



# IM Manager: Medical Claims

**IM Manager: Medical Claims** is a 'workflow' driven claims management system for health insurance companies.

What is workflow? Workflow is concerned with the automation of procedures where documents, information or tasks are passed between participants according to a defined set of rules to achieve, or contribute to, an overall business goal. A Workflow Management System is one that provides procedural automation of a business process by managing the sequence of work activities and invocation of appropriate human and/or IT resources associated with the various activity steps.

Rule-based workflows facilitate more disciplined claims processing with embedded control and tracking of work items in support of the company's business process.

Embedding robust process oriented components within Web-based applications speeds the time-to-market and lowers the cost of ownership.

Role-based processes mean that users only see those tasks that require their involvement.

### IM Solution

Many people notice something special when they see IM Manager. It does not look like any other application found on the web today. It is in fact one of the newest generations of Web applications utilizing the latest java-based technologies. Even though it looks like a normal Windows program, it runs through a web browser and all data and analyses run via the Internet. Because it exists on the Web, the most current version is always available, but it is never installed on the computer. Users can access the application from anywhere – in the office, at home, anywhere where there is a connection to the internet, and the data is always up to date.

### Instant Messaging

Real-time messages can be sent from one user to any other in the system. This is like email, but much faster. Messages can be either very general or associated with a specific project or task.

## The need for a medical claims administration application

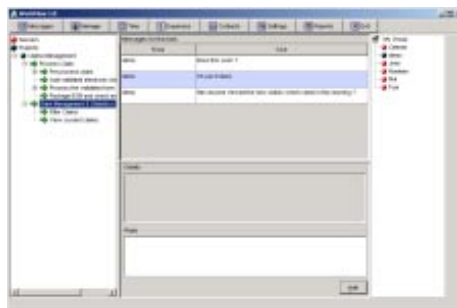
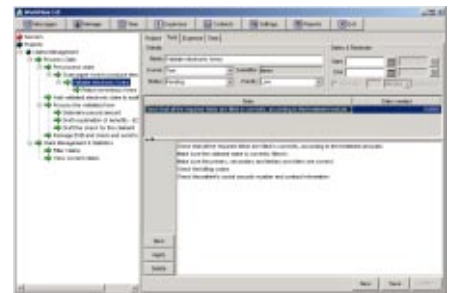
The U.S. healthcare industry generates more data than any other industry. Health insurance companies are inundated with paper work. Even electronic claims initiate a paper file full of unique attachments that need to be interpreted by medical professionals. As claims increase in number and compliance requirements grow, detailing the involved processes is becoming a priority. The industry as a whole is moving towards a more uniform approach, with standardization of transactions and code sets:

- **The Wall Street Journal** – "The U.S. health-insurance industry is stepping up efforts to solve one of the most intractable problems in the war on health costs: the processing of medical claims. Spurred by political and competitive forces, private insurance carriers are aiming to replace the morass of paper choking the nation's healthcare system with the sort of electronic transaction technology used by banks and airlines."
- **US Department of Health and Human Services** - At present, different insurers require different electronic and paper forms from health care providers filing claims. Under the new regulation all electronic claims transactions must follow the single standardized format. Providers will still be allowed to use paper forms, but the simplified process is expected to encourage more electronic filing.

Healthcare organizations are having to conform to the complex provisions of HIPAA (Health Insurance Portability and Accountability ACT) Public Law 104-191, which should simplify processes, bolster security and cut costs over the long run.

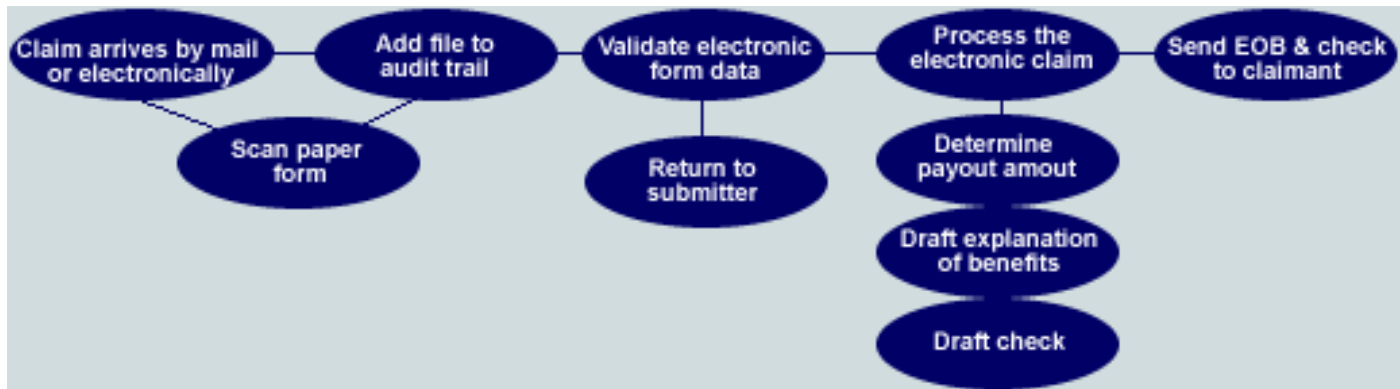
More and more companies are migrating their Claims Processing to the Internet. Today, of the 5 billion annual healthcare claims, approximately 1.75 billion are paper-based, while the rest are EDI-based. These are manual, error-prone, inefficient, and expensive processes. As more companies embrace internet technologies to capture claims, they could also be using its power to enhance their back office processing. Increasing business process efficiency is of utmost importance, allowing a health insurance company to gain a competitive advantage, and thus ultimately an increase in profit margins. There is a competitive advantage for the health insurance when turning to technology for claims processing. Reducing the time taken to process claims will win the attention and participation of both patients and providers.

The image on the right shows how the steps involved in processing a claim are broken down into sub steps, and assigned to specific employees. An individual claim passes through the various steps and it's progress can be monitored by an administrator at any given time. Users typically only see the steps where their input is required. Notification occurs when a claim is awaiting their attention. As healthcare policies change, the processes are changed to match. This image is shown in more detail over page.



Real-time instant messaging between users in the organization means that users of the system can easily send messages to each other. Messages can be generic ones on a session level or related to a specific process. This helps speed the processing of an individual claim, rather than depending on e-mail or other slow methods of communication.

## The claims process



Paper-based or EDI-based (electronic) claims are submitted to the health insurance company directly, or through a clearing house. Within the insurance company, paper-based forms are typically scanned both to create an electronic audit trail, and to aid further processing. Any claims that have errors such as missing billing codes are returned to the provider, and documented so that they can be fixed and resubmitted. Once all processing has been completed for a claim, payments are mailed, along with the Explanation of Benefits (EOBs) to the medical practice, to the billing service, or to a pre-arranged lock box at a local bank. *IM Manager: Medical Claims* is intended initially for use in the back office processing of claims within the insurance company, but it could easily be updated to include the other participants in the whole claims process, including the medical office or hospital, and third party intermediaries such as clearing houses.

The screenshot shows the WorkFlow 1.0 software interface. The main window displays a task list on the left and a task details panel on the right. The task details panel shows the following information:

- Project:** Validate electronic forms
- Owner:** Tom
- Submitter:** demo
- Status:** Pending
- Priority:** Low
- Dates & Reminder:** Start, End, Reminder, Minutes in advance
- Note:** Check that all the required fields are filled in correctly, according to the treatment and plan... (10/5/01)
- Task Description:** Check that all the required fields are filled in correctly, according to the treatment and plan. Make sure the claimant name is correctly filled in. Make sure the primary, secondary and tertiary providers are correct. Check the billing codes. Check the patient's social security number and contact information.

Buttons for 'New', 'Apply', and 'Delete' are visible at the bottom of the task details panel.

Claim processing is performed by passing a particular claim through a series of steps or processes, which are likely to be performed by different individuals, as shown above. Another advantage of using *IM Manager: Medical Claims* is that powerful reports can be generated by the users. These reports can be used to drill down through all of the data that is captured, and allow administrators to see what processes are outstanding, who the responsible parties are, and pinpoint bottlenecks in the business process. Statistical reports aid administrators to effectively manage their business.



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