King Saud University
College of Business Administration
Department of Health Administration

Executive Master in Health Administration

EHHA 506 – Health Insurance Administration
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HEALTHCARE REIMBURSEMENT

Learning Objectives

- **Describe the processing of an insurance claim.**
- **Explain how patient records and claims processing for new and established patients differ.**
- **Manage the office's insurance finances.**
- **Discuss the life cycle of an insurance claim.**
- **Maintain a medical practice's insurance claim files.**

HEALTHCARE REIMBURSEMENT

HOW HEALTHCARE REIMBURSEMENT WORKS?

- **In most industries, paying for a service or item is straightforward.**
- **You see the price, make the payment, and receive the item or service.**
- **The entire transaction takes a matter of seconds.**
- **Healthcare reimbursement is far more complex.**
- **The biggest difference between healthcare and other industries is that providers are paid after services are rendered.**

HEALTHCARE REIMBURSEMENT

HOW HEALTHCARE REIMBURSEMENT WORKS?

- **Healthcare reimbursement is often a month's long process that requires multiple steps, each of which can go wrong at any moment, further delaying payment to the provider and potentially saddling patients with bills they don't understand and therefore don't pay.**
- **Ultimately, healthcare reimbursement in full isn't even a guarantee.**

HEALTHCARE REIMBURSEMENT

HOW HEALTHCARE REIMBURSEMENT WORKS?

- **Some providers—mostly independent physicians—avoid the complex maze of healthcare reimbursement altogether by simply choosing not to accept insurance.**
- **Instead, they bill patients directly and avoid the administrative burden of submitting claims and appealing denials.**
- **Still, many providers can't afford to do this.**

HEALTHCARE REIMBURSEMENT

HOW HEALTHCARE REIMBURSEMENT WORKS?

- **Participating on multiple insurance panels means providers have access to a wider pool of potential patients, many of whom benefit from low-cost healthcare coverage under health insurance.**
- **More potential patients equal more potential healthcare reimbursement.**

HEALTHCARE REIMBURSEMENT

Processing an Insurance Claim

- **The processing of an insurance claim is initiated when the patient contacts a healthcare provider's office and schedules an appointment.**
- **The interview and check-in procedure for a patient who is new to the provider's practice is more extensive than for a returning patient.**

HEALTHCARE REIMBURSEMENT

Processing an Insurance Claim

- **The purpose of the new patient interview and check-in procedure is to obtain information, schedule the patient for an appointment, and generate a patient record.**
- **Basic office policies and procedures (e.g., copayments must be paid at the time of visit) should also be explained to each new patient.**

HEALTHCARE REIMBURSEMENT

Processing an Insurance Claim

- **For established patients, it is important to ask all returning patients if there have been any changes in their name, address, phone number, employer, or insurance plan.**
- **If the answer is yes, a new registration form should be completed, and the computerized patient database should be updated.**

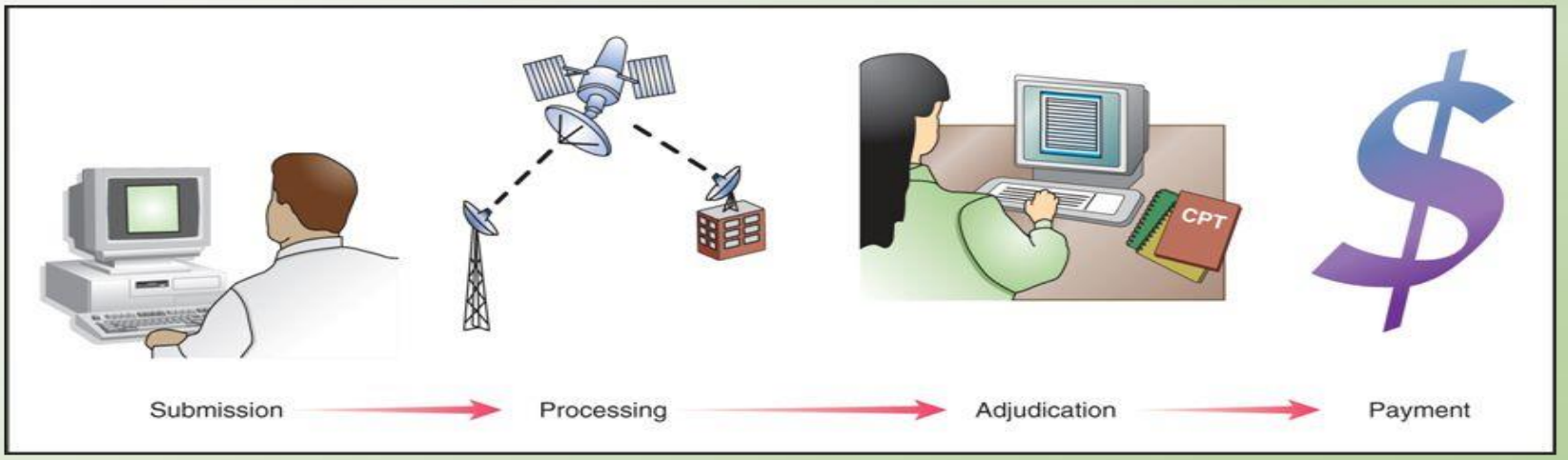
HEALTHCARE REIMBURSEMENT

Processing an Insurance Claim

The life cycle of a claim includes four stages (Figure 4-1):

- **Claims submission.**
- **Claims processing.**
- **Claims adjudication.**
- **Payment**

Figure 4-1 The life cycle of a claim includes four stages



HEALTHCARE REIMBURSEMENT

Processing an Insurance Claim

- **For claims assigned a "pending status" by the payer, the provider can respond by correcting errors and omissions on the claim and resubmitting for reconsideration.**
- **When the claim is denied (or rejected), the provider can appeal the payer's decision and resubmit the claim for reconsideration, attaching supporting documentation to justify procedures or services provided.**

HEALTHCARE REIMBURSEMENT

Processing an Insurance Claim

Claims submission

- **The life cycle of an insurance claim begins in the provider's office when the health insurance specialist completes the claim form using medical management software.**
- **Claims submission is the electronic or manual transmission of claims data to payers or clearinghouses for processing.**

HEALTHCARE REIMBURSEMENT

Claims submission

- **A healthcare clearinghouse is essentially the middleman between the healthcare providers and the insurance payers.**
- **A clearinghouse checks the medical claims for errors, ensuring the claims can get correctly processed by the payer.**
- **Once clean claims are established, the claims and any associated medical records are sent electronically to all appropriate medical organizations.**

HEALTHCARE REIMBURSEMENT

Claims submission

Why Use a Medical Billing Clearinghouse?

- **Efficient claim submission** involves many steps starting with the hospital that prepares a claim for services.
- **In order to maximize revenue**, it is necessary to optimize the claims process and the revenue cycle continuum.
- **This involves analyzing** the claims and billing process for possible improvements.

HEALTHCARE REIMBURSEMENT

Claims submission

Why Use a Medical Billing Clearinghouse?

- **Error checking or claim "scrubbing" is one of the primary functions of an electronic claims' clearinghouse.**
- **This allows a provider to quickly check if a claim will pass the basic requirements to be accepted by an insurance company.**
- **Insurance-specific error scrubbing decreases the time needed to successfully process a claim from days or weeks to seconds or minutes.**

HEALTHCARE REIMBURSEMENT

Claims submission

Why Use a Medical Billing Clearinghouse?

- **The clearinghouse also checks to make sure that the procedural and diagnosis codes being submitted are valid and that each procedure code is appropriate for the diagnosis code submitted with it.**
- **The claim scrubbing edit helps prevent time-consuming processing errors.**

HEALTHCARE REIMBURSEMENT

Claims submission

Why Use a Medical Billing Clearinghouse?

- **Providers, especially smaller ones, don't have the knowledgeable staff or resources to match this third-party scrubbing efficiency for each insurance type.**
- **Larger electronic medical billing clearinghouses have established relationships with multiple insurance payers by ensuring software compatibility and learning their systems over long periods of time.**
- **This can help the medical clearinghouse companies explain rejections to providers and offer guidance to meet the insurance company claim expectations.**

HEALTHCARE REIMBURSEMENT

Claims submission

- **Clearinghouses use secure networks to receive and remit electronic transactions that flow among payers, providers, and employees. A value-added network (VAN) is a clearinghouse that involves value-added vendors, such as banks, in the processing of claims.**
- **Using a VAN is more efficient and less expensive for providers than managing their own systems to send and receive transactions directly from numerous entities.**

HEALTHCARE REIMBURSEMENT

Claims Processing

- **Claims processing involves sorting claims upon submission to collect and verify information about the patient and provider.**
- **Clearinghouses and payers use software to automate the scanning and imaging functions associated with claims processing.**
- **Scanning technology "reads" the information reported on the claim and converts it to an image so that claims examiners can analyze, edit, and validate the data.**

HEALTHCARE REIMBURSEMENT

Claims Processing

- **A medical claims processor is someone who has a working knowledge of medical billing and coding.**
- **He should be knowledgeable with Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) coding systems.**
- **A medical claims processor is responsible for the accurate and timely adjudication of medical claims and can process claims using Windows based software.**

HEALTHCARE REIMBURSEMENT

Claims Processing

- **A medical claims processor should be knowledgeable about processing of claim forms and adjudication for allocation of deductibles and co-pays, co-insurance maximums and provider reimbursements are the main responsibilities of a medical claims' processor.**
- **In addition, she follows adjudication policies and procedures to ensure proper payment of claims.**

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Claims Adjudication

- **After the claim has been validated by the payer's claims examiner, it undergoes the claims adjudication process (Figure 4-15), in which the claim is compared to payer edits and the patient's health plan benefits to verify that the**
  - **Required information is available to process the claim.**
  - **Claim is not a duplicate.**
  - **Payer rules and procedures have been followed.**
  - **Procedures performed or services provided are covered benefits.**

Figure 4-15 the claims adjudication process

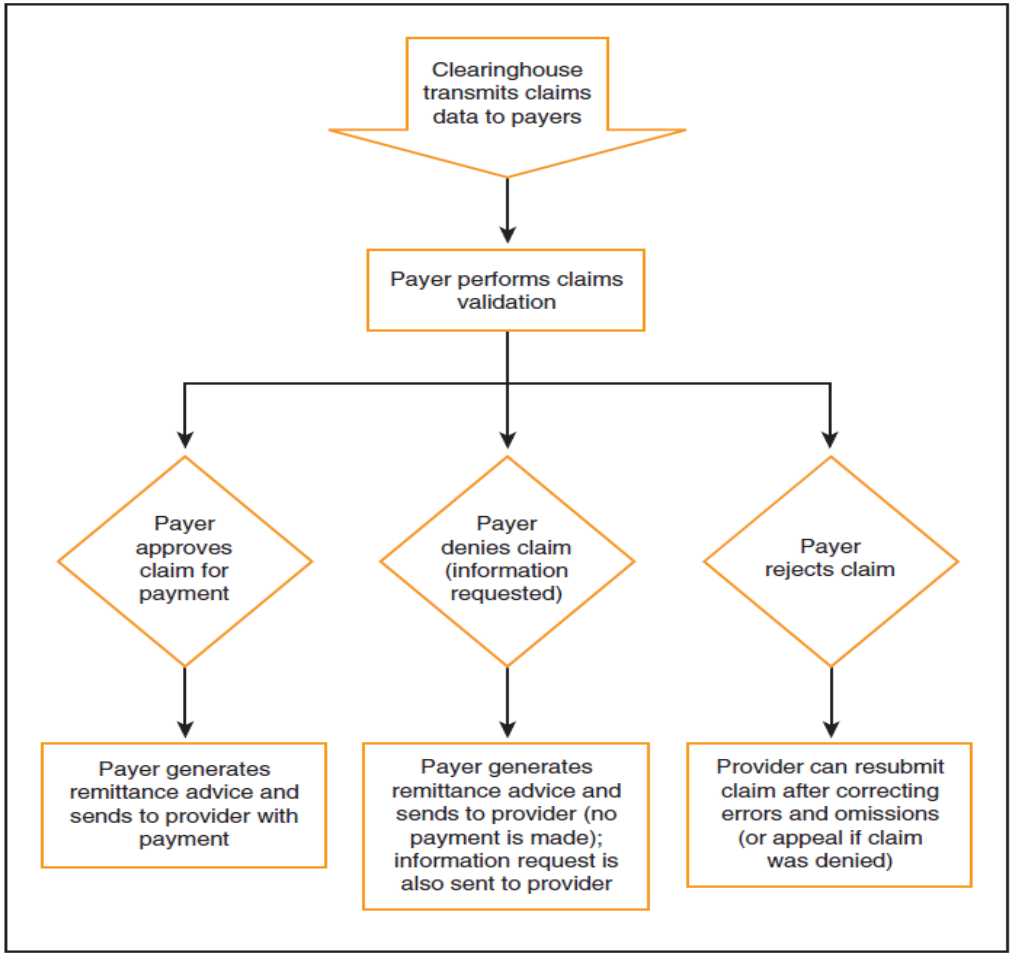

FIGURE 4-15 Claims adjudication and payment (Courtesy Delmar/Cengage Learning)

HEALTHCARE REIMBURSEMENT

Claims Adjudication

- **Medical claims adjudication refers to the determination of the payer's responsibility with respect to the member's benefits and provider payment arrangement.**
- **The insurance company has a few actions it can take – they either pay the full amount of the claim, deny the claim, or reduce the amount that is paid to the provider per contractual rates.**

HEALTHCARE REIMBURSEMENT

Claims Adjudication

- **During an adjudication of claims, the insurer will determine whether a particular demand for compensation falls within the coverage of the individual's insurance policy.**
- **The adjudication of a claim may involve several steps, beginning with the insured's initial filing of a claim and concluding with a determination by the insurer of the amount that will be paid or a denial of the claim.**

HEALTHCARE REIMBURSEMENT

Claims Adjudication

- **The payer analyzes each claim for patient and policy identification and compares data with its computerized database.**
- **Claims are automatically rejected if the patient and subscriber names do not match exactly with names in the computerized database.**
- **Use of nicknames or typographical errors on claims will cause rejection and return, or delay in reimbursement to the provider, because the claim cannot be matched.**

HEALTHCARE REIMBURSEMENT

Claims Adjudication

- **Procedure and service codes reported on the claim are compared with the policy's master benefit list to determine if they are covered.**
- **Any procedure or service reported on the claim that is not included on the master benefit list is a noncovered benefit and will result in denial (rejection) of the claim.**
- **This means that the patient's insurance plan will not reimburse the provider for having performed those procedures or services.**

HEALTHCARE REIMBURSEMENT

Claims Adjudication

- **Procedures and services provided to a patient without proper authorization from the payer, or that were not covered by a current authorization, are unauthorized services.**
- **This means that the payer requires the provider to obtain preauthorization before performing certain procedures and services, and because it was not obtained, the claim is denied (rejected).**

HEALTHCARE REIMBURSEMENT

Claims Attachments

- **A claims attachment is a set of supporting documentation or information associated with a healthcare claim or patient encounter.**
- **Claims attachment information can be found in the remarks or notes fields of an electronic claim or paper-based claim forms.**
- **Claims attachments are used for:**
  - **Medical evaluation for payment.**
  - **Past payment audit or review.**
  - **Quality control to ensure access to care and quality of care.**

HEALTHCARE REIMBURSEMENT

Payment of Claims

- **Once the adjudication process has been finalized, the claim is either denied or approved for payment.**
- **A remittance advice is sent to the provider, and an explanation of benefits (EOB) is mailed to the policyholder and/or patient.**
- **A remittance advice submitted to the provider electronically is called an electronic remittance advice (ERA).**
- **It contains the same information as a paper-based remittance advice, but the provider receives ERAs more quickly.**

HEALTHCARE REIMBURSEMENT

Payment of Claims

- **Remittance advice is the information a payer sends along with payments and/or claim denials.**
- **Essentially, it's an accounting of the amount billed, the amount disallowed (if any), any copayments, coinsurance or deductible amounts and reserves, as well as the amount reimbursed.**
- **It also contains codes that communicate details about the numbers covered in the report.**

HEALTHCARE REIMBURSEMENT

Payment of Claims

- **Providers use remittance advice information to process payments and adjustments to patient accounts.**
- **The remittance advice should be reviewed to make sure there are no processing errors (e.g., code changes, denial of benefits, and so on).**
- **Patients should review EOBs to find out whether claims were paid; if denied, the patient should contact the provider's office to determine whether the claim was resubmitted, requested information was sent to the payer, and so on.**

HEALTHCARE REIMBURSEMENT

Payment of Claims

- **After reviewing the remittance advice and posting payments and adjustments, any code changes, denials, and partial payments should be followed up on.**
- **The payer may need additional information to make a determination about a claim, and prompt compliance with such requests will expedite payment.**

HEALTHCARE REIMBURSEMENT

Payment of Claims

- **It is common for payers to include multiple patients on one remittance advice and to send the provider one check for multiple claims.**
- **Providers also have the option of arranging for electronic funds transfer (EFT), which means that payers deposit funds to the provider's account electronically.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

- **The services of medical insurance are basically established upon the nature of the relationship between the insurance company and medical providers.**
- **Tawuniya's commitment to pay full reimbursement of the medical expenses provided to the insured is positively reflected on the provider's interaction with our customers.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

- **In addition, Tawuniya uses Waseel system to link with medical providers and as to accomplish a record time of fast handling, processing, and reimbursing the providers' claims.**
- **The medical claim unit also undertakes reimbursing the customers for their prepaid medical expenses of treatment received in non-appointed providers in emergency cases.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Things to know before you submit a claim:

1. **All tests for sight and hearing correction and audiovisual aids, unless ordered by a licensed physician.**
2. **Any medical expenses related to Kidney dialysis.**
3. **All services and treatments related to dental implants or prosthesis or orthodontics or bridges fixed or moving, except occasioned by violent external means.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Things to know before you submit a claim:

4. **Devices, medicines, procedures and/or hormone treatment related to birth control, contraception or conception, sterility, impotency or infertility, and in- Vitro fertilization or any other artificial insemination procedures.**
5. **General health examinations, vaccinations, drugs or prophylactics which are not required for medical treatment of an ailment provided for herein (excluding the preventive measures specified by the Ministry of Health such as vaccinations, maternity care and childcare)**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

- **The medical insurance claims comprise the procedures adopted for the payment of medical expenses against the medical treatment to the Assured Person and the beneficiaries whether at the approved medical providers or non-approved medical providers.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Medical treatment at the approved medical providers (direct billing):

- **If the Assured Person or beneficiary is provided with the required medical treatment, the medical expenses are directly billed by the medical provider at Tawuniya's account.**
- **The beneficiary will only pay to the medical provider the deductible or expenses of medical services not included in the insurance cover or those in excess of the benefit limit.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Medical treatment at the approved medical providers (direct billing):

- **Tawuniya uses the electronic linking system with the medical provider (Waseel) to ensure the instant submitting and settlement of medical claims in accordance with the policy conditions and terms of contract between the two parties and in the manner that satisfies the obligations of both parties to provide the premier service to the customers.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Medical treatment at the non-approved medical providers (reimbursement of medical expenses:

- **In case of medical emergencies, non-availability of treatment at the approved medical provider or the emergency cases outside KSA whilst on vacation and business trips if covered by the policy, the Assured Person or beneficiary is compelled to visit a non-approved medical provider.**
- **In this case, the Assured Person will pay the full medical expenses in cash to the medical provider then apply to Tawuniya to for reimbursement of medical expenses paid.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Conditions of medical claims

- **The procedures of medical claims are subject to the terms, conditions, limitations, and exclusions of the policy.**
- **The deductible/ co-insurance clause will be applicable to the medical claims in accordance with the percentages stated in the policy. The customer will directly pay the deductible to the approved medical provider.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Conditions of medical claims

- **The reimbursement of medical expenses will be in respect of the cases presented to the company within thirty (30) days from being billed as specified in the policy.**
- **The amount of medical costs and expenses recoverable by the company to the customer for the medical treatment received at the non-approved medical providers are calculated on the basis of prevailing prices at the approved medical providers.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Conditions of medical claims

- **The amount of medical costs and expenses recoverable by the company to the customer for the medical treatment received at the non-approved medical providers outside the KSA are calculated based on prevailing prices at the approved medical providers inside KSA, unless otherwise provided for in the policy.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Conditions of medical claims

- **All necessary documents in support of the claim must be attached with the medical expenses reimbursement form to ensure the instant settlement of the amount payable the customers.**
- **Some healthcare services are subject to prior medical approval clause from the company.**
- **Therefore, the Assured Person shall obtain such prior approval to ensure his/ her right in reimbursement of medical expenses paid.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Conditions of medical claims

- **The cases of illness excluded from insurance cover are not compensated (please refer to the policy).**
- **The amount of medical expenses will not be recoverable if exceeded the maximum limit of cover specified in the table of benefits.**

HEALTHCARE REIMBURSEMENT

Tawuniya Medical Insurance Claims

Documentation in Support of a Claim

- **The medical report detaining the case.**
- **Laboratory results and radiology reports (in case the patient receives their services).**
- **Original invoices and receipts.**
- **A copy of the Medical Identification Card.**
- **A copy of the Exit &Re-entry visa (accompanied with the medical approval of Tawuniya in case of treatment outside the kingdom).**
- **To fill in the medical expenses' reimbursement form, which is electronically available in all branches of the company.**

THANK YOU