# MCO Claims Denial Information

## *Amerigroup:*

**Claims denial rate for DD LTSS taking out "duplicate claims" and "Provider errors"**
Amerigroup reported a cumulative total of 5819 denials. The total number of denied claims is 2082 after excluding duplicate claims and provider billing errors, representing a 1.21% denial rate across the spectrum of 171,966 total submitted claims.

**Examples of what the "other reasons" would be for denial of payments.**
Amerigroup reported 27% (1572) of all claims denied fell into a category defined as "Other". The following denial reasons represent the top five sub-categories in the "Other" category:

1) Claim Processed/Adjusted Previously
2) Termination (Member not eligible on DOS due to termination)
3) Initial coverage benefit limit met or exceeded
4) Original Claim Overpaid
5) State responsibility -- PRTF Program

## *Sunflower:*

**2014 HCBS YTD (1/1-7/30)**

Current: 2.96% (6,706/226,926)
Excluding Provider Error: 1.44% (3,193/221,366)

Excluded Codes:

EX17 DENY: REQUESTED INFORMATION WAS NOT PROVIDED
EX18 DENY: DUPLICATE CLAIM SERVICE
EX35 DENY: BENEFIT MAXIMUM HAS BEEN REACHED
EX46 DENY: THIS SERVICE IS NOT COVERED
EXDS DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
EXDZ DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
EXMH DENY: PLEASE SUBMIT TO MENTAL HEALTH VENDOR FOR PROCESSING
EXN8 INCORRECT NPI FOR PROVIDER
EX29 DENY: THE TIME LIMIT FOR FILING HAS EXPIRED

## *United:*

Requested claims denial rates for DD LTSS:

1. Denials without duplicates = 0.42%
2. Denials without duplicates & provider errors* = 0.38%

Other reasons for denial include:

- **Denial for correct billing address needed** – if the provider files a claim and the billing address on the claim differs from the address in our system, the claim denies while we resolve the discrepancy with the provider. If a provider has changed their billing address and failed to notify us, we don't want to send payments/remittance advices to the old or incorrect address. In these cases, we work to resolve the discrepancy with the provider and either update the address in our system, or request the provider file a corrected claim with the correct billing address.

- **Member terminated** – providers will see this denial if they file a claim for a member for a date of service before the member's effective date with UHC, or after the member's eligibility has been terminated.

- **Information doesn't support level of service** – providers will see this denial for a variety of provider billing errors. For example, if the provider bills multiple units for a date of service that is a once unit per day service, we would deny the claim. The provider resolution is to file a corrected claim with the appropriate units for the date of service.

- **NPI not billed** – providers will see this denial if we receive a claim without the provider's NPI and we believe an NPI is required for the service. On occasion, providers have received this denial in error if they are an atypical provider and the service provided does not require and NPI. Those claims are identified and submitted for adjustment.