



HHSC UNIFORM MANAGED CARE MANUAL

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Claims Summary Report Instructions

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	1.0	September 1, 2006	Initial version Uniform Managed Care Manual Chapter 5.6.1.2, Claims Summary Report Instructions
Revision	1.1	October 20, 2007	Chapter 5.6.1.2 is modified to include a listing of claim types. Definitions are removed and a reference to definitions in the Contract and Chapter 2.0, Uniform Managed Care Claims Manual is included.
Revision	1.2	April 10, 2008	Chapter 5.6.1.2 is modified to make the instructions applicable to UMCM Chapter 5.6.1.3, STAR Health Dental Claims Summary Report as well as Chapter 5.6.1.1, Claims Summary Report for the STAR, STAR+PLUS, CHIP, CHIP Perinatal, and STAR Health Programs.
Revision	2.0	March 1, 2012	Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, and 529-12-0002. Section I "Applicability" is updated to remove the CHIP Perinatal Program. Section II "Objective" is updated to clarify CHIP Perinatal reporting requirements. Section III "General" is updated to remove the CHIP Perinatal Program. Section IV "Claims Summary Report" is updated to change the reference from "EPO" to "CHIP RSA".
Revision	2.1	February 15, 2015	Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-08-0001, 529-10-0020, 529-12-0002, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration. Section I "Applicability of Chapter 5.6.1.2" is modified to add the Medicare-Medicaid Dual Demonstration. Section II "General" is modified to include applicability to Nursing Facility services, specify that claim form be used to submit claims and that clarify reporting of Nursing Facility Add-on and Nursing Facility Unit Rate and Coinsurance claims.
Revision	2.2	November 15, 2015	Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-13-0042, 529-13-0071, and 529-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual



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			<p>Demonstration.</p> <p>Section I “Applicability of Chapter 5.6.1.2” is modified to add the STAR Kids Program.</p> <p>Section II “General” is modified to add instructions for the MMPs.</p> <p>Section IV “Claims Summary Report” is modified to add sub-section B “Data Entry for Medicare-Medicaid Plans.”</p>
<p>¹ Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.</p> <p>² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.</p> <p>³ Brief description of the changes to the document made in the revision.</p>			



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I. Applicability of Chapter 5.6.1.2

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS (including the Medicare-Medicaid Dual Demonstration), CHIP, STAR Kids, and STAR Health Programs. In this chapter, references to “CHIP” or the “CHIP Managed Care Program(s)” apply to the CHIP Program. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all Programs, except where noted.

II. Objective

Managed Care Organizations (MCOs) contracting with the State of Texas to provide comprehensive health care services to qualified Program recipients must submit the Claims Summary Report in accordance with the Contract for services between HHSC and the MCO, and in accordance with the instructions below. Ad Hoc reports may be requested by HHSC as needed. For MCOs contracting with HHSC to provide CHIP Perinatal Health Care Services, the MCOs must submit and integrate the CHIP Perinatal data into the CHIP Program report.

III. General

The Claims Summary Report must be completed using the template provided by HHSC. Each MCO is required to submit a report for each Program, Service Area, and claim type. Claims data must be reported inclusive of services rendered by all providers. Claim type includes facility or professional services for Acute Care, Behavioral Health, Vision, Nursing Facility, and Long Term Services and Supports. Within each claim type, claims data must be reported separately in the applicable claim form.

For the STAR Health Program, American Dental Association (ADA) claims data should be reported on the STAR Health Dental Claims Summary Report.

For the Medicare-Medicaid Dual Demonstration (MMP), the MCO must report separate Claims Summary Reports for Medicare and Medicaid claims for each service area. This means that the MCO will submit a total of ten (10) reports per service area. Please refer to the UMCM Chapter 5.1.1 for a list of deliverable codes.

All shaded data fields in the Claims Summary Report represent fields where data input is required. All data fields not shaded represent cell-referenced data or calculations.

I. Applicability
Added by
Version 1.1
and Modified
by Versions
1.2, 2.0, 2.1,
and 2.2

II. Objective
Modified by
Versions 1.1
and 2.0

III. General
Modified by
Versions 1.1,
1.2, 2.0, 2.1,
and 2.2



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HHSC will provide the Claims Summary Report to the MCOs in an electronic format. Spreadsheet integrity is critical to the automated compilation of this data. MCOs may not alter the file name, worksheet name, existing cell locations, or the format of the data in the cells. MCOs may not add or delete any columns or rows to the spreadsheet.

Please refer to Chapter 5.6.1, for the Claims Summary Report Templates. Nursing Facility Add-on services will be reported using the template contained in Chapter 5.6.1.1; however, Nursing Facility Unit rate and Medicare Coinsurance will be reported using the template in Chapter 5.6.1.8.

IV. Claims Summary Report

The Claims Summary Report will provide HHSC with information on claims processed within the required timeframes. The claims processing requirements and required timeframes are presented in Chapter 2 of the Uniform Managed Care Manual. Applicable definitions are found in the CHIP RSA Managed Care Contract Terms and Conditions, the General Terms and Conditions, or the Uniform Managed Care Contract Terms and Conditions (as applicable to each MCO), and Chapter 2.0 of the Uniform Managed Care Manual. The Claims Summary Report must be submitted quarterly by the last day of the month following the reporting period.

IV. Claims
Summary
Report
Modified by
Version 2.0

A. Data Entry for the Claims Summary Report

Enter the following information on the Summary Sheet of the Claims Summary Report.

Claims Processor: The MCO's official name in Texas
Program: For example, STAR
Service Area: For example, Bexar
Claim Type: For example, Acute Care
State Fiscal Year: For example, 2015
Period: For example, Q1, Q2
Period start date: Month, day, and year, for example, 9/1/2015
Period end date: Month, day, and year, for example, 9/1/2015
Date Submitted: Month, day, and year, for example, 9/1/2015

If the MCO has subcontracted with a claim processor for one or more types of claims, enter the name of the subcontractor on the appropriate data entry sheet.

On each data entry sheet, enter the following information.

Clean Claims Adjudicated during the period: include any claims **Adjudicated** between the dates specified as Period Start Date and Period End Date. The number of claims denied, the number of claims paid, and the amounts paid are to be entered according to the time between the date of receipt and the date of



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Adjudication (claims Adjudicated within 30 days of receipt, 31 to 90 days after receipt, and more than 90 days after receipt).

Column I, Row 25 calculates the percentage of Clean Claims Adjudicated within 30 days of receipt.

Appealed Claims Adjudicated during the period: include any Appealed Claims **Adjudicated** between the dates specified as Period Start Date and Period End Date. The number of claims denied, the number of claims paid, and the amounts paid are to be entered according to the time between the date of receipt and the date of Adjudication (claims Adjudicated within 30 days of receipt, 31 to 90 days after receipt, and more than 90 days after receipt).

Column I, Row 43 calculates the percentage of Appealed Claims Adjudicated within 30 days of receipt.

Adjusted Claims Adjudicated during the period: include any claims **Adjusted** between the dates specified as Period Start Date and Period End Date. Enter the number of claims and the additional amount paid.

Claims Processed during the period: include any claims **Processed** between the dates specified as Period Start Date and Period End Date. These claims, Rejected Claims, Duplicate Claims, Deficient-Denied Claims, and Deficient-Pended Claims, are to be reported according to the definitions in Chapter 2.0 of the Uniform Managed Care Manual.

Other Claims: include all Other Unprocessed Claims and Capitated Service Claims between the Period Start Date and Period End Date. These claims are to be reported according to the definitions in Chapter 2.0 of the Uniform Managed Care Manual.

Interest penalties paid to providers between the Period Start Date and Period End Date are to be reported on row 68. Enter the total number of claims subject to interest penalties, that is, Clean Claims, or any portion of Clean Claims, that remain unadjudicated beyond 30 days from the date of receipt and the amount of interest paid to those providers.

B. Data Entry for Medicare-Medicaid Plans

MMPs should follow the above instructions for entering information on each Claims Summary Report with the exception of Medicare nursing facility claims.

For Medicare nursing facility claims paid on form 837i, MMPs should use the Medicare Nursing Facility CSR (deliverable code BEQ). Medicare nursing facility claims paid on forms UB04 or CMS 1500 should be reported on the Medicare Acute CSR (deliverable code BEM).

IV. B. Data
Entry for
MMPs added
by Version 2.2