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Description	The ***Process Claim*** business process receives original or adjusted claim (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction, assigns an internal control number, and • Determines its submission status, and based on that: o Performs Claims Edits: ✓ Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction. ✓ Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding. o Performs Claims Audits: ✓ Verify against historical information. ✓ Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity. o Suspends claim that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules. o Applies National Correct Coding Initiative (NCCI) Edits. o Applies Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate. o Prices Claims: ✓ Calculate state allowed amount. ✓ Calculate paid amount. **NOTE:** All fee-for-services claim types will go through most of the business process steps but with different business rules associated with the different claim types. Both Centers for Medicaid & Medicaid Services (CMS) and state policy determine business rules for claims edits, audits, and pricing methodologies. State business rules define whether the State Medicaid Agency (SMA) pays, suspends, flags for information, or denies a claim. State business rules define whether an edit is fatal or non-fatal as well. *See Constraints*. **NOTE:** An adjustment to a claim is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment information. **NOTE:** This business process is part of a suite including ***Calculate Spend-down Amount, Submit Electronic Attachment***, and ***Generate Remittance Advice*** business processes.
Trigger Event	Interaction-based Trigger Events:

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	• Receive claim via Accredited Standards Committee (ASC) X12 837 Health Care Claim fee-for-services claims transactions. • Receive Retail Pharmacy Claim Transaction (National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard). Environment-based Trigger Events: • Receive a scanned or direct-data-entered paper claim. • Periodic (e.g., daily, weekly) adjudication/payment cycles is due.
Result	• The SMA adjudicates a claim. • If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to send to submitter via ASC X12 277 Health Care Information Status Notification for requesting additional information. • If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). • If applicable, alert sent to ***Generate Remittance Advice*** business process with payment and/or error report information. • Alert sent to ***Prepare Provider Payment*** business process for payment. • If applicable, alert sent to send to ***Manage TPL Recovery*** business process for third-party insurance. • Alert sent to ***Manage Accounts Receivable Information*** business process with payment information. • Alert sent to ***Manage Accounts Payable Information*** business process with HCBS payment information. • Tracking information as needed for measuring performance and business activity monitoring.
Business Process Steps	**1. START:** Receive claim submission or claim adjustment information. **2.** Perform Fatal Edits: **a.** If electronic claim submission, perform ASC X12N edits for valid syntax and format, identifiers and codes, dates, and other information required for the transaction according to the agreed-upon levels 1-7 stated in the Trading Partner Agreement. **i.** If applicable, alert sent to submitter via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation

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	Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA). **END:** Business process stops. **b.** Validate that claim submission meets filing deadlines based on service dates. **c.** If applicable, reject claim for electronic or paper claim fatal validation errors and send alert to ***Generate Remittance Advice*** business process with error report information. **END:** Business process stops. **3.** Perform Non-Fatal Edits: **a.** Determine claim status as initial, adjustment to a processed claim, or a duplicate submission that is already in the adjudication process, but not yet completed and loaded into payment history (using a unique Patient Account Number). **i.** If applicable, associate the claim adjustment to the original claim submission. **b.** Validate provider information (e.g., provider taxonomy, National Provider Identification (NPI), enrollment status, approved to bill for this service). **c.** Validate member information (e.g., Member's eligibility status on the date of service, apply third-party resources to the claim). **i.** If applicable, alert sent to ***Manage TPL Recovery*** business process for third-party insurance. **d.** Validate member's health benefit covers the service and apply appropriate rules. For example: **i.** Because adult member benefit package does not cover dental services, deny the claim. **ii.** Member is in another health plan that is their primary insurance, and the Medicaid covers the same service. Designate the claim for the Coordination of Benefits (COB) and deny the claim. Under a payer-to-payer business model, the primary payer receives the COB claim. **e.** Validate appropriateness of service codes including correct code set versions, and correct association of services with diagnosis and member demographic and health status. **f.** If provider submits service authorization, referral or treatment plan number, verify the number, member, provider, service, and date(s) of service. **g.** If state-defined business rules identify certain edits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: Suspended Claim below. **4.** Perform Audits: **a.** Check payment history for duplicate processed claim using search key information such as in-house claim number, date of service, provider and member demographics, service, and diagnosis codes.

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	b. If provider did not submit service authorization, referral or treatment plan, and one exists on file, validate number, member, provider, service, and date(s) of service against claims history. **c.** Check Clinical Appropriateness of the services provided based on clinical, case, and disease management protocols. **d.** Perform Prospective Payment Integrity Check. **e.** If state-defined business rules identify certain audits that cause a claim to suspend, and a claim fails for one or more of them, go to Alternate Path: Suspended Claim below. **5.** Validate National Correct Coding Initiative (NCCI) (bundle/unbundle codes). **6.** If applicable, apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC) business rules, as appropriate. **7.** Perform Pricing: **a.** Calculates state allowed payment amount by applying pricing algorithms (e.g., member-specific pricing, DRG, APC). **8.** Check for presence of Coordination of Benefits (COB) claim information. **b.** If COB is present: **i.** Set status to Deny claim. **ii.** Flag and move claim to COB file. **iii.** Send alert to Send Outbound Process with claim adjudication information and claim. **9.** Send alert to ***Generate Remittance Advice*** business process with payment information. **10.** Send alert to ***Manage Accounts Receivable Information*** business process with payment information. **11.** Send alert to ***Manage Accounts Payable Information*** business process with payment information. **12. END:** Send alert to ***Prepare Provider Payment*** business process for payment. Alternate Path: Suspended Claim **1. START:** Claim has an assigned suspended status. **2.** Conduct Internal review **a.** If applicable, reviewer requests further information as an alert sent to requestor via ASC X12 277 Health Care Information Status Notification. **i.** If applicable, receive alert from receiver via ASC X12 TA1 Interchange Acknowledgment, 997 Functional Acknowledgment, 999 Implementation Acknowledgment, and/or the 824 Application Advice transaction(s) per Trading Partner Agreement (TPA).

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	ii. Internal review makes a determination to resolve the edit or audit in question. iii. END: Business process stops. **3.** Provider submits corrected information in response to an error notification. **a.** The claim passes the edit or audit based on additional information submitted in response to a request, such as the ASC X12 277 Health Care Information Status Notification. **NOTE:** The ***Submit Electronic Attachment*** business process generates this request and reviews the response to validate that the additional information submitted is sufficient to pass the edit or audit. **4.** If there is a favorably resolved suspended claim: **a.** Send alert to ***Generate Remittance Advice*** business process with adjudicated claim information. **b.** Go to step 7 of the ***Process Claim*** business process. **c.** **END:** Business process stops. **5.** If provider submits a corrected claim, process it as if it is an original claim. **a.** Go to step 2 of the ***Process Claim*** business process. **b.** **END:** Business process stops. **6.** If there is an unfavorably resolved suspended claim, send alert to ***Generate Remittance Advice*** business process with error report information. These include failures because the additional information requested for a suspended claim is not present, is inadequate or fails to satisfy the edit or audit. **7.** **END:** The SMA resolves the suspended claim. Alternate Path: Third Party Liability Failures **1.** **START:** The SMA identifies a third-party resource. **2.** If a Cost Avoidance for third-party liability exists, reject claim for edit errors. **3.** Send alert to ***Manage TPL Recovery*** business process for third-party insurance recovery. **4.** **END:** Send alert to ***Generate Remittance Advice*** business process with Edit Error Report information.
Shared Data	EDI Translator data store including ASC X12 Implementation Guide Validation Edits for Levels 1 through 7 Claim data store including payment, in-house claim number, and Patient Account Number information Provider data store including performing prospective program integrity (e.g., Healthcare Integrity and Protection Data Bank (HIPDB)) and Medicare/Medicaid sanctions information, provider network, and contract information Member data store including demographics, third-party insurance information, and

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	member-specific pricing Plan data store including health benefit information (e.g., covered services, units, life-time limits, units and funding limits for authorized services, and benefit package-specific rates) Reference data store including filing deadlines, code set, drug formulary, and service code formulary. Additional information includes Diagnosis Related Group (DRG), Ambulatory Payment Classification (APC), and National Correct Coding Initiative (NCCI) information Authorization data store including authorization and treatment plan information Rate setting data store including applicable rates Claims data store including adjudication and payment history information Financial data store including accounts receivable and accounts payable information
Predecessor	**Receive Inbound Transaction** ***Submit Electronic Attachment***
Successor	**Send Outbound Transaction** ***Calculate Spend-down Amount*** ***Generate Remittance Advice*** ***Prepare Provider Payment*** ***Manage Accounts Receivable Information*** ***Manage Accounts Payable Disbursement*** ***Manage TPL Recovery*** ***Submit Electronic Attachment*** ***Manage Data*** ***Manage Performance Measures***
Constraints	All claim types will go through most of the steps within the ***Process Claim*** business process main flow with some variance of business rules and information. Types of claim variances include: Institutional, Professional, Dental, Pharmacy, and Waiver claims, Medicare Crossover and Medicare Part D pharmacy claims, coordination of benefits claims received from payers secondary to Medicaid (e.g., for IHS eligibles), and TPL cost-avoided claims. The business rules will conform to federal and state-specific rules and pricing algorithms. Editing, auditing, and pricing variances could exist on services billed by claim type, provider taxonomy code, service line codes, and the process may require additional information. An adjustment to a claim follows the same business process path except that it requires a link to the previously submitted and processed claim in order to reverse

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	the original claim payment, and associate the original to the adjustment.
Failures	The ***Process Claim*** business process contains a series of potential points of failure. The claim could fail any edit or audit. Business rules define whether one or more edit or audit failures will result in suspending or denying the claim. Fatal Edit Failures: Claim information has fatal edit error. For example: • Claim submitted without all the required information. • Provider files claim after claim filing deadline. Other Edit Failures: Claim information has other errors. For example: • The SMA does not cover the service because not in health benefit, not provided in an approved facility or by an approved provider type. • Service is not appropriate based on member demographics. • Member has TPL coverage.
Performance Measures	• Time to complete the process: e.g., Real Time response = within __ seconds, Batch Response = within __ hour • Accuracy with which edits, audits and pricing algorithms are applied and paid amount is calculated = ___% • Consistency of decisions on suspended claims = ___% • Error rate = __% or less