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Claim Payments: In the June 23rd payment cycle, 88,856 claims received payments totaling over $27 million. The table below details payments from 5/19/2014 through 6/23/2014

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
5/19/2014	86,458	36,455	$26,264,139.56
5/26/2014	90,229	49,979	$30,502,265.98
6/2/2014	95,484	38,547	$25,345,444.26
6/9/2014	116,433	40,770	$28,588,099.12
6/16/2014	126,448	47,987	$34,171,114.48
6/23/2014	88,856	38,708	$27,003,199.09

Timely Filing Denials: Xerox has recently set exception 1882 (Timely Filing Limit Exceeded) to suspend to prevent improper timely filing denials. Claims that have received a timely filing denial after October 1, 2013 will be identified and given consideration for payment. Xerox will reprocess claims with dates of service after September 1, 2012. Please be advised, while we are considering timely filing for this time period, these claims may be subject to a post-payment review conducted by the Xerox Surveillance and Utilization Review (SUR) Unit in cooperation with the DHCS Quality Assurance Unit.

Reformatting the Remittance Advice (RA): Recent changes were implemented on June 14, 2014 to address how credit and debits are displayed in the adjustment section of the RA for **Professional** and **Dental** providers. There were also **Institutional** changes implemented in mid-May to address how credits and debits are displayed in the adjustment section. In addition to making the information easier to read, the number of pages will be condensed.

Claims with Exception 4418 (There is a conflict between the Procedure Code and Provider Specialty submitted on the claim): This edit impacted provider types; Behavioral Health, Behavioral Rehab Services, Personal Care Agencies and Home and Community Based Waivers providers. This was a system error that occurred which was applying the incorrect specialty for the procedure being billed on the claim. This error does not require providers to correct their specialty on file. A recent change was implemented to allow claims that suspended or denied for exception code 4418 to be reprocessed. No action is required by providers.

Cost of Care:

- Long Term Care (LTC): An issue was identified that resulted in overpayments on the cost of care segment for LTC claims. Claims impacted by this issue are being identified and will be reprocessed by Xerox in the coming weeks. No provider action is required at this time.

- Assisted Living Homes: The patient payment amount submitted on claims is currently not populated to the appropriate cost of care fields to deduct this payment from billed charges. System changes will be needed to apply the correct cost of care being submitted on claims. Claims impacted by this issue will be identified and reprocessed by Xerox. No provider action is required at this time.

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Crossover Claims: Xerox is working to identify claims impacted by multiple crossover issues to include problems with the applying the correct co-pay and deductible information, and underpayments to providers. Further details about this issue will be included in future versions of this MMIS Update document.

Tribal Reprocessing: 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 first reprocessing effort will appear on remittance advices over the next two payment cycles and included the following:

Health Professional Groups and Clinics

- Exception Code 4826 – Procedure/Formulary Max Units Exceeded Denials
- Exception Codes 4111, 4134, 4137, 4140 and 4142 – Age Restricted Code Denials
- Exception Code 3833 – Place of Service Denial

Xerox has started the Tribal re-processing effort. Claims will continue to be batched and re-processed/adjusted over the next several payment cycles.

Paper Claims: The National Uniform Claim Committee (NUCC) recently updated the CMS-1500 paper claim form. Xerox has made the necessary changes to fully support the new form. At present both the revised 02/12 version and the former 08/05 version will be accepted. Xerox is preparing new CMS-1500 instructions and this should appear on the updates page of medicaidalaska.com in the coming days. Adequate notification will be provided before sun-setting the acceptance of the 08/05 version.

Third Party Liability Avoidance (TPLA): Xerox is working in collaboration with DHCS to incorporate TPL avoidance into Health Enterprise. As these efforts are ongoing, providers must continue to submit EOB's or denial letters from the primary carrier to Xerox for manual review and consideration for claims payment. Additional information will be provided when new codes are updated in the system and claims impacted will be reprocessed.

New Waiver Services Billing Codes in Health Enterprise: Effective May 4, 2014, Health Enterprise now processes 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 have been reprocessed for payment. No action is required by providers to receive payment for these previously billed services.

Adjudication Dates for Debits and Credits: An issue affecting the timing of claims processed with debits and credits has been identified. Analysis is underway to identify and correct this issue to ensure that credits and debits are processed during the same payment cycle/ adjudication date. Please watch this MMIS Updates document for further information and instructions.

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Providers Being Paid to Incorrect Provider Type: Xerox is conducting analysis in order to correct a defect that is allowing providers to be incorrectly paid for services not valid for their provider type. This is most frequently observed with providers who are enrolled with at least two provider ID's and the same NPI number and have more than one provider type. One thing that can assist is billing the correct taxonomy codes and servicing zip + 4 that are assigned to each provider type. Providers can contact our Enrollment Department to confirm the taxonomy codes along with zip plus four. Once the full impact of this issue is been identified, a reprocessing effort will take place to correct previously billed claims. Future MMIS Updates releases will contain additional details regarding re-processing timelines and action, if any, that is required from providers.

ICD-10 Delayed Implementation: On April 1, 2014, Congress enacted the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) which delayed the adoption of ICD 10 diagnostic and procedure code sets until October 1, 2015. The U.S. Department of Health and Human Services is expected to release an interim final rule requiring the use of ICD-10 beginning October 1, 2015. It is expected that the interim final rule will require HIPAA covered entities to continue using ICD-9-CM through September 30, 2015. Please visit the provider updates page of medicaidalaska.com to view additional information as it becomes available.

Org Admin Change Requests: An Organization Administrator (Org Admin) acts as the Health Enterprise administrator for your organization. An Org Admin has the authority to create new User IDs, assign levels of access, and disable User IDs in Health Enterprise. Many providers act as their own Org Admin, or appoint their office manager to that role. If you would like to change who in your organization has Org Admin access, you may complete the Organization Administrator Change Request form now available at http://manuals.medicaidalaska.com/docs/forms.htm.

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, 1)
Provider Relations Unit Member Eligibility	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, 2)
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)

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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 June 17th, 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. Exceptions highlighted in green represent a substantial drop (>25%) in Inventory compared to the previously released MMIS update on May 8, 2014.

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	% Change	Status
1370	The Diagnosis Related Code is repeated or missing or invalid.	DME FQHC HPRF HCB RSL	1,757	66%	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.
1880	Claim is pending for review due to notes	DME	3,423	54%	These claims are suspending correctly. Only DME claims are affected. The manual intervention required is ongoing.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
1882	Claim exceeds timely filing and no proof of timely filing attached	BH DENT DME HCB HOSP HPRF PCA RSL SBS SNF/ICF TRAN TRB TRVL	10,278	85%	Claims are suspending correctly and being reviewed as part of normal processing.
1891	Void / Replace TCN Missing or Invalid	BH HCB HOSP HPRF SBS PCA TRB	166	-93%	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 TRB	176	-93%	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 TRB	363	-87%	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.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	4,812	26%	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 3,204 (84%) 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 HPRF PCA RSL	3,544	311%	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 3,089 (80%) of these are PCA claims. Some claims suspending for this edit were released for processing in May while the remaining affected claims are being analyzed.
3325	Rendering Provider License Expired	HPRF TRB FQHC	268	64%	This exception will recycle for 60 days and if the license is not updated the claim will deny. This edit is functioning correctly.
3329	Billing Provider License Expired – Suspend	HPRF	69	-36%	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.
3600	Category of Service cannot be determined from information on the claim	ASC BH CCA HPRF PHAR RPTC TRB	4,535	67%	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	% Change	Status
3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	10,604	-6%	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. Additional system changes are required to improve automated provider record matching. Taxonomy tables were updated in April and additional changes to the system are being researched for implementation.
3650	Provider Payee ID Not Found	Electronic Claims	474	-26%	A majority of these claims were released for processing.
3700	Provider on review	HPRF PCA RSL TRB	3,799	334%	These claims continue to be analyzed to determine if additional providers can be taken off review. Some claims suspending for this edit were released for processing while the remaining affected claims are being analyzed.
3800	Rendering Provider not in any Network associated to any of the Benefit Plans for the Member	HCB PCA	3,204	589%	Xerox is conducting further analysis to determine if these claims can be released for further processing.
3802	Billing Provider not in Network for Member	Electronic claims	364	-31%	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.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
3832	Medicaid coverage – Waiver claim excluded	CCA HCB RSL	21,939	237%	Xerox is conducting further analysis to determine if these claims can be released for further processing.
4076	Review for Medical justification – Prof Claim Types	DENT HPRF TRAN AIRAMB	4,785	48%	These claims are suspending correctly. Manual review required to move a claim forward is ongoing by Fiscal Agent nurses. Approximately 1,895 (50%) of these claims are from Ground Ambulance providers.
4105	Diagnosis Requires Review by the State	FPC HPRF	1,734	138%	Claims are suspending correctly and being reviewed as part of normal processing.
4418	There is a conflict between the Procedure Code and Provider Specialty submitted on the claim	BH PCA BRSC HCB	6,911	N/A	This occurred when the specialty included for the procedure was not the specialty that is being assigned to the claim. A recent change was implemented to allow claims that suspended or denied for exception code 4418 to be reprocessed.
4645	Out of State Pricing Segment Not Found	DME FPC HPRF LAB RSL HOSP	7,929	245%	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	% Change	Status
4826	Submitted units exceed the maximum units allowed for this procedure	BH DME HOSP HPRF RSL TRB	1,382	-9%	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. Claims with units without decimals are recognized correctly. A change has been identified that will resolve this issue by allowing OCR to recognize decimals. This update is scheduled for future release and a manual workaround has been implemented until the system correction can be made.
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	1,888	223%	Research is in progress to see if claims are related to out of state providers and/or other problems that need to be addressed.
4912	Procedure code requires pricing	DENT DME FPC HPRF LAB TRAN TRB TRVL	2,266	-3%	This exception occurs when all pricing methodologies have been exhausted and the calculated allowed amount is zero. The majority of suspended claims were released for processing while the remaining affected claims are being analyzed.
4916	Procedure / Modifier combination Pricing segment is set to Manual Review	DENT DME HOSP HPRF LAB	8,595	33%	A rate is not on file causing manual pricing on these claims. Criteria for determining waiver claims pricing was updated. Review of all pricing criteria is ongoing as the Fiscal Agent staff continues manually pricing these claims.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
5051	Bill Provider - No Match Service Authorization Bill Provider	BH BRS DENT DME FQHC HOSP HPRF PCA	8,432	-17%	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. 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	DME HCB PCA	1,005	178%	These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action.
6110	Member Medicare Pt B Eligibility w/No Attachment	BH DME HPRF	1,701	-32%	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 change to the processing rules for this edit code is scheduled for July.**

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
6280	Cost avoid for no EOB and no TPL dollars	BH DME HPRF RPTC SBS TRB	6,554	45%	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.
6430	Cost Avoid for no TPL $ but EOB exists	BH DENT DME FQHC HOSP HPRF PHYS RPTC THER THRCTR TRB	27,549	51%	The majority of these exceptions are from paper claims. Almost 15,000+ claims were submitted by Health Professional Groups. Several system changes related to TPL processing have been identified and are in development. Because each one must be manually reviewed, additional staff has been added to assist with processing these claims. **Analysis is being conducted to prevent future claims from posting this exception. Additional code sets are being considered for TPL Avoidance.**
6440	Cost Avoid when TPL dollars and EOB Exist	DENT DME HOSP HPRF TRB	5,225	118%	An automated process has been implemented to update the Other Payer section on claims and to allow Force Payment of this edit.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
6604	Possible Conflict / Different Provider	ASC BH DME ESRD FQHC HCB HOSP HPRF LAB NURS RSL SBS TRAN TRB TRVL	11,271	78%	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	4,816	-49%	Mass adjustments of these claims are currently underway and will be staggered to reduce risk of error.
8050	Service Authorization Unit of Measure Mismatch	BH HPRF TRVL	2,024	-45%	The Service Authorization unit of measure code does not equal the claim line unit of measure code. These claims are suspending incorrectly. 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 with additional fixes scheduled.
9090	No Fund Code Criteria	FQHC HOSP HPRF PCA TAXI	663	-18%	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.