Claims Resolution Log

Changes in system status are identified by ‘system updated’ or ‘system corrected’ in the System Status column of the Claims Resolution Log. Completed items will be available on a separate log.
Overpayments: Claim adjustments will begin within 90 days of the system being corrected/updated. If the system has not yet been corrected/updated, a date for reprocessing/adjusting claims will be determined once the system correction/update has been made. For system corrections or updates where the Claims Resolution Log indicates reprocessing is pending and the date of service is less than 24 months, providers have the option to submit corrected claims to expedite reprocessing or to wait for claims to be reprocessed systematically.
Underpayments: Resubmissions/adjustments will be completed on claims processed within eight quarters of the date in the Post Implementation Date column. For claims beyond eight quarters, providers will be responsible to resubmit/adjust the claims within 90 days of the date in the Post Implementation Date column. If claims are not received within 90 days of this date, timely filing will not be bypassed and the claims will not be processed. For Item Reference Numbers with claims beyond eight quarters additional bulletins will be published as needed.

Underpayment Pending

Date Added	Item Reference Number	Affected Area	Comments	System Status	Reprocessing Plans	Post Implementation Date	Revised Date
9/30/2011	13683	HCBS	Some claims were paid in error when the beneficiary had an active other insurance and the policy information was not included on the claim. This affected claims processed from 7/1/2010 through 7/31/2011.	Deferred to New MMIS	Pending	Pending	9/30/2011
4/30/2014	15604	Professional/ Outpatient	Some claims may have denied inappropriately for audit 6904 when a respiratory service was billed with an E&M service without modifier 25 on the same day by the same performing provider. This affected claims processed on and after 8/7/2009.	Diverted to KMMS	Pending	Pending	4/30/2014
11/30/2017	CMS Change Request 9911	Professional Crossover	The Medicare RA for QMB claims has been modified to indicate the QMB status of patients and reflect zero cost-sharing liability. Providers will need to identify the impacted claims which contain Group Code OA and CARC 209 with either Remark Code N781 (Deductible), N782 (Coinsurance), or N783 (Co-payment). Providers will need to adjust these claims to reflect the proper Group Code of PR and CARC of 1 (Deductible), 2 (Coinsurance), or 3 (Co-payment) as appropriate. This affected claims processed between 10/2/2017 and 12/7/2017.	OTR Completed	Ongoing	Pending	11/30/2017
3/31/2019	19462	General Provider	Some paper claims may have denied incorrectly with edit 4379 (NDC Must Be Present When Injection Billed) because the NDC did not transfer from paper to MMIS. Claims are being reviewed weekly to identify any additional claims that need reprocessing cycles. This affected claims processed from 3/22/2017 to Present.	Sign Off Requested	Paper claims are being reprocessed as issues are found.	Ongoing	6/30/2019
1/31/2021	21244	Professional	Copays may have applied incorrectly to claims with a Place of Service when all other copay criteria was submitted on the claim.	Post Implementation	Ongoing	Ongoing	1/31/2021
9/30/2021	21808	Outpatient/Outpatient Crossover	Claims may have denied for Edit 4270 (PROVIDER TYPE AND SPECIALTY IS NOT VALID FOR PROCEDURE) due to an update to covered benefits to allow all speacialtis of Provider Type and Speciality 01/010.	Post Implementation	Complete	10/7/2021	9/30/2021
9/30/2021	21822	Professional/ Professional Crossover	Claims that have denied for Edit 4317 (INCIDENTAL SERVICES ARE COS OF INITIAL ENCOUNTER) are being reprocesses due to procedure code 90792 being end-dated effective 12/31/2019	Post Implementation	Complete	10/11/2021	9/30/2021
12/6/2021	21930	Professional/ Professional Crossover	Claims may have denied for Edit 4270 (PROVIDER TYPE AND SPECIALTY IS NOT VALID FOR PROCEDURE) due to an update to covered benefits to allow Provider Type and Speciality 11/112 to bill procedure 90832.	Post Implementation	Pending	Pending	12/6/2021
12/6/2021	21956	Professional/ Professional Crossover	Effective with dates of service on and after 01/01/2022, RHC/FQHC will be allowed to bill procedures 92002, 92004, 92012 & 92014 for optometry services.	Hold	Pending	Pending	12/6/2021
12/6/2021	21957	Professional/ Professional Crossover	Effective with dates of service on and after 01/01/2022, coverage for mental health service for MediKan program will include procedures 97151, 97152, 97153, 97155, 97156, H0002, H0004, H0037, H0037-HK, H0038, H0038-HQ, H0049, H0050, H2011-HK, H2011-HO, H2015, H2015-HK, H2016, and H2016-HK.	Hold	Pending	Pending	12/6/2021

Overpayment Pending

Date Added	Item Reference Number	Affected Area	Comments	System Status	Reprocessing Plans	Post Implementation Date	Revised Date
1/31/2021	21244	Professional/ Professional Crossover	Copays may have applied incorrectly to claims with a Place of Service when all other copay criteria was submitted on the claim.	Post Implementation	Ongoing	Ongoing	1/31/2021

Underpayments System Corrected/Updated

Date Added	Item Reference Number	Affected Area	Comments	System Status	Reprocessing Plans	Post Implementation Date	Revised Date
1/31/2020	20264	General Provider	Claims may have denied for Edits 582 (NPI BILLING PROVIDER ID INVALID/INELIGIBLE ON DOS) and 583 (NPI BILLING PROVIDER ID INVALID/INELIGIBLE ON DOS) due to incorrect NPI effective dates being applied to the provider's NPI enrollment.	Prod Implementation but Post Imp indicator is N	Pending	Pending	1/31/2020
9/30/201	21792	Professional/ Professional Crossover	Claims may have denied for Edit 4270 (PROVIDER TYPE AND SPECIALTY IS NOT VALID FOR PROCEDURE) due to an update to covered benefits to allow all specialties of Provider Type 31.	OTR Completed	Completed	9/30/2021	9/30/2021

Overpayments System Corrected/Updated

Date Added	Item Reference Number	Affected Area	Comments	System Status	Reprocessing Plans	Post Implementation Date	Revised Date

Claims Resolution Log

Date Added	Item Reference Number	Affected Area	Comments	System Status	Reprocessing Plans	Post Implementation Date	Revised Date
1/31/2020	20252	LEA	LEA Providers' fee-for-service claims may have routed to the MCOs due to FEB NPI Crosswalk being determined at the batch level instead of the claim level. In August of 2019 LEA Providers were asked to re-enroll due to a policy change. This resulted in LEA providers submitting claims with dates of services contained within the dates of two providers records during the month their re-enrollment was effective. FEB was routing based on the date of service of the first claim in the batch whether or not subsequent claims in that batch had dates of service that were after the re-enrollment date. Due to incorrect routing, MCOs generated payments to LEA providers for services that should only be covered by KMAP.	System corrected on 12/19/2019	For LEA claims paid in error by an MCO, recoupment of the payment by the plans will be required. The plans will be reaching out directly to impacted providers to request return of the funds paid in error. If the claim was previously successfully submitted to KMAP and an MCO and payment was received from both organizations no additional action is required. However, if the claim was only paid by the MCO, the LEA would need to resubmit the claim to KMAP so that appropriate payment can be made	Post Imp Indicator is N	1/31/2020
12/31/2017	18175	General Provider	Some claims may have overpaid if there were paid details that should have had a reduction applied. This affects claims with dates of service from 7/1/2016 to Present.	System corrected on 5/28/2021	Pending	Ongoing	5/31/2021
6/30/2021	18125	General Provider	Paid claims that contained a detail denied for Edit 583 (NPI Performing Provider ID Invalid or Ineligible) were not receiving the appropriate budget reduction.	System corrected on 5/28/2022	Pending	Ongoing	6/30/2021
7/1/2021	17063	General Provider	Per the Budget Shortfall Reduction, claims paid by Kansas Medicaid were subject to a specific reduction percentage based on DOS of the claim unless specifically excluded based on the policy..	System corrected on 5/28/2021	Pending	Ongoing	6/30/2021