REQUORDIT

eBook

PAYER SOLUTIONS

REQUORDIT's Insurance Practice is pleased to present the collection of Payer Solutions that could have an immediate impact on your operational effectiveness while gaining efficiencies to drive down costs and improve outcomes for your members. .

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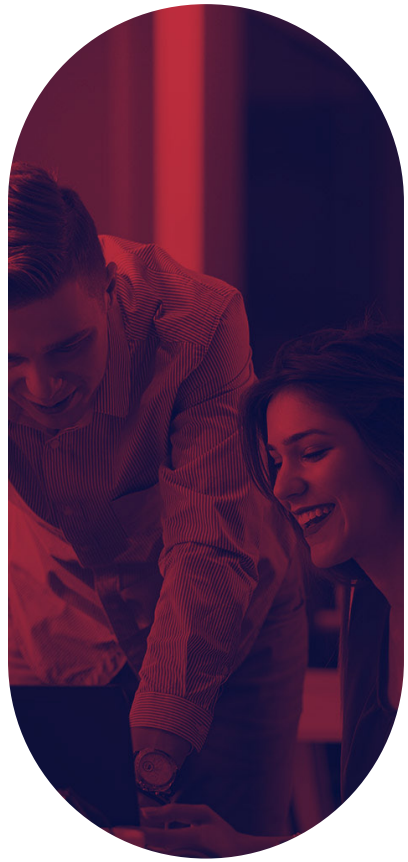
PROVIDER MANAGEMENT

PROVIDER MANAGEMENT BEYOND CREDENTIALING CAN BE A TEDIOUS TASK FOR PAYERS. KEEPING ABREAST OF ALL **OPEN ITEMS, ENSURING TIMELY REPORTING, AND MAINTAINING GOOD RELATIONSHIPS WITH PROVIDERS IS A KEY ASPECT TO LONG TERM SUCCESS.**

As such providing exceptional customer experiences with Providers is a key initiative among health insurers. An important aspect of that experience is how well an insurer responds to Provider appeals & grievances. The OnBase Insurance Solution can manage incoming Appeals & Grievances directly from a Provider Portal, or by mail, fax, or email. Once imported into OnBase distribution of appeal by type of can easily be accomplished. Typically, most appeals are financial in nature because a claim has been denied or rejected, and after 3 attempts, the provider only recourse is this process.

Other areas that OnBase assist in helping with Provider Relations is in their Sales Campaigns. OnBase can provide an easy interface from the provider portal for providers to request sales campaign support; capturing information about where the provider wants to host the sales activity, what additional resource support is needed, what funds are required. OnBase workflow can manage the request and assign tasks based upon the request, generate notifications back to providers to give status updates on the request and monitor time constraints that may be required for decision/support.



APPEALS & GRIEVANCES

APPEALS & GRIEVANCES WITHIN THE PAYER SPACE TODAY CAN BE A VERY COMPLEX AREA TO MANAGE. **VOLUMES ARE UNPREDICTABLE,** AND TYPES OF APPEALS & GRIEVANCES CAN VARY BOTH FROM SEVERITY (LIFE AND DEATH VS PROCEDURAL) **SOME REQUIRING IMMEDIATE ACTION WHILE OTHERS NEED REASONABLE RESPONSE TIMES.**

Varying types then requiring different service level agreements make this process a prime candidate for automate workflow, where the OnBase system can automatically prioritize work coming into the Appeals & Grievances coordinators.

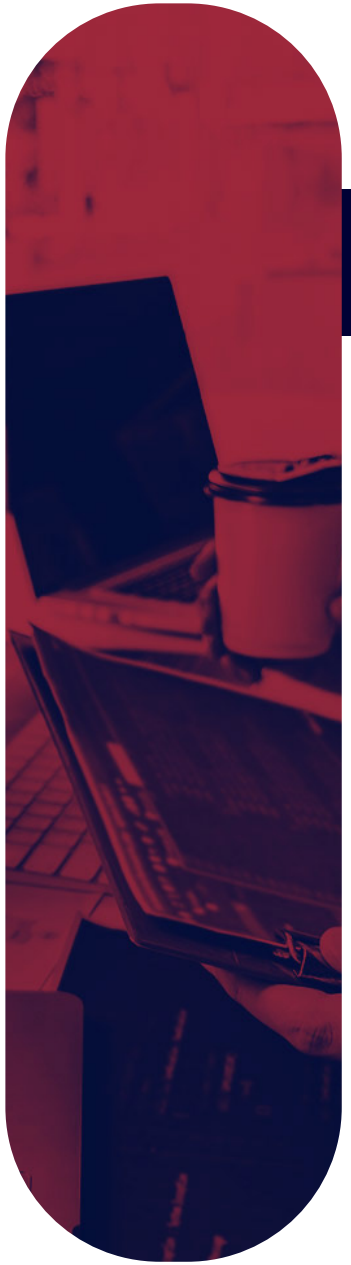
Classification easily occurs at point of capture to determine if it is an Appeal which could be life threatening (e.g. medication correction or medical treatment required) vs monetary (e.g. adjustment to deductible, etc.), can manage the distribution of the A&G, determining who needs to review, what approvals are required and where appropriate what type of correspondence needs to be created in response whether it is an initial acknowledgement letter that is often required by compliance, a determination letter once decision is reached, or a payment authorization notice when a financial component is included in the decision.

Appeals and Grievances can be submitted in various ways; directly from CMS (Center for Medicare & Medicaid Services) by phone/email or directly from the Provider through a Provider Portal when OnBase is exposed through that interface, providing an easy to use, easy to access interface that directly kicks off the process directly into workflow.

Phone Appeals are often handled by have the call center leverage OnBase eforms to capture the pertinent information and then it automatically drops into an OnBase workflow where it is tracked for SLAs so that theturnaround time is handled in an appropriate timeframe. Automated follow-up letters can also be generated and distributed to follow the required compliance for communications, which then automatically get stored back into OnBase for archival and audit purposes.

OnBase Appeals & Grievances solution not only provides an easy way to manage this high volume, manual intensive process, but it also can help to ease the audit requirements as OnBase will keep an audit trail of the entire process giving visibility to the process, approvals, and documents distributed, with complete date and timestamps.

CLAIMS ADJUDICATION



Typically, 80% of incoming claims into a health insurer are managed as EDI claims. However, the remaining 20% of paper claims coming in typically represent a very high volume and represent the highest cost associated to claims processing.

ONBASE CLAIMS PROCESSING SOLUTIONS HAVE HELPED REDUCE COSTS IN THIS AREA BY 15 – 30%.

OnBase workflow can provide an opportunity for payers to streamline their claims process by leveraging OnBase automate the claims process. Paper claims are brought into OnBase as well as all the EDI data is brought into OnBase where style sheets are applied to allow for viewing of claims data during exception handling. This allows for the efficient handling of exceptions. Further automation can be leveraged with AnyDoc Health Claim processing. These Advance capture capabilities allow for identification and classification of claims forms which can automatically determine if it is a duplicate claim. Integration with core systems can verify if coverage is in place and if the policy is in force before distributing to an assigned adjudicator. In some cases automated capture can pull line item data from the claim forms (e.g. UB04, CMS1500, etc.) converting values to an xml data stream which can be imported directly in core systems with the Web Service Publishing tools, in essence creating an EDI file from paper claims, eliminating costly data entry, improving process quality and decreasing processing times. Insurers have identified the ability to significantly **reduce headcount by more than 50%** in the data entry areas by implementing the OnBase claims processing solution.

CREDENTIALING

Managing Provider Credentialing can be a cumbersome time-consuming process for any health payer.

WITH THE ONBASE HEALTH INSURANCE SOLUTION – THE CREDENTIALING PROCESS CAN BE MANAGED **MORE EFFECTIVELY WITH A HIGHER DEGREE OF ACCURACY THAN THE MANUAL PROCESS IN MOST COMPANIES TODAY.**

The capture and management of core document related to the provider contract including the Provider Agreement (signed contract), licenses, proof of current insurance for the Provider are among some of the documents that can be stored and maintained within OnBase. The OnBase Folder structure allows for the segregation of this information in an easy to view, easy to access tabs, organized by year so that audits can easily be performed. OnBase can store metadata related to the documents (e.g. expiration dates, practice locations, etc.) which allows validation whether current documentation is on file for each requirement to be audited. When documents are missing, OnBase can automatically generation notifications via email, fax, or printed letter to request required information and set timers to automatically remind the credentialing department to follow-up if not received within a certain timeframe. OnBase can also keep related contract agreements by provider within the same file, and track billing addresses to tie to appropriate fee schedules.

MEDICAL REVIEW

AN EFFECTIVE MEDICAL REVIEW PROCESS FOR PAYERS **HAS THE POTENTIAL TO SAVE MILLION DOLLARS A YEAR FROM EFFICIENCIES GAINED.**

The OnBase Health Insurance solution can be used to automatically set up medical review for claims based upon various reasons; some initiated by CMS (Center for Medicare and Medicaid Services), some by legal, or some by random samplings. Core Claim systems can often be set to flag certain claims for fraud and abuse, which can also be triggered then in OnBase for Medical Review. The OnBase workflow will gather all related data and content on the claim to be reviewed and present a contextual view of information for the medical doctor or review board to examine.

Accommodating both automated and ad-hoc review of claims allow for a good statistical sampling enabling payers to control against fraudulent and erroneous claims in a structured automated fashion.

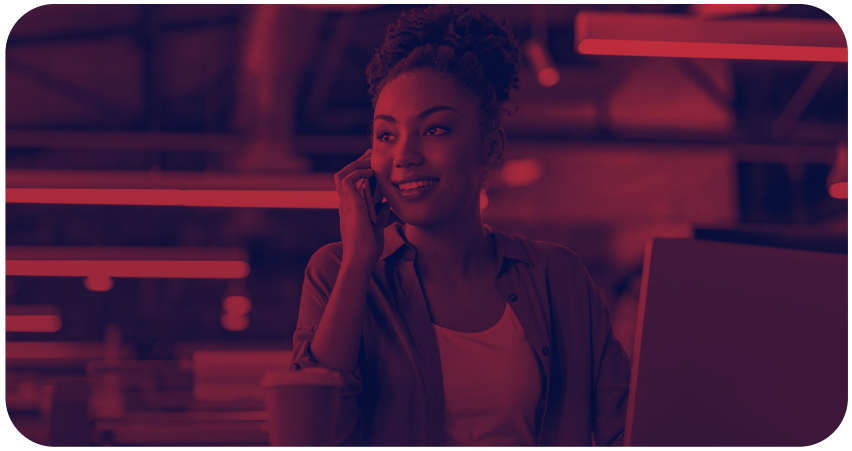
Claims can also be easily identified by the medical review process to be sent to the Medical Review Board or directly to the Chief Medical Officer for further review and determination.

OnBase keeps a complete audit trail of the entire review process and enables notes and annotations to be made throughout the review process. Data from these processes and other operational work processes managed in OnBase can also be extract to the Payer's data warehouse enabling extensive reporting for metric oriented organizations that Payers must be to control cost and manage high volume transactions.

Health Payer Solutions

NEW BUSINESS PROCESSING ENROLLMENT

New Business Processing for Payers is typically a manual paper intensive process with a heavy peak season due to Open Enrollment which often causes Health Insurers to hire temporary sales staff and support to manage the fluctuation in volume. Timing is critical in that once the sale is made, the new business issuance needs to follow as soon as possible. With most sales happening in the door to door, effective field operations are imperative to meet processing requirements.



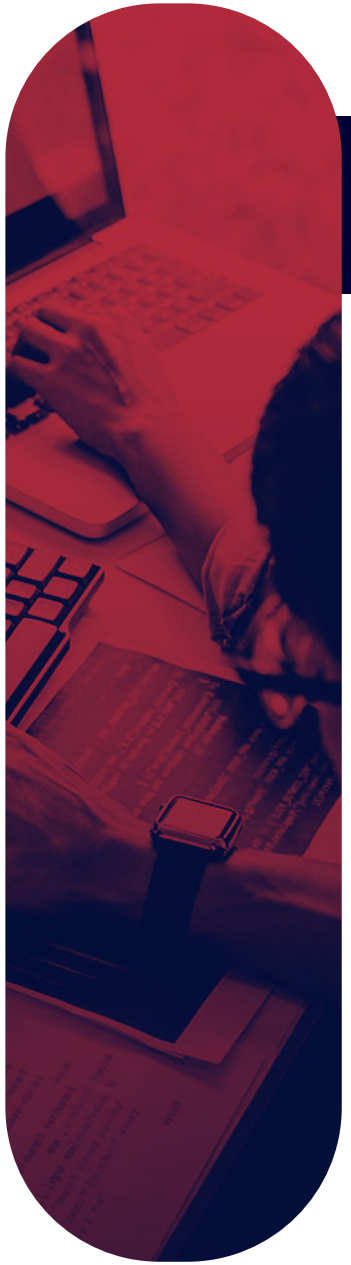
TYPICAL HEALTH INSURERS WHO USE ONBASE TO MANAGE THEIR OPEN ENROLLMENT PROCESS CAN **TAKE WHAT USE TO TAKE 7 DAYS TO ISSUE A NEW POLICY TO LESS THAN 24 HOURS.**

The OnBase Insurance Solution provides commercial health payers with the ability to automate the capture of applications from the point of receipt, regardless of file format or where it originates from. The Field Enrollment Solution is ideal for this segment of the business.

Managing missing and required supporting documents is simplified with the OnBase solution, which provides the ability to monitor required information and to improve the quality and timing of the new business process. Automatic notifications can be generated to sales agents when items are missing or do not pass the validation requirements.

OnBase provides the ability to dramatically decrease processing time by allowing for parallel processing and automation of many points within the business process. OnBase provides access to all the business documents right directly from the core line of business applications such as Trizetto Facets, etc. saving Customer Service rep over 5 hours per week. OnBase provides managers with an automated approach to monitor service level agreements and production levels, allowing them to spend the time more effectively in making underwriting decisions

CLAIMS MANAGEMENT



CLAIMS MANAGEMENT FOR A HEALTHCARE PAYER CAN BE **ONE OF THE MOST DEMANDING ASPECTS OF THEIR REVENUE CYCLE.**

Even with the standardization of the EDI 837 format to expedite processing of health claim forms electronically, Payers still find themselves with the daunting tasks of manually managing paper claims where accuracy, speed and costs have direct impact to the companies bottom-line. While some payers have turned to off shoring the manual data intensive data input of claims forms, which can lessen the overall costs but does not address the speed in which claims are being managed, having a significant impact to customer service levels.

Leveraging intelligent capture techniques to automatically identify standard forms such as CMS1500, UB04, and dental claim forms while also extracting pertinent data including line data associated to specific charge codes. Claims Management solutions can also be configured to automatically provide verification of the critical data extracted improving throughput. Once the data has been extracted and validated the solution will convert the data into an 837 ready format to be processed alongside of a payers EDI 837 process. The Claims Management solution can also be configured to handle exceptions through an automated workflow so that a knowledge worker can efficiently review and act.

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