Wyoming Department of Health

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

Archived: November 2021 through September 2024

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 – Resolved

The following table lists known issues that have been resolved.

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Member	Resolved	When Providers check member eligibility through the provider portal for codes that should be covered under the KIDA benefit plan they are given the NO result when the member has not had the service in over 1 years' time frame, and the member has eligibility for more than one benefit plan Scenario from production Procedure code: V2020 Eligibility inquiry is returning as Yes when member is having standalone KIDA benefit plan as of the inquired date. If member has both KIDA and BHC-FULL (or any other benefit plan which don't covers the procedure code), inquiry is returning as "No" for the procedure code.	9/14/2024
Claims (CE) - Claims Adjudication	Resolved	TCN with no Medicare has posted 1343 edit with IGNORE disposition instead of DENY.	9/14/2024

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Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Claims (CE) - Claims Adjudication	Resolved	Error code 7051 posted with Ignore disposition whereas the default disposition for the edit is Deny. Medicare - N for the claim. Error code 7051 has alternate disposition set as Ignore for Medicare - Yes. Ignore disposition should be posted only if the claim has got Medicare - Yes	9/14/2024
Claims (CE) - Claims Adjudication	Resolved	Lesser logic is not working and system is paying more units than billed on T-Nursing.	9/13/2024
Institutional Providers	Fixed	OPPS (Outpatient Facility) claims with APC Status Indicator A with a returned APC weight of 0.0 are being paid at $0.00. It has been determined this is occurring when the billing provider taxonomy is not one of the taxonomies allowed for OPPS services (282N00000X, 282NR1301X, 261QA1903X). It is recommended that providers resubmit their OPPS claims under the appropriate billing taxonomy for appropriate processing.	4/26/2024
Durable Medical Equipment Providers	Fixed	Claims containing Prior Authorizations that contain CPT that have 0 approved units (due to a PA not being required for the code in question) that are then causing claims to pay erroneously at $0.00, or to deny. It has been determined that Prior Authorizations should not be submitted with CPTs that do not require a PA. Education has been sent to providers as of April 20, 2024 to all Durable Medical Equipment Providers.	4/20/2024
All Providers	Fixed	Claims submitted with greater than 350 claim lines have encountered adjudication errors which is resulting in claims being held in a suspended status. Once a fix is implemented, suspended claims will be adjudicated.	4/13/2024

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Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Institutional Providers	Fixed	OPPS claims with admission type 1 = Emergency, claims are denying for outpatient visit limit thresholds in error. Once a fix is implemented, denied claims will be resurrected.	4/13/2024
Institutional Providers	Fixed	Claims submitted without an admission date, where the patient is deceased and there is an overlap with reported dates of service have paid in error. Once a fix is implemented, claims paid in error will be voided. **Provider Action Required:** Once impacted claims are voided, providers can implement the necessary changes to their admit dates and submit a clean claim.	4/13/2024
All Providers	Fixed	Claim Submission Templates for Direct Data Entry are requiring a Date of Service and Place of Service to allow the templates to save.	4/13/2024
All Providers	Fixed	OPPS Claims are being denied for Edit 7873 - 3M - WEB SERVICE ISSUE, or they are being held in a suspended status pending the resolution of this issue. Suspended claims will be released for adjudication. **Provider Action Required:** Providers with denied claims must submit clean claims for processing.	4/13/2024
ESRD Providers	Fixed	ESRD claims submitted with Medicare primary are not taking Medicare's payment and discount amounts into consideration when pricing. Claims are paying at $0.00. It has been determined that the reason claims were paying at $0.00 is due to the 837 missing other payer information at the line level of the claim. Once the fix is implemented claims (4/13/2024) will be denied instead of paying at $0.00.	4/13/2024

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Provider Action Required: To correct previously submitted claims, providers can void the claim and submit a clean claim, with the other insurance details included at the line level. Alternatively, providers can adjust paid claims to include other insurance details at the line level.	
FQHC	Fixed	FQHC claims submitted with Medicare as Primary are denying for Edit 7035 INVALID FQHC/ RHC/ IHS CLAIM in error. Once a fix is implemented, denied claims will be resurrected.	4/13/2024
Dental Providers	Fixed	Dental Claims are not processing correctly when billed secondary to Medicaid with Adjustment Reason Codes PR-49 and PR-119. Once the fix is implemented impacted claims will be reprocessed.	4/13/2024
Swing Bed Facilities	Fixed	Swing Bed Facility claims submitted between 1/13/2024 until 3/9/2024 paid $0.00 erroneously. Paid claims will be adjusted.	3/9/2024
Outpatient Claims	Fixed	Revenue code 0360 has denied as duplicate erroneously to other revenue codes. Once the fix is implemented, denied claims will be resurrected. Paid claims with denied lines will be adjusted.	3/9/2024
RHC/FQHC/IHS	Fixed	Encounter claims being adjusted are denying in error to edit 7051 IHS, FQHC, RHC, OR WIND RIVER DIALYSIS ENCOUNTER WITH AT LEAST ONE NON-COVERED SERVICE; or denying with no returned denial edit provided. Once a fix is implemented, denied claims will be resurrected	3/9/2024
Nursing Facilities and Swing Bed	Fixed	Nursing Home and Swing Bed claims posted Edit 7105 (INVALID REASSESSMENT DATE) erroneously. CARC: 96 – Non-covered charge(s)	3/9/2024

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Edit 7105 posting in error has forced the claims to suspend, and/or deny in error (when the PASRR Level I date is the same as the admission date.) Denied claims will be resurrected.	
Institutional Providers	Fixed	OPPS claims submitted with a Revenue code but no correlating HCPCS code, are pricing and paying at $0.00. In instances where Edit 7029 NO ALLOWED CHARGE SOURCE should apply, and deny the relevant line, lines are paying at $0.00. Once a fix is implemented, claims paid in error will be adjusted.	3/9/2024
Institutional Providers	Fixed	Outpatient Claims are denying incorrectly for Edit 1225 EXACT DUPLICATE OF A PAID CLAIM IN SYSTEM HISTORY and Edit 1227 SUSPECTED DUPLICATE OF A PAID CLAIM IN SYSTEM HISTORY. Once a fix is implemented, denied claims will be resurrected.	3/9/2024
All Providers	Fixed	Claims are suspending with no suspense edits due to edit 1384 – Account Code Assignment Failure. Once a fix is implemented, impacted claims will be re-adjudicated for processing.	3/9/2024
RHC, FQHC, IHS, ESRD, PRTF Providers	Fixed	Claims are being denied in error when Provider Rates are in the system. Claims are posting error code: 7012 – Provider Rate Not Found Associated CARC: B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.	**Second Resolution Date**: 3/9/2024 Issue Reopened: 2/15/2024 Original Resolution Date:11/18/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Fix has been implemented denied claims will be resurrected and impacted paid claims will be adjusted. **Update:** Additional impacted claims were identified, in February of 2024, for dates of services between August and September of 2023, which did not reimburse at the 8.88% anticipated rate. Denied claims will be resurrected.	
All Providers	Fixed	Claims submitted for Prior Authorized procedures with modifiers, where the claim billing provider is not the same as the servicing provider, was utilizing the incorrect units from the affiliated Prior Authorization. Once a fix is implemented, Prior Authorization unit usage will be corrected. Impacted claims will be adjusted to reflect the appropriate unit utilization. Claims paid in error will be reprocessed. Claims denied in error will be resurrected.	2/10/2024
All Providers	Fixed	Claims submitted with other insurance CARC 144 (Incentive adjustment, e.g., preferred product/service) have processed incorrectly. Once a fix is implemented claims will be adjusted.	2/10/2024
All Providers	Fixed	Claims for services limited to a threshold paid in error when services occurred in different calendar years but within the restricted range. Once a fix is implemented claims will be adjusted, and claims paid in error will be credited.	2/10/2024
Waiver Providers	Fixed	Claims billed with the same procedure codes, differentiated by a modifier have processed against the incorrect prior authorization line, resulting in inaccurate unit utilization and erroneous denials. Claims have denied for Edit 1121 CLAIM DOS NOT WITHIN PA DOS and 1122 CLAIM DATA NOT MATCHING PA	2/10/2024

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Once a fix is implemented unit utilization will be corrected and denied claims will be resurrected.	
Nursing Facilities and Swing Bed	Fixed	Nursing Home Claims have been pricing incorrectly. Currently, pricing is considering only the charges on first payable Room & Board line of the claim and ignoring the charges on other Room & Board lines submitted on the same claim. The claim should consider the sum of the submitted charges on all the payable Room & Board lines of the claim, and then the claim should utilize Lesser of logic. Once a fix is implemented, impacted claims will be adjusted to the appropriate reimbursement amounts.	1/13/2024
Institutional Providers	Fixed	Secondary OPPS claims have been overpaid when Medicare is Primary. Once a fix is implemented, impacted claims will be adjusted to the appropriate reimbursement amounts. Original Date Fixed: 10/27/2023 **Reopened 12/4/2023**. Note: The mass adjustment created as a result of the 10/27/2023 resolution date was completed on 12/7/2023. Subsequent mass adjustment for the subsequent fix implemented will be completed.	**Second Resolution Date**: 1/13/2024 Issue Reopened: 12/4/2023 Original Resolution Date: 10/27/2023
Medical and Outpatient Claims	Fixed	Benefit utilization (threshold) was applied when a service line was denied. WY Medicaid has fixed this issue; Providers can now resubmit impacted claims for processing. **Original System Status Message:**	**Third Resolution Date:**1/13/2024 Issue Reopened: 11/24/2023 Second Resolution Date: 10/25/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Benefit utilization (threshold) units are being removed in error when claims have denied, and no benefit utilization units have been used, causing discrepancies in the number of available threshold units a member has towards their benefit plans. **Reopened 9/9/2023.** Wyoming Medicaid has identified that this issue has impacted claims since the original defect was fixed. We are working to implement a new fix, once implemented the impacted Member's Benefit utilization (threshold) units will be re-stored accordingly and impacted claims can be re-submitted for processing. **Note: We encourage providers to keep track of the number of times a member has been seen in their facility and to obtain a Prior Authorization (PA) from the appropriate PA vendor when the member is close to meeting the benefit utilization threshold limit. **Expanded 10/23/2023.** Wyoming Medicaid is aware that this defect was recurring for denied claims that were mass resurrected. The new defects were resolved 10/25/2023. Once the fix is implemented denied claims will be resurrected. **Reopened 11/24/2023.** The new defects were resolved 1/13/2024.	Issue Expanded: 10/23/2023 Issue Reopened: 9/9/2023 Original Resolution Date: 6/13/2023
All Providers	Fixed	PA units are being utilized or deducted when the claim is in a denied status. This is causing the resubmitted claims to deny in error with error code 1123 - PA Units or Dollars Unavailable. Once the fix is implemented the PA units will be corrected and denied claims will be resurrected. Original Date Fixed: 11/04/2023	**Second Resolution Date:** 1/13/2024 Issue Reopened: 11/24/2023 Original Resolution Date: 11/4/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Reopened 11/24/2023 PA units are being utilized or deducted when the claim is in a denied status. This is causing the resubmitted claims to deny in error with error code 1123 - PA Units or Dollars Unavailable.	
Medical Claims	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 Original Fixed Date: 8/26/2023 On 09/06/2023 denied claims were resurrected, and paid claims were reprocessed. **Reopened 09/09/2023.** Any claims not captured in prior masses will be resurrected or reprocessed. Subsequent Fixed Date: 10/21/2023 Reopened 11/7/2023. Fix has been implemented. Any claims not captured in prior masses will be resurrected or reprocessed.	**Third Resolution Date:** 1/13/2024 Issue Reopened: 11/7/2023 Second Resolution Date: 10/21/2023 Issue Reopened: 9/9/2023 Original Resolution Date: 8/26/2023
All Providers	Fixed	Claims with Prior Authorizations have processed in error; the claim is not applying appropriate thresholds to frequency limitations. Fix has been implemented; denied claims will be resurrected and impacted paid claims will be adjusted.	12/16/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All Providers	Fixed	Prior Authorization (PA) cutback edit 1322 is not posting to lines where the PA units were cutback and paid on. Error Code: 1322- PA UNITS OR DOLLAR CUTBACK AND PAID Associated CARC: 151 - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. N435 - Exceeds number/frequency approved /allowed within time period without support documentation. The fix for this issue has been implemented and claims are now posting edit 1322 appropriately.	11/18/2023
Institutional Providers	Fixed	Providers are unable to add or modify occurrence span codes and condition codes on institutional claims. Fix has been implemented providers are now able to add or modify occurrence span codes and condition codes when adjusting DDE claims.	11/18/2023
All Providers	Fixed	Providers are unable to add attachments to electronically submitted appeals.	11/9/2023
All Providers	Fixed	Claims have denied for Edit 7008 - ELECTRONIC CLAIM WITH ATTACHMENT MORE THAN 30 DAYS OLD in error, when the necessary attachments were supplied within the required 30-Day limitation. Fix has been implemented; denied claims will be resurrected.	11/4/2023
Institutional Providers	Fixed	3M software is not returning the appropriate APC weight value for some institutional claims.	11/4/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Once a fix is implemented, impacted claims will be re-processed through the 3M software to produce the appropriate APC weight values.	
Medical and Outpatient Claims	Fixed	Procedure Code 87426 with Modifier 'QW' was deriving payment incorrectly. Paid claims will be reprocessed.	11/4/2023
Podiatry Providers	Fixed	Podiatry claims have been denied in error when billed for members that are not enrolled into Medicare as primary. The impacted claims have posted the following edit erroneously; Error Code 7177 – Podiatry Services on Non-Medicare Claim Associated CARC: 109 – Claim/Service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor Denied claims will be resurrected.	11/4/2023
Medical	Fixed	Claims have been denied as duplicates against the same claim, denied lines, and/or other claims, erroneously. Error Code 7143 – suspected conflict of a paid claim in system history Associated CARC: 18 – Exact duplicate claim/service Once the fix is implemented denied claims will be resurrected.	11/4/2023
Professional Providers	Fixed	Claims for professional and medical services are denying in error when a member has Medicare Part A but does NOT have Medicare Part B as their	10/27/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		primary insurance carrier, impacted claims are posting the following error code erroneously, Error Code 7183 – Medicare on Recipient (member) file, not on claim Associated CARC: 97- The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. MA04- Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either note reported or was illegible. The Agency is reviewing Members Medicare Part A and Part B eligibility spans and updating them with Medicare, as appropriate. Providers were contacted to submit claims to Medicare that are within timely filing prior to 12/31/2023.	
Nursing Facilities and Swing Bed	Fixed	PASRR error code 7105 (Invalid reassessment date), is being updated. Associated CARC: 96 – Non-covered charge(s) Denied claims will be resurrected. Original Resolution Date: 2/4/2023 **Reopened 10/03/2023.** This defect has been resolved. Denied claims will be resurrected.	**Second Resolution Date:** 10/21/2023 Issue Reopened: 10/3/2023 Original Resolution Date: 2/4/2023
Medical and DME Claims	Fixed	CPT E0114 was reimbursing at the incorrect rate of $0.00. This defect has been corrected.	10/21/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Paid claims will be adjusted to process according to the appropriate rate for the location of service.	
Anesthesia Providers	Fixed	Anesthesia claims were processing for partial payment when claims were received for multiple anesthesia procedures on the same date of service and was not applying the following edit properly: 7026 - MULTIPLE ANESTHESIA PROCEDURES BY SAME PROVIDER ON SAME DOS WITHOUT ATTACHMENT This defect has been corrected. Claims paid in error will be reprocessed, credited back, and will now post the appropriate denial reason. Providers may resubmit denied claims with the appropriate Attachment = Y indicators. Please ensure the required records are attached within 30 days of the date of the claims receipt.	10/21/2023
All Providers	Fixed	Providers are unable to submit appeals and appeal attachments for timely filing electronically via Direct Data Entry (DDE) in the Providers Portal. They are receiving and error message stating the following: "VM_CVM.407689: Unable to create Grievance and Appeals. Please contact System administrator." Wyoming Medicaid has identified this issue and has implemented the following work around for timely filing appeal submission until the root cause of this issue is fixed. Impacted Provider will need to follow the following work around procedures for appeal submission: 1. When entering the Appeal via DDE complete all field that contain an Asterisk (*) 2. When completing the field titled "**Reason**" please select the reason as "**Other**"	10/21/2023

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		3. In the box titled "**General Complaint Description" please add the following comment:** "*This Appeal Reason is Timely Filing, however due to Known Issue with Appeals Submission Portal, appeal reason selected is Other. Please process this appeal as an appeal for Timely Filing*." 4. Add the appropriate attachments, if applicable, and submit the Appeal The fix has been implemented, and providers should not experience further issues submitting Appeals via the Provider Portal. All previous attempts to appeal DDE claims denied for Timely Filing must be resubmitted.	
Nursing Facility	Fixed	For Nursing Facility claims submitted with Revenue Codes '0110', '0120', '0130', '0140', '0150', '0160' AND Medicaid is not Primary, error code 1811 is posting erroneously. This was also causing impacts to the claims pricing, deriving the claim submitted charge from the amount within the Room and Board line, and disregarding the total submitted charge for the claim as a whole. This issue has been resolved; Providers can now resubmit impacted claims for processing. ** Note: We encourage providers to review page 291 of the Wyoming Medicaid Institutional Provider Manual for instructions on appropriate Nursing Facility billing requirements. Please note, when Medicaid is primary all Room and Board revenue codes (0100 & 0101) must be combined and only appear on line one (1) of Medicaid's primary claim.	10/21/2023
Outpatient Claims	Fixed	Outpatient Claims did not apply the appropriate pricing logic when the OCE returns a blank APC weight. Wyoming Medicaid has identified and fixed these processing issues and impacted claims will be reprocessed.	10/21/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
FQHC	Fixed	FQHC claims submitted to Medicaid secondary to Medicare did not apply the appropriate lessor-of calculation when taking into consideration the payable balance after the primary carrier adjudication. Wyoming Medicaid has identified and fixed this issue, and FQHC claims are now processing according to the lessor-of calculation appropriately. Claims paid incorrectly will be reprocessed. Claims denied erroneously will be resurrected. Providers are able to resubmit denied claims for faster processing. Medicare Crossovers and Other Insurance (TPL) claims overpaid mass adjustment has been completed. The provider Field Representatives have sent emails to the email addresses on-file to the impacted ten (10) providers. Providers may also contact the Field Representatives at wyprovideroutreach@cns-inc.com.	10/7/2023
Professional and Dental Providers	Fixed	Professional and Dental claims were erroneously denying for the following edit: 5200 - CLAIM OR ADJUSTMENT PAST TIMELY FILING LIMITATION Wyoming Medicaid has identified and fixed these issues. Claims that are suspended will be adjudicated, claims denied erroneously will be resurrected. Providers are also able to resubmit denied claims for faster processing.	10/7/2023
Professional	Fixed	Professional claims billed for multiple lines have paid in error, wherein one line should have caused a header-level denial and the claim status was paid. Professional claims billed for services that should pay according to the Wyoming Medicaid Provider Fee Schedule are denying erroneously for the following edit: 1123 - PA UNITS OR DOLLARS UNAVAILABLE	9/23/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Wyoming Medicaid has identified and fixed these issues. Claims paid in error will be reprocessed for the appropriate denial. Providers are able to resubmit claims for faster processing. Claims denied in error will be resurrected.	
Optometry	Fixed	Optometry claims submitted for replacement lenses due medical necessity were denying erroneously for the following edit: 1747 - LIMIT EXCEEDED This edit is posting to claims without allowing the claim to suspend for manual review of attached records to support medical necessity of replacement lenses. Wyoming Medicaid has identified and fixed this issue. Denied claims will be resurrected.	9/23/2023
Outpatient Claims	Fixed	Outpatient Hospital claims are denying erroneously for the following edit: 7093 - R/A/P/O IS REQUIRED This edit is posting to claims when an appropriate R/A/P/O is indicated properly on the claim and has the appropriate primary taxonomy on file. Wyoming Medicaid has identified and fixed this issue, denied claims will be resurrected. Providers can also resubmit impacted claims for faster processing.	9/23/2023
Waiver Providers	Fixed	Waiver claims submitted with procedure codes T1016 and/or T2022 along with the UB modifier for members on the CCW benefit plan has been paying claims at the incorrect reimbursement rate. Wyoming Medicaid has identified and fixed this issue, impacted claims will be adjusted by WY Medicaid. Providers can also adjust impacted claims for faster re-processing.	9/22/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Ambulance Providers	Fixed	Medicare Crossover Ambulance claims and Claims submitted as secondary to Wyoming Medicaid with Medicare as the primary carrier are not pricing appropriately. Claims are being paid as Primary when Wyoming Medicaid is the secondary payor. Upon resolution overpaid claims will be adjusted. Wyoming Medicaid has identified this issue and after further review, Providers will need to make the following adjustments to impacted claims: 1. Providers will need to initiate an adjust on the impacted claims 2. Providers will need to update the TPL information on the claim 3. Providers will need to indicate TPL total amount paid with NO Claim Adjustment Reason Codes (CARC) on the header level of the TPL entry. 4. Providers will then add the amount paid along with the Claim Adjustment Reason Codes (CARC) on each line level of the TPL entry to account for how much TPL paid and assigned to each service line billed on the claim. 5. Once the provider has made the above updates the provider can submit the claim adjust for processing.	9/11/2023
All Providers	Fixed	When providers are entering a Direct Data Enty (DDE) claim with a negative Claim Adjustment Reason Code amount from the primary insurance EOB (Like Sequestration that would come as a credit) the Claims processing adjudication system is not translating the inputted information onto the claims properly. Wyoming Medicaid has identified this issue and is working to implement a	9/11/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		fix. Providers will need to resubmit, and/or adjust impacted claims for re-processing when fix is implemented. This issue has been fixed; Provider can now enter negative CARC values into the TPL session of direct data entry (DDE) claims.	
Inpatient Providers	Fixed	Claims with revenue code 0124 Psychiatric inpatient service with Prior Authorization (PA) reported at header level of the claim have a delay in processing status. Wyoming Medicaid has identified and fixed these processing issues and impacted claims will be adjudicated accordingly. Providers will need to review future Remittance Advice (RA) for claim processing details.	9/11/2023
Inpatient, Outpatient, and Skilled Nursing	Fixed	Revenue Codes 0531 and 0551 were not applying against the appropriate visit limit threshold, causing claims to deny erroneously. Providers will need to resubmit, and/or adjust impacted claims for re-processing when fix is implemented.	9/9/2023
All Providers	Fixed	835 and Medicaid Remittance Advice update. Medicaid is reporting Claim Adjustment Reason Code (CARC), CO 45 and should be reporting Other Adjustments, CARC OA 23, for the write off difference. Wyoming Medicaid has fixed this issue, 835 and Medicaid Remittance Advice generated on 08/18/2023 and onward will display CO 45 as CARC OA 23 to indicate Providers write off difference.	8/18/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All Provider	Fixed	Claims processing with Prior Authorizations (PAs) containing the same procedure codes, one line with a modifier and one line without a modifier are taking PA units away from the incorrect line. On 9/07/2023 paid claims were adjusted and denied claims were resurrected.	8/12/2023
Home Health	Fixed	Home health claims are denying and posting the following Prior Authorization (PA) Error Codes erroneously to claims causing denials: 1121 - CLAIM DOS NOT WITHIN PA DOS 1122 - CLAIM DATA NOT MATCHING PA Associated CARC/RARCs for Error code 1122 15: the authorization number is missing, invalid, or does not apply to the billed service or provider N54: claim information is inconsistent with pre-certified/authorized services Associated CARC/RARCs for Error code 1121 198: precertification or authorization exceeded N351: service date outside of the approved treatment plan service dates **8/12/23 UPDATE:** • Wyoming Medicaid has determined this issue is **not** a defect. • Providers are encouraged to review the PA against the claim information • Verify the PA is set up correctly, your Home Health NPI should be BOTH the “requestor” and the “servicing/treating” provider. Review dates of service, units, and revenue code(s)	8/12/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		• If the PA is set up incorrectly contact Telligen, the PA vendor, to make modifications. • When providers determine the issue and/or have the PA modified, providers should submit a new claim.	
Nursing Facility	Fixed	For Nursing Facility claims submitted with Revenue Codes '0110', '0120', '0130', '0140', '0150' ,'0160', '0119', '0129', '0100', '0180', '0181', '0182', '0183', '0184', '0185' ,'0189' , '0101' AND Medicaid is not Primary, error code 1811 is posting erroneously. This issue has been resolved; Providers can now resubmit impacted claims for processing.	8/7/2023
Inpatient Claims with Medicare or Other Insurance	Fixed	Medicaid's claim is posting Error code 1120 – Inpatient PSYCH claim requires PA, these claims are “in process”. Associated CARC/RARC: 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider. M62 – Missing/incomplete/invalid treatment authorization code. Wyoming Medicaid has fixed this issue; Claims will no longer be held for manual review for edit 1120.	8/3/2023
All Provider excluding Atypical Providers	Fixed	Claims submitted by Providers with more than one taxonomy and Provider ID, have denied in error with the following Error Codes: 1452- INVALID OR MISSING SERVICING OR RENDERING PROVIDER 1453- INVALID OR MISSING SERVICING OR RENDERING PROVIDER ID AT LINE	7/26/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		7127- UNIQUE NPI TO PROPRIETARY PROVIDER MATCH NOT FOUND Associated CARC/RARCs for Error code 1452 and 1453 16: Claims/Service lacks information or has submission/billing error(s). N290 - Missing/Incomplete/Invalid rendering provider primary identifier Associated CARC/RARCs for Error code 7127 A1: Claim/Service denied. N288 – Missing/Incomplete/Invalid rendering provider taxonomy We have identified and resolved this issue. Providers can now resubmit impacted claims for processing.	
Outpatient & Inpatient PAs (Prior Authorizations)	Fixed	Claims may be posting the following Prior Authorization (PA) Error Code erroneously to claims causing denials: 1121- CLAIMS DOS NOT WITHIN PA DOS 1122- CLAIMS DAT NOT MATCHING PA Associated CARC/RARCs for Error code 1122 15: the authorization number is missing, invalid, or does not apply to the billed service or Provider N54: claim information is inconsistent with pre-certified/authorized services. Associated CARC/RARCs for Error code 1121 198: precertification or authorization exceeded N351: service date outside of the approved treatment plan service dates	7/25/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Change Health Care (CHC) PAs will be updated with the billing provider NPI at the line level of the PA. The PAs are now updated, and providers may resubmit or adjust the impacted claims for processing.	
All Provider	Fixed	When providers are adjusting or voiding paid claims within the BMS system, an error occurs when attempting to add additional service lines to the claim. We have identified and resolved this issue. Providers can now adjust claims and add additional service line items.	7/24/2023
Anesthesia Claims	Fixed	Anesthesia claim issues identified: Error Code 7026 – Multiple anesthesia procedures by same provider on same DOS without attachment This error code is posting erroneously or not posting when it should. Taxonomy adjustment is not applied when the rendering provider is different on more than one anesthesia claim line. Once this fix is implemented denied claims will be resurrected and paid claims will be adjusted.	7/24/2023
Medical Claims	Fixed	Behavioral Health threshold (utilization) units are not being added back to the Members available units when a medical claim is voided. Behavioral Health and Occupational, Physical and Speech Therapy threshold units will be reviewed as well. Historical thresholds (utilization) units were updated. Originally resolved 2/4/2023. **Reopened 4/27/2023.**	**Second Resolution Date:** 7/17/2023 Issue Reopened: 4/27/2023 Original Resolution Date: 2/4/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Claims will be adjusted, or providers can re-submit denied claims for processing	
All Provider	Fixed	Claims have been denied with edit 7008: Electronic Claim with Attachment more than 30 days old; where attachments are present on the claim. This issue has been fixed, and denied claims will be resurrected. Alternatively, providers can resubmit denied claims for proper processing.	7/8/2023
Vison	Fixed	Vision claims with procedure code 92014 (eye exam & evaluation for established patient, 1 or more visits) is not posting correctly. Error code 1747 – limit exceeded Associated CARC/RARC: 119 – Benefit maximum for this time period or occurrence has been reached N362 – The number of days or units of service exceeds our acceptable maximum	6/27/2023
All – Eligibility Search	Fixed	When providers are verifying member eligibility within the Provider Portal and include a procedure code, the system may return false coverage. Dental providers are encouraged to use the Dental Fee Schedule located on the Medicaid website at https://www.wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins/Provider-Dental-Manuals All other providers are encouraged to use the online Fee Schedule to validate procedure code coverage, at https://www.wyomingmedicaid.com/portal/fee-schedules	6/16/2023
Outpatient Claims	Fixed	For claim lines priced under APCs, where the APC pricing is more than the billed charges, claims were capping payment to the billed charges at the line level. However, this charge capping should not be in effect. The	5/6/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		charge cap should only apply to lines paid using an alternate Medicaid fee schedule. Once all Outpatient Claims issues are corrected, paid claims will be adjusted.	
Durable Medical Equipment Providers	Fixed	The downloadable fee schedule from www.wyomingmedicaid.com erroneously indicated incorrect pricing adjustments for RR and NU modifiers. The fee schedule has been updated to reflect the appropriate rate adjustment for the RR and NU modifiers.	5/6/2023
Inpatient Claims	Fixed	Medicaid's claims are not updating the Prior Authorization Utilized units when the claim is priced via a Prior Authorization for PSYCH code 0124. Once this fix is implemented, utilized units will be corrected, and claims will be adjusted for appropriate payment amounts if necessary	4/1/2023
Hospice Claims	Fixed	Hospice claims are not going through the exact duplication criteria and are denying lines in the same claim. Once this fix is implemented, denied claims will be resurrected and paid claims will be adjusted.	4/1/2023
IHS	Fixed	New rates were effective for IHS providers 01/01/2023 and claims were subsequently adjusted; However, when the new rates were applied, code D9999 did not price correctly according to the new rate, and instead applied 'lesser of' pricing logic. Claims paid at the incorrect rate have been adjusted.	4/1/2023
All Providers	Fixed	Claims posting Error code 7185 are not displaying the paid historical claim(s) within the "Claim Limit List' within Provider Portal.	3/18/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Error code 7185 - Limit type visit edit Associated RARC: N640 – Exceeds number/frequency approved/allowed within time period. Claims do not need reprocessed.	
All	Fixed	Providers are not able to view uploaded attachments or determination letters within a Grievance and Appeal request within the Provider Portal.	3/18/2023
All Providers	Fixed	Claims posting Error code 1747 are not displaying the paid historical claim(s) within the “Claim Limit List’ within Provider Portal. Error code 1747 – limit exceeded Associated CARC/RARC: 119 – Benefit maximum for this time period or occurrence has been reached N362 – The number of days or units of service exceeds our acceptable maximum Claims do not need reprocessed.	3/18/2023
All -On-line Fee Schedule	Fixed	The online Medicaid Fee Schedule was displaying all taxonomies within the “Associated Taxonomy” section when searching procedure codes. The online Fee Schedule now reflects only the allowed taxonomies for a procedure code, https://www.wyomingmedicaid.com/portal/fee-schedules	3/4/2023
Behavioral Health Providers	Fixed	Behavioral Health providers with certain taxonomies that are not able to enroll with Medicare are having claims deny posting error code 7183 – Medicare on recipient file, not on claim	3/4/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Associated CARC/RARC: 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Denied claims will be resurrected.	
All – Claims with Attachments	Fixed	Providers unable to view the claim attachment in the Provider Portal when logged in under either the Claims Inquiry or Claims Access Profile. This has been fixed.	3/4/2023
Hospital and ASC Outpatient Claims	Fixed	Bilateral OPPS claims with modifier 50 were not priced correctly. Paid claims will be adjusted.	3/4/2023
Outpatient Claims	Fixed	Claims were denied erroneously with Error Code 7088 when the APC Status Indicator returned was either N or Z. This error code has been updated to not post when the APC Status Indicator is either N or Z. Associated CARC/RARC: 211 – National Drug Code (NDC) not eligible for rebate, are not covered. M119 – Missing /incomplete /invalid /deactivated /withdrawn NDC. Denied claims will be resurrected.	3/4/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Medicare Crossover Claims	Fixed	Medicare crossover claims with Medicare CARCs and RARCs added to the claim are denying erroneously and posting Error code 7183 – Medicare on recipient file, not on claim. Associated CARC/RARC: 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Denied claims will be resurrected.	3/4/2023
Atypical Providers – Claim Template	Fixed	Saved claim template was overwriting the NPI with the Provider ID, when the Atypical provider had an NPI. This has been corrected.	3/4/2023
Outpatient Claims	Fixed	Outpatient (OPPS) claims are not calculating the lesser of logic correctly. Once all Outpatient Claims pricing issues are corrected, paid claims will be adjusted.	2/18/2023
Medicare Crossover Claims	Fixed	Claims are paying more than the Medicare Patient Responsibility on crossover claims. Crossovers are not using the lesser of logic and is exceeding the assigned Medicare patient responsibility at header and line. Paid claims will be adjusted.	2/18/2023
Hospice Claims	Fixed	Some Hospice claims were paid erroneously when error code 7065 – Mult hospice rev codes, should have posted.	2/18/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Associated CARC/RARC: A1 – Claim/service denied. At least one Remark Code must be provided. M86 – Service denied because payment already made for same/similar procedure within set time frame. Paid claims will be adjusted.	
All Providers	Fixed	When providers have both paid and denied claims in the same payment cycle, they should receive one (1) remittance advice (RA), not two separate RAs.	2/4/2023
Home Health Providers	Fixed	Home health claims with Medicare or TPL are not processing consistently, resulting in overpayments. Claims will be adjusted for appropriate payment amounts, do not send checks.	2/4/2023
Medical Claims with Attachments	Fixed	Some claims revolving more than 30-days waiting for an attachment are not processing through to the 835 electronic payment file or Paper Remittance Advice (RA). Claims were processed and appeared on provider RAs dated 2/9/2023.	2/4/2023

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

Archived: November 2021 through September 2024

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Inpatient Medicare Crossover Claims	Fixed	Medicaid's claims are requiring a Prior Authorization (PA) erroneously when Medicare paid the claim. Inpatient Medicare crossover claims posting Error Code 7163 - Inpatient service requires PA. Associated CARC: 197 – Precertification/authorization/notification absent. Denied claims will be resurrected.	2/4/2023
Inpatient Claims	Fixed	Inpatient claims following an emergency room visit are denying erroneously with error code 7000 (First DOS verses admission date conflict). Associated CARC/RARC: 110 – Billing date predates service date MA40 – Missing/incomplete/invalid admission date Denied claims will be resurrected.	2/4/2023
Outpatient Claims	Fixed	Outpatient (OPPS) claims paying $0.00, when one or more lines did not have a payment from primary insurance. Paid claims will be adjusted.	2/4/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All (except Waiver)	Fixed	Claims with other insurance (TPL) added to the claims are posting error code 7141 erroneously and being denied. Error code 7141 - There is TPL identified to this claim, please login to the system to view the member's TPL information. Associated CARC/RARC: 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. MA04 – Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Denied claims will be resurrected.	2/4/2023
Outpatient Claims	Fixed	Outpatient claims being denied due to Error code 7875 – 3M DRG – Claim/Field Error Returned. Associated CARC/RARC: A1 – Claim/service denied. At least one Remark Code must be provided. MA07 – Alert: The claim information has also been forwarded to Medicaid for review. If claims denied with this error code, they will be resurrected.	2/4/2023
Real-time 270/271 Eligibility Transactions	Fixed	Real-time 270/271 member eligibility requests experiencing errors. This has been corrected and success message responses are occurring.	1/7/2023
Inpatient and Outpatient	Fixed	3M Version Update – GPCS v2023.0.0	1/7/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Medical and Outpatient Claims	Fixed	Original claim submissions are not posting a Prior Authorization (PA) edit or may post a PA edit and still pay the line, but when the claim is adjusted the PA edit may have posted accurately to the line or lines and paid or denied the claim appropriately. Error Code 1123: PA units or dollars unavailable Associated CARC/RARCs: 198: Precertification/authorization exceeded. N54: Claim information is inconsistent with pre-certified/authorized services. **Paid claims were adjusted on 1/10/2023.**	1/7/2023
Ambulance Claims with TPL or Medicare	Fixed	Ambulance claims with other insurance (TPL) or Medicare were denied erroneously due to error code 1751 posting to the claim. Error code 1751 – Code on claim requires manual review Associated CARC: 133 – The disposition of this service line is pending further review Denied claims will be resurrected.	1/7/2023
Medical Claims	Fixed	Surgeon claims are denying when the assistant surgeon's claim paid first, posting Error code 1747: Limit Exceeded. **Paid claims will be adjusted and denied claims will be resurrected.**	1/7/2023
All Providers	Fixed	Claims may have paid that should have been denied. Erroneously paid claims will be adjusted to post appropriate error codes.	1/7/2023

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All	Fixed	Error codes for denied claims are not appearing on the provider's 835 electronic payment file or Paper Remittance Advice (RA).	12/17/2022
All Providers (except waiver and dental	Fixed	Error code 7158 - Medicare Allowed Zero, is posting when the CARC/RARC entered on a line is CO-97. Reason code 97 indicates service is bundled with other lines by Medicare and zero paid. Error code 7158 has been updated and will post when Medicare allowed is zero = Medicare paid + sum of CARCs 1, 2, and 3. Denied claims will be resurrected.	12/17/2022
All Providers	Fixed	The suspected conflict of a paid claim in history is posting when the historical claim denied. Error code 7143: suspected conflict of a paid claim in history. **Denied claims will be resurrected.**	12/17/2022
Rural Health Care (RCH) Providers	Fixed	Rural Health Care (RHC) claims with TPL are not processing consistently, resulting in overpayments. Paid claims will be adjusted for the appropriate payments amounts, do not send checks.	12/17/2022
Tertiary Claims	Fixed	Tertiary claims not pricing correctly. **Paid claims will be adjusted.**	12/17/2022
Home Health	Fixed	Medicaid Fee Schedule was missing rates on Home Health Revenue Codes. The online Fee Schedule has been updated and the Home Health revenue codes reflect rates.	12/17/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Inpatient Claims	Fixed	Inpatient claim with other insurance had an approved amount greater than the patient responsibility reported on the claim. Paid claims were adjusted on 12/29/2022.	12/17/2022
Inpatient and Professional	Fixed	When the BMS receives an update for a Provider with a retroactive enrollment date, the system is not updating in all locations causing claim denials with Error Code 1359: Load line servicing provider data failed. Associated CARC/RARCs: 16: Claim or service lacks information or had submission or billing errors. N257: Missing, incomplete, or invalid billing provider or supplier primary identifier. **Denied claims will be** resurrected**.**	12/17/2022
Nursing Facility & Swing Bed Providers	Fixed	Date of death not being subtracted when revenue code 0101 and PA are on claim. **Paid claims will be adjusted.**	12/17/2022
All Providers	Fixed	Voided claims that are being resurrected (reprocessed) are not processing through duplicate editing. **Claims will be** resurrected**.**	12/17/2022
Inpatient Claims	Fixed	Provider initiated voids on the Provider Portal are denying and these voided TCNs are not processing to the RA. **Voided claims that were denied were** resurrected **on 12/30/2022.**	12/17/2022
Dental Claims	Fixed	Dental claims with one or more lines with $0.00 billed charges were denied and these should have appeared on the 12/23/22 RA or 835 file.	12/17/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Once Error code 1237: Missing line item submitted charge is updated to allow $0.00 as a valid charge*, these claims will be reprocessed.* **Update: On 2/4/2023, Error code 1237 should no longer post when the submitted charge on a line is $0.00.** **Denied claims were rekeyed on 2/8/2023 and will appear on RAs.**	
All Providers	Fixed	Providers submitting HIPAA claim adjustments on denied claims are failing or causing a take back claim, these claims may or may not appear on the Provider's RA/835. ***Important!*** Denied claims are to be resubmitted, **only** paid claims are to be adjusted.	12/17/2022
Medical Claims	Fixed	BMS selecting the CDTP (Communicable Disease Treatment Plan) benefit plan instead of the appropriate Medicaid benefit plan, causing claim denials. The Error Code 7076: CDTP claim exceeds threshold, is posting. **Denied claims will be** resurrected**.**	12/17/2022
Waiver Providers	Fixed	T2022: Case Management, Per Month Billing Requirements: Dates of service should be the full month, such as 7/1/2022 – 7/31/2022 Unit = 1 (this code is per month, not daily) Issues: The system is paying the available units on the P, since the Provider billed more than the one (1) unit per month. The paid units are being applied to the PA as used, which may exhaust the units. Future claims deny with no available units.	12/17/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		The BMS is being updated to limit T2022 to only allow one (1) unit per month. **Denied claims were resurrected and PA units have been updated as of 3/8/2023.**	
Waiver Claims	Fixed	Some Waiver claims (such as T2016) were being paid at $0.00 and not pricing from the Fee Schedule for the procedure code rate and benefit plan. Paid claims will be adjusted.	12/17/2022
All	Fixed	Some denied claims are not processing through to the 835 electronic payment file or Paper Remittance Advice (RA). These claims are to appear on the 1/6/23 RA and 835 file.	12/17/2022
RHC Claims	Fixed	RHC claims with other insurance were not pricing the lesser of logic. **Paid claims will be adjusted.**	12/17/2022
Hospice	Fixed	Patient liability not being deducted from hospice claims when revenue code 0658 was submitted on the claim. **Paid claims will be adjusted.**	12/17/2022
Medical and Outpatient	Fixed	Procedures that are "not allowed" for date of service are being reimbursed at $0, instead of being denied with Error Code 7006, procedure not allowed for service date. **Paid claims were adjusted on 12/30/2022.**	12/17/2022
All Providers (except Waiver)	Fixed	When entering other insurance details during Direct Data Entry on the Provider Portal, Providers are receiving an online error when entering the same reason code with different group codes.	12/17/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Example: CO-5 PR-5	
Dental Claims	Fixed	When submitting dental claims Direct Data Entry (DDE) in the Provider Portal, Providers received the error message, "Tooth Number/Letter is invalid for Service Line", when a tooth number was not required for the procedure.	11/5/2022
Outpatient Claims	Fixed	3M returning APC "00000" and being priced at $0. Due to the volume of claims, multiple masses will be completed to reprocess claims. ***12/17/2022 Update:*** Outpatient claims will be adjusted once the OPPS defects are resolved to avoid multiple reprocessing of the same claims.	10/29/2022
Dental Claims	Fixed	The BMS Provider Portal is not allowing Dental Providers to complete claim adjustments for tooth numbers, quadrants, and so on during the claim adjustment process.	10/29/2022
Dental Claims	Fixed	Adjusted dental claims (D8670) are paying at $0.00. ***12/19/2022 Update:*** Paid claims will be adjusted.	10/15/2022
Dental Claims	Fixed	Procedure D4342 and D4341 is currently not applying the 24-month limitation according to quadrant, which may contribute to denials in error. Once this issue is corrected, Providers can resubmit claims. Providers may resubmit denied claims and need to include the quadrant modifier when billing D4342 or D4341: 10: Upper right quadrant	10/15/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		20: Upper left quadrant 30: Lower left quadrant 40: Lower right quadrant	
Medical Claims	Fixed	Claims are denying erroneously for Members on the CDTP benefit plan. Error code 7067: Communicable Disease Treatment Plan (CDTP) claim exceeds threshold. Associated CARC/RARC A1: claim or service denied M54: missing, incomplete, or invalid total charges Denied claims were resurrected on 10/21/2022.	10/1/2022
Nursing Home	Fixed	NH claims are paying the per diem on crossover claims instead of lessor of logic. Paid claims were adjusted on 10/18/2022.	10/1/2022
Medical and DME Claims	Fixed	For patients with Medicare primary, Error code 7158 may be posting in error to services that are not covered by Medicare. Error code 7158 - Medicare allowed zero Denied claims were resurrected on 10/21/2022.	10/1/2022
All Providers (except waiver)	Fixed	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. Providers can resubmit claims once this fix has been completed.	9/20/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
RBRVS Medical Claims	Fixed	The following procedure codes were not reflecting the appropriate RBRVS Pricing: 22210; 22212; 22214; 22220; 22224; 22548; 22590; 22595; 22630; 22810; 22812; 22830; 22852; 27132; 27134; 27137; 27138; 85396. Paid claims were adjusted on 11/14/2022.	9/17/2022
All Providers (except Dental and Waiver)	Fixed	Other primary and secondary insurances (TPL) causing claim overpayments.	9/17/2022
All (except Dental)	Fixed	Invalid diagnosis codes are being removed from the claim file erroneously. The Call Center Representatives are not able to provide the diagnosis code but can provide which position using the diagnosis pointer (blank dx field). Providers can review these claims on the Provider Portal and resubmit the claim. 1421: invalid other diagnosis code 1091: diagnosis pointer invalid	9/17/2022
All Medical Providers	Fixed	Wyoming Medicaid has added multiple NDCs to J1050. Only paid claims with line denials with one (1) of these NDCs were adjusted on 9/9/2022.	9/7/2022
RHC/FQHC/IHS	Completed	Bypass for commercial payers (TPL)	9/7/2022
All Providers	Fixed	Duplicate editing not occurring on all claims. Claim voids will be completed to take back the duplicate claim payment, these will appear on the Provider's remittance advice (RA). Claims that should have denied as a duplicate will be voided, these voided TCNs will appear over the next several RAs.	9/3/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Nursing & Swing Bed Providers	Fixed	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.	9/3/2022
IHS, RHC, FQHC	Fixed	Claims with TPL/Medicare – not pricing correctly with the lesser of logic. Paid claims were adjusted on 9/7/2022.	9/3/2022
Medical Claims	Fixed	Medical claims for T2024 services and the Member eligibility of W99 are denying erroneously due to the rendering taxonomy or specialty. Claims are denying with Error code 7343 - rendering Provider Allowable Code (PAC) violation. Associated CARC 185: the rendering Provider is not eligible to perform the service billed Denied claims were resurrected on 9/8/2022.	9/3/2022
All Providers	Fixed	TCNs are not appearing on Remittance Advices (RAs) when they are paid or denied. Many claims that were not appearing were released and were on the 9/9/2022 RAs. ***Update:*** This defect has been reopened to resolve the remaining claims not appearing on RAs, this was resolved on 10/29/2022.	**Second Resolution Date:**10/29/2022 Issue Reopened: 10/9/2022 Original Resolution Date: 9/3/2022
Swing Bed Claims	Fixed	Swing bed claims not systematically deducting the date of discharge, date of death, or transfers when calculating calculated days.	9/3/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Claims denied with error code 7075 - institutional care invalid calculated days vs billed days. Associated CARC/RARCs: A1: Claims/service denied M53: Missing/incomplete/invalid days or units of service Denied claims were resurrected on 9/12/2022.	
Outpatient	Fixed	Outpatient (OPPS) claims are not considering the lesser of logic. Paid claims were adjusted on 9/8/2022.	8/12/2022
Outpatient Claims	Fixed	OPPS claims with line denials posting Error Code 7172 - APC relative weight missing (when a relative weight is being returned by 3M). Associated CARC/RARC 96: non-covered charges M86: service denied because payment already made for same/similar procedure within set time frame. Denied claims were resurrected and paid claims with denied lines were adjusted on 8/16/2022.	8/12/2022
All Providers (except Waiver and Dental)	Fixed	One Medicare crossover claim pays, but the second may be denied due to same Member and same date of service (for example: ambulance vs. emergency room, emergency room vs. inpatient). The following error codes are being updated to allow the second Medicare crossover claim to process through to payment – not auto-deny. Error code 7042: Outpatient services same day billed on separate claims. Associated CARC/RARC	8/11/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		18: exact duplicate claim or service M144: pre- or post-operative care payment is included in the allowance for the surgery or procedure Error code 7074: Inpatient claim duplicate of outpatient claim Associated CARC 60: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services Once the error codes are updated claims will be "in-process" to be manually reviewed to ensure the claim posting this error is a Medicare crossover claim. Denied claims were resurrected on 8/23/2022.	
Outpatient Claims	Fixed	Edit 7066 posting on OPPS claim bundled lines (APC Status Indicator N) incorrectly Associated CARC 16: claim or service lacks information or has submission or billing errors. Paid claims were adjusted on 8/15/2022.	8/6/2022
Immunization Claims	Fixed	CPT 90461 is to pay at zero dollars ($0.00), and the line is not to be denied. Denied claims were resurrected and paid claims with denied lines were adjusted on 8/8/2022.	8/6/2022
PASRR Level I Submitters	Fixed	PASRR Level I data entry text or wording changes No claims impact, Provider Portal screen updated.	8/6/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
All (except Waiver)	Fixed	Screen change to increase brightness of the **Enter Insurance Info** button/icon and underlined for visibility purposes.	8/6/2022
Hospice	Fixed	The BMS needed to deduct a day from Hospice claims with the following patient statuses: 01: Discharged home 02: Discharged or transferred 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 ***Update:*** Claims are pricing and processing as expected.	8/6/2022
All Providers	Fixed	NDC label names are incorrect and do not match NDC. No claims reprocessing required, informational only. ***Update:*** Reopened and updated on 9/3/2022.	**Second Resolution Date:** 10/22/2022 Issue Updated: 9/3/2022 Original Resolution Date: 8/6/2022
FQHC/RHC/IHS	Non-System Issue	Clarification: Medicaid claims ONLY Medicaid will always reimburse Providers the Medicaid encounter rate, even when the Provider's billed charges are less.	8/6/2022
All Providers	Fixed	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.	**Second Resolution Date:** 8/5/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		On 6/28/2022, this issue was reopened. ***Update:*** Retested on 8/5/2022 and claims are processing as expected. Providers may resubmit claims.	Issue Reopened: 6/28/2022 Original Resolution Date: 4/30/2022
Waiver Providers	Fixed	Procedure code T2023, claims posting Error Code 5110 - billed units exceed MUE quantity allowed. Associated CARC/RARC 96: no-covered charges N362: the number of days or units of service exceeds our acceptable maximum. ***8/1/2022 Update:*** The Agency determined the edit is posting correctly. Providers should contact their case managers with specific questions.	8/1/2022
Inpatient Claims	Fixed	Denied claims are utilizing Prior Authorization (PA) units. Steps remaining: Add the units back to the PAs Claims will be resurrected once the PAs have been updated. ***Update:*** Denied claims were resurrected 9/8/2022 and paid claims with denied lines were adjusted on 9/2/2022.	7/23/2022
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 need to delete saved templates with the inactive Provider ID and create new templates.	7/23/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
Immunization Claims	Fixed	Immunization administration claims: Procedure code 90460 is to be billed for the initial vaccine components, and then 90461 is to be billed for all remaining components. It appears that beginning in May, claims started denying erroneously with Error code 7056 - admin code must equal vaccine product. ***Update:*** Denied claims were resurrected on 8/1/2022.	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. ***Update:*** Paid claims with denied lines were adjusted on 8/4/2022.	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 prior authorization (PA). Once the issue is corrected, these claims will be resurrected. ***Update:*** 8/11/2022 - In researching the denied claims, CNSI determined these claims would deny for other reasons during the reprocessing. Claims were voided and Providers may resubmit these claims.	7/23/2022
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 Hospitals	Fixed	The Ambulatory Payment Classification (APC) Status Codes W for Outpatient Claims is causing issues and may cause a denial of your claims.	7/9/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Denied claims were resurrected and paid claims with denied lines were adjusted on 7/14/2022.	
All Medical Providers	Fixed	Procedure code 27299 is being denied with Error code 1332, unable to determine rate value. Associated CARC/RARCs 16: claim or service lacks information or has submission or billing errors N65: Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/Provider. Claims were resurrected on 7/14/2022.	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. Associated CARC/RARCs 97: the benefit for this service is in the payment or allowance for another service or procedure that has already been adjudicated M144: pre- or post-operative care payment is included in the allowance for the surgery or procedure. Denied claims were resurrected and paid claims with denied lines were adjusted on 7/14/2022.	7/9/2022
Outpatient, Nursing Home, Home Health, and Hospice Claims	Fixed	7/9/2022: Potential paid lines being denied, causing the entire OPPS claim to be denied. Once the issue is corrected, these claims will be resurrected. ***Update:*** On 9/3/2022 this defect was reopened and expanded to more claim types, this was fixed on 10/1/2022.	**Second Resolution Date:** 10/1/2022 Issue Reopened: 9/3/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Claims will be resurrected.	Original Resolution Date: 7/9/2022
DME	Fixed	Error code 7158 - Medicare allowed zero, posted erroneously to durable medical equipment (DME) claims. Associated CARC/RARCs A1: claim or service denied N8: crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication 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
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). Associated CARC/RARCs 16: claim or service lacks information or has submission or billing errors M62: missing, incomplete, or invalid treatment authorization code Issue was re-opened to address additional impacted claims and claims will be adjusted.	**Third Resolution Date:** 7/27/2023 Issue Reopened: 1/7/2023 Second Resolution Date: 7/23/2022 Issue Reopened: 7/11/2022 Original Resolution: 6/25/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Update: Paid claims with denied lines were adjusted on 8/8/2022. ***Update***: 1/7/2023 – The issue which caused this defect to be reopened is still pending resolution. Upon resolution, impacted claims will be adjusted.	
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. Associated CARC 31: patient cannot be identified as our insured Denied claims were resurrected on 6/23/2022.	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. Associated CARC/RARCs 16: claim or service lacks information or has submission or billing errors N257: missing, incomplete, or invalid billing Provider or supplier primary identifier These claims were resurrected 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. Associated CARC/RARCs 15: the authorization number is missing, invalid, or does not apply to the billed service or Provider N54: claim information is inconsistent with pre-certified/authorized services	6/11/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Denied claims were resurrected and paid claims with denied lines were adjusted on 6/23/2022.	
FQHC / RHC/ IHS / PRTF / ESRD / Hospice / Nursing Facilities	Fixed	Claim denials due to Provider rates not being found, Error code 7012. Associated CARC B7: this Provider was not certified or eligible to be paid for this procedure or service on this date of service. Denied claims were resurrected on 6/22/2022.	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. Associated CARC/RARCs for Error code 7093 A1: claim or service denied N251: missing, incomplete, or invalid attending Provider taxonomy Associated CARC for Error code 1452 16: claim or service lacks information or has submission or billing errors Once this issue is corrected, Providers need to resubmit these claims.	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	6/11/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Initially, resolved on 6/11/2022 and paid claims were adjusted on 6/27/2022.	
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 resurrected on 6/27/22. Associated CARC/RARCs for Error code 1122 15: the authorization number is missing, invalid, or does not apply to the billed service or Provider N54: claim information is inconsistent with pre-certified/authorized services Associated CARC/RARCs for Error code 1121 198: precertification or authorization exceeded N351: service date outside of the approved treatment plan service dates.	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 resurrected on 6/6/2022.	5/31/2022
Outpatient Claims	Fixed	Error code 7158 – Medicare allowed zero. Associated CARC/RARCs	5/28/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		A1: claim or service denied N8: crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication. Denied Outpatient Prospective Payment System (OPPS) claims were resurrected and paid claims with line denials were adjusted on 6/27/2022.	
All Providers	Fixed	When two (2) 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
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
IHS	Fixed	Claims denied due to Error code 7053, invalid revenue code on inpatient crossover, posting erroneously. Associated CARC/RARCs 16: claim or service lacks information or has submission or billing errors M50: missing, incomplete, or invalid revenue codes Providers may resubmit claims.	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 resurrected. Issue was re-opened to address additional impacted claims and claims have been resurrected.	4/16/2022 and 5/24/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
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* resurrected *on 5/3/2022.* *Denied claims with dates of service in 2021 were* resurrected *on 6/28/2022.*	3/5/2022 and 5/3/2022
Waiver Providers	Fixed	Bypass TPL (Other Insurance) editing for waiver claims. Claims will be resurrected.	4/30/2022
Dental Providers	Fixed	A Member's primary insurance for dental services is not being considered. Medicaid is paying these claims as though no other insurance is available resulting in an overpayment to the Provider. This issue was corrected, claims denied in error will be resurrected.	4/2/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
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 resurrected.	3/22/2022
Inpatient	Fixed	Possible overpayment due to other insurance not being deducted. Claims will be resurrected.	3/22/2022
ACES$ Providers	Fixed	ACES$ claims are being underpaid due to the add-on modifier percentages rate. Claims denied in error are being identified and resurrected.	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 resurrected.	3/19/2022
Ambulatory Surgery Centers	Fixed	The Ambulatory Payment Classification (APC) relative weights being reviewed for the claim appear to be denying with edit 7172. Associated CARC/RARC 96: Non-covered charges M86: service denied because payment already made for same or similar procedure within set time frame. This issue was corrected, claims denied in error will be resurrected.	3/19/2022
Dental Providers	Fixed	Procedure: D1110 may deny incorrectly for the limit being met.	3/19/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		This issue was corrected, claims denied in error will be resurrected.	
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. ***Update:*** Denied claims were resurrected and paid claims with denied lines were adjusted on 8/8/2022.	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 resurrected.	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 resurrected to pay out the amount of patient contribution withheld in error.	3/19/2022
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	3/19/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
		Chiropractic Visits Dietitian Visits Behavioral Health Visits Office Visits This issue was corrected, claims denied in error will be resurrected.	
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 resurrected.	3/19/2022
All Providers	Fixed	Claim may pay although the 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 resurrected.	3/5/2022
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 resurrected.	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 resurrected.	2/19/2022

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
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 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	When searching by the National Provider Identifier (NPI) number, all 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	PAs are not updating in the Benefit Management System (BMS) and are duplicating. Impacted claims are being identified and resurrected.	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 resurrected.	2/5/2022
All Providers	Fixed	The patient contribution is not updating correctly. Claims denied in error are being identified and resurrected.	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 resurrected.	1/22/2022

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

Archived: November 2021 through September 2024

Provider Type(s) Impacted	System Status	System Status Message	Date Fixed
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 resurrected.	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 resurrected.	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

Acentra Health and the state of Wyoming Department of Health (WDH) continuously look to improve and enhance the Benefit Management System (BMS). The following table lists the Agency's priority enhancements that have been implemented.

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
All Providers	Completed	Claims should be denied when entered for partial units. Claims should only be submitted for whole units, and a warning message should populate when claims are being entered via Direct Data Entry to notify the submitter of the error present. Claims that are submitted despite the error will be denied for Edit 7212 - UNIT(S) OF SERVICE IS PARTIAL AND NOT VALID.	3/9/2024	3/9/2024
Claims (CE) - Claims Adjudication	Completed	Edit 1775 bypass condition enhancement	7/13/2024	7/13/2024
All Providers	Completed	Provider Member Eligibility Search – Add Date of Last Transaction (DOS)	12/16/2023	12/16/2023
All Providers	Completed	Change to Reimbursement Methodology for ESRD Claims	10/30/2023	10/30/2023
All Providers secondary to Medicare	Completed	Medicare Supplemental Plan	10/30/2023	10/30/2023
Home Health Providers	Completed	EVV Home Health	10/30/2023	10/30/2023
All Providers	Completed	PAs Ignoring Treating Providers	9/14/2023	9/14/2023

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
All Providers	Completed	277CA Claims Transaction Acknowledgment	9/9/2023	9/9/2023
DME Providers	Completed	DME Codes – Rural and Non-Rural Rates	8/8/2023	8/8/2023
All Providers	Completed	Eligibility Inquiry Functionality - 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. This functionality is currently being reviewed for enhancements on how search results are displayed for a specific code eligibility inquiry when that code falls within a range of limited codes.	3/29/2023	3/29/2023
Waiver Providers	Completed	EVV/CareBridge claim denial error (edit) code New Error Code 7207: EVV Services must be submitted by CareBridge EVV. Associated CARC/RARCs: 95: Plan procedures not followed N824: Electronic Visit Verification (EVV) data must be submitted through EVV vendor	12/17/2022	12/17/2022
All Providers	Completed	Timely filing denial will not occur when the start date is before timely filing and the end date is after timely filing period.	12/17/2022	12/17/2022
All Providers	Completed	Allow Provider's visibility of the Medicaid Error codes on the Medicaid Paper Remittance Advice (RA).	9/3/2022	9/3/2022

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
		The September 9, 2022, Paper RA will be the first one to display Error Codes. For complete details and how-to steps, refer to the Wyoming Medicaid website (https://www.wyomingmedicaid.com/portal/) > What's New page > the updated "Retrieving Paper Remittance Advice" Quick Reference Guide.		
All Providers	Completed	Allow Provider's visibility of the Medicaid Error codes on the Provider Portal when inquiring on claims. For complete details and how-to steps, refer to the Wyoming Medicaid website (https://www.wyomingmedicaid.com/portal/) > What's New page.	9/3/2022	9/3/2022
All Providers	Completed	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. For complete details and how-to steps, refer to the Wyoming Medicaid website (https://www.wyomingmedicaid.com/portal/) > What's New page > the Member Eligibility, Code Reviews/Service Limits & Historical Claim Searches Quick Reference Guide.	9/3/2022	9/3/2022
All Providers	Completed	Reinstating Provider enrollment "Inactivity" terminations - 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.	8/6/2022	8/6/2022

Provider Type(s) Impacted	System Status	Change Request or Enhancement Description	Anticipated Release Date	Release Date
		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.		
All Providers (Except Dental and Waiver)	Completed	Outbound COBA eligibility file.	N/A	7/19/2022
All Providers	Completed	Provider Allowable Code (PAC) 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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