

# **Role of the Department of Insurance**

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**Prompt pay reporting and the “clean  
claim” complaint process for  
Medicaid Managed Care Organizations**

# **KRS 304.99-123 –**

## **Penalties for noncompliance with KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135 and 304.99-123**

- Allows the Department of Insurance to issue fines of up to \$1,000 per day or 10 percent of the unpaid claim (whichever is greater) if an insurer fails to pay, deny or contest:
  - At least 95 percent of the clean claims received during a calendar quarter; or
  - At least 90 percent of the total dollar amount of the clean claims received by an insurer during a calendar quarter.
- A separate fine of up to \$10,000 may be levied for willful and knowing violations or if an insurer has a pattern of repeated violations.

## **KRS 304.17A-702 –**

### **Claims payment timeframes – Duties of insurer**

- Requires “clean” claims to be paid, contested or denied within 30 days of receipt.

***Note: A “clean” claim is a properly completed billing instrument – paper or electronic – including the required health claim attachments and submitted in the form outlined in statute.***

## KRS 304.17A-700

# “Clean Claim”

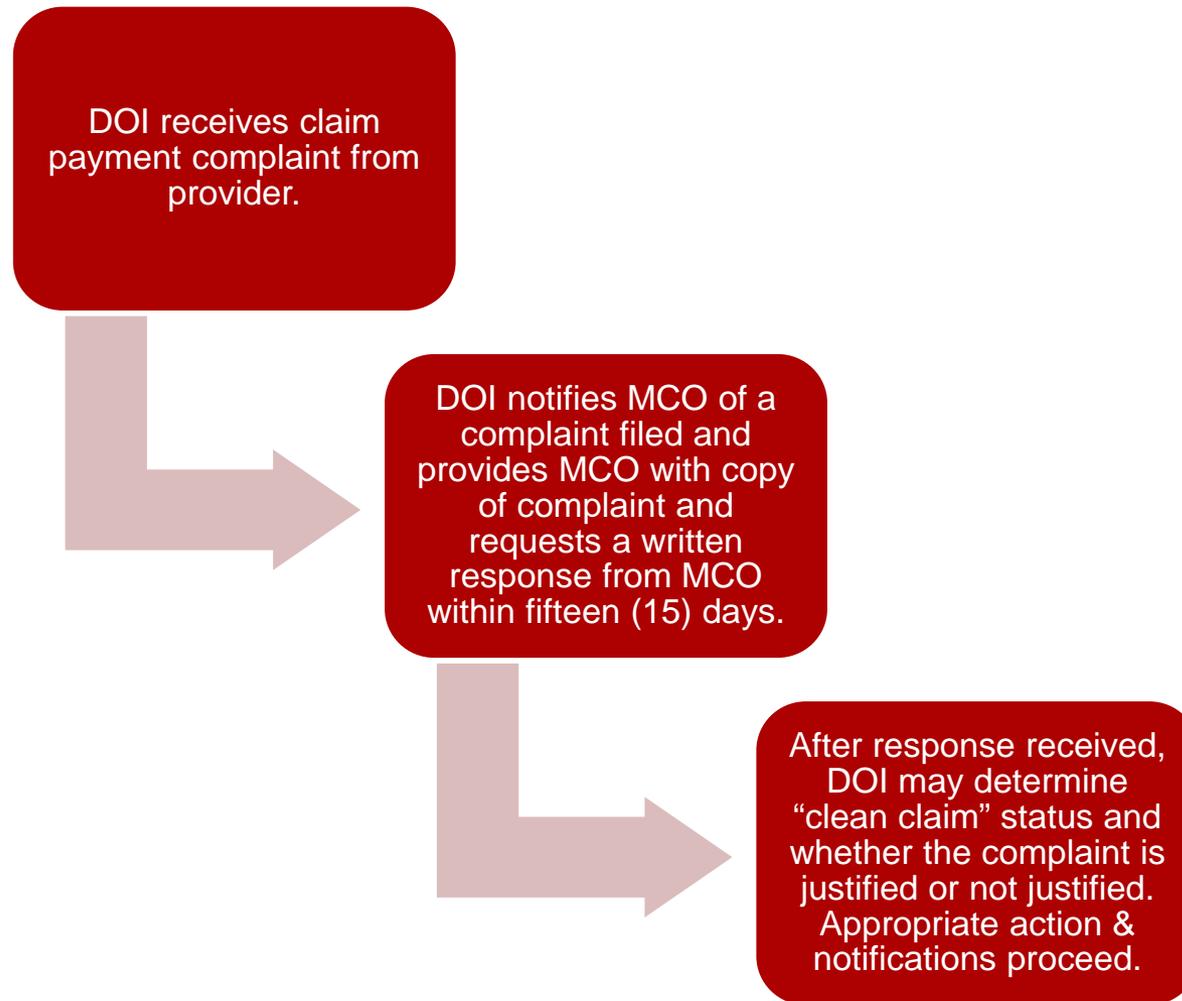
means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following applicable form:

- (a) A clean claim from an institutional provider shall consist of:
  1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
  2. Entries stated as mandatory by the NUBC; and
  3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.
- (b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.
- (c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.
- (d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

## **KRS 304.17A-730 – Payment of interest for failing to pay, denying or settling a clean claim as required**

- Requires insurers to pay interest at the applicable rate for failure to pay, deny or settle a claim within the 30-day period established in KRS 304.17A-702.
  - This interest attaches as a matter of law.

# Complaint Process



# Submitting a prompt payment complaint

➤ DOI website <http://insurance.ky.gov>

✓ ***File a Complaint***

✓ ***How to File a Medicaid Prompt Payment Complaint***

❖ Paper

- *Kentucky Department of Insurance Medicaid Prompt Payment Complaint Form* and submit all supporting documentation

❖ Electronic

- DOI website allows electronic submission
  - Go to Tab— ***File a Complaint*** —***Clean Claim Electronic Submission*** — the next step requires you to set up an E-Services Account—step by step instructions with graphics are provided in establishing an E-Services account.

# What does DOI need to efficiently & effectively process your complaint?

- Providers
  - Completed clean claim complaint form
  - Claims highlighted or specifically identified with a easily identifiable marking where DOI knows which services are being questioned
  - Copy of front and back of Member's ID card or copy from the MCOs' database confirming Member's status
  - Detailed explanation of complaint—for each services complaint is being filed for
    - What services are being complained about?
    - When was it originally submitted for payment?
    - Was it denied? Was it protested? Was it returned for more information?
    - How many times was it submitted and when?
    - Copy of pre-authorization if applicable
      - Has MCO provided a copy of all services requiring pre-authorizations?
    - Timelines with dates and copies of correspondence

**KENTUCKY DEPARTMENT OF INSURANCE  
MEDICAID PROMPT PAYMENT COMPLAINT FORM**

*Please remember, without proper documentation,  
your complaint cannot be processed!  
Use this form or set up an eServices account to  
submit online.  
Questions: Call 800-595-6053 (toll free in KY) or  
502-564-6034*

*Mail this completed form and all supporting  
documentation to:  
Medicaid Prompt Payment Compliance Branch  
Kentucky Department of Insurance  
P.O. Box 517  
Frankfort, KY 40602-0517  
Or fax it to 502-564-6090*

**Provider Name:** \_\_\_\_\_ **Provider ID:** \_\_\_\_\_  
Provider Type (e.g., pharmacist, physician, etc.): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Contact Person Name (printed): \_\_\_\_\_  
(First) (Last)  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_  
*On behalf of the provider, I certify that the information included is correct:*  
Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
**Managed Care Organization (MCO) Name:** \_\_\_\_\_  
**Member Name:** \_\_\_\_\_ **Member ID #:** \_\_\_\_\_

**DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT**  
*(See next page to file for additional dates of service)*

Reason(s) for complaint:  Delays  Denials  Authorization  Recoupment  
 Medical Necessity  Claim recoding/bundling  Interest only  
 Unsatisfactory settlement/offer  Other: \_\_\_\_\_  
Date services rendered: \_\_\_\_\_ Amount of original claim: \$ \_\_\_\_\_  
Date claim first sent to MCO: \_\_\_\_\_ Sent by:  Mail  Electronic  
*(Attach copy of original claim (UP-92, EOP, HCFA-1500, etc.) with any attachments sent)*  
Are you a participating provider with the MCO?  Yes  No  
Has the MCO acknowledged receipt of the claim?  Yes  No If yes, when? \_\_\_\_\_ *(Attach copy)*  
Has the MCO denied receipt of the claim?  Yes  No *(If yes, attach any documented written proof of your transmittal)*  
Has the MCO denied/contested the claim in writing?  Yes  No *(If yes, attach copy)*  
Please specify code(s) denied and reason(s) for denial. *(Please attach on separate sheet)*  
Has the MCO made any payment?  Yes  No If yes, how much? \$ \_\_\_\_\_, and when? \_\_\_\_\_  
Has the MCO requested additional information?  Yes  No If yes, what information was provided by you to  
the MCO and when was it provided? \_\_\_\_\_  
\_\_\_\_\_ *(Attach copy)*

**Medicaid Prompt Payment Complaint Form--Additional Dates of Service**

*Feel free to make copies of this page if you have additional dates of service.*

Provider Name & ID: \_\_\_\_\_

Member Name & ID: \_\_\_\_\_

Reason(s) for complaint:     Delays    Denials    Authorization    Recoupment  
    Medical Necessity    Claim recoding/bundling    Interest only  
    Unsatisfactory settlement/offer    Other: \_\_\_\_\_

Date services rendered: \_\_\_\_\_ Amount of original claim: \$ \_\_\_\_\_

Date claim first sent to MCO: \_\_\_\_\_ Sent by:  Mail    Electronic  
*(Attach copy of original claim (UP-92, EOP, HCFA-1500, etc.) with any attachments sent)*

Are you a participating provider with the MCO?  Yes    No  
Has the MCO acknowledged receipt of the claim?  Yes    No   If yes, when? \_\_\_\_\_ *(Attach copy)*  
Has the MCO denied receipt of the claim?  Yes    No   *(If yes, attach any documented written proof of your transmittal)*  
Has the MCO denied/contested the claim in writing?  Yes    No   *(If yes, attach copy)*  
Please specify code(s) denied and reason(s) for denial. *(Please attach on separate sheet)*  
Has the MCO made any payment?  Yes    No   If yes, how much? \$ \_\_\_\_\_, and when? \_\_\_\_\_  
Has the MCO requested additional information?  Yes    No   If yes, what information was provided by you to the MCO and when was it provided? \_\_\_\_\_  
\_\_\_\_\_  
*(Attach copy)*

Reason(s) for complaint:     Delays    Denials    Authorization    Recoupment  
    Medical Necessity    Claim recoding/bundling    Interest only  
    Unsatisfactory settlement/offer    Other: \_\_\_\_\_

Date services rendered: \_\_\_\_\_ Amount of original claim: \$ \_\_\_\_\_

Date claim first sent to MCO: \_\_\_\_\_ Sent by:  Mail    Electronic  
*(Attach copy of original claim (UP-92, EOP, HCFA-1500, etc.) with any attachments sent)*

Are you a participating provider with the MCO?  Yes    No  
Has the MCO acknowledged receipt of the claim?  Yes    No   If yes, when? \_\_\_\_\_ *(Attach copy)*  
Has the MCO denied receipt of the claim?  Yes    No   *(If yes, attach any documented written proof of your transmittal)*  
Has the MCO denied/contested the claim in writing?  Yes    No   *(If yes, attach copy)*  
Please specify code(s) denied and reason(s) for denial. *(Please attach on separate sheet)*  
Has the MCO made any payment?  Yes    No   If yes, how much? \$ \_\_\_\_\_, and when? \_\_\_\_\_  
Has the MCO requested additional information?  Yes    No   If yes, what information was provided by you to the MCO and when was it provided? \_\_\_\_\_  
\_\_\_\_\_  
*(Attach copy)*

# Identifiable mark to indicate the service for the complaint — *see the circle*

**1500** HEALTH INSURANCE CLAIM FORM  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/95

KENTUCKY SPIRIT HEALTH-INSURANCE CLAIMS PROCESSING DEPARTMENT  
 PO BOX 400  
 BARRINGTON, MO 63640-4001

KENTUCKY  
 6411 000001

PAGE: 1

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER  
 (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  
 BROWN KYLIEGHL MAR

3. PATIENT'S BIRTH DATE  
 02 20 11

4. INSURED'S NAME (Last Name, First Name, Middle Initial)  
 BROWN KYLIEGHL MAR

5. PATIENT'S ADDRESS (See Street)  
 22 SUMMIT DR

6. PATIENT RELATIONSHIP TO INSURED  
 Self  Spouse  Child  Other

7. INSURED'S ADDRESS (See Street)  
 22 SUMMIT DR

8. PATIENT STATUS  
 Single  Married  Other

9. CITY STATE KY  
 PADUCAH KY

10. TELEPHONE (Include Area Code)  
 (619) 6384995

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. EMPLOYMENT? (Current or Previous)  
 YES  NO

13. INSURED'S DATE OF BIRTH  
 02 20 11 M  F

14. AUTO ACCIDENT? PLACE (State)  
 YES  NO

15. EMPLOYER'S NAME OR SCHOOL NAME  
 UNEMPLOYED

16. OTHER ACCIDENT? YES  NO

17. INSURANCE PLAN NAME OR PROGRAM NAME  
 KENTUCKY SPIRIT HEALTH-INSURANCE CLAIMS PROCESSING DEPARTMENT

18. IS THERE ANOTHER HEALTH INSURANCE PLAN?  
 YES  NO  If yes, return to and complete item 9 a-d.

19. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.  
 SIGNATURE ON FILE

20. SIGNATURE ON FILE

21. DATE OF CURRENT ILLNESS (First symptoms) OR SURGERY (Accepted) OR PREGNANCY (LMP)  
 MM DD YY

22. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE, MM DD YY

23. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

24. NAME OF REFERRING PROVIDER OR OTHER SOURCE  
 17a. NPI 17b. NPI

25. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY  
 FROM 11 13 2011 TO 01 13 2012

26. OUTSIDE LAB? YES  NO  \$ CHARGES

27. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Repeat items 1,2,3 or 4 to item 34E by Line)  
 1. 765 10 3. V30 01

28. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO.

29. DEAR AUTHORIZATION NUMBER  
 00003060488

30. TABLE OF SERVICES

LINE	A. DATE OF SERVICE FROM MM DD YY TO MM DD YY	B. DATE OF SERVICE TO MM DD YY	C. CPT/HCPCS CODE	D. PROCEDURE, SERVICE, OR SUPPLY (Repeat Unusual Circumstances)	E. DIAGNOSIS POINTER	F. CHARGES	G. NET AMOUNT PAID	H. ICD-9 CODE	I. QUALIFIER	J. RENDERING PROVIDER ID #
1	11132011	11132011	21	99222	123	25000	1	NP		64326627
2	11142011	11142011	21	99232	123	12000	1	NP		64326627
3	11152011	11152011	21	99232	123	12000	1	NP		64326627
4	11162011	11162011	21	99238	123	13500	1	NP		64326627
5								NP		
6								NP		

31. FEDERAL TAXPAYER IDENTIFICATION NUMBER (SSN EIN)

32. PATIENT'S ACCOUNT NO. 014-00100

33. ACCEPT ASSIGNMENT? YES  NO

34. TOTAL CHARGE \$ 62500

35. AMOUNT PAID \$ 000

36. BALANCE DUE \$ 62500

37. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on this invoice are true and correct.)  
 David A. Schell, MD

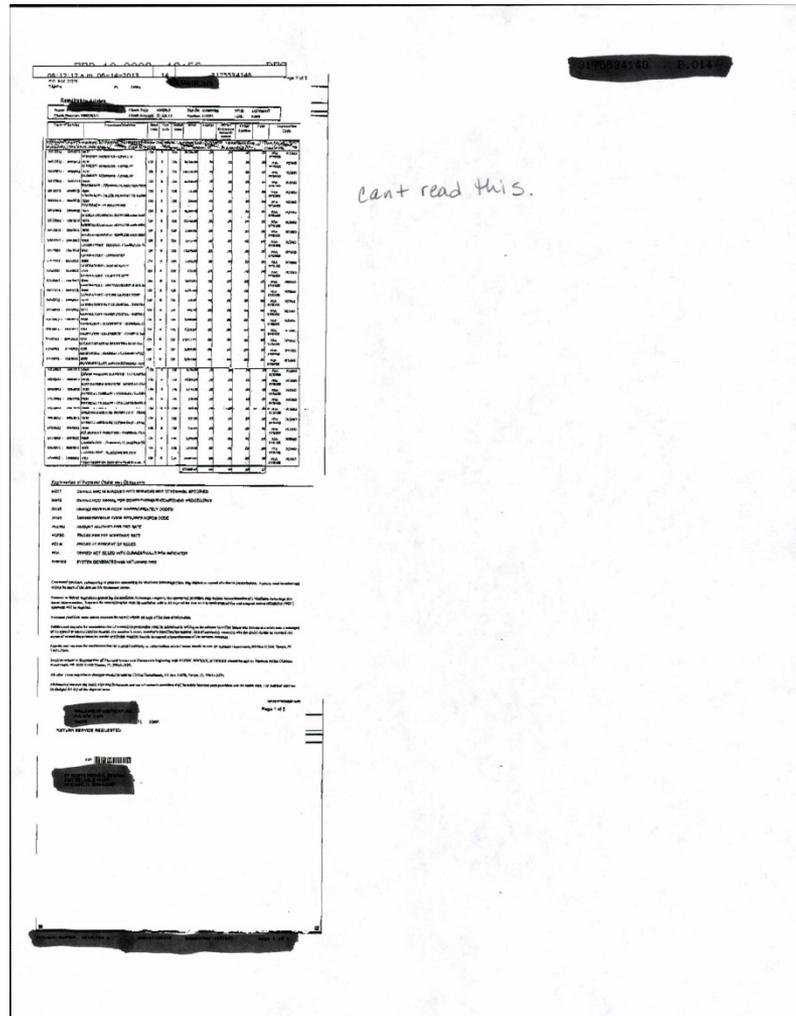
38. SERVICE FACILITY LOCATION INFORMATION  
 01 KENTUCKY AVENUE  
 PADUCAH KY 42003-3150

39. BILLING PROVIDER SWS & NPI #  
 64326627

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

# Please don't submit this as your supporting documentation



# What does DOI need to efficiently & effectively process your complaint?

## ❖ Managed Care Organizations—MCOs

- Acknowledgement of receipt of e-mails sent by DOI—either by automatic or manual
- More details in your explanation answering the complaint—be more specific
- Request extensions of time in writing and be precise with amount of time needed to complete requests—all extensions will be on a case by case basis and monitored

# *DOI Medicaid Prompt Payment Compliance Branch Process*

- Receive the complaint, review for attached documentation
- Enter the complaint by the individual member's name and assign a case number
  - Review the documentation to identify the number of claim lines associated with the individual member and identify which claims are in need of review.
  - Determine if additional information is needed from complaint and request if appropriate

# *DOI Medicaid Prompt Payment Compliance Branch Process*

- Notify the MCO in writing that a complaint has been received and provide a copy of the complaint to the MCO
  - The MCO is required to respond in writing to DOI within 15 days
- Upon receipt of the MCO's response, DOI will review and request additional information if necessary
  - DOI will make determination:
    - Clean Claim
    - Justified
    - Not Justified

# *DOI Medicaid Prompt Payment Compliance Branch Process*

- Notify the Provider and MCO of the determination
- If MCO is responsible for paying the claim, the claim is required to be paid within 30 days with interest if applicable
- MCO provides to DOI verification of payment at time of payment
- If either party disagrees with DOI determination, there are appeals processes which follow the Department of Medicaid Services appeals and hearings processes.

# Thank you

The Department of Insurance appreciates the cooperation of the Healthcare Service Providers, the Medicaid Managed Care Organizations and the Department for Medicaid Services as we collectively and cooperatively work to manage and improve the payment of claims and the delivery of healthcare for our citizens in the Commonwealth.

Please feel free to contact us if you have any questions.

<http://insurance.ky.gov>

800-595-6253