SOKOTO STATE CONTRIBUTORY HEALTHCARE MANAGEMENT AGENCY

[SOCHEMA]

CLAIMS AND DATA MANAGEMENT MANUAL

June 2018

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Section 1

1.00 Introduction/Background……

Making payment of SOCHEMA claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the SOCHEMA will pay Health care facility. SOCHEMA is expected to settle clean claims quickly and to Healthcare provider satisfaction. Because high customer satisfaction levels can give a company a competitive edge, reducing the time it takes to settle Healthcare provider claim especially fee for service and other related claims is one way to decrease the number of customer complaints and improve service. The use of claims management system software that speeds the process and minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses and time for processing claims.

Section 2

2.1 SOCHEM.: Monthly capitation payment process

2.11 Enrolment report is received, compiled and verified for completeness and validity by the 25th of the month

2.12 Based on the enrolment data approved, an empanelment list is generated

2.13 The empanelment list is then forwarded to the Finance department for capitation calculation

2.14 A payment schedule is prepared based on the active enrollees and the agreed rates. The schedule is being signed by the Compliance officer, Chief Finance, the Program Coordinator, the Provider Service Manager and the Director General approves the payment. The schedule is then forwarded to the finance department for payment.

2.15 The new database is to be published on or before 20th of the preceding month

2.16 All providers are to receive active enrollee list on or before the 1st of the new month

2.17 Capitation to be paid on or before 20th of the preceding new month.

Section 3

3.1 SOCHEMA: SOP for Issuance of Pre-authorization codes

3.11 .PA requests are received daily from providers via e-mail

3.12 Requests are cross-checked to contain Enrollee name, Enrollee identification number, Provider, Date of encounter, Diagnosis and Service/procedure.

3.12 PA codes are issued according to the benefit package and validity and as authorized by PSU (for all secondary care)

3.13 All PA codes are system generated.

3.14 Approved requests are sent to providers via e-mail; for denied requests, reasons for denials are also stated.

3.15 All issued PA for the Month are collated and send to the claims processor/examiner and the data team lead for claims processing and reporting respectively.

Section 4

4.1 SOP for Claims Processing

(Claims payment is based on the services that are not covered by capitation)

4.11 Utilization data are collected from the provider on or before the 5th of the following month via e-mail

4.12 Claims are strictly extracted from the utilization data

4.13 Claims are adjudicated according to benefit package (business rules), tariffs, validity, completeness and timeliness

4.14 Claims for Secondary care - Surgeries - are accompanied with medical reports. In cases when this is not done, medical report is requested via e-mail by the claims processor which should be reverted within 3 days

4.15 The medical reports are assessed by the SOCHEMA and approval is given, denied or further information requested with response timeline stated.

4.16 Processed claims are sent back to providers in the form of EOPs via e-mail. The issues are alighted and providers are to clarify (sort out) the issues, agree with the terms of payment and revert within 3 days. When this timeline is not met, a reminder is sent via SMS or phone calls by the data officers. A day extension is often given

4.17 Any response not sent in before the final claims cut-off is denied and cannot be re-visited.

Section 5

5.1 SOCHEMA SOP for Claims Processing payment

5.11 Compliance check must be done on or before the 15th of the following month of receipt

5.12 Final payment schedule/summary sheet is prepared according to programs and duly signed by approving authorities and forwarded to the finance department.

5.13 Payment must be done within 60 days from the month of utilization

5.14 EOPs in PDF are sent to all providers after confirmation from finance that payment has been made. For all providers, SA/DG is kept in copy.

Conclusion

Claim management is a vital aspect of financial scheme management. The processes have to be transparent and accountable. The use of technology will enhance the process time and reduce fraud.