Insurance Management Information System

Part 2

(management of claims and general management)

Training material-version 1.0

October 2014

Abbreviations

FSP	First Service Point
FTP	File Transfer Protocol
GB	Giga Byte
ICD	International Classification of Diseases
ID	Identification
IIS	Internet Information Server
IMIS	Insurance Management Information System
IP	Internet Protocol
IT	Information Technology
MoHP	Ministry of Health and Population
NRP	Nepali Rupee
SHSP	National Social Health Insurance
PHC	Primary Health Centre
SD	Secure Digital

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1 Introduction

The purpose of the document is to provide to provide instructions on using the Insurance Management Information System (IMIS). This second part of the training material of IMIS describes the functionality for submission and processing of claims (management of claims) and for managerial reporting (general management). It focuses on IMIS support of standard operating procedures for the Social Health Security Programme in Nepal. The material is complemented by the IMIS User Manual. It is intended as a background material for training of Social Health Security Programme staff. The material is a continuation of the first part of the training material.

The following typographic conventions are used:

Labels of fields for entering data or buttons in forms (screens) for clicking are in **bold.**

Headings of sections in the forms of names of applications are in *italics*.

2 Administration and initialization of IMIS

IMIS requires set up of several registers for its operation. There are appropriate tools for initialization and maintenance of such registers. Registers of IMIS represent major advantage of IMIS as they enable adjusting of IMIS to new requirements-e.g. new insurance products, new covered services, new prices and they enable also roll-out of SHSP scheme to new districts.

The following registers are maintained by IMIS:

- the register of (IMIS) users
- the register of locations (districts, VDC/municipalities, wards)
- the register of enrolment officers
- the register of (institutional) payers
- the register of insurance products
- the register of medical services
- the register of medical items
- the register of claim administrators
- the register of health facilities
- the register of pricelists

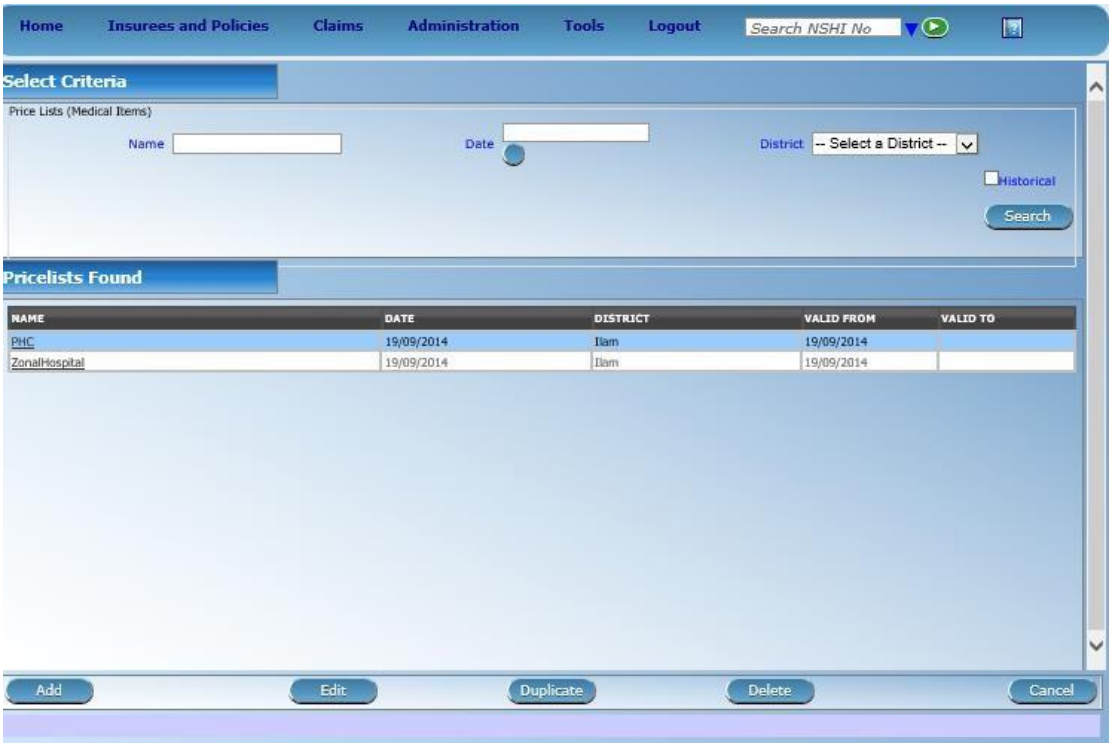
We covered a setup of all registers but three in the first part of the training material. The three registers left aside are the register of health facilities, the register of claim administrators and the register of pricelists. These three registers are exclusively used within claim submission and processing by IMIS. We will go through these three registers and we will show how to enter new items into these registers. Modifications of items in the registers will also be briefly described.

2.1 How to enter a new pricelist?

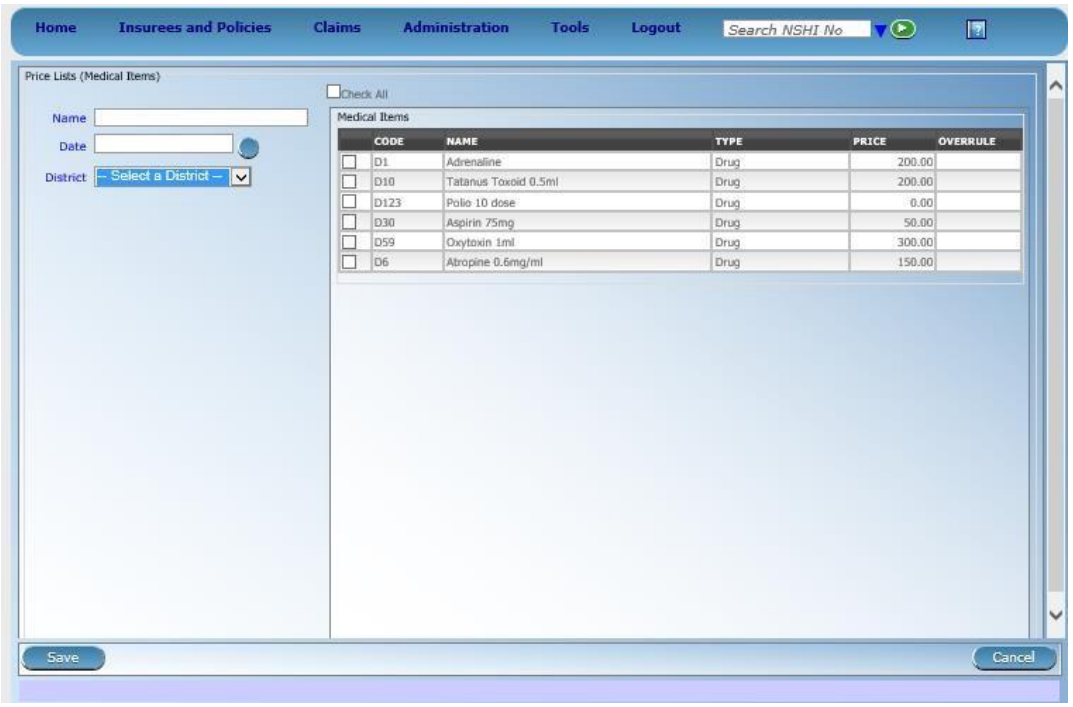
The register of medical services (medical items) contains all medical services (medical items) that can be remunerated within Social Health Security Programme (SHSP). It is common for all districts. However, a health facility (or a group of health facilities) may be not allowed to claim any medical service (e.g. a dispensary will not claim operations) and also price of a service (or medical item) can be different for different level of health facilities and different districts. Enabling such differentiation is the purpose of pricelists. Several different pricelists can be defined and entered into the register of pricelists and subsequently assigned to corresponding health facilities. It is a reason why pricelists are discussed before health facilities. Whereas lists of medical services (items) are common for the whole Social Health Security Programme, pricelists can be defined separately for health facilities and/or groups of health facilities.

This procedure can be performed only by a user with the role *Social Health Security Programme SHSPAdministrator*.

1. Select **Administration-> Price List -> Medical Services** for a pricelist of medical services or **Administration-> Price List -> Medical Items**. The following form appears (say for medical items):



2. Click on **Add** below. The following form appears:



3. Enter **Name** (a unique name) of the pricelist, **Date** of creation of the pricelist and **District** for which the pricelist is created. Alternatively, you can specify that the pricelist will be used nationwide (irrespective of a district). Select (by checking) appropriate medical services (medical items) from the common list medical services (medical items) in the box on the left of the form that should be included in the pricelist. You may also select all medical services (medical items) by checking the small square on the top and de-check services (items) in the box that shouldn't be included in the pricelist. Should be price of a service (item) in the pricelist differ from that in the common list, write the new price in the column **Overrule**. Click on **Save**.

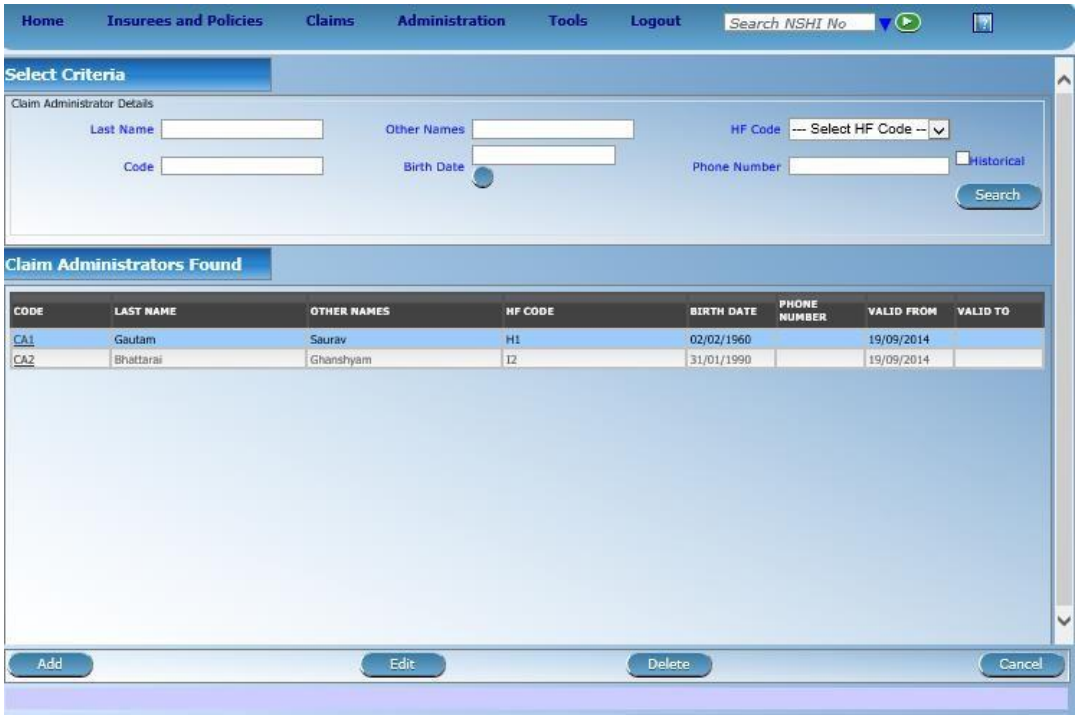
4. The new pricelist is entered and the form from the step 1 appears with the new pricelist in the list of pricelists. Any pricelist in the list can be modified by selection of the pricelist in the list and by clicking on **Edit** (for modification of the pricelist) or on **Delete** (for deletion of the pricelist). If a new pricelist should be created that is similar to a previous one, click on **Duplicate**.

2.2 How to enter a new claim administrator?

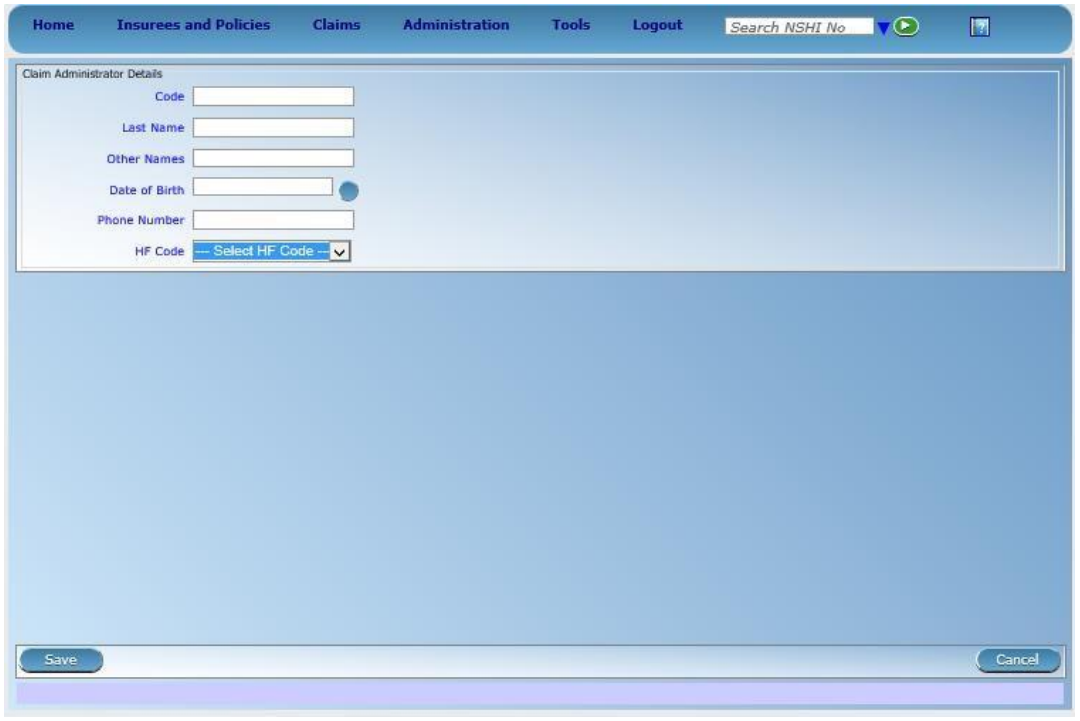
The register of claim administrators contains persons at health facilities that are finally responsible for submission of claims to the district Social Health Security Programme (SHSP) offices. One claim administrator can be in charge of submission of claims only for one health facility. Claim administrators are employees of health facilities and they are also in charge of communication with the Social Health Security Programme SHSP district offices on claim settlement. One health facility can have several claim administrators. The codes of claim administrators are indicated in claims and the claim administrators take over responsibility for correctness of claims on the side of contractual health facilities. This procedure can be

performed only by a user with the role *Social Health Security Programme SHSP Administrator*.

1. Select **Administration-> Claim Administrators**. The following form appears:



2. Click on **Add** below. The following form appears:



3. Enter a unique **Code** of the claim, his/her **Name,** his/her **Date of Birth, Phone Number** and select from the drop down list of the **HF Code** the corresponding health facility. Click on **Save**.

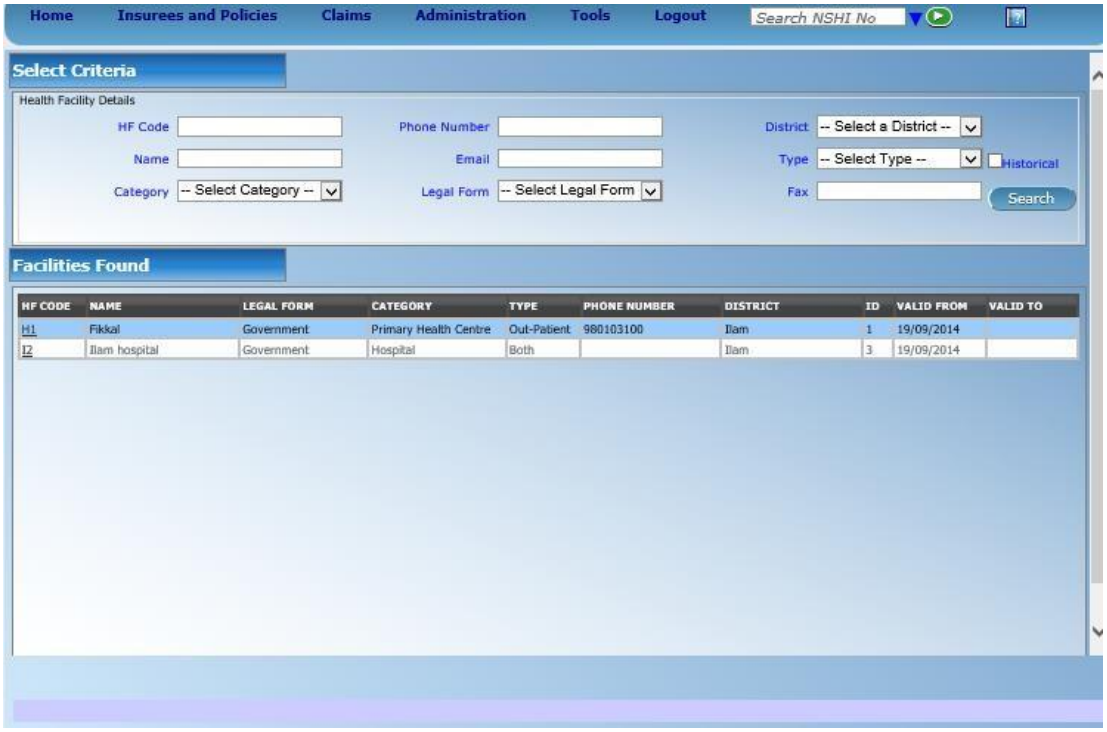
4. The new claim administrator is entered and the form from the step 1 appears with the new claim administrator in the list. Any claim administrator in the list can be modified by its selection and by clicking on **Edit** (for modification of the claim administrator) or on **Delete** (for deletion of the claim administrator).

2.3 How to enter a new health facility?

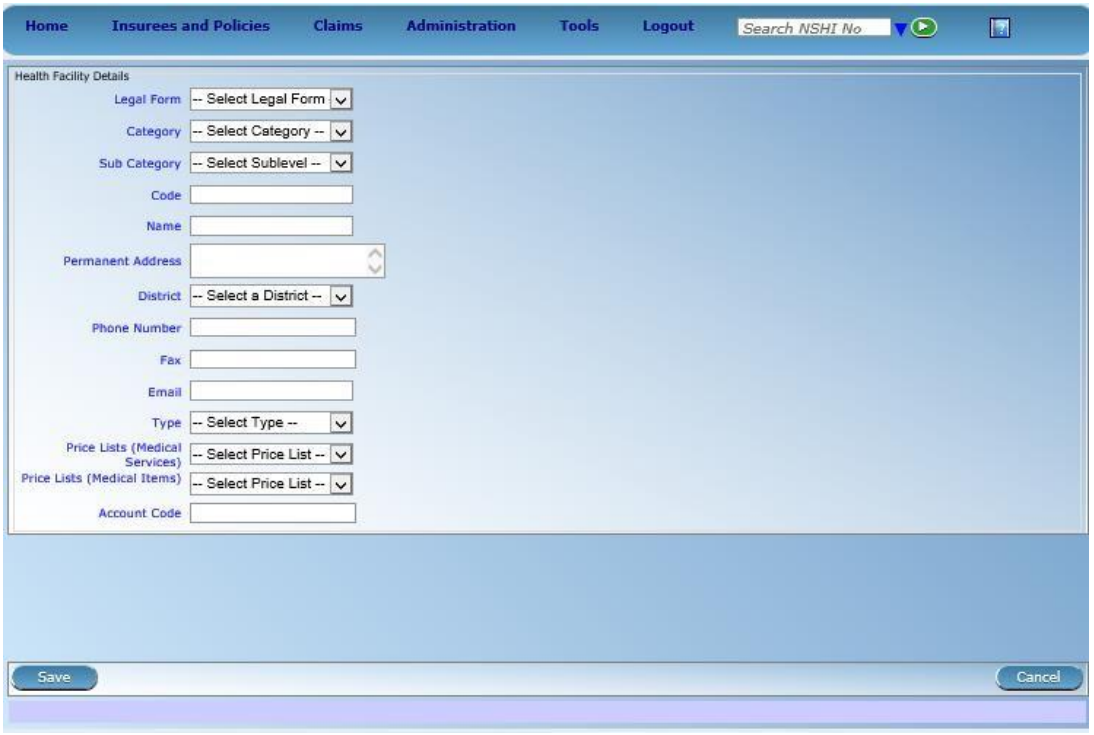
Generally, all health facilities that have right to submit claims (and to be remunerated) within the SHSP scheme, have to be entered into the register of health facilities.

This procedure can be performed only by a user with the role *SHSP Administrator*.

1. Select **Administration-> Health Facilities**. A list of already entered health facilities appears:



2. Click on **Add** below. The following form appears:



3. Select **Legal Form**, **Category** (hospital, health center, health post), **Sub Category** (for hospitals), **Type** (type of care provided by the health facility-out-patient, in-patient, both). Enter Code and **Name** of the health facility, its **Address** and select **District**. If available add **Phone number**, **Fax** and/or **E-mail.** Select one of available **Pricelists for Medical Services** and **Medical Items**. Pricelists define on one hand what medical services (medical items) can be remunerated to the health facility within the Social Health Security ProgrammeSHSP and on the other hand prices which are used for remuneration of the given health facility. Finally, enter **Account Code** that identifies the health facility in the report for the accounting system. Click on **Save**.

4. The new health facility is entered and the form from the step 1 appears with the new health facility in the list of health facilities. Any health facility in the list can be modified by selection of the health facility in the list and by clicking on **Edit** (for modification of the health facility) or on **Delete** (for deletion of the health facility).

3 Submission and processing of claims

One of principal functionalities of IMIS is submission and processing of claims of health facilities. IMIS allows entering and submission of claims. This functionality is available either through on-line IMIS clients on a computer (desktop PC, laptop etc.) that communicates with the central server via Internet, through mobile phone clients or through off-line clients. Further, IMIS allows processing of claims. Processing of a claim encompasses several stages. Firstly, it means checking whether the claim is correct from formal point of view and whether health care claimed satisfies criteria of coverage of a corresponding policy (or policies) of the patient. Secondly, it encompasses reviewing by a medical advisor who assesses whether claimed health care was justified and appropriate. Reviewing by a medical advisor can be complemented by acquiring of a feedback of the patient. A feedback of a patient confirms or rejects whether the claimed health care was provided at all, answers some questions relating to circumstances of provision of the health care and it assess overall quality of the claimed health care. Reviewing and acquiring feedbacks is followed by valuation of claims when all claimed (and not rejected up to now) medical services and medical items are valuated and a total amount to be remunerated to the health facility is calculated. Calculation of the total amount of a claim can be deferred in case some medical services and/or medical items have (according to the definition of the corresponding insurance product) relative prices[1].

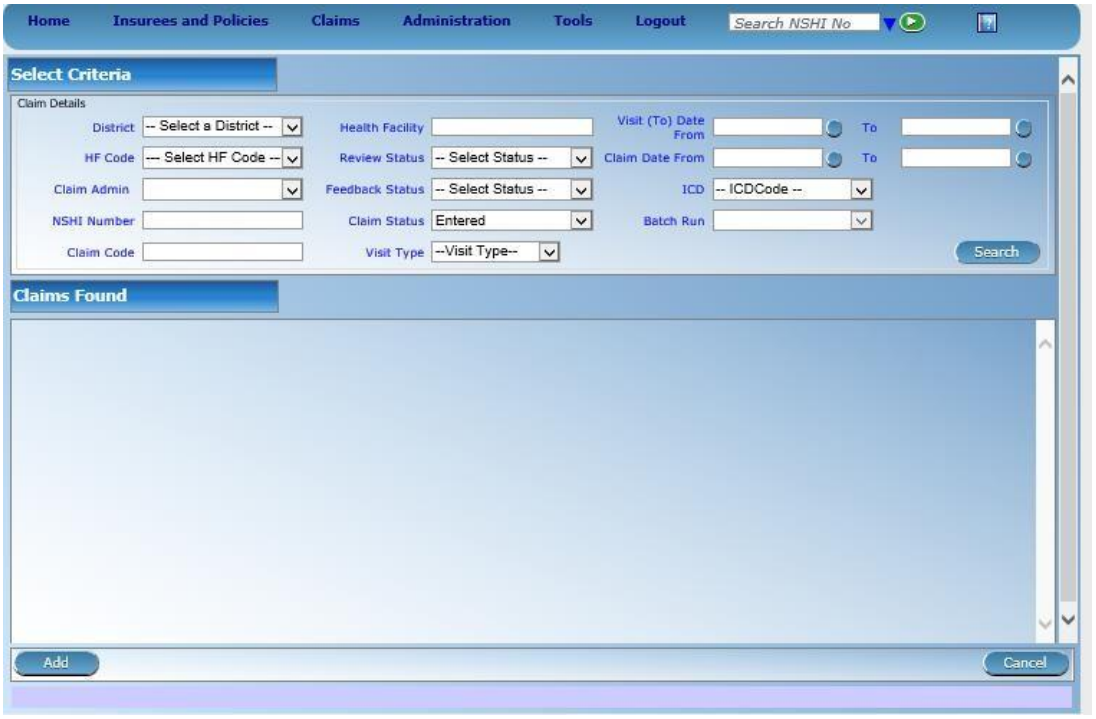
The following questions are most relevant to using of (the second phase) IMIS on-line client within the new SHSP scheme:

- How to enter a new claim?
- How to modify an (entered) claim?
- How to submit claims?
- How to select claims for reviewing and for feedback?
- How to review a claim?
- How to start valuation of claims?
- How to create a report for accounting system with data on remuneration of health facilities?

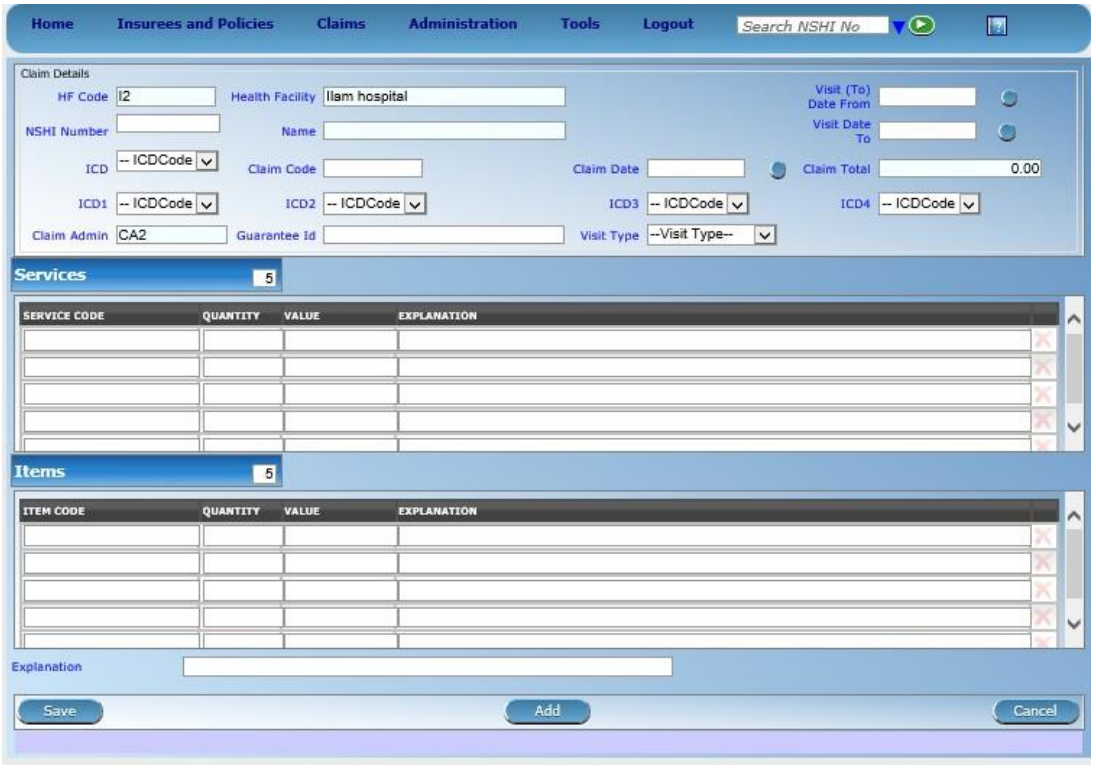
3.1 How to enter a new claim?

It is supposed that a paper form claim is at disposal to the user. This procedure can be performed only by a user with the role *Social Health Security Programme SHSP Clerk* or with the role *Claim administrator* and or *Claim contributor* for on-line and off-line client. If the user has the roles *Claim administrator* or *Claim contributor*, only claims of the health facility to which they are assigned can be entered. This functionality is available both for on-line and off-line clients.

1. Select **Claims-> Health Facility Claims**. The following form appears with the list of claims satisfying selection criteria in the upper part of the form:



2. Select **District** and **HF code** (Health Facility code) for which the claim is entered and select **Claim Admin**istrator. Click on **Add**. The following form for a new claim appears.

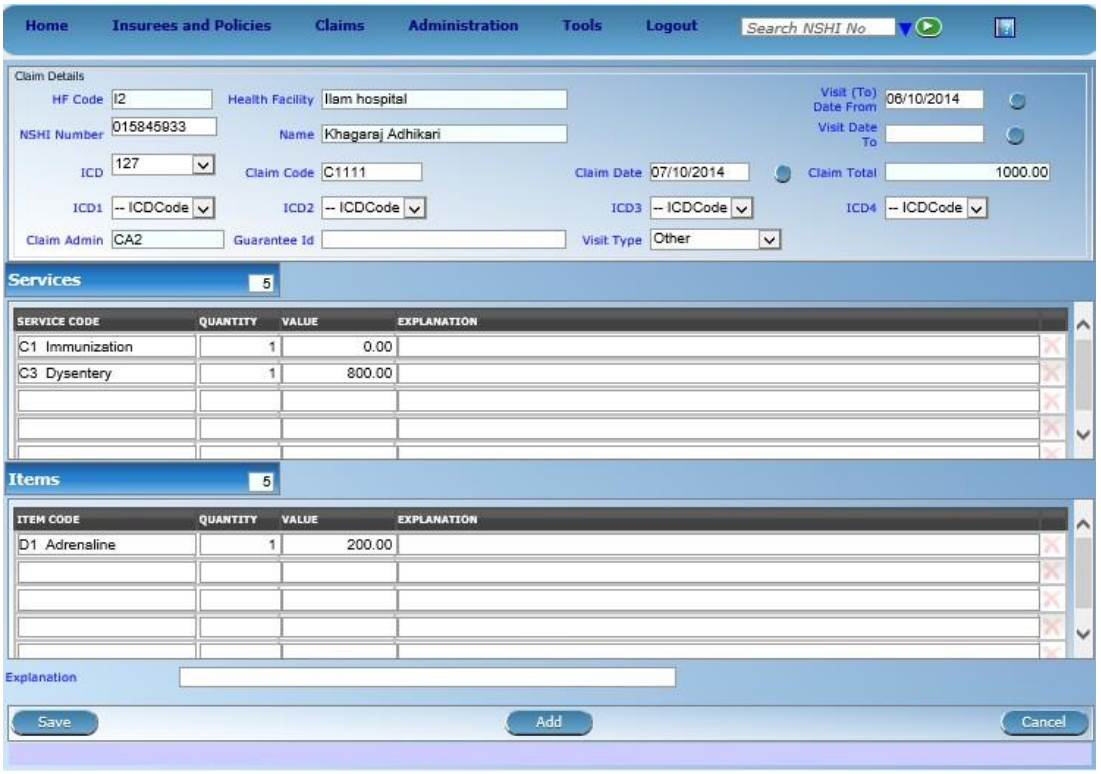


3. The form for entry of a claim appears. The **HF Code** (Health Facility Code) and the **Claim Admin**istrator Code are taken over from the previous form automatically. Select **ICD** code of a primary diagnosis from the claim and optionally up to four secondary

diagnoses in **ICD1-4** fields and enter **Social Health Security Programme membership SHSPnumber** of the patient. As a reaction on the entering of the SHSPSHSP membership number, the name of the patient appears in the field **Name**. You can check whether the SHSP number was entered correctly by comparing of the name acquired from the IMIS database with the actual patient's name in the claim. Enter a unique **Claim Code** (unique within the health facility), the date of issuing the claim **Claim Date,** enter **Visit Date From** (either the date of out-patient visit or the start date of a hospital admission) and enter **Visit Date To** (the last day of a hospital stay).

Enter medical services from the claim in the block *Services*. There is maximum number of services to be entered that is indicated in the box above. There is a choice of medical services offered that are in the pricelist of medical services associated with the health facility. Selecting a medical service from a list automatically assigns price of the service and unit quantity in the corresponding fields. These fields can be overwritten if necessary. The same exercise has to be repeated for medical items in the block *Items*. In case a service or an item was mistakenly entered, just click on the redcross on the right to clear the corresponding row in the box.

Click on **Save** to enter the claim. The claim enters the state ***Entered***.



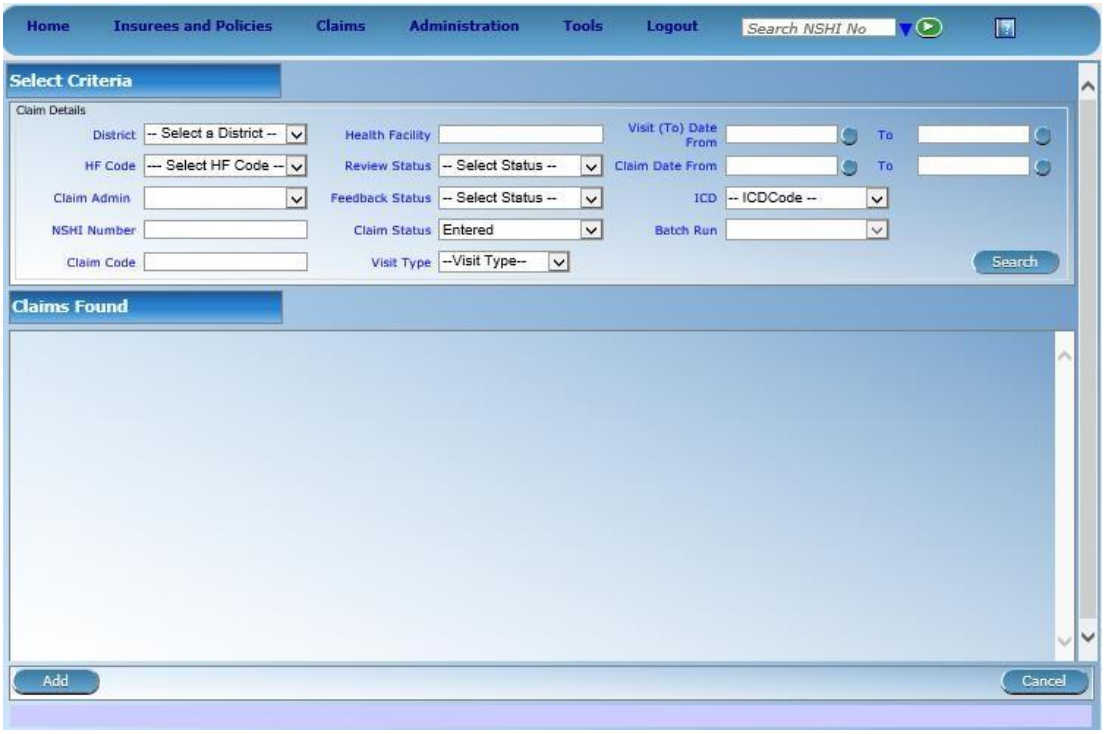
4. After saving of the claim the form with the claim remains displayed. You can click on **Print** to print a copy of the claim. You can click on **Add** to continue with entering of a new claim for the same health facility or you can click on **Cancel** to go back to the form from the step 1 in order either to initiate entering of claims for another health facility or to initiate another activity.

3.2 How modify an entered claim?

It may happen that after a claim is entered, some mistakes in entering may be revealed and the claim has to be corrected. It has to be clearly stressed that only claims in the state ***Entered*** can be corrected. As soon as a claim is submitted, it cannot be corrected any more (only modified while reviewing).

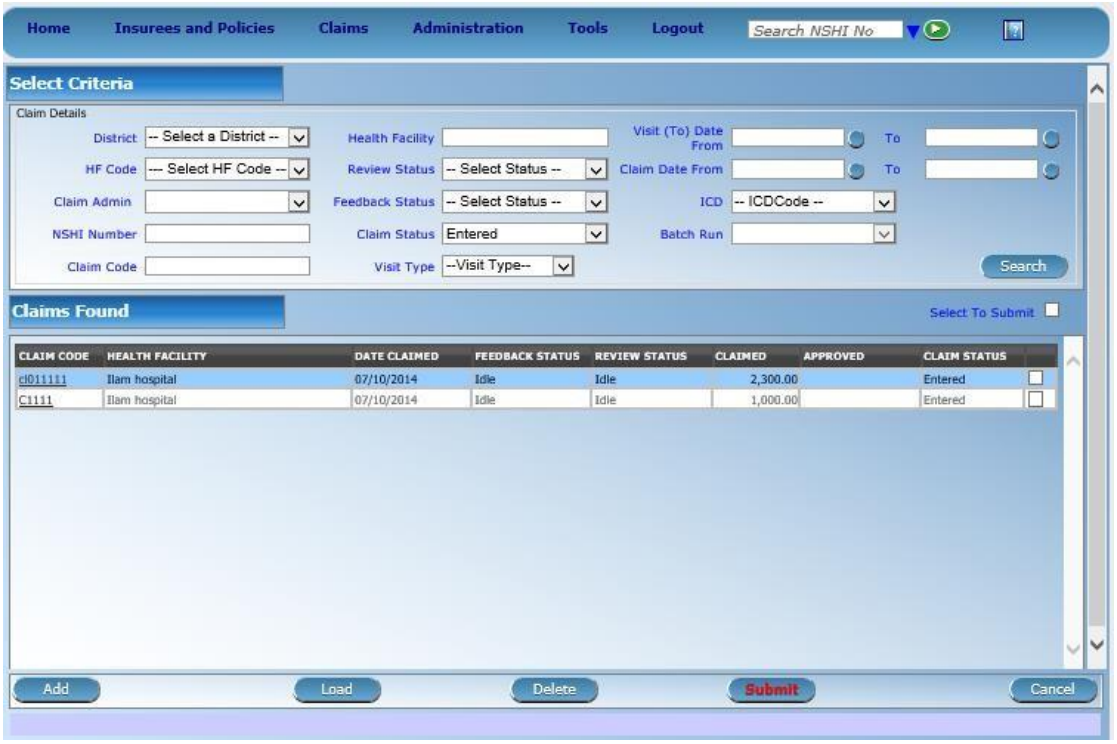
This procedure can be performed only by a user with the roles *SHSP Clerk*, Claim contributor and *Claim administrator*. If the user has the roles Claim administrator or Claim contributor, only claims of the health facility to which they are assigned can be modified This functionality is available both for on-line and off-line clients.

1. Select **Claims-> Health Facility Claims**. The following form appears:



2. Enter or select criteria for searching of claims in the section *Select Criteria*. If a claim should be corrected then only claims in the state ***Entered*** should be searched for. Click on **Search**. Have in mind that search criteria should be enough specific, otherwise IMIS refuses to display the list of searched claims due to an excessive length of the list (see the message at the bottom of the form in such case).

3. The list of claims satisfying search criteria appears:



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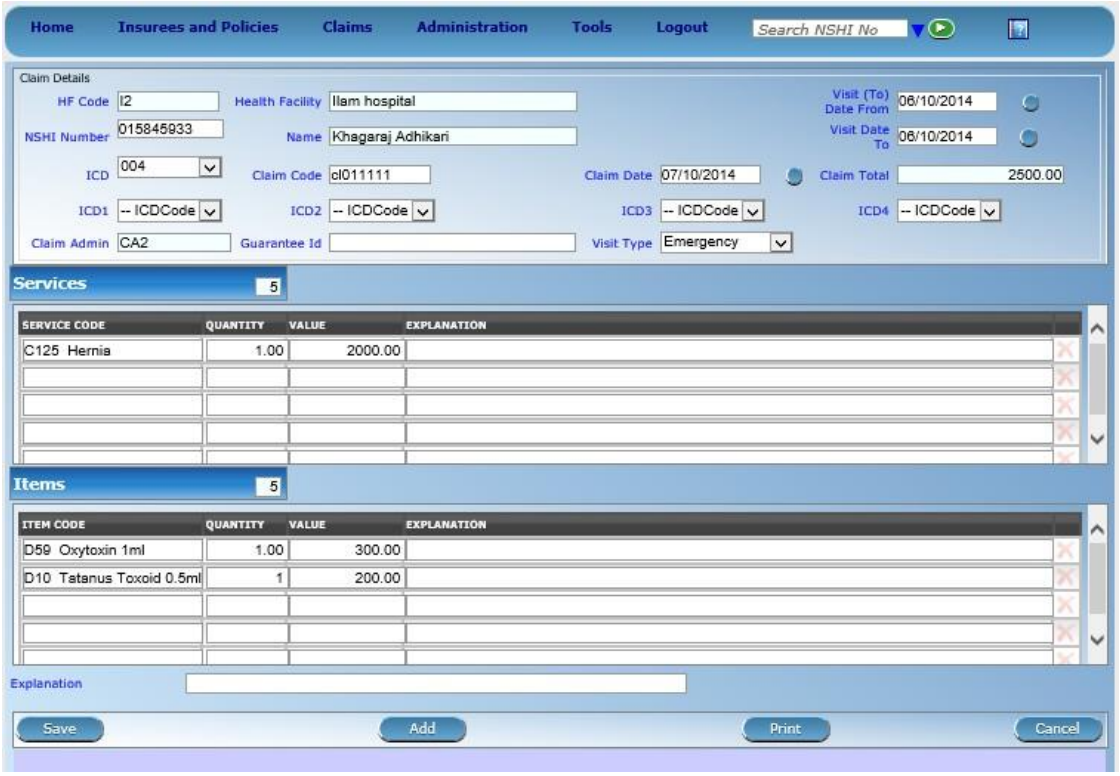
4. Select the claim for correction in the list (by clicking on an appropriate row in the list) and click on **Load**. The form with the selected claim is displayed.



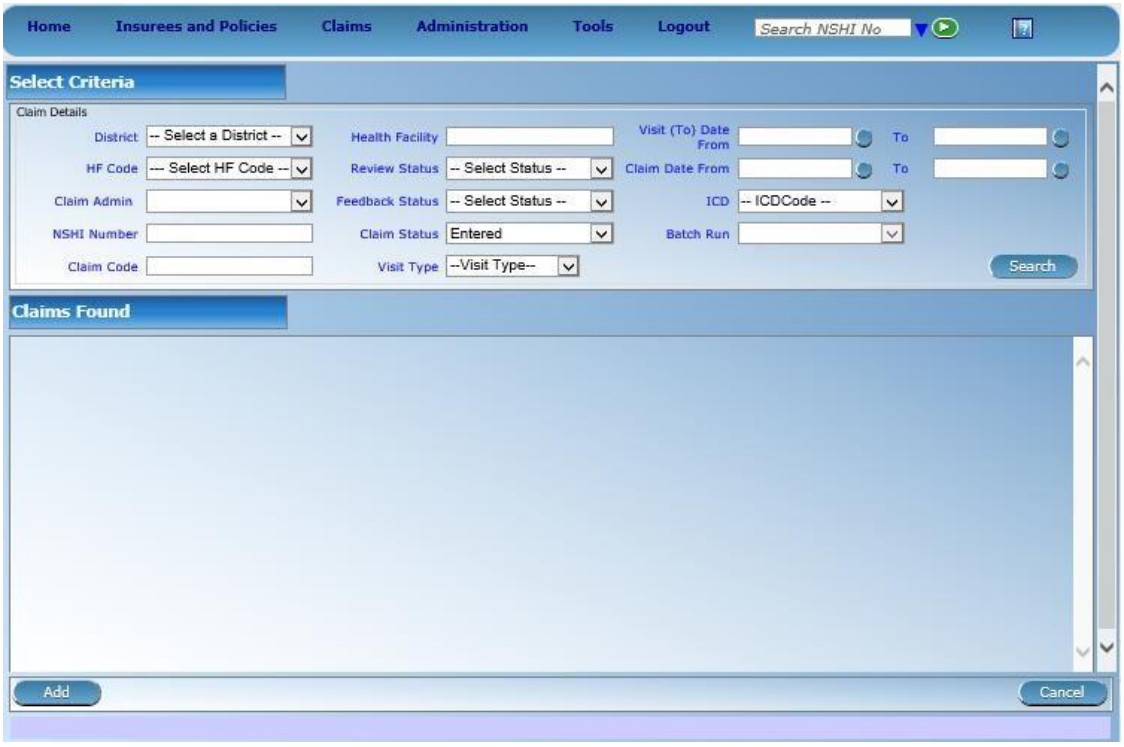
5. Add, modify or delete medical services and/or medical items in the form or modify fields in the heading of the claim. Click on **Save** to save changes. The claim still remains in the state ***Entered.***

3.3 How to submit claims?

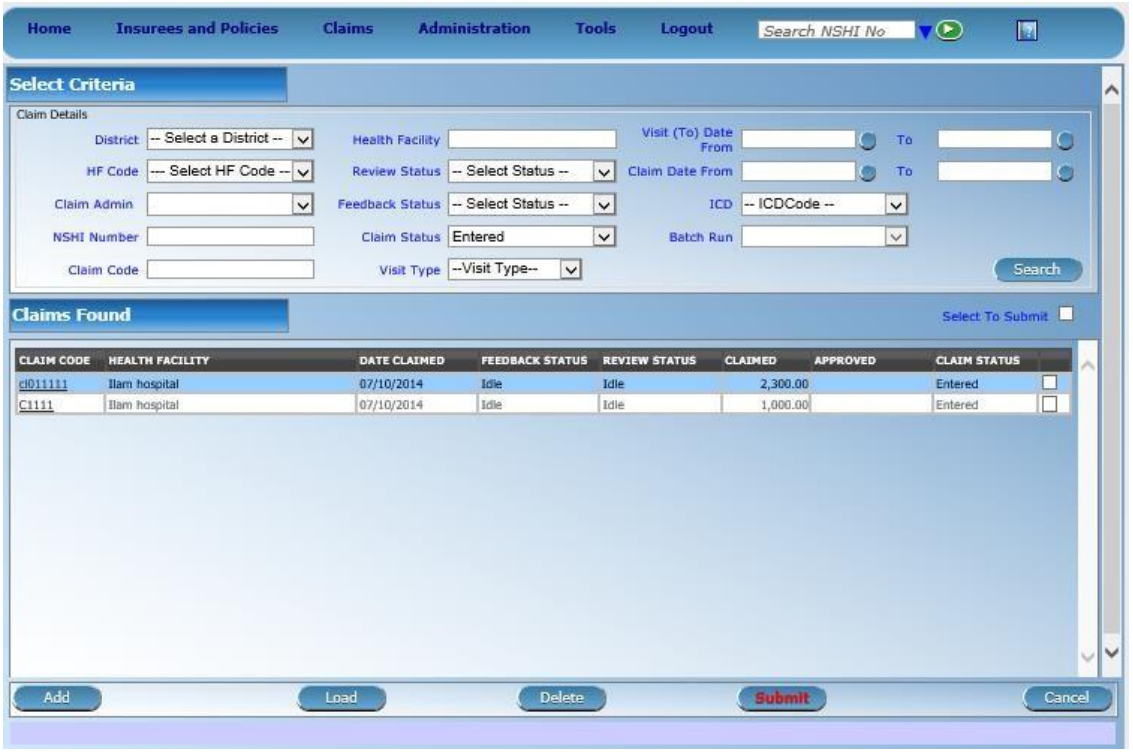
Claims that have been entered and there is no need for their correction, can be submitted. After a submission they cannot be corrected or deleted. They can be only reviewed and possibly rejected. Claims are checked just after submission automatically for formal correctness and conformance with the definition of corresponding insurance products. They pass to the state ***Checked*** or ***Rejected***,

This procedure can be performed only by a user with the roles *SHSP Clerk* or *Claim administrator* for off-line client. This functionality is available both for on-line and off-line clients.

1. Select **Claims-> Health Facility Claims**. The following form appears:

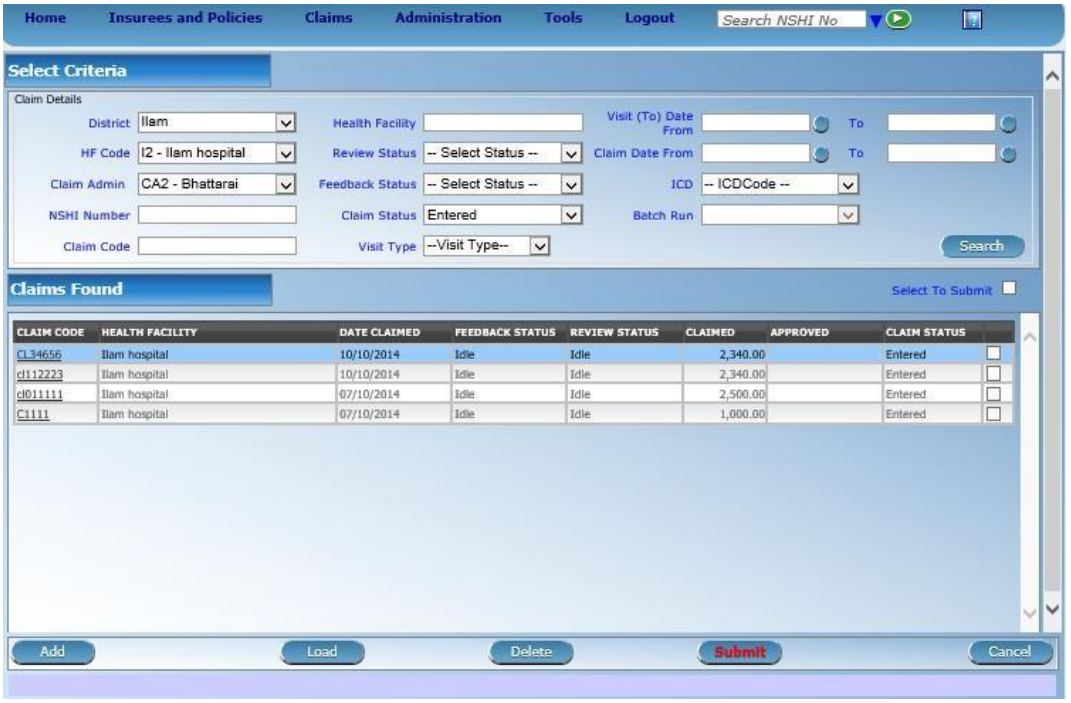


Or just click on **Cancel** after saving of the last claim**:**



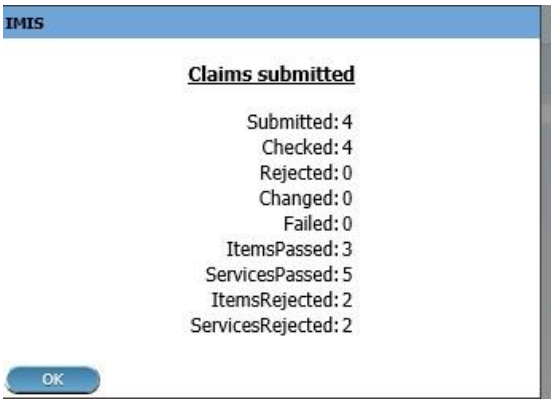
2. Enter or select criteria for searching of claims in the section *Select Criteria*. For submission, only claims in the state ***Entered*** should be searched for. Click on **Search**. Have in mind that search criteria should be enough specific, otherwise IMIS refuses to display the list of searched claims due to an excessive length of the list (see the message at the bottom of the form in such case).

3. The list of claims satisfying search criteria appears:



4. Select a claim for submission by checking the box in the last column in the list of displayed claims. Selection of claims for submission can be done on a mass scale clicking on the box **Select To Submit**. In that case all claims in the displayed list are marked for submission.

5. Click on **Submit**. A prompt appears asking whether really the marked claims should be submitted. All marked claims that are in the state ***Entered*** are submitted and passed to automatic checking. A statistics appears showing how many claims were successfully checked and how many rejected after their submission:

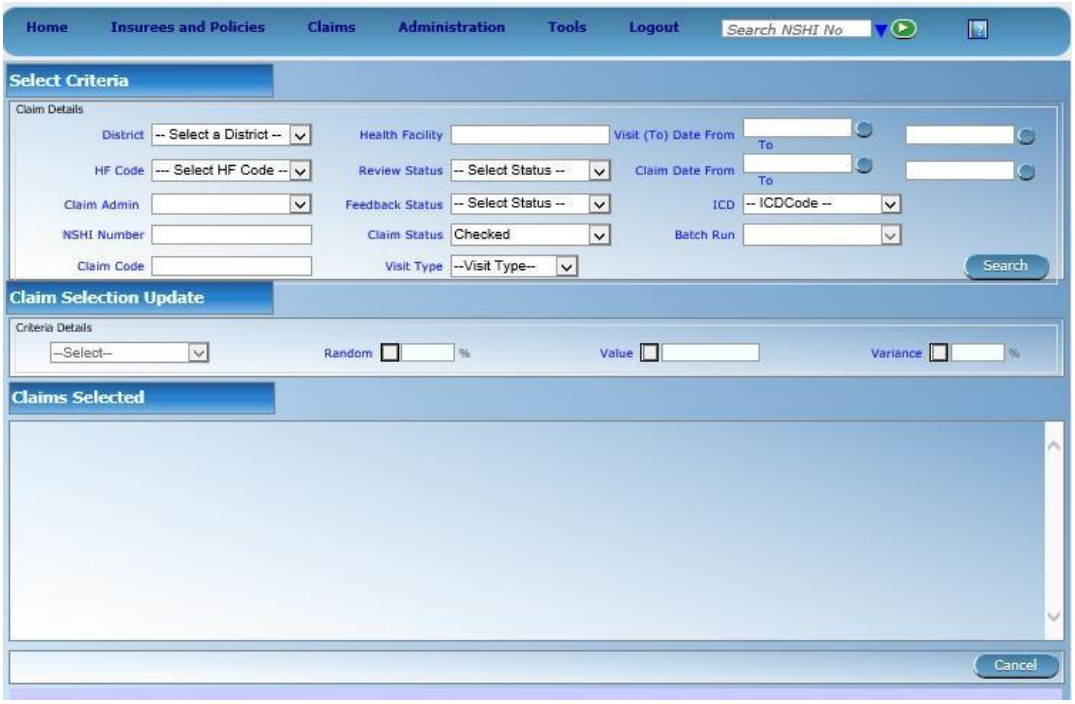


3.4 How to select claims for reviewing and for feedback?

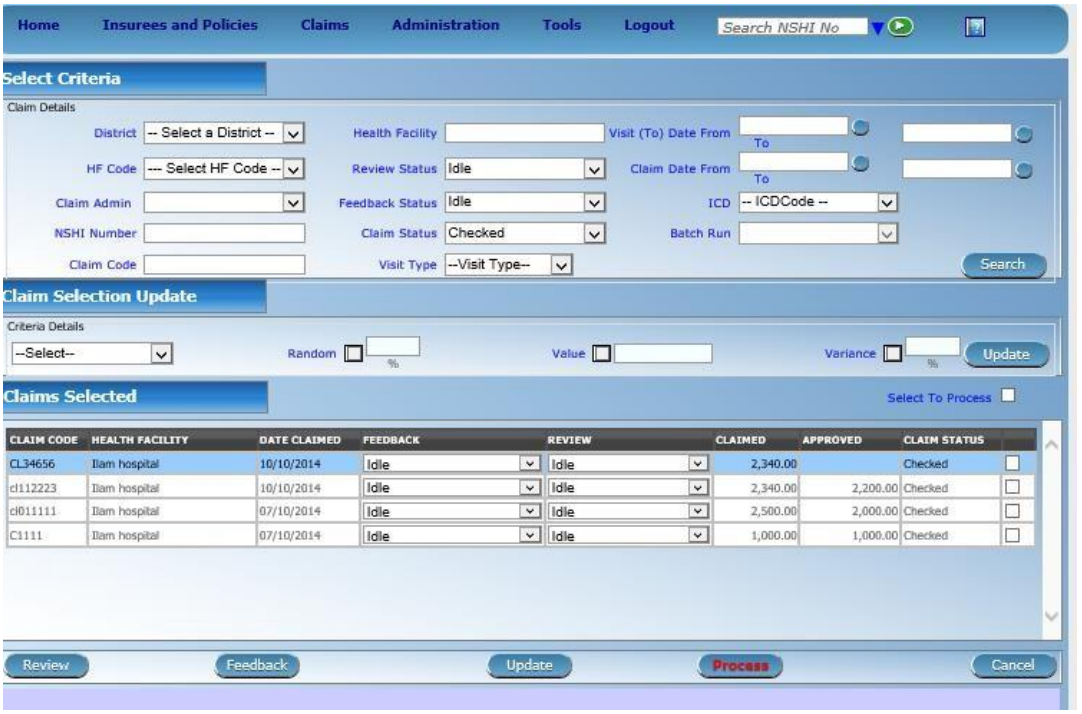
If the claims have been submitted and checked successfully they are in the state ***Checked***. In order to move them further in the processing they have to be reviewed by a medical advisor (the role SHSP Medical Officer) and feedbacks of the patients on them can be collected. It is not necessary to review or to get feedback for all claims. Only a sample is sufficient that can be even empty. However, all claims that in the state checked have to go through the process of selection for review and for feedback. Otherwise they cannot be valuated and afterwards remunerated to health facilities.

The procedure of selection of claims for review and/or feedback can be performed only by a user with the role *SHSP Medical Officer*. It is available only for on-line clients. The procedure follows:

1. Select **Claims-> Review**. The following form appears:

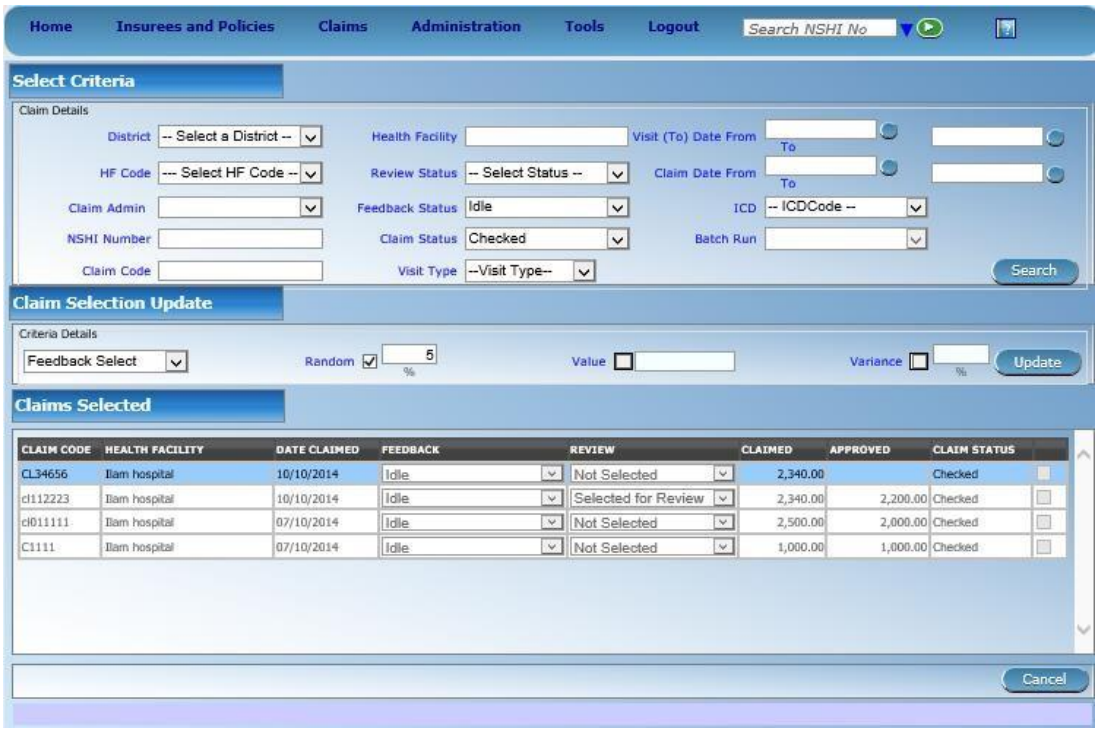


2. Enter in the section *Select Criteria* the criteria for selection of claims that you want to review and/or to ask for feedback. Generally, these claims should be in the state ***Checked*** (it is default in the selection criteria). You may, for example, select for claims that were claimed in specific period of time. You get the following form with the list of claims that satisfy the selection criteria:

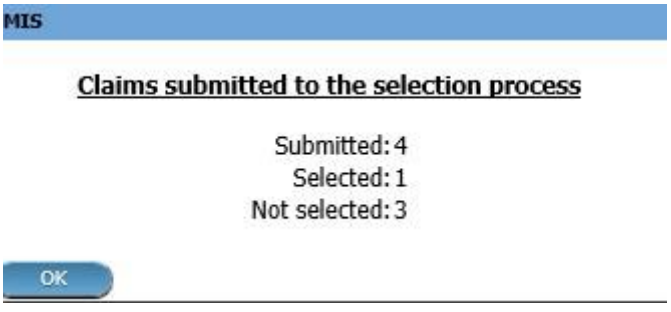


3. You have to select in the section *Claim Selection Update* whether claims for a review (select in the left field ***Review Select***) and for a feedback (select in the left field ***Feedback Select***). After that, you can select a method of the selection and its parameters. You can select claims from the list randomly. In that case click the field

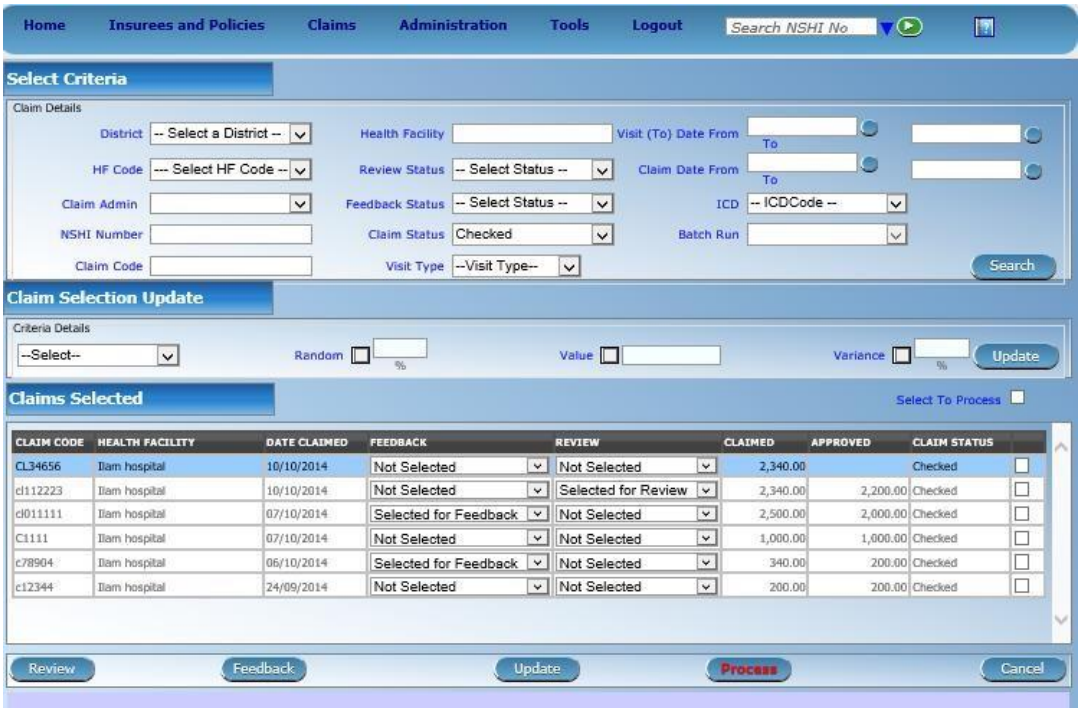
Random and specify in the next field percentage of claims that you want to select for review or feedback on random basis. Alternatively, you can select claims according to their absolute **Value** and specify in the next filed the threshold value. You can also select claims for a review or a feedback according to their value and according to **Variance** of claims with the same diagnosis and specify in the next field the minimal percentage of average value that the selected claims should exceed. Click on **Update** once for the selection for a review and once for the selection for a feedback.



4. An alert box appears asking for a confirmation of the selection method for claims to be reviewed or to be asked for a feedback. Further, a box showing how many claims were selected for a review or for a feedback:



The sub-state of selected claims will change from ***Idle*** either to ***Selected for review (feedback)*** or ***Not Selected for review (feedback):***

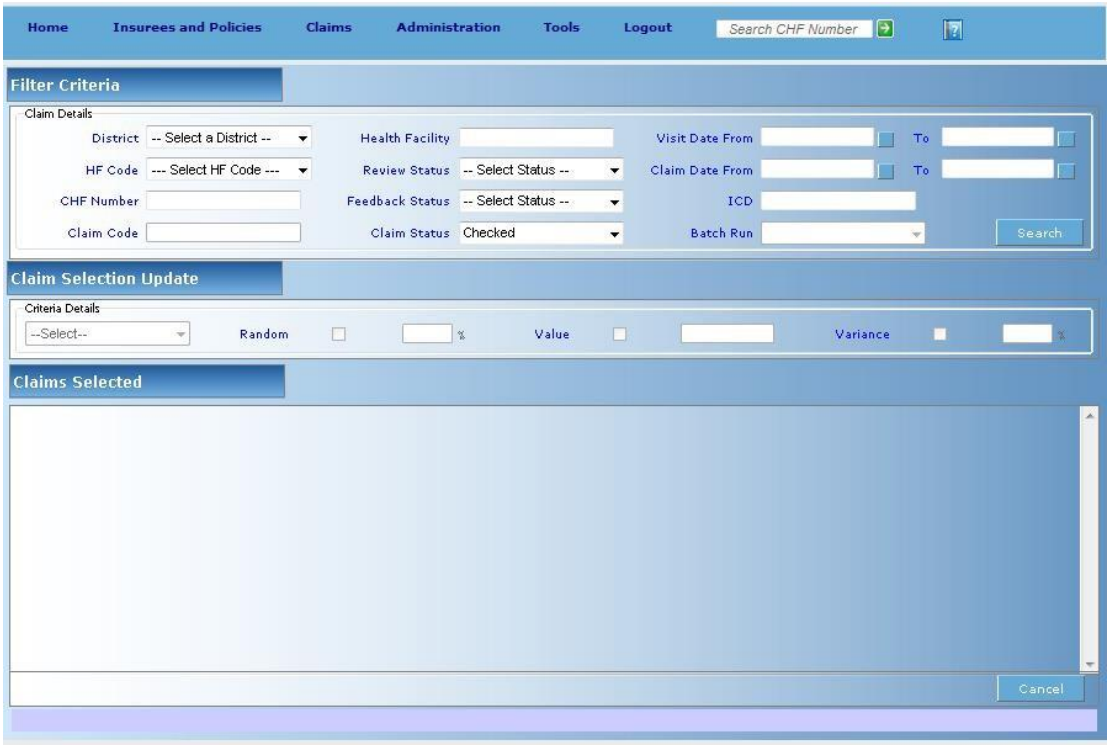


3.5 How to review a claim?

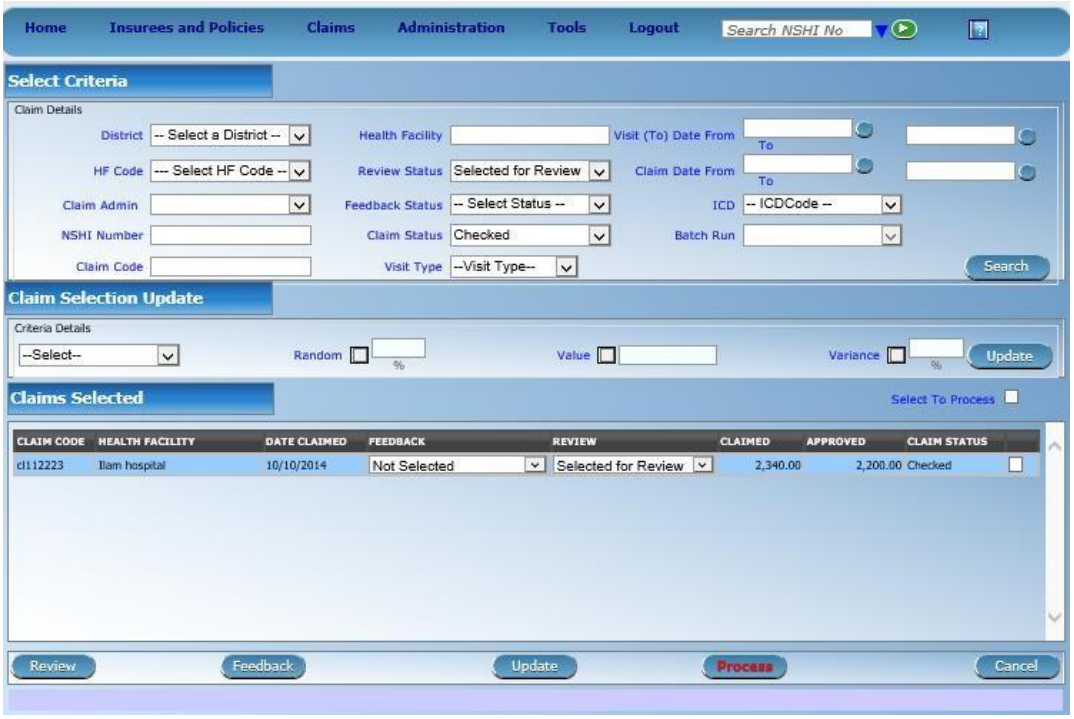
Claims that were selected for review in the previous procedure should be generally reviewed. However, it can happen that a user (SHSP Medical Officer) decides not to review all claims selected for a review. In that case, the user can still send such claims to further processing but he/she has to confirm his/her intention explicitly (see the next procedure). By reviewing a claim in the sub-state ***Selected for review***, the claim changes to the subs-state ***Reviewed***

The procedure of reviewing can be performed only by a user with the role *SHSP Medical Officer*. It is available only for on-line clients. The procedure follows:

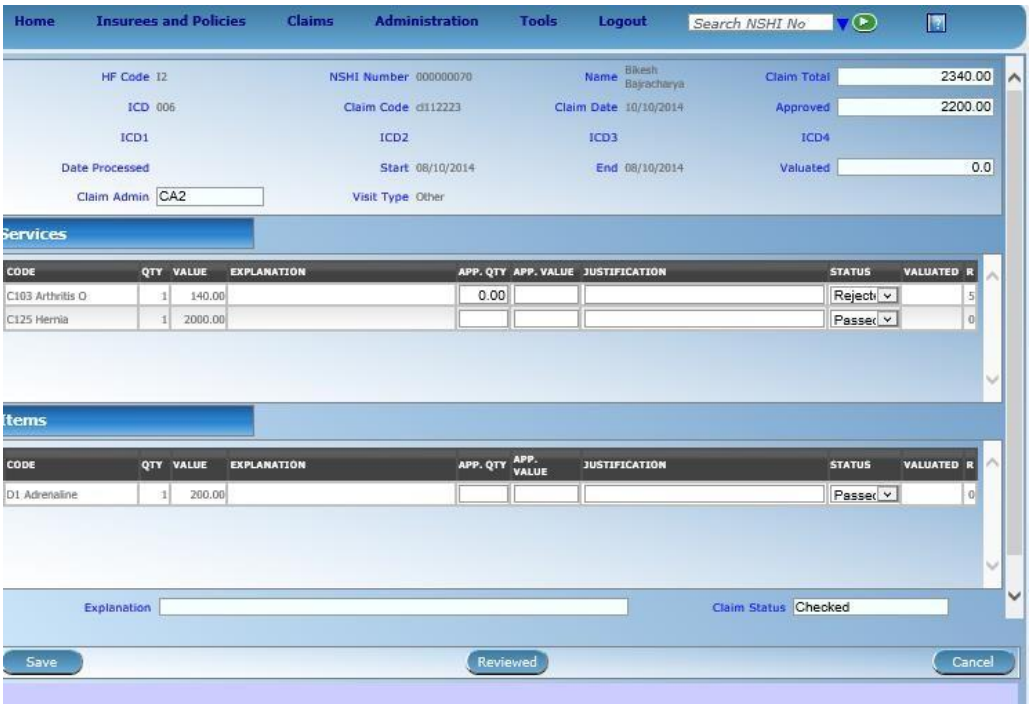
1. Select **Claims-> Review**. The following form appears:



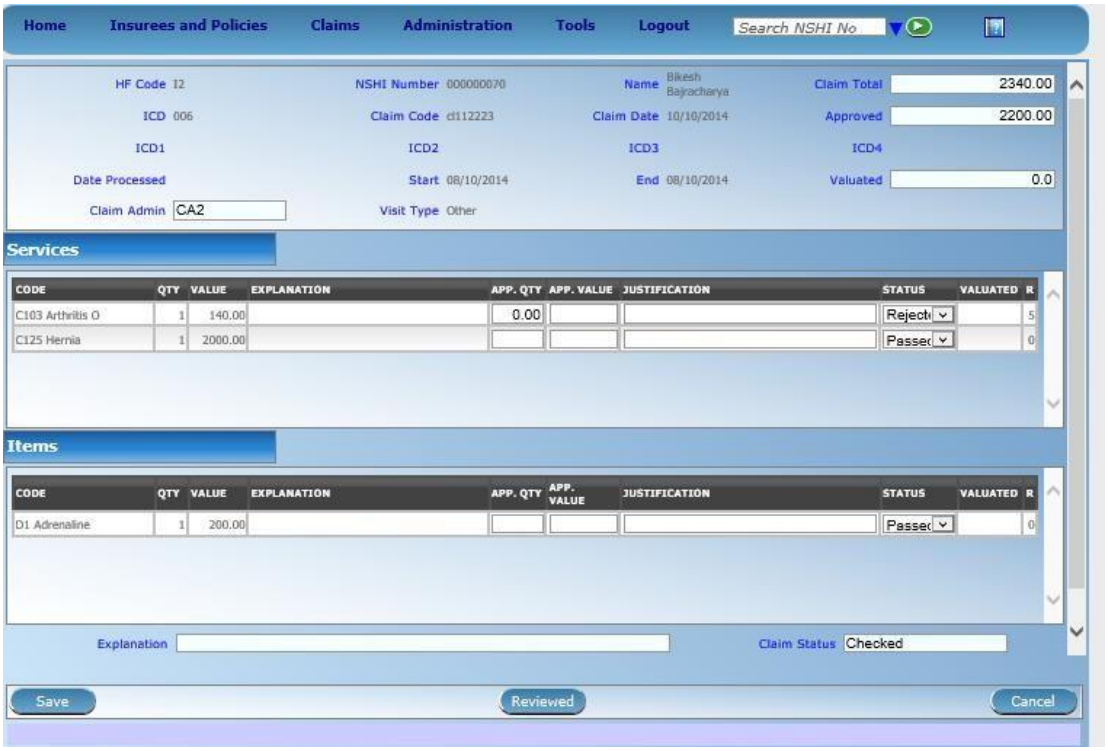
2. Select claims for reviewing. Especially select **Claim Status** as ***Checked*** and **Review Status** as ***Selected for Review.*** You may use other select criteria to further restrict the list of claims to be considered. Click on **Search**. A list of claims for review appears:



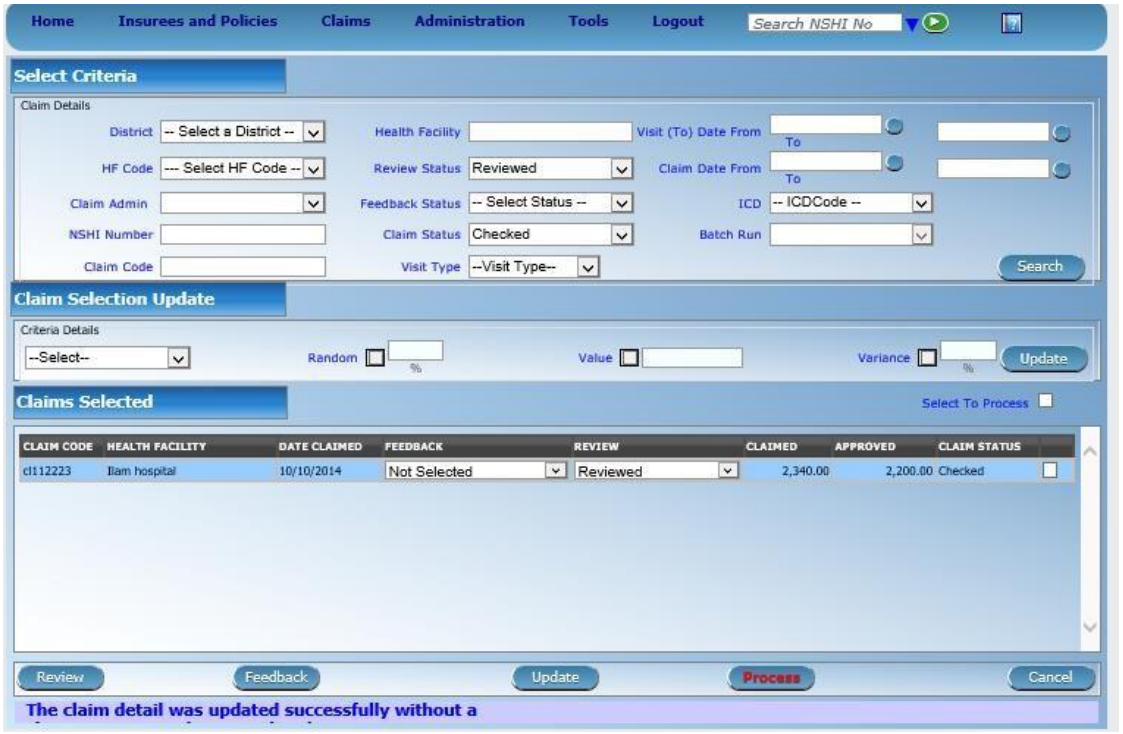
3. Select a claim in the list that you want to review and click on **Review** button. The following form with the claim to be reviewed appears:



4. It is de facto the form for a claim where additional fields are in each row for medical services and medical items. You enter in the field **App.Qty** a new number of provision of given service (medical item) if it differs from the original number entered with the claim. Similarly, you enter in the field **App.Value** a new value (price) of provision of given service (medical item) if it differs from the original value entered with the claim. You can even reject the whole medical service and/or medical items by changing the state to ***Rejected*** in the corresponding row in the column **Status.** You can explain your steps in the fields **Justification** for each changed medical service and/or medical item. You can your explanation to the whole claim in the field **Adjustments**. If you are ready with reviewing of the claim click on **Review** button. The changes will be saved and the sub-state ***Selected for Review*** of the claim will be changed to ***Reviewed***. If you just want to save adjustments you made click on **Save** button. In this case the claim will remain in the sub-state ***Selected for Review***.



5. You can review a claim repeatedly until it is set for further processing. The claim still remains in the sub-state ***Selected for Reviewed*** but its content can be reviewed and adjusted several times. When the reviewing is finished, click on **Review**. The claim goes into the sub-state ***Reviewed***.

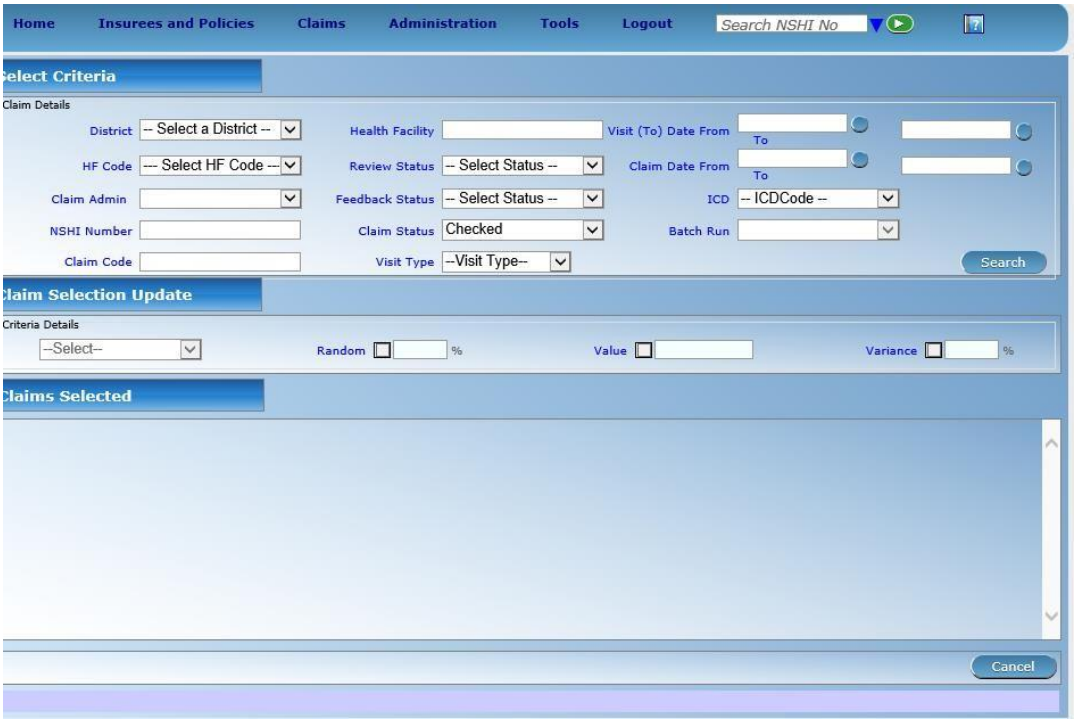


3.6 How to start valuation of claims?

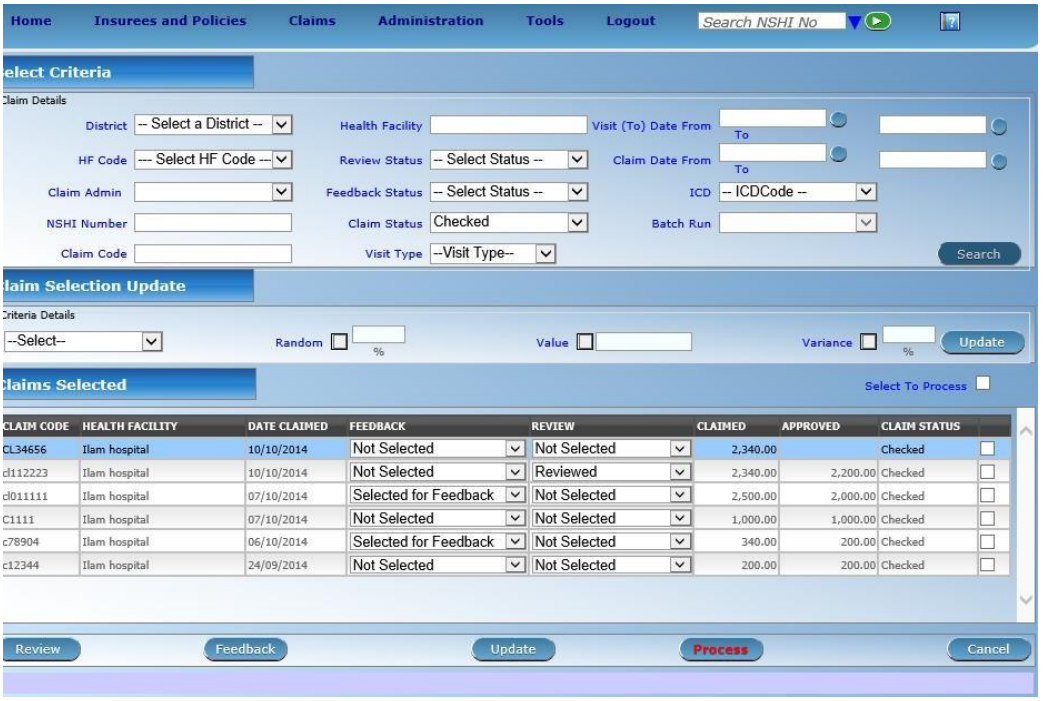
Claims that were reviewed or that were not selected for a review (and that were not selected for feedback or their feedback had been already collected) can be send to valuation. However, it can happen that a user (*SHSP Medical Officer*) decides not to review all claims selected for a review. In that case, the user can still send such claims to further processing but he/she has to confirm his/her intention explicitly.

The procedure of reviewing can be performed only by a user with the role *SHSP Medical Officer*. It is available only for on-line clients. The procedure follows:

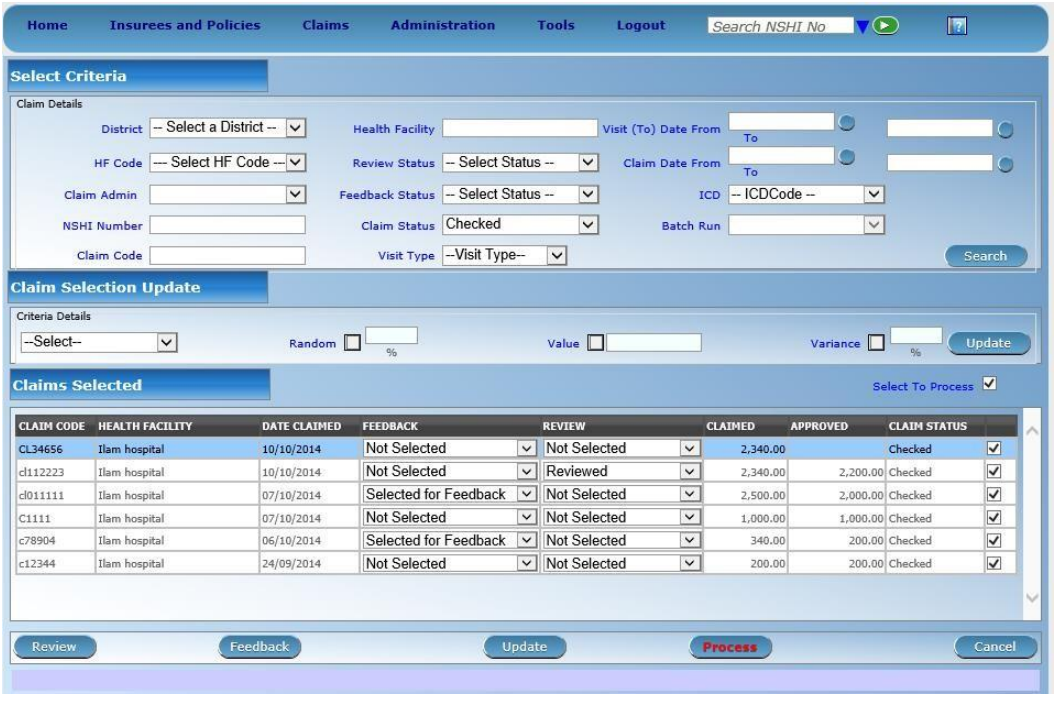
1. Select **Claims-> Review**. The following form appears:



2. Select claims for further processing. Especially select **Claim Status** as ***Checked.*** Click on **Search**. A list of claims for review appears:

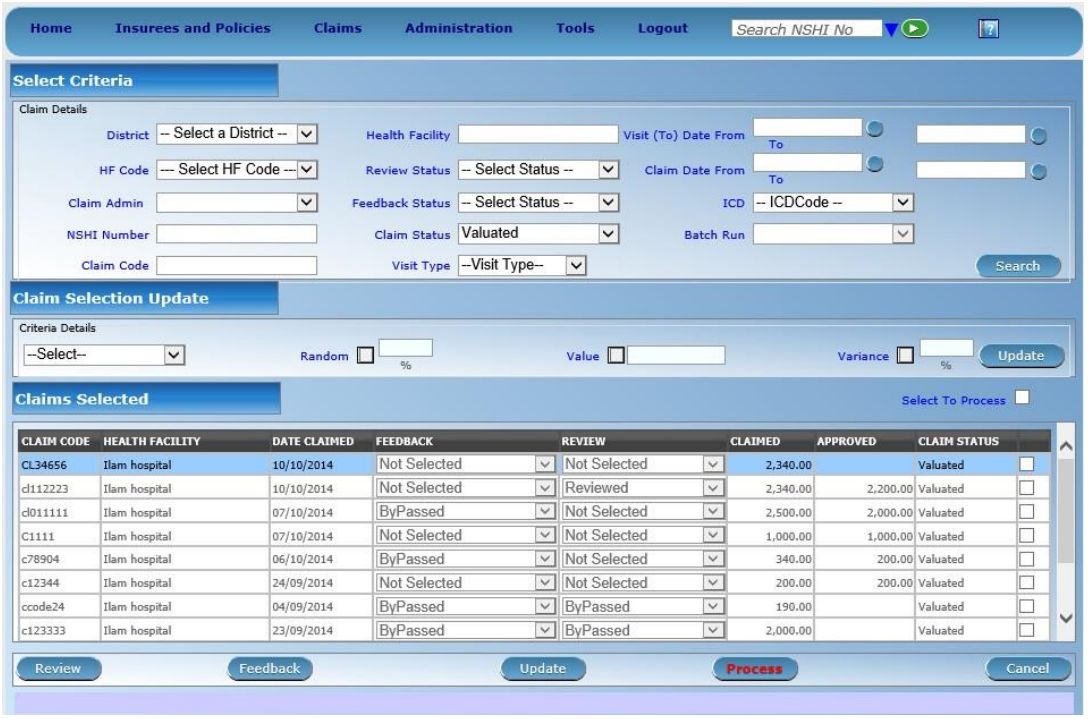


3. Select claims for further processing in that check the box on the right side of each row or you can do it on a mass scale by checking the box **Select To Process**. Only claims that are not in the sub-state ***Idle*** regarding review or feedback can be selected. Click on **Process** button.



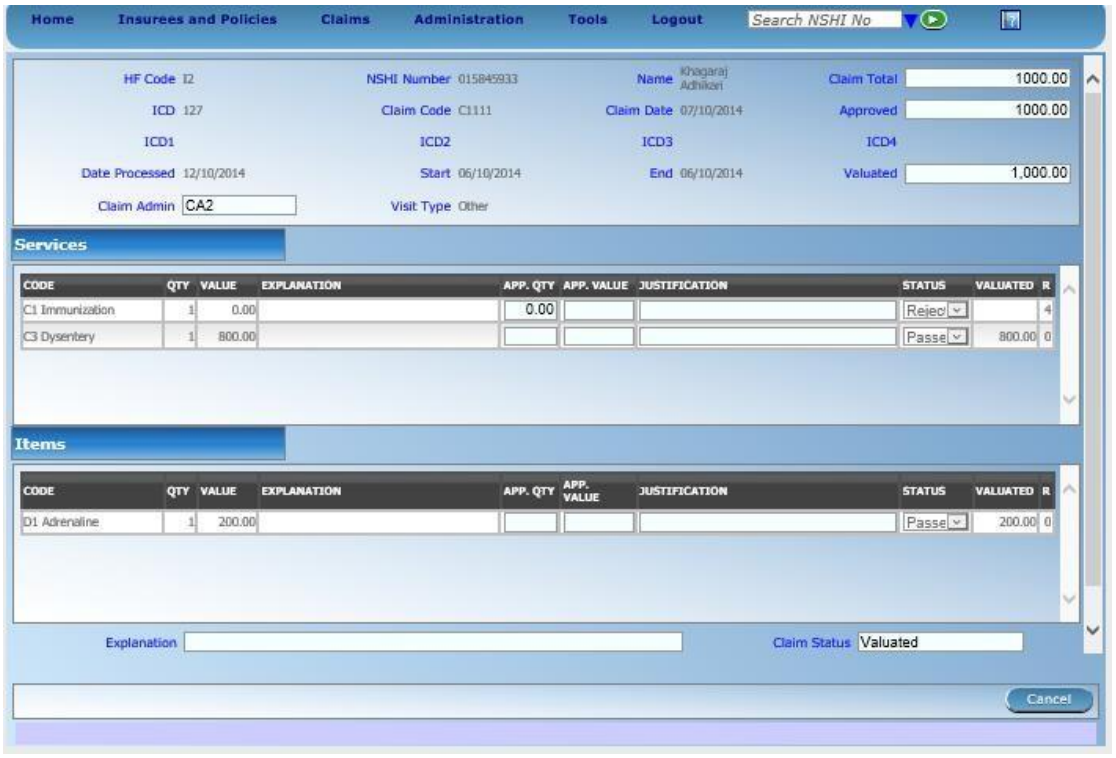
4. If among claims selected for processing were some claims in the sub-state ***Selected for Feedback*** or ***Selected for Review*** then an alert appears. If you answer **Yes** to the alert it means you want to proceed further although not all designated claims were reviewed or their feedbacks were collected. In that case the corresponding sub-states of such claims changes to ***ByPassed*** and the claims are processed further. The claims pass

further to the state ***Processed*** and to the final state ***Valuated***[2]. You can look at which claims passed to the state ***Processed*** or ***Valuated*** by searching in the *Review form*:



5. If you want to look to what amount a claim was valuated, select the claim in the list above and click on **Review**. There is the field **Valuated** associated with each medical service and/or medical item in the display of the claim and the total amount for the claim is given in the field **Valuated** within the head of the claim as well.

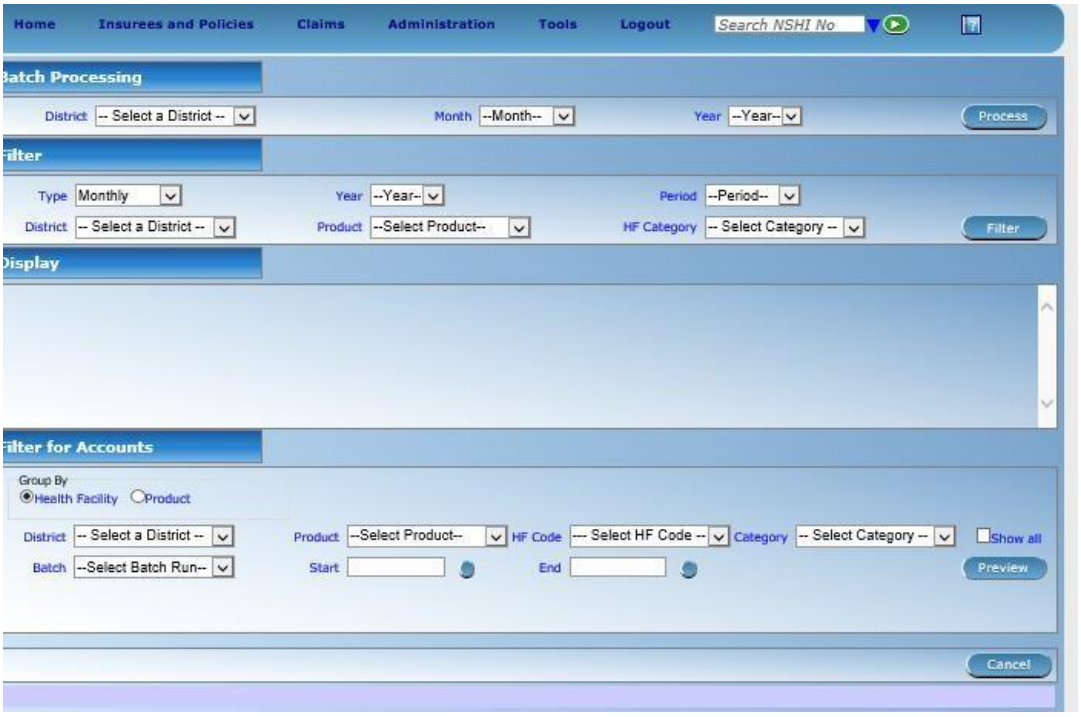
[2] Claims pass to the state ***Valuated*** only if all medical services and medical items in a claim have either absolute prices (it means not relative) or corresponding indexes for their relative prices had been already calculated. In the latter case such claims were definitely submitted to IMIS with a delay. If a claim has some medical services and/or medical items with relative prices and not yet calculated indexes for the corresponding period it parks in the state ***Processed***. Relative pricing will be not used by SHSP at bebinning.



3.7 How to create a report for the accounting system?

This procedure can be performed only by a user with the role *SHSP Accountant.* This functionality is available only for on-line clients.

1. Select **Claims-> Batch Run**. The following form appears:

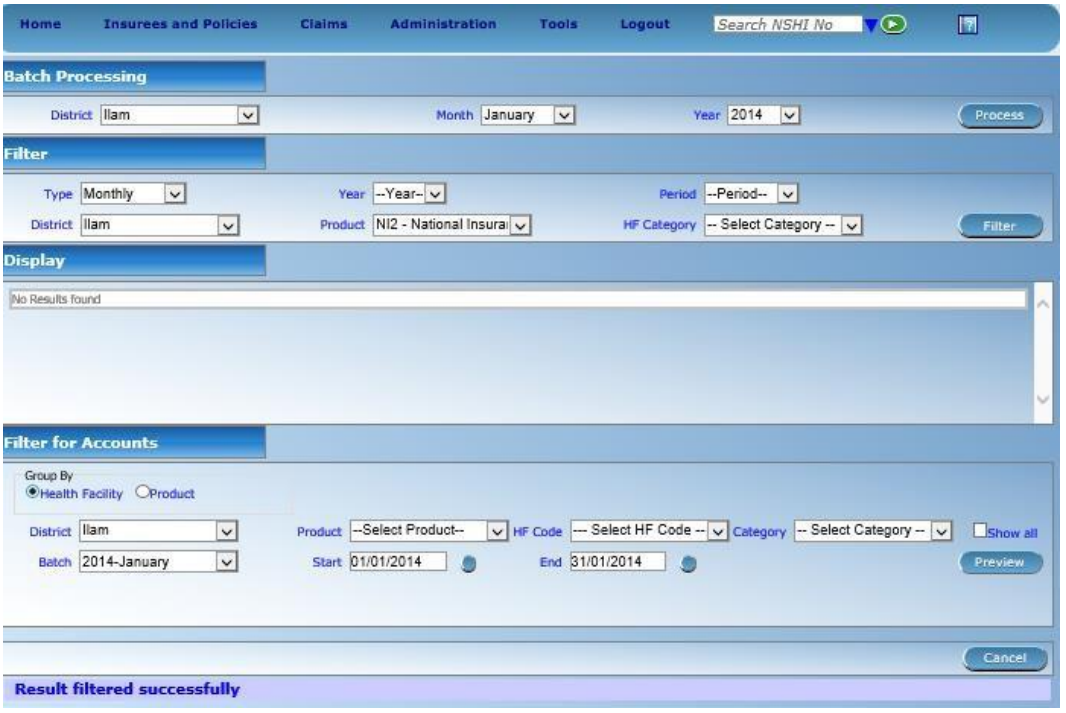


2. Select **District**, **Month** and **Year** for creation of a batch of claims[3] in the section *Batch Processing*. Month and Year determine last month of the calendar period for which calculation will be done. The preceding month is offered as a default. Click on **Process.**

3. A prompt is displayed whether you really want to start creation of the batch. It is important to have in mind that for given calendar period the batch can be calculated only once. A batch of claims is created for given month.

Reports for the accounting system are related to creation of batches that was described in the previous chapter. A report can be produced only for already created batches.

4. Select **District** and **Batch** in the section *Filter for Accounts* for which you want to create the report. You may also use further selection criteria to narrow the scope of the desired report. You may produce the record only for a specific insurance **Product**, for a specific health facility (**HF Code**) or a specific **Level** of health facilities. You may also specify a period **Start** and **End** for claims for which you want to create the report. Click on **Preview.**



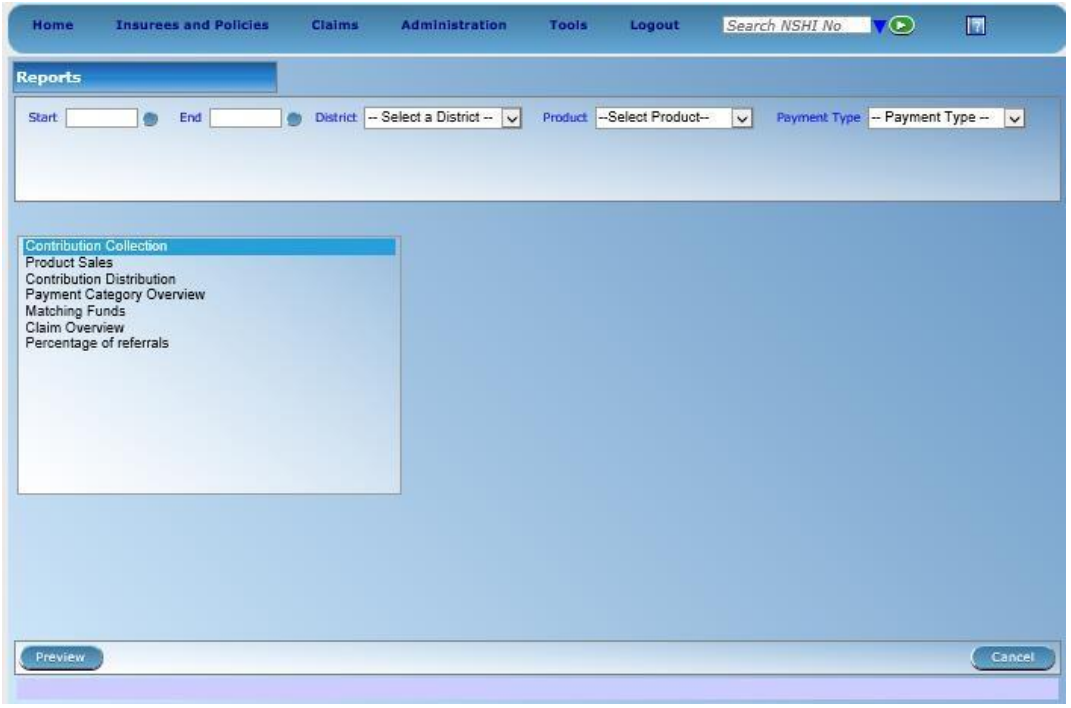
5. The report is displayed and it can be converted to other formats (*Excel, PDF, Word*) or printed by clicking on the icons in the upper right corner of the report.

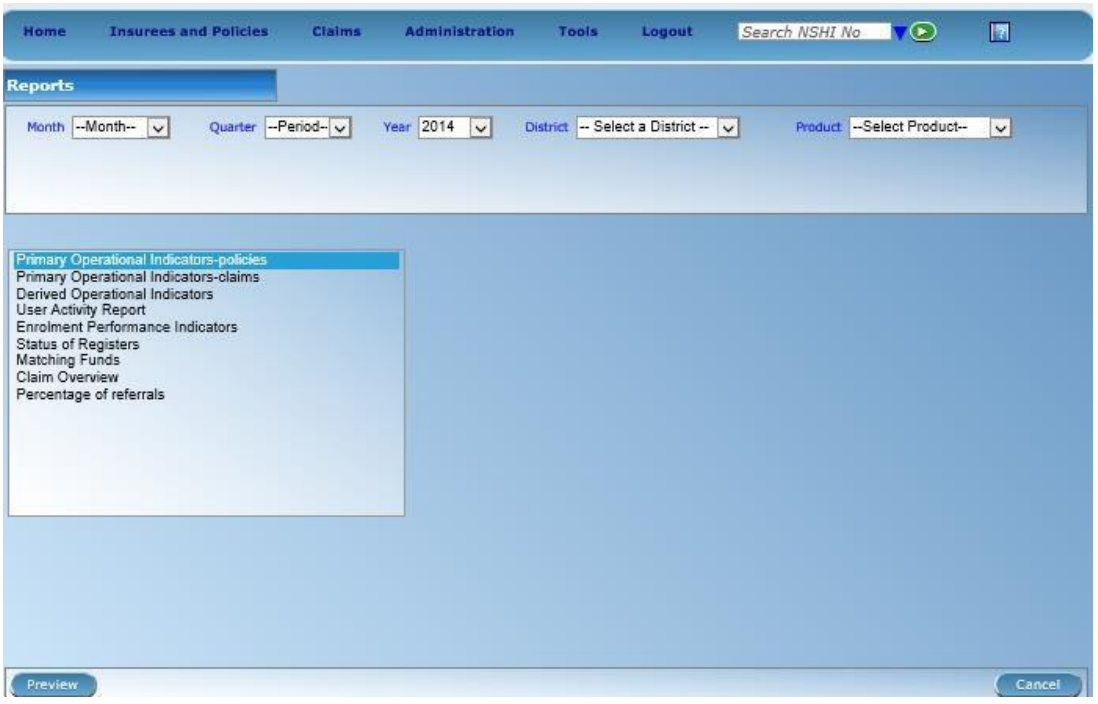
4 Managerial reports

A set of managerial reports is produced by IMIS.

This procedure can be performed only by a user with the role *SHSP Accountant or SHSP Manager* Distinct sets of reports are available for both roles. This functionality is available only for on-line clients.

1. Select **Tools-> Reports**. The following form appears for a user with the role *SHSP Accountant*:





2. Each of these reports has its own set of input parameters that are displayed in the form by selecting of the required report. The common input parameters are:

    - **Start** and **End** for specification of a period for which the report should be produced or
    - **Month, Quarter, Year** for the same purpose**,**
    - **District** for which the report should be produced**,**
    - Insurance **Product** for which the report should be produced and specific parameters

- **HF Code** if the report should relate to a specific health facility,
- **Payment Type** for specification of the type of payment for the report on collection of contributions,
- **Claim Status** for specification of claims that should be included in the *Overview of Claims*,
- **User Name** for specification of a user for which *User Activity Report* should be produced,
- **Enrolment Assistant** for specification of an enrollment assistant for which a report on *Insures without photos* should be produced.

3. Enter or select required input parameters of the selected report and click on **Preview**. The desired report is displayed.
4. You may print the report or convert it to other formats (*Word, PDF, Excel*) by clicking on icons in the right upper corner of the report
5. Click on **Go back to selector** to return to the form for selection of reports.