Beginning Billing Workshop Hospice

Health First Colorado (Colorado's Medicaid Program)
2016

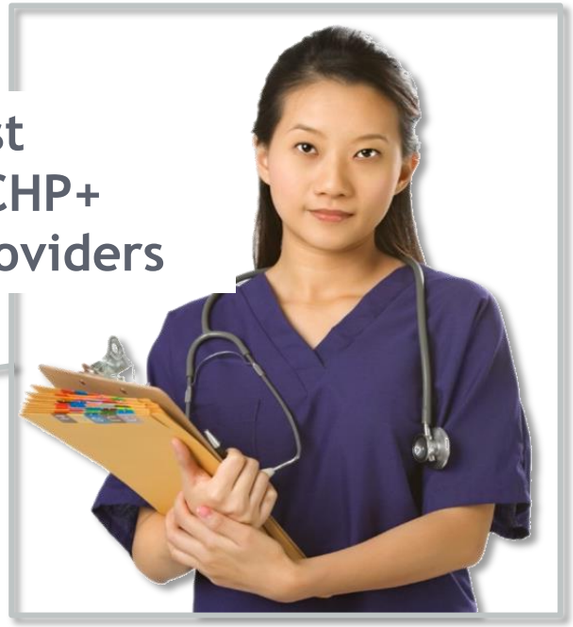
COLORADO
Department of Health Care Policy & Financing

Centers for Medicare & Medicaid Services

Xerox State Healthcare

COLORADO
Department of Health Care Policy & Financing

Health First Colorado/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

Provider Home Page

Find what you need here

Contains important information regarding Health First Colorado & 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:

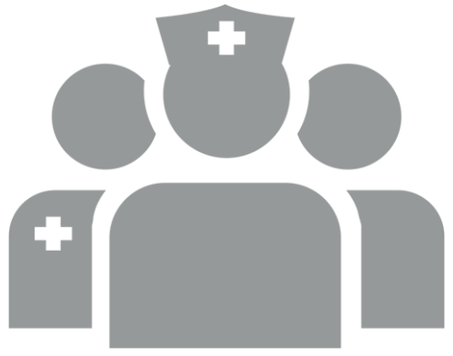
Everyone who provides services for Medical Assistance Program members

- 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 Health First Colorado 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

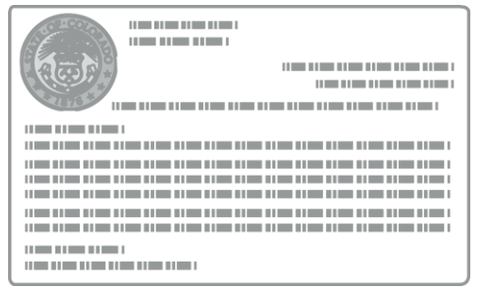
Verifying Eligibility

- 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



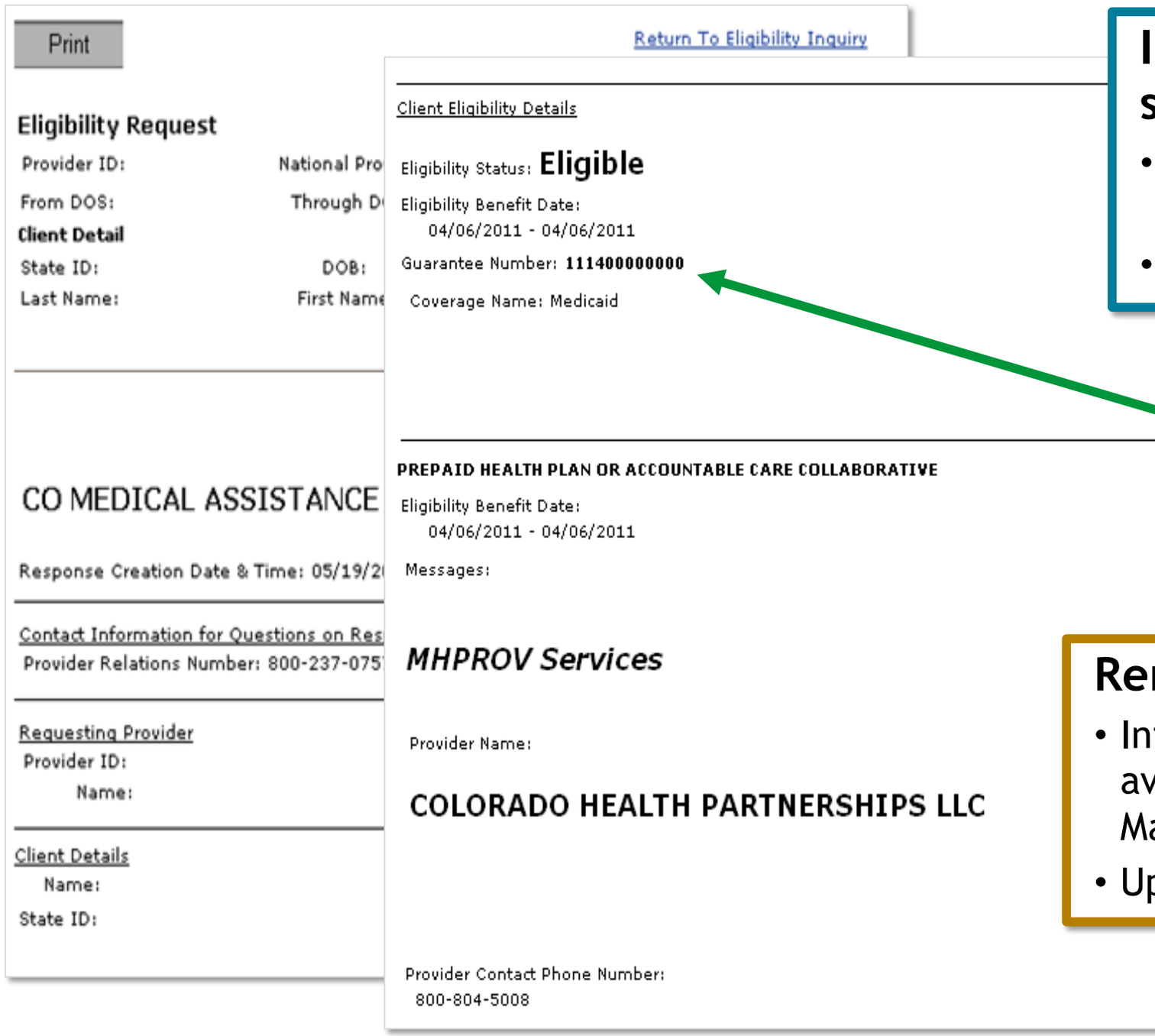
Health First Colorado ID Card with Switch Vendor

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:

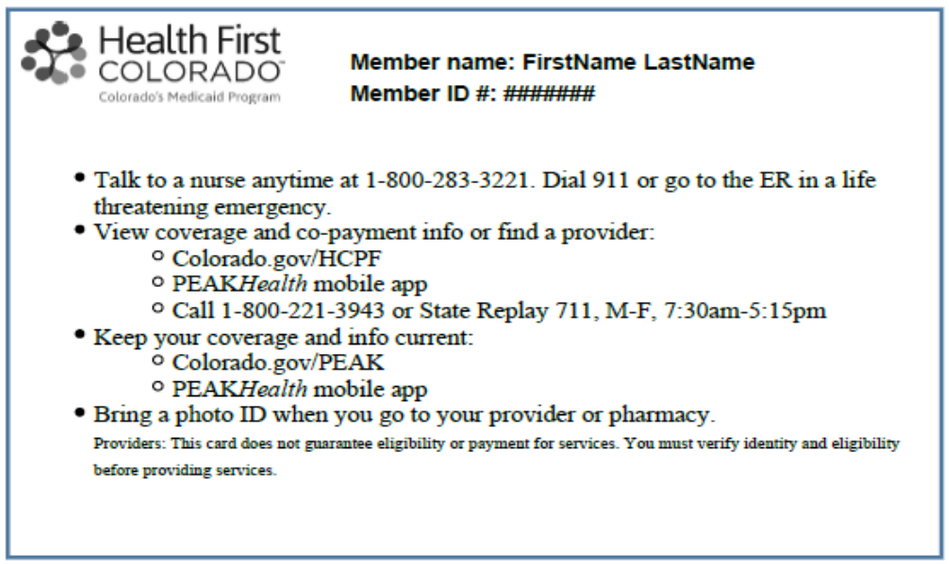
- Print copy of response for member's file when necessary

Reminder:

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

Health First Colorado Identification Cards

- Provider may begin seeing the newly branded cards as early as March 20, 2016


Health First COLORADO
Colorado's Medicaid Program

Member name: FirstName LastName
Member ID #: #######

- Talk to a nurse anytime at 1-800-283-3221. Dial 911 or go to the ER in a life threatening emergency.
- View coverage and co-payment info or find a provider:
  - Colorado.gov/HCPF
  - PEAK*Health* mobile app
  - Call 1-800-221-3943 or State Replay 711, M-F, 7:30am-5:15pm
- Keep your coverage and info current:
  - Colorado.gov/PEAK
  - PEAK*Health* mobile app
- Bring a photo ID when you go to your provider or pharmacy.

Providers: This card does not guarantee eligibility or payment for services. You must verify identity and eligibility before providing services.

- Older branded 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 Health First Colorado (Colorado's Medicaid Program) 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

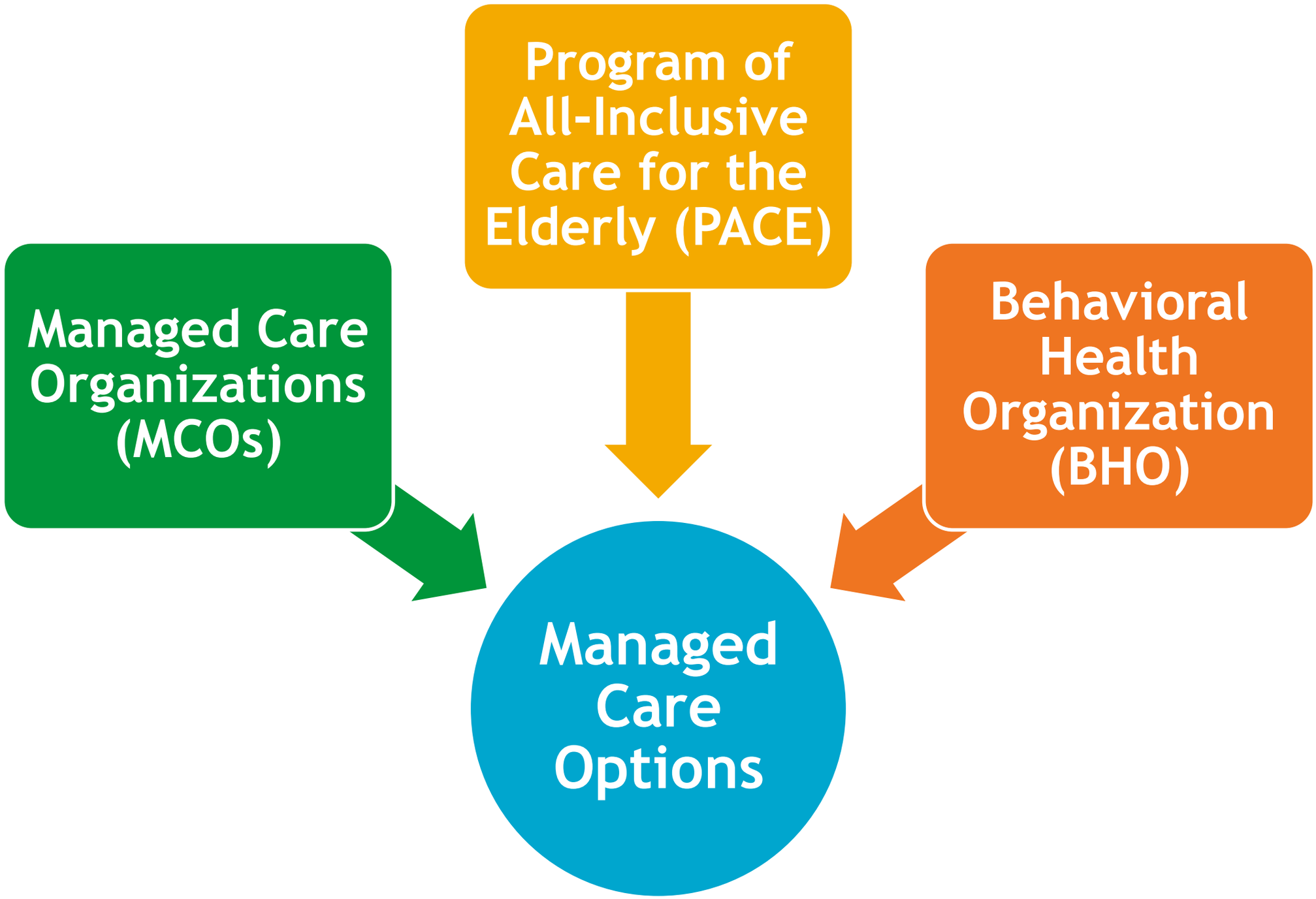
- Temporary coverage of Health First Colorado (Colorado's Medicaid Program) or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Health First Colorado Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other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

Eligibility Types

Presumptive Eligibility (cont.)

- Verify Health First Colorado Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Health First Colorado 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 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

Managed Fee-for-Service

Accountable Care Collaborative (ACC)

- All ACC members are Fee-for-Service members
- Connects Health First Colorado members to:
  - Regional Care Collaborative Organization (RCCO)
  - Health First Colorado Providers
  - Connects Health First Colorado 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

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 Health First Colorado co-pay
- Covers any service covered by Medicare
  - QMB Medicaid (QMB+)- members also receive Health First Colorado benefits
  - QMB Only- members do not receive Health First Colorado benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare

Medicare-Health First Colorado Enrollees

- Eligible for both Medicare & Health First Colorado
- Formerly known as “Dual Eligible”
- Health First Colorado is always payer of last resort
  - Bill Medicare first for Medicare-Health First Colorado Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denials(s) for six years

Third Party Liability

- Health First Colorado (Colorado's Medicaid Program) 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

- Health First Colorado 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

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

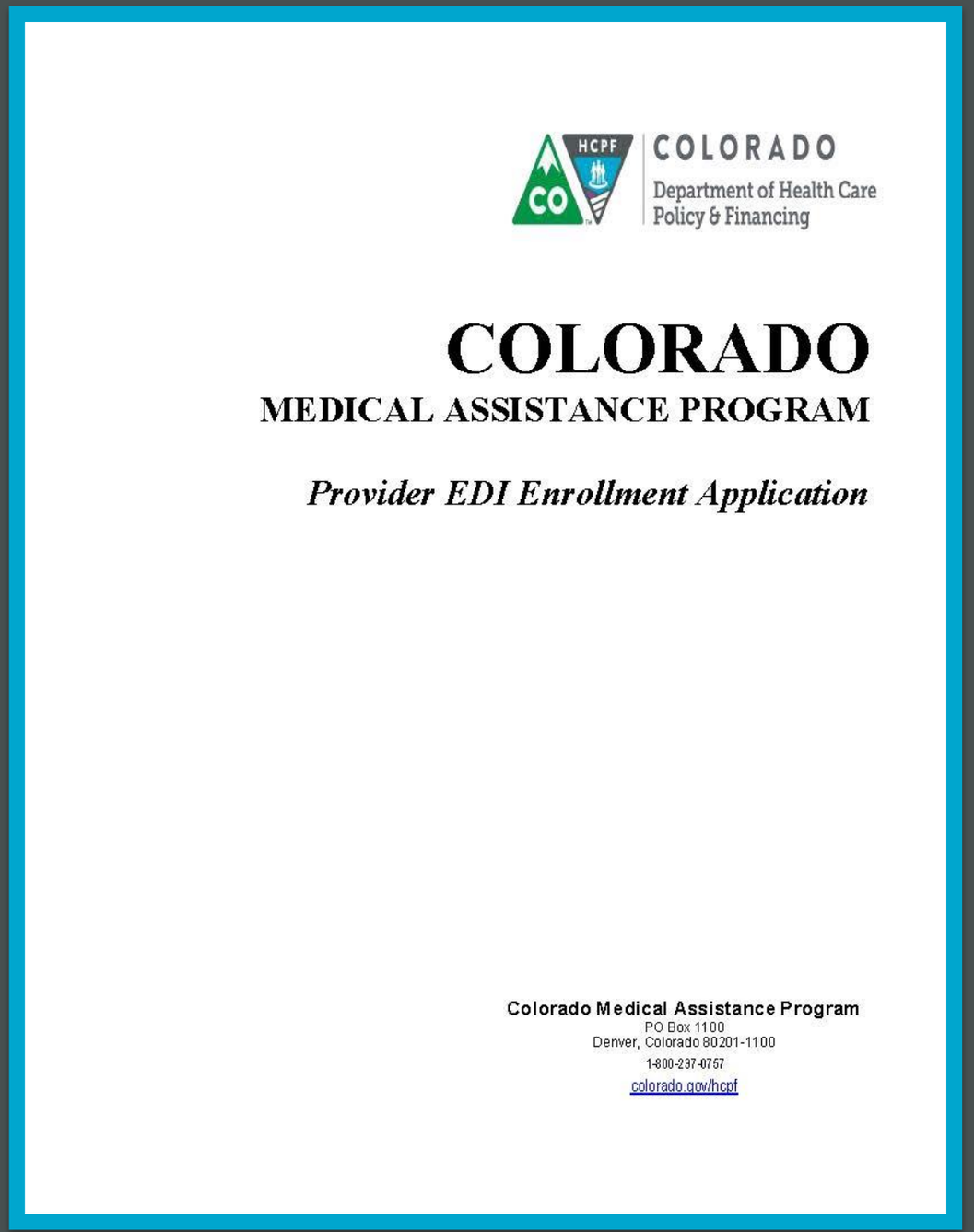
Submitting Claims

- 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

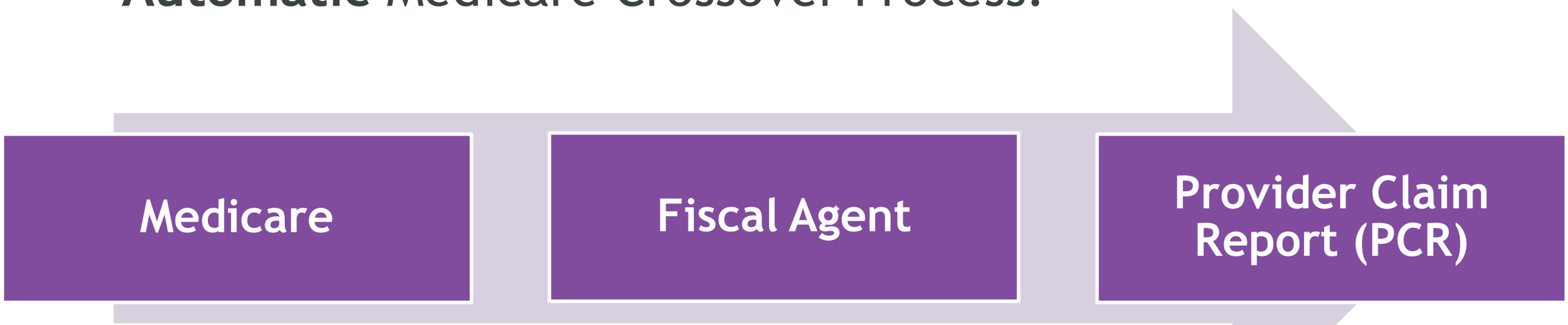
Providers must be enrolled with EDI to:

- 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

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

Transaction Control Number

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

Batch Number

Document Number

0 16 129 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/Health First Colorado 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 Health First Colorado
    - 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

Hospice Members in a Nursing Facility

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

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

Post Eligibility Treatment of Income (PETI)

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

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 Health First Colorado
- Reduced by amount that remains after certain County-approved deduction are applied, as reflected on the 5615
  - Reimbursement by Health First Colorado is subject to reasonable limits set by the Department

To Access PETI

All other payer sources must have been exhausted

AND

Cannot be a covered Health First Colorado service

OR

Must have Health First Colorado 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

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

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
- Health First Colorado Program denial PCR (if applicable)

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 Health First Colorado per PETI fee schedule

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

PETI Billing

- Provider is not required to be enrolled in Health First Colorado 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	Then
Provider is requesting more than what is allowed on PETI fee schedule	This amount must be amended to what is allowable on the PETI fee schedule
Member has medical trust	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 Health First Colorado
  - 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?

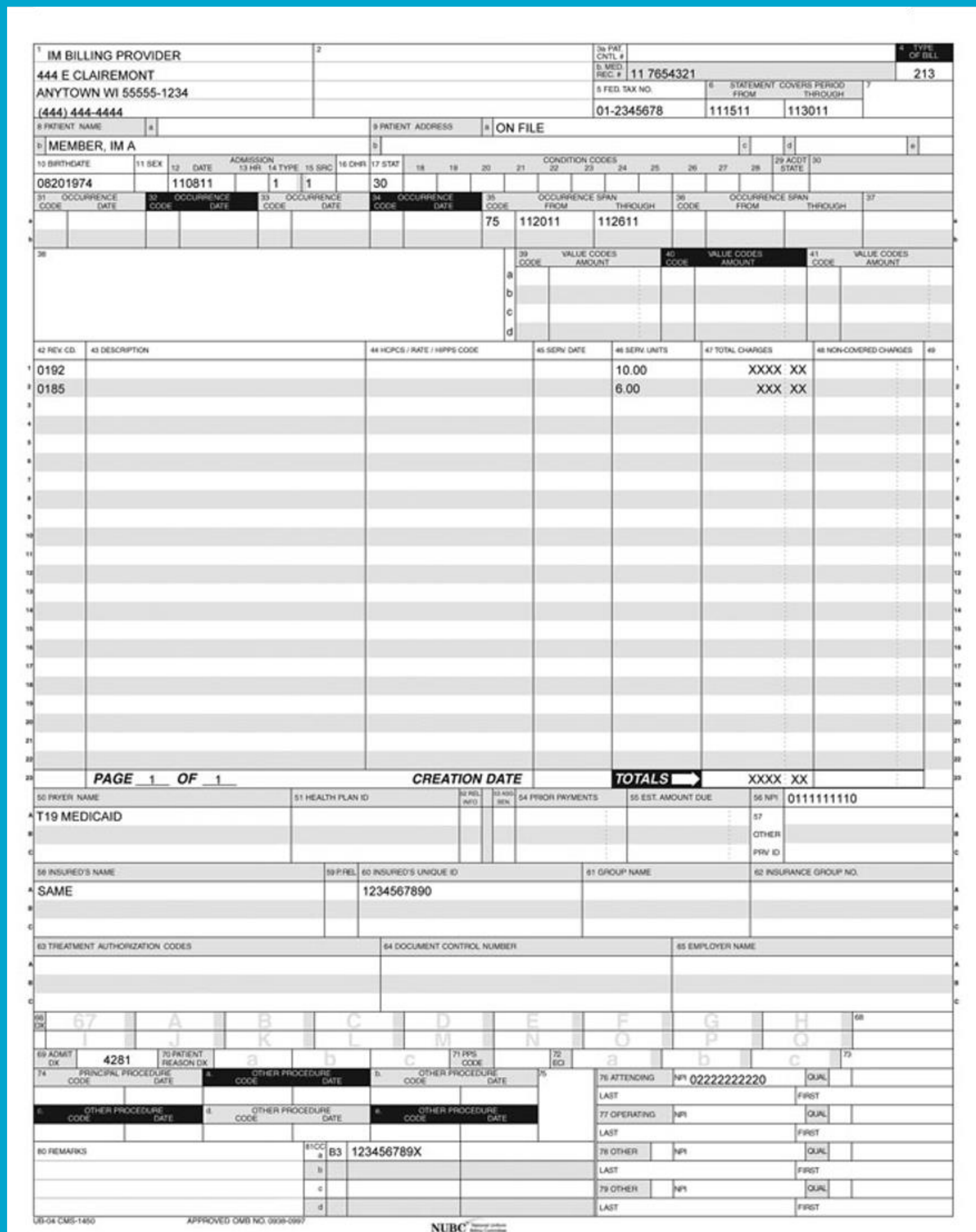
Hospice Routine Home Care

Hospice Inpatient Respite

Continuous Home Care

Hospice Physician Service (Visit)

UB-04

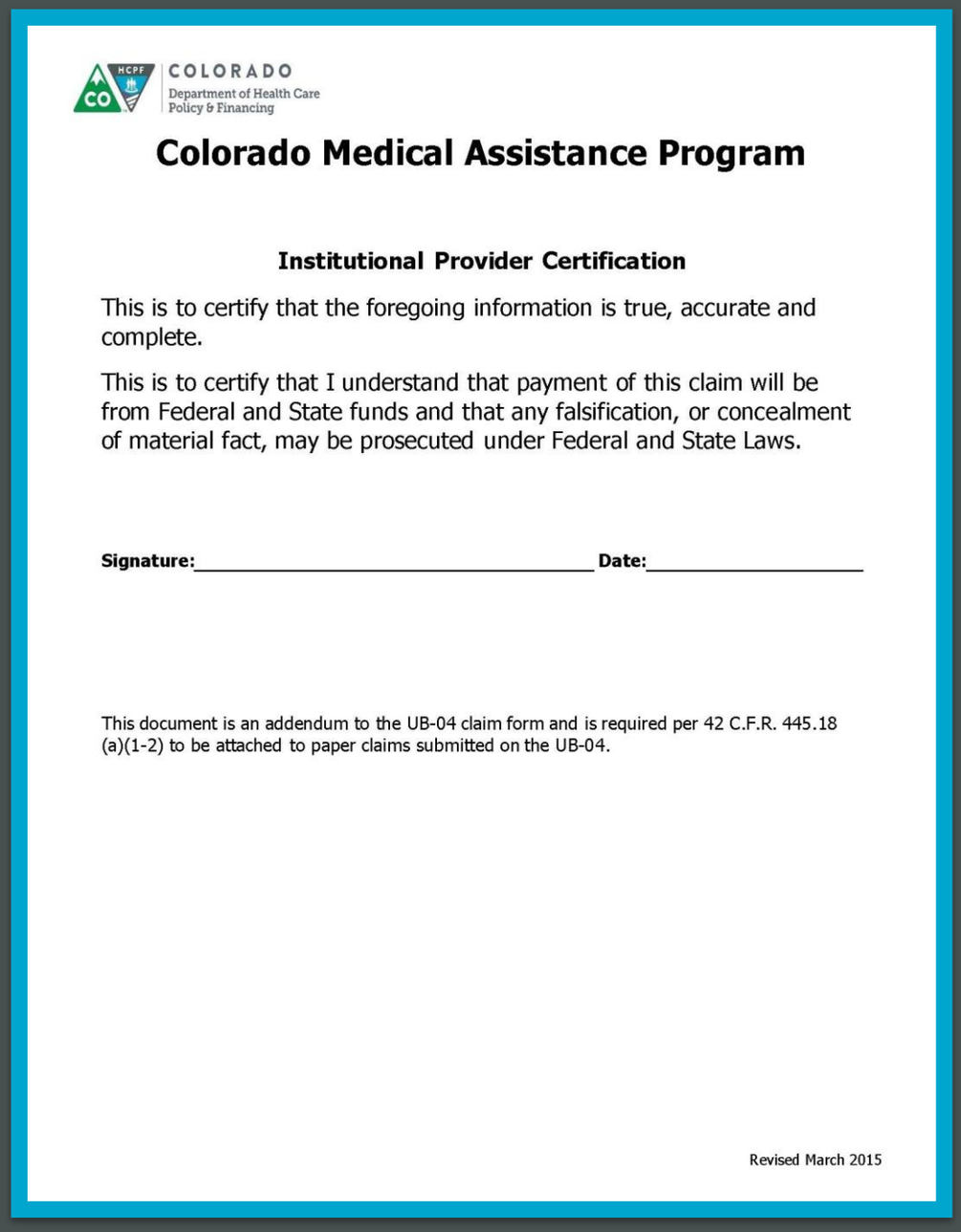

1 IM BILLING PROVIDER
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444
2
3a PAT. CNTL #
b. MED. REC. # 11 7654321
4 TYPE OF BILL 213
5 FED. TAX NO. 01-2345678
6 STATEMENT COVERS PERIOD FROM 111511 THROUGH 113011
7
8 PATIENT NAME a
b MEMBER, IM A
9 PATIENT ADDRESS a ON FILE
10 BIRTHDATE 08201974
11 SEX
ADMISSION 12 DATE 110811 13 HR 14 TYPE 1 15 SRC 1
16 DHR
17 STAT 30
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE 75 FROM 112011 THROUGH 112611
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
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 0192 10.00 XXXX XX
2 0185 6.00 XXX XX
PAGE 1 OF 1 CREATION DATE TOTALS XXXX XX
50 PAYER NAME T19 MEDICAID
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI 0111111110
57 OTHER PRV ID
58 INSURED'S NAME SAME
59 P.REL
60 INSURED'S UNIQUE ID 1234567890
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX 67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX 4281
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI 02222222220 QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC a B3 123456789X
b
c
d
UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

UB-04 is the standard institutional claim form used by Medicare and Health First Colorado 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

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

UB-04 Claims Submission

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333	2	3a PAT. CNTL # SM000123 b. MED. REC. #	4 TYPE OF BILL 812
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 01/06/08 THROUGH 01/31/08
8 PATIENT NAME a b Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street b Anytown c CO d 88888 e	

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DH	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
02/13/1980	F	12/06/03			1		30													

31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a 27	01/01/08													a
b														b

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**

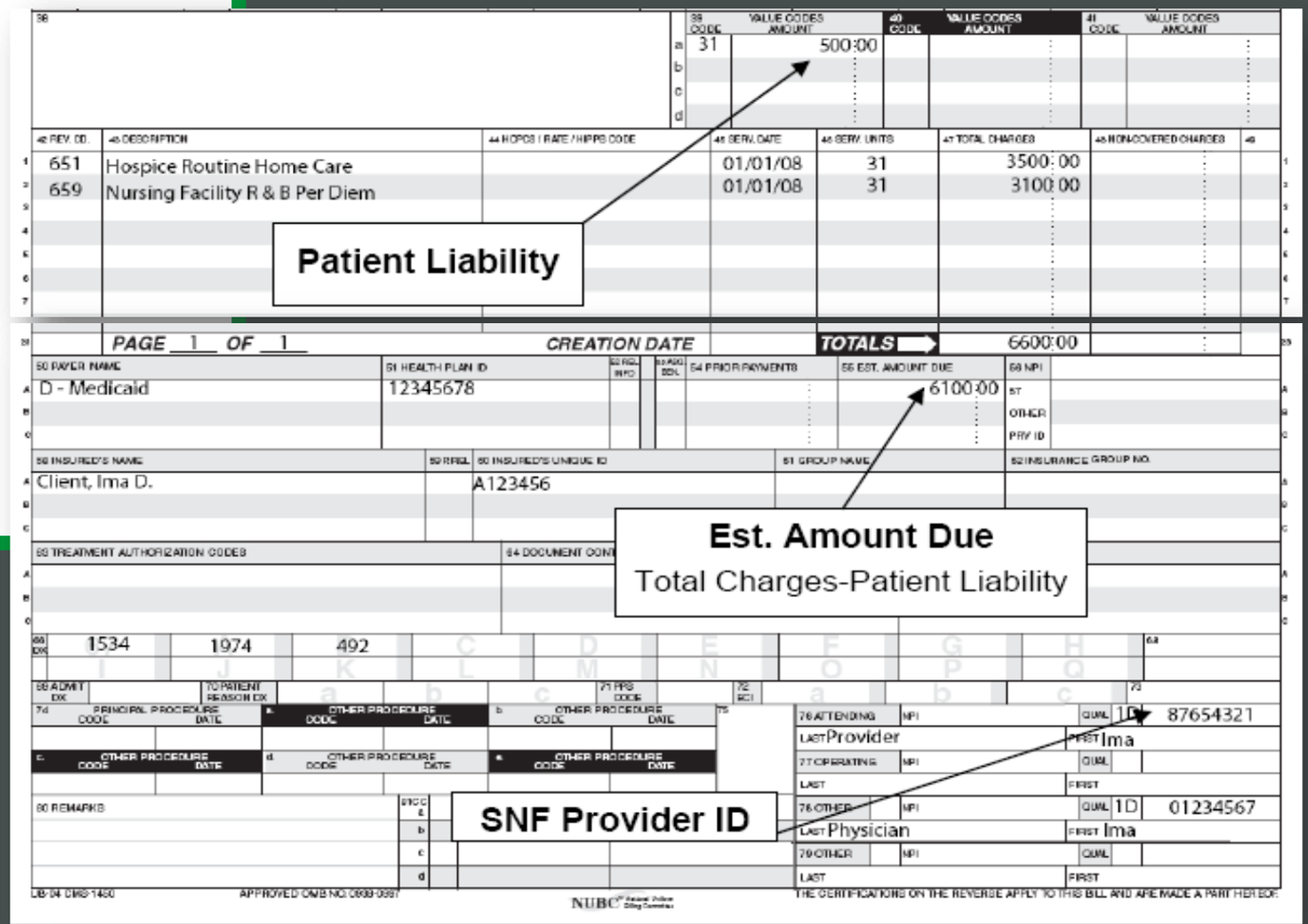
- 652

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

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



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

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	Health First Colorado 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

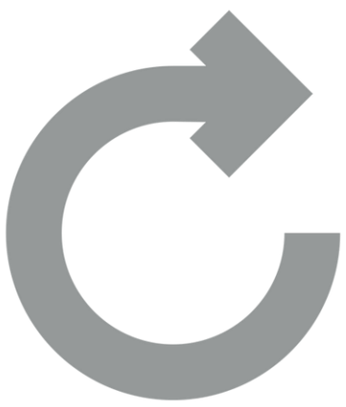
Reject	Denied	Accept	Paid
Claim has primary data edits – **not** accepted by claims processing system	Claim processed & denied by claims processing system	Claim accepted by claims processing system	Claim processed & paid by claims processing system

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

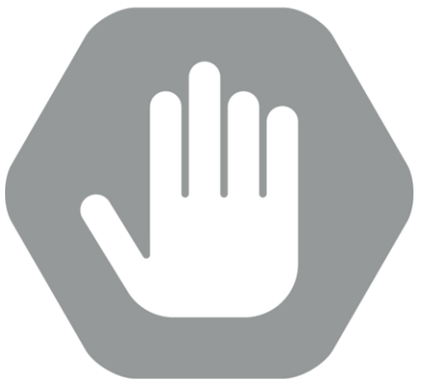
Adjustment

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 • Claim paid incorrectly	• Claim was denied • Claim is in process • Claim is suspended

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete 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	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

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* 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
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
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank you!