Wyoming Department of Health

Benefit Management System (BMS)
Claims Payment Known Issues & Enhancements

Updated: 07/29/2022

The following sections provide detailed information about known issues impacting claims payments, known issues that have been resolved, and information about change requests (CRs) and enhancements to the Benefit Management System (BMS).
Continue to check this page for updates as the issues are resolved.

Use the following quick links to navigate directly to the section you want to view.

Known Issues – Open

The following table lists known issues impacting claims payment. We are working to resolve these issues as quickly as possible.

Provider Type(s) Impacted	System Status	System Status Message	Anticipated Fix Date
Outpatient Claims	Fix in Progress	3M returning APC "00000" and being priced at $0.00	TBD
Waiver Providers	Fix in Progress	Procedure code T2023, claims posting Error Code 5110 - billed units exceed MUE quantity allowed.	TBD
All Providers (except waiver)	Fix in Progress	Other insurance policy end dates being reported, are not successfully ending the policy, causing claim denials. Edit 7141- TPL on Member file, not on claim.	TBD

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Nursing & Swing Bed Providers	Fix in Progress	Patient contribution being deducted from the original paid claim, when Provider voids the original paid claim and submits a new claim no patient contribution is being deducted. Once the Member files have been updated with the patient contribution amount from the voided claim, Providers will be notified to resubmit a clean claim.	TBD
All Providers	Fix in Progress	A claim line may deny for all units used when Prior Authorization (PA) units may still be available. Initially resolved on 4/30/2022 and providers instructed to resubmit claims. On 6/28/2022, this issue was reopened.	TBD
Hospice	Fix in Progress	The BMS should have deducted a day from Hospice claims with the following patient statuses: • 01: Discharged home • 02: Discharged/transfer to a short-term general hospital for inpatient care • 06: Discharged/transferred to home under care of organized home health • 20: Expired • 61: Discharged/transferred to SNF Once the issue is corrected, these claims will be reprocessed.	8/20/2022
All Providers (except Dental and Waiver)	Fix in Progress	Other primary and secondary insurances (TPL) causing claim overpayments.	8/20/2022
Outpatient & FQHC Claims	Fix in Progress	Outpatient (OPPS) and FQHC claims are not considering the lesser of logic.	8/20/2022

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Dental Claims	Fix in Progress	Adjusted dental claims (D8670) are paying at $0.00, related to WYUAT-1262. Once this issue is corrected, these claims will be reprocessed.	8/20/2022
Outpatient Claims	Fix in Progress	OPPS claims with line denials posting Error Code 7172 - APC relative weight missing (when a relative weight is being returned by 3M).	08/20/2022
PASRR Level I Submitters	Fix in Progress	PASRR Level I data entry text or wording changes	8/6/2022
All (except Waiver)	Fix in Progress	Screen change to have the **Enter Insurance Info** button/icon brighter and underlined for visibility purposes.	8/6/2022
DME Claims	Fix in Progress	NCCI edit 1800 - posting to DME claims and should not.	8/6/2022
All Providers (except waiver)	Fix in Progress	Claims with TPL/Medicare – not pricing correctly with the lesser of logic.	8/6/2022
All Providers (except waiver)	Fix in Progress	National Drug Codes (NDCs) not being updated or added to the BMS causing claim denials.	8/6/2022
All Providers	Fix in Progress	Duplicate editing not occurring on all claims. Claim adjustments will be completed to take back the duplicate claim payment, these will appear on the Provider's remittance advice (RA).	8/6/2022
Immunization Claims	Fix in Progress	CPT 90461 should pay at zero dollars ($0.00), and the line should not be denied. Once the issue is corrected, these claims will be reprocessed.	8/6/2022

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Known Issues – Resolved

The following table lists known issues that have been resolved.

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All	Fixed	Claim Template - When a provider has an active and an inactive provider ID and they save a template, the inactive provider ID was populated. Causing a claim edit (provider inactive) and not allowing providers to submit claims using the template. Providers should delete saved templates with the inactive provider ID and create new templates.	7/23/2022
Inpatient Claims	Fixed	Denied claims are utilizing Prior Authorization (PA) units. Steps remaining: • Add the units back to the PAs • Claims will be reprocessed once the PAs have been updated	7/23/2022
Immunization Claims	Fixed	Claims processed in May for immunizations may have been denied erroneously with edit 7056 - admin code must equal vaccine product. Once the issue is corrected, these claims will be reprocessed.	7/23/2022
Swing Bed Claims	Fixed	Swing bed nursing home claims (taxonomy 275N00000X), claims submitted with revenue code 0101 are not pricing off the PA (prior authorization). Once the issue is corrected, these claims will be reprocessed.	7/23/2022
Outpatient Claims	Fixed	Claims paying $0.00 due to the PA not having a dollar amount entered, which is stopping the claim from being priced. Next steps for claims are to be determined.	7/23/2022

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All Providers	Fixed	When completing an adjustment, the Rendering Provider Taxonomy is not copied from the original Transaction Control Number (TCN). Until this issue is resolved, Providers must enter the Rendering Provider Taxonomy in the adjustment. This issue has been resolved.	7/23/2022
Outpatient Claims	Fix	Potential paid lines being denied, causing the entire OPPS claim to be denied. Once the issue is corrected, these claims will be reprocessed.	7/9/2022
All Medical Providers	Fixed	Procedure code 27299 is being denied with Error code 1332, unable to determine rate value. These denied claims will be reprocessed.	7/9/2022
Professional Claims	Fixed	Claims denying incorrectly with Error code 7039, procedure is included in the post-operative care payment, but the services are not related surgical procedure. Denied claims were resurrected and paid claims with denied lines were adjusted on 7/14/2022.	7/9/2022
Outpatient Hospitals	Fixed	The Ambulatory Payment Classification (APC) Status Codes W for Outpatient Claims is causing issues and may cause a denial of your claims. Denied claims were resurrected and paid claims with denied lines were adjusted on 7/14/2022.	7/9/2022
DME	Fixed	Error code 7158 - Medicare allowed zero, posted erroneously to durable medical equipment (DME) claims. Denied claims were resurrected and paid claims with denied lines were adjusted on 6/27/2022.	6/26/2022
All Providers	Fixed	The reprocessing of adjusted claims is resulting in claim errors. These denials are appearing on a Provider's remittance advice (RA). Denied claims were resurrected and paid claims with denied lines were adjusted on 7/4/2022.	6/25/2022

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Outpatient Claims	Fixed	When a procedure code requires a Prior Authorization (PA) and the PA number is not entered on the claim, the line is posting Error code 1152 – code requires PA and no PA number submitted on claim. This is causing the remaining lines to price at zero dollars ($0.00). Issue was re-opened to address additional impacted claims and claims will be adjusted.	6/25/2022 and 7/23/2022
Laboratory	Fixed	Laboratory claims for Breast and Cervical Cancer (BCC) members denied with Error code 1716, unable to determine claim type due to claim type restriction. Claims will be reprocessed.	6/22/2022
All Providers	Fixed	Providers that recently made updates to their provider file may have had claims denied with Error code 1359, load servicing provider data failed. These claims were reprocessed on 6/27/2022.	6/22/2022
All Claims (except Waiver)	Fixed	Some claims are denying due to Error code 1122, claim data not matching PA, when the service does not require a PA. Some claims paid with denied lines with Error code 1122. Denied claims were resurrected and paid claims with denied lines were adjusted on 6/23/2022.	6/11/2022
All Providers	Fixed	Claims may pay zero dollars ($0.00) due to the 1373 & 1375 limit edits not processing as expected. 1373 - Limit Type Conflict Edit 1375 - Limit Type Units Edit Initially, resolved on 6/11/2022 and paid claims were adjusted on 6/27/2022.	6/11/2022
Providers Submitting Medicare Crossover Claims	Fixed	Medicare crossover claims with a referring, ordering, or prescribing Provider that is not enrolled as a Wyoming Medicaid Provider are being denied. This issue was previously reported as fixed; however, we are still seeing some instances of incorrect denials. Error codes 7093 and 1452 are posting to crossover claims. Once this issue is corrected, Providers need to resubmit these claims.	6/11/2022

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FQHC / RHC/ IHS / PRTF / ESRD / Hospice / Nursing Facilities	Fixed	Claim denials due to Provider rates not being found, Error code 7012. Denied claims were reprocessed on 6/22/2022.	6/11/2022
Waiver Providers	Fixed	Waiver PAs with procedure code S5170 and procedure code S5170 and modifier SE. Claims denied with Error codes 1122 and 1121 were reprocessed on 6/27/22.	6/3/2022
Waiver Claims	Fixed	Claims have paid without validating the procedure code and modifier, if applicable, against the PA. Claims that have paid and are determined paid in error will be voided. Once the voids have been completed providers may submit clean claims as appropriate.	6/2/2022
Outpatient Hospitals	Fixed	Some Providers' claims may deny due to 3M returning an invalid diagnosis message. Claims were reprocessed on 6/6/2022.	5/31/2022
Outpatient Claims	Fixed	Error code 7158 – Medicare allowed zero. Denied Outpatient Prospective Payment System (OPPS) claims were resurrected and paid claims with line denials were adjusted on 6/27/2022.	5/28/2022
All Providers	Fixed	When two modifiers are entered on the line, the charge is not reducing which may result in an overpayment. Paid claims were adjusted on 7/15/2022.	5/28/2022
IHS	Fixed	Claims denied due to Error code 7053, invalid revenue code on inpatient crossover, posting erroneously. Providers may resubmit claims.	5/28/2022

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Nursing Home Claims	Fixed	Extraordinary care claims, revenue code 0101 did not price from the PA. 5/16/2022 Claims were voided, providers may resubmit these claims. ***Update:*** On 7/12/2022, claims were re-keyed for providers.	5/28/2022
Nursing Facilities	Fixed	The Patient Pay Amount (PPA) is not being deducted for revenue code 0101. This issue was corrected, and paid claims were reprocessed. Issue was re-opened to address additional impacted claims and claims have been reprocessed.	4/16/2022 and 5/24/2022
All Providers (Except Waiver)	Fixed	CVS Caremark and ARGUS TPL coverage type was listed as medical which resulted in claims being denied in error. This coverage will be updated to pharmacy coverage or removed from the Member's plan as appropriate. ***Update:*** Denied claims were resurrected and paid claims with line denials were adjusted on 6/23/2022.	5/14/2022
All Providers	Fixed	Providers cannot, while completing an adjustment, change dollar amounts or units. To complete the change Providers will have to void the claims and resubmit a new claim with the correct units or dollar amount. Once the fix is completed, Providers can adjust claims without completing a void.	5/14/2022
All Providers	Fixed	Some Providers' claims may not be available for Remittance Advice (RA) generation. This is not affecting payments.	5/14/2022
All Providers (except waiver and dental)	Fixed	Edit 7166 – Medicare Deductible Greater than Allowed Amount is posting incorrectly causing denial. This is due to the Medicare Deductible Limit amount configuration for year 2022. *Claims with dates of service in 2022, were reprocessed on 5/3/2022.* *Denied claims with dates of service in 2021 were reprocessed on 6/28/2022.*	3/5/2022 and 5/3/2022

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Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Waiver Providers	Fixed	Bypass TPL (Other Insurance) editing for waiver claims. Claims will be reprocessed.	4/30/2022
Dental Providers	Fixed	A Member's primary insurance for dental services is not being considered. These claims are being paid by Medicaid as though no other insurance is available resulting in an overpayment to the Provider. This issue was corrected, claims denied in error will be reprocessed.	4/2/2022
Outpatient Hospitals	Fixed	When the Medicare paid amount is higher than the Medicaid allowed amounts, claims are not paying correctly.	4/2/2022
Dental	Fixed	Should have paid zero dollars on all the lines of the claim except the one line that was denied by the Other Payer. However, all other lines were paid and the one line that was denied by the Other Payer was denied. Claims will be reprocessed.	3/22/2022
Inpatient	Fixed	Possible overpayment due to other insurance not being deducted. Claims will be reprocessed.	3/22/2022
ACES$ Providers	Fixed	ACES$ claims are being under paid due to the add on modifier percentages rate. Claims denied in error are being identified and reprocessed.	3/19/2022
Waiver Provider	Fixed	Claims with procedure codes T2022 and T2031 are not paying as expected. Claims denied in error are being identified and reprocessed.	3/19/2022

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Ambulatory Surgery Centers	Fixed	The Ambulatory Payment Classification (APC) relative weights being reviewed for the claim appear to be denying with edit 7172. This issue was corrected, claims denied in error will be reprocessed.	3/19/2022
Dental Providers	Fixed	Procedure: D1110 may deny incorrectly for the limit being met. This issue was corrected, claims denied in error will be reprocessed.	3/19/2022
All Providers	Fixed	The incorrect Benefit Plan is being derived during claims processing. This happens when the servicing Provider is not present on the claim service line and billing Provider taxonomy is not considered for Benefit Plan derivation. Providers can now adjust any outstanding claims for this reason.	3/19/2022
All Providers	Fixed	CNSI is working closely with the state of Wyoming Department of Health on claims suspended for Provider Allowable Code (PAC) violations, which includes Provider Type, specialty, and subspecialty information. This issue was corrected, claims denied in error will be reprocessed.	3/19/2022
All Providers	Fixed	When a Provider adjusts a claim, drug information is not available as a selection on the Show Menu at the line level. Providers can now adjust a claim with drug information.	3/19/2022
All Providers	Fixed	A nursing home patient contribution for the month could be taken more than once if a legacy claim applied the contribution. After the update is completed, claims will be reprocessed to pay out the amount of patient contribution withheld in error.	3/19/2022

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Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All Providers	Fixed	Wyoming Medicaid is aware that the limits and units used for visits are being calculated incorrectly causing limits to be met in error. These include: • Occupational Therapy • Physical Therapy • Speech Therapy • Chiropractic Visits • Dietitian Visits • Behavioral Health Visits • Office Visits This issue was corrected, claims denied in error will be reprocessed.	3/19/2022
All Providers	Fixed	Wyoming Medicaid is aware that paid units are being updated incorrectly if Prior Authorization (PA) units are over utilized. The paid amount is calculated incorrectly after the cut back. This issue was corrected, claims denied in error will be reprocessed.	3/19/2022
All Providers	Fixed	Claim may pay although the Prior Authorization (PA) units are not available which can cause overpayments. Claims identified will be adjusted.	3/5/2022
Waiver Providers	Fixed	Some LT101s for Community Choices Waiver (CCW) Members were not added to the Benefit Management System (BMS) at the time of implementation in October 2021. This issue was corrected, claims denied in error will be reprocessed.	3/5/2022

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Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Dental Providers	Fixed	For dental claims, the Benefit Management System (BMS) is incorrectly using units on zero dollars ($0) billed lines when calculating total units used. Claims denied in error are being identified and reprocessed.	2/19/2022
All Providers	Fixed	Medicare crossover claims are incorrectly denying stating the modifier is invalid. Claims denied in error are being identified and reprocessed.	2/19/2022
All Providers	Fixed	When there is a procedure code without a modifier and the same procedure code with a modifier on a single Prior Authorization (PA), the utilized units are being applied to both procedure codes for legacy claims in error. CNSI is identifying PAs to be corrected to show correct utilization.	2/19/2022
All Providers	Fixed	Providers cannot currently search for templates using a Rendering Provider ID, which is not the same as Billing Provider ID.	2/19/2022
All Providers	Fixed	When searching by the National Provider Identifier (NPI) number, all Prior Authorizations (PAs) will not be visible as the system only shows PAs created for the last year. If a user believes not all PAs are returned on a search, additional filter criteria can be added during the search which removes the default.	2/19/2022
All Providers	Fixed	Prior Authorizations (PAs) are not updating in the Benefit Management System (BMS) and are duplicating. Impacted claims are being identified and reprocessed.	2/19/2022
All Providers	Fixed	Prior Authorization (PA) start dates on some claims are not updating. Claims denied in error are being identified and reprocessed.	2/5/2022

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Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All Providers	Fixed	The patient contribution is not updating correctly. Claims denied in error are being identified and reprocessed.	1/22/2022
All Providers	Fixed	Medicare eligibility for some Members is incorrectly reflected in the Benefit Management System (BMS), causing claims denial stating the client is Medicare eligible and claim must be filed to Medicare. Medicaid should be paying for these services since the Member is not Medicare eligible. Claims denied in error are being identified and reprocessed.	1/22/2022
All Providers	Fixed	Member benefit plans and eligibility for Modified Adjusted Gross Income (MAGI) Pregnancy are not updating as expected in the BMS. This issue was corrected, claims denied in error will be reprocessed.	1/15/2022
Nursing Home Crossover Claims	Fixed	Crossover claims from nursing homes are denying for invalid revenue codes. As an interim approach, claims are currently being suspended and manually processed. Claims denied in error are being identified and reprocessed.	1/1/2022
All Providers	Fixed	Claims for Qualified Medicare Beneficiaries (QMB) have inappropriately paid services that are non-covered services. Once this is corrected, claims will have been adjusted which results in recovery of funds paid incorrectly.	11/23/2021

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BMS Change Requests (CRs) and Enhancements

CNSI and state of Wyoming Department of Health (WDH) continuously look to improve and enhance the Benefit Management System (BMS). The following table lists enhancements we are developing for implementation.

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
All Providers	Enhancement in Progress	Allow Provider's visibility of the Medicaid Error codes on the Medicaid Paper Remittance Advice (RA).	9/3/2022	TBD
All Providers	Enhancement in Progress	Allow Provider's visibility of the Medicaid Error codes on the Provider Portal when inquiring on claims.	9/3/2022	TBD
All Providers	Enhancement in Progress	Enhance Member eligibility inquiries to include, but not limited to, claim history searches for vision and dental Providers to determine last service date for specific procedures.	9/3/2022	TBD
All Providers	Enhancement in Progress	Reinstating provider enrollment "Inactivity" terminations for billing providers who have not submitted a claim within 15-months may be terminated due to inactivity and a new enrollment with HHS Tech Group may be required. Reinstating provider enrollment "inactivity" terminations due to invalid email addresses, mailing/physical/payment addresses and phone numbers. Providers must maintain this information with the Provider Enrollment vendor, HHS Tech Group to avoid delays in Medicaid payments.	8/6/2022	TBD
Medical Providers	In Review	Add duplicate check edit logic to consider National Drug Codes (NDCs) also when J-codes are present on the claim line.	TBD	TBD

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
Home Health	In Review	Adding condition codes to by-pass edit 7183 (Medicare on Member File, Not on Claim) when the Provider taxonomy at the header of the claim is 251E00000X, Home Health. • XA: Condition Stable • XB: Not Homebound • XC: Maintenance Care • XD: No Skilled Service	TBD	TBD
Hospice Providers	In Review	To add Routine Home Care Payments 61 Days and Beyond (G0493 & G0494) • Revenue Code: 0651 • Procedure Codes: o G0493: 61 days and beyond – skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition o G0494: 61 days and beyond – skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition To add Service Intensity Add-On (SIA) Payment (G0162): • Revenue Code: 0651 • Procedure Code: G0162 (last 7 days of a Member's life)	TBD	TBD
All Providers	In Review	Provider claims inquiry - allow providers to view "suspend" error codes (edits).	TBD	TBD

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Waiver Providers	In Review	EVV/CareBridge claim denial error (edit) code	TBD	TBD
All Providers	In Review	277CA Claims Transaction Acknowledgment	TBD	TBD
All Providers	In Review	Member updates to TPL insurance coverage	TBD	TBD
All Providers	Future	Allow claims to be searched by Provider ID or NPI when these are moved to "erroneous data" fields due to errors (such as inactive, not enrolled, taxonomy, and so on)	TBD	TBD
All Providers	Future	Enable screen share capabilities to Call Center Representatives and Providers	TBD	TBD
Nursing Home & OPPS claims	Future	Large volume of Nursing Home claims and Outpatient claims are suspended with 1227 or 7143 when the one of the current or history paid claims is billed for the lab work, using same procedure/revenue codes with modifier on one of the claims • 1227: Suspected duplicate of a paid claim in system history • 7143: Suspected conflict of a paid claim in system history	TBD	TBD
All Providers	Future	Timely filing denial will not occur when the start date is before timely filing and the end date is after timely filing period.	TBD	TBD
Pharmacies	Future	• This enhancement will allow the pharmacy taxonomies (3336 xxxxxx) to complete online registration on the Wyoming BMS portal which will allow access to their 835s for pharmacy who bill Medicare crossover claims through BMS.	TBD	TBD

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Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
All Providers	Future	• Ability to copy a template from a saved template and retain the original template • Make changes to a saved template • Allow Providers to name templates • To grant Providers the ability to search templates by rendering Provider ID or National Provider Identifier (NPI); Member ID; or template name assigned by the Provider • Allow wildcard (%) searches when "Filtering"	TBD	TBD
All Providers (Except Waiver)	Future	TPL Header and Line Roll Down	TBD	TBD
RHC/FQHC/IHS	Future	Bypass for commercial payers (TPL)	TBD	TBD
All Providers	Future	Member rate changes to allow for a specific provider and member's claims with a letter of agreements (LOA) to be priced from an established rate vs. manual pricing.	TBD	TBD
Medical Claims	Future	Create a new error (edit) code for "Baby Delivery" claims submitted without procedure code 0500F	TBD	TBD
All Providers	Future	5% family cost sharing - co-payments	TBD	TBD
All Providers	Future	BCC Public Health Programs attachment process - reviewing alternatives	TBD	TBD
DME Providers	Future	Separate DMEPOS fee schedule	TBD	TBD

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All Providers	Future	Display on the claim the fee schedule the service was priced from (such as CME, BCC, CMHW, and so on)	TBD	TBD
Care Management Entity (CME) Providers	Future	Additional modifiers	TBD	TBD
PASSR Level II Submitters	Future	Remove PASRR Level II Requirement making LT101/PASRR Level I a prerequisite for completing a PASRR Level II	TBD	TBD
Medicare Crossovers	Future	New error (edit) code: Taxonomy only Allowed for Medicare Crossovers, or EPSDT Services for Children (KIDA, KIDB, KIDC)	TBD	TBD
All Providers	Future	Increase the number of TCNs displayed in the BMS when conducting claim searches, currently 10 TCNs are displayed.	TBD	TBD
All Providers	Future	Add total on lines of the Paper RA	TBD	TBD
Clinics	Future	WY Medicaid Providers Adverse Childhood Experiences (ACES) screenings will be eligible for payment in any clinical setting in which billing occurs through Medicaid fee-for-service	TBD	TBD
Clearinghouses & Billing Agents	Future	Produce 835s by Provider ID for Clearinghouses & Billing Agents	TBD	TBD
All Providers (Except Dental and Waiver	Completed	Outbound COBA eligibility file.	N/A	7/19/2022

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
All Providers	Completed	PAC (Provider Allowable Code) for Rendering Provider editing	7/9/2022	7/9/2022
All Providers	Completed	Allow Providers to submit Grievance & Appeals (G&As) and upload attachments on the Provider Portal (Provider Access profile). Allow Providers to view G&A determination and determination letters. ***Update:*** Provider Quick Reference Guide pending development.	Soft Go-Live 6/11/2022	6/11/2022

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