Update: MMIS Status

January 2, 2015

Claim Payments: In the December 22, 2014 payment cycle, 133,512 claims received payments totaling over $35,700,000. The table below details payments from 11/24/2014 through 12/22/2014.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
11/24/2014	109,402	37,008	$30,783,786.99
12/01/2014	87,766	29,990	$27,061,883.12
12/08/2014	108,098	35,235	$27,146,910.97
12/15/2014	96,310	34,621	$34,894,447.83
12/22/2014	133,512	47,190	$35,739,442.51

Third Party Liability Avoidance (TPLA): Xerox is working in collaboration with DHCS to incorporate TPL avoidance into Health Enterprise. As of December 12, 2014, the following Behavioral Health procedure codes have been placed on TPL avoidance; H0031, H2017, H2019, H2019-HQ, T1016, and H0033. Claim denials for no explanation of benefits (EOB) have been identified for reprocessing the week of December 15th and December 22nd.

Xerox and DHCS are also working on identifying additional provider types and code sets that are appropriate for TPL avoidance. 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 we expect that to be very soon. Impacted claims will be reprocessed.

Adjustment & Void Processing: The execution of adjustments and voids within Enterprise is substantially different when compared to Legacy MMIS processing. Enterprise reprocesses an entire claim when a line within the claim is adjusted or voided. Providers should also note that when claims are voided or adjusted, a receivable is created and the amount is recouped immediately. Each of these actions display on the weekly Remittance Advice documents.

A quick reference guide containing detailed instructions on the appropriate way to execute electronic adjustment and void transactions has been posted to the updates page of medicaidalaska.com. Providers are encouraged to review this reference guide and outreach to the Xerox Provider Inquiry line with any questions or clarifications that are necessary.
The quick reference guide can be accessed by following the link below.
http://manuals.medicaidalaska.com/docs/dnld/Update_Adjust_Void_Electronic_Claims_20141211.pdf.

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.

NPI Matching, Taxonomy and Zip+4: System improvements have been developed that should lead to better NPI matching and reduced suspense volume for NPI multi-match issues. If they have not already done so, providers are strongly encouraged to know and make use of their taxonomy codes and zip+4 that are listed on their provider file. This update was made on December 20, 2014, and claims are now being processed with this system logic.

For renderers affiliated with more than one group, and/or providers with multiple billing IDs, use of zip+4 and billing taxonomy 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.

Additional NPI mapping enhancements to include form type and procedure code were also made on December 20, 2014. Xerox and DHCS are working on developing additional mapping updates to further improve claims processing and reduce the number of claims suspended for exception 3620. Announcements regarding this effort will be included in future versions of this MMIS Update document.

Remittance Advice Updates: Beginning with the December 29, 2014 payment cycle, providers will notice additional enhancements to their Remittance Advice documents. The improvements include, but are not limited to; improved alignment in the recoupments and cycle decrease section, and the removal of commas when the member name field contains a null value. Lastly, providers will notice that financial recoupments will be listed by FCN on their RA.

Washington Fee Schedule Updates: Xerox has recently made system changes related to the State of Washington fee schedule for the following procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215. These changes were made to ensure that appropriate Washington rates are applied to claims for members 0-20 years of age. Providers are encouraged to report new issues or unexpected outcomes to the Xerox Provider Inquiry line.

Exception Code 5051: This exception has previously impacted providers who bill claims with service authorizations attached. Recent system updates have been put in place to improve claims payment in relation to service authorizations. These changes include mapping the billing provider ID submitted on a claim to the line level of a service authorization. Providers who have previously been impacted by 5051 denials are encouraged to resubmit claims and report any unexpected outcomes to the Xerox Provider Inquiry line.

Exception Code 0004: Xerox has made system changes to improve claims processing in relation to exception 0004. The exception is triggered when more than one claim is being processed on behalf of the same member at the same time. These improvements will minimize future suspended claim volume for exception 0004 and will assist with a smooth transition of these claims into the weekly payment cycle.

Exception Code 3801: This exception was triggered when the system determined that a member had not been assigned to a benefit plan. Xerox identified and reprocessed claims that denied for exception 3801 in error. If you believe you have claims that received a 3801 denial but were not reprocessed, please contact the Xerox Provider Inquiry unit for assistance.

Exception Code 1510: On December 20, 2014, Xerox corrected outstanding issues related to exception 1510. This system change has corrected issues related to the calculated covered dates of service for inpatient hospital claims. Providers who were previously experiencing claim denials related to 24 hour inpatient hospitalizations should be positively impacted by these updates.

Exception Code 1470: Xerox has corrected the logic that was previously causing exception 1470 to post in error. System updates have been made and Enterprise will now properly consider circumstances where a patient is admitted to the hospital via the emergency room or an observation bed and the hospital admit date is one day after the patient commences treatment. Providers are encouraged to begin testing this functionality by submitting claims that meet this criterion. Please alert the Xerox Provider Inquiry line if any new or unexpected outcomes begin to occur.

FQHC and Tribal Providers Paid for CPT 99386 and 99396: Recent system changes have been made to prevent FQHC and Tribal providers from being paid in error for these procedure codes. Updates were made to Professional, Dental, and Outpatient pricing methodology to bypass un-necessary procedure code steps for claims that will be encounter rate priced. This impacts Tribal Hospitals, Tribal Clinics, Federally Qualified Health Centers, and Rural Health Clinics. Xerox will announce reprocessing to recoup/recover claims paid in error at a later date.

Procedure Code 90832: Mental health providers may notice that CPT code 90832 shows up as 9006 on the Service Authorization look up in Health Enterprise. This is not an error in the system; Enterprise converts the CPT 90832 to 9006, an internal system list, during processing. Please continue to use 90832 and other appropriate codes when submitting requests for service authorization and claims for payment.

Tribal Reprocessing and Updates: 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.

Recent updates have been implemented to correct encounter rate issues experienced by Dental and Behavioral Health providers. These updates impact fee for service claims for dates of service prior to October 1, 2013. Outpatient services when billed with a lab service are now paying at the encounter rate only. Both of these issues are under post implementation review and will be reprocessed in coordination with the Division of Health Care Services. Some of the recent reprocessing jobs that have occurred for Tribal providers are identified below.

Health Professional Groups, Clinics, Behavioral Health and Outpatient Services

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

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 submitted on or after October 1, 2014, are subject to standard timely filing rules.

Exception Code 6090: Xerox has recently implemented system changes for exception 6090 that posted to claims in error when an ICF level of care was rendered, (revenue code 191 and 193). However, a workaround solution was applied while the system fix was being developed. No reprocessing for this exception code is scheduled to occur at this time. If a SNF level of care is billed, (revenue code 192) DHCS 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.

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 recent 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. Providers must include a referral with each date of service/claim submitted. AK Health Enterprise does not store referrals for application to subsequently submitted claims. 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.

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. A correction for this issue is scheduled for deployment in January. Once the system changes occur the impacted claims will be identified and reprocessed by Xerox. No provider action is required at this time.

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. The permanent fix was implemented on December 6, 2014.

Provider Appeal Submissions: There are approximately 720 (-27% since 11/24/2014) 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.

Provider Training Schedule 2015: Xerox is pleased to announce the 2015 Provider Training Schedule. Training locations and dates may be viewed on the Learning Management System (LMS) at http://learn.medicaidalaska.com. For a complete list of courses and descriptions, log in to the LMS and select Provider Training from the Provider dropdown menu.

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)

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)
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 December 22, 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 24, 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	1,059	-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	81	-94%	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	-	-100%	Xerox has resolved the outstanding inventory for claims posting exception 1891.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	504	18%	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	547	134%	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	238	153%	This exception will recycle for 60 days and if the license is not updated the claim will deny. This edit is functioning correctly.
3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	1,960	-27%	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.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
3700	Provider on review	HPRF PCA RSL TRB	480	-20%	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	114	-3%	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	656	-2%	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	657	-43%	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	1,218	4%	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	178	56%	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	1,268	-46%	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.
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	510	-32%	Research is ongoing to see if claims are related to out of state providers and/or other problems that need to be addressed.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
4912	Procedure code requires pricing	DENT DME FPC HPRF LAB TRAN TRB TRVL	260	-50%	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	448	-81%	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.
5220	Service Authorization record is pended w/errors - Header	DME HCB PCA	329	207%	These claims are set to automatically release for reprocessing each evening so that corrected claims process as the Service Authorization team takes action.
6430	Cost Avoid for no TPL $ but EOB exists	BH DENT DME HOSP HPRF PHYS THER THRCTR TRB	2,364	-7%	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	814	153%	Xerox is working to correct the issue impacting this exception code.
9090	No Fund Code Criteria	FQHC HOSP HPRF PCA TAXI	19	27%	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.