System Overview

EnCore Health Care Benefit Management Solutions

EnCore℠
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Introduction

EnCore health benefit management solutions are delivered by an array of highly efficient and productive applications to manage and administer health, dental, vision and prescription drug benefits. These include enrollment, eligibility, billing, electronic claims, auto-adjudication, clinical editing, medical management, customer service, ad hoc reporting, standard reporting and a host of additional processing capabilities functioning in compliance with HIPAA mandated transaction code sets in a secure environment.

Our proven health care benefits administration system delivers accurate, highly automated healthcare transaction processing solutions to group health plans, third-party administrators insurance companies, self-funded associations, Taft-Hartley Plans and employers.

EnCore facilitates increased productivity, reduced costs, an improved customer focus and the ability to help your enterprise adapt quickly to new business opportunities.

HIPAA readiness is addressed by an efficient solution developed by EnCore System Professionals and will continue to be enhanced as regulations change.

Solutions Optimized for Productivity

EnCore's comprehensive benefit management solutions are optimized to deliver rapid and accurate processing of your administrative, claims and reporting processes.

Integrated Third Party software and services are offered as needed to further enhance the functionality and use of EnCore Systems. These include: printing and mailing of checks, EOBs and letters; scanning and imaging; data entry; usual and customary data bases; length of stay, clinical editing and unbundling data bases; HRA, HSA; Flexible spending; Cobra; Taft-Hartley; Data Warehouse.

Billing and Member Administration

- Enrollment and eligibility
- Premium billing and allocation
- Accounts Receivable
- Sales Commissions
- COBRA

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- Benefit Plan Definition
- Fee Schedules/Provider Management
- Eligibility Determination
- EDI Auto Adjudication and Workflow
- Coordination of Benefits

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- Comprehensive set of Standard Reports
- EnCore-Report Builder - Ad hoc Reporting
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Each functional component may be implemented on a stand-alone basis and integrated with your current system, or all components may be purchased as an entirely integrated system to handle all the tasks necessary to administer your business. More detailed descriptions of EnCore system solutions are provided on the following pages. In addition, further detail is provided concerning the operator, batch or scheduled processing components. EnCore's global navigation system is intuitive and provides easy access to system capabilities when you need them.

Billing and Member Administration

Billing provides a comprehensive software solution for:

- Subscriber and dependent enrollment
- Member and dependent eligibility
- Premium billing
- Accounts receivable
- Sales commissions
- Premium allocation
- COBRA
- Reporting

The system was designed to either stand alone as an independent system or to work as a sub-system to Claims Management where transactions are automatically processed through the system in a manner totally transparent to the user. The system handles many types of insurance –including medical, dental, vision, and life. Eligibility and premium information is generated in report and electronic format for transmission to third-party insurers.

Enrollment can also be updated by EDI data feeds from various sources such as payroll systems and Taft-Hartley Hour Banking applications.

Each of the above functions is described below.

Membership Enrollment
The Member module maintains benefit and eligibility information by employer groups, subgroups, locations, and classes. It assigns a unique identification number to the responsible party as well as each of the covered dependents. The system has the ability to identify or access a member's file by member name, dependent name, AKA, member SSN, dependent SSN, or an alternate ID assigned to either the member or dependent. Some of the personal and coverage information that is stored in the database includes: social security number of both the insured and the dependents, dates of birth, address, home and business phones, gender, and employment information. The family register is maintained for all dependents and eligibility is automatically terminated based on user defined age restrictions.

Events such as marriages, divorces, adoptions, and student enrollment dates which affect eligibility are tracked by the system and automatically update eligibility to reflect dependent effective or termination dates. Member elections define the election period, insurance plan, coverage category, and plan options such as dollar volume, salary bracket, smoking/non-smoking, etc. Since all of the election parameters are user defined, each system can be customized to meet an organization's specific needs.

Eligibility
The system provides the capability to allow eligibility by member that is open until terminated by subscriber or employer group, premium hold, or the system can advance the eligibility date based on billing or payments received.

When payments and/or adjustments are applied to an invoice, the premiums are automatically distributed to the member billing records. Current or retroactive changes can be made through enrollment including the addition of new members, termination of members, and changes to coverage. Eligibility is updated to reflect the paid coverage and any changes made are reflected on the subsequent billing.

Employer Groups
Employer groups can be maintained at different levels allowing flexibility in billing and reporting. Employers can be divided into divisions or subgroups, each of which can be associated with a legal entity or business segment. Divisions can be further separated into locations, which allow options for plan election and premiums. Policies are created for each billing unit and can be related to the employer, division or location. Each policy defines the statement format to use and the sequencing and totaling of the statement roster.

Policyholders are billing entities that may be employer groups, individual members, or COBRA participants. Statements are calculated automatically based on the member, employer, division, location, and rate tables. Rates can be prorated down to a quarter of a month and all retroactive adjustments based on changes in enrollment are automatically calculated and billed.

Premiums/Statements
Premium schemes are defined by employer group and each scheme directs the billing module to a specific premium table. Premium tables are date effective and premium amounts are defined by coverage and type of eligibility. Under each premium table is an additional table that further breaks down the premium amounts into user defined codes and fee amounts for underwriting, reporting and allocation. The system accommodates monthly, quarterly and annual billing periods. Statements can be generated by policyholder upon request or by a predefined billing cycle.

The first page of the statement lists the balance forward, all payments and other transactions since the last statement, a total of retroactive and current billing, and any add-on administration fees. This page is designed to be returned with the payment. The roster portion of the statement first lists all retroactive adjustments by subscriber and covered period and then lists all covered subscribers for the current covered period.

Accounts Receivable
When a statement is produced, an open invoice is created in accounts receivable and any unapplied credits are posted to the invoice. The accounts receivable module provides the ability to track and age open invoices, balance and apply payments, issue adjustments and write-offs, and create bulk invoices for new policyholders.

Payments are batch entered where they are balanced and posted. Payments automatically post to the oldest open invoice first and receivable inquiry allows on-line viewing of invoices, payments, adjustments, charges, and details of posting.

The system provides collection tools including a delinquency report, delinquency notices, and a receivables aging report by policyholder. Holds can be placed on or removed from any policy that becomes delinquent. A hold ends all members' eligibility under that policy effective the day of the hold and can also prevent further billing of the policy.

Commissions
Commissions can be calculated and paid to agents, brokers and direct sales representatives.

Commissions are calculated using straight percentages, or multi-tiered plans can be created with graded percentages and cutoff levels.

Commissions can be based on billed premiums or payments received. Upon calculation, commission records are created and can be reviewed and adjusted prior to payment. An on-line commission history is available for commission questions and sales planning.

COBRA
COBRA administration capabilities are part of the Administration package. In addition to the standard data stored for each member, the system tracks all events which can affect COBRA eligibility for members and their dependents.

The system is integrated to work with Travis Software® COBRA Administration System for all notice and letter generation functionality and coupon billing capabilities.

Reports
A variety of reports are routinely produced and can be run for any time interval. In addition, the system produces member ID cards, export files, and labels for subscribers, members, employers, policyholders, brokers and agents.

Claims Processing
Our Claims Processing solutions provide a highly productive applications environment to ensure consistency and accuracy in the processing of your hospital, medical, dental, vision and pharmacy claims.

Our claims module optimizes productivity without sacrificing accuracy. A claim document need only be handled one time. All functions — including pre-authorizations, PPO administration and optional clinical editing are integrated into the claims entry procedure.

Expect a boost in productivity. Claims processors consistently complete a higher percentage of claims a day than competitive solutions. Our claims system components include:

- Plan Definition
- Eligibility Determination
- Duplicate Checking
- Coordination of Benefits
- Automatic Benefit Calculation
- Fee Scheduling
- Tooth History
- Adjustment Processing
- Auto Adjudication
- Electronic Data Interchange (EDI)
- Customer Service functions, including event tracking and claims history

Each of these components is described below. Following these functional descriptions, the claims examiner workflow process is summarized.

Plan Definition
Our claims processing component provides maximum flexibility in plan definition. We know that every group has diverse and unique plan benefits. Our goal was to create a system that is versatile enough to handle different plans without manual intervention. For example, not only can we attach a Plan Year Deductible, we can also attach a Family Monthly Deductible for designated services for a Plan.

The system utilizes a series of easily maintained plan parameter screens that use decision tree logic to define benefits. For those services requiring additional information from the claim to make a benefit determination, the system has built in screen prompts or questions that guide the processor through the decision making process. The system can literally handle hundreds of different benefit plans with varying deductibles, coinsurance, benefit rules, etc.

Eligibility Determination
The first step in the adjudication process is to determine if the patient is eligible for the claimed services on the dates indicated. The claims processing component fully integrates with the Administration component and automatically verfies that the patient is a qualified participant in the plan and that the incurred date(s) of service are within the effective date range of coverage.

Duplicate Checking
Because the claims processing component maintains a full history of claim information that can be accessed interactively, the system has a very high success rate for identifying duplicate claims. The duplicate checking routine uses a combination of provider identification, date of service range and billed amount to make an identification of an exact or possible duplicate claim.

Coordination of Benefits
A history of other carrier information necessary to make a determination on COB is stored in the database along with a master file of carrier names, addresses and phone numbers. Prior to determining if the claim should be coordinated, the system automatically windows information such as the other carrier(s) name, effective and cancellation dates, type of policy, type of eligibility coverage and insured's name. If additional information is needed, the processor can pend the claim and request the information from the participant, or both.

Automatic Benefit Calculation
The system automatically selects the plan type to use during adjudication. The processor enters the CPT code for the procedure and based on the provider's contracts at the time of service, the system uses the Out of Network, PPO, EPO or out-of-area plan of benefits. Calculation of a benefit payment is based on user defined coverage parameters. These parameters include the rules for deductibles, coinsurance rates, stop-loss, benefit maximums, type of COB and other computational elements.

Since there may be extenuating circumstances, the system allows the processor to override a calculation but requires the processor to enter claim notes documenting the reason for the override. All overrides are tracked by the system and appear on an audit report on a daily basis.

Fee Schedules
The claims processing component is designed to accept a variety of pricing options including standard U&C schedules, PPO fee schedules, RBRVS and user-defined fee schedules.

EnCore System Professionals works closely with several suppliers of schedule data and can offer assistance in purchasing the schedules that best fit your needs.

Tooth History
The tooth history for each participant is automatically updated during the processing of a dental claim. This function tracks a participant's dental history by procedure including tooth extractions, bridges, root canals, crowns, etc. and then, on request, graphically displays this information on a Tooth Chart Diagram.

Processors are able to access the detailed history of a single tooth. Calculation routines automatically use this data as it relates to occurrence limitations or dollar maximums.

Adjustment Processing
To adjust a claim in history, the processor need only modify the incorrect information. The system automatically adjusts the appropriate accumulators, producing a supplemental payment or applying an overpayment to the file where applicable. The system tracks voids, stops payments and the receipt of refunds. An audit trail of all adjustments is produced in hard copy form as well as held on-line.

Auto Adjudication
The claim system automatically adjudicates your claims received through EDI transactions.

When adjudicating claims through the Electronic Claims option, the system will display all the claims that edited for review and allow you to manage the workflow amongst the processing staff. Individual workflow queues are assigned to each Adjuster and claims are automatically "fed" to the adjuster until the queue is empty.

The Paper Claims option will allow you to enter, of course, all claims that were submitted on paper.

Within the Customer Service/Inquiry section of the system, you will have the ability to view summary and detailed information for all claims entered into the system.

Batch Adjudication
The following options are available under Batch Adjudication: edit pools, edit reason codes, edit assignments and edit tables. Edit tables have been created to define specific system and user defined rules to facilitate EDI transactions. Claims that do not pass these rules will edit during batch adjudication and then be automatically forwarded to the appropriate edit pool for manual intervention. Also, a user can define his/her own edit criteria by creating User Defined Edits within its own table. The functionality of the User Defined Edit table is somewhat different from the other edit tables. This option allows you to create and define your own edits at the Group level. For example: If a specific procedure is not covered for a group: you can identify that procedure code and "tell" the system to go to a specific edit (or be accepted or denied) when it is billed. Basically, you are creating your own "rules" for a Group.

Electronic Data Interchange
The EDI translator is a software tool that can be installed on a PC or Local Area Network, which allows the electronic receipt of claims from providers, hospitals or clearinghouses in the standard 4010 or 5010 formats. After receiving the transmitted claim data, the software performs user-specific edits. If the claim does not pass the front-end editing process, an error report is generated that can be transmitted to the provider. Error-free claims are then reformatted to the EnCore Claims Management specifications and sent to the Claims Adjudication Module.

EnCoreConnect – Blue Cross PPO Network Interface
This plug-in solution to the EnCore claims payment system is designed to facilitate the EDI interface between Taft-Hartley plans or other employer-sponsored health plans that are contracted with Blue Cross and its PPO Network.

EnCoreConnect manages both inbound and outbound claim files. It includes code crosswalks, editing and validation features as well as reporting capabilities. Once claims are validated, they are routed through the plan's core batch claims adjudication system and processed according to its benefit plan. Finalized claims are then routed back to Blue Cross for payment to their network providers. If the claim is designated as "fund-to-pay", the checks are produced by the Taft-Hartley fund office. All EOBs are produced by the fund office.

Customer Service
One of the main criticisms of an automated health administration system is that it requires the customer support representative to ask "20 questions" of an already angry participant before answering a phone inquiry. Our Customer Service component is designed to avoid this.

The Customer Service/Inquiry module is used to retrieve information in regards to claims payment, eligibility, COB information and other records. You can also use this module to track and diary phone calls and other events. The inquiry screen consists of one screen with menu options that enable you to access all aspects of a member's claims history, eligibility, authorizations, accumulators and other vital information. You can also request a copy of a paticular EOB to be printed or a claims history report to be generated.

Event Tracking
An effective customer service module must not only answer inquiries in an efficient manner, but must document these inquiries and be able to report on them. Our system has a unique event tracking feature which allows the service representative to document user defined events such as letters, phone calls, walk-ins, etc. All inquires are date and time stamped and are recorded with the name of the service representative taking the call. The event tracking function allows you to record customer service inquiries using different categories and also provides reporting capabilities.

The Event feature can also be used as a phone log. Customer service representatives can record the content of each incoming call and categorize the calls for reporting purposes. User defined codes Indicate the type of call, caller, regarding, etc. In addition, if follow-up is required, the customer service representative can log the event for follow up or route the call to another individual or department. Daily reports are generated for follow up purposes and to track productivity.

Claims Examiner Workflow Summary
The system requires basic information to process a standard paper claim. Other screens may become necessary in special circumstances such as pending or denying a claim, paying a third party, or updating coordination of benefits information. With EDI claims, all this information is pre-filled from the receipt of the electronic claims information.

The first step is to identify the type of claim, establish the patient, indicate if the claim was the result of an accident and determine whether or not there is other coverage.

The examiner identifies the type of claim (medical, dental, vision or flex), and the participant by identification number. At this time the system presents the family register and any notes pertaining to the family. The examiner then identifies the patient to whom the claim belongs and the system displays any patient notes on file, any previous claims for this patient that are pending additional information and any open subrogation or third party liability involvement in this file.
After the patient has been identified, the system presents coordination of benefits information input from prior claims and accepts any new information from the current claim to help the examiner make a determination on the primary carrier if applicable.

Next, the provider of service is identified and information pertaining to the claim as a whole is entered. This information includes the federal tax identification number, assignment of benefits, provider's patient identification number, any partial payment the participant may have already prepaid as well as the earliest and latest dates of service on the claim and the total dollar amount being billed. PPO contract information effective during the date of service range is displayed as well as comments or special instructions pertaining to this provider. The provider comments feature allows immediate identification of fraudulent providers or providers whose claims need to be audited prior to payment.

Finally, the examiner keys the dates of service, type of service, procedure code, diagnosis code and billed amount. At this time all of the necessary data has been entered and the system proceeds with the internal processing of the claim to determine a payment amount.

MEDICAL MANAGEMENT -- Authorizations, Case Management Concurrent Review
The Medical Management Module enables you to enter and track authorizations, manage a "case" and perform concurrent review. These processes are integrated with the core claims system and alerts claims and customer service personnel if an authorization or case is on file for a member.

Authorizations
Coding conventions used for authorization and case management are user-defined and provide the flexibility to tailor the system to individual needs and policies. Required and optional fields can be established during the setup of the authorization codes and security will limit users to adding, changing or viewing authorizations or cases. Some of the code-types used in the setup and maintenance of Medical Management are as follows:

- Authorization/Treatment Types
- Authorization/Case Management Sources
- Referral/Variance Reasons
- Adverse Events
- Status
- Locations
- Contacts
- Case Management Activities
- Outcomes
- Treatment Plans

- Level of Care
- Protocols
- Authorizations

Data files established in the system (Eligibility, Providers, etc.) can be accessed from the Authorization or Case Management screens. This offers a link between all processes for an individual member. An authorization can be linked to a case and/or a claim and based on benefit plan setup will look for an authorization on selected or all benefits. Authorizations can be entered manually, or imported into the system from a third party. Detailed information is captured based on the Authorization Type selected. Servicing, Primary Care and Referral Physician information is retained as well as occurrence and dollar limits. Individual CPT or HCPCS codes can be authorized and supplies can be tracked using rental or purchase price as indicated. A status of Approve, Pend or Deny is used for each authorization with user-defined reasons for pending or denying.

Case Management
Case Management is designed to setup and track a case based on an episode of illness. Extensive information can be maintained in regards to the case like contacts, diagnosis, procedures, treatment plans, activity records and more. Case Managers are also able to track and report their time spent on individual activities which in turn can be used for billing purposes.

Unlimited notepad capabilities are available throughout Medical Management and length of stay tables can be integrated from either Milliman & Robertson or QualMed.

Concurrent Review
Concurrent review and other reports can be generated to oversee the medical management operations of your organization

Reporting
EnCore System Professionals supports an extensive library of operational reports in most of its modules. Users are able to specify any time interval and frequency for generating specific reports.

- Claims Processing – Administrative Reports
- Claims Processing – Management Reports
- Billing and Administration – Administrative and Financial Reports
- Ad hoc Reporting

The following lists represent a sample of the above types of reports.

Claims Processing – Sample Administrative Reports
- Adjuster Productivity
- Transaction Register
- Claims Summary
- Claims Adjustments
- Override Report
- Pending Claims Report
- Processed Claims Cycle Time

Claims Processing – Sample Management Reports
- Denial Analysis
- Paid Claims Analysis
- Service/Benefit Analysis
- Claims Paid by Age/Sex of Claimant
- Top 25 Hospitals by number of admissions
- Top 50 Medical Providers/Top Dental Providers
- Inpatient Utilization by Major Diagnostic Category
- Outpatient Utilization by Top 25 Diagnoses
- Lag Matrix Report
- Coordination of Benefits

Billing and Administration – Sample Administrative and Financial Reports
- Billing and Cash Receipts Register
- Aged Receivables
- Delinquency Notices
- Fees Spreadsheet
- Experience Analysis
- Eligibility Adjustments
- Overage Notices

EnCore-Report Builder - Ad Hoc Reporting
Today, a business user requires more flexibility and customization capabilities to efficiently retrieve critical data which allows for timely decision making. Creation of custom or ad hoc reports from data residing in EnCore System Professionals application databases is easily accomplished using any Windows ODBC client report writer, such as Microsoft® Access, Excel or any Crystal Decision products. In combination with a proprietary ODBC driver, EnCore Report Builder enables users to gain real-time access to data stored in their system, turn it into useful information and print the results in attractive and professional looking formats. In addition, reports may be viewed on the user's workstation terminal or distributed to other users for review.

Training is available with emphasis on understanding our comprehensive series of database structures, which is essential for maximizing the reporting potential within your organization.

Global System Capabilities
Processors and data entry people are comfortable with our healthcare benefits administration system solutions and can easily leverage the systems' power and capabilities. Each module contains the built-in intelligence and ease of use that can significantly boost your processors' productivity. We hide the complexity and deliver true simplicity.

To this end, the EnCore System Professionals modules contain several global functions to assist with system use and navigation. These functions include:

- On-Line Help
- Audit Trails
- Alpha Lookup -- Searching by Name
- Notepad Capabilities
- Error Messages
- Default Values
- Function Keys

Each function is described below.

On-Line Help
On-line help is available for every field in the system. For a one-line description of acceptable or expected responses press the function key labeled HELP [F7]. Some fields require more than one line to define the appropriate values for a field, such as status codes or state codes. When this is the case, the one line description obtained above will direct you to enter "??" for a more detailed description.

The detailed help message can consist of one or more screens of information. Pressing [ENTER] either displays the next screen of information or returns you to your processing screen when the extended help message is concluded. In some cases, the values for a field are user defined in external files, such as service codes, adjustment reasons and situations. In this case, the one line description above will direct you to press the function key labeled [F1] (Lookup) for a list of valid codes.

Audit Trails
The EnCore System database is designed to provide a complete audit trail of demographic, billing and claims payment transactions. All changes to demographic data such as participant name and address are held in detail, date-stamped and recorded with the user who added or changed the data.

All of the accumulators used by the system provide a detailed audit trail as well. The system tracks every transaction that has affected each accumulator as well as any manual changes made to the accumulator and the reason for the changes.

Alpha Lookup -- Searching by Name
The alpha lookup feature is available for subscribers and members. This feature is integrated into all screens that request these identification fields. You can access the name lookup screen by pressing the Lookup Function Key [F1] when the cursor is at the Member SSN field.

The last name and first name are not case sensitive. They may be entered in upper or lower case or a combination of both. If there are more names than can be displayed on one screen, you may page through additional screens. Once a match is found, select the name you want to carry this number back to the screen you were working on. The system supports full name, partial name, and "sounds like" searches as well as partial keys. The method used depends on the information you have.

Unlimited Notepad Capability
The System has unlimited notepad capability at the family, patient, provider, authorization and claim level. It is our belief that notes are meant to be read and should not require a processor to exit a screen to do so. For this reason, the system automatically tags all notes for the processor to review at the appropriate time.

Error Messages
Should you at any time enter incorrectly formatted data into a data field or neglect to enter required data and then press the [ENTER] key, the computer will recognize your error and will respond with an error message on the line at the bottom of your screen (called the "message line"). The message will tell you what is wrong with the data entered and the cursor will remain on that field for re-entry.

Default Values
For convenience and speed, the system utilizes default values wherever possible to avoid redundant data entry. A default value can either be the most commonly used value for a field or the value that was previously keyed in

that field. Default Values are defined during the system implementation process. To use the default value, press [ENTER] at the field that has been established with a default value.

Function Keys
Function keys are special keys on a PC keyboard and are found on the top row of the keyboard. The monitor displays the function key labels along the bottom of the screen. The label for the function key tells you what action the function key performs. Function keys are dynamic and can change from screen to screen as well as within a screen. There are two advantages to using function keys. For you, the application user, function keys save keystrokes. To perform a given action, you can press a single key instead of pressing a series of keys.

Batch or Scheduled Processing — Operator Module
Regularly scheduled processing and maintenance is a necessary and important part of Claims Management. The particulars of day and time must be determined and agreed upon by the Information Technology and Claims Administration departments with the requirements of the Claims Management system in mind.

The Operator module is menu driven and contains selections for daily processing, yearly processing (1099 reporting), periodic and on-demand reporting, utilities for creating and installing interface files, and programs to load schedule tables. Daily/Nightly processing includes a History Update, which must be done after all claims processing has been completed for the day. No operator intervention is required during this processing, so that it can be scheduled to run at night after the regularly scheduled system backup. Completed claims are moved from the In Process database to the History database.

Report processing includes regularly scheduled weekly and monthly reports as well as reports generated on an "as needed" (by request) basis. These reports can be selected and scheduled by either the Claims main menu or the Operator menu. Scheduling should only be set by designated staff.

Data Import/Export programs are scheduled for data to be transferred electronically to outside sources or data received from outside sources. This may include, for example, eligibility data sent to an outside source, or claims history data imported from an outside source. Fee schedules are loaded using the Import Schedules selection.
Additionally, self-insured funds must print 1099s annually after all claims have been processed for the calendar year. From the Operator module, these can be generated for printing and for file submission to the IRS.

The System Letters section provides information on the tools used for creating and/or modifying system-generated pend, deny or mail back letters.

For additional information, please call EnCore System Professionals at 877-536-2673.

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