Policy & Procedure Enhancement Subcommittee Meeting

February 21, 2013

Agenda

- Public Comment
- Discussion of Challenges, Benefits, and Opportunities for Denied Claims Acceptance
- Discussion of Dental Data Submission Plans and Status
- Next Steps

Claims Denial Discussion

- **Current DSG Language:** *"Claims denied for completeness, errors or other administrative reasons (sometimes known as "soft" denials) should not be submitted until the claim has been paid."*
- **Claim Denial Collection Purpose:**
  - Equal Representation for Consumers, Providers and Payers
  - Capture of all claim/payment events so all common market place experiences can be characterized. This is essential in providing consumers and other APCD clients with a picture they consider realistic, fair and trustworthy
- **Sample Use Cases:**
  - Evaluation of claims denial reasons and frequency across state
  - Provide support information to consumer advocates
  - Identification of disparities in denials across insurers
  - Identification of disparities in denials across providers
  - Observation of denial activity and trends over time

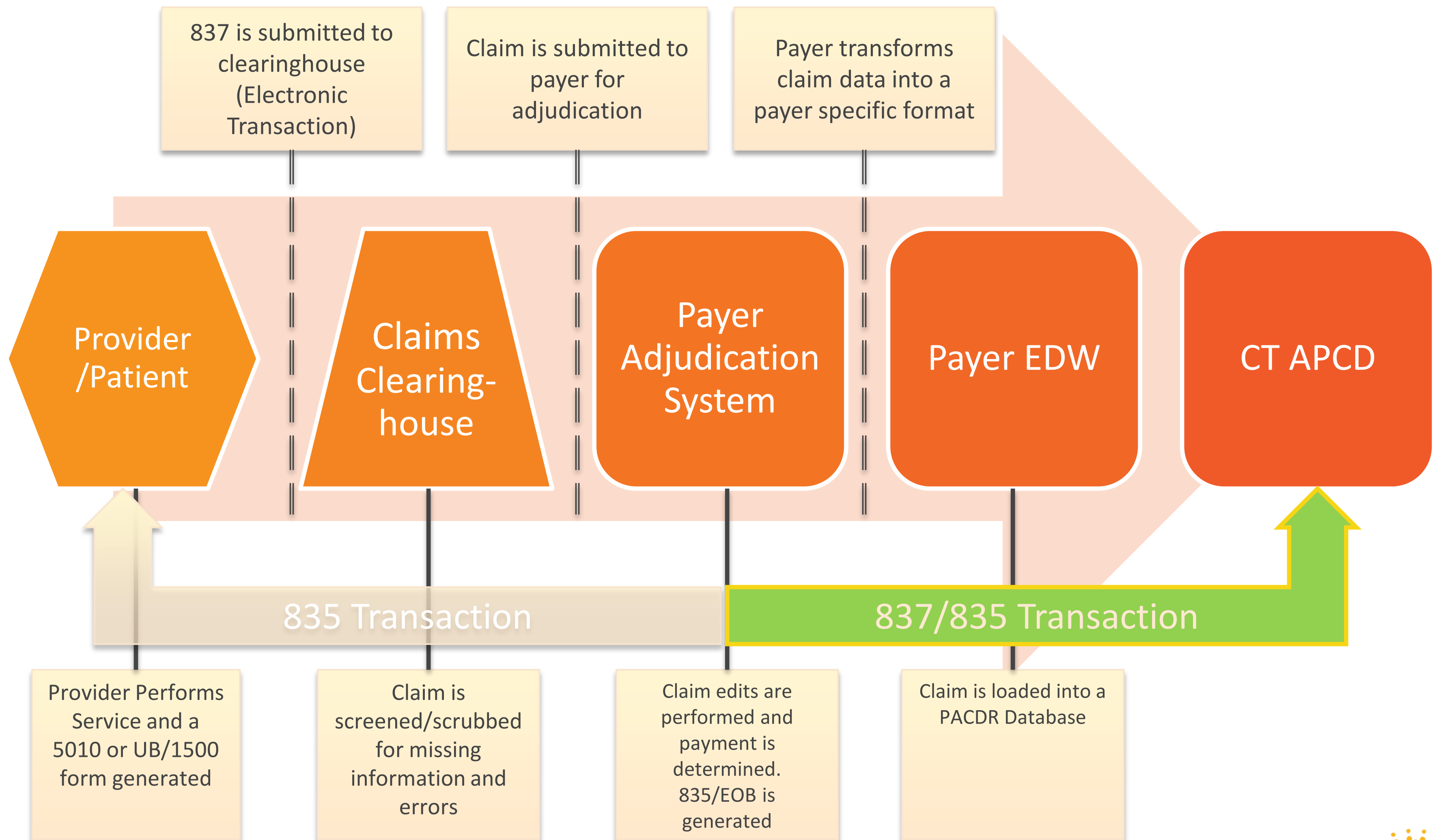
Claim Denial Data Components

- All insurers use Claims Adjustment Reason Codes (CARCs) to define what is being done with a particular service or claim. CARCs are on every 835 whenever the payment is anything less that the submitted charge, and are associated with the appropriate service or the entire claim.
- Remittance Advice Remark Codes (RARCs) are essentially a second level of greater specificity or granularity of information and, when applicable, appear on most 835s.
- CARCs and RARCs are maintained by a BCBSA Codes Committee and CMS respectively, and are updated three times a year, so there are changes to CARCs and RARCs as business needs change but there is standardization and consistency that allows for the easy capture of information.

Claim Denial Data Components

- This greater specificity helps providers and insurers understand what has occurred with the associated claim line adjudication.
- Insurers may not universally use all reason codes to the level of specificity intended, but they all use the codes today on 835s reporting back to physicians and other providers what is occurring with each claim and more specifically each claim line.
- Since we now have the data, we can do a lot of analytics, and try to show what was denied, when and why and if the claim line denial was adjusted in any way at any point in time, and why. We will even know if the claim was resubmitted and if the resubmission was repaid.
- **Although collection and utilization of denied claims is challenging, it is <u>not</u> impossible.**

Claims Denials Data Transfer Process (X12 Approach)



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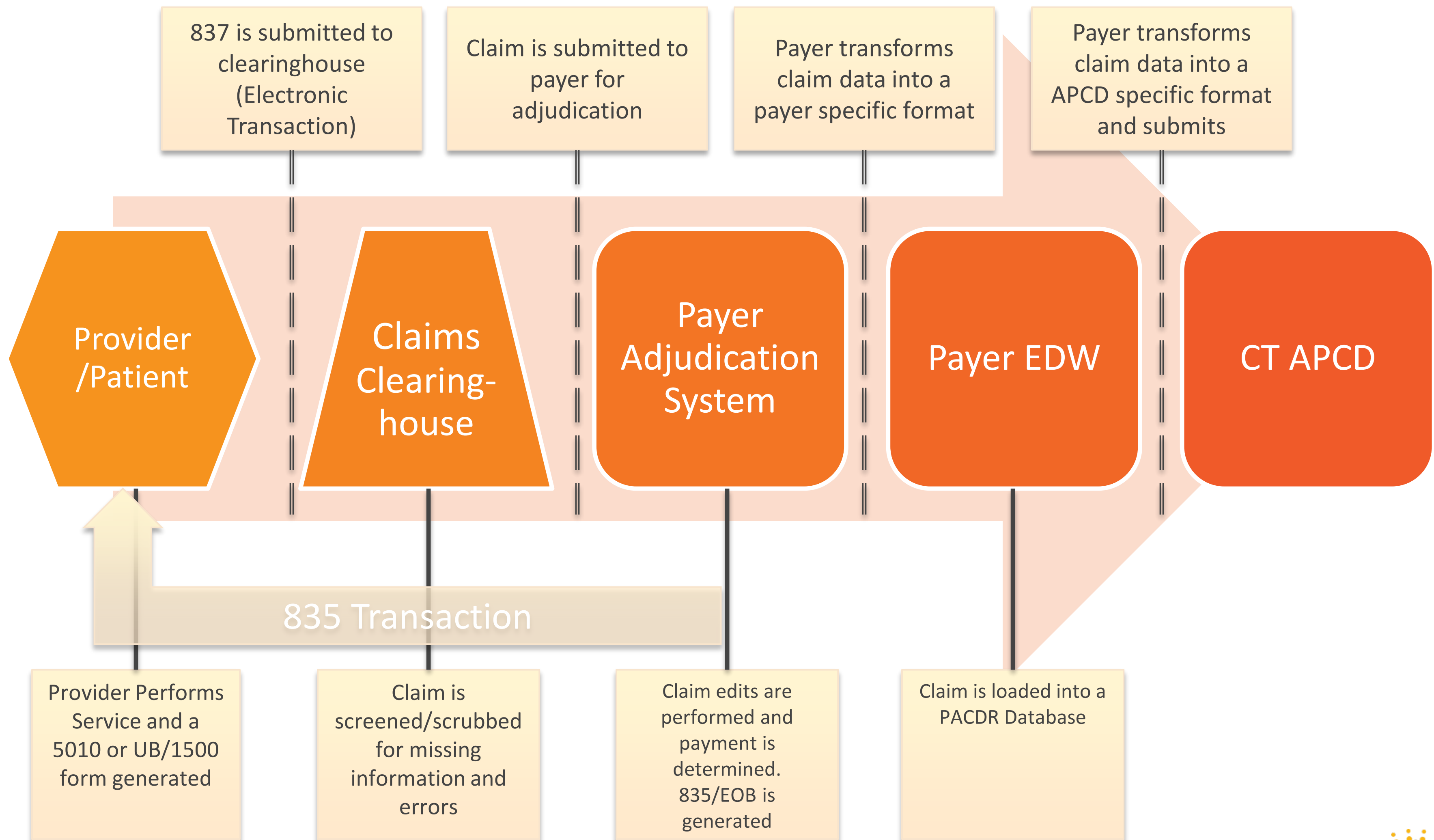
Claims Denials Data Transfer Process (PACDR Approach)



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Potential Tools Within CT's DSG Toolbox

Elmt	Data Element Name	Description	Element Submission Guideline
MC004	Payer Claim Control Number	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim
MC005A	Version Number	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.
MC038	Claim Status	Claim Line Status	Report the value that defines the payment status of this claim line
		Value	***Description***
		1	Processed as primary
		2	Processed as secondary
		3	Processed as tertiary
		4	Denied
		19	Processed as primary, forwarded to additional payer(s)
		20	Processed as secondary, forwarded to additional payer(s)
		21	Processed as tertiary, forwarded to additional payer(s)
		22	Reversal of previous payment
		23	Not our claim, forwarded to additional payer(s)
		25	Predetermination Pricing Only - no payment
MC080	Payment Reason	Payment Reason Code	Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter.
MC123	Denied Flag	Denied Claim Line Indicator	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was denied.
		Value	***Description***
		1	Yes
		2	No
		3	Unknown
		4	Other
		5	Not Applicable
MC124	Denial Reason	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.
MC139	Former Claim Number	Previous Claim Number	Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004. Use of "Former Claim Number" to version claims can **only** be used if approved by the APCD. Contact the APCD for conditions of use.

Claims Denial Integration Proposal

Iterative Approach:

Re-Determine:
- Repeat process to incorporate new findings
- Implement improvements
- Remove redundancies

Determine
- Feasibility/best practices (contingent on vendor selection and submitter ability) for collecting denied data from submitters.
- Additional resource needs
- Submitter ability to comply
- Necessary revisions to DSG

Request
- New data components
- Revisions to P&P
- Communication with stakeholders

Analyze
- Completeness of data received
- Accuracy and reasonability
- Basic stats and trends

Assess
- Reliability of information
- Data Shortcomings
- Ability to satisfy stakeholder use cases

Acceptance and Integration of Dental Claims

- *"The Administrator shall establish a similar schedule for the reporting of Dental Claims Data by Reporting Entities in the future. Said schedule and detailed reporting specifications shall be incorporated into a future revised version of the Submission Guide. Notification of such changes shall be provided to Reporting Entities through written notice and posted on the APCD website. "* **- *CT APCD Policy and Procedure***
- Dental claims data included within the current CT APCD data submission guide (DSG). Data layout and components mirror dental format found in other APCD states.
- Highly similar to collection of medical claims data.

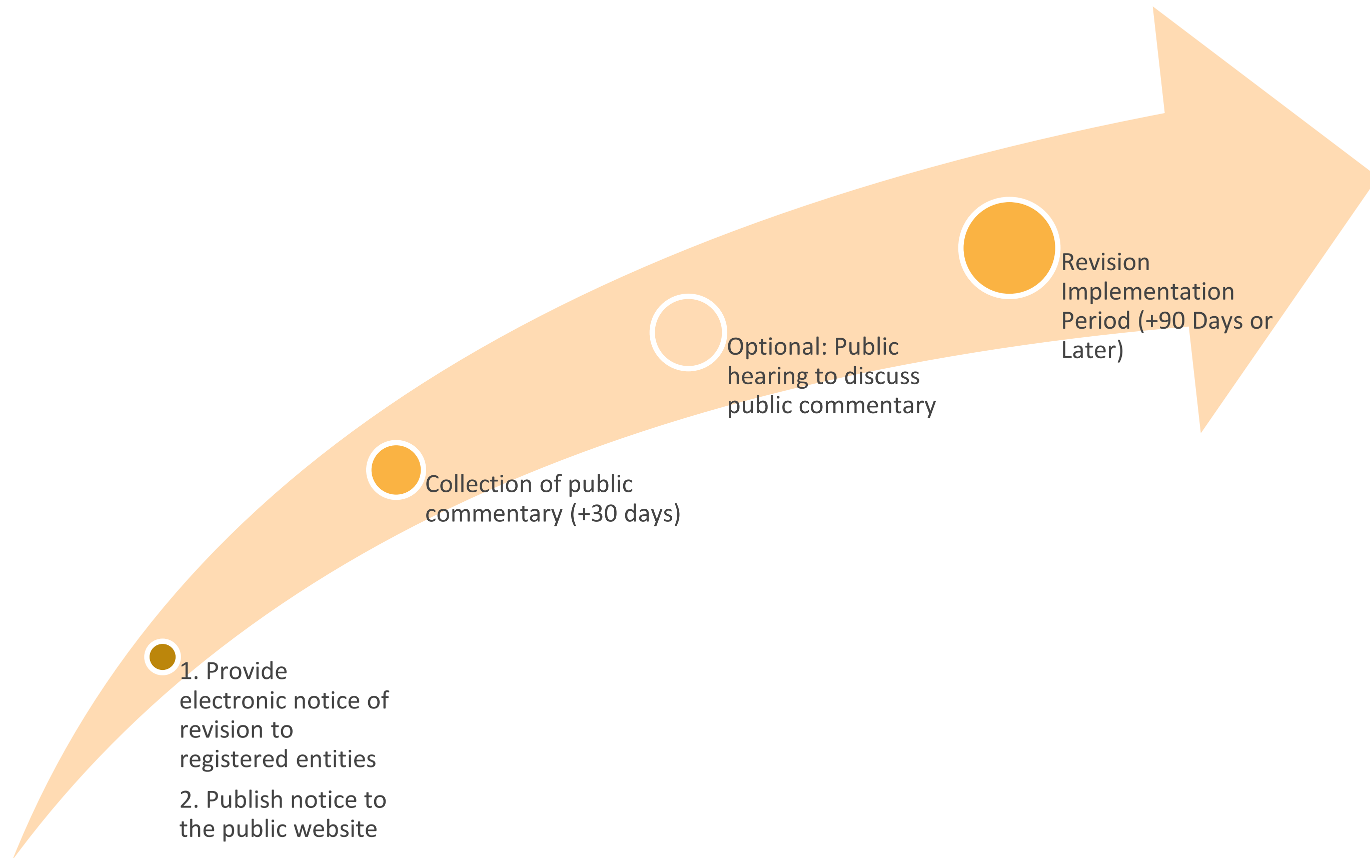
Dental Data Components

- Service/Paid Dates
- Provider IDs
- Diagnosis/Procedure Codes
  - Common Dental Terminology (CDT)
  - Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes
  - ICD Diagnosis Codes
- Financial Information:
  - Charged, Allowed, Paid, and Consumer Out-of-Pocket amounts
- Dental Specific Fields:
  - Tooth Number/Letter Identification
  - Dental Quadrant
  - Tooth Surface

Registered Submitters

- Delta Dental of New Jersey, Inc.
- Humana Dental Insurance Company
- United Concordia Insurance Company
- Aetna Life Insurance Company
- Mega Life & Health Insurance Company
- Renaissance Life & Health Insurance Company Of America
- Security Life Insurance Company Of America
- Starmount Life Insurance Company (Alwayscare)
- Stonebridge Life Insurance Company (Encore Dental)
- Ameritas Life Insurance Corporation
- Anthem Health Plans Inc.
- Chesapeake Life Insurance Company
- Connecticare Insurance Company
- Connecticut General Life Insurance Company
- Dentegra Insurance Company
- The Lincoln National Life Insurance Company
- Lincoln Life & Annuity Company of New York
- First Penn-Pacific Life Insurance Company
- The Chesapeake Life Insurance Company

Example of Dental Data Retrieval Timeline



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