KDHE- DHCF

Annual Contract Review

Sunflower Health Plan

2022

Table of Contents:

2022 Contract Review

Sunflower Health Plan

Findings Descriptions

Fully Met:

- All documentation listed under a State contract area, or component thereof, is present; and
- MCO staff provided responses to reviewers that are consistent with each other and with the documentation; or
- A State-defined percentage of all data sources – either documents or MCO staff provided evidence of compliance with State contract areas.

Substantially Met:

- After review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as stated above.

Partially Met:

- All documentation listed under a State contract area, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or
- MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or
- Any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a State contract area would result in a "Partially Met" designation for the provision as a whole.

Minimally Met:

- After review of the documentation and discussion with MCO staff, it is determined that although some contract requirements have been met, the MCO has not met most of the contract requirements.

Not Met:

- No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with State contract requirements; or
- No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the State) of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

Not Applicable:

- The contract provision is not applicable to the MCO.

Contract Area: Claims

Lead: Shelly Liby & Brett Ericson	2022 Finding:	2021 Finding:
Attachment I **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	NOT APPLICABLE
Attachment J **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	NOT APPLICABLE
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	NOT APPLICABLE
Requests:		
Documentation Requests: 1. 8/16/22 – Initial Review Request 2. 9/16/22 – Preliminary Review Request 3. 9/22/22 – Updated Review Request 4. 9/23/22 – Follow up Webinar Request		
Drop location: KANCARE>Sunflower>2022>Claims		

SHP Webinar 9/23/2022 1:00 – 3:00pm MCO Attendance List: Sunflower: Michelle Boller, Hannah Halstead, Janelle Carter, Gordy Johnston, Sherilyn Fahlstrom, Katie Walker KDHE Attendance List: Deirdre Harmon, Brett Ericson, Shelly Liby, Rhonda Kearney, Rolanda Ellis Gainwell Technologies Attendance List: Jennifer Kelly, Julie McDaniel, Kris Schaub, Cathy Lauer
Webinar Requests: 1. Sample #3- SF- will submit PNF when, resolution, & result of reprocessing. Add to UN Log & Encounters Log. Filing indicator not resolved, add CARC/RARC 2. Sample #8- SF is currently auditing and once complete will adjust claim & update response to reflect the summary. 3. Sample #10- SF- will work with encounters team regarding taxonomy build. 4. Sample #16- SF- will check on the taxonomy that was sent and follow up. CARC/RARC will be included and sent back as well. 5. Sample #17- SF- will follow up with the authorization requirements from the provider manual. 6. Sample #26- SF- will update summary to show how it maps to the encounters. 7. Sample #27- SF- will update summary to show how it maps to the encounters. 8. Sample #30- SF- this sample will be disregarded and removed from the list. 9. Sample #41- SF- will send documentation to KDHE for further review. 10. Sample #43- SF- will confirm coverage for procedure code.
Drop location: KANCARE>Sunflower>2022>Claims
Post-Webinar Requests: None
Drop location: KANCARE>Sunflower>2022>Claims
Comments:
Desk Review Notes: (another row, table, drop down, etc. can be include at your discretion.)
Webinar Notes:
Post-Webinar Notes:

2022 KC State
Contract Review Do

Recommendation/Summary (this language goes into the Final Scoring Letter):

KDHE requests the following issues be tracked using the Unified Log. The MCO should provide 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 7 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. • CO234: Contractual Obligation - This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT. • 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 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.	
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 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.	
3	11 12 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 2.1.3 Identify and calculate payment amounts according to the fee schedules, per diems, Diagnosis related	910

Issue	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
				group rates, capitation rates, case management fees, and global rates established by the State.	
4	26 27 51 52 53	Finding	The supporting documentation does not explain how the invoice maps to encounters.	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. 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. 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.	

Issue	Review Sequence Number	Review Outcome	Description	Impacted Contract Requirement	Unified Log Number
5	38	Finding	Remittance Advice Remark Code N479 appears on the remittance advice; however, it was not submitted on the encounter. • N479: Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	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 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. • 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 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.	
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 2.1.3	

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				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.	
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 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.	
9	3 44 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 1.0 Encounter Data	
11	17	Observation	SHP did not submit the prior authorization requirements from the provider manual, as requested in the webinar.	2.3.4.4 - General Audit Procedures 2.3.4.4.1 Throughout the duration of the CONTRACT, and for a period of six (6) years after termination of the CONTRACT, the CONTRACTOR or its 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	

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				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.	
12	34 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 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.	913