Adjudication Logic

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Adjudication Logic

Step 1: Confirm All Adjudication Rules Are Met

1. System determines which rules need to be checked based on the AdjudicationRules table based on the Insurer the claim lines are being adjudicated for.
2. Checks one claim line at a time for the rules based on the insurer adjudicating the claim line.
3. Checks the following rules:

Core Rules:

1. **'Invalid Billing Code'**
    1. Using the billing code specified on the claim line, the system looks for the following:
        1. Looks for the billing code ID and then compares to the billing codes set up in the Administration tab. The billing code must be marked as Active.
        2. This ties to the BillingCodes table in the database.
2. **Invalid date of service or number of units**
    1. Using the Start Date and End Date on the Claim line, the following rules must be true. If one of these rules is broken, the claim line will have the Invalid Date of Service or Number of Units denial reason
        1. Date of service must be prior to the date of adjudication
        2. Date of service from cannot be after the date of service to
        3. Units claimed is greater than 0
3. **Duplicate Claim Line Exists**
    1. First the logic takes the Billing code on the claim line. If the billing code modifier combination is marked in the Administration tab set up to allow more than one claim per day or if not there but the billing code is marked to allow more than one claim per day, this rule does not apply.
    2. If neither the billing code nor the billing code modifier are marked allow more than one claim per day, the logic then looks for any other claim line in the system with all of the same information as follows unless the billing code is set up to allow more than one claim per day:
        1. Date of Service
        2. Client ID
        3. Insurer
        4. Provider and Site
        5. Billing Code and Modifiers

3. The system will adjudicate the first claim for a day that is in approved, partially approved, or paid. It will then deny any other claims with the same information with the status of Duplicate Claim Line Exists.

4. **Invalid Diagnosis Code**
    1. Primary or first diagnosis on the claim line cannot be 799.9 for Professional Claims
    2. Principal and Admission diagnosis cannot be 799.9 for Institutional Claims.
    3. Compares all other diagnosis for the first, principal and Admission diagnoses to the DiagnosisDSMDescriptions table of the database. If the diagnosis code is not in the table, then the error will be received.
5. **Diagnosis Not Entered on Claim**
    1. If there is not a diagnosis entered for the claim line this error is received.
6. **Invalid Date(s) of service or number of units**
    1. If there is something wrong with the dates or units submitted on a claim line this message is displayed.
        1. Rules that apply include that the end date is before the start date of the claim line, the units is equal to zero, or if the billing code set up in the Administration tab has the 'End date must equal start date on a claim service line' checked and the claim line is for more than one day.
7. **Claim Includes Discharge Day**
    1. This is only used when the billing code details page 'Exclude Discharge Day' is marked 'Y'. This is done in the General Tab of the Billing Code details page of the Administration tab. This data is stored in the database in the BillingCodes table.
    2. This rule calculates dates based on number of days between the start date and end date of the claim lines and then compares to the total number of days authorized. If the number of days in the claim line matches the number of days authorized, this error is received.
8. **Dates of service not fully covered by contracts**
    1. Compares the dates in the ContractRates table for the date range of the contract. The system compares to the Start and End dates for the claim line. If an active contract does not cover all dates in the claim line, then the claim line will be marked with this error.
9. **No Contract exists for any claimed date of service**
    1. Compares the dates in the ContractRates table for the date range of the contract. The system compares to the Start and End dates for the claim line. If there is not a contract for any of the dates of the claim line, then the claim line will be marked with this error.
10. **No rate can be found for this claim line**
    1. The system uses the claim line provider, insurer and billing code information to find the contract. Once the contract is found, if a rate

cannot be found for the date(s) of the claim line, this error is received.

11. Rendering provider is required for this service

1. The system looks at the check box in the Contract page for the provider, 'Requires affiliate provider' to be checked on the contract.

2. Then will look for a rendering provider to be documented on the claim line. If no rendering provider is documented, this error is received. The rendering provider can be seen on the Claim Form page, in the Rendering Provider drop down for each claim line.

12. Specified rendering provider is not associated with the contract

1. The rule looks at the ContractRateAffiliates table. This uses the' 'All Associated Providers may deliver service' check box or 'Specify Associated Providers' button in the Rules pop up of the Contract page within the Provider tab. If the rule is enabled and there is not an associated provider set up to the contract rate, this rule will apply.

13. Specified rendering provider is not associated with the provider

1. This looks for the ProviderAffiliates table.
2. In the user interface, this is looking at the Associated Providers in the Provider Information Tab. If the provider that is documented on the Claim Line as the Rendering Provider is not in the Associated Providers field of the Provider Information tab, this error is received.

14. Rendering Provider is not Credentialed

1. This looks for the table Contracts for the column CredentialedRenderingProvider = 'Y'
2. The user interface set up of this is on the Contracts page of the provider record 'Rendering provider must be credentialed else the claim will be pended.'
3. The rules that must be met in order to not receive this error are the following: Credentialing status must be 'Completed' and the date range of the claim line falls within the date range of the credentialing. The credentialing is for the correct insurer or shared among all insurers must be how the credentialling is set up. Additionally, Billing Code on the claim line must be specified as credentialed on the credentialing screen.
    1. Credentialing Table and CredentialingProviderBillingCodes table are the tables in the database where this information is stored.

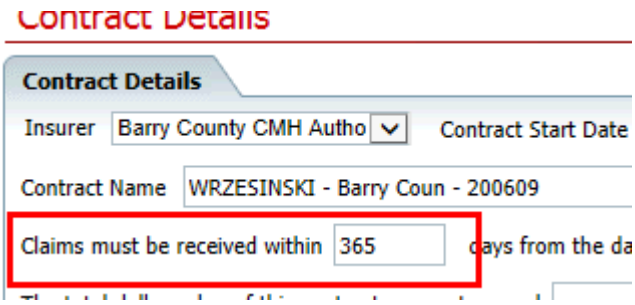
15. Provider not Credentialed

1. The system looks for the table Contracts for 'ProviderSiteCredential' flag = 'Y'
2. This is set up in the User Interface on the Contracts page of the provider record. The field name is 'Provider/Site must be credentialed else the claim will be pended.' If this is checked, this rule applies.

3. The rules that must be met in order to not receive this error are the following: Credentialing status must be 'Completed' and the date range of the claim line falls within the date range of the credentialing. The credentialing is for the correct insurer or shared among all insurers. Additionally, Billing Code on the claim line must be specified as credentialed on the credentialing screen.
    1. Credentialing Table and CredentialingProviderBillingCodes table is where this information is stored in the database.

16. Claim was received after the period mentioned in the Contract

1. In contracts set up this field is what determines this rule. The Claims must be received within field is what determines the period of time allowed for receiving the claim. It compares the Clean Claim Date of the claim line's Claim ID to this time frame.



2. In the database, this information is maintained in the Contracts table. The column is ClaimsReceivedDays field. Zero means there is no limit to the number of days. Otherwise, the number of days entered on the User Interface is kept here.

18. Member is eligible for any plan

1. This rule looks for at least one plan associated to the client that is not marked as Third Party Plan or as Information Only plan and where the claim line is within the plan effective date. And the billing code must be billable to the plan.
    1. The billing code being billable to the plan is set up in the Administration page, Billing Code details page, Standard Rules tab. Indicate all plans or specified plans. The user either sets up All Plans or can specify certain plans. The plans the client has associated in Client Plans and Time Spans can only be used if the billing code is set up to use that plan.
    2. The Third Party Plan or Information Only Plan is designated in the Plans details page of the Administration tab, in the Care Management tab of the page. If one of these two radio buttons are selected, this plan cannot be used to allocate to claim lines during the adjudication process.

3. The client's plans are set up in Client Plans and Time Spans. The bottom half of the page displays what coverage plans were effective for what time frames. This is used to determine for the Claim Line date(s) what plans to potentially allocate to.

2. The database tables used includes the CoveragePlans Table where ThirdPartyPlan = 'N' is checked and InsurerServiceAreas is checked to match the Insurer adjudicating to the client's plans based on Service Area. ClientCoverageHistory is also checked to confirm the dates the coverage plan is effective..

19. Third Party Plan Rules - There are 2 Rules

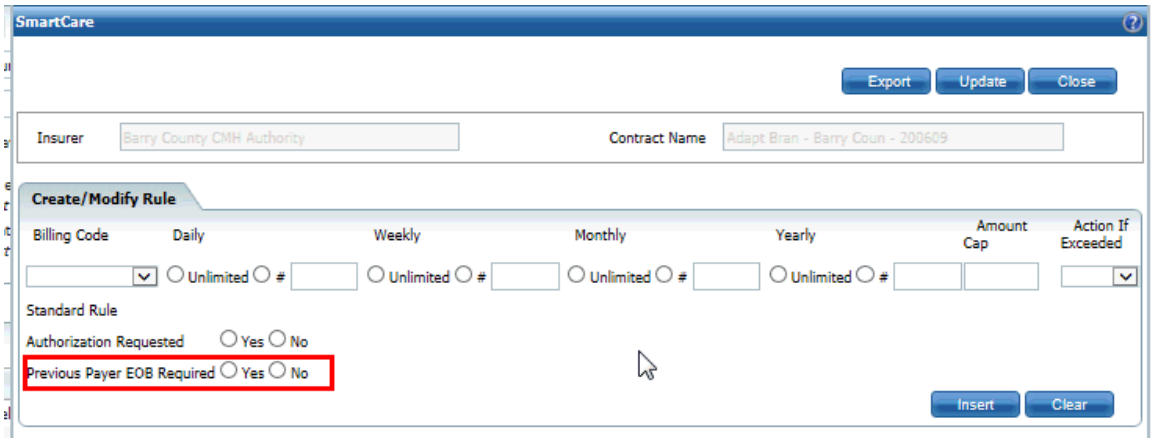
1. Claim line has to be approved manually after Third Party EOB received

1. When this rule is set, once the information is entered for a claim line as indicated below, this message will be received and the claim line will be pended. Staff have to manually approve the claim line.

2. Waiting for Third Party EOB

1. This rule will be received on a claim line and the claim line will be pended unless both of the following information is completed. Once the information is received, the system will adjudicate based on the information entered.

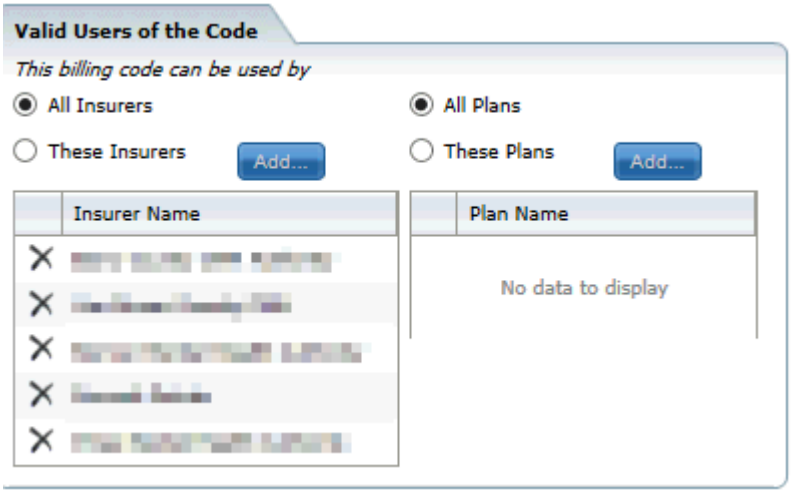
3. Both EOB rules look at the following to be in the system:
   1. First thing that is reviewed is the rule set up on the Contract. In the Provider Contracts page, if the 'Add contracted billing code rules' button is clicked, this pop up will appear. The rule 'Previous Payer EOB Required' can be set up by billing code and modifier combination within this pop up. If the rule is not answered or is marked 'Yes' then the system will consider the two Third Party EOB rules in adjudication. This means the default is to consider Third Party EOB rules. If this question is marked 'No' than for that provider, for that billing code and modifier, the system will not consider Third Party EOB rules during adjudication.



2. Next, the adjudication logic looks at the claim line. The claim line must have the Third Party EOB Received checked on the Claim Line details page (in the ClaimLines table EOBReceived = Y).
3. Secondly, the adjudication logic also looks for information entered on the Third Party EOB fields of the claim line in the Claim Form page. (ClaimLineCOBPaymentAdjustments table has a minimum of one row entered for the Claim Line.)

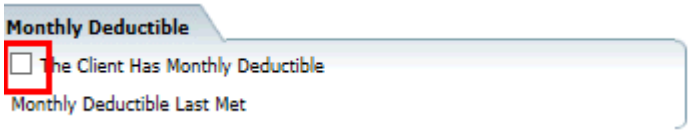
19. Billing Code is Not Billable to the Member's Plan

1. This message is received when the client's plan is not associated to be used by the billing code the claim line is for. This is set up in the Billing Codes page of the Administration tab in the Standard Rules tab of the page.



21. Date of Service occurred before the date the monthly deductible was met.

1. This rule applies when the client's coverage plan that was identified for the claim line to be allocated to has the 'The Client has Monthly Deductible' box checked in the Plan details page of the client's record. It then is looking for the date the monthly deductible was met in the Monthly Deductible tab of the Plan details page in the client's record. It is comparing the date met for the month the claim line occurred in to determine whether the dates of service of the claim line are before the date met. If before the date met, the claim line is pended for manual review. It can be manually approved to the correct plan at that time.



2. The logic of this is looking at the following tables:
    1. ClientMonthlyDeductibles

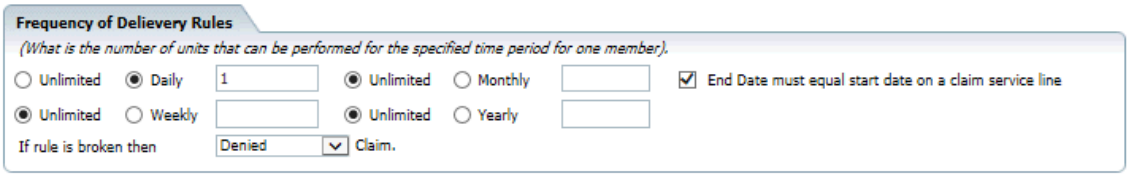
1. It is looking for dates that are before the date met. Dates of service that are the same date or after the date met can use the plan.
2. If the claim line spans for more than one day, and one or more days in the claim line is before the date met of the plan, this error will pend a claim line.

22. Spenddown not met for period covering date of service

2. This rule applies when the client's coverage plan that was identified for the claim line to be allocated to has the 'The Client has Monthly Deductible' box checked in the Plan details page of the client's record. It then is looking for the date the monthly deductible was met in the Monthly Deductible tab of the Plan details page in the client's record. When for the month of the claim line's date(s) of service there either is not an entry at all or the status of the entry is Unknown or Never, this message is received.
3. The logic of this is looking at the following tables:
    1. ClientMonthlyDeductibles
        1. Is there any record for the month and year of the claim line? If there is not a record for the month, this error is received.
        2. If there is a monthly deductible record
            1. But the date met is after one or more claim line days in the claim line, then the error is received.
            2. The deductible record is marked as Unknown or Never, then this error is received.

23. Billing Code Unit Frequency Exceeds Contract Rules & Billing Code Unit Frequency Exceeds Billing Code Rules

0. This is looking at the contract rules and the default billing rules in the system for the time frame limits. The limits are set in the fields as shown below on either the Provider Contracts page (contract rules) or the Billing Code Details page in the Administration tab.

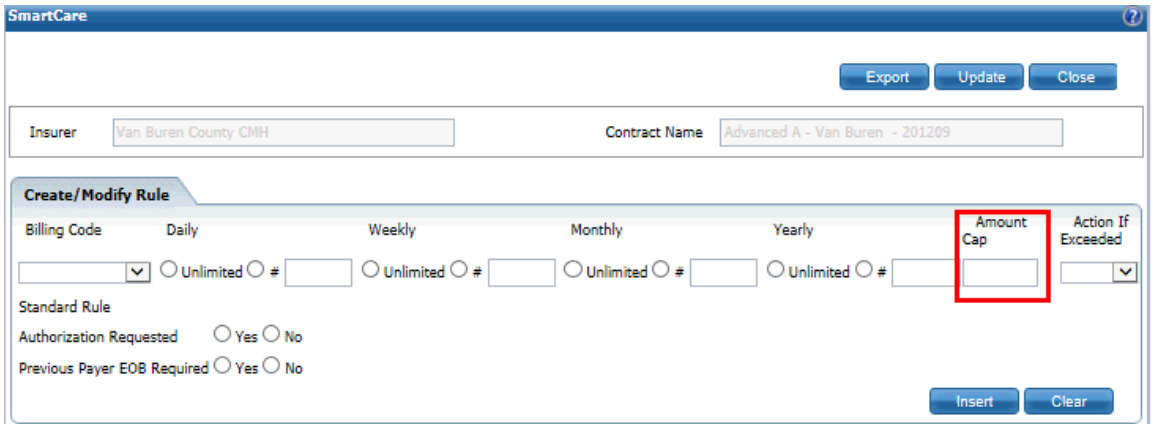


2. The system first checks the contract rules (Contract Rules table) and will use the contract rules over the default billing code rules.
3. If there are not rules set up on the contract, then it uses the rules set on the Billing Code details page of the administration tab (Billing Codes table).
4. It considers all claim lines for the same billing code that have a status of Approved, Paid, or Partially Approved and sums these

claim lines along with the current claim line. If the number exceeds the set amount in the rule, then the new claim line receives this error.

22. Contract Billing Code amount cap has been reached

2. This looks at the contract dollar cap amount for a specific billing code. The cap amount is set up in the Provider Contracts page, in the 'Add Contracted billing code rules' button. In the pop up, there is an Amount Cap that can be set by a billing code.
3. The system calculates the status of Approved, Paid, or Partially Approved and tracks the total amount paid. If total amount ore previously paid claim lines is equal to or greater than the contract amount, the claim line currently being adjudicated is denied.

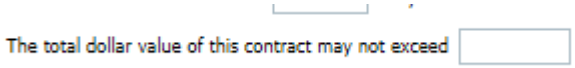


22. Claimed amount exceeds remaining contract billing code amount cap

1. This looks at the contract dollar cap amount for a specific billing code. The cap amount is set up in the Provider Contracts page, in the 'Add Contracted billing code rules' button. In the pop up, there is an Amount Cap that can be set by a billing code. (Shown in the rule above.)
2. The rule calculates the statue of Approved, Paid, or Partially Approved for the same billing code and sums these along with the current claim line. If the total amount exceeds the contract cap amount then the claim line will deny or pend. Then staff must either the claim line must be manually approved to pay the portion that can be paid up to the cap amount or the cap amount could be modified to allow full payment of the claim.

23. Contract amount cap has been reached

1. This looks at the total cap amount set on the contract page of the Provider Contracts page.



2. The rule compares the contract cap to the total balance of claim lines paid to this contract. If the new claim line amount exceeds the total cap amount the claim is pended or denied based on the set up adjudication rule in the administration tab.

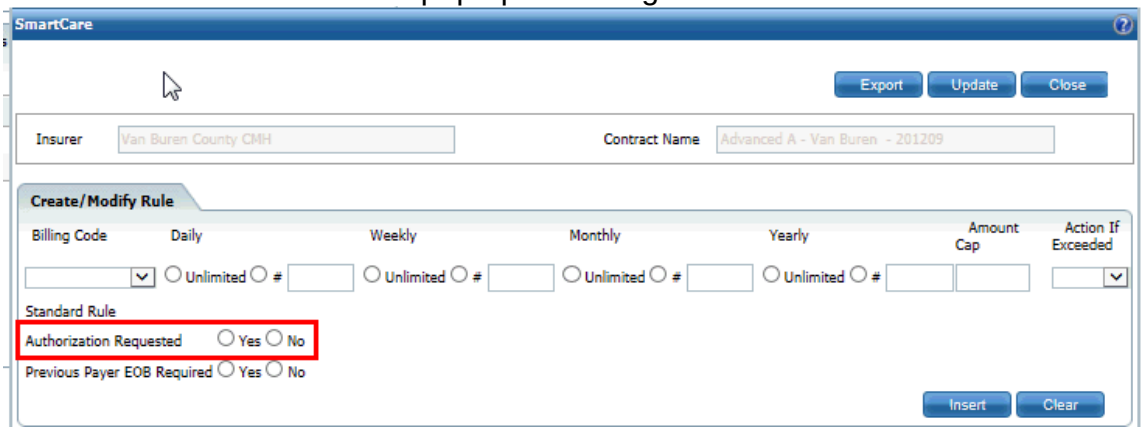
23. Claimed amount exceeds remaining contract amount cap

2. This looks at the contract dollar cap amount for the entire contract in the Provider Contracts page.
3. The rule calculates the statue of Approved, Paid, or Partially Approved for the same billing code and sums these along with the current claim line. If the total amount exceeds the contract cap amount then the claim line will deny or pend. Then staff must either the claim line must be manually approved to pay the portion that can be paid up to the cap amount or the cap amount could be modified to allow full payment of the claim.

24. Billing code requires authorization but one does not exist

0. In the system, you can set up that a billing code requires an authorization on both the Billing Code Details page (Standard Rules tab) or the Billing Code rules on the contract. The system checks the contract rule first for the billing code rules on the contract. If not set on the contract, it then looks at the Billing Codes table for the rule set for a Billing Code.

This is a screen shot of the pop up for Billing Code rules in Provider Contracts



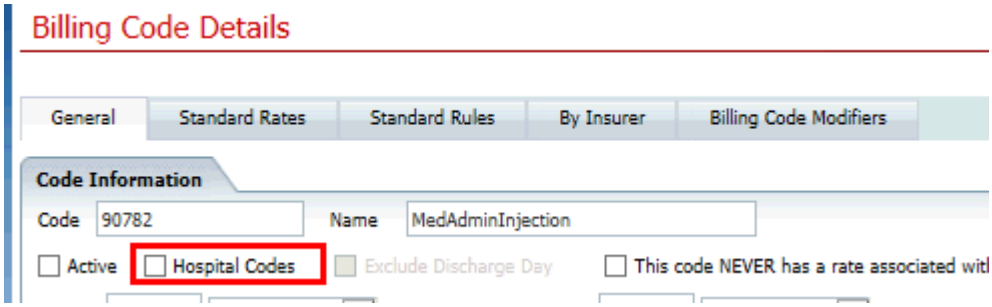
1. If the claim line billing code has this rule set, the system then looks for an authorization with a status of approved or partially approved for the date(s) of the claim line. There also must be remaining units to be used on the authorization. If authorization with status of approved or partially approved is not found, then this rule is given. If the authorization is found the units of the claim line exceed the units remaining on the authorization, then this error is received and the claim line is partially approved up to the amount approved on the authorization.

23. Multiple Rates for Claim Date Span

1. If there is more than one contract rate that covers one claim line and the claim line requires authorization, and there is not authorization to cover the entire claim line, the system will give this error as it cannot partially approve based on the different contract rates.

Custom Validation Logic

1. **All hospital claims with no Medicaid coverage should pend for manual review and approval.**
    1. If a Billing Code is marked as a Hospital code in the Administration tab, Billing Code Details page, General tab and the coverage plan is a Medicaid plan based on the plans identified by the customer and set in the custom stored procedure, then the claim line will have this error.
        1. The table that tracks if a billing code is a hospital code is BillingCodes table - HospitalCode column.



Step 2: Find an Authorization

As part of the adjudication rules, the system looks for an authorization for the claim line. This uses a stored procedure named, ssp_CMGetAuthorizationsRatesForClaimLineApproval. This stored procedure uses the table AuthorizationRates to find an authorization for the date of service on the claim line.

Step 3: If No Denial Reasons, Determining Amount to be Paid

1. If there are no denial reasons, then the system is ready to approve the claim line.
    1. First, it populates the ClaimLineAuthorizations table with the associated authorization found and units used.
        1. Uses the status of Approved, Partially Approved, and Partially Denied
        2. Updates the units used and status within this table.
            1. TotalUnitsApproved is used for Substance Abuse

        2. UnitsApproved is used for all other claim lines
    2. Populates the ProviderAuthorizations table with units used and status.
    3. If the authorization units are all used based on this claim line, then the ProviderAuthorizationHistory table is updated to mark the status of the authorization as closed.
2. Next, it calculates the amount to be paid
    1. Claimed Amount is calculated when the claim line is created in the system. Claimed Amount is calculated based on Charge Amount entered minus all adjustments for previous paid or allowed amounts.
        1. Example: Charge amount is $100.00 and an Allowed Amount of $75.00 is entered and a previous paid of $40.00 is entered. The system will calculate he Charge Amount - Allowed Amount.
            1. $100.00 - $75.00 = $25.00 (The $25.00 can be seen on the EOB pop up when entering information on the claim line.)
        2. The system will then subtract from the charge amount this calculated difference and any other previous paid.
            1. Claimed Amount = $100.00 - 25.00 - 40.00 = 35.00
    2. **The system when adjudicating then compares Contract Rate - Previous Paid amounts to the Claimed Amount previously calculated.**
        1. **If Contract Amount minus Previous Paid is greater than Claimed Amount, Claimed Amount is what is approved to pay.**
        2. **If Contract Amount minus Previous Paid is less than Claimed Amount, Contract Amount minus Previous Paid is what is approved to pay.**
3. Critical Error Checks
    1. Units Approved cannot be greater than Units Claimed
    2. Approved Amount cannot be greater than Claimed Amount
    3. If either of these occur, the error 'Critical Error - Units approved or amount approved are greater than claimed.' which will stop the adjudication process and will add this error to the error log.
4. If approved amount is less than the Claimed Amount then the claim line is set as Partially Approved. Reasons why are:
    1. Authorization cannot be found for some date(s) of service
        1. Unable to find units to cover all authorizations for the claim line. Looking for the same logic above for Approved, Partially Approved or Partially Denied authorization and the date range of the authorization covers the claim line.
    2. Claim line exceeds units remaining on authorization
        1. Unable to find units to cover all units of the claim line. Looking for the number of units remaining on an authorization and if the claim line exceeds this amount, this error is received.
    3. Billing Code Rate in Contract is Less than Claimed Amount
        1. The contract rate is less than the claimed amount.
        2. This includes if Billing Code rate from contract minus previous paid is less than the Claimed Amount.

5. If approved amount is equal to Claimed Amount the status is marked as Approved.
6. If payable amount is zero or less, than this means the claim line was already paid, so the status is switched to paid from Approved, Partially Approved, or Partially Denied.
7. Updates the ClaimLines table with the following columns as applicable based on the claim line status
    1. PayableAmount
    2. DenialReason
    3. PendedReason
    4. ToReadjudicate
    5. NeedstobeWorked
8. Adds a line to the Adjudications table with what was determined in the adjudication.
9. Adds a line to ClaimLineHistory table with the adjudication and outcome. This what the user can see in the history section of the Claim Line Details page.
10. AdjudicationContracts table is updated with what contracts and rates were used to adjudicate the claim line.
11. ContractRules table is updated - the TotalAmountUsed column is updated to reflect the amount of money not associated to the contract rules.
12. ClaimsApprovedandPaid amount is updated in the Contracts table to track the total amount billed to the contract.
13. ClaimLineCoveragePlans table - creates a row in this table to associated the coverage plan that is paying for the claim line. This can be seen from the user interface in the Claim Line details page, Allocation field.
    1. It looks for a coverage plan based on the Service Area associated to the Insurer (InsurerServiceAreas table). Then based on the client's coverage plans (CoveragePlanHistory) and the service area associated to the client's coverage plans.
14. If status is anything but Paid or Denied and 'Needs to be Worked' is not checked at this point in the process, then the claim line is added to the OpenClaims table.

Step 4: If there is a denial reason, documenting the denial:

1. If there are denial reasons:
    1. Claim line is marked as Denied or Pended based on rule set up in Contracts or Adjudication Rules as noted in the rules above.
    2. Claim line is marked 'To be Worked' based on the Adjudication Rules set up in Administration.
2. Creates a record in the ClaimLineDenials table if the status is Denied.
    1. AdjudicationDenialPendedReasons table is populated with all denied and pended reasons found by claim line.
        1. This table links to the AdjudiationID in Adjudications table.
3. If more than one claim line is adjudicated from the Claims list page, then a batch is created. This batch information is kept in the

AdjudicationBatches table. This table keeps track of a new batch with each adjudication and how many were approved, denied or pended.