Contract Area: Claims

Aetna Better Health	2023 Finding:
Scope of Work – Claims Management **Nursing Facilities** **5.14.1.F.1. (a)** The CONTRACTOR(S) shall: Pay at least the FFS rate to the NF.	SUBSTANTIALLY MET
5.14.1.F.1. (d) The CONTRACTOR(S) shall: Pay 90% of clean claims within fourteen (14) calendar days and 99.5% of clean claims within twenty-one (21) calendar days. The CONTRACTOR(S) will also provide technical assistance to nursing home Providers for claims submission.	FULLY MET
Attachment I – Pricing and Financial **Processing Requirements** **2.1.4** Deduct Member responsibility amounts (patient liability, client obligations, and spenddown) according to State guidelines when pricing claims. Note: Please refer to the "Patient Liability, Client Obligation and Spenddown Comparison Chart" in the KanCare Guide.	SUBSTANTIALLY MET
2.1.5 Price TPL and Medicare crossover claims at the lesser of the KMAP/MCO contracted rate or Medicare allowed amount on paper and electronic media.	FULLY MET
Attachment I – Adjudication **Edit/Audit Processing Requirements** **3.1.34** Track long-term care (LTC) (i.e., NF, NFMH, PRTF, and ICF/IID). Member leave days (hospital and therapeutic.)	SUBSTANTIALLY MET
3.1.35 Edit Member LTC information against authorized Member and provider level-of-care information.	SUBSTANTIALLY MET
Comments:	

Below is a summary of the issues found during the review. See the attached contract review results for the detailed response for each claim review: *ABH 2023 Claim-Encounter Contract Review – FINAL BOT Response.*

Draft Response was sent to ABH 10/26/2023
ABH rebuttal received 11/9/2023
BOT remediated in collaboration with ABH on the identified issues 11/14/2023 (items 2 and 8)
BOT began working with ABH on the outstanding issues 11/14/2023

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
1	1, 27	Finding	Claim processing/pricing error. 1) Nursing facility claims should not be applied to spenddown. The entry in the web service triggered the entry of spenddown $ on the encounter. Observation.	Attachment I – Pricing and Financial 2.1.4 Deduct Member responsibility amounts (patient liability, client obligations, and spenddown) according to State guidelines when pricing claims. Note: Please refer to the "Patient Liability, Client Obligation and Spenddown Comparison Chart" in the KanCare Guide.	Problem Notification Form: N/A Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: Outstanding (seq 27)
2	1	Finding	Claim processing/pricing error. 1) Beneficiary ineligible for Level of Care (LOC) billed.	Attachment I – Adjudication 3.1.35 Edit Member LTC information against authorized Member and provider level-of-care information.	Problem Notification Form: N/A Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: N/A
3	2 18-31 37 40 43 46-50	Observation	Encounter CARCs/RARCs do not match the RA. 1) Seq # 2, #18-#31, #37, #40, #43, #46-#50 The encounter build is at the header but claims process at the detail. The encounter should match the RA. 2) Seq # 2, #18-#31, #37, #40, #43, #46-#47, #49 CO45 on encounter but not on RA. The RA is reporting a Disallowed statement instead. CO45 should not be used for a denied service and the amount cannot equal the service charge. 3) Seq #25 CARC CO97 not on the encounter. CO97 (the benefit for this service is included in the	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. 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.	Problem Notification Form: 1) Outstanding 2) Outstanding 3) Outstanding 4) Outstanding Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: 1) Outstanding 2) Outstanding 3) Outstanding 4) Outstanding Adjustments: N/A

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
			payment/allowance for another service/procedure that has already been adjudicated) is reported at the header and on details on the RA but is not present on the encounter. The encounter should match the RA. 4) Seq #18 CARCs OA94/CO97 not on the encounter. OA94 (processed in excess of charges) and CO97 (the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated) is reported on the details on the RA but is not present on the encounter. The encounter should match the RA.		
4	2 18-21 23-31 37 46-47 49	Observation	Claim processing/pricing error. 1) Seq #2 Reserve day - revenue code 189. Revenue code 189 (other leave of absence; non-covered days) is paying $0 instead of denying for non-covered reserve days. KMAP would have denied details with edit 4215 (Revenue Code for Non-Covered LTC Reserve Days). Problem Notification Form Revenue 189 Paid at $0 Instead of Denied for SNF received 7/25/23. 2) Seq #18-#21, #23-#31, #46-#47, #49 Ancillary services revenue code processing. ABH is not denying content of service and paying $0 instead. KMAP would have denied	Attachment I – Adjudication 3.1.21 Edit nursing facility (NF), state mental health hospital, NF for mental health (NFMH), psychiatric residential treatment facility (PRTF), intermediary care facilities for individuals with intellectual disabilities (ICF/IID), and home- and community-based services (HCBS) waiver program claims against Member level-of-care, admit/discharge information, and program guidelines.	Problem Notification Form: 1) Revenue 189 Paid at $0 Instead of Denied for SNF 2) Ancillary Services for Skilled Nursing Claims 3) Outstanding 4) Revenue code 110 Paid at $0 for SNF Unified Log: 1) 1542 2) 1544 3) N/A 4) 1543 Claims Resolution Log: N/A Encounter Data Issues Log: 1) Outstanding 2) Outstanding

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
			details with edit 4271 (PT/PS Not Covered for Revenue Code). Problem Notification Form Ancillary Services for Skilled Nursing Claims was received 7/25/23. 3) Seq #19-#21, #23-#31 Non-covered revenue code processing. ABH is paying $0 instead of denying. KMAP would have denied detail with 4227 (Revenue Code Indicates Not Covered for DOS). A Problem Notification Form should be documented. 4) Seq #37 Revenue code 110 (room-board/private1) processing. ABH is paying $0 instead of denying. KMAP would have denied details with edit 4271 (PT/PS Not Covered for Revenue Code). Problem Notification Form Revenue code 110 Paid at $0 for SNF was received 7/25/23.		3) Outstanding 4) Outstanding Adjustments: N/A
5	6	Observation	Insufficient documentation. 1) The documentation submitted does not clearly explain why ABH pays primary without EOB information when there is Medicare or TPL on file. Problem Notification Form LTC Room and Board Paying as Primary was received 9/21/23 but it is not clear how this PNF applies to the issue.	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	Problem Notification Form: 1) LTC Room and Board Paying as Primary Unified Log: N/A Claims Resolution Log: To Be Determined Encounter Data Issues Log: To Be Determined Adjustments: To Be Determined

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				verify reports furnished in compliance with the provisions of the CONTRACT.	
6	14	Observation	Claim processing/pricing issue 1) The original claim was adjusted 6/23/23 - MCO ICN 22335E0174307A1/ Encounter ID 7023185024349. This claim was paid without a valid beneficiary level of care for the date of service. LOC 120 (NF – Nursing Facility 11/25-11/30/2023 only.	Attachment I – Adjudication 3.1.35 Edit Member LTC information against authorized Member and provider level-of-care information.	Problem Notification Form: N/A Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: Yes
7	15, 33, 37, 39, 44	Finding	Claims processing/pricing error. 1) Seq #33, #37, #39, #44 Rounding issue. ABH is paying less than the FFS rate. A Problem Notification Form should be submitted for this issue. 2) Seq #15 Pricing error. ABH is paying less than the FFS rate. A Problem Notification Form may be necessary for this issue.	Scope of Work – Claims Management Nursing Facilities 5.14.1.F.1. (a) The CONTRACTOR(S) shall: Pay at least the FFS rate to the NF.	Problem Notification Form: 1) Outstanding 2) To Be Determined Unified Log: N/A Claims Resolution Log: 1) Outstanding 2) To Be Determined Encounter Data Issues Log: 1) To Be Determined 2) To Be Determined Adjustments: 1) To Be Determined 2) To Be Determined
8	20-21 23-31 49	Observation	Inappropriate use of CARC/RARC on the RA. 1) ABH is inappropriately denying the non-covered revenue code using RARC N56 - procedure code billed is not correct/valid for the services billed or the date of service billed. A more appropriate RARC would be M50 - missing/incomplete/invalid	Attachment I – Claims Processing 4.3.5 Produce HIPPA-compliant remittance advices (paper and electronic) and deliver to providers. 4.3.6 Ensure all EOB codes sent on an 835 remittance advice are HIPAA compliant. If necessary, provide supplemental training materials for providers to understand the root cause of the	Problem Notification Form: Outstanding Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: Outstanding

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			revenue codes(s). ABH implemented a temporary fix 9/22/23 and is working on a permanent solution within 60 days.	denial when the HIPAA reason codes do not provide specific detail. 4.3.7 Report all error codes on the remittance advice (RA).	Adjustments: N/A
9	2 18 22 25 30	Observation	RA reporting issue. 1) Seq #2, #18, #22, #25, #30 Non-covered charge(s) statement. There is a Non-Covered Charge(s) statement reporting at the header on the RA. Problem Notification Form CO96 Noncovered Charges was submitted 7/25/23. 2) Seq #18 The patient liability is showing in the Client Obligation field on the RA and the full amount is not visible. The RA has been updated to support more than 7 characters; however, it is not known when that change was implemented or the source of the issue that caused the patient liability load or RA reporting issues (field and amount). A Problem Notification Form should be submitted for this issue. 3) Seq #25 CARCs/RARCs are not reporting on the RA for all claim details. The RA is not HIPAA compliant.	Attachment I – Claims Processing 4.3.5 Produce HIPPA-compliant remittance advices (paper and electronic) and deliver to providers. 4.3.6 Ensure all EOB codes sent on an 835 remittance advice are HIPAA compliant. If necessary, provide supplemental training materials for providers to understand the root cause of the denial when the HIPAA reason codes do not provide specific detail. 4.3.7 Report all error codes on the remittance advice (RA).	Problem Notification Form: 1) Non-covered Message on Remittance 2) To Be Determined 3) Outstanding Unified Log: 1) 1545 2) N/A 3) N/A Claims Resolution Log: N/A Encounter Data Issues Log: 1) N/A 2) N/A 3) N/A Adjustments: N/A

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
10	16-26 28-31 47	Observation	Claims processing/pricing error. 1) Patient liability was applied to a zero Paid claim. Previously known issue. PNF Patient Liability Applied to $0 Claims in Error received 4/25/23.	Attachment I – Pricing and Financial 2.1.4 Deduct Member responsibility amounts (patient liability, client obligations, and spenddown) according to State guidelines when pricing claims. Note: Please refer to the "Patient Liability, Client Obligation and Spenddown Comparison Chart" in the KanCare Guide.	Problem Notification Form: 1) Patient Liability Applied to $0 Claims in Error Unified Log: 1467 Claims Resolution Log: Outstanding Encounter Data Issues Log: Outstanding Adjustments: Outstanding
11	36-37	Finding	Claims processing/pricing error. 1) ABH is not editing for 18 total reserve days. KMAP would have denied detail with 6244 (Allow 18 Days Home Leave per Calendar Year). Problem Notification Form Skilled Nursing Reserve Day Editing received 7/25/23.	Attachment I – Claims Processing Requirements 3.1.34 Track long-term care (LTC) (i.e., NF, NFMH, PRTF, and ICF/IID). Member leave days (hospital and therapeutic.)	Problem Notification Form: 1) Skilled Nursing Reserve Day Editing Unified Log: N/A Claims Resolution Log: To Be Determined Encounter Data Issues Log: To Be Determined Adjustments: Outstanding
12	50	Observation	Claim processing/pricing error. 1) ABH incorrectly denied the claim for psychiatric diagnosis. Problem Notification Form Incorrect Denials for Psychiatric Diagnosis for SNF Therapy Codes was received 9/11/2023.	Attachment I – Claims Processing Requirements 1.8.15 Perform validity editing on all entered claims against provider, Member, and reference data.	Problem Notification Form: 1) Incorrect Denials for Psychiatric Diagnosis for SNF Therapy Codes Unified Log: 1557 Claims Resolution Log: Outstanding Encounter Data Issues Log: N/A Adjustments: Outstanding