Analysis of HFS-Contracted MCO Claims Processing and Payment Performance

For services in Q3 and Q4 of CY 2018

Illinois Department of Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

Introduction

Section 5-30.1 of Public Act 100-0580[1] amends the Public Aid Code to require Healthcare and Family Services (HFS) to "post an analysis of [Managed Care Organization, or] MCO claims processing and payment performance on its website every 6 months." The required analysis mandates a review and evaluation of hospital claims that are rejected and denied, the top 5 reasons for such actions, and timeliness of claims adjudication (focusing upon 30, 60, 90, and 90+ day time frames). This report is being provided to the Illinois General Assembly pursuant to Public Act 100-0580.

Date Span of Data

The data provided in this report covers Quarter 3 (Q3), or the dates July 1, 2018 through September 30, 2018, and Quarter 4 (Q4), or the dates October 1, 2018 through December 31, 2018, of calendar year 2018.

Data Inclusions and Exclusions

The data analyzed in this report focuses solely on institutional hospital claims, or claims submitted via 837I, or its paper variant (UB04), by hospitals. This means that all other claim types, including professional claims submitted via 837P, or its paper variant (CMS-1500), by hospitals and all other providers, are not included in this report. Professional claims billed by hospitals were excluded as they are processed and often paid in a different manner than institutional claims which makes aggregating the claims potentially misleading. In addition to these professional claims, adjustments were held back from this reporting period. Adjustments can complicate processing periods and reimbursement methodologies and can be triggered for various technical reasons, as such it was determined that adjustments should be set aside until common ground in the data between plans could be established.

Representative Sample.
This report seeks to review all MCO inpatient hospitalization data in whole, establishing the entire data set as the representative sample.

Note. All dollar values provided in this report have been rounded to the nearest hundred-thousand-dollar value. Additionally, the reimbursements detailed in this report do not include all payments made to hospitals under the Illinois Medicaid Program, as it excludes both fee-for-service payments made by HFS and other payments made as a result of the hospital assessment program.

Data Collection Process

The data for this report was collected via Microsoft Excel in a standardized spreadsheet format established by the OMI. The spreadsheet format was disseminated by HFS on behalf of the OMI in early May 2020 to all MCOs with the expectation that all health plans return the completed spreadsheets by May 29, 2019. OMI identified significant data errors and, in coordination with HFS, provided technical assistance to the plans. Final data sets were received by June 22, 2020.

All data in this report is provided via self-report from the MCOs. While the OMI seeks to provide data in the most accurate manner possible, data integrity errors may exist in this report related to discrepancies in the interpretation of instructions, variance in health plan data management, and the general potential for human error.

[1] See: http://www.ilga.gov/legislation/publicacts/100/100-0580.htm

Section 1. General Data

Unique Services and Denial Rate

To determine the rate at which hospital claims were being rejected or denied, the number of "unique services" was used instead of the raw volume of claims submitted to MCOs for payment. This was done because multiple claims can be submitted for one discrete service, or hospital stay. Counting unique services in effect removes duplicate claims. For example, if a provider were to submit a claim three times, each time receiving a denial for the same inpatient stay, that service under this methodology would be counted as a single denial. Additionally, given this same example, if a fourth claim submitted by the provider was paid, that service would be counted as a paid claim and not a denied claim, under this methodology – regardless of the three claims denials that occurred, leading to the service reimbursement. Tables 1A and 1B below show how many services were paid, denied, or rejected, and the associated dollar amounts, for Quarter 3 and 4, respectively.

Table 1A. Unique Services. 2018 Quarter 3

2018 Q3	Unique Service Count	Percent of Services	Charges billed	Amount Paid
Unique Services Submitted	965,225	100.00%	$ 7,231,700,000.00	$ 802,500,000.00
Payable/Paid Unique Services	799,615	82.84%	$ 5,458,100,000.00	$ 802,500,000.00
Rejected Unique Services	54,273	5.62%	$ 568,300,000.00	
Denied Unique Services	111,773	11.58%	$ 1,208,500,000.00	
Total Non-Payable (Denied + Rejected)	166,046	17.20%	1,776,800,000	

Table 1B. Unique Services. 2018 Q4

2018 Q4	Unique Service Count	Percent of Services	Charges billed	Amount Paid
Unique Services Submitted	942,374	100.00%	$ 7,107,700,000.00	$ 801,700,000.00
Payable/Paid Unique Services	786,020	83.41%	$ 5,424,200,000.00	$ 801,700,000.00
Rejected Unique Services	61,603	6.54%	$ 583,000,000.00	
Denied Unique Services	95,243	10.11%	$ 1,106,700,000.00	
Total Non-Payable (Denied + Rejected)	156,846	16.64%	1,689,700,000	

17.20% and 16.64% of unique services submitted for Quarter 3 (Q3) and Quarter 4 (Q4), respectively, were either rejected or denied.

Submissions Before Positive Adjudication

Table 2 focuses on efficiency in the claiming process. Providers have the ability to submit unpayable claims multiple times in order to achieve an adjudication determination. Additionally, claims that are negatively adjudicated due to missing or wrong information can be updated and resubmitted for re-adjudication. This table groups positively adjudicated claims by the number of submissions needed for that positive adjudication.

Table 2A. Number of Submissions Before Positive Adjudication
2018, Quarter 3

2018 Q3	Number of Claims	Percent of Claims	Net Liability
1st Submission	828,044	91.31%	$ 679,800,000.00
2nd Submission	66,687	7.35%	$ 152,100,000.00
3rd Submission	10,671	1.18%	$ 27,100,000.00
4th Submission	1,121	0.12%	$ 5,600,000.00
5th or More Submission	317	0.03%	$ 1,100,000.00
	906,840	100.00%	865,800,000

Table 2B. Number of Submissions Before Positive Adjudication
2018, Quarter 4

2018 Q4	Number of Claims	Percent of Claims	Net Liability
1st Submission	798,681	91.36%	$ 688,400,000.00
2nd Submission	66,694	7.63%	$ 147,300,000.00
3rd Submission	7,607	0.87%	$ 24,800,000.00
4th Submission	944	0.11%	$ 4,300,000.00
5th or More Submission	248	0.03%	$ 800,000.00
	874,174	100.00%	$ 865,700,000.00

With slightly less than 9% of paid claims being submitted two or more times before being reimbursed, the data suggests that the current state of hospital claiming across the MCOs is efficient. By efficient, it is meant that paid claims are usually paid upon first submission; no conclusions can be drawn about rejections or denials from these tables.

Timeframe of Claim Adjudication

Table 3 highlights the length of time it takes for claims, following submission, to be adjudicated by the MCOs.

Table 3A. Days for Claims to be Adjudicated
2018 Quarter 3

2018 Q3	Claims	% of Claims	# of Payable/ Paid Claims	Net Liability	# of Non-Payable*	Charges Billed for Non-Payable*
Claims Adjudicated (0-30 days)	961,855	83.45%	825,000	$ 687,500,000.00	145,460	$ 1,416,300,000.00
Claims Adjudicated (31-60 days)	66,115	5.74%	52,927	$ 118,300,000.00	12,621	$ 175,600,000.00
Claims Adjudicated (61-90 days)	25,575	2.22%	21,339	$ 30,000,000.00	2,741	$ 54,100,000.00
Claims Adjudicated (91+ days)	99,063	8.59%	85,424	$ 45,300,000.00	8,026	$ 111,500,000.00
Claims Awaiting Adjudication	1,684	NA	NA	NA	NA	NA
Claims Adjudicated For DOS During Reporting Period	1,152,608	100.00%	984,690	$ 881,000,000.00	168,848	$ 1,757,500,000.00

* Non-Payable means rejected or denied.

Table 3B. Days for Claims to be Adjudicated
2018 Quarter 4

2018 Q4	Claims	% of Claims	# of Payable/ Paid Claims	Net Liability	# of Non-Payable*	Charges Billed for Non-Payable*
Claims Adjudicated (0-30 days)	963,777	89.76%	830,852	$ 770,200,000.00	135,568	$ 1,319,900,000.00
Claims Adjudicated (31-60 days)	35,618	3.32%	27,647	$ 60,900,000.00	7,341	$ 123,300,000.00
Claims Adjudicated (61-90 days)	10,526	0.98%	8,104	$ 13,500,000.00	1,803	$ 32,700,000.00
Claims Adjudicated (91+ days)	63,839	5.95%	52,536	$ 32,900,000.00	7,394	$ 97,500,000.00
Claims Awaiting Adjudication	2,458	NA	NA	NA	NA	NA
Claims Adjudicated For DOS During Reporting Period	1,073,760	100.00%	919,139	$ 877,600,000.00	152,106	$ 1,573,400,000.00

* Non-Payable means rejected or denied.

The vast majority of hospital claims were adjudicated within 30 days, which improved in Quarter 4, moving from 83.45% to approximately 90%.

Note. *Table 3 transitions away from reviewing unique services, as detailed in Table 1 and focuses on total claim volume, as such totals between Table 1 and Table 3 will not match. Additionally, given the nature of "usual and customary charges," the non-payable value should not be viewed as an exact or estimated amount owed or lost.*

Adjudication to Payment

Table 4 focuses on the release of money from the MCOs to the provider, following the adjudication of the hospital claim.

Table 4A. Time from Adjudication to Payment 2018 Quarter 3

2018 Q3	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Timeframe of Payment to Provider Following Positive Adjudication (0-30 days)	773,155	90.81%	$ 751,900,000.00
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	12,619	1.48%	$ 24,100,000.00
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	26,270	3.09%	$ 33,500,000.00
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	39,339	4.62%	$ 45,600,000.00
Total Payments Pending to Provider Following Positive Adjudication	2,784	NA	$ 1,000,000.00
Total Payments Following Positive Adjudication (Doesn't include pending)	851,383	100.00%	$ 855,100,000.00

Table 4B. Time from Adjudication to Payment 2018 Quarter 4

2018 Q4	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Timeframe of Payment to Provider Following Positive Adjudication (0-30 days)	744,184	90.50%	$ 760,000,000.00
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	10,992	1.34%	$ 17,900,000.00
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	15,968	1.94%	$ 19,800,000.00
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	51,192	6.23%	$ 57,500,000.00
Total Payments Pending to Provider Following Positive Adjudication	1,604	NA	$ 2,000,000.00
Total Payments Following Positive Adjudication (Doesn't include pending)	822,336	100.00%	$ 855,200,000.00

Table 4 demonstrates that almost 91% of payments to hospitals from MCOs were made within 30 days of claims adjudication for both Quarter 3 and Quarter 4.

Submission to Payment

Table 5 focuses on the release of money from the MCOs to the provider, following the submission of the hospital claim.

Table 5A. Time from Submission to Payment 2018 Quarter 3			
2018 Q3	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Submission of Claim (0-30 days)	667,973	78.31%	$ 500,000,000.00
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	91,762	10.76%	$ 202,100,000.00
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	27,983	3.28%	$ 52,900,000.00
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	65,304	7.66%	$ 100,100,000.00
Total Payments Pending to Provider Following Positive Adjudication	2,749	NA	$ 1,000,000.00
Total (Not including Pending)	853,022	100.00%	$ 855,100,000.00

Table 5B. Time from Submission to Payment 2018 Quarter 4			
2018 Q4	**Number of Hospital Claims Paid**	**Percent of Hospital Claims Paid**	**Total Net Liability for Positively Adjudicated Hospital Claims**
Timeframe of Payment to Provider Following Submission of Claim (0-30 days)	681,483	82.75%	$ 583,000,000.00
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	52,362	6.36%	$ 140,700,000.00
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	20,297	2.46%	$ 34,100,000.00
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	69,443	8.43%	$ 97,400,000.00
Total Payments Pending to Provider Following Positive Adjudication	1,590	NA	$ 2,000,000.00
Total (Not including Pending)	823,585	100.00%	$ 855,200,000.00

Table 5 demonstrates that about 89% in Quarter 3 and about 89% in Quarter 4 of payments to hospitals from MCOs were made within 60 days of claim submission.

Section 2. Rejections and Denials

Rejected Claims

A rejected claim is one in which the determination of payment cannot be made. These claims may enter the MCOs clearinghouse (front-end) but do not get passed on to the health plan's billing system for payment processing and adjudication (back-end) due to missing administrative elements on the claim. In most cases, the provider may address the issue causing the rejection and re-submit the claim for processing.

Claim Adjustment Reason Code (CARC) Rejections

To gain common understanding across MCOs, hospital rejections by CARCs were collected and measured. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code rejection reasons are provided in Table 6.

Table 6A. Top 10 CARC Rejections 2018 Quarter 3

CARC Code	CARC Code Description	Total Claims Rejected	Percent of Claims Rejected
16	Claim/service lacks information or has submission/billing error(s).	16,068	24.02%
18	Exact duplicate claim/service	6,409	9.58%
96	Non-covered charge(s).	6,336	9.47%
27	Expenses incurred after coverage terminated.	5,268	7.87%
31	Patient cannot be identified as our insured.	4,418	6.60%
207	National Provider identifier - Invalid format	3,766	5.63%
177	Patient has not met the required eligibility requirements.	3,219	4.81%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	2,758	4.12%
32	Our records indicate the patient is not an eligible dependent.	2,279	3.41%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	2,234	3.34%
	Total Rejections (Duplicative)	66,900	

Table 6B. Top 10 CARC Rejections 2018 Quarter 4

CARC Code	CARC Code Description	Total Claims Rejected	Percent of Claims Rejected
16	Claim/service lacks information or has submission/billing error(s).	18,247	25.36%
207	National Provider identifier - Invalid format	7,200	10.01%
18	Exact duplicate claim/service	6,523	9.07%
177	Patient has not met the required eligibility requirements.	5,796	8.06%
96	Non-covered charge(s).	5,583	7.76%
27	Expenses incurred after coverage terminated.	4,887	6.79%
31	Patient cannot be identified as our insured.	3,278	4.56%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	2,452	3.41%
181	Procedure code was invalid on the date of service.	1,977	2.75%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	1,745	2.43%
	Total Rejections (Duplicative)	71,951	

Note. *While CARC and RARC codes are standardized, the manner in which a payer chooses to map CARCs and RARCs to their internal Explanation of Benefits (EOB), or proprietary coding can be nuanced, resulting in a difference in application or usage between plans.*

Remittance Advice Remark Code (RARC) Rejections

To gain common understanding across MCOs, hospital rejections by RARCs were collected and measured for the first time. Though each of the plans may map and utilize RARCs in a slightly different manner, the top 10 RARC code rejection reasons are provided in Table 7. RARCs provide additional information regarding claim action and may or may not be present on all claims. Table 7 describes only the top ten codes, thus the percentages shown do not equal 100%.

Table 7A. Top 10 RARC Rejections 2018 Quarter 3

RARC Code	Description	Total Claims Rejections	Percent of Claims Rejections
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	6,206	12.17%
N/A	(None/Invalid code reported by MCO)	5,973	11.71%
N30	Patient ineligible for this service.	5,309	10.41%
M86	Service denied because payment already made for same/similar procedure within set time frame.	4,661	9.14%
N34	Incorrect claim form/format for this service.	4,502	8.83%
N284	Missing/incomplete/invalid referring provider taxonomy.	3,336	6.54%
N381	Alert:Consult our contractual agreement for restrictions/billing/payment information related to these charges.	2,751	5.39%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	2,702	5.30%
N281	Missing/incomplete/invalid pay-to provider address.	1,754	3.44%
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	1,310	2.57%
	Total Rejections (Duplicative)	51,007	

Table 7B. Top 10 RARC Rejections 2018 Quarter 4

RARC Code	Desc	Total Rejections	Percent of Claims Rejected
N/A	(None/Invalid code reported by MCO)	9,836	17.14%
N284	Missing/incomplete/invalid referring provider taxonomy.	6,083	10.60%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	5,420	9.45%
N34	Incorrect claim form/format for this service.	4,533	7.90%
M86	Service denied because payment already made for same/similar procedure within set time frame.	4,452	7.76%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	3,862	6.73%
N30	Patient ineligible for this service.	3,565	6.21%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	2,227	3.88%
N281	Missing/incomplete/invalid pay-to provider address.	1,835	3.20%
N381	Alert:Consult our contractual agreement for restrictions/billing/payment information related to these charges.	1,738	3.03%
	Total Rejections (Duplicative)	57,377	

While the rejection reasons are varied, most of the data in the table demonstrates that most rejections are related to technical claiming issues (e.g. missing information, incomplete data, taxonomy issues, plan guideline issues, claim format, payee data, etc.).

Note. *The "None/ Invalid code reported by MCO" line in table 7A means either the rejection reason did not have a RARC associated with it (not all rejections need additional information in the form of a RARC) or the code provided by the MCO was invalid data.*

Denied Claims

A denied claim is a claim submitted by a provider that is not rejected by the clearinghouse, but is adversely adjudicated by an MCO based upon one of seven defined HFS denial reason codes. These claims are HIPAA compliant and are fully processed by the MCO claims system but may be denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue, or other non-contracted provider related issue.

Top Denial Reasons

Denial reasons were reported using CARCs and RARCs, as well as the seven HFS-approved denial codes. The seven denial code categories were created for MCOs to use when submitting encounter data to HFS. Table 8 focuses on denials grouped by denial reason code.

Table 8A. HFS Denial Reasons 2018 Quarter 3

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	9,715	8.25%
Additional Information	17,228	14.63%
Authorization	17,728	15.06%
Benefit / Covered Service	43,781	37.19%
Medical Necessity	446	0.38%
Pre-Certification	4,517	3.84%
Provider	24,308	20.65%
Total Denials	117,723	

Table 8B. HFS Denial Reasons 2018 Quarter 4

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	8,337	7.74%
Additional Information	16,966	15.75%
Authorization	12,812	11.89%
Benefit / Covered Service	44,080	40.92%
Medical Necessity	618	0.57%
Pre-Certification	4,735	4.40%
Provider	20,174	18.73%
Total Denials	107,722	

Across quarters, "Benefit / Covered Service" continues to be the primary denial reason code followed closely by issues related to "Additional Information", "Authorization", and "Provider". "Medical Necessity" of services continues to be a non-factor with respect to denials, for services that do not require prior authorization or additional information.

Claim Adjustment Reason Code (CARC) Denials

In an effort to gain common understanding across MCOs, hospital denials by CARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code denial reasons are provided in Table 9. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 9A. Top 10 CARC Denials 2018 Quarter 3

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
96	Non-covered charge(s).	19,120	14.66%
197	Precertification/authorization/notification/pre-treatment absent.	15,506	11.89%
16	Claim/service lacks information or has submission/billing error(s).	13,846	10.61%
29	The time limit for filing has expired.	11,177	8.57%
A1	Claim/Service denied.	9,390	7.20%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	7,881	6.04%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	6,266	4.80%
129	Prior processing information appears incorrect.	5,994	4.59%
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	4,033	3.09%
4	The procedure code is inconsistent with the modifier used.	3,891	2.98%
	Total Denials (Duplicative	130,466	

Table 9B. Top 10 CARC Denials 2018 Quarter 4

CARC Code	CARC Code Description	Total Claims denied	Percent of Claims Denied
96	Non-covered charge(s).	17,786	14.95%
16	Claim/service lacks information or has submission/billing error(s).	14,118	11.86%
197	Precertification/authorization/notification/pre-treatment absent.	13,392	11.25%
29	The time limit for filing has expired.	9,329	7.84%
A1	Claim/Service denied.	6,806	5.72%
129	Prior processing information appears incorrect.	6,715	5.64%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	6,245	5.25%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	5,414	4.55%
181	Procedure code was invalid on the date of service.	4,034	3.39%
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	4,027	3.38%
	Total Denials (Duplicative	119,003	

Overall, the CARC denial detail in Tables 9A and 9B compliment and expand on the information found in Tables 8A and 8B. While the primary denial reason is related to non-covered charges, most other codes detail procedural issues (precertification, benefit covered in another service, time limit for filing has expired, charge exceeds fee schedule, service not covered, etc.) providers are struggling to meet in accordance with plan requirements.

Remittance Advice Remark Code (RARC) Denials

In an effort to gain common understanding across MCOs, hospital denials by RARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 RARC code denial reasons are provided in Table 10. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 10A. Top 10 RARC Denials 2018 Quarter 3

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N/A	(None/Invalid code reported by MCO)	28,881	29.63%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	11,072	11.36%
M51	Missing/incomplete/invalid procedure code(s).	7,961	8.17%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	7,267	7.46%
N381	Alert:Consult our contractual agreement for restrictions/billing/payment information related to these charges.	6,815	6.99%
MA67	Alert:Correction to a prior claim.	3,749	3.85%
M50	Missing/incomplete/invalid revenue code(s).	2,415	2.48%
N30	Patient ineligible for this service.	2,289	2.35%
MA36	Missing/incomplete/invalid patient name.	2,117	2.17%
N34	Incorrect claim form/format for this service.	2,011	2.06%
	Total Denials (Duplicative	97,476	

Table 10B. Top 10 RARC Denials 2018 Quarter 4

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N/A	(None/Invalid code reported by MCO)	26,599	29.66%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	10,341	11.53%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	6,653	7.42%
N381	Alert:Consult our contractual agreement for restrictions/billing/payment information related to these charges.	5,621	6.27%
M51	Missing/incomplete/invalid procedure code(s).	5,401	6.02%
MA67	Alert:Correction to a prior claim.	3,721	4.15%
MA36	Missing/incomplete/invalid patient name.	2,838	3.16%
M67	Missing/incomplete/invalid other procedure code(s).	2,406	2.68%
N34	Incorrect claim form/format for this service.	2,264	2.52%
N30	Patient ineligible for this service.	2,065	2.30%
	Total Denials (Duplicative	89,671	

The data in Table 10A and 10B demonstrate that the HFS-contracted MCOs are relying heavily upon proprietary remittance advice coding or single-level CARC coding in their messaging to providers on denials, with just over 29% of denials in both Q3 and Q4 being attributed to “None / Invalid Code” used by MCOs.

Conclusion

Approximately 83% clearance rate of hospital claims reported against over $800M in payables in Q3 that held nearly constant (83.41%) in Q4 against another $800M in payables. Additionally, over 90% of hospital services as demonstrated in Q3 and Q4 are being adjudicated by HFS' MCOs upon first submission, another strong metric of efficiency.

From a financial perspective, hospital claiming from MCOs can be qualified as ***generally paying hospitals within 60 days of claims submission***. This characterization is supported by over 83% of claims in Q3 and almost 90% of claims in Q4 being adjudicated within 30 days of submission from a provider. These were followed by over 90% in both Q3 and Q4 of adjudicated claims resulting in actual payment to providers within 30 days. In totality, just over 89% in both Q3 and Q4 of payable claims are adjudicated and paid to providers within 60 days of submission. However, it must be noted that by this same standard, pursuant to 305 ILCS 5/5-30.1. Managed Care Protections, sub-section (g), more than 21% of claims in Q3 and just over 17% of claims in Q4 would be eligible for interest from MCOs, as they were not adjudicated and paid to the provider within 30 days of submission.

As with the previous report, CARCs and RARCs continue to be collected. However, each plan's use of CARCs and RARCs has its own nuances. While the inclusion of CARCs and RARCs provide additional detail, a crosswalk between plans would provide a better understand each plan's payment processes.

<u>HFS' Efforts to Improve Communications and Support</u>

To help improve communication between all providers and the MCOs, the Department has implemented a number of initiatives. Two important changes are:

- Currently, MCOs contract with multiple vendors that receive and process provider claims. Rejections can occur during this front end process and result in coding errors specific to that particular vendor, further complicating interpretations across plans To address this issue, HFS has contracted with Optum to deploy a system within the electronic claims processing environment that all MCO claims flow through in order to give HFS insight into the details of all claims and MCO responses. This will enable HFS to distinguish and quantify issues that are billing errors by providers, those that are legitimated denials by MCOs, and those that are improper rejections or denials by MCOs. After delays resulting from HFS lack of resources prior to and during the COVID emergency, HFS expects some MCOs to be integrated into the Optum solution in July and all of them by the fall.

- HFS has established a bi-weekly meeting between providers and MCOs to improve communication and address policy and procedural issues relating to provider rejections and denials of providers. These meetings have resulted in significant improvements in both provider billing and MCO claims processing. Significant payments to providers have come as a result of reprocessed claims following system corrections.

Office of Medicaid Innovation

This report was prepared by the Office of Medicaid Innovation (OMI) at the request of Department of Healthcare and Family Services (HFS).

The OMI is a specialty unit within the University of Illinois System that seeks to utilize U of I resources from across all of its campuses to provide administrative, clinical, and operational support to HFS in the administration of the Illinois Medical Assistance Program.

The OMI can be contacted at:

University of Illinois
Office of Medicaid Innovation
3135 Old Jacksonville Road
Springfield, Illinois 62704-6488

Definitions

Adjudicated Claim: A claim that has been processed by the MCO or its vendor, and a determination as to whether or not that claim is payable has been made. Claims that have been Rejected or Denied, or have been determined Payable, or that have been paid, are all adjudicated Claims.

Claim Adjustment Reason Code (CARC): A HIPAA mandated code set to be used in an Electronic Remittance Advice explaining why an action was taken on a claim.

Date of Submission: This is the date that a claim, paper or electronic, is received by either the MCO or their agent (i.e. EDI clearinghouse).

Denied/Denied Claim: A claim where the payment was denied by the MCO to a Provider corresponding to HFS defined administrative reasons/codes. These claims are HIPAA compliant and may be fully processed by the MCO claims system but are denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue and non-contracted Providers. For purposes of this report, MCOs are to report the relative counts into one of the following seven (7) Denial Reasons.

> **Note**: HFS defines denials as denial of payment for a claim for the seven Denial Reasons described in this section of the report, and only these reasons.
> Additional Information: Provider claim is denied because the Provider has failed to supply the required information and the MCO needs the Provider to submit more information to process the claim (i.e. doctor's notes).
>
> *Authorization*: Provider claim is Denied by MCO because Provider did not meet MCO's authorization policy on Provider network status, service limits, medical necessity, non-emergency services, or missing/invalid authorization form/record.
>
> *Benefit/ Covered Service*: Provider claim is denied by MCO because Provider did not meet MCO's policy for Covered Services which are eligible for reimbursement. Note that the MCO may cover some services which are traditionally not covered by HFS as stated under Section 104 of Chapter 100 – Handbook for Providers of Medical Services (https://www.illinois.gov/hfs/SiteCollectionDocuments/100.pdf). If there is TPL benefit for which the MCO Denied coverage, it should be reported as a Benefit/Covered Service denial.
>
> *Medical Necessity*: Provider claim is denied by MCO because Provider did not meet MCO's reimbursement policy for medical necessity.
>
> *Pre-certification*: Provider claim is denied by MCO because Provider did not meet MCO's pre-certification for Hospital and SUPR (formerly DASA) services.
>
> *Provider*: Provider claim is denied by MCO because: 1) Provider is sanctioned by OIG, 2) Provider is not registered with HFS, including Providers who are out-of-state and not registered with HFS, and 3) Provider isn't certified or eligible to be paid for this procedure/service on this date of service. It is expected that Provider works with HFS IMPACT/OIG team to activate their status so

that claims can be reprocessed by MCOs for reimbursement. (In each of these cases, MCOs have decided to reimburse $0 and nothing will change that reimbursement value, until the Provider is enrolled with HFS.)

Timely Filing: Provider claim is denied by MCO because Provider did not meet MCO's timely filing policy, including any waiver period.

Hospital Claims: All claims, billed by a provider who is enrolled with HFS' Medical Programs as a General Hospital (Provider Type 030), Psychiatric Hospital (PT 031), or Rehabilitation Hospital (PT 032). NOTE: Only report Institutional hospital claims are included in this report.

Paid Claim: A claim submitted by a provider to a MCO that has been adjudicated, resulting in reimbursement to the provider.

Payable Claim: A claim submitted by a provider to a MCO that has been adjudicated and determined to be payable.

Rejected/ Rejected Claim: A rejected billing claim is one in which the determination of payment cannot be made. These claims may enter payer claims system (front-end) but do not pass further into adjudication and payment processing (back-end) due to missing administrative elements on the claim. All claims categorized as denied/rejected due to ineligibility, or claims denied/rejected because a duplicate claim has already been paid, as a rejected claim.

Rejected claims are:

1) Claims submitted to an MCO that were accepted through the Electronic Data Interchange (EDI), but subsequently removed/deleted from the adjudication system;

2) Claims that rejected through the EDI translator for failing any SNIP (see definition below) validations; and

3) Any custom business rules implemented in EDI that reject claim submissions.

Examples of missing administrative elements include taxonomy code, value codes, occurrence codes, modifier codes, billed units, covered days, invalid recipient ID, notes, and NDC codes. In most cases, once the administrative element is added and the claim is resubmitted by the Provider to the MCO, the claim may be adjudicated.

Remittance Advice Remark Code (RARC): A HIPAA mandated code set to be used in an Electronic Remittance Advice explaining why an action was taken on a claim. It is used in addition to a CARC. Not all actions require a RARC.

Unique Service: Multiple claims can be submitted for one service. To report Unique Services only report unique combinations of a provider's NPI/ Medicaid ID, patient Recipient ID/ Medicaid ID, admission through discharge date, and bill type. NOTE: For institutional claims, report Unique Services at the claim level of detail.