Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q3 and Q4 of CY 2021

Illinois Department of Healthcare and Family Services

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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 timeframes). This report is being posted pursuant to Public Act 100-0580.

Date Span of Data

The data provided in this report covers Quarter3 (Q3), or the dates July 1, 2021 through September 30, 2021, and Quarter 4 (Q4), or the dates October 1, 2021 through December 31, 2021, of calendar year 2021.

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.

Notes.

1. All dollar values provided in this report have been rounded to the nearest thousand-dollar value.
2. Regarding Charges Billed – Hospitals independently develop the values submitted on their claim as Charges Billed. Billed charges may be significantly higher than the allowable payments negotiated between payers and hospital.
3. 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 to all MCOs, and the data was submitted by the MCOs by mid-October 2022.

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 Quarters 3 and 4, respectively.

Table 1A. Unique Services. 2021 Q3

2021 Q3	Unique Service Count	% Of Services	Charges billed	Amount Paid
Unique Services Submitted	1,782,259	100.00%	$10,815,760,000	$1,387,871,000
Payable/Paid Unique Services	1,591,284	89.28%	$8,733,354,000	$1,387,871,000
Rejected Unique Services	37,841	2.12%	$438,994,000	[redacted]
Denied Unique Services	153,134	8.59%	$1,481,649,000	
Total Non-Payable (Denied + Rejected)	190,975	10.72%	$1,920,643,000	

Table 1B. Unique Services. 2021 Q4

2021 Q4	Unique Service Count	% Of Services	Charges billed	Amount Paid
Unique Services Submitted	1,754,119	100.00%	$10,444,307,000	$1,310,375,000
Payable/Paid Unique Services	1,566,980	89.33%	$8,481,731,000	$1,310,375,000
Rejected Unique Services	52,382	2.99%	$491,510,000	[redacted]
Denied Unique Services	134,759	7.68%	$1,378,348,000	
Total Non-Payable (Denied + Rejected)	187,141	10.67%	$1,869,858,000	

Approximately 10.7% of unique services submitted for both Q3 and Q4, 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 2021 Quarter 3

2021 Q3	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,363,675	82.70%	$1,109,763,000
2nd Submission	232,318	14.09%	$230,355,000
3rd Submission	43,107	2.61%	$59,546,000
4th Submission	8,188	0.50%	$13,134,000
5th or More Submission	1,621	0.10%	$4,214,000
Total	1,648,909	100.00%	$1,417,012,000

Table 2B. Number of Submissions Before Positive Adjudication 2021 Quarter 4

2021 Q4	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,506,575	95.57%	$1,161,654,000
2nd Submission	61,687	3.91%	$147,946,000
3rd Submission	6,754	0.43%	$27,590,000
4th Submission	1,164	0.07%	$4,211,000
5th or More Submission	298	0.02%	$1,174,000
Total	1,576,478	100.00%	$1,342,575,000

In Quarter 3, 82.7% of claims were paid after one submission, and in Quarter 4, 95.6% were paid after one submission. The Quarter 3 percentage is historically low, but in Quarter 4 the percentage returned to a level consistent with what has been seen historically (about 95%). Discussions with the MCOs lead to the conclusion that the lower percentage reported in in Quarter 3 was due to some unusual circumstances. If this is the case, then the data suggests that the current state of hospital claiming across the MCOs continues to be efficient. Going forward the data will be monitored to see if further variations occur in future Quarters.

Note: 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
2021 Quarter 3

2021 Q3	Claims	% Of Claims	# Of Payable/ Paid Claims	Net Liability	# Of Non-Payable *	Charges Billed for Non-Payable*
Total Claims Adjudicated in 0-30 days	1,524,563	82.55%	1,365,518	$1,059,952,000	159,045	$1,534,454,000
Total Claims Adjudicated in 31-60 days	33,805	1.83%	23,562	$100,995,000	10,243	$296,600,000
Total Claims Adjudicated in 61-90 days	48,034	2.60%	43,683	$69,060,000	4,351	$78,573,000
Total Claims Adjudicated in 91+ days	240,512	13.02%	218,926	$193,740,000	21,586	$242,999,000
Total Claims Awaiting Adjudication	2,872					
Total Claims Adjudicated for DOS for Reporting Period	1,846,934	100.00%	1,651,689	$1,423,747,000	195,225	$2,152,625,000

* Non-Payable means rejected or denied.

Data for Q4 is shown on the next page.

Table 3B. Days for Claims to be Adjudicated 2021 Quarter 4						
2021 Q4	**Claims**	**% of Claims**	**# of Payable/ Paid Claims**	**Net Liability**	**# of Non-Payable ***	**Charges Billed for Non-Payable***
Total Claims Adjudicated in 0-30 days	1,667,993	94.99%	1,511,678	$1,107,919,000	156,315	$1,444,740,000
Total Claims Adjudicated in 31-60 days	26,089	1.49%	18,181	$92,026,000	7,908	$212,440,000
Total Claims Adjudicated in 61-90 days	11,806	0.67%	7,810	$29,816,000	3,996	$70,293,000
Total Claims Adjudicated in 91+ days	50,102	2.85%	39,481	$117,055,000	10,621	$184,183,000
Total Claims Awaiting Adjudication	3,943					
Total Claims Adjudicated for DOS for Reporting Period	1,756,017	100.00%	1,577,150	$1,346,816,000	178,840	$1,911,656,000
* Non-Payable means rejected or denied.						

The data in Table 3A shows that in Q3 82.5% of claims were adjudicated within 30 days, and that in Q4 approximately 95% of claims were adjudicated within 30 days. At the same time, the percentage of claims adjudicated 91+ days after submission in Q3 was about 4 times its historical level. These significantly different percentages are due largely to data submitted for Q3 for one MCO. Discussions with the MCO indicate that the data was influenced by a one-time circumstance in Q3. In Q4 (Table 3B), this MCO's performance returned to its historical levels. Future data submitted by this MCO will be monitored for further significant variations, but it is believed that the variations seen in Q3 data are unlikely to occur again.

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
2021 Quarter 3

2021 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)	1,622,433	98.23%	$1,398,881,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	24,313	1.47%	$19,915,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	796	0.05%	$1,450,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	4,108	0.25%	$3,376,000
Total Payments Pending to Provider Following Positive Adjudication	21		$126,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,651,650	100.00%	$1,423,622,000

Data for Q4 is shown on the next page.

Table 4B. Time from Adjudication to Payment 2021 Quarter 4			
2021 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)	1,468,260	93.10%	$1,271,239,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	96,988	6.15%	$67,257,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	9,614	0.61%	$5,295,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	2,159	0.14%	$2,972,000
Total Payments Pending to Provider Following Positive Adjudication	45		$53,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,577,021	100.00%	$1,346,763,000

Table 4 shows that approximately 98% of payments to hospitals from the MCOs were made within 30 days of claims adjudication in Q3. This percentage is the highest ever reported in Table 4 by a substantial margin, and it is a 4.5 percentage point increase over Q2 of 2021. Inspection of the data for CY 2021 shows that the improvement in payment timeliness is entirely linked to the improvement in the performance of all MCOs, with one MCO making a very large improvement in timeliness over CY 2020. In fact, a review of the data since CY 2019 shows a consistent improvement in payment timeliness for 4 of the 5 MCOs.

The performance of one MCO has shown more variation in improvement in claims payment timeliness, and this is reflected in the results for CY 2021. For Q4 2021 the percentage of claims paid within 30 days of adjudication declined from 98% to 94%. This decline was due to a decline in the payment timeliness for Q4 for this MCO. Nevertheless, the percentage for Q4 still reflects a historically high level of claims payment timeliness. The percentage of claims paid within 30 days of adjudication is a key measure, which will continue to be monitored in this report.

Submission to Payment

Table 5: Interval -release of money from the MCOs to the provider, following submission of the hospital claim.

Table 5A. Time from Submission to Payment 2021 Quarter 3			
2021 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)	1,305,540	79.04%	$914,952,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	79,854	4.83%	$239,681,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	44,444	2.69%	$71,600,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	221,822	13.43%	$197,389,000
Total Payments Pending to Provider Following Positive Adjudication	21	NA	$126,000
Total (Not including Pending)	1,651,660	100.00%	$1,423,622,000

Data for Q4 is shown on the next page.

Table 5B. Time from Submission to Payment 2021 Quarter 4			
2021 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)	1,376,163	87.26%	$940,026,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	141,089	8.95%	$249,248,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	17,845	1.13%	$36,622,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	41,975	2.66%	$120,867,000
Total Payments Pending to Provider Following Positive Adjudication	45		$53,000
Total (Not including Pending)	1,577,072	100.00%	$1,346,763,000

The data for Table 5 show that the percentage of claims paid within 30 day of submission was 79% for Quarter 3 and 87% for Quarter 4. These percentages are significantly lower that those for Q1 and Q2 of CY 2021 and are much lower in general compared to historical data. Examination of the data shows that the timeliness of claims payments for one MCO declined sharply in Q3. For this MCO, 49.2% of claims were paid within 30 days, and 40% of hospital claims were paid more than 90 days after submission. Also in Q3, the percentage of payments made by another MCO within 30 days submission fell to 74.9%, from 91.1% in Quarter 2. In Quarter 4 the timeliness of claims payments improved greatly for both MCOs : 88.7% and 96.2% of claims were paid within 30 days of submission. In the case of both MCOs, unusual but non-recurring circumstances were responsible for the unusual claims payment data in Q3. Experience in future Quarters will be monitored for future anomalies in the data.

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. Table 7describes only the top ten codes, thus the percentages shown do not equal 100%.

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 2021 Quarter 3

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
31	Patient cannot be identified as our insured.	30,410	49.61%
208	National Provider Identifier - Not matched.	6,999	11.42%
96	Non-covered charge(s).	5,342	8.71%
N/A	(None/Invalid code reported by MCO)	3,493	5.70%
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	3,443	5.62%
16	Claim/service lacks information or has submission/billing error(s).	3,407	5.56%
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.	2,170	3.54%
27	Expenses incurred after coverage terminated.	1,606	2.62%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1,205	1.97%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	828	1.35%
	Total Rejections (Duplicative)	61,303	

Table 6B. Top 10 CARC Rejections 2021 Quarter 4			
CARC Code	**CARC Code Description**	**Total Claims**	**Percent of Claims Rejected**
96	Non-covered charge(s).	9,470	21.34%
18	Exact duplicate claim/service	7,910	17.83%
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.	6,860	15.46%
208	National Provider Identifier - Not matched.	6,338	14.28%
16	Claim/service lacks information or has submission/billing error(s).	2,952	6.65%
31	Patient cannot be identified as our insured.	2,692	6.07%
N/A	(None/Invalid code reported by MCO)	2,179	4.91%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1,502	3.39%
27	Expenses incurred after coverage terminated.	1,495	3.37%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	795	1.79%
	Total Rejections (Duplicative)	44,371	

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 2021 Quarter 3

RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
M86	Service denied because payment already made for same/similar procedure within set time frame.	5,433	19.21%
N253	Missing/incomplete/invalid attending provider primary identifier.	5,413	19.14%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	4,842	17.12%
N30	Patient ineligible for this service.	4,166	14.73%
M56	Missing/incomplete/invalid payer identifier.	3,012	10.65%
N/A	(None/Invalid code reported by MCO)	2,114	7.47%
N286	Missing/incomplete/invalid referring provider primary identifier.	1,180	4.17%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	410	1.45%
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	406	1.44%
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	198	0.70%
	Total Rejections (Duplicative)	28,283	

Data for Q4 is shown on the next page.

Table 7B. Top 10 RARC Rejections 2021 Quarter 4			
RARC Code	**Code Description**	**Total Rejections**	**Percent of Claims Rejected**
N253	Missing/incomplete/invalid attending provider primary identifier.	4,859	27.71%
N30	Patient ineligible for this service.	3,955	22.56%
N/A	(None/Invalid code reported by MCO)	2,700	15.40%
M56	Missing/incomplete/invalid payer identifier.	2,586	14.75%
N286	Missing/incomplete/invalid referring provider primary identifier.	1,369	7.81%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	560	3.19%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	403	2.30%
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	149	0.85%
N519	Invalid combination of HCPCS modifiers.	146	0.83%
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	145	0.83%
	Total Rejections (Duplicative)	17,534	

While the rejection reasons are varied, 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.).

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
2021 Quarter 3

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	8,041	5.54%
Additional Information	78,360	54.00%
Authorization	12,662	8.73%
Benefit / Covered Service	38,869	26.78%
Medical Necessity	510	0.35%
Pre-Certification	4,443	3.06%
Provider	2,237	1.54%
Total Denials	8,041	5.54%

Data for Quarter 4 is shown on the next page.

Table 8B. HFS Denial Reasons 2021 Quarter 4		
Denial Reason	**# Claims Denied**	**Percent of Claims Denied**
Timely Filing	5,829	4.58%
Additional Information	64,691	50.86%
Authorization	14,359	11.29%
Benefit / Covered Service	35,649	28.03%
Medical Necessity	374	0.29%
Pre-Certification	5,255	4.13%
Provider	1,039	0.82%
Total Denials	127,196	100.00%

Across quarters Q3 and Q4, “Additional Information” is the primary denial reason code followed by issues related to “Benefit/Covered Service”, “Pre-Certification” and “Timely Filing”. “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 2021 Quarter 3

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
96	Non-covered charge(s).	36,514	23.90%
129	Prior processing information appears incorrect.	19,142	12.53%
18	Exact duplicate claim/service	17,947	11.75%
16	Claim/service lacks information or has submission/billing error(s).	16,141	10.56%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	15,397	10.08%
197	Precertification/authorization/notification/pre-treatment absent.	15,127	9.90%
N/A	(None/Invalid code reported by MCO)	10,558	6.91%
A1	Claim/Service denied.	9,366	6.13%
22	This care may be covered by another payer per coordination of benefits.	7,935	5.19%
29	The time limit for filing has expired.	7,075	4.63%
	Total Denials (Duplicative	152,782	

Data for Q4 is shown on the next page.

Table 9B. Top 10 CARC Denials 2021 Quarter 4			
CARC Code	**CARC Code Description**	**Total Claims denied**	**Percent of Claims Denied**
96	Non-covered charge(s).	33,328	19.39%
129	Prior processing information appears incorrect.	19,469	11.33%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	17,273	10.05%
197	Precertification/authorization/notification/pre-treatment absent.	16,822	9.79%
16	Claim/service lacks information or has submission/billing error(s).	12,324	7.17%
18	Exact duplicate claim/service	10,367	6.03%
N/A	(None/Invalid code reported by MCO)	9,656	5.62%
A1	Claim/Service denied.	7,983	4.65%
22	This care may be covered by another payer per coordination of benefits.	7,924	4.61%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	6,711	3.90%
	Total Denials (Duplicative	171,860	

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.) that 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 2021 Quarter 3

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	30,644	20.48%
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	16,454	10.99%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	15,429	10.31%
N/A	(None/Invalid code reported by MCO)	12,330	8.24%
M62	Missing/incomplete/invalid treatment authorization code.	7,146	4.78%
M86	Service denied because payment already made for same/similar procedure within set time frame.	6,174	4.13%
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	5,506	3.68%
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	4,330	2.89%
N253	Missing/incomplete/invalid attending provider primary identifier.	2,788	1.86%
N50	Missing/incomplete/invalid discharge information.	2,656	1.77%
	Total Denials (Duplicative)	149,654	

Data for Q4 is shown on the next page.

Table 10B. Top 10 RARC Denials 2021 Quarter 4			
RARC Code	**Description**	**Total Claims Denied**	**Percent of Claims Denied**
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	28,740	22.46%
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	17,207	13.45%
N/A	(None/Invalid code reported by MCO)	9,936	7.76%
M62	Missing/incomplete/invalid treatment authorization code.	7,615	5.95%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	6,258	4.89%
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	5,203	4.07%
M86	Service denied because payment already made for same/similar procedure within set time frame.	4,684	3.66%
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	4,023	3.14%
N253	Missing/incomplete/invalid attending provider primary identifier.	2,922	2.28%
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	2,834	2.21%
	Total Denials (Duplicative)	127,975	

The data in Table 10A and 10B demonstrate that the HFS-contracted MCOs continue to rely significantly upon proprietary remittance advice coding or single-level CARC coding in their messaging to providers on denials, with 8.24% of denials in Q3 and 7.76% of denials in Q4 being attributed to the “None / Invalid Code” used by MCOs.

Conclusion

There was an 89.3% clearance rate of hospital claims reported against $1,387M in payable claims in Q3. The clearance rate Q4 stayed at 89.3% against $1,310M in payables. Additionally, approximately 82.7% of hospital services claims in Q3 and 95.6% in Q4 are being adjudicated by HFS' MCOs upon first submission (another strong metric of efficiency). Note that the percentage of hospital claims adjudicated on first submission in in Q3 2021 was substantially lower than in either Q1 or Q2 of 2021, but that in Q4 of 2021 that percentage had returned to historical levels (95%). As mentioned above, the data reported in Q3 2021 is very likely an anomaly, but future behavior of this metric will be followed to confirm this.

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 approximately 84% of claims in Q3 and 96% of claims in Q4 being adjudicated within 60 days of submission from a provider. This was followed by approximately 98% of adjudicated claims in Q3 being paid to providers within 30 days of adjudication, and in 93%of adjudicated claims being paid within 30 days of adjudication in Q4. In totality, for Q3 2021approximately 83.9% of payable claims are adjudicated and paid to providers within 60 days of submission, and for Q4 approximately 96% are adjudicated and paid to providers within 60 days of submission. In Q3 there was obviously a substantial departure from the historical rate of claims being paid. As discussed above, this is the result of significant anomaly in the data one of the larger MCOs. As discuss above, this is likely attributable to unusual circumstances unlikely to recur. Note that the data returned to levels close to historical experience in Quarter 4. As data develops in the future this is an issue that will be followed. Finally, it must be noted that by the 30 day standard, pursuant to 305 ILCS 5/5-30.1. Managed Care Protections, sub-section (g), about 21.0% of claims in Q3 and 12.7% 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 previous reports, 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.

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 its campuses to provide administrative, clinical, and operational support to HFS in the administration of the Illinois Medical Assistance Program.

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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.