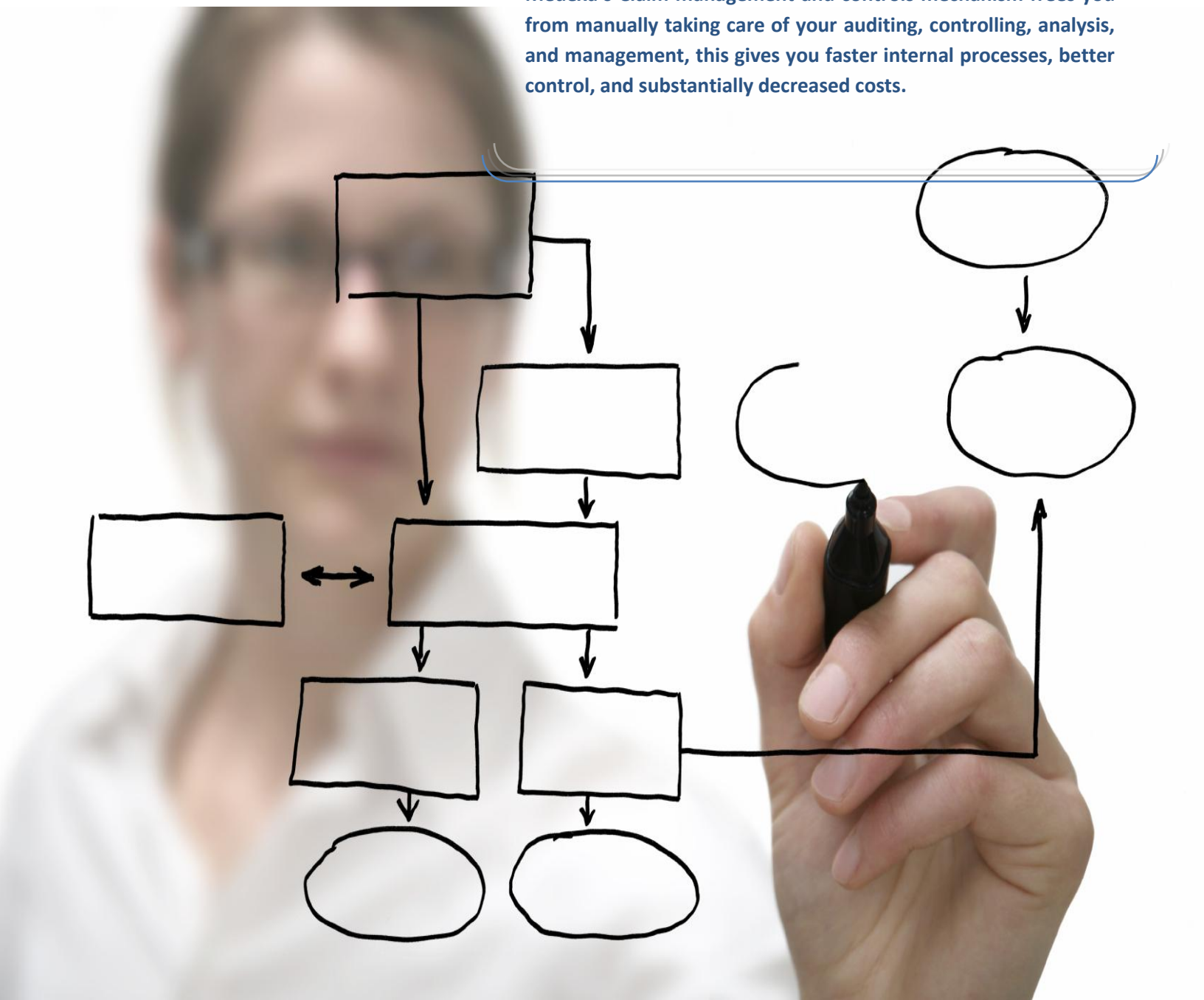
Medexa

Moving in the world to achieve better health care

Jordan Syria Libya Egypt & Oman

[Claim Management] 2009

Medexa's Claim management and controls mechanism frees you from manually taking care of your auditing, controlling, analysis, and management, this gives you faster internal processes, better control, and substantially decreased costs.

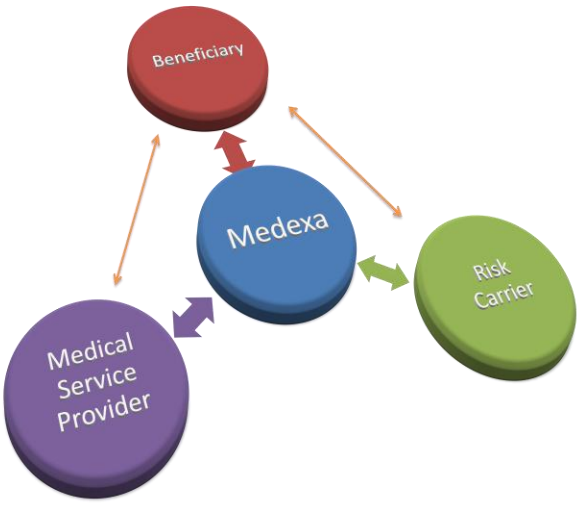


Medexa @Glance

Medexa is a privately-owned, Third Party Administrator (TPA) located in Amman, Jordan. Founded in 1999, **Medexa** has grown tremendously over the last 10 years, both in its customer base as well as in its knowledge and skills on current trends and emerging healthcare and insurance sectors.

Medexa prides itself on its dynamic environment – never content with the status quo, **Medexa** constantly strives to challenge conventional knowledge in healthcare and insurance sectors to bring the best solutions any for a given client.

Medexa business approach is based on partnering with our clients and understanding their exact needs to encourage success through mutual benefit and over the past 10 years our business has grown; however, our commitment to customer satisfaction has not been deterred. In fact, the changes the company initiated were for the sole purpose to fit the ever changing needs of our customers.



- Established 1999.
- Neutral Third Party Administrator (TPA).
- Capital exceeds **3,000,000** U.S. dollar.
- Passionate for Technology.
- **1st** regional smart card implementer.
- Serves **150,000** satisfied subscribers.
- Serves 5 countries in Middle East & Africa regions.
- Enjoys 87th skilled & specialized staff members.
- Availability & support **365 x 7 x 24**.
- Serves more than **20** satisfied Client.

Medexa working to provide health insurance expenses management services, for insurance and self-funded companies, using the most advanced and sophisticated technologies, to provide distinguished and quality healthcare and billing service, that helps in the reduction of misuse and/or fraud malpractice which ensures the reduction and reduce the high-costs resulting, without decreasing the rights of any parties.

Towards E-Health

Superior service and support is just one of the reasons Medexa's stands above the competition. We pride ourselves on implementing our healthcare claims processing software to match our client's specific business requirements. This attention to detail and dedication to customer support creates a smooth path in the transition from a legacy healthcare administrative system to the advanced solution Medex Management System (MMS) from implementation to support to new functionality. We are with you every step of the way.

MMS was designed around innovation. Medexa is the first and only TPA in the market that has a built-in ability and business automated solution that is Internet based open-architecture design, comply with international standards, and uniquely merges science, business and technologies to offer the industry a unique solution, unmatched by the competition.

Medexa relied on international medical references, issued by the World Health Organization (WHO) or supported by them, such as ICD-10, ICHI, ATC and HCPCS, to meet the 21st century requirements as well as the E-Health strategy and requirements , which are the ideal methodology to automate and digitalize the health care sector as WHO recommended .

Medexa own claims management solution that is advanced not only for today's regulations but also for upcoming requirements as it is tailored to meet e-health demands - that launched by the World Health Organization (WHO) in 2005- and made for 21st century.

Claim Management Layers

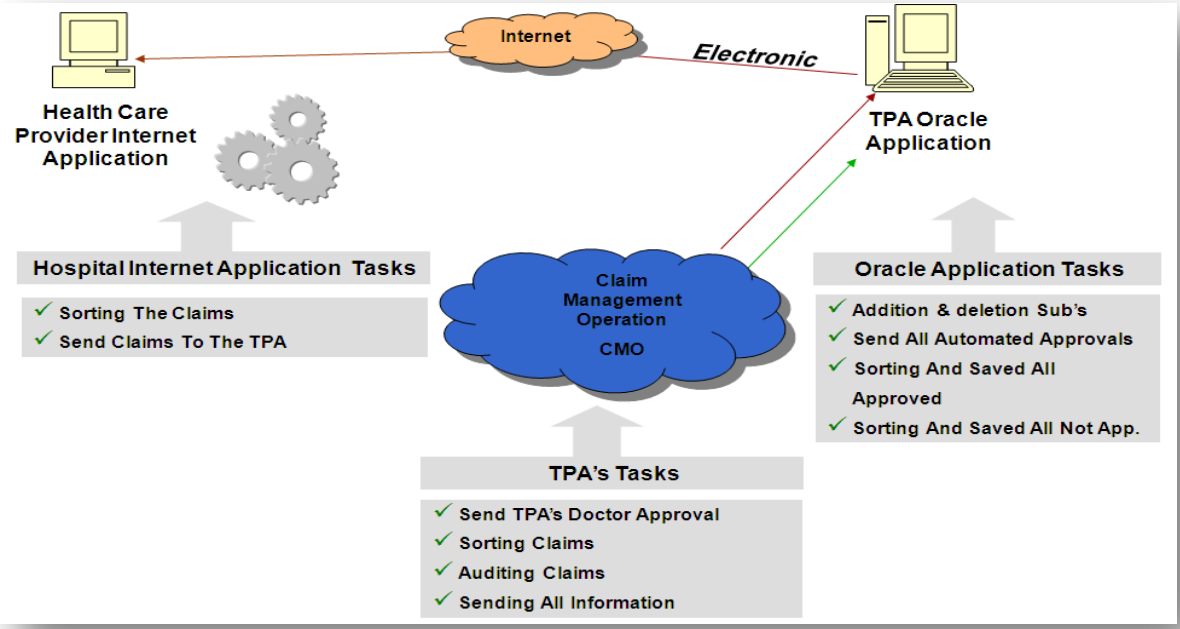
Medexa's Standard Operation Procedures (SOP) that it manages healthcare insurance claims is categorized into six stages; each stage contains number of checking and validation rules and conditions as follows:

1. The starting point is medical providers stage (On-Line)
2. Reception stage
3. Eligibility stage
4. Medical stage
5. Review stage
6. Financial stage

Medical providers Stage (On-Line)

During the presence of the patient in the medical providers, while the medical information is entered into specialized programs (on-line technique) without human intervention that gives automated medical procedure approval.

In This stage the electronic and automated robot claim analysis and auditor checks and validates more than 340 rules, condition and checking validation instantly.



Claim Management Layers

Reception Stage

The reception stage is the first claim processing stage , that is responsible to identifies volume of work needs to be done on daily bases, by logging shipments information received, and breaking down shipment into batches categorized by risk carrier. On both sub-stages we identify how many claims needs to be fully processed.

Eligibility Stage

The eligibility stage is the second claim processing stage, where all claims categorized, by shipments and batches and entered to the MMS system, the eligibility stage allows second level data entry to Maintain claims' basic information such as doctor, patient, claim components… etc. most of eligibility information are auto-identified by system, such as doctor id identifies doctor specialty, part, medical provider type… etc. also patient id identifies patient name, gender, marital status, age, relationship, head of family… etc.

Once the eligibility stage completed and upon saving claims data record, the system initiate eligibility checking and validation such as checks the patient age in accordance with doctor specialty… gender with doctor specialty… etc. the eligibility stage approximately contains 30 – 40 check and validation. Once this stage finalized, the user needs to confirm that all data has been correctly entered, by pressing the confirmation button.

Medical Stage

The Medical stage is the third claim processing stage, where all claim's medical information such as ICD-10,ICHI,HCPCS,ATC and Drugs… etc. entered after second stage confirmation with their information such as prices requested by medical provider, quantity (to compute consumption). This stage is very important as it consist eligibility check combined with medical factoid check as well as contract rules and conditions check as well as financial check and validation.

The medical stage represents the electronic and automated robot claim analysis and auditor, which checks and validates more than 300 rules, condition and checking validation instantly.

Review Stage

The review stage is final optional stage as it is developed to allow confirm or un-confirm the system checking results by identifying system answers, and then allows authorized person to perform his/her actions. The review stage used to intelligently allows system to perform auto approval, and train the system for auto approval and checking in the future.

Financial Stage

The financial stage represents where all processed claims are ready to be settled and finalized with all parties. As such we have to prepare a voucher letter attached to a detail reports and claims hard copy to be sent for Risk Carrier who will review and settle his part within certain period. That allows us to settle these claims with the medical providers and/or insured members.

The following diagram represents the five high-level stages of claim processing