KMAP Provider Communication

Provider Community: Adult Care Home

Item Reference	ACH 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Adult Care Home	
Issue	Automatic mass adjustment was initiated due to a retroactive 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	A mass adjustments correction was performed on 12/26 for 25 affected providers. Four remaining providers' claims were corrected on 1/16/2004.	
Provider Action	No action is needed	

Item Reference	ACH 1.1	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Adult Care Home	Resolved 10/21/2003
Issue	MMIS did not correctly calculate spans of days.	
Impact	Providers were paid more than the amount billed on their claim.	
Resolution	Permanent system change was identified and implemented on 10/21/2003.	
Provider Action	Provider to submit adjustment.	

Blue highlighted items indicate the issue was closed and no longer occurs.

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 Reference	CHHC 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	CDDO	Resolved 12/19/2003
Issue	Claims were being denied for "Performing provider not member of group."	
Impact	CDDOs claims are not being paid because affiliates are truly not members of the CDDO group.	
Resolution	Permanent system change was identified and implemented on 12/19/2003.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.1	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	CMHC	Resolved 12/18/2003
Issue	Amount paid includes payment amounts, state share and TPL deductions.	
Impact	This issue creates confusion when providers are posting remittance advices.	
Resolution	Removed the state share and TPL amounts from the amount paid columns as of the 12/18/2003 remittance advices.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.2	
Date Drafted	2/29/2004	
Date Revised	4/30/2004	
Groups Affected	CMHC	
Issue	The new MMIS was not originally designed to accommodate affiliate billing by Community Mental Health Centers (CMHCs).	Resolved 1/5/2004
Impact	Only one provider in the state had previously been approved to perform affiliate billing; however, because this wasn't carried over to the new MMIS that provider was unable to conduct any billings for approximately 8 weeks.	
Resolution	Permanent system change was identified and implemented in early January 2004.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.3	
Date Drafted	2/29/2004	
Date Revised	4/30/2004	
Groups Affected	HCBS	
Issue	Providers are stating a "slow-down" has occurred in getting their claims paid and that claims are suspending for Plans of Care (POC). Due to numerous system issues related to POC (inability to access the POCs, inability to modify/update and inability to submit POCs), EDS created a backlog of POCs to be entered into the system.	Resolved 1/2004
Impact	The HCBS community is not receiving timely payments.	
Resolution	SRS and EDS worked on approving the Plans of Care to resolve the backlog. Once Plans of Care were approved, affected claims were released for processing.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.4	
Date Drafted	2/29/2004	
Date Revised	4/23/2004	
Groups Affected	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	1,666 claims were in suspense for an out of balance condition. Approximate dollar amount was$1.3 million.	
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.	
Provider Action	For HCBS FE providers, KDOA decided that the eligibility file and plan of care must be the same or claims will be denied. Provider must contact the case manager to correct an out of balance situation.	

Item Reference	CHHC 1.5	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	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 were denied instructing providers to bill Medicare first.	
Resolution	Permanent system correction to bypass Medicare editing for these codes was implemented on 1/23/2004 and 1,068 affected claims were recycled.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.6	
Date Drafted	4/9/2004	
Date Revised	4/9/2004	
Groups Affected	CMHC	
Issue	Beneficiaries were being charged a $3 co-pay amount 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 co-pay amount for family therapy will continue.	
Provider Action	Providers need to collect the $3 co-pay for family therapy.	

Item Reference	CHHC 1.7	
Date Drafted	4/12/2004	
Date Revised	5/7/2004	
Groups Affected	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 incorrectly being paid the 50% FFP portion.	
Resolution	The table that controls the calculation of state share was updated on 4/7/2004. Claims to be adjusted were identified. EDS initiated the adjustment on 4/7/2004. (CO 6069)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.8	
Date Drafted	4/12/2004	
Date Revised	4/23/2004	
Groups Affected	Home Health	
Issue	Supply claims for home health were being denied 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	The cause of this issue was identified. EDS updated the Claims Resolution Manual to instruct clerks to force claims that meet this criteria. As of 4/16/2004, EDS recycled or adjusted all claims that were denied in error.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.9	
Date Drafted	4/12/2004	
Date Revised	4/12/2004	
Groups Affected	CMHC	
Issue	Medication checks (procedure code 90862) were being denied.	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 that deal with content of service. These claims are being denied 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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.10	
Date Drafted	4/15/2004	
Date Revised	6/4/2004	
Groups Affected	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 systematically removed the "penny out" lines on 4/22/2004. Claims previously paid one cent were adjusted so they processed under the correct POC line item. (CO 5803)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.11	
Date Drafted	4/15/2004	
Date Revised	4/23/2004	
Groups Affected	CMHC	
Issue	Claims were being denied for Plans of Care with a pay cap amount that had a dollar amount and a unit on the Plan of Care (POC).	Resolved: 2/2/2004
Impact	Claims were being underpaid.	
Resolution	When a POC has a type of "pay cap amount," the system looks 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 system correction was implemented on 2/2/2004. EDS created a mass adjustment and claims started to reprocess on 4/5/2004. Cleanup was completed on 4/14/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.12	
Date Drafted	4/15/2004	
Date Revised	4/23/2004	
Groups Affected	CMHC	
Issue	Claims related to "pay unit fee" prior authorization (PA) were being denied for "PA not found."	Resolved: 2/2/2004
Impact	Claims were being underpaid.	
Resolution	When the PA (i.e. Plan of Care) is a "pay unit fee price," the system expects the exact unit dollar amount being billed on the incoming claim. For example, if 10 units were approved at $2 each, and the provider billed 10 units and a total billed amount of $30, the claim would be denied indicating no PA on file. The system was corrected to allow for the billed amount to be different than what appears on the PA. EDS created a mass adjustment and claims started to reprocess on 4/5/2004. Cleanup was completed on 4/14/2004.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.13	
Date Drafted	4/15/2004	
Date Revised	4/23/2004	
Groups Affected	CMHC	
Issue	Claims were being suspended or denied as duplicates when the UD modifier was billed.	Resolved: 2/18/2004
Impact	If claims were submitted via any format except the Internet, claims were being suspended for review, causing a delay in payment. If claims were submitted via the Internet, they were being denied for duplicate denial. This occurred when a UD modifier was on the claim and the previous claims paid even if it was a different date of service.	
Resolution	The UD modifier was not being recognized as a unique modifier on different dates of service. This was corrected to allow claims to process without being suspended or denied unless it was an exact duplicate for the same date of service. The system was corrected on 2/18/2004. EDS reprocessed claims that were denied in error as duplicates on 4/22/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.14	
Date Drafted	4/15/2004	
Date Revised	8/6/2004	
Groups Affected	CMHC	
Issue	Claims were being denied for invalid diagnosis code for dates of service.	Resolved: 3/9/2004
Impact	Claims were being denied incorrectly.	
Resolution	Providers reported that they submitted claims with the new diagnosis code (78099) and it was denied for a January 2004 date of service. Another provider reported that 2003 claims were being denied for an invalid diagnosis code (Y45) when billed after 1/1/2004. EDS identified that the wrong beginning and ending effective dates were on the new diagnosis codes. The codes were updated with correct dates. (CO 6671) EDS automatically reprocessed the claims that were denied in error with invalid diagnosis codes on 7/15/2004.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.16	
Date Drafted	4/15/2004	
Date Revised	7/9/2004	
Groups Affected	CMHC	
Issue	Claims for CPT code 90862 were being denied as “procedure code is noncovered for this provider type and specialty.”(EOB 342).	Resolved: 5/4/2004
Impact	Claims were being denied incorrectly.	
Resolution	Claims that were being denied for CPT code 90862 for this provider type and specialty were 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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.17	System Corrected: 5/14/2004
Date Drafted	4/15/2004	
Date Revised	8/27/2004	Cleanup: 8/23/2004
Groups Affected	CMHC	
Issue	Claims for CTP code Y9117 with dates of service prior to 1/1/2004 are being denied as "benefit maximum for this time period has been reached." (EOB 262).	
Impact	Claims are being denied incorrectly for beneficiaries not in the MediKan benefit plan.	
Resolution	Audit 6069 (Allow 320 Units of Targeted Case Management Per Calendar Year) was modified on 5/14/2004 to only apply to MediKan beneficiaries. EDS identified and reprocessed claims that were denied in error. (CO 6976) EDS completed reprocessing claims on 8/23/2004.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.18	
Date Drafted	4/15/2004	
Date Revised	4/30/2004	
Groups Affected	CMHC	
Issue	Claims were being denied for timely filing even though the original converted ICN is indicated on the claim.	Resolved: 3/2004
Impact	Claims were being underpaid.	
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.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.19	
Date Drafted	5/4/2004	
Date Revised	5/4/2004	
Groups Affected	HCBS	Resolved: 3/18/04
Issue	Procedure code T1016, as well as similar HCBS procedure codes, was being denied for being part of family service coordination involvement.	
Impact	Claims were being denied in error.	
Resolution	The system was corrected to exclude HCBS procedure codes from the Family Service Coordination exception 4352.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.20	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	Home Health	Resolved: 4/20/2004
Issue	Claims for qualified Medicare beneficiaries (QMB) were being denied when the GY modifier was on the claim.	
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)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.21	
Date Drafted	6/9/2004	
Date Revised	8/17/2004	
Groups Affected	HCBS	
Issue	Procedure S5161 was paying at $25 per unit instead of the $30 allowed.	Resolved: 4/23/2004
Impact	Providers were being underpaid.	
Resolution	Installation of an emergency response system (S5161) was paying at $25 instead of the $30 allowed amount. This issue was corrected as of 4/23/04. EDS will adjust the affected claims and notify the providers when complete. EDS submitted the adjustments on 8/13/2004. (CO 6410)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.23	
Date Drafted	6/9/2004	
Date Revised	6/9/2004	
Groups Affected	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 were being denied 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)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	CHHC 1.25	
Date Drafted	6/9/2004	
Date Revised	7/9/2004	
Groups Affected	HCBS	
Issue	Claims were being denied with Y19 diagnosis code.	Resolved: 5/18/2004
Impact	Claims were being denied incorrectly.	
Resolution	Claims with diagnosis code Y19 were denied incorrectly as noncovered after 2/19/2004. This code was still covered for dates of service prior to 1/1/04 and should have been 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 the claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6588)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.27	
Date Drafted	6/28/2004	
Date Revised	8/6/2004	
Groups Affected	HCBS	
Issue	Claims were being denied when a single claim bypassed 120 units for targeted case management.	Resolved: 6/10/2004
Impact	Providers were not being paid.	
Resolution	Claims were being denied for exception 6051: allow 120 hours of targeted case management per calendar year. The claim should cut back to the units remaining to be allowed rather than be denied. This applies to claims with procedure code W1300. This issue was resolved on 6/10/04. EDS reprocessed the claims on 7/16/2004. (CO 6766)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Dental

Item Reference	DENT 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Dental	
Issue	MMIS could not accept teeth numbered 1 - 9 (old claims still cycling through MMIS).	Resolved 12/18/2003
Impact	This issue delayed claims payment from 10/16/2003 through 12/18/2003.	
Resolution	A permanent system correction was implemented on 12/18/2003, and EDS worked with DORAL to reprocess all affected claims to appear on the 12/25/2003 remittance advices.	
Provider Action	No action is needed.	

Item Reference	DENT 1.1	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	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	This issue delayed claims payment. Doral's system does not allow the input of claims by providers that do not have a provider number.	
Resolution	Applications were received and enrollments were processed. Information was received by Doral on 1/19/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	DENT 1.2	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	Dental	
Issue	The daily eligibility file transfer was not fully completed until 11/4/2003.	Resolved 11/4/2003
Impact	This issue caused a delay in claims processing between 10/16/2003 and 11/4/2003.	
Resolution	Daily files were corrected on 11/4/2003. The file transfer process was implemented. Doral obtains current MMIS information on a daily basis.	
Provider Action	No action is needed.	

Item Reference	DENT 1.3	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	Dental	
Issue	D9221 (deep sedentary anesthesia - each additional 15 minutes) was not paying units correctly. This problem was identified on 1/27/2004.	Resolved 3/11/04
Impact	Claims with this procedure code were not being paid correctly.	
Resolution	The MMIS correction was coded and tested on 2/20/04. Claims were identified and resubmitted by the end of the 2/7/2004 financial cycle. (Task # 6218)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	DENT 1.4	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	Dental	
Issue	Exchanges of data between contractors occasionally failed. Examples included HIPAA compliance checks; data content of files is missing; transfers and receipts do not match; and history files.	Ongoing as needed
Impact	This issue caused delays in claims processing as one or more of the contractors did not have current data necessary for accurate and timely claims processing.	
Resolution	These 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 addressed.	
Provider Action	No action is needed.	

Item Reference	DENT 1.5	
Date Drafted	2/29/2004	
Date Revised	5/28/2004	
Groups Affected	Dental	
Issue	Encounter rate table for Federally Qualified Health Clinic (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 did not pay correctly.	
Resolution	The system change was identified and implemented on 4/16/2004. This issue was resolved on 4/22/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	DENT 1.6	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	Dental	
Issue	Providers were providing services prior to their enrollments being completed. Examples for delays are incomplete applications, lack of signatures, and so forth.	Ongoing as needed.
Impact	Claims cannot be submitted until a provider number is issued and recognized by the MMIS.	
Resolution	These problems were resolved when the enrollment process was complete.	
Provider Action	No action is needed.	

Item Reference	DENT 1.7	
Date Drafted	6/9/2004	
Date Revised	6/25/2004	
Groups Affected	Dentist	
Issue	Dental anesthesia code (D9221) was being reimbursed at the incorrect level.	Resolved: 3/5/2004
Impact	Providers were not being paid correctly.	
Resolution	Dental anesthesia code (D9221) was being reimbursed 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)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	DENT 1.8
Date Drafted	6/9/2004
Date Revised	6/9/2004
Groups Affected	Dentist
Issue	Procedure D3220 was being denied in error when submitted with tooth #A.
Impact	Claims were being denied incorrectly.
Resolution	Processors were given clearer instructions regarding handling the processing of these claims. Claims denied in error were identified and reprocessed for proper payment on 3/29/04. (CO 6153)
Provider Action	No action is needed.

Resolved: 3/29/2004

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Rural Health Clinics & Federally Qualified Health Clinics

Item Reference	RHC 1.0	
Date Drafted	2/29/2004	
Date Revised	7/29/2004	
Groups Affected	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 administration payment beginning in November 2004.	Resolved: 3/17/2004
Impact	Providers were paid in error; the money needed to be recovered.	
Resolution	A letter was 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 cleanup occurred starting 7/22/2004 and was completed 7/30/2004.	
Provider Action	No action is needed.	

Item Reference	RHC 1.2	
Date Drafted	4/12/2004	
Date Revised	5/14/2004	
Groups Affected	RHC/FQHC	
Issue	RHC/FQHC were being paid too low in addition to the fee-for-service rate issue. They were being paid below normal physician fee-for-service rates.	
Impact	Claims were being underpaid significantly.	
Resolution	A partial system correction for this issue was identified and implemented on 4/16/2004. A solution was identified to resolve the incorrect pricing of claims when an invalid performing provider number was submitted. An adjustment was submitted for claims that were paid using the incorrect rate on 5/12/2004. (CO 6202)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	RHC 1.3
Date Drafted	4/12/2004
Date Revised	5/28/2004
Groups Affected	RHC/FQHC
Issue	Lab related claims for RHC were being paying fee-for-service (FFS) rates.
Impact	Overpayments occurring as lab-related claims should not be paid at all. Only face-to-face claims should be paid an encounter rate.
Resolution	A partial system correction for this issue was identified and implemented on 4/16/2004. A solution was identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. (CO 6202)
Provider Action	No action is needed.

Item Reference	RHC 1.4	
Date Drafted	4/9/2004	
Date Revised	5/28/2004	
Groups Affected	RHC/FQHC	
Issue	Starting on the 3/25/04 remittance advice, RHC and FQHC claims were not being paid at the encounter rate (per diem allowable). All services were processing at the nonencounter rate.	Resolved: 4/16/2004
Impact	Claims were being underpaid significantly. For example, office visit procedure code 99213 paid $18.03 instead of $65.95.	
Resolution	A partial system correction for this issue was identified and implemented on 4/16/2004. A solution was identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. (CO 5665)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	RHC 1.5	
Date Drafted	6/3/2004	
Date Revised	7/21/2004	
Groups Affected	RHC	
Issue	A $3 instead of $2 co-pay amount was being deducted from claims.	Resolved: 6/24/2004
Impact	Providers were being underpaid.	
Resolution	EDS identified the issue that caused the incorrect co-pay to be deducted. The system was updated on 6/24/2004 to reflect the accurate co-pay amount of $2 for Rural Health Clinic providers. EDS reprocessed the claims on 7/20/2004. (CO 6718)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Hospice

Item Reference	HSPC 1.0	
Date Drafted	2/29/2004	
Date Revised	4/30/2004	
Groups Affected	Hospice	
Issue	There was a 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 created a slow-down in the turnaround time providers can get their claims paid.	
Resolution	A temporary workaround solution was implemented to suspend claims to one specific location so that dedicated staff could focus on pricing these claims. A meeting was held with hospice providers on 1/14/2004 to identify methods to automate pricing process as a permanent system change. The system change is in progress as of 1/30/2004. (CO 5595)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Hospitals & Adult Care Home

Item Reference	HSPT 1.1	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	Resolved 12/26/2003
Issue	Outpatient claims were being denied for the entire line when only one detail should have been denied.	
Impact	Providers were not receiving payments for lines that could be paid.	
Resolution	A permanent solution was implemented and all affected claims were recycled by 12/26/2003.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.2	
Date Drafted	2/29/2004	
Date Revised	5/7/2004	
Groups Affected	Hospital	Inpatient Resolved 3/6/2004
Issue	Providers reported that "one-day" hospital claims were not processing correctly.	
Impact	Claims were being denied in error.	
Resolution	A system change was implemented on 4/16/2004. (CO 5648)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.4	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	Resolved 1/18/04
Issue	Providers disagreed with policy that allows payment on one-day discharge only for death or discharge to another facility.	
Impact	Claims were being denied and needed to be submitted as outpatient.	
Resolution	SRS and EDS reviewed policy and the system and determined that same-day admit and discharge will be allowed. System was updated and all claims that were denied for this criteria were reprocessed.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.5	
Date Drafted	2/29/2004	
Date Revised	8/17/2004	
Groups Affected	Hospitals and Adult Care Home	Resolved: 3/25/2004
Issue	Outpatient claims were incorrectly being denied for admitting diagnosis. Issues reoccurred at the end of March.	
Impact	Claims without an admitting diagnosis were denied incorrectly for error code 360.	
Resolution	A system change was identified and implemented on 3/25/04. EDS resubmitted claims that were denied in error on 8/13/2004. (TO 6702)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.6	
Date Drafted	3/2/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	Resolved 2/29/2004
Issue	Claims with a referring provider number present on the claim were being denied stating they needed a referral.	
Impact	Claims were being denied for referral.	
Resolution	ASK identified the problem causing this issue. The system was corrected on 2/29.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.7	System Corrected: 3/26/2004
Date Drafted	2/29/2004	
Date Revised	8/27/2004	Cleanup: 8/20/2004
Groups Affected	Hospital	
Issue	Lab HCPCS codes are being denied when ER E & M codes are present on the claim.	
Impact	Claims are being denied in error.	
Resolution	This issue was a result of EDS not converting outpatient claims to medical claims to process them for ER claims after HIPAA. As in interim solution, these claims were being worked manually and all services on the same date of service and the same claim as an E & M Emergency Room code were being forced. (CO 5270/5324). This issue was corrected. EDS completed the reprocessing of claims on 8/20/2004. EDS will provide an updated status when the system release date for this issue is established.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.8	
Date Drafted	3/2/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	Resolved 12/30/2003
Issue	Procedure codes valid as of 2003 were being denied as invalid even if the interChange MMIS showed the code as valid.	
Impact	Claims were being denied for invalid procedure code.	
Resolution	EDS updated procedure code edits.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.9	
Date Drafted	3/2/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	Resolved 2/10/2004
Issue	Medicare crossover claims were being denied for EOB 417 instead of only denying specific line items.	
Impact	Entire claim was denied when only one line item should have been denied.	
Resolution	EDS updated the edits associated with EOB 417 so that it would deny at the detail level instead of the claim (header) level.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.10	
Date Drafted	3/2/2004	
Date Revised	8/17/2004	
Groups Affected	Hospital	
Issue	Claims with TC and 26 modifiers were being processed incorrectly.	Resolved: 5/18/2004
Impact	Radiology claims were being denied as duplicates in error.	
Resolution	Resolution was completed on 3/5/2004. This issue was re-identified on 4/25/2004. The system was updated on 5/18/2004. (TO 6687) EDS resubmitted the denied claims on 8/13/2004.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.13	
Date Drafted	3/2/2004	
Date Revised	7/9/2004	
Groups Affected	Hospital	
Issue	Medicare inpatient claims paid with Part B benefits are not processing as third-party liability (TPL).	Ongoing research
Impact	Claims are being paid with a Medicare allowed amount that is less than TPL would pay.	
Resolution	EDS is implementing new processes to ensure the accuracy of keyed 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.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.15	
Date Drafted	3/2/2004	
Date Revised	4/30/2004	
Groups Affected	Hospital	
Issue	Psychiatric claims were being denied for prior authorization when other insurance made a payment.	Resolved 3/12/04
Impact	Claims were being denied 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	
Provider Action	Cleanup has been completed. If providers still have claims they believe were denied in error they should resubmit the claims for processing.	

Item Reference	HSPT 1.16	
Date Drafted	3/2/2004	
Date Revised	4/30/2004	
Groups Affected	Hospital	
Issue	Fetal monitoring was being denied for claims due to medical policy.	Resolved 1/19/2004
Impact	Claims were being denied for delivery due to fetal monitoring being present on the claim.	
Resolution	The SRS program manager approved a system change to not require medical necessity for fetal monitoring. This change was implemented on 1/19/2004.	
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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.17	
Date Drafted	3/2/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	
Issue	SOBRA claims were being denied due to noncoverage of emergency services without a local SRS approval.	Resolved 4/1/2004
Impact	Claims were being denied unless delivery is procedure code on claim.	
Resolution	SOBRA claims are paid automatically only if labor and delivery is involved. Even if it is 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.	
Provider Action	Review SOBRA guidelines and ensure that proper steps are taken before billing the claim.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.20	
Date Drafted	3/23/2004	
Date Revised	5/7/2004	
Groups Affected	Hospital	
Issue	Claims that post edit 570 will no longer be denied automatically 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.	
Impact	Hospital claims are automatically being denied by error code 570 for "total days billed less than covered days." These claims should suspend for review of the patient status code and the "from" and "to" dates. When the system was corrected for this issue, 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 corrected; otherwise, they would be denied. This issue was corrected on Friday, 4/16/04 but was not in time for the financial cycle. Provider's remittance advices for inpatient claims reflected denials for the week; however, very few paid claims appeared. Those paid claims were on the 4/29/04 remittance advices as they were confirmed to be in a paid status for this issue on 4/19/04.	Resolved: 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. EDS resubmitted the denied claims on 4/29/2004. (CO 5648)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.22	
Date Drafted	4/9/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	
Issue	Mom/baby claims were being denied, especially if they were submitted through ASK.	Resolved 4/7/2004
Impact	Claims were being denied in error and were underpaid.	
Resolution	The system was changed to verify that 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.	
Provider Action	Verify that any denied claims meet the processing guidelines. If the claim meets the guidelines, you can resubmit the claim. If the claim does not meet the guideline, please review and update if appropriate billing and resubmit.	

Item Reference	HSPT 1.23	
Date Drafted	4/9/2004	
Date Revised	5/28/2004	
Groups Affected	Hospital	
Issue	Inpatient psychiatric claims were being denied for "no prior authorization (PA) on file."	Resolved: 5/7/2004
Impact	Claims were being denied in error.	
Resolution	The system was expecting the date of service on the claim to be completely within the approved dates on the 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) All psychiatric claims with erroneous denials for "no PA on file" were reprocessed for reconsideration of payment on 5/7/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.25	
Date Drafted	4/15/2004	
Date Revised	6/11/2004	
Groups Affected	Hospital	
Issue	Claims with a 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 Web site to submit electronic claims must submit claims on paper.	
Resolution	CO 6654 added discharge codes 40 – 70 as valid codes for the Internet UB-92 inpatient claim form. (CO 6654)	
Provider Action	No action is needed.	

Item Reference	HSPT 1.29	
Date Drafted	4/27/2004	
Date Revised	4/27/2004	
Groups Affected	Physician and Hospital	
Issue	The ET modifier was sometimes reducing emergency room 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 does not have an emergent diagnosis, it will be reduced to the lower emergency room evaluation code (99281) rate.	
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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.31	
Date Drafted	4/27/2004	
Date Revised	4/27/2004	
Groups Affected	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.	
Provider Action	Request fee schedule if you need complete information on various fees.	

Item Reference	HSPT 1.32	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	Hospital	
Issue	Inpatient claims were being denied for no “to date of service” on the detail level.	Resolved: 4/15/04
Impact	Claims were being underpaid.	
Resolution	Exception 240, which requires a "To Date of Service," was being denied in error. Inpatient claims do not require a "To Date of Service." This issue occurred from approximately April 7-15 and was corrected on April 15. EDS resubmitted the denied claims on 4/29/2004. (TO 6388)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.33	
Date Drafted	5/4/2004	
Date Revised	5/4/2004	
Groups Affected	Hospital	
Issue	Outpatient claims were being denied for no procedure code for drugs and pharmaceuticals.	
Impact	Providers perceived that they were being underpaid.	
Resolution	All outpatient details historically and in the new system 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.	Resolved: 4/30/2004
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 nonclassified 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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	HSPT 1.34	
Date Drafted	5/4/2004	
Date Revised	7/20/2004	
Groups Affected	Hospital	
Issue	Outpatient claims were being denied for no revenue code on the claim.	Resolved: 4/26/2004
Impact	Claims were being denied incorrectly.	
Resolution	The system was corrected on 4/26/2004 to not post a revenue code error message on the claim when none was submitted on outpatient claims. EDS ran a system query to identify if any claims actually were 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 remittance advice. (CO 6707)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Local Education Agencies

Item Reference	LEA 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Local Education Agencies	
Issue	New LEA policy was implemented on 1/1/2004 that required a new place of service value. Providers were not aware until 12/1/2003. The ASK system was also not prepared to receive new values.	Resolved 1/16/2004
Impact	Claims were being denied for an invalid place of service. Providers were not able to get claims paid.	
Resolution	Denied claims were identified and corrected on 1/9/2004 remittance advices producing $1.7 million in payments to LEAs. ASK completed system changes on 1/16/2004.	
Provider Action	No action is needed.	

Item Reference	LEA 1.1	
Date Drafted	6/2/2004	
Date Revised	7/16/2004	
Groups Affected	Local Education Agency	
Issue	LEA claims were being denied for submission to Medicare in error.	Resolved: 7/16/2004
Impact	Claims were being denied incorrectly.	
Resolution	EDS ran reports to identify claims associated with this issue. The reports did not show any services for LEA providers that were denied for Medicare related edits. If a provider has examples, please send them to EDS.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Pharmacy

Item Reference	PHAR 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Pharmacy	Resolved 11/2003
Issue	Pharmacies did not understand new spenddown processing related to charges to collected from beneficiaries.	
Impact	Some pharmacies did not collect required spenddown amounts from beneficiaries.	
Resolution	Education was provided to pharmacies. EDS and SRS solicited input from pharmacies and implemented a solution to return amounts to collect from beneficiaries affected by spenddown in the co-pay field.	
Provider Action	No action is needed.	

Item Reference	PHAR 1.1	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Pharmacy	Resolved 10/18/2003
Issue	Some covered national drug codes (NDCs) could not be loaded systematically and had to be loaded manually.	
Impact	Until affected NDCs were loaded, claims were denied as not covered on the date of service.	
Resolution	Affected NDCs were corrected on 10/18/2003.	
Provider Action	Provider may need to resubmit outstanding claims.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	PHAR 1.2	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Pharmacy	Resolved 10/21/2003
Issue	Pharmacies were not receiving the ingredient cost field in claim responses.	
Impact	Providers were unsure of how to post paid claims.	
Resolution	This field was added to all pharmacy claim responses effective 10/21/2003.	
Provider Action	No action is needed.	

Item Reference	PHAR 1.3	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Pharmacy	Resolved 10/24/2003
Issue	Some edits and audits were not mapped to NCPDP reject codes.	
Impact	Providers were unsure of how to interpret reject codes.	
Resolution	Updates to affected codes were completed on 10/24/2003.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	PHAR 1.4	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Pharmacy	Resolved 10/17/2003
Issue	Providers received denials for drug claims for foster care and hospice beneficiaries.	
Impact	Providers did not receive payments on affected claims between 10/16/2003 and 10/17/2003.	
Resolution	The system change was identified and implemented on 10/17/2003.	
Provider Action	Providers may need to resubmit any outstanding claims.	

Item Reference	PHAR 1.5
Date Drafted	2/29/2004
Date Revised	4/9/2004
Groups Affected	Pharmacy
Issue	Pharmacies indicated a need to use usual and customary charges on pharmacy claims.
Impact	This issue affected the amount interChange uses 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. This issue is currently being reviewed in conjunction with changes being made to support spenddown processing. (CO# 6040)
Provider Action	No action is needed.

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	PHAR 1.7	
Date Drafted	4/7/2004	
Date Revised	7/16/2004	
Groups Affected	Pharmacy	
Issue	Pharmacies using QS1 software were billing incorrectly on dual-insurance beneficiaries.	
Impact	In researching this issue, EDS found that when billing for beneficiaries with dual insurance, pharmacies using QS1 could possibly be underpaid $1.50 to $3 per claim. Pharmacies will need to adjust these claims.	Resolved: 6/16/2004
Resolution	QS1 updated their software on June 11, 2004, and the issue of billing for beneficiaries with dual insurance through QS1 should be resolved. QS1 pharmacy users need to download the newest version of QS1. The EDI team is working with QS1 to inform pharmacy users. EDS tested this change June 21-28 to ensure the pharmacies that are billing QS1's new version are being paid correctly. Test results showed that QS1 software is working correctly when providers bill for beneficiaries with dual insurance. A global message was posted by July 2, 2004.	
Provider Action	Pharmacies will need to adjust these claims.	

Item Reference	PHAR 1.8	
Date Drafted	5/12/2004	
Date Revised	6/11/2004	
Groups Affected	Pharmacy / DME	
Issue	DME claims crossing over from Medicare for diabetic testing supplies were being denied.	Resolved: 5/12/2004
Impact	Claims were being denied, and providers were 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 were being denied correctly in KMAP as KMAP does not allow future billing dates. Claims with future dates must be billed on paper with the remittance advice.	
Provider Action	If denials received for future dates are invalid, the provider must bill the claim on paper and attach the Medicare remittance advice.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	PHAR 1.9	
Date Drafted	5/12/2004	
Date Revised	7/21/2004	
Groups Affected	Pharmacy and DME	
Issue	DME codes not subject to CLIA editing were being denied for needing a CLIA number.	Resolved: 5/7/2004
Impact	Providers were being underpaid.	
Resolution	The parameter from the old system to deny for CLIA did not include DME. The DME codes were removed from the list for needing CLIA. EDS updated the file and resolved the issue. EDS identified and reprocessed the claims denied in error on 7/15/2004. (CO 6281)	
Provider Action	No action is needed.	

Item Reference	PHAR 1.10	
Date Drafted	5/12/2004	
Date Revised	7/21/2004	
Groups Affected	Pharmacy and DME	
Issue	Claims were being paid in error when E0570 (nebulizer) was billed over limit.	Resolved: 4/29/2004
Impact	Providers were being overpaid.	
Resolution	Claims were being paid in error when the beneficiary had 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)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: State Institutions

Item Reference	STIN 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	State Institutions	
Issue	Claims submitted by state institutions were being denied 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	This issue was resolved through testing and billing education with both facilities as of 1/8/2004 and 1/15/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Electronic Submitters

Item Reference	EDI 1.1	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	
Issue	Claims were being 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	EDS and SRS resolved this issue through education with providers and electronic submitters as well as updates to the EDI companion guides clarifying the cardholder ID field.	
Provider Action	No action is needed.	

Item Reference	EDI 1.2	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	Resolved 10/21/2003
Issue	ASK was not providing the correct qualifier for the provider ID field.	
Impact	Affected electronic providers perceived their electronic claims were "lost."	
Resolution	ASK identified and corrected the issue on 10/21/2003. ASK resubmitted previously denied claims.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	EDI 1.3	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	
Issue	Billed date was imported as 1903 instead of 2003	Resolved 11/4/2003
Impact	This error affected 6,644 claims (multiple providers).	
Resolution	These providers were using an old version of PACS. Edit 554 (billed date is prior to date of service) was changed to prevent claims from being denied for this reason in the future. Affected claims were identified, corrected and reprocessed.	
Provider Action	No action is needed.	

Item Reference	EDI 1.4	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	
Issue	The ASK file system was creating duplicate file names for multiple files. The EDS system only detected the first file and did not acknowledge the duplicate files.	Resolved 12/5/2003
Impact	Providers' electronic submissions were not being processed	
Resolution	ASK and EDS identified the duplicate files and resubmitted the files for the providers.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	EDI 1.5	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	
Issue	ASK was rejecting claims with an error that the provider was submitting an invalid diagnosis code. ASK does not receive mainframe diagnosis code updates since interChange was implemented.	Resolved 11/14/2003
Impact	Providers that submitted invalid diagnosis codes received rejections from ASK.	
Resolution	ASK removed this edit from their EDI engine on 11/06 so the claims will be sent to interChange to appropriately adjudicate.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: General

Item Reference	GENP 1.0	
Date Drafted	2/29/2004	
Date Revised	4/30/2004	
Groups Affected	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 being denied for "PA not found on database" or were not decrementing the correct PA and therefore causing incorrect denials. This impacted all providers, including Home Health and HCBS.	
Resolution	The system was corrected on 1/30/2004. EDS will reprocessed the claims that were denied in error. (CO 4829)	
Provider Action	No action is needed.	

Item Reference	GENP 1.4	
Date Drafted	2/29/2004	
Date Revised	5/7/2004	
Groups Affected	All	
Issue	Providers were experiencing inadequate access to customer service.	Resolved: 6/4/2004
Impact	Providers were not able to reach Customer Service for KMAP program assistance or claims resolution.	
Resolution	The Customer Service queue size and allocation of dedicated lines was increased on 1/29/2004 as an interim solution. EDS added 12 employees to customer service on 4/23/2004. Improvement was immediate. This issue 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.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.6	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	All Providers Billing For MediKAN Services	Resolved 12/26/2003
Issue	MediKAN benefit plan was not set up correctly to generate payments to providers on behalf of beneficiaries with MediKAN coverage.	
Impact	12,847 professional claims and 1,927 institutional claims were denied between 10/20/2003 and 12/26/2003.	
Resolution	The system was corrected on 12/26/2003. All affected claims were recycled by the 1/22/2004 remittance advice.	
Provider Action	No action is needed.	

Item Reference	GENP 1.7	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	All	
Issue	The Internet claims resubmission option was not correctly resubmitting claims. Claims were being associated sporadically with the wrong provider.	Resolved 2/3/2004
Impact	Providers cannot access and correct previously denied claims on the KMAP secure site. Providers received incorrect information on remittance advices.	
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 by an automated message. The function was re-enabled around 5 p.m. on 2/3/04.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.8	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	All	
Issue	Providers could not search for eligibility on the Internet by name and date of birth.	Resolved 12/5/2003
Impact	Without being able to search by name, providers were not able to verify eligibility for some patients prior to providing services.	
Resolution	This search ability was added on 12/5/2003.	
Provider Action	No action is needed.	

Item Reference	GENP 1.10	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	All	
Issue	Providers reported that when requesting eligibility information, they intermittently received information on a beneficiary other than the one they originally requested.	Resolved 3/3/2004
Impact	If the provider did not notice that the response was for someone other than requested, they may have provided services for someone who was not eligible or informed a beneficiary who was eligible that they were not eligible.	
Resolution	This issue was resolved.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.11	System Corrected: 3/26/2004
Date Drafted	2/29/2004	
Date Revised	8/27/2004	Cleanup: 8/20/2004
Groups Affected	All	
Issue	HealthConnect Kansas-related claims are not processing as intended. ER claims, lab and radiology providers, and ambulance, to name a few, are being reviewed to ensure they are being paid appropriately.	
Impact	Claims are being denied when they should be paid for some providers.	
Resolution	EDS reviewed and modified exception code 1050 (HealthConnect Kansas referral) to ensure that the policy for HealthConnect Kansas referrals is being applied correctly. CO 5324 was implemented on 3/26/04. CO 5270 was implemented on 3/4/04. CO 5270 set claims to suspend for manual intervention effective 3/8/04. Claims affected by CO 5270 and 5324 for HealthConnect referral were reprocessed, even though the diagnosis was emergent, and appeared on the 8/26/2004 remittance advice. All HealthConnect Kansas claims have been suspended so they can be worked manually to try to decrease the number of claims processed incorrectly. EDS completed reprocessing of claims on 8/20/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.16	
Date Drafted	4/12/2004	
Date Revised	6/25/2004	
Groups Affected	All	
Issue	KMAP Web site does not display secondary insurance information.	Resolved: 6/23/2004
Impact	Without calling EDS, providers cannot determine the secondary insurer on file. The KMAP Web site states there is no TPL involvement when the MMIS does have TPL on file.	
Resolution	This issue only occurs 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 the 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)	
Provider Action	If provider receives a TPL denial and no TPL is on the web site, please contact beneficiary to get secondary insurance information.	

Item Reference	GENP 1.19	
Date Drafted	4/12/2004	
Date Revised	7/9/2004	
Groups Affected	All	
Issue	Claims with the same procedure code but a different modifier were being denied against each other.	Resolved: 6/252004
Impact	Providers were being underpaid.	
Resolution	The modifiers identified were not on the list to bypass duplicate auditing. The claims were processing according to policy. Research has been completed. The claims processed correctly. Per policy these modifiers are ignored during duplicate auditing.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.21	
Date Drafted	4/15/2004	
Date Revised	7/21/2004	
Groups Affected	All	Resolved: 6/4/2004
Issue	Claims initially were processed as Medicare and should have been TPL (and vice versa) could not be adjusted due to the system not allowing a change in claim type.	
Impact	Underpayments and/or overpayments occurred depending on the specifics of each claim.	
Resolution	System issue was resolved on 6/4/2004. EDS reprocessed the adjustments in mid-July. (CO 5168)	
Provider Action	Provider can void original claim on the Internet and resubmit new claim for processing as an interim solution.	

Item Reference	GENP 1.22
Date Drafted	4/15/2004
Date Revised	8/6/2004
Groups Affected	All
Issue	Reprocessing and mass adjustments were occurring and incorrectly resulted in recoupments.
Impact	Cash flow problems occurred for providers already impacted by system issues.
Resolution	This issue impacts rate changes, reprocessing to fix PCA codes, adjustments to increase payment on HCBS claims, and spenddown adjustments. These adjustments (which caused recoupments) impacted providers with existing cash flow issues. SRS placed adjustments on hold/review to evaluate the impact. EDS implemented a system change to evaluate overrides for items processed prior to 10/16/2003. These overrides allow claims to process for fields now needed such as admit diagnosis on inpatient claims. (CO 6904) This item is also covered in GENP 1.51. Please refer to GENP 1.51 for future updates.
Provider Action	Overpayments, such as duplicate payments, will not be recouped automatically at this time. If the provider wants recoupments initiated to balance their books, please submit the request on an individual basis and the recoupment will be completed.

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.23
Date Drafted	4/15/2004
Date Revised	5/7/2004
Groups Affected	All
Issue	The co-pay indicator was enabled for dual Medicare/Medicaid beneficiaries.
Impact	Beneficiaries were being required to pay the co-pay when providers believed that they should not pay.
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.
Provider Action	No action is needed.

Resolved: 5/3/2004

Item Reference	GENP 1.24
Date Drafted	4/15/2004
Date Revised	7/21/2004
Groups Affected	All
Issue	For IUD and Norplant insertions, the drug was being denied and the procedure was being paid.
Impact	Providers were being underpaid.
Resolution	The table was updated to prevent denials for edit 5525. EDS identified and resubmitted the claims denied in error on 7/7/2004 for reconsideration of payment. (Task 6400)
Provider Action	No action is needed.

Resolved: 4/15/2004

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.26	
Date Drafted	4/15/2004	
Date Revised	7/9/2004	
Groups Affected	All	Resolved: 4/13/2004
Issue	Claims for circumcision were being denied for unacceptable diagnosis code when billed with diagnosis code V502.	
Impact	Claims were being denied incorrectly.	
Resolution	The V502 diagnosis code was added as a valid diagnosis code for circumcision on 4/13/2004. (TO 6510)	
Provider Action	No action is needed.	

Item Reference	GENP 1.27	
Date Drafted	4/22/2004	
Date Revised	4/22/2004	
Groups Affected	Physician and Hospital	Resolved: 4/22/2004
Issue	Claims for sterilization were being denied when the form was attached.	
Impact	Claims were not being paid.	
Resolution	Tighter controls were put in place to ensure that the claims received have the federally-mandated sterilization form.	
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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.28
Date Drafted	4/22/2004
Date Revised	4/30/2004
Groups Affected	Physician and Hospital
Issue	Professional and facility charges for sterilization were being denied when the form was attached.
Impact	Claims were not being paid.
Resolution	When the professional and facility bill the exact same code without a modifier, the system views it as one sterilization per lifetime and denies the claim. Since the WC modifier was previously used, the system would differentiate that the claims were the same date of service, but one was facility and one was physician. The system was changed on 4/23/2004 to recognize that the following provider types and specialties are not duplicates to the physician's claim: 01/010, 01/351, 02/020, and 42/010. (CO 6427, 6428)
Provider Action	No action is needed.

Resolved: 4/23/2004

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.29	
Date Drafted	4/27/2004	
Date Revised	6/4/2004	
Groups Affected	All	
Issue	Claims were disappearing that were submitted since 3/1/04.	
Impact	Effective 3/1/2004, old provider numbers cannot be submitted on claims sent to EDS. Providers will not see these claims on their remittance advice or through the Web site.	Resolved: 5/7/2004
Resolution	Claims with the old provider numbers are not cross referenced to the provider remittance advice or returned. The system denies the claims but keeps the record under the beneficiary ID and date of service billed. 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.	
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 date of service to determine if the claim was received and number accurate in the system from what was submitted.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.30	
Date Drafted	4/27/2004	
Date Revised	5/7/2004	
Groups Affected	Inpatient	
Issue	EDS was keying an extra line on claims, which caused claims to be denied.	Resolved: 5/3/2004
Impact	Providers were being underpaid.	
Resolution	For paper claims, the total line was being entered into the MMIS as a line item; therefore, the claim was denied because there was no date of service. This also doubled the total billed amount on the claim. The character recognition software was corrected.	
Provider Action	Providers need to call customer service to request a 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.	

Item Reference	GENP 1.31	
Date Drafted	4/27/2004	
Date Revised	5/21/2004	
Groups Affected	Physician and Hospital	
Issue	For emergency room claims, either the professional claim or the facility claim was being paid and the other was being denied as a duplicate.	Resolved: 5/14/2004
Impact	Claims were 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.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.32
Date Drafted	4/27/2004
Date Revised	7/28/2004
Groups Affected	All
Issue	For consultations, the Internet was not allowing the referring provider number to be submitted on the claim.
Impact	Providers were unable to process claims through the Internet. Providers wanted the use of a dummy provider number, which 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 being denied 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.
Provider Action	Submit claims on the Internet with a valid provider number. Service location is not reviewed for consultations.

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.33	
Date Drafted	4/27/2004	
Date Revised	6/4/2004	
Groups Affected	All	
Issue	Electronic Medicare crossover claims were being denied with a statement that it must be billed to the primary insurance or that it requires an EOB.	
Impact	Providers were being underpaid.	Resolved: 4/27/2004
Resolution	Providers were submitting EOB/payment information with their claims; however, the EOB that was attached did not match the date of service, billed amount, or beneficiary name. The remittance advice message that KMAP uses is a HIPAA-compliant message. Due to the generic nature, the message did not state that the EOB needs to be reviewed for accuracy. In addition, claims submitted electronically with no third-party liability on file will receive this message.	
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 date of service. For denied electronic claims, review eligibility on the Web site for that date of service. If there is no third-party liability on the Web site, the claim needs to be submitted on paper for EDS to contact other insurer and update the files.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.34	
Date Drafted	4/27/2004	
Date Revised	6/7/2004	
Groups Affected	Physician and Hospital	
Issue	At the Provider Task Force Meeting, it was reported that only one surgery was being paid when multiple surgeries were performed.	N/A
Impact	Claims were not being paid.	
Resolution	Examples of this issue were not provided for EDS to research after the meeting. If a provider has examples of this issue, please send to EDS, Attention: Angie Casey. Since no examples have been received, this item is being closed.	
Provider Action	No action is needed.	

Item Reference	GENP 1.36	
Date Drafted	4/27/2004	
Date Revised	8/17/2004	
Groups Affected	Physician	
Issue	CPT code 81000 (urine analysis) was being denied because it was bundled even when it was the only item billed on the claim.	Resolved: 5/3/2004
Impact	Providers were potentially being underpaid.	
Resolution	EDS received examples of this issue and the reference file was updated on 5/3/2004. Claims reprocessing associated with CO 6493 was completed on 6/14/04. Claims reprocessing associated with CO 6708 was completed on 8/13/2004.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.37	
Date Drafted	4/27/2004	
Date Revised	4/27/2004	
Groups Affected	Physician and Hospital	Resolved: 4/27/2004
Issue	Office visit claims were being denied as M90 message (not covered more than once in a 12 month period).	
Impact	Providers perceived that they were being underpaid.	
Resolution	This is a correct denial. Medicaid pays 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.	

Item Reference	GENP 1.38	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	All	Resolved: 2/1/2004
Issue	Claims were being denied as a noncovered diagnosis code for MediKAN beneficiaries.	
Impact	Providers were being underpaid.	
Resolution	This issue was resolved to allow MediKAN beneficiaries' claims to process correctly. The 4314 exception is no longer being enabled in error. (CO 5234)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.39	
Date Drafted	5/4/2004	
Date Revised	5/4/2004	
Groups Affected	LTC and HCBS	
Issue	LTC and HCBS claims were being denied for invalid level of care.	Resolved: 3/26/2004
Impact	550 beneficiaries had level of care updated inadvertently when patient liability updates were made. This caused claims to be denied in error.	
Resolution	When the SRS worker sent 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 was corrected to accept the earlier of the two dates as the correct level of care. (TO 6057)	
Provider Action	No action is needed.	

Item Reference	GENP 1.40	
Date Drafted	5/4/2004	
Date Revised	5/28/2004	
Groups Affected	Physician and Hospital	Resolved: 4/22/2004
Issue	HCPCS code 76886 was being denied for male beneficiaries.	
Impact	Claims were being underpaid.	
Resolution	The system was corrected on 4/22/04 to allow 76886 for both male and female beneficiaries.	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.41	
Date Drafted	5/4/2004	
Date Revised	5/28/2004	
Groups Affected	All	
Issue	Claims with the 22 modifier were not paying at the correct level.	Resolved: 4/12/2004
Impact	Claims were 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)	
Provider Action	No action is needed.	

Item Reference	GENP 1.42	
Date Drafted	5/4/2004	
Date Revised	6/11/2004	
Groups Affected	All	
Issue	Procedure codes A0200 and A0210 were paying at zero amounts.	Resolved: 4/30/2004
Impact	Claims were 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 but then failed to allow EDS to manually price rather than pay at $0.00. This was corrected on 4/30/04. (TO 6468)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.44	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	Hospital	
Issue	Claims with dates of service prior to 3/26/04, but billed after 3/26/04, were being denied with the 32 modifier.	Resolved: 4/21/2004
Impact	Claims were 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 being denied in error when billed with the 32 modifier. This issue occurred on claims with a date of service prior to 3/26/04 but billed after 3/26/04. This was corrected on 4/21/2004.	
Provider Action	No action is needed.	

Item Reference	GENP 1.45	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	DME	Resolved: 5/4/2004
Issue	CPT code A4221 was being denied in error with EOB 1294.	
Impact	Providers were being underpaid.	
Resolution	The system was corrected to allow proper processing for CPT code A4221. (CO 6347)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.46	
Date Drafted	5/12/2004	
Date Revised	5/12/2004	
Groups Affected	All	
Issue	The Web site did not allow providers to correct the name or date 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 date of birth can be changed on the Internet. Remove the beneficiary ID from the field and tab through the field. You will receive the message, "Beneficiary ID not on file." Retype the beneficiary ID into the beneficiary ID field and tab through the field. The DOB and name will now automatically be updated to the correct information on file.	
Provider Action	No action is needed.	

Item Reference	GENP 1.47	
Date Drafted	5/12/2004	
Date Revised	5/12/2004	
Groups Affected	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 changes are released which may cause the Internet to function 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.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.52	
Date Drafted	6/3/2004	
Date Revised	7/21/2004	
Groups Affected	DME	Resolved: 5/26/2004
Issue	A4450 CPT code was being denied.	
Impact	Claims were being denied incorrectly.	
Resolution	EDS identified and corrected the system on 5/26/2004. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6652)	
Provider Action	No action is needed.	

Item Reference	GENP 1.53	
Date Drafted	6/3/2004	
Date Revised	7/9/2004	
Groups Affected	All	Resolved: 7/15/2004
Issue	Claims has a paid amount but no paid date is online.	
Impact	Providers' claims appear to be paid but are not on the warrant.	
Resolution	Claims that 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)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.54	
Date Drafted	6/3/2004	
Date Revised	7/21/2004	
Groups Affected	DME	
Issue	CPT code Z1236 was causing claims to be denied incorrectly.	Resolved: 5/13/2004
Impact	Claims were being denied incorrectly.	
Resolution	Z1236 was posting exact duplicate instead of suspect duplicate for claims submitted with Z1236 that edited against other Z1236 claims with modifier RR. This caused the claims to be denied as duplicate. The system was corrected and claims are now processing correctly. This issue affected all claims submitted with this scenario since 10/16/03. EDS identified and resubmitted claims denied in error on 7/20/2004. (CO 6553)	
Provider Action	No action is needed.	

Item Reference	GENP 1.56	
Date Drafted	6/3/2004	
Date Revised	7/9/2004	
Groups Affected	All	
Issue	Procedure code 99393 was being denied in error.	Resolved: 5/26/2004
Impact	Claims were being denied incorrectly.	
Resolution	Claims submitted with procedure code 99393, modifier 32 and place of service 71 were being denied in error for dates of service 3/26/04 and after. This issue was resolved and claims are now processing correctly. EDS identified and resubmitted claims denied in error on 7/2/2004. (CO 6632)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.58	
Date Drafted	6/3/2004	
Date Revised	8/6/2004	
Groups Affected	All	
Issue	Claims were being denied for procedure code J0207.	Resolved: 5/28/2004
Impact	Claims were being denied incorrectly.	
Resolution	A provider submitted examples where claims were denied for CPT J0207. While small in scope, EDS resolved the issue and will ran a query to identify additional claims that were denied in error. EDS reprocessed erroneously denied claims and informed providers when complete. (TO 6678)	
Provider Action	No action is needed.	

Item Reference	GENP 1.59	
Date Drafted	6/9/2004	
Date Revised	6/25/2004	
Groups Affected	DME	
Issue	Claims with a KO modifier were being denied in error.	Resolved: 3/3/2004
Impact	Providers were not being paid.	
Resolution	Claims with a KO modifier were being denied 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)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.61	
Date Drafted	6/9/2004	
Date Revised	8/6/2004	
Groups Affected	Local Health Departments	
Issue	Local health departments (LHD) were being paid at the Advanced Registered Nurse Practitioner (ARNP) rate.	Resolved: 6/15/2004
Impact	Providers were being underpaid.	
Resolution	LHD providers were encountering a reduction in reimbursement. Instead of being reimbursed at the maximum allowable rate for MD/DO, they were being reimbursed at 75% of the maximum allowable rate for ARNP/PA. This issue was being resolved and providers will be notified when adjustment to claims are complete. EDS anticipates the claims paid in error will have adjustments submitted by the end of July. (CO 6117)	
Provider Action	No action is needed.	

Item Reference	GENP 1.63	System Corrected: 6/24/2004
Date Drafted	6/9/2004	
Date Revised	8/27/2004	Cleanup: 8/20/2004
Groups Affected	Audiology	
Issue	Audiology claims are being denied in error.	
Impact	Claims are being denied incorrectly.	
Resolution	Claims were being denied for audiology procedure codes (V5030, V5040, V5050, V5060, V5070, V5080, V5100, V5120, V5130, V5140, V5150, V5170, V5180, V5190, V5210, V5220, V5230, V5242, V5243, V5248, V5249) billed with an RR modifier; billed by Provider Type/Specialty 18/183, 20/200, 22/220, 31/332, 31/349 with a paid date on or after 10/16/2003. EDS completed reprocessing the claims denied in error on 8/20/2004. (CO 6592)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.64	
Date Drafted	6/9/2004	
Date Revised	8/17/2004	
Groups Affected	Lab	
Issue	Lab codes 80000-89999 with modifier TC or 26 were being denied in error.	Resolved: 6/1/2004
Impact	Claims were being denied incorrectly.	
Resolution	Medical and outpatient claims for lab codes (80000-89999) with modifier 26 or TC were being denied in error. The system was updated on 6/1/04. Claims that were denied in error were resubmitted for reprocessing on 8/13/2004. (CO 6687)	
Provider Action	No action is needed.	

Item Reference	GENP 1.65	
Date Drafted	6/17/2004	
Date Revised	7/21/2004	
Groups Affected	All	
Issue	LEA providers received a large number of denials for "5652 – Headstart vs. LEA services."	Resolved: 6/21/2004
Impact	Claims were being denied incorrectly.	
Resolution	EDS is currently designing the system to process the claims according to LEA policies. EDS identified and reprocessed the claims for the 7/22/2004 remittance advice. (CO 6843).	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.68	
Date Drafted	6/28/2004	
Date Revised	8/6/2004	
Groups Affected	All	
Issue	Claims were being denied for error code 550: "Manual deny for adjustment."	N/A
Impact	Providers were not being paid.	
Resolution	EDS is researching to determine if 1) it is an appropriate denial and 2) what the appropriate message should be. EDS will inform the providers when the issue is resolved. This is being seen predominantly on Hospice claims. (CO 6387) This item is similar to GENP 1.51. Refer to GENP 1.51 for future updates.	
Provider Action	No action is needed.	

Item Reference	GENP 1.71	
Date Drafted	6/28/2004	
Date Revised	8/17/2004	
Groups Affected	All	
Issue	Claims were being denied as a noncovered Medicare service when Medicare paid the claim for the procedure code submitted to KMAP. In addition, exception code 2504 was being denied for third-party liability erroneously.	Resolved: 7/29/2004
Impact	Providers were not being paid.	
Resolution	During the annual HCPCS update the Medicare Coverage indicator was not updated on some of the HCPCS codes on file for KMAP. The HCPCS tape was reviewed to verify that the codes to indicate Medicare Coverage were appropriate. Providers were notified that the files were updated. EDS reprocessed claims on 8/13/2004. (CO 6465, 6534, 6627, 6628, & 6865)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.73
Date Drafted	7/9/2004
Date Revised	8/6/2004
Groups Affected	All
Issue	Claims with modifier 25 was being denied after 1/1/2004 date of service.
Impact	Providers were not being paid.
Resolution	Modifier 25 was end-dated for 1/1/2004 with the new system. This should have been open end-dated using 12/31/2299. This issue was corrected on 7/3/2004. EDS will identify and reprocess the claims denied in error, and contact the providers when complete. EDS anticipates the claims will be reprocessed by the end of July. (CO 6920)
Provider Action	No action is needed.

Resolved: 7/3/2004

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.75	
Date Drafted	7/9/2004	
Date Revised	8/17/2004	
Groups Affected	All	
Issue	Ultrasounds (also called sonograms) were being denied in error for procedure-to-diagnosis code.	
Impact	Providers were not being paid.	
Resolution	Procedure codes 76801-76828 that processed after 10/16/2003 were being denied in error when billed with the following diagnosis codes: 65663, 65653, 64003, 6258, 6259, V288, V234, V284, 64083, V2349, 64883, 65973, V237, 65633, 65643, 65120, 76811, 65523, 7965, 4286, 63380, 65553, 65413, 65803 and 6262. In addition, diagnosis code 65703 is now covered for procedure code 76811, and diagnosis code 78904 is covered for procedure code 76801. Procedure codes 76830 and 76831 were never covered to pay with diagnosis codes 6258 or 6268 but are now payable. These codes were approved by SRS to be payable. All of these codes were set to either pay or pay with review as of 7/7/2004. For procedure codes 76830 and 76831, diagnosis code 63380 is now covered as well. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete. This is a reminder that procedures that require review may receive denials for additional documentation. When this is received, the paper claim can be resubmitted with medical justification for the procedure. (CO 6947, 7107, & 7149) Claims were reprocessed on 8/13/2004.	Policy Updated: 8/6/2004
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Item Reference	GENP 1.76	System Corrected: 7/1/04
Date Drafted	7/9/2004	
Date Revised	8/27/2004	Cleanup: 8/20/2004
Groups Affected	DME	
Issue	DME supplies are being denied in error.	
Impact	Providers are not being paid.	
Resolution	The Max Fee List for procedure codes A6443, A6444, A6446, A6447, A6449, A6450, A6451, A6452, and A6454 were incorrectly end-dated 03/31/2004. The following provider types (PT) and specialties (PS) were impacted: PT/PS 05/ 050; PT/PS 25/250; PT/PS 25/255. This issue was corrected on 7/1/2004 for affected claims from 4/1/2004 to 7/1/2004. EDS identified and reprocessed the claims denied in error. They will appear on the 8/26/2004 remittance advice. (CO 6946)	
Provider Action	No action is needed.	

Item Reference	GENP 1.83	
Date Drafted	7/26/2004	
Date Revised	8/20/2004	
Groups Affected	All	
Issue	Co-pay amounts were being handled incorrectly for various procedure codes.	Resolved: 6/23/2004
Impact	Providers were being underpaid/overpaid depending on the code.	
Resolution	Provider type 11 with all provider specialties was taking co-pay from procedure code 90847 inappropriately. Claims with procedure codes G0154, 99601, and 99601 GY should have co-pay deducted. This issue was resolved. SRS determined no cleanup effort was needed. (CO 6851)	
Provider Action	No action is needed.	

Blue highlighted items indicate the issue was closed and no longer occurs.

KMAP Provider Communication

Provider Community: Optometry

Item Reference	OPT 1.1	
Date Drafted	4/27/2004	
Date Revised	7/21/2004	
Groups Affected	Optometry	
Issue	Claims were being denied for eyeglass frames and lenses for KAN Be Happy (KBH) eligible children.	Resolved: 4/21/2004
Impact	Providers were being underpaid.	
Resolution	Procedure code V2100 was being denied/cut back by limitation audit 6214 inappropriately. For example, for a 15-year old, who should not encounter that audit, the claim was cut back to only half of the allowed amount for the lens. The system was corrected on 4/21/2004. The claims denied in error were reprocessed on 7/15/2004. (CO 5647)	
Provider Action	No action is needed.	

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