



Landon State Office Building
900 SW Jackson Street, Room 900-N
Topeka, KS 66612

Robert Moser, MD, Secretary
Kari Bruffett, Director

Phone: 785-296-3981
Fax: 785-296-4813
www.kdheks.gov/hcf/

Sam Brownback, Governor

KanCare Implementation Activity: Front End Billing Solution

Date Posted: Nov. 27, 2012

Overview:

Effective January 1, 2013, the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) will offer the KanCare Front End Billing (FEB) solution. KanCare FEB is a free service to assist providers, billing agents, and clearinghouses participating in KanCare. The KanCare FEB option allows entities to continue submitting UB-04, CMS-1500, and dental KanCare claims directly to the State's fiscal agent just as Kansas Medicaid claims are currently submitted or to submit claims electronically to each managed care organization (MCO). Pharmacy point-of-service claims are excluded from the FEB service.

The FEB service will forward claims the same day to the beneficiary's KanCare MCO based on the beneficiary's assignment. FEB allows providers to continue submitting their Kansas Medicaid claims to the State's fiscal agent without any disruption to their billing processes. Providers, clearinghouses, and billing agencies who currently submit claims to the fiscal agent may continue to do so on January 1 without making changes to their billing systems.

Providers who continue to send electronic claims to the fiscal agent will receive a notification that their claims have been forwarded to the appropriate MCO through the ASC X12, Health Care Claim Acknowledgment (277), and a plain text batch submission report. Upon receiving claims from the fiscal agent, the MCO will process the claim through final adjudication and communicate this to the billing entity. KanCare Front End Billing (FEB) will allow providers to continue creating claims for submission as they currently do through the following methods:

- Provider Electronic Solution (PES) software
- ANSI ASC X12N 837 Health Care Claims (837) transaction
- Web-based provider portal (secure website)
- Paper

Providers who choose to bill paper claims must submit their claims to fiscal agent regardless of the KanCare MCO assignment. If the provider submits a paper claim directly to the KanCare MCO, the MCO will forward the paper claim to the fiscal agent and will send the provider a letter with instructions to send all future paper claims directly to the state's fiscal agent.

Additionally, to ensure effective coordination of benefits with the Medicare program, the FEB will also allow for the electronic COBVA submissions to be handled in the same manner they are today. HPES will continue to receive the electronic COBVA claims from Medicare. The KanCare FEB service will automatically forward COBVA claims to the beneficiary's KanCare MCO, based on the beneficiary's KanCare assignment at the time of service.

Health Policy Oversight Committee

Date: 12-6-12

Attachment: 7

The state and its contractors are very aware that the success of an implementation hinges on the ability to receive and process claims timeline and accurately. The status of the respective implementation and deployment efforts of the state and the MCOs is described below.

State's implementation status:

CMS Request	HP Item
<p>Reports demonstrating that the State has successfully tested the transition of claims clearinghouse system</p>	<p>Additional results will be available by 12/07/12 and upon completion of the testing activities with each MCO. Testing activities are scheduled with the MCOs between 10/29/2012 and 12/27/2012. The test results will show that claims have been forwarded to the corresponding beneficiary's MCO when the beneficiary is enrolled with an MCO.</p> <p>Completed activities: Testing of COBC and other EDI batch claims. Claims were successfully routed to each MCO. The testing of WEB and Paper claims is currently in progress.</p>
<p>Testing of data transfer to and from the State and the MCOs' successful ability to accept MMIS claims and process checks timely from that file</p>	<p>Additional results will be available by 12/07/12. Testing activities for FEB are scheduled with the MCOs between 10/29/2012 and 12/27/2012. The test results will show that the MMIS received a claim and included it on an outbound file to the beneficiary's respective MCO.</p> <p>Completed activities: The state fiscal agent has successfully completed the installation of a secure FTP site between each MCO and the MMIS to exchange data. Data are successfully exchanged between the MCOs and the MMIS production and test environments.</p>
<p>Evidence that LTSS providers have been informed of their option to submit a claim to the MMIS instead of directly to the MCO.</p>	<p>The FEB solution has been included in provider education since the first educational tour this summer and is included in materials on the KanCare website. More recently (11/7/2012), the State informed participants in its weekly implementation call that providers could choose to continue submitting claims to the MMIS directly as they do today or send them directly to the MCOs.</p> <p><u>A general bulletin to all providers</u> was posted to the fiscal agent's web site on 11/14/2012 to provide more detail regarding claims submission options. An alert (global message) announcing the availability of this bulletin was sent to all providers, including LTSS providers. The content of the bulletin will also be sent directly to LTSS providers as a global message through the secure provider site 11/30. The bulletin will be sent again on 12/02 to all providers except for provide type 24 (Pharmacy).</p>

These reports should include how the system operates for both in-network and out-of-network providers.

Test cases for in-network and out-of network providers are included in the claim submission test results mentioned above.

The MMIS will forward all claims received from all providers regardless of their in or is out-of-network status. If the submitter is an approved EDI submitter, the MMIS will receive the claims from all providers (in network or out-of-network) and forward them to the beneficiary's corresponding MCO.

MCOs' implementation status:

Sunflower State Health:

Sunflower State Health is currently testing the transition claims clearinghouse (also referenced as front-end billing) in coordination with the state and its fiscal agent. Internal and external testing activities are on schedule for deployment January 1st. Post go-live, Centene's claim implementation team will review and monitor check runs for 90 days. Separately, Centene's Internal Audit team will perform a comprehensive audit of a statistically valid sample, utilizing a confidence level of 99%, of all Sunflower processed claims including paid, denied, appealed, and adjusted claims.

To ensure all LTSS providers have been informed of their claims submission options Sunflower has included guidance in its billing manual and provider manuals. Both documents are available at www.sunflowerstatehealth.com or upon request. In addition to what is available online and in the manuals, Sunflower Provider Relations representatives will cover provider billing options in one-on-one orientations, group orientations and webinars. A schedule of the provider orientation schedule is posted on the Sunflower website. The state paper claims mailing address is provided on the back of the member's ID card. The paper claims billing process is the same for both in network and out-of-network providers.

Testing Status Summary

	Status	Deployment Date	Comments
834/Member Enrollment	In progress	12/3	Function
Subcontractors Enrollment Feed	In progress	12/8	Initial testing of outbound feeds to the following subcontractors was completed on 11/21 with the 834 Production file. Behavioral Health Vision Dental Pharmacy Transportation ID Card (Cenveo)

Clinical – PA & Care Mgmt	In progress	12/8 12/21	<p>Kansas prior authorization services configuration 100% complete, including behavioral health.</p> <p>Health Risk assessment configuration 100% complete.</p> <p>2 Year claims history data load 50% complete. Support development of transition of care plans.</p>
Electronic Visit Verification (First Data)	In progress	12/27	<p>Sunflower working directly with First Data/HP to execute testing activities of the 837.</p> <p>Authorization file requirements 100% complete.</p>
Provider Configurations	Complete	11/2 11/16	<p>Kansas specific provider functionality and configurations deployed.</p> <p>Initial online provider directory search deployed. Weekly data refreshes.</p>
Portals	In progress	12/1 1/1	<p>Wire-frames are complete for the portals based on current requirements. Content approvals are pending for the secure member and provider portals.</p> <p>Usability testing completion:</p> <p>sunflowerstatehealth.com = complete provider.sunflowerstatehealth.com = In progress member.sunflowerstatehealth.com = In progress</p>
Claims	In progress	12/21	<p>Claims: Benefit UAT will be complete by 11/30</p> <p>Payment arrangement testing will be 90% complete on 11/30</p> <p>End-to-end testing for all medical will begin 12/3 – this includes web, pre-adjudication, payables, etc.</p>

			<p>Testing starting 12/4.</p> <p>Scope includes: Behavioral Health Vision Dental Pharmacy Transportation</p>
Claims/Spenddown	In progress	1/1	<p>Business Requirements 100% complete and submitted to state for review.</p> <p>Validation of External Facing Material (web, EOB, EOP), 40% complete.</p> <p>Final Design for All Entities (including Subsidiary and Vendors), 40% complete.</p> <p>Spenddown WSDL File Testing with State 12/04/12</p>
Claims Clearing House/Front End Billing (FEB) Claims	In progress	1/1	<p>Business Requirements Document, 100% complete.</p> <p>Index File Formats submitted to the state.</p> <p>Edits have been submitted to the state.</p> <p>Testing scenarios have been submitted to the state.</p> <p>FEB system test files received 11/21 from HP, testing began 11/26</p>
Encounters/PR2	In progress	11/16 1/12	<p>PR2 testing in progress with the state.</p> <p>Production PR2 file to be submitted to state on 11/28.</p> <p>Encounters testing to begin 12/4.</p>

UnitedHealthcare:

Overall IT development status is "on track" for system deployment in December 2012. KanCare program components will be deployed over a series of dates between now and year end. A summary of United testing efforts by function is outlined below. All testing efforts and plans were developed in conjunction with the state of Kansas and subcontractor entities supporting the KanCare program.

The Long-Term Care provider manual (chapter 13) and training outlines claims submission methods, claims submission address and acceptable protocols, specifically highlighting the state's claims options: the state's MMIS, national clearinghouse or UnitedHealthcare. This information is also described in other chapters of the provider manual to cover other provider types (eg. Behavioral, Vision). UnitedHealthcare's provider advocates and provider call center representatives have been trained on these submission options and are well-versed in supporting provider inquiries on this topic and many others.

UnitedHealthcare in-network and out-of-network provider administration follows the same processes. UnitedHealthcare has developed unique testing scenarios to assess differing reimbursement policies by par or non-par provider as well as by provider type (eg. Facilities, HCBS, etc.). The claims auditing guidelines are in place to monitor claims and Provider Remittance Advice (PRA) quality against Kansas specific performance standards. Two independent audit criteria are implemented for all new business. For a period of a minimum of two weeks, standard new business implementation includes a review of 100% of claims received. During that period, target audits are conducted daily to ensure correct processing of specific claim types, provider types and special handling claims. Quality audits are conducted on a Sampling of all other claims daily to ensure correct processing. Remediation is implemented if required. Following implementation, approximately .05% of claims are audited (audit percentage may vary by subcontractor). The statistical audit is a precise measurement, allowing for detection of issues having the greatest impact on quality. In addition to the statistical audit, High Dollar Reviews, Individual Processor Reviews, Training Reviews, and Focus Audit Reviews enable error detection.

Testing Status Summary

Function	Status	Deployment Date	Comments
834/Member Enrollment	In progress	12/3	Monthly 834 test files received and processed; 100% pass rate. Daily 834 testing started 11/19. Testing in progress. 100% pass rate. Production 834 file: data discrepancy issues researched. State to update code for next file run. UHC in process of loading

			production file.
Subcontractors Enrollment Feed	In progress	12/8	Initial testing of outbound feeds to the following subcontractors completed using monthly 834 test files; 100% pass rate: Behavioral Health Vision Dental Pharmacy Nurseline Teledoc Transportation (Logisticare) ID Card (Fiserv) Member Materials (RRD) Daily 834 testing in progress.
Clinical – PA & Care Mgmt	In progress	12/15 12/21	Kansas prior authorization services configuration 100% complete. Health assessment 90% loaded and configured. 2 Year claims history data load 90% complete. Support development of transition of care plans inclusive of transportation and other subcontractor, where appropriate. Enhancements to behavioral health functionality on target for 12/21 deployment.
Electronic Visit Verification (First Data)	In progress	12/27	UnitedHealthcare working directly with First Data to execute testing activities. Requirements 98% complete. Authorization file requirements 100% complete.
Provider Configurations	Complete	11/2 11/16	Kansas specific provider functionality and configurations

			<p>deployed.</p> <p>Initial online provider directory search deployed. Weekly data refreshes.</p> <p>Note: Provider contract and credentialing loads in progress (upload upon receipt).</p>
Portals	In progress	<p>11/16</p> <p>12/8</p> <p>12/21</p>	<p>Wire-frames 100% complete for all 3 portals. Content approvals pending for UHCommunityPlan.com and MyUHC.com portals.</p> <p>Usability testing completion: UHCommunityPlan.com = 90% UHOnline.com = 80% MyUHC.com = 80%</p>
Claims	In progress	<p>12/15</p> <p>12/21</p>	<p>Kansas benefits configuration 100% complete. End-to-end testing scenarios complete; includes: claims submission, adjudication, check processing, EOB/PRA, and encounters reporting.</p> <p>Testing started 10/31.</p> <p>Scope includes: Behavioral Health Vision Dental Pharmacy Nurseline Teledoc Transportation (Logisticare)</p>
Claims Clearing House/Front End Billing (FEB) Claims	In progress	12/21	<p>Requirements 90% complete. File formats requirements 100%</p> <p>Testing plan finalized. Integrated with state FEB schedule.</p>

			<p>Initial testing in progress: 75% complete. Data issues identified and resolution in progress with the state and UHC eligibility set up issues. File State to update code for next file run. Additional testing runs scheduled through mid Dec.</p> <p>Scope includes testing with subcontractors: Behavioral Health Vision Dental Transportation (Logisticare)</p>
Encounters/PR2	In progress	11/16 1/12	<p>PR2 testing with state; 99% pass rate.</p> <p>PRVLST2 testing in progress; 99% pass rate. On target to complete week of 11/26.</p> <p>Production PR2 file in quality review; to be submitted to state on 11/30.</p> <p>Encounters test scenarios complete. Testing to begin 12/10.</p>
Reporting	In progress	1/19	<p>Partnering with the state and other MCOs to standardize report formats, finalize reporting requirements and data definitions.</p> <p>Testing scenarios and testing schedule to be updated pending completion of requirements.</p>

Amerigroup:

Amerigroup is working closely with KDHE on the transition claims clearinghouse system. The MCO is currently completing its development and internal testing and readying for a comprehensive test with KDHE as test files become available. In support of this, Amerigroup has provided a test plan and a set of test paper claims. The test plan provides for testing of the various components comprising the overall claims clearinghouse system/process, including:

- Trading partner setup
- Configuration
- NDC
- CLIA
- 837 outbound/999 inbound
- 277CA outbound/999 outbound
- Accept paper claim images
- Claim attachment images
- EOB

Testing requires staging of members and providers. Amerigroup has received and loaded the test 834s from KDHE into its development environment and has provided test provider files to KDHE. From these, Amerigroup has a common data set from which to draw test claims and is ready to coordinate the EDI batch file and paper/web test claims files.

Upon receipt of test data, Amerigroup follows normal processing, including compliance validations, edits, and adjudication in its development environment. Once adjudication is complete, the output files are sent to the bank for payment of EFT vendors or check creation. In production, upon creation of these files, the provider receives payment through EFT or check within the same day (EFT) or 24 to 48 hours (check).

Amerigroup is coordinating this process with its delegated vendors included in the clearinghouse process too, which includes vision and dental. Amerigroup generates the 834 eligibility files to these vendors from the 834 data received from the State. The delegated vendors' providers have already been included in the providers' files shared with the state for future processing of encounter data.

LTSS providers have been informed of their option to submit a claim to the MMIS via KMAP General Bulletin 12115. Amerigroup has also communicated this process to all its providers, including LTSS providers, via its provider manual currently posted on the web. The front-end billing process is also addressed in the provider orientation sessions, including the LTSS-specific provider orientations (see the attached document titled **Amerigroup LTSS Training Excerpt**).

Amerigroup is ready to handle claims for both in and out of network providers. Overall claim edits and processing are the same for both in and out of network providers. Once the out-of-network provider is configured, the claim processes according to normal rules. Amerigroup is ready to handle in and out of network providers' claims clearinghouse in its testing activities with Kansas.

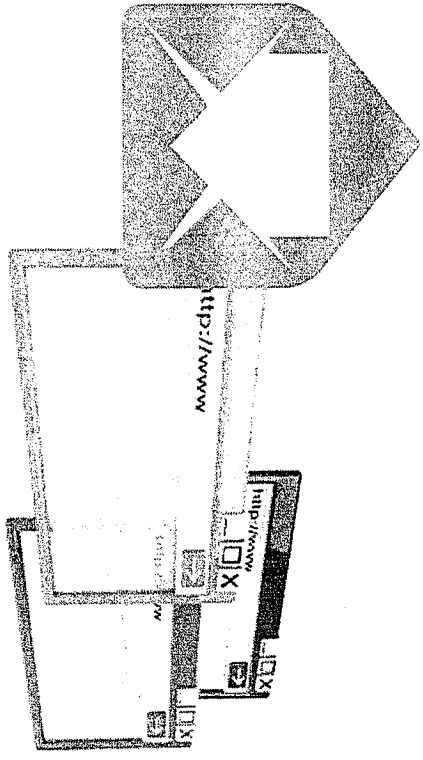
Testing Status Summary

Function	Status	Deployment Date	Comments
834/Member Enrollment	In progress	11/7	<p>Monthly 834 loaded to production and processing of initial monthly 834 completed 1/12.</p> <p>Test daily 834 files received and being processed. Compiling feedback on the first 2 sets of files relative to the scenarios and processing results.</p>
Subcontractors Enrollment Feed	In progress	12/20	<p>Test files sent to delegated vendors and all passed testing and in production except for transportation vendor and CMT BH DUR vendor who are both in UAT/vendor testing.</p> <p>Actual initial production runs for the vendors are not scheduled to start until the middle of December timeframe.</p>
Clinical – PA & Care Mgmt	In progress	12/5	Kansas prior authorization services configuration 100% complete.
Electronic Visit Verification (First Data)	In progress	12/27	Test auth file almost ready to send to FirstData – working on getting the provider identifiers aligned with the KMAP_IDs.
Provider Configurations	Complete	Ongoing	<p>Kansas specific provider functionality and configurations deployed.</p> <p>Note: Provider contract and credentialing loads in progress (upload upon receipt).</p>
Portals	In progress	12/18	<p>Member and Provider Portals in production and online.</p> <p>Specific lookup, data modification, and claim entry in development/testing and slated to move to production in 12/18 release.</p>

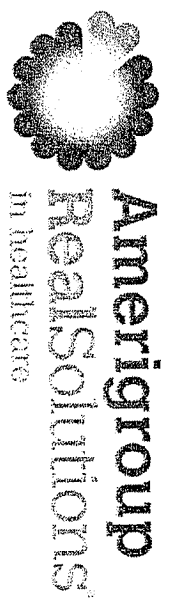
Claims	In progress	11/19 12/5	<p>Kansas benefits configuration 100% complete.</p> <p>Benefit configuration and claims testing Phase I 100% complete.</p> <p>Benefit configuration and claims testing Phase II 48% complete.</p>
Claims Clearing House/Front End Billing (FEB) Claims	In progress	12/21	<p>All components in UAT and on target to begin state testing except paper images and claim attachments, which are in development.</p> <p>Components include: COBA Trading Partner setup Configuration NDC CLIA 837 outbound/999 inbound 277CA outbound/999 inbound Accept paper claim images Claim attachments EOB</p> <p>Test plan and test paper claims sent to state. Coordinating test environment and test data internally and with state.</p> <p>Scope includes testing with subcontractors: Vision Dental Testing with Transportation will be supported although our transportation vendor received electronic claims and we do not expect any to come on paper or through the state.</p> <p>State testing status:</p> <p>Test 834s loaded</p> <p>Test COBA files processed with no issues identified just need to align test data – completely processed 5 claims to ready to pay status.</p>

Encounters/PR2	In progress	11/30 1/15	PR2 testing with state Production PR2 file to be submitted 11/28 with ongoing submissions thereafter. Encounters ready to begin testing 12/3.
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Options for Submitting Claims



- KanCare front-end
- By mail
- Web-based
(our website or 837)
- Via clearinghouse
- EVV system





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Options for Submitting Claims

MARKET-SPECIFIC: KANSAS

SAY:

We give you several options to submit claims:

CLICK

For your convenience, you can continue sending your Kansas Medicaid claims to the state in the same way you do today. KDHE will submit your claim information to each MCO through daily 837 batch files.

CLICK

By mail:

Submit a properly completed claim for all services performed or items/devices provided and include all required information, or the claim will not be considered a clean claim and will be denied. Don't alter or change any billing information (e.g., using white out, crossing out, writing over mistakes, etc.); altered claims will be returned to you with an explanation of the reason for the return.

There are critical fields on both the CMS 1500 and 1450 that we will not accept as handwritten if the claim contains any computer generated or typed data. Fields not identified as critical may contain handwritten data if it has been added for the first time. We'll accept claims from those providers who submit entirely handwritten claims.

For your convenience, you may continue sending your Kansas Medicaid claims to the state in the same way you do today. KMAP will submit your claim information to each MCO through daily 837 batch files. Paper claims may be sent to the state's fiscal agent at:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601

You can also find this information in your provider manual in Section 2.

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Paper and electronic claims must be filed within:

- 90 calendar days for PCPs, specialists, medical ancillary and LTSS service providers
- 180 calendar days for nursing facilities, hospitals, Indian Health providers, and other facilities such as Federal Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), and Rural Health Centers (RHCs)

 CLICK**Web-based Claims Submissions**

You can submit claims on our website by:

- Entering claims on a preformatted CMS-1500 and CMS-1450 claim template

-or-

- Uploading a HIPAA-compliant ANSI 837 5010 claim transaction

If you need assistance with electronic claims submission process, please contact our EDI Hotline at 1-800-590-5745.

 CLICK**Via clearinghouses**

You can submit claims electronically by using a clearinghouse via Electronic Data Interchange (EDI). By using the free electronic tools, we offer on our website, you may be able to reduce claims and payment processing expenses. Advantages to submitting your claims through EDI include:

- Faster processing than paper
- Enhanced claims tracking
- Real-time submissions directly to our payment system
- HIPAA-compliant submissions
- Reduced claim rejections
- Reduced adjudication turnaround time

You can submit claims through:

- Emdeon (formerly WebMD) — Claim Payer ID 27514
- Capario (formerly MedAvant) — Claim Payer ID 28804
- Availity (formerly THIN) — Claim Payer ID 26375
- The state of Kansas clearinghouse

An EDI claims submission guide is located at providers.amerigroup.com/KS.