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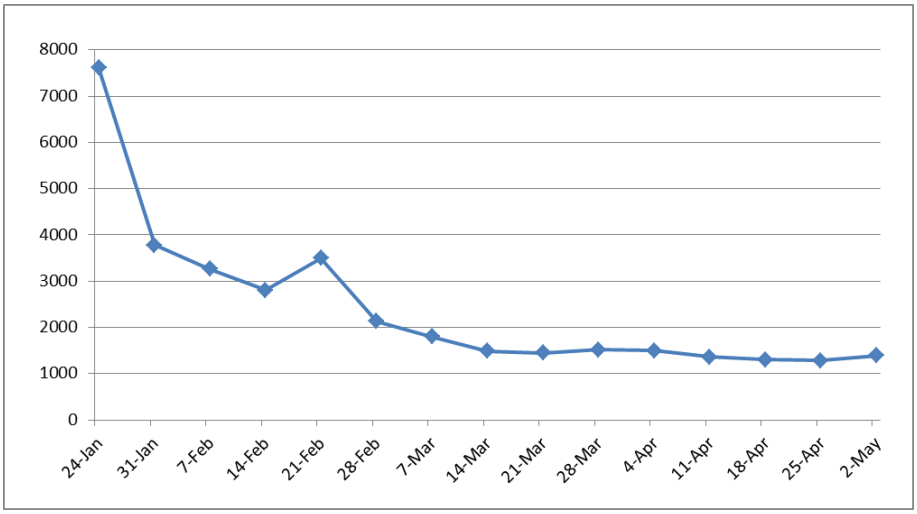
Processing levels remain constant in the areas of service authorizations, claim payments, and paper claims.

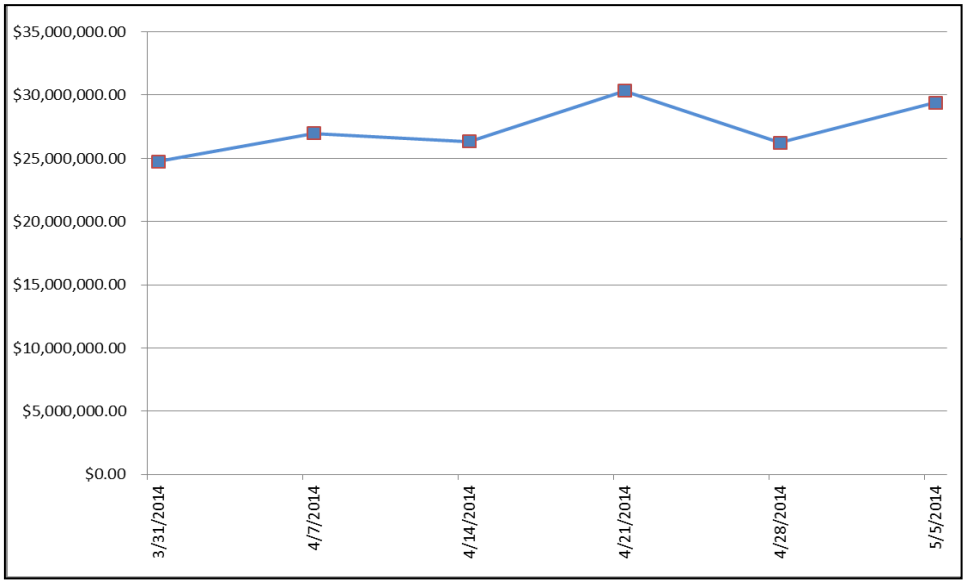
- **Service Authorizations**: Processing faxed service authorization requests continues to remain within normal processing standards. As of May 2nd, faxed DME requests are processing within 7 days of receipt, while the majority of other faxed requests are processing within 2 to 3 days of receipt.

Suspended Service Authorizations



- **Claim Payments**: In the April 28th payment cycle, 86,345 claims received payments totaling over $26.2 million. In the May 5th payment cycle, $29.4 million was paid on 101,398 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.

New Waiver Services Billing Codes in Health Enterprise: Effective May 3, 2014, Health Enterprise will now process waiver claims in accordance with the July 1, 2013 regulations. All claims processed on or after May 4, 2014 must be submitted with the "new" procedure code/modifier combinations and using the appropriate corresponding service authorization numbers. Claims processed on or after May 3rd using the following codes will be denied for lack of authorized units:

- T1016-U2 – Nursing Oversight and Care Management < 200 miles,
- T1016-U4 – Nursing Oversight and Care Management > 200 miles,
- T2034-U2 – Intensive Active Treatment < 200 miles
- T2034-U4 – Intensive Active Treatment > 200 miles
- T2001 – Escort

Additionally, claims that were previously submitted for the new services or using the new procedure codes that have been suspended or denied will be reprocessed for payment. Xerox will reprocess these claims within the next few weeks, and no action is required by providers to receive payment for these billed services.

Payment Checks: Warrants now have the provider's Alaska Medical Assistance ID printed on the check above the provider's name and address. This allows providers to link the payment to a specific billing provider ID.

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 in mid-May 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.

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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 reviewed and tested.

Mass Adjustments: Mass adjustments to reprocess approximately 2,070 claims meeting the following conditions were completed in the last two weeks:

- School-Based services claims denied for edit code 3343 – The Rendering Provider does not have a certification on file with type of certification in effect on the date of service.
- Claims denied for edit code 5180 – Service authorization ID not on claim

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.

Reminder: All provider licenses and certifications must be current to prevent claims from suspending or denying. Please submit a copy of all renewed licenses and certifications to Xerox as soon as you receive your updated documents. You may submit copies of renewed licenses and certifications to Xerox by fax to 907.646.4273 or by mail to:

Xerox
Attn: Enrollment Services
P.O. Box 240808
Anchorage, AK 99524-0808

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.

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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 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)
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 May 6th, 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	580	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	2,794	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 HCB HOSP HPRF RSL SBS SNF/ICF TRVL	1,691	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 PCA	2,181	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	2,308	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	2,390	**This error is tied to claims submitted prior to Oct 1, 2013 that usually suspend for edit codes 1891 and 1895 as well.** These claims must be manually worked.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	2,962	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 2,472 (83%) of the claims are from Health Professional Groups. **A change was implemented on April 29 allowing behavioral health claims to be released for processing.**
3321	Rendering Provider Certification Expired	DME HCB HPRF PCA TRAN	1,248	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 802 (64%) of these are PCA claims.
3325	Rendering Provider License Expired	HPRF	179	This exception will recycle for 60 days and if the license is not updated the claim will deny. This edit is functioning correctly. **This exception will be removed from the list if the number of suspended claims drops below 50.**

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
3329	Billing Provider License Expired – Suspend	HPRF TRAN	1,160	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 HPRF PHAR RPTC TRB	1,718	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 ALL provider types that require NPI	8,167	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 were updated in April and an additional fix is scheduled for mid-May.**
3650	Provider Payee ID Not Found	Electronic claims	243	**A majority of these claims were released for processing dropping the claim count from 6,090.**
3700	Provider on review	BRS HPRF PCA RSL	915	These claims continue to be analyzed to determine if additional providers can be taken off review. Approximately 660 (72%) of the claims impacted were submitted by Behavioral Rehabilitation providers.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
3800	Rendering Provider not in any Network associated to any of the Benefit Plans for the Member	BH HPRF PCA TRVL	2,582	**A majority of these claims were released for processing dropping the claim count from 7,058.** The remaining claims for services other than behavioral health and waiver services must be manually reviewed to determine if they should deny or move forward for payment. Almost 1,940 (73%) 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. **An additional fix is scheduled for mid-May.**
3802	Billing Provider not in Network for Member	Electronic claims	328	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 suspending for this edit were released for processing dropping the claim count from 6,050 to 328.**
3832	Medicaid coverage – Waiver claim excluded	CCA DME HCB RSL	6,045	These claims are suspending correctly. **Changes to waiver claims processing were successfully implemented in early May. The suspended claim count dropped from 14,065.**
4076	Review for Medical justification – Prof Claim Types	DENT HPRF TRAN	2,023	These claims are suspending correctly. Manual review required to move a claim forward is ongoing by Fiscal Agent nurses. Approximately 1,238 (61%) of these claims are from Ground Ambulance providers.
4105	Diagnosis Requires Review by the State	FPC HPRF	459	Manual work continues on these claims.
4645	Out of State Pricing Segment Not Found	DME FPC HPRF LAB	1,567	Analysis is in progress to determine if a change is needed or if the exception is working as designed.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
4826	Submitted units exceed the maximum units allowed for this procedure	DME HOSP HPRF RSL TRAN	915	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	488	A change has been identified to address how this edit processes. Approximately 171 of the claims (34%) are from Tribal providers. A change was implemented on April 16 which reduced the number of suspended claims from 6,074. Research is in progress to see if remaining claims are related to out of state providers.
4912	Procedure code requires pricing	CCA DENT DME HPRF LAB TRAN TRVL	1,420	This exception occurs when all pricing methodologies have been exhausted and the calculated allowed amount is zero. An error occurred causing outpatient claims to post when the provider did not have an institutional record. An emergency change as 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 in early May related to region codes. The majority of suspended claims were released for processing while the remaining affected claims are being analyzed.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
4916	Procedure / Modifier combination Pricing segment is set to Manual Review	DENT DME HOSP HPRF LAB	8,363	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 5,696 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 mid-May.** 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 DENT DME HCB NURS PCA TRAN	2,782	These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action. Almost 2,100 (75%) of these are Behavioral Health claims.
5221	Service Authorization record is pended w/errors – Line	BH DENT	2,375	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 2,210 (93%) of these are Behavioral Health claims.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
6110	Member Medicare Pt B Eligibility w/No Attachment	BH DME	2,254	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. The processing rules for this edit are being reviewed and a change is scheduled for late May.
6280	Cost avoid for no EOB and no TPL dollars	BH DME	891	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 in mid-April 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 DENT DME FQHC HOSP HPRF MD PHYS RPTC THER THRCTR TRB	20,239	The majority of these exceptions are from paper claims. Almost 14,575 (72%) 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.

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Edit/ EOB Code	Description	Providers Impacted	Impacted Claims	Status
6440	Cost Avoid when TPL dollars and EOB Exist	DENT DME HOSP HPRF TRB	1,842	An automated process has been implemented to update the Other Payer section on claims and to allow Force Payment of this edit. 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. **The remaining claims must be manually worked.**
6604	Possible Conflict / Different Provider	ASC BH ESRD FQHC HCB HOSP HPRF TRAN TRB TRVL	4,274	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 PCA TRAN TRVL	15,664	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. 8,835 of these claims are from taxi providers and 5,297 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 HPRF TRAN TRVL	3,723	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 with additional fixes scheduled.
9090	No Fund Code Criteria	FQHC HOSP HPRF PCA	826	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. **An additional fix is scheduled for mid-May.**