Billing Workshop
Rehabilitative OT/PT/ST

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:

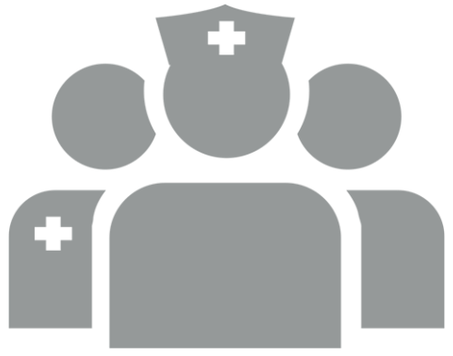
Everyone who provides services for Medical Assistance Program members

- 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

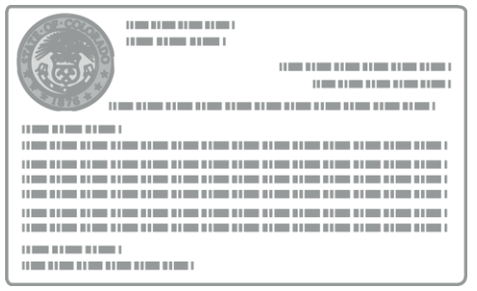
Verifying Eligibility

- 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



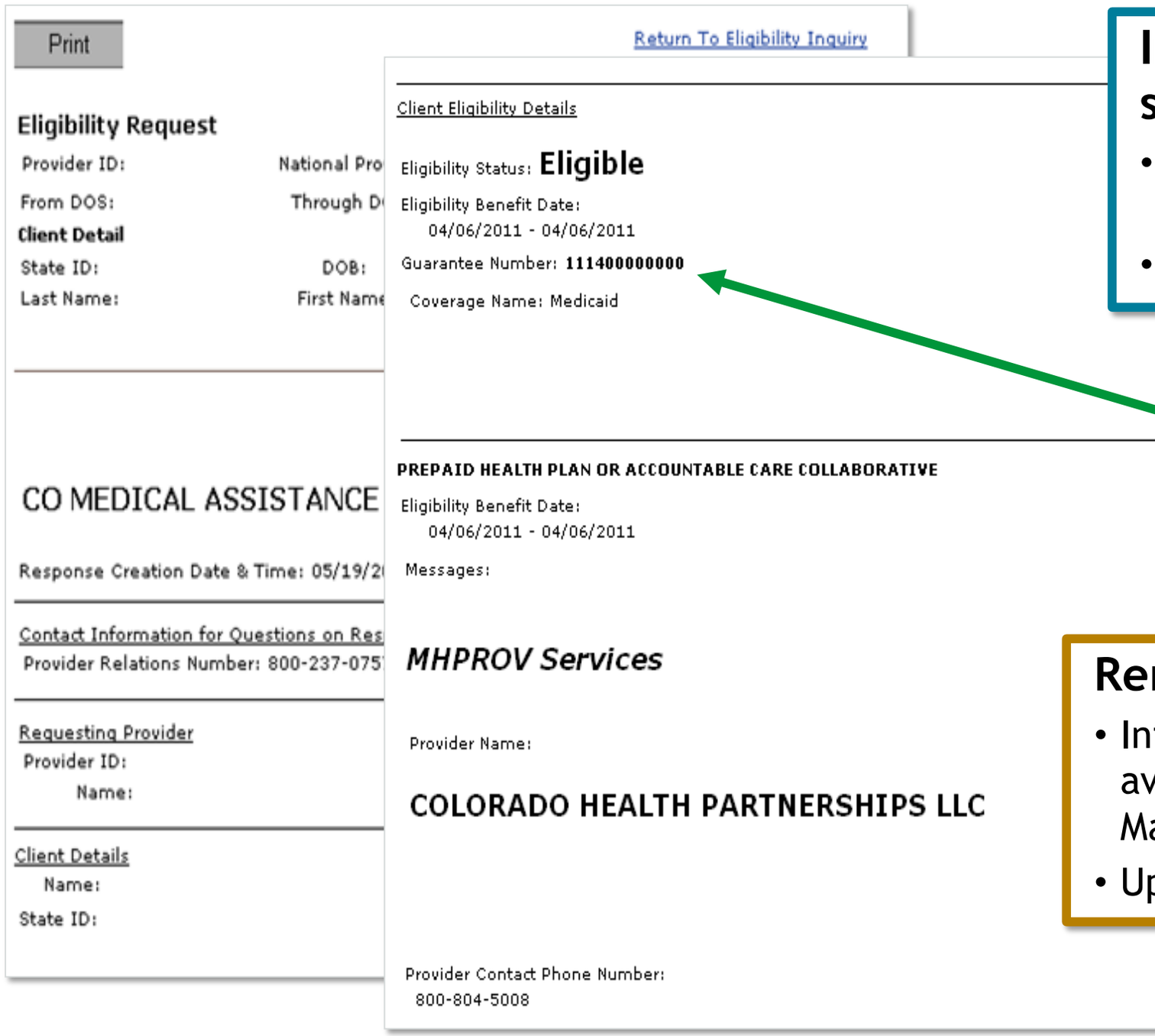
Medicaid ID Card with Switch Vendor

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

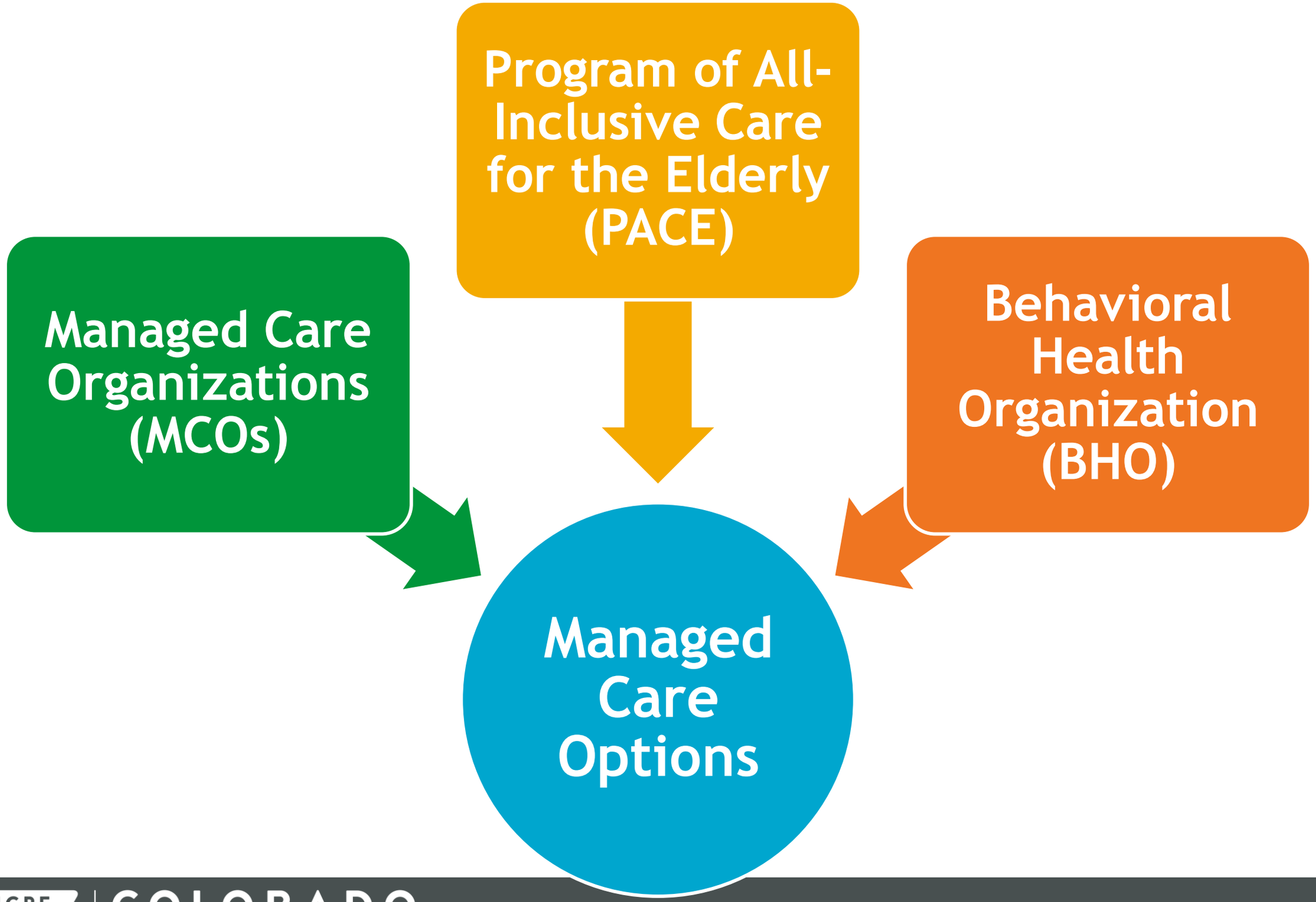
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and 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 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider

Medicare

- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other Third Party Liability (TPL)
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid (QMB+)- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare

Medicare-Medicaid Enrollees

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

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)
  - Example:
    - Charge = $500
    - Program allowable = **$400**
    - TPL payment = **$300**
    - Program allowable – TPL payment = **LOP**

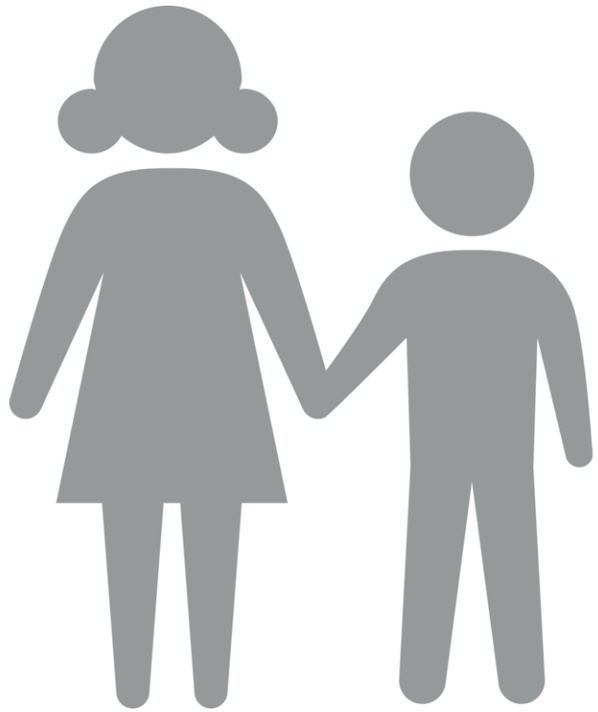
$400.00
- $300.00
= $100.00

Commercial Insurance

- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party's insurance

Co-Payment Exempt Members

Nursing Facility Residents



Children 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

Speech Therapy **Occupational Therapy** **Physical Therapy**	$3.00 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 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

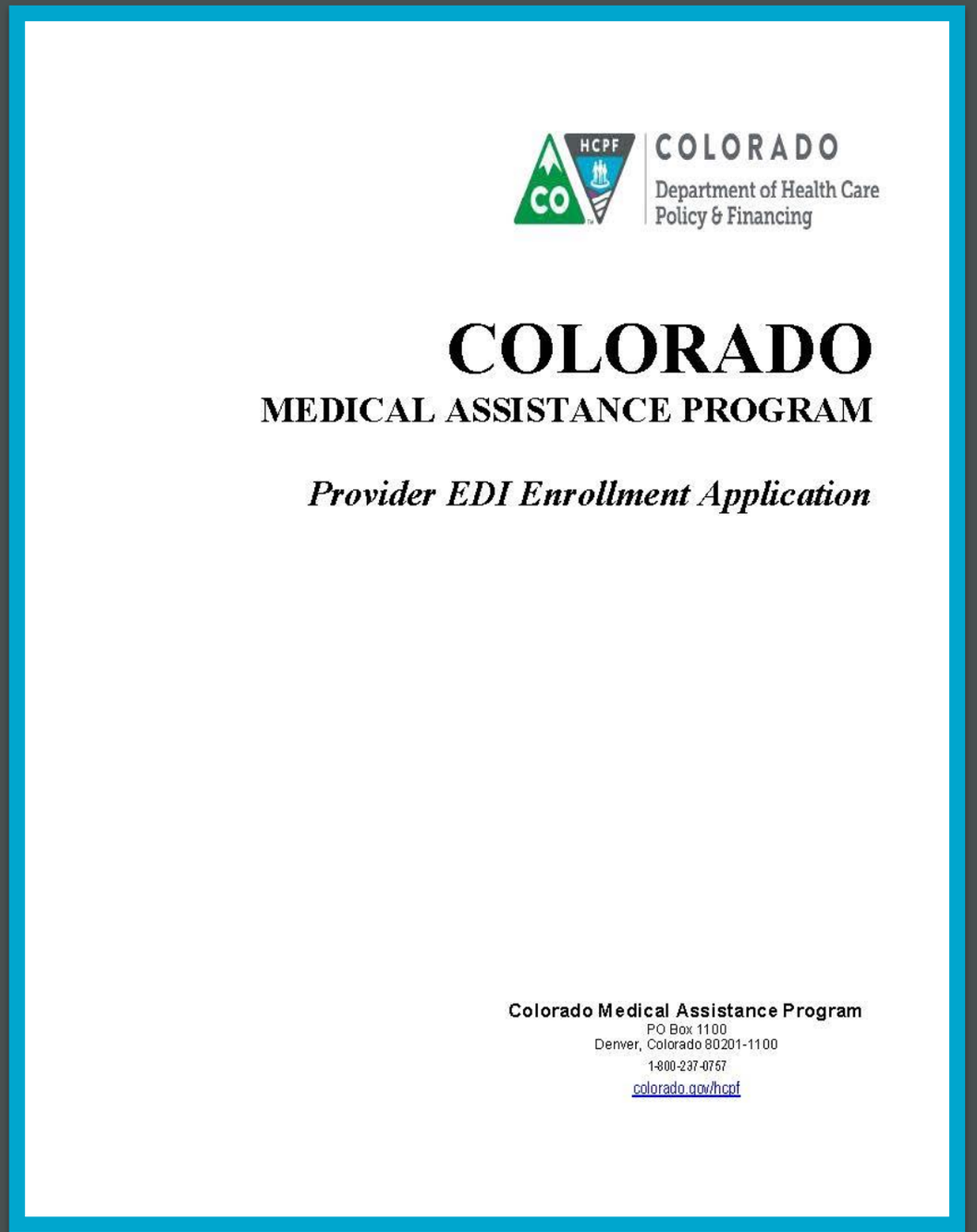
Submitting Claims

- 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

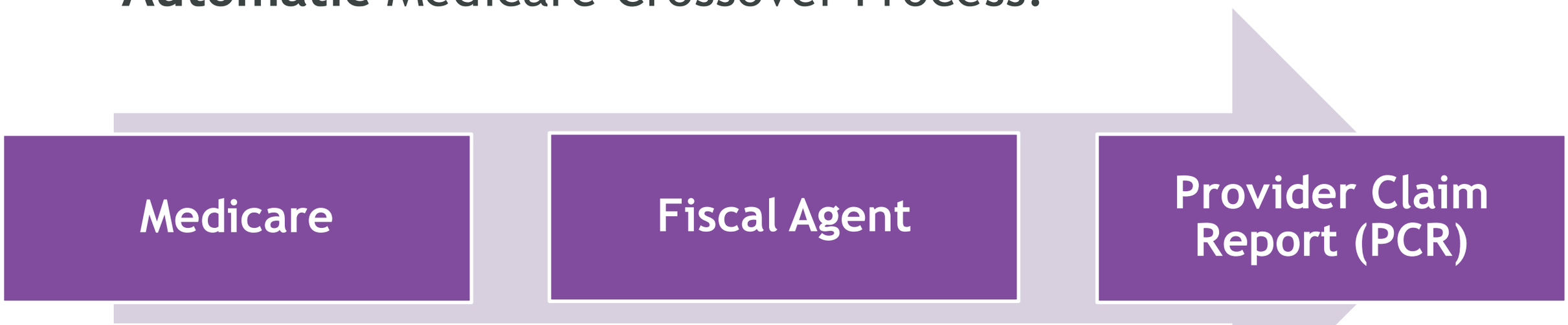
Providers must be enrolled with EDI to:

- 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

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 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

PAR Requirements

"Certification"

- Indicated by Physician's or Non-Physician Practitioner's (NNP) approval
- Requires dated signature on plan of care submitted by therapist

Requesting physician submits a prescription with the therapist's plan of care

- Submitted with PAR
- Must be written within 60 days of start date on PAR

PAR Facts

- Member may receive PT & OT services during same time period/service dates
- Duplicate therapy may not be performed on same dates of service (DOS)
- Members may not receive the same service for habilitative & rehabilitative therapy on the same DOS
  - e.g. member may not have habilitative (97110) & rehabilitative (97110) on the same DOS
- Separate PAR & necessary documentation required for each request

PAR Facts (cont.)

- PAR effective dates cannot exceed twelve (12) month span
- Approval depends on medical necessity, deemed by authorizing agent
- PAR requests must include legibly written & signed M.D./D.O. prescription
- Must include all of the following:
  - Diagnosis with ICD-9 code
  - Medical necessity for therapy
  - Number of therapy sessions needed per week

PAR Facts (cont.)

Adults:

- PARs are required for any Rehabilitative PT/OT therapy beyond the 12 month unit maximum 24 units PT and 24 units OT.
- PARs are required for all Habilitative PT/OT therapy in advance of therapy, with a maximum of 24 units PT and 24 units OT.

Children:

- Require a PAR only after 24 units PT and 24 units OT

Habilitative speech therapy:

- requires PAR for both children and adults

Within 365 day period, another evaluation can be requested if:

- Change in provider rendering services
- Change in diagnosis

PAR Facts (cont.)

- If member's medical condition requires more treatments than listed & authorized on original PAR:
  - New PAR is required
  - PAR must:
    - Include all required information previously noted
    - must show continued need, ongoing deficits, & progress toward treatment goals
- No retroactive PARs allowed
- Any claims submitted after 24 units of PT and/or 24 units of OT without PAR will not be reimbursed
- All Habilitative services require PAR prior to treatment

PAR Errors

If billing provider is not the rendering provider, make sure to:

- List name/address of prescribing provider in Box 2
  - Corresponds with Medicaid number in box 28
- Enter billing provider name/address in field # 25
- Enter billing provider number in field # 29

Note: If any necessary information is missing or invalid, PAR may be returned to provider or denied for lack of information

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

Physical and Occupational Therapy

- Services must be provided by:
  - State of Colorado licensed physical or occupational therapist who is an approved Medical Assistance Program provider
- Occupational Therapy Assistants (OTAs) & Physical Therapy Assistants (PTAs) are eligible to provide services:
  - under supervision of an approved, licensed physical or occupational therapist
- Services provided in the Home Health benefit:
  - must conform to Home Health benefit rules

Physical and Occupational Therapy (PTAs/OTAs)

- PTAs must:
  - be certified by DORA pursuant to Title 12 Article 41.204
  - work under supervision of a licensed physical therapist
    - as defined in Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) & accompanying rules as promulgated by State Board of Physical Therapy
- OTAs must:
  - practice under general supervision of a Colorado registered occupational therapist
  - Must be licensed

Medical Necessity

PT/OT/ST must be:

- in accordance with generally accepted standards of medical practice
- clinically appropriate in terms of type, frequency, & duration
- not primarily for the convenience of the child, parent or legal guardian, physician, or other health care provider
- cost effective

Not covered benefits of fee-for-service PT/OT/ST for any member, regardless of age:

- Education
- Personal need
- Comfort therapy
- Experimental
- Investigational

Fee-for-service PT/OT/ST requires:

- A medical (physiological) reason to perform services

Units of Service

- PTs & OTs have a combined daily limit of 5 units, which is separate from ST daily limit of 5 units
  - Member may receive 5 units of PT/OT & 5 units of ST on same Date of Service (DOS) as long as they are not duplicative services
- Consult Current Procedural Terminology (CPT) Manual for definitions for each coded service
  - Some codes represent a treatment session without regard to its length of time (1 unit maximum)
  - Some codes may be billed incrementally as “timed” units

Procedure Modifiers

Providers must use the appropriate modifier:

Physical Therapist	PT procedure code	**GP**
Occupational Therapist	OT procedure code	**GO**
Rehabilitation Agency / PT Clinic	PT procedure code	**GP**
	OT procedure code	**GO**
Speech Therapist	ST procedure code	**GN**

Note:

- May use additional modifiers as appropriate
- All Habilitative claims must have modifier HB in addition to the modifiers above
- Early Intervention providers: in addition to modifiers GO, GO, and GN, modifier TL must be attached to all claims for Early Intervention PT/OT/ST

Speech-language Therapy

- Services must be provided by or under supervision of certified speech pathologist or audiologist
- Services must be medically necessary
- Habilitative ST services require PAR
- Rehabilitative ST services do not require PAR
  - With exception of members determined to need a speech generating device (E2500-2512, E2351, E2599)
    - should be referred to a Medicaid-participating medical supplier for a PAR

Speech-language Therapy Providers

- Qualified Speech-language Pathologist or Audiologists
  - Must meet qualifications prescribed by federal regulations for participation at 42 CFR 484.4
  - Must meet all requirements under state law
  - Must be an approved Medical Assistance Program provider
  - As of July 1, 2013, all Speech-language Pathologists must be Department of Regulatory Agencies (DORA) certified

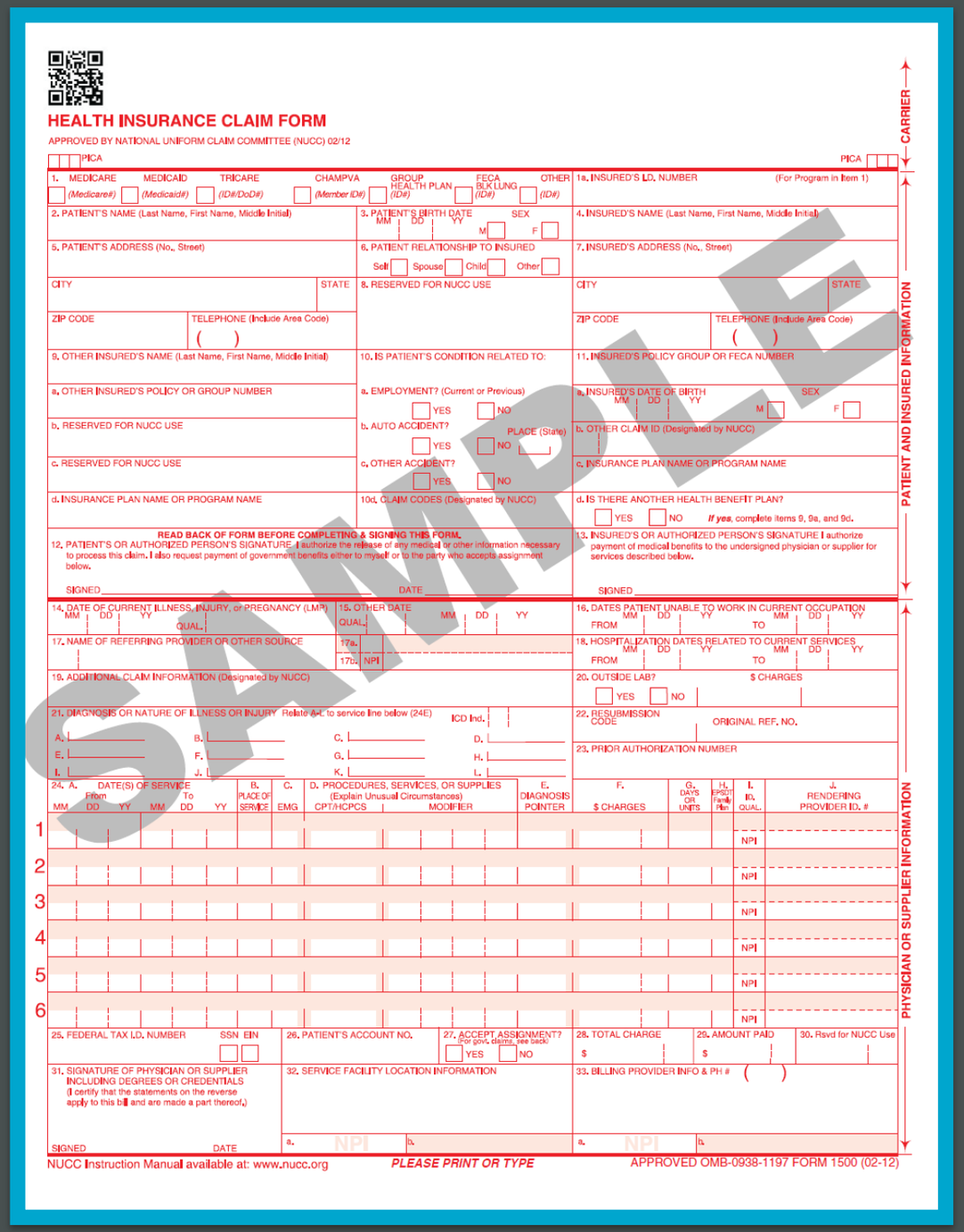
Speech Therapy Limitations

- Non-benefit procedures for adults:
  - Diagnostic procedures provided by an audiologist for purpose of determining general hearing levels
  - Diagnostic procedures for distribution of hearing device
  - Services provided for simple articulation or academic difficulties that are not medical in origin are non-benefit services

Speech Therapy Limitations (cont.)

- Maximum of 5 units service is allowed per date of service
- Services must be medically necessary
- Services must be prescribed/Approved by an M.D. or D.O.
- For more information on audiology services:
  - refer to the Audiology Billing Manual:
    - www.Colorado.gov/hcpf/billing-manuals

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 govt. 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)

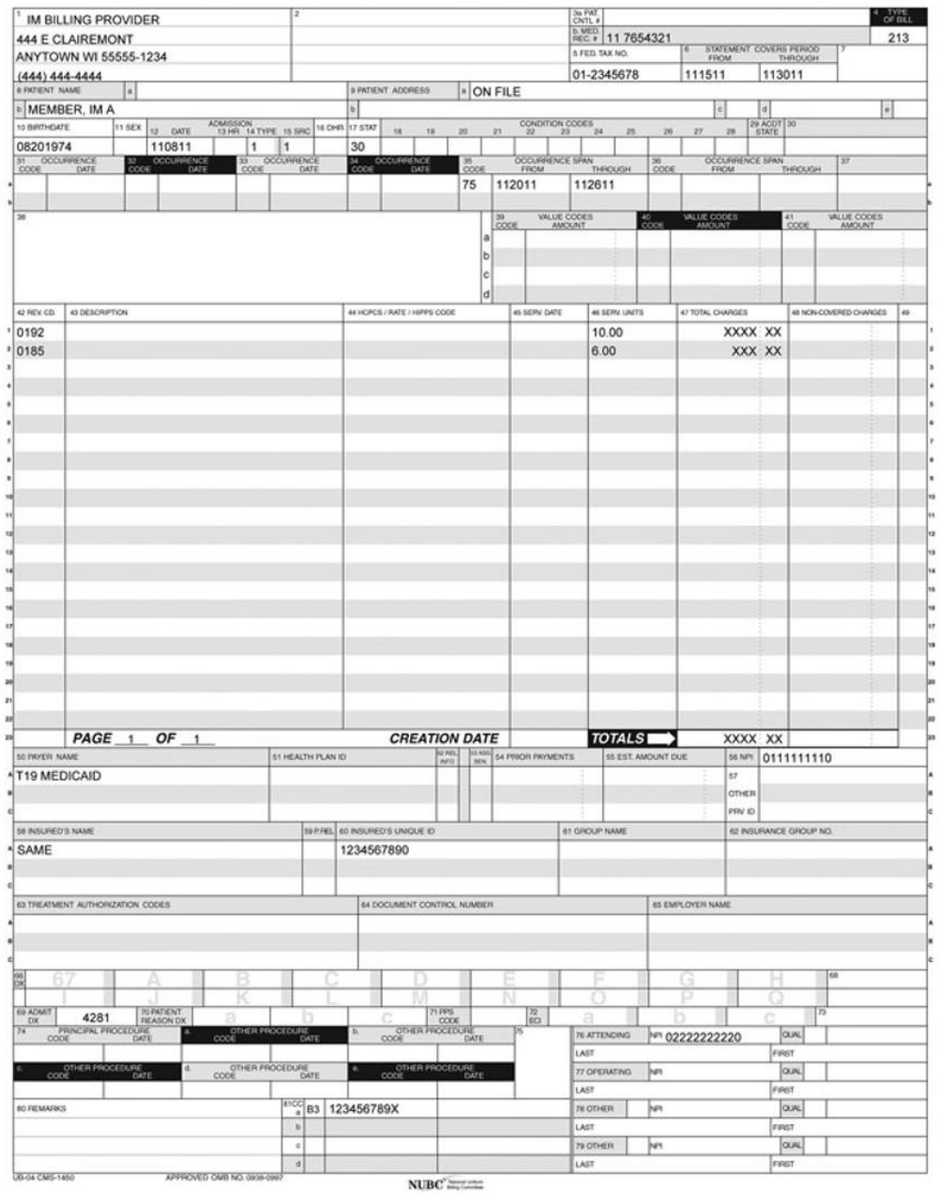
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

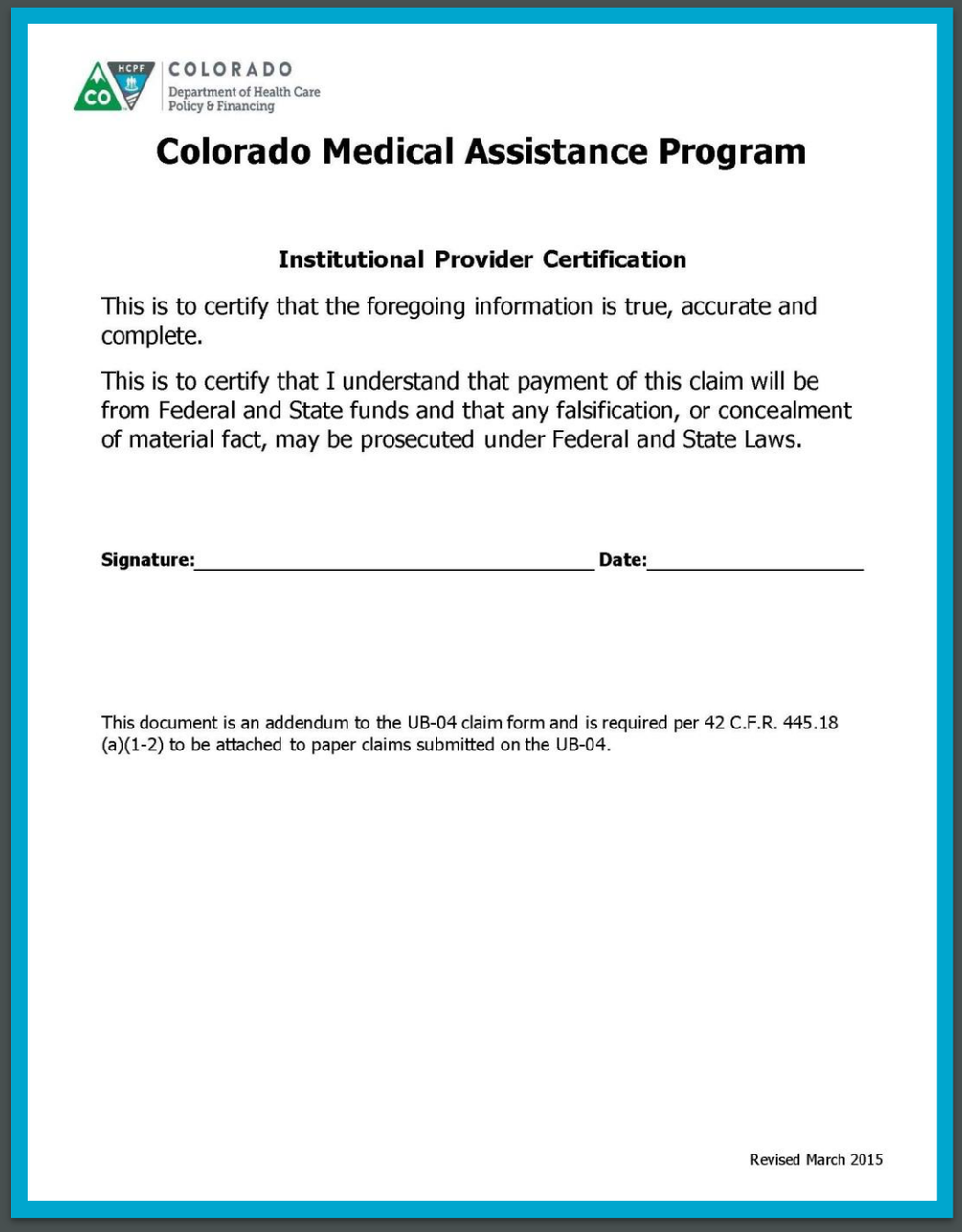
SAMPLE

UB-04



- **<u>PT and OT outpatient hospital</u>** paper claims must be submitted on UB-04 claim form or as an 837I transaction
- UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs
- Where can a Colorado Medical Assistance provider get the UB-04?
  - Available through most office supply stores
  - Sometimes provided by payers

UB-04 Certification



COLORADO
Department of Health Care Policy & Financing

Colorado Medical Assistance Program

Institutional Provider Certification

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

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

Signature:_____ **Date:**_____

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

Revised March 2015

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

Print a copy of the certification at:

Colorado.gov/hcpf/billing-manuals

Common Denial Reasons

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

Common Denial Reasons

PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total
Type of Bill	Claim was submitted with an incorrect or invalid type of bill

Claims Process - Common Terms

Reject

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

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

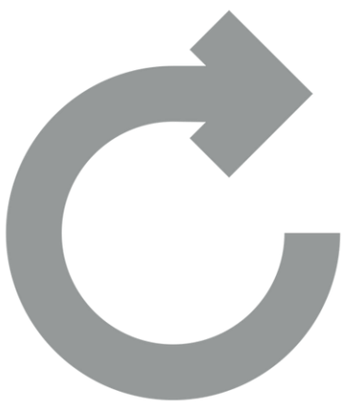
Claim processed & paid by claims processing system

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

Claims Process - Common Terms

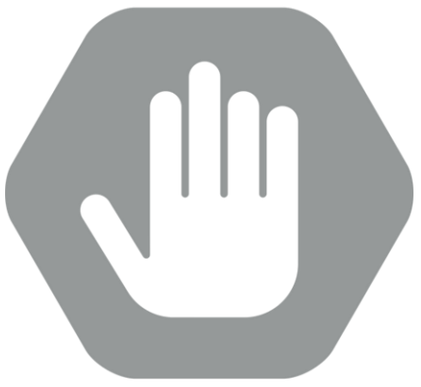
Adjustment

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



Rebill

Re-bill previously denied claim



Suspend

Claim must be manually reviewed before adjudication

Void

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

From the Noun Project:
“Delete” by Ludwig Schubert
“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
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!