KDHE-DHCF

Claims Contract Review

Sunflower Health Plan

2023

Contract Area: Claim/Encounter

Sunflower	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.	FULLY 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.	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.	FULLY MET
Comments:	

Recommendation/Summary:
See the attached contract review results (emailed separately) for a detailed response for each claim review - SHP 2023 Claim-Encounter Contract Review – FINAL BOT Response

Draft Response was sent to SHP 07/21/2023
SHP rebuttal received 08/04/2023
BOT remediated in collaboration with SHP on the identified issues 10/11/2023 (see item 6)
BOT began working with SHP on the outstanding issues 10/31/2023

Issue No.	Review Sequence Number	Review Outcome	Issue/Impact	Impacted Contract Requirement(s)	Follow Up Needed
1	1-43 45-50	Observation	Encounter CARCs/RARCs do not match the RA. 1) Seq #1-#3, #5-#11, #13-15, #32-#43, #45 The RA lists PR2 (coinsurance amount) and the encounter lists PR142 (monthly Medicaid patient liability amount). This issue has been referred to the KDHE EDI team for review. A PNF should be submitted for this issue. 2) Seq #4, #12 The RA lists SHP exception codes O2/92 and the encounter lists PR142. A PNF should be submitted for this issue. 3) Seq #16-31, #46-50 The RA lists CARCs/RARCs that do not match what is provided on the encounter. A PNF, CARC/RARC Mismatch on the Encounter to RA, was received. These issues should be added to the Encounter Data Issues Log.	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) Completed. CARC/RARC Mismatch on the Encounter to RA was received 5/25/23. Unified Log: 1) Outstanding 2) Outstanding 3) 1174 Claims Resolution Log: N/A Encounter Data Issues Log: 1) N/A 2) Outstanding 3) 50 Adjustments: N/A
2	1-3 5-11 13-15	Observation	Inappropriate use of CARC/RARC on the RA.		Problem Notification Form: 1) Outstanding

	24 32-43 45		1) Seq #1-#3, #5-#11, #13-15, #32-#43, #45 PR2 (coinsurance amount) is used on the RA instead of PR142 (monthly Medicaid patient liability). Referred to the KDHE EDI team for review. A PNF should be submitted for this issue. 2) Seq #24 CO242 (services not provided by network/primary care providers) and M115 (this item is denied when provided to the patient by a non-contract or non-demonstration supplier) were used on the RA. PNF, 92507 and 92508 Denied for Non-Contracted on NF Claims, was received.		2) Completed. 92507 and 92508 Denied for Non-Contracted on NF Claims was received 6/5/23. Unified Log: 1) N/A 2) 1204 Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: N/A
3	4 12	Observation	There are no CARCs/RARCs listed on the RA; therefore, the RA is not HIPAA compliant. 1) Seq #4, #12 The RA has only SHP exception codes listed and no corresponding CARCs/RARCs. PNF, CARC/RARC codes on the Paper Remittance Advice, was received.	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: Completed. CARC/RARC codes on the Paper Remittance Advice was received 5/25/23. Unified Log: 1173 Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: N/A

4	11 32-34 36 38-43 45	Observation	The RA is out of balance and is not HIPAA compliant. 1) Seq# 11, #32-#34, #36, #38-#43, #45 CO45 is listed on the RA but is not tied to an amount. A PNF should be submitted for this issue.	Attachment I – Claims Processing 4.1.1.6 MCO, TPL and Medicare payment data including allowed amounts, payment amounts, deductible, co-payments, co-insurance, paid date, denied date, claim adjustment reason codes/remittance advice remark codes (CARC/RARCs) 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: Outstanding Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: N/A
5	16-32	Observation	The encounter data does not match the claim. The Type of Bill (TOB) for the original encounter submission does not match what was submitted by the provider. 1) Seq #16-32 SHP misinterpreted instructions in the KanCare Guide. The third digit of the TOB on the encounter is being changed to 1 to reflect an initial encounter submission instead of sending what the provider submitted. A PNF should be submitted for this issue and this should be added to the Encounter Data Issues Log. SHP should submit the level of effort it will take to make this change.	Attachment J – Encounter Data and Other Data Requirements 1.4.1 Completeness The CONTRACTOR(S) must submit encounters that represent at least ninety-eight (98%) of the covered services provided by the Health Plan network and non-network providers. The CONTRACTOR(S) shall strive to achieve a one-hundred percent (100%) complete submission rate. All data submitted by the providers to the CONTRACTOR(S) must be included in the encounter submissions.	Problem Notification Form: Outstanding Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: Outstanding Adjustments: N/A
6	16-31 46-48	Observation	Encounters are denying for missing or invalid information. SHP is processing	Attachment I – Claims Processing	SHP rebuttal received 8/4/23. Upon review, KDHE determined no changes

	49 50		Medicare crossovers as they are submitted to Medicare. KMAP requires nursing facilities to submit using the LTC claim type. Accepting and processing claims as billed to Medicare is causing conflicts with encounter processing because of KMAP claim type billing requirements. SHP should process long term care claims as outlined in the KMAP Nursing/Intermediate Care Facility FFS Provider Manual. A Problem Notification Form should be documented, and the issue should be added to the Encounter Data Issues Log. SHP should submit the level of effort it will take to make this change. 1) Seq #16-#31, #46-#48, #50 - outpatient - Admit Date - Covered Days Value Code 2) Seq #49 - inpatient - Detail billed amount missing - Detail date of service not equal to from/thru date of service - Procedure code not on file	1.8.1 The CONTRACTOR(S) shall process all claims completely, timely and accurately. 1.8.15 Perform validity editing on all entered claims against provider, Member, and reference data.	were necessary and the issue will not be pursued. KDHE responded to the rebuttal request 10/11/23.
7	39	Finding	Claim processing error. 1) Seq #39 SHP allowed more than 10 reserve days to be paid. The claim will need to be adjusted.	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: N/A Unified Log: N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: Y

8	44 46-49	Observation	Claim processing error. 1) Seq #44 SHP failed to use the Denial of Payment for New Admissions – NF (DNPA)) status for the provider and the claim was paid in error. PNF, NF DNPA Status and Processing, was received. 2) Seq #46 The claim was denied for timely filing incorrectly. Claim needs to be reprocessed, if not already completed. 3) Seq #46-49 The clean claim was processed outside of 30 days. This is previously known issue. PNF, Claims Processing Timeliness – Claims Reorganization, was received. 4) Seq #49 The claim was applied to spenddown in error. The beneficiary was Medically Needy at the time the claim was processed and the claim was entered into the Spenddown Web Service. The entry in the web service triggered the entry of spenddown $ on the encounter. The claim was removed from web service; however, the encounter was not voided and replaced. The claim should be adjusted, if not already completed.	Attachment I – Claims Processing Requirements 3.1.19 Edit provider eligibility to perform type of service rendered on date of service, including editing of the provider's CLIA identification number, if necessary 1.8.1 The CONTRACTOR(S) shall process all claims completely, timely and accurately. Scope of Work 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.	Problem Notification Form: 1) Completed. NF DNPA Status and Processing was received 5/25/23. 2) N/A 3) Completed. Claims Processing Timeliness- Claims Reorganization received 8/19/22. 4) N/A Unified Log: 1) 1175 2) N/A 3) Claims Timeliness and aging inventory 4) N/A Claims Resolution Log: N/A Encounter Data Issues Log: N/A Adjustments: 1) N/A 2) Outstanding 3) N/A 4) N/A
9	16-31 47-50	Observation	The MCO claim status is Paid $0. Ancillary services are considered part of the nursing home per diem rate and should be denied instead of Paid $0. 1) Seq #16-#31, #47-#50	Attachment I – Claims Processing Requirements 2.1.7 Price using other payment methodologies as determined by the State, depending on beneficiary program eligibility or type of claim.	Problem Notification Form: Outstanding Unified Log: N/A Claims Resolution Log: N/A

			KMAP would deny these revenue codes using: - Edit 4227 (revenue code indicates not covered for date of services) - EOB 0779 (Detail denied. The revenue code given is either invalid, unacceptable, or noncovered) The KMAP reference files indicate the revenue codes are not allowed with provider type 03 (custodial care facility). A PNF should be submitted for this issue and this should be added to the Encounter Data Issues Log.	3.1.13 Maintain a function to process claims against an edit/audit criteria file or table and an error disposition file to provide flexibility in edit and audit processing (including system parameters) based on KMAP Benefit grid.	Encounter Data Issues Log: Outstanding Adjustments: N/A