

Life Journey of a Claim

Full Cycle of the Argus System

At the Doctor's Office

- The doctor prescribes medication for the patient.
- The doctor writes a prescription and gives it to the patient.
 - ? The doctor may consult the Formulary of the health insurance of the patient to determine which medication is a covered benefit.

To the Pharmacy

- The patient chooses a pharmacy...
 - ? The patient has a listing of participating pharmacies from which to choose.
 - If the patient goes to a participating pharmacy, the claim can be submitted online for payment and the patient will pay a copay.
 - If the patient goes to a non-participating pharmacy, the patient will need to pay full price for the prescription and save the receipt to submit it as a Direct Member Reimbursement claim.

At the Pharmacy

- The patient gives the prescription and his prescription card to the pharmacist.
- The pharmacist determines that her pharmacy accepts the insurance and goes to the computer terminal.
- The pharmacist creates a patient profile with the information provided on the prescription card of the patient.

Entering the Claim

- The pharmacist enters the prescription and submits the claim for payment...
 - ? The terminal is equipped with a modem that transmits the data to a switching network (Envoy, NDC, QS1, etc.)

- ? Some chain pharmacies have their own direct link to Argus (Eckerd's, Walgreens, etc.), that allows them to bypass the switching network.
- ? The switching network reads the BIN number (600428 identifies Argus) and sends the claim to the correct processor.

Arrival at Argus

- Some terminology changes at this point:
 - ? The patient becomes the member
 - (of a health plan).
 - ? The doctor becomes the Prescriber
 - (of the medicine).
 - ? The pharmacy becomes the provider
 - (of the medicine).
 - ? The health insurance becomes the customer
 - (of Argus).

The First Round of Edits

- All data fields are checked for the proper data type (alpha, numeric, or alphanumeric).
- The Customer ID or Processor Control Number is verified.
- The Fill Date is verified to be less than or equal to the date of transmission.
- The claim is checked for proper format for the following fields: Date of Birth, Sex, and Relationship Code.

To the Member File

- If there are any inappropriate characters or spaces in the submitted Member ID, an error is generated.
- The submitted Date of Birth and Relationship Code are compared to the member file, (if the customer requires this edit.)
 - ? If customer does not edit on the Date of Birth and Relationship Code, that information in the member record overrides the submitted information from the provider.

More Member Edits

- The member's age is calculated as Fill Date minus the Date of Birth.
- The member's eligibility is checked against the Fill Date and eligibility dates. If ineligible, an error is generated.
- If FEC Code is available, compare it to the Relationship Code. If ineligible, an error is generated.

Member Edits Continue

- Coverage information...
 - ? If the member file contains Coverage Codes and Coverage Effective Dates, they are compared to the Fill Date and the Coverage Codes.
 - ? If Fill Date is before Coverage Effective Date, an error is generated.
 - ? The Coverage Codes are retrieved from the member file to be used later in the process, if eligible.
- If a Member record is found, certain fields are captured and used later in the process.

To the Group File

- The Group ID from the Member file is used to match a record in Group.
 - ? If no match is made with the Group ID from the Member file in the Group file, the Group ID from the claim is used to match a record in Group.
 - ? If no match is made with the Group ID from the claim, the Generic Group ID is used.

Group Editing Continues

- If a Group ID is found, Coverage Codes are selected based on Coverage Effective Dates.
- Deduct ID and Benefit Period are matched and used, if available.
- Certain fields are captured from the Group file and used later in the process.

To the Client File

- The Client ID from the Member file is used to match a record in Client.
 - ? If no match is made with the Client ID from the Member file in the Client file, the Client ID from the claim is used.
 - ? If no match is made with the Client ID from the claim, the Generic Client ID is used.
- If a Member ID was not found, the Preauthorization or Auto-Ignore flags are checked for use.

Verifying Coverage in Client

- Group or Member Level Eligibility is determined.
 - ? This will determine if the Coverage Codes from the Member File or Group File are used.
- Certain fields are captured from the Client File and used later in the process.

To the Customer File

- The Customer ID from claim is used to match a Customer Record.
- Certain fields are captured from the Customer file and used later in the process.

To the Pharmacy File

- If the Pharmacy ID or NABP number is absent or invalid, an error is generated.
- Eligibility within a Pharmacy Network is determined.
 - ? The Fill Date is compared to the Effective Date to determine eligibility.
 - ? If Pharmacy is not eligible, an error is generated.
- Reimbursement and Dispensing Fee amount and the Status Code are read from the eligible Pharmacy Record.

Back to the Claim

- Vital processing information is checked on the submitted claim...
 - ? Rx Number, DAW Code, UCF Metric Quantity, Day Supply, etc.
- The NDC File is read to obtain information on the submitted drug.
- Prescriber and Deductible information is gathered for pricing purposes.

Checking the Benefits

- Benefit and pricing parameters are checked in the following order:
 - ? The Benefit Plan: determines drug coverage, sets day supply limitations, sets quantity limitations, holds various tables.
 - ? The Cost Plan: sets DAW logic, assigns copays (standard and miscellaneous) and multiple copay logic.
 - ? The Override Module: performs any edits that cannot be performed by online functions, and may override some online edits.

Checking More Benefits

- ? The Pricing Module: prices the claim, performs sales tax calculations, and defines how pricing of a claim will be determined...
 - Submitted Cost, Allowed Cost, MAC Cost, Submitted Total Cost, Plan Calculated Total Cost, AWP Less Discount, or U&C Cost.
- ? The Override Module: performs additional functions based on how the claim priced.
- ? The Cost Plan: performs Post Pay functions.
- ? DUR screening is performed at this point.

Editing for a Duplicate Claim

- The Prescriber Edit is used to determine how to check the validity of the Prescriber.
- The system checks for a Duplicate claim in the following way:
 - ? Existing claims are scanned for the same Customer ID, Client ID, Member ID, GCN and Fill Date as the incoming claim.
 - ? If the incoming claim has a non-unique Member ID and an identical Rx number, the claim is considered a duplicate.

Verifying a Duplicate Claim

- ? If the incoming claim has a unique Member ID, the Rx number is not checked and any incoming claim with the same Customer ID, Client ID, Member ID, GCN, and Fill Date is considered a duplicate of the existing claim.
- ? If an existing duplicate claim has been denied or reversed, the incoming claim is not considered a duplicate.
- ? Any incoming claim that has been considered a duplicate claim will generate the appropriate error.

Client Edits Used

- The Refill Too Soon Indicator is checked.
 - ? If the claim meets the criteria, an error is generated.
- The Preauthorization Indicator is checked to see if a Restricted Benefit Authorization is allowed.
 - ? If it is allowed and one is applicable to the claim, it is used.

More Client Edits Used

- Temporary Claim Status is determined based on errors generated:
 - ? If an error(s) is causing the claim to deny, the Preauthorization Indicator is checked to see if a Preauthorization is allowed.
 - If it is allowed and a Preauthorization exists that will override an error, it is used.
 - ? The Preauthorization Indicator is checked to see if a Customized Authorization is allowed.
 - If it is allowed and a Customized Authorization exists that is applicable, it is used.

Amounts Recorded

- If a Deductible is affected, the amounts from the claim are updated in Deduct.
- If an Authorization is used, the use is recorded on the Authorization Record. If the total number of refills is equal to or greater than the number of refills allowed, the Authorization is inactivated.
- The Submitted Calculated Balance is calculated and assigned to the claim based on the Pricing Module Information.

The Return to the Provider

- The Argus system then returns a rejected or a paid message back to the provider via a switching network or a direct link.

A Rejected Message

- The provider will read a message that will describe why the claim did not pay.
- The provider may call Argus' Call Center to learn more about the rejection.
 - ? The provider may edit the claim and resend it for possible payment.
- The member may be required to pay full price for the prescription if it is not covered by the Customer.

A Paid Message

- The provider will read the claim to determine the copay of the member.
- The provider collects the member's copay and dispenses the medication to the member.

An Informational Message

- The provider receives a message that gives them more information about the claim.
 - ? These messages may come with a Rejected or Paid claim.
 - ? This information could give DUR or Formulary information.