

Update: MMIS Status

August 14, 2014

Claim Payments: In the August 8th payment cycle, 101,275 claims received payments totaling over \$27 million. The table below details payments from 06/30/2014 through 08/04/2014.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
06/30/2014	98,036	37,987	\$27,097,959.22
07/07/2014	88,585	37,988	\$27,441,573.81
07/14/2014	123,249	33,016	\$35,894,469.94
07/21/2014	105,366	37,350	\$30,122,402.45
07/28/2014	90,435	36,723	\$27,013,355.46
08/04/2014	101,275	41,320	\$27,051,118.88

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 may now be given consideration for payment. Providers who received a timely filing denial for dates of service after September 1, 2012 can re-submit using their preferred method of claim submission.

Additionally, Xerox will work to identify and reprocess claims that received denials for 1882 with dates of service after September 1, 2012. This reprocessing effort will be announced at a later date. 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.

Taxonomy and Zip+4: Providers are encouraged to know and make use of their taxonomy codes and zip+4 that are listed on their provider file. For renderers affiliated with more than one group, and/or providers with multiple billing IDs, use of this information is critical to appropriately identifying the proper entity for payment. Failure to include taxonomies and zip+4s that match your provider file may result in adjudication delays and an increase in your suspended claim volume. Analysis and outreach is underway to identify providers who are experiencing a large suspense inventory based on preventable billing practices.

Assistant Surgeon Claims: Xerox has updated logic on the Assistant Surgeon codes covered by Alaska Medicaid for Assistant Surgeon claims billed with modifier 80, 81 and AS. Claims were released from suspense and appeared on remittance advices for the July 28, 2014 payment date. Claims that denied are being reprocessed this week and should appear on the August 4, 2014 remittance advice.

H0018 Impacting Behavioral Rehabilitation Services: Third Party Liability Avoidance (TPLA): Xerox recently implemented an update to bypass TPL editing for H0018 for Behavioral Rehabilitation Services; suspended claims were released on July 7, 2014 cycle. Denied claims were reprocessed on the July 14, 2014 cycle.

Xerox is working in collaboration with DHCS to incorporate TPL avoidance into Health Enterprise for additional services. As these efforts are ongoing, providers must continue to submit EOBs or denial letters from the primary carrier to Xerox for manual review and consideration for claims payment. Additional information will be provided when additional services are updated in the system and claims impacted will be reprocessed.

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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 following reprocessing has already occurred over the months of June and July:

Health Professional Groups, Clinics and Behavioral Health

- 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 Denials
- Behavioral Health Claims after October 1, 2013 dates of service only paying one Encounter rate for a multi-line claim.

Zero Pay Medicare Claims: Xerox is working to identify, correct, and reprocess Medicare crossover claims incorrectly paid at \$0.00. The reprocessing of these claims and the timing thereof, will be announced in advance using this MMIS Update forum.

Service Authorization Denials 5180 and 5010: Xerox is working to identify, correct and reprocess claims that have denied incorrectly for lack of service authorization in circumstances that do not require an authorization. The primary providers impacted by this issue are outpatient hospitals and professional settings. Xerox is also adjusting the system logic to prevent future erroneous denials. The reprocessing of these claims and the timing thereof, will be announced in advance using this MMIS Update forum.

Payerpath: Providers are still permitted to submit claims using Payerpath. At this time Xerox has not announced the discontinuation of Payerpath and providers are encouraged to submit claims by whatever means works best for their individual circumstances. Any decision to discontinue Payerpath at a future date will be clearly communicated, and be accompanied by training and other resources to prepare providers for such a transition.

Adjustment/Voids Scanning: Xerox has completed the effort to scan all AK05 Adjustment/Void forms into Enterprise. There is no backlog of AK05s waiting to be input into the system and the mailroom is current on this task. Xerox is processing AK05s each day and has identified additional resources to assist with the processing of these recently scanned AK05 forms. Xerox requests you do not submit duplicate submissions of AK05s.

Service Authorization Search Spans: When using Enterprise to search for service authorizations, please use the following tips to ensure the best results.

- Use the “Approved Date” field type for best results.
- Expand the search dates of your request by 10 days on both ends of your expected span.
 - Expected SA dates 01/03/2014 – 01/10/2014, expand search range to 12/24/13 – 01/20/2014 for best results.

J-Code Pricing Errors:

Xerox is currently analyzing J-Code pricing errors for claims that are currently suspended, as well as those previously adjudicated through Health Enterprise. Xerox is working to ensure that the correct NDC's are loaded into Enterprise and that these codes are paying at the appropriate rates. Further updates will be posted in upcoming MMIS Update releases. Xerox will also use this to communicate reprocessing efforts surrounding previously adjudicated claims.

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Cost of Care:

- Long Term Care (LTC): An issue was identified that resulted in overpayments and underpayments for LTC claims due to the application of LTC cost of care. 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 being deducted from billed charges when calculating payment. 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.

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.

Adjudication Dates for Debits and Credits: An issue affecting the timing of claims processed with debits and credits has been identified. Analysis is ongoing 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.

ICD-10 Delayed Implementation: On July 31, 2014, The U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.

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)

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Department	Lighter Call Periods	Contact Information
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)

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 August 4, 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 (>20%) in Inventory compared to the previously released MMIS update on July 2, 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

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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	398	-77%	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	7,805	128%	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 DENT DME HCB HOSP HPRF PCA RSL SBS SNF/ICF TRAN TRB TRVL	7,932	-23%	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	307	85%	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 are being manually worked.
1895	Claim not found on history	BH HCB HOSP HPRF PCA SBS TRB	339	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.

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1905	Billing Provider on claim does not match Billing Provider on replacement request	BH HCB HOSP HPRF PCA SBS TRB	189	-48%	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. Recent Xerox effort has reduced nearly half of the claims suspended for this reason.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	1,603	-67%	Reviewers manually audit claims to determine if a referral is valid so that the claim can be approved for payment. Recent Xerox effort has substantially reduced the number of claims suspended for this reason.
3321	Rendering Provider Certification Expired	DME HPRF PCA RSL	2,305	-35%	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). Some claims suspending for this edit were released, the remaining affected claims are being analyzed.
3325	Rendering Provider License Expired	HPRF TRB FQHC	175	-35%	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	151	119%	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	1,572	-65%	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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3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	8,669	-18%	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. Additional system changes are required to improve automated provider record matching.
3650	Provider Payee ID Not Found	Electronic Claims	491	4%	The majority of these claims were released for processing. Analysis continues for the remaining claims suspending for 3650.
3700	Provider on review	HPRF PCA RSL TRB	3,619	-5%	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	2,952	-8%	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	379	4%	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.
3832	Medicaid coverage – Waiver claim excluded	CCA HCB RSL	16,713	-24%	Xerox is conducting further analysis to determine if these claims can be released for further processing.

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4076	Review for Medical justification – Prof Claim Types	DENT HPRF TRAN AIRAMB	5,284	10%	These claims are suspending correctly. Manual review required to move a claim forward is ongoing by Fiscal Agent nurses. Approximately (50%) of these claims are from Ground Ambulance providers. Xerox has added additional resources in an effort to reduce this backlog.
4105	Diagnosis Requires Review by the State	FPC HPRF	2,219	28%	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	5,982	-13%	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	6,934	-13%	Analysis is in progress to determine if a change is needed or if the exception is working as designed. Xerox is assigning additional resources to assist with these claims.
4826	Submitted units exceed the maximum units allowed for this procedure	BH DME HOSP HPRF RSL TRB	1,260	-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.

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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	2,167	15%	Research is ongoing 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	2,686	19%	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	9,455	10%	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.
5051	Bill Provider - No Match Service Authorization Bill Provider	BH BRS DENT DME FQHC HOSP HPRF PCA	6,436	-24%	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	1,707	70%	These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action.

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6110	Member Medicare Pt B Eligibility w/No Attachment	BH DME HPRF	2,592	52%	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.
6280	Cost avoid for no EOB and no TPL dollars	BH DME HPRF RPTC SBS TRB	8,089	23%	If research indicates the edit is working correctly, electronic claims will deny. Providers will need to rebill and submit EOB.
6430	Cost Avoid for no TPL \$ but EOB exists	BH DENT DME FQHC HOSP HPRF PHYS RPTC THER THRCTR TRB	16,425	-40%	The majority of these exceptions are from paper claims. Almost 7,500+ 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	2,359	-55%	An automated process has been implemented to update the Other Payer section on claims and to allow Payment of this edit.

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6604	Possible Conflict / Different Provider	ASC BH DME ESRD FQHC HCB HOSP HPRF LAB NURS RSL SBS TRAN TRB TRVL	1,634	-86%	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.
8040	Service Authorization Units Fully Exceeded	DENT PCA TRAN TRVL	3,754	-22%	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	2,888	43%	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	649	-2%	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.