naviHealth | Guiding the Way

Frequently Asked Questions

Claims Processing

Q1 Where are authorizations generated?

naviHealth routinely delivers a data export generated from ADP to the health plan via nH Coordinate, providing authorizations for all associated members both in level of care and days of service.

Q2 When will the health plan process the claim?

When the claim submitted matches the authorization in both level of care and days of service, the health plan processes the claim in a timely manner.

Q3 What happens if a claim does NOT match authorizations?

If the claim does NOT match the authorization file, for a subset of health plans, the health plan will pay the claim as it was submitted as long as the submitted claim is at a lower daily rate than what was authorized. If the claim is at a higher daily rate than the authorization file states OR if the claim does NOT match for days of service, one of the following options will be decided by the health plan:

- The claim will remain in a "pending" state until rectified by the provider, OR
- The health plan will reject the claim, and the provider must rebill the claim.

Q4 Currently, what is the claims process for Blue Cross Blue Shield of Michigan?

Temporarily, for Michigan, the health plan is NOT adjudicating the claim to the authorization file. This process is currently handled by naviHealth, by comparing the claim to the authorization file on a quarterly basis. The submitted claim amount is then paid by Blue Cross Blue Shield of Michigan, and on a quarterly basis, if the level of care submitted does not match the level of care authorized, the provider will be liable for recovery on the overpaid claim.

Q5 How does naviHealth ensure timely payment for providers?

In order to help ensure the claim is going to match the authorization file and that providers get paid as timely as possible, naviHealth offers the following services:

- Our SICCs participate in a weekly interdisciplinary team meeting, during which time they can review any recent or upcoming discharges to confirm days of service and level of care with the provider.
- If the provider participates in the Triple-Check process, our Clinical Team Manager can call into the sessions to review any claims to reiterate days of service and levels of care. Providers may work directly with their Care Coordinator to arrange participation in the Triple-Check process.

Q6 What are HIPPS Codes and how do they relate to claims processing?

HIPPS codes are five-digit alphanumeric codes intended to identify a particular RUG level and the corresponding PPS Assessment completed to support that RUG level. naviHealth is responsible for assigning the RUG level, determined by the **nH Predict|Function** assessment. This occurs while the member is receiving care, therefore eliminating the need for the provider to complete multiple PPS assessments. A provider may elect to follow the PPS assessment schedule but is not obligated to do so.

© 2019 naviHealth, Inc. All Rights Reserved

When assigning the HIPPS code to the claim, the provider may use the Assessment Indicator 60 - Identifying the assessment as OBRA required and not PPS related. Providers are always required to follow the OBRA required assessment schedule.

© 2019 naviHealth, Inc. All Rights Reserved