Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q3 and Q4 of CY 2020

Illinois Department of Healthcare and Family Services

JB Pritzker, Governor
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Introduction

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

Date Span of Data

The data provided in this report covers Quarter 3 (Q3), or the dates July 1, 2020 through September 30, 2020, and Quarter 4 (Q4), or the dates October 1, 2020 through December 31, 2020, of calendar year 2020.

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 Billed. Billed charges may be significantly higher than the allowable payments negotiated between payers and hospital.
3. Reimbursements detailed in this report do not include all payments made to hospitals under the Illinois Medicaid Program, as it excludes both fee-for-service payments made by HFS and other payments made as a result of the hospital assessment program.

Data Collection Process

The data for this report was collected via Microsoft Excel in a standardized spreadsheet format established by the OMI. The spreadsheet format was disseminated by HFS on behalf of the OMI in early October 2021 to all MCOs, and the data was submitted by the MCOs by October 18, 2021.

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

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

Section 1. General Data

Unique Services and Denial Rate

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

Table 1A. Unique Services. 2020 Q3

2020 Q3	Unique Service Count	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,477,146	100.00%	$8,014,089,000	$1,018,475,000
Payable/Paid Unique Services	1,274,995	86.31%	$6,230,882,000	$1,018,475,000
Rejected Unique Services	77,461	5.24%	$484,125,000	
Denied Unique Services	124,720	8.44%	$1,299,081,000	
Total Non-Payable (Denied + Rejected)	202,181	13.68%	$1,783,206,000	

Table 1B. Unique Services. 2020 Q4

2020 Q4	Unique Service Count	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,811,457	100.00%	$7,954,792,000	$1,247,266,000
Payable/Paid Unique Services	1,511,365	83.43%	$5,795,524,000	$1,247,266,000
Rejected Unique Services	115,130	6.36%	$444,581,000	
Denied Unique Services	184,962	10.21%	$1,714,687,000	
Total Non-Payable (Denied + Rejected)	300,092	16.56%	$2,159,268,000	

13.7% and 16.6% 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 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 2020, Quarter 3

2020 Q3	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,239,005	93.62%	$969,468,000
2nd Submission	75,494	5.70%	$77,250,000
3rd Submission	8,023	0.61%	$16,432,000
4th Submission	574	0.04%	$1,832,000
5th or More Submission	295	0.02%	$858,000
Total	1,323,391	100.00%	$1,065,840,000

Table 2B. Number of Submissions Before Positive Adjudication 2020, Quarter 4

2020 Q4	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,236,373	94.36%	$890,739,000
2nd Submission	64,110	4.89%	$86,285,000
3rd Submission	6,997	0.53%	$14,838,000
4th Submission	535	0.04%	$1,904,000
5th or More Submission	2,216	0.17%	$995,000
Total	1,310,231	100.00%	$994,762,000

With approximately 6% 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
2020 Quarter 3

2020 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	1,496,154	97.55%	1,275,057	$999,524,000	221,097	$1,603,587,000
Total Claims Adjudicated in 31-60 days	19,113	1.25%	15,072	$35,238,000	4,041	$78,923,000
Total Claims Adjudicated in 61-90 days	6,415	0.42%	4,210	$5,122,000	2,205	$30,161,000
Total Claims Adjudicated in 91+ days	12,035	0.78%	8,416	$8,727,000	3,619	$24,208,000
Total Claims Awaiting Adjudication	1,987					
Total Claims Adjudicated For DOS For Reporting Period	1,533,754	100.00%	1,302,755	$1,048,611,000	230,962	$1,736,879,000

* Non-Payable means rejected or denied.

Table 3B. Days for Claims to be Adjudicated 2020 Quarter 4						
2020 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	1,505,888	1	1,284,047	$975,086,000	221,840	$1,851,586,000
Total Claims Adjudicated in 31-60 days	12,298	0	8,904	$40,868,000	3,394	$73,585,000
Total Claims Adjudicated in 61-90 days	4,475	0	2,768	$6,490,000	1,707	$12,659,000
Total Claims Adjudicated in 91+ days	6,806	0	5,193	$35,878,000	1,613	$16,441,000
Total Claims Awaiting Adjudication	6,430					
Total Claims Adjudicated For DOS For Reporting Period	1,529,560	1	1,300,912	$1,058,321,000	228,554	$1,954,271,000
* Non-Payable means rejected or denied.						

The vast majority of hospital claims were adjudicated within 30 days, with approximately 98% of claims 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
2020 Quarter 3

2020 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)	1,199,732	90.66%	$916,356,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	16,654	1.26%	$29,679,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	49,129	3.71%	$81,663,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	57,755	4.36%	$38,079,000
Total Payments Pending to Provider Following Positive Adjudication	121	0.01%	$67,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,323,730	100.00%	$1,065,777,000

Table 4B. Time from Adjudication to Payment
2020 Quarter 4

2020 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)	1,178,513	89.96%	$851,442,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	31,604	2.41%	$65,314,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	84,182	6.43%	$62,171,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	15,687	1.20%	$15,794,000
Total Payments Pending to Provider Following Positive Adjudication	165	NA	$41,000

Total Payments Following Positive Adjudication (Doesn't include pending)	1,309,986	100.00%	$994,721,000

Table 4 demonstrates that approximately 90% of payments to hospitals from MCOs were made within 30 days of claims adjudication for both Q3 and Q4.

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 2020 Quarter 3

2020 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)	1,131,747	85.53%	$793,310,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	39,913	3.02%	$98,732,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	51,042	3.86%	$69,903,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	100,568	7.60%	$103,832,000
Total Payments Pending to Provider Following Positive Adjudication	121	NA	$67,000
Total (Not including Pending)	1,323,270	100.00%	$1,065,777,000

Table 5B. Time from Submission to Payment 2020 Quarter 4

2020 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)	1,123,463	85.76%	$710,204,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	46,784	3.57%	$124,528,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	100,679	7.69%	$104,240,000

Timeframe of Payment to Provider Following Submission of Claim (91+ days)	39,060	2.98%	$55,749,000
Total Payments Pending to Provider Following Positive Adjudication	165	NA	$41,000
Total (Not including Pending)	1,309,986	100.00%	$994,721,000

Table 5 demonstrates that in both Q3 and Q4about 88% 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 2020 Quarter 3

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
N/A	(None/Invalid code reported by MCO)	35,925	42.21%
96	Non-covered charge(s).	11,040	12.97%
18	Exact duplicate claim/service	6,276	7.37%
27	Expenses incurred after coverage terminated.	5,730	6.73%
16	Claim/service lacks information or has submission/billing error(s).	4,354	5.12%
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	2,995	3.52%
31	Patient cannot be identified as our insured.	2,938	3.45%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	2,644	3.11%
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1,508	1.77%

181	Procedure code was invalid on the date of service.	1,333	1.57%
	Total Rejections (Duplicative)	85,104	

Table 6B. Top 10 CARC Rejections 2020 Quarter 4

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
N/A	(None/Invalid code reported by MCO)	39,633	45.64%
96	Non-covered charge(s).	6,600	7.60%
18	Exact duplicate claim/service	6,271	7.22%
31	Patient cannot be identified as our insured.	5,167	5.95%
27	Expenses incurred after coverage terminated.	5,098	5.87%
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	4,251	4.90%
16	Claim/service lacks information or has submission/billing error(s).	4,085	4.70%
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam.	2,479	2.85%
22	This care may be covered by another payer per coordination of benefits.	2,370	2.73%
133	The disposition of this service line is pending further review	2,093	2.41%
	Total Rejections (Duplicative)	86,831	

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

Remittance Advice Remark Code (RARC) Rejections

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

Table 7A. Top 10 RARC Rejections 2020 Quarter 3

RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
N/A	(None/Invalid code reported by MCO)	35985	52.03%

M86	Service denied because payment already made for same/similar procedure within set time frame.	11751	16.99%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	6282	9.08%
N30	Patient ineligible for this service.	2727	3.94%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	2690	3.89%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1898	2.74%
N329	Missing/incomplete/invalid patient birth date.	902	1.30%
N238	Incomplete/invalid physician certified plan of care.	811	1.17%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	523	0.76%
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification.	487	0.70%
	Total Rejections (Duplicative)	69,164	

Table 7B. Top 10 RARC Rejections 2020 Quarter 4

RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
N/A	(None/Invalid code reported by MCO)	40021	58.64%
M86	Service denied because payment already made for same/similar procedure within set time frame.	6637	9.72%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	6258	9.17%
N30	Patient ineligible for this service.	3673	5.38%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	3144	4.61%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1530	2.24%
M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	784	1.15%
N329	Missing/incomplete/invalid patient birth date.	633	0.93%
N962	The number of Days or Units of Service exceeds our acceptable maximum.	369	0.54%
M20	Missing/incomplete/invalid HCPCS.	330	0.48%
	Total Rejections (Duplicative)	68,251	

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
2020 Quarter 3

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	7,259	5.72%
Additional Information	34,213	26.97%
Authorization	15,105	11.91%
Benefit / Covered Service	40,174	31.66%
Medical Necessity	612	0.48%
Pre-Certification	1,127	0.89%
Provider	28,383	22.37%
Total Denials	126,873	

Table 8B. HFS Denial Reasons
2020 Quarter 4

Denial Reason	# Claims Denied	Percent of Claims Denied
Timely Filing	4,960	6.07%
Additional Information	37,946	28.60%
Authorization	14,738	12.63%

Benefit / Covered Service	30,100	33.59%
Medical Necessity	388	0.51%
Pre-Certification	1,190	0.94%
Provider	13,190	23.73%
Total Denials	102,512	

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

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 2020 Quarter 3

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
96	Non-covered charge(s).	38,036	18.84%
N/A	(None/Invalid code reported by MCO)	27,205	13.47%
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	19,635	9.72%
16	Claim/service lacks information or has submission/billing error(s).	12,394	6.14%
197	Precertification/authorization/notification/pre-treatment absent.	12,348	6.11%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	11,597	5.74%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	9,229	4.57%
29	The time limit for filing has expired.	7,031	3.48%
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	6,694	3.31%
204	This service/equipment/drug is not covered under the patient's current benefit plan	5,492	2.72%
	Total Denials (Duplicative)	201,934	

Table 9B. Top 10 CARC Denials 2020 Quarter 4			
CARC Code	**CARC Code Description**	**Total Claims denied**	**Percent of Claims Denied**
96	Non-covered charge(s).	33,381	18.59%
N/A	(None/Invalid code reported by MCO)	27,138	15.11%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	14,665	8.17%
197	Precertification/authorization/notification/pre-treatment absent	12,666	7.05%
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	10,085	5.62%
16	Claim/service lacks information or has submission/billing errors	9,379	5.22%
23	The impact of prior payer(s) adjudication including payments and/or adjustments	6,866	3.82%
18	Exact duplicate claim/service	5,213	2.90%
29	The time limit for filing has expired.	4,793	2.67%
22	This care may be covered by another payer per coordination of benefits.	4,672	2.60%
	Total Denials (Duplicative)	179,548	

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 2020 Quarter 3			
RARC Code	**Description**	**Total Claims Denied**	**Percent of Claims Denied**
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	34,820	23.41%
N/A	(None/Invalid code reported by MCO)	23,927	16.09%
N238	Incomplete/invalid physician certified plan of care.	19,629	13.20%
M51	Missing/incomplete/invalid procedure code(s).	11,336	7.62%

N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	5,668	3.81%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	5,195	3.49%
M50	Missing/incomplete/invalid revenue code(s).	3,619	2.43%
N479	Missing Explanation of Benefits	3,396	2.28%
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	3,217	2.16%
N30	Patient ineligible for this service.	2,840	1.91%
	Total Denials (Duplicative)	148,716	

Table 10B. Top 10 RARC Denials 2020 Quarter 4

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N/A	(None/Invalid code reported by MCO)	31,446	26.58%
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	30,144	25.48%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	4,276	3.61%
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	4,220	3.57%
M50	Missing/incomplete/invalid revenue code(s).	3,928	3.32%
N238	Incomplete/invalid physician certified plan of care.	3,368	2.85%
N479	Missing Explanation of Benefits	2,704	2.29%
M86	Service denied because payment already made for same/similar procedure within set time frame.	2,687	2.27%
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	2,639	2.23%
M51	Missing/incomplete/invalid procedure code(s).	2,322	1.96%
	Total Denials (Duplicative)	118,286	

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 86.3% clearance rate of hospital claims reported against over $1,019 M in payable claims in Q3 that declined to 83.4%) in Q4 against $1,247M in payables. Additionally, approximately 94% of hospital services in Q3 and also 94% in Q4 are being adjudicated by HFS' MCOs upon first submission, another strong metric of efficiency. Note that these numbers are down slightly compared to Q1 and Q2 of 2020.

From a financial perspective, hospital claiming from MCOs can be qualified as ***generally paying hospitals within 60 days of claims submission***. This characterization is supported by approximately 98% of claims in Q3 and 98% of claims in Q4 being adjudicated within 30 days of submission from a provider. These were followed by approximately 90% of adjudicated claims in both Q3 (90.7%) and Q4 of (90.0%) resulting in actual payment to providers within 30 days. In totality, approximately 88% of payable claims in Q3 and Q4 (88.5% and 88.5% respectively) 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), about 19% of claims in Q3 and also about 19% 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 in the prior 2 previous reports, it is noted that data from one health plan, CountyCare, is impacting the overall performance of MCOs regarding timely payment of claims. For Q3 and Q4 of 2020, 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 95.8% in Q3 and 96.1% in Q4, up from the actual percentages of 85.5% in Q3 and 85.8% in Q4. CountyCare's claims payment timeliness is unchanged compared to Q1 and Q2 of 2020. It continues to lag significantly behind the behind the performance of other MCOs.

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 legitimate denials by MCOs, and those that are improper rejections or denial by MCOs. As of December 2020, four of the 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 continues to conduct meetings between providers and MCOs to improve communications 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 were 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.

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Definitions

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

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

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

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

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

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

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

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

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

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

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

Rejected claims are:

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

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

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

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

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

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