Modernization Known Issues Updated on 6/21/2019| Page 1

The Modernization Known Issues List provides up-to-date information on current issues related to the MMIS that are impacting a significant number of providers. This document is intended to provide a concise list of current problems identified/reported in recent months. Please note that this is an informational list only. The resolution priority of an issue is not determined by whether or not it appears on this list.

NOTES: Items updated or new items added this week will appear in bold text. Items are sorted by Open Issues, then Closed Issues below.

Modernization Known Issues-OPEN

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
2	Prior Authorization	The Date of Decision for recipient eligibility is currently not available in the EVS system.	• Provider: Prior authorizations should continue to be submitted for review and decision. • Until further notice, the timely filing requirements for prior authorization(s) related only to retro-eligibility will not be applied. • Clinical requirements will still be enforced.	1/31/2019	TBD	N/A
3	Claims, Dental Claims	Dental claims will deny when the rendering provider on the claim is not equal to the rendering provider on the history claim. The claim will show edit *5065-(Possible Duplicate)* on the Web Portal until this issue has been resolved.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	TBD	TBD
47	Dental Claims	Some claims for bitewing images are being denied incorrectly when billed within 6 months of periapical images with error code 6126-(*Dental Services Not Allowed within Six Rolling Months*). Bitewing Images Procedure Codes: • D0270-(*Dental Bitewing Single Film*) • D0272-(*Dental Bitewings Two Films*) • D0273-(*Dental Bitewings Three Films*) • D0274-(*Dental Bitewings Four Films*) • D0277-(*Vert Bitewings-Sev to Eight*) Periapical Images Procedure Codes: • D0210-(*Intraoral Complete Series of* • *Radiographic Images*) • D0220-(*Intraoral Periapical First File*) • D0230-(*Intraoral Periapical EA Add Film*)	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/1/2019	TBD	TBD

Item #	Category	Description	• Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
48	Claims, Category of Service	Some claims are suspending with edit 931-(*Internal Error-Fund Code Assignment Failed*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	3/27/2019	TBD	TBD
49	Claims, DME	Some claims are denying inappropriately for Healthcare Common Procedure Coding System (HCPCS) codes for Provider Type 33- (*Durable Medical Equipment (DME), Disposable, Prosthetics*). The claim will show edit 4801-(*No Billing Rule for Procedure*) on the Web Portal until this issue has been resolved.	• Provider: No additional action needed. • Once resolved, claims will be released for processing.	4/2/2019	TBD	TBD
50	Claims, Provider Type 44 (Swing Bed, Acute Hospital)	The Provider Type 44 Billing Guidelines informs providers to submit with Type of Bill 0281-(*Skilled Nursing Facility-Swing Beds, admit through discharge claim*), which is not an available option on the Web Portal at this time.	• Provider: Submit your claim via EDI. • After the issue is resolved, providers with claims outside of timely filing as a result of not being able to submit will need to submit on the Web Portal including an attachment requesting review of timely filing per Known Issue #50.	4/9/2019	TBD	N/A
51	Claims, Managed Care, NDC (National Drug Code)	When a member is enrolled with a Medicaid Managed Care Organization (MCO), all details on outpatient or outpatient cross-over claims are being denied correctly with error code 2017-(*Client services covered by HMO*), except for Physician-Administered Drug (PAD) claim details. The PAD details billed with National Drug Codes (NDC) are being paid in error, as the service should also be denied with error code 2017-(*Client services covered by HMO*).	• Provider: No additional action needed.	4/12/2019	TBD	TBD
52	Claims, CPT Codes 36573 and 99475	Some claims billed with CPT codes 36573 (Insertion of PICC, without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older) and 99475-(*Initial Inpatient Pediatric Critical Care*) are being denied incorrectly with error code 4714-(*Age restriction on billing rule*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/8/2019	TBD	TBD

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
54	Claims, CPT Codes 01967 and 01968	Some claims billed with CPT codes 01967- (*Neuraxial labor analgesia/anesthesia for planned vaginal delivery*) and 01968-(*Anesthesia for caesarean delivery following neuraxial labor analgesia/anesthesia*) are pricing incorrectly.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/12/2019	TBD	TBD
55	Claims, Prior Authorization	Some claims are denying inappropriately with error codes 3008-(*Prior Auth Service Conflict*) and 3026-(*Modifier Does Not Match PA*) when the service and modifier billed on the claim do match the Prior Authorization (PA).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/12/2019	TBD	TBD
56	Claims, HCPCS Code H2011-GT	Some claims billed with the code H2011- (*Crisis Intervention service, per 15 minutes*) and modifier GT-(*Via interactive audio and video telecommunications systems*) are being denied incorrectly with error code 7270- (*Invalid procedure modifier combination*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/19/2019	TBD	TBD
57	Claims, Medicare Crossover Claims	Some claims are suspending with error code 931-(*Internal error-fund code assignment failed*) when Medicare crossover claims are received with a payment from Medicare, and Nevada Medicaid does not have a record of the member having Medicare.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/17/2019	TBD	TBD
58	Claims, Provider Type 65 (Hospice Long Term Care)	Some claims for Provider Type 65-(*Hospice Long Term Care*) submitted with a Patient Status of 41 indicating that the patient expired in the medical facility are being denied incorrectly with error code 572- (*Accommodation units not equal to header data range*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/25/2019	TBD	TBD

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
59	Claims, EDI (Electronic Data Interchange) Claims	New Electronic Data Interchange (EDI) claims submitted with a frequency code of “6” in Loop 2300, Segment REF02 is resulting in claims not completing the adjudication process when the initial claim has already been voided.	• Provider: For providers submitting claims through EDI and a claim has already been voided or denied, do not utilize frequency code “6” when resubmitting the claim. A new edit will be implemented to deny these claims. Providers are advised to utilize frequency code “1” in Loop 2300, Segment REF02 instead. • Once the new edit has been implemented, the impacted claims will be denied. • Providers will need to resubmit their claims. • The EDI Companion Guide will be updated appropriately.	5/6/2019	TBD	TBD
60	Claims, Institutional Claims	Some institutional claims are being denied incorrectly with error codes 676-(*Date of service exceeds timely filing)* and 677-(*Timely filing limit exceeded*) when the through date of service at the header level is within timely filing.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/8/2019	TBD	TBD
61	Claims	Some claims with CPT codes that were new in 2018 and submitted prior to the recycle reflected on August 17, 2018, remittance advices (Web Announcement 1662) are still showing as denied status with error codes 210-(*No rates on file*) and 309-(*Services not covered) incorrectly*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/6/2019	TBD	TBD
62	Claims	Some claims have been denied incorrectly with error code 3383-(*Sterilization consent form required – header level*) and/or 3384-(*Sterilization consent form required – detail level*) when a sterilization consent form was attached to the claim.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/1/2019	TBD	TBD

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
64	Claims, Provider Type 32 (Ambulance Air or Ground)	Some claims for Provider Type 32-(*Ambulance Air or Ground*) have denied incorrectly with error codes 4531-(*Procedure denied as duplicate to another current procedure*) / 4532-(*Procedure denied as duplicate to another historical procedure*) or 5056-(*Same procedure different modifiers, same date*), when there is more than one transport service on the same date of service.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	1/14/2019	TBD	TBD
65	Claims, Waiver Providers	Some claims for the below waiver provider types have been denied incorrectly with error code 4014-(*no pricing segment on file*). • 38-(*Home & Community Based Waiver-Individuals with Intellectual Disabilities and Related Conditions*) • 48-(*Home & Community Based Waiver for the Frail Elderly*) • 58-(*Waiver for Persons with Physical Disabilities*) • 59-(*Home & Community Based Services Waiver for the Elderly-Augmented Personal Care Services*).	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	5/29/2019	TBD	TBD
66	**Claims, Institutional Crossover Claims**	**Providers are not seeing Claims Adjustment Reason Codes (CARC) 23-(*The impact of prior payer(s) adjudication including payments and/or adjustments*) on the 835 file for Medicare bad-debt. In the previous MMIS system, Institutional crossover pricing adjustment amounts were made under two explanation of benefits (EOB)s:** • **ACA-CONTRACTUAL ADJUSTMENT to indicate what Medicaid allowed for the service (which was tied to CARC 45)** • **ATP-THIRD PARTY PAYMENT to reflect the adjustments made for Medicare payment. (which was tied to CARC 23)** **In the new MMIS, the institutional crossover pricing adjustments amounts are under a single EOB 9915 Medicare crossover claim cutback applied, which is tied to CARC 45-(*Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement*).**	• **Provider: No additional action needed.** • **Once resolved, claims will be automatically reprocessed to allow the institutional crossover claims to apply two separate EOB's with the appropriate CARC's**	**5/6/2019**	**TBD**	**TBD**

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
67	**Financial, Payment Number Issue**	**Some check numbers and check status are showing in error on the remittance advice (RA), as some are showing check numbers from the prior year as uncashed.**	• **Provider: No additional action needed.** • **We are working to resolve this issue for future RA's created.**	**6/19/2019**	**TBD**	**N/A**

Modernization Known Issues-CLOSED

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
1	Claims, Professional Claims	Claim will pend if the claim date spans across different Prior Authorization (PA) Line Items The claim will show edit *3009-(PARTIAL PA FOUND – EOB 0399)* on the Web Portal.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	1/29/2019	2/28/2019	N/A
4	Claims, Inpatient and Outpatient Claims	Inpatient and outpatient claims will suspend when the date variables entered are incorrect. The claim will show edit *5006-(Possible Duplicate of a Previously Paid Claim/Detail)* on the Web Portal.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	2/6/2019	N/A
5	Claims, XOVOT (Crossover-Other) Claims	Crossover only claims are being denied at this time. The claim will show edit *4801-(Service Not Covered*) on the Web Portal.	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	2/8/2019	2/8/2019
6	Long-Term Care (LTC) Claims	LTC claims are being denied. The claim will show the following edits on the Web Portal: • *270-(Header Total Billed Amount Missing)* • *508-(HDR Billed AMT Not Equal to DTL Billed AMT SUM)*	• Provider: No additional action needed.	2/2/2019	2/2/2019	2/5/2019
7	IVR Eligibility Check Error	An error is occurring in the IVR when checking the eligibility for an National Provider Identifier (NPI) that has no taxonomy code associated to it.	• Provider: Use the Web Portal to validate eligibility.	2/1/2019	2/12/2019	N/A
8	Claim Submission & Provider Enrollment	Effective dates for some Providers' National Provider Identifier's (NPI) were incorrectly converted, which can cause an error to appear on the Web Portal when submitting claims. The claim will show the following edits on the Web Portal: • *1012-(Attending PROV Not Enrolled)* *1974-(OPR PROV Not Enrolled)*	• Provider: No additional action needed. Once resolved, claims will be released for processing.	2/2/2019	2/3/2019	2/12/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
9	Claims Submission, Other Insurance Information	An error is occurring when a user copies a claim that contains other insurance information, as the procedure code value is missing at the service detail line. The following error will appear until resolved: *SubmitClaim error – Error: System.NullReferenceException: Object reference not set to an instance of an object*	• Provider: ○ Option 1: Enter a new claim using the copy "recipient information" functionality, until a resolution is in place. ○ Option 2: Enter a new claim without using the copy functionality, until a resolution is in place.	2/5/2019	2/19/2019	N/A
10	Web Portal, Search Fee Schedule, Prior Authorization Criteria	The Search Fee Schedule and Prior Authorization Criteria was providing inaccurate information for certain codes, as follows: • Magnetic Resonance Imaging (MRI) • Magnetic Resonance Spectroscopy (MRS) • Magnetic Resonance Angiography (MRA) • Positron Emission Tomography (PET)	• Provider: Users can now use the Portal to confirm authorization requirements. • Claims paid without a PA are subject to reprocessing. • Provider may request a retro-active authorization.	2/1/2019	2/25/2019	2/25/2019
11	Claims, H0004 & H2014	Claims reported with H0004-(*Alcohol and/or drug services*) and H2014-(*Skilled Training and Development, 15 minutes*) were paying an incorrect rate.	• Provider: No additional action needed. • Claims will be adjusted to pay the correct rate.	2/5/2019	2/7/2019	2/14/2019
12	Claim & Prior Authorization Submissions	An error may appear on the Web Portal when a user tries to create a Prior Authorization or Claim for a recipient with an apostrophe (') in their name.	• Provider: ○ *For Prior Authorizations*: Users can contact the call center regarding this issue. ○ *For Claims*: Please hold off on submitting these claims.	2/5/2019	2/19/2019	N/A
13	Provider Enrollment, API	Users that have an Atypical Provider Identifier (API) cannot access the Online Provider Enrollment (OPE) application for revalidation and change/update enrollment applications.	• Provider: Please hold off on submitting a revalidation and/or change/update. If this is an urgent request, please contact the call center.	2/6/2019	2/19/2019	N/A
14	Web Portal, Secure Correspondence	Delegate users cannot reply to secure correspondence messages submitted on the Web Portal.	• Provider: The delegate user can have the Admin/Provider user log-in and reply to the message or you can contact the call center.	2/6/2019	2/13/2019	N/A

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
15	Remittance Advice	Providers with multiple provider types associated to their National Provider Identifier (NPI) are unable to view all of their Remittance Advice (RA) documents on the Web Portal.	• Provider: Can contact the call center to obtain a copy of their RA.	2/7/2019	2/8/2019	N/A
16	Provider Enrollment, Revalidation and Change/Update Applications	Providers who try to complete their Revalidation and Change/Update Applications using the Online Provider Enrollment (OPE) tool may see an error on the "Request Information" panel that they cannot proceed to complete their application.	• Provider: Submit a New enrollment application, instead of submitting a Revalidation and/or Change/Update Application with a letter attached indicating that this is a Revalidation or Change Application. If this is an urgent request, please contact the call center.	2/7/2019	2/25/2019	N/A
17	Claims and Prior Authorization	Claims with multiple lines are not being validated through all of the lines when a Prior Authorization is approved for intervals. Claims denied inappropriately between dates: 1/29/2019 - 2/7/2019 with edit 3000-(*Units exceeds authorized units on prior authorizations)* will be reprocessed.	• Provider: No additional action needed.	2/7/2019	2/8/2019	2/8/2019
18	Claims, Applied Behavior Analysis	Applied Behavior Analysis (ABA) Procedure Code: *97153-(Adaptive Behavior TX by Tech)* is missing from audit *5036-(Possible Duplicate Practitioner to Practitioner*), which is causing claims to deny.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/8/2019	2/19/2019	2/12/2019
19	Claims, Dental	The following dental codes were incorrectly end-dated and caused inappropriate claim denials for: • *D4341-(Periodontal Scaling and Root Planning)* • *D1206-(Topical Fluoride Varnish)*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/9/2019	3/1/2019	3/1/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
20	Claims	Claims may be denying inappropriately with the below error codes when billing across days: • 5611-(*24 Units Alwd/Day)* • 5537-(*One Unit Allowed Per Day)* • 5538-(*Thirty-Two Units Allowed Per Day)* • 5539-(*Eight Units Allowed Per Day)* • 5603-(*Eight Units Allowed per Day)* • 5608-(*16 Units Allowed Per Day – PA override*) • 5622-(*One Unit Allowed Day Per Day)* • 5649-(*One Unit Allowed Per Day)* • 5686-(*4 Units Allowed Per Day-PA Override)*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/9/2019	2/11/2019	2/9/2019
21	Claims	Code 92133-*(Cmptr Ophth img optic nerve)* was incorrectly end-dated and caused inappropriate claim denials.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/10/2019	2/22/2019	2/21/2019
22	Claims	Code Q3014-(*Telehealth Facility Fee)* was incorrectly end-dated and caused inappropriate claim denials.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/10/2019	2/12/2019	2/14/2019
23	Pregnant Women, Medicare Eligibility	All Eligibility Verification Responses are returning Qualified Medicare Beneficiary (QMB) and Special Low Income Medicare Beneficiaries (SLMB) as benefit plans for all pregnant women.	• Provider: Medicare enrollment information is available on the "Other Insurance Details" of the EVS response, IVR and EDI 271. • The "Other Coverage Details" page will display if the recipient actually has Medicare Coverage. If no coverage is displayed, then they do not have Medicare Coverage.	2/8/2019	2/27/2019	N/A
24	Claims, Physician and Outpatient Claims	Physician and Outpatient claims are suspending for edit 7200-(*Miscellaneous Claims Xten Error*) when the clinical claims editor (ClaimsXten) is unable to process the claim.	• Provider: No additional action needed. • Once resolved, claims will be released for processing.	2/9/2019	3/25/2019	3/25/2019
25	Claims, Professional	Professional crossover claims for mass resubmissions are causing inappropriate claim denials for edit: 452-*(Calculated Detail Medicare Allowed Amount is Zero),* as the Medicare information is not getting copied from the original claim to the resubmitted claim.	• Provider: No additional action needed. Once resolved, claims will be reprocessed.	2/9/2019	2/26/2019	2/26/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
26	Claims, Appeals	Providers appealing converted legacy system claims by using secure correspondence are receiving an error when trying to use the legacy system's denial code reason(s).	• Provider: Select a denial code that has a similar denial reason that was used in the legacy system and put the actual code in the message of the secure correspondence to process your claims appeal.	2/11/2019	2/13/2019	N/A
27	Prior Authorizations, NOD Letters	Some blank Provider Notification of Determination (NOD) letters were sent that did not include details related to the service and the decision status.	• Provider: Use the Web Portal to review the PA determination. If there are additional questions, please contact the PA call center.	2/13/2019	3/11/2019	N/A
28	Provider Enrollment, Individuals Linking to a Group	An error may appear on the Web Portal when trying to link a National Provider Identifier (NPI) to a Group Provider when using an active group with inactive members. The following error may appear until resolved: "*The NPI you are trying to add is not valid. It may not be a valid Group NPI or it has been disabled or end dated.*"	• Provider: Attach a document with a written request to link to a group on the enrollment application.	2/7/2019	3/4/2019	N/A
29	Claims Submission, Other Insurance Information	Claims are denying inappropriately for Edit 2504-*(Client Covered by Private Insurance)* that has diagnosis code Z00129-*(Encounter for routine child health exam).*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/13/2019	2/27/2019	2/26/2019
30	Claims, Non-Covered Code	Claims are denying inappropriately for Procedure Code 94618-*(Pulmonary Stress Testing),* as the code is incorrectly listed as a non-covered code.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/13/2019	3/1/2019	2/27/2019
31	Prior Authorization, PCS	Some of the Personal Care Services (PCS) service plans are displaying an incorrect provider name.	• Provider: No additional action needed. • Nevada Medicaid is e-mailing the service plan information to the Provider with a note when the Provider name was displayed in error. • There is no impact to PA or Claims.	2/20/2019	3/4/2019	N/A

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
32	Claims, Advanced Practice Registered Nurses and Physician's Assistant	Some claims may be denying inappropriately for Provider Types: 24-*(Advanced Practice Registered Nurses)* and 77-*(Physician's Assistant)* regarding procedure code 99224-(*Subsequent Observation Care).* The claim will show the following edits on the Web Portal: • 5051-(*Possible Duplicate of Previously Paid Claim/Detail*) • 5004-(*Claim/Detail Conflicts with Previously Paid Service on Same or Overlapping DA*)	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/21/2019	3/9/2019	3/9/2019
33	Claims, Behavioral Health	Some claims may be denying inappropriately for Provider Type 82-*(Behavioral Health Rehabilitation Treatment)* for H0002-(*Alcohol and/or Drug screening)* and H2012-*(Behavioral health day treatment per hour) for the following codes:* • 300-(*Qualified Mental Health Professional*) • 301-*(Qualified Mental Health Associate Specialties)* The claim will show edit 4150-*(Rendering Provider is not certified to perform procedure billed)* on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/21/2019	3/1/2019	3/1/2019
34	Claims, Residential Treatment Centers and Hospital, Outpatient	Some claims may be denying inappropriately for Provider Types: 63-(Residential Treatment Centers) and 12-(Hospital, Outpatient). The claim will show the following edits on the Web Portal: • 5051-(*Possible Duplicate of Previously Paid Claim/Detail*) • 5004-(*Claim/Detail Conflicts with Previously Paid Service on Same or Overlapping DA*)	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/23/2019	3/14/2019	3/14/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
35	Claims, PCS	Some claims may be denying inappropriately for Personal Care Services (PCS) as possible duplicates. The claim will show edit 5034-(*Possible Duplicate: PCS to PCS*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/23/2019	3/1/2019	3/1/2019
36	Claims, PCS	Some claims may be denying inappropriately for Personal Care Services (PCS) Providers for Third Party Liability (TPL) editing. The claim will show edit 2504-(*Client Covered By Private Insurance*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/25/2019	3/1/2019	3/1/2019
37	Claims, Dental and Professional	Some users are receiving an error ("*Unable to process your claim*") on the Web Portal when trying to adjust Dental and Professional claims with multiple diagnosis pointers.	• Provider: Please hold off on submitting these claim adjustments. Please check back frequently for updates.	2/26/2019	3/4/2019	3/4/2019
38	Claims, Prior Authorization	Historical utilization of Prior Authorizations (PA) are causing some claims to pay additional units, which exceeds the PA allowed units.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed and overpayments will be recouped, as applicable.	2/19/2019	3/6/2019	3/6/2019
39	Claims, Dental	Some dental claims may be denying inappropriately for Provider Type 22-(*Dentist*) under procedure code: D8660-(*Preorthodontic treatment examination*). The claim will show edit 5510-(*One Unit Allowed per Lifetime*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/21/2019	3/1/2019	3/1/2019
40	Claims*, Special Clinics, School Based Health Centers*	Some claims are denying inappropriately for Provider Type 17, Specialty 174-(*Special Clinics: School Based Health Centers (SBHC)),* as the rate was end dated in error. The claim will show edit 3958-(*No Reimbursement Rule for Procedure*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/28/2019	3/5/2019	3/5/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
41	Claims, Other Insurance	An error may appear on the Web Portal that prevents some claims from getting submitted online when the user selects the "Other Insurance" option. The following error may appear until resolved: "*We had a problem processing last request.*"	• Provider: Please hold off on submitting these claims, if you receive this error message. Please check back frequently for updates.	3/4/2019	3/11/2019	N/A
42	Claims, Prior Authorization Member ID	Some claims are not denying appropriately when the Member ID used on the claim does not match the Member ID on the Prior Authorization (PA), which causes the claim to be paid against the wrong Member ID. Future claims submitted using the same PA may deny because all of the units have been used.	• Provider: Please validate you are using the correct member ID's PA on the claim submission. • Once resolved, claims will be automatically re-processed and units on the PA will be adjusted.	3/1/2019	3/28/2019	3/28/2019
43	Claims, CLIA License Number	Some claims are denying inappropriately as the system is currently only looking at the Billing Provider ID to find a valid CLIA License Number, instead of the rendering Provider CLIA License Number. The claim will show edit 4208-(*CLIA License number Invalid*) on the Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	2/27/2019	4/8/2019	4/8/2019
44	Claims, EPSDT	Some claims are denying inappropriately for services covered under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) program when submitted with an approved authorization that includes pricing. The claim could show the following edits on the Web Portal: • 4149-*(Billing provider is not certified to bill service)* • 4150-*(Rendering provider is not certified to perform procedure billed)* • 4871-*(Procedure code is not billable on this claim type)*	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed.	3/6/2019	3/11/2019	3/15/2019

Item #	Category	Description	Resolution/Work Around	Date Reported	Date Resolved	Recycle Date (If Applicable)
45	Claims, Crossover	Some Medicare claims are denying inappropriately when the claim is a crossover to Medicaid without a payment from Medicare due to deductible or if the service is denied by Medicare for dual eligible members. The crossover claim(s) will show edit 0452-(*Calculated detail Medicare Allowed Amount is Zero*) on the Web Portal. The non-crossover claim(s) will suspend with Edit 2500-(*Client covered by Medicare A*) or Edit 2502-(*Client covered by Medicare B*) as appropriate for review of the attachments.	• Provider: Please resubmit denied claims via the Web Portal, along with a copy of the Medicare EOB (Explanation of Benefits) and remark codes/descriptions.	2/26/2019	3/14/2019	N/A
46	Claims, Healthcare Common Procedure Coding System	Some claims with Healthcare Common Procedure Coding System (HCPCS) codes for members over the age of 21 were priced incorrectly, as the Pediatric Enhancement Rate was used instead of the Adult Rate, which is causing an overpayment. The Pediatric Enhancement Rates are also displaying the incorrect reimbursement amounts on the Provider Web Portal.	• Provider: No additional action needed. • Once resolved, claims will be automatically re-processed and overpayments will be recouped, as applicable.	3/8/2019	3/25/2019	3/25/2019
53	Claims, PT 13 (Psychiatric Hospital, Inpatient)	Some claims for Provider Type 13 are being denied incorrectly with error codes 4151 (Billing PT/PS Restriction on Revenue Code Billing Rule) and 4712-(*Age Restriction on Revenue Code Billing Rule*). Claims should be payable for members age 0-20 or 22 if the member was receiving services prior to turning age 21, and for members age 65 and older.	• Provider: No additional action needed. • Once resolved, claims will be automatically reprocessed.	4/10/2019	5/6/2019	5/6/2019
63	Claims, All Provider Types including Provider Type 85 (Applied Behavioral Analysis)	Some claims for all provider types including Provider Type 85-(*Applied Behavioral Analysis*) have denied or cutback incorrectly with error code 155-(*Prior authorization required*) as referenced in Web Announcements 1794 and 1803.	• Provider: No additional action needed.	12/20/2017	5/23/2019	5/22/2019 & 5/23/2019