Beginning Billing Workshop

CMS 1500

Health First Colorado
(Colorado’s Health First Colorado Program)

2017
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)-
  ➢ National Plan and Provider Enumeration System (NPPES)-
    • [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)
  ➢ Enumerator-
    • 1-800-456-3203
    • 1-800-692-2326 TTY
Department Website

www.colorado.gov/hcpf

For Our Providers
Provider Home Page

Find what you need here

Contains important information regarding Health First Colorado (Colorado’s Medicaid Program) & other topics of interest to providers and billing professionals

For Our Providers

- Why should you become a provider?
- Provider enrollment & revalidation
- Provider services (forms, rates & billing manuals)
- What’s new? (bulletins, newsletters, updates)

CBMS
Colorado Benefits Mgmt. System

DDDWeb

Web Portal

Get Help
Help for Providers

Get Info
FAQs & More

Find a Doctor
Are you a client looking for a doctor?

ATTENTION: Please visit Our Known Issues Web Page for Provider Web Portal Updates, Known Issues, and Non Issues
**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 Health First Colorado member

Billing Provider
Entity being reimbursed for service
Verifying Eligibility

• Always print & save copies of eligibility verifications
• Keep eligibility information in member’s file for auditing purposes
• Ways to verify eligibility:

  Colorado Medical Assistance Web Portal
  IVR 1-844-235-2387
  Health First Colorado ID Card with Switch Vendor
Eligibility Response Information

Eligibility Dates
Co-Pay Information
Third Party Liability (TPL)
Managed Care Plan
Medicare
Special Eligibility
BHO
Guarantee Number
Viewing Member Information
On the Search tab, enter the Member ID or Last Name, First Name and Birth date.

This search will display the Member in Focus page which provides Member Details, Coverage Details, Member Claims, Member Authorizations and Secure Correspondence.
Health First Colorado Identification Cards

- Older branded cards are valid
- Identification Card does not guarantee eligibility
Eligibility Types

• Most members = Regular Health First Colorado 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

- Claim must be marked as an emergency
- 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 card before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only
What Defines an “Emergency”?

• Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
  ➢ Active labor & delivery
  ➢ Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
    ▪ Placing health in serious jeopardy
    ▪ Serious impairment to bodily functions
    ▪ Dysfunction of any bodily organ or part
Eligibility Types

Presumptive Eligibility

• Temporary coverage of Health First Colorado or CHP+ services until eligibility is determined
  ➢ Member eligibility may take up to 72 hours before available

• Health First Colorado Presumptive Eligibility is only available to:
  ➢ Pregnant women
    • Covers Durable Medical Equipment (DME) and other outpatient services
  ➢ Children ages 18 and under
    • Covers all Health First Colorado covered services
  ➢ Labor / Delivery

• CHP+ Presumptive Eligibility
  ➢ Covers all CHP+ covered services, except dental
Eligibility Types

Presumptive Eligibility (cont.)

• Verify Health First Colorado Presumptive Eligibility through:
  ➢ Web Portal
  ➢ 271 Inquiry
  ➢ IVR

• Health First Colorado Presumptive Eligibility claims
  ➢ Submit to the Fiscal Agent
    • DXC Technology - 1-844-235-2387

• CHP+ Presumptive Eligibility and claims
  ➢ Colorado Access- 1-800-511-5010 or 1-888-214-1101
Managed Care Options

Managed Care Organization (MCO)

• Eligible for Fee-for-Service if:
  ➢ MCO benefits exhausted
  ➢ Service is not a benefit of the MCO
    ▪ Bill directly to the fiscal agent
Managed Care Options

Behavioral Health Organization (BHO)

• Community Mental Health Services Program
  ➢ State divided into five service areas
    ▪ Each area managed by a specific BHO
  ➢ Colorado Medical Assistance Program Providers
    ▪ Contact BHO in your area to become a Mental Health Program Provider
Medicare

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

Qualified Medicare Beneficiary (QMB)

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

Medicare-Health First Colorado Enrollees

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

• Health First Colorado pays Lower of Pricing (LOP)

➢ Example:
  ▪ Charge = $500
  ▪ Program allowable = $400
  ▪ TPL payment = $300
  ▪ Program allowable - TPL payment = LOP

\[
\begin{align*}
$400.00 \\
- \quad \$300.00 \\
= \quad \$100.00
\end{align*}
\]
Commercial Insurance

• Health First Colorado is 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

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner, Optometrist, Speech Therapy, RHC / FQHC</td>
<td>$2.00</td>
</tr>
<tr>
<td>DME / Supply</td>
<td>$1.00 per date of service</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$3.00</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$10.00 per covered day or 50% of average allowable daily rate - whichever is less</td>
</tr>
<tr>
<td>Psych Services</td>
<td>.50 per unit of service, 1 unit = 15 minutes</td>
</tr>
</tbody>
</table>
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)
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

Only a submitter who sends X12N batch transactions or receives X12N reports needs to enroll in EDI for a trading partner ID.

Providers no longer need to obtain a trading partner ID to access the web portal.

Colorado.gov/hcpf/EDI-Support
Crossover Claims

Automatic Medicare Crossover Process:

- Medicare
- Fiscal Agent
- Remittance Advice (RA)

• Crossovers may not happen if:
  ➢ NPI not linked
  ➢ Member is a retired railroad employee
  ➢ Member has incorrect Medicare number on file
Payment Processing Schedule

**Mon.**
- Fiscal Agent processes Electronic Funds Transfers (EFT) & checks
- Fiscal Agent posts RA to provider web portal

**Tue.**

**Wed.**
- EFT payments deposited to provider accounts

**Thur.**
- Weekly claim submission cutoff

**Fri.**
- Fiscal Agent processes submitted claims & creates RA

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**Department of Health Care Policy & Financing**

COLOrado
Electronic Funds Transfer (EFT)

Advantages

- Free!
- No postal service delays!
- Automatic deposits every Thursday!
- Safest, fastest, & easiest way to receive payments!
- Colorado.gov/hcpf/our-providers → Web Portal
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.

**Website:**

[www.ColoradoPAR.com](http://www.ColoradoPAR.com)

**Phone:**

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 posted electronically to 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
PARs Reviewed by the Department

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
Waiver PARs

Division for Intellectual & Developmental Disabilities (DIDD) Waivers

- Supported Living Services (SLS)
- Developmental Disabilities (DD)
- 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 HCPF 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)
**Internal Control Number**

**Region**
Two digits indicate the region. The region indicates how Health First Colorado received the claim.

**Batch Number**
Three digits indicate the batch range assigned to the claim. This is used internally by Health First Colorado.

**Year of Receipt**
Two digits indicate the year Health First Colorado received the claim.

**Julian Date of Receipt**
Three digits indicate the day of the year that the claim was received.

**Sequence Number**
Three digits indicate the sequence number assigned within a batch range.
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
  - Returned Claim
  - Use last ICN on 837I/837P/837D transaction
  - Keep supporting documentation
Timely Filing
Medicare/Health First Colorado Enrollees

Medicare pays claim
120 days from Medicare payment date

Medicare denies claim
60 days from Medicare denial date
Timely Filing Extensions

• Extensions may be allowed when:
  ➢ Commercial insurance has yet to pay/deny
  ➢ Delayed member eligibility notification
    • Delayed Eligibility Notification Form
  ➢ Backdated eligibility
    • Load letter from county
Timely Filing Extensions

Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Health First Colorado
    - Receive denial
  - 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

• Bill Electronically

• Steps you can take:
  ➢ Review past records
  ➢ Request billing information from member
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

Who completes the CMS 1500?

- HCBS/Waiver providers
- Vision providers
- Physicians/Other Practitioners
- Supply providers
- Surgeons
- Transportation providers
CMS 1500
## Common Denial Reasons

<table>
<thead>
<tr>
<th>Reason</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timely Filing</strong></td>
<td>Claim was submitted more than 120 days</td>
</tr>
<tr>
<td><strong>Duplicate Claim</strong></td>
<td>A subsequent claim was submitted after a claim for the same service has already been paid</td>
</tr>
<tr>
<td><strong>Bill Medicare or Other Insurance</strong></td>
<td>Health First Colorado is always the “Payer of Last Resort” - Provider should bill all other appropriate carriers first</td>
</tr>
</tbody>
</table>
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

Denied
Claim processed & denied by claims processing system

Paid
Claim processed & paid by claims processing system
Claims Process - Common Terms

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

Rebill
Re-bill previously denied claim

Suspend
Claim must be manually reviewed before adjudication

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

From the Noun Project:
“Delete” by Ludwig Schubert
“Stop” by Chris Robinson
“Check-Mark” by Muneer A.Safia
“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/Batch

- Preferred method
- Easier to submit & track

Paper

- Complete field 22 on the CMS 1500 claim form
Provider Remittance Advice (RA)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - Suspended

- Providers required to retrieve RA through Resources > Report Download
  - Via Web Portal
Provider Services

DXC
1-844-235-2387

- Claims/Billing/Payment
- Forms/Website
- EDI
- Updating existing provider profile
Thank you!