KMAP Provider Communication

Document Changes:

The following items were updated this week:

GENP 1.69

GENP 1.86

GENP 1.141

Document Additions:

ACH 1.2

CHHC 1.51

PHAR 1.20

GENP 1.143

GENP 1.144

GENP 1.145

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

KMAP Provider Communication

Provider Community: Adult Care Home

Item Reference	ACH 1.2	
Date Drafted	11/14/2005	
Date Revised	11/14/2005	
Groups Affected	Long Term Care	System: pending
Issue	Patient liability is not being deducted from Long Term Care converted claims.	
Impact	Providers are being over paid.	Cleanup: pending
Resolution	Patient liability is not being deducted from Long Term Care converted claims. Since nursing home claims were converted from TAD to inpatient crossover when Medicare is involved, patient liability is not being applied to the nursing home claim. Processing logic for inpatient crossover claims with provider type 03 (Custodial Care Facility) is being updated. Providers will be notified when corrected. (CO 8656)	
Provider Action	None at this time.	

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KMAP Provider Communication

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

Item Reference	CHHC 1.47
Date Drafted	2/11/2005
Date Revised	11/4/2005
Groups Affected	CMHC, HCBS
Issue	Claims are paying in error or are limiting targeted case management (TCM) services when TCM services are paid within the same month.
Impact	Providers are being overpaid and underpaid.
Resolution	• Claims are paying for T2048 and T1017 within the same calendar month. This is on a very sporadic basis. Most claims are denying correctly when a second service is submitted in the same month. This was fixed on 10/24/2005. Providers will be notified when claims are reprocessed. (CO 7780) • T1017 is limiting to 800 units per calendar year for all waivers. This limit should be for HCFE waiver only. Providers will be notified when the system is updated. (CO 8472)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

Item Reference	CHHC 1.49
Date Drafted	9/15/2005
Date Revised	11/10/2005
Groups Affected	Case Managers
Issue	Claims are being paid incorrectly under Program Cost Account (PCA) codes.
Impact	Providers are being overpaid.
Resolution	Claims with procedure code Y9124 (targeted case management) paid under the wrong PCA code (35008.) The claims should have paid under PCA code 56857 for any population that is not Pop Code 63 (FC-JJA) or Pop Code 65 (FC-Dual JJA.) This issue applies to the following provider type and specialty combinations: 21/232, 21/072, 21/073, and 21/074. The system was updated on 11/10/2005. Providers will be notified when claims are reprocessed. (CO 8494)
Provider Action	None at this time.

System Corrected: 11/10/2005

Cleanup: pending

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KMAP Provider Communication

Item Reference	CHHC 1.50
Date Drafted	11/05/2005
Date Revised	11/18/2005
Groups Affected	HCPD Providers
Issue	HCPD claims denied for "allow 1 unit of personal services per month in error".
Impact	Providers were not paid.
Resolution	HCPD claims denied for "allow 1 unit of personal services per month in error". The system was updated on 10/27/2005 to correct this. Providers will be notified when claims are reprocessed. (CO 8641)
Provider Action	None at this time.

System Updated: 10/27/2005

Cleanup: pending

Item Reference	CHHC 1.51
Date Drafted	11/22/2005
Date Revised	11/22/2005
Groups Affected	HCBS HI
Issue	Claims are denying for bundling when G0152 and 97532 are billed for the same date of service.
Impact	Providers are not being paid.
Resolution	Although codes G0152 and 97532 bundle correctly for all other benefit plans per national bundling guidelines, they should not bundle together for the HCBS HI benefit plan. Providers will be notified when the system is updated. (CO 8693)
Provider Action	None at this time.

System: pending

Cleanup: pending

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KMAP Provider Communication

Provider Community: Rural Health Clinics and Federally Qualified Health Clinics

Item Reference	RHC 1.8
Date Drafted	7/25/2005
Date Revised	7/25/2005
Groups Affected	RHC and FQHC
Issue	Providers are billing more than one unit for an encounter. When the system reduces the encounter to one, it is reducing the billed amount as well.
Impact	Providers are being underpaid.
Resolution	If the provider bills more than one unit, the encounter rate should not be reduced. Providers will be notified when this is corrected. Once corrected, claims will be reprocessed. (CO 8366)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

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KMAP Provider Communication

Provider Community: Hospitals and Adult Care Home

Item Reference HSPT 1.36

Date Drafted 6/28/2004

Date Revised 10/27/2005

Groups Affected Inpatient

Issue Claims are being paid with an incorrect diagnosis related grouping (DRG).

Impact Providers are being overpaid and underpaid.

Resolution

- Some MediKan (MKN) claims are not paying because the DRG is not loaded for MKN. All codes were loaded on 3/2/2005. Claims started reprocessing on 5/23/2005. (CO 7583)
  Reprocessed ICN Range: 8005143000001 – 8005143000147
- New DRG rates for 2005 were delayed in receipt. The DRGs and rates were loaded on 2/11/2005. Claims in suspense started to release on 2/11/2005. Claims started reprocessing on 5/23/2005. (CO 7599)
  Reprocessed ICN Range: 5205143001057 – 5205143001070
- Only the primary and secondary diagnosis codes were being used on a very limited number of claims. This was corrected on 2/15/2005. Claims started reprocessing on 5/23/2005. (CO 6421)
  Reprocessed ICN Range: 5205143000001 – 5205143000488
- Review of appropriate DRG pricing for all claims completed. Claims started reprocessing on 5/23/2005. (CO 7241)
  Reprocessed ICN Range: 5205143000489 – 5205143001027
- Cost outliers for cost to charge ratios need updated pricing. This issue was corrected on 4/25/2005. Claims started reprocessing on 7/23/2005. (CO 8035) Additional reprocessing will be performed. Additional claims started reprocessing on 10/19/2005.
  Reprocessed ICN Range: 5205203003680 – 5205203003695; 5205293004002 – 5205292032719
- Claims not previously reprocessed for DRG changes for the above change orders started reprocessing on 9/3/2005. (CO 8461)
  Reprocessed ICN Range: 520547000001 – 5205248004159
- Claims denied for new DRG rates effective on 10/1/2005. These claims were reprocessed on 10/14/2005. (CO 8598)
  Reprocessed ICN Range: 8005287000001 – 8005287000037
- When processing claims with length of stays of fewer than three days, the system was assigning DRGs 801-805 for neonatal claims. The system was corrected to retain DRG 385 on 9/10/2004. Claims denied in error were reprocessed on 9/23/2004. (CO 6791) Additional updates for DRG 385 not reading length of stay and DRGs 389 and 390 not being assigned appropriately are needed. Once completed, providers will be notified. (CO 8313)

System Corrected: pending

Cleanup: pending

Provider Action No action is needed.

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KMAP Provider Communication

Item Reference	HSPT 1.50
Date Drafted	9/15/2005
Date Revised	9/15/2005
Groups Affected	Long Term Care
Issue	Long term care (LTC) claims are paying at 100 percent and should pay at 67 percent.
Impact	Providers are being overpaid.
Resolution	Revenue code 181 should pay at 67 percent for provider type and provider specialty of 03/011. This issue is being corrected. Providers will be notified when complete. (CO 8468)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

Item Reference	HSPT 1.51
Date Drafted	9/15/2005
Date Revised	9/15/2005
Groups Affected	Hospitals
Issue	Heart transplant claims are being paid incorrectly by DRG. The claims should be paid at 70 percent of the allowed amount rate for the DRG.
Impact	Providers are being overpaid.
Resolution	Policy states heart transplant claims will be paid at 70 percent of the allowed amount. The system was updated on 9/9/05. Providers will be notified when claims are initiated for recoupment for the amount overpaid. (CO 8503)
Provider Action	None at this time.

System Corrected: 9/9/2005

Cleanup: Pending

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KMAP Provider Communication

Provider Community: Pharmacy

Item Reference	PHAR 1.18
Date Drafted	9/15/2005
Date Revised	9/15/2005
Groups Affected	Pharmacies
Issue	Pharmacies are unable to reverse claims when the prescription field is fewer than seven characters.
Impact	Providers are being overpaid.
Resolution	When pharmacists submit a prescription number with fewer than seven characters, the system populates the field with preceding zeros. Providers are not able to reverse these claims on the Internet. This situation will be corrected; providers will be notified. (CO 8488)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

Item Reference	PHAR 1.19
Date Drafted	10/6/2005
Date Revised	10/6/2005
Groups Affected	Pharmaceutical
Issue	Schedule II drugs that were indicated as a refill are denying for exception 5016 when the beneficiary does not have a level of care (LOC) that indicates residence in a nursing facility on the date of service or a diagnosis of V667 on the claim.
Impact	Providers are confused.
Resolution	Exception 351 (refill not allowed for narcotic drugs) should have posted. Exception 5016 (Schedule II drug more than 60 days from original prescription) should not have posted. The system is being updated to post the correct denial. Once complete, providers will be notified. (CO 8487)
Provider Action	None at this time.

System Corrected: pending

Cleanup: N/A

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KMAP Provider Communication

Item Reference	PHAR 1.20	
Date Drafted	11/22/2005	
Date Revised	11/22/2005	System: pending
Groups Affected	Pharmacy	
Issue	Claims are paying in error when the NDC was not covered for the beneficiary's benefit plan.	Cleanup: pending
Impact	Providers are being overpaid.	
Resolution	Only two claims have been identified. Providers will be notified when the system is corrected. (CO 8696)	
Provider Action	None at this time.	

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KMAP Provider Communication

Provider Community: General

Item Reference GENP 1.14b

Date Drafted 4/6/2004

Date Revised 11/10/2005

Groups Affected All

Issue Claims are denying in error for diagnosis code.

Impact Providers are not being paid.

Resolution

- Claims are sporadically denying for procedure versus diagnosis restriction (edit 4037 and EOB 0171). CO 8293 for denying in error with EOB 0171 was corrected on 8/4/2005. No additional reprocessing will be completed for CO 8293. CO 8297 was updated on 6/24/2005 for the following diagnosis codes: 37650, 37651, 37652, 3766, 37700, 37701 - 37704, 73303, 73309 - 73311, 7768, 80113, 80394, 80395, 90483, 80679, 87212, 87263, and 9046. Claims started reprocessing on 8/2/2005. (CO 8293 & 8297)
  Reprocessed ICN Range (CO 8297): 8005215000001 – 8005215000089; 5205215000001 – 5205215000008
- Anesthesia claims billed without a sterilization code were denying in error for sterilization (4311). This was corrected on 7/29/2005. Claims started reprocessing on 8/24/2005. (CO 8392)
  Reprocessed ICN Range: 8005236000001 – 8005236000004
- Claims paid when diagnosis was not payable with procedure. Exception 4286 was not setting. This situation was corrected on 9/30/2005. Providers will be notified when claims are reprocessed. (CO 8554)
- The system was updated to allow procedure 76380 to be billed with diagnosis code 220 on primary diagnosis code on 9/30/2005. Claims started reprocessing on 10/10/2005. (CO 8562)
  Reprocessed ICN Range: 5205284000001 – 5205284000105; 8005284000001 – 8005284000006
- Pre and post surgery days were updated to pay claims for different provider numbers and deny claims for same providers numbers when appropriate. Claims started reprocessing on 10/24/2005. (CO 8583)
  Reprocessed ICN Range: 8005294000001 – 8005294000006
- Dental claims should not deny for diagnosis indicator. This was corrected on 10/14/2005 for claims processed from 8/2/2005 to 10/14/2005. Claims started reprocessing on 11/10/2005. (CO 8597)
  Reprocessed ICN Range: 8005312000001 – 805312000060
- Claims are denying at the detail level for exception 4314, which should only apply to editing diagnosis codes at the header level. Providers will be contacted when corrected. (CO 8308)

System Corrected: pending

Cleanup: pending

Provider Action No action is needed.

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KMAP Provider Communication

Item Reference GENP 1.17

Date Drafted 4/12/2004

Date Revised 11/18/2005

Groups Affected Physician

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

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

Resolution

- The interim system issue was resolved on 6/24/2004. EDS is identifying the claims denied in error and will inform the provider when complete. EDS anticipates the claims will be reprocessed by mid-August. (CO 6487 and 6793) CO 6793 was written for a manual workaround procedure until CO 6487 can be completed. All applicable audits were identified and set to suspend for the manual intervention; thus, no cleanup is needed. CO 6487 moved to production on 10/8/2004 to automate this process.
- Multi-surgery audit 5017 was posting in error and causing claims to be denied. EDS identified the issue and is in the process of resolution. Providers will be notified when complete. (COs 6793 and 7127) CO 6793 for denials on assistant surgeon claims completed on 7/9/2004. Claims were reprocessed on 9/9/2004. CO 7127 cleanup was completed on 11/12/2004. Additional review of surgeon versus assistant surgeon claims was completed on 3/11/2005. Claims denied in error were reprocessed by 5/12/2005 for CO 7754. (CO 7754)

System Corrected: 11/10/2005

- Claims were paying incorrectly and allowed office visit claims to pay within 21 days of surgery. This issue was resolved on 9/22/2004. EDS will identify the claims and notify providers when reprocessed. (CO 6344, 7316, and 7342) CO 6344 and 7342 started claims reprocessing on 10/29/2004. CO 7316 started claims reprocessing on 11/4/2004.

Cleanup: pending

- Claims for cholecystectomy are being denied for 6169 (allow one per lifetime). This issue was resolved with CO 7962 issue (see bullet below within this item). Claims started reprocessing on 7/26/2005. (CO 7274)
  Reprocessed ICN Range: 8005207000003 – 8005207000071; 5205207000004 – 5205207000007
- Claims for hysterectomy were being denied in error by exception 6168 (allow one per lifetime) between surgeons and assistant surgeons. This was corrected on 3/11/2005. (CO 7754)
- On claims filed with procedures such as UGI technical components (TC), the claims are denying against professional and vice versa. This was corrected on 3/4/2005. Claims started reprocessing on 7/1/2005. (CO 7962)
  Reprocessed ICN Range: 5205164000006 – 5205164000043; 8005181000001 – 8005181000373
- The system was updated on 4/26/2005 to have claims deny pre-operative care only 1 day prior to surgery rather than 42 days prior (error 5705). Claims started reprocessing on 5/26/2005. (CO 8135)
  Reprocessed ICN Range: 5205144001530 – 5205144002800; 8005144000001 – 8005144000129
- Any procedure in range 10000 – 69999 with modifier 80 allows payments to the assistant surgeon and denies the primary surgeon. This situation occurs on a limited basis. This was corrected on 11/10/2005. Providers will be notified when claims start to reprocess. (CO 8231)

Provider Action No action is needed.

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KMAP Provider Communication

Item Reference GENP 1.66

Date Drafted 6/28/2004

Date Revised 10/7/2005

Groups Affected All

Issue Claims with prior authorization are being denied in error when the beneficiary is KAN Be Healthy (KBH) and the service is not normally covered. Claims are being denied for 11056, 11055, 11200, and 11201 per prior policy.

Impact Providers were not being paid.

Resolution

- Claims are being denied as not covered on date of service when a valid prior authorization is on file for the procedure. One example is that claims are being denied for sleep study when approved for a KBH eligible child. EDS identified the issue and is working on a solution. (COs 6070 and 6540) For CO 6399, claims with "price by prior authorization" were reprocessed and will appear on the 8/26/2004 remittance advice. For CO 6070, claims with "procedure not covered" were reprocessed and will appear on the 9/9/2004 RA. CO 6540 for claims that were denied for KBH when a prior authorization was on file was moved to production on 9/16/2004. EDS reprocessed the claims, and they appeared on the 10/7/2004 RA.

  Policy Updated: 9/10/2004

- Claims have required prior authorization for 11055, 11056, 11200, and 11201. SRS revisited the policy and removed the prior authorization requirement as of 8/5/2004. EDS reprocessed the claims on 10/1/2004, and they appeared on the 10/7/2004 RA. (CO 7133)

  System Corrected: pending

- KBH last and next screening dates (medical, vision, hearing, and dental) continue to update incorrectly. This issue will not cause the loss of beneficiary benefits. EDS is working on resolving this issue and will notify providers when complete. (CO 7504)

- Claims are denying when the beneficiary is KBH eligible and the service can be paid when a PA is on file. Claims have been suspended until system automation is implemented. Once complete, any claims denied in error will be reprocessed and providers will be notified. Claims for CO 6070 were reprocessed on 9/16/2004. CO 7690 is still pending correction. (CO 6070 &7690)

  Cleanup: pending

- Claims for beneficiaries older than 21 years are denying against history KBH claims when beneficiaries are actually less than 21 years. The four-year vision services limitation for adults should ignore KBH claims and not deny for audit 6219. This issue was corrected on 5/17/2005. (CO 8180) Claims started reprocessing on 7/14/2005.
  Reprocessed ICN Range: 5205195000001 – 5205195000065

- A small number of claims are setting edit 4021 (non-covered) that should set edit 4321 (KBH covered) when beneficiary is under the age of 21. Issue was corrected on 7/14/2005. Claims started reprocessing on 8/17/2005. (CO 8206)
  Reprocessed ICN Range: 8005227000040 – 8005227034519; 5205229000001 – 5205229011460

- When a beneficiary turns 21 years of age, the system will be updated to reset the beneficiary's eye exam and eye glasses medical card dates to 00/00/0000 to allow services to process under adult limitations. Providers will be notified when updated. (CO 8430)

Provider Action No action is needed.

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KMAP Provider Communication

Item Reference GENP 1.69

Date Drafted 6/28/2004

Date Revised 11/23/2005

Groups Affected All

Issue Claims are being denied or paid incorrectly for invalid provider type and specialty.

Impact Providers are not being paid.

Resolution

- Providers are receiving denials for provider type and specialty in error (exception code 4270). This is not a denial in error on majority of claims but does appear on some claims. (COs 6113, 6313, 6667, 6754, and 7220) CO 6754 was moved to production on 9/10/2004. Claims were reprocessed for CO 6754 and appeared on the 9/30/2004 RA. CO 6313 was corrected on 4/13/2004. Claims were reprocessed for CO 6313 and appeared on the 10/7/2004 RA. CO 6667 was corrected on 7/29/2004. Claims were reprocessed on 10/1/2004. CO 7220 was corrected on 8/25/2004 and claims were resubmitted for the 9/30/2004 RA. Claims suspended for CO 6113 were released on 9/9/2004 to continue processing.
- Audits will be enabled to allow the ability to set up limitation and contra auditing by billing provider, provider type, and provider specialty. (COs 7056 and 7057) This change was moved to production on 10/8/2004.
- Claims were being denied for S9123 and S9124 for provider type and specialty 12/120. This issue was corrected on 8/27/2004. (CO 7545) S9123 was being denied for provider type and specialty 05/501. This issue was corrected on 9/13/2004. (CO 7308) EDS identified and reprocessed erroneously denied claims on 10/7/2004. No further cleanup is needed.
- Claims were denying in error for minor surgery versus IVs, supplies, and injections due to provider type and specialties of 01/010 and 02/020 not being valid. CO 7139 was corrected on 01/18/2005. EDS identified 953 claims which were adjusted on 5/1/2005. CO 8073 to set up the contra audits differently is pending. (COs 7139 and 8073)
  Reprocessed ICN Range (CO 7139): 5205119000001 – 5205119000953
- Additional updates were made for minor surgery versus IVs, supplies, and injections. Providers will be notified when claims are reprocessed. (CO 8073)
- Procedures not listed in the *Home Health Manual*, such as 99070, did not deny for p rovider type and specialty. Letters with identified claims for possible recoupment were mailed by 10/6/2005. Claims started reprocessing on 10/24/2005. (CO 7954)
  Reprocessed ICN Range: 5205296019519 – 5205296019545
- Procedure code 88273 was denying in error for provider type and specialty. This issue was corrected on 4/25/2005. Claims started reprocessing on 5/23/2005. (CO 8109)
  Reprocessed ICN Range: 5205143001128 – 5205143001163; 8005143001224 – 8005143001230
- Procedure code 92507 was denying in error for provider type and specialty for provider type 26 with specialty 267. This issue was corrected on 11/4/2005. Providers will be notified when claims are reprocessed. (CO 8691)

System Corrected: pending

Cleanup: pending

Provider Action No action is needed.

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KMAP Provider Communication

Item Reference GENP 1.83

Date Drafted 7/26/2004

Date Revised 11/4/2005

Groups Affected All

Issue Co-pay amounts were being handled incorrectly for various procedure codes.

Impact Providers were being underpaid/overpaid depending on the code.

Resolution

- Provider type 11 with all provider specialties was taking co-pay from procedure code 90847 inappropriately. Claims with procedure codes G0154, 99601, and 99601 GY should have co-pay deducted. This issue was resolved. SRS determined no cleanup effort was needed. (CO 6851)
- When a beneficiary has ADAP with another coverage such as TXIX, co-pay is not deducting on services for the other coverage unrelated to ADAP. Co-pay should be taken. This issue was resolved on 5/6/2005. No recoupment is planned. (CO 7724)
- DME claims were not taking appropriate co-pay. This issue was corrected on 2/3/2005. 8,587 details were identified that did not take co-pay. No recoupments will occur at this time. (CO 7840)
- SRS approved not taking co-pay when baby claims are paid under mother's ID. The system was updated on 5/6/2005. Claims with co pay will be identified and providers notified when reprocessed. Providers, please do not adjust claims or they will wait 45 days for mom/baby processing. Claims started reprocessing on 7/2/2005. (CO 7841)
  Reprocessed ICN Range: 5205182140118 – 5205182140163
- EDS is modifying the co-pay logic to include the pregnancy diagnosis for inpatient claims. Co-pay is not to apply. This issue was corrected on 6/3/2005. Claims started reprocessing on 7/14/2005. (CO 7866)
  Reprocessed ICN Range: 5205195000066 – 5205195002226
- Dental services is not taking $3 co-pay for provider type 27 and $2 if beneficiary is older than 17 years. Providers will be notified when claims are reprocessed. This issue was corrected on 7/1/2005. No recoupments will be initiated. (CO 7957)
- Co-pay is being applied to ADAP drugs when the beneficiary is also medically needy with unmet spenddown. Co-pay should not apply in this situation. Providers will be notified when corrected. (CO 8246)
- If beneficiary is 18 on DOS, co-pay is not deducting. This was corrected on 10/11/2005. (CO 8391)
- Procedures E0443 and E0444 were taking a $3 co-pay and should not. This was fixed on 9/30/2005. Claims started reprocessing on 10/21/2005. (CO 8586)
  Reprocessed ICN Range: 5205293008342 – 5205293008735

System Corrected: pending

Cleanup: pending

Provider Action No action is needed.

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KMAP Provider Communication

Item Reference	GENP 1.86
Date Drafted	7/26/2004
Date Revised	11/23/2005
Groups Affected	Medicare Crossover Claims
Issue	Claims are denying in error for Medicare, and some are paying in error.
Impact	Providers are not being paid.
Resolution	• Starting 7/1/2004, claims are being denied for no Medicare paid date that crossed over from Medicare to EDS. EDS corrected this on 4/5/2005. No reprocessing will occur for this CO. (CO 7041) • Claims have paid the full amount for Part B when Medicare is on file; thus, the claim payment should have been denied to bill to Medicare first. EDS resolved the issue on 5/6/2005. Letters to notify providers of claims that may potentially be recouped were mailed on 8/15/2005. Any claim recoupment will be initiated by HMS to better coordinate with providers. (CO 7803) • KMAP has notified the Medicare Part A intermediary that KMAP is receiving incorrect allowed amounts on some electronic crossover claims. The Part A intermediary is intermittently sending an incorrect allowed amount to KMAP which in turn will cause an incorrect payment by KMAP based on the Medicare/Medicaid pricing logic. EDS is making system changes to ignore the Medicare allowed amount sent by the Medicare intermediary. EDS will calculate the Medicare allowed amount by adding Medicare paid, Medicare coinsurance, and Medicare deductible. EDS determined these Medicare fields from the Medicare intermediary appear to be correct. Providers will be notified when the system is updated. Once the system is updated, EDS will be able to initiate automatic reprocessing and recoupment of the overpayment. (COs 8658, 8659, and 8660) • Suspect provider exception 1077 should post on crossover inpatient claims. 1077 is not posting. EDS will contact providers when corrected. (CO 8337) • Medicare moved the Medicaid ID number from the Medicaid ID field to the TPL field on crossover files starting with the October 26, 2005, file. Claims denied for invalid beneficiary ID. EDS is changing the translation map. Providers will be notified when corrected. (CO 8671)
Provider Action	KMAP cannot correct paid claims on behalf of the providers since the incorrect information as received from Part A is currently on the latest version of the claims. Providers must initiate adjustments for correct payment.

System Enhanced: Pending

System Corrected: pending

Cleanup: pending

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KMAP Provider Communication

Item Reference	GENP 1.111
Date Drafted	11/02/2004
Date Revised	9/16/2005
Groups Affected	All
Issue	Claims are denying in error for edit 456(invalid procedure type).
Impact	Providers are not being paid.
Resolution	• EDS resolved the system issue on 12/3/2004. EDS identified 128 claims to be adjusted and 16,851 denied claims to be reprocessed. EDS reprocessed the claim details denied in error. The denied claims were reprocessed on 2/15/2005. Adjustments were completed on 5/4/2005. (CO 7391) **Reprocessed ICN Range:** 8005054000001 – 8005054016851; 5205123030070 – 5205123030150 • Web submitted claims are not auto-populating the procedure type which is causing some claims to deny. Providers will be notified when corrected. (CO 8486)
Provider Action	No action is needed.

System Corrected: pending

Cleanup: pending

Item Reference	GENP 1.112
Date Drafted	11/02/2004
Date Revised	11/02/2004
Groups Affected	All
Issue	Data not captured correctly is causing claims to be denied.
Impact	Providers are not being paid.
Resolution	Claims information (TPL amount, beneficiary name, and provider number) sent from the character recognition system to the MMIS is not transmitting correctly on a very small percentage of claims. EDS is working on resolving this issue and will notify providers when completed. (CO 7461)
Provider Action	No action is needed.

System Corrected: pending

Cleanup: N/A

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KMAP Provider Communication

Item Reference	GENP 1.122
Date Drafted	2/11/2005
Date Revised	8/19/2005
Groups Affected	NEMT
Issue	Claims are paying for NEMT providers incorrectly.
Impact	Providers are being overpaid.
Resolution	• Claims are paying when NEMT providers are billing date ranges on a detail line. Billing manuals instruct that the providers are to submit each date of service on a separate billed detail line. Once the system change is completed, EDS will identify overpaid claims, contact the providers with the list of ICNs, and initiate recoupments. (CO 7524) • Claims were paid for NEMT services (A0130, T2002, and T2003) under the QMB plan. These are non-covered. This was corrected on 5/2/2005. 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 8130) **Reprocessed ICN Range:** 5205228000001 – 5205228003851
Provider Action	If you billed a date range, submit adjustments through the Web site prior to the recoupment being initiated. You can split your billed dates into separate detail lines, and click Adjust. This process allows you to correct your billing and not have a recoupment initiated.

System Corrected: pending

Cleanup: pending

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

KMAP Provider Communication

Item Reference GENP 1.124

Date Drafted 4/29/2005

Date Revised 11/18/2005

Groups Affected All

Issue Third party liability amounts are not being reduced on some claims.

Impact Providers are being overpaid.

Resolution

- Some procedure codes, ICD-9 codes, and revenue codes inappropriately reflect "00" or blanks in the TPL Service Class field. The value of "00" occurred due to a missing step in the annual HCPCS update process. EDS is updating these fields so that the proper cost avoidance can occur. This was corrected on 7/15/2005. Providers will be notified when recoupments are initiated. (CO 8001)
- The institutional Web claim form sporadically drops the header from date, through date, and admit date. All professional Web claims do not maintain TPL information for the copy and adjust functions. Providers have to rekey this information on resubmissions and adjustments. Once the Web site is fixed, providers will be notified. (CO 8370)
- When providers enter 'Y' in the TPL field on the Web, the value sporadically does not transfer to Medicaid and denies for not TPL. Providers will be notified when corrected. (CO 8386)
- Twenty-five procedure codes with indicators set to expect TPL were changed to no TPL required on 8/2/2005. These procedure codes affected CMHC and HCBS providers. (CO 8409) Claims started reprocessing on 8/4/2005. **Reprocessed ICN Range:** 8005216000001 – 8005216001797; 5205216000001 – 5205216000031
- Claims are denying for TPL when a procedure code is excluded as requiring TPL for a small number of procedure codes. This issue was corrected on 10/21/2005. Claims started reprocessing on 11/15/2005. (CO 8460) **Reprocessed ICN Range:** 8005319000001 – 8005319009909; 520319000001 – 520319001069
- Edit 2081 for TPL coverage is denying some 60 region claims for Title XXI dental claims. Providers will be notified when this is corrected. (CO 8552)

System Corrected: pending

Cleanup: pending

Provider Action None at this time.

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KMAP Provider Communication

Item Reference	GENP 1.135
Date Drafted	7/25/2005
Date Revised	7/25/2005
Groups Affected	All
Issue	Claims are denying for client obligation out of balance and using a disposition line for a benefit plan other than the HCBS waiver. This results in claims denying when the claims should not deny.
Impact	Providers are not being paid.
Resolution	For all HCBS waivers except FE, for dates of service prior to 7/1/05, claims should pay and list patient obligation out of balance (exception 1078.) For all waivers on and after 7/1/05, claims should deny. Edit 1078 should never post for benefit plans other than HCBS. Once this is corrected, providers will be notified. (CO 8362)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

Item Reference	GENP 1.136
Date Drafted	8/8/2005
Date Revised	8/8/2005
Groups Affected	All
Issue	Claims for beneficiaries with multiple benefit plans are denying against the first benefit plan used.
Impact	Providers are not being paid.
Resolution	Beneficiaries with multiple benefit plans, such as a waiver program and Title XIX, should process against all benefit plans before a final denial is generated. Some claims are not processing through all plans, which creates a denial for a service covered by a benefit plan not used in processing. Providers will be notified when this is corrected. (CO 8407)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

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KMAP Provider Communication

Item Reference	GENP 1.140
Date Drafted	10/13/2005
Date Revised	10/13/2005
Groups Affected	All
Issue	Claims for beneficiaries with foster care benefit plan are denying for prior authorization on out-of-state claims.
Impact	Providers are being underpaid.
Resolution	Foster care beneficiaries do not require prior authorization for out-of-state services. The provider of service only needs to be enrolled in the Kansas Medical Assistance Program (KMAP) or willing to enroll and be approved by KMAP. Providers will be notified when the system is updated. (CO 8580)
Provider Action	None at this time.

System Corrected: pending

Cleanup: pending

Item Reference	GENP 1.141
Date Drafted	10/13/2005
Date Revised	11/23/2005
Groups Affected	All
Issue	Claims for Qualified Medicare Beneficiaries (QMB) are denying for prior authorization (PA).
Impact	Providers are not being paid.
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.

System Corrected: 10/25/2005

Cleanup: 11/18/2005

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KMAP Provider Communication

Item Reference	GENP 1.143	
Date Drafted	11/14/2005	
Date Revised	11/14/2005	
Groups Affected	Advanced Practice Nurse and Targeted Case Manager	System: pending
Issue	Procedure G9012 is denying in error for provider type and provider specialty of 09/093 (Advanced Practice Nurse/Nurse Practitioner), 21/231 (Targeted Case Manager/Assistive Technology), and 21/232 (Targeted Case Manager/Behavior Management).	Cleanup: Pending
Impact	Providers are not being paid.	
Resolution	Procedure G9012 is denying in error for provider type and provider specialty of 09/093, 21/231, and 21/232. Exceptions 6321 and 6333 were updated on 9/26/2005 to allow these providers type and provider specialties to pay. (CO 8666)	
Provider Action	None at this time.	

Item Reference	GENP 1.144	
Date Drafted	11/22/2005	
Date Revised	11/22/2005	
Groups Affected	Home Health Agency/DME	System: 11/14/2005
Issue	Procedures were denying in error for provider type and provider specialty of 05/050 (Home Health Agency) and 25/250 (DME/Medical Supply Dealer) when the DD modifier was billed on the detail.	Cleanup: pending
Impact	Providers were not being paid.	
Resolution	The following procedures were updated to pay when appropriate with the DD modifier: B4102, B4103, B4149, B4150, B4152, B1452-B4155, and B4157 through B5162. The system was updated on 11/14/2005. Providers will be notified when claims are reprocessed for denials from 1/1/2005 through 11/14/2005. (CO 8695)	
Provider Action	None at this time.	

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KMAP Provider Communication

Item Reference	GENP 1.145	
Date Drafted	11/22/2005	
Date Revised	11/22/2005	
Groups Affected	DME	System: 11/15/2005
Issue	Claims were denying when billed with procedure J2353.	
Impact	Providers were not being paid.	Cleanup: pending
Resolution	Claims were denying when billed with procedure J2353 (Octreotide Injection, Depot). The system was updated on 11/15/2005. Providers will be notified when claims are reprocessed for denials from 4/1/2004 through 11/14/2005. (CO 8694)	
Provider Action	None at this time.	

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