Attachment I – Claims Processing Requirements **2.0 Pricing and Financial** **2.1 Processing Requirements** **2.1.3** Identify and calculate payment amounts according to the fee schedules, per diems, Diagnosis related group rates, capitation rates, case management fees, and global rates established by the State.	SUBSTANTIALLY MET
Attachment J – Encounter Data and Other Data Requirements **1.0 Encounter Data** **1.1 Compliance with HIPAA-Based Code Sets** **1.1.8** Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient.	SUBSTANTIALLY MET
Attachment J – Encounter Data and Other Data Requirements **1.0 Encounter Data** **1.1 Compliance with HIPAA-Based Code Sets** **1.1.9** Remittance Advice Remark Codes (RARC) are used by the MMIS using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP). NOTE – Institutional, professional and dental claims contain CARC and RARC codes, while pharmacy claims contain NCPDP reject codes. RARCs are used in conjunction with CARCs to further explain a payment decision or to relay additional information. NCPDP reject codes are used to document denial reasons for pharmacy claims.	SUBSTANTIALLY MET

Recommendation/Summary:

Additional details provided to the MCOs. KDHE requests the following issues be tracked using the Unified Log. The MCO should provide the Business Operations Team (BOT) with weekly status updates on the issues until each are resolved.

The plan may proceed with any necessary adjustments. These should be noted when tracking the item on the Unified Log.

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
1	5 6 36 39 40 44 46 48 49 50	Finding	The encounter submitted should include all Claim Adjustment Reason Codes (CARCs) provided on the Remittance Advice (RA).	Attachment J - Encounter Data Requirements 1.1.8 Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient.	N/A
2	6	Finding	Incorrect usage of a CARC code. CARC CO45 was used for the entire billed amount of the detail of a claim. CO – Contractual Obligation 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	Attachment J - Encounter Data Requirements 1.1.8 Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient.	N/A
3	8	Finding	The claim was paid in error. The procedure code has an age limitation for the TXIX benefit plan that was not applied. Per policy E2009-080, adult dental services are not covered for HCBS/IDD. The KMAP dental manual excerpt ABH provided in the supporting documentation applies to members in an ICF/IID facility.	Attachment I - KanCare Claims Processing Requirements 2.1.3 Identify and calculate payment amounts according to the fee schedules, per diems, Diagnosis related group rates, capitation rates, case management fees, and global rates established by the State.	N/A
4	12 14 15	Finding	Problem Notification Form, State Institution Claims Not Paying at the Full State Established Rate, was	Attachment I - KanCare Claims Processing Requirements	1273

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
			submitted to the State 11/1/2022. System changes are outstanding.	2.1.3 Identify and calculate payment amounts according to the fee schedules, per diems, Diagnosis related group rates, capitation rates, case management fees, and global rates established by the State.	
5	13	Finding	Problem Notification Form, Type of Bill Paid in Error, was submitted to the State 11/1/2022. System changes are outstanding.	Attachment I - KanCare Claims Processing Requirements 2.1.3 Identify and calculate payment amounts according to the fee schedules, per diems, Diagnosis related group rates, capitation rates, case management fees, and global rates established by the State.	1272
6	31	Finding	Problem Notification Form, Skygen Vision Claim Place of Service Update, was submitted to the State 11/1/2022. System changes are outstanding.	Attachment I - KanCare Claims Processing Requirements 2.1.3 Identify and calculate payment amounts according to the fee schedules, per diems, Diagnosis related group rates, capitation rates, case management fees, and global rates established by the State.	1274
7	45	Finding	The encounter submitted should include all the Remittance Advice Remark Codes (RARCs) provided on the Remittance Advice (RA).	Attachment J - Encounter Data Requirements 1.1.9 Remittance Advice Remark Codes (RARC) are used by the MMIS using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP). NOTE – Institutional, professional, and dental claims contain CARC and RARC codes, while pharmacy claims contain NCPDP reject codes. RARCs are used in conjunction with CARCs to	N/A

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
				further explain a payment decision or to relay additional information. NCPDP reject codes are used to document denial reasons for pharmacy claims.	
8	6 12	Observation	The encounter was not submitted correctly. 1. Seq #6 - The encounter was not submitted as a crossover. 2. Seq #6/12 - No primary insurance was included on the encounter.	Attachment J – Encounter Data and Other Data Requirements 1.4 Enter Data Completeness, Accuracy, Timeliness, and Error Resolution The CONTRACTOR(S) shall provide complete and accurate encounters to the State. The CONTRACTOR(S) shall implement review procedures to validate encounter data submitted by providers. The following standards are hereby established:	N/A
9	11	Observation	A claim was adjusted but the original encounter was not voided.	Attachment J – Encounter Data and Other Data Requirements 1.4.4.2 Encounters cannot be adjusted; therefore, they must be updated through the Void and Replacement process. (See process described in the KanCare Guide). Encounters must be voided and a replacement sent within 30 days of identifying that the original encounter was in error.	N/A
10	15 16 18 48 49 50	Observation	Insufficient Documentation: 1. Seq #15 – Screen prints displaying the provider contracting update was not included in the supporting documentation. 2. Seq #16/18 - Although the supporting documentation confirms RAs prior to	5.16.1. Reports and Audits F. Throughout the duration of the CONTRACT, and for a period of ten (10) years after termination of the CONTRACT or from the date of completion of the audit, in accordance with 42 CFR § 438.3(h),	N/A

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
			5/7/2021 did not include a Disallowed column, it does not reference the Skygen issues from the Unified Log #660/789. 3. Seq # 48/49/50 - No documentation was provided to define the CMS Institutional Guidelines.	the CONTRACTOR(S) and any Subcontractors shall provide duly authorized representatives of the State or Federal government, access to all records and material, including financial records, relating to the CONTRACTOR(S)' provision of and reimbursement for activities contemplated under the CONTRACT. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the CONTRACT.	
11	34	Observation	Vendor Routing Issue. Procedures were billed by an optometrist; therefore, the claim should have been routed to the Vision vendor for processing instead of ABH denying the claim.	Attachment I – KanCare Claims Processing Requirements 1.5 Front End Billing (FEB) Requirements The FEB process was developed to assist in reducing provider administrative overhead and allowing providers to continue to bill in the same manner as they submit Kansas Medicaid claims. It also provides KDHE-DHCF a mechanism for data management. Claims will be split and forwarded to the appropriate managed care organization (MCO) by the Beneficiary's assignment on the earliest claim date of service. Front end editing will be applied to all claims sent to the MCOs based upon SNIP levels 1 through 4 compliance and validity editing. Electronic claims submitted to the Fiscal Agent will be forwarded to the MCO for processing via a daily 837 and NCPDP transactions. The CONTRACTOR(S) will be responsible for forwarding the appropriate claim types to their	N/A

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
				Subcontractors, for example; vision, dental, behavioral health and non-emergency medical transportation (NEMT).	