Claims Problem Solving Matrix

Fee-for-service (FFS) claims are the claims providers submit to be paid for services they have rendered to a client. All FFS claims are processed when submitted and approved are sent to Dept. of Administrative Services for payment around 5:30 p.m. each business day. Any claims that suspend will be reprocessed every night automatically, until the reason for suspending the claim has been resolved.

It is the Provider's responsibility to review all claims they have submitted to ensure that no further action is needed on the part of the Provider. When reviewing your claims and you find claims have not been approved and remain in "**Suspended**" or are in "**Denied**" status, they may have one or more of the following error messages or "exceptions" shown below. This grid shows the most common "exception" or error messages, what it the message means, and tips on how to possibly resolve the issue.

ERROR/EXCEPTION MESSAGE:	WHAT IT MEANS:	HOW TO FIX IT:
Maximum Billing Dates Reached (54)	This suspense reason occurs when the number of allowed days (344) for **Daily Residential** services has been reached, and this claim would exceed that 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).
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
System error occurred during processing; (109)	Something happened within the system that prevented it from accessing the individual's financial TXIX eligibility information when the claim	eXPRS attempts to reprocess suspended claims overnight each day. Once the system error is corrected, the claim will complete its submission process.

Processing aborted from step: load client Title XIX eligibility *(Could not send message)*	was submitted for payment processing. Most likely MMIS (where eXPRS accesses that information) was not available to communicate with the eXPRS.	
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Billed amount modified ***Reduced to fit within monthly allocation.*** **OR** ***Changed to amount of services delivered, pricedAmount: [0.00], billedAmount: [0.00]*** **OR** ***Allowed Rate: [##.##], Allowed Units: [#.#], pricedAmount: [##.##], billedAmount: [##.##].*** (48)	This suspense error occurs when the amount billed on a claim is different than the system calculated "priced" amount on the claim. This can occur when a monthly service claim is billed for only part of a month, or there is a claim amount calculation rounding error.	Submit an eXPRS Technical Assistance Request with the suspended claim information & request assistance to resolve & resubmit the claim for payment processing.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Billed units modified ***Delivered: [0.0] Allowed: [0.0]*** (49)	This suspense error occurs when the units billed for a claim exceeds the number of units allowed to be billed. This is most often seen on claims for	Contact the authorizing CME (CDDP or Brokerage) and have them review & make any necessary edits/updates to the authorization so you can rebill for the service.

	expenditure purchases or procedure code OR570, when the authorization has not been set up correctly by the authorizing Case Management Entity.	If the authorizing CME needs assistance with that edit/update work, they can submit a request to ODDS.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
A payee has not been designated for: [Provider Name, eXPRS ID #] (16)	A Dept of Admin Services Payee record has not yet been created for this provider in eXPRS to receive payments.	Providers new to using/being paid from eXPRS must have a payee record created for them by Financial services in order to receive payments. It is likely that this payee record is in the process of being created. eXPRS will automatically resubmit these suspended claims nightly until the suspense reason is resolved. When resolved, the system will move the claim through the remainder of the claims validation processes.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Provider is not an active Panel Member (15)	For services authorized within an individual's Plan of Care (POC), such as Foster Care or other In-Home Attendant Care services, the provider's record must be listed on the authorizing Case Mgmt Entity's (CME's)1 provider panel for the dates of service provided. The record must remain on the CME's panel (cannot be	Contact the authorizing CME and have them add your provider record back to their POC panel, or update their panel to extend the service dates for the record's panel listing to cover all the service dates in the claim. The suspended claim will be reprocessed by the system automatically, and should

	removed) or future SD billings and/or claims will suspend for this reason. [1] A "Case Mgmt Entity" or CME is either a County DD Program (CDDP), a Brokerage or the CIIS Program.	clear this suspense reason once the provider panel has been updated.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Invalid Provider Service or License (207)	The provider license dates are not completely within the time period listed on the claim submitted.	Please use the **eXPRS Technical Assistance Request webform** to request assistance for this issue. Please include detailed information on the claim that is suspended, and the provider site information.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Duplicate claim (4) OR ***Suspected duplicate claim*** (5)	There is another claim that is in approved status *(ie: has been paid)* that overlaps the dates of this claim, even if it's just one day that overlaps.	You can void the duplicate/overlapping claim, and submit a new claim for the correct dates.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Fails higher level prior auth ***Insufficient funds [-$xx.xx] on [mm/dd/yyyy] for Service Element: [xxx,xxx.xx]*** (9)	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.

ERROR/EXCEPTION MESSAGE:	WHAT IT MEANS:	HOW TO FIX IT:
Service begin date cannot be after current date (2)	You cannot submit claims for future dates. The claim was denied.	Recreate and submit the claim to fall with in allowable date ranges.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Service end date cannot be after current date (3)	You cannot submit claims for future dates. The claim was denied.	Recreate and submit the claim to fall with in allowable date ranges.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
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. The system doesn't know how to fund/finance the claim.	Please use the **eXPRS Technical Assistance Request webform** to request assistance for this issue.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
CPA not effective during DOS. (141)	Based on the authorization effective dates (CPA or SPA), there are dates in the claim that are not covered by the authorization's date range. This happens most commonly when there are multiple auths that cover the date span of the claim. ***For example****: a provider claims for an entire month, but the client has 2 CPAs that cover that month: one that ends and a new one that starts mid-month.*	You will have to create separate claims for each auth, with claim dates that fall within the date range of the applicable auths. In the example referenced, the provider would need 2 claims that together they equal the dates for the entire month (one for each CPA), instead of one claim for the whole month.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**

CPA not effective during DOS *(dates of service)* (141)	The claim has been adjusted because there is no auth in accepted status for one or more dates on the claim.	The claim may be adjusted to match the auth dates or the claim may be denied. You may need to work with the CME who authorized the client'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 (re)create claims to cover dates that were excluded as part of the adjustment.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
System error occurred during processing *(no other information provided)* (109)	Something happened within the system during the time the claim was being processed that stopped the claim from completing is submission process.	The system attempts to reprocess suspended claims each day. Once the system error is corrected, the claim will complete its submission process.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Client not enrolled in Case Management (20)	There isn't a SE48 (DD Case Management) CPA in accepted status that covers the entire date range of the claim being submitted.	Contact the CDDP that provides Case Management for the client in question. Most often this occurs when a client has transferred their Case Management services to a new county, but has not changed service providers. Once the Case Management SE48 CPA is in place, the claim should approve during the automatic nightly reprocessing.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**

Client Ineligible for DD services (25)	The client has not met the required OAR criteria for DD Eligibility to have DD Services. The client must have overall DD eligibility for services, as determined by their CDDP. This error means there is no information in the DHS systems that show that overall eligibility for DD services for the client has been established. ***For example***: *You may encounter this when a client is transitioning from childrens to adult services, and adult eligibility for services has not yet been established.*	To check a client's eligibility information *(if you have the appropriate user permissions),* please see the instructions in the "***How to View Client Information in eXPRS***" guide on the **eXPRS HELP menu**. If after reviewing that information, you believe there is an issue with the client's eligibility information, contact the CDDP that provides Case Management for the client in question to assist in problem solving/resolving the issue.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Client Ineligible for Service (26)	The client has not met the required service eligibility for this service. Meaning there is no service/waiver category code listed for this client that is required for this specific service, for one or more dates on this claim.	To check a client's service/waiver category codes and Medicaid eligibility (if you have the appropriate user permissions), please see the instructions in the "***How to View Client Information in eXPRS***" guide on the **eXPRS HELP menu**. If after reviewing that information, you believe there is an issue with the client's coding, contact the CDDP that provides Case Management for the client in question to assist in problem solving/resolving the eligibility issue.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**

Client Awaiting Service Eligibility (27)	The client is waiting on service eligibility. Meaning the system sees that the appropriate service/wavier category code and Medicaid eligibility code combination is in conflict for one or more dates on the claim. ***For example**: Client 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 client really has TXIX.	To check a client's service/waiver category codes and Medicaid eligibility (if you have the appropriate user permissions) please see the instructions in the "***How to View Client Information in eXPRS***" guide on the **eXPRS HELP menu**. If after reviewing that information, you see the client's eligibility coding is correct, you can attempt to re-submit the claim manually. See the "***How to Submit Multiple Claims***" guide for instructions. If there is indeed an issue with the client's coding, contact the CDDP that provides Case Management for the client in question to assist in problem solving/resolving the eligibility issue.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
CICS [*service* ***or*** *DD* ***or*** *Medicaid****] eligibility Web Service not available: [****additional technical information****]*** (109)	eXPRS is having troubles connecting with the other DHS information systems via the Web Services interface. There is a problem with the interface process.	This is a systems issue not related to eXPRS, but part of the other systems that eXPRS talks to, to retrieve client eligibility information. You may wait and try again later, to see if the interface issue has corrected itself

		or use the **eXPRS Technical Assistance Request webform** to request assistance for this issue and report the problem. They will likely ask you to repeat the entire error message you received.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
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 submitted is for services that are beyond this 365 day limit.	This error message is preventable if you are submitting your claims in a timely manner. If you delay in submitting your claims and the time period for submission has expired, we 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 *(due to a correction needed, etc)*, the suspended claim can be reviewed by State staff for an exception. Use the contact information on the **eXPRS Contact Us** page to request assistance or an exception. Please include detailed information for the claim(s) in question.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**

Claim Modifier fiscal year days limit exceeded. ***Fiscal year day limit 21 exceeded for claim modifiers [FAM, AWL, JAL, MED, NFS, PSY, VAC]*** ***(35)***	This claim exceeds or has exhausted the allowable days available in a FISCAL YEAR for use of the claim modifier (or group of modifiers). Please see the Provider Claim Modifier Codes reference sheet on the eXPRS HELP menu for more information.	SPD DD Program Administration has limited the number of absence days they will allow payment for, in a given DD service. 1. Review the claim to be sure you are using the correct modifier for the type of claim you are submitting for payment. 2. You can 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. Please see the applicable ODDS Standards & Procedures for the service for more information.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**

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 client 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.	You can try the following: 1. Review the claim to be sure you are using the correct modifier for the type of claim you are submitting for payment. 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 4. so, you can void the claim. Please see the applicable ODDS Standards & Procedures for the service for more information.
ERROR/EXCEPTION MESSAGE:	**WHAT IT MEANS:**	**HOW TO FIX IT:**
Claim Modifier consecutive day limit exceeded. ***Consecutive day limit 21 exceeded for claim modifiers [MED, AWL, CRS, FAM, JAL, NFS, PSY, VAC]*** ***(34)***	This claim exceeds or has exhausted the allowable CONSECUTIVE days available for use of the claim modifier (or group of modifiers). Please see the Provider Claim Modifier Codes reference sheet on the eXPRS HELP menu for more information.	SPD DD Program Administration has limited the number of absence days they will allow payment for, in a given DD service. 1. Review the claim to be sure you are using the correct modifier for the type of claim you are submitting for 2. payment. 3. You can edit the suspended claim to

		4. fall within the allowable time limits and resubmit. 5. It is possible that this claim exceeds the allowed payment timeline. If so, you can void the claim. Please see the applicable ODDS Standards & Procedures for the service for more information.

If you are still unable to determine why the claim is getting an error message, please use the **eXPRS Technical Assistance Request webform** to request assistance.

But please, try and see if you can resolve the issue yourself before requesting assistance.