| Provider Type | Number of Impacted Providers | Category | Issue | Date Issue Found | Number of Days Outstanding | Estimated Fix Date | Status | Resolution | Interest/Penalties Owed | Date Resolved | Tech Ops Incident/Problem Number |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Professional | All | Claims | A prepayment edit/denial requesting medical records is being applied to claims billing Allergy Testing. The prepayment review conflicts with the clinical policies. | 1/8/2025 | 246 | 2/28/2025 | Open | Prepayment code edit modification is being implemented to remove this edit being applied to Allergy Testing. A claims impact report is being pulled to identify denials and submit them for reprocessing. | Yes | | RITM07730752 |
| Professional | 500 | Overpayment | In 2023, the Local Education Agencies NCD Fee Schedule was added in error to multiple providers, thus causing some CPT codes to pay higher than allowed. Claims paid in error are currently being identified. Any claim line that paid more than $10 from the LEA Fee Schedule will be recouped and then reprocessed to pay from the appropriate fee schedule. Impacted providers can expect to receive communications before the recoupment takes place. | 6/1/2025 | 102 | TBD | Open | Impacted claims will be recouped and then reprocessed/paid from the appropriate fee schedule | No | | |
| Professional | Pending | Claims | WellCare has identified an issue impacting FQHC facilities billing well child visits that were processing under the individual provider instead of the group provider ID. This was causing underpayments for the well child CPT codes. | 6/12/2025 | 91 | 7/5/2025 | Open | WellCare has implemented pick logic updates for FQHC's billing well child visits w/ CPT's 99381-99385 and 99391-99395 to pick the Group PID over the Individual Provider PID. Impacted claims review under way and pending reprocessing. | Yes | | |
| Institutional and Professional | Pending | Claims | WellCare has identified an issue causing an increase in COB denials related to some of the Member TPL validations and updates not successfully being ingested into the WellCare systems. This issue has caused some WellCare members to reflect the incorrect OIC information on the Provider Portal. | 6/23/2025 | 80 | 8/31/2025 | Open | WellCare leadership has escalated this issue and currently has several parallel workstreams in progress. The Data Analytics team is generating and reviewing reports to identify any TPL records that errored out and were not ingested into the system. System enhancements are underway to produce a corrected TPL output file that can be appropriately ingested to update the WellCare portal and internal systems. Recent TPL updates are being reviewed and validated to initiate manual processing and reduce the overall claims impact. A global claims impact analysis is underway to determine which TPL records require updates and potential claims reprocessing. | Yes | | |
| Institutional | Pending | Claims | Pathology TC modifier issue. A ticket was submitted to Config to have a new fee schedule added for Outpatient Hospital Laboratory rates and in doing so, the X38 Outpatient Hospital Laboratory Fee Schedule was removed from OP Hosp facilities, this was on 6/25. This caused incorrect NOFEE denials for pathology codes billed with a TC modifier. | 7/17/2025 | 56 | 7/17/2025 | Open | On 7/17 it was learned that the new fee schedule was in addition to and not in place of the X38 fee schedule and it was added back to the facilities. Configuration is now accurate. An impact report has been pulled and claims are being reprocessed. | Yes | | RMS00241548<br>RMS00243789<br>RMS00245936 |
| Professional | 32 | Claims | There was an error identified in PCS claims are being manually processed. The days entered into the calculator were calculating the days authorized instead of the authorized units approved, which led to an underpayment in the per diem rates. | 7/24/2025 | 49 | 7/28/2025 | Closed | Education has been completed for processing and ensuring that the calculation uses authorized units approved rather than days. A global impact has been pulled to have any claims reprocessed that were underpaid. | Yes | 8/20/2025 | RMS00242065 |
| Institutional Hospice | Pending | Claims | WellCare has identified an issue for Hospice Providers causing CMD01 Denials (Denied: Not a Covered Medicaid Service) when billing Value Code G8. Per the NC Medicaid Clinical Coverage Policy, 3D Hospice Services, updated on 3/15/2024, Value code 68 was removed and replaced with G8. Some Hospices providers do not have the updated value code reimbursement logic for billing G8, causing the CMD01 denials. | 8/20/2025 | 22 | 9/30/2025 | Open | The WellCare Configuration Team is reviewing and updating all impacted Hospice Providers to ensure Value Code 68 is removed and G8 added to the reimbursement logic. A global impact report is being pulled to identify Hospice claims billing Value Code G8 that denied CMD01 incorrectly. Once the configuration updates are completed, the impacted claims will be reprocessed and adjusted to pay. | Yes | | RMS00245003 |
| Optical | 57 | Claims | Claims denied NOFEE for code is not a covered service on your fee schedule. Ophthalmologist are loaded with the Optometry fee schedule and provider states they should be reimbursed at the Physician Fee Schedule | 9/30/2021 | | 11/2/2021 | Closed | Providers updated to add Physican Services Fee Schedule to allow reimbursement for optometry related services. Claim adjustments complete. | No | 11/2/2021 | N/A |
| Various | 75 | Claims | Claims for newborns denied DN001 for no prior authorization in error | 10/25/2021 | | 11/23/2021 | Closed | Authorizations were waived for newborn claims. Claim adjustments complete. | No | 11/23/2021 | N/A |
| Dental | 4 | Claims | Dental ASC claims denied IH041 for invalid place of service in error | 10/24/2021 | | 11/17/2021 | Closed | Coding edit modification to allow reimbursement for dental services in an ASC setting. Claim adjustments complete. | No | 11/17/2021 | N/A |
| Dental | 12 | Claims | Dental surgery services incorrectly denied BMCD to bill Medicaid directly for ASC facilities | 11/8/2021 | | 12/3/2021 | Closed | Benefits configuration updated to reimburse dental services for all facilities. Claim adjustments complete. | No | 1/19/2022 | N/A |
| FQHC/RHC | 452 | Claims | FQHC T1015 Denial | 9/28/2021 | | 10/6/2021 | Closed | FQHC/RHC pricing updated. Claim adjustments complete. | No | 10/6/2021 | N/A |
| Various | 116 | Claims | IH118 denials for service is incidental service, not separately payable due to incorrect bundling of lab services | 11/3/2021 | | 12/3/2021 | Closed | Coding edit turned off to allow lab services to pay based on CCR and lab fee schedule. Claim adjustments complete. | No | 12/3/2021 | N/A |
| Various | 1793 | Claims | NDCTT: Drug manfacturer labeler is not allowed for rebate. Physician administered drugs not pricing according to the fee schedule | 10/7/2021 | | 10/21/2021 | Closed | Configuration update to allow reimbursement for drug codes when billed with the appropriate NDC code based on guidance received from the State. Claim adjustments complete. | Yes | 10/27/2021 | N/A |
| Various | 1631 | Claims | Non PAR treat as PAR; non par claims denied for no prior authorization during 9/30/21 - 11/30/21 period when non par providers were to follow PAR auth rules | 11/12/2021 | | 11/30/2021 | Closed | Authorization requirements waived for 9/30/21 - 11/30/21 for Non PAR providers. Claim adjustments complete. | No | 11/30/2021 | N/A |
| Various | 864 | Claims | Copays were being applied to services that were part of an EPSDT visit. | 11/19/2021 | | 1/17/2022 | Closed | System is now updated to no longer apply copays for services rendered as part of an EPSDT visit. | No | 4/11/2022 | N/A |
| Various | 1620 | Claims | Vaccine codes 0001A, 0004A, 0054A and 0071A paid $45. State retro updated rate back to April 1, 2021 to pay $65. Adjustment project captures claims for ALL NC Medicaid providers. | 3/10/2022 | | 2/8/2022 | Closed | Rates were previously updated; claim adjustments in process | No | 4/5/2022 | N/A |
| Various | 7 | Claims | Child First Services- update for CPT code 99499; DN001/INMOD denials | 1/21/2022 | | 2/24/2022 | Closed | System updates completed to pay claims at appropriate rate if provider submitted appropriate certification form. Adjustments complete | Yes | 3/15/2022 | N/A |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DME | 55 | Claims | DME & O&P claims denied IH033 for exceeding clinical guidelines and IH038 for inconsistent modifer used or required modifier is missing when billing with KX & KS modifiers | 1/26/2022 | | 2/11/2022 | Closed | Coding edits turned off to allow the use of modifers KX and KS. Claim adjustetments complete. | No | 2/11/2022 | N/A | | | |
| DME | 23 | Claims | DME & O&P claims denied INMOD for procedure code not payable on fee schedule and NOFEE for code is not a covered service on your fee schedule due to providers not configured with correct fee schedule per NC price grid | 11/11/2021 | | 2/24/2022 | Closed | Appropriate providers updated with DME & O&P fee schedules to allow payment for these services. Claim adjustments complete. | No | 2/24/2022 | N/A | | | |
| Various | 9 | Claims | Fee Schedule issue causing H2022 code to deny NOFEE for code not covered on fee schedule & INMOD for procedure code not payable on fee schedule- 2 Part Project: Part 1 for TJ & HE modifiers, Part 2 for CR, GT and blank modifiers | 1/31/2022 | | 2/18/2022 | Closed | Fee schedule updated to add modifiers TJ, HE, CR, GT and blank to allow appropriate reimbursement for HCPCS code H2022. Claim adjustments complete for both Part 1 and 2 projects. | No | 2/18/2022 | N/A | | | |
| Various | All | Claims | Received fee schedule update to remove all the following codes $65 rate for vaccine administration: 0001AEP, 0001A, 0002AEP, 0002A 0003AEP, 0003A 0004AEP, 0004A 0011AEP, 0011A 0012AEP, 0012A 0013AEP, 0013A 0031AEP, 0031A 0034AEP, 0034A 0064AEP, 0064A 0071AEP, 0071A 0072AEP, 0072A 0073AEP, 0073A. | 1/21/2022 | | 3/7/2022 | Closed | WellCare has implemented the fee schedule change as required. There are 534 claims remaining to be adjusted to pay the rate of $65. ***Claim adjustments complete | Yes (after 3/7/22) | 6/7/2022 | N/A | | | |
| Various | 1 | Claims | Claims incorrectly denying IH118 & IH123 for Revenue Code requires HCPCS code when Rev Code is billed without HCPCS or CPT code | 2/14/2022 | | 3/23/2022 | Closed | Edit updated to allow reimbursement when Revenue Codes are billed without HCPCS/CPT codes. Claim adjustments in process, ETA: TBD ***Claim adjustments complete | Yes | 6/7/2022 | N/A | | | |
| Behavioral Health | 151 | Claims | Claims denied NOFEE for code not covered on fee schedule and INMOD for procedure code not payable on fee schedule. BH provider types billing for CPT code Q3014 not on the custom BH Fee Schedules | 2/14/2022 | | 3/31/2022 | Closed | Fee schedule updated to add HCPCS code Q3014. Previous issue addressed claims for a single provider. Now addressing remaining claims for global impact, ETA: 4/30 **5/2- Claim adjustments complete | No | 5/2/2022 | N/A | | | |
| Various | 21 | Claims | Aged NCD SNIP Edit. Issue identified with our Standard SNIP edits that was part of the EDI Gateway upgrade that occurred mid-February. The standard edit, Service Facility Location Name should not be used, was deployed into production incorrectly and the issue was identified as part of our on-going EDI gateway validation efforts. | 3/25/2022 | | 3/30/2022 | Closed | The standard edit, Service Facility Location Name should not be used, was deployed into production incorrectly and the issue was identified as part of our on-going EDI gateway validation efforts. Issues are being resolved per provider. Depending on how the claim was submitted some providers will have to resubmit while most HHAX will resend us a corrected file. Claims began reprocessing 3/30/22. Claim count: 7,888 | Yes | 3/30/2022 | N/A | | | |
| Various | 1 | Claims | Taxonomy Issues. Issue identified with the BEGIN and END dates of a claim where the provider was active on different roster spans | 2/24/2022 | | 3/24/2022 | Closed | Updates made to rules that check the BEGIN and END dates. Claims were reran and are currently pending. Reran claim count: 54,071 | Yes | 3/24/2022 | N/A | | | |
| Various | 1113 | Claims | Claims denied for EOB for Preventative Care services. Preventative Care Service are to be paid as primary and not deny when patient has other insurance | 3/1/2022 | | 3/11/2022 | Closed | System has been updated to pay preventative care services as primary when billed with EP or TJ modifiers. | Yes | 3/11/2022 | N/A | | | |
| Various | 1 | Claims | Taxonomy Issues. Issue identified with the BEGIN and END dates of a claim where the provider was active on different roster spans | 2/24/2022 | | 3/24/2022 | Closed | Updates made to rules that check the BEGIN and END dates. Claims were reran and are currently pending. Reran claim count: 54,071 | Yes | 3/24/2022 | N/A | | | |
| Ambulance | 12 | Claims | Ambulance ONE CALL claims denying for multiple reasons; configuration update to reflect appropriate denial reason code; claims adjusted to reflect ONECA denial reason | 1/4/2022 | | 3/1/2022 | Closed | Benefits configuration updated for claims to deny ONECA. Claim adjustments complete to reflect appropriate denial reason code. | No | 3/1/2022 | N/A | | | |
| Various | 1 | Claims | Authorizations not required for Home Health providers during TOC period (Part 1) | 9/29/2021 | | 3/15/2022 | Closed | Authorization requirements waived during TOC period, 7/1/21 - 9/28/21 for Home Health providers. Claim adjustments complete. | No | 3/15/2022 | N/A | | | |
| Behavioral Health | 1 | Claims | Claims denied NOFEE for code not covered on fee schedule due to provider pick issues where claims incorrectly processed to group PID and processed as Non PAR or Q3014 missing from BH fee schedule. | 2/14/2022 | | 3/31/2022 | Closed | Individual providers were retro loaded PAR. Claims that incorrectly picked group ID and processed as Non PAR were reprocessed as PAR to the individual provider ID and Q3014 was added to BH schedule. Adjustments complete. | Yes | 3/28/2022 | N/A | | | |
| Various | 1353 | Claims | EPSDT claims denying DN018 for primary EOB for services that should be paid as primary by the Health Plan | 2/28/2022 | | 3/28/2022 | Closed | Script to be updated to exclude EPSDT services. Adjustments complete | No | 3/28/2022 | N/A | | | |
| Various | 289 | Claims | Maternity services denied for DN018 (requesting EOB from primary insurance) in error as Maternity services pay claims as primary. | 2/28/2022 | | 3/31/2022 | Closed | Script to be updated to exclude Maternity services and pay claims as primary. Adjustments complete. | No | 3/16/2022 | N/A | | | |
| Various | 118 | Claims | Radiology services denied DN001 for prior no authorization when valid authorizations exist (NIA vendor) | 3/3/2022 | | 3/22/2022 | Closed | Processing details updated to include NIA vendor authorization logic. Claim adjustments complete | No | 3/22/2022 | N/A | | | |
| Pharmacy | All | Pharmacy | Our PBM, CVS/CareMark removed the transmission fees for entire WellCare North Carolina Medicaid pharmacy network as of April 29, 2022. WellCare of NC will also inform contracted pharmacy providers that no transaction fees will be charged by WellCare of NC for the processing of all Medicaid pharmacy claims starting April 29, 2002 | 4/26/2022 | | 4/29/2022 | Closed | Our PBM, CVS/CareMark removed the transmission fees for entire WellCare North Carolina Medicaid pharmacy network as of April 29, 2022 | No | 4/29/2022 | N/A | | | |
| DME | 737 | Claims | Health Plan decision to load DME, orthotics and prosthetics fee schedules to the following provider Licenses: MD, DO, NP & PA. Current configuration is based on taxonomies; and O&P was loaded based on degrees of providers. These services are being billed by various providers outside of the taxonomies/degrees the fee schedules were loaded to remove provider abrasion and allow these Providers to administer the necessary DME/O&P services | 11/11/2021 | | 4/1/2022 | Closed | Loaded DME, orthotics and prosthetics fee schedules to the following provider Licenses: MD, DO, NP & PA. Additional updates to load licenses APRN, ARNP, DPM, APN, CNP, MSNNP, PAC & PO. Claim adjustments in process ***5/16- Claim adjustments complete | Yes | 5/16/2022 | N/A | | | |
| DME | All | Claims | Claims for DME (disposable supplies) denied CE524, NOFEE and INMOD when billed with the "NU" modifier. | 3/10/2022 | | 5/11/2022 | Closed | Fee schedules were updated to add the null/XX rows to codes back to the earliest effective date. Coding Edit modification implemented to remove identified codes to allow reimbursement when billed with NU modifier. (Codes- T4521-T4544; B4160, B4161, B4152, B4150, B4155, B4103, B4158, B4149, B4154, B4100, B4153, B4197, B4162, B4185). Claim adjustments complete. | No | 5/11/2022 | N/A | | | |
| Various | All | Claims | Claims denied for EOB for Medical Support Enforcement members. | 3/10/2022 | | 5/27/2022 | Closed | Received list of identified Medical Support Enforcement members. We will denote these members using a rider code to allow claims to pay as primary. Claims impacted are 1849 with claims expected to be reprocessed by 5/27/22. ***Claim adjustments completed on 5/5/22 | No | 5/5/2022 | N/A | | | |
| Hospital | All | Claims | Newborn Claims denied for authorization. We received updated state guidance for Newborn Claims and notifications. | 7/1/2021 | | 5/2/2022 | Closed | Reprocessing of normal newborn claims denied for no authorization completed on 4/26/22. Claim adjustments completed for claims with DRG 794 and 795. All other DRG's, will be reprocessed by 5/20/22. There are a total of 13 claims that require medical records for retro auth. Provider Relations have reached out for those specific claims. ***Claim adjustments complete | No | 5/7/2022 | N/A | | | |
| Various | 194 | Claims | Institutional claims were incorrectly denied for NDCUU/NDCTT. | 2/25/2022 | | 4/15/2022 | Closed | EDI/front end business rules will be updated to relax validation on institutional claims based on clarification received from the State; ETA for Claim adjustments in process, ETA: 4/22 **4/12- first round of adjustments are complete. | No | | INC0536090/PRB0042699 | | | |
| Various | 74 | Claims | Claims denied CECCD for critical care codes in ER setting same day discharge. Edit was setup for critical care ER visits where member was not admitted. Edit was updated to only apply on the ER line vs entire claim denial | 1/20/2022 | | 4/6/2022 | Closed | Edit updated to only apply denial to ER line when appropriate and not the entire claim. Claim adjustments in process, ETA: 4/30 **5/2- Claim adjustments complete | Yes | 5/2/2022 | N/A | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| Various | 22 | Claims | Claim denied CPT code 99509 DN018 for primary EOB. Member has other coverage as primary and script is denying claims for DN018. Per state guidance, No other third-party payer is responsible for covering PCS. | 3/28/2022 | | 4/13/2022 | Closed | Claims script was updated to process 99509 as primary when member has commercial insurance as primary carrier. Members who have Medicare as primary was already set up to pay as primary for PCS services. Claim adjustments in process, ETA: 4/26 ***4/26- Claim adjustments complete | No | 4/26/2022 | N/A |
| LHD | 93 | Claims | Claims for LHD groups denying HCPCS code T1002 NOFEE for code is not a covered service on your fee schedule. Configuration updated to add LHD fee schedules to individual providers to allow reimbursement for HCPCS code T1002. | 4/7/2022 | | 4/11/2022 | Closed | Configuration updated to add LHD fee schedules to individual providers to allow reimbursement for HCPCS code T1002. Claim adjustments in process, ETA: 4/22 ***4/26- Adjustments complete | No | 4/26/2022 | N/A |
| Various | All | Claims | Claim issue where claims/HCPCS code J1050 not should not hold for NDC; going out as paid status without a net amount. | 6/21/2022 | | 8/25/2022 | Closed | Claims hold has been corrected to review the NDC submitted. | No | 8/25/2022 | |
| Various | All | Claims | Claim denials on E/M codes when billed with procedure codes 96372 | 5/25/2022 | | 8/26/2022 | Closed | Claims edit will be updated to allow payment of these codes when billed together. Based on additional review, claims are denying appropriately. No action needed on these claims. | Yes | 8/16/2022 | |
| Various | All | Claims | Claims denied CPT codes 36591 and 36592, IH018 for NCCI denial for comprehensive/component procedures | 5/13/2022 | | 7/24/2022 | Closed | Edit under review to determine validity, impacted claims will be reprocessed if claims denied in error. **Claim adjustments complete | Yes | 7/27/2022 | |
| Various | All | Claims | J1750 denied IH014 for Srv/Proc/Mod Exceeds Standard Frequency Allowed. MUE is being applied incorrectly. | 7/7/2022 | | 8/12/2022 | Closed | Edit under review to determine validity, impacted claims will be reprocessed if claims denied in error. ***Review confirmed edit is firing appropriately. No additional action required. | Yes | 7/13/2022 | |
| Ambulance | All | Claims | NC DHHS is modifying the Ambulance Clinical Coverage Guidance to exclude the CMS Medical Condition list and the requirement of a secondary diagnosis. | 7/1/2022 | | 8/1/2022 | Closed | Removal of CE040 edit for ambulance claims. Adjustment project to be completed once update is complete ***Claim adjustments complete | No | 7/20/2022 | |
| Ambulance | 31 | Claims | EMS PAP claims denying TFLDN for timely filing, paying at 90% nonpar reduction or lesser of logic. Updated with PAP rate schedule per county and removed 90% reduction or lesser of logic where applicable | 6/9/2022 | | 6/15/2022 | Closed | Updated with PAP rate schedule per county and removed 90% reduction or lesser of logic where applicable. Claims adjustments in process ***Claim adjustments complete | Yes | 6/27/2022 | |
| Various | All | Claims | North Carolina Medicaid released rate changes for Inpatient, Rehab, Pysch and Outpatient services. PHPs have 45 days to implement the fee schedule and reprocess any impacted claims. Updates will result in a mass reprocessing claims project. The deadline to reprocess claims is 6/3/2022. The NCHA has requested a consistent EOB remark code for claim adjustments:<br><br>•(Outpatient claims) EOB 10143 CLAIMS REPROCESSED due to Hospital submitted CHARGEMASTER percentage changes to the OP RCC rates.<br>•(Inpatient CLAIMS) EOB 10144 CLAIMS REPROCESSED DUE TO RATE CORRECTIONS APPLICABLE TO DRG, PSYCH OR REHAB RATES. | 4/19/2022 | | 6/12/2022 | Closed | Remark codes created consistent with NCHA for claim adjustments. Recoveries completed for overpayments; no adjustments needed. | No | 6/12/2022 | |
| FQHC/RHC | All | Claims | T1015 reprocessing due to rate changes and some LHDS not processing at the correct rate | 3/1/2022 | | 6/14/2022 | Closed | Impacted claims will be adjusted to pay the correct T1015 per the state fee schedule. ***Claim adjustments complete | Yes | 6/7/2022 | N/A |
| Other | Medical Home Prog | Claims | Claims are rejecting or denying in error requiring primary EOB for maternal services. Impacted CPT codes are S0280 & S0281 | 8/2/2022 | | 10/13/2022 | Closed | EDI edits are being updated to allow claims payment; confirmed changed was deployed on 10/13; claims are now being addressed for payment **11/4- Rejected claims were reran and processed for payment | Yes | 11/4/2022 | |
| Various | All | Claims | Claims incorrectly denied NDCTT due to rebate table being blank; NDCUU denials misfired as the institutional outpatient claims were being validated against the NC NDC crosswalk in error | 10/1/2022 | | 10/10/2022 | Closed | Fix completed on 10/10; pending claim adjustments **11/8-Claim adjustments complete | No | 11/8/2022 | |
| DME | All | Claims | Claims denied HCPCS codes A4452 & A4450, DME medical supplies IH038 for modifier used or required modifier is missing. This edit fired based on a CMS guideline which states when codes for tape are reported by a durable medical equipment supplier, a modifier is required to indicate whether the tape was furnished with a urologic, ostomy or tracheostomy supply, a prosthetic or orthotic device or furnished in conjunction with a surgical dressing | 8/8/2022 | | 9/25/2022 | Closed | Coding edits will be turned off to allow -NU, RR or -UE modifiers should be used when billing DME and supplies. Claims will be adjusted once complete **Edit shut off on 9/25/2022; pending claim adjustments **10/28- Claim adjustments complete | Yes | 10/28/2022 | |
| LHD | All | Claims | Claims denied for INMOD or NOFEE for CPT code 0074A. Code is not reflected on the LHD Fee Schedule. State is in the process of updating fee schedule. Once update occurs WellCare will reprocess all impacted claims | 8/25/2022 | | 10/14/2022 | Closed | Manual adjustments in process to pay code up to $65; not to exceed bill charges **Claim adjustments complete | No | 10/7/2022 | |
| Various | All | Claims | Claims were denied for IH003, IH026, IH049. OPPS Cotiviti coding edits were configured. Since NCD facility claims aren't paid based on OPPS, all DPs related to OPPS coding edits were turned off and claims will be adjusted for payment. | 8/3/2022 | | 9/30/2022 | Closed | OPPS Cotiviti coding edits were configured. Claim adjustments in process. Project was broken into two phases. One phase is complete with the second phase currently in process. Claims reprocessing complete. | Yes | 9/30/2022 | |
| Other | All | Claims | Claims billed with 99140 with no modifier denied in error as CE015 – appropriate modifier required. System was configured to deny 99140 when procedure is not billed with an appropriate anesthesia modifier. | 8/30/2022 | | 9/20/2022 | Closed | After review, CE015 edit has been relaxed, and 99140 is payable when primary procedure is payable. Claim adjustments are in process. Manual process to pay claims in place to mitigate incorrect denials. | No | 9/20/2022 | |
| Various | All | Claims | Rehab/Psych claims weren't paid correct at Per diem rates. Hospitals aren't set up by Optum to pay at per diem rates or claims are grouping to a medical DRG instead of rehab/psych. Optum to configure hospitals correctly and holding claims that group to rehab/psych DRGs to be priced manually. | 5/9/2022 | | 9/16/2022 | Closed | Configuration updates in process to load facilities based on guidance received from the State. Configuration updates completed on 8/19. Claims reprocessing complete. | No | 9/16/2022 | |
| Various | All | Claims | Claims billed CPT 41899 were denied for no authorization and LTUNS – medical records requested. CPT 41899 was configured with an authorization requirement. UM has lifted the auth requirement. HP is working on removing the LTUNS denial as institutional outpatient claims get paid at a % billed. | 7/21/2022 | | 9/30/2022 | Closed | UM has lifted the auth requirement. HP is working on removing the LTUNS denial as institutional outpatient claims get paid at a % billed. Claim adjustments in process. **Claim adjustments complete; pending updates for the LTUNS denials; will pull global impact once hold is removed | Yes | | |
| Various | All | Claims | Flu vaccines denying NDCTT for needing rebate; missing one of the NDC codes | 11/8/2022 | 20 | 11/28/2022 | Closed | Rebate tables were updated. Claim adjustments are in process **Claim adjustments complete | No | 2/20/2023 | |

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| FQHC/RHC | All | Claims | Claims are denying T1015 as NOFEE and INMOD due to provider configuration setup. | 10/4/2022 | 80 | 12/23/2022 | Closed | Reconfiguration of provider setup in process to pay the FQHC encounter rates. Claims adjustments are in process **Claim adjustments complete | Yes | 2/8/2023 | |
| Various | All | Claims | Anesthesia claims denied INMOD incorrectly. Anesthesia claims were billed with more than 1 modifier and second modifier billed caused an issue resulting in INMOD denials. | 10/31/2022 | 30 | 11/30/2022 | Closed | System update to correct issue was completed November 2022. Claim adjustments in process. **Claim adjustments complete | No | 2/1/2023 | |
| Various | All | Claims | Claims denied for INMOD or NOFEE denial. Claims processed to incorrect provider ID. | 10/27/2022 | 33 | 11/29/2022 | Closed | This issued occurred for Ambulance Providers that share same TIN as County Health Departments. Ambulance provider name updated in Configuration to select Ambulance group correctly. Claims adjustments are in process | Yes | 1/12/2023 | |
| Various | All | Claims | Claims being denied CE329 and IH147 due to incorrect ICD10 provider billing error | 9/2/2022 | 120 | 12/31/2022 | Closed | WellCare is creating provider training and education material and possible edit modification to assist provider with billing according to ICD10 Excludes1 guidelines. **Appropriate training given to providers | No | 1/1/2023 | |
| Various | All | Claims | Vaccine codes 90619 & 90697 were paid in error | 10/3/2022 | 42 | 11/14/2022 | Closed | Recovery project in process to recoup payments made on codes 90619 & 90697 that were paid in error. Letters will be sent to impacted providers. | No | 12/30/2022 | |
| Various | All | Claims | Copay incorrectly applied to maternity related claims | 10/31/2022 | 3 | 11/3/2022 | Closed | Fix implemented to capture claims with pregnancy related diagnosis to waive copayment. Claim adjustments in process. **11/26- Adjustments complete | No | 11/26/2022 | |
| Various | All | Claims | Claims are underpaying due to providers were configured with the Nurse Practitioner E/M facility rate instead of the Nurse Practitioner E/M non facility rate fee schedule. | 2/15/2023 | 2 | 2/17/2023 | Closed | Providers have been updated to the correct non facility rate fee schedule. Claim adjustments are in process. | No | 3/9/2023 | |
| Various | 20 | Claims | Claims billed with 99509 on two separate service lines for the same DOS on the same claim, the second service line was denied CE035 – duplicate service in error. Coding edit was configured and recognizing second service lien as a duplicate service. Separate service lines represent split shifts and a different visit key is attached to the split shift. | 2/20/2023 | 65 | 4/26/2023 | Closed | Coding vendor cannot acknowledge the visit key and HP has made a decision to turn off edit. Bypass put in place on 4/26/23; claim adjustment in process **Claim adjustments complete | Yes | 5/23/2023 | |
| Various | 206 | Claims | Claims billed with 99509 denied LT126 for exceeding max units. Prepay edit is following the RISSNET file indication of 1 unit per date of service MUE. The state blog indicates providers are to be billing in 15 minute increments through 3-31-23 | 2/22/2023 | 51 | 4/28/2023 | Closed | Healthplan validating with the State which guidelines to follow to process payment for these services, the RISSNET or fee schedule. There is a bypass in place from 2/28-4/1 to allow these claims to pay as billed until clarification is received. Claim adjustments are in process, ETA: 4/28 **Edit shut off as of 4/1; Prepay created a new bypass until clarification is received from the State. Claim adjustments in process for date span 4/1-4/12 **Claim adjustments complete | No | 5/10/2023 | |
| Various | 62 | Claims | Claims billed with CPT code 93325 denied CE043 for Maximum frequency has been exceeded. 93325 was being counted towards the limit in error when other echo codes were being performed. 93325 should be recognized as an add on code and not a primary procedure. | 3/1/2023 | 75 | 5/15/2023 | Closed | NC state confirmed 93325 is an add-on code. Coding edits are in process to allow reimbursement of CPT code 93325 as an add-on when billed with primary codes 76825-76828. Claim adjustments are in process. **Claim adjustments complete; pending coding edit update, ETA: 5/15 *Issue resolved | Yes | 5/15/2023 | |
| Various | 200 | Claims | Anesthesia claims denied as CE030 – Primary procedure must be billed. Procedures 01968 or 01969 were not billed on the same claim or not billed on the same day as the primary procedure 01967. NC state confirmed the related procedure code (01967) may be on the same claim or must have been paid in history within two days (48 hours) of the subject procedure by same or different provider. | 3/15/2023 | 33 | 4/17/2023 | Closed | NC state confirmed the related procedure code (01967) may be on the same claim or must have been paid in history within two days (48 hours) of the subject procedure by same or different provider.<br>Edit modification is in process to allow 01968 or 01969 with 48 hours of primary procedure. **Claims adjustments are complete, pending edit update, ETA: 4/17 | No | 4/17/2023 | |
| Lab Testing | 20 Providers | Claims | Genetic Testing CPT Codes 81420, 81220, & 81329 have been denying as IH007 (ICD Code on the claim not supported by CPT billed). Per Clinical Policy 1S-4 Genetic Testing (effective 4-15-23), this service is available to all pregnant beneficiaries regardless of maternal age or risk so there should not be any diagnosis editing that would prevent a claim from processing. | 1/10/2024 | 610 | 3/4/2024 | Closed | WellCare is implementing a Code Edit Modification for the IH007 Edit to exclude pregnant beneficiaries and adjudicate claims per Clinical Policy 1S-4. Impacted claims were reprocessed and adjusted to pay w/ a completion date of 02/12/2024. | Yes | 2/12/2024 | State Ticket # 48887 - RMS00173584 & RMS00173830 |
| Hospice | 2 Providers | Claims | A Pricing Configuration error impacting Hospice Providers causing NOFEE & CMD01 (No Fee Schedule Rate & Not Covered Service) was identified. | 2/1/2024 | 588 | 2/5/2014 | Closed | The WellCare Configuration team reviewed and updated the system error causing the denials on 02/05/2024. Claims are no longer experiencing the denials. The impacted claims were reprocessed and adjusted to pay w/ a completion date of 02/14/2024. | No | 2/14/2024 | RMS00171510 & State Ticket #'s 52957 & 53167 |
| Outpatient Inst. | 38 Providers | Claims | Provider pricing configuration was updated to apply the PADP fee schedule to drug codes on outpatient institutional claims instead of the appropriate RCC rate. | 10/12/2023 | 700 | 2/20/2024 | Closed | Configuration was updated to ensure that all outpatient institutional claims had the PADP fee schedule removed and would pay according to RCC rate. Impacted claims with drug codes were reprocessed & adjusted to pay on 1/30/2024. Underpayments have been submitted for recoupment by the Recovery Team and Recovery Letters will be generated and sent to the Providers, as applicable | Yes | 1/30/2024 | RMS00170912 |
| TeleHealth | 85 | Claims | CE524 Denials (Modifier is Not Typical for Procedure) being applied incorrectly to Claims billing Telehealth Services Proc. Code T1015 w/ Modifier GT. | 12/7/2023 | 644 | 1/10/2024 | Closed | The Pre-Pay Team implemented a Code Edit Modification to allow payment for T1015 w/ Modifier GT that will go into effect by 12/26/2023. Reprocessing and Adjustment of the impacted Claims w/ the CE524 Denials was completed on 1/10/2024. | No | 1/10/2024 | Reprocessing: RMS00161024<br>State Ticket #'s 48941 & 50775 |
| SNF | 1 | Claims | State Ticket # 48796 - SNF Provider experiencing COB Denials (DN018 - EOB from Primary Insurance Required). Per State Guidelines, SNF Claims billing Taxonomy 314000000X, where the Member does not have Long-Term Care insurance, shall bypass Third-Party Liability. | 11/27/2023 | 654 | 1/26/2024 | Closed | WellCare identified 24 claims that were erroneously denied for COB and did not bypass to pay as primary. WellCare sent the claims for reprocessing as of 11/28 and adjustments were completed on 12/06/2024. The Configuration Team reviewed and validated the COB logic as updated to bypass. Since 11/27/2023, weekly reports have been pulled to ensure no other claims deny for primary for this requirement going forward. | Yes | 12/6/2023 | State Ticket # 48796 |

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| Outpatient Inst. | All | Claims | State enforced CIS edit LHM34001, "HCPCS or NDC Code missing for Revenue Code 025x or 063x", was introduced on 5/1/22. This differs from the previous edit of "HCPCS Code Missing for Revenue Code", which didn't specifically call out Rev. Codes 025x or 063x, that was in place prior to 5/1/22. Paid claims prior to 5/1/22 are being reviewed for potential recoups based on the updated edit for specific Rev. Codes. | 10/9/2023 | 703 | 1/31/2024 | Closed | CIS edit LHM34001 was updated and implemented 5/1/22 and WellCare of NC requires the HCPCS & NDC for adjudication of Rev. Codes 025x & 063x. The Encounters Team is reviewing previously accepted Encounter lines as reported that were missing Service Code or NDC prior to 5/2/22 and impacted claims have been submitted for Recoupment via Ticket # 327663. Impacted Providers will be receiving Recovery Letters, as applicable. | No | 1/25/2024 | Recovery Project RET # 327663 |
| Various | Pending Impact | Claims | CE046 Denials (Max Units Exceeded) being applied incorrectly to Proc. Code S9442 (Birthing Classes, Non-Physician). A new NC Edit for MUE was created in September of 2023 which conflicts with the CCP's, causing claims to deny for max units exceeded in error. | 11/13/2023 | 668 | 12/15/2023 | Closed | The Pre-Pay Team worked w/ Cotiviti, Optum, & the Configuration Team to update/remove the new MUE edit. Cotiviti has already removed the edit to match the CCP of 4. Pending Optum/Configuration Updates and impact reprocessing back to September 2023. Post Production review was completed on 11/13/2023 & Claims have been reprocessed. | Yes | 12/14/2023 | RITM05404186 / State Ticket # 47436 |
| Various | All | Claims | Select claims/codes were denied incorrectly for NDCTT, the encounters team is working on correcting the issue and updating their process. | 9/15/2023 | 727 | 12/15/2023 | Closed | WellCare of NC implemented a configuration update on 10/20/2023 to create a list of approved codes to be Excluded from the NDCTT denial, which matches the states HCPC bypass table. The configuration update went into effect on 11/17/2023. A global reprocessing project reprocess claims back to 10/01/2022 has been completed. As of 11/17/2023, claims are no longer denying as NDCTT in error and claims reprocessing is complete. | No | 12/14/2023 | INC0779201 |
| Various | Pending Impact | Claims | Identified overpayment issue when Corrected Claims (Frequency 7) were billed that did not initiate a Recoupment to the Initial Paid Claim (Frequency 1), causing overpayments. Impacted claims began w/ Claim Insert Date 09/01. | 10/25/2023 | 687 | 10/31/2023 | Closed | Configuration logic update was completed 10/31/2023 to initiate recoupments to Initial Claim (Frequency 1) when paying corrected claims (Frequency 7). WellCare initiating Recovery Process on impacted duplicate payments. | No | 12/28/2023 | |
| Anesthesia | 1 | Claims | Provider Pricing Configuration was not loaded w/ the correct fee schedules causing INMOD/NOFEE (Invalid Missing Modifier/No Fee Schedule Rate) when billing anesthesia claims. | 11/6/2023 | 16 | 11/30/2023 | Closed | Provider pricing configuration was retro-loaded w/ the applicable anesthesia fee schedules. 2000 Claims were reprocessed and adjusted to pay. | Yes | 11/30/2023 | |
| Various | All | Claims | Claims denied VISIO – Denied: Must submit claim to the Vision Vendor. | 6/1/2023 | 96 | 9/5/2023 | Closed | Benefits update is complete to deny the claim if primary DX is on NC Medicaid Envolve documentation. Claims associated with State Help Desk Tickets are being reprocessed. Global impact will be addressed after updates are complete. Claim adjustments completed on 09/05/2023. | No | 9/5/2023 | |
| Various | All- Facility Provider | Claims | Claims are being rejected by the State encounter stating the following: Other ICD-10 Diagnosis Code Effective Dates Do Not Agree With DOS. the state has logic stating if the code is not valid at time of admission, the POA should not be marked as "Y". State guidance provided effective 10/01: DHB to modify the Encounters system to reject inpatient claims when the diagnosis code(s) are not effective on the Occurrence Code 42 date or the Statement Through Date if Occurrence Code 42 isn't present on the encounter. | 5/10/2023 | 855 | 10/1/2023 | Closed | Per the State guideline provided 10/1/23, the configuration was updated and put into effect on 10/01/2023, and any encounters representing paid claims which were errored out by the Encounters system for this reason can be resubmitted. The Encounters Team worked through the outstanding claim resubmissions and advised that the reject volume has decreased since 10/01/2023. The remaining claim resubmissions that rejected again were submitted as examples to the state and deemed valid rejections. | No | 11/18/2023 | INC0779208 |
| Various | 526 | Claims | WellCare was using the 834 file in addition to vendor file for COB. Term information was captured off the 834. The only impacted were members who were not on the 834 at all but were on the vendor file with no term date. WellCare identified 532 members that contained OIC/TPL term dates as a result of this issue. Impacted claims were reprocessed to pay as primary. State then requested to have I&P applied to these claims | 6/30/2023 | 41 | 8/10/2023 | Closed | Claims were reprocessed to apply I&P as requested by the State | Yes | 8/10/2023 | |
| Various | All | Claims | Claims denied for LT126 for Exceeds Maximum Number of units. Another claim was billed for same code for a different provider/different specialty. | 4/17/2023 | 84 | 7/10/2023 | Closed | Edit modification in process to allow same services to be billed for different provider/different specialty. Claims for provider submitted via State ticket were adjusted; a global impact will be addressed once edit modification is complete. **Edit modification implemented on 6/25; pending claim adjustments **Claim adjustments complete | No | 8/11/2023 | |
| Various | 31 | Claims | Code 0171A denied for NOFEE or INMOD. Code was not listed on the physician's fee schedule in Xcelys. It's was only listed on the LHD and Physician's assistant fee schedule in Xcelys. | 6/28/2023 | 16 | 7/14/2023 | Closed | Fee Schedule team received procedure code 0171A in the new physician files that were published on 6/28/2023. Physician's fee schedule updated on 7/14/2023. **Claim adjustments complete | No | 7/20/2023 | |
| Various | 83 | Claims | Claims denied NOFEE, TFLDN, DN001 and/or placed in No Check Status. Claims were not previously paid for various reason: State had not assigned member PML, claims were submitted past the timely filing period or provider's configuration did not support code being billed at the time. | 4/26/2023 | 5 | 5/1/2023 | Closed | Provider configuration updates have occurred. Also, PML is no longer a requirement if member is not updated with PML in Xcelys. Claim adjustments in process **Claim adjustments complete | No | 6/2/2023 | |
| Various | All | Claims | CME services denied CE003, CE022, CE045 and CE360. Under NC Medicaid CCP 1A-5 and clarification from the state, providers are allowed to bill a certain set of codes and diagnosis. | 1/23/2023 | 98 | 5/1/2023 | Closed | Edits are being updated to allow providers that bill codes 99499, 99367, 99368, 90791 and 99170 to be reimbursed for those services without bundling when billed with at least one of the appropriate diagnosis codes as listed in the CCP. Claims adjustments complete; pending edit update; ETA: 5/10 **Edit modifications were completed on 5/1; impact report being ran to determine if additional adjustments are needed **Additional edit modification required for this issue to address IH147 denials. Edit modification to be completed by 6/25 **Confirming edit was implemented on 6/25; reviewing claims to determine if additional adjustments are needed **Edit modification implemented on 6/25; pending claim adjustments **Claim adjustments complete. | No | 8/3/2023 | |

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| Various | 60 | Claims | Claims denying HEAVD to submit claims to hearing vendor for codes that are exempt from the contract | 2/17/2023 | 31 | 3/20/2023 | Closed | Fix implemented to add codes to Xcelys production that should not deny to resubmit to HearUSA. Claim adjustments in process **Claim adjustments complete | No | 7/6/2023 | |
| Various | All | Claims | WellCare NC identified a population of claims that are being denied for lack of information. As per the prompt pay standards below, these claims should be pended to allow for the receipt of additional information needed for processing. WellCare is denying rather than pending these claims if all information is not present at the time of processing. | 7/13/2023 | 68 | 9/19/2023 | Closed | WellCare implemented system logic to Pend Claims for up to 90 days, when additional information is needed. A letter will be sent to the Provider outlining request for additional documentation. | No | 9/19/2023 | |
| Various | 70 | Claims | The Hospital DRG Base Rates were updated effective 07/01/2023. WellCare Configuration was updated w/ the new DRG Rates eff. 07/01 on 08/24/2023. Claims w/ DOS beginning 07/01/2023 that processed prior to the update completed on 08/24/2023 Underpaid. | 8/24/2023 | 32 | 9/25/2023 | Closed | WellCare Configuration was updated w/ the new DRG Rates eff. 07/01 on 08/24/2023. Claims w/ DOS beginning 07/01/2023 that processed prior to the update completed on 08/24/2023 were all reprocessed/adjusted to pay on 09/25/2023. | Yes | 9/25/2023 | |
| Personal Care Service Providers | 256 PCS Providers | Claims | Personal Care Service Providers billing Proc. Code 99509 in increments of 15 minutes (1 Unit) experiencing Underpayments based on claims erroneously capping at 1 Unit. The Fee Schedule Team identified the system configuration error and initiated the review, update, and reprocessing. Impacted Claims included Insert Dates after 01/25/2024 to 02/13/2024. | 2/6/2024 | 583 | 3/22/2024 | Closed | The Fee Schedule & Configuration Teams corrected the Procedure Pricing Table load issue on 02/13/2024. Current PCS claims billing 99509 are no longer capping at 1 unit. The impact report submitted for reprocessing was completed on 03/07 and all impacted claims have been adjusted to pay correctly. | No | 3/7/2024 | RMS00175319 |
| Vision Providers | 242 Providers | Claims | A Benefits Configuration issue was identified impacting Medical Vision that are denying claims with instructions to have Providers submit the claims to contracted Vendor Envolve. Envolve in turn is denying claims with instructions to bill WellCare. Vendor Envolve only pays claims for Routine Vision Services, while WellCare only is responsible for Medical Vision Services. | 2/16/2024 | 573 | 4/5/2024 | Closed | The Benefits Configuration Team is implementing a fix with an ETA for completion of 03/04/2024. A claims impact report was reprocessed and adjusted to pay w/ a completion date of 04/03/2024. | No | 4/3/2024 | RMS00179434 |
| Anesthesia/CRNA Providers | In Review | Claims | Configuration edit was set up to deny add on code 01968 when not billed at a 1:1 ratio with primary code 01967. | 6/28/2023 | 806 | 6/24/2024 | Closed | Coding Team implemented an edit modification on 07/08/2024, per state guidance received on 05/09/2024, to allow add-on codes when not billed at a 1:1 ratio w/ the primary code.<br>Received state guidance on 5/9/2024 that 1:1 match is not required.<br>GUIDANCE: The MD billed 01967 with AA and by using that modifier it meant there was NO additional assistance for him. The CRNA should not bill for 01967 because the AA modifier was used.<br>01968 is an add-on code… from the WEB: " An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. Sep 6, 2023".<br>The CRNA assisted with 01968 so bills with QK for their assistance.<br>Coding team in process of updating edit to reflect this change. | No | 7/9/2024 | RITM06580086 |
| Institutional / Professional Providers | 897 Providers | Claims | NC Fluoride Varnish limit rule was inadvertently activated in the production environment without ensuring that all configurations were accurately loaded. As a result claims denied incorrectly for LIMIT. | 5/23/2024 | 476 | 6/21/2021 | Closed | The production deployment occurred on 5/22 3PM & was terminated on 5/23 3PM. The misconfiguration was identified before the Post Production Review phase, allowing for swift correction within a 24-hour timeframe. Notification was promptly sent to the claims team, enabling them to re-tab and readjust unposted claims. Additionally, all posted claims affected by the error are being reprocessed to ensure accuracy. Moving forward, stringent validation procedures will be enforced to prevent similar errors, ensuring the integrity and efficiency of our claims processing system. | No | 6/21/2024 | RMS00192199 |
| Professional DME/HH | Pending | Claims | In April 2024 there was an update made to the LT014 edit that changed how it triggered benefit limits for CPT code A4452. A4452 should be payable at 80 units per month per NCD but it was incorrectly being limited to CMS rules. Any affected claims that were missed in the reprocessing are now being addressed and should post payment by month's end.This is in reference to state ticket 63571 which originated as state ticket 63571. Coding Analytics has also been emailed to advise if this was the only CPT code that was impacted with the update of this denial edit. | 8/6/2024 | 182 | 8/30/2024 | Closed | Benefit limits for CPT A4452 have been updated per NC Medicaid guidelines to be payable at 80 units per month. Impacted claims going back to April of 2024 are under review for reprocessing and adjustment. | Yes | 10/29/2024 | State Ticket # 63571 |

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| Obstetrical Services | 0 Providers | Claims | Claims for CPT code 99078 with modifier TH were being denied in error against the NC Medicaid bulletin that was posted on 4/1/2024. https://medicaid.ncdhhs.gov/blog/2024/04/16/changes-1e-5-obstetrical-services-policy-effective-april-1-2024. In this bulletin it stated that group prenatal care had been added as an optional service that may be provided to pregnant beneficiaries, effective July 1, 2023. Medicaid shall pay an incentive for group prenatal care when five or more visits are attended and documented in the health record. Records of this attendance must be available to NC Medicaid Direct or the NC Medicaid Managed Care health plans upon request. For the incentive, providers will bill CPT code 99078 with modifier TH. The configuration update has been initiated and upon completion an impact report, dating back to July 1, 2023, will be pulled and claims will be reprocessed. I&P will be paid for any claims submitted after 5/16/2024 provided that five or more visits have been attended and documented in the health recordsof tthis attendance are available upon the request of the Health Plan. | 8/15/2024 | 173 | 10/27/2024 | Closed | | Yes | 10/28/2024 | RITM06834405 |
| Professional | Pending | Claims | Claims for E/M codes that are billed with the EP modifier in the second position are paying as if no EP modifier was billed. There is a separate fee on the NC ACA and physicians fee schedule for E/M codes billed with the EP modifier. | 9/26/2024 | 131 | 10/23/2024 | Closed | 1. IT test claims with modifiers EP and 25 in positions 1 and 2 and with EP modifier only to determine if the claim would pay the fee for EP modifier when billed in any position.<br><br>2. IT confirmed that the Price Method should change to "multiple modifier pricing unordered", test claim confirmed that the claim will price correctly once the change is made.<br><br>3. Additional testing was done and confirmed with the Fee Schedule Team that is is not necessary to add an additional modifier in the procedure price screen to obtain the correct payment. | Yes | 11/4/2024 | RMS00208918 |
| All | All | Claims | Providers are unable to submit attachments via the WellCare Provider Portal. | 11/18/2024 | 297 | 12/11/2024 | Open | Root cause was javascript/query code that Chrome stopped supporting that had to updated to correct the issue in which providers were unable to submit attachments via the portal. | No | 12/11/2024 | |
| Outpatient Institutional | 115 | Claims | Hospital outpatient services denied for DN085/PINVP instead of pricing at RCC or fee schedule for outpatient hospital laboratory. | 8/7/2024 | 400 | | Closed | The WellCare Configuration Team has made the necessary updates to correct the reimbursement logic. An impact report has been pulled to capture all incorrectly processed claims. Claims are being reprocessed to pay at the correct RCC or fee schedule. | No | 1/2/2025 | RMS00200019 |
| Institutional | 44 Providers | Claims | Institutional claims are denying as non-covered services, but codes are listed on the covered code list. | 4/16/2024 | 513 | N/A | Open | VP of Operations sent question to state regarding 0202U specifically, however, configuration is researching additional codes denied that are appearing on fee schedule that denied as non-covered. | Yes | 4/4/2025 | RMS00186110 / RMS00187521 / RMS00226920 |
| Institutional | 3 | Claims | A reimbursement configuration issue is causing inpatient institutional claims to pay incorrectly w/ a SYSREHAB or SYSPSY1 system generated payment line instead of DRG pricing, causing underpayments. Review of impacted claims has identified 3 facilities experiencing this issue. | 8/14/2024 | 393 | 8/31/2024 | Open | The WellCare Configuration Team has initiated updates to the 3 impacted facilities to correct the reimbursement logic and mitigate the SYSREHAB & SYSPSY1 system generated lines from paying incorrectly. Claims testing is underway to ensure DRG reimbursement is applied correctly to new claim submissions. The Configuration Team to provide a determination on the time span involved and provide a complete claims impact for reprocessing and adjustment. | Yes | 9/9/2024 | RMS00198110 / RMS00202859 |