

# *Billing Workshop*

# *Rehabilitative OT/PT/ST*

Colorado Medicaid  
2015



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Centers for Medicare & Medicaid Services



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Medicaid

Medicaid/CHP+  
Medical Providers



Xerox State Healthcare



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# *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



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# *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



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

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - [www.dms.hhs.gov/nationalproidentstand/](http://www.dms.hhs.gov/nationalproidentstand/)
  - National Plan and Provider Enumeration System (NPPES)-
    - [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY



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# Department Website

The screenshot shows a web browser at the URL <https://www.colorado.gov/hcpf>. The page header includes the Colorado logo and the text "Colorado The Official Web Portal". The main heading is "COLORADO Department of Health Care Policy & Financing". A navigation menu contains "Home", "For Our Members", "For Our Providers", and "For Our Stakeholders". A callout box labeled "1" points to the URL in the browser's address bar. Another callout box labeled "2" points to the "For Our Providers" menu item. Below the navigation, a banner states: "We administer Medicaid, Child Health Plan Plus, and other health care programs for Coloradans who qualify." The main content area features four large buttons: "Explore Benefits" (with a magnifying glass icon), "Apply Now" (with a checkmark icon), "Find Doctors" (with a group of people icon), and "Get Help" (with an information icon). At the bottom, there are two promotional boxes: "Feeling Sick? For medical advice, call the Nurse Line: 800-283-3221" (with a nurse icon) and "Get Covered. Stay Healthy. colorado.gov/health" (with an umbrella icon).



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# Provider Home Page

Find what you need here

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

The screenshot shows the 'Provider Home Page' of the Colorado Department of Health Care Policy & Financing. The page has a blue header with the text 'The Official Web Portal' and a 'Translate' button. The main content area features the department's logo and name. A navigation menu includes 'Home', 'For Our Members', 'For Our Providers', 'For Our Stakeholders', and 'About Us'. The 'For Our Providers' section is the focus, containing four main categories: 'Why should you become a provider?' (with a cross icon), 'How to become a provider (enroll)' (with a document icon), 'Provider services (training, & more)' (with a dollar sign icon), and 'What's new? (bulletins, newsletters, updates)' (with a radio tower icon). Below these are quick links for 'CBMS Colorado Benefits Mgmt. System', 'DDweb', 'Web Portal', 'Get Help', 'Get Info', and 'Find a Doctor'.



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# Provider Enrollment

## Question:

What does Provider Enrollment do?

## Answer:

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

## Question:

Who needs to enroll?

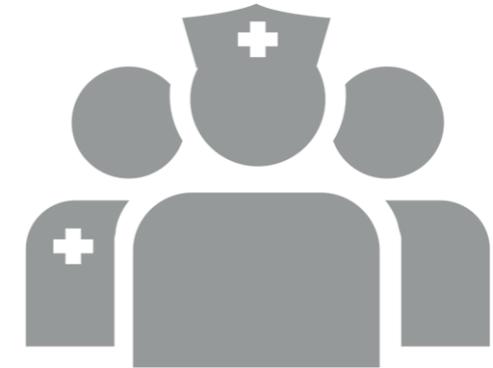
## Answer:

Everyone who provides services for Medical Assistance Program members

# *Rendering Versus Billing*

## **Rendering Provider**

Individual that provides services to a Medicaid member



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## **Billing Provider**

Entity being reimbursed for service



# Verifying Eligibility

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



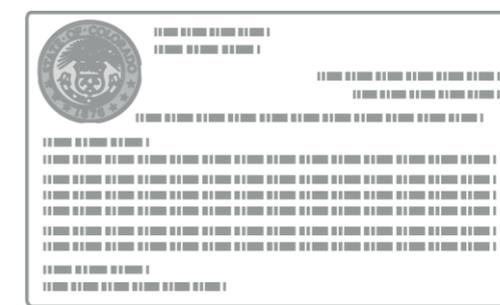
Colorado Medical  
Assistance Web Portal



Fax Back  
1-800-493-0920



CMERS/AVRS  
1-800-237-0757



Medicaid ID Card  
with Switch Vendor

# *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

**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

**CO MEDICAL ASSISTANCE**

Response Creation Date & Time: 05/19/2011

Contact Information for Questions on Res  
Provider Relations Number: 800-237-075

**Requesting Provider**

Provider ID:  
Name:

**Client Details**

Name:  
State ID:

## 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

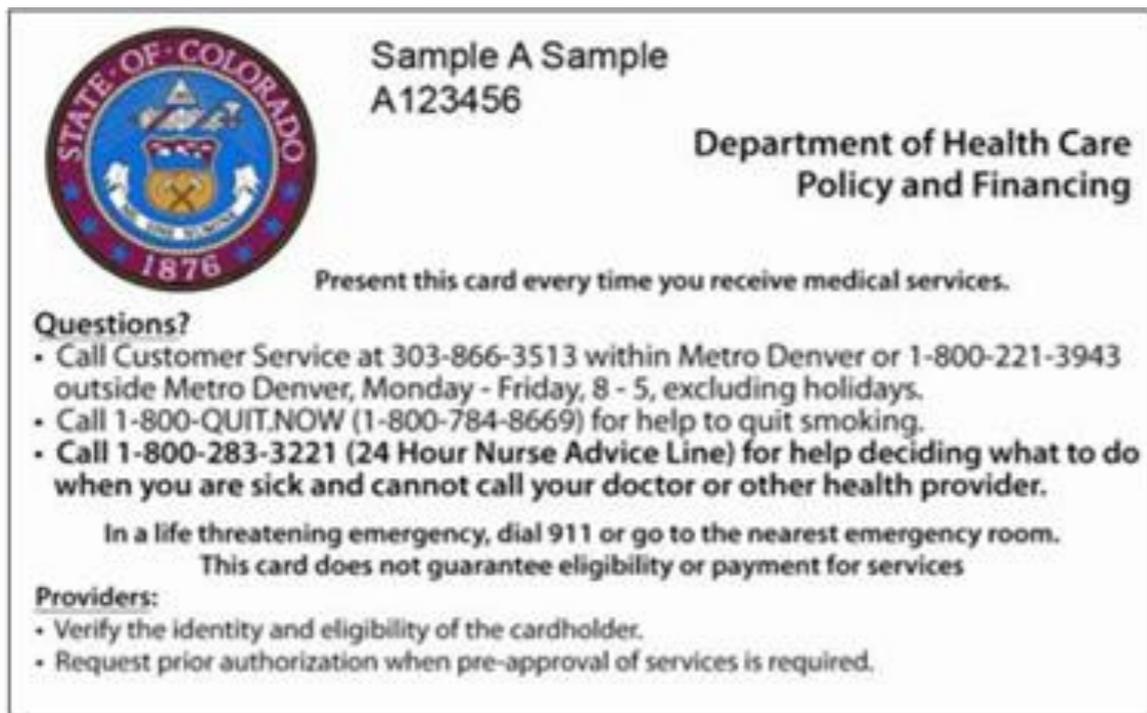
## Reminder:

- 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



# *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



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# *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



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# *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



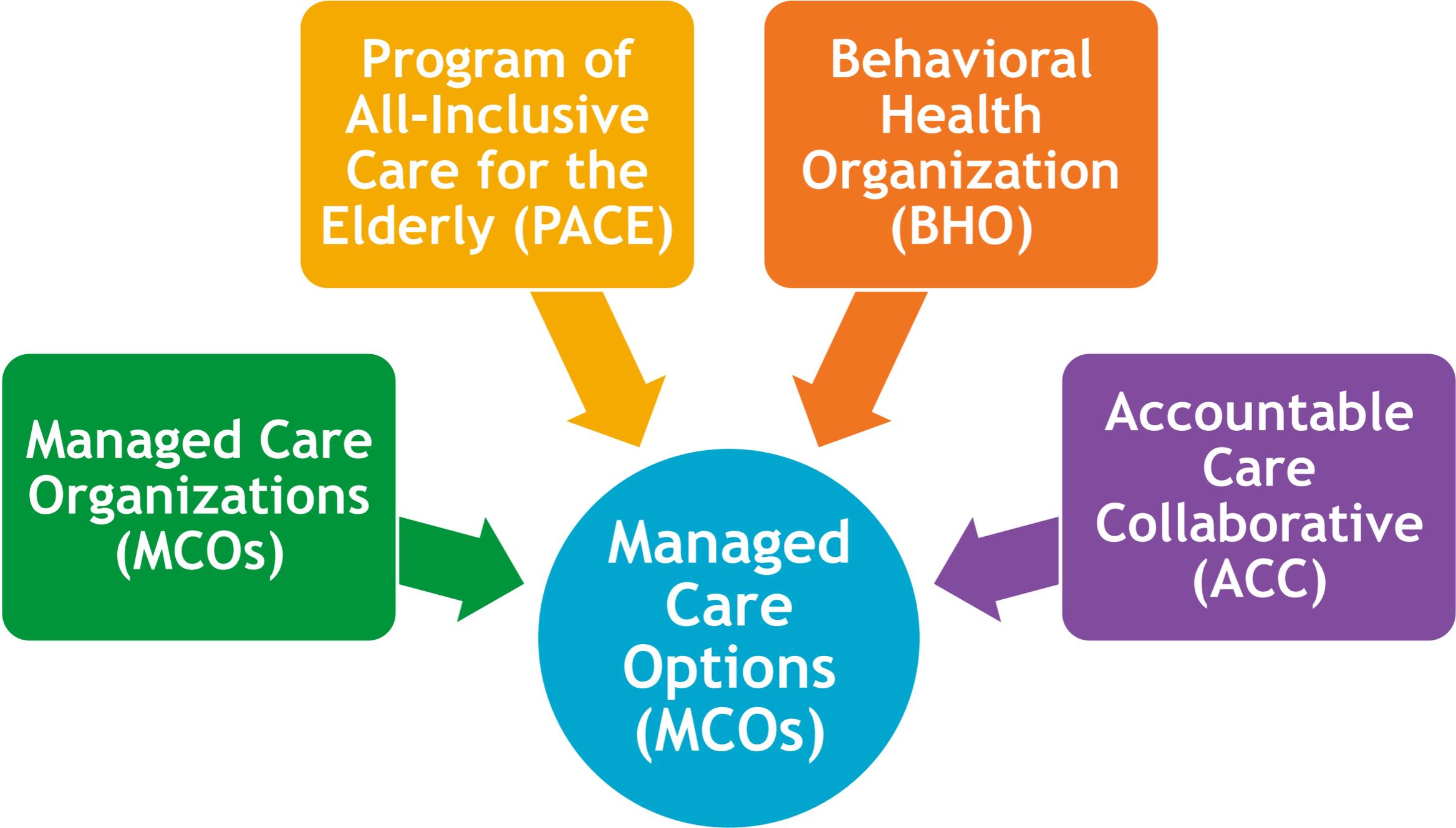
# *Eligibility Types*

## 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



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# *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



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# *Managed Care Options*

## Accountable Care Collaborative (ACC)

- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
  - Connects Medicaid members to:
- Helps coordinate Member care
  - Helps with care transitions



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# 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



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# Medicare

## Qualified Medicare Beneficiary (QMB)

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



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# 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



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# Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

- Charge = \$500
- Program allowable = **\$400**
- TPL payment = **\$300**
- Program allowable - TPL payment = **LOP**

$$\begin{array}{r} \$400.00 \\ - \$300.00 \\ = \$100.00 \end{array}$$

# *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



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# *Co-Payment Exempt Members*



**Nursing Facility  
Residents**



**Children**



**Pregnant  
Women**

# *Co-Payment Facts*

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- Collect from member at time of service
- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS
  - Transportation
  - Emergency Services
  - Family Planning Services



# *Specialty Co-payments*

Speech Therapy  
Occupational Therapy  
Physical Therapy

\$3.00 per date of  
service

# *Billing Overview*

Record  
Retention

Claim  
submission

Prior  
Authorization  
Requests  
(PARs)

Timely filing

Extensions for  
timely filing



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# 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



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# 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** MEDICAL ASSISTANCE PROGRAM

*Provider EDI Enrollment Application*

Colorado Medical Assistance Program  
PO Box 1100  
Denver, Colorado 80201-1100  
1-800-237-0767  
[colorado.gov/hcpf](http://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

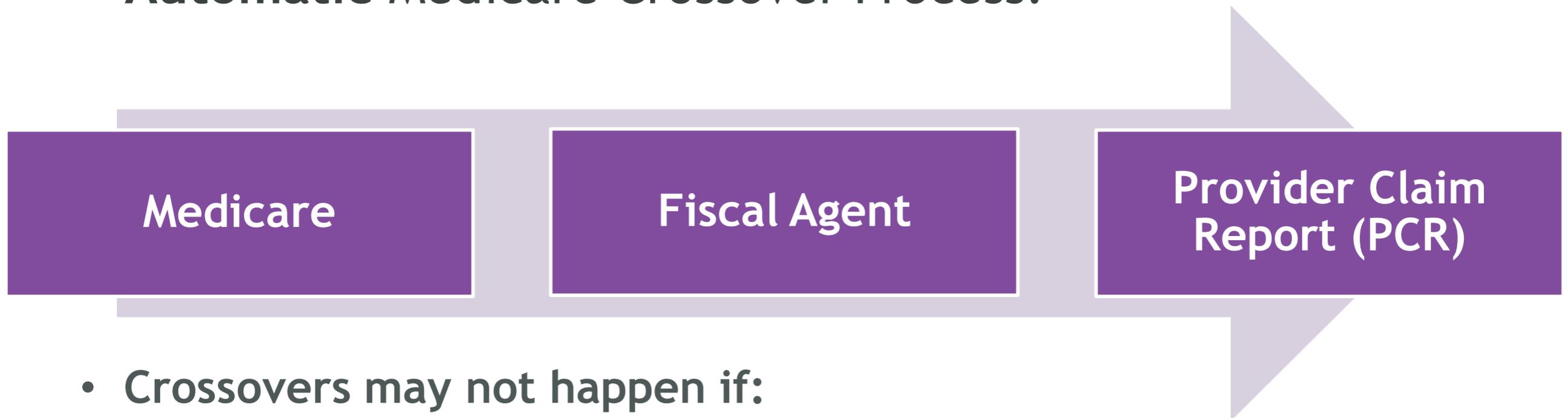
[Colorado.gov/hcpf/EDI-Support](http://colorado.gov/hcpf/EDI-Support)



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# Crossover Claims

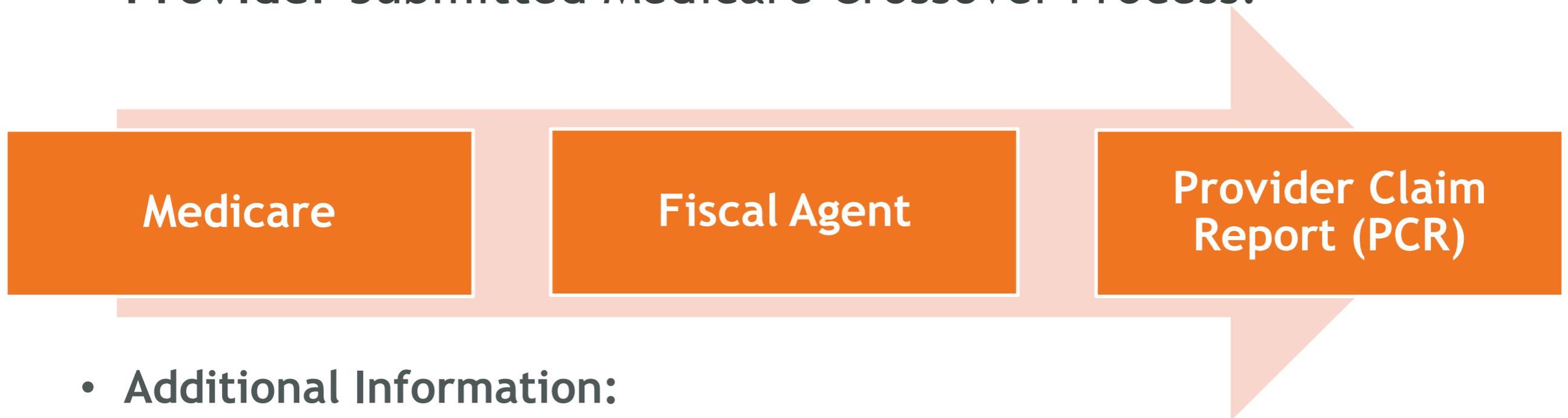
## Automatic Medicare Crossover Process:



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

# Crossover Claims

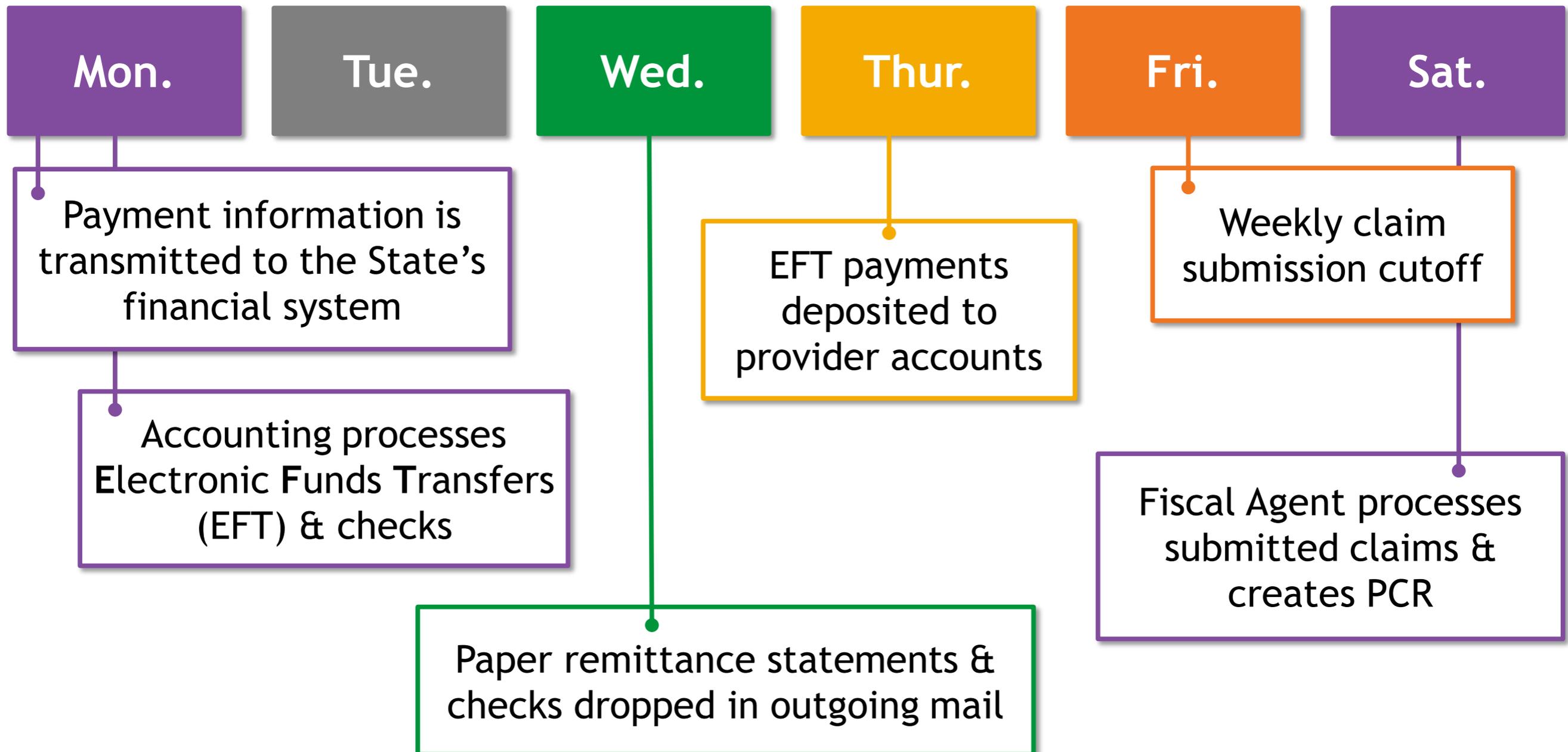
## Provider Submitted Medicare Crossover Process:



- **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](https://colorado.gov/hcpf/provider-forms) → Other Forms

# PARs Reviewed by ColoradoPAR

- With the exception of Waiver and Nursing Facilities:
  - The ColoradoPAR Program processes all PARs
    - including revisions
  - Visit [ColoradoPAR.com](http://ColoradoPAR.com) for more information

## Mail:

Prior Authorization Request  
55 N Robinson Ave., Suite 600  
Oklahoma City, OK 73102

## Phone:

Phone: 1.888.454.7686  
FAX: 1.866.492.3176  
Web: [ColoradoPAR.com](http://ColoradoPAR.com)



# *Electronic PAR Information*

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)
- 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



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# *PAR Letters/Inquiries*

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is only number accepted when submitting claims
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the ColoradoPAR Program
  - ensure you have the right PAR type
  - e.g. Medical PAR may have been requested but processed as a Supply PAR



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# *PAR Requirements*

## “Certification”

- Indicated by Physician's or Non-Physician Practitioner's (NNP) approval
- Requires dated signature on plan of care submitted by therapist

Requesting physician submits a prescription with the therapist's plan of care

- Submitted with PAR
- Must be written within 60 days of start date on PAR



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# *PAR Facts*

- Member may receive PT & OT services during same time period/service dates
- Duplicate therapy may not be performed on same dates of service (DOS)
- Members may not receive the same service for habilitative & rehabilitative therapy on the same DOS
  - e.g. member may not have habilitative (97110) & rehabilitative (97110) on the same DOS
- Separate PAR & necessary documentation required for each request



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# *PAR Facts (cont.)*

- PAR effective dates cannot exceed twelve (12) month span
- Approval depends on medical necessity, deemed by authorizing agent
- PAR requests must include legibly written & signed M.D./D.O. prescription
- Must include all of the following:
  - Diagnosis with ICD-9 code
  - Medical necessity for therapy
  - Number of therapy sessions needed per week



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# PAR Facts (cont.)

## Adults:

- PARs are required for any Rehabilitative PT/OT therapy beyond the 12 month unit maximum 24 units PT and 24 units OT.
- PARs are required for all Habilitative PT/OT therapy in advance of therapy, with a maximum of 24 units PT and 24 units OT.

## Children:

- Require a PAR only after 24 units PT and 24 units OT

## Habilitative speech therapy:

- requires PAR for both children and adults

## Within 365 day period, another evaluation can be requested if:

- Change in provider rendering services
- Change in diagnosis

# *PAR Facts (cont.)*

- If member's medical condition requires more treatments than listed & authorized on original PAR:
  - New PAR is required
  - PAR must:
    - Include all required information previously noted
    - must show continued need, ongoing deficits, & progress toward treatment goals
  - No retroactive PARs allowed
  - Any claims submitted after 24 units of PT and/or 24 units of OT without PAR will not be reimbursed
  - All Habilitative services require PAR prior to treatment



# PAR Errors

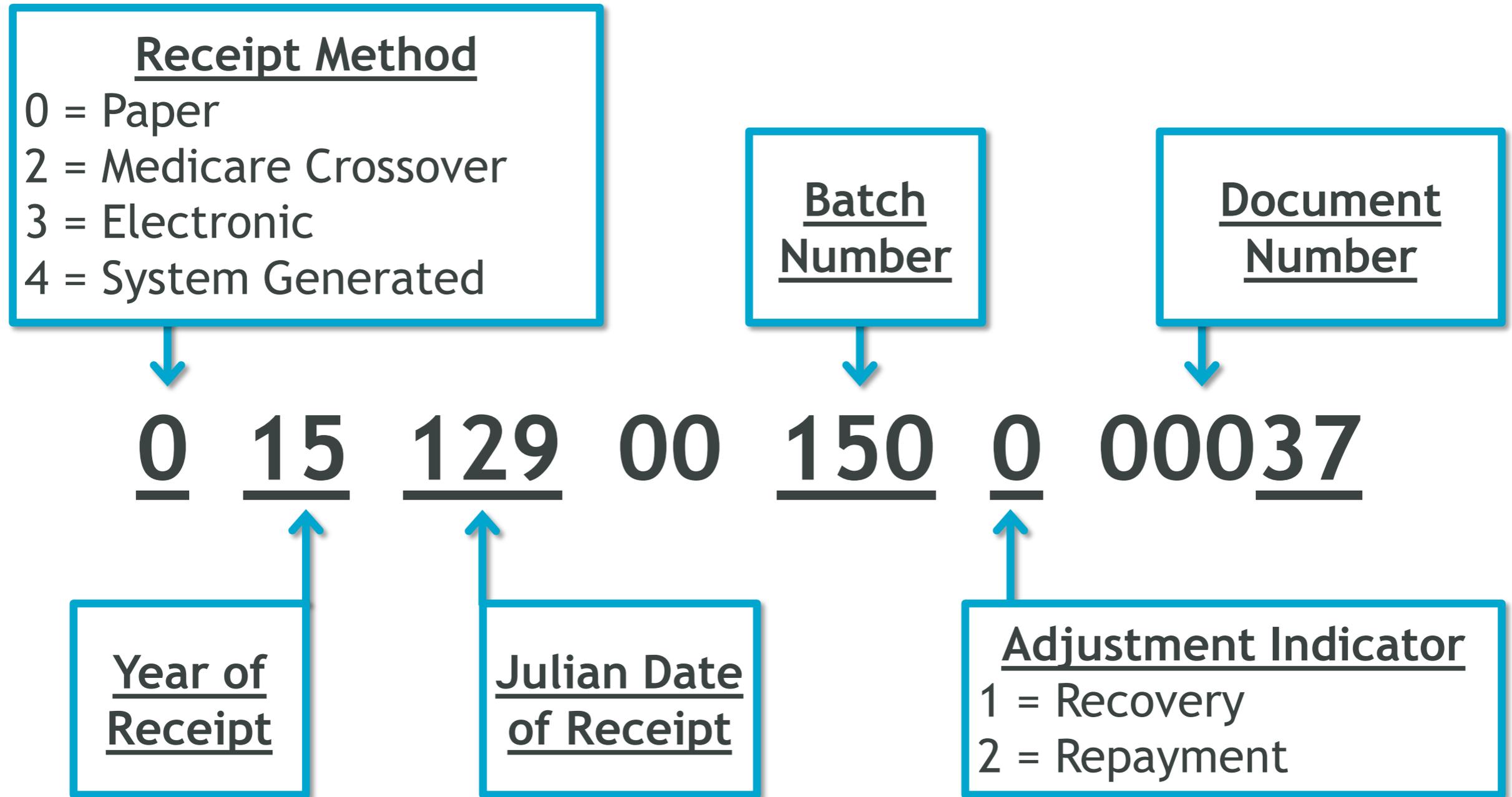
**If billing provider is not the rendering provider, make sure to:**

- List name/address of prescribing provider in Box 2
  - Corresponds with Medicaid number in box 28
- Enter billing provider name/address in field # 25
- Enter billing provider number in field # 29

Note: If any necessary information is missing or invalid, PAR may be returned to provider or denied for lack of information



# Transaction Control Number



# *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)



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# 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

120 days from Medicare  
payment date

Medicare denies claim

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



# *Physical and Occupational Therapy*

- Services must be provided by:
  - State of Colorado licensed physical or occupational therapist who is an approved Medical Assistance Program provider
- Occupational Therapy Assistants (OTAs) & Physical Therapy Assistants (PTAs) are eligible to provide services:
  - under supervision of an approved, licensed physical or occupational therapist
- Services provided in the Home Health benefit:
  - must conform to Home Health benefit rules



# *Physical and Occupational Therapy (PTAs/OTAs)*

- PTAs must:
  - be certified by DORA pursuant to Title 12 Article 41.204
  - work under supervision of a licensed physical therapist
    - as defined in Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) & accompanying rules as promulgated by State Board of Physical Therapy
- OTAs must:
  - practice under general supervision of a Colorado registered occupational therapist
  - Must be licensed



# Medical Necessity

## PT/OT/ST must be:

- in accordance with generally accepted standards of medical practice
- clinically appropriate in terms of type, frequency, & duration
- not primarily for the convenience of the child, parent or legal guardian, physician, or other health care provider
- cost effective

**Not covered benefits of fee-for-service PT/OT/ST for any member, regardless of age:**

- Education
- Personal need
- Comfort therapy
- Experimental
- Investigational

## Fee-for-service PT/OT/ST requires:

- A medical (physiological) reason to perform services



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# *Units of Service*

- PTs & OTs have a combined daily limit of 5 units, which is separate from ST daily limit of 5 units
  - Member may receive 5 units of PT/OT & 5 units of ST on same Date of Service (DOS) as long as they are not duplicative services
- Consult Current Procedural Terminology (CPT) Manual for definitions for each coded service
  - Some codes represent a treatment session without regard to its length of time (1 unit maximum)
  - Some codes may be billed incrementally as “timed” units



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# Procedure Modifiers

Providers must use the appropriate modifier:

Physical Therapist	PT procedure code	GP
Occupational Therapist	OT procedure code	GO
Rehabilitation Agency / PT Clinic	PT procedure code	GP
	OT procedure code	GO
Speech Therapist	ST procedure code	GN

## Note:

- May use additional modifiers as appropriate
- All Habilitative claims must have modifier HB in addition to the modifiers above
- Early Intervention providers: in addition to modifiers GO, GO, and GN, modifier TL must be attached to all claims for Early Intervention PT/OT/ST

# *Speech-language Therapy*

- Services must be provided by or under supervision of certified speech pathologist or audiologist
- Services must be medically necessary
- Habilitative ST services require PAR
- Rehabilitative ST services do not require PAR
  - With exception of members determined to need a speech generating device (E2500-2512, E2351, E2599)
    - should be referred to a Medicaid-participating medical supplier for a PAR



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# *Speech-language Therapy Providers*

- Qualified Speech-language Pathologist or Audiologists
  - Must meet qualifications prescribed by federal regulations for participation at 42 CFR 484.4
  - Must meet all requirements under state law
  - Must be an approved Medical Assistance Program provider
  - As of July 1, 2013, all Speech-language Pathologists must be Department of Regulatory Agencies (DORA) certified



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# *Speech Therapy Limitations*

- Non-benefit procedures for adults:
  - Diagnostic procedures provided by an audiologist for purpose of determining general hearing levels
  - Diagnostic procedures for distribution of hearing device
  - Services provided for simple articulation or academic difficulties that are not medical in origin are non-benefit services

# *Speech Therapy Limitations (cont.)*

- Maximum of 5 units service is allowed per date of service
- Services must be medically necessary
- Services must be prescribed/Approved by an M.D. or D.O.
- For more information on audiology services:
  - refer to the Audiology Billing Manual:
    - [www.Colorado.gov/hcpf/billing-manuals](http://www.Colorado.gov/hcpf/billing-manuals)



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# CMS 1500

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#)                    MEDICAID <input type="checkbox"/> (Medicaid#)                    TRICARE <input type="checkbox"/> (ID#/DoD#)                    CHAMPVA <input type="checkbox"/> (Member ID#)                    GROUP HEALTH PLAN <input type="checkbox"/> (ID#)                    FECA <input type="checkbox"/> (ID#)                    BLK LUNG <input type="checkbox"/> (ID#)                    OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE    SEX MM    DD    YY    M    F	
5. PATIENT'S ADDRESS (No., Street)  CITY    STATE		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
7. INSURED'S ADDRESS (No., Street)  CITY    STATE		8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous)    YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT?    YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT?    YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
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 _____ DATE _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM    DD    YY    QUAL _____		15. OTHER DATE MM    DD    YY    QUAL _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM    DD    YY TO MM    DD    YY 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?    \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate to service line below (24E). 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    B. PLACE OF SERVICE    C. EMG From MM    DD    YY To MM    DD    YY    SERVICE _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER    E. DIAGNOSIS POINTER    F. \$ CHARGES    G. DAYS OR UNITS    H. ICD-9-CM    I. ICD-10-CM    J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX ID. NUMBER    SSN    EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.    27. ACCEPT ASSIGNMENT? (For gov. plans, see back)    YES <input type="checkbox"/> NO <input type="checkbox"/>	
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 b. and are made a part thereof.)  SIGNED _____ DATE _____	
32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. NPI _____		33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. NPI _____	

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



# UB-04

- PT and OT outpatient hospital paper claims must be submitted on UB-04 claim form or as an 837I transaction
- UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs
- Where can a Colorado Medical Assistance provider get the UB-04?
  - Available through most office supply stores
  - Sometimes provided by payers



# UB-04 Certification



## Colorado Medical Assistance Program

### Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Revised March 2015

**UB-04 certification  
must be completed &  
attached to all claims  
submitted on the  
paper UB-04**

**Print a copy of the  
certification at:  
[Colorado.gov/hcpf/  
billing-manuals](http://Colorado.gov/hcpf/billing-manuals)**



# *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

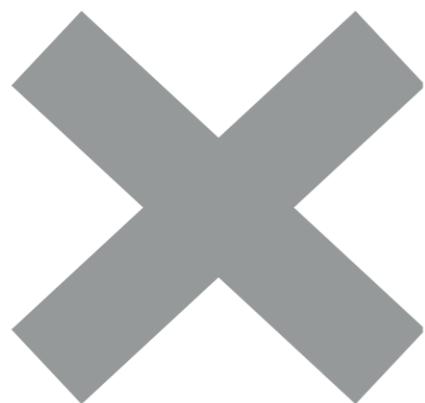
**Total Charges invalid**

Line item charges do not match the claim total

**Type of Bill**

Claim was submitted with an incorrect or invalid type of bill

# 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

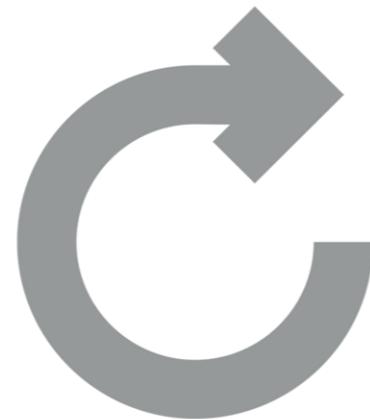
Claim processed & paid by claims processing system

# Claims Process - Common Terms



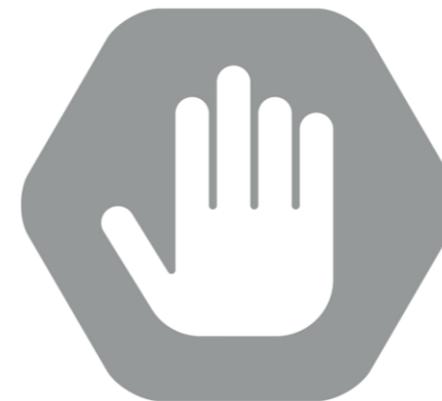
## Adjustment

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)

# 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

# *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



**COLORADO**

Department of Health Care  
Policy & Financing

# 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	04080000000000000001	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	30800000000000000003	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

## Recovery

\*\*\*\*\*  
\* ADJUSTMENTS PAID \*  
\*\*\*\*\*

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO 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 041008	114.24			
						NET IMPACT	21.42			

## Repayment

## Net Impact

## Voids

\*\*\*\*\*  
\* ADJUSTMENTS PAID \*  
\*\*\*\*\*

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO 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](mailto:helpdesk.HCG.central.us@cgi.com)

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training



*Thank you!*



**COLORADO**

Department of Health Care  
Policy & Financing