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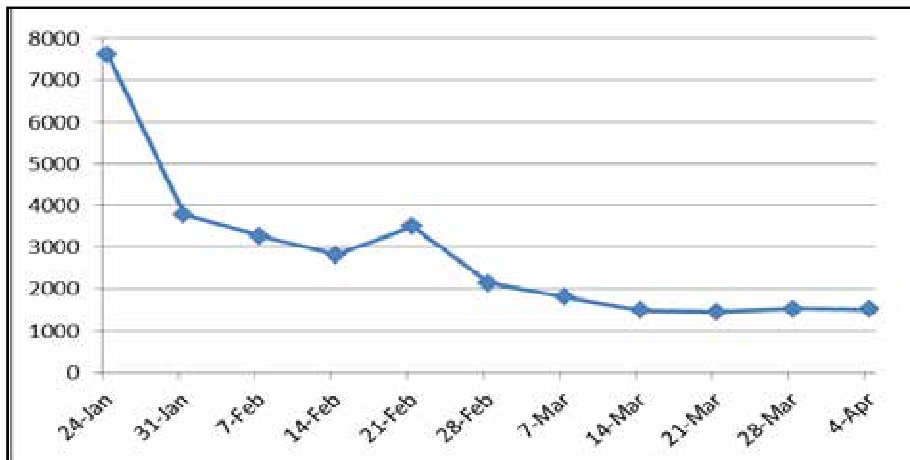
Processing levels remain constant in the areas of service authorizations, claim payments, and paper claims.

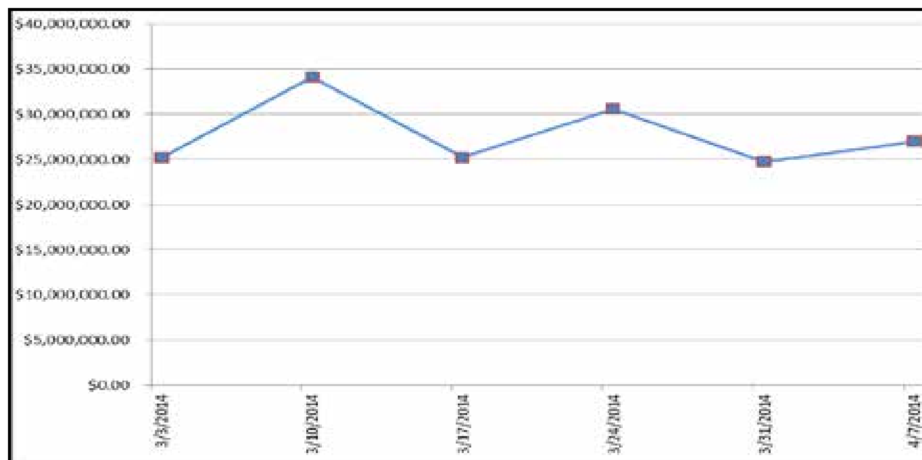
- **Service Authorizations**: Processing faxed service authorization requests continues to remain within normal processing standards. A temporary surge in processing times occurred last week due to the combination of a staffing outage and an increase in the number of requests typically received on a daily basis. As of April 8, the inventory of faxed requests shows that dental requests have returned to processing within 1 day of receipt, while the majority of other faxed requests are processing within 1 to 3 days of receipt.

Suspended Service Authorizations



- **Claim Payments**: Last week $27 million was paid to 77,839 claims.

Total Cash Reimbursement Amount



- **Paper Claims**: Paper claim processing remains current. The National Uniform Claim Committee (NUCC) recently updated the CMS-1500 paper claim form. While Alaska Medicaid makes changes to fully support the new form, both the revised 02/12 version and the former 08/05 version will be accepted. During this transition period, providers are encouraged to submit claims electronically or through the web portal.

Service Authorization Status Inquiry: All changes identified to date to correct the problem with random missing service authorization records on the online search capability have been implemented. However, an additional problem has now been identified and is being analyzed to determine further changes.

Service Authorization Letters: Changes targeted for early May are in progress to provide standard detailed reasons with more descriptive messages and the associated Regulation Citation on Service Authorization letters.

Reformatting the Remittance Advice (RA): The design work for the new RA continues. Phase 1 of the redesign is scheduled for implementation at the end of April and addresses how credits and debits are displayed in the Adjustment section on institutional RAs. In addition to making the information easier to read, the number of pages will be condensed.

Mass Adjustments: No significant mass adjustments have occurred since the last MMIS Update.

RBRVS Problem: Evaluation of the most effective way to stagger reprocessing claims paid incorrectly due to problems with the RBRVS factor continues. The factor problem was corrected in early March and all claims are now being paid with the correct factors.

Paper Claims with Exception 4826 (Submitted units exceed the maximum units allowed): If a unit is submitted with a decimal, the decimal is disregarded and any characters after the decimal become part of the whole number. For example, if 1 unit is reflected as 1.0 on the claim, the optical character recognition (OCR) program translates it to 10 units; 20.0 units becomes 200 units. This causes the claim to reject for too many units. **Units entered without a decimal process correctly. Providers can avoid claims suspending for this exception by entering whole numbers without a decimal in the units field.** A change targeted

as part of the new CMS-1500 claim form implementation will resolve this issue by allowing OCR to recognize decimals.

Tribal Providers: Specific issues are affecting timely and accurate processing of claims for Tribal providers. A mass adjustment to reprocess claims where the co-pay was taken for a tribal provider and the member is a native Alaskan is currently on hold until all known problems that affect claims are corrected. This is to reduce the number of times a single claim is reprocessed.

Complex Claims: In addition to the optimization changes to improve internal processing of claims with more than 100 lines that were previously implemented, a change was made March 29 to correct a problem experienced by 7 claims suspending with Exception 9379 (System Information Not Found). All claims with more than 100 lines have now been processed. All claims in this category will continue to be closely monitored.

Pharmacy: Newly enrolled pharmacies are not recognized, while recently dis-enrolled pharmacies are still showing as active. New pharmacies are being added manually to the pharmacy file to enable processing of claims. All changes to the automated interface are currently being tested and implementation is targeted for mid-April. Provider outreach is continuing as needed.

Call Center Support: If you need to contact Xerox, the following times are traditionally the lightest periods and you should experience a shorter call wait time than if you call at peak periods:

Department	Lighter Call Periods	Contact Information
Provider Relations Unit Provider Inquiry	From 8:00-9:30 a.m. After 2:00 p.m.	In Anchorage: 907.644.6800 (option 1,1) Outside Anchorage: 800.770.5650 (option 1, 1)
Member Eligibility Verification Provider Inquiry	From 8:00-9:30 a.m. After 2:00 p.m.	In Anchorage: 907.644.6800 (option 1,2) Outside Anchorage: 800.770.5650 (option 1, 1)

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Department	Lighter Call Periods	Contact Information
Service Authorization	From 8:00-9:30 a.m. After 2:00 p.m.	In Anchorage: 907.644.6800 (option 5) Outside Anchorage: 800.770.5650 (option 1, 2)

Outstanding Claim Inventory: The table on the following pages summarizes the exception codes that are receiving special monitoring. It does not provide reporting on all exception codes. The status reported is as of April 8, 2014.

The Providers Impacted column lists the provider types affected by the exception code if there are more than 50 claims associated with the provider category. The Impacted Claims column reflects the total number of claims for each exception. These numbers and the provider types change daily as additional improvements, processing and outreach occur. As issues are resolved, these suspended claims are released for processing and potential payment in the weekly cycle.

Even when a change is implemented, it can take several processing cycles to determine that it is working effectively. Changes are implemented on Saturday nights making the first time they impact a claims cycle the following Friday.

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Status of Processing Outstanding Claim Inventory

Legend for Providers Impacted			
Code	**Description**	**Code**	**Description**
ASC	Ambulatory Surgical Center	NURS	Nurses – Private Duty, RN, Agencies
BH	Behavioral Health	PCA	Personal Care Agency
BRS	Behavioral Rehabilitation	PHAR	Pharmacy
CCA	Care Coordinator Agency	PHYS	Physicians
DENT	Dental Groups and Dentists	RPTC	Residential Psychiatric Treatment Center
DME	Durable Medical Equipment Supplier	RSL	Residential Supported Living
FPC	Family Planning Center	SBS	School Based Services
FQHC	Federally Qualified Health Center	SNF/ICF	Skilled Nursing/Intermediate Care Facility
HCB	Home Community Based Agency	TCM	Targeted Case Management
HEAR	Hearing Aid Specialist	THER	Therapists – Speech, Physical, Occupational
HHA	Home Health Agency	THRCTR	Occupational/Physical Therapy Center
HOSP	Hospital – In-patient and out-patient	TRAN	Transportation – Taxi, Ambulance, Air
HPRF	Health Professional Group	TRB	Tribal Hospital or Clinic
ICFMR	Intermed Care Fac for Mentally Retarded	TRVL	Travel Accommodations
LAB	Independent Lab/X-ray	VISION	Optometrist, Vision Contractor

Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
1370	The Diagnosis Related Code is repeated or missing or invalid.	HPRF HCB PCA RSL VISION	800	An issue with this exception was previously corrected and claims processed. These particular claims did not get released due to issues with missing data, usually the Date of Service, on claims submitted in October 2013. A change was implemented in early March that caused the number of suspended claims to drop from 2,329.
1880	Claim is pending for review due to notes	DME	2010	These claims are suspending correctly. Only DME claims are affected. The manual intervention required is ongoing.
1882	Claim exceeds timely filing and no proof of timely filing attached	BH DME HCB HOSP HPRF RSL SNF/ICF TRVL	1,449	Claims are suspending correctly and being reviewed as part of normal processing.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
1891	Void / Replace TCN Missing or Invalid	BH HCB HOSP HPRF SBS	1,729	The exception indicates the requested void or replacement has already been voided or replaced, meaning the request cannot be processed. This error is tied to claims submitted prior to Oct 1, 2013. These claims must be manually worked.
1895	Claim not found on history	BH HCB HOSP HPRF PCA SBS	1,975	The Transaction Control Number (TCN) to be replaced or voided does not match a previously adjudicated claim in history. This error is tied to claims submitted prior to Oct 1, 2013. These claims are being manually worked.
1905	Billing Provider on claim does not match Billing Provider on replacement request	BH HCB HOSP HPRF PCA SBS	1,995	This error is tied to claims submitted prior to Oct 1, 2013. These claims must be manually worked.
2950	Payment cannot be made. The member is locked into another Provider	BH FQHC HPRF PHYS TRB	3,729	Reviewers manually audit claims to determine if a referral is valid so that the claim can be approved for payment. If the referral is not valid, the claim is denied. Approximately 2,500 (67%) of the claims are from Health Professional Groups and 630 (17%) are Behavioral Health claims. However, this edit may not be valid for Behavioral Health claims and analysis is in progress to determine why this edit it is posting. If research determines the edit is invalid for Behavioral Health claims, a change will be made that allows them to move forward for processing.
3321	Rendering Provider Certification Expired	CCA DENT DME HCB HOSP HPRF PCA TRAN	1,931	This exception will recycle for 60 days and if the certification is not updated the claim will deny with Exception 3660 (Rendering Provider Cert Expired – Deny). Almost 1,200 (62%) of these are PCA claims. A change was implemented February 15. Analysis will occur to insure the change has the expected outcome.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
3325	Rendering Provider License Expired	BH DENT DME HOSP HPRF RPTC TRB	2,016	This exception will recycle for 60 days and if the license is not updated the claim will deny. 1,300 (65%) of these are claims for Health Professional Groups. In addition to the change implemented in mid-February, another change was deployed in early March.
3329	Billing Provider License Expired – Suspend	DENT HPRF PCA RPTC TRVL	1,060	The Billing Provider does not have a license on file in effect on the Date of Service. The last Date of Service on the claim is after the license expiration date. Analysis of the edit criteria was completed in mid-March and this edit is functioning correctly.
3338	Billing Provider Certification Missing	SBS	200	The Billing Provider does not have certification on file that is in effect on the Date of Service. Updates to enrollment files occurred in late March. **A system fix was also made on March 29. The 200 claims indicated is what was suspended as of April 8 and equals what was also shown on the previous MMIS Update. The Xerox Claims Department reported that as of April 10, all suspended claims have been addressed. Therefore, if the number of impacted claims drops below 50 next week, this edit will be removed from the watch list.**
3600	Category of Service cannot be determined from information on the claim	ASC BH HPRF PHAR TRB	2,397	Category of Service and provider type combinations need changes to the processing criteria. Also, a problem that impacts these claims was found relating to the NPI crosswalk. This exception has a dependency with 4932 (Claim Type Cannot be Determined). Analysis is in progress to identify needed changes.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	6,982	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 if the problems are caused by failing to submit with the service location zip +4 code, using an incorrect taxonomy, or submitting on the wrong paper form. A system change to the NPI crosswalk is targeted for implementation in early May that will improve automated provider record matching. **The taxonomy tables are also being reviewed to determine if revisions are needed.**
3650	Provider Payee ID Not Found	Electronic claims	1,198	Analysis in progress to determine if this should deny.
3700	Provider on review	BRS HCB PCA RSL TRB	1,120	These claims continue to be analyzed to determine if additional providers can be taken off review. **Approximately 750 (67%) of the claims impacted are submitted by Behavioral Rehabilitation providers.**
3800	Rendering Provider not in any Network associated to any of the Benefit Plans for the Member	BH FQHC HCB HPRF PCA	2,830	Analysis continues to determine if additional changes are needed. Based on current information, the edit is working correctly. Claims must be manually reviewed to determine if they should deny or moved forward for payment. **Almost 2,000 (70%) of the suspended claims are for Behavioral Health providers. A problem with the logic for rendering providers has been identified with Behavioral Health and waiver claims that will require a system change. A target date has not been scheduled. Claims from Professional Health Groups and Personal Care Agencies will be set to deny.**

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
3802	Billing Provider not in Network for Member	Electronic claims	1,173	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. Claims are posting incorrectly from the electronic data interchange. Analysis is in progress.
3805	Benefit Plan coverage does not exist for this Member for the services being billed	BH DME FQHC HOSP HPRF LAB TRAN TRB	2,104	A change was implemented February 15. Analysis has indicated that the edit is now working correctly. The Fiscal Agent must manually work the remaining claims as well as any new ones that suspend for this reason. **This edit was set to Deny last week. Final analysis is in progress to verify there are no other issues before releasing these claims for processing.**
3832	Medicaid coverage – Waiver claim excluded	HCB RSL CCA	12,930	These claims are suspending correctly. They will continue to suspend until a change is implemented for new waiver regulations. **At this time, the changes are targeted for implementation at the end of April.** The disposition to the exception will be revisited at that time. Over 12,200 (94%) of these claims are from Home Based Care providers.
4076	Review for Medical justification – Prof Claim Types	DENT HPRF TRAN	2,490	These claims are suspending correctly. Manual review required to move a claim forward is ongoing by Fiscal Agent nurses. Approximately 1,700 (68%) of these claims are from Ground Ambulance providers.
4105	Diagnosis Requires Review by the State	FPC HPRF	375	Manual work continues on these claims.

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4125	Diagnosis Requires Review by Fiscal Agent	BH CCA DME FQHC HCB HOSP HPRF PCA SBS TRB	7,428	These claims require nurse review. Manual work continues and operational procedures have recently been streamlined. A change was implemented on March 22 for specified diagnosis codes if the member is under the age of 21. This impacted 30% of the claims with this edit and the number of suspended claims decreased from 10,585 claims 3 weeks ago. Another change is planned for early April that is related to date spans.
4645	Out of State Pricing Segment Not Found	DME FPC HPRF LAB TRAN	2,211	Analysis is in progress to determine if a change is needed or if the exception is working as designed.
4826	Submitted units exceed the maximum units allowed for this procedure	DME HOSP HPRF RSL TRAN	754	A problem has been identified that causes this exception to post in error on paper claims. The Optical Character Recognition (OCR) program that reads paper claims ignores decimal points and considers any number(s) after the decimal point as part of the whole units amount. For example, if 1 unit is submitted as 1.0, it is translated to 10 units in the OCR program. This causes the claim to reject for too many units. Claims with units without decimals are recognized correctly. A change has been identified that will resolve this issue by allowing OCR to recognize decimals.
4829	**Outpatient Institutional Rate for Provider on the Claim cannot be found, or Dates of Service are not within Institutional Rate Pricing Span**	**HOSP** **TRB**	**5,626**	**A change has been identified to address how this edit processes. Over 5,200 of the claims (92%) are from Tribal providers.**

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
4912	Procedure code requires pricing	CCA DENT DME FPC HCB HOSP HPRF LAB PCA PHAR PHYS RSL TRAN TRVL	31,731	This exception occurs when all pricing methodologies have been exhausted and the calculated allowed is zero. An issue was identified with the region codes on provider records. This impacts the ability to assign rates for certain claims. Analysis is in progress to determine a solution. At this time, these claims must be manually priced and processed. **A new error occurred that caused the number of claims to increase significantly from last week's reported 5,932. Outpatient claims are posting when the provider does not have an institutional record. An emergency fix is scheduled for April 10 so that suspended claims can be released for processing in the April 11 payment cycle.**
4916	Procedure / Modifier combination Pricing segment is set to Manual Review	DENT DME HOSP HPRF LAB	5,983	A rate is not on file causing manual pricing on these claims. **Factor codes related to waivers were updated. Review of the factor codes is ongoing as the Fiscal Agent staff continues manually pricing these claims**.
5051	Bill Provider - No Match Service Authorization Bill Provider	BH BRS DENT DME FQHC HPRF PCA	25,000 Denied and need mass adjustment 4,761 Suspended	Billing provider on the claim does not match the billing provider on the service authorization (SA). These claims denied. **Several changes to address SA problems have already been implemented. However, a new problem was recently identified**. Mass adjustments will be run to reprocess denied claims after the Service Authorization team completes their work. Due to the volume, the mass adjustments will be staggered to reduce risk of error. Suspended claims will also be released for processing.

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5220	Service Authorization record is pended w/errors - Header	BH DME HCB TRAN	2,168	These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action. Almost 1,650 (76%) of these are Behavioral Health claims.
5221	Service Authorization record is pended w/errors – Line	BH HCB	2,100	These claims are set to automatically release for reprocessing each evening so that the claim will process as the Service Authorization team takes action. Over 1,760 (84%) of these are Behavioral Health claims.
6110	Member Medicare Pt B Eligibility w/No Attachment	DME	1,908	This exception indicates the member has Medicare Part B coverage for the Dates of Service on the claim, but no attachment was submitted with the claim indicating an Explanation of Medicare benefits. A workaround is allowing these claims to move forward until a permanent change occurs to the system. A system change is targeted for mid-April.
6280	Cost avoid for no EOB and no TPL dollars	ICFMR SNF/ICF	437	If research indicates the edit is working correctly, electronic claims will deny. Providers will need to rebill and submit EOB. The suspended claims for this exception dropped from 10,200 five weeks ago after a change was implemented. However, further analysis revealed that it posts incorrectly when Exception 6430 (Cost Avoid for no TPL $ but EOB Exists) is Force Paid. **A change to the system was implemented on April 5. Analysis is in progress to verify the intended outcome was achieved. If so, these claims will be released for payment.**

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
6430	Cost Avoid for no TPL $ but EOB exists	BH DENT DME FQHC HOSP HPRF PHYS RPTC THER THRCTR TRB	22,726	The majority of these exceptions are from paper claims. Almost 15,300 (67%) are claims submitted by Health Professional Groups. Several system changes related to TPL processing have been identified and are in development. **A change was implemented April 5 and these claims can now be processed. Because each one must be manually reviewed, additional staff has been added to assist with processing these claims.**
6440	Cost Avoid when TPL dollars and EOB Exist	HOSP HPRF TRB	1,092	An automated process has been implemented to update the Other Payer section on claims and to allow Force Payment of this edit. **A system change is scheduled in mid-April to populate certain fields and correct how TPL is processed.**
6604	Possible Conflict / Different Provider	ASC BH BRS DENT ESRD FQHC HCB HOSP HPRF LAB NURS PHYS RSL TRAN TRB TRVL	5,631	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. In-patient and waiver criteria are under review. A change was implemented in mid-March to fix a problem tied to admit and discharge dates that was related to the process of checking for duplicate claims.

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8040	Service Authorization Units Fully Exceeded	DENT TRAN TRVL	13,551	Testing is in progress for system updates to correct this problem. Once the changes are approved, mass adjustments will occur to correct data on claims so that they can then be released for processing. Because of the volume of claims and the complexity of the changes, the mass adjustments will be staggered to reduce risk of error. **A target implementation date is pending as additional analysis continues.** Almost 7,300 of these claims are from taxi providers and 5,370 are from travel-related providers.
8050	Service Authorization Unit of Measure Mismatch	BH DME HCB HPRF TRAN TRVL	7,098	The Service Authorization unit of measure code does not equal the claim line unit of measure code. These claims are suspending incorrectly. A change was implemented in late March for transportation procedure codes and these claims were released for processing on March 27. **A new change has been identified to correct claims that are suspending with this exception although the claim does not require a Service Authorization.**
9090	No Fund Code Criteria	FQHC HPRF TRVL	679	Problems are tied to Category of Service. A problem with the NPI crosswalk was found this week that may impact these claims. Analysis continues on impacted categories to determine appropriate changes to allow them to move forward. A fix to the Category of Service (COS) assigned for EPSDT screening claims was implemented in early March.