



MEDICAL CLAIMS AND ENCOUNTER PROCESSING

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Medical Claims and Encounter Processing



- Medical claims and encounter processing is part of an integrated organization and process that is downstream of and dependent upon many other functions and departments within the Managed Care Organization (MCO).
- Claims/encounter administration consists of the following basic functions for the MCO and its customers:
 - Provider Network Administration
 - Plan Contract Administration
 - Benefit Administration






Medical Claims and Encounter Processing - Continued

- Medical Management Policy Administration
- Enrollment / Member Administration
- Information Technology
 - Ensures reimbursement methodologies such as capitation arrangements; fee for service; IPPS; OPSS; MS-DRG; APR-DRG arrangements and other arrangements are loaded in the processing system.
 - Upload and maintenance of all code sets required for processing medical claims/encounters (e.g. CPT-4; HCPCS; ICD -9-CM Diagnosis and Services codes; Revenue Codes; CCI edits; Place of Service Codes, Federal and State DRG codes and other Code Sets).
- Finance



Medical Claims and Encounter Processing - Continued

- The outcome of the medical claims/encounters and benefits administration process is the configuration and continuous maintenance of a robust and integrated processing system.
- The processing system is the source of information to comply with CMS regulatory requirements, meet business requisites, and ensure a fully developed set of reporting tools for corporate functions and activities.



Medical Claim and Encounter Submission

- Medical claims / encounters may be submitted and are accepted for processing in electronic form, Archcare's preferred method, or in paper.
 - Institutional providers bill on the UB-04 (paper claim form) or on the 837I HIPAA compliant electronic format.
 - Non-institutional providers bill on the CMS-1500 (paper claim form) or on the 837P HIPAA compliant electronic format.
- Providers must submit the correct medical claim/encounter form/format fully completed and data must be current and accurate.
- Medical claims and encounters must have all basic information necessary to adjudicate the claim/encounter in accordance with CMS billing requirements.



Role of the Clearinghouse

- The term "health care clearinghouse" is defined under 42 USCS § 1320d (2) as a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.
- Functions performed by the Clearinghouse:
 - Provides for the collection of the information needed to successfully exchange EDI transactions between network providers and the payer.
 - Establishes consistent editing acknowledgment & error handling of the electronic data interchange (EDI) transactions across network providers.





Role of the Clearinghouse - Continued

- Provides submitters with quicker acknowledgment for the claim/encounter transactions. This allows submitters to correct any errors and resubmit their transactions without having to wait for a batch cycle.
- Editing current ASC X12 Standard transactions established under HIPAA for inbound & outbound EDI transactions. Thereby preventing incomplete & inaccurate claim/encounters from entering the system.



Role of the Clearinghouse - Continued

- Claims/encounters processed through the clearing house are checked for missing or invalid data elements that may be turned on/off to comply with regulation and/or meet business needs, not limited to the following:
 - ICD-9-CM diagnosis codes must be submitted with the highest level of specificity for proper adjudication.
 - Compliant Medical Code Sets such as HCPCS, ICD-9-CM, CPT-4, Revenue Codes, must be current for date and year of service.
 - Place of service must be valid.
 - Service units can be required in the presence of a procedure code.
 - The National Provider Identifier (NPI) – for the rendering provider.
 - Billing provider Zip Code and County Code .
 - Admission date for inpatient facility claims.





Role of the Clearinghouse - Continued

- Claims that do not pass the editing process are returned to the provider, with a list of needed corrections; providers can then correct and resubmit these claims.
- Claims/encounters that pass the Gateway EDI editing process are translated into a HIPAA-compliant ANSI format and then sent to the payer.
- EDI claim/encounter submission flows directly into the payer's system



Medical Claims and Encounter Processing

Medical Claim / Encounter Rejections –

- Medical claims / encounters not submitted in accordance with CMS billing requirements and are found to be incomplete or invalid prior to or during entry into the claims processing system are returned to the provider of service by mail, with an attached form explaining the error(s).



Medical Claims and Encounter Processing - Continued

Adjudication of Medical Claims / Encounters –

- Medical claims / encounters submitted and fully completed in accordance with CMS billing instructions, are entered into the claims processing system for adjudication and are processed in accordance with processing criteria and rules entered and stored in the processing system.
 - Once the claim is loaded into the processing system, it must be adjudicated.
 - The adjudication process is the process of passing the claim/encounter through the processing logic until the claim is settled (Paid or Denied).
 - The adjudication process involves numerous 'set of rules' the claim/encounter must go through before becoming payable.



Medical Claims and Encounter Processing - Continued

There are several components to the adjudication process, not limited to the following:

- The adjudication process begins with a determination of whether or not the patient is eligible for benefits.
- Is the service a covered service.
- The process will evaluate the status of the provider.
- Ascertains the payment obligations of the health plan and the insured.
- Preauthorization requirement.
- Coordination of benefits.
- The process will determine if the service codes and diagnosis codes are valid and current on the date of service.
- Checks for the existence of a duplicate service.
- Determines if the claim was submitted beyond the claim timely filing requirements.





Medical Claims and Encounter Processing - Continued

Complete, accurate, and timely submission of encounter data is essential for all managed care plans. Medicaid encounter data (MEDS III) is used by the Department of Health for a variety of purposes including:

- Risk-adjusted premium rate setting.
- Quality Incentive Calculations.
- QARR/HEDIS Reporting.
- Assessing clinical risk, evaluating quality, access and appropriateness of care.
- Office of the Medicaid Inspector General (OMIG) utilizes MEDS III data to identify if members received care.
- Service utilization and other research activities.
- Statement of deficiencies are issued for non-compliance.



Medical Claims and Encounter Processing - Continued

It is important that providers submit complete and accurate 'clean' claim/encounters to increase claims processing efficiency by having fewer claims handled by an operator.

- Auto adjudication allows for the 'automatic adjudication' of the claim/encounter based on a set of rules established by the payer and configured in the processing system.
- Auto adjudication allows for faster and more accurate claims/encounter processing.
- This means a faster turnaround for the provider payment.
- Automating claims/encounter adjudication process improves efficiency and reduces expenses required for manual adjudication.





Medical Claims and Encounter Processing - Continued

Explanation of Payment (EOP):

- The Explanation of Payment issued contains the status of claim/encounter transactions processed by Archcare during a specific period and contains the following information:
 - A listing of all claims/encounters (identified by several items of information submitted on the claim) that have entered the claims processing system during the corresponding cycle.
 - The status of each claim (paid or denied).
 - A remark code that further explains or provides information about the claim outcome, as applicable.
 - Subtotals and grand totals of claims and dollar amounts.
 - Other pertinent financial information such as recoupment, negative balances, etc.
 - Checks and EOPs are generated and sent to provider on a weekly basis.



Medical Claims and Encounter Processing - Continued

Most common reasons why claims get denied:

- Incorrect ICD-9-CM Diagnosis Coding. Submit ICD-9-CM diagnosis codes to the highest level of specificity.
- Missing or invalid CPT-4 or HCPCS service codes.
- Incorrect claim form type for provider of service.
- Timely filing. Be aware of timely filing requirements.
- Patient was not covered on date of service.
- Requires prior authorization.
- Type of Bill Code on the UB-04 paper claim or 837I electronic format.



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Questions and Answers

