Michigan Department of Health and Human Services

MEDICAID HEALTH PLANS
MONTHLY CLAIMS PROCESSING REPORT

Report Month/ Year

GENERAL INSTRUCTIONS:

- This report is due 30 days after the end of the report month.
- Provide claims information for the report month for only the MEDICAID product line.
- Form instructions are on pages 2 and 3.

RETURN THIS FORM TO:

Using single sign-on and the MDHHS File Transfer Application.

File name should begin with Health Plan Acronym and end with month and year of report. (i.e., MHP Claims Report 012013).

SECTION I - Medicaid Health Plans:

1. HMO Name	2. Telephone Number ( ) -	3. Fax Number ( ) -
4. Name of Person Completing this Form	5. Email Address	

SECTION II - Claims Processing Inventory:

All claims as defined in this form	Number of Non-Pharmacy Claims		Number of Pharmacy Claims
1. Previous month's ending balance of unprocessed claims. (Line 11 of previous month's report)			
2. Claims received during report month.			
	≤ 30 days	**≤ 45 days**	**≤ 45 days**
3. Non-clean claims - provider notified of defect.			
4. Non-clean claims - provider notified of defect after 45 days of receipt.			
5. Total claims to be processed (lines 1 and 2) less (lines 3 and 4).			
	≤ 30 days	**≤ 45 days**	**≤ 45 days**
6. Clean claims **paid** (within days of receipt)			
7. Clean claims **rejected** (within days of receipt)			
8. Clean claims **paid** (after days of receipt)			
9. Clean claims **rejected** (after days of receipt)			
10. **TOTAL CLEAN CLAIMS PROCESSED** (Total Lines 6 through 9)			
11. Balance of all unprocessed claims at the end of the month. (Line 5 less Line 10)			
12. Of the number of all unprocessed claims reported on line 11, the number that are aged more than 45 days.			

SECTION III - Non-Pharmacy Claims Lag Information:

1. Average number of days between: Receipt of clean claim and date payment or rejection is mailed to the provider.	
2. Average Age of Unprocessed Claims (average number of days between receipt of claim and effective date of report)	

SECTION IV -Comments:

REPORTING INSTRUCTIONS:

- Do **not** report capitation payments to contracted providers.
- Report claims information for both contracted and non-contracted providers. This includes physicians, outpatient hospitals, inpatient hospitals and all other non-capitated providers.
- Report pharmacy claims (including claims paid by a PBM) separately using the same definitions.
- For purposes of calculating the number of days between receipt and payment, report the number of days between receipt and the date on the check or the date that the check is mailed, **whichever is later**.
- For paper claims, the date of receipt is the date the claim is mailed if the provider has proof of mailing. Otherwise, the date of receipt is the date the Plan stamps or perforates on the claim when received in the office.
- If the provider uses a clearinghouse for Medicaid claims processing, the date of receipt by the Plan will be the date the Plan, or the Plan's clearinghouse receives control of the claim from the provider's clearinghouse.
- If the provider's clearinghouse returns the claim, the claim will not be considered submitted to the Plan.
- If the provider and the Plan use the same clearinghouse, the date of receipt is the date the clearinghouse determines all edits and checks are complete.
- Report information in Section II, lines 5 – 10, for claims that have a paid or rejected date during the report month.

Authority: CHP Contract. **Completion:** Is required for contract compliance.	The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

DEFINITIONS (for form MSA 2009)
MEDICAID HEALTH PLANS - MONTHLY CLAIMS PROCESSING REPORT

CLEAN claim means a claim as defined in MCL 400.111 and OFIS Bulletin 2000-09 as follows:

- Is submitted within 1 year from the date of service, unless the provider's contract with the Plan requires a shorter time frame to file claims.
- Identifies the name and appropriate tax identification number of the health professional or the health facility that provided treatment or service and includes a matching provider ID number assigned by the Plan.
- Identifies the patient (member ID number assigned by the Plan, address, and date of birth).
- Identifies the Plan (Plan name and/or ID number).
- Lists the date (m/d/y) and place of service.
- Is for covered services (Services must be described using uniform billing coding and instructions (ANSI X12 837) and ICD-9-CM diagnosis. Claims submitted solely for the purpose of determining if a service is covered are not considered clean claims).
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided, that includes any applicable authorization number if prior authorization is required by the Plan.
- Includes additional documentation based upon services rendered as reasonably required by the Plan.
- Is certified by the provider that the claim is true, accurate, prepared with the knowledge and consent of the provider, and does not contain untrue, misleading, or deceptive information, that identifies each attending, referring, or prescribing physician, dentist, or other practitioner by means of a program identification number on each claim or adjustment of a claim.
- Is a claim for which the provider has verified the member's Medicaid eligibility and enrollment in the Plan before the claim was submitted.
- Is not a duplicate of a claim submitted within 45 days of the previous submission.
- Is submitted in compliance with all of the Plan's prior authorization and claims submission guidelines and procedures.
- Is a claim for which the provider has exhausted all known other insurance resources.
- When applicable, is a claim for which the provider verified with the Plan that she/he is the PCP of record.
- Is submitted electronically if the provider has the ability to submit claims electronically.
- Uses the data elements of HCFA1500 or UB92, as appropriate.

NON-CLEAN claim means a claim for which the Plan has notified the provider in writing that the claim contains one or more defects such that the claim cannot be processed, whether by the Plan's payment system or by a contracted clearinghouse's claims processing system. The defects on a non-clean claim include, but are not limited to, defects arising from failure to meet the standards for a clean claim, such as, missing other insurance information, missing prior authorization information or missing provider information. The claim may be returned to the provider with written notification of the defect(s) or the Plan may notify the provider in writing of the defect(s). The plan may correct the claim based on information from the provider or request that a corrected claim be submitted for processing.

PAID claim means a claim that is paid either in full or in part (a multi-line claim when not all claim lines are payable). A paid claim includes a clean claim that shows a payment of $0 when $0 is the appropriate payment (e.g., COB).

REJECTED claim means a claim that has been entered into the Plan's payment system and is rejected for reasons **other than** lack of adequate information to process the claim. A rejected claim also includes a claim that is paid $0 because the claim is not payable for reasons, including but not limited to, the claim was previously paid. A Plan may not reject a multi-line claim in its entirety, if a Plan determines that 1 or more covered services listed on a claim are payable.

UNPROCESSED claim means a claim that was entered into the Plan's payment system, but, as of the last day of the report month, had not been paid or rejected. An unprocessed claim is any claim in the system that is not paid or rejected.