hpi™

Getting Started with Online Reporting

A quick guide to the HPI Online Reporting Tool

Table of Contents

1. Introduction

Welcome to the HPI Online Reporting tool: an interactive reporting program that gives you access to many standard and custom reports. This tool will give you the ability to review your health plan's membership and claim information on your own schedule. HPI is excited to offer you this time-saving capability so that you can get the information you need quickly and easily.

Through the Online Reporting tool, you will have access to reports that offer comprehensive breakdowns of claims information and utilization, membership, and providers. The reports will help you:

- Analyze periodic changes in membership or utilization
- Evaluate trends that may impact plan costs and facilitate plan change decisions
- Recognize important areas of concern that may require in-depth analysis and review

a. Available Reports

You will be able to access some, perhaps all, of the reports listed below and the data included in each will be based on your granted permission level. When you reach the section of the tool where you are able to choose your reports you will see the list of reports available to your account. When you select the report, you will see the data that is available for you to view.

You may have access to the following reports:

- Member Census
- Check Journal Extract
- No Pay
- Benefit Analysis
- Paid Claims Summary by Member
- High Cost Claimant
- Top Providers (Physicians & Hospitals)
- Diagnosis Ranked by Total Paid
- Denied Claims
- Pended Claims
- Major Diagnostic Category
- Claims Lag Analysis
- Year-to-Date Summary
- Member Counts

b. Descriptions of Available Reports

This section provides a brief description of each report available through the Online Reporting tool. Detailed descriptions can be found by clicking the "**What is this report?**" link in the reporting tool. You may also hover your mouse over the link for a brief report description. All detailed report descriptions can be found in *Appendix A –Individual Report Descriptions* at the end of this guide.

Report Name	Description
Member Census	This report is a snapshot of all member data for a specified date in time. This report contains member name, date of birth, coverage effective dates, address, plan coverage levels, department (if available), benefit plan names, and date of hire (if applicable).
Check Journal Extract	This report presents all check activity over a specified period of time. The report includes check numbers, issue dates, payee names, amounts paid, claim numbers and incurred service dates.
No Pay	This report presents all domestic claims processed over a specified period of time for employers who are also the rendering provider of services. It includes information by facility department by incurred date. The report is also broken down by member and claim service lines.
Benefit Analysis	This report presents all costs, including the per member per month, by benefit category such as Inpatient Hospital, Outpatient Hospital, Physician Office Visits and Diagnostic X-rays and Labs. For each benefit description in the reported time period, the report displays the total amount of charges, total savings and reductions, total PPO discount, and total dollar amount paid. The report also shows the percentage of the total claim costs incurred and the PPO discount as a percentage per benefit.
Paid Claims Summary by Member	This report presents a summary of claims paid by member. The report displays employee and patient names, identification numbers, and the total number of claims for the report period per person. The report also specifies claim payment information including total amount of charges ineligible for payment, any patient responsibilities (deductibles, coinsurance, and copayments), amount deducted for coordination of benefits and adjustments, and the total net payment for all claims.
High Cost Claimant	This report displays the total amount of medical claims paid that exceed a specified dollar amount. The claims are ranked in descending order by paid amount. The report also presents the member's relationship to the employee. This report does not include prescription drug claims. Also, the report does not track toward the specific stop loss deductible of your reinsurance contract.
Top Providers (Physicians & Hospitals)	This report displays a list of providers ranked by claim counts or dollars paid. The report presents the hospital, facility or office name of the provider, the tax identification number, total net payment amount, and the total number of employee and dependent claims per provider for the specified date range.

Diagnosis Ranked by Total Paid	This report presents all claims in the specified date range by diagnostic category and is ranked in descending order. The report further breaks down each diagnosis by the total number of claims (and of those claims the total number of unique claimants) and inpatient versus outpatient utilization.
Denied Claims	This report presents claims that have been denied for various reasons, including duplicate submission, individual benefit maximum met, lack of response from member, patient not eligible at time of service, etc. The report displays patient names and their relationship to the employee. It also details the claim number, charged amount, and provider information.
Pended Claims	This report displays claims that have been received at HPI, but are in a pended status. The report shows the claim number, status in the system along with the date received, the date the service was incurred, the payee name, and the total amount to be paid.
Major Diagnostic Category	This report displays a summary of information about major diagnostic categories. For each major diagnostic category, the report presents the total number of claims processed under the category and the total amount paid for those claims.
Claims Lag Analysis	This report presents a range of months in which claims were incurred compared to a range of months in which claims were paid for Medical, Dental or Short Term Disability coverage. Gross paid claims are displayed, including those reimbursed by the reinsurance carrier. The report displays data in three separate sections: the total number of claims paid, the accumulated number of days for claims payment and the total dollars paid for those claims. The report shows the months in which claims were incurred on the vertical axis and shows the months in which claims were paid on the horizontal axis. The calculation of number of days for claims payment is based upon 5 business days, including holidays.
Year-to-Date Summary	This report displays information for Health Reimbursement Arrangements (HRA), Flexible Spending Accounts (FSA) for Medical & Dependent Care, Transportation & Parking, and Limited Medical Spending Accounts. All reports can be run separately for each account type. Each report will display each employee with the last four digits of their social security number, the total elections, deposits, reimbursements and plan balances.
Member Counts	This report displays a snapshot of the number of enrolled members by product (e.g., medical, dental, or vision coverage) for a specified date in time. This report contains group name and number, product, plan name, department, and counts by coverage level (if applicable).

2. User Support

In addition to this Getting Started Guide, the Online Reporting tool offers several types of assistance to help you use and understand the program.

a. Getting Started Guide

You are currently reading the Getting Started Guide. This guide is also available as a PDF downloadable file from the main page of the tool by clicking on **Getting Started Guide**. You can scroll through to locate the section you would like to view.

b. Report Descriptions

Each report has a detailed description available in PDF format to assist you in understanding:

- The information captured in the report
- Common uses of the report
- Required data parameters
- Time periods available for the report

For each report, you will find the information listed above by hovering your mouse over and then clicking on the "**What is this report?**" link (see example below). You can also find these documents in *Appendix A- Individual Report Descriptions* at the end of this guide.

c.   Who to Contact for Help

If you are ever unable to find the help you are looking for in the areas noted above, please feel free to reach out and speak with a member of the HPI team. The Account Manager assigned to your account can provide assistance or get you in contact with the correct person to resolve your concern.

3. Terminology

Before using the Online Reporting tool, here are some basic concepts and helpful term definitions. For a complete glossary of report terms, see *Appendix B – Glossary of Report Terms*.

a. Group Number

The group number required at the login page is your HPI group code. You can find your group code on your current invoice or standard monthly reporting package.

b. Terms used in Parameters

You will see the following terms when you access the reporting tool to run your reports. Here is a brief explanation of each to help you better understand how they are used to create your reports.

Term	Explanation
Admission Date	This represents the date a patient was admitted to the hospital or facility for an inpatient stay.
Coverage	The coverage represents the type of benefit plan available to members. Users will be given the choice to create their report by their applicable coverage(s) that may include Accidental Death & Dismemberment, Dental, Dependent Care, Dependent Life, Employee Life, Flex Medical, Grandfathered Life, Long Term Disability, Medical, Prescription, Qualified Transportation, Short Term Disability, Supplemental Life, or Vision.
Department	A code associated with an assigned employer group department name.
HH# or ID#	The 9-digit member identification number. The number usually begins with the letters "HH" and is shared by family members.
Incurred Date	This is the date range that indicates the date of service on the claim. Providers may not be able to submit a claim immediately, so the date range selected by the user will only include incurred dates for claims that have been submitted as of the last system refresh.
Issue Date	This date represents the day a payee payment was created.
Paid Date	This date represents the day when funds were submitted to the payee. A claim may not be paid on the date it was incurred or received.
Product	A product is the type of coverage to be represented in the report; this may include Medical, Dental, Vision or other coverage.
Plan	A code associated with a specific benefit plan option.

C. Terms used in Reports

You will see the following terms when your reports are created. Although most terms shown on the reports are self-explanatory, others are abbreviations or require further explanation. Here is a brief description of common terms. You will find an extensive listing of all report terms in *Appendix B – Glossary of Report Terms*.

Term	Explanation
COB	Abbreviation of "coordination of benefits." A COB column will present the dollar amount that is coordinated with the member's other plan benefits (that may or may not be with HPI).
Co-Ins	Abbreviation of "co-insurance." A Co-Ins column will show the total member co-insurance responsibility.
Copay	Abbreviation of "copayment." A Copay column will show the total amount of copayments to be applied to a claim.
Deduct	Abbreviation of "deductible." A deductible column will show the total deductible amount applied to a claim.
Disallow	This is the total amount that is not eligible to be paid by the plan. This amount includes member responsibilities such as deductibles, coinsurance, or copayments. It also includes any discounts taken by the provider network and any ineligible amounts.
From DOS	Abbreviation of "from date of service." This is the beginning of the range of service dates.
Group Code	This is the group number described in section a, *Group Number*, above.
IP Claims	Abbreviation of "Inpatient Claims." The IP Claims column displays the total number of inpatient claims.
Inelig	This is the total amount that is not eligible for reimbursement by the plan. This often includes services that may not be billed by providers, services that are not covered by the plan, or amounts that exceed benefit maximums.
Modifier	Abbreviation of "modifier code." A code used for claim payment processing to provide greater details on the type of procedure performed.
OP Claims	Abbreviation of "Outpatient Claims." The OP Claims column displays the total number of outpatient claims.
Paid	This is the total amount paid to a provider after all discounts and disallowed amounts are deducted (also referred to as "total paid").
PMPM	Abbreviation of "per member per month."

Procedure	Abbreviation of "procedure code." A code used for claim payment processing to describe the actual procedure performed.
Reason Code	The code produced when payment for a service is denied in whole or part.
Relation	Abbreviation of "relationship." This is the relationship of the presented member to the employee (can also be the employee).
Rev Code	Abbreviation of "revenue code." A code used for claim payment processing.
To DOS	Abbreviation of "to date of service." This is the end of the range of service dates.

4. Creating Your Reports

In the next steps, you'll learn how to select your desired reports, input the data parameters, and download the reports.

Selecting a Report - Employers

Once logged in, you will be brought to the screen shown below. There, you will have the choice to select from a number of reports. Available reports will be listed in a drop-down menu. The example below may not display the same reports that will be available to you. The reports that you see when you log in will be based on your granted permission level.
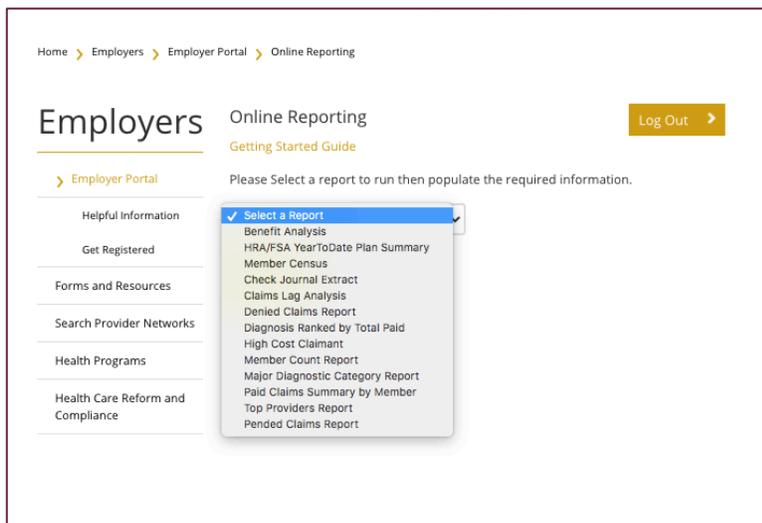
Selecting a Report – Brokers

You will have the choice to select from a number of employer reports as shown below. You also will see a list of employer groups for which you have permission to produce and review reports.
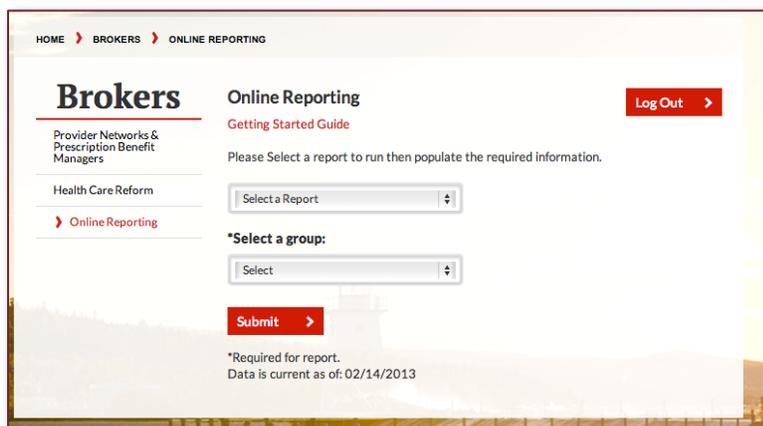
Choosing your Parameters – Employers and Brokers

Once you select the report you would like to run, you must fill in the custom parameters needed to create the report. The required parameters will be based on the report you select. Once all required parameters are entered for your desired report, the submit button will become available at the bottom of your page and you may run your report.

> ### *QUICK TIP*
>
> When entering ranges of dates, be sure to select the dates from the pop-out calendar. You may also type the dates in MM/DD/CCYY format (e.g., 02/04/2021 for February 4, 2021).

Member Census Report

To create the Member Census report you must select a specific date in time. If you do not select a date, the report will be created with data that is in the system as of the last refresh date. You also must enter the coverage that you would like displayed.

Check Journal Extract Report

To create the Check Journal Extract report, enter a starting check issue date for the time span you would like to see. You also must enter the ending issue date to complete the parameters.

No Pay Report

The No Pay report can be created by selecting a range of dates in which claims were paid. You must enter a "to" and "from" date range to complete the paid dates.

Benefit Analysis Report

To create the Benefit Analysis report, you must enter the range of dates in which claims were incurred and a range of dates in which claims were paid. For both required fields, you must select the "to" and "from" date range. The date range selected must be a minimum of three months.

Paid Claims Summary by Member

The Paid Claims Summary by Member report can be created by entering the range of dates in which claims were incurred and a range of dates in which claims were paid. For both required fields, you must select the "to" and "from" date range. Additionally, the product is also a required field.

If only the required fields are entered, the report will display all members that fall into the parameters. You may narrow down your report results by selecting an individual member or family; to do so you must enter the employee's identification number (starting with HH). If you would like only one member

to appear on the report, you can specify the member's date of birth (be sure to enter in MM/DD/CCYY format). If the date of birth is unknown, or two family members share a birthday, you may enter a first name.

High Cost Claimant Report

To create the High Cost Claimant report, you must enter the range of dates in which claims were incurred and a range of dates in which claims were paid. For both required fields, you must select the "to" and "from" date range. You must also enter the dollar amount for which claims must exceed. The exceeding amount must be entered without commas and dollar signs and must be greater than $5,000.

Top Providers Report

For the Top Providers report, you are required to enter the range of incurred and paid dates for the claims that you would like to drive the ranking of providers. You also must designate the plan product that will be connected to the ranking and the number of providers that you would like to appear.

You have the choice to run a report of ranked phyicians, facilities and hospitals; physicians only, or facilities and hospitals only. You may also choose to rank the providers by either the dollars paid or by the number of claims paid.

Diagnosis Ranked by Total Paid Report

To create the Diagnosis Ranked by Total Paid report, you must enter the range of dates in which claims were incurred and a range of dates in which claims were paid. For both required fields, you must select the "to" and "from" date range. You must also select the number of diagnoses to be listed via the drop-down menu.

Denied Claims Report

The Denied Claims report can be created by selecting a range of dates in which claims were paid. You must enter a "to" and "from" paid date range. You also must enter the plan product under which the claims were paid.

Pended Claims Report

To create the Pended Claims report, you must select the plan product under which the selected claims are being paid.

Major Diagnostic Category Report

To create the Major Diagnostic Category report, you must enter the range of dates in which claims were incurred and a range of dates in which claims were paid. For both required fields, you must select the "to" and "from" date range.

Claims Lag Analysis

To create the Claims Lag Analysis report, you must enter a range of dates in which claims were incurred and a range of dates in which claims were paid. For both required fields, you must select the "to" and "from" date range.

Year-to-Date Summary

To create the Year-to-Date Summary report, you must specify the plan year and account type under which balances will be displayed.

Member Counts

To create the Member Counts report, you must enter a specific date in time (e.g., 10/01/2020). If a user does not enter a specific date, the data in the report will reflect information in the system as of the last data refresh. Users also must select their preferred aggregation: by group, by plan, by department, or by plan within department, or department within plan.

Running and Saving Your Report

Once your parameters are set, click **Submit**. Your report will take up to afew seconds to several minutes to load and a file download screen will appear when the report is ready. You may continue to work on other applications while your report runs in the background.

You can choose to open the file or save it to your computer or local network. When naming your report, be sure to choose a name that will help you remember what you've requested**,** especially if you create multiple reports with different dates or settings.

Once you choose to open or save the file, it will be downloaded to your computer in Excel format and available to view, sort, and filter to fit your needs.

> ### *QUICK TIP*
>
> Since many of the reports you create may be confidential or may contain protected health information (PHI), please be sure to save your reports to a secure location and consider protecting the file with a password.

> ### *QUICK TIP*
>
> Remember that the data provided in your reports is current as of the date shown on the top of the report. That date is also found on the bottom of the parameters screen for each report.

5. System Safeguards and Limitations

The following system safeguards and limitations have been put into place to avoid producing unreliable reports or information that would violate privacy and security concerns

a. How frequently does HPI upload new information to the reporting system?

The data is refreshed nightly on the HPI website and is available as far back as 36 months from the current month. If any retroactive adjustments were made for claims processed in prior days, those adjustments will also be uploaded nightly.

If you run reports right after the data refresh, and then run the same reports with the same date parameters the next day, you will get the same results. Once the data refresh has taken place, you know that you will have access to the most recent information available.

If you want to know whether the nightly data refresh has happened yet, you can check the message in the bottom of the report parameters screen or the top of the produced report.

b. What minimum or maximum time spans apply to the reports?

If you're running reports on an incurred basis, you will need at least three months of claims experience (for instance, claims incurred from January 1, 2020 to March 31, 2020) with two months of run-out (for instance, claims paid through May 31, 2020). These date restrictions mean that your reports will be as accurate as possible in presenting the costs and utilization for the given time period. Data is available as far back as 36 months, so time spans cannot include more than three years.

c. Are there data restrictions for reports?

In addition to the parameter restrictions noted in section 4, *Creating Your Reports*, HPI will use a limited data set (which requires the removal of certain identifiers) where feasible in order to disclose only the minimum amount of personal health information (PHI) necessary for the intended report purpose. This safeguard has been put in place to comply with the HIPAA provisions of the HITECH Act, which requires business associates to comply with HIPAA's minimum necessary requirements.

d. How many months of data are available?

The tool contains information as far back as 36 months from the current month. For example, as of March 2020, the system contains data for claims incurred and paid from March 2017 through February 2020.

e. What level of detail will be available?

The level of detail available will be based on the report that you run. Certain membership reports will display data at the employee level; however, only the minimum amount of information necessary to interpret the report will be provided. Cost reports are typically available to the claim or claim line detail level.

For specific report details, go to the report selection screen and hover your mouse on the "**What is this report?**" link. If you select the link, a detailed description of the report will appear in a PDF downloadable file.

f. Will the level of personal health information be limited to only individuals with such access?

Users seeking a login password must complete the Employer Portal Access Form, which indicates whether or not the user can view personal health information (PHI). If the user's title within their company is not listed in the HIPAA Privacy section of the Summary Plan Description, they will be unable to gain access to view PHI details.

Reports that are available to users will be based on their granted permission level. Users who are not permitted to view PHI will not be able to view or download member-specific information.

6. Frequently Asked Questions (FAQ)

The following section addresses commonly asked questions and answers. If your question is not found below, please contact your Account Manager for help.

a. Can I save the reports I create?

Yes, you can save the reports that you create. When you create your report, you are given the choice to immediately open the file or save it to your computer or local network.

b. In what format are the reports created?

All reports are available only in Microsoft Excel format.

c. Do I need any special software?

In order to view and create the reports you need access to a web browser and Microsoft Excel.

d. Does HPI retain a copy of the reports I create?

No, HPI does not retain a copy of the report that you create, so you must save it to your computer or local network if you'd like to retain a copy (HPI recommends that you password protect your files or save to a secure location). However, HPI does retain a record of the report parameters that you choose, so the report can be recreated if necessary. Please note: the results of a recreated report may differ from the original report due to the timing of claims and eligibility processing.

e. How long will it take to create a report?

The time it takes to create the report after submitting the request depends on the amount of data requested. It may take several seconds up to several minutes for a report to become available after clicking the submit button. You may continue to work on other applications while your report runs in the background.

f. Where do I go if I have questions?

If you have questions that have not been answered in this guide, please contact your Account Manager.

g. Is training available?

The Online Reporting tool was designed to be user-friendly. At this time, formal training is not available, but your Account Manager is always available should you have any difficulty operating the program.

7. Troubleshooting

The section below includes helpful tips and suggestions for troubleshooting issues.

a. I'm entering my group number at the login page but I receive an error message.

If your error message looks like the example above, you may be entering your group number incorrectly. The group number is a six-digit code assigned to an employer or plan and usually begins with the number 00 (not letters OO). For example, a group number could be 001AB2 or 001XY1.

b. I entered report parameters but my submit button is gray and I cannot create the report.

For certain reports, there are required ranges or selections that must be entered to submit the report for creation. All required parameters contain an asterisk noting if it is a required field. When all required fields are completed, the submit button will be available.

c. I clicked submit to create a report but there is no data displayed in the report.

The report parameters that you chose may not be valid or data may not be available in the range specified.

d. I forgot my password. Can I retrieve it without contacting my Account Manager?

Yes, you can reset your password by clicking the **Forgot Password** link on the log in page. You will be prompted to answer the security questions that were set during your initial log in. Then you will be able to reset your password and log in. Please note, for the security of your plan, your password will expire and you will be required to reset it every six months.

Appendix A - Individual Report Descriptions

a. Member Census Report

What is captured in this report?
The Member Census report is a snapshot of all member data for a specified date in time. This report contains member name, date of birth, coverage effective dates, address, plan coverage levels, department (if available), benefit plan names, and date of hire (if applicable).

Why run this report?
This report is used to review member information and determine if any corrections are necessary. It is also used to create and filter specific member data. For example, a user may run this report and then filter to capture all dependents who will reach age 26 during the calendar year. The user may then analyze this data to know when the dependent children are scheduled to be terminated from their plan.

What are the required data parameters?
Users creating this report must enter a specific date in time (e.g. 04/01/2020). If a user does not enter a specific date, the data in the report will reflect information in the system as of the last data refresh. Users also must select a single benefit coverage to display.

b. Check Journal Extract Report

What is captured in this report?
The Check Journal Extract report presents all check activity over a specified period of time. The report includes check numbers, issue dates, payee names, amounts paid, claim numbers and incurred service dates.

Why run this report?
This report is designed to assist the user in identifying the checks, voids and refunds that have been issued on behalf of their benefit plan. It may be run for bank statement reconciliation as well as to see expenditures by providers in a given period of time.

What are the required data parameters?
Users must enter a span of check issue dates to retrieve the check journal entries.

c. No Pay Report

What is captured in this report?
The No Pay report presents all domestic claims processed over a specified period of time. It includes information by facility department by incurred date. The report is also broken down by member and

claim service lines. This report is only available when the rendering provider of service is also the HPI employer.

Why run this report?

This report is designed to assist the user in identifying the domestic claims that have been adjudicated on behalf of their benefit plan. It also may be used by the employer's patient accounts staff to post payments to the employer's account receivables system and to balance bill employees for domestic services rendered (if there is a balance due). For some users, this report replaces a provider explanation of benefits.

What are the required data parameters?

Users must enter a span of paid dates to create this report.

d. Benefit Analysis Report

What is captured in this report?

The Benefit Analysis report presents all costs by type of service such as Inpatient Hospital, Outpatient Hospital, Physician Office Visits and Diagnostic X-rays and Labs. For each benefit description in the reported time period, the report displays the total amount of charges, total savings and reductions, total PPO discount, and total amount paid. The report also shows the percentage of the total claim costs incurred and the percentage of the total claims eligible for PPO discount per benefit. This report has recently been updated to include the per member per month (PMPM) costs per benefit category.

Why run this report?

This report is designed to assist the user in identifying the costs to the health plan by type of service category. It may be run for multiple periods of time for comparative analysis. The report displays highest cost categories, which users can review to assess potential plan changes.

What are the required data parameters?

Users must enter a range of incurred dates and paid dates to create this report. The date range selected must be a minimum of three months.

e. Paid Claims Summary by Member Report

What is captured in this report?

The Paid Claims Summary by Member report represents a summary of claims paid by member. The report displays employee and patient names, identification numbers, and the total number of claims for the report period per person. The report also specifies claim payment information including the total amount of charges ineligible for payment, any patient responsibilities (deductibles,

coinsurance, and copayments), amount deducted for coordination of benefits and adjustments, and the total net payment for all claims.

Why run this report?

Users typically generate this report to assist their employees with claim questions. This report totals patient responsibilities, which are the subject of common employee concerns. This report can be created to display the information for all members, one family, or one member.

What are the required data parameters?

Users must enter a range of incurred and paid dates, and specify the desired product. The product refers to applicable medical, dental, vision or other coverage. Additionally, users have the option to run this report by a specific member by entering the member identification number. If a user would like to create the report for a dependent of an employee, the user may also enter the dependent's date of birth or first name in addition to the member identification number.

f. High Cost Claimant Report

What is captured in this report?

The High Cost Claimant report displays the total amount of medical claims paid that exceed a specified dollar amount in descending order by paid amount. The report presents the member's relationship to the employee (employee or a dependent). This report does not include prescription drug claims and does not track toward the specific stop loss deductible of your reinsurance contract.

Why run this report?

Typically, users create this report to view the number of members who are close to reaching the Specific Deductible amount. This is useful for determining the potential for claims covered by specific stop loss insurance.

What are the required data parameters?

Users must specify a range of incurred and paid dates. Additionally, they must enter the dollar amount that the reported claims must exceed. The amount entered must be $5,000 or greater.

g. Top Providers Report

What is captured in this report?

The Top Providers report displays a list of providers ranked by claim counts or dollars paid. The report presents the hospital, facility, or office name of the provider, tax identification number, total net payment amount, and the total number of member and dependent claims per provider for the specified date range.

Why run this report?

This report presents the providers that employees use most and enables the user to see the total amount paid by the plan to those providers. This information can be useful for analyzing appropriate plan structure.

What are the required data parameters?

Users are required to enter a range of incurred and paid dates, the total number of providers to be included in the report, and the desired product. The product refers to applicable medical, dental or other coverage. Users may also choose to view just the physicians and ancillary providers, or hospitals and facilities, or all. Additionally, users may request to rank the report by dollars paid or claim counts.

h. Diagnosis Ranked by Total Paid Report

What is captured in this report?

The Diagnosis Ranked by Total Paid report presents all claims in the specified date range by diagnostic category ranked in descending order. The report further breaks down each diagnosis by the total number of claims (and of those claims the total number of unique claimants) and inpatient versus outpatient utilization.

Why run this report?

This report is designed to assist the user in understanding costs to the health plan associated with specific diagnostic categories. It may help the user by identifying common or high cost disease categories. This can be used to assess the need for employee assistance programs such as disease management, at work exercise programs and other pro-active approaches to assisting employees in personal health management. It also can be used to assess the effectiveness of various wellness initiatives. This report can be created for multiple periods of time for comparative analysis.

What are the required data parameters?

Users must select incurred and paid date ranges, and must indicate the number of diagnosis categories to appear on the report. Users have the option to select a list of 25, 50, 100, 200, 500, or 1,000 categories.

i. Denied Claims Report

What is captured in this report?

The Denied Claims Report presents claims that have been denied for various reasons, including duplicate submission, individual benefit maximum met, lack of response from member, patient not eligible at time of service, etc. It also presents claims that were denied upon adjustment. The report displays patient names and their relationship to the employee. It also details the claim number, charged amount, and provider information.

Why run this report?

This report is designed to assist the user in understanding the claims being denied on behalf of the plan. Users may find this report useful when presented with questions from employees about specific claim denials.

What are the required data parameters?

Users are required to enter a range of paid dates and the desired product. The product refers to applicable medical, dental, vision or other coverage.

j. Pended Claims Report

What is captured in this report?

The Pended Claims report displays claims that have been received at HPI but are in a pended status. The report shows the claim number and its status in the system along with the date received, the date the service was incurred, the payee name, and the total amount to be paid.

Why run this report?

This report illustrates any outstanding financial liability for the plan. Users view this report to determine what claims will be up for funding and the dollar amounts to be funded.

What are the required data parameters?

Users must select the desired product code to be displayed. The product refers to applicable medical, dental, vision or other coverage.

k. Major Diagnostic Category Report

What is captured in this report?

The Major Diagnostic Category report displays a summary of information about major diagnostic categories. For each major category the report presents the total number of claims processed and the total amount paid for those claims.

Why run this report?

This report is typically created to aid users with condition-specific trend analysis. Users can draw on information in this report to make decisions regarding potential wellness and health management programs.

What are the required data parameters?

Users must select a range of incurred and paid dates to run this report.

l. Claims Lag Analysis Report

What is captured in this report?

The Claims Lag Analysis report presents a range of months in which claims were incurred compared to a range of months in which claims were paid for Medical, Dental or Short-Term Disability coverage. Gross paid claims are displayed, including those reimbursed by the reinsurance carrier. The report displays data in three separate sections: the total number of claims paid, the accumulated number of days for claims payment and the total dollars paid for those claims. The report shows the months in which claims were incurred on the vertical axis and shows the months in which claims were paid on the horizontal axis. The calculation of number of days for claims payment is based upon 5 business days, including holidays.

Why run this report?

This report may be used to monitor the turnaround time of claims and to develop completion factors that allow forecasting of monthly claims payments and an estimate of incurred but not reported claims (IBNR). Actuaries may refer to this report as a claims triangle and may use the report for setting claims reserves at the end of a plan year.

The estimated incurred but not reported (IBNR) calculation in the summary section below each coverage is only an estimate and not a guarantee of outstanding claims. Claims waiting for carrier or client reimbursement may inflate the average claims payment turnaround time.

What are the required data parameters?

Users must specify a range of incurred and paid dates to create this report. Typically, this report is run with a 24 month incurred look back and a rolling 12 months paid.

m. Year-to-Date FSA/HRA Summary Report

What is captured in this report?

The Year-to-Date Summary report contains information for Health Reimbursement Arrangements (HRA), Flexible Spending Accounts (FSA) for Medical & Dependent Care, Transportation & Parking, and Limited Medical Spending Accounts. All reports can be run separately for each account type. Each report will display each employee with the last four digits of their social security number, the total elections, deposits, reimbursements and plan balances.

Why run this report?

This report may be used to monitor plan balances on behalf of the plan or to respond to any questions that employees may have regarding the deposits or balances.

What are the required data parameters?
Users must specify the plan year and account type (HRA, FSA Medical/Dependent Care, Transportation & Parking or Limited Medical Spending Account). Typically, this report would be created for the current plan year, but may be created for a prior plan year for historical purposes.

n. Member Counts Report

What is captured in this report?
The Member Counts Report is a snapshot of the number of enrolled members by product (e.g., medical, dental, or vision coverage) for a specified date in time. This report contains group name and number, product, plan name, department, and counts by coverage level (if applicable).

Why run this report?
This report is used to review active membership counts at a point in time. It is also used to create and filter specific plan and department counts. For example, a user may run this report and then filter by plan to assess participation or migration between plans. The user may then analyze this data to identify the employee, spouse and dependent children counts to further help the user make decisions regarding plan continuation or termination, how to market the plan to a membership population, and how to budget for claims based upon the counts per plan.

What are the required data parameters?
Users creating this report must enter a specific date in time (e.g., 10/01/2020). If a user does not enter a specific date, the data in the report will reflect information in the system as of the last data refresh. Users also must select their preferred aggregation: by group, by plan, by department, or by plan within department, or department within plan.

Appendix B – Glossary of Report Terms

Adj	Abbreviation of "adjustment." Describes any modifications made on a claim for reasons other than patient responsibility or other insurance coordination.
Admin, Savings & Reductions	Amount deducted from total charge due to negotiated claims edits and denied claims (e.g., edits due to global billing changes and denials for duplicate submissions, maximum benefit limit, services not covered).
Admit Date	Date of admission for an inpatient hospital stay.
Benefit Description	Explanation of a plan provision.
Benefit Plan	A code to identify a specified plan for employers who offer more than one plan option.
Charge	Total amount billed by the rendering provider.
Claimant	Member whose claims are described in the report.
COB	Abbreviation of "coordination of benefits." A COB column will present the amount that is covered by other benefit plans.
Co-Ins	Abbreviation of "co-insurance." A Co-Ins column will show the amount responsibility member is responsible for as part of their co-insurance.
Copay	Abbreviation of "copayment." A Copay column will show the total amount of copayments to be applied to a claim.
Count	Number of claims.
Date of Check	Issue date on a check.
Date of Service	Date the member went to provider and received a service.
Deduct	Abbreviation of "deductible." A deductible column will show the total deductible amount applied to a claim.
Denied Amount	Total amount unable to be processed due to plan provisions.
Denied Reason	Explanation why a charge cannot be processed under the plan.
Department	Description of subset or division within a group plan.
Diagnosis	The identification of the member's reason for service. This may appear as a "diagnosis code." The code is used for claim payment processing.

Diagnosis Description	Further explanation of a diagnosis or diagnosis code.
Disallow	The total amount of member responsibility including deductibles, coinsurance, or copayments. It also includes any discounts taken by the provider network and any ineligible amounts.
Disc	Abbreviation of "discount." This is the contractual discount taken on a claim payment.
Effective Date	Identifies the start date of the member's coverage in the plan. In the Member Census, it may refer to the member effective date in benefit plans including, but not limited to, AD&D, Dental, Medical, Flex, Life, LTD or STD.
Employee ID	See Member ID.
Facility Name	Name of a provider.
Flexible Spending Account (FSA)	A tax-advantaged, employee-funded plan that can be used to pay for qualified medical expenses (medical FSA) and/or dependent care expenses (dependent care FSA).
Flexible Spending – Limited Medical Spending Account	A tax-advantaged, employee-funded plan that can be used to pay for qualified dental and/or visions expenses.
Flexible Spending Transportation & Parking Account	A tax-advantaged, employee-funded plan that can be used to pay for eligible work-related transportation and parking expenses. These eligible expenses could include daily or monthly parking expenses, bus fares, as well as train and subway tickets.
From DOS	Abbreviation of "from date of service." This is the beginning of the range of service dates.
Group Code	Group number (e.g., 001ABC).
Health Reimbursement Arrangement (HRA)	A tax-advantaged, employer-funded plan that reimburses employees for out-of-pocket medical expenses.
IBNR	An estimate of claims incurred but not reported.
Incurred	Date of service.
Inelig	This is the total amount that is not eligible for reimbursement by the plan. This often includes services that should not be billed by providers, services that are not covered by the plan, or amounts that exceed benefit maximums.
IP Claims	Abbreviation of "Inpatient Claims." The IP Claims column displays the total number of inpatient claims.
Length of Stay (LOS)	Number of days a member is in the hospital.
Major Diagnostic Category	A classification of diagnoses.

Medical Days	The calculation of the number of days for claims payment, based upon 5 business days, including holidays.
Modifier	Abbreviation of "modifier code." A code used for claim payment processing.
Member ID	A unique identification number given to all plan members.
OP Claims	Abbreviation of "Outpatient Claims." The OP Claims column displays the total number of outpatient claims.
Paid	This is the total amount paid to a provider after all discounts and disallowed amounts are deducted. Also referred to as "Total Paid."
Patient Acct #	A number received from the provider; used to identify the member in the providers' accounts.
Payee ID	The provider tax identification number.
Payee Name	The name of the entity receiving payment.
Payment Type	The status of the claim that was processed. Claims may be PAID, REFUND, VOID, etc.
Person Code	A two-digit code used in the HPI system to identify the individual's relationship to the employee.
Plan	A code associated with a specific benefit plan option.
Plan Balance	The amount of funds remaining in the employee's HRA or FSA account as of the date the report was created.
PMPM	Abbreviation of "per member per month."
Precert	Abbreviation of "precertification." This column details the precertification number identified in the HPI system.
Procedure	Abbreviation of "procedure code." A code used to describe the type of service provided. Used in claims processing.
Product	A product coverage type, which refers to medical, dental, vision or other coverage.
Reason Code	The code produced when payment for a service is denied in whole or part.
Relation	This is the relationship of the presented member to the employee (can also be the employee).
Rev Code	Abbreviation of "revenue code." A code used to describe the type of service provided. Used in claims processing.

Status	The claim or member standing. In the Pended Claims report, claims are in Pend status prior to being paid. In the Precertification Report, claims may be Open or Closed. In the Member Census report, members may be Active or Terminated.
To DOS	Abbreviation of "to date of service." This is the end of the range of service dates.
Total Claims	The dollar amount of claims submitted by the employee for reimbursement from either the HRA or FSA account.
Total Deposits	The amount of fund deposited into the employee's account as of the date the report was created.
Total Elections	In an HRA, the amount the employer has designated to fund the HRA for each employee at the beginning of the plan year. In an FSA, the amount the employee has elected at the beginning of the plan year. Deductions will be taken from the employee's paycheck pre-tax throughout the plan year.
Total Reimbursements	The amount of funds reimbursed from the HRA or FSA from the employee's account as of the date the report was created.
Underwriter	A three-digit internal code assigned to groups.
Volume	When available for Medical and Flexible Spending accounts, this is the total dollar amount that the member has elected for the specified benefit. This field may be populated when rates are billed based on volume for the coverage. When available for other coverages such as Life, STD, or LTD, this the total benefit amount.