KMAP Provider Communication

Provider Community: Adult Care Home

Item Reference	ACH 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Adult Care Home	
Issue	Automatic mass adjustment was initiated due to a retroactive rate change but the patient liability was not deducted correctly.	Resolved 1/16/2004
Impact	14,962 claims needed to be adjusted to correctly deduct the patient liability.	
Resolution	A mass adjustments correction was performed on 12/26 for 25 affected providers. Four remaining providers' claims were corrected on 1/16/2004.	
Provider Action	No action is needed	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: CDDO, HCBS, Home Health, and CMHC (*Also see GENP 1.0, 1.1, 1.2, 1.4, and 1.5)*

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

Item Reference	CHHC 1.1	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	Resolved 12/18/2003
Issue	Amount paid includes payment amounts, state share, and TPL deductions.	
Impact	This issue created confusion when providers posted remittance advices.	
Resolution	Removed the state share and TPL amounts from the amount paid columns as of the 12/18/2003 remittance advices.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	CHHC 1.3	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	
Groups Affected	HCBS	
Issue	Providers are stating a "slow-down" has occurred in getting their claims paid and that claims are suspending for plans of care (POC). Due to numerous system issues related to POC (inability to access the POCs, inability to modify/update and inability to submit POCs), EDS created a backlog of POCs to be entered into the system.	Resolved 1/2004
Impact	The HCBS community was not receiving timely payments.	
Resolution	SRS and EDS worked on approving the plans of care to resolve the backlog. Once plans of care were approved, affected claims were released for processing.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.4	
Date Drafted	2/29/2004	
Date Revised	4/23/2004	
Groups Affected	HCBS	
Issue	Plans of care were not set up with client obligation amounts that matched amounts found in KAESCES (the eligibility system).	Ongoing as needed.
Impact	1,666 claims were in suspense for an out of balance condition. Approximate dollar amount was $1.3 million.	
Resolution	POCs need to be updated by case managers. EDS is continually working with case managers so that as plans of care are corrected, the affected claims are recycled.	
Provider Action	For HCBS FE providers, KDOA decided that the eligibility file and plan of care must be the same or claims will be denied. Provider must contact the case manager to correct an out of balance situation.	

Item Reference	CHHC 1.5	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	
Groups Affected	Targeted Case Management	
Issue	Services were being denied for submission to Medicare as primary payor due to the implementation of national codes on 1/1/2004.	Resolved 1/23/2004
Impact	1,068 claims were denied instructing providers to bill Medicare first.	
Resolution	Permanent system correction to bypass Medicare editing for these codes was implemented on 1/23/2004, and 1,068 affected claims were recycled.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.6	
Date Drafted	4/9/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	
Issue	Beneficiaries were being charged a $3 co-pay amount for family therapy, when the manual states that it should be only for individual therapy.	Resolved: 4/7/2004
Impact	Beneficiaries were questioning why and/or stating that they cannot pay.	
Resolution	The new system allows for proper designation of family therapy. Family therapy is not considered a group therapy as it is individually focused. The $3 co-pay amount for family therapy will continue.	
Provider Action	Providers need to collect the $3 co-pay for family therapy.	

Item Reference	CHHC 1.7	
Date Drafted	4/12/2004	
Date Revised	10/15/2004	System Corrected: 4/7/2004
Groups Affected	CDDO	
Issue	Federal match (FFP) is not being reduced from claims. The full amount is being paid.	
Impact	Claims were being overpaid. The provider was incorrectly being paid the 50% FFP portion.	Cleanup: 9/23/2004
Resolution	The table that controls the calculation of state share was updated on 4/7/2004. Claims to be adjusted were identified. EDS initiated the first adjustment on 4/7/2004. An additional adjustment was completed on 9/23/2004. (CO 6069)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.8	
Date Drafted	4/12/2004	
Date Revised	4/23/2004	
Groups Affected	Home Health	
Issue	Supply claims for home health were being denied for exception 2502 (bill Medicare first).	Resolved: 2/24/04
Impact	Providers are being underpaid. Claims are being denied in error. Home health services billed with the GY modifier are not required to have a Medicare denial. Supplies that are billed in conjunction with the home health services with the GY modifier are not required to have a Medicare denial.	
Resolution	The cause of this issue was identified. EDS updated the *Claims Resolution Manual* to instruct clerks to force claims that meet this criteria. As of 4/16/2004, EDS recycled or adjusted all claims that were denied in error.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.9	
Date Drafted	4/12/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	
Issue	Medication checks (procedure code 90862) were being denied.	Resolved: 4/12/2004
Impact	Providers believed that they were being underpaid.	
Resolution	Medication checks (procedure code 90862) are content of service to individual therapy visits (procedure code 9080). The new system allows for more comprehensive processing of claims based on the Correct Coding Guidelines that deal with content of service. These claims are being denied correctly as content of service.	
Provider Action	Providers should evaluate their billing practices to ensure adherence to the Correct Coding Guidelines for any potential content of service procedure codes.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.10	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	System Corrected: 4/23/2004
Issue	HCBS claims are paying one penny because the plan of care (POC) was approved with a "penny out" line.	
Impact	Claims were being underpaid	Cleanup: 6/4/2004
Resolution	The POC was set up with too low of an approved amount. EDS identified these POCs and systematically removed the "penny out" lines on 4/22/2004. Claims previously paid one cent were adjusted so they processed under the correct POC line item. (CO 5803)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.11	
Date Drafted	4/15/2004	
Date Revised	4/23/2004	
Groups Affected	CMHC	
Issue	Claims were being denied for plans of care with a pay cap amount that had a dollar amount and a unit on the plan of care (POC).	Resolved: 2/2/2004
Impact	Claims were being underpaid.	
Resolution	When a POC has a type of "pay cap amount," the system looks at both units and dollars when decrementing if that POC is available to still use. If a claim has already processed against that line item, it considers the line "used" since the units have already been decremented. The system should use dollars only when the POC is pay cap amount. A system correction was implemented on 2/2/2004. EDS created a mass adjustment and claims started to reprocess on 4/5/2004. Cleanup was completed on 4/14/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.14	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	System Corrected: 3/9/2004
Issue	Claims were being denied for invalid diagnosis code for dates of service.	
Impact	Claims were being denied incorrectly.	
Resolution	Providers reported that they submitted claims with the new diagnosis code (78099) and it was denied for a January 2004 date of service. Another provider reported that 2003 claims were being denied for an invalid diagnosis code (Y45) when billed after 1/1/2004. EDS identified that the wrong beginning and ending effective dates were on the new diagnosis codes. The codes were updated with correct dates. (CO 6671) EDS automatically reprocessed the claims that were denied in error with invalid diagnosis codes on 7/15/2004.	Cleanup: 10/8/2004
Provider Action	No action is needed.	

Item Reference	CHHC 1.15	
Date Drafted	4/15/2004	
Date Revised	11/18/2005	
Groups Affected	CMHC	System Corrected: 6/4/2004
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.	Cleanup: 11/9/2005
Resolution	This system was corrected on 6/4/2004 to determine the modifiers for the Plans of Care. EDS completed claims reprocessing on 10/12/2004. (CO 6324) Additional cleanup was identified on 10/14/2005. Additional claims started reprocessing on 11/9/2005. **Reprocessed ICN Range:** 5205313000001 – 5205313000335	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.16	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	System Corrected: 5/4/2004
Issue	Claims for CPT code 90862 were being denied as "procedure code is noncovered for this provider type and specialty."(EOB 342).	Cleanup: 7/7/2004
Impact	Claims were being denied incorrectly.	
Resolution	Claims that were being denied for CPT code 90862 for this provider type and specialty were resolved as of 5/4/2004. EDS identified claims denied in error on 7/7/2004 and resubmitted them for reconsideration of payment. (CO 5646)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.17	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	
Groups Affected	CMHC	System Corrected: 5/14/2004
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).	Cleanup: 8/23/2004
Impact	Claims were being denied incorrectly for beneficiaries not in the MediKan benefit plan.	
Resolution	Audit 6069 (Allow 320 Units of Targeted Case Management Per Calendar Year) was modified on 5/14/2004 to only apply to MediKan beneficiaries. EDS identified and reprocessed claims that were denied in error. (CO 6976) EDS completed reprocessing claims on 8/23/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.18	
Date Drafted	4/15/2004	
Date Revised	4/30/2004	
Groups Affected	CMHC	
Issue	Claims were being denied for timely filing even though the original converted ICN is indicated on the claim.	Resolved: 3/2004
Impact	Claims were being underpaid.	
Resolution	A system change was implemented to allow providers to bill using a timely filing ICN. The beneficiary ID, provider number, and date of service on the timely filing ICN must match the claim submitted or the system will not bypass the timely filing requirement.	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.20	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	Home Health	Resolved: 4/20/2004
Issue	Claims for qualified Medicare beneficiaries (QMB) were being denied when the GY modifier was on the claim.	
Impact	Providers were being underpaid.	
Resolution	Procedure code 99601 was loaded as being billable with the GY modifier for all benefit plans except QMB. The system was corrected to allow 99601 to be billed with the GY modifier as of 4/20/04. (TO 6380)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.21	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	System Corrected: 4/23/2004
Groups Affected	HCBS	
Issue	Procedure S5161 was paying at $25 per unit instead of the $30 allowed.	
Impact	Providers were being underpaid.	Cleanup: 8/13/2004
Resolution	Installation of an emergency response system (S5161) was paying at $25 instead of the $30 allowed amount. This issue was corrected as of 4/23/04. EDS will adjust the affected claims and notify the providers when complete. EDS submitted the adjustments on 8/13/2004. (CO 6410)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.22	
Date Drafted	6/9/2004	
Date Revised	4/8/2005	System Corrected: 3/17/2004
Groups Affected	HCBS	
Issue	Procedure code T1016 is being denied in error.	
Impact	Claims are being denied incorrectly.	Cleanup: 9/17/2004
Resolution	Claims with procedure code T1016 were being denied in error. Claims were reprocessed but some claims were not corrected. EDS identified and reprocessed the additional claims for the 9/17/2004 remittance advice. (CO 6054)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.23	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	System Corrected: 4/21/04
Groups Affected	CMHC	
Issue	Local behavior management codes were being denied in error indicating no prior authorization (i.e., plan of care) on file.	
Impact	Claims were being denied incorrectly.	Cleanup: 5/7/2004
Resolution	Local behavior management codes were being denied in error indicating no prior authorization (i.e., plan of care) on file. Codes included in the denial were S5145, H0017, T1019HA, 90847, and H2013. Claims denied in error were identified and reprocessed by 5/7/04. (CO6394)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.24	
Date Drafted	6/9/2004	
Date Revised	5/6/2005	
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.	Policy Decision: 5/2/2005
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 (for example, 32 hours for individual, 32 hours for family, and 32 hours for group). The new system pays according to the state plan. SRS researched options and determined that 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. SRS determined that therapy hours (32 hours for adults and 40 hours for children) will be divided and counted accordingly. Eligible providers (CHMC's, psychiatrists, etc.) will have 32/40 hours for family and individual therapy and 32/40 hours for group therapy. Family and individual therapy are considered to be the same for this calculation and will not have separate hour limitations. The hours will also be provider type specific. (CO 6902)	Cleanup: 10/21/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.25	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	
Groups Affected	HCBS	System Corrected: 5/18/2004
Issue	Claims were being denied with Y19 diagnosis code.	
Impact	Claims were being denied incorrectly.	Cleanup: 7/2/2004
Resolution	Claims with diagnosis code Y19 were denied incorrectly as noncovered after 2/19/2004. This code was still covered for dates of service prior to 1/1/04 and should have been paid. The end date on the code was updated to allow claims to pay with dates of service prior to 1/1/04. This correction was made on 5/18/04. EDS identified the claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6588)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.26	
Date Drafted	6/28/2004	
Date Revised	11/4/2004	
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.	System Corrected: 2/11/2005
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 identified and reprocessed the claims for the 10/14/2004 RA. (CO 6397) 2. Patient liability was being deducted twice when adjustments are involved. EDS identified the problem and made the correction as of 2/11/2005. Claims started reprocessing on 02/15/2005. (CO 6933)	Cleanup: 2/15/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.27	
Date Drafted	6/28/2004	
Date Revised	8/19/2005	
Groups Affected	HCBS, Mental Health	
Issue	Claims were being denied for limitation audits incorrectly for calendar year or rolling 12 months.	
Impact	Providers were not being paid.	
Resolution	• Claims were being denied for exception 6051: allow 120 hours of targeted case management per calendar year. The claim should cut back to the units remaining to be allowed rather than be denied. This applies to claims with procedure code W1300. This issue was resolved on 6/10/04. EDS reprocessed the claims on 7/16/2004. (CO 6766) • Claims were being denied for exceptions 6008, 6043, 6076, 6109, 6128, and 6322. The exceptions were looking at a rolling 12 months limitation. The limitation was changed to calendar year on 2/17/2005. Claims started reprocessing on 3/1/2005. (CO 7899) **Reprocessed ICN Range**: 8005060000001 - 8005060000734; 5005060000001 - 5005060000304 • Mental Health consortium encounter claims were causing fee-for-service claims to deny for limitation audits. This was moved to production on 5/6/2005. Claims denied in error will be identified and reprocessed. Claims denied in error started reprocessing on 8/16/2005. (CO 7235) **Reprocessed ICN Range**: 8005227000017 - 8005227000091; 5205227004360 - 5205227004363	System Corrected: 2/17/2005 Cleanup: 8/16/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.28	
Date Drafted	7/9/2004	
Date Revised	10/22/2004	
Groups Affected	CMHC	System Corrected: 7/20/04
Issue	Claims are being denied for KAN Be Healthy (KBH) beneficiaries in excess of 32 hours of psychotherapy.	
Impact	Providers are not being paid.	Cleanup: 10/20/2004
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 identified and reprocessed the claims that were denied in error on 10/20/2004. (CO 6902)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.30	
Date Drafted	7/11/2004	
Date Revised	10/22/2004	
Groups Affected	HCBS FE	System Corrected: 10/8/2004
Issue	Claims are being denied when a plan of care is on file.	
Impact	Providers are not being paid.	Cleanup: 10/19/2004
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 resolved the issue on 10/8/2004. EDS identified and reprocessed the claims denied in error on 10/19/2004. (CO 6964)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.31	
Date Drafted	7/26/2004	
Date Revised	10/15/2004	System Corrected: 7/12/2004
Groups Affected	HCBS	
Issue	Home modifications are only paying $7,500 when a prior authorization/plan of care is approved for a higher dollar amount.	Cleanup: 8/27/2004
Impact	Providers were being underpaid.	
Resolution	The system was corrected on 7/12/2004. EDS completed reprocessing the claims on 8/27/2004. (CO 6981)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.32	
Date Drafted	8/2/2004	
Date Revised	7/5/2005	
Groups Affected	HCBS	System Corrected: 8/12/2004
Issue	Claims are being denied for "billable only every 55 days" on the 55th day.	
Impact	Providers are not being paid.	
Resolution	Claims are being denied with exception code 6027 for wellness monitoring, which is covered every 55 days or more. The claims are being denied on the 55th day or less when they should be denied for the 54th day or less. EDS identified and resolved the issue on 8/12/2004. EDS identified and reprocessed the claims that were denied in error. The claims will be on the 10/7/2004 and 10/14/2004 remittance advices. Additional cleanup was completed on 7/6/2005. (CO 6250) **Reprocessed ICN Range:** 8005181000374 - 8005144000471; 5205182138106 - 5205182138124	Cleanup: 7/6/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.33	
Date Drafted	8/2/2004	
Date Revised	10/22/2004	System Corrected: 7/23/2004
Groups Affected	CMHC	
Issue	The co-pay amount for CMHC claims with procedure code 90847 is being removed.	
Impact	Providers are being underpaid.	Cleanup: 10/19/2004
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 identified and adjusted the underpaid claims to include the $3 co-pay amount on 10/19/2004. (CO 7091)	
Provider Action	No action is needed.	

Item Reference	CHHC 1.34	
Date Drafted	8/2/2004	
Date Revised	11/12/2004	System Corrected: 6/22/2004
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.	Cleanup: 11/12/2004
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 identified and reprocessed the claims that were denied in error on 11/12/2004. (CO 7092)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.35	
Date Drafted	9/13/2004	
Date Revised	5/6/2005	
Groups Affected	HCBS SED	System Corrected: 11/12/2004
Issue	Claims are being denied for HCBS SED benefit plan with exception 2504 (bill other insurance).	
Impact	Claims are being denied incorrectly.	Cleanup: 5/3/2005
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. The correction was implemented on 11/12/2004. Claims for denials and adjustments started reprocessing on 5/3/2005. (CO 7256)	
	Reprocessed ICN Range: 5205122000025 – 5205122000288; 8005123004269 – 8005123004519	
Provider Action	No action is needed.	

Item Reference	CHHC 1.36	
Date Drafted	9/13/2004	
Date Revised	11/5/2004	
Groups Affected	CMHC	System Corrected: 8/14/2004
Issue	H2010 and 99070 are paying at a reduced rate.	
Impact	Providers are being underpaid.	Cleanup: 9/23/2004
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 7175 & 7272) Claims for CO 7175, which limited H2010 to one unit, were reprocessed and will appear on the 10/7/2004 remittance advice. No continued issues were identified for CO 7272.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.38	
Date Drafted	9/20/2004	
Date Revised	10/22/2004	
Groups Affected	CMHC	
Issue	The system is auto-denying claims or reducing the units for Psychotherapy services as exceeding the $284 limitations in error (Audit 6066 - $284 of Psych services per calendar month – Psychiatrist and audit 6165 - $284 of Psych services per calendar month – Psychologist).	System Corrected: 6/22/2004
Impact	These limitation audits are counting services based on performing provider type and specialty only. It should exclude certain details based on billing provider type and specialty.	Cleanup: 10/18/2004
Resolution	A change order has been written to exclude Early Intervention (08/183), Family Services Coordination for ECI (08/186), CMHC (11/111), Non CMHC Affiliates (11/122), and CMHC Partial Hospitalization (11/124) billing provider types. (CO 6586 & 6902) Claims associated with these change orders were reprocessed on 10/18/2004.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.39	
Date Drafted	9/20/2004	
Date Revised	11/12/2004	
Groups Affected	CMHC	Policy Update: Pending
Issue	If code T1019 (Personal Care Services, per 15 minutes) is billed with modifier HE (Mental Health Program) and HK (Special High Risk Mental Health) on the same day, only one is paid.	
Impact	Claims are denying as duplicate.	Cleanup: Pending
Resolution	A policy clarification is being written to research the status of these two modifiers. Information will be conveyed to the providers when they will be able to begin using the HE/HK modifiers. (CO 7271) This is a duplicate of CHHC 1.43. Please refer to CHHC 1.43 for future updates.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.40	
Date Drafted	9/20/2004	
Date Revised	8/1/2005	Policy Update: 11/4/2004
Groups Affected	CMHC	
Issue	Alcohol and Drug Day Treatment - T1008. The code was inactivated, but a new code was not cross-walked to replace it.	
Impact	Providers are unable to bill for this service after 3/31/2004.	Cleanup: N/A
Resolution	A policy was written with a replacement code. The crosswalk for T1008 is H0018. This was updated in the system on 11/4/2004 with an effective date of 1/1/2004.	
Provider Action	Rebill for claim payment.	

Item Reference	CHHC 1.41	
Date Drafted	9/13/2004	
Date Revised	10/29/2004	
Groups Affected	HCBS SED	System Corrected: Pending
Issue	Claims are being denied for HCBS SED benefit plan with exception 2504 (bill other insurance).	
Impact	Claims are being denied incorrectly.	Cleanup: Pending
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) This is a duplicate of CHHC 1.35. Please refer to CHHC 1.35 for future updates.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.42	
Date Drafted	9/13/2004	
Date Revised	10/29/2004	
Groups Affected	CMHC	System Corrected: Pending
Issue	H2010 and 99070 are paying at a reduced rate.	
Impact	Providers are being underpaid.	Cleanup: Pending
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) This is a duplicate of CHHC 1.36. Please refer to CHHC 1.36 for future updates.	
Provider Action	No action is needed.	

Item Reference	CHHC 1.43	
Date Drafted	9/13/2004	
Date Revised	5/6/2005	
Groups Affected	CMHC, HCBS	System Corrected: 3/9/2005
Issue	Claims are being denied when modifiers HE, HK, and KX are billed the same day for procedure codes T1019 and T2003.	
Impact	Providers are not being paid.	Cleanup: 5/3/2005
Resolution	Claims billed with T1019 and T2003 for same date of service but with modifiers HE, HK, or HK are being denied as duplicate. This issue was corrected on 3/9/2005. EDS reprocessed the claims denied in error starting on 5/3/2005. (COs 7271 and 7388) **Reprocessed ICN Range**: 5205123000001 - 5205123028605	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.44	
Date Drafted	2/11/2005	
Date Revised	2/11/2005	
Groups Affected	HCBS FE	System Corrected: Pending
Issue	Claims are not paying consistently when there are two details on one line item on the prior authorizations for the same procedure, same performing provider number, and same date of service.	
Impact	Providers are not being paid.	Cleanup: pending
Resolution	During the system design, it was determined that prior authorizations or plans of care (POC) would only be entered as one detail for the same date of service, procedure, and performing provider number. KDOA enters multiple POCs, some times, for the same date of service, procedure, and performing provider number. The system is being updated to allow for this to be a capability. This impacts HCBS FE only. Providers will be notified when the system is updated. (CO 7619)	
Provider Action	None at this time.	

Item Reference	CHHC 1.45	
Date Drafted	2/11/2005	
Date Revised	7/22/2005	
Groups Affected	All	
Issue	G9012 for case management not classified elsewhere are denying for assistive technology providers for HealthConnect referral and Medicare related edits.	Policy Decision: 12/31/04
Impact	Providers are not being paid.	
Resolution	Per policy, all national codes must have the HealthConnect referral or the Medicare denial. Assistive technology providers did not have processes in place to complete this. SRS approved the reprocessing of claims for 1/1/04-12/31/04 without the HealthConnect referral or the Medicare denials attached. Claims started reprocessing on 5/27/2005. This requirement will be enforced for calendar year 2005 and after. Additional reprocessing started on 7/20/2005. (CO 7725) **Reprocessed ICN Range:** 8005146000978 - 8005146001456; 5205145000304 – 5205145000311; 8005201000001 – 8005201000478	Cleanup: 7/20/2005
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.46	
Date Drafted	2/11/2005	
Date Revised	7/22/2005	
Groups Affected	HCBS FE	
Issue	Claims are not paying consistently when there are two prior authorizations on file for the same procedure, same performing provider number, and same date of service.	Enhancement: 3/5/2005
Impact	Providers are not being paid.	Cleanup: 7/5/2005
Resolution	During system design, it was determined that prior authorizations or plans of care (POC) would be entered only as one detail for the same date of service, procedure, and performing provider number. KDOA sometimes enters multiple POCs for the same date of service, procedure, and performing provider number. The system was updated on 3/5/2005 to allow for this to be a capability. This impacts HCBS FE only. Claims started reprocessing on 7/5/2005. (CO 7619) **Reprocessed ICN Range:** 5205182138125 – 5205182138141; 8005181000472 - 8005181000970	
Provider Action	None at this time.	

Item Reference	CHHC 1.48	
Date Drafted	4/29/2005	
Date Revised	5/31/2005	
Groups Affected	SED Waiver	System Corrected: 2/11/2005
Issue	The SED benefit claims are denying for diagnosis code coverage.	
Impact	Providers are not being paid.	Cleanup: 5/27/2005
Resolution	EDS loaded all appropriate diagnosis codes to the SED benefit plans. This issue occurred for one week in February and was corrected on 2/11/05. Claims denied in error for invalid diagnosis code started reprocessing on 5/27/2005. (CO 7859) **Reprocessed ICN Range:** 8005146001457 - 8005146001574; 5205145000313 - 5205145000337	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	CHHC 1.50	
Date Drafted	11/05/2005	
Date Revised	12/23/2005	System Updated: 10/27/2005
Groups Affected	HCPD Providers	
Issue	HCPD claims denied for “allow 1 unit of personal services per month in error.”	
Impact	Providers were not paid.	Cleanup: 12/16/2005
Resolution	The system was updated on 10/27/2005 to correct this issue. Claims were reprocessed on 12/16/2005. (CO 8641) **Reprocessed ICN Range:** 8005350000001 – 8005350000004; 5205350000001	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Dental

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

Item Reference	DENT 1.1	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	Dental	
Issue	Provider numbers for dental service providers including ICF-MRs, Local Health Departments, and Federally Qualified Health Centers were not assigned provider numbers with a dental provider type until after the changeover to Doral.	Resolved 1/19/2004
Impact	This issue delayed claims payment. Doral's system does not allow the input of claims by providers that do not have a provider number.	
Resolution	Applications were received and enrollments were processed. Information was received by Doral on 1/19/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.4	
Date Drafted	2/29/2004	
Date Revised	4/19/2004	
Groups Affected	Dental	
Issue	Exchanges of data between contractors occasionally failed. Examples included HIPAA compliance checks; data content of files is missing; transfers and receipts do not match; and history files.	Ongoing as needed
Impact	This issue caused delays in claims processing as one or more of the contractors did not have current data necessary for accurate and timely claims processing.	
Resolution	These problems were generally resolved that day, with a new file sent the next day. Data transfer problems occur from time to time and most issues are resolved as soon as possible after they occur. Outstanding issues have been identified and are being addressed.	
Provider Action	No action is needed.	

Item Reference	DENT 1.5	
Date Drafted	2/29/2004	
Date Revised	5/28/2004	
Groups Affected	Dental	
Issue	Encounter rate table for Federally Qualified Health Clinic (FQHC) dental service providers was not loaded. Currently, the MMIS pays these claims at the fee-for-service rate instead of the encounter rate.	Resolved: 4/22/2004
Impact	Dental claims submitted by these providers did not pay correctly.	
Resolution	The system change was identified and implemented on 4/16/2004. This issue was resolved on 4/22/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	DENT 1.7	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	
Groups Affected	Dentist	System Corrected: 3/5/2004
Issue	Dental anesthesia code (D9221) was being reimbursed at the incorrect level.	
Impact	Providers were not being paid correctly.	Cleanup: 10/7/2004
Resolution	Dental anesthesia code (D9221) was being reimbursed at the incorrect level. The pricing files and processes were updated to correctly price the claims on 3/5/04. EDS identified the claims priced in error and submitted adjustments on 5/13/2004. Additional claims were reprocessed on 10/7/2004. (CO 6137)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	DENT 1.9	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	System Corrected: 7/28/2004
Groups Affected	Lab	
Issue	Dental claims are being denied for allowing only one prophylaxis treatment per 180 days when no claim has been paid in the last 180 days.	Cleanup: 9/10/2004
Impact	Claims were being denied incorrectly.	
Resolution	EDS corrected this issue on 7/28/2004. EDS identified and reprocessed the denied claims on 9/10/2004. (CO 6335)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.10	
Date Drafted	7/9/2004	
Date Revised	5/24/2005	
Groups Affected	Dentist	
Issue	Dental claims are being denied as duplicate claims when different tooth numbers are involved.	System Corrected: 2/11/2005
Impact	Providers are not being paid.	
Resolution	Dental claims are being denied as exact duplicate claims when multiple lines for the same date of service are billed with different tooth numbers. These 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. (COs 5636, 6943, & 7704) CO 5636 was implemented on 6/8/2004 to automate the processing of some duplicate claims. CO 7704 was moved to production on 2/11/2005 to correct posting when no claim is in history. The seven claims were reprocessed on 3/12/2005 for this CO. Doral completed the cleanup on CO 6943 involving the 76 modifier in November 2004.	Cleanup: 11/8/2004
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.	

Item Reference	DENT 1.11	
Date Drafted	7/26/2004	
Date Revised	10/22/2004	System Corrected: 7/12/2004
Groups Affected	County Health Departments	
Issue	County Health Department dental claims are being denied in error.	
Impact	Providers are not being paid.	Cleanup: N/A
Resolution	Claims were not being paid to the County Health Departments for dental services. County Health Departments have been issued dental provider numbers. These will be used to bill dental claims. (CO 7026)	
Provider Action	Since the denied claims are under the County Health Department general physician/clinic number, claims need to be rebilled with the new numbers. No automatic reprocessing of claims will occur.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.12	
Date Drafted	8/2/2004	
Date Revised	10/29/2004	System Corrected: 6/14/2004
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.	Cleanup: 10/29/2004
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 identified the claims paid in error and initiated reprocessing on 10/29/2004. (CO 7083)	
Provider Action	No action is needed.	

Item Reference	DENT 1.13	
Date Drafted	10/19/2004	
Date Revised	10/29/2004	System Corrected: 10/8/2004
Groups Affected	Dentist	
Issue	Claims are being denied for the “only one extraction per day per quadrant is allowed for D7210” edit.	
Impact	Providers were underpaid.	Cleanup: 10/29/2004
Resolution	Claims were being denied for the “only one extraction per day per quadrant is allowed for D7210” edit. This issue was corrected on 10/8/04. EDS identified and reprocessed the claims denied in error on 10/29/2004. (CO 7433)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.14	
Date Drafted	11/02/2004	
Date Revised	5/24/2005	
Groups Affected	Dentist	System Corrected: 2/11/2005
Issue	Claims are denying in error for exception 266 for procedure code D2335 billed with tooth surface of "I" (inciscal angle).	
Impact	Providers are not being paid.	Cleanup: 5/23/2005
Resolution	The system was corrected to allow tooth surface of "I" for D2335 on 2/11/2005. Claims started reprocessing on 5/23/2005. (CO 7496)	
	Reprocessed ICN Range: 8005143001150 – 8005143001182; 5205143001071 – 5205143001107	
Provider Action	No action is needed.	

Item Reference	DENT 1.15	
Date Drafted	11/10/2004	
Date Revised	5/24/2005	
Groups Affected	Dentist	Policy Updated: 10/28/2004
Issue	Dental coverage was included in Major Medical coverage.	
Impact	Certain dental services are denying for other insurance inappropriately.	
Resolution	Per State direction, dental coverage was removed from the Major Medical coverage matrix on 10/28/2004. Claims were provided to Doral the week of 5/23/2005 to start reprocessing. (CO 7501)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.16	
Date Drafted	2/11/2005	
Date Revised	5/6/2005	
Groups Affected	Dentists	Process Corrected: Contact Doral for Update
Issue	Dental claims are denying for no prior authorization.	
Impact	Providers are not being paid.	
Resolution	Per Title XIX policy, dental providers are required to get prior approval to perform certain dental services, particularly in the adult population. Doral is responsible for granting prior authorization for these services and directly entering them into the EDS system. Once Doral enters the PA, it is immediately available to the EDS system. In review of the process, Doral will determine how to enter PAs more timely into the system. Since summer of 2004, all dental claims that require PA are set to suspend for manual review by Doral. Claim denials received by providers have been determined manually by Doral. No systematic denials are occurring for prior authorizations for dental services.	Cleanup: N/A
Provider Action	Contact Doral customer service when claim denies for prior authorization.	

Item Reference	DENT 1.17	
Date Drafted	2/11/2005	
Date Revised	5/6/2005	
Groups Affected	Dentists	Process Corrected: Contact Doral for Update
Issue	Co-pay is being deducted more than once on a date of service.	
Impact	Providers are being underpaid.	
Resolution	Co-pay is taken at the claim level. Most dentists bill all services that are provided on one day on the same claim. However, during Doral's processing, the claim may be separated into multiple claims causing co-pay to be taken multiple times. SRS is working with Doral to ensure that a claim stays together as received from the dentist. Providers will be informed when the process is established.	Cleanup: N/A
Provider Action	Contact Doral customer service when co-pay is deducted more than once on a date of service and the provider submitted all services on a single claim document.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.18	System Corrected: 1/6/05 suspending claims Cleanup: N/A
Date Drafted	2/11/2005	
Date Revised	4/8/2005	
Groups Affected	Dentist	
Issue	Claims appeared to be denying in error for "Allow no more than one intraoral complete series every 36 months."	
Impact	Providers perceived that they were not being paid.	
Resolution	Claims were paying correctly for "Allow no more than one intraoral complete series every 36 months." Exception 6154 is posting when there is no other complete series on file for the past 36 months. This exception is set to suspend for Doral to review manual claims on history to determine if claim should be paid. The exception is correct and no cleanup will be done since claims suspended. (CO 7755)	
Provider Action	None at this time.	

Item Reference	DENT 1.19	System Corrected: 6/15/2005 Cleanup: N/A
Date Drafted	3/18/2005	
Date Revised	7/22/2005	
Groups Affected	Title XXI Dentist	
Issue	Some Title XXI claims which are paid fee-for-service above the $2,000 threshold were denying for provider type and specialty.	
Impact	Providers were not getting paid.	
Resolution	Some Title XXI claims which are paid fee-for-service above the $2,000 threshold were denying for provider type and specialty. This was corrected on 6/15/2005. (CO 7991)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.20	
Date Drafted	6/10/2005	
Date Revised	8/1/2005	
Groups Affected	Dentist	System Corrected: 4/1/2005
Issue	D7210 was denying in error as invalid provider type to procedure code.	
Impact	Providers were not being paid.	Cleanup: 7/26/2005
Resolution	This occurred for the following provider type to provider specialty combinations: 13/131, 13/181, 27/270, 27/271, 27/272, 27/273, 27/274, 27/275, and 53/345. This was corrected on 4/1/2005. Claims started reprocessing on 7/26/2005. (CO 8224) **Reprocessed ICN Range:** 8005207000001 – 8005207000002; 5205214009780 – 5205214009782	
Provider Action	None at this time.	

Item Reference	DENT 1.21	
Date Drafted	10/27/2005	
Date Revised	10/20/2005	
Groups Affected	Dentist	System Updated: 10/8/2005
Issue	Dental medical policies were updated to allow coverage for provider type and specialty 08/080 and 31/351.	
Impact	Providers will expect an increase in covered services.	Cleanup: 10/24/2005
Resolution	Claims from 10/1/05 – 10/7/05, prior to the system update, will be reprocessed for an effective date of 10/1/05. Refer to medical policy numbers E2005-034, E2005-035, E2005-036, and E2005-07. Claims started reprocessing on 10/24/2005. (CO 8587) **Reprocessed ICN Range:** 8005297000001 – 8005297000521	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	DENT 1.22	
Date Drafted	10/20/2005	
Date Revised	11/18/2005	System Updated: 10/21/2005
Groups Affected	Dentist	
Issue	Claims denied for no encounter rate on file for provider types 03 (custodial care facility), 13 (public health agency), 27 (dentist), and 53 (head start facility) for procedure code D0210 (intraoral complete series – including bitewings).	Cleanup: 11/10/2005
Impact	Providers were not paid.	
Resolution	The system was updated to recognize these provider types for procedure code D0210 on 10/21/2005. Claims started reprocessing on 11/10/2005. (CO 8621) **Reprocessed ICN Range:** 8005314000001 – 8005314000040	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Rural Health Clinics & Federally Qualified Health Clinics

Item Reference	RHC 1.0	
Date Drafted	2/29/2004	
Date Revised	7/29/2004	
Groups Affected	Rural Health Clinics & FQHCs	
Issue	RHC/FQHC providers were paid Case Management fees for some of their beneficiaries during the February Cap adjustment run. These providers were not to be paid the $2 administration payment beginning in November 2004.	Resolved: 3/17/2004
Impact	Providers were paid in error; the money needed to be recovered.	
Resolution	A letter was mailed to inform the providers of this resolution. (CO# 5784) It was hoped that this could be accomplished through the cost settlement process and not require account receivables or recoupments. SRS determined these claims could not be recovered through the cost settlement process because of the timing involved in that process. The cleanup occurred starting 7/22/2004 and was completed 7/30/2004.	
Provider Action	No action is needed.	

Item Reference	RHC 1.1	
Date Drafted	4/12/2004	
Date Revised	10/15/2004	System Corrected: 3/1/2004
Groups Affected	RHC	
Issue	Rural Health Clinics (RHCs) have reported that Medicaid is being paid as the secondary insurance on a Medicare-related claim. The amount paid by Medicaid was more than the Medicare co-insurance.	Cleanup: 8/30/2004
Impact	Claims were being overpaid.	
Resolution	This issue was resolved on 3/1/2004. EDS completed submitting adjustments for this issue on 8/30/2004. (CO 5720)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	RHC 1.2	
Date Drafted	4/12/2004	
Date Revised	10/15/2004	
Groups Affected	RHC/FQHC	System Corrected: 4/16/2004
Issue	RHC and FQHC were being paid too low in addition to the fee-for-service rate issue. They were being paid below normal physician fee-for-service rates.	
Impact	Claims were being underpaid significantly.	Cleanup: 5/12/2004
Resolution	A partial system correction for this issue was identified and implemented on 4/16/2004. A solution was identified to resolve the incorrect pricing of claims when an invalid performing provider number was submitted. An adjustment was submitted for claims that were paid using the incorrect rate on 5/12/2004. (CO 6202)	
Provider Action	No action is needed.	

Item Reference	RHC 1.3	
Date Drafted	4/12/2004	
Date Revised	10/15/2004	
Groups Affected	RHC/FQHC	System Corrected: 4/15/2004
Issue	Lab related claims for RHC were being paying fee-for-service (FFS) rates.	
Impact	Overpayments occurring as lab-related claims should not be paid at all. Only face-to-face claims should be paid an encounter rate.	Cleanup: 5/13/2004
Resolution	A partial system correction for this issue was identified and implemented on 4/16/2004. A solution was identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. (CO 6202)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	RHC 1.4	
Date Drafted	4/9/2004	
Date Revised	10/15/2004	
Groups Affected	RHC/FQHC	System Corrected: 10/14/2004
Issue	Starting on the 3/25/04 remittance advice, RHC and FQHC claims were not being paid at the encounter rate (per diem allowable). All services were processing at the nonencounter rate.	
Impact	Claims were being underpaid significantly. For example, office visit procedure code 99213 paid $18.03 instead of $65.95.	Cleanup: 10/20/2004
Resolution	A partial system correction for this issue was identified and implemented on 4/16/2004. A solution was identified to resolve the incorrect pricing of claims when an invalid performing provider number is submitted. Claims were still paying two encounter rates, or more, when KBH services should deny as content of service. This was corrected on 10/14/2004. Claims were reprocessed on 10/20/2004. (CO 5665)	
Provider Action	No action is needed.	

Item Reference	RHC 1.5	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	System Corrected: 6/24/2004
Groups Affected	RHC	
Issue	A $3 instead of $2 co-pay amount was being deducted from claims.	
Impact	Providers were being underpaid.	Cleanup: 7/20/2004
Resolution	EDS identified the issue that caused the incorrect co-pay to be deducted. The system was updated on 6/24/2004 to reflect the accurate co-pay amount of $2 for Rural Health Clinic providers. EDS reprocessed the claims on 7/20/2004. (CO 6718)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	RHC 1.6	
Date Drafted	7/26/2004	
Date Revised	11/24/2004	
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.	System Corrected: 10/25/2004
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 resolved the issue on 10/25/2004. EDS identified four claims to adjust and 560 denied details to reprocess. EDS reprocessed the claims that were denied in error, and they should appear on the 2/17/2005 RA. (CO 7001) **Reprocessed ICN Range:** 8005041000001 - 8005041000255	Cleanup: 2/11/2005
Provider Action	No action is needed.	

Item Reference	RHC 1.7	
Date Drafted	3/18/2005	
Date Revised	8/19/2005	
Groups Affected	FQHC	
Issue	Some claims for benefit plans are denying for POS 50, 70, and 72 which are valid for FQHC.	System Corrected: 8/10/2005
Impact	Providers are not being paid.	
Resolution	The system is being updated to ensure that all benefit plans applicable to POS 50, 70, and 72 are included for provider type/provider specialty of 08/080 (FQHC and RHC). This was not corrected on 7/19/2005. The new update was completed on 8/10/2005. Claims started reprocessing on 8/16/2005. (CO 8098) **Reprocessed ICN Range:** 8005207000072 - 8005207000133; 8005227000092 – 80052270000165; 5205227004364 - 5205227004361	Cleanup: 8/16/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Hospice

Item Reference	HSPC 1.0	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	
Groups Affected	Hospice	System Corrected: 4/9/2004
Issue	There was a high volume of claims in suspense to be manually priced.	
Impact	As of 1/14/2004, 556 claims were in suspense to be manually priced. This created a slow-down in the turnaround time providers can get their claims paid.	Cleanup: N/A
Resolution	A temporary workaround solution was implemented to suspend claims to one specific location so that dedicated staff could focus on pricing these claims. A meeting was held with hospice providers on 1/14/2004 to identify methods to automate pricing process as a permanent system change. The system change was moved to production on 4/9/2004. (CO 5595)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPC 1.1	
Date Drafted	8/11/2004	
Date Revised	9/16/2005	
Groups Affected	Hospice	
Issue	Claims are being paid for beneficiaries with hospice coverage when no prior authorization is on file or the provider is not the hospice provider.	
Impact	Providers are being overpaid.	System Corrected: 7/1/2005 Cleanup: 9/10/2005
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. (COs 6279 & 6521) Claims were reprocessed for CO 6279 on 9/27/2004. Claims were reprocessed for CO 6521 on 10/1/2004. • Claims are paying for hospice room and board when there is no hospice assignment on file or the performing provider is not the hospice assignment. This issue was corrected on 7/1/2005. Letters to notify providers for claims that may potentially be recouped were mailed on 8/15/2005. Claims started reprocessing for recoupment on 9/10/2005. (CO 7921) **Reprocessed ICN Range:** 5205254003227 – 5205254004384	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPC 1.2	
Date Drafted	9/15/2005	
Date Revised	9/23/2005	System Corrected: 8/30/2005
Groups Affected	Hospice	
Issue	Hospice rate adjustments have been made retroactively, and providers were not paid the current rates.	
Impact	Providers were paid a different rate than currently loaded.	Cleanup: 9/16/2005
Resolution	The dates of service are after 10/1/2004 for claims processed between 1/10/2005 and 8/30/2005. This issue affects only three providers and is related to policy E2004-042. The claims started reprocessing on 9/16/2005. (CO 8489) **Reprocessed ICN Range:** 5205261000464 – 5205261000600	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Hospitals & Adult Care Home

Item Reference	HSPT 1.0	
Date Drafted	2/29/2004	
Date Revised	11/4/2004	
Groups Affected	Hospitals	
Issue	Claims are being denied for swing bed services.	System Corrected: 5/1/2004
Impact	Affected facilities did not receive payment for swing bed 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 swing bed services filed as Interim Care claims were corrected. An existing issue is ongoing for Inpatient Crossover claims for swing bed services as of 1/30/2004. An issue of Medicare related swing bed claims was resolved on 5/1/2004. CO 3704, 4803, 6276, & 6591 related to swing bed rate changes; no claims were identified for cleanup. All claims already reprocessed. CO 6276 also impacted state institutions and Adult Care Home pricing. CO 7196 completed processing on 11/4/2004.	Cleanup: 11/4/2004
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.2	
Date Drafted	2/29/2004	
Date Revised	10/22/2004	System Corrected: 4/16/2004
Groups Affected	Hospital	
Issue	Providers reported that "one-day" hospital claims were not processing correctly.	
Impact	Claims were being denied in error.	Cleanup: 10/19/2004
Resolution	A system change was implemented on 4/16/2004. Initial reprocessing occurred on 4/29/2004. Additional reprocessing was initiated on 10/19/2004. (CO 5648)	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.5	
Date Drafted	2/29/2004	
Date Revised	5/31/2005	System Corrected: 3/25/2004
Groups Affected	Hospitals and Adult Care Home	
Issue	Outpatient claims were being denied incorrectly for admitting diagnosis. Issues reoccurred at the end of March.	
Impact	Claims without an admitting diagnosis were denied incorrectly for error code 360.	Cleanup: 5/27/2005
Resolution	A system change was identified and implemented on 3/25/04. EDS resubmitted claims that were denied in error on 8/13/2004. (CO 6702) Additional claims cleanup claims started reprocessing on 5/27/2005. (CO 7010) **Reprocessed ICN Range:** 80051430002028 - 8005143002758	
Provider Action	No action is needed.	

Item Reference	HSPT 1.6	
Date Drafted	3/2/2004	
Date Revised	10/15/2004	System Corrected: 3/25/2004
Groups Affected	Hospital	
Issue	Claims with a referring provider number present were being denied stating they needed a referral.	
Impact	Claims were being denied for referral.	Cleanup: 8/13/2004
Resolution	ASK identified the problem causing this issue. The system was corrected on 2/29/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.7	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	
Groups Affected	Hospital	System Corrected: 3/26/2004
Issue	Lab HCPCS codes are being denied when ER E & M codes are present on the claim.	
Impact	Claims were being denied in error.	Cleanup: 8/20/2004
Resolution	This issue was a result of EDS not converting outpatient claims to medical claims to process them for ER claims after HIPAA. As in interim solution, these claims were being worked manually and all services on the same date of service and the same claim as an E & M Emergency Room code were being forced. (CO 5270/5324). This issue was corrected on 3/26/2004. EDS completed the reprocessing of claims on 8/20/2004.	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	HSPT 1.10	
Date Drafted	3/2/2004	
Date Revised	10/15/2004	System Corrected: 5/18/2004
Groups Affected	Hospital	
Issue	Claims with TC and 26 modifiers were being processed incorrectly.	Cleanup: 8/12/2004
Impact	Radiology claims were being denied as duplicates in error.	
Resolution	Resolution was completed on 3/5/2004. This issue was re-identified on 4/25/2004. The system was updated on 5/18/2004. (TO 6687) EDS resubmitted the denied claims on 8/13/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.12	
Date Drafted	3/2/2004	
Date Revised	10/15/2004	
Groups Affected	Hospital	System Corrected: 5/7/2004
Issue	Physical therapy series claims are being denied when the primary diagnosis code is a V-code.	
Impact	All related claims were being denied in error.	Cleanup: 9/7/2004
Resolution	EDS identified that these claims were being denied because the procedural edit to diagnosis restrictions was not functioning properly. (CO 5948 – Edit 4037/4259) This error was corrected on 5/7/2004. EDS identified and reprocessed the claims on 9/7/2004.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.13	
Date Drafted	3/2/2004	
Date Revised	10/15/2004	
Groups Affected	Hospital	System Corrected: 4/26/2004
Issue	Medicare inpatient claims paid with Part B benefits are not processing as third-party liability (TPL).	
Impact	Claims were being paid with a Medicare allowed amount that is less than TPL would pay.	
Resolution	EDS is implementing new processes to ensure the accuracy of keyed data. Claims are being adjusted as identified by the providers. Changes were put into production on 4/26/2004 to have inpatient claims with Medicare Part B processed as TPL.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.14	
Date Drafted	3/2/2004	
Date Revised	8/5/2005	
Groups Affected	Hospital	
Issue	KFMC outlier issues exist for processing reviews and recoupments.	Policy Decision: 8/5/2005
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. Documentation was reviewed and it was determined that the documentation did not support the use of the observation room services over the regular emergency room codes at this time.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.15	
Date Drafted	3/2/2004	
Date Revised	10/15/2004	
Groups Affected	Hospital	
Issue	Psychiatric claims were being denied for prior authorization when other insurance made a payment.	Resolved: 3/12/04
Impact	Claims were being denied in error.	
Resolution	Resolution page was updated to state claims are to be paid and not denied. System automation is currently being identified so manual intervention is not needed when other insurance is involved	
Provider Action	Cleanup has been completed. If providers still have claims they believe were denied in error they should resubmit the claims for processing.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.16	
Date Drafted	3/2/2004	
Date Revised	4/30/2004	
Groups Affected	Hospital	
Issue	Fetal monitoring was being denied for claims due to medical policy.	Resolved: 1/19/2004
Impact	Claims were being denied for delivery due to fetal monitoring being present on the claim.	
Resolution	The SRS program manager approved a system change to not require medical necessity for fetal monitoring. This change was implemented on 1/19/2004.	
Provider Action	Providers need to resubmit claims since the claims processed correctly per policy at the time. In addition, medical necessity denial code is used for many instances so claims cannot be easily identified through system review.	

Item Reference	HSPT 1.17	
Date Drafted	3/2/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	
Issue	SOBRA claims were being denied due to noncoverage of emergency services without a local SRS approval.	Resolved 4/1/2004
Impact	Claims were being denied unless delivery is procedure code on claim.	
Resolution	SOBRA claims are paid automatically only if labor and delivery is involved. Even if it is an emergency or life/death situation, the hospital manual clearly states the SRS field office must approve payment of claim before submission to EDS for payment.	
Provider Action	Review SOBRA guidelines and ensure that proper steps are taken before billing the claim.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.18	
Date Drafted	3/2/2004	
Date Revised	10/22/2004	
Groups Affected	Hospital	
Issue	A delay exists for approvals on timely filing requests greater than 24 months old.	SRS: 10/20/2004
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 completed reviewing requests received through September. Providers can look for new claims by the end of October.	
Provider Action	No action is needed.	

Item Reference	HSPT 1.20	
Date Drafted	3/23/2004	
Date Revised	10/15/2004	
Groups Affected	Hospital	
Issue	Claims that post edit 570 will no longer be denied automatically when billed on the Internet or on paper. These claims will suspend for review of the patient status code on the "from" and "to" dates and be processed accordingly. The same day admit/discharge inpatient claim should not be denied with edit 570.	System Corrected: 4/19/2004
Impact	Hospital claims were automatically being denied by error code 570 for "total days billed less than covered days." These claims should suspend for review of the patient status code and the "from" and "to" dates. When the system was corrected for this issue, 90% of the inpatient claims started to suspend for another system issue. The claims could not be released from the system until the system was corrected; otherwise, they would be denied. This issue was corrected on Friday, 4/16/04 but was not in time for the financial cycle. Provider's remittance advices for inpatient claims reflected denials for the week; however, very few paid claims appeared. Those paid claims were on the 4/29/04 remittance advices as they were confirmed to be in a paid status for this issue on 4/19/04.	Cleanup: Refer to HSPT 1.2
Resolution	The cause of the incorrect denials was identified and corrected on 4/16/2004. Reprocessing of suspended claims occurred on 4/16/2004. EDS resubmitted the denied claims on 4/29/2004. (CO 5648)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.21	
Date Drafted	3/23/2004	
Date Revised	10/22/2004	
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.	System Corrected: 10/8/2004
Impact	These claims are being suspended to avoid denials until a solution is in place. Providers are experiencing a delay in payment.	Cleanup: 10/18/2004
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 was corrected on 10/8/2004 to allow payment for claims where the beneficiary has eligibility that spans multiple benefit plans such as Medically Needy to TXIX. Claims denied in error were identified and reprocessing started 10/18/2004. (CO 6883)	
Provider Action	No action is needed.	

Item Reference	HSPT 1.22	
Date Drafted	4/9/2004	
Date Revised	4/9/2004	
Groups Affected	Hospital	
Issue	Mom/baby claims were being denied, especially if they were submitted through ASK.	Resolved 4/7/2004
Impact	Claims were being denied in error and were underpaid.	
Resolution	The system was changed to verify that the diagnosis, procedure, and revenue codes are newborn related. V3000 and V3001 diagnosis codes were excluded from the newborn diagnosis table. SRS approved adding V3000 and V3001 as newborn diagnosis codes.	
Provider Action	Verify that any denied claims meet the processing guidelines. If the claim meets the guidelines, you can resubmit the claim. If the claim does not meet the guideline, please review and update if appropriate billing and resubmit.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.23	
Date Drafted	4/9/2004	
Date Revised	5/28/2004	
Groups Affected	Hospital	
Issue	Inpatient psychiatric claims were being denied for “no prior authorization (PA) on file.”	Resolved: 5/7/2004
Impact	Claims were being denied in error.	
Resolution	The system was expecting the date of service on the claim to be completely within the approved dates on the PA. Psychiatric claims only require the “admit date” to be within the approved dates on the PA. Claims will now suspend for manual review and appropriate approval. (Task 6384) All psychiatric claims with erroneous denials for “no PA on file” were reprocessed for reconsideration of payment on 5/7/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.24
Date Drafted	4/12/2004
Date Revised	10/15/2004
Groups Affected	Hospital
Issue	SOBRA claims with pregnancy diagnosis codes or correct authorization from the SRS local office are being denied.
Impact	Claims were 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. System Corrected: 6/29/2004 Cleanup: 8/26/2004
Provider Action	No action is needed.

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.25
Date Drafted	4/15/2004
Date Revised	6/11/2004
Groups Affected	Hospital
Issue	Claims with a discharge status of 40 – 70 cannot be billed on the Internet.
Impact	Providers who do not have electronic means other than the KMAP Web site to submit electronic claims must submit claims on paper.
Resolution	CO 6654 added discharge codes 40 – 70 as valid codes for the Internet UB-92 inpatient claim form. (CO 6654)
Provider Action	No action is needed.

Resolved: 6/4/2004

Item Reference	HSPT 1.26
Date Drafted	4/15/2004
Date Revised	10/29/2004
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 identified and reprocessed claims that were denied for multiparity on 10/29/2004. (CO 7017)
Provider Action	No action is needed.

Policy Updated: 7/12/2004

Cleanup: 10/29/2004

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.27
Date Drafted	4/15/2004
Date Revised	10/15/2004
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. Refer to GENP 1.98 for clean up efforts. • 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. Refer to GENP 1.51 for future updates. • 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. Refer to HSPT 1.14 for future updates. • KFMC claims that were denied with edit 400 (units of service must be greater than zero) need to be reprocessed as paid details. EDS identified and reprocessed the detail lines which zero paid on 10/12/2004. (CO 7105)
Provider Action	No action is needed.

System Corrected: 10/12/2004

Cleanup: 10/12/2004

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.28	
Date Drafted	4/22/2004	
Date Revised	10/15/2004	
Groups Affected	Hospital	
Issue	Claims submitted through ASK are being denied 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 Cleanup: 9/3/2004
Impact	Claims were being denied incorrectly.	
Resolution	EDS corrected the system to analyze claims received from ASK to determine if the attending, operating, and other provider ID 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 was implemented on 5/21/2004. EDS completed reprocessing the claims on 9/3/2004. (CO 6227)	
Provider Action	No action is needed.	

Item Reference	HSPT 1.29	
Date Drafted	4/27/2004	
Date Revised	4/27/2004	
Groups Affected	Physician and Hospital	
Issue	The ET modifier was sometimes reducing emergency room fees down to the 99281 payment, which is a lower amount.	Resolved: 4/27/2004
Impact	A potential underpayment could occur.	
Resolution	KMAP pays emergency rooms higher rates only for an emergent diagnosis. If a claim does not have an emergent diagnosis, it will be reduced to the lower emergency room evaluation code (99281) rate.	
Provider Action	Review billing practices to determine if emergent codes are being used when appropriate to do so. If not, claims will continue to decrease to lower rate.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.30	
Date Drafted	4/27/2004	
Date Revised	11/24/2004	
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.	Enhancement 1/7/2005
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 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. This enhancement was completed. (CO 7027)	
Provider Action	No action is needed.	

Item Reference	HSPT 1.31	
Date Drafted	4/27/2004	
Date Revised	4/27/2004	
Groups Affected	Hospital	
Issue	The WC modifier price cannot be found on the fee schedule.	Resolved: 4/27/2004
Impact	Provider unsure what the reimbursement rate should be for billed claims.	
Resolution	The price for the WC modifier is listed under the different rate types for the ambulatory surgical center fee schedule section.	
Provider Action	Request fee schedule if you need complete information on various fees.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	HSPT 1.33	
Date Drafted	5/4/2004	
Date Revised	5/4/2004	
Groups Affected	Hospital	
Issue	Outpatient claims were being denied for no procedure code for drugs and pharmaceuticals.	
Impact	Providers perceived that they were being underpaid.	
Resolution	All outpatient details historically and in the new system have always required a procedure, HCPCS, or CPT on every detail line to process and pay correctly. For drug and pharmaceutical claims, hospitals are billing revenue codes only, as if billing inpatient claims. This is not a policy change. The only way to price a claim for outpatient is to know the specific “J” code and in most cases, NDC and drug name on the claim. Without the drug that was provided for outpatient service, KMAP cannot determine the price to reimburse the hospital.	Resolved: 4/30/2004
Provider Action	Providers need to evaluate their billing system to ensure that the “J” code is included on the claims for drugs and pharmaceuticals for outpatient claims. In addition, if the “J” code is non-classified or can cover multiple dosages, the NDC must be included in the remarks section of the HCFA 1500 or comment section of the 837 transaction. If providers have previously paid claims involving other insurance, do not resubmit as new claims to process the remaining lines. Please submit adjustment requests so the claim can process as a whole against other insurance paid amount.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.35
Date Drafted	5/12/2004
Date Revised	5/24/2005
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 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 was corrected, the system suspended the claims for manual review. (COs 6523 & 7008) On 9/16/2004, CO 6523 reprocessed claims from 10/23/2003 to 6/5/2004. CO 7008 completed claims reprocessing for process dates of 6/6/2004 - 7/14/2004 on 10/11/2004. Claims are being denied when the E-code is in sequence number 10-19. Claims should only deny if the E-code is primary or sequence. This was a very small impact to the number of claims. This caused claims to appear to be denied based on the admit date when the issue is unrelated to the admit date. EDS corrected the issue on 3/9/2005 and started reprocessing claims on 5/23/2005. (CO 7709) **Reprocessed ICN Range:** 8005143001231 - 8005143001330
Provider Action	No action is needed.

System Corrected: 3/9/2005

Cleanup: 5/23/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.37	
Date Drafted	7/11/2004	
Date Revised	10/22/2004	
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.	System Corrected: Pending
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) CO 6967, which places the DRG submitted in the diagnosis field of a finalized claim, was moved to production on 10/8/2004. CO 7236, which displays the DRG appropriately via the Internet was moved to production on 10/22/2004. No cleanup is needed on this as the claims will display correctly with correction.	Cleanup: N/A
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.38
Date Drafted	10/19/2004
Date Revised	9/2/2005
Groups Affected	Inpatient, Long Term Care
Issue	Claims that should be priced manually are ignoring manual pricing.
Impact	Providers are being underpaid and/or overpaid.
Resolution	• Claims that are priced manually for inpatient stays are ignoring the manual pricing and pricing a different amount. This occurs on claims that encounter exceptions 2519, 2057, and 4133. The system update was completed on 11/12/2004. Suspended claims were released for manual pricing on 11/15/2004. Claims that priced in error started reprocessing on 4/8/2005 for CO 7618. For CO 7417, claims started reprocessing on 5/23/2005. (CO 7417 & 7618) **Reprocessed ICN Range:** 5205140002473 - 5205140003343 • LTC claims that need manual pricing are not able to be priced manually. Claims are in suspense for the small percentage impacted. The system was updated on 3/8/2005. Claims have been released from suspense to start processing. Claims that were already paid started reprocessing on 5/6/2005. (CO 7805) **Reprocessed ICN Range:** 5205140003344 - 5205140003831 • Claims that need manual pricing on line one only are requiring EDS to price zero on lines 2 and after manually. System automation was completed on 8/5/2005. The claims started reprocessing on 8/22/2005. (CO 7865) **Reprocessed ICN:** 5205234000042 • Providers with LOC of "06" will be loaded systematically with new swing bed rates effective with DOS 1/1/2005. The updates were completed on 5/19/2005. Claims started reprocessing on 7/28/2005. (CO 7937) **Reprocessed ICN Range:** 5205209000001 - 5205209000003
Provider Action	No action is needed.

System Corrected: 8/5/2005

Cleanup: 8/22/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.40	
Date Drafted	11/02/2004	
Date Revised	7/5/2005	
Groups Affected	Inpatient	System Corrected: 1/11/2005
Issue	Claims are denying for edit 2515 on newborn claims.	
Impact	Providers are not being paid.	Cleanup: 7/1/2005
Resolution	Claims are denying for edit 2515 on newborn claims when the criteria for processing the newborn claim is met. This affects only a small percentage of claims. The claims are denying for name/number mismatch. This issue was resolved on 1/11/2005. EDS identified the claims denied in error and reprocessed them on 7/1/2005. (CO 7469) **Reprocessed ICN Range:** 8005181001744 - 8005181001754	
Provider Action	No action is needed.	

Item Reference	HSPT 1.41	
Date Drafted	2/11/2005	
Date Revised	5/31/2005	
Groups Affected	Long Term Care	
Issue	Claims are being denied before the maximum number of LOA days for nursing facilities and intermediate care facilities for mental health (ICF-MH) are met.	System Corrected: 12/7/2004
Impact	Providers are not being paid.	
Resolution	Outpatient claims were counting toward the annual 18 leave days per year for nursing facilities. Claims were denying with audit 6244 when the 18 days was not met. This was corrected on 12/7/04. Claims denied in error will be identified and reprocessed. Claims started reprocessing on 5/26/2005. (CO 7669) Reprocessed ICN Range: 8005143001331 - 8005143001642 Outpatient claims were counting toward the annual 21 leave days per year for ICF-MH. Claims were denying with audit 6244 when the 21 days was not met. This was corrected on 12/7/04. Claims denied in error were reprocessed by 2/28/2005. (CO 7191) Reprocessed ICN Range: 5005052914009 - 5005052914016; 8005059000001 - 8005059000129	Cleanup: 5/26/2005
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.42	
Date Drafted	2/11/2005	Policy Approved: 1/11/05
Date Revised	5/24/2005	
Groups Affected	Long Term Care	
Issue	Beneficiaries with level of care (LOC) 011 are denying for providers who have approval for LOC 01.	System Update: 3/8/2005
Impact	Providers are not being paid.	
Resolution	Beneficiaries with LOC 011 are denying with providers who have approval for LOC 01. SRS determined that the beneficiary's LOC 011 can be paid with a provider's approved LOC of 01. The system was updated on 3/8/2005 to pay these claims. Claims started reprocessing on 5/23/2005. (CO 7768) **Reprocessed ICN Range:** 8005143001643 – 8005143002027	Cleanup: 5/23/2005
Provider Action	None at this time.	

Item Reference	HSPT 1.43	
Date Drafted	3/18/2005	
Date Revised	9/30/2005	
Groups Affected	LTC, Swing Bed	
Issue	LTC and swing bed claims should price using the detail from date of service or allow for LOC 100 for procedure T2048.	System Corrected: 9/1/2005
Impact	Providers are being underpaid or overpaid depending upon the rate that is being used.	
Resolution	• The claims are using the header from date of service on all details which may use incorrect rates for the time period. This change was moved to production on 9/1/2005. Claims started reprocessing on 9/30/2005. (CO 7984) **Reprocessed ICN Range:** 5205271000001 – 5205271009906 • Claims are denying for level of care (LOC) 100 for procedure T2048 (BH LTC Res R & B, per diem) in error. This issue was corrected on 6/16/2005. Claims started reprocessing on 8/2/2005. (CO 8120) **Reprocessed ICN Range:** 8005214000001 – 8005214000004	Cleanup: 9/30/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.44	
Date Drafted	3/18/2005	
Date Revised	7/22/2005	
Groups Affected	Inpatient	Policy Updated: 3/3/05
Issue	Effective 2/14/2005, the reimbursement rate paid to hospitals billing for the outpatient observation/stabilization service (using billing code H2013) will be paid at a per diem rate of $750.	
Impact	Providers are being underpaid.	Cleanup: 7/14/2005
Resolution	The rate update was made on 3/3/05. Claims processed under the old rate will be identified and reprocessed for dates of service of 2/14/05 – 3/3/05. Claims were reprocessed on 7/14/2005. (CO 7982) **Reprocessed ICN Range:** 5205195002227 - 5205195002231	
Provider Action	No action is needed.	

Item Reference	HSPT 1.45	
Date Drafted	4/29/2005	
Date Revised	9/30/2005	
Groups Affected	Inpatient	System Corrected: 8/5/2005
Issue	Third party liability amount is not being reduced on some inpatient claims.	
Impact	Providers are being overpaid.	Cleanup: 9/27/2005
Resolution	TPL is not being deducted from inpatient claims when it is present on the claim. This issue is sporadic and does not occur on all claims. This issue was corrected on 8/5/2005. Letters for claims identified for possible overpayment were mailed to providers on 9/12/2005. Claims started reprocessing on 9/27/2005. (CO 8086) **Reprocessed ICN Range:** 5205269000001 – 5205269000890	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.46	
Date Drafted	4/29/2005	
Date Revised	5/24/2005	System Corrected: 4/25/05
Groups Affected	ASC	
Issue	Procedure code 51500 (excision of urachal cyst or sinus) is denying in error for ASC setting.	
Impact	Providers are not being paid.	Cleanup: 5/23/2005
Resolution	51500 was denying in error for ASC setting (PT/PS 01/010). This issue was corrected on 4/25/05. Claims completed reprocessing on 5/23/2005. Only four claims needed to be manually reprocessed. (CO 8108)	
Provider Action	None at this time.	

Item Reference	HSPT 1.47	
Date Drafted	6/10/2005	
Date Revised	9/30/2005	
Groups Affected	Inpatient	System Corrected: 8/5/2005
Issue	Revenue codes on inpatient claims are being paid incorrectly on some claims.	
Impact	Providers are being overpaid.	
Resolution	Edits for revenue code not being covered on date of service (error 4227), revenue code requiring medical necessity (4253), revenue code restricted for age (4254), revenue code and provider type not covered (4271), and invalid claim type for revenue code (4374) should set but are not in some cases. This issue was corrected on 8/5/2005. Letters for claims identified for possible recoupment were mailed to providers on 9/7/2005. Claims started reprocessing on 9/20/2005. (CO 8228) **Reprocessed ICN Range:** 5205262000001 – 5205262000006; 8005249000001 – 8005249003321	Cleanup: 9/20/2005
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.48	
Date Drafted	7/5/2005	
Date Revised	10/21/2005	
Groups Affected	Outpatient	System Corrected: 9/1/2005
Issue	Claims are paying when timely filing requirements have not been met.	
Impact	Providers are being overpaid.	
Resolution	Timely filing exception for over 24 months (exception 555) is not posting on detail lines two and after for outpatient claims. The claims do not have the proper documentation to allow for bypass of timely filing and thus, are paying in error. Corrections were made on 9/1/2005 in production. Letters were mailed to providers on 9/23/2005 for potential claim recoupments. Claims started reprocessing on 10/21/2005. (CO 8292) **Reprocessed ICN Range:** 5205291016792 - 5205291018620	Cleanup: 10/21/2005
Provider Action	None at this time.	

Item Reference	HSPT 1.49	
Date Drafted	7/5/2005	
Date Revised	10/7/2005	System Corrected: 10/7/2005
Groups Affected	Hospital	
Issue	Claims are posting exception 1062 (hospital billing provider using incorrect type of bill) in error.	
Impact	Providers are not being paid.	Cleanup: 10/7/2005
Resolution	This situation occurs on a small number of claims and not on all hospital claims. This correction moved to production on 10/7/2005. Claims started reprocessing on 10/7/2005. (CO 8294) **Reprocessed ICN Range:** 8005280000065 - 8005280003011	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.53	
Date Drafted	10/6/2005	
Date Revised	11/18/2005	
Groups Affected	Inpatient	System Corrected: 10/3/2005
Issue	Claims are paying when both mother accommodations and baby accommodations are billed on the same inpatient claim.	
Impact	Providers are being overpaid.	Cleanup: 11/17/2005
Resolution	The system was updated on 10/3/2005. Letters were mailed to providers on 11/1/2005 to notify them of claims potentially overpaid. Claims started reprocessing on 11/17/2005. (CO 8273) **Reprocessed ICN Range:** 5205321000031 – 5205321000043	
Provider Action	None at this time.	

Item Reference	HSPT 1.55	
Date Drafted	10/13/2005	
Date Revised	11/4/2005	System Updated: 10/6/2005
Groups Affected	Swing Bed	
Issue	Swing bed rates with dates of services between 1/1/05 and 5/19/05 have been retroactively updated.	
Impact	Providers need to have claims reprocessed at the new rates.	Cleanup: 10/27/2005
Resolution	The updates were completed on 10/6/2005. Claims started reprocessing on 10/27/2005. (CO 8582) **Reprocessed ICN Range:** 5205300000001 – 5205300000374	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	HSPT 1.56	
Date Drafted	10/13/2005	
Date Revised	11/18/2005	
Groups Affected	ASC	System Corrected: 10/4/2005
Issue	Procedure codes 37766 and 50950-50 had incorrect max fee amounts on file.	
Impact	Providers are being overpaid and underpaid.	Cleanup: 11/17/2005
Resolution	Code 37766 was paying at $2,022.54 and should pay at $1,022.54. Code 50950-50 was paying at $1,361.70 and should pay at $2,042.55. The system was updated on 10/4/2005. Claims started reprocessing on 11/17/2005. (CO 8585) **Reprocessed ICN Range:** 5205321000013 – 5205321000030	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Local Education Agencies

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Pharmacy

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	PHAR 1.5	
Date Drafted	2/29/2004	
Date Revised	4/29/2005	
Groups Affected	Pharmacy	
Issue	Currently KMAP does not use the usual and customary field. Although a provider may send the usual and customary charge, it is not considered when a pharmacy claim is processed.	Enhancement: 4/5/2005
Impact	The usual and customary charge can be important when calculating the reduction of a beneficiary's spenddown. It also becomes helpful when drug rebate is processed.	
Resolution	KMAP will begin using the usual and customary charge in addition to the gross amount due charge on pharmacy claims. Providers will be given notification prior to this change becoming effective. (COs 6929, 6953, 6960, 7065, 7123, 7124, 7143, 7152, and 7257) This enhancement was completed on 4/5/2005.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	PHAR 1.6	
Date Drafted	2/29/2004	
Date Revised	7/22/2005	
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 processed incorrectly as paid or denied claims that will be reimbursed by KMAP.	Policy Decision: Spring 2004
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	EDS started returning the co-pay and spenddown amount in the co-pay field of the NCPDP transaction in spring 2004. No additional changes are planned.	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	PHAR 1.8	
Date Drafted	5/12/2004	
Date Revised	6/11/2004	
Groups Affected	Pharmacy / DME	
Issue	DME claims crossing over from Medicare for diabetic testing supplies were being denied.	Resolved: 5/12/2004
Impact	Claims were being denied, and providers were not being paid.	
Resolution	Medicare requires that the DME supplier bill the range of dates for diabetic supplies. This range includes future dates. For instance, if the DME supplier is billing on 5/1/04, they bill 5/1/04 to 5/31/04. These claims were being denied correctly in KMAP as KMAP does not allow future billing dates. Claims with future dates must be billed on paper with the remittance advice.	
Provider Action	If denials received for future dates are invalid, the provider must bill the claim on paper and attach the Medicare remittance advice.	

Item Reference	PHAR 1.9	
Date Drafted	5/12/2004	
Date Revised	10/15/2004	System Corrected: 5/7/2004
Groups Affected	Pharmacy and DME	
Issue	DME codes not subject to CLIA editing were being denied for needing a CLIA number.	Cleanup: 7/15/2004
Impact	Providers were being underpaid.	
Resolution	The parameter from the old system to deny for CLIA did not include DME. The DME codes were removed from the list for needing CLIA. EDS updated the file and resolved the issue. EDS identified and reprocessed the claims denied in error on 7/15/2004. (CO 6281)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	PHAR 1.10	
Date Drafted	5/12/2004	
Date Revised	8/5/2005	
Groups Affected	Pharmacy and DME	
Issue	Claims were being paid in error when E0570 (nebulizer) was billed over limit or denied for QMB.	System Corrected: 6/20/2005
Impact	Providers were being overpaid and underpaid.	
Resolution	• Claims are being paid in error when the beneficiary had already received a nebulizer (E0570) within the last three calendar years. The issue was identified and resolved on 7/14/2004. EDS submitted the adjustments on 7/15/2004 and 10/15/2004 for the claims paid in error. (CO 6287) • QMB claims are being denied in error for nebulizers. The system was updated on 6/20/2005. Claims started reprocessing on 8/3/2005. (CO 8074) **Reprocessed ICN Range:** 5205215000009 – 5205215000010; 8005215000090 – 8005215000133	Cleanup: 8/3/2005
Provider Action	No action is needed.	

Item Reference	PHAR 1.11	
Date Drafted	6/28/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 8/5/2004
Issue	Claims are being denied for error code 6306 on beneficiaries younger than age of 21.	
Impact	Providers were 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) Non-POS claims denied in error were identified and reprocessed on the 9/23/2004 remittance advice.	Cleanup: 9/23/2004
Provider Action	POS-submitted claims were not reprocessed since pharmaceuticals may not have been dispensed. If dispensed and error code 6306 was received, providers can resubmit claims on POS to be paid.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	PHAR 1.12	
Date Drafted	7/11/2004	
Date Revised	10/8/2004	
Groups Affected	Internet Submitters	
Issue	Pharmacy claims cannot be entered on the Internet with Submission Clarification Code (header), Pregnancy Indicator (header), and Other Coverage Code (detail).	Enhancement: 10/8/2004
Impact	The absence of these fields can cause 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) The enhancement coding is complete and moved to production on 10/8/2004. The addition of the above three fields to the pharmacy Web format will be explained to providers in the next Pharmacy Bulletin (in October 2004).	
Provider Action	No action is needed.	

Item Reference	PHAR 1.14	
Date Drafted	7/26/2004	
Date Revised	7/26/2004	System Corrected: 1/3/2005
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.	Cleanup: N/A
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 implemented a correction to allow for these claims to be worked manually. (CO 6683)	
Provider Action	If pharmacist dispensed drug, please submit for reimbursement.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	PHAR 1.15	
Date Drafted	8/2/2004	
Date Revised	10/29/2004	
Groups Affected	Pharmacy	System Corrected: 2/2/2004
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.	Cleanup: N/A
Resolution	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. Since most claims were not POS related, no recoupment will be initiated. (CO 5582)	
Provider Action	No action is needed.	

Item Reference	PHAR 1.16	
Date Drafted	5/27/2005	
Date Revised	5/27/2005	System Corrected: 5/25/2005
Groups Affected	Pharmacy	
Issue	Pharmacy claims are receiving exception 911 (internal error) denials in error.	
Impact	Providers are not receiving payment approval for dispensing of drugs.	Cleanup: N/A
Resolution	Pharmacy claims are receiving exception 911 (internal error) denials in error. This issue was corrected on 5/25/2005. (CO 8179)	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	PHAR 1.17	
Date Drafted	5/27/2005	
Date Revised	10/21/2005	
Groups Affected	Pharmacy	System Corrected: 10/13/2005
Issue	Providers are being paid for claims that should not be paid.	
Impact	Providers are being underpaid and overpaid.	
Resolution	The DESI flag for the NDC files from CMS is being overlaid with the First Data Bank (FDB) file's DESI flag. The CMS flag, which indicates coverage, should take precedence. Thus, if the CMS tape states that the NDC is not covered, the FDB flag may be overlaying the CMS flag and allowing claims to be paid. CO 8096, which loaded all CMS DESI code values to the NDC file, was completed on 5/19/2005. The remaining change orders were implemented on 10/13/2005. (COs 8096, 8153, and 8154)	Cleanup: N/A
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: State Institutions

Item Reference	STIN 1.0	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	State Institutions	
Issue	Claims submitted by state institutions were being denied for invalid type of bill and other edits due to transition of these facilities from turnaround documents to the UB92 form.	Resolved 1/15/2004
Impact	Payments to two state institutions were delayed for approximately-8 weeks.	
Resolution	This issue was resolved through testing and billing education with both facilities as of 1/8/2004 and 1/15/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Electronic Submitters

Item Reference	EDI 1.0	
Date Drafted	2/29/2004	
Date Revised	9/14/2004	
Groups Affected	Electronic Submitters	
Issue	Providers were not pleased with the EDS/SRS implementation of the HIPAA 835 transaction. The 837 P, 270, and 271 translation maps are not accurate to HIPAA guidelines.	
Impact	Providers requested changes to the 835 transaction before they begin using the electronic transaction. Until then, providers using electronic RAs may have to post RAs manually. 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. EDS resolved this issue on 9/13/2004. (CO 7074) If a name with more than 50 characters is received, per HIPAA, only 35 characters should be allowed with the remaining characters being truncated. Otherwise, the provider never receives a response. EDS is resolving this issue and will notify providers when complete. (CO 5789, 5793, 6429, & 7122) COs 5789, 5793, & 6429 were cancelled and will be covered by CO 7122. CO 7122 was moved to production on 9/13/2004.	System Corrected: 9/13/2004
Resolution	An ongoing focus group of affected providers has yielded approximately 32 recommendations to EDS/SRS. This effort is continuing based on feedback from providers.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	EDI 1.1	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	
Issue	Claims were being denied for “beneficiary name is missing” or “invalid beneficiary ID.”	Resolved 11/15/2003
Impact	Electronic providers were not supplying the beneficiary name in the correct field as required by the SRS HIPAA companion guides for claims transactions.	
Resolution	EDS and SRS resolved this issue through education with providers and electronic submitters as well as updates to the EDI companion guides clarifying the cardholder ID field.	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	EDI 1.3	
Date Drafted	2/29/2004	
Date Revised	4/9/2004	
Groups Affected	Electronic Submitters	
Issue	Billed date was imported as 1903 instead of 2003.	System Corrected: 8/13/2004
Impact	This error affected 6,644 claims (multiple providers).	
Resolution	These providers were using an old version of PACS. Edit 554 (billed date is prior to date of service) was changed to prevent claims from being denied for this reason in the future. Affected claims were identified, corrected and reprocessed. ASK had a reoccurrence of this issue from 6/28/2004 to 8/13/2004. 635 denied claims were reprocessed and started to appear on the 2/24/2005 RA. (CO 7622)	Cleanup: 2/17/2005
Reprocessed ICN Range	800504300000 – 800504300063	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

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

Item Reference	EDI 1.6	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	
Groups Affected	ASK submitters	
Issue	Claims submitted by ASK are being denied for invalid other provider field.	ASK Corrected: 7/7/2004
Impact	Claims were being denied incorrectly.	
Resolution	The alpha location field is being transmitted at the end of the provider number, which causes it to be unrecognizable. EDS worked with ASK to move correction to production on 7/2/2004. (CO 6065) Since EDS cannot identify ASK transmission issues, there will be no automatic reprocessing of claims.	
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. Refer to the Web site for more information: https://www.kmap-state-ks.us/Documents/EDI/ask-eds-march.pdf. Please continue to review the EDI site for future updates.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	EDI 1.7	
Date Drafted	7/26/2004	
Date Revised	11/12/2004	
Groups Affected	Electronic 837	System Corrected: 10/22/2004
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.	Cleanup: N/A
Resolution	Providers will be allowed to bill TPL claims with no allowed amount when the carrier denied indicator is enabled. The system was updated on 10/22/2004 to allow the denied indicator to be used. Providers who received a denial with a "Y" indicator on the original claim can resubmit the claims. (CO 6716)	
Provider Action	None at this time.	

Item Reference	EDI 1.8	
Date Drafted	11/02/2004	
Date Revised	11/02/2004	System Corrected: 2/11/2005
Groups Affected	All	
Issue	Claims are denying for beneficiary name mismatch when transmitted on the 837 transaction if the name is not all uppercase.	Cleanup: N/A
Impact	Providers are not being paid.	
Resolution	All X12 data received should be translated by EDS to all uppercase and not cause a denial. EDS is working on resolving the system issues. This affected only one provider, who has changed the formatting. No cleanup needed. (CO 7498)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: General

Item Reference	GENP 1.0	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	System Corrected: 1/30/2004
Groups Affected	All: (Primarily HCBS & Home Health)	
Issue	MMIS was not correctly locating approved prior authorization records (plans of care) on file.	
Impact	Claims were being denied for "PA not found on database" or were not decrementing the correct PA and therefore causing incorrect denials. This impacted all providers, including Home Health and HCBS.	Cleanup: 3/31/2004
Resolution	The system was corrected on 1/30/2004. EDS reprocessed the claims that were denied in error on 3/3/2004. (CO 4829)	
Provider Action	No action is needed.	

Item Reference	GENP 1.1	
Date Drafted	2/29/2004	
Date Revised	9/13/2004	System Corrected: 2/19/2004
Groups Affected	All (Except Pharmacy)	
Issue	Claims with detail lines spanning dates of services and for more than one unit are being reduced to only one unit.	
Impact	Claims are not paying the full amount due to providers.	Cleanup: 9/9/2004
Resolution	A temporary procedure for 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 was disabled. Changes were made on daily limitation audits. EDS reprocessed the claims on 9/9/2004. (CO 5227 & 7285)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.2
Date Drafted	2/29/2004
Date Revised	10/21/2005
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. EDS completed the recoupments by the end of October for CO 5211 for exact duplicates. CO 5211 for suspect duplicate claims remains to be processed. Letters for the suspect duplicate claims for potential recoupments were sent to providers the week of 9/19/2005. Claims denied in error for suspect duplicate started reprocessing on 9/16/2005. Change order 4432 was completed on 9/24/2004. Letters were mailed to providers on 10/4/2005 for potentially overpaid claims. Claims started reprocessing on 10/21/2005. (CO 4432, 5211, and 7397) **Reprocessed ICN Range** (CO 8211): 5205261000001 – 5205261000463; 8005259000018 – 8005259001121; 5205291000001 - 5205291000078 • CO 7397 moved to production 1/7/2005 for crossover claims that paid duplicate. • Some audits were not setting when dates overlapped. This was corrected on 5/6/2005. Claims were reprocessed with CO 7947 on 6/9/2005. Letters were mailed to providers on 10/4/2005 for potentially overpaid claims. Claims started reprocessing on 10/21/2005. (CO 7607) **Reprocessed ICN Range:** 5205291000001 - 5205291000078 • Claims with procedure S0610, which is once in a lifetime procedure paid more than once. This was corrected on 4/25/2005. Claims started reprocessing during the week of 5/2/2005. (CO 8114) **Reprocessed ICN Range**: 5605124906002 – 5605124906010 • Duplicate payment is occurring when payment is made for the same component of physician or independent lab services. This issue was corrected on 9/6/2005. Claims paid in error will be reprocessed with CO 5211 above. (CO 8232)
Provider Action	No action is needed.

System Corrected: 9/6/2005

Cleanup: 10/21/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.3	
Date Drafted	2/29/2004	
Date Revised	10/8/2004	
Groups Affected	All	
Issue	Claims are paying zero dollars when Medicare is involved but should have produced KMAP payment.	System Corrected: 7/16/2004
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. Claims were reprocessed for CO 6438 on 10/1/2004.	Cleanup: 10/1/2004
Provider Action	No action is needed.	

Item Reference	GENP 1.4	
Date Drafted	2/29/2004	
Date Revised	5/7/2004	
Groups Affected	All	
Issue	Providers were experiencing inadequate access to customer service.	Resolved: 6/4/2004
Impact	Providers were not able to reach Customer Service for KMAP program assistance or claims resolution.	
Resolution	The Customer Service queue size and allocation of dedicated lines was increased on 1/29/2004 as an interim solution. EDS added 12 employees to customer service on 4/23/2004. Improvement was immediate. This issue will continue to be monitored. Customer Service is now averaging hold times of approximately 2 minutes. We appreciate your patience and hope you are experiencing significant improvement in response times.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.5	
Date Drafted	2/29/2004	
Date Revised	10/7/2005	
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 Web site for claim inquiries or contact EDS or SRS for assistance regarding each denied claim. This issue greatly impacts 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) This change appeared on the 10/14/2004 RA. • 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. The system change moved to production on 10/7/2005 for the 10/13/2005 RA. (COs 6022 and 6023) • CO 5857 was moved to production on 9/10/2004. This allows display of the TPL carrier code on the remittance advice. • Providers are unable to determine the amount allowed for inpatient claims that are paid using the DRG methodology. Payment is correct but the allowed amount cannot be seen. This issue was corrected on 10/22/2004 for the 10/28/2004 RA. (CO 7456) • Crossover Part B claims show only one detail line for CMHC claims. Providers cannot reconcile RA due to this issue. The system change moved to production on 10/7/2005 for the 10/13/2005 RA. (CO 6150) • When mass adjustments result in no payment difference, they will be suppressed on the RA. When EDS' automatic reprocessing results in a denial, they will be suppressed on the RA. This moved to production for the 2/17/2005 RA. (CO 7620) • On the RA summary page, there are several cumulative total fields indicating year-to-date information. This has not been reset for 2005. This has been corrected as of the RAs dated 9/8/05 and after. (CO 7875) • Incorrect mother claim amounts are being reported on the adjustment RAs in the Patient Responsibility Amount, Claim Adjustment Amount, and Line Item Provider Payment columns. The amounts should report as they did originally. CHHCs are impacted the most. This was corrected for the 3/24/2005 RA. (CO 7883)	Enhancement: 10/13/2005 System Correction: 10/13/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.11	
Date Drafted	2/29/2004	
Date Revised	10/15/2004	
Groups Affected	All	
Issue	HealthConnect Kansas-related claims are not processing as intended. ER claims, lab and radiology providers, and ambulance, to name a few, are being reviewed to ensure they are being paid appropriately.	System Corrected: 3/26/2004
Impact	Claims were being denied when they should have been paid for some providers.	
Resolution	EDS reviewed and modified exception code 1050 (HealthConnect Kansas referral) to ensure that the policy for HealthConnect Kansas referrals was being applied correctly. CO 5324 was implemented on 3/26/04. CO 5270 was implemented on 3/4/04. CO 5270 set claims to suspend for manual intervention effective 3/8/04. Claims affected by CO 5270 and 5324 for HealthConnect referral were reprocessed, even though the diagnosis was emergent, and appeared on the 8/26/2004 remittance advice. EDS completed reprocessing of claims on 8/20/2004.	Cleanup: 8/20/2004
Provider Action	No action is needed.	

Item Reference	GENP 1.12	
Date Drafted	2/29/2004	
Date Revised	12/16/2005	
Groups Affected	All	Policy Update: 8/17/2004
Issue	Title XXI carve-outs are not paying appropriately. They are processing under the guidelines for Title XIX carve-outs.	
Impact	Some providers could not be paid and others were being paid for services that should be denied and billed to the managed care organization.	Cleanup: N/A
Resolution	Exception 2017 will be modified to reflect accurately 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 co-pay 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 issue was closed and no longer occurs.

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.13	
Date Drafted	3/30/2004	
Date Revised	10/29/2004	
Groups Affected	All	
Issue	Claims are being suspended or denied due to system calculated zero payment. Many claims are also paying zero dollar amounts.	System Corrected: 10/8/2004
Impact	Claims are not being paid correctly.	
Resolution	Edit 4200 is causing claims to be suspended, denied, or paid a zero dollar amount. One of the main causes for edit 4200 posting is that the beneficiary is eligible for only a portion of the stay. EDS completed moved the change to production on 10/8/2004. Cleanup for previously denied claims was completed for CO 6070. (CO 5624 & 6501)	Cleanup: 11/4/2004
	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. 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." Claims reprocessed will start appearing on the 11/4/2004 RA. (CO 6344)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.14a
Date Drafted	4/6/2004
Date Revised	10/21/2005
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; 4) extra space on 837P transaction. Claims are encountering Edits 4244, 4229, 4030, 4029, 4342, or 4362 (which are all related to diagnosis system issues) and are being denied incorrectly.
Impact	
Resolution	• 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 were reprocessed. CO 6975 was moved to production on 9/10/2004. The claims for CO 6975 started reprocessing on 11/5/2004. (CO 5656, 6975, and 6546) Additional claims for CO 5656 were identified on 2/21/2005 and started reprocessing on 5/20/2005. **Reprocessed ICN Range:** 800514000001 – 800514000019; 5204193008000 – 5204194001000 • 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) • 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. CO 7070 to update part of the criteria moved to production on 9/1/2005. Claims started reprocessing for CO 7070 on 9/16/2005. (COs 7070 and CO 8312) **Reprocessed ICN Range:** 8005259000001 – 8005259000017 • Header level edits 4229 for primary diagnosis code on review is being set on non-primary diagnosis codes. This issue was resolved on 11/19/2004. All claims processed in error were reprocessed by 1/12/2005. (CO 7382) • Qualified Medicare Beneficiary (QMB) claims were denying for no diagnosis. This was corrected on 3/2/2005. Claims denied in error started reprocessing on 5/27/2005. (CO 7938) **Reprocessed ICN Range:** 8005145001523 – 8005145008477; 8005146000001 – 8005146000977 • Edit 4229 (diagnosis on review) was enhanced to allow it to set at the header only for inpatient claims, and edit 4244 was updated to post at detail, if appropriate. This change (CO 8255) was moved to production on 9/1/2005. Claims started reprocessing on 9/16/2005. CO 8063 for header level primary diagnosis on review is still pending correction. (COs 8063 & 8255) **Reprocessed ICN Range:** 5205257002775 – 5205257003289 • An additional space is being inserted on the 837P HIPAA transaction. The system was corrected on 6/3/2005. Claims started reprocessing on 9/20/2005. (CO 8065) **Reprocessed ICN Range:** 8005262000001 – 8005262016537 • Claims with pregnancy or family planning diagnosis code indicator are denying for HealthConnect Referral. This was corrected on 7/27/2005. Claims started reprocessing on 8/22/2005. (CO 8119) **Reprocessed ICN Range:** 5205234000001 – 5205234000041; 8005234000001 – 8005234000162
Provider Action	No action is needed.

System Corrected: 9/1/2005

Cleanup: 10/10/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.15	
Date Drafted	4/9/2004	
Date Revised	10/15/2004	System Corrected: 9/24/2004
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.	Cleanup: 9/28/2004
Impact	Provider confusion occurred and they had to contact EDS for actual outcome.	
Resolution	System issue was resolved on 9/24/2004. Cleanup to allow correct ICN to be viewed for past claims was completed on 9/28/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.16	
Date Drafted	4/12/2004	
Date Revised	10/15/2004	
Groups Affected	All	
Issue	KMAP Web site does not display secondary insurance information.	Resolved: 6/23/2004
Impact	Without calling EDS, providers could not determine the secondary insurer on file. The KMAP Web site stated there was no TPL involvement when the MMIS does have TPL on file.	
Resolution	This issue only occurs randomly, and the core issue has not been determined. Research of examples provided indicate that while the beneficiary had TPL on file, the dates entered in the search were for months that the beneficiary was ineligible for KMAP. No eligibility or TPL will be returned on the Internet when this occurs. (CO 6786)	
Provider Action	If provider receives a TPL denial and no TPL is on the web site, please contact beneficiary to get secondary insurance information.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.18	
Date Drafted	4/12/2004	
Date Revised	9/14/2004	
Groups Affected	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 adjust claims through the Web site. They must submit a request to EDS to void or adjust the claim.	System Corrected: 7/16/2004
Resolution	When voiding a claim on the Internet, providers receive a message that the void transaction failed. When adjusting a claim on the Internet, providers receive a message that the adjustment cannot be done and to contact the Help desk. Between 11/16/2003 and 7/30/2004, providers may have filed claims without a corresponding diagnosis pointer on the detail line. Claims that were identified as paid during this time frame without the diagnosis pointer were appropriately recouped on the 8/19/2004 remittance advice. To assist the provider community, EDS reviewed affected claims and resubmitted any claims that did not contain a diagnosis pointer on the detail line with a default value of one. These claims appeared on the 8/26/2004 remittance advice. If providers filed claims with invalid values (other than 1, 2, 3, or 4), EDS cannot correct the claims on behalf of the provider. In these cases, providers need to correct and resubmit the claims. (CO 6575 and 6711) Additional cleanup was identified for the diagnosis code indicator. Additional cleanup was completed on 5/27/2005. (CO 6711)	Cleanup: 5/27/2005
Provider Action	Providers must enter diagnosis cross-reference on detail when using Internet submission.	
Reprocessed ICN Range:	8005147000001 - 8005147000129	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.19	
Date Drafted	4/12/2004	
Date Revised	7/9/2004	
Groups Affected	All	
Issue	Claims with the same procedure code but a different modifier were being denied against each other.	Resolved: 6/25/2004
Impact	Providers were being underpaid.	
Resolution	The modifiers identified were not on the list to bypass duplicate auditing. The claims were processing according to policy. Research has been completed. The claims processed correctly. Per policy these modifiers are ignored during duplicate auditing.	
Provider Action	No action is needed.	

Item Reference	GENP 1.20	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	
Groups Affected	All	
Issue	Spenddown processing is confusing or inaccurate. This is occurring due to beneficiary files not updating correctly as well. This problem affects Community Mental Health Centers (CMHCs), it appears, more than other providers as many of their beneficiaries have spenddown amounts and rely on CMHC services.	Enhancement Completed: 6/17/2004 Cleanup: 9/3/2004
Impact	Claims were not applying toward spenddown amount or providers did not understand the processing or messages, such as "TPL/spenddown amount cannot be more than allowed amount."	
Resolution	EDS redesigned the system and corrected spenddown reporting. EDS researched procedure codes that CMS lists as never allowed for an individual's spenddown. If the beneficiary had qualified Medicare beneficiary (QMB) eligibility and it is covered by Medicare, many claims that should have counted toward spenddown did not. EDS reviewed the CMS tape that indicates Medicare coverage. Results were reviewed with SRS and file updates were made as approved by SRS. The reference file was updated on 5/11/2004. (COs 5421, 6465, 6627, and 6628) EDS completed reprocessing the claims on 9/3/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.23
Date Drafted	4/15/2004
Date Revised	5/7/2004
Groups Affected	All
Issue	The co-pay indicator was enabled for dual Medicare/Medicaid beneficiaries.
Impact	Beneficiaries were being required to pay the co-pay when providers believed that they should not pay.
Resolution	EDS researched the issues and determined that according to state policy, Medicare eligibility does not exempt beneficiaries from a co-pay requirement. Some beneficiaries are exempt based on their level of care.
Provider Action	No action is needed.

Resolved: 5/3/2004

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

Resolved: 4/15/2004

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.25	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 4/21/2004
Issue	Remittance advices are not displaying $2 co-pay amounts.	
Impact	The claim was not being reduced by the $2 co-pay amount, and claims are being overpaid.	Cleanup: 8/27/2004
Resolution	The co-pay table that identifies which services and/or providers should have co-pay amounts removed from claims did not include all provider types and specialties that should be included in co-pay deduction. The result is that co-pay amounts were deducted for Indian Health Clinics and clinic/maternity but not for general practice doctors and rural health clinics. (Task 6203). EDS completed the adjustments on 8/27/2004.	
Provider Action	No action is needed.	

Item Reference	GENP 1.26	
Date Drafted	4/15/2004	
Date Revised	10/15/2004	System Corrected: 4/13/2004
Groups Affected	All	
Issue	Claims for circumcision were being denied for unacceptable diagnosis code when billed with diagnosis code V502.	Cleanup: 6/14/2004
Impact	Claims were being denied incorrectly.	
Resolution	The V502 diagnosis code was added as a valid diagnosis code for circumcision on 4/13/2004. Claims that denied in error were reprocessed on 6/14/2004. (TO 6510)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.27	
Date Drafted	4/22/2004	
Date Revised	4/22/2004	
Groups Affected	Physician and Hospital	
Issue	Claims for sterilization were being denied when the form was attached.	Resolved: 4/22/2004
Impact	Claims were not being paid.	
Resolution	Tighter controls were put in place to ensure that the claims received have the federally-mandated sterilization form.	
Provider Action	Providers must ensure that they use the proper forms. Hospitals must ensure that they review the form that the provider uses prior to the sterilization to receive payment.	

Item Reference	GENP 1.28	
Date Drafted	4/22/2004	
Date Revised	10/15/2004	
Groups Affected	Physician and Hospital	
Issue	Professional and facility charges for sterilization were being denied when the form was attached.	System Corrected: 4/23/2004
Impact	Claims were not being paid.	
Resolution	When the professional and facility bill the exact same code without a modifier, the system views it as one sterilization per lifetime and denies the claim. Since the WC modifier was previously used, the system would differentiate that the claims were the same date of service, but one was facility and one was physician. The system was changed on 4/23/2004 to recognize that the following provider types and specialties are not duplicates to the physician's claim: 01/010, 01/351, 02/020, and 42/010. Claims that denied in error were reprocessed on 7/2/2004. (CO 6427, 6428)	Cleanup: 7/2/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.29	
Date Drafted	4/27/2004	
Date Revised	6/4/2004	
Groups Affected	All	
Issue	Claims were disappearing that were submitted since 3/1/04.	
Impact	Effective 3/1/2004, old provider numbers cannot be submitted on claims sent to EDS. Providers will not see these claims on their remittance advice or through the Web site.	Resolved: 5/7/2004
Resolution	Claims with the old provider numbers are not cross referenced to the provider remittance advice or returned. The system denies the claims but keeps the record under the beneficiary ID and date of service billed. Providers will not see the claims on their remittance advice or through the Web site. No change is planned for electronic claims as providers are not sending accurate billing to be captured in the system by the new provider number. EDS has no paper document able to return.	
Provider Action	Submit claims with new provider numbers. If you believe that your claim was submitted with the new provider number, call customer service and inquire by beneficiary number and date of service to determine if the claim was received and number accurate in the system from what was submitted.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.31	
Date Drafted	4/27/2004	
Date Revised	5/21/2004	
Groups Affected	Physician and Hospital	
Issue	For emergency room claims, either the professional claim or the facility claim was being paid and the other was being denied as a duplicate.	Resolved: 5/14/2004
Impact	Claims were not being paid.	
Resolution	Both claims should pay for professional component and facility. EDS is researching this issue. The examples that EDS received did not reflect duplicate denial. The denials were for invalid modifier.	
Provider Action	No action is needed.	

Item Reference	GENP 1.32
Date Drafted	4/27/2004
Date Revised	7/28/2004
Groups Affected	All
Issue	For consultations, the Internet was not allowing the referring provider number to be submitted on the claim.
Impact	Providers were unable to process claims through the Internet. Providers wanted the use of a dummy provider number, which is not available at this time.
Resolution	The system only evaluates the claim to determine if the referring provider number on the claim is valid. It does not review for the PCP. If claims are being denied for this reason, examples need to be provided. For the dummy provider number, SRS is taking into consideration if one should be established for billing purposes.
Provider Action	Submit claims on the Internet with a valid provider number. Service location is not reviewed for consultations.

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

Revised: 12/30/2005

KMAP Provider Communication

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

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.35	
Date Drafted	4/27/2004	
Date Revised	10/22/2004	
Groups Affected	All Medicare Part A and Part B providers	
Issue	All Medicare claims are not crossing over to Medicaid.	System Corrected: 6/18/2004
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 recovered Medicare Part A claims from 11/2003 – 5/2004 that were not sent to KMAP. The 30,000+ claims started processing in KMAP on 10/22/2004. All Medicare Part B and Part A claims have been recovered.	Cleanup: 10/29/2004
Provider Action	If Medicare Part B and Part A claims are not on the KMAP eligibility file, please resend to KMAP as Medicare reports all recovery by them is complete. Please note you can send these claims on 837 or via the Internet without attaching the paper RA.	

Item Reference	GENP 1.36	
Date Drafted	4/27/2004	
Date Revised	10/15/2004	System Corrected: 5/3/2004
Groups Affected	Physician	
Issue	CPT code 81000 (urine analysis) was being denied because it was bundled even when it was the only item billed on the claim.	Cleanup: 8/13/2004
Impact	Providers were potentially being underpaid.	
Resolution	EDS received examples of this issue and the reference file was updated on 5/3/2004. Claims reprocessing associated with CO 6493 was completed on 6/14/04. Claims reprocessing associated with CO 6708 was completed on 8/13/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.37	
Date Drafted	4/27/2004	
Date Revised	4/27/2004	
Groups Affected	Physician and Hospital	Resolved: 4/27/2004
Issue	Office visit claims were being denied as M90 message (not covered more than once in a 12 month period).	
Impact	Providers perceived that they were being underpaid.	
Resolution	This is a correct denial. Medicaid pays for only one comprehensive office visit every 12 months.	
Provider Action	Ensure patient has not had a comprehensive office visit evaluation in the last 12 months.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.39	
Date Drafted	5/4/2004	
Date Revised	5/4/2004	
Groups Affected	LTC and HCBS	
Issue	LTC and HCBS claims were being denied for invalid level of care.	Resolved: 3/26/2004
Impact	550 beneficiaries had level of care updated inadvertently when patient liability updates were made. This caused claims to be denied in error.	
Resolution	When the SRS worker sent a patient liability change for an HCBS beneficiary, the level of care effective date was inadvertently changed as well. If an effective date for level of care is in the system already, the system should not allow a change in effective date later than the existing date. The system was corrected to accept the earlier of the two dates as the correct level of care. (TO 6057)	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.41	
Date Drafted	5/4/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 4/12/2004
Issue	Claims with the 22 modifier were not paying at the correct level.	
Impact	Claims were being underpaid.	Cleanup: 5/13/2004
Resolution	Historically, the 22 modifier was used as both pricing and just informational. This caused claims to be paid inconsistently in the new system. The pricing files were updated to reflect the correct price for the 22 modifier combination. The system correction was made on 4/12/04. Claims priced in error were reprocessed on 5/13/2004. (TO 6407 and 6052)	
Provider Action	No action is needed.	

Item Reference	GENP 1.42	
Date Drafted	5/4/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 4/30/2004
Issue	Procedure codes A0200 and A0210 were paying at zero amounts.	
Impact	Claims were being underpaid.	Cleanup: 5/28/2004
Resolution	Procedure codes A0200 and A0210 should suspend for manual pricing (exception 6000) but were not suspending. The codes were added to the covered benefits needing manual pricing but then failed to allow EDS to manually price rather than pay at $0.00. This was corrected on 4/30/04. Claims that were priced at zero were reprocessed on 5/28/2004. (TO 6468)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.43	
Date Drafted	5/4/2004	
Date Revised	10/8/2004	System Corrected: 2/1/2004
Groups Affected	Hospital and Physicians	
Issue	EKG claims are being denied in error.	
Impact	Claims are being underpaid.	Cleanup: 10/7/2004
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 reprocessed all remaining denied claims on 10/7/2004. (CO 5606)	
Provider Action	No action is needed.	

Item Reference	GENP 1.44	
Date Drafted	5/4/2004	
Date Revised	5/14/2004	
Groups Affected	Hospital	
Issue	Claims with dates of service prior to 3/26/04, but billed after 3/26/04, were being denied with the 32 modifier.	Resolved: 4/21/2004
Impact	Claims were being underpaid.	
Resolution	Procedure codes 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 were being denied in error when billed with the 32 modifier. This issue occurred on claims with a date of service prior to 3/26/04 but billed after 3/26/04. This was corrected on 4/21/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.45	
Date Drafted	5/4/2004	
Date Revised	10/15/2004	System Corrected: 5/4/2004
Groups Affected	DME	
Issue	CPT code A4221 was being denied in error with EOB 1294.	
Impact	Providers were being underpaid.	Cleanup: 9/20/2004
Resolution	The system was corrected to allow proper processing for CPT code A4221. Claims denied in error were reprocessed on 5/6/2004 and 9/20/2004. (CO 6347)	
Provider Action	No action is needed.	

Item Reference	GENP 1.46	
Date Drafted	5/12/2004	
Date Revised	5/12/2004	
Groups Affected	All	
Issue	The Web site did not allow providers to correct the name or date of birth for beneficiaries who have denied claims for this reason.	Resolved: 5/12/2004
Impact	The perception is that these claims must be billed through another mechanism such as PES, ASK, or paper.	
Resolution	Name and date of birth can be changed on the Internet. Remove the beneficiary ID from the field and tab through the field. You will receive the message, “Beneficiary ID not on file.” Retype the beneficiary ID into the beneficiary ID field and tab through the field. The DOB and name will now automatically be updated to the correct information on file.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.47	
Date Drafted	5/12/2004	
Date Revised	5/12/2004	
Groups Affected	All	
Issue	Providers want to be able to bill on Friday and receive payment the following week but the Internet submission is sometimes unavailable.	Resolved 5/12/2004
Impact	Providers' cash flow for what they are accustomed to is impacted.	
Resolution	Claim processing is to be completed within 30 days of submission. Waiting until Friday, for expected payment on the following week, provides a very small window to get payment the following week. Every other Friday, system changes are released which may cause the Internet to function slower than normal. We highly encourage billing earlier in the week for you to potentially receive payment on claims the following week.	
Provider Action	Bill as early in the week as possible to allow system processing time as well as avoiding potential delays on Fridays during system releases.	

Item Reference	GENP 1.48	
Date Drafted	5/12/2004	
Date Revised	10/22/2004	
Groups Affected	Psychiatry	
Issue	Claims are being denied for meeting the limitation audit for psychiatric services per month.	System Corrected: 10/8/2004 Cleanup: 10/20/2004
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. These provider types are Clinic (08), Mental Health (11), and Laboratory (28). The system was corrected to exclude billing provider types and specialties that are not included in this list. In addition to this issue, EDS reviewed with SRS all limitation audits for psychiatric services to ensure that they are being set correctly. (CO 7056 & 7057) EDS moved the new design to correct this issue to production on 10/8/2004. EDS identified the claims processed in error and started reprocessing on 10/20/2004. (CO 6586 & 6902)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.49
Date Drafted	5/12/2004
Date Revised	11/18/2005
Groups Affected	All
Issue	Claims are being denied as content of service for items that should not be denied, including wellness visits against skilled nursing services, while others are being paid in error.
Impact	Claims are being processed incorrectly.
Resolution	• Procedure code 76856, which denied claims in error, was corrected. Clams were reprocessed and appeared on the 8/26/2004 RA. (CO 6922) • 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) An additional issue with S5190 denying against T1001 was identified. These claims were reprocessed on 5/13/2005. (CO 8036) **Reprocessed ICN Range:** 8005133000001 – 800513300005; 5205133000001 • Procedure code 83615, which denies content of service against procedure code 80053, will have this relationship to each other removed per a policy update. When updated, procedure code 83615 will not deny against procedure code 80053. The system was corrected on 11/10/2004. EDS reprocessed 563 claim adjustments with details denied in error on 5/1/2005. (CO 7374) **Reprocessed ICN Range:** 5205121015029 – 5205121015579 • All content of service codes for items, such as office visits that are performed after surgery, are also being reviewed for incorrect payment. Providers will be contacted when updates are made and claims are reprocessed. (CO 7375 and 7804) CO 7375 for surgery versus pre and post op care was corrected on 4/5/2005. For CO 7375, denied claims started reprocessing on 5/26/2005, and letters were sent to affected providers on 5/31/2005 for claims that were overpaid. Claims that were overpaid started recoupment on 8/1/2005. **Reprocessed ICN Range:** 5205144001530 – 5205144002800; 8005144000130 – 8005144004846; 5205186002596 – 5205186018059; 5205213000001 – 5205213023286 • Audit 5924 for content of service is posting on detail two only when it should post on some details as well as after detail 2. This is sporadic. This was corrected on 5/9/2005. Letters were sent by 9/23/2005 to notify providers of claims that potentially may be recouped. Claims started reprocessing on 10/21/2005. (COs 6810 and 7736) **Reprocessed ICN Range:** 5205291001982 – 5205291016791; 5205291018621 - 5205292032718 • Some office visit claims are denying sporadically for surgery claims on history when none exists. The system was updated on 11/30/2004. Claims started reprocessing on 10/26/2005. (CO 7765) **Reprocessed ICN Range:** 8005299000001 – 8005299001878; 5205299000001 – 5205299000620 • Procedures that are noncovered and part of content of service are reporting just as noncovered on RA. For example, venipuncture falls into this scenario. The system was updated to post content of service message instead of noncovered message for claims that completed processing after 6/3/2005. (CO 7863) • All windows are being reviewed to ensure that lab and NCCD bundling are in sync. Providers will be notified when complete. CO 8447 for correcting audits 6151, 6152, and 6153 (which relates to allowing 1 MRI scan per day) was corrected on 8/18/05 to ensure retroactive for dates 10/12/03 to 4/25/05. Claims started reprocessing on 9/10/2005 for CO 8447. (COs 7917 and 8447) **Reprocessed ICN Range:** 5205254003227 – 5205254004384 • Adjustment claims are not processing through bundling logic as new day claims do. This issue was corrected on 7/1/2005. (CO 8186)
Provider Action	No action is needed.

System Corrected: 8/18/2005

Cleanup: 10/26/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.50	
Date Drafted	5/12/2004	
Date Revised	10/29/2004	
Groups Affected	Physician	
Issue	Provider claims are being denied for billing of vaccines for children (90723).	System Corrected: 8/26/2004
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 (CO 6878) 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 was resolved through a policy update on 8/11/2004. Claims that were paid or denied in error started reprocessing on 10/29/2004. (CO 5084)	Cleanup: 10/29/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.51
Date Drafted	6/3/2004
Date Revised	10/21/2005
Groups Affected	All
Issue	Claims that were paid prior to 10/16/03 now are being denied when adjustments are made.
Impact	Funds are being recouped from providers.
Resolution	• The new MMIS was implemented with changes to reflect policies and handle new HIPAA regulations. Claims that processed in the old system are now 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. (COs 6904, & 7183) CO 6583 was completed on 5/25/2004. CO 5425 was moved to production on 9/10/2004. No cleanup is needed. COs 6904 and 7380 were moved to production on 10/8/2004. Adjustments denied for accident date and cause mismatch (exception 427) were reprocessed on 10/15/2004 (CO 7380). Adjustments were denied for timely filing for previously paid claims (exceptions 545, 555, and 556) and admit date invalid (exception 276) were reprocessed on 10/15/2004 (CO 7462). Adjustments for claims submitted electronically from Medicare that denied for 243 (Medicare paid date) were reprocessed on 10/1/2004 (CO 7373). • 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 no longer will see the message on claims finalized after this date. No claims were identified for reprocessing that had not already been reprocessed. • Exception code 5019 was enabled in error for adjustments. This error was resolved. EDS identified and reprocessed the claims that denied in error on 10/29/2004. (CO 7158) • Claims that denied and were reprocessed were denied again for timely filing. EDS will review each of the 80 region timely filing denials to determine if the original claim was filed timely. If so, the 80 region will be resubmitted and set to bypass timely filing. Claims started reprocessing the week of 2/21/2005. (CO 7603) **Reprocessed ICN Range**: 8005056000001 – 8005056003286 • Additional cleanup for adjustments that denied in error is being completed. Cleanup has been completed. For any adjustment with an ICN starting with 50 or 52 that you believe still needs to be reprocessed, please contact customer service. (CO 7925 and CO 7927) • Claims submitted with old provider number in the referring physician field from 10/16/2003 – 3/30/2004 were denying for exceptions 0635 and 0636 when adjustments were performed. They are now set to suspend to adjudicate appropriately. Claims started reprocessing on 9/20/2005. (CO 8506) **Reprocessed ICN Range:** 8005263000001 – 8005263002653 • LTC claims were denying for invalid diagnosis code when submitted as mass adjustments. Claims started reprocessing on 10/21/2005. (CO 8482) **Reprocessed ICN Range:** 8005285000001 - 8005285000007
Provider Action	No action is needed.

System Corrected: 9/13/2004

Cleanup: 10/12/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.52	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	System Corrected: 5/26/2004
Groups Affected	DME	
Issue	A4450 CPT code was being denied.	
Impact	Claims were being denied incorrectly.	Cleanup: 7/2/2004
Resolution	EDS identified and corrected the system on 5/26/2004. EDS identified claims denied in error on 7/2/2004 and resubmitted them for reconsideration of payment. (CO 6652)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.53	
Date Drafted	6/3/2004	
Date Revised	7/9/2004	
Groups Affected	All	Resolved: 7/15/2004
Issue	Claims have a paid amount but no paid date is online.	
Impact	Providers' claims appear to be paid but are not on the warrant.	
Resolution	Claims that contain financial errors are listed on a report each week. Each claim is researched individually and resolved. No system changes are necessary at this time. (CO 6538)	
Provider Action	No action is needed.	

Item Reference	GENP 1.54	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	
Groups Affected	DME	System Corrected: 5/13/2004
Issue	CPT code Z1236 was causing claims to be denied incorrectly.	
Impact	Claims were being denied incorrectly.	Cleanup: 7/20/2004
Resolution	Z1236 was posting exact duplicate instead of suspect duplicate for claims submitted with Z1236 that edited against other Z1236 claims with modifier RR. This caused the claims to be denied as duplicate. The system was corrected and claims are now processing correctly. This issue affected all claims submitted with this scenario since 10/16/03. EDS identified and resubmitted claims denied in error on 7/20/2004. (CO 6553)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.55	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	System Corrected: 5/11/2004
Groups Affected	Lab	
Issue	Claims were being denied for HCPCS code 88141 for provider type 31.	
Impact	Claims were being denied incorrectly.	Cleanup: 9/30/2004
Resolution	The SRS program manager approved this code to be covered by provider type 31. The change was made on 5/11/04. EDS completed the reprocessing of the claims for the 9/30/2004 remittance advice. (CO 6552).	
Provider Action	No action is needed.	

Item Reference	GENP 1.56	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	System Corrected: 5/26/2004
Groups Affected	All	
Issue	Procedure code 99393 was being denied in error.	
Impact	Claims were being denied incorrectly.	Cleanup: 7/2/2004
Resolution	Claims submitted with procedure code 99393, modifier 32 and place of service 71 were being denied in error for dates of service 3/26/04 and after. This issue was resolved and claims are now processing correctly. EDS identified and resubmitted claims denied in error on 7/2/2004. (CO 6632)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.57	
Date Drafted	6/3/2004	
Date Revised	9/8/2004	
Groups Affected	All	System Corrected: 5/28/2004
Issue	Claims were denied for no medical necessity or documentation, and the provider sent the attachment after marking the electronic claim as attachment to be sent.	
Impact	Claims are being denied incorrectly.	Cleanup: 9/3/2004
Resolution	Claims may have been denied in error awaiting the attachment for an electronic submitted claim. The process for implementing attachments for electronic claims was not fully implemented. This issue 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 completed reprocessing on 9/3/2004. (CO 6669)	
Provider Action	No action is needed.	

Item Reference	GENP 1.58	
Date Drafted	6/3/2004	
Date Revised	10/15/2004	
Groups Affected	All	
Issue	Claims were being denied for procedure code J0207.	Resolved: 5/28/2004
Impact	Claims were being denied incorrectly.	
Resolution	A provider submitted examples where claims were denied for CPT J0207. While small in scope, EDS resolved the issue and will ran a query to identify additional claims that were denied in error. EDS reprocessed erroneously denied claims and informed providers when completed. (TO 6678)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.59	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	
Groups Affected	DME	System Corrected: 3/3/2004
Issue	Claims with a KO modifier were being denied in error.	
Impact	Providers were not being paid.	Cleanup: 9/17/2004
Resolution	Claims with a KO modifier were being denied in error. A table was updated to recognize the KO modifier on 3/3/04. Claims denied in error were identified for EDS to reprocess and were resubmitted on 5/13/2004. Additional reprocessing was completed on 9/16/2004. (CO 6053)	
Provider Action	No action is needed.	

Item Reference	GENP 1.60	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	
Groups Affected	DME	System Corrected: 8/9/2004
Issue	E1399 claims were paying a zero amount.	
Impact	Providers were being underpaid.	Cleanup: 9/2/2004
Resolution	E1399 claims are manually priced. Processors were not entering the allowed amount on claims, which caused them to pay at a zero allowed amount. This issue was corrected on 5/17/2004. Some claims were reprocessed in June, but many still paid a zero amount. This issue has been re-opened as another system correction is needed. Claims that were processed at zero dollars will be identified and providers will be notified when complete. (CO 6557 & 6558) CO 6557, related to Medicare claims, had claims reprocessed on 8/26/2004. CO 6558 was corrected and claims started reprocessing on 8/26/2004.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.61	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	System Corrected: 6/15/2004
Groups Affected	Local Health Departments	
Issue	Local health departments (LHD) were being paid at the Advanced Registered Nurse Practitioner (ARNP) rate.	
Impact	Providers were being underpaid.	Cleanup: 7/19/2004
Resolution	LHD providers were encountering a reduction in reimbursement. Instead of being reimbursed at the maximum allowable rate for MD/DO, they were being reimbursed at 75% of the maximum allowable rate for ARNP/PA. This issue was resolved on 6/15/2004. EDS reprocessed the claims paid in error on 7/19/2004. (CO 6117)	
Provider Action	No action is needed.	

Item Reference	GENP 1.62	
Date Drafted	6/9/2004	
Date Revised	10/29/2004	System Corrected: 9/10/2004
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.	Cleanup: 11/1/2004
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 that were denied in error started reprocessing on 11/1/2004. (CO 6975)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.63
Date Drafted	6/9/2004
Date Revised	7/5/2005
Groups Affected	Audiology
Issue	Audiology claims are being denied in error.
Impact	Claims were being denied incorrectly.
Resolution	• Claims were being denied for audiology procedure codes (V5030, V5040, V5050, V5060, V5070, V5080, V5100, V5120, V5130, V5140, V5150, V5170, V5180, V5190, V5210, V5220, V5230, V5242, V5243, V5248, V5249) billed with an RR modifier; billed by Provider Type/Specialty 18/183, 20/200, 22/220, 31/332, 31/349 with a paid date on or after 10/16/2003. EDS completed reprocessing the claims denied in error on 8/20/2004. (CO 6592) • Claims are denying because purchase of a hearing aid is counting toward the rental limitation. Procedure code V5050 should not deny for rental limitation audit 6928. The system was corrected on 3/11/2005 to resolve this issue. Claims denied in error started reprocessing on 5/27/2005. (CO 7671) **Reprocessed ICN Range:** 5205144000001 - 5205144000003 • Claims were denying procedure V5014 (hearing aid repairs) six months prior to a hearing aid purchase. This was corrected on 5/2/2005. Claims started reprocessing on 7/1/2005. (CO 8129) **Reprocessed ICN Range:** 800581001733 – 8005181001743; 5205182138142
Provider Action	No action is needed.

System Corrected: 5/2/2005

Cleanup: 7/1/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.64	
Date Drafted	6/9/2004	
Date Revised	10/15/2004	System Corrected: 6/1/2004
Groups Affected	Lab	
Issue	Lab codes 80000-89999 with modifier TC or 26 were being denied in error.	
Impact	Claims were being denied incorrectly.	Cleanup: 8/13/2004
Resolution	Medical and outpatient claims for lab codes (80000-89999) with modifier 26 or TC were being denied in error. The system was updated on 6/1/04. Claims that were denied in error were resubmitted for reprocessing on 8/13/2004. (CO 6687)	
Provider Action	No action is needed.	

Item Reference	GENP 1.65	
Date Drafted	6/17/2004	
Date Revised	10/15/2004	System Corrected: 6/21/2004
Groups Affected	All	
Issue	LEA providers received a large number of denials for “5652 – Headstart vs. LEA services.”	
Impact	Claims were being denied incorrectly.	Cleanup: 7/22/2004
Resolution	EDS is currently designing the system to process the claims according to LEA policies. EDS identified and reprocessed the claims for the 7/22/2004 remittance advice. (CO 6843).	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.67	
Date Drafted	6/28/2004	
Date Revised	10/22/2004	
Groups Affected	All	System Corrected: 10/8/2004
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.	Cleanup: 10/22/2004
Resolution	The interChange MMIS was 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. Claims were resubmitted for processing on 10/22/2004 for CO 6979.	
Provider Action	No action is needed.	

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

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.70	
Date Drafted	6/28/2004	
Date Revised	8/1/2005	
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. These were determined to be correct denials. The beneficiary must be 21 years old on date of consent and was not. Thus, the claims denied correctly per federal regulations. (CO 7075)	
	Provider claims are being denied when the surgeon's date of signature is 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 three days before surgery. Claims completed reprocessing on 12/6/2004. (CO 7192)	Policy Decision: 10/18/2004
	Providers who are billing family planning related ICD-9 codes are receiving denials. The V723 (gynecologic examination) should be payable and allow three interim family planning visits per year (exception 6166 is posting incorrectly). Claims denied due to CO 7584 will be reprocessed by the beginning of January. (CO 7209 and 7584). Cleanup for CO 7209 for invalid posting of exception 6166 was completed on 11/4/2004. For CO 7584, 201 claims were reprocessed on 2/28/2005. Reprocessed ICN Range: 5005059914055 - 5005059914080; 5005059906001 - 5005059906002	System Corrected: 4/29/2005
	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. 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. Other claims were denied clerically in error. Claims were reprocessed on 12/6/2004. (CO 6856)	Cleanup: 7/23/2005
	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. Codes impacted are 50610 and 50612 when billed together or with one of the following codes: 99211, 99212, 99213, 99214, S0610, S0612, and T1001. (CO 7182 and CO 7909) All claims impacted by CO 7182 were reprocessed as of 11/5/2004. CO 7909 deals with the same procedures billed with V diagnosis codes such as V723 and V259. CO 7909 was corrected on 4/29/2005 and claims started reprocessing to apply correct FFP and PCA to claims on 5/23/2005. (COs 7182 and 7909) Reprocessed ICN Range (CO 7909): 5205140000001 - 5205140002472	
	SRS provided instructions for reprocessing denied claims, if appropriate, based on claim form. EDS will notify providers when complete. Claims completed reprocessing on new SRS instructions as of 12/6/2004. (CO 7192)	
	Claims billed with either 00840 or 58661 were approved by SRS to pay when billed with diagnosis V252. This was updated on 1/10/2005. Claims started reprocessing on 7/2/2005. (CO 7800) Reprocessed ICN Range: 8005181000471 – 8005181000970; 8005204000001 – 8005204000088	
	Procedure codes 99212 and 99213, which are denying duplicate to different performing providers, were updated to deny for same provider on the same DOS (audits 5574). This was completed on 11/9/2004. Claims were processed the week of 2/28/2005. (CO 7623) Reprocessed ICN Range: 5005059914001 - 5005059914025	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.71	
Date Drafted	6/28/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 7/29/2004
Issue	Claims were being denied as a non-covered Medicare service when Medicare paid the claim for the procedure code submitted to KMAP. In addition, exception code 2504 was being denied for third-party liability erroneously.	
Impact	Providers were not being paid.	Cleanup: 8/13/2004
Resolution	During the annual HCPCS update the Medicare Coverage indicator was not updated on some of the HCPCS codes on file for KMAP. The HCPCS tape was reviewed to verify that the codes to indicate Medicare Coverage were appropriate. Providers were notified that the files were updated. EDS reprocessed claims on 8/13/2004. (CO 6465, 6534, 6627, 6628, & 6865)	
Provider Action	No action is needed.	

Item Reference	GENP 1.72	
Date Drafted	6/28/2004	
Date Revised	10/15/2004	
Groups Affected	Lab	System Corrected: 10/8/2004
Issue	CPT code 81000 is being denied for invalid CLIA certificate.	
Impact	Providers are not being paid.	Cleanup: 10/21/2004
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. EDS corrected this issue on 10/8/2004. Claims denied in error were reprocessed for the 10/28/2004 RA. (CO 6875)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.73	
Date Drafted	7/9/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 7/3/2004
Issue	Claims with modifier 25 were being denied after 1/1/2004 date of service.	
Impact	Providers were not being paid.	Cleanup: 7/14/2004
Resolution	Modifier 25 was end-dated for 1/1/2004 with the new system. This should have been open end-dated using 12/31/2299. This issue was corrected on 7/3/2004. EDS identified and reprocessed the claims denied in error on 7/14/2004. (CO 6920)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.75
Date Drafted	7/9/2004
Date Revised	4/29/2005
Groups Affected	All
Issue	Ultrasounds (also called sonograms) and other MRIs or X-rays are being denied in error for procedure-to-diagnosis code.
Impact	Providers are not being paid.
Resolution	Procedure codes 76801-76828 that processed after 10/16/2003 were being denied in error when billed with the following diagnosis codes: 65663, 65653, 64003, 6258, 6259, V288, V234, V284, 64083, V2349, 64883, 65973, V237, 65633, 65643, 65120, 76811, 65523, 7965, 4286, 63380, 65553, 65413, 65803, and 6262. In addition, diagnosis code 65703 is now covered for procedure code 76811, and diagnosis code 78904 is covered for procedure code 76801. Procedure codes 76830 and 76831 were never covered to pay with diagnosis codes 6258 or 6268 but are now payable. These codes were approved by SRS to be payable. All of these codes were set to either pay or pay with review as of 7/7/2004. For procedure codes 76830 and 76831, diagnosis code 63380 is now covered as well. (CO 6947, 7107, and 7149) Claims were reprocessed on 8/13/2004. The following procedure codes have been approved and/or updated for coverage by 1/31/2005: • Diagnosis codes 65573, 64630, 65660, 64193, and 64403 can be payable with procedures 76801, 76802, 76812, 76817, 76818, 76825, 76826, 76827, and 76828. • Diagnosis codes 6202, 6212, and 6264 can be payable with procedures 76830 and 76831. • Diagnosis codes 65543 and 65993 can be payable with procedure code 76811. • Diagnosis code 65683 can be payable with procedure code 76817. • Diagnosis codes 87210, 9106, and 931 may be payable with procedure 70250. • Diagnosis codes 78930 and 1320 can be payable with procedure code 76830 and 76831. EDS will identify claims previously denied details which need adjustments. Completely denied claims started reprocessing on 3/16/2005. Adjustments started reprocessing on 4/28/2005. (CO 7693) **Reprocessed ICN Range**: 8005076000001 - 8005076000770; 5205118000001 - 5205118000179
Provider Action	No action is needed. This is a reminder that procedures that require review may receive denials for additional documentation. When this is received, the paper claim can be resubmitted with medical justification for the procedure.

Policy Updated: 1/15/2005

Cleanup: 4/28/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.76	
Date Drafted	7/9/2004	
Date Revised	10/15/2004	
Groups Affected	DME	System Corrected: 7/1/04
Issue	DME supplies were being denied in error.	
Impact	Providers were not being paid.	Cleanup: 8/20/2004
Resolution	The Max Fee List for procedure codes A6443, A6444, A6446, A6447, A6449, A6450, A6451, A6452, and A6454 were incorrectly end-dated 03/31/2004. The following provider types (PT) and specialties (PS) were impacted: PT/PS 05/ 050; PT/PS 25/250; PT/PS 25/255. This issue was corrected on 7/1/2004 for affected claims from 4/1/2004 to 7/1/2004. EDS identified and reprocessed the claims denied in error. They will appear on the 8/26/2004 remittance advice. (CO 6946)	
Provider Action	No action is needed.	

Item Reference	GENP 1.77	
Date Drafted	7/9/2004	
Date Revised	7/9/2004	System Corrected: 7/6/2004
Groups Affected	Crossover claims	
Issue	Crossover claims are being denied for the whole claim instead of just the detail that should be denied.	Cleanup: 10/7/2004
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. Claims denied in error were reprocessed and started to appear on the 10/7/2004 RA. (CO 6937)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.78	
Date Drafted	7/11/2004	
Date Revised	10/8/2004	Policy Updated: 7/20/2004
Groups Affected	Crossover	
Issue	Claims are being denied in error as content of service for procedure code G0156.	
Impact	Providers are not being paid.	Cleanup: 10/8/2004
Resolution	Procedure code G0156 is being denied against procedure code 99213. The cause of the denial was identified and corrected on 7/20/2004. EDS identified and reprocessed the claims that were denied on 10/8/2004. (CO 6938)	
Provider Action	No action is needed.	

Item Reference	GENP 1.79	
Date Drafted	7/11/2004	
Date Revised	10/8/2004	System Corrected: 7/20/2004
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.	Cleanup: 10/8/2004
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 was identified and corrected on 7/20/2004. EDS identified and reprocessed the claims processed in error on 10/8/2004. (CO 6938)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.80	
Date Drafted	7/11/2004	
Date Revised	8/5/2005	
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.	System Corrected: 7/1/2005
Impact	Providers are being overpaid.	
Resolution	• Beneficiaries are allowed one set of frames and lenses every four years if they are older than 20 years. The cause of the payment was corrected on 7/11/2004. EDS identified claims paid in error and initiated recoupments after notifying providers of claims to be recouped. The recoupments started on 10/15/2004. (TO 6961) • The system is not counting V2100 and V2200 as a half pair of lenses. Claims for full lenses are still paying instead of cutting back. This issue was resolved. Claims started reprocessing on 8/2/2005. (CO 7735) **Reprocessed ICN Range:** 8005214000005 – 800521400083; 5205214009783 – 5205214010187	Cleanup: 8/3/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.81	
Date Drafted	7/20/2004	
Date Revised	10/22/2004	
Groups Affected	All	System Corrected: 8/17/2004
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.	Cleanup: 10/22/2004
Impact	Claims are being denied incorrectly.	
Resolution	EDS has identified and is working on the solution for this issue. The system was fixed on 8/17/2004. Claims that were denied in error were reprocessed and will start appearing on the 10/7/2004 RA. Remaining claims are processing for the 10/28/2004 RA. (CO 6898 and 6609).	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.82	
Date Drafted	7/11/2004	
Date Revised	10/8/2004	
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 updated the system on 10/8/2004. (CO 6921)	Policy Update: 10/8/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.84	
Date Drafted	7/26/2004	
Date Revised	5/6/2005	
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	Providers received a letter dated 11/5/04 regarding adjustments that would be done on claims that contained invalid performing provider numbers. The letter was a result of the following two issues: • Medicare Crossover Claim: EDS received group numbers from Medicare in the performing provider field. • Professional Claims (non-crossovers): Between June 2004 and October 2004 EDS overlaid the individual performing provider ID submitted by the provider with the billing provider ID. On 11/12/04, EDS/SRS informed providers they should disregard this letter as we were exploring other options to correct as many of the claims as possible. Claims identified on the 11/5/04 reports had other errors on them that required the claims to be reprocessed for other reasons. The errors may have resulted from data submitted by the provider, data submitted by Medicare, or EDS claims processing errors. As EDS attempted to clean up other issues, some claims identified on the 11/5/04 report may have resulted in denied adjustments with a reason of "invalid performing/referring provider ID." Providers can choose to correct these claims or wait and allow EDS to determine if these claims can be corrected systematically. EDS identified performing provider numbers for all remaining electronic claims. Reprocessing will be done automatically and providers will be notified when complete. Reprocessing started automatically and providers were notified the week of 4/18/2005 that no additional work is needed on their part. (CO 7016) EDS is implementing a system enhancement to review service location on performing provider for all system auditing. Once complete, providers will be notified. (COs 7764 & 7785) Both COs were moved to production on 5/6/2005 for audits to review providers based on service location.	System Corrected: 10/8/2004 System Enhancement: 5/6/2005 Cleanup: 4/18/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.85	
Date Drafted	7/26/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 10/8/2004
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.	Cleanup: N/A
Resolution	The system will be corrected to ensure that claims denied for spenddown are the only claims that post the EOB 9922. CO 5624 was moved to production on 10/8/2004. (CO 5624)	
Provider Action	No action is needed.	

Item Reference	GENP 1.87	
Date Drafted	7/26/2004	
Date Revised	10/8/2004	
Groups Affected	SOBRA Spenddown Claims	Policy Update: 9/10/2004
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.	Cleanup: N/A
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. Systematic cleanup is not needed as eligibility staff will review manually. (CO 6577)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.88
Date Drafted	7/26/2004
Date Revised	11/12/2004
Groups Affected	All
Issue	Claims are being denied when correct qualifier codes exist on the claim.
Impact	Providers are not being paid.
Resolution	Institutional 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 9/10/04. Claims started reprocessing on 11/5/2004. (CO 6704)
Provider Action	No action is needed.

System Corrected: 9/10/2004

Cleanup: 11/15/2004

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.89
Date Drafted	7/26/2004
Date Revised	10/7/2005
Groups Affected	All
Issue	Claim adjustments are processing but are not decreasing the prior authorization, so subsequent claims do not pay. Claims also are being paid in error instead of requiring prior authorization.
Impact	Providers are not being paid or are being overpaid depending on the circumstance.
Resolution	• Claims that encounter the 3021 prior authorization exception and have a prior authorization (PA) on file should pay and decrease the prior authorization by the appropriate units. The PA units also should be credited when an adjustment occurs that does not allow the next claim to pay. The system was corrected on 7/29/2004 (CO 5978). EDS identified and reprocessed the affected claims on 9/27/2004. (CO 5978) COs 6292 and 6706 were cancelled because they are covered by CO 5978. • Claims with procedure codes Y9105 and 90816 are being paid for some benefit plans. EDS corrected this issue on 9/10/2004. EDS identified and reprocessed claims on 10/20/2004. (CO 6520) • Claims are being paid more than the PA approves for dollars or units. This has been corrected. EDS has identified 60,000 claims overpaid. Recoupment letters were sent to notify affected providers on 6/13/2005. Claims started reprocessing on 9/16/2005. (CO 7286) **Reprocessed ICN Range:** 5205257000573 – 5205257002774 • Claim adjustments were not adding approved dollar and units back to PA. Subsequent claims were denying in error. CO 7518 moved into production on 1/7/2005 to correct this issue. No additional cleanup is needed. Claims were suspended and not overpaid. (COs 7518 and 7519) • Claims are denying for HealthConnect Referral (1050) when a PA with type 4 or 2 is on file. Exception 1050 should be bypassed when billed in conjunction with POS 21. This was corrected on 2/11/2005. All claims denied in error were reprocessed by 5/2005 (CO 7495) • T1001 for HCBS FE paid at $30.00 instead of $37.10. This was corrected on 3/9/2005. Claims priced in error will be reprocessed. GENP 1.100 for CO 7727 completed this cleanup on 5/5/2005. (CO 7606) • Claims are denying for “allow one wheelchair every five years” (exception 6034) when a prior authorization is on file. This issue was corrected on 9/2/2005. Claims started reprocessing on 9/15/2005. (CO 7968) **Reprocessed ICN Range:** 8005258000001 – 8005258000021 • Claims for HCBS providers were paying S5126 and S5126 UC without hitting the PA for DOS from 1/1/2004 to 10/19/2004. This issue was corrected on 3/25/2005. Claims will be reprocessed and recouped if no PA is on file. Claims started reprocessing on 5/16/2005. (CO 8030) **Reprocessed ICN Range:** 5205136000001 – 5205136002001 • HCBS FE claims paid prior to the authorization effective date on the plan of care. This issue was corrected on 7/1/2005. Letters to notify providers for claims that may be potentially recouped were mailed on 8/3/2005. Claims started reprocessing on 8/16/2005 for RA dated 8/25/2005. Additional claims have been identified to reprocess on 9/15/2005. Claims started reprocessing on 9/30/2005. (CO 8051) **Reprocessed ICN Range:** 5205227004369 – 5205227007583; 5205271011757 – 5205271013972 • Claims are paying for out of state providers when no prior authorization is on file. This situation was corrected as of 8/20/2005. (CO 8393).
Provider Action	No action is needed.

System Corrected: 9/2/2005

Cleanup: 9/30/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.90	
Date Drafted	7/26/2004	
Date Revised	9/16/2005	
Groups Affected	All	System Corrected: N/A
Issue	Claims are being denied as part of bundling when processing of other lines occurs after the bundling process.	
Impact	Providers perceived that they were not being paid appropriately.	
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. DHPF decided the claims processing will remain as is per policy. No system changes will be made. (CO 6854)	Cleanup: N/A
Provider Action	No action is needed.	

Item Reference	GENP 1.91	
Date Drafted	7/26/2004	
Date Revised	10/15/2004	
Groups Affected	All	System Corrected: 8/13/2004
Issue	Claims are being paid when another claim has already been paid for the same procedure code, performing provider, dates of service, and beneficiary.	
Impact	Providers are being overpaid.	Cleanup: See GENP 1.101
Resolution	Claims should not be paid when another claim exists in a paid status for the same procedure code, performing provider, dates of service, and beneficiary. The system was corrected on 8/13/2004. EDS will notify providers prior to the recoupments process to assist providers in planning of cash flow. (CO 6995) This item will be closed as a duplicate to GENP 1.101. Please refer to GENP 1.101 for a status on reprocessing.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.92	
Date Drafted	8/2/2004	
Date Revised	10/29/2004	System Corrected: 6/4/2004
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.	Cleanup: 10/20/2004
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 identified and reprocessed the denied claims on 10/20/2004. (CO 7085)	
Provider Action	No action is needed.	

Item Reference	GENP 1.93	
Date Drafted	8/2/2004	
Date Revised	11/12/2004	System Corrected: 7/1/2004
Groups Affected	All	
Issue	Physician claims were being denied against laboratory claims in error and vice versa.	
Impact	Providers are not being paid.	Cleanup: 11/12/2004
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 identified and reprocessed the denied claims on 11/12/2004. (CO 7088)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.94	
Date Drafted	8/2/2004	
Date Revised	10/22/2004	
Groups Affected	All	System Corrected: 7/28/2004
Issue	Claims for procedure code 92567 are being denied in error.	
Impact	Providers are not being paid.	Cleanup: 10/20/2004
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 identified the claims denied in error and started reprocessing the claims on 10/20/2004. (CO 7089)	
Provider Action	No action is needed.	

Item Reference	GENP 1.95	
Date Drafted	8/2/2004	
Date Revised	11/30/2004	
Groups Affected	All	
Issue	KAN Be Healthy (KBH) screenings are not being updated with services provided by FirstGuard network providers.	System Corrected: 5/20/2004
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 October 2004. FirstGuard is pending further updates until their new system is transitioned. This item is being closed due to no MMIA work pending. 2. Additional nonencounter claims were not updating KBH, which may have caused denials. EDS corrected this issue on 5/20/2004. No cleanup will be performed. (CO 5284)	Cleanup: 11/29/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.96	
Date Drafted	8/2/2004	
Date Revised	5/6/2005	
Groups Affected	All	
Issue	Co-pay amounts are being deducted in error from claims provided by exempt providers, such as ARNPs.	System Corrected: 10/8/2004
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 resolved this issue on 10/8/2004. EDS identified claims impacted and will start reprocessing to pay the additional $2 co-pay amount or recoup the $2 co-pay depending upon the performing provider. (CO 7119). Claims started reprocessing on 5/1/2005 to refund co-pay where appropriate.	Cleanup: 5/1/2005
Provider Action	No action is needed.	

Item Reference	GENP 1.98	
Date Drafted	8/9/2004	
Date Revised	4/8/2005	
Groups Affected	All	System Corrected: 1/7/2005
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.	Cleanup: 4/8/2005
Resolution	Border city providers were not being paid the correct peer group rates. Providers who are not in a border city were being paid at times when they should not. EDS corrected the issue on 1/7/2005. (CO 7069) Claims paid or denied in error were identified on 4/7/2005 and started reprocessing.	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.99
Date Drafted	8/9/2004
Date Revised	11/4/2004
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 identified the overpaid claims and initiated the recoupments on 11/5/2004. (CO 6325) A total of 14 additional adjustments and 45 additional denied claims were identified. EDS reprocessed these claims during the week of 2/21/2005. (CO 7580)
Reprocessed ICN Range:	5005052914017 - 5005052914028; 8005054000001 - 8005054000043
Provider Action	No action is needed.

System Corrected: 11/19/2004

Cleanup: 2/25/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.100
Date Drafted	8/9/2004
Date Revised	9/2/2005
Groups Affected	All
Issue	FFP rate is not processing correctly or program cost account (PCA) code is not applying correctly.
Impact	Providers are being overpaid or underpaid.
Resolution	S0610 and S0612 were paying 100% instead of the 90% FFP and 10% state certified match. The following procedure codes are also being impacted by FFP issues: Y9514, Y9569, Y9570, 90804, 90806, and 90808. EDS is working on resolving the S0610 and S0612 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 6831) CO 5315 for the "Y" series and "9" series procedure codes was corrected on 6/2/2004. These claims were reprocessed on 9/16/2004. The FFP rate was processing on the process date rather than the date of service. The issue was resolved on 10/11/2004 to use the processing date instead of DOS. No cleanup or reprocessing for recoupments is planned by SRS. CO 7728 was loaded to production on 5/6/2005. SED waiver claims are paying at 100% instead of FFP for PT/PS 11/123. EDS resolved this on 10/27/2004. EDS will identify claims overpaid and initiate recoupments. Letters identifying the claims impacted were sent on 4/5/2005. Claims have started reprocessing for recoupments. Please see letter sent to each CMHC for more details. (CO 7043) Family planning codes were paying at 60/40 certified match instead of the correct match of 90/10. Providers were underpaid. CO 7624 was implemented on 2/1/2005 to allow pregnant woman and postpartum to be indicators. For CO 7727, the certified rate match was fixed on 12/23/2004 and claims started reprocessing on 5/5/2005. CO 7969 moved to production on 8/5/2005 for corrections. Claims started reprocessing for CO 7969 on 8/30/2005. (COs7624, 7727, and 7969) **Reprocessed ICN Range (CO 7727):** 5205124000001- 5205124002663 **Reprocessed ICN Range (CO 7969):** 5205182134968 - 5205182137888; 5205242000001 - 5205242002989 PCA code did not set correctly for procedures 52647 80, 52648 80 or WC or 30, 55520 WC, T1019, 58579, and T2011 and 50 miscellaneous other claims, which affected HCBS FE plans. Once corrected, providers will be notified when claims are reprocessed. (CO 7388 & 7945) CO 7388 corrected the PCA setting for modifiers on 3/9/2005. 63,219 adjustments were initiated on 5/3/2005. **Reprocessed ICN Range (CO 7388):** 5205122002880 - 5205123028605 **Reprocessed ICN Range (CO 7945):** 5205181000001- 5205181134833 The wrong PCA code is on LTC claims for beneficiaries in NFMHs and state psychiatric hospitals. This was determined not to have been occurring. The PCA code is correct. (CO 7547) Positive behavioral support (PBS) claims are not paying for PT/PS 21/233 or 238 for procedures 90866 22, 90882 22, and 90885 22. Providers are receiving FFP and should be paid at 100%. This was corrected on 3/9/2005. Claims started to reprocess on 5/4/2005. (CO 7910) **Reprocessed ICN Range:** 5205123030002 - 5205123030009 T1017 and W1374 performed by PT/PS 21/237 are paying under FE waiver and should pay under HI waiver. This issue was corrected on 5/6/2005. Claims started reprocessing on 6/13/2005. (CO 7947) **Reprocessed ICN Range:** 5205160000001 - 5205160003070 T1017, S5150, and T1005 were cutting back limitation on rolling 12 months instead of calendar year. This issue was corrected on 4/20/2005. Denied or cutback claims started reprocessing on 5/27/2005. (CO 8089) **Reprocessed ICN Range:** 5205145000340 - 5205145000407; 8005146001575 - 8005146001660
Provider Action	No action is needed.

System Corrected: 8/5/2005

Cleanup: 8/30/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.101	
Date Drafted	8/11/2004	
Date Revised	10/15/2004	
Groups Affected	All, including CMHC	System Corrected: 7/29/2004
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 were 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 reprocessing of claims started on 9/16/2004. All claims that were reprocessed began appearing on the 9/30/2004 RA. (CO 6995, 6996)	Cleanup: 9/20/2004
Provider Action	No action needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.102	
Date Drafted	8/11/2004	
Date Revised	10/15/2004	
Groups Affected	All	
Issue	Claims are being denied or cutting back erroneously when single unit pricing indicators are present for procedures or disposition with full fail and paid status. This is causing claims to be denied in error.	System Corrected: 6/10/2004
Impact	Providers were being underpaid.	
Resolution	1. Claims that price with a single unit indicator were not cutting back allowed units correctly for the detail lines. The allowed amount was being reducing, but the billed units were not being reduced. This caused the final pricing to divide the allowed amount in half and pay the providers approximately half of what should be paid. EDS resolved this issue on 6/10/2004. (CO 6542 & 7175) Claims were reprocessed on 8/13/2004. 2. Audits that were set up for full fail with a paid status were cutting back the claim. For example, one claim set audit 6053 with a paid status and cut back the claim to 1 unit. The claim did not pay at the correct amount. EDS resolved this issue on 6/4/2004. (CO 6532) Claims were reprocessed on 9/10/2004.	Cleanup: 9/10/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.103	
Date Drafted	8/11/2004	
Date Revised	8/19/2005	
Groups Affected	Indian Health Services	System Corrected: 5/25/2005
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	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. This issue reoccurred and was corrected in May. Letters to notify providers for claims that may potentially be recouped were mailed on 8/3/2005. Claims started reprocessing on 8/16/2005 for the RA dated 8/25/2005. (CO 7159) **Reprocessed ICN Range:** 5205227000001 - 5205227000504	Cleanup: 8/16/2005
Provider Action	No action is needed.	

Item Reference	GENP 1.104	
Date Drafted	9/13/2004	
Date Revised	10/29/2004	
Groups Affected	All	Policy Decision: 10//14/2004
Issue	Physical therapy claims are being denied for V571-V579 diagnosis codes.	
Impact	Providers are not being paid.	
Resolution	Physical therapy claims (procedure codes 97001, 97032, 97035, and 97110) 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 reviewed the policy related to rehabilitative services to determine if these diagnosis codes should be covered. SRS approved coverage of these diagnosis codes on 10/12/2004 and the system was updated on 10/14/2004. EDS identified and reprocessed the denied claims on 10/29/2004. (CO 7480)	Cleanup: 10/29/2004
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.105	
Date Drafted	9/13/2004	
Date Revised	5/6/2005	
Groups Affected	All	
Issue	Claims are being denied for procedure to diagnosis code (exception 4037) in error.	
Impact	Providers are not being paid.	System Corrected: 11/12/2004 Cleanup: 5/1/2005
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. Claims are suspending effective 8/25/2004 to be worked manually so claims will not deny. The system was corrected as of 11/12/2004. Once implemented, EDS identified 33,664 details to be adjusted and 13,168 denied claims details to be reprocessed. EDS will reprocess the claims denied in error and notify providers when complete. EDS has reprocessed the 13,168 denied details which will start appearing on the 2/17/2005 RA. EDS started reprocessing claims that needed adjustments on 5/1/2005. (CO 7226) **Reprocessed ICN Range:** 800504600001 – 8005046013678; 5205121000001 - 5205121015028	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.107	
Date Drafted	10/19/2004	
Date Revised	11/24/2004	
Groups Affected	DME	
Issue	Claims with procedure codes that start with L for prosthetic and orthotic are being denied in error.	Policy Decision: 10//12/2004
Impact	Providers are being underpaid.	
Resolution	DME claims that start with procedure code L are not being paid for provider type 25 and provider specialty 277. The L procedure codes denied are related to prosthetic and orthotics. This was resolved on 10/12/04. EDS identified 29 claims to adjust and 98 claims denied to be reprocessed. These were reprocessed the week of 2/21/2005. (CO 7464)	Cleanup: 2/21/2005
Reprocessed ICN Range	8005052000001 - 8005052000098; 5005056906026 - 5005056906055	
Provider Action	No action is needed.	

Item Reference	GENP 1.108	
Date Drafted	10/19/2004	
Date Revised	5/24/2005	System Corrected: 10/11/2004
Groups Affected	All	
Issue	Claims billed with E0431 RR GH and E1390 RR QH for provider type 25 and provider specialty 250 are denying in error.	
Impact	Providers are being underpaid.	Cleanup: 5/23/2005
Resolution	This issue was corrected on 10/11/04. Claims started reprocessing on 5/23/2005. (CO 7459) **Reprocessed ICN Range**: 8005143001183 - 8005143001223; 5205143001108 - 5205143001127	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.109	
Date Drafted	10/19/2004	
Date Revised	11/12/2004	System Corrected: 10/8/2004
Groups Affected	All	
Issue	FFP for H1002 was paying incorrectly.	Cleanup: 11/11/2004
Impact	Providers were being overpaid.	
Resolution	Claims billed with H1002 are being overpaid and not excluding the FFP. This was corrected on 10/8/04. EDS identified and reprocessed claims that overpaid on 11/11/2004. (CO 7452)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.110	
Date Drafted	10/19/2004	
Date Revised	7/22/2005	
Groups Affected	Dentist	
Issue	Spenddown is not reporting correctly.	
Impact	Providers and beneficiaries do not know accurate spenddown amounts.	
Resolution	Claims are paying incorrectly when the spenddown is unmet. Physician claims are showing a co-pay amount when spenddown is unmet. Details that deny with spenddown preemptive set are applying to spenddown. New claims and/or adjustments that have applied to spenddown are showing RAs with double the amount. A system solution is being coded to address these with the following logic: 1. If spenddown is unmet, MN benefit plan should not pay provider. Claim should apply to spenddown. This was corrected on 2/11/2005. Cleanup was completed on 7/14/2005. (CO 7477) 2. If spenddown is unmet, the billed amount should apply to spenddown. Co-pay should only be applied after spenddown is met. This was corrected on 2/11/2005. Cleanup was completed on 7/14/2005. (CO 7477) 3. If detail denies with a spenddown preemptive, it should not apply to spenddown. Beneficiary should not get double credit for charges that were only incurred once. This was corrected on 2/11/2005. Cleanup was completed on 7/14/2005. (CO 7477) 4. The RA should only reflect what actually applied to spenddown. This was corrected on 2/11/2005. Cleanup was completed on 7/14/2005. (CO 7477) 5. If duplicate claim has already been applied to spenddown, the new paid or denied claim should not apply to spenddown again. This was corrected on 2/11/2005. No cleanup will be done. (CO 7448) **Reprocessed ICN Range (CO 7477):** 5205182138144 - 5205182140116	System Corrected: 2/11/2005 Cleanup: 7/14/2005
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.113	
Date Drafted	11/02/2004	
Date Revised	11/02/2004	
Groups Affected	All	System Corrected: 10/28/2004
Issue	Claims are denying in error for exception 4340.	
Impact	Providers are not being paid.	
Resolution	Procedure codes S0610, S0612, T1001, 99211, 99212, 99213, and 99214 were denying in error for exception 4340. This was corrected on 10/28/04. EDS identified 23 claims to be adjusted and 75 denied details to be reprocessed. Claims that denied in error were reprocessed on 1/21/2005. Adjustments were reprocessed on 2/23/2005. (CO 7532)	Cleanup: 2/25/2005
Reprocessed ICN Range	8005053000001 - 8005053000075; 5005052914017 - 5005052914028	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.114	
Date Drafted	11/02/2004	
Date Revised	11/02/2004	System Corrected: 1/7/2005
Groups Affected	All	
Issue	The Beneficiary Eligibility Window on the Provider Web site is displaying the incorrect policy holder.	
Impact	Providers are receiving incorrect information through the eligibility screen which causes providers to submit hard-copy claims.	Cleanup: N/A
Resolution	The Beneficiary Eligibility Window on the Provider Web site displays the incorrect policy holder. EDS corrected this issue on 1/7/2005. (CO 7525)	
Provider Action	No action is needed.	

Item Reference	GENP 1.115	
Date Drafted	11/02/2004	
Date Revised	11/02/2004	System Corrected: 10/25/2004
Groups Affected	All	
Issue	Claims billed with J7302 are denying as not covered for family planning.	Cleanup: 12/10/2005
Impact	Providers are not being paid.	
Resolution	This issue was corrected on 10/25/04. EDS identified six details denied. These claims were reprocessed and appeared on the 12/10/2005 RA. (CO 7511)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.116	
Date Drafted	11/02/2004	
Date Revised	12/10/2004	System Corrected: 10/14/2004
Groups Affected	All	
Issue	Claims billed with J2001 (injection, Lidocaine HCL for intraveneousinfusion 10 mg) are denying in error.	
Impact	Providers are not being paid.	Cleanup: 12/9/2004
Resolution	J2001 was denying in error. This was corrected on 10/14/04. EDS identified and reprocessed non-POS claims that denied in error. (CO 7458)	
Provider Action	If a provider received a denial on a POS claim and dispensed the drug anyway, please resubmit the claim for payment. Non-POS claim denials will be reprocessed automatically.	

Item Reference	GENP 1.117	
Date Drafted	11/08/2004	
Date Revised	12/10/2004	System Corrected: 12/10/2004
Groups Affected	All	
Issue	Claims are paying in error for provider numbers with multiple provider type and specialty segments when one segment is closed.	Cleanup: 12/29/2004
Impact	Providers are being overpaid.	
Resolution	EDS resolved this issue on 12/10/2004. All cleanup was completed 12/29/2004. (CO 7377)	
Provider Action	No action is needed.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.118	
Date Drafted	11/08/2004	
Date Revised	7/5/2005	
Groups Affected	All	Enhancement: 1/7/2005
Issue	Claims are paying fee-for-service incorrectly for beneficiaries covered under the Title XXI benefit plan.	
Impact	Providers are being overpaid.	Cleanup: 7/14/2005
Resolution	Claims were paying fee-for-service incorrectly for beneficiaries covered under the Title XXI benefit plan. The system update was completed on 1/7/2005. The claims paid in error were identified, and recoupment letters were sent to affected providers on 6/13/2005. Claims started the recoupment process on the 7/14/2005 RA. (CO 7453) **Reprocessed ICN Range:** 5205182137889 - 5205182183105	
Provider Action	No action is needed.	

Item Reference	GENP 1.119	
Date Drafted	11/08/2004	
Date Revised	11/30/2004	
Groups Affected	All	System Corrected: N/A
Issue	SOAP server errors occur when providers submit claims on the Internet.	
Impact	Providers do not realize the claim was submitted and paid and then resubmit the claim which is denied.	Cleanup: N/A
Resolution	Providers submitting claims via the Internet receive a SOAP error and assume that the claim did not process. The provider then resubmits the claim and receives a duplicate denial message which is confusing to the provider. Work is being completed to stop the SOAP server errors which are very random and small in proportion to the 6,000+ claims received each day. Continued focus is done to monitor system capacity to decrease SOAP server errors.	
Provider Action	When a SOAP server error is received, perform a claim inquiry to determine if the claim was processed and paid before attempting to resubmit.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.120
Date Drafted	11/10/2004
Date Revised	11/10/2004
Groups Affected	Hospice
Issue	Hospice coverage was included in the Medicare Replacement policies.
Impact	Certain hospice services were denying for other insurance inappropriately.
Resolution	Per State direction, TPL analysts removed hospice coverage from all Medicare Replacement policies on 10/15/2004.
Provider Action	If billing for hospice services under the HMO Medicare Plan and the service(s) denied for other insurance, the provider needs to rebill the service.

Policy Updated: 10/15/2004

Cleanup: 7/14/2005

Item Reference	GENP 1.121
Date Drafted	2/11/2005
Date Revised	8/19/2005
Groups Affected	All
Issue	Claims are denying in error as duplicate to other claims.
Impact	Providers are not being paid.
Resolution	• Inpatient and inpatient crossover claims are denying as suspect duplicate against outpatient claims for the same or overlapping dates on different providers. Claims meeting this criteria were set to suspend for manual intervention. The fix was completed on 5/6/2005. Claims denied in error started reprocessing on 7/22/2005. (CO 7821) **Reprocessed ICN Range:** 8005203000001 - 8005203007179 • When claims are voided in the system, they deny against the voided claim. This issue was resolved on 1/2/05. EDS identified 416 pharmacy claims, one dental claim, seven physician claims, and four hospital claims that denied incorrectly. Claims started reprocessing on 7/2/2005. (CO 7670) **Reprocessed ICN Range:** 8005181000971 - 8005181001732 • Nursing home claims are setting duplicate exception 5004 against claims other than inpatient, other long term care claims, and crossover claims. This was corrected on 8/5/2005. Since claims were set to suspend and manually paid correctly, no reprocessing of claims is needed. (CO 8222)
Provider Action	None at this time.

System Corrected: 8/5/2005

Cleanup: 8/5/2005

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.123	
Date Drafted	4/29/2005	
Date Revised	7/5/2005	
Groups Affected	All	
Issue	Claims are denying for procedure to diagnosis code when providers would like to see the claims covered or they should be covered.	
Impact	Providers were not being paid.	
Resolution	The system was updated to pay for the following procedures to diagnosis code: • Diagnosis codes 65453, 64103, 65223, 632, 63410, 65133, and 65673 for the following procedures: 76801, 76802, 76812, 76817, 76825, 76826, 76827, and 76828 • Diagnosis code 85011 for the following procedure codes: 70450,70460, and 70470 • Diagnosis code 7895 with procedure 76830 • Diagnosis code 650 for the following procedure codes: 76801, 76802, 76805, 76810, 76811, 76812, 76815, 76815, 76817, 76818, 76819, 76825, 76826, 76827, 76828, and 76855 • Diagnosis code 64000 with procedures 76802, 76811, 76812, 76825, 76826, 76826, 76827, and 76828 • Diagnosis code 6260 with procedures 76830, 76831, 76801, 76805, 76810-76812, 76815-76819, 76825-76828, and 76855 Some of these combinations are due to updates in approved coverage by SRS; other combinations were previously paid and should be paid. Please note some of these combinations will require medical necessity documentation. Coverage without documentation is not guaranteed. Claims started reprocessing on 7/6/2005. (CO 8076) **Reprocessed ICN Range:** 8005181001755 - 8005181002153	System Corrected: 4/25/2005 Cleanup: 7/6/2005
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.125	
Date Drafted	4/29/2005	
Date Revised	8/19/2005	
Groups Affected	ADAP	
Issue	Claims are denying when a beneficiary has ADAP and another benefit plan.	
Impact	Providers are not being paid.	System Corrected: 6/3/2005 Cleanup: 8/16/2005
Resolution	• When a beneficiary has ADAP and another benefit plan that overlaps the ADAP coverage, the claim stops at the other plan and denies when ADAP coverage is available. EDS resolved the issue on 6/3/2005. Claims started reprocessing on 8/16/2005. (CO 7833) **Reprocessed ICN Range:** 8005227000001 – 8005227000016 • The system needs to allow claims submitted on a format other than pharmacy to pass through the ADAP benefit plan and process to completion in other benefit plans. Claims denied for the ADAP benefit plan with exception 2033, claim type invalid for benefit plan, because a medical service was submitted on a HCFA for the beneficiary. After further review, the service did pass through the ADAP plan and paid or denied in the beneficiary's MKN benefit plan correctly. No system change is needed. (CO 7972)	
Provider Action	None at this time.	

Item Reference	GENP 1.126	
Date Drafted	4/29/2005	
Date Revised	7/22/2005	System Corrected: 4/21/05
Groups Affected	Psychiatric	
Issue	Procedure code S5145 (foster care therapeutic) is denying in error.	
Impact	Providers are not being paid.	Cleanup: N/A
Resolution	S5145 was denying in error for DOS 1/1/03 through 3/31/03. This issue was corrected on 4/25/05. Claims were reprocessed under different change orders. No further cleanup will be done on this item. (CO 8097)	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.128	
Date Drafted	4/29/2005	
Date Revised	11/4/2005	
Groups Affected	DME Suppliers	Policy & System Updated: 11/4/2005
Issue	Diabetic supplies are crossing over from Medicare and denying because of a difference in policies. Medicare allows future dates for the month; Medicaid does not.	
Impact	Providers cannot take advantage of the automatic crossover process.	Cleanup: N/A
Resolution	SRS provided policy E2004-040 to allow the system to review the from date only on diabetic supplies. If the from date of service is on or before the current date, the claims will process. The system will no longer review the through date which is future dated for the month. This policy was approved, and system design and implementation are in process. This moved to production on 11/4/2005. (CO 8018)	
Provider Action	None at this time.	

Item Reference	GENP 1.130	
Date Drafted	5/5/2005	
Date Revised	10/7/2005	System Corrected: 10/7/2005
Groups Affected	Professional claims	
Issue	Claims are not retaining manual pricing which allows for pricing above the maximum fee schedule.	
Impact	Providers are being underpaid.	Cleanup: N/A
Resolution	When manually pricing a medical claim, the system changed the manual price back to the maximum fee rather than allow an override for a higher amount allowed per policy. The system was updated to correct this issue on 10/7/2005. (CO 8115)	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.131	
Date Drafted	5/5/2005	
Date Revised	8/1/2005	
Groups Affected	Mid-level Practitioners	System Corrected: 5/13/2005
Issue	Claims are paying at the regular mid-level practitioner (MLP) and exempt physician rate instead of the higher pediatric rate.	
Impact	Providers are being underpaid.	Cleanup: 7/21/2005
Resolution	Claims for ages 0-18 should pay at the higher pediatric rate. The system was updated on 5/13/2005. Claims started reprocessing on 7/21/2005. (CO 8136) **Reprocessed ICN Range:** 5205202000001 - 5205202005059	
Provider Action	None at this time.	

Item Reference	GENP 1.132	
Date Drafted	5/27/2005	
Date Revised	7/22/2005	
Groups Affected	Professional - HCFA 1500	System Corrected: 5/2/2005
Issue	Claims are paying when the performing provider is not part of the group.	
Impact	Providers are being overpaid.	Cleanup: 5/2/2005
Resolution	During claims processing, the performing provider number is not using the service location (alpha character at the end of the provider number) to ensure that the performing provider is part of the group. Claims are paying when the performing provider is not part of the group. This was corrected on 5/2/2005 and claims were reprocessed. (CO 8185)	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.133	
Date Drafted	5/27/2005	
Date Revised	8/1/2005	
Groups Affected	Laboratory	System Corrected: 5/11/2005
Issue	Procedure codes 84436 and 82756 are denying in error for allowing one telephonic transmission of post-system electrocardiogram rhythm strip(s) every 30 days.	
Impact	Providers are not being paid.	Cleanup: pending
Resolution	Exceptions 6185 and 6186 for denials should apply to procedure codes 93012 and 93014 only. This was corrected on 5/11/05. Claims started reprocessing on 7/29/2005. (CO 8168) **Reprocessed ICN Range:** 800509000001 - 800509000014; 5205209000004 - 5205209000102	
Provider Action	None at this time.	

Item Reference	GENP 1.134	
Date Drafted	7/5/2005	
Date Revised	8/5/2005	
Groups Affected	All	System Corrected: 6/17/2005
Issue	Claims have paid in error when procedure 59409 is part of the labor and delivery in a maternity center setting and have denied in error for procedure 99213.	
Impact	Providers are being overpaid and not paid.	Cleanup: N/A
Resolution	Claims should have posted a denial for exceptions 5515 and 5516 for procedure code 59409 performed in a maternity center setting versus supplies. Claims should not have denied for exceptions 5515 and 5516 for procedure code 99213. This issue was corrected on 6/17/2005. No claims were identified which have not already been adjusted by other cleanup. No further action will be done. (CO 8253)	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.137	
Date Drafted	8/18/2005	
Date Revised	8/19/2005	
Groups Affected	ARNP	System Corrected: 8/4/2005
Issue	Claims for therapeutic injections are denying when billed by an ARNP.	
Impact	Providers are not being paid.	Cleanup: 8/17/2005
Resolution	Claims for therapeutic injections should be paid when billed by an ARNP. Procedure codes 90782, 90783, 90784, and 90788 were denying as non-covered for ARNP provider types 09/093, 09/094, and 09/095. The codes were updated to pay as of 8/4/2005. Cla ims started reprocessing on 8/17/2005. (CO 8432) **Reprocessed ICN Range:** 5205229011461 - 5205229011549; 8005229000001 - 8005229000048	
Provider Action	None at this time.	

Item Reference	GENP 1.138	
Date Drafted	9/15/2005	
Date Revised	9/23/2005	
Groups Affected	ICF/MR and Custodial Care Facility	System Corrected: 9/15/2005
Issue	Procedure codes 99321-99323 and 99331-99333 were denying for POS 33 (custodial care facility) and POS 54 (ICF/MR).	
Impact	Providers were not being paid.	Cleanup: 9/20/2005
Resolution	Per policy E2005-023, POS codes 33 and 54 became acceptable place of service codes to use with procedure codes 99321-99323 and 99331-99333. The effective date of this change was made retroactive to 9/15/03. The system was updated on 9/15/05. Claims started reprocessing on 9/20/2005 for claims using the effective date of 9/15/2003. (CO 8500) **Reprocessed ICN Range:** 8005263002654 – 8005263003811; 5205263000001 – 5205263000041	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Item Reference	GENP 1.141	
Date Drafted	10/13/2005	
Date Revised	11/23/2005	System Corrected: 10/25/2005
Groups Affected	All	
Issue	Claims for Qualified Medicare Beneficiaries (QMB) are denying for prior authorization (PA).	
Impact	Providers are not being paid.	Cleanup: 11/18/2005
Resolution	Procedures for a QMB do not require a PA. The system is being updated to bypass the PA requirement for QMBs. This change was moved to production on 10/25/2005. Claims started reprocessing on 11/18/2005. (CO 8584) **Reprocessed ICN Range:** 8005321000001 – 8005321000012	
Provider Action	None at this time.	

Item Reference	GENP 1.142	
Date Drafted	10/20/2005	
Date Revised	11/18/2005	
Groups Affected	DME Suppliers	System Updated: 10/6/2005
Issue	Procedure codes E0608, E0618, and E0619 were paying in error for exception 6016 for the limitation of allowing only six-month apnea monitor rentals.	
Impact	Providers were not being paid.	Cleanup: 11/19/2005
Resolution	The system was updated on 10/6/2005. Letters were mailed to providers on 11/10/2005 to communicate the claims which potentially will be recouped. Claims that initiated additional payment started reprocessing on 11/4/2005. Claims that initiated potential recoupment started reprocessing on 11/19/2005. (CO 8589) **Reprocessed ICN Range:** 8005308000001 – 8005308000405; 5205324000001 – 5205324001718	
Provider Action	None at this time.	

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

Revised: 12/30/2005

KMAP Provider Communication

Provider Community: Optometry

Item Reference	OPT 1.1	
Date Drafted	4/27/2004	
Date Revised	10/15/2004	
Groups Affected	Optometry	System Corrected: 4/21/2004
Issue	Claims were being denied for eyeglass frames and lenses for KAN Be Healthy (KBH) eligible children.	
Impact	Providers were being underpaid.	Cleanup: 7/15/2004
Resolution	Procedure code V2100 was being denied/cut back by limitation audit 6214 inappropriately. For example, for a 15-year old, who should not encounter that audit, the claim was cut back to only half of the allowed amount for the lens. The system was corrected on 4/21/2004. The claims denied in error were reprocessed on 7/15/2004. (CO 5647)	
Provider Action	No action is needed.	

Item Reference	OPT 1.2	
Date Drafted	4/27/2004	
Date Revised	10/15/2004	
Groups Affected	Optometry	System Corrected: 8/17/2004
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 were being denied incorrectly.	Cleanup: 9/24/2004
Resolution	EDS corrected the issue on 8/17/2004. EDS identified and reprocessed the claims that were denied in error. The claims will appear on 10/7/2004 RA. (CO 6609)	
Provider Action	No action is needed.	

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

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