Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q3 and Q4 of CY 2019

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 timeframes). 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, 2019 through September 30, 2019, and Quarter 4 (Q4), or the dates October 1, 2019 through December 31, 2019, of calendar year 2019.

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 hundred-thousand-dollar value.
2. Regarding Charges Billed – Hospitals independently develop the values submitted on their claim as "charges," detailed in the tables of this report as: Charges Billed. Charges Billed are often significantly higher than both negotiated reimbursement rates and provider cost. A study[2] looking at 2012 data found that, on average, hospital charges were 3.4 times as much as their Medicare-allowable cost.
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.

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

[2] Ge Bai and Gerard F. Anderson, GF, A., CP, T., UE, R., R, M., GA, M., . . . Pines, J. (2015, June 01). Extreme markup: The fifty Us hospitals with the Highest Charge-To-Cost RATIOS: Health Affairs Journal. Retrieved February 8, 2021, from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1414

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 October 2020 to all MCOs and returned by October 30, 2019.

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.

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. 2019 Q3

2019 Q3	Unique Service Count	% of Services	Charges Billed	Amount Paid
Unique Services Submitted	882,377	100.00%	$ 6,607,100,000.00	$ 870,800,000.00
Payable/Paid Unique Services	770,236	87.29%	$ 5,276,000,000.00	$ 870,800,000.00
Rejected Unique Services	40,918	4.64%	$ 427,300,000.00	
Denied Unique Services	72,013	8.16%	$ 908,300,000.00	
Total Non-Payable (Denied + Rejected)	112,931	12.80%	$ 1,335,600,000.00	

Table 1B. Unique Services. 2019 Q4

2019 Q4	Unique Service Count	% of Services	Charges Billed	Amount Paid
Unique Services Submitted	873,033	100.00%	$ 6,631,300,000.00	$ 843,900,000.00
Payable/Paid Unique Services	765,646	87.70%	$ 5,296,600,000.00	$ 843,900,000.00
Rejected Unique Services	33,829	3.87%	$ 380,000,000.00	
Denied Unique Services	73,840	8.46%	$ 955,800,000.00	
Total Non-Payable (Denied + Rejected)	107,669	12.33%	$ 1,335,800,000.00	

12.8% and 12.33% of unique services submitted for Q3 and Q4, respectively, were either rejected or denied.

Submissions Before Positive Adjudication

Table 2 focuses on efficiency in the claiming process. Providers can 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 2019, Quarter 3

2019 Q3	Number of Claims	Percent of Claims	Net Liability
1st Submission	771,373	96.99%	$ 839,500,000.00
2nd Submission	20,152	2.53%	$ 44,200,000.00
3rd Submission	3,319	0.42%	$ 10,400,000.00
4th Submission	388	0.05%	$ 1,400,000.00
5th or More Submission	108	0.01%	$ 700,000.00
Total	795,340	100.00%	$ 896,200,000.00

Table 2B. Number of Submissions Before Positive Adjudication 2019, Quarter 4

2019 Q4	Number of Claims	Percent of Claims	Net Liability
1st Submission	757,531	97.21%	$ 828,400,000.00
2nd Submission	18,312	2.35%	$ 38,800,000.00
3rd Submission	3,012	0.39%	$ 9,400,000.00
4th Submission	339	0.04%	$ 1,400,000.00
5th or More Submission	92	0.01%	$ 200,000.00
Total	779,286	100.00%	$ 878,200,000.00

With approximately 3% of paid claims being submitted two or more times before being reimbursed in the 2 quarters, 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
2019 Quarter 3

2019 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	864,833	92.12%	749,513	$ 809,800,000.00	111,060	$ 1,139,400,000.00
Total Claims Adjudicated in 31-60 days	32,743	3.49%	25,473	$ 46,200,000.00	6,141	$ 108,600,000.00
Total Claims Adjudicated in 61-90 days	11,373	1.21%	8,989	$ 11,700,000.00	1,475	$ 20,300,000.00
Total Claims Adjudicated in 91+ days	29,844	3.18%	19,010	$ 23,700,000.00	4,173	$ 60,000,000.00
Total Claims Awaiting Adjudication	15,172	NA				
Total Claims Adjudicated For DOS For Reporting Period	938,793	100.00%	802,985	$ 891,400,000.00	122,849	$ 1,328,300,000.00

* Non-Payable means rejected or denied.

Table 3B. Days for Claims to be Adjudicated
2019 Quarter 4

2019 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	830,375	91.38%	729,385	$ 777,400,000.00	99,367	$ 1,161,100,000.00
Total Claims Adjudicated in 31-60 days	50,383	5.54%	40,492	$ 71,500,000.00	9,165	$ 129,700,000.00
Total Claims Adjudicated in 61-90 days	8,321	0.92%	5,890	$ 12,300,000.00	1,607	$ 30,100,000.00
Total Claims Adjudicated in 91+ days	19,659	2.16%	10,708	$ 20,900,000.00	3,411	$ 53,300,000.00
Total Claims Awaiting Adjudication	19,859	NA				
Total Claims Adjudicated For DOS For Reporting Period	908,738	100.00%	786,475	$ 882,000,000.00	113,550	$ 1,374,200,000.00

* Non-Payable means rejected or denied.

The vast majority of hospital claims were adjudicated within 30 days, with slightly more than 90% of claim adjudicated within 30 days in both quarters.

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
2019 Quarter 3

2019 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)	662,305	85.20%	$715,300,000.00
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	21,530	2.77%	$44,100,000.00
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	14,022	1.80%	$22,200,000.00
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	79,501	10.23%	$93,300,000.00
Total Payments Pending to Provider Following Positive Adjudication	141,592	NA	$149,500,000.00
Total Payments Following Positive Adjudication (Doesn't include pending)	777,358	100.00%	$874,900,000.00

Table 4B. Time from Adjudication to Payment
2019 Quarter 4

2019 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)	584,053	84.30%	$ 580,100,000.00
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	11,607	1.68%	$ 38,600,000.00
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	22,577	3.26%	$ 54,800,000.00
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	74,612	10.77%	$ 78,200,000.00
Total Payments Pending to Provider Following Positive Adjudication	204,754	NA	$ 250,600,000.00
Total Payments Following Positive Adjudication (Doesn't include pending)	692,849	100.00%	$ 751,700,000.00

Table 4 demonstrates that about 85% of payments to hospitals from MCOs were made within 30 days of claims adjudication for both Q3 and Q4.

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
2019 Quarter 3

2019 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)	602,513	77.44%	$ 600,800,000.00
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	56,098	7.21%	$ 111,700,000.00
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	21,755	2.80%	$ 38,000,000.00
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	97,623	12.55%	$ 124,500,000.00
Total Payments Pending to Provider Following Positive Adjudication	141,592	NA	$ 149,500,000.00
Total (Not including Pending)	777,989	100.00%	$ 875,000,000.00

Table 5B. Time from Submission to Payment
2019 Quarter 4

2019 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)	508,089	73.16%	$ 437,500,000.00
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	70,413	10.14%	$ 135,800,000.00
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	24,415	3.52%	$ 55,100,000.00
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	91,613	13.19%	$ 123,900,000.00
Total Payments Pending to Provider Following Positive Adjudication	204,754	NA	$ 250,600,000.00
Total (Not including Pending)	694,530	100.00%	$ 1,002,900,000.00

Table 5 demonstrates that about 84% in Q3 and about 83% in Q4 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
2019 Quarter 3

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
16	Claim/service lacks information or has submission/billing error(s).	11,599	23.98%
18	Exact duplicate claim/service	4,900	10.13%
96	Non-covered charge(s).	4,489	9.28%
27	Expenses incurred after coverage terminated.	4,372	9.04%
31	Patient cannot be identified as our insured.	4,048	8.37%
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	2,965	6.13%
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.	1,959	4.05%
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1,919	3.97%
177	Patient has not met the required eligibility requirements.	1,833	3.79%
22	This care may be covered by another payer per coordination of benefits.	1,733	3.58%
	Total Rejections (Duplicative)	48,371	

Table 6B. Top 10 CARC Rejections
2019 Quarter 4

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
18	Exact duplicate claim/service	3,530	15.77%
96	Non-covered charge(s).	3,518	15.72%
31	Patient cannot be identified as our insured.	3,025	13.51%
16	Claim/service lacks information or has submission/billing error(s).	2,968	13.26%
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.	1,646	7.35%
27	Expenses incurred after coverage terminated.	1,380	6.16%
177	Patient has not met the required eligibility requirements.	1,346	6.01%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	1,124	5.02%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	799	3.57%
26	Expenses incurred prior to coverage.	556	2.48%
	Total Rejections (Duplicative)	22,385	

Note. *While CARC and RARC codes are standardized, the way 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
2019 Quarter 3

RARC Code	RARC Description	Total Rejections	Percent of Claims Rejected
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	6,206	19.63%
N/A	(None/Invalid code reported by MCO)	5,973	18.89%
N30	Patient ineligible for this service.	5,309	16.79%
M86	Service denied because payment already made for same/similar procedure within set time frame.	4,661	14.74%
N34	Incorrect claim form/format for this service.	4,502	14.24%
N284	Missing/incomplete/invalid referring provider taxonomy.	3,336	10.55%
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	2,751	8.70%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	2,702	8.54%
N281	Missing/incomplete/invalid pay-to provider address.	1,754	5.55%
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	1,310	4.14%
	Total Rejections (Duplicative)	31,621	

Table 7B. Top 10 RARC Rejections
2019 Quarter 4

RARC Code	RARC Description	Total Rejections	Percent of Claims Rejected
M86	Service denied because payment already made for same/similar procedure within set time frame.	3,333	20.88%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	3,159	19.79%
N30	Patient ineligible for this service.	3,067	19.21%
N/A	(None/Invalid code reported by MCO)	2,641	16.54%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	1,083	6.78%
N329	Missing/incomplete/invalid patient birth date.	497	3.11%
N362	The number of Days or Units of Service exceeds our acceptable maximum.	371	2.32%
M47	Missing/incomplete/invalid Payer Claim Control Number.	216	1.35%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	184	1.15%
M20	Missing/incomplete/invalid HCPCS.	168	1.05%
	Total Rejections (Duplicative)	15,965	

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
2019 Quarter 3

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	5,708	6.60%
Additional Information	14,918	17.25%
Authorization	16,718	19.33%
Benefit / Covered Service	42,395	49.02%
Medical Necessity	646	0.75%
Pre-Certification	290	0.34%
Provider	5,810	6.72%
Total Denials	86,485	

Table 8B. HFS Denial Reasons
2019 Quarter 4

Denial Reason	# Claims Denied	Percent of Claims Denied
Timely Filing	3,491	4.14%
Additional Information	13,205	15.65%
Authorization	22,414	26.57%
Benefit / Covered Service	38,351	45.46%
Medical Necessity	482	0.57%
Pre-Certification	522	0.62%
Provider	5,894	6.99%
Total Denials	84,359	

Across quarters, “Benefit / Covered Service” continues to be the primary denial reason code followed by issues related to “Authorization”, “Additional Information”, 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

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
2019 Quarter 3

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
96	Non-covered charge(s).	16,018	14.72%
16	Claim/service lacks information or has submission/billing error(s).	11,470	10.54%
197	Precertification/authorization/notification/pre-treatment absent.	11,143	10.24%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	9,595	8.81%
A1	Claim/Service denied.	7,936	7.29%
29	The time limit for filing has expired.	6,069	5.58%
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	5,159	4.74%
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	4,817	4.43%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4,439	4.08%
181	Procedure code was invalid on the date of service.	3,508	3.22%
	Total Denials (Duplicative)	108,853	

Table 9B. Top 10 CARC Denials
2019 Quarter 4

CARC Code	CARC Code Description	Total Claims denied	Percent of Claims Denied
96	Non-covered charge(s).	15,002	18.93%
16	Claim/service lacks information or has submission/billing error(s).	10,391	13.11%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	8,941	11.28%
197	Precertification/authorization/notification/pre-treatment absent.	6,970	8.79%
A1	Claim/Service denied.	6,562	8.28%
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	5,265	6.64%
29	The time limit for filing has expired.	3,492	4.41%
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	2,653	3.35%
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	2,323	2.93%
204	This service/equipment/drug is not covered under the patient’s current benefit plan	1,941	2.45%
	Total Denials (Duplicative)	79,255	

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
2019 Quarter 3

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N/A	(None/Invalid code reported by MCO)	12,093	15.38%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	10,341	13.15%
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	9,565	12.17%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	7,608	9.68%
N362	The number of Days or Units of Service exceeds our acceptable maximum.	5,099	6.49%
M51	Missing/incomplete/invalid procedure code(s).	4,561	5.80%
MA67	Alert: Correction to a prior claim.	2,407	3.06%
MA36	Missing/incomplete/invalid patient name.	2,255	2.87%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	2,094	2.66%
N30	Patient ineligible for this service.	1,851	2.35%
	Total Denials (Duplicative)	78,620	

Table 10B. Top 10 RARC Denials
2019 Quarter 4

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N/A	(None/Invalid code reported by MCO)	10,895	16.31%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	9,582	14.34%
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	8,881	13.30%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	6,665	9.98%
N362	The number of Days or Units of Service exceeds our acceptable maximum.	5,158	7.72%
M51	Missing/incomplete/invalid procedure code(s).	3,733	5.59%
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	1,910	2.86%
MA67	Alert: Correction to a prior claim.	1,685	2.52%
N30	Patient ineligible for this service.	1,532	2.29%
M62	Missing/incomplete/invalid treatment authorization code.	1,237	1.85%
	Total Denials (Duplicativ)	66,798	

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 15.38% of denials in Q3 and 16.31% of denials in Q4 being attributed to "None / Invalid Code" used by MCOs.

Conclusion

There was an approximately 87% clearance rate of hospital claims reported against over $871M in payables in Q3 that held steady (87.70%) in Q4 against another $843M in payables. Additionally, over 95% of hospital services 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 90% of claims in both Q3 and Q4 being adjudicated within 30 days of submission from a provider. These were followed by approximately 85% in both Q3 and Q4 of adjudicated claims resulting in actual payment to providers within 30 days. In totality, approximately 85 % in Q3 (84.66%) and Q4 (83.29%) 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 22% of claims in Q3 and over 26% 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. It should also be noted that data from one health plan, CountyCare, appears to be impacting the overall performance regarding timely payment of claims. If CountyCare's claims data were to be excluded from the analysis, the percentage of claims paid within 30 days of submission would climb to 87.04% in Q3 and 82.83% in Q4, from 77.44% in Q3 and 73.16% in Q4. However, CountyCare is under a Corrective Action plan with regards to timely payment and has been showing improvement.

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.

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

To help improve communication between all providers and the MCOs, the Department has implemented several 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 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 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. As of December 2020, four of five MCOs are fully connected to the Optum ACE/iEDI system and all claims and responses are being captured and sent to the HFS Data Warehouse. The last MCO is scheduled to go live in January. HFS is beginning to analyze data to identify issues in billing and claim adjudication.

- HFS conducts meetings between providers and MCOs to improve communication and address policy and procedural issues relating to provider rejections and denials. Significant payments to providers have come as a result of reprocessed claims following system corrections in response to these meetings. In addition, the meetings have been moved from a bi-weekly status, to a monthly status with agreement from providers.

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.