Process Claim

Benefit Management System (BMS)

Fiscal Agent

Start

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

Validate Claim

Resolve Third
Party Liability

Verify Codes
Allowed (Edits)

Resolve Prior
Authorization

Check Service
Pricing

Check
Duplicate
Claim

Record Cap Limit
Data & Assess
Medical Policy
Exceptions

Determine
Claim
Disposition

Claim Payment
& Reporting
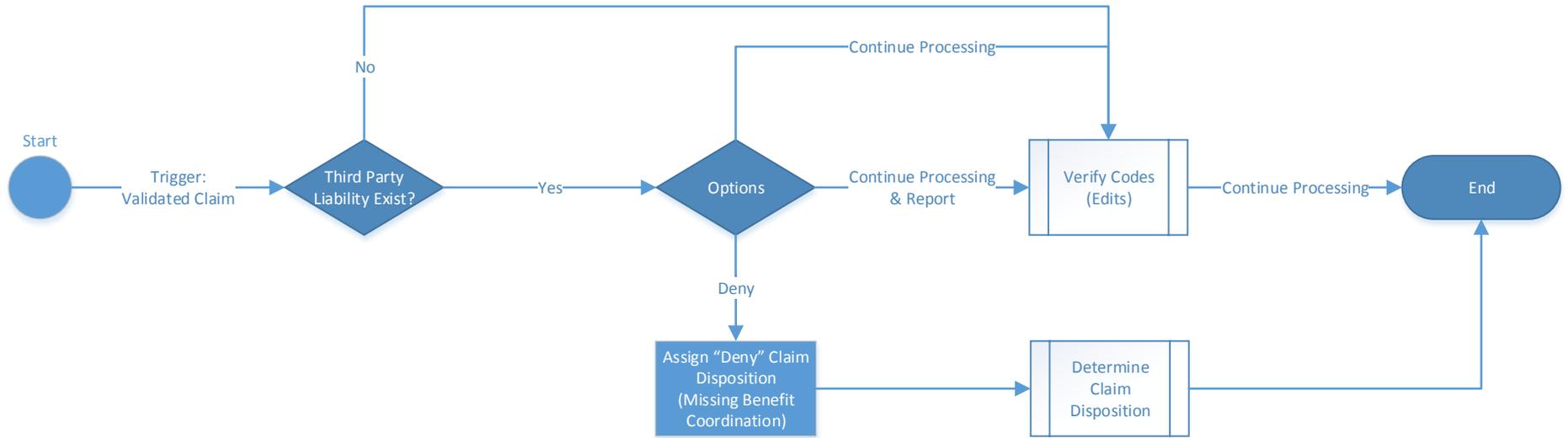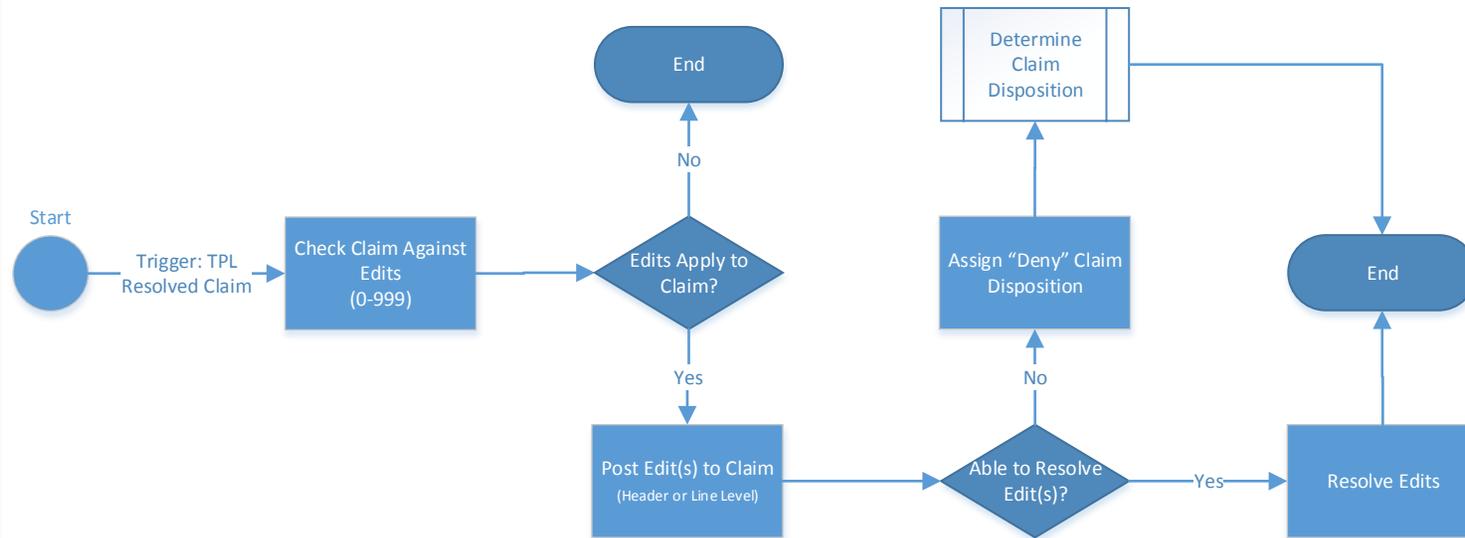
End
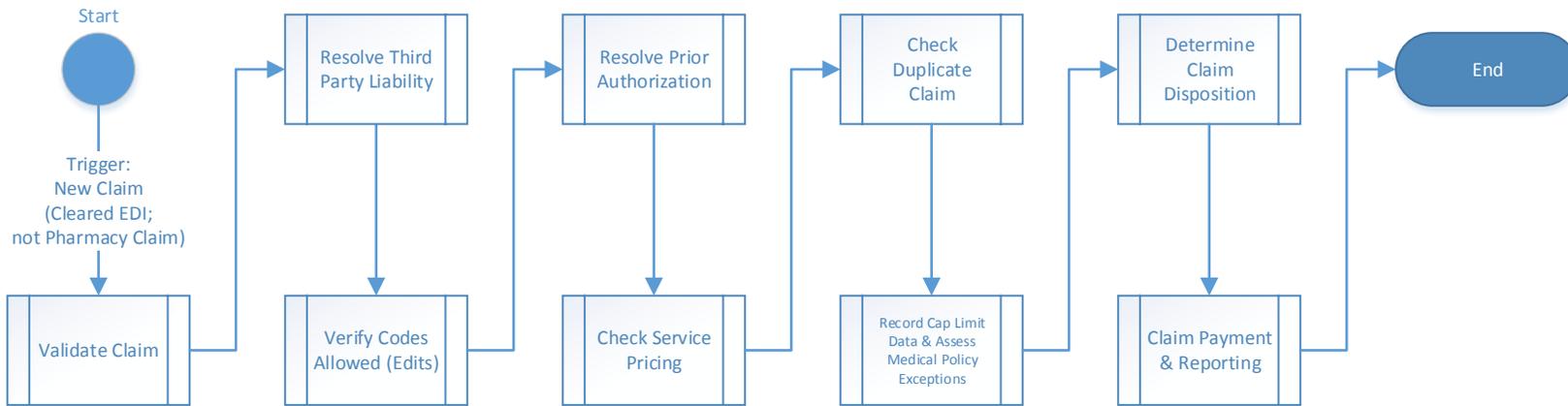
- This is the high level as-is process for processing claims by the Agency. The Agency is flexible to Proposers' means of claim processing.

Validate Claim

0. Process Claim

Fiscal Agent

Start

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

Assign TCN

Claim Payment
& Reporting

Assign "Deny" Claim
Disposition

Proper Claim Form? — No

Proper Claim Form? — Yes → Valid WY Claim?

Valid WY Claim? — No

Valid WY Claim? — Yes → Valid Member?

Valid Member? — No

Valid Member? — Yes → Valid Provider?

Valid Provider? — No

Valid Provider? — Yes → End

Resolve Third Party Liability

Fiscal Agent

Start

Trigger:
Validated Claim

Third Party Liability Exist?

No

Yes

Options

Continue Processing

Continue Processing & Report

Deny

Verify Codes (Edits)

Continue Processing

Assign "Deny" Claim Disposition (Missing Benefit Coordination)

Determine Claim Disposition

End

Verify Codes Allowed (Edits)

Fiscal Agent

Start → Trigger: TPL Resolved Claim → **Check Claim Against Edits (0-999)** → **Edits Apply to Claim?**

- No → **End**
- Yes → **Post Edit(s) to Claim** (Header or Line Level)

Post Edit(s) to Claim → **Able to Resolve Edit(s)?**

- No → **Assign "Deny" Claim Disposition** → **Determine Claim Disposition** → **End**
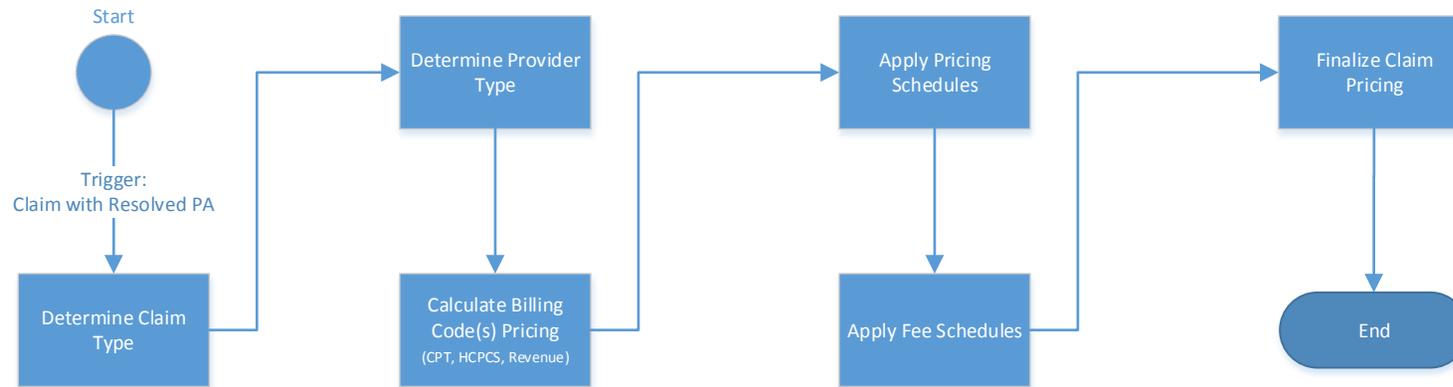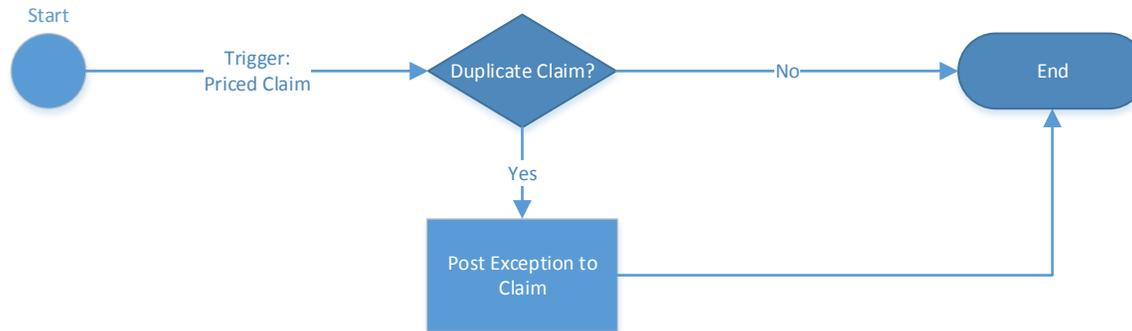- Yes → **Resolve Edits** → **End**

● 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."
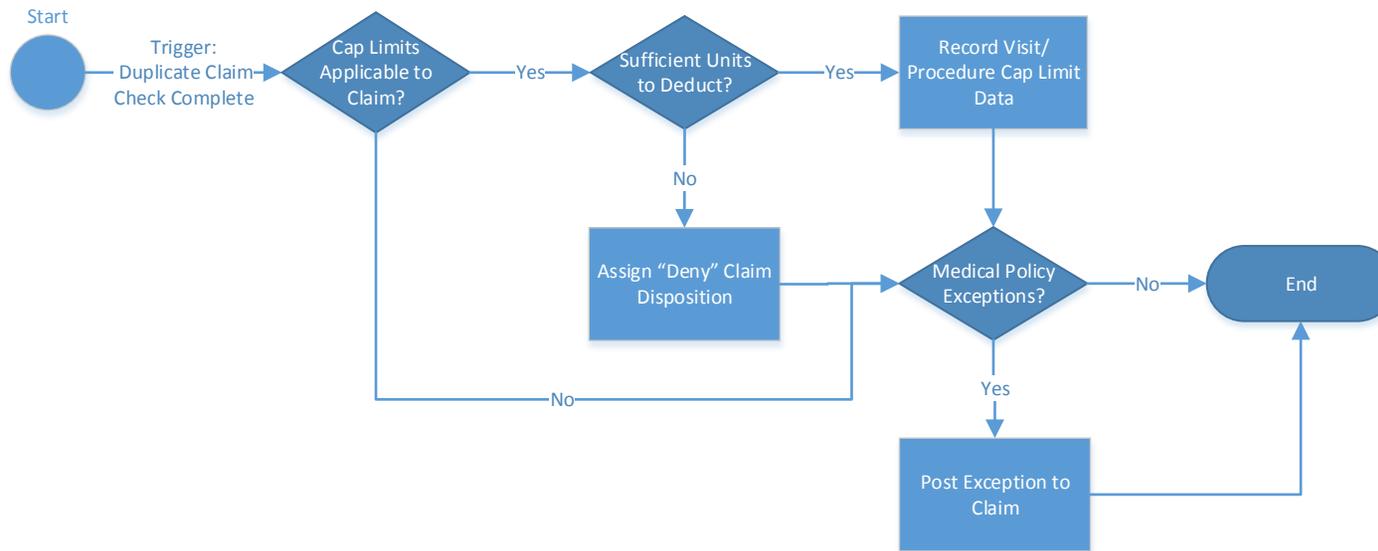
Resolve Prior Authorization
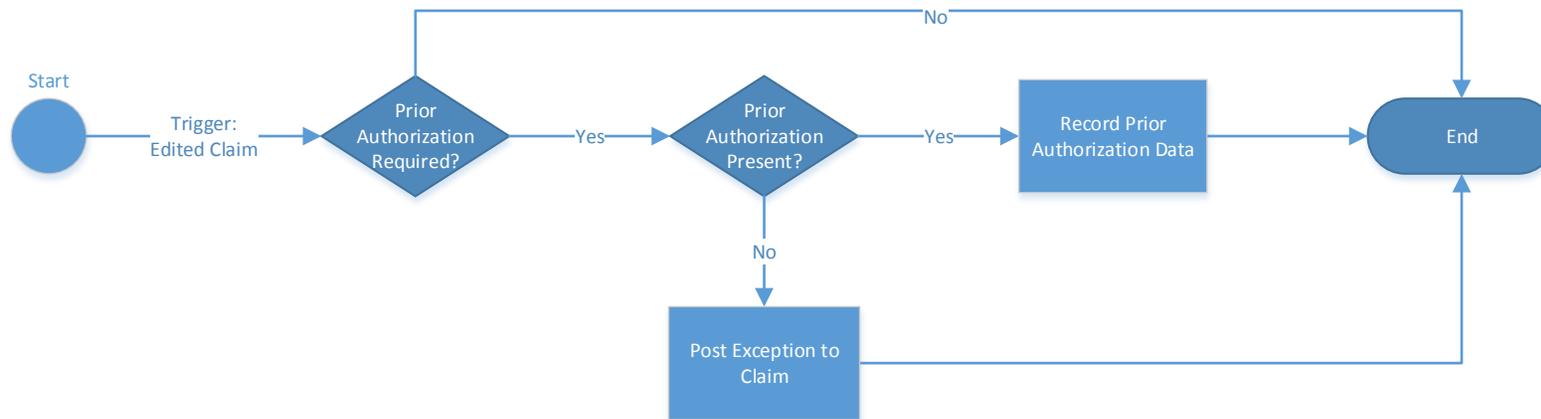
● Within the "Record PA Data" step in the process ensure that: 1. there units left; 2. dates match; 3. do code(s) match; 4. provider match; 5. client match; 6. modifier(s) match…

Check Service Pricing

Fiscal Agent

Start

Trigger:
Claim with Resolved PA

Determine Claim Type

Determine Provider Type

Calculate Billing Code(s) Pricing
(CPT, HCPCS, Revenue)

Apply Pricing Schedules

Apply Fee Schedules

Finalize Claim Pricing

End

● 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.

Check Duplicate Claim

Fiscal Agent

Start

Trigger:
Priced Claim

Duplicate Claim?

No

End

Yes

Post Exception to
Claim

● 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

Fiscal Agent

Start

Trigger: Duplicate Claim Check Complete

Cap Limits Applicable to Claim? —Yes→ Sufficient Units to Deduct? —Yes→ Record Visit/ Procedure Cap Limit Data

Cap Limits Applicable to Claim? —No→

Sufficient Units to Deduct? —No→ Assign "Deny" Claim Disposition

Medical Policy Exceptions? —No→ End

Medical Policy Exceptions? —Yes→ Post Exception to Claim

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

Determine Claim Disposition

Fiscal Agent

Start

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

Posted Edit(s) &
Exception(s)?

No

Yes

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

Action

Pay

Pay, But Report

Force

Assign "Pay" Claim
Disposition

To
SAO
(in batch
File)

Claim Payment
& Reporting

Suspend

Super Suspend

Assign "Suspended"
Claim Disposition

Remain
At
Fiscal
Agent

Suspend
Claim

End

Deny

Assign "Denied"
Claim Disposition

Remain
At
Fiscal
Agent

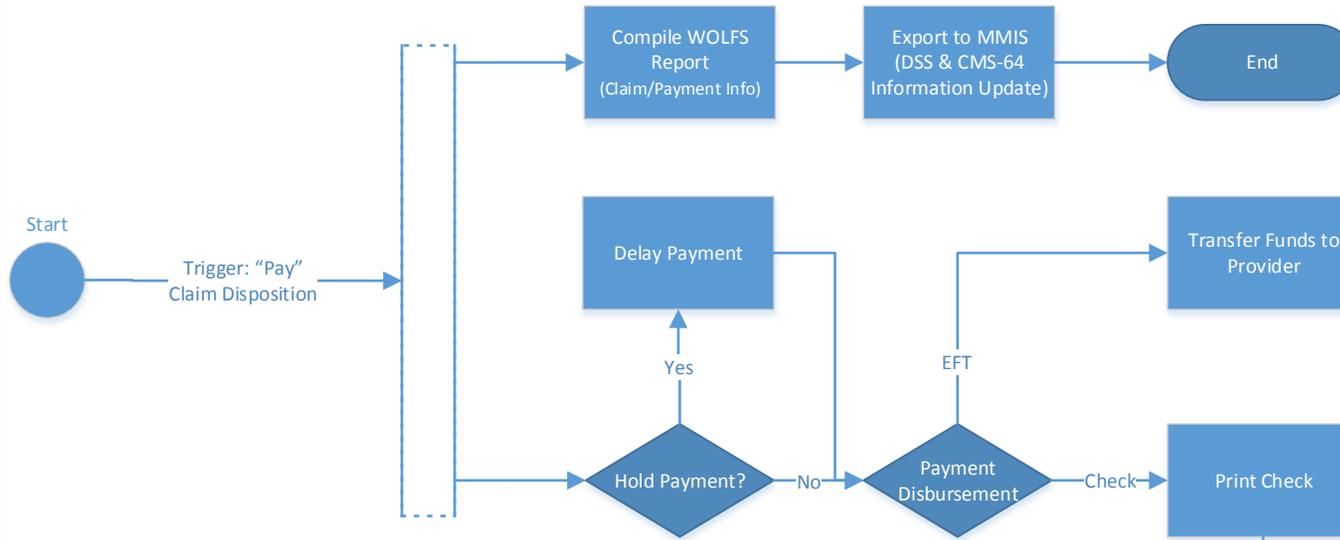Claim Payment
& Reporting

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.

Pay & Report Claim

State Auditor's Office (SAO)

Start

Trigger: "Pay" Claim Disposition

Compile WOLFS Report (Claim/Payment Info)

Export to MMIS (DSS & CMS-64 Information Update)

End

Delay Payment

Yes

Hold Payment? — No — Payment Disbursement

EFT

Transfer Funds to Provider — EFT Information

Check

Print Check

Forward Check(s) to Fiscal Agent

Fiscal Agent

Start

Trigger: "Deny" & "Pay" Claim Dispositions

Compile Remittance Advice (RA)

Mail RA to Provider

Mail Check(s)
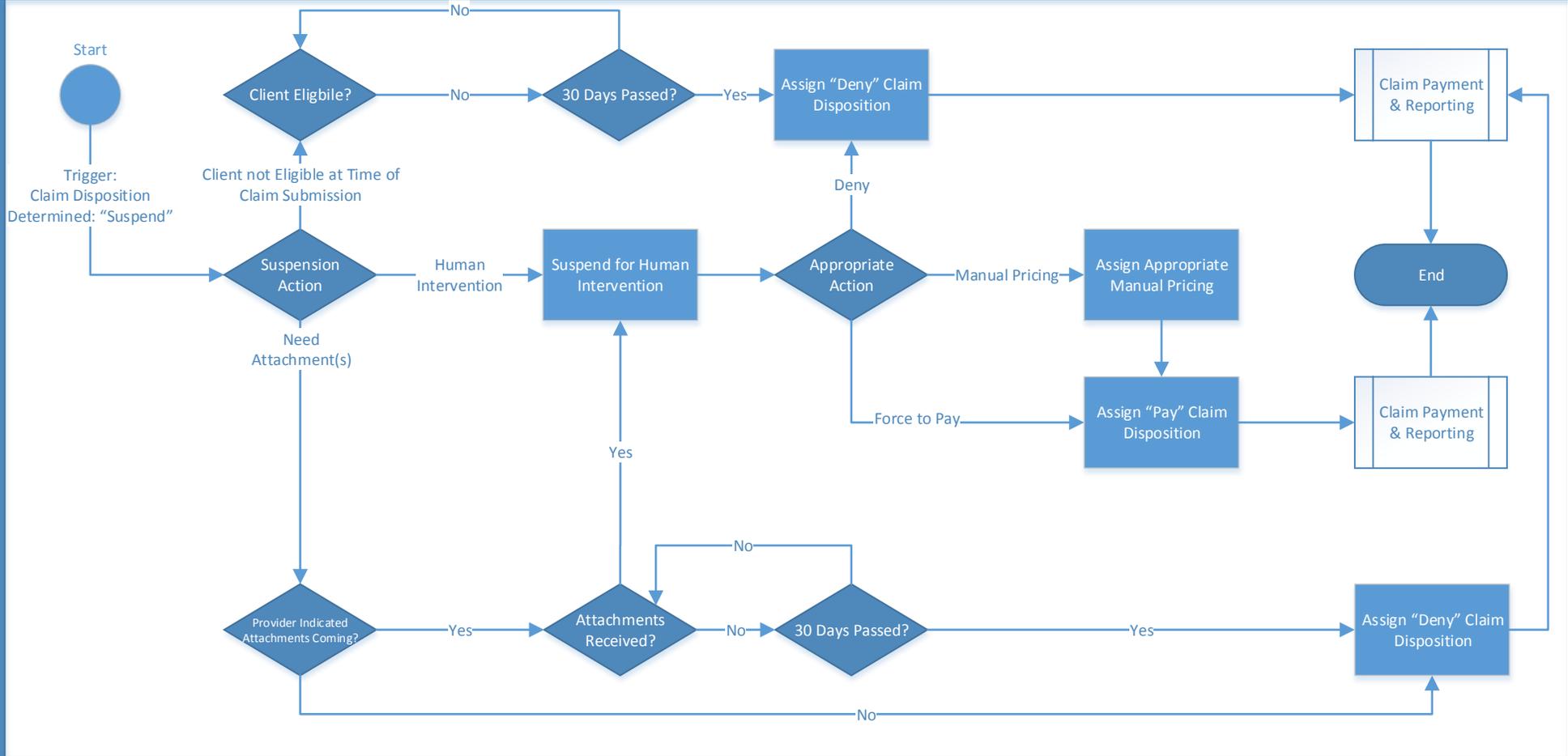
Update Web Portal with RA & Payment Information

End

● 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.

Suspend Claim

Fiscal Agent

Start

Trigger:
Claim Disposition
Determined: "Suspend"

Client not Eligible at Time of
Claim Submission

Client Eligbile? — No → **30 Days Passed?** — Yes → **Assign "Deny" Claim Disposition** → **Claim Payment & Reporting**

No (loop back from Client Eligbile)

Suspension Action — Human Intervention → **Suspend for Human Intervention** → **Appropriate Action**

Need Attachment(s)

Deny → **Assign "Deny" Claim Disposition**

Appropriate Action — Manual Pricing → **Assign Appropriate Manual Pricing** → **Assign "Pay" Claim Disposition** → **Claim Payment & Reporting**

Force to Pay → **Assign "Pay" Claim Disposition**

End

Provider Indicated Attachments Coming? — Yes → **Attachments Received?** — No → **30 Days Passed?** — Yes → **Assign "Deny" Claim Disposition**

No (loop back Attachments Received)

Yes (Attachments Received → Suspend for Human Intervention)

No (Provider Indicated Attachments Coming → bottom path)

No (30 Days Passed → loop)

- The new Contractor will need to be able 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.