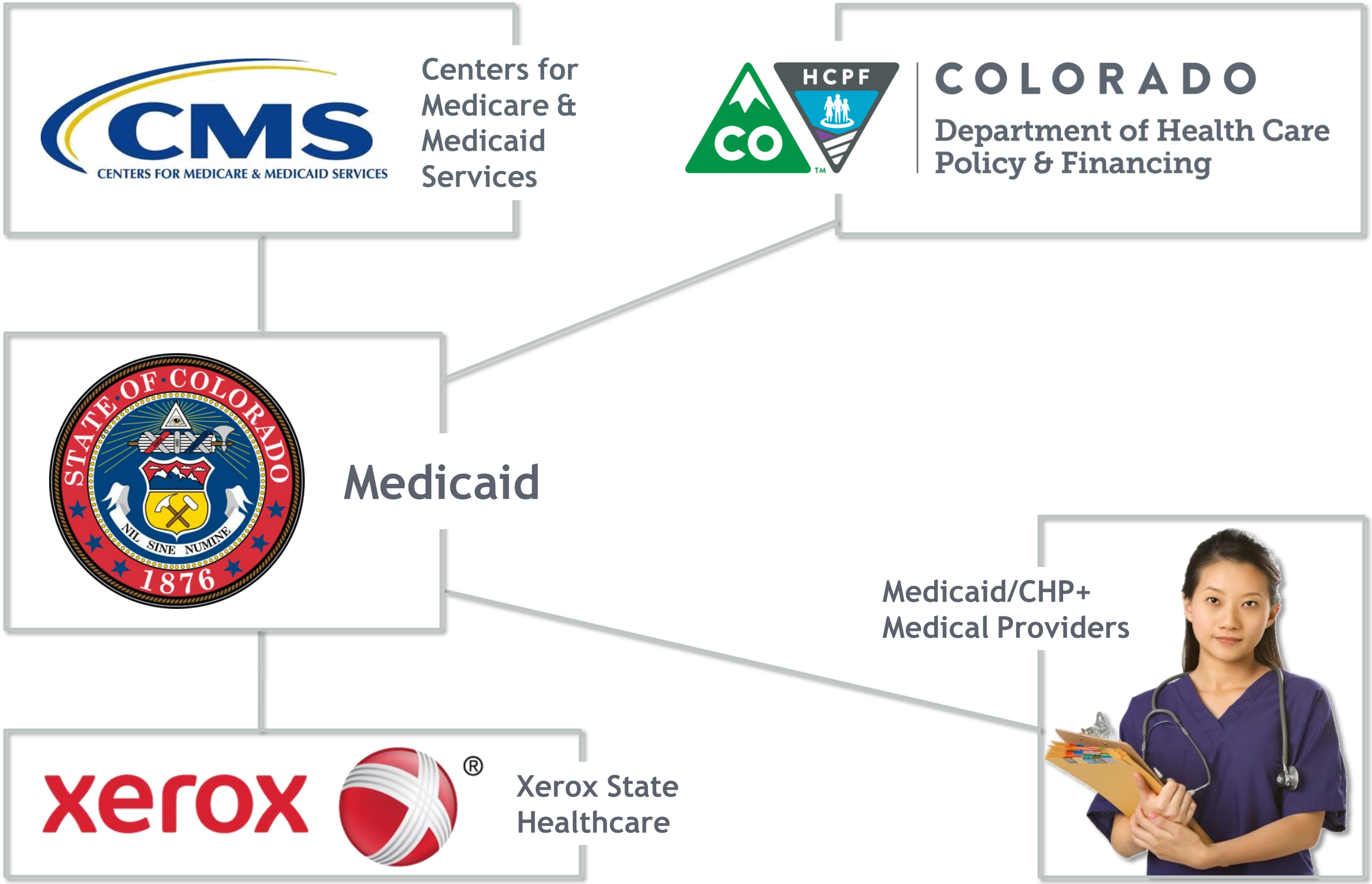
# *Beginning Billing Workshop DME Supply*

Colorado Medicaid
2015

COLORADO
Department of Health Care
Policy & Financing


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
Centers for Medicare & Medicaid Services
HCPF
CO
COLORADO
Department of Health Care Policy & Financing
STATE OF COLORADO
NIL SINE NUMINE
1876
Medicaid
xerox
Xerox State Healthcare
Medicaid/CHP+ Medical Providers

# *Training Objectives*

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - How to ensure your claims are timely
  - When to use the CMS 1500 paper claim form
  - How to bill when other payers are involved

# *What is an NPI?*

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

# *What is an NPI? (cont.)*

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html?redirect=/nationalprovidentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

# Department Website

1

www.colorado.gov/hcpf

https://www.colorado.gov/hcpf

Colorado The Official Web Portal

Translate

HCPF

COLORADO

Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers

2

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore Benefits

Apply Now

Find Doctors

Get Help

Feeling Sick?

For medical advice, call the Nurse Line:

800-283-3221

Get Covered. Stay Healthy.

colorado.gov/health

# Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

# *Provider Enrollment*

**Question:**

What does **Provider** Enrollment do?

**Answer:**

Enrolls **providers** into the Colorado Medical Assistance Program, *not* members

**Question:**

Who needs to enroll?

**Answer:**

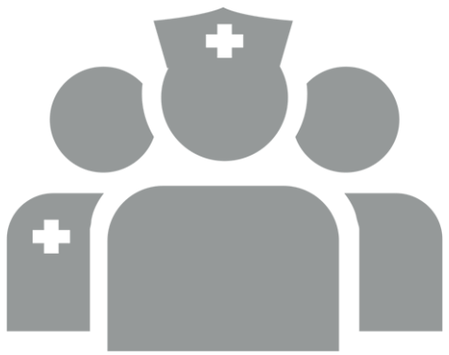
Everyone who provides services for Medical Assistance Program members

- Additional information for provider enrollment and revalidation is located at the Provider Resources website

# *Rendering Versus Billing*

**Rendering Provider**

Individual that provides services to a Medicaid member



**Billing Provider**

Entity being reimbursed for service

From the Noun Project:
"Medical-Team" icon created by Pieter J. Smits
"Hospital" icon created by Carlotta Zampini

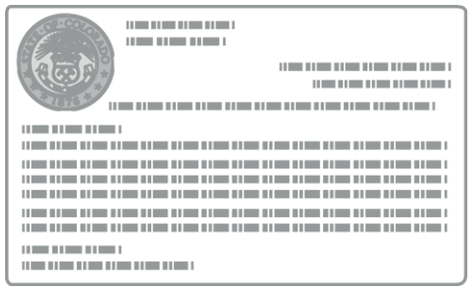
# *Verifying Eligibility*

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

**Colorado Medical Assistance Web Portal**

**Fax Back 1-800-493-0920**

**CMERS/AVRS 1-800-237-0757**



**Medicaid ID Card with Switch Vendor**



From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

# *Eligibility Response Information*

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number

# Eligibility Request Response (271)

Print

Return To Eligibility Inquiry

**Eligibility Request**

Provider ID: National Pro

From DOS: Through D

**Client Detail**

State ID: DOB:

Last Name: First Name

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/2

Contact Information for Questions on Res

Provider Relations Number: 800-237-075

Requesting Provider

Provider ID:

Name:

Client Details

Name:

State ID:

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

**PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE**

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Messages:

***MHPROV Services***

Provider Name:

**COLORADO HEALTH PARTNERSHIPS LLC**

Provider Contact Phone Number:
800-804-5008

**Information appears in sections:**

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

**Successful inquiry notes a Guarantee Number:**

- Print copy of response for member's file when necessary

**Reminder:**

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

# *Medicaid Identification Cards*

- Both cards are valid
- Identification Card does not guarantee eligibility

Sample A Sample
A123456

Department of Health Care
Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

**In a life threatening emergency, dial 911 or go to the nearest emergency room.**
**This card does not guarantee eligibility or payment for services**

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

# *Eligibility Types*

- Most members = Regular Colorado Medicaid benefits
- Some members = different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members = additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance

# *Eligibility Types*

## Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services

# *Eligibility Types*

## Non-Citizens

- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

# *What Defines an "Emergency"?*

- Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
  - Active labor & delivery
  - Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
    - Placing health in serious jeopardy
    - Serious impairment to bodily functions
    - Dysfunction of any bodily organ or part

# *Eligibility Types*

## Presumptive Eligibility

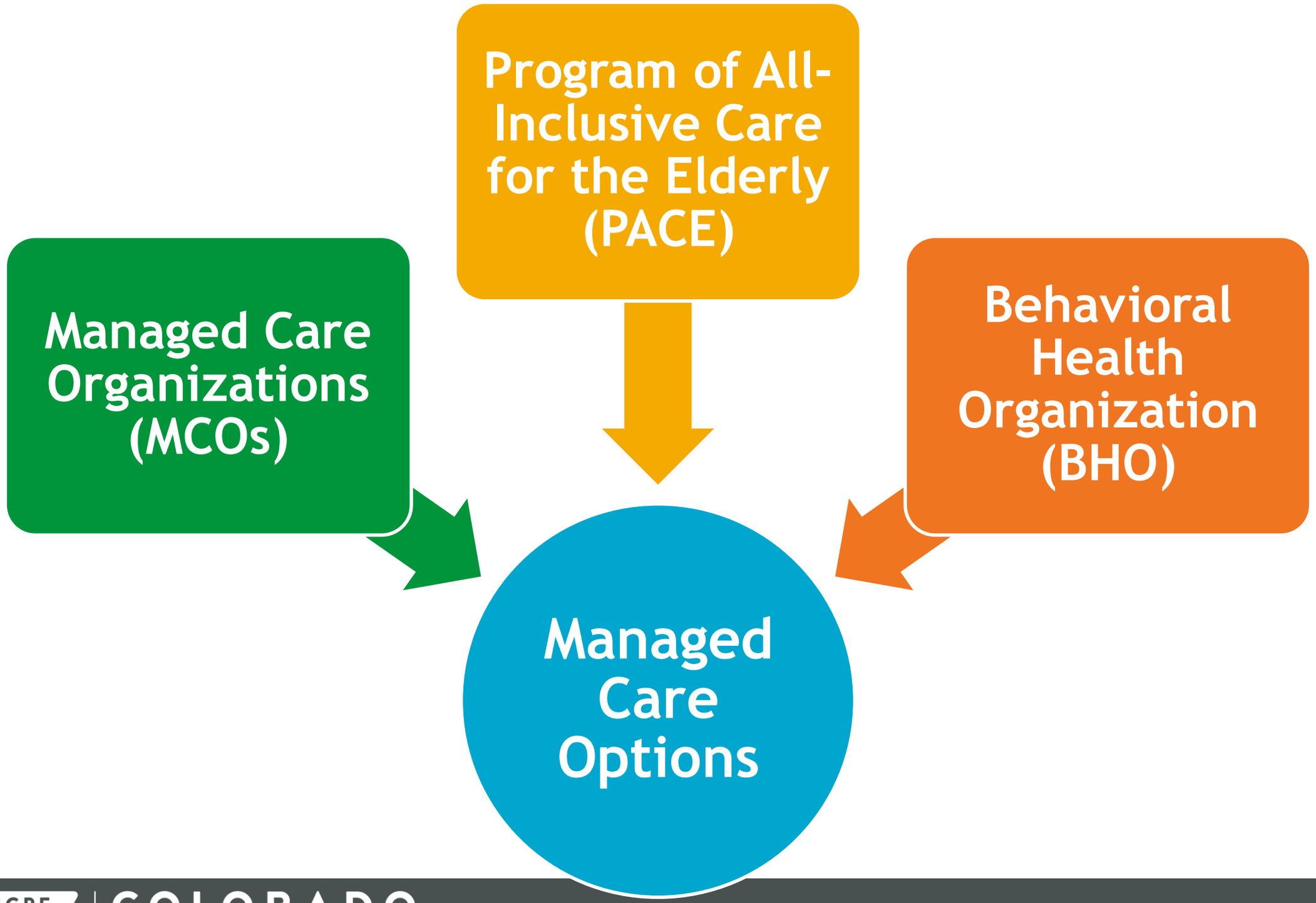
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

# *Eligibility Types*

## Presumptive Eligibility (cont.)

- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101

# Managed Care Options



# Managed Care Options

## Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out

# *Managed Care Options*

## Behavioral Health Organization (BHO)

- Community Mental Health Services Program
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider

# Medicare

- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

# *Medicare*

## Qualified Medicare Beneficiary (QMB)

- Bill like any other Third Party Liability (TPL)
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid (QMB+)- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim

# Medicare

## Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always payer of last resort
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denials(s) for six years

# *Third Party Liability*

- Colorado Medicaid pays Lower of Pricing (LOP)
  - Example:
    - Charge = $500
    - Program allowable = **$400**
    - TPL payment = **$300**
    - Program allowable – TPL payment = **LOP**

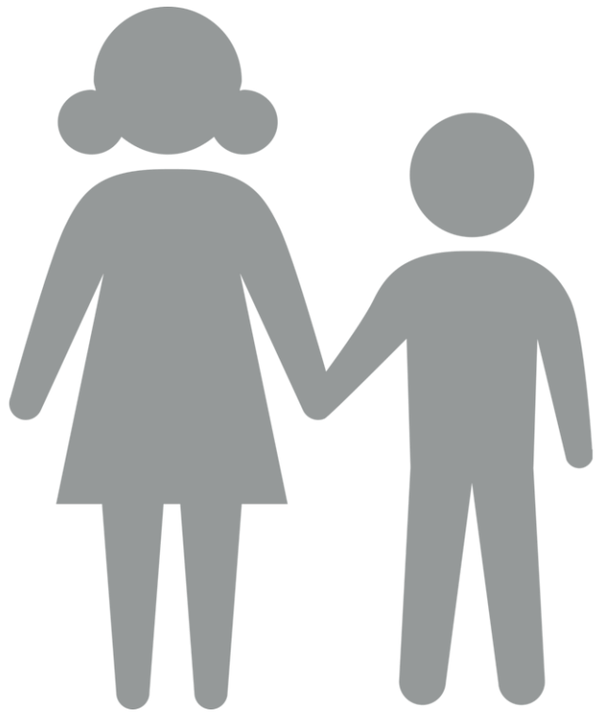
| | |
|---|---|
| | **$400.00** |
| **-** | **$300.00** |
| **=** | **$100.00** |

# *Commercial Insurance*

- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party's insurance

# *Co-Payment Exempt Members*

Nursing Facility Residents



Children

Pregnant Women



From the Noun Project:
"Nursing-Home" by Iconathon
"Children" by OCHA Visual Information Unit
"Maternity-Cycle" by HCPF

# *Co-Payment Facts*

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- A provider may not deny services to an individual when such members are unable to immediately pay the co-payment amount. However, the member remains liable for the co-payment at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS
  - Transportation
  - Emergency Services
  - Family Planning Services
  - Behavioral Health Services

# *Specialty Co-Payments*

| | |
|---|---|
| DME / Supply | $1.00 per date of service |

# *Billing Overview*

Record Retention

Claim submission

Prior Authorization Requests (PARs)

Timely filing

Extensions for timely filing

# Record Retention

- Providers must:
  - Maintain records for at least 6 years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

# Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

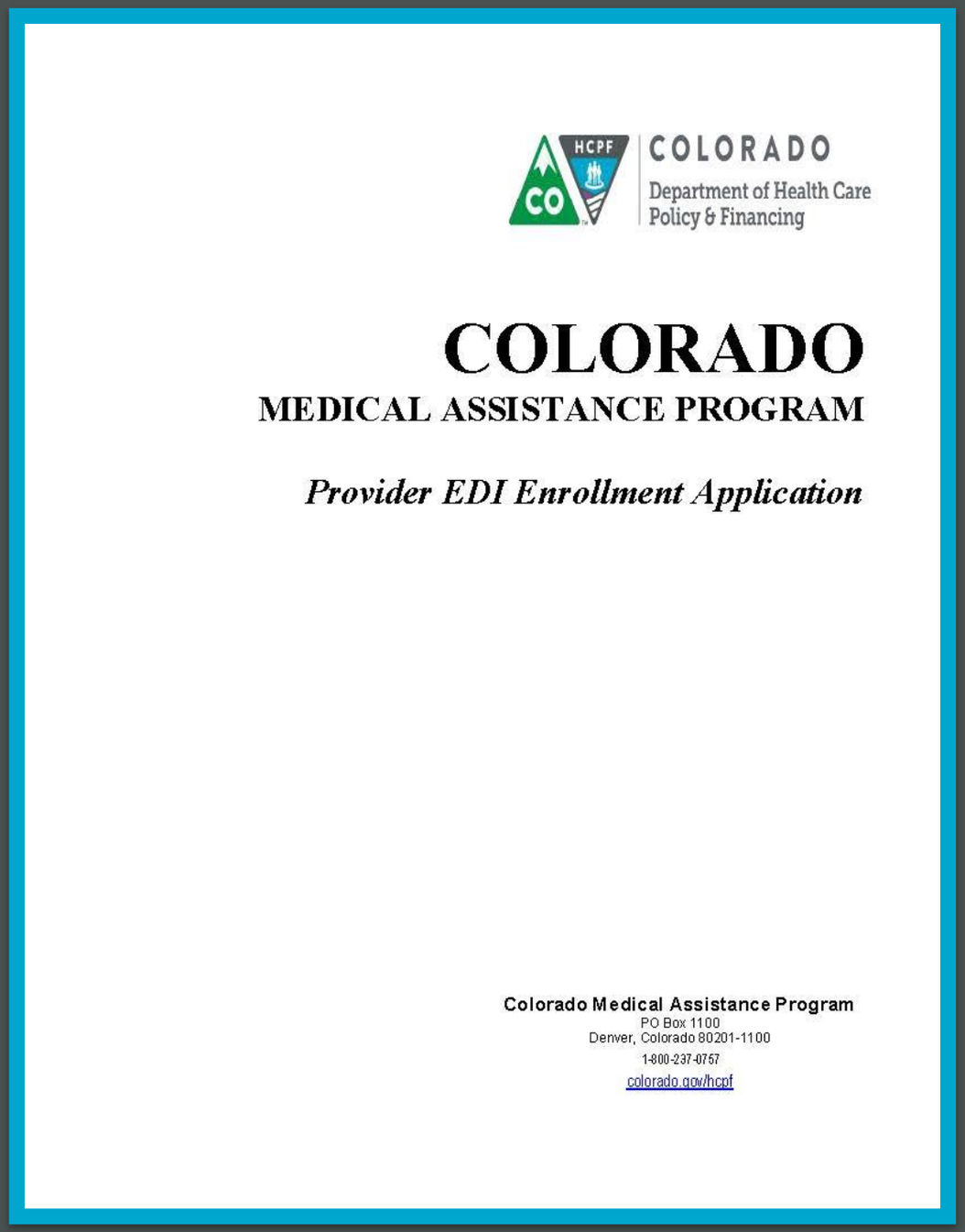
# *Submitting Claims*

- Methods to submit:
  - Electronically through Web Portal
  - Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  - Paper only when:
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

# *ICD-10 Implementation*

| | |
|---|---|
| Claims with Dates of Service (DOS) **on** or **before** 9/30/15 | **Use ICD-9 codes** |
| Claims with Dates of Service (DOS) **on** or **after** 10/1/2015 | **Use ICD-10 codes** |
| Claims submitted with both ICD-9 and ICD-10 codes | **Will be rejected** |

# Providers Not Enrolled with EDI


COLORADO
Department of Health Care Policy & Financing

COLORADO
MEDICAL ASSISTANCE PROGRAM

*Provider EDI Enrollment Application*

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

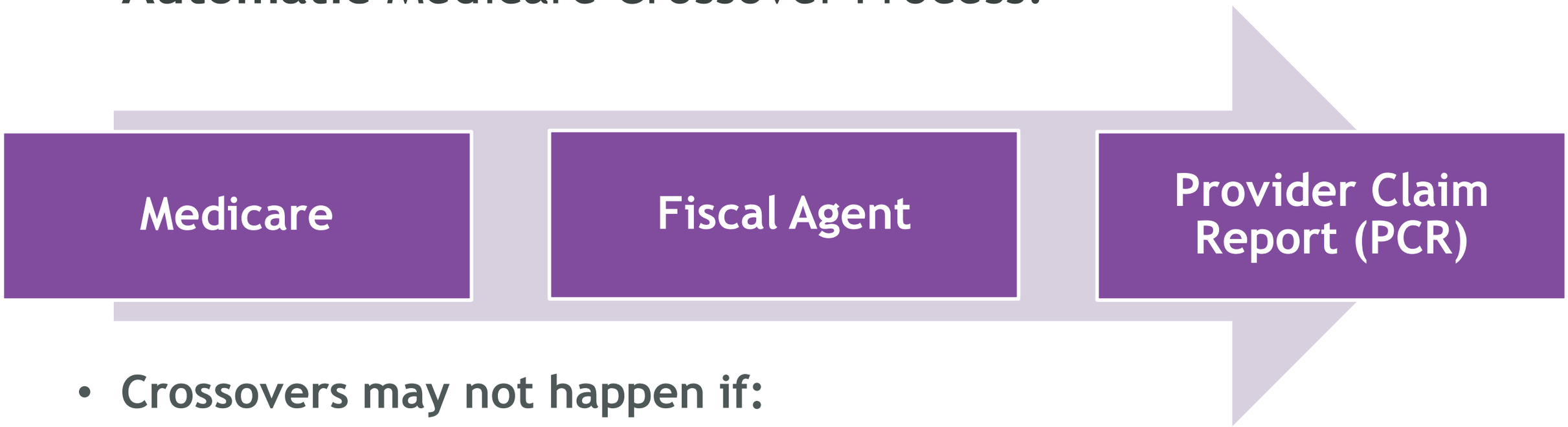
**Providers must be enrolled with EDI to:**

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
  - Select Provider Application for EDI Enrollment

Colorado.gov/hcpf/EDI-Support

# *Crossover Claims*

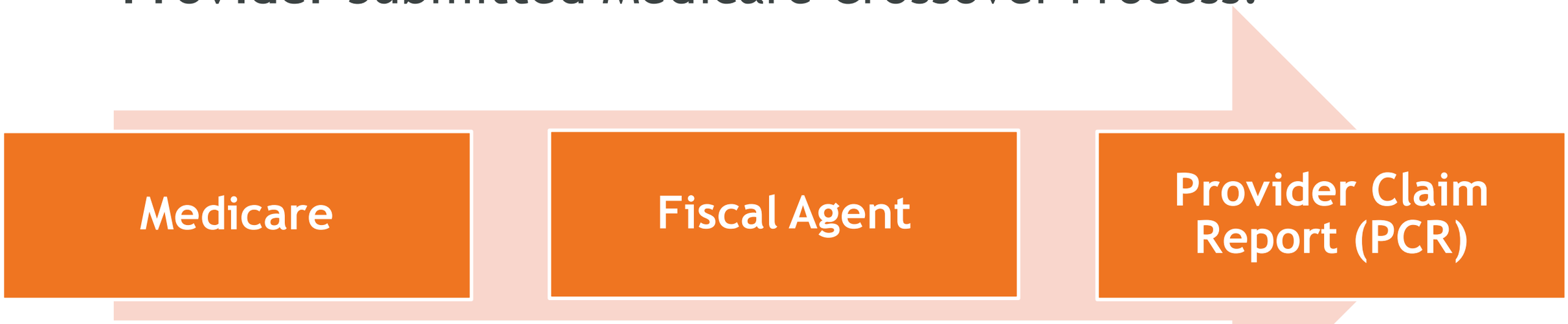
**Automatic** Medicare Crossover Process:




- **Crossovers may not happen if:**
  - NPI not linked
  - Member is a retired railroad employee
  - Member has incorrect Medicare number on file

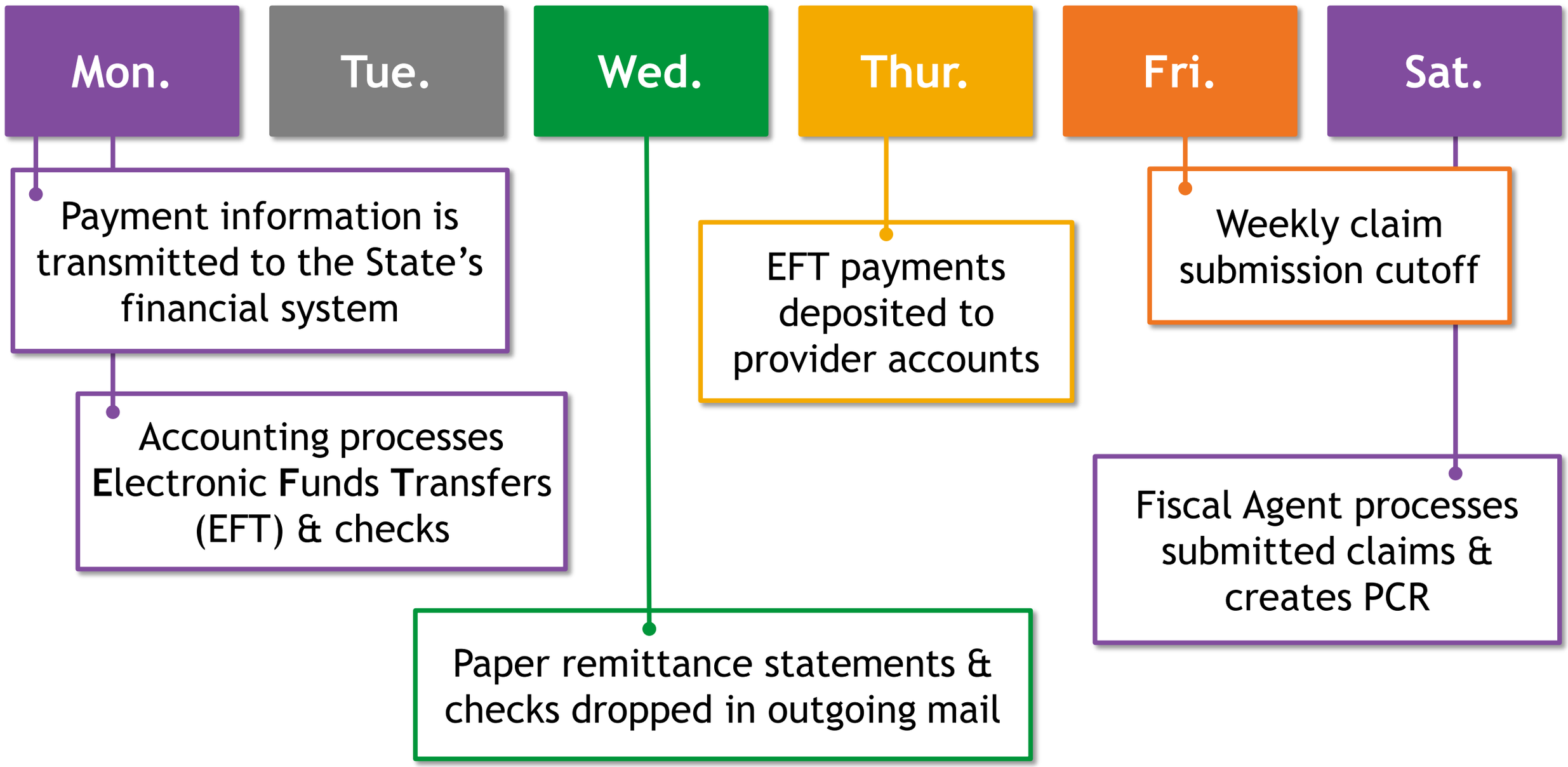
# *Crossover Claims*

**Provider** Submitted Medicare Crossover Process:




- **Additional Information:**
  - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - Crossovers may be submitted on paper or electronically
  - Provider must submit copy of Standard Paper Remittance Advice (SPR) with paper claims
  - Provider must retain SPR for audit purposes

# Payment Processing Schedule



# *Electronic Funds Transfer (EFT)*

## Advantages

- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- Colorado.gov/hcpf/provider-forms → Other Forms

# *PARs Reviewed by ColoradoPAR*

- eQHealth Solutions processes all PARs
  - With the **exception of Waiver and Nursing Facilities**
  - including revisions
  - Visit ColoradoPAR.com for more information

| Mail: | Phone: |
| --- | --- |
| eQHealth Solutions<br>Attn: Colorado Medicaid Program<br>5802 Benjamin Center Dr., Suite 105<br>Tampa, FL 33634 | Phone: 1.888.801.9355<br>FAX: 1.855.440.3747<br>Web: ColoradoPAR.com |

# *Electronic PAR Information*

- PARs/revisions processed by the ColoradoPAR Program must be submitted via eQSuite®
- The ColoradoPAR Program will process PARs submitted by phone for:
  - emergent out-of-state
  - out-of area inpatient stays
  - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

# *PAR Letters/Inquiries*

- Final PAR determination letters are mailed to members and providers by the Department's fiscal agent
- Letter inquiries should be directed to the fiscal agent, not ColoradoPAR
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the fiscal agent
  - ensure you have the right PAR type
    - e.g. Medical PAR may have been requested but processed as a Supply PAR

# *Transaction Control Number*

**Receipt Method**
0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

**Batch Number**

**Document Number**

**0 15 129 00 150 0 00037**

**Year of Receipt**

**Julian Date of Receipt**

**Adjustment Indicator**
1 = Recovery
2 = Repayment

# *Timely Filing*

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

# Timely Filing

**From "through" DOS**

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

**From delivery date**

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

**From DOS**

FQHC Separately Billed and additional Services

# Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)

# *Timely Filing*

## Medicare/Medicaid Enrollees

| Medicare pays claim | Medicare denies claim |
| --- | --- |
| 120 days from Medicare payment date | 60 days from Medicare denial date |

# *Timely Filing Extensions*

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

# *Timely Filing Extensions*

## Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available

# *Timely Filing Extensions*

## Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member

# *Timely Filing Extensions*

## Backdated Eligibility

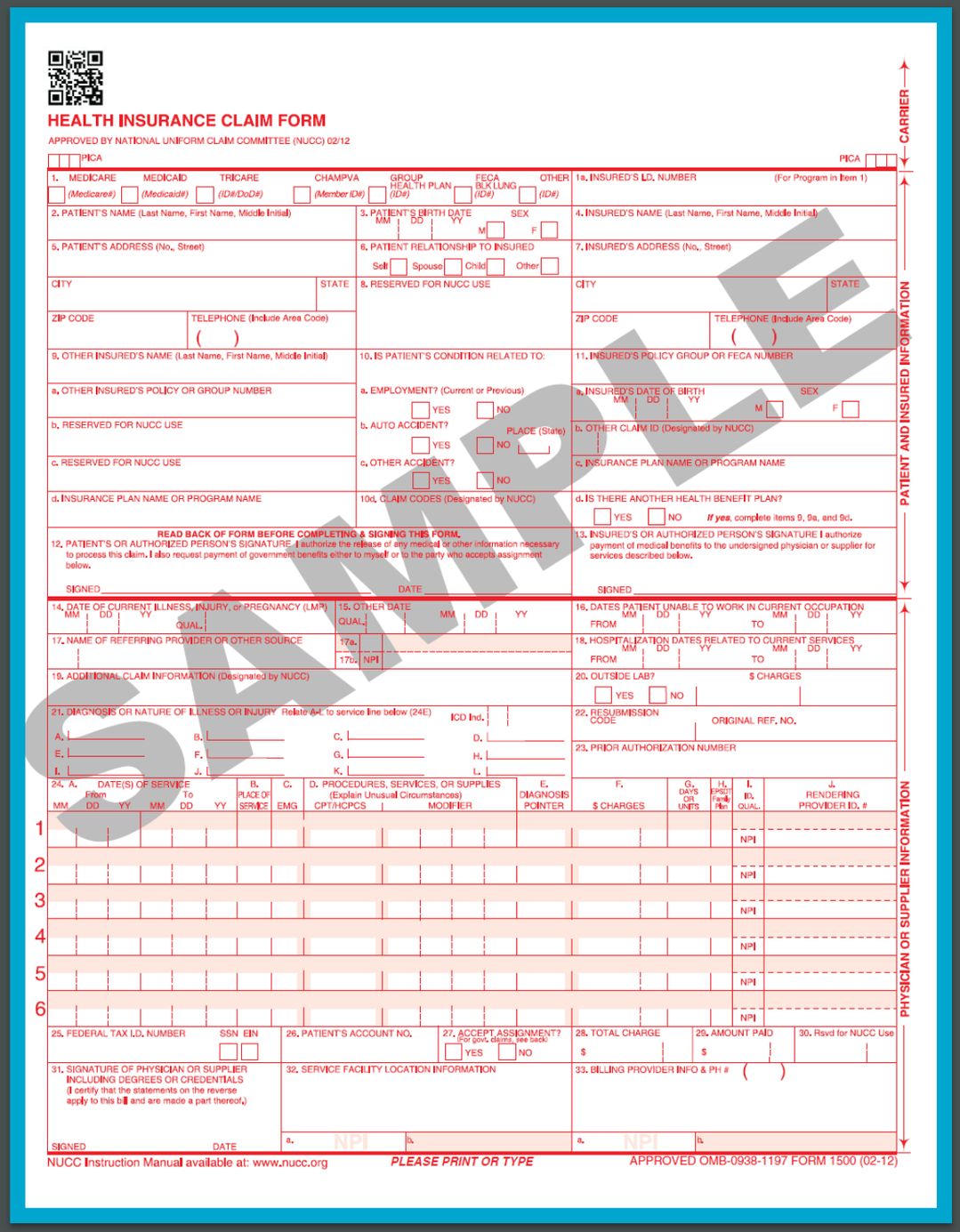
- 120 days from date county enters eligibility into system
  - Report by obtaining State-authorized letter identifying:
    - County technician
    - Member name
    - Delayed or backdated
    - Date eligibility was updated

# *CMS 1500*

**What are some of the DME services billed on the CMS 1500?**

- Wheelchairs
- Walkers
- Repairs
- Disposable Supplies
- Incontinence Products

# CMS 1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| | 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

# *Fraud and Abuse*

**False Claims Act**

- Submitting claim for services or items not provided
- Falsifying elements on a claim (e.g. DOS, Units, etc.)
- See CRS 25.5-4-303.5 et seq

**Anti-Kickback Statute**

- Prohibits exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) referral of federal health care program business
- See 42 U.S.C. 1320a-7b

**Stark Law**

- Prohibits physicians from referring patients to medical facilities in which physician has a financial interest
- See 42 U.S.C. 1395nn

# *Fraud and Abuse*

- Failure to use proper coding when billing may:
  - Result in claims being denied
  - Place provider in jeopardy of recovery actions and/or state or federal civil sanctions
  - To avoid improper coding, use procedure codes & modifiers as instructed in Provider Bulletins and Provider Manuals

# *DME Reimbursement Billing: By-MSRP*

- Cannot receive more for item than maximum purchase price (MPP) as identified in fee schedule
- For items without MPP:
  - Reimbursement rate = manufacturer's suggested retail price (MSRP) less set percentage
    - Percentage includes DME handling
  - Copies of invoices & documented MSRP shall be submitted with claims that have line items over $30

# *DME Reimbursement Billing: By-MSRP*

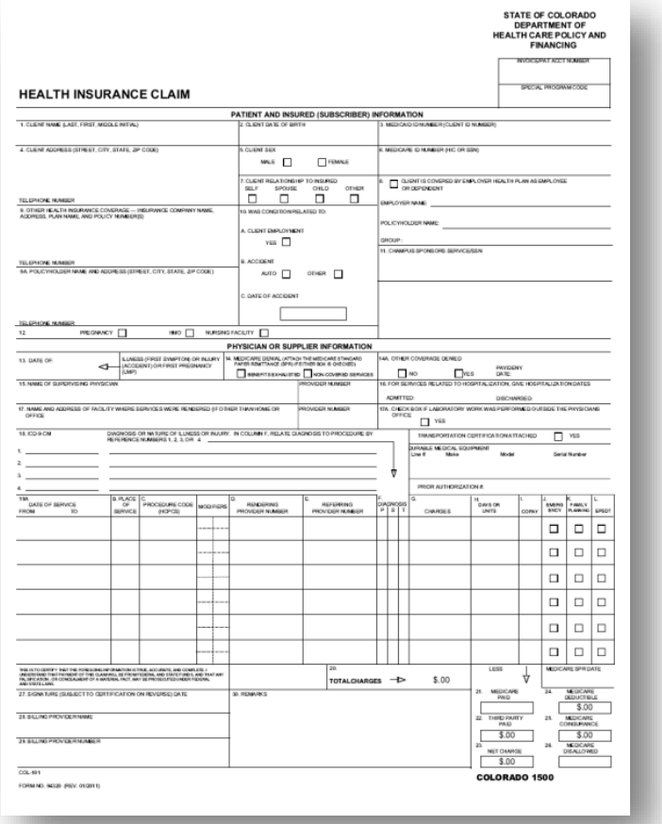
- Acceptable MSRP documentation:
  - MSRP, LIST Price, Retail Price. Originals must be maintained in provider's files
    - per Department regulations
  - Providers cannot bill for state sales tax collection

# *DME Reimbursement Billing: By Invoice*

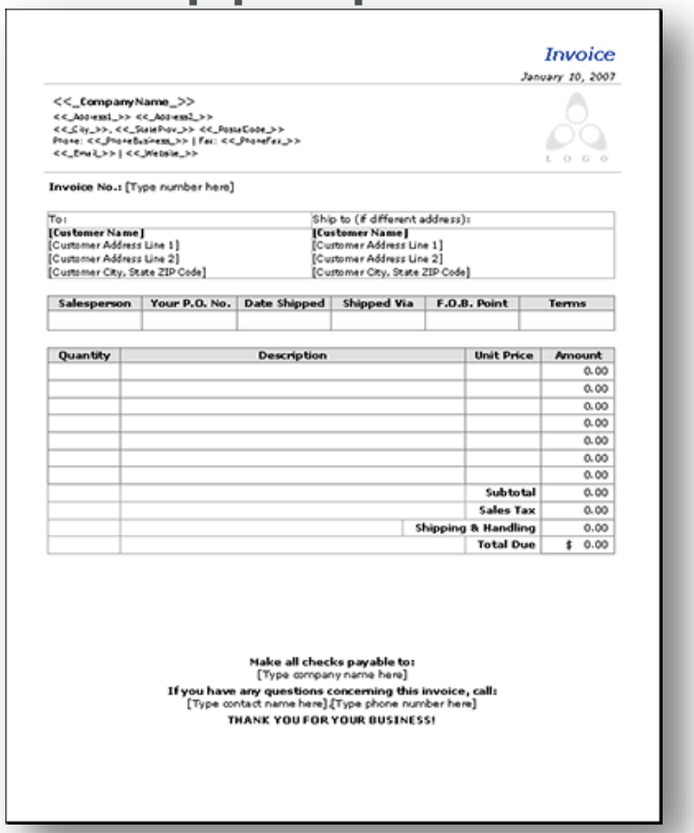
- Cannot receive more for item than maximum purchase price (MPP) as identified in fee schedule
- For items without MPP that also do not have an MSPR:
  - Reimbursement rate = the actual acquisition invoiced cost
    - Actual acquisition costs are manufacturer's list price for the item, minus any standard trade discount applied to lower the actual cost to provider
    - Does not include any time-sensitive or otherwise conditional discounts available to provider
  - If billing for handling, it should be at percentage of actual acquisition cost of the products

# *Miscellaneous Supply Codes*

- Miscellaneous codes are manually priced and require MSRP documentation or an invoice, must be billed on paper if over $30, and must include the appropriate HCPCS code




**Or**




**Note:**
For new equipment please include:
- Make
- Model
- Serial #

**Appropriate HCPCS code**

**Copy of MSRP invoice or actual acquisition cost**

# *Unrelated Manufacturer*

- Only invoices from unrelated manufacturers or wholesale distributors shall be allowed
- Invoices are not allowed from
  - Related owners
  - Related parties
- See rule 10 CCR 2505-10 Section 8.590.7.A

# *Related Owner*

- Individual with 5% or more ownership interest of a manufacturer
- One entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business
- DME supplier has control of or is affiliated with manufacturer

# *Related Party*

- Member of owner's immediate family, including:
  - Spouse
  - Natural, adoptive parent, or step-parent
  - Natural, adoptive child, or stepchild
  - Sibling or stepsibling
  - In-laws
  - Grandparents and grandchildren

# *Custom Manufacturing*

- Invoices for Supplies or DME manufactured by provider must include detailed cost information for
  - Acquisition
  - Material
  - Time and labor

# *Used Equipment*

- Written, signed and dated agreement from the member accepting the equipment
- Members and providers may negotiate trade-in amount on member-owned used equipment
- Medicaid will pay up to 60% of the new cost for used pieces of equipment
  - On PAR or claim, list serial number in “Additional Information” section of the CMS 1500
  - Providers are not required to take trade-ins
- See 10 CCR 2505-10 8.590.7.D & 8.590.7.G

# *Date of Death*

- Following are allowable the month of member's death:
  - Durable medical rental equipment
  - Oxygen
  - Bulk supplies drop-shipped to member's home
- Following date of death, recoveries will be made for:
  - Other services
  - Rental and bulk supplies billed after the month of member's death

# *Common Denial Reasons*

| | |
|---|---|
| **Timely Filing** | Claim was submitted more than 120 days without a LBOD |
| **Duplicate Claim** | A subsequent claim was submitted after a claim for the same service has already been paid |
| **Bill Medicare or Other Insurance** | Medicaid is always the “Payer of Last Resort” - Provider should bill all other appropriate carriers first |

# *Common Denial Reasons*

| | |
|---|---|
| **PAR not on file** | No approved authorization on file for services that are being submitted |
| **Total Charges invalid** | Line item charges do not match the claim total |

# *Claims Process - Common Terms*

## Reject

Claim has primary data edits – **not** accepted by claims processing system

## Denied

Claim processed & denied by claims processing system

## Accept

Claim accepted by claims processing system

## Paid

Claim processed & paid by claims processing system

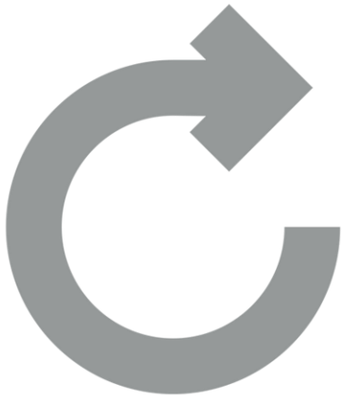


From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

# *Claims Process - Common Terms*

## Adjustment

Correcting under/overpayments, claims paid at zero & claims history info



## Rebill

Re-bill previously denied claim

## Suspend

Claim must be manually reviewed before adjudication

## Void

"Cancelling" a "paid" claim (wait 48 hours to rebill)



From the Noun Project:
"Delete" by Ludwig Schubert
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# *Adjusting Claims*

- What is an adjustment?
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

| Adjust a claim when | Do not adjust when |
| --- | --- |
| • Provider billed incorrect services or charges<br>• Claim paid incorrectly | • Claim was denied<br>• Claim is in process<br>• Claim is suspended |

# *Adjustment Methods*

## Web Portal

- Preferred method
- Easier to submit & track

## Paper

- Complete field 22 on the CMS 1500 claim form



From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Paper" by Kristina

# *Provider Claim Reports (PCRs)*

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal

# *Provider Claim Reports (PCRs)*

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

# Provider Claim Reports (PCRs)

**Paid**

* CLAIMS PAID *

| INVOICE NUM | CLIENT NAME | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SVC FROM | TO | TOTAL CHARGES | ALLOWED CHARGES | COPAY PAID | AMT OTH SOURCES | CLM PMT AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|
| 7015 | CLIENT, IMA | Z000000 | 040800000000000001 | 040508 | 040508 | 132.00 | 69.46 | 2.00 | 0.00 | 69.46 |
| PROC CODE - MODIFIER 99214 - | | | | 040508 | 040508 | 132.00 | 69.46 | 2.00 | | |

TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46

**Denied**

* CLAIMS DENIED *

| INVOICE NUM | CLIENT NAME | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SERVICE FROM | TO | TOTAL DENIED | DENIAL REASONS ERROR CODES |
|---|---|---|---|---|---|---|---|
| STEDOTCCIOT | CLIENT, IMA | A000000 | 30800000000000003 | 03/05/08 | 03/06/08 | 245.04 | 1348 |

TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

# Provider Claim Reports (PCRs)

## Adjustments

**********
* ADJUSTMENTS PAID *
**********

| INVOICE NUM | --- CLIENT NAME ------- | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SVC FROM | TO | ADJ RSN | TOTAL CHARGES | ALLOWED CHARGES | COPAY PAID | AMT OTH SOURCES | CLM PMT AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Z71 | CLIENT, IMA | A000000 | 40800000000100002 | 041008 | 041808 | 406 | 92.82- | 92.82- | 0.00 | 0.00 | 92.82- |
| PROC CODE - MOD | T1019 - U1 | | | 041008 | 091808 | | 92.82 | 92.82- | | | |
| Z71 | CLIENT, IMA | A000000 | 40800000000200002 | 041008 | 041808 | 406 | 114.24 | 114.24 | 0.00 | 0.00 | 114.24 |
| PROC CODE - MOD | T1019 - U1 | | | 041008 | 041808 | | 114.24 | 114.24 | | | |
| | | | | | | NET IMPACT | | 21.42 | | | |

Recovery

Repayment

Net Impact

## Voids

**********
* ADJUSTMENTS PAID *
**********

| INVOICE NUM | – CLIENT NAME ------- | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SVC FROM | TO | ADJ RSN | TOTAL CHARGES | ALLOWED CHARGES | COPAY PAID | AMT OTH SOURCES | CLM PMT AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A83 | CLIENT, IMA | Y000002 | 40800000000100009 | 040608 | 042008 | 212 | 642.60- | 642.60- | 0.00 | 0.00 | 642.60- |
| PROC CODE - MOD | T1019 - U1 | | | 040608 | 042008 | | 642.60- | 642.60- | | | |
| | | | | | | NET IMPACT | 642.60- | | | | |

# *Provider Services*

| Xerox<br>1-800-237-0757 | CGI<br>1-888-538-4275 |
| --- | --- |
| Claims/Billing/Payment | Email helpdesk.HCG.central.us@cgi.com |
| Forms/Website | CMAP Web Portal technical support |
| EDI | CMAP Web Portal Password resets |
| Updating existing provider profile | CMAP Web Portal End User training |

# *Thank you!*