Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q1 and Q2 of CY 2018

Illinois Department of Healthcare and Family Services

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Legislative Mandate

Public Act 100-0580, found at:
http://www.ilga.gov/legislation/publicacts/100/100-0580.htm

Section 5-30.1 of Public Act 100-0580 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).

Introduction

As HFS introduced mandatory-managed care in July 1, 2014, Illinois began to transition one of the largest Medicaid programs in the nation from its legacy fee-for-system origins to a multi-payer managed care environment. Since that time, HFS has refined its MCO program with the introduction of *HealthChoice Illinois (HCI)*, reducing the overall number of MCOs, and has expanded MCO coverage statewide. In response to stakeholder concerns and feedback, the General Assembly adopted Public Act 100-0580, addressing the administrative, operational and financial concerns of hospitals under the expanded HFS Managed Care System. This report, as mandated by the Illinois legislature, discusses the concerns of hospital providers, and the status of MCOs.

Date Span of Data

The data provided in this report covers Quarter 1 (Q1), or the dates January 1, 2018 through March 31, 2018, and Quarter 2 (Q2), or the dates April 1, 2018 through June 30, 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, is not included in this report.

Representative Sample.

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

Variances from Last Report.

To provide a more comprehensive understanding of the MCO's claims processing and payment systems, the approach and format of this report differs from that of the initial report posted on Nov 8, 2018. It is anticipated that future reports will continue to be iterative, as more detailed information becomes available to the Department.

- Removal of outpatient services. In the initial report, some professional services billed via 837P from hospitals were mixed in with inpatient hospital claims. In this report, these claims were excluded as they are billed on a professional claim and thus are processed and often paid in a different manner than institutional claims.
- Adjustments. In an effort to gain a general understanding of the state of hospital claims, adjustments were held back from this reporting period. Adjustments have the ability to

significantly 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.

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 Office of Medicaid Innovation (OMI) at the request of HFS. All data in this report is provided via self-report from the MCOs. While the OMI and HFS seek 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.

The OMI is a specialty unit within the University of Illinois (U of I) 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:

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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 1 and 2, respectively.

Table 1A. Unique Services
2018 Quarter 1

2018, Q1	Unique Services	% of Services	Charges billed*	Amount Paid*
Unique Services Submitted	736,039	100%	$5,373,900,000	$583,500,000
Payable/ Paid Unique Services	616,108	83.71%	$4,009,900,000	$583,500,000
Rejected Unique Services	44,227	6.01%	$518,500,000	
Denied Unique Services	75,704	10.29%	$845,500,000	
Total Non-Payable (Denied + Rejected)	119,931	16.29%	$1,364,000,000	

Table 1B. Unique Services
2018 Quarter 2

2018, Q2	Unique Service	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,011,371	100.00%	$7,035,900,000	$780,400,000
Payable/ Paid Unique Services	835,244	82.59%	$5,306,200,000	$780,400,000
Rejected Unique Services	58,183	5.75%	$586,100,000	
Denied Unique Services	117,944	11.66%	$1,143,500,000	
Total Non-Payable (Denied + Rejected)	176,127	17.41%	$1,729,600,000	

16.29% and 17.41% of unique services submitted for Quarter 1 (Q1) and Quarter 2 (Q2), respectively, were either rejected or denied.

Note. *The marked increase in the total volume of unique services from Quarter 1 to Quarter 2 is attributed to HealthChoice Illinois becoming active statewide at the beginning of Quarter 1, and initial 90-day plan switch periods expiring at the beginning of Quarter 2.*

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.

Table 2A. Number of Submissions Before Positive Adjudication 2018, Quarter 1

2018, Q1	Claim Count	% of Claims	Net Liability
1st Submission	613,988	95.51%	$576,300,000
2nd Submission	23,348	3.63%	$45,300,000
3rd Submission	4,518	0.70%	$6,400,000
4th Submission	708	0.11%	$1,500,000
5+ Submission	300	0.05%	$400,000
	642,862	100.00%	$629,800,000

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

2018, Q2	Claim Count	% of Claims	Net Liability
1st Submission	826,627	95.16%	$755,800,000
2nd Submission	35,206	4.05%	$60,600,000
3rd Submission	5,276	0.61%	$10,800,000
4th Submission	1,226	0.14%	$2,300,000
5+ Submission	318	0.04%	$500,000
	868,653	100.00%	$830,200,000

With slightly less than 5% 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 1

2018, Q1	Claims	% of Claims	# of Payable/ Paid Claims	Net Liability	# of Non-Payable*	Charges Billed for Non-Payable*
Claims Adjudicated (0-30 days)	689,032	88.37%	576,402	$437,800,000	112,697	$1,250,400,000
Claims Adjudicated (31-60 days)	69,811	8.95%	51,226	$162,000,000	18,613	$267,900,000
Claims Adjudicated (61-90 days)	8,332	1.07%	5,927	$13,700,000	2,408	$45,000,000
Claims Adjudicated (91+ days)	12,530	1.61%	7,885	$12,000,000	4,650	$54,900,000
Claims Awaiting Adjudication	3,902	NA	NA	NA	NA	NA
Claims Adjudicated For DOS During Reporting Period	779,716	100.00%	641,440	$625,500,000	138,368	$1,618,200,000

* Non-Payable means rejected or denied.

Table 3B. Days for Claims to be Adjudicated 2018 Quarter 2

2018, Q2	Claims	% of Claims	# of Payable/ Paid Claims	Net Liability	# of Non-Payable*	Charges Billed for Non-Payable*
Claims Adjudicated (0-30 days)	970,616	92.58%	806,033	$659,400,000	164,638	$1,511,400,000
Claims Adjudicated (31-60 days)	51,858	4.95%	39,962	$119,400,000	11,908	$218,600,000
Claims Adjudicated (61-90 days)	12,141	1.16%	9,387	$23,300,000	2,758	$55,300,000
Claims Adjudicated (91+ days)	13,732	1.31%	8,048	$17,300,000	5,688	$60,200,000
Claims Awaiting Adjudication	4,786	NA	NA	NA	NA	NA
Claims Adjudicated For DOS During Reporting Period	1,048,377	100.00%	863,430	$819,500,000	184,992	$1,845,500,000

* Non-Payable means rejected or denied.

The vast majority of hospital claims were adjudicated within 30 days, with a slight improvement in Quarter 2, moving from just over 88% to approximately 92.5%.

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 1

2018 Q1	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Payment to Provider Following Positive Adjudication (0-30 days)	507,651	79.39%	$479,900,000
Payment to Provider Following Positive Adjudication (31-60 days)	30,959	4.84%	$30,600,000
Payment to Provider Following Positive Adjudication (61-90 days)	53,570	8.38%	$60,500,000
Payment to Provider Following Positive Adjudication (91+ days)	47,238	7.39%	$54,200,000
Total Payments Pending to Provider Following Positive Adjudication	1,919	NA	$400,000
Total (Not including Pending)	639,418	100.00%	$625,200,000

Table 4B. Time from Adjudication to Payment 2018 Quarter 2

2018 Q2	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Payment to Provider Following Positive Adjudication (0-30 days)	753,001	87.61%	$681,600,000
Payment to Provider Following Positive Adjudication (31-60 days)	17,991	2.09%	$28,700,000
Payment to Provider Following Positive Adjudication (61-90 days)	36,659	4.26%	$47,600,000
Payment to Provider Following Positive Adjudication (91+ days)	51,886	6.04%	$60,000,000
Total Payments Pending to Provider Following Positive Adjudication	3,843	NA	$1,600,000
Total (Not including Pending)	863,380	100.00%	$819,400,000

Table 4 demonstrates that nearly 80% in Quarter 1 and almost 88% in Quarter 2 of payments to hospitals from MCOs were made within 30 days of claims adjudication.

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 1

2018 Q1	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Payment to Provider Following Submission of Claim (0-30 days)	441,358	69.03%	$326,600,000
Payment to Provider Following Submission of Claim (31-60 days)	85,536	13.38%	$156,600,000
Payment to Provider Following Submission of Claim (61-90 days)	48,405	7.57%	$53,600,000
Payment to Provider Following Submission of Claim (91+ days)	64,081	10.02%	$88,100,000
Total Payments Pending to Provider Following Positive Adjudication	1,971	NA	$600,000
Total (Not including Pending)	641,351	100.00%	$625,500,000

Table 5B. Time from Submission to Payment 2018 Quarter 2

2018 Q2	Number of Hospital Claims Paid	Percent of Hospital Claims Paid	Total Net Liability for Positively Adjudicated Hospital Claims
Payment to Provider Following Submission of Claim (0-30 days)	692,467	80.57%	$518,100,000
Payment to Provider Following Submission of Claim (31-60 days)	69,349	8.07%	$169,800,000
Payment to Provider Following Submission of Claim (61-90 days)	39,059	4.54%	$53,100,000
Payment to Provider Following Submission of Claim (91+ days)	58,584	6.82%	$76,300,000
Total Payments Pending to Provider Following Positive Adjudication	3,936	NA	$2,100,000
Total (Not including Pending)	863,395	100.00%	$819,500,000

Table 5 demonstrates that over 82% in Quarter 1 and almost 88% in Quarter 2 of payments to hospitals from MCOs were made within 60 days of claims 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

In an effort to gain common understanding across MCOs, hospital rejections 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 rejection reasons are provided in Table 6.

Table 6A. Top 10 CARC Rejections 2018 Quarter 1

CARC Code	CARC Code Description	Total Claims Rejected	Percent of Claims Rejected
16	Claim/service lacks information or has submission/billing error(s).	5,738	11.61%
18	Exact duplicate claim/service	5,660	11.46%
27	Expenses incurred after coverage terminated.	5,373	10.88%
96	Non-covered charge(s).	4,568	9.25%
181	Procedure code was invalid on the date of service.	3,937	7.97%
32	Our records indicate the patient is not an eligible dependent.	3,760	7.61%
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	3,068	6.21%
31	Patient cannot be identified as our insured.	3,024	6.12%
207	National Provider identifier - Invalid format	2,148	4.35%
177	Patient has not met the required eligibility requirements.	1,684	3.41%
	Total Rejections (Duplicative)	**49,402**	

Table 6B. Top 10 CARC Rejections 2018 Quarter 2

CARC Code	CARC Code Description	Total Claims Rejected	Percent of Claims Rejected
16	Claim/service lacks information or has submission/billing error(s).	16,750	23.51%
100	Payment made to patient/insured/responsible party.	6,079	8.53%
207	National Provider identifier - Invalid format	5,722	8.03%
181	Procedure code was invalid on the date of service.	5,518	7.74%
27	Expenses incurred after coverage terminated.	5,268	7.39%
18	Exact duplicate claim/service	5,234	7.35%
22	This care may be covered by another payer per coordination of benefits.	4,264	5.98%
96	Non-covered charge(s).	3,289	4.62%
177	Patient has not met the required eligibility requirements.	3,087	4.33%
32	Our records indicate the patient is not an eligible dependent.	2,844	3.99%
	Total Rejections (Duplicative)	**71,249**	

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 MCOs.*

Remittance Advice Remark Code (RARC) Rejections

In an effort to gain common understanding across MCOs, hospital rejections by RARCs were also 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 1

RARC Code	Description	Total Claims Rejected	Percent of Claims Rejected
N30	Patient ineligible for this service.	8,455	25.50%
M86	Service denied because payment already made for same/similar procedure within set time frame.	4,547	13.71%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	4,067	12.27%
	(None/Invalid code reported by MCO)	2,369	7.14%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	1,596	4.81%
N284	Missing/incomplete/invalid referring provider taxonomy.	1,592	4.80%
N34	Incorrect claim form/format for this service.	1,542	4.65%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	890	2.68%
N381	Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	669	2.02%
N329	Missing/incomplete/invalid patient birth date.	665	2.01%
	Total Rejections (Duplicative)	**33,157**	

Table 7B. Top 10 RARC Rejections 2018 Quarter 2

RARC Code	Description	Total Claims Rejected	Percent of Claims Rejected
N30	Patient ineligible for this service.	8,409	18.62%
N284	Missing/incomplete/invalid referring provider taxonomy.	4,706	10.42%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	3,692	8.18%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	3,204	7.10%
N34	Incorrect claim form/format for this service.	3,190	7.06%
M86	Service denied because payment already made for same/similar procedure within set time frame.	3,171	7.02%
	(None/Invalid code reported by MCO)	3,151	6.98%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	2,227	4.93%
N281	Missing/incomplete/invalid pay-to provider address.	1,569	3.47%
N277	Missing/incomplete/invalid other payer rendering provider identifier.	1,016	2.25%
	Total Rejections (Duplicative)	**45,155**	

While N30 – "Patient ineligible for this service" is the most common rejection reason in both Q1 and Q2, the rest 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 issues.

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 1

Denial Reason	Number of Claims Denied	Percent of Claims
Timely Filing	6,958	7.31%
Additional Information	14,409	15.14%
Authorization	16,260	17.08%
Benefit / Covered Service	43,351	45.54%
Medical Necessity	253	0.27%
Pre-Certification	2,104	2.21%
Provider	11,854	12.45%
Total Denials	**95,189**	

Table 8B. HFS Denial Reasons 2018 Quarter 2

Denial Reason	Number of Claims Denied	Percent of Claims
Timely Filing	9,413	6.42%
Additional Information	24,759	16.88%
Authorization	23,532	16.04%
Benefit / Covered Service	55,246	37.66%
Medical Necessity	427	0.29%
Pre-Certification	5,248	3.58%
Provider	28,090	19.15%
Total Denials	**146,715**	

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 small value with respect to denial reason, 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 1

CARC Code	Description	Total Denials	Percent of Denials
96	Non-covered charge(s).	25,937	20.81%
16	Claim/service lacks information or has submission/billing error(s).	13,371	10.73%
197	Precertification/authorization/notification/pre-treatment absent.	12,194	9.78%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	11,411	9.15%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	8,932	7.17%
29	The time limit for filing has expired.	7,006	5.62%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	6,946	5.57%
A1	Claim/Service denied.	5,478	4.39%
18	Exact duplicate claim/service	3,287	2.64%
204	This service/equipment/drug is not covered under the patient's current benefit plan	3,272	2.62%
	Total Denials (Duplicative)	**124,649**	

Table 9B. Top 10 CARC Denials 2018 Quarter 2

CARC Code	Description	Total Denials	Percent of Denials
96	Non-covered charge(s).	27,167	15.96%
16	Claim/service lacks information or has submission/billing error(s).	23,513	13.81%
197	Precertification/authorization/notification/pre-treatment absent.	20,676	12.15%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	15,075	8.86%
29	The time limit for filing has expired.	13,322	7.83%
A1	Claim/Service denied.	13,119	7.71%
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	7,828	4.60%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	6,868	4.03%
204	This service/equipment/drug is not covered under the patient's current benefit plan	4,103	2.41%
18	Exact duplicate claim/service	4,088	2.40%
	Total Denials (Duplicative)	**170,230**	

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.) and suggests that providers may not have been completely familiar with plan billing requirements upon the implementation of HCI.

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 for Q2. 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. RARC Denials 2018 Quarter 1

RARC Code	Description	Total Denials	Percent of Denials
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	18,058	19.83%
(None/ Invalid code reported by MCO)	(None / Invalid code reported by MCO)	12,827	14.08%
M20	Missing/incomplete/invalid HCPCS.	8,963	9.84%
N381	Alert:Consult our contractual agreement for restrictions/billing/payment information related to these charges.	7,206	7.91%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	7,076	7.77%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	4,706	5.17%
M51	Missing/incomplete/invalid procedure code(s).	3,838	4.21%
M50	Missing/incomplete/invalid revenue code(s).	2,351	2.58%
M86	Service denied because payment already made for same/similar procedure within set time frame.	2,049	2.25%
N479	Missing Explanation of Benefits	1,976	
	Total Denials (Duplicative)	**91,086**	

Table 10B. Top 10 RARC Denials 2018 Quarter 2

RARC Code	Description	Total Denials For RARC	Percent of Denials
(None/Invalid code reported by MCO)	(None/Invalid code reported by MCO)	39,491	28.73%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	15,638	11.38%
M51	Missing/incomplete/invalid procedure code(s).	13,794	10.03%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	9,348	6.80%
N381	Alert:Consult our contractual agreement for restrictions/billing/payment information related to these charges.	8,405	6.11%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	5,626	4.09%
M20	Missing/incomplete/invalid HCPCS.	5,347	3.89%
M50	Missing/incomplete/invalid revenue code(s).	3,893	2.83%
M67	Missing/incomplete/invalid other procedure code(s).	3,476	2.53%
MA36	Missing/incomplete/invalid patient name.	2,729	1.99%
	Total Denials (Duplicative)	**137,468**	

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 14% in Q1 and almost 29% in Q2 of denials being attributed to "None / Invalid Code" used by MCOs.

Conclusion

From an operational perspective, hospital claiming to MCOs can be qualified as ***efficient***. This is supported by the 83% clearance rate of hospital claims reported against over $500M in payables in Q1 that held nearly constant (82.5%) in Q2 against $780M in payables, as HFS' managed care system experienced a significant expansion across all of Illinois. Additionally, over 95% of hospital claims as demonstrated in Q1 and Q2 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 30 days of claims submission****, su*pported by over 88% of claims in Q1 and 92% of claims in Q2 being adjudicated within 30 days of submission from a provider. These were followed by over 79% in Q1 and 87% in Q2 of adjudicated claims resulting in actual payment to providers within 30 days. In totality, just over 82% in Q1 and over 88.5% in Q2 of 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 30% of claims in Q1 and just under 20% of claims in Q2 would be eligible for interest from MCOs, as they were not adjudicated and paid to the provider within 30 days of submission.

This report collected CARCs and RARCs in an attempt to bring consistency between all plans. However, each plan's use of CARCs and RARCs has its own nuances. While the level of detail in this second report has been improved, future reports should develop a crosswalk methodology to better understand how each plan utilizes CARCs and RARCs, as well as any unique MCO coding methodology. In addition, a large number of rejections occur at the clearinghouse level (front end) and not within the MCO claiming systems. As a result, some of the rejection data could have been interpreted differently by each MCO. The impact of front end clearinghouse processing could be significant, as it requires some providers to manage rejections via various **acceptance reports**[i] **o**r **claims status reports**, in addition to standardized remittance advice.

<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:

1. Centralized Clearinghouse. HFS is in process of contracting with a centralized clearinghouse to support the submission of all claims to all MCOs, improving the Department's ability to know why provider claims are rejected, denied, or approved, and why any adverse decisions may be occurring. HFS anticipates that the clearinghouse will become operational as early as the spring of 2020.
2. Bi-weekly Provider Meetings. 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.

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.