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ABSTRACT

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Developing a Training Manual for the Y2 System

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The purpose of this study is to develop a training manual for the Y2 system to be used by the Customer Service department at Company X. Company X is currently using Reflections, a legacy system, as its primary operating system. In depth and on-going training will be required as they transition from the Reflections system to the Y2 system. Development of a training manual is required because the Y2 system does not come with any formal documentation or training material. Much of the functionality of the Y2 system is user-defined. Thus, the configuration of the system will vary from company to company based on their individual business needs and practices. For this reason, standardized training materials for the system could not be provided.

Company X has created a Configuration Team to set up the new system and define the functionality it needs. To aid in the set-up and configuration of the system, Company Y provided an outside consultant who is an expert on the configuration of the system. The consultant worked with the Configuration Team to define the functionality and help set the system up.

The Configuration Team became the subject matter experts regarding the Y2 system. The researcher worked closely with the Configuration Team in developing the training manual for the new system. The team became the primary resource for the information that was used in creating the training manual.

The end result of this study will be a training manual to be used by the Customer Service department. The manual will be used both during the formal training of the system and a job performance aid after the training is completed.

During the course of this study, Company X adjusted its timeline for the system implementation and pushed back the go-live date by three months. Due to the new timeline for go-live, training on the Y2 system could not be conducted prior to the deadline for this study. Employees, other than the Configuration Team, do not have access to the new system yet. Therefore, the researcher was unable to conduct any type of survey, distribute the training manual for review or conduct any training.

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CHAPTER I: INTRODUCTION

Company Overview

Company X is a local health insurance company. It was incorporated as a group Health Maintenance Organization (HMO) in November, 1982 by the physicians of a local clinic. It became operational April 1, 1983, with the clinic being its first employer group. During the next ten years, the clinic grew and expanded. In March 1994 Company X, the clinic, a local hospital and a regional catholic health and human services organization combined to form a regional health care system. The HMO license was expanded in October 1995, allowing the ability to offer indemnity products including Point of Service (POS), Preferred Provider Organization (PPO) and Third Party Administrator (TPA) plans. Today, it serves approximately 76,000 members.

Company X is currently using Reflections, a legacy system. The Reflections system is used to house member information, demographics, employer history, policy information, claims history and a history of all company contact with the member; provider information, licenses, office locations, reimbursement methodology, network affiliations and a history of all company contact with the provider; employer group information, demographics, contact information, policy history and a history of all company contact with the employer; contract information, fee schedules, network affiliation information, services allowed and locations; claims processing. Through the course of business, it has encountered many situations where the Reflections system was unable to handle its business needs. To accommodate those needs, the programming staff created and added home grown solutions to the Reflections system. These solutions serve

merely as a work-around. They are not the ideal and often need to be tweaked to accommodate new products or processes.

Management has recognized the shortcomings of the Reflections system. They realized that if Company X wants to stay competitive in the market and continue to offer new products to meet the growing demands of its customers, they will need to install a more robust and adaptable computer system.

After a lengthy search and several demonstrations, management decided to go with Company Y and their Y2 system as a replacement for the Reflections system. The Y2 system is robust and provides the functionality required to meet its business needs. Much of the functionality in the Y2 system is user-defined. This will allow Company X to set up the system to meet its current needs and future needs allowing for future growth and product development.

Company Y does not provide any written documentation for setting up or using the system. Instead, an outside consultant who is an expert in the configuration of the Y2 system worked with Company X to set up and configure the system to meet its business needs. Because the Y2 system is a beta version, the consultant also acted as a liaison with Company Y to help correct any problems or issues encountered during the configuration process.

Statement of the Problem

Company X has a new computer system that does not come with any documentation or formal training materials. The researcher will develop a training manual for use in the Customer Service department.

Purpose of the Study

The purpose of this study is to develop a training manual for the Y2 system for use in the Customer Service department. The training manual will serve as a resource during the initial training of employees on the new system and also as a job aid for use on the floor by employees after they have completed training.

Assumptions of the Study

The following are assumptions made by this study: Company Y does not provide any training materials for the Y2 system. Employees at Company X require training on the Y2 system to perform their jobs.

Definition of Terms

1. *Auto-Adjudication* - To automate the handling of health care claims, from receipt to payment, without manual intervention ("Auto-Adjudication," n. d.).
2. *Beta Version* - The beta version of a product still awaits full debugging or full implementation of all its functionality, but satisfies a majority of the requirements. Beta versions (or just betas) stand at an intermediate step in the full development cycle. Developers release them to a group of beta testers (or, sometimes, to the general public) for a user test. The testers report any bugs that they found, features they would like to see in the final version, etc. When a beta becomes available to the general public it often becomes used almost as widely as the finished product (when developers subsequently complete that product). Usually developers of freeware or open-source betas release them to the general public while proprietary betas go to a relatively small group of testers. Recipients

of highly proprietary betas may have to sign a non-disclosure agreement ("Beta Version," n. d.).

3. *Health Maintenance Organization (HMO)* – An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. . . . Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:
    - An organized system for providing health care or otherwise assuring health care delivery in a geographic area
    - An agreed upon set of basic and supplemental health maintenance and treatment services
    - A voluntary enrolled group of people (United HealthCare Corporation, p. 38).
4. *Indemnity* – An insurance program in which the insured person is reimbursed for covered expenses (United HealthCare Corporation, p. 41).
5. *Job Performance Aid* – A job performance aid (JPA) provides procedural or factual guidance in the performance of a task. JPAs are used on the job to guide performance while skill is being developed, and as a reference guide, by experienced workers, to clarify or update them on a particular task (Campbell, 1999, p. 58).
6. *Legacy System* - a computer system or application program which continues to be used because of the cost of replacing or redesigning it. The implication is that the system is large, monolithic, difficult and expensive to modify ("Legacy System," n. d.).

7. *Point of Service (POS)* – A health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. . . (United HealthCare Corporation, p. 58).
8. *Preferred Provider Organization (PPO)* – A program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (fewer copayments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant copayments. . . (United HealthCare Corporation, p. 60).
9. *Third Party Administrator (TPA)* – An independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk (United HealthCare Corporation, p. 71).
10. *Windows* - Windows are primarily associated with graphical displays where they can be manipulated with a pointer, e.g. mouse, stylus or touchpad, containing either some kind of graphical interface, or a textual representation, of the output of and allowing input for one of a number of simultaneously running computer processes ("Windows," n. d.).

Limitations of the Study

The limitations of this study are as follows: It pertains only to Company X's configuration of the Y2 system. It will also be limited to just the training required for the Customer Service department.

CHAPTER II: LITERATURE REVIEW

Problem Statement

The problem of this study is to develop a training manual for the Y2 system to be used by the Customer Service department at Company X.

Job Performance Aids

A job performance aid (JPA) provides clearly written, easy-to-follow, illustrated instructions walking the user through steps necessary to do the job correctly (Campbell, 1999). The Use of JPAs can be essential to performing the duties of a job correctly. No matter how complete, engaging or effective the training is, students will not be able to retain everything they learned in class. A loss of information to some degree is inherent in the process.

> Using a JPA to help perform a task provides a natural and effective way of committing the necessary information to long-term memory. JPA users eventually learn to do without them, but find it comforting to have a reference readily available if and when the need for help arises (Campbell, 1999, p.58).

The JPA provides a crutch the user can use when and if they need. It becomes a resource they can use on an as-needed basis. However, a JPA can be more than just a crutch for the user. “They reduce the time needed to master task performance and facilitate the transfer of learning from the classroom or other training setting to the job” (Campbell, 1999, p. 59).

Job performance aids (JPAs) can take a number of different formats. The five basic types are procedural guides, worksheets, checklists, decision tables, and flowcharts

(Campbell, 1999). A training manual is essentially a procedural guide. A procedural guide is used to present steps in a task which are generally performed in a sequential order.

A training manual can, in essence, serve a dual purpose. It can be used both during and after formalized training. Training manuals can serve as reference documents during formal training courses. In formal training courses, they help promote learning and aid in the transfer of knowledge and skill (Campbell, 1999). Well designed and organized training materials will be used as reference material following the training as well as during the training itself (Kelty, 1999). Therefore, when preparing a training manual, the design is an important aspect to keep in mind.

Writing Style

A major factor in how successful the training manual will be is writer's ability to communicate clearly in writing (Booher, 1999). The writer's style, choice of words and grammar will all have an impact on the learner's experience. If the topic is very technical, it is becomes even more important to select the words carefully.

Not all training manuals should be written the same. How a manual is written will depend upon its intended audience (Bremer, 1999). Writing for highly-skilled technical employees will differ from writing for the average line worker.

A few premises of writing are:

- Your job is to get the information into the reader's brain as quickly, easily and enjoyably as possible…
- Your main function is to communicate, not to write a manual…
- Understand your audience…

- Write for people, not for professors…
- Be the reader's advocate.
- You are part of the user's interface…
- Test your work… (Bremer, 1999, p. 17).

Training manuals should not be written like text books. It is acceptable for manuals to have a more conversational style (Davis, 1999). While a writer has much more grammatical leeway when writing a manual, as there are no hard and fast rules for manuals, there are some rules that must be followed: spelling, proper word usage and punctuation (Bremer, 1999).

To keep the information clear, concise and easy to follow, sentences should be kept simple. They should be limited to a single idea. How-to information should be presented in task statements using short phrases and numbered steps. Task statements include or begin with an action word. The action word describes the specific behavior that is expected of the reader. When paragraphs and sentences are short and simple, they are more inviting and easier to read and follow. Readers will be put off by longer more complicated sentences and paragraphs. Another way to keep the training manual simple and easy to follow is to use headings and subheadings.

Using a lot of headings and subheadings serves four purposes:

1. It keeps the book divided into small, easy-to-absorb chunks.
2. It allows the reader to zero in on the exact section they want to read without fishing around.
3. It familiarizes readers with all the sections…

4. It makes it easier for you to organize the book and explain each subject independently (Bremer, 1999, p. 24).

Readers can only take in so much information at a time. By helping the reader break the material into smaller chunks of information it becomes less intimidating. The reader won't feel like she has to struggle to get through the material to find what she's looking for.

Sequencing

"Sequencing is arranging the material selected in some logical manner for presentation" (Technology Training Systems, Inc., 1997, p. 6). There is no one right way to sequence training material. The three main ways of sequencing information are task order, whole-part-whole, and the behaviorist approach. Task order is the step-by-step procedural order used to complete a task. A variant of the task order method is called work patterns. Work patterns starts with an overview of the functional basics and then proceeds in an order that would be followed when typically using the product. The whole-part-whole method describes the process as a whole. Then more specific information is presented. Finally, the smaller parts are brought together and presented as a whole. The behaviorist approach begins with the details and specifics and builds up to the end result.

Graphics

Graphics are very important to training manuals. "There are many times when showing pictures of step one, step two and step three of a process with short captions explains things better than paragraphs of text" (Bremer, 1999, p. 38). When used appropriately, graphics and illustrations can enhance understanding and aid in the transfer

of learning. If one or two pictures can get the point across as well as or better than a paragraph of text, use them. Graphics can clarify or emphasize a point. They can help avoid confusion and misunderstanding.

Format

There are two main options to consider when determining the format for the training manual: electronic or onscreen and printed hard copy. Each has advantages and disadvantages. Some things to consider before choosing a format are: Who is the audience? What is the intended purpose of the manual? What type of information is being presented? Most people prefer to read a printed or hard copy. When it comes to reading information on a computer screen:

> Most people hate it. It can be hard on the eyes, and difficult to see clearly. With most screens, you can't see a full page at a time, so you're constantly messing with the mouse and scrolling. You're tied to your computer (Bremer, 1999, p. 53).

However, printed material can become outdated quickly and is not as easy to update. For financial as well as other reasons, documentation is moving away from the printed format and moving to the electronic format. With the rate of improvements with technology and increases in bandwidth and data transfer speeds, instructions and help menus are moving more and more to an online format as opposed to just onscreen. As technology advances and both hardware and software are getting smarter, products will be able to contain their own help menus. However, the time when printed manuals are totally gone is still a long way off.

CHAPTER III: METHODOLOGY

Overview of the Study

Company X is converting from a legacy system to Company Y's Y2 system. Company Y does not provide any formal training or documentation for the Y2 system. The purpose of this study is to develop a training manual for the Y2 system to be used by the Customer Service department at Company X. This training manual will be used during the employee's initial formal training on the Y2 system and as a job performance aid after training is completed.

Teams and Roles

After Company X made the decision to go with Company Y and their Y2 system, it developed a two year implementation strategy. Because much of the functionality of the system is user defined, the first step was to determine what functionality they needed and what functionality they just wanted. To do this, they formed five process teams, each representing a major function of the company. Each team was charged with a broad goal of what they wanted the new system to do. The Reimbursement Team was given the direction of "Pay claims accurately and efficiently, utilizing clearly written practices while increasing the auto-adjudication rate." The Member Acquisition Team was given the direction of "Develop efficient processes to initiate new products to Company X and its members, including the enrollment of member information utilizing new system software." The Customer Service Team was given the direction "Focus on meeting the needs of members/providers. Create efficient processes to increase and maintain member self service." The Network Development Team was given the direction of "Purchase

provider services offering flexibility in contract yet maintaining ease for claims processing." The Care Management Team was given the direction of "Improve health outcomes utilizing Disease Management. Incorporate prior authorization and pre-certification data into process to improve the outcomes for those diseases with highest dollars spent. Include utilization of proper resources to research data." The teams started by looking at and flowing out existing processes and practices for the area they were charged with. This helped the teams identify areas that were causing problems or required manual interventions. It also helped identify areas for process improvements. The next step was to create a "wish list" of what they wanted the new system to do. They were instructed to "think outside the box" and not limit themselves to what they knew the system could do, but rather what they would want the system to do if they were creating their ideal system. The process teams were not just limited to making recommendations for the system. They were also to look at and make recommendations on the business processes themselves. When the process teams completed their tasks, they presented their recommendations to senior management (Appendix E).

Before the board of directors approved the project, they were given five goals the implementation of the new system would accomplish: 1) Enable product development: Implement a new generation transaction system that will enable Company X's strategy to transition from a boutique company (single product HMO) to a Health Benefits Company capable of providing a full range of fully and self-insured products for an increasingly competitive and demanding market place. 2) HIPAA EDI: Expand Company X's ability to fully enable HIPAA (Health Insurance Portability and Accountability Act) compliant EDI (Electronic Data Interchange) transactions and assure optimal compliance. 3)

Operational Efficiencies: Improve operations and productivity through the use of software that can auto-adjudicate a greater number of claims and better support cross-departmental workflow. 4) Mitigate risk associated with operating a highly customized computer system that is dependent upon the knowledge of one or two key people. 5) Address the process teams' recommendations.

Senior management also created an Implementation Team. This team was made up of management and key stakeholders of the new system implementation. They conducted weekly meetings to get updates on the status of the system configuration. They were also empowered to make decisions regarding business processes. However, if a process change required a change in company policy, then it had to go to senior management for a decision. The Configuration Team reported out to the Implementation Team each week. They gave updates on the progress of the system. When a decision needed to be made regarding a business process, the Configuration Team would present the case, explain the available options, and provide any recommendations they had. The Implementation Team would then take this information and make the final decision.

The Configuration Team was created by management with representation from all the primary departments affected by the implementation of the new system. They were charged with configuring the system and setting it up. All the recommendations made by the process teams were passed along to the Configuration Team. They determined whether or not it was possible for the system to accommodate them. Senior management also relayed to them any changes they were making in the business processes based on the recommendations of the process teams so any impacts on the new system could be considered.

Process

The Configuration Team worked with the consultant and learned what the system could do. They reviewed the suggestions made by the process teams and determined which ones could be implemented and which ones could not. They began loading company information into the system. They worked closely with management to ensure business processes and practices were being considered. Before too much information was loaded into the system, they began a testing phase to make sure the system was doing what they wanted. They went through two more phases of loading information and then testing. They also worked with management whenever a business decision needed to be made e.g. What information is required? What information should be displayed? How should this situation be handled? They made sure the system followed business process decisions made by the Implementation Team and business practice decisions made by department management.

As the Configuration Team was setting up the system, they were also documenting everything they did. Every time they went to the Implementation Team for a decision, they documented why a decision needed to be made, what the decision was, and who made the decision. These documents are referred to as Implementation Decision Documents. There were a total of 482 issues brought to the team and documented on Implementation Decision Documents. They also assigned an owner to each process they reviewed. This way they would know who is responsible for making decisions if questions should arise in the future. If more than one option was available to deal with a situation, they documented why the decision was made to go with the option they did.

Every step they went through in setting up the system was documented as to why and how it was done.

When the system configuration was completed, the researcher worked with the Configuration Team to learn the new system. The Configuration Team identified all the major processes and procedures for each department. To aid in both learning the system and writing the training manual, the researcher and the Configuration Team flowed out all the major processes they identified.

Summary

Process teams were created to analyze the current processes using the Reflections system and make recommendations for the new Y2 system to senior management. Senior management created an Implementation Team charged with overseeing the project and making decisions regarding business processes. Management also created a Configuration Team charged with setting up and configuring the new system. When the configuration and set up of the new system was completed, the researcher worked with the Configuration Team to learn the new system and flow out the major processes for each department to aid in the creation of the training manual.

CHAPTER IV: RESULTS

Introduction

The purpose of this study is to develop a training manual for the Y2 system. The manual will be used by the Customer Service department at Company X during the formal system training and as a job performance aid while on the job after the training is completed.

System Access

Before development of the manual could begin, access to the system needed to be determined. Company Y divided their Y2 system into different modules based on the type of information being accessed or the type of action being performed. Access to the system can be set at different levels based on the permissions and security granted to the user. A user can be denied access to a module completely. A user can be granted view only access. This allows the ability to view information, but does not allow the user to update or change information or perform any actions. The user can be granted access to view information and update or change information and perform actions with limitations. Finally, the user could be granted unlimited access. This would allow viewing all information, the ability to update or make changes and perform actions without any restrictions or limitations. The Configuration Team worked with management to determine what permissions and security to grant each employee based on their role in the company. Employees were only given the access they need to perform their job.

Manual Design

To be consistent with the layout of the system, the training manual was also divided into modules. The system has 33 separate modules. Eleven are considered core modules and the remaining 22 are considered reference modules. The 11 core modules are member, employer, provider, claims, contract, fee tables, policy administrator, case management, authorization, call tracking and accounts receivable. The training manual for the core modules must be completed before the go-live date. The training manual for the reference modules is not a top priority and some will be completed after the go-live date. The module design of the training manual was done to keep the material consistent and to avoid duplicating material. Multiple departments and many different positions will need to access a single module in the system. Though different positions may have different access levels, they will still be accessing the same module the same way. The procedure does not change. To avoid the duplication of writing the same information in separate manuals for each position or each department, training modules were written for each module in the system. Separate training modules were written for the different access levels of each module in the system. A view only module was written as well as a module for making updates, changes and performing different actions. In essence, a library of modules was created. In this manner, the training manual for a specific position becomes a customized program plan with just the curriculum needed for that position. The employee receives a training manual or program plan made up of just the modules needed for their position. The Training and Development department worked with management to determine which modules were required for each position. Thus, a customized program plan was created for each position in the company.

This also allows for flexibility with training and the training manual. With the implementation of the new system, business processes are being reviewed and revised. In addition to reviewing business processes, the organizational structure is also being reviewed. Positions are being realigned and job duties may be changing. As job duties change, needed access to the system may change and require new training. These changes can easily be accommodated. Previously, a new manual would have to be written, or at the least, changes would have had to be made to the existing manual. Now it will only require adjustments to be made to the program plan. Newly needed modules that already exist can be added from the library and ones no longer needed can be removed from the program plan. No more rewriting or changes required.

Module Design

Management decided the modules will be laid out in a policy followed by procedure format. The policy is the "why" something is done. The procedure is the "how" something is done. This format was chosen to help offset the company's poor history of documentation. Employees often question why a process is followed or a procedure is done. Too frequently, the response to that question is "I don't know. That's how we've always done it." Occasionally, if it was checked into, it was discovered that the process or procedure is now obsolete, incorrect, or unnecessary. With the policy attached right to the procedure, the question is answered before it is even asked. It will also help to identify when a procedure becomes outdated or needs to be revisited and revised. The policy can be anything from a formal company policy to a documented decision made by the Implementation Team. The purpose is to understand the reason behind why a procedure is followed.

The procedure portion of each module is divided up into smaller chunks or subsections using headings and subheadings. The new system is windows based and the screens are sectioned into tabs. Each tab contains a different set of information and performs a different function. The “view only” modules are broken down into smaller subsections based on the tab. Each tab has its own subsection and corresponding subheading. Each subsection reviews the information that is visible on that tab. The “procedure” modules are broken down into smaller subsections based on task. If the procedure can be broken down into smaller tasks, each task then has its own subsection and corresponding subheading. These subsections may or may not correspond to separate tabs. One subsection may cover only one tab or it may cover several tabs.

By breaking the modules down into subsections, the material is not as overwhelming and is easier to digest. It also allows the user to locate specific information quicker and easier. Because the manual will also be used as a job performance aid, users may only need to reference certain parts of the manual. The use of subsections and subheadings will make it easier to find the needed information.

Graphics are used heavily in the manual. Screen prints are used to show what the users will see on the screen. They help the users verify they are on the correct screen. They also help them locate information on the screen. Screen prints of just the specific fields being referenced help the users know which fields to focus on when looking for information. They show the users which fields to enter information in. If they must click on a specific button or checkbox, a screen print of that field eliminates any confusion and shows the users exactly what to do.

Text in the manual is kept short and simple. In the “procedure” modules the text is mainly in the format of numbered steps. Each step kept as short as possible. Small blocks of text are used only when needed to clarify or explain a part of the process or procedure. In the “view only” modules, if there is a large number of fields that need to be identified or described, the descriptions are kept short, simple and are numbered. If there are not many fields on a tab that need to be identified or described, small blocks of text are used to explain the information on the tab. Text is kept simple and to a minimum. It should not be overbearing to the users. Its purpose is merely to identify information found on the screen or to walk the users through steps needed to complete a process.

Manual Review

Every time the researcher completed a procedure for a module it was reviewed by the Configuration Team member who is the subject matter expert in the area being covered. This review ensured the information in the manual is accurate and complete. This review also helped ensure all possible options and scenarios are covered. When a module was completed, management reviewed it. The management review ensured all processes and procedures and all their variations performed by a department are covered in the manual.

CHAPTER V: DISCUSSION

Summary

Company X purchased a new operating system, the Y2 system. The new system is windows based which is different than the Reflections system, their current operating system. Much of the functionality of the Y2 system is user defined. To determine what functionality they wanted and to configure the system and set it up, Company X created different teams to handle the various stages of the process. Five process teams were created to brainstorm and determine what functionality the company wanted if they were to create their "ideal" system. The Configuration Team was created to set the system up. They were given the recommendations made by the process teams and charged with determining which ones were feasible and making them happen. The Implementation Team was created to oversee the project.

Research was done for this study through a review of literature. Information was gathered regarding the design of training manuals and job performance aids. Content, format, writing style, graphics and sequence were all considered and reviewed during this phase of the study. The information or content for the training manual was provided by the Configuration Team.

The researcher worked closely with the Configuration Team in creating the training manual. They set the system up and are also the subject matter experts. Together, process flows were created for all the major functions of the system. From these process flows, procedures were created. Related procedures were combined to create modules.

The training manual is, in essence, like a library made up of all the different modules necessary to use the system.

Limitations

Because much of the functionality of the system is user defined, this study is limited to Company X's configuration of the Y2 system. This study is also limited to just the training required for the Customer Service department. During the course of this study, Company X adjusted its timeline for the system implementation and pushed back the go-live date by three months. Due to the new timeline for go-live, training on the Y2 system could not be conducted prior to the deadline for this study. Employees, other than the Configuration Team, do not have access to the new system yet. Therefore, the researcher was unable to conduct any type of survey regarding the training manual.

Proposed Survey Instrument

Had timelines allowed, the researcher would have liked to conduct unstructured interviews to get feedback regarding the training manual. An unstructured interview would allow for a more conversational style and allow the researcher to probe further and get more detailed feedback for possible improvements to the manual. Interviews would be conducted after both the formal training is completed and the employee has been using the new system for at least a week. Company X has chosen to transition to the new system based on date of service. That means there will be several months that Customer Service is working on both the old and new systems simultaneously. This timeline would allow the employees a chance to get in and use the new system and to use the manual as a job performance aid prior to the interviews. The researcher would ask four basic questions:

1. Was the manual clear and easy to follow?
2. Was anything unclear or confusing?
3. Do you find the manual helpful in performing your job?
4. Do you have any suggestions or improvements to make the manual better?

The researcher would probe further and get more details based on the answers given to these questions. The researcher could then use the feedback gathered through these interviews to make any needed changes to the training manual. The researcher would also compile the information gathered in the interviews and present it in aggregate to management to serve in part as an evaluation of the manual.

Recommendations

Formal system training is going to be provided on a module by module basis. Anyone with the same access level can be in the same class. This means that people from several different departments can be in the same training class. The classes are not going to be department specific.

Had timelines allowed, this study would have benefited from interviewing users of the manual to get feedback on strengths, weaknesses and possible improvements. This is especially true considering the manual will also be used as a job performance aid after the initial training is completed.

Customer Service is one of only three departments at Company X that has a dedicated trainer. The other two departments with dedicated trainers, Claims and Health Management, could also benefit from a similar study. More importantly, those departments that do not have a dedicated trainer could benefit most from a study like this. Current training for those departments is almost exclusively done by shadowing other

employees in the department. Because these departments do not have a trainer to help them after the initial system training is completed, they will rely almost exclusively on the manual.

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Appendix A: Sample Policy

Documentation of Customer Contacts Policy

DEPARTMENT:	**Policy Number**	**Date Issued**	**Date Revised**	**Date Reviewed**
Administration	P901-013 B	11-21-96	12-22-97 10/10/00	1-28-99 11/4/99, 11-16-00 10/11/01
TITLE: Documentation of Customer Contacts	**Page** 1 of 1	**Approval:** President/COO		**Policy Author:** Manager, Customer Service

Policy:

All employees of Company X who have contact with members are responsible for logging/documenting any contact and content of the contact in the Customer Service Inquiry Module (CSIM).

The purpose of this policy is to help ensure consistency of customer contacts, provide documentation and data to enhance customer service and satisfaction. This includes in-person and telephone contacts/interactions with or regarding current or prospective:

- Members
- Providers

- Employer groups/representatives
- Brokers/agents
- Service vendors (when the service or issue affects the above-noted customers)

Contact is defined as: phone call; fax received or sent.

All calls will be logged/documented according to the CSIM call logging manual and any applicable interdepartmental and departmental procedures. These records are considered permanent and should not be edited. The manual will be maintained by the Customer Service Department.

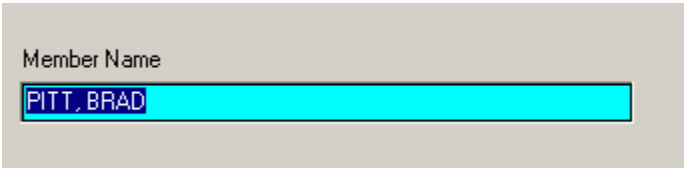
All leaders will be responsible for ensuring their staff's compliance with this policy and the CSIM call logging manual.

Appendix B: Sample Procedure

Logging a Member Call

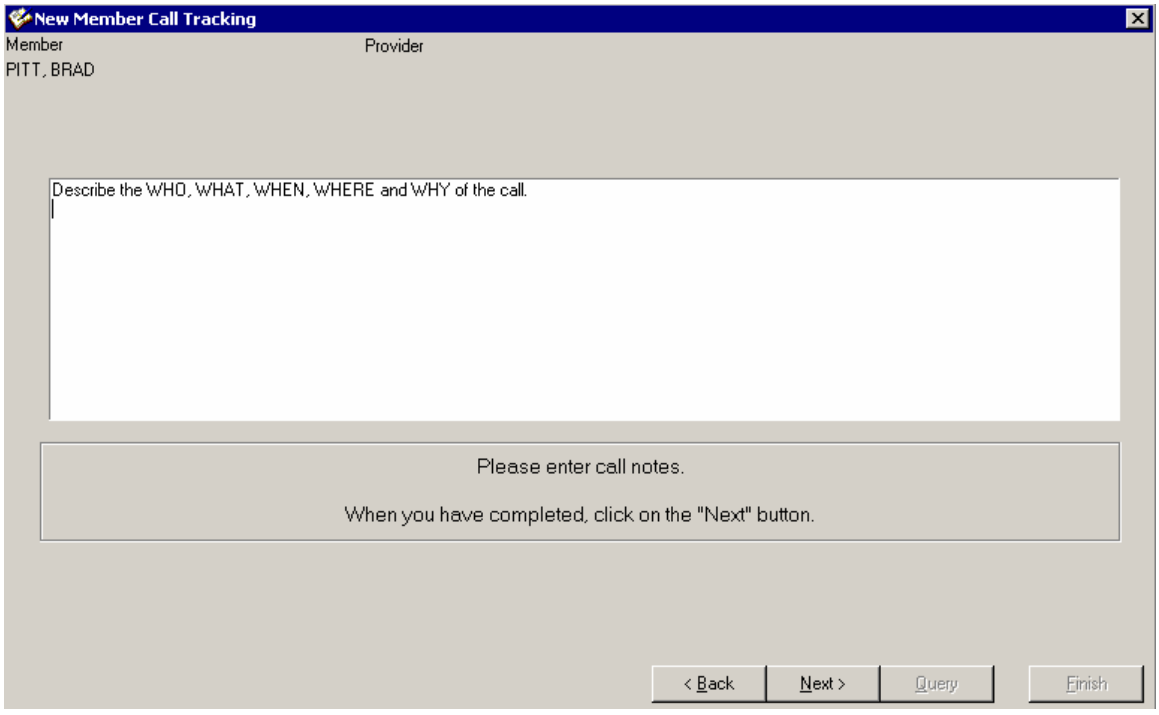
1. **CLICK** on the CALLS tab 

2. **CLICK** on the CREATE A NEW CALL icon 

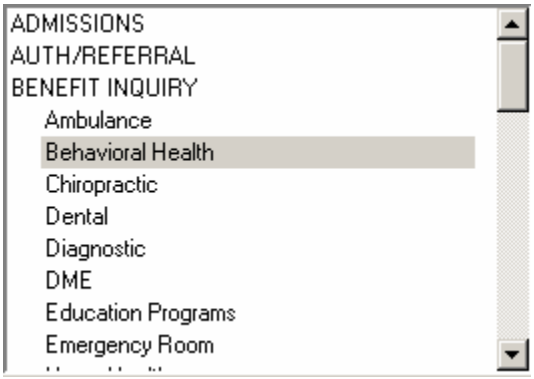


The member's name will automatically populate the field.

3. **CLICK** on 



4. **TYPE** the call notes in the white field
5. **CLICK** on 

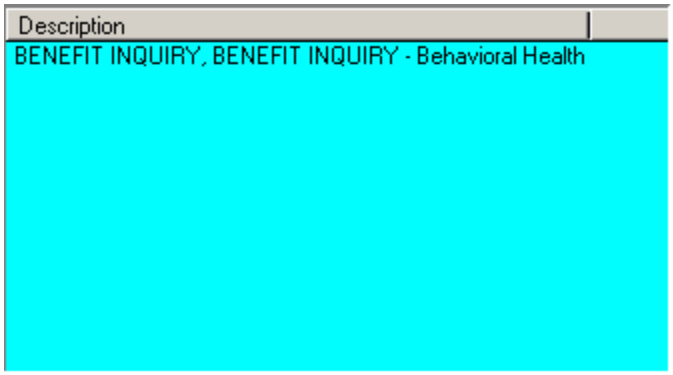


6. **DOUBLE-CLICK** on the correct call type

The next tier of call codes will appear below the call type selected.

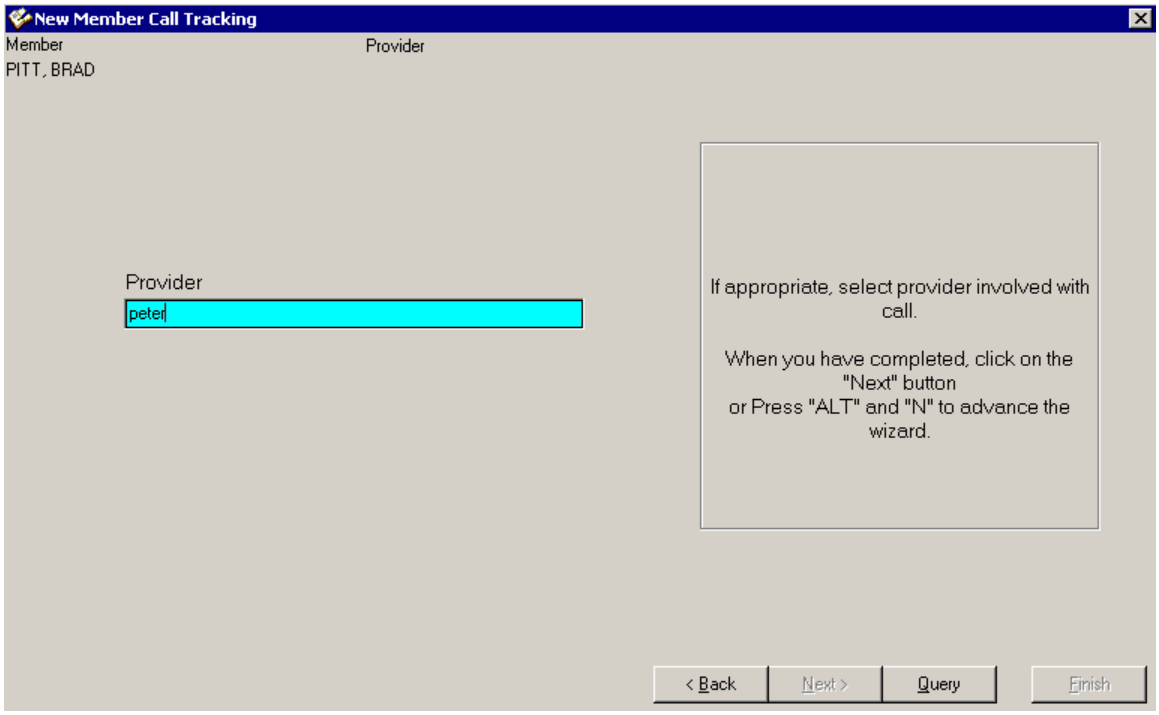
7. **CLICK** on the correct call code

8. **CLICK** on 



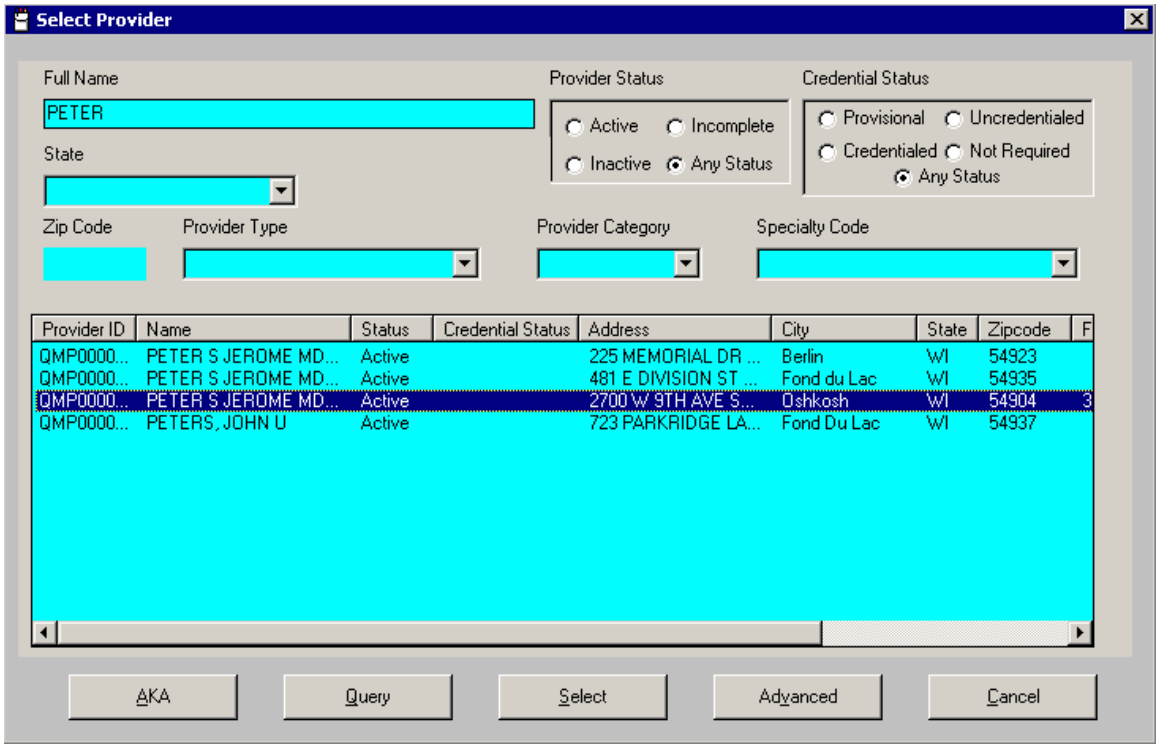
The call code will now appear in the DESCRIPTION field.

9. **CLICK** on 



10. If the call is pertaining to a particular provider, **TYPE** the provider's name in the PROVIDER field (format is last name, first name or just last name)

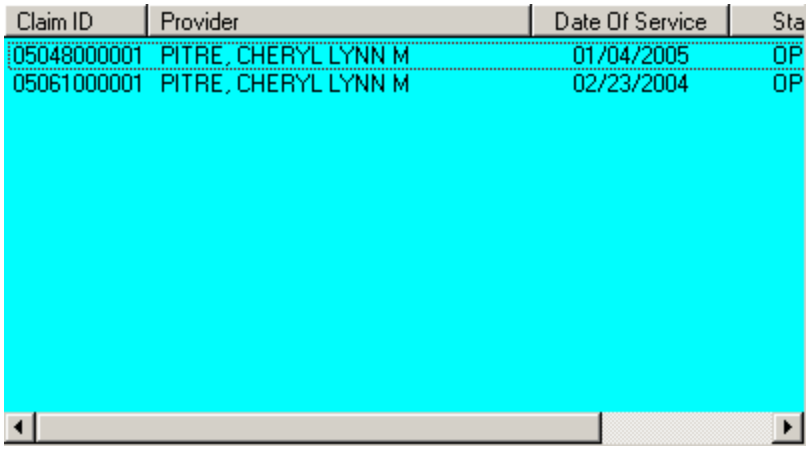
    a. **CLICK** on Query



b. **CLICK** on the correct provider

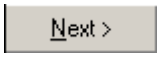
c. **CLICK** on 

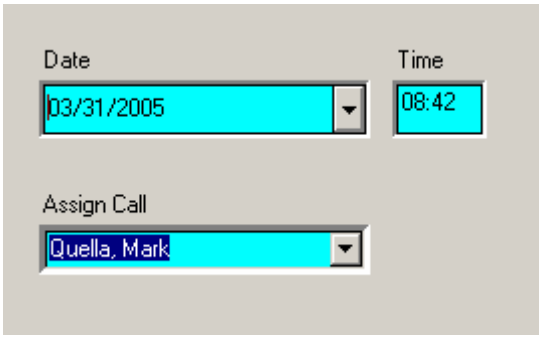
11. **CLICK** on 



If a provider was entered and claims exist in the system for that provider, they will display.

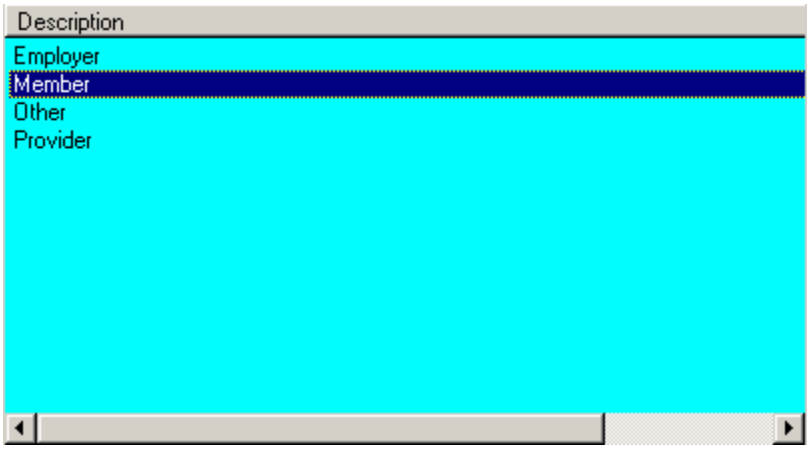
a. If the call is pertaining to a claim that displays, **CLICK** on the claim (this will attach the claim to the call log – only one claim can be attached to a call log)

b. **CLICK** on 



The date, time and user's name will automatically populate the fields.

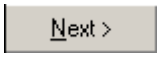
12. **CLICK** on 



13. **CLICK** on the correct caller DESCRIPTON

14. **CLICK** on 

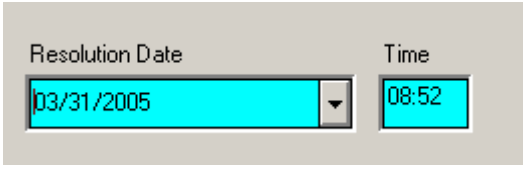
15. If the call is NOT resolved – you have more follow-up work to do for the call – do not check the CALL RESOLVED checkbox.

    a. **CLICK** on 

    b. **CLICK** on 

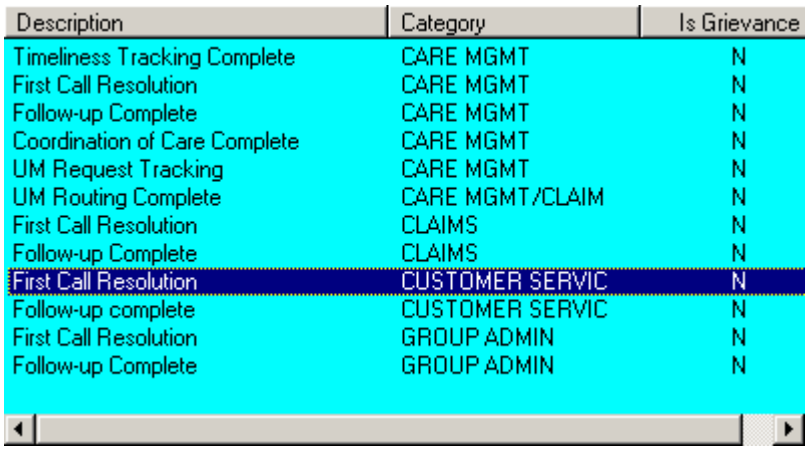
16. If the call is resolved, **CLICK** the CALL RESOLVED checkbox

17. **CLICK** on 



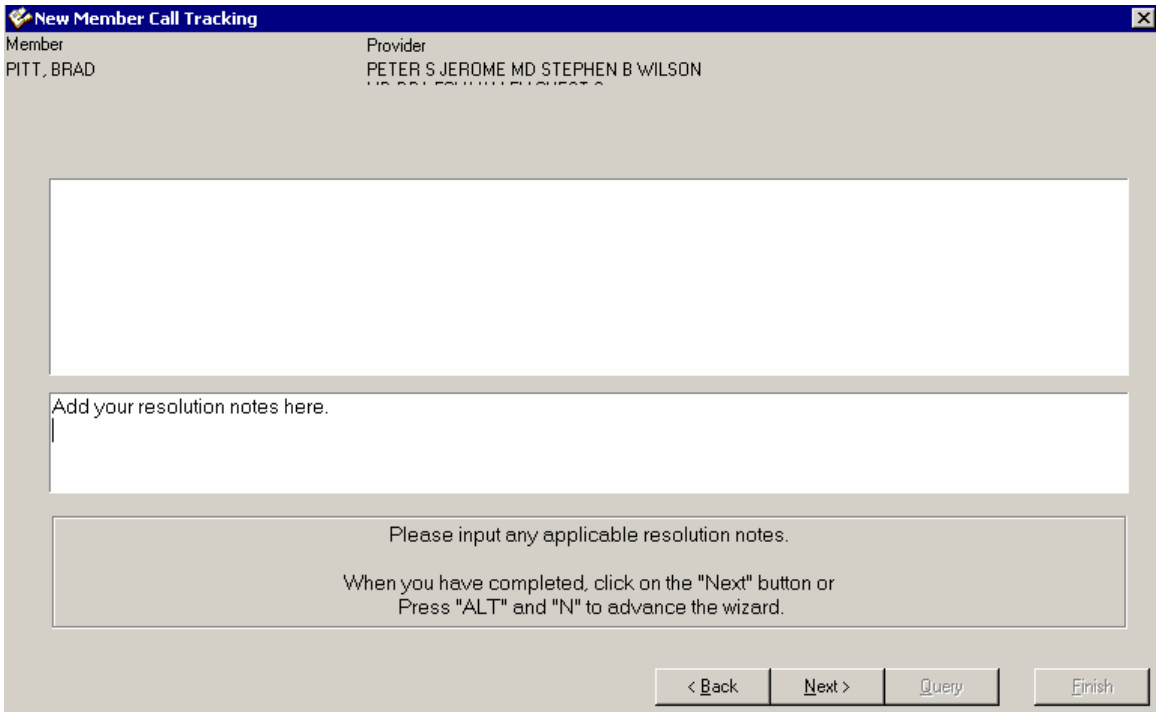
The current date and time will automatically populate the fields.

18. **CLICK** on 



19. **CLICK** on the correct resolution description

20. **CLICK** on 

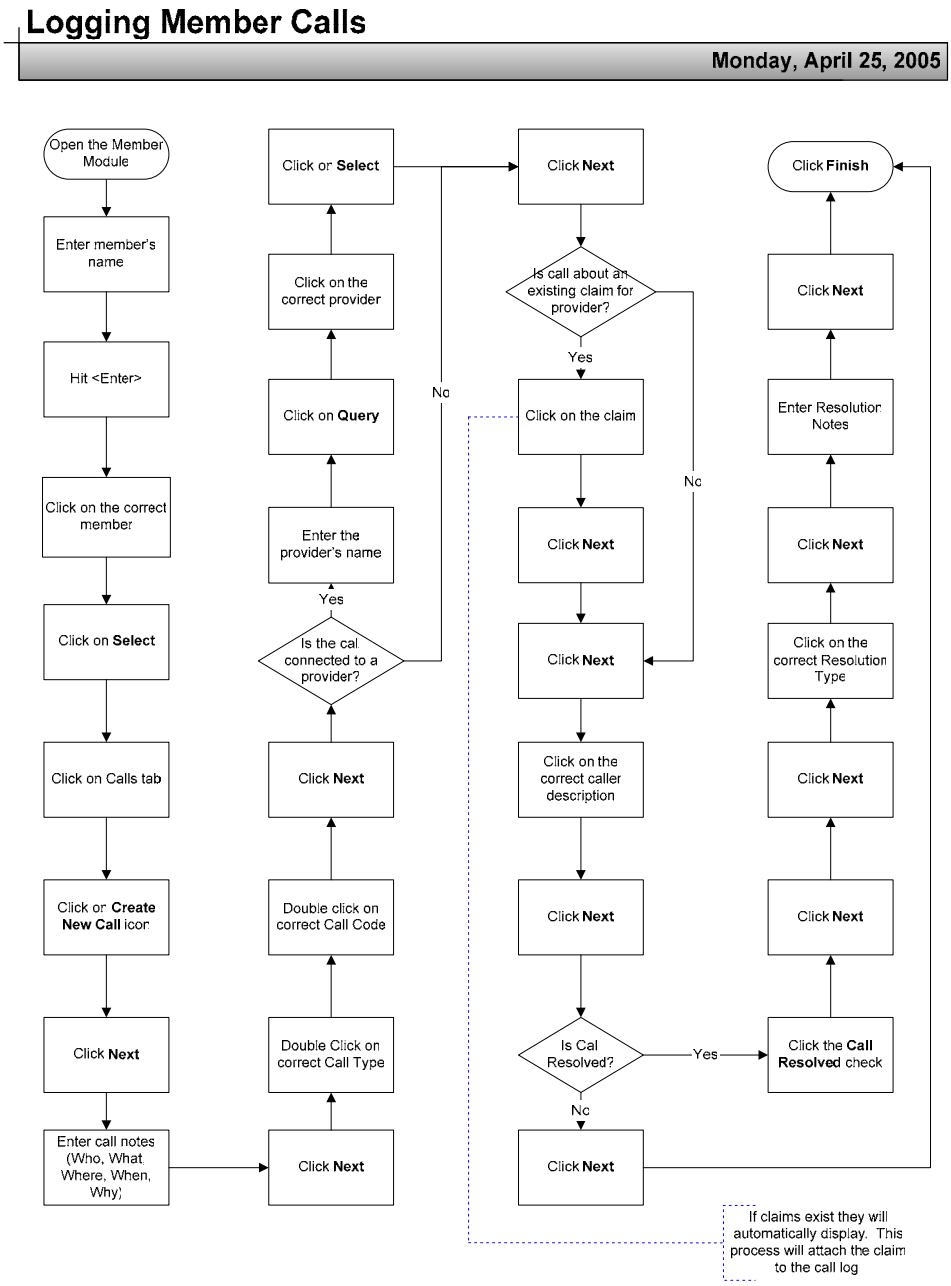


21. **TYPE** your resolution notes in the bottom white field

22. **CLICK** on 

23. **CLICK** on 

Appendix C: Sample Process Flow



Appendix D: Sample Implementation Decision Document

Implementation Decision Document

QuickBase #: 0070	**Date:** 07-21-04	**Author(s):** Chris Reffke

Title: (From QuickBase)
Prospective Member Calls

Consensus Participants:
07-21-04 Meeting with Dave Bloedorn, Peggy Huss, Chris Reffke, Darla Schmidt, Lavonne Simon

Document Change Log:

Description of Decision/Issue:

Decision needs to be made as to whether or not we will continue to log prospective member calls.

Potential solutions:

1. Continue to log prospective member calls.
2. Discontinue logging prospective member calls

Recommendation:

- Continue to log prospective member calls. New guidelines will need to be written as to what information would need to be acquired from members for logging purposes. This will allow Group Administration to easily check the prospective members to see if they have called in and attach the enrollment record to the subscriber number already assigned to that member. In this case we will have a complete record of all calls received on those specific members.

Considerations: (Include Costs if applicable)

- We looked at the requirements for continuity of care issues thru care management when meeting with prospective members and found that we would need to log this information.
- We also looked at Customer Service and provider information that may be given out and found that this is definitely something that would have to be logged on a prospective member level.

Final Decision:

- Recommendation approved by implementation team on July 27, 2004 to continue to log prospective member calls.

Appendix E: Process Team Recommendations

Care Management To Be

Pre-certification:

- If admission date not available, allow provider to pend form until they have the admission date and can then submit the form.
- Notification of pended forms (electronic reminder).
- Web Portal: Have eligibility checked through the web.
- Have online precertification.
- Have the system check for pre-cert. and notify provider or facility if member terms.
- Auto notify provider of approval.
- Auto log authorization into Y2.
- Initiate letters or emails and log into Y2.
- Have admission date a required field.
- Have system not allow pre-cert if member is disenrolled.
- Have a disclaimer on Web site.
- Y2: Have pre-cert notification updated from Web.
- Have the system generate a log or Q work flow of admissions/reviews for each day.
- Have provider/contact person's phone number or email address show up on screen if patient is not admitted.
- Have the system not allow pre-cert if member is disenrolled.

Retro-authorization:

- Delete complete process. If claim received with no authorization, follow claims processing. (Applies to in network and out of network providers). Would go through CFU process instead.

Recommendations to SLT

Member Acquisition:

1. Quoting new business prospects and generating renewal information:
   Allow brokers the ability to generate preliminary quotes themselves online. To achieve this, a more sophisticated quoting system should be developed/purchased. Delivery of the rates via the web should also be a function of the software. In addition we will need software to deliver the rates/underwriting information online.

2. I would like to make the recommendation for COMPANY X to consider becoming a COBRA administrator. We could target the small/medium size companies because they are the ones that struggle the most with this administration, however we could offer it to large employer as well. Below are the pros/cons that I can think of initially:

   PROS:

   A. Additional revenue – we would need to find out what the market of current COBRA administrators charge for this service. Are they just getting the 2% additional that can be charged to the member or does the group just pay us a flat administrative fee pmpm?
   B. Improve timeliness in enrollment processing – rather than struggling with getting enrollment updates from the group's administrator, we would have the Y2 system generate the applicable COBRA paperwork and send it directly to the member with the HIPAA certificate. Once the COBRA runs out, Y2 would generate a notice 30 days prior to the exhaustion to the member and advise them of their rights to our Individual Conversion plan (if they remain in our service area).
   C. More timely receipt of payments – by working directly with the ex-employee as a direct result of letter "B" above, we would also be able to receive COBRA payments directly vs. waiting to get paid by the employer and avoid unnecessary lags in claim processing for the COBRA member.
   D. Customer Service to the Employer and Ex Employee – no more would they have to deal with each other when their relationship terminated (some on very bad terms). The Employer reaps the benefit of only having to work with COMPANY X vs. COMPANY X and another company that does their COBRA administration. The ex-employee feels more comfortable in making premium payments to the carrier direct vs. the former employer.

   CONS:

   A. Additional education - would need to be obtained by Group Administration staff to properly administer COBRA/State Continuation.
   B. Cost Benefit Analysis - Need to ensure additional administrative costs do not out weigh additional revenue. (I'm hoping many of the event-driven letters the Y2 system has to offer could keep administrative costs to a minimum)

3. Y2 and the Employer Group portal are going to lead us down the path of handling enrollments electronically. Because my enrollment staff would be handling less paper enrollments, I would like them to "partner" with the Account Managers in Sales to go out to open enrollment meetings and be able to enter enrollment elections online right at the employer.

   PROS:

   A. Timely enrollment - elimination of many of the missed data elements filled out on the paper application, which cause delays in members being enrolled and receiving their member materials.
   B. Improved data integrity – because employees would be filling out their "applications" online, we would avoid data entry errors by my staff.
   C. PCP election integrity – Group Administration would no longer have to assign PCP's because the employee would work with my staff at the workplace to select their PCP. Could reduce duplicate card requests caused by initial PCP changes. We could also help new physicians establish practices by encouraging new members to elect them if they do not have a preference.
   D. Educational opportunities – my staff could work with the employees to show them how to access the web portal and how to update their demographic information, change PCP's, view claims, etc. Could also show them an example of what their member handbook will look like and go over with them briefly its' components and where to look for answers to their questions.

   This process could also be repeated upon new business sales as well.

Recommendation Summary
(To be used in with process detail provided in Member Acquisition report)

Implementation time frame

- **A.** Recommendation is part of the system go live
- **B.** Recommendation has a firm implementation go live date of 3,6 or 9 months post go live.
- **C.** Recommendation has been accepted by Y2 as a system enhancement and will be a part of their next software release.

Enrollment of a New Group:

Recommendation	*System impact*	*Time Frame*
1) Receive group application either as a scanned document or allow group to fill out application online through employer group web portal. Enrollments could also be received electronically (in HIPAA compliant format) through employer group web portal. Both pieces of data could be reviewed by Group Administration staff prior to loading into the Y2 system.	Outside Y2	N/A
2) There would need to be some sort of "tracking" mechanism in Y2 to account for all enrollment mail received. (whether electronically or via paper) This would assist the manager of Group Administration to distribute work evenly amongst staff and also assist in the budgeting process.	Y2	A
3) Would like Y2 to be set up automatically to send data file for member materials (cards/handbooks) to fulfillment vendor as determined by GA manager.	Y2	A
4) If paper enrollment received, look into the possibility of either scanning the documents or microfiche. Currently, way too much time is spent by assistant in manually organizing by group, by member last name for filing.	Outside Y2	N/A
5) Also, if application is incomplete, such as missing a critical data element, it can be entered into the system and pended rather than the application physically sitting in a pend box for follow up. Letter describing info needed to activate enrollment would need to be developed. Could we customize reasons for pending status, including missing other insurance info?	Y2	A
6) If a COBRA enrollment application is received, would like the system to have an indicator showing it is COBRA coverage and have the system actually calculate the ending COBRA coverage date. Right now, we only enter the start date for COBRA with a flag showing 18, 29, or 36 months of that coverage.	Y2	A
7) For late applicants that have the 18-month waiting period, we would like to enter the application as pended, send out a letter to that affect, and have the system prompt us a month before the 18 months is up so we may follow up with the group to see if the person still wants the coverage.	Y2	A

8) Seeking a prompt from Y2 to inform the enrollment staff if a group is termed when they enter a retroactive enrollment prior to the group's termination date.	Y2	A
9) Current Grandchild report is run monthly to check if grandchild should be termed based on parent's age (who is also a dependent on the policy). Is there a way to link the grandchild (dependent) to the parent (who is also a dependent) to evaluate when the grandchild should be termed?	Y2	A
10) Would like the ability to have the system track expiration dates for Informed Consent to Authorize Release of PHI form and auto generate a letter requesting a renewal of this release.	Y2	A
11) Disability Process – for those reviewed annually, can we put a date in the system when we confirmed the disability and then flag for a letter to go to the subscriber 30 days prior to the annual review for reaffirmation of the disability?	Y2	A
12) COBRA report – same as #11. Desire an automatic letter trigger 30 days prior to the expiration of COBRA to be sent to the employer for applicable termination papers.	Y2	A

Senior Plus Enrollment

Recommendation	***System impact***	***Time Frame***
1. Need to determine if Y2 can somehow offer the same functionalities achieved by Goldmine. Currently, enrollments are entered twice, once in Goldmine and once in CSC. This is too redundant. Would desire to enter in Y2 and have the thank you letter and any other functions of Goldmine done by the Y2 system. (event-driven letters…ie. Thank you letter upon enrollment, etc.)	Y2	A
2. I believe the Y2 system offered some sort of direct contact with CMS for enrollment submission. We would definitely want to take advantage of that vs. the current process. (see notes "Enrollment – Senior Plus)	Y2	A
3. Need to have ID card data file generated and sent to outside vendor (Medialink) for printing and fulfillment. Would still like capability to print a card here at COMPANY X for walk-ins in need of a card same day or allow them to print a temporary card from the Member portal (Health Trio).	Y2	A
4. Seeking reporting functionality from Y2 on demographics and enrollment changes for Senior Plus after McCoy & Grouch reports are reviewed. Currently done in excel.	Y2	A

Billing Process

Recommendation	*System impact*	*Time Frame*
1. Need to be able to continue processing enrollments while billing process is executed. If billing is run via batch overnight, how will errors be addressed?	Y2	A
2. Possible capability to send an electronic file of the bills to an outside vendor for printing and mailing. *Barriers:* a. How could we still review the bills of groups that are renewing in a given month to ensure accuracy of renewal rates prior to mailing? b. Certain groups receive the "billing reconciliation sheet" with their bills. Would need to identify to fulfillment vendor which groups to ensure they receive it. (mostly in small group to assist with timely terminations) c. I realize Y2 offers capability to have 1 group # for employees selecting multiple lines of business by product (ie. HMO/POS), but what if employer desires separate groups for classes such as hourly, salary, COBRA, retirees, etc. How would fulfillment vendor identify to collate appropriately? d. Y2 system would need to be able to identify all bills for the FCC chamber so as to electronically send to them for further processing/mailing/payment collection.	Outside Y2	?
3. Need to be able to view bills generated online for calls received from the employer group, capability of reprinting for "lost bills", etc.	Y2	A
4. Bills need to be posted to the A/R account immediately to be able to apply incoming cash receipt to.	Y2	A
5. Would be slick to post bills online in employer group portal for the group to download and print off!	Portal	Portal Implementation time frame
6. Need functionality to do ASO billings for PPO arrangements.	Y2	A
7. Y2 needs to support allowing an administrative fee on the billing for those not on EFT. Also, would need this functionality for groups selecting a bundled Consumer Driven product.	Y2	A

Deliver of Materials

Recommendation	*System impact*	*Time Frame*
1. Must allow the ability to handle al a carte benefit plan design. When making updates to the deductible, co-insurance, lifetime maximums, would like these fields updated across all benefits within the plan design.	Y2	A

2. If a benefit plan is modified, need to be assured that the change is reflected on all groups that have that plan at the time of change.	Y2	A
3. If a Summary of Member Responsibility Table is changed or created, can the Y2 system drop the same co-payments, deductibles, coinsurance and out-of pocket, etc. accumulators into the Summary Benefit sheets used by the Sales department?	Y2	A

Ongoing Maintenance

Recommendation	*System impact*	*Time Frame*
HIPAA Certificates:		
1. The only thought I had for this area would be to utilize the Member Portal through Health Trio and allow the member to print a copy of their own HIPAA if the former employer does not send on to them after termination.	Y2	A
2. When processing terminations, how can Y2 assist us in notification to claims department regarding incurred/paid claims after term date, especially if retroactive?	Y2	A
Student Status:		
1. Rather than running a report monthly for dependents turning 19 or semi-annually for the 20-24 year olds, we would like to see the student status surveys be an event driven letter or one that could be programmed to be sent out at certain times of the year. Could this be printed in group # order?	Y2	A
2. Would also like capability of running a report showing those not responding to the survey after the initial request is sent out. We currently do a "2nd chance" mailing for those non-respondents, but need a systematic way to do so.	Y2	A
3. Looking for Y2 to allow us to enter various rules for student status across various groups and complete the survey process according to those defined rules.	Y2	A

Account Reconciliation

Recommendation	*System imp*	*Time Fr*
1. I believe Y2 offered the capability of breaking down the application of the premium payment by subscriber. If this can be done, can the system run a comparison of what was paid to what was billed on a subscriber basis and generate an "unpaid" listing of subscribers to be followed up with the group or eligibility administrator? Any possibilities of electronic reconciliation	Outside Y2	N/A

with eligibility administrators like Hewitt, Ebenx, etc.?		

Schedule A 5500 info:

2. Does the Y2 system have the capability to generate the information needed for completing a Schedule A 5500 in a format that can be given to the groups? Could this information be posted to the Employer web portal down the road?	Y2	A

Cash Receipt Processing:

3. We would like the Y2 system to work in conjunction with the banking software used to initiate the monthly auto withdrawals for premium and be able to take that information and post it directly to the customer's accounts.	Y2	A
4. If we could utilize some type of "tear off" remittance (that has all applicable information needed) from the premium billing that the group could send in with their payment, might we be able to work with our bank to generate a file to the Y2 system to auto-post those 1 to 1 transactions to the accounts in Y2?	Y2	A

Applying Premium Rates to Groups:

5. We would like to see Underwriting creating the various rate tables right in the Y2 system (rather than Excel) and Group Admin would then only have to pull the applicable rate table from that "library of rate tables" and apply to the group, based on their benefit selection.	Y2	A

Late Payment Procedure for Large Groups:

6. Process could improve by being able to set different parameters/thresholds for verification of premium payment within Y2 and if not received by predefined date, a late letter would be auto-generated and sent out to the group.	Y2	A

Pharmacy Collections Process:

7. When a member is terminated and has incurred pharmacy claims beyond that term date, we are looking for Y2 to be able to identify all of those claims and auto generate a letter to the member requesting reimbursement for those charges. The current process involves the use of macros/TCL requests to gather the data and generate the applicable correspondence.	Y2	A

Group Sales Process (small and large group)
New business and renewals

Recommendation	***System impact***	***Time Frame***

Preliminary Rating/presentation of rates

1) Agents/Account managers can access preliminary rates on web portal.	Portal	Portal time line
2) Agents can receive answers to specific questions via e-communication	Portal	Portal time line
3) Preliminary quote requests are "logged" for agent monitoring	Y2	A

4) Activity can be flagged for future activity. Quote follow up Agent communication Clarification	Y2	A
5) Reports needed for Underwriting are automated.	Y2	A
6) Reports that are presented to groups are automated (DS input needed to determine process).	Y2	A

Underwriting Submission

7) Agents can submit group on line a. Drop down fields for required information b. Confirmation of receipt c. Automated delivery of rates d. Monitoring	Portal	Portal time line

Renewal Acceptance of Rates

8) Group acceptance can be done online.	Portal	Portal time frame
9) HSP is an automated process based on what is entered in the system.	Y2	A
10) Change form process is eliminated by new process (?). Currently a change form is done/distributed and Group Administration makes changes to CSC. New business alert-notification.	Outside Y2	?

Additional Marketing Materials will be available on line for either group and or agents.

- COC - Member Handbook - Member responsibility tables - Accolades - Provider Directory - Agent Guide - Underwriting Requirements - Additional benefits - Etc.	Portal	Portal time line

Underwriting

1. Automation of reports used in underwriting. (Retrieval of information used in renewal underwriting and monthly financial reports)	Y2	A
2. Online underwriting transactions/administration- viewing, applying and accepting rates.	Portal	Portal time line

Reimbursement Process Team
4/15/04

Goal Statement: Pay accurately and efficiently utilizing clearly written practices while increasing the auto-adjudication rate and working within the limits of automation for contracting.

To process a claim to pay accurately and efficiently, three key data sets must be entered into the Y2 system. These include:

1) Certificate of Coverage benefits/limitations which includes benefit summary information including co-pays, deductibles, accumulator restrictions and select rider language
2) Industry standard descriptive terms and identifying codes for reporting medical services and procedures performed by health care providers as well as the "rules" to apply to process these codes
3) Provider and contractual terms

To build the above data sets into Y2 it will be imperative that COMPANY X identify what our current business practices are and what standards/criteria are to be applied when applying these practices. Once COMPANY X business practices are established/confirmed it is necessary to develop written guidelines that identify these standards as well as where accountability lies for setup and maintenance of such standards.
Once standards are set, they must be programmed down to the code level in the Y2 system. Without this step, the Reimbursement Team believes that many of the current manual processes and inconsistencies will continue.

General Recommendations:

- Determine what resources are needed to pay claim and the hierarchy of applying this resource. A pay practice guideline/hierarchy must be established and maintained. Such resources include Medicare guidelines, National Correct Coding, AMA/Ingenix.
- Establish a new position of insurance coder specialist who will be accountable to take the COC and benefits and interpret down to the code level. This staff person would be needed to perform initial set-up as well maintenance.

Thus, the Reimbursement Process team has identified issues that require a decision in each of the 3 main elements identified above.

1) **Who is accountable to interpret and oversee the programming of the Certificate of Coverage and benefits so that the benefits are paid appropriately?**

- What is COMPANY X's business practice as it relates to DME items? What items can be rented vs. purchased? Does the rental price apply to the purchase price? Is the billed rental price applied to purchase price or is the allowed/contracted price applied to the purchase price? (p. 17)
- Does COMPANY X review therapy claims over 13 visits for State of Wisconsin members for medical necessity? (p. 33)
- What services count toward a TMJ benefit? Are the codes that are identified to count toward the benefit maintained? (p. 34)
- What is COMPANY X's policy regarding payment of urgent care claims for POS members? (p. 37)
- What is COMPANY X's process to determine if a service is medical vs. mental health? (p. 10)

2) How will COMPANY X maintain appropriate codes are set up to match benefits and the pay practices that apply to such codes?

- What code review package does COMPANY X desire to follow? What rules are part of this package as it relates to claims payment, eg. Unbundling, global fee? (p. 26)
- Who is accountable to maintain standard code sets that providers submit (CPT, ICD-9, HCPCS, J codes)? (p. 21)
- Who is accountable to verify that if contract compensation is affected when codes change? (p. 22)
- What standard does COMPANY X follow to determine if a code is valid? (p. 21)
- What process is followed to make changes to codes? (p. 21)
- Who is accountable to obtain and maintain standard data used in current COMPANY X provider contracts: Medicare Facility/Non-facility fee schedule, J code Medicare fee schedule, Medicare assistant surgeon indicators, DRG"s? (p. 22)
- What pay practice does COMPANY X follow for all acceptable modifier codes? Does a modifier drive payment? If more than one modifier on a claim, is there a hierarchy to follow to determine payment? (p. 23, 24)
- Can COMPANY X accept claims from anesthesia that are billed as anesthesia type of service but billed with a surgical CPT code? (p. 11)

3) What are COMPANY X's provider/contract standards?

- Does COMPANY X have a standard for methods of contracting? Is it acceptable to write contracts that will require manual adjudication? Examples include DME contracts written to a product code level, contracts that don't include all providers under a tax ID or at a specific

location, contracts that don't include all services the provider offers, etc. (p. 17)
- Before a contract is written, are the compensation terms reviewed to determine that they can be administered and the ease of such administration? (p.11)

Furthermore, the Reimbursement Team identified the following questions related to business practices:

- If a provider is contracted with both HSM and Multiplan, which discount/contract takes priority? (p. 25)
- Does COMPANY X want to apply different criteria to determine medical necessity for assistant surgeon to AMG providers? (p.23)
- Is it COMPANY X's desire to continue to review therapy under the current process which requires entirely manual documentation or can a change be made that would allow the system to track more efficiently? (p. 33)
- When can a provider be given non-recoupment status? This leads to significantly more manual intervention to allow payment. (p. 41)
- COMPANY X currently send some debts to collection but also list to write off to bad debt. Is this a cost-effective process? What procedure does COMPANY X desire to follow? (p. 41)
- When a group has not paid a premium, does COMPANY X want to hold claims until the premium is paid? (p. 44)
- What COB guidelines does COMPANY X desire to follow? (p. 8)
- When COMPANY X has authorized care as outpatient and AHS facility bills as inpatient, how should COMPANY X handle? Currently claims overrides and pays for the care but does not track toward the inpatient level of care. (p. 8)
- What rules does COMPANY X follow for demographic data entry? Currently names, addresses, etc are not entered in a systematic format and can cause member identification issues. (p. 11)
- Does COMPANY X desire to develop an auditing department? (p.9)
- How does COMPANY X desire to administer benefit for "onset of illness or injury" when the member resides outside the service area? (p. 12)

While recognizing the above issues require resolution, the Reimbursement Team chose to take each manual process or step, identified from the time a claim enters the door until the time a correct payment is made, and identify the "root cause" for the manual intervention. If any of the above issues relate, it is highlighted in "green".

Claims Entry Process

EDI Claims:

Issue:

A paper report is run once the claims are downloaded into current system.

Reason:

Claims analyst cannot find these claims without crosschecking against a paper report. There is no electronic notification system of the claims that were entered via EDI.

TO BE:

The EDI claims will electronically route to the Claims Analyst based on the Analyst's pre-defined workload.

Paper Claims:

Issue:

Mail Clerk manually assigns each claim a number/identifier.

Reason:

Current system is unable to assign a unique number when entering the claim.

TO BE:

System will assign the claim a number at the time the claim information is entered into the system.

Issue:

Data Entry Analyst identifies injury related diagnoses and sends to Advana.

TO BE:

Y2 will identify injury related diagnoses or if injury box is marked "yes" and automatically route to Advana.

Issue:

If a provider is not set up in the current system the claim is routed to the Provider Maintenance Specialist. Once entered it is returned to the Data Entry Analyst.

TO BE:

If a provider is not in system, allow Data Entry Analyst enter the entire claim except the provider data. Analyst sends copy to Provider Maintenance Specialist to enter provider. Once entered by Provider Maintenance Specialist, the claim will electronically route back into the claims adjudication queue.

Claims Entry Process (cont.)

Issue:
If a member was previously covered by COMPANY X and is no longer enrolled in any group, Data Entry Analyst reviews and then denies.
TO BE:
Y2 will automatically deny if member was previously enrolled but now ineligible.

Issue:
After the Data Entry Analyst enters a claim into the system, she sorts the paper claim.
Reason:
The current system is unable to sort claims into work queues.
TO BE:
After the claim is entered, Claim would electronically route to an analyst based on the analysts' pre-defined workload. This would eliminate the rest of the sorting.

General Claims Adjudication Process

Issue:
Currently Claims system does not allow auto-denial.
TO BE:
Only claims that come to the Claims Analyst queue are those that Y2 has addressed all edits and determined that a manual review is needed.
Y2 will be able to automatically deny:

- Duplicate claims
- Claims with exclusion edit (as determined by coding expert). This needs to be specified to the CPT and ICD-9, HCPCS code level
- Invalid CPT codes
- Combination of invalid diagnosis with CPT code
- Claim not within timely filing limit
- Pharmacy claim that is not COMPANY X liability
- Combination of invalid modifier with CPT code
- If benefit has a benefit limit, Y2 will auto-deny when limit is met or exceeded and no authorization is present. In cases where an authorization allows > benefit, Y2 will track these services for reporting purposes. Someone needs to be accountable to review monthly report, preferably Care Management.
- If a benefit has a benefit limit and the claim only partially exceeds the limit, Y2 will auto-deny the portion over the limit and allow the rest of the claim to adjudicate.

TO BE:
Y2 will automatically pay for a service that requires an authorization and authorization is on file. It will also link associated charges to that authorization, eg. Radiology, anesthesiology.

General Claims Adjudication Process (cont.)

Issue/Concern:
COMPANY X still has issue where COMPANY X authorizes care as outpatient level but St. Elizabeth /Mercy bills as an inpatient level. Currently claims overrides to pay the bill and does not count the days toward inpatient charges. How does COMPANY X want to pay claims that are billed at different levels of care? How would the new system configure if COMPANY X continues to override and pay the claim? We recommend that Care Management resolve this issue with AHS entities. Care Management must verify that orders for admission match authorization prior to discharge. Most insurance companies would deny as "billed in error". (IBNR and inpatient days may be affected if COMPANY X denies claim.)

Issue:
Currently CSC cannot pick up who is paid if it is different from the vendor. AP cannot see when someone is paid other than the vendor.
TO BE:
Y2 will be able to show who payment is made to even if there are multiple parties paid. This would include capturing the multiple addresses of who was paid.

Issue:
Current system identifies when a member has other insurance in general and this edit then stops all claims.
TO BE:
Identify and capture other insurance by category: medical, dental, vision, pharmacy.

Issue:
Currently there are discrepancies/inconsistencies in how COMPANY X applies coordination of benefit rules. COMPANY X does not perform COB banking.
TO BE:
COMPANY X needs to review and re-visit how COMPANY X desires to apply COB. We recommend that BOC make business decision and set rules based on review of COB section and options provided in the Business Assessment document from Y2. Further the issue of whether COMPANY X performs COB banking must be addressed.

General Claims Adjudication Process (cont.)

Issue:
Currently the Claims Auditor receives all batches of claims and audits according to the Analyst's expertise level.
TO BE:
Batch will have already been audited by the Data Entry Auditor. Y2 will randomly select claims completed by Analysts and queue to Analyst Auditor for review against payment/process guidelines for accuracy.

Issue:
Claims analysts/auditors cannot verify that a contract is paying according to the terms written.
TO BE:
We recommend an auditing department be developed to oversee all COMPANY X functions. We recommend this be housed in Training and Development. Training and Development can work closely with the auditors to identify, develop, and deliver training needs. Examples of areas to audit include contract compensation, benefit payment, member entry, new group set-up, and authorization entry.

Issue:
Currently Analyst Auditor manually tracks Claims Analyst errors on audit sheet.
TO BE:
Y2 will tally the number of claims processed per analyst. Auditors will enter the error information into a spreadsheet housed in Y2. This will then calculate the overall percentage daily.

Issue:
If an error is found in the adjudication process, the claim is sent back to the analyst to correct.
TO BE:
Claims with errors will automatically queue from the auditor back to the analyst to correct.

General Claims Adjudication Process (cont.)

Issue:
If Claims has a claim that may require a medically necessary review (TMJ, Infertility, developmental delay), claims sends a copy to Care Management requesting a decision.
TO BE:
Coder needs to determine what can be automatically denied vs. what needs to queue to Care Management for review. Once Care Management has reviewed and made determination, the claim will queue back to the Claims Analyst.

Issue:
Currently it is difficult to suppress data on an EOB or suppress an entire EOB.
TO BE:
Y2 will be able to suppress data fields on an EOB or suppress sending an EOB.

Issue:
Currently multiple departments manually track certain types of cases exclusive of one another. These include transplants, Paradigm, and high $ cases.
TO BE:
COMPANY X needs to determine what each department is tracking and why and then maintain this information in one central place in Y2 rather than depend on department manually tracking.

Issue:
COMPANY X currently does not administer the mental health benefit. From previous experience with UBH, there is need to identify what services/codes be tracked to the medical benefit vs. the mental health benefit.
TO BE:
COMPANY X must develop a process to determine what services are covered under medical benefit vs. mental health benefit. We recommend the coding specialist and behavioral health manager work to develop the configuration of this benefit and then work to have programmed into system.

General Claims Adjudication Process (cont.)

Issue:
Current claims process does not allow claims billed with type of service "anesthesia" but billed with surgical CPT code to be crosswalked to the matching ASA code. COMPANY X contracts with anesthesia groups are written to provide for the crosswalk.
Reason:
A decision was made base on review by compliance that COMPANY X should not crosswalk claims.
TO BE:
COMPANY X must determine if anesthesia can submit claims under surgical CPT codes are valid. We recommend this be reviewed as part of the claims payment practice subcommittee established by BOC. If the decision is made that anesthesia cannot bill in this manner, Contracting must be notified and contracts amended.

Issue:
COMPANY X pays claims according to Tax ID, Provider Name, Provider location, and specialty. However, many tpa's and other insurers who access the COMPANY X PPO panel, do not require all such fields. This leads to these payors processing claims for COMPANY X PPO providers inaccurately.
TO BE:
COMPANY X must determine the importance of contracting to the level required for HMO/POS and whether a different standard exists for PPO payors.

Issue:
Errors can be made when selecting/locating the correct member or provider.
Reason:
COMPANY X does not follow a standard formatting for data entry into the system for names, suffixes, hyphens, abbreviations.
TO BE:
COMPANY X will develop a policy and procedure for data entry into the new system that requires consistent standard entry.

General Claims Adjudication Process (cont.)

Issue:
Currently when a department wants to review claims for a particular member or type of member, the member is flagged and it stops all claims from releasing.
Reason:
The current system is unable to flag a member for a specific or limited review.
TO BE:
Y2 will have the capability to flag members requiring a review by diagnosis, code, or a time frame and claims will be reviewed for that particular issue rather than all claims.

Issue:
When a claim is received from out of area, a review is required to determine if the service is the initial onset of an illness or injury.
Reason:
COMPANY X does not have clear guidelines for payment of these services.
TO BE:
We recommend that this issue be discussed/resolved identifying our policy for payment of care received outside the service area and whether it is covered. Currently there are issues related to members that live outside the service area, college students, and snowbirds. Thus, every claim outside of the service area is reviewed to see if it relates to the above types of members.

Alliance Laundry

Issue:
Claims analyst checks system manually to see if provider was ever or is a PCP and is currently in-plan
Reason:
COMPANY X sold a product with benefits that current system cannot administer.
TO BE:
COMPANY X needs to verify that system and automatically control payment of any new products/benefits via a test system. i.e. if provider is or was ever a PCP, waive co-pay on selected services.

Issue:
Claims analyst must manually verify if the claim has an infertility diagnosis
Reason:
This employer group has an infertility rider. Currently no other plans do.
TO BE:
The system will be able to identify groups with infertility rider and allow claims to pay according to the benefit purchased and to track $ to infertility benefit limit.

Ambulance

Issue:

The Claims Analyst must enter location of start and finish of service and then manually check system for authorizations surrounding transport.

Reason:

The current system's ambulance benefit is not entered to auto adjudicate.

TO BE:

Emergent transport is defined as transport from any location to a hospital setting. If the transportation is to any other location (SNF, Home) the claim will require an authorization from Care Management.

Y2 will need to identify when an ambulance transport is to a hospital the claim will automatically pay. IF the transport is not to a hospital, Y2 will look for an authorization. IF authorization, the claim will automatically pay. If no authorization the claim will automatically deny.

Chiropractic Claims

Issue:
All chiropractic claims are currently processed manually.
Reason:
The current system cannot automatically administer the contract terms for chiropractors.
TO BE:
Y2 will identify a Plan Vendor. If the claim is for the 1st visit of the calendar year, Y2 will pay the case rate. Y2 will identify if the claim is not for the 1st visit and the case rate has already been paid to adjudicate with no payment. It is imperative to keep in mind what the EOB will look like to the member and the vendor.

Issue:
Claims analyst determines if diagnosis is possibly injury related and sends to Advana.
TO BE:
Y2 will identify injury related diagnoses and automatically send to Advana. COMPANY X needs to have business decision/coder that can recommend which codes should be flagged. This can be done in conjunction with Advana.

Issue:
Care billed by a non-plan provider requires manual intervention.
Reason:
Current system cannot automatically look for auth and link for HMO nor apply U&C amounts to POS member.
TO BE:
Y2 will identify that claim is from non-plan provider and whether member is HMO vs. POS. If the member is HMO, Y2 will look for authorization. If no authorization, Y2 will automatically deny. If authorization found, Y2 will pay fee for service. IF the member is identified as POS, Y2 will automatically pay according to U&C. it will be able to show the non-covered amount (amount over U&C).

COB Letters

Issue:
Report off of CSC must be re-formatted and sent to outside vendor to send out COB letters quarterly.
TO BE:
Y2 will be programmable to send letters automatically off system rather than re-work by IS and outsourcing letter. When a letter is sent, it will track in the subscriber and member screens.

Issue:
If a COB letter is not returned and a claim is received, claims denies claim for lack of other insurance information.
TO BE:
When the claim is denied, another COB questionnaire or directions on how to provide other insurance will be triggered with the EOB denying the claim.

Durable Medical Equipment

Issue:
Claims Analyst manually enters a unique code in the CPT field.
Reason:
Select DME contracts are written to pay to a level more specific that HCPCS codes.
TO BE:
Standardize the way DME contracts are written so that they don't specify beyond the HCPCS code level. We would like contract compensation to reflect national codes not unique codes. Develop a test process to run new contract compensation through system before agreeing to contract compensation with the vendor.

Issue:
Claims Analyst manually tracks rental price in call log system.
Reason:
Current system is not able to apply rental price of item to the purchase price to prevent COMPANY X from paying beyond the purchase price.
TO BE:
Y2 will track rental amounts up to the purchase price of the item. We are not sure where COMPANY X would get the purchase price on rental items that don't require authorization. COMPANY X may need to require DME vendors to submit purchase price on the rental claim. We desire for Y2 to automatically deny after the purchase price is met. Also we desire for Y2 to automatically deny if no authorization is on file and an authorization is required.

** How does COMPANY X determine when to apply rental price toward a purchase? Is there a listing of such items? We recommend the development of a list of items/codes that should be considered as rent to purchase items. We recommend that Care Management and claims work together to develop this list.

End Stage Renal

Issue:
Claims must manually review claim to determine liability against Medicare liability.
Reason:
Medicare has specific benefits for end stage renal disease that must be followed to determine liability.
TO BE:

a) Care manager would flag member with onset of illness and Y2 would be set up to calculate the liability.
b) Claims would investigate the 1st claim with diagnosis 585, identify date, and all following claims would be auto adjudicated according to the determined date/liability.

ER Claims

Issue:
Claims currently change the capacity code to “a”.
Reason:
Current system is not set up to allow ER claims for non-plan providers to pay in plan for POS members. COMPANY X’s current business practice allows all ER visits to be paid in plan.
TO BE:
Y2 will be able to apply business rule to POS members.

Issue:
When a member is in the ER with >8hours of observation, claims must manually waive the co-pay.
Reason:
Current system cannot calculate time in ER or identify a subsequent admission.
TO BE:
Y2 will be able to waive co-pay if it is an inpatient/outpatient bill type with ER REV code on the claim.

Issue:
Claims manually changes place of service on ER bills if service is for IV therapy.
Reason:
Current system cannot process claim without applying an ER co-pay. An ER co-pay does not apply for IV therapy services received in the ER setting.
TO BE:
IV therapy claims would process to IV therapy benefit and not be linked to place of service and ER co-pay.

HSM

Issue:
Any member getting benefits via the HSM discount must be manually calculated.
Reason:
HSM provider are not contracted providers in general but are discounted only if Care Management arranges prior to receipt of care.
TO BE:
Authorization would have a field that identifies discount amount. The claims system would automatically calculate according to what was entered in this field. We would need to identify facility discount vs. professional discount.

Maintenance of Codes

Issue:
Codes flag in system as invalid and then need to be reviewed to determine if current/correct.
Reason:
Currently there is no staff assigned to proactively maintain accuracy of claims codes in the system.
TO BE:
Develop coding specialist position with accountability to proactively maintain and update claims codes.

Issue:
In situations where a code must be set up, the Medical Review Coordinator requests approval to make a change, forwards to Benefits Specialist and awaits response that change has been made.
TO BE:
If the code is not set up, the coding specialist will research code and then make appropriate changes. Once change is made, the claim will electronically route back to the claims adjudication queue.

Medicare Fee Schedule Database Update

Issue:

Decision Support retrieves Medicare files from web site including

- Facility/non-Facility fee schedule
- J Code Fee schedule
- Assistant surgeon indicators
- DRG fee schedule

Reason:

Decision Support is able to manipulate data into usable spread sheet.

TO BE:

The accountabilities would be transitioned and maintained by the coding specialist. The Coding Specialist would enter changes into Y2 and notify appropriate parties when complete, such as Provider Maintenance Specialist who would re-program contracts linked to the above data files. Further the coding specialist will verify if the changes made annually to standard fee sets will alter compensation stated in contract language.

Modifier 80

Issue:
Payment of assistant surgeon is a manual process.
Reason:
Current system does not have assistant surgeon processing guideline built.
TO BE:

a) We recommend COMPANY X use Medicare assistant surgeon guidelines
b) Load guideline in system and claim will automatically adjudicate. We recommend that COMPANY X will NOT determine payment amount against the surgeon's charges but determine based on the assistant surgeon's billed amount.

Issue:
When Medicare guideline indicates assistant surgeon is not warranted by "o", claims has the claim further reviewed if it was billed by Affintiy.
Reason:
Affinity is treated differently than all other providers and gets a second review by Care Management using Milliman and the operative report.
TO BE:
Follow Medicare guidelines for all providers.

Modifiers 54,55,56

Issue:
3 modifiers are removed and analyst manually calculates payment according to industry guidelines, then adds modifier back.
Reason*:*
System is unable to process according a modifier guideline.
To BE:
Y2 will be able to read modifier and apply appropriate discount and continue to adjudicate.

**COMPANY X needs to determine what claims processing guideline they will follow to determine order and discount for modifiers.

Multiplan

Issue:
Analyst must check Multiplan website for discount for all out of plan providers through the website. They then manually enter information off website into our system.
To BE:
Have 2 discount columns, one for the % and the other for a dollar amount, in the pay fields where analyst can enter the discount $ amount or %. If a discount % is entered, the system will enter the appropriate $ amount.
This would allow COMPANY X to audit and report savings from Multiplan rather than depending that Multiplan invoice is correct and accurate regarding savings.

** COMPANY X needs a business decision as to what discount to apply first: Multiplan, HSM.

Multiple Surgery

Issue:
Currently, there is no mechanism to pick up if multiple surgeries can be billed together. Once determined that procedures can be billed together the system is unable to calculate payment on 2nd or 3rd procedure.
Reason:
Current system is not set up with code review package.
To BE:
Determine code review package to be used. Adapt these standards as COMPANY X business standards. It is critical that package purchased be maintained and kept current. Y2 should auto-adjudicate based on these standards.

Paradigm

Issue:
Analyst must manually check to verify if auth is still current.
To BE:
Y2 will be able to pick up if auth is current and allow claim to continue to process.

Issue:
When COMPANY X pays a claim for a member under the Paradigm contract, claims must enter a line into the claim identifying as Paradigm
Reason:
Line is added so COMPANY X can run report to track $.
TO BE:
Paradigm members will be flagged by Care Management at time of notification. This flag will only stop claims related to the diagnosis on the claim rather than stopping all claims. Further, we will be able to pull reports off the “flagged” field.

POS/Pre-cert Penalty

Issue:
Current system is unable to apply pre-cert penalty, if applicable, or to pay at out of plan benefit level applying U&C.
Reason:
Current system can not be programmed to process the POS out of plan benefits.
To BE:
Y2 will apply POS benefits appropriately, i.e. ER, urgent care, ambulance, facility pre-cert penalty, U&C for professional charges

Routine Mammogram

Issue:
Any mammogram claim must be manually reviewed to determine if there have been any routine mammograms in the past year.
Reason:
Current system is unable to review history for “routine mammogram” codes and then allow to pay.
To BE:
Y2 must be able to read by diagnosis code and procedure code to determine benefit. It will need to be able to review claims history as well.

**COMPANY X/coder will need to identify routine mammogram codes to be loaded into the system that don’t need to be reviewed manually.

Sterilization

Issue:
COMPANY X has members with sterilization benefit, however sponsors do not allow COMPANY X to "pay" for this benefit.
Reason:
Due to our catholic affiliations, COMPANY X has outsourced payment of this benefit.
TO BE:

a) COMPANY X re-prices claims but they are not entered into our system. Then, the claim is forwarded to outsource carrier.
b) Providers submit sterilization claims directly to outsource carrier. There are 8 procedure codes that would need to go out. Y2 would need to pick up ancillary charges as well.

Issue:
Analysts must change claim type to allow charges to pull on a report to allow payment to Unified Life.
Reason:
Current system does not identify diagnosis by line item.
TO BE:
Y2 would be able to pull all claims either by identified procedure or identified diagnosis code to go to outsourced vendor.

Issue:
Analysts must review vasectomy dates to determine if the submitted claim falls within the global time frame guideline.
Reason:
Current system does not track global time frame guideline.
TO BE:
Y2 will be able to be programmed to look at dates and procedures. Code review package will include global fee programming.

Subrogation

Issue:
Analyst must go out and look for advice sent from Advana on I drive in excel spreadsheet.
To BE:
Advana advices will go directly into system by each claim and then cue analyst to continue process according to advice received.

Issue:
When Advana advice is not received within 30 days, Analyst must contact subrogation analyst to follow-up with Advana.
TO BE:
Y2 will assign any suspended Advana claims >30 days to subrogation analyst work queue for f/u. or suspended Advana claims >30 day would go directly to Advana to notify that COMPANY X is waiting for a response.

Issue:
Advana calls COMPANY X to acquire allowed amounts when claim was an EDI claim.
Reason:
EDI claims with injury diagnosis were previously sent automatically to Advana and no one has manually entered a “claim type”. Based on COMPANY X payment system, payment cannot be directed to a benefit without a claim type.
TO BE:
COMPANY X will direct payments to appropriate benefit based on procedure, type of bill, place of service, or diagnosis that provider bills to COMPANY X rather than COMPANY X changing to fit appropriate benefit. **Essentially, COMPANY X will not use or assign a claim type. This process change affects all claims, not just subrogation.**

Surgical Center

Issue:
Claims change the type of service so the claim will track to the correct benefit.
TO BE:
We will not use the place of service to drive tracking to the benefit but rather program to track according to type of service.

Therapy

Issue:
COMPANY X manually pays State WI members 50 total therapy visits without medical necessity review.
Reason:
State of Wisconsin benefit allows 50 visits and it's easier to allow the 50 visits without review than fight with the member.
To Be:
COMPANY X needs to determine if reviewing State WI members for medical necessity for therapy is appropriate and good use of resources. Currently COMPANY X does review all other members after 13 visits.

Issue:
COMPANY X currently tracks all PT/OT/ST in call log by both Care Management staff and Claims staff.
Reason:

1) COMPANY X chooses to count visits by body location.
2) COMPANY X currently requires a review after 13 visits to determine medical necessity. There has been previous concern regarding over-utilization of therapy services.
3) COMPANY X starts the count of 13 visits over if a member has had surgery related to the therapy he is receiving.

TO BE:
We recommend COMPANY X will change business policy and instead allow 13 PT, 13 OT or 13 ST visits before a review is done. Y2 will automatically pay for the 1st 13 visits and then look for an authorization. If no authorization is found, Y2 will automatically deny.

TMJ

Issue:
Analyst must change TOS to 'J' for non-surgical TMJ services.
Reason:
System is unable to have services count toward TMJ benefit without the 'J'
TO BE:
If claim has a definitive TMJ diagnosis, Y2 will automatically pay and track to TMJ benefit if identified as non-surgical. Coding specialist will need to identify codes that are specifically TMJ. Y2 will be able to automatically deny services above the benefit max in the same line on the claim and show in the non-covered field. (Services without definitive TMJ diagnosis will still require manual review to determine coverage)

Transplant Drug Charges

Issue:
Transplant drugs are manually applied to the transplant benefit max. Transplant members are maintained in a manual spreadsheet.
Reason:
Rx claims are not paid in house.
TO BE:
Coding Specialist, along with Pharmacy director, will identify immunosuppressant drugs and set up system to allow these drugs to track to the transplant benefit.

Transplant

Issue:
COMPANY X manually identifies transplant members.
Reason:
Current system cannot identify transplant members. This is needed so we can process according to the transplant benefit.
TO BE:
When a member is identified by care management as a transplant member, care management will flag member as either pre or post transplant. We need to identify codes related to this particular type of transplant and set up system to track to the transplant benefit. We would not use claim type ITP, ITF, OTP or OTF to track the transplant benefit.
Claims received that have been re-priced by URN will be entered by claims entry clerk using a contracted amount field to identify the discounted/re-priced amount and claim will go into work queue. All claims re-priced by URN will automatically track to the transplant benefit.
(Could URN be set up to run the same as Multiplan, going out to a website? Could URN submit claims to us electronically? Could the re-priced amount be put in the comments field?)

Urgent Care

Issue:
Claims changes field 5 to “A”.
Reason:
Current system is not set up to allow urgent care claims for non-plan providers to pay in plan for POS members. Current business practice allows onset of illness or injury to be paid in plan.
TO BE:
Determine COMPANY X’s business rule for payment of urgent care claims for POS members. (Is it COMPANY X’s business rule to treat urgent care facility claims the same as ER claims?) We recommend that BOC develop business rules for how to apply said benefit.

Issue:
Claims are unable to process IV therapy billed in urgent care without changing place of service.
TO BE:
IV therapy claims will process to IV therapy benefit and charge co-pay only if billed with an office visit code.

Update to Financials

Issue:
Once the Provider Maintenance Specialist updates a provider address or sets up a new provider, she sends the paper copy of the claim back to recovery analyst to complete.
Reason:
It is done manually due to the current system has no way to electronically send notification of completion.
TO BE:
Once the Provider Maintenance Specialist completes the provider data update, Y2 would queue the claim back to the recovery analyst.

Issue:
Once the Recovery Analyst identifies an address change for a member, she must give the information to customer service to enter.
Reason:
Recovery Analyst does not have security to make the changes to the address field.
TO BE:
Recovery Analyst will have security to change address information rather than go to customer service. However, an audit process will be required as part of the process to monitor that information changed was correct and appropriate.
** **Overall, there must be an audit trail for all data changes.**

Issue:
When a check is received and it's been determined that it is for a claim that has been reversed, the Recovery Analyst writes up a voucher that identifies where the money should be credited.
Reason:
Current system must be manually updated.
TO BE:
No paper vouchers would be needed. The Recovery Analyst will enter the amount received to the appropriate claim and Y2 will apply the money to the appropriate General Ledger accounts. This eliminates the Recovery Analyst from having access to accounts payable, manual voucher entry, and potentially picking wrong GL accounts.

Update to Financials (cont.)

Issue:
When the Recovery Analyst reverses a claim, she must write up a CFU and enters on a spreadsheet.
Reason:
The CFU and spreadsheet is used to manually track reason for reversal and to verify that the check received was taken care of.
TO BE:

a) Develop an electronic CFU where it can alert claims that a specific claim needs to be reversed and why. Once the claim has been completed, the system will notify the CFU requestor.
b) When the Recovery Analyst reverses a claim she will not need to fill out CFU but will make notes in claim system that identifies reason for reversal. The reason will also be able to be reported on.

Issue:
When a claim is reversed the current system creates a new claim and claim number.
Reason:
Current system cannot process a reversal in the original claim.
TO BE:
Keep one document in the system. Y2 will be able to make corrections to the original claim. Instead of creating a new claim, we will be able to add lines to the original claim and be able to correct by line.

Issue:
When a check is returned/received with new COB information, the Recovery Analyst must forward to customer service to update the screen.
Reason:
Recovery Analyst does not have access/security to change the COB information.
TO BE:
Recovery Analyst would route to COB analyst to update COB. COB analyst would then route back to Recovery Analyst via an electronic work queue.

Update to Financials (cont.)

Issue:
When a subrogation refund is received, the Recovery Analyst manually tracks in a spreadsheet.
Reason:
There is no current way to follow subrogation payments.
TO BE:
The Recovery/Subrogation Analyst will apply the refund toward the claim indicating the reason. This will all be done in the original claim by adding lines to the claim.

Issue:
Currently the Recovery Analyst notifies Advana of receipt of monies.
Reason:
Current system cannot track to notify of receipt of recovery.
TO BE:
When the Recovery Analyst applies money to claim, Y2 will automatically notify Advana.

Issue:
When a provider sends back a payment for Sr. Plus member, the Recovery Analyst return the money to the provider with a letter generated outside the CSC system.
Reason:
Current system cannot generate letter in compliance CMS guidelines.
TO BE:
Outside letters and tracking will be done in Y2. This applies to letters COMPANY X sends requesting the provider return Medicare payment to COMPANY X.

Update to Financials (cont.)

Issue:
When COMPANY X has paid out more than was due, COMPANY X must recover that amount. This becomes a manual process for any vendors with a “non-recoup” status.
Reason:
Select providers have been given “non-recoup” status, either by request or due to contract language.
TO BE:

a) Meet with 2 largest provider groups that have “non-recoup” status (Agnesians, UW) about any ways to improve relationship and see if new system will meet their needs regarding remittances.
b) Decrease listing of “non-recoup” contracted vendors that do not have contractual language that requires process.

Issue:
When a refund is requested from a non-recoup vendor, a letter is generated out of Word.
TO BE:
The letter will be generated and tracked via Y2. When the refund is received and applied, it would come off the tracking system. The second notice letter will be sent automatically based on the tracking system that the refund was not received. Further, if the refund is not received and it’s determined that the amount will go to collections, the letter will go out automatically, notify collections agency and notify accounts payable of status.

Issue:
Once we send debt to collections, finance writes off the amount to bad debt.
Reason:
A business decision was made by finance to handle collections amounts in this manner.
Recommendation:
Review this business decision. Is this what COMPANY X wants to do? Why are we sending to collections if we have decided to write off to bad debt? It does cost COMPANY X money to send to collections.

Update to Financials (cont.)

Issue:
Currently COMPANY X runs a negative vendor report to pick up any dollars that we cannot recover by applying to a future payment.
Reason:
This report manually tracks what money is due back.
TO BE:
We request a more readable report that includes: member #, invoice #, vendor #, member name, vendor name, claim #, Date of Service, amount.

Issue:
Currently finance manually enters dollar amounts from update report into Excel spreadsheet.
Reason:
Finance uses a check and balance against the system information to make sure that the released claims have been sorted to the correct company (LOB).
TO BE:
Y2 will automatically run financial reports and have audit trail. This manual spreadsheet may be able to be eliminated in the future if we are able to trust the system and audit checks that are in place prior to the report reaching finance.

Issue:
Current system runs cash requirement report and is able to identify non-recoup vendors and automatically holds all negative invoices.
TO BE:
Desire that Y2 will also have this capability.

Update to Financials (cont.)

Issue:
Currently AP system is set to hold payment for vendors with a negative balance. When doing this, the system holds the next claims when the vendor has a zero balance or lesser balance.
TO BE:
COMPANY X needs system to be set up to not hold these claims but be released.

Issue:
Error report is reviewed and errors are forwarded to either Group Administration or IS to correct.
TO BE:
When the recovery analyst runs the AP update, the error report will queue automatically to the above departments to correct. Then the next time the update report is run, the claim will appear on the update report. We need to have a business process that these errors are corrected immediately so claims are able to pay timely.

Run adjustment report to verify that checks have been applied to claim appropriately. Any claims on the report require a review. We aren't sure that the adjustment report will be necessary in the future.

Y2 will allow staff to pull up a check (either external or COMPANY X check) and be able to view what claims are attached to the check and any other applicable data. This would eliminate the need to maintain manual spreadsheets.

Issue:
Currently when Group Administration is notified of a retroactive termination of a member, they run a report and send to Recovery Analyst. She holds for 45 days and then re-processes accordingly.
Reason:
The member involved had claims paid and now member is without coverage.
TO BE:
When Group Administration retroactively terminates a member, Y2 will queue those claims to be re-processed with 45 day lag period. Further if Group Administration re-enrolls a member, it will queue Y2 to re-process the claims immediately.

Update to Financials (cont.)

ISSUES/Questions:
A business decision needs to be made about process to follow when a group changes benefits retroactively or group terminates retroactively.
When a group has not paid premium, does COMPANY X want to decide whether COMPANY X wants to hold or release claims?

Issue:
Currently when we write a check to a vendor, the vendor may get 3 separate checks for members under the HMO, POS, and Medicare.
Reason:
Current system cannot merge the LOB's to print a check for 1 vendor.
TO BE:
Run checks as 1 company with 1 check/vendor.

Issue:
Finance must manually match a check with the remit.
TO BE:

a) The remit will be sent electronically to provider and the $ will be sent electronic file transfer. Provider will be able to review the remit/payment via the Provider portal; or
b) Check system will be in Y2 and will be able to match check and remit and put in envelope for mailing, or at least put them together; or
c) Consider outsourcing the check generation and remits to external vendor.

Issue:
Currently AMG receives remit electronically but COMPANY X still runs a hard copy of the remits.
Reason:
AMG desires a hard copy.
TO BE:
Process change that requires AMG to print remits off the electronic remit that they already receive.

Update to Financials (cont.)

Issue:
Batch audit and verify balance reports need to be compared to all the reports that are run at month end.
Reason:
Sue Willard prefers to verify against an Excel spreadsheet rather than the multiple reports. This process is due to work flow preference and not because the current system doesn't capture the information.
TO BE:
We do want the new system to still be able to capture reports. We need the report team to discuss detail of these reports going forward.

Issue:
When we complete month end, many different staff have to come in if the end of the month occurs on a weekend.
TO BE:
Y2 will be able to generate the reports automatically and not require manual intervention to perform month end. (this would eliminate Sue Willard's ability to do a manual double check of the numbers)

Issue:
Recovery Analyst currently has to run update report at month end.
TO BE:
Y2 will be able to start report automatically based on a set date/time without manual intervention.

Update to Financials (cont.)

Issue:
Membership numbers are received from warehouse reports/group administration.
TO BE:
Membership totals would be available in Y2 and easily accessible to all. Finance would not have to wait for the report to be distributed. The membership numbers would be available online.

Issue:
Wire transfers are done through a bank website.
TO BE:
COMPANY X will have electronic fund transfer for payment method and also record the payment to the appropriate GL account.

Issue:
Currently to reconcile a retro funded group, the process is quite manual with regard to entering data off reports onto spreadsheet.
TO BE:
After identifying what data is needed to perform reconciliation, Y2 will run the report and automatically fill the appropriate field in the spreadsheet.

Issue:
Currently finance sends W-9s to all vendors, sending to the vendor's claims payment address in the CSC system. We gather this information to then send out 1099s.This may not be the correct address for 1099 submission. We then await the W-9 return with corrected information.
Reason:
COMPANY X only captures the claims payment address, not a federal id address to send 1099. CSC does have field to capture both addresses.
TO BE:
Contracting will capture Federal ID address at time of contracting. This would significantly decrease the amount of changes required upon return of the form.

Update to Financials (cont.)

Issue:
Several different departments may be the initial site of notification of address changes, tax id changes, etc for both contracted and non-contracted providers. The department that receives the information may not be aware that other departments use the changes.
TO BE:
When any department is notified of tax ID change, address change, the information will be routed/shared with the following departments: Finance, Provider File Maintenance/Contracting. This will be for contracted or non-contracted providers.

Issue:
COMPANY X purchases Convey software to maintain accurate 1099 form.
TO BE:
Y2 will run 1099's for both claims vendors and administrative vendors. Y2 will be able to identify any vendor where payment is >$600 and print 1099s. Y2 will also capture any wire transfers and electronic funds transfers and generate 1099's.

Network Development

Team Members: Melinda Mauk-Templeton, Tim Binder, Barb Gore, Sue Hastings, Tammy Maas and facilitator Sue Bayer-Jabb.

Team Charter

The Network Development Team will establish, maintain and optimize provider service goals in alignment with AHS mission, vision and values.

Team Goal Statements

Purchase provider services offering flexibility in contract yet maintaining ease for claims processing.

Areas to include and consider:

- Work within the limits of automation for the system
- How do we maintain information for those providers we don't hold contracts for (Out of Plan)?
- Provider database/credentialer relationship (can we sever this relationship and extract info from Y2)
- Audit reimbursement against how contract is written
- Processes for HMO, POS, PPO
- How do we deal with providers that we have a contract with but they are not loaded in the system (UW MDs)
- Process for test environment for any new processes
- Process to ensure adequate number of specialty providers

Metrics:

- Decrease the time for provider set-up (time contract signed till time provider payable = ? days)
- Increase % of EDI providers and claims
- Increase % of electronic payment & supporting documents
- 100% automated recouperation of payment errors
- Same day turnaround (provider status change to time info entered into system)
- Decrease % denials due to coding errors by providers

As Is: Measure time for setting-up a new provider

(Time until the system can process a claim for provider)

Type of Data	What needs to be completed	Average time it takes to be completed in Credentialer
New Practitioner who is approved through Credentialing at PAC (if existing contract is already in place)	New practitioner who has a completed pif, and all necessary information has been provided to contracting analyst	Average of 24 hr turnaround to get information data entered into Credentialer and get documentation to Provider File Specialist
New Practitioner who is approved through Credentialing at PAC (if NEW contract needs to be completed/ implemented)	Need to complete contract process, and gather necessary information for all new practitioners	Average of 1 working week turnaround to get information data entered into Credentialer and get documentation to Provider File Specialist
New practitioner who does not go through Credentialing for COMPANY X	Check to see if practitioner has completed AHS credentialing for one of the other entities. If so, no pif may need to be obtained. If practitioner has not completed AHS credentialing the COMPANY X contractor may request a pif. If not, all necessary information has to be gathered by contracting analyst	Average of 2 to 3 days to get information data entered into Credentialer and get documentation to Provider File Specialist

As Is: Measure of time for changing current provider data

(Time from the provider status change to time info is entered into system)

Category	Type of Data Change	What needs to be completed	Average time it takes to be completed in Credentialer
Practitioner	Change/correction to practitioner name (first, last, mid. Init.)	Validate change and document /enter change into Credentialer	1 to 2 business days
Practitioner	Change in practitioner contract (term with one contract, become active with another existing contract)	Gather and distribute supporting documentation and enter change(s) as appropriate into Credentialer	1 day to 1 week
Practitioner	Change in practitioner contract (term with one contract, become active under a brand NEW contract)	Complete necessary paper work, distribute information, enter information into Credentialer	1 day to 1 week
Practitioner	Change in office location (moving from one location to another)	Investigate change and enter as appropriate	1 day to 1 week
Office Master	Change in office location information (phone #, fax #)	Investigate change and enter as appropriate (is everyone at this location moving or just one individual practitioner, etc.)	1 day to 1 week
Group Master	Change in Group Information (group name, tax id #, location)	Pass information on to Provider Information Analyst to investigate change and enter as appropriate	1 day to 1 week
EIN Master	Change in billing information	Pass information on to Provider Information Analyst to investigate change and enter as appropriate	1 day to 1 week

Contracting Analysts' prioritization criteria:

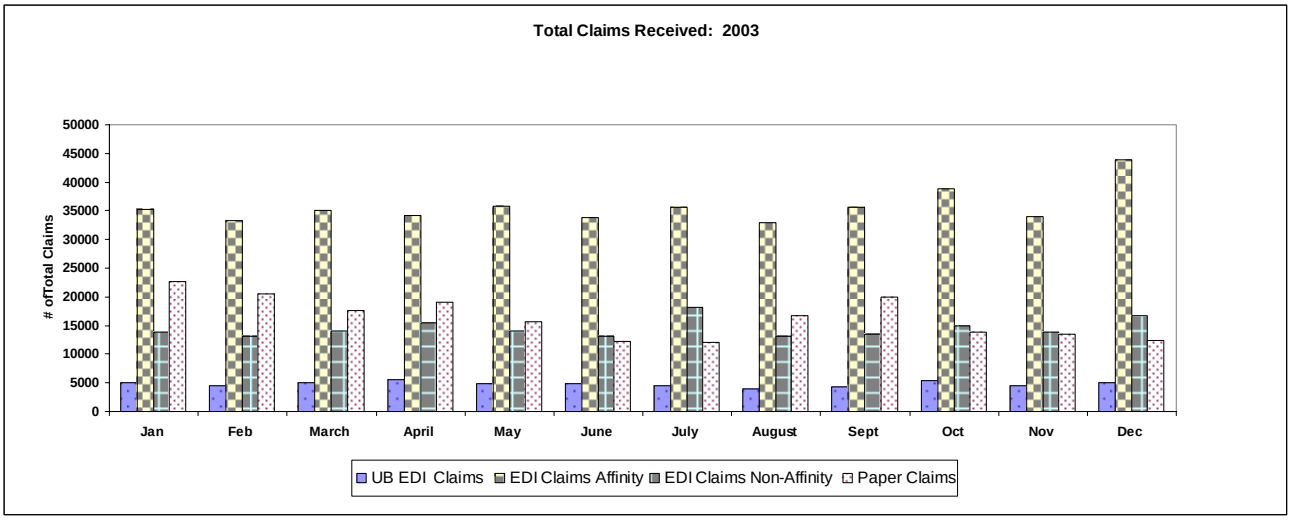
1. Changes for the immediate/local COMPANY X service area get completed first (outlying areas – Milwaukee, Stevens Point, etc. may be delayed depending on workload).
2. Changes for PCPs get completed as soon as possible, then specialists, then mid level practitioners.
3. Changes in fax #s are done as time permits.
4. Changes related to office locations moving in the future (several months out may be delayed depending on workload).

As Is: Denials, Coding Errors, Auto Recuperation, EDI

Measure current % EDI providers and claims

About 80% of claims submitted come via EDI. 98% of the EDI claims are Contracted Providers.

Month (2003)	UB EDI Claims	Paper Claims	EDI Claims: Affinity	EDI Claims: Non-Affinity	Total Claims
Jan	4,959	22,734	35,271	13,840	76,804
Feb	4,519	20,473	33,321	13,103	71,416
March	5,007	17,595	35,105	14,044	71,751
April	5,519	19,079	34,213	15,429	74,240
May	4,870	15,679	35,876	14,006	70,431
June	4,852	12,284	33,756	13,073	63,965
July	4,586	12,126	35,587	18,096	70,395
August	4,020	16,737	32,854	13,152	66,763
Sept	4,376	19,907	35,665	13,419	73,367
Oct	5,430	13,766	38,876	14,949	73,021
Nov	4,467	13,434	33,965	13,819	65,685
Dec	5,114	12,378	43,852	16,785	78,129
Total	**57,719**	**196,192**	**428,341**	**173,715**	**855,967**



Measure current % of electronic payment & supporting documents

AMG is the only provider with electronic payment and remit.

Automated recuperation of payment errors

If there is an error, claims will recoup the money, but there are a few exceptions. In some cases the contract is written not allowing COMPANY X to recoup. Examples: Fond du Lac Regional Clinic, St Agnes Hospital and UW Systems. This is because we are not able to make the correction to the specific claim, causing reconciliation issues on the provider side.

% of Denials due to coding error by providers

Sample of the highest frequency of denial codes (N = 15) over a 6 month period:
7/1/03-12/31/03

Code	Number of Denials
118	796
X codes	684
754, 755, 756	246
Total	**1,726 (annual estimate = 3,452)**

Code	Denial Type
118	Charges billed in error (check debit)
X04	Modifier missing or inconsistent with procedure code
X05	Procedure code is inconsistent with place of service
X06	This procedure code is inconsistent with the patient's age
X07	This procedure is inconsistent with the patient's sex

X08	The procedure code in inconsistent with the patient's age
X09	The diagnosis is inconsistent with the patient's age
X10	The diagnosis is inconsistent with the patient's gender
X11	This diagnosis is inconsistent with the procedure
X12	The diagnosis is inconsistent with the provider type
X13	The date of death precedes the date of service
X14	The date of birth follows the date of service
754	Invalid CPT code submitted
755	Invalid modifier submitted
756	Invalid diagnosis code submitted

To Be: Metrics

Subject	What to Measure	Goal
New provider who is approved through Credentialing at PAC (if existing contract is in place)	Complete and accurate data entry into Y2 by the target date	Average of 1 business day from the time the provider is credentialed (PAC)
New Practitioner who is approved through Credentialing at PAC—with an existing reimbursement methodology	Complete and accurate data entry into Y2 by the target date	Average of 2 business days from the time of contract completion (when it is signed)
New reimbursement methodology	Complete and accurate data entry into Y2 by the target date	Average of 1 month from the time of conception to the time released into production (1 month for testing)
New practitioner who does not go through Credentialing for COMPANY X (is usually discovered after the fact)	Complete and accurate data entry into Y2 by the target date	Average of 1 business day after the facts have been verified
Re-credentialed practitioner with an existing contract (did not fail the credentialing process)	Complete and accurate data entry into Y2 by the target date	Average of 2 business days from the time the Work Team receives it.
Termed providers, groups or contracts	Provider status changes in Y2 (internal notifications only, not including notifications to members) by the target date	Average of 1 business day from the time the notice of change was received

Type of Data Change	What to Measure	Goal
Practitioner/provider records: • Name • Term with one contract, active with another contract • Office location	Complete and accurate data entry into Y2 by the target date	Average of 1 business day (after validation of the change)
Master tables: • Office • Group • EIN • Specialty	Complete and accurate data entry into Y2 by the target date	Average of 1 business day (after validation of the change)

To Be: Metrics

Subject	What to Measure	Goal
Claims that are EDI	Number of EDI transactions vs. total number of transactions.	85% of all transactions received will be EDI.
Electronic payment	Types of remittance	50% of the number of remittance advices for non-AMG providers will be Electronic
Automated recuperation of payment errors (recommendation that Y2 will reconcile to the individual claim at the detail level so that contracts can be re-negotiated)	Rate of recuperation (All contracts will allow recuperation)	100 % auto-recuperation on payment errors
Denials due to coding errors by providers	Provider coding errors.	100 % of the provider coding errors will automatically be denied.

Recommendations for Business Rules

Throughout the remainder of this document you will see codes such as BR 1, BR 2, BR 3, etc. (following “Recommendations”). These codes identify topics or issues where our team sees a need for a “Business Rule” to be established. A complete listing of “Business Rules Needed” can be found at the end of this document, labeled “Appendix A: Business Rules Needed”.

Credentialing

Concerns

- Credentialer and CSC require duplicate data entry, resulting in data inaccuracies. Many steps are manual functions.

Recommendations

- The software systems must have a complementary data structure; intelligent parallel functions are necessary between Y2 and the credentialing software used by the CVO.

- Exchange of data will be according to an established schedule, allowing the system to update automatically.

- Synchronization (similar to Palm Pilots and a computer) will allow the user to identify which data to accept when making changes in data. Flags will occur when same data field is changed in both systems (when data does not match). This cues the user to review and select the correct data.

- System queues will trigger a verification process, allowing the user to verify the changes and/or to back out if the changes are incorrect. (Example: "Do you want to change provider name?").

Provider set-up

Concerns

- Manual processes create inefficiencies and the potential for communication failures and omitted steps. (Example: Demographic data related to providers with prescription writing capabilities is currently provided to Express Scripts (ESI) by manually completing an ESI form and faxing.)

- Duplication of data entry creates a high risk for discrepancies.

- Criteria for data entry may or may not be established between the two systems.

- Multiple departments enter pieces of information into the various data fields, resulting in assorted data entry methodologies for "credentialed" vs. "non credentialed" practitioners/ providers.

- No accountability is in place for the completion of any "record as a whole". The current documented process allows for individual field ownership across multiple departments.

Recommendations

- The system will block the creation of duplicate provider records, permitting a provider to be entered into the system only once.

- Different contracts will be able to be associated with a/any provider.

- Business rules and payment rules will be set-up at the appropriate provider level. Business and payment rules will be documented and maintained. The system will be flexible enough to set up payment rules at the appropriate contract payment level (e.g. Klingbeil, Cheng).

- Y2 will allow global maintenance of data to occur.

- The system will house e-mail addresses at all levels: individual practitioner, group, contract, credentialing, and billing.

- The system will house mailing addresses at all levels: individual practitioner, group, contract, credentialing, and billing.

- A designated mailing address field, separate from the billing and service location addresses, needs to be created.
- Managed Care Contractors and Provider Relations will be included in the distribution of any communication related to provider information.

- Data field entries will trigger a workflow/process. (Examples: specialty field data entry will initiate a taxonomy code process, DEA field data entry will initiate an Express Scripts/Navitus process, new provider data entry will automatically initiate a notification workflow process for appropriate departments.)

BR 1 Data entry standards will be established for provider demographics, system wide. (Examples: hyphenated names, spelling out or abbreviating "Saint".)

BR 2 A single source (team) for entering providers into the system needs to be established for credentialing and contracting.

The following list shows some examples of possible "event triggers" which will initiate a workflow. This listing is not all inclusive!

Event Trigger	Workflow initiated	Sends notification to
Change in practitioner specialty	Specialty	Contracting Credentialing Enrollment/Group Administration Taxonomy
Change in professional title/licensure	Title/Licensure	Contracting Credentialing Taxonomy
Updated certification (Example: An Allied Health Professional who wants to be a PCP)	Certification	Contracting Credentialing Enrollment/Group Administration
Change in federal tax ID number	EIN	Billing Contracting TPA
Change in office location	Office	Billing Contracting Credentialing Provider Relations TPA

Contracting and Type of Agreement

Provider Types

COMPANY X has many business needs that relate to the providers of medical services for COMPANY X members. This table places the providers into categories.

	Provider Type	Specific Provider Types	Example(s)
1	Integrated delivery system	Provider Hospital Organization	Affinity
2	Facility	Hospital Open MRI Skilled Nursing Facility Ambulatory Surgical Center Sub-Acute	Oshkosh Open MRI Ripon Medical Center
3	Practitioner	Professional Chiropractor Anesthesiologist Optometrist	FV anesthesia
4	Ancillary	Home Health DME	WIVA
5	Outsourced	UBH HSM (Center of Excellence) ESI URN MHS MultiPlan	

Reimbursement Types

This table lists types of reimbursement and indicates which provider types are contracted in this manner.

Reimbursement Type	Provider Type				
	1	**2**	**3**	**4**	**5**
Discount off charges	X	X	X	X	
Per diem	X	X		X	
Fixed fee schedule (with or without carve outs) (includes rentals and purchases)	X	X	X	X	
DRGs (with and without outliers	X	X			
APCs (for ambulatory surgical centers)	X	X			
Networks/negotiated contracts					X
Capitation	X		X		X

Case rate	X	X	X		
Global	X	X			X
RUG codes - SNFs	X	X			
Fee for Service *(No #5's in the To Be process)*	X	X	X	X	

General Contracting/ Reimbursement

Concerns

- Contracts are not standardized.
- Some customization has been performed in CSC to follow the specifications of the contract.
- Configuration of contract terms into CSC can be misinterpreted. When errors are discovered concerning the interpretation, costs can be incurred related to analysis, recovery, and/or re-processing of claims.
- Inconsistencies occur in how certain field values are assigned. (Example: Fee indicator field will have case rate assigned to some claims when the lesser of logic is not included in the contract.)
- CSC cannot pay and deny on the same detail line, so detail lines are split into 2 lines: one is paid and one is denied. This can result in skewed data by doubling the quantity and under-representing the billed charges, unless Decision Support cleanses the data.
- Item numbers (primarily for DME claims) are used by CSC in the adjudication process, but are not available for any reporting applications.
- Some contracts are based on Average Wholesale Price (AWP) and are not treated in the same manner as the Medicare Physicians Fee Schedule. The ESI system is not linked to the claim's system for an AWP pricing link.
- Some CPT/HCPCS codes are defined according to the unit of measure/ quantity, resulting in inconsistencies in CSC.
- On UB 92 claims, either the revenue code or the CPT/HCPCS code can be entered, but not both. The present policy is to input the

CPT code, if available. HCPCS has few R codes, so there can be confusion about what the code represents. The other issue was in a data analysis where the detail was requested. This causes errors in reporting because facility contract analysis uses a different methodology than the analysis for professional charges. (Example: Comparing facility detail charges against the Medicare Part B Physician Fee Schedule would be erroneous.)

- Prospective payment methodology may reimburse greater than billed charges which is an issue for plans with deductibles.

- COMPANY X has current contracts, benefit plans and claims processing guidelines that conflict (Example: Anesthesia contract language not in agreement with claims processing guidelines, consumer driven plans in conflict with the existing chiropractor contracted compensation, etc.)

Recommendations

- The degree of customization in Y2 is unknown. Contracting guidelines need to be analyzed to look at ways of increasing contract consistency.

- A process for clearly communicating contract terms to the IS staff needs to be improved.

- The discount that was applied at the time of adjudication will be tracked with an identifier.

- Y2 will allow for payment and denial on the same detail line.

- Y2 will allow for viewing and reporting of the item numbers for DME and other claims.

- Y2 will have a drug file associated with the claims processing system for repricing, and will have look-up and reporting capabilities.

- Contracts, benefit plans and claims processing guidelines will not conflict.

BR 3 Is contracting standardization desirable, and if so, under what circumstances?

BR 4 If a prospective payment exceeds billed charges, will COMPANY X hold the member accountable for the contractual allowed amount in excess of billed charges?

Each reimbursement type will be examined in the following pages.

Discounts

Concerns

- Discount off charges reimbursement is less controlled than other reimbursement types. Measuring the impact is difficult because the provider can change their retail fees at any time.

- The system does not capture the actual discount (Example: 10%, 15%, 20%, etc.) used at the time of adjudication.

Recommendations

- When faced with a discount off charges contract, continue the present process of fixing the discount in the form of a fee schedule for a set period of time.

- The system will allow for the contract terms to be viewable with the dates and an indicator for each detail line, showing how the reimbursement was determined.

Per Diem

Concern

- Establishing a per diem schedule is complex due to the different rate for the different types of hospital stays (NICU, surgical, medical, mental health ICU, etc.) Determining the driving episode is difficult, especially for a lengthy stay. The per diem rate could

exceed the charge amounts in certain situations for ancillary services. This creates a problem for the deductible plans.

Recommendation

- Y2 will have per diem repricing capabilities.

Fixed Fee Schedule

Concerns

- Contracting is sometimes unable to negotiate a contract other then a discount off charges. When possible, Contracting tries to fix their discounted fees into a fixed fee schedule preferably with a CPI escalator clause in an attempt to predict the financial impact going forward.

- Fee schedules can be updated or changed. It may be necessary to pull a contract to try to determine what fee schedule a provider was compensated at in order to determine which fee schedule/reimbursement was administered at the time of a claim.

- Providers can "carve out" highly specialized codes for a different reimbursement amount (Examples: negotiated fee, fee based on a discount off their charges, or a percent of Medicare). The remainder of the contract will usually have a different reimbursement rate, along with a default representing a discount off charges.

- COMPANY X uses a percent of Medicare as a basis for contracts which need to be updated. COMPANY X doesn't have anyone designated to be responsible for Medicare updates.

Recommendations

- An audit trail will document the date and rate of the change.

- Y2 will allow for certain codes or ranges of codes to be carved out and for other reimbursement methodologies in the same contract.

- COMPANY X will establish someone accountable to keep up with Medicare changes and initiate the downloads from the Medicare carriers sites on a timely basis.

BR 5 The fee schedule will be re-calculated for at least a year, based on a discount off charges at the time of contract negotiation or renewal. (Example: Add a Consumer Price Index escalator to the contract that will make adjustments at the time of renewal.)

Diagnosis Related Groups (DRGs)

Concerns

- Consistent criteria for contracts, such as DRGs, are lacking.

- DRG reimbursement is based on an assigned DRG, with an associated weight, and multiplied it by an agreed upon amount ('base rate'). These contracts may contain outlier clauses that will allow different or additional reimbursement for outliers that may be determined by a dollar and/or day threshold. This allows for a provider to receive a higher payment.

- Our present system uses the DRG grouped by the system, which calculates payment using the weight entered in the contract set-up, multiplied by the negotiated base rate. This is essentially converting the reimbursement into a fee schedule.

- DRG payments can exceed the actual billed charges, creating an issue for members with deductible plans.

Recommendations

- The most current Medicare DRG grouper must be installed prior to the beginning of Medicare's fiscal year.

- All outliers will be tied to a day threshold so providers are not rewarded strictly on high cost. Different carve-outs will be

available: DRG based reimbursement for certain types or ranges of DRGs, other reimbursement methodologies and a default discount. The system will continue to automatically group all inpatient claims, regardless of reimbursement, for reporting purposes.

- Y2 will be date sensitive, along with more interactive and automated features for DRG repricing, unless it is in conflict with the contract.

BR 6 Recommendation is for Contracting to define the DRG Grouper (Medicare) and how it will be calculated in the contract. (Example: Rate will be based on the Medicare DRG grouping and weight based on the date of discharge).

Ambulatory Patient Classification (APC) Groups

Concerns

- Reimbursement is not based on APCs or ASCs at this time. Some contracts have had claims processed based on ASCs (Example: Community Health Plan) but they are processed in a manner similar to a fee schedule (procedure code = ASC = $'x').

- If COMPANY X chooses to contract with CMC for any Medicare contracts, we might be required to reimburse using APC reimbursement methodology. This creates consequences for members with deductible plans. This also occurs if the APC groupings are greater than the billed charges. We recommend having the expertise and resources necessary to set up reimbursement prior to contracting with this reimbursement methodology.

Recommendations

- Y2 will have the capability for grouping, repricing and processing according to APC as a way of planning for these contracts in the future.

- The expertise and resources will be available for setting-up reimbursement prior to contracting with this reimbursement methodology.

Resource Utilization Groups (RUGs)

Concern

- RUGs reimbursements are implemented similar to a fee schedule rather than as a true RUGs reimbursement. (Example: RUG provided by the Skilled Nursing Home x negotiated amount for RUG, times the number of days for each RUG). Without "lesser of" wording in the contract, reimbursement could be greater than billed charges. This can become an issue with the deductible plans as well.

Recommendations

- If COMPANY X contracts with CMS for a Medicare contract, COMPANY X might have to reimburse like Medicare and will need the system capability for this type of reimbursement.

Fee for Service

Concerns

- Claims are processed on a fee for service basis for out of plan services, some of which are subject to determined usual and customary fees. The usual and customary amount is now based on a certain percentile of a nationally recognized product (ADP). Based on claims processing guidelines, under certain circumstances, 100% of charges are allowed in order to hold the member harmless.

- It is difficult to project the cost of fee for service types of reimbursement.

Recommendations

- Fee for service contracts are not recommended when looking at costs.

Network/Negotiated Contracts

Concerns

- Transfer of data, reports, mapping of data and timing of the receipt of data and reports are issues with UBH and ESI.

- CSC had limitations regarding transplants (URN) for "all inclusive rates", based on an episode of care (associating facility and professional claims with possibly multiple Tax ID numbers to one contractual payment for specific services and/or a range of time).

Recommendations

- Criteria, including language requiring ESI/UBH to give us sufficient notice if they are going to make changes that would impact the ability to accept and map the data, will be established prior to signing the contracts/service agreements.

- Y2 will have episode of care logic and will associate and facilitate the procedures necessary to capture the negotiated contracts and network deals.

Capitation

Concerns

- Capitation is cost effective if the cost is lower than the utilization, but might not be cost effective if utilization is higher than expected. Currently, there are no capitation contracts.

- Capitation is difficult to measure against other reimbursement methods on a detail basis. However, it does provide the ability to predict costs for the health plan. Variation is based on membership variation.

Recommendations

- Y2 will have the capability for capitation (preferably to a service level), allowing for the opportunity to capitate selected services in the future.

Case Rates

Concerns

- Case rate-type arrangements are made with chiropractors, which pays them a set rate for each member they see, regardless of number of visits for that year. The contracts are written to pay the chiropractor on the 1st visit of the calendar year, which causes issues for plans with deductibles. A business decision was made to pay the chiropractors, in addition to the chiropractors collecting the deductible, and to manipulate the EOB going to the member so that is does not reflect the payment. Will Y2 be able to accommodate this business decision? We recommend verifying system capability to accommodate the present business decision.

Recommendations

- Y2 will be able to accommodate this business decision, as this business decision needs to be continued.

Global Rates

Concerns

- Episode of care logic is lacking in the CSC system. Administration of any global rates requires significant manual interventions.

Recommendations

- Y2 will have logic and the capability to automatically include multiple providers with multiple Tax IDs for global payment.

Special Situation

Concerns

- Anesthesia contracts are based on ASA base units plus time units, multiplied by a negotiated rate. In addition, there is a contract for a flat rate for OB epidurals. The time in minutes is required. CSC does not automatically calculate the time units.

Recommendations

- Y2 will automatically calculate the time units. When a provider uses the surgical codes, Y2 will crosswalk the surgical codes to

the ASA code (a business decision was not to change the codes). Y2 will be able to mix methodologies within one anesthesia claim, as sometimes the claim will have procedures that are not reimbursed on a base plus time basis, but as a surgical procedure.

Delegated Entities
Examples: UW, Express Scripts, Prevea, UBH

Concerns

- Claim services performed at UW cannot be traced back to the appropriate contract (UW-HSM-URN).

- COMPANY X doesn't know which specialty actually performed services; it is possible that UW is providing services for things COMPANY X could provide in this area.

- All claims from UW are processed under the clinic/hospital provider number, rather than individual practitioner number.

- The top UW providers are entered into CSC as individuals for Express Scripts (ESI) pharmacy processing.

- Timeliness of notification of provider information from external entities. Changes and the accuracy of data from delegated parties needs to be addressed. No one holds accountability for ensuring that monthly data files are received from external entities, that the data is in an acceptable format, and that the data files are loaded as appropriate.

Recommendations

- External files will load automatically after passing all edit checks. The system will generate a workflow message if/when errors are encountered. Clear accountability for resolution of data exchange issues will be established.

- Updated external data files received from delegated entities (full files, new records, additions, terminations, etc.) will be entered/uploaded on a regularly scheduled basis.

BR 7 When executing a contract with any delegated entity (e.g. UBH, Prevea, and UW) the contract will contain language related to the expectation of clean data exchange/interfacing capabilities. Data exchange issues will be worked through before a contract is implemented.

BR 8 Standard terminology will be established and enforced to ensure that data received from externals is formatted according to a standard.

BR 9 Are all UW providers to be loaded individually (with claims processed accordingly), or will claims be processed under the clinic/hospital provider number?

Directories

Concern

- Any printed directory is out of date the minute it is printed.

Recommendations

- Flags or switches will identify that a specific practitioner or facility/ ancillary provider is to print in a specific directory (related to product/ contract), at a specific office location, providing specific specialty services.
- Printed directories will be offered once per year.
- Users will be able to search for directory information by using the portal. The search would be by employer group and by product.
- The system will have automated look-up for providers and benefits.
- The user will have the ability to print his or her directory.

Br 10 A governing group needs to be established to review what information goes into each directory and which providers/facilities should/should not be included. The determinations of this group need to be documented and maintained. This entity should also set the standards for directory formatting, and review any request(s) for format changes that deviate from the established standard format for each directory.

BR 11 Regulations (OCI, CMS, or NQCA) related to providing printed directories need to be researched, documented, and updated on an ongoing basis as rules change. Business rules need to be established based on the findings.

BR 12 Indicators will be developed for what to pull for the different directories so that it is automated.

PPO Third Party Administrator (TPA) Data Extracts

Concerns

- The current process requires manual interventions (checking information, compiling information, formatting the data, and sending data to TPAs).

- The feedback provided by the secure email server system is not reliable when indicating if the data transfer was completed.

Recommendations

- The extract of PPO TPA data will be fully automated. Y2 will generate data files on a scheduled basis (monthly, weekly, etc., as determined).

- TPA will only access the data that is appropriate for the particular contracted employer group/contract.

- The output format will be automated so that the end-user can select to receive their preferred format (such as an Excel file or text file).

- A secure email server will inform when there is a data transfer error, such as incomplete data transfer.

- TPAs will have access to real time data via the website. E-mail notices will be generated at least monthly to remind the TPAs of the updates to the system.

BR 13 COMPANY X will expand to become a TPA.

Provider Relations

Concerns

- Most of the processes for Provider Relations are manual and documentation is in two systems.

- There is difficulty getting updated information from providers.

Recommendations

- Criteria will be set so that a new contract or new provider triggers a system-generated workflow. This will inform Provider Relations of the initial education needs.

- The security level will be set to allow only Provider Relations staff access to information that is documented about the providers, thereby allowing the staff to document in one location.

- The system will have a tickler file that generates workflows.

- Contracting will receive automatic notification when a contract is due for renewal and so that they can make a determination if the contract should be auto-renewed or be allowed to lapse.

- Provider Relations will receive the next step of the workflow if the provider information needs to be updated.

- Adequate call log codes are needed that accurately describe the different reasons for Provider Relations calls.

BR 14 How often is provider information to be updated?

Updating Provider Information

Concerns

- Information from outside sources lacks a consistent data form and is not always provided in a timely manner.

- Updates to each system do not cascade to the other affected entities and require manual changes for each one.

- Notification of informational changes are a manual process and do not always make it to the effected parties.

- When a termination date is entered into Credentialer, it automatically shows that that the provider is termed, even though the actual date for termination is months later.

Recommendations

- Work queues will be generated for the appropriate person(s).

- Auto-renewals will generate a work queue that will trigger when to check for updated information. (List the providers that Scott and Carole do monthly).

- The portals will allow providers to submit updates to the system.

- Audit trails will automatically track who changed what, when it was changed, and why it was changed. A list of codes needs to be developed so that the user can select the reason from a list, which then can be used for reporting. Having a note pad for entering free text will allow the user to document additional information concerning changes that were made.

- The system will allow for mass updates by group, by tax ID, by data field and by provider (a “refresh all” ability or global replacement). When a contract is termed, associated providers will also be terminated (auto-update).

- Notification of provider data changes will be system generated. The system will be able to generate notification letters and e-mail. The list of people for notification will need to be identified.

- Date of termination needs to match the actual termination date, not the date of entry. The update should not occur until the actual effective date.

BR 15 Securities must be defined concerning who can actually change provider information in the system. Preferably, data will go to a team of people who are responsible for determining the data as valid. The team will determine who has responsibility to update the validated information and data enter into system. The system will provide prompts that will warn the user concerning the data he/she is changing. For example a prompt could show, "You are changing the provider specialty from _____ to _____. Do you what to save this change?"

Event Triggers

Event	Workflow Name	Possible Departments Needing Notification
Change in practitioner specialty	Specialty	Contracting Credentialing Enrollment/Group Admin Taxonomy
Change in professional title/licensure	Title/Licensure	Contracting Credentialing Taxonomy
Updated Certification (e.g. Allied Health Professional who chooses to be a PCP)	Certification	Contracting Credentialing Enrollment/Group Admin

Br 16 The notification process related to changes in provider information needs to be redefined: who needs to be notified, with what information and in what time frame ?

BR 17 Who and what information is to be included in directories?

BR 18 How often is provider information to be updated for directories?

BR 19 When a provider is terminated, when is the change to show up in the directory?

Audits/Testing/Release to Production

Concerns

- There is no audit in the current claims system (CSC), so when changes are made in provider information, there is no way of seeing who made the change and why.

- Errors are found after the fact.

- Limited manual audits are currently in place to validate data that is entered into Credentialer.

- Claim testing is currently done in a creative manner, as CSC does not have a test module. Comparisons and outcomes of proposed changes cannot be run and evaluated.

Recommendations

- Anything that needs to be audited can be audited.

- An auto-generated audit will always be run 90 days after the contract/provider effective date.

- A separate testing environment will be established. Safeguards will be in place so that any testing of the system will not change data in the real system.

- Anything that could be a risk to AHS (anything requiring system manipulation) will be tested and audited before being released into production. (Examples: proposed changes in benefit plans, changes in products, changes in contract reimbursement, and a new reimbursement rate/type.)

- All contracts will be tested by running a claim against it. The proposal is to run a bank of representative claims against the contract to see how they test out. This bank of claims would not be static, but rather would be revised periodically to capture current claims data. In addition to testing against claims, the system will be able to test the contract against a bank of representative providers, allowing for another way to check for bugs in the system.

- For contract proposals, “what if” scenarios will be run to show the effect of contract changes. Running the scenario on existing providers will help show the differences in contract proposals.
- All benefit plans/products will be tested. Any changes made to a plan/product will be tested independent of other changes. Therefore, if more than one change is to be made, test only one at a time.

- Do not release anything to production until there is 100 % accuracy in the test.

Renewals

Concerns

- There is no easy way to monitor what a change in contract will mean financially.
- The annual request is handled manually.

Recommendations

- If there is a non-auto-renew contract change, a financial impact report will automatically be generated. A historic snapshot will be run for a comparison.
- The system will generate the provider fee schedule analysis (standard report).
- In addition, it will generate the facility analysis, which will have drill down capabilities and explanations for any variations.
- Renewal dates will trigger the standard reports.
- Annual requests will be auto-generated.

Reports

Concern

Much of the process is manual, from the requests to running the queries.

Recommendations

- Pulling off reports/queries will be easier.
- The user will be able to generate his/her own reports.
- Templates will be available for customization by the user (user can pick the desired fields from a query.)
- System generated reports will go out on a scheduled basis (triggered by date).

Appendix A: Business Rules Needed

BR 1 Data entry standards will be established for provider demographics, system wide. (Examples: hyphenated names, spelling out or abbreviating "Saint".)

BR 2 A single source (team) for entering providers into the system needs to be established for credentialing and contracting.

BR 3 Is contracting standardization desirable, and if so, under what circumstances?

BR 4 If a prospective payment exceeds billed charges, will COMPANY X hold the member accountable for the contractual allowed amount in excess of billed charges?

BR 5 The fee schedule will be re-calculated for at least a year, based on a discount off charges at the time of contract negotiation or renewal. (Example: Add a Consumer Price Index escalator to the contract that will make adjustments at the time of renewal.)

BR 6 Recommendation is for Contracting to define the DRG Grouper (Medicare) and how it will be calculated in the contract. (Example: Rate will be based on the Medicare DRG grouping and weight based on the date of discharge).

BR 7 When executing a contract with any delegated entity (e.g. UBH, Prevea, and UW) the contract will contain language related to the expectation of clean data exchange/interfacing capabilities. Data exchange issues will be worked through before a contract is implemented.

BR 8 Standard terminology will be established and enforced to ensure that data received from externals is formatted according to a standard.

BR 9 Are all UW providers to be loaded individually (with claims processed accordingly), or will claims be processed under the clinic/hospital provider number?

BR10 A governing group needs to be established to review what information goes into each directory and which providers/facilities should/should not be included. The determinations of this group

need to be documented and maintained. This entity should also set the standards for directory formatting, and review any request(s) for format changes that deviate from the established standard format for each directory.

BR 11 Regulations (OCI, CMS, or NQCA) related to providing printed directories need to be researched, documented, and updated on an ongoing basis as rules change. Business rules need to be established based on the findings.

BR 12 Indicators will be developed for what to pull for the different directories so that it is automated.

BR 13 COMPANY X will expand to become a TPA.

BR 14 How often is provider information to be updated?

BR 15 Securities must be defined concerning who can actually change provider information in the system. Preferably, data will go to a team of people who are responsible for determining the data as valid. The team will determine who has responsibility to update the validated information and data enter into system. The system will provide prompts that will warn the user concerning the data he/she is changing. For example a prompt could show, "You are changing the provider specialty from _____ to _____. Do you what to save this change?"

BR 16 The notification process related to changes in provider information needs to be redefined: who needs to be notified, with what information and in what time frame?

BR 17 Who and what information is to be included in directories?

BR 18 How often is provider information to be updated?

BR 19 When a provider is terminated, when is the change to show up in the directory?

Customer Service Team Charter

The Customer Service Team will work to develop, enhance, and champion all internal and external customer service experiences, including, but not limited to:

> *Members, Providers, Employer Groups, Sponsors, Co-workers, Brokers, and any potential customers in the community we serve.*

Focus on meeting the needs of members/providers utilizing Web Portals. Create efficient processes to increase and maintain member self service.

Areas to include and consider:

- Inquiries on benefit offerings and current coverage
- Inquiries on claims payment status
- Disease management calls or questions
- Questions from members, providers, employers, brokers, staff, and company employees
- Employer reports
- Processes for all COMPANY X product offerings

Metrics:

- Number of first call resolutions
- Self serve adoption rate
    - Customer Service, Claims, Group Administration and Health Management
- Decrease number of provider inquiries
- Decrease number of member inquiries
- Minimize COMPANY X staff inquiries

Need for Workflow/Tasks/Tickler File

Opportunities:

Work queues and functions similar to Tasks will be available in Y2. A tickler file will be used to send a reminder to COMPANY X staff to call a customer back.

Related Flowchart(s):

- After initial call to Customer Service (Page 3)
- Claims inquiry from members or COMPANY X staff (Page 10)
- PPO calls from contracted providers to Provider Relations (Page 24)

Current Issues:

There is not a system reminder to call a customer back when an issue is unresolved on the first call. Today post-it notes and screen prints clutter employee's desks. These reminders can get misplaced and forgotten.

Provider Relations is documenting in Outlook Tasks and CSC which is a duplication of documentation.

Contract/Credentialing Information Available in Y2

Opportunities:

Contract/credentialing status will be available in Y2.

The provider discount will be easily accessed in Y2.

Work queues and functions similar to tasks will be available in Y2. Securities will be set so only appropriate staff would have access to confidential data.

Related Flowchart(s):

PPO calls from contracted providers to Provider Relations (Page 24)
Provider/PPO inquiries from members and providers (Page 21)
Inquiries to Provider Relations from contracted providers about where they are in the credentialing process (Page 25)

- Claims inquiries from members or COMPANY X staff (Page 10)

Current Issues:

Providers call Provider Relations to verify their contract/credentialing status and to check the network in which they are contracted. Provider Relations also receives calls about TPAs not reimbursing correctly.

The staff is using Outlook Tasks to document information in addition to the call logs. The staff has concerns about confidential or sensitive information being accessed by all COMPANY X employees.

Communication of Changes, Updates, and Exceptions

Opportunities:

Updates will be housed in Y2, allowing the user to search by keyword for the document. The user will also be able to list the documents chronologically, as this tool can aid the user in finding the details. Information from newsletters, e-mail, etc. needs to be housed in a central area and archived for future reference. Examples of information that will be logged: changes, updates, and exceptions.

Another suggestion is for a pop-up notification when the user logs on. This will immediately advise the user of an update. By publishing the notifications for everyone to see, rather than by department, the risk of someone missing a critical piece of data is reduced.

Included in the information to be posted is:

Who made the decision/source of the statement
Date the information was originated
Update
Key words for the search function

Related Flowchart(s):

- Changes, updates, exceptions can affect all business practices. Please refer to flowcharts, pages 1-29.

Current Issues:

An e-mail is sent that does not automatically reach all the necessary parties. The information contained in the message needs to be stored permanently, rather than in a binder, e-mail folder, or on a post-it-note. New staff will not have received the message and would not have access to the information. The information is difficult to maintain in a desk procedure, as not all departments use them and update them.

Claims Follow-up Automation

Opportunities:

When in Y2, the user will be able to click on the claims data that needs to be transferred to a work queue in the Claims Department for review.

The CFU will have the ability to be marked as a high priority.

The user will also have the ability to add notes. The CFU will be sent back to Customer Service via the work queue.

Automated CFUs transferred between departments with be tracked and stored for reporting needs.

Related Flowchart(s):

- Coordination of benefits inquiries (Page 9)
- Claims inquiries from members or COMPANY X staff (Page 10)
- Grievance or written complaints/Sr. Plus (Page 29-30)

Current Issues:

The system is manual with paper copies of CFUs being transferred between Customer Service and Claims. Any tracking of where the CFU is and what has been accomplished is manual.

Need for Additional Fields to Capture Responsible Party

Opportunities:

The availability in Y2 to track more than four coordination of benefits (COB) fields. It will allow Customer Service to begin tracking insurance changes, and allow us to be flexible with long term members that have had to make changes in insurance due to change in employment or changes by employers.

Related Flowchart(s):

- Coordination of benefit inquiries (Page 9)

Current Issues:

CSC has a limitation of four COB fields; therefore the system can only track the last four changes the member has had, loosing important history.

Benefit Accumulators

Opportunities:

Clearly document the accumulators associated with a given number, i.e. is the accumulator benefit year (include what the benefit year is), calendar year, is there carry over, lifetime, month, day, etc. and what is the dollar amount.

Document if any exceptions were agreed upon in the sales process, i.e. apply deductible that was met with prior carrier. When the individual member's accumulators are updated there needs to be clear documentation of the credit (dollar amount, where the amount came from and why).

For more details behind an accumulator, the system will provide an additional screen showing which claims are associated with the accumulator, by simply clicking on the accumulator field.

Business decisions need to be made concerning how to handle a plan change during the year and how to handle a change in deductible. The benefit year needs to be clearly defined and illustrated.

Related Flowchart(s):

- Claims inquiries from members of COMPANY X staff (Page 10)

Current Issues:

It is very difficult to identify what claims were processed and applied to an accumulator.

When an employer group changes benefits in the middle of their benefit year it is very difficult to understand what accumulator is most current and in effect.

Current accumulator screen has many defined accumulator periods that are abbreviated and not always clear.

Accumulators do not appear on the accumulator screen until a claim is processed and applied to it.

Viewing Correspondence within Y2 Sent to External Audiences

Opportunities:

In Y2, the ability to script correspondence, track the intended parties, and refer back per member, would ensure the Customer Service Representatives are aware of the issue/situation/concern the member has regarding a mailing they received from a department within COMPANY X.

Related Flowchart(s):

- Coordination of benefits inquiries (Page 9)
- Eligibility inquiry/change from member (Page 12)
- PCP inquiry from member (Page 14)
- Disease Management/Health Management calls (Page 19)
- Case Management questions (reviews) from members, providers, or COMPANY X staff (Page 20)
- Grievance or written complant/Sr. Plus (Page 30)

Current Issues:

CSC does not have a feature to allow viewing of past correspondences. Customer Service Representatives rely on the members' ability to describe the document they have received. If the sending department notified Customer Service these notes are housed in many places, leaving the Rep searching for the documentation to respond appropriately to the caller.

Practitioner / Credentialer / CSC databases

Opportunities:

- Y2 will house information about a provider so that all calls concerning provider data can be answered in Customer Service.
- Updates from Prevea, UW Madison, and UBH will automatically be loaded into Y2.
- The credentialing database will be linked to Y2 to eliminate duplication of data entry.
- A "flagging" system in Y2 will show if a provider is credentialed, or not.
- Data from the credentialing software will be accessible in Y2.
- Lists of discounts, (provider specific) will be viewable.
- AMG/AHS Provider Bios - Link from AHS Intranet to Y2.
- Data for the provider directories will come from Y2.

Related Flowchart(s):

- Benefit questions from members, providers, or COMPANY X staff (Page 5)
- Benefit questions from prospective members (Contracted Group) (Page 6)
- Benefit questions from employer groups (Page 7)
- Benefit questions from prospective groups or brokers (Page 8)
- Claims Inquiries from members or COMPANY X staff (Page 10)
- Calls to CS and CM concerning available providers and facilities (Page 11)
- Disease Management/Health Management Calls (Page 19)
- Provider/PPO Inquiries from members and providers (Page 21)
- UBH Inquiries from members or providers (Page 22)
- ESI request from members or providers (Page 23)
- PPO calls from contract providers to provider relations coordinator (Page 24)
- Inquiries to provider relations from contracted providers about where they are in the credentialing process (Page 25)
- Calls to provider relations from prospective providers asking about participating providers/facilities: requesting to join (including the written request) (Page 26)

Current Issues:

- CSC and Credentialing software require duplicate entry of data, (larger margin for human error).
- Data inaccurate and user needs to check multiple places for desired information.

- Calls referred to Nurse Direct when caller requests detailed information about a provider, (BIO's).
- Providers are "manually" entered into CSC so ESI can access the information.
- A non-contracted provider is only entered for billing purposes.

Integration and Flow of Information Regarding Authorizations

Opportunities:

Authorizations should link to the requirement for the benefit. Y2 will automatically show if an authorization is needed for the benefit and will list the benefit that applies. The user will be able to search for the item by keyword and/or by the CPT code. Other pertinent information, such as the benefit accumulator, will show along with the benefit.

COMPANY X staff will be able to access the information without having to go through Customer Service.

Call could just be transferred to the Care Management Technician without Customer Service having to check which nurse should get the authorization call.

Related Flowchart(s):

- Inquiries concerning if an authorization is on file (members/providers) (Page 16)
- Referral, authorization, and precertification calls from members, prospective members and COMPANY X staff (Page 18)
- Authorizations, referrals, precertifications and concurrent reviews from providers (Page 17)

Current Issues:

There is no reference in CSC showing if an authorization is required. No links exist among authorizations, claims, call logs, etc. Several areas must be checked to find the member's benefits, requirements, and accumulator.

Connectivity and Consistency of Disease Management, Case Management and Quality Improvement Information

Opportunities:

Disease registries, case management information, and contact information should be housed in Y2. In addition, the Case Management screen should show the criteria to be used when assessing whether or not the member is appropriate for case management services. Securities will limit the PHI that can be accessed to what is necessary in order for the user to do their job. At minimum, a flag in the member's file will show that he/she is in the disease management program or is being case managed. The user will be able to identify the assigned nurse. Although there is no nurse individually assigned to members in the quality improvement projects (such as mammography reminder program), there will information regarding who to contact listed in QSCI for these projects.

Related Flowchart(s):

- Case Management questions (reviews) from members, providers, or COMPANY X staff (Page 20)
- Disease Management/Health Management calls (Page 19)

Current Issues:

Customer service has a paucity of information concerning who to contact for Disease Management and Quality Improvement issues.

Case management criteria are currently in a Desk Procedure in the Care Management Department.

Because calls are logged into registries which are not accessible to Customer Service there is a barrier to communication. When pulling up a member in CSC there is not immediate notification that a member is being case managed and who the case manager is. Care management uses different databases for Disease Management, Baby and Me, and Case Management information. Entry of information into CSC does not occur because it would require duplicate entry of information.

Goldmine Address Changes

Opportunities:

Create a link between Goldmine and Y2 updating Senior Plus address changes as they are modified in Y2.

Current Issues:

Today Customer Service sends address changes to Senior Plus using Email. These changes are sent each time a call comes in from a Senior Plus member. The changes are then manually entered into Goldmine.

Call Logs

Opportunities:

All employees are required to document all customer contacts per COMPANY X's plan-wide policy, we have an opportunity to revise and redefine the call types to more accurately reflect current business needs.

All calls entered with a primary and secondary call type to allow an opportunity for automated reporting. Certain call types will prompt for inclusion of information (i.e. claim type will prompt for a date of service, provider and dollar amount).

The call logs will be searchable by call type, date of call, and date of service.

Multiple call types can be assigned to a call log.

Prospective members: A call log will prompt for last name, first name, date of birth, and employer, which can be cross referenced with enrollment, so if a prospective member becomes a member the call log will be attached to the member file.

Related Flowchart(s):

- Call logs (Page 31)

Current Issues:

The call types need to be revised and redefined. All employees are not documenting in call logs as is stated in the company policy. Different departments are using alternative systems for documenting call logs in order to reduce duplication of documentation.

The call logs are not searchable, making it difficult to find a specific call.

Call log reports require a lot of manual intervention to track the actual number of calls received on a specific issue.

Therapy authorizations are entered in the call log for tracking purposes for claims, but no authorizations is needed for the service.

Call logs are listed in the order received, not by the date of service. This again, makes finding a specific call difficult.

Enabling Company-Wide Reporting Functions

Opportunities:

Users will run simple queries and more complex routine processes from Y2 using built in criteria. When more detailed reports are needed from Decision Support, a request must be submitted. User- friendly report requests will available both in a hard copy and on-line.

Related Flowchart(s):

- Request for a report from an employer group (Page 27)

Current Issues:

Users are not able to run their own reports. Routine simple queries are requested from D.S. or I.S. A report request is submitted to D.S. or I.S. The report form is burdensome to many requestors.

Data Validation

Opportunities:

To increase customer service delivery of accurate data, the data entry on the front end needs to be accurate. To accomplish this, a data validation check should be included for all date and numeric fields in the claims, enrollment, and authorization sections of Y2.

Dates should be checked for reasonability. Example: Service Date should never be beyond today's date. End Service Date should never be prior to Start Service Date. Birth Date should never be greater than today's date. Birth Date of a subscriber should calculate to be at least 18 years of age.

Financial fields should have a maximum amount allowed to be entered, which can be overwritten after prompting or warning the person entering the data.

CPT, HCPCS, ICD9 and Revenue codes should be checked against acceptable value list.

Gender specific procedures should be validated against defined criteria.

While discussing customer satisfaction, it was also recommended to build in additional data integrity by adding an auditing department. This department would audit data entry in all areas, including claims, customer service, group admin, provider entry from multiple areas, and reimbursement methodologies.

Current Issues:

Data is found to be inaccurate causing erroneous reporting. If financial data is found to be inaccurate because of reimbursement methodology errors, many hours, days, or months are spent reversing claims. Errors found on the backend usually cost other department many man hours.