AHCCCS
Arizona Health Care Cost Containment System

CLAIMS DASHBOARD REPORTING GUIDE

EFFECTIVE: JULY 1, 2016

I. PURPOSE

The AHCCCS Claims Dashboard Reporting Guide applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. The purpose of the Guide is to provide instructions to Contractors on how to complete the Claims Dashboard Report for submission to and review by the Division of Health Care Management (DHCM), as required by contract.

DES/DDD reports Long Term Care data and data received from its Acute Care subcontractors.

II. DEFINITIONS

ADJUDICATED CLAIM	A claim that has been received and processed by the Contractor which resulted in payment or denial of payment.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.
DATE OF RECEIPT (DOR)	Date claim received by Contractor
ELECTRONIC DATA INTERCHANGE (EDI)	Claims that are submitted to the Contractor electronically through a clearinghouse or the Contractor's web site.
PENDED CLAIMS	Claim(s) that is/are manually or electronically suspended awaiting review and/or instruction for adjudication.
PROCESSING	Processing includes all the steps that a Contractor puts claims through from receipt, up to and including, mailing of the remittance advice or final execution of the EFT. The time to process is calculated in calendar days from the date of receipt of the claim to the date of the check, the date of the remittance advice for denied claims, or the date the Electronic Funds Transfer (EFT) occurs. The date on the check is the SAME date that the check is put in the mail.

RECOUPMENT An action initiated by the Contractor to recover all or part of a previously paid claim(s). Recoupments include Contractor initiated/requested repayments, as well as overpayments identified by the Provider where the Contractor seeks to actively withhold or withdraw funds to correct the overpayment from the Provider. For purposes of this Policy, a recoupment is a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days. An adjustment that is greater than $50,000 and is completed within 30 days is not considered a recoupment but must be tracked and made available to AHCCCS upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

III. CLAIMS DASHBOARD REPORT

A. GENERAL INSTRUCTIONS

1. The Contractor shall submit a monthly Claims Dashboard, along with all attachments, as specified in the AHCCCS Contract Section F, Attachment F3, Contractor Chart of Deliverables and RBHA Contract, Exhibit-9, Deliverables.

2. Each Claims Dashboard is dedicated to one line of business.

3. A separate Claims Dashboard worksheet must be submitted for each of the following claim form types:
   a. UB92 or 837I,
   b. CMS1500 or 837P,
   c. Dental Claim Form or 837D, and
   d. All claim form types combined.

4. If the Contractor has a sub-contract with a Third Party Administrator (TPA) to process claims, a dashboard for each of the TPA's claim form types, as listed above, must be submitted. Pharmacy Benefit Management (PBM) claims are the exception, and should not be reported in either of the Contractor's dashboards or a separate dashboard.

5. The Contractor must continuously track and report recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the Contractor must report the Cumulative Recoupments monthly as part of the Claims Dashboard until the end of the contract year. These recoupments are listed on the Cumulative Recoupment worksheet. Cumulative Recoupments should continually be reported on this worksheet throughout the contract year, so that at the end of the contract year the worksheet will contain all cumulative recoupments taken during the year.

6. Information is provided in the dashboard for a rolling 12-month period of reporting data.

7. A cover letter should accompany the report submission. The cover letter should include **all** explanations for variations as required in the field descriptions indicated in the matrix below. The Contractor should review changes in the Dashboard from month to month and should explain any specific anomalies in the cover letter. For example; Membership had a steep increase and Total Claims Receipts had a sharp decrease in the same month. Additionally, the cover letter should include a detailed explanation of reported Cumulative Recoupments.

8. If a Contractor is in compliance with the contractual standards on this deliverable, for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the Contractor is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

B. CLAIMS DASHBOARD COVER LETTER (ATTACHMENT A) INSTRUCTIONS

Include the following information on the report cover letter. Please be sure to indicate, if any of the following information is not applicable.

1. The cover letter should include all explanations for reported variations as required by the reporting guidelines for each field of the spreadsheet.

2. Should the Contractor identify significant reporting variations in addition to those required below, an explanation should be included in the cover letter.

3. Denials:
   a. List top five reasons for claim denials and how many claims denied during the reporting period for each denial reason.
   b. List the five providers with the greatest number of claim denials; include how many claims are denied for each provider.

4. Special Projects for those claims identified in Field A15 of the Claims Dashboard:
   a. List all providers for which the Contractor is working on a special claims processing or claims review project. Include the following information:
      i. Reason for project,
      ii. How many claims are affected, and
      iii. Stratify claim count by age of claim (0-30 days, 31-60 days, etc.) using each of the following;
         a) Stratify by date of receipt,
         b) Stratify by start of project date.

5. Cumulative Recoupments:
   a. The Contractor must include the following information for reported cumulative recoupments per TIN:
      i. How was the need for the recoupment(s) identified,
      ii. What process(es) will be utilized to recover the funds, and
      iii. How will the affected provider(s) be notified.

C. CLAIMS DASHBOARD (ATTACHMENT B) INSTRUCTIONS

FIELD NUMBER	FIELD LABEL	REPORTING GUIDELINE
A1	MEMBERSHIP	Membership - As of the first day of the month, following the month for which data is reported, per AHCCCS website which can be found in the Resources section of the website under Population Reports, AHCCCS Population Statistics.
A3	TOTAL CLAIMS RECEIPTS	Reported as the month's accumulated total. Total claims received.
A4	TOTAL PAPER CLAIMS	Reported as the month's accumulated total. Total claims submitted via paper (e.g. claims submitted by mail or PDF).
A5	% PAPER CLAIMS	Reported as the month's accumulated total. Percentage of total claims submitted via paper: $\frac{\text{Total Paper Claims}}{\text{Total Claims Receipts}}$ Note: This field is automatically populated.
6	% ELECTRONIC CLAIMS	Reported as the month's accumulated total. *Highlight field and provide an explanation if this falls below contract performance minimum.* Percentage of total claims submitted in Electronic Data Interchange (EDI) format: $\frac{\text{(Total Claims Receipts – Total Paper Claims)}}{\text{Total Claims Receipts}}$ Note: This field is automatically populated.

FIELD NUMBER	FIELD LABEL	REPORTING GUIDELINE
A7	% CLAIMS PAID VIA EFT	Reported as the month's accumulated total. *Highlight field and provide an explanation if this falls below contract performance minimum.* Percentage of claims paid via Electronic Funds Transfer (EFT): Total number of claims paid via EFT Total number of claims paid
A8	% ELECTRONIC CLAIMS REMITTANCES	Reported as the month's accumulated total. *Highlight field and provide an explanation if this falls below contract performance minimum.* Percentage of claims remittance advice issued electronically, either through an 835 transaction or a data equivalent electronic format (web, download, etc.): Claims Remittance Advice Issued Electronically Total Claims Remittance Advice
A9	CLAIMS PENDING 0 TO 30 DAYS OLD	Reported as of the last day of the month. The number of claims in this age band.
A10	CLAIMS PENDING 31 TO 45 DAYS OLD	Reported as of the last day of the month. The number of claims in this age band.
A11	CLAIMS PENDING 46 TO 60 DAYS OLD	Reported as of the last day of the month. The number of claims in this age band.
A12	CLAIMS PENDING 61+ DAYS OLD	Reported as of the last day of the month. The number of claims in this age band.
A13	CLAIMS PENDED FOR MEDICAL REVIEW 61+ DAYS	Reported as of the last day of the month. Total number claims pended for medical review that are 61+ days old.
A14	TOTAL CLAIMS PENDING	Reported as of the last day of the month. The total number of pending claims, excluding special claims projects. *Highlight field and provide an explanation if there is a 5% increase, from the previous reporting month.*
A15	TOTAL CLAIMS PENDING NOT INCLUDED IN FIELD ABOVE	Reported as of the last day of the month. Total number of claims not considered in field above, due to special claims projects.

FIELD NUMBER	FIELD LABEL	REPORTING GUIDELINE
A16	AVERAGE DAY'S RECEIPTS	Reported as the month's accumulated total. Average day's receipts: Total receipts for the month Number of work days in the month
A17	DAYS WORK ON HAND AS OF EOM	Reported as of the last day of the month. Number of days work on hand as of the end of the month: ALL Claim Types: Total Claims Pending Average Daily Claims Processed Professional (CMS1500, 837P): Total Professional Claims Pending Average Daily Professional Claims Processed Dental (Dental Claim Form, 837D): Total Dental Claims Pending Average Daily Dental Claims Processed Institutional/Hospital (UB95, 8371): Total Institutional Claims Pending Average Daily Institutional Claims Processed (Average Daily Claims Processed is calculated using the following formula: # of Claims Processed EOM for the reporting month/ # of work days in the reporting month.)
A18	% PENDED CLAIMS NOT PAID IN 30 DAYS	Reported as of the last day of the month. Percentage of pended claims not paid in 30 days: Total claims pended greater than 30 days Total claims pending Note: This field is automatically populated.
A19	AVERAGE AGE OF CLAIMS PENDED FOR MEDICAL REVIEW EOM	Reported as of the last day of the month. Average age of claims pended for medical review: Sum of the ages of each claim pending medical review Total number of claims pended for medical review

FIELD NUMBER	FIELD LABEL	REPORTING GUIDELINE
A20	TOTAL CLAIMS DENIED	Reported as the month's accumulated total. Total number of claims denied in a month.
A21	% CLAIMS DENIED	Reported as the month's accumulated total. *Highlight field and provide an explanation if there is a 15% increase, from the previous reporting month. For example if the previous month's percent claims denied was 10%, the Contractor must provide an explanation if the current month's percent is 11.5% or greater.* Percentage of claims denied: Total number of claims denied in the month Total number of claims processed in the month Note: This field is automatically populated.
A22	TOTAL DOLLARS DENIED	Reported as the month's accumulated total. Total dollars denied.
A23	AVERAGE TIME TO PROCESS ALL CLAIMS	Reported as the month's accumulated total. Average time to process all claims: Sum of the ages of each processed claim (including denials) in the month Total number of claims processed (including denials) in the month
A24	TOTAL CLAIMS PROCESSED EOM	Reported as the month's accumulated total. Total amount of claims processed during the reporting month. Highlight field and provide an explanation if there is a 5% decrease, from the previous reporting month.
A25	WHERE THERE IS A CONTRACTED PAYMENT ARRANGEMENT, THE % OF CLAIMS PROCESSED WITHIN CONTRACTED DEADLINE	Reported as the month's accumulated total. Percentage of total claims processed that were processed within the contracted deadline. This reporting measure is for those Contractors that have contracts with submitters that specify processing of clean claims in time frames different than AHCCCS contract stated 30 days.
A26	% OF CLAIMS PROCESSED IN 0 TO 30 DAYS	Reported as the month's accumulated total. Of the claims not included in A25, the percentage of total clean claims that were adjudicated within 30 days of receipt of the clean claim. *Highlight field and provide an explanation if this falls below contract performance minimum.*

FIELD NUMBER	FIELD LABEL	REPORTING GUIDELINE
A27	% OF CLAIMS PROCESSED IN 0 TO 60 DAYS	Reported as the month's accumulated total. Of the claims not included in A25, the percentage of total clean claims that were adjudicated 60 days of receipt of the clean claim. *Highlight field and provide an explanation if this falls below contract performance minimum.*
A28	EDI AUTO-PROCESSING RATE	Reported as the month's accumulated total. Claims that are received via EDI and adjudicated in the claims system without manual review or manual intervention. EDI claims auto-processing rate: $\frac{\text{Total number of EDI claims auto-processed}}{\text{Total number of EDI claims processed}}$
A29	AUDITED % OF CORRECTLY PAID CLAIMS	Reported as the month's accumulated total. Percentage of claims paid correctly, for the reporting period, as determined from internal audit procedures.

TO BE REPORTED ON THE ALL CLAIM TYPES WORKSHEET ONLY		
B1	INCURRED BUT NOT RECEIVED CLAIMS (IBNR)	Reported as the month's accumulated total. The liability for services rendered for which claims have not been received.
B2	RECEIVED BUT UNPAID CLAIMS (RBUCS)	Reported as the month's accumulated total. Received but unpaid claims divided by the average daily medical expenses for the period, net of sub-capitation expense.
B3	ESTIMATED TOTAL MEDICAL CLAIMS LIABILITY	Reported as the month's accumulated total: IBNR + RBUCS
B4	AMOUNT OF INTEREST PAID IN THE REPORTING PERIOD	Reported as the month's accumulated total. If none enter "0".
B5	AUDITED % OF CORRECTLY PAID CLAIMS	Reported as the month's accumulated total. Percentage of claims paid correctly, for the reporting period, as determined from internal audit procedures.
B6	TOTAL AMOUNT OF ADVANCES & LOANS PAID	Reported as the month's accumulated total. Total amount of advances paid to providers in the reporting period. If none enter "0".

TO BE REPORTED ON THE CUMULATIVE RECOUPMENTS WORKSHEET		
C1	PROVIDER NAME	Name of the provider recoupments are being requested from.
C2	PROVIDER TIN	The TIN the cumulative recoupments have been tracked under.
C3	MONTH OF RECOUPMENT	The month the recoupment(s) was/were requested from the provider.
C4	CUMULATIVE RECOUPMENT AMOUNT	The total of cumulative recoupments during the month reported for the provider.
C5	TOTAL NUMBER OF CLAIMS	The number of claims being recouped from the provider.
C6	BEGINNING DATE OF SERVICE	First date of service in the range of dates for the claims being recouped.
C7	END DATE OF SERVICE	Last date of service in the range of dates for the claims being recouped.
C8	BRIEF SUMMARY OF RECOUPMENT REASON(S)	Provide a brief summary explaining the reason(s) for recoupment(s).