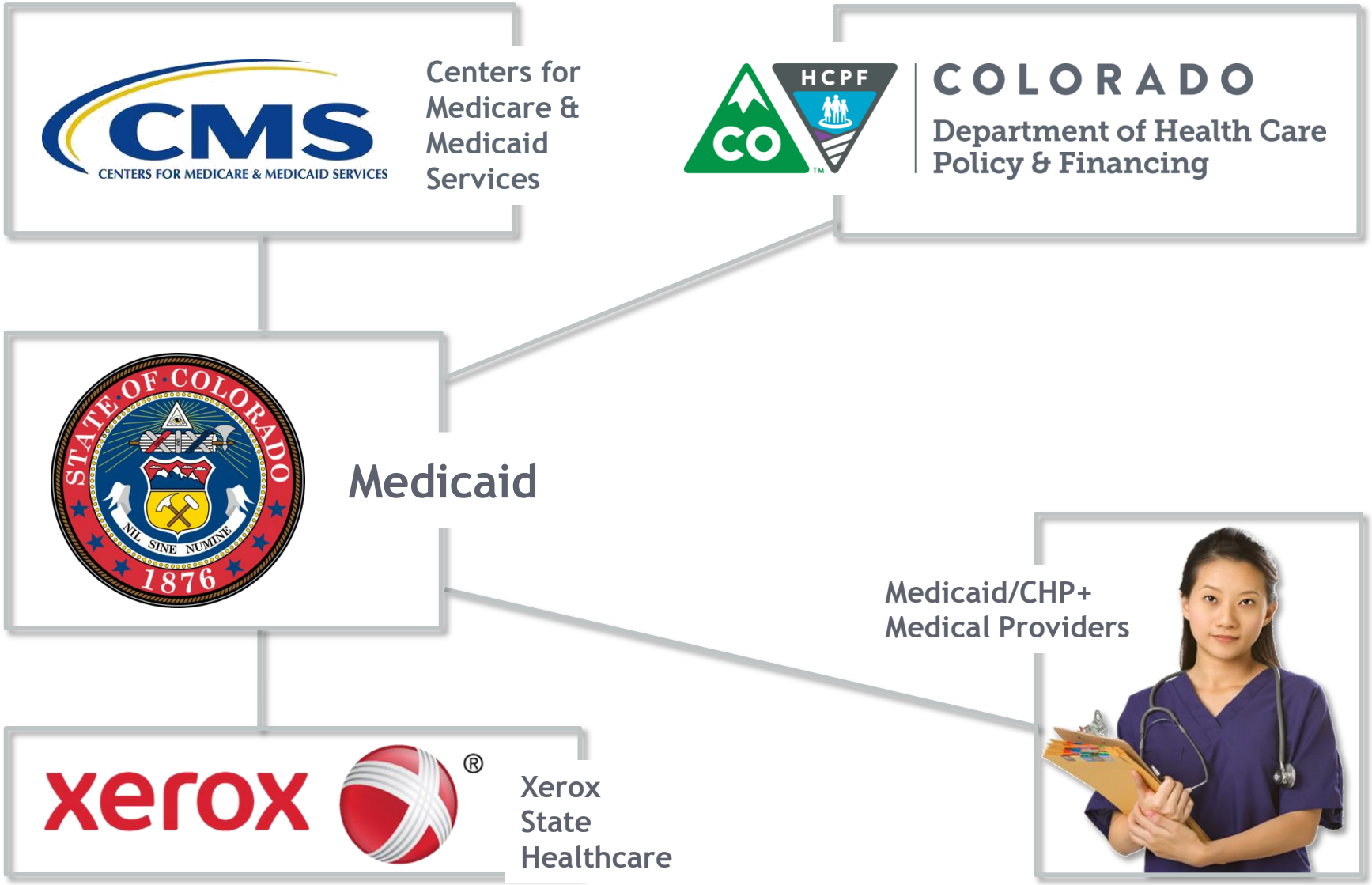
# *Beginning Billing Workshop Nursing Home Visitor Program*

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
Medicaid/CHP+ Medical Providers
xerox
Xerox State Healthcare

# *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

# *Nurse Home Visitor Program*

- Who's involved?
  - Colorado Department of Health Care Policy and Financing
  - Colorado Department of Human Services
  - Invest in Kids
    - What it is and how to obtain one
- Statutes, Rules, Guidance
  - 26-6.4-101 C.R.S
  - 10 C.C.R 2505-10 § 8.749
  - Medicaid Billing Manual
  - State Plan Amendment

# *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.dms.hhs.gov/nationalproldentstand/
  - 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

The Official Web Portal

Translate

COLORADO
Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers | For Our Stakeholders | About Us

## For Our Providers

- Why should *you* become a provider?
- How to become a provider (enroll)
- Provider services (training, & more)
- What's new? (bulletins, newsletters, updates)

- CBMS Colorado Benefits Mgmt. System
- DDweb
- Web Portal
- Get Help
- Get Info
- Find a Doctor

# *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:**

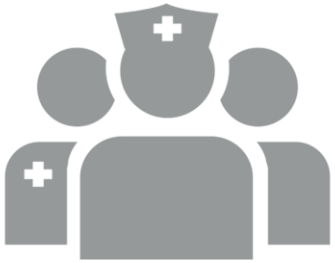
Everyone who provides services for Medical Assistance Program members

- 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



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**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

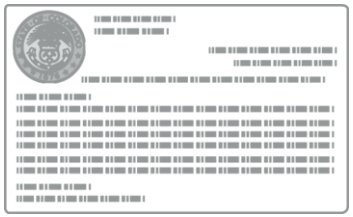
# *Verifying Eligibility*

- 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
  - Presumptive Eligibility
- Some members = additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance

# *Eligibility Types*

## Presumptive Eligibility

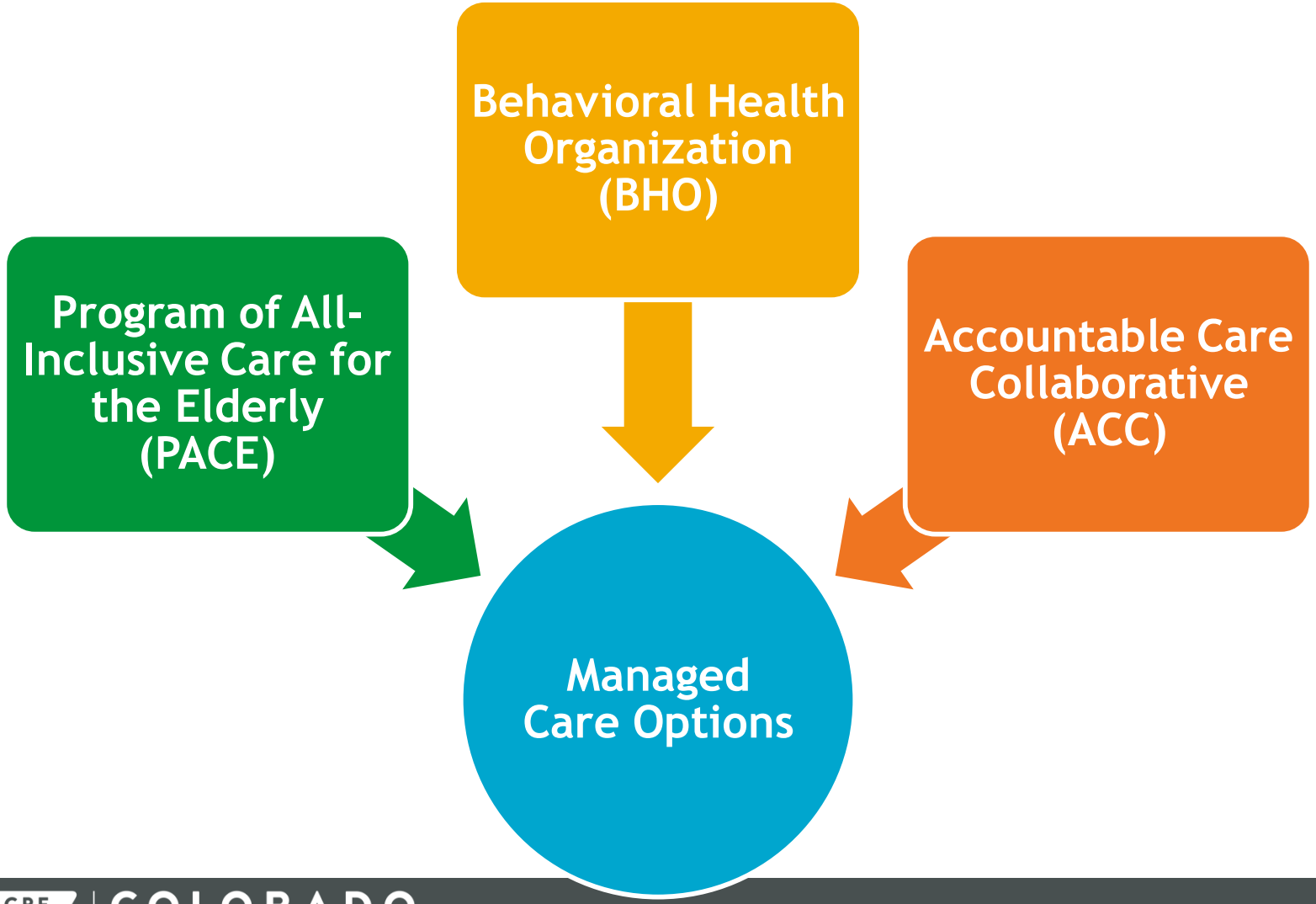
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers Durable Medical Equipment (DME) and other outpatient services
  - 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

## 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

# Managed Fee-for-Service

## Accountable Care Collaborative (ACC)

- All ACC members are Fee-for-Service members
- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
  - Connects Medicaid members to:
    - Care management and navigation support from RCCOs
    - Connects members to a medical home
    - Access to education and special programs
    - Help with non-medical community resources
- Helps coordinate Member care
  - Helps with care transitions

# 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

## 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*

**Pregnant Women**

# *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

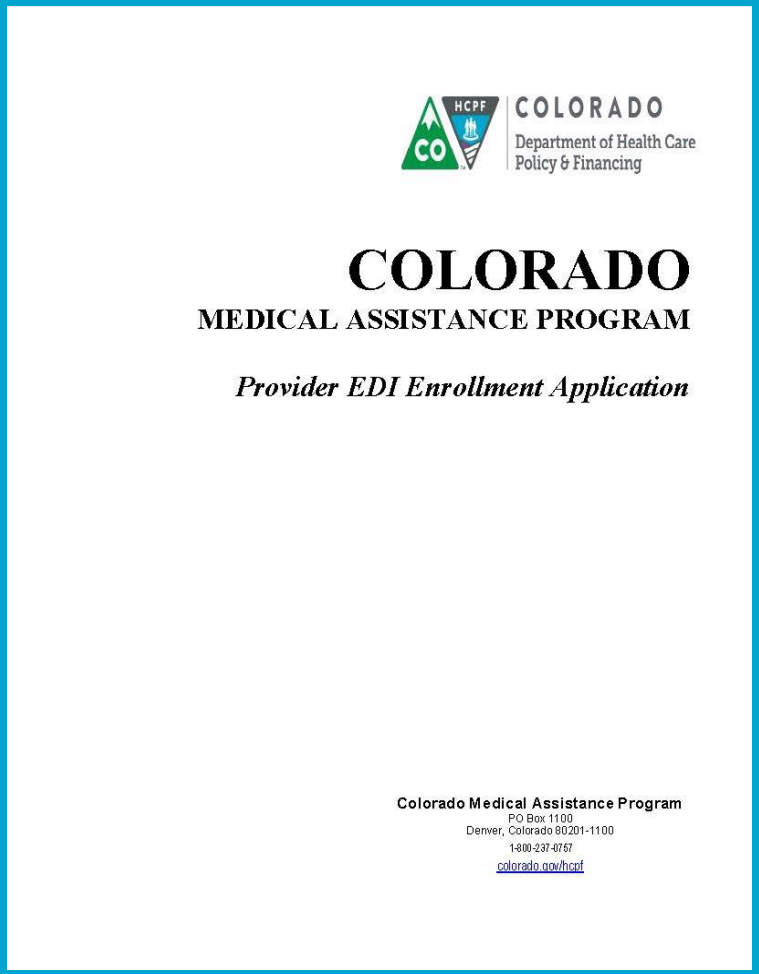
- Methods to submit:
  - Electronically through Web Portal
  - Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  - Paper only when:
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

# ICD-10 Implementation Delay

**ICD-10 Implementation delayed until 10/1/2015**

| | |
|---|---|
| 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

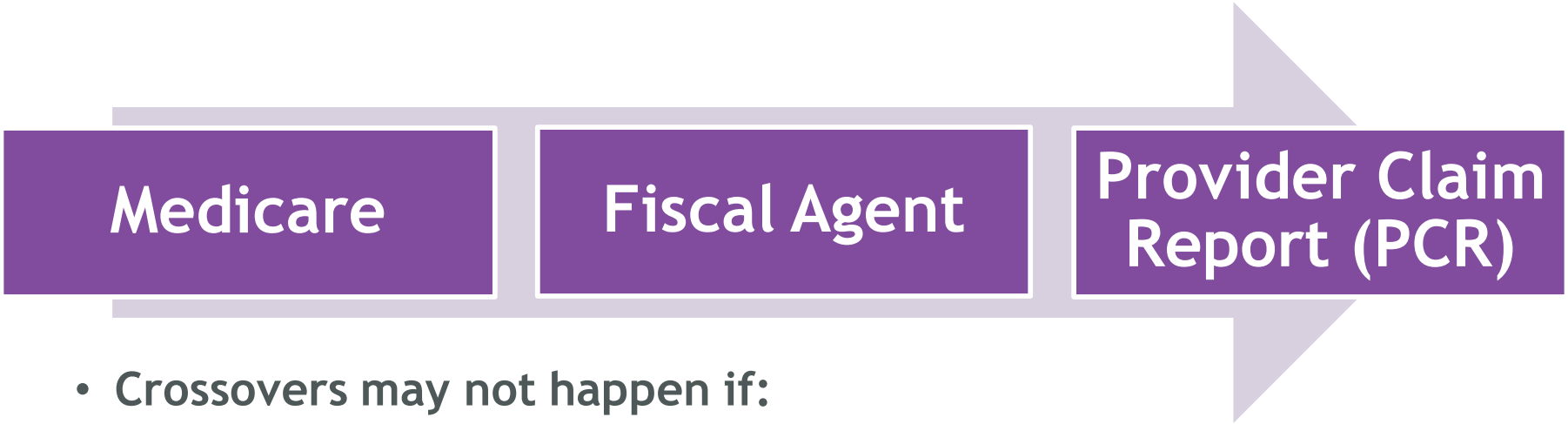
**Providers must be enrolled with EDI to:**

- 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

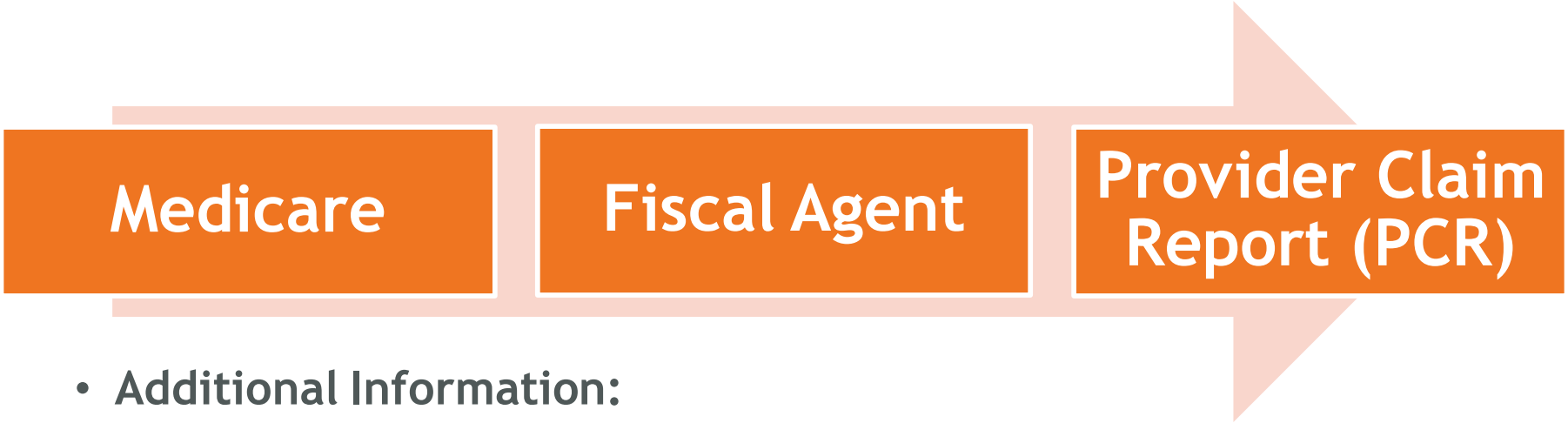
**Automatic** Medicare Crossover Process:




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

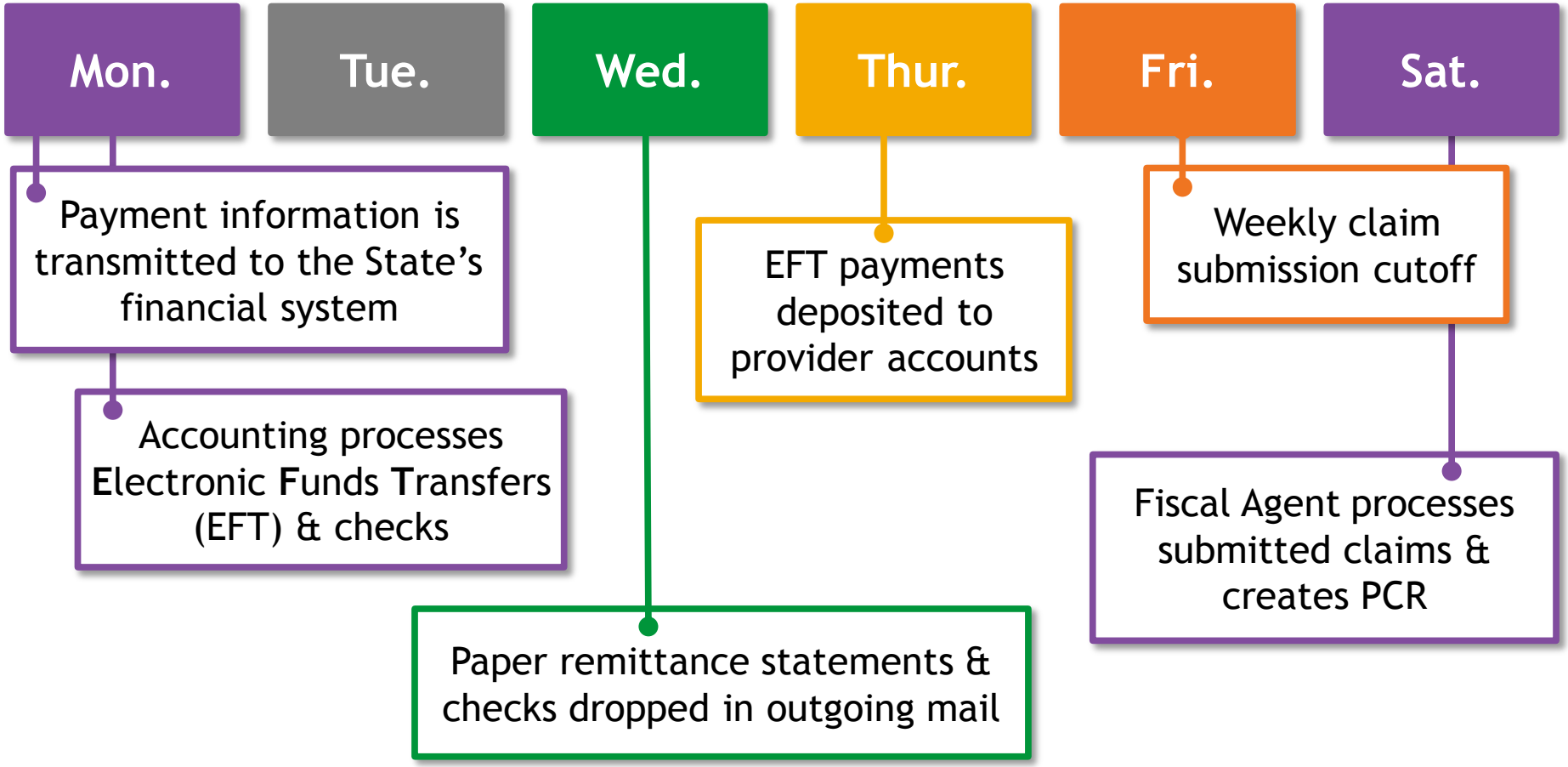
# Crossover Claims

**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 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

# 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 837I transaction
  - Keep supporting documentation
- Paper Claims
  - UB-04- enter Occurrence Code 53 and the date of the last adverse action

# *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

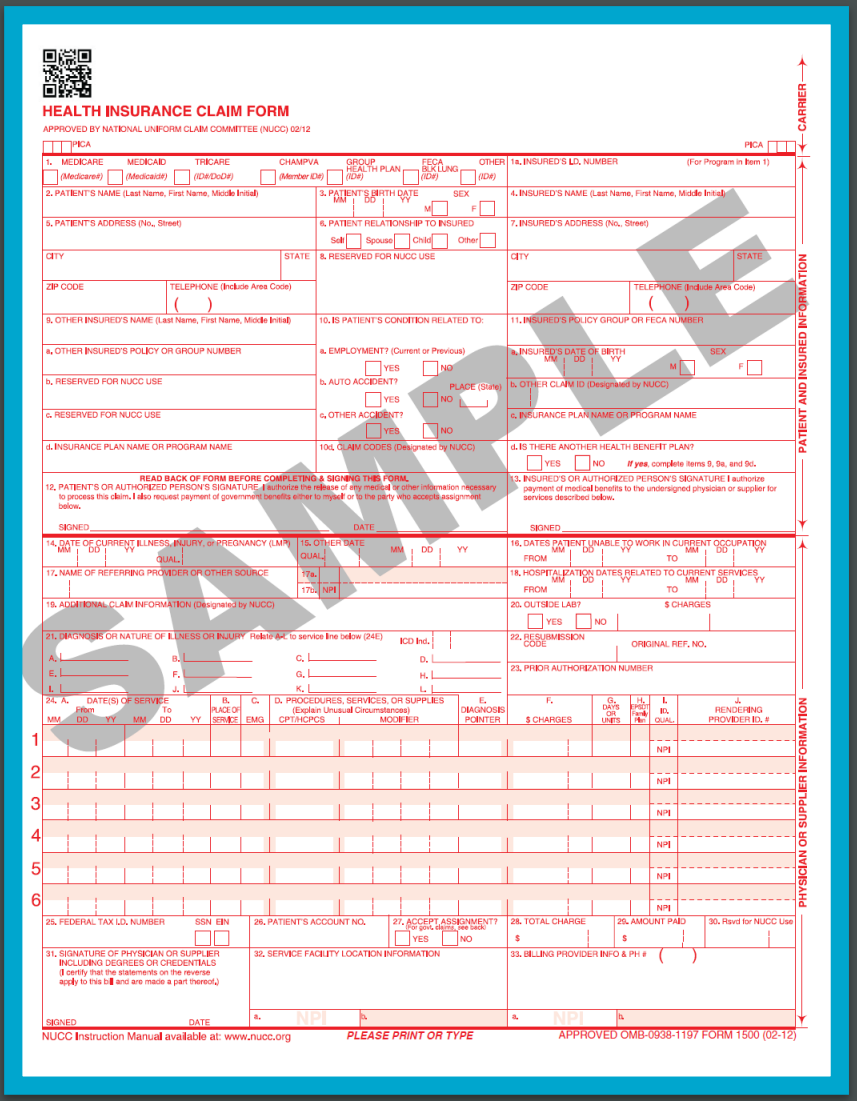
- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility 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



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? YES NO PLACE (State)

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 QUAL. MM DD YY

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 Fam. 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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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

# *Procedure Codes*

- G9006
  - Coordinated Care Fee, Home Monitoring
  - Use this code when billing services for the mother
- T1017
  - Targeted Case Management
  - Use this code when billing services for the child
- Services for the mother and services the child must be billed on separate claims

# *Places of Service*

- Reimbursement rate is dependent on Place of Service
  - Bill Place of Service Code 12 (Home) or any TCM that occurs away from the office/agency
  - Bill other Place of Service codes for TCM that occurs at your office/agency including but not limited to:
    - 11 (Office)
    - 50 (FQHC)
    - 71 (Public Health Agency)
    - 72 (RHC)

# *Units of Service*

- 1 unit equals 15 minutes of TCM
- A maximum of fifteen (15) units will be reimbursed in any calendar month per mother/child couple
- May be divided between the mother and child if both are Medicaid-eligible in the same month
- May be provided:
  - In the home/off-site setting
  - In the office
  - A combination of both

# Units of Service

- Time spent on TCM should be rounded to the nearest whole unit
- Documentation in the chart should support the number of units billed

| Service Time | Units Billed |
|---|---|
| 5 minutes | No units may be billed |
| 10 minutes | 1 unit may be billed |
| 23 minutes | 2 units may be billed |

# *Modifiers*

- 1st modifier field must always be HD (pregnant/parenting program)
- If Home TCM and Office TCM on the same date of service or span:
  - Line Item 1: Procedure code, Modifier 1 is HD, first place of service code
  - Line Item 2: Procedure code, Modifier 1 is HD, Modifier 2 is 76 (duplicate service), other place of service code

# Diagnosis Codes

- Diagnosis codes that are appropriate for this program include but are not limited to the following:

| Member Description and Stage | Diagnosis Code | Description |
|---|---|---|
| Pregnant Woman | V22<br>V22.0<br>V22.1<br>V23 | Normal pregnancy<br>Supervision of normal first pregnancy<br>Supervision of other normal pregnancy<br>Supervision of high-risk pregnancy |
| Mother from Delivery through 2-3 Months Postpartum | V24.2 | Routine postpartum follow-up |
| Mother after 2-3 Months Postpartum to Child's 2nd B-day | V68.9 | Encounter for unspecified administrative purpose |
| Child-Infancy through 2nd B-day | V20<br>V20.1 | Health supervision of infant or child<br>Other healthy infant or child receiving care |

# *Span Billing*

- Alternative billing method allowed for some services, including NHVP
  - Rather than billing each encounter separately with individual dates of service, Span Billing allows you to bill one line item for:
    - The same service provided to the same member
    - Over a period of time on multiple dates of service
  - For instance if TCM was provided to the same member on three different dates of service:
    - Span of dates can be entered in the “From Date” field and the “To Date” field on one line item
    - Rather than billing three line items for each separate date of service

# *Span Billing*

- The span "From Date" and the span "To Date" should be within the same month
  - ie. 10/1/15 – 10/31/15
  - not 10/15/15 – 11/15/15
- No additional claims for that specific service for that member during that span will be paid once the span claim is paid
- If you need to add units, you must adjust the span claim
  - Do not submit an additional claim

# 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

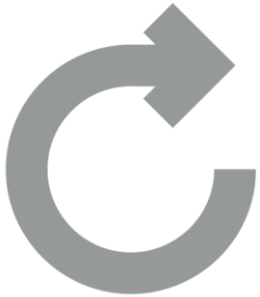


From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

# *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
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

# *Adjusting Claims*

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

**Adjust a claim when**

- Provider billed incorrect services or charges
- Claim paid incorrectly

**Do not adjust when**

- Claim was denied
- Claim is in process
- 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- | | | | |
| 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 | | | | |
| | | | | | | 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
**1-800-237-0757**

- Claims/Billing/Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

## CGI
**1-888-538-4275**

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

*Thank you!*