Oracle Health Insurance Claims Management supports the import, processing, and release of claims for payment. Authorizations can be recorded for the procedures that require permission in advance. Claimed amounts that are a result of an accident can be recovered from third parties.

Claims
Oracle Health Insurance Claims Management can be used to settle claims from healthcare providers and members. Received claim files and claims received via a web service / integration point are imported automatically. Claims received on paper can be entered manually. Claims from healthcare providers that use their own procedure codes can still be imported automatically by means of coding rules. This prevents system malfunction and avoids further manual processing.

When the claim is being processed, the covered amounts and the amounts to be paid out are calculated for each claim line. During this process, the rules recorded for the products and the tariff and provider contracts are taken into account.

During processing, the following types of messages can be displayed:
- Error: These are messages stating that the claim line will not be paid out.
- Warning: These are messages that have no effect on the amount to be paid out, but mean that close attention should be paid during the remainder of the process.
- Forcible error: These are messages that the user can decide to treat as a warning or an error.

Adjudication rules can also be created in Oracle Health Insurance Claims Management. During processing, these rules determine whether claims still require manual ‘screening’. Claims that do not satisfy the defined rules are then processed automatically. It can be determined in the messages whether manual ‘screening’ is required. The advantage of this is that manual intervention is only necessary for claims with specific messages and in special situations.

After the claim has been processed, the claimant receives a specification of the result. This specification can be a file (using a standard record layout), a paper specification, or an announcement on an internet site. The moment at which a claim is paid is determined by the agreements that were recorded in Oracle Health Insurance Claims management provider contracts.

An agreement can be made with healthcare providers to take on a debtor risk. In such
cases, the non-covered part of a claim is still paid to the healthcare provider and a claim against the policyholder is created automatically.

Pre-Authorizations
If permission for procedures is required from the healthcare payer before those procedures are provided, pre-authorizations can be imported or entered manually. A request for a pre-authorization is processed, 'screened' where necessary, and then adjudicated. When claims are being processed, automatic checks are performed to establish whether authorization is required, whether it has been granted, and whether the claim is within the defined limits.

Advance Payments
In Oracle Health Insurance Claims Management, advance payments can be paid automatically for claims that cannot be settled on time. Once advance payments have been made, they are automatically deducted when claims are being settled. Support is also provided for advances on current account and advance payments for healthcare activities.

Third Party Recourse
If claimed healthcare costs are the consequence of an accident, support is provided to recover these costs from third parties. To do this, the member must fill out a questionnaire. The recoverable part of the costs is determined on the basis of the information obtained. This amount is then collected from the insurance company in question. This also applies to any late claims.

Adjustments
If after a claim has been settled it is discovered that errors were made by the claimant or the healthcare payer, the claim can be retrospectively adjusted. The claim then must be released for adjustment. When the adjustment is entered, the original situation is saved. The claims process then automatically calculates the difference compared to the amounts that were originally paid and entered. Adjustments can also be supplied electronically and processed digitally.

Process Control
‘Control figures’ can be selected for process control. They can be used to:
- provide insight into the throughput speed of the processing
- focus on exceptional situations
- check the process from ‘top to bottom’.

Products
Products can be used to compile healthcare insurance products. A product consists of modules for coverage, yearly deductible, and contracted healthcare.
Coverage

Basic and supplementary products are supported. A supplementary product provides the coverage for procedures that are not fully covered in a basic product or includes more extensive coverage.

The rules for coverage are linked to 'coverage groups' consisting of clustered procedures (for example, dental treatments). For the procedures in a coverage group, various rules can be used to determine the scale of the coverage:

- a percentage of the agreed fee
- a maximum fee
- a maximum amount or maximum number for each period (for example, a maximum of three physiotherapy sessions per calendar year).

Coverage rules can be configured in multiple stages. The first five physiotherapy sessions in a calendar year, for example, could have 100% coverage and the following treatment sessions 50% coverage.

Coverage groups can be placed in a hierarchy. The hierarchically higher coverage group can have its own coverage rules. The higher hierarchical coverage group determines the maximum coverage over the total coverage for the lower coverage groups.

The amount of coverage for procedures in a coverage group can vary depending on the age of members, the specific diagnosis, the diagnosis-treatment combination, and data about the claimed procedure (for example, the type of care provider).

Coverage rules can be formulated that specify the first portion of a claimed amount or number is not covered. These are 'thresholds'.

Procedures that do not have 100% coverage mean that members have to pay for the procedures themselves. These payments can again be insured by means of full or partial coverage of the non-covered part in a supplementary product, for example.

Finally, restrictive rules can be applied for coverage:

- the restriction that the prior permission of the healthcare payer is required before a procedure will be provided
- the restriction that a certain time (qualifying period) must have elapsed before the coverage is provided.

Yearly Deductible

Products can be configured so that it is possible to choose a yearly deductible amount. If a member has opted for a yearly deductible, this amount is deducted from the claimed amounts to be paid out. As soon as the sum of claimed amounts to be paid out exceeds the yearly deductible amount, the payment will be made.

If the healthcare provider submits a claim for a member, agreements can be made about the debtor risk. When the healthcare payer takes over the debtor risk, any yearly deductible amount to be deducted can later be recovered from the policyholder.

A yearly deductible is expressed in an amount per calendar or policy year and applies to each member or each policy. Members can be indemnified from the yearly deductible on the basis of their age, or certain procedures can be excluded from the yearly
deductible conditions. It is also possible to have members purchase a mandatory yearly deductible based on the payment of premium.

**Contracted Healthcare**

For a particular product, it is possible to record whether contracts must be entered into with care providers (contracted healthcare) for procedures or groups of procedures (for example, dental treatment). In principle, members who have a policy for a product with contracted healthcare must receive their healthcare from the relevant care providers. For products with contracted healthcare, an adjustment premium can be requested.

A member with a policy for a product with contracted healthcare may be treated by a care provider without a contract. However, in that case discount rules can apply to the fee and therefore to the amount that is covered.

**Provider Contracts**

Provider contracts are agreements with one or more providers registered in Oracle Health Insurance Claims Management that are formally ratified. There are two types of contracts: location contracts and individual contracts.

A location contract may be signed with a practice, (medical) institution, or group practice. Only an individual provider (in the form of a medical institution, practice, or group practice) or medical institution (in the form of a medical institution) may be used as counterparty.

The individual provider contract can only be signed with an individual provider and has a medical institution and/or practice and/or group practice as counterparty.

Within a provider contract, it is possible to register information about:

- payment date
- restricting the scope of a provider contract based on the following:
  - insurance type
  - brand, branded product, or risk-bearing insurance company
  - contracted care
  - claim origin
- counterparties
- fraud check
- counterparties
- flex fields
- individual agreements
- agreed deviations

**Prices**

A price is the cost of a procedure that has been provided. This amount is not connected to the coverage provided by one or more healthcare products. A price is expressed as:

- a fixed amount
- formula calculation (for example, pharmacy services)
- a number of points, each of which has a fixed fee.
In a number of situations, prices are split:

- if multiple healthcare providers claim part of the price – for example, the costs for a specialist and the costs for the hospital
- to make a distinction between the provision of a procedure and any repair or maintenance costs.

A fee is charged for a procedure that has been provided or for a subscription system. Prices can be degressive, which means that the price depends on the extent of the healthcare provided during a certain period. Factors can also be allocated to procedures for calculation of the scale. Surcharges can be allocated to occupational groups (a positive or negative percentage of the price). Rules can also be formulated for payments in relation to a price, expressed in a percentage of the price. In this way, for example, amounts can be transferred to umbrella organizations or pension funds.

**Code Systems**

Code systems support the import and maintenance of code systems for procedure types, procedures and diagnoses, including diagnosis-treatment combinations.

**Procedures**

Standardization of procedure codes facilitates electronic claim traffic. The standardized codes are usually maintained centrally for each country and then imported into code systems.

The procedures can be grouped according to different requirements, which greatly improve efficiency. In the claims process, for example, a request for an authorization can be registered for a group of procedures. These groups can also be used in product compilation or the recording of tariffs and other healthcare agreements.

Checks can be configured for the imported procedures, based on the characteristics of the member receiving healthcare, such as:

- the age category
- the gender
- the age category in combination with the residential area.

Administrative rules can also be drawn up for the imported procedures, for example:

- if recording data on a member is mandatory in connection with claims for the procedure (for example, member data cannot be recorded for claims for nitrogen)
- if the procedure can be claimed twice
- if the claim for the procedure is an indication of possible third party recourse
- when a claimed procedure must result in an agreement with a medical advisor
- a payment scheme.

These rules can also be formulated if the supply of procedures is subject to VAT.
Diagnoses (and Diagnosis-Treatment Combinations)

Code systems for recording diagnoses are supported, which means that the medical reason for a particular procedure can also be recorded. Standardized treatment plans can be used for procedures that require advance permission from the healthcare payer.

In Oracle Health Insurance Claims Management products, the diagnosis can also be made a decisive factor for the coverage of a procedure. For example, this enables provision of 100% coverage for diagnoses of a chronic illness and deviations in other cases.

CONTACT US

For more information about Oracle Insurance, visit oracle.com/insurance or call +1.800.735.6620 to speak to an Oracle representative.

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- Oracle Health Insurance Disbursements and Collections
- Oracle Health Insurance Policy Administration
- Oracle Health Insurance Policy Administration Data Marts
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The following complementary applications are available:
- Oracle Documaker Enterprise Edition
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- Oracle Human Workflow
- Oracle Health Insurance Enterprise Rating
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