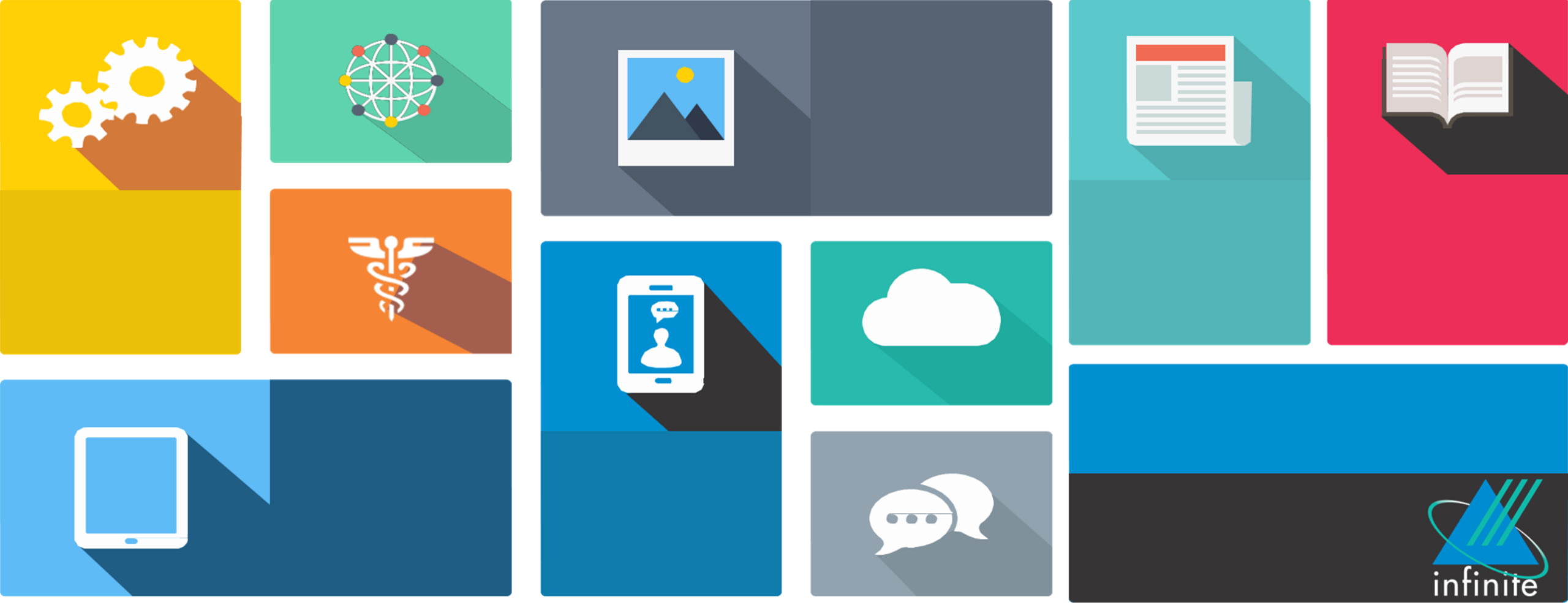
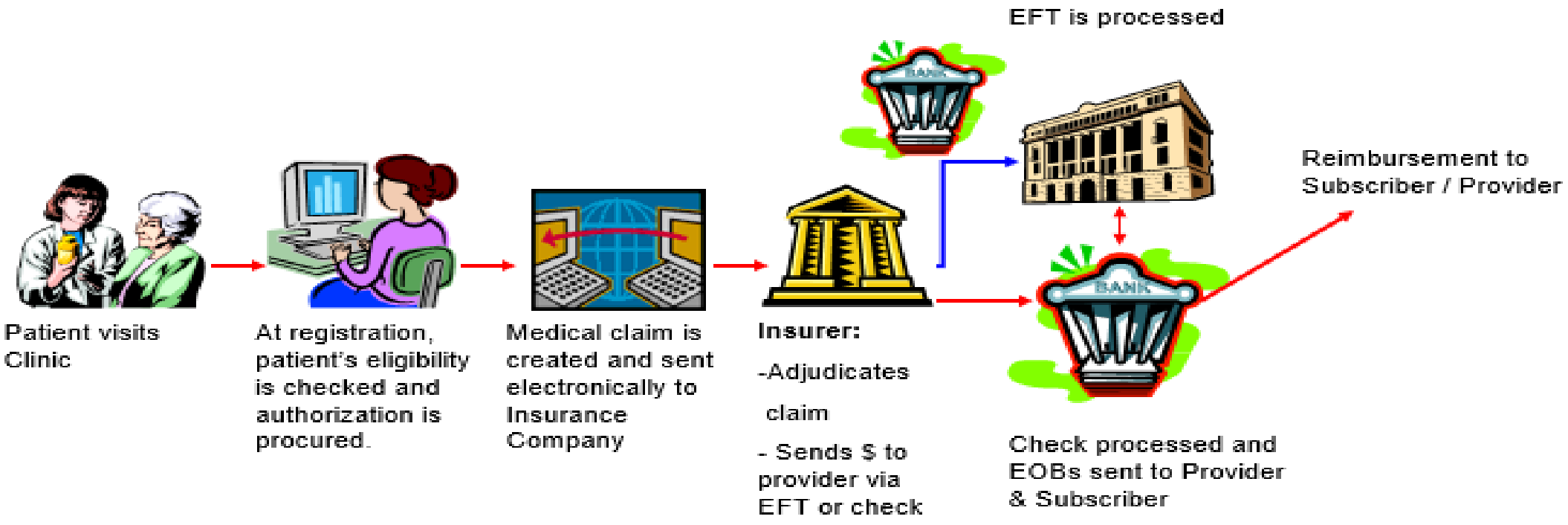


Claim

Claim Overview

Detailed invoice that a health care provider sends to the health insurer, exactly showing the services that have been rendered by the providers to the patient.



Key Players in the Medical Claims Process

Healthcare providers

- A healthcare provider is any facility or practice where you receive and are billed for a product or service related to your personal health.

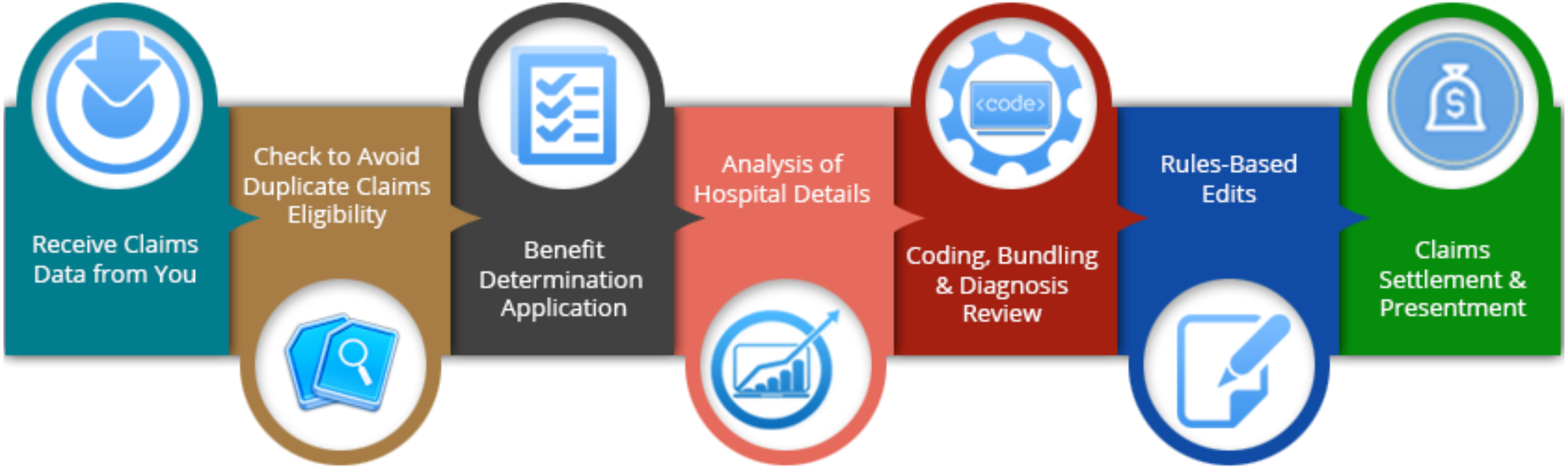
Insurance companies

- Health insurance companies subsidize medical care for qualifying patients, called policyholders.

Member

- A Member is any individual who has purchased health insurance.

Claims Life Cycle



Claim Types

Professional Claims

- Generated for work performed by physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services.
- Form Type – CMS 1500

Institutional Claims

- Submitted by the group providers to the organization for the members.
- Form Type – CMS 1450 (UB-04)

Dental Claims

- Claims submitted by the dental providers.
- Form Type – ADA

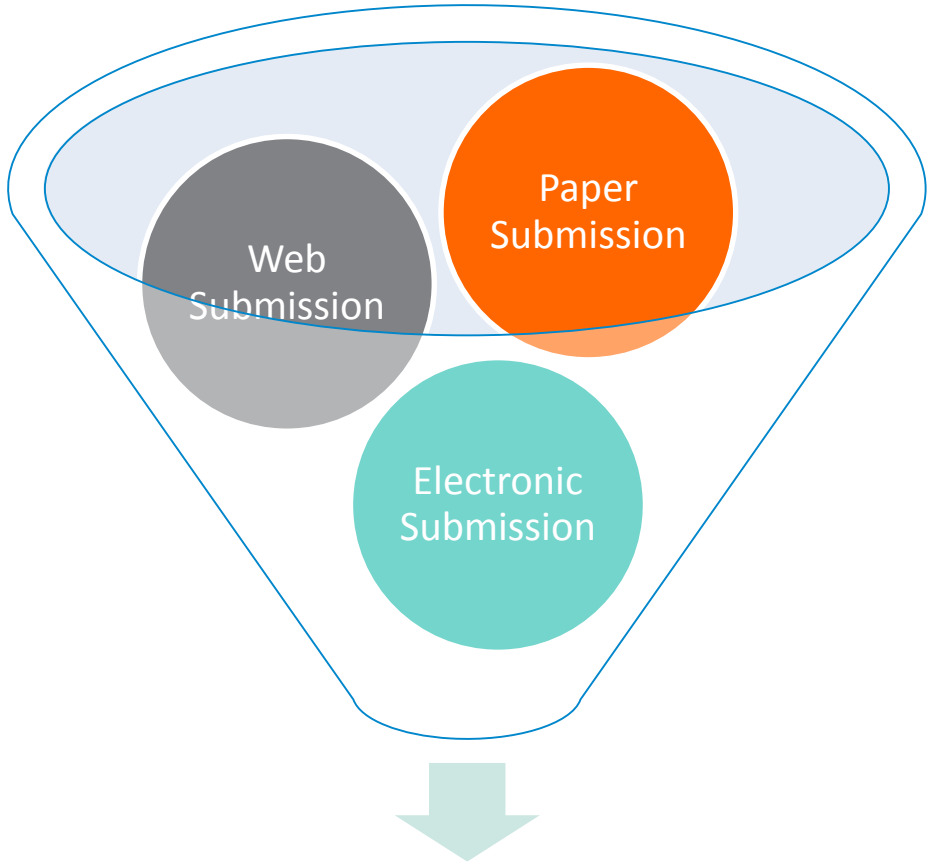
Pharmacy Claims

- **C**over the medicine and dispensing costs associated with supplying prescribed pharmaceutical items to patients.
- Form Type – NCPDP

Claims Entry

Set of information on a medical claim

- Member Data
- Provider Data
- Date of service
- Diagnosis code
- Procedure Code
- Place of service
- Service units
- Payment Details
- etc



Code sets & Provider Identifiers

Medical codes are used for encoding data, medical diagnosis codes, or medical procedure codes. Codes are used for statistical and medical billing purposes.

- ICD 9 & 10 Codes
- HCPCS (CMS's Healthcare Common Procedure Coding System) - used primarily to identify products, supplies, and services not included in the CPT
- CPT codes (American Medical Association's Current Procedural Terminology) – For Medical, Surgical, diagnostic procedures
- NDC Codes (Universal Product identifier for human drugs)
- Revenue Codes (where the procedure or service was provided)
- DRG codes (500 Diagnosis related groups)

Provider ID's

- NPI
- Tax ID
- SSN
- Legacy Id's

Claim Entry - Claim fields and usage

National Provider ID - National Provider Identification. Refers to the standard unique health identifier for each health care provider which is required to be adopted under HIPAA.

Member Id - Member is one who took the service from provider.

Coinsurance - An arrangement by which an insurance plan, Medicare, Medicaid or other third party share the cost of medical expenses.

Copay - A cost-sharing arrangement in which the MCO (Managed Care Organization) enrollee pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug).

Deductible Amount - The part of a member's health care expenses that the patient must pay before coverage from the insurer begins. A fixed amount that a Medicare or other third-party patient must pay for medical services before Medicare coverage begins. The deductible must be paid annually

Claim fields and usage (Contd..)

Physical Location - Physical location where the health care service was provided.

Reimbursement Amount-The reimbursement amount is the allowed charge minus any base rate changes such as TPL, patient liability, or co-pay.

Category of Service: The services for which enrolled providers are authorized to bill.

Fund code: The budget and funding sources that apply to a claim.

Diagnosis Code: A standard code used to describe the nature of a patient's illness or injury.

Procedure Code: Indicates the procedure or service provided.

Claim Attachment: Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

Claim Adjudication

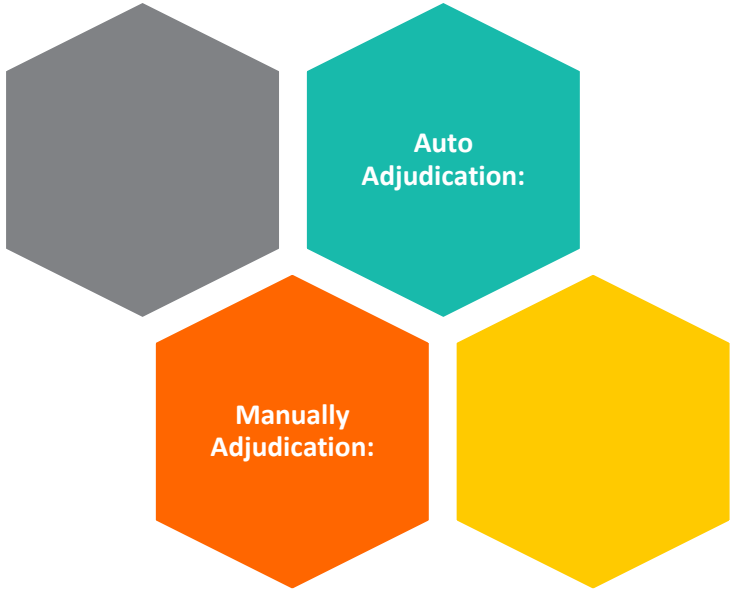
"Claims adjudication" is a phrase used in the insurance industry to refer to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

Auto Adjudication:

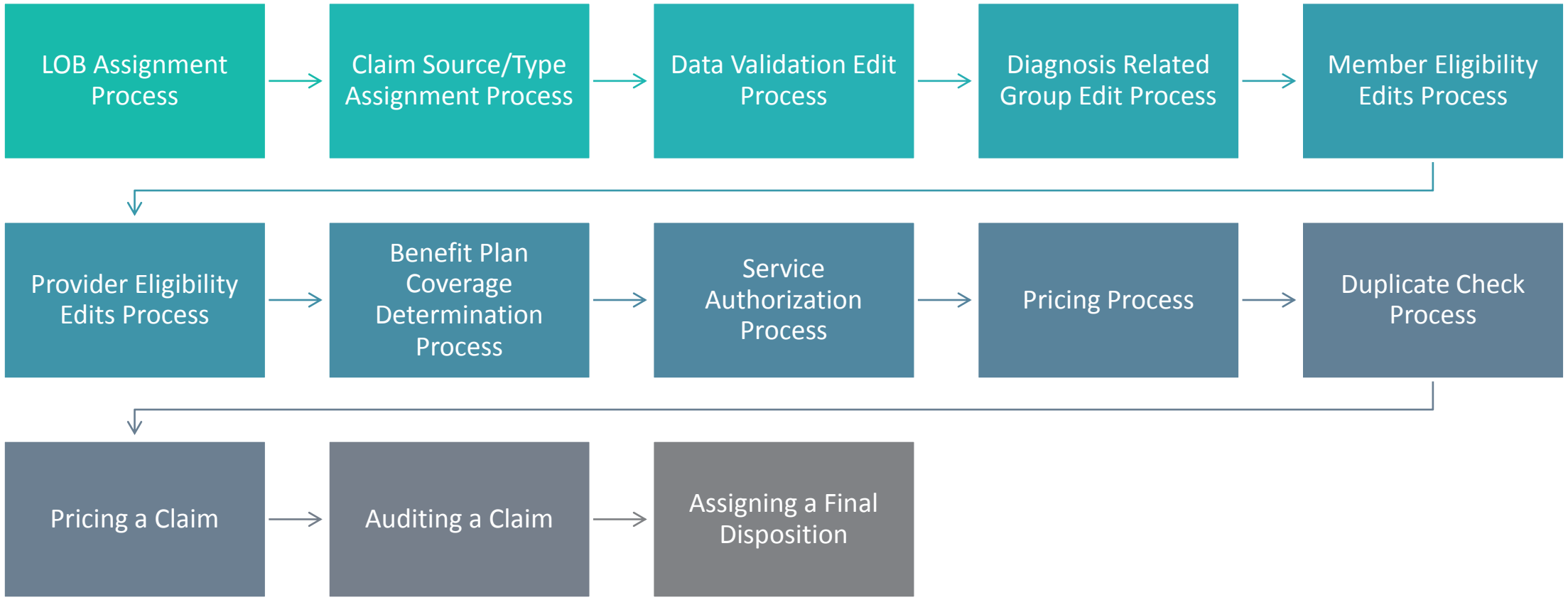
Through this process, the claims are subjected to edit checks, including duplicate payment checks, provider and member eligibility checks, coverage checks and various other edit checks that are specific to provider types and specialties. The claim is priced based on the information submitted on the claim.

Manually Adjudication:

- Processor can payout the claim.
- Deny – uncovered service.
- Pended for additional information – accidental details.
- Routed for review – medical review.



Adjudication



EOB/ERA

- An explanation of benefits (EOB form) is a statement sent by a payer to covered individuals explaining what medical treatments and/or services were paid for on their behalf.
- ERA : An electronic remittance advice is an electronic version of a payment explanation which provides details about providers' claims payment.

Patient Responsibility

- **Copay :** A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.
- **Deductible :** The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.
- **Co-Insurance :** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.

Claims Edit

- Business Rule is a statement that defines or constrains some aspect of the business. Intended to control or influence the behaviour of the business.
- What if a rule is not followed by the system ?
- Inform the user that the rule has been violated by posting an Edit.

Example:

if
The Member ID on the claim does not have a corresponding row on the member master database.
then
Post Exception 2000

if
The procedure code on the claim is invalid.
then
Post Exception 1000

Thank You