

129-5-10. Definitions. Each of the following terms, when used in K.A.R. 129-5-10 through 129-5-21, shall have the meaning specified in this regulation:

(a) “Act” means kancare prompt payment act, K.S.A. 2014 Supp. 39-709f and amendments thereto.

(b) “Allowed amount” means any claim or portion of a claim that the provider and the managed care organization agree in good faith is correct and should be paid under the participating provider agreement with the managed care organization and under kancare program policies.

(c) “Claim” means any of the following:

(1) A bill for services;

(2) a line item of service; or

(3) all services for one beneficiary within a bill.

(d) “Clean claim” means any claim that can be processed without obtaining additional information from the provider of the service or from a third party. This term shall include any claim with errors originating in the state’s claims system. This term shall not include any claim from a provider who is under investigation for fraud or abuse and any claim under review for medical necessity.

(e) “Day” means calendar day. If the 30th calendar day or the 90th calendar day falls on a weekend or a holiday, then the 30th calendar or 90th calendar day shall be deemed to occur on the following business day.

(f) “Managed care organization” means an entity that has contracted with the Kansas medical assistance program for the provision of managed care services to medicaid beneficiaries in Kansas.

(g) “Provider” means a health care provider that has entered into a participating provider agreement with a managed care organization.

(h) “Unpaid claim” means any claim that has not been paid by a managed care organization and meets one of the following conditions:

(1) Is not subject to a bona fide dispute as specified in K.A.R. 129-5-15; or

(2) has not yet been processed and denied by a managed care organization. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-11. Applicability. The act shall apply only to each claim with a date of service on or after the effective date of the act, which was July 1, 2014. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-12. Electronic and paper claims. The act shall apply to each claim submitted under kancare to a managed care organization, whether the claim is submitted in electronic or paper format. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-13. Date claim is deemed to be received. If a provider submits a claim to a managed care organization by mail, the managed care organization shall be deemed to have received the claim no more than three business days after the claim was mailed, unless proven otherwise. If the provider submits the claim electronically, the managed care organization shall be deemed to have received the claim no more than 24 hours after the claim was submitted, unless proven otherwise. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-14. Notice of denial or need for additional information; processing additional information; suspension of time periods. (a) If a claim is not a clean claim and cannot be either paid or processed and denied within 30 days after the managed care organization's receipt of the claim, the managed care organization shall send a written or electronic notice acknowledging receipt and indicating the status of the claim. The notice shall include the date on which the claim was received by the managed care organization and shall state one of the following:

(1) The managed care organization refuses to pay all or part of the claim, with specification of each reason for denial.

(2) Additional information is necessary to determine whether all or any part of the claim shall be paid, with specification of what information is necessary. This notice shall constitute the managed care organization's request for additional information from the provider.

Each notice shall also identify the code for each reason for denial or for requesting additional information, if any, and shall include any other information necessary to inform the provider of the specific issues related to each claim.

(b)(1) The 90-day period for payment or for processing and denial of claims other than clean claims shall not include the days between the managed care organization's first request for additional information and the managed care organization's receipt of the provider's initial response to the request. The time period for payment of claims shall not be suspended following the submission by the managed care organization of a second or subsequent request for additional information to a provider on any single claim.

(2) After receipt of all requested additional information, the managed care organization shall perform one of the following:

(A) Pay the claim in accordance with the 90-day time period specified in the act; or

(B) issue a notice to the provider stating that the managed care organization refuses to pay all or part of the claim and specifying each reason for denial.

(c) Failure to comply with this regulation shall subject the managed care organization to a direct cause of action by the provider for interest on the unpaid portion of the claim as specified in the act. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-15. Claims subject to bona fide dispute. An unpaid claim that is subject to a bona fide dispute, including any claim that a managed care organization has reason to believe is fraudulent and any claim undergoing a review for medical necessity, shall not be subject to the interest requirements of the act. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-16. Partially paid claims. If a managed care organization pays a portion of a claim within the time limits specified in the act, then only the unpaid portion of that claim shall be subject to the interest provisions of the act. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-17. Resubmitted claims. For each corrected claim resubmitted by a provider due to a provider error on the initial submission of the claim, the applicable 30-day or 90-day time limit for processing and full payment of the allowed amount or for processing and denial shall begin on receipt of the corrected claim by the managed care organization. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-18. Date claim is deemed to be paid. Each claim shall be deemed paid on one of the following dates:

(a) The date on which the managed care organization issued a check for payment and any corresponding explanation of benefits to the provider; or

(b) the date on which the managed care organization electronically transmitted a notice of payment to the provider. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-19. Interest on unpaid claims. (a) The principal amount due on which the interest payment shall be calculated shall be the allowed amount due but unpaid at the contracted rate for the service. All interest due under the act shall be applied only to the principal amount due as specified in this subsection and not to any unpaid interest. Interest calculated under the act shall not be compounded.

(b) Each managed care organization shall keep accurate and sufficient records for each interest payment and its corresponding claim documentation and shall provide a detailed report to the state upon request. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)

129-5-20. Retroactive rate, program, and policy changes and clarifications. A claim shall not be deemed to be an unpaid claim if a retroactive rate, program, or policy change creates an unpaid balance on a claim that the managed care organization has previously paid.

(Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-
_____.)

129-5-21. Retroactive eligibility. If a provider submits a request for payment to a managed care organization before the patient is determined by the state to be eligible for medicaid, then the request shall not be deemed a claim under the act until the date on which the managed care organization is notified by the state that the patient was medicaid-eligible on the date of service. (Authorized by and implementing K.S.A. 2014 Supp. 39-709f and 75-7403; effective P-_____.)