Beginning Billing Workshop Practitioner

Colorado Medicaid
2015

COLORADO
Department of Health Care Policy & Financing

Centers for Medicare & Medicaid Services

COLORADO
Department of Health Care Policy & Financing

Medicaid

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

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:

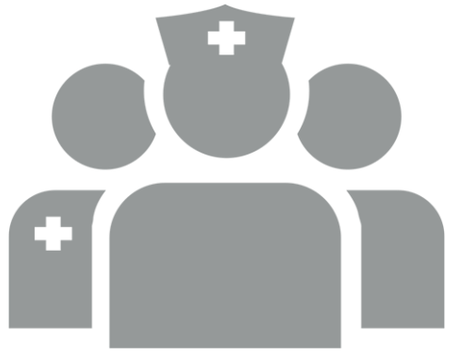
Everyone who provides services for Medical Assistance Program members

- 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

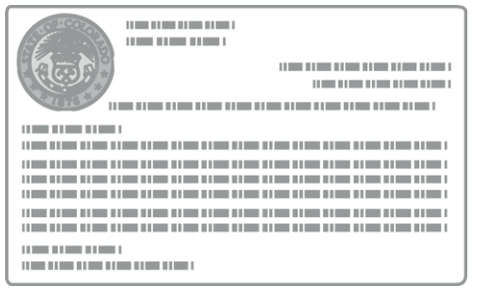
Verifying Eligibility

- 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



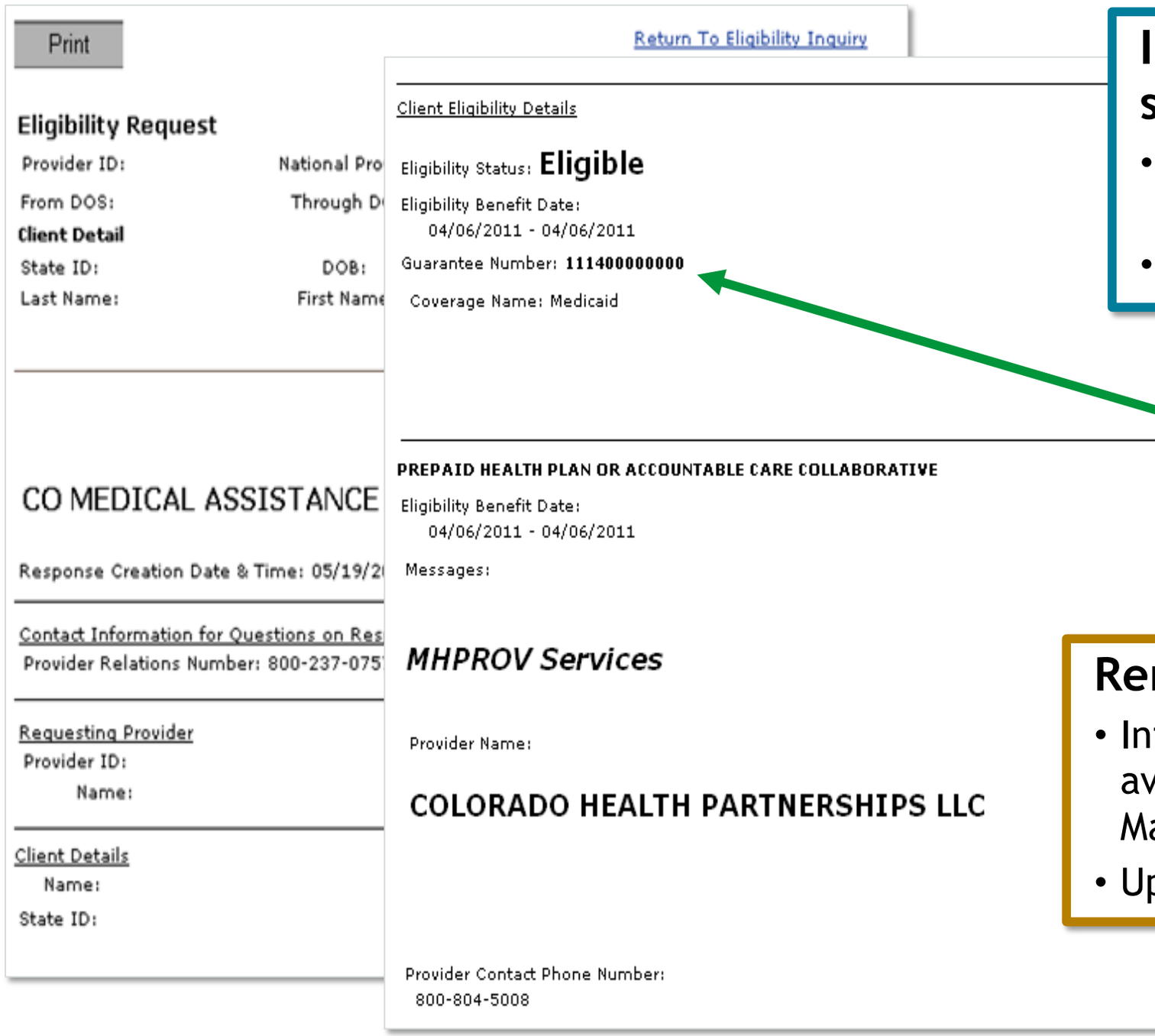
Medicaid ID Card with Switch Vendor

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)



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

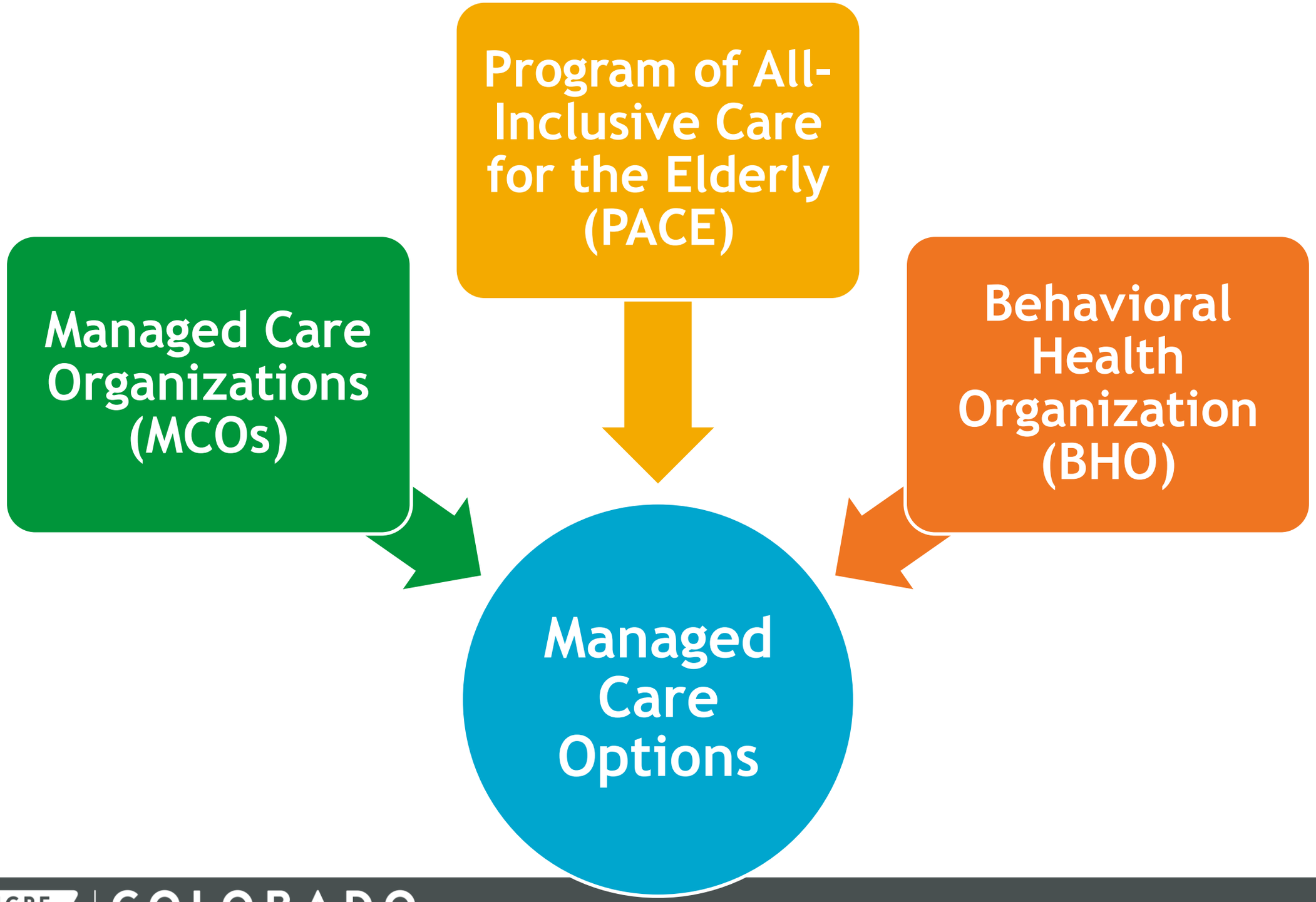
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and 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**

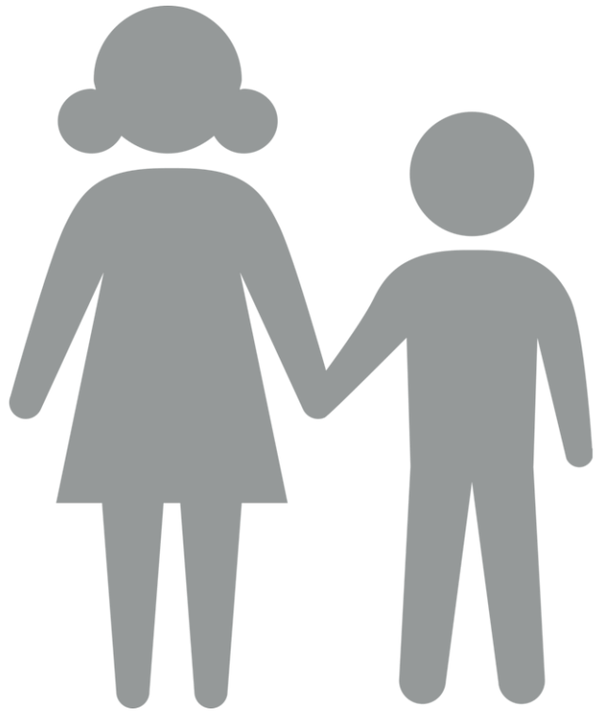
$400.00
- $300.00
= $100.00

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

Practitioner	**$2.00 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

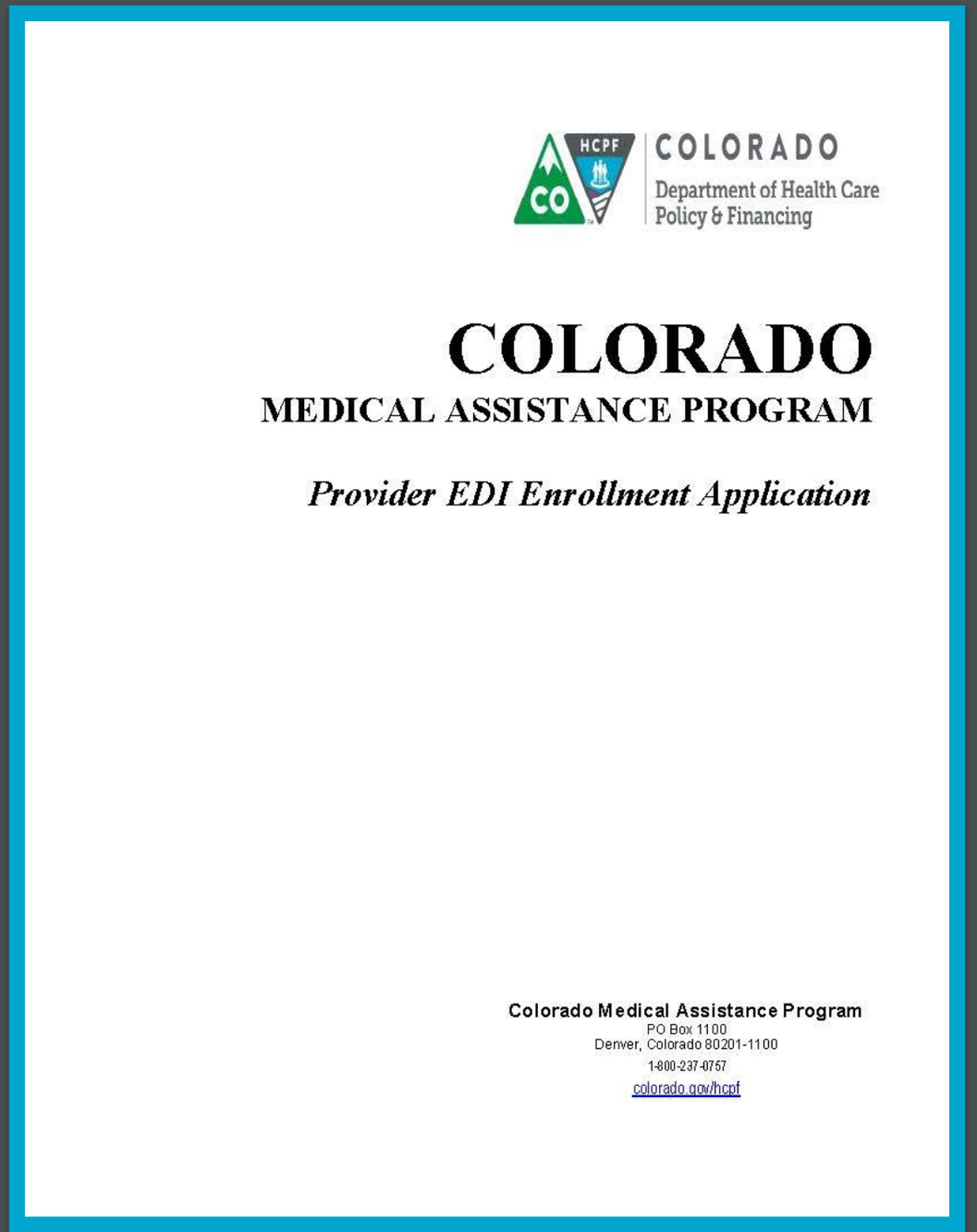
Submitting Claims

- 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

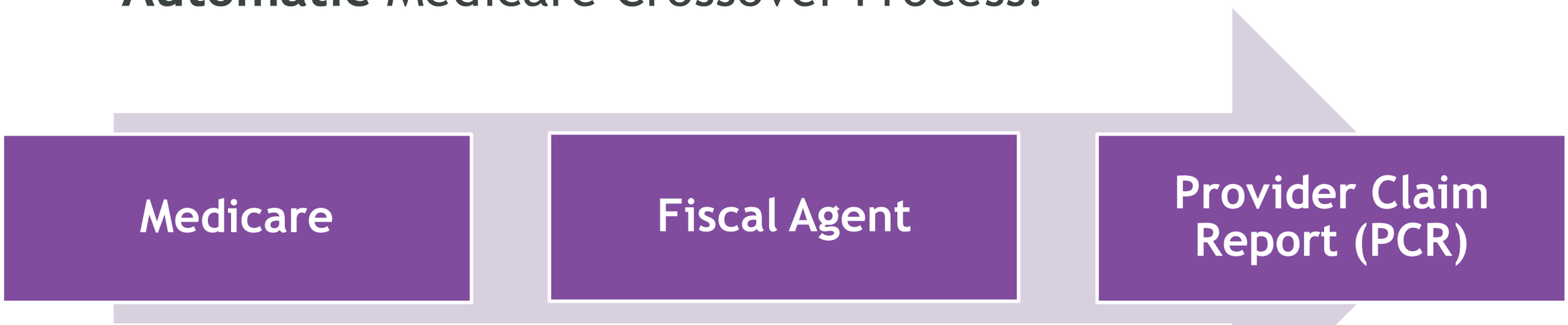
Providers must be enrolled with EDI to:

- 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

Mon.

- Payment information is transmitted to the State's financial system
- Accounting processes **E**lectronic **F**unds **T**ransfers (EFT) & checks

Tue.

Wed.

- Paper remittance statements & checks dropped in outgoing mail

Thur.

- EFT payments deposited to provider accounts

Fri.

- Weekly claim submission cutoff

Sat.

- Fiscal Agent processes submitted claims & creates PCR

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 Attn: Colorado Medicaid Program 5802 Benjamin Center Dr., Suite 105 Tampa, FL 33634	Phone: 1.888.801.9355 FAX: 1.855.440.3747 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

Who completes the CMS 1500?

HCBS/Waiver providers

Vision providers

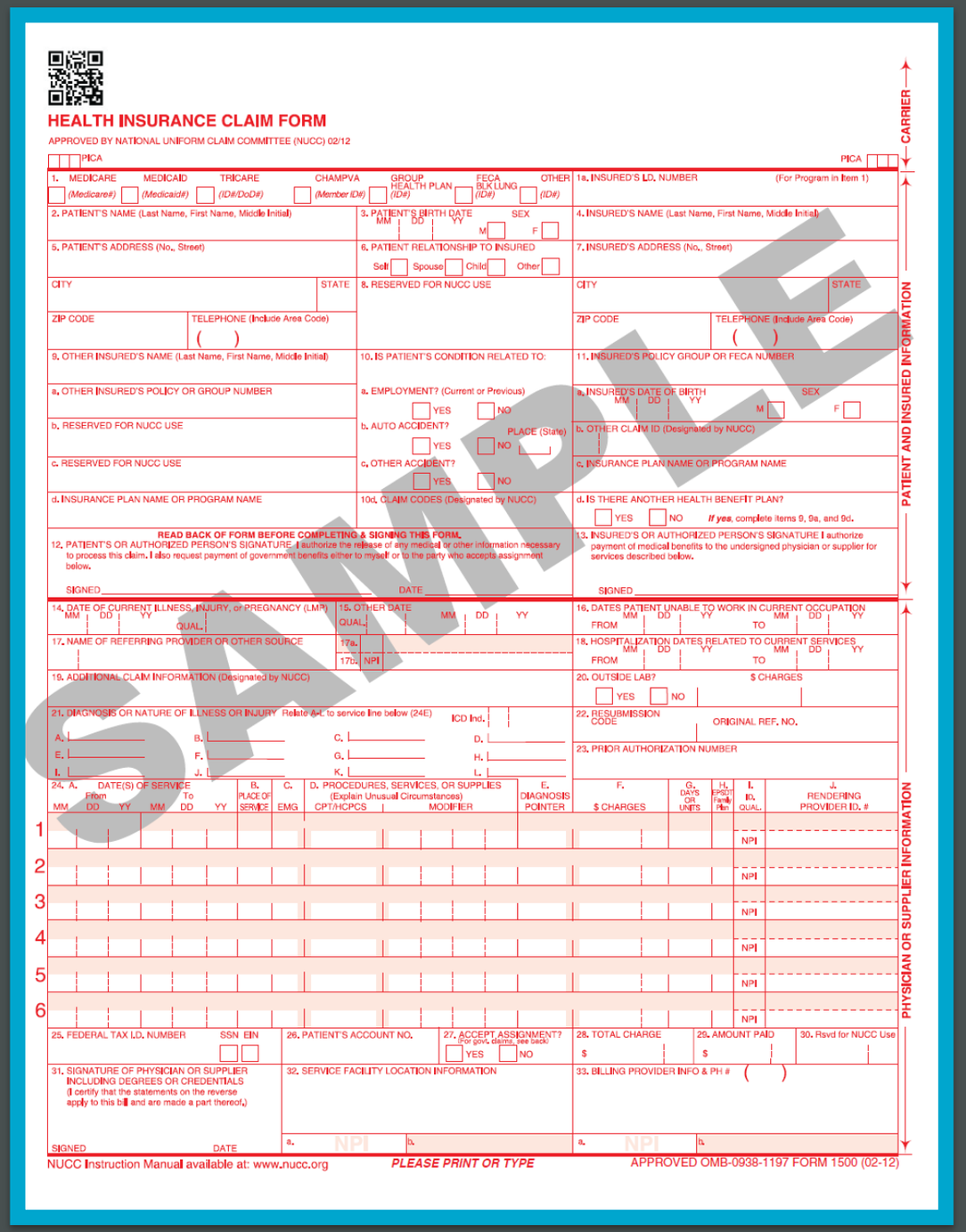
Physicians/Other Practitioners

Supply providers

Surgeons

Transportation providers

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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 gov. 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

EPSDT Program

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program
  - Federally mandated health care benefits package for essentially all Colorado Medical Assistance Program children
    - Ages birth through 20 years
  - Emphasizes preventive care
    - Focuses on early identification and treatment of medical, dental, vision, hearing, and developmental concerns

EPSDT Program (cont.)

- EPSDT establishes a regular pattern of healthcare through routine health screenings, diagnostic, treatment services
  - See the AAP Bright Futures periodicity for recommended well child visits
    - www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
  - EPSDT well child screenings must include testing for lead poisoning
    - at 12 and 24 months or between 36 and 72 months if not previously tested
    - This continues to be a CMS requirement for all Medicaid eligible children until Colorado can provide enough data to show it is not a concern in this region

EPSDT - D = Diagnostic

- When a screening indicates the need for further evaluation, diagnostic services must be provided
  - The referral should be made without delay
  - Provide follow-up to make sure that the child receives a complete diagnostic evaluation

EPSDT - T = Treatment

- Health care must be made available:
  - Treatment or other measures to correct/improve illnesses or conditions discovered by the screening
- All services must be provided:
  - If Medicaid coverable
  - If medically necessary
    - Even if the service is not available under the State plan to other Medicaid eligibles

EPSDT - Medical Necessity

- No arbitrary limitations on services allowed
  - e.g., one pair of eyeglasses or 10 PT visits per year
- Additional services above what is covered in State plan must be allowed for any child or youth 20 and under:
  - when medically necessary
    - Must be Medicaid coverable as listed in 1905(a)(c) of the Social Security Act
- State may determine which treatment it will cover:
  - among equally effective & actually available alternative treatments
  - as long as the determination is specific to the individual child

EPSDT - Medical Necessity (cont.)

- EPSDT does NOT include:
  - Experimental/Investigational Treatments
  - Services or items not generally accepted as effective
  - Services primarily for caregiver or provider convenience
  - Services or items in which an equally effective but less expensive option is available

EPDST – How to Request Services or Items – PAR Process

- Use the standard PAR process outlined earlier in this presentation
- You can and should request services or items where the code list shows it is not a benefit of Colorado Medicaid
  - i.e. circumcisions, personal care

Letter of Medical Necessity

- Must include a letter of medical necessity (LMN) with request
  - Letters should include appropriate CPT and HCPC codes, units or other details related to the request
  - Detailed information as to how the service or procedure will improve or maintain the child/youth health, prevent it from worsening or prevent the development of additional health problems
  - Include duration and treatment goals for the request as well as any previous treatments and responses
  - Is the service or item safe?
  - How do you believe the item to be effective?
    - Send relevant internet documents, manufacturer information, etc. with your request

EPSDT PAR Requests

- Providers can submit a PAR for non-covered services or items to be reviewed under EPSDT guidelines to the appropriate third party vendor that authorizes that category of service
- All requests for services or items will be reviewed by the appropriate third party vendor for medical necessity and a response will be returned to the requesting provider
  - May be a response that is pended for additional information
  - May be approved
  - May be denied and will include a reason for denial
  - May be partially approved and will include what specific items were denied and why
- For more information on procedures, please visit the ColoradoPAR website at ColoradoPAR.com

ABCD Program

- Assuring Better Child Health and Development through the Use of Improved Screening Tools Project
  - ABCD helps Primary Care Providers improve identification of developmental delays through standardized testing
    - Assists in implementing efficient & practical office screenings
    - Helps practices learn about reimbursement for development screenings
    - Promotes early identification and referral
    - Facilitates links to other community services
    - More information at www.coloradoabcd.org

Colorado Medicaid

Examples of Services

- Surgery
- Vaccines / Immunizations
- Laboratory
- Radiology
- SBIRT
- Obstetrics
- PCP/ Well Child Visits
- Early Intervention

Surgery

- Surgical reimbursement includes
  - Payment for the operation
  - Local infiltration
  - Digital block or topical anesthesia
  - Normal, uncomplicated follow-up care
- If surgery has 30 post operation days and you bill an office visit within those 30 days, it will deny
  - Office visit is included in your surgical reimbursement

Modifiers on Multiple Procedures

- Modifier 59 – Distinct Procedural Service
  - Used to identify procedures/services:
    - that are not normally reported together
    - but are appropriate under the circumstances
  - Modifier 59 should be used only if:
    - a more descriptive modifier is un-available
    - the use of modifier 59 best explains the circumstances
      - Clinical documentation MUST justify usage
  - Please see the Department's Provider Bulletin regarding Modifier 59 for more information

Vaccines / Immunizations

Immunizations for children:

- A benefit when recommended by Advisory Committee on Immunization Practices (ACIP)
  - for members aged 18 and under
  - only admin fee reimbursed
- Available from federal Vaccines for Children Program (VFC)
- For ages 18 through 20, reimbursed as adults

Immunizations for adults:

- A benefit when recommended by ACIP (subject to Colorado Medical Assistance Program rules)
  - or when needed to enter school/work force for adults 21+
  - covers the admin fee and vaccine

- For more information: Colorado.gov/hcpf/billing-manuals

Billing Procedures for Immunizations

- To be reimbursed for an immunization claim:
- Bill BOTH administration code & vaccine product

Administration Code

Bill administration codes as one line item

Vaccine Products

Bill vaccine product as separate line item

- Vaccines are reimbursed at set rate
- Vaccines obtained through Vaccines for Children (VFC) are reimbursed at $0
  - as they are available at no cost to provider

Telemedicine

Who Can Provide Services?

- Federally Qualified Health Center
- Clinic
- Physician
- Osteopath
- Licensed Clinical Social Worker
- Physician Assistant
- Psychologist
- Rural Health Clinic
- Nurse Practitioner
- Licensed Professional Counselor

Telemedicine Billing

- Bill all Telemedicine services electronically as a 837P or on the CMS 1500 claim form
- Providers may only bill procedure codes for which they are eligible to bill
- PAR requirements remain the same
- Bill Managed Care or BHO when appropriate
- For further information
  - Telemedicine Billing Manual
  - Volume 8, section 8.200.3.B

Laboratory

- Provider who actually performs the laboratory test is the only one eligible to bill & receive payment
- Providers may only bill for tests actually performed in their office or clinic
- Testing performed by independent laboratories or hospital outpatient laboratories must be billed by the laboratory
  - For more information, please consult Rule 8.660
- In order to receive Medical Assistance Program payment, All laboratory service providers must be:
  - Clinical Laboratory Improvement Act (CLIA) certified
  - Medical Assistance Program enrolled

Radiology

Professional Component

The analysis and reading of the x-ray

- Use 26 modifier to show Professional Component

Technical Component

The actual taking of the x-ray

- This is the facility usage for the x-ray
- Use TC modifier to show Technical Component

- Only use these modifiers when:
- Different providers perform professional and technical components of procedure

Radiology

Billing bilateral services

For bilateral code

- Use 1 unit with correct procedure code

For non bilateral codes

- 1st line – Use just HCPCS code with 1 unit
- 2nd line – Use 1 unit, HCPCS code, and modifier 50

Radiology

- PAR Requirements
  - Outpatient settings need to obtain a prior authorization for:
    - Non-emergent CT
    - Non-emergent MRI
    - All PET and SPECT scans
      - If the emergency indicator box is checked on the claims, CT and MRI tests are exempt from prior authorization
    - PAR Revisions due to the test changing just prior to the time of the service need to be submitted within 48 hours
    - For a list of all the procedure codes requiring PARs, visit the Radiology Manual:
      - Colorado.gov/hcpf/billing-manuals

SBIRT

- Screening, Brief Intervention and Referral to Treatment
  - Technique used to identify and treat drug/alcohol abuse for members ages 12 +
  - All primary care providers can render services and bill for SBIRT
  - Requires special certification and training.
  - Training can be done through online or in-person services.
  - See Billing Manual for more information
    - Colorado.gov/hcpf/billing-manuals

Obstetrical Care

- Pregnant women under age 21 are also eligible for EPSDT services, including dental, vision care, and health checkups
- Woman in maternity cycle are exempt from co-payment
  - Provider must mark co-payment indicator on the electronic format or on the paper claim form
- Undocumented women are eligible for emergency services only
  - Labor and delivery are considered emergency services

Obstetrics
Procedure Coding

Global Care

- Providers should bill medical care provided during pregnancy, labor and delivery, and postpartum period using the global OB codes
- Use delivery date as date of service

Non-Global Care

- Unusual Services
- Services/Conditions unrelated to pregnancy or delivery
- Complications of pregnancy
- Certain adjunctive services

Obstetrics
Separate Procedures

These services should be billed **in addition** to global obstetrical care charges:

- Prenatal testing
- Testing, including ultrasound
- Clinical laboratory testing
- Adjunctive services
- Initial antepartum visit
- Conditions requiring additional treatment
- Case management
- Medical or surgical complications

Obstetrics
Separate Procedures (cont.)

These services should be billed **in addition** to global obstetrical care charges:

Anesthesia	Epidural anesthesia	Assistant surgeon at cesarean delivery	Family planning
Surgical sterilization	Newborn care in the hospital	Examination & evaluation of healthy newborn	Newborn resuscitation or care of high-risk newborn

Conditions unrelated to pregnancy

Obstetrics
Common Billing Issues

- Most common denial for OB care
  - Edit 1026 – OB Service Billed Incorrectly
- When does this edit deny claims?
  - Billing for antepartum + global care
  - Billing for postpartum care + global care
- There are many codes for billing OB services
  - Choose appropriate procedure code and modifier for your service
- Remember: you cannot bill for both global care and antepartum and/or postpartum care

Modifiers: Multiple Infants

- Use appropriate Vaginal or Cesarean delivery procedure code and bill one (1) unit of service for first baby without any modifier
- Modifier 22- use with additional infants
  - Each additional infant must be billed on separate lines using modifier 22 for codes 59409, 59514, 59612 or 59620
  - Indicate one (1) unit for each additional infant in unit field on claim
- Use appropriate ICD-9-CM diagnosis code to indicate multiple infants
  - Date of service must be delivery date

Modifiers: Multiple Infants

Use Modifier UK when:

Both mother and newborn must be in the hospital to bill this charge

Don't use Modifier UK when:

Mother has been discharged or infant is transferred to a different hospital

- Charges must be submitted under newborn's State ID
- You can no longer use the mother's State ID and modifier UK

Obtaining an Infant's Medicaid ID

- In order for county to enroll newborn, notify county Department of Human/Social Services of all the following:
  - infant's full legal name
  - birth date
  - gender
  - mother's State ID
- Anyone can report the birth of a newborn
  - This can be done online at the Department's Add-a-Baby web page
- Local Healthy Communities Outreach Coordinators can also assist with this process

Ultrasound Restrictions

Limited to two (2) per low-risk or uncomplicated pregnancy

Billed as separate CPT codes

Sterilizations

- Claims must be filed on paper
- All providers associated with a sterilization procedure most include the MED-178 Sterilization Consent Form (MED-178)
- Member must
  - Be at least 21 years of age
  - Be mentally competent
  - Give informed consent
- At least 30 days, but not more than 180 days, must pass between date MED-178 was signed by member and the date of the sterilization procedure (except in specific circumstances of preterm delivery or emergency abdominal surgery)

Sterilization Form

COLORADO MEDICAID STERILIZATION CONSENT FORM (MED-178)

Client's Medicaid ID: _____

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (1. Health Care Provider or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation know as a _____ (2. Type of Procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (3. Date of Birth).

I, _____ (4. Name of Client), hereby consent of my own free will to be sterilized by _____ (5. Health Care Provider or Clinic) by a method called _____ (6. Type of Procedure). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to representatives of the U.S. Department of Health and Human Services, or employees of programs or projects funded by the Department but only for determining if federal laws were observed.

I have received a copy of this form.

_____ (7. Client's Signature) _____ (8. Date of Signature)

You are requested to supply the following information, but it is not required: *(9. Ethnicity and Race)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have read to the client this consent form in _____ (10. Language) language and explained its contents to the client. To the best of my knowledge and belief, the client has understood this explanation.

_____ (11. Interpreter's Signature) _____ (12. Date of Signature)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (13. Name of Client) signed the consent form, I explained to client the nature of the sterilization operation _____ (14. Type of Procedure), the fact that it is intended to be a final and irreversible procedure, and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual that client consent can be withdrawn at any time and that the client will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. Client knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (15. Signature of Person Obtaining Consent) _____ (16. Date of Signature)

_____ (17. Name of Facility Where Information About Sterilization Was Given to Client)

_____ (Address of Facility (including city, state, and zip code))

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (18. Name of Client) on _____ (19. Date of Procedure), I explained to the individual the nature of the sterilization operation known as _____ (20. Type of Procedure), the fact that it is intended to be a final and irreversible procedure, and the discomforts, risks, and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that client consent can be withdrawn at any time and that the client will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old ad appears mentally competent. Client knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph that is not used.**)

21.(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization procedure was performed.

21.(2) The sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ a. Premature delivery. Expected date of delivery: _____
- ☐ b. Emergency abdominal surgery (describe circumstances): _____

_____ (22. Signature of Person Who Performed Procedure) _____ (23. Date of Signature)

Revised: 09/13

COLORADO
Department of Health Care Policy & Financing

Common Sterilization Errors

- Common Errors
  - Using an old version of the Med-178 (2004) form
  - Missing member's signature
  - Type of operation entered in Consent differs from that in Physician's Statement
  - Incomplete facility address
    - Must include zip code
  - Operation performed less than 30 days or more than 180 days from signature date

Early Intervention

- Early Intervention services are those provided to a young child who have or are at risk for developmental disabilities or special needs
  - Children are eligible birth through age two (2)
- All codes billed by a provider/practitioner for children who are receiving services as a part of an approved Individual Family Service Plan (IFSP) should be billed using the TL modifier
  - Sick Care
  - Nurse visit
  - Therapies
  - Assistive Technology
  - Audiology services
  - Nutrition services

Universal Procedure & Diagnosis Coding

- HIPAA requires providers to use universal Current Procedural Terminology (CPT) coding guidelines
  - Medicaid payment policies are based on CPT descriptions
  - Providers are required to consult CPT manual definitions for each code they submit for reimbursement
- Providers must also use International Classification of Diseases, 10th Revision, Clinical Modification diagnosis codes (ICD-10)

CPT Coding Guidelines

- Some codes represent a treatment session, regardless of length of time, so each code is correctly billed as one session or one (1) billable unit
  - Do not bill non-timed codes with greater than one (1) unit
  - Bill non-timed codes such as 92507, and 92508 (otorhinolaryngology services) with one (1) unit per date of service
- Other codes may be billed as number of "timed" units
  - For example, 92607 and 92608 (evaluation and therapeutic services)
- Note: Do not bill 92607 without 92608 if the time is beyond one (1) hour

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

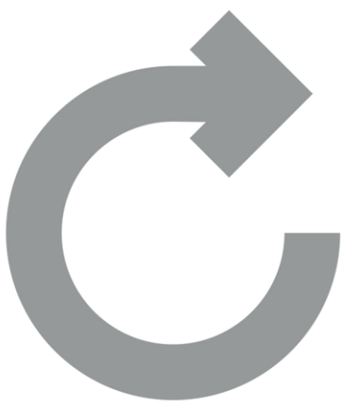
Claim processed & paid by claims processing system

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

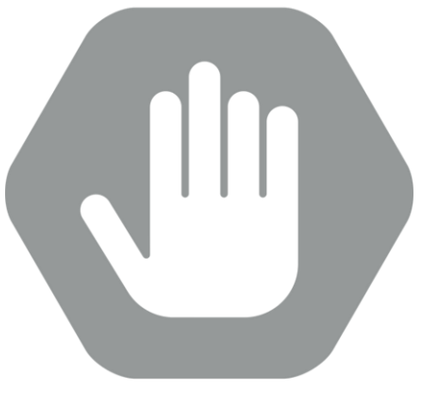
Adjustment

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	DATES OF SVC 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	DATES OF SERVICE 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

Recovery

Repayment

Net Impact

****

* 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	041008		114.24				
						NET IMPACT	21.42				

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
- 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!