[Kan. Stat. Ann. § 39-709h.]

§ 39-709h. Medical assistance program; patient encounter data; requirements imposed on managed care organizations; audits; rules and regulations: Social Welfare

(a) Upon request by a participating healthcare provider under the Kansas medical assistance program, the secretary of health and environment shall provide accurate and uniform patient encounter data that complies with the federal health insurance portability and accountability act of 1996 and applicable federal and state statutory and regulatory requirements, including, but not limited to, the:

(1) Managed care organization claim number;

(2) patient medicaid identification number;

(3) patient name;

(4) type of claim;

(5) amount billed by revenue code and procedure code;

(6) managed care organization paid amount and paid date; and

(7) hospital patient account number.

(b) Upon receiving a request for patient encounter data pursuant to subsection (a), the department of health and environment shall furnish to the participating healthcare provider all requested information within 60 calendar days after receiving the request for data. The department of health and environment may charge a reasonable fee for furnishing requested data, including only the cost of any computer services, including staff time required.

(c) (1) The secretary shall require any managed care organization providing state medicaid or children's health insurance program services under the Kansas medical assistance program to provide documentation to a healthcare provider when the managed care organization denies any portion of any claim for reimbursement submitted by the provider, including a specific explanation of the reasons for denial and utilization of remark codes, remittance advice and health insurance portability and accountability act of 1996 standard denial reasons.

(2) Each managed care organization shall offer quarterly in-person training on remark codes and health insurance portability and accountability act of 1996 standard denial reasons and any other denial reasons or remark codes specific to the managed care organization.

(d) The secretary shall require managed care organizations providing state medicaid or children's health

insurance program services under the Kansas medical assistance program to offer quarterly in-person education regarding billing guidelines, reimbursement requirements and program policies and procedures utilizing a format approved by the secretary and incorporating information collected through semi-annual surveys of participating healthcare providers.

(e) The secretary shall develop uniform standards to be utilized by each managed care organization providing state medicaid or children's health insurance program services under the Kansas medical assistance program regarding:

(1) A standardized enrollment form and a uniform process for credentialing and re-credentialing healthcare providers who have signed contracts or participation agreements with any such managed care organization;

(2) procedures, requirements, periodic review and reporting of reductions in and limitations for prior authorization for healthcare services and prescriptions;

(3) retrospective utilization review of re-admissions that complies with any applicable federal statutory or regulatory requirements for the medicaid program or the children's health insurance program, prohibiting such reviews for any recipient of medical assistance who is re-admitted with a related medical condition as an inpatient to a hospital more than 15 days after the recipient patient's discharge;

(4) a grievance, appeal and state fair hearing process that complies with applicable federal and state statutory and regulatory procedure requirements, including any statutory remedies for timely resolution of grievances, appeals and state fair hearings, imposed upon managed care organizations providing state medicaid or children's health insurance program services; and

(5) requirements that each managed care organization, within 60 calendar days of receiving an appeal request, provide notice and resolve 100% of provider appeals, subject to remedies, including, but not limited to, liquidated damages if provider appeals are not resolved within the required time.

(f) The secretary shall procure the services of an independent auditor for the purpose of reviewing, at least once per calendar year, a random sample of all claims paid and denied by each managed care organization and each managed care organization's subcontractors.

(1) Each managed care organization and each managed care organization's subcontractors shall be required to pay any claim that the independent auditor determines to be incorrectly denied. Each managed care organization and each managed care organization's subcontractors may also be required to pay liquidated damages, as determined by the department of health and environment.

(2) Each managed care organization and each managed care organization's subcontractors shall be required to pay the cost of audits conducted under this subsection.

(3) The provisions of this subsection shall expire on January 1, 2020.

(g) The secretary shall require each managed care organization to pay 100% of the state-established per diem rate to nursing facilities for current medicaid-enrolled residents during any re-credentialing process caused by a change in ownership of the nursing facility.

(h) On and after the effective date of this section, a managed care organization providing state medicaid or children's health insurance program services under the Kansas medical assistance program shall not discriminate against any licensed pharmacy or pharmacist located within the geographic coverage area of the managed care organization that is willing to meet the conditions for participation established by the Kansas medical assistance program and to accept reasonable contract terms offered by the managed care organization.

(i) The secretary shall adopt rules and regulations as may be necessary to implement the provisions of this section prior to January 1, 2018.