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Claim Payments: In the November 24, 2014 payment cycle, 109,402 claims received payments totaling over $30,500,000. The table below details payments from 10/27/2014 through 11/24/2014.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
10/27/2014	88,771	41,016	$26,258,396.45
11/3/2014	103,043	35,292	$26,628,262.52
11/10/2014	98,985	30,166	$29,932,132.32
11/17/2014	93,807	30,646	$24,593,707.82
11/24/2014	109,402	37,008	$30,783,786.99

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. CPT codes H0018 and H0019 billed by Behavioral Health Providers are on avoidance currently and reprocessing has occurred. CHAP groups, which service our IHS facilities, and School-Based Services have also been placed on TPL avoidance. Additional information will be provided when new codes are updated in the system and we expect that to be very soon. Impacted claims will be reprocessed.

Exception Code 3801: Xerox is working to identify claims that have denied for exception code 3801 in error. This exception is triggered when the system determines that a member has not been assigned to a benefit plan. A data fix is expected to correct the benefit plan assigned and a reprocessing should occur the week of November 24, 2014.

Exception Code 6090: Xerox has worked to develop a workaround for claims that are suspended for exception code 6090 in error (*Member has Medicare Part A coverage for the Dates of Service on the claim*). This issue impacts Long Term Care Providers when billing the ICF level of care, (revenue codes 191). Xerox is running a nightly job to bypass the edit. If a SNF level of care is billed, (revenue code 192) the state will review those claims to assure we have a notice of Medicare Non Coverage for part A members.

CMS-1500 Claim Form Instructions: New CMS-1500 claim form instructions were recently posted to Alaska Medicaid website. These instructions are a valuable tool for providers, as they help clarify appropriate field values to ensure appropriate claims adjudication. Please use these instructions as a companion to, and not a replacement for, the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, available at http://nucc.org.

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.

Out of State Pricing: Xerox continues to add resources and identify more efficient ways to process claims that suspend for out of state pricing. Xerox is working to update claims processing logic to ensure that exceptions are triggered appropriately for out of state pricing based on servicing location, versus those providers with out of state billing addresses.

Additionally, out of state providers submitting claims to Alaska Medicaid, please include a copy of your home state fee schedule and/or payment criteria. This should assist with processing times in relation to out of state pricing and lead to improved payment accuracy for providers. Please note that Xerox and DHCS will verify the authenticity of these documents prior to pricing the claim.

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Medicare Vision Claims: Changes in how Xerox processes Medicare Vision Claims were implemented on November 13, 2014. These changes were intended to prevent inappropriate denials of these claims for missing EOB attachments and other issues reported by the provider community. Initial analysis of these changes appears to have resolved many of the outstanding issues. Providers are encouraged to closely review their upcoming Remittance Advice, and report additional problems to the Xerox Provider Inquiry line if they suspect additional claims were denied in error.

Claim Denials – Exception Code 2950: Providers have reported a pattern of claim denials for exception code 2950, *Member is locked into another Provider*. Xerox is working with providers on a case by case basis to determine if the 2950 denials are appropriate as each provider/member combination is unique. To date the primary source of 2950 denials appears to be based on referrals that do not meet the required criteria. A reminder about acceptable referral criteria was published in the *Ask Medicaid* section of the September 2014 Provider Newsletter and can be found using the following link http://manuals.medicaidalaska.com/docs/dnld/Newsletter_201409.pdf.

Paper UB-04 Billing - Payer Name Requirements: When billing Alaska Medicaid for services on a UB-04 paper claim form, providers must enter "Medicaid" in box 50a, 50b, or 50c, Payer Name. If any other name is used in place of Medicaid (i.e., Alaska Medicaid, Alaska Medical Assistance, DenaliCare, Denali Kid Care, Xerox) the claim will deny with exception code 1320.

Claims with Exception 4418 (There is a conflict between the Procedure Code and Provider Specialty submitted on the claim): This edit has impacted the following provider types: Behavioral Health, Behavioral Rehab Services, Personal Care Agencies and Home and Community Based Waivers providers. This problem originally appeared in April/May 2014 and has recently resurfaced. This system error applies the incorrect specialty for the procedure code that is billed on a 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. Xerox is running a nightly job to process the exception code. This issue is currently being tested for a permanent fix in the system.

Timely Filing Denials: Xerox has set exception 1882 (Timely Filing Limit Exceeded) to suspend to prevent improper timely filing denials 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. Claims submitted on or after October 1, 2014, are subject to standard timely filing rules.

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 universe included more than 5,000 claims and had a significant financial impact throughout the Alaska Medicaid provider community. Reprocessing of these claims is nearing completion. Please alert the Xerox Provider Inquiry line for any outstanding or unresolved claim denials.

Additionally, new system logic that will improve the payment accuracy of MRIs and Medical imaging service in both the inpatient and outpatient settings is in the final testing stages. Please review future versions of this MMIS Update document for more information about these changes.

Provider Appeal Submissions: There are approximately 1,000 (-30% since 11/1/2014) provider appeals being processed 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. Once complete, these resources will be posted to the Messages and Announcements page at medicaidalaska.com.

Adjustment & Void Processing: At this time Xerox is unable to process adjustment/void forms that are accompanied by a check. Xerox is actively working to resolve this issue and the corresponding backlog that this has created. This inventory will be processed as soon as the functionality is repaired.

To help expedite the processing of adjustment and void requests, Xerox encourages providers to use one of the following two options: 1) Providers can use the electronic adjustment option within their electronic billing software package. 2) Submit 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.

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

- 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.
- Edit 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

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. Analysis shows that DESI drug and J-code claims processing has recently improved. Claims that previously denied for Exception 4375 will be identified and reprocessed. 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.

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)
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)

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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 November 20, 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 November 4, 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	1,075	1%	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.
1882	Claim exceeds timely filing and no proof of timely filing attached	All Provider Types	1,397	0%	Claims are suspending correctly and being reviewed as part of normal processing. Recent Xerox effort has substantially reduced claims suspended for this exception.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
1891	Void / Replace TCN Missing or Invalid	BH HCB HOSP HPRF SBS PCA TRB	193	69%	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	21	-88%	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.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	428	-5%	Reviewers manually audit claims to determine if a referral is valid so that the claim can be approved for payment.
3321	Rendering Provider Certification Expired	DME HPRF PCA RSL	234	123%	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	94	-53%	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	8	-95%	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.

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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	2,684	-14%	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	9	-84%	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	600	8%	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	118	-28%	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	7	17%	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	670	-3%	Claims are suspending correctly and being reviewed as part of normal processing.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
4418	There is a conflict between the Procedure Code and Provider Specialty submitted on the claim	BH PCA BRSC HCB	1,158	-38%	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 RSL HOSP	1,168	11%	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	114	-61%	This exception appears to be functioning properly. Suspended claims are being reviewed to verify units.
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	2,328	-16%	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	66	-28%	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	752	-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.

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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	522	2%	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.
5220	Service Authorization record is pended w/errors - Header	DME HCB PCA	2,355	-14%	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	767	-27%	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 HOSP HPRF PHYS THER THRCTR TRB	107	-68%	Analysis is being conducted to prevent future claims from posting this exception.
8040	Service Authorization Units Fully Exceeded	DENT PCA TRAN TRVL PRV DTY NRS	77	-14%	Xerox is working to identify and reprocess claims that denied for 8040 in error.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
8050	Service Authorization Unit of Measure Mismatch	BH HPRF TRVL	15	-29%	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.
9090	No Fund Code Criteria	FQHC HOSP HPRF PCA TAXI	2,547	15%	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.