# *Beginning Billing Workshop Waiver*

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
- **Waiver Providers currently <u>do not</u> require an NPI**

# *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

# *Billing Provider Number*

**Billing Provider**

Entity being reimbursed for service

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

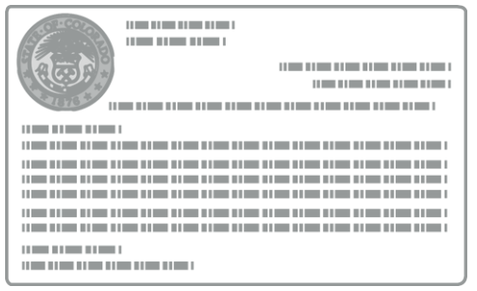
# *Verifying Eligibility*

- 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**

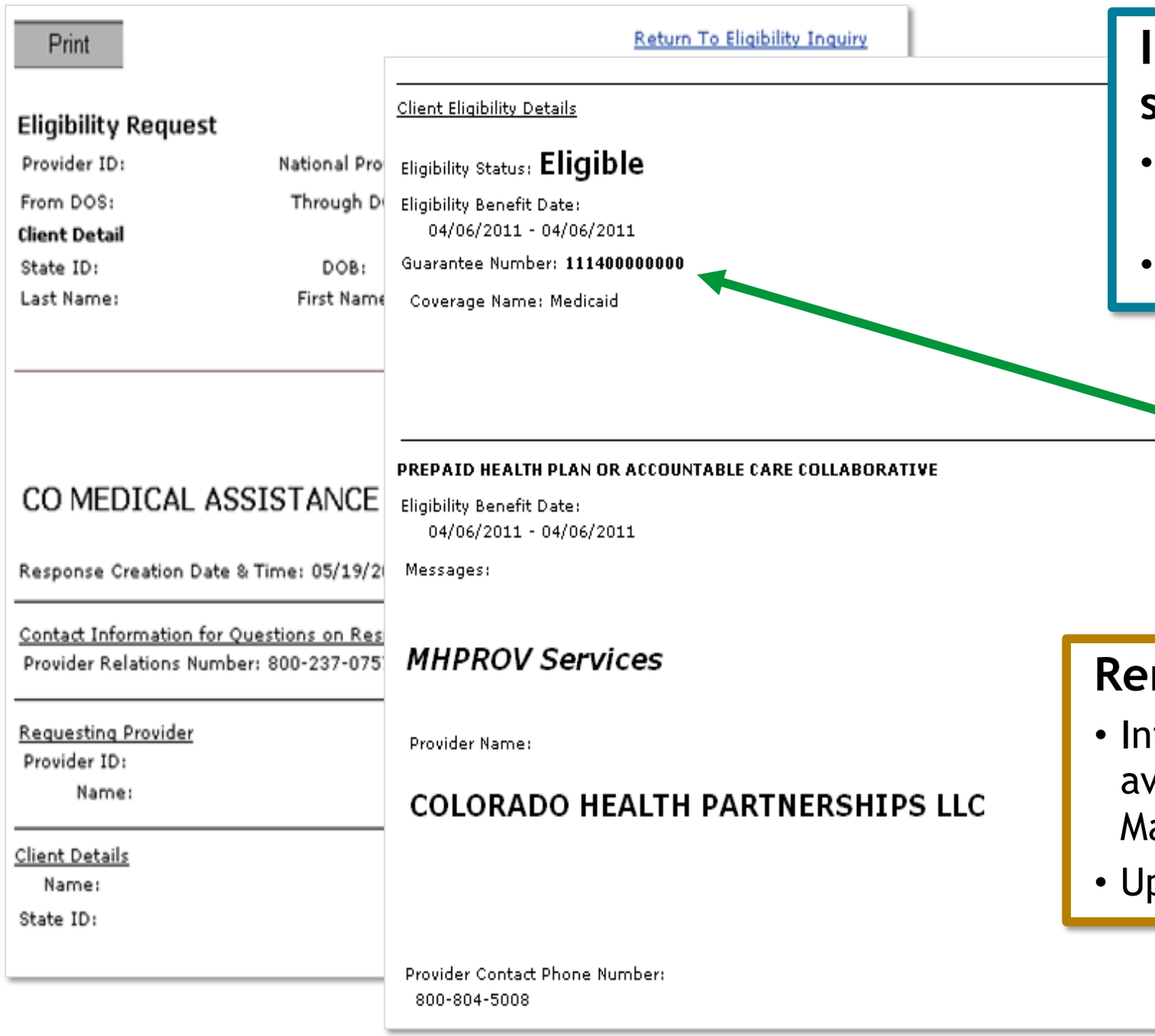


From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

# *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.

# *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** |

# *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

# *Waiver PARs*

## Community Centered Board Adult & Children DHS Waivers

- Supported Living Services (SLS)
- Developmental Disabilities (CCT-DD/SLS)
- Children's Extensive Support (CES)

## Local County Department of Human Services DIDD Waiver

- Children's Habilitation Residential Program (CHRP)

# *Waiver PARs (cont.)*

## Case Management Agency Adult & Children LTSS Waivers

- Elderly Blind and Disabled (EBD)
- Community Mental Health Services (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Children's Home Community Based Services (CHCBS)
- Children With Autism (CWA)
- Children with Life Limiting Illness (CLLI)

# Waiver Prior Authorization Form

**STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

COLORADO
Department of Health Care Policy & Financing

QUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINME **EBD-U1**

**HCBS - Persons who are Elderly, Blind, and Disabled (EBD) Waiver**

PA Number being revised:

Revision? ☐ Yes ☐ No

| 1. CLIENT NAME | 2. CLIENT ID | 3. SEX | 4. BIRTHDATE |
|---|---|---|---|
| | | ☐ M ☐ F | |

| 5. REQUESTING PROVIDER # | 6. CLIENT'S COUNTY | 7. CASE NUMBER (AGENCY USE) | 8. DATES COVERED | |
|---|---|---|---|---|
| | | | From: | Through: |

**STATEMENT OF REQUESTED SERVICES**

| 9. Description | | 10. Provider | 11. Modifier | 12. Max # Units | 13. Cost Per Unit | 14. Total $ Authorized | 15. Comments: |
|---|---|---|---|---|---|---|---|
| **S5105** Adult Day Services, Basic (U1) | | | | | | | |
| **S5105** Adult Day Services, Specialized (U1) | | | TF | | | | |
| **T2031** Alternative Care Facility (ACF) (U1) | | | | 1 | $50.95 | $50.95 | |
| **T2038** Community Transition Services, Coordinator (U1) | | | | | | | |
| **A9900** Community Transition Services, Items Purchased (U1) | | | | | | | |
| **T2025** Consumer Directed Assistance Support Services (CDASS) (Cent/ Unit) (U1) | | | | | | | |
| **T2040** CDASS Per Member/ Per Month (PM/PM) (U1) | Fiscal Employer Agent (FEA) (U1) | | | | | | |
| **S5165** Home Modifications (U1) | | | | | | | |
| **S5130** Homemaker (U1) | | | | | | | |
| **H0038** IHSS Health Maintenance Activities (U1) | | | | | | | |
| **S5130** IHSS Homemaker (U1) | | | KX | | | | |
| **T1019** IHSS Personal Care (U1) | | | KX | | | | |
| **T1019** IHSS Relative Personal Care (U1) | | | HR, KX | | | | |
| **T2029** Medication Reminder, Install/Purchase (U1) | | | | | | | |
| **S5185** Medication Reminder, Monitoring (U1) | | | | | | | |
| **A0100** NMT, Taxi (U1) | | | | | | | |
| **A0120** NMT, Mobility Van | Mileage Band 1 (0-10 miles) (U1) | | | | | | |
| **A0120** NMT, Mobility Van To and From Adult Day | Mileage Band 1 (0-10 miles) (U1) | | HB | | | | |
| **A0130** NMT, Wheelchair Van | Mileage Band 1 (0-10 miles) (U1) | | | | | | |
| **A0130** NMT, Wheelchair Van To and From Adult Day | Mileage Band 1 (0-10 miles) (U1) | | HB | | | | |
| **T1019** Personal Care (U1) | | | | | | | |
| **T1019** Personal Care, Relative (U1) | | | HR | | | | |
| **S5160** Personal Emergency Response System (PERs) Install/Purchase (U1) | | | | | | | |
| **S5161** PERs, Monitoring (U1) | | | | | | | |
| **S5151** Respite Care, ACF (U1) | | | | | | | |
| **S5150** Respite Care, In Home (U1) | | | | | | | |
| **H0045** Respite Care, NF (U1) | | | | | | | |
| A | | | | | | | |

Find Adult HCBS Prior Approval and Cost Containment workbook for Waiver programs on the Department's website

**Colorado.gov/hcpf/provider-forms**

# *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)

# *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)

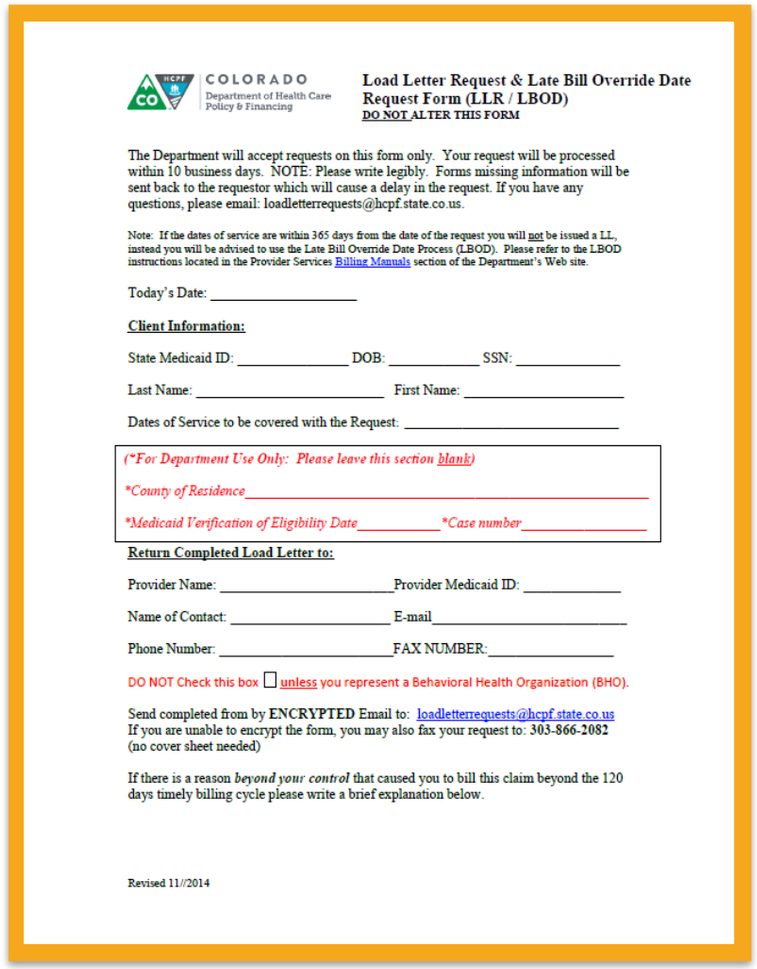
# *Timely Filing Extensions*

- Extensions may be allowed when:
  - Backdated eligibility
    - Load letter from Department

# *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



COLORADO
Department of Health Care Policy & Financing

**Load Letter Request & Late Bill Override Date Request Form (LLR / LBOD)**
**DO NOT ALTER THIS FORM**

The Department will accept requests on this form only. Your request will be processed within 10 business days. NOTE: Please write legibly. Forms missing information will be sent back to the requestor which will cause a delay in the request. If you have any questions, please email: loadletterrequests@hcpf.state.co.us.

Note: If the dates of service are within 365 days from the date of the request you will not be issued a LL, instead you will be advised to use the Late Bill Override Date Process (LBOD). Please refer to the LBOD instructions located in the Provider Services Billing Manuals section of the Department's Web site.

Today's Date: _____

**Client Information:**

State Medicaid ID: _____ DOB: _____ SSN: _____

Last Name: _____ First Name: _____

Dates of Service to be covered with the Request: _____

*(*For Department Use Only: Please leave this section blank)*

**County of Residence*_____

**Medicaid Verification of Eligibility Date*_____ **Case number*_____

**Return Completed Load Letter to:**

Provider Name: _____Provider Medicaid ID: _____

Name of Contact: _____ E-mail_____

Phone Number: _____FAX NUMBER:_____

DO NOT Check this box ☐ unless you represent a Behavioral Health Organization (BHO).

Send completed from by **ENCRYPTED** Email to: loadletterrequests@hcpf.state.co.us
If you are unable to encrypt the form, you may also fax your request to: **303-866-2082** (no cover sheet needed)

If there is a reason ***beyond your control*** that caused you to bill this claim beyond the 120 days timely billing cycle please write a brief explanation below.

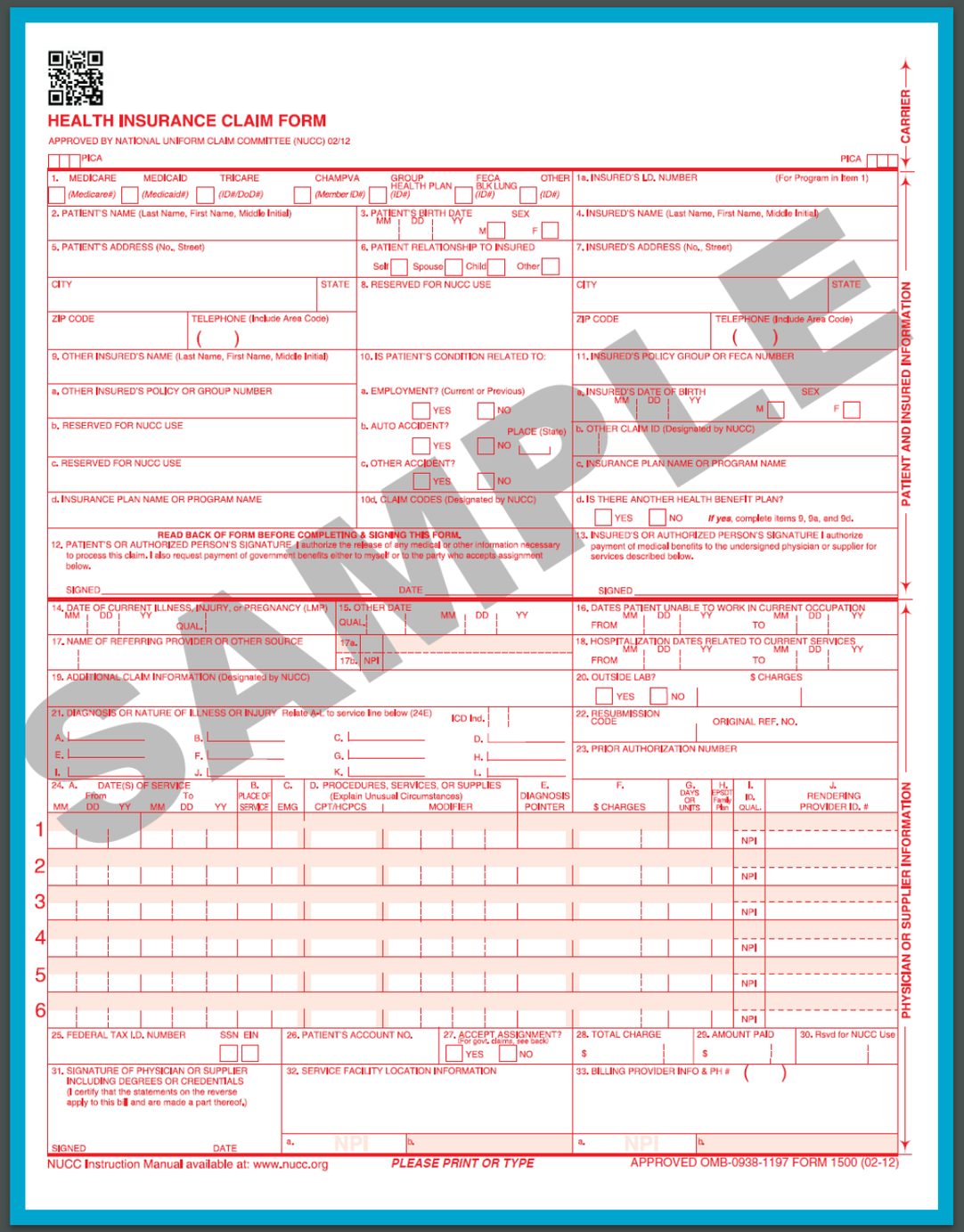
Revised 11//2014

# *CMS -1500*

## Who completes the CMS -1500?

HCBS/Waiver Providers

# 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

# *Long-term Services and Supports Adult Waiver Programs*

Community Mental Health Support (CMHS)

Elderly, Blind and Disabled (EBD)

Spinal Cord Injury (SCI)

Colorado Choice Transitions (CCT)*

Brain Injury (BI)

*CCT is not a waiver

# *Adult Long-term Services and Supports Waiver Programs*

| Program | Modifier | Program Code |
|---|---|---|
| BI | U6 | 89 |
| EBD | U1 | 82 |
| CMHS | UA | 94 |
| CCT* | UC | 95 |
| SCI | U1,SC | M5 |

*CCT is not a waiver

# *HCBS-BI Requirement*

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility or hospital care for persons with a diagnosis of a brain injury
- Members Served
  - Age 16 +
  - Brain injury must have occurred prior to age 65
  - Persons with a brain injury as defined in the Colorado Code of Regulations with specific diagnoses
- Level of Care Requirements
  - Nursing Facility or Hospital Level of Care

# *HCBS-EBD Requirement*

- Primary Purpose of Program
  - The EBD program provides home or community based alternative to nursing facility care for elderly, blind, and disabled persons
- Members Served
  - Age 18 +
  - Persons living with HIV/AIDS
  - Elderly persons with a functional impairment (aged 65+)
  - Blind or physically disabled persons (aged 18-64)
- Level of Care Requirements
  - Nursing Facility Level of Care

# *HCBS-CMHS Requirement*

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility care for persons with a major mental illness
- Members Served
  - Age 18 +
  - Persons with a diagnosis of major mental illness as defined in the Colorado Code of Regulations with specific diagnoses
- Level of Care Requirements
  - Nursing Facility Level of Care

# *HCBS-CCT Requirement*

- Primary Purpose of Program
  - To provide home or community based services and supports to individuals transitioning out of long term care facilities
- Members Served
  - Age 18 +
  - Persons eligible for the EBD, CHMS, BI, SLS or DD waivers
  - For more information, visit www.Colorado.gov/hcpf/coloradochoicetransitions
- Level of Care Requirements
  - Nursing Facility Level of Care
- Individuals must be willing to live in qualified housing:
  - A home owned or leased by the individual or family member
  - An apartment with a lease and lockable access and egress which includes living, sleeping, bathing and cooking areas over which the individual or a family member has domain and control
  - A community-based residential setting in which no more than 4 unrelated individuals, not including caretakers, reside

# *HCBS-SCI Requirement*

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility or hospital care for persons with a spinal cord injury
- Members Served
  - Age 18+
  - Persons with a spinal cord injury as defined in the Colorado Code of Regulations with specific diagnoses
  - Residing in the Denver/Metro area
    - Adams, Arapahoe, Douglas, Denver, Jefferson
- Level of Care Requirements
  - Nursing Facility or Hospital Level of Care

# *Consumer Directed Attendant Support Services (CDASS)*

- Allows BI, EBD, CMHS, SCI Adult HCBS members to direct their own care
- Delivery option provides the following for Adults:
  - Personal Care
  - Homemaker Services
  - Health Maintenance Activities

# *In Home Support Services (IHSS)*

- Assists CHCBS, EBD & SCI Adult HCBS members in directing their own care through an agency
- Managed by an In-Home Support Services Agency
- IHSS Delivery Option provides the following for Adults:
  - Personal Care
  - Homemaker Services
  - Health Maintenance Activities
- IHSS Delivery Option provides the following for children:
  - Health Maintenance Activities

# *Division for Intellectual & Developmental Disabilities (DIDD) HCBS Waiver Programs*

Supported Living Services (SLS)

Developmental Disabilities (DD)

Children's Extensive Support Services (CES)

# *Waiver Programs*

| Program | Modifier | Program Code |
|---|---|---|
| DD | U3 | 85 |
| SLS | U8 | 92 |
| CES | U7 | 90 |
| TCM | U4 | 87 |

# *HCBS-DD Requirement*

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who are in need of access to services and supports 24 hours a day that will allow them to live safely and participate in the community
- Level of Care Requirements
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID)

# *HCBS-SLS Requirement*

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who can either live independently with limited supports or who, if they need extensive supports, are already receiving that high level of support from other sources
- Level of Care Requirements
  - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID)

# *HCBS-CES Requirement*

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization have a diagnosis of a Developmental Disability with intense behavioral and/or medical needs
- Members Served
  - Birth through age 17
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID)
    - Child has a behavior or medical condition that is so intense that it requires near constant line of sight supervision

# *Targeted Case Management (TCM)*

- It is not optional to have TCM for members enrolled in a waiver

# *Long-term Services and Supports Children's HCBS Waiver Programs*

Children's Home and Community Based Services (CHCBS)

Children with Life Limiting Illness (CLLI)

Children With Autism (CWA)

# *Other Children's HCBS Waiver Programs*

Children's Habitation Residential Program (CHRP)

# *Waiver Programs*

| Program | Modifier | Program Code |
|---|---|---|
| CHCBS | U5 | 88 |
| CLLI | UD | 97 |
| CWA | UL | 96 |
| CHRP | U9 | 93 |

# *HCBS-CHCBS Requirement*

- Primary Purpose of Program
  - Provides case management & In-Home support services for children who:
    - Are at risk of institutionalization in a hospital or skilled nursing facility
    - And would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources
- Members Served
  - Birth through age 17
- Level of Care Requirements
  - Who meet the established minimum criteria for hospital or skilled nursing facility levels of care & who are medically fragile

## HCBS-CHCBS Case Management Responsibilities

| | |
|---|---|
| ☐ | Inform member and/or guardian(s) of the eligibility process |
| ☐ | Arranges for face-to-face contact w/ member within 30 calendar days of receipt of referral |
| ☐ | Completes ULTC-100.2 |
| ☐ | Assesses member's health and social needs |
| ☐ | Develops Prior Approval and Cost Containment Record Form of services and projected costs for State approval |
| ☐ | Submits a copy of approved Enrollment Form to the County for Colorado Medical Assistance Program State identification number |
| ☐ | Monitors and evaluates services |
| ☐ | Reassesses each child |
| ☐ | Demonstrates continued cost effectiveness, whenever services increase or decrease |

# *HCBS-CLLI Requirement*

- Primary Purpose of Program
  - Provides care for children who are at risk of institutionalization in a hospital & have a diagnosis of a life-limiting illness
  - Provide Palliative Care to children with a life limiting illness
- Members Served
  - Birth through age 18
- Level of Care Requirements
  - Who meet institutional level of care for inpatient hospitalization

# *HCBS-CWA Requirement*

- Primary Purpose of Program
  - Provides behavioral therapy for children who are at risk of institutionalization and have a medical diagnosis of Autism
- Members Served
  - Birth through age 5
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)

# *HCBS-CHRP Requirement*

- Primary Purpose of Program
  - Provides care for foster children who are at risk of institutionalization and have a diagnosis of a Developmental Disability with extraordinary needs
- Members Served
  - Birth through age 20
- Level of Care Requirements
  - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)

# *Critical Incident Reporting*

- Types of Critical Incidents to Report
  - Suspected Abuse, Mistreatment
  - Suspected Neglect
  - Suspected Exploitation
  - All Deaths
  - Serious Illness or Injury
  - Medication Errors
  - Damage or Theft of Member's Property
  - All High Risk Issues
  - All unplanned Hospitalizations

# *Critical Incident Reporting*

- HCBS providers who experience a critical incident involving a member enrolled in waiver programs:
  - Are required to report all critical incidents to member's case manager within 24 hours of discovery
  - May also be required report applicable incidents to appropriate authorities such as:
    - Department of Public Health and Environment
    - Adult or Child Protective Services
    - Local law enforcement

# *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 |

# *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

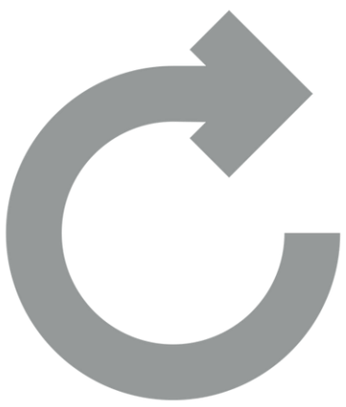


From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

# *Claims Process - Common Terms*

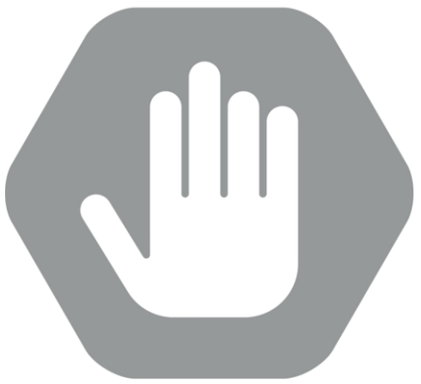
## Adjustment

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 | 041808 | | 114.24 | | | | |
| | | | | | | NET IMPACT | 21.42 | | | | |

**Voids**

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* ADJUSTMENTS PAID *

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

# *Provider Services*

| Xerox<br>1-800-237-0757 | CGI<br>1-888-538-4275 |
| --- | --- |
| Claims/Billing/Payment | Email helpdesk.HCG.central.us@cgi.com |
| Forms/Website | CMAP Web Portal technical support |
| EDI | CMAP Web Portal Password resets |
| Updating existing provider profile | CMAP Web Portal End User training |

# *Thank you!*