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	EFFECTIVE DATE March 1, 2012	
Medicaid and CHIP Dental Services CLAIMS SUMMARY REPORT INSTRUCTIONS		Version 2.0

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	2.0	March 1, 2012	Initial version Uniform Managed Care Manual Chapter 5.6.1.5, "Medicaid and CHIP Dental Services Claims Summary Report Instructions."

¹ Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions

² Revisions should be numbered in accordance 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.

³ Brief description of the changes to the document made in the revision.



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Applicability

This chapter applies to Dental Contractors participating in the Texas Medicaid and/or CHIP Dental Programs. The requirements in this chapter apply to both Programs, except where noted.

Objective

Dental Contractors participating as a dental indemnity insurer or single-service health maintenance organization (also referred to as a “dental maintenance organization” or “DMO”) in the Texas Medicaid/CHIP Dental Programs must submit a Claims Summary Report (CSR) in accordance with the HHSC Dental Services Contract and the instructions below.

General

The Claims Summary Report must be completed using the template provided by HHSC. Claims data must be reported inclusive of services rendered by all providers. American Dental Association (ADA) claims data should be reported on the Dental Services Claims Summary Report.

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.

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

Please refer to Chapter 5.6.1.4, for the “Dental Services Claims Summary Report Template” for both the Medicaid and CHIP Dental Services Programs.

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 included in Chapter 2.0 of the Uniform Managed Care Manual. Applicable definitions are found in the Medicaid/CHIP Dental Services Contract Terms & Conditions, and Chapter 2.0 of the Uniform Managed Care Manual. The Claims



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Summary Report must be submitted quarterly by the last day of the month following the reporting period.

Data Entry for the Claims Summary Report

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

Dental Contractor: The Dental Contractor's official name in Texas
Claims Processor: The Dental Contractor's official name, or name of subcontracted claims processor
Program: For example, Medicaid Dental
State Fiscal Year: For example, 2013
Period: For example, Q1, Q2, etc.
Period start date: Month, day and year, e.g., 9/1/2012
Period end date: Month, day and year, e.g., 11/30/2012
Date Submitted: Month, day and year, e.g., 12/31/2012

If the Dental Contractor has subcontracted with a claim processor, enter the name of the subcontractor on the appropriate data entry sheet. Complete one data entry sheet per Claims Processor.

On each data entry sheet, enter the following:

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

Column I, Row 14 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, i.e., claims Adjudicated within 30 days of receipt, 31 to 90 days after receipt, and more than 90 days after receipt.



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Column I, Row 22 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 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 66. Enter the total number of claims subject to interest penalties, i.e., 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.