Centennial Care Reporting Instructions
Claims Activity – Report #47

Report Objective

This report has two main areas of focus:

1. Claims Activity – To capture data related to the disposition of claims, timeliness of claims adjudication, payments on clean claims to providers, interest paid, and claim aging.

   This section of the report captures claims data separately for physical health providers, behavioral health providers, I/T/Us (Indian Health Service, Tribal health providers, and Urban Indian providers), and specialty-pay providers (day activity providers, assisted living providers, nursing facilities, home care agencies, and community benefit providers).

2. Claims Payment Accuracy – To report the findings of the managed care organization's (MCO's) internal audit of quarterly claim payments and to monitor the accuracy of those claims paid.

General Instructions

The MCO is required to submit this report on a quarterly basis. This report is due on the 30th day of the month following the end of the reporting quarter. If a report due date falls on a weekend or a State of New Mexico holiday, receipt of the report the next business day is acceptable. Please adhere to the following reporting periods and due dates:

Quarter	Reporting Period	Report Due Date
Q1	January 1 – March 31	April 30
Q2	April 1 – June 30	July 30
Q3	July 1 – September 30	October 30
Q4	October 1 – December 31	January 30 of subsequent year

Other General Instructions

An Excel workbook is provided as a separate attachment for submission. Quantitative data and any qualitative data **must** be entered in the Excel workbook. The MCO must ensure that data is entered in all fields. The report will be considered incomplete if any field is left blank. Use "ND" if there is no data available to report. Use "N/A" if the data field is not applicable. Formulas provided in the workbook shall not be altered by the MCO. An electronic version of the report in Excel must be submitted to the New Mexico Human Services Department (HSD) by the report due dates listed above. The report shall be submitted via the State's secure DMZ FTP site. The date of receipt of the electronic version will serve as the date of receipt for the report.

To assist MCOs with the use of the template, all cells within the template are viewable. This allows the user to move the cursor into any cell of the template and enables the user to see the formulas in the cells that calculate automatically. Although certain cells are locked and protected, the user's ability to view the formulas should assist in the MCO's understanding of the template and calculations performed. It is important to note that when populating the templates with data, users are not to use the "cut and paste" function in Excel, as this may cause errors to the cell formulas. Additionally, certain cells have been shaded and locked to prevent data entry where data is not required or not applicable to the particular item or category.

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For sections of this report that capture data for multiple reporting periods (both current and prior quarters), the MCO is required to restate previously submitted data. Reporting data in this manner will take advantage of the most current, complete, and accurate information available.

The MCO shall submit the electronic version of the report using the following file labeling format: MCO.HSD47.Q#CY##.v#. The "MCO" part of the labeling should be the MCO's acronym for their business name. With each report submission, change the quarter reference (Q# - e.g., Q1), the calendar year (CY## - e.g., CY19), and the version number (v# - e.g., v1), as appropriate. The version number should be "1" unless the MCO is required to resubmit a report for a specified quarter. In those instances, the MCO will use "2" and so on for each resubmission.

The Reporting Period, MCO Name, and Report Run Date must be entered in the fields provided at the very top left corner of the first worksheet in the Report. Using the format illustrated below, enter the start and end dates for the Reporting Period. The MCO Name should be the MCO's full business name. Using the format illustrated below, enter the Report Run Date. The Report Run Date refers to the date that the data was retrieved from the MCO's system. All dates and the MCO name entered on the first worksheet will automatically populate the top of all other worksheets in the report.

Reporting Period	MM/DD/YYYY	through	MM/DD/YYYY
MCO Name	MCO's Full Name		
Report Run Date	MM/DD/YYYY		

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in each of the tabs prior to submitting the Report. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports may result in monetary penalties of $5,000 per report, per occurrence.

The MCO shall include a signed Centennial Care Report Attestation Form with each Report submitted. Failure to submit a signed attestation form by the Report due date will result in the entire Report being late. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit timely reports may result in monetary penalties of $1,000 per report, per calendar day. The $1,000 per calendar day damage amounts will double every ten calendar days.

Related Contract Requirements

1. Section 4.19 – Claims Management
2. Section 4.21 – Reporting Requirements
3. Section 7.3 – Failure to Meet Agreement Requirements

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Definitions

Adjudicated Claim	A claim that has completed processing and has a final disposition or system status of paid or denied, regardless if payment or denial has been issued to the provider.
Claim	A bill for services submitted to the MCO. A claim can be submitted manually (via paper) or electronically. For the purposes of this specific report, "claim" refers to the claim at the header level. The MCO must not include claim information from the detail claim-line level in counts, dollars or other input.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in HSD's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
Claims Received	Claims accepted for processing and recognized as received by the MCO. Exclude adjusted claims reprocessed due to MCO errors.
Claims Pending Adjudication	A claim for which the adjudication process has been suspended for reasons such as awaiting additional information, under review for medical necessity, and non-provider-related issues (e.g., manual processing requirement).
Paid Claim	A claim that has reached final adjudication status and has at least one paid line, including sub-capitated claim lines that may show as zero paid dollars. Paid claims with one or more denied lines can be referred to as "Partial Paid" claims. For the purpose of this report, Paid claims and Partial Paid claims are the same.
Denied Claim	A claim that has reached final adjudication and does not have any paid lines or sub-capitated lines.
I/T/U	Indian Health Service, Tribal health providers, and Urban Indian providers, including facilities that are operated by a Native American/Alaskan Indian tribe, authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.
Specialty-Pay Providers	Day activity providers, assisted living providers, nursing facilities, home care agencies, and community benefit providers.
Dollar Accuracy Rate (DAR)	The percentage of dollars paid correctly relative to the total paid amount. Calculation – Total paid dollars minus overpayments and underpayments divided by the total paid dollars.

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Claims Payment Accuracy (CPA)	The percentage of audited claims paid correctly without financial/payment errors. Refer to Section VIII for list of error codes. Calculation – Total number of audited claims minus the number of claims with financial/payment errors divided by the total number of audited claims.
Procedural Accuracy Rate (PAR)	The percentage of audited claims without procedural errors. Refer to Section VIII for list of error codes. Calculation – Total number of audited claims minus the number of claims with procedural (non-financial/non-payment) errors divided by the total audited claims.
Overall Accuracy Rate (OAR)	The percentage of claims without financial/payment or procedural errors. Calculation – Total number of audited claims minus the number of claims with errors divided by the total audited claims.

Section I: Summary

Before entering data in the workbook, ensure that the "Summary" tab is selected. The "Summary" tab provides consolidated information for claims activity and claims payment accuracy by the current quarter and by each of the four most recently complete prior quarters.

With the exception of Reporting period information and the MCO's name, all fields in this tab are auto-populated using data reported in Sections III through VIII and do not require data entry.

Enter the reporting period, MCO name, and report run date on the top portion of the worksheet (Columns B through D, Rows 1 through 3). Note that this information will auto-populate within all other tabs for Sections II through VIII.

Note that the report through date entered in cell D1 is also used to populate many column/section headings within this workbook. As such, it is important that the correct date format of MM/DD/YYYY be used when entering the applicable report through date.

Information within this worksheet is limited to the five most recent calendar year (CY) quarters. Each column contains information for a specific quarter.

- Column C contains information for the current CY quarter.
- Columns D-G contain information for each of the four completed CY quarters prior to the current CY quarter.

The Claims Payment Accuracy section of the table is limited to the four most recent calendar year (CY) quarters.

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Row Header	Row(s)	Description
Total Claims Received (Count)	11 24 37 50	The total number of EDI claims and paper claims received each quarter and each provider type.
Total Claims Pended (Percentage)	12 25 38 51	The percentage of claims which are still pending at the end of the quarter.
Total Clean Claims Adjudicated (Count)	13 26 39 52	Of the total number of claims received each quarter, the total number of clean claims adjudicated (paid/denied).
Total Clean Claims Paid (Percentage)	14 27 40 53	Percentage of total clean claims adjudicated that resulted in a paid status.
Total Clean Claims Denied (Percentage)	15 28 41 54	Percentage of total clean claims adjudicated that resulted in a denied status.
Adjudication Timeliness: % Adjudicated	17-19 30-32 43-45 56-58	Of the total number of claims received each quarter that have been adjudicated, the number of clean claims that were adjudicated (paid and denied) within a certain number of calendar days of receipt. Adjudication %'s can be measured against the applicable contract standard % listed within Column B.
Total Claims Paid (Dollars)	20 33 46 59	The total amount of paid dollars for adjudicated paid claims received in the quarter.
Interest Paid (Dollars)	21 34 47 60	The dollar amount of interest paid for adjudicated clean claims paid that were received in the quarter and did not meet the contractual timeframes for payment.
Interest Paid Percent of Total Claims Paid	22 35 48 61	Interest paid divided by total claims paid.

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Row Header	Row(s)	Description
Procedural Accuracy Rate PAR (%)	65	The percent of audited claims without procedural errors.
Dollar Accuracy Rate DAR (%)	66	The percent of dollars paid correctly relative to the total paid amount.
Claims Payment Errors (Dollars)	67	The total dollar amounts for over/underpayments associated with audited claims identified with errors.

Section II: Analysis for Physical Health, Behavioral Health, ITUs, and Specialty Pay

This section of the report collects qualitative analysis regarding claims adjudication and claims payment. "Cutting and pasting" responses from previous quarters is strongly discouraged.

Section II is made up of 4 separate tabs, one for each of the four provider type groupings.

Claims Activity Summary Table
The table at the top of each tab is auto-populated using information reported in other sections of the report and does not require data entry. Row numbers identified in the tables correspond to the row numbers of the tables from where the data originates. This information is to be used in support of responses to the analysis questions located below the table.

Descriptions for each of the line-items are located within sections of the instructions that correspond to the source data.

Analysis Questions
Analysis questions are located within each provider-specific analysis tab. The analysis questions are broken into 3 sections covering general claims payment, claim denial reasons and claims payment accuracy.

Sections III through VI: Physical Health (III), Behavioral Health (IV), ITUs (V), and Specialty Pay Providers (VI)

The following instructions apply to the "Physical Health" tab (Section III), the "Behavioral Health" tab (Section IV), the "ITUs" tab (Section V), and the "Specialty Pay" tab (Section VI) of the workbook. These four tabs capture claims activity information for the specific provider type groupings.

Reporting Claims Activity Data on a Rolling 8-Quarter Basis
Sections III through VI are formatted to capture data on a rolling 8-quarter basis. Each quarterly column/section within these tabs corresponds to the quarter the claim was received by the MCO. The

worksheet is formatted to capture quarterly data starting with the most recently complete quarter's data followed by each prior quarter's data.

Additional Reporting Considerations

Unless specifically identified, all descriptions and references in the tables below apply to each of the four tabs covered in this section.

The billing provider listed on the claim is to be used to classify claims into one of the following four provider type groupings: physical health, behavioral health, ITUs, and specialty-pay providers.

With each new quarterly report submission, the MCO shall update previously submitted data related to earlier quarters as necessary.

Column Headers

Column Header	Column	Description
Number of Claims ("#")	Multiple	Total number of claims associated with each applicable row header. Note that some cells within these columns are calculated automatically and data entry is not required.
Dollar Amount ("$")	Multiple	For each applicable row header, the corresponding dollar amounts for claim counts reported within the "#" column.
Percent of Total/Subtotal ("%")	Multiple	The percent of claim counts associated with a particular row header relative to a total/subtotal claim count. Percentages within these columns are calculated automatically; data entry is not required.

Claims Received and Claims Pended

Row Header	Row	Description
Total Claims Received (Count)	8	The total number of claims received in the quarter. This number should include both EDI and paper claims accepted for processing /adjudication, and recognized as received within the quarter.
Total Claims Pended	9	The total number of claims accepted for processing /adjudication which are pending for review.

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Clean Claim Standards & Timeliness

Contract standards for timeliness vary based on the type of provider (billing) associated with the claim. The following row header data field tables are formatted to separately address clean claim standards and timeliness applicable to each provider type within the following groupings:

- The "Physical Health" (Section III) and "Behavioral Health" (Section IV) tabs; and
- The "ITUs" (Section V) and "Specialty Pay" (Section VI) tabs

Clean Claim Standards & Timeliness – PH and BH tabs only:

Row Header	Row	Description
PH and BH Tabs Only: Clean Claims Adjudicated Within 30 Calendar Days of Receipt **Note:** Contract Standard 90% Clean Claims Within 30 Days	12	**PH and BH Tabs Only:** Of the total number of claims received in the quarter, the number of clean claims that were adjudicated (paid or denied) **within 30 calendar days** of receipt. Amounts in this row are calculated automatically; data entry is not required.
PH and BH Tabs Only: Clean Claims Paid (within 30 calendar days of receipt)	13	**PH and BH Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims paid **within 30 calendar days** of receipt.
PH and BH Tabs Only: Clean Claims Denied (within 30 calendar days of receipt)	14	**PH and BH Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims denied **within 30 calendar days** of receipt.
PH and BH Tabs Only: Clean Claims Adjudicated within 90 Calendar Days of Receipt Contract Standard 99% Clean Claims Within 90 Days	17	**PH and BH Tabs Only:** Of the total number of claims received in the quarter, the number of clean claims that were adjudicated (paid or denied) **within 90 calendar days** of receipt. Amounts in this row are calculated automatically; data entry is not required.

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Clean Claim Standards & Timeliness – PH and BH tabs only:

Row Header	Row	Description
PH and BH Tabs Only: Clean Claims Paid (within 90 calendar days of receipt)	18	**PH and BH Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims paid **within 90 calendar days** of receipt. **Note that amounts entered in this row must also include the amounts entered in Row 13.**
PH and BH Tabs Only: Clean Claims Denied (within 90 calendar days of receipt)	19	**PH and BH Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims denied **within 90 calendar days** of receipt. **Note that amounts entered in this row must also include the amounts entered in Row 14.**
PH and BH Tabs Only: Clean Claims Adjudicated More Than 90 Calendar Days From Receipt	21	**PH and BH Tabs Only:** Of the total number of claims received in the quarter, the number of clean claims that were adjudicated (paid or denied) **more than 90 calendar days** from receipt. Amounts in this row are calculated automatically; data entry is not required.
PH and BH Tabs Only: Clean Claims Paid (more than 90 calendar days from receipt)	22	**PH and BH Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims paid **more than 90 calendar days** from receipt. **Note that amounts entered in this row must exclude the amounts entered in Row 18.**

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Clean Claim Standards & Timeliness – PH and BH tabs only:

Row Header	Row	Description
PH and BH Tabs Only: Clean Claims Denied (more than 90 calendar days from receipt)	23	**PH and BH Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims denied **more than 90 calendar days** from receipt. **Note that amounts entered in this row must exclude the amounts entered in Row 19.**

Clean Claim Standards & Timeliness – ITUs and Specialty-Pay tabs only:

Row Header	Row	Description
ITUs and Specialty–Pay Tabs Only: Clean Claims Adjudicated Within 15 Calendar Days of Receipt **Note:** Contract Standard 95% Clean Claims Within 15 Days	12	**ITUs and Specialty–Pay Tabs Only:** Of the total number of claims received in the quarter, the number of clean claims that were adjudicated (paid or denied) **within 15 calendar days** of receipt. Amounts in this row are calculated automatically; data entry is not required.
ITUs and Specialty–Pay Tabs Only: Clean Claims Paid (within 15 calendar days of receipt)	13	**ITUs and Specialty-Pay Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims paid **within 15 calendar days** of receipt.
ITUs and Specialty–Pay Tabs Only: Clean Claims Denied (within 15 calendar days of receipt)	14	**ITUs and Specialty-Pay Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims denied **within 15 calendar days** of receipt.
ITUs and Specialty–Pay Tabs Only: Clean Claims Adjudicated within 30 Calendar Days of Receipt Contract Standard 99% Clean Claims Within 30 Days	17	**ITUs and Specialty–Pay Tabs Only:** Of the total number of claims received in the quarter, the number of clean claims that were adjudicated (paid or denied) **within 30 calendar days** of receipt. Amounts in this row are calculated automatically; data entry is not required.

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Clean Claim Standards & Timeliness – <u>ITUs and Specialty-Pay tabs only</u>:

Row Header	Row	Description
ITUs and Specialty–Pay Tabs Only: Clean Claims Paid (within 30 calendar days of receipt)	18	**ITUs and Specialty-Pay Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims paid **within 30 calendar days** of receipt. **Note that amounts entered in this row must also include the amounts entered in Row 13.**
ITUs and Specialty–Pay Tabs Only: Clean Claims Denied (within 30 calendar days of receipt)	19	**ITUs and Specialty-Pay Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims denied **within 30 calendar days** of receipt. **Note that amounts entered in this row must also include the amounts entered in Row 14.**
ITUs and Specialty–Pay Tabs Only: Clean Claims Adjudicated More Than 30 Calendar Days From Receipt	21	**ITUs and Specialty–Pay Tabs Only:** Of the total number of claims received in the quarter, the number of clean claims that were adjudicated (paid or denied) **more than 30 calendar days** from receipt. Amounts in this row are calculated automatically; data entry is not required.
ITUs and Specialty–Pay Tabs Only: Clean Claims Paid (more than 30 calendar days from receipt)	22	**ITUs and Specialty-Pay Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims paid **more than 30 calendar days** from receipt. **Note that amounts entered in this row <u>must exclude</u> the amounts entered in Row 18.**

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Clean Claim Standards & Timeliness – ITUs and Specialty-Pay tabs only:

Row Header	Row	Description
ITUs and Specialty–Pay Tabs Only: Clean Claims Denied (more than 30 calendar days from receipt)	23	**ITUs and Specialty-Pay Tabs Only:** Of the total number of claims received in the quarter and adjudicated, the number of clean claims denied **more than 30 calendar days** from receipt. **Note that amounts entered in this row must exclude the amounts entered in Row 19.**

Interest Paid

Row Header	Row	Description
Dollar Amount of Interest Paid	25	The dollar amount of interest paid for adjudicated clean claims paid that were received in the quarter and did not meet the contractual timeframes for payment.

Claims Adjudicated Average Turnaround Time (Days)

Row Header	Row	Description
Average Received Turnaround Time (in days)	30	For claims received in the quarter, the average number of days from the date of the service identified on the claim to the date the claim is received by the MCO.
Average Claim Turnaround Time (in days)	31	For claims received in the quarter, the average number of days from the date the claim is received by the MCO (date stamped) to the date the claim is adjudicated.
Average Payment Turnaround Time (in days)	32	For claims received in the quarter, the average number of days from the date a claim is adjudicated until the date of payment. If the adjudication date is the same as the date of payment, the turnaround time is 0.
Average Days Claims Pended For Review	33	For claims received in the quarter that were pended for review, the average number of days the claims were pended for review.

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Section VII: Claim Denial Reasons

Before entering data in the workbook, ensure that the "Claim Denial Reasons" tab is selected. This section of the report captures the count of claim denial reasons for the current reporting period for each of the four provider types: physical health providers, behavioral health providers, I/T/Us, and specialty-pay providers.

Column Header	Column	Description
Denial Reason	A (A & B)	The first 11 rows of each table are prepopulated with claim denial reasons. Enter a short description in the last row for any denial reason not included in the first 11 rows where the corresponding count of denied claims is in the top 12 claim denial reasons (based on counts). If necessary, the MCO should designate each of its own denial reasons into one of the prepopulated categories. Denial reasons at the header level should be reported.
Count	C	Number of corresponding denied claims for each of the denial reasons listed in Column A.
Percent of Denied Claims	D	The percent of denied claim counts for each denial reason relative to the total denied claim counts reported in the table. Amounts in this column are calculated automatically; data entry is not required.

Section VIII: Claims Payment Accuracy

Before entering data in the workbook, ensure that the "Claims Payment Accuracy" tab is selected. This section of the report captures the findings of the MCO's internal audit of quarterly claim payments and monitors the accuracy of those claims paid.

This section of the workbook captures data for the current quarter and the three prior quarter(s). This section contains four subsections that correspond to each of the four quarters of data and are each labeled according to the applicable quarter.

The Claims Payment Accuracy tab contains four sections, one for each quarter, containing two tables for the following:

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- Audit Summary – captures key metrics from the claims audit report regarding dollar accuracy rate, claims payment accuracy rate, procedural accuracy rate and overall accuracy rate.

- Summary of Errors – captures error information by the type of error and the corresponding dollar amounts of the over/under payments.

Claims Audit Requirements

The MCO must conduct a quarterly audit of claims processed within the quarterly reporting period. All subcontractor claims must be eligible for selection in the internal audit. The MCO must not select a single claim for audit in multiple categories. The quarterly claims audit must review a minimum of 100 randomly-selected claims for each of the following claim types:

1. Inpatient Hospital Claims
2. Outpatient Hospital Claims
3. Professional Claims
4. Behavioral Health Claims
5. Nursing Facility Claims
6. I/T/U Claims
7. Crossover Claims
8. HCBS Claims
9. Dental Claims
10. FQHC/RHC Claims

The MCO may provide audit results from any additional claim reviews not required and not included within the required claim audits identified above. All applicable information resulting from these optional reviews of other claim types is to be reported within the designated section of the Audit Summary table. See below for additional instructions.

The claims audit must include the following attributes to be tested for each claim selected (not all attributes may apply to each claim that is selected for the audit):

1. Claim data correctly entered into the claims processing system
2. Claim is associated with the correct provider
3. Service obtained the proper authorization
4. Member eligibility data at time of processing correctly applied
5. Allowed payment amount agrees with contracted rate
6. Duplicate payment of the same claim has not occurred
7. Denial reason applied appropriately
8. Effect of modifier codes correctly applied
9. Documentation submitted is sufficient
10. Other insurance properly considered and applied
11. Proper service/procedure coding
12. Correct payment amount
13. Timely payment

The audit must be conducted by a unit independent of the claims management unit. For verification purposes, the MCO shall maintain records of the population of claims being used in these audits.

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If the MCO subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, the subcontractor claims must be eligible for selection in the internal audit.

Audit Summary

Column Header	Column	Description
Mandatory Claim Types And Other Claim Types (Optional)	A (A & B)	Description of the audited claim type. Mandatory Claim Types: Rows 9-19, 51-61, 93-103, and 135-145 are prepopulated with the required audit claims types. Data entry is not required. Other Claim Types (Optional): Rows 22-24, 64-66, 106-108, and 148-150 capture information related to additional audit claims types where the MCO has the option of reporting audit results. If applicable, enter a description for the other claim type(s).
Total Number of Audited Claims	C	The total number of claims audited during the reporting period. A minimum of 100 claims must be audited for each of the 10 mandatory claim types. Amounts in this column are calculated automatically by summing the number of claims without errors and the number of claims with errors (Columns D, E, and F); data entry is not required.
Number of Claims without Error	D	The count of claims with no errors for each claim type listed in Column A.
Number of Claims with Financial/Payment Errors	E	The number of audited claims that contained a financial/payment error. Financial/Payment errors are described in the Listing of Error Codes and Categories section below and include the following: • F-1: Pricing Error • F-2: Duplicate Charges Paid • F-3: Paid Non-covered Charges

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Column Header	Column	Description
Number of Claims with Procedural Errors	F	The number of claims that had a procedural (non-financial/non-payment) error. Procedural errors are described in the Listing of Error Codes and Categories section below and include the following: • P-1: Ineligible Member • P-2: Applied Incorrect Benefits • P-3: Coding Error • P-4: Incorrect Physician/Facility Rate Selected • P-5: Ineligible Provider • P-6: MCO Processing Error • P-7: Medically Unnecessary Service • P-8: Number of Units Incorrect • P-9: Overlooked Authorization • P-10: Policy Violation • P-11: Poor Documentation
Number of Claims with Errors	G	The number of claims for the claim type listed in Column A that were found to have an error (financial/payment or procedural). Amounts in this column are calculated automatically by summing the number of claims with errors (Columns E and F); data entry is not required.
Total Dollars Paid	H	Total amount of dollars paid for audited claims associated with each claim type listed in Column A.
Amount of Overpayments	I	Total amount of dollars overpaid for audited claims associated with each claim type listed in Column A.
Amount of Underpayments	J	Total amount of dollars underpaid for audited claims associated with each claim type listed in Column A. **Enter as a positive number.**
Dollar Error	K	Amounts in this column are calculated automatically by summing the dollar amounts for over/underpayments (Columns I and J) associated with each claim type listed in Column A; data entry is not required.
Dollar Accuracy Rate (DAR) (%)	L	The percent of dollars paid correctly relative to the total paid amount. Amounts in this column are calculated automatically as follows: Total dollars paid (Column H) less dollar error amount (Column K) divided by total dollars paid (Column H). Data entry is not required.

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Column Header	Column	Description
Claim Payment Accuracy (CPA) (%)	M	The percent of audited claims paid correctly without financial/payment errors. Refer to list of applicable error codes below. Amounts in this column are calculated automatically as follows: Total number of audited claims (Column C) less the number of claims with financial/payment errors (Column E) divided by the total number of audited claims (Column C). Data entry is not required.
Procedural Accuracy Rate (PAR) (%)	N	The percent of audited claims without procedural errors. Refer to list of applicable error codes below. Amounts in this column are calculated automatically as follows: Total number of audited claims (Column C) less the number of claims with procedural (non-financial/non-payment) errors (Column F) divided by the total number of audited claims (Column C). Data entry is not required.
Overall Accuracy Rate OAR (%)	O	The percent of claims without financial/payment or procedural errors. Amounts in this column are calculated automatically as follows: Total number of audited claims (Column C) less the number of claims with errors (Columns E and F) divided by the total number of audited claims (Column C). Data entry is not required.

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Summary of Errors

Column Header	Column	Description
Error Category	A (A & B)	Rows 31 – 45, 73 – 87, 115 – 129, and 157 - 171 are prepopulated with error category descriptions. Data entry is not required. The table containing the list of error codes, categories and descriptions is located at the end of this section.
Error Code	C	Rows 31 – 45, 73 – 87, 115 – 129, and 157 - 171 are prepopulated with the corresponding error codes for the error category descriptions listed within Column A; data entry is not required.
Number of Claims with Errors	D	The number of claims (for all claim types audited) that were found to have the error listed in Column A. Note that the total amounts automatically calculated for this column must tie to the corresponding total amounts for the number of claims with errors within the Audit Summary table.
Percent of Total Errors Identified	E	The percent of claims with errors for each error category relative to the total amount of claims with errors for all error categories. Amounts in this column are calculated automatically; data entry is not required.
Dollars Overpaid in Error	F	Total amount of dollars overpaid for audited claims associated with each error category listed in Column A.
Dollars Underpaid in Error	G	Total amount of dollars underpaid for audited claims associated with each error category listed in Column A. **Enter as a positive number.**
Dollar Error	H	Amounts in this column are calculated automatically by summing the dollar amounts for over/underpayments (Columns F and G) associated with each error category listed in Column A; data entry is not required. Note that the total amounts automatically calculated for this column must tie to the corresponding total amounts for dollar errors within the Audit Summary table.
Percent of Total Dollar Error (Underpaid and Overpaid)	I	The percent of dollar error amounts for each error category relative to the total dollar error amount for all error categories. Amounts in this column are calculated automatically; data entry is not required.

Centennial Care Reporting Instructions
Claims Activity – Report #47

Listing of Error Codes and Categories

The codes listed in the following table are applicable to the Summary of Errors section of this worksheet. Note that codes that begin with the letter "F" are related to financial/payment errors. Codes that begin with the letter "P" are related to procedural errors.

Error Category	Error Code	Error Description
Pricing Error	F-1	Allowed payment amount does not agree with contracted rate.
Duplicate Charges Paid	F-2	Duplicate payment of the same claim has occurred.
Paid Non-covered Charges	F-3	Payment made for a non-covered service.
Ineligible Member	P-1	Member was not eligible on date of service.
Applied Incorrect Benefits	P-2	Member not eligible to receive services listed in claim.
Coding Error	P-3	The services were not commensurate with the level billed. Modifier codes incorrectly applied.
Incorrect Physician/Facility Rate Selected	P-4	Claim is not associated with the correct provider/facility.
Ineligible Provider	P-5	Services were rendered by a provider that is not enrolled as a Medicaid provider.
MCO Processing Error	P-6	Claim data incorrectly entered into the claims processing system.
Medically Unnecessary Service	P-7	Physician records do not include a reason for the service or prescription.
Number of Units Incorrect	P-8	The number of units in the claims is incorrect.
Overlooked Authorization	P-9	The proper service authorization was not obtained.
Policy Violation	P-10	The claim violates Federal, State or MCO policy.
Poor Documentation	P-11	Documentation of service is incomplete or unsatisfactory (e.g., the billing provider did not submit documentation; the referring provider did not submit documentation; The MCO did not document the service at all, etc.).