KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

General Billing

Updated 3.2018

PART I
GENERAL BILLING FEE-FOR-SERVICE PROVIDER MANUAL
KANSAS MEDICAL ASSISTANCE PROGRAM

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FORMS All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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INTRODUCTION Updated 12/17

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

FORM REORDERING
Forms and corresponding instructions are available on the public and secure websites. All forms can be duplicated for use except the CMS 1500 Claim Form, UB-04, and Pharmacy Claim forms.

To order Pharmacy Claim forms, providers must send their requests to the following address:

Office of the Fiscal Agent
Attention: Fiscal Agent Liaison
PO Box 3571
Topeka, KS 66601-3571

The fiscal agent does not provide the CMS 1500 Claim Form, UB-04, or ADA Dental Claim forms. They must be obtained from a claim form supplier. Listed below are vendors who supply these forms. This is not an all-inclusive list.

CMS 1500 Claim Form
Advantage Print Source
PO Box 67176
Topeka, KS 66667
785-235-6868
www.advantageprintsource.com/index.html

TFP Data Systems
1-800-482-9367, ext. 58029

The Government Printing Office
1-866-512-1800

UB-04
Advantage Print Source
PO Box 67176
Topeka, KS 66667
785-235-6868

FORM REORDERING Updated 02/17

ADA Dental Claim Forms
American Dental Association
Attention: Catalog Sales
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746
www.adacatalog.org

5000. ELECTRONIC MEDIA CLAIM Updated 03/18

Electronic Billing

Remittance advices (RA) and warrants (checks) are produced weekly for all claims. Electronic media claims (EMCs) allow providers to experience **improved cash flows**. EMC submission is the easiest and most efficient way to submit claims.

The fiscal agent offers various methods for EMC submission. Some of these include:

- Batch claim submission through information system vendor or through software supplied by the fiscal agent
- On-line claim entry through the Kansas Medical Assistance Program (KMAP) website

All claim types can be submitted electronically. Pharmacy Claim forms can be submitted through point-of-service (POS) or batch methods. Contact the Customer Service department for assistance with online services. Contact the EDI department for assistance with electronic file transfers and Provider Electronic Solutions (PES) software. Both departments can be reached at 1-800-933-6593.

Refer to the *General Benefits Fee-for-Service Provider Manual* or the benefits/limitations section of each program provider manual for all benefit/limitation criteria.

Questions regarding checks or claim adjudication information contained on the RA should be directed to Customer Service at 1-800-933-6593.

~~Electronic Documentation Signature~~

~~Electronic signatures that meet the following criteria are acceptable for Medicaid documentation:~~

- ~~Identify the individual signing the document by name and title~~
- ~~Include the date and time the signature is affixed~~
- ~~Ensure the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence~~
- ~~Provide for nonrepudiation, that is, strong and substantial evidence that will make it difficult for the signer to claim the electronic representation is not valid~~

~~The use of an electronic signature is deemed to constitute a signature and has the same effect as a written signature on a document.~~

~~The provider must have written policies and procedures in effect regarding the use of electronic signatures. In addition to complying with security policies and procedures, the provider who uses computer keys of electronic signatures must sign a statement ensuring exclusive access and use of the key or computer password. The policies and procedures and statement of exclusive use must be maintained at the provider's location and available upon request by the state or fiscal intermediary. Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies.~~

~~Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance may result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.~~

~~An original signature is still required on the Provider Agreement when the KMAP provider enrollment application is submitted on paper.~~

5000. Updated 03/18

~~**Electronic Documentation**~~

~~Electronic documentation that meets the following criteria is acceptable for Medicaid:~~

- ~~Meet all documentation and signature requirements contained in the *General Benefits Fee-for-Service Provider Manual*~~
- ~~Meet all documentation and signature requirements specific to the program and services provided~~
- ~~Ensure the documentation cannot be altered once entered~~
- ~~Maintain a system to document when records are created, modified or deleted to provide an audit trail~~

~~Providers must have written policies and procedures in effect regarding the use of electronic documentation that must be maintained at their location and available upon request by the State or fiscal intermediary. These requirements for clinical documentation apply only to Medicaid claims and do not preclude other state or federal requirements.~~

~~Failure to properly authenticate medical records (sign and date the entry) and maintain written policies and procedures regarding electronic documentation and security compliance may result in the recoupment of Medicaid payments or other actions deemed appropriate by the State.~~

~~***Note:*** Documentation can be requested at any time to verify that services have been provided within program guidelines.~~

5100. TIMELY FILING Updated 02/17

Initial Filing of Medicaid/MediKan Claims

KMAP must receive claims **within 12 months of the date the service was provided** (KSA 39-708a). Inpatient hospital services must be received within 12 months of the date of discharge or the last date of service on an interim bill. Nursing facility claims must be received within 12 months from the last day of the month in which the service was billed. Claims not received within 12 months as defined here will be denied.

Filing a Claim Prior to Beneficiary Becoming Kansas Medicaid/MediKan Eligible

For timely filing purposes, the provider can file a claim for services provided to a beneficiary whose application for benefits is delayed due to a pending determination of eligibility. The provider can enter the word **"PENDING"** in place of the beneficiary identification (ID) number on paper claims or enter all 9s on electronic submission. The claim will deny with HIPAA claims adjustment reason code (CARC) 140 (Patient/Insured health identification number and name do not match) on the RA.

When a beneficiary's eligibility is approved, the provider can enter the Medicaid ID number and resubmit the claim with the original internal control number (ICN). When the beneficiary's eligibility is approved, it is the beneficiary's responsibility to notify the provider of eligibility. If the provider believes eligibility has been determined but the provider has not been notified by the beneficiary, eligibility can be checked on the KMAP website (refer to Section 1200 of the *General Introduction Fee-for-Service Provider Manual*), or by calling the Automated Voice Response System (AVRS) or Customer Service.

Note: If the member is a newborn and does not have an ID number, reference the *Hospital Fee-for-Service Provider Manual*, Section 7020, **Newborn Services**, for specific billing instructions.

Claim Reimbursement for Retroactive Medicaid Eligibility

In a limited number of cases, a MediKan or Medicaid beneficiary may become retroactively eligible. Claims previously denied because the beneficiary was not eligible and with dates of service within 12 months can be submitted using the electronic, web-based provider portal (secure website) or paper method for processing.

Once retroactive eligibility has been confirmed, all outstanding claims need to be submitted to KMAP within a year from the date the beneficiary was notified. (This is the sent date on the Notice of Action letter mailed to the beneficiary.) If the dates of service are over 12/24 months old, these claims cannot be adjudicated without receiving timely filing bypass.

If the beneficiary has given the provider a copy of the Notice of Action, this can be attached to the claim. The claim will be sent through regular claims processing and timely filing will be bypassed. If timely filing is bypassed, the explanation of benefits (EOB) code 2038 (Claim Processed in Accordance with Kansas Medical Assistance Timely Filing Policies for Retroactive Eligibility Claims) will be on the RA.

Filing Dates Between 12 and 24 Months

Claims which are originally filed within 12 months of the service date but are not resolved before the 12-month filing limitation expires may be resubmitted to Medicaid for up to 24 months from the date of service. **When resubmitting a claim, include the original ICN in the appropriate field as specified in the billing instructions.**

5100. Updated 02/17

Resubmissions do not require attachments proving timely filing if the claim was originally submitted to the fiscal agent within 12 months from the date of service and the following data elements are **unchanged** from the original submission:

CMS 1500 Claims
Same beneficiary ID number
Same performing provider number
Same billing provider number
Same dates of service
Same procedure code

UB-04 Claims (Inpatient/Outpatient/LTC)
Same beneficiary ID number
Same provider number
Same dates of service
Same revenue codes (inpatient/LTC only)
Same billed amount
Same procedure code (outpatient only)

Dental Claims
Same beneficiary ID number
Same performing provider number
Same billing provider number
Same procedure code
Same dates of service
Same tooth number
Same tooth surface

Pharmacy Claims
Same beneficiary ID number
Same billing provider ID/service location
Same dispense date (date of service)
Same national drug code (NDC)
Same RX number
Note: For compound drugs, all ingredients must match.

When any of these data elements change, proof of timely filing must be attached to the claim.

Claims with Dates of Service Not Submitted Within 12 Months or Older than 24 Months

If 12-month timely filing has not been established or the claim is for dates of service older than 24 months, the claim must be mailed to the address below with the following documentation for timely filing bypass review:

- A cover letter explaining the beneficiary has received retroactive Medicaid eligibility
- A copy of the Notice of Action letter, if provided by the beneficiary
  Note: If the provider does not have a copy of the Notice of Action, the Timely Filing Coordinator can retrieve the Notice of Action and attach it to the claim for processing.
- Original red claim form

Note: Bypassing timely filing does not guarantee payment of the claim. The claim must meet all other program requirements.

Claims originally filed within 12 months of the sent date on the Notice of Action, but not resolved before the 12-month filing limitation expires, can be resubmitted to Medicaid up to 24 months from the date of service.

Timely filing bypass mailing address
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

Providers can check claim status on the KMAP website or by contacting Customer Service at 1-800-933-6593.

5100. Updated 02/17

Claims not submitted within 12 months of the date of service cannot be billed to the beneficiary when a provider has knowledge of Medicaid coverage. Claims which are timely filed and subsequently denied because of provider errors cannot be billed to the beneficiary if the provider fails to correct the errors and resubmit the claim for final adjudication within 24 months from the date of service. **Regardless of original timely filing or resubmissions, state regulations prohibit KMAP from processing any claim received beyond 24 months from the date of service**. Noncovered Medicaid services may be billed to the beneficiary when the beneficiary is notified prior to the provision of services.

Initial Filing of Medicare or Third-Party Related Claims

Claims must be filed to Medicare or the third-party payer within 12 months of the service date. Once benefits have been determined by Medicare or the third-party payer, the fiscal agent must receive the claim within 12 months of the date of service or with proof of timely filing attached. (Reference **Filing Dates Between 12 and 24 Months Old** criteria given above.) It is recommended that a claim filed with Medicare or a third-party payer also be filed with Medicaid within 12 months of the date of service to ensure timely filing criteria is met. However, the Medicare or third-party liability EOB can be used for proof of timely filing if the date on that EOB falls within the 12-month timely filing period.

When the claim is filed in a timely manner with Medicare or a third party, the provider can attach a copy of the claim submitted to Medicare or the third party with documentation of the claim's original submission date or a dated copy of proof of payment or denial from Medicare or the third party which proves they received the claim within 12 months of the service date. (If the claim is Medicare-related and was originally timely filed but exceeds the 24-month limitation, it may be filed to Medicaid within 30 days of Medicare's response. This is the only situation in which a claim over 24 months old will be considered for payment.) If a provider is unable to prove a claim was initially timely filed with any other carrier and the dates of service are over 12 months old, Medicaid cannot consider the claim for payment.

5100. Updated 06/17

Helpful tips to aid in processing of timely filing:

- The provider can request assistance from Customer Service for specific claims processing problems.
- The provider should not wait until 24 months to seek assistance.
- The provider should use a cover letter.
- The provider should not write on the face of the claim or use sticky notes.
- The provider should be specific and clearly explain why timely filing should be bypassed.
- The provider should include a contact name and phone number with their request. If the fiscal agent has questions or needs clarification, the contact person will be notified.
- If additional documentation is required, the provider has 10 business days after being contacted to get that documentation to the fiscal agent. If it is not received within 10 business days, the request is closed and the claim will be denied.
- If the request is due to retroactive eligibility and the provider does not have the retroactive eligibility letter, the fiscal agent can access the letter, but the provider must indicate retroactive eligibility in the cover letter.
- Adjustment requests due to an inpatient utilization contractor review must have the contractor's recoupment letter attached.
- The provider is responsible for all information on the face of the claim being correct and current. If the claim is more than 24 months old, for instance, the provider number must be updated to reflect the current KMAP provider ID.
- Proof of why timely filing should be bypassed should be attached along with the cover letter and claim. This proof should be something similar to an RA or EOB rather than something from the provider's own computer program.
- The provider should send information for timely filing bypass requests to:

  Office of the Fiscal Agent
  Timely Filing Coordinator
  PO Box 3571
  Topeka, KS 66601-3571

All timely filing requests are tracked. Any Customer Service agent can assist providers with questions once the request is received.

If the request is denied, providers are contacted and the claim is not processed; however, if the request is approved, it is processed immediately.

5300. APPEALS PROCESS Updated 12/11

If a provider disagrees with the action Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has taken on a claim, he or she has the right to request an administrative fair hearing under the Kansas Administrative Procedures Act, K.S.A. 77-501, et seq. and K.A.R. 30-7-64 et seq.

To request an appeal on a timely basis, the provider must send a written request for such an appeal to:

Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, KS 66612-1327

The request must be received by that office within 30 days of the date of the notification letter. Because such notices are mailed to the provider, three days are added to the 30-day appeal period.

The provider does not need to use any special form to request a fair hearing. The provider can simply put the request in writing and send it to the Office of Administrative Hearings. The request must specifically request a fair hearing. The request should describe the decision appealed and the specific reasons for the appeal.

5400. REMITTANCE ADVICE/CLAIM DISPOSITION Updated 02/17

RAs have been designed to provide detailed information in an easy-to-understand format with content tailored to the various claim types including hospital, pharmacy, professional, and nursing facility. RAs itemize all payments to providers, including line-item explanations of the adjudication of each claim. In addition, all suspended claims, denials, financial transactions, and notices are included on the RAs. The RA groups the services by agency. The agency is identified directly under the provider number as SRS-629 or KDOA-039. Electronic RAs (835) are also available. The provider can call the EDI department at 1-800-933-6593 for additional information on receiving RAs electronically.

The RA is organized in six sections: remittance notices, denied claims, paid claims, financial transactions, activity summary, and suspended claims. Claims within each section are presented in sequential order by beneficiary last name, three digits of the first name, and the ICN region code.

Each section of the RA is subtotaled, including claim counts, submitted charges, allowable reimbursement, and paid reimbursement. The RA summary provides cumulative totals for the current payment period, month-to-date, and year-to-date totals. The totals included for all providers are:

- Number of claims paid, denied, suspended, adjusted, and processed
- Dollar amount processed
- Financial transactions including payouts and recoupments
- Warrant amount

The following fields are common to all RA formats:

Provider Number:	Identifying the provider for whom the RA was printed
RA #:	A unique nine-digit number identifying the RA
Agency:	Agency identified (SRS-629 or KDOA-039)
RA As Of:	The last day of the period for which the RA was produced
Page:	Page number of the RA
Beneficiary Name:	The name of the beneficiary for whom the claim was made
Medicaid ID Number:	The Medicaid ID number of the beneficiary
Internal Control Number:	The internal control number for the claim
Service Dates From To:	The beginning and ending date of service
Billed Amount:	The dollar amount the provider billed for the service rendered
Allowed Amount:	The dollar amount allowed by Medicaid for the service
Spenddown:	The spenddown amount
Payment Amount:	The dollar amount paid by Medicaid for the claim
EOB SYS INS:	EOB, a code indicating the reason for the payment or denial
Category Totals:	Category totals
Agency Totals:	Agency totals
Provider Totals:	Provider totals

For questions regarding the claim adjudication information contained on the RA or electronic remittance notice (ERN), providers can contact Customer Service at 1-800-933-6593.

5400. Updated 05/12

Locked Claims
If an electronic adjustment request is denied with EOB 0480 (DENIED. CLAIM/CLAIM ADJUSTMENT REQUEST IS FOR A CLAIM THAT HAS PREVIOUSLY BEEN REVIEWED/ADJUSTED), the claim on which the adjustment is being requested has been locked and cannot be adjusted. If a new day claim is submitted and denied with EOB 0480, the claim matches a locked claim in history and cannot be processed.

To unlock a claim, submit an **Individual Adjustment Request** form on the Forms page to KMAP. Indicate in the Remarks section (Field 19) the reason for the request to have the claim unlocked. Submitting an unlock request does not guarantee the claim will be unlocked. If the unlock request is denied, the request will be returned to the provider.

5500. ELECTRONIC DEPOSIT OF FUNDS Updated 02/17

The State of Kansas offers **electronic deposit of funds** to vendors who request this service. Electronic deposit gives the provider access to funds without the delay normally associated with mailing of state warrants.

Many providers receive funds from more than one state agency. All payments for the state are made through the same payment system. The system is unable to process payments to more than one bank account for each vendor. If an agency has requested electronic deposit through another state agency, all funds will be deposited using the bank information originally provided. The agency must decide if all payments will be made electronically or if all payments will be made through paper warrants.

To enroll in the electronic deposit program, the provider can contact Customer Service for a copy of the Electronic Deposit of Vendor Payment form.

5600. ADJUSTMENTS/REFUNDS Updated 02/16

Adjustments

In order to be considered for additional payment, **underpayment** adjustments must be submitted within two years from the date of service on the claim. Underpayment adjustments received for dates of service more than two years old cannot be processed by the fiscal agent and will be returned to the provider.

Overpayment adjustments can be submitted and will be processed regardless of how old the date(s) of service. As a result of the Patient Protection and Affordable Care Act, changes have been made to overpayment threshold amounts. For claims with dates of service May 22, 2010, and after, there is not a minimum requirement for overpayment adjustments.

Overpayment Recoupments

When a claim has paid incorrectly resulting in an overpayment, the overpayment amount is subject to recoupment regardless of when the claim paid or how old the dates of service.

Once an overpayment is identified, a recoupment letter is sent to the provider. If the provider disagrees with the recoupment, a response must be made within the time specified in the recoupment letter. When a response is not received within the specified time, the overpayment adjustment is deducted from a future RA. If the provider is a low-volume provider and no claims have been paid within 60 days of the adjustment date, a refund check will be requested. Adjusted amounts may vary from the original identified amount due to system changes that have occurred since payment of the original claim.

Finalized adjustments have an ICN beginning with a 5. To identify the specific beneficiary involved, it is necessary to refer to the adjustment notification letter sent to your facility.

Date of Death

The "TO" date of service for services provided during the month of a beneficiary's date of death should be the actual date of death. For services which are reimbursed on a monthly basis (such as DME rentals), the TO date of service should be billed as the beneficiary's date of death rather than the last day of the monthly statement being billed.

KDHE-DHCF will begin using the death data information received monthly from the Office of Vital Statistics. This data is compared to the provider enrollment information we have on file. If it is determined the provider file needs to be updated, KDHE will confirm this information through a verification process. Through this process, you may receive a letter to ensure the files are updated appropriately. Recoupment(s) will be initiated and notification will be sent if claims have been paid for dates of service after the reported date of death.

Refunds

If an overpayment is discovered on the RA, complete the **Individual Adjustment Request** form on the Forms page reporting the overpayment. If several overpayments have been made, complete the **Multiple Adjustment Request** form on the Forms page. All identified overpayments will be recovered. If the provider has sufficient claims volume, a recoupment will be processed on a subsequent RA. If the provider is a low-volume provider and no claims have been paid within 60 days of the adjustment date, a refund check will be requested.

5600. Updated 06/17

Refund checks can be sent to:

Medicaid TPL/Financial Unit
PO Box 3571
Topeka, KS 66601-3571

The provider must submit the necessary information (such as the recoupment letter or RA) in order for the Collections department to determine how to apply the refund check. Providing this information will assist in eliminating errors in posting to accounts.

Requests for Additional Payments

If it appears an underpayment has been made for a claim appearing on the RA, the provider can adjust the claim on the KMAP website, call Customer Service, or complete the **Individual Adjustment Request** or **Multiple Adjustment Request** form on the Forms page.

After processing the underpayment, results are reported on a subsequent RA. The original claim will appear on the RA with negative dollar amounts. The adjusted claim will be located directly above the original claim. The adjusted claim will have an ICN that begins with a 5.

When there is a need to adjust a claim that has been adjusted before, the provider must indicate the **adjusted** claim's ICN on either the **Individual Adjustment Request** or **Multiple Adjustment Request** form. The original claim's ICN has been voided from the KMAP system.

Adjustment Request Minimums

Underpayment adjustment requests must exceed a minimum amount on a claim for hospital, pharmacy, or nursing facility and minimum amount per service on all professional claims (unless it is to correct the history). Below are the minimum amounts for underpayments:

Hospital per claim - inpatient	$12.00 Inpatient
Hospital per claim - outpatient	$5.00 Outpatient
Nursing facility per claim	$12.00
Pharmacy per prescription	$5.00
Professional per service	$5.00

Adjustments cannot be processed for zero paid claims unless other insurance, Medicare, or patient liability is involved, and the provider wants to adjust any of these items. When all of the details but one on a claim have been paid, the provider must submit a new claim for the unpaid detail only.

Hospital Claims

If an inpatient hospital stay is denied as inappropriate based on an inpatient utilization contractor review, the physician inpatient evaluation & management (E&M) service claims will be recouped and can be resubmitted as outpatient services. Other ancillary nonphysician claims will not be recouped.

5700. BILLING/COLLECTION AGENCIES Updated 11/10

If a KMAP provider uses a billing agent to file Medicaid claims or contracts with a collection agency to recover outstanding payments, the billing agent or collection agent may contact the fiscal agent on behalf of the provider when they are administratively (the act of processing medical claims) trying to submit or resubmit a claim. The billing agency or collection agency must have **either** one of the following:

- The ICN
- The date of service (DOS) and either one of the following:
    - The beneficiary's ID number
    - The Medicaid provider number

Here are the only examples where a billing agent or collection agent may contact the fiscal agent:

- The collection agency/billing agent has an ICN, or DOS, the beneficiary's ID number and/or the provider's Medicaid number. The fiscal agent's staff can talk to the collection agency/billing agent about that claim.
- A collection agency/billing agent calls in to follow-up on the resubmission of a claim. An update of payment or denial can be given.
- Determination of eligibility for a beneficiary.

The fiscal agent **cannot** disclose to a collection agency/billing agent:

- Any diagnoses on a claim
- Other services given to this beneficiary
- Answer any questions that are not administrative in nature about the processing or reprocessing of a claim

5800. CMS 1500 Claim Form Updated 12/17

Providers must use the CMS 1500 paper or equivalent electronic claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website or billed through Provider Electronic Solutions (PES). When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider. The Kansas MMIS uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information is not recognized unless submitted in the correct fields as instructed.

An example of the CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms) heading.

Any of the following errors can cause a CMS 1500 Claim Form to deny or be sent back to the provider:

- Sending a KanCare paper claim to KMAP.
- Sending a CMS 1500 claim form carbon copy.
- Using a PO Box in the Service Facility Location Information field.

The fiscal agent does not furnish the CMS 1500 Claim Form to providers.

Submission of Claims
Send completed claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571

5900. COMPLIANCE WITH SECTION 6032 OF FEDERAL DEFICIT REDUCTION ACT
Updated 04/13

Any KMAP provider, including any KMAP managed care organization, who receives or makes $5 million in annual KMAP payments, must comply with Section 6032 of the Deficit Reduction Act of 2005 (DRA) as a condition of receiving payment under KMAP. The $5 million amount, for KMAP purposes, is based on paid claims, net of any adjustments to those claims. **It is the responsibility of providers or provider entities to make the determination as to whether they meet the $5 million threshold.**

To comply with Section 6032, the provider must ensure he or she has implemented all of the following requirements:

1. The provider must establish written policies that provide detailed information about the federal laws identified in Section 6032(A) and any Kansas laws imposing civil or criminal penalties for false claims and statements, or providing whistleblower protections under such laws.
2. In addition to the detailed information regarding the federal and state laws, the provider's written policies must contain detailed information regarding the provider's own policies and procedures to detect and prevent fraud, waste, and abuse in federal healthcare programs, including Medicare and KMAP.
3. The provider must provide a copy of its written policies to all of its employees, contractors, and agents of the vendor.
4. If the provider maintains an employee handbook, the provider must include in its employee handbook a specific discussion of the federal and state laws described in its written polices; the provider's policies and procedures for detecting and preventing fraud, waste, and abuse; and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging fraud, waste, or abuse in a federal healthcare program, including Medicare and KMAP, to the provider or to the appropriate authorities.

Any KMAP provider who receives or makes annual payments of $5 million or more under KMAP must certify annually that it complies with Section 6032 of the DRA. Specifically, each year, providers must complete and submit the form attesting compliance with Section 6032 of the DRA to KDHE-DHCF. This form can be downloaded from the KMAP website. This form must be submitted in the quarter following the end of each federal fiscal year (October to December) but before January 1 of the following year.

KDHE-DHCF and partner agencies, Kansas Department for Children and Families and Kansas Department for Aging and Disability Services, have the responsibility to ensure compliance with the requirements. In addition to the annual certification, compliance is determined through retrospective reviews by the fiscal agent and contractors and through other state audits. Providers must be prepared to submit the following items within 10 days of the request of the fiscal agent, contractor, or state agency:

- Copies of written or electronic policies that meet the federal requirements
- Written description of how the policies are made available and disseminated to all employees and to all employees of any contractor agent for each provider or provider entity
- Copies of any employee handbook, if the provider maintains a handbook

Compliance with these requirements is mandatory. Any provider or provider entity that fails to comply with the annual attestation or the submission of information will be subject to sanction, including suspension of Medicaid payments or termination from participation in KMAP.