KMAP Provider Communication

Provider Community: CDDO, HCBS, Home Health, and CMHC (*Also see GENP 1.2, 1.4, and 1.5)*

Item Reference CHHC 1.15

Date Drafted 4/15/2004

Date Revised 9/8/2004

Groups Affected CMHC

Issue Claims are being denied 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.

Impact Claims are being denied for no Prior Authorization (PA) on file for the second Plan of Care on file with the same base procedure code.

Resolution This system was corrected on 6/4/2004 to determine the modifiers for the Plans of Care. EDS anticipates completing the reprocessing of claims by the beginning of October. (CO 6324)

Provider Action No action is needed.

System Corrected: 6/4/2004

Cleanup: Pending

Item Reference CHHC 1.22

Date Drafted 6/9/2004

Date Revised 9/17/2004

Groups Affected HCBS

Issue Procedure codes T1016 and T1019 are being denied in error.

Impact Claims are being denied incorrectly.

Resolution

1. Claims with procedure code T1016 were being denied in error. (CO 6054) Claims were reprocessing but some claims were not corrected. EDS is identifying the additional claims to be reprocessed and will notify providers when complete. EDS anticipates claims reprocessing will be completed by the end of August.
2. Claims for T1019 are being resolved with a system correction. Providers will be notified when corrected. (CO 7271)

Provider Action No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	CHHC 1.24
Date Drafted	6/9/2004
Date Revised	8/16/2004
Groups Affected	CMHC
Issue	Positive behavioral support services are being denied after 32 hours of service are provided.
Impact	Providers perceive their claims are being denied in error.
Resolution	The Kansas state plan as approved by the federal government allows the state to pay 32 total hours for adults and 40 total hours for children for all psychiatric therapy. These totals accumulatively apply to all therapy, which includes individual, family, and group, from any provider. The prior system allowed claims to pay at 32/40 hours for each therapy type (i.e., 32 hours for individual, 32 hours for family, and 32 hours for group). The new system pays according to the state plan. SRS is researching options to determine if they can adjust the state plan to higher limits. This issue 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.

Policy Decision: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	CHHC 1.26
Date Drafted	6/28/2004
Date Revised	9/17/2004
Groups Affected	HCBS FE
Issue	Edit 1078, patient obligation distribution does not balance, is causing some claims to be denied in error, and patient liability is being deducted twice.
Impact	Providers are not being paid.
Resolution	1. Providers are receiving denials for "patient obligation distribution does not balance" when the plan of care appears to be accurate. This denial is caused in error when the dates entered on a plan of care are for less than a full month. The system should recognize a prorated month. The system was corrected on 9/10/2004. EDS will identify the claims and reprocess. Providers will be contacted when complete. (CO 6397) 2. Patient liability was being deducted twice when adjustments are involved. EDS identified the problems and is making the corrections. Providers will be notified when resolved. (CO 6933)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	CHHC 1.28
Date Drafted	7/9/2004
Date Revised	8/27/2004
Groups Affected	CMHC
Issue	Claims are being denied for KAN Be Healthy (KBH) beneficiaries in excess of 32 hours of psychotherapy.
Impact	Providers are not being paid.
Resolution	Claims were being denied after 32 hours for KBH beneficiaries who are allowed 40 hours of psychotherapy. The system was changed on 7/1/2004 to remove the edit for 32 hours of psychotherapy if the beneficiary is 20 years old or younger. EDS will identify and reprocess the claims that were denied in error and contact the providers when completed. (CO 6463 & 6902) The cleanup process has been postponed for State review.
Provider Action	No action is needed.

System Corrected: 7/1/04

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	CHHC 1.30
Date Drafted	7/11/2004
Date Revised	9/17/2004
Groups Affected	HCBS FE
Issue	Claims are being denied 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 are paid up to the maximum allowed on the first line item found, and then are denied on subsequent claims, resulting in the subsequent plan of care line items not being processed. EDS has identified and is in the process of resolving the issue. Upon completion, EDS will identify and reprocess the claims denied in error. EDS will notify providers when completed. (CO 6339 & 6964)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	CHHC 1.32
Date Drafted	8/2/2004
Date Revised	8/16/2004
Groups Affected	HCBS
Issue	Claims are being denied for "billable only every 55 days" on the 55th day.
Impact	Providers are not being paid.
Resolution	Claims were being denied with exception code 6027 for wellness monitoring, which is covered every 55 days or more. The claims were being denied on the 55th day or less when they should be denied for the 54th day or less. EDS has identified and is resolving the issue. Once corrected, EDS will identify and reprocess the claims that were denied in error. Providers will be notified when corrected. (CO 6250)
Provider Action	No action is needed.

System Corrected: 8/12/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	CHHC 1.33
Date Drafted	8/2/2004
Date Revised	8/2/2004
Groups Affected	CMHC
Issue	The co-pay amount for CMHC claims with procedure code 90847 is being removed.
Impact	Providers are being underpaid.
Resolution	Claims for procedure code 90847 (family psychotherapy) were deducting a $3 co-pay amount. The system was changed to not deduct the co-pay for this procedure code. EDS will identify and adjust the underpaid claims to include the $3 co-pay amount. Upon completion, EDS will notify providers. (CO 7091)
Provider Action	No action is needed.

System Corrected: 7/23/2004

Cleanup: Pending

Item Reference	CHHC 1.34
Date Drafted	8/2/2004
Date Revised	8/2/2004
Groups Affected	HCBS HI
Issue	Claims are being denied for only 936 units of rehabilitation therapy per calendar year.
Impact	Providers are not being paid.
Resolution	Claims were being denied for not allowing more than 936 units of rehabilitation therapy (exception code 6242) per calendar year when 3,744 units should be allowed per calendar year. EDS corrected this issue on 6/22/2004. EDS will identify and reprocess the claims that were denied in error. Providers will be notified upon completion. (CO 7092)
Provider Action	No action is needed.

System Corrected: 6/22/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	CHHC 1.35
Date Drafted	9/13/2004
Date Revised	9/17/2004
Groups Affected	HCBS SED
Issue	Claims are being denied for HCBS SED benefit plan with exception 2504 (bill other insurance).
Impact	Claims are being denied incorrectly.
Resolution	Edit 2504 is denying claims for HCBS SED beneficiaries and instructing the providers to bill other insurance. This issue was identified and the system is being corrected. Providers will be notified when the correction is implemented. Once implemented, EDS will identify and reprocess the claims denied in error. (CO 7256)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	CHHC 1.36
Date Drafted	9/13/2004
Date Revised	9/17004
Groups Affected	CMHC
Issue	H2010 and 99070 are paying at a reduced rate.
Impact	Providers are being underpaid.
Resolution	The H2010 and 99070 procedure codes are being reduced incorrectly for payment. The amount per unit is being reduced below the KMAP per unit allowed amount. This issue was identified and EDS is correcting the system. Providers will be notified when the correction is implemented. Once implemented, EDS will identify and reprocess the claims denied in error. (CO 7272)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Dental

Item Reference	DENT 1.10
Date Drafted	7/9/2004
Date Revised	9/14/2004
Groups Affected	Dentist
Issue	Dental claims are being denied as duplicate claims when different tooth numbers are involved.
Impact	Providers are not being paid.
Resolution	Dental claims were being denied as exact duplicate claims when multiple lines for the same date of service (DOS) were billed with different tooth numbers. These dental claims should post as a suspect duplicate claim and suspend for manual review of different tooth numbers. EDS corrected this issue on 9/10/2004. EDS will identify and reprocess the claims denied in error. (CO 5636 & 6943)
Provider Action	To avoid the claim denying as a duplicate claim, dental providers may bill the procedure with a 76 modifier to indicate the procedure is not a duplicate.

System Corrected: 9/10/2004

Cleanup: Pending

Item Reference	DENT 1.11
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	County Health Departments
Issue	County Health Department dental claims are being denied in error.
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 and reprocess the claims. The providers will be notified upon completion. (CO 7026)
Provider Action	No action is needed.

System Corrected: 7/12/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	DENT 1.12
Date Drafted	8/2/2004
Date Revised	8/2/2004
Groups Affected	Dentist
Issue	Claims for procedure code D2920 (re-cement crown) for beneficiaries ages 0-20 were paid in error.
Impact	Providers were overpaid.
Resolution	Claims for procedure code D2920 should be paid without prior authorization for beneficiaries over 20 years of age only. Claims were paid for 0-20 years of age. This issue was corrected on 6/14/2004. EDS will identify the claims paid in error and initiate recoupment if necessary after notifying providers. (CO 7083)
Provider Action	No action is needed.

System Corrected: 6/14/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Hospice

Item Reference	HSPC 1.1
Date Drafted	8/11/2004
Date Revised	9/8/2004
Groups Affected	Hospice
Issue	Claims are being paid for beneficiaries with hospice coverage when no prior authorization is on file.
Impact	Providers are being overpaid.
Resolution	Medical and outpatient claims were being paid for hospice beneficiaries when there was no prior authorization on file for the service being rendered. This issue was identified and resolved on 7/19/2004. EDS will identify the claims impacted and initiate recoupment. EDS anticipates completing the cleanup by the end of September. (CO 6279 & 6521)
Provider Action	No action is needed.

System Corrected: 7/19/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Rural Health Clinics & Federally Qualified Health Clinics

Item Reference	RHC 1.6
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	RHC/FQHC
Issue	Claims are being denied when billed with the information modifier TD. The denial reason is 4270 – invalid provider type and specialty.
Impact	Providers are not being paid.
Resolution	Providers should not use 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 upon completion. At that time, EDS will identify and reprocess the claims that were denied in error. (CO 7001)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Hospitals and Adult Care Home

Item Reference	HSPT 1.0
Date Drafted	2/29/2004
Date Revised	8/25/2004
Groups Affected	Hospitals
Issue	Claims are being denied for swingbed services.
Impact	Affected facilities did not receive payment for swingbed services between 10/20 and 12/26/2003.
Resolution	The system was corrected on 12/25/2003. 110 affected claims were identified and reprocessed on 12/25/2003. Following this correction, additional reports indicated that only swingbed services filed as Interim Care claims were corrected. An existing issue is ongoing for Inpatient Crossover 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.
Provider Action	No action is needed.

System Corrected: 3/10/2004

Cleanup: Pending

Item Reference	HSPT 1.11
Date Drafted	3/2/2004
Date Revised	9/14/2004
Groups Affected	Hospital
Issue	ER claims submitted with an ET modifier are being denied stating “no pricing segment on file.”
Impact	All ER claims submitted with an ET modifier are being denied.
Resolution	It was brought to EDS’ attention that this is still an issue. EDS corrected the issue on 9/10/2004. Claims denied in error will be reprocessed and providers will be notified when resolved. (CO 6975). This is a duplicate of GENP 1.62. Please refer to this item for cleanup activities.
Provider Action	No action is needed.

System Corrected: 9/10/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	HSPT 1.14
Date Drafted	3/2/2004
Date Revised	9/17/2004
Groups Affected	Hospital
Issue	KFMC outlier issues exist for processing reviews and recoupments.
Impact	Claims are being recouped using different guidelines than standard coding practice or provider manuals.
Resolution	The benefit team determined which 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 the recoupments due to false labor issue to determine if they were recouped inappropriately. KFMC and EDS resolved the outlier issue.
Provider Action	No action is needed.

Policy Decision: Pending

Item Reference	HSPT 1.18
Date Drafted	3/2/2004
Date Revised	8/20/2004
Groups Affected	Hospital
Issue	A delay exists for approvals on timely filing requests greater than 24 months old.
Impact	Claim payments are being delayed for months. A/R increases at hospitals.
Resolution	SRS added additional resources to eliminate the backlog. Process changes were made also to approve claims quicker. SRS anticipates being up-to-date by the end of September.
Provider Action	No action is needed.

SRS: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	HSPT 1.19
Date Drafted	3/2/2004
Date Revised	8/16/2004
Groups Affected	Hospital
Issue	Kansas Medical Assistance Program (KMAP) medical policy is different than Medicare's policy.
Impact	Claims are being denied by KMAP as the secondary insurance for claims that are paid by Medicare. Different billing guidelines require providers to bill on paper and not use an electronic process.
Resolution	SRS is developing a plan to review differences in policies.
Provider Action	No action is needed.

Policy Decision: Pending

Item Reference	HSPT 1.21
Date Drafted	3/23/2004
Date Revised	9/17/2004
Groups Affected	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 cannot determine how to pay the claim.
Impact	These claims are being suspended to avoid denials until a solution is in place. Providers are experiencing a delay in payment.
Resolution	A solution was implemented on 6/4/2004 for claims where eligibility spanned multiple segments but was for the same benefit plan (CO 6218). Claims were reprocessed for CO 6218 on 9/9/2004. The system is being corrected to allow payment for claims where the beneficiary has eligibility that spans multiple benefit plans such as Medically Needy to TXIX. (CO 6883)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	HSPT 1.24
Date Drafted	4/12/2004
Date Revised	9/14/2004
Groups Affected	Hospital
Issue	SOBRA claims with pregnancy diagnosis codes or correct authorization from the SRS local office are being denied.
Impact	Claims are being denied incorrectly.
Resolution	EDS has identified the following causes for this 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 the pregnancy diagnosis grouping. The coverage for SOBRA is being changed to allow most diagnosis codes for SOBRA to suspend for manual review. This was completed as of 6/29/2004. 3. Exception code 4244, diagnosis is not covered for benefit plan, edits for all acceptable diagnosis codes for the SOBRA approval and pregnancy grouping. This should occur only with TB claims. The SOBRA claims should be denied only if the primary and secondary (Other 1 on UB 92) claim form is not part of the approved SOBRA coverage by the local SRS office. This issue was resolved. Claims will be reprocessed, and EDS will notify providers when completed. EDS reprocessed the claims on 8/26/2004 to suspend for manual review. Claims started appearing as processed on the 9/2/2004 RA.
Provider Action	No action is needed.

System Corrected: 6/29/2004

Cleanup: 8/26/2004

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	HSPT 1.26
Date Drafted	4/15/2004
Date Revised	8/16/2004
Groups Affected	Hospital
Issue	Claims are being denied with spontaneous miscarriage diagnosis codes or multiparity diagnosis.
Impact	Claims are being denied incorrectly.
Resolution	Claims being denied for multiparity codes are not a change from the old system. SRS reviewed and approved for EDS to bypass sterilization form requirements for multiparity diagnosis code V615. This policy was updated on 7/12/2004. Spontaneous miscarriage (diagnosis code 63490) has been covered. If you have examples of denials, contact EDS. EDS will identify and reprocess claims that were denied for multiparity and inform providers when completed. (CO 7017)
Provider Action	No action is needed.

Policy Updated: 7/12/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference HSPT 1.27

Date Drafted 4/15/2004

Date Revised 8/6/2004

Groups Affected Hospital

Issue Hospitals have difficulty getting claims paid when KFMC-initiated adjustments and/or recoupments process.

Impact Claims are being denied incorrectly.

Resolution EDS/SRS/KFMC are researching the following items:

- Review of admission dates on psychiatric claims. KFMC and EDS worked together to resolve this 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 was created to identify the border city hospitals affected.
- KFMC adjustment EOB is not showing up on KFMC adjustments. KFMC and EDS resolved the issue.
- Adjusted claims are being denied. Research revealed that adjustments are processing under guidelines that did not apply when the claim originally paid, and some of those claims are being denied due to these new edits and audits instead of partially recouping the dollars as it did in the past. The providers are submitting their claims to the adjustment department to reprocess, and these claims are being sent back to the provider indicating that they need to resubmit through regular claims processing because denied claims cannot be adjusted. The adjustment department will now forward those claims for processing if a copy of the claim is attached.
- Place of Service (POS) edits related to instruction to bill 99281 for OB checks that do not qualify for observations. Claims are being denied due to POS not being as the system is expecting. The issue is that KFMC reviewed observation rooms and determined that the observation did not meet the criteria established by SRS. Providers were instructed to rebill 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. EDS is currently researching the number of claims that were denied and need to be reprocessed.
- KFMC claims that were denied with edit 400 (units of service must be greater than zero) need to be reprocessed as paid details. EDS will identify and reprocess the detail lines as zero paid. (CO 7105)

Provider Action No action is needed.

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	HSPT 1.30
Date Drafted	4/27/2004
Date Revised	8/16/2004
Groups Affected	Hospital
Issue	Inpatient claims that are submitted online require a From Date of Service on each detail line.
Impact	Providers are spending additional time to submit claims on the Internet.
Resolution	Since the Institutional Claim screen on the Internet is used for inpatient *and* outpatient claims, the system must edit for the From Date of Service presence, regardless of claim type, to ensure that it is present since it is a required field for outpatient detail lines. SRS/EDS will determined that this fail-safe feature should be enhanced to recognize the difference between inpatient and outpatient since inpatient LTC claims also need the From Date of Service. SRS approved a change order to recognize the type of bill and require From Date of Service on outpatient claims only. It will be implemented once prioritized by SRS. (CO 7027)
Provider Action	No action is needed.

Enhancement Pending

Item Reference	HSPT 1.35
Date Drafted	5/12/2004
Date Revised	9/17/2004
Groups Affected	Inpatient
Issue	Claims are being denied for E-code when there is not an E-code on the paper claim.
Impact	Claims are being denied incorrectly.
Resolution	The optical character recognition (OCR) system, also known as RRI, is reading field 78 for E-code instead of field 77. EDS identified the issue and is working to fix RRI to read field 78 for the E-code. Until the error is corrected, the system will suspend for manual review claims with E-codes that were denied. EDS is validating that claims reprocessing affected by this issue is complete. (CO 6523 & 7008) EDS will notify providers when complete. CO 6523 reprocessed claims from 10/23/2003 to 6/5/2004. CO 7008 is pending to reprocess claims for process dates of 6/6/2004 – 7/14/2004.
Provider Action	No action is needed.

System Corrected: 7/2/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	HSPT 1.36
Date Drafted	6/28/2004
Date Revised	9/10/2004
Groups Affected	All
Issue	Claims are being paid with an incorrect diagnosis related grouping (DRG).
Impact	Providers are being overpaid.
Resolution	When processing claims with Length of Stays of fewer than 3 days, the system was assigning DRGs 801-805 for neonatal claims. The system was corrected to retain DRG 385 on 9/10/2004. Claims denied in error will be reprocessed. Providers will be notified when complete. (CO 6791)
Provider Action	No action is needed.

System Corrected: 9/10/2004

Cleanup: Pending

Item Reference	HSPT 1.37
Date Drafted	7/11/2004
Date Revised	9/17/2004
Groups Affected	Inpatient
Issue	Hospitals are receiving back diagnosis related groupings (DRGs) submitted on the 837 transaction as a diagnosis code on a finalized claim.
Impact	Providers are confused since they did not submit the diagnosis code that is being submitted in the DRG field.
Resolution	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 issue is corrected. (COs 6967 & 7236)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Pharmacy

Item Reference	PHAR 1.5
Date Drafted	2/29/2004
Date Revised	9/14/2004
Groups Affected	Pharmacy
Issue	Providers are unable to use the usual and customary charge on pharmacy claims.
Impact	This issue affects the amount interChange uses 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 will be moved to the pharmacy claims as the billed amount. The gross amount due will no longer be used for the usual and customary charge. Providers will be notified when this change is completed. (COs 6929, 6953, 6960, 7065, 7123, 7124, 7143, 7152, & 7257)
Provider Action	No action is needed.

Enhancement: Pending

Item Reference	PHAR 1.6
Date Drafted	2/29/2004
Date Revised	9/14/2004
Groups Affected	Pharmacy
Issue	Providers are receiving a co-pay amount of $3 for beneficiaries receiving services under the Medically Needy program but have not truly met their spenddown amount. 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 co-pay amount per the response from KMAP. However, the beneficiary has not truly met their spenddown and should be responsible for the medication cost.
Resolution	An interim solution is for Pharmacy providers to verify eligibility through the KMAP Website to ensure the remaining spenddown amount is zero. EDS and SRS are evaluating a permanent solution through discussions.
Provider Action	No action is needed. The most recent communication to EDS stated that SRS staff will work with the SRS Pharmacy Program Manager to determine the necessary action.

Policy Decision: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	PHAR 1.11
Date Drafted	6/28/2004
Date Revised	8/13/2004
Groups Affected	All
Issue	Claims are being denied for error code 6306 on beneficiaries younger than age of 21.
Impact	Providers are not being paid.
Resolution	Providers were receiving error code 6306, denial of limit of five single source prescriptions per month. This error code should not be generated for beneficiaries younger than 21 who are KBH qualified. The age limitation for audit 6306's criteria was updated on 8/5/2004 so the audit would not occur for beneficiaries younger than 21. (CO 6402) Claims denied in error will be identified and reprocessed.
Provider Action	No action is needed.

System Corrected: 8/5/2004

Cleanup: Pending

Item Reference	PHAR 1.12
Date Drafted	7/11/2004
Date Revised	8/16/2004
Groups Affected	Internet Submitters
Issue	Pharmacy claims cannot be entered on the Internet with clarification code (header), pregnancy indicator (header), and other coverage code (detail).
Impact	The absence of these fields causes claims to be denied on the Internet, and the providers can only submit them through point of sale, 837, or on paper.
Resolution	EDS is coding an enhancement to allow pharmacy claims to be entered with these fields and will notify providers when completed. (CO 6951)
Provider Action	No action is needed.

Enhancement: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	PHAR 1.13
Date Drafted	7/26/2004
Date Revised	8/16/2004
Groups Affected	Pharmacy
Issue	Pharmacists are unable to override some drug utilization review (DUR) edits when they should be able to do so.
Impact	Pharmacists are unable to override some prescriptions and dispense the pharmaceuticals at the correct billing practice.
Resolution	Pharmacists will be able to use override code 99 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)
Provider Action	No action is needed.

Policy Updated: Pending

Cleanup: Pending

Item Reference	PHAR 1.14
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	Pharmacy
Issue	Compound drugs are being denied incorrectly when multiple eligibility segments are possible. This has occurred on a beneficiary who has ADAPD, MN, and QMB coverage.
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 will notify providers when this correction is implemented. Once implemented, EDS will identify claims that may have been denied in error and reprocess once pharmacists are contacted to ensure the drug was dispensed and payment is owed. (CO 6683)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	PHAR 1.15
Date Drafted	8/2/2004
Date Revised	9/17/2004
Groups Affected	Pharmacy
Issue	Some pharmacy claims are being denied 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 caused a claim to be denied when it was submitted with a decimal in the metric quantity field (i.e., 8.18) and the NDC supplied on the claim had 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) CO 7059 was resolved as billing issue. CO 7145 is still pending correction. 2. The pharmacy/compound audit error codes should be set when a beneficiary tries to receive excessive medication for items such as oral impotency pills. This issue was corrected on 3/3/2004. EDS is identifying claims for possible recoupment. (CO 5582)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	PHAR 1.16
Date Drafted	8/9/2004
Date Revised	7/9/2004
Groups Affected	Pharmacy
Issue	Zanamivir and Osetamivir are being paid above the limitations set from October 1 to April 30 (flu season).
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 a non-covered prescription outside of flu season. • Limit Osetamivir oral suspension to no more than 75 ml per flu season. This is a non-covered prescription outside of flu season. • Limit Osetamivir capsules to no more than 10 per flu season. This is a non-covered prescription outside of flu season. EDS is correcting this issue and will notify providers when completed. Once corrected, EDS will identify the claims paid in error and will initiate recoupments. (CO 6225)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: State Institutions

Item Reference	STIN 1.1
Date Drafted	5/12/2004
Date Revised	9/17/2004
Groups Affected	State Institutions
Issue	State institution claims are being paid without reducing the amount by the patient obligation and various other payment issues.
Impact	Providers are being overpaid.
Resolution	1. State institution claims are being paid without reducing the amount 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. Thirty claims, as of 4/14/04, have been identified as being overpaid. EDS has identified the issue and is correcting the system to resolve the overpayment. (CO 5955 & 6106) CO 5955 was corrected on 4/13/2004. CO 6106 is still pending correction. 2. If a State Institution billed more than the allowed amount, the system was paying the billed amount in error. This was corrected as of 6/18/2004 to pay no more than the greater of the two. (CO 6276) Provider representatives have met with individual state institutions. Claims were reviewed and reprocessed if necessary. No automatic reprocessing will be done.
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Electronic Submitters

Item Reference	EDI 1.7
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	Electronic 837
Issue	Edit 2504 posts on claims with third-party liability (TPL). However, the claim does not contain an allowed amount and the carrier denied indicator is on. This occurs on batch claims using the 837 transaction.
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 indicator is enabled. Once the resolution is implemented, EDS will notify providers. EDS will identify and reprocess any claims denied and not resubmitted. (CO 6716)
Provider Action	Submit carrier denied claims on paper or the Internet. Do not submit on batch 837 transaction until system resolution is implemented.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: General

Item Reference	GENP 1.2
Date Drafted	2/29/2004
Date Revised	8/12/2004
Groups Affected	All
Issue	Duplicate payments were made to providers instead of correctly denying subsequent submissions of duplicate claims.
Impact	Duplicate medical and outpatient claims were paid to 1,716 providers.
Resolution	EDS will send letters to providers notifying them of possible recoupment. Recoupment will take place two weeks following the mailing. (CO 4432 & 5211) EDS anticipates completing the recoupments by the end of September.
Provider Action	No action is needed.

System Corrected: 1/21/2004

Cleanup: Pending

Item Reference	GENP 1.3
Date Drafted	2/29/2004
Date Revised	9/14/2004
Groups Affected	All
Issue	Claims are paying zero dollars when Medicare is involved but should have produced KMAP payment.
Impact	All providers submitting claims reporting Medicare denials are receiving zero payment amounts due to the MMIS incorrectly processing the Medicare paid amount as zero.
Resolution	This issue was corrected and implemented on 1/28/2004. (CO 4719, 5272, 5443, 5487, & 6438) COs 5443 & 5487 were corrected on 3/3/2004. This posts no Medicare paid date when appropriate. CO 4719, which allows for medical necessity claims to be bypassed, has reprocessed some claims as reported on the 8/26/2004 remittance advice. CO 5272, which allows the Medicare covers indicator to be recognized, was corrected on 5/19/2004. Claims were reprocessed on 8/26/2004. CO 6438, which corrects payment at the header, was corrected on 7/16/2004. Providers will be notified when claims are corrected.
Provider Action	No action is needed.

System Corrected: 7/16/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.5
Date Drafted	2/29/2004
Date Revised	9/14/2004
Groups Affected	All
Issue	New paper remittance advices (RAs) and HIPAA EOB codes are difficult for providers to understand.
Impact	Providers need to access the Website for claim inquiries or contact EDS or SRS for assistance regarding each denied claim. This is greatly impacting overall access to Customer Service.
Resolution	Focus meetings were held with providers in Topeka, Wichita and Hays in January. An interim solution to revise HIPAA EOB code mapping to incorporate providers' suggestions was implemented on RAs dated 2/12/2004. A permanent solution includes redesigning the existing RAs based on provider suggestions for ease of posting, including the following items: • Move suspended claims to the end of RA and only list critical information such as ICN, patient account number, and date of service. (CO 6012) • Print the billing provider name in header on all pages. This change was implemented on the 4/2/2004 RA. • Make several formatting changes, such as move EOBs to the end of the line, include third-party liability (TPL) amount as its own field, and reorder the amount fields. The TPL carrier is not printed on the RA message. HIPAA message codes do not have a code that allows for printing TPL carrier. (COs 6022 & 6023) • CO 5857 was moved to production on 9/10/2004. This allows display of the third-party liability (TPL) carrier code on the remittance advice.
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.

Enhancement: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.9
Date Drafted	2/29/2004
Date Revised	8/12/2004
Groups Affected	All
Issue	Providers cannot view weekly payment amounts or a readable remittance advice (RA) from the KMAP Website.
Impact	Providers must call Customer Service for this information.
Resolution	This functionality will be available in the future through the following change orders. • CO 6655 will add a Web page (Payment Inquiry) to the secure KMAP Website that will allow providers to view payment information for the most recent payment cycle as well as search for previous payment amounts using date ranges. • CO 6657 will add a Webpage (Remittance Advice) to the secure KMAP Website that will allow providers 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)
Provider Action	No action is needed.

Enhancement: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.12	
Date Drafted	2/29/2004	
Date Revised	9/14/2004	
Groups Affected	All	
Issue	Title XXI carve-outs are not paying appropriately. They are processing under the guidelines for Title XIX carve-outs.	Policy Update: 8/17/2004
Impact	Some providers cannot be paid and others are being paid for services that should be denied and billed to the managed care organization.	
Resolution	Exception 2017 will be modified to accurately reflect the carve-outs for Title XXI beneficiaries, and claims will be reprocessed. (Tied to policy E2004-005, CO 6014, 6015, 6016). CO 6014 was implemented on 8/17/2004. This exempted copay for Title XXI beneficiaries. COs 6015 and 6016 were implemented on 7/8/2004. This allowed Title XXI beneficiaries for drug coverage to process correctly.	
Provider Action	No action is needed.	

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.13
Date Drafted	3/30/2004
Date Revised	8/23/2004
Groups Affected	All
Issue	Claims are being suspended or denied due to system calculated zero payment. Many claims are also paying zero dollar amounts.
Impact	Claims are not being paid correctly.
Resolution	Edit 4200 is causing claims to be suspended, denied, or paid a zero dollar amount0. One of the main causes for edit 4200 posting is that the beneficiary is eligible for only a portion of the stay. EDS identified the cause and will notify providers when the issue is resolved. (CO 5624 & 6501) EDS identified the reason that caused claims to pay a zero amount or be overpaid. Claims were being paid 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 remittance advice 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)
Provider Action	No action is needed.

System Corrected: Research Ongoing

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference GENP 1.14

Date Drafted 4/6/2004

Date Revised 9/10/2004

Groups Affected All

Issue Claims are being denied for diagnosis for the following reasons: 1) not covered for benefit plan; 2) diagnosis to sex is conflicting; 3) primary or secondary diagnosis code is non-emergent.

Impact Claims are encountering Edits 4244, 4229, 4030, 4029, 4342, or 4362 (which are all related to diagnosis system issues) and are being denied incorrectly.

System Corrected: Pending

Cleanup: Pending

Resolution

1. Claims are being denied 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. The claims for CO 5656 and 6546 have been reprocessed. CO 6975 was moved to production on 9/10/2004. EDS will notify providers when the reprocessing of claims denied in error is complete. (CO 5656, 6975, and 6546)
2. If the diagnosis and sex are not conflicting, exception 4031 should not cause the claim to be denied. EDS corrected the error on 8/12/2004. Claims were reprocessed on 8/29/2004. (CO 5929)
3. For emergency room claims to pay, the primary OR secondary diagnosis code needs to be emergent. One of the codes can be non-emergent. Claims are being denied 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 and reprocess claims denied in error. (CO 7070)

Provider Action No action is needed.

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.15
Date Drafted	4/9/2004
Date Revised	9/10/2004
Groups Affected	CMHC
Issue	When a provider opens an ICN that starts with a 55, the ICN changes to a 59 ICN. Providers cannot determine if a payment or recoupment has been made.
Impact	Provider confusion occurs and they must contact EDS for actual outcome.
Resolution	System correction still not resolved. EDS will notify providers when correction is completed.
Provider Action	No action is needed.

System Corrected: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference GENP 1.17

Date Drafted 4/12/2004

Date Revised 9/14/2004

Groups Affected Physician

Issue Claims are being denied as duplicate claims for surgeon or assistant surgeon when one physician was already paid. Claims are also being denied for multiple surgeries in some instances.

Impact Claims are being denied incorrectly. For instance, if the surgeon bills first, the assistant surgeon's claim with the "80" modifier will be denied as duplicate to the surgeon's claim. If the assistant surgeon's claim with the "80" modifier pays first, the surgeon's claim will be denied as duplicate to the assistant surgeon's claim.

System Corrected: Pending

Cleanup: Pending

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 will be reprocessed by mid-August. (CO 6487 & 6793) CO 6793 was written for a manual workaround procedure until CO 6487 can be completed. All applicable audits were identified and set to suspend for the manual intervention.
2. Multi-surgery audit 5017 was posting in error and causing claims to be denied. EDS identified the issue and is in the process of resolution. Providers will be notified when complete. (CO 6793, 7126 & 7127) CO 6793 for denials on assistant surgeon claims completed on 7/9/2004. Claims were reprocessed on 9/9/2004.
3. Claims were paying incorrectly and allowed office visit claims to pay within 21 days of surgery. This issue was resolved on 6/10/2004. EDS will identify the claims and notify providers when reprocessed. (CO 6344)
4. Claims for cholecystectomy are being denied for 6169 (allow one per lifetime). EDS identified the issue and is in the process of resolution. Providers will be notified when complete. (CO 7274)

Provider Action No action is needed.

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.35
Date Drafted	4/27/2004
Date Revised	8/16/2004
Groups Affected	All Medicare Part A and Part B providers
Issue	All Medicare claims are not crossing over to Medicaid.
Impact	Providers experience a delay in payment and/or expend resources to send claims on paper.
Resolution	Medicare identified for Medicaid that they were not processing the beneficiary eligibility file since 10/16/03. The only claims that were crossing over to Medicare were claims with a date of service prior to 11/1/03. Medicare reported that they have updated their system with Kansas Medical Assistance Program (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 that were not sent to KMAP. All Medicare Part B claims have been recovered.
Provider Action	If Medicare Part B claims are not on the KMAP eligibility file, please resend to KMAP as Medicare reports all recovery by them is complete.

System Corrected: 6/18/2004

Cleanup: Pending

Item Reference	GENP 1.43
Date Drafted	5/4/2004
Date Revised	8/12/2004
Groups Affected	Hospital and Physicians
Issue	EKG claims are being denied in error.
Impact	Claims are being underpaid.
Resolution	Exception codes 4285 and 4286 are causing EKG claims to be denied 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)
Provider Action	No action is needed.

System Corrected: 2/1/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.48
Date Drafted	5/12/2004
Date Revised	9/17/2004
Groups Affected	Psychiatry
Issue	Claims are being denied for meeting the limitation audit for psychiatric services per month.
Impact	Claims are being denied incorrectly.
Resolution	Claims are being denied 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. The system is being corrected to exclude billing provider types and specialties that 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 being set correctly. (CO 6462) EDS is currently working on the design to correct this problem and is reviewing the policy with SRS concerning this limitation.
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.49
Date Drafted	5/12/2004
Date Revised	9/17/2004
Groups Affected	Physician
Issue	Claims are being denied as content of service for items that should not be denied, including wellness visits against skilled nursing services.
Impact	Claims are being denied incorrectly.
Resolution	1. Procedure code 76856 that denied claims in error was corrected. Clams were reprocessed and will appear on the 8/26/2004 remittance advice. (CO 6854 & 6922) 2. Skilled nursing services versus wellness monitoring (such as office visits) were being denied in error. This issue was corrected on 6/4/2004 for exception code 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) 3. CO 6854 will allow content of service lines to reprocess if other claim lines were denied.
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.50
Date Drafted	5/12/2004
Date Revised	8/23/2004
Groups Affected	Physician
Issue	Provider claims are being denied for billing of vaccines for children (90723).
Impact	Claims are being denied incorrectly.
Resolution	Under the Vaccines for Children (VFC) 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 the correction was implemented on 6/4/2004. (CO 6486 & 6878) Claims that were denied or paid in error related to the implementation of Pediatrix coverage have been reprocessed and will appear on the 8/26/2004 remittance advice. Some VFC are covered for beneficiaries who are 19 years of age and older. Reimbursement has been incorrect in some cases and has caused over and/or underpayment. This issue is being resolved through a policy. Providers will be notified when complete. (CO 5084)
Provider Action	No action is needed.

System Corrected: 6/4/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.51
Date Drafted	6/3/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Claims that were paid prior to 10/16/03 are now being denied when adjustments are made.
Impact	Funds are being recouped from providers.
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 being denied or paying a zero amount. EDS is reviewing adjustment denials to determine how to auto fill 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 5425, 6583, 6904, 7181, & 7183) CO 5425 was moved to production on 9/10/2004. 2. Providers are receiving the message "manual deny for adjustment in error." This issue predominantly affects Hospice claims. (CO 6387) This issue was corrected on 9/10/2004. Providers will no longer see the message on claims finalized after this date. Exception code 5019 was enabled in error for adjustments. This error was resolved. EDS will identify and reprocess the claims. (CO 7158)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.55
Date Drafted	6/3/2004
Date Revised	8/13/2004
Groups Affected	Lab
Issue	Claims are being denied for HCPCS code 88141 for provider type 31.
Impact	Claims are being denied incorrectly.
Resolution	The 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 cleanup by the end of September. (CO 6552).
Provider Action	No action is needed.

System Corrected: 5/11/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.62
Date Drafted	6/9/2004
Date Revised	9/14/2004
Groups Affected	Lab
Issue	Code 73560 TC is being denied in error, as well as claims with the ET modifier.
Impact	Claims are being denied incorrectly.
Resolution	Procedure 73560 (radiology exam of the knee) is being denied in error for no pricing segment on file. CO 6975 to correct the issue was moved to production on 9/10/2004. Claims denied in error will be reprocessed and providers will be notified when resolved. (CO 6975)
Provider Action	No action is needed.

System Corrected: 9/10/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.66
Date Drafted	6/28/2004
Date Revised	9/10/2004
Groups Affected	All
Issue	Claims with prior authorization are being denied in error when the beneficiary is KAN Be Healthy (KBH) and service is not normally covered. Claims are being denied for 11056, 11055, 11200, and 11201 per prior policy.
Impact	Providers are not being paid.
Resolution	1. Claims are being denied as not covered on date of service when a valid prior authorization is on file for the procedure. One example is that claims are being denied for sleep study when approved for a KBH eligible child. EDS has identified the issue and is working on a solution. (CO 6070 & 6540) CO 6399 for claims with "price by prior authorization" have been reprocessed and will appear on the 8/26/2004 remittance advice. CO 6070 for "procedure no covered" has been reprocessed and will on the 9/9/2004 RA. CO 6540 for claims that were denied for KBH when a prior authorization was on file was moved to production. EDS will notify providers when claims have been reprocessed. 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 that were denied will be identified and reprocessed. EDS will notify providers when complete. (CO 7133)
Provider Action	No action is needed.

Policy Updated: 9/4/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.67
Date Drafted	6/28/2004
Date Revised	8/23/2004
Groups Affected	All
Issue	Claims are being denied stating that medical necessity documentation is needed.
Impact	Providers are receiving claim denials stating "diagnosis not payable with procedure" for claims that require clinical review of medical necessity attachments.
Resolution	The interChange MMIS is being modified to allow claims that require clinical review to appropriately suspend for review prior to being denied for "diagnosis not payable with procedure." (CO 6363 & 6979) Claims were submitted for reprocessing on 8/13/2004 for CO 6363. CO 6979 is still pending cleanup.
Provider Action	No action is needed.

System Corrected: 7/14/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.69
Date Drafted	6/28/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Claims are being denied incorrectly for invalid provider type and specialty.
Impact	Providers are not being paid.
Resolution	1. Providers are receiving denials for provider type and specialty in error (exception code 4270). This is not a denial in error on majority of claims but does appear on some claims. EDS is resolving the last CO (6113) and will notify providers when corrected. (CO 6113, 6313, 6667, 6754, & 7220) CO 6754 was moved to production on 9/10/2004. CO 6313 was corrected on 4/13/2004. CO 6667 was corrected on 7/29/2004. 2. Audits will also be enabled to allow the ability to set up limitation and contra auditing by billing provider, provider type, and provider specialty. (CO 7056 & 7057) 3. Claims are being denied for S9123 and S9124 for provider type and specialty 12/120. This issue was corrected on 8/27/2004. EDS will identify erroneously denied claims and contact providers when reprocessing is complete. (CO 7245)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.70
Date Drafted	6/28/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Miscellaneous sterilization and family planning issues including denials are occurring.
Impact	Providers are being underpaid.
Resolution	A small number of claims are being denied for beneficiaries who are older than 21 when the claim has sterilization procedures. This should not occur if the proper sterilization form is attached. EDS is working on a resolution and will notify providers when complete. Only nine claims have been identified with this issue. (CO 7075)
	Provider claims were being denied when the surgeon's date of signature was more 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 was 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)
	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 7209 for invalid posting of exception 6166 was corrected on 8/20/2004.
	Providers are receiving denials with exception codes 4312 – No surgeon ID number on the claim. This occurs when the system incorrectly sets the "attachment to use" indicator to "N." EDS is researching 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)
	More than one initial family planning and/or annual family planning service was paid for the same date of service. This issue was 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)
	SRS provided instructions for reprocessing denied claims, if appropriate, based on claim form. EDS will notify providers when complete. (CO 7192)
Provider Action	No action is needed.

Policy Decision: Pending

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.72
Date Drafted	6/28/2004
Date Revised	9/17/2004
Groups Affected	Lab
Issue	CPT code 81000 is being denied for invalid CLIA certificate.
Impact	Providers are not being paid.
Resolution	Claims with procedure code 81000 are being denied for providers with a type 2 CLIA certificate. EDS is working on adding the type 2 CLIA certificate to the valid certificates for billing CPT 81000. An interim solution is for EDS to suspend and work the claims manually. Once corrected, EDS will notify providers and reprocess the denied claims. (CO 6875)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.74
Date Drafted	7/11/2004
Date Revised	9/14/2004
Groups Affected	All
Issue	The co-pay amount is appearing as $2 when Medicare paid more than the KMAP allowed amount.
Impact	Providers do not know if they should be charging a co-pay.
Resolution	The medical policy team and SRS program manager will review the policy to determine instructions for providers.
Provider Action	No action is needed.

Policy Decision: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.77
Date Drafted	7/9/2004
Date Revised	7/9/2004
Groups Affected	Crossover claims
Issue	Crossover claims are being denied for the whole claim instead of just the detail that should be denied.
Impact	Providers are not being paid.
Resolution	Providers were receiving an entire claim denial when one procedure code was loaded on the reference file as non-covered for the qualified Medicare beneficiary 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)
Provider Action	No action is needed.

System Corrected: 7/6/2004

Cleanup: Pending

Item Reference	GENP 1.78
Date Drafted	7/11/2004
Date Revised	9/17/2004
Groups Affected	Crossover
Issue	Claims are being denied in error as content of service for procedure code G0156.
Impact	Providers are not being paid.
Resolution	Procedure code G0156 is being denied against procedure code 99213. The cause of the denial has been identified and the correction is in progress. EDS will notify providers when corrected. EDS will identify and reprocess the claims that were denied. (CO 6938)
Provider Action	No action is needed.

Policy Updated: 7/20/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.79
Date Drafted	7/11/2004
Date Revised	7/29/2004
Groups Affected	Crossover
Issue	Claims are being paid in error when they should be content of service for procedure code T1004.
Impact	Providers are being overpaid.
Resolution	Procedure code T1004 is paying in error when they should be denied if billed on the same day as S9131 GP. The cause of the payment has been identified and the correction is in progress. EDS will notify providers when corrected. EDS will identify claims paid in error and initiate recoupments after notifying providers of claims to be recouped. (CO 6938)
Provider Action	No action is needed.

System Corrected: 7/20/2004

Cleanup: Pending

Item Reference	GENP 1.80
Date Drafted	7/11/2004
Date Revised	9/17/2004
Groups Affected	Optometry
Issue	Claims for beneficiaries are being paid when the beneficiary is older than 20 years and has had a previous claim paid for lenses and frames in the last four years.
Impact	Providers are being overpaid.
Resolution	Beneficiaries are allowed one set of frames and lenses every four years if they are older 20 years old. The cause of the payment has been identified and the correction is in progress. 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)
Provider Action	No action is needed.

System Corrected: 7/11/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.81
Date Drafted	7/20/2004
Date Revised	9/8/2004
Groups Affected	All
Issue	Claims submitted for qualified Medicare 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.
Impact	Claims are being denied incorrectly.
Resolution	EDS has identified and is working on the solution for this issue. Providers will be notified when it is resolved. Once implemented, claims that were denied in error will be reprocessed. The system was fixed on 8/17/2004. (CO 6898 and 6609).
Provider Action	No action is needed.

System Corrected: 8/17/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.82
Date Drafted	7/11/2004
Date Revised	8/23/200
Groups Affected	All
Issue	The co-pay amount is currently not being deducted from claims when the emergency indicator on the diagnosis code is "Y."
Impact	SRS is spending more funds than potentially necessary.
Resolution	The co-pay logic will be changed to exempt beneficiaries, who normally are eligible for co-pay, to have co-pay deducted for emergency services based on the following criteria instead of the diagnosis: • Outpatient claim billed with the following: 99281-99285, 99291, 99292, or 99218; all services on same claim will be exempt from co-pay • Medical claim with a place of service billed as emergency room (23) • Inpatient claim 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 of the effective date of the change when the system is updated. (CO 6921) Co-pay is being deducted from newborn claims when the mother's beneficiary ID is used. The co-pay logic looks at emergency diagnosis codes only and not newborn diagnosis codes to exclude co-pay from being applied. The policy is being reviewed to determine if newborn diagnosis codes can be used. In the meantime, the system will continue to deduct a co-pay if the provider uses the mother's beneficiary ID.
Provider Action	No action is needed.

Policy Update: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.84
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	All
Issue	Professional claims that contain a group number in the performing provider field are being paid in error.
Impact	Providers are being overpaid.
Resolution	Professional claims that contain a group number in the performing provider field should not be paid. Edit 1008 should post to deny the claims. The system is being corrected. Providers will be notified when complete. Upon completion, EDS will notify providers of claims impacted and initiate recoupments. (CO 7016)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.85
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	All
Issue	Claims are being denied for qualified Medicare beneficiaries and medically needy with a spenddown deductible applied (explanation of benefit 9922) to the claim.
Impact	Providers are confused because the claim denies correctly, but the EOB 9922 posts to the claim in error. The provider sees the incorrect explanation on the remittance advice and expects that they must recover the full claim amount from the beneficiary. The claim should instead be resubmitted with corrections.
Resolution	The system will be corrected to ensure that claims denied for spenddown are the only claims that post the EOB 9922. EDS will notify providers when corrected. (CO 7019)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.86
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	Medicare Crossover Claims
Issue	Claims that are crossed over from Medicare to EDS are being denied for no Medicare paid date.
Impact	Providers are not being paid.
Resolution	Starting 7/1/2004, claims are being denied for no Medicare paid date that crossed over from Medicare to EDS. EDS is working to identify what cause and will notify providers when corrected. Once corrected, EDS will reprocess the claims that were denied in error. (CO 7041)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.87
Date Drafted	7/26/2004
Date Revised	9/10/2004
Groups Affected	SOBRA Spenddown Claims
Issue	SOBRA claims are not properly processing against the spenddown logic.
Impact	SOBRA claims are not being applied to spenddown amounts causing potential overpayment to providers and inaccurate decrementing of the beneficiary spenddown record.
Resolution	The current SOBRA eligibility does not always provide for spenddown processing. EDS will enhance the system to allow SOBRA claims to be paid using either spenddown logic or non-spenddown logic. The system was corrected on 9/10/2004. EDS will identify and reprocess claims that had SOBRA and medically needy (spenddown) eligibility and notify providers when complete. (CO 6577)
Provider Action	No action is needed.

Policy Update: 9/10/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.88
Date Drafted	7/26/2004
Date Revised	9/10/2004
Groups Affected	All
Issue	Claims are being denied when correct qualifier codes exist on the claim.
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 resolved this issue on 9/10/2004 and will identify claims to reprocess. (CO 6704)
Provider Action	No action is needed.

System Corrected: 9/10/2004

Cleanup: Pending

Item Reference	GENP 1.89
Date Drafted	7/26/2004
Date Revised	9/14/2004
Groups Affected	All
Issue	Claim adjustments are processing but are not decreasing the prior authorization so subsequent claims do not pay. Claims are also being paid in error instead of requiring prior authorization.
Impact	Providers are not being paid or are being overpaid depending on the circumstance.
Resolution	1. Claims that encounter the 3021 prior authorization exception and have a prior authorization on file, should pay and decrease the prior authorization by the appropriate units. The prior authorization units should also be credited when an adjustment occurs that does not allow the next claim to pay. The system was corrected on 7/29/2004. EDS will identify and reprocess the affected claims. (CO 5978) COs 6292 & 6706 were cancelled because they are covered by CO 5978. 2. Claims with procedure codes Y9105 and 90816 are being paid for some benefit plans. EDS corrected this issue on 9/10/2004 and will notify providers when claims are reprocessed. (CO 6520) 3. Claims are being paid more than the prior authorization approves for dollars or units. EDS is resolving the issue and will notify providers when complete. (CO 7286)
Provider Action	No action is needed.

System Corrected: 9/10/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.90
Date Drafted	7/26/2004
Date Revised	7/26/2004
Groups Affected	All
Issue	Claims are being denied as part of bundling when processing of other lines occur after the bundling process.
Impact	Providers are not being paid.
Resolution	A claim detail line is being denied as part of bundling when the other line with which it bundled was denied. Since bundling occurs before duplicate, limitations, and contraindication audits, a detail line is denied for bundling causing the limitation audit to be denied as well. For example, if procedure codes 11721 and 11056 are billed on the same claim, 11721 denies as content of service (bundling) to procedure 11056. Then, procedure 11056 is denied in the prior authorization process. If the 11056 denial occurred first, 11721 would not have denied as content of service. EDS is correcting the error and will notify providers upon completion. (CO 6854)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.92
Date Drafted	8/2/2004
Date Revised	8/2/2004
Groups Affected	DME
Issue	Claims for E0439 RR and E1391 RR are being denied in error for "bill to Medicare first."
Impact	Providers' claims are not being paid.
Resolution	Claims for E0439 RR and E1291 RR were denied in error for "bill to Medicare first" for claims with a date of service on or after 1/1/2004. EDS corrected the issues. EDS will identify and reprocess the denied claims. Providers will be notified when reprocessing is complete. (CO 7085)
Provider Action	No action is needed.

System Corrected: 6/4/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.93
Date Drafted	8/2/2004
Date Revised	8/2/2004
Groups Affected	All
Issue	Physician claims were being denied against laboratory claims in error and vice versa.
Impact	Providers are not being paid.
Resolution	Physician claims and laboratory claims were being denied against each other because both exceptions 5583 and 5584 were failing at the same time on a claim detail line. EDS resolved this issue. EDS will identify and reprocess the denied claims. Providers will be notified when reprocessing is complete. (CO 7088)
Provider Action	No action is needed.

System Corrected: 7/1/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.94
Date Drafted	8/2/2004
Date Revised	9/14/2004
Groups Affected	All
Issue	Claims for procedure code 92567 are being denied in error.
Impact	Providers are not being paid.
Resolution	Claims for procedure code 92567 were being denied in error when billed with the following provider type/provider specialty combinations: 08/080 and 08/081. Claims for beneficiaries between the ages of 0-3 with the following provider types and provider specialties were being denied: 08/183 and 08/186. EDS corrected this issue on 7/16/2004. EDS will identify the claims denied in error and notify providers when reprocessing is complete. (CO 7089)
Provider Action	No action is needed.

System Corrected: 7/28/2004

Cleanup: Pending

Item Reference	GENP 1.95
Date Drafted	8/2/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	KAN Be Healthy (KBH) screenings are not being updated with services provided by FirstGuard network providers.
Impact	Providers are not being paid for services that 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, such as KBH screenings with claims information submitted to FirstGuard. This causes claims to be denied that require KBH screens to be current for FirstGuard for some codes such as sleep studies for KMAP. FirstGuard completed sending claims to EDS up to September 2003. They will continue to send the remaining historical months. Once completed, EDS will notify providers. 2. Additional non-encounter claims were not updating KBH, which may have caused denials. EDS corrected this issue on 5/20/2004. (CO 5284)
Provider Action	No action is needed.

System Corrected: 5/20/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.96
Date Drafted	8/2/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Co-pay amounts are being deducted in error from claims provided by exempt providers, such as Advanced Registered Nurse Practitioners (ARNPs).
Impact	Providers are being underpaid and potentially overpaid.
Resolution	The system is reviewing only the billing provider number instead of the billing and performing provider numbers to determine if a co-pay should be applied. The performing provider number should be used in addition to the billing provider. Thus, some co-pay is being deducted from claims in error. For example, an ARNP provider, who is exempt from co-pay, is having a co-pay amount 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 co-pay amount or recoup the $3 co-pay depending upon the performing provider. (CO 7119)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.97
Date Drafted	8/9/2004
Date Revised	8/9/2004
Groups Affected	All
Issue	Claims are being denied for procedure code T1001, which incorrectly allows for one nursing evaluation per lifetime.
Impact	Providers are not being paid.
Resolution	Audit 6253 (allow one nursing evaluation per lifetime) is posting incorrectly 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 and reprocess claims denied in error. (CO 7130)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.98
Date Drafted	8/9/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Out-of-state providers are being paid in error when they are not in a border city and are not being paid correctly when they are in a border city.
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 in a border city 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)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Item Reference	GENP 1.99
Date Drafted	8/9/2004
Date Revised	8/20/2004
Groups Affected	Physician
Issue	Providers are being paid for KAN Be Healthy (KBH) medical screen and E&M code on the same date of service.
Impact	Providers are being overpaid.
Resolution	Claims were not posting for denials of E&M code when a KAN Be Healthy medical screen is conducted on the same date of service for the same provider. EDS resolved the issue. EDS will identify the overpaid claims and initiate recoupments. (CO 6325)
Provider Action	No action is needed.

System Corrected: 8/10/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.100
Date Drafted	8/9/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	FFP rate is not processing correctly for S0612 and S0160 as well as not being applied on effective date correctly."
Impact	Providers are being overpaid.
Resolution	S0610 and S0612 were 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) The FFP rate was processing on the process date rather than the date of service. This issue was resolved on 8/11/2004. EDS will identify and reprocess the claims, and notify providers when complete. (CO 7163)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.101
Date Drafted	8/11/2004
Date Revised	8/20/2004
Groups Affected	All, including CMHC
Issue	The history file used in claims processing for limitation audits and duplicate history is not being updated correctly. The performing provider field is being updated with the billing provider number.
Impact	Providers are potentially being 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 were sent to providers who may have been potentially overpaid. 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)
Provider Action	No action is needed.

System Corrected: 7/29/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.103
Date Drafted	8/11/2004
Date Revised	8/11/2004
Groups Affected	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.
Impact	Providers are being overpaid.
Resolution	More than one encounter was being paid for the same beneficiary with more than one procedure on the same date of service. This issue affected alpha procedure codes that 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 recoupments. The providers will be notified when complete. (CO 7159)
Provider Action	No action is needed.

System Corrected: 8/6/2004

Cleanup: Pending

Item Reference	GENP 1.104
Date Drafted	9/13/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Physical therapy claims are being denied for V571-V579 diagnosis codes.
Impact	Providers are not being paid.
Resolution	Physical therapy claims submitted with V571-V579 used to pay in the prior system. These claims are now being denied. In review of the prior system, these claims were paying in error as SRS had no medical policy established to cover the diagnosis codes. SRS is reviewing the policy related to rehabilitative services to determine if these diagnosis codes should be covered.
Provider Action	No action is needed.

Policy Decision: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Item Reference	GENP 1.105
Date Drafted	9/13/2004
Date Revised	9/17/2004
Groups Affected	All
Issue	Claims are being denied for procedure to diagnosis code (exception 4037) in error.
Impact	Providers are not being paid.
Resolution	Dental and medical crossover claims are being denied when a diagnosis code other than the primary or secondary are non-covered for the procedure code. The claims should be denied for procedure to diagnosis only if the diagnosis is invalid for the procedure in the primary or secondary position. This issue was identified and EDS is correcting the system. Providers will be notified when the system is corrected. Once implemented, EDS will identify and reprocess the claims denied in error. (CO 7226)
Provider Action	No action is needed.

System Corrected: Pending

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.

KMAP Provider Communication

Provider Community: Optometry

Item Reference	OPT 1.2
Date Drafted	4/27/2004
Date Revised	8/20/2004
Groups Affected	Optometry
Issue	Procedure code V2201 is listed as a covered code for qualified Medicare beneficiaries. However, when a claim is billed with code V2201, it immediately is denied as non-covered.
Impact	Claims are being denied incorrectly.
Resolution	EDS corrected the issue on 8/17/2004. EDS will identify and reprocess the claims that denied in error. (CO 6609)
Provider Action	No action is needed.

System Corrected: 8/17/2004

Cleanup: Pending

Blue highlighted items indicate the case is closed due to resolution and will be moved to the Closed Provider Claims Issue List after one week. They are also located under Bulletins.