Generate Remittance Advice

OM Payment and Reporting	
Generate Remittance Advice	
Item	**Details**
Description	The ***Generate Remittance Advice*** business process describes the activity of preparing remittance advice/encounter Electronic Data Interchange (EDI) transactions that providers use to reconcile their accounts receivables. This business process begins with receipt of information resulting from the ***Process Claim*** business process, performing required manipulation according to business rules and formatting the results into the required output information that process sends to **Send Outbound Transaction**.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive the claims information from the ***Process Claim*** business process.
Result	• Alert to send to provider Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice transaction. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive claims information from the ***Process Claim*** business process. 2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, e.g., bundling or unbundling of services. 3. Generate remittance advice transaction. 4. Send alert to send to provider ASC X12 835 Health Care Claim Payment/Remittance Advice transactions. 5. **END:** If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).
Shared Data	Provider data store including provider network and contract information Claims data store including payment information
Predecessor	***Process Claim***
Successor	**Send Outbound Transaction** ***Manage Data***
Constraints	Remittance Advice-Encounter Reports conforms to the format and content in accordance with federal and state-specific reporting requirements, e.g., using HIPAA Transaction Standard Companion Guide that may differ based on situational fields determined by state policy.

OM Payment and Reporting	
Generate Remittance Advice	
Item	**Details**
Failures	• Unresolved conflicts in the reported details in the remittance advice.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which remittance advice/encounter report rules are applied = ___% • Error rate = __% or less

Inquire Payment Status

OM Payment and Reporting	
Inquire Payment Status	
Item	**Details**
Description	The ***Inquire Payment Status*** business process begins with receiving an Accredited Standards Committee (ASC) X12 276 Health Care Claim Status Request transaction or a request for information received through other means such as email, paper, telephone, facsimile, web, or Automated Voice Response (AVR). The business process handles the request for the status of a specified claim(s), retrieves information from the claims payment history, and generates the response information. In addition, the business process formats the information into the ASC X12 277 Health Care Information Status Notification transaction, or other mechanism for responding, via the media used to communicate the inquiry, and sends claim status response via the **Send Outbound Transaction**.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive status request via ASC X12 276 Health Care Claim Status Request transaction. Environment-based Trigger Events to include but not limited to: • Receive status request via email, mail, mobile device, facsimile, telephone, or web.
Result	• Requester received claims status information. • If applicable, response sent via ASC X12 277 Health Care Information Status Notification transactions to requester. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Tracking information as needed for measuring performance and business activity monitoring.

OM Payment and Reporting	
Inquire Payment Status	
Item	**Details**
Business Process Steps	1. **START:** Receive claim status request. a. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process ends. 2. Agency logs claim status request. 3. Validate requester has authorization to receive requested information. 4. Inquire the payment status information to obtain required requested data elements (e.g., member birth date, member last and first name, member ID, claim service date, internal control number, medical record number). 5. Generate claim status response. 6. If applicable, provide claim status response via ASC X12 277 Health Care Information Status Notification transactions to requester. 7. **END:** If applicable, receive alert from submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).
Shared Data	Claim data store including payment information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter*** ***Generate Remittance Advice*** ***Apply Mass Adjustment***
Successor	**Send Outbound Transaction**
Constraints	Payment Status Inquiry and Response will conform to the format and content in accordance with federal and state-specific requirements, e.g., using HIPAA Transaction Standard Companion Guide that may differ based on situational fields determined by state policy.
Failures	• The State Medicaid Agency (SMA) does not receive the claim Payment Status Inquiry submission.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which payment status rules are applied = __% • Consistency with which payment status rules are applied = __%

OM Payment and Reporting	
Inquire Payment Status	
Item	**Details**
	• Error rate = __% or less

Prepare Provider Payment

OM Payment and Reporting	
Prepare Provider Payment	
Item	**Details**
Description	The ***Prepare Provider Payment*** business process is responsible for the preparation of the payment report information. Reports sent via email, mail, or Electronic Data Interchange (EDI) to providers and used to reconcile their accounts receivable. Many Home and Community-Based Services (HCBS) are not part of the traditional Medicaid health plan. Services tend to be member specific and often arranged through a plan of care. Atypical providers who render services for HCBS waivers may not have authorization, or may not adjudicate in the same manner as other health care providers. This business process begins with receipt of HCBS information from the ***Process Claim*** business process or capitation information from ***Process Encounter*** business process, performing required manipulation according to business rules, and formatting the results into the required information. The capitation payment activity includes a per-member-per-month payment for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This business process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement (TPA) and includes retrieving enrollment and benefit transaction information from the Member data store, retrieving the rate information associated with the plan from the Provider or Contractor data store, and formatting the payment into the required information.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Alert from ***Process Claim*** business process to prepare HCBS payment. • Alert from ***Process Encounter*** business process to prepare capitation payment. Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., monthly) is due for capitation payment.
Result	• Generated Provider's payment report. • Alert to send HCBS payment information to member. • Alert to send capitation payment information to member. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	<u>HCBS Payment</u> 1. **START:** Receive alert from ***Process Claim*** business process. 2. Perform required information manipulation according to business rules,

OM Payment and Reporting	
Prepare Provider Payment	
Item	**Details**
	including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services. 3. Calculate payment amount. 4. Generate payment report. 5. **END:** Send alert to submit HCBS payment information to member. <u>Capitation Payment</u> 1. **START:** Periodic timetable is due for capitation payment. 2. Perform required information manipulation according to business rules, including the reporting of any edit or audit errors that resulted in denials or modifications of payment from the reimbursement amount submitted on the claim, such as bundling or unbundling of services. 3. Calculate payment amount. 4. Generate payment report. 5. **END:** Send alert to submit capitation payment information to member.
Shared Data	Claims data store including payment information Reference data store including code set, drug formulary, and service code formulary information Care management data store including prior authorization information Member data store including demographics and third-party insurance information Provider data store including provider network and contract information Contractor data store including provider network and contract information Financial data store including accounts payable information
Predecessor	***Process Claim*** ***Process Encounter***
Successor	**Send Outbound Transaction** ***Manage Contractor Payment***
Constraints	The ***Prepare Provider Payment*** business process will adhere to the federal and state policies and business rules that may differ by state.
Failures	• No alerts received from ***Process Claim*** or ***Process Encounter*** business processes.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which rules are applied =___% • Consistency with which rules are applied=___%

OM Payment and Reporting	
Prepare Provider Payment	
Item	**Details**
	• Error rate =___% or less

Process Claim

OM Claims Adjudication	
Process Claim	
Item	**Details**
Description	The ***Process Claim*** business process receives original or adjusted claim (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction, assigns an internal control number, and • Determines its submission status, and based on that: o Performs Claims Edits: ✓ Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction. ✓ Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding. o Performs Claims Audits: ✓ Verify against historical information. ✓ Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity. o Suspends claim that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules. o Applies National Correct Coding Initiative (NCCI) Edits. o Applies Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate. o Prices Claims: ✓ Calculate state allowed amount. ✓ Calculate paid amount. **NOTE:** All fee-for-services claim types will go through most of the business process steps but with different business rules associated with the different claim types. Both Centers for Medicaid & Medicaid Services (CMS) and state policy determine business rules for claims edits, audits, and pricing methodologies. State business rules define whether the State Medicaid Agency (SMA) pays, suspends, flags for information, or denies a claim. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*. **NOTE:** An adjustment to a claim is on an exception use case to this business process that follows the same process path except it requires a link to the previously

OM Claims Adjudication	
Process Claim	
Item	**Details**
	submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Remittance Advice*** business processes.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive claim via Accredited Standards Committee (ASC) X12 837 Health Care Claim fee-for-services claims transactions. • Receive Retail Pharmacy Claim Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events to include but not limited to: • Receive a scanned or direct-data-entered paper claim. • Periodic (e.g., daily, weekly) adjudication/payment cycles is due.
Result	• The SMA adjudicates a claim. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to ***Generate Remittance Advice*** business process with payment and/or error report information. • Alert sent to ***Prepare Provider Payment*** business process for payment. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Alert sent to ***Manage Accounts Receivable Information*** business process with payment information. • Alert sent to ***Manage Accounts Payable Information*** business process with HCBS payment information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive claim submission or claim adjustment information. 2. Perform Fatal Edits:

OM Claims Adjudication	
Process Claim	
Item	**Details**
	a. If electronic claim submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement. i. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. b. Validate that claim submission meets filing deadlines based on service dates. c. If applicable, reject claim for electronic or paper claim fatal validation errors and send alert to ***Generate Remittance Advice*** business process with error report information. **END:** Business process stops. 3. Perform Non-Fatal Edits: a. Determine claim status as initial, adjustment to a processed claim, or a duplicate submission that is already in the adjudication process, but not yet completed and loaded into payment history (using a unique Patient Account Number). i. If applicable, associate the claim adjustment to the original claim submission. b. Validate provider information (e.g., provider taxonomy, National Provider Identification (NPI), enrollment status, approved to bill for this service). c. Validate member information (e.g., Member's eligibility status on the date of service, apply third-party resources to the claim). i. If applicable, alert sent to ***Manage TPL Recovery*** business process for third-party insurance. d. Validate member's health benefit covers the service and apply appropriate rules. For example: i. Because adult member benefit package does not cover dental services, deny the claim. ii. Member is in another health plan that is their primary insurance, and the Medicaid covers the same service. Designate the claim for the Coordination of Benefits (COB) and deny the claim. Under a payer-to-payer business model, the primary payer receives the COB claim. e. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. f. If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. g. If state-defined business rules identify certain edits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate

OM Claims Adjudication	
Process Claim	
Item	**Details**
	Path: Suspended Claim below. 4. Perform Audits: a. Check payment history for duplicate processed claim using search key information such as in-house claim number, date of service, provider and member demographics, service, and diagnosis codes. b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history. c. Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols. d. Perform Prospective Payment Integrity Check. e. If state-defined business rules identify certain audits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: Suspended Claim below. 5. Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes). 6. If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules, as appropriate. 7. Perform Pricing: a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC). 8. Check for presence of Coordination of Benefits (COB) claim information. a. If COB is present: i. Set status to Deny claim. iii. Flag and move claim to COB file. iv. Send alert to ***Send Outbound Process*** with claim adjudication information and claim. 9. Send alert to ***Generate Remittance Advice*** business process with payment information. 10. Send alert to ***Manage Accounts Receivable Information*** business process with payment information. 11. Send alert to ***Manage Accounts Payable Information*** business process with payment information. 12. **END:** Send alert to ***Prepare Provider Payment*** business process for payment. Alternate Path: Suspended Claim 1. **START:** Claim has an assigned suspended status. 2. Conduct Internal review a. If applicable, reviewer requests further information as an alert sent to

OM Claims Adjudication	
Process Claim	
Item	**Details**
	requestor via ASC X12 277 Health Care Information Status Notification. i. If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). ii. Internal review makes a determination to resolve the edit or audit in question. iii. **END:** Business process stops. 3. Provider submits corrected information in response to an error notification. a. The claim passes the edit or audit based on additional information submitted in response to a request, such as the ASC X12 277 Health Care Information Status Notification. **NOTE:** The ***Submit Electronic Attachment*** business process generates this request and reviews the response to validate that the additional information submitted is sufficient to pass the edit or audit. 4. If there is a favorably resolved suspended claim: a. Send alert to ***Generate Remittance Advice*** business process with adjudicated claim information. b. Go to step 7 of the ***Process Claim*** business process. c. **END:** Business process stops. 5. If provider submits a corrected claim, process it as if it is an original claim. a. Go to step 2 of the ***Process Claim*** business process. b. **END:** Business process stops. 6. If there is an unfavorably resolved suspended claim, send alert to ***Generate Remittance Advice*** business process with error report information. These include failures because the additional information requested for a suspended claim is not present, is inadequate or fails to satisfy the edit or audit. 7. **END:** The SMA resolves the suspended claim. <u>Alternate Path: Third Party Liability Failures</u> 1. **START:** The SMA identifies a third-party resource. 2. If a Cost Avoidance for third-party liability exists, reject claim for edit errors. 3. Send alert to ***Manage TPL Recovery*** business process for third-party insurance recovery. 4. **END:** Send alert to ***Generate Remittance Advice*** business process with Edit Error Report information.
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 Claim data store including payment, in-house claim number,

OM Claims Adjudication	
Process Claim	
Item	**Details**
	and Patient Account Number information Provider data store including performing prospective program integrity (e.g., Healthcare Integrity and Protection Data Bank (HIPDB)) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, third-party insurance information, and member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates Claims data store including adjudication and payment history information Financial data store including accounts receivable and accounts payable information
Predecessor	**Receive Inbound Transaction** ***Submit Electronic Attachment***
Successor	**Send Outbound Transaction** ***Calculate Spend-down Amount*** ***Generate Remittance Advice*** ***Prepare Provider Payment*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Disbursement*** ***Manage TPL Recovery*** ***Submit Electronic Attachment*** ***Manage Data*** ***Manage Performance Measures***

OM Claims Adjudication	
Process Claim	
Item	**Details**
Constraints	All claim types will go through most of the steps within the ***Process Claim*** business process main flow with some variance of business rules and information. Types of claim variances include: Institutional, Professional, Dental, Pharmacy, and Waiver claims, Medicare Crossover and Medicare Part D pharmacy claims, coordination of benefits claims received from payers secondary to Medicaid (e.g., for IHS eligibles), and TPL cost-avoided claims. The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to a claim follows the same business process path except that it requires a link to the previously submitted and processed claim in order to reverse the original claim payment, and associate the original to the adjustment.
Failures	The ***Process Claim*** business process contains a series of potential points of failure. The claim could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the claim. Fatal Edit Failures: Claim information has fatal edit error. For example: • Claim submitted without all the required information. • Provider files claim after claim filing deadline. Other Edit Failures: Claim information has other errors. For example: • The SMA does not cover the service because not in health benefit, not provided in an approved facility or by an approved provider type. • Service is not appropriate based on member demographics. • Member has TPL coverage.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hour • Accuracy with which edits, audits and pricing algorithms are applied and paid amount is calculated = ___% • Consistency of decisions on suspended claims = ___% • Error rate = __% or less

Process Encounter

OM Claims Adjudication	
Process Encounter	
Item	**Details**

OM Claims Adjudication	
Process Encounter	
Item	**Details**
Description	The ***Process Encounter*** business process receives original or adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction and determines its submission status, and based on that: • Performs Encounter Edits: o Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction. o Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding. • Performs Encounter Audits: o Verify against historical information. o Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity. • Suspends encounter that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules. o Apply National Correct Coding Initiative (NCCI) Edits. o Apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate. o Prices Encounters: ✓ Calculate state allowed amount. ✓ Calculate paid amount. ✓ Set paid amount to zero dollars. **NOTE:** All encounters will go through most of the business process steps but with different business rules associated with the different encounter claim types. Both Centers for Medicare & Medicaid Services (CMS) and state policy determine business rules for encounter edits, audits, and pricing methodologies. State business rules define whether an encounter goes to a to-be-paid status, suspends, flags for information, or denies. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*. **NOTE:** An adjustment to an encounter is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed encounter in order to reverse the original encounter and associate the original and replacement encounter in the calculation information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Financial Report*** business processes.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive encounter via Accredited Standards Committee (ASC) X12 837 Health

OM Claims Adjudication	
Process Encounter	
Item	**Details**
	Care Claim encounter transactions. • Receive Retail Pharmacy Encounter Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events to include but not limited to: • Periodic timetable (e.g., daily, weekly) is due for adjudication and payment cycles.
Result	• The State Medicaid Agency (SMA) adjudicates an encounter. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • Alert sent to ***Prepare Provider Payment*** business process for capitation payment. • If applicable, alert sent to ***Generate Financial Report*** business process with payment and/or error report information. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive encounter submission or encounter adjustment information. 2. Perform Fatal Edits: a. If electronic encounter submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement. i. If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. b. Validate that encounter submission meets filing deadlines based on service dates. c. If applicable, reject encounter for electronic fatal validation errors and send alert to ***Generate Financial Report*** business process with error

OM Claims Adjudication	
Process Encounter	
Item	**Details**
	report information. **END:** Business process stops. 3. Perform Non-Fatal Edits: a. Determine encounter status as initial, adjustment to a processed encounter, or a duplicate submission that is already in the adjudication process but not yet completed and loaded into encounter payment history (using a unique Patient Account Number). i. If applicable, associate encounter adjustment to original encounter submission. b. Validate provider information (e.g., provider taxonomy, NPI, enrollment status, approved to bill for this service). c. Validate member information (e.g., demographics, eligibility status on the date of service). d. Validate the SMA covers service in member's health benefit and apply appropriate rules. For example: i. Adult member benefit package does not cover dental services so deny the encounter. e. Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. f. If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. g. If state defined business rules identify certain edits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops. 4. Perform Audits: a. Check encounter history for duplicate processed encounter using search key information such as in-house encounter number, date of service, provider and member demographics, service, and diagnosis codes. b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history. c. Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols. d. Perform Prospective Payment Integrity Check. e. If state defined business rules identify certain audits that cause an encounter to suspend, and an encounter fails for one or more of them, send alert to ***Generate Financial Report*** business process with error report information. **END:** Business process stops.

OM Claims Adjudication	
Process Encounter	
Item	**Details**
	5. Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes). 6. If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules. 7. Perform Pricing (Shadow-Pricing): a. Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC). b. Calculates to-be-paid amount by deducting: i. Contributions provided by Member. ii. Provider advances, liens, and recoupments. 8. Send alert to ***Prepare Provider Payment*** business process for payment. 9. **END:** Send alert to ***Generate Financial Report*** business process with payment information. <u>Alternate Path: Suspended Encounter</u> 1. **START:** Provider submits corrected information in response to an error notification. 2. Process it as if it is an original encounter. a. Go to step 2 of the ***Process Encounter*** business process. 3. **END:** Business process stops.
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 encounter data store including payment, in-house encounter number, and Patient Account Number information Provider data store including performing prospective program Integrity (e.g., HIPDB) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, eligibility, enrollment, and member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates Encounter data store including adjudication and encounter payment history information

OM Claims Adjudication	
Process Encounter	
Item	**Details**
	Financial data store including accounts receivable and accounts payable information
Predecessor	**Receive Inbound Transaction** ***Submit Electronic Attachment***
Successor	**Send Outbound Transaction** ***Calculate Spend-down Amount*** ***Generate Financial Report*** ***Submit Electronic Attachment*** ***Manage Data***
Constraints	All encounter claim types will go through most of the steps within the ***Process Encounter*** business process main flow with some variance of business rules and information. Types of counter variances include: Institutional, Professional, Dental, Pharmacy, and Waiver encounters; Medicare Crossover and Medicare Part D pharmacy encounters; and Coordination of Benefits (COB) encounters received from payers secondary to Medicaid (e.g., for IHS eligibles). The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by encounter claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to an encounter follows the same business process path except that it requires a link to the previously submitted and processed encounter in order to reverse the original encounter and associate the original to the adjustment.
Failures	The ***Process Encounter*** business process contains a series of potential points of failure. The encounter could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the encounter. Fatal Edit Failures: Encounter information has fatal edit error. For example: • Encounter submitted without all the required information. • Encounter submitted after encounter filing deadline. Other Edit Failures: Encounter information has other errors. For example: • The SMA does not cover the service because it is not in the health benefit, or is not in an approved facility or performed by an approved provider type. • Service is not appropriate based on member demographics.
Performance Measures	• Time to complete ***Process Encounter*** business process: e.g., Real Time response = within __ seconds, Batch Response = within __ hour • Accuracy with which edits, audits, and pricing algorithms are applied and to-be-paid and paid amount is calculated = ___% • Consistency of decisions on suspended encounters = ___%

OM Claims Adjudication	
Process Encounter	
Item	**Details**
	• Error rate = __% or less

Manage Data

OM Payment and Reporting	
Manage Data	
Item	**Details**
Description	The ***Manage Data*** business process is responsible for the preparation of the data sets and delivery to federal agencies (e.g., Centers for Medicare & Medicaid Services (CMS), Social Security Administration (SSA).) Information exchange may include extraction of Medicaid and CHIP Business Information and Solutions (MACBIS) information needs (i.e., fee-for-services, managed care, eligibility and provider information). The ***Manage Data*** business process includes activity to extract the information, transform to the required format, encrypt for security, and load the electronic file to the target destination. The uses for the information include: • Research and evaluation of health care activities. • Staff can forecast the utilization and expenditures for a program. • Staff can analyze policy alternatives. • State and federal agencies can respond to congressional inquiries. • Matches to other health related databases.
Trigger Event	Environment-based Trigger Events to include but not limited to: • Periodic (e.g., quarterly) timetable for information is due. • Receive request for information.
Result	• Information message sent to target destination. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive time event or request to initiate ***Manage Data*** business process. 2. Extract required information from source data stores. 3. Transform information to meet business and technical needs of target destination. 4. Apply necessary encryption algorithms for security. 5. **END:** Send message with information to the target destination.

OM Payment and Reporting	
Manage Data	
Item	**Details**
Shared Data	Claims data store including claims, encounters, adjudication, and historical information Care management data store including treatment plan, outcomes, and authorization information Plan data store including Medicaid State Plan, health plan, health benefits, reference, performance measures, and benchmarks information Compliance Incident data store including anomalies and adverse action information Member data store including demographics, eligibility determination, enrollment, grievance and appeals, communication, and outreach information Provider data store including provider network, eligibility determination, enrollment, grievance and appeals, communication, and outreach information Contractor data store including provider network, enrollment, grievance and appeals, communication, and outreach information Financial data store including accounts payable and accounts receivable information
Predecessor	**NOTE:** Many MITA Framework business processes collect data for extraction of information and send to target destination. The following are the business processes that manage primary data stores. ***Manage Case Information*** ***Manage Contractor Information*** ***Manage Member Information*** ***Manage Provider Information*** ***Manage Budget Information*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information*** ***Generate Financial Report*** ***Process Claim*** ***Process Encounter*** ***Generate Remittance Advice*** ***Manage Compliance Incident Information*** ***Maintain State Plan*** ***Manage Health Plan Information*** ***Manage Health Benefit Information*** ***Manage Performance Measures*** ***Manage Reference Information***
Successor	**Send Outbound Transaction**

OM Payment and Reporting	
Manage Data	
Item	**Details**
Constraints	The ***Manage Data*** business process will adhere to the federal requirements for submission of information to federal agency.
Failures	• Requested information is not available for extraction. • Transformation does not meet the federal requirements for submission. • Information message does not meet the target destination submission requirements.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which the State Medicaid Agency (SMA) applies rules =___% • Consistency with which the SMA applies rules =___% • Error rate =___% or less

Calculate Spend-Down Amount

OM Claims Adjudication	
Calculate Spend-Down Amount	
Item	**Details**
Description	A person that is not eligible for medical coverage when they have income above the health plan standards may become eligible for coverage through a process called spend-down (see ***Determine Member Eligibility*** business process). The ***Calculate Spend-Down Amount*** business process is responsible for tracking spend-down amounts and determining if a member meets its responsibility through the submission of medical claims. The ***Process Claim*** business process automatically accounts for the spend-down amount during adjudication. Once the member has met the spend-down obligation, a modification of eligibility status allows Medicaid payments to begin and/or resume. This typically occurs in situations where a member has a chronic condition and is consistently above the resource levels, but it may also occur in other situations. The ***Calculate Spend-Down Amount*** business process begins with the receipt of member's health plan information from ***Enroll Member*** business process that requires a predetermined amount the member will be financially responsible for prior to Medicaid payment for any medical services.
Trigger Event	Interaction-based Trigger Events to include but not limited to: • Receive health plan information from ***Enroll Member*** business process.
Result	• Member has met spend-down obligation. • Alert sent to ***Manage Member Information*** with spend-down information. • Sent notification that Member has met spend-down obligation to member via ***Manage Applicant and Member Communication*** business process.

OM Claims Adjudication	
Calculate Spend-Down Amount	
Item	**Details**
	• Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive health plan information from ***Enroll Member*** business process 2. Determine spend-down obligation amount. 3. Receive claim including payment information. 4. Subtract medical claim amounts from member's spend-down until they meet their responsibility. 5. Send alert to ***Manage Member Information*** with spend-down information. 6. **END:** Send notification that member has met spend-down obligation via ***Manage Applicant and Member Communication*** business process.
Shared Data	Member data store with demographics and spend-down information Claims data store with payment information
Predecessor	***Enroll Member*** ***Process Claim***
Successor	***Manage Applicant and Member Communication*** ***Maintain Member Information***
Constraints	The calculate spend-down will conform to the state-specific policies that may differ by state.
Failures	• No health plan information from ***Enroll Member***.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within__ hours • Accuracy with which rules are applied • Consistency of decisions and disposition = __% • Error rate = __% or less

Submit Electronic Attachment

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
Description	The ***Submit Electronic Attachment*** business process begins with receiving attachment information that either a payer requests (solicited) or a provider submits (unsolicited). The solicited attachment information can be in response to requests for more information from the following business processes for example: ***Process***

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
	Claim, Process Encounter, ***Authorize Service***, ***Authorize Treatment Plan***, and ***Manage Estate Recovery***. The business process links attachment information to the associated applicable transaction (e.g., claim, prior authorization, treatment plan) or suspends for a predetermined time set by state specific business rules, after which the business process purges information. The business process validates the successfully associated attachment information using application-level edits, determining whether the information provides the additional information necessary to adjudicate (i.e., approve, suspend or deny) the transaction.
Trigger Event	Interaction-based Trigger Event: • Receive claim via Accredited Standards Committee (ASC) X12 837 Health Care Claim transaction. • Receive Retail Pharmacy Claim Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). • Receive ASC X12 277 Health Care Information Status Notification requesting additional information. • Receive ASC X12 278 Health Care Servicer Review Information transaction. Environment-based Trigger Event: • Periodic timetable to associate suspended attachment information with subsequently received transactions.
Result	• The State Medicaid Agency (SMA) accepts and associates attachment information with the appropriate transaction (e.g., claim, prior authorization, treatment plan, etc.). • If applicable, the SMA rejects attachment information as invalid. • If applicable, the SMA suspends attachment information awaiting the receipt of a matching transaction. • If applicable, the SMA purges attachment after duration of predetermined time. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	1. **START:** Receive attachment information. 2. Validate attachment provides all required information. 3. Associate attachment information with applicable transaction. 4. Validate application level edits such as provider, member, and benefit information, and association with transaction. 5. Determine whether the attachment supplies the additional information as required by state business rules. 6. If applicable, reject attachment information as invalid. **END:** Business process stops.

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
	7. If applicable, suspend attachment information awaiting the receipt of a matching transaction. **END:** Business process stops. 8. If applicable, purge attachment after duration of predetermined time. **END**: Business process stops. 9. **END:** The SMA accepts and associates attachment information with the appropriate transaction.
Shared Data	Claims data store with transaction information Provider data store with provider network information Member data store with demographic information Care Management data store with authorization information Financial data store including accounts receivable information
Predecessor	**Receive Inbound Transaction** ***Process Claim*** ***Process Encounter*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Authorize Referral*** ***Manage Estate Recovery***
Successor	**Send Outbound Transaction** ***Process Claim*** ***Process Encounter*** ***Authorize Service*** ***Authorize Treatment Plan*** ***Authorize Referral*** ***Manage Estate Recovery***
Constraints	The attachment information will conform to the format and content in accordance with national standards and state-specific rule-reporting requirements, e.g., using HIPAA Transaction Standard Companion Guide, and contain valid required information content based on several criterion (e.g., type of claim, type of service, provider type, and member demographic). The attachment will be consistent with the associated original transaction per state rules, and will contain the correct information for this business process to execute.
Failures	• Quality of the image too bad to render as usable. • Cannot locate applicable transaction (i.e., claim, prior authorization).

OM Claims Adjudication	
Submit Electronic Attachment	
Item	**Details**
	• Attachment is missing required information.
Performance Measures	• Time to complete the process: Real Time response = within __ seconds, Batch Response = within __ hours • Accuracy with which the SMA applies and associates attachments rules = __% • Number of attachments = __% of total claims. (Processing a higher percentage of claims attachments may indicate that a state is able to utilize more clinical information when determining whether a claim meets state payment rules) • Error rate of correctly re-associating attachment information = __% or less

Apply Mass Adjustment

OM Claims Adjudication	
Apply Mass Adjustment	
Item	**Details**
Description	The ***Apply Mass Adjustment*** business process begins with the receipt or notification of retroactive modifications. These changes may consist of modified rates associated with Healthcare Common Procedure Coding System (HCPCS), Claim Payment/Advice Transaction (CPT), Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment by identifiers (e.g., claim/bill type, HCPCS, CPT, Revenue Code(s), or member identification) that the State Medicaid Agency (SMA) paid incorrectly during a specified date range. The business process applies a predetermined set or sets of parameters that may reverse or amend the paid or denied transactions and repay correctly. **NOTE:** Do not confuse this process with the claim adjustment within the adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, mass adjustments historically refer to large-scale modifications in payments as opposed to disenrollment of a group of members from a Managed Care Organization (MCO).
Trigger Event	Environment-based Trigger Event: • Receive a mass adjustment notification of retroactive rate or program modifications. • Correction of system errors resulting in incorrect payment amounts. • Identification of incorrectly denied claims
Result	• Validated mass adjustment information applied to previous payment records. • If applicable, alert sent to notify member via ***Manage Applicant and Member Communication*** business process of relevant modifications. • If applicable, alert sent to notify provider via ***Manage Provider Communication*** business process of relevant modifications. • If applicable, alert sent to notify contractor via ***Manage Contractor Communication*** business process of relevant modifications. • If applicable, alert sent to send to provider Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice transactions. • If applicable, alert sent to ***Manage Accounts Receivable Information*** business process of relevant modifications. • If applicable, alert sent to ***Manage Accounts Payable Information*** business process of relevant modifications. • Tracking information as needed for measuring performance and business activity monitoring.

OM Claims Adjudication	
Apply Mass Adjustment	
Item	**Details**
Business Process Steps	1. **START:** Receipt or notification of incorrect payments or denials, based on retroactive rate modifications, program modifications, retroactive modifications in member eligibility, or system errors. 2. Identify the parameters necessary to locate claim records. 3. Enter parameters (i.e., corrected information). 4. Apply the predetermined set of parameters that reverse the incorrect payments or denials. 5. If applicable, produce mass adjustment request report. 6. Review the mass adjustment report for validity and accuracy. 7. If applicable, send alert to notify member via ***Manage Applicant and Member Communication*** business process of relevant modifications to their cost share. 8. If applicable, send alert to notify provider via ***Manage Provider Communication*** business process of relevant modifications. 9. If applicable, send alert to send to provider ASC X12 835 Health Care Claim Payment/Advice transactions. 10. If applicable, send alert to notify contractor via ***Manage Contractor Communication*** business process of relevant modifications. 11. If applicable, send alert to ***Manage Accounts Receivable Information*** business process of relevant modifications. 12. If applicable, send alert to ***Manage Accounts Payable Information*** business process of relevant modifications. 13. **END:** Apply mass adjustment to previous payments.
Shared Data	Claims data store with transaction information Provider data store with provider network and contract information Contractor data store with provider network and contract information Member data store with demographic information Plan data store including policy information Health Benefit data store including benefit program and benefit information Financial data store including accounts receivable and accounts payable information
Predecessor	***Manage Provider Recoupment*** ***Manage Cost Settlement***
Successor	***Manage Provider Communication*** ***Manage Contractor Communication*** ***Manage Applicant and Member Communication***

OM Claims Adjudication	
Apply Mass Adjustment	
Item	**Details**
	Process Claim ***Process Encounter*** ***Generate Remittance Advice*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Information***
Constraints	The mass adjustment will correctly identify payments for adjustments. Processes may vary by state.
Failures	• Cannot locate all claims, capitation payments, or denials specified for adjustment.
Performance Measures	• Time to complete the process: e.g., Real Time response = within ___seconds, Batch Response = within ___ hours • Accuracy with which edit, audit, and pricing rules are applied = ___% • Error rate = ___% or less