

Integrating Healthcare Claims Administration with EDI, Imaging and Workflow

Processing Flow Narrative

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Introduction

In the nineties, the large accounting and consulting practices pedaled costly “office re-engineering” engagements as the means by which the health plan could reduce costs and improve operating efficiencies. Unfortunately, most engagements failed to deliver the results touted to the health plan - the technological infrastructure needed to sustain improvements did not exist or was not affordable for most health plans. Significant progress has been made, however, and today, the right mix of technology can truly revolutionize the traditional healthcare claims processing department—at an affordable price.

The remainder of this document describes how healthcare claims are processed today by a large health plan that has implemented ICI’s Healthcare Claims Administration System, including HIPAAxchange™, a HIPAA transaction compliance engine.

EDI, Imaging and Workflow

Management realized the health plan would be receiving both paper claims and electronically submitted claims for the foreseeable future. Therefore, the objective was to minimize or eliminate the data entry function and to quickly merge the flow of electronic and paper claims into a common processing path.

Claims that are submitted electronically (as 837 transactions) are validated, translated into the formats recognized by the auto-adjudication module of the claims administration system and automatically routed to a general workflow queue by HIPAAxchange. Paper claims are imaged, output as compliant 837’s and sent to HIPAAxchange - and then follow the same path as an electronically submitted 837.

The workflow application selects and automatically routes the claims to various user-defined queues, including “specialty” queues. For example, management decided to route claims that failed auto-adjudication to examiner “X” if the member’s last name began with “A”, “B” or “C”. The examiner can click the next available claim in the queue, and ICI’s claims entry screens are automatically populated with the claims information so the examiner can quickly resolve any discrepancies. Whether the claim originated as an electronic 837 transaction or as a paper claim, the examiner can view the “image” of the claim with a click of the mouse.

Workflow rules can also be implemented to route claims to various “specialty” queues — for example, management can route claims with specific diagnosis codes to a “case management” queue, and/or route COB claims to a “COB” queue and/or route claims submitted by non-California providers to an “out-of-state” queue.

Auto- (“Mass”) Adjudication

The auto-adjudication module adjudicates the claims that are stored in the auto-adjudication queue. If auto-adjudication rejects the claim because of an unknown SSN or provider, for example, the claim is routed to a specialty or general examiner queue for exception processing. If the claim has an invalid SSN, the system will generate a “mailback” letter to the provider, explaining that this participant is not a member of the health plan. By selecting the claim and clicking a specific queue, the examiner can also quickly and easily route the claim to

the “case management” queue or to another examiner or manager.

Quality Control / Audit Processing

After the claim has been adjudicated, it is passed to the Benefits Payable application unless it meets user-defined audit selection criteria. For example, management may want to automatically pend 2% of all claims, 100% of claims for processor “X” and “Y”, 100% of all claims over \$5,000, and 25% of all claims for provider “Z”.

Claims that meet these criteria are routed to a “quality control” queue where they can be reviewed interactively by auditors and either released to the Benefits Payable application or returned to the examiner for correction.

Benefits Payable Processing

Once the claim reaches the Benefits Payable application, a check can be generated the same day, or the payment can be held until additional user-defined criteria are met. For example, management may decide to send member checks daily and “consolidated” (a.k.a. “bulk”) checks to the provider weekly. Or management may decide to send checks to providers whenever the total check amount is greater than some user-defined amount, or the oldest claim on the remittance advice is “n” days old.

Electronic Checks / EOBs / Remittance Advices

The health plan can print the checks, EOBs and remittance advices in-house, or the system will electronically transmit a file to ABF (Automated Business Fulfillment, an outsourcing company providing “back office” support). ABF will print the checks, EOBs and remittance advices, and mail them to the plan participants, providers and third party payees. Of course, HIPAAxchange also sends 835 transactions to the “pay to” provider if the provider has agreed to accept them.

Workflow Management Windows

Management windows enable viewing outstanding claims from various perspectives, such as a list of claims that are in the “case management” queue, for example, or by clicking on a claim, an image of the claim will be displayed. Examiners can see how many claims are in each queue, see the date of the oldest claim in each queue, or even move claims from one queue to another.

Conclusion

An investment in the right technology can provide a truly measurable return of up to 85% in savings. Studies show that paper claims cost approximately \$5.40 per claim in time, materials, salaries, benefits and supplies. The same claim submitted electronically may only cost \$0.85! Streamlining the traditional claims processing department with a combination of EDI, a robust imaging/workflow component and ICI’s Healthcare Claims Administration System can restyle the manner in which the health plan serves its members.