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KanCare All MCO Training

Spring 2021

aetna™

Aetna Better Health® of Kansas

sunflower health plan™

UnitedHealthcare®

Community Plan

Welcome, Introductions & Agenda

- Welcome
- Introductions
  - Aetna Better Health of Kansas
  - Sunflower Health Plan
  - United HealthCare

- Agenda for the day
  - Session 2 –
    - Denials & Helpful Hints
    - Policy Updates

Top 5 CMS-1500 Denials

Top 5 Professional Claim denials:

1) Send Primary Carriers EOB
2) Submitted after Provider filing limit
3) No authorization on file
4) Content of Service
5) Multiple Providers NPI is not valid

Top 5 UB Claim Denials

Top 5 UB-04 Claim denials:

1) No authorization on file
2) Send Primary Carriers EOB
3) Submitted after Provider filing limit
4) Billing Providers information not valid
5) Member Name Number Date of Birth Do Not Match, Please resubmit

Prior Authorization Denials

Claim or claim line denied because a prior authorization was required and not obtained or the prior authorization was requested and denied.

CO 197: Precertification/authorization/notification absent

A PA is required for the service billed and one was not requested

CO 39: Services denied at the time authorization/pre-certification was requested

A PA has been requested and processed but was denied by our clinical staff

- If a PA was obtained and a provider believes the PA denial is being applied in error, submit a claims reconsideration or formal appeal
- If a PA was required and none was obtained, the services denied for no PA are a provider contractual write-off
- Each MCO has a specific process in place to address members who are retroactively deemed eligible

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Member Has Other Insurance

Claim or claim line denied because member has other insurance (Medicare or other commercial plan) responsible for payment prior to Medicaid consideration of payment

PI 252: An attachment/other documentation is required to adjudicate this claim/service

CO 252: An attachment/other documentation is required to adjudicate this claim/service

Original claim was submitted without primary/secondary payer information

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Content of Service

Claim or claim line denied or zero paid because the service being billed is considered included in the payment of another service provided on the same date of service

CO 97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- Check KMAP Policy and National Correct Coding Initiative (NCCI) rules for the code or codes impacted to ensure the initial claim was submitted correctly
  - KMAP General bulletin 16065 posted in July 2016 provides a list of codes always considered content of service per KMAP policy
  - IVs, medications, supplies, and injections provided on the same day as an ambulatory/outpatient surgery procedure are considered content of service of the surgery and cannot be billed separately
  - Medical supplies and injections (99070 and J7030-J7130) are considered content of service of ER room visits and Observation stays

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Timely Filing

Claim denied because the service being billed was billed outside the Providers Timely Filing guidelines.

PI29: The time limit for filing a claim has expired

Providers must check their individual contract with each MCO

- New Day Claims, generally 180 days from the date of Service
  - Retro-eligibility, 180 days from the date the member was deemed eligible
- Corrected Claims, generally 365 days from the date of service

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Missing Required Documentation

Claim or claim line denied for missing required documentation

CO 16: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

CO 252: An attachment/other documentation is required to adjudicate this claim/service

Required information for processing the claim was not submitted on the claim or as an attachment. Common examples of missing items or attachments: NDC codes, Sterilization Consent Form, Present On Admission (POA) indicator required

- Providers needing assistance to determine what documentation is required can contact the MCO Provider Services call team
- Identify the required information missing from the claim, make the necessary corrections to the claim, and submit a corrected claim to the appropriate MCO
- If a provider feels the required documentation was provided with the initial claim and the claim was denied incorrectly by an MCO, submit a claims reconsideration or a formal appeal

Note: This denial reason code may return on O/P hospital claims billed with no procedure code

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Provider Information not valid

Claim denied because the NPI(s) on the claim are not valid

CO16: Billing provider not found on the State Provider file. Please submit with correct Tax ID, Taxonomy and/or Zip code.

N77: Multiple provider's NPI not valid

- Provider would need to verify NPI has been enrolled in KMAP and has a valid/active KMAP identification number.
- Provider needs to verify correct Tax Id, Taxonomy and/or Zip code is accurate on the KMAP file. If not correct, submit a Provider Maintenance request to KMAP.
- If provider has not enrolled, provider will need to submit enrollment through the KMAP Provider Enrollment Wizard.

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Members' Name, Number, Date of Birth do not match

Claim denied because the members name, number, and or date of birth do not match.

140: Members' name, members' KanCare number, members' date of birth mismatch.

N382: Members' name, members' KanCare number, members' date of birth do not match, please resubmit.

Providers should check KMAP for the members eligibility, using the members' KanCare number. KMAP is the "source of truth" to verify date of birth and spelling of the members' name.

- If a specific MCO has the incorrect information and does not match KMAP please work with that MCO.

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Recent Policy Changes

Policy Changes

- Refer to KMAP General Bulletin 21011 – specific requirements of Telemedicine services.
  - New ICD-10 Diagnosis Codes and PCS Procedure Codes – related to COVID-19. These new codes will identify conditions resulting form COVID-19.
- Link will take you to all Telemedicine Bulletins
  - https://www.kmap-state-ks.us/Documents/Content/Provider/COVID%2019%20.pdf
- Telemedicine training doc and Telemedicine FAQs
  - https://www.kmap-state-ks.us/Public/Workshop%20Schedule/Workshop%20Materials.asp

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Recent Policy Changes

Policy Changes

- KMAP General Bulletin 20262 – Updated 2/2021
  - COVID-19 Vaccine Coverage During the Public Health Emergency
    - Any provider currently allowed to provide vaccines may bill for COVID vaccine administration with the exception **of Rural Health Centers (RHCs) and Federal Qualified Health Centers (FQHCs). For these providers, vaccine administration is considered content of service and should not be billed as an RHC/FQHC encounter or as a service under any other Medicaid provider number or procedure code.**
- KMAP General Bulletin 21019 – effective 2/1/2021
  - PHE COVID-19 Vaccine Administration Billing by Pharmacy DME Providers.
    - Billing provider must be 25/255 Provider Type/Specialty

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Recent Policy Changes

Policy Changes

- Place holder for Potential Bulletin – Specific Brand Admin codes for C19 vaccines
- Placeholder for Potential Bulletin – Treatments with Antibody cocktails

Recent Policy Changes

Policy Changes

- KMAP General Bulletin 20229 - effective 1/1/2021
  - The Emergency Room (ER) codes will be set at the same Emergency Room Professional (ERP) Rates:

CPT Code	Rate
99281	$37.14
99282	$37.14
99283	$37.14
99284	$90.35
99285	$90.35

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Questions?

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