Analysis of HFS-contracted MCO Claims Processing and Payment Performance

For services in Q1 and Q2 of CY 2024

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 1 (Q1, or the dates January 1, 2024, through March 31, 2024) and Quarter 2 (Q2, or the dates April 1 2024, through June 30, 2024) of calendar year 2024.

Data Inclusions and Exclusions

The data analyzed in this report focus solely on institutional hospital claims, or claims submitted via the 837I, or its paper variant (UB-04), by hospitals. This means that all other claim types, including professional claims submitted via 837P, or its paper variant (CMS-1500), by hospitals and all other providers, are not included in this report. Professional claims billed by hospitals were excluded as they are processed and often paid in a different manner than institutional claims, which makes aggregating the claims potentially misleading. In addition to these professional claims, adjustments were held back from this reporting period. Adjustments can complicate processing periods and reimbursement methodologies and can be triggered for various technical reasons; as such, it was determined that adjustments should be set aside until common ground in the data between plans could be established.

Representative Sample.

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

Notes.

1. All dollar values provided in this report have been rounded to the nearest thousand-dollar value.
2. Regarding Charges Billed – Hospitals independently develop the values submitted on their claim as Charges Billed. Billed charges may be significantly higher than the allowable payments negotiated between payers and the hospital.
3. Reimbursements detailed in this report do not include all payments made to hospitals under the Illinois Medicaid Program, as it excludes both fee-for-service payments made by HFS and other payments made as a result of the hospital assessment program.

Data Collection Process

The data for this report was collected via Microsoft Excel in a standardized spreadsheet format established by the OMI. The spreadsheet format was disseminated by HFS on behalf of the OMI to all MCOs, and the data was submitted by the MCOs by the end of February 2025.

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 1 and 2, respectively.

Table 1A. Unique Services. 2024 Q1

2024 Q1	Unique Service Count	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,815,630	100.00%	$ 11,665,916,000.00	$ 1,586,515,000.00
Payable/Paid Unique Services	1,627,801	89.65%	$ 9,932,362,000.00	$ 1,586,515,000.00
Rejected Unique Services	53,269	2.93%	$ 347,289,000.00	
Denied Unique Services	134,560	7.41%	$ 1,386,265,000.00	
Total Non-Payable (Denied + Rejected)	187,829	10.69%	$ 23,331,832,000.00	

Table 1B. Unique Services. 2024 Q2

2024 Q2	Unique Service Count	% of Services	Charges billed	Amount Paid
Unique Services Submitted	1,757,628	100.00%	$ 11,473,072,000.00	$ 1,629,475,000.00
Payable/Paid Unique Services	1,610,249	91.61%	$ 10,017,948,000.00	$ 1,629,475,000.00
Rejected Unique Services	24,313	1.38%	$ 199,231,000.00	
Denied Unique Services	123,066	7.00%	$ 1,255,893,000.00	
Total Non-Payable (Denied + Rejected)	147,379	8.39%	$ 22,946,144,000.00	

Roughly 8%-11% of unique services submitted for Q1 and Q2 were either rejected or denied.

Submissions Before Positive Adjudication

Table 2 focuses on efficiency in the claiming process. Providers can submit unpayable claims multiple times 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 2024 Quarter 1

2024 Q1	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,604,474	95.49%	$ 1,516,238,000.00
2nd Submission	71,241	4.24%	$ 121,773,000.00
3rd Submission	3,776	0.22%	$ 18,399,000.00
4th Submission	583	0.03%	$ 1,398,000.00
5th or More Submission	230	0.01%	$ 630,000.00
Total	1,680,304	100.00%	$ 1,658,438,000.00

Table 2 B. Number of Submissions Before Positive Adjudication 2024 Quarter 2

2024 Q2	Number of Claims	Percent of Claims	Net Liability
1st Submission	1,599,207	97.04%	$ 1,561,591,000.00
2nd Submission	43,600	2.65%	$ 94,364,000.00
3rd Submission	3,362	0.20%	$ 8,778,000.00
4th Submission	1,588	0.10%	$ 2,753,000.00
5th or More Submission	165	0.01%	$ 568,000.00
Total	1,647,922	100.00%	$ 1,668,054,000.00

In both Quarter 1 and Quarter 2, approximately 95% to 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 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
2024 Quarter 1

2024 Q1	Claims	% of Claims	# Of Payable/ Paid Claims	Net Liability	# Of Non-Payable *	Charges Billed for Non-Payable*
Total Claims Adjudicated in 0-30 days	1,838,480	97.51%	1,647,406	$1,489,653,000	191,074	$1,756,013,000
Total Claims Adjudicated in 31-60 days	15,737	0.83%	10,588	$65,698,000	5,149	$94,226,000
Total Claims Adjudicated in 61-90 days	9,039	0.48%	5,848	$22,172,000	3,191	$65,476,000
Total Claims Adjudicated in 91+ days	22,081	1.17%	16,471	$81,002,000	5,610	$110,880,000
Total Claims Awaiting Adjudication	5,950					
Total Claims Adjudicated for DOS for Reporting Period	1,885,337	100.00%	1,680,313	$1,658,525,000	205,024	$2,026,595,000

* Non-Payable means rejected or denied.

Table 3 B. Days for Claims to be Adjudicated 2024 Quarter 2						
2024 Q2	**Claims**	**% of Claims**	**# of Payable/ Paid Claims**	**Net Liability**	**# of Non-Payable***	**Charges Billed for Non-Payable***
Total Claims Adjudicated in 0-30 days	1,781,655	98.23%	1,626,885	$1,526,704,000	154,770	$1,436,782,000
Total Claims Adjudicated in 31-60 days	12,207	0.67%	7,780	$80,063,000	4,427	$103,746,000
Total Claims Adjudicated in 61-90 days	6,719	0.37%	4,174	$22,591,000	2,545	$60,271,000
Total Claims Adjudicated in 91+ days	13,194	0.73%	9,084	$38,742,000	4,110	$81,890,000
Total Claims Awaiting Adjudication	3,169					
Total Claims Adjudicated for DOS for Reporting Period	1,813,775	100.00%	1,647,923	$1,668,099,000	165,852	$1,682,689,000
* Non-Payable means rejected or denied.						

The data shows that approximately 97% to 98% of claims were adjudicated within 30 days for both Q1 and Q2. 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
2024 Quarter 1

2024 Q1	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)	1,619,688	96.39%	$ 1,612,319,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	54,045	3.22%	$ 39,138,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	5,054	0.30%	$ 2,931,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	1,318	0.08%	$ 727,000
Total Payments Pending to Provider Following Positive Adjudication	208		$ 3,411,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,680,313	100.00%	$ 1,658,526,000

Data for Quarter 2 is shown on the following page.

Table 4 B. Time from Adjudication to Payment 2024 Quarter 2			
2024 Q2	**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)	1,498,332	90.92%	$ 1,494,983,000
Timeframe of Payment to Provider Following Positive Adjudication (31-60 days)	82,452	5.00%	$ 128,384,000
Timeframe of Payment to Provider Following Positive Adjudication (61-90 days)	49,945	3.03%	$ 31,999,000
Timeframe of Payment to Provider Following Positive Adjudication (91+ days)	16,787	1.02%	$ 9,753,000
Total Payments Pending to Provider Following Positive Adjudication	407		$ 2,980,000
Total Payments Following Positive Adjudication (Doesn't include pending)	1,647,923	100.00%	$ 1,668,099,000

Table 4A shows that approximately 96% of claims were paid to providers within 30 days of adjudication, with a drop to approximately 90% in Table 4 B. As in the previous report, most MCOs paid virtually all of their claims within 30 days of adjudication, with one MCO being significantly slower and lowering the overall average. The Department will continue to monitor each MCOs performance in regards to this metric.

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 2024 Quarter 1			
2024 Q1	**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)	1,570,879	93.49%	$ 1,353,414,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	79,637	4.74%	$ 192,113,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	11,441	0.68%	$ 27,431,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	18,148	1.08%	$ 82,156,000
Total Payments Pending to Provider Following Positive Adjudication	208	0.01%	$ 3,411,000
Total (Not including Pending)	1,680,313	100.00%	$ 1,658,525,000

Data for Q2 is shown on the next page.

Table 5B. Time from Submission to Payment 2024 Quarter 2			
2024 Q2	**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)	1,471,867	89.32%	$ 1,305,975,000
Timeframe of Payment to Provider Following Submission of Claim (31-60 days)	93,178	5.65%	$ 245,605,000
Timeframe of Payment to Provider Following Submission of Claim (61-90 days)	53,910	3.27%	$ 62,857,000
Timeframe of Payment to Provider Following Submission of Claim (91+ days)	28,561	1.73%	$ 50,682,000
Total Payments Pending to Provider Following Positive Adjudication	407		$ 2,980,000
Total (Not including Pending)	1,647,923	100.00%	$ 1,668,099,000

Table 5A shows that about 93% of claims in Q1 were paid within 30 days of submission of the claim, with Table 5B showing a drop to about 89%. As with Tables 4A and 4B, the drop in performance was due to one MCO, with the rest of the MCOs paying 99% or more of claims within 30 days. Experience in future Quarters will continue to be monitored for future anomalies in the data.

Section 2. Rejections and Denials

Rejected Claims

A rejected claim is one in which the determination of payment cannot be made. These claims may enter the MCO's 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 resubmit 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 2024 Quarter 1

CARC Code	CARC Code Description	Total Claims	Percent of Claims Rejected
18	Exact duplicate claim/service	33,615	35.82%
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.	28,029	29.87%
N/A	(None/Invalid code reported by MCO)	6,916	7.37%
31	The patient cannot be identified as our insured.	4,553	4.85%
96	Non-covered charge(s).	4,381	4.67%
16	The claim/service lacks information or has submission/billing error(s).	3,904	4.16%
27	Expenses incurred after coverage terminated.	2,547	2.71%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	2,252	2.40%
26	Expenses incurred prior to coverage.	1,020	1.09%
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	862	0.92%
	Total Rejections (Duplicative)	**93,846**	

Table 6B. Top 10 CARC Rejections 2024 Quarter 2			
CARC Code	**CARC Code Description**	**Total Claims**	**Percent of Claims Rejected**
N/A	(None/Invalid code reported by MCO)	9,319	27.24%
18	Exact duplicate claim/service	7,159	20.92%
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.	3,197	9.34%
27	Expenses incurred after coverage terminated.	2,817	8.23%
16	The claim/service lacks information or has submission/billing error(s).	2,287	6.68%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	2,217	6.48%
31	The patient cannot be identified as our insured.	1,807	5.28%
272	Coverage/program guidelines were not met.	1,062	3.10%
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient-specific.	794	2.32%
26	Expenses incurred prior to coverage.	749	2.19%
	Total Rejections (Duplicative)	34,216	

Note. *While CARC and RARC codes are standardized, how 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 2024 Quarter 1

RARC Code	Code Description	Total Rejections	Percent of Claims Rejected
N111	No appeal right except for duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	32,903	40.41%
N130	Consult the plan benefit documents/guidelines for information about restrictions for this service.	30,844	37.88%
N/A	(None/Invalid code reported by MCO)	6,684	8.21%
N30	The patient is ineligible for this service.	3,567	4.38%
M56	Missing/incomplete/invalid payer identifier.	2,754	3.38%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	1,071	1.32%
N640	Exceeds the number/frequency approved/allowed within period.	959	1.18%
N329	Missing/incomplete/invalid patient birth date.	839	1.03%
N657	This should be billed with the appropriate code for these services.	264	0.32%
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	218	0.27%
	Total Rejections (Duplicative)	**81,430**	

Table 7B. Top 10 RARC Rejections 2024 Quarter 2			
RARC Code	**Code Description**	**Total Rejections**	**Percent of Claims Rejected**
N/A	(None/Invalid code reported by MCO)	8,632	32.43%
N111	No appeal right except for duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	6,856	25.76%
N130	Consult the plan benefit documents/guidelines for information about restrictions for this service.	3,728	14.01%
N30	The patient is ineligible for this service.	3,567	13.40%
M56	Missing/incomplete/invalid payer identifier.	1,361	5.11%
N640	Exceeds the number/frequency approved/allowed within period.	867	3.26%
N329	Missing/incomplete/invalid patient birth date.	769	2.89%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	160	0.60%
N351	Service date outside of the approved treatment plan service dates.	94	0.35%
N31	Missing/incomplete/invalid prescribing provider identifier.	87	0.33%
	Total Rejections (Duplicative)	**26,616**	

While the rejection reasons are varied, the data in the table demonstrates that most rejections are related to technical claiming issues (e.g., missing information, incomplete data, taxonomy issues, plan guideline issues, claim format, payee data, etc.).

Denied Claims

A denied claim is a claim submitted by a provider that is not rejected by the clearinghouse but is adversely adjudicated by an MCO based upon one of seven defined HFS denial reason codes. These claims are HIPAA compliant and are fully processed by the MCO claims system but may be denied for payment due to enforcement of payer-defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue, or other non-contracted provider-related issue.

Top Denial Reasons

Denial reasons were reported using CARCs and RARCs, as well as the seven HFS-approved denial codes. The seven denial code categories were created for MCOs to use when submitting encounter data to HFS. Table 8 focuses on denials grouped by denial reason code.

Table 8A. HFS Denial Reasons
2024 Quarter 1

Denial Reason	Number of Claims Denied	Percent of Claims Denied
Timely Filing	10,131	9.26%
Additional Information	41,326	37.76%
Authorization	10,838	9.90%
Benefit / Covered Service	34,937	31.92%
Medical Necessity	275	0.25%
Pre-Certification	4,519	4.13%
Provider	7,424	6.78%
Total Denials	109,450	100.00%

Note: Data for Quarter 2 is shown on the next page.

Table 8B. HFS Denial Reasons 2024 Quarter 2		
Denial Reason	**Number of Claims Denied**	**Percent of Claims Denied**
Timely Filing	5,124	5.01%
Additional Information	42,930	41.93%
Authorization	11,176	10.92%
Benefit / Covered Service	29,618	28.93%
Medical Necessity	201	0.20%
Pre-Certification	5,080	4.96%
Provider	8,245	8.05%
Total Denials	102,374	100.00%

Across quarters Q1 and Q2, “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 with respect to denials, for services that do not require prior authorization or additional information.

Claim Adjustment Reason Code (CARC) Denials

To gain common understanding across MCOs, hospital denials by CARCs were collected and measured for the first time. Though each of the plans may map and utilize CARCs in a slightly different manner, the top 10 CARC code denial reasons are provided in Table 9. As only the top 10 reasons are shown, the percentages do not equal 100%.

Table 9A. Top 10 CARC Denials 2024 Quarter 1

CARC Code	CARC Code Description	Total Claims Denied	Percent of Claims Denied
129	Prior processing information appears incorrect.	17,666	13.42%
N/A	(None/Invalid code reported by MCO)	12,854	9.76%
197	Precertification/authorization/notification/pre-treatment absent.	12,817	9.74%
16	The claim/service lacks information or has submission/billing error(s).	10,888	8.27%
96	Non-covered charge(s).	9,784	7.43%
29	The time limit for filing has expired.	9,185	6.98%
18	Exact duplicate claim/service	8,638	6.56%
A1	Claim/Service denied.	8,378	6.36%
22	This care may be covered by another payer per the coordination of benefits.	6,928	5.26%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	5,663	4.30%
	Total Denials (Duplicative)	**131,637**	

Table 9B. Top 10 CARC Denials 2024 Quarter 2			
CARC Code	**CARC Code Description**	**Total Claims denied**	**Percent of Claims Denied**
129	Prior processing information appears incorrect.	15,788	13.08%
18	Exact duplicate claim/service	13,552	11.22%
197	Precertification/authorization/notification/pre-treatment absent.	13,526	11.20%
N/A	(None/Invalid code reported by MCO)	11,278	9.34%
16	The claim/service lacks information or has submission/billing error(s).	9,492	7.86%
96	Non-covered charge(s).	8,101	6.71%
A1	Claim/Service denied.	7,361	6.10%
208	National Provider Identifier - Not matched.	6,347	5.26%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	5,349	4.43%
22	This care may be covered by another payer per the coordination of benefits.	4,956	4.10%
	Total Denials (Duplicative)	**120,743**	

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 (precertification, benefit covered in another service, time limit for filing has expired, charge exceeds fee schedule, service not covered, etc.) that providers are struggling to meet by plan requirements.

Remittance Advice Remark Code (RARC) Denials

In an effort 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 2024 Quarter 1

RARC Code	Description	Total Claims Denied	Percent of Claims Denied
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	18,797	19.13%
N111	No appeal right except for duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	14,798	15.06%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	7,882	8.02%
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	6,662	6.78%
N130	Consult the plan benefit documents/guidelines for information about restrictions for this service.	5,724	5.83%
N216	We do not offer coverage for this type of service, or the patient is not enrolled in this portion of our benefit package.	4,603	4.69%
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.	3,221	3.28%
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	3,106	3.16%
MA36	Missing/incomplete/invalid patient name.	2,276	2.32%
MA43	Missing/incomplete/invalid patient status.	1,998	2.03%
	Total Denials (Duplicative)	**98,237**	

Table 10B. Top 10 RARC Denials 2024 Quarter 2			
RARC Code	**Description**	**Total Claims Denied**	**Percent of Claims Denied**
N/A	(None/Invalid code reported by MCO)	15,915	17.63%
N199	Additional payment/recoupment approved based on payer-initiated review/audit.	13,333	14.77%
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	13,068	14.48%
N111	No appeal right except for duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	6,801	7.54%
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	4,173	4.62%
N216	We do not offer coverage for this type of service, or the patient is not enrolled in this portion of our benefit package.	2,770	3.07%
N19	Procedure code is incidental to the primary procedure.	2,505	2.78%
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	2,490	2.76%
N130	Consult the plan benefit documents/guidelines for information about restrictions for this service.	2,391	2.65%
N50	Missing/incomplete/invalid discharge information.	2,065	2.29%
	Total Denials (Duplicative)	**90,249**	

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 Q1 and Q2 being attributed to the “None / Invalid Code” used by MCOs.

Conclusion

There was an 89.7% clearance rate of hospital claims reported against $1,587M in payable claims in Q1. The clearance rate in Q2 increased to 91.6% against $1,629M in payables. Additionally, approximately 95% to 97% of hospital services claims in Q1 and Q2 were adjudicated by HFS' MCOs upon first submission (another strong metric of efficiency).

From a financial perspective, hospital 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 Q1 and Q2 being adjudicated within 60 days of submission from a provider. This was followed by approximately 96% of adjudicated claims in Q1 being paid to providers within 30 days of adjudication, and in 90% of adjudicated claims being paid within 30 days of adjudication in Q2. This drop was due to the performance of one MCO. The MCO's performance will continue to be monitored by program staff, but the overall rate is still high. In totality, for Q1 and Q2 2024, the vast majority of payable claims are adjudicated and paid to providers within 60 days of submission (98.2%-95%). 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 6% of claims in Q1 and 11% 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.

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 detail, 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 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.