



CHS-Claims system overview EX. (A)

Plan or Contract Year structure

Benefit Logic:

Utilizes: CPT's, ICD-9's, DRG's, HCPCS, fee schedules, CRV's and others.

Provider fee schedules

PPO fee schedules and on-line repricing

complete recall - system can report all changes, how a benefit was paid 5 years ago as well as last month and by whom.

Pre-registration (optional)

Automatic Adjudication (optional)

Capitation processing

Per occurrence tracking

Physician Referral tracking

Coordination of Benefits

Processor alerted to:

Pre-registrations

Pre-certs

COB

VIP

Claimant notes

Dependent notes

Family notes

Provider notes

Student status

Over % of specific stop-loss

COBRA status

Aegis Integrated add on's

VIRTUAL CLAIMS EXAMINER

- **Detect Fraud and Abuse with Virtual Examiner**

- Monitors the internal claims process of an organization to maximize financial recoveries
- Allows healthcare organizations to enhance their current claims adjudication system with more

than 33 million claims edits per claim

- Monitors an organization's internal claims process to identify unclean claims and reduce payment for improper or erroneous coding

- **Contain Costs**

- Evaluates claims for fraudulent and abusive billing practices

- Identifies claims that may involve third-party liability/coordination of benefits, case management Opportunities, physician billing education and many other cost recovery reports

- **Process Up to 125,000 Claims Per Hour**

- Exponentially increases efficiencies over reviewing claims manually

- Reduces the need to maintain massive claims and administrative staffs

- **Comply with Today's Standards**

- Developed using commercially available coding rules, the latest clinical guidelines and the expertise of clinicians, claims examiners and contract negotiators

- Affords flexibility to comply with frequent business and legislative changes

- **Incorporate Seamlessly**

- Installs in one to two hours

- Fully integrates into existing systems

- Runs seamlessly on Windows formats

- Uses a SQL interface so users do not have to change their data input procedures

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The software on its own after the normal claims system edits are done, has identified savings of up to 15 percent in professional costs on each A/P check run before the payment of claims have been made – retaining thousands of premium dollars annually for our clients.

IntelliOpt - “inside” (safety net) one step further

IntelliOpt is unique from other similar type products in the market. In fact, there are several areas that differentiate IntelliOpt:

- **Finding the Needle in the Haystack**

- By systematically applying our anomaly identification edits across 100% of monthly paid claims, IntelliOpt can present only those claims that appear anomalous and at a minimum should be reviewed for payment accuracy as they may have slipped thru the cracks of the front end claims editing system and have been overpaid.

- With IntelliOpt the claim anomalies that are identified and are presented through an organized workflow, we then go back and capture overpayments that other systems/vendors do not.

- **Providing Actionable Information**

- The analytics provided on IntelliOpt not only display a clear picture of the healthcare spend, but also provide the detailed claim line and procedure information that is needed to make decisions supported by the data.

- **Solution Oriented**

- IntelliOpt offers the ability to utilize the data to support multiple services. The ability to provide subrogation, member outreach and other services driven by the data can provide opportunity for additional cost savings.

Information displayed on IntelliOpt is driven by utilizing the claim and membership data provided thru the claims system: medical and pharmacy claims data, and membership eligibility data.