Biller's Meeting Q&A

November 20, 2008

Q: Has the timing out feature within Provider Connect been shortened? Primarily over the last 3 weeks, this feature has appeared to become shorter and shorter.

A: We will submit a tech request to investigate this issue. A Tech Request was submitted to IT on Friday, Nov. 21st to request this issue to be resolved.

Q: How long should we wait for a response on the first submittal of a claim before we submit it again?

A: For paper claims, wait until we have reached the date that is close to the date you submitted the first claim, plus 2 weeks to allow for publication to a RA. We are currently at September 29th as of Friday, Nov 21st. Otherwise, 30 days would be a good gauge. Please be sure to review the RA and the exceptions report before resubmitting.

Q: If faxes were sent in, how soon should they appear on the RA?

A: Timing is based on the completeness of the information being submitted. If the information is complete, it will follow the basic 10 days to RA guideline. If the information is not complete and additional research/contact is needed, it will be longer. Be sure to check the weekly status of where the Claims Area is on working the Faxes/Adjustments, which can be found on the Provider Connect Welcome Page.

Q: What is the status of the system issue with recouping money on claims not paid?

A: All 25 claim records have been corrected, with some claims still needing to be processed through Finance to complete the fix. Of the 25 claims, 24 claims have already cleared for payment as of Dec. 5th, 2008. The remaining 3 claims will clear out of the system when the next check run is completed, on Dec 15th, 2008.

Q: Can we email claim numbers to someone for claims that need to be voided on paid claims?

A: Yes, you can email them to Becky Schuetz, Daniel Dubois, or Jennifer Roberts.

Q: Will timely filing be overridden for an administrative error on KHS' part?

A: Yes.

Q: How do we access our 837/Provider Connect exceptions?

A: The Billing Manual posted on the KHS website can provide guidance on locating and working exceptions. If further help is needed, contact Becky Schuetz or Daniel Dubois and they can walk you through the process.

Q: Can the webinar/biller meeting dates be added to the Welcome Page of Provider connect?

A: Yes, we have added the information for the next event on the Welcome Page.

Q: How do we get batches of exceptions to drop off the exceptions?

A: If you edit a claim it will rerun the whole batch, removing the corrected claim. Until a claim is corrected, it will remain on the exception reports. Or, you may email Becky, Daniel, or Jennifer and they can work with IT to remove the batch.

Q: Can the new COB Credentialing Form be re-used as a blanket letter?

A: The form will need to be completed for each individual provider which it pertains to. The form may then be copied and used on the applicable patients' claims.

Q: Will the Wheatland's letter be sufficient for Medicare non-credentialed providers, or do the biller's need to obtain a new letter from Wisconsin Physician Services?

A: Yes, the Wheatland's letter is sufficient. However, the Provider Notice for December 2008 will address usage of the new COB Credentialing Form to be used for claims submitted in December and after.

Q: Do we need to continue to put Medicare in box 11 of the claim form if we are submitting the credentialing letter or form?

A: Yes.

Q: The registration pending report is only being received once every few weeks.

A: This issue was reported to IT last Friday, Nov. 14th.

Q: We used to receive an authorization letter, but they are not being received now. Who do we call?

A: Care Management. Becky was informed that they are running these on a weekly basis. They are still going to be placed into Provider Connect for providers to view. The reason the providers saw a stop is because the process became automated. Then the process somehow stopped on Oct. 5th. This is currently being worked on by IT staff and should be up and running very shortly.

Q: Why are units no longer included on the authorization letter?

A: Units were removed from authorization letters based on Provider feedback. Showing authorized units would not accurately reflect units available, depending upon claims submission and timing of receipt of the letter.

Q: There were a large number of claims denying no EOB. KMAP shows no other insurance.

A: KHS has received COB files from EDS that need updated manually. Becky, Daniel, and Adrian are updating them manually. We will receive a corrected file from EDS near the beginning of December. Furthermore, we are not getting Medicare information from EDS, but we are updating them as we confirm the COB information. If you observe needed corrections, please call Daniel or Adrian, or you can email/fax the claim number and a short explanation. As they update the files, all claims are being sent through re-adjudication.

Q: What is the status of the Spenddown backlog?

A: About 500 claims left. Some of them are pending resolution with EDS. If you have concerns, you may contact Claims Representative David Cole, or Daniel to check.

Q: Within my exceptions, I am seeing claims with claim number zero.

A: Send to Jennifer to investigate.

Q: Is there any way to receive a list of patients needing clinical events added, so the providers will know who to update or when the last update was?

A: At this time there is not. When training was done in July regarding new processes, it was encouraged to providers to stagger their patients for updates because at 18 months a suspension will occur, but it will not hurt anything to update prior to that.

Q: A few attendees indicated they have received a “Thank You” letter from Care Management.

A: Care Management is not aware of any such letter being produced. Please forward a copy to the Care Management Area if you have a copy of this letter.

Comment: Upon receipt of faxes, Member Services will send an email confirmation to the Biller to alert them of our receipt.

Next Mtg Location Options: Coffeyville, Central, or Pawnee