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# Report On Managed Care Claims Processing – Rate Of Denials

*Presentation for the:*  
Medical Care Advisory Committee

# Presentation Outline

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Purpose of Review

Study Approach

Analysis Results

*Managed Care Overall Claims Denial Rate*

*Denial Rates By Provider Type*

*Payment Rates For Denied Claims*

*Timeliness For Paying Previously Denied Claims*

Conclusions

# Timely Payment Of Health Care Claims Is Core Requirement For The District's Managed Care Plans

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- ❑ Claims processing is a central administrative function that health plans must effectively execute to avoid payment problems for providers
  
- ❑ Through electronic claims processing, the District's three managed care organizations (MCOs) – AmeriHealth, MedStar Family Plan, Trusted -- are required to pay clean claims within 30 days to satisfy timely filing requirements
  
- ❑ Like most health plans, the District's MCOs employ a series of automated edit checks on all claims submitted for payment by healthcare providers in the Medicaid and Alliance programs.
  
- ❑ Included among the numerous potential problems this system of edit checks is designed to eliminate are:
  - Duplicate or overpayments
  - Payments to out-of-network or otherwise ineligible providers
  - Payments for services delivered to non-eligible patients

# The Issue of Claims Denial For Health Plans Focuses On Whether The Managed Care Companies Are Acting In Good Faith

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- ❑ Because the District's 30-day timely payment requirement does not apply to claims that are initially denied, some providers express concerns that managed care plans are unjustifiably denying a high rate of claims as a cash management strategy
- ❑ Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the health plans' networks, and potentially cause access to care issues for beneficiaries in the Medicaid and Alliance programs
- ❑ Therefore, this analysis addresses this issue by reporting on the incidence of denied claims in the managed care program and the reasons for the denials. Additionally, outcomes for claims that were initially denied but subsequently approved and repaid are also examined

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# More Than 2.2 Million Managed Care Claims Processed In 2014 Were Tracked For This Review

- ❑ The key steps executed for this analysis were as follows:
  - First, all MCO denied claims with dates of service in calendar year 2014 were obtained from the District's three full-risk MCOs and established as the master dataset. This data extraction yielded approximately 411,000 claims.
  - Second, this master dataset was used to categorize provider types to match DHCF naming schemes and search for all claims with missing identifiers
  - Third, using DHCF's Medicaid Management Information System Management (MMIS), all patient encounters in 2014 were extracted yielding over 2.2 million records
  - Fourth, the dataset containing denied MCO claims (Step 1) was then merged with the dataset containing accepted encounters from MMIS (Step 2), using the beneficiaries' Medicaid ID, first date of service, last date of service, and billing provider NPI as the matching variables. This established in the same dataset, more than 2.2 million claims that were paid, denied, and initially denied but paid at a later date

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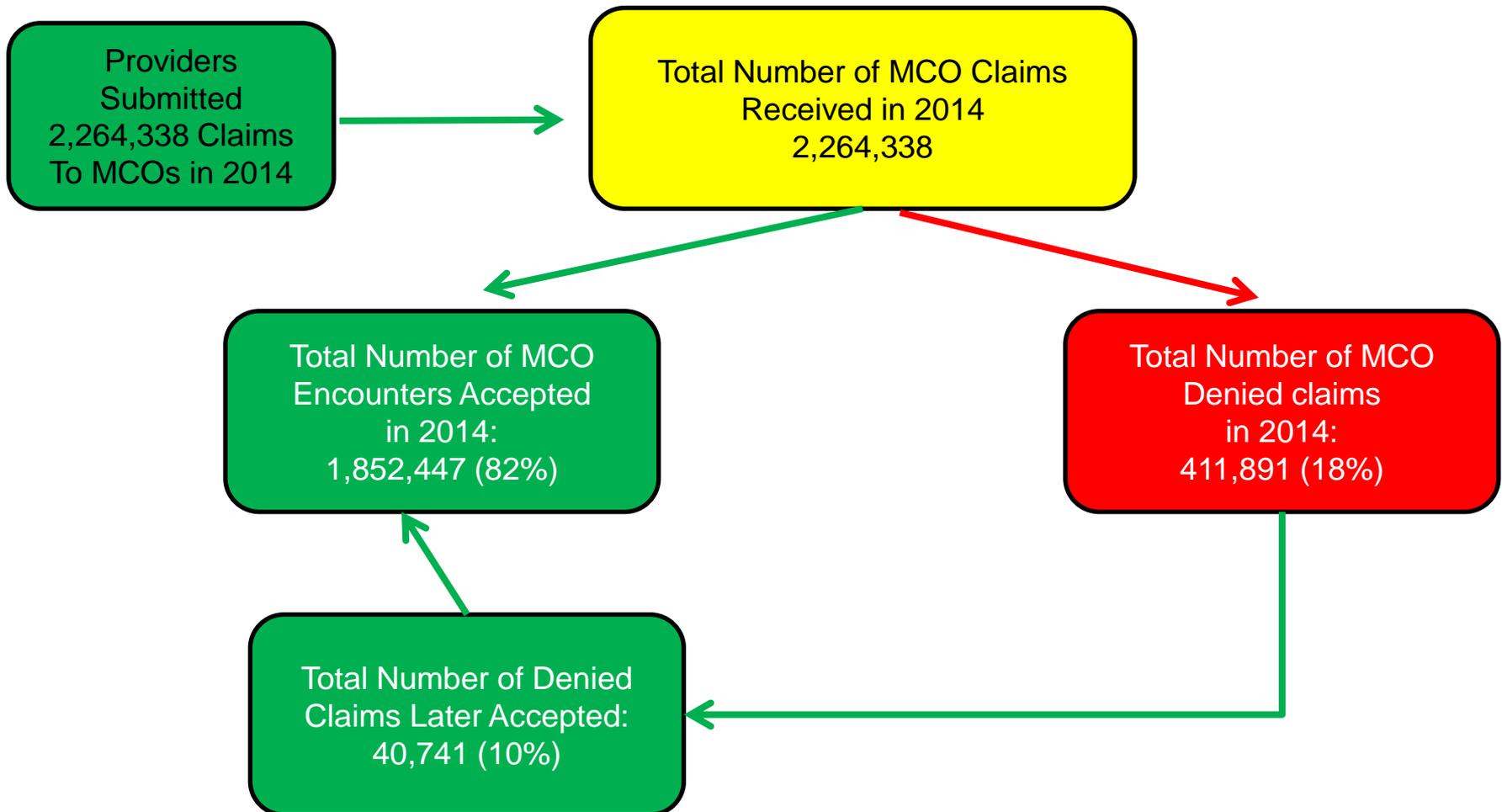
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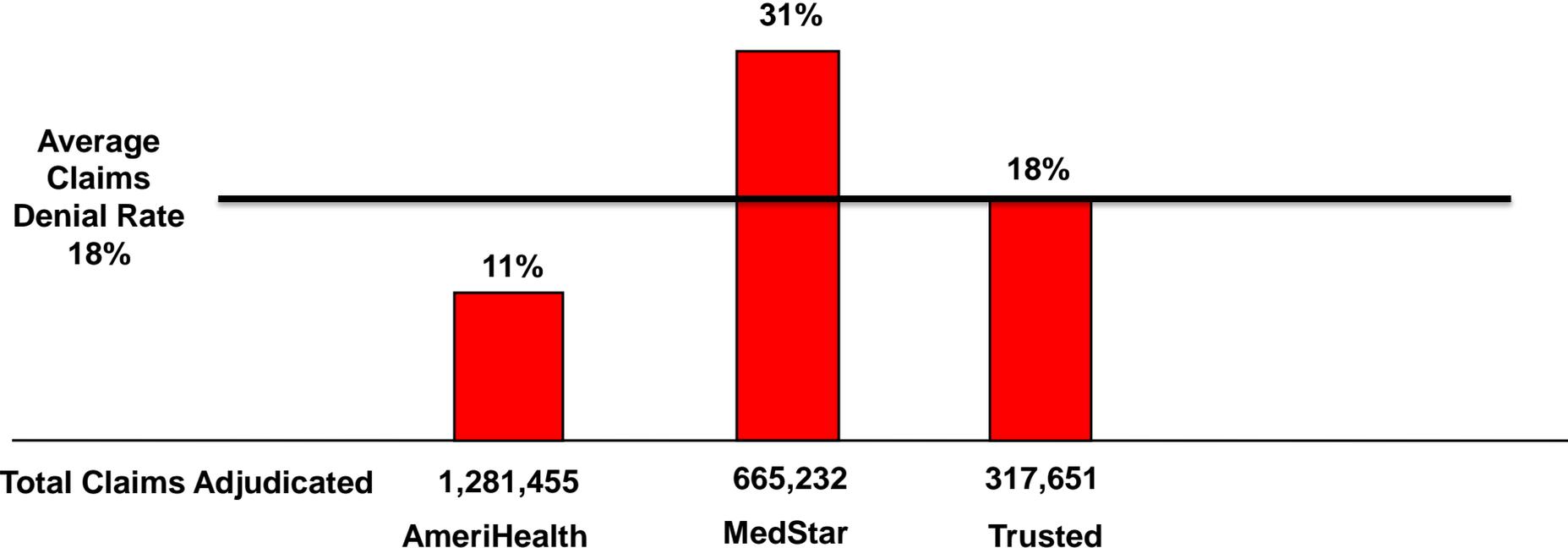
# Less Than Two Of Every Ten Claims Submitted For Payment To The District's MCOs Are Denied



Note: Patient encounters with 2014 dates of service from DHCF's MMIS system were merged with MCO files containing denied claims for the same period. The claims run out period was through February 2015.

# MedStar's Claims Denial Rate Is Significantly Above The Districtwide Average For The Three Health Plans

## Claims Denial Rates For Each Full-Risk Health Plan, 2014



Source: DHCF's MMIS and MCO claims denial files.

# MCOs Deny Claims For Many Reasons But The Most Frequent Relates To Service Coverage

MCO Claims Denial Rate, 2014



Claims Paid

82%

Claims Denied

18%

N = 2,264,338

■ Paid ■ Denied

Denial Reason	Total Claims	Percent of Total Claims Denied
Service coverage issue	74,471	21%
Duplicate Claim*	42,187	12%
Provider network issue	31,366	9%
Untimely filing issue	28,031	8%
Denied - LabCorp responsibility	23,054	6%
Exceeded allowable units issue	20,810	6%
Member eligibility issue	20,433	6%
Other reasons	120,311	32%

Note: \*Approximately 13% of duplicate claims were submitted more than once.

Source: DHCF's MMIS and MCO claims denied files.

# The Rate Of Denied Claims Are Highest For Two Of The Smallest Provider Groups Calling Into Question A MCO Cash Management Motive

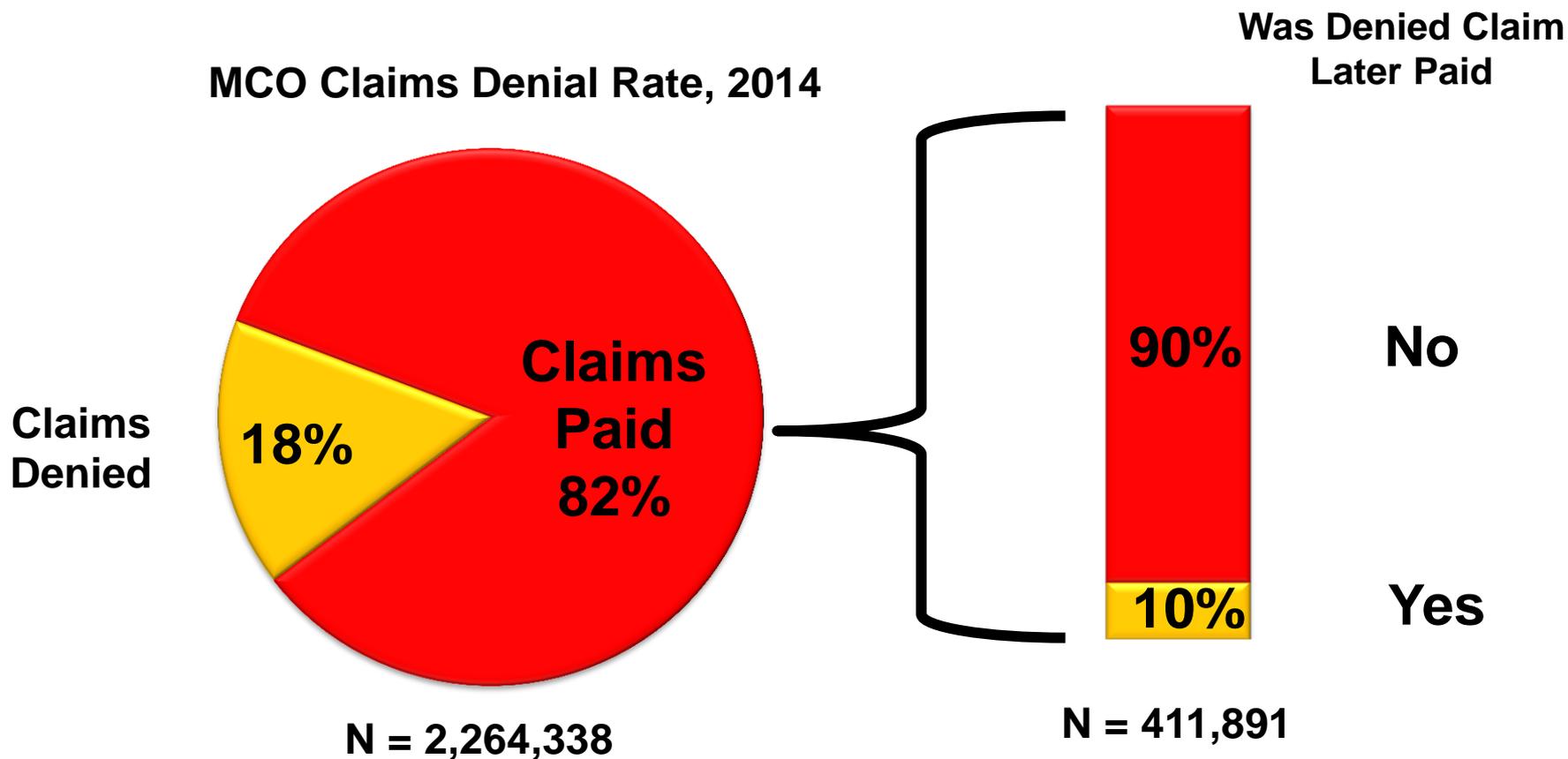
## Denied Claims By Provider Type, 2014

Provider Type	Number of Total Claims	Claims Denied as a Proportion of Total
Private Clinic	36,420	53%
Mental Health Clinic	24,248	33%
Nurse Practitioner	37,533	23%
DME	20,085	23%
Physician	939,089	22%
Hospital	269,784	22%
FQHC	103,530	11%
Pharmacy	262,014	11%

Note: \*Approximately 13% of duplicate claims were submitted more than once.

Source: DHCF's MMIS and MCO's denied claims files, 2014

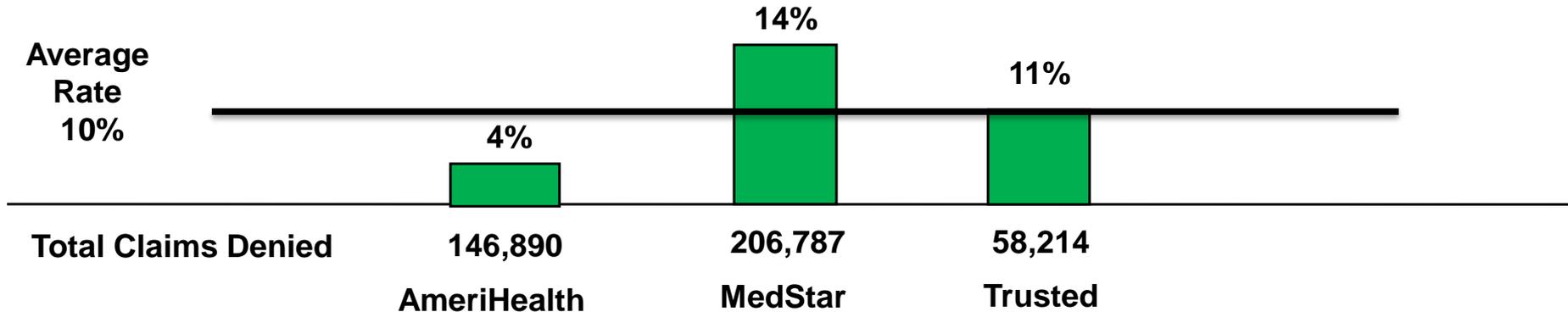
# Only Ten Percent of Claims Initially Denied Were Later Paid



Note: Patient encounters with 2014 dates of service from DHCF's MMIS system were merged with MCO files containing denied claims for the same period. The claims run out period was February 2015.

# The Payment Rates For Initially Denied Claims Vary Across The Three Health Plans But Do Not Raise Cause For Concern

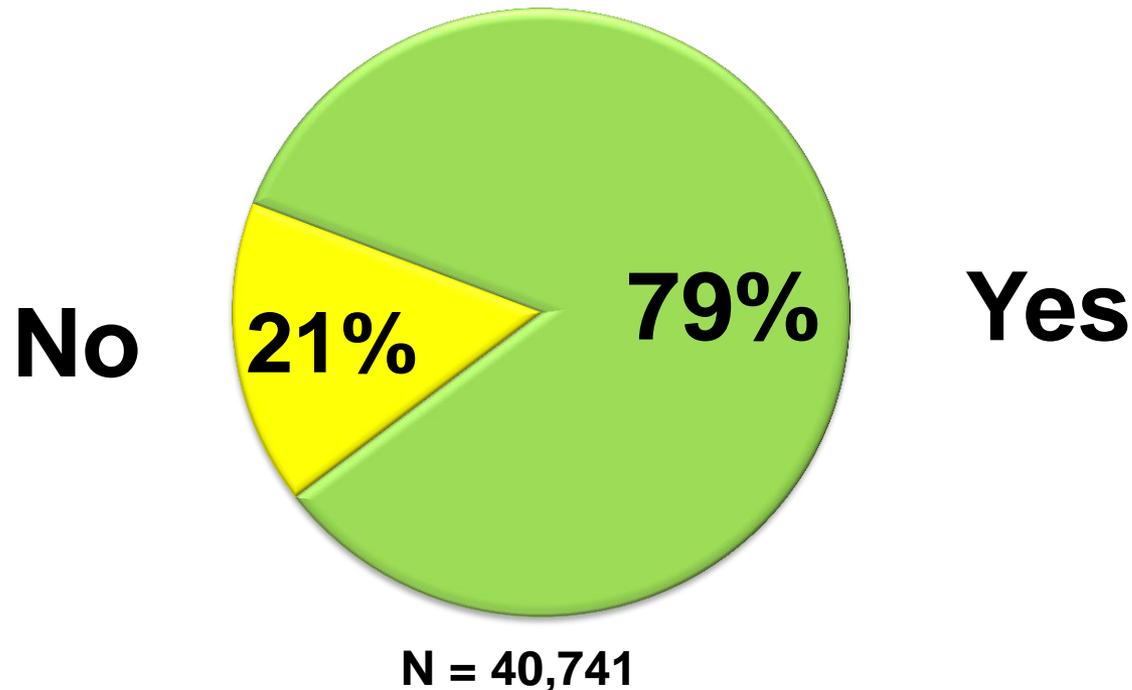
## MCO Pay Rates For Claims Originally Denied, 2014



# Though Not Required, MCOs Still Paid Nearly Eight of Ten Claims That Were Initial Denied Within 30 Days

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Was Denied Claim Paid Within 30 Days Of Initial Denial



# For Some Provider Types, However, The Average Time That Elapsed Before Claims That Were Paid After Initially Being Denied Was High

Provider type	Average Number Of Days From Initial Denial To Acceptance
Dentist	15
Hospital	21
Nursing Facility	26
Physician	36
Mental Health Clinic	40
Lab	42
DME	55
Pharmacy	58
FQHC	66

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- ❑ Effective and fairly administered health plans must execute payments to providers for eligible claims without significant delay
- ❑ Data from claims filed in 2014 show that less than 20 percent of provider claims for Medicaid and the Alliance program are denied by the District's three full-risk health plans.
- ❑ There were numerous reasons that caused claims denial with the most common being whether the health care service provided was covered by the plan.
- ❑ Nonetheless, when the totality of the findings is considered, there does not appear to be any evidence to indicate that the health plans are inappropriately denying large numbers of claims to reserve cash
- ❑ Notably, low denial rates (especially for high volume providers), modest approval rates for claims initially denied, and the observed rapid payment rates for such claims, militate against the charge of bad faith claims processing