This is the high level as-is process for processing claims by the Agency. The Agency is flexible to Proposers’ means of claim processing.
Validate Claim

Fiscal Agent

Start

Trigger: New Claim (Cleared EDI; not Pharmacy Claim)

Assign TCN

Assign “Deny” Claim Disposition

Claim Payment & Reporting

Proper Claim Form?

Valid WY Claim?

Valid Member?

Valid Provider?

Yes

Yes

Yes

Yes

No

No

No

No

End

Yes

Yes

Yes

Yes

No

No

No

No
Resolve Third Party Liability

0. Process Claim

Start

Fiscal Agent

Trigger: Validated Claim

Third Party Liability Exist?

Yes

Options

Continue Processing & Report

Verify Codes (Edits)

Deny

Assign “Deny” Claim Disposition (Missing Benefit Coordination)

Determine Claim Disposition

No

Continue Processing

End
Verify Codes Allowed (Edits)

- Edits are applied: 1. by set/groups (see below); 2. Online edits (checking client eligibility), which are resolved instantly; 3. Batch edits (batches of claims bump up against historical already-processed claims) to check for duplicate claims and anomalies.
- Edits are applied in sets or groups. Group one could include edit numbers 5, 20, 33, 140, 348, 852, 967, 968, 983, 999. The claim could run through the first set or group of edits, and if a deny edit posts to the claim, it would continue processing, and bypass subsequent groups of edits. If and when the claim was resubmitted with the appropriate resolution to the posted edits, it would then process through the subsequent groups of edits.
- Deny/Suspend edits can post at the header level (provider, member, valid WY Claim...) and or the line level. A claim can pay all lines but one too, and deny just a line... When claims pay and process, it’s not all or nothing...
- There are “showstopper” edits. If a showstopper ever posts, the claim will automatically deny no matter what. “Showstopper” is not an independent disposition, it would be a “deny.”
Within the “Record PA Data” step in the process ensure that:
1. there units left; 2. dates match; 3. do code(s) match; 4. provider match; 5. client match; 6. modifier(s) match...
Revenue codes pertain to Institutional claims and home health claims. It depends on the type of claim and the provider type that is billing, as to how Revenue codes are used. For example, for a hospital (OPPS), there is a "little black box" which decides if the revenue code pays and does it require a procedure code in order to pay. Home Health pays ONLY off revenue codes, there is a fee schedule, and each revenue code has a fee schedule that pertains to the revenue code when it’s a home health.
This would be a batch check, meaning, claims being processed would be batch checked against already processed claims to determine duplicate claims.
Record Cap Limit Data & Assess Medical Policy Exceptions

- The "cap limit" function of this process functions like the PA process. Units must be deducted.
Determine Claim Disposition

Fiscal Agent

0. Process Claim

Start

Trigger: Claim Has Been Assigned a Disposition at a Claim Header Level or Line Level

Reviewed Any Posted Edit(s) & Exception(s)?

Yes

No

Review Any Posted Edit(s) & Exception(s)

Action

Pay

Pay, But Report

Force

Suspend

Super Suspend

Deny

Assign “Pay” Claim Disposition

Assign “Suspended” Claim Disposition

Assign “Denied” Claim Disposition

To SAO (in batch File)

Remain At Fiscal Agent

Remain At Fiscal Agent

Claim Payment & Reporting

Suspend Claim

Claim Payment & Reporting

End

Provider is not Paid (Report on RA)

“Showstopper” is a reference to an edit, that if it ever posts, the claim (header or line) denies no matter what.

Please note: Edits, audits, logic, and hard coded logic all have a unique edit number assigned to it.
It would be efficient and critical in order for the RA to tie back to the SAO payment information before the RA is sent out. If there was a payment delay or suspension, then that would be conveyed to the provider so they would know that the claim they submitted was processed or that they must take corrective action so that their payments can be dispersed.
8. Determine Claim Disposition

The new Contractor will need to be able to contend with: Letters of Agreement, manual pricing for invoices, reading operative reports and checking ambulance reports.

Episodes of Care: looking at claims pertaining to an instance of care for a client even if they are seeing multiple providers in order to obtain the care that they need. It is a requirement to be able to pull all the claims that processed in an entire “episode of care” for an individual.