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Payments: From January 20, 2016 through February 17, 2016, an average of 131,037 claims totaling $35.6 million was paid on a weekly payment cycle. The table below details payments from 1/20/2016 through 2/17/2016.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
2/17/2016	103,913	30,254	$33,542,196.85
2/10/2016	113,579	28,119	$38,636,232.19
2/3/2016	128,885	35,891	$36,401,549.91
1/27/2016	115,179	29,847	$35,866,057.60
1/20/2016	193,627	31,125	$33,466,709.64

February Fixes and Updates:

- **Claims receiving exceptions 3801 and 3805** have been temporarily suspended while Xerox works to correct a recent issue causing erroneous claims denials. Some member eligibility files, benefit plans and enrollment spans, are not updating consistently. Xerox is monitoring the members' records and associated claims impacted on a weekly cycle. Providers will need to resubmit these claims for processing.
- **CLIA certification** for certain outpatient services is required. System updates will be made to more effectively address these requirements. At this time, Xerox is suspending all claims with CLIA requirements to ensure valid certifications are on file. These claims will be reviewed and processed weekly until updates are made. Affected providers may see exception 4401, *No CLIA Cert entry for Provider Dates of Service*, and will be contacted by Provider Enrollment for current CLIA information.
- **Several provider licensing exceptions** started posting on claims after February 13, 2016. Recent changes were made to business license adjudication processes and associated exceptions in the system. Xerox is aware that some providers have been inappropriately impacted when a valid license is on file. Any claims submitted by these providers will be revalidated and processed weekly until another system update is made to correct the issue. The exceptions currently being addressed by Xerox are 3325, 3326, 3327, 3329, 3330, 3363 and 3364.
- **FQHC claims** are now adjudicating without applying member co-pay amounts. System changes corrected an issue where copays were inappropriately deducted from FQHC claims. Any claims that processed incorrectly will be reprocessed. Xerox also identified that some FQHC claims were denying for exception 4419, *There is a conflict between the Procedure Code and Provider Type submitted on the claim.* The service and provider type conflict was isolated to psychotherapy codes billed by a licensed clinical social worker. System corrections were implemented. Impacted claims are currently being reviewed and reprocessed.
- **Behavioral health claims receiving exception 6709**, *Service Limit Exceeded.* A recent change was made that will consider appropriate behavioral health service limits before deducting service authorization units. Any behavioral health claims that were previously denied due to exception 6709 or exception 8040, *Service Authorization Units Exceeded*, are being reviewed against service limits and applicable service authorizations. Any claims inappropriately denied will be adjusted.
- **Limits for Dietitian/Nutrition claims for procedure code 97802 and 97803** were being enforced incorrectly. The issue has been corrected. All affected claims will be identified and reprocessed.

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- **Third Party Liability Avoidance** (TPLA) allows a provider to bypass the requirement to bill other insurance carriers prior to billing Medicaid under certain circumstances. Currently, the following behavioral health procedure codes have been placed on TPLA: H0031, H2017, H2019, H2019-HQ, H0033, and T1016. Xerox, in collaboration with DHCS, is working to incorporate additional behavioral health services.
- **Exception 4596**, *The diagnosis code qualifier or version in not a valid value*. This exception is posting inappropriately to some claims submitted on paper and suspending the claim. These claims are being manually processed and a permanent MMIS correction is projected for March 2016. There are a number of paper claims that are receiving this exception legitimately as well. Providers should ensure that the ICD version submitted on the claim is correct, legible, and within the appropriate field. Additionally, ensure that the ICD version is consistent with the diagnosis code set used and appropriate for the reported dates of service. For guidance on the appropriate version, please review the specific claim form instructions which can be found at http://manuals.medicaidalaska.com/docs/ProviderReference.html.
- **Time–based mental health procedure codes** should be billed with the largest increments necessary to account for the total service length provided to the member. For example, if a member is seen for a psychotherapy session lasting a total of 90 minutes, a combination of one unit of 90837 (60 minutes) and one unit of 90832 (30 minutes) should be used. Billing three units of 90832 (a 30-minutes code) is not appropriate. The same guidance applies to group psychotherapy sessions and the modifier “U7” (a 30-minute modifier). For example, if a member participates in a 90-minute group psychotherapy session, a combination of 90853 (60 minutes) and 90853-U7 (30 minutes) should be used. Billing three units of 90853-U7, which would also equate to 90 minutes, is inappropriate because the largest possible time increments are not being utilized. National coding standards require use of codes representing the largest time increment most appropriate for the service rendered. Be sure to review all billing guidance associated with time-based procedure codes prior to billing.

January Fixes:

- **Service details on professional claim 835 transactions (electronic RA)** were not appearing when claims were paid at full value. A correction has been implemented to ensure service details appear on 835 transactions for all claims.
- **Exception 4121**, *The Diagnosis Code is not valid for Line Date of Service on the Claim*. System coding has been corrected to properly apply dental diagnosis codes and ICD versions during claims adjudication. Dental providers are reminded that while diagnosis codes are optional on dental claims, if they are included, the correct ICD code set and qualifier must be used. For additional clarification on dental ICD code set and qualifier requirements, please review the *ADA 2012 Claim Form Instructions* which can be found at http://manuals.medicaidalaska.com/docs/ProviderReference.html.
- **Certain Mental Health claims were incorrectly posting exception code 3663**, *The operating psychiatrist's License is Expired*. The MMIS was not reading the active license information on the provider enrollment file. Xerox has corrected the issue and all affected claims have been reprocessed.
- **Some Medicare Crossover claims have been inappropriately receiving exception code 3810,** *The submitted service on the claim is not covered by the Benefit Plan for this member.* This exception has been inappropriately affecting Medicare Crossover claims that contain ambulatory surgical center, outpatient physical therapy, speech therapy and occupational therapy services. The issue has been resolved in the MMIS and Xerox is currently evaluating claims for reprocessing.
- **Exception 6706,** *Adult Dental Annual Benefit Met*, has been corrected in the system. This exception was posting inappropriately on some encounter rate claims. Any claim that received this exception in error was suspended by Xerox personnel and manually reviewed to ensure the member’s benefit limit had not been met. All impacted claims have been reprocessed.

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- **IRS Form 1099s** have been mailed to providers. In the event the amount indicated on your 1099 differs from the final RA, please disregard the RA amount as your 1099 contains correct financial information. A Xerox staff member will contact all affected providers with a detailed explanation and answer any questions you may have.

Service Authorization Updates and Edits:

- **Exception Code 8040**, *Service Authorization Units Exceeded*. Changes have been made to the system's service authorization logic for exceptions 8040 and 6709 *(see February Fixes and Updates)*. Xerox has been reviewing claims and SAs affected by this issue in stages: specific authorization types, claims denied after October 1, 2013 with the new SA numbers (10 digits), and claims denied after October 1, 2013 with old SA numbers (8 digits). Xerox personnel are reviewing all paid claims with associated service authorizations for unit discrepancies. Any authorizations that have remaining units are being identified and cross-referenced against all claims that were previously denied for exception codes 8040 or 6709.

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 of overpayments.

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

Claims Reprocessing:

- **Reprocessing of Payout claims:** A significant work effort was accomplished in December 2015 and continues through March 2016. Xerox is working on identifying and reprocessing all impacted claims that were impacted by early system issues that resulted in claim denials. Some of our key areas that have been reprocessed include but not limited to:
    - RBRVS rate reprocessing
    - Inpatient weekend and length of stay cutbacks
    - Medicare Cross Over Reprocessing, (1994 and zero pays where co-insurance and deductible information was not mapped correctly)
    - Tribal Encounter and Retro Rate Reprocessing
- **Potential Recoupment Notices**: As MMIS corrections and enhancements are implemented, Xerox is reprocessing any affected claims. In certain instances, providers may have previously received overpayment for services. These claims have been identified and are being validated. Any recoupments that occurred without proper notification will be voided and the original reimbursement will be reinstated until proper notification detailing the amount, repayment options, and the appeal process, can be issued.

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Expired Licenses, Certifications, Permits and Grants

Providers may have recently noticed that their claims have been suspended for expired licenses as the new year came. If the appropriate licenses are not updated through the Provider Enrollment Department, the claims will be set to deny. All provider licenses, certifications, permits and grants must be current to prevent claims from suspending or denying. Please submit a copy of all renewed licenses, certifications, permits and grants to Xerox as soon as you receive your updated documents. You may submit copies to Xerox by fax to 907.646.4273 or by mail to:

Xerox State Healthcare
Attn: Enrollment Services
P.O. Box 240808
Anchorage, AK 99524-0808

Questions? Contact Provider Enrollment at 907.644.6800, option 2, or toll-free in Alaska at 800.770.5650, option 1, 3.

NPI Matching, Taxonomy and Zip+4:

MMIS improvements have been implemented and more are being 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**.

Providers may have noticed an increase in exception code **5050**, *billing provider does not match the billing provider on the service authorization.* This exception is posting correctly. Providers should verify that the information on their claim and the provider information on the corresponding service authorization are correct. Providers are strongly encouraged to continue to bill with NPI, billing taxonomy and the servicing zip+4 of the billing address to assist in mapping claims to the correct provider ID number.

Xerox Corrective Action Plan Still in Effect

The Xerox Corrective Action Plan (CAP) is still in effect. This CAP addressed corrective actions for Alaska Medicaid claims processing issues. For more information about the CAP and to review the current status, go to http://dhss.alaska.gov/dhcs/Pages/news/Xerox_plan.aspx.

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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 Enrollment	From 8:00-9:30 a.m. After 2:00 p.m.	In Anchorage: 907.644.6800 (option 2) Outside Anchorage: 800.770.5650 (option 1, 3)
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)

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 February 17, 2016.

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 suspended for each exception. These numbers and the provider types change daily as new claims are received and 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 inventory on January 19, 2016.

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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The following inventories represent original submitted claims only. Voided and adjusted claims have been excluded.

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	289	24%	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	2562	19%	Xerox has received 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. Providers are reminded that claims must be submitted within 12 months of the date of service.
2950	Payment cannot be made. The member is locked into another Provider	FQHC HPRF PHYS TRB	608	-52%	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	170	-73%	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).
3329	Billing Provider License Expired	All Provider Types	1468	1690%	Outreach is being made to affected providers. As licenses are updated, the claims are released. Providers that have renewed licenses should submit them to Provider Enrollment.
3620	Billing Provider NPI matches multiple IDs	Electronic Claims ALL provider types that require NPI	2030	-52%	If the Billing Provider NPI matches multiple IDs, the MMIS cannot determine which provider record to use for processing. Provider outreach continues to help providers understand how to submit claims correctly if the issues 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 MMIS changes are in development to improve automated provider record matching.
3700	Provider on review	HPRF PCA RSL TRB	556	875%	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	1422	47%	Xerox is conducting further analysis to determine if these claims can be released for processing.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
4076	Review for Medical justification – Prof Claim Types	HPRF TRAN AIRAMB	3135	21%	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	75	525%	Claims are suspending correctly and being reviewed as part of normal processing.
4596	The diagnosis code qualifier or version is not a valid value.	All Provider Types	294	-67%	This is affecting claims submitted on paper. Any claim that is suspended for this code is manually reviewed and processed. If the incorrect version is submitted on the claim form, the claim will be denied.
4645	Out of State Pricing Segment Not Found	DME FPC HPRF RSL HOSP	845	29%	Xerox is assigning additional resources to assist with these claims.
4680	Zero Units with greater than zero amount on claim	All provider types capable of submitting Crossover and Outpatient claims	2985	100%	This is exception code is currently being reviewed. Crossover and outpatient claims are impacted by this exception code.
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	353	87%	This exception's inventory fluctuates. Research is ongoing to see if claims are related to out of state providers and/or other issues need to be addressed.
4912	Procedure code requires pricing	DENT DME FPC HPRF LAB TRAN TRB TRVL	2004	29%	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.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
4916	Procedure / Modifier combination Pricing segment is set to Manual Review	DENT DME HOSP HPRF LAB	1366	-2%	This exception posts when a rate is not on file for the specified combination requiring manual pricing on these claims. Ongoing evaluation of these combinations occurs to determine if new pricing criteria should be adopted.
6060	Service Authorization record is pended w/errors - Header	DME HCB PCA	3609	-58%	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	66	-53%	Xerox is performing a trend analysis of all claims receiving this exception to identify ways to reduce the number of future claims. This may include targeted outreach.
8040	Service Authorization Units Fully Exceeded	BH DENT PCA CCA HCB TRAN TRVL DME RPTC	23	64%	Xerox continues to work on issues related to Service Authorizations. See detailed update on the Service Auth cleanup and 8040 issue. Providers are reminded to verify service authorization limits prior to rendering and billing services.