

Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
Closed	1	Multiple EVV files were being received and the FI system wasn't able to handle them. This has since been corrected or The system encountered errors during the Electronic Visit Verification (EVV) process. The system run time was adjusted to process files every 15 minutes. This change resolve the issue.	100%	
Closed	2	While processing Remittance Advices the system issued a service error. The error was researched and the system was modified to prevent additional issues from occurring.	100%	
Closed	3	The Remittance Advices process encountered issues while posting documents to the portal. The system was updated and run processes modified, thus resolving this issue.	100%	
Closed	4	Fee-for-service claims for members also enrolled on a Managed Care Plan were denying inappropriately.	100%	98 - All Providers
Closed	6	FQHC providers who are performing transportation services were not being paid for the transportation services in FI. Changes were required in FI to add new contracts to allow an FQHC provider to bill for Transportation of a recipient to and from their facility to receive service. FQHC providers who have a transportation specialty code were re-assigned the new contract for the same effective dates as their enrollment for the transportation specialty.	100%	
Closed	7	Report of SPACES in the 'MEDICARE-PAID-AMT' across all four TMSIS claims files. Fix tested and deployed resolving this issue.	100%	
Closed	9	835s being generated by the FI did not balance and were therefore rejected back to the FI by the Deloitte EDI system. The OMES validates all inbound and outbound transactions for HIPAA compliance. Any file or transaction that doesn't meeting the HIPAA editing is rejected back to the sender of the transaction to be corrected and resent. or The 835 balancing issue resulted from custom repricing by the stored procedure, the COB dollars remained on the lines that were repriced to "zero", causing 835 CAS segments generated for the lines to be out of balance. The new change is if amount paid is >0, then sum of detail COB amounts will be rolled up to first payable line and COB amounts on other lines will be updated to 0.00, except for first payable line.	100%	
Closed	11	HMS reported MCE payment amount on MyCare encounters for CLMEX00099 files is being populated with 0.00. System updates made and confirmed MyCare encounters worked correctly.	100%	
Closed	12	The system was not storing the phone numbers when received. This caused issues on the 834. The process was modified to capture the other phone types.	100%	



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Closed	13	This item was needed to correct the claims processing for Assertive Community Treatment services which are part of the ODM behavioral health benefit. Gainwell began the process by running a report identifying all ACT claims that were denied for edit 611. The problem was a mismatch between the number of units requested on the PA. MITS didn't count units in order to process claims whereas FI does.	100%	84/95
Closed	14	FQHC Transportation claims were not paying correctly. The system was updated to process the claims.	100%	
Closed	16	Various Medicaid School Program claims issues have been resolved.	100%	21
Closed	17	A providers' claims were not processing correctly due to issue with pricing not working. The contract fee schedules were updated and pay correctly. A mass adjudication was process to fix past claims.	100%	43
Closed	18	Specific tickets for 820/834 issues were opened to replace this high level entry in the tracker.	100%	
Closed	19	Aetna reported seeing a limited number of SRS members on the 834 files. Correction deployed.	100%	
Closed	20	Plans reported not seeing all the span segments they expected on the 834 files. Correction deployed.	100%	
Closed	21	Issue reported with the 834F files containing other values other than "030" (audit). The process was updated resulting is the correct 834F to be produced.	100%	
Closed	22	Dialysis Center Claims Not Paying Correctly. Tables updated to pay correctly going forward. Previously submitted claims were reprocessed and paid correctly.	100%	59
Closed	23	A system issue prevented some claims from being converted from our MITS system to our FI system. Therefore, when adjustments are submitted, they may get stuck in an unfinalized status until the original claim can be converted. Once the original claim is converted, the adjustment claim will continue to process to a finalized status.	100%	98
Closed	24	An error in FI claims adjudication caused claims to deny inappropriately for nursing services. A configuration change updated the system resolving this issue.	100%	PT 84 and PT 95
Closed	25	With the transition of Trading Partner (TP) management, to the new OMES TP vendor, MITS was not being updated with trading partner data changes. MITS received a data refresh of TP data and applied that update in the MITS system. 835s for claims submitted to MITS, via the MITS Secure Provider Portal, are now being directed to the correct trading partner.	100%	All Providers
Closed	28	The incorrect application of the timely filing edit 311 for hospital providers. Once the patient is discharged, all interim bills must be voided before the final admit through discharge claim can be submitted. The final claim must be a complete admit through discharge bill type 111 reiterating all charges submitted on prior advance interim bills. The timely filing determination for inpatient hospital claims should begin on the date of discharge, not the date of admission.	100%	
Closed	29	TPL Coverage information in FI vs MITS mismatch	100%	
Closed	30	The format of FI Tracking ID for MCE Claim files in CERT region is not per the guidelines established in the Companion Guides.	100%	

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Closed	32	The 834 files do not always report the available phone numbers for a member. Changes are underway to capture the phone numbers in FI so that they will be reported on the 834 files.	100%	
Closed	33	All NDC codes must be 11 digits per the HIPAA Technical Report Type 3 guidelines. NDCs must also be valid and found during the NDC code set validation.	100%	
Closed	34	FI should accept 0913 in days format and not units- Provider Maximus allows you to enter as days in a date span, but FI can only read it as units per day and places all units entered on a single day.	100%	MITS Provider Types 88 State Operated ICF and 89 Non State Operated ICF.
Closed	35	Managed Care Plans have received updates on their 834C files that include historical assignments even though those assignments have not had any changes made to them.	100%	
Closed	36	Managed Care Plans have received updates on their 834C files indicating that a member's assignment has been terminated when the member's assignment is still active.	100%	88 and 89
Closed	38	H0005 paying at the incorrect rate for LSWs	100%	
Closed	39	90839 with a U4 modifier is denying for edit 376. The claims are selecting the wrong contract term.	100%	
Closed	40	Verify that all ICF SAM requests are accounted for in the PMT project list.	100%	
Closed	41	Verify that all NF SAM requests are accounted for in the PMT project list.	100%	
Closed	43	Edit 313 Ventilator Claim Failed to Pay Correctly	100%	22
Closed	44	System configuration was causing T1000 claims to deny for an invalid place of service.	100%	19
Closed	45	T1001 claims paying at \$0.	100%	21
Closed	46	This defect impacted acupuncturists, chiropractors, and physicians rendering acupuncture services. The work included configuring FI to only allow payment for covered acupuncture services when an allowable Dx was listed on the claims (per rule 5160-8-51). It also included configuring FI to include POS restrictions and only making payment to eligible rendering and billing providers.	100%	1
Closed	47	FI contracts for enrolled paraprofessionals were updated to stop claims being denied when they follow ODM policy for providers of ACT services/. Claims were reprocessed once FI configuration was corrected.	100%	19/995
Closed	48	DME claims denying inappropriately for edit 611 requiring a prior authorization	100%	1
Closed	50	The Hospice Redesign project resolved multiple issues discovered with the initial Hospice design for the Fiscal Intermediary (FI).	100%	44
Closed	51	Non-claims related payments were not being reported on separate PDF Remittance Advices (RAs).	100%	1
Closed	52	A provider was able to void the same claim twice and the system created two reversals. We'd expect the system to adjudicate the second reversal differently as the expectation is that only one void/reversal can be done.	100%	98 - All Providers

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Closed	53	ICF providers ineligible for a full month's payment due to termination.	100%	MITs Provider Types 88 State Operated ICF and 89 Non State Operated ICF.
Closed	54	Recoupment amounts on the Remittance Advice (RA) of the 835 are not currently tied to specific claims after the initial RA is submitted on an 835. Prior period RAs are rolled up into a total RA amount. A product change is required so that these details will be available on the RA.	100%	98 - All Providers
Closed	55	Some Medicaid School Program (MSP) claims converted with incorrect payment amounts which causes the Fiscal Intermediary (FI) to recoup too much money on reversals when claim adjustments are submitted.	100%	21
Closed	59	Claims that should have rejected were loaded and processed with incorrect provider information.	100%	98 - All Providers
Closed	61	Providers completing adjustments through EDI for claims originally adjudicated in MITs may experience a delay in processing while ODM ensures claims are properly converted.	100%	All MCEs
Closed	62	Member condition codes missing for nursing facility enrollment resulting in incorrect capitation payment.	100%	All MCEs
Closed	63	The 834 is reporting some incorrect managed care effective dates to MCOs	100%	
Closed	64	The 834 is not reporting some managed care enrollments to MCOs	100%	All MCEs
Closed	65	The FI 834 is sending Add/Change/Term/Delete transaction codes which do not correspond to the managed care enrollment updates made to a member.	100%	All MCEs
Closed	66	Some retroactive changes in eligibility are reported as terminations to MCOs on the 834.  Eligibility/Managed Care Assignment Differences between MITs and FI	100%	All MCEs
Closed	68	Special condition codes in FI that are used to identify members who have opted in/out of Medicare does not match the special condition codes in the source system (MITs).	100%	All MCEs
Closed	70	Sending accurate weekly paid claims files to TPL pay and chase vendor HMS. Processing of 837 submitted by HMS to adjust claims for TPL payment recovery. Reports detailing the adjustments and errors results from HMS 837 submission.	100%	All Providers
Closed	71	Development of NF and ICF rate setting module, including the online annual cost report and the MDS processing for NFs.	FI - 100 SI - 100%	86
Closed	72	When a provider reports payment from a third-party payer other than Medicare, claims are being overpaid because the third-party payment is not being considered or deducted when calculating the Medicaid payment.	100%	Various
Closed	73	FI is not recognizing valid Prior Auths (PAs) in the system. The PA is valid in MITs, but not being recognized in FI.	100%	MITs Provider Types 84 (MH Providers) and 95 (SUD Providers)

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Closed	74	Providers completing adjustments through EDI for claims originally adjudicated in MITS may experience a delay in processing while ODM ensures claims are properly converted.	100%	98 - All Providers
Closed	75	Claims and attachments Claims are not suspending with edit 163 or 6253 as we would expect to wait for attachments when PWK segment is included in EDI claim submission but are instead denying	100%	98 - All Providers
Closed	76	Claim information submitted on the 837 does not match the information populated in Vue360/Administrator for the associated ICN returned on the 277CA	100%	
Closed	77	277CA responses are not being received for all claims submitted.	100%	98 - All Providers
Closed	78	Working towards resolving issues of claims converting from MITS to the Fiscal Intermediary.	100%	98 - All Providers
Closed	79	Count Gap between 276 , 277 Responses	100%	98 - All providers
Closed	80	Pro-Rated Share of Cost (SOC) claims deduction.  The "Pro-Rated" SOC on file for a recipient should be deducted from NF, ICF-IID, and Hospital claims for corresponding dates of service (DOS) billed.	100%	01 - Hospital 02 - Psychiatric Hospital 86 - NURSING FACILITY 88 - STATE OPERATED ICF-MR 89 - NON-STATE OPERATED ICF-MR
Closed	81	The process for Delivery Kick Payment (DKP) to compensate MCEs for additional cost of childbirth beyond the regular capitation process has changed. DKPs are submitted as a FFS claim. DKP claims are matched against submitted encounters to validate services were rendered prior to payment.	100%	All MCEs
Closed	83	To support the FQHC, RHC, OHF wrap around claim processing, the 271 Eligibility Response transaction must contain the 7 digit ODM assigned program ID for the plan in which the member is enrolled so that providers submitting wrap-around claims can identify the members program correctly.	100%	12
Closed	86	FI Adjudicating Claims for Timely Filing Incorrectly	100%	
Closed	87	OMES EDI identified missing test trading partner	100%	
Closed	89	FI is not recognizing supervisors on the claim to pay at the supervisors rate.	100%	BH Providers
Closed	90	Defect related to adjustments	100%	
Closed	91	MITS Claim converted to FI incorrectly	100%	98 - All Providers
Closed	92	Defect: NF Cross-over Claims: Bypass Contract Edits and Allow to Properly Process for Payment.	100%	86
Closed	93	Updates needed to custom contracts for RHC providers.	100%	
Closed	95	The service codes H0015, H0015 HK ,H0015 HK TG, H0015 TG are paying at the incorrect rate.	100%	
Closed	96	Claim routed to incorrect contract term-the MD/DO contract.	100%	

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Closed	97	Each DRG payment includes a flat hospital specific capital add-on payment and if the hospital has a medical education program, the hospital is paid a medical education allowance (calculated as hospital specific Med Ed add-on x the DRG relative weight/SOI the claim grouped to).	100%	98 - All Providers
Closed	98	Copayment exemptions configured in MITS but not FI	100%	98 - All Providers
Closed	99	Edit 311 Posting Incorrectly for initial claims and adjustments	100%	All Providers
Closed	100	Claims are being denied for the same service code, but with a different place of service.	100%	MITS Provider Type 84 (MH Providers)
Closed	101	755 rejection provides insufficient information for resolution and resubmission of claims	100%	98 - All Providers
Closed	102	Clinical laboratory procedures all require an appropriate level of certification for these procedures to be paid. This law requires any facility performing examinations of human specimens (e.g., tissue, blood, urine, etc.) for diagnosis, prevention, or treatment purposes to be certified by the Secretary of the Department of Health and Human Services. For many professional medical groups and hospitals, the facility will possess the appropriate CLIA certification not the rendering or attending practitioner. Currently FI only has the ability to interrogate the attending/rendering practitioner which is causing institutional and professional claims denials for these clinical laboratory procedures.	100%	98 - All Providers
Closed	103	Some PPS rate discrepancies starting 10-1-2023. PPS rates need to be updated and impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	104	Some contracts for FQHC/RHC are not set up correctly in PNM/FI PNM and/or the data did not transmit properly to FI. When the contract is not in FI the claims will not be processed. After fixed, impacted claims need reprocessed/adjusted. This includes Edit 101, 102 and 6209.	100%	FQHC (12) and RHC (5)
Closed	105	FQHC/RHC Visit Payment Issue - Separate visits are payable on the same DOS when they are different FQHC services. Right now, if the FQHC renders two different services on the same DOS the second claim will deny incorrectly. After fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	106	T1015 code on claims for wraparound payments are being incorrectly assigned as the primary payer in the ERAs (instead of secondary which prevents FQHCs from auto posting)	100%	All Providers
Closed	107	Services rendered to straight Medicaid members in PAY status, but paying zero (FQHC site specific). After fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	108	FQHC/RHC claims for wraparound payments are denying incorrectly when a service not covered by Medicare is rendered to MyCare recipient (dental, vision, BH service rendered by non-eligible Medicare practitioner, transportation). After fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)



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Closed	109	FQHC/RHC claims denying incorrectly with edit 6269 (ORP). After fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	110	FQHC/RHC transportation claims are denying incorrectly with edit 1124 (ORP). After fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	112	Due to a taxonomy issue in PNM, FQHC/RHC claims denying incorrectly with Edit 153 (edit is carved out and shouldn't be posting). After fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	113	When FQHC bill dental claims, now an ORP edit is incorrectly denying the claim. After fixed ORP issue fixed, impacted claims need reprocessed/adjusted.	100%	FQHC (12) and RHC (5)
Closed	111 114 115 116 117	FQHC/RHC issues have been consolidated into a single entry targeted for completion by February 12, 2025. This project will address: <ul style="list-style-type: none"> <li>• CPSE ID 111, 114, 115 - Will end inappropriate claim rejections and payment denials for a range of provider contracting errors impacting FQHC/RHCs</li> <li>• CPSE ID 116 - Medicare and TPL Bypass requirements</li> <li>• CPSE ID 117 - Will correct COB calculations for crossover and wrap claims with complex primary payer combinations</li> </ul> Reprocessing of impacted claims will begin sometime in March once the bulleted items have been fixed.	100%	FQHC (12) and RHC (5)
Closed	119	Inpatient hospital claims denying with edit 201	100%	
Closed	120	1099 conversion issues	100%	
Closed	121	PACDR Claims from Aetna Assigned wrong Planid is closed	100%	
Closed	122	Edit 606 error on DKP Claims - PA# doesn't match	100%	All MCEs
Closed	124	Issue is many of these edits are being applied to the same detail. CARC 272 links up with edit 293. Based on review of claims this issue is related to the living arrangement code and Custom wheel chair items (CRT). Once a wheelchair is deemed as custom all parts and accessories should be excluded from the living arrangement edit and details should process and pay.	100%	98 - All Providers
Closed	125	Medicare-Medicaid crossover claims not crossing - Medicare Claims showing MA07 adjudication code stating claim was forwarded to Medicaid, are not showing received or processed by Medicaid	100%	98 - All Providers
Closed	128	Secondary not paying up to full Medicaid allowable	100%	Durable Medical Equipment Suppliers/Pharmacies
Closed	129	Modifier denials. Claims billed with no modifier following the fee schedule. Team reconfigured these procedures by adding modifiers to allow the system to pay these codes instead of deny.	100%	Durable Medical Equipment Suppliers
Closed	130	Modifier denials. Claims billed with no modifier following the fee schedule. - impacts all claim types and providers not just DME and is related to current logic in FI around coordination of benefits payments.	100%	



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Closed	134	Current Patient Liability spans are not always reported on the 834 files that are sent to the Managed Care Plans.	100%	All MCEs
Closed	135	All hospice room and board claims (T2046) are now denying inappropriately with edit 837 (medically unlikely). NCCI edits (including edit 837) should not post to any hospice claims. Edit 837 (Medically Unlikely) shows this description: Medically Unlikely Edit (MUE) Procedure code T2046 is denied based on an NCCI edit because the units of service exceed the medically unlikely limit per claim detail for the same date of service.	100%	Hospice providers
Closed	136	Edit 210 and Edit 218 is inappropriately posting on inpatient hospital claims when there is no eligibility at the beginning of the stay	100%	1
Closed	137	Timely Filing Edits Edit 6187 – FQHC_RHC Wrap Exceeds Timely Filing Limits Edit 6181 REVIEW FOR TIMELY FILING DOCUMENTATION Edit 6019 UR Resubmittal Exceeds 180 Day Timely Filing Limit Edit 6042 UR Resubmittal Exceeds 60 Day Timely Filing Limit Edit 541 Claim Line Submission Window Exceeded Edit 543 Inpatient Claim Submission Window Exceeded (claim Thru date)	100%	98 - All Providers
Closed	138	MCE Claims Extract File (Claims to MCO Export-CLMEX00096) does not contain denied claims, only paid claims	100%	All MCEs
Closed	139	Misplaced, missing CARC/RARC on 835 documents. FI returned a RARC at the header level (MOA) but returned the CARC (CAS) at the detail. These should both be at the same level either header or detail. The N569 should have been returned in the LQ segment at the same level as the CAS segment.	100%	All Providers
Closed	140	Ohio specific rules to pay for custom wheelchair institutional claims will be corrected. Currently the PA needed to correctly process the institutional portion of the CRT is paying \$0 because the PA process is suspended. Related items are closed and consolidated into this CPSE item for tracking of Durable Medical Equipment work. Items closed include 123, 126, 127, 131, 132, 133, 141, 156, 157, 158, 159.	100%	Durable Medical Equipment Suppliers
Closed	142	Recipient Eligibility ticket volume increase due to differences between MITS and FI	100%	98 - All Providers
Closed	143	Portal claims denying with edit 101 and no billing provider is displayed on the claims in VUE360.	100%	98 - All Providers
Closed	144	Lifting of PA requirements Non-Institutional Policy - dental provider who is experiencing a similar issue of not having their claims paid (the ones requiring PA), even with the current lifting of PA requirements	100%	98 - All Providers
Closed	149	Rx TPL coverage is being loaded as Comprehensive Medical coverage in FI.	100%	All Providers



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Closed	150	These 12 - 276 transactions were sent on August 23, 2024. The 277 response transactions were not returned until August 29, 2024. Do we have any concept of how often this is happening? This does not meet the CAQH CORE Claim Status (276/277) Infrastructure Rule CS.2.0 published April 2022 Section 4.5. The ticket also included a list of 270 Eligibility inquiries that have yet to receive a 271 response?? The 270 Eligibility transactions are from multiple trading partners. The lack of eligibility information could be impacting a members care. The first 270 transaction in the list is from August 17, 2024. That means it has been more than two weeks without a response.	100%	98 - All Providers
Closed	151	To support the FQHC, RHC, OHF wrap around claim processing, the 271 Eligibility Response transaction must contain the 7 digit ODM assigned program ID for the plan in which the member is enrolled so that providers submitting wrap-around claims can identify the members program correctly.	100%	All Providers
Closed	152	PACDR adjustment question from Liberty Dental. Liberty Dental is Anthem's new Dental vendor.	100%	
Closed	153	Report on any claims needing reprocessing. This is tied to CPSE ID 73 that was resolved.	100%	MITs Provider Types 84 (MH Providers) and 95 (SUD Providers)
Closed	154	Some hospice claims are denying for invalid LOCKIN when the hospice provider specialty submitted on the claim does not match the hospice provider specialty in the system.	100%	44 - Hospice
Closed	161	Beginning 9/1/2024 the 271 Eligibility Response is missing the Patient Liability / Responsibility information.	100%	
Closed	162	FI is inappropriately denying certain services when the member has Emergency Alien coverage.	100%	All Providers
Closed	163	Claims and PAs expect to wait for attachments when PWK segment is included in EDI claim submission but are instead denying.	100%	98 - All Providers
Closed	164	277CA not generated for AmeriHealth DKP submission . 2 files submitted by AmeriHealth on 11/21/2024 does not have 277CA response.	100%	
Closed	166	Edit "1124 - Claim requires Ordering/Referring" is posting on hospital claims. It should only apply to professional.	100%	"01" - Hospitals
Closed	167	Provider Missing 835s	100%	98 - All Providers
Closed	170	TBQ Medicare information is correct	100%	All Providers
Closed	172	SSRS reports TPL26 TPL 27 TPL 29 TPL 30 not capturing all the claims submitted by HMS on an 837	100%	All Providers