



Robots-as-a-Service

Solution Overview & Robot Experience

The most significant cost of completing business processes is human labor. HPA's digital workforce gives enterprises flexibility in automating high-volume or redundant tasks, ensuring consistent outcomes are delivered in a fraction of the time.

Automate processes, empower people

HPA's virtual, robotic workforce can automate any process that does not require intuition or "gut feeling." Our robots deliver successful outcomes to specification, allowing your staff to focus on processes that bring greater value to your business and customers.

Performance at scale

Unlike human labor, HPA's robots are flexible, scalable, and consistent. RaaS eliminates data entry errors and decreases processing time at a fraction of the cost. With our unique service model, our automation experts help you identify automation opportunities within your organization, build and deploy the workflows on your behalf, and continually monitor the day-to-day performance of your bots.

Do more, save more

There are no hidden licensing or per-bot fees. You define what a successful transaction looks like and we bill you monthly for the successes our robots deliver. Plus, volume discounts are applied automatically should you experience fluctuations in work to be automated.

Our fully-managed RPA service model is 2-5 times more cost effective than traditional RPA models.

\$250M+
in daily financial
transactions

2,200+
robots processing
work daily

650+
workflows
automated

90+
enterprise
clients

Discover the automation possibilities in your business

With deep expertise in healthcare technology automation, HPA helps payers reduce time-consuming operational tasks, improve administrative efficiency, and ensure accurate data management across the technology solution set, including Cognizant's line of TriZetto

Healthcare Products—Facets®, QNXT™, QicLink™, as well as third-party applications like McKesson CCMS and VITAL, CMS PC Pricers, ITS, Blue2, MedHOK, Micro-Dyn DRG and APC, and Medi-Cal sites.

Claims Adjudication		Enrollment	Provider Maintenance	Other
Authorizations	Duplicates	Manual Enrollment	Provider Setup	Refunds
Provider Matching	Adjustments	PCP Updates	Contract Updates	Claim Creation
COB	Encounter Claims	TRC Reports	Network Updates	Contract Maintenance
Corrected Bills	Manual Pricing	Letter Generation	Roster Loading	UM Maintenance
Specialty Claims	Interest Payments	MAS Reports	Demographic Updates	Auditing

HPA's Facets® Experience

Claims

Adjustments:

- **Access Fee;** Create adjustment by matching claims from client-provided file to original claim in Facets, then cross over to mainframe ITS and create an NFO6.
- **Bluesquare;** Create adjusted claim in Facets and cross over to the ITS web portal.
- **Generic;** Clear all line-level pricing overrides and re-adjudicate the claim.
- **Recovery;** Bypass overpayment recovery or issue refund letter.
- **Q-Codes;** Reprice and apply overrides using pricing from payer's web portal.
- **MSRE;** Update allowed amounts for multiple surgery reduction pends.
- **Provider Update;** Update claim's provider based on client-provided report.
- **Home Health CMS Claims;** Reprice home health claims using external CMS pricer.
- **Claim Creation;** Pay interest back to members based on client-provided report.

Authorizations:

- **AUTH;** Search and apply authorizations to claims.

Claim Scrubbing:

- **XC;** Scrub member/provider selection before moving into workflow.
- **MEXC/PAUD;** Review claim notes for member/provider payment exceptions.
- **Review Subscriber Payment;** Determine whether payment should be made to the provider or subscriber.
- **MM/MLTM;** Validate/update claims with multiple modifiers.
- **Manual Processing for Individual Products;** Research member's office visit frequency and add service rule overrides as needed, otherwise paying the claim.
- **Proactive Reports (NONITS);** Check and deny claims with non-par out of state providers.
- **Proactive Reports (MEDEXCL);** Validate and disallow non-applicable procedure codes.
- **Member Audits;** Supply screenshots and documentation for CMS audits.
- **Claims Re-pend;** Re-pend claims to correct queue.

- **J-Codes;** Determine if J-Code is billed with valid NDC using external website.
- **Therapy Bundling;** Bundle therapy services together based on date of service.

Specialty Claims:

- **Outpatient ER (Opt In);** Reprice outpatient emergency room claims for opt-in members.
- **Inpatient (Opt In);** Reprice inpatient claims for opt-in members.
- **Dialysis;** Process Medicare and Medicaid dialysis claims using CMS ESRD pricer and Facets data.
- **SNF RUG;** Reprice and process Skilled Nursing Facility claims for Resource Utilization Groups.
- **SNF Therapy/Custodial;** Reprice and process Skilled Nursing Facility therapy/custodial claims.
- **Critical Access Hospital;** Price inpatient and outpatient claims according to Medicare guidelines.
- **DME Host SF Code Match;** Determine if DME charges are rental or purchase, calculate and add allowed amounts to claim.
- **ASCP;** Price acute care claims that bill an office visit based on surgical codes.
- **FSA Procedure;** Process flex spending withdrawal requests.

Duplicate Claims:

- **DUP;** Research and resolve possible duplicate claims by adjustment or denials.
- **FREQ;** Research and resolve possible duplicate/adjusted hospital claims.

COB:

- **COB;** Determine if claims should be paid or denied and calculate patient's responsibility.
- **Medicare COB;** Apply pricing adjustments using EOB or Facets service rules.
- **COB Letter Notes;** Notate when members/dependents COB letters have been mailed.
- **Sanctions/Crossover;** Verify and apply sanctions for COB.
- **COB OOP Split;** Apply copay to lab and X-ray claims based on member's benefit plan and daily claim history.

Encounter Data:

- **Encounter Claims;** Enter encounter claims using a client-provided spreadsheet.
- **Claim Lines;** Enter and update history claim service lines.

Configuration Processes

- **NetworX;** Update agreement rates in NetworX.

Provider Maintenance

- **PDEM;** Resolve provider demographics mismatches on claims.
- **PUNK;** Resolve unknown/missing providers on claims.
- **AGR;** Resolve unknown/missing provider agreements.
- **DIRE;** Research and select provider.
- **OON Providers;** Update provider records with out-of-network agreements.
- **New Group Setup;** Create new provider group records.
- **Group Renewal;** Renew/update provider group records.
- **Provider Network Update;** Terminate or add networks on provider records.

Enrollment

- **Add/Term/Update;** Add/terminate/update member/subscriber enrollments.
- **TRR Reports;** Update eligibility segments based on enrollment requests from CMS.
- **VIP;** Update member's VIP type.
- **Auto-recovery Update;** Update member accounts for overpayments and reductions.
- **ID Card Ordering;** Order new or replacement ID cards.
- **Membership and Billing Letters;** Generate and prepare change of marketplace letters.
- **Member Audits;** Supply screenshots and documentation for CMS audits.

Billing

- **Payment Posting;** Post credit card payments.
- **Commission Adjustment;** Post commission adjustments from group.
- **Refunds;** Post refunds from provider.
- **Refunds Receipt;** Create receipts for previously-applied refunds post check-write.

HPA's QXNT™ Experience

Claims

Adjustments:

- **Interest Payments;** Create interest claims.
- **Reverse and Adjust Price;** Reverse paid claims and adjust pricing.
- **Quarterly Fee Schedule Updates;** Reverse claims and re-adjudicate in order to be processed through updated Fee Schedules.
- **Risk;** Adjust diagnosis codes for CMS RAPS reporting.
- **Edit225 (High Cost Pharmacy);** Pay or deny pharmaceutical products using provider-specific high-cost threshold crosswalks.
- **DRG Pricing;** Determine DRG using the Micro-Dyn/#M APC-DRG tool and apply DRG pricing using client-specific crosswalks.
- **EAPG Pricing;** Validate claim line data and apply pricing from a state-provided spreadsheet.
- **IHT Percentage Reductions;** Apply MTR recommendations based on the iHealth report.
- **LTSS;** Process claims according to Medicaid rules.
- **MedPost;** Deny specific service lines and reprice based on client-provided report.
- **PCP Copay;** Adjust copay on claims for primary care visits based on market standard, reversing claims where required.
- **Remove OOP;** Remove patient's responsibility from claims.
- **Sequestration Pricing;** Apply 2% reduction for Medicare sequestration.
- **Sequestration Removal;** Remove incorrectly applied sequestration pricing.
- **Legacy System Sunsetting;** When sunsetting a system, make adjustments to service lines in either system based on specific criteria.
- **VOID;** Void claims using a void reason crosswalk.

Authorizations:

- **Q-Auth Creation/Updates;** Create and update authorizations.
- **Edit 205/408;** Research and apply authorizations using VITAL and MedHOK applications.
- **Edit 236;** Research and apply referrals for specific services.

- **Edit 367;** Research and apply authorizations using VITAL, CCMS, and MedHOK applications.
- **Edit 610;** Analyze service code hierarchy to reconcile authorized services from UM document and the claim.

Claim Scrubbing:

- **Add Memo/Add Attribute;** Add memos or attributes for various claim updates.
- **Edit 101/201;** Research and reconcile claim provider/member details either with provided information or EDI.
- **Member Not Found/No Affiliation;** Research and add missing members/providers to claims.
- **Units Correction;** Update units on claim to match units from EDI.
- **Validation;** Reconcile discrepancies between original EDI data and the imported claim.

Standard QNXT Pends:

- **Edit 219;** Pay or deny surgical services based on claim submission date.
- **Edit 224 (Maternity);** Pay or deny maternity care claims using EDI data.
- **DME;** Research and apply authorizations for DME rentals.
- **Edit 225;** Apply manual pricing based on scenario-specific rules.
- **Edit 225 Repricing;** Apply manual pricing for inpatient and outpatient claims, excluding renal dialysis claims.
- **Edit 311/541;** Process claims according to the timely filing rules.
- **Edit 334;** Research and resolve edits resulting from Micro-Dyn APCActive integration.

Specialty Claims:

- **HCC/AHA;** Process PHP claims.
- **Vaccine Denials;** Deny service lines with flu immunization procedure codes.
- **IPA Denials;** Deny claims to the correct IPA.
- **CBAS;** Price and research authorizations for community-based adult service based on state-specific guidelines.
- **State-specific Processing;** Process claims based on state-specific guidelines.

Duplicate Claims:

- **Edit 519/522/531/532/533/1034/1111;** Research and reconcile potential duplicate claims by paying or denying the claim.
- **Edit 913 (ZADJUSTMENTS);** Process claims based on status of patient's historical claims.

COB:

- **Edit 216/252;** Pay or deny claims based on services using various COB crosswalks.
- **Edit 262;** Create a continuous span of a member's COB records.
- **COB;** Determine if claims should be paid or denied and calculate patient's responsibility.

Encounter Data:

- **Atypical Encounter Claims;** Research and add pay-to provider to existing claims.

Configuration Processes

- **Benefit Configuration;** Update benefit terms with ICD-10 diagnosis codes.
- **Provider Contract Updates;** Add new contracts for previously-configured providers.
- **Secondary Claim Job;** Schedule the secondary claim job creation process.
- **Fee Schedule Updates;** Update contract terms with new rates based on fee schedules.

Provider Maintenance

- **Provider Load;** Build providers, pay-to entities, and service locations.
- **Provider Term;** Term provider networks and contracts.
- **Update Provider;** Update provider on claims using supplied information.
- **Provider Contract;** Update provider records with new contracts.

Enrollment

- **Call Tracking;** Log calls that were received by Member Services for PCP updates.
- **Dual Enrollment;** Determine primacy for dual-enrolled members.
- **Eligibility Recon;** Add and terminate member enrollments based off client-provided report.
- **Enrollment Updates;** Update termination dates for member enrollments.
- **EAM to QNXT Sync;** Reconcile information between QNXT and EAM.
- **MAS Reports;** Terminate eligibility based on eligibility report.
- **Optional Supplement Disenroll;** Terminate member's optional coverage.
- **PCP Default;** Update PCP for defaulted members.
- **PCP Affiliations;** Retroactively update PCP affiliations and term dates for active members.
- **TRR;** Process CMS TRR reports:
 - **TRR 121;** Reconcile member's LIS info between EAM and QNXT.
 - **TRR 071;** Terminate member's standard plan and add hospice plan.
 - **TRR 072;** Terminate member's hospice plan and add standard plan.

Billing

- **Financial Penalty;** Create claims to bill providers for submitting paper claims.
- **Payment Posting;** Post premium payments to Member module.
- **Refunds;** Reverse and adjust claims, and refund payment for specific procedures.

About HPA, A Cognizant Company

HPA is a provider of fully-managed robotic process automation services; documenting, building, deploying, and managing digital workforces on our clients behalf. Learn more at www.hpa.services.

About Cognizant

Cognizant (Nasdaq-100: CTSH) is one of the world's leading professional services companies, transforming clients' business, operating and technology models for the digital era. Our unique industry-based, consultative approach helps clients envision, build and run more innovative and efficient businesses. Headquartered in the U.S., Cognizant is ranked 195 on the Fortune 500 and is consistently listed among the most admired companies in the world. Learn how Cognizant helps clients lead with digital at www.cognizant.com or follow us [@Cognizant](https://twitter.com/Cognizant).

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