| | |
|---|---|
| **Attachment I**<br>**2.0 Pricing and Financial**<br>**2.1 Processing Requirements**<br>**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**<br>**1.1 Compliance with HIPAA-Based Code Sets**<br>**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 |
| **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).<br>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 | Review Sequence Number | Review Outcome | Description | Impacted Contract Requirement | Unified Log Number |
|---|---|---|---|---|---|
| 1 | 5<br>7<br>9 | Finding | The usage of Claim Adjustment Reason Code CO234 is not appropriate. CO45 should be used to reflect the difference between the Billed Amount and the Allowed Amount.<br>• CO234: Contractual Obligation - This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the | Attachment J - Encounter Data Requirements<br><br>1.1.8<br>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 | |

| Issue | Review Sequence Number | Review Outcome | Description | Impacted Contract Requirement | Unified Log Number |
|---|---|---|---|---|---|
| | | | NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.<br>• CO45: Contractual Obligation - 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). | specify whether the reduction is the responsibility of the provider or the patient. | |
| 2 | 10 | Finding | Place of service 21 (Inpatient Hospital) cannot be billed under the Rural Health Clinic/Federally Qualified Health Clinic provider number and, instead, should have been billed under the group number. See 8-5 of the RHC/FQHC FFS Provider Manual. Note: the group (eff 10/25/2021) was not effective on the date of service of the claim (8/19/2021). | Attachment I - KanCare Claims Processing Requirements<br><br>2.1.3<br>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. | |
| 3 | 11<br>12<br>15 | Finding | SHP incorrectly denied the professional fee on a State Hospital claim. Problem Notification Form: State Hospital Reimbursement – Prof Fees (96X Rev Code) has been received. | Attachment I - KanCare Claims Processing Requirements<br><br>2.1.3<br>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. | 910 |
| 4 | 26<br>27<br>51<br>52<br>53 | Finding | The supporting documentation does not explain how the invoice maps to encounters. | Attachment I - KanCare Claims Processing Requirements<br><br>2.1.3 | |

| Issue | Review Sequence Number | Review Outcome | Description | Impacted Contract Requirement | Unified Log Number |
|---|---|---|---|---|---|
| | | | | 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.<br><br>Attachment J - Encounter Data Requirements<br><br>1.1.8<br>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.<br><br>1.1.9<br>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).<br><br>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. | |
| 5 | 38 | Finding | Remittance Advice Remark Code N479 appears on the remittance advice; however, it was not submitted on the encounter.<br>• N479: Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). | Attachment J - Encounter Data Requirements<br><br>1.1.9<br>Remittance Advice Remark Codes (RARC) are used by the MMIS using standard codes defined and | |

| Issue | Review Sequence Number | Review Outcome | Description | Impacted Contract Requirement | Unified Log Number |
|---|---|---|---|---|---|
| | | | | maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).<br><br>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. | |
| 6 | 41 | Finding | The encounter was submitted incorrectly with Claim Adjustment Reason Code CO45. No documentation was submitted to address error.<br>• CO45: Contractual Obligation - 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<br><br>1.1.8<br>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. | |
| 7 | 43 | Finding | SHP denied the claim instead of processing under the QMB Benefit Plan on file for the date of service. | Attachment I - KanCare Claims Processing Requirements<br><br>2.1.3<br>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. | |

| Issue | Review Sequence Number | Review Outcome | Description | Impacted Contract Requirement | Unified Log Number |
|---|---|---|---|---|---|
| 8 | 51 | Finding | The invoice provided indicates the date of service of 1/21/21 was cancelled; however, SHP paid this date of service. | Attachment I - KanCare Claims Processing Requirements<br><br>2.1.3<br>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. | |
| 9 | 3<br>44<br>48 | Observation | System update for Claims Filing Indicator Problem Notification Form is outstanding. | Per KMAP TPL manual, In conjunction with the Standard Implementation Guide, KMAP requires the SBR09 segment in the 2000B or 2320 loop if the 837 file contains an MB (Medicare B) or MA (Medicare A) in order to create a Medicare crossover claim. | 777 |
| 10 | 16 | Observation | There is an encounter build issue. Taxonomy 261QF0400X should have been submitted for the billing provider on the encounter. This would have allowed the encounter to crosswalk to the Federally Qualified Health Center provider number. | Attachment J - Encounter Data Requirements<br><br>1.0 Encounter Data | |
| 11 | 17 | Observation | SHP did not submit the prior authorization requirements from the provider manual, as requested in the webinar. | 5.16.1. Reports and Audits<br><br>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), 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 | |

| Issue | Review Sequence Number | Review Outcome | Description | Impacted Contract Requirement | Unified Log Number |
|---|---|---|---|---|---|
| | | | | and material and to verify reports furnished in compliance with the provisions of the CONTRACT. | |
| 12 | 34<br>35 | Observation | SHP incorrectly denied the service as non-covered. Problem Notification Form: Non-Vision TPL Policies Loaded by Envolve Vision has been received. | Attachment I - KanCare Claims Processing Requirements<br><br>2.1.3<br>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. | 913 |