Electronic Claim and Member Management for Health Management Office

The Task

To enhance efficiency of the claim processing process and aid in growth plans through increased throughput and scalability.

The Challenges

- To integrate processes related to primary care physician, the HMO and the government funding bodies (CMS / ACHA)
- To comply with regulations on various plans including Medicare, Medicaid, and type of claims ranging from Professional, Institutional, and Dental Claims
- To support various claim submission and processing mechanisms
- To comply with EDI and reporting mechanisms of the various Government agencies involved

The Solution

Binary Spectrum developed a robust platform that automates electronic claims, remittances, member enrollment, eligibility and disenrollment processes for a large HMO.

The following are some of the features of solution:

- Support for multiple integration mechanisms for Vendor interactions
- Compliance checks and acknowledgement generation
- Parsing and Validation mechanisms
- Automated Workflow and Rule Management
- Support for Real-time Messages
- Loads the claims into HMO's database (No claim will be loaded into it, until all errors are fixed).

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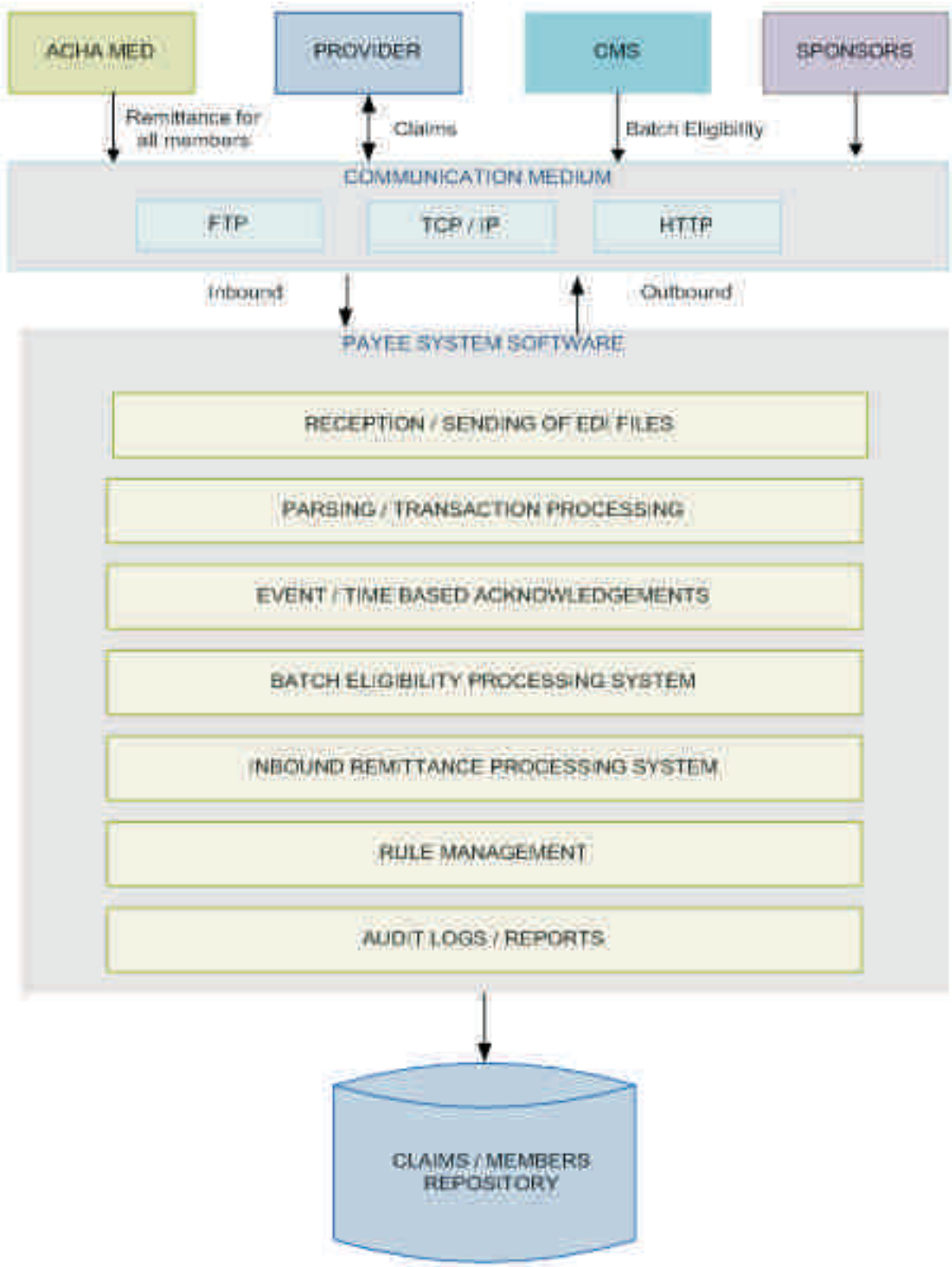

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EDI Messages Supported:

For Batch transactions:

- 837 P/I (professional / institutional) – Electronic Claim files
- 835 – Healthcare electronic Remittance advice request form
- 834 – Enrollment and disenrollment for Medicaid eligibility
- 820 – Electronic response files for premium Payments to insurer

For Real time transactions:

- 271 / 272 – Member eligibility request / response
- 276 / 277 – Claim status request / response
- 278 – Authorization and Referrals

The Result:

The client has scaled up the claims processing capability, and is able to do so in a timely manner while being able to deal with a variety of vendors.