How to Access the Suspended Claim Report in eXPRS
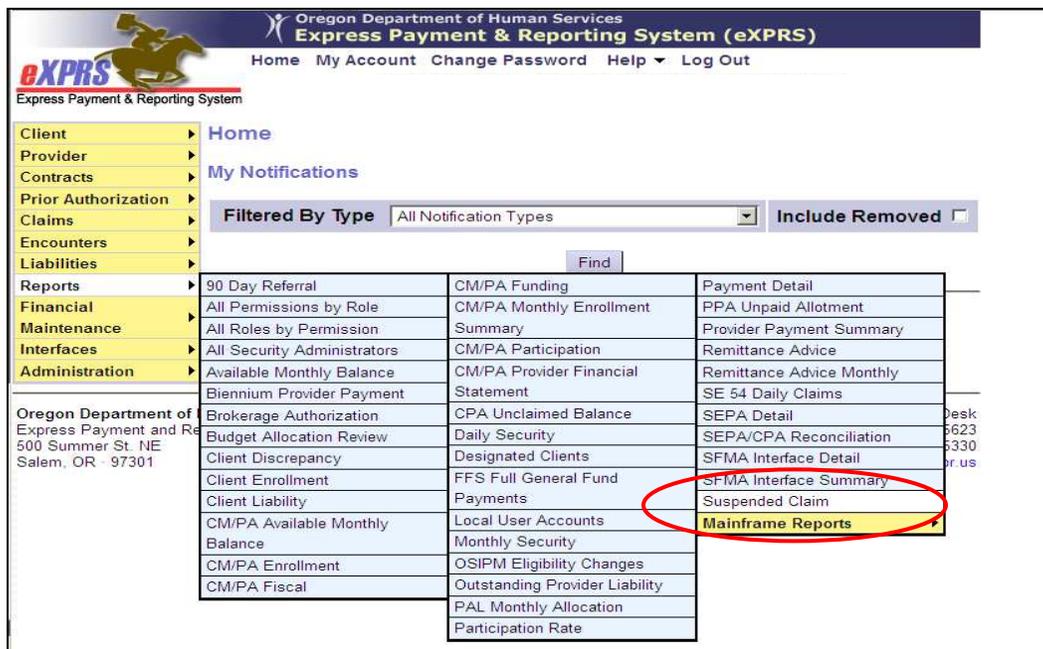*(updated 10/11/16)*

There are many reasons why a claim may suspend in eXPRS, and often, it is when the claim suspends that the Provider, CDDP or Brokerage first discovers there is an issue or problem that needs resolution.

To help identify when claim suspensions occur and the reason for the suspension so Providers, CDDPs and/or Brokerages can begin problem-solving the issue, they can utilize the **SUSPENDED CLAIM** report in eXPRS to see what claims have suspended and for what reason.

To access the *SUSPENDED CLAIM* report in eXPRS:

1. Login to eXPRS.

2. From the left-hand yellow navigation menu select **Reports → Suspended Claims**. Your menu may not have as many reports listed as shown below, but the Suspended Claim report is always the last report on the menu.

3. In the search criteria options available, enter the criteria you need to return a list of suspended claims. Red asterisk (*) indicates a required field.

4. For the search criteria entered, if there are suspended claims in eXPRS, the report will return a summary list of those, by service element and suspense rule. Each blue entry is a hyperlink. If you click on the hyperlink for the entry you want, it will take you to a list of all the claims associated with that summary line. *Please note – that the hyperlinks and sub-report of claim or encounter details only works if the report is run in HTML*.

These are the same **Rule Descriptions** and **Exception text** that are found on the individual claim in the **Current Exceptions** section.

5. In the sub-report, you can now see details for each claim (ICN, client prime, claim dates and exception reason). This information can be used to help identify which individuals may need assistance in resolving a Medicaid eligibility issue, or if you need to contact DHS for further assistance.

6. There are a variety of reasons a claim may suspend. Below is listed a few of the more common suspense **Rule Descriptions** (reasons why a claim is suspended) and its explanation.

Suspense Rule Description	Exception (shown on claim details)	What it really means
Fails higher level prior auth;	*Insufficient funds [$0.00 on mm/dd/yyyy] for provider*	This is the suspense rule that applies to CM RFFS claims only (for SE48/148/248), and means the claim is suspended because there is "*insufficient funds rationed for Provider*." A RFFS claim with this suspense reason is waiting processing for payment in a scheduled RFFS processing cycle. The claim is suspended because funds to pay it have not been released yet, thus the reason "insufficient funds."

Awaiting payment cycle		This means the claim has been processed to approved, but is waiting for the scheduled payment cycle for the type of claim to be run to process for payment.
Client Awaiting Service Eligibility	*Client waiting on service eligibility.* *Svc Cat:* [DDC] *Title XIX Cd:* [N]	This means there is a conflict between the individual's service category (aka: waiver) code and their Medicaid eligibility code. For example: if an individual has a service category code of DDC (meaning they are enrolled to the DD comp waiver) and a TXIX eligibility code of "N" (meaning: no, not TXIX eligible) for the date of the claim/encounter, it will suspend. An individual must have TXIX eligibility (code is "Y", for yes) to be enrolled to a waiver (have the waiver code of DDC). If it says "N" with a DDC, that is a coding conflict; the system doesn't know how to process the claim or encounter, and will suspend it until the coding is adjusted to a combination that will allow approval.
Suspected Duplicate. *Date range or portion of the date range overlaps an approved claim.*	Will show the ICNs for the other claims that overlap.	Just as it states; there is one or more date(s) in the suspended claim that overlaps with another claim that has already been approved and paid. We can't pay twice for the same day/dates of service, so the second claim will suspend as a suspected duplicate to avoid duplicate payment.

Funding formula for claim not found	*Funding formula not found for:* [DDK Y M3 7/20/2015 to 7/31/2015]	Each claim must be paid according to a funding rule established for the specific service procedure code and client eligibility combination to ensure we are claiming the appropriate percentage of federal match funding. If this suspense reason is given, the system has not found an appropriate funding rule in the system to use to fund this claim.
Provider is not active	*Provider is not an active Panel Member*	All providers authorized and paid via POC authorized services must be listed on the authorizing CDDP or Brokerage's POC panel. This means the provider's record has been inadvertently removed from the authorizing CDDP/Brokerage's panel, and must be re-added for the claim to successfully process for payment.
A payee has not been designated for:	[Name of provider & SPD ID#]	Providers who are not paid via the FMAS payroll vendor (ie: PSWs), they must have a DHS payee record established to facilitate payment directly from eXPRS/DAS before the claim will successfully process for payment.
Client not enrolled in Case Management	*Client not enrolled in Case Management*	All I/DD clients must have an active authorization for CM services that covers the dates any other services authorized in eXPRS can be successfully authorized and paid.
Invalid Provider Service or License	*Provider credential dates not within the time period claimed.*	All providers must have an "approved to work" credential date range(s) that covers all the dates being claimed for payment.

No approved claims for day prior to absence claim for same service.		An individual must have attended (been present and received) the claimed residential service before an absence payment for that same service can be approved. We will not pay an absence claim for the first day of actual service (not been in this service with any provider prior to the absence claim).
Claim Modifier consecutive days limit exceeded.	*Consecutive day limit 45 exceeded for claim modifiers [MED, CRS, NFS, PSY]* [client prime] *MED*	Absences from a 24-hour residential service that ODDS will pay absence claims for are limited (see the applicable Service Element Standards and Procedures for specific time limits for that service). eXPRS knows what each time-limit is, and if absence claims are submitted that exceed those limits, they will suspend. The individual must have returned to and received the service for at least one day for the absence claim time-limits to re-set.
System error occurred during processing.	*Processing aborted …*	There was a system error or processing interruption that occurred and prevented the claim or encounter from successfully completing the submission process.

The *SERVICE DELIVERED PROBLEM SOLVING MATRIX*, *CLAIMS PROBLEM SOLVING MATRIX* or the *ENCOUNTER or RFFS PROBLEM SOLVING MATRIX*, available on the **eXPRS HELP** menu, may be of additional assistance in problem solving suspended claims or encounters. Please see those documents for more information.