KMAP GENERAL BULLETIN 13014

Submission of KanCare Claims to KMAP
Helpful Electronic Claims Tips

Front End Billing Overview

With the implementation of KanCare, Kansas Medical Assistance Program (KMAP) now supports a free service called Front End Billing (FEB) as a convenience for enrolled KMAP providers and registered billing agents/Electronic Data Interchange (EDI) submitters. FEB allows submission of web, Provider Electronic Solutions (PES), and electronic 837 claim batches directly to KMAP. Through FEB, providers can submit both traditional KMAP fee-for-service claims as well as KanCare claims through KMAP. KMAP will utilize KanCare enrollment information to forward the claims to the beneficiary's corresponding managed care organization (MCO) or process the claim as fee-for-service (for excluded services or populations).

FEB is a free service provided as a convenience to providers and submitters. The FEB service is not mandatory for KanCare providers or EDI submitters. KanCare providers and EDI submitters can choose to submit electronic claims directly to the MCOs if that is more efficient for individual billing processes.

Claim Submission Status

Providers, PES users, and EDI submitters who submit batches of claims to KMAP can access a response file indicating if the batch was received successfully. For KanCare claims as well, they will receive an updated response file from KMAP once the MCO has received the claims. This will let them know whether specific claims were accepted or rejected by the beneficiary's MCO. Submitters can download their response files through the same download/upload process they use through PES or the KMAP Trade Files area. **It is critical all submitters check their batch submit reports and work any batch or claim rejections to avoid any interruptions in payment.**

The **How to read the Batch Submit Report** guides on the KMAP website have been updated with additional information specifically addressing the MCOs and individual claims. The guides include an example of the new report with labeled sections. They also include instructions for PES users on how to retrieve and display the reports within PES.

KMAP
Kansas Medical Assistance Program
- Bulletins
- Manuals
- Forms

Customer Service
- 1-800-933-6593 (in-state)
- 785-274-5990
  8:00 a.m. - 5:00 p.m.
  Monday - Friday

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Common Errors

- **Date of Birth** - The most common claim rejection from PES users and EDI submitters is related to an incorrect beneficiary date of birth on the claim. The date of birth submitted must match the information on the beneficiary's Medicaid file in order to be accepted. Individual claim rejections for incorrect date of birth can be easily found on the batch submit report.
- **Incorrect Gender** – Providers need to be sure the beneficiary's gender value is completed and correct.
- **Incorrect Name** – Data validation edits compare the beneficiary name submitted on the claim with the beneficiary's name on his or her case. Errors in the spelling of the beneficiary's name could result in the claim being rejected.
- **Taxonomy Code** – Providers need to include the taxonomy value associated with their enrollment as a KMAP provider.

Tracking Claims Submitted to KMAP for MCO Payment

Claims submitted to KMAP and forwarded to an MCO are assigned a unique tracking number that begins with "KS". In addition to the tracking number, providers will also receive a message indicating to which MCO the claim has been forwarded. Claims are automatically forwarded to MCOs every two hours. Once an MCO has received and processed claims forwarded by KMAP, providers and submitters will be able to download a claim acknowledgement report. The report provides detail results on whether the MCO accepted or rejected the claim. Claims rejected by the MCO include specific reasons for the rejection. Once the MCO has accepted a claim, the provider or submitter can follow up with the MCO regarding potential payment as well as expect a corresponding remittance advice based on the MCO's claims processing timelines.

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HP Enterprise Services is the fiscal agent of KMAP.

Amerigroup (AGP) Claim Processing Guide

	Submission Source			
	FEB	**Clearinghouse**	**MCO Portal**	**Claim Status**
Claim Submission	Until 8a Daily	Cut-off May Vary	Until 1p Daily	Source Reject Report Only
o Deadline for claim entry will vary by vendor - submitters should confirm submission deadlines when using 3rd party sources o Authenticare (EVV) submissions may experience up to 24 hours between authentication and claim file creation.				
Claim Files Retrieval	8a - 12p Daily	8a - 12p Daily	2p Daily	File Reject Report - 277CA
o AGP retreives consolidated files from all sources once per day between 8am and 12 noon. o AGP creates a data reject report for any file that is not retrievable				
Claim Processing	12p - 6a Daily	12p-6a Daily	2p-6a Daily	Pending / Paid / Reject
o Consolidated claim files are processed once per day. Each claim successfully processed is assigned a status o AGP creates a written notice for any claim rejected which is mailed to the provider				
Claim Review	1-10 days	1-10 days	1-10 days	Pending / Paid by 6a on portal
o Currently AGP is manually reviewing every claim submitted to confirm the integrity of our adjudication process o After implementation clean claims will be assigned a paid status and process during the next cycle o Claims that require review may pend for an additional period | AGP will meet the state standard for TAT				
Pay/Deny Status (P/D-S)	1 day	1 day	1 day	Pending / Paid
o Claims placed in a paid/denied status will generate an EOP | EOPs process on Tues/Weds/Thurs/Sat				
EFT / Check Disbursement	1 day	1 day	1 day	Paid
o During the EOP process a EFT transaction file is created and sent through our vendor to banking institutions for disbursement of funds o Banking institutions vary on when funds become available in the customer's account				
Check Delivered	1-5 days	1-5 days	1-5 days	Paid
o Checks are sent USPS 1st Class | 1st Class delivery guarantee by USPS is 1-5 days				
Total Processing Time				These times represent the range of a typical provider experience from submission through a submission source to claim payment
Nursing Facilities	4-17 days	4-17 days	3-16 days	
Other Providers	4-33 days	4-33 days	3-32 days	
Contractual Standards	NOTE: Contract standard begins on receipt of claim by AGP not submission			
Nursing Facilities	90% of Clean Claims in 14 days | 99.5% of Clean Claims in 21 days			
All Others	100% of Clean Claims in 30 days			

Claims Submission Methods:	1. Sunflower State Secure Web Portal at www.SunflowerStateHealth.com a. To register for the Portal, b. www.SunflowerStateHealth.com c. Click on "Log In" d. Click on "Register" under the Provider Secure Log in area e. Supply the information requested. f. You will receive an e-mail with a link. Follow the link to complete the registration process. 2. Submit claims electronically through one of the preferred Sunflower State EDI Clearinghouses: Emdeon, SSI, Gateway, Availity, Smart Data Solutions. Our electronic payor id is 68069. If you are having issues with electronic billing, please call our EDI department at 800-225-2573 extension 25525 or e-mail at EDIBA@centene.com 3. Submit claims through KMAP. Please see KMAP General Bulletin 12115 issued November, 2012. This bulletin is posted on the Sunflower State website. Click on For Providers, Provider Resources, Manuals and Guides, Guides – KanCare Bulletin-KMAP Billing. 4. For HCBS providers, submit through AuthentiCare 5. Submit paper claims to KanCare, PO Box 3571, Topeka, KS 66601-3571
Claims Status Methods:	1. Sunflower State Secure Web Portal a. Follow the instructions above to register for the Portal b. All claims submitted to Sunflower State will be reflected in the Portal. As an example, if the claim is submitted via the KMAP site, once received by Sunflower State, the claim will be viewable in the Sunflower State Secure Web Portal. 2. Utilize the Sunflower State Interactive Voice Response (IVR) Line at 877-644-4623 and follow the prompts to check claims status. You will be required to utilize the NPI number, tax id, member ID and date of birth so have these items available in preparation for the call. 3. Call Sunflower State Provider Services at 877-644-4623 and follow the prompts to Provider Services.
Claims Remittance Methods:	1. Sunflower State utilizes PaySpan Health to administer Electronic Funds Transfer and Electronic Remittance Advice. a. To register for PaySpan call 877-331-7154 to receive the registration code. Go to www.payspanhealth.com and click the Register Now button. Enter the registration code, Provider ID Number (PIN) and Tax ID Number. 2. Paper Checks and Paper Remittance Advices
Payment Frequency	<u>Sunflower State Health Plan</u> Two Check Runs Per Week: a. Tuesday Check Run – EFT/ERA funds available Wednesday. Paper Checks/Paper Remittance Advice *mailed* on Wednesday b. Thursday – EFT/ERA funds available Friday. Paper checks/ Paper Remittance Advice *mailed* on Friday. <u>Cenpatico Behavioral Health</u> a. Monday Check Run – EFT/ERA funds available Tuesday. Paper Checks/Paper Remittance Advice *mailed* on Tuesday b. Thursday – EFT/ERA funds available Friday. Paper checks/ Paper Remittance Advice *mailed* on Friday. <u>OptiCare</u> a. Wednesday Check Run – EFT/ERA funds available Friday. Paper Checks/Paper Remittance Advice *mailed* on Friday <u>US Script</u> a. Wednesday Check Run – EFT/ERA funds available Friday. Paper Checks/Paper Remittance Advice *mailed* on Friday <u>MTM</u> a. Friday Check Run – EFT/ERA funds available one day post check run. Paper Checks/Paper Remittance Advice *mailed* one day post check run <u>DentaQuest</u> a. Friday Check Run – EFT/ERA funds available one day post check run. Paper Checks/Paper Remittance Advice *mailed* one day post check run

PAYMENT FREQUENCY

	FEB	Clearinghouse	MCO Portal
From Claim Submission to Claim Received by MCO Claims System	<3 Business Days	1 Business Day or Same Day	1 Business Day or Same Day
From Claim Submission to Claim Appears on MCO Secure Portal with Current Adjudication Status*	<4 Business Days	1 Business Day or Same Day	1 Business Day or Same Day
Number of Days for Pends and Other Claims Review From Date Claims Received by MCO	< 7 Business Days on Average	< 7 Business Days on Average	< 7 Business Days on Average
From Claim Received by MCO to Final Payable (Paid/Denied)	< 7 Business Days on Average State Requirement = <20 Days for Clean Claims	< 7 Business Days on Average State Requirement = <20 Days for Clean Claims	< 7 Business Days on Average State Requirement = <20 Days for Clean Claims
From Claim Hitting Payable to EFT Received by Provider	1 Business Day or Same Day Depending on Bank	1 Business Day or Same Day Depending on Bank	1 Business Day or Same Day Depending on Bank
From Claim Hitting Payable to Provider Receiving Paper Check	2-4 Business Mail Days	2-4 Business Mail Days	2-4 Business Mail Days

UnitedHealthcare Community Plan

Dear Providers:

As we move forward with the KanCare transition and providers begin to submit claims, many natural questions and concerns have been raised. We would like to assist with providing some additional information about the claim and authorization processes to help address provider questions and concerns and to make the transition process as smooth as possible.

Claim Submission and Timeline

We encourage all providers to submit claims for January dates of service as soon as possible rather than waiting for your regular billing cycle. The submission of at least a few claims will allow us to verify that your claims are flowing through the process correctly.

Providers may submit claims electronically through a claim clearinghouse. Our payer ID for KanCare is 96385. Providers may also submit directly through the UnitedHealthcare provider portal. You may also submit paper claims to the following address:

KMAP
P.O. Box 3571
Topeka, KS 66601-3571

If you continue to submit claims through the state's Front End Billing (FEB) process, the claims follow this general claim timeline:

- The claims will be received and loaded into our system within 24 – 48 hours of your submission through the FEB
- You will be able to see your claims in our web portal approximately 3-4 days from your FEB submission.
    - You will not be able to check the paid status of your claims on the KMAP website for dates of service on or after 1/1/2013.
    - Participating and non-participating providers can check claim status on UHCOnline.com after you create a user name and password on the secure website.
    - Providers must be loaded in the claim system to create a user name and password.

	FEB	Clearinghouse	MCO Portal	Claim Status on MCO Web Portal Appears As
Claim Submission	-	-	-	-
Claim Transferred	1 day*	1 day	Immediate	-
Claim Reviewed	1-10 days	1-10 days	1-10 days	Pending – viewable approx. 3 days after claim transferred
Payment/Denial Determination	1 day	1 day	1 day	Paid/Denied
EFT Transaction (If applicable)	1 day	1 day	1 day	Paid/Denied
Check Cut (If applicable)	1 day	1 day	1 day	Paid/Denied
Check Delivered	1-3 days	1-3 days	1-3 days	Paid/Denied
Total Processing Time	4-17 days	4 17 days	3-16 days	Paid/Denied

*Claim Transferred referred to claims being transferred from EVV (where applicable) to HP and then from HP to UnitedHealthcare.

- Your Provider Advocate can assist you with setting up your user name and password on our website, and can provide training on how to check member eligibility and claim status.

You may also contact our Provider Call Center at 877-542-9235 for assistance with claim status.

During the transition period, your claims will initially be placed in a pending status because we are manually reviewing all claims for accuracy. This is a temporary process to minimize denials that we will discontinue once we are confident we have identified and addressed early claims issues.

Issues with Viewing Claim Status Online

Some providers have reported their inability to view certain claims on our web portal in a timely manner. We did experience a technical error where a number of claim files were not loaded in our claim system in a timely manner. Claims that should have loaded on January 10th were not loaded until January 16th. The reason for the error has been identified and corrected. We apologize that providers were not able to see these first claims in a timely manner. Going forward, you should be able to view your claims approximately 3 days after they have been transferred to UnitedHealthcare. Please note, this did not impact any nursing facility claims. If at any time you cannot view a claim in accordance with the timeframes above, please contact your Provider Advocate and they will assist you.

Authorizations

We will continue to honor current authorizations and plans of care through the 90 day continuity of care period. As new service needs arise, we ask all providers to seek authorization only for those services that are listed on our prior authorization list. The list can be found in Chapter 4 of our Provider Administrative Guide on www.uhccommunityplan.com.

Provider Communications

Provider communication is critical as we work through this transition together. To facilitate communication of time sensitive information, we will communicate with you via email, continued postings on our issues log (found on www.uhccommunityplan.com) and through your Provider Advocate. If we do not have an email address on file for the appropriate contacts within your facilities and organizations, please contact your Provider Advocate.

We will also continue to post important provider information on our website at www.uhccommunityplan.com so please visit our site often. Our Provider Administrative Guide is also available at this location.

You may also contact our Provider Call Center at 877-542-9235 at any time for assistance.

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