Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: CDDO, HCBS, Home Health, and CMHC

Also see GENP 1.2, 1.4, and 1.5

Item Ref: CHHC 1.14

Drafted: 4/15/2004

CMHC	Issue:	Claims were denying for invalid diagnosis code for dates of service.	System Corrected: 3/9/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Provider reported that they submitted claims with the new diagnosis code (78099) and it denied for January 2004 DOS. Another provider reported that 2003 claims were denying for 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 to allow correct processing. (CO 6671) EDS has targeted the reprocessing of claims to occur by the end of August.	

Message: Claims were denying for invalid diagnosis codes. The system was updated with correct beginning and ending effective dates on the old and new codes. Claims started processing correctly on 3/9/2004. EDS will reprocess the claims and notify providers when this is completed.

Provider Action: No action is needed. Claims that were denied in error with invalid diagnosis codes will automatically be reprocessed by EDS.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.15

Drafted: 4/15/2004

CMHC	Issue:	Claims are denying for no Plan of Care on file when a provider is approved for two services for the same procedure code and a modifier is allowed on one of the procedure codes.	System Corrected: 6/4/2004 Clean-up: Pending
	Impact:	The Prior Authorization (PA) logic is not looking correctly at the modifiers on the Plans of Care. Claims are being denied for no PA on file for the second Plan of Care on file that has the same base procedure code.	
	Resolution:	The system was corrected on 6/4/2004. The reprocessing of claims related to this item is currently pending. (CO 6324)	

Message: Claims are denying for no Plan of Care on file when a provider is approved for two services for the same procedure code and a modifier is allowed on one of the procedure codes. The system was corrected on 6/4/2004. EDS will correct claims applied to wrong Plan of Care and will reprocess claims denied in error.

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: CHHC 1.17

Drafted: 4/15/2004

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).	System Corrected: 5/14/2004 Clean-up: Pending
	Impact:	Claims are being denying 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 will identify and reprocess claims which denied in error. (CO 6976)	

Message: 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 will identify and reprocess claims which denied in error.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.21

Drafted: 6/9/2004

HCBS	Issue:	Procedure S5161 is paying at $25.00 per unit instead of the $30.00 allowed.	System Corrected: 4/23/2004 Clean-up: Pending
	Impact:	Providers are being underpaid.	
	Resolution:	Installation of an emergency response system (S5161) was paying at $25.00 instead of the $30.00 allowed amount. This issue was corrected as of 4/23/04. EDS will adjust the affected claims and notify the providers when complete. EDS anticipates the adjustments will be completed by the middle of August. (CO 6410)	

Message: Installation of an emergency response system (S5161) was paying at $25.00 instead of the $30.00 allowed amount. This issue was corrected as of 4/23/04. EDS will adjust the affected claims and notify the providers when complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Item Ref: CHHC 1.22

Drafted: 6/9/2004

HCBS	Issue:	Procedure code T1016 was denying in error.	System Corrected: 3/3/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims with the T1016 were denying in error. (CO 6054) Reprocessing of claims had previously been done but some claims were not corrected. EDS is identifying the additional claims to be reprocessed and will notify providers when complete.	

Message: Claims with the T1016 were denying in error. Reprocessing of claims had previously been done but some claims were not corrected. EDS is identifying the additional claims to be reprocessed and will notify providers when complete.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.24

Drafted: 6/9/2004

CMHC	Issue:	Positive behavioral support services are being denied after 32 hours are provided.	
	Impact:	Providers perceive their claims are denied in error.	
	Resolution:	The Kansas state plan as approved by the federal government allows the state to pay 32 hours total for adults and 40 total hours for children for all psychiatric therapy. This total means all therapy which includes individual, family, and group from any provider. The prior system was allowing claims to pay at 32/40 hours for each (i.e., 32 hours for individual, 32 hours for family, and 32 hours for group.) The new system was set up to pay per the state plan. SRS is researching options to determine if they can get the state plan adjusted to higher limits. This particularly impacts children on the SED HCBS waiver program who are in intensive psychiatric therapy.	

Message: The state plan as approved by the federal government allows the state to pay 32 hours total for adults and 40 total hours for children for all psychiatric therapy. This total means all therapy which includes individual, family, and group from any provider. The prior system was allowing claims to pay at 32/40 hours for each (i.e., 32 hours for individual, 32 hours for family, and 32 hours for group.) The new system was set up to pay per the state plan that the federal government approved. SRS is researching options to determine if they can get the state plan adjusted to higher limits. This particularly impacts children on the SED HCBS waiver program who are in intensive psychiatric therapy.

Provider Action: Review your plans of care to ensure that you are working to the state approved plan.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.26

Drafted: 6/28/2004

HCBS FE	Issue:	Edit 1078: "Patient obligation distribution does not balance", is denying some claims in error.	
	Impact:	Providers are not being paid.	
	Resolution:	Providers are receiving denials for patient obligation does not balance when the plan of care appears to be accurate. This is caused in error when the dates entered on a plan of care are not for a full month. The system should recognize a prorate for the month. EDS has determined the issue and is in the process of making the system fix. Providers will be notified when the issue is resolved. (CO 6397)	

Message: TBD

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: CHHC 1.27

Drafted: 6/28/2004

HCBS	Issue:	Claims denying when single claim bypasses 120 units for targeted case management.	System Corrected: 6/10/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims are 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 deny. This applies to claims with procedure code W1300. This issue was resolved on 6/10/04. EDS anticipates the reprocessing of claims to be initiated by the middle of August. EDS will notify providers when claims are reprocessed which denied in error. (CO 6766)	

Message: Claims are 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 deny. This applies to claims with procedure code W1300. This issue was resolved on 6/10/04. EDS will notify providers when claims are reprocessed which denied in error.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.28

Drafted: 7/9/2004

CMHC	Issue:	Claim are denying for KAN Be Healthy (KBH) beneficiaries for more than 32 hours of psychotherapy.	System Corrected: 7/1/04 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims are denying after 32 hours for KBH beneficiaries when they are allowed 40 hours of psychotherapy. The system has been changed to not edit for 32 hours of psychotherapy for beneficiaries between the ages of 0-20. This fix was made on 7/1/2004. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete. EDS anticipates the claims to be reprocessed by the middle of August. (CO 6902)	

Message: Claims are denying after 32 hours for KBH beneficiaries when they are allowed 40 hours of psychotherapy. The system has been changed to not edit for 32 hours of psychotherapy for beneficiaries between the ages of 0-20. This fix was made on 7/1/2004. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.29

Drafted: 7/11/2004

CMHC	Issue:	Co-pay is currently not deducted from claims when the emergency indicator on the diagnosis code is "Y" in the system.	
	Impact:	SRS is spending more funds than potentially necessary.	
	Resolution:	Co-pay is currently not deducted from claims when the emergency indicator on the diagnosis code is "Y" in the system. The co-pay logic will be changed to exempt beneficiaries, who normally are eligible for co-pay, to have co-pay deducted for emergency services based on the following instead of the diagnosis: • The claim is Outpatient billed with the following: 99281-99285, 99291, 99292, or 99218; all services on same claim will be exempt from co-pay; or • The claim is Medical with a place of service billed as emergency room (23); or • The claim is Inpatient with an admit code of 1 (emergency care provided for a person admitted through an emergency room) or 2 (urgent care requiring first available accommodation). EDS will notify providers when the system is updated and the effective date of the change. (CO 6921)	

Message: Co-pay is currently not deducted from claims when the emergency indicator on the diagnosis code is "Y" in the system. The co-pay logic will be changed to exempt beneficiaries, who normally are eligible for co-pay, to have co-pay deducted for emergency services based on the following instead of the diagnosis:

- The claim is Outpatient billed with the following 99281-99285, 99291, 99292, or 99218; all services on same claim will be exempt from co-pay; or
- The claim is Medical with a place of service billed as emergency room (23); or
- The claim is Inpatient with an admit code of 1 (emergency care provided for a person admitted through an emergency room) or 2 (urgent care requiring first available accommodation.)

EDS will notify providers when the system is updated and the effective date of the change.

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: CHHC 1.30

Drafted: 7/11/2004

HCBS FE	Issue:	Claims are denying when a plan of care is on file.	
	Impact:	Providers are not being paid.	
	Resolution:	When KDOA enters a plan of care with more than one line item on a letter, the submitted claims pay up to the maximum allowed on the first line item found and subsequent claims deny after this. They do not reach the subsequent plan of care line items. EDS has identified the issue and is in the process of designing and coding a fix. EDS will notify providers when complete. Once complete, EDS will identify the claims denied in error and reprocess them. (CO 6964)	

Message: When KDOA enters a plan of care with more than one line item on a letter, the submitted claims pay up to the maximum allowed on the first line item found and subsequent claims deny after this. They do not reach the subsequent plan of care line items. EDS has identified the issue and is in the process of designing and coding a fix. EDS will notify providers when complete. Once complete, EDS will identify the claims denied in error and reprocess them.

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: Dental

Item Ref: DENT 1.9

Drafted: 6/9/2004

Lab	Issue:	Dental claims are denying for allowing only 1 prophylaxis treatment per 180 days and there is no claim paid in the last 180 days.	
	Impact:	Claims are denying incorrectly.	
	Resolution:	Dental claims are denying for allowing only 1 prophylaxis treatment per 180 days and there is no claim paid in the last 180 days. EDS has tested the system fix and is working on moving the changes to production. Providers will be notified when issue is resolved. (CO 6335)	

Message: Dental claims are denying for allowing only 1 prophylaxis treatment per 180 days and there is no claim paid in the last 180 days. EDS has determined the issue and is in the process of making a correction. Providers will be notified when issue is resolved.

Provider Action: No action is needed.

Revised: 7/28/2004

Item Ref: DENT 1.10

Drafted: 7/9/2004

Dentist	Issue:	Dental claims are denying as duplicates when different tooth numbers are involved.	
	Impact:	Providers are not being paid.	
	Resolution:	Dental claims are denying as exact duplicate when multiple lines for the same DOS are billed with different tooth numbers. These dental claims should post suspect duplicate and suspend for manual review of different tooth numbers. The issue has been identified and is being coded to resolve. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete. Dental providers may bill with a 76 modifier to indicate the procedure is not a duplicate. (CO 6943)	

Message: TBD

Provider Action: To avoid the claim denying as duplicate, dental providers may bill the procedure with a 76 modifier to indicate the procedure is not a duplicate.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

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: Pending
	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.	

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.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: RHC 1.1

Drafted: 4/12/2004

RHC	Issue:	RHCs have reported that Medicaid paid as secondary on a Medicare related claim. The amount paid by Medicaid was more than the Medicare co-insurance.	System Corrected: 3/1/2004 Clean-up: Pending
	Impact:	Claims are being overpaid.	
	Resolution:	The issue was resolved by 3/1/2004. EDS anticipates submitting adjustments for this issue before the end of August. (CO 5720)	

Message: RHCs have reported that Medicaid paid as secondary on a Medicare related claim. The amount paid by Medicaid was more than the Medicare co-insurance. The issue was resolved by 3/1/2004. Recent examples have been researched and a determination made that the issue was resolved on 3/1/2004. EDS will reprocess the claims and notify providers when this is completed.

Provider Action: No action is needed.

Revised: 7/21/2004

Item Ref: RHC 1.5

Drafted: 6/3/2004

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

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

Provider Action: No action is needed at this time.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: Hospitals and Adult Care Home

Item Ref: HSPT 1.5

Drafted: 2/29/2004

Hospitals and Adult Care Home	Issue:	Outpatient Claims incorrectly denying for admitting diagnosis. Issues reoccurred at the end of March.	System Corrected: 3/25/2004
	Impact:	Claims without an admitting diagnosis denied in error for error code 360.	
	Resolution:	A fix was identified and implemented on 3/25/04. EDS anticipates resubmitting claims denied in error prior to the middle of August. (TO 6702)	Clean-up: Pending

Message: Between 10/16/2003 and 10/29/2003 claims incorrectly denied for admitting diagnosis. This issue was identified and corrected on 10/29/2003. Affected claims were reprocessed on the 11/5/2004 RA. Claims impacted by the second occurrence of this issue will be identified and reprocessed. Providers will be notified when this is completed.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.7

Drafted: 2/29/2004

Hospital	Issue:	Lab HCPCS codes are denying when ER E & M codes are present on the claim.	System Corrected: 3/26/2004 Clean-up: Pending
	Impact:	Claims are denying in error.	
	Resolution:	Will provide an updated status when the system release date for this defect has been established. This issue is a result of EDS not being able to convert outpatient claims to medical in order to process them for ER claims after HIPAA. These claims are currently being worked manually and all services on the same date of service and the same claim as an E & M Emergency Room code are being forced.(CO 5270/5324). The system fix has been implemented. Claims with this issue were suspended and manually processed.	

Message: Providers are encountering denials for lab HCPCS codes even when emergency room E & M codes are present on the claim. This issue is currently being researched to determine the permanent resolution. Watch for future communication from EDS once this has been resolved. EDS plans to reprocess any claims that denied in error once the issue has been corrected. The system fix has been implemented.

Provider Action: No action needed by providers.

Revised: 5/28/2004

Item Ref: HSPT 1.10

Drafted: 3/2/2004

Hospital	Issue:	Claims with TC and 26 modifiers are being processed incorrectly.	System Corrected: 5/18/2004 Clean-up: Pending
	Impact:	Radiology claims are denying as duplicates in error.	
	Resolution:	Resolution completed on 3/5/2004. Issue was re-identified on 4/25/2004. The system was updated on 5/18/2004. Claims will need to be identified and then will be reprocessed by EDS. (TO 6687) EDS anticipates resubmitting claims denied prior to the end of July.	

Message: Due to a problem in recognizing the TC and 26 modifiers, radiology claims were denying in error as duplicate claims. This issue was corrected on 3/5/2004. The affected claims were recycled. Issue was re-identified on 4/25/2004. The system was updated on 5/18/2004. Claims will need to be identified and then will be reprocessed by EDS.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.12

Drafted: 3/2/2004

Hospital	Issue:	Physical therapy series claims are denying when the primary diagnosis code is a V-code.	System Corrected: 5/7/2004 Clean-up: Pending
	Impact:	All related claims are denying in error.	
	Resolution:	EDS identified cause of denials due to procedure to diagnosis restrictions. Edit is not functioning properly. (CO 5948 – Edit 4037/4259). This was corrected on 5/7/2004. EDS will identify claims to be reprocessed. EDS anticipates this will be completed prior to the middle of August.	

Message: Physical therapy series claims were denying when the primary diagnosis code is a V-code. This was corrected on 5/7/2004. EDS will identify claims to be reprocessed and will notify providers when this is completed.

Provider Action: No action is needed.

Revised: 7/21/2004

Item Ref: HSPT 1.14

Drafted: 3/2/2004

Hospital	Issue:	KFMC outlier issues for processing reviews and recoupments.	System Corrected: Pending Clean-up: Pending
	Impact:	Claims being recouped under different guidelines than standard coding practice or provider manuals.	
	Resolution:	The benefit team has determined what observation codes should be billed instead of down-coding the observation to an ER code. A policy will be written to allow these codes to be billed and the provider manual will be updated. The benefit team continues to review recoupments that were done due to false labor issue to determine if they were recouped inappropriately. The “outlier issue” has been resolved by KFMC and EDS.	

Message: The benefit team has determined what observation codes should be billed instead of down-coding the observation to an ER code. A policy will be written to allow these codes to be billed and the provider manual will be updated. The benefit team continues to review recoupments that were done due to false labor issue to determine if they were recouped inappropriately. The “outlier issue” has been resolved by KFMC and EDS.

Provider Action: No action is needed.

Revised: 7/16/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.18

Drafted: 3/2/2004

Hospital	Issue:	Delay in approvals on timely filing requests over 24 months old.	
	Impact:	Claim payments delayed for months. A/R increases at hospital.	
	Resolution:	SRS added additional resources to eliminate backlog. Process changes have also been made to approve claims quicker.	

Message: Additional State resources have been dedicated to review timely filing requests.

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: HSPT 1.19

Drafted: 3/2/2004

Hospital	Issue:	KMAP medical policy is different than Medicare's policy.	
	Impact:	Claims denied by KMAP as secondary which are paid by Medicare. Different billing guidelines required providers to bill on paper and not use electronic process.	
	Resolution:	SRS will be developing a plan to review differences in policies.	

Message: 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 837 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 837 transaction.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.21

Drafted: 3/23/2004

Hospital	Issue:	When a beneficiary receives a service that spans multiple days and his or her eligibility changes from one program to another during that service period, the system is not able to determine how to pay the claim.	
	Impact:	These claims are being suspended to avoid denials until a solution is in place. Delay in payment is occurring to the providers.	
	Resolution:	A solution was implemented on 6/4/2002 for claims where eligibility spanned multiple segments but was for the same benefit plan. (CO 6218). A system fix to allow payment for claims where the beneficiary has eligibility for part of the stay is being coded. (CO 6464) A solution was identified for claims where eligibility spanned benefit plans such as Medically Needy to TXIX. Change Order 6883 was documented to allow payment for claims where the beneficiary has eligibility which spans multiple benefit plans such as Medically Needy to TXIX.	

Message: When a beneficiary receives a service that spans multiple days and his or her eligibility changes during that time, the system is not able to determine how to pay the claim. These claims are being suspended to avoid denials until a solution is in place.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.24

Drafted: 4/12/2004

Hospital	Issue:	SOBRA claims with pregnancy diagnosis codes or correct authorization from the SRS local office are denying.	System Corrected: 6/29/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS has identified causes for denial. 1) Pregnancy diagnosis code V270 was not loaded for automatic approval as a SOBRA claim. This diagnosis code was added to the pregnancy diagnosis code grouping on 4/16/2004. 2) The coverage criteria for SOBRA excluded all diagnosis codes from payable except for pregnancy diagnosis grouping. The coverage for SOBRA is being changed to allow most diagnosis codes for SOBRA to suspend for manual review. Tentative date for complete addition of these codes has not been determined. 3) Exception 4244 which is "diagnosis is not covered for benefit plan" is looking for all diagnosis codes to be acceptable for the SOBRA approval and pregnancy grouping. The only time that this should occur is with TB claims. The SOBRA claims should only deny if the primary and secondary (which is Other 1 on UB 92) claim form is not part of the approved SOBRA coverage by the local SRS office. This issue has been resolved. Claims will be recycled for reprocessing and EDS will notify providers when complete. EDS anticipates the claims to be reprocessed by the middle of August. (CO 6771).	

Message: SOBRA claims with pregnancy diagnosis codes or correct authorization from the SRS local office are denying. Exception 4244 for all other SOBRA invalid denials has been fixed and is working correctly. Claims denied incorrectly will be resubmitted by EDS for reprocessing.

Provider Action: No action is needed.

Revised: 7/23/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.26

Drafted: 4/15/2004

Hospital	Issue:	Claims are denying with spontaneous miscarriage diagnosis codes or multi-parity diagnosis.	System Corrected: 7/12/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims denying for multi-parity codes are not a change from the old system. SRS reviewed and approved EDS to bypass sterilization form requirements for multi-parity diagnosis V615. This was updated on 7/12/2004. Spontaneous miscarriage (diagnosis 63490) has been covered. If you have examples of denials, contact EDS. EDS will identify claims denied for multi-parity, reprocess, and inform providers when complete. (CO 7017)	

Message: Claims denying for multi-parity codes are not a change from the old system. SRS reviewed and approved EDS to bypass sterilization form requirements for multi-parity diagnosis V615. This was updated on 7/12/2004. Spontaneous miscarriage (diagnosis 63490) has been covered. If you have examples of denials, contact EDS. EDS will identify claims denied for multi-parity, reprocess, and inform providers when complete.

Provider Action: No action is needed.

Revised: 7/16/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.27

Drafted: 4/15/2004

Hospital	Issue:	Hospitals are having difficulty in getting claims paid again when KFMC initiated adjustments and/or recoupments process.	System Corrected: 6/4/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS/SRS/KFMC are researching the following: • Review of admission dates on psychiatric claims. KFMC and EDS worked together and resolved the issue. • Reimbursement issues due to misalignment of peer groups. Research showed that this issue affected only border city hospitals. The peer grouping was revised and a report is being created to identify the border city hospitals affected. • KFMC adjustment EOB is not showing up on KFMC adjustments. The issue can be closed. KFMC and EDS have resolved the issue. • Adjusted claims denied. Research revealed that adjustments are processing under guidelines that did not apply when the claim originally paid and some of those claims are denying due to these new edits and audits instead of partially recouping the dollars as it did in the past. The providers are sending in their claims to the adjustment department to reprocess and these claims were being sent back to the provider indicating that they needed to resubmit through regular claims processing because denied claims could not be adjusted. The adjustment department will now forward those claims for processing if a copy of the claim is attached instead of returning to provider. • Place of Service (POS) edits related to instruction to bill 99281 for OB checks that do not qualify for observations. Claims are denying due to POS not being as system is expecting. The adjusted claims have been corrected. The issue is when observation rooms were being reviewed by KFMC and determined that the observation did not meet the criteria established by SRS, then providers were instructed to re-bill using the lower level ER code. Claims were being denied because the place of service was conflicting with the procedure code being billed. This issue will be resolved once the policy change for issue HSPT 1.14 is completed. Currently researching how many claims were denied and need to be reprocessed.	

Message: Hospitals are having difficulty in getting claims paid again when KFMC initiated adjustments and/or recoupments process. The adjusted claims have been corrected.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.28

Drafted: 4/22/2004

Hospital	Issue:	Claims are denying that are submitted through ASK for attending, operating, or other provider number even if the number was submitted correctly on the claim. ASK is treating the attending, operating, and other provider number as a state license number. This is being indicated on the 837 transaction sent to EDS as a license number and the system is treating it as such.	System Corrected: 5/21/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS is coding changes that when claims are received from ASK, the attending, operating, and other provider ID fields will be analyzed to determine if the value is a provider ID or a license number. If both a state license number and a provider number are received, precedence will be given to the provider number. The change went into production on 5/21/2004. EDS is currently validating that the fix is working as expected. EDS anticipates the reprocessing of claims to occur before the end of August. (CO 6227)	

Message: ASK is treating the attending, operating, and other provider number as a state license number. This is being indicated on the 837 transaction sent to EDS as a license number and the system is treating it as such. EDS is coding changes so that when received from ASK, the attending, operating, and other provider ID fields will be analyzed to determine if the value is a provider ID or a license number. If both a state license number and a provider number are received, precedence will be given to the provider number. The change went into production on 5/21/2004. EDS is currently validating that the fix is working as expected. EDS anticipates the reprocessing of claims to occur before the end of August.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.35

Drafted: 5/12/2004

Inpatient	Issue:	Claims are denying for E-code when no E-code is on the paper claim.	System Corrected: 7/2/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	The optical character recognition (OCR) system, also known as RRI, is reading field 78 for E-code instead of field 77. EDS has identified the issue and is working to fix RRI to read field 78 for the E-code. As a work around, claims with E-codes, that are set to deny, will be set for manual review (i.e., suspended) to ensure claims are not denied in error until the RRI fix is complete. EDS is validating that reprocessing of claims affected by this issue is complete. (CO 7008)	

Message: The optical character recognition (OCR) system, also known as RRI, is reading field 78 for E-code instead of field 77. EDS has identified the issue and is working to fix RRI to read field 78 for the E-code. As a work around, claims with E-codes, that are set to deny, will be set for manual review (i.e., suspended) to ensure claims are not denied in error until the RRI fix is complete. All claims submitted since 10/24/2003 and denied in error for e-code will be identified and reprocessed by EDS. EDS will notify providers when complete.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: HSPT 1.36

Drafted: 6/28/2004

All	Issue:	Claims paying with incorrect DRG.	
	Impact:	Providers are being over paid.	
	Resolution:	When processing claims with length of stays of less than 3 days, the system is assigning DRGs 801-805 for neonatal claims. The system should keep the DRG of 385. (CO 6791)	

Message: When processing claims with length of stays of less than 3 days, the system is assigning DRGs 801-805 for neonatal claims. The system should keep the DRG of 385. Once the system is corrected, EDS will inform the providers then identify the claims impacted, reprocess, and recoup the difference.

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: HSPT 1.37

Drafted: 7/11/2004

Inpatient	Issue:	Hospitals are receiving DRGs submitted on the 837 transaction back as a diagnosis code on a finalized claim.	
	Impact:	This confused providers as they did not submit the diagnosis code that is being submitted in the DRG field.	
	Resolution:	The current 837I transaction map is formatting the HI segment in loop 2300 where H101 = D (diagnosis related group (DRG)) into the corresponding ubDiagX (diagnosis field) with an index of 99. The claim has a 99 or the submitted DRG on the finalized claim. A DRG should not be entered as a diagnosis. The issue has been identified and is being designed and coded to resolve. EDS will notify providers when the fix is complete. (CO 6967)	

Message: The current 837I transaction map is formatting the HI segment in loop 2300 where H101 = D (diagnosis related group (DRG)) into the corresponding ubDiagX (diagnosis field) with an index of 99. The claim has a 99 or the submitted DRG on the finalized claim. A DRG should not be entered as a diagnosis. The issue has been identified and is being designed and coded to resolve. EDS will notify providers when the fix is complete.

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: Local Education Agencies

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 the issue is resolved.

KMAP Provider Communication

Provider Community: Pharmacy

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 Customary charges were not included in NCPDP 5.1. The usual and customary field (426 – DQ on the iC 5.1 specifications) will be pulled into the pharmacy claims as billed amount. Gross amount due (430-DU) will no longer be used for the usual and customary charge. Providers will be notified when this is complete. (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 is needed.

Revised: 7/28/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: PHAR 1.6

Drafted: 2/29/2004

Pharmacy	Issue:	Providers are receiving a co-pay amount of $3.00 for beneficiaries receiving services under the Medically Needy program but have not truly met their spenddown. Claims are being incorrectly processed as paid or denied claims that will be reimbursed by KMAP.	
	Impact:	Pharmacies are dispensing prescriptions and only charging a $3.00 co-pay per the response from KMAP when the beneficiary has not truly met their spenddown and should be responsible for the cost of the medication.	
	Resolution:	Interim solution for Pharmacy providers is to verify eligibility through the KMAP website to ensure remaining spenddown amount is $0.00. EDS and SRS are still evaluating the permanent solution through design discussions.	

Message: Previously, if a pharmacy submitted a claim for a Medically Needy (Spenddown) beneficiary and the claim denied, the claim would post the billed amount towards the beneficiary's spenddown amount. When resubmitting the same claim with an override code to override the denial, some claims came back as "Paid" with only a $3.00 co-pay. An interim solution was implemented during the middle of February 2004, such that only paid claims will post to a beneficiary's spenddown amount. If providers are not confident of the responses they are receiving specifically related to spenddown processing, they may access the secure provider website to verify eligibility and see the beneficiary's remaining spenddown amount.

Provider Action: No action is needed. Latest communication to EDS was that SRS staff would work with the SRS Pharmacy Program Manager to determine what future action needed to be taken.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

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 Clean-up: 7/15/2004
	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)	

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

Item Ref: PHAR 1.11

Drafted: 6/28/2004

All	Issue:	Claims are denying for error code 6306 on beneficiaries under the age of 21.	
	Impact:	Providers are not being paid.	
	Resolution:	Providers are receiving the 6306 denial of limit of five single source prescriptions per month. This should not set for beneficiaries under the age of 21 who is KBH qualified. EDS is researching to determine how to resolve and will contact providers when fix is complete. (CO 6402)	

Message: TBD

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: PHAR 1.12

Drafted: 7/11/2004

Internet Submitters	Issue:	Pharmacy claims cannot be entered on the Internet with certain fields.	
	Impact:	Pharmacy claims cannot be entered on the Internet with clarification code (header), pregnancy indicator (header), and other coverage code (detail).	
	Resolution:	Pharmacy claims cannot be entered on the Internet with clarification code (header), pregnancy indicator (header), and other coverage code (detail). The absence of these fields cause certain claims not to be able to be processed on the Internet (i.e., they deny) and the providers can only submit them through POS, 837, or on paper. EDS is coding an enhancement to allow this and will notify providers when complete. (CO 6951)	

Message: Pharmacy claims cannot be entered on the Internet with clarification code (header), pregnancy indicator (header), and other coverage code (detail). The absence of these fields cause certain claims not to be able to be processed on the Internet (i.e., they deny) and the providers can only submit them through POS, 837, or on paper. EDS is coding an enhancement to allow this and will notify providers when complete.

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: State Institutions

Item Ref: STIN 1.1

Drafted: 5/12/2004

State Institutions	Issue:	State institution claims are paying without reducing them by the patient obligation.	
	Impact:	Providers are being overpaid.	
	Resolution:	Claims are paying without reducing the state institution claims by the patient obligation amount. Patient obligation should be applied when the provider enters value code D3 in field 39 on the UB92 claim form and an amount is entered. Thirty claims, as of 4/14/04, have been identified as being overpaid. EDS has identified the issue and is coding to resolve the overpayment. Providers will be notified when fix is complete. (CO 6106)	

Message: TBD

Provider Action: No action is needed. Overpayments will be recouped once the system issue has been resolved. EDS will notify providers once complete.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: Electronic Submitters

Item Ref: EDI 1.0

Drafted: 2/29/2004

Electronic Submitters	Issue:	Providers were not pleased with the HIPAA 835 transaction implemented by EDS/SRS.	
	Impact:	Providers have requested changes be incorporated into the 835 before they begin utilizing the electronic transaction. Until then, providers using electronic RAs may have to post RAs manually.	
	Resolution:	Ongoing focus group of affected providers has yielded approximately 32 recommendations to EDS/SRS. This effort is continuing based on feedback from providers.	

Message: EDS and SRS have been working with electronic submitters who receive 835 files to incorporate feedback. If you receive an 835 and have feedback you would like to submit for consideration, please contact the EDS EDI Unit.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: EDI 1.5

Drafted: 6/3/2004

ASK submitters	Issue:	Claims submitted by ASK are denying for invalid other provider field.	
	Impact:	Claims are denying incorrectly.	
	Resolution:	The alpha location field is being transmitted at the end of the provider number which causes it to be unrecognizable. EDS is working with ASK to determine how to resolve.	

Message: As the date gets closer to the elimination of ASK as an option for submitting electronic claims to KMAP, providers need to start testing their new electronic submission. Issues such as claims denying for invalid other provider field are not experienced on transmission modes other than ASK. Call EDI immediately to set your schedule for transition. Call 800-933-6593 or email edi.kmap@ksxix.hcg.eds.com to get started today!

Provider Action: Time is running out and problems continue to exist with ASK translation. PLEASE move quickly to the EDS free software or a vendor who is HIPAA compliant. See following location for further information: https://www.kmap-state-ks.us/Documents/EDI/ask-eds-march.pdf. Please continue to review the EDI site for future updates.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: General

Item Ref: GENP 1.2

Drafted: 2/29/2004

All	Issue:	Duplicate payments were made to providers instead of correctly denying subsequent submissions of duplicate claims.	System Corrected: 1/21/2004
	Impact:	Duplicate Medical and Outpatient claims paid to 1,716 providers.	
	Resolution:	Report will produce letters to providers notifying them of possible recoupments. Recoupments will take place 2 weeks following the mailing. (CO# 5211)	Clean-up: Pending

Message: Between 10/16/2003 and 2/2/2004, duplicate payments were made to providers as a result of a processing error. The error has been identified and permanently corrected. Initial letters sent to provider identifying suspended duplicate payments were incorrect. A date has not been established for generation of revised letters. Providers may request the overpayments be recouped by sending requests to EDS Adjustment Unit.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.5

Drafted: 2/29/2004

All	Issue:	New paper remittance advices (RAs) and HIPAA EOB codes are difficult for providers to understand.	
	Impact:	Providers have to perform web claim inquiries or contact either EDS or SRS for assistance on each denied claim. This is greatly impacting overall access to Customer Service.	
	Resolution:	Focus meetings held with providers in Topeka, Wichita and Hays in January. Interim solution is to revise HIPAA EOB code mapping to incorporate providers' suggestions. Interim solution implemented on RAs dated 2/12. Permanent solution includes redesigning the existing RAs based on provider suggestions for ease of posting, including the following: • Move suspended claims to end of RA and only list critical information such as ICN, patient account number, and date of service. • Print billing provider name in header on all pages. This change was moved into production on the 4/2/2004 RA. • Make several formatting changes, such as moving EOBs to end of line, include third party liability (TPL) amount as own field, and reordering amount fields. The TPL carrier is not printed on the RA message. HIPAA message codes do not have a code that allows for printing of TPL carrier.	

Message: In response to providers' concerns, EDS and SRS solicited input from the provider community on the paper RAs. EDS and SRS are incorporating provider feedback into new RAs that should be more conducive to the posting process. The first phase of this project was to incorporate provider suggestions to better map the HIPAA EOB codes to the Kansas local EOB codes. This was implemented with the 2/12/2004 RAs. We are currently working on the second phase of this project to produce drafts of reformatted RAs for provider input. Once the drafts are developed, we will notify providers through a global message. EDS and SRS have had several resources focused on the RA redevelopment project. Drafts have gone through several iterations and will be distributed to those providers who participated in the "RA Revamp Focus" meetings within the next few weeks. As feedback is received and plans are made for the implementation of the final RAs, we will forward advance communication and samples to the provider community prior to the first printing of the new RAs.

Provider Action: No action is needed. A system change was implemented on 4/2/2004 to print the provider name in the header on all pages. Providers can check the KMAP website for TPL carrier under Beneficiary Eligibility.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.9

Drafted: 2/29/2004

All	Issue:	Providers are not able to get weekly payment amounts or a readable RA from the KMAP website.	
	Impact:	Providers must call Customer Service for this information.	
	Resolution:	This functionality will be available in the future. Change Order 6655 will add a new web page called “Payment Inquiry” to the secure KMAP Website. Providers will be able to see payment information for the most recent payment cycle as well as search for previous payment amount using date ranges. Change Order 6657 will add a new web page called “Remittance Advice” to the secure KMAP website. Providers will be able to view and print images of their most recent hard copy RA as well as search for previous RAs using date ranges. Once implementation dates have been determined, providers will be notified through updates to this document and a global message.	

Message: Providers have expressed concerns that they are not able to see their weekly payment amounts on the KMAP website. This is an enhancement we are working on. However, until this is implemented, providers may access their weekly payment amount through the Automated Voice Response system without having to hold for Customer Service. Providers have also indicated a need to print a readable RA from the KMAP website. We are also working on this functionality and will notify providers once it is available.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.11

Drafted: 2/29/2004

All	Issue:	HealthConnect Kansas related claims are not processing as intended. ER claims, lab & radiology providers and ambulance to name a few are being reviewed to ensure they are paying appropriately.	System Corrected: 3/26/2004 Clean-up: Pending
	Impact:	Claims are denying when they should pay for some providers.	
	Resolution:	Exception 1050 (HealthConnect Kansas referral) is being reviewed and modified to ensure that the policy for HealthConnect Kansas referrals is being applied correctly. CO# 5270 set claims to suspend effective 3/8/04 and manually be worked. CO# 5324 moved to production on 3/26/04. All HealthConnect Kansas claims have been suspended so they can be manually worked to try to decrease the number of claims processed incorrectly.	

Message: EDS and SRS are aware that some claims that should not require a HealthConnect referral are currently denying inappropriately. Until a permanent solution is implemented claims are being suspended and worked manually. Once a permanent solution is identified, EDS will reprocess affected claims.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.12

Drafted: 2/29/2004

All	Issue:	Title XXI carve-outs are not paying appropriately. They are processing under the guidelines for Title XIX carve-outs.	
	Impact:	Some providers are not able to be paid and others are being paid for services that should deny to be billed to the MCO.	
	Resolution:	Exception 2017 is being modified to accurately reflect the carve-outs for Title XXI beneficiaries and claims will be reprocessed as a result. (Tied to policy E2004-005, CO# 6013, 6014, 6015, 6016).	

Message: EDS and SRS are aware that some services that should process as a carve-out to the TXXI program are inappropriately processing as a carve-out to TXIX. Consequently, some providers are not able to be paid and other providers are being paid for services that should deny to be billed to the MCO. A permanent solution has been identified and affected claims will be reprocessed once implemented.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.13

Drafted: 3/30/2004

All	Issue:	Claims are suspending or denying due to system calculated payment of $0.00. Many claims are also paying $0.00.	System Corrected: Research Ongoing Clean-up: Pending
	Impact:	Claims are hitting Edit 4200 and are not being paid correctly.	
	Resolution:	Claims are suspending, denying, or paying $0.00 due to system calculated payment of $0.00. The claims are hitting 4200 and are not paying correctly. Each issue is being researched individually to determine what is causing the claims to pay at a zero dollar amount. One of the main causes for edit 4200 posting is when the beneficiary is eligible for only a portion of the stay. CO 6344 was moved to production on 5/25/2004 to resolve the issue of a beneficiary being eligible for partial dates of service only. Affected claims with CO 6344 will be automatically adjusted by EDS. CO 6529 has been written by EDS to resolve the reason the remaining claims that are paying zero are occurring. Once the fix has been completed, EDS will notify providers. CO 5624 has been identified as being related to this issue. CO 6344 is completed. The clean up associated with this change order is scheduled for the end of July.	

Message: Claims are suspending, denying, or paying $0.00 due to system calculated payment of $0.00. The claims are hitting 4200 and are not paying correctly. Each issue is being researched individually to determine what is causing the claims to pay at a zero dollar amount. One of the main causes for edit 4200 posting is when the beneficiary is eligible for only a portion of the stay. CO 6344 was moved to production on 5/25/2004 to resolve the issue of a beneficiary being eligible for partial dates of service only. Affected claims with CO 6344 will be automatically adjusted by EDS. CO 6529 has been written by EDS to resolve the reason the remaining claims that are paying zero are occurring. Once the fix has been completed, EDS will notify providers.

Provider Action: No action is needed.

Revised: 7/28/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.14

Drafted: 4/6/2004

All	Issue:	Claims are denying for diagnosis not covered for benefit plan.	System Corrected: 5/7/2004 Clean-up: Pending
	Impact:	Claims are hitting Edits 4244, 4229, 4030, 4029, 4342, or 4362 (which are all related to diagnosis system issues) and are denying incorrectly.	
	Resolution:	Claims are denying due to diagnosis not covered for benefit plan in error. Providers will see the following exception related to these: 4244, 4229, 4030, 4029, 4342, and 4362. EDS identified a fix and is in the process of correcting the error. Once the system is resolved, EDS will notify providers. EDS will also identify claims denied in error and reprocess the claims after the issue is resolved. (CO 5656 and 6546)	

Message: Claims are denying due to diagnosis not covered for benefit plan in error. Providers will see the following exception related to these: 4244, 4229, 4030, 4029, 4342, and 4362. EDS identified a fix and is in the process of correcting the error. Once the system is resolved, EDS will notify providers. EDS will also identify claims denied in error and reprocess the claims after the issue is resolved.

Provider Action: No action is needed.

Revised: 7/23/2004

Item Ref: GENP 1.15

Drafted: 4/9/2004

CMHC	Issue:	When a provider opens an ICN which starts with a 55, the ICN changes to a 59 ICN. Provider cannot determine if a payment or recoupment has been made.	
	Impact:	Provider confusion occurs and they must contact EDS for actual outcome.	
	Resolution:	EDS is working on a solution. (COs 6264, 6265, and 7013)	

Message: To be written when research and resolution complete.

Provider Action: Contact EDS customer service until resolved if you have questions on payment.

Revised: 7/23/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.17

Drafted: 4/12/2004

Physician	Issue:	Claims are denying as duplicates for surgeon or assistant surgeon when one physician was already paid.	System Corrected: 6/24/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly. For instance, if the surgeon bills first, the assistant surgeon's claim with the "80" modifier will deny as duplicate to the surgeon's claim. If the assistant surgeon's claim with the "80" modifier pays first, the surgeon's claim will deny as duplicate to the assistant surgeon's claim.	
	Resolution:	The interim system issue was resolved on 6/24/2004. EDS is identifying the claims denied in error and will inform the provider when complete. EDS anticipates the claims to be reprocessed by the middle of August. (CO 6487 & 6793) Task order 6793 was written for a manual workaround until change order 6487 can be completed. All applicable audits have been identified and set to suspend for the manual workaround.	

Message: The interim system issue was resolved on 6/24/2004. EDS is identifying the claims denied in error and will inform the provider when complete. A permanent solution is being completed to automate the process.

Provider Action: No action is needed. Claims will be reprocessed for proper payment once issue is resolved.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.18

Drafted: 4/12/2004

All	Issue:	When voiding a claim on the Internet, providers are receiving a message that the void transaction failed. When adjusting a claim on the Internet, providers are receiving a message that the adjustment cannot be done and to contact the help desk.	
	Impact:	This is an intermittent issue and occurs on a very small percentage of claims that providers try to adjust or void. Providers cannot get claims voided automatically or to adjust claims through the web. They must submit a request to EDS to void or adjust the claim.	
	Resolution:	Issue is being coded by EDS to resolve the cause. (CO 6264/6265)	

Message: EDS will update this log when resolution is complete

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.20

Drafted: 4/15/2004

All	Issue:	Spenddown processing is confusing or inaccurate. This is occurring due to beneficiary files not updating correctly as well. This affects CMHCs, it appears, more than other providers as many of their beneficiaries have spenddown and rely on CMHC services.	System Corrected: 6/17/2004 Clean-up: Pending
	Impact:	Claims are not applying toward spenddown or providers do not understand the processing or messages coming back such as "TPL/spenddown amount cannot be more than allowed amount".	
	Resolution:	Redesigning of system and correction of reporting is in process. Updates will be posted when available. One issue that EDS is researching concerns procedure codes which CMS list as never allowed for an individual's spenddown. If they have QMB eligibility and it is Medicare covered, many claims that should count toward spenddown are not. EDS is reviewing the CMS tape received that indicates Medicare coverage. Results will be reviewed with SRS and file updates made as approved by SRS. The reference file was updated on 5/11/2004. EDS will identify and reprocess the claims and notify providers when completed. (COs 6465, 6627, and 6628)	

Message: Spenddown processing is confusing or inaccurate. This is occurring due to beneficiary files not updating correctly as well. This affects CMHCs, it appears, more than other providers as many of their beneficiaries have spenddown and rely on CMHC services. EDS will reprocess the claims and notify providers when this is completed.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.22

Drafted: 4/15/2004

All	Issue:	Reprocessing and mass adjustments are occurring and incorrectly resulting in recoupments.	
	Impact:	Cash flow problems are occurring for providers already impacted by system issues.	
	Resolution:	Rate changes, reprocessing to fix PCA codes, adjustments to increase payment on HCBS claims, and spenddown adjustments are impacted. These adjustments (which are causing recoupments) are impacting providers with cash flow issues already. SRS has placed adjustments on hold/review to evaluate the impact before they are done. EDS is implementing code to evaluate override for items processed prior to 10/16/2003. These overrides will allow claims to process for fields now needed such as admit diagnosis on inpatient claims. (CO 6904)	

Message: SRS will evaluate all mass adjustments before having them initiated. Emphasis will be placed on not running adjustments for provider communities still impacted by other issues.

Provider Action: If an overpayment has occurred, such as duplicate payments, these will not be recouped automatically at this time. If the provider wants recoupments initiated for balancing of their books, please submit the request on an individual basis and the recoupment will be completed.

Revised: 7/28/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.25

Drafted: 4/15/2004

All	Issue:	RA is not displaying $2.00 co-pay.	System Corrected: 4/21/2004 Clean-up: Pending
	Impact:	The claim is not being reduced by the $2.00 and claims are being overpaid.	
	Resolution:	The co-pay table that is used to identify which services and/or providers should have co-pay removed from claims did not include all provider types and specialties which should be included in co-pay deduction. The result is that Indian Health Clinics and clinic/maternity had co-pay deducted; and general practice doctors and rural health clinics did not have co-pay deducted. (Task 6203). EDS anticipates the adjustments for this issue will be created prior to the end of August.	

Message: The co-pay logic has been corrected to not take co-pay from clinic/maternity and Indian Health Clinics. The co-pay logic has been corrected to deduct co-pay from general practice doctors and rural health clinics. EDS will do a mass adjustment in the future.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

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 the issue is resolved.

Item Ref: GENP 1.35

Drafted: 4/27/2004

All Medicare Part A and Part B providers	Issue:	All Medicare claims are not crossing over to Medicaid.	System Corrected: 6/18/2004 Clean-up: Pending
	Impact:	Providers experience a delay in payment and/or expend resources to send claims on paper.	
	Resolution:	Medicare identified for Medicaid that the beneficiary eligibility file was not being processed by Medicare since 10/16/03. The only claims that were crossing to Medicare are claims with DOS prior to 11/1/03. Medicare has reported that they have updated their system with KMAP eligibility. Claims for 11/1/2003 will start crossing over. EDS will confirm claims are crossing over. Medicare will assess how to recover claims from 11/2003 – 5/2004 which were not sent to KMAP.	

Message: Medicare has reported that they have updated their system with KMAP eligibility. Claims for dates of service after 11/1/2003 will start crossing over. EDS will confirm claims are crossing over. Medicare will assess how to recover claims from 11/2003 – 5/2004 which were not sent to KMAP. Exciting news: The policy for electronic submission of Medicare crossover claims has changed. 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 837 HIPAA transaction submission. Your PES manual provides instructions on being able to complete this which is included below as well.

For your 837 transaction, please see your software support or vendor to determine where to place the information on the claim or refer to the HIPAA implementation guides, which can be downloaded from www.wpc-edi.com. You do not need to send the attachment for the Medicare crossover claim! This is to allow you a more provider friendly, hassle free approach. Don't wait for Medicare to do your claims processing. Start submitting claims via PES or the 837 transaction. To process correctly, please ensure to always include the Medicare paid amount, allowed amount, co-insurance, deductible, and finalized (i.e., paid/denied) date.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.36

Drafted: 4/27/04

Physician	Issue:	CPT code 81000 (urine analysis) is denying because it is bundled even when it is the only item billed on the claim.	System Corrected: 5/3/2004 Clean-up: Pending
	Impact:	Providers are potentially being underpaid.	
	Resolution:	Examples were received by EDS and the reference file was updated on 5/3/2004. Claims will need to be identified for reprocessing by EDS. (COs 6708 and 6493) The reprocessing of claims associated with CO 6493 was completed on 6/14/04. The reprocessing of claims associated with CO 6708 is tentatively scheduled for the middle of August.	

Message: CPT code 81000 (urine analysis) is denying because it is bundled even when it is the only item billed on the claim. Examples were received by EDS and the reference file was updated on 5/3/2004. Claims will need to be identified for reprocessing by EDS. Providers will be notified when this is complete.

Provider Action: Please submit examples of this issue occurring for research, if you are experiencing the issue.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.48

Drafted: 5/12/2004

Psychiatry	Issue:	Claims are denying for meeting the limitation audit for psychiatric services per month.	
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims are denying for exceeding the dollar limitation of $284 per month when they have not exceeded the amount. This limitation should count only if the performing provider type and specialty are 11/112 and the billing provider type and specialty are 08/183, 08/186, 11/111, 11/122, 11/124, or 28/282. This is not occurring. The system is being corrected to exclude billing provider types and specialties which are not included in this list. EDS will inform providers when corrected. In addition to this issue, EDS will review all limitation audits for psychiatric services to ensure that they are setting correctly. (CO 6365 / 6462) EDS is currently working on the design for the system fix. EDS is currently reviewing the policy with SRS concerning this limitation.	

Message: Claims are denying for exceeding the dollar limitation of $284 per month when they have not exceeded the amount. This limitation should count only if the performing provider type and specialty are 11/112 and the billing provider type and specialty are 08/183, 08/186, 11/111, 11/122, 11/124, or 28/282. This is not occurring. The system is being corrected to exclude billing provider types and specialties which are not included in this list. EDS will inform providers when corrected.

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: GENP 1.49

Drafted: 5/12/2004

Physician	Issue:	Claims are denying as content of service for items that should not deny.	
	Impact:	Claims are denying incorrectly.	
	Resolution:	Error code 5926 is posting in error and denying claims as being content of service. This edit posted when there were no other claims on history for the provider. It is very small in scope. EDS is working on a solution and will notify providers when complete. (CO 6334)	

Message: TBD

Provider Action: To be determined when final resolution is determine.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.50

Drafted: 5/12/2004

Physician	Issue:	Provider claims are being denied for billing of vaccines for children (90723).	
	Impact:	Claims are denying incorrectly.	
	Resolution:	Under the Vaccine's for Children program, a provider should be paid when billing the vaccine code (90723) and administration code (90471 or 90472) on the same claim. Claims should only be denied when the vaccine code and administration code are billed separately. The cause was identified and moved to production on 6/4/2004. (CO 6486 & 6830)	

Message: Claims are being denied when billing for vaccines for children (Procedure code 90723). One of the causes of these denials was identified and a system fix was moved into production on 6/4/2004. A second fix is being completed before reprocessing is done. Claims denied in error will be identified and reprocessed by EDS.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.51

Drafted: 6/3/2004

All	Issue:	Claims which paid prior to 10/16/03 are now denying when adjustments are made.	
	Impact:	Providers have funds recouped.	
	Resolution:	The new MMIS was implemented with changes to reflect policies and handle new HIPAA regulations. Claims that processed in the old system are now denying or zero paid. We are reviewing adjustment denials to determine how to auto plug fields and/or process claims without information not previously required. In some cases, the adjustments will remain denied as the original claim processed in error under the old MMIS. (CO 6583)	

Message: The new MMIS was implemented with changes to reflect policies and handle new HIPAA regulations. Claims that processed in the old system are denying or zero paid. We are reviewing adjustment denials to determine how to auto plug fields and/or process claims without information not previously required. In some cases, the adjustments will remain denied as the original claim processed in error under the old MMIS. EDS will keep providers updated through this log.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.55

Drafted: 6/3/2004

Lab	Issue:	Claims are denying for HCPCS code 88141 for provider type 31.	System Corrected: 5/11/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims were being denied for HCPCS code 88141 for provider type 31. SRS program manager approved this code to be covered by provider type 31. The change was made on 5/11/04. EDS will reprocess claims that denied prior to this time period and will inform providers when it is complete. (CO 6552).	

Message: Claims were being denied for HCPCS code 88141 for provider type 31. SRS program manager approved this code to be covered by provider type 31. The change was made on 5/11/04. EDS will be reprocessing claims that denied prior to this time period and will inform providers when it is complete.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.57

Drafted: 6/3/2004

All	Issue:	Claims denied for no medical necessity or documentation and the provider sent the attachment after marking the electronic claim as attachment to be sent.	System Corrected: 5/28/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims may have been denied in error awaiting the attachment for an electronic submitted claim. The process for implementing attachments for electronic claim was not fully implemented. This has been resolved and claims are now processing with the attachment when received within the time frame required. EDS will review prior claims and reprocess where needed for incorrect denials. EDS anticipates the reprocessing will be initiated by the end of August. (CO 6669)	

Message: This has been resolved and claims are now processing with the attachment when received within the time frame required. EDS will review prior claims and reprocess where needed for incorrect denials.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.58

Drafted: 6/3/2004

All	Issue:	Claims were denying for procedure code J0207.	System Corrected: 5/28/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	A provider submitted examples where claims were denied for CPT J0207. While small in scope, EDS resolved the issue and will also run a query to identify any additional claims that denied in error. EDS will reprocess erroneously denied claims and inform providers when complete. EDS anticipates this will be completed prior to the end of July. (TO 6678)	

Message: Claims were denying for procedure code J0207. A provider submitted examples where claims were denied for CPT J0207. While small in scope, EDS resolved the issue and will also run a query to identify any additional claims that denied in error. EDS will reprocess erroneously denied claims and inform providers when complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.60

Drafted: 6/9/2004

DME	Issue:	E1399 claims were paying zero.	System Corrected: 5/17/2004 Clean-up: Pending
	Impact:	Providers are being under paid.	
	Resolution:	E1399 claims are manually priced. Processors were not entering the allowed amount on claims which caused claims to pay at a zero allowed amount. Instructions to processors were re-emphasized and claims stop if posting zero allowed amount and cannot be forced now until resolved. This was completed on 5/17/2004. Some claims were reprocessed in June, but many still paid zero. This issue has been re-opened as another system fix is needed. Claims which were processed at zero dollars will be identified and providers will be notified when complete. (CO 6558)	

Message: E1399 claims are manually priced. Processors were not entering the allowed amount on claims which caused claims to pay at a zero allowed amount. Instructions to processors were re-emphasized and claims stop if posting zero allowed amount and cannot be forced now until resolved. This was completed on 5/17/2004. Some claims were reprocessed in June, but many still paid zero. This issue has been re-opened as another system fix is needed. Claims which were processed at zero dollars will be identified and providers will be notified when complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.61

Drafted: 6/9/2004

Local Health Departments	Issue:	Local health departments (LHD) are paying at the ARNP rate.	System Corrected: 6/15/2004 Clean-up: Pending
	Impact:	Providers are being under paid.	
	Resolution:	LHD providers are encountering a reduction in reimbursement. Instead of being reimbursed at the maximum allowable rate for MD/DO, they are being reimbursed at 75% of the maximum allowable rate for ARNP/PA rate. This is 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)	

Message: LHD providers are encountering a reduction in reimbursement. Instead of being reimbursed at the maximum allowable rate for MD/DO, they are being reimbursed at 75% of the maximum allowable rate for ARNP/PA rate. This is being resolved and providers will be notified when adjustment to claims are complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.62

Drafted: 6/9/2004

Lab	Issue:	Code 73560 TC is denying in error.	
	Impact:	Claims are denying incorrectly.	
	Resolution:	Procedure 73560 (radiology exam of the knee) is denying in error for no pricing segment on file. EDS has determined the issue and is in the process of resolving the problem. Providers will be notified when issue is resolved. (CO 6975)	

Message: Procedure 73560 (radiology exam of the knee) is denying in error for no pricing segment on file. EDS has determined the issue and are in the process of resolving the problem. Providers will be notified when issue is resolved.

Provider Action: No action is needed.

Revised: 7/16/2004

Item Ref: GENP 1.63

Drafted: 6/9/2004

Audiology	Issue:	Audiology claims are denying in error.	System Corrected: 6/24/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Claims are denying 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 for paid date on or after 10/16/2003. EDS is researching the issue and when the system is corrected, will notify providers when claims are reprocessed. EDS anticipates the claims denied in error will be resubmitted by the middle of August. (CO 6592)	

Message: Claims are denying 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 for paid date on or after 10/16/2003. EDS is researching the issue and when the system is corrected, will notify providers when claims are reprocessed.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.64

Drafted: 6/9/2004

Lab	Issue:	Lab codes 80000-89999 with modifier TC or 26 denying in error.	System Corrected: 6/1/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	Medical and outpatient claims for lab codes (80000-89999) with modifier 26 or TC denied in error. The system was updated on 6/1/04. EDS is identifying the claims and will notify providers when reprocessed. EDS anticipates claims denied in error will be resubmitted prior to the end of July. (CO 6687)	

Message: Medical and outpatient claims for lab codes (80000-89999) with modifier 26 or TC denied in error. The system was updated on 6/1/04. EDS is identifying the claims and will notify providers when reprocessed.

Provider Action: No action is needed.

Revised: 7/21/2004

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".	
	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).	

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 the issue is resolved.

Item Ref: GENP 1.66

Drafted: 6/28/2004

All	Issue:	Claims with prior authorization are denying in error when beneficiary is KBH and service is not normally covered.	
	Impact:	Providers are not being paid.	
	Resolution:	Claims are denying as not covered on date of service when a valid prior authorization is on file for the procedure. One example is claims are denied for sleep study when approved for a KBH eligible child. EDS has identified the issue and is working on a fix. When the fix is complete, the providers will be notified and EDS will reprocess claims after this. (CO 6070)	

Message: Claims are denying as not covered on date of service when a valid prior authorization is on file for the procedure. One example is claims are denied for sleep study when approved for a KBH eligible child. EDS has identified the issue and is working on a fix. When the fix is complete, the providers will be notified and EDS will reprocess claims after this.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.67

Drafted: 6/28/2004

All	Issue:	Claims are denying stating that medical necessity documentation is needed.	
	Impact:	Providers are receiving claim denials stating “diagnosis not payable with procedure” for claims that require clinical review of medical necessity attachments.	
	Resolution:	The interChange MMIS is being modified to allow claims that require clinical review to appropriately suspend for review prior to denying for “diagnosis not payable with procedure.” (CO 6363 & 6979)	

Message: Claims that require medical necessity documentation attachments are to suspend (for error code 4285) during processing for clinical review by EDS. When the required documentation is either missing or not found to support claim payment, the claim would appropriately deny for EOB 1295, 502, 509, 548 or 116. However, due to a processing issue, these claims have not suspended for clinical review but have erroneously denied for EOB 1200 (HIPAA reason code 11) stating "diagnosis not payable with procedure" (error code 4286). As an interim solution, EDS began suspending all claims that would deny for EOB 1200 for clinical review effective 7/14/2004. Claims submitted with appropriate documentation after the interim fix on 7/14/2004 will suspend for clinical review. EDS is gathering criteria to identify claims previously denied in error and will reprocess them in order for the claims to go through a clinical review for medical necessity. Please continue to check this document for updates related to the reprocessing.

Provider Action: No action is needed.

Revised: 7/16/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.68

Drafted: 6/28/2004

All	Issue:	Providers are getting denied claims for error code 550: "Manual deny for adjustment."	
	Impact:	Providers are not being paid.	
	Resolution:	Providers are receiving the message of "manual deny for adjustment in error". 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)	

Message: TBD

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: GENP 1.69

Drafted: 6/28/2004

All	Issue:	Claims are denying for provider type and specialty invalid on some claims which should not.	
	Impact:	Providers are not being paid.	
	Resolution:	Providers are receiving denials for provider type and specialty in error. This is not a denial in error on majority of claims but does appear on some claims. EDS is researching the cause and will notify providers when corrected. (CO 6113; CO 6754)	

Message: TBD

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.70

Drafted: 6/28/2004

All	Issue:	Some claims are denying in error for no surgeon ID on hysterectomy form.	
	Impact:	Providers are not being paid.	
	Resolution:	Providers are receiving denials with exception codes 4312 – No surgeon ID number on the claim. This is occurring when the system incorrectly sets the "attachment to use" indicator to "N". EDS is researching the fix to the issue and will notify providers when complete. This is a small percentage of denials for hysterectomies. Most denials are valid due to no hysterectomy form attached or on file; or invalid hysterectomy form. (CO 6856)	

Message: Providers are receiving denials with exception codes 4312 – No surgeon ID number on the claim. This is occurring when the system incorrectly sets the "attachment to use" indicator to "N". EDS is researching the fix to the issue and will notify providers when complete. This is a small percentage of denials for hysterectomies. Most denials are valid due to no hysterectomy form attached or on file; or invalid hysterectomy form.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.71

Drafted: 6/28/2004

All	Issue:	Claims are denying as non-covered Medicare service when Medicare paid the claim for the procedure code submitted to KMAP.	
	Impact:	Providers are 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 will be reviewed to identify the codes which should indicate Medicare Coverage is appropriate. Once completed and updated in the KMAP, the providers will be notified that the files have been updated. EDS will then reprocess the claims which denied in error. (CO 6627)	

Message: 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 will be reviewed to identify the codes which should indicate Medicare Coverage is appropriate. Once completed and updated in the KMAP, the providers will be notified that the files have been updated. EDS will then reprocess the claims which denied in error.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.72

Drafted: 6/28/2004

Lab	Issue:	CPT code 81000 is denying for invalid CLIA certificate.	
	Impact:	Providers are not being paid.	
	Resolution:	Claims with procedure code 81000 are denying for providers with a type 2 CLIA certificate. EDS is working on adding the type 2 CLIA certificate to the valid certificates for billing the 81000 CPT. An interim work around is for EDS to suspend and work the claims manually. Once permanent fix is in place, EDS will notify providers and reprocess any denied claims. (CO 6875)	

Message: Claims with procedure code 81000 are denying for providers with a type 2 CLIA certificate. EDS is working on adding the type 2 CLIA certificate to the valid certificates for billing the 81000 CPT. An interim work around is for EDS to suspend and work the claims manually. Once permanent fix is in place, EDS will notify providers and reprocess any denied claims.

Provider Action: No action is needed.

Revised: 7/9/2004

Item Ref: GENP 1.73

Drafted: 7/9/2004

All	Issue:	Claims with modifier 25 are denying after 1/1/2004 DOS.	System Corrected: 7/3/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Modifier 25 was end dated for 1/1/2004 with the new system. This should have been open end dated with 12/31/2299. This was corrected as of 7/3/2004. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete. EDS anticipates the claims will be reprocessed by the end of July. (CO 6920)	

Message: Modifier 25 was end dated for 1/1/2004 with the new system. This should have been open end dated with 12/31/2299. This was corrected as of 7/3/2004. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.74

Drafted: 7/11/2004

All	Issue:	Co-pay is appearing as $2.00 when Medicare paid more than the KMAP allowed amount.	
	Impact:	Providers do not know if they should be charging a co-pay.	
	Resolution:	The medical policy team and SRS program manager will be reviewing the policy to determine the instruction to give to providers.	

Message: TBD

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.75

Drafted: 7/9/2004

All	Issue:	Ultrasounds (a.k.a. sonograms) are denying in error for procedure to diagnosis code.	System Fixed: 7/12/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Procedure codes 76801-76828 that processed after 10/16/2003 were denying in error when billed with the following diagnosis codes: 65663, 65653, 64003, 6258, 6259, V288, V234, V284, 64083, V2349, 64883, 65973, V237, 65633, 65643, and 6262. Procedure codes 76830 and 76831 were never covered to pay with diagnosis codes 6258 or 6268. These have also been approved by SRS to be payable. All of these have all been set to either pay or pay with review as of 7/7/2004. 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)	

Message: Procedure codes 76801-76828 that processed after 10/16/2003 were denying in error when billed with the following diagnosis codes: 65663, 65653, 64003, 6258, 6259, V288, V234, V284, 64083, V2349, 64883, 65973, V237, 65633, 65643, 64090, 64093, and 6262. Procedure codes 76830 and 76831 were never covered to pay with diagnosis codes 6258 or 6268. These have also been approved by SRS to be payable. All of these have all been set to either pay or pay with review as of 7/12/2004. 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.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.76

Drafted: 7/9/2004

DME	Issue:	DME supplies are denying in error.	System Corrected: 7/1/04 Clean-up: Pending
	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 was fixed as of 7/1/2004. This affected claims after 4/1/2004 to the fix date. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete. EDS anticipates the claims will be reprocessed by the middle of August. (CO 6946)	

Message: 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 was fixed as of 7/8/2004. EDS will identify the claims denied in error, reprocess them, and contact the providers when complete.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.77

Drafted: 7/9/2004

Crossover claims	Issue:	Crossover claims are denying for the whole claim instead of just the detail which should deny.	System Corrected: 7/6/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Providers wee receiving an entire claim denial when one procedure code was loaded on the reference file as non-covered for QMB and the provider indicated a Medicare payment on the claim. This issue was resolved on 7/6/2004. Task order 6937 was documented to identify all claims that need to be reprocessed. (CO 6937)	

Message: Providers wee receiving an entire claim denial when one procedure code was loaded on the reference file as non-covered for QMB and the provider indicated a Medicare payment on the claim. This issue was resolved on 7/6/2004. Task order 6937 was documented to identify all claims that need to be reprocessed.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.78

Drafted: 7/11/2004

Crossover	Issue:	Claims are denying in error as content of service for procedure code G0156.	
	Impact:	Providers are not being paid.	
	Resolution:	Procedure code G0156 is denying against procedure code 99213 in error. The cause of the denial has been identified and a system fix is being coded. EDS will notify providers when corrected. After the system is corrected, EDS will identify claims denied in error and reprocess the claims. (CO 6938)	

Message: Procedure code G0156 is denying against procedure code 99213 in error. The cause of the denial has been identified and a system fix is being coded. EDS will notify providers when corrected. After the system is corrected, EDS will identify claims denied in error and reprocess the claims.

Provider Action: No action is needed.

Revised: 7/11/2004

Item Ref: GENP 1.79

Drafted: 7/11/2004

Crossover	Issue:	Claims are paying in error when they should be content of service for procedure code T1004.	
	Impact:	Providers are being over paid.	
	Resolution:	Procedure code T1004 is paying in error when they should be denied if billed on same day as S9131 GP. The cause of the payment has been identified and a system fix is being coded. EDS will notify providers when corrected. After the fix, EDS will identify claims paid in error and initiate recoupments after notifying providers of claims to be recouped. (CO 6938)	

Message: Procedure code T1004 is paying in error when they should be denied if billed on same day as S9131 GP. The cause of the payment has been identified and a system fix is being coded. EDS will notify providers when corrected. After the fix, EDS will identify claims paid in error and initiate recoupments after notifying providers of claims to be recouped.

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.80

Drafted: 7/11/2004

Optometry	Issue:	Claims for beneficiaries are paying when the beneficiary is over 20 years old and has had a previous claim paid for lenses and frames in the last four years.	
	Impact:	Providers are being overpaid.	
	Resolution:	Claims for beneficiaries are paying when the beneficiary is over 20 years old and has had a previous claim paid for lenses and frames in the last four years. Beneficiaries are allowed one set of frames and lenses every four years if they are over 20 years old. The cause of the payment has been identified and a system fix is being coded. EDS will notify providers when corrected. After the system is corrected, EDS will identify claims paid in error and initiate recoupments after notifying providers of claims to be recouped. (TO 6961)	

Message: Claims for beneficiaries are paying when the beneficiary is over 20 years old and has had a previous claim paid for lenses and frames in the last four years. Beneficiaries are allowed one set of frames and lenses every four years if they are over 20 years old. The cause of the payment has been identified and a system fix is being coded. EDS will notify providers when corrected. After the system is corrected, EDS will identify claims paid in error and initiate recoupments after notifying providers of claims to be recouped.

Provider Action: No action is needed.

Revised: 7/11/2004

Blue highlighted items have been previously closed as the issue is resolved.

Item Ref: GENP 1.81

Drafted: 7/20/2004

All	Issue:	Claims submitted for QMB beneficiaries are being denied in error for various reasons, including procedure invalid for provider type or specialty, procedure not covered for place of service, and provider not covered for beneficiary age.	System Corrected: Pending Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS has identified a system fix for this issue. The fix is in progress and providers will be notified when it is resolved. Once it is implemented, claims denied in error will be reprocessed. (CO 6898 and 6609).	

Message: Claims submitted for QMB beneficiaries are being denied in error for various reasons, including procedure invalid for provider type or specialty, procedure not covered for place of service, and procedure not covered for beneficiary age. EDS has identified a system fix for this issue. The fix is in progress and providers will be notified when it is resolved. Once it is implemented, claims denied in error will be reprocessed.

Provider Action: No action is needed.

Revised: 7/20/2004

Blue highlighted items have been previously closed as the issue is resolved.

KMAP Provider Communication

Provider Community: Optometry

Item Ref: OPT 1.2

Drafted: 4/27/2004

Optometry	Issue:	Procedure code V2201 is listed as a covered code for QMB beneficiaries. However, when a claim is billed with code V2201, it immediately denies as non-covered.	
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS is designing a resolution for this issue. Once it is implemented, the claims denied in error will be reprocessed. (CO 6609)	

Message: Code V2201 is listed as a covered code for QMB beneficiaries. However, when a claim is billed with code V2201, it immediately denies as non-covered. EDS is designing a resolution for this issue. Once it is implemented, the claims denied in error will be reprocessed.

Provider Action: No action is needed.

Revised: 7/9/2004