Update: MMIS Status

November 4, 2014

Claim Payments: In the October 27, 2014 payment cycle, 88,771 claims received payments totaling over $26,000,000. The table below details payments from 09/29/2014 through 10/27/2014.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
09/29/2014	103,419	34,245	$27,961,641.73
10/06/2014	107,097	37,338	$31,758,954.08
10/13/2014	105,494	35,269	$40,510,263.64
10/20/2014	106,512	36,209	$29,439,324.66
10/27/2014	88,771	41,016	$26,258,396.45

Paper Claims: Effective October 15, 2014, Alaska Medicaid transitioned to exclusive acceptance of the 02/12 version of the CMS-1500 paper claim form. As of this date, the 08/05 version is no longer accepted. As always, providers are encouraged to submit claims electronically or through the web portal. Questions? Please contact Provider Inquiry using the call center support table below.

Professional Remittance Advice Format: The release of the new Professional Remittance Advice format was executed on October 6, 2014. Similar to the Institutional RA reformatting effort referenced below, these highly anticipated updates will assist providers reconcile their RA's , and present payment information in an organized and easier to read format. Providers needing information or clarification about the new RA format are encouraged to contact the Xerox Provider Inquiry line.

Dental and Pharmacy Remittance Advice Format: The new Dental and Pharmacy Remittance Advice formats were implemented on October 11, 2014. The first RA messages using this new format were sent on October 13, 2014. Enhancements are a result of provider feedback and Xerox/DHCS collaboration to deliver payment information in a user-friendly format. Providers needing assistance or clarification about the new RA formats are encouraged to contact the Xerox Provider Inquiry line.

Phase I of the RA reformatting project is complete. Xerox and DHCS will now initiate a second round of RA changes that will correct additional items beyond the recently released formatting updates. Future versions of this MMIS Update document will contain additional details about these changes.

New Configuration – Member ID's (Payerpath): Member IDs generated using the State of Alaska's new eligibility system carry a unique ten digit configuration that begins with the number two (2). These member IDs are recognized by Alaska Health Enterprise and are actively loaded on a regular basis. Changes within the coding of Payerpath were necessary to facilitate the new ID configuration being passed from Payerpath to Enterprise.

Beginning October 12, 2014, Payerpath accepted member IDs that begin with two (2) on CMS-1500 forms. This functionality for Dental, Institutional and Transportation providers was implemented on October 19, 2014. For questions or clarifications about this updated functionality please contact the Xerox EDI support line using the information in the *Call Center Support* table below. For more information about the new eligibility system, ARIES, please use the following link as a resource: http://dhss.alaska.gov/dpa/Documents/dpa/pdf/ARIES_Overview.pdf

Timely Filing Denials: Xerox has set exception 1882 (Timely Filing Limit Exceeded) to suspend to prevent improper timely filing denials. This allowance is for claims that were submitted between October 1, 2013 and September 30, 2014. Claims that received a timely filing denial during this span may now be considered for payment.

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.

MRIs, and Medical Imaging Services: Xerox has identified claims for MRI's and other medical imaging services appended with modifier-26 for reprocessing. This highly anticipated effort was executed starting with the October 20, 2014 payment cycle. This effort will continue over the next several payment cycles to ensure that all of the impacted providers and claims are included. This universe includes more than 5,000 claims and is expected to have a significant financial impact throughout the Alaska Medicaid provider community. For questions or concerns about this reprocessing effort please contact the Xerox Provider Inquiry line.

Some of the most recent updates include:

- A list of emergent codes have been allowed to bypass Service Authorization requirements when performed in the emergency room.
- Exception code 5180 has been set to suspend to allow Xerox processors to review and process claims. Claims are being actively worked by Xerox.
- Dental codes D0230 and D0240 are currently denying when multiple claim lines are submitted for the same date of service, additional logic is being configured to allow for more than one unit on a single date of service.
- Imaging Service that use informational modifier RT/LT is under review to assure claims are paying accurately.

Provider Appeal Submissions: There are approximately 1,400 provider appeals being worked by the Xerox Appeals Department. Xerox has added additional staff and resources to help process the appeals backlog. Some of these appeals are duplicate submissions and/or pertain to claims impacted by unresolved system issues. Providers are encouraged to submit only one appeal per TCN. Providers are also encouraged to review future versions of the MMIS Update document to avoid submitting appeals that cannot be processed due to previously identified system issues.

Xerox is working with DHCS to develop resources and materials to assist providers with accurate and complete submission of their first level appeals. A new First Level Appeal Cover Sheet is the first document in development, and when released, will clarify the required documentation for appeals submission. Once complete, these resources will be posted to the Messages and Announcements page at medicaidalaska.com.

Adjustment & Void Processing: Xerox is developing a quick reference guide for provider use that covers the adjustment/void process. This document will provide detailed instructions regarding how to navigate the adjustment and void processing. Once complete, this quick reference will be located on the Messages & Announcements page at medicaidalaska.com.

To help expedite the processing of adjustment and void requests, Xerox encourages providers to use one of the following two options. Providers can use the electronic adjustment option within their electronic billing software package. A second alternative is submitting adjustment/void requests via the web portal, however this option is only available for claims that were originally submitted through the web portal. Paper claim adjustments will continue to be accepted and processed.

This ensures that provider requests are processed timely and reduces the opportunity for processing errors. For questions about how to submit electronic void/adjustment requests please contact the EMC HIPAA (EDI Electronic Billing) phone number shown in the Call Center Support table below.

Small Hospital Pricing: Xerox is conducting analysis to determine the impact of Small Hospital pricing errors that have been reported. Analysis is underway to identify which services are being underpaid and/or paid at rates that do not coincide with negotiated facility rates. Once analysis is complete, Xerox will make outreach to providers to discuss the provider impact and coordinate a

reprocessing plan. Providers are encouraged to report underpayments and other unique circumstances to the Xerox Provider Inquiry line using the *Call Center Support* table below.

Provider Disclosure Statement: Providers are encouraged to return the Provider Disclosure Statement form that was sent in August 2014 as quickly as possible. Returning this form is required to maintain enrollment with Alaska Medicaid. This form is required by CFR Title 42 Part 455 Subpart B - *Disclosure of information by providers and fiscal agents* and Subpart E – *Provider screening and enrollment (link below).* Please note that this form is also required for all new enrollment applications that are submitted to Alaska Medicaid. For questions or concerns about the Provider Disclosure Statement, please contact the Xerox Provider Enrollment department.
http://www.ecfr.gov/cgi-bin/text-idx?SID=a2503b90d128c450d097c2c2caa24b1f&node=42:4.0.1.1.13&rgn=div5

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. A list of recent tribal reprocessing and upcoming efforts is shown below.

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.
- TPLA CHA/P reprocessing
- Behavioral Health claims previously denied for rendering exceptions
- Clinics impacted by the 2014 retro rates are beginning to be reprocessed for targeted providers. Additional providers will be reprocessed over the coming weeks.
- 4125 Denials impacting Health Professional Groups and Clinics will be reprocessed over the coming weeks.

Waiver and Personal Care Services: Specific issues are affecting timely and accurate processing of claims for waiver services. All claims will be reprocessed when all defect fixes have been deployed. This is to reduce the number of times a single claim is reprocessed. The following reprocessing occurred between September and October:

- Edit code 5051 continues to impact providers Xerox is running a nightly fix to process claims posting this exception code.
- S5100 and S5101-recent updates have been made to allow these two codes to be billed on the same date of service for the same member. Reprocessing occurred late September and early October.
- TEFRA Benefit Plan is currently in the system and claims are being identified for reprocessing
- Edit 4418 posting to claims has been corrected for Waiver services. Claims that have been impacted have been sent through for reprocessing.

J-Code Pricing Errors:

Xerox is currently analyzing J-Code pricing errors for claims that are 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.

Drug Efficacy Study Implementation (DESI Drugs): Xerox is currently working to identify and resolve issues surrounding claim submissions for DESI drugs. Recent changes have

been made to allow claims that were previously setting Exception 4375 to process for payment. Claims that previously denied for Exception 4375 will be identified and reprocessed. No provider action is required at this time.

CLIA Exception 4400: The CLIA certification type on file for the procedure code submitted on the claim does not match the CLIA provider certification type on the provider file for the dates of service on the claim.

Recent system changes have been implemented to prevent claims from denying for exception 4400. Xerox is identifying claims that previously denied for this exception and will reprocess these claims over the next several payment cycles. No provider action is required at this time.

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.

NPI Matching, Taxonomy and Zip+4: Xerox and DHCS are working to refine the NPI matching logic that is currently suspending provider claims with exception 3620. System improvements are in development that should lead to better NPI matching and reduced suspense volume for NPI multi-match issues. In preparation for this, 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.

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.

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)

Department	Lighter Call Periods	Contact Information
Service Authorization	From 8:00-9:30 a.m. After 2:00 p.m.	In Anchorage: 907.644.6800 (option 5) Outside Anchorage: 800.770.5650 (option 1, 2)
EMC HIPAA (EDI, Electronic Billing)	From 8:00-9:30 a.m. After 2:00 p.m.	In Anchorage: 907.644.6800 (option 3) Outside Anchorage: 800.770.5650 (option 1, 4)

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 October 30, 2014.

The Providers Impacted column lists the provider types affected by the exception code if there are more than 100 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 October 17, 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

Update: MMIS Status

November 4, 2014

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	1,067	69%	An issue with this exception was previously corrected and claims processed. Analysis is ongoing to determine the most appropriate action to take on these remaining claims.
1880	Claim is pending for review due to notes	DME	56	-69%	These claims are suspending correctly. Recent Xerox effort has substantially reduced the number of claims suspended for this exception.
1882	Claim exceeds timely filing and no proof of timely filing attached	All Provider Types	1,396	3%	Claims are suspending correctly and being reviewed as part of normal processing. Recent Xerox effort has substantially reduced claims suspended for this exception.
1891	Void / Replace TCN Missing or Invalid	BH HCB HOSP HPRF SBS PCA TRB	114	-49%	The exception indicates the requested void or replacement has already been voided or replaced, meaning the request cannot be processed. Analysis to correct this issue is underway.
1895	Claim not found on history	BH HCB HOSP HPRF PCA SBS TRB	172	55%	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	2	-97%	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 the claims suspended for this exception.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	452	105%	Reviewers manually audit claims to determine if a referral is valid so that the claim can be approved for payment.

Update: MMIS Status

November 4, 2014

Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
3321	Rendering Provider Certification Expired	DME HPRF PCA RSL	105	239%	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).
3325	Rendering Provider License Expired	HPRF TRB FQHC	198	-23%	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	175	99%	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. This exception is functioning correctly.
3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	3,125	-1%	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.
3700	Provider on review	HPRF PCA RSL TRB	558	90%	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.

Update: MMIS Status

November 4, 2014

Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
3800	Rendering Provider not in any Network associated to any of the Benefit Plans for the Member	HCB PCA	163	-20%	Xerox is conducting further analysis to determine if these claims can be released for further processing. Recent Xerox effort has substantially reduced claims suspended for this reason.
3832	Medicaid coverage – Waiver claim excluded	CCA HCB RSL	693	-52%	Xerox is conducting further analysis to determine if these claims can be released for further processing. Recent Xerox effort has substantially reduced claims suspended for this reason.
4076	Review for Medical justification – Prof Claim Types	HPRF TRAN AIRAMB	1,876	-3%	These claims are suspending correctly. Manual review required to move a claim forward is ongoing by Fiscal Agent nurses. Xerox has added additional resources in an effort to reduce this backlog.
4105	Diagnosis Requires Review by the State	FPC HPRF	1,051	0%	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	290	753%	This occurred when the specialty included for the procedure was not the specialty that is being assigned to the claim. Analysis is ongoing to determine the appropriate processing steps to clear these claims from suspense. No provider action is required at this time.
4645	Out of State Pricing Segment Not Found	DME FPC HPRF LAB RSL HOSP	2,756	-18%	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	92	-72%	This exception appears to be functioning properly. Suspended claims are being reviewed to verify units.

Update: MMIS Status

November 4, 2014

Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	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 TRB	836	14%	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	512	20%	This exception occurs when all pricing methodologies have been exhausted and the calculated allowed amount is zero. Analysis is ongoing to determine if prices can be established for the codes currently suspending for this exception.
4916	Procedure / Modifier combination Pricing segment is set to Manual Review	DENT DME HOSP HPRF LAB	2,729	-20%	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	1,051	-45%	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	336	-37%	These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action.

Update: MMIS Status

November 4, 2014

Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
6110	Member Medicare Pt B Eligibility w/No Attachment	BH DME HPRF	90	-72%	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.
6430	Cost Avoid for no TPL $ but EOB exists	BH DENT DME FQHC HOSP HPRF PHYS RPTC THER THRCTR TRB	2,211	56%	The majority of these exceptions are from paper claims. 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. As noted above, additional code sets are being considered for TPL Avoidance.**
8040	Service Authorization Units Fully Exceeded	DENT PCA TRAN TRVL PRV DTY NRS	165	70%	Mass adjustments of these claims are currently underway and will be staggered to reduce risk of error. Xerox is also working to identify and reprocess claims that denied for 8040 in error.
8050	Service Authorization Unit of Measure Mismatch	BH HPRF TRVL	222	-80%	The Service Authorization unit of measure code does not equal the claim line unit of measure code.. 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.

Update: MMIS Status

November 4, 2014

Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
9090	No Fund Code Criteria	FQHC HOSP HPRF PCA TAXI	204	-53%	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.