800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

May 01, 2024

RE: **Medicaid FFS Utilization Review Manual**

KFMC Health Improvement Partners (KFMC) is the Medicaid Fee-for-Service utilization review contractor for the Kansas Department of Health and Environment Division of Health Care Finance (KDHE-DHCF) to perform utilization reviews to safeguard against unnecessary utilization of services and ensure efficiency, economy, and quality of care to Kansas Medicaid members.

Our primary functions include the operation of a review system to monitor the quality, diagnosis and procedure validation, medical necessity, discharge appropriateness, and appropriateness of health care provided.

KFMC has provided a Utilization Review Manual for your reference related to this work. As a reminder, the identified Case Review Contact person within your facility will be the individual responsible for gathering, disseminating, and organizing any information needed during the review process.

As noted in the Medicaid Utilization Review manual, hospitals must furnish KFMC with the complete medical record for cases to be reviewed. If a hospital fails to provide KFMC with requested information within the required time frames at any point during the review process, a Technical Denial will be issued.

KFMC will accept medical records and review cases in the following formats:

- Electronically, following specific KFMC naming convention sent via KFMC's Secure File Transfer Process (SFTP)
- Secure electronic download from copy service company's login portals
- Images of medical records in PDF/Multi-page TIF format on encrypted removable media
- Hard copy

KFMC encourages the use of our Secure File Transfer Process. If you would like access to this site, please complete the Secure File Transfer User Access Agreement.

KFMC Secure File Transfer User Access

KFMC would like to share some common findings we encounter.

- Missing admission orders
- Missing Discharge summaries
- Procedure notes are printing in the middle of the patient orders

- Missing medical records for ALL days requested
- Copy services will send parts of the medical record but not the entire record
- Medical record documentation for all billed charges during Cost Outlier review
- Electronic records – we encourage everyone to communicate with your IT department or copy service to streamline what is exported or printed to decrease duplication. For example, multiple pages of discharge paperwork that is provided to the patient is duplicated in the copies of the records we receive. If you contract out services to a copy company, this may be an area for improvement and cost savings.
- Some operative records will print every field on a separate page even if there is no content within that field.
- Missing History & Physicals on outpatient surgery and ambulatory surgical cases
- History & Physical documentation – if H&P previously completed, referenced, and on file with the patient's medical records, it still needs to be provided for our review.
  For example: "*The patient has been re-examined and there were no significant clinical changes since the history and physical was performed*." This is not enough information and does not provide medical necessity support for the admission and/or procedure.

We want to thank everyone for their efforts to be efficient and complete as possible.

If you have any questions or need additional information, please contact me at 785-273-2552, x 366. KFMC is excited to continue working with you.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

Enclosures

2024
KFMC Health Improvement Partners Utilization Review Manual

Contract Number: 46430

Date: May 1, 2024

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

KFMC Health Improvement Partners (KFMC)
Medicaid FFS Utilization Review Manual
7/1/23-6/30/25

I. Introduction

KFMC Health Improvement Partners (KFMC) has been designated by the Kansas Department of Health and Environment, Division of Healthcare Finance (KDHE-DHCF) to provide utilization, DRG validation, and quality review services for the State of Kansas.

KFMC is a physician-sponsored organization. Our primary functions will include the operation of a review system to monitor the quality, diagnosis and procedure validation, medical necessity, discharge appropriateness, and appropriateness of health care provided.

II. Site and Timing of Review

A. Site of Review

All acute care hospitals and ambulatory surgical centers in Kansas, including border city hospitals designated by KDHE will be subject to KFMC's review of Kansas Medicaid FFS cases.

KFMC will review cases in a variety of formats through the Topeka location. KFMC will accept medical records in the following formats:

- Electronically, following specific KFMC naming convention sent via KFMC's Secure File Transfer Process (SFTP)
- Secure electronic download from copy service company's login portals
- Images of medical records in PDF/Multi-page TIF format on encrypted removable media.
- Hard copy

B. Timing of the Review Process

Weekly, KFMC pulls data from the fiscal agent identifying Medicaid fee-for-service claims for selection. KFMC will initiate review activities by selecting cases to be reviewed and notifying the hospitals and ambulatory surgical centers to make available those medical records that have been selected.

Hospitals must furnish KFMC with the complete medical record for cases to be reviewed. A complete medical record for a cost outlier selection includes the itemized bill with identified revenue codes and UB-04.

The facilities will be given thirty (30) calendar days from the date of the request to supply medical records to KFMC. If the information has not been received within twenty (20) calendar

days following the initial request, KFMC will issue a second request. If the facility is unable to provide the requested information by the close of business on the thirtieth (30th) day, a Technical Denial (TD) letter will be issued.

If a facility fails to provide KFMC with requested information, i.e., medical record, billing information, etc., within the required time frames at any point during the review process, a Technical Denial will be issued.

The "Technical Denial" is not eligible for reconsideration. However, KFMC is authorized to reopen the case if the hospital or ambulatory surgical center supplies the information at a later date not to exceed 90 days following the date of the Technical Denial letter (Hospital Provider Manual, Section 8410, pg. 8-48 to 8-49).

KFMC will initiate review activities immediately upon receipt of the medical records. If the Review Coordinators or Peer Reviewers are unable to complete the review due to missing an essential component of the medical record, the facility will be asked to submit the missing documentation within fifteen (15) calendar days of the date of the written notification. The hospital or ambulatory surgical center will be notified of the missing documentation in writing. If the documentation is not submitted within the required timeframe, a technical denial will be issued. Missing documentation will only be requested on records where the review cannot be completed. Completion timeframes for cases pended for missing documentation will extend 15 additional days.

C. Opportunity to Discuss

The following procedures will be used to give physicians and facilities an opportunity to discuss potential concerns.

A Review Coordinator will apply MCG® guidelines, DRG validation/coding guidelines, and coverage policies as applicable to selection categories. If the case does not meet guidelines, the Review Coordinator will summarize the potential concerns and refer the case to a Peer Reviewer.

A Peer Reviewer will review the referred concern(s) and make a decision applying his/her medical judgment. The Peer Reviewer will determine if each issue raised by the Review Coordinator is indeed a potential concern and if there is any other potential concern with the care provided which was not raised by the Review Coordinator. KFMC uses Kansas Peer Reviewers. Whenever possible, the Peer Reviewer will be from the same specialty as the attending physician (or source of the potential concern if different from the attending physician).

When a potential concern is identified by the initial Peer Reviewer, a Review Coordinator will use the referral information to create an inquiry letter. KFMC's notification process is designed to encourage the facility and physician(s) to discuss the concern and to prepare a joint response to KFMC.

1. When the issue involves an adverse decision that may affect reimbursement, the inquiry letters will be sent to the facility with a copy to the attending physician(s).

2. When the issue involves a quality of care decision, original inquiry letters will be sent to the individual physician(s) providing the care and the facility.

   If a physician involved in providing the questioned care was a resident or intern, the inquiry and final decision letters will be addressed to the attending physician and facility where the services were provided.

   If the hospital and/or physician(s) wish to discuss the case with KFMC following receipt of an inquiry letter they may call KFMC's toll-free number. Arrangements will be made for the physician to discuss a case with KFMC's Medical Director, if requested. A written response is required.

The hospital and physician(s) will be allowed twenty (20) calendar days to provide a response to an inquiry letter. The response may be provided by telephone followed by a written request. If a telephone discussion takes place, a KFMC staff member and/or Physician Reviewer will document the specifics of the telephone conversation for reference.

The hospital and/or physician(s) will be asked to follow-up the phone call with a letter documenting **the new information provided** to KFMC during the phone call. They will also be required to send a copy of the hospital's medical record, if not already in KFMC's possession. This written documentation should be sent to:

KFMC
800 SW Jackson, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext. 307
Fax: 785/273-0237
***E-mail: casereview@kfmc.org**
***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "This is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request **including new evidence or other additional information** to promote resolution of the stated concern (if new information is not provided, the case is not eligible for reconsideration); and
5. Medicaid recipient identification number (obtained from the first page of this letter).

Additional written information supplied by providers and/or physicians that do not desire discussion with KFMC should be sent directly to the address listed above. The information must be received within twenty (20) calendar days following the date of the inquiry letter.

Physicians and hospitals have the option to fax additional information on potential concerns to KFMC. The fax number is **(785) 273-0237**. The faxed information should include the same patient identification information as the written letter as noted above. KFMC encourages all faxes to be followed by the original letter via mail.

If no response to an inquiry letter with a potential concern is received, the case will not be sent to a second Reviewer. KFMC will consider the potential concern confirmed without additional review.

All additional information, including any written or telephone response received during the comment period, and the medical record will be available for review by a second Reviewer. The second Reviewer will determine if each potential concern is confirmed or resolved.

KFMC will send a final decision letter following the determination on every case for which an initial inquiry letter was sent. The hospital and all involved physicians will be notified of resolved issues as well as notified of confirmed concerns.

III. Review Functions

The following review functions will be performed on cases, as applicable to selection category selected for review (unless otherwise directed by KDHE) as well as specific case referrals as requested by KDHE. The purpose for each review function is identified below.

A. Admission Review

Admission Review is to determine if the admission was medically necessary and if the medical services were provided in the most appropriate setting. The medical record will be reviewed by a KFMC Review Coordinator using appropriate guidelines. If the admission cannot be approved using the guidelines, the case will be referred to a Peer Reviewer for a decision regarding the medical necessity of the admission.

B. Discharge Review

Discharge Review is to determine if the patient was medically stable on discharge from all settings or if the discharge was initiated prematurely. The medical record will be reviewed retrospectively by a Review Coordinator using the appropriate guidelines and his/her own clinical expertise. If the discharge cannot be approved using the guidelines, the case will be referred to a Physician Reviewer for a decision regarding the appropriateness of the discharge.

C. DRG Validation Review

DRG Validation Review is to determine if the diagnostic and procedural information that led to the DRG assignment is correct and substantiated in the medical record. Coding validation will include a review for:

- Correct ICD-10-CM diagnosis and procedure codes;
- Correct sequencing of principal diagnosis/procedure code;
- Validation of principal diagnosis by comparison to approved criteria; and
- Information comparison from the claim to the medical record documentation to validate the correct sex, age, patient disposition, diagnoses, and procedures.

Whenever the diagnoses/procedures, as shown on the claim, are not supported by the clinical information in the medical record, the information will be further analyzed by a Reviewer/Peer Reviewer.

If the diagnosis is not reported on the claim but clearly documented in the medical record by the physician, the Review Coordinator may add the diagnosis without a referral to a Peer Reviewer.

Whenever the principal diagnosis/procedure codes are incorrectly coded or sequenced, a Review Coordinator will revise the codes following standard ICD-10-CM coding conventions. In the case where a medical issue is present, the issue will be referred to a Peer Reviewer.

If the diagnosis and/or procedure information changed during the initial review is determined to be incorrect by the second Reviewer, the diagnoses/procedures will be revised to a new DRG.

A RHIA, RHIT, CCS, or CCA with extensive coding experience and several years' experience with the DRG reimbursement system will be responsible for the overall DRG validation process.

D. CPT Validation Review

CPT Validation Review is to determine if the diagnosis/procedure information submitted on the claim is supported by the documentation in the medical record and to determine if the correct CPT code was assigned.

E. Coverage Review

Coverage Review is to determine if the services provided are in compliance with the KDHE coverage guidelines. The medical record will be reviewed by a Review Coordinator applying the appropriate KDHE coverage guidelines. If a medical decision is indicated prior to making a coverage determination, the case will be referred to a Physician Reviewer. Whenever the treatment provided is not included as a covered service, notification of coverage denials will be issued.

F. Quality Review

Quality Review is to determine if professionally recognized standards of care are met. Those cases requiring quality review failing a guideline or determined by the Review Coordinator to contain a potentially gross and flagrant quality problem will be referred to a Peer Reviewer for a determination.

G. Length of Stay Review

Length of Stay Review is to determine if the days billed beyond the DRG day limit is medically necessary. The medical record will be reviewed by a KFMC Review Coordinator using appropriate guidelines. If the days billed beyond the DRG day limit cannot be approved using the guidelines, the case will be referred to a Peer Reviewer for a decision regarding the medical necessity of each questioned day.

H. Documentation Review

Documentation Review is to determine if the documentation present in the medical record is sufficient to complete a review. The medical record will be reviewed by a Review Coordinator applying the documentation guidelines. If documentation is missing, incomplete, or illegible, the Review Coordinator will determine if she/he is able to proceed with the review due to missing an essential component of the medical record.

If the Review Coordinator or Peer Reviewers are unable to complete the review due to missing an essential component of the medical record, the provider will be asked to submit the missing documentation within fifteen (15) calendar days of the date of the written notification. Providers will be notified of the missing documentation in writing. If the documentation is not submitted within the required timeframe, a technical denial will be issued. Missing documentation will only be requested on records where the review cannot be completed. Completion timeframes for cases pended for missing documentation will extend 15 additional days.

If able to proceed, the documented issue may be addressed in an inquiry letter to the facility.

IV. Case Selection Categories

The monthly case selection will be completed using the following selection categories:

- Cost Outliers
- Interim Bill Review
- Inpatient Hospital Admissions (Day Outliers)
- Inpatient Hospital Admissions (Short-term Stays)
- Inpatient Psychiatric Hospitals
- Readmissions

- Transfers
- DRG Validation (Higher-weighted DRGs)
- Hospital Inpatient Setting (Long-term Stays with a Single Comorbidity)
- Hospital Inpatient Setting (Long-term Stays with No Comorbidities)
- Hospital Inpatient Setting (Long-term Stays with Multiple Comorbidities)
- Ambulatory Surgery Center
- Outpatient Surgery

A. Cost Outliers

KFMC will review cost outlier claims. A cost outlier is defined as an acute hospital admission where total charges have exceeded the Medicaid FFS defined trim point for the assigned DRG.

For those cases selected for cost outlier review, the hospital must provide a copy of the medical record, a copy of the itemized bill sufficiently detailed for KFMC to identify each single item or service billed, and the UB-04 within thirty (30) calendar days of the request.

Each record will also be reviewed to determine if all services provided were medically necessary and appropriate. Cases will be referred to a Peer Reviewer if they cannot be approved by the Review Coordinator using established clinical and coverage guidelines. If the admission was medically necessary, but individual items/services were found to be unnecessary or non-covered, costs for these items/services will be subtracted from total costs.

Outlier reviews examine itemized bills to determine if the services are covered benefits, if charges are reasonable and medically necessary, and if the services should be bundled with the room and board charge. If there are itemized charges which should be denied on the outlier review, these charges will be deducted from the total billed amount. The resulting adjusted total billed amount will be used to perform the DRG payment calculation. Guidelines for outlier reviews include:

- The room and board revenue code, as defined by the UB-04 guidelines and Uniform Billing Editor, indicates the level of care provided to the patient. This code also provides information on the national "usual and customary" charges for that level of room and board. Normally, this rate includes the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.
- Routine supply items found in the "floor stock" would generally be available to all patients receiving supplies in that location. The supply items are included in the general cost of the room in which the services are delivered and are not separately billable.
- Services identified in this *Hospital Fee-for-Service Provider Manual* as denied in an outpatient setting may also be reviewed during inpatient cost outlier review to determine if these services are medically appropriate and separately billable from the room and board charge.

- If the charge is not a covered benefit, it will be denied during the outlier review.
- The item must be medically necessary, furnished at the direction of a physician, and delivered to or used on or for the patient for whom it was ordered.
- Charges for personal comfort items requested by the patient are excluded from coverage. The patient may be charged for such a service if he or she requested it with knowledge that they will be charged. If the patient is not informed, they may not be charged, and the provider will not receive any reimbursement for these charges.
- Pharmacy or implant charges greatly exceeding NADAC cost will be denied during the outlier review.

B. Readmissions

KFMC will retrospectively review hospital readmissions that occur after discharge from the same or another hospital. When calculating the readmission time frame, the day of admission and the day of discharge will not be counted. Utilization review of readmissions will occur for beneficiaries who are readmitted as an inpatient to a general hospital between 1 and 15 days of discharge.

Readmission (Same Day)
When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms related to or for evaluation and management of the prior stay's medical condition, hospitals must combine onto a single claim. If a claim for the first stay has already been filed and paid, the hospital must initiate an adjustment and combine both the original and subsequent stay onto a single claim.

When a patient is discharged or transferred from an inpatient hospital and is readmitted to the same inpatient hospital on the same day for symptoms unrelated to or not for evaluation and management of the prior stay's medical condition, hospitals must bill for two separate stays on two separate claims.

The readmission pairs will be reviewed to determine if a patient was medically stable on discharge or prematurely discharged resulting in a readmission. If the readmission was to the same hospital and the physician reviewer determined it was the direct result of a premature discharge, the readmission will be denied. If a premature discharge resulted in an admission to a different hospital, a denial of payment for the first admission will occur. If the first stay of the readmission pair is determined to be an appropriate discharge and the physician reviewer determined the second stay was medically unnecessary, the readmission will be denied.

Medical records shall be reviewed to determine if the readmission was the result of an inappropriate discharge from the initial admission based on one of the following criteria:

- A medical readmission for a continuation or recurrence for the initial admission or closely related condition (e.g. readmission for diabetes following an initial admission for diabetes).

- A medical complication related to an acute medical complication related to a care during the initial admission (e.g. patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).
- An unplanned readmission for a surgical procedure to address a continuation or a recurrence of a problem causing the initial admission (e.g. readmitted for appendectomy following a primary admission for abdominal pain and fever).
- An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection).
- The unplanned readmission is the result of a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards prior to discharge or during the post-discharge follow-up period.
- An issue caused by a premature discharge from the same facility.
- Readmission is medically unnecessary.

The following are excluded from readmission review:

- Readmission that is planned (such as for repetitive treatments, i.e. cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments).
- Readmission due to malignancies, burns, cystic fibrosis, or anemia.
- Readmission due to bone marrow transplants.
- Obstetrical admission.
- Readmission that stems from an initial stay discharge status of "left against medical advice".
- Admission to a skilled nursing facility (SNF), long-term acute care facility (LTAC), or inpatient rehabilitation facility (IRF).
- Admission for treatment when the primary diagnosis is psychiatric.
- Transfer of patient to receive care not available at the first facility.

C. Inpatient Psychiatric Hospital

KFMC will retrospectively review inpatient psychiatric hospital admissions to determine if the admission was medically necessary, appropriate DRG assignment, and if the patient was medically stable on discharge.

D. Transfers

KFMC will retrospectively review inpatient hospital transfers to determine if the transfer was medically necessary, appropriate DRG assignment, and if the patient was medically stable on transfer.

All patient-initiated transfers are subject to utilization review. When a patient transfers from an inpatient hospital bed to a swing-bed unit and acute care continues to be provided, payment for

the swing-bed will be denied or recouped. The only purpose for this type of transfer is for the hospital to obtain reimbursement beyond the DRG payment.

E. Ambulatory Surgery

KFMC will retrospectively review cases involving ambulatory surgery performed in ambulatory surgery centers. The purpose of the review will be to ensure that surgical procedures performed in an ambulatory setting are medically necessary, meet professionally recognized standards of care, and are billed in compliance with KDHE policies and coverage guidelines.

Procedural coding validation will be conducted to ensure the accuracy of CPT procedure codes appearing on the claim.

F. Day Outliers – Inpatient Hospital Admissions

KFMC will review day outlier claims. A day outlier is defined as an acute hospital admission in which the length of stay exceeds the Medicaid FFS defined trim point for the assigned DRG exceeding outlier status as defined by the Fiscal Agent. The purpose for review of day outliers is to determine if care is provided at the appropriate level of care for each day of hospitalization.

G. Short Stays – Inpatient Hospital Admissions

KFMC will review one and two day stays to determine if the admission was medically necessary. To identify a short-stay admission, the length of stay is calculated including the day of admission and excluding the day of discharge.

If the case cannot be approved by the Review Coordinator using established guidelines, it will be referred to a Physician Reviewer.

H. DRG Validation (Higher-weighted DRGs)

KFMC will retrospectively review claims identified through analysis of adjusted claims and the sequential change in the assigned DRG weights. If a claim showed a change to a higher weight from the originally assigned DRG, the case will be identified for review.

I. Multiple, Single, or No Comorbidity Complications – Hospital Inpatient Setting

KFMC will review claims for appropriate code assignment where there are comorbid/complication code(s) identified on the claim that impacts the DRG assignment.

J. Outpatient Surgery

KFMC will retrospectively review cases involving outpatient surgery. The purpose of the review will be to ensure that surgical procedures are medically necessary, meet professionally recognized standards of care, and are billed in compliance with KDHE policies and coverage guidelines.

Procedural coding validation will be conducted to ensure the accuracy of CPT procedure codes appearing on the claim.

K. Interim Bill Review

KFMC will retrospectively review interim bills to determine the appropriate DRG for the entire length of stay. Cost-outlier review will also be performed. Stays billed on an interim basis will be reviewed as an entire stay once the final bill is processed and paid.

V. Reconsiderations, Appeals and Administrative Hearings and Support

A. Reconsideration

The purpose of the KFMC reconsideration process is to allow the hospital or attending physician an opportunity for a reconsideration when dissatisfied with an adverse review determination. If a response to an inquiry letter is received by KFMC after the final determination letter has been sent to the involved parties, the response will be considered a request for reconsideration. The reconsideration process applies to all adverse determinations. Requests based on eligibility or coverage issues are not eligible for reconsideration. A reconsideration determination will be based upon:

- The information and documentation that led to the initial adverse determination.
- The information and documentation found in the medical record.
- Additional medical information and documentation submitted by those involved parties previously not received.

Peer reviewers who have not had previous involvement with the case in question will reconsider the adverse decision. KFMC continues to match the specialty and setting of the peer reviewer whose issue is under review.

Process Timeframes

A request for reconsideration must be submitted in writing to KFMC within thirty (30) calendar days from the date of the notice of the adverse determination.

Content of a Request

A request for reconsideration can be made by any party notified of the adverse determination and must be submitted in writing to KFMC and should state, "This is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request **including new evidence or other additional information** to promote resolution of the stated concern (if new information is not provided, the case is not eligible for reconsideration); and
5. Medicaid recipient identification number (obtained from the first page of this letter).

Notification

Following completion of reconsideration activity, a written notice of the determination will be sent to all involved parties. The written notice will contain the rationale for the reconsidered determination and a statement informing the parties of their appeal rights.

KFMC's reconsidered utilization and DRG determinations are final and binding upon all parties unless an appeal is filed with the State of Kansas, Department of Administration, Office of Administrative Hearings or the reconsidered determination is later reopened and revised by KFMC. KFMC's reconsidered determinations for quality are final and binding upon all parties. There is no further appeal mechanism unless the determination is later reopened and revised by KFMC.

Reopening/Revisions to a Reconsidered Determination

KFMC's reconsideration determinations may be reopened and revised within one year from the date of the reconsideration determination notice if:

- There is a clerical error in the statement of the reconsideration determination that directly affects the outcome of the reconsideration.
- There is an apparent error in the evidence on which the reconsideration determination was based; or
- KFMC is directed by the Kansas Department of Health and Environment.

B. Administrative Fair Hearing

KFMC will work closely with KDHE-DHCF staff to provide all the necessary medical record documentation, overview of the review process, the initial determination letter, provider/practitioner reconsideration request, and outcome of the KFMC reconsideration process for use in the administrative and/or Fair Hearing. KFMC will assemble an agency summary for review and approval by the KDHE-DHCF State Fair Hearing Manager. Upon approval, KFMC will deliver the agency summary to the Office of Administrative Hearings (OAH) and provide a mailing of the agency summary to the appellant. It is understood that participation by the contractor will include live testimony at the administrative Fair Hearings and presentation of the case in addition to outside depositions and participation discussions with KDHE-DHCF as needed.

KFMC will attend all hearings in person and present the case to the Administrative Judge at the OAH.

VI. Optional Review Intervention

Kansas Department of Health and Environment may select an isolated case(s) for review. At that time, KFMC will proceed with review as requested.

VII. Confidentiality and Disclosure of Information

KFMC has developed policies and guidelines that ensure KFMC compliance with all security and confidentiality regulations. If you desire additional details, please contact KFMC.

If the UR contractor elects to use an independent physician reviewer other than their inhouse medical director or staff, the identity of the physician reviewer will be kept confidential and not disclosed if the UR contractor does all of the following:

- The UR contractor or its staff reviews the same medical records as were used by the independent physician reviewer.
- The UR contractor or its staff reviews the conclusions of the independent physician reviewer.
- The UR contractor reaches the same or substantially the same conclusions as the independent physician reviewer.
- The UR contractor or a member of its staff who participated in the review is present at and testifies in any administrative hearing, trial, or judicial proceeding concerning the UR review.

The UR contractor or its staff may testify as to the qualifications of the independent physician reviewer without waiving the above identity protection of the independent physician reviewer.

The UR contractor or its staff may offer a copy of the report from the independent physician reviewer where the identity of the independent physician reviewer is redacted and deleted from the report without waiving the above identity protection of the independent physician reviewer.

The "need to testify" requirement (as satisfied by the foregoing paragraph) shall not apply in reviews of administrative decisions or in judicial reviews unless the UR contractor or its staff are specifically subpoenaed to appear and testify in that proceeding. If the identity protection is allowed in the lower level proceeding, that protection will continue throughout a review process. The purpose for the above identity protection is to ensure a forthright and candid peer review assessment of the medical records by a physician reviewer.

VIII. Attachments

A. Criteria-Guidelines for Case Review
B. Template Letters for Case Review

KFMC
CRITERIA/GUIDELINES FOR CASE REVIEW

KFMC will use written guidelines to conduct case review. Criteria utilized by KFMC will be submitted to the Kansas Department of Health and Environment for review and approval. The criteria will be used by non-physician reviewers to screen cases. The Kansas Medical Assistance Program (KMAP) Provider Manuals are a reference for all areas.

The following references will be used by KFMC when conducting retrospective review activities:

A. **Utilization Review Criteria**
   1. MCG guidelines

B. **Quality Criteria**
   1. MCG Guidelines

C. **Discharge Criteria**
   1. MCG Guidelines

D. **DRG/CPT Validation Criteria**
   1. International Classification of Disease (ICD), Clinical Modification Code book
   2. American Hospital Association (AHA) Coding Clinic for ICD code assignment
   3. AHA Coding Handbook
   4. CMS Coding Clarifications
   5. ICD Coding Conventions
   6. The Merck Manual
   7. American Medical Association (AMA) Current Procedural Terminology (CPT) Code book
   8. AMA CPT Assistant

E. **Coverage Criteria**
   1. KMAP Hospital Provider Manual.

F. **Ambulatory Surgery Criteria**
   1. MCG Guidelines

G. **Discharge**
   1. MCG Guidelines

H. **Cost Outlier**
   1. KMAP Hospital Provider Manual
   2. Uniform Billing (UB) Editor
   3. UB04 Claim Form Directions
   4. KMAP Coverage Guidelines

I. **Length of Stay**
   1. MCG Guidelines

KFMC
TEMPLATE LETTERS FOR CASE REVIEW

Template letters are provided below.

MEDICAID FEE-FOR-SERVICE (FFS)
KFMC HEALTH IMPROVEMENT PARTNERS
800 SW Jackson Street, Suite 700 / Topeka, Kansas 66612
Telephone: (785) 273-2552 Toll-free: 1-800-432-0770 x340 FAX: (785) 273-0237

RECORDS REQUEST

DATE OF FIRST REQUEST: 03/21/2023 SELECTION DATE: 03/21/2023

CASE REVIEW CONTACT
FACILITY NAME
FACILITY ADDRESS
CITY, ST ZIP

X **Routine Selection**

Attached is a listing of the medical records needed for review. Please submit these cases in their entirety within **30** calendar days of the date of this letter. **KFMC would prefer medical record(s) to be sent electronically**, but will accept medical records in the following formats:

1. Electronically, following specific KFMC naming convention sent via KFMC's Secure File Transfer Process (SFTP). If you DO NOT have access please contact KFMC at 1-800-432-0770.
2. Secure electronic download from copy service company's login portals.
3. Images of medical records in PDF/Multi-page TIF format on encrypted removable media. File name must include patient name.
4. Hard copy.

For ambulatory or outpatient surgery records, please send documentation of medical necessity rationale for procedure, e.g. office notes, prior treatment, history and physical.

___ **Cost Outlier Selection - The following documentation MUST be received with the record(s):**

1. Itemized Bill with REVENUE CODES
2. UB04

PLEASE NOTE: The totals of the UB04 & Itemized Bill should match the total of the submitted claim.

PLEASE RETURN THIS LETTER AND THE ENCLOSED LIST OF SELECTED CASES ALONG WITH THE REQUESTED INFORMATION TO:

KFMC Health Improvement Partners
Attn: Review Assistant
800 SW Jackson Street, Suite 700
Topeka, KS 66612

___ **SECOND REQUEST** For: ___Medical Record ___Itemized Bill With Revenue Codes ___Copy UB04

Your hospital was notified of the medical records and/or billing information to be copied and/or retrieved for KFMC review. It is a requirement that the requested information be supplied to KFMC within 30 days of the first request. KFMC acknowledges that the 30 day time frame has not lapsed; however, in order to comply with established procedures, a second notice/reminder letter is being sent to your facility.

KFMC would prefer medical record(s) to be sent electronically, but will accept medical record(s) in the following formats:

1. Electronically, following specific KFMC naming convention sent via KFMC's Secure File Transfer Process (SFTP). If you DO NOT have access please contact KFMC at 1-800-432-0770.
2. Secure electronic download from copy service company's login portals.
3. Images of medical records in PDF/Multi-page TIF format on encrypted removable media. File name must include patient name.
4. Hard copy.

If your facility fails to supply the medical records and/or billing information (if applicable) by **April 20, 2023** KFMC is required to issue a Technical Denial/No Medical Record. Reference: KMAP Fee-for-Service Provider Manual, Section 8410 page 8 - 45.

If you have recently made these records available to KFMC, please call immediately at 1-800-432-0770 x340.

If you have any questions, do not hesitate to contact KFMC's Review Team at 1-800-432-0770 x340.

HOSPITAL: 123456789A FACILITY NAME - CITY, ST **NPI:** 1234567890

ICN MCAID ID #	PATIENT NAME	AGE DOB	PT CONTROL # MRN	SELECTION	SERVICE DATES FROM	 THRU
1234567891234 00123456789	LAST, FIRST M	23 01/01/2000	ABCD1234567890 M012345678	AMBSC 03/21/2023	02/01/2023	02/02/2023

NUMBER OF RECORDS: 1

NOTE(S):

1. **Please return a copy of this list with the medical records.**

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
NOTIFICATION OF BILLING ERROR

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization. KFMC reviews Medicaid Fee-for-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

The hospitalization identified above appears to have been billed inappropriately. We are advising the Kansas Medicaid FFS Program of this determination.

[Billing Issue]

For reimbursement, the hospital must submit a corrected FFS claim to the Kansas Medical Assistance Program.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: follow processes outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to

request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding the information in this letter, please contact the Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext. 340
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

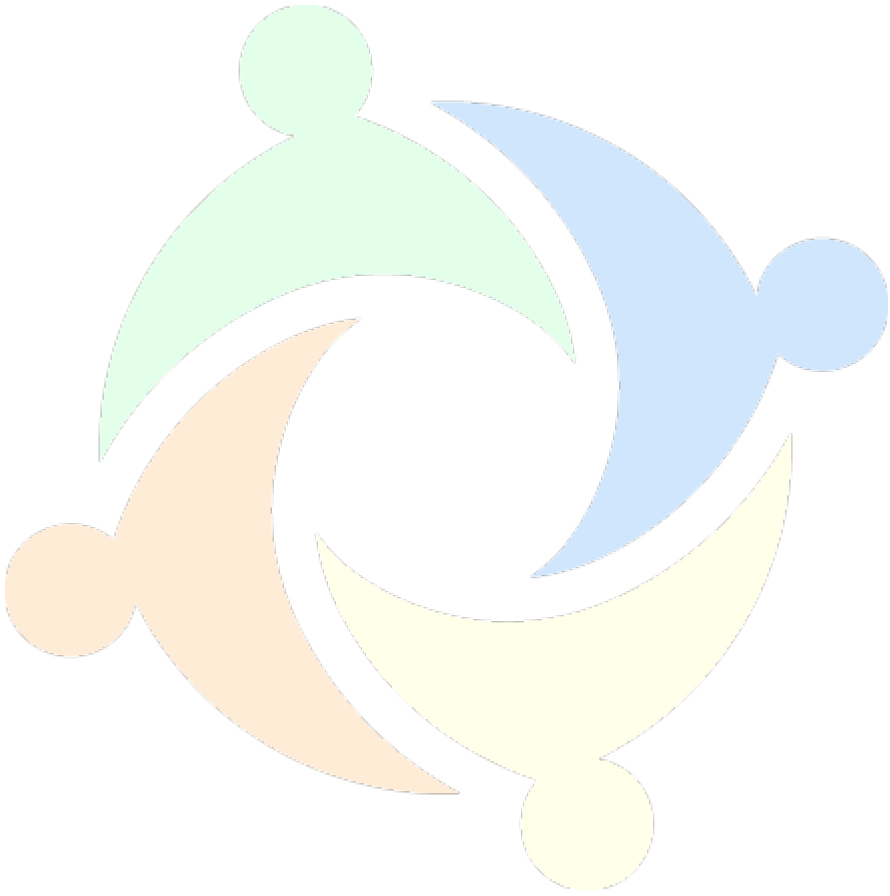
Sincerely,

Michelle Sigmund
Director of Clinical Care Review & Quality Improvement

xc: Hospital Business Office, Medicaid Claims

Patient: (RC14A) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.



800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
NOTICE OF BILLING INQUIRY

[Date]

[Hospital Name & Address]

Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

Kansas Health Improvement Partners (KFMC), under contract with Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), has reviewed the Medicaid Fee-for-Service (FFS) case identified above. KFMC reviews Medicaid cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

The episode of care referenced above has been reviewed. Based upon review of the medical record provided by the facility, the following concern(s) has/have been raised regarding the billing:

This inquiry provides you an opportunity to submit additional documentation. Your response, along with a copy of this letter should be received at the address in the heading of this letter no later than (enter date 10 days from the date of this letter). The hospital should not resubmit a claim to the Fiscal Agent at this time. Please direct your response to KFMC's Medicaid Case Review Team at:

KFMC
800 SW Jackson, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext. 340
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

If a response is not received within the ten (10) day time frame, the preliminary decision described in this letter will become the final determination.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

(RC21A) 06/01/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
NOTICE OF RESOLVED BILLING CONCERN

Selection Date:
Patient Name:
Medicaid ID#
From Date:
To Date:
FFS ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization. KFMC reviews Medicaid Fee-For-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

A KFMC reviewer has reviewed the medical record for the hospitalization identified above. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq. You were given an opportunity to discuss this case with us and this letter will serve as notification of the determination. Based on the information in the medical record, and any additional information provided, the following concern(s) has/have been resolved:

Determination of Reviewer:

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: follow processes outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override. Please include a copy

of this letter.

Please send any corrected claims, including a copy of this letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

At the present time no other action will be taken by KFMC except informing the hospital by this letter.

If you have any questions regarding this letter, please contact the Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

Patient Name:
KFMC/ns (RC22A) 06/01/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF COVERAGE DENIAL, TPL

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization.

At least 10 (ten) calendar days prior to this notification, your facility was provided an opportunity to submit additional information regarding investigation, payment or denial of third-party payment related to this patient's hospitalization. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq.

The Kansas Medical Assistance Program (Medicaid) is secondary payor to all other insurance programs and should be billed only after payment or denial has been received from such carriers. Documentation available to KFMC on the date of this notice indicates:

[Reason for denial]

Do not re-submit the claim. The amount paid for these services will be recouped by KDHE-DHCF. Any and all services by ancillary providers, including physicians, during these non-covered days will be recouped. KDHE-DHCF has an established minimum adjustment amount. Amounts less than the minimum adjustment will not be processed by KDHE-DHCF.

If the hospital and/or physician believe the findings described above are incorrect, they have a right

to request reconsideration within thirty (30) days from the date of this notice. You must submit your request for reconsideration in writing directly to:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request including new evidence or other additional information to promote resolution of the stated concern;
5. A copy of this letter.

If the request for reconsideration is not received according to the procedure outlined above, this determination will become final within thirty (30) calendar days from the date of this notice. When this determination becomes final, KDHE-DHCF will recoup the amount paid for the non-certified services.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: follow processes outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days

from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF COVERAGE INQUIRY, TPL

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4915, et seq., K.S.A. 65-4921 42 U.S.C. § 1320(c)-9, et seq.

The Kansas Medical Assistance Program is secondary payor to all other insurance programs and should be billed only after payment or denial has been received from such carriers. The medical record indicates:

Issue to be addressed

This inquiry provides you an opportunity to submit additional documentation. Your documentation along with a copy of this letter and the medical record (unless previously mailed to KFMC) should be received no later than (date 10 days from the date of this letter) . Please direct your response to the Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

If no response is received by the due date, a notice of Coverage Denial will be issued, and the amount paid for these services will be recouped by KDHE-DHCF. Additionally, any and all services by ancillary providers, including physicians, during these non-covered days will be recouped.

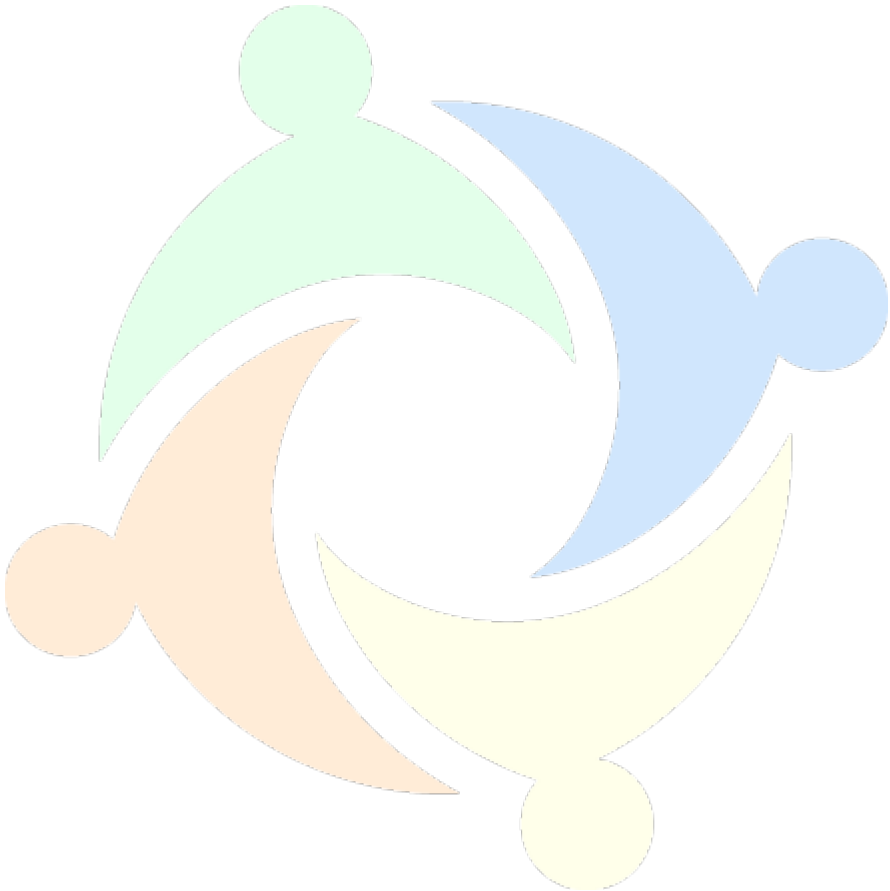
Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

(RC19A) 06/01/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.



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Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
COVERAGE RESOLVED CONCERN

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization. KFMC reviews Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

A KFMC reviewer has reviewed the medical record for the hospitalization identified above. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq. You were given an opportunity to discuss this case with us and this letter will serve as notification of the determination. Based on the information in the medical record, and any additional information provided, the concern(s) has/have been resolved.

The response from (enter name of person responding to billing inquiry) was received and appreciated.

Determination

If you have any questions regarding this letter, please call KFMC.

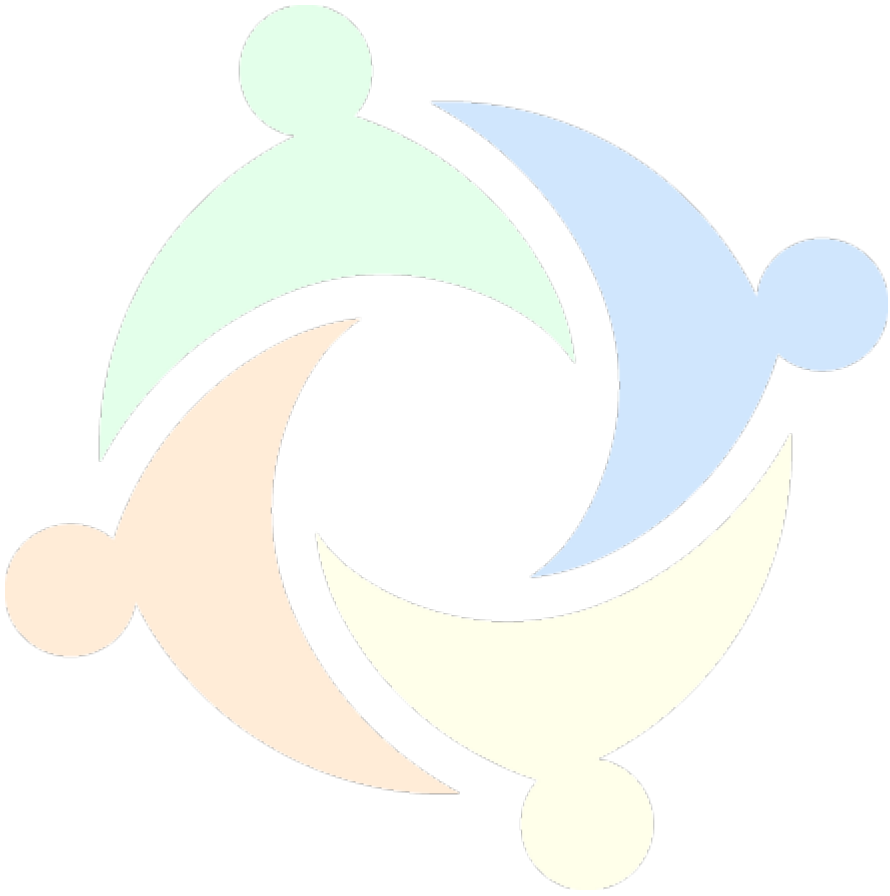
Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

Patient Name:
KFMC/ (RC23A) 06/01/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.



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Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
CPT INQUIRY

Date

CR Contact name/address

Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

The Medicaid FFS case identified above was selected by KFMC Health Improvement Partners (KFMC) for retrospective review under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). We are required to perform validation on all cases selected for review to ensure the diagnostic and procedural codes reported by the facility and resulting in the assignment by the fiscal agent are supported by physician documentation in the medical record. The information in this letter is confidential and may be redisclosed only in accordance with regulations found in 42 CFR 480.107-108. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921 42, et seq., U.S.C. § 1320(c)-9, et seq.

The episode of care referenced above has been reviewed. Based upon review of the medical record provided by the facility, the following question(s) has/have been raised concerning the diagnoses/procedures submitted.

Review Coordinator's Questions:

Preliminary Determination of Peer Reviewer, who is Board Certified in (PR Specialty): (If not reviewed by PR: NA)

We recognize the medical record may not give a complete clinical picture and the source of a problem may not be readily apparent. Therefore, we are sending this inquiry simultaneously to the physician(s) involved in the care and to the facility. A coordinated response is encouraged, although each letter recipient may reply individually.

You are being provided an opportunity to comment on this case. A written response from the facility, addressed to the KFMC Case Review Manager at the address in the heading of this letter, must be received by **(enter date 20 days from date of letter)** ***(along with a copy of this letter)***. Please direct your response to KFMC's Case Review Manager:

KFMC
800 SW Jackson, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

If a response is not received within the twenty (20) day timeframe, the preliminary decision described in this letter will become the final determination.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

If not reviewed by PR use Michelle's signature and delete Dr. Tipton's
Or if reviewed by PR, delete Michelle's signature and use Dr. Tipton's

Kyle Tipton, MD
Medical Director

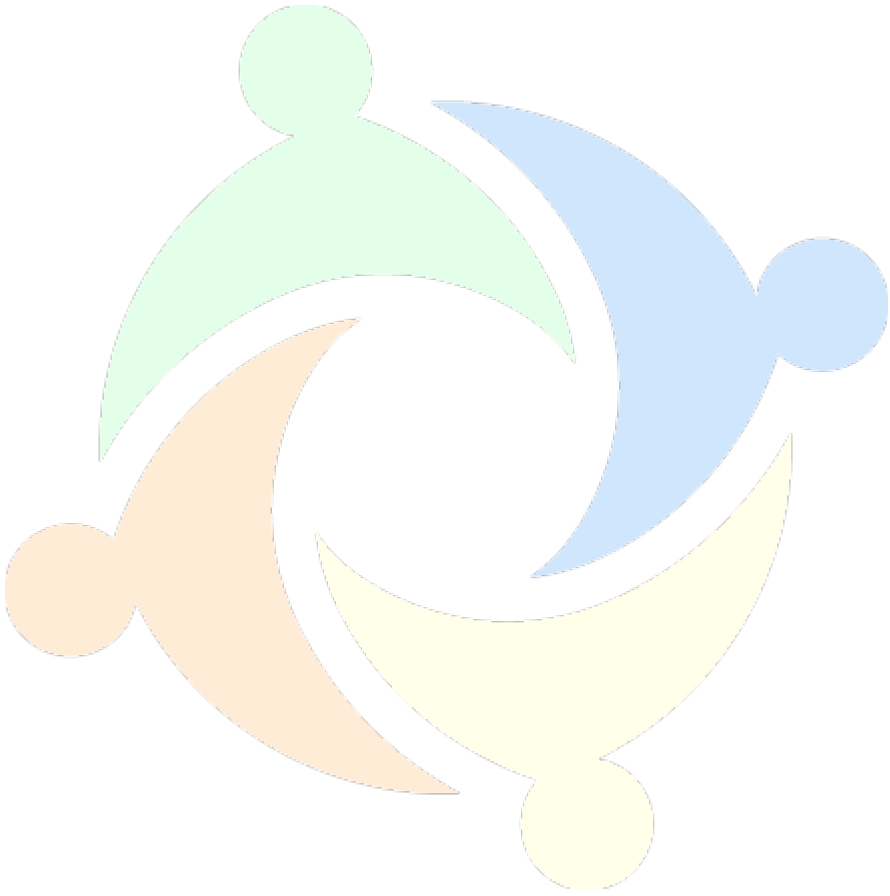
XC: Responsible physician

Patient: Patient name

KFMC/nas

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance

Portability and Accountability Act (HIPAA) and implementing regulations.



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Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF CPT RESOLVED CONCERN

[Date]

[Facility name/address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

The Medicaid case identified above was selected by the KFMC Health Improvement Partners (KFMC), for retrospective review under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). We are required to perform validation on all cases selected for review to ensure the diagnostic and procedural codes reported by the facility and resulting in the assignment by the fiscal agent are supported by the physician's documentation in the medical record.

A KFMC reviewer (if reviewed by PR, enter "who is Board Certified in" and the PR's specialty) , has reviewed the episode of care referenced above. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq. You were given an opportunity to discuss this case with us and this letter will serve as notification of the final determination. Based on the information in the medical record, and any additional information provided, the following concern(s) has/have been resolved.

Determination of Reviewer:

The response from (name of person responding to the ASC inquiry) was received and appreciated.

Determination

At the present time no other action will be taken by KFMC except informing the physician and/or the hospital by this letter. If you have any questions regarding this letter, please contact KFMC's

Case Review Manager at:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

If not reviewed by PR use Michelle's signature and delete Dr. Tipton's
Or if reviewed by PR, delete Michelle's signature and use Dr. Tipton's

Kyle Tipton, MD
Medical Director

XC: Physician name

Patient:

KFMC/nas (ASC02) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
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Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF CPT REVISION

[Date]

[Facility name/address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

The Medicaid case identified above was selected by Kansas Health Improvement Partners (KFMC), for retrospective review under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). We are required to perform validation on all cases selected for review to ensure the diagnostic and procedural codes reported by the facility and resulting in the assignment by the fiscal agent are supported by the physician's documentation in the medical record.

A KFMC reviewer has reviewed the episode of care referenced above. In accordance with regulations found in 42 CFR 480.107-108.This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, 42 U.S.C. § 1320(c)-9, et seq.

Based on the medical record and any other available information, we have changed the code(s). This revision is attributed to the hospital: yes__ no___(X either yes or no)

Determination of Reviewer: (If reviewed by PR, add: who is Board Certified in *[Specialty])*

If no response to inquiry, add "No response was received following the ASC Inquiry"

If response received, add "The response from [name of person responding to the ASC inquiry] was received and appreciated".

If no response to ASC inquiry, copy determination from ASC inquiry letter, or if case went to 2nd PR, enter 2nd PR's determination

We are advising the Kansas Medicaid Program of these changes. KDHE-DHCF has an established minimum adjustment amount If the CPT revision results in less than the "minimum adjustment" amount it will not be processed by KDHE-DHCF. The hospital does not need to resubmit a claim to the Fiscal Agent.

If the hospital and/or physician believe the findings described above are incorrect, they have a right to request reconsideration within thirty (30) days from the date of this notice. You must submit your request for reconsideration in writing directly to:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request including new evidence or other additional information to promote resolution of the stated concern;
5. A copy of this letter.

If the request for reconsideration is not received according to the procedure outlined above, this determination will become final within thirty (30) calendar days from the date of this notice. When this determination becomes final, KDHE-DHCF will recoup the amount paid for the non-certified services.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: follow processes outlined in the KMAP provider manuals. If

the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct any overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

If not reviewed by PR use Michelle's signature and delete Dr. Tipton's
Or if reviewed by PR, delete Michelle's signature and use Dr. Tiptons's

Kyle Tipton, MD
Medical Director

XC: (Responsible Physician)
Business Office, Medicaid Claims

Patient:

KFMC/nas (ASC05) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
DRG INQUIRY

[Date]

[Hospital Name & Address]

Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

The Medicaid case identified above was selected by KFMC Health Improvement Partners (KFMC) for retrospective review under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). We are required to perform diagnostic related group (DRG) validation on all cases selected for review to ensure the diagnostic and procedural codes reported by the facility and resulting in the DRG assignment by the fiscal agent are supported by physician documentation in the medical record. The information in this letter is confidential and may be redisclosed only in accordance with regulations found in 42 CFR 480.107-108. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921 42, et seq., U.S.C. § 1320(c)-9, et seq.

The episode of care referenced above has been reviewed. Based upon review of the medical record provided by the facility, the following question(s) has/have been raised concerning the diagnoses/procedures submitted.

Review Coordinator's Question(s):

Type RC's question(s)

Preliminary Determination of Peer Reviewer, who is Board Certified in (Board Specialty): If no PR review, deleted "who is Board Certified in" and add N/A

Codes and narrative description (this section is N/A for disposition or age change only):

Claim Diagnosis Code(s)		KFMC Diagnosis Code(s)	

Claim Procedure Code(s)		KFMC Procedure Code(s)	

Claim DRG: KFMC DRG:

We recognize the medical record may not give a complete clinical picture and the source of a problem may not be readily apparent. Therefore, we are sending this inquiry simultaneously to the physician(s) involved in the care and to the facility. A coordinated response is encouraged, including new evidence or other additional information to promote resolution of the stated concern, although each letter recipient may reply individually. **If you previously queried the attending physician regarding the additional diagnosis, please include that documentation in your reply.**

You are being provided an opportunity to comment on this case. A written response, addressed to the KFMC Medicaid Case Review Team at the address in the heading of this letter, must be received by (enter date 20 days from the date of this letter). Please direct your response to the KFMC Medicaid Case Review Team at:

KFMC
800 SW Jackson, Suite 700 / Topeka, KS 66612
Telephone: 785/273-2552, ext. 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

If a response is not received within the twenty (20) day time frame, the preliminary decision described in this letter will become the final determination.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

or

Kyle Tipton, MD

Medical Director
If reviewed by PR, delete Michelle's signature. If not reviewed by PR, delete Dr. Tipton's signature

XC: Physician

Patient:
KFMC/nas (RC03A) 06/01/2020

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
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www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
DRG RE-REVIEW RESULT LETTER

[Date]

[Name/address of person requesting re-review]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) has completed the re-review of a DRG revision for the above-named Medicaid recipient. The information in this letter is confidential and may be redisclosed only in accordance with regulations found in 42 CFR 480.107-108. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915 et seq., K.S.A. 65-4921 et seq., 42 U.S.C. § 1320(c)-9, et seq.

Based upon the documentation in the medical record, it was the decision of the KFMC reviewer to [confirm, modify, or resolve] the final DRG revision that was issued by KFMC. Listed below are the appropriate diagnoses and procedure codes:

Claim Diagnoses Code(s)		**KFMC Initial Diagnoses Code(s)**		**KFMC Final Diagnoses Codes(s)**	

Claim Procedure Code(s)		**KFMC Procedure Diagnoses Code(s)**		**KFMC Final Procedure Codes(s)**	

Claim DRG:		**KFMC Initial DRG:**		**KFMC Final DRG:**	

Determination of Reviewer:

The response from (name of person asking for the re-review) was received and appreciated.

The determination of this re-review is final and effective on the date of this letter. To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: Follow process outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance

Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you should have any questions regarding the information contained in this letter, please contact KFMC's Medicaid Case Review Team at:

KFMC.
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

Or

Kyle Tipton, MD
Medical Director

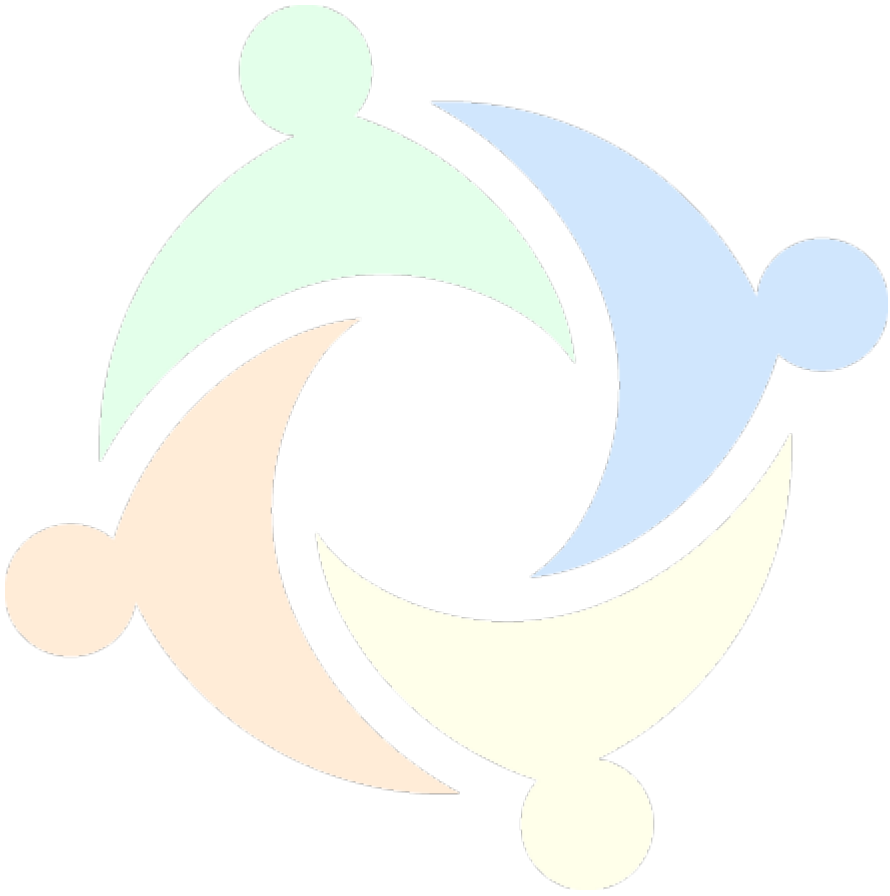
If reviewed by a PR, delete Michelle's signature. If no PR review, delete Dr. Tipton's signature

XC: Hospital Business Office, Medicaid Claims
Physician, unless physician was one requesting re-review
If re-review requested by someone other than Case Review Contact, xc CR Contact

Patient Name:
KFMC/nas

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a

manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.



800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
NOTICE OF DRG RESOLVED CONCERNS

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization. KFMC reviews Medicaid Fee-for-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting. The information in this letter is confidential and may be redisclosed only in accordance with regulations found in 42 CFR 480.107-108. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921 42, et seq., U.S.C. § 1320(c)-9, et seq.

A KFMC reviewer, who is Board Certified in (PR Specialty, if no PR, delete "who is Board Certified in") has completed a review of the medical record for the hospitalization identified above. You were given an opportunity to discuss this case with us and this letter will serve as notification of the final determination. Based on the information in the medical record, and any additional information provided, the following concern(s) has/have been resolved:

Determination of Reviewer:

The response from (name of person responding to DRG Inquiry) was received and appreciated.

Determination

Codes and narrative description:

Claim Diagnosis Code(s)		KFMC Diagnosis Code(s)	

Claim Procedure Code(s)		KFMC Procedure Code(s)	

Claim DRG: KFMC DRG:

At the present time no other action will be taken by KFMC except informing the physician and/or the hospital by this letter.

If you have any questions regarding this letter, please contact the KFMC Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

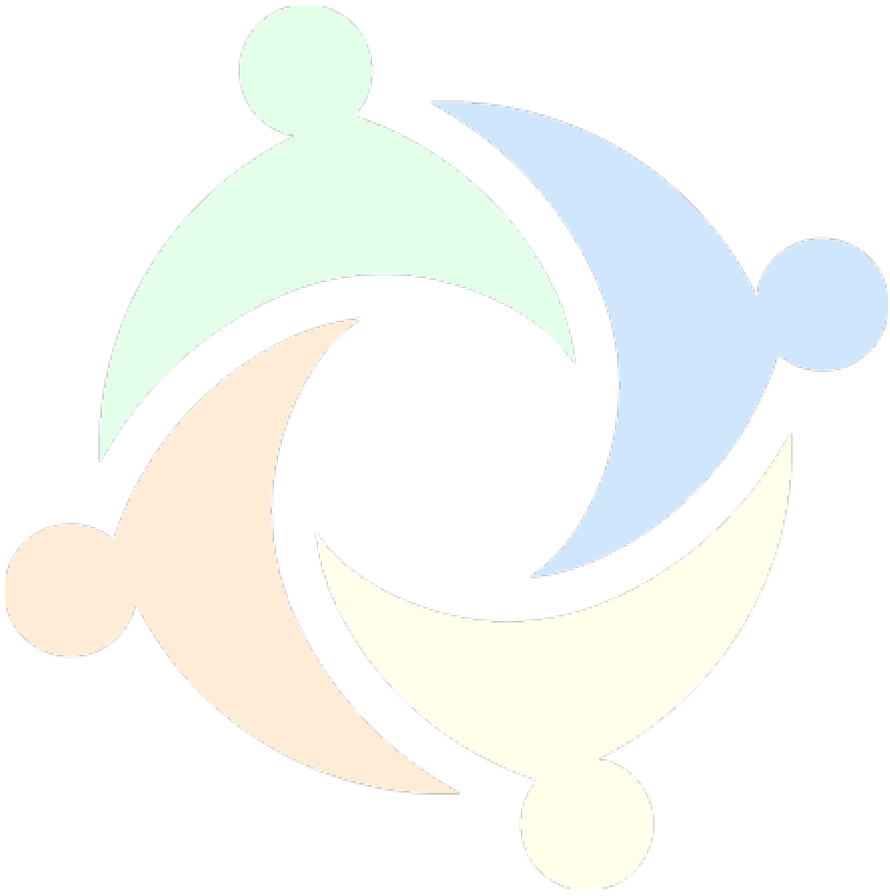
or

Kyle Tipton, MD
Medical Director
If reviewed by PR, delete Michelle's signature, if no PR, delete Dr. Tipton's signature

XC: Physician

Patient:
KFMC/nas

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.



800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF DRG REVISION

[Date}

[Hospital Name & Address]

Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

The Medicaid case identified above was selected by KFMC Health Improvement Partners (KFMC), for retrospective review under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). We are required to perform diagnostic related group (DRG) validation on all cases selected for review to ensure the diagnostic and procedural codes reported by the facility and resulting in the DRG assignment by the Fiscal Agent are supported by the physician's documentation in the medical record.

A KFMC Peer Reviewer, who is Board Certified in has reviewed the episode of care referenced above. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq. Based on the medical record and any other available information, we have changed the code(s). This revision is attributed to the hospital: _ yes _ no

Determination of Reviewer:

If response received: The response from (name of person responding) was received and appreciated.

If no response received: No response was received following the DRG Inquiry.

Determination

Codes and narrative description (this section is N/A for disposition or age change only):

Claim Diagnosis Code(s)		KFMC Diagnosis Code(s)	

Claim Procedure Code(s)		KFMC Procedure Code(s)	

Claim DRG: KFMC DRG:

We are advising the Kansas Medicaid Fee-for-Service (FFS) Program of these changes. KDHE-DHCF has an established minimum adjustment amount. If the DRG revision results in less than the "minimum adjustment" amount it will not be processed by KDHE-DHCF. The hospital does not need to resubmit a claim to the Fiscal Agent.

If the hospital and/or physician believe the findings described above are incorrect, they have a right to request a re-review within thirty (30) days from the date of this notice. You must submit your request for a re-review in writing directly to the KFMC Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a re-review request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the re-review request, including new evidence or other additional information to promote resolution of the stated concern and
5. A copy of this letter.

A copy of the complete medical record must accompany the request, unless a copy is already in KFMC's possession. If the request for a re-review is not received according to the procedure outlined above, this determination will become final within thirty (30) calendar days from the date this notice was received.

Within thirty (30) calendar days of the determination becoming final you have the right to request an administrative fair hearing appeal pursuant to K.A.R. 30-7-68 et seq. Within that time the written request for such an appeal should be received by the State of Kansas Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327. Failure to timely request or pursue such an appeal may adversely affect your rights on

any other judicial review actions.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: Follow process outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

or

Kyle Tipton, MD
Medical Director
If reviewed by PR, remove Michelle's Signature. If no PR review, remove Dr. Tipton's signature

XC: Hospital Business Office, Medicaid Claims
Physician

Patient:
KFMC/nas (RC08A) 06/01/2020

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800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF DENIED DAYS

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), has reviewed this hospitalization. KFMC reviews Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

A KFMC Peer Reviewer, who is Board Certified in (PR Specialty), has reviewed the medical record for the hospitalization identified above. This peer review report is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq. Based on the information in the medical record, and any additional information provided, it has been determined days through did not meet Medicaid's guidelines for payment.

Determination of Peer Reviewer:

[PR Determination]

Total denied days:

By copy of this letter the attending physician has been informed of this decision. This decision does not mean that this Medicaid recipient may not be hospitalized in the future for this or any other condition. It does mean, however, that the Kansas Medicaid Program has been informed a portion of this hospitalization is not certified.

If the hospital and/or physician believe the findings described above are incorrect, they have a right to request reconsideration within thirty (30) days from the date of this notice. You must submit your request for reconsideration in writing directly to:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request including new evidence or other additional information to promote resolution of the stated concern;
5. A copy of this letter.

If the request for a reconsideration is not received according to the procedure outlined above, this determination will become final within thirty (30) calendar days from the date of this notice. When this determination becomes final, KDHE-DHCF will recoup the amount paid for the non-certified services. All monies paid on this claim will be recouped per KDHE-DHCF guidelines. Once recoupment has occurred, the hospital must submit a corrected claim, indicating non-covered days, to the Kansas Medical Assistance Program for reimbursement on Medicaid approved days.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

> LESS THAN 24 MONTHS OLD: follow processes outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the “Timely Filing ICN” field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

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Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Kyle Tipton, MD
Medical Director

XC: Hospital Business Office, Medicaid Claims
(Physician)

Patient:

KFMC/nas

(RC13A) 06/01/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
NOTICE OF CONFIRMED QUALITY DETERMINATION

[Date]

[Hospital Name & Address
Separate Letter to Provider]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) has reviewed this hospitalization. KFMC reviews Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting. Our primary purpose is to identify areas where care can potentially be improved and to provide feedback to physicians and facilities. This peer review is intended to be a collegial interaction with the goal of improving patient care. The information in this letter is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq.

A KFMC Peer Reviewer, who is Board Certified in (PR Specialty), has completed a review of the medical record for the hospitalization identified above. You were given an opportunity to discuss this case with us and this letter will serve as notification of the final determination. Based on the information in the medical record, and any additional information provided, the following quality concern(s) has/have been confirmed.

Determination of Peer Reviewer:

Enter either No response was received following the QA Inquiry, or – the response from (person responding) was received and appreciated.

[Issue]

The quality issue is confirmed to (Name/title of person/department)

At the present time no other action will be taken by KFMC except informing the physician and/or the hospital by this letter and entering this information into our database for pattern analysis. On an ongoing basis KFMC analyzes patterns of care for concerns which may have significance beyond this single episode. If such a pattern involving patient care provided by a physician and/or hospital is identified, there will be ample opportunity for the physician(s) and/or the hospital to address the issues with KFMC.

If the hospital and/or physician believe the findings described above are incorrect, they have a right to request reconsideration within thirty (30) days from the date of this notice. You must submit your request for reconsideration in writing directly to:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request including new evidence or other additional information to promote resolution of the stated concern;
5. A copy of this letter.

If you should have any questions, please contact KFMC at the above address.

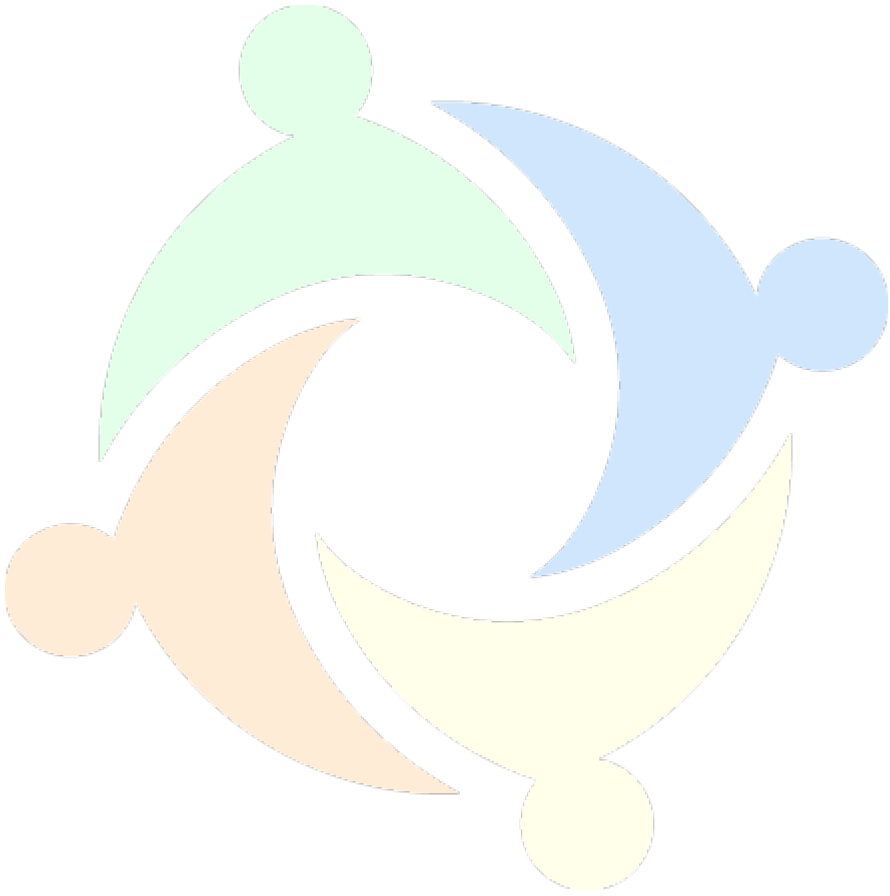
Sincerely,

Kyle Tipton, MD
Medical Director

Patient:

KFMC/nas (RC16A)06/01/2020

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.



800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
RE-REVIEW OF QUALITY CONCERNS - CONFIRMED

[Date]

[Name/Address of person requesting re-review]

Selection Date:
Patient Name:
Medicaid ID#
Admission:
Discharge:
ICN#:
MRN #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) is the designated QIO-like (Quality Improvement Organization) for the state of Kansas authorized by the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) to review inpatient hospital services provided to Medicaid recipients in the state of Kansas. We review Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting. Our primary purpose is to identify areas where care can potentially be improved and to provide feedback to physicians and facilities. This peer review is intended to be a collegial interaction with the goal of improving patient care. The information in this letter is considered confidential and is subject to the confidentiality and nondisclosure provisions of K.S.A. 65-4915, et seq., K.S.A. 65-4921, et seq., 42 U.S.C. § 1320(c)-9, et seq.

During the review process, the Peer Reviewer, who is Board Certified in (PR's Board Specialty), reviewed the medical record for the above-named Medicaid recipient. Based on information in the record, it had been determined a quality concern existed.

Determination of Peer Reviewer:

[copy original determination from QA Confirmed letter]

We have completed our re-review of the episode of care referenced above. A physician reviewer not involved in the initial review has carefully reviewed the medical record and any additional

information that was provided with the request for re-review. The following concern(s) has/have been confirmed by the Peer Reviewer:

Determination of Peer Reviewer:

[re-review determination]

At the present time no other action will be taken except informing you and the facility by this letter and entering this information into our database for pattern analysis. On an ongoing basis, KFMC analyzes patterns of care for concerns that may have significance beyond a single episode. If such a pattern involving patient care provided by a physician or facility is identified, there will be ample opportunity for the physician(s) and the facility to address the issues with the KFMC.

The decision is not eligible for Administrative Fair Hearing.

If you should have any questions regarding the information contained in this letter, please contact KFMC's Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Kyle Tipton, MD
Medical Director

Patient Name:

KFMC/nas (RE08A) 06/01/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health

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www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
RE-REVIEW OF QUALITY CONCERNS - RESOLVED

[Date]

[Hospital Name/Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR #:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), has reviewed this hospitalization. KFMC reviews Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting. Our primary purpose is to identify areas where care can potentially be improved and to provide feedback to physicians and facilities. This peer review is intended to be a collegial interaction with the goal of improving patient care. The information in this letter is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101.

During the review process, the KFMC Peer Reviewer, who is Board Certified in (PR Specialty), reviewed the medical record for the above-named Medicaid recipient. Based on information in the record, it had been determined a quality concern existed.

Determination of Peer Reviewer:

[original determination]

We have completed our re-review of the episode of care referenced above. A peer reviewer not involved in the initial review has carefully reviewed the medical record and any additional information that was provided with the request for re-review. The Peer Reviewer has determined no quality problem exists.

Determination of Peer Reviewer:

[re-review determination]

The quality concern originally assigned to (Name of QA originally assigned) is resolved.

At the present time no other action will be taken by KFMC except informing the physician and/or the facility by this letter.

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

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Sincerely,

Kyle Tipton, MD
Medical Director

Patient:
KFMC/nas (RE09A) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
ACKNOWLEDGMENT LETTER TO
REQUEST FOR RECONSIDERATION

[Date]

[Facility Name & Address]

Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
Medical Record #:

Dear :

Your request for a reconsideration of the (issue for reconsideration) issued for the above named Medicaid recipient has been received.

A copy of the medical record is currently in the KFMC office. However, any additional information ***(along with a copy of this letter)*** can be submitted in writing or via telephone but must be received by [10 days from date of letter].

A reviewer will base his/her decision on all available information. You will receive written notice of the outcome.

If you have any questions regarding this matter, please contact KFMC's Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext. 340
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Neta Smith
Senior Review Coordinator

XC:

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
UR RECONSIDERATION REVIEW DETERMINATION:

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) has completed the reconsideration that was requested for the above-named Medicaid recipient to review the termination of benefits decision that was recommended for this patient's hospitalization as indicated above. An opportunity to discuss this case was given to the facility and the physician. This peer review report is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101.

After a review of the medical record and any additional information provided the reviewer, a determination was made to the original denial decision made in this case.

Determination of Peer Reviewer, who is Board Certified in (Board Specialty):

Therefore, KFMC is recommending that benefits not be provided for specified in this letter.

Per Kansas Medical Assistance Program, Fee-for-Service Provider Manual, "When an inpatient hospital admission is determined not to be medically necessary by the utilization reviewer and results in recoupment of payment, the provider may resubmit the claim as an outpatient service. Providers will need to review the inpatient admission recoupment letter for instructions and time frames for resubmittal."

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: Follow process outlined in the KMAP provider manuals. If the

dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

The determination of this reconsideration is final and effective on the date of this letter. To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

If you have questions regarding this review, please contact KFMC at:

Medicaid Case Review Team
KFMC

800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org
***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Kyle Tipton, MD
Medical Director

XC: Hospital Business Office, Medicaid Claims

Patient:
KFMC/nas

(RE05A) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
PAST TIME ALLOWED
RECONSIDERATION REQUEST

[Date}

[Facility Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR#:
DOB:

Dear :

Reply is made to your letter received concerning your request for reconsideration of the . We understand from your letter you do not agree with the final determination recommended by the reviewer on this case. The decision was based on documentation in the medical record.

It will not be possible for KFMC to conduct a reconsideration for this case. As stated in the original denial letter dated, all requests for reconsideration must be received within 30 calendar days from the date of the denial letter. Since more than 30 calendar days have passed since the original denial, it will be necessary for you to contact the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) to obtain further review of this hospitalization.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of the original notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

If you have any questions regarding the information in this letter, please contact KFMC's Case Review Manager at:

KFMC
800 SW Jackson St, Suite 700 /Topeka, Kansas 66612
Telephone: 785/273-2552
*E-mail: casereview@kfmc.org

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Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

Patient:

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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MEDICAID FEE-FOR-SERVICE (FFS)
RECONSIDERATION REVIEW DETERMINATION: RESOLVED

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
Medical Record #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) has completed the Reconsideration that was requested for the above-named Medicaid recipient to review the termination of benefits decision that was recommended for this patient's hospitalization as indicated above. An opportunity to discuss this case was given to the facility and the physician. This peer review report is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101.

Following a request for the KFMC reconsideration, the KFMC Peer Reviewer, who is Board Certified in (PR's board specialty) , re-reviewed the medical record and any additional information provided. Based upon that information, the physician reviewer has determined the original concern has been RESOLVED.

Determination of Peer Reviewer:

This letter is to advise you of the reviewer's determination and to inform you that we are recommending to the State Medicaid Agency that benefits be paid for this hospitalization.

The Kansas Foundation for Medical Care has taken this action pursuant to the terms of a contract between KFMC and Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). The decision reached by KFMC is advisory only. The State maintains the final authority regarding claims payment.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: Follow process outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

If you have any questions regarding this information, please contact KFMC's Medicaid Case Review Team at:

KFMC
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Telephone: 785/273-2552
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Kyle Tipton, MD
Medical Director

XC:

Patient Name:
KFMC/

(RE06A) 6/1/2021

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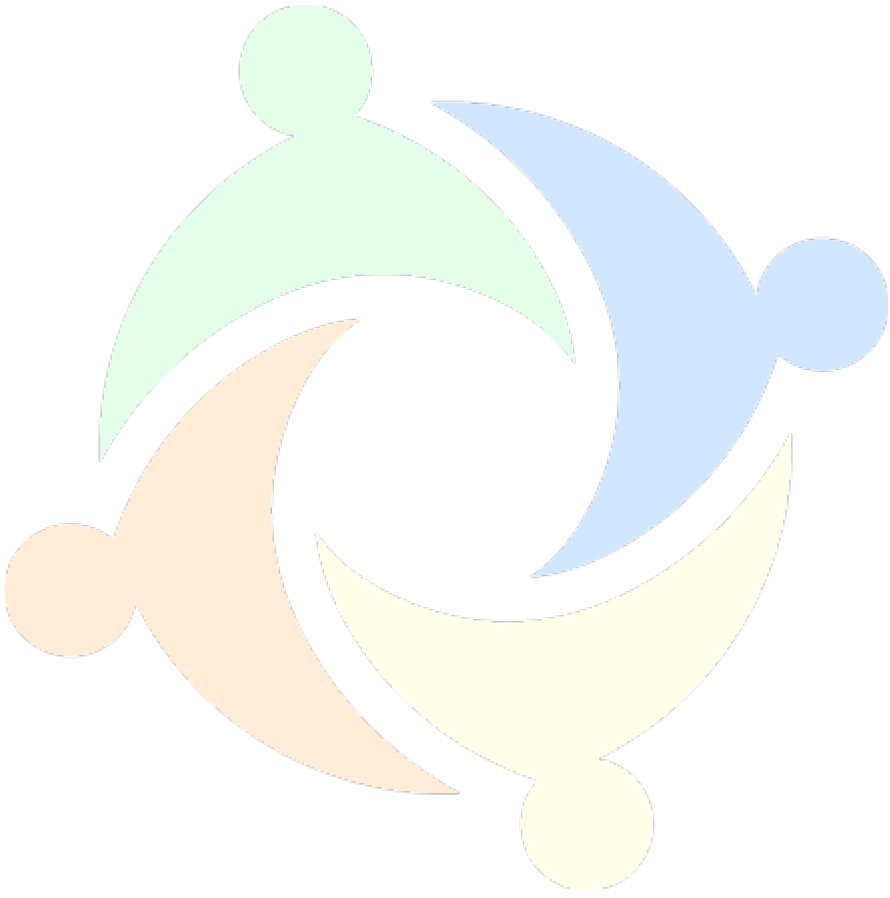
implementing regulations.



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Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS)
REOPENED CASE FOLLOWING
ISSUANCE OF A TECHNICAL DENIAL/MISSING DOCUMENTATION

[Date]

[Hospital Name/Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
Medical Record #:
DOB:

Dear :

The Medicaid case identified above was selected by the KFMC Health Improvement Partners (KFMC) for the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). Medicaid FFS cases are reviewed to determine if the services meet medically acceptable standards of care, are medically necessary and delivered in the most appropriate setting.

KFMC did not receive the specific documentation as requested for the hospitalization identified above. Therefore, a technical denial was issued on [Date TD Issued] .

The now been submitted by the hospital and KDHE-DHCF has approved the reopening of the case. Therefore, KFMC is able to proceed with the required case review activities.

If you have any questions concerning the information in this letter, please contact KFMC's Case Review Manager at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

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Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims

MS/nas

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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MEDICAID FEE-FOR-SERVICE (FFS)
DENIAL OF CASE REOPEN

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) reviews inpatient and outpatient services. KFMC reviews Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The hospital identified above did not submit the (documentation missing) necessary to complete the review for this hospitalization within the required timeframes as requested by KFMC. Therefore, certification for payment was technically denied on (Date of technical denial). The technical denial will become final on the 90th day from the date of the original KFMC technical denial letter. Any amount paid for the noncertified services will be recouped by KDHE-DHCF. According to KDHE-DHCF guidelines, technical denials are not eligible for reconsideration but may be reopened if the hospital supplies the information within 90 days of the original Technical Denial. Technical denial will still be charged to the hospital.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of the original notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

If you have any questions regarding this letter, please contact KFMC's Medicaid Case Review Team

at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: casereview@kfmc.org

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Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: KFMC File

(RC15B) 6/1/21

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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www.kfmc.org

MEDICAID FEE-FOR-SERVICE (FFS) TECHNICAL DENIAL:
_ NO MEDICAL RECORD _ NO ITEMIZED BILL _ NO UB 92/04
_ MISSING DOCUMENTATION

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#
Admission Date:
Discharge Date:
FFS ICN#:
Medical Record #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC) under contract with Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) reviews inpatient and outpatient services. KFMC reviews Medicaid FFS cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

The hospital identified above did not submit the information necessary to complete the review for this hospitalization within the required timeframes as requested by KFMC. The hospital failed to submit the (missing documentation). The technical denial will become final on the 90th day from the date of this Technical Denial letter. According to KDHE-DHCF guidelines, technical denials are not eligible for reconsideration but may be reopened if the hospital supplies the information within 90 days of this Technical Denial. Technical denial will still be charged to the hospital.

If you have questions concerning this notice, please contact KFMC's Medicaid Case Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

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To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

If the information necessary to complete the review for this hospitalization is not received within 90 days of this letter, a correction of this overpayment should be made. Please mail a check for the full amount, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit monthly payments will result in the debt being referred to the State Debt Set Off program and KDHE legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Michelle Sigmund, RHIT, CCS
Director of Clinical Care Review & Quality Improvement

XC: Hospital Business Office, Medicaid Claims
KFMC File

Patient:
KFMC/ (RC15A) 6/1/21

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
HOSPITAL NOTICE OF ADMISSION DENIAL

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
Medical Record #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), has reviewed this hospitalization. KFMC reviews Medicaid Fee-For-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

A KFMC Peer Reviewer, who is Board Certified in (PR Specialty) , has reviewed the medical record for the hospitalization identified above. This peer review report is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101. Based on the information in the medical record and any additional information provided, it has been determined the admission did not meet Medicaid's guidelines for payment because:

Determination of Peer Reviewer:

By copy of this letter the admitting physician has been informed of this decision. This decision does not mean that this Medicaid recipient may not be hospitalized in the future for this or any other condition. It does mean, however, that the Kansas Medicaid FFS Program has been informed this hospitalization is not certified.

Per Kansas Medical Assistance Program, Fee-for-Service Provider Manual, "When an inpatient hospital admission is determined not to be medically necessary by the utilization reviewer and results in recoupment of payment, the provider may resubmit the claim as an outpatient service. Providers will need to review the inpatient admission recoupment letter for instructions and time frames for resubmittal."

If the hospital and/or physician believe the findings described above are incorrect, they have a right to request reconsideration within thirty (30) days from the date of this notice. You must submit your request for reconsideration in writing directly to:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request including new evidence or other additional information to promote resolution of the stated concern;
5. A copy of this letter.

If the request for reconsideration is not received according to the procedure outlined above, this determination will become final within thirty (30) calendar days from the date of this notice. When this determination becomes final, KDHE-DHCF will recoup the amount paid for the non-certified services.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

> LESS THAN 24 MONTHS OLD: Follow process outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN" field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.
>
> OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program

Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Kyle Tipton, MD
Medical Director

XC: Hospital Business Office, Medicaid Claims

Patient:
KFMC/nas (RC07A) 6/1/21

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
PHYSICIAN NOTICE OF ADMISSION DENIAL

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), has reviewed this hospitalization. KFMC reviews Medicaid Fee-For-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting.

A KFMC Peer Reviewer, who is Board Certified in (PR Specialty), has reviewed the medical record for the hospitalization identified above. This peer review report is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101. Based on the information in the medical record and any additional information provided, it has been determined the admission did not meet Medicaid's guidelines for payment because:

Determination of Peer Reviewer:

KFMC has identified you as the admitting physician because you wrote the admission order on the medical record. All monies paid to you for this patient during this hospital stay may be recouped. This decision does not mean that this Medicaid FFS recipient may not be hospitalized in the future for this or any other condition. It does mean, however, that the Kansas Medicaid Program has been informed this hospitalization is not certified.

Per the Kansas Medical Assistance Program Fee-for-Service Provider Manual, Section 8410, page 8-49, "When an inpatient hospital admission is determined not to be medically necessary by the utilization reviewer and results in recoupment of payment, the provider may resubmit the claim as an outpatient service. Providers will need to review the inpatient admission recoupment letter for instructions and time frames for resubmittal."

If the hospital and/or physician believe the findings described above are incorrect, they have a right to request reconsideration within thirty (30) days from the date of this notice. You must submit your request for reconsideration in writing directly to:

Medicaid Case Review Team
KFMC
800 SW Jackson St, Suite 700/ Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

The letter should state, "this is a reconsideration request," and include:

1. Patient name;
2. Name of facility where service was provided;
3. Date of admission;
4. A specific reason for the reconsideration request including new evidence or other additional information to promote resolution of the stated concern;
5. A copy of this letter.

If the request for reconsideration is not received according to the procedure outlined above, this determination will become final within thirty (30) calendar days from the date of this notice. When this determination becomes final, KDHE-DHCF will recoup the amount paid for the non-certified services.

To request an Administrative Fair Hearing pursuant to K.A.R. 30-7-68 et seq., submit your written request within thirty (30) calendar days, plus three (3) days for mailing, from the date of this notice. The written request should be received by the State of Kansas, Department of Administration, Office of Administrative Hearings, 1020 South Kansas Avenue, Topeka, Kansas 66612-1327.

Following the utilization review, providers should review the findings and adjustments. Not all claims are eligible for correction/resubmission. For those that are, please resubmit as follows:

LESS THAN 24 MONTHS OLD: Follow process outlined in the KMAP provider manuals. If the dates of service on the claims are between 12 and 24 months old and the original claim was filed within 12 months of the date of service, please resubmit corrected claims through your normal processes. Be sure to include the ICN of the original claim in the "Timely Filing ICN"

field to avoid having the corrected claim deny for timely filing. You do not need to request timely filing overrides for claims meeting this criteria.

OLDER THAN 24 MONTHS OLD: If the dates of service on the claims are older than 24 months, please resubmit corrected paper claims to the address below. If providers are sending in corrected claims beyond 24 months old, and they are not received within 45 days from the date of the final denial letter, the claims will not be approved for timely filing bypass/override.

Please send any corrected claims, including a copy of the denial letter, that require 24-month timely filing override to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
Timely Filing Coordinator
PO Box 3571
Topeka, KS 66601-3571

In order to correct this overpayment, it will be recovered from future remittance advice payments. Any outstanding balance after 60 days of this letter should be refunded via a check, made payable to Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), to:

Kansas Department of Health and Environment
Division of Health Care Finance
Attn: Elaine Boeselager
PO Box 2428
Topeka, Kansas 66601

A copy of this letter should be included with your payments.

Failure to submit payments will result in the debt being referred to the State Debt Set Off program and KDHE/DHCF legal department for collection.

If you have any questions regarding this letter, please call KFMC.

Sincerely,

Kyle Tipton, MD
Medical Director

Patient:

KFMC/nas (RC07B) 6/1/2021

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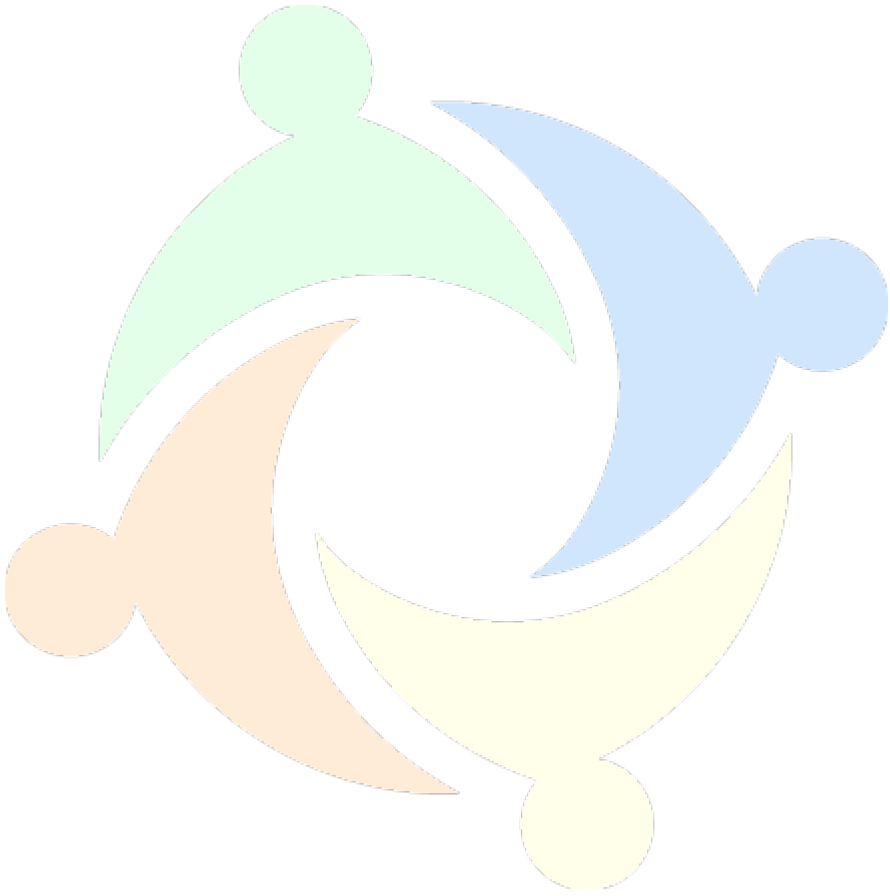

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www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
NOTICE OF (UR or QA) RESOLVED CONCERNS

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :

KFMC Health Improvement Partners (KFMC), under contract with Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF), has reviewed this hospitalization. KFMC reviews Medicaid Fee-for-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting. The information in this letter is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101.

A KFMC reviewer, who is Board Certified in (PR Specialty), has completed a review of the medical record for the hospitalization identified above. You were given an opportunity to discuss this case with us and this letter will serve as notification of the final determination. Based on the information in the medical record, and any additional information provided, the following concern(s) has/have been resolved:

Determination of Peer Reviewer:

At the present time no other action will be taken by KFMC except informing the physician and/or the hospital by this letter.

If you have any questions regarding this letter, please contact the KFMC Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org
***Note: E-mail address is not for use with protected health information without adequate encryption by the sender.**

Sincerely,

Kyle Tipton, MD
Medical Director

XC:

Patient:
KFMC/ (RC06A) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.

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Topeka, Kansas 66612
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Fax: 785-273-0237
www.kfmc.org

MEDICAID FEE-FOR-SERVICE PROGRAM (FFS)
(UR OR QA) INQUIRY

[Date]

[Hospital Name & Address]

Selection Date:
Patient Name:
Medicaid ID#:
Admission Date:
Discharge Date:
FFS ICN#:
MR #:
DOB:

Dear :
The Medicaid case identified above was selected KFMC Health Improvement Partners (KFMC) for retrospective review under contract with the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). KFMC reviews Medicaid Fee-for-Service (FFS) cases to determine if the services meet medically acceptable standards of care, are medically necessary, and delivered in the most appropriate setting. Our primary purpose is to identify areas where care can potentially be improved and to provide feedback to physicians and facilities. This peer review is intended to be a collegial interaction with the goal of improving patient care and the efficient use of health care resources in the most appropriate setting. The information in this letter is considered confidential and is subject to the confidentiality and nondisclosure provisions of: K.S.A. 65-4915, et seq., and 42 U.S.C. § 11101.

The episode of care referenced above has been reviewed. Based upon review of the medical record provided by the facility, the following question(s) has/have been raised concerning the care provided.

Review Coordinator's Questions:

Preliminary Determination of Peer Reviewer, who is Board Certified in (PR Specialty) :

We recognize the medical record may not give a complete clinical picture and the source of a

problem may not be readily apparent. We are also notifying of our concerns and offering an opportunity to discuss the concerns we have raised. A coordinated response is encouraged, including new evidence or other additional information to promote resolution of the stated concern, although each letter recipient may reply individually. A written response must be received by **(Due date 20 days from date of letter)**. The medical record ***(along with a copy of this letter)*** must also be provided to KFMC by the facility, unless previously mailed to KFMC. Please direct your response to the KFMC Medicaid Case Review Team at:

KFMC
800 SW Jackson St, Suite 700 / Topeka, Kansas 66612
Telephone: 785/273-2552, ext 340
Fax: 785/273-0237
*E-mail: msigmund@kfmc.org

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If a response is not received within the twenty (20) day time frame, the preliminary decision described in this letter will become the final determination.

Sincerely,

Kyle Tipton, MD
Medical Director

XC:

Patient:
KFMC/nas

(RC02A) 6/1/2021

This letter contains Protected Health Information (PHI) and should be treated as confidential, private, and protected in a manner consistent with the Social Security Act and the Health Insurance Portability and Accountability Act (HIPAA) and implementing regulations.