# Update: MMIS Status

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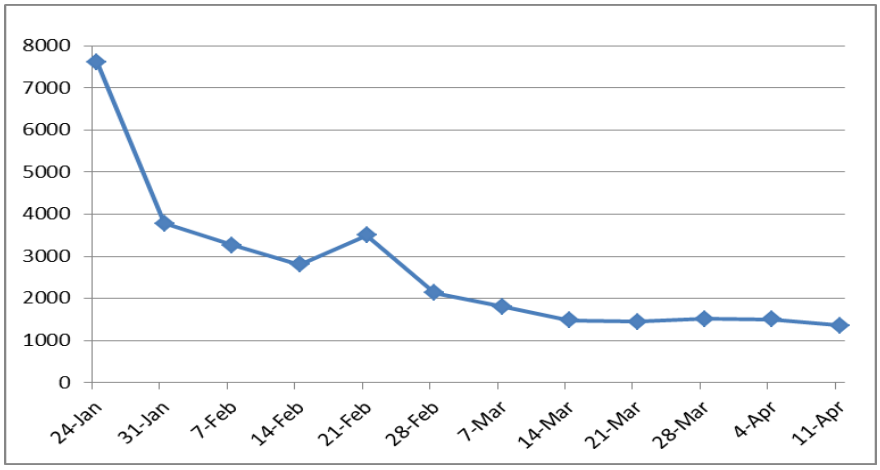
Processing levels remain constant in the areas of service authorizations, claim payments, and paper claims.

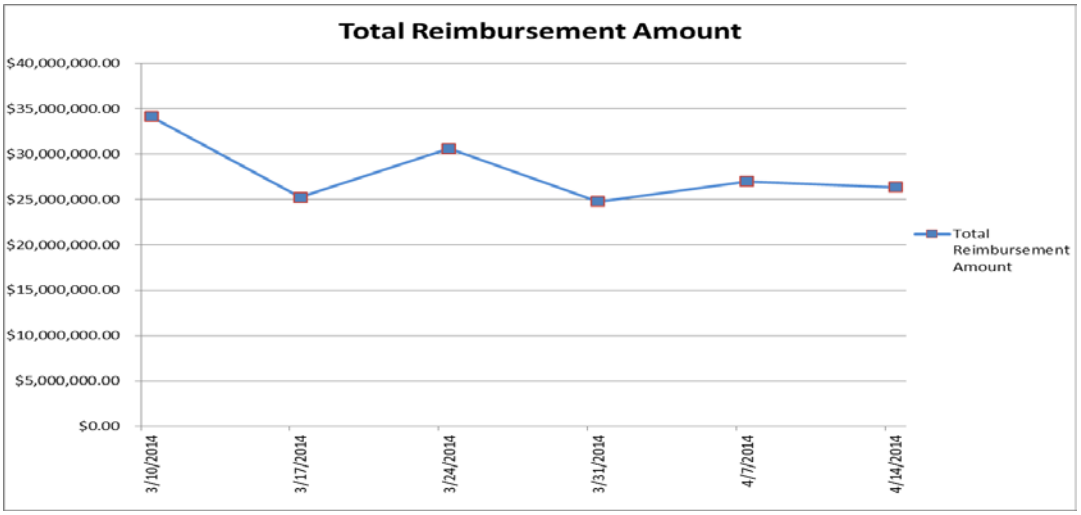
- **Service Authorizations**: Processing faxed service authorization requests continues to remain within normal processing standards. As of April 15, the inventory of faxed requests shows that dental requests have returned to processing within 1 day of receipt, while the majority of other faxed requests are processing within 1 to 3 days of receipt.

**Suspended Service Authorizations**




- **Claim Payments**: $26.3 million was paid to 81,537 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 Denial Letters**: Changes targeted for mid-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**: Mass adjustments to reprocess approximately 570 claims meeting the following conditions were completed this week:

- Claims for retroactive rate adjustment
- Claims for transportation services impacted by 8040 (Service Authorization Units Fully Exceeded).
- Claims that were previously denied

**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.

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**Tribal Providers:** Specific issues are affecting timely and accurate processing of claims for tribal providers. All claims will be adjusted when all tribal defect fixes have been deployed. This is to reduce the number of times a single claim is reprocessed. The following claims issues are affecting tribal providers:

- Behavioral Health claims paying at the encounter rate for dates of service prior to October 1st
- Claims that have both enhanced adult and emergent dental services
- Claims that have had the co-pay taken for a tribal provider and the member is an Alaska Native

**Complex Claims**: 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.

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**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<br><br>Provider Inquiry | From 8:00-9:30 a.m.<br><br>After 2:00 p.m. | In Anchorage: 907.644.6800 (option 1,1)<br><br>Outside Anchorage: 800.770.5650 (option 1, 1) |
| Member Eligibility Verification<br><br>Provider Inquiry | From 8:00-9:30 a.m.<br><br>After 2:00 p.m. | In Anchorage: 907.644.6800 (option 1,2)<br><br>Outside Anchorage: 800.770.5650 (option 1, 1) |
| Service Authorization | From 8:00-9:30 a.m.<br><br>After 2:00 p.m. | In Anchorage: 907.644.6800 (option 5)<br><br>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 15, 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<br>HCB<br>PCA<br>RSL<br>VISION | 831 | 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 | 2,330 | 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<br>DME<br>HCB<br>HOSP<br>HPRF<br>RSL<br>SNF/ICF<br>TRVL | 1,474 | 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<br>HCB<br>HOSP<br>HPRF<br>SBS | 1,778 | 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<br>HCB<br>HOSP<br>HPRF<br>PCA<br>SBS | 1,984 | 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<br>HCB<br>HOSP<br>HPRF<br>PCA<br>SBS | 2,001 | 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<br>FQHC<br>HPRF<br>PHYS<br>TRB | 3,963 | 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 2,650 (67%) of the claims are from Health Professional Groups and 674 (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<br>DENT<br>DME<br>HCB<br>HOSP<br>HPRF<br>PCA<br>TRAN | 1,740 | 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). Approximately 900 (52%) 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<br>DENT<br>DME<br>HOSP<br>HPRF<br>RPTC<br>TRB | 1,681 | This exception will recycle for 60 days and if the license is not updated the claim will deny. Approximately 1,000 (59%) 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<br>HPRF<br>PCA<br>RPTC<br>TRAN | 1,231 | 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. |
| 3600 | Category of Service cannot be determined from information on the claim | ASC<br>BH<br>CCA<br>PHAR<br>TRB | 2,015 | 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. |
| 3620 | Billing Provider NPI matches multiple IDs | Electronic Claims<br><br>ALL provider types that require NPI | 7,050 | 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 | 3,221 | Analysis in progress to determine if this should deny. |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 3700 | Provider on review | BRS<br>HCB<br>PCA<br>RSL | 1,238 | These claims continue to be analyzed to determine if additional providers can be taken off review. Approximately 848 (68%) of the claims impacted were submitted by Behavioral Rehabilitation providers. |
| 3800 | Rendering Provider not in any Network associated to any of the Benefit Plans for the Member | BH<br>CCA<br>FQHC<br>HCB<br>HPRF<br>PCA | 3,392 | 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 2,500 (74%) 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. |
| 3802 | Billing Provider not in Network for Member | Electronic claims | 3,209 | 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<br>DME<br>HOSP<br>HPRF<br>LAB<br>TRAN<br>TRB | 1,702 | 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. |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 3832 | Medicaid coverage – Waiver claim excluded | HCB<br>RSL<br>CCA | 13,399 | 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 12,500 (94%) of these claims are from Home Based Care providers. |
| 4076 | Review for Medical justification – Prof Claim Types | DENT<br>HPRF<br>TRAN | 2,378 | These claims are suspending correctly. Manual review required to move a claim forward is ongoing by Fiscal Agent nurses. Approximately 1,650 (69%) of these claims are from Ground Ambulance providers. |
| 4105 | Diagnosis Requires Review by the State | FPC<br>HPRF | 367 | Manual work continues on these claims. |
| 4645 | Out of State Pricing Segment Not Found | DME<br>FPC<br>HPRF<br>LAB | 1,901 | 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<br>HOSP<br>HPRF<br>RSL<br>TRAN | 879 | 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. |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 4829 | Outpatient Institutional Rate for Provider on the Claim cannot be found, or Dates of Service are not within Institutional Rate Pricing Span | HOSP<br>TRB | 6,074 | A change has been identified to address how this edit processes. Almost 5,700 of the claims (94%) are from Tribal providers. **A fix was implemented on April 16 which will reduce the suspended claim count to 432.** |
| 4912 | Procedure code requires pricing | CCA<br>DENT<br>DME<br>HCB<br>HPRF<br>LAB<br>PCA<br>TRAN<br>TRVL | 2,765 | 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 impacting 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. **An error occurred causing outpatient claims to post when the provider did not have an institutional record. An emergency fix was implemented on April 10 so that suspended claims were released for processing in the April 11 payment cycle. The impacted number of claims decreased from 31,731. Two additional changes were implemented last weekend related to region codes. These changes should further reduce suspended claims in the April 18 payment cycle.** |
| 4916 | Procedure / Modifier combination Pricing segment is set to Manual Review | DENT<br>DME<br>HOSP<br>HPRF<br>LAB | 7,302 | 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. |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 5051 | Bill Provider - No Match Service Authorization Bill Provider | BH<br>BRS<br>DENT<br>DME<br>FQHC<br>HPRF<br>PCA | 25,000 Denied and need mass adjustment<br><br>5,146 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. **An additional change is scheduled for the end of April.** 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. |
| 5220 | Service Authorization record is pended w/errors - Header | BH<br>DME<br>HCB<br>TRAN | 2,338 | These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action. Approximately 1,700 (73%) of these are Behavioral Health claims. |
| 5221 | Service Authorization record is pended w/errors – Line | BH<br>HCB | 2,188 | 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 1,840 (84%) of these are Behavioral Health claims. |
| 6110 | Member Medicare Pt B Eligibility w/No Attachment | DME | 2,042 | 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. |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 6280 | Cost avoid for no EOB and no TPL dollars | ICFMR<br>RPTC<br>SNF/ICF<br>TRAN | 497 | 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. |
| 6430 | Cost Avoid for no TPL $ but EOB exists | BH<br>DENT<br>DME<br>FQHC<br>HOSP<br>HPRF<br>PHYS<br>RPTC<br>THER<br>THRCTR<br>TRB | 22,093 | The majority of these exceptions are from paper claims. Almost 14,750 (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 | DENT<br>DME<br>HOSP<br>HPRF<br>TRB | 1,187 | 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. **A change was implemented on April 12 to correct a mapping problem that was occurring on the front end of claims that should prevent the number of claims suspended for this exception from increasing.** |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 6604 | Possible Conflict / Different Provider | ASC<br>BH<br>BRS<br>DENT<br>ESRD<br>FQHC<br>HCB<br>HOSP<br>HPRF<br>LAB<br>NURS<br>PHYS<br>RSL<br>TRAN<br>TRB<br>TRVL | 5,315 | 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. |
| 8040 | Service Authorization Units Fully Exceeded | DENT<br>PCA<br>TRAN<br>TRVL | 14,367 | 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. 8,100 of these claims are from taxi providers and 4,770 are from travel-related providers. |

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| Edit/ EOB Code | Description | Providers Impacted | Impacted Claims | Status |
|---|---|---|---|---|
| 8050 | Service Authorization Unit of Measure Mismatch | BH<br>DME<br>HCB<br>HPRF<br>TRAN<br>TRVL | 1,847 | 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. **A partial fix was implemented that reduced the number of claims impacted from 7,100 to 1,847 with additional fixes scheduled.** |
| 9090 | No Fund Code Criteria | FQHC<br>HOSP<br>HPRF<br>TRVL | 694 | Problems are tied to Category of Service. A problem with the NPI crosswalk was found 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. |