> Process fields

The range of Electronic Data Interchange (EDI) standards used to exchange health care claims between payers and providers is diverse. Each market uses a different standard and commonly knows multiple variations.

In order to process a claim, it needs to be stored in a generic data model. This chapter describes that data model, that is, the fixed structure and fields. In addition to the fields in the fixed data model, the claim record can be extended by user defined properties (dynamic fields).

A claim represents one or more services that have been provided for an insurable person or object. The word 'claim' is commonly used to refer to the claim *including its details*, that is, including claim lines, messages, pend reasons, and so on. For example, when the text says that a 'claim' is processed, it means that all the constituent parts of the claim are processed. The term 'claim header' is used to refer to the claim record *without* its constituent parts.

Some scenarios require the provider to obtain pre-approval for a specific service. This approval request (referred to as a reservation from now on) has the same level of specificity as an actual claim, and is processed exactly like an actual claim. A reservation does not result in payment, but it can lead to general ledger entries. The finalized reservation represents an approval or denial for when the actual claim is processed.

In addition to representing an approval for the actual claim, a reservation also reserves limit consumption. This means the reservation 'protects' part of the limit from other claims and other reservations, to the effect that it can only be used by the claims that correspond to the reservation.

When the corresponding claim is processed, the system matches its lines to the reservation (lines) and uses the reserved consumption during the benefit calculation. It is possible that the reservation claim and the actual claim are slightly different, that is, another procedure code or another provider.

In some scenarios a member might like to check the cost for a specific service. That is ask for a "quote". A quote also has same level of specificity as an actual claim and is processed exactly like an actual claim with an exception that it does not update accumulators, no limits are consumed. Also, a quote does not result in payment. It is possible to generate ledger entries.

Since quote and reservation claims follow the same specificity of a claim, they can potentially participate in the claim flows that look across claims, for example, medical cases, episodes, combination adjustment rules etc. Note that the configured rules in the application apply to quotes and reservations as well. For example, a quote line becoming a triggering line for an episode (which is intended for an actual claim). The if the application needs to treat quotes and reservations differently from actual claims, this behavior has to be part of that rule’s configuration.

For simplicity's sake, in the text the word claim will encompass both the reservation claim, quote claim and the actual claim; whenever the text only applies to an actual claim, a reservation claim or quote claim, it will be specified.

Design Choices

Storing Non-Matched Data Elements

A claim can have any number of data elements, such as the serviced person or object, the rendered procedure and the servicing provider. When the claim is loaded the data elements in the XML claim file are cross-checked against the providers, persons or objects, procedures etc. stored in the database.

It is possible that no match is found and that no reference can be made to for example the provider record. This typically happens when the provider records in the application are not up to date. When this happens, the claim is loaded as normal, but the 'unmatched' data element in the XML file is stored on the claim record as a character string. This character string is visible in the user interface, so that a claims processor can manually edit and correct the claim.

The claim record stores multiple character strings per unmatched data element. For example, to capture a serviced person or object, the claims model includes the following fields:

- Non matched entity type
- Non matched alternate key
- Non matched name
- Non matched address
- Non matched entity date
- Non matched dynamic field name
- Non matched dynamic field value

These fields will only have values if the person or object was unmatched. The insurable person or object is not the only data element that can be unmatched. The following list are the data elements that can be stored on the claim record in case there was no match:

- Relations
- Providers
- Specialty
- Procedures
- Diagnoses

- Modifiers
- Messages
- Location Type

Not all data elements are stored on the claim in case of a non match. For example dynamic fields and payer codes are not. If any of these fail to match, the claim will fail to load. The XML response will contain an explanatory message.

Cascading Field Values

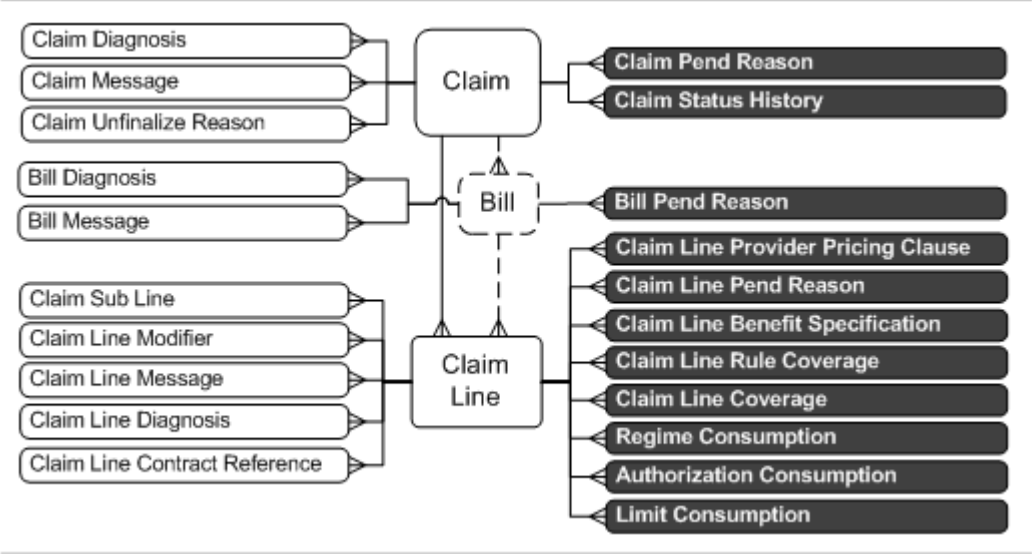
Any claim refers to a serviced persons or objects. The actual level on which that field is positioned in the claim structure can vary per standard. More specifically, some claim forms store the person or object on the claim header, other forms can specify a different person or object per claim line.

Some forms may even allow you to specify the data element on multiple levels in a claim, given that a value on a specific level overrides the value on the header level. For example, if the serviced person or object is provided on both the claim header and on the claim line, the value on the line overrides the value on the header.

The claim has three levels that stored data elements. From high-level-to-specific these are: the claim header, the bill and the claim line. A data element value on the more specific level always overrides whatever value is specified at a higher level. If no value is specified on the specific level, the higher level value is inherited.

Model

The following image reflects the hierarchy of the concepts discussed in this section and aims to provide the reader with a sense of how the entities tie together. It does not contain the level of detail of a full fledged entity relation diagram. White entities reflect information that is imported into Claims. Black entities represent entities that are the result of processing the claim in Claims.



Claim Header

The claim header stores the following fields:

Field	Description
Authorization Code	This field stores the authorization code as supplied on the incoming claim.
Brand	The brand used in context of user access restrictions on this claim.
Claim Date	The date that the claimant created the claim.
Claim Set	The set, sent in by the provider, that contains the claim
Claimant Provider	The provider that created the claim.
Claimant Relation	The relation that created the claim.
Classification	This field stores the classification of the claim (automatically determined during claims classification).
Classification Scheme	This field stores the scheme that was used to classify the claim.
Code	Mandatory. Identifier for this claim.
Due Date	The date that the claim is due for payment.
End Date	The last (latest) claim line of end date.
Entry Date	The date the claim was entered in Claims.
Expiration Date	The date after which the reservation consumption expires.
External Remarks	Free text remark field.

Field	Description
Form	Mandatory. Specifies the form of the claim, for example, EDI versus paper.
Data Access Group	The code used in context of user access restrictions on this claim.
Ind Changed in UI	If checked, the claim has been changed in the UI after it has been unfinalized.
Ind Emergency	If checked, the services on this claim is/are qualified as emergency services.
Ind External Benefits	If checked, Claims will send out the claim for determining benefits.
Ind External Pricing	If checked, Claims will send out the claim when it needs (re)pricing.
Ind High Priority	If checked, the claim will be picked up for processing with high priority
Ind Ignore History	If checked, across claims rules will ignore claims in history.
Ind Manual	If checked, the claim entered the system through manual entry.
Ind Preprocessing Done	If checked, indicates that the claim has been through preprocessing.
Ind Pricing Done	If checked, indicates that the claim has been through a pricer.
Ind Send out for Preprocessing	If checked, indicates that the claim may be sent out through the Prefinalized Out IP for Preprocessing
Ind Send out for Pricing	If checked, indicates that the claim may be sent out through the Prefinalized Out IP for Pricing
Internal Remarks	Free text remark field.
Location Provider	The location where the services was/were rendered.
Location Type	The type of location where the services was/were rendered.
Next Payer Code	The payer where the claim must be sent once it is finalized.
Paid Date	The date that the preceding payer finalized this claim.
Payer Code	The payer code used in context of user access restrictions on this claim.
Payment Beneficiary Provider	The provider to which the payment for this claim is due.
Payment Beneficiary Relation	The relation to which the payment for this claim is due.
Payment Receiver Provider	The provider that will receive the payment for this claim.
Payment Receiver Relation	The relation that will receive the payment for this claim.
Payment Specification Receiver Provider	The provider that will receive the payment specification.

Field	Description
Payment Specification Receiver Relation	The relation that will receive the payment specification.
Preceding PayerCode	The payer that processed this claim before it was received by the current payer.
Price Date	The date that this claim was priced.
Process Type	The type of the process to follow, either C(laim) or R(eservation) or Q(uote)
Provider Entity Reference	A free text external reference to the serviced person or object on this claim.
Provider Reference	An external reference to this claim.
Receipt Date	The date that the payer received the claim.
Referral Provider	The provider that referred the serviced person or objectin context of the services specified on this claim.
Service Provider	The provider that rendered the services specified on this claim.
Service Specialty	The specialty under which the services specified on this claim were rendered.
Serviced Entity Type	The type of the entity for which the claim is entered (person or object).
Serviced Entity	The person or object that has undergone the services specified on this claim.
Start Date	The first (earliest) claim line start date
Status	Reflects the current state of the claim in the processing flow. Possible values are: ENTRY, INITIAL, SENT OUT FOR PREPROCESSING, SENT OUT FOR PRICING, MANUAL PRICING, PRICING DONE, MANUAL PRICING ADJUDICATION, PRICING ADJUDICATION DONE, PRICING FINALIZED, MANUAL BENEFITS, BENEFITS DONE, MANUAL ADJUDICATION, ADJUDICATION DONE, FINALIZED and CHANGE.
Total Allowed Amount	The allowed amount accumulated over all claim lines
Total Allowed Amount Currency	The currency of the total allowed amount.
Total Claimed Amount	The claimed amount as specified when the claim was entered
Total Claimed Amount Currency	The currency of the total claimed amount.
Total Covered Amount	The covered amount accumulated over all claim lines
Total Covered Amount Currency	The currency of the total covered amount.
Type	Mandatory. Restitution or Provider claim?

Claim Messages

A claim message represents a piece of information within the context of that claim's traversal through the process. Claim messages service two important purposes. First, claim messages provide context as to why a claim processed the way it did. Second, messages serve as hooks to pend a claim for manual inspection and intervention.

A claim can have zero, one or multiple messages attached to it:

Field	Description
Claim	The claim to which the message belongs.
Value0 through value9	The parts of the message text that are determined at run time.
Message	The message that specifies severity and the static part of the message text.
Origin	The origin of the message that specifies in what interval of the claims processing flow the message was added. Possible values are: ADJUDICATION, PRE BENEFITS, BENEFITS, COVERAGE, ENROLLMENT, EXTERNAL, MANUAL, PAYMENT STATUS, PRE PRICING, PRICING, PRICING LIMIT, PRICING NO RECALCULATION, RESERVATION and SANITY CHECKS
Skip Tag	The skip tag which was added though the callout.
Overturned Indicator	Indicates whether a claim message is overturned. An overturned message acts like an informative message. Only Deny messages can be overturned.
Overturned By	The user who overturned the claim message.

Notes

Notes are used to maintain a proper record of history of claims. Furthermore, the document discussions, conversations, actions carried out and advice given to claimants can be recorded in the form of notes.

A claim can have zero, one or multiple notes attached to it:

Field	Description
Claim	The claim to which the note belongs
Version	The version of the note (when an existing note is updated a new version of that note containing the updates is created; existing records of notes are never updated)
Note Text	The text of the note

Claim Diagnoses

A claim diagnosis represents a piece of information within the context of the person's or object's state of being when the service was provided, or the reason why the service was provided. This information may affect the applicable benefits.

A claim can have zero, one or multiple diagnoses attached to it:

Field	Description
Claim	The claim to which the diagnosis belongs.
Diagnosis	The diagnosis that is specified on the claim.
Type	The type of the diagnosis (for example principal, admitting, e-code).
Sequence	The relative importance of this diagnosis on this claim.

Within a claim, a specific diagnosis can only be present once for a specific diagnosis type. The claim diagnosis with the lowest sequence number is interpreted as the *primary* diagnosis on the claim. The primary diagnosis is the diagnosis that Claims uses to evaluate benefit specifications. See the implementation guide on Product Definition for further elaboration.

Claim Unfinalize Reasons

A claim that is fully processed within Claims attains the status "finalized". It's possible that a claim needs to be corrected after it has been finalized. In Claims this is supported by a mechanism that "unfinalizes" a claim. After unfinalizing a claim, the claim can be changed and reprocessed. When a claim is unfinalized, the claims operator or integration point that unfinalized the claim is required to specify one or more reasons explaining why the claim has been unfinalized.

Every time a claim is unfinalized, any existing unfinalize reasons are discarded before the new reasons are attached. Unfinalize reasons attached to a claim only apply to the most recent unfinalization. A claim can have zero, one or multiple unfinalize reasons attached to it:

Field	Description
Claim	The claim that is unfinalized.
Unfinalize Reason	The reason that leads to the unfinalize.
Source Reference	The reference to the source document that triggered the unfinalize.

Whether or not the sourceReference field is mandatory depends on the configuration of the unfinalize reason.

Claim Pend Reasons

A claim may pend for external intervention, usually because a human operator needs to work the claim before it can continue to be processed. Whenever a claim pends, one or more reasons are attached to that claim, explaining why the claim pended. Both the conditions under which a claim pends and which pend reasons apply is driven by configuration.

A claim can have zero, one or multiple pend reasons attached to it:

Field	Description
Claim	The claim to which the pend reason belongs.
Pend Reason	The pend reason

Claim pend reasons store only the current pend reasons, that is, they are discarded once the claim is resubmitted. The full history of pend reasons is stored in separate entity named "Claim Pend Reason History".

Claim Status History and Claim Pend Reason History

The position of a claim in the processing flow is reflected by a claim's status. The claim status history keeps track of all status transitions, so that it is possible to trace back how a claim flowed through the processes and how long it took to complete certain steps within the process. The claim status history entity has the following fields:

Field	Description
Claim	The claim the history is for.
Status	The status of the claim at date time.
Datetime	Date and time when the claim entered the status.

The claim status history keeps all statuses of a claim up to and including the current status. Even when Claims receives a new copy of the same claim through the claims in integration point, the status history is kept intact and continued. A number of claim statuses reflect that the claim has pended. The reasons why a claim pended are also stored as a detail of a claim status history that logs a pend status. A claim pend reason history entity has the following fields:

Field	Description
Claim Status History	The claim status history entry under which the pend reason was active. Only the claim status history entries for the statuses MANUAL PRICING, MANUAL BENEFITS and MANUAL ADJUDICATION are eligible.
Code	Code of the claim line. Only filled for claim line pend reasons.
Bill Provider Reference	Provider reference of the bill. Only filled for bill pend reasons, given that the provider reference was specified.
Pend Reason	The pend reason.
Resolved by	The user who resolved the pend reason.
Resolved Datetime	The date and time when the pend reason was resolved.

For example, a typical claim status history for a claim that pended for manual adjudication:

Claim	Status	Datetime	Remark
1234	INITIAL	2010-04-21 15:00.000	First version enters Claims
1234	PRICING DONE	2010-04-21 15:10.000	
1234	PRICING ADJUDICATION DONE	2010-04-21 15:10.050	
1234	BENEFITS DONE	2010-04-21 15:10.100	
1234	MANUAL ADJUDICATION	2010-04-21 15:10.200	Need for external intervention detected
1234	ADJUDICATION DONE	2010-04-22 12:00.000	External intervention completed
1234	FINALIZED	2010-04-22 12:01.000	Processing complete

The claim was pended for manual adjudication because a plastic surgery procedure was detected for claim line 3. The pend reason for plastic surgery is attached to both the claim and claim line level. The claim pend reason history contains the following information:

Claim status history (entry)	Line Code	Bill Reference	Pend reason
Claim 1234, MANUAL ADJUDICATION on 2010-04-21 15:10.200			Plastic surgery
Claim 1234, MANUAL ADJUDICATION on 2010-04-21 15:10.200	3		Plastic surgery

Claim Event History and Claim Line Event History

There could be several reasons why the claim events that have been sent out, need to be stored:

- to make these events visible in the UI
- to use these logged events to prevent that the same event is reraised

The claim event history entity has the following fields:

Field	Description
Claim Status History	The claim status history record to which the claim event history record is attached.
Event	The event of the claim event rule, published in the message.
Ind Display in UI	Should the claim events fired by this rule be shown in the UI?
Level	The level of the event that was sent (Claim, Claim with Lines or Claim Line).
Topic	The topic of the claim event rule, published in the message.

For events especially of level 'Claim Line' and 'Claim with Lines' the claim lines for which the event was fired are stored in the claim line event history, with the following fields:

Field	Description
Claim Event History	The claim event history record to which the claim line event history record is attached.
Claim Line Code	The identification of the claim line for which the event was fired.

Claim Callout History

There could be several reasons why claim callouts need to be stored:

- to make these callouts visible in the UI

- to track and audit execution of callouts to external components

Note that the existence of Claim Callout History does not preclude a callout from executing again when the callout rule is triggered again (for example upon reprocessing of the claim).

The claim callout history entity has the following fields:

Field	Description
Claim Status History	The claim status history record to which the claim callout history record is attached.
Definition Code	The code of the callout definition used to execute the callout
Definition Descr	The description of the callout definition used to execute the callout
Request Sent Datetime	The date and time when the request message was sent
Response Received Datetime	The date and time when the response message was received
Ind Display in UI	Should the claim events fired by this rule be shown in the UI?

Claim Tag Actions

Claim tag actions defined for a particular claim per distinct configured skip tag the action to be taken, for example for skip tag iCES action REDO would mean that the results from a previous callout to iCES should be discarded and the callout should be made again.

A claim can have zero, one or multiple tag acions attached to it:

Field	Description
Claim	The claim to which the tag action belongs.
Skip Tag	The skip tag
Action	The action to be taken.

Claim Lines

A claim line represents an actual health care service. A claim consists of one or multiple claim lines:

Field	Description
Allowed Amount	The allowed amount

Field	Description
Allowed Amount Currency	The currency of the allowed amount.
Allowed Number of Units	The allowed number of units provided by an external application, manual pricing or internal pricing engine.
Authorization Code	This field stores the authorization code as supplied on the incoming claim line.
Authorization Exception Type	Specifies the type of authorization (authorization, notification or referral) for which this claim line is exempt from any authorization requirement.
Benefits Age Input Date	The date used for age determination in benefits selection.
Benefits Provider	The provider that is used in context of the evaluation of benefit rules.
Benefits Input Amount	The amount based on which the benefits are calculated.
Benefits Input Amount Currency	The currency of the benefits input amount.
Benefits Input Date	The date used for benefits selection.
Bill	The bill to which this claim line belongs. See the section on Bills for further clarification.
Claim	The claim to which this claim line belongs.
Claim Line	The reservation line that is matched against the actual claim line for consumption. The only allowed reference from claim line to claim line is the one from a line belonging to a claim with process type C(laim) to a line belonging to a claim with process type R(eservation).
Claimed Amount	The charged amount as specified by the claimant.
Claimed Amount Currency	The currency of the claimed amount.
Claimed Number of Units	Mandatory. The charged number of units as specified by the claimant.
Classification	This field stores the classification of the claim line (automatically determined during claims classification)
Classification Authorization	This field stores the authorization that was used as grounds for the classification of the claim line
Code	Mandatory. Identifier for this claim line, unique within the claim.
Covered Amount	The covered amount as calculated by Claims
Covered Amount Currency	The currency of the covered amount
Covered Number of Units	The covered number of units as calculated by Claims

Field	Description
End Date	Service end date
Ind Encounter	If checked, this claim line is an encounter claim line.
Ind Emergency	If checked, the service on this claim line is qualified as an emergency service.
Ind Keep Benefits	If checked, this line remains untouched when the claim is reprocessed for benefits, nor does it trigger external intervention rules for manual benefits.
Ind Keep Pricing	If checked, this line remains untouched when the claim is repriced, nor does it trigger external intervention rules for manual pricing.
Ind Keep Price Principal Procs	If checked, then the principal price procedure indicators remain untouched by derivation rules.
Ind Manual Benefits	If checked, the coverage for this claim line has been manually altered.
Ind Manual Pricing	If checked, the allowed amount for this claim line have been manually altered.
Ind Price Principal Procedure1	If checked, then procedure1 is marked as principal for pricing purposes.
Ind Price Principal Procedure2	If checked, then procedure2 is marked as principal for pricing purposes.
Ind Price Principal Procedure3	If checked, then procedure3 is marked as principal for pricing purposes.
Ind Replaced	If checked, then this claim line is replaced by another claim line.
Ind Locked	If checked, then this claim line is locked for any changes. This means that the claim line cannot be updated and that it will not be again processed when the claim that it belongs to is reprocessed (all results on the claim line will be kept). This indicator cannot be directly set: • It will be automatically checked when an unfinalize reason with a checked Lock Claim Lines indicator is used to unfinalize the claim that the claim line belongs to • It will be automatically checked when the claim that the claim line belongs to or the specific claim line is pended by an external intervention rule with a checked Lock Claim Lines indicator * Locked claim lines can be unlocked (indicator unchecked) by the Unlock Lines action in the Change Claim page or through the Claims In and Claims Update integration points See Claim Line Locking Scenarios in the Appendices part of the Claims Flow guide for more information.
Location Provider	The location where the service was rendered.
Location Type	The type of location where the service was rendered.

Field	Description
Payment Receiver Provider	The provider that will receive the payment for this claim line.
Payment Receiver Relation	The relation that will receive the payment for this claim line.
Preceding Payer Paid Amount	The accumulated amount that has been paid to the claimant by the all preceding payers.
Preceding Payer Paid Amount Currency	The currency of the preceding payer paid amount.
Price Individual Provider	The individual provider that is used for pricing.
Price Organization Provider	The organization provider that is used for pricing.
Price Input Date	The date that is used for pricing.
Price Input Number of Units	The number of units that is used as input to pricing.
(procedure 1) [1]	Specifies the service rendered.
(procedure 2)	Specifies the service rendered.
(procedure 3)	Specifies the service rendered.
Process as In	If checked, this claim line is processed as though the benefits provider is in one of the product provider groups on the claim line start date. If unchecked, the benefits provider is evaluated as normal.
Provider Entity Reference	A free text external reference to the serviced person or object on this claim line.
Provider Reference	A free text external reference to this claim line.
Referral Provider	The provider that referred the serviced person or object in context of the service specified on this claim line.
Reservation Code	Used for matching reservation matching.
Reservation Line Code	Used for matching reservation matching.
Sequence	Mandatory. Order (for UI and processing) of this claim line in context of the claim to which it belongs. A claim can have up to 999.999 lines.
Service Provider	The provider that rendered the service specified on this claim.
Service Specialty	The specialty under which the service specified on this claim is rendered.
Serviced Entity Type	The type of the entity for which the claim line is entered (person or object).

Field	Description
Serviced Entity	The person or object that has undergone the services specified on this claim line
Skip Tag	The skip tag which was added through the callout.
Skip Tag Allowed	The skip tag which was added through the callout or replacement rule that led to update of allowed amount or units.
Start Date	Mandatory. Service start date
Status	Indicates the status of the claim line: APPROVED or DENIED. If the claim line has not yet been or is being processed, the status is blank.
Replaced by Line	Specifies the claim line by which this line is replaced.
Replaces Line	Specifies the claim line that replaces this claim line.
Waiting Period Input Date	The date used for determining the waiting period.

Claim Line Overrides

A claim line override holds values that override the information retrieved in the claims flow.

Field	Description
Authorization Regime	The authorization regime that applies to this line. This overrides the information retrieved in the claims flow.
Coverage Specification	The coverage benefit specification to be used in this line. This overrides the information retrieved in the claims flow.
Coverage Regime	The regime that specifies the coverage that should apply to this line. This overrides the information passed back through the enrollment interface.
Coverage Regime No Auth	The regime that specifies the coverage that should apply to this line in case no authorization is found. This overrides the information passed back through the enrollment interface.
Family Code	The unique identifier for the family of the person or object. This overrides the information passed back through the enrollment interface.
Funding Arrangement	The funding arrangement to be used to determine the product category.
Post Benefit Regime	The post benefit regime that applies to this line. This overrides the information retrieved in the claims flow.
Product	The product to be used for benefits. This overrides the information passed back through the enrollment interface.

Field	Description
Product Family	The product family to be used to determine the product category.
Product Line	The product line to be used to determine the product category
Subscription Date	The date that specifies the start of the policy contract. This overrides the information passed back through the enrollment interface.
Waiting Period Regime	The waiting period regime that applies to this line. This overrides the information retrieved in the claims flow.

Claim Line Messages

Identical to its counter part on the claim, a claim line message represents a piece of information within the context of that claim's traversal through the calculation / adjudication process. A claim line can have zero, one or multiple messages attached to it:

Field	Description
Claim Line	The claim line to which the message belongs.
Value0 through value9	The parts of the message text that are determined at run time.
Message	The message that specifies severity and the static part of the message text.
Origin	The origin of the message that specifies in what interval of the claims processing flow the message was added. Possible values are: ADJUDICATION, PRE BENEFITS, BENEFITS, COVERAGE, ENROLLMENT, EXTERNAL, MANUAL, PAYMENT STATUS, PRE PRICING, RESERVATION, PRICING, PRICING LIMIT, PRICING NO RECALCULATION and SANITY CHECKS
Product	The product to which the messages applies.
Skip Tag	The skip tag which was added through the callout.
Overturned Indicator	Indicates whether a claim line message is overturned. An overturned message acts like an informative message. Only Deny messages can be overturned.
Overturned By	The user who overturned the claim line message.

Claim Line Diagnoses

Identical to its counter part on the claim, a claim line diagnosis represents a piece of information on the context of the performed health care service. A claim line can have zero, one or multiple diagnoses attached to it:

Field	Description
Claim Line	The claim line to which the diagnosis belongs.
Diagnosis	The diagnosis that is specified on the claim line.
Type	The type of the diagnosis (for example principal, admitting, e-code).
Sequence	The relative importance of this diagnosis on this claim line.

Within a claim line, a specific diagnosis can only be present once for a specific diagnosis type. The claim line diagnosis with the lowest sequence number is interpreted as the *primary* diagnosis on the claim line. The primary diagnosis is the diagnosis that Claims uses to evaluate benefit specifications. See the implementation guide on Product Definition for further elaboration.

Claim Line Modifiers

A claim line can have multiple modifiers attached to it:

Field	Description
Claim Line	The claim line to which the modifier belongs.
Modifier	The modifier that is specified on this claim line.

Claim Line Parameters

Claim line parameters are used to override, at the claim line level, the parameter values for the coverage regime used to calculate the claim line's benefits. This feature is typically used in the special circumstance where a copay or coinsurance should be ignored for a specific claim line, even though it would normally apply.

Field	Description
Claim Line	The claim line to which the parameter belongs.
Cover Withhold Category	The cover withhold category of which the percentage or amount should be overwritten.
Percentage	The percentage of the amount of the rendered procedure that is either covered or withheld.
Amount per Unit	The nominal amount per unit of the rendered procedure that is either covered or withheld.

Field	Description
Currency	The currency of the amount per unit.
Product	If specified, the value in this record only applied to regimes adjudicated under the specified product

Claim Line Limits

Claim line limits are used to override, at the claim line level, the maximum height of a limit used to calculate the claim line's benefits. This feature is typically used in the special circumstance where a limit maximum should be stretched beyond the maximum for the plan for a specific claim line or serviced person or object.

Field	Description
Claim Line	The claim line to which the parameter belongs.
Limit	The limit towards which should be counted; identifies the counter to be used.
Cover Withhold Category	The cover withhold category of which the percentage or amount should be overwritten.
Maximum Amount	The maximum amount to be applied.
Currency	The currency of the maximum amount.
Maximum Number	The maximum number of units to be applied.
Maximum Service Days	The maximum number of service days to be applied.
Product	If specified, the value in this record is only applied to regimes adjudicated under the specified product.
Reached Action	The action when the limit is reached (stop or continue)

Claim Line Contract References

A claim line can have multiple contract references

Field	Description
Claim Line	The claim line to which the contract reference applies
Contract Reference	The contract reference that applies to this claim line.

Claim Line Pend Reasons

A claim line can have multiple pend reasons attached to it:

Field	Description
Claim Line	The claim line to which the pend reason belongs.
Pend Reason	The pend reason

Claim line pend reasons store only the current pend reasons. The full history of pend reasons is stored separate entity.

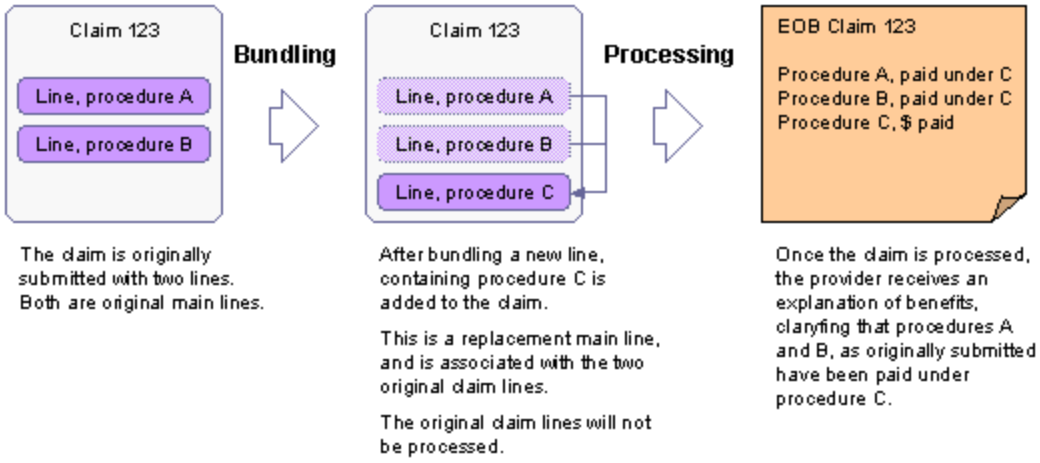
Replaced Lines

It is possible that a claim contains lines that have been replaced by other lines within that same claim. A claim line that is replaced is referred to as an 'original' line. A claim line that replaces an original line is referred to as a 'replacement' line.

A replacement line must be associated with one or more original lines. Likewise, an original line is associated with one or more replacement lines. Original lines are ignored during claims processing, that is, the replacement line is processed instead. To clarify, consider the following scenario.

A provider sends in a claim with two claim lines for the same serviced person or object: the first line refers to procedure A, the second line refers to procedure B. Because procedure A and B commonly go together, the payer has introduced procedure C, which represents the combination of procedure A and B. The payer has set up all pricing and benefit rules within the context of procedure C.

Consequently, before the claim is processed, the claim lines containing procedure A and B are replaced by a single claim line, containing procedure C. This process is known as bundling. However, once the claim is processed, the explanation of benefits has to correspond to the way the claim was originally submitted, that is, it has to refer to procedure A and B. For this reason the claim lines containing procedure A and B must be retained, even though they are not used when the claim is processed.



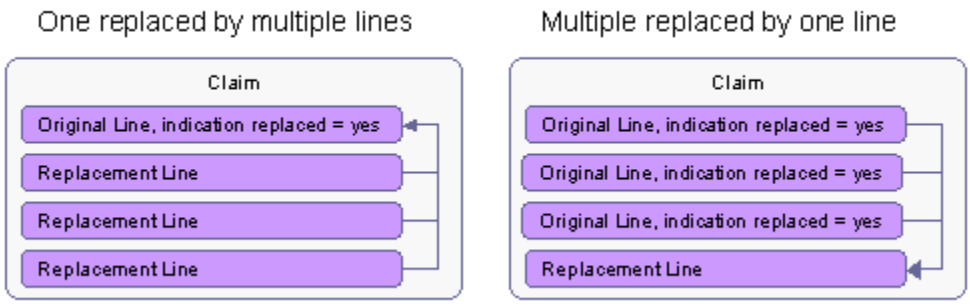
Note that this example describes a situation where multiple lines are replaced by one line. The opposite is also possible, that is, one line is replaced by multiple lines. This process is referred to as unbundling. The claims data model can capture both transformations without loss of information. Also note that many-to-many replacement cannot be captured by the model, for example, a situation where procedure A and B are replaced by procedure C, D and E.

In the claims data model the link between original lines and replacement lines is captured by three fields on the claim line:

- An optional reference to a line that is replaced by this line
- An optional reference to a line that replaces this line
- An indicator that whether or not this line is replaced (and should be processed or not)

In a situation where one original line is replaced by multiple replacement lines, the replacement lines contain a reference to the original line, that is, the reference specified in the first bullet.

In a situation where multiple original lines are replaced by a single replacement line, all the original lines contain a reference to the single replacement line, that is, the reference specified in the second bullet.



In addition, for each original line that is replaced, the indicator is set to indicate that the line is replaced. Although the indicator stores redundant information (the reference between the original and replacement line implies the line's replacement), it is included for processing purposes: when the claim

line is processed, there is no need to check all other claim lines to see whether or not it has been replaced in the situation where one original line is replaced by many replacement lines.

Coordination of benefits details

In some specific situations, a claim that has already been partially paid by a primary payer is re-processed by a second payer so that (a part of) the amount not paid by the primary payer may be paid by the second payer. For this reason a claim line accommodates the following information:

- Preceding payer code
- Amount paid by preceding payer
- Date on which the preceding payer paid
- Next payer code

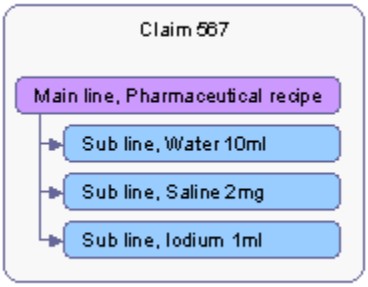
The purpose of the preceding payer code is to (be able to) validate that the processed claim has been adjudicated by the correct payer in a COB situation where the processing payer is not the primary payer. The implementation of this validation is to be determined as a part of claims processing.

The purpose of the next payer code is to be able to determine the next destination payer in a COB situation. This information does not directly affect the processing of the claim, but may be required in resulting claim output. Note that neither the preceding payer code, nor the next payer code are stored as a reference to the Claims Payer Code entity; both are implemented as character fields.

The claims data model does not store amounts such as the deductible amounts and limit amounts applied by a preceding payer. These amounts can be added as dynamic fields.

Claim sub lines

A single claim line may encompass one or more sub lines. A sub line only stores procedure information, that is, the procedure code, the pertaining code definition and the quantity. Procedures captured in a sub line reflect a sub component of the procedure captured in the pertaining claim line. For example, the procedure code in the claim line specifies a custom pharmaceutical recipe, while the procedure codes in the sub lines specify the actual ingredients and quantities.



The sublines represent the ingredients of the recipe in the main line.

The sublines may be used for the processing of the claim, but the processing results are always associated with the main line.

For example, the ingredients and their quantities may be used to determine the allowed amount of the recipe in the main line. Once the total allowed is calculated, it is stored on the main line level.

The information in the sub line may be used to process the pertaining claim line correctly, but are not processed independently. Any processing results are stored at the main line level. For example, in order to determine the allowed amount for the custom pharmaceutical recipe, Claims is set up to use a specific calculation. The input for this calculation is the list of all the ingredients and their corresponding quantities and the result is the allowed amount. The actual allowed amount is then stored in the main line.

A claim line can have up to 99 claim sub lines. A sub line has a sequence number within the context of the parent claim line:

Field	Description
Claim Line	The claim line to which this sub line belongs
Claimed Number of Units	The number of claimed procedure units
Procedure	The service or goods provided
Sequence	Identifier of this sub line in context of the claim line

Claim Line Rule Coverages

A claim line can have one or more claim line rule coverages. A claim line rule coverage consists of the following fields:

Field	Description
Claim Line	The claim line to which the coverage belongs
Cover Withhold Rule	The cover withhold rule that resulted in this rule coverage
Post Cover Withhold Rule	The post cover withhold rule that resulted in this rule coverage
Coverage Label	The label that specifies the nature of the amount (for example copay or deductible)
Amount	The covered or withheld amount
Currency	The currency of the amount
Number of Units	The covered or withheld number of units
Action	Indicates whether the amount is a covered amount or a withheld amount.
Product	The product to which the applied benefit belongs

The claim line rule coverage pinpoints the exact cover withhold rule that led to a piece of coverage or withhold. After that, claim line rule coverages are aggregated into claim line coverages with the same label. For examples, see the Coverage Regime Model.

Claim Line Coverages

A claim line can have one or more claim line coverages. A claim line coverage consists of the following fields:

Field	Description
Claim Line	The claim line to which the coverage belongs
Coverage Label	The label that specifies the nature of the amount (for example copay or deductible)
Amount	The covered or withheld amount
Currency	The currency of the amount
Number of Units	The covered or withheld number of units
Action	Indicates whether the amount is a covered amount or a withheld amount.
Product	The product to which the applied benefit belongs

The coverage label specifies what the amount or number represents such as the "copay" or "deducted" amount. The amount or number of units specifies how much is specified under that label. The sequence specifies the order in which the labels are displayed in the user interface. Note that this sequence has nothing to do with the sequence in which the benefit rules are applied.

Claim Line Benefit Specifications

A claim line can have one or more claim line benefit specifications. A claim line benefit specification consists of the following fields:

Field	Description
Claim Line	The claim line for which the regime is evaluated
Benefit Specification	The benefit specification that is evaluated
Coverage Regime	The coverage regime that is evaluated
Authorization Regime	The authorization regime that is evaluated

Field	Description
Reservation Regime	The reservation regime that is evaluated
Waiting Period Regime	The waiting period regime that is evaluated
Post Benefits Regime	The post benefits regime that is evaluated
Product	The product to which the applied benefit belongs
Product Benefit Specification	The combination of product and benefit specification that was used to calculate benefits for the claim line
Product Provider Group Status	IN if the benefits provider is in at least one of the product provider groups. OUT otherwise.
Product Provider Group	The product provider group used to verify that the productProviderGroupStatus is IN Unspecified in case the productProviderGroupStatus is OUT
Specific Provider Group Status	IN if the benefits provider is in at least one of the benefit specification provider groups. OUT otherwise.
Specific Provider Group	The benefit specification provider group used to verify that the specificProviderGroupStatus is IN Unspecified in case the specificProviderGroupStatus is OUT
Inherited Provider Group Status	The provider group status that the line inherited through being part of a medical case
Processed as In	If claimLine.processAsIn = 'Y' and no overriding coverage regime is specified, then this value is set to 'Y'; in this situation the processAsIn indicator is directly responsible for the claim line being processed as if in network.

When the claim line used an overriding regime, the benefit specification, product benefit specification and the six fields that track the provider network status are left empty.

Claim Line Provider Pricing Clauses

A claim line can have one or more claim line provider pricing clauses. A claim line provider pricing clause consists of the following f ields:

Field	Description
Claim Line	The claim line for which provider pricing clause is applied
Provider Pricing Clause	The provider pricing clause that is applied

Field	Description
Fee Schedule Line	The fee schedule line that is applied (only filled when a fee schedule is applied)
Sequence	The order in which the provider pricing clause is applied
Mark	The way a claim line is marked with respect to the pricing rule. For example, the claim line can be primary or secondary in a combination adjustment rule
Amount	The amount (plus, minus or zero) that shows the difference to the last outcome
Currency	The currency of the amount

Limit Consumptions

A claim line may have one or more limit consumptions. Limit consumption are described in the Adjudication Limits section of the Benefit Rules implementation guide.

Bills

A bill represents a provider's invoice for a serviced person or object. Since a person can submit multiple invoices as a single claim, the bill is modeled is a subgroup of claim lines within a claim. A claim can be composed of one or more bills, each of those bills composed of one or more lines. Bills are only allowed in claims of the type "restitution claim".

For example, suppose a person sends in both the doctors bill and a dentist bill in a single request for reimbursement. The single request translates into a single claim. In the example, the claim contain two bills, each consisting of one or more lines.

If a claim consists of bills, all claim lines in that claim must belong to a bill. Claim lines are sequenced within the context of the claim, regardless of whether or not a claim contains the bill-level. A claim can consist of zero, one or multiple bills:

Field	Description
Authorization Code	This field stores the authorization code as supplied on the incoming bill.
Bill Date	The date on which the physical bill was created.
Claim	The claim to which this bill belongs.
Ind Emergency	If checked, the services on this bill is/are qualified as emergency services.
Location Provider	The location where the services was/were rendered.

Field	Description
Location Type	The type of location where the services was/were rendered.
Payment Receiver Provider	The provider that will receive the payment.
Payment Receiver Relation	The relation that will receive the payment.
Provider Entity Reference	An free text external reference to the serviced person or object on this bill.
Provider Reference	An external reference to this bill.
Referral Provider	The provider that referred the serviced person or object in context of the services specified on this bill.
Service Provider	The provider that rendered the services specified on this bill.
Service Specialty	The specialty under which the services specified on this bill were rendered.
Serviced Entity Type	The entity type for which the bill is created (person or object)..
Serviced Entity	The person or object that has undergone the services specified on this bill.

Bill Messages

A bill can have multiple messages attached to it:

Field	Description
Bill	The bill to which the message belongs.
Value0 through value9	The parts of the message text that are determined at run time.
Message	The message that specifies severity and the static part of the message text.
Origin	The origin of the message that specifies in what interval of the claims processing flow the message was added. Possible values are: ADJUDICATION, PRE BENEFITS, BENEFITS, COVERAGE, ENROLLMENT, EXTERNAL, MANUAL, PAYMENT STATUS, PRE BENEFITS, PRE PRICING, RESERVATION, PRICING, PRICING LIMIT, PRICING NO RECALCULATION and SANITY CHECKS

Bill Diagnoses

A bill can have multiple diagnoses attached to it:

Field	Description
Bill	The bill to which the diagnosis belongs.
Diagnosis	The diagnosis that is specified on the bill.
Type	The type of the diagnosis (for example principal, admitting, e-code).
Sequence	Specifies the relative importance of this diagnosis on this bill.

Within a bill, a specific diagnosis can only be present once for a specific diagnosis type. The bill diagnosis with the lowest sequence number is interpreted as the *primary* diagnosis on the bill. The primary diagnosis is the diagnosis that Claims uses to evaluate benefit specifications. See the implementation guide on Product Definition for further elaboration.

Bill Pend Reasons

A bill can have multiple pend reasons attached to it:

Field	Description
Bill	The bill to which the pend reason belongs.
Pend Reason	The pend reason

A bill pend reason represents the current active pend reasons. Once a pend reason is no longer active, it is copied to the pend reason history and discarded. The full history of pend reasons is stored in a separate entity.

Providers and relation overview

Claims contain information about the people and organizations relevant to that particular claim. These people and/or organizations all represent a role within the context of the claim. The claims model distinguishes two types of people/organizations:

- Providers - All individuals and organizations on the claim that represent health care providers within the context of the claim.
- Relations - All persons and organizations on the claim that do not represent health care providers within the context of the claim.

A claim has references to individual and organization providers representing the following roles:

- The servicing provider
- The servicing location
- The referring provider
- The price individual provider - individual provider only
- The price organization provider - organization provider only
- The benefits provider
- The payment receiver
- The payment specification receiver
- The payment beneficiary
- The claimant

A claim has references to persons and organizations representing the following roles:

- The payment receiver
- The payment specification receiver
- The payment beneficiary
- The claimant
- The serviced person or objject

Note that some roles on the claim can be represented by a provider or a relation, for example, on a provider claim, the claimant is likely to be a provider and on a restitution claim the claimant is likely to be a relation.

Process fields

The processing results of a claim depend both on the information provided on the claim and the way that Claims is set up. Which specific piece of information on the claim is actually *used* to determine the processing results differs per country. Consider the following example:

In country A the provider contract is always derived from the servicing location, while in country B the provider contract is always derived from the provider that generated the claim, that is, the claimant. The concept of having a contracted provider is consistent in both countries; the actual provider that fulfills this role is different.

Because the derivation of the contracted provider is country dependent, it is not a 'hard coded' derivation in Claims' processing flow. Consequently the claims data model (and the canonical claims

message) not only captures information that was provided on the original claim: they also capture derived information that is used to process the claim. These fields are referred to as process fields.

The process fields are the following:

- The due date (claim)
- The price organization provider (claim line)
- The price individual provider (claim line)
- The price input date (claim line)
- The price input units (claim line)
- The price principal procedure indicators (claim line)
- The benefits provider (claim line)
- The benefits input amount including the currency (claim line)
- The benefits age input date (claim line)
- The benefits input date (claim line)

These fields can be set in two ways: either their values are sent in through the claims in integration point or claims update integration point, or the values are derived by derivation rules configured within Claims. In addition, the price principal procedure indicators can also be changed through the Change Claims page.

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1. the usage names of the procedures are configurable under the claims form

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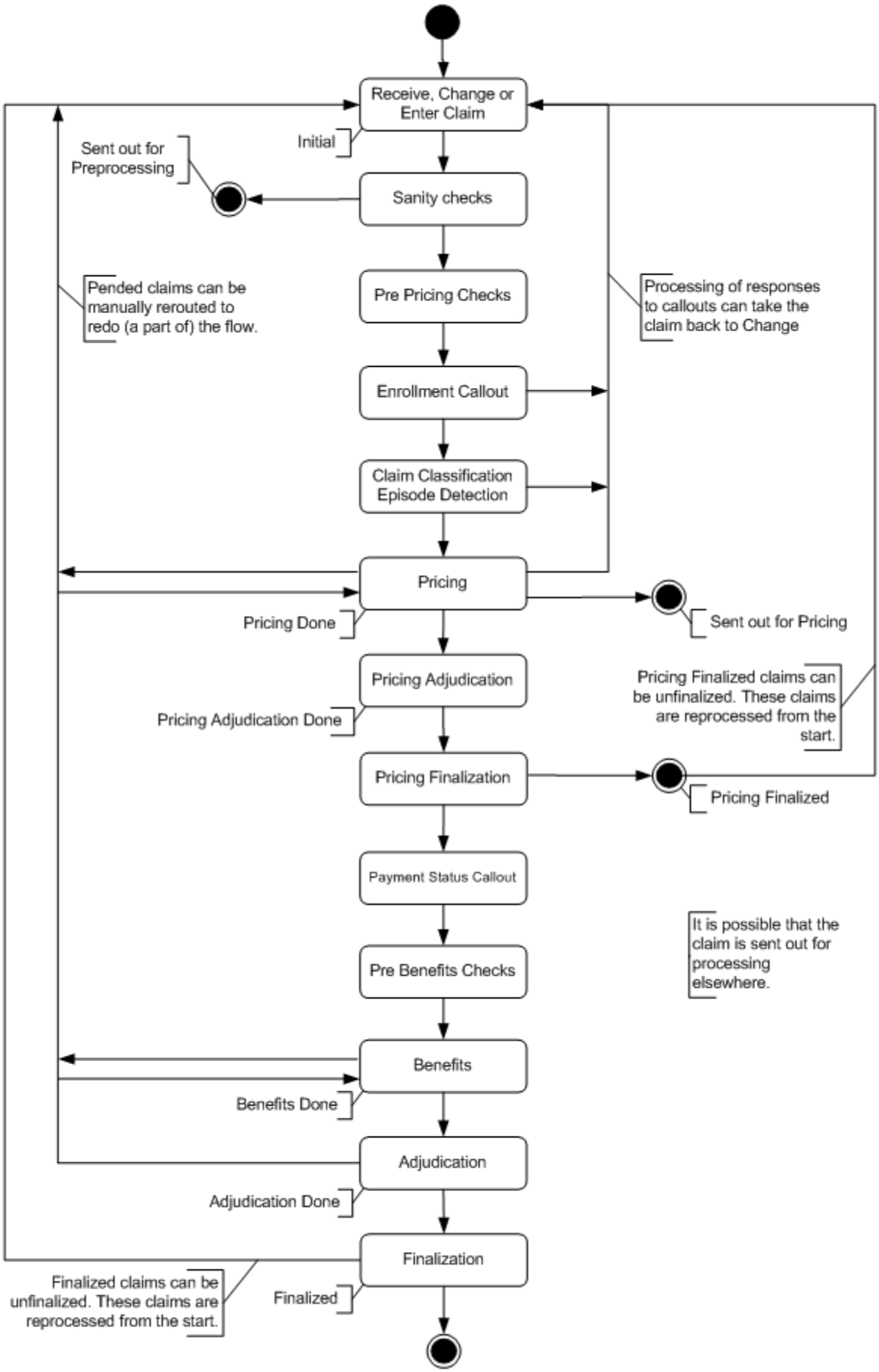
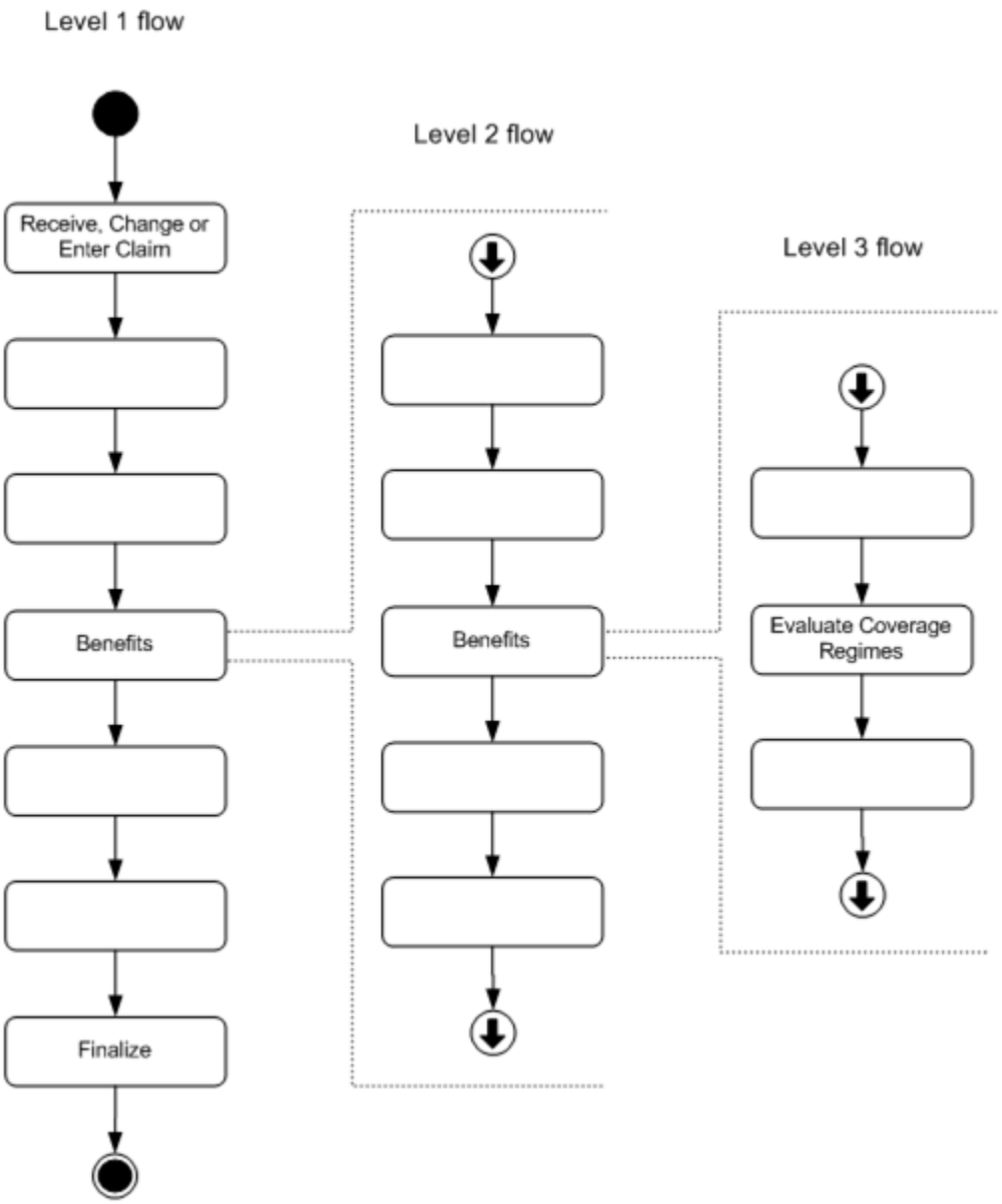


The claims flow is described in three levels of detail. The figure above displays the level 1 claims flow, that represents the bird's-eye view of what it takes to process a claim. Each of the process boxes of the level 1 flow is further detailed in a level 2 flow. Each of the subsequent chapters discusses a level 2 flow.

The level 2 flow holds enough detail to clarify the behavior of that part of the claims process, with the exception of a few more complex parts. In these cases, a level 3 flow is used to zoom in on what happens in a level 2 process step.



The status of a claim reflects the claims position in the flow. A claim can have only one status at a time. In the claim flow figures, a status transition is depicted by a yellow text label. The text reflects the new status of the claim. The following claim statuses exist:

Status	Description
Entry	The claim has been manually keyed in and saved, but not yet submitted.
Initial	The claim has been received via the integration point, or it has been keyed in and submitted or it has been changed and is resubmitted. Claims in this status are being processed.
Sent out for Pricing	A claim attains this status when a claim indicates that it (1) should be priced by a component other than Claims and (2) has not passed that pricing component. A pricing component determines the allowed amount per claim line. A copy of the claim is available for external components and is sent upon request. The claim remains in this status until the claim is overwritten by a new copy of the claim, received "claims in" integration point.
Manual Pricing	A claim attains this status when the claim pends as a result of a configured intervention rule. Processing is suspended. The claim can be manually priced through the user interface.
Pricing Done	A claim attains this status when it has has passed all pre pricing checks and pricing logic.
Manual Pricing Adjudication	A claim attains this status when the claim pends as a result of a configured intervention rule. Processing is suspended. A user needs to manually accept or deny the claim
Pricing Adjudication Done	The claim has either been manually accepted, denied or has given Claims no reason to pend it for manual pricing adjudication.
Pricing Finalized	A claim attains this status when its benefits should be calculated by an external component. The pricing process is finalized after which a copy of the claim is available for external components and is sent upon request.
Manual Benefits	A claim attains this status when the claim pends as a result of a configured intervention rule. Processing is suspended. The claim's benefits can be modified through the user interface.
Benefits Done	The applicable benefits have been determined and the claim has passed all pre benefits checks.
Manual Adjudication	A claim attains this status when the claim pends as a result of a configured intervention rule. Processing is suspended. A user needs to manually accept or deny the claim.
Adjudication Done	The claim has either been manually accepted, denied or has given Claims no reason to pend it for manual adjudication.
Finalized	The claim is processed and the results have been written to the Claims Transaction Repository. The processing results of this claim are now visible to other claims.

Status	Description
Change	The claim can be changed through the user interface

A claim line can have the following statuses. The claim line status is set as soon as a claim reaches the status PRICING ADJUDICATION DONE (when benefits are evaluated externally) or ADJUDICATION DONE (when benefits are evaluated internally). Before that, the claim line status field is empty.

Status	Description
Approved	The claim line is approved. The covered amount of the claim line is to be paid.
Denied	The claim line is denied. The covered amount is set to 0.00.

Receive, Change or Enter Claim

A claim can either be received electronically in an EDI format or can be entered through the user interface. Claims can be sent in electronically through the claims in integration point. Claims can also be keyed in through the user interface. The claim can be saved while entering such that the entering can be continued later. Only when the user indicates that the claim is completely entered the claim is considered received and the automatic processing starts.

As this is the first step of processing a claim, this is also where claims fields can be updated. For example, a claim that has pended for manual action may require that a field on the claim is changed before it is resubmitted. In order to make that change, the claim is returned to the start of the flow.

Sanity Checks

This step contains a number of hard coded checks that validate the information on the claim and verify that the claim specifies the information that is required to start processing.

There are two types of hard coded checks: completeness checks and general checks. Completeness checks ensure that all information on the claim can be mapped to the resident reference data, for example, is the specified person or object known to Claims? General checks ensure the consistency of the claim, for example, a claim line end date cannot be prior to its start date. Some general checks do touch upon user configuration. For example, a user can specify that a particular procedure requires the serviced person to be over a certain age. The check that ensure that the specified person meets applicable age conditions is hard coded. The actual age on the procedure code is user configurable.

Failing a hard coded check means that a fatal message is attached to the violating claim or claim line. A fatal message on the line will result in the denial of that line. A fatal message on the claim will result in the denial of the entire claim, including all its lines.

Pre Pricing Checks

This step contains the user configured rules and checks that do not require any information on the products that may apply to a claim (line). There are two types of user configurable logic: dynamic checks and derivation rules.

A dynamic check sets a condition that takes any combination of fields on the claim or claim line as input. The condition can either be triggered per claim or per claim line. The outcome is binary. Claims or claim lines that fail to meet the condition acquire the message specified on the dynamic check. This message can be either fatal or informative. Fatal messages result in the denial of the claim or claim line.

The other piece of configurable logic that executes during pre pricing is a rule, rather than a check. The difference being that a check represents a condition that the claim or claim line is required to meet, while a rule represents a certain action on, or triggered by, the claim. A derivation rule sets the value of a claim or claim line field. This value can be derived from any combination of fields on the claim or claim line.

Enrollment Callout

Per person or object, per claim, Claims sends out a request for that person or object's product information. The returned information is required to determine the applicable benefits later in the process. Another important piece of information that is returned in the response is the unique code for a person or object's family. This code is required to keep track of limits that count per family rather than counting per person or object.

The returned enrollment information is temporarily stored in Claims and is discarded as soon as the claim is rerouted to a part of the flow where it requires a new enrollment callout.

Claim Classification

The evaluation of the model for claim classification (for details on the model, see the Implementation Guide for Pricing Components) is split into two parts:

- determining which classification scheme is used (executed in the pre pricing checks)

- applying the classification scheme to all claim lines (done after the callout for the DRG grouper), that is, this step in the flow

For more detail see Pre-Pricing Checks and Reservation Selection, Claim Classification, and Episode Detection.

Callouts to external components can be executed at the beginning and at the end of the classification step. The processing of responses to these callouts can take the claim back to the Change status. This depends on the nature of the callout response.

Pricing

During this step it is determined whether the claim still requires pricing. If it does, and the claim indicates that it should be priced outside of Claims, then the claim is sent out in order to be repriced.

If the claim indicates that it should be priced in Claims, then the claim stays inside. If the claim meets the conditions set by at least one of the external intervention rules, the claim pends and can be manually priced. External intervention rules are user configured.

Callouts to external components can be executed at the end of the pricing step. The processing of responses to these callouts can take the claim back to the Change status. This depends on the nature of the callout response.

Pricing Adjudication

This step filters out claims which require manual review of the claim after pricing. Claims that require manual review are pended by executing the external intervention rules for step 'Manual Pricing Adjudication'. If the claim or one of its claim lines meets the conditions set by at least one of the external intervention rules, the claim pends. The user is presented with the options of (1) accepting the way Claims processed the claim, (2) denying the entire claim or (3) rerouting the claim to an earlier step in the flow in order to change the claim's fields or results.

Pricing Finalization

This part is only executed when a claim is marked for external benefits; for internal benefits, the step is skipped and the finalization is done at the very end, after benefits.

In pricing finalization, concurrent use of provider limits is checked. Once such a concurrent use is detected, the step of selection and application of reimbursement methods and pricing rules is

automatically executed again. After pricing finalizing, a copy of the claim is available for the external benefits component through the claims out integration point.

Pricing Finalized claims can be unfinalized through the user interface or an integration point. Unfinalizing a claim means that the claim is open for changes, but the claim will need to go through the entire processing flow in order to be finalized again.

Payment Status Callout

Per person or object, per claim, Claims sends out a request for information on that person or object's payment status. The response to this callout takes the form of product specific messages. In turn, these messages can be used to deny the claim, serve a hook for an external intervention rule, in order to pend the claim, or simply provide information visible in the user interface. This callout can be disabled through a setting in the Claims configuration file.

Pre Benefits Checks

In this step, three types of checks and rules are triggered. All pre benefit checks and rules are user configured. Pre benefit checks are typically checks that require product specific information that may apply to a claim (line). The three types of configurable rules/checks are: dynamic checks, derivation rules and combination rules.

The dynamic checks and derivation rules are identical to their pre pricing counter parts, the difference being that they are executed later in the flow. Pre benefit dynamic checks are always triggered in the context of a product. The rationale is that, any check ignorant of product information should have been a pre pricing check.

Combination checks are similar to dynamic checks. The difference is that combination checks validate across claim and claim line history, rather than within a single claim or claim line. In other words, a combination is able to compare lines that belong to different claims. A typical example of a combination check is the detection of duplicate claim lines.

Benefits

In Claims benefit are configured as benefit specifications. A benefit specification applies within the context of a group of procedures and specifes a number of additional conditions based on any field on the claim or claim line. Three different types of benefit specifications exist; for waiting periods, for authorization requirements and for coverage benefits.

The first type imposes a waiting period, that is, the period of time that a person or object needs to be subscribed to a product before (part of) its benefits become active.

The second type of benefit specification imposes a requirement for an authorization. Claims stores authorizations, which are sent in through an integration point. For each claim line that requires an authorization, a matching authorization needs to be present in order for the (full) benefits to apply. What actually constitutes a matching authorizations is a user configured piece of logic referred to as an authorization matching function.

The last type of benefits specification actually specifies the coverage. Based on the user configured cover withhold rules, Claims calculates what part of claim should be covered, and what part should be withheld. Applicable limits are consulted and updated. Applicable cases are detected and created.

Once the benefits have been applied, the application can execute callouts to external components.

Re-evaluate External intervention Rules

At this step the external intervention rules are evaluated a second time. If the claim or one of the claim lines meets the conditions set by at least one of the external intervention rules, the claim pends and the benefits can be manually modified.

Execute End Benefits Callouts

At this step of the flow the application checks if any End Benefits callout rules apply to the claim. If so, the application halts the claim at its current location in the claims flow. The claim's status is not changed. The callout rules that apply to the claim are then executed sequentially, in order of their specified sequence.

The application executes the End Benefits callout rules for claims independent of the Keep Benefit setting of the claim lines. Note that the claims flow does not cleanup the results of a previous Benefits step for claim lines with Keep Benefits set to Yes. This means that calling out and resubmitting a claim with such claim lines more than once, can result in claim lines holding details from more than one callout.

If the callout definition specifies a "Response Logic" dynamic logic function, this logic processes the response message. The response message can update dynamic fields and add a message through a pre-defined method. Sending in (fatal) messages will however not impact the status of the claim or claim line that was set in the previous step. If the response of the callout has to set the claim or claim line status, or if it should lead to reprocessing the claim, the response should be send in through a Claims

Update IP request message. This option is only available for callout definitions with an asynchronous messaging pattern.

Re-evaluate External Intervention Rules

As a final step the external intervention rules are evaluated a second time. If the claim or one of the claim lines meets the conditions set by at least one of the external intervention rules, the claim pends and the benefits can be manually modified.

Adjudication

This step filters out claims which require manual review. All other claims continue to be processed. Claims that require manual review are pended by executing the external intervention rules for the last time. If the claim or one of its claim lines meets the conditions set by at least one of the external intervention rules, the claim pends. The user is presented with the options of (1) accepting the way Claims processed the claim, (2) denying the entire claim or (3) rerouting the claim to an earlier step in the flow in order to change the claim's fields or results.

Finalization

The most important part of finalizing a claim is the detection of concurrent use of counters and cases. Concurrent use must be detected in order to prevent a counter from exceeding its limit due to the simultaneous processing of multiple claims. Likewise, the creation of the identical overlapping cases is detected. Once a claim is cleared and confirmed not to be in conflict with other claims, a snapshot of the claim, that is, a claim transaction, is stored in the Claims Transaction Repository.

Finalized claims can be unfinalized through the user interface or an integration point. Unfinalizing a claim means that the claim is open for changes, but the claim will need to go through the entire processing flow in order to be finalized again.

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Sanity Checks

This step holds a number of checks and rules that execute immediately once the claim enters the processing flow. Note that this step is not performed for locked claim lines and replaced claim lines. The sanity checks flow is schematically depicted by the following figure: mage::sanity-checks-1.png[Sanity Checks]

Remove Existing Messages

The messages attached to the claim, claim line and bills that were attached in a previous sanity checks step are removed.

Derivation Rules

A derivation rule sets the value of certain fields on a claim, bill or claim line. There are two types of derivation rules, that is, for dynamic and fixed fields and for process fields. At this point in the flow, only derivation rules are executed for which the "step" field has the value "pre reversal" which means no process field drivation rules. Pre reversal derivation rules are evaluated *even if* a fatal message is attached to the same (or higher) level as specified by the derivation rule. The pre reversal derivation rules are evaluated in the following order: claim (header) first, bill second, claim line last. Then, if multiple derivation rules exist, they are executed in order of the configured sequence (sequence null is evaluated last).

Reverse Edits

Reverse edits is a step that always needs to be carried out, both for a claim that comes from the Change page and for a claim that is processed again through the Claims In IP, Claims Update IP or Claims Reprocessing IP (note that this step is skipped for new claims).

Edits that are marked by a tag can be reversed automatically. Whether that actually needs to be done, can be set by an operator in the Change page or by an IP though claim tag actions. These actions refer to a particular claim and a particular skip tag, which can be set through either a callout rule or a replacement rule.

When are edits reversed?

Edits are reversed depending on the claim tag action:

- Redo - The edit is reversed **unless**
  - One of the lines on the claim has a checked KP/KB/Locked indicator AND was added by the callout / replacement rule
  - One of the lines on the claim has a checked KP/KB/Locked indicator AND has a **fatal** message added by the callout rule
  - One of the lines on the claim has a checked KP/KB/Locked indicator AND has an allowed amount set by the callout rule
- Skip or Force - The edit is reversed **unless**
  - One of the lines on the claim has a checked Locked indicator AND was added by the callout / replacement rule
  - One of the lines on the claim has a checked Locked indicator AND has a **fatal** message added by the callout rule
- * One of the lines on the claim has a checked Locked indicator AND has an allowed amount set by the callout rule
- Hold - The edit is not reversed.

What is reversed?

Edits are reversed per skip tag. Note that edits on locked claim lines are not reversed. Reversing an edit means:

- Claim lines that were added by the callout rule(s) or a replacement rule(s) using the skip tag are removed. If the added line replaced original lines, the original lines are restored.

- Any allowed amount and allowed number of units field that was set through the callout rule(s) using the skip tag is cleared (set to 0) and the accompanying skip tag for allowed is cleared.
- Any claim line message that was added through the callout rule(s) using the skip tag are removed

Rematching

When reference data like relations, providers and procedures are loaded into Claims from an external source, it can occasionally be that the claim is stored through the Claims In Integration Point while one or more references cannot be resolved. As a result, for the unresolved reference data, unmatched values are stored on the claim, bill or claim line. There are ways to resolve this:

- by manually picking the right reference data through a list of values in the 'Receive, Change or Enter Claim' page
- by updating the reference through the Claims Update Integration Point
- by loading the more recent reference data and then reprocessing the claim so that another attempt is made to match the reference data

This last practice is automated through the rematching step. At all three levels, non-matches are being tried to resolve (a non-match is recognizable by the combination of a missing reference and at least one one of the corresponding non-matched fields being filled). The way of resolving differs, either by * trying to match the non-matched code field against the reference table. This structure applies to:

- Serviced entity type (claim, bill and claim line) - matching against insurable entity types
- Serviced person (claim, bill and claim line) - matching against persons
- Serviced object (claim, bill and claim line) - matching against objects
- Service specialty (claim, bill and claim line) - matching against specialties
- Messages (claim, bill and claim line) - matching against messages
- Modifiers (claim line) - matching against modifiers
- Claim line contract references (claim line) - matching against contract references
    - trying to match the combination of the unmatched code field and the unmatched code definition field against the reference table. This structure applies to:
- Service provider (claim, bill and claim line) - matching against providers
- Location (claim, bill and claim line) - matching against providers
- Referral provider (claim, bill and claim line) - matching against providers
- Price individual provider (claim line) - matching against individual providers

- Price organization provider (claim line) - matching against organization providers
- Benefits provider (claim line) - matching against providers
- Procedure (claim line) - matching against procedures belonging to the flex code system as specified under the claims form
- Procedure 2 (claim line) - matching against procedures belonging to the flex code system as specified under the claims form
- Procedure 3 (claim line) - matching against procedures belonging to the flex code system as specified under the claims form
- Claim sub line procedure (claim sub line) - matching against procedures
    - trying to match the combination of the unmatched code field, the unmatched code definition field and the type code against the reference table.

This structure applies to:

- Diagnoses (claim, bill and claim line) - matching against diagnoses
    - trying to match the combination of the unmatched code field and the claim form code against the reference table.

This structure applies to:

- Location type (claim, bill and claim line) - matching against location types
    - trying to match either the code or the combination of the unmatched code field and the unmatched code definition field against the reference table.

This structure applies to:

- Claimant (claim) - matching against relations respectively providers
- Payment specification receiver (claim) matching against relations respectively providers
- Payment beneficiary (claim) matching against relations respectively providers
- Payment receiver (claim, bill and claim line) matching against relations respectively providers

Once a match has been made, the non-matched fields are cleared - just like an update through the UI or the Claims Update Integration Point would accomplish.

Note: Rematching for persons also includes rematching on relation or provider identifiers .

Claim Level Completeness Check

The purpose of this check is to make sure that every piece of information is matched, that is, that the information provided in the claims "in" integration point message has been successfully mapped to the reference data. This check is also executed for each bill that may be underlying to the claim. The claim completeness check is executed regardless of existing fatal messages.

The following claim fields are checked for non-matches:

- Serviced entity type
- Serviced entity (person or object)
- Service provider
- Service specialty
- Claimant
- Location
- Location type
- Referral provider
- Payment receiver
- Payment specification receiver
- Payment beneficiary
- Claim messages
- Claim diagnoses

The following bill fields are checked for non-matches:

- Serviced entity type
- Serviced entity (person or object)
- Service provider
- Service specialty
- Location
- Location type
- Referral provider
- Payment receiver
- Bill Messages
- Bill Diagnoses

A field is considered to be non-matched in the event that no foreign key has been set for that field *and* at least one of the pertaining non-matched fields contains a value. When a non-match is detected the following message is attached to the claim:

Code	Sev	Text
CLA-FL-PPRI-006	Fatal	The {field name} is not matched.
CLA-FL-PPRI-007	Fatal	One of the {field name} is not matched.

Examples:

CLA-FL-PPRI-006	Fatal	The serviced entity is not matched.
CLA-FL-PPRI-006	Fatal	The claimant is not matched.
CLA-FL-PPRI-007	Fatal	One of the message codes is not matched.
CLA-FL-PPRI-007	Fatal	One of the diagnoses codes is not matched.

Note that *any* non-match will lead to a fatal message on the claim. There is no distinction given the importance of the field. A non-matched serviced entity and non-matched tenth claim diagnosis code will both lead to a fatal message. One message is attached for each non-matched field.

Claim Line Level Completeness Check

The purpose of this check is twofold. First, this check makes sure that everything that was provided on a claim line is actually matched. Second, it is to make sure that everything vital from a processing point of view, is present. As claims are processed per line, this latter check only on the line level. The claim line completeness check is executed regardless of existing fatal messages.

The following claim line fields are checked for non-matches:

- Serviced entity type
- Serviced entity (person or object)
- Service provider
- Service specialty

- Location
- Location type
- Referral provider
- Payment receiver
- Price organization provider
- Price individual provider
- Procedure
- Procedure 2
- Procedure 3
- Benefits provider
- Claim line messages
- Claim line diagnoses
- Claim line modifiers
- Claim line contract references
- Claim sub line procedure

In the event that a non match is detected, a fatal message is attached to the line. One message is attached for each non-matched field:

Code	Sev	Text
CLA-FL-PPRI-006	Fatal	The {field name} is not matched.
CLA-FL-PPRI-007	Fatal	One of the {field name} is not matched.

Examples:

- CLA-FL-PPRI-006 - The serviced entity is not matched.
- CLA-FL-PPRI-006 - The claimant is not matched.
- CLA-FL-PPRI-007 - One of the claim line message codes is not matched.
- CLA-FL-PPRI-007 - One of the claim line diagnoses codes is not matched.

Because any non matched field may be key in determining the right price or benefit, the CLA-FL-PPRI-006 and 007 are fatal. Claim line procedures are an exception: a configuration option is available for non matched claim line procedures to result in an informative message rather than a fatal message. This

configuration is available under the claims form. If the "Fatal non match" indicator is unchecked for a procedure, and that procedure is unmatched, the following message is generated instead of the the CLA-FL-PPRI-006:

Code	Sev	Text
CLA-FL-PPRI-020	Info	The {procedure display name} is not matched.

The procedure display name value is configured under the claims form.

After the non-matches have been checked, the system re-checks the serviced entity. If the serviced entity is neither matched nor unmatched, that is, not specified at all, then the following message is generated:

Code	Sev	Text
CLA-FL-PPRI-008	Fatal	The serviced entity must be specified.

The completeness check only covers those fields which are not mandatory in the claims data model. These are fields that can be on multiple levels or may be non-matched. Mandatory fields (such as the claim line start date) are not checked at this point; if this field was not specified the claim would not have been accepted by the integration point.

Claim Line Level General Checks

After the completeness check, a number of basic checks regarding time validity and the use of procedures are done for each claim line. General checks are only executed on line level because information on the claim or bill level is inherited down to the claim line level. Claim line level general checks are not evaluated if a fatal message (of origin MANUAL, EXTERNAL or SANITY CHECKS) exists that is attached to the claim line, or the bill or claim to which the line belongs.

Time validity of codes

All the codes that can be used on a claim or claim line can have a start date and an end date. The check whether a code is valid on the right date of the claim is performed in this step. The check is performed in the following way

At the claim level no time validity checks will be performed. This is because the claim has no "as-of" date to check a code's validity against. In addition, if the claim holds provider and diagnosis information, that information will have inherited down to the lines that did not specify their own. Since the lines are checked, checking at the claim level is redundant.

For procedures, diagnoses, providers and flex code values, the code must be valid on the start date of the claim line. More precise:

- The procedure/diagnosis/provider/flex code's start date must be on or before the start date of the claim line
- The procedure/diagnosis/provider/flex code's end date must be either unspecified, on or after the start date of the claim line

If this is not the case the following message will be attached to the claim line:

Code	Sev	Text
CLA-FL-PPRI-002	Fatal	The value of the code {code} in the field {'field display name'} should be valid at {'claimline.startdate'}

If this is not the case with flex codes on dynamic records the following message will be attached to the claim line:

Code	Sev	Text
CLA-FL-PPRI-018	Fatal	The value of the code {code} in the field {'record field display name'} on dynamic record {'field display name'} should be valid at {'claimline.startdate'}

Procedure age and gender

A claim line can specify up to three procedures. This step handles the validation of a claim line with regard to the allowed age and gender that can be specified on procedures. These attributes represent conditions that must be met by a serviced person in order to claim the specified procedure. The age is determined as the age on the claim line start date.

If the person fails to meet the age and or gender conditions, then the following message is attached to the claim line.

Code	Sev	Text
CLA-FL-PPRI-003	Fatal	The serviced person's age {'person.age'} exceeds the age bounds {'procedure setting.age from'}, {'procedure setting.age to'}, as specified for the procedure.
CLA-FL-PPRI-021	Fatal	The serviced person's age {'person.age'} exceeds the age bounds {'procedure setting.age from'}, {'procedure setting.age to'}, as specified for the second procedure.
CLA-FL-PPRI-022	Fatal	The serviced person's age {'person.age'} exceeds the age bounds {'procedure setting.age from'}, {'procedure setting.age to'}, as specified for the third procedure.

Note that the bounds on the procedure are inclusive: if the "age to" is 75 and the person is exactly 75 years old on the as-of date, then no fatal message is attached.

In the event that the procedure gender attribute is specified, the gender of the serviced person has to be the same. If this is not the case, then the following message is attached to the claim line:

Code	Sev	Text
CLA-FL-PPRI-004	Fatal	The serviced person's gender {'serviced person.gender'} does not match the gender {'procedure setting.gender'} specified for the procedure.
CLA-FL-PPRI-023	Fatal	The serviced person's gender {'serviced person.gender'} does not match the gender {'procedure setting.gender'} specified for the second procedure.
CLA-FL-PPRI-024	Fatal	The serviced person's gender {'serviced person.gender'} does not match the gender {'procedure setting.gender'} specified for the third procedure.

Note that this check is only relevant if the claim or claim line relates to a serviced person. It does apply to serviced objects.

Serviced Entity Type

An additional validation is executed to check whether the serviced entity type is valid for the line of business related to the claim form.

Code	Sev	Text
CLA-FL-PPRI-025	Fatal	The serviced entity type {type} is not valid for line of business {code}.

Evaluate External Intervention Rules

All external intervention rules of the sub type MANUAL CHANGE are evaluated. A rule triggers when all a claim, claim line or bill satisfies all criteria set by the rule.

For each triggered external intervention rule, the specified pend reason is checked: if the reattach indicator is unchecked *and* the pend reason history indicates that the same pend reason has been previously attached on the same level (claim, bill or line), then the pend reason is not attached and the claim will not pend because of this external intervention rule. Otherwise, the specified pend reason is attached to the claim, claim line or bill, and added to the claim pend reason history.

If *no* pend reasons are attached as a result of the external intervention rule evaluation, then the claim skips ahead to the "Pre Pricing" step. Otherwise, the claim indicators "Preprocessing Done?" and "Pricing Done?" are unchecked and the claim status is set to CHANGE. See the implementation guide on claims flow configuration for more details on how to configure external intervention rules.

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