



Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q3 and Q4 of CY 2023



Illinois Department of
Healthcare and Family Services

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Introduction

Section 5-30.1 of Public Act 100-0580¹ 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 the timeliness of claims adjudication (focusing upon 30, 60, 90, and 90+ day timeframes). This report is being posted according to Public Act 100-0580.

Date Span of Data

The data provided in this report covers Quarter 3 (Q3, or the dates July 1, 2023 through September 30, 2023) and Quarter 4 (Q4, or the dates October 1, 2023 through December 31, 2023) of calendar year 2023.

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 as a 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 hospitals.
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 because 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 the end of September 2024.

All data in this report is self-reported by the MCOs. While the OMI seeks to provide data in the most accurate manner possible, data integrity errors may exist 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 claim 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. 2023 Q3				
2023 Q3	Unique Service Count	% Of Services	Charges billed	Amount Paid
Unique Services Submitted	1,775,365	100.00%	\$ 11,240,169,000.00	\$ 1,525,021,000.00
Payable/Paid Unique Services	1,618,220	91.15%	\$ 9,749,828,000.00	\$ 1,525,021,000.00
Rejected Unique Services	11,785	0.66%	\$ 95,443,000.00	
Denied Unique Services	145,360	8.19%	\$ 1,394,898,000.00	
Total Non-Payable (Denied + Rejected)	157,145	8.93%	\$ 22,480,338,000.00	
Table 1B. Unique Services. 2023 Q4				
2023 Q4	Unique Service Count	% Of Services	Charges billed	Amount Paid
Unique Services Submitted	1,760,672	100.00%	\$ 10,930,703,000.00	\$ 1,504,166,000.00
Payable/Paid Unique Services	1,622,854	92.17%	\$ 9,549,129,000.00	\$ 1,504,166,000.00
Rejected Unique Services	12,646	0.72%	\$ 106,028,000.00	
Denied Unique Services	125,172	7.11%	\$ 1,275,547,000.00	
Total Non-Payable (Denied + Rejected)	137,818	7.83%	\$ 21,861,407,000.00	

Roughly 8%-9% of unique services submitted for 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 2023 Quarter 3			
2023 Q3	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,578,353	96.33%	\$ 1,445,912,000.00
2nd Submission	55,959	3.42%	\$ 84,964,000.00
3rd Submission	3,546	0.22%	\$ 13,053,000.00
4th Submission	520	0.03%	\$ 1,152,000.00
5th or More Submission	168	0.01%	\$ 379,000.00
Total	1,638,545	100.00%	\$ 1,545,460,000.00
Table 2B. Number of Submissions Before Positive Adjudication 2023 Quarter 4			
2023 Q4	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,593,493	97.05%	\$ 1,446,779,000.00
2nd Submission	45,921	2.80%	\$ 82,309,000.00
3rd Submission	2,143	0.13%	\$ 8,976,000.00
4th Submission	317	0.02%	\$ 989,000.00
5th or More Submission	82	0.00%	\$ 181,000.00
Total	1,641,955	100.00%	\$ 1,539,234,000.00

In both Quarter 3 and Quarter 4, approximately 97% of claims were paid on the first submission, which is in line with most historical data for this table. It shows that the current state of hospital claiming, across the MCOs, is efficient. Note: by efficient, it means 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 2023 Quarter 3						
2023 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	1,773,470	96.27%	1,582,627	\$ 1,426,592,000.00	190,843	\$ 1,519,039,000.00
Total Claims Adjudicated in 31-60 days	24,231	1.32%	18,071	\$ 66,202,000.00	6,160	\$ 108,055,000.00
Total Claims Adjudicated in 61-90 days	8,295	0.45%	5,815	\$ 13,141,000.00	2,480	\$ 44,043,000.00
Total Claims Adjudicated in 91+ days	36,130	1.96%	32,036	\$ 39,545,000.00	4,094	\$ 65,287,000.00
Total Claims Awaiting Adjudication	104					
Total Claims Adjudicated for DOS for Reporting Period	1,842,126	100.00%	1,638,549	\$ 1,545,481,000.00	203,577	\$ 1,736,424,000.00
* Non-Payable means rejected or denied.						

Table 3B. Days for Claims to be Adjudicated 2023 Quarter 4						
2023 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	1,752,577	97.29%	1,603,443	\$ 1,402,385,000.00	149,134	\$ 1,397,817,000.00
Total Claims Adjudicated in 31-60 days	15,741	0.87%	10,952	\$ 80,631,000.00	4,789	\$ 99,934,000.00
Total Claims Adjudicated in 61-90 days	13,275	0.74%	10,744	\$ 25,795,000.00	2,531	\$ 42,760,000.00
Total Claims Adjudicated in 91+ days	19,808	1.10%	16,817	\$ 30,431,000.00	2,991	\$ 48,930,000.00
Total Claims Awaiting Adjudication	166					
Total Claims Adjudicated for DOS for Reporting Period	1,801,401	100.00%	1,641,956	\$ 1,539,242,000.00	159,445	\$ 1,589,441,000.00
* Non-Payable means rejected or denied.						

The data shows that approximately 97% of claims were adjudicated within 30 days for both Q3 and Q4. These numbers are consistent with historical experience.

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 2023 Quarter 3			
2023 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)	1,535,741	93.73%	\$ 1,427,379,000.00
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	100,973	6.16%	\$ 104,430,000.00
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	1,526	0.09%	\$ 7,636,000.00
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	126	0.01%	\$ 201,000.00
Total Payments Pending to Provider Following Positive Adjudication	183		\$ 5,834,000.00
Total Payments Following Positive Adjudication (Doesn't include pending)	1,638,549	100.00%	\$ 1,545,480,000.00

Data for Quarter 4 is shown on the following page.

Table 4B. Time from Adjudication to Payment 2023 Quarter 4			
2023 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)	1,480,581	90.17%	\$ 1,369,746,000.00
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	132,644	8.08%	\$ 100,095,000.00
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	28,035	1.71%	\$ 65,628,000.00
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	197	0.01%	\$ 700,000.00
Total Payments Pending to Provider Following Positive Adjudication	499		\$ 3,073,000.00
Total Payments Following Positive Adjudication (Doesn't include pending)	1,641,956	100.00%	\$ 1,539,242,000.00

Table 4A shows that approximately 94% of claims were paid to providers within 30 days of adjudication, with a drop to approximately 90% in Table 4B. As in the previous report, most MCOs paid virtually all their claims within 30 days of adjudication. One MCO's performance caused the drop in the overall average. The Department has conducted discussions with this MCO and determined that although the MCO did demonstrate improvements in this metric during the reporting period, the results were still below the performance of the other MCOs. As such, the Department will continue to monitor their performance to ensure improvements are continuing and that the MCO is rising up to or exceeding the performance level of the other MCOs.

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 2023 Quarter 3			
2023 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)	1,457,761	88.97%	\$ 1,222,833,000.00
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	140,309	8.56%	\$ 252,643,000.00
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	7,999	0.49%	\$ 24,011,000.00
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	32,297	1.97%	\$ 40,160,000.00
Total Payments Pending to Provider Following Positive Adjudication	183	0.01%	\$ 5,834,000.00
Total (Not including Pending)	1,638,549	100.00%	\$ 1,545,481,000.00

Data for Q4 is shown on the next page.

Table 5B. Time from Submission to Payment 2023 Quarter 4			
2023 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)	1,429,452	87.06%	\$ 1,184,606,000.00
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	149,807	9.12%	\$ 186,885,000.00
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	45,065	2.74%	\$ 132,950,000.00
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	17,108	1.04%	\$ 31,715,000.00
Total Payments Pending to Provider Following Positive Adjudication	524		\$ 3,086,000.00
Total (Not including Pending)	1,641,956	100.00%	\$ 1,539,242,000.00

Table 5A shows that about 89% of claims in Q3 were paid within 30 days of submission of the claim, with Table 5B showing a drop to about 87%. As with Tables 4A and 4B, the drop in performance was due to one MCO, with the rest of the MCOs paying 93% or more of claims within 30 days. This MCO did demonstrate improvement during the reporting period, but the overall results were not at the level of the other MCOs. As such, MCO payment experience in future Quarters will continue to be monitored by the Department.

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

Claim Adjustment Reason Code (CARC) Rejections

To gain a 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 2023 Quarter 3			
CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
18	Exact duplicate claim/service	2,959	14.91%
N/A	(None/Invalid code reported by MCO)	2,742	13.82%
16	Claim/service lacks information or has submission/billing error(s).	2,619	13.20%
27	Expenses incurred after coverage terminated.	2,145	10.81%
31	Patient cannot be identified as our insured.	1,958	9.87%
96	Non-covered charge(s).	1,109	5.59%
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.	1,097	5.53%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	999	5.04%
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	850	4.28%
140	Patient/Insured health identification number and name do not match.	632	3.19%
	Total Rejections (Duplicative)	19,841	

Table 6B. Top 10 CARC Rejections 2023 Quarter 4

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
18	Exact duplicate claim/service	3,573	16.59%
N/A	(None/Invalid code reported by MCO)	2,821	13.10%
16	Claim/service lacks information or has submission/billing error(s).	2,460	11.42%
27	Expenses incurred after coverage terminated.	2,328	10.81%
31	Patient cannot be identified as our insured.	1,997	9.27%
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.	1,958	9.09%
96	Non-covered charge(s).	1,366	6.34%
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	1,020	4.74%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	738	3.43%
197	Precertification/authorization/notification/pre-treatment absent.	719	3.34%
	Total Rejections (Duplicative)	21,535	

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 a 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 2023 Quarter 3			
RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
N/A	(None/Invalid code reported by MCO)	2,602	24.58%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	2,368	22.37%
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	2,338	22.09%
M56	Missing/incomplete/invalid payer identifier.	1,274	12.03%
N329	Missing/incomplete/invalid patient birth date.	1,014	9.58%
N351	Service date outside of the approved treatment plan service dates.	107	1.01%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	94	0.89%
M76	Missing/incomplete/invalid diagnosis or condition.	77	0.73%
N822	Missing procedure modifier(s).	74	0.70%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	69	0.65%
	Total Rejections (Duplicative)	10,586	

Table 7B. Top 10 RARC Rejections 2023 Quarter 4			
RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	3,168	26.09%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	3,151	25.95%
N/A	(None/Invalid code reported by MCO)	2,604	21.44%
M56	Missing/incomplete/invalid payer identifier.	1,301	10.71%
N329	Missing/incomplete/invalid patient birth date.	923	7.60%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	125	1.03%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	114	0.94%
N351	Service date outside of the approved treatment plan service dates.	103	0.85%
N822	Missing procedure modifier(s).	88	0.72%
N640	Exceeds number/frequency approved/allowed within period.	73	0.60%
	Total Rejections (Duplicative)	12,143	

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 issues, 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 2023 Quarter 3		
Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	10,161	7.32%
Additional Information	41,356	29.80%
Authorization	15,331	11.05%
Benefit / Covered Service	53,278	38.38%
Medical Necessity	572	0.41%
Pre-Certification	8,848	6.37%
Provider	9,254	6.67%
Total Denials	138,800	100.00%

Note: Data for Quarter 4 is shown on the next page.

Table 8B. HFS Denial Reasons 2023 Quarter 4		
Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	3,916	3.69%
Additional Information	37,473	35.29%
Authorization	15,160	14.28%
Benefit / Covered Service	36,551	34.42%
Medical Necessity	327	0.31%
Pre-Certification	5,304	5.00%
Provider	7,453	7.02%
Total Denials	106,184	100.00%

Across quarters Q3 and Q4, “Additional Information” and “Benefit/Covered Service” continue to be the primary denial reasons followed by issues related to “Authorization.” Medical Necessity” of services continues to be a non-factor concerning denials, for services that do not require prior authorization or additional information.

Claim Adjustment Reason Code (CARC) Denials

To gain a 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 2023 Quarter 3			
CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
16	Claim/service lacks information or has submission/billing error(s).	22,826	13.67%
197	Precertification/authorization/notification/pre-treatment absent.	21,372	12.80%
129	Prior processing information appears incorrect.	17,965	10.76%
N/A	(None/Invalid code reported by MCO)	14,109	8.45%
96	Non-covered charge(s).	11,184	6.70%
22	This care may be covered by another payer per coordination of benefits.	9,218	5.52%
29	The time limit for filing has expired.	9,055	5.42%
A1	Claim/Service denied.	8,932	5.35%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	8,502	5.09%
18	Exact duplicate claim/service	7,364	4.41%
	Total Denials (Duplicative)	167,027	

Table 9B. Top 10 CARC Denials 2023 Quarter 4			
CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
197	Precertification/authorization/notification/pre-treatment absent.	17,395	13.46%
129	Prior processing information appears incorrect.	14,911	11.54%
N/A	(None/Invalid code reported by MCO)	12,754	9.87%
A1	Claim/Service denied.	9,406	7.28%
96	Non-covered charge(s).	9,387	7.26%
22	This care may be covered by another payer per coordination of benefits.	9,019	6.98%
16	Claim/service lacks information or has submission/billing error(s).	8,176	6.33%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	7,012	5.42%
18	Exact duplicate claim/service	6,877	5.32%
208	National Provider Identifier - Not matched.	4,139	3.20%
	Total Denials (Duplicative)	129,258	

Overall, the CARC denial detail in Tables 9A and 9B complements and expands 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 that providers are struggling to meet by plan requirements (precertification, benefit covered in another service, the time limit for filing has expired, charge exceeding fee schedule, service not covered, etc.).

Remittance Advice Remark Code (RARC) Denials

To gain a 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 2023 Quarter 3			
RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	15,266	15.86%
N64	The 'from' and 'to' dates must be different.	14,519	15.09%
N/A	(None/Invalid code reported by MCO)	9,660	10.04%
N4	Missing/Incomplete/Invalid Prior Insurance Carrier(s) EOB.	7,008	7.28%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	6,466	6.72%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	5,547	5.76%
MA04	Secondary payment cannot be considered without the identity or payment information from the primary payer. The information was either not reported or was illegible.	4,640	4.82%
M62	Missing/incomplete/invalid treatment authorization code.	4,060	4.22%
N216	We do not offer coverage for this type of service, or the patient is not enrolled in this portion of our benefit package.	2,797	2.91%
MA36	Missing/incomplete/invalid patient name.	1,890	1.96%
	Total Denials (Duplicative)	96,243	

Table 10B. Top 10 RARC Denials 2023 Quarter 4			
RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N/A	(None/Invalid code reported by MCO)	20,631	21.83%
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	12,681	13.41%
N4	Missing/Incomplete/Invalid Prior Insurance Carrier(s) EOB.	6,512	6.89%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	6,174	6.53%
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	5,394	5.71%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	4,545	4.81%
MA04	Secondary payment cannot be considered without the identity or payment information from the primary payer. The information was either not reported or was illegible.	4,220	4.46%
N216	We do not offer coverage for this type of service, or the patient is not enrolled in this portion of our benefit package.	3,060	3.24%
N253	Missing/incomplete/invalid attending provider primary identifier.	2,762	2.92%
N286	Missing/incomplete/invalid referring provider primary identifier.	1,856	1.96%
	Total Denials (Duplicative)	94,529	

The data in Tables 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 between 20% and 40% of claims in Q3 and Q4 being attributed to the “None / Invalid Code” used by MCOs.

Conclusion

There was a 91.2% clearance rate of hospital claims reported against \$1,525M in payable claims in Q3. The clearance rate in Q4 held steady at 92.2% against \$1,504M in payables. Additionally, approximately 97% of hospital service claims in Q3 and Q4 were adjudicated by HFS' MCOs upon first submission (another strong metric of efficiency).

From a financial perspective, hospitals claims from MCOs can be qualified as ***generally paying hospitals within 60 days of claims submission***. This characterization is supported by approximately 98% of claims in Q3 and Q4 being adjudicated within 60 days of submission from a provider. This was followed by approximately 94% of adjudicated claims in Q3 being paid to providers within 30 days of adjudication, and in 90% of adjudicated claims being paid within 30 days of adjudication in Q4. This drop was due to the performance of one MCO; however, the overall rate is still high. The Department will continue to monitor this MCOs performance improvement activities to ensure its outcomes are rising up to or exceeding the performance level of the other MCOs. In totality, for Q3 and Q4 2023, most payable claims are adjudicated and paid to providers within 60 days of submission (96.2%-97.5%). Finally, it should be noted that by the 30-day standard, under 305 ILCS 5/5-30.1. Managed Care Protections, sub-section (g), about 11% of claims in Q3 and 13% 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 nuances. While the inclusion of CARCs and RARCs provides additional details, a crosswalk between plans would provide a better understanding of each plan's payment processes.

Office of Medicaid Innovation

This report was prepared by the Office of Medicaid Innovation (OMI) at the request of the 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 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 issues, 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 twthat 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 a 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 the Provider works with the 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, are 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 an MCO that has been adjudicated, resulting in reimbursement to the provider.

Payable Claim: A claim submitted by a provider to an 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 the 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 are 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 were 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 codes, value codes, occurrence codes, modifier codes, billed units, covered days, invalid recipient IDs, 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.