

# *Beginning Billing Workshop*

## *Hospice*

Colorado Medicaid  
2016



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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 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.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProidentStand/index.html?redirect=/nationalprovidentstand/](http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProidentStand/index.html?redirect=/nationalprovidentstand/)
  - National Plan and Provider Enumeration System (NPPES)-
    - [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY



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# 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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# 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 'Provider Home Page' of the Colorado Department of Health Care Policy & Financing. The page has a blue header with the text 'The Official Web Portal' and a 'Translate' button. The main content area features the department's logo and name. A navigation menu is located below the header, with 'For Our Providers' selected. The 'For Our Providers' section is titled and contains four main categories, each with an icon and a brief description. Below these categories are six quick links, each with a mouse cursor icon and a label: 'CBMS Colorado Benefits Mgmt. System', 'DDweb', 'Web Portal', 'Get Help', 'Get Info', and 'Find a Doctor'.



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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

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



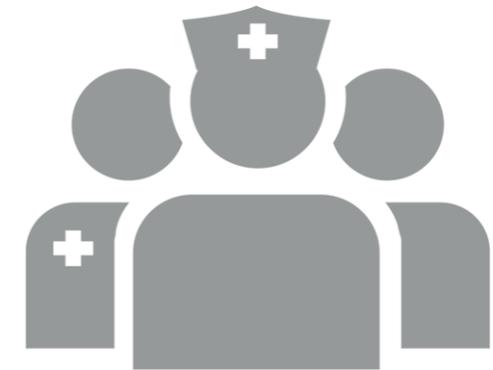
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# *Attending Versus Billing*

## **Attending Provider**

Individual that provides services to a Medicaid member



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## **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:



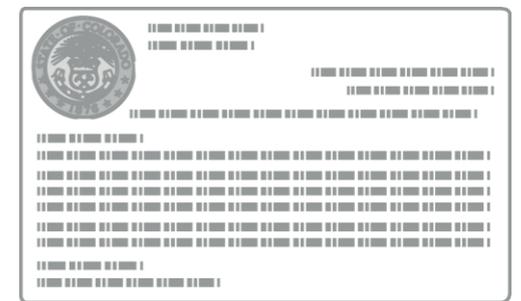
Colorado Medical  
Assistance Web Portal



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: 800-237-0751

---

**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

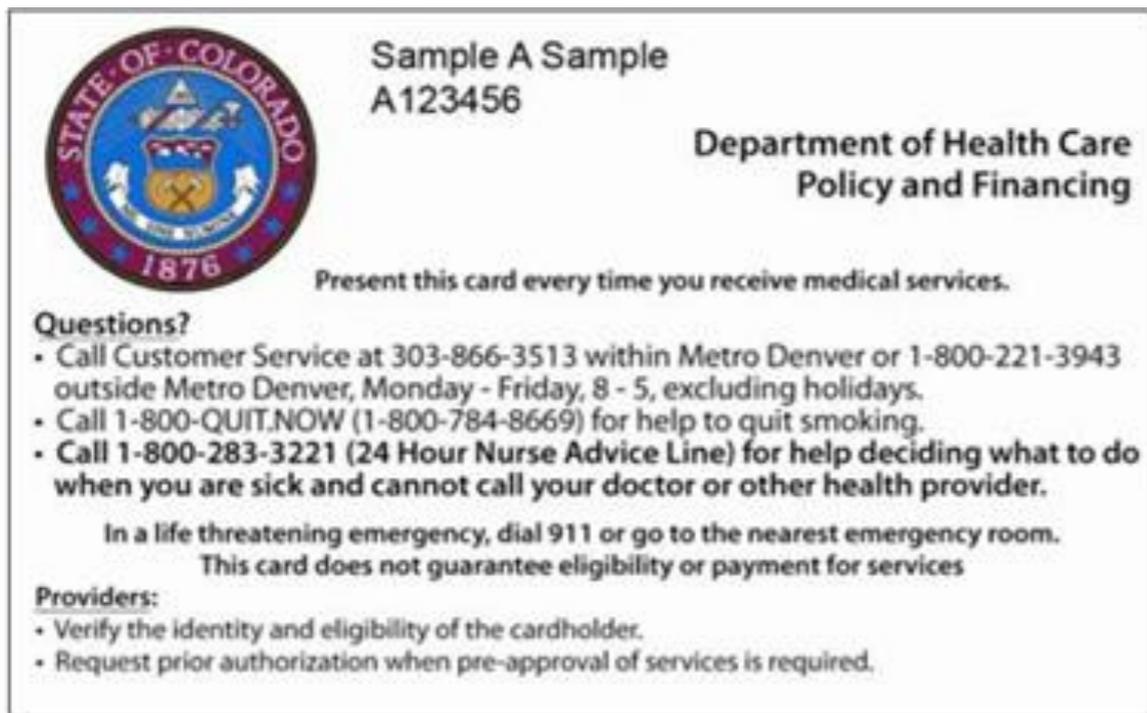
## Reminder:

- 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



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# *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



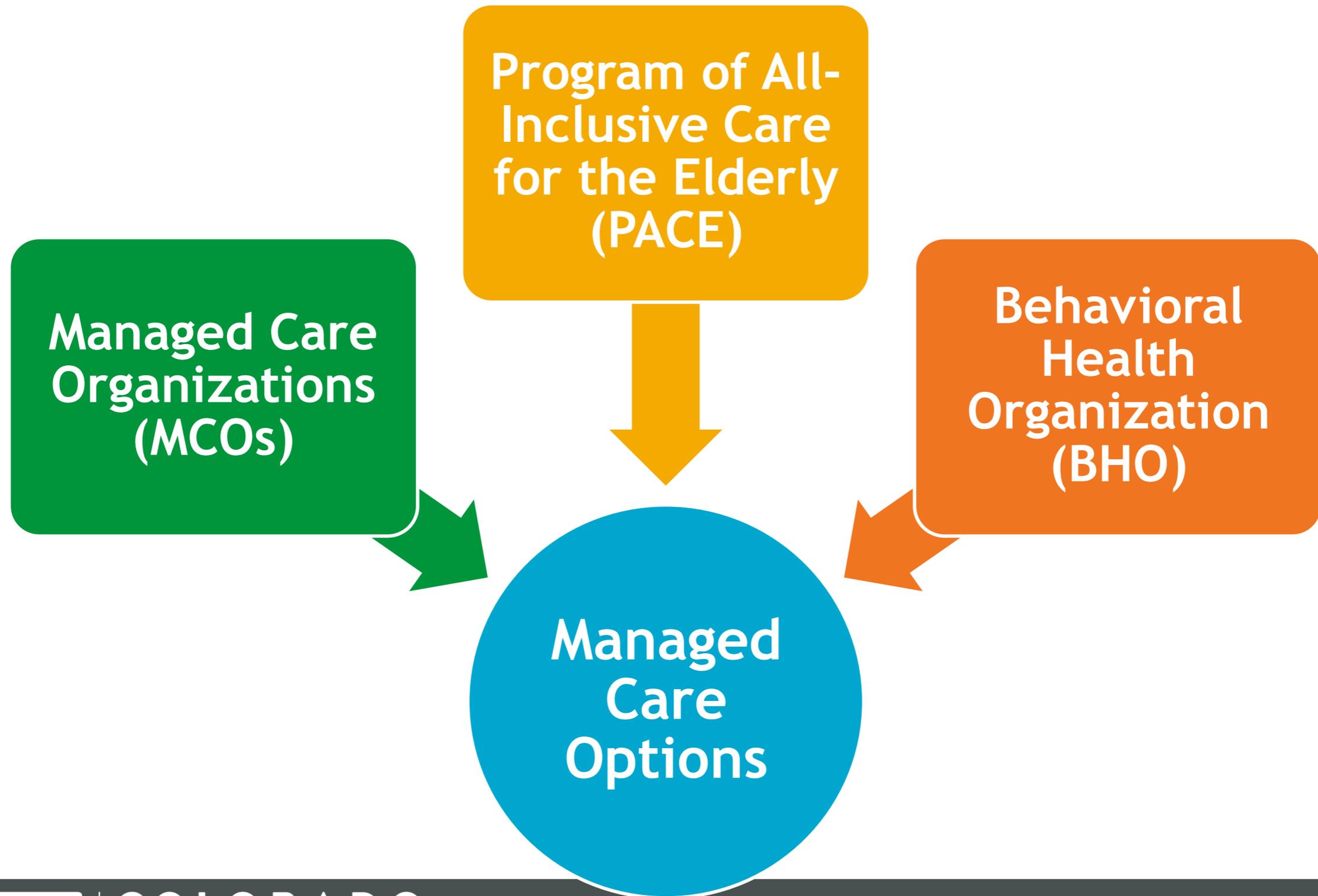
# *Eligibility Types*

## 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



# 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



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# *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 Fee-for-Service

## Accountable Care Collaborative (ACC)

- All ACC members are Fee-for-Service members
- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
  - Connects Medicaid members to:
    - Care management and navigation support from RCCOs
    - Connects members to a medical home
    - Access to education and special programs
    - Help with non-medical community resources
- 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 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



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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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# *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



# 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



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# Providers Not Enrolled with EDI



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## **COLORADO** MEDICAL ASSISTANCE PROGRAM

*Provider EDI Enrollment Application*

Colorado Medical Assistance Program  
PO Box 1100  
Denver, Colorado 80201-1100  
1-800-237-0767  
[colorado.gov/hcpf](http://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

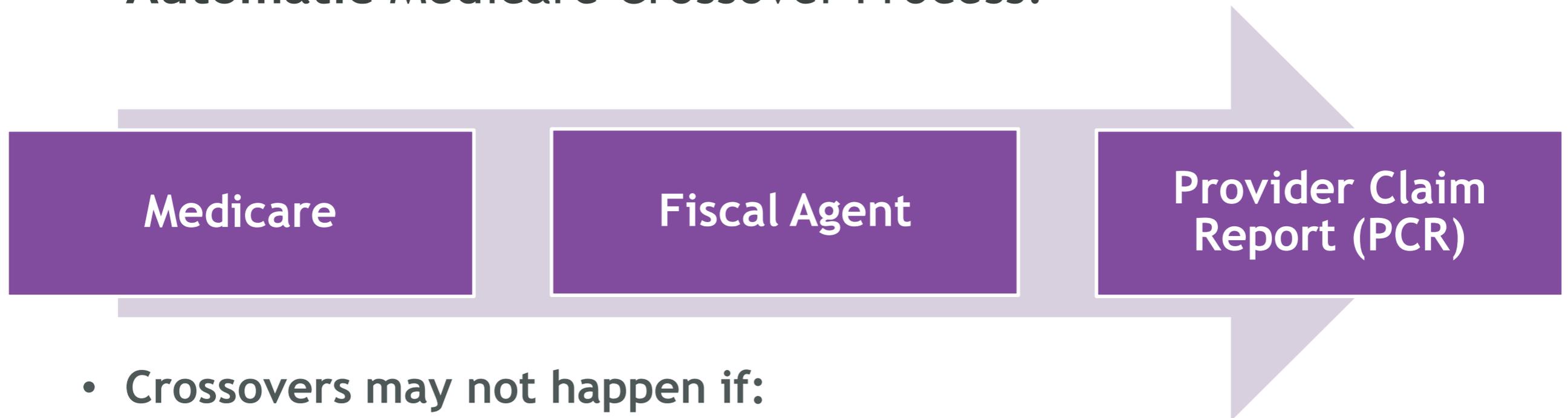
[Colorado.gov/hcpf/EDI-Support](http://Colorado.gov/hcpf/EDI-Support)



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# Crossover Claims

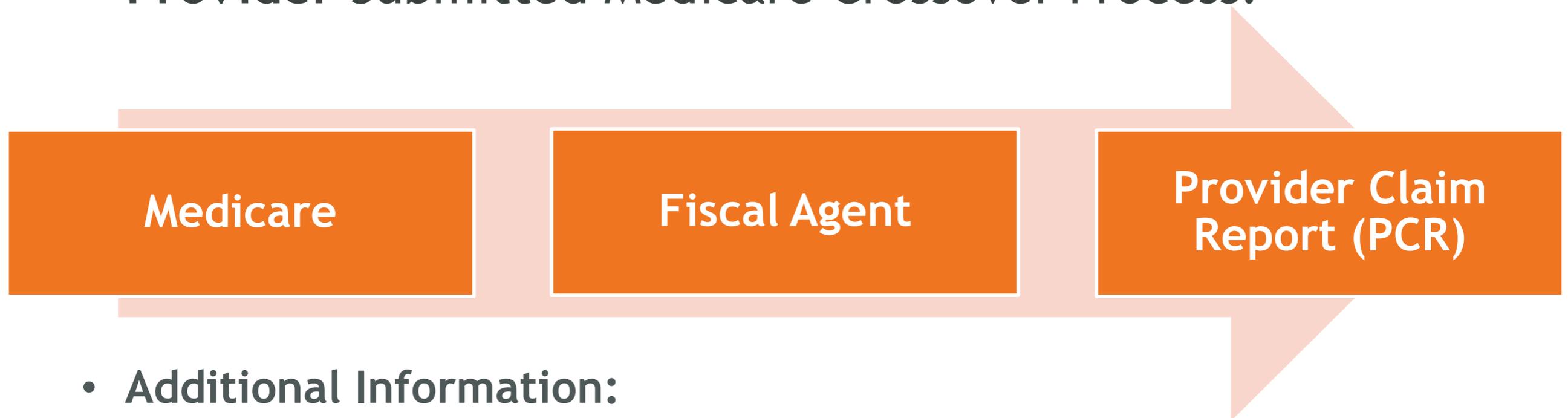
## Automatic Medicare Crossover Process:



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

# Crossover Claims

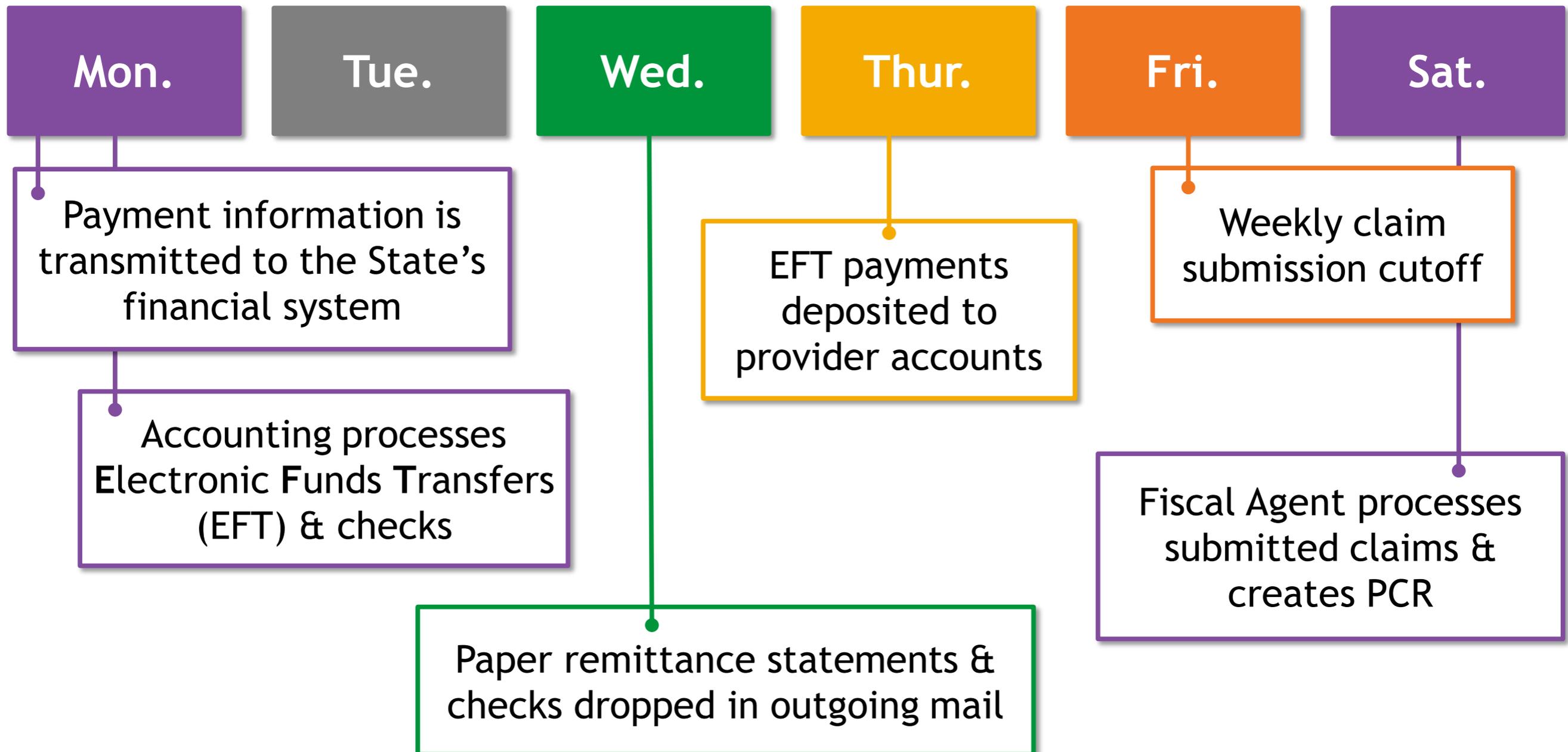
## Provider Submitted Medicare Crossover Process:



- **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

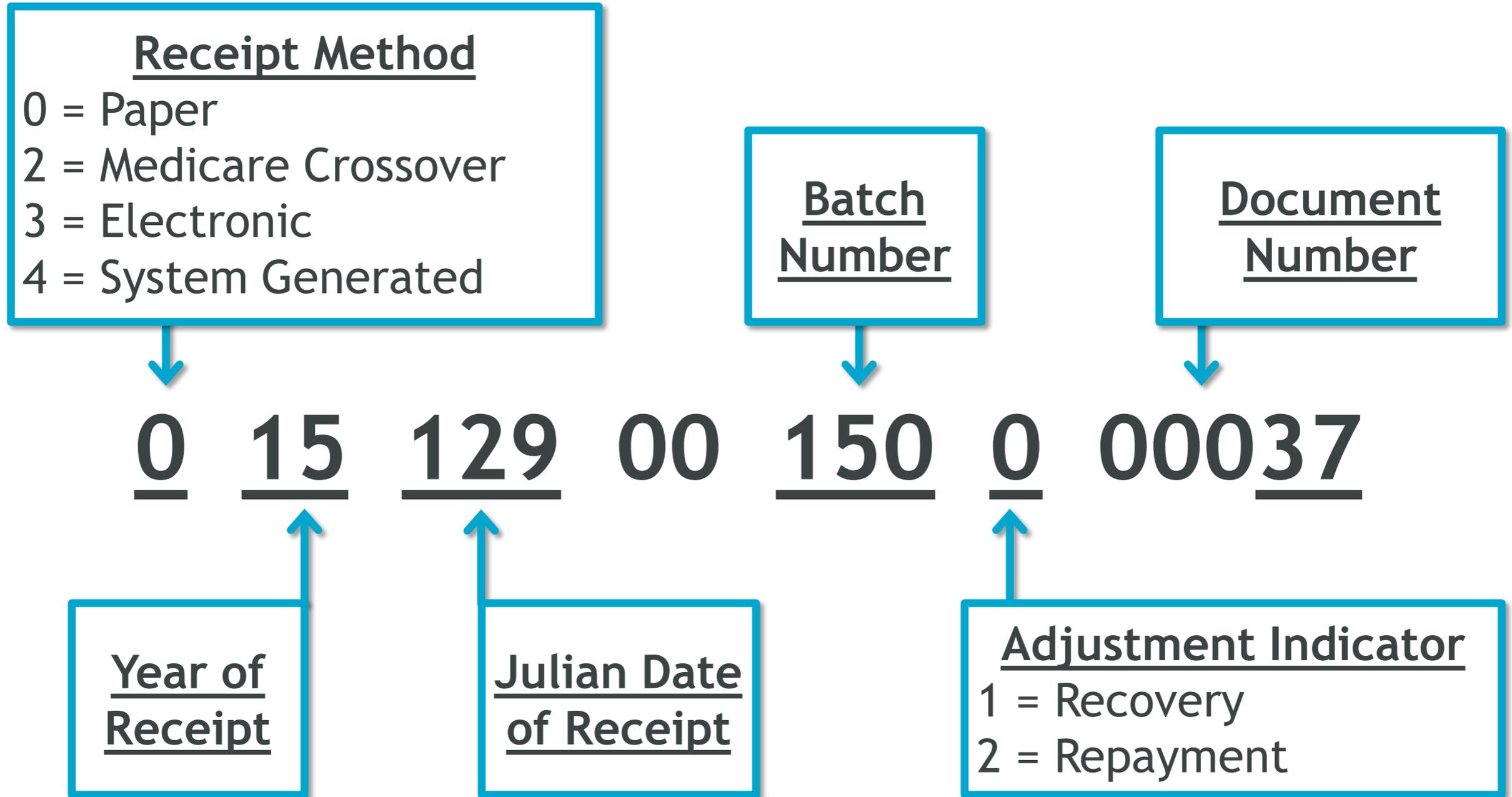


# *Electronic Funds Transfer (EFT)*

## Advantages

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



# *Timely Filing*

Medicare/Medicaid Enrollees

Medicare pays claim

120 days from Medicare  
payment date

Medicare denies claim

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



# *Hospice*

- Hospice services are available to Medical Assistance Program members with a terminal illness
  - Life expectancy of nine (9) months or less
  - Palliative treatments include:
    - Hospice services & interventions that are not curative
    - Provide the greatest degree of relief and comfort for symptoms of terminal illness
    - Members age 20 and under can receive curative care



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# *Hospice Members in a Nursing Facility*

- ULTC 100.2
  - Not required if member has already been determined eligible for Medicaid when hospice member enters a nursing facility (NF)
  - Required if Medicaid eligibility for hospice member is pending
  - Required if member does not have an active ULTC 100.2 & leaves hospice status and remains in NF



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# *Nursing Facility Member Pay*

- If a member passes away while residing in a NF:
  - Member pay goes to NF if member pay is equal to or less than NF charge
  - Amount is pro-rated if member pay is greater than NF charge
- Nursing Facility is responsible for collecting the member payment and Hospice rate and to report it on the claim
- Obtain member pay amount from NF and always include amount on claim



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# *Post Eligibility Treatment of Income (PETI)*

If a member does not make a member payment -  
there is No PETI!!



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# *Post Eligibility Treatment of Income (PETI)*

- Reduction of resident payment to an NF for costs of care provided to the resident for services that are:
  - Medically necessary
  - Not covered by Medicaid
- Reduced by amount that remains after certain County-approved deduction are applied, as reflected on the 5615
  - Reimbursement by Medicaid is subject to reasonable limits set by the Department



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# *To Access PETI*

All other payer sources must have been exhausted

**AND**

**Cannot be a covered Medicaid service**

**OR**

Must have Medicaid denial

(You must first submit a claim to the Colorado Medical Assistance program)

# *PETI Process Overview*

## NF or family pays provider:

- Usually done once PETI approval received

## NF reports PETI on:

- 837I
- UB-04

# *To Submit PETI Request*

- All NF PETI requests must include the following two forms:
  - Nursing Facility Post Eligibility Treatment of Income Request (NF PETI) Program form
  - NF PETI Medical Necessity Certification form
- All required signatures
- All supporting documents
- Provider statement
- Provider's invoice
- Medicaid Program denial PCR (if applicable)



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# *PETI - Submit to Fiscal Agent*

- May submit NF PETI directly to the Department's fiscal agent, without first submitting to the Department if:
  - All combined request(s) per calendar year are under \$400
  - Requested service is not an adult benefit of Medicaid per PETI fee schedule



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# *PETI - Submit to Department*

- Submit to the Department first if:
  - Charges exceeding \$400 per year and all health insurance charges must be prior authorized by Department
  - If the fee schedule notes an MP (Manually Priced) then submit to the department



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# *PETI Billing*

- Provider is not required to be enrolled in Medicaid in order to provide services to PETI-eligible residents
- Submit claims for approved NF PETI amounts on claim with:
  - Member's room and board amount
  - Member liability amount
- Claims processing system automatically completes the calculations
- PETI documentation shall be retained by NF for 6 years for audit purposes



# PETI - If...Then

**If**

Provider is requesting more than what is allowed on PETI fee schedule

**Then**

This amount must be amended to what is allowable on the PETI fee schedule

**If**

Member has medical trust

**Then**

PETI charges must be paid from medical trust

# *PETI Revenue Codes*

- 999 - Health Insurance Premiums & Other Services
  - All premiums must first be approved by State
- 962 - Vision & Eye Care
- 479 - Hearing & Ear Services
- Claims must have Accommodation Revenue Code:
  - 119 Private
    - Must be approved by Colorado Medicaid
  - 129 Semi-Private
- Claims must have a member liability



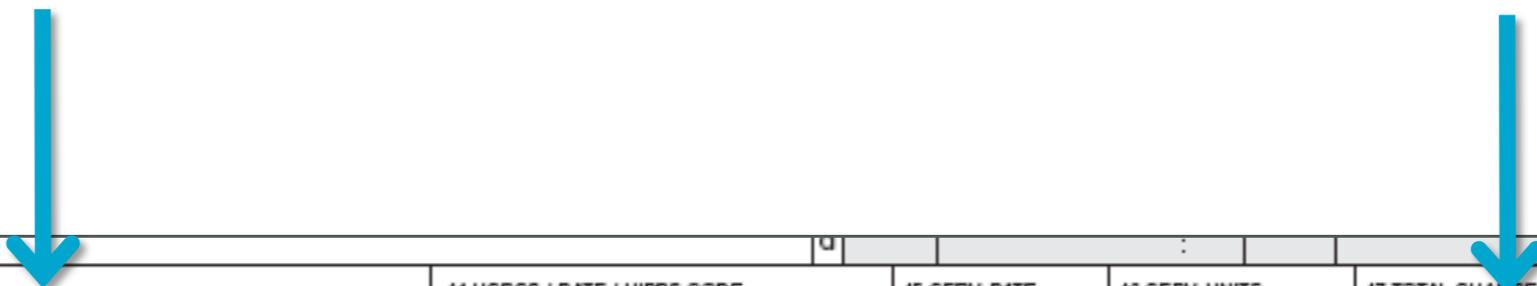
# PETI Occurrence Span Dates

- Date(s) of services rendered or insurance payments made
  - May be single dates
  - No future dates
- Span dates do not have to fall within Statement Covers Period

36	OCCURRENCE SPAN	
CODE	FROM	THROUGH
76	03/06/2015	03/06/2015

# PETI Services

- Enter approved amount paid to service providers



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 129	Semi-Private	90.05		30	2701.50		1
2 479	Hearing and Ear Care			1	35.00		2
3 962	Vision Care			1	30.00		3

# PETI Services

- Charges must be less than or equal to member payment entered for Value Code 31 (Patient Liability Amount)

39				39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	80	30:00							
b	31	103:00							
c		:							
d		:							

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Semi-Private	90.05		30	2701:50		
479	Hearing and Ear Care			1	35:00		
962	Vision Care			1	30:00		



# *Nursing Facility Contacts*

To send NF PETI requests to the Department

Nursing Facility PETI Program  
Department of Health Care Policy & Financing  
1570 Grant Street  
Denver, CO 80203  
Fax: 303.866.3991

For NF PETI related questions  
not directly related to billing  
please contact Susan Love at 303-866-4158



# *CMS 1500*

What services are billed on the CMS 1500?

**Medical Director**

**Interventions**

# UB-04

What Services are billed on the UB-04?

Hospice Routine  
Home Care

Hospice Inpatient  
Respite

Continuous Home  
Care

Hospice Physician  
Service (Visit)

# 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 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](http://Colorado.gov/hcpf/billing-manuals)**



# 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



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# UB-04 Claims Submission

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		9a PAT. CNTL # SM000123		4 TYPE OF BILL 812	
8 PATIENT NAME a Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 01/06/08 THROUGH 01/31/08	
b Anytown		c CO		d 88888		e	
10 BIRTHDATE 02/13/1980	11 SEX F	12 DATE 12/06/03		13 HR	14 TYPE	15 SRC	16 DHI
17 STAT 30		18		19	20	21	22
23		24	25	26	27	28	29 ACDT STATE
30		31		32		33	
34		35		36		37	
31 OCCURRENCE CODE 27	32 OCCURRENCE DATE 01/01/08	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	38 OCCURRENCE DATE

Occurrence Code 27  
Hospice plan established

30 - Still patient  
40 - Expired at home  
41 - Expired - SNF/other facility  
42 - Expired - Place unknown



# UB-04 Claims Submission

Rev Codes  
calculated  
in days

- 651
- 655
- 656
- 659

Rev Codes  
calculated  
in hours

- 652

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		01/06/08	8	624.00		1
652	Hospice Continuous Home Care		01/18/08	24	480.00		2
652	Hospice Continuous Home Care		01/19/08	16	320.00		3
652	Hospice Continuous Home Care		01/20/08	8	160.00		4
655	Hospice Inpatient Respite		01/21/08	3	249.00		5
656	Hospice General Inpatient Care		01/24/08	1	350.00		6
651	Hospice Routine Home Care		01/25/08	9	702.00		7
659	Nursing Facility R & B Per Diem		01/06/08	20	1100.00		8



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# UB-04 Claims Submission

MMIS makes all claim calculations

- Bill full \$100.00
- (per diem rate) amount
- Reimbursement for rev code 659 is calculated (systematically) at 95% of NF per diem, minus patient payment

38	39	40	41
CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT
31	500.00		

42	43	44	45	46	47	48
REV. CD.	DESCRIPTION	HOSPIS / RATE / HIPPB CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NONCOVERED CHARGES
651	Hospice Routine Home Care		01/01/08	31	3500.00	
659	Nursing Facility R & B Per Diem		01/01/08	31	3100.00	

**Patient Liability**

PAGE 1 OF 1		CREATION DATE	TOTALS
			6600.00

50	51	52	53	54	55	56	57
PAYER NAME	HEALTH PLAN ID	REFL	INSUR. ID	PRIOR PAYMENTS	EST. AMOUNT DUE	NPI	ST
D - Medicaid	12345678				6100.00		

**Est. Amount Due  
Total Charges - Patient Liability**

58	59	60	61	62	63	64	65	66	67	68	69	70
INSURER NAME	REFL	INSURER'S UNIQUE ID	GROUP NAME	INSURANCE GROUP NO.	TREATMENT AUTHORIZATION CODES	DOCUMENT CODE	ADMIT DX	PATIENT REASON EX	PPS CODE	RCI	ATTENDING NPI	QUAL ID
Client, Ima D.		A123456					1534	1974	492		87654321	10

74	75	76	77	78	79	80
PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	ATTENDING NPI	OPERATING NPI	OTHER NPI	OTHER NPI	REMARKS
		87654321				

**SNF Provider ID**



# *UB-04 Claims Submission*

- Common Billing Issues
  - Hospice units of service are invalid if:
    - More than 5 days of respite care (655) is billed
    - Less than 8 or more than 24 hours of continuous home care (652) are billed on single date
  - Units greater than total days
    - Units of service total more than statement covered days
  - Reimbursement for NF residents is made for services delivered up to the date of discharge when the member is discharged, alive or deceased, including applicable per diem payment for the date of discharge



# *Date of Death*

- Payment is made for date of death and day of discharge (DOD)
  - Home care rate applies if discharge is from general or respite inpatient care
    - Unless member dies at an inpatient level of care
    - Inpatient level of care - the applicable general or respite rate is paid for discharge rate



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# *Date of Death*

- Payment for NF residents is made for services delivered up to date of discharge (alive or deceased)
  - Includes applicable per diem payment for DOD
- For the month of the member's death, the following are allowable
  - Durable medical rental equipment
  - Oxygen

# *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

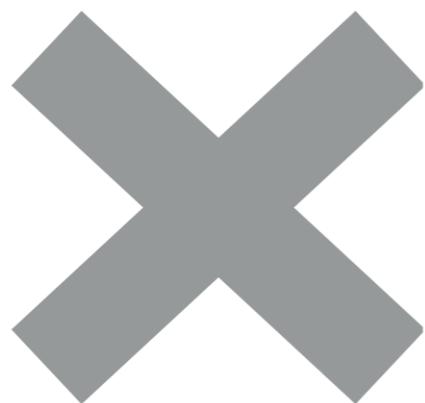
**Total Charges invalid**

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

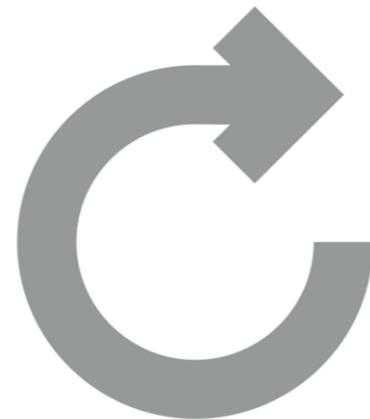
Claim processed & paid by claims processing system

# Claims Process - Common Terms



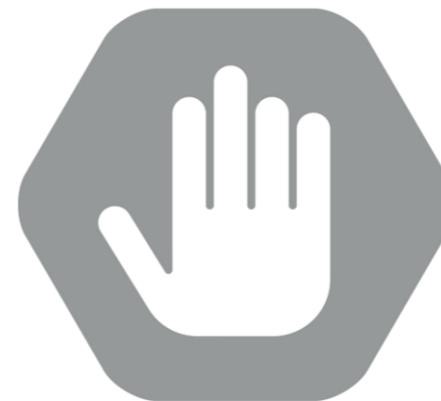
## Adjustment

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



# *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



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# 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

Updating existing provider profile

**CGI**  
1-888-538-4275

Email [helpdesk.HCG.central.us@cgi.com](mailto: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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