Contract AreAttachment 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/ Encounter Data Issues Log
1	26 27 29 30 40	Finding	Claim processing/pricing error. 1) Seq #26 – spenddown was entered into the WSDL but was not applied to the claim. 2) Seq #27 – the incorrect procedure code was used on the claim. It should have been A0200 (non-emergency transportation/lodging-escort). 3) Seq #29 – processor changed values on the claim, so the claim paid $0 in error, when payment should have been made. 4) Seq #30 – processor changed values on the claim, so the claim paid $0 in error when it should have been denied. 5) Seq #40 - the claim was denied in error for unacceptable diagnosis code because the correct policy attachment was not used.	Attachment I – 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
2	5 10 45 46 47 48 49	Finding	The encounter submitted should include all the Claim Adjustment Reason Codes (CARCs) provided on the RA. 1) Seq #5, 45 – PR27 is on the RA but not the encounter. 2) Seq #10 – CO45 is included on the encounter but is not on the RA. 3) Seq #46, 47 – OA23 is on the RA but not on the encounter. 4) Seq #48 – OA23/CO45/N647 on the RA but the encounter lists CO45 on every detail. 5) Seq #49 – The RA shows CO6/CO45 for Detail 1 is on the RA and the encounter shows CO6/CO94; no CARCs listed for Details 2/3 on the RA and the encounter shows CO45.	Attachment J – Encounter Data and Other 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

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number/ Encounter Data Issues Log
3	48	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
4	48 49	Finding	The encounter submitted should include all the Remittance Advice Reason Codes (RARCs) provided on the RA. 1) Seq #48 – N647 is on the RA but is not included on the encounter. 2) Seq #49 – The RA shows RARC N129/N647 and the encounter only shows N129.	Attachment J – Encounter Data and Other 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 further explain a payment decision or to relay additional information. NCPDP reject codes are used to document denial reasons for pharmacy claims.	N/A

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number/ Encounter Data Issues Log
5	11 12 28 38	Observation	The encounter submitted should include all the CARC codes provided on the RA. (T-MSIS multiple CARC/RARC, corrected June 2021) 1) Seq #11, 12 – OA23 is on the RA but not on the encounter. 2) Seq #28 – CO45/CO109 is on the RA but CO45 is on the encounter. 3) Seq #38 – OA23/CO45 is on the RA but OA23 is on the encounter.	Attachment J – Encounter Data and Other 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
6	3 4 6 9	Observation	CARC codes are missing on RA but are reporting on the encounter. 1) Seq #3, 4, 6, 9 – CO94 should be reported on the RA to indicate payment was more than the billed charge. 94 - Processed in Excess of charges.	Attachment J – Encounter Data and Other 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
7	5 14 15 30 46 47 49	Observation	The encounter was not submitted correctly. 1) Seq #5, 14, 15, 46, 47, 49 – the encounter was submitted with an MCO status of Paid $0 when the MCO claim was denied (unrelated to COB). 2) Seq #30 – the encounter was submitted with an MCO Denied status when the MCO claim paid $0.	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

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number/ Encounter Data Issues Log
8	29	Observation	Claim was adjusted but the original encounter was not voided and replaced.	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
9	29 30	Observation	Insufficient documentation: 1) Seq #29, 30 – the documentation does not provide the employee coaching date.	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), 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.	N/A

Issue Type	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number/ Encounter Data Issues Log
10	1 13 28 46 47 49	Observation	Problem Notification Form, Incorrect CARC Reporting on Claim, was submitted 12/12/22. System Changes are outstanding. 1) Seq #1 – CO97 2) Seq #13, 28, 49 – CO45 3) Seq #46, 47 – OA23	Attachment I – Claims Processing Requirements 4.3.5 Provide HIPAA-compliant remittance advices (paper and electronic) and deliver to providers.	N/A