

# KanCare Rapid Response Stakeholder Issues Log – 1.25.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
1	12.31.12	Members	Q: When/how will people know who their assigned care manager is going to be? A: Each of the MCOs will be making care management assignments in the next few days, and will be reaching out to members to advise them and establish connection. In interim, members or their authorized representatives can call the MCO call centers and inquire.	12.31.12	Resolved	12.31.12
2	12.31.12	Mental Health service providers	Q: Third Party Liability – what type of private insurance company denials for specific mental health service codes will be required in order to submit claims for payment by MCOs? A: Each MCO will honor KDHE’s TPL list.	1.7.13	Resolved	1.2.13
3	1.2.13	Providers using EVV system for claims submission	Resolved Issue: HCBS Providers whose claims are submitted through EVV (Kansas AuthentiCare) rarely see claims in a pended status/critical exception status. Typically once a service is reported, it is matched to a prior authorization record in real time. Providers then see that AuthentiCare forwards claims for payment processing the morning after they have been confirmed. Over the next 24-48 hours, providers may see some claims in a critical exception status in AuthentiCare, related to missing authorization. This event is a one-time occurrence as part of the transition being resolved by Authenticare, the State, and the MCOs. Providers do not need to take additional action on these pended claims. During the next 24-48 hours providers should see that any pended claims have been automatically submitted for processing. MCOs are committed to promptly paying claims for services submitted through EVV. At this time, there is no indication affected providers will experience any delays in payment due to the temporary pending of EVV related claims. <b>[Updated 1.4.13:</b> EVV/AuthentiCare claims have automatically been processed to match the January authorizations with the correct payer assignment. Confirmed claims are now being successfully submitted with the payer information.]	1.7.13	Resolved	1.4.13

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4	1.2.13	Community Mental Health Centers	Q: When will the screening tool for inpatient mental health care be revised to capture the KanCare MCOs so that member assignment can be reflected; who is responsible for that change; and will the change also be made in our electronic version of the tool? A: The change will be made soon; KDADS is responsible for making the change; and corresponding changes also will be made in the electronic version.	1.7.13	Resolved	1.3.13
5	1.2.13	Members and providers	What beneficiary groups are excluded from KanCare (e.g., MediKan, SOBRA, QMB)? And will claims for them continue as FFS? A: the list of excluded beneficiaries is included in the first of the “Frequently Asked Questions” in the Provider section of the KanCare website ( <a href="http://www.kancare.ks.gov/download/Beneficiaries_Excluded_from_KanCare.pdf">http://www.kancare.ks.gov/download/Beneficiaries_Excluded_from_KanCare.pdf</a> ). Services provided to those beneficiaries will continue to be handled through the fee for service system.	1.3.13	Resolved	1.3.13
6	1.3.13	Providers and members	Reviewed list of beneficiaries excluded and saw QMB listed as excluded, but in meeting in Dec. we were told QMBs would be split among MCOs, and we have seen some that are assigned. A: QMBs can be confusing because two types: (1) only QMB – these members are not in KanCare; and (2) QMB + full Medicaid eligibility/QMB + 6 month spenddown – these members are in KanCare.	1.3.13	Resolved	1.3.13
7	1.3.13	NF members	When we have an incident, such as a fall, should we notify the members’ MCO? If so, how advise? A: Follow existing state reporting requirements, and also Medicare notification requirement. Beyond that, good to notify MCO care manager, but not required (and this will occur quite naturally once care managers are assigned and participating).	1.3.13	Resolved	1.3.13
8	1.3.13	FMS provider	Who and how do we assign client obligation starting 1.1.13? Do we continue to do that in KMAP as in the past (could only do for those we provide TCM for, and we no longer providing TCM) – so how now? A: Will develop response and include in issues log. [Update 1.25.13: A: The MCO care coordinator will assign client obligation with the member. FMS providers do not assign client obligation.]	1.17.13	Resolved	1.25.13
9	1.3.13	Providers	*As to PA: If Medicare primary, are PAs needed? A: No. Any	1.3.13	Resolved	1.3.13

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			exceptions? A: No. What is preferred method of submitting PA request to MCOs? A: Can call, fax or submit via website, whichever is most convenient for you.			
<b>10</b>	1.3.13	Primary care providers	When patient assigned to county health department as PCP, is that ok? A: Yes – and can change whenever you’d like. Q: Did they have claims reflecting the county health department as provider, is that why assigned there? A: That is one of the assignment considerations. Q: Have a pediatric practice whose panel size decreased noticeably – why? A: Provide details to KDHE as to that provider and we will look into it; goal is to keep people connected to existing providers. [1.10.13 update: The provider has been contacted, the research completed and the results provided to the provider. No system issues have been identified.]	1.10.13	Resolved	1.10.13
<b>11</b>	1.3.13	PRTFs and CMHCs	CMHC has received a request for continued stay review at PRTF. We understood CMHCs will no longer be conducting these reviews – is that correct? A: Yes, that is correct. We distributed issues memo on this, and it’s on the KDADS website, under the behavioral health tab. (Link: <a href="http://csp.kdads.ks.gov/agency/mh/Documents/Policy%20Changes%20and%20Transition%20Planning.pdf">http://csp.kdads.ks.gov/agency/mh/Documents/Policy%20Changes%20and%20Transition%20Planning.pdf</a> )	1.3.13	Resolved	1.3.13
<b>12</b>	1.4.13	Youth providers	Q: As Healthwave youth members are being assigned to different MCOs, will they be receiving full medical card, or different PA process through Cenpatico for behavioral health services? A: All former Healthwave youth are in KanCare; they will have cards (and providers can verify assignment via KMAP website); authorization processes apply equally across Title 19 and 21 programs. Continue youth BH services as usual; no special authorization required; contact assigned MCO with any specific questions.	1.4.12	Resolved	1.4.12
<b>13</b>	1.4.13	Members	For 4.1.13 effective date in changing plans, what is the March cutoff date for switches? A: Any day during the month you can make a change effective first day of the next month. Even if miss the monthly file run date, there are daily updates so can change up to last day of	1.4.12	Resolved	1.4.12

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			previous month.			
14	1.4.13	RHC providers	Q: How will RHC claims be adjudicated (understand won't involve a wrap payment)? A: Each RHC is given a PPS rate, and will get the higher of either the base PPS rate or the updated PPS rate. Q: As to individual claims, how will those be adjudicated? A: All MCOs will be paying the case rate per encounter.	1.4.12	Resolved	1.4.12
15	1.4.13	Providers	Q: We are starting to see members whose current providers (doctor, hospital) are not yet in the network of their assigned MCO. Can they continue to see those providers and will those providers get full payment in this first 90 days, and can members await to see how the networks develop in that time? A: Yes; the 100% fee for service payment will continue through that 90 days, whether in network or not.	1.4.12	Resolved	1.4.12
16	1.4.13	Home Infusion providers	Q: Yesterday I was told that all home infusion providers will need prior authorization from United; is that correct? A: Yes, that is correct; however, for right now we do not want any service to be denied for lack of PA, so proceed with the service and submit the claim. Q: Also, need PA request form for United and not seeing on website. A: We are sending to you directly right now, and that form will soon be posted for general access on United's website. Q: Any guidelines for renting Enteral Pumps? A: In provider manuals, as part of DME benefit. Q: In old Medicaid, could only buy them; with physical health MCOs could rent. What will be approach of KanCare MCOs? A: Generally we will mirror the Medicaid benefit. In specific circumstances, can discuss with care manager and see if purchase would be better option; it will depend on the member's circumstances.	1.4.12	Resolved	1.4.12
17	1.4.13	Pharmacy providers	Q: What is the Amerigroup pharmacy claim denial error? A: Coordination of benefits denial, we think related to Medicare members and Part D coverage. This issue has been resolved and pharmacies should continue to submit claims as usual. Q: Pharmacy helping someone who is dual eligible – how can family	1.4.12	Resolved	1.4.12

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			know which Part D plan person has? A: Available on CMS website, and Amerigroup will help you navigate that (can do by a direct online pharmacy information exchange).			
18	1.4.13	Providers	Q: Clients who are Healthwave 21 and involved in addictions treatment; have current authorizations through Cenpatico (didn't use KCPC in past). Do we use KCPC now for those members? A: Yes. Q: Do current authorizations extend, or do we go into KCPC? A: Current authorizations are good. Use KCPC on a go-forward basis, which means you'll need to do a KCPC assessment into system for those members for any future authorizations. Translation services/Amerigroup: Are those services available only when members calling in for direct discussions, or also for member appointments? A: Available for both.	1.4.12	Resolved	1.4.12
19	1.7.13	FQHC	Q: Can FQHC be listed as PCP? A: Yes . Q: Some members are reporting they are told cannot have FQHC as PCP. A: MCOs will re-educate the call center staff on this issue, as it is the expectation of the state and MCOs that this is appropriate. Q: Can we access panel of patients via MCO websites? A: Yes.	1.7.13	Resolved	1.7.13
20	1.7.13	OB provider	Q: How handle current OB patients if we have to split their care between old vs. new policies/carriers? A: Global payments will continue to be split. For specifics, KDHE has posted a detailed document on the KanCare Provider FAQ page.	1.9.13	Resolved	1.8.13
21	1.7.13	FQHC	Q: Have all membership cards been sent out? Patient came in with letter saying would be getting temporary card. Sunflower: We started with temporary card/letter, and followed up with permanent ID cards. All now sent, and either option valid for service delivery. United and Amerigroup: All cards have been sent, but if any problem getting it or need another, member can call member services and get a replacement.	1.7.13	Resolved	1.7.13
22	1.7.13	Providers	Q: Can non-contracted providers use the MCOs' websites to confirm member eligibility?	1.7.13	Resolved	1.7.13

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			<p>A: Please see the Enrollment Verification Process memo (<a href="http://www.kancare.ks.gov/download/Enrollment_verification_resources.pdf">http://www.kancare.ks.gov/download/Enrollment_verification_resources.pdf</a>) for options.</p> <p>Q: In the meantime, we can continue to use the KMAP system, right? Yes.</p>			
23	1.7.13	Provider	<p>Q: We submitted claims through Authenticare last week. We don't have contracts finalized with any MCO. How will we know status of claims? MCOs: You will receive explanation of payment, and you can follow up with any questions via our provider services line.</p>	1.7.13	Resolved	1.7.13
24	1.7.13	CMHC	<p>Q: Dual eligible member; when get denial from Medicare (very limited benefit) --- will all three MCOs continue the practice of paying those denied claims? MCO: Yes. As we process claims, if there are any questions or issues, let us know and we will work it through together.</p> <p>Q: We planning to use KMAP to bill and get the 835 from each of the three MCOs, but CMHCs have discovered that United doesn't provide 835 EOB. Is that correct? United: Yes. We provide a pdf available online, but not an 835 that's postable. We are working on alternative resolution. [<b>Update 1.10.13:</b> United can provide an 835 if the provider bills it directly or through a clearinghouse; United is piloting a solution for providers who use the FEB solution.] [<b>Additional update 1.25.13:</b> United has announced that they had a pilot in place for providers that need a postable 835 and to please contact your United HCBS Provider Advocate if you would like to participate in the pilot.]</p>	1.14.13	Resolved	1.10.13
25	1.7.13	Providers and members	<p>Q: Last week one of our members got call from neurologist saying have to cancel appointment scheduled for today because not contracted yet. I thought for first 90 days that didn't matter – is that correct? A: You are correct. If provider has misunderstanding about that, we will be happy to follow up with that provider to give that assurance. Providers can refer to the Continuity of Care document posted on the KanCare Provider FAQ page. (Caller will send details to <a href="mailto:KanCare@kdheks.gov">KanCare@kdheks.gov</a> for followup.)</p>	1.14.13	Resolved	1.9.13
26	1.7.13	CMHC	Detailed billing question: In 2012, we billed to KHS. When we	1.7.13	Resolved	1.7.13

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			provided services sometimes we do the same service on the same day multiple times, and would bill them in different claims – and would reject as duplicate – so we were able to put a modifier to denote not a duplicate. Had to use a different modifier to get the same result in the KMAP system. Can MCOs tell which of these we should use? A: MCOs will contact caller to advise on this detail and post on their issues log.			
27	1.7.13	OB/GYN provider	<p>Q: If we have patients – new born or new OB/GYN – and have claims from Nov. or Dec., will they be able to get Medicaid for those prior months? Now that it is 2013, can they still be able to get retroactive eligibility? A: Yes.</p> <p>Q: Will that retroactive eligibility apply to all three MCOs? A: Yes – it is a state eligibility decision, so applies equally to all the MCOs and across the entire program. Can be eligible for up to three months, back to date of Medicaid application.</p> <p>Q: Is timely filing limit 90 days? A: Need to refer to your contract; but general standard for Amerigroup is 90 days, for United is 90 days, and for Sunflower is 180 days.</p> <p>Q: For patients eligible under SOBRA, for labor and delivery, is that still an option? A: Yes. SOBRA is still covered, but not part of KanCare program --- so claims for those members should continue to be billed to KMAP as previously.</p>	1.7.13	Resolved	1.7.13
28	1.7.13	FMS provider	<p>Q: FMS provider; do billing; submitted claims last Friday to all three claims via EVV; understood payments being made daily – is that correct, and can I view that online?</p> <p>Amerigroup: We pay four times per week, and will be happy to explain to you how to check your own status, via provider services line.</p> <p>United: We pay five days per week, and for claims that come through the EVV we will send you a written EOB, and will be happy to walk through that with you. An online solution is being built.</p> <p>Sunflower: We pay 2 times per week; will have someone reach out to you to walk through the process to view status online.</p> <p>Q: On 835 I download through KMAP, today's download only</p>	1.7.13	Resolved	1.7.13

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			contained DD claims and no others. Is that correct? A: Yes – the 835 via KMAP will reflect only the claims to be paid by the state.			
29	1.8.13	CMHC	Initial authorizations – all begin 1.1.13? How get more authorizations when go over initial limits? Is there a specific # to call? Should clinician call? A: Can submit by fax, web or phone. Will have MCO staff connect with you to walk through each scenario/question you have and decide which option works best for you.	1.8.13	Resolved	1.8.13
30	1.8.13	Providers	We have a practice that went into KMAP to check to see which MCO a member assigned to; didn't see MCO assignment, so called KMAP, and was told that the member is Medicaid eligible but not KanCare assigned. What is the deal there? A: There are a few beneficiary populations not included in KanCare, so could be that, but would need specific ID to research. So – contact KDHE with member ID number to research the specifics if have a question on this issue.	1.8.13	Resolved	1.8.13
31	1.8.13	Providers	Q: Contracting with specific lab provider in Parsons – will that happen within the first 90 days? All are working on that, and anticipate will be done in that time period; if not, will continue to treat as participating provider as the contracting process gets completed.	1.8.13	Resolved	1.8.13
32	1.8.13	FQHCs	FQHC assignment as PCP – Sunflower reported that people were assigned to specific providers within the FQHC, and will shift that to FQHC; is that correct? Yes. Want to remind everyone to be aware of and responsive to HIPAA protections.	1.8.13	Resolved	1.8.13
33	1.8.13	Members wanting to make PCP change	Q: If a member wants to change PCP, information on website under consumer referrals info says the health plan would like to have a record of that change. How does member go about doing this and letting MCO know the info? A: Member can call MCO customer service center and they can assist them in making PCP changes.	1.8.13	Resolved	1.8.13
34	1.8.13	TA waiver providers	TA waiver – utilization review manager says it has transitioned to ADRC; having an issue when contact them saying no one is able to complete the assessment there. A: This is not an ADRC function, but will be handled by specialized contractors. KDADS will connect with	1.10.13	Resolved	1.8.13

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			you to discuss and provide details.			
35	1.8.13	PCP providers	<p>Q: Member came in to PCP yesterday, and PCP wanted to refer to dermatologist. United said that since her PCP she is not listed as the member's PCP, will have to call and change that – how do they do that?</p> <p>A: First, no referral is required for a specialist; can access that as needed. As to PCP – if you have a patient in your office and they need PCP changed, member can call directly or you can facilitate that so long as patient is available to confirm authorized. If the new PCP not in network yet, we are keeping note of the desired change and will implement it as soon as in network.</p>	1.8.13	Resolved	1.8.13
36	1.8.13	Clinics	<p>Had an issue getting precertification via Amerigroup: This is difficult and physician is having to participate in the call – office staff not able to do this. Doctors do not have the time to be on the phone like that, and especially if an urgent issue.</p> <p>A by Amerigroup: If an emergent situation, provide the care. We are addressing the specific situation that arose yesterday with you separately, and will finish that with you directly.</p>	1.8.13	Resolved	1.8.13
37	1.8.13	CMHC	<p>On claims process: when we send to front end billing at KMAP, how long does it take to get into the MCO website? A: Those cycles are running approximately every two hours. If you do not see your claims on the MCO website contact KMAP to address specifics (and HP will call this provider directly to resolve current situation).</p>	1.8.13	Resolved	1.8.13
38	1.8.13	Parent	<p>Daughter is Sunflower member; needs seizure medication and having trouble getting the Rx filled – having to do one day at a time. A: Jean – we apologize for that frustration and will get this addressed and resolved immediately. If anything systemic, Sunflower will reflect issue and resolution on their issues log.</p>	1.8.13	Resolved	1.8.13
39	1.8.13	Newborn care providers	<p>Q: Having issues with newborn notification process; working on a standardized notification form which may provide more info than needed. Concern is with Sunflower's provider manual – hospital <b>must</b> notify Sunflower within 1 day of delivery with specific status</p>	1.8.13	Resolved	1.8.13

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			information. Not all moms/babies will be Medicaid eligible when baby is born. A: We do require notice of pregnancy; manual does say hospitals should contact us – but do that as soon as possible, and there will not be a financial penalty. The claim will not deny because of the notification timing. Q: What about if become Medicaid eligible after birth? A: You don't need to do a notification in that situation.			
40	1.8.13	Hospital provider with more than one NPI/line of business	Q: Remits/EFTs – signed up with United and can separate by NPI, for clinic vs. home health, etc. Will that be the case for the other MCOs? A: Amerigroup and Sunflower – yes, and we will contact you to walk you through the process details. Q: Case management contact for HCBS members – what is the process for that? A: Call or email care managers/member services to get assignment info – contact details provided.	1.8.13	Resolved	1.8.13
41	1.8.13	FQHCs	Can you explain how the auto assignment process works? Is there a process in place for us to “retrieve our patients”? A: Auto assignments are based on claim history primarily. Sunflower – we have identified that we assigned to individuals rather than FQHC, so we are revisiting that to correct assignments.	1.8.13	Resolved	1.8.13
42	1.8.13	Individual behavioral health provider	90% of my clients are not showing up on MCO assignment systems, but Medicaid eligible (and primarily foster children). A: You can rely on the KMAP info as to assignment. MCOs: we will contact you directly to discern what the issue may be and resolve it. If this reveals anything systemic, MCOs will reflect issue/resolution on their issues log.	1.8.13	Resolved	1.8.13
43	1.8.13	CMHC	Q: United – what is the TCM limit? 15 hours over 3 months? Or unlimited? A: Unlimited. Q: Amerigroup – outpatient therapy limits? Appears from latest info that individual, group, family have no limits – correct? A: That is correct.	1.8.13	Resolved	1.8.13
44	1.8.13	Providers	Q: When will EVV claims that have passed from KMAP to MCO be processed and visible at MCOs? A: All verify claims have been	1.8.13	Resolved	1.8.13

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			received, and are being monitored. Q: When will they be paid? Next check run after cleared (Sunflower – Thur.; United – daily; Amerigroup – 4 days/week).			
45	1.8.13	Providers	How do we find out who is assigned to our agency as provider representative/provider advocate? A: Sunflower – on our website. Amerigroup – provider reps are reaching out to those providers for whom they are assigned, but we will connect to you directly now. United – on our website/issues log, have listed primary contact for different provider types, but we will have provider rep reach out to you now.	1.8.13	Resolved	1.8.13
46	1.9.13	Provider	Pharmacist told of a problem – United – difficulty billing DME (glucometer, diapers, syringes). A: Need to bill as medical on 1500 claim form, and United will also reach out to him to ensure clear.	1.9.13	Resolved	1.8.13
47	1.9.13	CMHC	Q: Sub-part of TPL issue for CMHCs. Our organization has TPL letters that we've obtained from guarantors, not already listed on KMAP website. Will MCOs honor those TPL letters? A: Sunflower: While we've committed to those on KMAP website, we will need to see the specific letters before we can decide whether/how to honor. United: If you send in with claim, we will honor. How do that with electronic submission? United: Keep the letter on file and note the date in your claim submission. For more details, United will also outreach to you. Amerigroup: We want to see letters and will outreach to you to obtain those.	1.9.13	Resolved	1.9.13
48	1.9.13	FMS provider	Q: An FMS provider. How are we going to get POC changes; will we get NOAs from MCOs to know if service approved? Amerigroup – we are sending updated authorizations and you should receive shortly. If you have a specific question beyond that, call and talk with Margaret Zillinger. Sunflower – we will communicate via authorization, and will double check to insure FMS communication is part of that process. United – we will update via authorizations and shouldn't be a service level change that precedes your being able to get the authorization and enter into your system. If an urgent need for change, we will	1.9.13	Resolved	1.9.13

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			contact the FMS provider. Q: How timely will we get the notice? Amerigroup: As soon as the service plan/authorization is updated.			
49	1.9.13	Member, provider	Q: If a member sees an out of network provider, will they be balance billed? A: Cannot balance bill the member – either in the first 90 days (when full Medicaid rate will be paid) or after that (when if not in network will get 90% of the rate). If the provider is not a Medicaid provider at all, it could attempt to not bill Medicaid and directly bill the member. Q: If a CMHC provides two different services in one day, will the CMHC still be able to bill both? A: Yes – same rules as operated under pre-KanCare.	1.9.13	Resolved	1.9.13
50	1.9.13	RHC provider	Q: We near state line at Nebraska; if we send someone to out of state provider, will the service be paid for? United – for first 90 days, but after that will need to be in network, so send info about those providers to us so we can invite them into network. Amerigroup – if in 90 days or an emergency, yes; after 90 days, receiving facility will need an authorization. If you have provider to consider, send info to us. Sunflower – same. Q: Sunflower rep said that so long as in first 90 days will get paid for services so long as follow PA rules --- but her take was have to be as if out of network; my take was as if in network. A: Your take is correct and we will revisit with provider rep. Q: When doing labs we send out – do we bill as internally, or should resulting lab company be billing? A: The resulting lab company should be billing. Q: As an RHC, what is considered as RHC for purposes of the claim? In the past some people wanted on UB format; some on 1500 format with taxonomy number. A: From a claim form perspective, each MCO will accept on same claim forms you've used in the past. Continue to bill as you have always billed KMAP. From a Front-End Billing perspective, we suggest you always follow up your batch claims to	1.9.13	Resolved	1.9.13

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			ensure that any general updates in the form requirements are successfully addressed.			
51	1.9.13	Pharmacy	Q: We assist people with medications – ordering, picking up, etc. Are the auto refill policies changing with the MCOs? United – we did post that last night – we do not have auto refill. Amerigroup – we updated our issue log – we do not offer auto refill, but if pharmacy offers, you can take advantage of that. Sunflower – will be on issues log; we do not offer auto refill, but if pharmacy offers, you can use.	1.9.13	Resolved	1.9.13
52	1.9.13	Optical benefit	Contact lens benefit: If have exhausted that benefit, will you be able to use glasses benefit? United: This is a value add benefit, and can be used once per calendar year. If under age 21, still eligible for glasses in the year? A: If accessing the VAB, it is an “either/or” benefit as a VAB. Q: Also, the reverse --- if have used 2 of 3 glasses benefit, can use the contact lens benefit? A: Will have optical benefit staff call you to discuss in specific detail.	1.9.13	Resolved	1.9.13
53	1.9.13	CMHC	Q: If we have a global TPL letter, is there someone at KDHE we can forward to in order to update the KMAP list? A: Yes – send to us one time and we will load into system. Where to send: KMAP -- Attn: TPL Department, fax #: 785.267.7687. Q: For denial code when have a global denial, what code should we use (in addition to date of the global denial letter)? MCOs will get that info to you and include in their issues log.	1.9.13	Resolved	1.9.13
54	1.9.13	Health Departments	Q: If a health department is showing as PCP, will you be sweeping them all out of that category? A: We will reach out to them directly to verify that they want to remain in that category. They can contact us in the meantime if they would like to do that. Q: Need help getting remittance advice from United’s website. A: Your provider rep that has been helping you will help you with that.	1.9.13	Resolved	1.9.13
55	1.9.13	FMS provider	Q: 2012 claims that are out of authorization; PD waiver. Since we don’t have any TCMs here, who do we contact to get that corrected? KDADS program staff will connect with you to resolve. <b>Update: 1.15.13:</b>	1.16.13	Pending	1.15.13

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			<p>Client Authorizations Not Found in KS AuthentiCare for FE, PD, TA and TBI Waiver Clients:  Providers are not currently finding all of their client authorizations for FE, PD, TA and TBI Waiver clients in KS AuthentiCare. These were the authorizations not yet sent to KS AuthentiCare by the time First Data loaded the January, 2013 authorizations with the designated MCO as payer. These late authorizations may include January services as well as some services for late 2012.</p> <p>Since clients are now members of MCOs, and since our authorization data will now be imported through KMAP from the applicable MCO, providers of services for these clients who are missing authorizations in KS AuthentiCare are advised to follow the following procedure:</p> <p>* For clients missing December, 2012 authorizations in KS AuthentiCare: claims with dates of service (DOS) in December, 2012, will need to be billed directly through KMAP. First Data is no longer loading 2012 authorizations as KMAP is no longer the payer of record for clients' HCBS FE, PD, TA and TBI waiver services.</p> <p>* For clients missing January, 2013 authorizations in KS AuthentiCare: claims for dates of service January, 2013 are to be billed through KS AuthentiCare.as long as the MCO has revised the case information for FE, PD, TA and TBI waiver clients, and has sent that authorization information through HP to First Data. If providers cannot find a January, 2013 client authorization in KS AuthentiCare, providers are advised to contact that client's MCO to request the authorization be sent to HP who will forward to KS AuthentiCare.</p> <p>* Effective by February 1, 2013, all authorization data will be present from each MCO so that claims billing through KS AuthentiCare should be unaffected.</p>			

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			* KMAP remains the current payer for HCBS MRDD Waiver clients.			
56	1.9.13	Front End Billing	Q: Billing on KMAP FEB system; some went through fine, but Amerigroup is rejecting all claims – what is issue/resolution here? A: Amerigroup is paying FEB claims, so will contact you directly to discuss.	1.9.13	Resolved	1.9.13
57	1.9.13	PCP providers	Q: Can someone explain about referrals and authorizations? United’s provider services line staff said we have to be PCP of record to get the authorization. United: Doesn’t matter if you are PCP of record, any PCP can call about authorizations. Can get an error message if seeking authorization for service that doesn’t need one, but it will say that. Will follow up with re-education of our call center staff. Sunflower: Any PCP can see member and generate authorization requests, when needed. Amerigroup: Same.	1.9.13	Resolved	1.9.13
58	1.9.13	PCP	Q: Do KanCare plans cover dental issues at physician offices? A: If not covered on Medicaid before, not covered now except for limited preventative benefit as a value-added service. So, if abscess, may cover interim antibiotic treatment, but not dental treatment unless extraction.	1.9.13	Resolved	1.9.13
59	1.10.13	SNF	Preauthorizations --- seems may have some conflicting information; when NF resident on Medicaid goes to hospital and comes back, we understand don’t need preauthorization to resume services with United, correct? United: Correct. Q: Also don’t need for specialist care, correct? United: correct. Q: But with Amerigroup, do need? Amerigroup: If coming back for Medicare service, don’t need to authorize; during continuity of care period, don’t need to authorize (but will require this after first 90 days – will issue for 12 month periods); if getting specialty care, don’t need to authorize. Sunflower? A: No authorization needed for specialist in network; no authorization needed in continuity of care period; bed holds/NF – we will coordinate with NF when being discharged from hospital, and update the authorization at that time. MCOs will continue internal education about these details, and also will outreach to this caller to walk	1.10.13	Resolved	1.10.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			through any remaining details and questions.			
60	1.10.13	PRTF	We've not received any training on billing; were told it would look the same, but not successful in getting claims to go through so fear something may have changed. A: It has not changed. HP will outreach to you promptly and be sure any questions are answered and any issue is addressed.	1.10.13	Resolved	1.10.13
61	1.10.13	Hospitals	Guidelines for when an episode of inpatient care spans old Medicaid and KanCare; or when MCO assignment changes during an episode of care? A: If crossover in timing or crossover in MCO assignment --- the relinquishing payer is responsible for inpatient services up to and including discharge date; any services after that discharge date is responsibility of the new MCO. KDHE will include this in on the Provider FAQ page on KanCare website and here on the issues log.	1.14.13	Resolved	1.10.13
62	1.10.13	CMHCs	Amerigroup said to use the old KHS registration forms if we get an SED client. Others same? A: Sunflower will send their form; United has no form yet – will get their information out when developed.	1.10.13	Resolved	1.10.13
63	1.10.13	HCBS provider	Question about 835 – how will HCBS providers receive from MCO's so it can be loaded into Authenticare? Sunflower: via secure portal and we will follow up and explain how. United: earlier answer (Authenticare claims come through FEB, so we don't have postable 835 yet; working on it); will contact you; Amerigroup: we will also call you to address.	1.10.13	Resolved	1.10.13
64	1.10.13	Providers	United Payer ID on electronic claims is not working via Zirmed clearinghouse, payer ID 96385 (working fine for other MCOs). United: Will connect with Zirmed and work with them to do a crosswalk to other payer ID number.	1.10.13	Resolved	1.10.13
65	1.10.13	Providers	Q: With United's office moving, what will that affect as to fax # or customer service #? A: Only the personal desk phones of management and executive staff. Q: For first time someone would go from acute facility to SNF, who is responsible for transportation, and what transportation should we use? Sunflower: This will be addressed as part of discharge planning	1.10.13	Resolved	1.10.13

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			by care managers. Amerigroup: Also, transportation that NF is responsible for via daily rate is still their responsibility.			
66	1.10.13	CMHC	Q: Initial authorization/service limits --- For example, when 60 units over 3 months, when does the 3 months start? A: Clock starts on first date of service. Q: FEB claim submitted for Optum BH on Tues – cannot yet view any claims status – says forwarded to United. How can I check on this? HP response: We will walk you through that process.	1.10.13	Resolved	1.10.13
67	1.10.13	DD providers	Q: T1017 discussion on yesterday's call --- can you briefly repeat that and tell where guidance is being posted? Yes: 2 procedure codes that were to continue as FFS for DD members were accidentally crossing over to MCOs; that has been corrected and those services will continue as FFS. Claims will be redirected back to FFS and processed this week/paid next week. Providers who submitted claims for those services do not need to do anything different. Q: Some members/families have not yet heard from MCO care manager. How long should they wait before initiating contact themselves? Sunflower: Almost all of our members have been outreached to, but some were not directly reached – go ahead and call us if we've not connected yet. United: Our outreach is starting with LTSS that are carved in; for people using DD waiver services, encourage you to contact us if want to connect before we outreach. Amerigroup: We will continue our outreach, but if any urgent need you can call us at any time.	1.10.13	Resolved	1.10.13
68	1.11.13	SNF	Billing services with a MH dx code – had some follow up discussion with Sunflower – is there a solution? A: We are addressing that with an internal workaround and it is resolved – will circle back to caller specifically to ensure the information loops are closed.	1.11.13	Resolved	1.11.13
69	1.11.13	County Health Department	Context of these questions are: When have member with both Medicaid and private insurance. Because we are not contracted with any private insurance, we have a problem with BCBS --- they pay the client but we do not get paid. Any suggestions how to manage that	1.11.13	Resolved	1.11.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			issue? Amerigroup: After you receive the denial from private insurance, note the denial and bill us directly for services we are responsible for managing. Q: Most insurance companies, because we are not contracted, do not send us the correspondence to send on; but member gets the payment. A: This is not an MCO or KanCare issue, but rather a commercial insurance carrier issue. KDHE can outreach if we can be of assistance in the dialogue with insurance carriers.			
70	1.11.13	Providers	Do we need to get a prior authorization for speech therapy? Was told: No. Q: Does this include all KanCare members? Was told: Depends on which KanCare plan you have. But we thought that all KanCare members have same benefits. Amerigroup: There are some distinctions based upon value-added service criteria and sometimes service rules vary by age or waiver participation, so it really does depend upon the person's individual situation. We will call you to talk through any additional specific questions or details you'd like to explore.	1.11.13	Resolved	1.11.13
71	1.11.13	NF/HCBS providers	*Q: For brand new clients, we get to financial discussions and they need to go apply for Medicaid. In past, we got them to SRS to get Medicaid application going; then they would refer to AAA; pick of case management and get care plan developed --- then we'd know funding, etc., and see if viable admission. Now --- since 1.1.13, getting referred to one of the three MCOs. Who is developing care plan and how is that communicated back to me so can make decisions as to admission? A: KDHE walked caller through new flow, including engagement of ADRC for the assessment and referral to MCOs for care management. *Q for MCOs: Who is doing the POC, and how is that communicated back to me, the provider? Do we have contact persons? A: When we receive notice of new waiver member, a service coordinator is assigned to visit with the person and complete the POC, and you will be notified of results. If you have specific questions or members you want to check on, contact MCO for direct connection.	1.11.13	Resolved	1.11.13

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			*Q as to existing members: How will I know which MCO they are assigned to? A: You may look current members up in KMAP system.			
72	1.11.13	SNF	<p>*Prior authorization requirements and member status changes. Current resident in hospital; going to extend the 10 day medical leave; family intends to release his room; state rules allow return to next available bed. Do we need prior authorization for that? United: No. Sunflower: Yes, and case manager will help you get authorization. Amerigroup: During the 90 day transition period, will not need prior authorization. After that, will vary by situation and we will walk you through those details.</p> <p>*Medicare member who is going to be extending stay long term and become Medicaid eligible. Need Prior authorization? Amerigroup: Yes. United: We don't require prior authorization for NF stays, and we will be sending you a list of contacts that you can connect with just for information and support. Sunflower: We will assign case managers and work with you on a case-by-case basis. All: When Medicare is primary, do not require prior authorization.</p> <p>*Prior authorization coming out of hospital for whether a person should come to a NF; the process seeks lots of clinical and other data that we don't have yet but the hospital has --- seems like that requirement is at the wrong place, and wanted to give that feedback.</p>	1.11.13	Resolved	1.11.13
73	1.11.13	SNF	On "Medicaid pending" status: Some facilities have cases that are pending 8 months+; once approved, will the authorization go back to time when application submitted? A: If the application takes that long, we will not assign to an MCO from beginning. Customer will have coverage, but it will be fee for service for back months beyond three months. More broadly: When you see the eligibility decision taking beyond 45 days, reach out to KDHE for assistance in managing the situation. As soon as you know of eligibility, contact assigned MCO to work with them on care management.	1.11.13	Resolved	1.11.13
74	1.11.13	OB/Gyn	*If a commercial plan is primary and they don't require PA, do we have to follow Medicaid rules or the primary's rules? A: Follow the primary	1.11.13	Resolved	1.11.13

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			payer's rules. *If Medicaid eligibility is established within 3 months of application, does that amount of coverage go to the MCO? Yes – up to 3 months retroactive will go to the chosen MCO.			
75	1.11.13	Members	Caller shared a vignette about KanCare member interacting with a receptionist about the member's physician being in some but not all KanCare networks; did advise member that for 90 days can continue as is, but will need to switch MCOs after that time if want to keep PCP who is member of a different network. May want to continue to reiterate that 90 day protection message. A: Thank you for that example; it is good that the member got the correct answer – for the first 90 days of KanCare, it doesn't matter whether your PCP is in your MCO's network or not; the PCP will be treated as in the MCO's network.	1.11.13	Resolved	1.11.13
76	1.11.13	CMHC	Q for Amerigroup --- any status update as to new CPT codes for 2013 that are not paying, but rejecting as not covered codes --- when will those claims show as payable? What all codes are affected? A: It is a handful of codes; we are working on that and will contact you with a more specific update. Specifics will also be reflected on Amerigroup's issues log.	1.11.13	Resolved	1.11.13
77	1.11.13	FMS provider	Payment submission Q: In past, would confirm claims on Thur., could see claims approved on Fri., next Mon. could print out list of paid claims and receive payment the next Fri. Not seeing today claims as approved that were sent last week; so wanting update. [Also: United showed one payment, which was paid by paper check rather than EFT. Need to be paid EFT. United: we will follow that up promptly; may be a timing of your EFT request.] A: Timeline as to claim processing: *HP: When come through KMAP, providers will see that it's pending for a couple of hours, and then should see whether accepted or rejected (HP sends files to MCOs every 2 hours). Providers can also look to see individual results by claim. If see was accepted but not yet	1.11.13	Resolved	1.11.13

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			<p>seeing payment on MCO site, do a claims status inquiry to the MCO.</p> <p>*Sunflower: When we receive the file from KMAP or through our secure website, we process the claim and issue payments 2 x per week. We will double check to ensure you are EFT in our system and to check your specific claim status.</p> <p>*Amerigroup: 24-48 hours to process claim from time it's transferred by KMAP. From there you should see claim status via secure logon. Will have your provider relations rep walk you through the process.</p> <p>*United: 48 hours from time we pick up from KMAP to see on our website; if direct claim submission to our system will see in 24 hours.</p>			
78	1.11.13	Dieticians	<p>What is your coverage for dietician services for adults? A: Whatever the Medicaid benefit was in the past, continues in future under KanCare. We have an adult member who said Amerigroup told her the service would be covered (not a Medicaid-covered service); Amerigroup will connect with you to discuss.</p>	1.11.13	Resolved	1.11.13
79	1.11.13	Vision providers	<p>When KMAP shows member on spenddown, and go to Opticare to check on eligibility, it shows eligible. Is that correct? Sunflower: In general, spenddown is built into all of our systems and will apply. However, we will want to discuss the specifics of this member's situation with you and will call you directly to do that.</p>	1.11.13	Resolved	1.11.13
80	1.14.13	Rural Health Clinic	<p>*Provider-based RHC; limited info on billing guidelines from all three MCOs; can each of them provide me that? Also, we provide obstetric services through RHC – on Amerigroup's FAQ we are directed to use T1015 ... is that only for ob visits, or every RHC visit? Also has us use a modifier we are not familiar with. Amerigroup: We will contact you directly and then we will post the info on our issues log. United: Our issue log has a couple of questions on RHC billing guidelines, and also our admin manual. Overall: You shouldn't have to do anything more than under Kansas Medicaid. Also we can have provider advocate outreach to you. Sunflower: Should be minimal changes from under Medicaid; will provide both direct outreach and additional info for providers.</p>	1.14.13	Resolved	1.14.13

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81	1.14.13	SNF	Change in admission date required by Sunflower, from actual admission date (sometimes several years ago) to 1.1.13. Not really accurate, and concerned that this will cause us problems down the road. Do we need to do this for Amerigroup? Amerigroup: No – we have a workaround on this one. Sunflower: We want to make sure we pay your claim properly; will see about the ability to have a workaround – and if we do, will communicate that with you.	1.14.13	Resolved	1.14.13
82	1.14.13	Home Health	In past, we were allowed 15 business days under Kansas Medicaid to get the information developed and make request for 60-day retroactive to initiation service authorization request. Will that continue? Amerigroup: We'd prefer that you call us immediately upon knowing of the need, so we can help ensure the need gets met. We can retro auth if necessary, but prefer to know as soon as possible. Q: So, send auth request immediately and advise that you will be doing the assessment and clinical info will follow? All MCOs: Yes – do that exactly.	1.14.13	Resolved	1.14.13
83	1.14.13	Skilled Nursing Facility	Q for United/Amerigroup: How do we find out who our provider representatives are? United: We are in the process of finalizing our list of care management assignments, but from billing standpoint it is Jennifer – and will have her call you; will be distributing to all NFs a listing of assigned care managers; patient responsibility advocate = Carolyn W. (contact info on our issues log). Amerigroup: Will be Gina Windling – and will have her call you later today.	1.14.13	Resolved	1.14.13
84	1.14.13	Skilled Nursing Facility	Our claims are all showing as “pending”. As an independent facility, we rely on weekly payment. No payments received, but on all three MCO sites our claims are shown as “pending”; will those be paid by this Friday? All MCOs will check and advise.	1.14.13	Resolved	1.14.13
85	1.14.13	Substance Use Disorder provider	Cenpatico faxed an authorization; the request and service related to our Hutchinson location, but the authorization showed Topeka; we called to address, and they said – don't worry about that, because we bill by NPI. In the past that has mattered, so want to be sure that response was accurate. Sunflower: We will follow up about that to	1.14.13	Resolved	1.14.13

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			ensure it is paid properly, and will also connect back with you to confirm.			
86	1.14.13	Specialty providers	Called first week of Jan. for speech therapy and outpatient surgery authorizations. Are being told it could take up to two weeks; or for Sunflower up to 30 days. Is that correct for all three? United: You don't need to have those authorizations during this first 90 day period, but do encourage you to use the process. However, the two week period is not accurate for us; we don't put any type of time frame on it, and process authorization requests promptly. Amerigroup: Same answer; we will call you back to discuss details. Sunflower: Same answer, and will call to check the details. MCOs will put authorization requirements and timing information in their issues logs.	1.14.13	Resolved	1.14.13
87	1.14.13	Community Mental Health Center	Do you have a list of covered/non-covered behavioral health dx codes across all three MCOs? All three: Same as what you had under KHS; nothing new or different. Q: Is there anything published by state through KMAP? No – same list as KHS had and followed.	1.14.13	Resolved	1.14.13
88	1.14.13	Financial Management Services provider	Submitted claims for DD waiver-related FMS services through KMAP; claims got sent from KMAP to MCOs incorrectly; HP was able to get them back and paid us this week; however, when look on Sunflower's and United's claims status website, those claims are still there (cannot tell on Amerigroup's site). HP: There were some additional DD-related procedure codes that we reprocessed and corrected. If they'd previously been forwarded to MCOs, we will initiate voids over to the MCOs so they can void those out. After this past week, you should not see anything further like that – all have been identified and corrected.	1.14.13	Resolved	1.14.13
89	1.14.13	Home Health	Frustrated about claim processing and payment process with all of the MCOs. Need claims-based assistance. The call center staff do not have the type of help we need, and we have payroll due on Friday; need to have claims paid promptly. All three MCOs will reach out to the provider for specific claims assistance.	1.14.13	Resolved	1.14.13
90	1.14.13	Community Mental Health	Our rehabilitation providers have in the past been required to take web-based training; are we to continue? A: Yes.			

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		Center				
91	1.14.13	Psychiatric Residential Treatment Facility	*Experiencing hospital-like utilization reviews by MCO staff every three days or so, and being told they will be calling again in a few days. What is the state’s expectation around this issue? KDADS: We are discussing the issue internally and building some assistance/responsive info this week; will communicate that out to all PRTFs. *Currently KHS had mandated training for in-home family therapy. Is that still a requirement? A: Yes.	1.14.13	Resolved	1.14.13
92	1.14.13	EVV	Got first Sunflower remittance download today; lists 11 individuals; 1 was paid – 10 were not – error message says no prior authorization. Sunflower: That is an error on our part; those claims should not have been denied; with apologies, we will address and correct promptly and outreach to you to confirm when corrected.	1.14.13	Resolved	1.14.13
93	1.14.13	Home Infusion Provider	We still are trying to get logged into your systems and still struggling with all three; our contracts are still pending, so no provider #; we got an email from Sunflower saying we didn’t need a provider #; Amerigroup says cannot without a provider number. We cannot bill through KMAP, because it requires separate DME/Rx billing – we were allowed to do them together under previous physical health MCOs and are hoping to be able to bill them together with the KanCare MCOs. We are billing electronically. MCOs: We will get this clear internally and connect with you to resolve promptly. [Update 1.25.13: To more comprehensively address this and similar issues, we have posted a document to provide tips in an effort to help providers who are submitting claims electronically. We have also included information from each MCO regarding their typical claims processing timeframes. You can access the document on the KMAP web site by clicking the Search button on the Bulletins page available <a href="#">here</a> . The document is also embedded in the “status” column of this issue entry.]	1.17.13	Resolved	1.25.13
94	1.14.13	Hospitals	When we are trying to move someone to NF, are told that our social workers cannot any longer conduct the Level II screenings. We had them specially trained to complete them so that we could get our	1.14.13	Resolved	1.14.13



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			patients placed. NFs are saying they got notice that the hospital staff can no longer do them – it is now the responsibility of another entity. A: This is now an ADRC function; KDADS will connect with the caller to ensure this is clear.			
95	1.14.13	Psychiatric Residential Treatment Facilities and private mental health providers	*Critical incidents – will the MCOs have access to the critical incident portal, or should we be reporting to them also? A: The MCOs will have their own access and you do not need to separately report. *Can we continue to do the SED pre-screenings? A: Yes – current practice on that issue can and should continue. * We have billed the behavioral health codes that had higher rates than what was loaded; will that be corrected? A: Yes – the correct, higher rates will be loaded and paid.	1.14.13	Resolved	1.14.13
96	1.14.13	NFMH	We serve 23 residents between ages 21-65. They have Kansas Medicaid eligibility, but not assigned an MCO. Why? A: That is because they are not enrolled in KanCare, primarily due to the “IMD rule” of CMS associated with their place of service. These members remain fee for service only due to the IMD exclusion for that age range. Their status remains business as usual.	1.14.13	Resolved	1.14.13
97	1.15.13	Home Health	Q about authorizations and retro eligibility. We have two patients that have lost eligibility entirely during the conversion. [Note: Transition to KanCare is not the cause of any change in eligibility status; such a change is from another cause.] When they regain eligibility, will it be retroactive and will any authorizations be honored? All MCOs --- yes; just call when you have the details available and we will work through the situation with you.	1.15.13	Resolved	1.15.13
98	1.15.13	Home Plus	*Q: I’ve submitted claims through KMAP and still seeing them as “pending” – feel lost in that don’t know what that means and whether/when claims will be paid. Also, claims I submitted to KMAP last Friday are not showing up online with either Amerigroup or United websites. All MCOs: We will call you to advise specifically about the status of your claims. We know this level of detail requires additional support and we will provide that to you today.	1.15.13	Resolved	1.15.13

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			*Q: How do you find out/know what the status of your application is to be a provider network member. MCOs: Will take care of that status update in the call back to you today as well.			
99	1.15.13	Working Healthy	For Amerigroup: We have Working Healthy individuals and we have been required to get higher liability insurance than we currently have. United and Sunflower have waived those requirements and allowed us to contract. Question: We are not medical facility, but HCBS case management and Working Healthy --- will you work with us on that, Amerigroup? A: We will look at what you submitted for credentialing and get back to you with a response.	1.15.13	Resolved	1.15.13
100	1.15.13	Community Mental Health Center	*Fee schedule for services – fee maximums do not match what we are currently being reimbursed by state. Is that correct? A: There were some errors that we are fixing at state level (and perhaps additional in United’s listing; United will call you directly to address those details) *Medicaid screening listed as a code different from what we currently used to bill the state. A: The new screening code is correct. *PRTF/CBA grant services listed – thought that had expired. A: You are correct; those services have expired.	1.15.13	Resolved	1.15.13
101	1.15.13	Kansas Pharmacist Association	*Pharmacies are understanding they will have 90D standing PAs – but some are being required to submit PAs, including for services not previously requiring PAs. A: Send the details to KDHE pharmacist. [Update 1.25.13: This was for a drug that previously went through SmartPA, so the pharmacy never noticed it was being Prior Authorized. The MCO for this claim does not yet have PA for this claim automated.] *Temporary ID cards without plans showing on the cards – how soon will members be receiving “permanent” cards? A: For members who are foster children, they get temporary cards the day the child comes into custody – then the next day get into eligibility system. From there, the MCO should issue a medical card within about three days.	1.17.13	Resolved	1.25.13
102	1.15.13	Medical Center	Yesterday we called Amerigroup and were told that the claims we submitted will not be paid until we become part of their network. A: That is an error; we will get it addressed; we will call you back to	1.15.13	Resolved	1.15.13

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			confirm resolution.			
103	1.15.13	Providers	Know that for first 90D, providers not contracting will still get 100% payment; after that 90D, they will get 90% of FFS. Question: Can they bill the other 10% to members? A: No.	1.15.13	Resolved	1.15.13
104	1.15.13	Nursing Facility – Mental Health	*For one facility, submitted claims on Friday; got acknowledgement on some that they were forwarded, but when called Sunflower this morning was told they don't have the claims yet. Is that because it is an NFMH? Sunflower: May be, but we will check the details and call you back with clarity. *With other facility, didn't get the notice that claims were forwarded on, but when called Sunflower they had the claims. What's the deal there? HP: We will look and that and get back with you on details.	1.15.13	Resolved	1.15.13
105	1.15.13	Ob/gyn	PA requirements for radiology – United. Under the PA list it says "radiology/imaging" --- does that mean all radiology, or only advanced imaging (field rep said probably does mean all, and PA unit said sounds weird, but we will PA you) --- what is correct? United: That doesn't sound accurate (i.e., all radiology), but we will get the details clear, communicate them to you, and also publish the details better. *Sunflower: Who is responsible to do PA for sonogram – provider or hospital? Asked last week and was told would get a response; none received yet and need to move on one. A: Sorry – will get you the answer, and proceed with the one that is needed now. *Q for State: Lady we serve in NF is showing as lost Medicaid eligibility – doesn't seem right – how can we help her? A: Have patient or authorized representative call Russell to get addressed.	1.15.13	Resolved	1.15.13
106	1.15.13	Community Mental Health Center	HCBS/SED waiver: Period of time between parent choice document and eligibility certification/when the financial eligibility is determined and the person assigned an MCO. Will the MCO retro authorize those services that occurred in the interim? A: Yes. So if an MCO said they'd only go back 24 hours, that is incorrect? A: Yes, that is incorrect.	1.15.13	Resolved	1.15.13
107	1.15.13	Nursing	*Q for Sunflower: Our claims showing as pending because we need	1.15.13	Resolved	1.15.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
		Facility providers not yet contracted	<p>authorization since non participating provider. A: No auths are needed for the first 90 days; will re-educate our team; we have a denial code that typically is used, but not in the first 90 days and you should not have received that answer. Will look up your claims and get back to you that it is resolved.</p> <p>*Q for Amerigroup: You do have my claims, but person I spoke with said it could take up to 21 days to process, so be patient. How quick is the standard turnaround? A: Typically more quickly than that. We will check your claims and get back to you with clarity and will re-educate our staff on that issue.</p> <p>*Q for HP: Batch submit claims via KMAP – haven't seen transfer report that I know of. A: It's in the batch report, or on individual claims it appears at the bottom.</p> <p>*Q: Want to get in and set up a user on each of the MCO websites. I'm hearing that if not a contracting provider, cannot see the claims. Amerigroup: You do need to be a fully contracted provider and have a provider ID issued in order to access that part of our website. Sunflower: Would prefer that you be a network member, but do not need to be contracted to see your claims. United: You do need to be a contracting provider to get into our provider web portal, but you can call provider services to get information.</p>			
<b>108</b>	1.15.13	Community Mental Health Center	<p>*M0064 HCPC Level 2 code --- brief office visit; being told to use this instead of old "medication management" code. Will this code be covered by MCOs? Amerigroup/Sunflower: We are carrying over same codes as covered by KHS/Medicaid system; don't know of any problem with any covered code. United: Don't see that as a covered code, but if you think that's a problem please call to discuss.</p> <p>*Crisis/complexity CPT add-on codes – when will you have knowledge of what those add-on codes will pay? MCOs: Those codes/rates are currently being loaded; will have someone outreach to you with a status update.</p>	1.15.13	Resolved	1.15.13
<b>109</b>	1.15.13	PharmaCare	*Minimum dispensing fee was to be \$3.40 for all MCOs – correct? A:	1.15.13	Resolved	1.15.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
		Health Specialist	<p>Yes. So – need to notify Optum that their contract is not accurate; shows \$1.25 as dispensing fee. United: That is not okay; apologize for runaround; we will figure out what’s going on there promptly and call you back with update.</p> <p>*Q for Sunflower: Said you don’t want to give log-in for providers not in network, but willing to work around that; can we get that consideration? A: We will outreach to you to resolve that.</p> <p>*Authorization for pump: Having trouble getting authorization for one unit/month of pump. Lots of work for United and Sunflower (Amerigroup’s is easy process). Sunflower: We will work on making this more accessible and call you back.</p>			
110	1.15.13	Nursing Facility	<p>Seeing claims as pending with Sunflower and want to know what this means in terms of timing for payment --- two weeks? Other?</p> <p>Sunflower: Will have someone call you with specific information about when you claims will pay.</p>	1.16.13	Pending	
111	1.15.13	Community Mental Health Center	<p>Sunflower claim payments are not matching the fee schedule I thought was in force; why is that? Sunflower: We will contact you to walk through the details with you and ensure we are clear as to your question about reimbursement rates.</p>	1.15.13	Resolved	1.15.13
112	1.15.13	Ob/gyn	<p>*When is a PA required during the 90 day period? Thought if was already in place, didn’t have to do a new one. But if new during the 90-day period, will the claims process without a PA? A: General rule is that those in place will be honored during the 90-day transition period; for new – if it is a procedure for which the plans require participating providers get a PA,, participating and non-par providers alike should get a PA. Non-par providers do not need to PA everythinbut do need to PA those services that require PA for new or post-90 day service. United: Those rules are as we intend them – but won’t deny claim for it. Amerigroup: If someone already under care, don’t require it; if new, not required but preferable. Sunflower: If existing auth, will honor; if new, both participating and non-participating providers should get the PA.</p>	1.15.13	Resolved	1.15.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			*Maternity notification: When try to submit to Amerigroup, it's stating that we need an ID number --- does that mean an Amerigroup-specific member ID #, a provider ID #, or other? A: Don't need any of that; will correct internally and report that resolution back to you.			
<b>113</b>	1.15.13	Hospital	Called in on Friday about speech therapy; manual says pre-auth is required; someone was to call me on Friday but no contact yet – someone tried to call and left #, but when called back it was disconnected; have email exchange with two Amerigroup staff, but no resolution yet. Amerigroup: CEO will call you right after this call to get resolution.	1.15.13	Resolved	1.15.13
<b>114</b>	1.16.13	County Health Departments	*Q for United: Was told that in order to get RA, have to sign up with Optum, so called to register with them – but because we are a county and share a tax ID #, were told that we have to have all of the county departments sign up to get electronic payments and RAs. Sent the question to provider rep, but haven't heard back yet. A: United will follow up with you directly, and will put the response on issues log for other county-based providers to see. *Q for state: KMAP bulletin on 1/2 said vaccine administration fee would increase, but didn't specify codes involved; then on 1/3 a bulletin was posted that indicated one of the codes was going away. Need some clarification on that. A: Will have KDHE staff contact you and also will issue a clarification that ties to those two bulletins. [See update posted at issue #127 below for clarification.]	1.18.13	Resolved	1.17.13
<b>115</b>	1.16.13	Home Health Provider	Amerigroup/Sunflower: Wondering about status of claims; show as "pending" and one even shows "paid," but don't see any payment in my account yet. A: Amerigroup/Sunflower will specifically address your questions and tell you when to expect the payment to land. Both: "Pending" means it's held for internal review, not that provider needs to do something more or different. Would contact you if that was the case.	1.16.13	Resolved	1.16.13
<b>116</b>	1.16.13	Physician	United: Had pediatric patient yesterday that needed Albuterol refilled; got fax saying it was still under review; child needs the medicine	1.16.13	Resolved	1.16.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			promptly to avoid hospitalization, so Mom paid out of pocket. A: United will have pharmacy team check that and resolve immediately.			
117	1.16.13	Rural Health Clinic	*Sunflower: Have a patient that needs to designate PCP; do I put the doctor's NPI, or the RHC's NPI? A: Use the RHC's NPI. *Same for all MCOs? Yes. *On line for PCP, we should put the name of the supervising physician? Yes.	1.16.13	Resolved	1.16.13
118	1.16.13	Hospital	*If Medicare is primary, and Medicaid secondary, do we need authorization for services? All: No. *What is best way to get a pre-cert for radiology or surgery? By phone? Fax? Taking a lot of time, and want to compress that. A: We are troubleshooting that process to speed it up, and will call you to get some reference numbers. Meanwhile, remember claims will pay without the authorization; just want to get you in the practice of using that process. *Who is contact at each MCO to discuss electronic remits and electronic transfers? A: Either call the provider services line, or discuss with your specific provider relations staff who can assist you directly or get the assistance.	1.16.13	Resolved	1.16.13
119	1.16.13	FMS provider	*For United: Client who in Jan. shows up in Authenticare as United; submitted some claims; think they went to United, but cannot see their status. Now the client shows in KMAP as with Amerigroup for the same month. Submitted more claims and don't know where they went or their status. A: United will follow up on the access to claims information issue; state staff will follow up on reported change in MCO assignment. *For State: Mid-month change of MCOs isn't what was supposed to happen, correct? A: You are correct, that should not happen, so KDHE will work with you to get the details. *Q for Amerigroup: Cannot get onto your provider site either to check on claims. A: We typically reserve that for contracted providers, but will work with you to ensure your questions are addressed.	1.18.13	Pending	

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
120	1.16.13	Physician	<p>*If patient wants to change PCP from one noted on card, to one in our office, how can that be done? All MCOs: Member can call at any time to change PCP and we will issue revised card to reflect new PCP; also we have an open PCP approach, so any PCP can provide services in the meantime.</p> <p>*Two patients this week – one Amerigroup; one United – had this issue. For Amerigroup patient was told that had to submit a specific form [A: this is not accurate, but will follow up with our staff]. For United, patient was told could not see new PCP until changed in their system [A: this is not accurate, but will follow up with our staff].</p>	1.16.13	Resolved	1.16.13
121	1.16.13	Providers	Where are all MCOs on loading contracts in your system? Sent contracts in late December, and still have patients saying that we are not reflected as participating. A: Amerigroup and Sunflower – we will check on your specific status; generally takes about 30 days for contract to process completely. United – timeline depends on whether already participating in commercial line.	1.16.13	Resolved	1.16.13
122	1.16.13	Nursing Facility	<p>*Office manager having difficulty with initial payment submission; does not understand the error codes. Do we use general phone number for each company to call with questions on claims payment issues? All MCOs: will have provider advocate/relations rep reach out to you for information and any needed clarification on this. HP: How are you submitting claims? A: Directly through KMAP front end billing portal. HP: We will look at your claims and see if there are specific error codes we can explain to you.</p> <p>*Names/numbers for Amerigroup and Sunflower provider reps? Will have them contact you directly to answer any questions and get you their contact information.</p>	1.16.13	Resolved	1.16.13
123	1.16.13	Nursing Facility	*Sunflower: All of my residents had to have their physicians changed; did change form and sent in; what is going to happen when that physician bills you guys and is not on the card as PCP? A: We have open PCP process, so any PCP billing will get paid. However, we do want to get that corrected, so will call you directly to discuss and	1.16.13	Resolved	1.16.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			resolve.			
124	1.16.13	Assisted Living and Nursing Facility	<p>*Sunflower and Amerigroup: Have contract for one service side but not other. How long have to wait until get the other? Sunflower: Think you only need to have one contract with different attachments; but will check that and let you know. Amerigroup: We will also check and provide you feedback.</p> <p>*On 1/3 sent in claims for Jan 1-2 to test if go through. Could see that they were received; not seeing status with two of the three MCOs. And on the one I can see, the payment amounts are not correct. Plus sent multiple claims in on Jan 3<sup>rd</sup> that still show “pending” with MCO that I can see. MCOs and HP: Will go in and check your claims and provide you feedback.</p> <p>*Q: How many times a year can a member change MCOs? A: Can change once per month for initial 90 day period; then remain in MCO for the rest of that year.</p> <p>*Q: What happens if only available PCP will only sign up with one of the three MCOs? A: Don’t think that will happen; by the time the 90 day continuity of care period ends, think those contracts will be achieved. Members have until April 4 to change MCOs.</p>	1.16.13	Resolved	1.16.13
125	1.16.13	Nursing Facility	<p>*For Sunflower: What is status of claims submitted with pre-1.1.13 admission dates – still need to make that change? A: No – do not make that change; we have built and are testing our workaround. Q: If changing that on your end, how long will it be in “pending” status while you are making those changes? Continue to get the answer “it’s pending”. Sunflower: Looks like your claims are set to pay on Thur. night/Fri. EFT delivery.</p> <p>*Are MCOs aware of quarterly rate changes and patient liability? A: Yes. Sunflower: We see those amounts clearly identified, but will follow up with you as to what you are seeing.</p> <p>*For Amerigroup: Cclaims were being edited out for odd reasons, but think we got them all resolved. Are we good to go? Amerigroup: Yes.</p>	1.16.13	Resolved	1.16.13
126	1.17.13	Nursing	Amerigroup: Provider update saying we have to enter value code of	1.17.13	Resolved	1.17.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
		Facility	23 – say already required – but our system has always picked up D3 automatically. A: Think it has to be entered, but will confirm and get back to you.			
127	1.17.13	County Health Department	<p>*Yesterday asked about signing up with Optum via United, in way that we can get our RAs from United for our services only; no call on that yet. United: Thought we had called you/closed loop, but will do that today.</p> <p>*Amerigroup was going to send RA by COB yesterday but don't have. A: Didn't have that as a deliverable from yesterday's discussion, but will be happy to do that today</p> <p>*State on vaccine codes: We have information drafted; when peer reviewed will be posted, and also KDHE staff will reach out to each provider that called with inquiry.</p> <p>[1.18.13 update regarding vaccine codes, folded in here for ease of access: The new Vaccines for Children (VFC) allowed maximum regional administration rate is \$20.26 and Kansas has chosen to raise our rate to that amount for all Providers. This rate is in effect as of 1/1/13 for 90460 ONLY. Per CMS directive, Kansas Medicaid has non-covered 90461 as of January 1<sup>st</sup>. Per communication with CMS, it is their position that under the terms of the VFC program, providers can only bill a flat fee per vaccine given by injection or by intranasal or oral routes, regardless of the number of vaccines/toxoid components. Additionally, CMS has communicated to States that the 90460 code is the appropriate code to be used in conjunction with the administration of the VFC vaccine. Furthermore, CMS has issued the following statement: "Under the VFC statute...VFC providers are required to comply with the ACIP schedule regarding the appropriate periodicity, dosage, and contraindications applicable to pediatric vaccines, which stipulates that combination vaccines are to be used if recommended."</p> <p>We are in conversation with CMS on the codes of 90471 and 90472 as</p>	1.17.13	Resolved	1.17.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			it relates to VFC administration. At the present time, use of these codes for the administration of the VFC vaccines is allowable. The codes of 90471 and 90472 currently reimburse at a rate of \$14.15. We are awaiting CMS approval for a PCP specific rate update for these two codes.]			
128	1.17.13	Hospital and physician clinic billing	<p>*MediKan coverage --- who is going to handle that program now? A: That will still be the state and everything will remain the same.</p> <p>*Q: Flu shots – if under 18, was no coverage for flu shots in the past. Still the same with the three MCOs? A: You have to go to a “vaccine for children provider” or won’t be covered for kids.</p> <p>*Q: If not enrolled for electronic RAs/checks, will we get paper RAs and checks in the meantime? A: Yes – that is correct.</p> <p>*Q: If United is secondary to Medicare, no need for prior auth, true? Yes. We were told that United needs a discharge date? A: From a member care perspective, we would like to get the discharge date – is that a problem for you at all? No – but just want guidance. We will do that, both by calling you and by putting on our issues log.</p>	1.17.13	Resolved	1.17.13
129	1.17.13	Nursing Facilities/ NFMHs	<p>*Q: On call/webinar with United yesterday and they said could get log-ins if non provider, for their website. True for Sunflower? Yes – will outreach to you to address any questions/get that set up. True for Amerigroup? If not a provider, don’t typically allow login access, but want to call you and walk through the options with you.</p> <p>*On Tuesday asked about a claim that was supposed to go to Sunflower – resolution? A: That has been rekeyed and received by Sunflower now.</p> <p>*Used FEB for claims and they went to Amerigroup; when called to check, was told they are in “correspondence” category, and would be there for up to 30 days. A: That is not correct – will follow that up also when we call you.</p> <p>*Been trying all week to get PA for lady in acute hospital to come into our SNF– getting lots of push back from Sunflower. Should be quicker and more effective. A: You are correct; we will follow up to you (will</p>	1.17.13	Resolved	1.17.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			call admission staff) and also work with our medical management team to do better and quicker.			
130	1.17.13	Substance Use Disorder outpatient provider	Always used Provider Connect via ValueOptions; looking to find something similar for all three MCOs – essentially an online claim submission process. Any advice you can give me? HP: Do you want a single portal, or each of the three MCOs directly? I think for each of the three. HP: You have that option via KMAP website, similar to the ValueOptions process. Will have someone outreach to you to walk you through that process. Once received here, we will forward to each of the three MCOs based on member assignment. United: You can also bill through each of the separate MCOs directly – want to explore that? Yes – would like to visit with each of the MCOs and learn more about their systems, and then pick the one that fits best.	1.17.13	Resolved	1.17.13
131	1.17.13	Primary care clinics	Want to elaborate on yesterday’s discussion re: members locked in the plan for year after initial period. How often can change PCP? A: As often as they want to they can change it, and will be effective the next day. What if they have a PCP that is not us, but we are in the MCO network – can we treat them with PCP services the day they walk in? Yes – so long as in the member’s MCO network, can serve them immediately.	1.17.13	Resolved	1.17.13
132	1.17.13	DD waiver case managers	*Some of our members assigned to Sunflower have not received you member packets yet. Sunflower: All of our member packets have gone out, so something amiss; will reach out to you to discuss specifically. *One CM has young child and got no packet; checked with HP and discovered address is wrong – but per DCF it is right – and MCO cannot do an address change, so how get this addressed? A: KDHE staff will be happy to work through the details to resolution (CM involved will call KDHE staff).	1.17.13	Resolved	1.17.13
133	1.17.13	Home Health Agency	*United: Sent claims in between 1/3-1/11; none of them show up on your website; when we call, response we get is that United is not able to see those claims. Wondering what is going on. United: We will	1.17.13	Resolved	1.17.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			<p>connect with you to research those claims and resolve any issue afoot. Will research today and call you late today or early tomorrow.</p> <p>*All three MCOs: All bills we sent in 1/2 – 1/13, no payment yet. About \$40K worth of bills. What’s going on? A: All MCOs will research your situation and give you a call back.</p> <p>*How long does it take for you guys to pay, generally? A: Sunflower – right now we are manually looking at all claims, so a bit slower than normal; but typically we make payments Tues/Fri, so the next of those days past the claim being processed. Amerigroup: We will need to look at your claims and then will advise you of specific status. United: same; and your provider advocate will be reaching out to you.</p> <p>*If I send bills in to MCO, what would make some show up and some others not – not seeing any at all on United’s – what is going on? United: They should all show up, so we’ll see what’s going on and will absolutely get back to you within an hour.</p>			
134	1.17.13	Nursing Facility	<p>* Concerns related to all MCOs: Amerigroup – none of our claims showing on website; can access, and we submitted claims 1/4 and 1/10. United – send claims but cannot get in because still waiting for password that was supposed to be coming in mail. Sunflower – claims show as “pending,” but got letter denying for of them ... got into issue of claims being diverted to Cenpatico because of diagnosis code. Have been outreaching and being told will get calls back, but not getting the calls or the answers. No luck at all via email.</p> <p>A: All MCOs will ensure that you get contact.</p> <p>*Prior authorization for United on temporary stay? A: If United is primary payer, don’t need prior auth but do need notice that they are there. Then do we need prior auth for longer-term custodial stay? No.</p> <p>*Wondering about EFTs and ERAs – will address these specifics when people call me back as well.</p>	1.17.13	Resolved	1.17.13
135	1.18.13	Hospital	<p>*Medical nutritional services provided by dietician. Covered? How bill? All MCOs: Covered same as before, and if a covered benefit, bill same as before.</p>	1.18.13	Resolved	1.18.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			*United: Can we see link on your website to 2013 radiology CPT codes? A: Will follow up with you on that, and put on our issues log.			
136	1.18.13	Nursing Facility	Owned by City of Stockton, which also has an ambulance service. Will there be a problem separating the billing/payment in this situation? All MCOs: So long as you have separate NPIs, no problem at all.	1.18.13	Resolved	1.18.13
137	1.18.13	PRTF	*For Sunflower: our provider rep had been Lisa; emails are coming back; do we have a new provider rep? A: Yes – <a href="mailto:Ydenton@cenpatico.com">Ydenton@cenpatico.com</a> and we will re-route previous rep’s email. *Thanks for quick payment from you. *For Amerigroup: All of our claims are in “pending” status. A: We will follow up with you and provide updated status details. *United: First batch denied by an error, and second batch not found. Was told would be a 30 day review and response period on my claims inquiry. Insisted on a supervisor, and was told will research and advise. A: Our behavioral health lead will reach out to you today and ensure all of your questions are answered.	1.18.13	Resolved	1.18.13
138	1.18.13	Ob/gyn	*Sunflower: Had asked about who is responsible for getting sonogram PA – us or hospital? Answer we were given: hospital. But the hospital is refusing to schedule unless we get PA. A: We will outreach to the hospital to make that clear. *With how long it is taking contracts to get finalized (we have signed with 1 of 3, other 2 underway), has anyone thought about extending the continuity of care past the April 4 <sup>th</sup> deadline? A: State’s period for most services is the 90 days; we are not planning to extend, but expecting that MCOs work with providers to get them into network in that 90 day period. Amerigroup: So long as you actively in process, we will continue to work with you. We will have provider relations follow up with you today as to contract status. Sunflower: Typically takes 30 days after contract signed to get credentialing done; get contracts in quickly so we can get that process done. United: So long as in process of contracting, will continue to honor continuity of care.	1.18.13	Resolved	1.18.13
139	1.18.13	Medical alerts	Amerigroup/Sunflower: Have not received contracts from either of	1.18.13	Resolved	1.18.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
		provider	you. Amerigroup/Sunflower: Provider relations will follow up with you today.			
<b>140</b>	1.18.13	Rural Health Clinics	<p>*Allergy injections through an RHC. RHC rule is must have a face to face visit before can do that; but provider reps are putting out different information. All: We will have to check that detail and get back with you; and will put on issues log. United: Allergy shots cannot be billed under RHC number because not a face to face with one of your practitioners.</p> <p>*RHC encounters – ob/prenatal care visits – need to submit those with T1015 code? Provider reps were to get back with me, and have heard from all but Amerigroup, and it was their FAQs where I obtained the information. Since I printed that, the document is no longer on their website. So – still need to hear from Amerigroup on that code issue, as well as what happened to providers’ FAQ document. Amerigroup: Will find out what happened to that document, and get it re-posted; and we have someone cued up to call you on that question.</p>	1.18.13	Resolved	1.18.13
<b>141</b>	1.18.13	Pediatric dental provider	<p>*Sunflower: We have questions about IV sedation units; are afraid that some of our units are not being accepted, and need some more detailed guidelines. Very detailed question – is there someone who can help us? A: Yes – happy to walk through very code specific detail with you, and will call you today.</p> <p>*Sunflower: Sent in all credentialing info on 11.16.12, and haven’t gotten response; feeling like things are up in the air and not getting contacts back to our outreach. A: We will connect with you today and get all questions answered.</p>	1.18.13	Resolved	1.18.13
<b>142.a</b>	1.18.13	County Health Department	<p>*One health department exception issue is that we don’t have to include NDC with Rx claims; however, our claims being denied because don’t have NDC number. Do MCOs know about this exception the health departments have? Amerigroup: You are correct and our pharmacist will follow up with you today.</p> <p>*One medicine’s code was discontinued 12.31.12 and we cannot find the new code, plus not sure as to what billing dosage we will need to</p>	1.25.13	Resolved	1.25.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			<p>bill. A: KDHE is aware of this, is researching it and will get the information to you and others.</p> <p><b>[Update 1.25.13:</b> The provider who called is correct that 340B providers do not have to submit NDCs with their physician-administered drug claims.</p> <p>For the second issue, there were several changes to the Medroxyprogesterone codes the first of the year. It appears CMS decided to simplify by replacing J1051 and J1055 with J1050. They also changed the description for J1050 from 100mg to 1mg. At this time J1050 is the only option for the provider to use. It's possible down the road CMS will add a new code specific to contraception.</p> <p>The provider should bill 150 units per injection. They will notice a decrease in reimbursement because of the changes. J1055 was based on AWP pricing and hadn't been updated for a while. J1050 is reimbursed at the Medicare ASP rate. Reimbursement will drop from around \$50 to \$30 when they bill 150 HCPCS units (1 injection).]</p>			
<b>142. b</b>	1.18.13	FMS provider	<p>*United: T2040 – DD claims that got through KMAP to MCOs in error. HP was going to retrieve and correct. I see on United's site (but not the case on other MCOs) that those claims are being paid to us – which will be a duplicate payment – so will need attention.</p> <p>*Signed up via a claims processor who tells me that we are signed up for EFT payment with United, but getting by paper check. A: United: We will have provider rep get you responses to both of these issues today.</p> <p>*Amerigroup: When we search on your site, can only do by Amerigroup's specific member number; any way to do by name? A: Not sure can change to that search option, but will connect with you today to be sure you understand all available options.</p>	1.18.13	Resolved	1.18.13
<b>142</b>	1.18.13	Nursing Facility	<p>*Sunflower: Claims are being denied for administrative reasons; referred me to someone who said need a W9, but our corporate office</p>	1.18.13	Resolved	1.18.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			already provided it. A: We will get that cleared up with you today.			
143	1.18.13	Providers	Hoping all the MCOs will be able to provide a payment schedule – for yourselves and all of your subcontractors – so we will all know what days you pay. A: HP – we are developing a consolidated document that will have all of the KMAP and MCO payment info, with claim submission tips and processing timelines. We will include in those discussions all of the MCO subcontractors. Will post on KMAP website (and likely all MCOs). [ <b>Update 1.25.13:</b> To more comprehensively address this and similar issues, we have posted a document to provide tips in an effort to help providers who are submitting claims electronically. We have also included information from each MCO regarding their typical claims processing timeframes. You can access the document on the KMAP web site by clicking the Search button on the Bulletins page available <a href="#">here</a> . The document is also embedded in the “status” column of this issue entry.]	1.25.13	Resolved  KanCare Provid Billing Tips Overvi	1.25.13
144	1.18.13	Nursing Facility	Going to see a quicker turnaround on claim payments? A: The State’s contract with the MCOs sets the standard at all clean claims within 30 days; pay for performance rate in 20 days; NF claims – 90% of clean claims are to be processed within 14 days. Amerigroup: We’ve pushed out a lot of NF claims in past two days, and will call you today to give you fresh info. Sunflower: Same – pay claims on Tues. and Fri., and process will continue to get quicker. United: Same; pay claims every week day for NFs and HCBS providers. Process will get quicker after this initial period where we are more closely reviewing every claim.	1.18.13	Resolved	1.18.13
145	1.18.13	Nursing Facility	*Revenue codes – getting conflicting info on what codes to use for LTC vs. skilled nursing care. United: In order for us process and pay properly, need you to bill: 101 – custodial care; 120 – skilled level of care. Amerigroup: Just use 120 as you were before. Sunflower: Will need to double check this detail and call you back. *Authorizations: Who requires and who does not; and after 90D or new resident. KDADS: Each MCO is going to put out a very brief	1.23.13	Pending	

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			bulletin that describes those processes. Each MCO will post and KDADS will send out via state licensing data base.			
146	1.18.13	HCBS and Home Health provider	<p>*Confirmed via Authenticare on Wed. that claims are on Sunflower's site, but cannot see on United or Amerigroup. Amerigroup: We will check your specific claim status and contact you. United: Also will follow up with you. Usually takes 3 days for claims to show on our site after submit via front end billing.</p> <p>*Will each of you reiterate one more time that we are owned by hospital so many of us have same taxpayer ID, but all have separate NPI. We will be able to separate our claims and remits by NPI, right? All MCOs: Yes.</p>	1.18.13	Resolved	1.18.13
147	1.18.13	Providers and Members	<p>*Any exception to 4/4 choice period for members to select MCO? KDHE: We intend to hold to that choice period, and continue to monitor that each MCO has strong network for members to choose within.</p> <p>*New members after 4/4 have 90 days to switch plans? A: Yes. People eligible after 1.1.13 have a 90 day choice period from date of eligibility.</p>	1.18.13	Resolved	1.18.13
148	1.18.13	Nursing Facility	Having trouble getting claims submitted to all three MCOs, through Provider Electronic Solutions (PES) or KMAP website. I'm a little confused and not able to get in touch with people. Sunflower: We gave some conflicting info about admit dates, and you do not need to change those. We want to have someone contact you and walk through claim submission with you as you do it, so any questions can be answered as you do that. Amerigroup: I know our management level staff have been working with you and will call you back today to help understand why your claims are rejecting. United: Someone will reach out to you to be sure you understand what is going on with your claims.	1.18.13	Resolved	1.18.13
149	1.22.13	Substance Use Disorder Providers	Sunflower/Cenpatico: Our SUD facility was told to fax the multi-party release of information form we have clients sign, to Sunflower. Is that going to be true from now on, and do other MCOs need it also? A:	1.22.13	Resolved	1.22.13

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			Yes – Sunflower will need faxed to us moving forward; United: Yes we do need that. Amerigroup: We may need in some circumstances, but not others; we will follow up with you specifically.			
150	1.22.13	Nursing Facility	<p>*All: Under old Medicaid, when we billed through KMAP website, our claims processed over weekend and paid out the following Thursday. When checking on this with one of the MCOs, was told it would be up to 30 days. A: That is not accurate. Here’s basic flow/info:</p> <p>--Sunflower: When you submit through KMAP website, download nightly, may take up to 24 hours; then if clean we pay on our next check run (2 x week) – slower initially because checking carefully.</p> <p>--United: Going through KMAP adds 24-48 hours getting into our system; our target is contractual requirement of 14 days initially, and getting quicker after initial phase where we are checking more manually.</p> <p>--Amerigroup: 24-48 hours after receive from HP, you can see in our system; then processing is affected by issues such as patient liability confirmation. Then it pays on the next of our 4x week payments.</p> <p>*Under KMAP, I could get instant pay/denial response, with a code if denied. Will I get something like that from MCOs if I submit through their web systems? Amerigroup: When go through our web portal, will get acknowledgement of receipt then automatic status update in 24-48 hours; if a denial code, can many times go right in and correct. United: Similar, but we will contact you to walk through precise details. Sunflower: Immediate acknowledgement; c. 24 hours get status update.</p>	1.22.13	Resolved	1.22.13
151	1.22.13	Primary care provider	<p>*Family practice doctor facility biller – bill multiple clinics for one provider via same NPI. Will have same problem with MCOs? Amerigroup: Do you have separate NPIs for the satellite groups? Provider: We do not – would that help? A: We think so, and will call you to address.</p> <p>*Flu shots vaccines (for children) - lots of the hospitals/health departments in our area are out of flu shots. Can there be any</p>	1.25.13	Resolved	1.22.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			exception to having flu shots for children given and paid for at one of our clinics? All MCOs: Don't know of any exception. KDHE: We will do some further research, given the situation you've described, and will include outcome on our KanCare issues log. <b>[Response update from KDHE 1.22.13: The Vaccines For Children Program still has some flu vaccine available. Please contact Martha Froetschner at 785-925-1990 if you are in need of additional vaccine.]</b>			
152	1.22.13	Nursing Facility	<p>*Which provider # should be showing on our claims? KMAP ID or individual provider ID? Amerigroup: You can bill with either. United: We want tax ID # and NPI.</p> <p>*With United, we have a couple of different provider #s with you – in other lines of business, and we'd like to have all Medicaid claims show up together. Is that feasible? United: Will do some research on this and get back with you.</p> <p>*Share of cost – does this need to show on the claim? If so, what value code should I be using? Amerigroup: Yes – and use value code 23 in field 39. Sunflower: Will call you with those details. United: Doesn't have to show on claim; you can populate the other box similar to Amerigroup, but we don't require it.</p>	1.22.13	Resolved	1.22.13
153	1.22.13	Critical Access Hospital	<p>*Inpatient claim through United – through UR that we use, patient was eligible for inpatient care; United uses different tool, and decided only eligible for observation. Tried to find reference online/manuals as to how to bill for this and couldn't find answer as to what charges allowed, what type of bill, etc. United: Will have provider advocate call you.</p> <p>*How do we keep this from happening in future? United: We will need to dig into the details and give you broader advice; we will look into why it converted to observation and how you should bill that. United will post this issue and resolution on its issues log.</p>	1.22.13	Resolved	1.22.13
154	1.22.13	FMS providers	*Have several HCBS patients in Manhattan referred to us prior to KanCare launch, but we cannot find them in Authenticare, so cannot get charges keyed to them. A: Loading new PAs into AuthentiCare is	1.25.13	Resolved	1.25.13

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			<p>a freshly resolved issue. KDADS will connect with you to describe how this process will work for you.</p> <p><b>[Update 1.25.13:</b>  FMS claims are created each Saturday of a month in KS AuthentiCare for the current month for providers to confirm. Providers have complete control of which part of a month to confirm the claims for the clients in their FMS caseload. Typically, providers confirm the clients' FMS claims once they have provided any of the tasks designated as an FMS responsibility. On the first Saturday of the following month, the previous month's FMS claims disappear and the new current month's claims appear for provider confirmation.</p> <p>As MCOs have forwarded February 1 and ongoing authorizations for their members, KS AuthentiCare will create by the month FMS claims for each member February 1 and ongoing. The January, 2013 authorizations loaded by First Data on January 2, 2013, included FMS for all members whose Plans of Care were approved for that service prior to the January 2nd import from HP. For any Plans of Care that include FMS detail lines which fall into the categories mentioned above, MCOs are to follow the process in the above-mentioned scenarios.</p> <p>Should the provider have problems viewing claims contact Candace Cobb at 785-248-1343 or client support services at Firstdata.com. ]</p> <p>*Where do we send wellness monitoring paperwork for any of our HCBS patients? A: KDADS will address this issue both with you directly and via description in issues log.</p> <p><b>[Update 1.25.13:</b>  A. Wellness monitoring reports will be sent to the care coordinator at the MCOs. Fax Numbers:  Amerigroup: 855-225-9937</p>			

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			United: 866-740-5114 Sunflower: 877-851-3990]			
155	1.22.13	Home Health provider	*Payments are not coming through timely; get lots of misinformation when we call in; beyond frustrated. KDHE: This is why we have these daily calls so people can raise these issues and get them addressed. You are right that MCOs are being more cautious in reviewing claims in this first period. Amerigroup: We have been in contact with caller; many of her claims processed over weekend and we are following up on the rest. Sunflower: Will contact you directly to ensure questions addressed/update provided. United: Will follow up with your rep and check into the concern about 6-week processing of EFT request.	1.22.13	Resolved	1.22.13
156	1.22.13	Nursing Facility	*Electronic remits: Just completed our enrollment for electronic remits. How do we obtain copies pending approval of that request? Amerigroup: You will get a paper RA until that's approved; will call you to confirm details. United: You have a national contract with us – so does your question apply to United? Yes – to the extent that I'm not sure where claims will show when paid. So – your national rep will call you to clarify and confirm. Sunflower: You will receive a paper RA, but also we will call you to walk through how to access via website. *Our claims are processing through our clearinghouse and KMAP. But problems from there: --Amerigroup is rejecting them because we bill as 61 (and should bill as 66). A: We will connect with you and walk you through resolution. --Sunflower: Claims rejecting for admitting diagnosis. A: Claims should not be rejected for that, so we will correct and reprocess.	1.22.13	Resolved	1.22.13
157	1.22.13	Critical Access Hospital	*Do MCOs require split billing from ER vs. inpatient? Medicaid did, but physical health MCOs did not. Amerigroup/Sunflower: We do not require split bill. United: Need to confirm and advise. *When you call us back with an answer, are those responses also being put on your website? United: We put many on our issues log (e.g., split billing question) – things of broader interest. We will put	1.22.13	Resolved	1.22.13

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			<p>this issue on the United issues log.</p> <p>*Patients are saying that MCOs are calling them to say that we are not in their network. But, we've submitted contracts and they are still pending. All: None of us are doing those kind of outbound calls, but will certainly check to ensure message is not being delivered like that.</p>			
158	1.22.13	Provider	<p>*Sunflower: Claims sit in pending since 1.11.13 – called to get help – told they have 30 days. A: That answer was not correct and we will call you today to get that resolved.</p>	1.22.13	Resolved	1.22.13
159	1.22.13	Nursing Facility	<p>*Sunflower: Some of our admission diagnosis codes are being crossed over to Cenpatico for mental health, and getting letters saying they are denied. How do we avoid that crossover and denial? A: We have developed a system fix to resolve that issue. Please be assured that you do not have to do anything; we have re-keyed those claims to process properly; a few denials did erroneously go out, but that is inaccurate and you don't need to do anything. If you'd like, will connect you directly to assure.</p> <p>*When bill through EDS, see that Sunflower and Amerigroup is correcting to pay the correct daily rate. United is not making that change automatically --- how can we get those adjustments made? United: We will call and walk you through how to do that online (will be Carol with Evercare billing agent that you have standing relationship with on billing issues). It is our intention to have all NF rates correctly loaded, so will need to reconfirm that with you.</p>	1.22.13	Resolved	1.22.13
160	1.22.13	Home Infusion Provider	<p>*On Friday's call you talked about developing a consolidated document with all claim submission timeline; not seeing that on KMAP site yet. HP: We still working on that; anticipate having posted by close of business tomorrow, 1.23.13. Will announce when it's there and how to access it.</p> <p>*Length of time on authorizations for infusion pumps: Getting 1 mo from one; 3 mo from another. Sunflower: Will depend on needs of the individual. Most are pediatric oncology patients and will need at least a year, and looking for consistency. A: Will work with our</p>	1.22.13	Resolved	1.22.13

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			medical team to see if there is a consistent standard we can apply to guide this situation. United: We are trying to get providers familiar with the authorization process. We will get back to you as to length of time issue in these circumstances. Amerigroup: We will call you back today.			
<b>161</b>	1.23.13	Nursing Facility	*Trying to change type of bills on Sunflower website right now; told to use 65 or 66 (changing from what have previously used – 61). Sunflower: will review your claims and verify they went through or get back with you. United: We are asking for similar change so will reach out to you as well.	1.23.13	Resolved	1.23.13
<b>162</b>	1.23.13	Community Mental Health Center	Regarding Non-Emergency Medical Transportation: We are getting calls from patients trying to arrange for reimbursement for their own mileage, and being told that cannot bill for that. In past had been allowed to use own resources for transportation and then turn in mileage and be reimbursed. Is that still a covered benefit? MCOs: Yes – all three will continue to reimburse this through KanCare.	1.23.13	Resolved	1.23.13
<b>163</b>	1.23.13	FMS provider	*In past, always got Notice of Action we knew when changes were occurring in a member’s plan of care. When doing training with each MCO, told will not be doing date of birth (DOB)-based assessments ... will be doing at all? United: We’ve not made a lot of changes yet, because we are honoring current plans of care for now (unless need additional care or find a gap). Will have staff call and visit with you. *Will there continue to be annual DOB assessments, so we will know to be looking for them? United: We will do annual at a minimum, but not necessarily tied to DOB. Amerigroup: You may be confusing our plan of care (POC) work with the annual Level of Care review? We’re doing POC changes and will not be limited to DOB, but more frequent. Will have staff call you to discuss further. Sunflower: We are honoring current POCs, so very few changes; when any occur, will communicate that to the FMS provider via phone or fax. Will also have staff outreach to you to discuss. *Is there any specific type of communication method or form that you	1.23.13	Resolved	1.23.13

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			prefer from us to address consumer questions or concerns? Also, if we have a worker in the house and see, e.g., a fall, do you want to know about that? Sunflower: Best contact for you to use on member issues is the case manager, and we will get you a list of who your members' case managers are. Amerigroup: For any clinical issues, would want you to talk with our Long Term Support Services group, and they will reach out to you and walk through best way. United: Same as Amerigroup.			
164	1.23.13	Nursing Facility	<p>*Medicare A&amp;B co-insurance claims: How are they going to be processed if claims do not cross over; or are they going to cross over? If we need to enter them, we've been entering in Kansas site itself; are we going to need to enter those to each MCOs' separate site? KDHE: State will continue to receive COB file from Medicare, and forward to MCOs. For claims you'd been sending in individually, you can continue to submit them through the FEB process. Will confirm and post in issues log if there is anything more or different for providers to do.</p> <p><b>[Update: KDHE confirmed they can be submitted through FEB/KMAP.]</b></p> <p>*For United: Had submitted a bunch of claims earlier, and know the rev codes were to shift to 120/101 for custodial. We'd submitted all with 120 – so for those which were inaccurate, do I need to wait for them to deny or can I go ahead and resubmit them now. A: We will check that and contact you for clear guidance.</p>	1.23.13	Resolved	1.23.13
165	1.23.13	Psychiatric Residential Treatment Facility	<p>*United: Set up in system as a new provider, and now claims only paying at 40%. Working with Denise who is working with a claims specialist who says our claims need to be on UB format rather than current practice/KMAP web. United: We are working on that and will be connecting with you to provide clear guidance.</p> <p>*The state's call log is reflecting issues as resolved when they are referred to an MCO for treatment. If not completely resolved, I think it should show as pending. A: Rather than not include MCO-specific issues at all, we opted to note that the subject matter was addressed, but have the state log show as resolved if it is a plan-specific matter or</p>	1.23.13	Resolved	1.23.13

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			a very provider-specific matter and the plan has undertaken to address with the provider. State issues or system issues we are noting as pending until the final resolution is noted/published. We also ask the MCOs to include information on their issues logs about how individual issues that could apply to other stakeholders have been resolved.			
166	1.23.13	Home Plus Facility	*Amerigroup: 3 of our 4 clients are your members; we billed 2 weeks ago; tried to check on it and was told bluntly that “we have 30 days to pay the claim.” We are running into cash flow problems. A: That 30 day statement is incorrect; we apologize for that and will follow up for some internal correct. In addition, we will call you today to update you on your claim status specifically.	1.23.13	Resolved	1.23.13
167	1.23.13	Hospitals and PCPs	*Spend down members --- how will claims be paid if, e.g., member has a \$300 spend down not yet met. Will it show paid \$0 and we have to bill member, or how is that set up? Amerigroup: Claim will be reduced by the amount of member liability that is due. Sunflower: Same. United: Same. So, we would be able to bill the member for what is not paid? Yes. *Amerigroup: On website, you have orientation sessions noted; are they the same ones we’ve already attended? A: Some are – the general orientation sessions; some are specialized, but we are happy to customize to meet your need and will call you to discuss that.	1.23.13	Resolved	1.23.13
168	1.23.13	Providers	*At previous call, we recommended a summary that would have all the #s of each MCOs for prior authorization contacts. Was that developed/posted? KDHE: It is being developed but not posted yet – we will announce when it is. *Could we have updates on # of provider applications still pending completion? KDHE: This is something we will follow up with MCOs on today; that is a good suggestion, and we will pursue a way to report that out.	1.28.13	Pending	
169	1.23.13	Community Mental Health Center	Amerigroup: We received your MH outpatient treatment report form. Trying to prior authorize the CPST services for 60+ of our clients. What is the timeline/cycle for when these PA requests are due? A: Will	1.23.13	Resolved	1.23.13

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			generally be on a 90 day cycle; some are being done more frequently. We will have our MH staff call and discuss with you.			
170	1.23.13	Home Health	*In filling out our information on OASIS, what should we be selecting as the descriptor for the current Medicaid plans? Previously picked #3, Medicaid FFS. Think maybe we now should pick #4 which is Medicaid managed care. This question relates to Medicaid primary members. Sunflower: don't know; will check and call you back. Amerigroup: This is probably #4, but we will check and confirm back to you. The MCOs will post this on their issues logs.	1.23.13	Resolved	1.23.13
171	1.23.13	Members; Personal Care Attendants	*United: I am a guardian for brother on TBI waiver. You have 97 or 99% on service level calls. Does that mean answered or resolved? A: That means answered, but we are also high on resolution performance. Do you have an issue not resolved? Yes – haven't had good consistency from call center staff in terms of understand our issues and getting us to care coordinator. United: I will have the head of our clinical team call you. *Grievance policies --- traditionally consumers are at the whim of FMS, and if you have a disagreement with them they take us off of AuthentiCare. We have no recourse against FMS's and then are cut off and cannot be paid. United: We are particularly concerned about any gap in care. We will connect with you today.	1.23.13	Resolved	1.23.13
172	1.23.13	Community Mental Health Center	*Suggestion: MCOs are giving updates as to # of claims paid out and such. Can you publish by MCO as to where they are in terms of where they are paying vis-à-vis dates received? A: We will consider that suggestion. *Question for United: We've submitted over \$250K of claims and have received \$300 in payments; have received 1/3 of claims paid by each of the other MCOs. See in your system that claims were paid 1.17, but no check yet. A: That is odd; payments sent 1.17 should have been received already. We will follow up with you today.	1.23.13	Resolved	1.23.13
173	1.23.13	FMS Provider	*FMS/authorization issues to consider with MCOs in 1:1 meetings. 20 TA waiver POCs that will expire at end of this month. We don't design	1.30.13	Resolved	1.25.13

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			<p>POCs and assign hours. We understand continuity of care and getting people paid, but if we don't have something from MCOs that justifies the services, we cannot authorize payments. We don't know how to reach case managers and don't have new POCs coming in.</p> <p>*Outstanding payroll – as FMS provider, we have very little margin and it will be used up if we don't get payment; gets us into vulnerable position.</p> <p>KDHE: As to protection on current POCs and authorizing/submitting claim for those services: We have 90 day protection for all HCBS members, and the current plan of care stays in place for that period of time. Recognize you need more details in some situations. We will issue additional information to ensure clarity on this for FMS providers and members.</p> <p><b>[1.25.13 update:</b></p> <ul style="list-style-type: none"> <li>• MCOs will outreach to all FMS providers to make connections for communication around POCs and payment.</li> <li>• For the expired POCs, FMS providers should please reach out to MCOs and ensure they issue updated ongoing, at a minimum until 3/31/13, authorizations to HP who will submit them to KS AuthentiCare in their daily export to ensure services can be confirmed in KS AuthentiCare and exported to the applicable MCO through the HP export process for claims payment.</li> <li>• FMS providers should consider approved POCs as valid beyond expiration dates until at minimum 3/31/13. MCO Care Coordinators (or Service Coordinators or Case Managers) are meeting with HCBS members and updating POCs, but until the new POC is in place, the current POCs and all services contained therein are valid until such updates.]</li> </ul>			
174	1.23.13	FMS provider	Sunflower: You previously said we could get a list of care managers; can we also get list of their supervisors and a phone number? Yes; will connect with you to provide that information.	1.23.13	Resolved	1.23.13
175	1.23.13	Community	Sunflower issued a claim denial on a psychological test; said because	1.23.13	Resolved	1.23.13

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		Developmental Disability Organization	to qualify for benefit under the plan, not covered; had been covered before and there had been no PA required for psych testing in the past. Is this testing covered? Sunflower: We want to connect with you to understand all the details; under our contract with the State we are to mirror previous benefits.			
176	1.24.13	Physicians, Clinic	*Amerigroup: Getting payments but having some denials on labs due to no CLIA number on claims. Provider rep said will reprocess without that but your manual says must have it. What is accurate guidance on this issue? A: We will double check and advise you clearly, and put on issue log.	1.24.13	Resolved	1.24.13
177	1.24.13	Community Mental Health Center	*What denial code do we use to bill third party not covered service? Were using 184, but presume no longer valid. Sunflower: 184; will put on our issue log. United: On our Q&A; continue to use 184 or use 192 – either is fine. Amerigroup: 184 or 192 also, I think; but will confirm and call. *United: When we are looking for claims status, do we need to pull up each physician provider in order to check that? A: No sure but will have staff contact you directly to clear.	1.24.13	Resolved	1.24.13
178	1.24.13	Rural Health Clinics	*Been contacted by RHCs and they are concerned that if we don't contract with all MCOs, how will they address payment of encounters. Will it be 90% of encounter rate? Sunflower: Want to get them all in, but if not – 90% of encounter rate. United: Same. Amerigroup: We intend to pay 100% of encounter rate. [Update: KDHE will post clarifying information for RHCs on this issues log.]	1.28.13	Pending	
179	1.24.13	Physician	*Sunflower: We have over 40 claims pending because your customer service says we need to send W-9; sent twice; when we check status they say cannot find. Have involved provider rep/manager, but they not clear on status either. Confident provider rep will get back to us, but hope soon. A: You do not need a W-9 for claims payment and will ensure that gets clarified internally. *United: Problems with customer service/pre-cert department. Not clear on what is required for specific procedures. Told all out of	1.24.13	Resolved	1.24.13

Issue #	Date Identified	Affected Groups	Issue Description	Est. Date of Resolution	Status	Resolution Date
			network providers require prior authorization, and when remind of 90D continuity of care say not for you. A: Apologize for that inaccurate response; want to connect with you to get specifics so we can do more spot training. Q: Also – customer service reps are rude and act put out, but web site down. A: Didn't know that and will follow up promptly. Q: 1.9.13 issue log #33, issue reported with KanCare payer ID not working for some clearinghouses – update to that? A: Should have been updated this Monday, and answer is to use the 577 number until the 96 number fixed.			
<b>180</b>	1.24.13	Nursing Facility	*United: Call center staff say we need to address KMAP to adjust any claims so can get paid; when we say cannot go through KMAP, and try to do that, they get frustrated. Once claims forwarded to MCO, we cannot get on there and adjust claims. A: The info you were given is incorrect; we know you cannot adjust claims on KMAP. You need to make claims adjustments either through your clearinghouse or through United's website. Q: We were told NFs cannot get on United's website to adjust yet and we couldn't get on there to check because the website is down. A: Thanks for that information; will check the website and follow up with you promptly.	1.24.13	Resolved	1.24.13
<b>181</b>	1.24.13	Psychiatric Residential Treatment Facility	*We have submitted \$240K in claims; received \$300; problems with all three. United is fixing; Amerigroup is pending; Sunflower – no success in reaching you. Sunflower: Will outreach to you today.	1.24.13	Resolved	1.24.13
<b>182</b>	1.24.13	Nursing Facility	*Sunflower: Asked what revenue codes to use on bill and what type of bill needs to be on claim. Yesterday said to use 65X or 66X and I don't know the difference between the two; plus we had used 61X in past. A: 21X is type for nursing facilities. Will have a billing person to connect with you to ensure have you in system correctly and address any questions. *Amerigroup: Type of bill; how do you have us loaded for billing? A: You should be billing 21X.	1.24.13	Resolved	1.24.13
<b>183</b>	1.24.13	Community	*Code T1017 TCM. There were some issues with that code in terms of	1.31.13	Resolved	1.25.13

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		Mental Health Center	claims not being forwarded. I've found that some are being forwarded and some not; and some are being paid by both. SED waiver and CMHC affiliate providers are not being crossed over. KDHE: That is an error; we will get addressed/corrected. [Update 1.25.13: Error discovered by not allowing PT/PS 11/122 (CMHC affiliate) and 11/123 (SED provider) TCM claims to be passed through to MCOs from Front End Billing, in addition to 11/111 (CMHC). This has been corrected effective the evening of 1.24.13. HP is reprocessing claims and voiding any paid FFS, and forwarding to MCOs for payment.]			
184	1.24.13	Pharmacists	*Q: Vitamin B-12 shots and folic acid. One of my members is getting a non-covered for those when had been covered. Amerigroup: They are covered. Sunflower: If covered through Medicaid, covered by us, bring issues to us so we can check. United: Covered; we had a minor issue on that and corrected it. (United to put on issues log.) *Nebulizers: Patients to come in and get, then pharmacy follows up to see if covered item while patient walking out the door – don't know in advance if a covered item for the pt. Seems backward. All MCOs: Nebulizers don't need authorization; always covered; just bill as DME.	1.24.13	Resolved	1.24.13
185	1.24.13	Billing entity	*Bill for several different entities. As to RHCs: Was told by Amerigroup that our RHC billing practice will not change. Is that the same with Sunflower? A: Yes. And since you bill for multiple, can we call and walk through all the details with you? Yes	1.24.13	Resolved	1.24.13
186	1.24.13	Hospital and Physicians	*Is it a state requirement that we have to have provider's SSN in the information that we give to three MCOs in order to get loaded into their system? KDHE: Think that is accurate and related to program integrity requirements, but will confirm and post response on issue log. *United: Trying to connect about setup of our providers (some are incorrect); can someone call me? Yes – will do that promptly.	1.31.13	Pending	
187	1.24.13	Hospital	*Amerigroup: We are contracted; sent all requested paperwork; sent again all liability insurance since renewed 1.1.13; all patients still being	1.24.13	Resolved	1.24.13

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			told our doctors are not credentialed with Amerigroup and they are upset. A: Will check on the status of your credentialing; we got many applications late; will follow up and call you back today. *MCOs: On OB deliveries, am told just have to send notification, but our staff are being told have to pre-cert. Amerigroup: Notify and we give reference number, but no pre-cert required. Sunflower: Notify only. United: Notify only. *If fax, how get response? Amerigroup and Sunflower: will get response back via fax. United: Will follow up and advise you of that specific.			
188	1.24.13	Nursing Facility	*Sunflower: Medicaid claims are being denied; coming back as have to file with Medicare first – what’s up? A: Will research and get back with you. *We are LTC facility; have residents that come into facility and then go onto Medicaid (pending when come in). Is it true that we have to get pre-authorization before someone can come into our facility? KDADS: Process will not change for those who are not yet Medicaid eligible. Q: We don’t know which MCO she will be assigned with. A: Right – so once eligibility is established, the member will be assigned an MCO and that MCO will reach out to you (or once you know who is assigned, reach out to them).	1.24.13	Resolved	1.24.13
189	1.24.13	FMS provider	*How are we going to be notified when there is a change in MCO? MCOs: Providers should check eligibility regularly for any change (at least monthly); and as we become aware of changes we will also be advising FMS providers via a new care manager. KDHE: And remember that MCO changes take effect the first of the next month after a change is made.	1.24.13	Resolved	1.24.13
190	1.24.13	Community Mental Health Center	*Does the practice of only one biller number to be used for CMHC services continue? KDHE: We will get clarity on that issue, in light of earlier TCM confusion. [Update 1.25.13 – please see #183 above.]	1.31.13	Resolved	1.25.13
191	1.25.13	Nursing	*Amerigroup Provider call at 1:00 this afternoon. Could the	1.25.13	Resolved	1.25.13

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		Facility	information from that call be made available for those of us not in attendance? Amerigroup: This is an open forum to answer questions as they arise for providers. No agenda, but if you have any questions contact us and we will help you at any time. *Number for that call? 866.590.5055, code: 5494768			
192	1.25.13	Nursing Facility	*Thanks to United for success in billing process/ease of transition; received first payment yesterday. Just received email this morning about billing info; said revenue code should be 101. I've been using 120 as in past, and claims going through. Do I need to switch those going back? A: Switch to custodial for room and board going forward. *Sunflower/Amerigroup: Getting error and denial codes quickly, even though not claims paid yet, and have question about an error code we are seeing. Amerigroup/Sunflower: Will call you directly about error code question, and will put details in our issues logs.	1.25.13	Resolved	1.25.13
193	1.25.13	Hospital and physicians	*How find out about reimbursement schedule? We have questions about how certain codes will be paid. Amerigroup: We are reimbursing per your contract or Medicaid fee schedule. Will call you directly to discuss questions. United: We are using Medicaid fee schedule and codes you've been using, and will reach out to discuss. Sunflower: Same as United. Q: Is Medicaid fee schedule on KanCare website? KDHE: On the KMAP website. *Do we use same payer ID # for DME as for other services we deliver? A: Yes.	1.25.13	Resolved	1.25.13
194	1.25.13	Case Management for people with DD	*Amerigroup: One of our customer's parents contacted you to see about enrolling for additional respite services (a value-added service). Were told not available until 2014. A: That is incorrect information; we will follow up with you and member to get it corrected (and also circle back and correct internally).	1.25.13	Resolved	1.25.13
195	1.25.13	Community Mental Health Center	*Amerigroup: Received partial payment/partial denial for peer support, saying there was a max of 12 units per day. When asked about why, was sent KMAP manual, which was SUD manual (rather than MH) as basis of policy. A: Apologize for that error; we are	1.25.13	Resolved	1.25.13

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			correcting and we will reprocess those claims. Also will call you to ensure resolved.			
196	1.25.13	Dental providers	*For additional dental coverage for adults: Can you provide additional details as to what is covered in that value added benefit? Amerigroup: Added 2 cleanings per year, plus medically necessary exams. Will get additional specifics and get back with you. United: Our benefit is one cleaning, one xray and one exam per year. Have details in our manual online. Also can use your provider advocate as a resource for these types of details.	1.25.13	Resolved	1.25.13
197	1.25.13	Nursing Facility	*Revenue code for billing. For United, say 101 for custodial care. But, for Amerigroup/Sunflower, continue using 120? Amerigroup: Yes. Sunflower: Yes. *Authorizations for long-term residents: Do those all have to be faxed (as opposed to online)? Amerigroup: I think you can do those online, but let me follow up and report back to you. Sunflower: Should be able to do both online and fax, and we also will call you to ensure you have access to do that.	1.25.13	Resolved	1.25.13
198	1.25.13	NAMI Kansas	Question for ombudsman about weekly report. Fairly general and some of us are interested in a little more detail. Some info suggests top areas of subject for consumers. Would like a breakdown by subject for all calls coming in, and also some discussion about what kind of written report will be available to the public about the nature of these calls, that may be posted and updated periodically. Also – as important as info about calls resolved, interested in smaller number of calls not resolved and what the nature of those are. Another dimension of our discussion: What does it mean to have the call resolved? Ombudsman: Happy to discuss in depth any questions or concerns you may have. Your points are well taken and I am developing more comprehensive documentation and reporting protocols. As to resolution, the standard is: When the consumer tells me that the matter is resolved. I’ve provided legislative testimony and online posting information, and am developing reporting which	1.25.13	Resolved	1.25.13

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			<p>will be available online as well going forward. Will call you to follow up more completely with you.</p> <p>*Timeline for getting reports posted? A: First report will summarize January.</p> <p>*Will reports also include information about unresolved issues --- by general nature of the call? A: Yes.</p>			
199	1.25.13	Adult Day Care	<p>*Doing initial billing under this program. Do we continue with AuthentiCare entering clock in/clock out? Yes.</p> <p>*Had a question for AuthentiCare about a payment, and they said that would have to talk with MCOs. Do we continue to download info and upload to KMAP process? KDADS: We will get back with you to provide specific details and assistance. Also: We are going to post information about flow of claim process generally, including those which start with the KMAP Front End Billing process.</p>	1.25.13	Resolved	1.25.13
200	1.25.13	Federally Qualified Health Center	<p>*HP: Payment schedule work still underway? A: Yes – being finalized today and will be posted later today or Monday. <b>[Update 1.25.13:</b> To more comprehensively address this and similar issues, we have posted a document to provide tips in an effort to help providers who are submitting claims electronically. We have also included information from each MCO regarding their typical claims processing timeframes. You can access the document on the KMAP web site by clicking the Search button on the Bulletins page available <a href="#">here</a>. The document is also embedded in the “status” column at issue #93 above.]</p> <p>*Scion Dental – for both United and Amerigroup – are requiring us to bill a “dental dump” code as well as specific code in order to process our FQHC claims. This will cause problems down the line, especially as to federal and state reporting, quality reporting, etc. Asking that you reconsider the requirement that we use an additional procedure code to trigger the encounter rate. Amerigroup: We are discussing that based on your previous request to us, and will report resolution. United: Same with us. Q: If you can keep us advised via KAMU, that</p>	1.25.13	Resolved	1.25.13

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			would help; we are concerned about potential cash flow issues because we are holding off on billing pending that resolution.			
201	1.25.13	Nursing Facility	*United: Have billed for four different facilities and three of them have erred out saying the member not eligible as of 1.1.13. Customer service representative has been very helpful, but cannot see the resolution yet. United: We will get someone from our Evercare organization to follow up with you promptly, and will build on the customer service rep's work.	1.25.13	Resolved	1.25.13
202	1.25.13	Home Plus Facility	*Have a couple trying to get on HCBS; we and family have questions and confusion about assignment to MCO and next steps. KDHE: You have several questions here, and we want to address with the details, so we will call you do discuss, and both of the involved MCOs will do so as well. [Update 1.25.13: Followed up with provider and will process assignment choice pending confirmation from member.]	1.29.13	Resolved	1.25.13
203	1.25.13	FMS provider	*United: Have received some updates, but awaiting update on electronic remittance advices. Don't use any kind of clearinghouse. United: We can put you in our pilot project to test access to electronic RAs; will contact you with those details to participate. *Amerigroup: Is there a personal contact for us down here in Wichita? Yes. Gina Windling covers that area – 877.434.7579, ex. 50519. Also: when we called your 800# we were unable to get case coordinator name, which is important in order to exchange good info. A: That was corrected weeks ago, and we have been providing those. We will call you back to provide that information.	1.25.13	Resolved	1.25.13
204	1.25.13	Nursing Facility	*We are seeing ID cards for residents, and for Sunflower we have question about PCP noted on the card. How big of a problem is that for the resident? Does it affect care? Do we need to get that changed? Sunflower: Regardless of who is on the card, the member can see any PCP they choose. If you call, we can promptly reassign a PCP and issue a new card. There will be no impact on ability to access or get paid for PCP services regardless of who is on the card. KDHE: That is true for all MCOs – KanCare has an open PCP panel approach.	1.25.13	Resolved	1.25.13

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			<p>When the MCO first made PCP assignments, not all PCPs were in the network. For first 90 days, can go to any PCP and the provider will get full payment; after 90 days, so long as in the MCO's network, can go to any PCP for full payment.</p> <p>*HCBS: Starting process to shift in December; have been approved by Medicaid; signed up for Sunflower; waiting to hear from case manager; made call to Sunflower. What is process to get the assessment and POC developed? Sunflower: We will contact you promptly to have a case manager assist you with the process and with placement.</p>			