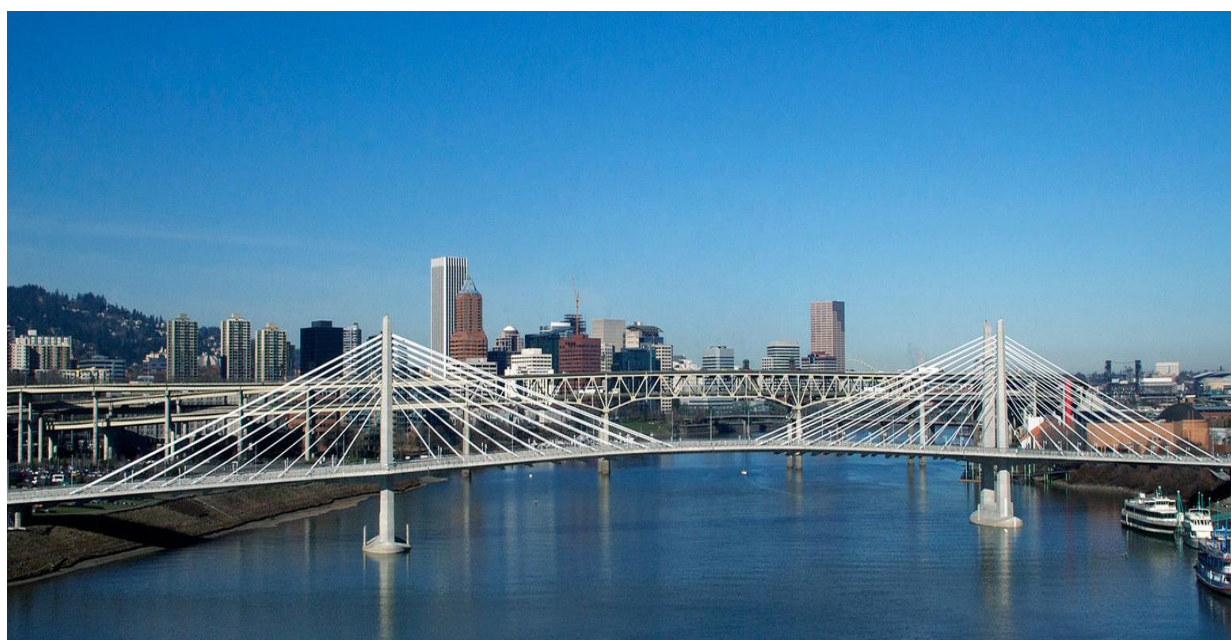


HEALTH SHARE PATHWAYS

HEALTH SHARE OF OREGON IN PARTNERSHIP WITH
PERFORMANCE HEALTH TECHNOLOGY



CIM Provider Tools

Health Share of Oregon

CIM Provider Tools

CIM - Community Integration Manager Main Menu ▾

Mental Health Organization Management
3993 Fairview Industrial Drive SE _____ Claims- P.O. Box 5490-97304 or P.O. Box 5308-97304
Salem, OR 97302 Salem OR 97304
Phone: (503)362-2818, Fax: (503)566-9801

Current User:
Carrie Coordinator2 (carriec2) [\[Profile\]](#)
Login Time:
01/30/2018 10:31:07 AM [\[Logout\]](#)

[Claim Search](#) Search for information on claims

[Code Search](#) Search for DX and CPT Codes

[Demographics](#) Find providers, offices, and contacts

[Imported Claim Files](#) View uploaded and imported claim files

[Member Search](#) Check eligibility and send referrals

[Provider Services](#) Provider services and links

[Referral Manager](#) Manage and review referrals

[Referral Reports](#) Create referral reports

[Register User](#) Register a new user

[Reports](#) Reports related to CIM

[Voucher Viewer](#) View claim payment vouchers

System Messages:

06/23/2017 04:16 PM
CIM Changelog Now Available

06/16/2017 01:20 PM
Message from PaySpan, 6/16/17

11/29/2016 02:02 PM
CIM access deactivation time frame

05/04/2016 12:00 AM
5/4/16 MHO CIM users who enter authorizations: Submit Pre-Auth button

09/17/2015 12:04 PM
PH Tech Provider ICD-10 Guidelines

07/30/2013 12:00 AM
Health Share of Oregon CCO web portal

©2018 Performance Health Technology Version: 7.7.4.2 | [Changelog](#) | [Status](#) | Need help? [Write us a message](#)

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Introduction

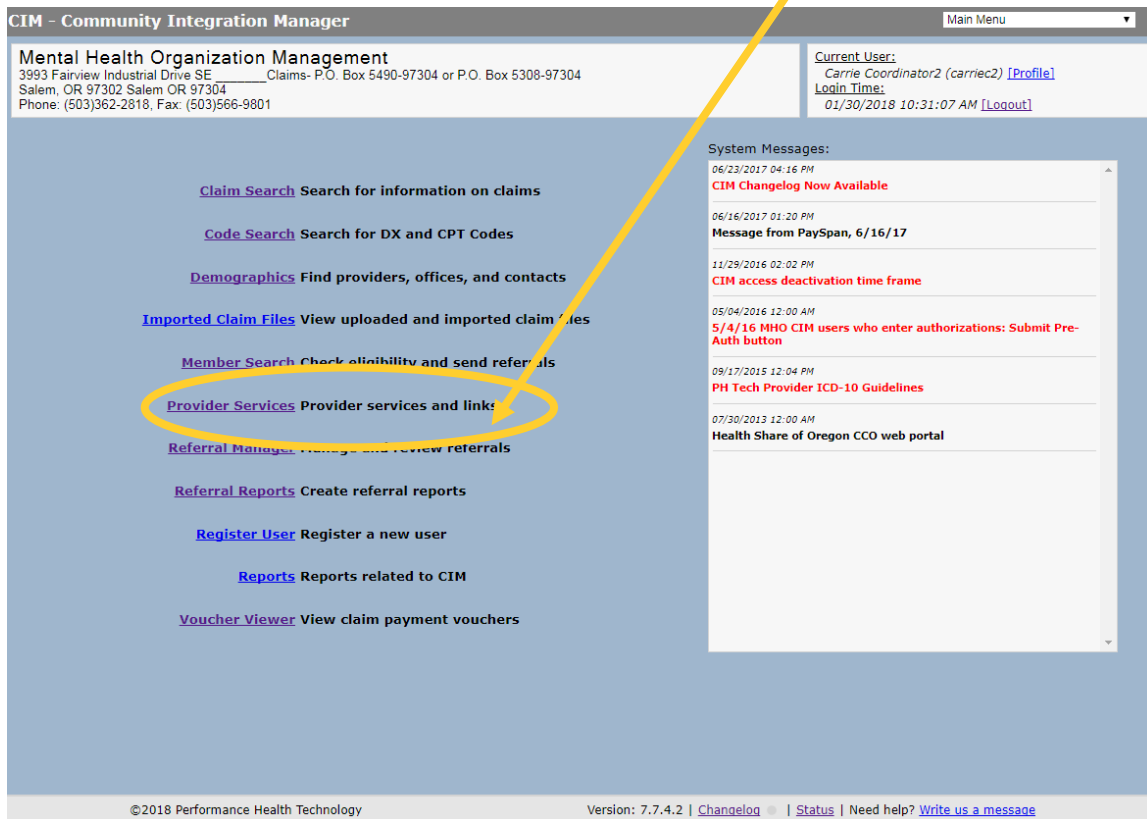
Community Integration Manager

Community Integration Manager (CIM) is available to check eligibility status, authorization status, and claims status. Health Share of Oregon (HSO) providers will use CIM to authorize, monitor, and manage authorizations submitted by the provider agencies, as well as document important actions (example: clinical notes). CIM eliminates much of the paperwork and faxing associated with the authorization process.

The objective of this document is to focus on specific tools to assist providers and assumes the provider already has access to the system. The provider should, at a minimum, be able to access eligibility.

A more comprehensive manual about CIM is posted on the Provider Services link in CIM.

From the Main Menu, click on the Provider Services link:



This will take you to another screen, where you can access the CIM Manuals:

◀ [BACK TO MAIN MENU](#) **Quick Links** Provider Services ▾

Filter:

- [Adjudicator Rules](#) List of adjudication rules for authorizations.
- [CIM Provider Manual](#) CIM Provider Manual
- [Health Systems Division Line Search](#) Search the Health Systems Division (formerly DMAP) priority line for covered benefits.
- [Federal Register](#) Federal Register Search (provided by PHTECH)
- [UPIN Search](#) Search for provider UPINs
- [WCHHS Web Site](#) Washington County Health and Human Services
- [Health Share Pathways Provider Resources](#) Health Share Pathways Provider Resources
- [Health Systems Division Prioritized Line](#) Health Systems Division (formerly DMAP) Prioritized Line, Health Services Commission [EXTERNAL]
- [GOBHI CIM User Manual](#) GOBHI CIM User Manual
- [Health Share of Oregon Provider CIM User Manual](#) Health Share of Oregon Provider CIM User Manual 2012
- [AAPC ICD-9 to ICD-10 Translator](#) AAPC ICD-9 to ICD-10 Translator
- [Health Share CIM Provider Tips](#) Health Share CIM Provider Tips

The more comprehensive manual will cover everything including accessing the system, registering other users, and checking eligibility.

This document is, in a sense, an extract of the CIM manual. It is intended to help the provider focus on how to look for authorizations and claims.

Using Referral Manager

Your office can use Referral Manager to view authorizations to your office/agency. Below you will find specific instructions on locating authorizations.

Important Note: The Referral Manager function is not as detailed as the Referral Report function. For more informative reports that can be both printed and downloaded (into Microsoft Excel, for example), please see the Referral Reports section of this manual.

Using the Referral Manager to look at Status of Authorizations

There are various authorizations statuses. Below are some examples.

1) Approved or Auto-Approved

The provider’s authorization is approved, either manually by County Plan Staff, or auto-approved by the system as a result of programmed rules.

2) Pend- Retro-Authorization

This status indicates that the start date is more than forty-five days prior to the submitted date and requires action by a County Plan Staff to pay claims.

3) Pend- Global Auth Exists

This status indicates that another authorization with the Global authorization type is effective for the member for whom the provider submitted another request. This requires action by County Plan Staff to Approve, Cancel, or Deny the authorization.

4) Invalid Provider

This status indicates that the authorization was submitted by a provider or submitter office who is not allowed to submit the particular authorization type.

5) Received

Received is the default pend status and may appear in a number of other situations where the system rules are not correctly followed.

Important Note: When an authorization is in a pended status, the status appears in a **blue font**. This is a **non-terminal** status. Think of a non-terminal status as being unlocked or open. If changes need to be made in any of the fields of an authorization in a non-terminal or pended status, the submitter of the authorization can do them. The submitter cannot make a change to any authorization in a **terminal** or locked status unless she has Plan Administrative security access to the system. A terminal status is denoted by either a **red font** for non-claims paying statuses (**Denial**, for example) or by a **green font** for claims paying statuses (**Auto-approved**).

Reference #:	689643 (Notes)	Attached Documents (0)
Status:	Received	<input type="button" value="Reprocess"/> billingsupport@multco.us
Auth #:	None	

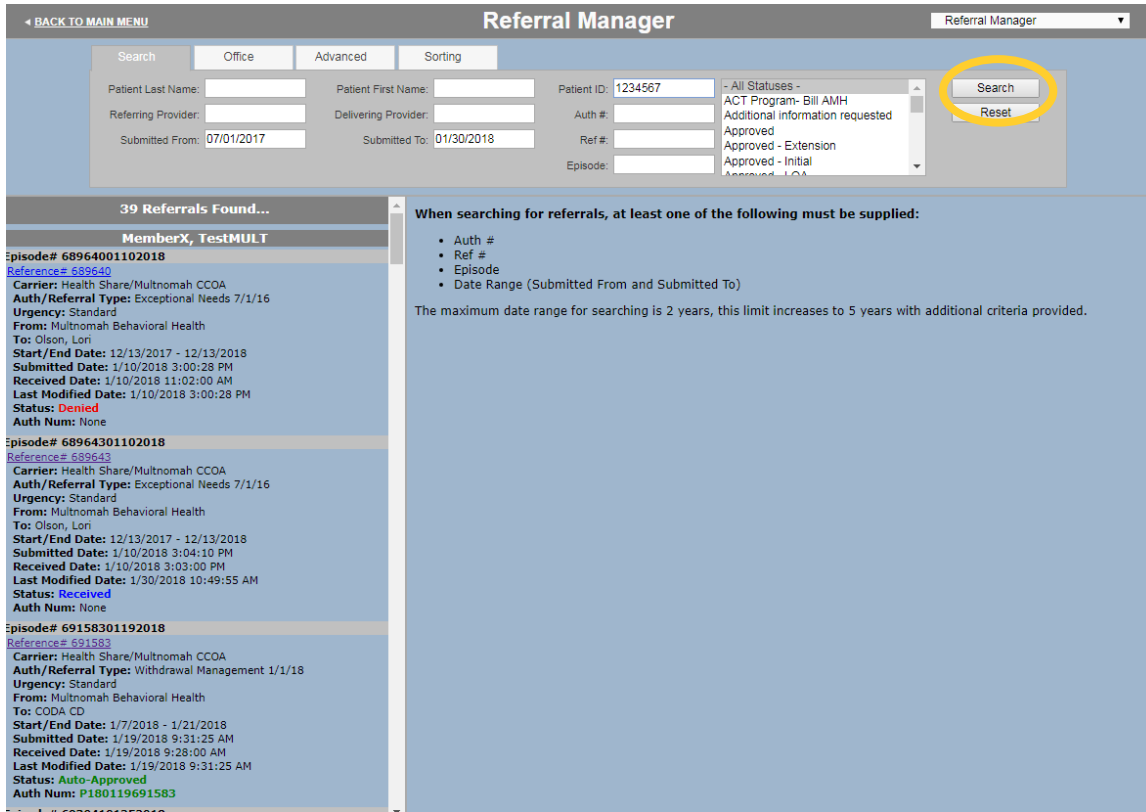
Steps for finding Status of authorizations:

- 1) Select Referral Manager from the Main Menu.
- 2) Type a date span to reflect the submission date of the authorizations you wish to view. **This date does not refer to the start date of the authorization but the date the authorization was entered in CIM.** In order to search by start or end date criteria you will need to use the Referral Reports tool.
- 3) Select status you wish to view by clicking on it. Multiple statuses may be selected by holding down the Control key while selecting with the mouse.

Important Note: A specific, “dummy” client name is used in the example given above in order to preserve member confidentiality. Although you will have the option of searching by an individual member’s name or Recipient ID (Pt. ID:), in most

cases you are trying to find all the authorizations entered for a particular day, week or month, and will not include a specific member’s name or identifying information.

4) Click on the **Search** button.



Along the left is a vertical listing of the members and associated Reference numbers in blue font. By clicking on the Reference # link on the left side of the screen, the authorization detail screen will appear in the frame to the right.

Referral Reports

Referral Reports is another way to see all of the pre-authorizations to or from your office. This report provides all the same information as Referral Manager, but in a different format that provides a way to pull the data from the system and create an

Excel spreadsheet that you can sort and work. It can easily be printed from this area by hitting the **To File** button to print the entire report.

The screenshot shows the 'Referral Reports' interface. At the top, there is a navigation bar with 'BACK TO MAIN MENU' and 'Referral Reports'. Below this is a search and filter section with tabs for 'Search', 'Office', 'Proc / DX', 'Details', 'Sorting', and 'Advanced'. The search filters include fields for Patient Last Name, Patient First Name, Patient ID (1234567), Referring Provider, Delivering Provider, Auth#, Submitted From (07/01/2017), Submitted To (01/30/2018), Ref#, and Episode. A dropdown menu for '- All Statuses -' is open, showing options: 'ACT Program- Bill AMH', 'Additional information requested', 'Approved', 'Approved - Extension', 'Approved - Initial', and 'Approved - LOA'. The 'To File' button is circled in yellow. Below the search filters, there is a 'Print' button and a 'Date Range: 07/01/2017 to 01/30/2018' field. The main content area displays 'Showing 36 referral(s). Max of 100 (full list can be exported to file)'. The current report is titled 'Preauthorization - Exceptional Needs 7/1/16' with a 'View Notes' link. The report details include: Member: MEMBERX, TESTMULT - 04/21/1960 - ID 1234567X (HEALTH SHARE/MULTNOMAH CCOA) TEST MEMBER; Preauthorization Details: Status: Denied, Urgency: Standard, Referring: Multnomah Behavioral Health, Authorization #: Not Authorized, Start: 12/13/2017, Delivering: Olson, Lori J, PMHNP, Referral #: 689640, End: 12/13/2018, Facility: None, Episode #: 68964001102018, Diagnosis Codes: None, Diagnosis Code Groups: Primary Auth; Services: Service Identifier: 689640-1, Procedure Codes: None, Procedure Code Groups: Outpatient FFS 7/1/16, Max Dollars: \$1,200.00, Visit/Units: None, Cost to Date: None, Visits to Date: None; Additional Information: Comments: Approved for 1 year 12/13/2017 to 12/13/2018. KMac, 12/13/17. // Submission: Alicia Thompson from Verity Integrated Behavioral Health Services on January 10, 2018 3:00:28 PM Received Date: January 10, 2018 11:02:00 AM

Locating Open Authorizations for Renewing and Updating

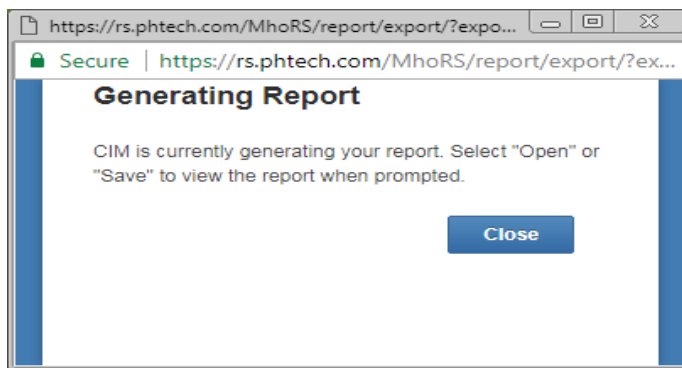
An additional feature of the Referral Reports is that it allows you to select date ranges to provide a way to see what authorizations are due to expire thus allowing care coordinators, providers, and Health Share of Oregon to see what authorizations are due to expire that may require them to be updated or renewed.

Exporting to an Excel File

- 1) Set the parameters using the tabs at the top of the screen such as the Search tab to select the date range and specific member’s claims. You can set parameters in the other tabs to narrow down your search by Office, Procedure/Diagnosis code groups, or carrier. Selecting more criteria further refines the results of your search.
- 2) Using the Advanced tab, you can create the report to export. (See below)



- 3) Click on the **To File** button. You will get a window that says “Generating Report” as it creates your report.



- 4) You will then be able to open the file and save it to your computer or network.
- 5) The Excel file will provide a lot of data that is found on the authorizations. You can sort or filter this information based on what is most helpful to you. Examples of what you might sort on:

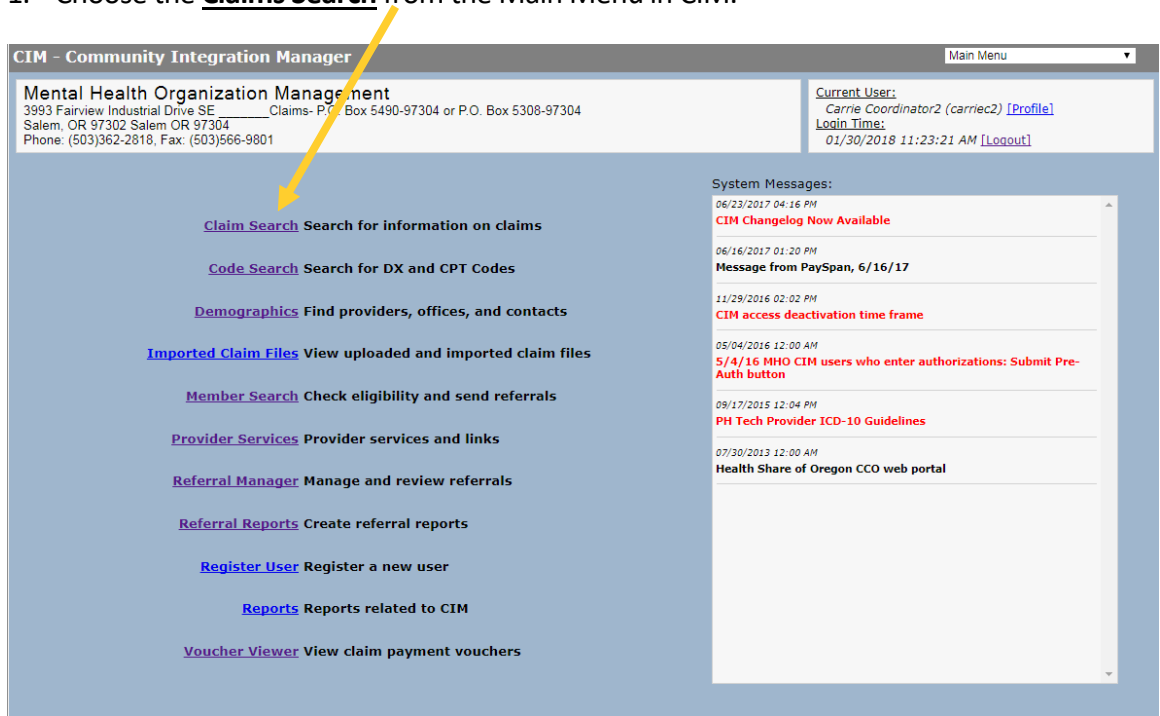
- a. Start or end dates of the authorization
- b. Type of authorization
- c. Specific clients
- d. Cost to Date (CTD) – this is the amount of money that has been paid on the authorization

Checking Claim Status Online

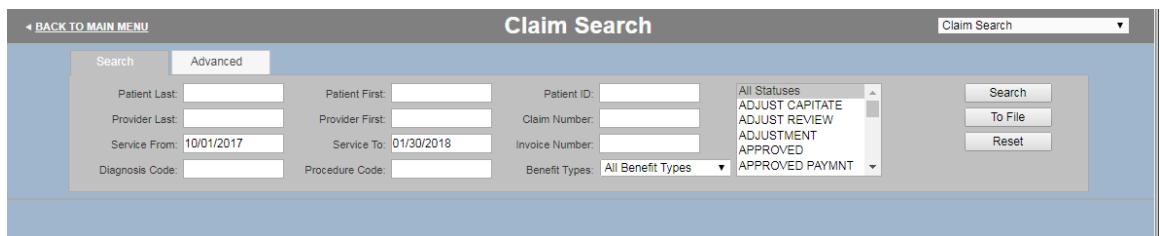
Claims Status

You can check status of claims on the system by specific client, by provider, or by vendor.

1. Choose the **Claims Search** from the Main Menu in CIM.



2. On the Search tab, enter the **date of service** range for which you want to query (defaults to today's date).



- If you want to see claims for a specific rendering provider at your office; type your provider’s last name in the Provider Last: field. Likewise, you can search for a specific member’s claims by entering the Member’s ID.

← BACK TO MAIN MENU **Claim Search** (Test system - contains PHI) Claim Search

Search Advanced

Patient Last: Patient First: Patient ID: 1234567
 Provider Last: Provider First: Claim Number:
 Service From: 01/01/2017 Service To: 01/30/2018 Invoice Number:
 Diagnosis Code: Procedure Code: Benefit Types: All Benefit Types

All Statuses
 ADJUST CAPITATE
 ADJUST REVIEW
 ADJUSTMENT
 APPROVED
 APPROVED PAYMNT

Search To File Reset

Claim Search Results - 2 Claim(s) found
 Type To Filter

Medicaid, Mentally
 DOB: 06/23/1994
 Policy No.: 1234567
 Carrier: Health Share/Clackamas CCOA
 Beneficiary: Health Share/Clackamas CCOA
[Add Patient Note](#) | [View Patient Notes](#)

Claim ID: 04182017W80002 (Professional) **Ref #:** 629823 (P170419629823) **Received:** 04/18/2017

[\(0\) Documents](#) [0 Related Claim\(s\)](#) **No Supplemental Info** Send an E-mail to [Claims Processing](#)

DxCode Version: ICD-10 DX1: [F43.12](#)

Provider (Office): Pengelly, Kim T (Clackamas County Community Health)

Vendor	Proc. Code / NDC / Modifiers	Units	Svc. Date	Place of Svc.	Status	EOB	Charges	Write Off	Amt. Allowed	Add. Pat.	Deduct.	Copay Amt.	Coins.	COB Amt.	Withhold Amt.	FFSE Amt.	Net Amt	Transaction # / Rpt Date / Adj Run
Clackamas County Community Health	Proc: H0004	1	3/01/2017	12	In Process		\$100.00	(\$775.00)	\$875.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$875.00	Adj Run: HSJESSICATEST
Total:							\$100.00	(\$775.00)	\$875.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$875.00	

Claim ID: 04182017W80001 (Professional) **Received:** 04/18/2017

[\(0\) Documents](#) [0 Related Claim\(s\)](#) **No Supplemental Info** Send an E-mail to [Claims Processing](#)

DxCode Version: ICD-10 DX1: [F15.20](#)

Provider (Office): Pengelly, Kim T (Clackamas County Community Health)

Vendor	Proc. Code / NDC / Modifiers	Units	Svc. Date	Place of Svc.	Status	EOB	Charges	Write Off	Amt. Allowed	Add. Pat.	Deduct.	Copay Amt.	Coins.	COB Amt.	Withhold Amt.	FFSE Amt.	Net Amt	Transaction # / Rpt Date / Adj Run
Clackamas County Community Health	Proc: H0004 Mod: HF	1	1/01/2017	11	In Process		\$700.00	\$882.54	\$17.46	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$17.46	Adj Run: HSJESSICATEST
Total:							\$700.00	\$882.54	\$17.46	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$17.46	

Total Payments \$892.46 Total Amt. Allowed \$892.46 Total Charges \$800.00

Member Name: The member’s name will be located in the top middle of the screen.

Policy Number: The MAP recipient ID will be located just under the member’s name.

Claim Number: Located in the top left hand corner of screen in blue. A PH Tech claim number will begin with the month/day/year followed by the analyst’s system ID number and a random sequence.

Received date: This will reflect the date PH Tech received the claim.

E-Mail Link to claims processor: This feature is highlighted in blue and should be used only when a claim has been fully processed. This link can no longer be used to request data elements on the claim, but one can still use it to check status of a claim, request a claim to be reprocessed because an authorization is now in place, and certain other scenarios. (Refer to the memo Health Share distributed dated 4/9/15 by the PH Tech Compliance Officer.)

DX Field: The diagnoses billed on the claim PH Tech received will be displayed at top left of screen under the claim number.

Provider of service: The name of the provider will be located in this field.

(Office): The provider's office will appear in parentheses after the provider's name.

Procedure Code/Modifier: Billed procedures with modifiers will be located in this field.

Service Date: This will indicate the date of service on the claim.

Status: The status indicates where the claim is in the process. See details of claim statuses outlined below.

EOB (Explanation of Benefits): This field will give a brief explanation on how the claim was processed.

Charges: The amount billed, by line and then by total.

Amount Allowed: This is the amount allowed by contract for the services billed.

Withhold: This is the amount that is with held from payment of the contracted amount, if it applies.

Payment: Payment made on the claim after withholds, if they apply.

Transaction#/Report Date: This is the transaction (process) date of the claim or check number the payment. It is also the date of the voucher.

Review of Claim Statuses

In Process: All claims that have this status with no transaction date or check number in the last column of the claim search screen have been received and are in the processing stage. Once they are in the final processing stage there will be a transaction number and report date.

Denied or Approved: Claims in either status were auto-approved or denied by CIM adjudication.

Approved Review or Denied Review : Indicates the claim was reviewed by an analyst before releasing.

Pend: Claim is being held for further review.

Using EOB Codes to Determine Claim Denials

Below is a Reported EOB Code list. The codes are reported on the vouchers to explain briefly how the claim was processed. This is especially important when working denials because it allows you to determine why the claim was denied so corrections can be made if necessary.

You can correct claims online by using the e-mail link from the claim which is covered in this manual on page 13.

Denials are the most common reason claims are corrected. Using the Reported EOB codes and the DMAP line search you can determine if the service is a covered benefit and whether the diagnosis and treatment pair are payable.

Using the CIM online DMAP Line Search is a fast and easy way to get to that information. This can be accessed on the Provider Services link from the CIM Main Menu.

Some of the common denials are:

109- Diagnosis is considered Medical vs. Mental Health and service needs to be submitted to the correct medical carrier.

11- The diagnosis is inconsistent with the procedure. This is due to the diagnosis/treatment pair not payable per the current DMAP Prioritized List.

15 – No valid authorization found by the system for that date of service or provider.

198- Dollar amount on the authorization exceeded.

Reported EOB's

EOB	EOB Name	EOB Explanation
109	Claim not covered by this payor/contractor	Service is considered medical vs. mental health and needs to be submitted to the correct medical carrier
11	The diagnosis is inconsistent with the procedure	The diagnosis is inconsistent with the procedure.
16	Cm/svc lacks info needed for adjudication.	Incorrect billing by provider.
15	Pymt adj as submitted auth missing, invalid, or	No valid authorization found by the system for that date of service or provider
18	Duplicate claim/service.	Duplicate service found for the same date of service and same provider.
198	Payment denied/reduced for exceeded auth	Dollar amount on authorization exceeded.
24	Pymt adj. Chrgs covered under capitation agreemt.	Provider has a capitated contract.
26	Expenses incurred prior to coverage.	Not eligible on date of service.
27	Expenses incurred after coverage terminated.	Not eligible on date of service.
4	Proc code inconsistent with/or missing modifier.	This service must be billed with the appropriate modifier
96	Non-covered charges(s)	Non-covered charges. Typically based on provider agreement.
97	Pmt adjusted, included in pmt for another svc/proc	Payment is included in the payment for another service.
8	Proc code inconsistent with prov type/specialty	Provider does not have the level of credentials to bill this service.
129	Prior processing information appears incorrect.	Adjustment or additional payment made to a previously reported claim.
22	Pymt adj care may be covered by another payer COB.	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Pymt adj as charges have been pd by another payer.	Payment adjusted because charges have been paid by another payer.
29	The time limit for filing has expired.	The time limit for filing has expired.
119	Benefit max. for this time period reached.	Maximum units for this time period have been billed.
146	Pymt denied as diagnosis invalid on date of svc.	Payment denied because the diagnosis was invalid for the date(s) of service reported.
B7	Prov wasn't certified/eligible to be pd for this	This provider was not certified/eligible to be paid for this procedure/service on this date of service.