Beginning Billing Workshop
Pediatric Personal Care Benefit

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

National Provider Identifier (NPI)

- Class A and Class B Home Care Agencies must have an NPI in order to bill
- The NPI for a Personal Care Agency should be listed under Taxonomy: Custodial Facility 311Z0000X

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:

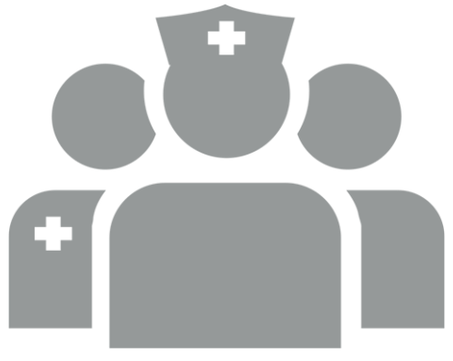
Everyone who provides services for Medical Assistance Program members

- 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

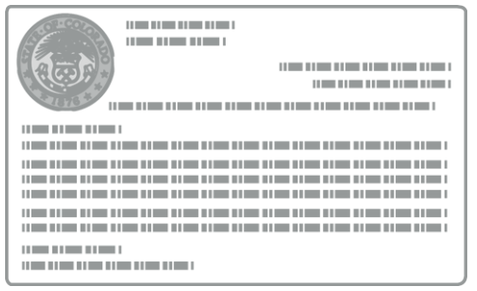
Verifying Eligibility

- 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



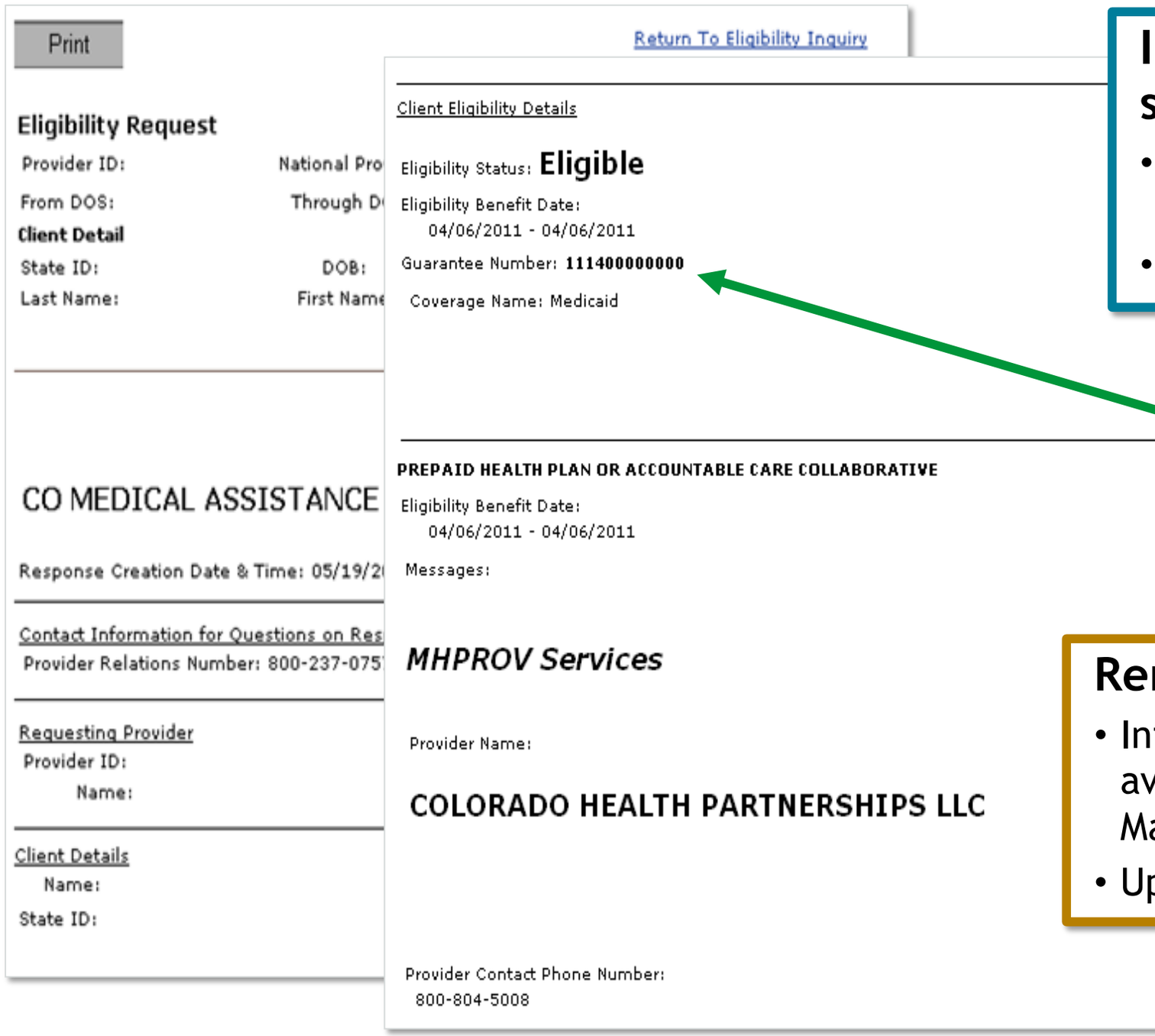
Medicaid ID Card with Switch Vendor

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
  - Non-Citizens
  - Presumptive Eligibility
- Some members = additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance

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

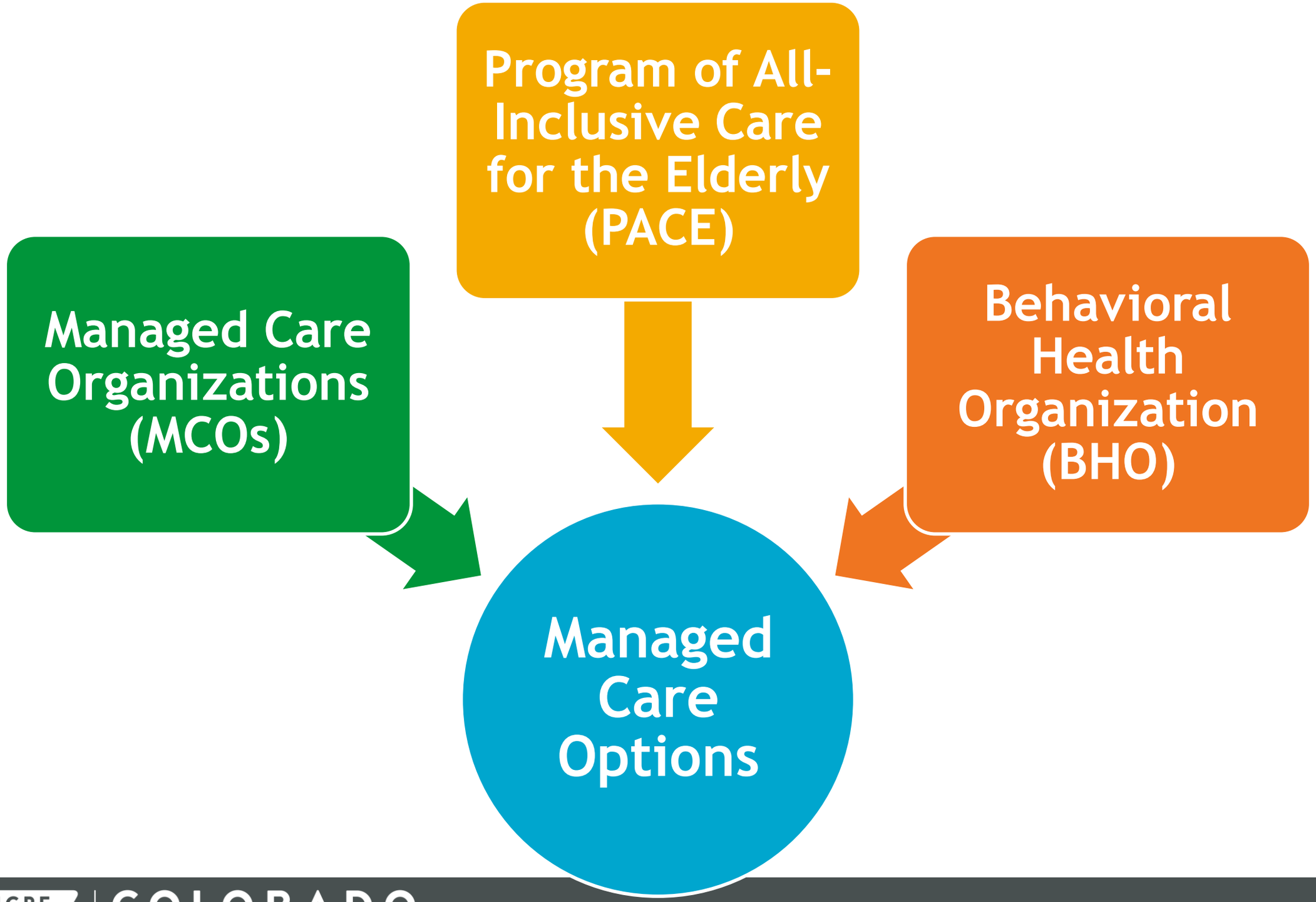
- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers Durable Medical Equipment (DME) and other outpatient services
  - 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

Medicare

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

Medicare

Qualified Medicare Beneficiary (QMB)

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

Medicare

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always payer of last resort
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denials(s) for six (6) years

Third Party Liability

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

$400.00
- $300.00
= $100.00

Commercial Insurance

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

Billing Overview

Record Retention

Claim submission

Prior Authorization Requests (PARs)

Timely filing

Extensions for timely filing

Record Retention

- Providers must:
  - Maintain records for at least six (6) years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

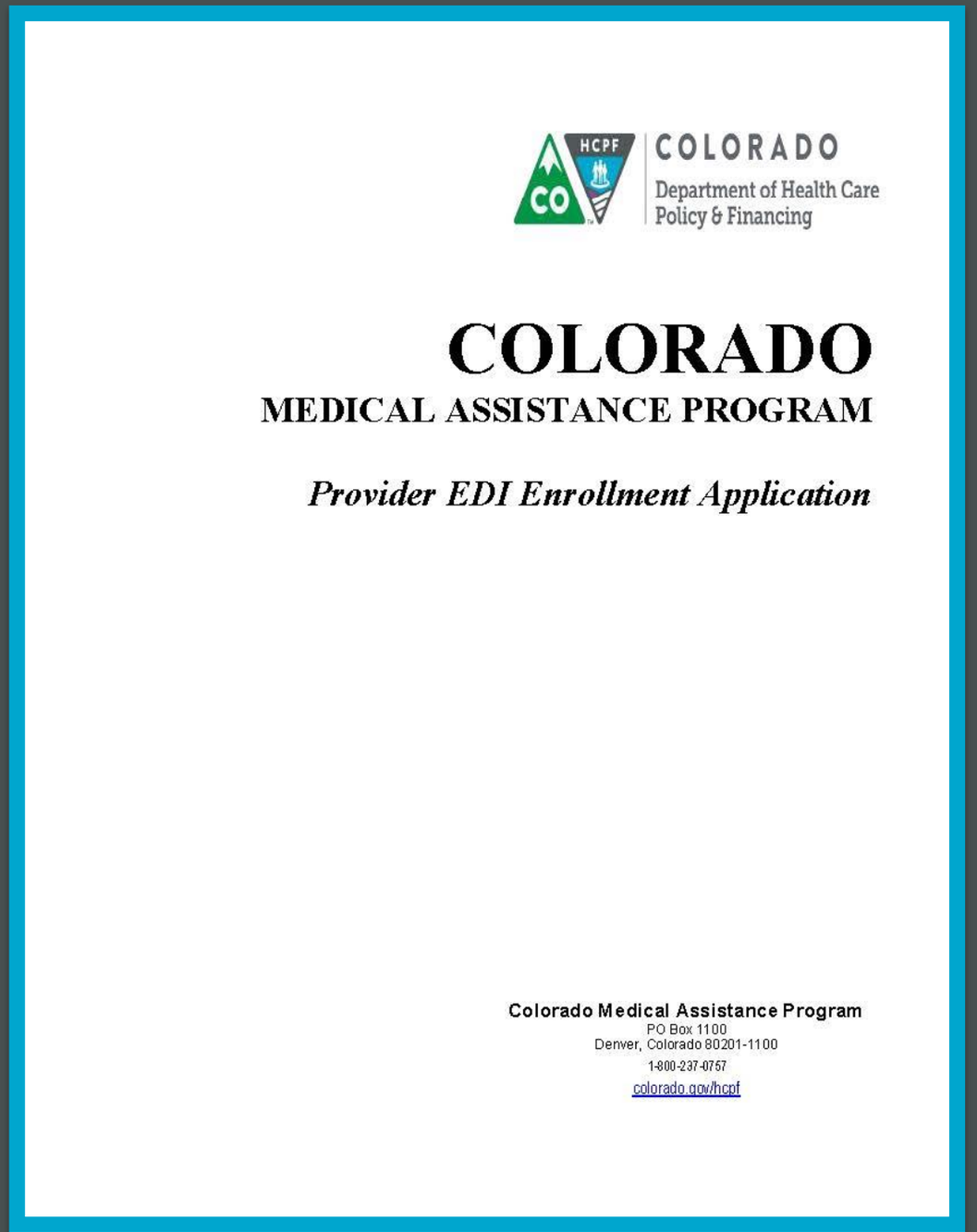
Submitting Claims

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

ICD-10 Implementation

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

Providers Not Enrolled with EDI


COLORADO
Department of Health Care Policy & Financing

COLORADO
MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

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

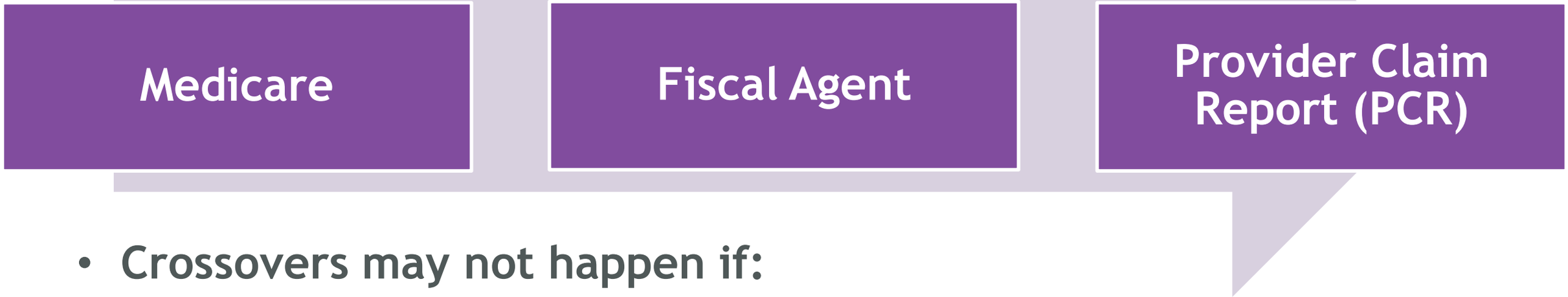
Providers must be enrolled with EDI to:

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

Colorado.gov/hcpf/EDI-Support

Crossover Claims

Automatic Medicare Crossover Process:



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

Crossover Claims

Provider Submitted Medicare Crossover Process:

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

Payment Processing Schedule

Mon.

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

Tue.

Wed.

- Paper remittance statements & checks dropped in outgoing mail

Thur.

- EFT payments deposited to provider accounts

Fri.

- Weekly claim submission cutoff

Sat.

- Fiscal Agent processes submitted claims & creates PCR

Electronic Funds Transfer (EFT)

Advantages

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

PARs Reviewed by ColoradoPAR

- The ColoradoPAR Program reviews PARs for the following categories or services and supplies: diagnostic imaging, durable medical equipment, inpatient out-of-state admissions, medical services (including transplant and bariatric surgery), physical and occupational therapy, pediatric long term home health, private duty nursing, Synagis®, vision, audiology and behavioral therapy
  - Please note: for the above categories, all PARs for members age 20 and under are reviewed according to EPSDT guidelines
  - ColoradoPAR does not process PARs for dental, transportation, pharmacy, or behavioral health services covered by the Behavioral Health Organizations
  - Visit www.ColoradoPAR.com for more information

Website:	Phone:
www.ColoradoPAR.com	Phone: 1.888.801.9355 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

To Submit PAR for Personal Care

- Personal Care agencies responsible for these documents:
  - Physician-signed 485 Home Health Certification and Plan of Care
  - Personal care provider-completed Personal Care Assessment Tool (PCAT)
  - Any other relevant evidence of medical necessity for the personal care support requested
- Submit to online PAR portal

Final PAR Determination

- Providers will be notified of the final PAR determination via the online PAR portal, eQSuite®
  - If the PAR is approved, then a provider will receive notification of the number of hours of personal care services that may be provided
- Before the PAR is denied or partially denied, the doctor who requested the PAR will be called to discuss the PAR in a Peer-To-Peer review
- If the Peer-To-Peer review still results in a denied or partially denied PAR, your client can work with you and their doctor on these options:
  - PAR Reconsideration
  - Submit a new PAR that includes additional medical information needed for the PAR review
- Members may file an appeal with an administrative law judge

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

Required PAR Documents

Personal Care Assessment Tool (PCAT)

PCAT must be completed by Personal Care provider

485 Plan of Care

Plan of Care must be signed by a licensed physician or advanced practice nurse

Any Additional Supporting Documentation

Any documentation that supports the need for specific tasks and/or the amount of hours requested

Personal Care Policies

- Members cannot receive Waiver or Home Health CNA support and Personal Care Benefit support for the same task
  - One (1) exception: when two (2) people are needed for a task
    - Must provide sufficient documentation that more than one worker is needed to complete a task and that adaptive equipment cannot be used
- Personal Care providers are required to communicate with Home Health providers to ensure no duplication of services
- When a Personal Care PAR requests task(s) already covered by an active Home Health PAR, the **personal care PAR will be denied**

Personal Care Policies (cont.)

- PAR effective dates cannot exceed 12 month span
- Approval depends on medical necessity, determined by third-party PAR vendor
- PAR requests must include legibly written 485 signed by M.D./D.O. or advance practice nurse
- Must include all of the following:
  - Diagnosis with ICD-10 code
  - Medical necessity for Personal Care
  - Request for Personal Care service time needed per day

Personal Care PAR Facts

- Change in Condition requires a PAR revision
  - The Personal Care provider is required to request a revision to the Care Plan and PAR as necessary when the member experiences a change in condition necessitating a change in the amount, duration, or frequency of Personal Care Services being delivered to the member

All Personal Care Benefit services require a PAR prior to treatment

Personal Care 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

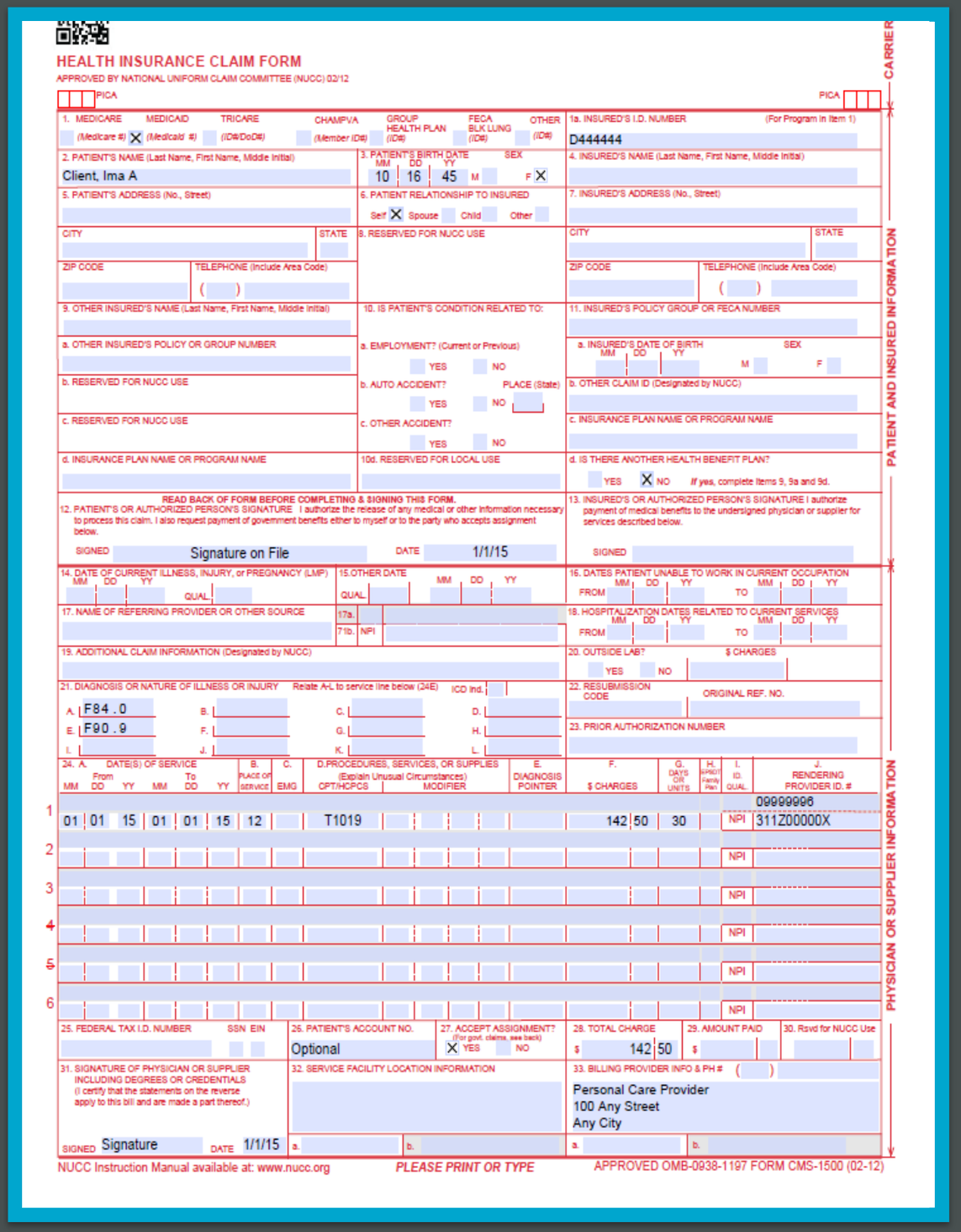
- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility 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

CMS 1500



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare #) X / 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): D444444
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A	3. PATIENT'S BIRTH DATE MM DD YY: 10 16 45 — SEX M / F X
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self X / Spouse / Child / Other
CITY / STATE	8. RESERVED FOR NUCC USE
ZIP CODE / TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES / NO
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES / NO — PLACE (State)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES / NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
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: Signature on File — DATE: 1/1/15	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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — Relate A-L to service line below (24E) ICD Ind. — A. F84.0 / B. / C. / D. / E. F90.9 / F. / G. / H. / I. / J. / K. / L.	

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM / TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM / TO	
20. OUTSIDE LAB? YES / NO — $ CHARGES	
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. #

	From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER				$ CHARGES						J. RENDERING PROVIDER ID. #
																				09999996	
1	01	01	15	01	01	15	12		T1019					142	50	30		NPI		311Z00000X	
2																		NPI			
3																		NPI			
4																		NPI			
5																		NPI			
6																		NPI			

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: Optional	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X / NO	28. TOTAL CHARGE: $ 142 50
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: Signature DATE: 1/1/15	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( ): Personal Care Provider, 100 Any Street, Any City
a. / b.	a. / b.		a. / b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Personal Care Benefit

- Non-medical support in-home for 17 defined personal care tasks
  - e.g. toileting, bathing, dressing, meal preparation
- Requires evidence of medical necessity
- Requires prior authorization through the PAR process
- For Medicaid members 20 years old and younger
- Meet EPSDT criteria

Pediatric Personal Care Tasks

- Ambulation/Locomotion
  - Such as physical support with walking or moving from place to place with or without an assistive device
- Bathing/Showering
  - Such as preparing bathing supplies and cleaning up after the bath, as well as applying soap, rinsing, and drying
- Dressing
  - Such as putting on and taking off clothing
- Feeding
  - Such as making sure food is the right temperature and consistency
- Hygiene- Hair Care/Grooming
  - Such as shampooing, conditioning, simple styling, and combing

Pediatric Personal Care Tasks

- Hygiene – Mouth Care
  - Such as brushing, flossing, swabbing teeth, and rinsing mouth
- Hygiene – Nail Care
  - Such as soaking, filing nails, and cuticle care
- Hygiene – Shaving
  - Such as shaving face, legs, and underarms with electric or safety razors
- Hygiene – Skin Care
  - Such as applying over-the-counter lotion or other skin care products
- Meal Preparation
  - Such as preparing, cooking, and serving food

Pediatric Personal Care Tasks

- Medication Reminders
  - Such as verbally communicating that it is time for medication and opening a pre-filled container
- Mobility – Positioning
  - Such as moving an individual to a new position in a wheelchair while keeping the body properly aligned
- Mobility – Transfer
  - Such as physically supporting an individual to safely move an individual from bed to a wheelchair next to the bed
- Toileting – Bladder Care
  - Such as assisting an individual with using a toilet or bedpan, changing a diaper, emptying and rinsing the bedpan, and cleaning skin

Pediatric Personal Care Tasks

- Toileting – Bowel Care
  - Such as changing and cleaning an individual after a bowel movement, assisting an individual using the bathroom, and changing any clothing or pads
- Toileting – Bowel Program
  - Such as emptying an ostomy bag
- Toileting – Catheter Care
  - Such as emptying a catheter bag

The PCAT includes detailed information about when each of these tasks may need skilled care instead of non-skilled personal care

Pediatric Personal Care

- Services must be provided by:
  - State of Colorado licensed Class A or Class B agency
- Legally responsible adults are **not eligible** to provide services:
  - If Personal Care Services are provided by the member's parent, spouse or other legally responsible adult, they cannot be reimbursed by Medicaid
- Services provided in conjunction with the Home Health benefit and/or HCBS waiver services:
  - Must coordinate with the Home Health agency and/or waiver Case Manager

Medical Necessity

Personal Care 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 Personal Care benefit service for any member, regardless of age:

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

Fee-for-service Personal Care requires:

- A medical (physiological) reason to perform services

Units of Service

- T1019
  - Unit = 15 minutes
  - 15 minutes = $4.75

Rendering and Billing Provider Numbers

- Personal Care must be billed using the CMS 1500 form
- Each agency's specific billing number will be used to reimburse the claim

Common Denial Reasons

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

Common Denial Reasons

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

Claims Process - Common Terms

Reject

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

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

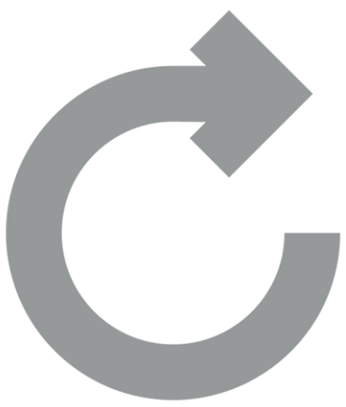
Claim processed & paid by claims processing system

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

Claims Process - Common Terms

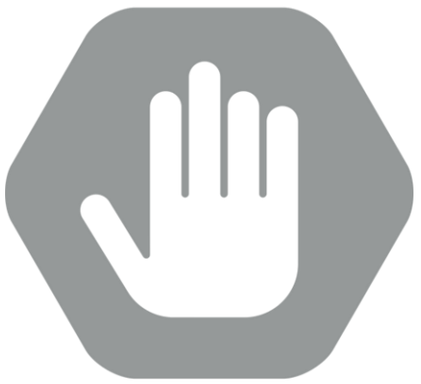
Adjustment

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



Rebill

Re-bill previously denied claim



Suspend

Claim must be manually reviewed before adjudication

Void

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

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

Adjusting Claims

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

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

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

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete field 22 on the CMS 1500 claim form

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

Provider Claim Reports (PCRs)

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

Provider Claim Reports (PCRs)

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

Provider Claim Reports (PCRs)

Paid

* CLAIMS PAID *

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

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

Denied

* CLAIMS DENIED *

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

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

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

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

Provider Claim Reports (PCRs)

Adjustments

Recovery

Repayment

Net Impact

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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	CGI 1-888-538-4275
Claims/Billing/Payment	Email helpdesk.HCG.central.us@cgi.com
Forms/Website	CMAP Web Portal technical support
EDI	CMAP Web Portal Password resets
Updating existing provider profile	CMAP Web Portal End User training

Thank you!