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Connecticut's Health Insurance Marketplace

All-Payer Claims Database Policy & Procedures Enhancements Subcommittee Meeting

May 8, 2014

Agenda

- Call to Order and Introductions
- Public Comment
- Approval of Minutes for the February 21, 2014 Meeting
- Overview of Claims Adjustment Reason Codes and Remittance Advice Codes
- Review of Denied Claims Data Use Cases
- Discussion of Dental Data Collection and Stakeholder Engagement
- Next Steps
- Future Meetings

Overview of Claims Adjustment Reason Codes and Remittance Advice Codes

Denial and Adjustment Code Sets

	Claim Adjustment Group Codes (CAGC)	Claim Adjustment Reason Codes (CARC)	Remittance Advice Remark Codes (RARC)	NCPDP Reject Code
Purpose:	Assigns financial responsibility for the Claims Adjustment Reason Code (CARC).	Offers a reason for the positive/negative financial adjustment specific to particular claim or service referenced	Delivers supplemental information (in addition to a CARC) about why a claim or service line is not paid in full	Provides information regarding a retail pharmacy claim rejection
Code Set Steward:	ASC X12 Standards Committee	Codes Maintenance Committee (BCBSA)	Centers for Medicare & Medicaid Services (CMS)	National Council for Prescription Drug Programs (NCPDP)
Count:	5	~268	~930	NA
Example:	**CO -** *Contractual Obligation* **CR -** *Corrections and Reversal* **OA -** *Other Adjustment* **PI -** *Payer Initiated Reductions* **PR -** *Patient Responsibility*	**26** - *Expenses incurred prior to coverage.*	**N19** - *Procedure code incidental to primary procedure.*	NA
Reference:	http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/	http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/	http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/	https://www.ncpdp.org/

Denial and Adjustment Code Set Values Examples[1]

CARC	CARC Description[2]	RARC	RARC Description[3]	ASC X12 CAGC
163	Attachment/other documentation referenced on the claim was not received.	N678	Missing post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
24	Charges are covered under a capitation agreement/managed care plan.			CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR

1. ***CAQH CORE 360 Rule:*** *http://www.caqh.org/CORECodeCombinations.php*
2. ***Washington Publishing Company:*** *http://www.wpc-edi.com/reference/*
3. ***Washington Publishing Company:*** *http://www.wpc-edi.com/reference/*

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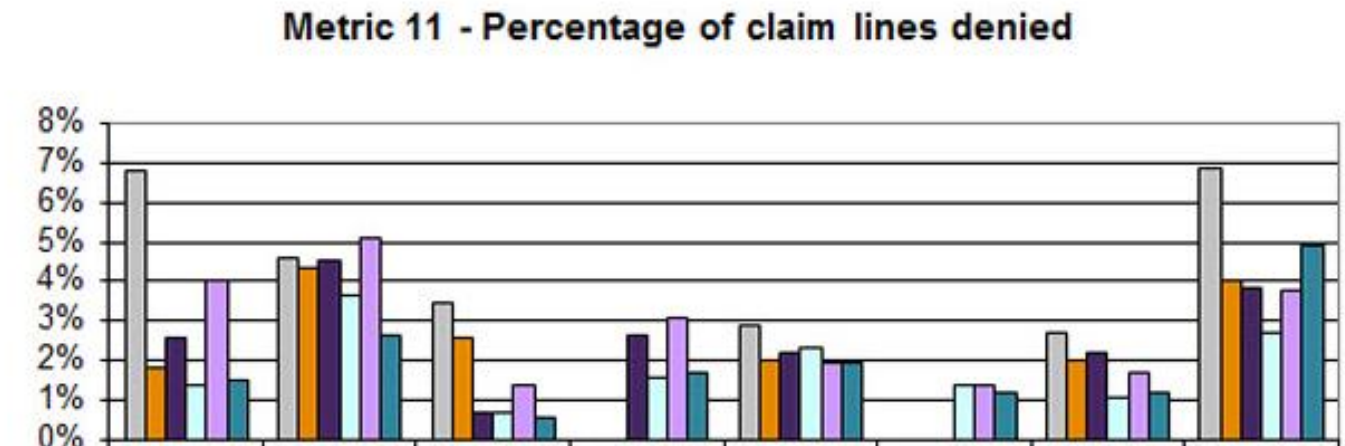
AMA National Health Insurer Report Card Findings (Years 2008 – 2013)*



	Aetna	Anthem	Cigna	HCSC	Humana	Regence	UHC	Medicare
2008	6.80%	4.62%	3.44%		2.90%		2.68%	6.85%
2009	1.81%	4.34%	2.56%		2.03%		2.02%	4.00%
2010	2.57%	4.50%	0.67%	2.67%	2.18%		2.21%	3.82%
2011	1.38%	3.62%	0.68%	1.59%	2.33%	1.36%	1.05%	2.73%
2012	4.00%	5.07%	1.39%	3.06%	1.97%	1.38%	1.71%	3.78%
2013	1.50%	2.64%	0.54%	1.70%	1.97%	1.18%	1.18%	4.92%

***American Medical Association:** *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

*** The AMA NHRIC results are based on data pulled from the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic health care transactions. Metrics are self-reported and provided by NHXS, based in Sacramento, CA.*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Reason Codes For a Denial (2008 – 2013)

Aetna		Anthem		Cigna		HCSC		Humana		Regence		UHC	
CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%
96	37.18%	204	29.40%	96	29.17%	16	40.37%	125	23.66%	16	29.41%	16	30.19%
49	10.12%	16	19.95%	197	22.77%	96	17.47%	96	21.86%	204	23.23%	96	23.43%
227	9.84%	96	10.46%	204	13.12%	227	11.21%	94	19.43%	50	9.79%	B20	8.46%
55	9.59%	45	9.10%	49	11.65%	B5	6.85%	16	12.88%	167	6.94%	38	5.58%
226	7.67%	38	4.79%	55	5.77%	179	5.94%	197	8.09%	51	5.98%	15	4.76%
119	5.84%	227	4.32%	50	4.30%	49	5.64%	165	3.94%	226	4.61%	56	4.06%
197	5.56%	other	21.97%	51	3.78%	197	4.04%	204	3.36%	49	4.45%	197	3.88%
165	3.68%			other	9.44%	other	8.47%	other	6.78%	227	4.17%	227	3.23%
other	10.52%									other	11.40%	49	3.23%
												204	3.10%
												other	10.08%

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Reason Codes For a Denial

CARC	CARC Description	# Payers	Cumulative % of Denials	Average % Per Payer
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6	140%	23.3%
197	Precertification/authorization/notification absent.	5	44%	8.9%
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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	5	35%	7.0%
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	5	33%	6.6%
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	5	133%	26.6%
204	This service/equipment/drug is not covered under the patient's current benefit plan	4	69%	17.2%
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	2	12%	6.1%
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2	15%	7.7%
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	2	10%	4.9%
165	Referral absent or exceeded.	2	8%	3.8%
Grand Total		**38**	**498%**	**13.1%**

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

AMA National Health Insurer Report Card Findings*

Most Frequently Reported Remark Codes For a Denial (2008 – 2013)

Aetna		Anthem		Cigna		HCSC		Humana		Regence		UHC	
RARC	%	RARC	%	RARC	%	RARC	%	RARC	%	RARC	%	RARC	%
N130	33.89%	N29	13.22%	N130	58.23%	N130	22.45%	N22	24.83%	N29	33.81%	N115	31.06%
N179	12.22%	N193	11.87%	N30	12.03%	MA100	20.50%	N115	21.74%	N429	10.60%	N174	14.57%
M41	9.99%	N179	9.29%	M118	8.54%	N366	16.24%	N130	9.54%	N179	9.93%	M77	8.05%
N56	8.72%	N221	7.66%	N175	6.65%	M127	10.38%	N4	5.92%	N517	9.46%	N54	7.86%
N20	7.51%	N155	6.45%	N216	4.11%	N4	9.29%	M77	4.65%	N130	7.45%	N429	6.14%
N54	7.16%	MA92	6.05%	other	10.44%	N225	7.44%	N489	4.55%	N102	6.69%	N386	5.75%
N517	5.92%	N161	4.28%			N202	5.46%	MA130	3.36%	M135	4.49%	N179	5.27%
N429	5.01%	N174	3.99%			M29	3.24%	M62	3.29%	N463	4.30%	M51	4.70%
other	9.58%	N301	3.92%			other	4.99%	N386	3.13%	N30	3.63%	M86	4.22%
		N232	3.84%					M53	3.03%	other	9.65%	other	12.37%
		M127	3.68%					other	15.96%				
		other	25.75%										

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

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AMA National Health Insurer Report Card Findings*

Most Frequently Reported Remark Codes For a Denial

RARC	RARC Description	# Payers	Cumulative % of Denials	Average % Per Payer
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	5	132%	26.4%
N29	Missing documentation/orders/notes/summary/report/chart.	2	59%	29.4%
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	2	52%	26.0%
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	4	34%	8.6%
N30	Patient ineligible for this service.	2	34%	17.1%
N429	Not covered when considered routine.	3	32%	10.6%
N22	This procedure code was added/changed because it more accurately describes the services rendered.	1	24%	23.7%
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	2	23%	11.7%
N161	This drug/service/supply is covered only when the associated service is covered.	1	22%	22.0%
N193	Specific federal/state/local program may cover this service through another payer.	1	20%	20.0%
Grand Total		**23**	**432%**	**18.8%**

**American Medical Association:* *http://www.ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/national-health-insurer-report-card/denials.page*

Future Changes to CARC and RARC Submissions

- Two primary problems in the reporting of claim payment adjustments:
  1. Existence of individual health plan approaches to mapping the plan's internal proprietary codes to CARCs/RARCs
  2. Adjustment/denial code combinations are based on proprietary, health plan-specific business scenarios

- An industry mandate for the use of operating rules to support implementation of the HIPAA standards included in Section 1104 of the ACA.
- Operating Rules and standards for ERA and EFT in the process of being implemented.

Review of Denied Claims Data Use Cases

Denied Claims in CT: High Volume Procedures

High Volume Denied Procedures Within CT[1,2]

Service Count/% Denied by Masked Payer
Time Span: 10/1/2012 – 11/1/2013

CPT / HCPCS	Procedure Description	Payer A		Payer B		Payer D		Grand Total	
		Service Count	% Denied	Service Count	% Denied	Service Count	% Denied	Total Service Count	Total % Denied
99213	Office Outpt Low to Moderate Severity (15 Min)	-	0.0%	16,519	1.6%	15,058	1.1%	31,577	1.4%
99214	Office Outpt Moderate to High Severity (25 Min)	12,562	1.1%	10,416	1.2%	-	0.0%	22,978	1.1%
99232	Subsequent Hospital Care	4,344	2.4%	1,767	8.6%	8,875	3.0%	14,986	3.5%
81002	Urinalysis Nonauto W/O Scope	3,944	22.0%	-	0.0%	3,819	10.2%	7,763	16.2%
90471	Immunization Admin	-	0.0%	-	0.0%	1,801	31.3%	1,801	31.3%
90658	Flu Vaccine, 3 Yrs, Im	-	0.0%	-	0.0%	1,040	30.8%	1,040	30.8%
76499	Radiographic Procedure	266	92.9%	205	97.1%	242	62.4%	713	83.7%
G0202	Screening Mammography Digital	-	0.0%	679	24.4%	-	0.0%	679	24.4%
77052	Computer Aided Detection Screening Mammography	-	0.0%	679	24.3%	-	0.0%	679	24.3%
76645	Us Exam, Breast(S)	-	0.0%	522	24.5%	-	0.0%	522	24.5%
Grand Total		**21,116**	**6.4%**	**30,787**	**3.9%**	**30,835**	**6.0%**	**82,738**	**5.3%**

1) *Source: MDEdge, product of the Physicians Advocacy Institute (PAI) Inc.*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

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Denied Claims Across Regional States: High Volume Procedures

High Volume Denied Procedures Across States[1,2]

% of Services Denied by Procedure
Time Span: 5/1/2012 – 11/1/2013

CPT / HCPCS	Procedure Description	CT	MA	NJ	NY	Grand Total
70450	Ct Head/Brain W/O Dye	5.9%	4.0%	6.8%	5.6%	**6.2%**
71010	Chest X-Ray	7.9%	3.5%	6.6%	5.1%	**5.8%**
71020	Chest X-Ray	5.7%	2.8%	5.6%	8.3%	**6.2%**
77052	Computer-Aided Detection Screening Mammography	5.4%	1.6%	2.7%	2.9%	**2.8%**
93000	Electrocardiogram, Complete	2.1%	2.9%	3.1%	1.8%	**2.7%**
93010	Electrocardiogram Report	0.0%	4.2%	9.9%	3.8%	**5.2%**
99213	Office Outpt Low to Moderate Severity (15 Min)	2.0%	2.3%	4.0%	3.0%	**2.8%**
99214	Office Outpt Moderate to High Severity (25 Min)	1.7%	2.3%	3.3%	1.9%	**2.6%**
99232	Subsequent Hospital Care	4.3%	5.4%	7.3%	3.5%	**5.8%**
99233	Subsequent Hospital Care	3.9%	4.6%	6.7%	5.6%	**5.1%**
Grand Total		**2.8%**	**3.2%**	**4.9%**	**4.9%**	**4.1%**

1) *Source: MDEdge*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

Denied Claims Data Use Cases

Use Case #1

Effective for dates of service on or after January 1, 2007, Medicare will pay for BMM services for *dual-energy x-ray absorptiometry (*CPT code 77080) when this procedure is used to monitor osteoporosis drug therapy. New CPTs have also been assigned to BMMs.

In Connecticut, using this code and other available information Payer E has a denial rate of 33% in the last 12 months, while Payer A, Payer B, and Payer D all have denial rates below 5%. This causes the denial rate for Payer E to be 6 times higher, a rate based on information from a selection of Connecticut physicians during this time period.

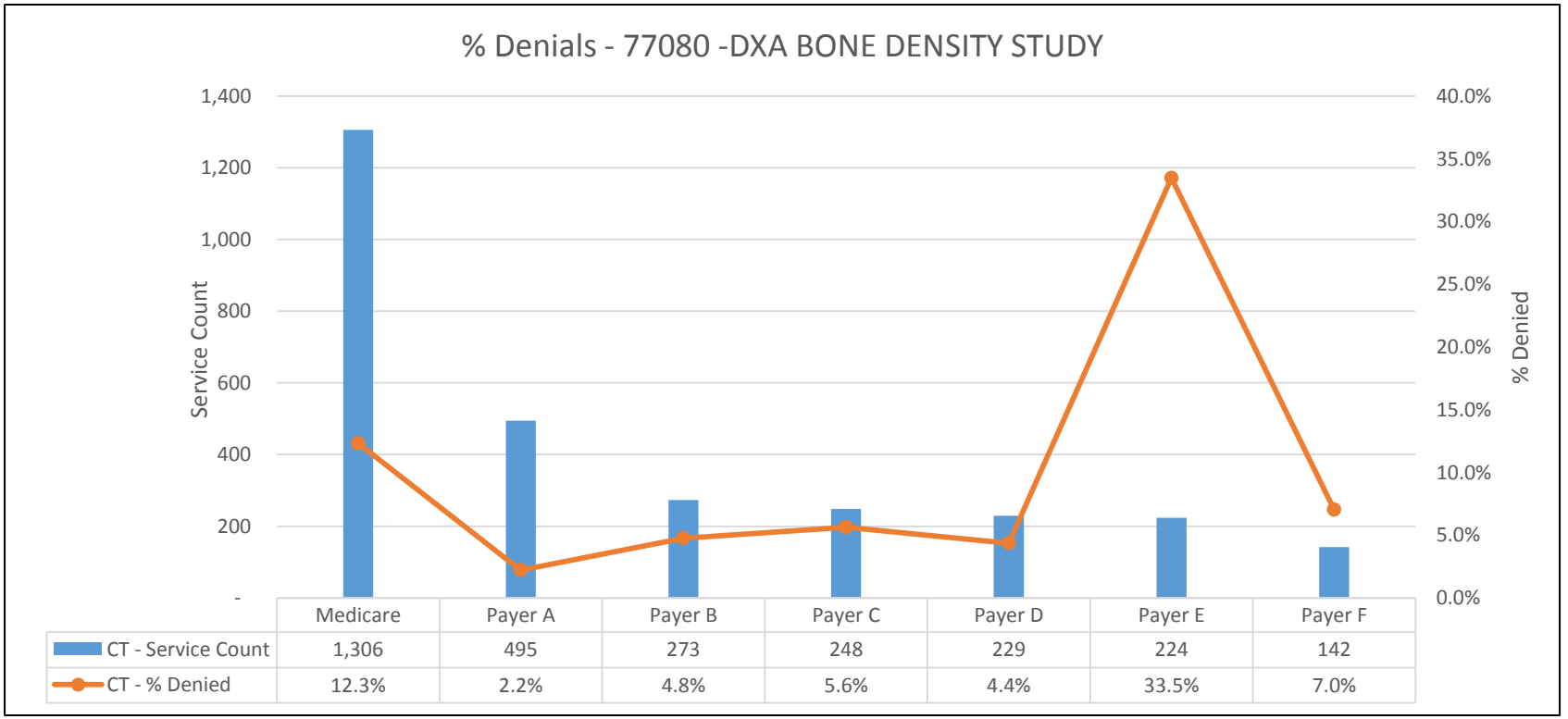
This example highlights the variation in insurers' interpretation of medical necessity in the context of this diagnostic study. If a patient had a particular need for the nature of this procedure due to their personal and family history of bone mass loss, this data in combination with other information would support the patient's ability to make an informed decision.

Denied Claims Data Use Cases

Case #1: % Denied Claims for DXA Bone Density Scan[1,2]

Service Count/% Denied by Masked Payer

Time Span: 5/1/2012 – 11/1/2013



	Medicare	Payer A	Payer B	Payer C	Payer D	Payer E	Payer F
CT - Service Count	1,306	495	273	248	229	224	142
CT - % Denied	12.3%	2.2%	4.8%	5.6%	4.4%	33.5%	7.0%

1) *Source: MDEdge*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

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Denied Claims Data Use Cases

Use Case #2

In Connecticut, a simple X-ray exam of the foot had a significant denial by Payer J by nearly 60%, while Payer C, Payer B and Payer D demonstrated a denial rate below 2.5%.

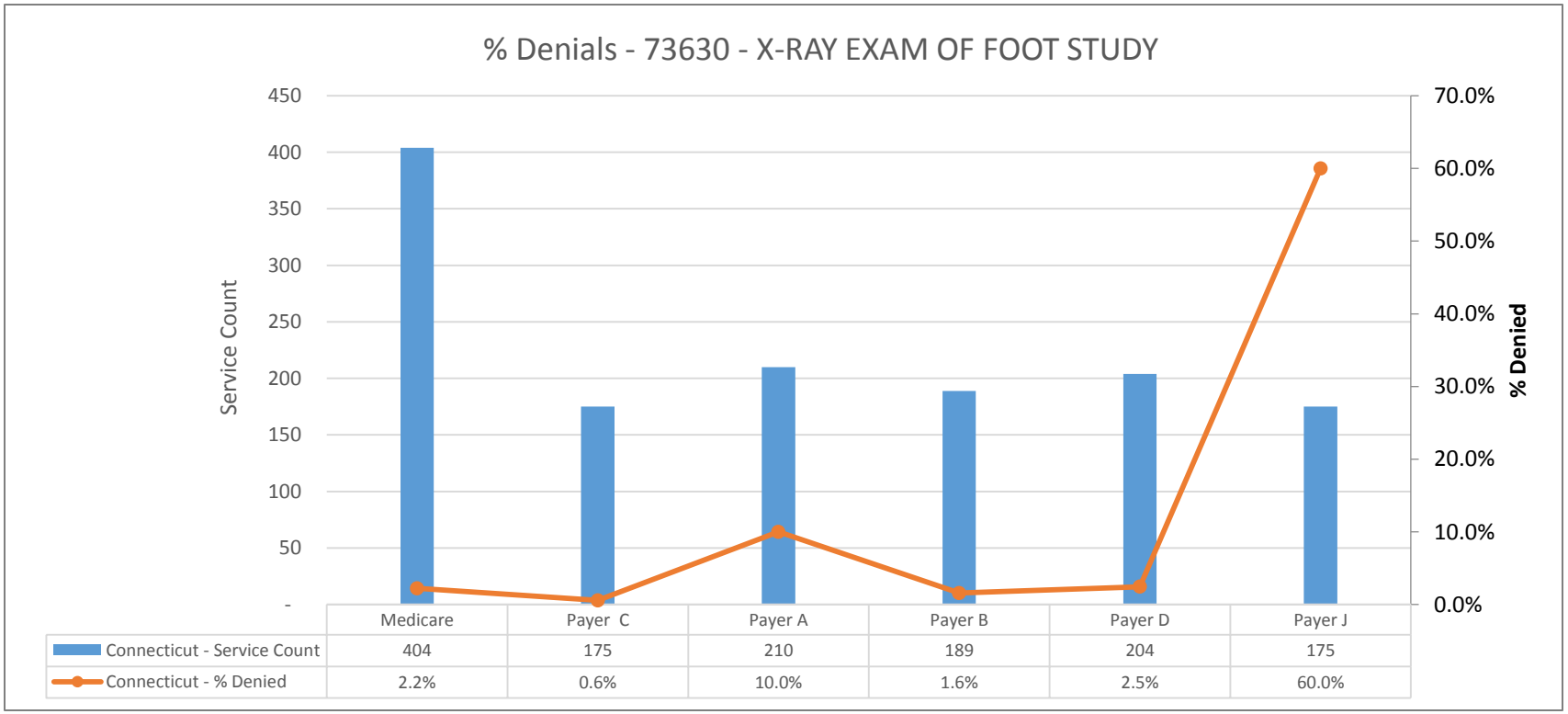
This rate becomes important when a patient has need for an X-ray exam of their foot due to an injury. The denied claims information may be more likely used in the context of a general case of inquiry, rather than tied to a particular condition, chronic or otherwise, however, this information continues to demonstrate profound differences in denial rates by insurer by service/procedure (CPT code).

Denied Claims Data Use Cases:

Use Case #2: % Denied Claims for X-Ray Exam of Foot[1,2]

Service Count/% Denied by Masked Payer

Time Span: 5/1/2012 – 11/1/2013



	Medicare	Payer C	Payer A	Payer B	Payer D	Payer J
Connecticut - Service Count	404	175	210	189	204	175
Connecticut - % Denied	2.2%	0.6%	10.0%	1.6%	2.5%	60.0%

1) *Source: MDEdge*
2) *Claims and denial information derived from a repository containing information for approximately 5% of physicians in CT and for more than 5,700 physicians across NY, NJ, MA and CT*

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Denied Claims Data Use Cases

Use Case #3

Jane is a 40 year old independent IT consultant. She wishes to directly purchase health insurance and is evaluating multiple insurance companies. She has a family history of colorectal cancer and wants to know which insurers may more often deny the medically necessary diagnostic procedures provided that she has a family history and need for frequent colonoscopies. She would like additional information through her assessment to indicate the process to demonstrate the importance of having a colonoscopy, as a 40 year old female. She asks "Is there any place this information is available?"

If Connecticut were to maintain information on denied claims, which included data on denied medical services and procedures, frequency of denial, which insurers denied the procedure more often, and other relevant data, Jane would have a wealth of information to support an informed decision in her determination of which insurance company would be best for her given her family history and current medical condition.

Denied Claims Data Use Cases

Use Case #4

A patient sees their doctor and the doctor orders an expensive diagnostic procedure. The insurance company has not published their denial rules and the doctor is unaware that they will be denying the charge for the procedure already provided. More than two weeks after the diagnostic procedure is completed the insurance company informs the doctor that they have denied the claim.

When the doctor informs the patient that he is financially liable, the patient conveys upset and confusion as he repeatedly asks, “Why couldn’t someone tell me there was a substantial risk that the insurance company would deny the procedure? Is this a common thing that happens and which insurance company in Connecticut would pay for the procedure, so I can determine if I need to change insurance companies?”

Denied Claims Data Use Cases

Use Case #5

Ruth is the Human Resources manager with a small employer in Connecticut and is reviewing their insurance coverage. They are a tight knit group and have just lost one of the staff to cancer. This has made the staff keenly aware of cancer screening. Being a small company she is using an Insurance Broker to help her evaluate Insurance companies.

While she likes her broker, she is also aware that insurance companies compensate brokers based on volume, which can bias their recommendations. She asks “Is there anywhere that I can independently research how often insurance companies are denying cancer screenings?

Next Steps

Discussion of Dental Data Collection and Stakeholder Engagement

Dental Data Background/Current Stats

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 Background/Current Stats

Not Registered or Estimated Lives Not Provided

- 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.
- Connecticut General Life Insurance Company
- The Chesapeake Life Insurance Company

Registered and Provided Covered Lives Estimate

- Delta Dental of New Jersey, Inc.
- Chesapeake Life Insurance Company
- Connecticare Insurance Company
- Dentegra Insurance Company
- The Lincoln National Life Insurance Company
- Lincoln Life & Annuity Company of New York
- First Penn-Pacific Life Insurance Company

Dental Data Background/Current Stats

Dental Data Current 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

Dental Data Discussion

Discussion Topics:

1. **Requirements, Enforcement, and Compliance to Billing Standards For Dental Health Care Claims (2012 ADA Dental Claim Form & 837/835 EDI):**
   - Industry Acceptance Rate of Billing Standards (Paper vs. EDI)
   - Billing Variations Across Providers (Dentists and Other Providers)
   - Data Collection Variations Across Payers
   - Demarcation Between Services Billed to Medical Benefit vs. Dental Benefit
   - Barriers to Capturing Dental Service Utilization Information
   - Barriers to Capturing Dental Clinical Information
2. **Opportunities to Improve The Dental Data Submission Guide (DSG) Requirements:**
   - Potential Additions To The Dental DSG Contents
   - Potential Exclusions/Redundancies To The Dental DSG Contents
3. **Opportunities For Dental Data Usage:**
   - Topics of Research Interest and Usage Within CT

APCD Policies and Procedures Implications

- APCD legislation definition of reporting entity includes dental carriers (CGS 38a-1091)
- Policies and Procedures require submission of dental data in the future, based on a schedule to be established by APCD Administrator as part of a revised Data Submission Guide (DSG)
- DSG revisions require 30 public comment period, effective 90 days after final revisions posted

Next Steps