Contract Area: Claims

UnitedHealthCare	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.	FULLY 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. *NOTE: KDHE was unable to accurately identify crossover claims from UHC. KDHE believes the research/correction of the CO45 issue may identify the source of this issue. See number 4 below.*	MINIMALLY 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.	FULLY MET
Comments:	

Recommendation/Summary:

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. *UHC 2023 KC Claim-Encounter Contract Review – FINAL BOT Response.*

NOTE: KDHE was unable to accurately identify crossover claims from UHC; thus, scored RFP requirement 2.1.5 as Minimally Met. KDHE believes the research/correction of the CO45 issue may identify the source of this issue. See number 4 below.

Draft Response was sent to UHC: 11/30/2023

UHC rebuttal received: No rebuttal
BOT remediated in collaboration with UHC on the identified issues: N/A
BOT began working with UHC on the outstanding issues: 12/18/2023

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
1	1 - 46	Observation	Encounter CARCs/RARCs do not match the RA. 1) Seq 1 - 46 The RA is reporting PR2/PR142 and the encounter is reporting PR142. This is an existing issue that was identified in the 2022 State Contract Review. Problem Notification Form Encounter Missing Multiple CARCs/RARCs (Unified Log 716) was received 2/28/23.	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: Encounter Missing Multiple CARCs/RARCs Unified Log: 716 Claims Resolution Log: N/A Encounter Data Issues Log: 38 Adjustments: N/A
2	2-3 5 11 14-17 22 27 30 34 36-38 41 43 45 47	Observation	Inappropriate use of CARC/RARC on the RA. 1) Seq 2-3, 5, 11, 14-17, 22, 27, 30, 34, 36-38, 41, 43, 45, 47 CARC CO45 was used for the entire billed amount for the detail of a claim. UHC is posting an internal edit which is tied to CO45, causing CO45 to report on the RA incorrectly. This is an existing issue that was identified in the 2022 State Contract Review. Problem Notification Form Inappropriate CARC Reporting on Remittance	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: Inappropriate CARC Reporting on RA Unified Log: 696 Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: N/A

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
			Advice (RA) (Unified Log 696) was received 12/12/2022. 2) Seq 47 OA23 reporting on the RA but not on the encounter. This is an existing issue that was identified in the 2022 State Contract Review. Problem Notification Form Inappropriate CARC Reporting on Remittance Advice (RA) (Unified Log 696) was received 12/12/2022.		
3	15 22 30 35 43 44	Observation	Claim processing/pricing error. 1) Seq 15, 22, 30, 35, 43, 44 Processing error. UHC does not require a COB EOB when processing LTC claims. KMAP policy uses the TPL coverage types G (skilled care in a nursing facility) and Z (intermediate care in a nursing facility) to identify LTC primary insurance coverage on file and would not bypass the COB edit if these coverage types were on file.	Attachment I – KanCare Claims Processing Requirements 3.1.7 Identify potential and existing TPL (including Medicare) and deny or pay and report the claim, depending on the edit, if it is for a covered service under a third party resource, for applicable claim types and covered periods.	Problem Notification Form: To Be Determined (TBD) Unified Log: N/A Claims Resolution Log: TBD Encounter Data Issues Log: TBD Adjustments: TBD
4	5 11 15-28 30-31 33-38 43-44 46 48-50	Observation	Encounter was not submitted correctly. 1) Seq 5, 11 The supporting documentation indicates primary payment but, the encounter was submitted with primary insurance paying $0: - B - Other $0 (Medicare Xover) - CI, TPL paying $0 (TPL Adjustment Summary). The encounter was not built correctly.	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:	Problem Notification Form: 1) TBD 2) TBD Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: 1) TBD 2) TBD

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
			2) Seq 5, 11, 15-28, 30-31, 33-38, 43-44, 46, 48-50 UHC is using CO45 with the full billed amount when reporting Medicare and/or TPL info (TPL Adjustment Summary).		Adjustments: 1) TBD 2) TBD
5	15-17 22 25 30 34-39 43 44	Observation	Insufficient documentation. 1) Seq 15, 16, 22, 30, 35, 39, 43, 44, 46, 50 UHC did not answer the question about why the encounter has TPL info when there was no TPL EOB and COB was bypassed during claim processing. 2) Seq 17, 25, 34, 35, 36, 37, 38 UHC did not answer the question about why M was used to bypass the COB edit.	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.	Problem Notification Form: N/A Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: N/A
6	39	Finding	Claim processing/pricing error. 1) Seq 39 Hospital reserve day limit of 10 was exceeded due to a clerical error.	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: TBD Unified Log: N/A Claims Resolution Log: TBD Encounter Data Issues Log: N/A Adjustments: TBD
7	46-50	Observation	Timely claims processing issue. 1) Seq 46, 47, 48, 49, 50 The clean claim was not processed within 30 calendar days of receipt.	Scope of Work 5.14.1.B.1 100% of all clean claims including adjustments must be processed and paid or processed and denied within thirty (30) calendar days of receipt.	Problem Notification Form: N/A Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
					Adjustments: N/A
8	41	Observation	Claim processing/pricing error. 1) Seq 41 Pricing error. The payment rate for detail 1 was not calculated at 67%.	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.	Problem Notification Form: TBD Unified Log: N/A Claims Resolution Log: TBD Encounter Data Issues Log: N/A Adjustments: TBD
9	44	Finding	Claim processing/pricing error. 1) Seq 44 UHC paid less than the FFS rate. Note: Claim was adjusted 7023186111722, $231.32	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: TBD Unified Log: N/A Claims Resolution Log: TBD Encounter Data Issues Log: N/A Adjustments: No
10	5 11 39	Observation	Claim processing/pricing error. 1) Seq 5, 11, 39 UHC processed the claim with Medicare as the primary payor, instead of TPL.	Attachment I – KanCare Claims Processing Requirements 3.1.8 Edit to ensure that TPL including Medicare and Medicare inpatient Part-B payments, have been coordinated with and applied to claims.	Problem Notification Form: TBD Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: Yes