Alabama Medicaid Agency

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Alabama interChange Project

Alabama interChange Claims Processing Operations Manual

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1. Introduction

The Claims Processing functional area is the foundation for the Alabama Medicaid Management Information System (AMMIS). Claims Processing handles all provider claims by using a combination of manual and computerized functions and fulfills the essential requirements of making timely and accurate claim payments to eligible providers—on behalf of eligible recipients—for services covered under the Medicaid program.

1.1 Claims Processing Unit Functions

The primary functions for the Claims Processing area are as follows:

- Claims resolution
- Inventory management
- Paper claims data entry

1.2 Claims Processing Forms

All forms referenced in this document can be found in iTRACE. The table below documents the various forms and where to find them in iTRACE.

Forms	Location
CMS-1500 Billing Facsimile UB-04 Billing Facsimile Dental Billing Facsimile Pharmacy Billing Facsimile	https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/Reports.asp?Subsystem=Third%20Party%20Liability

1.3 Input, Processes, and Output

1.3.1 Input

The table below documents the inputs to the Claims Processing functional area.

Claims Processing Inputs

Input	Source	Purpose
Data corrections	Resolutions specialists	To correct information, override, edit, audit, or deny the claim or claim detail.
Electronic files - claims and encounters	Billing agencies Managed Care providers Providers	To input claims received via electronic media
Paper claims (including individual claim adjustments)	Providers	To input paper claims from providers

Input	Source	Purpose
System-generated claims	AMMIS	To input data that is created by other *AMMIS* programs to pay managed care case management fees and capitated payments to eligible providers for enrolled recipients.

1.3.2 Processes

Processes accomplished in the Claims Processing functional unit include the following:

- Claims adjudication
- Claims history and extracts
- Claims payment and Claims operations
- Claims resolution
- Electronic claims management
- Inventory management
- Paper claims data entry
- Encounter claims processing

Claims Adjudication

Claims adjudication comprises three system processes that combine to accurately adjudicate Medicaid claims to a final disposition. These processes are as follows:

- Claims editing
- Claims pricing
- Claims auditing

Claims Editing

The first part of the claims processing cycle is the application of claim edits. Edits compare information on the current claim to other information on parts of the same claim or information on recipient, provider or reference files. The following provides a sample of the common edits:

- Procedure requires prior authorization and no prior authorization is on file.
- Provider number is not on the provider file.
- Recipient is eligible under the pregnant women and children's program for only pregnancy-related services and the diagnosis code is not pregnancy-related.

NOTE:

Edits can be very simple or very complex but they are all related only to data on the current claim.

If a claim or claim detail fails an edit, an error status code (ESC) is posted to the claim record. Multiple error status codes can be posted to a claim or detail in a single claim cycle. This enables all identified errors to be resolved at one time, unless the errors are related to provider or recipient editing. In this case, no further editing can take place until the errors are resolved, as other edits are performed based on provider and recipient specifics.

Example: If the provider number is not on the provider file, the claim cannot be edited for valid provider type or specialty or for provider eligibility for the date of service. The claim will either deny or be returned to the provider, depending on the Agency's policy.

When edits are set on a claim, the edit disposition table is accessed for the system to determine the following:

- If the edit failure should suspend the claim for manual review and resolution.
- If the claim should be automatically denied.
- If processing should continue for the claim and report out for follow-up or tracking.

Claims that pass all of the system edits are passed on to claims pricing and claims auditing.

Claims Pricing

Each State Medicaid program determines the pricing method to be used to pay providers for services rendered. In Alabama, the pricing methods used include the following:

Pricing Method	Pricing Method Description
Average Wholesale Price (AWP) - 10% (EAC), State MAC (SMAC), Wholesale Acquisition Cost (WAC) + 9.2%, Federal Upper Limit (FUL) and Department of Justice (DOJ)	Price paid to pharmacy providers for drugs dispensed.
Customary Charge	A rate set by the State for a specific service and a specific provider that will be paid to the Medicaid provider who renders that service.
MAX Fee	A rate set by the State for a specific service that will be paid to the Medicaid provider who renders that service.
Per diem	A fixed amount paid per day for a set of services to hospital inpatient or nursing home providers.
Percent of charges	A fixed percent amount that is applied to the billed charges for designated services.

Each service on an incoming claim is priced based on the method designated by the Agency. The price is based on the prices found on the provider customary rate, provider outpatient rate, and provider NH/IP rate tables, the procedure code max fee table, and the drug code rate tables, as well as on the approved pricing logic that is coded in AMMIS. This portion of the pricing logic is referred to as preliminary pricing.

After a claim has been through the audit process and is ready for final disposition, a process called final pricing occurs. In final pricing, the sum of all claim detail prices is calculated and then reduced by amounts previously paid by other insurance companies and amounts the recipient must pay for services, such as nursing home patient liability and co-payments. The final price becomes the amount that will be paid to the provider for the service(s) rendered.

After preliminary pricing, the claim moves to the claim auditing process.

Claim Auditing

Claim auditing is the process of comparing certain fields on the current claim to other fields on the same claim, to other claims currently in process, or to other paid claims that are already in claims history. The following describes the audit types:

Audit Type	Audit Description
Duplicate	Detect both exact duplicate claims and suspected duplicate claims. ***Examples**:* If two claims from the same provider for the same recipient have the same date of service, same procedure code, same modifier, and the same billed amount, an exact duplicate audit may be set. If two different providers bill for the same service on the same day, a suspect duplicate audit may be set.
Hard-coded	Compare the current claim with past claims for certain conditions that are outside other audit criteria. ***Examples**:* A non-standard time period may need to be coded for a limitation audit. A complex set of relationships may need to be determined across multiple time periods.
Limitation	Identify and restrict services that exceed established program and medical policy limits. ***Example**:* Program policy limits office visits to 14 per calendar year. Medical policy limits tooth extractions to once per tooth in a lifetime.
Relationship	Restrict services that are defined as similar in purpose to other Medicaid services as defined by State Medicaid policy. ***Example**:* If an office visit and an office surgery code are billed separately on the same day, but medical policy defines that the office visit charge should be included in the price for the surgery, a relationship audit will set.

Claims that have passed all edits and audits and have been priced are passed to AMMIS for financial processing. Those claims that fail edits and audits and whose disposition is set to suspend will be suspended until resolution occurs. Once resolution occurs, those claims will also be passed to AMMIS for financial processing.

Claims History and Extracts

Claims history involves the processing and data management functions associated with creating and maintaining the large-scale finalized claims history files and databases and ensuring that a minimum of 36 months of full claims history is available in AMMIS. After each financial cycle, finalized claims are moved to the history database.

Claims Payment and Claims Operations

Payment and claims operations are the final processes in the claims processing cycle. During the financial cycle, a Remittance Advice (RA) is produced for each payee displaying their claims for that financial cycle.. The RA details the amount paid or the reasons for claim denial or suspense. Alabama specific Explanation of Benefit (EOB) codes will appear on paper RAs instead of the generic Health Insurance Portability and Accountability Act (HIPAA) standard codes.

Claim page sort order is by claim type, then by claim status as follows: Inpatient Crossover, Medical Crossover, Outpatient Crossover, Dental, Inpatient, Inpatient Encounter, Inpatient Nursing Home, Medical, Outpatient, Drug, Compound Drug. Second sort is by claim status: Adjustment, Denied, Paid, Suspended.

- Example: A doctor's RA sorts as: Crossovers, then Medicaid (each with the Adjusted, Denied, Paid, Suspended sort).
- Example: A hospital's RA sorts as: Inpatient Crossover, Outpatient Crossover, Inpatient, Inpatient Encounter, and Outpatient (each with the Adjusted, Denied, Paid, Suspended sort).

RAs are divided into the following primary sections:

Function	Function Description
Adjusted claims	Lists all claims that have been adjusted and the net financial result of the adjustment.
Credit Balance Due	"Letter" noting total amount due to Medicaid if account receivables are greater than payments.
Denied claims	An accounting of all claims denied in the financial cycle.
Explanation of Benefits	Lists EOB descriptions for header and detail EOBs posted on claims pages.
Financial items	Lists payouts (non-claim expenditures), refund checks received from the payee, and accounts receivables (both claim and non-claim).

Function	Function Description
Financial summary	The total dollar amount paid during the current financial cycle, year-to-date and net payments amounts for the current cycle and year-to-date totals. ▪ The 'top' of the payment section displays the check or electronic funds transfer (EFT) amount. It will appear visually in the middle of the page as NET PAYMENT. If a credit balance is due to Medicaid, the NET PAYMENT is displayed as 0.00. The amount due appears on the CREDIT BALANCE DUE 'letter' that is the last page of the RA. ▪ If payee receives a Capitation Payment, it appears as a single line and amount in this 'top' section. ▪ The 'bottom' of the payment section displays any other financial data that may affect NET EARNINGS. ▪ If any of the payment is sent to the IRS, the deduction amount is noted in the 'bottom' section, and detailed in a message at the very bottom of the page. Additionally, this section reports the narrative descriptions for each EOB code that appears on the RA.
Paid claims	An accounting of all claims paid in the current financial cycle.
Suspended claims	An accounting of all claims still in process and the reason for the suspense.
Third Party Information	Lists the third party policy information for claims which denied for other insurance.

Providers use the RA to post and reconcile open accounts within their business practice. RAs are produced on paper and merged with paper checks, if applicable, after each financial cycle. RAs that contain payments sent to providers via EFT will be printed and mailed to providers beginning on the Monday following the financial cycle.

An example of each RA can be found on iTRACE at the following path:
https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/Reports.asp?Subsystem=Financial

Claims Resolution

Claims that fail edits and audits and have their dispositions set to suspend are viewed through the online data corrections panel. The claims resolution specialists will review and resolve suspended claims. Each edit and audit has defined resolution instructions that are approved by the Agency Medicaid program administrators.

Resolutions specialists identify the edit or audit that is set and utilize the approved resolution instructions to complete the following:

- Correct data entry errors.
- Deny the claim or claim detail.
- Override the edit or audit.

- Return the claim to the provider for additional information.

All claims that are resolved are then sent back through the entire edit, pricing, and audit process until all errors are corrected, overridden, or denied so the claim will be ready for financial processing.

Electronic Claims Management

Electronic Media Claims (EMC)—also known as Electronic Claims Management (ECM)—is the core element in improving claims processing efficiencies and reducing time to process claims to their final disposition. Several common methods for providers to submit claims electronically are as follows:

- Public Internet to Alabama Medicaid Secured Web Portal.
- Dial-Up to Alabama Medicaid Secured Web Portal.
- From Alabama Medicaid Agency over private Multi-protocol Label switching (MPLS) circuits.
- Secured File Transfer Protocol (SFTP) (over public internet) from approved Contracted Vendors.
- Diskette/CD/DVD/Magnetic Tape.
- Interactive transmission and response from Clearinghouses with an approved site to site Virtual Private Network (VPN) connection.

Providers who use in-house computer systems or external billing service agencies can obtain electronic claim record specifications and program their systems to extract billing data in the required formats. The following list identifies the common format standards:

- Health Insurance Portability and Accountability Act (HIPAA).
- National Council for Prescription Drug Programs (NCPDP).

Software products enable providers to load programs on their personal computers (PCs) and enter billing information into pre-programmed and formatted claim entry screens to collect the required data. Many of the programs offer pre-editing of certain information to improve the accuracy of the data when it is submitted to AMMIS for processing.

The following modes of submission are available with the various software products:

Submission Type	Submission Description
Web Portal	The provider connects to the Alabama Medicaid Web Portal via a Secure Socket Layer (SSL) across the public internet for upload and download of claims transactions.
Dial-Up	A provider without an Internet Service Provider (ISP) may connect to the Web Portal via a dialup connection to a Cisco Universal Gateway. This allows a toll-free dial-up connection to the Alabama Medicaid Secured Web Portal.

Submission Type	Submission Description
Diskette/CD/DVD/Magnetic Tape	The provider downloads the completed claim records to the selected media and mails it to EDS for processing.

Interactive transmissions and responses through clearinghouses enable providers to enter individual pharmacy claims or eligibility transactions using software loaded on a PC or point of service device (POS) provided by a third party vendor or clearinghouse. The interactive transaction is processed to final disposition, and receives an electronic response in a matter of seconds.

The Alabama Medicaid Secured Web Portal interface is designed to not only support batch file uploads and downloads but also to provide users the ability to perform interactive requests by completing the online claim submission, eligibility, claim status or prior authorization request forms.

> All providers who submit claims electronically must sign electronic billing agreements. The billing agreement is a substitute for provider signatures and documents provider accountability for each individual claim.

Regardless of the mode of electronic claim submission, all claims follow similar standards for processing. Every claim received is submitted to the AMMIS and is assigned a unique ICN, which begins the inventory control process for all claims.

Each authorized submitter receives a unique individual Trading Partner ID in addition to an individual provider number which produces a Personal Identification Number (PIN) for access to the Alabama Medicaid Secured Web Portal for security purposes. All magnetic media—tapes, diskettes, CD-ROM, or DVD —are delivered to Operations and the delivery is recorded in a log on the date of the receipt.

> All magnetic media claims are assigned a claim ICN within one business day of receipt.

Other electronic processing features include:

Feature	Feature Description
Automated Voice Response System (AVRS)	An automated system that allows providers to utilize a touch tone telephone to obtain information on check amounts, individual claim status (either paid or denied), individual prior authorization status, procedure code pricing, National Drug Code (NDC) pricing, household inquiry, recipient eligibility, third party coverage, and benefit limit status.
Electronic Funds Transfer (EFT)	The paying of providers for approved claims via electronic financial transfer of funds from EDS directly into the provider's bank account.

Feature	Feature Description
Electronic Remittance Advice (RA)	Electronic Remittance Advice, a method for providers to obtain an electronic version of finalized claim accounting records from the Alabama Medicaid Secured Web Portal.

Inventory Management Processes

As each claim passes through the various processes, it is tracked within AMMIS for claims inventory management reporting. The total count of all claims input received from all sources—Alabama Medicaid Secure Web Portal, diskette, CD, DVD, magnetic tape, paper, or POS—are recorded as the claims beginning inventory. Each claim that suspends is assigned to a system control location that groups together comparable failures of edits or audits for common resolutions processing.

This common grouping enables easy reporting and rapid tracking of claims inventory problems and also allows claims to be located easily at any point during claims processing. All claims that are paid and denied are also counted and reported during each processing cycle. By balancing the number of claims received to the number of claims finalized and suspended, the claims manager can keep control of the location and timely processing of all claims and initiate immediate action to prevent and resolve claims inventory backlogs.

Paper Claims Data Entry Options

Paper claims are entered into AMMIS using optical character recognition (OCR) technology. In the OCR claims entry method, claim data is read electronically during the scanning process. If the OCR process reads the entire claim, the data is sent directly to the system for processing. If any character or field cannot be read through OCR, the claim is sent to a repair station. A data entry operator must then determine which character—or characters—must be corrected. Once the claim is corrected, the claim data is sent for processing. The entire batch must pass all keying rules before it is retired from the scanning process and sent to processing. After the batch is retired, the batch is processed in AMMIS in the same manner as electronic claim records.

1.3.3 Output

The table below documents the outputs from the Claims Processing functional area.

Claims Processing Outputs

Output	Source	Purpose
Payment records	Financial cycle	Records used to produce checks or EFT transactions.

Output	Source	Purpose
Reports	AMMIS	Record action on claims that were processed. Monitors and tracks claim inventories. Summarizes dollars paid and reasons paid or denied. Provides claims history for research purposes.
Suspended claims	Edit or audit cycles	Claims that could not complete processing because they did not pass edits or audits and required resolution.
Updated claim records	AMMIS	Completed records of processed claims that are posted to history files and databases.

1.4 Functional Area Responsibilities

The following responsibilities for the Claims Processing functional unit were extracted from section 20.382 of the Invitation to Bid (ITB):

1. Operate the Claims/Encounter Processing component of the MMIS, including improvements as they are implemented.
2. Perform all data processing operations to support Claims/Encounter processing requirements, including:
   - Edit processing
   - Suspense resolution
   - Claim pricing
   - Adjudication processing
3. Execute claims/encounters processing cycles and generate outputs on a State-approved schedule, in accordance with the standards determined by the State.
4. Process UB-04, CMS-1500, and other State-approved claim/encounter forms.
5. Generate and process capitation payments for HMO and managed care providers.
6. Process and generate payments to Primary Medical Providers (PMP) and lock-in providers for case management fees.
7. Process Medicare coinsurance and deductible charges from providers on hard-copy and electronic media claims.
8. Provide on-line, real-time adjudication of claims submitted interactively through value-added networks (VANs) or PCs.
9. Review and process all claims and other transactions submitted (including both hard-copy and EMC claims) against the most current and appropriate files/database tables.

10. Process "special" claims, including late billing, recipient retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other State-defined situation, in accordance with State instructions.
11. Maintain a method to process for payment any specific claim(s) or claim type(s), as directed by the State, on an exception basis.
12. Edit all claims/encounters in accordance with State program policy, benefits, and limitations as defined by the State.
13. Price all claims in accordance with State program policy, benefits, and limitations as defined by the State.
14. Provide the State with on-line inquiry access to current claims/encounters status data.
15. Provide on-line access to the claims history file/database for both paid and denied claims.
16. Provide on-line access to suspended claims data and the exception control file defining the disposition of edits and audits.
17. Provide and maintain thirty-six (36) months of non-drug adjudicated claims history for all transactions processed to final disposition and for use in editing/auditing non-drug claims.
18. Maintain eighteen (18) months of history for use in processing drug claims.
19. Maintain all claim data elements defined by the state on claims history.
20. Maintain an adequately staffed claims/encounters resolution unit to resolve claims suspended for edits and audits designated by the State as a Contractor resolution responsibility.
21. Maintain a close working relationship between the claims resolution unit and the State to develop new edits and audits, write the claims resolution instructions, and resolve claims in accordance with program policy and procedures.
22. Manually and systematically review and resolve any claims/encounters that suspend for any of the edits and/or audits as determined by the State.
23. Verify that services billed are consistent with services previously billed to the recipient and that they comply with State policy and medical criteria.

    NOTE—This requirement was deleted during the GAP sessions.
24. Process, deny or recoup claims with potential third party liability or Medicare coverage as directed by the State. Supply the provider with instructions and third party information to facilitate billing the third party.
25. Process as encounters, claims with HMO covered services for HMO recipients as directed by the State.
26. Suspend for review by Contractor or State staff, as required by the State, those specific providers, procedure codes, or provider types placed on prepayment review by the State.
27. Ensure that suspended claims/encounters are resolved in accordance with State-approved procedures.
28. Process all claims, encounters and other claims-related transactions in accordance with the program policy, benefits, and limitations as defined and established by the State.
29. Provide an audit trail for all claims and adjustments from time of receipt to time of payment so a claim may be located at any time and so that all failed edits and edit dispositions can be identified.

30. Implement and operate procedures to identify claims suspended as a result of data entry errors and correct such errors.
31. Resolve provider appeals on claim denials or cutbacks in accordance with State-approved procedures or refer to the State if unable to resolve.
32. Designate a staff person to serve as a contact point for the State who will coordinate the resolution of all exceptional claims submitted by the State.
33. Provide staffing as needed to resolve claims requiring PAs and/or attachments, such as TPL, sterilization, hysterectomy and abortion consent documents and Medicare attachments or medical review.
34. Maintain sufficient staff to manually price certain claims according to State-specified criteria.
35. Monitor the use of override codes during the claims resolution process to identify potential abuse, based on State-defined guidelines.
36. Maintain a system of Explanation of Payments (EOP) advice codes and messages for suspended and denied claims, adjustments, and certain paid claims. Obtain State approval for all new EOP messages developed by the Contractor. NOTE—The Explanation of Payments (EOPs) will be referenced as Remittance Advices (RAs) in the new system.
37. Maintain and update claims control, exception control, medical criteria, and other parameter files as required and in accordance with State change control procedures.
38. Liaison with the Medicare contractors to facilitate testing and processing of Medicare crossover claims.
39. Prepare and distribute operational and performance reports according to system requirements specified by the State.
40. Transmit a monthly file of adjudicated claims and encounter records to be used by the State for additional reporting and research. The file will be provided in a format approved by the State and will contain all fee for service and encounter claims adjudicated in the management reporting period.
41. Produce and submit to the State, on a timely basis, all required claims and encounter processing reports.
42. Make written recommendations on any area in which the Contractor thinks improvements can be made.
43. Receive and process all outpatient claims in the same format as they are submitted to Medicare. Medicare utilizes the Outpatient Prospective Payment System (OPPS) whereby providers may submit all procedure codes rendered for a date of service. This may require receiving and processing procedure codes that have a zero price. Accepting straight Medicaid claims utilizing the Medicare format will preclude providers from maintaining two (2) billing formats for outpatient claims.

1.5 Performance Expectations

The following performance expectations for the Claims Processing functional unit were extracted from section 20.383 of the Invitation to Bid (ITB):

1. Meet all federal and State Processing Requirements.
2. Perform weekly edit/pricing cycles.
3. Perform at least one (1) audit processing cycle weekly.
4. Perform on-line, real-time adjudication of claims transmitted via electronic submissions twenty-one (21) hours a day, seven (7) days a week.
5. Process claims received according to the following standards:
   - Ninety percent (90%) within thirty (30) calendar days of receipt.
   - Ninety-nine percent (99%) within ninety (90) calendar days of receipt.
   - (Note: Processed claims are those claims adjudicated to final payment or denial status and ready for release to financial processing.)
6. Process all claims transactions suspended for reasons other than medical review to pay or deny status within twenty-five (25) calendar days of receipt.
7. Process provider adjustment requests and State initiated adjustments according to the following standards:
   - Ninety-five percent (95%) within thirty (30) calendar days of receipt.
   - Ninety-nine percent (99%) within ninety (90) calendar days of receipt.
8. Enter provider refunds within fifteen (15) business days of receipt.
9. Process to completion all adjustments resulting from system-caused or Contractor-caused errors within twenty-five (25) calendar days of identification of the error.
10. Deliver the monthly adjudicated claims file to the State within five (5) business days of the last payment cycle of the month.

2. Paper Claims Data Entry

The Paper Claims Data Entry Unit consists of the data entry operators who enter information from scanned images into AMMIS. The unit is responsible for keying paper claims.

2.1 Paper Claims

Paper claims are entered into AMMIS using optical character recognition (OCR) technology. In the OCR claims entry method, claim data is read electronically during the scanning process. If the OCR process reads the entire claim without error, the data is sent directly to the system for processing. If the OCR cannot read any character or field, the claim is sent to a Recognition Research Incorporated (RRI) repair station. A data entry operator must then determine which character(s) must be corrected. Once the claim is corrected, the claim data is sent for processing. The entire batch must pass all keying rules before it is retired from the scanning process and sent to processing. After the batch is retired, the batch is processed in AMMIS in the same manner as electronic claim records.

If a scanned claim is identified as lacking critical claim information such as provider number or recipient number, the data entry operator can tag the claim as a Return to Provider (RTP) claim. After the scanning system retires the batch, a rework report is produced that identifies the claims to be returned. Each business day, the mailroom supervisor prints the rework report that identifies the claims to be returned. Using the report, a document control specialist pulls the paper claims from the original batch, attaches a cover sheet identifying the RTP reason and puts the claim and coversheet in an envelope to be mailed to the provider. A cover sheet on the batch is used to denote the claim(s) were returned to the provider.

NOTE:

Refer to the Data Entry Manual for specific instructions on the procedures for entering each claim type using RRI.

3. Claims Resolutions

The Resolutions Unit consists of the specialists trained to review and resolve all claims that have been suspended. The claims resolution specialists are responsible for Agency-approved resolution procedures to resolve edit and audit failures on suspended claims.

In addition to these tasks, claims resolution specialists are responsible for recommending updates to resolution procedures, referring potential fraudulent claims for further investigation, and suggesting new edits or audits to improve claims processing efficiencies.

3.1 Performing Claims Resolution

AMMIS edits claims data for validity, presence, and relationship to other data on the same claim, and audits the current claims against other claims in history for service limitations, relationships, duplicates, and other data. Claims that do not pass the edits/audits and are set to suspend will appear on the data corrections panel. The panel containing the suspended claim will show all fields necessary for the specialist to determine whether final adjudication is to force, deny or correct the suspended item.

Claims resolution specialists apply Agency-approved procedures—documented in the Resolutions Manual—to resolve the edits or audits appearing on the suspended claim. This process enables the claim to complete its' processing. A resolution specialist completes the following procedures to resolve a suspended claim:

1. Review the suspended claim utilizing the data corrections panel.
2. Using the Resolutions Manual, locate the error that is causing the claim to fail.
3. Follow the directions in the Resolutions Manual to resolve the error.
4. Key the appropriate data correction(s) using the data corrections panel.
5. Release the claim for immediate re-verification of edits/audits.
6. Continue this process until the claim edits/audits have been resolved.

4. Inventory Management

CMS requires that AMMIS operate at specified performance levels. For the claims processing area, this translates to the following:

- Ninety percent (90%) of clean claims must be processed within thirty (30) days.
- Ninety-nine percent (99%) of clean claims must be processed within ninety (90) days.
- All claims must be finalized within twelve (12) months from the date of receipt.

These performance requirements require that comprehensive and explicit claims inventory monitoring procedures be in place. The Claims Manager is responsible for the following tasks:

- Gathering daily inventory status reports from data entry, resolutions, and adjustment units.
- Gathering and reviewing AMMIS claims inventory management reports produced weekly through AMMIS.
- Taking action to prevent inventory backlogs.
- Implementing inventory reduction plans if backlogs occur.

4.1 Inventory Status Reports

The Claims Manager receives and reviews the following inventory status reports:

- Aged Suspended Report (CLM-0065-D)
- Claims Processing Daily Summary (CLM-0016-D)

Note: An example of these reports can be found on iTRACE at the following path: https://pwb.alxix.slg.eds.com/alxix/Subsystem/Utils/Reports.asp?Subsystem=Claims

4.1.1 Aged Suspended Report (CLM-0065-D)

- The Aged Suspended Report shows all suspended claims by location code. Within each location code, the report shows the number of claims that have been suspended within various aging buckets. Utilizing this report, the Claims Manager can quickly determine the status of suspended claims based on age and can alert the claims resolution specialists to concentrate on those claims greater than 30 days old.

4.1.2 Claims Processing Daily Summary (CLM-0016-D)

The Claims Processing Daily Summary report lists summary information by claim type for a claim adjudication cycle. For CMS 1500, an additional break out by provider type will be listed.

The report lists the following information:

- Total processed claims by claim type.
- Total claims approved for payment by claim type.
- Total number of denied claims by claim type.
- Total number of suspended claims by claim type.

Utilizing the statistics provided in this report, the Claims Manager can divert resources to data entry needs or resolution problems.

5. Glossary

The table below defines the terms used in the Claims Processing functional area:

Claims Processing Functional Area Terms

Term	Definition
Adjustment	A transaction to take back payment on a claim already paid and to reprocess and repay the claim correctly. Adjustments may be caused by an error in data entry, the reference file, or the automated system.
Audit	An error condition on a claim that is related to something on the current claim when compared to other historical claims or other lines within the same claim. ***Examples**:* Duplicate service of a claim already paid. Service billed that exceeds benefit limitation for the number of allowed hospital days in a calendar year. Service billed that is included in another procedure already paid.
Claim	A paper document or electronic record sent by a provider to document services rendered and to request payment for those services.
Claim Cycle	A combination of system processes that take a claim from receipt through financial processing.
Claim Record	A combination of data elements from a submitted claim and auxiliary reference that defines everything needed and used to process a claim.
Control Location	An identifying code used in claims processing that is assigned to groups of similar edits or audits to track and manage claims inventory and to provide an audit trail of claims processing activity.
Data Correction	An action that a resolutions specialist performs on a suspended claim to correct information on the claim, override the edit or audit that set on the claim or deny the claim.
Disposition	The actions taken for each edit or audit on a claim. These actions include pay, suspend, manual deny, auto deny or return. Dispositions can typically be set differently for each claim type and submission media within a claim type. ***Examples**:* An edit that sets when the recipient identification number is not on file may be set to auto deny for electronically submitted claims because the provider entered the claim information. An edit that suspends for claims submitted on paper to allow verification that no data entry error was made.

Term	Definition
Edit	An error condition on a claim that is related to missing data, incorrect data or data that does not meet certain relationships on the current claim. ***Examples**:* Recipient number not on the Recipient Eligibility File. Procedure code not allowed to be billed by the billing provider type. Diagnosis code that is missing from the claim.
Remittance Advice (RA)	A set of formatted reports that inform Medicaid providers of the payment status for each claim processed in AMMIS. The RA also provides a financial accounting of the provider's services with the Medicaid program.
Online Claim Adjudication/Resolution	A process to resolve suspended claims that uses formatted online screens to enter corrections to claims or to enter override or deny transactions to move the claim forward in processing.
Override	An action performed by a data correction specialist to bypass a claim edit or audit that has set on a suspended claim.
Recycle	A process that takes a single suspended claim, groups of suspended claims, or all suspended claims back through a claims cycle to be re-edited, re-priced, and re-audited.
Resolution Procedures	A defined set of instructions approved by the State that describes what to look for and what steps to take to resolve a suspended claim.
Return to Provider (RTP)	A manual letter that is attached to a non-processed claim. The letter and the claim are sent back to the provider to be corrected and resubmitted.