NHI Bahamas

Physician Claims and Report of Service Submission Manual

5-4-2017

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Contents

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1 Purpose of Document

This document is written with the purpose of providing NHI Primary Care Providers with a simple how-to manual outlining how they must submit NHI claims and reports of service. This document applies to both capitated and fee-for-service (FFS) NHI Primary Care Providers as the process is the same for both types of provider.

2 Claims and Report of Service Overview

Report of service means describing and submitting information required by the NHIA, including – but not limited to – the nature of services delivered to beneficiaries.

Reports of service, when aggregated, allow for ongoing utilization and population health analyses. They also provide valuable insight into activity levels and types of services delivered by individual Providers, which assists the NHIA in performance monitoring and audit.

All Providers – whether compensated through capitation or FFS – are required to submit report of service information for all beneficiary visits. For FFS Providers, the report of service also acts as the claim submission.

Although these claims, and the activity reported within them, only determine how FFS Providers are compensated, fully or partially capitated Providers are still required to follow the process. This enhances the NHIA's ability to make evidence-based decisions about the administration of NHI Bahamas, including population health matters and rate adjustments, as required.

Claims submission must use the NHIA report of service portal.

When a Provider submits a report of service, there are required fields that must be completed to complete the submission. These include:

- the appropriate code from the NHI Physician Services Fee Schedule;
- at least one ICD-10 diagnosis/symptom that best describes the reason for the visit; and
- any requisitions or prescriptions for covered services associated with the visit.

An incomplete submission will not be processed for payment.

To report the primary diagnosis/symptom for the visit, Providers are required to use the ICD-10 medical classification system.

3 Claim and Report of Service Submission Process

The following section provides step-by-step instructions explaining how an NHI Primary Care Provider would go about submitting a claim/report of service after a Beneficiary encounter. As this form is web-based, any physician (or named delegate – see Step 5 of Section 3.2) looking to submit a report of service will require an active internet connection.

3.1 Preamble

It is recommended that Primary Care Providers submit this form in a timely fashion upon the completion of a Beneficiary encounter – no later than 30 days post-encounter.

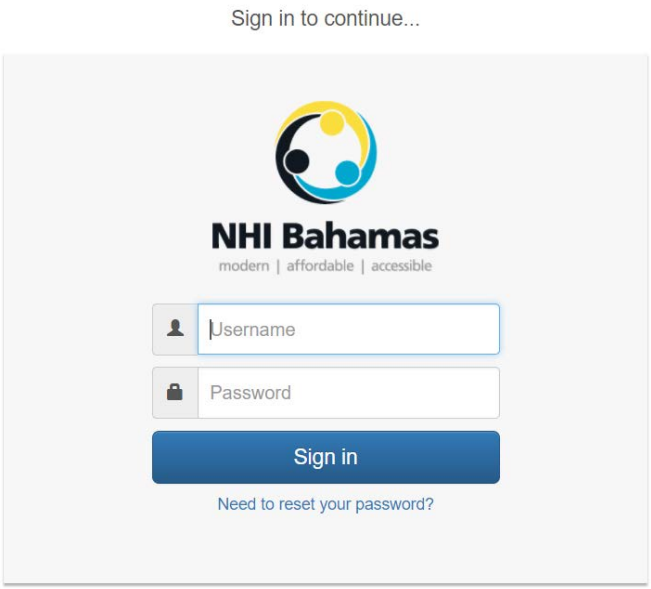
For FFS Providers, any claims/reports of service submitted more than 30 days after the delivery of service will not be processed and thus, not paid out.

For capitated Providers, any reports of service submitted more than 30 days after delivery of service will result in administrative penalties. See NHIA Payment Policy for details.

It is expected that a Primary Care Provider would be capturing their usual medical records during the encounter – either electronically or in a paper-based fashion. Some of this may be required in the report of service submission process.

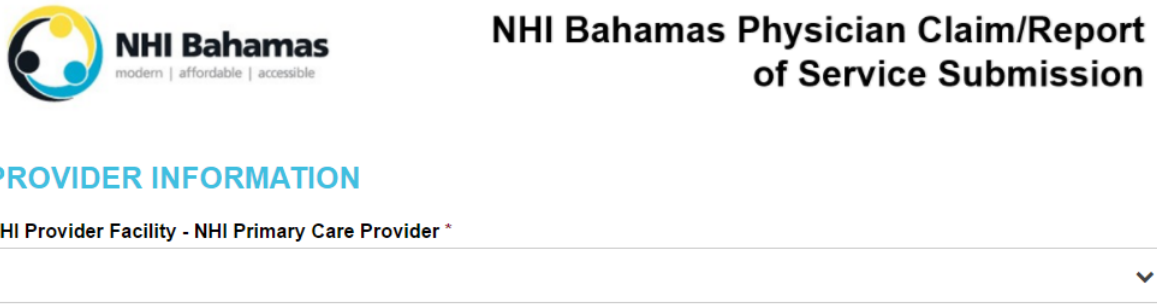
3.2 Detailed Submission Walkthrough

Step 1: ***Sign-in to the NHI Claim/Report of Service Portal***



The NHIA will provide each NHI Primary Care Provider with a unique user ID and password to access the claim/report of service submission form.

Step 2: ***Enter your information into the "Provider Information" section***

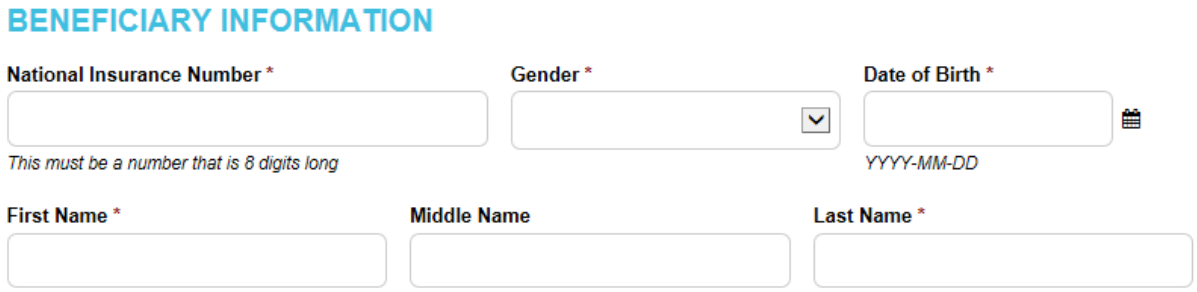


After logging in, you will be redirected to the Claim/Report of Service submission form.

The top of this form includes the "Provider Information" section.

The "NHI Provider Facility – NHI Primary Care Provider" field will have a dropdown menu with all the facilities you work at based on the log-in credentials you entered in Step 1. If you only work at one facility, then there will only be one option to select.

Step 3: ***Enter the Beneficiary's information into the "Beneficiary Information" section***

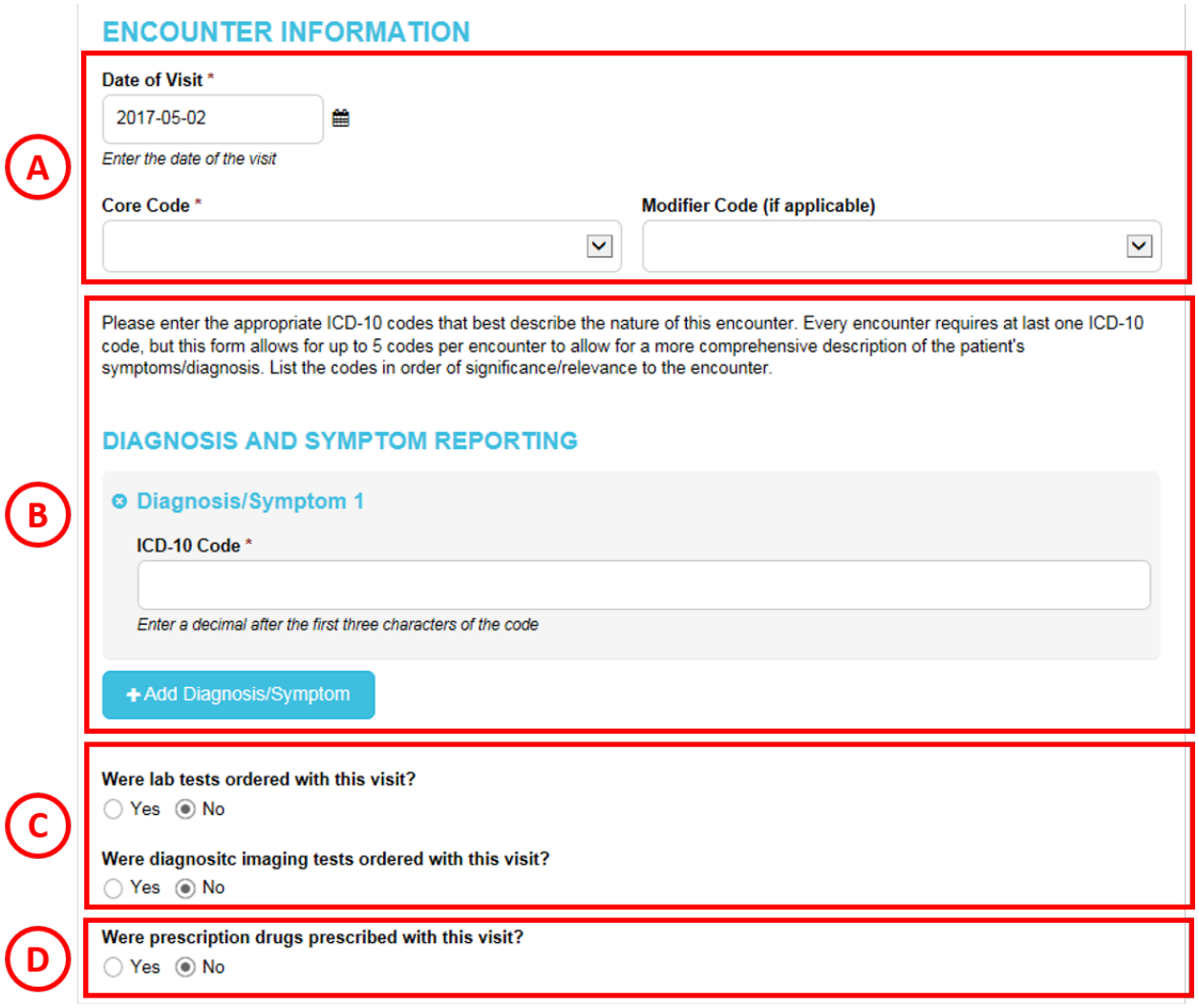


You will be required to enter the Beneficiary's:

- National Insurance Number
- Gender
- Date of Birth
- First, middle (if applicable), and last name as it appears on their NIB Smart Card

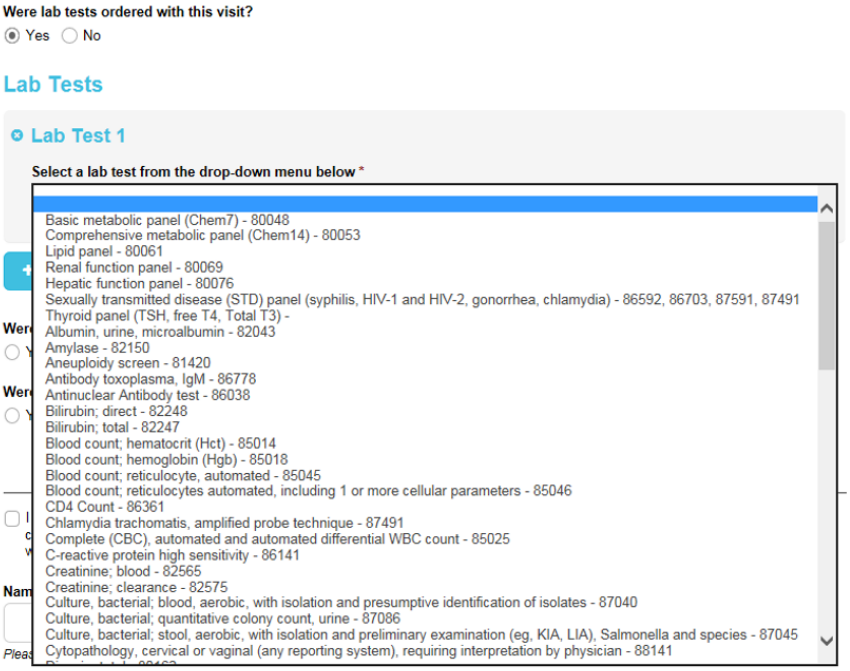
Step 4: ***Enter details about the visit in the "Encounter Information" section***

This step of the process contains a number of different parts which are outlined in more detail in the table below the image.



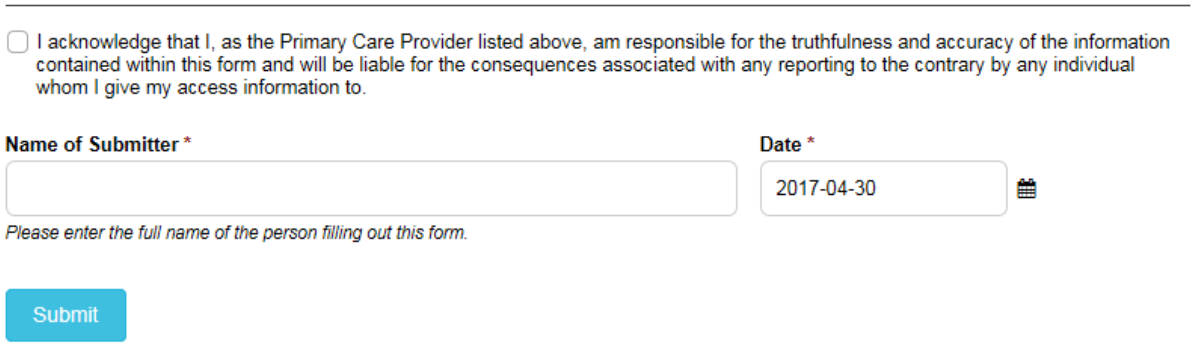
Activity	Description
A Date and Visit Code Submission	In this section of the form, you are required to enter the date on which the visit took place (the default value will be the current date). In addition, you must select the appropriate "Core Code" from the dropdown box based on the extent of the services provided during the visit. This dropdown box is prepopulated with all of the core codes included in the NHI Physician Fee Schedule (i.e. PC001 – Simple Visit, PC002 – Intermediate Visit, etc.). If the visit took place at a Beneficiary's home (home visit – either by a physician or a nurse) or it was your first time ever seeing this Beneficiary,

Activity	Description
	you would select the appropriate modifier code from the "Modifier Code" dropdown box. Refer to NHI Coding Guide for details on how to code your visit accurately.
B Diagnosis and Symptom Reporting	This is the section where you would enter the appropriate ICD-10 code(s) most relevant to the encounter. Entered in order of importance/relevance to the encounter, the form allows for up to five ICD-10 codes to be entered per report of service, but all submissions must include at least one ICD-10 code. If you wish to include additional codes, just click the blue "Add Diagnosis/Symptom" button and additional fields will become visible. As the ICD-10 code field is free-text at this time, it is important that you take the time to enter the proper code using the accepted structure (i.e. putting a decimal point after the first three characters).
C Laboratory and/or Diagnostic Imaging (D.I.) Reporting	The NHIA has developed custom requisition forms for laboratory and D.I. services that are ordered as a result of a physician encounter. Although NHI Primary Care Providers are not required to transcribe the contents of these requisition forms directly into the report of service form, they are required to declare what (if any) tests were ordered as a result of the visit being reported. If lab and/or D.I. tests were ordered as a result of the current encounter being reported, the Primary Care Provider would select "Yes" and then select the appropriate test from the dropdown list that appears. See the screenshot below.

Activity	Description
	 For lab tests, common panels appear first and then the remainder of the tests are listed alphabetically in the following format: “Lab Test Name – CPT Code”. For D.I. tests, all tests appear alphabetically in the following format: “D.I. Test Name – CPT Code”. For both laboratory and D.I. tests, you are allowed to attach up to 10 tests to a single encounter.
D Prescription Drug Reporting	In order to track compliance and monitor performance/utilization, NHI Primary Care Providers are required to enter any drugs prescribed during a visit when submitting a report of service. To limit the administrative burden on Providers, the only information required is the name of the drug in the free-text field provided (see screenshot below). 

Activity	Description
	The form allows for up to 10 prescription drugs to be named with a report of service.

Step 5: ***Consent and sign-off on the form before submitting***



NHI Primary Care Providers are encouraged to fill out this form themselves, but it is understood that some Providers may give their access credentials to clerks/administrators to do this process for them.

NHI Primary Care Providers are allowed to do this, but only if they acknowledge that they are ultimately responsible for the information submitted (see consent statement in Step 5 screenshot). If someone else who has the NHI Primary Care Provider's access credentials knowingly inputs false/inaccurate information, it is still the NHI Primary Care Provider who is accountable for any consequences.

Whoever completes this form must enter their full name into the "Name of Submitter" field so there is a record of who has completed a report of service.

Step 6: ***Review contents and submit***

After one has completed all the required fields of the form, it is recommended that you do a review to ensure that all the information is truthful and accurate before submitted. Once you are satisfied with the contents of the report, click "Submit" to complete the report of service submission process.

Step 7: ***Take note of submission receipt upon submission***

After submitting the claim/report of service, a confirmation page will appear that will include the details of the form as well as a Unique Tracking Number. It is recommended that you take note of this tracking number in case there end up being issues with the submission. You will also be sent an electronic copy to the email address used for your username.