Addiction and Prevention Services
State Quality Committee

This report shows the detail of how many claims were processed by ValueOptions each month, the timeframe for processing and the percentage of claims processed that denied.

AGGREGATE ANALYSIS REPORT

Final

Reporting Period **FROM:** March 1, 2008 **TO:** May 30, 2008

Unit/Team/Department:
PIHP Quality Improvement

Topic/Project:
Claims payment timeliness and accuracy report

Claim Accuracy Audit (VO # 23, Grid Row #18)
Open Claims Inventory and Turn Around Time (VO # 24, Grid Row #19)
Claim Denial Reasons (VO #49)

Monitoring Standard:
42 CFR 438.240 Quality Assessment and Performance Improvement Program
42 CFR 438.242 Health information System
42 CFR 438.114 and 438.210 Coverage Rules and payment policies
42 CFR 438.404 Data on claims denials

Goal:
The PIHP will track and report monthly to SRS/AAPS an audit of claims data entry and claims inventory analysis.

Objectives:
To assure the documentation is capturing the audits of claims data to ensure accuracy and compliance with claims payment standards
To evaluate for trends that may require system intervention or education
To allow data to be presented consistently for Committee evaluation and response

Data Collection Activities:
Data was collected from ValueOptions CareConnect System claims. The Claims Accuracy Audit consists of random audits of claims data entry. The Open Claims Inventory and Turn Around Time (TAT) consist of claims inventory analysis that reports claim aging for all open claims. The report includes total counts of claims by each day bucket. The TAT report includes percentage of unclean claims percentage by day buckets. TAT includes detail on total paid, amount billed, denied detail, etc. These reports were listed in RFP as being reported quarterly, but the state has requested that the report is received monthly. This report is not due until 45 days after the close of a quarter.

Results: See Next Page

Addiction and Prevention Services
State Quality Committee

Medicaid and Block Grant March 2008

Kansas Claims and Audit Statistics (Reporting Requirement # 23 and #24) - Medicaid & Block Grant
Month Ending 3/31/2008

Claims Timeliness Results

Measures the percentage of claims processed within the required turnaround timeframe.
The number reflects the percentage of claims processed and paid/denied within 30, 60 and 90 calendar days.

	Percentage	Number in timeframe/total
Percent Paid in 30 Calendar Days	97.78%	15802/16161
Percent Paid in 60 Calendar Days	98.48%	15916/16161
Percent Paid in 90 Calendar Days	98.93%	15988/16161

Claims Accuracy Results

Audited claims will be categorized and reported by percentages in the following categories:

Financial Accuracy (Payment Errors):
Financial errors are created when incorrect information is entered into the system creating an overpayment, underpayment or non-payment.
They are calculated as follows:

Calculation: Overpaid Amount + Underpaid Amount / (divided by) Total paid amount = Financial Error Amount

Mechanical (Statistical) Errors
Mechanical errors are any errors that generate incorrect information, but do not create an overpayment or underpayment. They are calculated as follows:

Calculation: Number of Claim Elements Correctly Completed / (divided by) Total Number of Claim Elements = Mechanical Error Total

	Percentage
Financial Accuracy	99.64%
Mechanical Accuracy	99.95%

Claims Denial/Paid Results

Claims processed and paid includes all claims that are processed and finalized through the financial system. Dollars reflect paid dollars.
Approved claims represent claims that are finalized and approved for payment. The figures reflect number, percentage and dollars paid.
Denied claims represent claims that are finalized and denied for payment. The figures reflect, number, percent and total paid dollars.

	Claim Count	Percentage	Total Paid
Claims Processed and Paid	22521		
Approved	20221	89.79%	$1,976,483.81
Denied	2300	10.21%	$0.00

Open Inventory

Figures represent number of open claims in each age range, as well as billed dollars associated with those claims,
Explanantion of all claims that exceed 90 days is noted below.

Total Open Inventory

Age	Claim Count	Total Billed
0-7	509	$102,633.69
8-15	171	$53,889.18
16-30	110	$21,954.88
31-45	3	$545.00
46-60		
61-90		
> 90*		

Total Open Inventory	793

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Medicaid and Block Grant April 2008

Kansas Claims and Audit Statistics (Reporting Requirement # 23 and #24) - Medicaid & Block Grant
Month Ending 4/30/2008

Claims Timeliness Results

Measures the percentage of claims processed within the required turnaround timeframe.
The number reflects the percentage of claims processed and paid/denied within 30, 60 and 90 calendar days.

	Percentage	Number in timeframe/total
Percent Paid in 30 Calendar Days	99.63%	12814/12862
Percent Paid in 60 Calendar Days	100.00%	12862/12862
Percent Paid in 90 Calendar Days		

Claims Accuracy Results

Audited claims will be categorized and reported by percentages in the following categories:

Financial Accuracy (Payment Errors):
Financial errors are created when incorrect information is entered into the system creating an overpayment, underpayment or non-payment.
They are calculated as follows:

Calculation: Overpaid Amount + Underpaid Amount / (divided by) Total paid amount = Financial Error Amount

Mechanical (Statistical) Errors
Mechanical errors are any errors that generate incorrect information, but do not create an overpayment or underpayment. They are calculated as follows:

Calculation: Number of Claim Elements Correctly Completed / (divided by) Total Number of Claim Elements = Mechanical Error Total

	Percentage
Financial Accuracy	99.91%
Mechanical Accuracy	99.96%

Claims Denial/Paid Results

Claims processed and paid includes all claims that are processed and finalized through the financial system. Dollars reflect paid dollars.
Approved claims represent claims that are finalized and approved for payment. The figures reflect number, percentage and dollars paid.
Denied claims represent claims that are finalized and denied for payment. The figures reflect, number, percent and total paid dollars.

	Claim Count	Percentage	Total Paid
Claims Processed and Paid	14197		
Approved	11466	80.76%	$2,050,322.36
Denied	2731	19.24%	$0.00

Open Inventory

Figures represent number of open claims in each age range, as well as billed dollars associated with those claims,
Explanantion of all claims that exceed 90 days is noted below.

Total Open Inventory

Age	Claim Count	Total Billed
0-7	1224	$245,035.80
8-15	36	$10,561.60
16-30	28	$25,847.88
31-45	5	$1,230.00
46-60	0	
61-90	0	
> 90*	0	

Total Open Inventory	1293

Medicaid and Block Grant May 2008

Kansas Claims and Audit Statistics (Reporting Requirement # 23 and #24) - Medicaid & Block Grant
Month Ending 5/31/2008

Claims Timeliness Results

Measures the percentage of claims processed within the required turnaround timeframe.
The number reflects the percentage of claims processed and paid/denied within 30, 60 and 90 calendar days.

	Percentage	Number in timeframe/total
Percent Paid in 30 Calendar Days	99.78%	13544/13574
Percent Paid in 60 Calendar Days	100.00%	13574/13574
Percent Paid in 90 Calendar Days	100.00%	

Claims Accuracy Results

Audited claims will be categorized and reported by percentages in the following categories:

Financial Accuracy (Payment Errors):
Financial errors are created when incorrect information is entered into the system creating an overpayment, underpayment or non-payment. They are calculated as follows:

Calculation: Overpaid Amount + Underpaid Amount / (divided by) Total paid amount = Financial Error Amount

Mechanical (Statistical) Errors
Mechanical errors are any errors that generate incorrect information, but do not create an overpayment or underpayment. They are calculated as follows:

Calculation: Number of Claim Elements Correctly Completed / (divided by) Total Number of Claim Elements = Mechanical Error Total

	Percentage
Financial Accuracy	99.97%
Mechanical Accuracy	99.98%

Claims Denial/Paid Results

Claims processed and paid includes all claims that are processed and finalized through the financial system. Dollars reflect paid dollars.
Approved claims represent claims that are finalized and approved for payment. The figures reflect number, percentage and dollars paid.
Denied claims represent claims that are finalized and denied for payment. The figures reflect, number, percent and total paid dollars.

	Claim Count	Percentage	Total Paid
Claims Processed and Paid	14474		
Approved	11468	79.23%	$1,960,183.45
Denied	3006	20.77%	$0.00

Open Inventory

Figures represent number of open claims in each age range, as well as billed dollars associated with those claims,
Explanantion of all claims that exceed 90 days is noted below.

Total Open Inventory

Age	Claim Count	Total Billed
0-7	460	$135,539.44
8-15	30	$8,171.02
16-30	46	$24,576.00
31-45	2	$1,105.00
46-60	0	
61-90	0	
> 90*	0	

Total Open Inventory	538

Conclusions:

- 90% of claims paid within 30 days of receipt: the standard was met and improved each month in this reporting period:
  - March 2008 - 97.78%
  - April 2008 – 99.63%
  - May 2008 – 99.78%

- 99% of claims paid within 60 days of receipt: the standard was met for two of the three months in this reporting period. The standard was met in April 2008 (100.00%) and in May 2008 (100.00%). The standard was just below standard in March at 98.48%.

- 100% of claims paid within 90 days of receipt: the standard was met in February 2008 (100.00%) and in April 2008 (100.00%), but not met in March 2008 (98.93%).

- All standards for claim processing: were met in April 2008.

DENIED CLAIMS	PERCENTAGE DENIED
July 2007	14.00 %
August 2007	15.39 %
September 2007	13.27 %
October 2007	19.74 %
November 2007	22.19 %
December 2007	18.18%
January 2008	16.06%
February 2008	5.57%
March 2008	10.21%
April 2008	19.24%
May 2008	20.77%

- Denied Claims: In this reporting period, March 2008 through May 2008, the percentage of denied claims has increased each month. The percentage of claims denied significantly increased from March 2008 (10.21%) to April 2008 (19.24%) and more than doubled from March 2008 (10.21%) to May 2008 (20.77%).
- In April 2008, there were 25.67% Medicaid claims denied and 16.00% Block Grant claims denied.
- In May 2008, there were 33.95% Medicaid claims denied and 13.97% Block Grant claims denied.
- The increase in denials for May 2008 might be related to a claims edit that was added by VO to deny claims that did not have the National Provider Identification (NPI) number on it. They were required by law to do so.

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Denied Claims Reasons: May 2008

Block Grant	
Denial Code	**% of BG Denials**
NPI Used not on file	13.4%
Incorrect service code used	11.8%
Place of service does not match file	11.8%
Provider Capacity not listed on claims submitted	11.5%
Location not on file	11.5%
Provider not contracted at this location	11.5%
Member/Provider funding mismatch	11.4%
Auth Required, Not found	2.7%
90 Day Timely filing issues	1.9%
Tax ID not specified	1.7%

Medicaid	
Denial Code	**% of Medicaid**
NPI Used not on file	9.1%
Auth Required, Not found	6.2%
Incorrect service code used	6.2%
Place of service not specified	6.1%
Previously submitted	6.1%
Provider not contracted at this location	5.4%
Place of service does not match file	5.3%
No out of plan coverage	5.0%
Other Health Insurance-INVESTIGATE	4.2%
Internal hold code, review	4.2%

Preliminary Recommendations to Committee:
It is recommended to the Committee that data trending continue. **It is also recommended by the Committee that this aggregate analysis be shared at the SRS Regional QI meeting and posted on the ValueOptions website for public access**.

Date Presented to SQC: 8/26/2008 **BY:** Kim Brown

Recommendations from the Committee for action: Recommendation and changes made by the SQC to the preliminary recommendations are noted above in **bold**.

Person Responsible to follow-up and date due: Kim Brown Due: 11/6/08