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Payments: From April 13, 2016 through May 18, 2016, an average of 133,664 claims totaling $39.2 million was paid on a weekly payment cycle. The table below details payments from 4/13/2016 through 5/18/2016.

Final Payment Cycle Date	Total Paid Claims	Total Denied Claims	Total Reimbursement Amount
5/18/2016	110,289	32,576	$39,234,514
5/11/2016	147,388	43,657	$44,142,103
5/4/2016	146,666	51,810	$41,459,909
4/27/2016	112,510	30,668	$31,732,729
4/20/2016	147,524	34,389	$40,589,741
4/13/2016	137,604	28,665	$38,190,081

May Fixes and Updates:

- **Claims receiving exceptions 3801 and 3805** have been temporarily suspended while Xerox worked to correct a recent issue causing erroneous claims denials for member eligibility. Some member eligibility files, benefit plans and enrollment spans, were not updating consistently. Xerox has reviewed and processed all claims that were previously suspended for exception 3801 and 3805. On the May 25, 2016 payment cycle, providers may be impacted by claims denied for exception 3801. These claims are valid denials based on the member's eligibility in the system and the date of service on the claim.
- **Claims receiving exception 7864**, *3 months/lifetime exceeded Supplement Employment.* Recently, some claims have denied in error for supplemental employment services, T2019 unmodified and T2019 HQ. While Xerox works to identify the cause and implement a permanent solution, all claims receiving exception 7864 have been set to suspend. Xerox is reviewing these claims weekly to allow payment if service limits have not been exceeded. Claims for pre-employment services, T2019 CG and T2019 TT, will also be reviewed and released for payment if limits have not been exceeded until a solution is implemented.
- **LTC co-pay impacting professional and outpatient services outside an LTC facility**. Previously, a copay was inappropriately being deducted from professional and outpatient service claims for services that were provided outside an long-term care (LTC) facility to a member that is an LTC resident. Providers are now able to identify LTC members on claims to avoid a copay deduction.

  Professional Services: Providers should enter "LTC" in the shaded area of field 24g, *Days or Units*, on the CMS-1500. Providers submitting electronic 837P transactions should continue to use Loop 2400 Segment SV115 to identify LTC residents.

  Outpatient Services: Providers should enter condition code "AJ", *Payer Responsible for Copay*, in a Condition Code field for paper or electronic claim formats.
- **FY2017 dental service coverage changes**. System modifications have been made to accommodate dental service coverage changes beginning July 1, 2016.
  - Codes previously covered under adult emergent dental that are now covered under enhanced adult dental and will require a service authorization: D0272, D0277, D2160, D2161, D2332, D2335, D2393, D2394, D2940
  - Codes previously covered for all recipients that are now covered only for children under 21: D3240, D3920, D7111
  - Codes that are no longer covered by Alaska Medicaid: D0350, D5130, D5140, D5927, D5928, D5958, D5959, D5960, D7292, D7293, D7294

  The fee schedule for dental services provided on and after July 1, 2016 is now available at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.
- **Free-standing birth centers**. Effective May 1, 2016, free-standing birth centers (FSBC) may enroll as Alaska Medicaid providers and bill for their services directly to Alaska Medicaid. Direct-Entry Midwives will no longer be reimbursed for the use of an FSBC (i.e., may no longer submit claims with the U5 modifier) and may bill only for the professional services they provide. System configuration changes are being made to accommodate the new FSBC provider type and billing guidelines. An FSBC billing manual and additional billing guidelines are available at http://manuals.medicaidalaska.com, as will a revised Direct-Entry Midwife manual.

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- **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 validated and processed weekly until another system update is made to correct the issue. Additionally, providers with multiple Alaska Medicaid enrolled locations are reminded to use the correct and complete facility address where billed services are rendered. This will aid in mapping the claim to the license(s) on file. The exceptions currently being addressed by Xerox are 3325, 3326, 3327, 3329, and 3330.

April Fixes:

- **Ambulatory Surgical Centers (ASC) billing Medicare cross over claims**. There was a prior system issue that was causing cross over claims billed by an ASC to inappropriately deny for exception 3810, *The submitted service on the claim is not covered by the Benefit Plan for this member*, and 3847, *Provider Cannot Submit this Invoice Type*. The error was corrected and all impacted claims were reprocessed for the April 27, 2016 payment cycle. All new-day cross over claims submitted by ASC providers should process correctly.
- **Inpatient claims suspended for exception 9379**, *System Information Not Found,* were released for payment on May 4, 2016. The claims were temporarily suspended after a system issue was identified on April 16, 2016 that would have caused the claims to deny erroneously. Xerox isolated and corrected the issue on April 30, 2016.
- **Exception 7812**, *1 Plan of Care allowed per 365 days.* Some waiver claims were inappropriately denied when providers billed for a second plan of care service (T2024) within 365 days of the first despite having an approved service authorization. Xerox has modified a service limit configuration to allow a claim submission for a second plan of care within 365 days of the first if there is an approved service authorization on file and included on the claim. All impacted claims were reprocessed.
- **Care coordinators reporting TEFRA services.** A system modification has been made to allow care coordinators to bill for TEFRA-related services separately from Waiver-related services for TEFRA-qualified members. The following procedure codes and modifiers are now required when billing for TEFRA services:

TEFRA Service	Procedure Code	Modifier	Service Limit
Program Intake Screening	T1023	CG**	1*
Service Assessment	T2024	-	1*
Service Reassessment	T2024	U4	1 per 365 days
Plan of Care Development	T2024	CG**	1 per 365 days

** Upon entering program*

*** New modifier requirement*

These codes must be used on all TEFRA-related claims. Reprocessing of previously-denied TEFRA-related care coordination services will include use of the CG modifier for program intake screen and POC development.

Codes used for Waiver-related care coordination services have not changed. If billing for Waiver services, use the following procedure codes:

Waiver Service	Procedure Code	Modifier
Program Intake Screening	T1023	-
Case Management	T2022	-
Plan of Care Development	T2024	U2

- **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 analyzed for reprocessing. Reprocessed claims may not result in additional payment if the service limits have been met.

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- **CLIA certification** for certain outpatient services is required. System updates were made to more effectively address these requirements. Claims with CLIA requirements will receive one of the following exceptions if a valid CLIA certification is not on file.

  - Exception 4400, *The CLIA Certification Type on file for the Procedure Code submitted on the claim does not match the CLIA Provider Certification Type on the Provider file for the Dates of Service on the Claim*
  - Exception 4401, *No CLIA Cert entry for Provider Dates of Service*
  - Exception 4403, *The Procedure Code submitted on the claim is a Laboratory Code and the Provider billing for the services does not have a CLIA Number on file*
  - Exception 4410, *Provider not certified for lab type*

  Affected providers should contact Provider Enrollment to verify and update information on their provider enrollment file.

- **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 are placed on TPLA:

90791	90846	96101	H0002	H0018	H0038	H2011	H2019	T1016
90832	90847	96118	H0010	H0020	H0046	H2012	Q3014	T1023
90834	90849	99408	H0011	H0031	H0047	H2015	S9484	
90837	90853	H0001	H0014	H0033	H2010	H2017	T1007	

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. 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

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Claims Reprocessing:

- **Reprocessing of Payout claims:** Xerox is working on identifying and reprocessing all impacted claims impacted by early system issues that resulted in claim denials. Some of our key areas that have been reprocessed include but not limited to:
  - Ambulatory Surgery Center cross over claims
  - Part A nursing home cross over claims
  - Tribal outpatient reimbursing as fee-for-service plus the encounter rate
  - CHA/P inappropriate multiple cutbacks
  - 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. Providers identified with overpayments will receive a Recoupment Notice letter detailing the overpayment amount, repayment options, and the appeal process. Any recoupments that occur without proper notification will be voided and the original reimbursement will be reinstated until proper notification is issued.

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.

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.

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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)

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.

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 May 19, 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 April 13, 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
1882	Claim exceeds timely filing and no proof of timely filing attached	All Provider Types	1616	14%	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	1323	34%	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	241	159%	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	1107	-31%	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	834	-65%	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	979	11%	These claims continue to be analyzed to determine if additional providers may be taken off review.
3832	Medicaid coverage – Waiver claim excluded	CCA HCB RSL	1021	-11%	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	6287	26%	These claims are suspending correctly. Fiscal Agent nurses must manually review attached medical justification before claim is processed. Xerox has added additional resources in an effort to reduce this backlog.
4105	Diagnosis Requires Review by the State	FPC HPRF	39	5%	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	103	-61%	This is primarily 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.

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Edit/EOB Code	Description	Providers Impacted	Impacted Claims	% Change	Status
4645	Out of State Pricing Segment Not Found	DME FPC HPRF RSL HOSP	1690	84%	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	330	-37%	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	3107	-16%	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	1467	-39%	This exception posts when a rate is not on file for the specified combination and the claim requires manual pricing. Ongoing evaluation of these combinations occurs to determine if new pricing criteria should be adopted.
6060	TPL is indicated on the claim but no TPL Policy is found for the Member on File	All Provider Types	5996	-17%	These claims are manually reviewed for accuracy. Providers must submit a valid TPL EOB with the claim to assist with TPL validation.
6430	Cost Avoid for no TPL $ but EOB exists	BH DENT DME HOSP HPRF PHYS THER THRCTR TRB	32	-32%	These claims require manual review of associated TPL information. 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	38	-10%	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.