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Whitepaper

Claims Adjudication

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Introduction

After a medical claim is submitted, the insurance company reviews the claim and determines its financial responsibility for making the payment to the provider.

This process is referred to as claims adjudication. The insurance company can decide to pay the claim in full, deny the claim, or reduce the amount paid to the provider.

How does a claim get accepted or rejected?

During claims adjudication the payer evaluates the claim and decides two important things:

1. Whether the medical claim is valid, and
2. How much of the claim they will reimburse

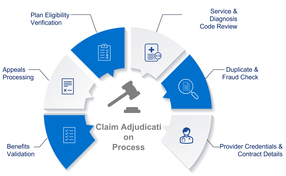
If the claim is accepted, the payer will issue provider reimbursement and charge the patient for any remaining amount. The payer may deny the claim if the patient has insufficient coverage or did not get pre-authorization for a service. If a payer denies a medical claim, the patient may have to submit an appeal to gain coverage for the care costs.

The payer may also reject a claim. This happens when the claim does not meet formatting requirements or contains an error in medical coding. Rejected medical claims can be resubmitted for payment once the errors have been corrected.

Usually, when claims are submitted electronically, the software may help to avoid errors, such as incorrect or incomplete information before it is submitted for payment. This increases the chances of claim acceptance.

Steps involved in the claim adjudication process

It is important to know the different steps of claim adjudication to understand how the insurance company determines how claims are paid, rejected, or denied.



Eligibility verification

In the initial process of claim review where we check the claims for simple errors and omissions, if left undetected can lead to significant costs. So, it is important to verify patient identity and eligibility to ensure that any missing data is immediately acquired for generating a complete claim. During the review, the reviewer must ensure that the data provided in the claim documents can be verified and backed by original source documents.

Verification of fraudulent/ duplicate claims

When a claim is submitted to the Payer for reimbursement, it is checked whether the claim is duplicate or fraudulent and if it needs checking on a few parameters. This involves checking if the insurance coverage is active, followed by ensuring that the diagnostics and procedure codes match the codes listed on the claim, filing of claims well after the deadline, and other types of fraud.

Coding, Bundling, and Diagnosis review

Evaluation of pre-certification or authorization records to identify cases where there is an absent or invalid pre-certification issue. Such cases are liable to take place when the diagnosis, procedure, or date of service cannot be correlated to the information provided in the pre-certification or authorization.

Detailed analysis of provider

Cross-verification of the claims should be conducted for evaluating the claims' authenticity. It helps to rule out cases where unlisted procedures were implemented on patients despite not having a medical necessity. For this, it is important to verify if every necessary document is in the required order for the claim to be processed successfully. This helps to avoid delays and denials of claim settlements.

Benefit determination

Benefit determination is the process by which claims information is matched with benefit information to confirm whether the services delivered are covered under the terms of the member's defined health benefits and if all the corresponding benefit adjudication rules are applicable.

Appeals processing

If your health insurer refuses to pay a claim or ends your coverage, you have the right to appeal the decision and have it reviewed by a third party. You can ask your insurance company to reconsider its decision and they have to explain why they've denied your claim or ended your coverage

Auto-Adjudication of claims

Auto-adjudication is the process of paying or denying insurance and public benefits claims quickly without reviewing each claim manually.

Auto-adjudication uses advanced AI software to scan for errors, then matches key details to decide on approval, denial, or making a change to the claim automatically.

Limitations to claims auto-adjudication

Adopting new technologies like auto-adjudication reduces the time taken to adjudicate a claim through a manual process, but there are a few limitations.

There are multiple reasons which could prevent auto adjudication. As it is a new technology and still in the development phase, some adjudication platforms have limitations regarding accepting certain loops or segments carried in the EDI. In these cases, things such as primary payer adjustments, and other PR02 contractual adjustments may cause claims to be pending for review.

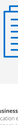
Claims auto-adjudication can be subject to even more causes such as billing errors, and mapping data from downstream data sources. Additionally, factors such as name mismatches can also cause pends for many platforms. If a provider bills the claim as jenny but the patient is on file is jennifer, how does your platform handle that?

How to improve auto-adjudication

Validation checks such as member matching, provider matching, and business rules and edits can help improve auto-adjudication to handle those discrepancies.

Member Matching

Member matching can help to reduce pends by normalizing differences between proper names and nicknames of the members. Additionally, this type of data validation and cleanup can resolve additional inconsistencies such as members being billed under their Social Security Number instead of their correct member ID.



Provider Matching

Provider matching works similarly to member matching and can help ensure only clean normalized claim data is presented to the system. Provider name variations, ID numbers, tax IDs, and other billing identifiers can be normalized through prior validation processes

Applying Business Rules and Edits

Other adjudication edits can be used to screen for other business cases preventing auto adjudication. This can include EDI edits and can go further such as ensuring that all diagnosis codes used are specific enough for payment. Custom or proprietary business rules can be enforced such as mapping provider contact information.

Benefits of Claim Auto Adjudication

1. Accurate analysis of the validity of claims to detect fraud and identify duplicate claims to prevent revenue loss.
2. Validation of data against adjudicating systems and computation of the valid claim amount for profitable collections.
3. Machine-assisted adjudicated claims process with result-driven project plans tailored to your needs.
4. Process transparency for enhanced collaboration with our clients; client-specific training for operational excellence.
5. Compliance with HIPAA regulations and ever-changing guidelines for the maximum security of confidential information.

The final thoughts

The US government spends billions on healthcare, and considerable time gets wasted in claims processing and claim denial management. Claim auto adjudication with adaptive technologies can help in ensuring value by increasing accuracy, claim denials, reducing manual efforts, and accelerating the entire process. Though there are multiple claim adjudication systems today, they are not enough for the US Healthcare industry owing to their less user-friendly approach. However, with emerging AI technologies coming to the fore, we are optimistic that old adjudication systems will soon be replaced with new age adaptive adjudication systems.