Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Adult Care Home

Item Ref: ACH 1.0

Drafted: 2/29/2004

Adult Care Home	Issue:	Automatic mass adjustment was initiated due to a retro-active rate change but the patient liability was not deducted correctly.	Resolved 1/16/2004
	Impact:	14,962 claims needed to be adjusted to correctly deduct the patient liability.	
	Resolution:	Corrected mass adjustments were performed on 12/26 for 25 affected providers. Four remaining providers' claims were corrected on 1/16/2004.	

Message: Mass adjustments were performed on 12/26/2003, for any claims affected by retro-active rate changes that failed to deduct the patient liability correctly. No additional action is needed by providers at this time.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Item Ref: ACH 1.1

Drafted: 2/29/2004

Adult Care Home	Issue:	MMIS was not correctly calculating spans of days.	Resolved 10/21/2003
	Impact:	Providers have been paid more than the amount billed on their claim.	
	Resolution:	Permanent fix identified and implemented on 10/21/2003	

Message: Due to a processing issue, the MMIS did not correctly calculate spans of days on adult care home claims. Consequently, some providers may have been overpaid. This issue was permanently corrected on 10/21/2003. If you identify an overpayment on your 10/30/2003 due to this error, please submit an adjustment to correct payment.

Provider Action: Provider to submit adjustment.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: CDDO, HCBS, Home Health and CMHC

Also see GENP 1.0, 1.1, 1.2, 1.4, and 1.5

Item Ref: CHHC 1.0

Drafted: 2/29/2004

CDDO	Issue:	Claims are denying for "Performing provider not member of group".	Resolved 12/19/2003
	Impact:	CDDOs are not able to get any claims paid because affiliates are truly not members of the CDDO group.	
	Resolution:	Permanent fix identified and implemented on 12/19/2003.	

Message: Between 10/16/2003 and 12/19/2003, the KMAP MMIS incorrectly denied claims with an error of “Performing provider not member of group”. This issue was identified on 12/19/2003 and the incorrect denials have been reprocessed. If you identify any claims that did not get reprocessed, you may resubmit them via the KMAP secure website or contact Customer Service and request they be recycled.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Item Ref: CHHC 1.1

Drafted: 2/29/2004

CMHC	Issue:	Amount paid includes payment amounts, state share and TPL deductions.	Resolved 12/18/2003
	Impact:	Creates confusion when providers are posting RAs.	
	Resolution:	Removed the state share and TPL amounts from the amount paid columns as of the 12/18/2003 RAs.	

Message: The first RAs generated through the new interChange MMIS included State Share and TPL amounts in the Paid amount column on RAs. This issue was identified and corrected as of RAs dated 12/18/2003.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.2

Drafted: 2/29/2004

CMHC	Issue:	New MMIS was not originally designed to accommodate affiliate billing by CMHCs	Resolved 1/5/2004
	Impact:	Only 1 provider in the state had previously been approved to perform affiliate billing; however, because this wasn't carried over to the new MMIS they were unable to conduct any billings for approximately 8 weeks.	
	Resolution:	Permanent fix identified and implemented in early January, 2004.	

Message: The interChange MMIS was not originally set-up to accommodate CMHC affiliate billing. Accordingly, CMHC affiliates were not able to get claims paid between October 16, 2003 and early January, 2004. This issue was identified and permanently corrected on 1/5/2004. EDS and SRS have worked closely with providers who bill on behalf of affiliates to ensure affected claims are no longer denying specifically due to an affiliate billing arrangement.

Provider Action: No action needed by provider.

Revised: 4/30/2004

Item Ref: CHHC 1.3

Drafted: 2/29/2004

HCBS	Issue:	Providers are stating a "slow-down" has occurred in getting their claims paid and that claims are suspending for Plans of Care. Due to numerous system issues related to POC (inability to access the POCs, inability to modify/update and inability to submit POCs) we created a backlog of POCs to be entered into the system.	Resolved 1/2004
	Impact:	HCBS community is not receiving payments timely.	
	Resolution:	SRS and EDS both worked on approving the Plans of Care to resolve the backlog. Once Plans of Care were approved, affected claims were released for processing.	

Message: Between 10/16/2003 and late December, 2003, SRS and EDS experienced a back-log related to Plan of Care processing. Additional approvers were able to bring Plan of Care processing during January, 2004. Due to the backlog, affected providers may have experienced claims denying for “No PA on database”. As current Plans of Care were approved, affected claims were released for processing. Reprocessing of affected claims occurred throughout February, 2004. Additional efforts will continue through 3/15/2004 to identify any claims previously denied for Plan of Care related issues that have not yet reached a paid status.

Provider Action: No action needed by provider.

Revised: 4/30/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.4

Drafted: 2/29/2004

HCBS	Issue:	Plans of Care were not set-up with client obligation amounts that matched amounts found in KAESCES (the eligibility system).	Ongoing as needed.
	Impact:	1666 claims were in suspense for an out of balance condition. Approximate dollar $1.3 M.	
	Resolution:	POCs need to be updated by case managers. EDS is continually working with case managers so that as Plans of Care are corrected the affected claims are recycled.	

Message: All HCBS except Frail Elderly – Some Plans of Care were not set up with the correct client obligation amounts. Accordingly, affected claims suspended due to an "out of balance" condition. EDS is continually working with case managers to get affected Plans of Care corrected and claims recycled as needed.

Provider Action: For HCBS FE providers, KDOA decided that the eligibility file and plan of care must be equal or claims will deny. Provider must get with case manager to correct out of balance.

Revised: 4/23/2004

Item Ref: CHHC 1.5

Drafted: 2/29/2004

Targeted Case Management	Issue:	Services are being denied for submission to Medicare as primary payor due to the implementation of national codes on 1/1/2004.	Resolved 1/23/2004
	Impact:	1,068 claims denied instructing providers to bill Medicare first.	
	Resolution:	Permanent fix to bypass Medicare editing for these codes was implemented on 1/23/2004 and 1,068 affected claims were recycled.	

Message: Effective 1/1/2004 targeted case management services had to be billed using national codes. A list of national codes can be found under the Bulletins section of the KMAP website. Between 1/1/2004 and 1/23/2004 some claims filed using the new national codes denied with instructions to providers to bill Medicare first. The permanent fix to this error was identified and corrected on 1/23/2004. All incorrect denials have been recycled.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.6

Drafted: 4/9/2004

CMHC	Issue:	Beneficiaries are now being charged a $3.00 co-pay for family therapy, when the manual states that it should only be for individual therapy.	Resolved: 4/7/2004
	Impact:	Beneficiaries are questioning why and/or stating that they cannot pay.	
	Resolution:	The new system allows for proper designation of family therapy. Family therapy is not considered a group therapy as it is individually focused. The $3.00 co-pay for family therapy will continue.	

Message: The new system allows for proper designation of family therapy. Family therapy is not considered group therapy as it is individually focused. The $3.00 co-pay for family therapy will continue. The manual will be updated to clarify this.

Provider Action: Providers need to collect the $3.00 co-pay for family therapy.

Revised: 4/9/2004

Item Ref: CHHC 1.7

Drafted: 4/12/2004

CDDO	Issue:	Federal match (FFP) is not being reduced from claims. The full amount is being paid.	Resolved: 4/7/2004
	Impact:	Claims are being overpaid. The provider is being paid the 50% FFP portion which should not be occurring.	
	Resolution:	The table that controls the calculation of state share was updated on 4/7/2004. Claims to be adjusted have been identified. EDS initiated the adjustment on 4/7/2004. (CO 6069)	

Message: Claims normally reduced by the FFP rate were overpaying. The system issue was resolved on 4/7/2004. EDS initiated adjustments for these claims on 4/27/2004.

Provider Action: No action needed by providers.

Revised: 5/7/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.8

Drafted: 4/12/2004

Home Health	Issue:	Supply claims for home health are denying for exception 2502 (bill Medicare first.)	Resolved: 2/24/04
	Impact:	Providers are being underpaid. Claims are being denied in error. Home health services billed with the GY modifier are not required to have a Medicare denial. Supplies that are billed in conjunction with the home health services with the GY modifier are also not required to have a Medicare denial.	
	Resolution:	Cause of the issue had been identified. Claims Resolution Manual updated to instruct clerks to force claims meeting this criteria.	

Message: Home health claims billed with the GY modifier and the related supply claims were denied in error indicating claims must be filed first to Medicare. These claims are not required to have a Medicare denial. Manual instructions have been updated to instruct the clerks to bypass the Medicare editing for this situation.

Provider Action: No action needed. As of 4/16/2004, EDS has recycled or adjusted all claims denied in error.

Revised: 4/23/2004

Item Ref: CHHC 1.9

Drafted: 4/12/2004

CMHC	Issue:	Medication checks (procedure code 90862) are denying.	Resolved: 4/12/2004
	Impact:	Providers believe that they are being underpaid.	
	Resolution:	Medication checks (procedure code 90862) are content of service to individual therapy visits (procedure code 9080). The new system allows for more comprehensive processing of claims based on the Correct Coding Guidelines which deal with content of service. These claims are denying correctly as content of service.	

Message: Medication checks (procedure code 90862) are content of service to individual therapy visits (procedure code 9080). The new system allows for more comprehensive processing of claims based on the Correct Coding Guidelines which deal with content of service. These claims are denying correctly as content of service.

Provider Action: Providers should evaluate their billing practices to ensure adherence to the Correct Coding Guidelines for any potential content of service procedure codes.

Revised: 4/12/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.10

Drafted: 4/15/2004

CMHC	Issue:	HCBS claims are paying one penny because the Plan of Care (POC) was approved with a "penny out" line.	Resolved: 6/4/2004
	Impact:	Claims are being underpaid	
	Resolution:	The POC was set up with too low of an approved amount. EDS identified these POCs and will systematically remove the "penny out" lines on 4/22/2004. Claims previously paid one cent will be adjusted so they process under the correct POC line item. (CO 5803)	

Message: HCBS claims are paying one penny because the Plan of Care (POC) was approved with a "penny out" line. The POC line item approved for one cent was removed on 4/22/2004. EDS submitted adjustments on 6/4/2004.

Provider Action: No action is needed.

Revised: 6/4/2004

Item Ref: CHHC 1.11

Drafted: 4/15/2004

CMHC	Issue:	Claims are denying for Plans of Care with pay cap amount that have a dollar amount and a unit on the Plan of Care (POC).	Resolved: 2/2/2004
	Impact:	Claims are underpaying.	
	Resolution:	When a POC has a type of "pay cap amount", the system is looking at both units and dollars when decrementing if that POC is available to still use. If a claim has already processed against that line item, it considers the line "used" since the units have already been decremented. The system should use dollars only when the POC is pay cap amount. A fix was implemented on 2/2/2004. Clean up was completed on 4/14/2004.	

Message: The Plan of Care for "pay cap amount" should be entered with dollars only. However, if the POC has a unit, it should be ignored by the system. This fix for the system to ignore the units was implemented on 2/2/2004. When setting up POC, the case manager should still set dollars only.

Provider Action: No action is needed. EDS created a mass adjustment and claims started to reprocess on 4/5/2004.

Revised: 4/23/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.12

Drafted: 4/15/2004

CMHC	Issue:	Claims related to “pay unit fee” PA are denying for “PA not found” edit.	Resolved: 2/2/2004
	Impact:	Claims are underpaying.	
	Resolution:	When the PA (i.e. Plan of Care) is a “pay unit fee price”, the system was expecting the exact unit dollar amount being billed on the incoming claim. An example is that if 10 units were approved at $2.00 each and the provider billed 10 units and a total billed amount of $30.00, the claim would deny indicating no PA on file. The system has been corrected to allow for the billed amount to be different than what appears on the PA.	

Message: When the PA (i.e. Plan of Care) is a “pay unit fee price”, the system was expecting the exact unit dollar amount being billed on the incoming claim. An example is that if 10 units were approved at $2.00 each and the provider billed 10 units and a total billed amount of $30.00, the claim would deny indicating no PA on file. The system has been corrected to allow for the billed amount to be different than what appears on the PA.

Provider Action: No action is needed. EDS created a mass adjustment and claims started to reprocess on 4/5/2004. Clean up was completed on 4/14/2004.

Revised: 4/23/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.13

Drafted: 4/15/2004

CMHC	Issue:	Claims are suspending or denying as duplicates when UD modifier is billed.	Resolved: 2/18/2004
	Impact:	If claims are submitted via any format except the Internet, claims were suspending for review, causing a delay in payment. If claims were submitted via the Internet, the claims would deny for duplicate denial. This occurred when a "UD" modifier was on the claim and previous claims paid even if different DOS.	
	Resolution:	The UD modifier was not being recognized as a unique modifier on different DOS. This has been corrected to allow claims to process without suspending or denying unless it was an exact duplicate for the same DOS. This system fix occurred on 2/18/2004.	

Message: The UD modifier was not being recognized as a unique modifier on different DOS. This has been corrected to allow claims to process without suspending or denying unless it was an exact duplicate for the same DOS. This system fix occurred on 2/18/2004.

Provider Action: No action is needed. Claims that were denied in error as duplicate were reprocessed by EDS on 4/22/2004.

Revised: 4/23/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.16

Drafted: 4/15/2004

CMHC	Issue:	Claims for CPT code 90862 are being denied as “procedure code is non-covered for this provider type and specialty” (EOB 342).	System Corrected: 5/4/2004 Clean-up: 7/7/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims that were denying for CPT code 90862 for this provider type and specialty have been resolved as of 5/4/2004. EDS identified claims denied in error on 7/7/2004 and resubmitted them for reconsideration of payment. (CO 5646)	

Message: Claims that were denying for CPT code 90862 for this provider type and specialty have been resolved as of 5/4/2004. EDS identified claims denied in error on 7/7/2004 and resubmitted them for reconsideration of payment. (CO 5646)

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.18

Drafted: 4/15/2004

CMHC	Issue:	Claims are being denied for timely filing even though the original converted ICN is indicated on the claim.	Resolved: 3/2004
	Impact:	Claims are underpaying.	
	Resolution:	A system change was implemented to allow providers to bill using a timely filing ICN. The beneficiary ID, provider number, and date of service on the timely filing ICN must match the claim submitted or the system will not bypass the timely filing requirement.	

Message: Claims are being denied for timely filing. A system change was implemented to allow providers to bill using a timely filing ICN. The beneficiary ID, provider number, and date of service on the timely filing ICN must match the claim submitted or the system will not bypass for timely filing.

Provider Action: No action is needed.

Revised: 4/30/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.19

Drafted: 5/4/2004

HCBS	Issue:	Procedure code T1016, as well as similar HCBS procedure codes, were denying for being part of family service coordination involvement.	Resolved: 3/18/04
	Impact:	Provider's claims are denying in error.	
	Resolution:	The system was corrected to exclude HCBS procedure codes from the Family Service Coordination exception 4352.	

Message: HCBS claims that were denying for exception 4352 (Family Service Coordination) are now paying correctly. EDS completed the reprocessing of these claims by the end of April.

Provider Action: No action required by providers.

Revised: 5/4/2004

Item Ref: CHHC 1.20

Drafted: 5/4/2004

Home Health	Issue:	Claims for QMB beneficiaries were denying when the GY modifier was on the claim.	Resolved: 4/20/2004
	Impact:	Providers were being underpaid.	
	Resolution:	Procedure code 99601 was loaded as being billable with the GY modifier for all benefit plans except QMB. The system was corrected to allow 99601 to be billed with the GY modifier as of 4/20/04. (TO 6380)	

Message: Claims that were denying for the GY modifier with the QMB benefit plan and 99601 CPT code are now processing correctly. EDS reprocessed the claims on 5/6/2004.

Provider Action: No action needed at this time.

Revised: 5/14/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: CHHC 1.23

Drafted: 6/9/2004

CMHC	Issue:	Local behavior management codes were being denied in error indicating no prior authorization (i.e., plan of care) on file.	Resolved: 4/21/04
	Impact:	Claims are denying incorrectly.	
	Resolution:	Local behavior management codes were being denied in error indicating no prior authorization (i.e., plan of care) on file. Codes included in the denial were S5145, H0017, T1019HA, 90847, and H2013. Claims denied in error were identified and reprocessed by 5/7/04. (CO6394)	

Message: Local behavior management codes were being denied in error indicating no prior authorization (i.e., plan of care) on file. Codes included in the denial were S5145, H0017, T1019HA, 90847, and H2013. Claims denied in error were identified and reprocessed by 5/7/04.

Provider Action: No action needed.

Revised: 6/9/2004

Item Ref: CHHC 1.25

Drafted: 6/9/2004

HCBS	Issue:	Claims were denying with Y19 diagnosis code.	System Corrected: 5/18/2004 Clean-up: 7/2/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims with diagnosis code Y19 denied incorrectly as non-covered after 2/19/2004. This code was still covered for dates of service prior to 1/1/04 and should have paid. The end date on the code was updated to allow claims to pay with dates of service prior to 1/1/04. This correction was made on 5/18/04. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6588)	

Message: Claims with diagnosis code Y19 denied incorrectly as non-covered after 2/19/2004. This code was still covered for dates of service prior to 1/1/04 and should have paid. The end date on the code was updated to allow claims to pay with dates of service prior to 1/1/04. This correction was made on 5/18/04. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment.

Provider Action: No action is needed.

Revised: 7/9/2004

Provider Community: Dental

Item Ref: DENT 1.0

Drafted: 2/29/2004

Dental	Issue:	Single digit tooth number. MMIS could not accept teeth numbered 1 - 9 (Old claims still cycling through MMIS).	Resolved 12/18/2003
	Impact:	Delayed claims payment from 10/16/2003 through 12/18/2003.	
	Resolution:	Permanent fix implemented on 12/18/2003.	

Message: Between 10/16/2003 and 12/18/2003 the KMAP MMIS was not processing tooth numbers correctly. Accordingly, claims that required tooth numbers for processing denied incorrectly. The permanent fix was implemented on 12/18/2003 and EDS worked with DORAL to reprocess all affected claims to appear on the 12/25/2003 RAs.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: DENT 1.1

Drafted: 2/29/2004

Dental	Issue:	Provider numbers for dental service providers including ICF-MRs, Local Health Departments, and Federally Qualified Health Centers were not assigned Provider Numbers with a dental provider type until after the changeover to Doral.	Resolved 1/19/2004
	Impact:	Delayed claims payment. Doral's system will not allow the input of claims by providers that have no Provider Number.	
	Resolution:	Applications have been received and enrollments have been processed. Information was received by Doral on 1/19/2004.	

Message: Provider numbers for dental service providers were not assigned Provider numbers with a dental provider type. This caused delayed payment on claims. Information was received by Doral on 1/19/2004 and this issue was fixed.

Provider Action: No action needed by providers.

Revised: 4/19/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: DENT 1.2

Drafted: 2/29/2004

Dental	Issue:	Transfer of daily eligibility file. File was not fully completed until 11/4/2003.	Resolved 11/4/2003
	Impact:	Delay in claims processing between 10/16/2003 through 11/4/2003.	
	Resolution:	Daily files fixed on 11/4/2003. The file transfer process has been implemented. Doral obtains current MMIS information on a daily basis.	

Message: There was a problem with the transfer of daily eligibility information. This caused claims to delay processing. The process was implemented and Doral obtains the current MMIS information on a daily basis. This issue was resolved on 11/4/2003.

Provider Action: No action needed by providers.

Revised: 4/19/2004

Item Ref: DENT 1.3

Drafted: 2/29/2004

Dental	Issue:	D9221 (deep sedentary anesthesia - each additional 15 minutes) not paying units correctly. Identified on 1/27/2004.	Resolved 3/11/04
	Impact:	Claims with this procedure code are not being paid correctly.	
	Resolution:	The MMIS fix was put in place and tested 2/20/04. Claims were identified and resubmitted by the end of the 2/7/2004 financial cycle. (Task # 6218)	

Message: D9221 was not paying units correctly. This was causing claims with this procedure code to not pay correctly. The MMIS fix was put in place and tested on 2/20/2004. Claims were identified and resubmitted by the end of the 2/7/2004 financial cycle.

Provider Action: No action needed by providers.

Revised: 4/19/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: DENT 1.4

Drafted: 2/29/2004

Dental	Issue:	Exchanges of data between contractors occasionally fail. Examples include HIPAA compliance checks; data content of files is missing; transfers and receipts do not match; history files.	Ongoing as needed.
	Impact:	Delays in claims processing as one or more of the contractors do not have current data necessary for accurate and timely claims processing.	
	Resolution:	Problems were generally resolved that day, with a new file sent the next day. Data transfer problems occur from time to time and most issues are resolved as soon as possible after they occur. Outstanding issues have been identified and are being worked on.	

Message: Exchanges of data between contractors occasionally fail. This is causing delays in claims processing as one or more of the contractors do not have the current data necessary for accurate and timely claims processing. Most issues are resolved as soon as possible after they occur. Outstanding issues have been identified and are being worked on.

Provider Action: No action is needed by providers.

Revised: 4/19/2004

Item Ref: DENT 1.5

Drafted: 2/29/2004

Dental	Issue:	Encounter rate table for FQHC dental service providers was not loaded. Currently, the MMIS pays these claims at the fee-for-service rate instead of the encounter rate.	Resolved: 4/22/2004
	Impact:	Dental claims submitted by these providers would not pay correctly.	
	Resolution:	A system fix for this issue was identified and implemented on 4/16/2004. Anticipated completion date is 5/21/2004. (CO 5838)	

Message: Claims filed by FQHCs for dental services since 10/16/2003 were paying the fee-for-service rate instead of the encounter rate. The system issue was resolved on 4/22/2004. Claims paid in error were identified and adjustments were submitted on 5/28/2004.

Provider Action: No action needed by provider. The system issue was resolved on 4/22/2004.

Revised: 5/28/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: DENT 1.6

Drafted: 2/29/2004

Dental	Issue:	Providers are providing services prior to their enrollments being completed. Examples for delays are incomplete applications, lack of signatures, etc.	Ongoing as needed.
	Impact:	Claims can't be submitted until a Provider Number is issued and recognized by the MMIS.	
	Resolution:	These problems are resolved when the enrollment process is complete.	

Message: Providers are providing services prior to their enrollments being completed. Examples for delays are incomplete applications, lack of signatures, etc. For Title XIX providers, eligibility dates can be adjusted as needed by the State. For Title XXI providers, services provided prior to the contract being completed are non-payable.

Provider Action: No action needed.

Revised: 4/19/2004

Item Ref: DENT 1.7

Drafted: 6/9/2004

Dentist	Issue:	Dental anesthesia code (D9221) is reimbursing at the incorrect level.	Resolved: 3/5/2004
	Impact:	Providers are not being paid correctly.	
	Resolution:	Dental anesthesia code (D9221) was reimbursing at the incorrect level. The pricing files and processes were updated to correctly price the claims on 3/5/04. EDS identified the claims priced in error and submitted adjustments on 5/13/2004. (CO 6137)	

Message: Dental anesthesia code (D9221) was reimbursing at the incorrect level. The pricing files and processes were updated to correctly price the claims on 3/5/04. EDS identified the claims priced in error for adjustments on 5/13/2004.

Provider Action: No action needed.

Revised: 6/25/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: DENT 1.8

Drafted: 6/9/2004

Dentist	Issue:	Procedure D3220 where denying in error when submitted with tooth #A.	Resolved: 3/29/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	Procedure D3220 were denying in error when submitted with tooth #A. Processors were given clearer instructions on handling the processing of these claims. Claims denied in error were identified and reprocessed for proper payment on 3/29/04. (CO 6153)	

Message: Procedure D3220 where denying in error when submitted with tooth #A. Processors were given clearer instructions on handling the processing of these claims. Claims denied in error were identified and reprocessed for proper payment on 3/29/04.

Provider Action: No action needed.

Revised: 6/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Rural Health Clinics & FQHCs

Item Ref: RHC 1.0

Drafted: 2/29/2004

Rural Health Clinics & FQHCs	Issue:	RHC/FQHC providers were paid Case Management fees for some of their beneficiaries during the February Cap adjustment run. These providers were not to be paid the $2.00 administration payment as beginning in November 2004.	System Corrected: 3/17/2004 Clean-up: 7/22/2004
	Impact:	Providers were paid in error and now the money will need to be recovered.	
	Resolution:	SRS is to determine if the money paid in error can be recovered through cost settlement and then a letter will be mailed to inform the providers of this resolution. (CO# 5784) It was hoped that this could be accomplished through the cost settlement process and not require account receivables or recoupments. SRS determined these claims could not be recovered through the cost settlement process because of the timing involved in that process. The clean-up occurred starting 7/22/2004. It should be finished by 7/30/2004.	

Message: RHC and FQHC providers were paid Case Management fees for some enrollees as part of the February Capitated Payment processing. These payments were paid in error and will be recouped. SRS is evaluating how to conduct this recoupment and will communicate this to providers through a letter in the future. The clean-up occurred starting 7/22/2004. It should be finished by 7/30/2004.

Provider Action: No action is needed.

Revised: 7/29/2004

Item Ref: RHC 1.2

Drafted: 4/12/2004

RHC/FQHC	Issue:	RHC/FQHC are being paid too low in addition to the fee-for-service rate issue. They are being paid below normal physician fee-for-service rates.	
	Impact:	Claims are being underpaid significantly.	
	Resolution:	A partial system fix for this issue was identified and implemented on 4/16/2004. A solution has been identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. An adjustment was submitted for claims that were paid using the incorrect rate on 5/12/2004. (CO 6202)	

Message: RHC/FQHCs are being paid too low in addition to the fee-for-service rate issue. They are being paid below normal physician fee-for-service rates. A partial system fix for this issue was identified and implemented on 4/16/2004. A solution has been identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. An adjustment was submitted for claims that were paid using the incorrect rate on 5/12/2004.

Provider Action: No action is needed.

Revised: 5/14/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: RHC 1.3

Drafted: 4/12/2004

RHC/FQHC	Issue:	Lab related claims for RHC are paying fee-for-service (FFS).	
	Impact:	Overpayments are occurring as lab-related claims should not pay at all. Only face-to-face claims should be paid an encounter rate.	
	Resolution:	A partial system fix for this issue was identified and implemented on 4/16/2004. A solution has been identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. (CO 6202)	

Message: RHC/FQHCs are being paid too low in addition to the fee-for-service rate issue. They are being paid below normal physician fee-for-service rates. A partial system fix for this issue was identified and implemented on 4/16/2004. A solution has been identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. An adjustment was submitted for claims paid using the incorrect rate on 5/12/2004.

Provider Action: No action is needed.

Revised: 5/28/2004

Item Ref: RHC 1.4

Drafted: 4/9/2004

RHC/FQHC	Issue:	Starting on the 3/25/04 RA, RHC and FQHC claims are not paying at the encounter rate (per diem allowable). All services are processing at the non-encounter rate.	Resolved: 4/16/2004
	Impact:	Claims are being underpaid significantly. For example, office visit procedure code 99213 paid $18.03 instead of $65.95.	
	Resolution:	A partial system fix for this issue was identified and implemented on 4/16/2004. A solution has been identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. (CO 5665)	

Message: Due to a processing issue, RHC/FQHC claims were paying at an incorrect rate. This issue was resolved on 4/16/2004. the claims will be identified and adjusted. An adjustment was submitted for claims paid using the incorrect rate on 5/12/2004.

Provider Action: No action is needed.

Revised: 5/28/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: RHC 1.5

Drafted: 6/3/2004

RHC	Issue:	Copay is being deducted from claims at $3.00 instead of $2.00.	System Corrected: 6/24/2004 Clean-up: 7/20/2004
	Impact:	Providers are being underpaid.	
	Resolution:	EDS has identified the issue which has caused the incorrect copay to be deducted. The system was updated on 6/24/2004 to reflect the accurate copay amount of $2.00 for Rural Health Clinic providers. Providers will not have to reprocess claims as EDS will handle reprocessing claims paid with copay deducted incorrectly. EDS reprocessed the claims on 7/20/2004. (CO 6718)	

Message: Copay is being deducted from claims at $3.00 instead of $2.00. System updates were made on 6/24/2004 to reflect the accurate copay amount of $2.00 for Rural Health Clinic providers. Providers will not have to reprocess claims as EDS will handle reprocessing claims paid with copay deducted incorrectly. EDS reprocessed the claims on 7/20/2004.

Provider Action: No action is needed at this time.

Revised: 7/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Hospice

Item Ref: HSPC 1.0

Drafted: 2/29/2004

Hospice	Issue:	High volume of claims in suspense to be manually priced.	Resolved 1/30/2004
	Impact:	As of 1/14/2004 556 claims were in suspense to be manually priced. This creates a slow-down in the turnaround time providers can get their claims paid.	
	Resolution:	Temporary workaround implemented to suspend claims to one specific location so that dedicated staff could focus on pricing these claims. Meeting was held with hospice providers on 1/14/2004 to identify methods to automate pricing process as a permanent fix. Permanent fix in progress as of 1/30/2004. (CO 5595)	

Message: Hospice claims have required manual review for pricing which in turn increases the amount of time before a claim can be adjudicated and paid. EDS and SRS have met with Hospice providers and developed criteria to automate what has historically been a manual process. Claims are currently being worked manually and the automated pricing is scheduled to begin in May 2004.

Provider Action: No action needed by providers.

Revised: 4/30/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Hospitals & Adult Care Home

Item Ref: HSPT 1.1

Drafted: 2/29/2004

Hospital	Issue:	Outpatient claims are denying the entire line when only 1 detail should be denied.	Resolved 12/26/2003
	Impact:	Providers are not receiving payments for those lines that could be paid.	
	Resolution:	Permanent solution implemented and all affected claims recycled by 12/26/2003.	

Message: Between 10/16/2003 and 12/26/2003 outpatient claims that should have only denied a detail resulted in entire claim denials. This issue was permanently corrected and affected claims recycled to appear on the 12/26/2003 RA.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: HSPT 1.2

Drafted: 2/29/2004

Hospital	Issue:	Providers have reported that "one-day" hospital claims are not processing correctly.	Inpatient Resolved 3/6/2004
	Impact:	Claims are being denied in error.	
	Resolution:	A system change was implemented on 4/16/2004. (CO 5648)	

Message: Due to a processing error, “one-day” hospital claims were denied. The system issue was resolved on 4/16/2004. Claims denied in error were identified and reprocessed on 4/29/2004.

Provider Action: No action needed by providers.

Revised: 5/7/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.4

Drafted: 2/29/2004

Hospital	Issue:	Providers disagree with policy that allows payment on one-day discharge only for death or discharge to another facility.	Resolved 1/18/04
	Impact:	Impact is claims deny and need to be submitted as outpatient.	
	Resolution:	SRS reviewing medical policy to determine if any change to it is appropriate or if it will remain as is. SRS/EDS reviewed policy and system. Determined that same-day admit and discharge will be allowed. System updated and all claims that denied for this criteria have been reprocessed.	

Message: Same day admit and discharge will be allowed. All claims affected were reprocessed by 4/2/04.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: HSPT 1.6

Drafted: 3/2/2004

Hospital	Issue:	Claims with a referring provider number present on the claim are denying stating they need a referral.	Resolved 2/29/2004
	Impact:	Claims denying for referral.	
	Resolution:	ASK identified the problem causing this and the fix went to production on 2/29.	

Message: Hospitals submitting claims through ASK may have encountered denials stating a referring provider ID was required although providers believed a referring provider ID was on the claim submitted. ASK has identified the issue causing this and the related solution was moved to production on 2/29/2004. Providers will need to resubmit any claims they believe denied in error due to this issue.

Provider Action: Provider to resubmit claims.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.8

Drafted: 3/2/2004

Hospital	Issue:	Procedure codes valid as of 2003 are denying as invalid even if the interChange MMIS shows the code as valid.	Resolved 12/30/2003
	Impact:	Claims denied for invalid procedure code..	
	Resolution:	Updated procedure code edits.	

Message: Between 10/16/2003 and 12/30/2003 providers may have encountered denials for “invalid procedure code” even if the procedure code was valid. The interChange MMIS procedure code edits were updated in late December, 2003 to correct this all affected claims were recycled.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Item Ref: HSPT 1.9

Drafted: 3/2/2004

Hospital	Issue:	Medicare crossover claims denying for EOB 417 instead of only denying specific line items.	Resolved 2/10/2004
	Impact:	Entire claim denies when only one line item should have denied.	
	Resolution:	EDS updated the editing associated with EOB 417 so that it would deny at the detail level instead of the claim (header) level.	

Message: Providers have encountered denials for EOB 417 that resulted in entire claim denials when truly only a specific detail line should have denied. This issue was permanently fixed on 2/10/2004 and all affected claims have been reprocessed.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.13

Drafted: 3/2/2004

Hospital	Issue:	Medicare Inpatient claims paid with Part B benefits not processing as TPL.	System Corrected: Ongoing research Clean-up: N/A
	Impact:	Claims are paying with Medicare allowed amount which is less than TPL would pay.	
	Resolution:	EDS is implementing new processes to ensure the accuracy of the keying of data. Claims are being adjusted as identified by the providers. Changes were put into production on 4/26/2004 to have inpatient claims with Medicare Part B processed as TPL.	

Message: EDS implemented new processes to improve accuracy of entry. Changes were put into production on 4/26/2004 to have inpatient claims with Medicare Part B processed as TPL. Kansas Medical Assistance Program (KMAP) now allows YOU, the provider, to control your Medicare submission electronically. Effective June 18, 2004, you can submit your claims using the Provider Electronic Solutions (PES) software or through your 835 HIPAA transaction submission. You do not need to send the attachment for the Medicare remittance advice! This is to allow you a more provider friendly, hassle free approach. Don't wait for Medicare to forward your claims to EDS for processing. Start submitting claims via PES or the 835 transaction.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.15

Drafted: 3/2/2004

Hospital	Issue:	Psychiatric claims denying for PA when other insurance made payment	Resolved 3/12/04
	Impact:	Claims are denying in error.	
	Resolution:	Resolution page will be updated to state claims are to be paid and not denied. System automation is currently being identified so manual intervention is not needed when other insurance is involved	

Message: Psychiatric claims denied for PA when other insurance made payment. This was a clerical error. Steps have been put into place to prevent denials.

Provider Action: Cleanup has been completed. If providers still have claims they believe were denied in error they should resubmit the claims for processing.

Revised: 4/30/2004

Item Ref: HSPT 1.16

Drafted: 3/2/2004

Hospital	Issue:	Fetal monitoring was denying claims due to medical policy.	Resolved 1/19/04
	Impact:	Claims denying for delivery due to fetal monitoring being present on claim.	
	Resolution:	SRS program manager approved update to system to not require medical necessity for fetal monitoring. Change implemented on 1/19/04.	

Message: Delivery claims denied due to fetal monitoring being present on claims. Medical necessity requirement was removed on 1/19/2004. Providers will need to resubmit denied claims for reconsideration of payment.

Provider Action: Providers need to resubmit claims since the claims processed correctly per policy at the time. In addition, medical necessity denial code is used for many instances so claims cannot be easily identified through system review.

Revised: 4/30/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.17

Drafted: 3/2/2004

Hospital	Issue:	Do not agree with SOBRA claim denials due to non-coverage of emergency services if local SRS has not approved.	4/1/2004
	Impact:	Claims are being denied unless delivery is procedure code on claim.	
	Resolution:	SOBRA claims will pay automatically only if labor and delivery is involved. Even if an emergency or life/death situation, the hospital manual clearly states the SRS field office must approve payment of claim before submission to EDS for payment.	

Message: Policy stands as is. Review General Provider Manual for steps to get prior approval of payment before submitting claims.

Provider Action: Review SOBRA guidelines and ensure that proper steps are taken before billing the claim.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.20

Drafted: 3/23/04

Hospital	Issue:	Claims that post edit 570 will no longer auto-deny when billed on the internet or on paper. These claims will suspend for review of the patient status code on the "from" and "to" dates and be processed accordingly. The same day admit/discharge inpatient claim should not be denied with edit 570.	Resolved: 4/19/04
	Impact:	Hospital claims are hitting error code 570 for "total days billed less than covered days" and auto-denying. These claims should suspend for review of the patient status code and the "from" and "to" dates. When the new code to fix the 570 was moved into production, 90% of the inpatient claims started to suspend for another system issue. The claims could not be released from the system until the system was fixed; otherwise, they would deny. This fix went into the system on Friday, 4/16/04 but did not make the financial cycle. **Provider's RAs for inpatient claims will reflect denials for the week; however, very few paid claims will appear. These paid claims will be on the 4/29/04 RA as they were confirmed to be in a paid status for this issue on 4/19/04.**	
	Resolution:	The cause of the incorrect denials was identified and corrected on 4/16/2004. Reprocessing of suspended claims occurred on 4/16/2004. Denied claims were resubmitted by EDS on 4/29/2004. (CO 5648)	

Message: Claims that post edit 570 will no longer auto-deny when billed on the internet or on paper. These claims will suspend for review of the patient status code on the "from" and "to" date and be processed accordingly. The issue causing this edit to post in error was resolved on 4/16/2004. **Provider's RAs for inpatient claims will reflect denials for the week; however, very few paid claims will appear. These paid claims will be on the 4/29/04 RA as they were confirmed to be in a paid status for this issue on 4/19/04.**

Provider Action: No action needed by provider. EDS will automatically reprocess the claims that were erroneously denied.

Revised: 5/7/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.22

Drafted: 4/9/2004

Hospital	Issue:	Mom/baby claims are all denying especially if submitted through ASK.	Resolved 4/7/04
	Impact:	Claims are denying in error and are being underpaid.	
	Resolution:	The processing of Mom/Baby claims changed. The system was changed to verify the diagnosis, procedure, and revenue codes are newborn related. V3000 and V3001 diagnosis codes were excluded from the newborn diagnosis table. SRS approved adding V3000 and V3001 as newborn diagnosis codes.	

Message: The system used Mom/Baby logic to identify "Baby Girl," "Baby Boy,", or "Newborn" in the first name and by the DOB being within 365 days of the DOS. The system now expects the DOB to be within 365 days of the DOS but does not look at the name. Instead, the system reviews the claim to determine if at least one of the revenue codes, diagnosis codes, or procedure codes are considered newborn codes. V3000 and V3001 were added by SRS as newborn diagnosis codes on 4/7/2004. Please follow processing guidelines in submission of Mom/baby claims.

Provider Action: Verify that any denied claims meet the processing guidelines. If the claim does meet the guidelines, you can resubmit the claim. If the claim does not meet the guideline, please review and update if appropriate billing and resubmit.

Revised: 4/9/2004

Item Ref: HSPT 1.23

Drafted: 4/9/2004

Hospital	Issue:	Inpatient psychiatric claims are denying for "no prior authorization (PA) on file".	
	Impact:	Claims are denying in error.	
	Resolution:	The system was expecting the DOS on the claim to be completely within the approved dates on the prior authorization (PA). Psychiatric claims only require the "admit date" to be within the approved dates on the PA. Claims will now suspend for manual review and appropriate approval. (Task 6384)	

Message: Due to processing issue, the system was expecting the DOS on the claim to be completely within the approved dates on the prior authorization (PA). Psychiatric claims only require the "admit date" to be within the approved dates on the PA. Claims will now suspend for manual review and appropriate approval.

Provider Action: None is needed. All psychiatric claims with erroneous denials for "no PA on file" were reprocessed for reconsideration of payment on 5/7/2004.

Revised: 5/28/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.25

Drafted: 4/15/2004

Hospital	Issue:	Claims with discharge status of 40 – 70 cannot be billed on the Internet.	Resolved: 6/4/2004
	Impact:	Providers who do not have electronic means other than the KMAP website to submit electronic claims, must submit claims on paper.	
	Resolution:	Change Order 6654 added discharge codes 40 – 70 as valid codes for the web UB-92 Inpatient claim form. (CO 6654)	

Message: Previously, the UB-92 claim form on the KMAP website did not have status code values in the range of 40 – 70 in the "Status" drop-down box. This has been corrected and provider can now submit claims with status codes within the range of 40 – 70.

Provider Action: Discharge codes 40 – 70 need to be billed on other electronic means (other than the KMAP website) or on paper.

Revised: 6/11/2004

Item Ref: HSPT 1.29

Drafted: 4/27/2004

Physician and Hospital	Issue:	The ET modifier is sometimes reducing ER fees down to the 99281 payment, which is a lower amount.	Resolved: 4/27/2004
	Impact:	A potential underpayment could occur.	
	Resolution:	KMAP pays emergency rooms higher rates only for an emergent diagnosis. If a claim has no emergent diagnosis, then it will be reduced to the lower emergency room evaluation code (99281) rate. This is a correct processing of the claim.	

Message: The ET modifier is sometimes reducing ER fees down to the 99281 payment, which is a lower amount. KMAP pays emergency rooms higher rates only for an emergent diagnosis. If a claims has no emergent diagnosis, then it will be reduced to the lower emergency room evaluation code (99281) rate. This is a correct processing of the claim.

Provider Action: Review billing practices to determine if emergent codes are being used when appropriate to do so. If not, claims will continue to decrease to lower rate.

Revised: 4/27/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.31

Drafted: 4/27/2004

Hospital	Issue:	The WC modifier price cannot be found on the fee schedule.	Resolved: 4/27/2004
	Impact:	Provider unsure what the reimbursement rate should be for billed claims.	
	Resolution:	The price for the WC modifier is listed under the different rate types for the ambulatory surgical center fee schedule section.	

Message: The WC modifier price cannot be found on the fee schedule. The price for the WC modifier is listed under the different rate types for the ambulatory surgical center fee schedule section.

Provider Action: Request fee schedule if you want complete information on various fees.

Revised: 4/27/2004

Item Ref: HSPT 1.32

Drafted: 5/4/2004

Hospital	Issue:	Inpatient claims are denying for no “to date of service” on the detail level.	Resolved: 4/15/04
	Impact:	Claims are being underpaid.	
	Resolution:	Exception 240, which requires a "To Date of Service," was denying in error. Inpatient claims do not require a "To Date of Service." This issue occurred from approximately April 7 – 15 and corrected on April 15. Previously denied claims were resubmitted by EDS on 4/29/2004. (TO 6388)	

Message: Exception 240, which requires a "To Date of Service," was denying in error. Inpatient claims do not require a "To Date of Service." Issue occurred from approximately April 7 – 15 and corrected on April 15. EDS will reprocess the claims and notify providers when corrected. Previously denied claims were resubmitted by EDS on 4/29/2004.

Provider Action: No action needed at this time.

Revised: 5/14/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.33

Drafted: 5/4/2004

Hospital	Issue:	Outpatient claims are denying for no procedure code for drugs and pharmaceuticals.	Resolved: 4/30/2004
	Impact:	Providers believe that they are being underpaid.	
	Resolution:	All outpatient details in the new system and even historically have always required a procedure, HCPCS, or CPT on every detail line to process and pay correctly. For drug and pharmaceutical claims, hospitals are billing revenue codes only, as if billing inpatient claims. This is not a policy change. The only way to price a claim for outpatient is to know the specific "J" code and in most cases, NDC and drug name on the claim. Without the drug that was provided for outpatient service, KMAP cannot determine the price to reimburse the hospital.	

Message: Outpatient claims are denying for no procedure code for drugs and pharmaceuticals. All outpatient details in the new system and even historically have always required a procedure, HCPCS, or CPT on every detail line to process and pay correctly. For drug and pharmaceutical claims, hospitals are billing revenue codes only, as if billing inpatient claims. This is not a policy change. The only way to price a claim for outpatient is to know the specific "J" code and in most cases, NDC and drug name on the claim. Without the drug that was provided for outpatient service, KMAP cannot determine the price to reimburse the hospital.

Provider Action: Providers need to evaluate their billing system to ensure that the "J" code is included on the claims for drugs and pharmaceuticals for outpatient claims. In addition, if the "J" code is non-classified or can cover multiple dosages, the NDC must be included in the remarks section of the HCFA 1500 or comment section of the 837 transaction. If providers have previously paid claims involving other insurance, do not resubmit as new claims to process the remaining lines. Please submit adjustment requests so the claim can process as a whole against other insurance paid amount.

Revised: 5/4/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: HSPT 1.34

Drafted: 5/4/2004

Hospital	Issue:	Outpatient claims were denying for no revenue code on the claim.	System Corrected: 4/26/2004 Clean-up: N/A
	Impact:	Claims are denying incorrectly.	
	Resolution:	The system was corrected not to post a revenue code error message on the claim when none was submitted on outpatient claims. This correction occurred on 4/26/2004. EDS ran a system query to identify if any claims actually denied due to the revenue code error message posting on the claim. No claims denied for this reason; thus, there are no claims to reprocess. Future claims will not have the confusing message on the RA. (CO 6707)	

Message: The system was corrected not to post a revenue code error message on the claim when none was submitted on outpatient claims. This correction occurred on 4/26/2004. EDS ran a system query to identify if any claims actually denied due to the revenue code error message posting on the claim. No claims denied for this reason; thus, there are no claims to reprocess. Future claims will not have the confusing message on the RA.

Provider Action: No action is needed.

Revised: 7/20/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Local Education Agencies

Item Ref: LEA 1.0

Drafted: 2/29/2004

Local Education Agencies	Issue:	New LEA policy implemented on 1/1/2004 requiring a new Place of Service value. Providers were not aware until 12/1/2003. ASK system was also not prepared to receive new values.	Resolved 1/16/2004
	Impact:	Claims are denying for an invalid Place of Service. Providers are not able to get claims paid.	
	Resolution:	Denied claims were identified and corrected on 1/9/2004 RAs producing $1.7 million in payments to LEAs. ASK completed system changes on 1/16/2004.	

Message: A new LEA policy was implemented on 12/1/2003 requiring providers to begin using new Place of Service values. The ASK system was not ready to accept the new values as of the 12/1/2003 policy effective date. Resulting denied claims were identified and corrected on the 1/9/2004 RA.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: LEA 1.1

Drafted: 6/2/2004

Local Education Agency	Issue:	LEA claims are denying for submission to Medicare in error.	System Corrected: 7/16/2004 Clean-up: N/A
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS is currently researching this issue. EDS ran reports to identify claims associated with this issue. The reports did not show any services for LEA providers denied for Medicare related edits. If a provider has examples, please send them to EDS.	

Message: EDS is currently researching this issue. EDS ran reports to identify claims associated with this issue. The reports did not show any services for LEA providers denied for Medicare related edits. If a provider has examples, please send them to EDS.

Provider Action: No action is needed.

Revised: 7/16/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Pharmacy

Item Ref: PHAR 1.0

Drafted: 2/29/2004

Pharmacy	Issue:	Pharmacies did not understand new spenddown processing related to what charges to collect from beneficiaries.	Resolved 11/2003
	Impact:	Some pharmacies did not collect required spenddown amounts from beneficiaries.	
	Resolution:	Education provided to Pharmacies. Solicited input from Pharmacies and implemented solution to return amounts to collect from beneficiaries affected by spenddown in the Co-pay field.	

Message: With the implementation of interChange, pharmacies were not able to determine the amount to collect for (Medically Needy (Spenddown) beneficiaries before dispensing medication. EDS and SRS asked for feedback from the pharmacy community and began sending back the outstanding Spenddown amount due from the beneficiary in the Co-Pay field in November, 2003.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: PHAR 1.1

Drafted: 2/29/2004

Pharmacy	Issue:	Some covered NDCs could not be loaded systematically and must be loaded manually.	Resolved 10/18/2003
	Impact:	Until affected NDCs were loaded, claims denied as not covered on the date of service.	
	Resolution:	Affected NDCs corrected on 10/18/2003.	

Message: Between 10/16/2003 and 10/18/2003 some NDCs that must be loaded manually were not entered into the interChange MMIS. Consequently, claims filed for affected NDCs denied as not being covered on the date of service. Affected NDCs were identified and updated in the MMIS on 10/18/2003. If you encountered non-covered denials between 10/16/2003 and 10/18/2003, you may need to resubmit claims for reconsideration since the NDC updates.

Provider Action: Provider may need to resubmit outstanding claims.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: PHAR 1.2

Drafted: 2/29/2004

Pharmacy	Issue:	Pharmacies were not receiving the Ingredient Cost field in claim responses.	Resolved 10/21/2003
	Impact:	Providers were unsure of how to post paid claims.	
	Resolution:	Permanent fix implemented on 10/21/2003 to being sending back this amount.	

Message: Pharmacies indicated a need to receive the Ingredient Cost field in claim responses. This field was added to all pharmacy claim responses effective 10/21/2003.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Item Ref: PHAR 1.3

Drafted: 2/29/2004

Pharmacy	Issue:	Some Edits and Audits were not mapped to NCPDP reject codes.	Resolved 10/24/2003
	Impact:	Providers were unsure of how to interpret reject codes.	
	Resolution:	Updates to affected codes were completed on 10/24/2003.	

Message: Some claim Edits and Audits were not mapped to NCPDP reject codes. Accordingly, providers were unsure how to interpret some rejection codes. Updates to affected codes were completed on 10/24/2003

Provider Action: No action needed by provider.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: PHAR 1.4

Drafted: 2/29/2004

Pharmacy	Issue:	Providers received denials for drug claims for Foster Care and Hospice beneficiaries.	Resolved 10/17/2003
	Impact:	Providers could not receive payments on affected claims between 10/16/2003 and 10/17/2003.	
	Resolution:	Permanent fix identified and implemented on 10/17/2003.	

Message: Drug claims filed for Foster Care and Hospice beneficiaries were incorrectly denying due to lock-in. Consequently, providers were not able to successfully get claims to a paid status between 10/16/2003 and 10/17/2003. The permanent fix for this was implemented on 10/17/2003. If providers have outstanding claims that have not yet been resubmitted, please resubmit them for consideration.

Provider Action: Providers may need to resubmit any outstanding claims.

Revised: 4/9/2004

Item Ref: PHAR 1.5

Drafted: 2/29/2004

Pharmacy	Issue:	Inability to use usual and customary charge on pharmacy claims	
	Impact:	Affects the amount used by interChange to reduce a beneficiary's spenddown record as well as drug rebate amounts.	
	Resolution:	Use of Usual and Customer charges were not included in NCPDP 5.1. Currently being reviewed in conjunction with changes being made to support spenddown processing. (CO# 6040)	

Message: Pharmacies have indicated a need to use Usual and Customary Charges on pharmacy claims. The use of Usual and Customary Charges was not included in NCPDP 5.1. This change is currently being reviewed in conjunction with changes being made to support Spenddown processing.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: PHAR 1.7

Drafted: 4/7/2004

Pharmacy	Issue:	Pharmacies using QS1 software are billing incorrectly on dual-insurance beneficiaries.	System Corrected: 6/16/2004 Clean-up: N/A
	Impact:	In researching this issue, we have found that when billing for beneficiaries with dual insurance, pharmacies using QS1 could possibly be underpaid $1.50 to $3.00 per claim. Pharmacies will need to adjust these claims.	
	Resolution:	QS1 updated their software on June 11, 2004 and the issue of billing for beneficiaries with dual insurance through QS1 should be resolved. Note – QS1 Pharmacy users need to make sure they download the newest version of QS1. The EDI team is working with QS1 in getting the information out to the Pharmacy users. EDS will be doing testing June 21 through June 28 to ensure the Pharmacies that are billing QS1's new version is paying correctly. Test results show that QS1 software providers when billing for beneficiaries with dual insurance is working correctly. A global message will be posted by July 2, 2004.	

Message: QS1 updated their software on June 11, 2004 and the issue of billing for beneficiaries with dual insurance through QS1 should be resolved. Note – QS1 Pharmacy users need to make sure they download the newest version of QS1. The EDI team is working with QS1 in getting the information out to the Pharmacy users. EDS will be doing testing June 21 through June 28 to ensure the Pharmacies that are billing QS1's new version is paying correctly. Test results show that QS1 software providers when billing for beneficiaries with dual insurance is working correctly.

Provider Action: Pharmacies will need to adjust these claims.

Revised: 7/16/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: PHAR 1.8

Drafted: 5/12/2004

Pharmacy / DME	Issue:	DME claims crossing over from Medicare for diabetic testing supplies are denying.	Resolved: 5/12/2004
	Impact:	Claims are denying and providers are not being paid.	
	Resolution:	Medicare requires that the DME supplier bill the range of dates for diabetic supplies. This range includes future dates. For instance, if the DME supplier is billing on 5/1/04, they bill 5/1/04 to 5/31/04. These claims are denied correctly in KMAP as KMAP does not allow future billing dates. Claims with future dates must be billed on paper with the RA.	

Message: Medicare requires that the DME supplier bill the range of dates for diabetic supplies. This range includes future dates. For instance, if the DME supplier is billing on 5/1/04, they bill 5/1/04 to 5/31/04. These claims are denied correctly in KMAP as KMAP does not allow future billing dates. Claims with future dates must be billed on paper with the RA.

Provider Action: If denial received for future date invalid, then the provider must bill the claim on paper with the RA from Medicare attached.

Revised: 6/11/2004

Item Ref: PHAR 1.9

Drafted: 5/12/2004

Pharmacy and DME	Issue:	DME codes not subject to CLIA editing are denying for needing a CLIA number.	System Corrected: 5/7/2004 Clean-up: 7/15/2004
	Impact:	Providers are being underpaid.	
	Resolution:	The parameter from the old system for denying for CLIA did not include DME. The new system does. The DME codes needed to be removed from the list for needing CLIA. EDS updated the file and has resolved the issue. EDS identified and reprocessed the claims denied in error on 7/15/2004. (CO 6281)	

Message: The parameter from the old system for denying for CLIA did not include DME. The new system does. The DME codes needed to be removed from the list for needing CLIA. EDS updated the file and has resolved the issue. EDS identified and reprocessed the claims denied in error on 7/15/2004.

Provider Action: No action is needed. EDS will identify affected claims and recycle. Notification will be provided when complete.

Revised: 7/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: PHAR 1.10

Drafted: 5/12/2004

Pharmacy and DME	Issue:	Claims are paying in error when E0570 (nebulizer) is billed over limit.	System Corrected: 4/29/2004
	Impact:	Providers are being overpaid.	
	Resolution:	Claims are paying in error when the beneficiary has already received a nebulizer (E0570) within the last three calendar years. The issue was identified and resolved on 4/29/04. EDS submitted the adjustments on 7/15/2004 for the claims paid in error. (CO 6287)	Clean-up: 7/15/2004

Message: Claims are paying in error when the beneficiary has already received a nebulizer (E0570) within the last three calendar years. The issue was identified and resolved on 4/29/2004. EDS submitted the adjustments on 7/15/2004 for the claims paid in error.

Provider Action: No action is needed. EDS will identify affected claims and recoup the overpayment. Notification will be provided when complete.

Revised: 7/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: State Institutions

Item Ref: STIN 1.0

Drafted: 2/29/2004

State Institutions	Issue:	Claims submitted by state institutions were denying for invalid type of bill and other edits due to transition of these facilities from turnaround documents to the UB92 form.	Resolved 1/15/2004
	Impact:	Payments to two state institutions were delayed for approximately-8 weeks.	
	Resolution:	Resolved through testing and billing education with both facilities as of 1/8/2004 and 1/15/2004.	

Message: Due to a combination of interChange MMIS processing errors and provider education, claims filed by state institutions were denying for invalid type of bill between 10/16/2003 and 1/15/2004. This issue was resolved through billing education and testing with both facilities as of 1/8/2004 and 1/15/2004.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Electronic Submitters

Item Ref: EDI 1.1

Drafted: 2/29/2004

Electronic Submitters	Issue:	Claims denied for Beneficiary Name is Missing or Invalid Beneficiary ID.	Resolved 11/15/2003
	Impact:	Electronic providers were not supplying the beneficiary name in the correct field as required by the SRS HIPAA companion guides for claims transactions.	
	Resolution:	Resolved through education with providers and electronic submitters and updates to the EDI companion guides clarifying the cardholder ID field.	

Message: Between 10/16/2003 and mid November, 2003 electronic claims were denying for "Beneficiary name is missing" or "Invalid beneficiary ID". These denials were related to the beneficiary name not appearing in the correct field as required by the SRS HIPAA companions guides for claims transactions. This was resolved by contact with electronic submitters and vendors and updates made to the companion guides.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: EDI 1.2

Drafted: 2/29/2004

Electronic Submitters	Issue:	ASK was not providing the correct qualifier for the provider ID field.	Resolved 10/21/2003
	Impact:	Affected electronic providers perceived their electronic claims were "lost".	
	Resolution:	ASK identified issue and implemented fix on 10/21/2003. Previously denied claims were resubmitted by ASK.	

Message: Between 10/16/2003 and 10/21/2003 claims received from ASK did not contain a qualifier required for the provider ID field. Consequently, claims were received by the KMAP interChange MMIS but without a provider ID. Because the claims did not come to EDS with a valid provider ID (due to the missing qualifier), Customer Service could not locate affected claims by provider ID and the claims could not be routed to the provider's RA. This issue was identified with ASK and a permanent fix implemented on 10/21/2003. ASK corrected and resubmitted all claims previously denied.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: EDI 1.3

Drafted: 2/29/2004

Electronic Submitters	Issue:	Billed date was imported as 1903 instead of 2003	Resolved 11/4/2003
	Impact:	This affected 6644 claims (multiple providers) that had this issue.	
	Resolution:	It was determined that these providers were using an old version of PACS. Edit 554 (billed date is prior to date of service) was set to pay and list to prevent the claims denying for this reason in the future	

Message: Between 10/16/2003 and 10/21/2003 electronic claims were denied due to "Billed date is prior to date of service". This was caused by providers using on old version of PACS. Affected claims were identified, corrected and reprocessed.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: EDI 1.4

Drafted: 2/29/2004

Electronic Submitters	Issue:	ASK file system was creating duplicate file names for multiple files. The EDS system only detected the first file and did not pick up the duplicate files.	Resolved 12/5/2003
	Impact:	Providers electronic submissions were not getting processed	
	Resolution:	ASK and EDS identified the duplicate files and resubmitted the files for the providers	

Message: Due to a file transfer issue between ASK and EDS, some claims transmissions were not getting input into the KMAP interChange MMIS between 10/16/2003 and 12/5/2003. ASK and EDS identified the problem and resubmitted all affected files for providers.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: EDI 1.5

Drafted: 2/29/2004

Electronic Submitters	Issue:	ASK was rejecting claims with an error that the provider was submitting an invalid diagnosis code. ASK is not receiving mainframe diagnosis code updates now that interChange is live.	Resolved 11/14/2003
	Impact:	Providers submitting with invalid diagnosis codes would receive rejections from ASK. Providers could bill using new, valid codes and if they did not match the older codes ASK edited against, the claim would get rejected.	
	Resolution:	11/6 ASK is removing this edit from their EDI engine so the claims will be sent to interChange to appropriately adjudicate.	

Message: Prior to the interChange MMIS, ASK would edit data from providers for valid codes. Between 10/16/2003 and 11/14/2003 claims were being rejected by ASK with an error that diagnosis codes were invalid. ASK is no longer performing this check and therefore not rejecting claims for invalid diagnosis. If a provider submits a claim with an invalid diagnosis, the claim will be processed by the interChange MMIS and denied accordingly.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: General

Item Ref: GENP 1.0

Drafted: 2/29/2004

All (Primarily HCBS & Home Health)	Issue:	MMIS was not correctly locating approved Prior Authorization records (Plans of Care) on file.	Resolved 1/30/2004
	Impact:	Claims were denying for "PA not found on database" or not decrementing the correct PA and therefore causing incorrect denials. This impacted all providers, including Home Health and HCBS.	
	Resolution:	Permanent fix identified and corrected on 1/30/2004. EDS will reprocessed claims denied in error. (CO 4829)	

Message: Between 10/16/2003 and 1/30/2004, the KMAP interChange MMIS was not correctly finding approved Prior Authorization records. Accordingly, claims denied for “PA not found on database” or did not decrement the correct PA resulting in incorrect payments or incorrect denials. This issue was permanently fixed on 1/30/2004. EDS began reprocessing these claims on 3/26/2004. Reprocessing of claims was completed on 4/16/2004.

Provider Action: No action needed by providers.

Revised: 4/30/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.4

Drafted: 2/29/2004

All	Issue:	Access to Customer Service.	Resolved: 6/4/2004
	Impact:	Providers are not able to reach Customer Service for KMAP program assistance or claims resolution.	
	Resolution:	Customer Service queue size and allocation of dedicated lines was increased on 1/29/2004 as an interim solution. EDS added additional people (12) into customer service on Friday, 4/23/2004. Improvement already started to be seen the week of 4/26/2004. this will continue to be monitored. Customer Service is now averaging hold times of approximately 2 minutes. We appreciate your patience and hope you are experiencing significant improvement in response times.	

Message: In response to provider concerns, EDS has increased the call center queue size on 1/29/2004 so that fewer callers would be disconnected. SRS and EDS are implementing several enhancements over the next 60 days to improve the accuracy of information and decrease the amount of time it takes to support callers in an effort to reduce hold times. Customer Service is now averaging hold times of approximately 2 minutes. We appreciate your patience and hope you are experiencing significant improvement in response times.

Provider Action: No action needed by providers.

Revised: 5/7/2004

Item Ref: GENP 1.6

Drafted: 2/29/2004

All Providers Billing For MediKAN Services	Issue:	MediKan benefit plan was not set-up correctly to produce payments to providers on behalf of beneficiaries with MediKAN coverage.	Resolved 12/26/2003
	Impact:	12,847 Professional claims and 1,927 Institutional claims denied between 10/20/2003 and 12/26/2003.	
	Resolution:	Permanent fix identified and corrected on 12/26/2003. All affected claims were recycled by the 1/22/2004 RA.	

Message: Between 10/16/2003 and 12/26/2003, claims submitted for MediKAN beneficiaries denied. This issue was identified and corrected by 12/26/2003. All affected claims were recycled and appeared on RAs throughout January, 2004.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.7

Drafted: 2/29/2004

All	Issue:	Internet claims resubmission option was not correctly resubmitting claims. Randomly claims were being associated with the wrong provider.	Resolved 2/3/2004
	Impact:	Providers cannot pull up and correct previously denied claims on the KMAP secure site. Providers received incorrect information on RAs.	
	Resolution:	EDS temporarily disabled the ability for both EDS and providers to perform internet resubmissions on 2/2 and 2/3. Providers who attempted to resubmit claims were informed of the temporary disablement thru and automated message. The function was re-enabled around 5:00 p.m. on 2/3.	

Message: In early February, EDS temporarily disabled the ability for providers to perform claim resubmissions through the web. This outage was in response to providers sporadically receiving incorrect claims responses. An interim solution was implemented and the functionality was restored on 2/3/2003 at 5:00 p.m.

Provider Action: No action needed by providers.

Revised: 4/9/2004

Item Ref: GENP 1.8

Drafted: 2/29/2004

All	Issue:	Providers need to be able to search for eligibility on the web by name and date of birth.	Resolved 12/5/2003
	Impact:	Without being able to search by name, providers are not able to verify eligibility on some patients prior to providing services.	
	Resolution:	This functionality was added as of 12/5/2003.	

Message: In response to providers' request, EDS and SRS added the ability to search for beneficiary eligibility by name and date of birth. This functionality was added as of 12/5/2003.

Provider Action: No action needed by provider.

Revised: 4/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.10

Drafted: 2/29/2004

All	Issue:	Providers are reporting that when requesting eligibility information they are intermittently receiving information on a beneficiary other than for whom they originally requested.	Resolved 3/3/2004
	Impact:	If the provider did not catch that the response was for someone other than requested, they may provide services for someone who is not eligible or inform a beneficiary who is eligible that they are not eligible.	
	Resolution:	This issue has been resolved.	

Message: Providers have reported that intermittently when requesting eligibility information on the KMAP website they will receive a response for a beneficiary other than for whom they requested. EDS and SRS are aware of this issue and are researching it for a permanent solution. In the interim, EDS and SRS stress that providers validate the name of the beneficiary on web responses to ensure the response is for the patient on which you inquired.

Provider Action: Provider to check name on EVS response to validate it is the patient on which they inquired.

Revised: 4/9/2004

Item Ref: GENP 1.16

Drafted: 4/12/2004

All	Issue:	KMAP website is not displaying secondary insurance information.	Resolved: 6/23/2004
	Impact:	Providers cannot determine, without calling EDS, what secondary insurer is on file. The KMAP website will state no TPL involvement when the MMIS does have TPL on file.	
	Resolution:	This issue is only occurring randomly and the core issue has not been determined. Research of examples provided indicate that while the beneficiary had TPL on file, the dates entered in search were for months that the beneficiary was ineligible for KMAP. No eligibility or TPL will be returned on the Internet when this occurs. (CO 6786)	

Message: If a provider receives a TPL denial and TPL is not shown on the website, you may verify TPL coverage through AVRS, the beneficiary's ID card or by contact KMAP Customer Service at 1-800-933-6593.

Provider Action: If provider receives a TPL denial and no TPL is on the web site, please contact beneficiary to get secondary insurance information.

Revised: 6/25/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.19

Drafted: 4/12/2004

All	Issue:	Claims with the same procedure code but different modifier are denying against each other.	Resolved: 6/252004
	Impact:	Underpayments are occurring to the provider.	
	Resolution:	The modifiers identified are not on the list to bypass duplicate auditing. The claims are processing according to policy. Research has been completed. The claims processed correctly. Per policy these modifiers are ignored during duplicate auditing.	

Message: Claims with the same procedure code but different modifier are denying against each other. For example, T1019 HC pays and T1019 HK denies for the same DOS. EDS will update this log when research and resolution is complete.

Provider Action: No action is needed. Provider notification and reprocessing of claims will occur when issue is resolved.

Revised: 7/9/2004

Item Ref: GENP 1.21

Drafted: 4/15/2004

All	Issue:	Claims initially processed as Medicare and should be TPL cannot be adjusted due to system not allowing change in claim type. Vice versa occurs as well.	System Corrected: 6/4/2004 Clean-up: 7/21/2004
	Impact:	Underpayments and/or overpayments are occurring depending on the specifics of each claim.	
	Resolution:	System issue was resolved on 6/4/2004. EDS has reprocessed the adjustments as of the middle of July. (CO 5168)	

Message: Providers have submitted claims as crossover, TPL, or no other insurance involvement. The claim needs to have TPL added or Medicare added or other insurance removed. Adjustments are needed to correct system processing or to add TPL payment information. The issue preventing these adjustments was corrected on 6/4/2004. EDS has reprocessed the adjustments as of the middle of July.

Provider Action: Provider can void original claim on the Internet and resubmit new claim for processing as a work around.

Revised: 7/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.23

Drafted: 4/15/2004

All	Issue:	Dual Medicare/Medicaid beneficiaries have the co-pay indicator as “Y”.	Resolved: 5/3/2004
	Impact:	Beneficiaries are being required to pay the co-pay when providers believe that they should not be.	
	Resolution:	EDS researched the issues and determined that according to state policy, Medicare eligibility does not exempt beneficiaries from a co-pay requirement. Some beneficiaries are exempt based on their level of care.	

Message: Providers reported that the system is requiring beneficiaries to pay a co-pay when they are Medicare eligible. Research determined this is existing state policy and no system issue exists.

Provider Action: No action needed.

Revised: 5/7/2004

Item Ref: GENP 1.24

Drafted: 4/15/2004

All	Issue:	For IUD and Norplant insertions, the drug is being denied and the procedure is being paid.	System Corrected: 4/15/2004 Clean-up: 7/7/2004
	Impact:	Providers are being underpaid.	
	Resolution:	The table has been updated to prevent denials for edit 5525. EDS identified the claims denied in error and resubmitted them on 7/7/2004 for reconsideration of payment. (Task 6400)	

Message: For IUD and Norplant insertions, the drug is being denied and the procedure is being paid. The system was corrected on 4/23/2004. EDS identified the claims denied in error and resubmitted them on 7/7/2004 for reprocessing.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.26

Drafted: 4/15/2004

All	Issue:	Claims for circumcision are denying for unacceptable diagnosis code when billed with V502.	Resolved: 4/13/2004
	Impact:	Claims are being denied incorrectly.	
	Resolution:	The V502 diagnosis code has been added as a valid diagnosis code for circumcision for 4/13/2004. (TO 6510)	

Message: The V502 diagnosis code has been added as a valid diagnosis code on 4/13/2004. EDS identified all denied claims and resubmitted them for reconsideration of payment on 6/14/2004.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.27

Drafted: 4/22/2004

Physician and Hospital	Issue:	Claims for sterilization are denying when the form is attached.	Resolved: 4/22/2004
	Impact:	Claims are not being paid.	
	Resolution:	Tighter controls are in place to ensure that the claims received have the federally mandated sterilization form.	

Message: Both the Professional Manual and the Hospital Manual state "The sterilization consent form mandated by federal regulation must be used. All voluntary sterilization claims submitted without this specific consent form will be denied." This is not a program change. Due to the tighter controls, claims with the physician's variation of the form will be denied. Major differences in forms that are being seen: 1. The federal form number in the upper left hand corner is not present; 2. The provider number line and date line is not the last required information on the bottom right had corner of the form; 3. If the provider number line is present, the surgeon's provider number is not indicated or does not match the surgeon's claim on file. The federally mandated form must be used. If a claim for a physician had prior payment for sterilization procedure, it does not guarantee payment to the hospital if the form has posted an audit and determined to be invalid. Additionally, any claims being adjusted by KFMC with original paid dates prior to 10/23/2004 will be reviewed and processed against the original submission to avoid KFMC review negatively impacting prior payment for the sterilization not associated with their review.

Provider Action: Providers must ensure that they use the proper forms. Hospitals must ensure that they review the form that the provider uses prior to the sterilization to receive payment.

Revised: 4/22/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.28

Drafted: 4/22/2004

Physician and Hospital	Issue:	Professional and facility charges for sterilization are denying when the form is attached.	Resolved: 4/23/2004
	Impact:	Claims are not being paid.	
	Resolution:	When the professional and facility bill the exact same code without a modifier, the system is reviewing this as one sterilization per lifetime and denying the claim. Since the WC modifier was previously used, the system would differentiate that the claims were the same DOS but one was facility and one was physician. A fix will be made to the system to recognize provider types and specialties, of the following, are not duplicates to the physician's claim: 01/010, 01/351, 02/020, and 42/010. Issue fixed on 4/23/2004. (CO 6427, 6428)	

Message: Claims denying for one sterilization per lifetime for a small group of provider types and specialties will be reviewed and reprocessed by EDS. Providers will be notified when claims are reprocessed.

Provider Action: No action needed.

Revised: 4/30/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.29

Drafted: 4/27/2004

All providers	Issue:	Claims are disappearing that have been submitted since 3/1/04.	Resolved: 5/7/2004
	Impact:	Effective on 3/1/2004, old provider numbers are not to be submitted on claims sent to EDS. Providers will not see these claims on their remittance advice or through the web site.	
	Resolution:	Claims with the old provider numbers are not cross walked to the provider remittance advice or returned. The system denies the claims but keeps record under the Beneficiary ID and DOS billed. However, due to the crosswalk no longer occurring, providers will not see the claims on their remittance advice or through the web site. No change is planned for electronic claims as providers are not sending accurate billing to be captured in the system by the new provider number. EDS has no paper document able to return.	

Message: Please submit all your claims with the new provider number. This includes re-bills of claims denied prior to 3/1/04. Claims will not be cross walked for providers to see on the remittance advice or website.

Provider Action: Submit claims with new provider numbers. If you believe that your claim was submitted with the new provider number, call customer service and inquire by beneficiary number and DOS to determine if claim was received and number accurate in the system from what was submitted.

Revised: 6/4/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.30

Drafted: 4/27/2004

Inpatient	Issue:	EDS is keying an extra line on claims which is causing claim to deny.	Resolved: 5/3/2004
	Impact:	Underpayments are occurring.	
	Resolution:	For paper claims, the total line is being entered into the MMIS as a line item; therefore, the claim gets denied because there is no date of service. This also doubles the total billed amount on the claim. A system fix for the character recognition software has been implemented. It is being verified for new claims.	

Message: A system fix has been implemented on not keying the total line on the claim as a detail line. This will also stop the total billed amount appearing as double on the RA.

Provider Action: Providers need to call customer service to request claim to be reprocessed or resubmit the claim. Due to the various denial messages that can be received, this issue is too large to narrow to the specific claims for EDS to reprocess.

Revised: 5/7/2004

Item Ref: GENP 1.31

Drafted: 4/27/2004

Physician and Hospital	Issue:	For emergency room claims, either the professional claim or the facility claim is paid and the other is denied as a duplicate.	Resolved: 5/14/2004
	Impact:	Claims are not being paid.	
	Resolution:	Both claims should pay for professional component and facility. EDS is researching this issue. The examples that EDS received did not reflect duplicate denial. The denials were for invalid modifier.	

Message: For emergency room claims, either the professional claim or the facility claim is paid and the other is denied as duplicate. This is causing claims to not be paid. EDS is researching this issue and updates will be posted when available. The examples that EDS received did not reflect duplicate denial. The denials were for invalid modifier.

Provider Action: None at this time.

Revised: 5/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.32

Drafted: 4/27/04

All	Issue:	For consultations, the Internet is not allowing the referring provider number to be submitted on the claim.	System Corrected: N/A Clean-up: N/A
	Impact:	Providers are unable to process claims through the Internet. Providers want the use of a dummy provider number. This number is not available at this time.	
	Resolution:	The system only evaluates the claim to determine if the referring provider number on the claim is valid. It does not review for the PCP. If claims are denying for this reason, examples need to be provided. For the dummy provider number, SRS is taking into consideration if one should be established for billing purposes.	

Message: For consultations, the Internet is not allowing the referring provider number to be submitted on the claim. The system only evaluates the claim to determine if the referring provider number on the claim is valid. It does not review for the PCP. If claims are denying for this reason, examples need to be provided. For the dummy provider number, SRS is taking this under consideration if one should be established for billing purposes.

Provider Action: Submit claims on the Internet with a valid provider number. Service location is not reviewed for consultations.

Revised: 7/28/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.33

Drafted: 4/27/04

All	Issue:	Electronic Medicare crossover claims are denying with a statement that it must be billed to the primary insurance or that it requires an EOB.	Resolved: 4/27/2004
	Impact:	Providers are being underpaid.	
	Resolution:	Providers are submitting EOB/payment information with their claims; however, the EOB that is attached does not match the date of service, billed amount, or beneficiary name. The RA message that is used by KMAP is a HIPAA compliant message. Due to the generic nature, the message does not state that the EOB needs to be reviewed for accuracy. In addition, if claims are submitted electronically and there is no third party liability on file, this message will be received.	

Message: Electronic Medicare crossover claims are denying with a statement that it must be billed to the primary insurance or that it requires an EOB. Providers are submitting EOB/payment information with their claims; however, the EOB that is attached does not match the date of service, billed amount, or beneficiary name. The RA message that is used by KMAP is a HIPAA compliant message. Due to the generic nature, the message does not state that the EOB needs to be reviewed for accuracy. In addition, if claims are submitted electronically and there is no third party liability on file, this message will be received.

Provider Action: When receiving the message that the provider must bill the primary insurance or that it requires an EOB, the provider should ensure that the EOB submitted with the paper claim matches the claim detail for billed amount, beneficiary name, and DOS. For electronic claims, if denial is received, review eligibility on web site for that DOS. If there is no third party liability on the web site, claim needs to be submitted on paper for EDS to contact other insurer and update the files.

Revised: 6/4/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.34

Drafted: 4/27/2004

Physician and Hospital	Issue:	At the Provider Task Force Meeting, it was reported that only one surgery is being paid when multiple surgeries are done.	N/A
	Impact:	Claims are not being paid.	
	Resolution:	Examples of this issue were not left for EDS to research after the meeting. If a provider has examples of this occurring, please send to EDS, Attention: Angie Casey. Since no examples have been received, this item is being closed.	

Message: It has been reported that only one surgery is being paid when multiple surgeries are done. Examples of this issue were not given to EDS. If a provider has examples of this occurring, please send to EDS, Attention: Angie Casey. Since no examples have been received, this item is being closed.

Provider Action: None at this time.

Revised: 6/7/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.37

Drafted: 4/27/2004

Physician and Hospital	Issue:	Office visit claims are denying as M90 message (not covered more than once in a 12 month period).	Resolved: 4/27/04
	Impact:	Providers think that they are being underpaid.	
	Resolution:	This is a correct denial. Medicaid will pay for only one comprehensive office visit every 12 months.	

Message: Office visit claims are denying as M90 message (not covered more than once in a12 month period). This is a correct denial. Medicaid will pay for only one comprehensive office visit every 12 months.

Provider Action: Ensure patient has not had a comprehensive office visit evaluation in the last 12 months.

Revised: 4/27/2004

Item Ref: GENP 1.38

Drafted: 5/4/2004

All	Issue:	Claims are denying as non-covered diagnosis code for MediKan beneficiaries.	Resolved: 2/1/04
	Impact:	Providers are being underpaid.	
	Resolution:	The system issue has been resolved to allow MediKan beneficiaries' claims to process correctly. The 4314 exception is no longer setting in error. (CO 5234)	

Message: Claims that were denying in error for the 4314 exception (MediKan beneficiary not covered for this procedure code) has been corrected. EDS identified the claims and resubmitted them for reconsideration of payment on 5/12/2004.

Provider Action: None at this time.

Revised: 5/14/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.39

Drafted: 5/4/2004

LTC and HCBS	Issue:	LTC and HCBS claims were denying for invalid level of care.	Resolved: 3/26/04
	Impact:	550 beneficiaries had level of care updated inadvertently when patient liability updates were made. This caused claims to deny in error.	
	Resolution:	When the SRS worker was sending a patient liability change for an HCBS beneficiary, the level of care effective date was inadvertently changed as well. If an effective date for level of care is in the system already, the system should not allow a change in effective date later than the existing date. The system has been fixed to accept the earlier of the two dates as the correct level of care. (TO 6057)	

Message: LTC and HCBS claims were denying for invalid level of care. EDS has corrected the system to not allow a level of care to be changed prior to the current effective date. This correction occurred on 3/26/04. Claims that were denied in error will be reprocessed automatically by EDS who will publish when the reprocessing is complete.

Provider Action: None at this time.

Revised: 5/4/2004

Item Ref: GENP 1.40

Drafted: 5/4/2004

Physician and Hospital	Issue:	HCPCS code 76886 was denying for male beneficiaries.	Resolved: 4/22/04
	Impact:	Claims were being underpaid.	
	Resolution:	The system has been corrected to allow 76886 to be allowed for both male and female beneficiaries. The system was corrected by 4/22/04. (TO 6405)	

Message: HCPCS code 76886 was denying for male beneficiaries. On 4/22/04, the system was corrected to allow for processing of the 76886 code for male beneficiaries. EDS reprocessed denied claims on 5/13/2004.

Provider Action: No action needed at this time.

Revised: 5/28/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.41

Drafted: 5/4/2004

All	Issue:	Claims with the 22 modifier were not paying at the correct level.	Resolved: 4/12/04
	Impact:	Claims are being underpaid.	
	Resolution:	Historically, the 22 modifier was used as both pricing and just informational. This caused claims to be paid inconsistently in the new system. The pricing files were updated to reflect the correct price for the 22 modifier combination. The system correction was made on 4/12/04. (TO 6407 and 6052)	

Message: Claims with the 22 modifier were pricing inconsistently. The pricing files have been updated to reflect correct prices when the 22 modifier is involved. This correction was completed on 4/12/04. EDS identified claims denied in error and resubmitted them on 5/13/2004.

Provider Action: No action needed at this time.

Revised: 5/28/2004

Item Ref: GENP 1.42

Drafted: 5/4/2004

All	Issue:	Procedure codes A0200 and A0210 are paying at zero amounts.	Resolved: 4/30/04
	Impact:	Claims are being underpaid.	
	Resolution:	Procedure codes A0200 and A0210 should suspend for manual pricing (exception 6000) but were not suspending. The codes were added to the covered benefits needing manual pricing and are now failing to allow EDS to manually price rather than pay at $0.00. This was corrected by 4/30/04. (TO 6468)	

Message: Procedure codes A0200 and A0210 were paid at $0.00 since 3/1/04. This has been corrected as of 4/30/04. EDS reprocessed the claims on 5/28/2004.

Provider Action: No action needed at this time.

Revised: 6/11/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.44

Drafted: 5/4/2004

Hospital	Issue:	Claims with dates of service prior to 3/26/04, but billed after 3/26/04, were denying with the 32 modifier.	Resolved: 4/21/04
	Impact:	Claims are being underpaid.	
	Resolution:	Procedure codes 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 were denying in error when billed with the 32 modifier. This occurred on claims with DOS prior to 3/26/04 but billed after 3/26/04. This was corrected on 4/21/04.	

Message: Procedure codes 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 were denying in error when billed with the 32 modifier. This occurred on claims with DOS prior to 3/26/04 but billed after 3/26/04. This was corrected on 4/21/04. Claims were identified and submitted for reconsideration of payment on 4/24/2004. (CO 6258)

Provider Action: No action needed at this time.

Revised: 5/14/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.45

Drafted: 5/4/2004

DME	Issue:	CPT code A4221 was denying with EOB 1294 in error.	Resolved: 5/4/04
	Impact:	Providers are being underpaid.	
	Resolution:	The system has been fixed to allow proper processing for CPT code A4221. (CO 6347)	

Message: CPT code A4221 was denying in error with EOB 1294. The system has been fixed as of 5/4/2004. EDS identified all claims denied for this issue on 5/7/2004 and submitted them for reconsideration of payment.

Provider Action: No action needed.

Revised: 5/14/2004

Item Ref: GENP 1.46

Drafted: 5/12/2004

All	Issue:	The web site does not allow you to correct names or dates of birth for beneficiaries who have denied claims for this reason.	Resolved: 5/12/2004
	Impact:	The perception is that these claims must be billed through another mechanism such as PES, ASK, or paper.	
	Resolution:	Name and DOB can be changed on the Internet. Remove the beneficiary ID from the field and tab out completely from the field. You will receive message: "Beneficiary I.D. not on file." Re-key the beneficiary ID into the beneficiary ID field and tab out of the field. The DOB and name will now automatically be updated to the correct information on file.	

Message: Beneficiary Name and DOB can be changed on the Internet. Remove the beneficiary ID from the field and tab out completely from the field. You will receive message: "Beneficiary I.D. not on file." Re-key the beneficiary ID into the beneficiary ID field and tab out of the field. The DOB and name will now automatically be updated to the correct information on file.

Provider Action: Use technique above to change beneficiary name and number on the claim that previously denied.

Revised: 5/12/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.47

Drafted: 5/12/2004

All	Issue:	Providers want to be able to bill on Friday and receive payment the following week but the Internet submission is sometimes unavailable.	Resolved 5/12/2004
	Impact:	Providers' cash flow for what they are accustomed to is impacted.	
	Resolution:	Claim processing is to be completed within 30 days of submission. Waiting until Friday, for expected payment on the following week, provides a very small window to get payment the following week. Every other Friday system releases are made in the system which may cause the Internet to be functioning slower than normal. We highly encourage billing earlier in the week for you to potentially receive payment on claims the following week.	

Message: Claim processing is to be completed within 30 days of submission. Waiting until Friday, for expected payment on the following week, provides a very small window to get payment the following week. Every other Friday, system releases are made in the system which may cause the Internet to be functioning slower than normal. We highly encourage billing earlier in the week for you to potentially receive payment on claims the following week.

Provider Action: Bill as early in the week as possible to allow system processing time as well as avoiding potential delays on Fridays during system releases.

Revised: 5/12/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.52

Drafted: 6/3/2004

DME	Issue:	A4450 CPT code is denying.	System Corrected: 5/26/2004 Clean-up: 7/2/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS has identified the issue with claims denying for A4450 CPT code. The system was corrected on 5/26/2004. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6652)	

Message: EDS has identified the issue with claims denying for A4450 CPT code. The system was corrected on 5/26/2004. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment.

Provider Action: No action is needed.

Revised: 7/21/2004

Item Ref: GENP 1.53

Drafted: 6/3/2004

All	Issue:	Claims have a paid amount but no paid date is online.	Issue Resolved: 7/15/2004
	Impact:	Providers' claims appear paid but are not on the warrant.	
	Resolution:	Claims which contain financial errors are listed on a report each week. Each claim is researched individually and resolved. No system changes are necessary at this time. (CO 6538)	

Message: TBD

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.54

Drafted: 6/3/2004

DME	Issue:	CPT code Z1236 is denying.	System Corrected: 5/13/2004 Clean-up: 7/2/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	Z1236 was posting exact duplicate instead of suspect duplicate for claims submitted with Z1236 which edited against other claims with Z1236 with modifier RR. This caused the claims to deny as duplicate. The system has been corrected and claims are now processing correctly. This has affected all claims submitted with this scenario since 10/16/03. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6553)	

Message: Z1236 was posting exact duplicate instead of suspect duplicate for claims submitted with Z1236 which edited against other claims with Z1236 with modifier RR. This caused the claims to deny as duplicate. The system has been corrected and claims are now paying correctly. This has affected all claims submitted with this scenario since 10/16/03. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment.

Provider Action: No action is needed.

Revised: 7/21/2004

Item Ref: GENP 1.56

Drafted: 6/3/2004

All	Issue:	Procedure code 99393 is denying in error.	System Corrected: 5/26/2004 Clean-up: 7/2/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims submitted with procedure code 99393 with modifier 32 and place of service 71 denied for date of service 3/26/04 and after in error. This issue has been resolved and claims are now processing correctly. EDS identified the claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6632)	

Message: Claims submitted with procedure code 99393 with modifier 32 and place of service 71 denied for date of service 3/26/04 and after in error. This issue has been resolved and claims are now processing correctly. EDS identified the claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

Item Ref: GENP 1.59

Drafted: 6/9/2004

DME	Issue:	Claims with a KO modifier are denying in error.	Resolved: 3/3/04
	Impact:	Providers are not being paid.	
	Resolution:	Claims with a KO modifier were denying in error. A table was updated to recognize the KO modifier on 3/3/04. Claims denied in error were identified for EDS to reprocess and were resubmitted on 5/13/2004. (CO 6053)	

Message: Claims with a KO modifier were denying in error. A table was updated to recognize the KO modifier on 3/3/04. Claims denied in error were identified for EDS to reprocess and were resubmitted on 5/13/2004.

Provider Action: None action needed.

Revised: 6/25/2004

Item Ref: GENP 1.65

Drafted: 6/17/2004

All	Issue:	LEA providers have started receiving a large number of denials for "5652 – Headstart vs. LEA services".	System Corrected: 6/21/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS is currently designing the system to process the claims according to LEA policies. EDS will identify the claims which need to be reprocessed after the issue is resolved. (CO 6843).	Clean-up: 7/14/2004

Message: EDS is currently designing the system to process the claims according to LEA policies. Once more information is available, this document will be updated and a global message distributed to providers.

Provider Action: None needed at this time.

Revised: 7/21/2004

Blue highlighted items have been previously closed as an issue resolved and no longer occurring.

KMAP Provider Communication

Provider Community: Optometry

Item Ref: OPT 1.1

Drafted: 4/27/2004

Optometry	Issue:	Claims are being denied for eyeglass frames and lenses for KBH eligible children.	System Corrected: 4/21/2004 Clean-up: 7/15/2004
	Impact:	Lower payment reimbursement.	
	Resolution:	Procedure code V2100 is hitting limitation audit 6214 and is being denied/cut back inappropriately. For example, for a 15 year old, which should never have hit the audit, this was cut back to only 1/2 allowed for the lens. This situation has been identified and a correction was implemented. The files were updated on 4/21/2004. The claims denied in error were reprocessed on 7/15/2004. (CO 5647)	

Message: Claims are being denied for eyeglass frames and lenses for KBH eligible children. Procedure code V2100 is hitting limitation audit 6214 and is being denied/cut back inappropriately. For example, for a 15 year old, which should never have hit the audit; this was cut back to only 1/2 allowed for the lens. This situation has been resolved as of 4/21/2004. The claims denied in error were reprocessed on 7/15/2004.

Provider Action: No action is needed.

Revised: 7/21/2004