21 Claims Administration

Objectives

After completing this module, you will be able to:

- describe the roles of technology and personnel in claims processing,
- discuss the use of codes and edits in claim processing, and
- state the main questions that must be answered in processing a claim.

A **claim** is a request to an insurer or health plan for payment of benefits. In health coverage, it usually takes the form of an itemized statement of healthcare services delivered by a healthcare provider to a covered person, along with the cost of those services. The person or entity submitting a claim is called the **claimant**; this may be an insured, but in health coverage it is most often a provider. **Claims administration** or **claims processing** is the receiving, reviewing, adjudicating, and paying of claims. (To **adjudicate** a claim is to make determinations and decisions about it.)

In this module we examine the processing of health plan claims by automated computer systems and by claims examiners and other personnel; learn about important elements of processing systems, such as standardized claim forms, diagnosis and treatment codes, and edits; and survey the adjudication of a claim by identifying the questions that must be answered before a claim can be paid.

Health Plan Claims

Traditional Insurance and Health Plans

In traditional indemnity health insurance, the provider sends a bill to the insurer for the services delivered (or less commonly the insured pays the provider herself and then sends a claim to the insurer with the provider's bill attached as documentation). The insurer processes the claim to determine if payment is in fact due and if so pays the provider or insured.

In a health plan, the claims function varies by plan type and provider compensation arrangement. In some cases a plan such as an HMO does not receive claims requesting payment for services rendered because providers are prepaid for delivering those services to members by means of a capitation payment, or because they are paid a salary. Instead, the plan receives **encounter reports**. An **encounter** is a visit by a plan member to a provider of healthcare or related services. An encounter report includes the services provided, the date of service, the diagnosis, and other information. A health plan uses encounter reports to track utilization and provider practice patterns and as a basis for future capitation amounts.

However, most healthcare professionals are compensated by health plans on a discounted fee-for-service (FFS) basis or a combination of FFS and capitation, and hospitals are typically paid their regular charges minus a percentage discount, case

rates, or fixed rates for specific procedures. In these cases, claims are submitted, and health plan claims processing is very similar to that of traditional insurance.

Technology

In the past health plan claims were mostly paper documents received by mail and reviewed and adjudicated by plan employees. Today, typically between 80 and 90 percent of a plan's claims are processed by automated, computerized systems, sometimes more. Providers generally transmit claims to a plan by electronic data interchange (EDI) (discussed in the preceding module). When paper claims are received, the data is entered into the electronic system so that they can be automatically processed. Increasingly, **optical character recognition (OCR)** technology is used to convert printed or even handwritten text into electronic files.

Electronic claims processing systems perform routine and simple tasks, such as verifying that an individual is a plan member or that a doctor is a network provider. And most health plans also use such systems to make decisions that require more in-depth analysis. A database containing member profiles, member benefit packages, provider profiles, provider compensation arrangements, and other information is either integrated with or part of an expert software system enabling the claims system to make higher-level claims decisions. Such a system attempts to replicate the process an expert claims examiner uses to solve a problem to arrive at the same decision that the expert would. This process is commonly called **auto-adjudication**.

Federal legislation promotes the electronic transmission of claims and the automation of claims processing. Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standardize electronic claims submission and payment while safeguarding the privacy and security of individuals' health information.

Personnel

Of course, computers cannot do everything and cannot run themselves—many health plan employees are involved in processing claims. A claims administration department includes the following personnel:

- Data entry clerks key in information from paper documents, and other employees convert documents into electronic data in other ways (such as scanning and OCR). This function is often outsourced.

- Other employees are variously called **claims examiners, processors, reviewers, analysts, or adjudicators**. Their exact duties may vary by title or plan, but essentially they review and adjudicate claims that are not electronically processed for some reason, typically because they present some complication or there is an inconsistency in the data or other problem.

- **Claims adjustors** deal with claims that have been paid incorrectly. For instance, if an insufficient amount is paid and the provider protests, the adjustor reviews the case and ensures that the correct amount is paid.

- Specialists of various sorts handle complicated cases and address such matters as quality control, regulatory compliance, coordination of benefits, and medical management.

- Supervisors and managers oversee the work of claims examiners, other employees, and automated systems. They may also handle complex and large-amount claims.

Explaining the payment or denial of a claim to a provider or member is typically handled by the member services department (discussed in the next module), not claims, although of course the two departments must work closely together.

A claims administration department may be organized by plan type (HMO, PPO, etc.), service type (hospital, physician, etc.), in-network and out-of-network care, or employer group (especially for large groups). Some health plans contract with insurance companies or third-party administrators to process certain types of claims, such as routine claims, out-of-network claims, or claims for specialty services such as radiology, behavioral health, and pharmacy.

Information

A claims administration department both takes in a great deal of information and supplies information to other plan departments. For a claims database the following types of information are needed:

- information on members and their covered dependents, including date of birth, gender, and PCP;

- information on providers, including the national provider identifier (NPI), network or non-network status, and any restrictions on the types of services a provider can perform for the plan;

- general information on provider compensation (such as fee schedules) and the specific compensation arrangement the plan has with each provider (including risk-pooling, discounts, etc.); and

- requirements for members, including cost-sharing (deductibles, copayments, and coinsurance) and authorization and referral requirements.

The information that is needed is also affected by compensation methods, as discussed above. If a provider is paid by capitation or salary, only encounter reports with a relatively limited amount of information is required. On the other hand, if a provider is compensated by fee-for-service, a fee schedule, a discount off charges, or similar methods, full claim information is needed. Typically, a plan's claims processing system must be able to handle both types of arrangements. For example, in an HMO a PCP may be paid by capitation but a specialist by discounted FFS.

The claims department is also a source of information for the plan. Data obtained in the claims process is transmitted to and used by other departments, including member services, finance, information management, medical management, provider relations,

contracting, and others. It may also be used for marketing purposes, but there are regulatory restrictions—a member must agree to this.

Finally, a claims department uses data to generate a variety of periodic reports to help it manage its own productivity and quality. These include the percentage of claims processed within a certain timeframe, such as 30 days; the percentage auto-adjudicated; the percentage rejected or denied; and the percentage adjusted and/or appealed.

Key Elements of Claim Processing

Standard Claim Forms

Most health plans have done away with their own claims forms and require the use of these nationally standardized forms:

- **UB-04**—required by the Uniform Billing Code of 2004 and used by healthcare facilities and organizations (hospitals, clinics, home healthcare agencies, etc.).

- **CMS-1500**—developed by the Centers for Medicare and Medicaid Services (CMS) and used by healthcare professionals such as physicians.

Codes

To indicate in a claim a patient's medical condition and the service or treatment provided, claimants must use standard **diagnostic and treatment codes**. A code is a series of numbers and letters that corresponds to a specific diagnosis or treatment. These codes help simplify and standardize claims processing.

- For diagnoses, the required code set is the **International Classification of Diseases (ICD)**. As of October 1, 2013, for healthcare transactions covered by HIPAA (including most claims) the Tenth Revision of the ICD **(ICD-10)** will be required.

- For treatments, the most frequently used code set is the **Physicians' Current Procedural Terminology (CPT)**. This is a list of medical services and procedures performed by physicians, hospitals, and other healthcare providers, with a unique 5-digit code for each. CPT codes are maintained by the American Medical Association and are also referred to as Healthcare Common Procedure Coding System (HCPCS) Level 1 codes.

Edits

An electronic claims processing system, as well as the procedures followed by claims examiners, includes **edits**. These are criteria that, if unmet, result in a claim being "kicked out" of the process and "pended"—that is, the claim is not automatically processed, but instead payment is delayed while the claim is scrutinized and concerns addressed. For example, an electronic system generally includes an edit that identifies a claim in which the service provided is not generally associated with the diagnosis reported. Such a claim would be kicked out and reviewed to see if the service was in fact appropriate.

Adjudicating a Claim

Adjudicating a claim (determining whether it should be paid and if so how much) can be thought of as satisfying a number of questions about the claim. In this section we review the main questions.

Member and Provider Status and Timely Billing

- The system must confirm that the person who received the services being billed was a member of the plan and eligible for benefits on the date the services were provided.

- It must be confirmed that the provider is enrolled in the plan's claims system. If not, the claim will be sent back to her with a request for information so that she can be enrolled.

- If a plan does not pay benefits for out-of-network care or pays a higher level of benefits for in-network care, it must be determined whether the provider is a network provider.

- Most plans require that a provider bill within a certain time (typically 90 to 180 days) after a service has been delivered. If a claim is submitted after that time, it is not generally paid, and the provider is not allowed to bill the member for the service. Therefore, it must be confirmed that the claim has been submitted within the required time after the service was delivered.

Edits relying on dates of service, member numbers, providers' NPIs, and other data are used to identify claims that do not satisfy the above conditions and must be examined or denied.

The Healthcare Service

An automated claims system (or a claims examiner) must also ascertain whether the healthcare service provided to the member was a covered service under the member's benefit package, medically necessary and appropriate, authorized if required, and actually performed.

Uncovered Services

As we have seen, some healthcare services are not covered by a health plan. These include experimental treatments as well as procedures not needed to address an illness or injury (such as cosmetic surgery). Such uncovered services must be identified by the process and the claim denied.

Medical Necessity and Appropriateness

As we have learned in this course, health plans pay benefits only for healthcare services that are medically necessary and appropriate, and the claims process includes confirming that the services provided were in fact necessary and appropriate. This also promotes healthcare quality by ensuring that members receive the services that are most likely to result in positive outcomes. And it reduces a plan's medical malpractice

liability—a plan can be liable for the negligent acts of its employees or medical staff and in some cases contracted providers, so it must take measures to ensure that the care they provide is appropriate.

Clinical edits flag claims for which additional medical information is needed, such as when diagnosis and treatment codes are missing, incomplete, or invalid. The claim is kicked out of the system, and the provider must resubmit it with complete and correct information. Edits are also triggered by conflicting information (a diagnosis code for tonsillitis and a treatment code for bursitis) or illogical responses or codes (a maternity service for a male). Such claims must be examined and clarified. Clinical edits are typically supplied by an external vendor whose software specializes in healthcare codes and is integrated with the health plan's claims system.

Authorization

As we have also learned, for some services most health plans have authorization or referral requirements that must be met for benefits to be payable. An electronic claims processing system is typically set up to recognize these services and look for a corresponding authorization in the plan's databases. If authorization is not found, the claim will be flagged and reviewed by a claims examiner.

If authorization was not obtained, the health plan is not obligated to pay for the service; more traditional plans may pay a reduced amount (typically 50 percent). In some plans the authorization for a particular case may stipulate how much will be paid.

Delivery

Obviously, if a service billed was not actually provided to a member, the plan will not pay, and fraud may even be involved. If information is insufficient to show that a service was in fact rendered, or if something indicates that the service may not have been rendered (such as a nonemergency service reported for a Saturday, or a physician billing for more visits on a certain date than would be reasonably possible during a working day), the claim must be examined and more information sought.

The Amount

The system (or claims examiner) calculates the amount to be paid for a claim based on numerous factors. These include the provider compensation arrangement that applies (fee schedule, discount off charges, etc); any cost-sharing owed by the member (deductible, copayment, or coinsurance, including differences for network and non-network care); any payment instructions stipulated by an authorization; and other considerations.

It must also be ascertained whether a member is covered under another health plan, and if so, whether coordination of benefits applies. Recall that coordination of benefits provisions are designed to prevent a person covered under more than one health plan from receiving more in benefits than her actual expenses and to ensure that each plan pays the correct amount.

Summarizing the Process

To summarize the proceeding paragraphs, the process by which a claim is adjudicated can be seen as satisfactorily answering a series of questions:

- Was the individual who received healthcare services a member of the plan and eligible for benefits when the services were provided?
- Is the provider enrolled in the plan's claims system? Is the provider in the plan's network?
- Has the claim been submitted in a timely manner?
- Is the service covered?
- Was the service medically necessary and appropriate?
- Was an authorization or referral required for the service, and if so, was it obtained?
- Was the service actually provided?
- What benefits are payable?
- Does the member have any other health insurance coverage?

Claim Investigations

If a claim lacks important information, a plan may simply deny it, and the provider must modify and resubmit it. In other cases, if a claim triggers an edit, or if a claims examiner has reason to question the claim, there may be a **claim investigation**—the plan seeks further information before making a decision. Usually this involves only short, simple searches or requests, such as checking a medical record or calling a doctor's office. Such basic investigations are typically handled by claims examiners by phone, email, or mail or database search.

However, a few claims require extensive investigation. A good deal of information may be needed, or information may not be easy to obtain. An interview or extensive communications with a provider or member may be necessary. Expertise may be required, such as from the plan's medical staff. A claims specialist or supervisor may take over the claim.

Sometimes fraud is suspected. Such cases are turned over to a plan's special investigative unit (SIU), staffed by people trained and experienced in fraudulent schemes and how they can be detected and dealt with. If fraud is in fact detected, an SIU may work with the plan's legal department or law enforcement agencies.

Regulation

As mentioned above, HIPAA promotes the electronic transmission of health plan claims in a standardized format. HIPAA also protects the privacy and security of members' health information while allowing health plans to conduct investigations. In addition, the

NAIC Unfair Claims Settlement Practices Act, adopted in whole or in part by many states, sets standards for the handling and investigation of insurance claims. The Act lists certain insurer or health plan actions and defines them as unfair claims practices, and if a plan commits these actions so frequently that they can be considered to constitute a general business practice, the plan is in violation of the Act. A health plan may not conceal from a claimant information relevant to a claim. A plan must promptly acknowledge receipt of a claim and communications related to the claim. It cannot delay paying a claim by asking for redundant or unnecessary information and documentation. It must generally process a clean claim (one that does not require the plan to seek additional information) within 30 days of receipt. It must have reasonable cause to delay adjudication of a claim to conduct an investigation, and an investigation must be finished in 30 days unless it cannot be reasonably completed in that time.

Conclusion

Prompt and accurate processing of claims is a key driver of member satisfaction with a health plan, and it is also critical to maintaining good working relationships with providers. Therefore, a successful health plan will select and train its claims personnel and manage its claims department with an eye to providing top-notch service.