Connecticut
Medicaid Managed Care Council
Behavioral Health Subcommittee

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Meeting Summary: July 15, 2004

Chair: Jeffrey Walter

Review of the charge of the work group by the Medicaid Managed Care Council

Jeffrey Walter stated that he had provided the work group and the Council with a single commercial HMO report of denied BH claims for a particular quarter. The HUSKY MCOs were asked to generate a similar report, with the goal being to identify reasons for denied claims, using common repotting parameters among the plans. The report would be the basis for MCO/practitioner interventions and resolution of a percentage of claim adjudication delays. The impact of such interventions would lead to an outcome measurement of the increase in the number of claims paid in a timely manner on the first submission. This BH claims template could then be applied to other services.

The DSS is required to define the specifications of any new or changed reports in the contract, giving the HUSKY MCOs 90-day notice to comply with the reporting provisions.

Parameters of the Claims Denial reports

- There was agreement that the reporting unit would be the **service unit.**

- Reporting parameters were discussed at length:

There was some dissention as to whether the multiple denial reasons per a service unit should be the basis of the report. While this could inflate the number of claim denial reasons, inclusion of only the "primary denial reason" or a hierarchy of denial reason would require either a subcontractor system change or manual extraction process. At the end of the meeting, it was decided that **each plan would report on all denial reasons by service unit.**

- There was agreement on the following claims denial categories:
  - Member not eligible
  - Duplicate claim, already paid.
  - Claim exceeds timely filing
  - Claim is for a non-contracted service
  - Authorization issues (see last bullet)
  - Coding issues that include diagnosis, incorrect procedure code (i.e. service code does not match the service authorization, etc), incomplete claims information.
  - Benefit coordination issue
  - Other: claim is for a BH service not covered, service is not a Medicaid service, service is not in the DSS/MCO contract, etc.

- A second report will be required that details the reasons why a claim was denied for authorization problems. The categories for this report are:
  - No authorization
  - Units exceed authorization,
  - Units are outside of authorization date range
  - Other

- The discussion included a description of the various terms, noting that a rejected claim may not become part of the claims denial report. In brief:
    - Clean claims are those that have all the information correctly completed on the form and is readable by the claim scanner.
    - A rejected claim could be due to client HUSKY ineligibility, claim sent to the wrong MCO, missing or incorrect provider ID or client ID numbers, information on the form is unreadable by the scanner, etc. A rejected claim may not show up in the claims denial report, as it is rejected before starting the adjudication process.
    - Pending claims may be duplicate claims or claims that require medical records review, or pending due to other reasons.
    - Adjudicated claims are those claims that are processed and either approved or denied, with an accompanying Explanation of Benefits (EOB).

Next Steps:

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- The DSS will review previous MCO claims inventory reports that include paid, pending and unpaid claims and determine if the reports provide useful data for denied claims.
- Each MCO will provide their report on claims denials by reason categories.
- The DSS will inform the MCOs of the report specifications as discussed at this meeting, the receipt of the DSS letter will start the 90-day clock on the delivery of the reports. The DSS will draft a letter by August 1 to this effect for input from the work group before final MCO notification.