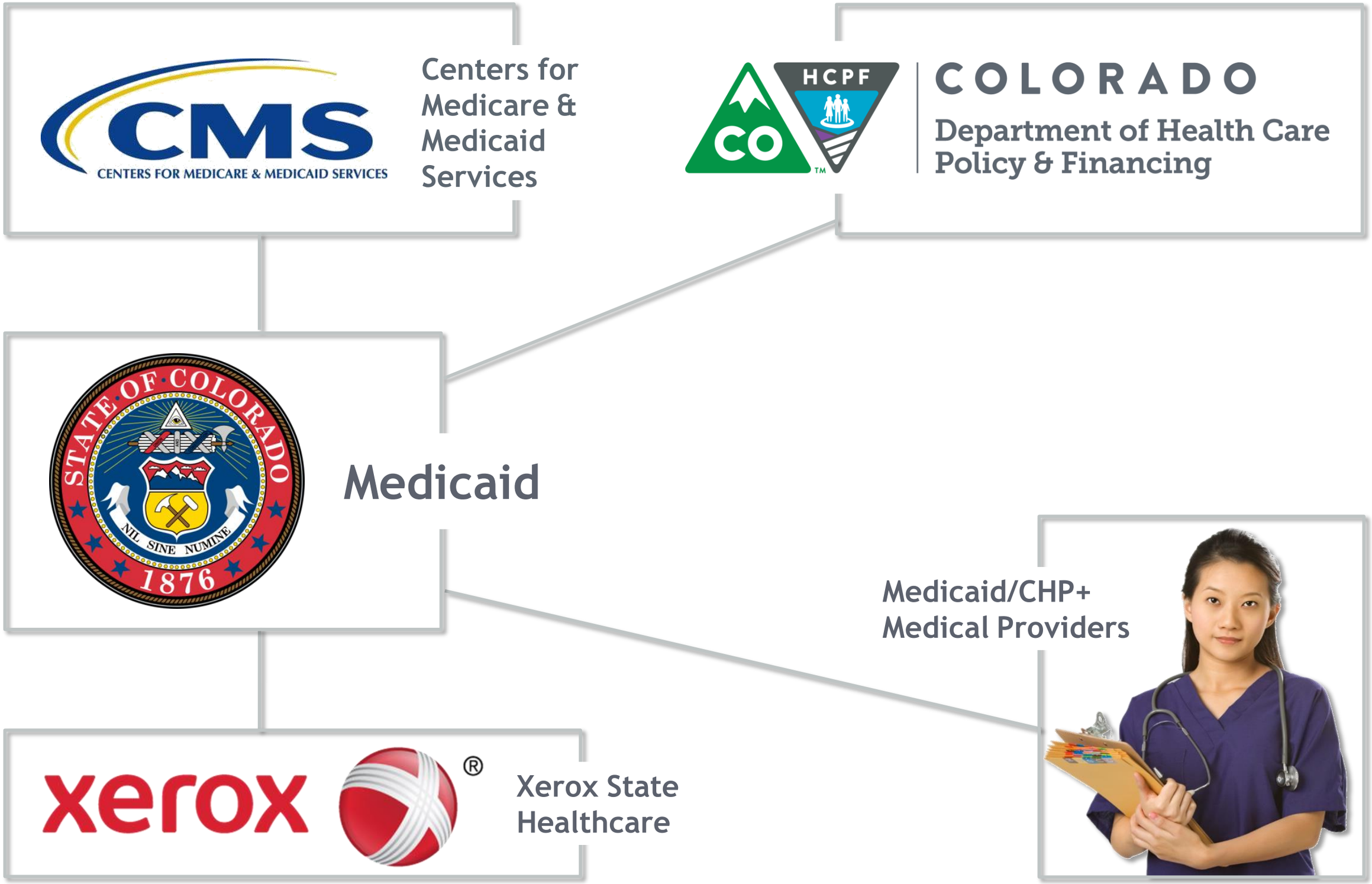
Beginning Billing Workshop Waiver

Colorado Medicaid
2015

COLORADO
Department of Health Care
Policy & Financing


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

Training Objectives

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

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes
- **Waiver Provider currently <u>do not</u> require a NPI**

What is an NPI? (cont.)

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

Department Website

1

www.colorado.gov/hcpf

https://www.colorado.gov/hcpf

Colorado The Official Web Portal

Translate

HCPF

COLORADO

Department of Health Care Policy & Financing

Home | For Our Members | For Our Providers

2

For Our Providers

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

Explore Benefits

Apply Now

Find Doctors

Get Help

Feeling Sick?

For medical advice, call the Nurse Line:

800-283-3221

Get Covered. Stay Healthy.

colorado.gov/health

Provider Home Page

Find what you need here

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

Provider Enrollment

Question:

What does **Provider** Enrollment do?

Answer:

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

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

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

Billing Provider Number

Billing Provider

Entity being reimbursed for service

From the Noun Project:
"Hospital" icon created by Carlotta Zampini

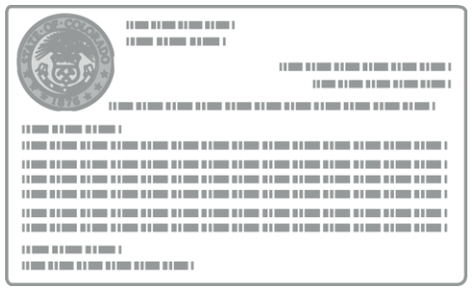
Verifying Eligibility

- 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.

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

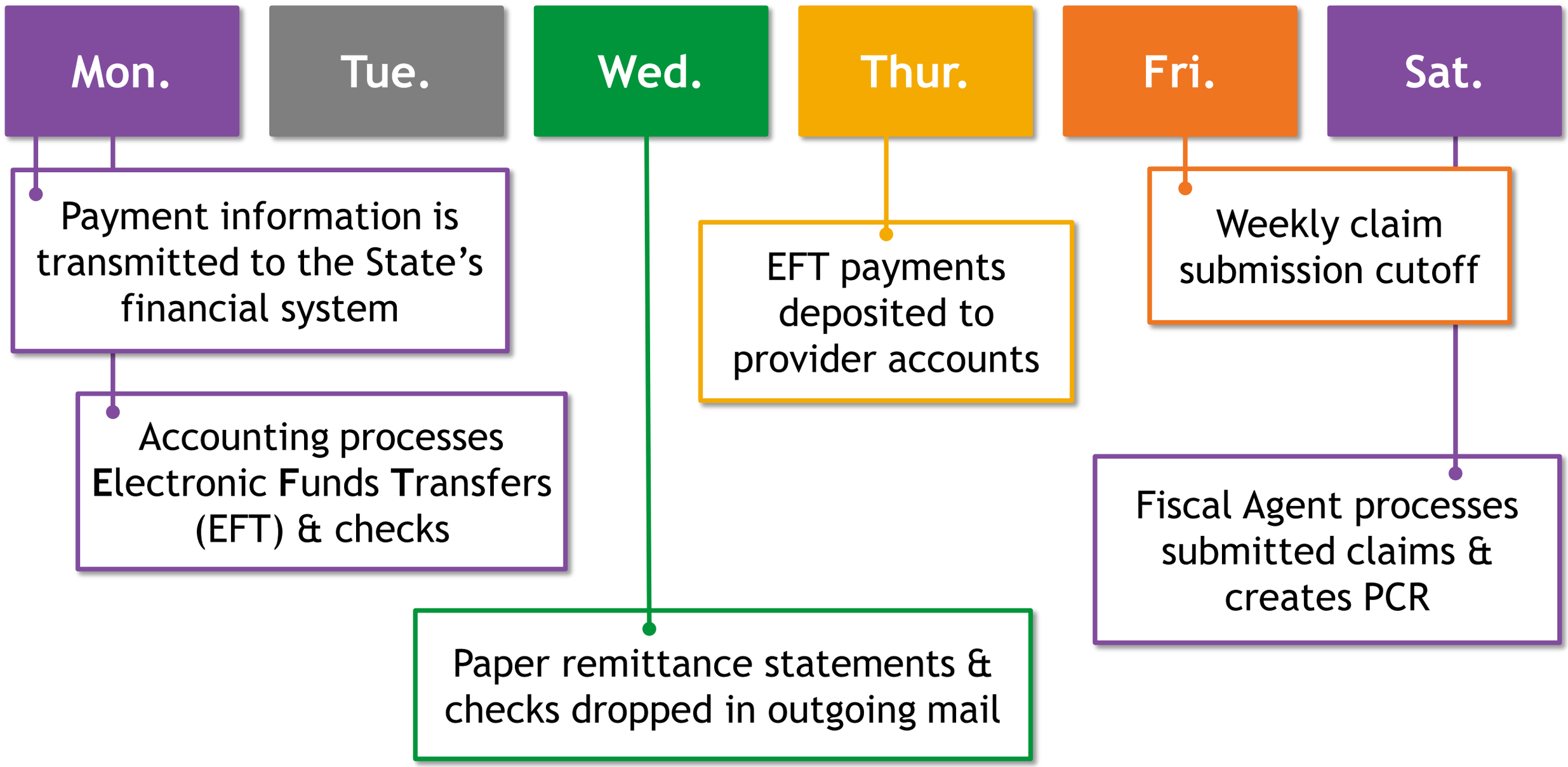
Submitting Claims

- 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**

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

Waiver PARs

Community Centered Board Adult & Children DHS Waivers

- Supported Living Services (SLS)
- Developmentally Disabled (CCT-DD/SLS)
- Children's Extensive Support (CES)

Local County Department of Human Services DHS Waiver

- Children's Habilitation Residential Program (CHRP)

Waiver PARs (cont.)

Case Management Agency Adult & Children LTSS Waivers

- Elderly Blind and Disabled (EBD)
- Community Mental Health Services (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Children's Home Community Based Services (CHCBS)
- Children With Autism (CWA)
- Children with Life Limiting Illness (CLLI)

Waiver Prior Authorization Form

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO Department of Health Care Policy & Financing

QUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINME EBD-U1

HCBS - Persons who are Elderly, Blind, and Disabled (EBD) Waiver

PA Number being revised:

Revision? Yes No

1. CLIENT NAME		2. CLIENT ID	3. SEX	4. BIRTHDATE
			M F	
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

9. Description		10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (U1)							
S5105 Adult Day Services, Specialized (U1)			TF				
T2031 Alternative Care Facility (ACF) (U1)				1	$50.95	$50.95	
T2038 Community Transition Services, Coordinator (U1)							
A9900 Community Transition Services, Items Purchased (U1)							
T2025 Consumer Directed Assistance Support Services (CDASS) (Cent/ Unit) (U1)							
T2040 CDASS Per Member/ Per Month (PM/PM) (U1)	Fiscal Employer Agent (FEA) (U1)						
S5165 Home Modifications (U1)							
S5130 Homemaker (U1)							
H0038 IHSS Health Maintenance Activities (U1)							
S5130 IHSS Homemaker (U1)			KX				
T1019 IHSS Personal Care (U1)			KX				
T1019 IHSS Relative Personal Care (U1)			HR, KX				
T2029 Medication Reminder, Install/Purchase (U1)							
S5185 Medication Reminder, Monitoring (U1)							
A0100 NMT, Taxi (U1)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (U1)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)		HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (U1)						
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)		HB				
T1019 Personal Care (U1)							
T1019 Personal Care, Relative (U1)			HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (U1)							
S5161 PERs, Monitoring (U1)							
S5151 Respite Care, ACF (U1)							
S5150 Respite Care, In Home (U1)							
H0045 Respite Care, NF (U1)							
A							

Find Adult HCBS Prior Approval and Cost Containment workbook for Waiver programs on the Department's website

Colorado.gov/hcpf/provider-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

Waiver

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)

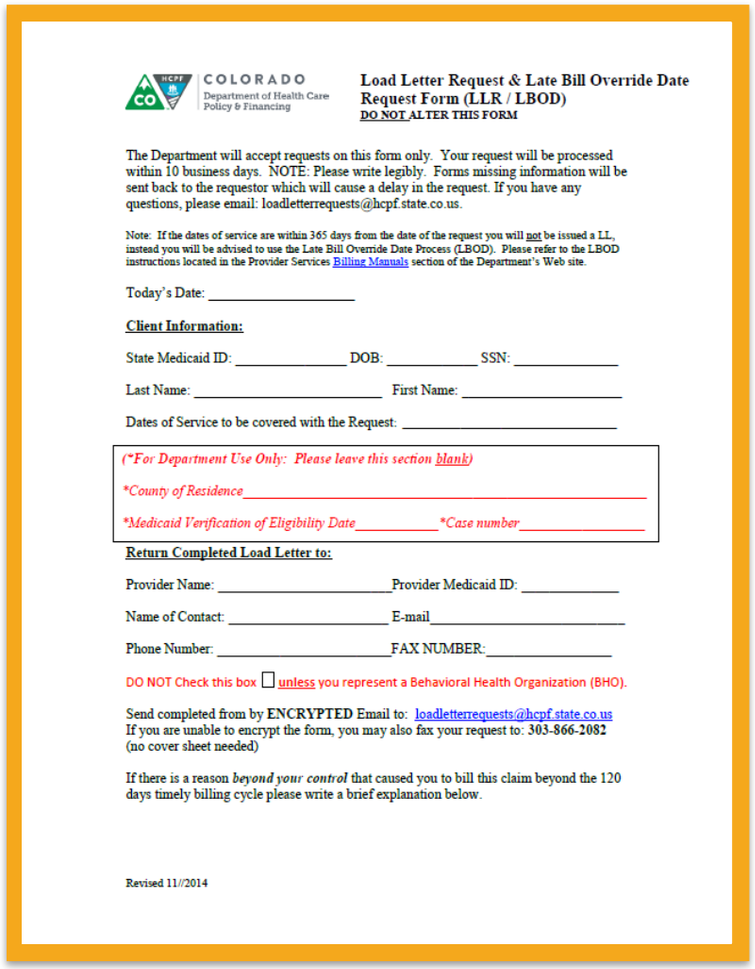
Timely Filing Extensions

- Extensions may be allowed when:
  - Backdated eligibility
    - Load letter from Department

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



COLORADO
Department of Health Care Policy & Financing

Load Letter Request & Late Bill Override Date Request Form (LLR / LBOD)
DO NOT ALTER THIS FORM

The Department will accept requests on this form only. Your request will be processed within 10 business days. NOTE: Please write legibly. Forms missing information will be sent back to the requestor which will cause a delay in the request. If you have any questions, please email: loadletterrequests@hcpf.state.co.us.

Note: If the dates of service are within 365 days from the date of the request you will not be issued a LL, instead you will be advised to use the Late Bill Override Date Process (LBOD). Please refer to the LBOD instructions located in the Provider Services Billing Manuals section of the Department's Web site.

Today's Date: _____

Client Information:

State Medicaid ID: _____ DOB: _____ SSN: _____

Last Name: _____ First Name: _____

Dates of Service to be covered with the Request: _____

*(*For Department Use Only: Please leave this section blank)*

**County of Residence*_____

**Medicaid Verification of Eligibility Date*_____ **Case number*_____

Return Completed Load Letter to:

Provider Name: _____ Provider Medicaid ID: _____

Name of Contact: _____ E-mail_____

Phone Number: _____ FAX NUMBER:_____

DO NOT Check this box ☐ unless you represent a Behavioral Health Organization (BHO).

Send completed from by **ENCRYPTED** Email to: loadletterrequests@hcpf.state.co.us
If you are unable to encrypt the form, you may also fax your request to: **303-866-2082** (no cover sheet needed)

If there is a reason *beyond your control* that caused you to bill this claim beyond the 120 days timely billing cycle please write a brief explanation below.

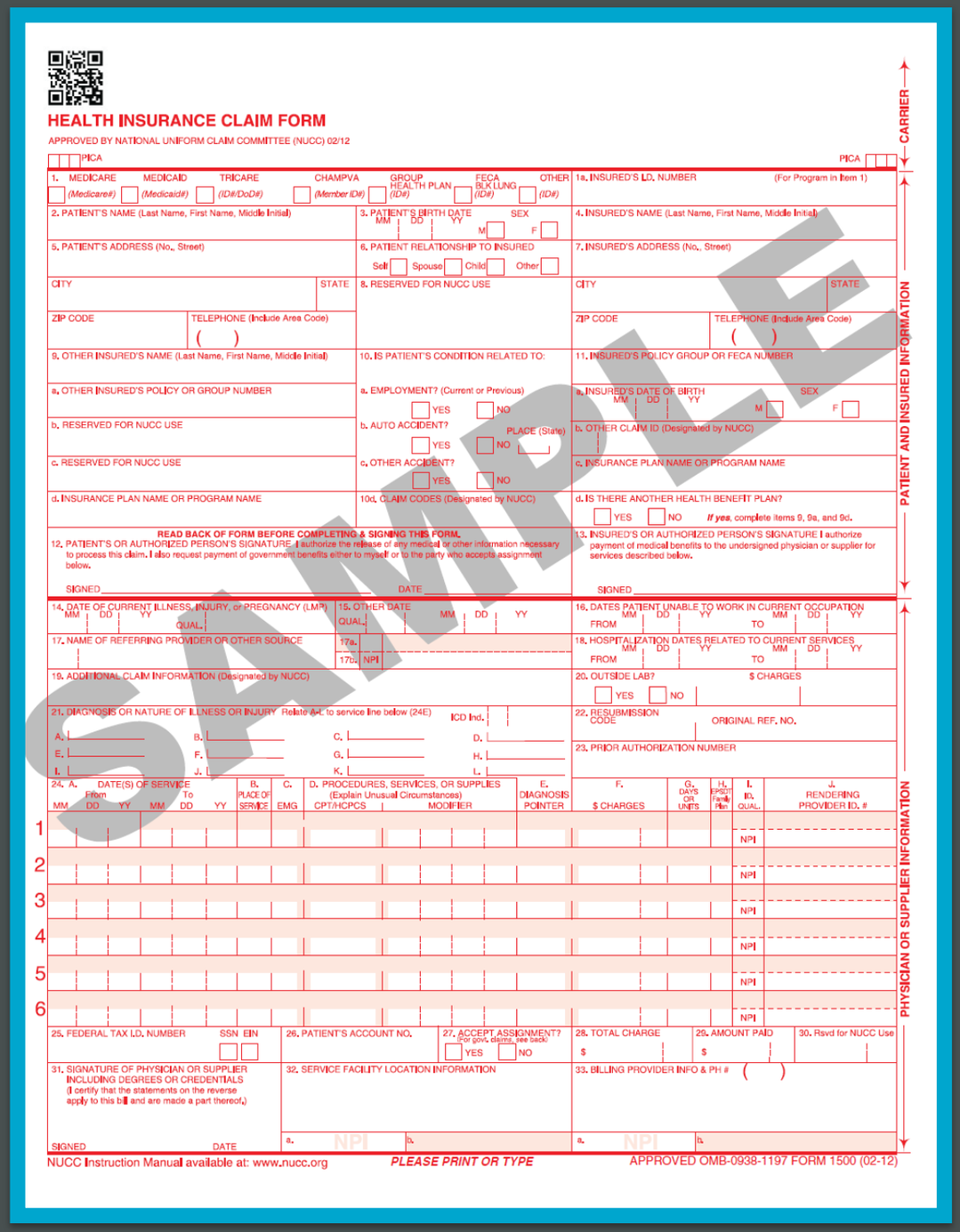
Revised 11//2014

CMS -1500

Who completes the CMS -1500?

HCBS/Waiver 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? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Long-term Services and Supports Adult Waiver Programs

- Community Mental Health Support (CMHS)
- Elderly, Blind and Disabled (EBD)
- Spinal Cord Injury (SCI)
- Colorado Choice Transitions (CCT)
- Brain Injury (BI)

Adult Long-term Services and Supports Waiver Programs

Program	Modifier	Program Code
BI	U6	89
EBD	U1	82
CMHS	UA	94
CCT	UC	95
SCI	U1,SC	M5

HCBS-BI Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility or hospital care for persons with a diagnosis of a brain injury
- Members Served
  - Age 16 +
  - Brain injury must have occurred prior to age 65
  - Persons with a brain injury as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes
- Level of Care Requirements
  - Nursing Facility and Hospital Level of Care

HCBS-EBD Requirement

- Primary Purpose of Program
  - The EBD program provides home or community based alternative to nursing facility care for elderly, blind, and disabled persons
- Members Served
  - Age 18 +
  - Persons living with HIV/AIDS
  - Elderly persons with a functional impairment (aged 65+)
  - Blind or physically disabled persons (aged 18-64)
- Level of Care Requirements
  - Nursing Facility Level of Care

HCBS-CMHS Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility care for persons with a major mental illness
- Members Served
  - Age 18 +
  - Persons with a diagnosis of major mental illness as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes
- Level of Care Requirements
  - Nursing Facility Level of Care

HCBS-CCT Requirement

- Primary Purpose of Program
  - To provide home or community based services and supports to individuals transitioning out of long term care facilities
- Members Served
  - Age 18 +
  - Persons eligible for the EBD, CHMS, BI, SLS or DD waivers
  - For more information, visit www.Colorado.gov/hcpf/coloradochoicetransitions
- Level of Care Requirements
  - Nursing Facility Level of Care
- Individuals must be willing to live in qualified housing:
  - A home owned or leased by the individual or family member
  - An apartment with a lease and lockable access and egress which includes living, sleeping, bathing and cooking areas over which the individual or a family member has domain and control
  - A community-based residential setting in which no more than 4 unrelated individuals, not including caretakers, reside

HCBS-SCI Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility level of care for persons with a spinal cord injury
- Members Served
  - Age 18+
  - Persons with a spinal cord injury as defined in the Colorado Code of Regulations with specific diagnostic codes
  - Residing in the Denver/Metro area
    - Adams, Arapahoe, Douglas, Denver, Jefferson
- Level of Care Requirements
  - Nursing Facility Level or Hospital Level Care

Consumer Directed Attendant Support Services (CDASS)

- Allows BI, EBD, CMHS, SCI Adult HCBS members to direct their own care
- Delivery option provides the following for Adults:
  - Personal Care
  - Homemaker Services
  - Health Maintenance Activities

In Home Support Services (IHSS)

- Assists CHCBS, EBD & SCI Adult HCBS members in directing their own care through an agency
- Managed by an In-Home Support Services Agency
- IHSS Delivery Option provides the following for Adults:
  - Personal Care
  - Homemaker Services
  - Health Maintenance Activities
- IHSS Delivery Option provides the following for children:
  - Health Maintenance Activities

Division of Intellectual & Developmental Disabilities (DIDD) HCBS Waiver Programs

Supported Living Services (SLS)

Developmental Disabilities (DD)

Children's Extensive Support Services (CES)

Waiver Programs

Program	Modifier	Program Code
DD	U3	85
SLS	U8	92
CES	U7	90
TCM	U4	87

HCBS-DD Requirement

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support outside or inside the family home, allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who are in need of services and supports 24 hours a day that will allow them to live safely and participate in the community
- Level of Care Requirements
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

HCBS-SLS Requirement

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support outside family home, allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who can either live independently with limited supports or who, if they need extensive supports, are already receiving that high level of support from other sources
- Level of Care Requirements
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

HCBS-CES Requirement

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization have a diagnosis of a Developmental Disability with intense behavioral and/or medical needs
- Members Served
  - Birth through age 17
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)
    - Additional program criteria needed

Targeted Case Management (TCM)

- TCM is an optional benefit for members enrolled in the following programs
  - HCBS-DD (Developmental Disabilities) Waiver
  - HCBS-SLS (Supported Living Services) Waiver
  - HCBS-CES (Children's Extensive Support) Waiver
  - Early Intervention Services (EI)

Long-term Services and Supports Children's HCBS Waiver Programs

Children's Home and Community Based Services (CHCBS)

Children with Life Limiting Illness (CLLI)

Children With Autism (CWA)

Other Children's HCBS Waiver Programs

Children's Habitation Residential Program (CHRP)

Waiver Programs

Program	Modifier	Program Code
CHCBS	U5	88
CLLI	UD	97
CWA	UL	96
CHRP	U9	93

HCBS-CHCBS Requirement

- Primary Purpose of Program
  - Provides case management & In-Home support services for children who:
    - Are at risk of institutionalization in a hospital or skilled nursing facility
    - And would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources
- Members Served
  - Birth through age 17
- Level of Care Requirements
  - Who meet the established minimum criteria for hospital or skilled nursing facility levels of care & who are medically fragile

HCBS-CHCBS Case Management Responsibilities

- ☐ Inform member and/or guardian(s) of the eligibility process
- ☐ Arranges for face-to-face contact w/ member within 30 calendar days of receipt of referral
- ☐ Completes ULTC-100.2
- ☐ Assesses member's health and social needs
- ☐ Develops Prior Approval and Cost Containment Record Form of services and projected costs for State approval
- ☐ Submits a copy of approved Enrollment Form to the County for Colorado Medical Assistance Program State identification number
- ☐ Monitors and evaluates services
- ☐ Reassesses each child
- ☐ Demonstrates continued cost effectiveness, whenever services increase or decrease

HCBS-CLLI Requirement

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization in a hospital & have a diagnosis of a life-limiting illness
  - Provide Palliative Care to children with a life limiting illness
- Members Served
  - Birth through age 18
- Level of Care Requirements
  - Who meet institutional level of care for inpatient hospitalization

HCBS-CWA Requirement

- Primary Purpose of Program
  - Provides behavioral therapy for children who are at risk of institutionalization and have a medical diagnosis of Autism
- Members Served
  - Birth through age 5
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)

HCBS-CHRP Requirement

- Primary Purpose of Program
  - Provides care for foster children who are at risk of institutionalization and have a diagnosis of a Developmental Disability with extraordinary needs
- Members Served
  - Birth through age 20
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)

Occurrence Reporting

- Types of Critical Incidents to Report
  - Suspected Abuse, Mistreatment
  - Suspected Neglect
  - Suspected Exploitation
  - All Deaths
  - Serious Illness or Injury
  - Medication Errors
  - Damage or Theft of Member's Property
  - All High Risk Issues
  - All unplanned Hospitalizations

Occurrence Reporting

- HCBS providers who experience a critical incident involving a member enrolled in waiver programs:
  - Are required to report all critical incidents to member's case manager within 24 hours of discovery
  - Should also report applicable incidents to appropriate authorities
    - Department of Health Care Policy and Financing
    - Department of Public Health and Environment
    - Adult or Child Protective Services
    - Local law enforcement

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

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

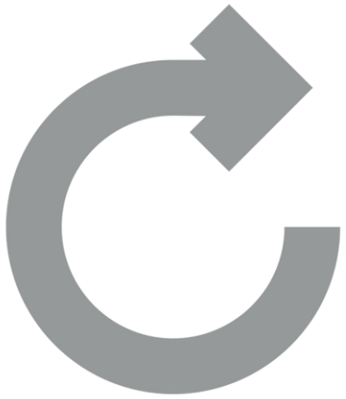
Claim processed & paid by claims processing system

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
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Adjusting Claims

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

Adjust a claim when	Do not adjust when
• Provider billed incorrect services or charges • Claim paid incorrectly	• 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	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	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	CGI 1-888-538-4275
Claims/Billing/Payment	Email helpdesk.HCG.central.us@cgi.com
Forms/Website	CMAP Web Portal technical support
EDI	CMAP Web Portal Password resets
Updating existing provider profile	CMAP Web Portal End User training

Thank you!