# *Billing Workshop*
# *Audiology*

Colorado Medicaid
2016

COLORADO
Department of Health Care Policy & Financing

Centers for Medicare & Medicaid Services

COLORADO
Department of Health Care Policy & Financing

# Medicaid

Xerox State Healthcare

Medicaid/CHP+
Medical Providers

# *Training Objectives*

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

# *What is an NPI?*

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

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

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

# Department Website

1

www.colorado.gov/hcpf

# Provider Home Page

**Find what you need here**

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

# *Provider Enrollment*

**Question:**

What does **Provider** Enrollment do?

**Answer:**

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

**Question:**

Who needs to enroll?

**Answer:**

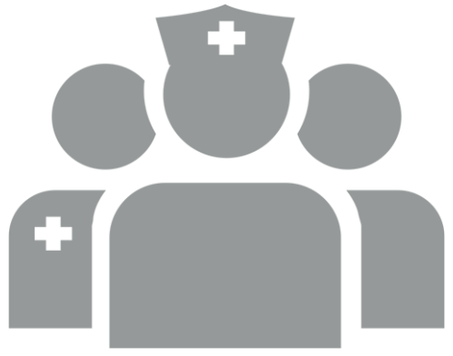
Everyone who provides services for Medical Assistance Program members

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

# *Rendering Versus Billing*

**Rendering Provider**

Individual that provides services to a Medicaid member



**Billing Provider**

Entity being reimbursed for service

From the Noun Project:
"Medical-Team" icon created by Pieter J. Smits
"Hospital" icon created by Carlotta Zampini

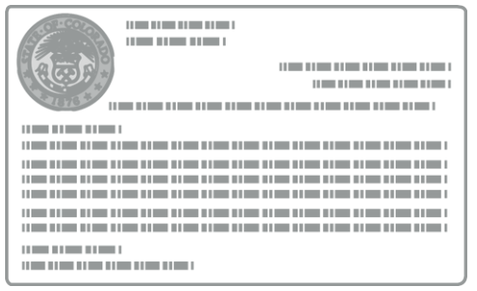
# *Verifying Eligibility*

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

**Colorado Medical Assistance Web Portal**

**Fax Back 1-800-493-0920**

**CMERS/AVRS 1-800-237-0757**



**Medicaid ID Card with Switch Vendor**

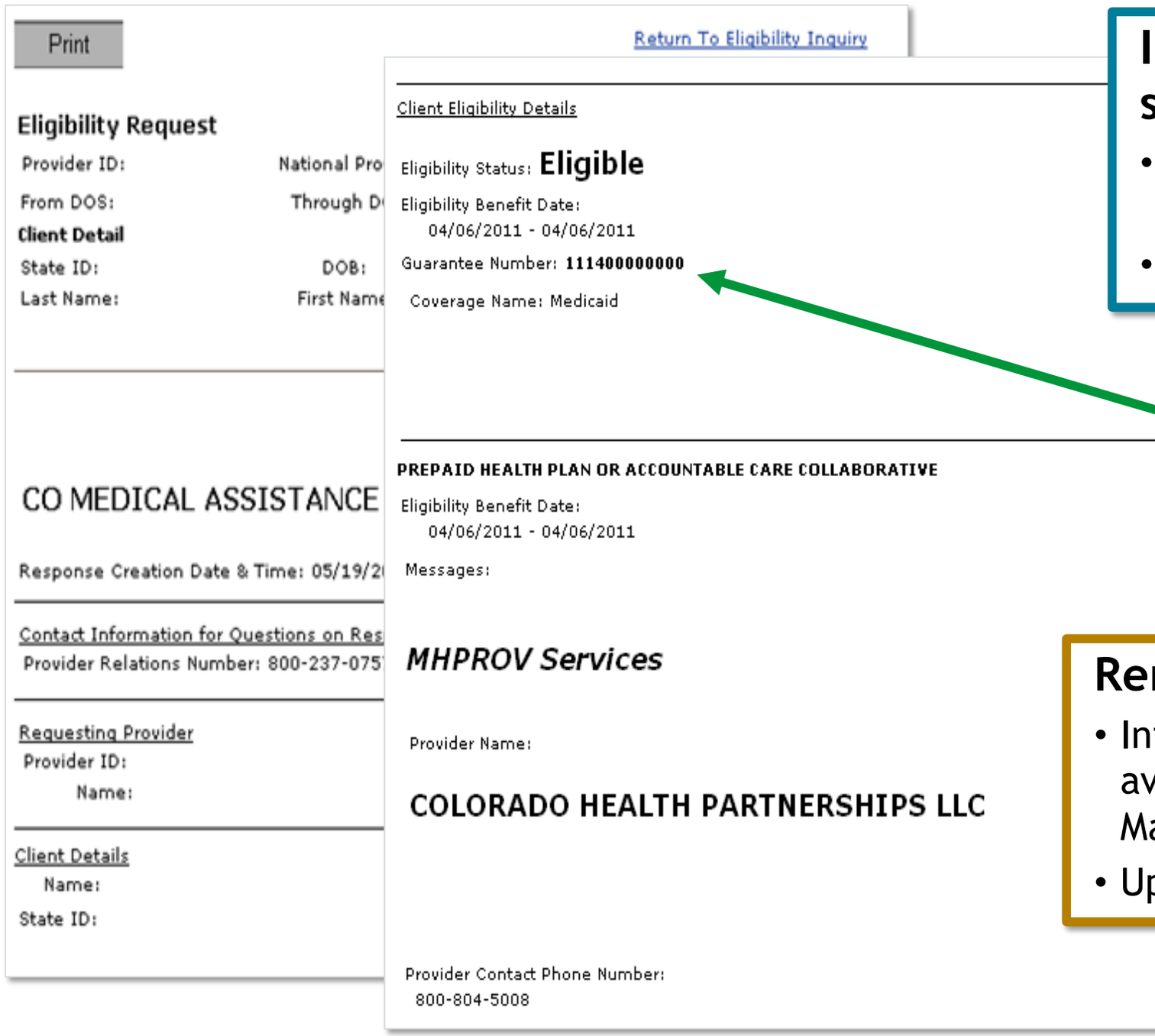


From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

# *Eligibility Response Information*

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number

# Eligibility Request Response (271)




**Information appears in sections:**

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

**Successful inquiry notes a Guarantee Number:**

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

**Reminder:**

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

# *Medicaid Identification Cards*

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

Sample A Sample
A123456

Department of Health Care
Policy and Financing

Present this card every time you receive medical services.

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

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

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

# *Eligibility Types*

- Most members = Regular Colorado Medicaid benefits
- Some members = different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members = additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance

# *Eligibility Types*

## Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services

# *Eligibility Types*

## Non-Citizens

- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

# *What Defines an "Emergency"?*

- Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
  - Active labor & delivery
  - Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
    - Placing health in serious jeopardy
    - Serious impairment to bodily functions
    - Dysfunction of any bodily organ or part

# *Eligibility Types*

## Presumptive Eligibility

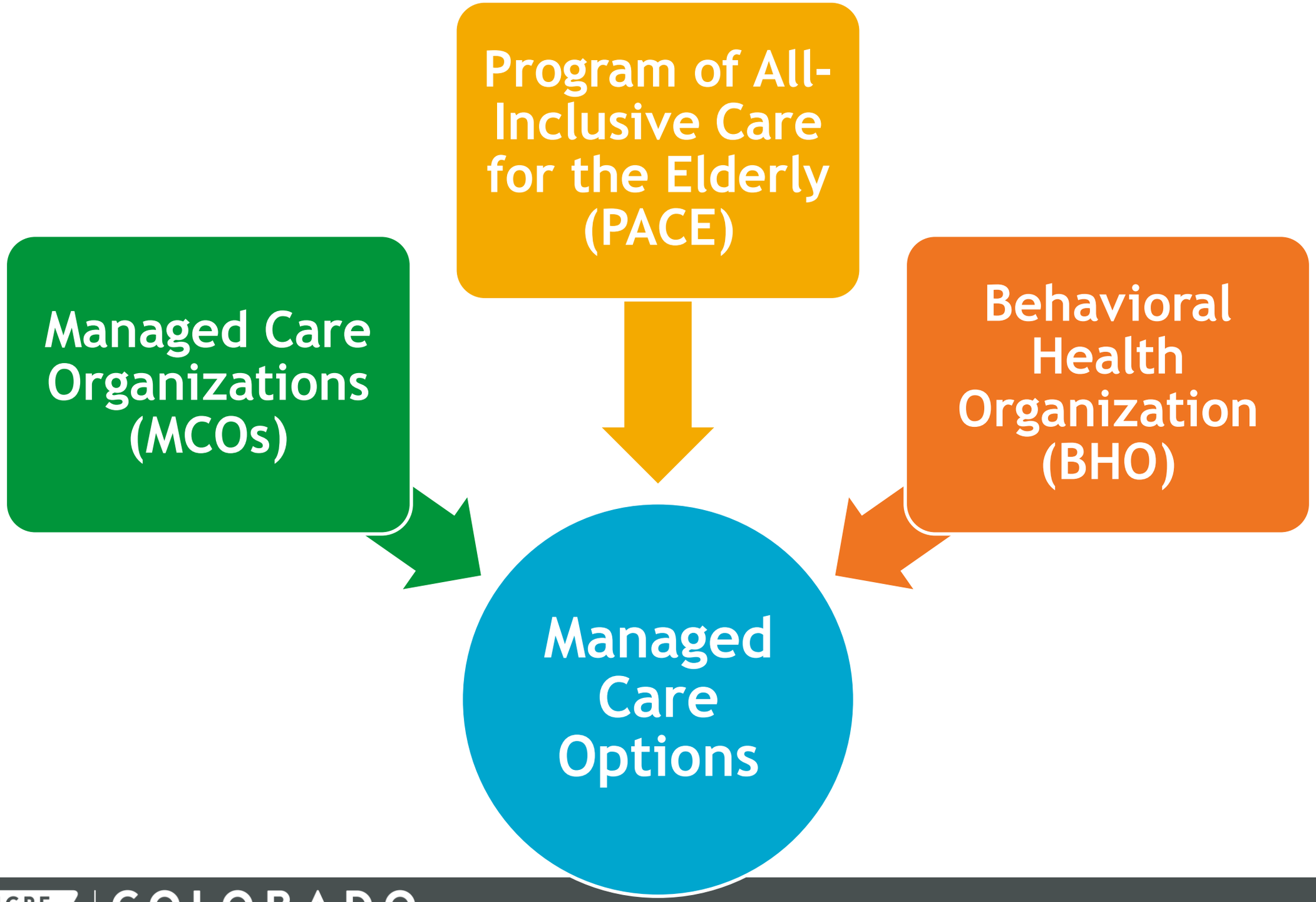
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

# *Eligibility Types*

## Presumptive Eligibility (cont.)

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

# *Managed Care Options*



# *Managed Care Options*

## Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out

# *Managed Care Options*

## Behavioral Health Organization (BHO)

- Community Mental Health Services Program
  - State divided into five (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 (6) 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**

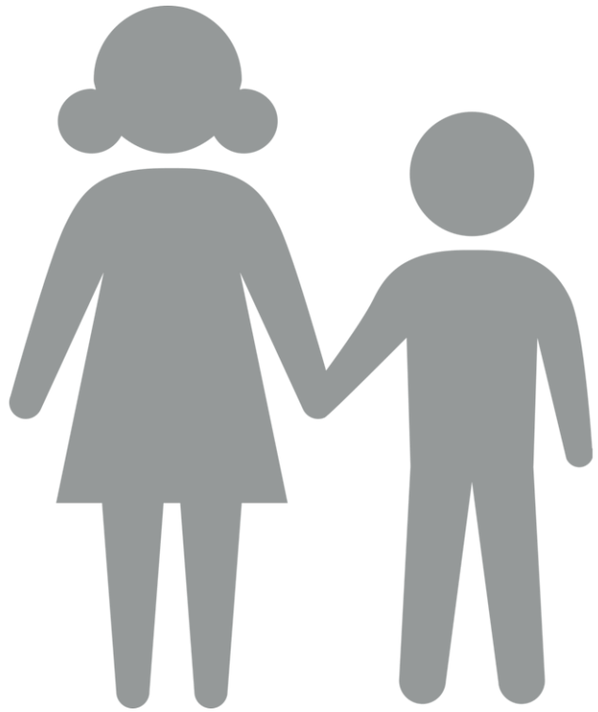
**$400.00**
**- $300.00**
**= $100.00**

# *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 and Former Foster Care Eligible***

**Pregnant Women**

***former foster care eligible still has a pharmacy co-pay**



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)
- Youth from birth to 18 years old are considered children
- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS
  - Transportation
  - Emergency Services
  - Family Planning Services
  - Behavioral Health Services

# *Specialty Co-payments*

| | |
|---|---|
| **Audiologist** | $2.00 per date of service |

# *Billing Overview*

Record Retention

Claim submission

Prior Authorization Requests (PARs)

Timely filing

Extensions for timely filing

# *Record Retention*

- Providers must:
  - Maintain records for at least six (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

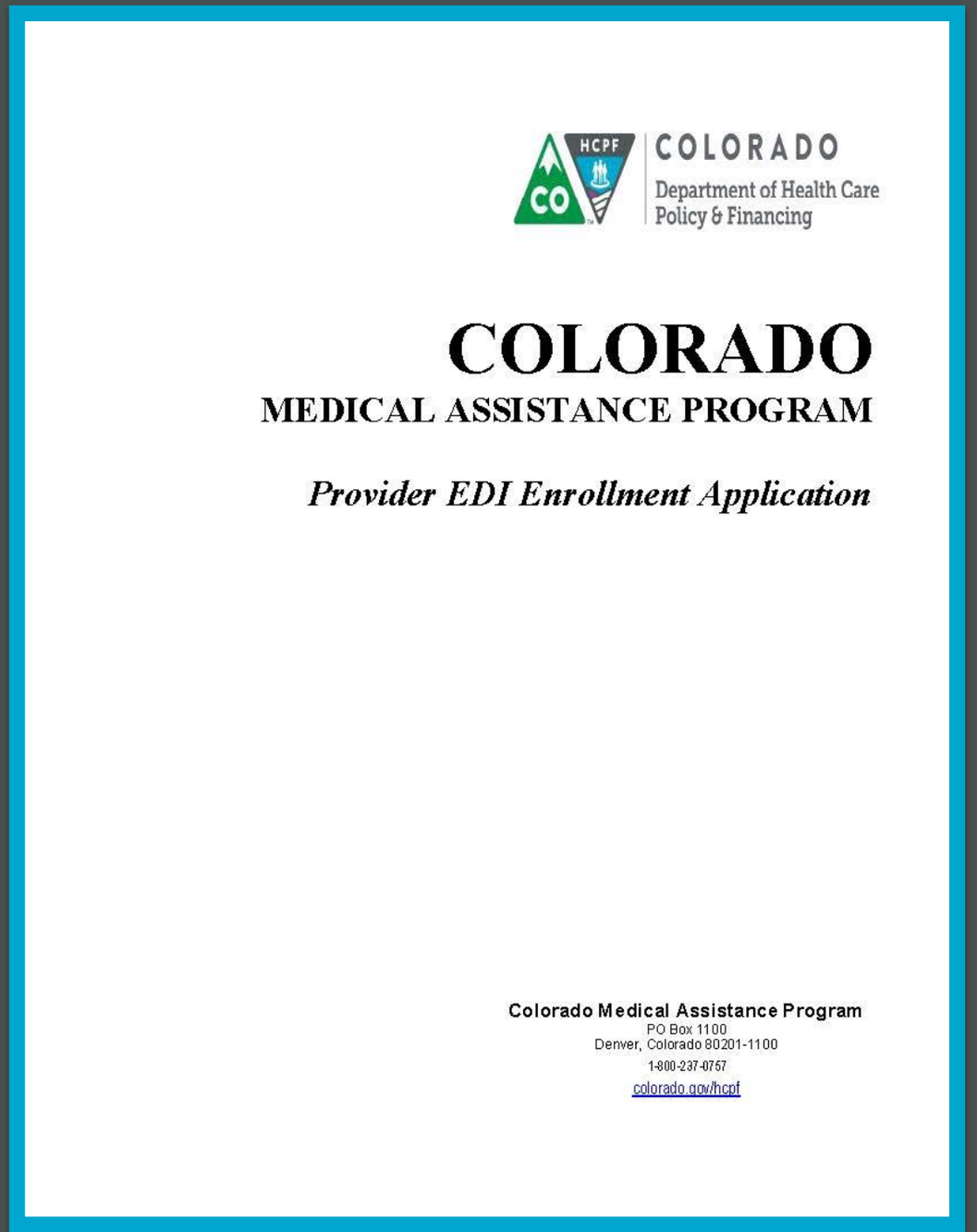
# *Submitting Claims*

- Methods to submit:
  - Electronically through Web Portal
  - Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  - Paper only when:
    - Pre-approved (consistently submits less than five (5) per month)
    - Claims require attachments

# *ICD-10 Implementation*

| | |
|---|---|
| Claims with Dates of Service (DOS) **on** or **before** 9/30/15 | **Use ICD-9 codes** |
| Claims with Dates of Service (DOS) **on** or **after** 10/1/2015 | **Use ICD-10 codes** |
| Claims submitted with both ICD-9 and ICD-10 codes | **Will be rejected** |

# *Providers Not Enrolled with EDI*



COLORADO
Department of Health Care Policy & Financing

**COLORADO**
**MEDICAL ASSISTANCE PROGRAM**

***Provider EDI Enrollment Application***

**Colorado Medical Assistance Program**
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

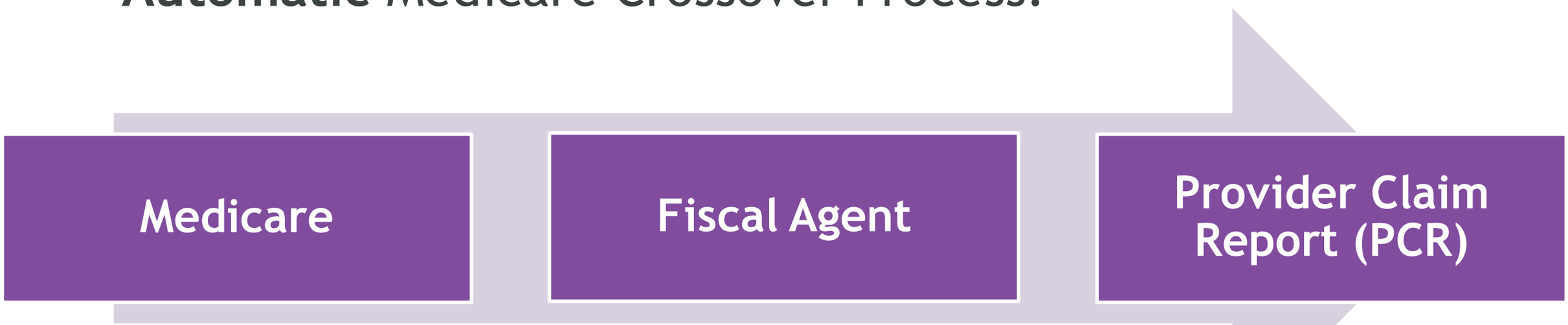
**Providers must be enrolled with EDI to:**

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
  - Select Provider Application for EDI Enrollment

Colorado.gov/hcpf/EDI-Support

# *Crossover Claims*

**Automatic** Medicare Crossover Process:




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

# *Crossover Claims*

**Provider** Submitted Medicare Crossover Process:

- **Additional Information:**
  - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - Crossovers may be submitted on paper or electronically
  - Provider must submit copy of Standard Paper Remittance Advice (SPR) with paper claims
  - Provider must retain SPR for audit purposes

# *Payment Processing Schedule*

**Mon.**

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

**Tue.**

**Wed.**

- Paper remittance statements & checks dropped in outgoing mail

**Thur.**

- EFT payments deposited to provider accounts

**Fri.**

- Weekly claim submission cutoff

**Sat.**

- Fiscal Agent processes submitted claims & creates PCR

# *Electronic Funds Transfer (EFT)*

## Advantages

- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- Colorado.gov/hcpf/provider-forms → Other Forms

# *PARs Reviewed by ColoradoPAR*

- 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®, vision, audiology and behavioral therapy
  - Please note: for the above categories, all PARs for members age 20 and under are reviewed according to EPSDT guidelines
  - 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 only if provider fills out the eQSuite® Exception Request Form and has been granted an exception from using eQSuite® when:
  - Provider is out-of-state, or the request is for an out-of-area service
  - Provider submits, on average, five or fewer PARs per month and would prefer to submit a PAR by telephone or facsimile
  - Provider is visually impaired

# *PAR Letters/Inquiries*

- Final PAR determination letters are mailed to members and providers by the Department's fiscal agent
- Letter inquiries should be directed to the fiscal agent, not ColoradoPAR
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the fiscal agent
  - ensure you have the right PAR type
    - e.g. Medical PAR may have been requested but processed as a Supply PAR

# *Transaction Control Number*

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

**Batch Number**

**Document Number**

**0 15 129 00 150 0 00037**

**Year of Receipt**

**Julian Date of Receipt**

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

# *Timely Filing*

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

# *Timely Filing*

**From "through" DOS**

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

**From delivery date**

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

**From DOS** | FQHC Separately Billed and additional Services

# *Documentation for Timely Filing*

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)

# *Timely Filing*

## Medicare/Medicaid Enrollees

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

# *Timely Filing Extensions*

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

# *Timely Filing Extensions*

## Commercial Insurance

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

# *Timely Filing Extensions*

## Delayed Notification

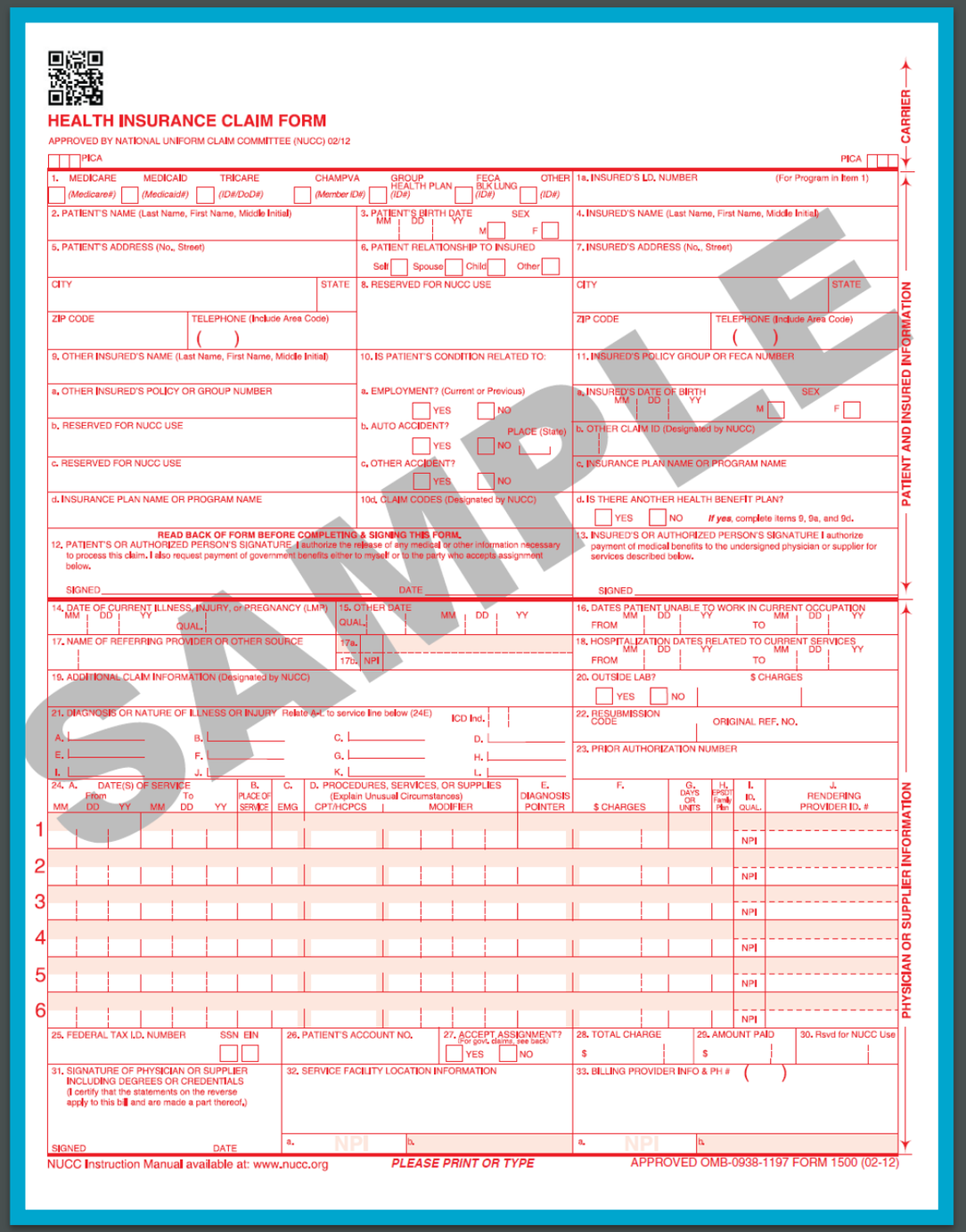
- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility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

# *Timely Filing Extensions*

## Backdated Eligibility

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

# CMS 1500



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

*PLEASE PRINT OR TYPE*

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

# *CMS 1500*

## What Audiology services can be billed on the CMS 1500?

Follow-up Newborn hearing Testing

Cochlear Implants

Hearing Aids

# *Audiology Benefits*

- Hearing benefits are limited to the minimum services required to meet the member's medical needs
  - See Volume 8.280.06
- Hearing aids for children ages 20 and under
- Softband hearing aids (bone anchored hearings aids) for children ages 20 and under
- Speech therapy, hearing exams, diagnostic testing, surgeries and related hospitalizations are regular benefits
- Services are generally limited by age
  - Members 20 years old and younger and adults part of the Supported Living Services (SLS) waiver
  - With exceptions of Cochlear Implants, which require prior authorization
- Reimbursement for newborn hearing screens is included in the hospital delivery payment
- Separate follow-up testing for a newborn that has failed initial screening is reimbursable to the practitioner

# *Audiology Benefits*

- Non-Covered Benefits for Adults ages 21 and over:
  - Hearing aids and ear molds for the purpose of noise reduction and swimming and hearing aid insurance are not a benefit
  - Exams and evaluations are a benefit only when a concurrent medical condition exists

- For more information on audiology services refer to the Audiology Billing Manual at:
  - www.colorado.gov/hcpf/billing-manuals

# *Hearing Aids*

- Trial Rental Period is included in the purchase reimbursement for the hearing aid(s)
  - Use the last day of the rental period as the date of service
- Hearing Aids may be replaced if:
  - Improperly fit
  - Have been lost or stolen
  - Are no longer medically appropriate for the child
- Hearing aids are expected to last three to five years
- Hearing aid batteries are a benefit
  - Only for members ages 20 and younger

# *Procedure Codes*

- Hearing “packages” are no longer used
- Individual services may require prior authorization
  - See fee schedule
- Services must be submitted for payment using HCPCS and CPT codes
- Providers should bill their usual and customary charges
- Hearing aids cannot be billed as a pair
  - Each individual hearing aid must be billed on separate lines with appropriate left and right modifier
  - One unit per line maximum

# *Colorado Home Intervention Program (CHIP)*

- Outreach service of the Early Education Department of the Colorado School for the Deaf and the Blind (CSDB)
- Provides services in the home to children:
  - From newborn to preschool
  - Who are deaf or hard of hearing
    - Newborns identified with a hearing loss diagnosed from an audiologist receive further assessment and therapy services
- Reimbursable Medicaid benefit
- CHIP has many participating providers, including:
  - Audiologists and speech and language pathologists
  - Teachers of the deaf and hard of hearing

# *Colorado Home Intervention Program (CHIP)*

- Medicaid benefit services provided under this program
  - Do not require Prior Authorization
- Services providers must be Medicaid enrolled
- All provider enrollment and claims submission requirements apply
- Bill using procedure codes:
  - 96111, 96115, 99341, 92521, 92522, 92523, 92524, 96105 and V5011
- For more information:
  - Visit the CSDB Website: www.csdb.org
- For NCCI (National Correct Coding Initiative) edits on these codes:
  - www.Colorado.gov/pacific/hcpf/provider-implementations

# *Colorado Hearing Resource Regional Coordinators*

- Sponsored by:
  - The Department of Public Health and Environment (CDPHE)
  - The Department of Education (DOE)
- Ten regional coordinators throughout the state
- Coordinators work with audiologists and families to match children with hearing loss to the appropriate CHIP therapist
- CO-Hear coordinators provide technical assistance for:
  - Hearing loss, amplification and language assessment
  - Family-centered intervention for professionals, agencies and families
- For more information, visit:
  - www.cohandandvoices.org/resources/coguide/11_cohears.htm

# *Health Care Program*

- For children with special needs
- Audiology Regional Coordinators provide:
  - Consultation information
  - Technical assistance
  - Referral services to families of children with special health care needs
- For more information:
  - www.cdphe.state.co.us

# *Common Denial Reasons*

| | |
|---|---|
| **Timely Filing** | Claim was submitted more than 120 days without a LBOD |
| **Duplicate Claim** | A subsequent claim was submitted after a claim for the same service has already been paid |
| **Bill Medicare or Other Insurance** | Medicaid is always the “Payer of Last Resort” - Provider should bill all other appropriate carriers first |

# *Common Denial Reasons*

| | |
|---|---|
| **PAR not on file** | No approved authorization on file for services that are being submitted |
| **Total Charges invalid** | Line item charges do not match the claim total |

# *Claims Process - Common Terms*

## Reject

Claim has primary data edits – **not** accepted by claims processing system

## Denied

Claim processed & denied by claims processing system

## Accept

Claim accepted by claims processing system

## Paid

Claim processed & paid by claims processing system



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

# *Claims Process - Common Terms*

## Adjustment

Correcting under/overpayments, claims paid at zero & claims history info

## Rebill

Re-bill previously denied claim

## Suspend

Claim must be manually reviewed before adjudication

## Void

“Cancelling” a “paid” claim (wait 48 hours to rebill)



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

# *Adjusting Claims*

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

## Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

## Do not adjust when

- Claim was denied
- Claim is in process
- Claim is suspended

# Adjustment Methods

## Web Portal

- Preferred method
- Easier to submit & track

## Paper

- Complete field 22 on the CMS 1500 claim form



From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Paper" by Kristina

# *Provider Claim Reports (PCRs)*

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal

# *Provider Claim Reports (PCRs)*

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

# Provider Claim Reports (PCRs)

## Paid

* CLAIMS PAID *

| INVOICE NUM | CLIENT NAME | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SVC FROM | DATES OF SVC TO | TOTAL CHARGES | ALLOWED CHARGES | COPAY PAID | AMT OTH SOURCES | CLM PMT AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|
| 7015 | CLIENT, IMA | Z000000 | 040800000000000001 | 040508 | 040508 | 132.00 | 69.46 | 2.00 | 0.00 | 69.46 |
| PROC CODE - MODIFIER 99214 - | | | | 040508 | 040508 | 132.00 | 69.46 | 2.00 | | |

TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46

## Denied

* CLAIMS DENIED *

| INVOICE NUM | CLIENT NAME | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SERVICE FROM | DATES OF SERVICE TO | TOTAL DENIED | DENIAL REASONS ERROR CODES |
|---|---|---|---|---|---|---|---|
| STEDOTCCIOT | CLIENT, IMA | A000000 | 30800000000000003 | 03/05/08 | 03/06/08 | 245.04 | 1348 |

TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

# Provider Claim Reports (PCRs)

**Adjustments**

**Recovery**

**Repayment**

**Net Impact**

**********

* ADJUSTMENTS PAID *

**********

| INVOICE NUM | --- CLIENT ------ NAME ------- | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SVC FROM | TO | ADJ RSN | TOTAL CHARGES | ALLOWED CHARGES | COPAY PAID | AMT OTH SOURCES | CLM PMT AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Z71 | CLIENT, IMA | A000000 | 40800000000100002 | 041008 | 041808 | 406 | 92.82- | 92.82- | 0.00 | 0.00 | 92.82- |
| PROC CODE - MOD T1019 - U1 | | | | 041008 | 091808 | | 92.82- | | | | |
| Z71 | CLIENT, IMA | A000000 | 40800000000200002 | 041008 | 041808 | 406 | 114.24 | 114.24 | 0.00 | 0.00 | 114.24 |
| PROC CODE - MOD T1019 - U1 | | | | 041008 | 041008 | | 114.24 | | | | |
| | | | | | | NET IMPACT | 21.42 | | | | |

**Voids**

**********

* ADJUSTMENTS PAID *

**********

| INVOICE – NUM | CLIENT ------ NAME ------- | STATE ID | TRANSACTION CONTROL NUMBER | DATES OF SVC FROM | TO | ADJ RSN | TOTAL CHARGES | ALLOWED CHARGES | COPAY PAID | AMT OTH SOURCES | CLM PMT AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A83 | CLIENT, IMA | Y000002 | 40800000000100009 | 040608 | 042008 | 212 | 642.60- | 642.60- | 0.00 | 0.00 | 642.60- |
| PROC CODE - MOD T1019 - U1 | | | | 040608 | 042008 | | 642.60- | 642.60- | | | |
| | | | | | | NET IMPACT | 642.60- | | | | |

# *Provider Services*

| Xerox<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!*