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Payments: From April 22, 2015 through June 10, 2015, an average of 107,600 claims totaling $29.5 million was paid on a weekly payment cycle. The table below details payments from 4/22/2015 through 6/10/2015.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
4/22/2015	94,973	29,134	$30,116,253.24
4/29/2015	100,627	28,441	$26,514,278.67
5/5/2015	104,293	33,603	$31,943,080.49
5/12/2015	112,221	36,411	$30,359,942.84
5/19/2015	96,280	30,532	$28,298,841.30
5/26/2015	96,825	26,637	$25,086,636.24
06/03/2015	138,648	28,913	$27,619,012.93
06/10/2015	117,003	39,626	$35,938,894.90

Notable April Fixes and Updates:

- Providers may have noticed exception 1994, *There is no Deductible or Coinsurance On Crossover Claim submitted*, posting on Medicare part B and C cross overs. Fixes will address the mapping of the co-insurance and deductible information to apply the correct pricing logic to these claim types. Outpatient and professional services are impacted. The exception has been set to suspend to validate that the co-insurance and deductible information are accurately reporting on the claim. Reprocessing is underway for claims that were previously suspended for exception 1994. The results of this reprocessing should start to appear on RA's following the 5/26/15 payment cycle. Xerox is currently validating crossover claims that originally denied or partially paid by verifying correct deductible and coinsurance applications. The last step in this process will be to reprocess the old denials for the coinsurance and deductible information issue.
- Claims have erroneously denied for exception 1580, O*perating physician number is missing or invalid.* The operating physician is not required on all claim types and claims were denying in error for professional services. The fix occurred in April and claims are currently being analyzed for reprocessing.
- System corrections for length of stay cutback for C-section were completed in April. Claims are currently being analyzed for reprocessing.
- System enhancements are currently underway for Assistant Surgeon claims to allow for codes that are sometimes payable based on medical justification. Once the changes have been made, providers will begin seeing exception 4076, *Review for Medical Justification,* post to claims that are sometimes payable based on medical justification. This is still being tested but we anticipate the enhancement will be completed in the coming weeks.
- Certain waiver claims are incorrectly posting 8930, *Residential Habilitation not on same DOS*, for procedure code T2016 and T2016 TG. Corrections are being implemented to allow these codes to be considered on the same date of service. Exception code 8930 is currently set to suspend until the issue is corrected. The suspended claims will be analyzed daily to determine if the T2016 has been billed before the T2016 with a TG modifier on the same date of service. Inappropriately denied claims are also being identified for reprocessing.
- Long-term Care claims are being improperly denied for exception 4131, A*dmitting diagnosis age conflict*. This issue was resolved in April 25, 2015. Impacted claims are currently being analyzed for reprocessing.

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Notable May Fixes:

- Exception code 4645, *Out of State Pricing Segment not found*, was posting incorrectly. The system was not reading the pricing segment on file when modifiers 26 and TC were submitted on the claim. Xerox is validating the system correction and will continue to manually price any adversely impacted claims.
- Exception code 4680, *Zero Units with greater than zero amount on claim.* This error caused claims to suspend for review when they should've been automatically adjudicated. Xerox and the state are currently reviewing the associated codes and making updates accordingly. The most notable impacts are crossover and professional claims. Once all of the affected codes are updated, claims will be processed.
- Crisis Intervention Services (S9484) is posting exception code 7856, *Crisis Intervention Daily Service Limit Exceeded.* Additional criteria are being added to the system to address the exception improperly posting on claims. Once the fix is implemented, Xerox will reprocess the claims.

Upcoming June Fixes:

- Exception code 4626, *Accommodation days is not equal to the covered days*. This error is positing on inpatient claims and is impacting the ability to pay a 24 hour inpatient stay. Xerox and the state will be reviewing impacted claims once the issue is resolved and reprocessing will occur on those claims, the fix is scheduled for June 27, 2015.
- Box 25 on the new ADA Dental claim forms had a correction implemented on June 13, 2015 to correct an issue where a leading zero was populating in box 25. Xerox did implement a work around on paper claims while the issue was being resolved. The leading zero was causing claims to deny inappropriately and all impacted claims will be identified and reprocessed in the coming month.
- In 2013, an issue developed in the Alaska Medicaid Health Enterprise system that affected Alaska Medicaid received payments processing, specifically provider financial transactions and 1099s. The issue was isolated to repayments from providers in the form of a check. These payments included transactions such as overpayment for anticipated voids or recoupments, TPL reimbursement, and advancement repayments made in 2014. The issue was resolved in May 2015 and Xerox is currently processing all payments submitted by check during 2014. Affected providers will see adjustments to their financial accounts reflected on upcoming RAs in the Financial Transaction and Summary sections as they are processed. Although the provider's financial transactions and current 1099 amounts may appear incorrect on the RA, the adjustments will have no impact on the final Year-To-Date Total Paid amount. All affected 2015 1099s will be manually reviewed to ensure all checks were processed and applied appropriately.

Service Authorization Updates:

- A major reprocessing effort is underway to correct the used units on approved service authorizations. The table below provides the list of authorization types that have been updated along with the remaining types still being reviewed. Future claims reprocessing may be required but sufficient notice will be provided prior to any recoupments.

Completed
Personal Care Attendant
Inpatient Hospital - Inpatient Psych, Inpatient Hospital - UM
Outpatient Hospital / CAMA Treatments, Pharmacy Drugs
Professional, Private Duty Nursing, Outpatient Hospital/ASC - UM
Behavioral Rehab Services, CAMA Treatments, Hospice
Transportation (Emergent)

Vision
Home Infusion Therapy, Hearing Aids & Hearing Aid Supplies
In Progress
Dental
Transportation & Accommodation (Non-Emergent),
Home Health Services
Residential Psych
Waiver
Enhanced Adult Dental Service
DME/Medical Supplies
Radiology
Mental Health Outpatient Services

- **Inpatient Qualis SA issues:** There was a problem with the file transfer process between the Qualis Inpatient Service Authorization system and the MMIS. Xerox and Qualis are actively working to resolve and reconcile impacted service authorizations that have been impacted from the file transfer process. These authorizations do not have the updated continuous stays approved for inpatient claims, including RPTC. A full reconciliation will be performed in the coming weeks to ensure all affected date segments are properly updated. Providers are encouraged to contact Xerox Provider Inquiry to assist in reconciling the approval dates on impacted service authorizations.

Claims Reprocessing:

- **Exception 9854 Posting to Providers Remittance Advice:** Many providers have made inquiries regarding Remittance Advice documents containing claims suspending with exception code 9854. Exception 9854, *First Time Mass Adjustment*, posts on claims that Xerox is staging for reprocessing. Providers should note that claims posting 9854 have not been adjudicated, but are simply being evaluated for reprocessing. Xerox is working with the State of Alaska to review the staging of claims posting 9854 to ensure that the reprocessing efforts minimize the number of times a single claim is touched. When reviewing a Remittance Advice, claims suspended for 9854 are a sign that the process of correcting impacted claims is underway.
- Upcoming reprocessing resulting in recoveries, or the recoupment of overpayments, will be communicated to providers in advance. Repayment options will be discussed before the recoupment is made.
- Xerox and the State of Alaska are evaluating reprocessing for the scenarios listed below. This is not an all-inclusive list, but represents the reprocessing that is most likely to occur in the coming weeks:
  - Crossover reprocessing is currently underway for exception code 1994. Xerox processed and released around 4,500 claims after applying a fix to apply the coinsurance deductible to the claims. Additional analysis and testing is being completed on the denied and partially paid claims.
  - A claim reprocessing that caused erroneous denials, also referred to as the Bad Member Mass Adjustment, improperly adjusted claims with dates of service, 2010, 2011 and 2012.
  - A reprocessing for RBRVS claims is currently being tested. The issue being corrected was a rounding error in the RBRVS pricing logic. The claims will be corrected to reflect the correct payment amount.
  - All remaining Tribal defects and CRs are being reviewed for reprocessing.

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Cost of Care:

- Long Term Care (LTC): An issue was previously identified that resulted in overpayments and underpayments for LTC claims due to the misapplication of LTC cost of care. This issue has been corrected. Claims impacted by this issue are being identified and will be reprocessed by Xerox. Providers who desire to adjust their claims prior to the Xerox reprocessing effort may do so at this time.
- Assisted Living Homes: An update to accurately calculate the patient payment amounts submitted on claims was implemented on January 31, 2015. This issue may have resulted in overpayments to providers. At this time, providers can begin submitting adjustments to impacted claims. If providers choose not to submit adjustments, claims impacted by this issue will be identified and reprocessed after the appropriate provider notifications take place.

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.

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.

Additional NPI mapping enhancements, to include form type and procedure code, were also recently completed. Xerox and DHCS have developed additional mapping updates to further improve claims processing and reduce the number of claims suspended for exception 3620. This improved system functionality was added to Health Enterprise on March 28, 2015. New analysis is underway to identify additional areas where providers may be positively impacted by further adjustments to the NPI logic.

Timely Filing Denials:

Xerox has set exception 1882, 1982, and 1212, (Timely Filing Limit Exceeded) to suspend to prevent improper timely filing denials for claims for dates of service submitted between October 1, 2013 and December 31, 2014. Xerox has been instructed to approve timely filing for the following reasons.

- Claims impacted by known defects will be reprocessed and timely filing overridden.
- Claims processed or denied in error by Xerox.
- Appeals should also be considered timely for known defects.
- Adjustments will be considered timely for known defects.

Providers are encouraged to submit proof of timely filing in relation to claims that were previously denied as part of system defects or processing errors. While this is not a provider requirement, attaching proof of timely filing in relation to defects will help accurate reprocessing of the previously denied or reduced claims.

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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)

ICD-10 Updates:

The ICD-10 implementation is set for October 1, 2015. Claims submitted with dates of service on or after the October 1, 2015 deadline will require appropriate ICD-10 diagnosis and surgical procedure codes to process.

The required ICD-10 code set will affect all service authorization types for requested dates of service on or after October 1, 2015. Providers should anticipate changes to all authorization request forms and accompanying communication for each type of authorization request in the coming weeks.

Providers have access to Alaska Medical Assistance ICD-10 training through live instructor-led training sessions and computer-based training modules. Topics include: *Basic Information about ICD-10, Impacts and Changes, and Impacts for Non-Diagnosing Providers*.

These courses are designed to give providers a general understanding of ICD-10 and the impact it will have once ICD-10 goes into effect on October 1, 2015. Providers can sign up for live courses, as well as access the computer-based training modules on the Alaska Medicaid Learning Portal at https://learn.medicaidalaska.com.

Xerox and the state have been working with trading partners since March 23, 2015 to perform required end-to-end testing and optional syntactical testing as part of the ICD-10 certification. This testing process is used to ensure the compatibility of changes to billing software and programs with Alaska Medical Assistance and ICD-10 coding. As of May 28, 2015, 10 of 110 trading partners have started the testing process, with several others scheduled to test in the next few weeks.

Any trading partners that have not started the testing process should contact the Alaska Medical Assistance ICD-10 Support staff by emailing AK-ICD10-Support@xerox.com or calling 855.744.8142 (toll free) or 907.644.8142 for more information about the testing procedures.

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Outstanding Claim Inventory:

The table on the following pages summarizes the exception codes that are receiving special monitoring. It does not provide reporting on all exception codes. The status reported is as of June 16, 2015.

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. Exceptions highlighted in green represent a substantial drop (>20%) in Inventory compared to the previously released MMIS update on April 1, 2015.

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	118	-21%	Recent Xerox effort has substantially reduced the volume of claims suspending for this exception.
1882	Claim exceeds timely filing and no proof of timely filing attached	All Provider Types	1,361	-352%	Xerox has received new instructions on processing claims for timely filing and is working to apply this logic to suspended claims, and claims that may have denied in error.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	1564	67%	Reviewers manually audit claims to determine if a referral is valid so that the claim can be approved for payment. We will begin adding resources to these claims to drive down inventory.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
3321	Rendering Provider Certification Expired	DME HPRF PCA RSL	127	-101%	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).
3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	102	-1419%	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 in development to improve automated provider record matching.
3700	Provider on review	HPRF PCA RSL TRB	372	-89%	These claims continue to be analyzed to determine if additional providers can be taken off review.
3832	Medicaid coverage – Waiver claim excluded	CCA HCB RSL	1016	29%	Xerox is conducting further analysis to determine if these claims can be released for processing.
4076	Review for Medical justification – Prof Claim Types	HPRF TRAN AIRAMB	1283	49%	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	623	-26%	Claims are suspending correctly and being reviewed as part of normal processing.
4645	Out of State Pricing Segment Not Found	DME FPC HPRF RSL HOSP	1512	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	303	23%	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	437	-211%	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	498	-74%	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	489	45%	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	1,755	-123%	Analysis is being conducted to prevent future claims from posting this exception.
8040	Service Authorization Units Fully Exceeded	BH DENT PCA CCA HCB TRAN TRVL DME RPTC	2376	61%	Xerox continues to work on issues related to Service Authorizations.