HEALTHeNET User Guide

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v1.1

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HEALTHeNET User Guide

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1. Overview

HEALTHeNET is an application on the HEALTHeCOMMUNITY Portal; it is one of the largest successful administrative data exchanges in the country and used by 95% of provider organizations in Western New York. The all-payer search capability enables provider staff to go to one place and have a high confidence level that they will obtain relevant, important, and timely information on a patient.

2. Help and Support

For more information or training on the HEALTHeNET, please contact the Help Desk.

For HEALTHeNET Support

24/7 Help Desk Support	**877.895.4724**
Local Help Desk Support	**716.842.6343**

3. Access and Login

The HEALTHeNET application is accessed via the HEALTHeCOMMUNITY Portal. HEALTHeCOMMUNITY Portal users that are set up with access to the HEALTHeNET application will be presented with a badge that enables them to launch a new browser tab and load the HEALTHeNET application.

4. User Roles

There are two types of users that can access the main HEALTHeNET application: practice office users and payer users.

Practice office users represent the majority of system users who are working staff in healthcare provider offices that leverage the system to submit inquiries to payers. Payer users represent a smaller set of users who are payer employees who may need to use the HEALTHeNET application for more administrative functions (such as verifying responses from their own systems, troubleshooting reported issues, and demoing / training providers on the application).

For the most part, the application functionality for these two user roles is equivalent. Where there are differences between the two roles they are called out explicitly in the following documentation.

5. Menu and Navigation

Once the application has loaded, users are presented with a left navigation menu form, which they may navigate to different pages to conduct inquiries and transactions. The left-hand side navigation menu can be minimized or expanded.

Within the navigation menu, the user may have a number of available options (depending on account set up and the permissions granted to the user).

- By clicking on the username pull down option (towards the top of the menu options), there may be one or two options available
    - All users have a logout option to end their session and log out of the application
    - Payer users who have been set up with a practice office mode user capability have an option to switch to/from practice office mode (used to simulate the practice office user experience for the requesting provider list)
- Other menu rows represent inquiries and transactions the user can conduct within the system. Available menu options include:
    - Eligibility Inquiry
    - Claims Status Inquiry
    - Referral/Auth Inquiry
    - Referral Request
    - Provider Inquiry
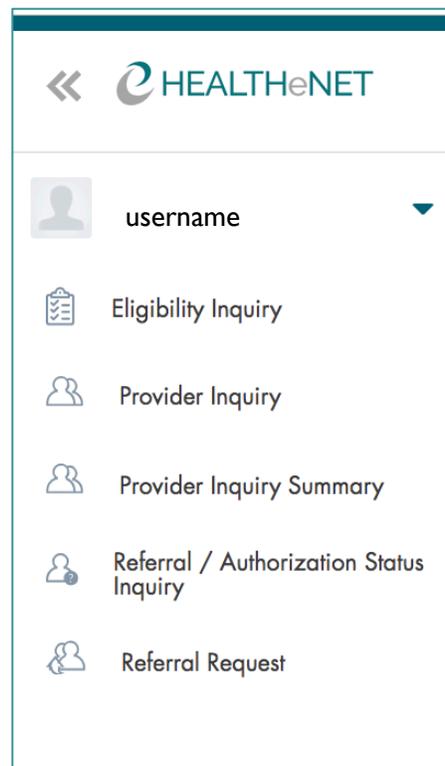
     o Provider Inquiry Summary
     o Consent Inquiry
     o Batch Submission

6. Form Components and Patterns

To submit inquiries and review payer responses, each transaction offers users a form page and one or more response pages. There are some common components, patterns, and workflows across many of the forms that are described in this section. Transaction-specific details are described further below in this document.

6.1. Payer Selection

All of the inquiry transactions that are directed to payers (eligibility inquiry, claims status inquiry, referral/auth inquiry, referral request, provider inquiry and provider inquiry summary) require the selection of a payer from the drop-down menu at the top of the form. Upon selection of a payer, the form contents below will load based on payer specific form preferences; each form may be presented a bit differently for each payer in terms of the input fields that are presented to the user.

6.2. Prover Search/Selection

For the inquiry transactions that are directed to payers (eligibility inquiry, claims status inquiry, referral/auth inquiry, referral request, provider inquiry and provider inquiry summary), the users may be prompted to select one or more providers (e.g. the requesting provider for the inquiry, or a desired servicing provider for a referral request).

Payer ID	First Name	Last Name	Tax ID	NPI	Address	City	State	Zip Code	Taxonomy
000538113001	Meaghan	Aalto	160743094	1487940292	621 10th St Hodge 2 3rd Fl	Niagara Falls	NY	14301-0708	207V00000X
000538113002	Meaghan	Aalto	160743094	1487940292	621 10th St	Niagara Falls	NY	14301-1813	207V00000X
000538113003	Meaghan	Aalto	160743094	1487940292	6934 Williams Rd Ste 650	Niagara Falls	NY	14304-3084	207V00000X
000470182005	Charles	Abate	133544120	1720180003	1980 Crompond Rd	Cortlandt Manor	NY	10567-4144	....
000534663001	Ali	Abbas	161447141	1811900285	3495 Bailey Ave	Buffalo	NY	14215-1129	....

- The providers that are loaded for user selection will be specific to the payer selected in the inquiry form. Each payer supplies their own provider list to the system on a regular basis. Due to this, there may be variation in the providers available under one payer vs. another.
- For the requesting provider search and selection list for practice office users (and payer users in practice office user mode), the list is presented as a sub-set of the payer's overall provider list. The payer's overall provider list is filtered down based on one or more tax IDs that are associated to the practice office user's associated practice group. This list can be searched using a single global search field.
- For the servicing provider search and selection list on the referral request form, and for the requesting provider list for payer users (not operating in practice office user mode), the payer's overall provider list is fully available to be searched; there is no filtering of the list by tax ID. Due to the volume of records that would be returned without any filtering input, the UI requires

some search inputs from the user before records are returned. This search can be conducted through column specific search fields towards the top of the table.

- Once the user finds the intended provider (in either of the table patterns), they can select the row for that provider and continue with other form sections / submission.

6.3. Field and Form-Level Validation

All of the forms in the HEALTHeNET UI provide input validation feedback to users as form inputs are entered/submitted. Invalid inputs will be highlighted to the user via in-line error messages/field highlighting indicating the detected issue

6.4. Info Buttons

Informational buttons exist on certain pages of the application to help guide the user through completing the form. The info buttons can be clicked to expand guidance text, and can be clicked again to be closed.

6.5. Submitting Inquiries

Once sufficiently completed, inquiry forms can be submitted either by clicking [Submit] at the bottom of each form or by hitting the enter/return key on your keyboard from a text inputs fields within the form.

6.6. Navigating Back

If desired (e.g. if an inquiry input needs adjustment), users can return to the inquiry form with the previously submitted contents by navigating "back" in the web browser.

6.7. Tip Sheet

Available for all transactions and contain payer specific information.

7. HEALTHeNET Inquires and Transactions

7.1. Eligibility Inquiry

Allows authorized users to conduct eligibility inquiries in order to verify and review a patient's plan(s) and benefits.

7.1.1. Eligibility Inquiry Content and Details

- Payer selection
    - Payer selection is required in order to submit the form
    - For the eligibility inquiry, an option is available to send an inquiry to all payers (except Lifetime, Medicaid, YourCare)
- Requesting provider selection (applies for BlueCross BlueShield of Western New York and BlueShield of Northeastern New York only)
    - If the requesting provider list is present, a requesting provider selection or a "Provider Not In List" selection is required
    - The "Provider Not In List" option is only present for the eligibility inquiry transaction
- Member / Subscriber information
    - At least two of the following are required: Member #, name (first and last), DOB, or SSN
- Dependent information

- o If present and if any dependent field is populated, then name (first and last) and DOB are required
        - o The dependent form section is present for some payers, but not all. Other payers may return dependent information based on other input to the member section (e.g. name, DOB).
- Benefits/Service type information
        - o Values for the eligibility date and service type are both required
                - ▪ Both of these fields have default values, but the user can change them as desired
        - o The eligibility date field defaults to the current date
        - o The service type field defaults to "General Benefits" (unless the payer is NY Medicaid in which case the field defaults to "Health Benefit Plan Coverage")
        - o For the service type field, some payers will accept up to ten different service type selections; others will accept only one. The service type field may be either a single-select or a multi-select field depending on the payer.

7.1.2. Eligibility Response

- In the event of multiple responses (for an all payer inquiry), multiple plans from a single payer, and/or in the event of exceptions or errors (e.g. payer did not respond, payer could not find patient), users will be presented with an eligibility response summary list page.
        - o Positive responses are displayed in a top table and can be clicked and opened for a detailed view of information for each plan.
        - o Exceptions and errors are noted in a lower table and just provide summary information; exceptions and errors are not openable/do not have additional details within.
- In the event of a single positive response with plan details, the details page will automatically be displayed after the response is returned. The details page consists of:
        - o Payer information
        - o HEALTHeLINK consent preference
        - o Requesting provider information (if returned by the payer)
        - o Member information
        - o Dependent information (if the eligibility response returned is for a dependent vs. a subscriber)
        - o Primary care and OB/GYN providers
        - o Other insurance information
        - o Benefit plan coverage information
        - o Plan details
        - o Benefits
- About the benefit plan coverage section
        - o The benefit plan coverage section provides high-level plan information for the member.
                - ▪ The top area of this section provides high-level information as provided in the payers response, such as the plan name, insurance type, and coverage status.
                - ▪ The lower part of this section is presented in a table-like format, and provides detailed information about specific dimensions of the benefit plan coverage. Details that are potentially surfaced in this table area include:
   - • Deductible

- Copay
- Coinsurance
- Stop Loss
- Limits
  o For deductible, stop loss, and limits, data can be provided by the payer to indicate a remaining vs. a total amount. If such data is provided, it will be presented to the user with a graphical "meter" representation of how much has been used of total amount.

- For any of the information noted above, there may be different benefit details for in network vs. out of network services. Out of network benefit plan coverage details can be viewed by expanding the out of network area towards the bottom of the section.
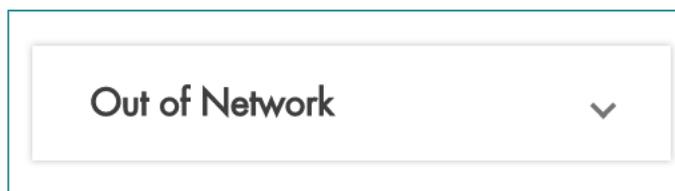
- About the benefits section
  o The benefits or service type list section lists out all the individual benefits that are returned by the payer for the member's plan. The list of benefits is listed alphabetically on the left-hand side of the section, and users can scroll through the list to find benefit(s) of interest.
  o Benefits can be selected one-at-a-time to display the coverage details for that specific benefit in the right-hand side of the section
  o The content that may be displayed for each benefit is similar to the content that may be presented at the benefit plan coverage level. Coverage status, coverage level, deductible, copay, coinsurance, stop loss, and limits may/may not be present depending on the plan content returned by the payer.
  o Certain payers will return information that indicates different coverage levels or conditions under a single benefit based on different conditions or qualifiers. For example, a given service may have different coverage depending on the location (e.g.
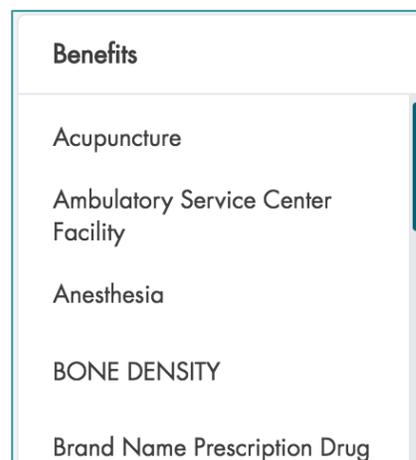
outpatient vs. inpatient) or the servicing provider (PCP vs. specialist). Where such qualifications are indicated, there may be multiple mini-tables under a single benefit to indicate the different coverage conditions for each qualifier.

- o For any of the information noted above for individual benefits, there may be different benefit details for in network vs out of network services. Out of network benefit details can be viewed by expanding the out of network area towards the bottom of the main benefit information section on the right hand side.

- Print view
  - o Due to the one-at-a-time display of individual benefits in the eligibility response page, a print capability is available at the top of the page allowing the user to generate a page that displays multiple benefits at once

  - o If the user requests the print view, the user will be prompted to select if the print view should include out-of-network benefits and if it should include individual benefits

- Transaction shortcuts
  - o The eligibility response page allows users to "jump" to other transaction forms with pre-populated data (e.g. requesting provider, member details) via a navigation drop down at the top of the page
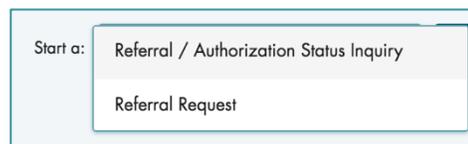
7.2. Claims Status Inquiry

Allows authorized users to send a claims status inquiry to connected payers in order to check on the status of a previously submitted claim.

7.2.1. Claims Status Inquiry Contents and Details

- Payer selection
  - o Required in order to submit the form
- Requesting provider selection
  - o Required in order to submit the form
- Claim information
  - o Either claim number OR a Claim Date Range with a member ID (from the member/subscriber section) are required in order to submit the form
  - o Submitted charges and bill type input fields are present for most but not all payers
- Member/Subscriber information
  - o If submitting without a claim number, member ID is required
- Dependent information
  - o If present and if any dependent field is populated, then name (first and last) and DOB are required
  - o The dependent form section is present for some payers but not all. Other payers may return dependent information based on other inputs to the member section (e.g. name, date range).

7.2.2. Claims Status Inquiry Response

- In the event of multiple responses (e.g. for a date range-based query where there are multiple matching claims for a member), users will be presented with a claims status response summary list page. Each claim record can be clicked and opened for a detailed view of information for each claim.
- In the event of a single positive response with claim details the details page will automatically be displayed after the response is returned. The details page consists of:
  - Requesting provider information
  - Member information
  - Dependent information (if the claims status response returned is for a dependent vs. a subscriber)
  - Claim information
  - Claim service types
- Transaction shortcut
- The claims status response page allows users to "jump" (via a drop down at the top of the page) to a provider inquiry if the payer supports provider inquiry. Data will be pre-populated (e.g. requesting provider, member details).
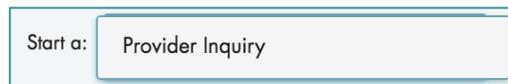
7.3. Referral/Authorization Status Inquiry

Allows authorized users to send either a referral status inquiry or an authorization status inquiry to connected payers in order to check on the status of a previously submitted referral or authorization request.

7.3.1. Referral/Authorization Status Inquiry Content and Details

- Payer selection
  - Required in order to submit the form
- Requesting provider selection
  - Required in order to submit the form
- Inquiry information
  - Requires referral/authorization (and authorization type) selection
  - A subscriber ID is required in addition to either a referral/authorization number or a referral / authorization date range
- Dependent Information
  - If present and if any Dependent field is populated, then Name (First and Last) and DOB are required.
  - The Dependent form section may be present for some payers but not all. Other payers may return dependent information based on other inputs to the Member section (e.g. name, date range).

### 7.3.2. Referral/Authorization Status Inquiry Response

- In the event of multiple responses (e.g. for a date range based query where there are multiple matching referrals / authorizations for a member), users will be presented with a referral/authorization response summary list page. Each record can be clicked and opened for a detailed view of information for each referral / authorization.
- In the event of a single positive response, the details page will automatically be displayed after the response is returned. The details page consists of:
    - Payer name
    - Referral/authorization # and status information
    - Requesting provider information
    - Member information
    - Dependent information (if the referral/authourization status response returned is for a dependent vs. a subscriber)
    - Servicing provider
   - Referring provider
    - Referral/Authorization details

7.4. Referral Request

Allows authorized users to send a referral request to connected payers.

7.4.1. Referral Request Contents and Details

- Payer selection
    - Required in order to submit the form
- Requesting provider selection
    - Required in order to submit the form
- Servicing provider selection
    - Required in order to submit the form
- Member/Subscriber information
    - Either member number or name (both first and last) and DOB are required
- Diagnosis code lookup
    - Required in order to submit the form.
    - Performs a search of entered text to find matching ICD-10 descriptions and / or codes
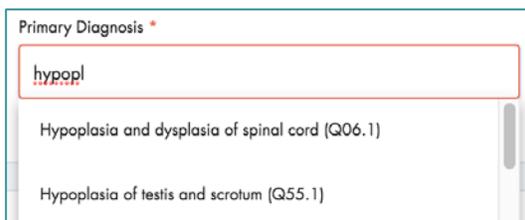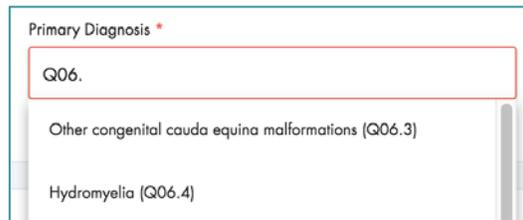
- Referral information
    - Start date, duration, and service facility are all required to submit the form
        - Each of these input fields loads with default values in place, which can be submitted as is or changed by the user as desired
    - The available duration periods vary by payer

- Related causes
  - If a related cause or auto accident is selected and the selected country is the United States, then an accident state must be specified
  - The dependent form section may be present for some payers, but not all. Other payers may return dependent information based on other inputs to the member section (e.g. name, date range).

7.4.2. Referral Request Response

- Only a single response should be expected for a referral request; there is no multi-response list page concept as exists for the eligibility, claims status inquiry, and referral/authorization inquiry transactions.
- In the event of a positive response, the referral request response details page will be displayed. The details page consists of:
  - Payer name
  - Referral # and status information
  - Requesting provider information
  - Servicing provider
  - Member information
  - Dependent information (if the referral request response returned is for a dependent vs. a subscriber)
  - Referral details

7.5. Provider Inquiry & Provider Inquiry Summary (BlueCross BlueShield of Western New York and BlueShield of Northeastern New York only)

The provider inquiry and provider inquiry summary transactions are related transactions for providers to submit inquiries to connected payers and to check on the status and updates for past inquiries.

7.5.1. Provider Inquiry

Allows authorized users to submit inquiries (e.g. specific detailed questions regarding a claim) to connected payers.

7.5.1.1. Provider Inquiry Contents and Details

- Payer selection
  - Required in order to submit the form
- Requesting provider selection
  - Required in order to submit the form
- Patient information
- Claim information
  - Inquiry information and inquiry message are required to submit the form
  - Some inquiry information values require an associated claim or patient ID
  - User can browse and upload attachments up to 20 MBs
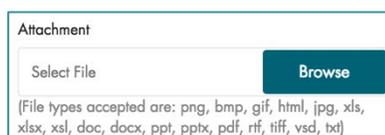
- Provider contact information
  - Name and contact information for the user will be auto-filled into this section, but can be edited as desired

7.5.1.2.   Provider Inquiry Response

- Once a provider inquiry is successfully received by the payer, a simple acknowledgement with a reference ID for the submitted inquiry is returned to the user.

7.5.1.3.   Provider Inquiry Summary Contents and Details

- Payer selection
  - Required in order to submit the form
- Requesting provider selection
  - Required in order to submit the form
- Inquiry date range
  - Defaults to a time window of the past month
  - Can be set as far back as six months
- Filter options
  - All filter options elements are optional and can be used to constrain the number of inquiry records that are returned

7.5.1.4.   Provider Inquiry Summary Response

- In the event of multiple responses (e.g. query where there are multiple matching provider inquiries returned to the user), users will be presented with a provider inquiry summary response summary list page. Each record can be clicked and opened for a detailed view of information for each provider inquiry.
- In the event of a single positive response with provider inquiry details, the details page will automatically be displayed after the response is returned. The details page consists of:
  - Inquiry Information (including payer message response if inquiry is closed)
  - Provider Information (based on what was submitted in inquiry)
  - Patient Information (based on what was submitted in inquiry)
  - Claim Information (based on what was submitted in inquiry)
  - Attachment (based on what was submitted in inquiry)