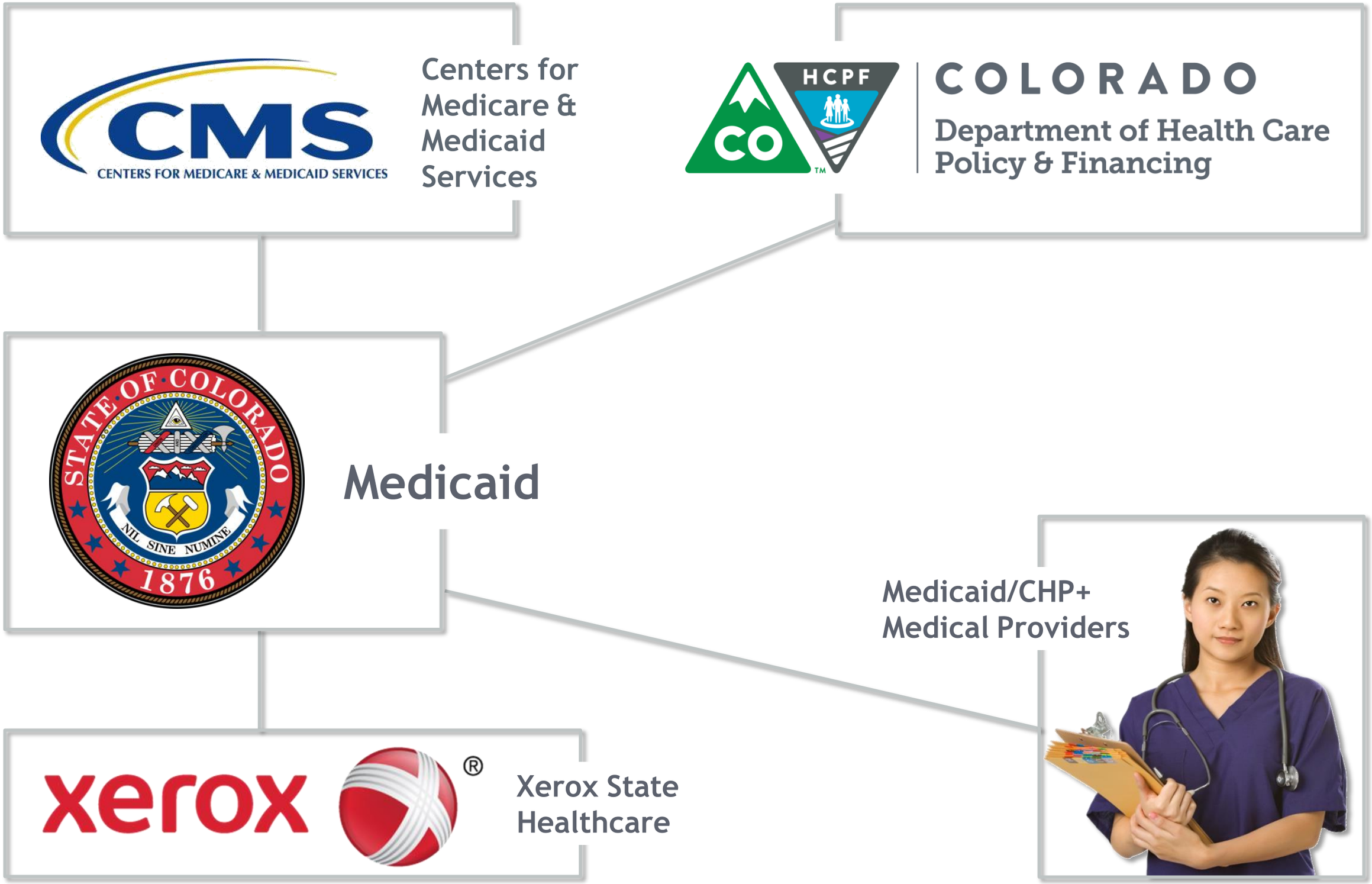
# *Beginning Billing Workshop UB-04*

Colorado Medicaid
2016

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 UB-04 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

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:**

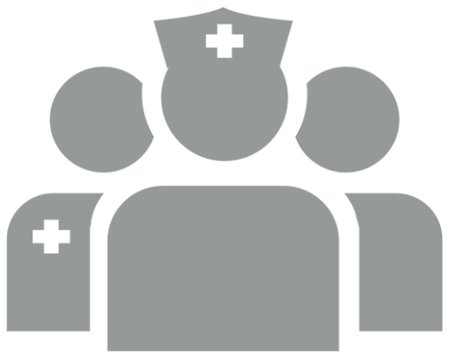
Everyone who provides services for Medical Assistance Program members

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

# *Attending Versus Billing*

**Attending 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

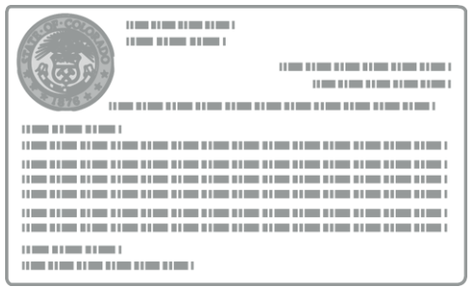
# *Verifying Eligibility*

- 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)

Print

Return To Eligibility Inquiry

**Eligibility Request**

Provider ID: National Pro

From DOS: Through D

**Client Detail**

State ID: DOB:

Last Name: First Name

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/2

Contact Information for Questions on Res

Provider Relations Number: 800-237-075

Requesting Provider

Provider ID:

Name:

Client Details

Name:

State ID:

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

**PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE**

Eligibility Benefit Date:
04/06/2011 - 04/06/2011

Messages:

***MHPROV Services***

Provider Name:

**COLORADO HEALTH PARTNERSHIPS LLC**

Provider Contact Phone Number:
800-804-5008

**Information appears in sections:**

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

**Successful inquiry notes a Guarantee Number:**

- Print copy of response for member's file when necessary

**Reminder:**

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

# *Medicaid Identification Cards*

- Both cards are valid
- Identification Card does not guarantee eligibility

Sample A Sample
A123456

Department of Health Care
Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

**In a life threatening emergency, dial 911 or go to the nearest emergency room.**
**This card does not guarantee eligibility or payment for services**

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

# *Eligibility Types*

- Most members = Regular Colorado Medicaid benefits
- Some members = different eligibility type
  - 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

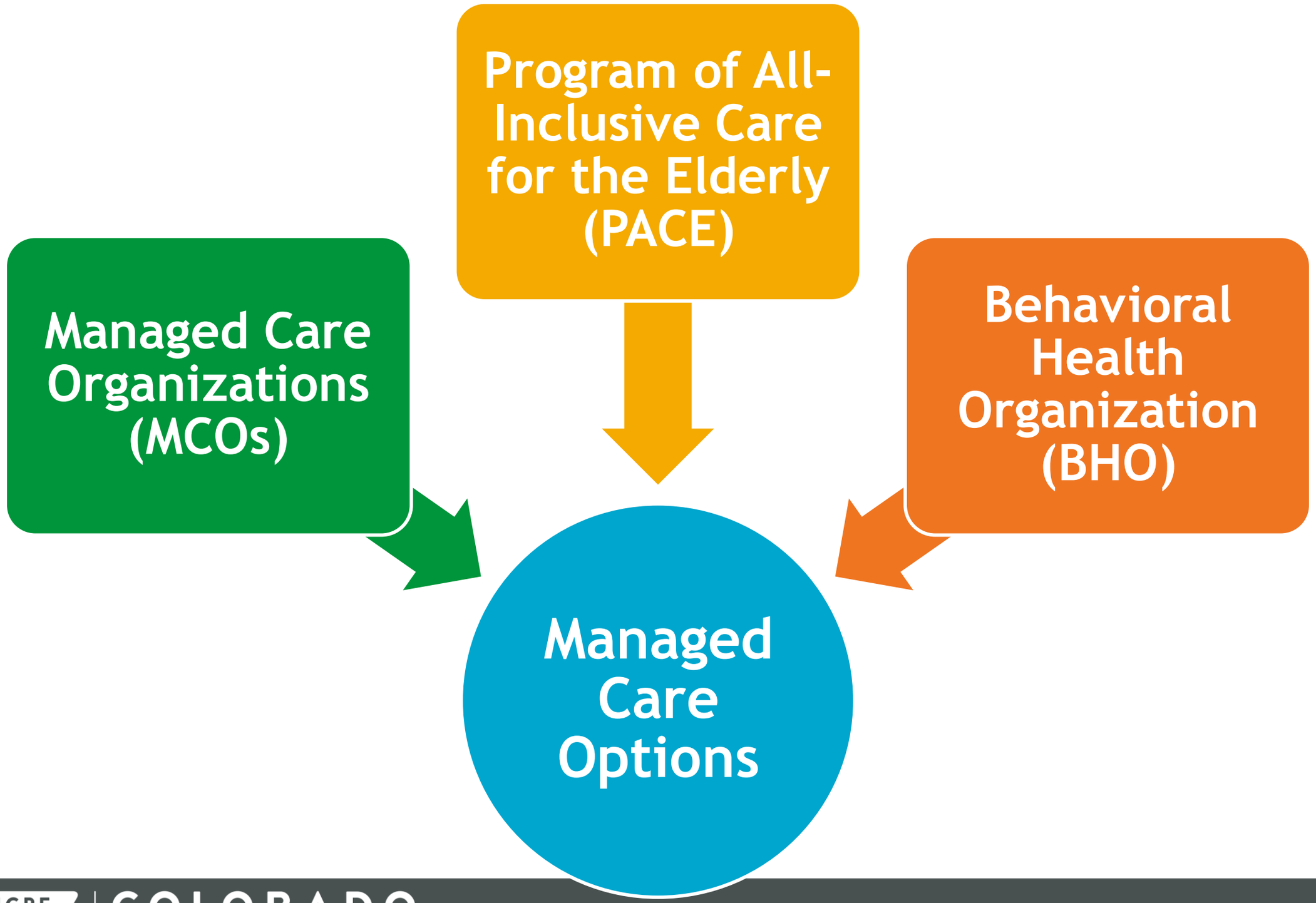
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and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

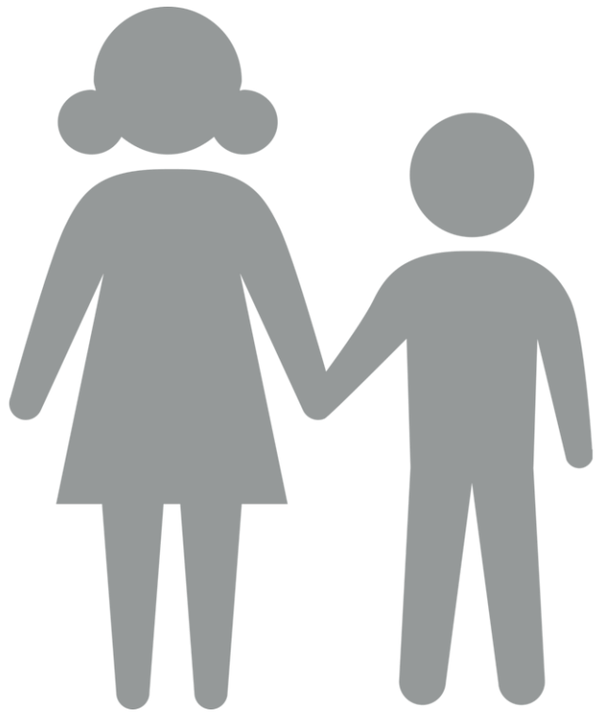
| | |
|---|---|
| | **$400.00** |
| **-** | **$300.00** |
| **=** | **$100.00** |

# *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, Optometrist, Speech Therapy, RHC / FQHC | $2.00 |
| DME / Supply | $1.00 per date of service |
| Outpatient | $3.00 |
| Inpatient | $10.00 per covered day or 50% of average allowable daily rate- whichever is less |
| Psych Services | .50 per unit of service, 1 unit = 15 minutes |

# *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

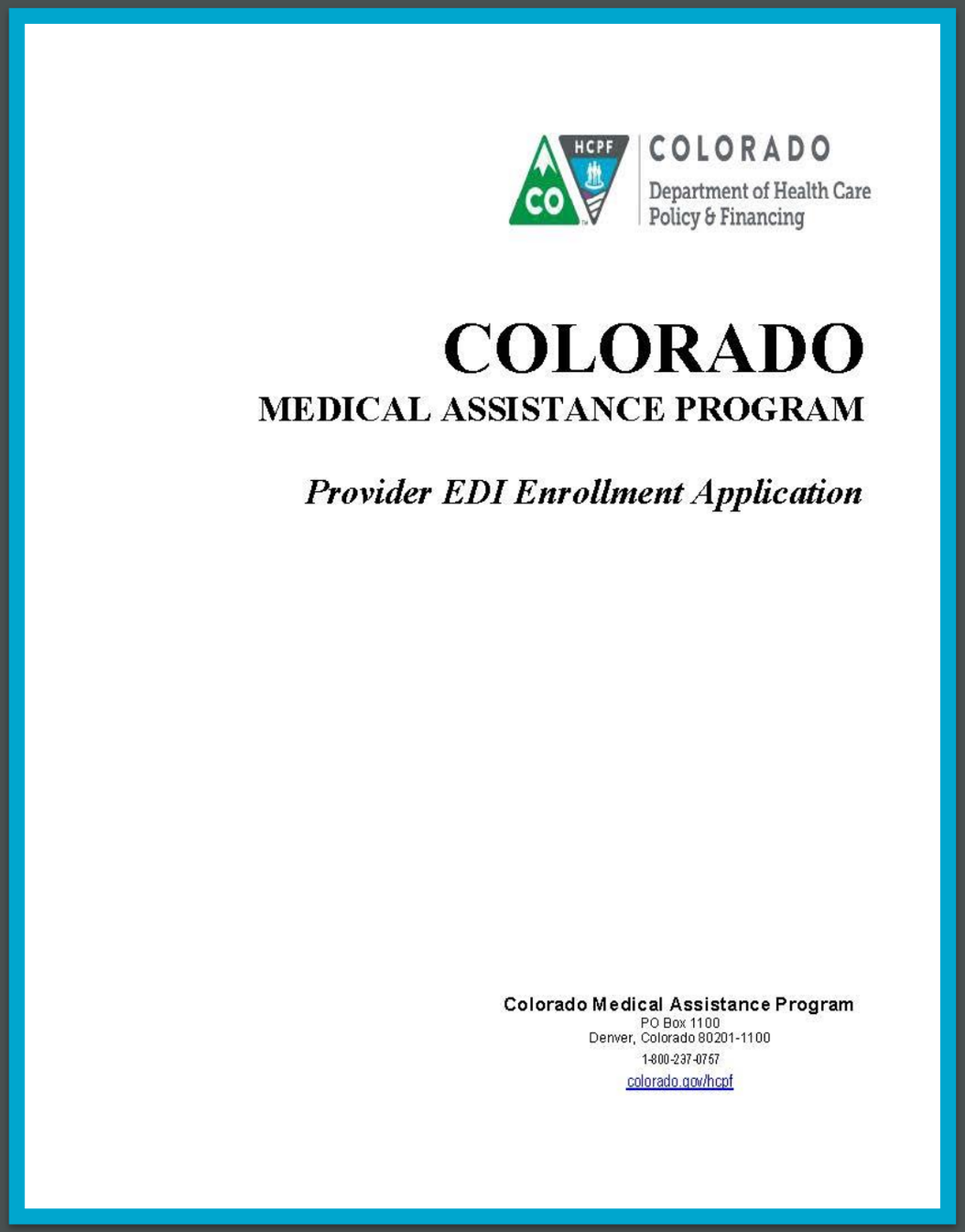
# *Submitting Claims*

- 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

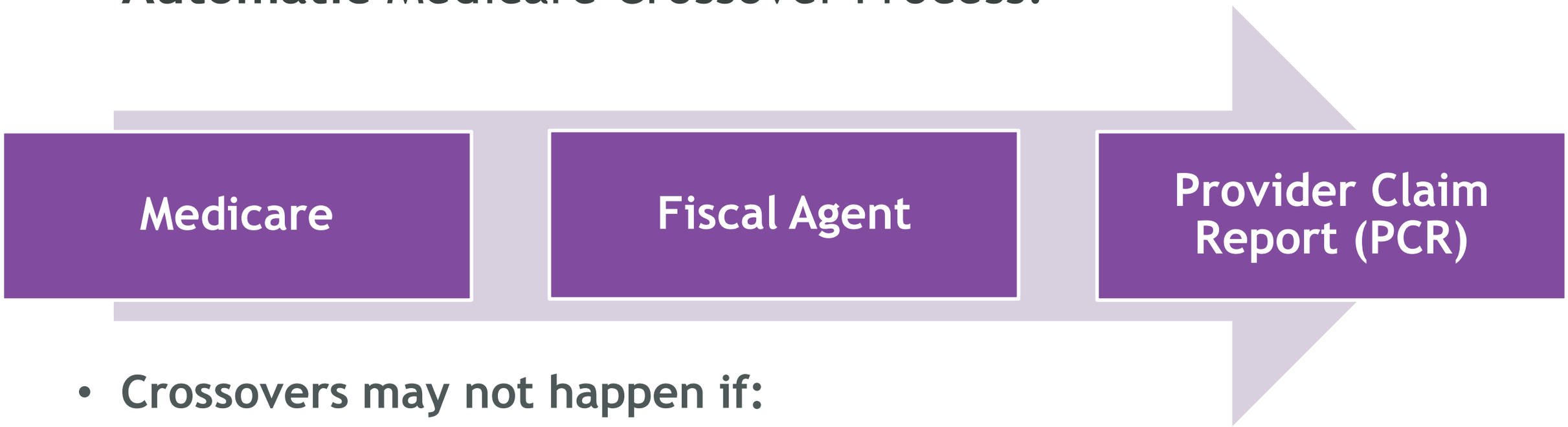
**Providers must be enrolled with EDI to:**

- 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*

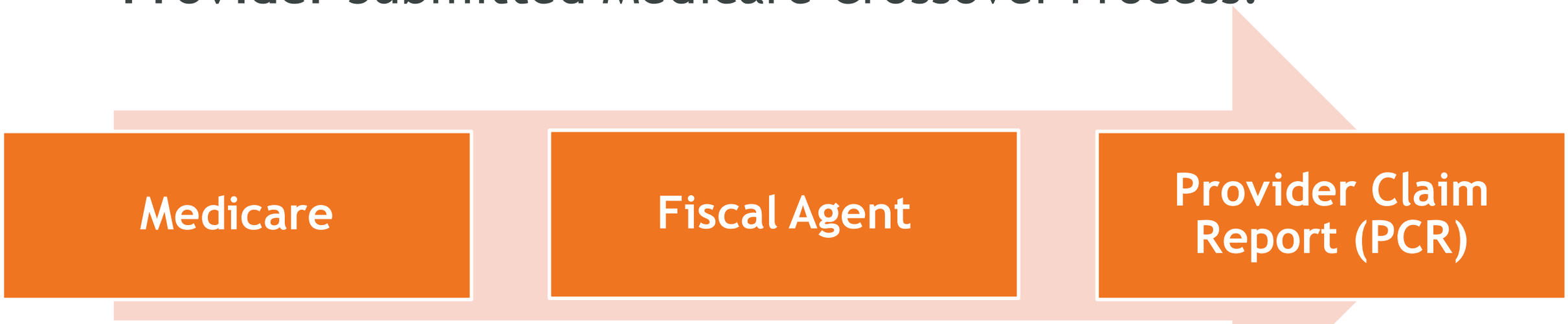
**Automatic** Medicare Crossover Process:




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

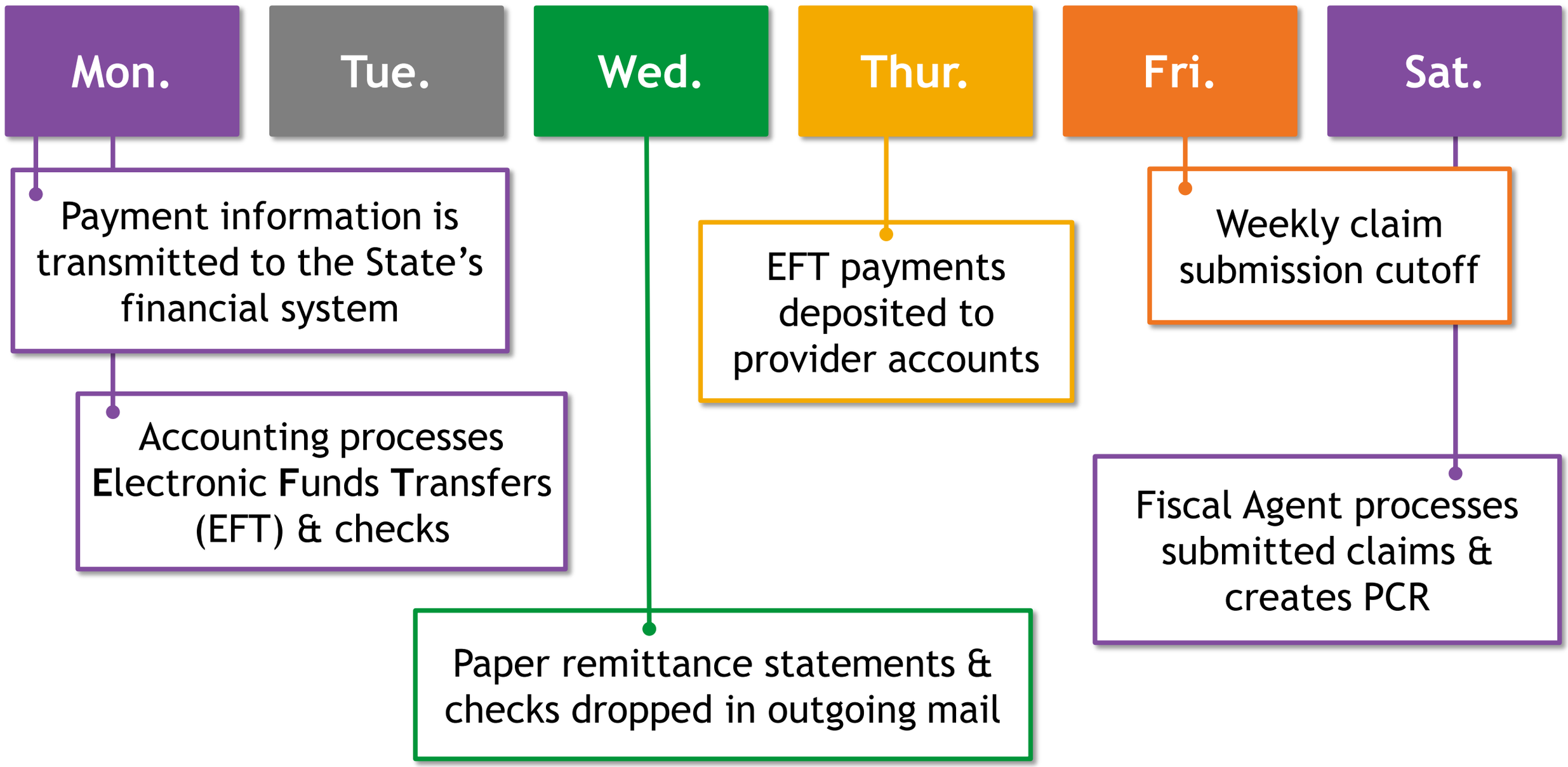
# *Crossover Claims*

**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



# *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*

- The ColoradoPAR Program reviews PARs for the following categories or services and supplies: diagnostic imaging, durable medical equipment, inpatient out-of-state admissions, medical services (including transplant and bariatric surgery), physical and occupational therapy, pediatric long term home health, private duty nursing, Synagis®, and vision
  - ColoradoPAR does not process PARs for dental, transportation, pharmacy, or behavioral health services covered by the Behavioral Health Organizations
  - Visit www.ColoradoPAR.com for more information

| Website: | Phone: |
| --- | --- |
| www.ColoradoPAR.com | Phone: 1.888.801.9355<br>FAX: 1.866.940.4288 |

# *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

# *PARs Reviewed by the Department*

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is the ONLY number accepted when submitting claims
- **Long Term Care Nursing Facility PARs only**

# *Transaction Control Number*

**Receipt Method**
0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

**Batch Number**

**Document Number**

**0 15 129 00 150 0 00037**

**Year of Receipt**

**Julian Date of Receipt**

**Adjustment Indicator**
1 = Recovery
2 = Repayment

# *Timely Filing*

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

# Timely Filing

**From "through" DOS**

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

**From delivery date**

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

**From DOS**

FQHC Separately Billed and additional Services

# Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837I transaction
  - Keep supporting documentation
- Paper Claims
  - UB-04- enter Occurrence Code 53 and the date of the last adverse action

# *Timely Filing*

## Medicare/Medicaid Enrollees

| Medicare pays claim | Medicare denies claim |
| --- | --- |
| 120 days from Medicare payment date | 60 days from Medicare denial date |

# *Timely Filing Extensions*

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

# *Timely Filing Extensions*

## Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available

# *Timely Filing Extensions*

## Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member

# *Timely Filing Extensions*

## Backdated Eligibility

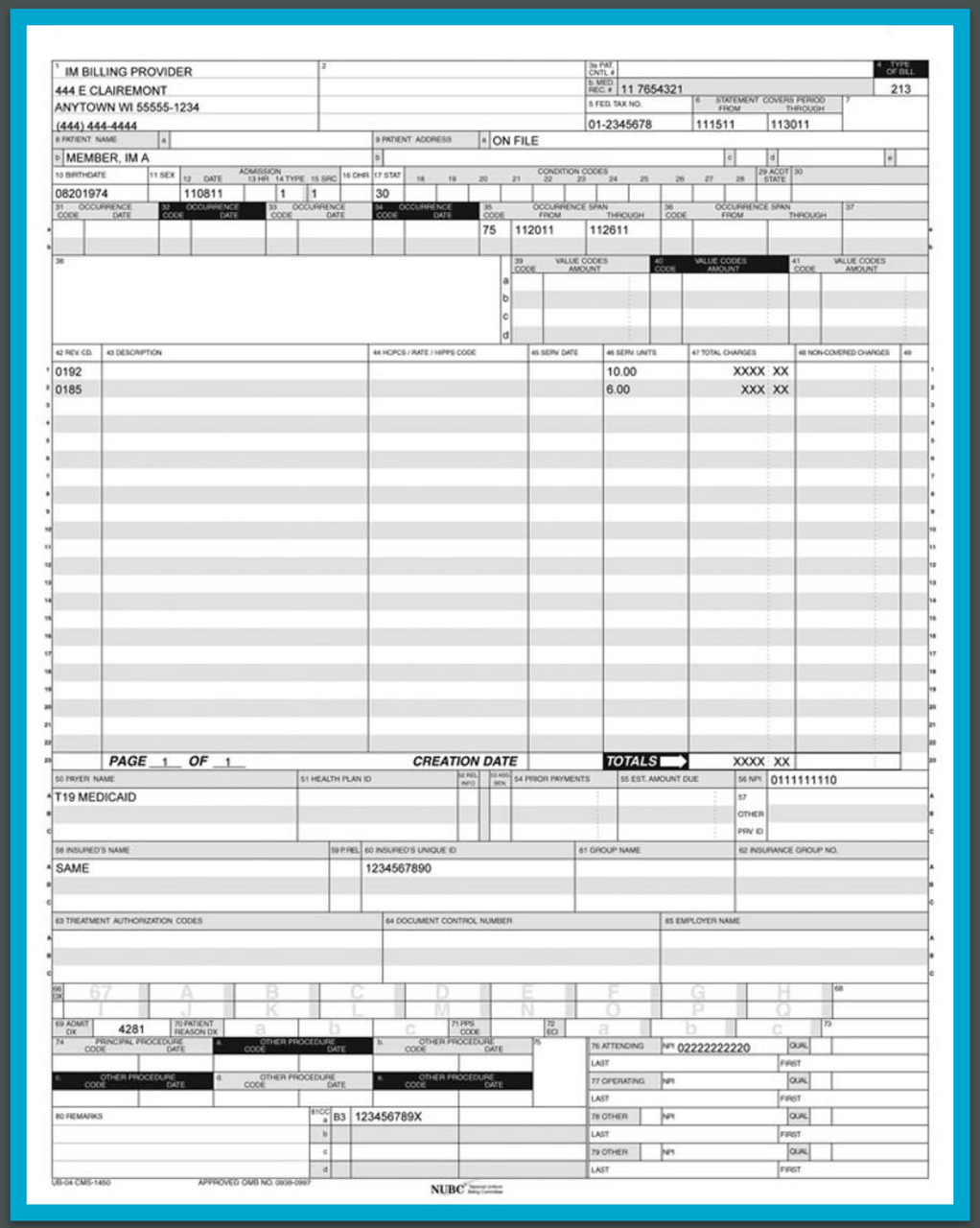
- 120 days from date county enters eligibility into system
  - Report by obtaining State-authorized letter identifying:
    - County technician
    - Member name
    - Delayed or backdated
    - Date eligibility was updated

# *UB-04*

## Who completes the UB-04?

- Inpatient Hospital
- Nursing Facility
- Home Health/ PDN
- Hospice
- Dialysis Centers
- Residential Treatment Centers
- Outpatient Hospital
- Outpatient Lab
- Rural Health Clinics
- FQHC
- Indian Health Services
- Hospital-Based Transportation

# 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

# UB-04 Certification

COLORADO
Department of Health Care Policy & Financing

**Colorado Medical Assistance Program**

**Institutional Provider Certification**

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

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

**Signature:**_____ **Date:**_____

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

Revised March 2015

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

**Print a copy of the certification at:**

Colorado.gov/hcpf/billing-manuals

# *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

# *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

# *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

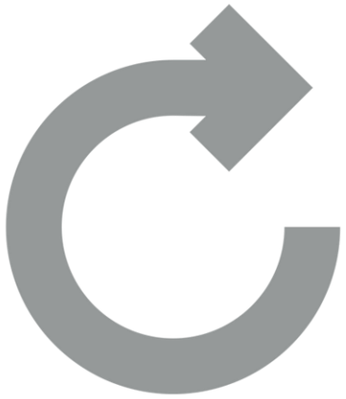


From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

# *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
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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<br>• Claim paid incorrectly | • Claim was denied<br>• Claim is in process<br>• Claim is suspended |

# *Adjustment Methods*

## Web Portal

- Preferred method
- Easier to submit & track

## Paper

- Complete Adjustment Transmittal form
- Be concise & clear



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**

**Recovery**

**********
* 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 | | | |

**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<br>1-800-237-0757 | CGI<br>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!*