Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
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	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	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	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	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	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	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	152	PACDR adjustment question from Liberty Dental. Liberty Dental is Anthem's new Dental vendor.	100%	
Closed	153	Report on any claims needing reprocessing. LaChanda to get with Nana and provide Gainwell direction. This is tied to CPSE ID 73 that is resolved.	100%	MITS Provider Types 84 (MH Providers) and 95 (SUD Providers

Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
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
Open	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.	90%	98 - All Providers
Open	62	Member condition codes missing for nursing facility enrollment resulting in incorrect capitation payment.	95%	All MCEs
Open	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.	10%	All MCEs
Open	66	Some retroactive changes in eligibility are reported as terminations to MCOs on the 834.	10%	All MCEs
Open	67	Capitation Rate Adjustment processing and how the data is reported on the 820 transaction is being validated. These processes will be activated in FI Production after the validation is complete.	90%	All MCEs
Open	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).	95%	All MCEs
Open	69	When it is determined that a member has more than one Recipient ID, the IDs need to be linked together in FI. Linking the IDs will allow the 834 to report when a Recipient ID has been made Secondary and is no longer active.	80%	All MCEs
Open	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.	25%	Various
Open	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	90%	98 - All Providers
Open	77	277CA responses are not being received for all claims submitted.	50%	98 - All Providers
Open	79	Count Gap between 276 , 277 Responses	50%	98 - All providers
Open	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.	0%	
Open	82	Need access to claims dating back to 2014.	25%	98 - All Providers
Open	85	Vendors across the Ohio Medicaid Enterprise System (OMES) are working together to ensure that member data and provider data from the source(s) of truth are aligned across modules. This reconciliation has been taking place weekly. Out of sync issues has been greatly reduced. This process will continue until out of sync issues are completely resolved.	55% (Ongoing activity, will vary every week)	All Providers

Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
Open	88	Currently in OMES, providers are not required to report individual rendering practitioners in the detailed rendering lines for FQHC and RHC claims. This is not consistent with existing policy. The system will be adjusted to request that PNM and FI/VUE360 be modified so that FQHCs and RHCs are required to report individual rendering practitioners in the detail rendering lines of their claims. (Services rendered by mid-level health care workers (e.g., registered nurses) and unlicensed dependent practitioners (i.e., behavioral health trainees) at FQHCs and RHCs will continue to be reported under the overseeing practitioners' NPIs. Transportation, DME, laboratory, and radiology should continue to be reported under the organizational/billing NPI.)	10%	FQHC (12) and RHC (5)
Open	89	FI is not recognizing supervisors on the claim to pay at the supervisors rate.	25%	BH
Open	91	MITS Claim converted to FI incorrectly	80%	98 - All Providers
Open	92	Defect: NF Cross-over Claims: Bypass Contract Edits and Allow to Properly Process for Payment.	99%	86
Open	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).	25%	98 - All Providers
Open	98	Copayment exemptions configured in MITS but not FI	5%	98 - All Providers
Open	99	Edit 311 Posting Incorrectly for initial claims and adjustments	40%	All Providers
Open	101	755 rejection provides insufficient information for resolution and resubmission of claims	50%	98 - All Providers
Open	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.	20%	98 - All Providers
Open	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.	99%	FQHC (12) and RHC (5)
Open	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)	80%	FQHC (12) and RHC (5)

Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
Open	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.	90%	FQHC (12) and RHC (5)
Open	111	FQHC/RHC transportation claims are paying incorrect amounts when more than one unit is reported on the claim. After fixed, impacted claims need reprocessed/adjusted.	90%	FQHC (12) and RHC (5)
Open	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.	90%	FQHC (12) and RHC (5)
Open	114	FQHC/RHC claims that include dietitian services reported under FQHC/RHC medical are denying incorrectly when rendering provider is a dietitian. After fixed, impacted claims need reprocessed/adjusted.	80%	FQHC (12) and RHC (5)
Open	115	FQHC/RHC automatic crossover claims coming directly from Medicare are not paying cost sharing as expected. After fixed, impacted claims need reprocessed/adjusted.	80%	FQHC (12) and RHC (5)
Open	116	FQHC/RHC COB claims not processing as expected when non-Medicare/non-Medicaid TPL included on the claim. After fixed, impacted claims need reprocessed/adjusted.	40%	FQHC (12) and RHC (5)
Open	117	FQHC/RHC COB claims not processing correctly for members enrolled straight Medicaid and traditional Medicare. After fixed, impacted claims need reprocessed/adjusted.	90%	FQHC (12) and RHC (5)
Open	119	Inpatient hospital claims denying with edit 201	95%	
Open	120	1099 conversion issues	0%	
Open	123	10% payment/decimal point payment issue	80%	Durable Medical Equipment Suppliers
Open	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.	90%	98 - All Providers
Open	126	Overpayments on B9998U1-HCPCS with modifier-Enteral	25%	Durable Medical Equipment Suppliers/Pharmacies
Open	127	Enteral formula underpayments	90%	Durable Medical Equipment Suppliers/Pharmacies
Open	128	Secondary not paying up to full Medicaid allowable	70%	Durable Medical Equipment Suppliers/Pharmacies

Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
Open	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.	50%	
Open	131	Denied, bundled and referenced NCCI edits	80%	Durable Medical Equipment Suppliers/Pharmacies
Open	132	Ineligible rendering provider. Claim had several procedure codes that paid but others denied.-Affiliation errors	80%	Durable Medical Equipment Suppliers/Pharmacies
Open	133	Incorrect payment based on quantities allowed for gloves and incontinent products (liners, pullups or briefs). Quantity allowed is 300/month as of 1/01/24; system still using old, allowed amount of 200/month. Affected codes: T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4535, T4543	80%	Durable Medical Equipment Suppliers/Pharmacies
Open	134	Current Patient Liability spans are not always reported on the 834 files that are sent to the Managed Care Plans.	95%	All MCEs
Open	136	Edit 210 and Edit 218 is inappropriately posting on inpatient hospital claims when there is no eligibility at the beginning of the stay	20%	
Open	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)	90%	98 - All Providers
Open	138	MCE Claims Extract File (Claims to MCO Export-CLMEX00096) does not contain denied claims, only paid claims	70%	All MCEs
Open	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.	0%	All Providers
Open	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.	50%	Durable Medical Equipment Suppliers
Open	141	PA Alignment rules for DME billing. Currently PAs are lifted, but some claims are not being processed because some claims have an approved PA number on the claim that is not being recognized by the system. Both edits need released in order for a claim to be processed	90%	Durable Medical Equipment Suppliers
Open	142	Recipient Eligibility ticket volume increase due to differences between MITS and FI	10%	98 - All Providers

Status	Public CPSE ID	Provider Description	Percent Complete	Provider Type
Open	143	Portal claims denying with edit 101 and no billing provider is displayed on the claims in VUE360.	90%	98 - All Providers
Open	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	10%	98 - All Providers
Open	145	Several claims that have been denied due to the CARC/RARC information message: "Precertification/authorization/notification/pre-treatment absent." along with the adjudication error: "CONTRACT TERM REQUIRES UM	0%	98 - All Providers
Open	149	Rx TPL coverage is being loaded as Comprehensive Medical coverage in FI.	0%	All Providers
Open	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.	0%	12
Open	155	Claims are being denied for the same service code, but with a different place of service.	30%	
Open	156	CO-197 PRECERT/AUTH ABSENT denials for E0445, A7520, E0465, A6209 U1, A7000, B4154, B4155, B4153, E0431, A4483, B9998 U1, B9998 U2, B9002 when authorization is not required.	80%	Pharmacies/Durable Medical Equipment Suppliers
Open	157	CO-4 MISSING MODIFIER denials for B4088, A4450, A4452, A4217 supplies when no modifier exists on the ODM Fee Schedule	95%	Pharmacies/Durable Medical Equipment Suppliers
Open	158	OA-18 EXACT DUPLICATE CLAIM OR SERVICE on A4927, A4930 and A6402 claims when the claim quantity is within the ODM Fee Schedule Frequency Limit. This issue occurs also on claims providers attempt to correct and resubmit. (New 9/18)	95%	Pharmacies/Durable Medical Equipment Suppliers
Open	159	CO-284 PRECERT/AUTH MAY BE VALID BUT DOES NOT APPLY TO BILLED SERVICE denials on B4161, B4160 and A7521 U1 claims	80%	Pharmacies/Durable Medical Equipment Suppliers
Open	161	Beginning 9/1/2024 the 271 Eligibility Response is missing the Patient Liability / Responsibility information.	0%	
Open	162	FI is inappropriately denying certain services when the member has Emergency Alien coverage.	25%	All Providers
Open	163	Claims and PAs expect to wait for attachments when PWK segment is included in EDI claim submission but are instead denying.	90%	98 - All Providers