

CRAM21

21st Century CLAIMS RECONCILIATION AUTOMATED MANAGEMENT SYSTEM

5/2004

- **Introduction**

CRAM21 is a 21st Century solution for the special A/R needs of Drug Chains. It repeats and expands the functions of the original CRAM released in the 1990s. The new system is rewritten for today's advanced cyberspace technology. A major improvement is provided by the addition of an array of new labor saving functions made possible by the Internet-connected platform.

CRAM21 provides browser-based Internet accessibility. This enables the distributed processing capabilities needed by today's dynamic business activities. Thus, open participation by all parties to the Accounts Receivable operations of the Drug Chain are achieved for greater efficiency.

Drug Chain management, A/R operatives and Payers can now directly access A/R information when they need to know without intermediary interactions. Such access operates under a security scheme with controlled authorizations. This capability eliminates the intermediary delays and expense required in older, static systems needed to create and deliver A/R reports in hardcopy.

CRAM21's ultimate justification is its ability to substantially shrink the average A/R item settlement cycle while reducing processing and labor costs. The open accessibility and the addition of automated collection features included in CRAM21 make significant contributions to A/R economies by this technological modernization.

Drug chain management realizes the unusually high number of problems of reconciliation is caused by inadequate full payment for individual claims. It is a common occurrence that payment items are shorted in the amount paid due to imperfect and incomplete adjudication.

Part of the settlement efficiency achieved by CRAM is a result of its automatic offset acceptance feature that forces marking claims PAID that have a small offset or adjustment. This automatic offset is controlled by user designated criterion. This enables concentration of A/R efforts to more productive collection activity focused on unacceptable deductions and for no pays.

The deduction offsets applied by the Payer are oftentimes appropriate to correct oversights of the adjudication process. Some of these may also be due to a negotiated contractual price concession. Other potential reductions may be a result of Plan non-compliance, a published price disparity, Plan deductibles or an applicable capitation condition that was not intercepted by the processor or other similar reasons for denial.

Other reasons for payment disparities are manifold but the common causes of no payment or inadequate payment include reversals, returns, partially dispensed quantities, substitutions, etc.

The objective of the CRAM21 claims reconciliation system is to simplify and automate the item tracking, control and maintenance of the open-item Accounts Receivable file of the claims submitted by the Providers. It facilitates reconciliation by taking into account the adjustments and mark-downs as a standard and automated feature of the system. It provides a method of screening acceptable versus unacceptable "mark-down" transactions on a CRAM-designated acceptance criterion.

- **CRAM21 Operating Characteristics**

The CRAM21 system expects that most claims and payment inputs be provided in machine processable media although there is provision for manual entries. A claims data file provided by the Sponsor's processor (i.e. – NDC) is routinely delivered to Drug Providers operating under contract to the Payers. These files are customarily provided in the industry standard format defined by NCPDP (National Council of Pharmacy Processing) which is now compliant with HIPAA standards.

Payment tapes created by the Drug Benefit Sponsors are customarily provided in the HIPAA standard formats as well. There may be occasions when the Sponsor (Payer) supplies files created by data entry external to the Reconciliation system and may not be in the industry standard format. Customized procedures provided by DPRx will then be required for compatible entry into CRAM21.

The CRAM21 system is developed using free or a low cost database technology and software. These are compatible with the free operating system capabilities of the popular LINUX platform. MySQL is employed as the database supported by Redhat LINUX Distro or others such as LINUX Distro (SUSE, Debian, Etc.) or UNIX like OS (FreeBSB). The system is recommended for operation as a website requiring a minimum of two Intel servers.

- **Standard CRAM Reconciliation System Components**

The basic functional components of the system are the following program modules:

1. Weekly Claims Edit & Load to CRAM21 Database
2. Reconciliation of Payments to Open Claims
3. On-line Inquiry and Maintenance of CRAM21 Claims Database
4. Archiving and Purging of the Closed Claims Database

There are a total of nine additional supporting program modules in the CRAM21 system. Each of the modules can be launched from a common menu allowing the maximum efficiency in module mobility for the CRAM21 User.

Module 1. Inputs or reads a claim's file or files provided by the Processor or Processors performing the real-time adjudication of claims submitted from the Point of Service (Pharmacy POS). Claims are segregated by this CRAM21 procedure into several groups: (a) valid claims; (b) duplicate claims; (c) zero balance claims; (d) unauthorized claims; and (e) re-submitted claims.

Only the valid claims are added (appended) to the CRAM21 database of claims. Reports are produced for each of the segregated "exception" types. These are in control order thereby providing accounting and analysis totals by the dispensing entities (i.e. - Stores).

The valid claims report produced is a summary report giving the dollar amounts due for reimbursement: by Store or Provider. This system function is usually a weekly activity.

Module 2. Function is to "read" the input of the Sponsor's (Payer) payment file or files as received and immediately convert the data into the CRAM21 system's internal payment file format. The payments in this file are edited and aggregated as a batch file for subsequent reconciliation processing by CRAM21.

Detail reports are produced in this process for accounting control purposes. A summary report is also produced that gives totals by Provider entity and also by individual Plan. This procedure is ordinarily a weekly activity.

Module 3. Performs the primary reconciliation function. It applies the batch payment data file to CRAM's Claims Database. Payments are compared to claims by matching identification keys and are posted where a match is confirmed and the claim is currently "open" and the payment is appropriate.

Not all payments that are entered (read as input) meet the requirements of closing or retiring an open claim. Consequently, all the claims are classified in the following manner for various report categories: (a) non-compliant partial payments; (b) No-Match payments; (c) Negative Payments; (d) Denied payments; (e) Duplicate payments; and (f) those that matched perfectly and were accepted.

Collectively, these reports provide a comprehensive disclosure of the screened disposition that was made of these transaction types. Each transaction is either posted or what change was made to the individual claim's database record.

A report of detail is provided for each category and a summary report is made for the cleared payments that resulted in a zero balance or satisfied the allowable discount percentage criterion. This is performed by Store and by Provider.

Module 4. Is a claims maintenance function. It allows individual review of each claim and the on-line modification thereto where called for. This review and modification function can be of considerable assistance in achieving accounting control. This function, of course, is restricted to only authorized personnel by administratively controlled security provisions. This security is achieved by Password-only entry to the on-line function.

Module 5. A function that allows purging of paid and zero balance claims when deemed appropriate and in conformance to prescribed control procedures. Those items that are purged are archived to off-line permanent storage for audit and retrieval purposes. The unpurged file items that remain active are open items and retained (post purge date) Paid items. The former remain for disposition based on future matching transactions, if any.

- **CRAM21 Special Features For Improved Efficiency & Collections**

- √ **Acrobat pdf A/R Reports Online to Authorized Inquiring Parties**

Controlled access of all or selective system reports using Acrobat .pdf report files delivery to remote Internet connected PCs for display or printing of hardcopy. These reports use a default of current month unless otherwise indicated for another period by the inquirer.

- √ **Online Inquiry and Correction of Claims and Payments With Logging**

Controlled access to Claims and Payment files for inquiry and/or correction with logging of all authorized inquiry and modification. Administrator designates authorized company personnel (e.g. – A/R Department personnel) to directly assist in the collection process. Enables A/R personnel to simultaneously view open claims while on the phone with Payer's A/P personnel.

- √ **Multiple Data Entry Methods for Supplied Claims and Payment Files**

Delivery and Transfer of Claims and Payment files by multiple methods and media: FTP ("File Transfer Protocol"), CD ROM, DVD and a designated standard DAT tape. Reports provided of delivery aggregate contents to sender and User's Administrator by automatic Email message.

- √ **Continuing Compliance With HIPAA Standards**

Compliance with HIPAA standards for claims (v5.1) and payment (#585) data communications. Maintenance upgrades provided by DPRx as they are issued in the future under the DPRx maintenance agreement. Internet based transfers performed with compliance to HIPAA requirements, which may require User acquisition of security tools. Online reports are stripped of Patient identification data.

- √ **Aged A/R Statements Automatically Emailed to Payers**

Automatic A/R Delinquency Statements for unpaid claims by Email to Payers (using .pdf reporting) aged 30, 60 and 90+ days from incurred liability date. These statements may be controlled by Payer-specific parameters set by Administrator; otherwise, the default master parameters take precedence (e.g. – Calendar month/Semi-Monthly; 30/60/90 day periods, Aggregate/By Store, etc.)

√ **Coordination of Benefits Handling**

Provision for Coordination of Benefits (“COB”) accounting/handling for up to 3 payers. Up to three payers for each claim accommodated by CRAM21 provided. These partial claims may be contained in separate Claims files provided by NDC and integrated by CRAM21. System treats each Payer independently for collection delinquencies.

• **Closer Look At Standard CRAM Modules and Reports**

√ **The On-line Maintenance function**

An important feature of the CRAM reconciliation system is it’s easy to use, on-line maintenance function. Each claim in the claims database is uniquely identified by various keys such as Store number, prescription Rx number, Date filled, and Payer ID. These identifiers are used in combination to research and retrieve claims.

The system finds the first Rx, which enables paging through the entire family of Rxs fostered by the first in the Rx group.

All aspects of the prescription data are displayed on one screen for each prescription. Four options are available: Add, Change; Delete and Inquiry. The viewer may move the cursor freely in the change screen and make modifications as required to the changeable fields. (Authorization required for any alteration.)

√ **CRAM Reports and Functionality**

All the following CRAM reports have a common organization as it pertains to the presentation sequence of data. In every case, unless otherwise noted, the data is sorted by Rx/Refill-Number within Store-Number within the major control of Billing Method, or what is sometimes called Plan Designation. This sequence is common for detail reports as well as summary reports. In most instances, appropriate amount and numeric totals are provided for each control level.

The following descriptions of procedures and reports arbitrarily assume certain logic of exception handling that may be altered or customized for a new CRAM User. As an example, resubmission coded payments are reported but not acted on in the Claims database. This may not be the treatment desired by a new CRAM User but may be changed as a customized feature.

√ **Weekly Claims Processing & Reports**

I. Re-submitted Claims Exception Report:

The industry standard claims format makes provision for the repeated submission of a claim (claim record is coded with a re-submission character). CRAM intercepts these records and performs disclosure of the classification and separation.

These claims are checked against the claims database to confirm the existence of the original claim by Rx-Number and the Store-Number. No action is taken in regard to recording the submission to the Claims Database; however, the report produced for all re-submitted claims will indicate, by message, whether or not a corresponding claim is found on the database.

Further analysis, if necessary, may disclose that the original claim was voided for cause with the conclusion that no action should be taken with the re-submitted claim.

The report display includes: Rx Identification, Store-number, and dispense date. Amount and quantity are not displayed for each such claim. The total number of Re-submitted claims is shown by Store.

II. Duplicate Claims Exception Report:

This report shows all duplicate claims submitted in the entry claims file. A duplicate claim is one that was found to already exist in the claims database. This determination is based on the Store-Number and Rx-Number (with refill-Number) matching with corresponding exactness.

No action is taken to record the duplicate entry to the claims database. It is important to note that the same prescription may be submitted under more than one billing Method or Plan. The report will show the Billing Method submitted.

III. Unauthorized Claims Exception Report:

The name of this transaction is self-explanatory. No action is taken to write this record in any file or the claims database. Unauthorized claims are pre-identified on the incoming record by inserting a special code. Such records may exist as the result of an unfilled or returned prescription. In any event, there is no liability assigned to the claim value.

The unauthorized claims report list all such claims by Rx-Number and dispensing date. Included is a count of the number of such claims encountered within each Store, for the designated period reported. Physician license number is included in the display by the corresponding Rx-Number, if provided.

IV. Zero Balance Claims Exception Report:

Certain circumstances exist that no charge will be due as a reimbursement for the Provider because the Co-pay exacted from the buyer equals or exceeds the Dispensing Fee and Ingredient cost together. These claims are not posted to the Claims database but are shown in this Exception report displaying the number encountered by each Store.

V. Claims Summary Report:

No detail of transaction is provided in this report. Its purpose is to provide amount due totals by Store-Number. These totals, of course, are batch totals corresponding to the period represented by the tapes submitted by the claims adjudication processor (i.e. – Argus for 7/1/94 through 7/15/94).

An optional feature of this routine is provided to the User to enable selection of specific Billing Method or Plans for this report and; thereby, limit the scope of the batch submitted. If no specific selection is made, all Billing Methods or Plans contained on the tape will be included in the report.

√ **Weekly Payments Processing & Reports**

VI. Payment Tape Conversion: Payment Detail:

Each payment is listed containing the following comprehensive payment data: Rx/Refill-Number, Dispense date, Ingredient Cost, C-Pay, Professional Fee Amount, Amount Due, Amount Paid, and a Sponsor-supplied error code, if provided/applicable.

Multiple payments for the same Store/Rx are grouped together to assist in the identification of payment reversals and duplicate payments. Payment reversals would normally appear as three separate payments: original payment, negative payment, and revised payment. Duplicate payments would appear as two or more positive payments for the same Store/Rx.

The Provider Payment Tapes give no indication of whether multiple payments for the same Store/Rx are adjustments to an original payment or duplicates.

The details and totals provided in this report are not necessarily exclusive for any time period of dispense dates. The totals provided are more for control of batch submissions rather than for accounting period control.

VII. Payment Tape Conversion:

Summary by Store-Number. This report is simple in its construction and purpose. Totals of the number of claims paid and the aggregate amount paid for these claims is displayed for each Store-Number.

A total of the number of payment records inputted ("read") is also provided for control purposes.

√ **Reconciliation Processing for Payments**

VIII. No-Claims Found Exception Report:

It is important to identify current payments that fail to find a match of an open unpaid claim. This report itemizes detail of such unmatched payments such that financial control can be reconciled. Further, Sufficient data is provided for search to be launched and an analysis made of activity to determine the proper application of the payments so listed.

The line item data fields include Rx/Refill-Number, Date Dispensed, Payer, Amount Due, and Amount Paid. It should be noted that Refill-Number may not be part of payment data and consequently is not used for matching purposes.

IX. Duplicate Payment Exception Report:

A current payment that is found to be matched with a claim that has been previously been marked as paid is called a Duplicate payment regardless of the amount paid.

All current duplicate payments processed are displayed in detail in this report but are not posted to the claims database. While they may continue to reside on the batch payment file submitted, no other recording is made for this data.

The data itemized for each payment is Rx/Refill-Number, Data Dispensed, Payer, Amount Due, and Amount Paid. Also displayed is the originating payment amount and payment date found in the claims database. The total number of duplicate payments by Store-Number is provided on control break.

XI. Partial Payments Exception Report

This is the most significant feature of the reconciliation process. It employs an elected management parameter about partial payment settlement as it pertains to designated Providers.

As expected, Payments that are equal to the amount due for an open (unpaid) claim on the database are posted and the claim is marked as "PAID".

The unique custom CRAM feature of this procedure occurs when a Payer discounts the amount due and makes a partial payment. When the partial payment encountered in processing, CRAM applies a User-designated level of acceptance whereby the payment is accepted as Payment-In-Full; thereby, incurring a non-recoverable mark-down as settlement for the claim. Thus, the claim is closed or retired.

The feature performs as follows: (1) the User has designated by parameter the minimum amount acceptable in lieu of the full payment - i.e. 95% minimum of an amount due; (2) the payment is posted to the database; and (3) closes the claim as "PAID"

Also provided is a maximum difference amount figure (another parameter) that over-rides any exceeding amount for the any acceptance triggered by the minimum-percentage allowance feature. An example is a \$500 due amount that is partially paid with a \$485 payment (meeting the 95% minimum criterion) and does not exceed the maximum amount offset parameter set at \$75.00 resulting in avoidance of rejection of the acceptance of this discounted payment. If exceeded, the claim is not posted to the claim payment-accepted database and, consequently, would be not marked as "PAID".

Acceptance criterion parameters may be customized to individual Payers; otherwise, the default master values for all Payers are used.

If the User does not provide or "set" these payment level parameters, the default values pre-set in the system are 0% minimum and \$9,999.99 maximum discount amount. The consequences of these default values results in any payment amount being accepted for satisfaction of the amount due (not recommended).

The payments that appear on this exception report are restricted to only those that due not cleared as accepted (not meeting minimum percentage discount requirements and exceeding the maximum dollar discount amount) and, hence, are not posted as "PAID".

The detail of data displayed includes: (1) Rx/Refill-Number, (2) Date-Dispensed, (3) Amount-Due, (4) Payer, (5) Amount-Paid, (6) Difference between Due & Paid, and (7) the percentage of the amount paid to the amount due. Totals are provided for each amount and numeric fields.

XII. Denied Payment Exception Report.

This report provides a hard copy or display of previously open claims that have been denied for payment by the Sponsor/Payer. The processing for

this report includes a posting to the claims database of the denial resulting in an amount paid of zero and closed as an open item.

The report display includes the (1) Rx/Refill-Number, (2) Date-Dispensed, (3) Amount/claimed, (4) Payer; (5) Amount Paid as the zero amount confirmation and a reason code. Totals are provided for the number of denials, the previous Amount Due, and the Zero Amount paid.

XIII. Negative payments Exception Report.

Negative payments are usually adjustments and corrections to payment data previously encountered and posted to the corresponding claim in the Claims Database.

It should be noted that the on-line inquiry function is an additional method of making adjustments and corrections to open claims' records stored on the Claims Database.

The detail data displayed in this report includes (1) Rx/Refill-Number, (2) Data-Dispensed, (3) Amount-Due, (4) Payer; and (4) Amount-Paid. The pre-existing payment and payment date, if any, contained in the claim record is also displayed.

The data displayed is grouped by Store-Number. Amount totals are NOT provided. The number of negative payments is provided by Store-Number.

XIV. Payment Summary By Claim Age Date.

This is not an exception report. The net effect of applying and posting the current payment batch file to the claims database is summarized in this report by Store-Number within Billing Method within the complete current batch processed.

The report display includes detail line data of Number of Payments posted, total of Amount Due affected, total of settlement Amount Paid, the difference between the Due and Paid fields, and the percentage of paid-to-due amounts. Each level of control totals is provided the User.

√ **Additional and Supplementary Reports**

XV. Claims Aging Detail.

The purpose of this report is to list all open claims for a specified Billing method and/or Store-Number showing the age of each claim: 30 days, 60 days, or 90+ days. The age is calculated as the difference between the NDC Claims load date (period ending data for the NDC batch) and the current date.

The report display includes detail of each claim selected: (1) Rx/Refill-Number, (2) Dispense-Date, (3) Aging-Date, (4) Amount-Due, (5) Status Code, and (6) RJ code.

XVI. Claims Aging Summary.

This report is vital to managing accounts receivable. It summarizes the claims data listed in the Claims Aging Detail. The Claims Aging Summary reports the total number of claims and the total amount due grouped by age (30 days, 60 days and 90+ days) for each Store-Number with collateral group totals by Billing Method.

XVII. Open Claims Listing.

This is another important Accounts Receivable report. The Open Claims Listing selects all unpaid claims which are older than a User specified aging date (i.e. – all open claims loaded prior to 01/01/94). Selection is further qualified by Billing Method and/or Store-Number.

The claims selected are listed in detail showing (1) Rx/Refill-Number, (2) Date-Dispensed, (3) Aging-Date, (4) Status-Code, and (5) Reject-Code. The total number of claims selected and the total amount due are reported by Store-Number, Billing Method, and Grand Total.

XVIII. Paid Claims Listing.

This is a control and analysis type report. The User provides a specific date of payment parameter and the routine selects all claims with a payment settlement residing on the claims database for that User specific date.

The report lists the selected paid claims and displays detail data which includes (1) Rx/Refill-Number, (2) Date-Dispensed, (3) Amount –Due, (4) Amount-Paid, (5) Due/Paid Difference Amount, and (6) the settlement percentage of Paid to Due amounts.

The collateral amount and numeric totals are provided as well.

- **Summary of CRAM21 Features and Benefits**

CRAM21, the DPRx Claims Reconciliation Automated Management System, is a very application specific system tailored to the special needs of third party processing for Providers and Drug Benefit Sponsors.

The newly implemented HIPAA standards for this data are accommodated to circumvent conversion software to backtrack data to pre-HIPAA systems.

Historically, there has been an increasingly sophisticated approach to Provider Contracts. More complex incentive and restriction dispensing programs continue to be implemented. In most cases these contracts are different from Provider to Provider thereby introducing another level of complexity that compounds the difficulty for manual methods of accounting and resulting in loss of accounting control.

The impact on managing the Accounts Receivable accounting; therefore, becomes very cumbersome. This results from the on-line processor not having the ability to impose the discounts contracted for at the time of adjudication.

In these cases, the Plan Sponsor imposes the discounts upon receipt of the gross calculations which may be provided on a paper statement or in machine processable form (i.e. – DAT cartridges, CD ROM, or by data communications means).

After taking the discounts, the Benefit Sponsor sends the payment file for each line item payable. Without a system such as CRAM21, the Drug Chain

accounts receivable manager must deal with a very tedious matching job between each claim and the disparate amount paid for each claim.

CRAM21, with parametric definitions of discounting, automatically matches payments and screens for the correct discount and exposes those at variance to the contract specifications and cites them for special attention. This greatly reduces the labor that otherwise would be required for manual processing.

The CRAM21 system provides a multitude of reports that enables comprehensive accounting control and tracking of this otherwise difficult accounting task.

An extensive set of program modules is provided with a manual control program that makes the system operation extremely User friendly operating under the modern techniques of Browser based screens.

DPRx has also anticipated user requests for the most common and popular hardware/software economic platforms. CRAM21 currently uses a LINUX platform with multiple Intel type servers. The software of implementation is open architecture and the free software databases of MySQL and collateral development languages of C++, Java and/or PHP. These resource capabilities provide the most economic approach to modern day processing.

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