

Biller's Meeting

May 21, 2009

Q: Will "Service Not in Provider's Profile" (SNIPP) denials be reworked upon completion of the system correction?

A: The SNIPP denials have been reworked daily prior to being published on the RA. If you find one that has slipped through, please contact Becky Schuetz or Daniel Dubois to aid in resolution.

Q: What is the status of the claims system decision?

A: The KHS Board of Managers has granted KHS permission to explore contract terms and they are in process. We are internally identifying what it will take for implementation and conversion.

Q: Will KHS ever be able to alter the ICN assignment by eCura to provide clarity of identifying information about the claim, as well as, making interpretation of re-adjudications clearer?

A: No, eCura's mechanism for assigning ICN's cannot be altered.

Q: Why do we get a denial of 'EOB Missing', but when the TPL file is checked in eCura there is no other coverage?

A: This is caused by the daily updates currently occurring. We will soon be moving to a weekly TPL update that should reduce these occurrences. Re-adjudications will be completed by KHS in late June and early July. This instance could also be caused by the information we receive from KMAP on the spenddown report, if the claim is denied by KMAP due to other insurance. If you see these denials and there is no COB on ProviderConnect, please check the KMAP website as well. If there is a discrepancy between the two, please contact Becky or Daniel to assist with rectifying the problem.

Q: Will the eligibility changes affect the merging issues?

A: Unfortunately, no. You will need to continue to contact us to correct the Medicaid ID's which need merged.

Q: For Waiver kids, when we are waiting for the plan of care, will there be an option of backdating the eligibility date?

A: Please contact Care Management for individual consideration.

Q: For system issues, like Insurance Terminated, will KHS do the cleanup of incorrectly denied claims?

A: Yes. Please see 'Retro-Eligibility Changes' topic in the June 2, 2009 Provider Notice, 2.10.

Q: Once Medicaid ID's are required on the claims, what do we do about patients getting screens?

A: They are the exception. You may key in all 9's for the Medicaid ID in the instance of a screening patient.

Q: Our 835 file comes back with the SSN instead of the Medicaid ID. Will this be fixed as well?

A: The 835 file will provide the ID that is submitted to KHS. Once Medicaid ID's are required, you should no longer see the SSN coming back on the 835.

Q: Is there a limit of 1,000 units for submitting an authorization exception?

A: Exception authorization requests are considered individually.

Q: In relation to authorized units, we are dealing with a lag in our billing, so not all of our authorized units have been billed to KHS, but we are reaching the 75% used point. How can we get additional units authorized when we have not yet billed all rendered units?

A: Although a backend review is occurring, KHS encourages providers to continue to track units provided. You will need to contact the Care Management team at 1-877-642-9283 to discuss any possible options to adding additional units to the authorization. Typically, additional units will not be added until 75% of the units already authorized have been billed and paid.

Q: [In response to our discussion of needing actual EOBs with submitted claims to KHS]...Sometimes all we get from the primary insurance is a print from their website.

A: The documentation that is submitted with the claim must have all the information regarding how the primary insurance processed the claim. We have noticed that sometimes the primary does not put all the information about how they processed the claim, which is why we ask for the EOB, rather than the screen print. If all you get is the screen print, then you will need to make certain that they have the denial reasons listed, as well as the payment and allowable. We still encourage all providers to utilize ProviderConnect to enter their COB claims, in order to expedite claims processing.

Q: To whom do we fax recoupment requests?

A: Fax them to the attn of 'Recoupments', fax # 785.575.9345.

Q: We submitted corrected claims that we believed to be within the timely timeframe. We were requesting alteration of units on the claim. But, when they were rekeyed the claims denied timely filing. Why did this happen?

A: For corrected claims that are beyond the original 12 months from the date of service, box 22 must have the original claim number included for tracking purposes.

Q: Is box 22 required even if we are close to the 12 months initial filing date?

A: We use actual receipt date for timely filing measurement, so unless the claim is past the 12 months, or could be by the time we receive it at the KHS office, box 22 would not be required.

Q: Can we use the box 22 number when doing online editing?

A: Yes.

Q: What's up with the login time?

A: Please contact TechSupport, with a copy to Becky Schuetz and Daniel Dubois to seek aid in resolving.

Q: For the past week, for initial claims, when I am entering a new claim the reason code 184 paid appropriately. However, when I edited a claim and used the reason code 184 the claim denied for 'No EOB'. This seems to be happening consistently.

A: It carries the dollars to the billed, but we would need to see an example to explain what is occurring.

Q: In the CFO meetings this week, high duplicate denials were mentioned and it was requested that all providers evaluate their processes to help decrease them. How do I know if our office is included?

A: Each provider needs to review their claim submissions/denials. If duplicate denials are being received, then a review of procedures in your office should be completed to avoid additional duplicate submissions.

Q: The summary page of the Remittance Advice does not match the Executive Director report – why?

A: We are currently evaluating the cause for this discrepancy. Additional internal reporting has been requested to aid in the process. An update will be provided upon completion.

Q: What about adoptions for Medicaid ID v. member name?

A: If MMIS has correct information, please contact Becky Schuetz or Daniel Dubois as they can help with successful claims submission.

Follow-up Q: If the update has not occurred in MMIS, can we fax a copy of the legal document to KMAP for update?

A: To find out how KMAP wants this process to occur, you will need to contact them. KMAP's customer service number is 1-800-933-6593.

Q: Will billers be able to utilize hot keys in Provider Connect at some point?

A: This is feature is not available within eCura.