Update: MMIS Status

January 30, 2014

Numerous issues have been identified with Alaska Medicaid Health Enterprise (Health Enterprise), the Medicaid Management Information System (MMIS) implemented October 1, 2013. Although system updates have corrected various problems, there are still outstanding issues that continue to impact claims processing.

The Department of Health and Social Services (DHSS) and Xerox continue to work together to resolve these problems. In addition to the progress being made by the technical staff, we have been contacting providers to provide assistance with billing errors, and are increasing staffing levels throughout the organization in order to improve provider outcomes. Semi-automated workarounds continue to be implemented to eliminate some of the manual intervention required to process claims.

Progress is being made. Call wait times in the travel unit continue to improve. Service authorization inventories have been reduced tremendously by focusing on a specific area each week and recent enhancements have streamlined data entry and processing. The backlog of new provider enrollment applications is down as well. The staff to address the inventory of paper claims has recently been tripled and more are scheduled to be added.

The combined impact of issues has caused a higher than normal inventory of suspended claims, resulting in delays of payments. In addition to system issues, Health Enterprise automated application of certain Alaska Medical Assistance program rules that were not enforced in the old MMIS. This has also added to the increase of suspended claims. Although there is still work to be done, significant progress has been made to reduce the claims inventory.

The following table summarizes the edits causing the majority of suspended claims and the associated processing status. The Impacted Claims column reflects the status as of January 28, 2014. These numbers change daily as additional improvements, processing and outreach occur. As issues are resolved, these suspended claims will be released for processing and potential payment. The Status column includes steps that providers can take to submit accurate claims. Updated status will be published every two weeks.

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Status of Processing Outstanding Claim Inventory

Status of High Dollar Claims: Claims with a few line items are being manually processed. A change is scheduled at the end of February to allow processing claims that have a large number of line items.

Edit/ EOB Code	Description	Claims Impacted	Status
1880	Claim is pending for review due to notes	1,600	These claims are suspending correctly. Only DME claims are affected. The manual intervention required is ongoing. A system change was implemented late January.
1882	Claim exceeds timely filing and no proof of timely filing attached	680	Claims are suspending correctly and being reviewed.
1891	Void / Replace TCN Missing or Invalid	470	This error is tied to claims submitted prior to Oct 1, 2013. Analysis of a change to correct this issue is in progress.
1895	Claim not found on history	560	This error is tied to claims submitted prior to Oct 1, 2013. Analysis of a change to correct this issue is in progress.
1905	Billing Provider on claim does not match Billing Provider on replacement request	530	This error is tied to claims submitted prior to Oct 1, 2013. Analysis of a change to correct this issue is in progress.
2950	Payment cannot be made. The member is locked into another Provider	3,700	Steps performed by reviewers for manual “valid referral” determination are under evaluation to see if they can be automated.
3155	Claim is professional and Rendering Provider NPI not on file	5,600	A change scheduled for early February will allow these claims to move forward.
3321	Rendering Provider Certification Expired Greater than 60 days	2,760	A change scheduled for early February will correct some of these exceptions. If a provider’s certification truly expired, a notification letter will be sent after 60 days.
3325	Rendering Provider License Expired <= 60 Days	990	This exception will recycle for 60 days and if the license is not updated the claim will deny.
3329	Billing Provider License Expired – Suspend	400	Additional analysis is needed on remaining claims after changes were implemented.

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Edit/ EOB Code	Description	Claims Impacted	Status
3337	Billing Provider License Missing – Deny	630	Additional analysis is needed on remaining claims after changes were implemented.
3338	Billing Provider Certification Missing – Deny	560	Additional analysis is needed on remaining claims after changes were implemented.
3600	Category of Service cannot be determined from information on the claim	1,500	Analysis is ongoing.
3620	Billing Provider NPI matches multiple IDs	8,000	If the Billing Provider NPI matches multiple IDs, the system cannot determine which provider record to use for processing. Provider outreach continues to help providers understand how to submit claims correctly. Common problems include failing to submit with the service location zip code, using an incorrect taxonomy, and submitting on the wrong paper form.
3650	Provider Payee ID Not Found	550	Analysis in progress to determine if this should deny.
3660	Rendering Provider Cert Expired – Deny	815	Research has completed on most claims and they will move forward for final processing. Mass adjustment is scheduled end of January.
3700	Provider on review	2,800	The remaining claims are being analyzed to determine if additional providers can be taken off review.
3800	Rendering Provider not in any Network associated to any of the Benefit Plans for the Member	1,000	Analysis continues. System change scheduled in early February will address some situations.
3802	Billing Provider not in Network for Member	100	Majority of remaining claims may be affected by NPI/invalid provider issue – meaning system cannot determine the provider; otherwise, appears to be a situation in which Provider is not enrolled. If that is the case, the claims will be denied.
3805	Benefit Plan does not exist for this Member for the services billed	1,000	Some changes have been implemented. Research is in progress to identify additional changes.

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3810	Benefit Plan found but service not covered for member	5,500	These claims are suspending correctly. They will continue to suspend until a change is implemented in early February for new waiver regulations. The disposition to the exception will be revisited at that time.
3832	Medicaid coverage – Waiver claim excluded	5,500	These claims are suspending correctly. They will continue to suspend until a change is implemented in early February for new waiver regulations. The disposition to the exception will be revisited at that time.
4076	Review for Medical justification – Prof Claim Types	2,700	These claims are suspending correctly. Manual review required to move a claim forward is ongoing.
4105	Diagnosis Requires Review by State	400	Enhancement scheduled early February. Manual work continues and a workaround will facilitate processing.
4125	Diagnosis Requires Review by FA	4,860	Enhancement scheduled early February. Manual work continues and a workaround will facilitate processing.
4645	Out of State Pricing Segment	1,020	Enhancement scheduled early February.
4826	Submitted units exceed the maximum units allowed	4,000	Codes were updated and claims have been identified for reprocessing. A mass adjustment is in progress.
4912	Procedure code requires pricing	2,900	Analysis is in progress.
4916	Procedure / Modifier combination Pricing segment is set to Manual Review	6,000	A rate is not on file causing manual pricing on these claims. Research is in progress to determine if the manual steps can be automated. Codes were updated 1/24 for DME.
5051	Bill Prv-No Match SA Bill Prv	25,000	Billing provider on the claim does not match the billing provider on the service authorization (SA). These claims denied. After a SA field is populated, mass adjustments will be run to reprocess claims.
5220	SA record is pended w/errors - Header	1,060	Review continues to identify types of specific service authorizations that are candidates for automatic approval.

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5221	SA record is pended w/errors – Line	350	Updated a large number of travel Service Authorizations to approved status. Review continues to identify types of specific service authorizations that are candidates for automatic approval.
6110	Mbr Medcr Pt B Elig w/No Attch	1,300	Impacts DME claims. Development of a workaround is in progress. This will allow these claims to move forward until a permanent change occurs to the system.
6280	Cost avoid for no EOB and no TPL dollars	10,200	Paper claims will continue to suspend until the inventory is reduced. If research indicates the edit is working correctly, electronic claims will deny. Providers will need to rebill and submit EOB.
6430	Cost Avoid for no TPL $ but EOB exists	7,700	Impacted claims will slowly decrease as the inventory of paper claims is entered. Changes scheduled in early February will fix related problems.
6600	Exact duplicate	40	Analysis is continuing on the remaining inventory.
6604	Possible Conflict / different Provider	9,800	Additional criteria for duplicate edit check will enable these claims to auto-adjudicate and not require staff intervention. These claims are being worked daily until the additional criteria is identified and implemented.
7990	UR unit of measure code does not equal claim line item unit of measure code	1,145	A change is scheduled for mid-February to correct this exception.
8040	SA Units Fully Exceeded	5,600	Analysis is in progress to identify system changes. The disposition on Transportation claims will be set to Deny and they will then move forward.
8050	SA Unit of Measure mismatch	6,400	A change is scheduled for early February to correct this exception.
9090	No Fund Code Criteria	2,000	Problems are tied to Category of Service. Analysis continues on impacted categories to determine appropriate changes to allow them to move forward.