GlobeMed

Out-Patient Benefits Management

TABLE OF CONTENTS

Out-Patient Benefits Management (OBM)

01. Introduction

02. Product Configuration

02. Members' Administration

03. Network Management

04. Online Eligibility / Automated Prior Authorization / Claims Submission / Adjudication

05. Advanced Expert System

    05. Medical Rules
    07. Dental Rules
    09. Coding Rules

10. Analytics, Business Intelligence & Reporting

GlobeMed

GlobeMed's Out-Patient Benefits Management (OBM) solution combines state-of-the-art IT platform, industry know-how and best practices to effectively manage payers' out-patient benefits plans and improve members' experience, while controlling costs. Our OBM can be integrated within GlobeMed's full TPA services or offered as a standalone solution based on a Software as a Service (SaaS) model.

Out-patient care covers a wide range of medical services and procedures conducted on an out-patient basis in hospitals, clinics, diagnostic centers, dental clinics, optical centers, etc. Out-patient procedures include lab tests, radiology, physiotherapy, doctor consultations, optical and dental services and much more.

PRODUCT CONFIGURATION

GlobeMed's OBM solution gives you the flexibility to design your own out-patient benefits plans, and offers the versatility to accommodate any combination of benefits, conditions, and restrictions to optimize the financial performance of your plans; these include limitations, co-payments, coinsurance, waiting period, restricted network, etc.

MEMBERS' ADMINISTRATION (PUMA - BASIC)

GlobeMed's policy management application offers two approaches to administer your members' portfolio and verify eligibility of benefits.

Integration Option

Under this option, the member and benefits data is hosted on your system and is retrieved in real-time through an online integration with the GlobeMed application.

Hosted Option

Under this option the member and benefits data is hosted on the GlobeMed system. Policy administration is managed directly through the GlobeMed application allowing you to:

- Add/delete members
- Modify member information
- Modify member benefits
- Suspend member access
- Access member information/medical file (subject to user authority level)
- Access to predefined claims, production and performance reports
- Manage renewals and new applications
- Calculate premium/refunds for added/deleted members

In either approach, data can be transferred between GlobeMed system and your system using several integration methods.

NETWORK MANAGEMENT

GlobeMed's network application allows you to manage all technical aspects of your healthcare provider including tariffs, discounts, payment terms, and other contractual obligations.

Furthermore, you can manage your healthcare provider profiles including addresses, contact numbers, medical specialties, working hours, and doctors' information.

Finally, the application allows you to create and customize your healthcare provider networks.

ONLINE ELIGIBILITY / AUTOMATED PRIOR AUTHORIZATION / CLAIMS SUBMISSION / ADJUDICATION

GlobeMed's OBM solution permits real-time processing of claims based on a web-enabled portal carrying all the eligibility and certification functions. Our portal allows the healthcare provider to check the patient's eligibility online, complying with the plan restrictions and conditions (benefit inclusion/ exclusion, restrictions related to the network of providers, territorial limits, co-payments, deductibles, financial limitations, etc.).

Moreover, the solution provides automated authorization of coverage and claims adjudication on a real-time basis, from the healthcare provider's facility.

Supported by:

ARC

It integrates ARC, the expert decision support systems which comprises rules that were enhanced and enriched over the years in order to maximize the automated controls performed on each and every transaction being executed. You also have the option to handle prior authorization requests for all or for pre-selected cases only.

Finally, the healthcare provider can submit the claims digitally to you, from the same portal eliminating the need for data entry and paperwork. The online system is valuable not only for its controls, but also for the visibility and transparency it provides over the whole process.

With requests for certifications and claims being processed online by healthcare providers, you will have full visibility on certifications and claims as they happen enabling you to better manage cash flows and reserves, and to promptly attend to your members' needs and expectations.

Thus, less waiting time, better customer care and cost containment are all secured in the process.

ARC

ADVANCED EXPERT SYSTEM

ARC, our advanced expert system checks out-patient claims against the automated medical rules and edits* to identify any potential problem while rendering out-patient services. It is based on well renowned databases and dictionaries including a standard medical dictionary based on medical necessity rules, coding edits dictionary and a medico-administrative dictionary for the rules related to policy benefits and restrictions.

The automated rules comprised of medical, dental and coding rules, include:

1. MEDICAL RULES

Disease versus age

Checks if the disease(s) given are within the accepted age bracket.

Disease versus gender

Checks if the disease(s) given are related to the correct gender.

Disease versus age & gender

For a specific disease, the age bracket differs between a male and a female.

Procedure versus age

Checks if the procedure(s) requested are within the accepted age bracket.

Procedure versus gender

Checks if the procedure(s) requested are related to the correct gender

Procedure versus age & gender

For a specific procedure, the age bracket differs between a male and a female.

** Some rules are not applicable in all territories*

Panels

Detects if the item test is part of a panel, which replaces a list of tests by one item for tariff purposes.

Tests & sub-tests

Detects the presence of a main test and one of its components within the same transaction.

Procedure versus periodicity & cross-periodicity

Detects any repetition of procedures within a specific period of time. While the cross-periodicity rule detects unnecessary repetition of these grouped procedures.

Procedure versus disease (medical necessity)

Detects the procedure compatibility with the patient's diagnosis as mentioned in the medical report.

Medical supplies (HCPCS) versus disease

Detects if the type of prosthesis compatible with the disease.

Disease versus length of stay (LOS)

Detects if the LOS is compatible with the medical claim.

Procedure versus length of stay (LOS)

Detects if the LOS is compatible with the surgical claim.

Procedure versus pathology

Detects if the pathology request is compatible with the surgery / procedure requested.

2. DENTAL RULES

Procedure versus disease (medical necessity)

Checks if the service(s) claimed are supported by diagnosis codes which validate medical necessity based on evidence based clinical standards of care.

Tooth number versus age

Detects if tooth number reported is compatible with the patient age based on normal tooth eruption chart for FDI/universal tooth numbering systems.

Procedure versus number of teeth

Checks if the number of teeth reported is compatible with the dental procedure claimed. Some of the procedures have different codes depending on the number of teeth the procedure was performed on in a single visit.

Procedure code versus tooth number

Checks if the tooth number reported is compatible with the dental procedure claimed. Some of the procedures can be performed only on a certain set of teeth (primary/permanent; anterior/posterior).

Periodicity / cross-periodicity

Detects any repetition of procedures within a specific period of time. While the cross-periodicity rule detects unnecessary repetition of these grouped procedures.

Sequencing

Checks if the dental procedures' order relates to normal dental treatment sequel and detects any abnormal patterns.

Frequency

Detects if a dental service code daily allowed frequency has been exceeded.

3. CODING RULES

GlobeMed's ARC comprises coding edits engine that performs several code checks to control improper and incorrect coding leading to inaccurate billing and inappropriate payment.

It is designed to provide immediate feedback about potential errors, and alert the users in the different stages of the claims and revenue cycle management through several checks. This tool can also be run on data extracts/reports for coding review and correction before sending to payers or collectors.

GlobeMed automated coding edits' dictionaries are based on coding conventions and official guidelines, covering different classifications including American, Australian & WHO. It examines records and analyses disease and intervention codes:

- In combination with other codes and/or
- In a sequence and/or
- For their presence or absence and/or
- For their specificity

To detect the following:

Duplication

Checks if disease and intervention codes are assigned more than once.

Specificity

Detects if diseases codes lack specificity by using 'unspecified' and 'other specified' diagnoses codes.

Sequencing

Checks if diseases codes are incorrectly sequenced such as unacceptable principal diagnosis / procedure.

Bundling

Detects if a procedure code is reported with other procedure codes that are components, or part of the descriptor of the first code, or included in the first code for well-identified reasons.

Mutually exclusive procedure

Checks if mutually exclusive codes are assigned together in the same encounter when it is unreasonable to expect services to be performed at a single patient encounter.

Frequency

Detects if a service code daily allowed frequency has been exceeded.

Mismatching

Checks if procedure codes are mismatching with other procedures codes for well-identified reasons, such as sequential procedures, misuse or inappropriate methodology for code submission as identified in the coding guidelines.

Add-on coding

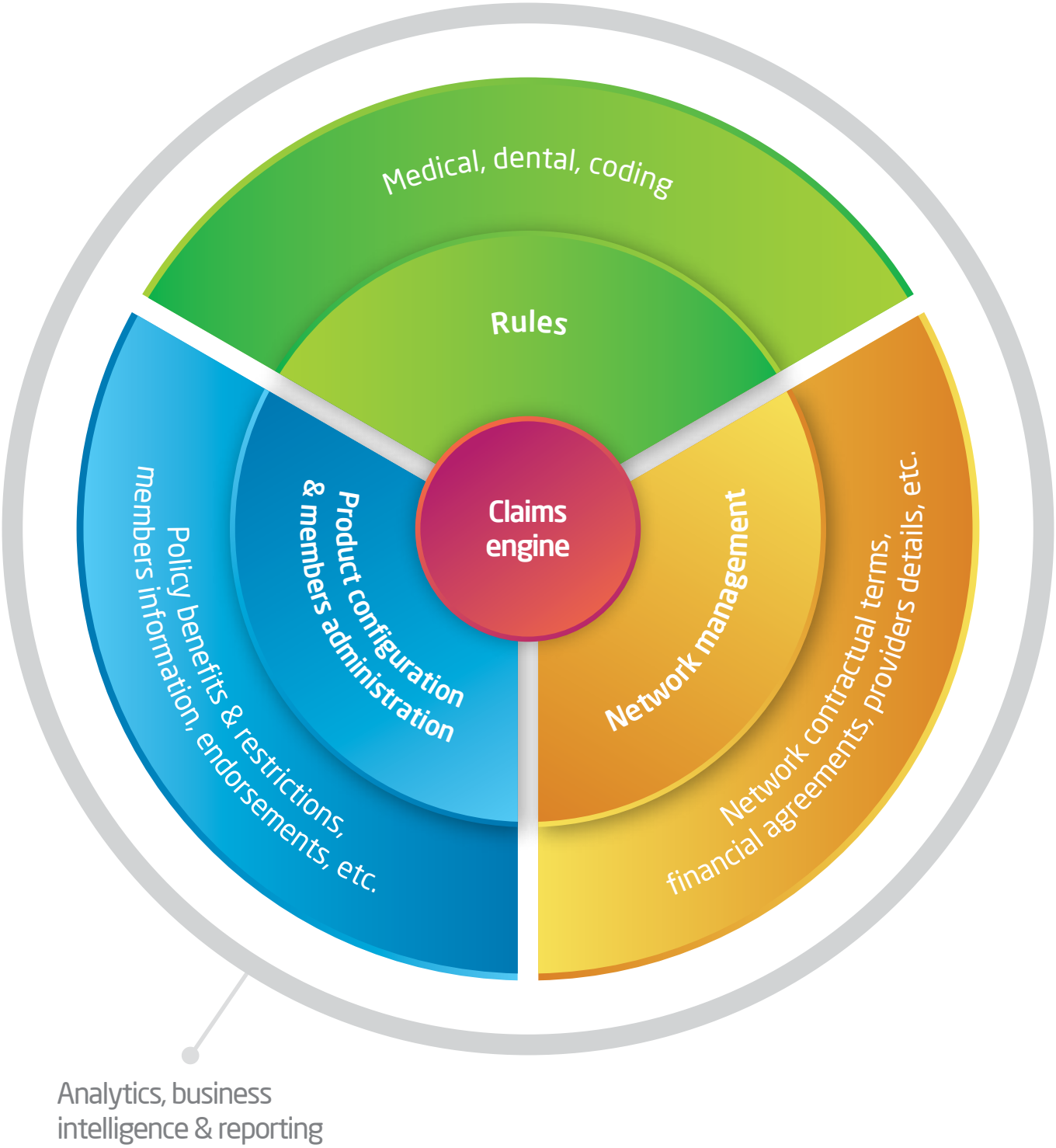
Checks if add-on codes are sequenced as principle diagnosis and are not reported with related primary codes.

ANALYTICS, BUSINESS INTELLIGENCE & REPORTING

GlobeMed provides payers with business intelligence tools along with pre-defined automated and real-time reports. A variety of reports can be generated to help you monitor and follow-up on every step of the process: claims details, paid and outstanding out-patient services invoices, savings generated on incurred out-patient claims, and many other detailed reports that support critical program monitoring.

GlobeMed's reporting capabilities ensures transparency, data integrity and a complete out-patient claims trail.

OBM Components



GlobeMed Group provides services and solutions for the management of healthcare benefits.

With over 25 years of experience, the company was among the first to introduce web-enabled solutions.

It has franchisees in 12 countries, servicing over 100 clients with 3.5 million cardholders benefitting from access to its automated cross-border network of healthcare providers.

At GlobeMed our stakeholders can focus on what they do best and leave the rest to us.

HEADQUARTERS

Lot 210 Business Center,
Jisr El Wati, Sin El Fil,
P.O. Box 55664 Beirut, Lebanon
T. 00961 1 518318

info@globemedgroup.com
www.globemedgroup.com

OBM-B1216-V1.2