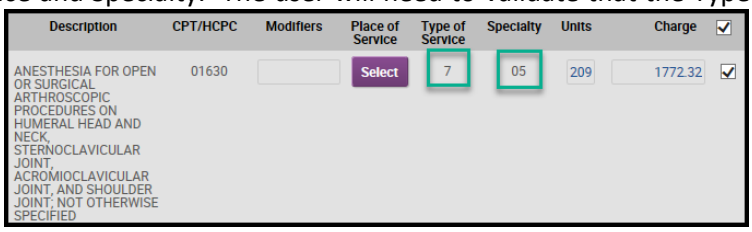


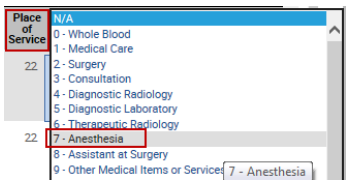
A location from the dropdown should be selected as this value is used for contract evaluation.

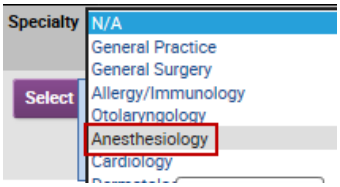
****Special Note for Facilities that bill for Anesthesiologists****

Patient Estimates includes special logic to produce an accurate estimate for Anesthesiologist reimbursement. Due to the special methodology that utilizes a multiplier, base units and time units one an extra verification is needed to ensure an accurate Anesthesiologist estimate is crated. Facilities

pricing for Anesthesiologists using Claims Search will not require any additional set up beyond indicating on the specific line item the Type of Service and Specialty. The user will need to validate that the Type of Service shows a 7 and that Specialty shows a 05. If these are not correct, then click on the two "select" buttons on the line item charge for the Anesthesiologist. The Type of Service must be set to 7 – Anesthesia and the Specialty must be set to Anesthesiology (05). This will allow the system to utilize the necessary logic to properly produce an estimate for an Anesthesiologist.

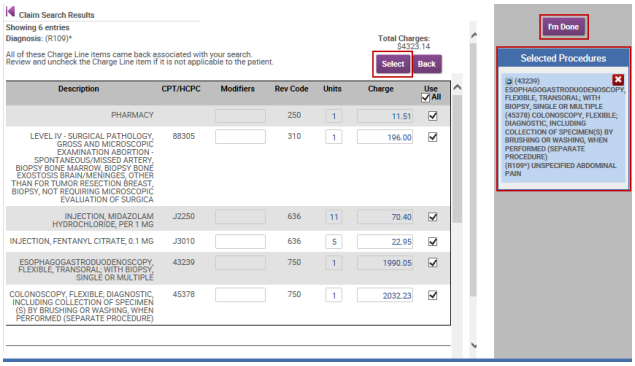






The user can click on Place of Service or Type of Service to add those values for any of the other professional line items if desired. This is not required to produce an accurate estimate on these remaining professional line items. If the claims search returns a Place of Service for a specific line item, it will be displayed.

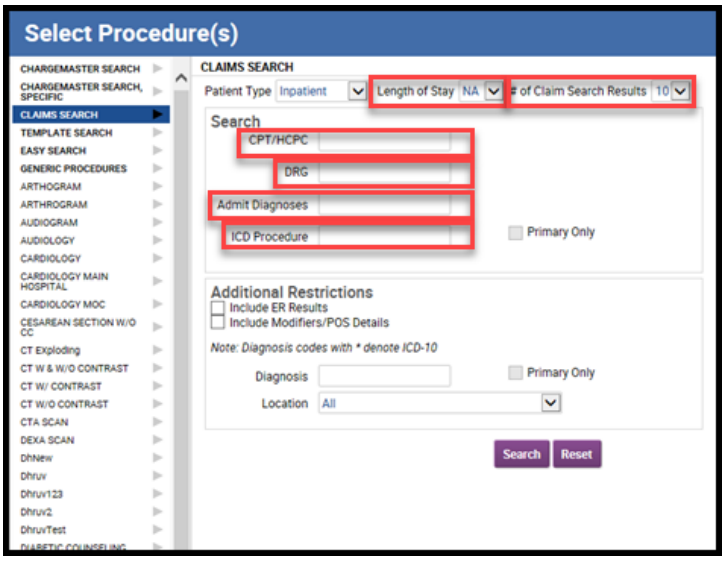
Once all line items are decided on by the user they will need to click on the 'Select' button at the very top to add the entire list of procedures (institutional and professional) to the cart. Once the user clicks on 'I am done' the system will process the estimate.



Inpatient Search Options

Length of Stay (Optional)

This option is used to limit claims that specifically indicate the patient only 'X' number of day in the hospital. The default 'NA' looks at all length of stay values from 1 to a default maximum number of days set by the client.



# of Claims Search Results

Users can limit the number of groupings displayed. The default value is 10. This can be decreased to as low as 5 and as high as 50.

CPT/HCPC

A CPT code can be used to search. Since CPT codes are not typically on inpatient claims the search will crosswalk the CPT code to an appropriate ICD Procedure Code and search through claims for any claims that have the matching procedure codes present. All results are returned for the selection.

DRG

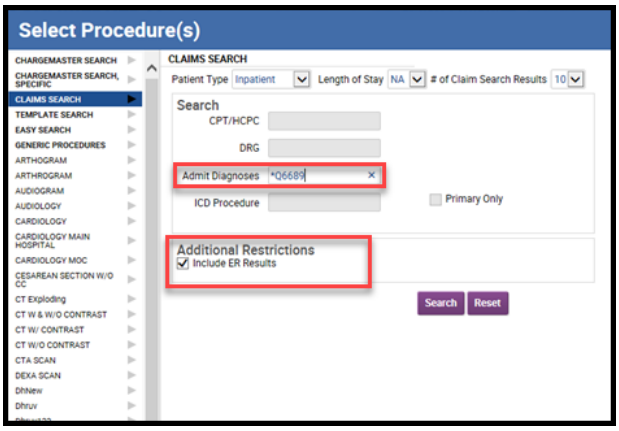
The user can search by entering a DRG or a description of the DRG code. All claims with the input DRG will be returned.

ICD Procedure

The user can enter an ICD procedure to complete a search. If the 'Primary Only' option is checked, the search of the claims will be limited to those that have this ICD Procedure as primary. When left unchecked the search for this ICD Procedure will be irrespective of whether it is primary or secondary.

Admit Diagnosis

This feature will create groupings based solely on an admission diagnosis. This works by taking the diagnosis entered by the user and finding all claims groupings that include that diagnosis code on the claim. When this feature is used the screen changes slightly as the search criteria is different.

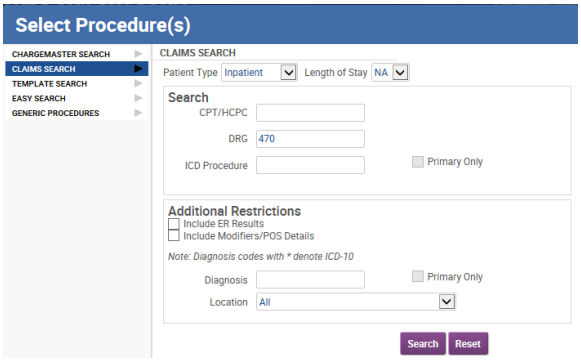


The Additional Restrictions block changes to match the new search logic. All options except for the Include ER Results are removed and it is checked by default. This is intentional as this search is most often used for patients that have been admitted from the ER and in which no procedure is either schedule or known. This field, as with all others can take either a specific diagnosis code or can be searched by typing in the first few characters of the word.

Additional Restrictions

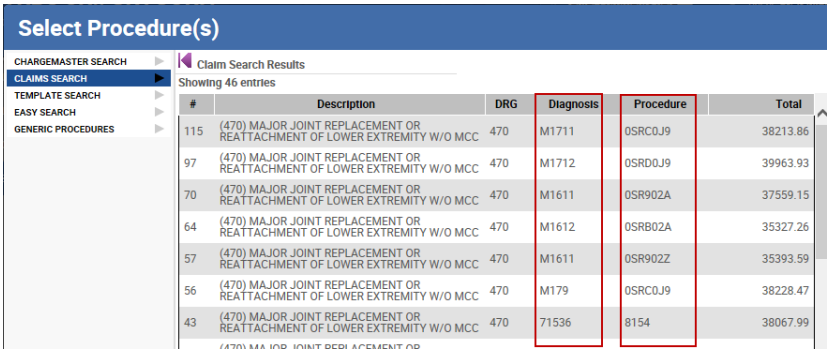
The same additional restrictions that are available for Outpatient searches are also available for Inpatient searches with the same functionality.

A sample of an Inpatient scenario utilizing a DRG search is displayed. Once the code has been entered the user will press the 'Search' button to obtain a list of matching claims that utilized this DRG.

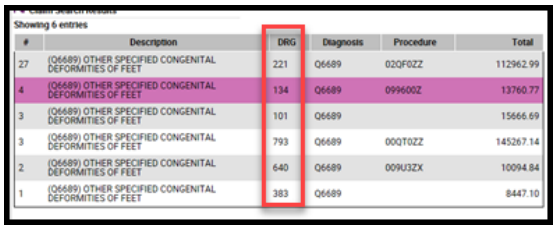


Once the user clicks on Search the tool will find all claims matching the input DRG. The user will now need to select the claims grouping with the diagnosis and procedure code that best fit the scheduled procedure.

If the user is unsure of the most appropriate Diagnosis and/or Procedure code the best practice is to select the first grouping as that is the most common grouping found in during the Claims Search. Hovering over the DRG, Diagnosis or Procedure code will allow the user to get a more detailed explanation of the code.

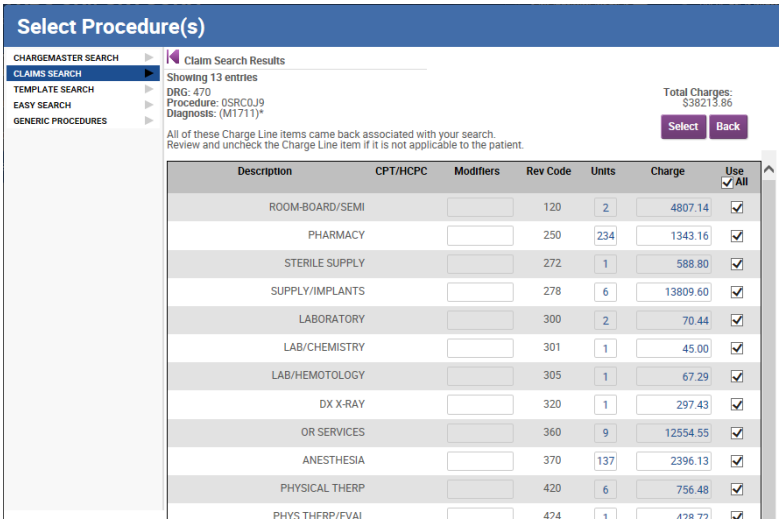


When a Search is conducted using an Admitting Diagnosis a similar set of groupings is displayed, however in this instance you will notice that the DRGs are listed by decreasing frequency. All the DRGs displayed are claims groupings in which this Admitting Diagnosis appeared.



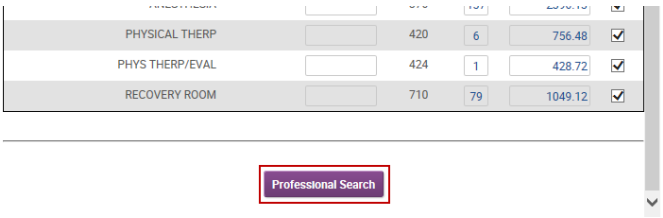
Once the desired grouping is selected, regardless of search method used, the user will be presented a line item display of all charges that are included in the grouping that was selected.

The user can uncheck any line items that will not be carried out on this encounter and modify the modifiers and units appropriately to suit this encounter in the same fashion as was done for an Outpatient.



At this point, the user is done choosing line items for institutional inpatient services. If the facility does not produce combined estimates, or does not wish to add professional line items, the user should click on the 'Select' button and all checked line items will be added as Selected Procedures. The user can now produce the Inpatient institutional only estimate.

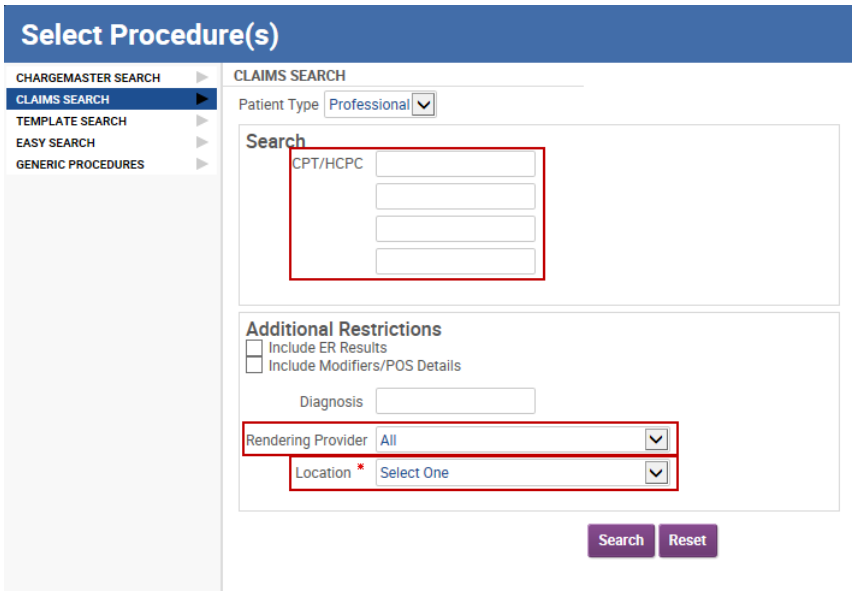
If the client is configured to produce Combined Estimates the end user can add professional line items to the estimate by clicking on the Professional Search button. The same steps should be followed that were outlined during the Outpatient search for Combined Estimates.



Professional Search Options

CPT/HCPC

You can enter up to 4 distinct CPT/HCPC codes to produce a Professional Estimate. Entry can be done by numeric code or a search of the description can also be used. The search is done using the entire Professional Claims database. Only claims that have the specified CPT is searched for and used to create the line items. If a claim has multiple CPTs, all will be displayed.



Additional Restrictions

The same additional restrictions for ER Results, Modifiers/POS Details and Diagnosis that were available for Outpatient searches are available for Professional searches.

Rendering Provider

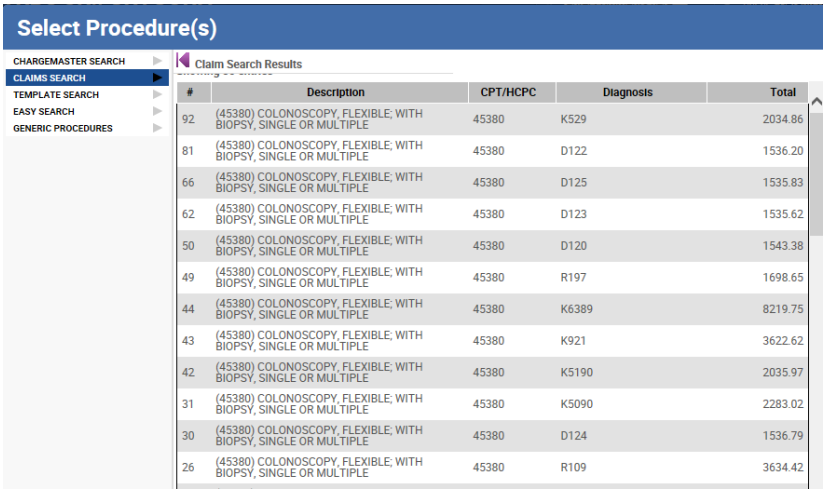
If a Rendering Provider is selected, professional claims search is limited to looking only for that rendering provider in the Professional Claims database.

Location

A location from the dropdown must be selected as this value is used for contract evaluation.

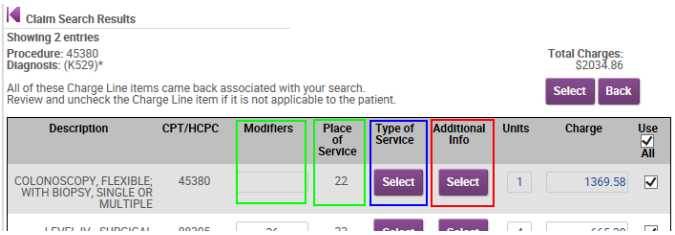
A sample of a Professional search utilizing a CPT/HCPC search is displayed. Once the code has been entered the user will press the 'Search' button to obtain a list of matching visits that utilized this CPT/HCPC.

The user will now need to select the grouping with the procedure and diagnosis that best fits the scheduled procedure, or the first procedure that has produced the most results. Once the desired grouping is selected the user will be presented a line item display of all charges that are included in the grouping that was selected



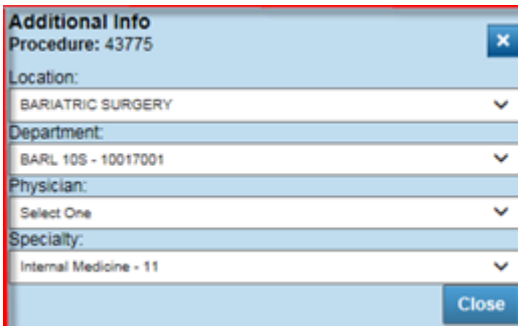
The user will select the most appropriate grouping based on the known diagnosis if the user is unsure of the diagnosis it is recommended that the entry with the highest number of hits be selected. Hovering the mouse over any of the Descriptions will list all the CPTs that are included in that grouping. Hovering the mouse over the CPT/HCPC code or the Diagnosis code will provide a description of the code.

Upon selecting a claim grouping the user will be presented with a screen that will allow them to edit the Modifiers, Place of Service, Type of Service and the Units. Modifiers and Place of Service are optional and do not need to be changed to produce an estimate. Depending on the types of estimates being produced by the user the Type of Service may be required. The Additional Info field must be filled out for all line items in order to produce a valid estimate.



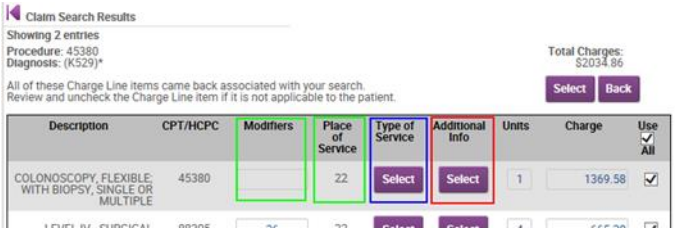
Additional Info

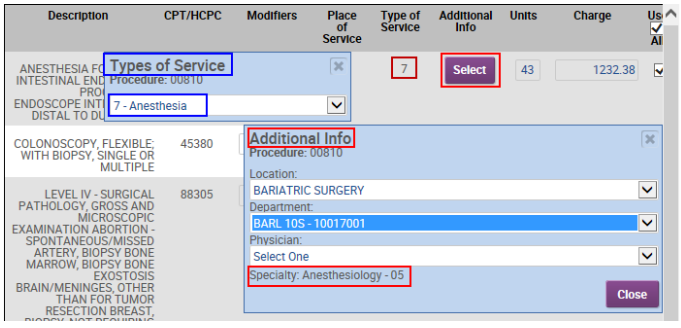
Depending on your client configuration all or some of the fields may have default information. If your facility is configured with this default information you are not required to fill out these fields for a professional estimate. In order to produce an accurate estimate the user must click on the Select button for each line item. Upon clicking on the Select button the user will be presented with a pop-up box asking for further information. The user will need to fill out any information not already displayed in the dropdown fields. If the drop-down fields are completely blank then no data is being provided for those particular fields and they do not need to be filled out. Leaving these fields blank when there is data to fill them in may result in an inaccurate estimate being produced for physician estimates.



****Special Note for Facilities that bill for Anesthesiologists****

Patient Estimates includes special logic to produce an accurate estimate for Anesthesiologist reimbursement. Due to the special methodology that utilizes a multiplier, base units and time units one extra step is required in order to produce an accurate Anesthesiologist estimate. Facilities pricing for Anesthesiologists using Claims Search will not require any additional set up beyond indicating on the specific line item the Type of Service and Specialty (under Additional Info). The user will need to validate that the Place of Service indicates a 7. If it does not, click on the number (or Select button) and a pop up box will allow you to change the Type of Service. Now click on the Select button under





Additional Info and validate that the Specialty indicates Anesthesiology (05). If this is not hard coded you will be presented with a drop-down box to select the correct Specialty. This will allow the system to utilize the necessary logic to properly produce an estimate for an Anesthesiologist.

Once all line items are decided on by the user they will need to click on the 'Select' button to add the professional line item(s) to the cart. Once the user clicks on 'I am done' the system will produce an estimate.