GROUPWARE TECHNOLOGIES, INC.

Provide® Enterprise Care Management Software

SC Health Insurance Premium Reimbursement User Guide

Provide® Enterprise

SC Health Insurance Premium Reimbursement User Guide

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The Health Insurance Premium Reimbursement Billing Module in Provide Enterprise was developed in cooperation with SC ADAP and provider agencies. It includes the following features and process enhancements:

1) Coordinates the timeline for billing for both service providers and SC ADAP
2) Provides claim eligibility alerts to service providers at the point of submission
3) Allows cost-allocation for portions of premiums unable to be reimbursed by SC ADAP
4) Allows service providers to attach information during billing submission
5) Simplifies billing and re-billing SC ADAP for previously rejected claims
6) Provides faster reimbursement from SC ADAP

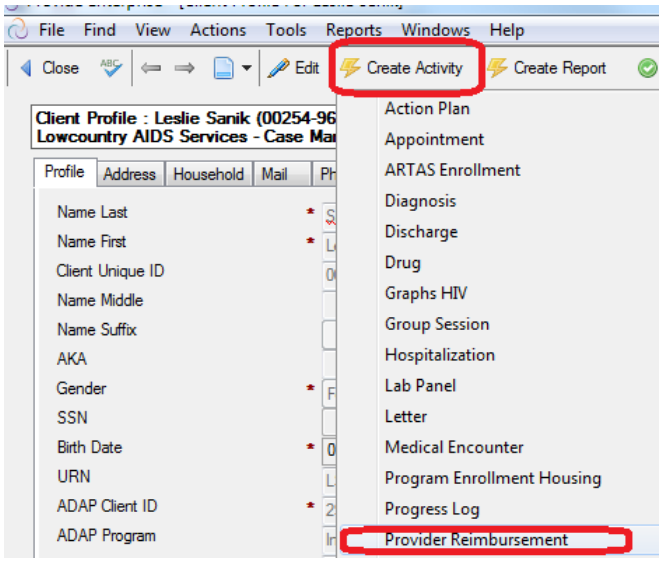
Data entry for the reimbursement process includes creating the "Provider Reimbursement" record at a client level. After all Provider Reimbursement records are entered for a billing period, the "Batch Provider Reimbursement" is created and submitted to SC ADAP for processing. These processes are detailed below.

CREATING A PROVIDER REIMBURSEMENT RECORD

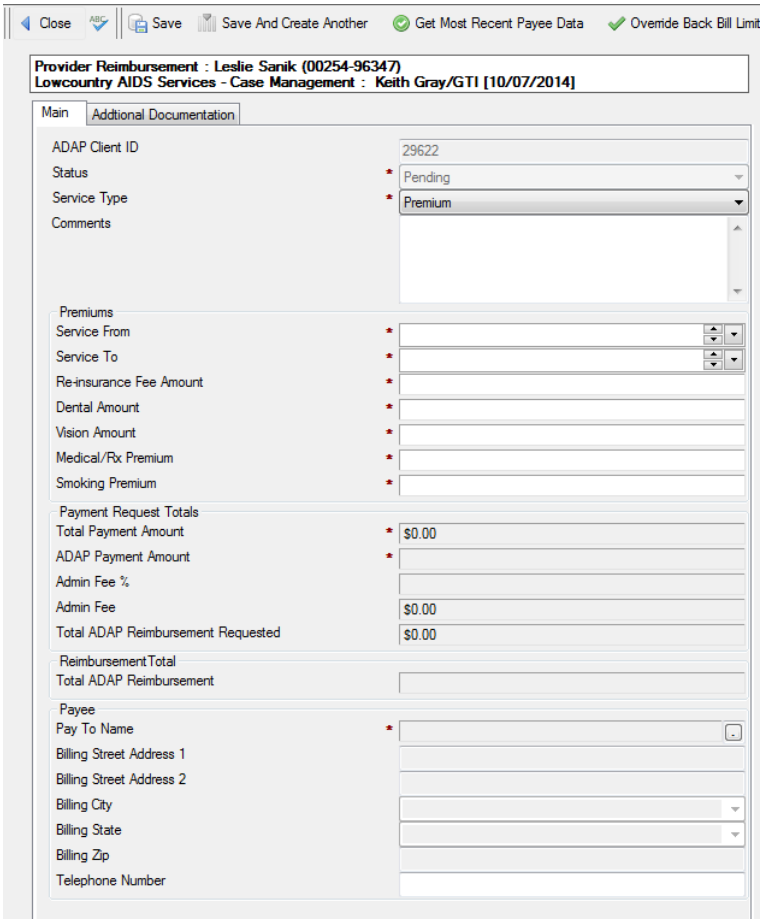
Provider Reimbursement records are used to request reimbursement from the SC ADAP program for Health Insurance Premium payments made by a service provider on behalf of an eligible client.

To create a "Provider Reimbursement", follow the steps below:

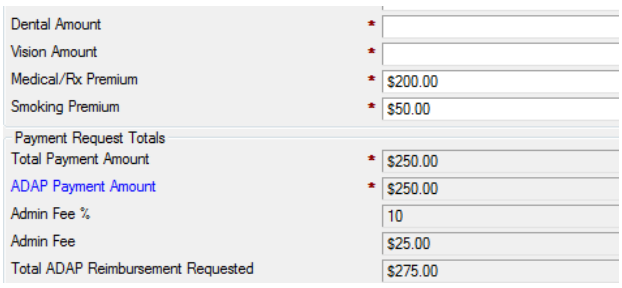
- Navigate to an individual client's profile, either via one of the "Views" of clients, or from the "Find\Client" screen.
- Select Create Activity – Provider Reimbursement



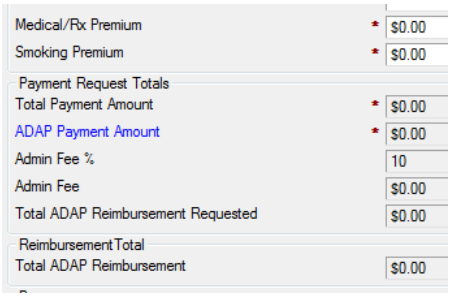
- The Provider Reimbursement record, seen below will open on your screen:



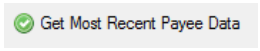
- Fill out the fields as described below:
  - **Comments:** Enter any comments related to the premium reimbursement request.
  - **Service From/Service To:** Enter the dates that the health insurance premium being paid covers.
    - Once entered, the form will retrieve the Prescription and Smoking Premium amounts from the ADAP Status Insurance record which is active in the selected time frame (similar to that in the figure below). The "Payment Request Totals" will be computed (and will change) as the Premium Amounts are computed and additional fields entered.

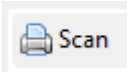


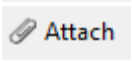
- If an ADAP Status Insurance record is not found, the Premium amounts will default to zero. They can then be entered manually.



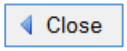
- The following premium amount additions can be manually entered. They will affect the "Payment Request Totals" just below the Premiums and will refresh automatically as data is entered in these fields. NOTE: If a change in Medical/RX Premium or Smoking Premium occurs, the amounts can be modified manually in the applicable fields.
  - **Re-Insurance Fee Amount**: Enter the appropriate re-insurance fee.
  - **Dental Amount:** Document the costs of the dental insurance.
  - **Vision Amount:** Enter the amount of the vision insurance.
- The Payment Request Totals are computed based on the amounts entered in the previous five fields. These are detailed below:
  - **Total Payment Amount**: Computed Total of the following fields:
    - Medical/RX Premium
    - Smoking Premium
    - Re-Insurance Fee Amount
    - Dental Amount
    - Vision Amount
  - **ADAP Payment Amount:** Computed Total of the following fields:
    - Medical/RX Premium
    - Smoking Premium
  - **Admin Fee %**: This percent is defined by SC DHEC and is documented in an ADAP Administrative Rate record.
  - **Admin Fee:** This amount is computed based on the percentage listed in the "Admin Fee %" and the "ADAP Payment Amount".
  - **Total ADAP Reimbursement Requested**: This field is computed by adding the following together:
    - **ADAP Payment Amount**
    - **Admin Fee**
  - **Amount Not Paid by ADAP**: This is computed based on subtracting
    - **ADAP Payment Amount** from
    - **Total Payment Amount**

- **Funding Source of non ADAP Portion:** Select the funding source paying for the non-ADAP potion of the premium.
- **Total ADAP Reimbursement:** Computed – amount to be paid by ADAP (including Admin Fee)
- **Pay To Name:** Select who the reimbursement will be paid to. Address information will fill in as you do so (if the reference databases contain an address for the selection). NOTE: If the client already has a documented "Provider Reimbursement" record, you can use the 

button in the Windows toolbar to copy the Payee information room the most recent "Provider Reimbursement" record into the current record.
- **Attachment Type:** If you are going to attach additional documentation to this record, select whether the attachment will be an image (jpeg or tiff file) or a "File" Attachment (such as a Microsoft Word document or a PDF file).
- **Images/File Attachments:** If attaching an image and you have a compatible scanner directly connected to your computer, use the 

button to scan the document into this record. Otherwise, use the 

button. This will activate a Windows "Open" Dialog box that you can use to select and attach the appropriate image or file to this record.

- After filling out all required documentation for your request, click on 

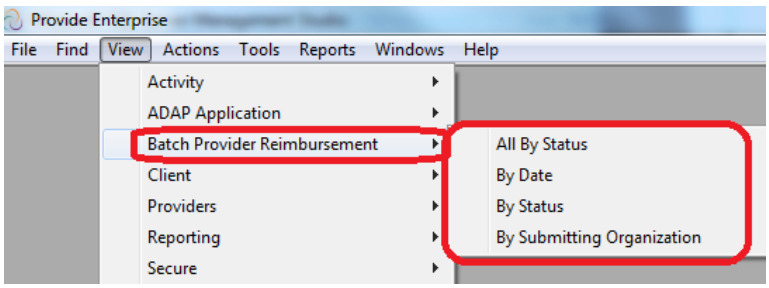
button. When prompted with "Do You Want to Save your Changes?" select the

button. Your request wills save and close, returning you to the screen that you were on when you started creation of the "Provider Reimbursement" record.

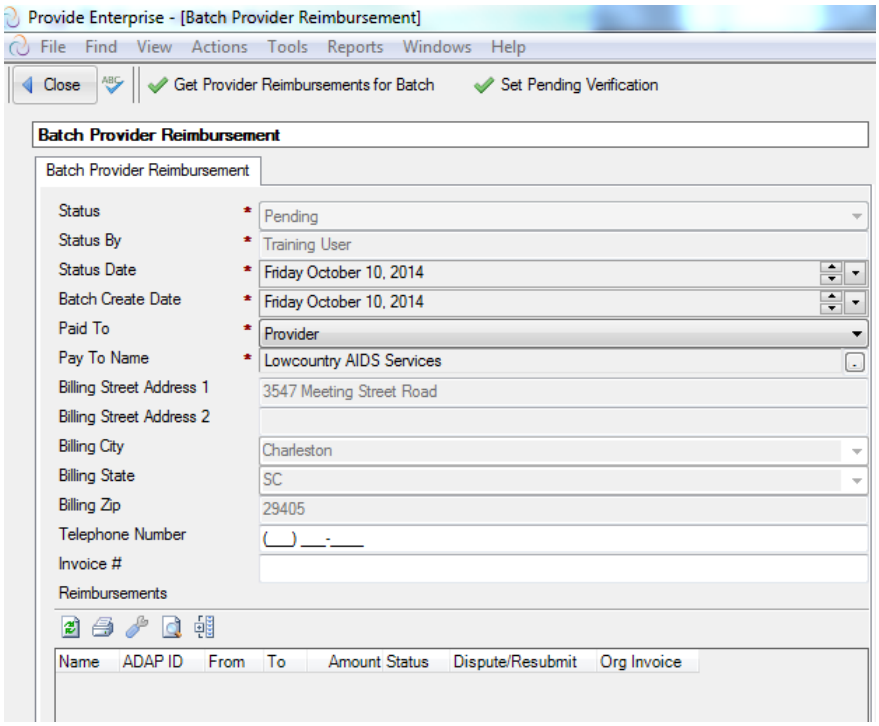
CREATING A BATCH PROVIDER REIMBURSEMENT

Bath Provider Reimbursement records are used once all individual client level documentation has been completed for a billing period. It is used to pull all individual requests into one "batch" that will be validated, processed, and eventually submitted to SC ADAP for payment. To create a "Batch Provider Reimbursement" record, follow these steps.

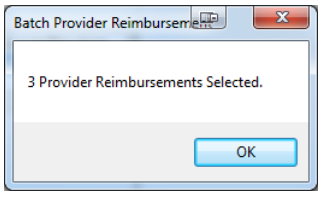
- In the View menu, navigate to one of the Batch Provider Reimbursement views, seen in the figure below.



- Click the Create Batch Provider Reimbursement button to open a Batch Reimbursement, similar to that in the figure below.



- NOTE: The "Pay To Information" defaults to your agency.
- Click the Get Provider Reimbursements for Batch button to select any pending "Provider Reimbursement" records for your agency where the "Service From Date" (in the "Provider Reimbursement" is on or before the "Batch Create Date" of the "Batch Provider Reimbursement" record. A dialog, similar that the in the figure below will appear to inform you of how many requests will be pulled into the batch.

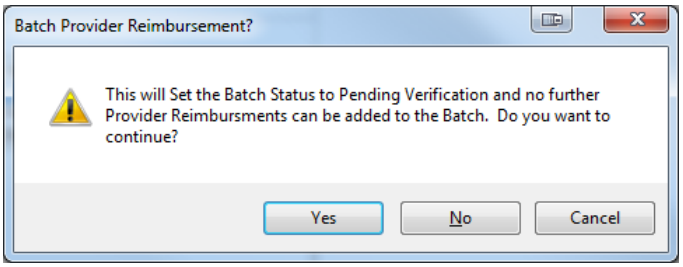


NOTE: Any Dispute or Resubmit Reimbursements from previous Batches will also be pulled into the "Batch Provider Reimbursement".

- The "Invoice #" field will be automatically computed as a sequential number, however, you can edit the value in this field to match your own internal Invoice number if necessary.
- NOTE: The Get Provider Reimbursements for Batch can be used multiple times until the request has been set to "pending verification". If you need to save the "Batch Provider Reimbursement" request prior to submitting it for verification, simply click on Close button. When prompted with

"Do You Want to Save your Changes?" select the Yes button. You can go back into the Batch later and click on the Edit button to make needed changes.

- Once all "Provider Reimbursement" records that you want to submit for payment are included in the "Batch Provider Reimbursement", you can submit the batch for verification. To do this, simply click the Set Pending Verification button. A dialog similar to that in the figure below will appear. To continue, click the Yes button. Clicking the No or Cancel buttons will cancel this function and return you to the Batch Request. NOTE: Once you have done this to the batch, you will no longer be able to add Provider Reimbursements to this request.



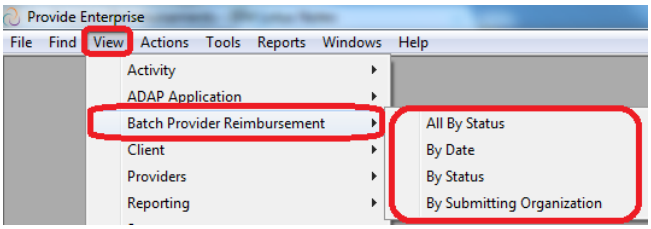
- The Verification and Eligibility Agents will pick up the Batch and process it next time it is run. The Verification and Eligibility Agent will process the Batch, perform a Medicaid Eligibility Check, and perform detailed program validation, based on SC ADAP standards. The validation logic is outlined later in this guide.

- Set Pending Verification – Sets Status of Batch Provider Reimbursement to "Pending Verification". Once set, no other Provider Reimbursement can be added to the batch. Select Clients for Batch (ADAP Only) – Allows ADAP to create Provider Reimbursements for selected Clients.

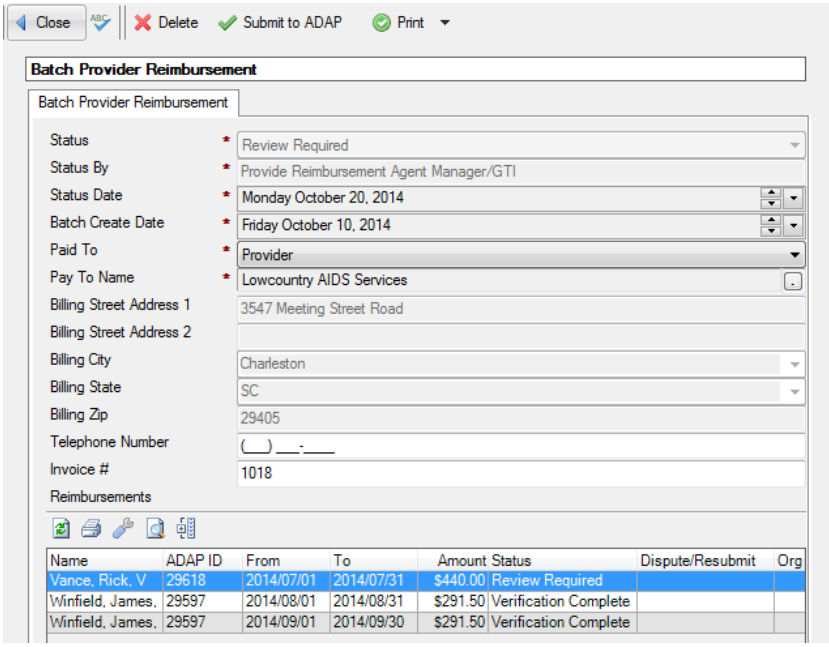
POST VERIFICATION STEPS

After the eligibility and verification process have completed (typically overnight), you will need to review the Provider Reimbursements and address any documents where "Review" is required. To do this, follow the steps below.

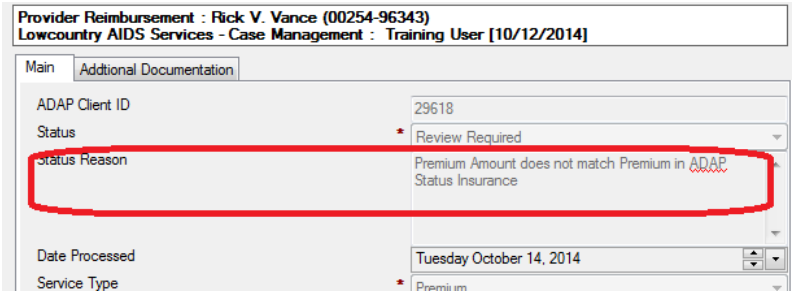
- Navigate to the Batch Provider Reimbursement views (View\Batch Reimbursement\...)



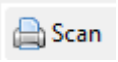
- Double click on the Batch Provider Reimbursement you wish to review. It will open on your screen and you can review the individual provider reimbursement records within the view.



- If you see any Provider Reimbursements in the status of “Review Required”, you must review the individual record before submitting to ADAP.
- Double click on the individual record to review the message as to see the “Status Reason” (similar to that in the example below) and determine what action(s) are required by you prior to submitting the request to SC ADAP.



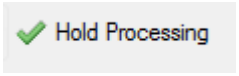
- Click the

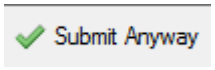
button to bring the document into edit mode so that you can make any needed changes.
- If additional documentation is required, simply navigate to the “Additional Documentation” tab.
- If attaching documentation, select the type of attachment (either “File” or “Image”). If you select “Image” and are directly connected to a TWAIN compatible scanner, you can directly scan documentation into this Provider Reimbursement by clicking the 

button.

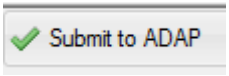
- If you have saved your documentation in a word document or a pdf file, you can use the

button to attach the documents to the Provider Reimbursement.
- After adding in any require documentation, you will have the ability to do any of the following on this individual provider reimbursement record.
    - **Cancel Reimbursement** – Using the

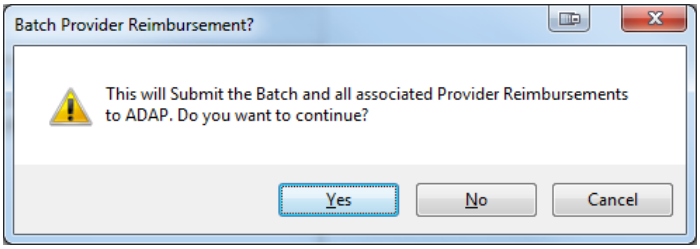
button will remove this reimbursement from the batch and set it so that it will not be picked up by any future Batches. If necessary, you can reverse this by going directly into the Provider Reimbursement and clicking "Reprocess Reimbursement".
    - **Hold Processing** – The 

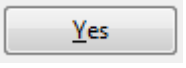
button will remove this provider reimbursement from the batch. This Provider Reimbursement Batch will get picked up by the next Batch created.
    - **Submit Anyway** – If the Status of the Provider Reimbursement is "Review Required", you can elect to use the 

button to submit the Provider Reimbursement to SC ADAP in spite of the reason that review was required of this record. The Status on this record will be "Verification Complete – Review Required".

- After reviewing each of the "Review Required" Provider Reimbursement records, you can submit the Batch to ADAP.
- This is done by clicking the 

button in the Provider Reimbursement record. A message similar to that below will open on your screen.



- Selecting the 

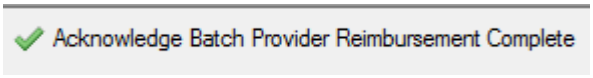
button will send the batch to ADAP and will change the status of the batch and all related Reimbursements to "Submitted to ADAP". If you had not finished reviewing attached Provider Reimbursements that were in a status of "Review Required", he status of the records will be set to "Verification Complete – Review Required", alerting SC ADAP staff that the record needs to be reviewed.
- Once the request is "Submitted to ADAP", processing will move to the SC ADAP staff queue.

PROVIDER STEPS (POST ADAP COMPLETION)

SC DHEC ADAP Staff will complete processing of these requests and will "Complete" the request. Once the batch is completed, your staff can review the request and print associated reports.

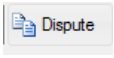
NOTE: Any batches with a message of "Provider Reimbursements, Returned, Rejected, or Adjusted" indicates that ADAP staff has not paid the request as submitted and that the request needs to be reviewed.

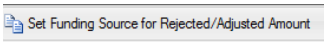
To see these requests, simply navigate to any of the views of Provider Reimbursements (View\Batch Provider Reimbursement\...) and look for the "Complete" requests. Double click on the actual Batch Provider Reimbursement you wish to review.

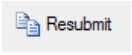
Within these requests, there will be a 

button within the batch. Clicking that button will simply acknowledge that the request has been reviewed.

For each individual line item that was "Rejected" or "Approved for Payment – Adjusted", you can review the request and, if necessary perform the following functions. Double click on the client level provider reimbursement to perform these actions.

- For a "Rejected" or "Approved for Payment – Adjusted" Reimbursement, Providers can –
    - **Dispute** – The 

button will make a copy of the original Provider Reimbursement that will be included in the next Batch. The new Provider Reimbursement will be marked as a "Dispute" record and will contain a link to the original Reimbursement. You will need include additional documentation in this new record. The original Provider Reimbursement will also be flagged as a "Dispute" record.
    - **Set Funding Source for Rejected/Adjusted Amount** – The 

button will allow you to select the appropriate funding source for the remaining Reimbursement amount.
- For a "Returned" Reimbursement, Providers can
    - **Resubmit** – The 

button can be used to make a copy of the Provider Reimbursement that will be included in the next Batch. The new Provider Reimbursement will be marked as a "Resubmit" record and will contain a link to the original Reimbursement. You may need to include additional documentation. The original Provider Reimbursement will also be flagged that it was resubmitted.

At this point, the Batch is complete.

PROVIDER REIMBURSEMENT VALIDATION LOGIC AND ASSOCIATED ERRORS

Below, the validation logic that is used when the system evaluates the Provider Reimbursement is detailed. If the client does not meet the validation for the individual item, an error message is described

and detailed in the "Status Reason" field of the Provider Reimbursement. NOTE: The messages are cumulative meaning that there could be multiple issues for a given Provider Reimbursement.

- **Enrollment Validation:** Provide Enterprise (PE) validates that the Client is in Enrolled in the state Insurance Assistance Program on the "From Date" of the Provider Reimbursement. This is based on the "Continuation Effective Date" in the ADAP Status Insurance record (not the effective date). ***Error Message****:* Active ADAP Status Insurance not found for Service date.

- **ADAP Payment Amount:** For those with a valid enrollment, PE checks that the "ADAP Payment Amount" in the Provider Reimbursement record matches the "Total Premium Amount" in the associated "ADAP Status Insurance" record. ***Error Message****:* Premium Amount does not match Premium in ADAP Status Insurance.

- **Overlapping Enrollment:** PE validates that the "Provider Reimbursement" record is not a duplicate and that the Service From/Service To dates do not overlap another existing "Provider Reimbursement" record. ***Error Message****:* A duplicate or overlapping Provider Reimbursement exists for Service From date.

- **Valid Dates:** PE will verify that the "Service From" date is not more than 12 months in the past. During initial implementation, this is suspended to allow users to back bill. ***Error Message****:* Service From date is outside the 12 month billing window.

- **Adherence Verification:** PE bases adherence on the "Reimbursement" records used by ADAP to document that reimbursement has been made for medication.

    - If there are no ARV's for the client, the compliance check will start from the date the client became eligible for Adherence checking (60 days from Current Enrollment Period effective date) through the Service From Date of the Provider Reimbursement. The days between those dates are the days out of compliance.
    - If ARV's exist, the most recent ARV record with a Date Filled in or before the Service From MONTH of the Provider Reimbursement will be used. This is so an ARV Fill in the same month as Service From Date will be used for adherence checks i.e. a 6/5/2014 fill for a 6/1/2014 Service From Date (in the Provider Reimbursement).
    - If the End Date of the ARV is on or after the Service From Date (in the Provider Reimbursement), the Client is Compliant (Including those filled in the same month as the Service From)
    - If the End Date of the ARV is before the Service From Date, compliance is determined using the Adherence Check Logic noted above.
    - Note: The payment is outright rejected and the user will be not be able to submit the Provider Reimbursement if the days out of compliance is > 69 - flagged in the Provider Reimbursement as "According to our records, Client has not had ARV's filled in over 60 days. Reimbursement cannot be submitted". All earlier flags are notifications of potential non-compliance only, the Provider Reimbursement can still be submitted.
    - ***Error Message: 10-39 days out of compliance:*** According to our records, Client has not had ARV's filled in the past 30 days.
    - ***Error Message: 40-69 days out of compliance:*** According to our records, Client has not had ARV's filled in the past 60 days.

- ***Error Message: 69 days out of compliance***: According to our records, Client has not had ARV's filled in over 60 days. Reimbursement cannot be submitted.