

Beginning Billing Workshop *FQHC / RHC*

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 or UB 04 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/
- National Plan and Provider Enumeration System (NPPES)-
 - www.nppes.cms.hhs.gov
- Enumerator-
 - 1-800-456-3203
 - 1-800-692-2326 TTY



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NEW! 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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NEW! 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 website's header with the Colorado logo and HCPF logo. The main navigation bar includes links for Home, For Our Members, For Our Providers, For Our Stakeholders, and About Us. The 'For Our Providers' section is highlighted and contains 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 this, there are three service tiles: 'Get Help Dept. Fiscal Agent 1-800-237-0757' (with a phone icon), 'Get Info FAQs & More' (with a question mark icon), and 'Find a Doctor Are you a client looking for a doctor?' (with a doctor icon).



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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?

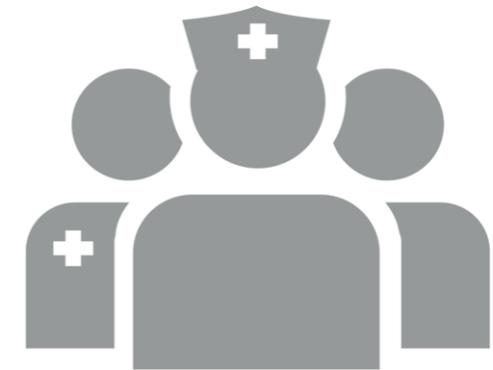
Answer:

Everyone who provides services for Medical Assistance Program members

Attending Versus Billing

Attending Provider

Individual that provides services to a Medicaid member



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:



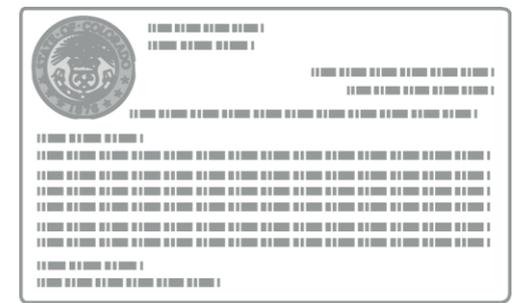
Colorado Medical
Assistance Web Portal



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

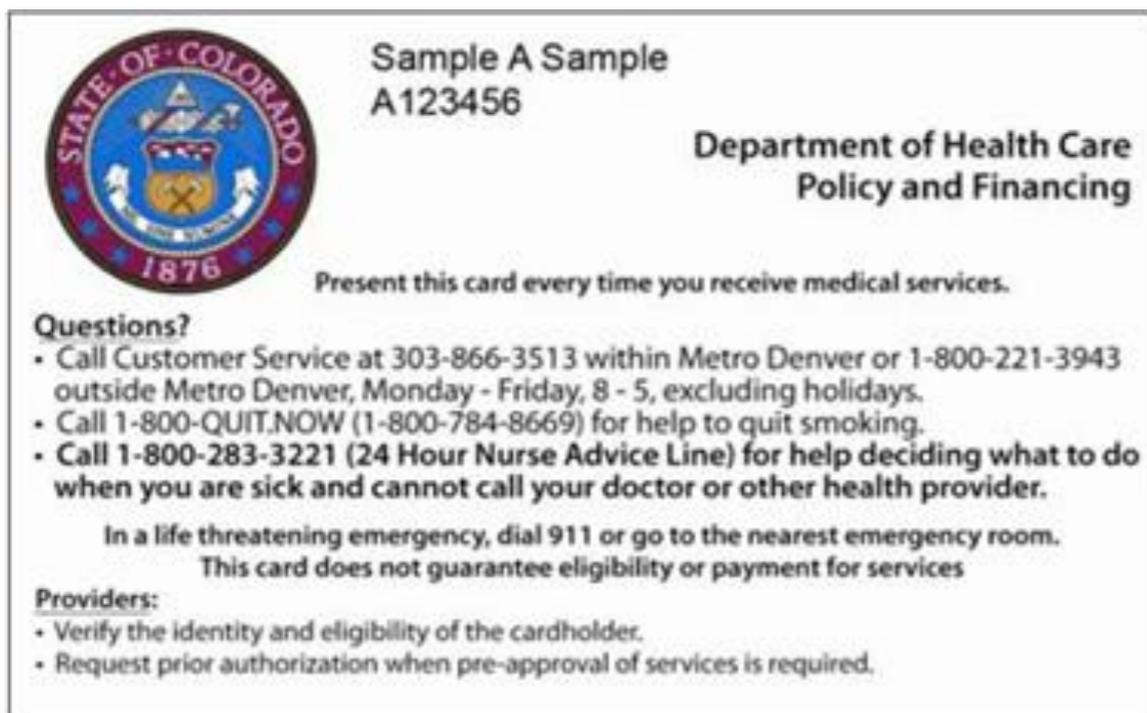
Reminder:

- 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.)

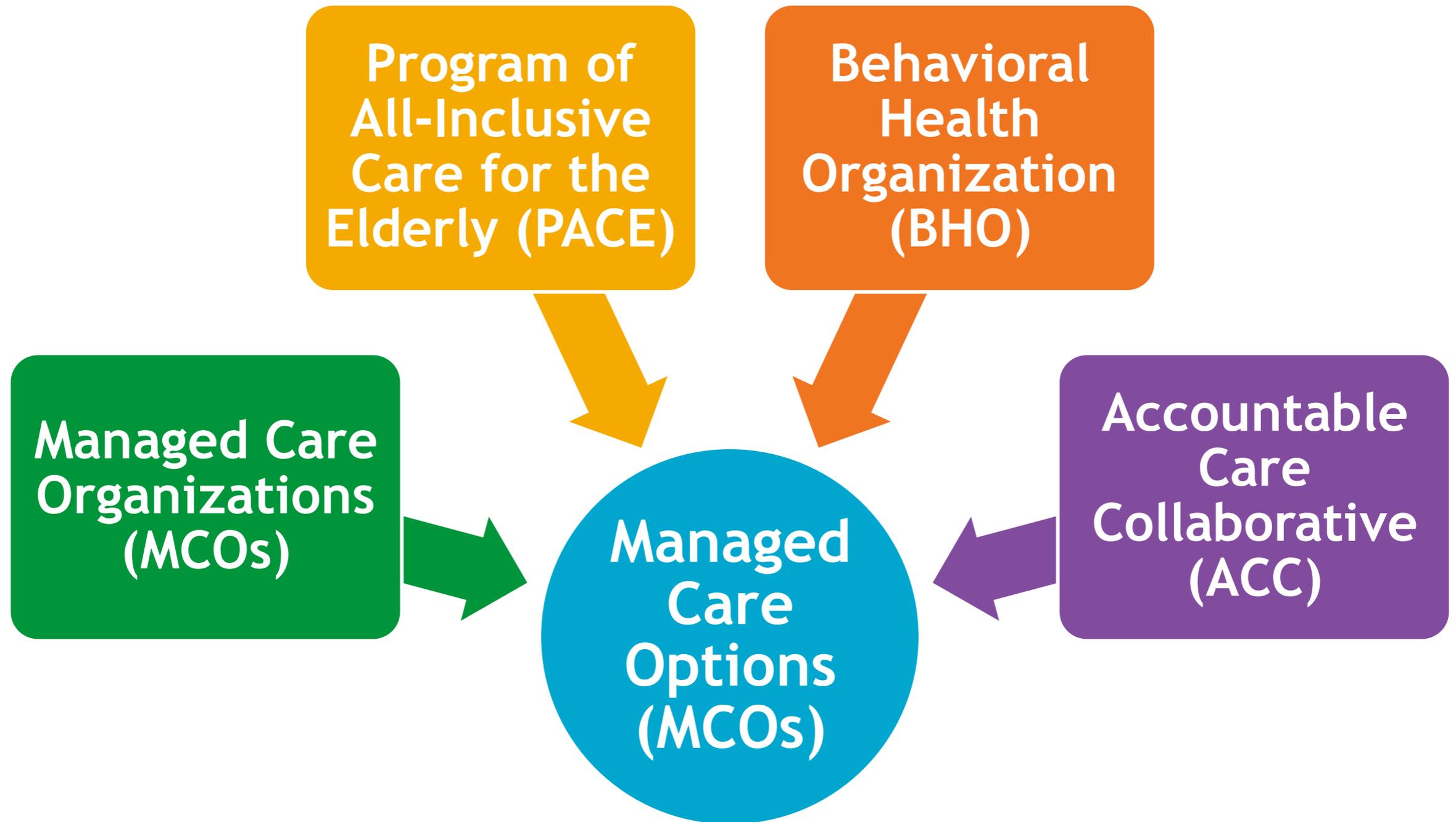
- Verify Medicaid Presumptive Eligibility through:
 - Web Portal
 - Faxback
 - CMERS
 - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
 - Submit to the Fiscal Agent
 - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
 - Colorado Access-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



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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



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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**

Specialty Co-Payments

FQHC / RHC

\$2.00 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

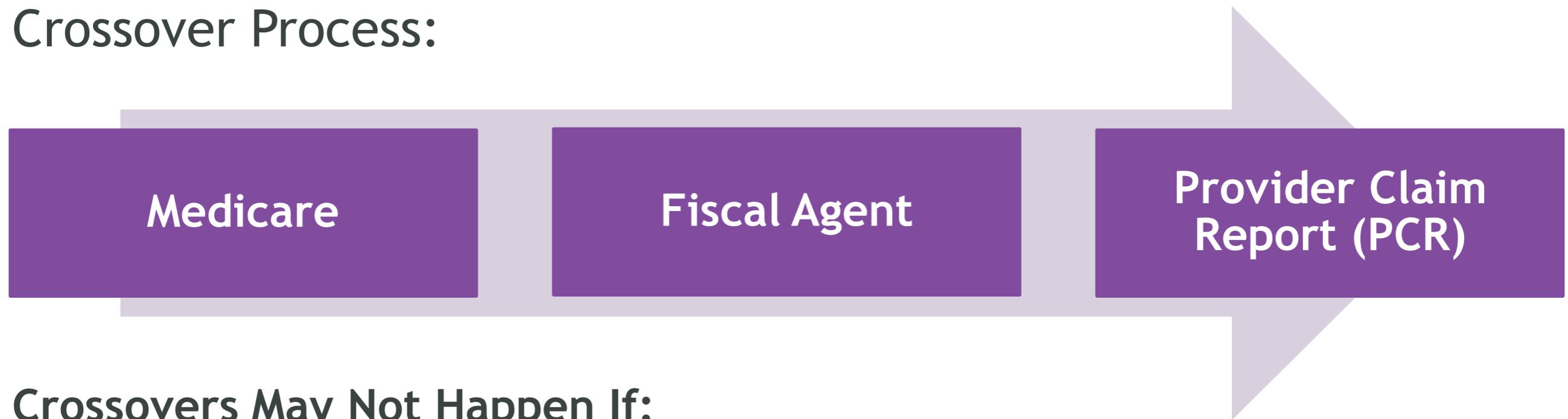
Claims submitted with both ICD-9 and ICD-10 codes

Will be rejected



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

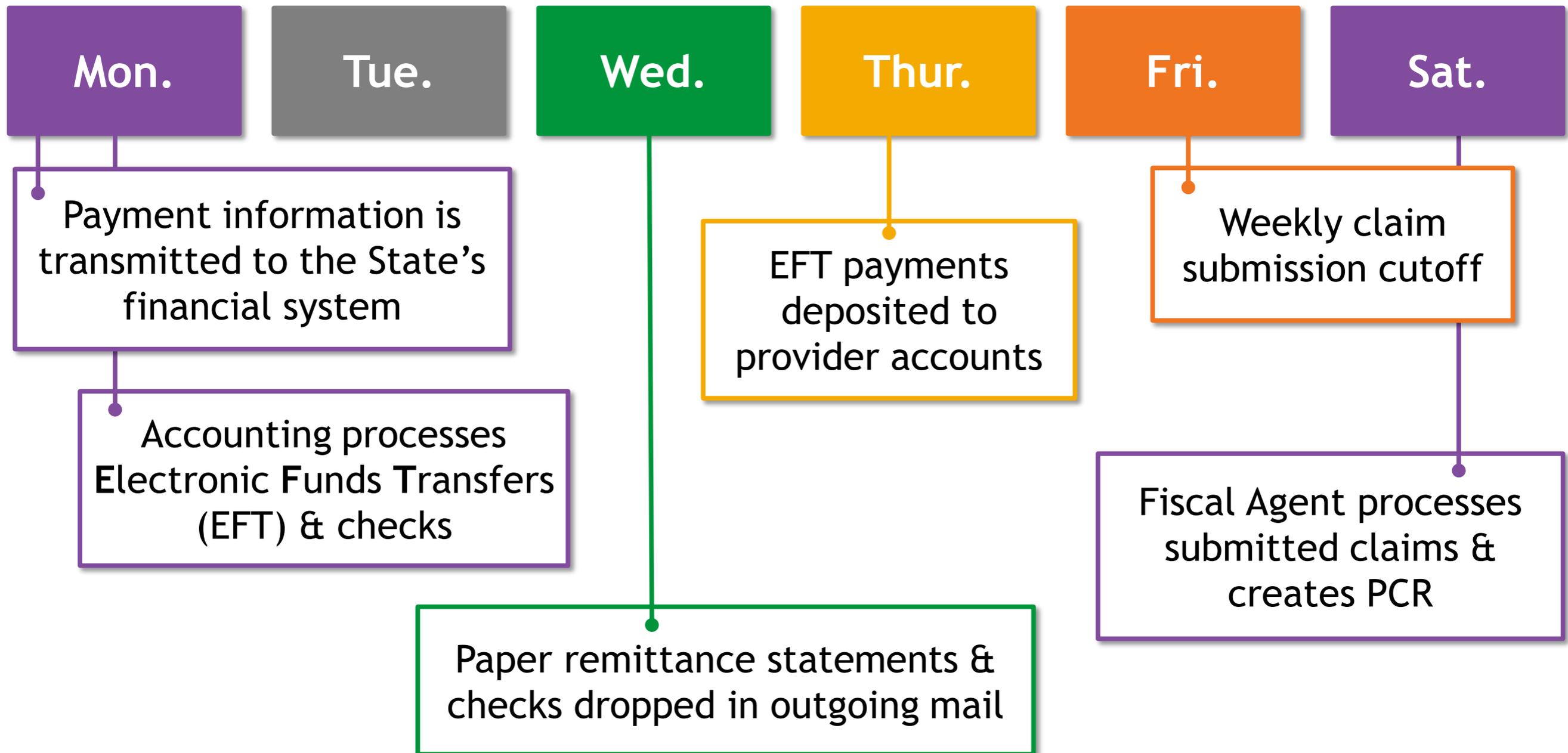
Provider Submitted Crossover Process:



Additional Information:

- Submit claim yourself if Medicare crossover claim not on PCR within 30 days
- Crossovers may be submitted on paper or electronically
- Providers must submit copy of SPR with paper claims
- Provider must retain SPR for audit purposes

Payment Processing Schedule

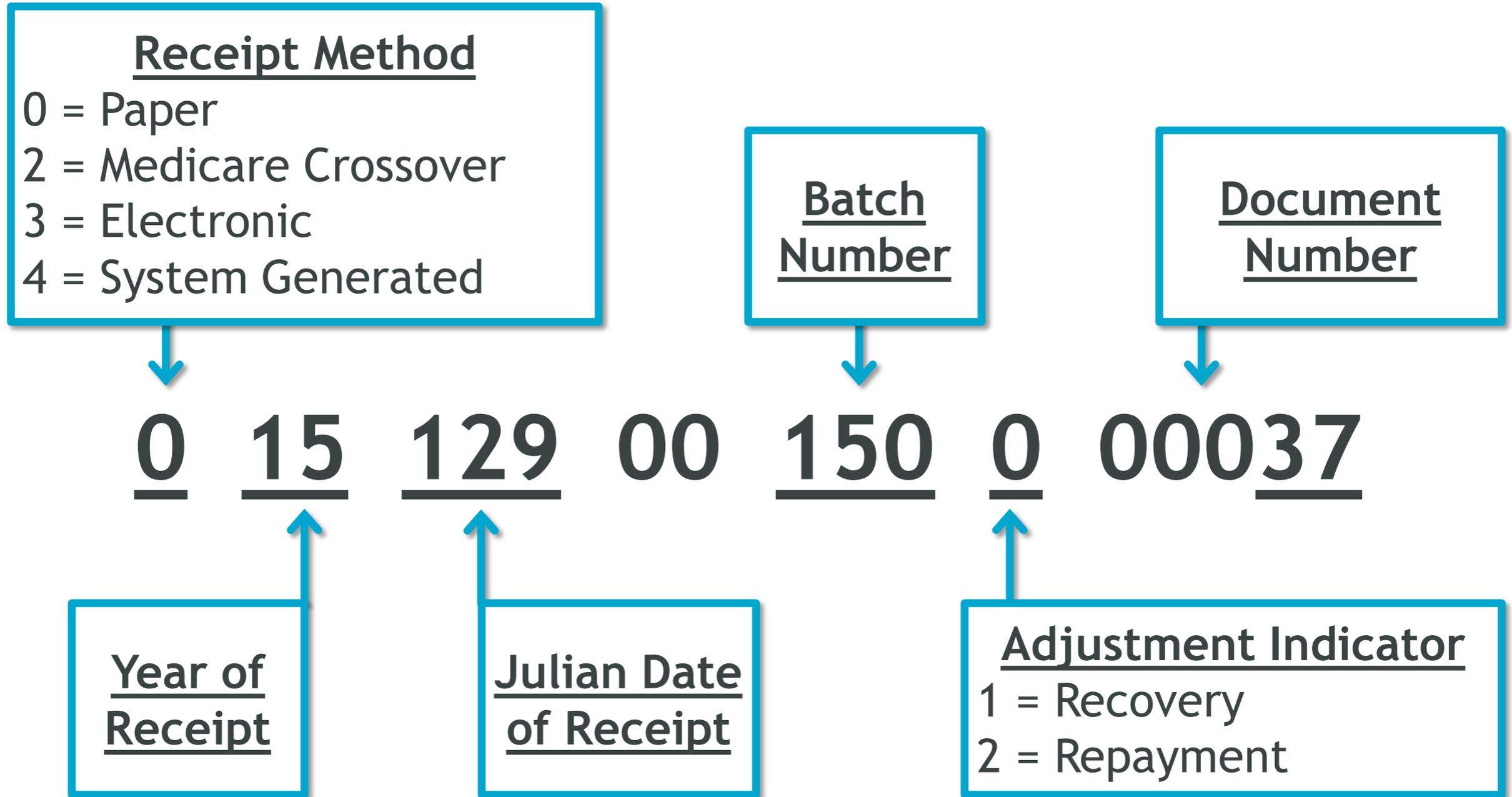


Electronic Funds Transfer (EFT)

Advantages

- Free!
- No postal service delays
- Automatic deposits every Friday
- Safest, fastest & easiest way to receive payments
- [Colorado.gov/hcpf/provider-forms](https://colorado.gov/hcpf/provider-forms) → Other Forms

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 837I transaction
- Keep supporting documentation

Paper Claims

- UB-04- Enter Occurrence Code 53 and the date of the last adverse action



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Timely Filing

Medicare/Medicaid Enrollees

Medicare pays claim

120 days from Medicare
payment date

Medicare denies claim

60 days from Medicare
denial date



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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



UB-04

What are some of the services billed on the UB-04?

FQHC

Rural Health Clinics

- Outpatient Primary Care

- Physician services
- PA, NP, nurse mid-wife services
- Incidental related services and supplies, including visiting nurse care, and related medical supplies

UB-04

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

The image shows a UB-04 institutional claim form with the following key data points:

- 1 IM BILLING PROVIDER:** 444 E CLAIREMONT, ANYTOWN WI 55555-1234, (444) 444-4444
- 2 MEMBER, IM A:** DOB 08201974, SEX 1, DATE 110811, ADM 1, DISC 1, STAT 30
- 3 ADMIT DATE:** 110811
- 4 ICD-9-CM CODES:** 0192, 0185
- 5 ICD-10-CM CODES:** 75
- 6 PROCEDURE CODES:** 4281
- 76 ATTENDING:** NP 0222222220
- 77 OPERATING:** NP
- 78 OTHER:** NP
- 79 OTHER:** NP
- 80 REMARKS:** B3 123456789X



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.

**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](https://colorado.gov/hcpf/billing-manuals)**

National Drug Codes (NDC)

States must:

- Collect rebates for physician administered drugs
 - Required by Deficit Reduction Act of 2005
 - Required for federal financial participation funds to be available for these drugs
- Collect 11-digit NDC on all outpatient claims
 - For drugs administered during course of patient's clinic visit

NDC located on medication's packaging

- Must be submitted in 5digit-4digit-2digit format



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UB-04 Tips

Do

Submit multiple-page claims electronically

Do Not

- Submit “continuous” claims
- Add more lines on the form
 - Each claim form has set number of available billing lines
 - Billing lines in excess of designated number are not processed or acknowledged

Type of Bill 71X

- FQHCs and RHCs must use type of bill 71X
 - FQHC and RHC claims submitted with type of bill 73X will be denied
- For more information refer to FQHC/RHC specialty manual on Department's website:
 - [Colorado.gov/hcpf/billing-manuals](https://colorado.gov/hcpf/billing-manuals)



Sending Physicians Off-Site

Physicians providing services at hospitals:

- Services are billed as carved-out services on Colorado 1500 or as 837P transaction
- If physician is reimbursed under their salary for off-site service, then off-site service is to be billed by FQHC/RHC

Physicians providing services at home or nursing facility:

- Services are billed as encounters on UB-04/837I
- Physicians should not bill Fee-For-Service for services when billed by FQHC/RHC

Carved-Out Services

- Services not included in the encounter rate
- Delivery codes:
 - Do not bill for rev codes 152 and 151
 - Bill CPT codes 59409, 59410, 59412, 59414, 59515
- Hospital visits



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Carved-Out Services (cont.)

- Implanon Contraceptive - See Billing Manual
- Gardasil® - Eligible women ages 21 - 26
 - Bill CPT code 90649
 - This code includes AWP of vaccine plus 10% plus an administration fee
 - See Billing Manual

Revenue or Diagnosis Code

Revenue Code Use:

- All FQHCs should use 529 on first line of UB-04 claim
- All RHCs should use 521 on first line of UB-04 claim
- All other procedures provided during the visit should be on the claim using the appropriate revenue code for that procedure

Diagnosis Code Use:

- Diagnosis code for preventive EPSDT visits is V20.2
- All vaccine administrations, including influenza, can be billed as encounters if they meet encounter criteria

837I

Institutional Claim Changes

- Some Value Codes have been restricted by the National Uniform Billing Committee (NUBC)
- The following cannot be billed electronically but can be billed on paper:
 - A1, A2, A7, B1, B2, B7, C1, C2, and C7



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EPSDT

EPSDT must be billed on UB-04 claim form



Multiple Encounters

Different services, same day: Dental and Medical

- Bill different diagnosis codes
- Will receive up to two encounter payments when billed separately
- Mental health services can be billed as an encounter to BHO, not to MMIS, on same date of service as Dental or Medical

Note: Dental Services are billed through DentaQuest



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Dental Services

- Bill 837D via or 2006 ADA Paper Claim Form via DentaQuest
- Dental services are paid at an encounter rate
- Use dental CDT codes
- Must follow Colorado Medical Assistance Program guidelines to determine if services are a benefit
- Medicaid children and adult benefits are outlined in Dental Billing Manual



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Behavioral Health Organization (BHO)

- For Medicaid members who are:
 - Enrolled in BHO & seen at FQHC/RHC by a mental health professional
- Claim for Mental Health services must be billed to BHO by FQHC/RHC if:
 - Diagnosis & all procedures during visit, are listed in Appendix T
 - Community Mental Health Services Program (Covered Diagnoses and Procedures)
 - [Colorado.gov/hcpf/billing-manuals](https://colorado.gov/hcpf/billing-manuals)-> Appendices



Mental Health Services

- For Medicaid members who are:
 - Seen at FQHC/RHC and primary diagnosis is a mental health condition
 - Condition listed in Appendix T
(Community Mental Health Services Program)
- If treatment includes a procedure code not listed in Appendix T:
 - FQHC/RHC may bill Medicaid for “Encounter Rate”



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Lock In Program

- Designed to prevent misuse of pharmaceuticals
- For members who:
 - have been prescribed narcotics by three or more prescribers and,
 - used three or more pharmacies in three months
- Any provider can ask for a client to be reviewed by contacting the Department
 - Ask for the Lock-in Specialist at 303-866-3672



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Lock In Program

Only one prescriber will be allowed to submit claims

Only one Pharmacy will be allowed to submit claims

- With a referral, client may be allowed to see two prescribers

- If you are not the Pharmacy (or physician) listed you will receive error:
- NCPDP Reject 50 (Non-matched Provider Number)
- NCPDP Reject 56 (Non-matched Prescriber ID)



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SBIRT

Screening, Brief Intervention and Referral to Treatment

See Billing Manual for more information



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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

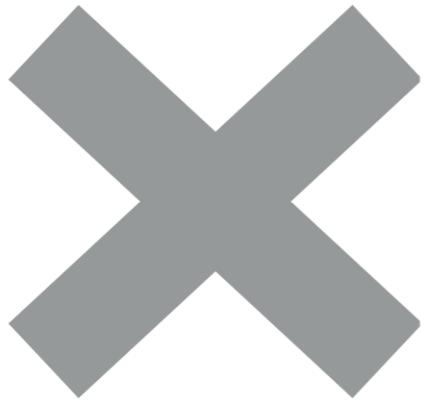
Total Charges invalid

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

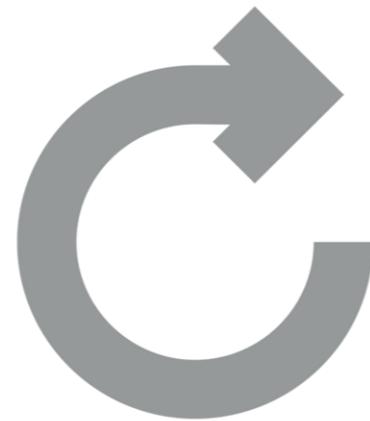
Claim processed & paid by claims processing system

Claims Process - Common Terms



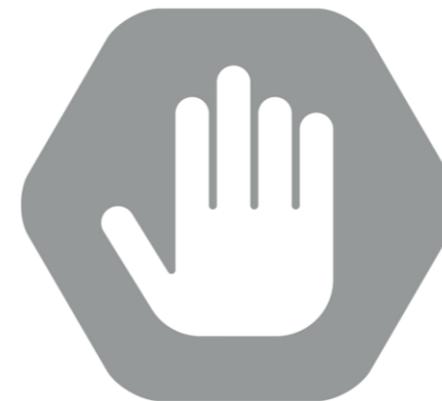
Adjustment

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 Adjustment Transmittal form
- Be concise & clear

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



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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	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-			
						NET IMPACT	642.60-			



Provider Services

Xerox
1-800-237-0757

Claims/Billing/ Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

CGI
1-888-538-4275

Email helpdesk.HCG.central.us@cgi.com

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training



Thank you!



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Department of Health Care
Policy & Financing