Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

KMAP Provider Communication

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

Also see GENP 1.2, 1.4, and 1.5

Item Ref: CHHC 1.15

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: 8/23/2004
	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) EDS completed reprocessing claims on 8/23/2004.	

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. EDS completed reprocessing claims on 8/23/2004.

Provider Action: No action is needed.

Revised: 8/27/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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. EDS anticipates the reprocessing of claims will be completed by the end of August.	

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. EDS anticipates the reprocessing of claims will be completed by the end of August.

Provider Action: No action is needed.

Revised: 8/6/2004

Item Ref: CHHC 1.24

Drafted: 6/9/2004

CMHC	Issue:	Positive behavioral support services are being denied after 32 hours are provided.	Policy Decision: Pending
	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: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 or patient liability is deducting twice.	
	Impact:	Providers are not being paid.	
	Resolution:	1. 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. (CO 6397) 2. Patient liability is being deducted twice when adjustments are involved. (CO 6933)	

Message: EDS has determined what the issues are and are in the process of making the system fix. Providers will be notified when the issues are resolved.

Provider Action: No action is needed.

Revised: 8/6/2004

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. The clean up has been postponed for State review. (CO 6463 & 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. The clean up has been postponed for State review.

Provider Action: No action is needed.

Revised: 8/27/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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: 8/12/2004

Item Ref: CHHC 1.31

Drafted: 7/26/2004

HCBS	Issue:	Home modifications are paying only $7,500 when a prior authorization/plan of care is approved for more.	System Corrected: 7/12/2004
	Impact:	Providers are being underpaid.	
	Resolution:	The system was fixed on 7/12/2004. EDS anticipates completing reprocessing of claims by the end of August. (CO 6981)	Clean-up: Pending

Message: Home modifications are paying only $7,500 when a prior authorization / plan of care is approved for more. The system was fixed on 7/12/04. EDS anticipates completing reprocessing of claims by the end of August.

Provider Action: No action is needed.

Revised: 8/13/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: CHHC 1.32

Drafted: 8/2/2004

HCBS	Issue:	Claims are denying for billable only every 55 days when it is the 55th day.	System Corrected: 8/12/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims are denying with exception 6027 for wellness monitoring which is covered every 55 days or more. The claims are denying on the 55th date or less when they should deny for 54th day or less. EDS has identified the issue and is in the processing of resolving it. Providers will be notified when fixed. Once fixed, EDS will identify claims denied in error and reprocess them. (CO 6250)	

Message: Claims are denying with exception 6027 for wellness monitoring which is covered every 55 days or more. The claims are denying on the 55th date or less when they should deny for 54th day or less. EDS has identified the issue and is in the processing of resolving it. Providers will be notified when fixed. Once fixed, EDS will identify claims denied in error and reprocess them.

Provider Action: No action is needed.

Revised: 8/16/2004

Item Ref: CHHC 1.33

Drafted: 8/2/2004

CMHC	Issue:	Copay for CMHC claims with procedure code 90847 was being removed.	System Corrected: 7/23/2004 Clean-up: Pending
	Impact:	Providers are being under paid.	
	Resolution:	Claims for procedure code 90847 (family psychotherapy) were deducting a $3.00 copay. This has been changed to not remove the copay from this procedure code. EDS will identify the claims underpaid and adjust them for the increased payment of the copay. Once complete, EDS will notify providers. (CO 7091)	

Message: Claims for procedure code 90847 (family psychotherapy) were deducting a $3.00 copay. This has been changed to not remove the copay from this procedure code. EDS will identify the claims underpaid and adjust them for the increased payment of the copay. Once complete, EDS will notify providers.

Provider Action: No action is needed.

Revised: 8/2/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: CHHC 1.34

Drafted: 8/2/2004

HCBS HI	Issue:	Claims were denying for only 936 units of rehabilitation therapy per calendar year.	System Corrected: 6/22/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims were denying for allowing no more than 936 units of rehabilitation therapy (exception 6242) per calendar year when 3744 units should be allowed per calendar year. This has been corrected by EDS on 6/22/2004. EDS will identify the claims denied in error and reprocess them. Once this is complete, providers will be notified. (CO 7092)	

Message: Claims were denying for allowing no more than 936 units of rehabilitation therapy (exception 6242) per calendar year when 3744 units should be allowed per calendar year. This has been corrected by EDS on 6/22/2004. EDS will identify the claims denied in error and reprocess them. Once this is complete, providers will be notified.

Provider Action: No action is needed.

Revised: 8/2/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	System Corrected: 7/28/2004 Clean-up: Pending
	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. The system was fixed on 7/28/2004. EDS will identify claims that were denied in error and reprocess them. (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. The system was fixed on 7/28/2004. EDS will identify claims that were denied in error and reprocess them.

Provider Action: No action is needed.

Revised: 8/6/2004

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 5636 & 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: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: DENT 1.11

Drafted: 7/26/2004

County Health Departments	Issue:	County Health Department dental claims are denying in error.	System Corrected: 7/12/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims were not being paid to the County Health Departments for dental services. The issue has been resolved. EDS will identify the claims and reprocess them. Once complete, the providers will be notified. (CO 7026)	

Message: Claims were not being paid to the County Health Departments for dental services. The issue has been resolved. EDS will identify the claims and reprocess them. Once complete, the providers will be notified.

Provider Action: No action is needed.

Revised: 7/26/2004

Item Ref: DENT 1.12

Drafted: 8/2/2004

Dentist	Issue:	Claims for D2920 (re-cement crown) for beneficiaries 0-20 paid in error.	System Corrected: 6/14/2004 Clean-up: Pending
	Impact:	Providers were overpaid.	
	Resolution:	Claims for D2920 should be paid without prior authorization for beneficiaries over 20 years of age only. Claims paid for 0-20 years of age. The issue was corrected on 6/14/2004. EDS will identify the claims paid in error and initiate recoupment if necessary after notifying provider. (CO 7083)	

Message: Claims for D2920 should be paid without prior authorization for beneficiaries over 20 years of age only. Claims paid for 0-20 years of age. The issue was corrected on 6/14/2004. EDS will identify the claims paid in error and initiate recoupment if necessary after notifying provider.

Provider Action: No action is required

Revised: 8/2/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

KMAP Provider Communication

Provider Community: Hospice

Item Ref: HSPC 1.1

Drafted: 8/11/2004

Hospice	Issue:	Beneficiaries with hospice coverage are having claims paid when no prior authorization is on file.	System Corrected: 7/19/2004 Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	Medical and outpatient claims are being paid for hospice beneficiaries who should not. There is no prior authorization on file for the service being rendered. This issue has been identified and was resolved on 7/19/2004. EDS will identify the claims impacted and initiate recoupments. EDS anticipates completing the clean up by the end of August. (CO 6279 & 6521)	

Message: Medical and outpatient claims are being paid for hospice beneficiaries who should not. There is no prior authorization on file for the service being rendered. This issue has been identified and was resolved on 7/19/2004. EDS will identify the claims impacted and initiate recoupments. EDS anticipates completing the clean up by the end of August.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

KMAP Provider Communication

Provider Community: Rural Health Clinics & FQHCs

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 September. (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 anticipates submitting adjustments for this issue before the end of September.

Provider Action: No action is needed.

Revised: 8/20/2004

Item Ref: RHC 1.6

Drafted: 7/26/2004

RHC / FQHC	Issue:	Claims are denying when billed with the information modifier TD. The denial is 4270 – invalid provider type and specialty.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims should not be using the TD modifier as a pricing modifier. EDS should pay these claims with the base code when the TD modifier is billed. EDS is working on the resolution and will notify providers when complete. Once fix is implemented, EDS will identify the claims denied in error and reprocess them. (CO 7001)	

Message: Claims should not be using the TD modifier as a pricing modifier. EDS should pay these claims with the base code when the TD modifier is billed. EDS is working on the resolution and will notify providers when complete. Once fix is implemented, EDS will identify the claims denied in error and reprocess them.

Provider Action: No action is needed.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

KMAP Provider Communication

Provider Community: Hospitals and Adult Care Home

Item Ref: HSPT 1.0

Drafted: 2/29/2004

Hospitals	Issue:	Claims are denying for swingbed services.	System Corrected: 3/10/2004 Clean-up: Pending
	Impact:	Affected facilities were not able to receive payment for swingbed services between 10/20 and 12/26/2003.	
	Resolution:	Permanent fix identified and implemented on 12/25/2003. 110 affected claims identified and recycled on 12/25/2003. Following this, additional reports showed that this did fix swingbed services filed as Interim Care claims. An existing issue is still ongoing for Inpatient Cross-over claims for swingbed services as of 1/30/2004. An issue of Medicare related swingbed claims was resolved on 5/1/2004. (CO 3704, 4803, 6276, 6591, & 7196 – Reprocessing is outstanding) CO 6276 also impacts State institutions and Adult Care Home pricing.	

Message: Since 10/16/2003, providers have encountered intermittent denials on swingbed claims. Although one fix was identified and corrected on 12/25/2003, additional work is being done to ensure future changes will permanently correct denials for "invalid type of bill" on claims filed with types of bill between 180 – 184. On the 2/19/2004 and 2/26/2004 RAs, providers may have seen denials for "Invalid type of bill" for non-swingbed related services that were billed using valid types of bill. This was also related to subsequent processing issues stemming from the swingbed denials. Affected non-swingbed claims were reprocessed within the same cycle the issue was identified and appeared on the 2/19/2004 and 2/26/2004 RAs. The issue of Medicare related swingbed claims billed with revenue code 120 denying or zero paying was resolved prior to 5/1/2004. Claims will be reprocessed and will include rate change, if applicable.

Provider Action: No action is needed.

Revised: 8/25/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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: 8/20/2004
	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. EDS completed the reprocessing of claims on 8/20/2004.	

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. EDS completed the reprocessing of claims on 8/20/2004.

Provider Action: No action needed by providers.

Revised: 8/27/2004

Item Ref: HSPT 1.11

Drafted: 3/2/2004

Hospital	Issue:	ER claims submitted with an ET modifier are denying stating "no pricing segment on file".	Resolved 1/29/2004
	Impact:	All ER claims submitted with an ET modifier are denying.	
	Resolution:	It has been reported without examples that this is still an issue. EDS will be looking for examples to validate if this issue is still present.	

Message: ER claims submitted with an ET modifier were denying for "no pricing segment on file" prior to the end of January, 2004. It has been reported without examples that this is still an issue. EDS will be looking for examples to validate if this issue is still present.

Provider Action: No action needed by providers.

Revised: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 by the end of September.	

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: 8/13/2004

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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: HSPT 1.18

Drafted: 3/2/2004

Hospital	Issue:	Delay in approvals on timely filing requests over 24 months old.	SRS: Pending
	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. SRS plans to be caught up by the end of September.	

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

Provider Action: No action is needed.

Revised: 8/20/2004

Item Ref: HSPT 1.19

Drafted: 3/2/2004

Hospital	Issue:	KMAP medical policy is different than Medicare's policy.	Policy Decision: Pending
	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: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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

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 end of September. (CO 6358 & 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: 8/13/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: HSPT 1.26

Drafted: 4/15/2004

Hospital	Issue:	Claims are denying with spontaneous miscarriage diagnosis codes or multi-parity diagnosis.	Policy Updated: 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: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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. • KFMC claims which denied with edit 400 (units of service must be greater than zero) need to be reprocessed as paid details. EDS will identify claims and reprocess detail as zero paid. (CO 7105) 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: 8/6/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: HSPT 1.30

Drafted: 4/27/2004

Hospital	Issue:	Inpatient claims that are being submitted online are asking for the from date on each detail line.	Enhancement: Pending
	Impact:	Providers are having to spend extra time to submit claims on the Internet.	
	Resolution:	The institutional claim screen on the Internet is used for both inpatient and outpatient claims. Therefore, the institutional claim screen has to edit regardless of claim type. Thus, the from date is a required field on all claims entry for detail lines to ensure providers do not submit outpatient claims without the from date of service. SRS/EDS will consider if this fail safe feature should be enhanced to recognize the difference between inpatient and outpatient as inpatient LTC also needs the from date. SRS has approved adding an enhancement to the system to recognize type of bill and require From Date of Service on outpatient claims only. A change order has been written and will be implemented once prioritized by SRS. (CO 7027)	

Message: Inpatient claims that are being submitted online are asking for the from date on each detail line. The institutional claim screen on the Internet is used for both inpatient and outpatient claims. Therefore, the institutional claim screen has to edit regardless of claim type. Thus, the from date is a required field on all claims entry for detail lines to ensure providers do not submit outpatient claims without the from date of service. SRS/EDS will consider if this fail safe feature should be enhanced to recognize the difference between inpatient and outpatient as inpatient LTC also needs the from date. SRS has approved adding an enhancement to the system to recognize type of bill and require From Date of Service on outpatient claims only. A change order has been written and will be implemented once prioritized by SRS.

Provider Action: To increase the speed of entering the from date, providers can use "hot" keys that most Microsoft based systems have. 1) Highlight the from date in the header. 2) Right click on mouse over the highlighted from date and click on copy, or hit "Ctrl" and "C" simultaneously to copy the From date. 3) Click on each detail line. 4) In detail line entry, place your cursor and either right click mouse and click on paste; or high "Ctrl" and "V" simultaneously to paste the From date. This process saves keying time.

Revised: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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

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 & 7236) Testing is complete. EDS anticipates updating the production system by the middle of September.	

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. Testing is complete. EDS anticipates updating the production system by the middle of September.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	Enhancement: Pending
	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: 6/16/2004

Item Ref: PHAR 1.6

Drafted: 2/29/2004

Pharmacy	Issue:	Providers are receiving a copay 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 copay 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 copay. 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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	System Corrected: 8/5/2004 Clean-up: Pending
	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) The age limitations on the audit criteria for audit 6306 was updated on 8/5/2004 so the audit would not set for beneficiaries under the age of 21. Claims denied in error will be identified and reprocessed.	

Message: TBD

Provider Action: No action is needed.

Revised: 8/13/2004

Item Ref: PHAR 1.12

Drafted: 7/11/2004

Internet Submitters	Issue:	Pharmacy claims cannot be entered on the Internet with certain fields.	Enhancement: Pending
	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: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: PHAR 1.13

Drafted: 7/26/2004

Pharmacy	Issue:	Pharmacists are unable to override some DUR edits when they should be able to do so.	Policy Updated: Pending Clean-up: Pending
	Impact:	Pharmacists are unable to override some prescriptions and dispense the pharmaceuticals at the correct billing practice.	
	Resolution:	Pharmacists will be able to use the override code 99. This code will be able to be used when the following exceptions occur: • Minimum and maximum units based on clinically appropriate dosing guidelines • Excessive utilization • Under utilization • Early/late refill • Billed product quantity is greater than the allowed estimated drug charge (150 less or more) EDS will notify providers when the override is available. (CO 5544)	

Message: Pharmacists will be able to use the override code 99. This code will be able to be used when the following exceptions occur:

- Minimum and maximum units based on clinically appropriate dosing guidelines
- Excessive utilization
- Under utilization
- Early/late refill
- Billed product quantity is greater than the allowed estimated drug charge (150 less or more)

EDS will notify providers when the override is available.

Provider Action: No action is needed.

Revised: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: PHAR 1.14

Drafted: 7/26/2004

Pharmacy	Issue:	Compound drugs are denying incorrectly when multiple eligibility segments are possible. This has occurred on a beneficiary who has ADAPD, MN, and QMB coverage.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are receiving denials and cannot dispense compound drugs.	
	Resolution:	Compound drugs will process so that each detail (NDC) within the compound will be considered under all possible combination of benefit plans. EDS is working on the system fix and will notify providers once implemented. Once implemented, EDS will identify claims that may have denied in error and reprocess once pharmacists are contacted to ensure drug was dispensed and payment is owed. (CO 6683)	

Message: Compound drugs will process so that each detail (NDC) within the compound will be considered under all possible combination of benefit plans. EDS is working on the system fix and will notify providers once implemented. Once implemented, EDS will identify claims that may have denied in error and reprocess once pharmacists are contacted to ensure drug was dispensed and payment is owed.

Provider Action: No action is needed.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: PHAR 1.15

Drafted: 8/2/2004

Pharmacy	Issue:	Some pharmacy claims are denying in error for compound drugs. Other drugs are not setting the audit.	
	Impact:	Providers are not being paid or providers are not dispensing the medication that is needed by beneficiaries. Beneficiaries are receiving over dosage limitation.	
	Resolution:	1. Error code 4313 has denied a claim when it was submitted with a decimal in the metric quantity field (i.e., 8.18) and the NDC supplied on the claim has a quantity supply limitation that is not outside the parameter for the drug. EDS is working to resolve the cause of the issue. It impacts a limited number of claims. When corrected, EDS will notify the providers. (CO 7059 & 7145) 2. The pharmacy/compound audit error codes should set when a beneficiary tries to receive excessive medication for items such as oral impotency pills. Issue was fixed on 3/3/2004. EDS is identifying claims for recoupment determination. (CO 5582)	

Message:

1. Error code 4313 has denied a claim when it was submitted with a decimal in the metric quantity field (i.e., 8.18) and the NDC supplied on the claim has a quantity supply limitation that is not outside the parameter for the drug. EDS is working to resolve the cause of the issue. It impacts a limited number of claims. When corrected, EDS will notify the providers.
2. The pharmacy/compound audit error codes should set when a beneficiary tries to receive excessive medication for items such as oral impotency pills. Issue was fixed on 3/3/2004. EDS is identifying claims for recoupment determination.

Provider Action: No action is needed.

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: PHAR 1.16

Drafted: 8/9/2004

Pharmacy	Issue:	Zanamivir and Osetamivir are being paid above the limitations set during October 1 to April 30 (flu season).	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	Pharmacy claims should set the following limits: • Limit Zanamivir inhalation to no more than 20 per flu season (10/1 – 4/30). This is non-covered when no flu season. • Limit Osetamivir oral suspension to no more than 75 ml per flu season. This is non-covered when not flu season. • Limit Osetamivir capsules to no more than 10 per flu season. This is non-covered when no flu season. This issue is being corrected by EDS and providers will be notified. Once corrected, EDS will identify the claims paid in error and will initiate recoupments. (CO 6225)	

Message:

Pharmacy claims should set the following limits:

- Limit Zanamivir inhalation to no more than 20 per flu season (10/1 – 4/30). This is non-covered when no flu season.
- Limit Osetamivir oral suspension to no more than 75 ml per flu season. This is non-covered when not flu season.
- Limit Osetamivir capsules to no more than 10 per flu season. This is non-covered when no flu season.

This issue is being corrected by EDS and providers will be notified. Once corrected, EDS will identify the claims paid in error and will initiate recoupments.

Provider Action: No action is needed.

Revised: 7/9/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 and various other payment issues.	System Corrected: 7/16/2004 Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	1. 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 5955 & 6106) 2. If a State Institution bills greater than the allowed amount, the system was paying the billed amount in error. This has been corrected as of 6/18/2004 to pay no more than the greater of the two. (CO 6276)	

Message:

1. 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 5955 & 6106)
2. If a State Institution bills greater than the allowed amount, the system was paying the billed amount in error. This has been corrected as of 6/18/2004 to pay no more than the greater of the two. (CO 6276)

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

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 and the 837 P, 270 and 271 translation maps need updating.	
	Impact:	1. 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. 2. Currently, the translation map outputs the value received in CLMO5-3 to both the cde_place_of_service and cde_pos, and ignores the value received in SV105. The map should only output the value received in CLM05-3 to the cde_pos if SV105 is not submitted. EDS is resolving this issue and will notify providers when complete. (CO 7074) 3. If a name with more than 50 characters is received, per HIPAA, which should only allow 35 characters and truncate remaining. Otherwise, the provider never receives a response. EDS is resolving this issue and will notify providers when complete. (CO 5789, 5793, 6429, & 7122)	
	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:

1. 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.
2. Currently, the translation map outputs the value received in CLMO5-3 to both the cde_place_of_service and cde_pos, and ignores the value received in SV105. The map should only output the value received in CLM05-3 to the cde_pos if SV105 is not submitted. EDS is resolving this issue and will notify providers when complete. (CO 7074)
3. If a name with more than 50 characters is received, per HIPAA, which should only allow 35 characters and truncate remaining. Otherwise, the provider never receives a response. EDS is resolving this issue and will notify providers when complete. (CO 7122)

Provider Action: No action is needed.

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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. (CO 6065)	

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: 8/12/2004

Item Ref: EDI 1.6

Drafted: 7/26/2004

Electronic 837	Issue:	Edit 2504 posts on claims with TPL, but no allowed amount is submitted and the carrier denied flag is set. This occurs on batch claims using the 837 transaction.	System Corrected: Pending Clean-up: Pending
	Impact:	Provider must bill carrier denied claims on paper or via the Internet.	
	Resolution:	Providers will be allowed to bill TPL claims with no allowed amount when the carrier denied flag is set. Once the resolution is implemented, EDS will notify providers. For any claims denied and not resubmitted, EDS will identify them and reprocess. (CO 6716)	

Message: Providers will be allowed to bill TPL claims with no allowed amount when the carrier denied flag is set. Once the resolution is implemented, EDS will notify providers. For any claims denied and not resubmitted, EDS will identify them and reprocess.

Provider Action: Submit carrier denied claims on paper or Internet. Do not submit on batch 837 transaction until system resolution is implemented.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

KMAP Provider Communication

Provider Community: General

Item Ref: GENP 1.1

Drafted: 2/29/2004

All (Except Pharmacy)	Issue:	Claims with detail lines spanning dates of services and for more than 1 unit are being reduced to only 1 unit.	System Corrected: 2/19/2004 Clean-up: Pending
	Impact:	Claims are not paying the full amount due to providers.	
	Resolution:	Temporary workaround of billing separate days on separate details was communicated to providers on 12/22 and 12/31. EDS mass-adjusted affected claims for providers. Edit 637 has been shut off. Changes have been made on daily limitation audits. Everything has been recycled. Claims are being identified and EDS will notify providers when reprocessing is complete. (CO# 5227)	

Message: Claims with detail lines spanning multiple dates of services and for more than 1 unit were reduced to only 1 unit between 10/16/2003 and 2/20/2004. This limitation was permanently fixed on 2/19/2004 and affected claims reprocessed. Claims are being identified and EDS will notify providers when reprocessing is complete.

Provider Action: No action needed by providers.

Revised: 8/12/2004

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 Clean-up: Pending
	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 4432 & 5211) EDS anticipates completing the recoupments by the end of September.	

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. EDS anticipates completing the recoupments by the end of September.

Provider Action: No action is needed.

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.3

Drafted: 2/29/2004

All	Issue:	Claims paying zero dollars when Medicare is involved but should have produced KMAP payment.	System Corrected: 2/20/2004 Clean-up: Pending
	Impact:	All providers submitting claims reporting Medicare denials are receiving $0.00 payments due to the MMIS incorrectly processing the Medicare paid amount as $0.00.	
	Resolution:	Permanent fix identified and in production as of 1/28/2004. (CO 4719, 5272, 5443, 5487, & 6438) CO 4719, which allows for medical necessity to be bypassed, has had claims reprocessed and will appear on the 8/26/2004 RA.	

Message: All providers submitting claims that include Medicare denials are receiving $0.00 payments due to a processing error associated with the interChange MMIS Medicare algorithm. This issue has been identified and permanently fixed. In order for the system to recognize that Medicare denied payment on an electronically submitted claim, the Medicare payment amount should be submitted as zero and the Medicare paid date should have a valid date.

Provider Action: No action needed by provider.

Revised: 8/23/2004

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.	Enhancement: Pending
	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. Feedback on the draft RAs have been received from providers. Finalization for design is occurring. EDS will notify providers when complete and it will be implemented.

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: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	Enhancement: Pending
	Impact:	Providers must call Customer Service for this information.	
	Resolution:	This functionality will be available in the future. Change Order 6655 has been written to 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 has been written to 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. (CO 6655 & 6657)	

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: 8/12/2004

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: 8/20/2004
	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. Claims affected by CO 5270 for HealthConnect referral even though diagnosis is emergent, have been reprocessed and will appear on the 8/26/2004 RA. 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. EDS completed reprocessing of claims on 8/20/2004.	

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. EDS completed reprocessing of claims on 8/20/2004.

Provider Action: No action is needed.

Revised: 8/27/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	Policy Update: Pending
	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: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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:	1. 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. EDS has identified the cause and will notify providers when resolved. (CO 5624 & 6501) One of the main causes for edit 4200 posting is when the beneficiary is eligible for only a portion of the stay. 2. A system issue had been identified which caused claims to pay at $0.00 or be overpaid. Claims were paying for office visits that occurred within 21 days after the surgery. Office visits are normally considered content of service to the surgery. The claims affected will start being reprocessed with the RA date of 8/26/2004. Please be aware that office visits that have surgery within 21 days will create a recoupment ICN (region 52) with the message, "Denied. Exceeds program limitation. Office/Hospital visits are considered content of service up to 21 days after minor surgery." (CO 6344)	

Message:

1. 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. EDS has identified the cause and will notify providers when resolved. One of the main causes for edit 4200 posting is when the beneficiary is eligible for only a portion of the stay.
2. A system issue had been identified which caused claims to pay at $0.00 or be overpaid. Claims were paying for office visits that occurred within 21 days after the surgery. Office visits are normally considered content of service to the surgery. The claims affected will start being reprocessed with the RA date of 8/26/2004. Please be aware that office visits that have surgery within 21 days will create a recoupment ICN (region 52) with the message, "Denied. Exceeds program limitation. Office/Hospital visits are considered content of service up to 21 days after minor surgery."

Provider Action: No action is needed.

Revised: 8/23/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.14

Drafted: 4/6/2004

All	Issue:	Claims are denying for diagnosis for miscellaneous reasons, 1. Not covered for benefit plan; 2. Diagnosis to sex is conflicting; 3. Primary or secondary diagnosis code is non-emergent.	System Corrected: Pending 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:	1. 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, 6975, and 6546) The claims for CO 5656 and 6546 have been reprocessed. 2. If the diagnosis and sex are not conflicting, exception 4031 should not deny the claim. This is being resolved by EDS who will notify providers when complete. (CO 5929) 3. For emergency room claims to pay, the primary OR the secondary diagnosis code needs to be emergent. Both codes do not need to be emergent. One of the codes can be non-emergent. Claims are denying when either the primary or secondary diagnosis code on an emergency room claim is non-emergent. EDS is working on a system resolution and will notify providers when complete. Once complete, EDS will identify claims denied in error and reprocess the claims. (CO 7070)	

Message:

1. 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. The claims for CO 5656 and 6546 have been reprocessed.
2. If the diagnosis and sex are not conflicting, exception 4031 should not deny the claim. This is being resolved by EDS who will notify providers when complete.
3. For emergency room claims to pay, the primary OR the secondary diagnosis code needs to be emergent. Both codes do not need to be emergent. One of the codes can be non-emergent. Claims are denying when either the primary or secondary diagnosis code on an emergency room claim is non-emergent. EDS is working on a system resolution and will notify providers when complete. Once complete, EDS will identify claims denied in error and reprocess the claims.

Provider Action: No action is needed.

Revised: 8/23/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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)	

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

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. Claims are also denying for multiple surgeries in some instances.	System Corrected: Pending 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:	1. 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. 2. Multi-surgery audit 5017 is posting in error and denying claims. EDS has identified the issue and is in the process of resolution. Providers will be notified when complete. (CO 6793, 7126 & 7127) 3. Claims are paying incorrectly and allowing office visit claims to pay within 21 days of surgery. This was resolved on 6/10/2004. EDS will identify the claims and notify providers when reprocessed. (CO 6344)	

Message:

1. 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.
2. Multi-surgery audit 5017 is posting in error and denying claims. EDS has identified the issue and is in the process of resolution. Providers will be notified when complete.
3. Claims are paying incorrectly and allowing office visit claims to pay within 21 days of surgery. This was resolved on 6/10/2004. EDS will identify the claims and notify providers when reprocessed.

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

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.18

Drafted: 4/12/2004

All	Issue:	Various Internet updates are needed.	
	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:	1. 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. 2. Between October 16, 2003 and July 30, 2004, provider may have filed claims without a corresponding diagnosis pointer on the detail line. Claims that were identified as paid during this time without the diagnosis pointer were appropriately recouped on the 8/19/2004 remittance advice. To assist the provider community, we are reviewing affected claims this week and will resubmit any claims that did not contain a diagnosis pointer on the detail line with a default value of one. These claims are scheduled to appear on provider's 8/26/2004 remittance advice. If providers filed claims with invalid values (value other than 1, 2, 3, or 4), we will not be able to correct the claims on behalf of the provider. In these cases, providers will need to correct the claims and resubmit them. (CO 6575 & 6711)	

Message:

1. 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.
2. Between October 16, 2003 and July 30, 2004, provider may have filed claims without a corresponding diagnosis pointer on the detail line. Claims that were identified as paid during this time without the diagnosis pointer were appropriately recouped on the 8/19/2004 remittance advice. To assist the provider community, we are reviewing affected claims this week and will resubmit any claims that did not contain a diagnosis pointer on the detail line with a default value of one. These claims are scheduled to appear on provider's 8/26/2004 remittance advice. If providers filed claims with invalid values (value other than 1, 2, 3, or 4), we will not be able to correct the claims on behalf of the provider. In these cases, providers will need to correct the claims and resubmit them.

Provider Action: Providers must enter diagnosis cross-reference on detail when using Internet submission.

Revised: 8/23/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	Enhancement Completed: 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 5421, 6465, 6627, and 6628) EDS anticipates reprocessing the claims the first week of September.	

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. EDS anticipates reprocessing the claims the first week of September.

Provider Action: No action is needed.

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.25

Drafted: 4/15/2004

All	Issue:	RA is not displaying $2.00 copay.	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 copay table that is used to identify which services and/or providers should have copay removed from claims did not include all provider types and specialties which should be included in copay deduction. The result is that Indian Health Clinics and clinic/maternity had copay deducted; and general practice doctors and rural health clinics did not have copay deducted. (Task 6203). EDS anticipates the adjustments for this issue will be created prior to the end of August.	

Message: The copay logic has been corrected to not take copay from clinic/maternity and Indian Health Clinics. The copay logic has been corrected to deduct copay 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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 have started crossing over. Medicare will assess how to recover Medicare Part A claims from 11/2003 – 5/2004 which were not sent to KMAP. All Medicare Part B claims have been recovered.	

Message: Medicare has reported that they have updated their system with KMAP eligibility. Claims for dates of service after 11/1/2003 have started crossing over. Medicare will assess how to recover Medicare Part A claims from 11/2003 – 5/2004 which were not sent to KMAP. All Medicare Part B claims have been recovered. 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. If Medicare Part B claims are not on KMAP, resend to KMAP as Medicare reports all recovery by them is complete.

Revised: 8/16/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.43

Drafted: 5/4/2004

Hospital and Physicians	Issue:	EKG claims were denying in error.	System Corrected: 2/1/2004
	Impact:	Claims are being underpaid.	
	Resolution:	Exceptions 4285 and 4286 were denying EKG claims in error. The system was updated to allow for proper payment of the EKG claims on 2/10/2004. EDS is verifying all reprocessing is complete. (CO 5606)	Clean-up: Pending

Message: EKG claims were denying in error. The system was corrected on 2/10/04 to allow claims to process to payment appropriately. EDS reprocessed the claims by 4/30/2004. EDS is verifying all reprocessing is complete.

Provider Action: No action needed at this time.

Revised: 8/12/2004

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 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

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.49

Drafted: 5/12/2004

Physician	Issue:	Claims are denying as content of service for items that should not deny. This includes wellness visits against skilled nursing services.	System Corrected: 6/4/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	1. Procedure code 76856 that denied claims in error (CO 6922) have been reprocessed and will appear on the 8/26/2004 RA. (CO 6854) 2. Skilled nursing services v. wellness monitoring (i.e. office visits) were denying in error. This was corrected on 6/4/2004 for exception 5511 and the following procedure codes: S5190, G0154, S9529, S9800, S9802, T1001, T1002, T1003, W1357, W1359, Y2504, Y2514, and 99213. Claims were reprocessed on 8/20/2004. (CO 6714)	

Message:

1. Procedure code 76856 that denied claims in error (CO 6922) have been reprocessed and will appear on the 8/26/2004 RA.
2. Skilled nursing services v. wellness monitoring (i.e. office visits) were denying in error. This was corrected on 6/4/2004 for exception 5511 and the following procedure codes: S5190, G0154, S9529, S9800, S9802, T1001, T1002, T1003, W1357, W1359, Y2504, Y2514, and 99213. Claims were reprocessed on 8/20/2004.

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

Revised: 8/27/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.50

Drafted: 5/12/2004

Physician	Issue:	Provider claims are being denied for billing of vaccines for children (90723).	System Corrected: 6/4/2004 Clean-up: Pending
	Impact:	Claims are denying incorrectly.	
	Resolution:	1. 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 & 6878) Claims that denied or paid in error related to the implementation of Pediatrix coverage (CO 6878) have been reprocessed and will appear on the 8/26/2004 RA. 2. Some VFC are covered for beneficiaries who are 19 years of age and older. Reimbursement has been incorrect in some cases; thus, this caused over and/or underpayment. The issue is being resolved through a policy. Providers will be notified when complete. (CO 5084)	

Message: Claims are being denied when billing for vaccines for children (Procedure code 90723).

1. 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. Claims that denied or paid in error related to the implementation of Pediatrix coverage (CO 6878) have been reprocessed and will appear on the 8/26/2004 RA.
2. Some VFC are covered for beneficiaries who are 19 years of age and older. Reimbursement has been incorrect in some cases; thus, this caused over and/or underpayment. The issue is being resolved through a policy. Providers will be notified when complete.

Provider Action: No action is needed.

Revised: 8/23/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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:	1. 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, 6904, 7181, & 7183) 2. Providers are receiving the message of "manual deny for adjustment in error". EDS is correcting the issue. EDS will inform the providers when the issue is resolved. This is being seen predominantly on Hospice claims. (CO 6387) 3. Exception 5019 set in error on adjustments. This has been resolved. EDS will identify the claims and reprocess them. (CO 7158)	

Message:

1. 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.
2. Providers are receiving the message of "manual deny for adjustment in error". EDS is correcting the issue. EDS will inform the providers when the issue is resolved. This is being seen predominantly on Hospice claims.
3. Exception 5019 set in error on adjustments. This has been resolved. EDS will identify the claims and reprocess them.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 anticipates completing the clean up by the end of September. (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: 8/13/2004

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 first of September. (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: 8/13/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.60

Drafted: 6/9/2004

DME	Issue:	E1399 claims were paying zero.	System Corrected: Pending 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 6557 & 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: 8/12/2004

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) EDS is currently testing the system fix.	

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. EDS is currently testing the system fix.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.63

Drafted: 6/9/2004

Audiology	Issue:	Audiology claims are denying in error.	System Corrected: 6/24/2004 Clean-up: 8/20/2004
	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 completed reprocessing the claims denied in error on 8/20/2004. (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 fixed the system on 6/24/2004 and completed reprocessing the claims on 8/20/2004.

Provider Action: No action is needed.

Revised: 7/21/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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. Claims are denying for 11056, 11055, 11200, and 11201 per prior policy.	Policy Updated: 8/5/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	1. 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 & 6540) CO 6399 for claims with "price by PA" have been reprocessed and will appear on the 8/26/2004 RA. 2. Claims have required prior authorization for 11055, 11056, 11200, and 11201. SRS revisited the policy and removed the prior authorization requirement as of 8/5/2004. Claims denied will be identified and reprocessed. EDS will notify providers when complete. (CO 7133)	

Message:

1. 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 6399 for claims with "price by PA" have been reprocessed and will appear on the 8/26/2004 RA.
2. Claims have required prior authorization for 11055, 11056, 11200, and 11201. SRS revisited the policy and removed the prior authorization requirement as of 8/5/2004. Claims denied will be identified and reprocessed. EDS will notify providers when complete. (CO 7133)

Provider Action: No action is needed.

Revised: 8/23/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.67

Drafted: 6/28/2004

All	Issue:	Claims are denying stating that medical necessity documentation is needed.	System Corrected: 7/14/2004 Clean-up: Pending
	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) Claims were submitted reprocessing on 8/13/2004 for CO 6363. CO 6979 is still pending clean up.	

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: 8/23/2004

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:	1. Providers are receiving denials for provider type and specialty in error (exception 4270). 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; 6313, 6667, & 6754) 2. Audits will also be enabled to allow the capability to set up limitation and contra auditing by billing provider, provider type, and provider specialty. (CO 7056 & 7057)	

Message:

1. Providers are receiving denials for provider type and specialty in error (exception 4270). 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.
2. Audits will also be enabled to allow the capability to set up limitation and contra auditing by billing provider, provider type, and provider specialty.

Provider Action: No action is needed.

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.70

Drafted: 6/28/2004

All	Issue:	Miscellaneous sterilization and family planning issues including denials are occurring.	
	Impact:	Providers are being underpaid.	
	Resolution:	1. A small number of claims are denying for beneficiaries who are over 21 years of age when the claim has sterilization procedures. If the proper sterilization form is attached, this should not occur. EDS is working on a resolution and will notify providers when complete. Only nine claims have been identified with this issue. (CO 7075) 2. Provider claims were denying when the surgeon's date of signature was greater than 30 days from the surgery date. SRS reviewed this policy and it is inappropriate. Federal regulations do not dictate a time frame for signature after the surgery; it only requires the surgeon's signature for no more than 3 days before surgery. Due to the complexity and tedious work involved in identifying denials for this specific reason, EDS will need a number of months to review each claim. If the provider's claim denied for surgeon's signature and the only issue with the claim is date of signature, they can call customer service to reprocess their claim now instead of waiting for the reprocessing effort. (CO 7192) 3. Providers who are billing family planning related ICD-9 codes are receiving denials. The V723 (gynecologic examination) should be payable and allow 3 interim family planning visits per year (exception 6166) is posting incorrectly. EDS is working on a resolution and will notify providers when complete. (CO 6903 & 7209) CO 7207 for invalid posting of exception 6166 was corrected on 8/20/2004. 4. 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) 5. More than 1 initial family planning and/or annual family planning service has been paid for same date of service. The issue has been resolved on 8/16/2004. EDS will identify the claims and initiate recoupments. Codes impacted are 50610 and 50612 when billed together, or with one of the following codes: 99211, 99212, 99213, and 99214. (CO 7182) 6. SRS has provided instructions on reprocessing denied claims if appropriate based on claim form. EDS will notify providers when complete. (CO 7192)	

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.70, Continued

Message:

1. A small number of claims are denying for beneficiaries who are over 21 years of age when the claim has sterilization procedures. If the proper sterilization form is attached, this should not occur. EDS is working on a resolution and will notify providers when complete. Only nine claims have been identified with this issue.
2. Provider claims were denying when the surgeon's date of signature was greater than 30 days from the surgery date. SRS reviewed this policy and it is inappropriate. Federal regulations do not dictate a time frame for signature after the surgery; it only requires the surgeon's signature for no more than 3 days before surgery. Due to the complexity and tedious work involved in identifying denials for this specific reason, EDS will need a number of months to review each claim. If the provider's claim denied for surgeon's signature and the only issue with the claim is date of signature, they can call customer service to reprocess their claim now instead of waiting for the reprocessing effort.
3. Providers who are billing family planning related ICD-9 codes are receiving denials. The V723 (gynecologic examination) should be payable and allow 3 interim family planning visits per year (exception 6166) is posting incorrectly. EDS is working on a resolution and will notify providers when complete. CO 7207 for invalid posting of exception 6166 was corrected on 8/20/2004.
4. 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.
5. More than 1 initial family planning and/or annual family planning service has been paid for same date of service. The issue has been resolved on 8/16/2004. EDS will identify the claims and initiate recoupments. Codes impacted are 50610 and 50612 when billed together, or with one of the following codes: 99211, 99212, 99213, and 99214. (CO 7182)
6. SRS has provided instructions on reprocessing denied claims if appropriate based on claim form. EDS will notify providers when complete.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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 1.74

Drafted: 7/11/2004

All	Issue:	Copay 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 copay.	
	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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.76

Drafted: 7/9/2004

DME	Issue:	DME supplies are denying in error.	System Corrected: 7/1/04 Clean-up: 8/20/2004
	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 identified the claims denied in error, reprocessed them, and they will appear on the 8/26/2004 RA. (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 7/1/2004. This affected claims after 4/1/2004 to the fix date. EDS identified the claims denied in error, reprocessed them, and they will appear on the 8/26/2004 RA.

Provider Action: No action is needed.

Revised: 8/27/2004

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. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.78

Drafted: 7/11/2004

Crossover	Issue:	Claims are denying in error as content of service for procedure code G0156.	Policy Updated: 7/20/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Procedure code G0156 is denying against procedure code 99213. The cause of the denial has been identified and a system fix is being coded. EDS will notify providers when corrected. EDS is identifying claims denied and will reprocess them. (CO 6938)	

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

Provider Action: No action is needed.

Revised: 8/16/2004

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.	System Corrected: 7/20/2004 Clean-up: Pending
	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: 7/29/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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

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. EDS is currently testing the modifications. (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: 7/29/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.82

Drafted: 7/11/2004

ALL	Issue:	Copay is currently not deducted from claims when the emergency indicator on the diagnosis code is "Y" in the system.	Policy Update: Pending
	Impact:	SRS is spending more funds than potentially necessary.	
	Resolution:	Copay is currently not deducted from claims when the emergency indicator on the diagnosis code is "Y" in the system. The copay logic will be changed to exempt beneficiaries, who normally are eligible for copay, to have copay 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 copay; 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) Copay is being deducted from newborn claims when the mother's beneficiary ID is used. The copay logic looks at emergency diagnosis codes only and not newborn diagnosis codes to exclude copay from applying. The policy is being reviewed to determine if newborn diagnosis codes can be used. In the meantime, the system will continue to deduct copay if the provider uses the mother's beneficiary ID.	

Message: Copay is currently not deducted from claims when the emergency indicator on the diagnosis code is "Y" in the system. The copay logic will be changed to exempt beneficiaries, who normally are eligible for copay, to have copay 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 copay; 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.

Copay is being deducted from newborn claims when the mother's beneficiary ID is used. The copay logic looks at emergency diagnosis codes only and not newborn diagnosis codes to exclude copay from applying. The policy is being reviewed to determine if newborn diagnosis codes can be used. In the meantime, the system will continue to deduct copay if the provider uses the mother's beneficiary ID.

Provider Action: No action is needed.

Revised: 8/23/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.84

Drafted: 7/26/2004

ALL	Issue:	Professional claims that have a group number in the performing provider field are paying in error.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	Professional claims that have a group number in the performing provider field should not pay. Edit 1008 should post to deny the claims. A system fix has been identified and is being implemented. Providers will be notified when fixed. EDS will initiate recoupments once fix is complete and will notify providers of claims impacted before initiating the recoupments. (CO 7016)	

Message: Provider type 11 with all provider specialties are taking co-pay from procedure code 90847 inappropriately. The system fix has been identified. When corrected, EDS will notify providers and reprocess the claims.

Provider Action: No action is needed.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.85

Drafted: 7/26/2004

ALL	Issue:	Claims are denying with QMB and MN eligibility with a spenddown deductible applied (explanation of benefit 9922) to the claim.	System Corrected: Pending Clean-up: Pending
	Impact:	Confusion is caused to the provider because the claim denies correctly, but the EOB 9922 posts to the claim in error. The provider sees this on the remittance advice and expects that they must recover the full amount of the claim from the beneficiary. The claim should instead be resubmitted with corrections.	
	Resolution:	To ensure that claims that deny for spenddown are the only claims which post the EOB 9922, a system fix has been identified and is being coded. EDS will notify providers when corrected. (CO 7019)	

Message: Confusion is caused to the provider because the claim denies correctly but the EOB 9922 post to the claim in error. The provider sees this on the remittance advice and expects that they must recover the full amount of the claim from the beneficiary. The claim should instead be resubmitted with corrections. The correction of the claim would be based on the other exceptions which failed on the claim. For instance, if the provider received a message that performing provider number is invalid, then this would be the correction made by the provider. A system fix is being coded to ensure that claims that deny for spenddown are the only claims which post the EOB 9922. EDS will notify providers when corrected.

Provider Action: If no amount is received in the spenddown / TPL applied field, then the provider can contact customer service to ensure that the 9922 message was posted in error.

Revised: 7/26/2004

Item Ref: GENP 1.86

Drafted: 7/26/2004

Medicare Crossover Claims	Issue:	Claims that are crossed over from Medicare to EDS are being denied for no Medicare paid date.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Starting 7/1/2004, claims are denying for no Medicare paid date which crossed over from Medicare to EDS. EDS is working to identify what is causing the issue and will notify providers when corrected. Once corrected, EDS will reprocess the claims that denied in error. (CO 7041)	

Message: Starting 7/1/2004, claims are denying for no Medicare paid date which crossed over from Medicare to EDS. EDS is working to identify what is causing the issue and will notify providers when corrected. Once corrected, EDS will reprocess the claims that denied in error.

Provider Action: No action is needed.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.87

Drafted: 7/26/2004

SOBRA Spenddown Claims	Issue:	SOBRA claims are not properly processing against the spenddown logic.	Policy Update: Pending Clean-up: Pending
	Impact:	SOBRA claims are not applying to spenddown and providers may be overpaid and the beneficiary spenddown record may not be decremented.	
	Resolution:	The current SOBRA eligibility does not always provide for spenddown processing. With the implementation of the change, the logic will allow SOBRA claims to be paid using either spenddown logic or non-spenddown logic. EDS will notify providers when implemented. Once implemented, EDS will identify claims which had SOBRA and medically needy (i.e. spenddown) eligibility and reprocess them. (CO 6577)	

Message: The current SOBRA eligibility does not always provide for spenddown processing. With the implementation of the change, the logic will allow SOBRA claims to be paid using either spenddown logic or non-spenddown logic. EDS will notify providers when implemented. Once implemented, EDS will identify claims which had SOBRA and medically needy (i.e. spenddown) eligibility and reprocess them.

Provider Action: No action is needed.

Revised: 8/16/2004

Item Ref: GENP 1.88

Drafted: 7/26/2004

ALL	Issue:	Claims are denying when correct qualifier codes exist on the claim.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims are posting edit 457 when correct qualifier codes (i.e., BR and BQ) are on the claim and are used for each ICD-9 code present on the claim. EDS is resolving this issue and will notify providers when complete. (CO 6704)	

Message: Claims are posting edit 457 when correct qualifier codes (i.e., BR and BQ) are on the claim and are used for each ICD-9 code present on the claim. EDS is resolving this issue and will notify providers when complete.

Provider Action: No action is needed.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.89

Drafted: 7/26/2004

ALL	Issue:	Claim adjustments are processing and not decreasing the prior authorization so subsequent claims will not pay in error. Claims are also paying in error instead of requiring PA.	System Corrected: 7/29/2004 Clean-up: Pending
	Impact:	Providers are not being paid or are being overpaid depending on the circumstance.	
	Resolution:	1. When claims process and hit the 3021 prior authorization exception and a prior authorization is on file, the claim should pay and decrease the prior authorization by the appropriate units. This should also be credited when an adjustment occurs which does not allow the next claim to pay. The system was corrected on 7/29/2004. EDS will identify the claims which need to be reprocess and will reprocess them. (CO 5978, 6292, & 6706) 2. Claims with procedure codes Y9105 and 90816 are paying for some benefit plans. EDS has identified issues and will notify providers when corrected. (CO 6520)	

Message:

1. When claims process and hit the 3021 prior authorization exception and a prior authorization is on file, the claim should pay and decrease the prior authorization by the appropriate units. This should also be credited when an adjustment occurs which does not allow the next claim to pay. The system was corrected on 7/29/2004. EDS will identify the claims which need to be reprocess and will reprocess them.
2. Claims with procedure codes Y9105 and 90816 are paying for some benefit plans. EDS has identified issues and will notify providers when corrected.

Provider Action: No action is needed.

Revised: 8/12/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.90

Drafted: 7/26/2004

ALL	Issue:	Claims are denying as part of bundling when processing of other lines occur after the bundling process and denial is caused.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	A claim detail is denied as part of bundling when the other line with which it bundled denied. Since bundling occurs before duplicate, limitations, and contra indication audits), a detail is denied for bundling and then the limitation audit denies as well. For example, if procedure codes 11721 and 11056 are billed on the same claim, 11721 denies as content of service (i.e., bundling) to procedure 11056. Then, procedure 11056 goes through the prior authorization process and denies. If the denial of 11056 had occurred first, 11721 would not have denied as content of service. EDS is coding a change to the system to resolve the issue. Once complete, EDS will notify providers. (CO 6854)	

Message: A claim detail is denied as part of bundling when the other line with which it bundled denied. Since bundling occurs before duplicate, limitations, and contra indication audits), a detail is denied for bundling and then the limitation audit denies as well. For example, if procedure codes 11721 and 11056 are billed on the same claim, 11721 denies as content of service (i.e., bundling) to procedure 11056. Then, procedure 11056 goes through the prior authorization process and denies. If the denial of 11056 had occurred first, 11721 would not have denied as content of service. EDS is coding a change to the system to resolve the issue. Once complete, EDS will notify providers.

Provider Action: No action is needed until system fix is implemented.

Revised: 7/26/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.91

Drafted: 7/26/2004

ALL	Issue:	Claims are paying when another claim has already paid for the same procedure code, same performing provider, same dates of service, and same beneficiary.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	Claims should not pay when another claim exist in a paid status for the same procedure code, same performing provider, same dates of service, and same beneficiary. EDS is working on the resolution and will notify providers when completed. Once complete, EDS will initiate recoupments and notify providers prior to the recoupments to assist in planning of cash flow. (CO 6995)	

Message: Claims should not pay when another claim exist in a paid status for the same procedure code, same performing provider, same dates of service, and same beneficiary. EDS is working on the resolution and will notify providers when completed. Once complete, EDS will initiate recoupments and notify providers prior to the recoupments to assist in planning of cash flow.

Provider Action: No action is needed.

Revised: 8/13/2004

Item Ref: GENP 1.92

Drafted: 8/2/2004

DME	Issue:	Claims for E0439 RR and E1391 RR denied in error for bill to Medicare first.	System Corrected: 6/4/2004 Clean-up: Pending
	Impact:	Providers claims not being paid.	
	Resolution:	Claims for E0439 RR and E1291 RR denied in error for bill to Medicare first. This occurred for claims with DOS on or after 1/1/2004. EDS has corrected the issues. The claims denied in error will be identified and reprocessed by EDS. Providers will be notified when reprocessing is complete. (CO 7085)	

Message: Claims for E0439 RR and E1291 RR denied in error to bill to Medicare first. This occurred for claims with DOS on or after 1/1/2004. EDS has corrected the issues. The claims denied in error will be identified and reprocessed by EDS. Providers will be notified when reprocessing is complete.

Provider Action: No action is needed

Revised: 8/2/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.93

Drafted: 8/2/2004

All	Issue:	Physician claims were denying against laboratory claims in error and vice versa.	System Corrected: 7/1/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Physician claims and laboratory claims were denying against each other as both exceptions 5583 and 5584 were failing at the same time on a claim detail. This issue has been resolved by EDS. The claims denied in error will be identified and reprocessed. Once this is complete, providers will be notified. (CO 7088)	

Message: Physician claims and laboratory claims were denying against each other as both exceptions 5583 and 5584 were failing at the same time on a claim detail. This issue has been resolved by EDS. The claims denied in error will be identified and reprocessed. Once this is complete, providers will be notified.

Provider Action: No action is needed.

Revised: 8/2/2004

Item Ref: GENP 1.94

Drafted: 8/2/2004

All	Issue:	Claims for procedure code 92567 are denying in error.	System Corrected: 7/16/2004 Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Claims for procedure code 92567 when billed by the following provider type / provider specialty combinations were denying in error: 08/080 and 08/081. Also for beneficiaries between the ages of 0-3, provider types and provider specialties of the following were denying: 08/183 and 08/186. This was corrected by EDS on 7/16/2004. EDS will identify the claims denied in error and notify providers when reprocessing is complete. (CO 7089)	

Message: Claims for procedure code 92567 when billed by the following provider type / provider specialty combinations were denying in error: 08/080 and 08/081. Also for beneficiaries between the ages of 0-3, provider types and provider specialties of the following were denying: 08/183 and 08/186. This was corrected by EDS on 7/16/2004. EDS will identify the claims denied in error and notify providers when reprocessing is complete.

Provider Action: No action is needed.

Revised: 8/2/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.95

Drafted: 8/2/2004

All	Issue:	Kan Be Healthy (KBH) screenings are not being updated with services provided by FirstGuard network providers.	System Corrected: 5/20/2004 Clean-up: 8/5/2004
	Impact:	Providers are not being paid for services which require KBH on file.	
	Resolution:	1. FirstGuard encounter claims from September 2003 to the present are not being transmitted to EDS. As a result, information is not being updated, KAN Be Healthy (KBH) screenings for example, with claims information submitted to FirstGuard. This causes claims to deny which require KBH screens to be current for FirstGuard or some codes such as sleep studies for KMAP. FirstGuard completed sending claims up to September 2003 to EDS. They will continue to send the remaining historical months. Once completed, EDS will notify providers. 2. Additional non-encounter claims are not updating KBH which may have caused denials. This was fixed on 5/20/2004. (CO 5284)	

Message:

1. FirstGuard encounter claims from September 2003 to the present are not being transmitted to EDS. As a result, information is not being updated, KAN Be Healthy (KBH) screenings for example, with claims information submitted to FirstGuard. This causes claims to deny which require KBH screens to be current for FirstGuard or some codes such as sleep studies for KMAP. FirstGuard completed sending claims up to September 2003 to EDS. They will continue to send the remaining historical months. Once completed, EDS will notify providers.
2. Additional non-encounter claims are not updating KBH which may have caused denials. This was fixed on 5/20/2004.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.96

Drafted: 8/2/2004

All	Issue:	Copay is being deducted from claims provided by exempt providers, such as ARNPs, when it should not be.	
	Impact:	Providers are being underpaid and potentially overpaid.	
	Resolution:	Claims logic is reviewing only the billing provider number instead of the billing and performing provider numbers to determine if copay should be applied. The performing provider number should be used in addition to the billing. Thus, some claims have copay deducted which should not have copay deducted. For example, an ARNP provider, who is exempt from copay, is having a copay deducted when billing claims where a physician group provider number appears as the billing provider. EDS is working on a resolution to this issue and will notify providers when complete. Once complete, EDS will identify claims impacted and reprocess to pay the additional $3.00 or recoup the $3.00 depending upon the performing provider. (CO 7119)	

Message: Claims logic is reviewing only the billing provider number instead of the billing and performing provider numbers to determine if copay should be applied. The performing provider number should be used in addition to the billing. Thus, some claims have copay deducted which should not have copay deducted. For example, an ARNP provider, who is exempt from copay, is having a copay deducted when billing claims where a physician group provider number appears as the billing provider. EDS is working on a resolution to this issue and will notify providers when complete. Once complete, EDS will identify claims impacted and reprocess to pay the additional $3.00 or recoup the $3.00 depending upon the performing provider.

Provider Action: No action is needed.

Revised: 8/2/2004

Item Ref: GENP 1.97

Drafted: 8/9/2004

All	Issue:	Claims are denying T1001 to allow for one nursing evaluation per lifetime inappropriately.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are not being paid.	
	Resolution:	Audit 6253 (allow one nursing evaluation per lifetime) is posting inappropriately on procedure code T1001. This affects provider type 13 with specialty 131. EDS is working on resolving this issue and will notify providers when complete. Once complete, EDS will identify claims denied in error and will reprocess them. (CO 7130)	

Message: Audit 6253 (allow one nursing evaluation per lifetime) is posting inappropriately on procedure code T1001. This affects provider type 13 with specialty 131. EDS is working on resolving this issue and will notify providers when complete. Once complete, EDS will identify claims denied in error and will reprocess them.

Provider Action: No action is needed.

Revised: 8/9/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.98

Drafted: 8/9/2004

All	Issue:	Out-of-state providers are being paid when not on border cities in error and are not being paid correctly when on border cities.	System Corrected: Pending Clean-up: Pending
	Impact:	Overpayments and underpayments are occurring for providers.	
	Resolution:	Border city providers are not being paid the correct peer group rates. Providers who are not border cities are getting paid at times when they should not. EDS is in the process of correcting the issue and will notify providers when complete. (CO 7069)	

Message: Border city providers are not being paid the correct peer group rates. Providers who are not border cities are getting paid at times when they should not. EDS is in the process of correcting the issue and will notify providers when complete.

Provider Action: No action is needed.

Revised: 8/9/2004

Item Ref: GENP 1.99

Drafted: 8/9/2004

Physician	Issue:	Providers are getting paid for KAN Be Healthy (KBH) medical screen and E&M code on same date of service.	System Corrected: 8/10/2004 Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	Claims are not posting for denials of E&M code when a KAN Be Healthy (KBH medical screen is conducted on the same date of service for the same provider. The system has been corrected. EDS will identify the overpaid claims and initiate recoupments. (CO 6325)	

Message: Claims are not posting for denials of E&M code when a KAN Be Healthy (KBH medical screen is conducted on the same date of service for the same provider. The system has been corrected. EDS will identify the overpaid claims and initiate recoupments.

Provider Action: No action is needed.

Revised: 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.100

Drafted: 8/9/2004

ALL	Issue:	S0612 and S0160 are paying 100% of allowed amount instead of the 90% FFP and 10% certified match.	System Corrected: Pending Clean-up: Pending
	Impact:	Providers are being overpaid.	
	Resolution:	1. S0610 and S0612 are paying 100% instead of the 90% FFP and 10% state certified match. Other procedure codes being impacted by FFP issues are the following: Y9514, Y9569, Y9570, 90804, 90806, and 90808. EDS is working on resolving the issue and will notify providers when complete. Once complete, EDS will identify the overpaid claims and adjust them for recoupment of the overpaid amount. (CO 5315, 6831) 2. FFP rate was processing on process date and not date of service. This was resolved on 8/11/2004. EDS will identify the claims, reprocess, and notify providers when complete. (CO 7163)	

Message:

1. S0610 and S0612 are paying 100% instead of the 90% FFP and 10% state certified match. Other procedure codes being impacted by FFP issues are the following: Y9514, Y9569, Y9570, 90804, 90806, and 90808. EDS is working on resolving the issue and will notify providers when complete. Once complete, EDS will identify the overpaid claims and adjust them for recoupment of the overpaid amount.
2. FFP rate was processing on process date and not date of service. This was resolved on 8/11/2004. EDS will identify the claims, reprocess, and notify providers when complete.

Provider Action: No action is needed.

Revised: 7/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.101

Drafted: 8/11/2004

All including CMHC	Issue:	The history file used in claims processing for limitation audits and duplicate history was not being updated correctly. The performing provider field was being updated with the billing provider number.	System Corrected: 7/29/2004 Clean-up: Pending
	Impact:	Providers could have been potentially underpaid or overpaid.	
	Resolution:	The history file used in claims processing for limitation audits and duplicate history was not being updated correctly. The performing provider field was being updated with the billing provider number. When limitation audits or duplicate history was performed claims would not set limitation audits correctly that use the performing provider field. This issue was resolved on 7/29/2004. On August 11, 2004, letters have been sent to providers who may have been potentially over paid. The recoupment process will start on or after 8/26/2004. The reprocessed claims for erroneous denials will occur at the same time. EDS will notify providers when complete. (CO 6995, 6996, & 7191)	

Message: The history file used in claims processing for limitation audits and duplicate history was not being updated correctly. The performing provider field was being updated with the billing provider number. When limitation audits or duplicate history was performed claims would not set limitation audits correctly that use the performing provider field. This issue was resolved on 7/29/2004. On August 11, 2004, letters have been sent to providers who may have been potentially over paid. The recoupment process will start on or after 8/26/2004. The reprocessed claims for erroneous denials will occur at the same time. EDS will notify providers when complete.

Provider Action: No action is needed.

Revised 8/20/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.102

Drafted: 8/11/2004

All	Issue:	Claims are denying for or cutting back erroneously when single unit pricing indicators are on procedures or disposition with full fail and paid status. This is causing claims to deny in error.	System Corrected: 6/10/2004 Clean-up: Pending
	Impact:	Providers are being under paid.	
	Resolution:	1. Claims that price with a single unit indicator are not cutting back allowed units correctly for the details. The allowed amount is reducing but the billed units are not. This is causing the final pricing to divide the allowed amount in half and pay the providers approximately half of what should be paid. This issue was resolved on 6/10/2004. (CO 6542 & 7175) Clean up was completed on 8/13/2004. 2. Audits that are set up for full fail with a paid status are cutting back the claim. For example, one claim set audit 6053 with a paid status and cutback the claim to 1 unit. The claim is not paying at the correct amount. This issue was resolved on 6/4/2004. (CO 6532) EDS anticipates completing the clean up by the first of September. EDS will be identifying the claims that have been underpaid and will reprocess them. Once complete, the providers will be notified.	

Message:

1. Claims that price with a single unit indicator are not cutting back allowed units correctly for the details. The allowed amount is reducing but the billed units are not. This is causing the final pricing to divide the allowed amount in half and pay the providers approximately half of what should be paid. This issue was resolved on 6/10/2004. Clean up was completed on 8/13/2004.
2. Audits that are set up for full fail with a paid status are cutting back the claim. For example, one claim set audit 6053 with a paid status and cutback the claim to 1 unit. The claim is not paying at the correct amount. This issue was resolved on 6/4/2004. EDS anticipates completing the clean up by the first of September.

EDS will be identifying the claims that have been underpaid and will reprocess them. Once complete, the providers will be notified.

Provider Action: No action is needed.

Revised: 8/11/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

Item Ref: GENP 1.103

Drafted: 8/11/2004

Indian Health Services	Issue:	More than one encounter is being paid for the same beneficiary with more than one procedure on the same date of service.	System Corrected: 8/6/2004 Clean-up: Pending
	Impact:	Providers are being over paid.	
	Resolution:	More than one encounter is being paid for the same beneficiary with more than one procedure on the same date of service. This affected alpha procedure codes which were not captured on the encounter logic for Indian Health Services. The issue was corrected on 8/6/2004. EDS will identify the claims over paid and initiate a recoupment. The providers will be notified when this occurs. (CO 7159)	

Message: More than one encounter is being paid for the same beneficiary with more than one procedure on the same date of service. This affected alpha procedure codes which were not captured on the encounter logic for Indian Health Services. The issue was corrected on 8/6/2004. EDS will identify the claims over paid and initiate a recoupment. The providers will be notified when this occurs.

Provider Action: No action is needed.

Revised: 8/11/2004

Blue highlighted items have been previously closed as the issue is resolved. Closed items are moved to the "Closed Provider Claims Issue List" after one week and can be found on the "Bulletins" page as well.

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.	System Corrected: 8/17/2004
	Impact:	Claims are denying incorrectly.	
	Resolution:	EDS is testing a resolution for this issue. Once it is implemented, the claims denied in error will be reprocessed. (CO 6609)	Clean-up: Pending

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 testing a resolution for this issue. Once it is implemented, the claims denied in error will be reprocessed.

Provider Action: No action is needed.

Revised: 8/20/2004