SMT STRATEGIES GLOBAL

Dhamani Claims Readiness Toolkit

A practical assessment and action-planning guide for Oman's private healthcare organizations

24 checks across six readiness areas

Use the companion scorecard to assess your workflow, identify unverified handoffs, assign owners, and build an evidence-based action plan.

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Includes an editable Excel scorecard and action tracker

Independent SMT educational resource. Not an FSA publication, platform certification, or substitute for your current contracts and applicable requirements.

SAMPLE - Selected pages only; workbook not included

START HERE

Use this toolkit in a working meeting

This toolkit helps a team examine its own Dhamani-related claims workflow. The main output is an agreed list of gaps, owners, and closure evidence. The assessment is useful both before a deployment and when reviewing an existing operation.

Choose one workflow first

Start with one facility, one service line, and one payer relationship. Write that scope at the top of your working notes. A narrow review is easier to verify than a general statement that the entire organization is ready.

Bring the people who own the work

Invite the revenue-cycle lead, a clinical documentation representative, payer-contracting lead, health IT lead, and an executive sponsor. Add a TPA or integrator contact where the workflow depends on them. The suggested hospital owners in the workbook are starting roles, not assigned individuals.

Complete the files in this order

1. Read the rating rules on page 4.
2. Review the workflow on page 5.
3. Rate all 24 controls in the Assessment tab.
4. Review Summary and the critical gaps.
5. Assign owners and dates; track closure in Actions.

Use evidence references rather than patient records

Enter internal reference names such as SOP-ELIG-v2 or TEST-014. Keep clinical records and identifying information in your authorized systems. Do not paste patient names, identifiers, clinical histories, or real claim attachments into this workbook.

A quick baseline is only the beginning

Use a short first review to locate uncertainty. Validate ratings with dated procedures, reviewed tests, and accountable staff before leadership relies on the result.

SAMPLE - Selected pages only; workbook not included

WORKFLOW REVIEW

Follow the handoffs from cover to cash

Stage	Question for the team	Evidence to inspect
Coverage	Who checks current coverage and triggers a recheck?	Verification procedure and a de-identified review
Authorization	Who confirms the decision and passes its conditions to care and billing?	Payer instructions and authorization handoff
Care and documentation	Does the record support the service and charge?	Documentation review and clarification route
Submission	What distinguishes transmission from acceptance and payer decision?	Transaction status definitions and test results
Exception recovery	Who handles technical errors, missing information, and disputes?	Separate queues, contacts, deadlines, and submission history
Payment	How do payer responses and funds reconcile to claims?	Variance log and reconciliation review

Test an ordinary case and an exception

Use authorized, de-identified scenarios: a changed appointment, missing attachment, failed exchange, amended treatment plan, rejected claim, unmatched payment, or system outage. Select the cases relevant to your scope; do not assume every transaction has the same rules.

Name the handoff receiver

For every transfer, identify what the receiving team needs, how it acknowledges receipt, and how incomplete work returns to the sender. A sent email or closed ticket is not enough if the next team cannot act.

Leadership question

Can we trace one appropriate, covered service from verification through a payer decision and a reconciled payment, including the exceptions?

SAMPLE - Selected pages only; workbook not included

READINESS AREA 1 OF 6

Claims workflows

Follow the claim all the way to cash.

C1 Coverage is checked before the service. CRITICAL

Your workflow checks active cover, network, benefits and patient responsibility, with rechecks when appointments or coverage change.

Evidence: An approved verification checklist and a de-identified workflow review.

Next action: Map coverage checks from booking to service; agree recheck triggers and the escalation path.

C2 Submission and payer decisions stay distinct. CRITICAL

Staff distinguish a transmitted or accepted transaction from a payer decision and a paid claim. Missing information and technical errors have separate routes.

Evidence: A status map and reviewed examples using no patient identifiers.

Next action: Define the claim status map, including technical acceptance, payer decision and payment; assign each exception route.

C3 Rejected claims have a controlled recovery path.

Rejections are classified, corrected and tracked against the applicable payer and regulatory resubmission conditions, with duplicate submissions controlled.

Evidence: An exception register, verified applicable deadlines and a recovery procedure.

Next action: Build a rejection register with reason, owner, next action, applicable deadline and resubmission history.

C4 Adjudication and payment are reconciled.

The team can trace submitted claims through payer responses, payments, adjustments and unresolved variances.

Evidence: A reconciliation procedure and a reviewed variance log.

Next action: Reconcile submitted, adjudicated and paid amounts; route discrepancies and age unresolved balances.

SAMPLE - Selected pages only; workbook not included