Claims Problem Solving Matrix

Providers submit Fee-for-service (FFS) claims to be paid for services they have rendered to an individual. FFS claims are processed when they are submitted, and approved claims are sent to the Department of Administrative Services for payment around 5:30PM each business day.

Providers are responsible to review all claims they have submitted to ensure that no further action is needed their part. When claims are in **Suspended** or **Denied** status, they may have one or more of the following **Exceptions** show below. This grid shows common Exceptions messages, what they mean and how to resolve the issue. Claims that suspend are reprocessed every night automatically, until the reason has been resolved.

Error message	What it means	How to fix it
Maximum Billing Dates Reached *(54)*	This occurs when the number of allowed billable days (344) for Daily Residential services has been reached, and this claim would exceed the allowed days billed limit.	There is nothing to fix, these claims will remain in suspended status to be available to replace a claim that was paid, if it is later voided. The allowed 344-day limit for days paid for Daily Residential services will reset with the individual's annual ISP (POC).
System error occurred during processing (no other information provided) *(109)*	A system issue occurred when the claim was being processed that prevented it from completing the submission process.	Wait for the system to reprocess the suspended claims the next day. Once the system error is corrected, the submission process will complete.

System error occurred during processing *(109)* *Processing aborted from step: load client Title XIX eligibility (Could not send message)*	A system issue prevented eXPRS from accessing the individual's financial TXIX eligibility information when the claim was submitted for payment processing. For example, MMIS may not have been available to communicate that information to eXPRS.	eXPRS will attempt to reprocess the suspended claim overnight each day. Once the system error is corrected, the claim will complete its submission process.
Billed amount modified *(48)* 1. Reduced to fit within monthly allocation. 2. Changed to amount of services delivered, pricedAmount: [#.##], billedAmount: [#.##] 3. Allowed Rate: [##.##], Allowed Units: [#.#], pricedAmount: [##.##], billedAmount: [##.##].	This occurs when the amount billed on a claim is different than the system calculated "priced" amount on the claim, such as when a monthly service claim is billed for only part of a month, or there is a claim amount calculation rounding error.	Submit a TAR with the suspended claim information and request assistance to resolve and resubmit the claim for payment processing.
Billed units modified *(49)* Delivered: [#.#] Allowed: [#.#]	This occurs when the units billed for a claim exceeds the number of units allowed to be billed. For example, on expenditure purchases, or procedure code OR570, when the authorization has not been input correctly by the authorizing Case Management Entity.	Ask the authorizing CME to review & make any necessary edits/updates to the authorization so you can rebill for the service. If the authorizing CME needs assistance with this, they can submit a TAR to ODDS.
A payee has not been designated for: [Provider Name, eXPRS ID #] *(16)*	A Department of Administrative Services Payee record has not yet been created for this provider in eXPRS.	New providers must have a payee record created for them by Financial Services to receive payments. It is likely that this payee record is in the process of being created. eXPRS will automatically resubmit these claims nightly until the

		suspense reason is resolved, and then process the claim through the remainder of the claim validation process.
Provider is not an active Panel Member *(15)*	For services authorized in an individual's Plan of Care, the provider's record must be on the authorizing CME's Provider Panel. The record must also remain on the CME's panel or future SD billings and/or claims will suspend for this reason.	Contact the authorizing CME to confirm your provider record is active on their Provider Panel, or to make the needed updates to their panel (e.g. Extend the service dates for your record's panel listing to cover all the service dates in the claim). The suspended claim will be reprocessed by the system automatically.
Invalid Provider Service or License *(207)*	The provider license dates are not completely within the time period listed on the claim submitted.	Complete a TAR to get assistance with this issue. Include detailed information on the claim and the provider site information.
Duplicate claim *(4)* *Suspected duplicate claim* *(5)*	There is another paid claim that is in approved status that overlaps the dates of this claim, even if it's just one day that overlaps.	Void the duplicate/overlapping claim and submit a new claim for the correct dates. **OR** Update and correct the claim by following instructions in the guide: **How to Void or Correct CPA Service Claims**.
Fails Higher Level Prior Auth *(9)* Insufficient Funds [-$##.##] on [MM/DD/YYYY] for Service Element: [###,###.##]	There is not enough SEPA funding to support payment of the services billed in this claim. The funding limitation must be increased by the ODDS Contracts Administration Unit in order to successfully pay this claim.	Notify the authorizing CDDP or Brokerage of the issue. They will then work with the ODDS Contracts Admin Unit to adjust the funding limitation amount.
Service begin date cannot be after current date	Claims cannot be submitted for future dates. The claim was denied.	Recreate and submit the claim to fall within allowable date ranges.

(2) *Service end date cannot be after current date* *(3)*		
Funding formula for claim not found *(10)*	There is not an applicable funding rule established for payment for one or more dates of the claim, so eXPRS cannot determine how to fund/finance the claim.	Submit a TAR.
CPA not effective during DOS.[1] *(141)*	There are dates in the claim that are not covered by the authorization's effective date range (CPA or SPA). This can occur when there are multiple authorizations that cover the date span of the claim. For example, a provider claims for an entire month, but the individual has 2 CPAs that cover that month: one that ends and one that begins mid-month.	Create separate claims for each authorization with claim dates that fall within the effective date range of the applicable authorization.
CPA not effective during DOS. *(141)*	The claim has been adjusted because there is no **Accepted** authorization for one or more dates on the claim.	The claim may be denied or adjusted to match the authorization dates. Work with the CME who authorized the individual's services to make sure there is an accepted authorization that covers all the dates you need to submit claims for. Once done, you may need to recreate claims to cover dates that were excluded as part of the adjustment.

[1] DOS stands for "Date of Service"

Client not enrolled in Case Management *(20)*	The individual doesn't have an SE48 Case Management CPA in **Accepted** status that covers the entire date range of the claim being submitted. This often occurs when an individual has transferred their Case Management services to a new county but has not changed service providers.	Contact the CDDP that provides Case Management for the individual in question. Once the SE48 CPA is in place, the claim should approve during the automatic nightly reprocessing.
Client Ineligible for DD services *(25)*	There is no information in the DHS systems that shows that overall eligibility for DD services for the individual has been established. The individual must meet the required OAR criteria for DD Eligibility to have DD Services and have overall DD eligibility for services determined by their CDDP.	Check the individual's eligibility information (see the guide: **How to Use the View Client Page in eXPRS).** If you believe there is an issue with the individual's eligibility information, contact the CDDP that provides Case Management for the individual to assist in resolving the issue.
Client Ineligible for Service *(26)*	The individual has not met the required service eligibility for this service. This means the required service/waiver category code for this service is not listed on the individual's record for one or more dates on this claim.	Check the individual's service/waiver category codes and Medicaid Eligibility information (see the guide: **How to Use the View Client Page in eXPRS).** If you believe there is an issue with the individual's coding, contact the CDDP that provides Case Management for the individual to assist in resolving the eligibility issue.
Client Awaiting Service Eligibility *(27)*	The individual is waiting on service eligibility, meaning the system sees that the appropriate service/wavier category code and Medicaid eligibility code	Check the individual's service/waiver category codes and Medicaid Eligibility information (see the guide: **How to Use the View Client Page in eXPRS).**

	combination is in conflict for one or more dates on the claim. **For example**: An individual has a service/waiver category code of DDC, but Medicaid eligibility code of TXIX=No. Medicaid is required (=Yes) to in order for claims to process with a DDC code. Sometimes the TXIX Medicaid information isn't available for eXPRS due to a system issue, so eXPRS assumes TXIX = No when the individual really has TXIX.	If you see the individual's eligibility coding is correct, you can attempt to re-submit the claim manually (see the guide: **How to Submit Multiple Claims)**.
CICS [service/DD/Medicaid] eligibility Web Service not available: [additional technical information] *(109)*	eXPRS is unable to connect with other ODHS information systems via the Web Services interface process.	This issue is not related to eXPRS; it is caused by other systems that provide eXPRS with an individual's eligibility information. Wait and try again later to see if the issue corrects itself, or submit a TAR to request assistance.
Claim exceeds time limit for claims submission *(204)*	Medicaid regulations stipulate that all claims for payment must be submitted within 365 days of the date of service. This claim is for services that are beyond this 365-day limit.	This error message is preventable if you submit claims in a timely manner. ODDS cannot guarantee payment on any claims submitted outside the required timelines. However, if the same time period was previously claimed, and a new claim was submitted in its place (e.g. due to a correction), the suspended claim can be reviewed by State staff for an exception. Complete a TAR to request assistance.

Claim Modifier fiscal year days limit exceeded. *(35)* Fiscal year day limit 21 exceeded for claim modifiers [FAM, AWL, JAL, MED, NFS, PSY, VAC] *Claim Modifier consecutive day limit exceeded.* *(34)* Consecutive day limit 21 exceeded for claim modifiers [MED, AWL, CRS, FAM, JAL, NFS, PSY, VAC] (34)	SPD DD Program Administration has limited the number of absence days they will pay to providers. This claim exceeds the allowable days available in a Fiscal Year or the allowable consecutive days available for use of a claim modifier or group of modifiers. Please see the guide: **Provider Absence Claim Modifier Codes** for more information.	1. Ensure you are using the correct modifier for the type of claim you are submitting. 2. Edit the suspended claim to fall within the allowable time limits and resubmit. 3. It is possible that this claim exceeds the allowed payment timeline. If so, you can void the claim.
No approved claim found for day prior to absence claim for same service. *(33)*	Per SPD DD Program policy, the use of absence modifiers requires that the individual has received the service prior to the absence. There must be a claim for the service in approved status immediately prior to the start date of your absence claim.	1. Ensure you are using the correct modifier for the type of claim you are submitting. 2. Edit the suspended claim to fall within the allowable time limits and resubmit. 3. It is possible that this claim exceeds the allowed payment parameters. If so, you can void the claim.