UnitedHealthcare COMMUNITY & STATE KanCare

Last updated: **Archive for 2012 - 2014**

PLEASE NOTE: To assist with identification of new entries, issues and updates for this week can be found in **blue font**.

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
12/27/12	1	Members	Identified Issue: Medicare/Medicaid eligible members (Dual Eligibles) may receive a member Identification card that has a Primary Care Physician's (PCP's) name other than the PCP they normally see for Medicare. It is our intention to defer to the PCP used for Medicare for individuals that have both Medicare and Medicaid.	A small number of Medicare/Medicaid (Dual Eligibles) members may still receive an ID card that has a Primary Care Physician (PCP) listed on the front that is not the same PCP they use for Medicare. For those members impacted, a phone call will be placed to the member by our Member Advocate team to explain the issue and assist with any questions the member or guardian may have.	Completed	N/A	2/28/13
12/27/12	2	General Providers	Can you provide more information on Electronic Funds Transfer and EDI?	Providers may go to www.uhccommunityplan.com, select For Health Care Professionals and then select Kansas in the drop down box. Under the Electronic Data Interchange link, providers may access the form to sign up for Electronic Funds Transfer. We will have a Claim Filing and EDI Fact Sheet posted at this location by the first week in January as well. The Provider Administrative Guide may be found under the Provider Information link. This information is found on our public site - a user ID and password is not required to access this information. Providers may also contact their Provider Advocate for assistance with EDI questions.	Completed	N/A	12/28/12
12/27/12	3	General Providers	Providers would like additional information on UnitedHealthcare's "uhccommunityplan.com" website, as well as the secure provider portal (UHConline.com).	Providers may access our general website at www.uhccommunityplan.com without a user ID and password. On this website you will find United contact information, our Provider Administrative Guide, search for network providers, and other general plan information. To access our secure website www.UHConline.com, providers can go to UHConline.com and create a user name and password to the secure website. Under the "Help" section, providers will find step by step instructions on how to sign up on the website. You do not need a provider ID, and will use your Tax Identification Number to set up your user name and password. Your Tax Identification Number will have to be loaded in our system before you can establish your user name and password to the secure website. Provider services (phone #: 877-542-9235) or your assigned provider advocate may provide addition support and assistance if you have questions.	Completed	N/A	12/28/12

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12/27/12	4	General Providers	Please provide contact information that providers may reach out to if they have specific questions about networking and contracts.	Physicians and providers may contact our Provider Services Department at 877.542.9235, or to reach someone directly regarding contracting and network questions or issues, or please contact the individuals listed below:	Completed	N/A	12/28/12
				Physical Health Providers Contact: Network Management at ks.net.mgmt@uhc.com			
				BH/SUD Providers Contact: Sandra Hashman, Telephone: 913-333-4051, Email: Sandra.hashman@optum.com			
				Dental Providers Contact: Network Development, 855-878-5372 for contracting, Email: providerservices@sciondental.com or call 855-878-5372			
				Vision Providers Contact: : Network Management at 866-416-0150, Email: providerservices@ocularbenefits.com or call 866-921-7962			
				HCBS Providers Contact: **Western KS:** Tamara Sands, Telephone: 620-227-2498, Email: tamara_sands@uhc.com; **Central/SE KS:** Shandy Ricketts, Telephone: 316-794-2252, Email: sricketts@uhc.com; **NE KS:** Krista Hayes, Telephone: 913-333-4013, Email: kristahayes@uhc.com An HCBS provider territory map can be found on our website at www.uhccommunityplan.com, Click on For Health care Professionals, select Kansas from the drop down box, and scroll down to the contacts section			
				Physical Therapy / Occupational Therapy and Speech Language Pathology Providers Contact: Susie Seace, Telephone: 972-252-8785, Email: Susie.seace@optum.com			
				Nursing Facilities For contract questions contact: Jennifer Everett, Telephone: 913-323-1050, Email: Jennifer_everett@uhc.com For provider support questions contact our Nursing Facility Provider Support Line at 888-823-8751 NF Provider Advocates: **Eastern KS**: Carol Buckner, Telephone 913-217-3528, Email carol_buckner@uhc.com; **Western KS:** Michelle Sims, Telephone 913-323-1037, Email: michelle_m_sims@uhc.com A Nursing Facility provider territory map can be found on our website at www.uhccommunityplan.com, Click on For Health care Professionals, select Kansas from the drop down box, and scroll down to the contacts section			

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				Pharmacy Provider Contact: Jennifer Murff, Telephone: 913-333-4002, Email: Jennifer.murff@uhc.com			
				Transportation Providers Contact: Percy Day, Telephone: 800-243-5560 ext 208, Email: percy.day@logisticare.com or, Rita Preble, Telephone: 800-243-5560 ext 212, Email: ritap@logisticare.com			
12/27/12	5	Care Coordination	When may a member or responsible party find out who their assigned Case Manager is?	UnitedHealthcare received our enrollment files and has assigned care coordinators to Long Term Support and Services (LTSS) members. Assignments will be completed by January 1st, and outreach will begin January 2, 2013. Welcome letters will also be mailed to the members identifying who the name of their case coordinator is. Members may call Member Services at 877-542-9238 for assistance in identifying their assigned care coordinator.	Completed	N/A	12/28/12
12/27/12	6	General Providers	Do Rural Health Clinics need to bill with their group NPI only, or are they also required to bill with the rendering provider's NPI as well?	Rural Health Clinics may bill with both the group NPI and rendering provider NPI, or they may bill with the group NPI only.	Completed	N/A	12/28/12
12/27/12	7	Nursing Facilities	CHANGE ALERT: United will not require prior authorizations on custodial (residential) nursing facility stays as was indicated in our Provider Administrative Guide.	Effective 1/1/2013, UHC KanCare members who reside in a nursing facility will NOT require Prior Authorization for the custodial (residential) stay. Facilities do not need to submit any prior authorization information when claims are submitted for residential nursing facility services. Communication is being sent to Nursing facilities. This includes nursing facilities for mental health (NFMH) and ICF MR facilities.	Completed	N/A	12/28/12
12/28/12	8	Provider Network	How do I find out if a particular physician or other health care provider is in UnitedHealthcare's network?	Please go to our online directory at uhccommunityplan.com or by calling our Member Services Department at 877-542-9238.	Completed	N/A	12/28/12
12/28/12	9	General Providers	What is UnitedHealthcare's payer identification number?	UnitedHealthcare has a Medicaid-specific payer ID that providers should use. The Payer Identification number for UnitedHealthcare Community Plan of Kansas is 96385.	Completed	N/A	12/28/12
12/28/12	10	CDDOs	Do CDDO's need a business associate agreement to communicate with MCO's?	We will defer to the state's direction on their issue log regarding this issue. It is our understanding that a separate business associate agreement is not required by UnitedHealthcare.	Completed	N/A	1/10/12
12/28/12	11	Behavioral Health Providers	What is the fax number for mental health staff to use when faxing in pre-screening assessments?	The fax number for the Behavioral Health/Mental Health providers to use when faxing in the pre-screening assessments for PRTF and inpatient admissions to Optum is 855-657-3526. Please fax within the one business day.	Completed	N/A	12/28/12
12/28/12	12	General Providers	How do I obtain a roster of the members who are assigned to my primary care practice?	The master patient roster for providers is available on the secure provider portal. Go to www.uhconline.com and then click on Tools and Resources and then Reports. Select the PCP panel report from the drop down box.	Completed	N/A	12/28/12
12/31/12	13	General Providers	Will UnitedHealthcare follow the Third Party Liability Non-covered List process as defined in KMAP Waiver Bulletin 12132?	Yes, UnitedHealthcare will follow the process outlined in KMAP Waiver Bulletin 12132 for the payers and services codes identified. The denial code for providers to use is the same as with the state's process - CARC code 192.	Completed	N/A	12/31/12

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1/2/13	14	Members/ Providers	Where can we locate the issues log?	UnitedHealthcare has provided a link to our issues log which can be found at http://www.uhccommunityplan.com. Click on For Health Professionals and select Kansas from the dropdown box. Scroll down to find the issues log.	Completed	N/A	1/1/13
1/2/13	15	General Providers	HCBS Providers whose claims are submitted through EVV (Kansas AuthentiCare) rarely see claims in a pended status/critical exception status. Typically once a service is reported, it is matched to a prior authorization record in real time. Providers then see that AuthentiCare forwards claims for payment processing the morning after they have been confirmed. Over the next 24-48 hours, providers may see some claims in a critical exception status in AuthentiCare, related to missing authorization. This event is a one-time occurrence as part of the transition being resolved by Authenticate, the State, and the MCOs. Providers do not need to take additional action on these pended claims. During the next 24-48 hours providers should see that any pended claims have been automatically submitted for processing. MCOs are committed to promptly paying claims for services submitted through EVV.	At this time, there is no indication affected providers will experience any delays in payment due to the temporary pending of EVV related claims.	Completed	N/A	1/2/13
1/3/12	16	Behavioral Health	We have traditionally had to submit outpatient treatment plans for each member after 4 visits, is that still the case?	For now, we will not require the treatment plan after the 4th visit. These will be reviewed on a case by case basis in the future.	Completed	N/A	1/3/13
1/3/12	17	General Providers	For dual eligibles when Medicare is primary, do providers need to follow United's prior authorization processed?	When Medicare is primary and KanCare is secondary, providers do not have to obtain prior authorization from United for covered services. If the Medicare coverage exhausts for a particular service and KanCare becomes the primary payer for that service, we ask that providers obtain prior authorization but only if required on our prior authorization list **(which does not include all services)**	Completed	N/A	1/3/13
1/3/13	18	General Providers	Do we credential locum tenens providers and what is the process we use?	UHC will honor CAQH credentialing. We are researching specific direction on how locum tenens providers should be handled and will post the answer here shortly. UPDATE: The provider credentialing process can take up to 90 days. If a locum tenens provider will be covering for a short time period, credentialing the provider may not be the best option. Services provided by a locum tenens provider may be billed under the TIN and NPI of the provider being covered for. Add a Q6 modifier to the service codes to indicate the services were provided by a locum tenens provider.	Completed	N/A	5/29/13
1/3/13	19	General Providers	Is the Prior Authorization form on website for United?	Yes. Go to www.uhccommunityplan.com. Click on For Health Professionals, then select Kansas from the drop down box. Then click on the Provider Forms navigation box on the left side of the page.	Completed	N/A	1/7/13

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1/3/13	20	Pharmacy	For pharmacies, will the state's auto refill process still be available?	At this time, we do not have an auto-refill process in place.	Completed	N/A	1/3/13
1/3/13	21	General Providers	What is the number for our after-hour nurse line?	The nurse line number is 855-575-0136.	Completed	N/A	1/3/13
1/3/13	22	General Providers	If a provider is listed as PCP and has members assigned and the provider does not want to function as a primary care provider - who should the provider contact to get their status corrected?	Providers can contact their Provider Advocate for assistance. The Provider Advocate can request the provider's PCP status be changed and the members re-assigned as appropriate.	Completed	N/A	1/3/13
1/3/13	23	Pharmacy	Why are pharmacy claims being rejected?	When a pharmacy attempts to use the KMAP ID (instead of the UHC ID) for a member to create a claim, a pop up screen will appear instructing the pharmacy on how to resubmit the claim for payment. UPDATE 1/7/13 - this problem has been repaired in the system. Pharmacies are able to use the KMAP ID when submitting claims without the pop up.	Completed	N/A	1/7/13
1/4/13	24	General Providers	Is prior authorization required for all services provided by non-contracting providers?	Please see Issue #97 for the updated response to this question.	Completed	N/A	4/4/13
1/4/13	25	Rural Health Clinics	How will RHC claims be paid?	Claims will be adjudicated and paid at the encounter level. UHC will pay the PPS case rate as determined by the State.	Completed	N/A	1/2/13
1/4/13	26	General Providers	I am receiving an error message when I request an electronic eligibility transaction (270/271 transaction) - how can I get this resolved?	This issue has been resolved.	Completed	N/A	1/31/13
1/4/13	27	Home Infusion Services	Do home infusion services require prior authorization and where is this located on the website?	Yes, home infusion services do require prior authorization. The prior authorization list can be found the in Chapter 4 of the Provider Administrative Guide on www.uhccommunityplan.com. Click on For Health Professionals and select Kansas from the drop down box to get to the Kansas provider page.	Completed	N/A	1/2/13
1/4/13	28	General Providers	Is there a different United member ID number providers must use to verify member eligibility on the United website? The KMAP ID number does not work.	It is our intention for providers to use the member KMAP ID number. At this time, there is a technical issue with our website recognizing the KMAP member ID number. We are working to quickly resolve this issue. In the meantime, providers may look up members using the Alpha Search function and the member name and date of birth, or may call our Provider Services Call Center at 877-542-3235 for eligibility verification assistance. UPDATE: Providers are able to enter the member KMAP ID number to verify member eligibility on our website. Our system will locate members when their KMAP member ID is entered, but the KMAP number will not display. We are working on this issue.	Completed	N/A	9/2/15
1/7/13	29	Care Coordination	There were questions regarding the timing of care coordinator outreach to nursing facility residents who are transitioning though the Money Follows the Person program.	Our care coordinators are continuing to conduct outreach to members, priority cases are being worked first which includes any members currently transitioning via the MFP program. Other residential nursing facility members can expect care coordination outreach toward the end of January. Current authorizations and plans of care are being honored.	Completed	N/A	1/7/13

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1/7/13	30	FQHCs	Can the FQHC be listed as a member's PCP, or only the individual practitioners within the FQHC?	The FQHC can be listed as the member's PCP.	Completed	N/A	1/7/13
1/8/13	31	CMHC	Is there a limit to the number of units that can be billed for Targeted Case Management provided by CMHC's?	No there is not a limit to the number of units for targeted case management.	Completed	N/A	1/8/13
1/8/13	32	General Providers	For EVV claims how quickly will claims show once they have cleared KMAP and have been submitted to the MCO?	It takes approximately three days from the time the provider submits the claim until the claim status can be viewed in web portal.	Completed	N/A	1/8/13
1/9/13	33	General Providers	I am being told that United KanCare payor id 96385 is not working through my clearinghouse.	We have been notified some clearinghouses do not have our payor id set up yet. For providers billing through Emdeon we have established a process where the claims can be submitted through our existing payor id number of 87726 until KanCare payor id is loaded. Zirmed has confirmed they have our payer ID loaded and we are working with them to ensure claims are being transmitted. A similar concern has been reported relative to claims submitted through ASK and we are working to resolve that issue. UPDATE: These issues have been resolved.	Completed	N/A	1/10/13
1/9/13	34	General Provider	Will UnitedHealthcare accept blanket denial letters that providers have collected in addition to those maintained by the state?	UnitedHealthcare will honor blanket denial letters, which should be submitted with claim when filing on paper. For claims submitted electronically, providers should use the date on the TPL letter in the Other Payor Date Adjudicated field.	Completed	N/A	1/9/13
1/9/13	35	FMS	How will Financial Management Service providers be notified of plan of care changes? Will FMS providers still receive a notice of action letter?	When the plan of care changes, the Care Coordinators will update the authorization that is loaded in Authenticate. In emergent situations, the safety and well being of the member should always take precedence over prior authorization procedures.	Completed	N/A	1/9/13
1/9/13	36	Behavioral Health Providers	Will denial code 184 be accepted for claims that have been denied by Medicare because the provider is not a Medicare approved provider type?	Yes, denial code 184 is appropriate and will be accepted.	Completed	N/A	1/9/13
1/10/13	37	Nursing Facility	When a nursing facility resident on Medicaid goes to hospital and then returns to the nursing facility, is a prior authorization required?	United does not require prior authorization for bed holds or for residential, or custodial, nursing facility stays. A prior authorization is not needed.	Completed	N/A	1/10/13
1/10/13	38	General Provider	Will I receive an 835 for the claims I submit to United?	Providers who submit any claims through OptumInsight can receive an 835. For providers who use the front end billing option only, which includes EVV, we have developed an alternative process to allow providers to receive a postable 835. Providers should contact their Provider Advocate for assistance with this process.	Completed	N/A	1/10/13
1/15/13	39	General Provider	Do all radiology services require a prior authorization?	No. There are very limited radiology services that require a prior authorization. They include MRI, MRA, PET and SPECT PET scans. CLARIFICATION: PET and SPECT PET scans are non-covered services under the Kansas Medicaid plan. Even if a prior authorization is obtained, this is not a covered service.	Completed	N/A	5/23/13

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<tr><th>Date Added</th><th>Item Ref #</th><th>Impacted Area</th><th>Question/Issue</th><th>Response/Resolution</th><th>Status</th><th>Reprocessing Plans (if necessary)</th><th>Date Revised or Resolved</th></tr>
<tr><td>1/16/13</td><td>40</td><td>General Provider</td><td>If multiple providers share the same tax identification number, but have and bill with different NPI numbers, will each entity receive separate checks and RAs by NPI?</td><td>Yes, providers that share the same TIN but bill with different NPIs should be able to have separate checks and remittance advices. However, there have been claim processing issues that have impacted payment to the correct entity. Please see issue #108 for additional information.</td><td>Completed</td><td>N/A</td><td>6/28/13</td></tr>
<tr><td>1/16/13</td><td>41</td><td>General</td><td>Can you provide a timeline that follows a claim through the billing process from initial billing through payment?</td><td><table>
<tr><th></th><th>FEB</th><th>Clearinghouse</th><th>MCO Portal</th><th>Claim Status on MCO Web Portal Appears As</th></tr>
<tr><td>Claim Submission</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Claim Transferred</td><td>1 day*</td><td>1 day</td><td>Immediate</td><td>-</td></tr>
<tr><td>Claim Reviewed</td><td>1-10 days</td><td>1-10 days</td><td>1-10 days</td><td>Pending – viewable approx. 3 days after claim transferred</td></tr>
<tr><td>Payment/Denial Determination</td><td>1 day</td><td>1 day</td><td>1 day</td><td>Paid/Denied</td></tr>
<tr><td>EFT Transaction (If applicable)</td><td>1 day</td><td>1 day</td><td>1 day</td><td>Paid/Denied</td></tr>
<tr><td>Check Cut (If applicable)</td><td>1 day</td><td>1 day</td><td>1 day</td><td>Paid/Denied</td></tr>
<tr><td>Check Delivered</td><td>1-3 days</td><td>1-3 days</td><td>1-3 days</td><td>Paid/Denied</td></tr>
<tr><td>Total Processing Time</td><td>4-17 days</td><td>4 17 days</td><td>3-16 days</td><td>Paid/Denied</td></tr>
</table></td><td>Completed</td><td>N/A</td><td>1/18/13</td></tr>
<tr><td>1/16/13</td><td>42</td><td>General Provider</td><td>Are breast pumps covered?</td><td>The benefit for breast pumps is unchanged from 2012. We have identified that there is a national breast pump supply shortage. We have identified a national DME provider who does have breast pumps available that can ship the pumps to members. Please notify Nan Kartsonis if a breast pump is needed 913-333-4005.</td><td>Completed</td><td>N/A</td><td>1/18/13</td></tr>
<tr><td>1/17/13</td><td>43</td><td>Hospital</td><td>If UnitedHealthcare is the secondary payor does UnitedHealthcare require notification of discharge date?</td><td>Notification of the discharge is not required. However, from a care coordination and care management perspective, notification would be appreciated.</td><td>Completed</td><td>N/A</td><td>1/18/13</td></tr>
<tr><td>1/17/13</td><td>44</td><td>ICF MR</td><td>Do ICF MR claims require a diagnosis code?</td><td>Yes - a valid diagnosis code is required for all claims.</td><td>Completed</td><td>N/A</td><td>1/18/13</td></tr>
<tr><td>1/18/13</td><td>45</td><td>RHC</td><td>Can RHCs bill for allergy injection visits?</td><td>No - RHCs cannot bill for allergy injections and be paid the encounter rate. A covered RHC encounter requires a face-to-face visit with a healthcare professional or practitioner. If the allergy injections are provided by a nurse - an encounter cannot be billed.</td><td>Completed</td><td>N/A</td><td>1/18/13</td></tr>
<tr><td>1/18/13</td><td>45</td><td>Nursing Facilities</td><td>What Revenue Codes should be billed for room and board?</td><td>The revenue codes to bill for room and board to UnitedHealthcare for KanCare members include:
Revenue Code 101- for Medicaid nursing facility stays
Revenue Code 120 - for post-acute nursing facility stays that meet the Medicare guidelines for skilled care</td><td>Completed</td><td>N/A</td><td>1/18/13</td></tr>
<tr><td>1/22/13</td><td>46</td><td>Hospital</td><td>Do we have to generate a split bill if there is an emergency department service and an inpatient admission?</td><td>If an emergency department visit results in an inpatient admission, the emergency department visit is included in the inpatient DRG payment and a separate claim is not required.</td><td>Completed</td><td>N/A</td><td>1/22/13</td></tr>
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1/22/13	47	Hospital	If an inpatient facility determined a member met criteria for inpatient admission but the MCO indicated only observation is appropriate, how should the facility bill for the service?	If the inpatient service is billed without an authorization after the transition period, the inpatient claim will deny for no authorization. If the observation stay is billed, the claim would pay as observation does not require authorization.	Completed	N/A	1/22/13
1/22/13	48	Nursing Facilities	Do providers need to report the patient liability on claims?	No - nursing facilities do not need to report the patient liability on claim forms. Providers should bill their normal charge, the allowance will be reduced by the appropriate patient liability amount.	Completed	N/A	1/22/13
1/23/13	49	FMS	How often will plan of care assessments be completed and are they tied to the members date of birth?	Assessments will be completed at least annually and more often as needed to meet member needs. The assessments will not continue to be tied to the member date of birth.	Completed	N/A	1/23/13
1/23/13	50	Nursing Facilities	If we have submitted claims and the revenue code has changed do I need to wait for the denial or can I resubmit claims immediately?	You can re-submit the claims immediately.	Completed	N/A	1/23/13
1/23/13	51	Hospital	How are claims paid when a member has spend down?	The allowed amount of the claim will be reduced by the patient liability amount. The provider would then collect the member liability from the member.	Completed	N/A	1/23/13
1/23/13	51	HCBS	When filling out the OASIS form do we use option 3 or option 4?	We recommend using option 4 for Medicaid HMO/Managed Care	Completed	N/A	1/23/13
1/24/13	52	Behavioral Health Providers	What denial codes should be used when billing third party patient liability claims?	Providers can use denial code 192 for third party liability, and can use denial code 184 for claims that have been denied by Medicare because the provider is not a Medicare approved provider type.	Completed	N/A	1/23/13
1/24/13	53	Rural Health Clinics	How will claims be addressed for non-contracted providers?	During the 90 day transition period, providers will be paid at 100% of the Kansas Medicaid allowed amount or encounter rate. After the transition period, non-contracted providers will be paid at 90% of the encounter rate.	Completed	N/A	1/23/13
1/24/13	54	Pharmacy	Are vitamin B12 and folic acid shots covered?	Yes both shots are covered services.	Completed	N/A	1/24/13
1/24/13	55	Pharmacy	Does a patient have to come to the pharmacy to see if a nebulizer is a covered item for that individual?	No - UnitedHealthcare does not require a prior authorization for coverage of a nebulizer. Pharmacies would bill for this service under the medical benefit as a DME provider and not the pharmacy benefit.	Completed	N/A	1/24/13
1/25/13	56	CMHCs/ Behavioral Health Providers	Claims billed with a 99 place of service code are being denied.	The system configuration to correct this denial was completed on 5/15/13. Impacted claims should have been caught as part of a manual workaround and adjusted during claim processing. If providers have identified claims denied in error for POS 99, please contact your Provider Advocate for assistance in having those claims adjusted.	Completed	Impacted claims were identified as part of the manual workaround and adjusted during claim processing.	6/14/13

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1/25/13	57	Nursing Facilities	Can a nursing facility submit or correct a UB04 claim on the UnitedHealthcare website?	UB04 billers cannot submit or correct claims via uhconline.com. Providers can sign up with OptumInsight for free, or they can use Office Alley for this purpose. To clarify: OptumInsight has a web portal system that allows providers to Batch submit claims (they must be able to have an 837 X12 standard file configuration) or they can data enter Professional claim types on the portal. If the provider needs to data enter UB04 claim types then they must use a different portal program. We recommend Office Ally because there is no cost to the provider and we have had good reports of their customer service and helpfulness.	Completed	N/A	4/25/14
1/25/13	58	Hospital	What is the extended dental benefit for adult members?	Our value added dental benefit includes one cleaning, one exam and 1 x-ray per adult member per year.	Completed	N/A	1/25/13
1/28/13	59	Nursing Facilities	When attempting to sign up through OptumInsight to submit claims online - the information on the web page indicates it is a low cost option for providers - not a free service.	When you access the OptumInsight main webpage, it does state it is a low cost option clearinghouse. However, if you are submitting your claims to UnitedHealthcare the service is free. Please continue to sign up for the process as there will not be a cost for submitting UnitedHealthcare claims. To clarify: OptumInsight has a web portal system that allows providers to Batch submit claims (they must be able to have an 837 X12 standard file configuration) or they can data enter Professional claim types on the portal. The OptumInsight portal cannot be used by UB04 billers as an online claims portal to key individual claims for submission. The OptumInsight portal accepts electronic batch submissions only. UB billers who are seeking an online claim entry portal for UB04 online claim submission must use a different portal program. We recommend Office Ally because there is no cost to the provider and we have had good reports of their customer service and helpfulness.	Completed	N/A	4/24/14
1/28/13	60	Hospital	Do hospitals need to call for a prior authorization with a CPT/Procedure code when a member is admitted from the emergency room?	No - prior authorization is not required for admissions through the emergency room. We do request that hospitals notify us of the admission.	Completed	N/A	1/28/13
1/29/13	61	Behavioral Health Providers	What modifier should be used when different providers render the same service on the same day?	When billing for multiple encounters on the same day with different diagnosis codes and different procedure codes, add modifier 25. If billing with the same procedure code use modifier 76 first followed by modifier 25	Completed	N/A	1/29/13

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1/29/13	62	General Providers	I received a patient liability letter but it did not have the member name, only the member ID number.	We did experience a mail merge error in the generation of our January patient liability letters. This issue has been corrected and the letters beginning in February will include both the member name and member ID number.	Completed	N/A	1/29/13
1/29/13	63	Hospitals	How long does a pre-authorization take to receive for rehabilitation services?	Pre-authorization for rehabilitation services can take up to 14 days. If the treatment is emergent in nature you can request an expedited request.	Completed	N/A	1/29/13
1/29/13	64	Behavioral Health Providers	Some services have visit limits. How can a provider find out how many visits a member has used and how many the member has remaining?	Providers may call an Optum Behavioral Health Care Advocate who can provide the information.	Completed	N/A	1/29/13
1/29/13	65	Nursing Facilities	How can nursing facilities find out who the care coordinator is for their facility?	Please contact your Provider Advocate and they can assist in providing this information.	Completed	N/A	1/29/13
2/1/13	66	Behavioral Health Providers	Is transportation a covered benefit for a member to get to a therapy appointment?	Transportation is a covered benefit for a member to get to a therapy appointment.	Completed	N/A	2/1/13
2/4/13	67	Behavioral Health Providers	How often is the 834 file being transferred?	The 834 file is transferred daily.	Completed	N/A	2/4/13
2/5/13	68	DME/Home Infusion	How does the pharmacy bill code B9998? Prior to KanCare Medicaid told us how much to bill.	This code will require prior authorization as it is an unspecified code. Providers will need to have the applicable medical necessity and information regarding the specific service to be provided when calling for prior authorization. Pricing for this code is consistent with state policy. This is a manually priced code and the allowance is set as part of the prior authorization review.	Completed	N/A	5/24/13
2/6/13	69	Behavioral Health Providers	How will service limits be handled if a member changes MCO?	If a Member changes MCOs during the calendar year as allowed by the state, the member's service limits will be restarted once becoming a United/Optum member.	Completed	N/A	2/6/13
2/6/13	70	FMS	How can I find out who the UnitedHealthcare care coordinators and clinical contacts are for my clients?	A member of our clinical team has been reaching out to all FMS providers on an individual basis. Go to www.uhccommunityplan.com, click on For Health Professionals and select Kansas from the drop down box. Scroll down on that page and you will see we have posted the FMS Contact List under the link for the Issues Log.	Completed	N/A	2/11/13
2/7/13	71	Behavioral Health Providers	Correction. UnitedHealthcare has discovered a number of mental health codes have been paying incorrectly. The correct payment rates will be loaded this weekend (2/9) and all claims previously submitted and paid at the incorrect rates will be reprocessed. Providers do not need to resubmit their claims.	The claims related to this issue were identified and we believe were adjusted as of April, 2013. If you believe you have examples of claims that have not been adjusted, please contact your Provider Advocate for assistance with having those claims adjusted.	Completed	Claims adjusted as of April, 2013	5/24/13
2/7/13	72	Home Health Agency	Can a process be put in place that addresses which services require authorization and which codes providers can bill relative to acute care and long term home health services?	All home health services, other than assessments, require prior authorization. Please reference Chapter 4 of our Provider Administrative Guide on www.uhccommunityplan.com for a complete list of services that require prior authorization.	Completed	N/A	5/24/13

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2/7/13	73	Home Health Agency	When a pre-authorization is loaded on the website we cannot go back in and see the status of the authorizations. Can this be corrected?	We have verified providers are able to check the status of authorization via our online portal. Providers should report new concerns to their Provider Advocate.	Completed	N/A	5/24/13
2/11/13	74	Nursing Facilities	Nursing facilities are receiving EOBs from UnitedHealthcare and the facilities are confused as to what to do with the information and prefer not to receive this information.	UnitedHealthcare has been sending EOBs when nursing facility residents had patient liability. After obtaining consensus from nursing facilities and their associations, we will discontinue this practice. Nursing facilities will not continue to receive the EOBs.	Completed	N/A	2/11/13
2/12/13	75	Pharmacy	Can instructions be provided to pharmacies regarding when authorizations are required for DME and how pharmacies should bill for DME provided to KanCare beneficiaries?	We are posting a link on our website with information to assist pharmacies with DME questions. Go to www.uhccommunityplan.com, click on For Health Professionals and select Kansas from the drop down box. Scroll down on that page and you will see we have posted the FMS Contact List under the link for the Issues Log.	Completed	N/A	2/13/13
3/6/13	76	Behavioral Health Providers	Is diagnosis code V71.09 an accepted Behavioral Health Diagnosis when billing for an intake evaluation.	Yes UnitedHealthcare accepts V71.09 as an acceptable Behavioral Health Diagnosis bode when billing for an intake evaluation.	Completed	N/A	3/6/13
3/11/13	77	General Provider	How should Advance Nurse Practitioners bill for their services?	Advance Nurse Practitioners are required to be enrolled and bill for the services they provide. The mid-level practitioner must be listed as the performing practitioner in box 24J of the CMS 1500 form.	Completed	N/A	5/24/13
3/29/13	78	Nursing Facility /HCBS Providers	Nursing facilities have been experiencing denials for room and board claims with a S23 denial.	This relates to an incorrect denial tied the original resident admission date being prior to the 1/1/2013 effective date of KanCare. A process has been implemented to handle future claims accurately. Claims denied in error for this reason have been identified and are being adjusted and re-processed.	Completed	Impacted claims were identified and reprocessed by 5/1/13	5/24/13
3/29/13	79	HCBS Providers	Some HCBS claims are denying with a V6H denial code which relates the number of units billed and the date span billed.	We identified this issue and have a process in place to eliminate these denials as of 3/13/13. We did go back and identify impacted claims and reprocessed them for payment as of 4/30/13. If you have claims that are still denied incorrectly with this denial code please contact your Provider Advocate. UPDATE: We identified an additional code, T1016, that has continued to deny with a V6H denial after the initial fix. That system fix has been requested and is scheduled to be completed on 7/1/13. Providers experiencing this issue should contact their Provider Advocate for assistance with having these denials manually worked until the final system configuration is completed. UPDATE: As of 7/19/13 we have a process in place to ensure new day claims process correctly. An adjustment project is being initiated to adjust claims billed with T1016 that denied for V6H. A targeted completion date will be posted when available. UPDATE: The estimated completion date for adjustments is 9/2/13.	Completed	Claims denied in error were adjusted for payment.	9/3/13

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3/29/13	80	Physical Health Providers	Requirement to bill the 25 modifier when and E&M service is billed on the same date of service as a vaccine or vaccine administration	This requirement has been pended by the state at this time. A 25 modifier does not have to be added to E&M code under these circumstances. Providers will be notified of changes to this requirement. UPDATE: UnitedHealthcare will follow the state guidance on this issue. Although the 25 modifier is not required when billing preventative evaluation and management codes (99381-99397) in conjunction with immunization administration codes, it is strongly recommended that providers do so in preparation for this requirement being implemented at some point in the future. If you are billing any other evaluation and management code in conjunction with immunization administration codes, providers must follow correct coding guidelines and append the 25 modifier as appropriate to ensure appropriate payment of all services.	Completed	Impacted claims were identified and reprocessed	5/31/13
3/29/13	81	HCBS/LTC Providers	Some HCBS services are to be billed with the same code with different payment amounts depending upon the waiver - and are not paying correctly.	We are currently paying claims, but not always at the correct amount for the waiver. This took a reprogramming change to accommodate different rates for the same codes. This reprogramming will be complete in late April/early May. UPDATE: The system fixes are in place. If providers have additional claims paid at the incorrect waiver rate, please contact your Provider Advocate who can assist with getting the claims adjusted.	Completed	Provider Advocates will request adjustments as claims are identified.	5/24/13
3/29/13	82	General Provider	Some providers received payment for covered services at 35% of billed charges rather than at the Medicaid fee schedule amount.	This is an issue with how certain providers were set up, resulting in payment at 35% of billed charges rather than at the Medicaid fee schedule amount. Provider records were corrected on 3/27/2013. (While this issue is closed, a similar issue was identified - please see issue #110 for additional information)	Completed	Impacted claims were identified and reprocessed as of 3/27/13	5/24/13
3/29/13	83	HCBS Providers	Some HCBS providers received payment for covered services at 40% of billed charges rather than at the appropriate Medicaid fee schedule amount.	This is an issue with how certain providers were set up resulting in payment at 40% of billed charges rather than at the Medicaid fee schedule amount. Correction of the provider files impacted by this issue was completed on 4/15/13. Impacted claims were adjusted as of 5/6/13. Providers should work with their Provider Advocate to assist with adjusting any outstanding claims.	Completed	Impacted claims were adjusted as of 5/6/13	5/24/13

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3/29/13	84	FQHC/RHC	Payment at encounter rate for claims billed with Place of Service 11, 21 and 22	We experienced some set up issues for this provider type. We are working on correcting this set up as well as paying claims correctly. The final work on this project was completed on 4/5/13. New claims after that date will process correctly. We have conducted a sweep of the processed claims to identify claims paid incorrectly and are working those adjustments at this time. UDPATE: All system configuration to correct RHC/FQHC will be completed on 10/1/13. After the system configuration is confirmed, we will initiate claims projects to identify and adjust any remaining claims. UPDATE: The system configuration was completed ahead of schedule on 9/16/13. We believe all adjustments have been completed. If providers have outstanding claims not adjusted relative to this issue, they are encouraged to report them to their Provider Advocate.	Completed	System configuration completed on 9/16/13. Claims have been adjusted.	9/20/13
3/29/13	85	FQHC	FQHC payment for BH services	We experienced some set up issues for this provider type. We are working on correcting this set up as well as paying claims correctly. The final work on this project was completed on 4/5/13. New claims after that date will process correctly. We have conducted a sweep of the processed claims to identify claims paid incorrectly and are working those adjustments at this time. UDPATE: All system configuration to correct RHC/FQHC will be completed on 10/1/13. After the system configuration is confirmed, we will initiate claims projects to identify and adjust any remaining claims. UPDATE: The system configuration was completed ahead of schedule on 9/16/13. We believe all adjustments have been completed. If providers have outstanding claims not adjusted relative to this issue, they are encouraged to report them to their Provider Advocate.	Completed	System configuration completed on 9/16/13. Claims have been adjusted.	9/20/13
3/29/13	86	Hospitals	Birth weight issue	Inpatient claims being billed for newborn deliveries are being denied in error when a birth weight diagnosis code is not submitted on the claim. Birth weight diagnosis codes should only be required when a provider is seeking reimbursement of the neonatal DRG rates. We have identified how to fix this issue and are currently estimating the timeline. UPDATE: The system fix for this issue was implemented 3/29/13. Impacted claims are scheduled to be adjusted by 5/28/13.	Completed	Impacted claims are scheduled for adjustment by 5/28/13	5/24/13

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3/29/13	87	Hospice	Hospice/Nursing Facility issues	Hospice codes T2042, T2043, T2044, T2045, and T2046 are not paying at the correct rate. For procedure code T2046, the provider will be paid at 95% of the nursing facility rate that is billed. We encourage providers to bill at the correct room and board rate for the specific nursing facility. For the other 4 codes most providers will receive overpayments while this issue is researched and resolved. UPDATE: For codes T2042-T2045 the system configuration will be completed early on 10/21/13. The adjustment project is targeted for completion by 12/31/13. UPDATE: This project was completed early on 12/5/13	Completed	The adjustment project is targeted for completion by 12/31/13. Completed early on 12/5/13	12/5/13
3/29/13	88	HCBS/LTC Providers	Define the formula UnitedHealthcare uses to calculate the number of units approved on authorizations.	We take the number of units per day indicated by the care plan and multiply that by the number of days in the month. If the hours are indicated by "the week" – we just take the hours per week divided by 7 x the number of days in the month.	Completed	N/A	3/29/13
3/29/13	89	Nursing Facilities	New nursing facility rates	We have completed multiple claims projects to ensure providers are paid at the appropriate rate for first through third quarter claims. Please see issue #124 for additional information regarding payment of nursing facility claims. We have two outstanding adjustment projects. UPDATE: The targeted completion date for the first project has been moved to 9/30/13, and the completion date for the second adjustment project is 10/7/13. UPDATE: The adjustments for this issue were completed early on 9/28/13.	Completed	See issue #124 on this log regarding reprocessing information.	10/3/13
4/1/13	90	Hospitals	Critical Access Hospitals with skilled nursing facility/swing bed units are not being paid for the skilled nursing facility services.	There are 3 primary issues that impact these claims: 1) Lessor of logic is being applied to the nursing facility claims in error - system configuration to correct this issue is scheduled for 6/5/13 - expected date of claim adjustment is 6/28/13 2) Present on Admission (POA) indicators are being required for nursing facility claims in error - system configuration to correct this issue is scheduled for 6/5/13 - expected date of claim adjustment is 6/28/13 3) The date of admission is being used to determine the appropriate per diem rate in error (rather than the date of service) - the resolution of this issue is still being determined UPDATE: The claim adjustment project to correct these claims was completed on 6/19.	Completed	The claim adjustment project to correct these claims was completed on 6/19.	6/28/13

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4/1/13	91	Medical Practice Providers	Dental codes D1206 and D1208 are inappropriately denying when billed by physical health providers.	D1206 and D1208 are allowed to be billed by both medical and dental providers. At this time, when these codes are billed by medical providers, claims are denying indicating the code is not covered and/or that all dental codes must be billed to the dental vendor. Both denials are incorrect and are being researched and corrected. UPDATE: The system configuration was completed early on 6/6/13 and new day claims are now processing correctly. A claims adjustment project has been initiated and the target completion date is 7/17/2013. UPDATE: The adjustment project to correct these claims was completed early on 7/2/13. UPDATE: We are receiving reports from medical providers that these codes are not paying correctly and we are researching this issue. For Local Health Departments Only: On or after 6/1/13, D1206 and D1208 must be billed to Scion (the UHC dental subcontractor). Claims billed directly to UHC for these services after 6/1/13 will appropriately deny as E37 - bill dental vendor. UPDATE: The system configuration was corrected on 10/18 to address the new day claims that were processing incorrectly for medical providers. The targeted completion date for claim adjustments is 12/15/13. Health departments - please see note above for Local Health Departments. UPDATE: This claim project completed early on 12/2/13	Completed	Claim adjustments targeted for 12/15/13. Project completed early on 12/2/13	12/2/13
4/1/13	92	Nursing Facilities	Nursing Facilities have received TPL/COB denials when the member eligibility file indicates the member has a primary payer, including Medicare.	Nursing Facilities have been receiving TPL/COB denials on claims where the member eligibility file indicates the member has a primary payer, including Medicare. This is incorrect as nursing facility claims should bypass the TPL claims editing. A temporary work around is in place to pay these claims correctly. Also, in some cases when the nursing facility claims did pay correctly, providers are receiving recoupment letters indicating UHC should not have paid primary. This letter is being sent in error and we are working to ensure no recoupment activities occur unless appropriate. UPDATE: System fix to process the state TPL file was completed on 6/22. A claim adjustment project has been initiated to reprocess claims that have denied incorrectly due to third party liability. Additional information regarding targeted adjustment completion date will be provided when available. UPDATE: An estimated completion date for the adjustment project is 9/18. UPDATE: The targeted completion date for this project was moved up to 9/11/13.	Completed	The estimated completion date for the adjustment project is 9/11.	9/11/13

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4/1/13	93	Dental Providers	Dental providers are reporting customer service and support issues in working with Scion Dental.	UnitedHealthcare is working closely with Scion Dental to address and resolve a variety of provider-reported concerns. If you are experiencing concerns with your service level from Scion Dental, please contact David Rossi, COO of UnitedHealthcare, at 913-333-4006 or at david.rossi@uhc.com.	Completed	N/A	5/24/13
4/1/13	94	General Providers	Define when a prior authorization is and is not required when UnitedHealthcare is the secondary payer.	When UnitedHealthcare is the secondary payer, and the service being provided is a covered service under the primary payer, prior authorization from UnitedHealthcare is not required (we honor the authorization of the primary payer). When UnitedHealthcare is the secondary payer, and the provider knows the service being provided is not covered by the primary payer, then prior authorization is required.	Completed	N/A	4/1/13
4/2/13	95	Physical Therapy Providers	Concern expressed regarding the time it takes to get authorization for therapy services	As a reminder, providers may bill up to 12 physical therapy visits before a prior authorization is required. Providers may initiate therapy and submit the prior authorization request while the 12 visits are ongoing.	Completed	N/A	4/2/13
4/3/13	96	General Providers	Claims with 6 units billed for CPT Code 90472 are paying at 5 units rather than 6.	We identified this issue and have a process in place since March to eliminate these denials. Claims from January - March have were adjusted as of 5/16/13. If providers have identified any claims that have not been adjusted, they should work with their Provider Advocate to request the claims be adjusted.	Completed	Impacted claims were adjusted as of 5/16/13	5/24/13
4/4/13	97	General Providers	Clarification regarding when a prior authorization is required for participating and non-participating providers	UnitedHealthcare and Optum Behavioral Health do not require non-participating providers to obtain prior authorization for services that are not on the prior authorization list. If the service being provided is identified as requiring a prior authorization in the Provider Administrative Guide, both participating and non-participating providers are required to obtain a prior authorization. If the service does not require a prior authorization in the Provider Administrative Guide, authorization is not required for either participating or non-participating providers. This provision does not apply to United's subcontractors (LogistiCare, OptiCare and Scion Dental). Additional communication to providers to clarify this issue will be forthcoming.	Completed	N/A	4/4/13
4/4/13	98	General Providers	J7302 is not paying correctly when billed by mid level providers	When mid level providers have billed J7302, we have been inappropriately reducing the payment amount. This code should be paid at 100% of the Kansas Medicaid allowance when billed by mid level providers. This code has been set up to pay mid level providers at 100% of the Kansas Medicaid allowance as of 4/11/13. Impacted claims were identified and adjusted as of 5/6/13.	Completed	Impacted claims were identified and adjusted as of 5/6/13	5/24/13

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4/8/13	99	General Providers and Members	Does UnitedHealthcare cover trips from an Emergency Room back to a member's home, and if so, is this service available 24 hours a day, 7-days per week?	Yes. Through LogistiCare, we cover trips home from the Emergency Room and the trips will be arranged any time of day. We do request that you allow up to 3-hours for the ride, particularly those scheduled in the overnight hours. To arrange transportation, please call 1-877-796-5847.	Completed	N/A	4/8/13
4/8/13	100	HCBS Providers	How does UnitedHealthcare process the client obligation?	The client obligation amounts are received on a file from the state a few days before the end of the month. 1) The file is loaded and a report is generated to identify UHC members and their client obligation amount for the month 2) The Care Coordinator team assigns the client obligation to a provider - if the member was eligible the prior month, we assign to the same provider, if the member transitioned from another plan the prior auth history file is used to assign a provider, if the member is new to Medicaid, client obligation will be assigned once services are started - after the assessment has been completed 3) A mail merge file is generated and member and provider letters are generated defining the client obligation - this entire process takes several days to complete.	Completed	N/A	4/8/13
4/15/13	101	General Providers	Does UnitedHealthcare offer a translation service?	Yes. UnitedHealthcare does offer a translation service. It is available free of charge to members by calling our Member Services Center at (877) 542-9238 or, if arranged by a provider, by calling Provider Services, at (877) 542-9235. UnitedHealthcare uses LanguageLine Solutions. Members or Providers may call UnitedHealthcare to arrange for a translator, who will be available by telephone to assist, including providing support for members at physician appointments.	Completed	N/A	4/15/13
4/15/13	102	Nursing Facilities	Some nursing facility residents received subrogation letters. What should facilities advise their residents to do with these letters?	It has been brought to our attention that a limited number of nursing facility residents have received subrogation letters. These letters were sent in error and the members can disregard them. We are working to insure that these letters are not issued to nursing facility residents in the future.	Completed	N/A	4/15/13
4/15/13	103	General Providers	Why are claims being denied for incorrect POS when submitted through Clearing House?	We discovered recently that Emdeon put an edit in their system changing the Place of Service (POS) to 50 on claims coming to United (via Emdeon) causing the claims to deny for “incorrect POS”. We have spoken to Emdeon and they recognize that this was their issue and that they should not have put the edit in place. We sent them the claims we identified that they made this edit to and they are resubmitting on behalf of the providers by changing the POS back to the POS on the original claim. Once we receive the corrected claims from Emdeon, they should process through our system. Emdeon handles many claims processed via other Clearing Houses like ASK, etc.	Completed	Once Emdeon identifies claims and resubmits them to UHC with the correct POS, we will process them.	4/15/13

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4/17/13	104	General Providers	Claims have been paid by United as primary when another payer is the primary carrier, resulting in overpaid claims.	We experienced some issues in receiving and loading the member COB information. While the issue was being worked on, we elected to pay claims as primary rather than holding claims for the issue to be resolved, knowing the result would be the overpayment of some claims. Once the COB information is loaded and tested, we will adjust the overpaid claims. Providers do not have to request the claims be adjusted. UPDATE: Providers have been notified of the overpayments and claims have been adjusted. Any outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount. Providers should submit a check for the overpayments if they do not anticipate claim volume to offset the overpayment amount.	Completed	Outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount.	12/15/13
4/19/13	105	Infusion Providers	Is a pharmacy authorization required for enteral formula?	No, a pharmacy authorization is not required. Enteral formula is covered under the DME benefit, and a medical prior authorization is appropriate.	Completed	N/A	4/19/13
5/1/13	106	Hospitals with Long Term Care	Hospital payments for long term care services have been delayed.	Please see updated provided on issue #90	Completed	Please see update provided on issue #90	6/28/13
5/1/13	107	General Providers	Addresses for providers to utilize for communication with UnitedHealthcare are:	**To File Paper Claims:** KMAP PO Box 3571 Topeka, KS 66601-357`			
				To Submit a Reconsideration Request: UnitedHealthcare PO Box 5270 Kingston, NY 12401			
				To Submit a Claim Appeal (after reconsideration request) UnitedHealthcare Attention: Claim Appeals PO Box 31364 Salt Lake City, UT 84131-0364			
				To Submit a Provider Complaint: UnitedHealthcare Attention: Provider Complaint PO Box 31364 Salt Lake City, UT 84131-0364			
				Request for State Fair Hearing: Office of Administrative Hearing 1020 S. Kansas Avenue Topeka, KS 66212			

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				To Refund an Overpayment: Providers may submit refund checks to the following address: UnitedHealthcare PO Box 5230 Kingston, NY 12401 The check should be accompanied by the following information: member name, member Medicaid ID number, date of service, amount originally paid, amount overpaid, reason account is considered overpaid, claim number (if available), UID from recovery letter (if applicable) copy of remittance advice, name and telephone number of person submitted the refund in case questions arise. For convenience, a spreadsheet can be found on our website. The spreadsheet can be completed and mailed with the refund check to the above address. The overpayment refund spreadsheet can be found at www.uhccommunityplan.com. Click on For Health Professionals, select Kansas from the drop down box, and then click on the Provider Forms link.			
5/1/13	108	General Providers	Some providers, such as county health departments, that share a Tax Identification Numbers with other agencies or provider entities, need payments to be directed to each entity individually rather than being combined on one check and remittance advice for the TIN.	We put a process in place as of 4/18 to assist in making better selections when processing claims. Although this should resolve the majority of issues, some providers may continue to see claims process incorrectly. We continue to work on solving this issue for all providers. UPDATE: We have implemented a manual process for these claims effective 8/19 to reduce the incidence of claims processing to the incorrect provider. Claims processed in error will be adjusted and the target date for the additional adjustments will be posted when available. UPDATE: The estimated completion date for health department claims is targeted for 10/31/13. The adjustments were completed early on 10/18/13.	Completed	Claims were adjusted on 10/18/13	10/25/13

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5/10/13	109	General Providers	Providers are receiving denials with denial code N425 - Statutorily Excluded related to modifiers QK and QY billed with anesthesia services	We are investigating this issue and determining the root cause at this time. We will provide additional information regarding this issue following the completion of our research. UPDATE: Anesthesia services will pay at 100% of the KS Medicaid rate for network providers, and at 90% of the KS Medicaid rate for non-contracted providers after the continuity of care period. Modifiers should not change the amount UHC pays on anesthesia claims. All anesthesia claims must be billed with an appropriate anesthesia modifier. If no modifier is billed the claim will deny. The QY modifier is a non-covered service so claims billed with this modifier will deny as non-covered as state policy indicated anesthesia physicians may not bill for time when they are solely supervising a CRNA. Only direct patient time (face to face) may be billed. Although providers are required to bill correctly with appropriate modifiers, we are working to configure our system to process these claims appropriately. Additional information will be posted as it becomes available regarding system configuration completion dates and final claim adjustment dates. UPDATE: System configuration was completed on 6/26. Claim adjustment project is being initiated. A targeted adjustment completion date will be provided when available. UPDATE: The targeted adjustment completion date is August 16.	Completed	Adjustment project completed 8/1/13	8/23/13
5/10/13	110	Nursing Facilities	We identified this week that 96 nursing facilities are being paid room and board claims at 35% of the billed rate. This is due to a systems setup issue, and is impacting claims submitted since 4/30/2013. UPDATE: We identified this week 4 additional providers relative to the above issue. The system correction will be effective for these 4 additional providers on 5/31/13 and affected claims will be identified and adjusted for payment after the system fix is in place.	This issue has been given top priority and we are working to get the agreement IDs corrected as quickly as possible. All claims that paid at 35% will be automatically adjusted for payment (providers will not need to resubmit). UPDATE: The system fix for the original 96 providers was implemented on 5/21/13. The impacted claims are targeted to be adjusted by 6/19/13. UPDATE: All claims for the initial 96 providers identified have completed the adjustment process on 6/14/2013. We will provide a targeted completion date for the remaining providers when it is available. UPDATE: The claims adjustment project to adjust the claims for the remaining 4 providers has been initiated and is targeted for completion on 7/12/13. UPDATE: The claim adjustment project to correct the claims for the remaining 4 providers was completed on 7/5/13.	Completed	All claims were adjusted as of 7/5/13	7/12/13

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5/14/13	111	Home Infusion / DME Providers	What is United's policy on the rental vs. purchase of enteral pumps (i.e. if a patient will be using enteral nutrition for longer than 10 months, a pump will be purchased). And what is United's policy for a contingency plan for those patients with purchased pumps (i.e. if a patient has a pump that breaks in the middle of the night, what is the process?).	UHC policy indicates that if the member has a long term or lifetime need for an enteral pump and that need is supported by medical necessity, the purchase of the pump will be authorized. UHC is following the state's policy in regards to contingency plans for purchased pump breakage. A rental pump will be allowed when a purchased pump needs repair or is receiving yearly scheduled maintenance. If a purchased pump is broken beyond repair, a new pump will be approved for purchase. The provider will need to supply documentation indicating the broken pump cannot be repaired when requesting authorization for a replacement pump. The state provides coverage for two HCPCS codes for an enteral pump. B9000 and B9002. For rental pumps the prior authorization will be approved for the date range requested. If no specific timeframe is requested then the current prior authorization process is to approved for 90 days. All approvals are based on medical necessity.	Completed	N/A	5/14/13
5/14/13	112	Home Infusion / DME Providers	How long will the prior authorization for B9998 be effective, and will providers have to send in information every month. Under fee-for-service previously, the pricing could be matched to submitted claims for 6-12 months at a time.	When the prior authorization for B9998 is approved (including the pricing) it is effective for the dates requested by the provider. If no specific timeframe is requested then the current prior authorization process is to approved for 90 days. All approvals are based on medical necessity.	Completed	N/A	5/14/13
5/14/13	113	Home Infusion / DME Providers	What enteral codes require a prior authorization? Under fee-for-service previously, anyone over 21 years of age required an authorization. The codes in question are the B codes related to enteral nutrition (B4034, B4035, etc.).	For Medicaid and CHIP members, there is no specific prior authorization requirement for enteral nutrition codes. Prior authorization would only be required if the billed charges for these items is more than $500.00. Members who are on one of the HCBS waivers (LTSS Members) require prior authorization for all enteral nutrition codes regardless of the billed amount on these services. These services would not be covered for members who reside in facility that receives a per diem rate from UHC as enteral nutrition and all related services are considered part of the per diem payment made and would not be paid separately.	Completed	N/A	5/14/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
5/15/13	114	General Providers	Providers have been paid at the incorrect rate for the vaccine administration codes 90471 and 90472 for members 18 and younger. When will these claims be adjusted to pay at the correct rate?	We received a retroactive fee schedule adjustment for these codes and are loading the new rates. Because this issue relates to a large number of claims and these same claims will have to be adjusted again for the PPACA rate increase, the State has agreed to allow us to wait for the PPACA rate changes and to adjust these claims one time to include both the retroactive rate increase and the PPACA rate increase. UPDATE: At this time we believe all claims requiring adjustment relative to the PPACA rate adjustment are complete the with exception of RHC/FQHC claims. UPDATE: The initial project for RHC/FQHC claim adjustments completed 1/20/14. However, we are continuing the process of identifying any outstanding claims and will complete additional projects as necessary. In an effort to ensure we have captured all claims requiring adjustment, we continue to research and validate appropriate adjustments and will submit additional adjustments projects as claims are identified. We have additional adjustments projects in progress relative to PPACA adjustments, and anticipate their completion by 3/31/14. UPDATE: The estimated completion date for all claims is 4/15/14. UPDATE: While most of the adjustments are completed, we have several additional claim projects that need to be completed and the estimated completion date is 5/16/14. UPDATE: We have identified additional claims for adjustment, and are targeting a completion date on all PPACA related claim adjustment projects by 7/15/14. UPDATE: The targeted completion date for the remaining PPACA claim adjustments was moved 8/31/14. UPDATE: We have been monitoring the status of the remaining adjustments, and are completed with 96% of the outstanding adjustments at this time.	Completed	The PPACA claim adjustments were completed 8/20/14.	8/20/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
5/16/13	115	Ambulance Providers	Why are some claims for non-emergent transportation of a member via an ambulance being denied? Providers are being told these services have to be coordinated through LogistiCare.	We are researching and refining our process for how non-emergent transportation in an ambulance should be billed and paid. Additional direction will be posted by next week regarding this issue. UPDATE: The original process was to require hospitals and ambulance providers to authorize non-emergent ambulance transports through LogistiCare, our NEMT vendor. As a result of provider feedback, we have elected not to require authorization through Logistic are for ambulance transports to avoid additional administrative tasks for providers. However, additional system configuration is required to implement this change. Until that configuration is complete, claims filed with the ambulance transportation codes may not process correctly. Once the system configuration is completed, we will identify impacted claims and reprocess them for correct payment. For code A0428 - this code requires use of an appropriate ambulance modifier. For accurate payment of this code, providers who did not originally bill the code with an appropriate modifier will need to submit corrected claims to receive payment for those services. UPDATE: The adjustment project has been submitted and has a targeted completion date of 10/28/13. UPDATE: The adjustment project was completed early on 10/8/13.	Completed	The adjustment project has an estimated completion date of 10/28/13. Completed early on 10/8	10/11/13
5/23/13	116	DME Providers	Providers are reporting that when billing DME supplies using a date range, claims are being denied with the denial reason of "billed date pre-dates service date"	We are researching a resolution to this issue so we can allow billing of date ranges per state policy. UPDATE: At this time, for providers to receive payment when billing a date range, the claim will have to be filed on or after the last date on the claim. We are currently investigating other potential options relative to this issue and will communicate as more information becomes available. UPDATE: Research is complete and we are unable to accept future date billed claims. As a result, for providers to receive payment when billing a date range, the claim will have to be filed on or after the last date on the claim.	Completed	Providers may re-file claims with date ranges on our after the last date on the claim.	8/8/14
5/28/13	117	340B Pharmacy	Why are 340B claims denying for missing NDC?	340B claims have incorrectly denied for missing NDC. The NDC is not required on 340B claims. We have corrected the system and claims processed after Monday, 5/20 should not deny for this reason. No additional action is necessary on the part of the provider. Impacted claims are targeted for adjustment by 6/28/13. UPDATE: All claims impacted by this issue were adjusted on 6/24.	Completed	All claims were adjusted as of 6/24	6/28/13

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5/25/13	118	Hospitals / Sleep Study Providers	Why are claims for authorized sleep studies on children denying?	Sleep Studies are a covered service for children, with prior authorization. We've recently identified that some claims billed for these authorized services for children are denying in error. We are actively reviewing root cause and resolution. UPDATE: Claims denied for this service in error are currently being adjusted. UPDATE: A manual workaround was put in place 6/5 to ensure new day claims do not deny if a Prior Authorization is on file until the system is correct. Claims were adjusted as of 5/31.	Completed	A manual workaround was put in place 6/5 to ensure new day claims do not deny if a Prior Authorization is on file until the system is correct. Claims were adjusted as of 5/31.	6/28/13
5/29/13	119	Hospitals	Hospital providers are billing 41899 and the service is being denied	41899 is a covered service for hospitals and ambulatory surgery centers. The service has been denying in error. We have a system configuration fix targeted for 6/14/13. Once the system configuration is complete, claims denied in error will be identified and adjusted for payment. UPDATE: System fix was completed on 6/14. Claims for adjustment are being identified. A targeted adjustment date will be provided when available. UPDATE: The estimated completion date is July 26th.	Completed	The estimated completion date is July 26th.	8/2/13
5/31/13	120	Hospitals	Hospital claims for emergency department facility charges billed with an ET modifier are not processing correctly	The system was corrected on 4/10/13 to address this issue. The initial project to adjust claims was completed on 5/30/13. An additional project is underway to capture and adjust any additional claims. We do not have a targeted completion date at this time. UPDATE: Final adjustments were completed on 5/31/13.	Completed	Impacted claims were adjusted as of 5/31/13	6/14/13
5/31/13	121	Hospice Providers	Patient liability is not being applied appropriately to procedure code T2046	We are researching a resolution to this issue. We do not have a targeted completion date at this time. Once the system is corrected, we will identify impacted claims and reprocess them to accurately deduct the patient liability. UPDATE: The system configuration to correct this issue is complete. Claims for dates of service January - March were adjusted on 4/18/13. We are running a final project to adjust claims between April 1st and June 26th. The target completion date for the final adjustment project will be posted when available. UPDATE: At this time, we estimate the completion of these adjustments by mid-October based on our standard overpayment recovery process. UPDATE: We have identified very few claims impacted by this issue and have targeted their adjustment completion by mid-November.	Completed	Estimated completion date of mid-November based on our standard overpayment recovery process.	11/15/13

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5/31/13	122	HCBS Providers	Client obligation for HCBS claims is not always being deducted correctly.	We are aware we have intermittent issues with deducting the client obligation correctly for HCBS claims. Providers are encouraged to contact their Provider Advocate who can assist them with submitting these claims for adjustment.	Completed	Provider Advocates will request adjustments as claims are identified.	5/31/13
6/5/13	123	Pharmacy	How will claims from non-contracted pharmacies be paid for prescriptions required by children in foster care?	UHC will pay pharmacy claims at 100% of the Kansas Medicaid allowance for both contracted and non-contracted pharmacy providers (both in and out of state) relative to children in foster care. The pharmacy must contact Jennifer Murff with OptumRx at 913-333-4002 with notification that the pharmacy has an unpaid claim due to non-par status for a United Medicaid beneficiary in the Foster Care Program. 1) If a pharmacy is contracted with OptumRx but not contracted for the KanCare program - after validation, Optum will enter an authorization in the claim system so the claim can electronically process. 2) If the pharmacy is not contracted with OptumRx in any way - after validation, Optum will secure the prescription information (i.e. Universal Claim Form) from the pharmacy and will issue reimbursement through a manual check process.	Completed	N/A	6/7/13
6/5/13	124	Nursing Facilities	Why are nursing facility claims continuing to pay at the first quarter rates?	We have identified that our claims system was selecting the nursing facility room and board rate based upon the date of admission rather than the date of service in error. Because most beneficiaries' admission date is prior to the KanCare effective date of 1/1/13, the system was selecting the earliest rate which is the first quarter. The system configuration to correct this issue is complete. UPDATE: We have two outstanding adjustment projects relative to nursing facility claims. UPDATE: The targeted completion date for the first project has been moved to 9/30/13, and the completion date for the second adjustment project is 10/7/13. UPDATE: The adjustment project was completed early on 9/28/13.	Completed	Two adjustment projects are in process. The targeted completion date for the first adjustment project is 9/30/13 and the targeted completion date for the second adjustment project is 9/28/13.	10/3/13

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6/6/13	125	HCBS Providers	Why are authorizations for Money Follows the Person (MFP) services not in AuthentiCare?	MFP authorizations have stopped transmitting to AuthentiCare. The system fix to address this error has been identified and should be implemented within the next 3 weeks. Providers may contact their Provider Advocate for assistance with a billing work-around to facilitate payment for the MFP services until the authorizations can be transmitted to AuthentiCare. UPDATE: The system fix that will allow MFP authorizations to be transferred to AuthentiCare will be implemented by 6/17 so new authorizations after that date should transmit appropriately. The backlog of authorizations that have been pending for the system fix will be transmitted to AuthentiCare by 6/19/13. UPDATE: 6/21/13: This issue was corrected for all new authorizations on Friday 6/14/2013. All previous authorizations that had not been sent were transmitted to Authenticate and loaded on Wednesday 6/19/2013.	Completed	Providers can now bill claims for these services as authorizations are in place.	6/24/13
6/7/13	126	Hospice Providers	Will UHC consider changing its policy and not require a prior authorization for T2046?	As a result of requests from network providers, we are currently reviewing our policy to require a prior authorization for T2046. It is our intent to revise this policy and not continue to require prior authorization for the room and board billed by the Hospice provider when the member resides in a nursing facility. We are working to change system configurations and processes at this time. We do not have an effective date yet but will post it as soon as it is available. UPDATE: The system configuration is targeted for completion on 9/25/13. UPDATE: The system configuration was completed on 9/18/13 and the claims adjustments are targeted for completion on 10/30/13. UPDATE: The claims adjustments were completed early on October 2, 2013.	Completed	Claims adjustments targeted for completion 10/30/13. Completed early on 10/2/13	10/11/13
6/12/13	127	General Providers	How can providers receive a retroactive authorization for services when the member's eligibility was retroactively assigned and not in place on the date the services were rendered?	Providers should not request retroactive authorization for these services. Instead, providers should file the claim, and include documentation that confirms the eligibility was assigned retroactively along with documentation that demonstrates the medical appropriateness of the service that would be provided as part of a normal prior authorization process. The claim will be routed for review and consideration given the retroactive nature of the member's eligibility.	Completed	N/A	6/14/13

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6/14/13	128	School-based Service, Early Intervention, Local Education Agency and Health Start Providers	Why are some school-based services, Early Intervention Services ordered through an Individual Education Plan (IEP) or Independent Family Services Plan (IFSP), Local Education Agencies (LEAs), Head Start Facilities, and Part C of the Individuals With Disabilities Education (IDEA) Act claims being paid by United?	These services are not covered under KanCare and are being paid by UnitedHealthcare in error. The services should be billed to the state, and the state continues to be the appropriate payer of these services. We are in the process of researching why these claims are paying rather than denying as non-covered services. UHC will identify paid claims and will work with providers to refund payments made in error. UPDATE: The estimated adjustment completion date is December 15th based on our standard overpayment recovery process. UPDATE: The system configuration was completed ahead of schedule and was implemented into production on 8/5. New day claims will now appropriately deny if received. UPDATE: We have completed 92% of these claims adjustments. The remaining providers will have to submit checks for the overpayments as we will not have future claims to adjust the overpayments against. UPDATE: Providers have been notified of the overpayments and claims have been adjusted. Any outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount. Providers should submit a check for the overpayments if they do not anticipate claim volume to offset the overpayment amount.	Completed	Outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount.	12/15/13
6/14/13	129	PRTF	Why are claims not paying correctly for PRTF residents who are over the age of 17?	Corrections to the PRTF contracts are underway which will facilitate payment for members 18 & older in a PRTF setting. The contract changes were completed on 6/21/13 and system correction is expected to be complete by 7/30/13. In the interim, all claims with T2048 (PRTF) are being stopped and processed manually at the appropriate rate until the permanent fixes are in place. UPDATE: The system configuration was completed by 7/30/13 and claims have been adjusted as of 8/9/13.	Completed	The system configuration was completed by 7/30/13 and claims have been adjusted as of 8/9/13.	8/16/13
6/14/13	130	PRTF	It was reported that a PRTF is receiving payments at 40% of the expected payment amount.	This is the result of a provider set-up issue. We are reviewing and validating the provider set-up for each PRTF to ensure providers are paid at the appropriate rate. The target date for system correction is 7/30/13. In the interim, all claims with T2048 (PRTF) are being stopped and processed manually at the appropriate rate until the permanent fixes are in place. UPDATE: The system configuration was completed by 7/30/13 and claims have been adjusted as of 8/9/13.	Completed	The system configuration was completed by 7/30/13 and claims have been adjusted as of 8/9/13.	8/16/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
6/14/13	131	DME Providers	Are incontinent supplies (diapers) a covered benefit for adults?	Incontinent supplies (diapers) are not a covered service for adult members. UHC has issued some authorizations for this service in error as it is not a covered benefit. We will honor authorizations already issued for the service, but will not authorize any future services. Claims for dates of service with an authorization will be paid.	Completed	N/A	6/14/13
6/14/13	132	Orthodontist / Dental	What orthodontic services are covered by UnitedHealthcare?	Orthodontic services require prior authorization (PA) and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.	Completed	N/A	6/14/13
6/24/13	133	Nursing Facility	UHC identified a system issue causing claims to deny for prior authorization when using Revenue Code 101. Services billed with a 101 Revenue Code do not require prior authorization.	The system fix to prevent this from happening on new day claims will go in on 6/24/2013. All claims denied in error for needing a PA on revenue code 101 will be adjusted. A estimated completion date for that adjustment project will be provided as soon as available. UPDATE: System was corrected on 6/26 and all claims impacted by this issue will be adjusted by 7/8. UPDATE: Two projects were initiated. The first adjustment project was completed on 7/8/13. Final project targeted for completion by 7/15/13. UPDATE: Correction: The final project was submitted on 7/15 not targeted for completion on 7/15/13. A targeted completion date will be posted when available. We recently discovered some additional claims denied for this reason. The system was corrected on 7/19. A claims project will be submitted to adjust the additional denied claims and the targeted completion date will be provided when available. UPDATE: The estimated completion date for the second project is 8/15 which includes claims with dates of service from 6/24-7/2. An additional adjustment project for claims with dates of service 7/3 - 7/19 will be initiated. The targeted completion date will be posted when available. UPDATE: The estimated completion date is 8/22 for claims with dates of service 7/3 - 7/19. UPDATE: Adjustment projects were completed as of 8//16/13.	Completed	Adjustment projects were completed as of 8/16/13	8/23/13

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6/28/13	134	Hospice / General Medical Providers	How will UnitedHealthcare administer the Concurrent Care for Children program?	UHC will continue to pay medical and/or curative services not related to the terminal diagnosis for children on hospice. Hospice providers will continue to be responsible for coordination and payment of all services related to the terminal illness. Non-hospice (other medical providers) must coordinate with the hospice provider for children who have elected hospice. Prior authorization for all services not related to the terminal illness will no longer be required. Medical providers will be responsible for obtaining prior authorization for those services on the United prior authorization list that are not related to the terminal illness. No special modifier is required to bill for the medical services, and claims may be submitted electronically, online or on paper.	Completed	N/A	6/28/13
6/28/13	135	Rural Health Clinics	RHCs are not being paid the encounter rate for claims billed with place of service 32.	Per guidance from the state, UHC is evaluating additional place of service codes for which encounter payment should be allowed. We are investigating a solution for this issue. At this time we do not have a defined date for a system fix or a date for which claims will be adjusted. UPDATE: We have identified a solution and are working to update our system configuration. An estimated date of completion will be provided as soon as it is available. UPDATE: The estimated date of completion for the system configuration is 10/1. A targeted completion date for adjustments will be posted when available. UPDATE: The system configuration was completed on 9/16/13. New day claims will process correctly after this date. A claim adjustment project is being initiated the targeted completion date is 12/31/13. UPDATE: Although we continue to work on this project, claim adjustments were not completed by 12/31/13. The new targeted completion date for the claim adjustment project is 2/21/14. UPDATE: The claim project completed early on 2/12/14.	Completed	Completed early on 2/12/14	2/12/14

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6/28/13	136	Hospital / General Medical Providers	Claims are being paid by Optum Behavioral Health even though there is not behavioral health diagnosis or procedure code on the claim.	Based on our initial research, this appears to be an individual provider load issue. If you are experiencing this issue, please report it to your Provider Advocate so we can research to ensure provider set up is appropriate. UPDATE: The system configuration to correct this issue will be completed on 10/24/13. After the configuration is complete, an adjustment project will be initiated. A targeted completion date will be posted when available. UPDATE: We were unable to move the configuration solution into production due to unexpected testing results. An estimated correction date will be posted when available. UPDATE: This issue had 2 components. The first component that impacted lab claims was resolved on 10/28/13 which includes new day claims and claims adjustments. The second component being researched revealed their was no payment impact on claims processed by Optum Behavioral Health versus United Healthcare Community Plan. If providers have identified claims that paid inappropriately or that denied in error relative to this issue, please notify your Provider Advocate.	Completed	TBD	11/4/13
6/28/13	137	Laboratories / Hospitals	Coverage of genetic testing	There is a new state policy indicating codes related to genetic testing are now covered under Kansas Medicaid. The state policy was implemented at United on 4/15. We are researching why claims are still denying as non-covered services. Please note, all codes related to genetic testing require medical necessity documentation at the time of claim submission. If claims were submitted without medical documentation, the denial would be appropriate until the medical documentation is received. UPDATE: It was determined claims were denying appropriately due to lack of medical documentation. Providers who received denials may resubmit claims with required documentation.	Completed	N/A	7/17/13
7/5/13	138	General Providers	For providers who receive electronic remittance advices (835 transaction), the internal United subscriber ID was provided rather than the Kansas Medicaid ID number on electronic remittance advices generated after 6/22/13.	Historically, UnitedHealthcare has returned the member's Kansas Medicaid ID number on Electronic Remittance Advices (ERAs). On 6/22/13, a system change was implemented in error that resulted in the Kansas Medicaid ID number being replaced with the member's UHC subscriber ID. This may result in some providers experiencing difficulties or inability to electronically post payments related to these ERAs. The correction will be effective on Monday, 7/8/13. ERAs generated on 7/8/13 and after will be corrected and will include the Kansas Medicaid ID number for UHC members. UPDATED: System fix was implemented as scheduled.	Completed	N/A	7/12/13

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7/5/13	139	General Providers	UHC was not initially pricing COB claims using the correct state of KS pricing methodologies for both Medicare primary and Commercial primary claims resulting in incorrect payments to providers.	United has implemented a manual process to correctly price these claims while a permanent system fix is being investigated. Claims that were paid in error will be identified and reprocessed. More information will be provided when available. UPDATE: The adjustment project is scheduled to be initiated in stages. Letters will generate between 8/14 and 9/20 with an estimated completion date for the project between 11/1 and 12/15 UPDATE: We have completed 94% of these adjustments. 45 claims are outstanding as the providers do not have enough current claim volume to recoup the overpayments against at this time. UPDATE: Providers have been notified of the overpayments and claims have been adjusted. Any outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount. Providers should submit a check for the overpayments if they do not anticipate claim volume to offset the overpayment amount.	Completed	Outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount.	12/15/13
7/11/13	140	Hearing Aid Providers	Hearing aids are being denied for members over the age of 21.	All members are eligible for this benefit. The age limitation configuration for hearing aids was corrected on 6/21/13. Prior authorization is required on hearing aids per the Provider Administrative Guide. Claims that denied in error will be identified and adjusted. A targeted adjustment date will be posted when available. UPDATE: The targeted completion date for the adjustment project is 9/18. UPDATE: The adjustments for these claims were completed early on 8/26/13.	Completed	Claims were reprocessed by 8/26/13	9/3/13
7/11/13	141	Hearing Aid Providers	Hearing aids are not being reimbursed at the correct rate.	The system allowance was corrected on 6/21/13. Prior authorization is required on hearing aids per the Provider Administrative Guide. Claims paid at the incorrect rate will be identified and adjusted. A targeted adjustment date will be posted when available. UPDATE: The targeted completion date for the adjustment project is 9/18. UPDATE: The adjustments for these claims were completed early on 8/26/13.	Completed	Claims were reprocessed by 8/26/13	9/3/13

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7/12/13	142	General Providers	Vaccine administration codes that are billed with the correct units are denying with a V77 denial code.	In the VFC provider communication previously posted to the UnitedHealthcare Community Plan Portal, providers were instructed to bill a $0.01 charge on the state-supplied vaccination code, in addition to the appropriate code for administration of the vaccine. UnitedHealthcare has recently received examples where some providers are billing a $0.00 charge on the state-supplied vaccination code, causing the maximum units exceeded denial on the administration code (V77 denial). Providers will need to correct and re-submit their claims with a $0.01 charge for the claims to pay correctly. This is consistent with Federal Requirements relative to PPACA.	Completed	Providers will need to correct and re-submit their claims with a $0.01 charge for the claims to pay correctly.	7/12/13
7/17/13	143	General Providers	Claims billed with a J1050 are denying as a non-covered service in error.	This issue was corrected on 6/3/13. New claims after that date should process correctly. However, when the claim adjustment project to correct the claims denied in error was implemented, the claims were paid at the allowed amount and the lessor of logic was not applied resulting in overpayment. The overpaid claims will be identified and adjusted for payment. The targeted date for adjustment completion will be posted when available. UPDATE: The estimated adjustment completion date is targeted for December 1 based on our standard overpayment recovery process. UPDATE: Providers have reported this denial again for the J1050. We are researching the root cause for the new denials. UPDATE: The system configuration needed to eliminate these denials was completed on 10/18/13. The targeted completion date for claim adjustments is 12/12/13. UPDATE: This project for claims that denied in error completed early on 12/2/13. UPDATE: The adjustment project for the overpaid claims is 12% complete. For the majority of these claims, we are waiting for adequate claim volume from the providers to allow recoupment of the overpayment. UPDATE: Providers have been notified of the overpayments and claims have been adjusted. Any outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount. Providers should submit a check for the overpayments if they do not anticipate claim volume to offset the overpayment amount.	Completed	Outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount.	12/15/13

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7/17/13	144	General Providers	Claims billed with a J1050 are denying with an invalid place of service code denial.	We are correcting our system to remove the place of service restriction. A targeted completion date is not available at this time. UPDATE: The system configuration was completed on 7/26 so new day claims received after 7/26 should be processing correctly. A targeted claims adjustment date will be posted when available. UPDATE: As of 8/18 this issue has been closed. All claims should be adjusted. Provider should notify their Provider Advocate of any claims not adjusted for this issue.	Completed	As of 8/18 this issue was corrected.	8/23/13
7/17/13	145	HCBS Providers	Claims for adult day care that are billed with a 99 Place of Service code are denying as a missing/invalid place of service.	We are correcting our system to allow POS code 99 when billed with S5102. A targeted completion date is not available at this time. UPDATE: The adjustment project has been submitted and is targeted for completion by 8/16/13. UPDATE: The claims adjustment project was completed on 8/16/13.	Completed	Claims adjustment project was completed on 8/16/13	8/16/13
7/17/13	146	DME	We have a higher volume of claims denying for no prior authorization than we expected after the continuity of care period that ended on 5/31/13.	United had an authorization waiver in place during the continuity of care period to ensure claims were not denied when submitted without a prior authorization. As of 6/1 that authorization waiver was lifted and we are seeing some claims denying for no authorization that were not expected. We are researching the root cause of these denials. More information will be provided when the research is completed. UPDATE: Our initial research has indicated the primary providers impacted are DME providers. We are working to correct our system and once complete, we will identify the claims for adjustment. Please note - DME services with a total billed amount of $500 continue to require prior authorization. Claims identified for adjustment will include only those under the $500 threshold. A targeted adjustment timeframe will be provided when available. We continue to research other prior authorization related issues. UPDATE: The system configuration to correct this issue was completed on 9/23/13 so new day claims after this date will process correctly. UPDATE: The targeted completion date for this claims adjustment project is 11/15/13. UPDATE: Claims were adjusted early on 10/21/13.	Completed	Claims adjusted early 10/21/13	10/25/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
7/17/13	147	General Providers	All services provided to children in foster care should pay at 100% regardless of the providers network status with UHC (par and non-par).	We are making the necessary system changes to pay all providers at 100% for services rendered to children in foster care. Once system changes are completed, new day claims will process completely and an adjustment project will be initiated to adjust claims for providers who were not paid at 100% of the Kansas Medicaid fee schedule. UPDATE: The system configuration is completed. UPDATE: We were able to identify claims impacted by this issue. UPDATE: The underpaid claims relative to this issue were adjusted on 9/17/13.	Completed	Claims were adjusted by 9/17/13	9/20/13
7/17/13	148	General Providers	Newborn visited billed by physicians are being overpaid.	There was an error in the fee schedule resulting in these services being paid at 40% of billed charges rather than at the Medicaid fee schedule, resulting in claims being overpaid. Additional details regarding targeted dates for system correction and claim adjustment will be provided when available. UPDATE: The fee schedule correction was completed in April. We will initiate our standard overpayment recovery process to adjust the overpaid claims with paid dates prior to 4/22/13. The targeted completion date for recovery of overpayments 12/15/13. UPDATE: These overpayments are tied to one provider group. We are waiting for adequate claim volume from this provider to recoup the overpaid claims. UPDATE: Providers have been notified of the overpayments and claims have been adjusted. Any outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount. Providers should submit a check for the overpayments if they do not anticipate claim volume to offset the overpayment amount.	Completed	Outstanding overpayments are due to the providers not having adequate claim volume to offset the recoupment amount.	12/15/13
7/17/13	149	Nursing Facilities	Revenue codes 180 & 181 were not originally included in nursing facility contracts to allow payment. Facilities are receiving denials when billing these revenue codes as a result.	A contract amendment to add these services to facility contracts were mailed the week of 7/19/13. An adjustment project to identify and reprocess claims is in process. Targeted adjustment dates will be provided when available. UPDATE: An adjustment project has been submitted. An estimated adjustment completion date is 8/16/13. UPDATE: The claims were adjusted ahead of schedule and were completed on 8/9/13.	Completed	The claims were adjusted ahead of schedule and were completed on 8/9/13.	8/9/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
7/19/13	150	Hospitals / Physicians	Observation stays are being denied in error.	The root cause for these denials is being researched. Additional information will be provided as it becomes available. UPDATE: Research has indicated this is a provider billing issue related to the procedure code being utilized for an observation stay. Per KMAP policy, the only code allowed to be billed for observation stays is 99218. Claims billed with any other code were denied appropriately.	Completed	Claims billed with codes other than 99218 will have to be corrected and re-filed.	8/2/13
7/16/13	151	Hospitals	Pharmacy services billed on a hospital claim are denying in error.	The root cause for these denials is being researched. Additional information will be provided as it becomes available. UPDATE: It was determined through research that this was an individual provider billing issue and not a global issue.	Completed	Will work with individual provider to resolve.	8/16/13
7/25/13	152	DME	DME codes that are manually priced per state policy are not pricing correctly within UHC's system.	These codes were configured with UHC's standard default pricing which prices claims at 40% of the billed charges resulting in providers not getting paid as expected. UPDATE: The system configuration was completed on 11/15/13 and new day claims are processing correctly as of that date. UPDATE: When these claims were originally processed, they were either denied as non-contracted or were paid at an incorrect rate. When these claims are adjusted, if no invoice was submitted with the original claim, the claims will be denied and providers will be instructed to re-file the claim with the original invoice attached so we will have the information needed to manually price the claims. UPDATE: When reviewing the adjustment project, none of the claims had the necessary invoice, so adjustments could not be processed for additional payment. Providers who received an underpayment may submit a corrected claim with the invoice attached to receive the additional payment due for these claims. UPDATE: Our provider advocate team will reach out to the impacted providers by 1/17/14 to assist them with submitting corrected claims or reconsiderations. UPDATE: All providers impacted have been contacted by their advocate. This issue is being closed.	Completed	All providers impacted have been contacted by their advocate.	1/10/14
7/25/13	153	General Providers	Kan Be Healthy exams billed with the EP modifier are not paying according to the KMAP standard fee schedule.	The root cause is being researched. Additional information will be provided as it becomes available. UPDATE: It was determined through research that this is an individual provider issue and not a global issue.	Completed	We will work with the individual provider to resolve.	8/16/13

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7/25/13	154	Hospice	Some hospice providers are experiencing prior authorization related denials in error.	We know hospice providers are receiving denials related to how the prior authorizations are being loaded. The root cause is under investigation. Although the root cause is currently under investigation, it appears this relates to the type of prior authorization that is being submitted and the date ranges. UPDATE: We have decided to remove prior authorization requirements for all hospice services. The system configuration date to implement this change is targeted for 9/25/13. Once the configuration is complete, we will initiate a claims project to adjust hospice claims that denied for no prior authorization. UPDATE: The system configuration to remove prior auth requirements for all hospice services was completed on 9/18/13. Claims adjustments were completed early on 10/14/13	Completed	Claims adjusted as of 10/14/13	10/18/13
8/2/13	155	Anesthesia Providers	Clarification of billing requirement	All anesthesia services must be billed with an appropriate modifier. Providers are encouraged to review the UHC anesthesia billing policy at www.uhccommunityplan.com.	Completed	Corrected claims with modifiers are required.	8/2/13
8/2/13	156	Hospital Providers	Some newborn hospital claims are not paying at the appropriate rate.	Providers are reporting that the incorrect DRG is being assigned for some newborn claims. We are researching this issue and working on a resolution. UPDATE: As of 8/30/13, new day claims should have the appropriate neonate DRG assigned. Claims related to this issue will be adjusted after we correct the DRG issue in Item 161 of this log. UPDATE: Inpatient claims billed with a neonatal DRG are targeted for adjustment completion on 12/31/13. UPDATE: Claim adjustments were not completed on 12/31/13. We are actively working on this claim adjustment project and will post a new claim adjustment date when available. UPDATE: The targeted completion date for the claims adjustment project is 1/24/14. This adjustment project completed on 1/27/14.	Completed	This adjustment project completed on 1/27/14.	1/27/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
8/2/13	157	Hospital or ER Professional Providers	Emergent ER claims are being paid at the non-emergent rate.	Providers are reporting that emergent ER claims are being paid at the non-emergent rate. We are researching the root cause and will provide more information as it becomes available. UPDATE: It has been determined we are only considering the primary diagnosis code rather than both the primary and secondary diagnosis code to determine if a claim is emergent. UPDATE: The system configuration to correct this issue is scheduled for completion on 10/18/13. UPDATE: New day claims are processing correctly as of 10/18/13. The targeted completion date for claim adjustments in 12/31/13. UPDATE: The majority of new day claims began processing correctly on 10/18/13. However, some additional adjustments were made to correct isolated issues after that date. Providers may have continued to see claims process incorrectly from 10/18/13 through 11/15/13. UPDATE: This claim project completed early on 12/9/13.	Completed	This claim project completed early on 12/9/13.	12/9/13
8/9/13	158	Ambulance / Health Departments	What should ambulance providers or health departments do if a payment is received for a member who received services for a different county agency using the same tax identification number in error?	Our recommendation is that providers who receive the payment in error cash and post the checks received so there is record of the transaction. Please notify UHC of the issue. We are working on a correction process to process the payment to the correct county agency and will recoup the payments made to the wrong county agency in error. It is not recommended that providers return the checks or send refund checks.	Completed	Claims will be identified and adjusted to pay to the correct entity.	11/1/13
8/9/13	159	HCBS Providers	HCBS Providers are receiving authorization denials with denial codes UM1 and UM2 when an authorization is in place.	As of July 25, 2013, the error that was causing the inappropriate UM1 and UM2 denials has been fixed. A claims adjustment project for claims denied inappropriately has been created, and a target completion date for all claims adjustments impacted by the issue will be posted to this issues log as soon as possible. If you have any questions in the meantime, please contact your Provider Advocate. UPDATE: The initial adjustment project was completed 9/3/13. We will complete one additional adjustment project to ensure all claims impacted by this issue are adjusted. The estimated completion date for the final project will posted when available. UPDATE: The estimated completion date for the adjustment project is 10/30/13. UPDATE: Claims were adjusted early on 10/14/13.	Completed	Completion date for the adjustment project was 10/14/13.	10/25/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
8/16/13	160	General Providers	What is United's process for recovering overpayments?	We are required per our contract to notify providers in writing prior to initiating overpayment recoupments. When overpayments are identified, United will send a letter to the provider explaining the overpayment. If the provider takes no action once the letter is received, adjustments are held for 45 days prior to initiating recoupments. If the provider notifies United that they agree with the recoupments, the recoupments will be processed at that time. We encourage providers to notify United at the time the letter is received in order to expedite the processing of the recoupment.	Completed	N/A	8/16/13
8/23/13	161	Hospitals	Providers are reporting that we are not calculating DRG outliers correctly.	This issue is currently being researched and additional information will be provided when available. UPDATE: The system configuration to correct this issue was completed on 10/18/13. The targeted completion date for claims adjustments is 12/31/13. UPDATE: The targeted completion date for claims adjustments has been moved up to 11/29/13. UPDATE: The claim adjustment project completed early on 11/15/13.	Completed	The claim adjustment project completed early on 11/15/13.	11/15/13
8/28/13	162	Hospice Providers	Claims billed with service code T2042 are denying as invalid place of service when a valid place of service is being billed. Valid POS codes include 12, 31, 32, 34 and 14.	We have identified the system configuration changes needed to correct this issue. The implementation of those changes are in process. After the system configuration is completed, we will identify and adjust claims denied in error. UPDATE: The system configuration was completed on 12/9/13. The targeted completion date for the adjustment project is 2/1/14. UPDATE: The claim adjustments were completed early on 1/14/14.	Completed	The claim adjustments were completed early on 1/14/14.	1/14/14
9/6/13	163	Medical Practice Providers	Claims for professional services rendered in a nursing facility setting are denying for no prior authorization in error.	We are researching the root cause of this issue and will provide additional information as available. UPDATE: The system configuration was completed early on 10/14/13 and new day claims will process correctly as of this date. A targeted completion date for the claims adjustment is 12/1/13. UPDATE: The claim adjustment project was completed on 12/1/13.	Completed	Claim adjustment project completed on 12/2/13	12/2/13
9/6/13	164	Medical Practice Providers	Claims for professional services rendered in a hospital setting are denying for no prior authorization in error.	We are researching the root cause of this issue and will provide additional information as available. UPDATE: We confirmed as of 9/2/13 that the system configuration is now corrected and new day claims are processing correctly. A targeted completion date for the claims adjustment is 12/1/13. UPDATE: The claim adjustment project was completed on 12/1/13.	Completed	Claim adjustment project completed on 12/2/13	12/2/13

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9/6/13	165	DME	Procedure code A4554 (underpads) are being denied as non-covered in error.	The root cause of this issue is a UHC national policy that is not in line with state policy. Although we are working to address this issue, providers may bill underpads with the appropriate medical diagnosis in addition to an incontinence diagnosis to facilitate claims payment until the system issue is resolved. We are initiating the appropriate system configurations to resolve this issue. Additional information will be provided as available. UPDATE: The system configuration to correct this issue was completed on 9/23/13. A targeted completion date for claims adjustment will be posted when available. UPDATE: The estimated completion date for claim adjustments is 11/15/13. UPDATE: Claims were adjusted early on 10/15/13.	Completed	Claims were adjusted early on 10/15/13.	10/25/13
9/6/13	166	Behavioral Health	CMHCS are receiving denials when E&M services are billed on the same day as behavioral health therapy or case conference services	The root cause is related to a provider configuration issue. We have corrected the configuration on 19 of the 27 CMHCs and the remaining 8 will be completed on 9/13/13. UPDATE: As of 9/13 all CMHC provider configuration issues have been corrected and providers should not continue to see these denials. Impacted claims have been identified and adjusted.	Completed	System configuration is corrected and impacted claims have been adjusted.	9/13/13
9/6/13	167	Behavioral Health	Targeted case management services are denying for no prior authorization in error.	The system configuration to correct this issue is in process. Once the system configuration is completed, impacted claims will be identified and adjusted for payment. Targeted completion dates will be provided when available. UPDATE: The system configuration was completed 9/23/13. An adjustment project is being submitted and the targeted completion date will be posted when available. UPDATE: Claim adjustments were completed on 9/30/13.	Completed	Claims adjustments were completed on 9/30/13.	10/3/13
9/6/13	168	Behavioral Health	Community psychiatric supportive treatment services are being subjected to an incorrect benefit limitation of 2 per year in error.	The system configuration to correct this issue is in process. Once the system configuration is completed, impacted claims will be identified and adjusted for payment. Targeted completion dates will be provided when available. UPDATE: The system configuration was completed 9/17/13. An adjustment project is being submitted and the targeted completion date will be posted when available. UPDATE: Claims impacted by this issue were adjusted by 9/18/13.	Completed	Claims were adjusted by 9/18/13	9/27/13
9/6/13	169	Behavioral Health	Procedure code S5110 is denying for invalid place of service in error.	The system configuration to correct this issue is in process. We are reviewing a daily report to manually ensure these services process correctly until the system is updated. Claims that initially denied have been adjusted for payment. UPDATE: The manual process was implemented as of 7/15/13 to ensure new day claims are not denied in error. Claims historically denied have been adjusted.	Completed	Claims historically denied have been adjusted	9/16/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
9/6/13	170	Behavioral Health	Medicine checks and individual behavioral therapy services performed on the same day are denying as content of service in error.	The root cause is related to a provider configuration issue. We have corrected the configuration on 19 of the 27 CMHCs and the remaining 8 will be completed on 9/13/13. UPDATE: As of 9/13 all CMHC provider configuration issues have been corrected and providers should not continue to see these denials. Impacted claims have been identified and adjusted.	Completed	System configuration is corrected and impacted claims have been adjusted.	9/13/13
9/6/13	171	Medical Practice Providers	In some cases, when providers are billing VFC vaccines for reporting purposes only with a $0.01 charge, they are being paid $0.01 in error. The vaccine code should not have an allowance as only the administration code is allowed.	We have determined the root cause of this issue and are working on the system configuration correction. These claims will not be adjusted if the overpayment is below our claims adjustment threshold of $10. UPDATE: As of February 15, 2014 UHC is no longer paying on the VFC vaccines and claims are correctly being processed at $0 payment. UPDATE: Additional review indicates we do have claims where the overpayment exceeded the $10.00 adjustment threshold. Claims that paid more than $10.00 on the VFC vaccine code will have the overpayment recouped in accordance with our standard overpayment recovery process. Provider will receive overpayment notification letters. UPDATE: The anticipated completion date for overpayment recovery is 7/21/14. UPDATE: Overpayment recovery completed on 7/21/14.	Completed	Provider will receive overpayment notification letters. The completion date for overpayment recovery was 7/21/14.	7/21/14
9/16/13	172	DME	Claims for DME services should be exempt from all Medicare Part B editing. This is based on a policy clarification UHC received from the state on 8/26/13.	Per the policy clarification UHC should be exempting DME services from Medicare Part B editing. We are working on the system configuration needed to implement this change. A targeted completion date for the system configuration and appropriate claims adjustment projects will be posted when available. UPDATE: The system will be fixed by 10/1/13 for this issue. The targeted completion date for claims adjustments is 12/31/13. UPDATE: The adjustment project completed early on 12/12/13.	Completed	Claim adjustments were completed early on 12/12/13	12/12/13
9/20/13	173	Medical Practice Providers	Providers billing newborn home visit services using codes 99502, H1000, H1005 are denying for no prior authorization in error.	These codes were set up to require a prior authorization in error. We are working on the system configuration update to remove these codes from the prior authorization requirement and will submit an adjustment project after the system configuration is completed. UPDATE: The system configuration was completed early on 10/14/13 and new day claims will process correctly as of this date. The targeted completion date for the claims adjustment project is 12/1/13. UPDATE: The claim adjustment project was completed on 12/1/13.	Completed	Claim adjustment project completed on 12/2/13	12/2/13

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
10/3/13	174	Medical Practice Providers / General Providers	Non-participating providers are receiving denials for services that are not on the prior authorization list.	Non-participating providers are subject to the same prior authorization list as participating providers. Services that are not on the prior authorization list should not be denying for prior authorization. The system configuration is in process to correct this issue. A targeted configuration completion date will be posted when available. UPDATE: The targeted completion date for system configuration is 11/5. UPDATE: The configuration was completed early on 10/28/13. Issues were discovered in testing impacting claims billed with a modifier. Additional configuration will need to be completed for those claims to process correctly. For claims billed with no modifier, adjustments are in process and a targeted completion date will be posted when available. UPDATE: For claims that were billed WITHOUT a modifier that denied for no prior authorization in error, the claims adjustment project is targeted for completion on 12/12/13. UPDATE: The claims project for claims billed WITHOUT a modifier completed 12/2/13. The system configuration necessary to process claims billed with a modifier was completed 12/31/13 so new day claims are processing correctly, and a date for claims adjustments will be posted following completion of the system configuration. UPDATE: We discovered a few codes were missed in this project. Additional configuration to include those codes is underway and the system configuration is targeted to complete 1/20/14. UPDATE: The system configuration completed early on 1/13/14. The targeted completion date for claim adjustments is 2/28/14. UPDATE: The adjustment project completed early on 2/26/14.	Completed	The adjustment project completed early on 2/26/14.	2/26/14
10/3/13	175	Medical Practice Providers	The Value Added Service for school or sports physicals are denying when not billed by the member's primary care physician.	Our initial policy relative to this Value Added Service indicated the school or sports physical would be covered when provided by the member's PCP. We have updated our configuration to allow this Value Added Service to be billed by other providers as well. The system configuration to allow payment to non-PCPs for this service was completed on 9/30/13. Information relative to possible claims adjustments will be provided when available. UPDATE: Impacted claims were adjusted on 10/28/13.	Completed	Claims were adjusted on 10/28/13	11/1/13

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10/3/13	176	Medical Practice Providers	Per state policy, school or employment physicals should be billed using an E&M office visit procedure code. Some of these services are being denied.	We are researching the root cause of this issue and will post additional information when available. UPDATE: The system has been corrected for E&M code 99212 when billed with V703. Additional E&M codes are being configured to be allowed when billed with V703. A claims project for claims billed with 99212 is being initiated and a targeted completion date will be posted when available. UPDATE: The targeted completion date for this claims adjustment project is 11/25/13. UPDATE: The claims relative to this issue were adjusted early on 11/6/13.	Completed	The claims relative to this issue were adjusted early on 11/6/13.	11/8/13
10/3/13	177	General Providers	CPT code 36415 should deny as content of service per state policy. Some claims for this service are being paid.	This code should deny as content of service. We are researching the root cause of this issue and will post additional information when available. UPDATE: The system configuration to correct this issue is targeted for completion on 12/11/13. Since this incorrect configuration resulted in claims overpayments, once the configuration is corrected we will utilize our standard overpayment recovery process to adjust the claims. These claims were all overpaid, and will be handled in accordance with our standard overpayment recovery process for claims with a paid amount over $10. Claims that do not meet that threshold will not be adjusted. UPDATE: With the timing of the overpayment recovery process steps, the estimated completion date for the overpayment recovery process is 5/1/14. All claims paid at a dollar amount under our overpayment threshold, so no additional action will be taken on these claims.	Completed	All claims paid at a dollar amount under our overpayment threshold, so no additional action will be taken on these claims.	1/31/14
10/11/13	178	Hospital	State policy allows for payment of cochlear implant surgery (69930) and the cochlear implant (L8614) on the same date of service.	United has denied the L8614 as content of the cochlear implant surgery in error. We are working on the system configuration to correct this issue and the completion date is targeted for 12/15/13. Claims denied for this reason to date were adjusted as of 10/11/13.	Completed	Claims identified to date were adjusted on 10/11/13	12/15/13
10/11/13	179	DME	Diabetic test strips (A4253) are denying for maximum frequency per day exceeded in error.	The system configuration was corrected on 9/7/13 to address this issue. The estimated completion date for claim adjustments is 11/15/13. UPDATE: This item is specific to A4253 and the denial for maximum frequency per day exceeded in error. The system was corrected on 9/7/13 and all impacted claims completed adjustment on 11/12/13.	Completed	Adjustments completed 11/15/13	1/3/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
10/18/13	180	Medical Practice Providers and Hospital Providers	United is inappropriately bundling lab services into code 80050 and then is denying 80050 as non-covered.	We are working to correct our system configuration to address this issue. A targeted completion date will be posted when available. UPDATE: The system configuration to correct this issue was completed on 11/11/13. A targeted completion date for adjustments will be posted when available. UPDATE: The overpayments relative to this issue will go through our standard overpayment recovery process; providers will receive an overpayment letter. The adjustment project for the underpaid claims is targeted for 2/28/14. UPDATE: The adjustment project for the underpayments completed early on 2/12/14. The overpayments are scheduled to be adjusted by 6/30/14 in accordance with our overpayment recovery process. UPDATE: Providers who were overpaid relative to this issue should see the recoupments on their remittance advices. Adjustments were completed on 4/10/14.	Completed	Providers who were overpaid relative to this issue should see the recoupments on their remittance advices. Adjustments were completed on 4/10/14.	4/10/14
10/18/13	181	Hospital	State policy indicates when hospitals bill fetal stress tests are always content of service to the observation room.	Currently UHC is paying for the fetal stress test and denying the hospital observation stay rather than paying the observation stay and denying the fetal stress test as content of service. The system configuration to correct this issue is scheduled to be completed on 11/4/13. After the configuration is completed, a claims project will be initiated and a targeted adjustment completion date will be posted when available. UPDATE: The state has clarified their policy is to pay the fetal stress test and deny the observation when billed on the same day by the same provider. Per this clarification, we are configuring our system to be consistent with the state policy as described above. A targeted date for system configuration and claim adjustments will be posted when available. UPDATE: The targeted completion date for the system configuration is 3/31/14. A date for adjustments will be posted when available. UPDATE: The system configuration completed early on 2/5/14. The targeted adjustment completion date is 3/28/14. UPDATE: The claim adjustment project completed early on 3/6/14.	Completed	The claim adjustment project completed early on 3/6/14.	3/6/14

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11/1/13	182	Medical Practice Providers and Hospital Providers	ER E&M codes, observations codes, and surgery code are not processing and paying correctly.	This appears to be related to content of service logic that is being applied in error. We are still researching the solution to this issue. UPDATE: The majority of claims we have reviewed processed accurately applying appropriate content of service methodology. We continue to research the state's global surgery policy to ensure we are in line with expectations. System configuration and any necessary adjustment timeframes will be posted when available. UPDATE: The research on this issue is complete and we are processing claims in accordance with state policy. United will outreach to providers to discuss national correct coding and correct modifier usage when billing ER, observation and surgery.	Completed	The research on this issue is complete and we are processing claims in accordance with state policy.	1/24/14
11/11/13	183	Hospice Providers	Yearly hospice rate updates	The new hospice rates were loaded by UHC on 10/22/13. The adjustment project submitted returned no claims identified for adjustment.	Completed	No claims were identified for adjustment.	11/11/13
11/11/13	184	General Issues for all Providers	Spenddown amount on provider remittance advice.	We should be returning Spenddown amounts with a PR 178, however we do have examples from providers where these amounts are being returned with a CO 45. We have received examples and are in the process of researching why this is occurring. The root cause is still under investigation. UPDATE: The system configuration request has been submitted. At this time we don't have an estimated completion date but will post it when available. Our initial research indicates claims are processing with a PR 178 applied to the spenddown amount. Providers are encouraged to report examples to their Provider Advocate if they are experiencing this issue. UPDATE: The system configuration is targeted for 8/23/14. UPDATE: The system configuration was completed on 8/23/14.	Completed	The system configuration is targeted for 8/23/14.	8/29/14
11/11/13	185	Medical Practice Providers	RHC/FQHC payment when there is primary insurance involved	RHC/FQHC providers should be paid up to their state encounter rate when claims are processed secondary to a primary insurance. Currently, UHC is applying standard lessor of coordination of benefit logic, resulting in secondary claims being underpaid. This issue should be corrected for new day claims as on 10/15/13. A targeted completion date for adjustments will be posted when available. Providers should disregard any refund letters they are receiving relative to this issue at this time. UPDATE: The targeted completion date for adjustments is 2/28/14. UPDATE: The adjustments completed early on 2/4/14.	Completed	The adjustments completed early on 2/4/14.	2/4/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
11/11/13	186	Lab/ Radiology Providers	Lab claims are denying for invalid or inactive CLIA certification.	System configuration was updated to ensure we were processing claims in line with CLIA requirements. When this edit was turned on it resulted in a larger number of claims denying for invalid or inactive CLIA on file. We believe this is partially being caused by UHC not having the CLIA certificate loaded to all provider records correctly. This is being researched. Some of these denials are valid as the provider does not have current CLIA on file with UHC. While this issue is being researched, an estimated complete date for system configuration and claim adjustment is not available. UPDATE: New day claims should process correctly as of 11/27/13. An estimated completion date will be posted when available. UPDATE: The estimated completion date for claim adjustment is 2/5/14. UPDATE: This project was completed early on 1/20/14. We are doing some additional validation and will complete additional adjustment projects if additional claims are identified. A very small number of claims were identified that were not adjusted, and we expect those claims to complete adjustment by 2/28/14. UPDATE: The adjustment project completed early on 2/27/14.	Completed	The adjustment project completed early on 2/27/14.	2/27/14
11/11/13	187	General Issues for all Providers	Claims are denying for invalid billing address	We have determined that our system is trying to match billing address (physical address) to the provider Remit Address in our system. Currently if this does not match, the claim denies. We are investigating the possibility of reviewing additional addresses on the provider file to get an address match in order to reduce the number of address denials. This would allow providers to continue to have a PO BOX in our system and eliminate the need for completing address updates to impacted provider records. More information will be provided when available. UPDATE: We have added additional steps in our process which should remediate this issue, as long as the address filed on the claim matches one of the addresses United has on file for the provider. Claims denied for invalid billing address will be identified and adjusted. A targeted completion date for the adjustment project will be posted when available. UPDATE: The targeted completion date for the claims adjustment project is 4/4/14. Please note: The estimated completion date for the claim adjustment project is now 3/14/14. UPDATE: The claim adjustment project completed early on 3/12/14.	Completed	The claim adjustment project completed early on 3/12/14.	3/12/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
11/11/13	188	Hospitals	Procedure code 99070 and 99070 ET are denying content of service in error	Provider are reporting prior to 1/1/13 they were paid for 99070 and 99070 ET in addition to surgery and emergency room evaluation and management codes. We are researching this issue as language in the KMAP hospital manual indicates that all supplies are included in the surgery or ER E&M code. We are working with the state to verify appropriate policy. UPDATE: The state has issued a policy clarification to the MCOs indicating that 99070 ET will be allowed when billed with a surgery. Our system configuration project has been updated to reflect this clarification and the configuration completion is targeted for 3/1/14. UPDATE: Per state clarification, this update cannot be put into place until 6/16/14. We will post a targeted completion date following the policy implementation in June. UPDATE: The system configuration was completed on 6/16/14. This is not a retroactive policy - so there are no claims projects associated with this change.	Completed	The system configuration was completed on 6/16/14. This is not a retroactive policy - so there are no claims projects associated with this change.	6/16/14
11/11/13	189	Hospice Providers	Hospice procedure code T2046 is denying in error as being non-covered	When we loaded the new 2014 hospice rates, procedure code T2046 was removed from the agreement in error. UPDATE: System configuration was completed on 11/15/13 and new day claims processed after that date will pay correctly. UPDATE: The targeted completion date for the claim adjustment project is 2/21/14. UPDATE: The adjustment project completed early on 2/5/14.	Completed	The adjustment project completed early on 2/5/14.	2/5/14
11/15/13	190	Medical Practice Providers	Providers are reporting prior authorization denials for Evaluation and Management codes (99201-99601). This includes both par and non-par providers.	These codes were originally configured to require prior authorization in error. The system configuration to correct this issue was completed on 11/4/13. The claim adjustment project is targeted for completion on 12/12/13. UPDATE: This claim project completed early on 12/2/13.	Completed	Claims adjusted early on 12/2/13	12/2/13

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12/6/13	191	Hospital Providers	Critical Access Hospital only - issue related to how United is are applying the cost adjustment factor	In some cases, it appears United is calculating the cost adjustment factor and then applying the lessor of logic in error. It appears this is only impacting a limited number of outpatient claims. We are working on the system configuration needed to correct this issue and a targeted completion date will be posted when available. UPDATE: The estimated completion date for the system configuration is 1/31/14. The targeted completion date for adjustments will be provided after the system configuration is completed. UPDATE: The system configuration completed early on 1/16/14. The targeted completion date for the adjustment project is 4/7/14. UPDATE: The claim adjustment project completed early on March 3, 2014. If hospitals have questions regarding their adjusted claims, they are encouraged to contact their Provider Advocate for assistance.	Completed	The claim adjustment project completed early on March 3, 2014.	3/3/14
12/20/13	192	Pharmacy	Pharmacy providers have reported claims are denying for COB in error.	The TPL/COB file sent by the state to UHC was not being used by our pharmacy partner. They loaded the file 10/25 and realized the TPL/COB information did not load correctly, resulting in pharmacy claims denying for TPL/COB in error. Optum RX backed out the TPL/COB file so claims would no longer deny. TPL information has now been loaded and effective 2/3/14, OptumRx will begin editing claims for TPL. Pharmacy providers will need to follow standard protocol if claims are denied and the pharmacy believes that is an error. The call center staff can assist providers with questions relative to TPL issues. Pharmacy claims that were overpaid due to not applying third party liability editing will be remediated through a post pay billing process with the primary insurance.	Completed	Not applicable	2/21/14

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1/3/14	193	Hospital Providers	Yearly DRG rates effective 10/1/13	These rates were loaded as of 12/15/2013. A project has been submitted for claims adjustments. UPDATE: The overpayments relative to this project have been submitted and will go through the standard overpayment recovery process with an estimated completion timeframe of 6/30/14; impacted providers will receive overpayment letters. The underpaid adjustments have been submitted and the targeted completion date for the adjustment project is 3/17/14. UPDATE: The underpayment adjustments completed early on 2/26/14. The overpayments will be handled in accordance with standard overpayment recovery processes which is targeted for 5/23/14. UPDATE: The overpayment recoveries were completed as of 5/23/14.	Completed	The overpayment recoveries were completed as of 5/23/14.	5/23/14
1/3/14	194	Medical Practice Providers and Hospital Providers	Clarification regarding when the sterilization consent form must be submitted with claims	The surgeon performing the sterilization procedure is responsible for obtaining a complete and accurate Sterilization Consent Form. United will use the consent form when processing all sterilization-related claims. However, it is recommended other providers billing services related to sterilizations, including hospitals, obtain a copy of the Sterilization Consent Form from the surgeon PRIOR to the service being performed to validate the form is completed and correct. If a claim is submitted prior to a valid consent form being on file with United, the claim will be denied and the provider will be responsible for resubmitting a valid claim after the sterilization consent form is on file. No sterilization related claim can be paid without a valid and accurate Sterilization Consent Form on file with United.	Completed	N/A	1/3/14

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1/10/14	195	Medical Practice Providers and Hospital Providers	PRTF - Planned versus Unplanned Service	For medical claims for youths in a Psychiatric Residential Treatment Facility (PRTF), if the diagnosis on the claim is categorized as “planned” per State policy, the claim is payable by United. Medical claims for youths in a PRTF with an "unplanned" diagnosis code per State policy should have been denied by United so the provider can receive reimbursement from the State. As of 12/15/13, our system is configured to deny the claims with "unplanned" diagnosis codes. We are currently identifying those claims paid during 2013 in error as these claims are overpaid. The overpayments relative to this project will go through the standard overpayment recovery process with an estimated completion timeframe of 6/30/14; impacted providers will receive overpayment letters and will need to refund United and then seek payment directly from the State. UPDATE: The estimated completion date for overpayment recovery was moved to 6/20/14. UPDATE: The claim overpayment project completed on 6/19/14.	Completed	The claim overpayment project completed on 6/19/14.	6/19/14
1/10/14	196	Medical Practice Providers	Coverage of an additional influenza procedure code (90686).	This code was implemented into our system on 12/9/2013 retro-active to 8/1/2013. A claims adjustment project has been submitted and is estimated to be completed on 2/28/2014. UPDATE: The adjustment project completed early on 2/11/14.	Completed	The adjustment project completed early on 2/11/14.	2/11/14
1/10/14	197	Medical Practice Providers	Coverage of Additional Onabotulinumtoxin A Procedure Codes (52287 and 64615).	These codes were implemented into our system on 12/31/2013 retro-active to 1/01/2013. A claims adjustment project has been submitted, an estimated date of completion for the project will be provided when available. UPDATE: After evaluating the adjustment project, we identified these claims were paid at a rate that exceeds the Medicaid fee schedule rate resulting in overpayments. The overpayments will be handled through our standard overpayment recovery process and providers will receive notification letters. The estimated date for completion of overpayment recoveries is 6/20/14. UPDATE: The overpayment for this issues was resolved as of 4/7/14. All overpayments have been recovered.	Completed	The overpayment for this issues was resolved as of 4/7/14. All overpayments have been recovered.	4/7/14

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1/10/14	198	General Providers	There was a printing error and some Kansas providers received a duplicate check printing.	Duplicate reimbursement checks were mailed the week of December 17th as the result of a printing error in which single checks were printed twice. Providers should cash one of the two identical checks they received and should remove any second (duplicate) posting of the check/payment from patient accounts, if applicable. Please shred or destroy the duplicate check(s). If you already deposited both checks to your bank, the bank will only honor one check. However, our treasury department is working daily reports to ensure that duplicate checks are not cashed in error. To avoid this error in the future, additional reconciliation steps and supervisor signs-offs are being added to our processes. We apologize for any inconvenience this issue may have caused. If you have any questions, please contact your local UnitedHealthcare Network Management Representative or Hospital and Facility Advocate, or call Provider Services at 877-842-3210.	Completed	N/A	1/10/14
1/17/14	199	Hospital Providers	2014 updates to cost adjustment factors for Critical Access Hospitals	The system configuration to update the new Critical Access Hospital cost adjustment factors was completed prior to the 1/1/14 effective date. Claim adjustments will not be required relative to this change.	Completed	Claim adjustments will not be required relative to this change.	1/17/14
1/17/14	200	Behavioral Health Providers and HCBS Providers	Inclusion of Positive Behavioral Support services into KanCare	Our system was configured to accommodate the inclusion of PBS services into KanCare as of 1/13/14. There were no claims identified for adjustment.	Completed	There were no claims identified for adjustment.	1/17/14
1/17/14	201	Nursing Facility and HCBS	2014 rate changes for ICF/MRs	These rates are retroactively effective back to 10/1/13 based on the Federal fiscal year. The rates were loaded in our system on 1/14/14 retroactive to 10/1/13. An adjustment project is being submitted and the estimated completion date is 3/7/14. UPDATE: These adjustments were completed early on 2/19/14.	Completed	These adjustments were completed early on 2/19/14.	2/19/14

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1/17/14	202	General Providers	Timely Filing	On 12/4/13, UnitedHealthcare elected to temporarily bypass timely filing edits in an effort to assist providers with completion of their claims impacted by various claim issues. In addition, we have identified all claims that have denied for timely filing and are submitting an adjustment project to reprocess these claims. The targeted completion date for claims adjustments is 2/28/14. UPDATE: Professional claims relative to timely filing denials are targeted for adjustment by 2/28/14. Institutional claims adjustment are targeted for completion on 3/31/14. UPDATE: Adjustments for professional claims completed early on 2/10/14. Institutional claims are still targeted for adjustment by 3/31/14. UPDATE: The claim adjustment project completed early on March 3, 2014.	Completed	The claim adjustment project completed early on March 3, 2014.	3/3/14

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1/17/14	203	Hospice Providers	Physician recertification for additional hospice care	Our current process is for providers to submit a physician recertification statement with the first claim for dates of service following the initial 180 day coverage period. We then use the physician recertification statement for all claims submitted during the 60 day coverage period. A new physician certification statement is then required for each additional 60 day coverage period. Based on provider feedback, our intention is to remove the requirement for providers to submit the physician recertification statement with claims. The system configuration to accommodate this change will take 60-90 days. Until the configuration is effective, providers will need to continue to submit the physician recertification statement for the first claim submitted for each additional 60 day period. This change in policy will not be effective when the system configuration is completed and the policy change will not be retroactive. UPDATE: The system configuration is targeted for 3/19/14. Once confirmed completed, providers will not have to submit physician recertification statements for the additional 60 day coverage periods for future claims submitted after the configuration change. UPDATE: The system configuration completed early on 3/17/14. As a result, any claim received 3/17/14 will no longer require the physician recertification statement to be submitted for claim payment. Claims submitted prior to 3/17/14 will still require a physician recertification statement to be on file.	Completed	Not applicable	3/21/14

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1/24/14	204	General Providers	Paper Remittance Advices are not being automatically mailed to providers effective 1/1/2014.	As part of Administrative Simplification, the Committee on Operating Rules for information Exchange requires that all health insurers offer EFT (electronic funds transfer) and ERA (electronic remittance advices) to all providers as of 1/1/14. As a result, paper remittance advices will no longer be automatically sent to providers. Providers now must be set up to receive both a paper check and a paper remittance advice. Providers may request they continue to receive a paper remittance advice by either calling 800-210-8315, faxing 800-985-5930 or emailing ERA_EFT_Requests@uhc.com with their request. Providers should be prepared to provide the provider Name and TIN and the request to reinstate the paper EOB/Remittance Advice. It will take approximately 5-7 working days for the system update.	Completed	Not applicable	1/21/14
1/24/14	205	General Providers	Procedure codes S0316 and S9460 will be exempt from NCCI Medically Unlikely Edits (MUE).	Effective 10/1/14, procedure codes S0316 (Disease Management Program, Follow-up/Reassessment) and S9460 (Diabetic Management Program, Nurse Visit) will be exempt from the NCCI Medically Unlikely Edits (MUE). This was configured in our system as of 12/16/13. A claim adjustment project has been submitted and the targeted completion date will be posted when available. No claims were identified for adjustment.	Completed	No claims were identified for adjustment.	1/31/14
1/24/14	206	General Providers	Procedure code T1502 will be exempt from NCCI Medically Unlikely Edits (MUE).	Effective with dates of service 1/1/13, procedure code T1502 will be exempt for NCCI Medically Unlikely Edits (MUE). This was configured in our system as of 12/16/13. A claim adjustment project has been submitted and the targeted completion date will be posted when available. No claims were identified for adjustment.	Completed	No claims were identified for adjustment.	1/31/14
1/24/14	207	General Providers	The state will utilize Medicare's Tier 1 pricing for codes in the 81200-81383 range effective 1/1/13.	Effective with dates of service 1/1/13, the state will utilize Medicare's Tier 1 pricing for the coverage of select molecular pathology/gene analysis codes in the range of 81200-81383. This was configured in our system as of 12/16/13. A claim adjustment project date will be posted when available. UPDATE: The anticipated claim adjustment date was moved up to 4/4/14. UPDATE: The claim adjustment project completed early on 3/19/14.	Completed	Claim adjustment project completed on 3/19/14.	3/19/14

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1/24/14	208	Nursing Facilities and DME Providers	Custodial Care Facilities and DME providers are exempt from filing claims to Medicare Part B prior to filing claims to UHC.	Effective with dates of service 1/1/13, the following types of providers are exempt from filing claims to Medicare Part B prior to filing claims to UnitedHealthcare: Custodial Care Facilities and DME providers. This was configured in our system as of 10/1/13. The claims adjustments relative to this issue were completed on 12/12/13.	Completed	Adjustments were completed on 12/12/13	1/24/14
1/24/14	209	General Providers	United will process claims in accordance with state algorithms for Medicare primary and non-Medicare primary claims.	Effective with dates of service 1/1/13, United will ensure all COB claims are processed in accordance with state algorithm when Medicare is primary and when a non-Medicare payer is primary. The final system configuration adjustments relative to these algorithm were completed on 12/15/13 and claims related to this issue were adjusted by 12/31/13.	Completed	Adjustments were completed by 12/31/13.	1/24/14
2/7/14	210	Transportation Providers	United currently requires non-emergency ambulance transport services to be prior authorized for claims payment.	United has elected to reverse this policy retroactive to 1/1/13. The system configuration for this policy change is targeted for completion on 2/26/14. Once the system configuration is completed, an adjustment project will be submitted to adjust non-emergency claims denied for no prior authorization. A targeted adjustment completion date will be posted when available. UPDATE: The system configuration was completed early on 2/10/14. The targeted completion date for adjustments will be posted when available. UPDATE: The anticipated claim adjustment date was moved up to 4/4/14. UPDATE: The claim adjustment project completed 3/31/14.	Completed	The claim adjustment project completed 3/31/14.	3/31/14

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2/7/14	211	Hospital Providers	Removal of the prior authorization requirement for normal newborn inpatient admissions as long as the inpatient length of stay is less than 4 days.	United has elected to remove the prior authorization requirement for normal newborn inpatient stays as long at the length of stay is less than 4 days. The system configuration to implement this change is targeted for completion on 3/12/14. The policy change will be made retroactive back to 1/1/13. When the system configuration is complete, a claim adjustment project will be submitted and a targeted adjustment completion date will be posted when available. UPDATE: The system configuration for this issue has been in place since 1/1/2013. However, the waiver for the prior authorization requirement is conditional upon providers entering a code within one of the following ICD-9 CM procedure code ranges in field 74 of the UB04: 7200 - 7499 or 7540 - 7592. We will still proceed with an adjustment project to re-process any normal newborn hospital claims that denied for no prior authorization. UPDATE: The targeted completion date for claim adjustments was moved up to 4/15/14. UDPATE: This adjustment project completed early on 3/24/14.	Completed	This adjustment project completed early on 3/24/14.	3/24/14
2/7/14	212	Hospitals and Medical Practice Providers	Non-high tech radiology procedures are denying for prior authorization in error.	We have identified that some non-high tech radiology procedures are denying for no prior authorization in error. The system configuration to correct this issue is targeted for completion on 3/5/14. After the configuration is completed, and adjustment project will be submitted and the adjustment completion date will be posted when available. UPDATE: The system configuration date was moved out to 3/12/14. UPDATE: The system configuration was completed on 3/12/14 so new day claims will process correctly as of this date. A targeted completion date for claim adjustments will be posted when available. UPDATE: The targeted adjustment date for adjustments is 5/1/14. UPDATE: The claim adjustment project completed early on 4/2/14.	Completed	The claim adjustment project completed early on 4/2/14.	4/2/14

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2/8/14	213	Dental Providers	Dental providers may be experiencing claim overpayments for claims processed between 1/31/14 through 2/7/14.	Claims processed between 1/31/14 and 2/7/14 were paid at a rate above 100% of the Medicaid fee schedule in error. The configuration to correct this issue was completed on 2/7/14. Information regarding how overpayments will be handled will be posted when available. UPDATE: It was determined the overpayments would be handled through a recoupment process that was completed as of 2/14/14.	Completed	It was determined the overpayments would be handled through a recoupment process that was completed as of 2/14/14.	2/14/14
2/14/14	214	Targeted Case Managers	Per state policy, targeted case managers cannot be paid for day services (T2021) effective 1/1/14.	Effective with dates of service on and after January 1, 2014, Provider type 21 (Targeted Case Management) should no longer be allowed to be reimbursed for T2021. The system configuration to apply this requirement will be in place by 4/1/14. Once the system configuration is completed, any claims paid to targeted case managers for this service will require adjustment. Additional information will be provided at that time. UPDATE: Until the system configuration is completed, we are accommodating this policy through a manual claim process. We do not anticipate the need to adjust claims due to the manual process, but a determination will be made once the configuration is completed. UPDATE: As of 4/1/14, we are compliant with state policy and are ensuring Targeted Case Managers are not paid for T2021 (day services).	Completed	As of 4/1/14, we are compliant with state policy and are ensuring Targeted Case Managers are not paid for T2021 (day services).	4/1/14
2/24/14	215	Medical Practice Providers	Some Evaluation & Management codes are intermittently denying for no prior authorization in error.	These codes were configured as requiring a prior authorization in error. System configuration is in process to correct this issue. Claims will be adjusted once the configuration is completed, and a targeted claim adjustment date will be posted when available. UPDATE: The system configuration is targeted for completion on 3/12/14. A targeted claim adjustment date will be posted after the configuration is completed. UPDATE: The system configuration to address this issue completed on 3/12/14 and a targeted completion date for claim adjustments will be posted when available. UPDATE: The targeted completion date for claim adjustments was moved to 5/16/14. UPDATE: The claim adjustment project completed early on 5/2/14.	Completed	The claim adjustment project completed early on 5/2/14.	5/9/14

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2/24/14	216	General Providers	Claims billed with POS 03 (school) are denying in error for invalid POS.	The system configuration to correct this issue is in progress. Claims will be adjusted once the configuration is completed, and a targeted claim adjustment date will be posted when available. UPDATE: The system configuration is targeted for 4/2/14. A claim adjustment project will be initiated once the configuration is completed. UPDATE: The system configuration completed early on 3/24/14. The targeted completion date for claim adjustments is 5/9/14. UPDATE: The claim adjustment project completed early on 4/14/14.	Completed	The claim adjustment project completed early on 4/14/14	4/14/14
2/24/14	217	Medical Practice Providers	Yearly rate update for the anesthesia conversion factor	The annual updated was loaded in our system on 2/11/14 and we will provide the details on the claim adjustment project when they are available. UPDATE: The claim adjustment project is targeted for completion on 4/5/14. UPDATE: The claim adjustment project completed early on 3/6/14.	Completed	The claim adjustment project completed early on 3/6/14.	3/6/14
2/24/14	218	Behavioral Health Providers	Claims billed for code T2011 (PASSR) are being processed incorrectly	This code is not configured correctly in our system, and the system change to correct this issue is in process. Claims will be adjusted once the configuration is updated, and the targeted adjustment date will be posted when available. UPDATE: Additional discussion on this issue is required with our state partner. UPDATE: The state has agreed verbally that T2011 is a service paid by the state (not the MCOs). When a final written policy is received, we will update our system configuration accordingly. UPDATE: The system correction was completed on 4/6/14 and all the claims were set for recoupment as of 5/6/14.	Completed	The system correction was completed on 4/6/14 and all the claims were set for recoupment as of 5/6/14.	5/9/14

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3/7/14	219	Behavioral Health Providers	PRTF Room & Board claims (T2048) is subject to patient liability, but UHC has not been applying patient liability to this service code.	We are researching the system configuration required to ensure consistent application of patient liability to this service code. Additional updated will be provided when available. Claims relative to this issue are overpaid. UPDATE: The estimated completion date for the system configuration is 4/6/14. UPDATE: The system configuration to correct this issue was completed on 3/31/14. However, it will be a few weeks before we are able to initiate overpayment recoupment for impacted claims. UPDATE: The overpayment process has been initiated. Providers who were overpaid relative to this issue can expect to receive notification letters around 6/6/14. UPDATE: The estimated completion date for overpayment recovery is 8/1/14. UPDATE: The overpayment recovery related to this issue was completed on 8/1/14.	Completed	The estimated completion date for overpayment recovery is 8/1/14.	8/1/14
3/7/14	220	Hospice Providers	Patient liability is not consistently being applied to the Hospice Room & Board code (T2046).	We are researching the system configuration required to ensure consistent application of patient liability to this service code. Additional updated will be provided when available. Claims relative to this issue are overpaid. UPDATE: The estimated completion date for the system configuration is 4/6/14. UPDATE: We have validated our system configuration is correct, however, we have determined this issue is presenting itself when both the nursing facility and hospice have billed for the same member with overlapping dates of service. We are developing an approach to remediate this issue. Hospice and nursing facilities need to ensure they are not billing for the same dates of service. Additional information will be posted relative to claim adjustments when available. UPDATE: The targeted date for claim adjustments is 6/30/14. UPDATE: The claim adjustment project completed on 7/2/14.	Completed	The claim adjustment project completed on 7/2/14.	7/2/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
3/14/14	221	Hospital Providers	Critical Access Hospitals that are providing skilled nursing facility or swing bed services are not always being paid at the correct rate.	The UHC system is applying "lessor of" logic on some swing bed claims in error. We are researching the system configuration and provider loading solutions required to address this issue. More detailed information will be provided when available. UPDATE: The system configuration to correct this issue is targeted for 4/16/14. A targeted claim adjustment date will be provided after the configuration is completed. UPDATE: The system configuration to address this issue completed early on 4/7/14. UPDATE: The system configuration to address this issue completed 4/9/14 and new day claims are processing correctly as of that date. A targeted completion date will be posted for the claim adjustment project when available. UPDATE: Additional system configuration work is needed for claims to process correctly. The targeted completion date of the additional configuration will be posted when available. UPDATE: The targeted configuration date is 5/2/14. UPDATE: The system configuration was completed on 5/2/14. A targeted date for claim adjustment will be posted when available. UPDATE: The targeted date for claim adjustment is 6/30/14. UPDATE: The claims in the current project are on target for a 6/30/14 completion date, but this project is for skilled nursing facility claims only. A new issue log item was added to track the status of the swing bed claim adjustments (Issue Log Item #242) UPDATE: The nursing facility claims project completed on 6/16/14. The swing bed claim adjustment project is being tracked on Issue Log Item #242.	Completed	The nursing facility claims project completed on 6/16/14. The swing bed claim adjustment project is being tracked on Issue Log Item #242.	6/16/14

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3/14/14	222	Nursing Facilities	Second quarter Nursing Facility Rate updates	We are aware that Q2 nursing facility rates go into effect 4/1/14. At this time, we are waiting to receive the Q2 rates. Given the timeframe, we do not anticipate having the Q2 rates fully loaded prior to their 4/1/14 effective date. Nursing facility providers may elect to hold their claims for 4/1/14 and beyond dates of service until the rates are confirmed loaded to avoid working claim adjustments if they prefer. UPDATE: We received the Q2 nursing facility rates from the state on 3/17/14. The estimated completion date for the rate loading 4/18/14. Claims will be adjusted after the rates are loaded. A targeted adjustment date will be posted when available. UPDATE: Q2 nursing facility rates are fully loaded as of 4/14/14. UPDATE: We have confirmed all rates are loaded correctly, and are now determining if any claims were filed that require adjustment. UPDATE: We expect all claims impacted by Q2 nursing facility rate updates to complete adjustment 5/16/14. UPDATE: The claims adjustment project completed ahead of schedule on 5/9/14.	Completed	The claims adjustment project completed ahead of schedule on 5/9/14.	5/19/14
3/21/14	223	Pharmacy	Medicare Part D Copayment Assistance Update – CY 2014 - The Medicare Part D Copayment assistance amount was changed to $6.35. Effective with the implementation date for each MCO, retroactive to dates of service on and after January 1, 2014.	The maximum amount we can pay for Medicare Part D Copayment Assistance was changed to $6.35. The new rate was loaded in our system as of 1/30/14 and will be retroactively adjusted to 1/1/2014. Claims that processed between 1/1/14 and 1/30/14 will be adjusted. The targeted completion date for the claim adjustments is 4/21/14. UPDATE: The claim adjustment project completed early on 3/24/14.	Completed	The claim adjustment project completed early on 3/24/14.	3/24/14
3/21/14	224	Medical Practice Providers	Payment of 100% of Medicare Rates for Certain Primary Care Codes (PPACA PCP Bump Rates)	The updated PPACA rates were loaded on 2/25/14. Claims processed between 1/1/2014 and 2/25/14 will need to be adjusted to pay the appropriate 2014 PPACA rate. A targeted completion date will be posted when available. UPDATE: United will adjust claims that were underpaid. There will not be a project initiated to recoup overpayments resulting from the 2014 rate updates. A targeted completion date for the underpayments will be posted when available. UPDATE: The targeted completion date is 6/6/14. UPDATE: The claim adjustments completed early on 5/20/14.	Completed	The claim adjustments completed early on 5/20/14.	5/20/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
3/21/14	225	Medical Practice Providers and Hospital Providers	The January 1, 2014, version of the Medicaid NCCI practitioner and outpatient hospital procedure-to-procedure (PTP) edit files included six new edits which CMS has decided to delete in the April 1, 2014, version (v2014q2) of the edit files, retroactive to January 1, 2014.	The following codes will be deactivated effective with the implementation date for each MCO, retroactive to dates of service on and after January 1, 2014. Column I codes / Column II codes 1) 19282 / 1) 19281 2) 19284 / 2) 19283 3) 19286 / 3) 19285 4) 19288 / 4) 19287 5) 37237 / 5) 37236 6) 37239 / 6) 37238 United will process these changes following receipt of the Medicare file on 4/1/14, retroactive to 1/1/14. Claims that denied as a result of these deleted edits will be identified and adjusted for payment. The targeted completion date for the claim adjustments will be posted when available. UPDATE: The NCCI changes noted above were implemented in our system on 4/13/14. We located no claims that required adjustment.	Completed	The NCCI changes noted above were implemented in our system on 4/13/14. We located no claims that required adjustment.	4/3/14
3/31/14	226	Medical Practice Providers	Physicians sharing a TIN with an RHC or FQHC may experience denials when billing global OB codes.	The system configuration to correct this issue is being researched. In the interim, we are utilizing a manual process to identify and adjust claims impacted by this issue. UPDATE: Until the system configuration is completed to address this issue, we will periodically identify claims and submit them for adjustment. The first claim project is targeted for completion on 5/16/14. Providers may also work with their Provider Advocate to request individual claim adjustments. UPDATE: The first claim project completed early on 4/10/14. Until the system configuration is completed, we will continue to run periodic claim adjustment projects for claims impacted by this issue. UPDATE: We have identified a fix for our claim system, and the targeted completion date for the system configuration is 6/15/14. An additional claims project will be submitted once the system configuration is corrected. UPDATE: A second interim claim project has been initiated. The expected completion date for this project is 6/12/14. We will submit one final project after the system configuration is completed. UPDATE: The system configuration date was moved up to 6/9/14. The second interim claim project completed early on 5/30/14. No additional claims were found - issues closed as of 6/9/14.	Completed	The system configuration date was moved up to 6/9/14. The second interim claim project completed early on 5/30/14.	6/9/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
3/31/14	227	Home Health/Home Infusion Providers	Home health providers have been experiencing incorrect payments on procedure code S0316.	We are researching the system correction to address this issue and additional information will be posted when available. UPDATE: We have determined the code does have the correct rate on the fee schedule. The incorrect payments are provider specific and based on how the individual provider contracts were loaded. We have identified 39 providers with claims paid at an incorrect rate and are working with the network/contracting team to update the provider contracts in our system. Once this is completed, claims can be adjusted for these providers. UPDATE: We have completed 35 of the 39 provider contract updates in our system. As each individual provider's contract is corrected in the system, and individual claim project for that provider will be submitted. The status of the individual claim projects will be communicated with impacted providers on a case by case basis.	Completed	The final claim project completed - issue is closed	6/27/14
3/31/14	228	Home Health/Home Infusion Providers	Home Health providers have been experiencing additional administrative requests when billing procedure code 99600.	We are researching the system correction to address this issue and additional information will be posted when available. UPDATE: The system configuration to correct this issue is targeted for completion on 5/16/14. A targeted claim adjustment date will be posted when available. UPDATE: The system configuration completed early on 4/14/14. A targeted claim adjustment date will be posted when available. UPDATE: The targeted completion date for claim adjustments was moved up to 5/18/14. UPDATE: The claim adjustment project completed early on 4/30/14.	Completed	The claim adjustment project completed early on 4/30/14.	4/30/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
3/31/14	229	Targeted Case Managers	When T1017 for Targeted Case Management is billed, there are intermittent pricing issues resulting in the code not paying at the correct rate.	We are researching the system correction to address this issue and additional information will be posted when available. UPDATE: The system configuration to correct this issue has been submitted and escalated but we don't have an estimated date of completion at this time. UPDATE: The rate correction configuration was completed and the initial claim project completed early on 4/10/14. We will run an additional claim adjustment project to ensure all claims were captured and adjusted. UPDATE: The second claim adjustment project has been submitted for processing. The targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustments is 5/16/14. UPDATE: The claim adjustment project completed early on 5/1/14.	Completed	The claim adjustment project completed early on 5/1/14.	5/1/14
3/31/14	230	I/DD Waiver Providers	Some I/DD waiver claims have denied for an NPI in error for some atypical providers.	Claims should no longer be denying for this reason as we have a manual process in place to address this issue. We have identified claims that require adjustment, and the claims adjustments are targeted for completion no later than 4/16/14. UPDATE: The claim adjustment project completed early on 3/31/14.	Completed	The claim adjustment project completed early on 3/31/14.	3/31/14
2/17/14	231	Medical Practice Providers	UHC National Payment policy for DX and other restrictions is being applied to procedure code 92587 (Otoacoustical Emission Testing) in error	UHC's national payment policy is being applied to procedure code 92587 in error. The system configuration to correct this issue is targeted for 5/15/14. We have submitted an interim claim project to identify claims paid in error, and that initial claim project is targeted for completion on 5/6/14. A final claim project will be submitted once the configuration is completed. UPDATE: The initial claim adjustment project completed early on 4/14/14. An additional claim adjustment project will be initiated after the system configuration is corrected. UPDATE: The system configuration completed early on 5/5/14. A final claim project will be submitted to adjust any remaining outstanding claims, and a targeted completion date for the claim adjustment project will be posted when available. UPDATE: The final claims project completed ahead of schedule on 5/15/14.	Completed	The final claims project completed ahead of schedule on 5/15/14.	5/19/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
4/21/14	232	Hospital Providers	Critical Access Hospital claims for O/P services are being denied or identified for overpayment when the O/P services were billed separately from the I/P claim. Per KS policy CAH are the only type of hospital that are allowed to bill these services separately.	We are researching the root cause and solution to this issue. Additional information will be posted when available. UPDATE: We have submitted the system configuration project to correct this issue. The targeted completion date is 5/30/14. UPDATE: The targeted completion date for the system configuration was moved up to 5/15/14. A claim adjustment project will be submitted after the configuration is completed, and the claim adjustment completion date will be posted when available. UPDATE: The system configuration completed on 5/27/14. The estimated completion date for claims adjustments is 6/6/14. UPDATE: The claims adjustments completed early on 6/2/14. UPDATE: Providers are reporting this issue is re-occurring. Although the system was corrected on 5/28/14. However, the standard operating procedure document that is used to process pended claims was not updated appropriately. The request to have the standard operating procedure document has been submitted and the targeted date for completion is 9/5/14. Claims will be adjusted after the update is complete and the targeted claim adjustment date will be posted when available. UPDATE: The system configuration completed 8/22/14. The targeted completion date for claim adjustments will be posted when available. UPDATE: The estimated date for completion of the claim adjustment project is 10/3/14. UPDATE: The adjustment project completed early on 10/1/14.	Completed	The adjustment project completed early on 10/1/14.	10/1/14
4/21/14	233	Medical Practice Providers	Claims billed by Mid Level Practitioner's for Kan Be Healthy screens (services billed with an EP modifier) are being underpaid when the provider is PPACA eligible. These services should be paid at 100% and we are currently applying the Mid Level payment reduction in error.	The system configuration to correct this issue is in process. The estimated configuration completion date is 4/28/14. A claim adjustment project will be initiated after configuration is completed. UPDATE: The system configuration completed early on 4/23/14. The targeted completion date for claim adjustments will be posted when available. UPDATE: The claim adjustments completed on 5/8/14.	Completed	The claim adjustments completed on 5/8/14.	5/8/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
4/25/14	234	Hospitals and Nursing Facility Providers	Important notice for UB billers regarding attending provider requirement	To ensure HIPPA compliance, all UB04 claims must include the attending provider information on the claim beginning 4/23/2014. Any claim processed on or after 4/23/2014 will reject for missing attending provider if attending physician is not submitted on the claim. UB billers should immediately begin filing all UB04 claims with attending provider information to avoid claim rejections for missing attending provider. This will impact all providers billing on a UB04 claim form (paper or electronic) without exception. Please see the notice in the Bulletins section of our website (www.uhccommunityplan.com) for additional information.	Completed	N/A	9/2/15
4/25/14	235	Hospital Providers	Critical Access Hospitals are reporting secondary claims are being overpaid.	We identified an error in our coordination of benefits manual calculation process that was resulting in overpayments to Critical Access Hospitals. The process document was corrected effective 4/21/14 and claim processors attended a training session on 4/22/14. We believe the issue is resolved for new day claims. An overpayment recovery process will be initiated. Providers who do not wish to wait for the overpayment recovery process may refund overpayments as unsolicited refunds per the unsolicited refund process found on our website at www.uhccommunityplan.com at the Claims and Member Information link. UPDATE: The estimated completion date for all recoveries is 9/15/14. UPDATE: The outstanding claim recoveries were completed on 8/29/14.	Completed	The completion date for all recoveries was 8/29/14.	8/29/14
4/25/14	236	General Providers and Medical Practice Providers	Claims billed for PT/OT/ST are denying for PA before they hit the 12 limit threshold.	Providers should be allowed 12 visits of PT/OT/ST (12 for each type of therapy). Our system was counting those services together resulting in a Prior Authorization denial prior to the limit actually being hit. Our system was corrected on 4/8/2014. A claims project has been submitted to correct impacted claims. The targeted completion date for claims adjustments is 5/28/2014. UPDATE: The claim adjustment project completed early on 5/3/14.	Completed	The claim adjustment project completed early on 5/3/14.	5/3/14

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4/25/14	237	Indian Health Clinics	2014 yearly rate update for Indian Health Centers	Updated rates were received on 4/25/14 with a retro-active effective date of 1/1/2014. Rate updates were completed on 5/15/2014. A claim adjustment project has been submitted and the claim adjustment completion date will be posted when available. UPDATE: The estimated claim adjustment date is targeted for 6/23/14. UPDATE: The claim adjustments completed early on 5/29/14.	Completed	The claim adjustments completed early on 5/29/14.	5/29/14
5/12/14	238	General Providers	2Q updates to the Pricing of Molecular Pathology Codes	Updated rates were received on 5/12/14 with a retro-active effective date of 4/1/14. Rate updates were completed in our system on 5/14/14. A claims report ran to identify impacted claims found no claims impacted.	Completed	A claims report ran to identify impacted claims found no claims impacted.	5/19/14
3/19/14	239	General Providers	Medicare Rates for Primary Care Procedure Codes 99408 and 99409 - CY 2013	Procedure codes 99408 and 99408 were added for coverage on 2/1/14. These codes are eligible for the enhanced PPACA rate for eligible providers. The enhanced rates were loaded for these two procedure codes on 4/8/14. A claims report ran to identify impacted claims found no claims impacted.	Completed	A claims report ran to identify impacted claims found no claims impacted.	5/19/14
5/30/14	240	Nursing Facility Providers	Third quarter nursing facility rate updates	We received the Q3 rates from the state on 5/28/14. We are currently loading these rates in our system with a goal of completing the rate updates by 7/1/14. UPDATE: We are on target to have the third quarter rates loaded prior to 7/1/14. Rates were loaded prior to the 7/1/14 effective date.	Completed	Not applicable	6/27/14
5/30/14	241	Hospital Providers and Medical Practice Providers	Diagnosis Codes defined by the state as "sometimes" emergent for the purposes of ER down coding were not consistently configured resulting in ER codes being down coded when there was a "sometimes" emergent diagnosis code in the primary or secondary position.	We have submitted the system configuration to correct this issue. The targeted completion date for the system configuration will be posted when available. A claim project will be submitted after the system configuration is completed, and the targeted completion date for the claim adjustment project will be posted when available. UPDATE: The estimated completion date for the system configuration is 7/28/14. UPDATE: The system configuration completed early on 7/14/14. We are initiating the claim adjustment project. The targeted completion date for adjustments will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 9/12/14. UPDATE: The claim adjustment project was completed on 8/19/14.	Completed	The targeted completion date for the claim adjustment project is 8/19/14.	8/19/14

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6/6/14	242	Hospital Providers	Swing bed claims (TOB 18X) are being paid their correct per diem amount plus the CAH CAF. CAF should only be paid on acute I/P discharges.	We are currently determining the root cause of this issue and will submit required system configuration corrections when the root cause is identified. Claims will be adjusted after the system configuration is corrected. UPDATE: The targeted completion date for the system configuration is 7/31/14. A completion date for the claim adjustment target will be posted after the configuration is completed. UPDATE: The state of Kansas provided clarification on 7/11/14 that the Cost Adjustment Factor is applied to swing bed claims which is consistent with how United has been processing. As a result, this issue is closed.	Completed	The state of Kansas provided clarification on 7/11/14 that the Cost Adjustment Factor is applied to swing bed claims which is consistent with how United has been processing. As a result, this issue is closed.	7/11/14
6/6/14	243	General Provider	Our claims processing system is only reading the first modifier submitted on the claim. This results in claims being paid or denied incorrectly.	We are currently determining the root cause of this issue and will submit required system configuration corrections when the root cause is identified. Claims will be adjusted after the system configuration is corrected. UPDATE: The targeted system configuration date is estimated to be completed by 9/30/14. Claims with multiple modifiers are being worked through a manual review process currently, so we are not anticipating a claims adjustment project after we complete the system configuration. UPDATE: The targeted system configuration date is 10/31/14 for an effective date of 11/1/14 to be consistent with the state policy effective date. UPDATE: The system configuration completed early on 10/20/14. There are no claims identified for adjustment.	Completed	The system configuration completed early on 10/20/14. There are no claims identified for adjustment.	10/24/14
6/6/14	244	Behavioral Health / Substance Use Disorder Providers	Procedure code T1023 (Behavioral Health I/P screening) is denying for PA in error.	We have determined the root cause of this issue and are working on the system configuration correction. A claim project will be submitted after the system configuration is completed. UPDATE: After further research it has been determined that prior authorization is required for T1023 in a behavioral health setting. Claims are denying correctly. Optum Behavioral is doing education with providers. Providers with questions/concerns should contact their Optum Behavioral Health provider advocate.	Completed	Not applicable - prior auth required and claims denied correctly	6/13/14

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6/13/14	245	Behavioral Health / Substance Use Disorder Providers	Claims billed with procedure codes H0036 and T1017 may be denying in error for prior authorization (PA) when there is a PA on file for the member to receive additional units above the standard limit.	A system configuration ticket is in process to correct this issue. The estimated completion date for the system configuration is 6/25/14. A claim project will be submitted after the system configuration is completed. UPDATE: The system configuration completed early on 6/16/14. The targeted completion date for claim adjustments is 7/16.14. UPDATE: The claim adjustment project completed early on 7/8/14.	Completed	The system configuration completed early on 6/16/14. The claim adjustments completed early on 7/8/14.	7/8/14
6/13/14	246	Behavioral Health / Substance Use Disorder Providers	T1019 has 2000 unit limit (lifetime) prior to requiring a prior authorization (PA). At this time our system is denying T1019 for a PA before the 2000 units have been used.	A system configuration ticket has been submitted to correct this issue, and the estimated completion date will be posted when available. A claim project will be submitted after the system configuration is completed. UPDATE: The targeted completion date for the system configuration is 7/11/14. The estimated claim adjustment date will be posted after the system configuration is complete. UPDATE: The system configuration completed early on 6/24/14. As a result, new day claims should not deny for this reason. The claim adjustment project cannot be completed until issue #248 on this issue log is resolved. UPDATE: The targeted completion date for the claim adjustment project is 9/15/14. UPDATE: The claim adjustment project was completed 8/18/14.	Completed	The claim adjustment project was completed 8/18/14.	8/18/14
6/13/14	247	Behavioral Health / Substance Use Disorder Providers	Procedure code 90870 (ECT's) are not paying the correct rate for both facility and physicians.	We are researching the root cause of this issue. A system configuration correction will be submitted once the root cause is identified. Claims will be corrected following completion of the system configuration. UPDATE: Claims paid in error due to this issue are being adjusted as a special project while we continue to complete the system configuration. The targeted completion date for the initial claim adjustment project is 7/7/14. UPDATE: The claim adjustment project completed early on 6/24/14. The system configuration is still in process but we have implemented a process to catch and process claims correctly until the system configuration can be completed. UPDATE: The system configuration is targeted for completion on 8/8/14. UPDATE: The system configuration completed on 7/30/14. No additional claims were identified for adjustment, so all claims were adjusted by 7/30/14 as well.	Completed	System configuration and adjustments completed by 7/30/14	7/30/14

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6/6/14	248	Behavioral Health / Substance Use Disorder Providers	Behavioral health providers are reporting that individual, family, group therapy are denying when billed with a POS 12.	We have determined that claims are denying in error as requiring a prior authorization due to the services being billed with a Place of Service as Home (POS 12). A system configuration ticket is being submitted, and a targeted completion date will be posted when available. The targeted completion date for the claim adjustment project will be posted after the system configuration is completed. UPDATE: The system configuration is targeted for completion on 8/8/14. A claim project will be submitted after the system configuration is completed. UPDATE: The system configuration completed early on 7/15/14. The targeted completion date for claim adjustments is 9/15/14. UPDATE: The claim adjustments completed early on 7/28/14.	Completed	The claim adjustments completed early on 7/28/14.	7/28/14
6/20/14	249	Behavioral Health / Substance Use Disorder Providers	Behavioral procedure codes billed with non-behavioral V diagnosis codes may be denying as non-contracted for some providers.	A system configuration ticket is being submitted, and a targeted completion date will be posted when available. The targeted completion date for the claim adjustment project will be posted after the system configuration is completed. UPDATE: Behavioral procedure codes billed with non-behavioral V diagnosis codes may be denying as non-contracted for some providers. We have determined claims billed with diagnosis code 78099 are not denying as previously reported. We are manually identifying and adjusting claims so providers should not be experiencing denials while we correct our system configuration. UPDATE: The estimated completion date for the system configuration is 11/21/14. UPDATE: The system configuration completed on 11/11/14. There is no claim project applicable to this issue.	Completed	The system configuration completed on 11/11/14. There is no claim project applicable to this issue.	11/11/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
6/20/14	250	Behavioral Health / Substance Use Disorder Providers	We received the PRTF rates that are effective 7/1/14 from the state on 6/18/14.	The targeted completion date for loading the new rates is 8/1/14. At this time, we anticipate having to adjust claims related to the rate change. If possible, providers are encouraged to hold claims for dates of service 7/1/14 and after until confirmation of the completion of the rate loading is provided. This will avoid the need for providers to post both the initial payment and subsequent adjustments. For claims received prior to the completion of the rate loading, we will post the targeted completion date for adjustments when available. UPDATE: The new rates were loaded as of 7/28/14. No claims were identified for adjustment.	Completed	The new rates were loaded as of 7/28/14. No claims were identified for adjustment.	7/28/14
6/20/14	251	Behavioral Health / Substance Use Disorder Providers	We received the state mental health institution rates that are effective 7/1/14 from the state on 6/16/14.	The targeted completion date for loading the new rates is 8/1/14. UPDATE: The new rates were loaded on 7/10/14. No claims were identified for adjustment.	Completed	No claims were identified for adjustment.	7/10/14
6/27/14	252	Hospice Providers	The state of Kansas provided clarification that hospice services (T2042, T2043, T2044, T2045) are covered under Medicare Part A. Claims billed for these services for members who have Medicare Part A coverage will require a Medicare Part A remittance advice prior to processing by UHC.	We will update our system configuration to ensure claims are auditing for Medicare Part A as applicable by member. The targeted completion date for the system configuration is 7/28/14. UPDATE: The targeted system configuration date is now targeted for 8/13/14. UPDATE: The system configuration completed early on 8/6/14. This is not a retroactive change and as a result there is not an associated claim adjustment project.	Completed	Not applicable	8/6/14
7/11/14	253	Behavioral Health / Substance Use Disorder Providers	Substance Abuse codes H0004, H0005, H0006, and H0007 have a combined limit of 240 units per episode. At this time our system is set up with 60 unit limit, causing some claims to deny in error for units exceed unit limitation.	We are working to correct our system configuration to address this issue. A targeted completion date will be posted when available. UPDATE: The targeted completion date for the system configuration is 9/30/14. The targeted completion date for claim adjustments will be posted after the system configuration is completed. UPDATE: The targeted completion date for the system configuration has been moved to 10/22/14. UPDATE: The system configuration completed on time. Additional information on a claim adjustment project will be posted when available. UPDATE: No claims were identified for adjustment and this item is considered resolved.	Completed	No claims were identified for adjustment and this item is considered resolved.	10/31/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
6/18/14	254	Medical Practice Providers	Providers are reporting we are down coding critical care codes 99291 and/or 99292 when they are billed with POS 21 (I/P hospital). These codes should have ER down coding logic applied when billing in a POS 23 (ER)	We are working to correct our system configuration to address this issue. A targeted completion date will be posted when available. UPDATE: The targeted completion date for the system configuration is 8/15/14. The targeted completion date for claim adjustments will be posted after the system configuration is completed. UPDATE: The targeted completion date for the system configuration was moved to 9/1/14. UPDATE: The system configuration was completed on 9/1/14. A claims project is being submitted and the targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustment project 10/3/14. UPDATE: The claim adjustment project completed early on 10/1/14.	Completed	The claim adjustment project completed early on 10/1/14.	10/1/14
7/18/14	255	Dental Providers	Our dental vendor (SCION) is not currently receiving TPL information on our members. This may result in dental claims being paid as primary when the claims should edit for other insurance.	We have submitted the necessary request to have our system changed to correct this issue. A targeted completion date will be posted when available. Providers are encouraged to ensure the primary payer EOB is submitted with claims (when applicable) to facilitate accurate claim processing. UPDATE: The estimated date of completion for the system configuration with Scion is April 11, 2015. UPDATE: The system updates were completed as scheduled on 4/11/15. At this time, Scion is evaluating the claims review that is needed now that they have access to all COB information. An update on the status of the claims review will be provided when available. UPDATE: The estimated date of completion of the overpayment recoupment process is 12/18/15.	In Process	The estimated date of completion of the overpayment recoupment process is 12/18/15.	7/31/15

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
7/18/14	256	DME Providers	Procedure code E0570 (Nebulizer) is not pricing at the correct rate. Providers are being underpaid for this code.	The system configuration ticket to correct this issue has been submitted. The targeted completion date for the system configuration will be posted when available. The anticipated date for claim adjustments will be posted after the configuration is completed. UPDATE: The system configuration to correct this issue was completed on 7/22/14. The targeted completion date for the claim adjustment project will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 9/5/14. UPDATE: The adjustment project completed on 8/22/14.	Completed	The targeted completion date for the claim adjustment project is 8/22/14.	8/22/14
7/25/14	257	Nursing Facility Providers	Nursing facilities have requested some verbiage addition to our Member Handbook relative to covered benefits for nursing facility residents.	We will add the following clarification on page 24 in the Long Term Care / Nursing Facility Services section: “If you have qualified for Long-Term Care/Nursing Facility Services, please note that other benefits listed in this handbook may not apply. You will need to review the “Long-Term Care/Home and Community-Based Services supplement” This will help to clarify for both members and providers that once a member is admitted to a nursing facility, many benefits or services outlined in the regular member handbook become the responsibility of the nursing facility as part of the daily rate paid to nursing facilities for the members' custodial care. To find a complete list of services to be provided as part of the nursing facility daily payment, please reference the State Nursing Facility/Intermediate Care Facility provider manual.	Completed	Not applicable	9/2/15

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8/8/14	258	HCBS Providers	We are having an issue with HCBS claims denying for A04 (not covered) or A12 (non-contracted) in error.	This issue appears to be related to some recent configuration updates for HCBS providers. We believe the configuration will be updated by 8/13/14 to address this issue. UPDATE: The system configuration put into place did not resolve all issues, we are continuing to research for identification of other causes for this denial. UPDATE: New day claims processed after 8/29/14 should process correctly and not experience an A04 or A12 denial, with the exception of TCM services (T1017) billed for members who are either on the DD waitlist or are DD eligible but not on the DD waiver. UPDATE: A claim project has been submitted to capture claims inappropriately denied for A04 or A12 that have not already been adjusted. We are continuing to work on a solution for TCM provided to members on the DD waitlist or who are DD eligible. The targeted completion date will be posted when available. UPDATE: The targeted completion date for claim adjustments is 10/31/14. UPDATE: The claim project completed early on 10/9/14.	Completed	The claim project completed early on 10/9/14.	10/9/14
8/22/14	259	Hospital Providers	Code 99070 (with no modifier) is denying when it is being billed by itself or with other ancillary services. Per KMAP policy, this code should pay in this situation.	We are researching the root cause of the issue at this time, and will provide additional information on correct timeframes when available. UPDATE: A system configuration ticket has been submitted to correct this issue. The targeted completion date is 10/1/14. A claims project will be submitted once the system configuration is completed. UPDATE: The system configuration completed early on 9/17/14. The claim adjustment project is being submitted and the targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 10/31/14. UPDATE: The claim project completed early on 10/9/14	Completed	The claim project completed early on 10/9/14	10/9/14

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8/29/14	260	General Providers	Some Physician and Hospital providers are reporting service are being denied as non-contracted in error when a Behavioral Health diagnosis is submitted on the claim.	We are researching the root cause of the issue at this time, and will provide additional information on correct timeframes when available. UPDATE: The targeted completion date for the system configuration is 11/14/14. UPDATE: The system configuration completed early on 10/20/14. The targeted completion date for the claim adjustment project will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 12/31/14. UPDATE: The claim adjustment project completed early on 12/19/14.	Completed	The claim adjustment project completed early on 12/19/14.	12/19/14
9/12/14	261	Nursing Facility Providers	Q3 NF (rates effective 7/1/14) rate changes: The original rates we received from KDADS were incorrect. Correct rates were received on 8/25/14.	The corrected rates are fully loaded as of 9/11/14. A claim project was submitted to adjust claims to the corrected rates. The targeted completion date for the claim adjustments will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 10/24/14. UPDATE: The targeted completion date for the claim adjustment project has been revised to 11/21/14. UPDATE: The claim adjustment project completed early on 11/3/14.	Completed	The claim adjustment project completed early on 11/3/14.	11/6/14
9/19/14	262	Hospital Providers	Effective with processing dates on and after September 2, 2014, retroactive to discharge dates on and after October 1, 2013, the Out of State Outlier CCR is 0.544394 and the correct DRG rate is 3,723.	All Out of State hospital inpatient claims with a discharge date of 10/1/13 through 8/25/14 were overpaid due to an incorrect DRG base rate. Impacted providers should have received our standard overpayment recovery letter regarding this issue. We expect overpayments to be recovered no later than 11/1/14. UPDATE: The overpayment recoveries are targeted for completion by 12/15/14.	Completed	The overpayment recoveries are targeted for completion by 12/15/14.	12/15/14
9/19/14	263	General Provider	Between the dates of 9/1/14 and 9/17/2014 some providers received claims denials with an denial reason code of "service not covered" in error. This was due to incorrect system configuration.	Effective 9/17/14 our system was corrected to address this issue. Claims received between 9/1 and 9/17/14 were impacted. A claim adjustment project is being submitted and the targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 10/31/14. UPDATE: The claim adjustment project completed early on 10/9/14.	Completed	The claim adjustment project completed early on 10/9/14.	10/9/14

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9/29/14	264	HCBS Providers and Targeted Case Management Providers	Posted update regarding the Continuity of Care Period	As part of the implementation of the Intellectual and Developmentally Disabled Waiver (I/DD) into the KanCare program, the State of Kansas instituted a continuity of care period. This period was designed to ensure there were no service disruptions by having MCOs waive the need for prior authorizations for the provision of member care through July 31, 2014. UnitedHealthcare has extended that period through the end of September, but please note it will be ending on October 1, 2014, and all I/DD waiver services and targeted case management services will need to have a prior authorization in place for a claim to be approved. If you have any questions please contact your provider advocate which is listed on our website or call our provider services line at 877-542-9235. Additional information about the program and any subsequent changes may be found at http://www.uhccommunityplan.com/health-professionals/ks.html.	Completed	Not applicable	9/2/15
10/10/14	265	HCBS Providers	HCBS TBI providers are reporting procedure code H2014 is being underpaid.	The system configuration to address this issue is targeted for 11/1/14. The targeted completion date for the claim adjustment project will be posted after the system configuration is completed. UPDATE: The system configuration to correct this issue was completed on 10/21/14. The targeted completion date for completion of claim adjustment projects is 12/5/14. UPDATE: The claim adjustment project completed early on 11/11/14.	Completed	The claim adjustment project completed early on 11/11/14.	11/11/14

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10/10/14	266	HCBS Providers and Targeted Case Management Providers	The targeted case management code (T1017) may deny in error for members who are on the I/DD wait list or who have a qualifying I/DD diagnosis and are receiving TCM services only but are not on the I/DD waiver.	At this time, we do not have an estimated date for system configuration. However, we are reviewing denials to identify these claims and are adjusting them as they are identified. Providers may contact their Provider Advocate to notify them of claims denied in error to request an adjustment until the system configuration is completed. UPDATE: The estimated completion date for the system configuration is targeted for 10/31/14 which will allow new day claims to process correctly. In the meantime, providers may continue to contact their Provider Advocate to notify them of denial errors to request claim adjustments. UPDATE: We were able to correct 60% of the impacted provider records as of 10/31/14 which should result in new day claims for these providers processing correctly. The remaining 40% of providers will require a different resolution process that is estimated for completion by 12/2/14. UPDATE: The remaining providers are configured correctly as of 11/17/14. A final claim project has been submitted to adjust any remaining T1017 claims that denied in error. The targeted completion date for the final claim adjustment project will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 12/31/14. UPDATE: The claim adjustment project completed early on 12/12/14.	Completed	The claim adjustment project completed early on 12/12/14.	12/12/14
10/20/14	267	Hospital Providers	It was determined during an internal claim audit that we were denying O/P hospital claims billed with a 981 revenue code (professional fee) are denying non-covered in error.	We are determining the root cause of this issue at this time, and will post detail regarding the targeted completion dates for system configuration and claim adjustments when available. UPDATE: The root cause has been identified and we have submitted a request to correct the system configuration. A targeted completion date for the configuration will be posted when available. UPDATE: The targeted completion date for system configuration was moved up to 12/1/14. The targeted completion date for the claim adjustment project will be posted following completion of the system configuration. UPDATE: The targeted completion date for the claim adjustment project 1/9/15. UPDATE: The claim adjustment project completed early on 12/22/14.	Completed	The claim adjustment project completed early on 12/22/14.	12/22/14

Date Added	Item Ref #	Impacted Area	Question/Issue	Response/Resolution	Status	Reprocessing Plans (if necessary)	Date Revised or Resolved
10/31/14	268	Nursing Facility	Updated ICF-MR rates effective 10/1/14	The new rates were loaded on 10/22/14 retroactive to 10/1/14. A claim project has being submitted and the estimated date of completion is 12/15/14. UPDATE: The claim adjustment project completed early on 11/20/14.	Completed	The claim adjustment project completed early on 11/20/14.	11/20/14
10/31/14	269	Hospital Providers	Updated DRG weights and rates effective 10/1/14	The rates were received from the state of Kansas on 10/1/14. The estimated date of completion of the loading of the rates and weights is 11/17/14. A claim project will be submitted following completion of the loading of the rates retroactive to 10/1/14. The targeted completion date for the claim adjustment project will be posted when available. UPDATE: The new DRG rates were loaded on 11/17/14. A claim project has been submitted and the targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustment project for underpaid claims is 2/6/15. Claims that were overpaid will follow our standard overpayment recovery process. UPDATE: The claim adjustment project for underpaid claims completed early on 1/2/15. Claims that were overpaid will follow our standard overpayment recovery process. UPDATE: Providers impacted by overpayments should begin receiving letters the week of 2/8. The estimated date for the claims to be fully recouped is 6/1/15. Providers who agree with the recoupments identified in the notification can call the number on the notification letter and request the adjustments be initiated immediately. UPDATE: As of 3/16/15, all claims have been processed for recoupment.	Completed	The claim adjustment project for underpaid claims completed early on 1/2/15. Claims that were overpaid were processed for recoupment 3/16/15.	3/16/15
10/31/14	270	General Providers	Additional coverage for flu vaccine codes 90685, 90687, 90688	We received notification from the state regarding the new coverage for these codes on 10/28/14 with a coverage retroactive date of 8/1/14. The estimated date of completion for loading these new codes is 11/24/14. A claim project will be submitted after the codes are loaded retroactive to 8/1/14. The targeted completion date for the claim adjustment project will be posted when available. UDPATE: The system configuration was completed 11/17/14. A claim project has been submitted and the targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 2/6/15. UPDATE: The claim adjustment project completed early on 1/7/15.	Completed	The claim adjustment project completed early on 1/7/15.	1/7/15

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11/6/14	271	General Providers	Vaccine procedure code 90686 is paying when billed as part of a Vaccine for Children when it should pay $0.00.	We are researching the root cause of this issue. A system configuration request will be submitted after the root cause is identified. The targeted completion date will be posted when available. UPDATE: The targeted completion date for the system configuration to correct this issue is 12/1/14. There will not be a claim adjustment project since the overpayment amounts are under the adjustment threshold. UPDATE: The system configuration completed 11/30/14. There will not be a claim adjustment project since the overpayment amounts are under the adjustment threshold.	Completed	Overpayments are under the adjustment threshold so no claim projects are planned.	11/30/14
12/12/14	272	General Providers	KanCare Paper Claim Address Change effective 2/1/2015	The paper claim address for KanCare claims will change effective 2/1/15. Paper claims submitted on or after 2/1/15 should not be sent to the KMAP claim address. A notification will be distributed to network providers. Providers may also access a bulletin with the new paper claim address information at www.uhccommunityplan.com. Select Kansas and the information will be posted at the Bulletins link.	In Process	Not applicable	12/12/14
12/12/14	273	Hospital Providers	Outpatient hospital claims billed with a 761 revenue code are denying in error as being an observation related charge. This revenue code is for a treatment room not observation. Claims should process based on the CPT code billed, the revenue code should not be the only source for a claim to deny.	We are determining the root cause of this issue at this time, and will post detail regarding the targeted completion dates for system configuration and claim adjustments when available. UPDATE: The system configuration to correct this issue is targeted for completion on 2/20/15. A claims project will be submitted after the configuration is completed and we will post a targeted claim adjustment date when available. UPDATE: The system configuration completed early on 1/16/15. The targeted effective date for the claim adjustment project is 2/27/15. UPDATE: The claim adjustment project completed early on 2/6/15.	Completed	The claim adjustment project completed early on 2/6/15.	2/6/15

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12/19/14	274	Hospital Providers and Nursing Facility Providers	It was determined during a weekly internal claim review that we have claims denying for invalid type of bill (TOB) in error. Hospital and NF providers may be experiencing claim denials.	The system configuration to correct this issue is targeted to be completed on 12/22/14. A claim project will be submitted once we confirm the system correction is complete. The targeted completion date for the claim adjustment project will be posted when available. UPDATE: The system configuration was corrected on 12/22/14. A claim project has been submitted and the targeted completion date will be posted when available. UPDATE: The targeted completion date for the claim adjustment project is 2/13/15. UPDATE: The claim adjustment project completed early on 1/16/15.	Completed	The claim adjustment project completed early on 1/16/15.	1/16/15
12/19/14	275	General Providers	Providers billing procedure code G0471 are experiencing front end rejections when billing this code. This is an error as this code is valid as of 10/1/14. Since claims are rejected prior to entering our system, no claims project can be completed. Providers will be require to resubmit their claims once our system configuration is corrected.	The targeted completion date for the system configuration to correct this issue is 2/1/15. Once the system is corrected, providers may resubmit their claims for processing. UPDATE: After our system configuration is corrected, the state will re-send impacted claims to United to eliminate the need for providers to re-submit their claims. UPDATE: The system configuration completed early on 12/31/14. The state has been notified and they will be re-sending the impacted claims to United for processing. UPDATE: The state has indicated they plan to send the claims to UHC on 1/23/15. UPDATE: The state did sent the claims on 1/21/15. The claims are processing in our system.	Completed	N/A	1/21/15