Office of the Inspector General

A PERFORMANCE AUDIT OF KANSAS' MEDICAID CLAIMS PROCESSING

Does KHPA Have Effective Oversight of Its Fiscal Agent's Medicaid Claims Processing to Ensure Timeliness and Accuracy of Payments?

A Report to the Kansas Health Policy Authority Board

January 2010

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Audit Summary

Audit Purpose

To determine whether KHPA's oversight ensures the fiscal agent's compliance with federal and contractual requirements related to timeliness and accuracy of claims processing.

Conclusion

Based on testwork performed for the time period FY 2005 – FY 2009, the Office of Inspector General concluded that KHPA and its fiscal agent complied with applicable federal and contractual requirements, but should review whether K.S.A. 39-708a aligns with 42 CFR 447.45 requirements. KHPA's oversight includes numerous controls designed to provide assurance the fiscal agent's claims processing is both timely and accurate. Less than two percent of claims in our sample were not processed timely, as defined by contractual timeliness standards which are more stringent than federal standards. While some overpayments appear to slip through claims processing controls, Kansas' Medicaid fee-for-service payment error rate compares favorably with the national average for federal fiscal year 2006. We have included eight recommendations to improve KHPA's oversight practices and provide further assurance that claims will be paid accurately and timely, and reduce the likelihood and costs associated with claim processing errors.

The audit report is divided into two sections. The first section addresses the fiscal agent's performance and KHPA's oversight with regard to the *timeliness* of claim processing. OIG auditors analyzed KHPA's system of controls and completed testwork to determine whether claims were processed timely. We found that the controls related to timeliness, for the most part, are operating effectively. However, even if timeliness standards are currently being met, it is important that KHPA exercises effective managerial controls to ensure the fiscal agent *continues* to meet the timeliness requirements. We believe that strengthening several controls could minimize the risk that unforeseen problems could arise that would adversely impact the timeliness of claims processing.

1. KHPA should consider including an indicator for clean and non-clean claims in MMIS. Without this indicator, it is difficult to assess whether the fiscal agent met current timeliness standards.

2. KHPA should ensure the fiscal agent quality assurance team's process for calculating the percentage of aged claims agrees with current contractual timeliness standards. The calculation method they use is not the same as the current timeliness standard which requires stratified calculations based on clean and non-clean claims.

3. KHPA management should establish clear policies for the assessment of damages for failure to comply with contract timeliness standards and define criteria under which damage assessment on the fiscal agent will be imposed or waived.

4. Appropriate KHPA staff should review the list of timely filing exceptions we provided and identified in this report, and where appropriate, initiate recoupment and also review timely filing procedures to minimize overpayments and ensure compliance with federal requirements. This recommendation has already been implemented by KHPA staff.

5. KHPA legal staff should be consulted to determine whether the exemptions to the federal timely filing requirement specified by K.S.A. 39-708a are in compliance with federal law.

The second section of the audit report addresses the fiscal agent's performance and KHPA's oversight with regard to the *accuracy* of claim processing, i.e., overpayment by paying inaccurate or inappropriate claims. Kansas' Medicaid claims processing engine, the MMIS, which is operated by the fiscal agent, is CMS-certified and passed its SAS-70 audits for the past few years. KHPA employs a system of controls which provides a reasonable level of assurance in preventing processing of erroneous claims. To illustrate:

- Approximately 30 percent of the claims submitted to the MMIS are rejected by the system's edits and audits.
- The fiscal agent SURS staff's reviews and detection methods identified $3 million in overpayments to providers in FY 2007 and almost $2 million in FY 2008.
- Kansas' payment error rate measurement (PERM) Medicaid fee-for-service error rate is 4.62 percent, which is slightly lower than the national average Medicaid fee-for-service error rate of 4.7 percent for federal fiscal year 2006.

However, KHPA's system of claims processing controls is not designed to provide 100 percent assurance against erroneous claims. Achieving this level of certainty would require that every claim be subjected to a comprehensive validation process with added procedures and associated costs that could be burdensome for the providers and too costly to implement by KHPA and its fiscal agent. KHPA must maintain and look to improve its system for preventing, detecting and correcting erroneous claims and recouping overpayments. Our audit testwork on a few edits revealed that some erroneous claims can slip through the edit and audit controls that are currently in place. For example, we found 14 claims totaling over $2,000 that do not meet gender restrictions and 243 claims totaling $24,811 that do not meet age restrictions. Reducing the opportunity for overpayment could help contain long-term program expenditures.

The OIG provided three recommendations for strengthening the controls designed to promote the accuracy of claims, as follows:

6. KHPA fee-for-service program managers should identify all required program and procedure limits and restrictions and ensure they have corresponding edits and audits in the MMIS. The fiscal agent and KHPA claims staff should determine whether the current system testing is adequate to detect errors.

7. Appropriate KHPA staff should review the list of exceptions or errors we have provided in this report, and where appropriate, initiate recoupment. Any edits not attached to specific procedure codes should be attached to prevent the same types of exceptions or overpayments in the future. KHPA has already started implementing this recommendation.

8. KHPA management should establish clear policies for the assessment of damages for failure to comply with contract accuracy standards and define criteria under which damage assessment on the fiscal agent will be imposed or waived.

In conclusion, the OIG's analysis confirmed that KHPA's system of controls provides assurance of compliance with federal and contractual requirements related to timeliness and accuracy of claims processing. However, there are opportunities for further improvement. While we believe the resulting program savings would exceed the cost of implementing the recommendations, we recognize that current budgetary constraints and reduced staffing levels make it difficult for KHPA to implement additional control measures.

We wish to thank Christiane Swartz, Maria Montgomery, Rolanda Ellis, SURS staff, members of HP Enterprise Services' Quality Assurance team, and other members of KHPA's Medicaid staff for their assistance throughout the course of this audit.

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Audit Scope and Methodology

Medicaid paid more than $1.3 billion dollars to provide health care coverage to uninsured low-income Kansans in fiscal year (FY) 2009. About 66 percent of the funds or almost $880 million was expended by the Kansas Health Policy Authority (KHPA) through the Fee-for-Service (FFS) program, which pays providers directly for services to Medicaid beneficiaries. KHPA's fiscal agent processes these provider payments and is contractually required to ensure claims are accurate and processed timely.

This audit addresses the following questions:

(1) How does KHPA oversee its fiscal agent's claims processing?
(2) Is KHPA's oversight effective to ensure its fiscal agent's compliance with contractual obligations and federal requirements related to timeliness and accuracy of payments?

To answer the audit questions, we analyzed a sample of *adjudicated claims*[1] data, we interviewed the Deputy Medicaid Director, Business Analysis Testing and Claims Management Senior Manager and the Claims Manager at KHPA and its fiscal agent, Electronic Data Systems (EDS)[2] staff, and reviewed and analyzed relevant laws, regulations, the fiscal agent contract, and materials related to the oversight of claims processing. To assess the reliability of the Medicaid Management Information System (MMIS) data, we reviewed findings from the Statement on Auditing Standards 70 (SAS-70) and the Centers for Medicare and Medicaid Services (CMS) certification reviews. These confirm that the controls they tested which relate to the completeness and validity of MMIS data are operating with sufficient effectiveness. We relied on this finding.

We have excluded several things from our analyses. For instance, our claims data was limited to fee-for-service (FFS) claims. It did not include out-of-state provider payments, which are covered under separate individual contracts, and managed care encounter payments. In addition, our accuracy analysis was limited to gender, age and death restrictions and excludes any determination related to eligibility, medical necessity and pricing. It also excludes a determination of the timeliness and accuracy of the fiscal agent's contractually required reports.

This audit was conducted in accordance with applicable generally accepted government auditing standards. Those standards require the audit be planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objectives.

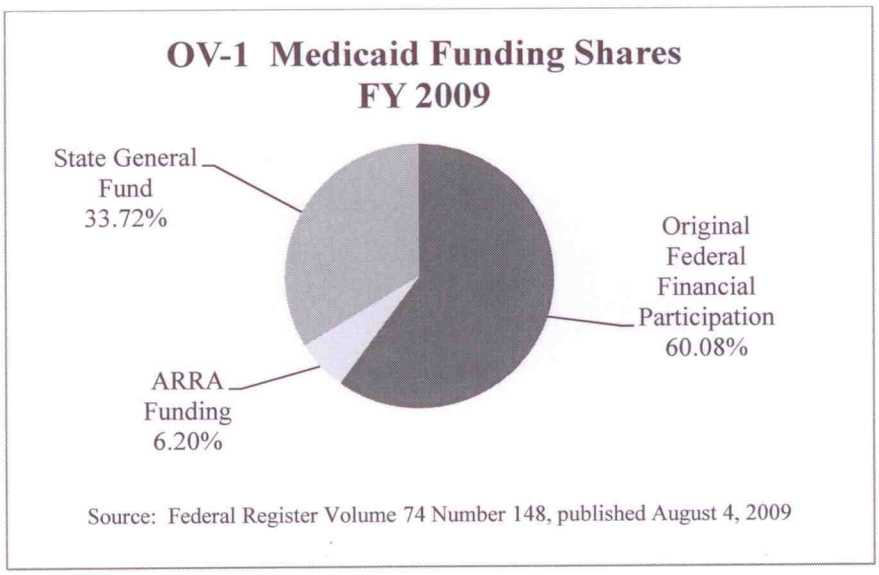
This report is intended to provide general information about KHPA's oversight of its fiscal agent's claims processing and the accuracy and timeliness of fee-for-service claims processing. It

[1] Claims that have been processed and determined to be paid or denied
[2] EDS was acquired by Hewlett Packard in August 2008 and has since changed its name to HP Enterprise Services.

should not be construed as a comprehensive, in-depth review of individual claims. If additional procedures or targeted audits of specific types of claims or MMIS functions had been performed, other reportable matters might have come to our attention that may need corrective action. Such procedures would require more time than was intended for this audit.

Overview of Kansas' Medicaid Claims Processing

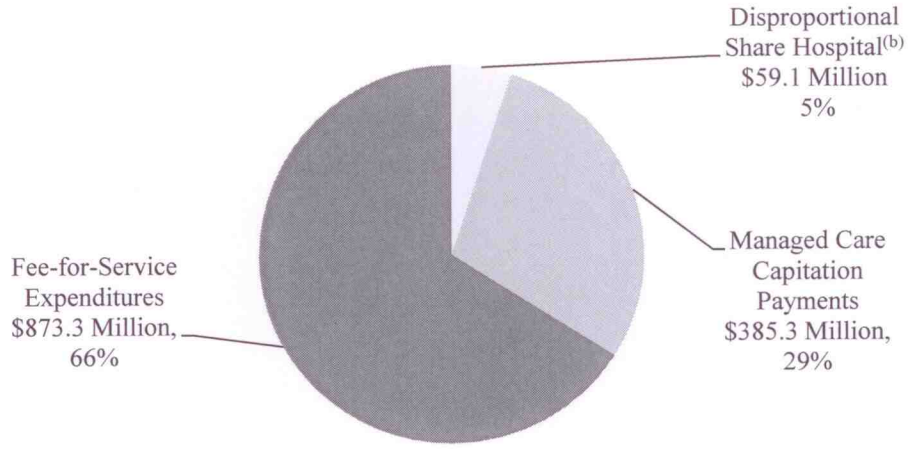
Enacted in 1965 under Title XIX of the Social Security Act, the Medicaid program is a medical assistance program for low income individuals, the aged and people with disabilities. In Kansas, the federal government pays approximately 60 percent of the cost of the program, with the state paying the remaining 40 percent. In fiscal year (FY) 2009, the federal government's share of the State's Medicaid costs increased to 66.3 percent or about $870 million, while the State's share decreased to 33.7 percent or about $440 million under the American Recovery and Reinvestment Act of 2009 (ARRA). The chart OV-1 shows the State and federal medical assistance percentages for FY 2009.



As shown in OV-2 on the following page, of the State's $1.3 billion Medicaid medical assistance costs in FY 2009, 66 percent was expended through the Fee-for-Service (FFS) program, which directly pays providers for services rendered primarily to individuals who are aged or disabled. Managed Care[3], which is not addressed in this audit, makes up approximately 29 percent.

[3] To provide managed care, KHPA pays managed care organizations (MCOs) a per capita fee, also known as a capitation payment, for each eligible beneficiary for whom the MCO provides services. Eligibility for managed care is largely limited to pregnant women, parents and children.

OV-2 Medicaid Medical Assistance[a]
FY 2009



$1.3 Billion

(a) Includes only Medicaid expenditures for medical assistance by KHPA and does not include administration costs or Medicaid medical assistance expenditures by SRS, KDOA and JJA.
(b) Payments are made to hospitals based on established formulas.

Source: KHPA Medical Assistance Report (MAR) FY 2009

To support the efficient and effective management of the Medicaid program, the federal government pays 90 percent of the cost of the design, development, installation or enhancement, and 75 percent for the operation of states' mechanized Medicaid claims processing and information retrieval systems, also known as Medicaid Management Information Systems (MMIS). To receive federal reimbursement, CMS must certify the MMIS is designed as intended. According to Section 11115 of CMS' State Medicaid Manual, the states' MMIS are required to meet certain objectives, including "more accurate and timely claims processing." The State met CMS certification requirements for its MMIS and was allowed to claim reimbursement for MMIS operational costs.

CMS allows for a fiscal agent who is a private contractor to the state to design, develop, install or operate an MMIS. In 2002, the Department of Social and Rehabilitation Services (SRS) entered into a contract with EDS for the design, development, installation and operation of the State's replacement MMIS for a period beginning February 1, 2002 to June 30, 2008. Under the EDS contract, SRS has the option to renew for five additional one-year periods. This renewal option was subsequently amended to two additional periods for (1) a term of three years, July 1, 2008 through June 30, 2011, and (2) a term of two years, July 1, 2011 through June 30, 2013.

The Kansas Health Policy Authority (KHPA), which was created in the 2005 Legislative Session, acquired oversight of MMIS operations when it became the single state Medicaid agency for Kansas in July 2006. KHPA has since exercised the option to renew EDS' contract

until June 30, 2011. The total fiscal agent contract cost for FY 2009 amounted to about $33.3 million. KHPA reduced the initial FY 2010 contract costs to about $32.0 million after reductions to the contract of about $3.7 million were effected due to agency budget cuts. The reductions resulted in the elimination of positions in managed care enrollment, customer service, Kansas Medical Assistance Program (KMAP) liaisons and dental services, as well as termination of managed care beneficiary denial letters.

The fiscal agent is paid for each claim processed, as well as for each managed care capitation[4] payment, system maintenance and modification, and KMAP liaison services. The MMIS processes clean claims in real time and suspended claims in hourly cycles. There is no required number of claims the fiscal agent has to process. In FY 2008, the fiscal agent processed more than 18 million claims.

Electronic or paper claims can be submitted and processed through MMIS, as shown in OV-3 on the following page. Electronic claims go through automated systems while paper claims are imaged using Intelligent/ Optical Character Recognition (ICR/OCR) software or manually entered in the MMIS by fiscal agent staff. Claims are assigned unique identifying internal control numbers (ICN) and are subject to applicable automated edits and audits which validate the data submitted. Valid claims are processed and questionable claims are suspended for manual review prior to adjudication. Payment files associated with adjudicated claims are forwarded weekly to the Department of Administration (DoA) for payment. Adjustments may be made for any identified overpayment or underpayment.

[4] Capitation payment - Fixed amount paid periodically to a healthcare provider for a group of specified healthcare services regardless of quantity, rendered per enrollee, e.g. HMO payments that are a fixed amount per beneficiary per month.

OV-3: KANSAS MEDICAID MANAGEMENT INFORMATION SYSTEM CLAIMS PROCESSING FLOWCHART

SUBMISSION	INPUT	AUTOMATED REVIEW	ADJUDICATION/RESOLUTION	PAYMENT	ADJUSTMENT
• Providers may submit claims as follows: **Paper:** Completed paper claim forms, including paper attachments. **Electronic:** *Provider Electronic Solutions (PES)* – fiscal agent software that enables providers to submit claims electronically, receive claim status, and verify beneficiary eligibility. *Web* – claims batch upload *Internet* - Claims submitted online through direct data entry to the web claim submission form. **Point-of-Sale (POS):** Pharmacy claims submitted and processed in real-time through automated systems.	• Submitted claims enter the MMIS, are extracted into electronic formats and assigned internal control numbers (ICN). • Paper claims are scanned using an intelligent/ optical character recognition software (ICR/ OCR), which may require manual support from fiscal agent staff.	• Claims are screened against data in the MMIS, including non-history related edits[(a)], history-related audits[(b)] and medical policy to determine whether claims satisfy program or processing requirements.	• A claim may be set to pay[(c)], deny or suspend. • If a claim is suspended, it is put on hold pending manual review by appropriate staff using KHPA approved claims resolution guidelines. Authorized fiscal agent staff may override the edit/audit, correct the data, deny the claim, or route the claim to other appropriate staff for resolution. Exceptions or errors found may result in system or policy changes.	• Every week[(d)], the fiscal agent submits pay files of claims adjudicated to be paid to the Kansas Department of Administration for payment. • Remittance Advices (RA) are sent to providers.	• Paid claims may be adjusted for overpayments or underpayments due to TPL recoveries, repricing, etc. • Claims that are processed incorrectly are reprocessed by the fiscal agent with KHPA approval.

(a) An edit verifies that the claim contains valid data. For example, it confirms that the provider number is legitimate.
(b) An audit checks the current claim against previous claims for conflicts. For example, if the claim is for an appendectomy, which is a once-in-a-lifetime procedure, the system checks to see whether the patient has had an appendectomy before.
(c) Some claims may not meet edit/audit criteria but may be paid if the edit/audit is set to 'PAY and LIST,' meaning that the edit/audit will not suspend the claim but the claim will be listed on the CLM-6518-D 'Pay But Report Edit/Audit' Report.
(d) The weekly financial cycle generally runs each Friday.

There are six general types of fee-for-service (FFS) claims processed by the MMIS. These are medical or professional, inpatient, outpatient, dental, pharmacy and long-term care[5]. Medical/ Professional claims constitute at least 50 percent and pharmacy claims constitute at least 25 percent of Medicaid claims processed in FY 2008 and 2009, as shown in OV-4.

[5] See definitions in Appendix B.

OV-4: TOTAL CLAIMS PROCESSED BY TYPE[a]						
CLAIMS	FY 2007	% OF TOTAL	FY 2008	% OF TOTAL	FY 2009	% OF TOTAL
Medical/Professional[b]	7,888,951	55.9%	10,263,707	56.1%	9,279,095	49.6%
Pharmacy	4,332,735	30.7%	5,728,933	31.3%	4,664,381	24.9%
Outpatient[b]	813,687	5.8%	989,434	5.4%	2,980,137	15.9%
Dental	315,805	2.2%	377,388	2.1%	1,219,451	6.5%
Long-Term Care	551,505	3.9%	678,495	3.7%	422,845	2.3%
Inpatient[b]	222,195	1.6%	260,445	1.4%	143,116	0.8%
TOTAL	**14,124,878**	**100%**	**18,298,402**	**100%**	**18,709,025**	**100%**

(a) Number of claims processed by claim type was not available prior to FY 2007.
(b) These numbers include Medicare crossover claims.
Source: KMAP Annual Fiscal Reports

According to KHPA staff, outpatient claims increased in FY 2009 due to increases in psychiatric residential treatment facility (PRTF), prepaid ambulatory health plan (PAHP), prepaid inpatient health plan (PIHP), and senior companion services. Dental claims increased during the same year due to an increase in the Medicaid population served, including individuals dually eligible for Medicaid and Medicare, and an increase in Medicaid participating dental providers.

Does KHPA's Oversight Ensure the Fiscal Agent's Compliance with Contractual and Federal Requirements Related to Timeliness and Accuracy of Claims Payments?

Timeliness Discussion and Findings

KHPA has several controls to assess the fiscal agent's quality of performance and adherence to federal regulations related to claims processing timeliness. Federal regulations address timely filing requirements by providers and timely processing by the fiscal agent.

Medicaid providers are required by federal law to submit claims for services rendered in a timely manner. Federal regulation 42 CFR 447.45 directs states to require providers to submit all claims no later than 12 months from the date of service. K.S.A. 39-708a allows for exemptions to this timely filing rule as follows:

- If the services were provided to a child who at the time of service was in the custody of the secretary, or a child for whom the agency has entered into an adoptive support agreement if the medical vendor did not have actual knowledge of that fact prior to the expiration of the 12-month period.
- If the claim was submitted to Medicare within 12 months of the date of service, paid or denied for payment by Medicare, and subsequently submitted for payment to the state medical assistance program within 30 days of the Medicare payment or denial date.
- If the claim is determined payable by reason of administrative appeals, court action or agency error.
- If the claim is for emergency services rendered by providers located outside the state who are not already enrolled as state medical assistance program providers.
- If the claim is determined by the [KHPA Executive Director] to be the result of extraordinary circumstances.

We did not find any federal law that allows states to make exemptions that extend the timely filing period beyond the 12-month period 42 CFR 447.45 requires. 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.

KHPA policy allows for Medicare crossover claims submitted after 24 months from date of service to be paid. According to the KMAP general billing provider manual, claims which were originally filed within 12 months of the service date but not resolved may be resubmitted to Medicaid for up to 24 months from the date of service. However, an even longer period may be allowed if a Medicare claim was originally timely filed with Medicare, but exceeds the 24-month

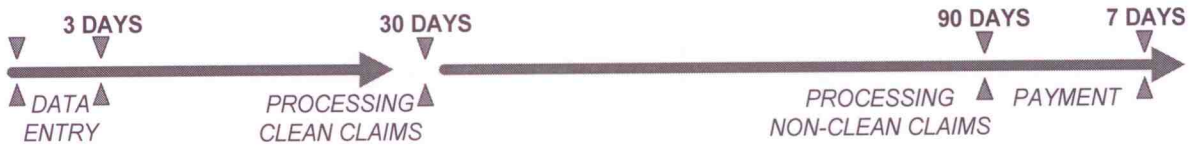
limitation. In this case, the claim may be filed with Medicaid within 30 days of Medicare's response.

State medical assistance programs are federally required to ensure the timely processing[6] of claims for payment. 42 U.S.C. 1396a(a)(37) requires states to pay 90 percent of clean claims - claims requiring no further written information or substantiation - within 30 days from receipt of the claim. Non-clean[7] claims are required to be paid within one year, with certain types of claims allowed longer processing time.

The fiscal agent contractual timeliness standard is more stringent than the federal timeliness standard. Until the end of FY 2008, KHPA required its fiscal agent to process all claims within 30 days. However, because KHPA policy allows up to 45 days for newborn and NEMT claims and up to 90 days for adjustments to process, KHPA amended the fiscal agent contractual standard for claims processing timeliness in May 2008. Currently, KHPA requires its fiscal agent to adjudicate all clean claims and 97 percent of non-clean claims within 30 days, with the remaining three percent within 90 days from receipt of the claim.

As shown in Table I-1, non-clean paper claims may take up to 100 days to be paid. The fiscal agent contract allows (1) data entry of paper claims into the MMIS to take up to three days, and (2) payment processing, once the fiscal agent has adjudicated a claim to be paid, to take up to seven days, in addition to the 90-day processing time.

I-1: CLAIMS PROCESSING TIMELINE



Source: EDS contract performance expectations

KHPA has several controls in place to ensure claims processing timeliness standards are met. In addition to including timeliness performance expectations in the fiscal agent contract that are more stringent than federal requirements, KHPA has done the following:

- Added penalty clauses, e.g. damage assessments, in the contract to ensure the fiscal agent conforms to timeliness requirements.
- Assigned claims management staff to oversee the fiscal agent's claims processing, including resolving claims-related issues and reviewing various reports, such as the fiscal

[6] See Appendix C.
[7] A non-clean claim is a claim submitted into MMIS with incomplete information and requires obtaining additional information from the service provider or from a third party to properly process and pay.

agent's quality assurance monthly report on claims processing timeliness, weekly aged claims and other exception reports.

- Developed provider manuals that include instructions for timely filing claims.
- Worked with the fiscal agent to put together business practice manuals for claim issues resolution and timely filing, among other things.
- Included system edits in the MMIS to prevent claims not timely filed from being paid.

These controls, if operating as intended, help ensure timeliness standards are met. To determine whether the above mentioned controls are working effectively, we tested a sample of claims to calculate timeliness of claims processing and to identify aged claims, discussed policies related to timely filing and timely processing with KHPA claims management staff, reviewed the fiscal agent timely filing business practice manual and the provider general billing manual, met with the fiscal agent's quality assurance staff and reviewed their audit reports related to claims processing timeliness, and surveyed a sample of providers to assess their perception of the timeliness of the fiscal agent's claims processing. Our findings are as follows:

1. Timely filing requirements were not met for eight claims totaling $1,229 in our sample of paid claims. To determine whether claims were paid that did not meet the provider timely filing requirement, we looked at a sample of 295 claims from FY 2005 to FY 2008 that appear to have been submitted late. KHPA staff concurred that timely filing requirements were not met for eight of those exceptions. According to KHPA staff, the other claims in our sample were originally submitted on time, but reprocessed due to rate changes or errors.

2. *Less than two percent of the claims in our sample were not adjudicated within 30 days.* We requested a sample of approximately 3.9 million adjudicated claims covering FY 2005 to FY 2008. This sample constitutes roughly eight percent of about 49 million claims the fiscal agent processed for the same time period. For each of the claims in our sample, we compared the date it entered the MMIS to the date it was adjudicated to identify aged claims. As I-2 shows, claims processed more than 30 days decreased from more than 52,000 in FY 2005 to a little over 2,000 in FY 2008.

I-2: CLAIMS ADJUDICATED MORE THAN 30 DAYS AFTER SUBMISSION FY 2005-2008

FISCAL YEAR	NUMBER OF CLAIMS IN SAMPLE	CLAIMS ADJUDICATED > 30 DAYS	PERCENT
2005	969,077	52,718	5.44%
2006	968,920	6,805	0.70%
2007	969,700	966	0.10%
2008	963,524	2,061	0.21%
TOTAL	**3,871,221**	**62,550**	**1.62%**

Source: OIG analysis of MMIS claims data.

3. The fiscal agent's internal quality assurance audits show the fiscal agent did not meet timely claims processing standards from FY 2005 to FY 2008, but met new standards in FY 2009. The fiscal agent's quality assurance staff conducts monthly reviews of whether the fiscal agent met contractual performance expectations, including those for claims adjudication timeliness, and their findings, as shown in I-3, corroborate the results of our timeliness analysis. The quality assurance findings below show the fiscal agent has not met timeliness standards for 47 of 48 months in FY 2005 to FY 2008. According to KHPA staff, contributing factors include (1) KHPA policy allowing a longer timeline of 45 days to process claims for newborn and NEMT services and (2) adjustments taking up to 90 days to process. These timelines were longer than the initial fiscal agent contractual timeliness standard of 30 days to adjudicate claims.

KHPA did not take steps to resolve the issue until May 2008 when they changed the contract standard to accommodate longer processing times for newborn and NEMT claims, as well as adjustments. According to the fiscal agent's quality assurance audit findings, the fiscal agent met the new timeliness contract requirements for FY 2009.

I-3: INTERNAL QUALITY ASSURANCE AUDIT FINDINGS ON TIMELINESS FY 2005 - FY 2009

SPECIFIC REQUIREMENT (RFP SECTION #4.3.2.2.3)	MONTHLY COMPLIANCE				
	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Original Standard: All claims including adjustments must be processed and ready for payment or denial within 30 days of receipt in the Fiscal Agent's mailroom, except that all error-free adult care home transactions must be processed in the first cycle after receipt.	0/12	0/12	0/12	1/12	n/a
New Standard: All clean claims and 97 percent of non-clean claims must be processed and ready for payment or denial within 30 days of receipt in the Fiscal Agent's mailroom, and the remaining three percent of non-clean claims (newborn, NEMT and adjustments) must be processed and ready for payment within 90 days of receipt in the Fiscal Agent's mailroom.	n/a	n/a	n/a	n/a	12/12

Source: Fiscal Agent Quality Assurance staff.

We requested KHPA staff provide the actual percentage of aged claims based on the population of claims received from FY 2005 to FY 2008. The data KHPA staff provided showed aged claims constitute 1.05 percent of about 49.2 million claims received during the time period. There were about 152,000 aged claims in FY 2005; 173,000 in FY 2006; 68,000 in FY 2007 and 123,000 in FY 2008.

According to KHPA staff, post MMIS implementation review activities occurred between 2004 and 2006. KHPA and fiscal agent staff acknowledged there were many startup issues identified after the MMIS went online in October 2003 that were resolved primarily in FY 2004 and FY 2005. For example, the billing form, UB-92, was new to long-term care providers and some edits

applied to other claim types submitted on the form were not applied to long-term care claims resulting in aged claims. Since long-term care providers did not receive timely notice of their incorrect claims, KHPA allowed the claims to be reprocessed.

KHPA staff indicated KHPA contributed to the fiscal agent being out of compliance with the timely processing requirement for some claims requiring program managers' review and approval. KHPA staff discussed with the fiscal agent (1) claims pending for more than 30 days awaiting KHPA program manager review and approval and (2) the need to increase KHPA program manager awareness of aged claims; and, required the fiscal agent to submit daily and weekly reports of claims exceeding 30 days with an explanation for the delays. A decision was also made to notify program managers electronically of the aged claims, copying the KHPA claims management team so they can follow up with the program managers.

4. KHPA has elected not to assess damages on the fiscal agent for not meeting claims processing timeliness standards since the beginning of the contract period. An important control designed to ensure good performance is a penalty clause. KHPA has a penalty clause in its fiscal agent contract, which states the fiscal agent shall be assessed one dollar per business day for each claim not processed within the required time frame. As shown in I-4, had KHPA assessed damages on the fiscal agent for the aged claims identified in our sample, damages would have amounted to almost $1.0 million in FY 2005. However, the amount of potential liquidated damages decreased to less than $40,000 in FY 2006. Potential liquidated damages for FY 2007 and FY 2008 were significantly less at about $3,400 and $7,700, respectively. Damages would be higher if based on the actual number of aged claims KHPA staff identified which is more than eight times the number of aged claims in our sample.

I-4: ESTIMATED DAMAGES [(a)] FOR CLAIMS ADJUDICATED MORE THAN 30 DAYS AFTER RECEIPT, FY 2005-2008

CLAIM TYPE	FY 2005	FY 2006	FY 2007	FY 2008
Dental	$52,089	$24,844	$508	$89
Pharmacy	$1,057	$11	$11	$16
Long Term Care	$583,924	$289	$247	$0
Medical/Professional	$43,760	$7,407	$242	$3,811
Inpatient	$16,145	$1,367	$2,123	$157
Outpatient	$56,411	$720	$69	$42
Medicare Crossovers	$235,018	$4,438	$217	$3,623
TOTALS	**$988,404**	**$39,076**	**$3,417**	**$7,738**

[(a)] $1 per claim per business day that the claim is not processed after 30 days.

Source: OIG analysis of MMIS data

We provided KHPA staff with a complete list of claims associated with the above-mentioned potential damages. According to KHPA staff, a previous Kansas Department on Aging (KDOA) policy related to long-term care (LTC) in-mass rate change requests help explain the number of

LTC aged claims. KDOA staggered provider recoupments related to these rate changes, causing affected LTC claims not to be adjudicated for long periods of time. However, because this timeliness issue was caused by KDOA policy, KHPA did not assess damages on the fiscal agent for these LTC claims. KHPA staff said this process has been revamped and KHPA now actively monitors LTC claims weekly and works closely with KDOA to ensure rate change requests are valid. In addition, KHPA staff said they have made significant improvements in processing nursing home claims.

KHPA staff also informed us an incorrect process followed by the fiscal agent, not at the direction of KHPA, contributed to the number of aged pharmacy claims. When a provider inquired about a claim he or she felt was denied incorrectly, the fiscal agent would pull the original claim rather than reprocess the claim. This process created artificially long adjudication timelines for affected claims. According to KHPA staff, the fiscal agent has ceased following this process.

As stated in the fiscal agent contract, "the fiscal agent contractor shall pay the State for failure to meet performance requirements at the sole discretion of the State. Written notification of each failure to meet a performance requirement shall be given to the fiscal agent contractor prior to assessing liquidated damages. If KHPA elects not to exercise a damage clause in a particular instance, this decision shall not be construed as a waiver of the State's rights to pursue future assessment of that performance requirement and associated damages."

According to KHPA staff, because resolutions and timeframes for correction were agreed upon by KHPA and the fiscal agent, and met by the fiscal agent, KHPA deemed it unnecessary to assess damages for not meeting claims processing timeliness standards. Contributing factors to KHPA's decision not to assess damages also may have included the newness of the MMIS that resulted in issues early in its implementation and the fiscal agent's good faith effort to monitor and improve its claims processing timeliness through its quality assurance process.

5. Of the 100 providers who participated in our online survey, 96 said their claims were mostly or always reimbursed timely. We conducted a survey of Medicaid providers in October of 2008 to assess their perception of the fiscal agent's timeliness in processing claims reimbursements. Of the providers in our sample, 94 percent said they submit their claims electronically. Sixty eight percent said they submit claims either weekly or daily.

Timeliness Conclusion and Recommendations

Conclusion: KHPA's oversight is reasonably effective in ensuring the fiscal agent's timely processing of claims. However, we have five recommendations for KHPA management to consider, which could provide further assurance that claims will be processed in a timely manner and in accordance with contractual requirements.

Recommendations:

1. KHPA should consider including an indicator for clean and non-clean claims in MMIS at the point of adjudication. Without this indicator, it is difficult to assess whether the fiscal agent met current timeliness standards.

2. KHPA should ensure the fiscal agent quality assurance team's process for calculating the percentage of aged claims agrees with current contractual timeliness standards. Current quality assurance timeliness measurements are based on total claims processed. This measurement conforms with the previous timeliness standard but not with the current timeliness standard which requires stratified calculations based on clean and non-clean claims. The current timeliness standard would result in varying threshold numbers/percentages of timely processed claims from period to period, depending on the number of clean and non-clean claims.

3. KHPA should develop a guidance policy clarifying KHPA's position, and defining criteria under which damage assessment on the fiscal agent for not meeting contractual timeliness standards will be imposed or waived. This policy would ensure consistency in decision making.

4. Appropriate KHPA staff should review the timely filing exceptions listed in this report, and where appropriate, initiate recoupment. Staff should also review timely filing procedures to minimize exceptions and ensure compliance with federal requirements.

5. KHPA legal staff should review whether exemptions to the federal timely filing requirement allowed by K.S.A. 39-708a comply with federal law.

Accuracy Discussion and Findings

KHPA conducts several oversight activities to assess the fiscal agent's quality of performance and adhere to federally mandated claims processing accuracy requirements. These activities include prepayment and post-payment reviews which ensure claims processing accuracy. Federal accuracy standards consider risk factors associated with beneficiary eligibility, third party liability, policy violations, limitations, documentation, medical necessity, coding errors, data entry errors, duplication, pricing, and system logic. Our testwork to determine claims processing accuracy is limited to only a sample of edits.

Federal regulation 42 CFR 447.45 requires prepayment and post-payment claim reviews to ensure the accuracy of Medicaid payments. Prepayment reviews consist of the following:

- Verification that the recipient was included in the eligibility file and the provider was authorized to furnish the service.
- Checking that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, gender, service location.
- Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed.
- Verification that a payment does not exceed any reimbursement rates or limits in the State plan.
- Checking for third party liability.

Post-payment claim reviews consist of developing and reviewing recipient utilization profiles, provider service profiles, and exceptions criteria and identifying exceptions so the agency can correct inappropriate practices or "misutilization" of recipients and providers.

The KHPA OIG has identified prepayment and post-payment reviews KHPA and its fiscal agent perform to ensure claims are processed accurately, and have determined that KHPA has sufficiently complied with federal requirements related to accuracy.

The MMIS has automated edits and audits to ensure only valid claims are adjudicated and paid and incomplete or questionable claims are flagged for manual review prior to payment or denial. The key function of an edit is to detect an unfavorable condition on a claim, for example, a procedure or diagnosis code is not on file. The key function of an audit is to apply a limitation. While applying the limitation, the system looks at the current day claims activity as well as historical claims data that meet the same criteria to make a determination. In all, the MMIS had over 1,500 edits and audits as of July 2009.

We reviewed the MMIS' edits and audits and determined they sufficiently address the elements of a prepayment review, as follows:

- *Verification the recipient was included in the eligibility file and the provider was authorized to furnish the service.* The MMIS has several form and field edits, as well as provider and beneficiary specific edits that appear to comply with this requirement. For example, the MMIS has an edit to prevent claim processing when a beneficiary ID number is missing or not on file, the beneficiary date of birth is after the claim date of service, the billing provider ID number submitted is not on file, and the performing provider type and the claim type do not match.
- *Checking that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, gender, service location.* The MMIS appears to have edits that satisfy this requirement, such as edits for procedures with age restrictions and gender restrictions.
- *Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed.* The MMIS appears to have edits that satisfy this requirement, such as edits for duplicate Medical, Physician and Dental claims.
- *Verification that a payment does not exceed any reimbursement rates or limits in the State plan.* The MMIS appears to have edits that satisfy this requirement, such as edits that allow only one unit home glucose monitor per 730 days, only one complete eye exam every 1,460 days, only 320 units targeted case management (TCM) per calendar year, only one type of adhesive per 30 days and only one type of skin barrier per 30 days.
- *Checking for third party liability (TPL).* The MMIS appears to have edits that satisfy this requirement, such as an edit for suspect TPL and multiple TPL. According to the fiscal agent TPL business practice manual, the fiscal agent uses system edits in claim processing, ongoing research and TPL system updates, data matches, leads from sources, and other approaches to contain costs. To support the TPL function, the fiscal agent contracts with Health Management Systems (HMS) to maintain TPL data, perform cost avoidance and post pay recovery and track recovery cases and collections. The MMIS generates claim bills that are sent to insurance companies for payment or denial of services.

According to KHPA's claims program review, 27 percent of about 227,000 claims processed weekly in FY 2007 and 30 percent of about 199,000 claims processed weekly in FY 2008 were denied. These claims may have been denied electronically or after manual review. The primary reasons why claims are denied are as follows: procedure was not covered on date of service, National Provider Identifier (NPI) billing provider ID was invalid or ineligible on date of service, non-covered procedures were considered content of service, benefit plan was invalid for claim type, beneficiary was covered by other insurance, HealthWave service was not billed by MCO, provider type and specialty were not valid for the procedure, and Vaccines for Children Program (VFC) covered immunizations for children. While edits and audits in the MMIS may be

overridden by specific fiscal agent or KHPA staff, there are specific instructions and conditions needed to perform an override and resolve the issue. According to KHPA claims staff, MMIS tracks and generates a report listing edit and audit overrides and the staff performing the overrides.

KHPA's post-payment reviews are primarily done through the surveillance and utilization review subsystem (SURS) process. SURS is a federally mandated program[8] for monitoring providers and consumers of Medicaid services. KHPA contracts out this service to its fiscal agent, which has about 17 staff members who perform provider reviews, consumer reviews, and fraud and data analyses. Oversight of this program is primarily provided by KHPA's utilization review manager. On average, the fiscal agent's SURS staff conducts about 31 reviews each quarter.

As part of the post-payment review process, the fiscal agent also conducts desktop reviews of electronic claims with third party liability (TPL) to ensure Kansas Medicaid is always the payor of last resort. Claims included are those that have TPL dollar amounts or TPL indicators. Providers are required to submit acceptable documentation in response to these TPL reviews.

In addition to implementing federally required prepayment and post-payment reviews, KHPA has several controls in place to ensure effective oversight of claims processing, in particular, accuracy. These activities include an annual SAS 70 audit of the fiscal agent's controls, annual contract performance evaluations, on-going monitoring of the fiscal agent's claims processing and system test plan to detect errors in and outside the MMIS, reviews of the fiscal agent's internal quality assurance audit findings and oversight of the fiscal agent's surveillance and utilization reviews of potential overpayments to providers or beneficiaries. In addition, two federal oversight activities supplement KHPA's efforts: (1) Kansas Medicaid is subject to federal Payment Error Rate Measurement (PERM) reviews, and (2) the Centers for Medicare and Medicaid Services certified that the Kansas MMIS adheres to federal design requirements. Furthermore, the fiscal agent, through its internal quality assurance audits, conducts regular self-assessments to determine whether they met contractual performance expectations.

1. KHPA's fiscal agent contract required an annual SAS 70 audit of the fiscal agent's controls. The fiscal agent hired Ernst and Young to conduct its annual SAS 70 audit. The Statement on Auditing Standards No. 70, commonly abbreviated as SAS 70, defines the professional standards used by a service auditor to assess the internal controls of a service organization and issue a service auditor's report.

In the 2008 report, Ernst and Young stated they applied tests to specific controls over the operating effectiveness of the MMIS and opined that the controls tested were operating with sufficient effectiveness to provide reasonable, but not absolute, assurance that control objectives

[8] 42 CFR 456

were achieved during the period tested. Control objectives, which were specified by the fiscal agent, included processing Medicaid payments accurately and timely. Ernst and Young reported the fiscal agent's controls are suitably designed to provide reasonable assurance that specified control objectives would be achieved if the described controls were complied with satisfactorily.

2. The Kansas MMIS is CMS-certified. Through the federal MMIS certification process, CMS verifies state Medicaid systems are designed to support the efficient and effective management of the Medicaid program. Certification also validates that systems are operating as described in the prior approval documents and all associated contracts submitted to CMS. In the absence of federal certification, Medicaid systems are not authorized to receive the enhanced federal matching rate of 75 percent for their operation.

The fiscal agent contract requires the fiscal agent ensure that federal certification approval for the maximum allowable enhanced federal financial participation (FFP) for the MMIS is obtained retroactive to the day the system becomes operational and is maintained throughout the term of the contract. The contract also stipulates should de-certification of the MMIS, or any component part of it, occur prior to contract termination or the ending date of any subsequent contract extension, the fiscal agent contractor shall be liable for resulting damages. In October 2003, the Kansas MMIS met CMS certification requirements and KHPA was allowed to claim reimbursement for MMIS operational costs.

3. KHPA's contracts and fiscal agent operations staff conducts annual performance evaluations of its fiscal agent to make sure the fiscal agent is meeting performance expectations. The fiscal agent contract lists specific performance standards the fiscal agent must meet, including standards related to accuracy and timeliness of claims processing, as well as the amount of liquidated damages the fiscal agent will be assessed for failure to meet performance requirements.

In FY 2008, KHPA's annual evaluation of its fiscal agent's operations found issues related to edits and limits, pricing, input and payment. Problems identified include defects in:

- provider type and specialty edits,
- Medicare-related claims being batched and keyed incorrectly,
- online entry of corrections to claims with errors,
- claims being overpaid due to issues with tracking long-term care (LTC) beneficiary leave days (hospital and therapeutic) and,
- TPL not being deducted correctly from other claim types besides Dental.

According to KHPA staff, the fiscal agent and KHPA have been able to resolve identified deficiencies through corrective action plans. Therefore, KHPA has not assessed the fiscal agent damages for those deficiencies.

4. KHPA's business analysis testing and claims management staff conducts on-going monitoring of the fiscal agent's claims process. Various MMIS reports are created that allow for claims inventory tracking, management and analysis. Reports include the number and dollars of suspended, denied, flagged and total claims; claims statistics that include volume, speed, error and accuracy; MMIS issues related to overpayments and underpayments that KHPA and fiscal agent staff are working on; timely filing statistics which list the number of daily timely filing requests received, including those for retroactive claims; and, weekly MMIS statistics showing the age of suspended claims per claim type. According to KHPA staff, daily, weekly, monthly and quarterly reports are reviewed when received.

If KHPA staff finds problems the reports are reviewed more often. Any problems or concerns with the reports are taken up during the weekly Claims Management meeting between KHPA and the fiscal agent claims management teams. In addition, KHPA staff informed us that, while the fiscal agent has not always been in compliance, issues were addressed, resolutions discussed and timeframes for corrections were agreed upon and met.

5. KHPA's business analysis and testing unit used to oversee the fiscal agent's system test plan to detect errors in and outside the MMIS. Test cases to detect errors in the MMIS span all types of valid inputs into the MMIS. The test cases present information to the MMIS that conform to all applicable State policies and should process correctly based on those policies. There are also test cases designed to detect errors outside the MMIS. Entities external to the MMIS cause these types of errors and may represent providers or organizations that feed information to the MMIS. The latter type of test case anticipates possible errors (unintentional or otherwise) introduced in the information input into the MMIS.

KHPA staff responsibilities include oversight of the system test plan, review and approval of test cases, review and approval of test results including documentation updates, and assisting in the development and execution of all user acceptance test cases. Since December 2009, KHPA's business analysis and testing unit has no staff to perform these functions.

6. KHPA claims staff reviews the fiscal agent's internal quality assurance audit findings and resolves problems found. As shown in Table II-1, the fiscal agent has made some progress in complying with the contract requirement for data entry accuracy. According to KHPA staff, specific instances of inaccurate processing were addressed as they occurred. For example, when the fiscal agent's document management center data entry staff was not capturing other insurance information submitted with dental claims, KHPA staff discussed the issue with the fiscal agent and agreed the fiscal agent would submit quarterly reports of claims processed incorrectly. It was also agreed the fiscal agent would restrict keying of claims to more experienced staff. Furthermore, modifications were made to the intelligent character recognition/optical character recognition (ICR/OCR) system to prompt fiscal agent staff to

capture TPL information. According to KHPA staff, these changes reduced the number of provider complaints regarding inaccurate processing of dental claims when other insurance was involved.

II-1: INTERNAL QUALITY ASSURANCE AUDIT FINDINGS - DATA ENTRY						
RFP SECTION #	SPECIFIC REQUIREMENT	MONTHLY COMPLIANCE				
		FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
4.3.2.2.11 (a)	95% of all paper claims for each claim type were free of data entry errors.	0/12	0/12	5/12	9/12	8/12
4.3.2.2.11 (b)	95% of adjustments were free of data entry errors	0/12	4/12	8/12	7/12	10/12
Source: EDS' Quality Assurance staff						

7. KHPA's surveillance and utilization review manager oversees the fiscal agent's surveillance and utilization reviews which recoup overpayments made to providers or beneficiaries. SURS is a federally mandated[9] program for monitoring Medicaid providers and consumers to safeguard against unnecessary or inappropriate use of services and excess payments, assessing the quality of services, and providing for the control of the utilization of services.

The fiscal agent SURS staff identified $3.0 million in overpayments to providers in FY 2007. That amount decreased by 63.2 percent in FY 2008 to $1.9 million. According to SURS staff, the decrease is largely due to a change in their reporting process. Two events explain the reduction in overpayments identified in FY 2008. In FY 2007, SURS reported identified overpayments at the time adjustments were made but prior to the cases closing. Beginning in FY 2008, they no longer report identified overpayments until all appeal options have been exhausted by providers and the cases closed. This causes a delay in reporting overpayments. Based on KHPA's instruction, the fiscal agent's SURS staff has also discontinued conducting reviews based on statistical random sampling and extrapolating findings to a larger number of claims.

Table II-2 shows overpayments by finding. At least 50 percent of recoupments initiated by SURS were for claims billed and paid in excess of program limitations. These claims totaled almost $2 million in FY 2007 and almost $1 million in FY 2008. Documentation problems were another cause for recoupment. Some claims lacked supporting documentation or had documentation which did not support units and amounts billed. These totaled about $700,000 for both FY 2007 and FY 2008. Except for prior authorized services, the fiscal agent does not keep supporting documentation for services providers billed. However, providers are required to keep all documentation which supports services rendered and provide them in the event of a review or an audit.

[9] 42 CFR 456

II-2: SURS - IDENTIFIED RECOUPMENT BY FINDINGS, FY 2007-2008					
MAJOR FINDINGS KEY	DESCRIPTION	2007	% OF TOTAL	2008	% OF TOTAL
Program Limits					
Program Limitations	The claims billed and reimbursed exceed the program limitations for this service.	$1,973,840	65%	$970,091	50%
	Sub-total	**$1,973,840**	**65%**	**$970,091**	**50%**
Documentation Issues					
Nondocumented Services	There was no documentation to support the service billed and reimbursed.	$469,671	15%	$509,435	26%
Documentation Does Not Support Services Billed	Documentation did not support services billed.	$81,749	3%	$55,458	3%
No Documentation Provided	No documentation provided	$0	0%	$11,687	1%
Units	Documentation did not support units billed and reimbursed.	$136,202	4%	$111,398	6%
Incorrect Billed Amount	Billed amount was incorrect	$0	0%	$31,556	2%
	Sub-total	**$687,622**	**22%**	**$719,534**	**38%**
Coding Issues					
Incorrect Coding	The wrong procedure code was billed and paid for the service.	$65,472	2%	$74,668	4%
Upcoding	Procedure code billed and paid at a higher dollar amount than is supported by the records	$110,667	4%	$12,904	1%
	Sub-total	**$176,139**	**6%**	**$87,572**	**5%**
Other [(a)]		**$202,294**	**7%**	**$145,592**	**7%**
	TOTALS	**$3,039,895**	**100%**	**$1,922,789**	**100%**

(a) Duplicate Services, Medical Necessity, PCCM Referrals, Non-Covered Services, Content Of, Prescribing Practice, Suspected Fraud, Fiscal Agent Error, Quality
Source: OIG analysis of SURS data

Fiscal agent SURS staff conducts beneficiary reviews to identify lock-in determination. Beneficiaries determined to be inappropriately using their medical card are restricted to assigned "lock-in" medical providers for an initial probationary period of two years, with possible extension if the beneficiary continues to misuse services. Standard assignments for lock-in beneficiaries are a physician and pharmacy. If emergency room or outpatient services have been used inappropriately, lock-in assignment includes a hospital.

Direct lock-in can be initiated without a beneficiary review when confirmed abuse has been identified. If a beneficiary disagrees with the lock-in determination restrictions, he or she can appeal the decision by requesting an internal appeal redetermination or a fair hearing. Fiscal agent SURS staff conducts (1) a pre-stop lock-in review three months before the termination of the initial lock-in period and (2) a post lock-in review six to 12 months after the initial lock-in termination date. Lock-in assignments are allowed to terminate or expire when a utilization review determines the beneficiary has appropriately used his or her medical benefits. Lock-in assignments can be terminated without a utilization review if direction is received from the Office of Administrative Hearings or authorized KHPA personnel.

8. Kansas Medicaid is subject to federally mandated Payment Error Rate Measurement (PERM) reviews. Designed to comply with the Improper Payments Information Act of 2002[10], CMS implemented the PERM program to measure improper payments in Medicaid and the Children's Health Insurance Program (CHIP). Three CMS contractors perform statistical calculations, medical records collection, and medical/data processing review of selected claims.

In Kansas, the Medicaid fee-for-service error rate is 4.62 percent, which is slightly lower than the national average Medicaid fee-for-service error rate of 4.7 percent for federal fiscal year 2006. This rate includes errors identified in medical and processing reviews. Claims processing errors identified in the PERM report include incorrect provider end-dating, lack of complete third party liability (TPL) verification documentation, clerical errors in manual pricing, and a system edit incorrectly posted. KHPA's corrective action plan to address these issues includes terminating provider eligibility instead of provider specialty end-dating, conducting audits of a TPL random sample, educating and training staff about pricing and diagnosis-related group (DRG) calculations, and making changes to system edits to ensure claims are processed correctly.

In our opinion, these controls if operating as intended, contribute to improving MMIS claims processing accuracy. To determine whether claims processing controls related to accuracy are working effectively, we reviewed the fiscal agent quality assurance audit findings on claims processing accuracy, surveyed providers to assess their perception of the fiscal agent's claims payment accuracy, met with KHPA's claims management staff, reviewed the MMIS list of edits and audits and conducted testwork on three of the edits and audits, as well as an analysis of services after death. Our findings are as follows:

1. *Ninety eight of 100 Medicaid providers we surveyed in October 2008 said claims processed were always accurate or mostly accurate.* Thirty eight said their claims were always reimbursed accurately and 60 said their claims were reimbursed mostly accurately. Nonetheless, some of the comments we received from providers included:

[10] IPIA; Public Law 107-300

- Medicare claims do not always crossover.
- Medicaid, as the payer of last resort, overpays on *secondary claims* 50 percent of the time, thus requiring subsequent corrections.
- When overpaid in error, it's practically impossible for providers to get the fiscal agent to take back the money owed Medicaid but the provider gets penalized in audits.
- There is a major problem with spenddown and getting information to correctly bill claims.
- Customer service is terrible, better trained staff are needed.

We asked KHPA staff about the issues raised by some providers. According to them, only providers approved by the Medicare Intermediary to submit crossover claims are flagged in MMIS. Claims submitted by providers not on the Medicare Intermediary's list would not be paid. Some Medicare crossover issues KHPA staff encountered in the past include clerical errors and TPL service classes not loaded correctly into MMIS. To resolve these issues, staff training was conducted and KHPA participated in workgroup meetings with providers. According to KHPA staff, errors related to these issues are now dropping. However, because there is more Medicare crossover claims compared to other claim types and more information to capture, Medicare crossover claims tend to have more errors than other claim types.

2. KHPA has not assessed damages on its fiscal agent for not meeting data entry accuracy contractual requirements. The fiscal agent contractor must meet the following data entry standards: (a) for each claim type, 95 percent of all paper claims and (b) for each type of input, 95 percent of all prior authorization documents, all screening forms, and all other types of inputs entered by the fiscal agent must be free of data entry errors. Damages are set at $500 per percentage point for each sample in which the accuracy rate falls below any of the above standards. The fiscal agent has not always met this standard[11], failing 57.5 percent of the time from FY 2005 to FY 2009. As an example, had damages been imposed for every month in FY 2009 the fiscal agent was not in compliance with the data entry accuracy standards, damages would have amounted to $3,500.

KHPA claims staff reviews the fiscal agent's internal quality assurance audit findings on data entry accuracy and resolves problems found with fiscal agent staff. According to KHPA staff, other states said they take into consideration the overall performance of the fiscal agent when determining whether to assess penalties, and where the requirement was exceeded most of the time, they waived the penalties. In addition, the current fiscal agent inherited a backlog of mostly paper claims from the previous fiscal agent. The current fiscal agent was not staffed to support a paper-driven process but has since made significant improvements in keeping claims inventory under control.

[11] See Table II-1.

3. We found 15 claims totaling $623 for services billed prior to being rendered. We analyzed a sample of 112 adjudicated claims from FY 2005 to FY 2009 that appear to have been billed before services were provided. We asked KHPA staff the reason for these Edit 554 exceptions. According to KHPA staff, they set the edit to 'pay and list' to allow claims to be processed until they could resolve the issue of a vendor clearinghouse submitting claims for providers with a billed year of 1903. These claims were listed in the "Pay but Report Edit/Audit" Report for monitoring purposes. According to KHPA staff, recoupment was initiated for these claims in September 2009.

4. We found 14 claims totaling $2,397 that do not meet gender restrictions. We reviewed 11 procedure codes with gender restrictions, analyzed related claims data from FY 2005 to FY 2009 and found Edit 4035 did not prevent these claims from being paid even though they did not meet gender restrictions.

II-3: PROCEDURE CODES AND GENDER RESTRICTIONS TESTED FY 2005-2009

PROCEDURE CODES & RESTRICTIONS TESTED	RECIPIENTS	EXCEPTIONS FOUND (# of claims)	AMOUNT	YEAR PAID
For Female Beneficiaries:				
Intrauterine fetal transfusion	Male	1	$317	FY2007
Vaginal procedures anesthesia	Male	1	$102	FY2008
Destruction of vaginal lesions	Male	1	$66	FY2007
Sub-total		**3**	**$485**	
For Male Beneficiaries:				
Dilation of urethral stricture	Female	1	$54	FY2006-07
Male genital procedures anesthesia	Female	1	$134	FY2009
Bladder neck transurethral resection	Female	1	$450	FY2006
Circumcision	Female	8	$1,274	FY2005-09
Sub-total		**11**	**$1,912**	
4035 TOTAL		**14**	**$2,397**	

Note: Edit 4035 - Procedure code vs. sex restriction. If the beneficiary's gender does not match the procedure code file sex restriction on the reference database, post the edit.
Source: OIG analysis of MMIS data

As shown in Table II-3, three of the exceptions totaling $485 were for female procedures, such as vaginal procedures anesthesia, provided to male recipients. We reviewed these claims and verified the recipients' gender is actually male. Eleven exceptions totaling $1,912 were for male procedures, such as male circumcision, provided to female recipients. We reviewed these claims and verified the recipients were actually female, except for two. In addition to the 14 claims in Table II-3, we found three other claims with gender errors, in the amount of $1,676. These were corrected or recouped by fiscal agent staff before we provided them with our list of exceptions.

We informed KHPA staff of the 14 claims in Table II-3. They subsequently initiated the following:

- Recoupment of the payments for vaginal procedures anesthesia, destruction of vaginal lesions, and dilation of urethral stricture.
- Correction of two beneficiaries' files to reflect their actual genders, one of whom had circumcision and the other received male genital procedures anesthesia.
- Restriction of claims for intrauterine fetal transfusion to females only and restriction of bladder neck transurethral resection to males only after KHPA's senior program manager reviewed the edit settings.

Claims for circumcision that appear to have been provided to females may have been for appropriate services reported incorrectly by providers and allowed to be paid by the system. In cases where the mother's Medicaid number is billed for services, such as circumcision, provided to her newborn, providers are instructed to record the newborn's first name as "baby boy", "baby girl" or "newborn" and provide the newborn's information. Based on our review of these claims, it would appear the mother's gender was recorded instead of the newborn's gender.

5. We found 243 claims totaling $24,810 that do not meet age restrictions. We reviewed 22 procedure codes with age-specific restrictions and analyzed related claims data from FY 2005 to FY 2009. We found Edit 4034 did not always prevent a claim from being paid even if the beneficiary's age does not match the age limitations for the procedure restrictions or covered benefit restriction.

II-4: PROCEDURE CODES AND AGE RESTRICTIONS TESTED FY 2005-2009			
PROCEDURE CODES & RESTRICTIONS TESTED[a]	**RECIPIENTS**	**EXCEPTIONS FOUND (# of claims)**	**AMOUNT**
For Unborn			
Intrauterine fetal transfusion	ages 25-83	**5**	**$3,373**
For Newborn			
Catheterization of umbilical vein	age 32	1	$36
Subsequent intensive care for low birth weight infant	ages 46-64	2	$240
History and examination of normal newborn	ages 8-41	100	$7,372
Physician attendance at delivery	ages 17-57	13	$698
Newborn resuscitation	ages 24-27	3	$394
	Sub-total	**119**	**$8,740**
For younger than 1 year			
Anesthesia for all procedures on the larynx and trachea in children	ages 36-73	6	$570
Anesthesia for hernia repairs in the lower abdomen	ages 5-47	4	$784
Periodic comprehensive preventative medicine reevaluation and management, infant	ages 8-39	48	$1,808
	Sub-total	**58**	**$3,162**
For 2 years and younger			
Tracheostomy	age 64	1	$215
Initial pediatric critical care	ages 6-54	10	$934
Subsequent pediatric critical care	ages 11-88	8	$2,639
	Sub-total	**19**	**$3,788**
For 1-4 years			
Preventative medicine services	ages 8-48	**5**	**$298**
For younger than 5 years			
Umbilical hernia repair	age 24	**1**	**$435**
For child			
Closed treatment of radial head subluxation, nursemaid elbow	ages 35-37	**2**	**$299**
For 5 to 11 years			
Preventative medicine services	ages 0-1	**6**	**$295**
For younger than 12 years			
Tonsillectomy and Adenoidectomy	ages 16-64	5	$2,021
Adenoidectomy	ages 16-51	8	$1,515
Preventative medicine services	ages 16-35	9	$469
	Sub-total	**22**	**$4,005**
For 12 to 39 years			
Preventative medicine services	ages 1-8	**4**	**$235**
For 40 to 64 years			
Preventative medicine services	ages 14-27	**2**	**$180**
	TOTAL	**243**	**$24,810**

(a) *Edit 4034 - Procedure code vs. age restriction.* If the beneficiary's age does not match the age limitations for the procedure restrictions or covered benefit age restriction, post the edit.
Source: OIG analysis of MMIS data

We provided KHPA staff with a complete list of these claims. KHPA staff provided the following information:

- *Intrauterine fetal transfusion.* No age restriction was attached to this procedure code, which was set to accept ages 000 – 999. KHPA's senior program manager reviewed the settings and determined this procedure code should be limited to ages 9 - 54, the age restriction for pregnancy. The age restriction for this procedure code will be updated on January 1, 2010.
- *Catheterization of umbilical vein, history and examination of normal newborn, physician attendance at delivery, newborn resuscitation, infant initial and periodic comprehensive preventative medicine reevaluation and management.* Claims for these services may be billed under the mother's Medicaid beneficiary identification number.
- *Subsequent intensive care for low birth weight infant, anesthesia for all procedures on the larynx and trachea in children, anesthesia for hernia repairs in the lower abdomen.* No age restriction was attached to these procedure codes, which were set to accept ages 000 – 999. KHPA's senior program manager reviewed the settings and determined these procedure codes should be limited to children less than one year old. The age restriction for these procedure codes will be updated on January 1, 2010.
- *Tracheostomy, initial and subsequent pediatric critical care.* No age restriction was attached to these procedure codes, which were set to accept ages 000 – 999. KHPA's senior program manager reviewed the settings and determined these procedure codes should be limited to children less than two years old. The age restriction for these procedure codes will be updated on January 1, 2010.
- *Umbilical hernia repair.* No age restriction was attached to the procedure code, which was set to accept ages 000 – 999. KHPA's senior program manager reviewed the settings and determined this procedure code should be limited to ages 0 – 4. The age restriction for this procedure code will be updated on January 1, 2010.
- *Tonsillectomy and adenoidectomy, primary adenoidectomy.* No age restriction was attached to the procedure codes, which were set to accept ages 000 – 999. KHPA's senior program manager reviewed the settings and determined these procedure codes should be limited to ages 0 – 11. The age restriction for this procedure code will be updated on January 1, 2010.
- *Closed treatment of radial head subluxation, nursemaid elbow.* No age restriction was attached to the procedure code, which was set to accept ages 000 – 999. KHPA's senior program manager reviewed the settings and determined this procedure code should be limited to ages 0 – 17. The age restriction for this procedure code will be updated on January 1, 2010.
- *Initial comprehensive preventive medicine evaluation and management for ages 1-4, 5-11 and 18-39, periodic comprehensive preventive medicine reevaluation and management for ages 1-4, 5-11, 12-17 and 40-64 (preventative medicine services).* In one case, the age

restriction edit was inappropriately bypassed by fiscal agent staff for a newborn claim billed with an incorrect procedure code. KHPA staff said they will (a) update the resolution manual for Edit 4034 with clearer information, (b) request the fiscal agent review the procedure groups associated with this edit to ensure all necessary codes are included and (c) request the fiscal agent review the claims to determine whether they were appropriately paid. KHPA staff have also initiated recoupment of one of the claims for services specific to ages 40-64 in the amount of $64.

We asked for clarification from KHPA staff regarding the procedure codes restricted to newborns that appear to be provided to older individuals. According to staff and the Hospital Provider Manual, if a patient is newborn, (a) "newborn", "baby boy" or "baby girl" should be entered in the First Name field and (b) providers should use the newborn's date of birth, but (c) may use the mother's beneficiary identification number. KHPA staff also informed us an alternative criteria exists in MMIS to identify newborn claims, which when met, would cause the system to set the newborn indicator to 'yes' and the claim would suspend for 45 days while waiting for the newborn's beneficiary identification number to be entered in the eligibility system.

According to KHPA staff, in practice, they no longer require the First Name field to be "newborn", "baby boy" or "baby girl" to process a newborn claim. KHPA staff informed us they will modify the provider manual to clarify the two billing options for newborn services to providers. Nonetheless, all exceptions we found indicate the beneficiaries' age as much older, and some claims for preventative medicine services appear to be for the incorrect age brackets.

Our analysis focused solely on whether the age-restriction edits were effective and not on whether services were medically necessary. We looked at a few beneficiary profiles for some of these claims, as follows:

- *Intrauterine fetal transfusion.* One claim was a Medicare crossover outpatient claim for services provided in January 2008 to an 83 year-old female with a primary diagnosis of pneumonia, who died the same year. Another was an outpatient claim for services provided in April 2006 to a 54 year-old male with anemia in neoplastic disease, who died the following month.
- *Subsequent intensive care for low birth weight infant.* One claim was a professional claim for services provided in April 2007 to a 64 year-old male with a primary diagnosis of coronary atherosclerosis.
- *History and examination of normal newborn.* One claim was a professional claim for services provided in August 2008 to a 41 year-old female who delivered a baby in a hospital. While this service is restricted to newborns, it would appear the mother's date of birth was provided instead of the newborn's date of birth.

- *Anesthesia for all procedures on the larynx and trachea in children.* One claim was a professional claim for services provided in January 2005 to a 73 year-old male with a primary diagnosis of unilateral partial paralysis of vocal cords or larynx, who died the following month.

6. We found 154 claims totaling $19,080 for services supposedly provided to deceased beneficiaries. We provided KHPA staff with a list of claims for services that were supposedly rendered after a beneficiary's date of death. SURS staff subsequently initiated recoupment for 152 of these claims. We asked KHPA claims staff to review the dates of death on two other claims. Also included in our list were:

- 224 claims totaling $49,001 which SURS was already in the process of recouping,
- 480 claims totaling $131,322 which KHPA staff said had incorrect initial dates of death which have since been corrected, and
- Nine claims totaling $382 which processed when dates of death were not yet uploaded in MMIS or with dates of service incorrectly reported by providers.

The fiscal agent's SURS staff performs an annual post-pay review to identify claims paid after a beneficiary's date of death, and recoups those claims as appropriate. SURS' review showed they have identified claims for recoupment totaling $133,569 in 2005; $5,935 in 2006; $798 in 2007 and, $92,698 in 2008. KHPA staff said they are looking at increasing the review intervals to a minimum of twice a year. KHPA currently relies on eligibility staff updates to beneficiary records in the state's computerized eligibility system, KAECSES, for beneficiaries' dates of death. The MMIS receives daily updates from KAECSES. KHPA staff said they will continue to look at options for improvement in this area and are planning to acquire death record data feeds from KDHE in the future.

Accuracy Conclusion and Recommendations

Conclusion: KHPA's oversight is reasonably effective in ensuring the fiscal agent's claims processing accuracy. However, claims processing overpayments remain a risk. Based on our test work, surveillance and utilization review findings, findings from KHPA's monitoring activities, the fiscal agent's quality assurance findings, and the federally mandated PERM findings, some overpayments appear to slip through claims processing controls. While KHPA has supplemental controls, such as the SURS process and KHPA's pay and chase procedures, we are including three recommendations for KHPA management to consider. These recommendations could provide further assurance that claims will be processed accurately and in accordance with contractual requirements.

Recommendations:

6. To strengthen the effectiveness of edits and audits and minimize overpayments, (a) KHPA fee-for-service program managers should identify all required program and procedure limits and restrictions and ensure they have corresponding edits and audits in the MMIS and (b) the fiscal agent and KHPA claims staff should determine whether the current system testing is adequate to detect errors.

7. KHPA management should assign appropriate staff to review the list of exceptions or errors we have provided and identified in this report, and where appropriate, initiate recoupment. Any edits not attached to specific procedure codes should be attached to prevent the same types of exceptions or overpayments in the future.

8. KHPA management should establish clear policies for the assessment of damages for failure to comply with contract accuracy standards and define criteria under which damage assessment on the fiscal agent for not meeting contractual accuracy standards will be imposed or waived. This policy would ensure consistency in decision making.

Appendix A

Agency Response

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KANSAS HEALTH POLICY AUTHORITY

January 11, 2010

Nick Kramer
Inspector General
Kansas Health Policy Authority
109 S.W. 9th Street, 7th Floor
Topeka, KS 66612-1280

Dear Mr. Kramer:

The Kansas Health Policy Authority (KHPA) has received the Office of the Inspector General's (OIG) report regarding its audit of KHPA's oversight of its fiscal agent to ensure compliance with federal and contractual requirements related to timeliness and accuracy of claims processing, and appreciates the opportunity to respond to the report. KHPA found the conclusions generated by the audit informative. We are pleased that the audit findings revealed no systemic problems warranting significant and immediate action.

KHPA Comments on OIG Conclusions and Recommendations

1 - Timeliness:

Conclusion: KHPA's oversight is reasonably effective in ensuring the fiscal agent's timely processing of claims. However, we have five recommendations for KHPA management to consider, which could provide further assurance that claims will be processed in a timely manner and in accordance with contractual requirements.

Recommendations:

1. KHPA should consider including an indicator for clean and non-clean claims in MMIS at the point of adjudication. Without this indicator, it is difficult to assess whether the fiscal agent met current timeliness standards.

   KHPA Response:
   KHPA agrees with this recommendation.

   Instead of creating an indicator, KHPA will create a specific data request for the HP Quality Assurance team that will pull the claims into the two categories requested, clean and non-clean claims. This approach will accomplish the intended outcome of the OIGs recommendation and be a less costly solution than creating an additional data element. Estimated cost: $1,000.

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www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

2. KHPA should ensure the fiscal agent quality assurance team's process for calculating the percentage of aged claims agrees with current contractual timeliness standards. Current quality assurance timeliness measurements are based on total claims processed. This measurement conforms with the previous timeliness standard but not with the current timeliness standard which requires stratified calculations based on clean and non-clean claims. The current timeliness standard would result in varying threshold numbers/percentages of timely processed claims from period to period, depending on the number of clean and non-clean claims.

   KHPA Response:
   KHPA concurs. Putting in place the process outlined in response to recommendation #1 will allow for recommendation #2 to be implemented.

3. KHPA should develop a guidance policy clarifying KHPA's position, and defining criteria under which damage assessment on the fiscal agent for not meeting contractual timeliness standards will be imposed or waived. This policy would ensure consistency in decision making.

   KHPA Response:

   KHPA will develop a general guidance policy that will establish criteria under which damage assessments will be imposed or waived when a contractor fails to fulfill its contractual requirements.

4. Appropriate KHPA staff should review the timely filing exceptions listed in this report, and where appropriate, initiate recoupment. Staff should also review timely filing procedures to minimize exceptions and ensure compliance with federal requirements.

   KHPA Response:

   KHPA agrees that Federal Regulation 42 CFR 447.45 seems to direct states to require providers to submit all claims no later than 12 months from the date of service. However, the regulation then establishes exceptions for payment of the claims past the 12 months. The regulation is ambiguous and the common interpretation among states and federal agencies has been that exceptions to the timely filing are allowable. The practice of by-passing timely filing for claims submitted past 12 months from the date of service has never been questioned by CMS or any other auditor. It is common practice amongst states as demonstrated by a recent poll conducted by KHPA. In addition, KSA.39-708(a) allows for exceptions to the 12 months timely filing rule. The Medicaid Program was specifically audited through Payment Error Rate Measurement (PERM) on the retroactive eligibility process and found to be in compliance with the regulation including payments made for claims filed past 12 months from the date of service.

   For these reasons, and in light of the legal opinion expressed below, KHPA does not plan to implement this recommendation to recoup payments from providers.

   KHPA will continue to closely monitor that only those claims that meet the qualifying criteria to be filed beyond the 12 months limit are considered for payment.

5. KHPA legal staff should review whether exemptions to the federal timely filing requirement allowed by K.S.A. 39-708a comply with federal law.

   KHPA Response:

KHPA appreciates the request to review this area of Medicaid law. In our opinion, K.S.A. 39-708a(b) is not, on its face, inconsistent with 42 C.F.R. 447.45 (d)(1). The basic issue raised by the OIG concerns federal regulatory pre-emption of state statutes. Moreover, any possible pre-emption is mitigated by:

1. an ambiguous federal Medicaid regulatory subsection that does not match with the federal Medicaid statutory basis for the regulation;
2. a long-standing state statute which has never been questioned by federal auditors; and,
3. a state statute that does not limit itself to Medicaid but covers payments by the state from any source.

2 - Accuracy:

Conclusion: KHPA's oversight is reasonably effective in ensuring the fiscal agent's claims processing accuracy. However, claims processing overpayments remain a risk. Based on our test work, surveillance and utilization review findings, findings from KHPA's monitoring activities, the fiscal agent's quality assurance findings, and the federally mandated PERM findings, some overpayments appear to slip through claims processing controls. While KHPA has supplemental controls, such as the SURS process and KHPA's pay and chase procedures, we are including three recommendations for KHPA management to consider. These recommendations could provide further assurance that claims will be processed accurately and in accordance with contractual requirements.

Recommendations:

6. To strengthen the effectiveness of edits and audits and minimize overpayments, (a) KHPA fee-for-service program managers should identify all required program and procedure limits and restrictions and ensure they have corresponding edits and audits in the MMIS and (b) the fiscal agent and KHPA claims staff should determine whether the current system testing is adequate to detect errors.

   KHPA Response:
   KHPA agrees with these recommendations:

   (a) A review that focuses on the age and gender related edits has begun. Due to the number of edits and audits involved it is a lengthy process.

   As a part of normal business practices, there is a process in place to review edits and audits. When implementing new edits/audits, a formal design process is followed to ensure the edit/audit is properly designed and implemented. KHPA program managers with the help of KHPA/HP Policy staff identify limitations and restrictions that need to be part of the edits and audits to support their programs.

   In addition, the KHPA Claims team oversees the resolution review process. Through this process, new edit/audits and changes to existing edit/audit pages are reviewed before they are implemented. These reviews are conducted weekly. The team also conducts an annual review of the edits and audits as part of the ongoing update and maintenance of the resolution manual. During this review, modifications to edits and audits are reviewed for accuracy.

   (b) Although testing remains a key agency focus when implementing system changes, KHPA currently has no testing unit staff due to budget reductions and has limited capacity to perform this important function.

7. KHPA management should assign appropriate KHPA staff to review the list of exceptions or errors we have provided and identified in this report, and where appropriate, initiate recoupment. Any edits not

attached to specific procedure codes should be attached to prevent the same types of exceptions or overpayments in the future.

KHPA Response:
KHPA agrees with this recommendation.

KHPA will direct HP to conduct a review of claims process for age/gender restriction to identify any incorrect payments twice a year. Procedural instructions will be reemphasized with the processing staff to ensure continual education and understanding of Kansas program policies and guidelines. Additionally, KHPA will continue the weekly and annual reviews of the resolution edit/audit manual.

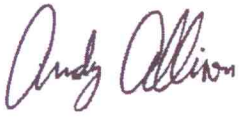
8. KHPA management should establish clear policies for the assessment of damages for failure to comply with contract accuracy standards and define criteria under which damage assessment on the fiscal agent for not meeting contractual accuracy standards will be imposed or waived. This policy would ensure consistency in decision making.

KHPA Response:

KHPA will develop a general guidance policy that will establish criteria under which damage assessments will be imposed or waived when a contractor fails to fulfill its contractual requirements.

We appreciate the efforts of the OIG's staff in conducting the audit and being willing to discuss early drafts of the audit. They were responsive in responding to our comments and committed to factual accuracy. Thank you for the opportunity to respond to the draft audit report.

Sincerely,



Andrew Allison, PhD
Acting Executive Director

cc: Dr. Barbara Langner, Acting Medicaid Director
Christiane Swartz, Medicaid Deputy Director and Director of Operations
Maria Montgomery
Rolanda Ellis

Appendix B

Glossary and Acronyms

Adjudication The process whereby a claim passes through all the edit and audit criteria until it is determined whether all program requirements have been met and whether the claim is to be paid or denied.

Aged Claims Claim adjudicated after more than 30 days of entering MMIS.

ARRA American Recovery and Reinvestment Act of 2009

Audits Limitations applied to specific procedures, diagnoses, or other data elements after editing and validating the claim to ensure conformity and consistency of claim payment. A formal or periodic checking of accounts, such as a drug audit or a nursing home audit.

Capitation A specified amount paid periodically to a healthcare provider for a group of specified healthcare services regardless of quantity rendered. A fee is paid per person, such as the HMO payments that are a fixed amount per beneficiary per month. Capitation fees are paid for each enrollee, regardless of whether an enrollee actually received a service. The use of capitation separates the payment process from the claims submission process. Encounter claims are submitted for historical data, not for payment. Also known as capitation payment or rate.

CFR Code of Federal Regulations

CHIP Children's Health Insurance Program

Claim A bill for services, a line item of service, or all services for one recipient within a bill.

Clean Claim A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

CMS Centers for Medicare and Medicaid Services

Dental Claim Claim for dental services that may include dental exams, x-rays, sealants, cleanings, fluoride treatments, crowns, root canals and anesthesia for dental services. Dental services are a required service for most Medicaid-eligible individuals under the age of

	21, as a required component of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.
DoA	Kansas Department of Administration
Documentation/ Database Contractor	PERM contractor who requests state Medicaid and CHIP policies that are used for the medical and data processing reviews, sends the states a list of their sampled claims to populate, standardizes the format of the claims data and sends it to the review contractor for data processing reviews.
DRG	Diagnosis-Related Group
Edits	A set of parameters against which a claim transaction is compared. The verification and validation of claims data for detection of errors or potential error situations.
EDS	Electronic Data Systems
FFP	Federal Financial Participation
FFS	Fee-for-Service
FY	State Fiscal Year
HCBS	Home and Community Based Services
HMS	Health Management Systems
ICN	Internal Control Number
ICR	Intelligent Character Recognition
Inpatient Claims	Claims for inpatient hospital services (other than services in an institution for mental diseases) ordinarily furnished in a hospital for the care and treatment of inpatients. Except for nurse-midwife services, they are furnished under the direction of physicians or dentists.
KHPA	Kansas Health Policy Authority
KMAP	Kansas Medical Assistance Program
K.S.A.	Kansas Statute Annotated
LTC	Long-term Care. Claims in this category include those provided at home, in the community and in nursing homes. In-Home services help seniors remain in their homes and communities and include attendant care services, homemaker services, respite care and adult day care. Community services are designed for

	seniors with the ability to travel to the point of service and encourage seniors to remain active members of the community. Hospice care is provided for terminally ill individuals.
MAR	Medical Assistance Report
MCO	Managed Care Organization
Medical/ Professional Claims	Claims for services provided in this category include office visits, obstetrical and newborn services, immunization administration, as well as rehabilitative therapy services such as physical therapy, occupational therapy and speech therapy. Mid-Level practitioners such as Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) must be enrolled as a Medicaid provider to bill for services.
MMIS	Medicaid Management Information System. A mechanized claims processing and information retrieval system.
NEMT	Non-Emergency Medical Transportation
Non-Clean Claim	Claims that require further investigation or development beyond the initial information submitted. Errors or omissions result in requests for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or access to other information necessary to resolve discrepancies.
NPI	National Provider Identifier
OCR	Optical Character Recognition
OIG	KHPA Office of Inspector General
Outpatient Claim	Claim for outpatient hospital services must be provided under the direction of a physician or dentist. Preventive, diagnostic, therapeutic, rehabilitative, and palliative services are included and may include various types of organized outpatient programs for psychiatric treatment. The institution must meet the requirements for participation in Medicare and be licensed or approved as a hospital by State authority.
PA	Physician Assistant
Payment Date	The date of the check or other form of payment.
PERM	Payment Error Rate Measurement
Pharmacy Claims	Claims for prescription drugs which are included in the Master Contract Agreement between CMS and the manufacturer, with the exception of certain exclusions. All drugs must be prescribed

	by licensed practitioners and dispensed by licensed pharmacies, approved dispensing physicians, or approved hospitals. All claims for covered drugs (including refills) must be substantiated by a prescription from a licensed practitioner. Certain drugs/drug categories require the prescribers to obtain prior authorization.
Receipt Date	The date the fiscal agent receives the claim, as indicated by its date stamp.
Review Contractor	PERM contractor who schedules on-site data processing reviews with each of the states and conducts medical reviews on FFS claims and examines the medical record to ensure the documentation supports medical necessity and to verify coding accuracy.
SAS-70	Statement on Auditing Standards No. 70
SRS	Kansas Department of Social and Rehabilitation Services
Statistical Contractor	PERM contractor who collects the universe of claims data for Medicaid and CHIP fee-for-service (FFS) and managed care from the states, draws a random sample of claims from the quarterly universes submitted by the states, and sends the samples to the PERM documentation/database contractor.
SURS	Surveillance and Utilization Review Subsystem
TPL	Third Party Liability
UB 92	A standard claim form used to bill hospitals, home health, and LTC services.

Appendix C

The chart on the following page shows a comparison of the Federal timeliness requirements and the fiscal agent's contractual timeliness requirements.

TIMELINESS STANDARDS	
FEDERAL REQUIREMENTS[1]	**FISCAL AGENT CONTRACTUAL REQUIREMENTS**
TIMELY PAYMENT – CLEAN CLAIMS	
90 percent of clean[2] claims made for services covered under the State plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims. 99 percent of such claims are paid within 90 days of the date of receipt of such claims[3].	100 percent of clean claims must be processed and ready for payment or denial within 30 days of receipt in the fiscal agent's mailroom, except all error free adult care home claims must be processed in the first cycle after receipt[4]. Adjudicate all error-free, long-term care turn- around claim transactions within seven days of receipt by the Contractor[5].
TIMELY PAYMENT – NON-CLEAN CLAIMS	
All other claims are paid within 12 months of the date of receipt, with the following exceptions: (a) Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system[6], (b) Medicaid claims relating to Medicare claims filed in a timely manner are paid within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim[7], (c) Claims from providers under investigation for fraud or abuse. (d) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.	97 percent of all non-clean claims including adjustments must be processed and ready for payment or denial within 30 days of receipt in the fiscal agent's mailroom. The remaining three percent of all non-clean claims (Newborn, NEMT and adjustments) must be processed and ready for payment or denial within 90 days[8]. Correctly adjudicate all suspended claims, except those suspended for medical review, within 30 days of receipt by the Contractor[9].
TIMELY SUBMISSION	
Require providers to submit all claims no later than 12 months from the date of service.	No claim filed more than 12 months after the time the service was rendered shall be allowed or paid except[10]: (a) if the services were provided to a child who at the time of service was in the custody of the secretary, or a child for whom the agency has entered into an adoptive support agreement if the medical vendor did not have actual knowledge of that fact prior to the expiration of the 12-month period, (b) if the claim was submitted to Medicare within 12 months of the date of service, paid or denied for payment by Medicare, and subsequently submitted for payment to the state medical assistance program within 30 days of the Medicare payment or denial date, (c) if the claim is determined payable by reason of administrative appeals, court action or agency error, (d) if the claim is for emergency services rendered by providers located outside the state who are not already enrolled as state medical assistance program providers, or (e) if the claim arises out of circumstances described above and is determined not to be payable under any such item, but the [KHPA Executive Director] determines that such claim is the result of extraordinary circumstances.
Sources: 42 U.S.C.1396a (a)(37), 42 CFR 447.45, K.S.A. 39-708a, KHPA fiscal agent contract	

1. 42 U.S.C.1396a (a)(37). Also see 42 CFR 447.45
2. Clean claims require no further written information or substantiation in order to be paid. Those otherwise are non-clean claims.
3. The [CMS] Administrator may waive these requirements upon request by an agency if the agency has shown good faith in trying to meet the standards.
4. Section 4.3.2.2.3
5. Section 8.1.7.9b
6. See 42 CFR 447.272
7. Medicaid, as the payer of last resort, pays for Medicare crossover claims.
8. Section 4.3.2.2.3
9. Section 8.1.7.9a
10. K.S.A. 39-708a