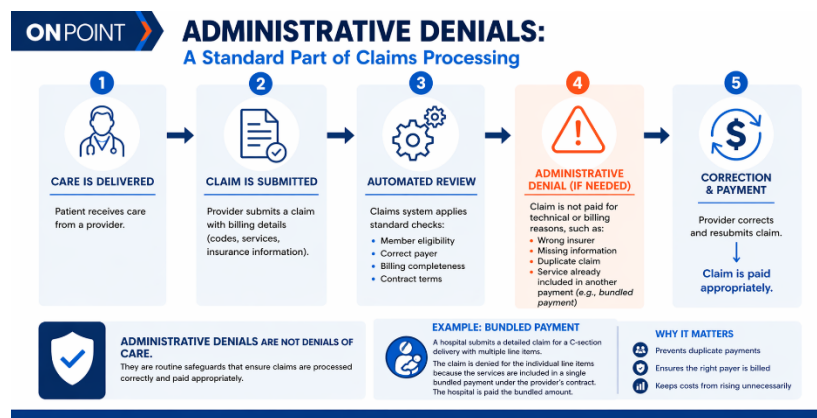


## Administrative Denials: What They Really Reflect

Administrative denials occur when a claim or claim line (a single claim can have dozens of lines) is not paid for billing or technical reasons, not because of medical necessity. While a claim may initially receive an administrative denial, it can be reprocessed upon submission of corrected information.

Common examples of administrative denials include:

- The individual is not a member of the plan
- The service billed differs from what was authorized
- Another payer is responsible
- Missing or incomplete billing information
- Duplicate or overlapping claims
- Contracted payment rules (e.g., bundled payments)



### Let's explore this with real-world examples:

#### 1. Wrong Insurance on File

Susan leaves her state job and enrolls in a new health plan through her private sector employer. After the change, she receives care at the MA Hospital Emergency Department, but they still have her old insurance information on file and submit the claim to the GIC. The claim is administratively denied and not paid because Susan is no longer enrolled in GIC coverage. MA Hospital Emergency Department updates the insurance information and resubmits the claim to the correct insurer, and it is paid appropriately.

#### 2. Bundled Payment

Betsy delivers her baby via c-section at MA Hospital. The provider submits a detailed claim with multiple line items describing each part of the delivery. Under the provider's negotiated contract with Betsy's insurance carrier, the delivery is paid as a single bundled payment that includes all services. The carrier's logic rejects all but one of the claim lines, issuing administrative denials for each, and pays one bundled amount that includes those services.

#### 3. Primary Care Capitation

Jane is enrolled in a Medicaid ACO that participates in a primary care capitation model. Jane visits her PCP for a sick visit. The provider submits a claim to her ACO for the sick visit in order

to track the services provided; however, the claim itself is administratively denied because the service was paid under a monthly capitation payment.

Both health plans and providers rely on automated, rules-based systems to process a high volume of claims and ensure they are paid correctly. Administrative denials are a necessary and standard part of this process across the U.S., including in Medicare, Medicaid, and the Group Insurance Commission. They are essential safeguards that ensure claims meet basic billing, eligibility, and payment requirements before funds are issued.

These rules exist to ensure that claims are paid accurately, once, and by the appropriate payer, and to prevent improper payments that drive up costs across the system. If administrative denials were prohibited, plans and public programs would be forced to pay claims that do not meet these requirements, resulting in significant improper payments and higher costs without any corresponding revenue to cover them.