Beginning Billing Workshop Waiver

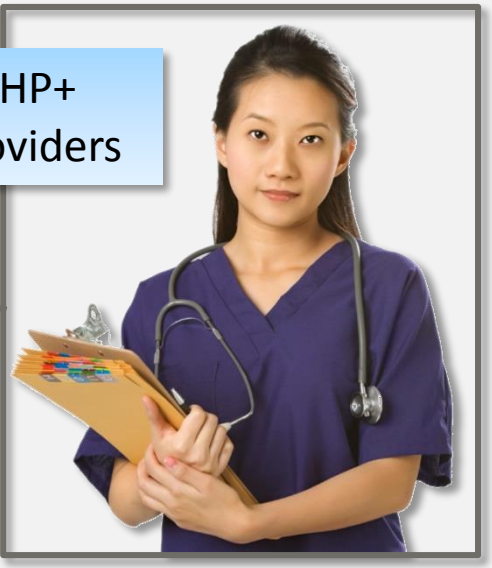
Colorado Medicaid
2014

Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing

Medicaid

Medicaid/CHP+ Medical Providers



Xerox State Healthcare

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

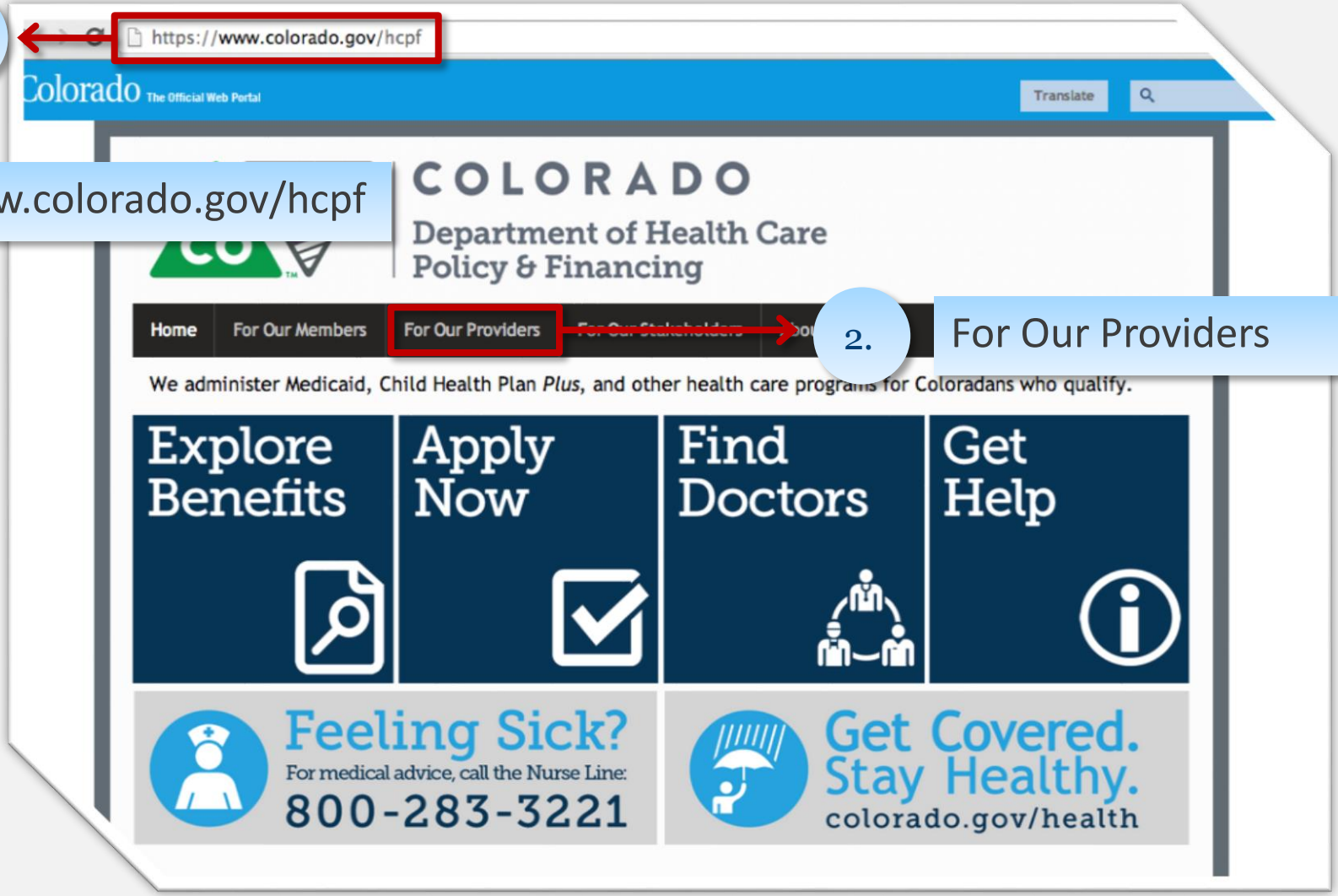
What is an NPI?

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY
  - **Waiver Provider currently <u>do not</u> require a NPI**

NEW! Department Website

1. https://www.colorado.gov/hcpf

www.colorado.gov/hcpf

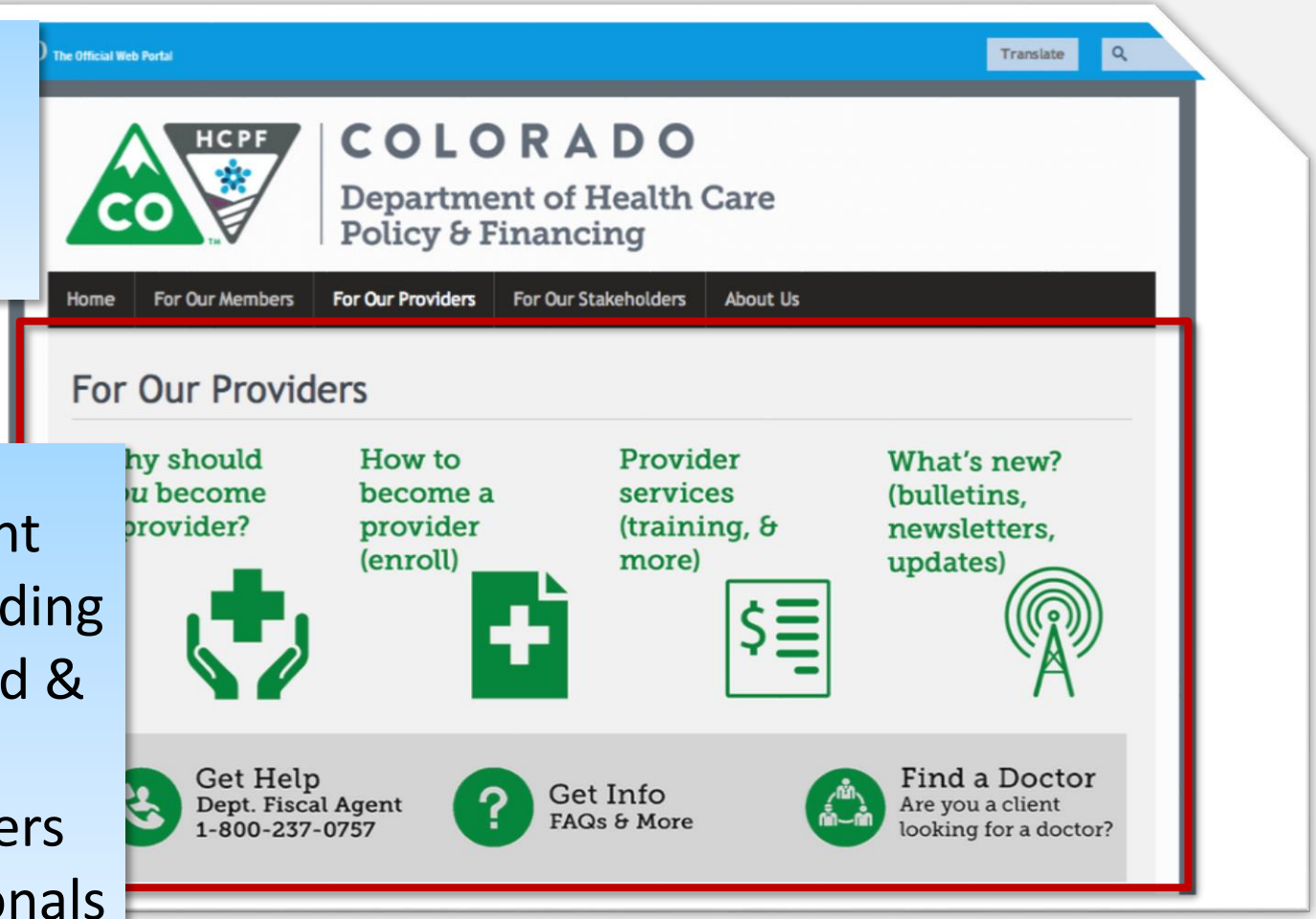


2. For Our Providers

NEW! 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

Billing Provider Number

Billing Provider

- Entity being reimbursed for service

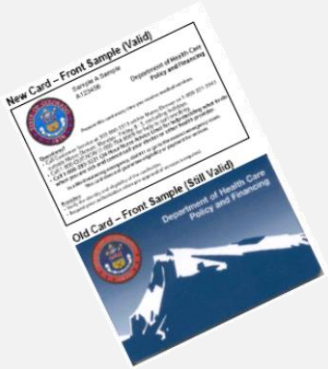
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Web Portal

Fax Back
1-800-493-0920

CMERS/AVRS
1-800-237-0757

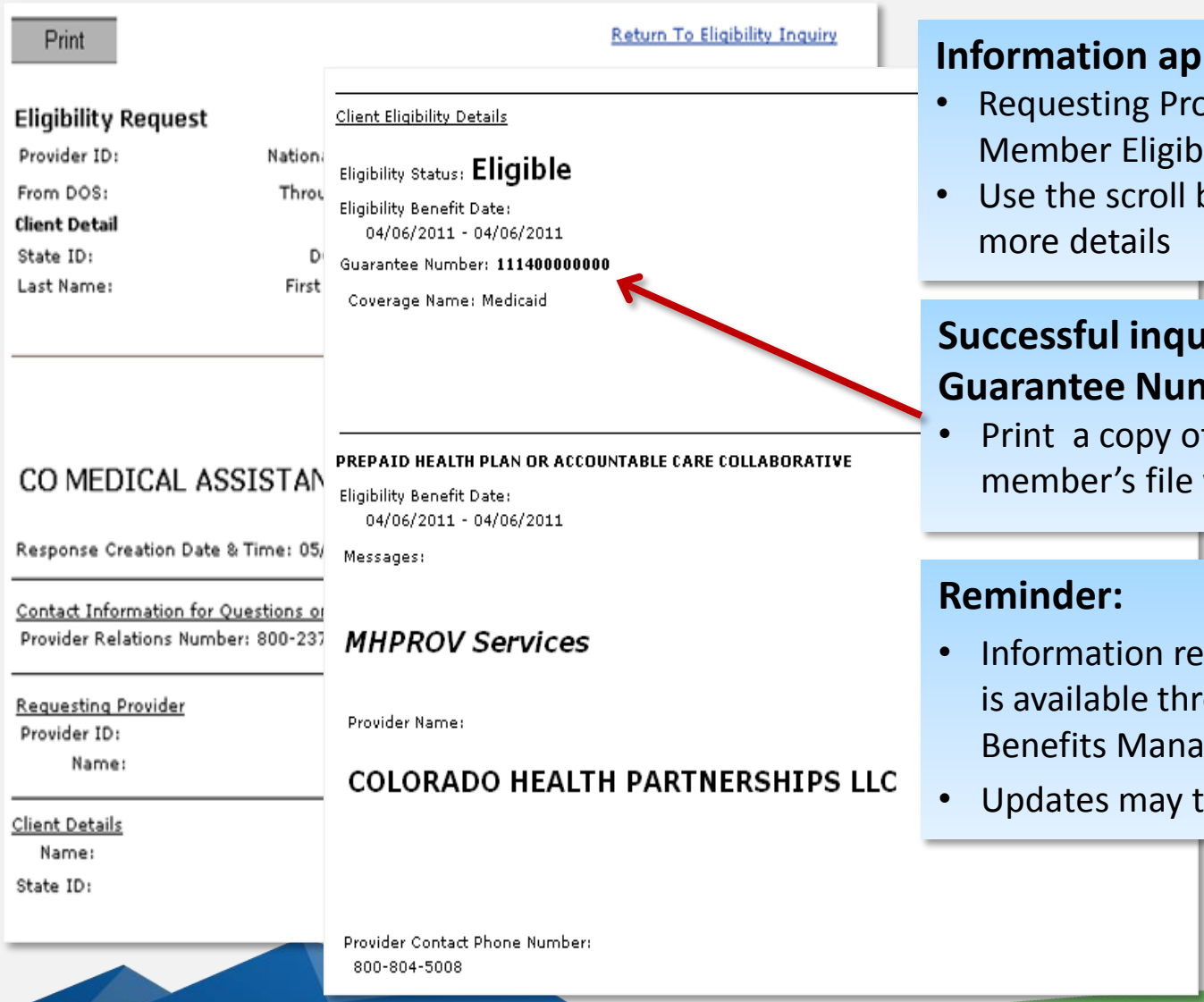


Medicaid ID Card with Switch Vendor

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 the scroll bar to the right to view more details

Successful inquiry notes a Guarantee Number:

- Print a copy of the response for the 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

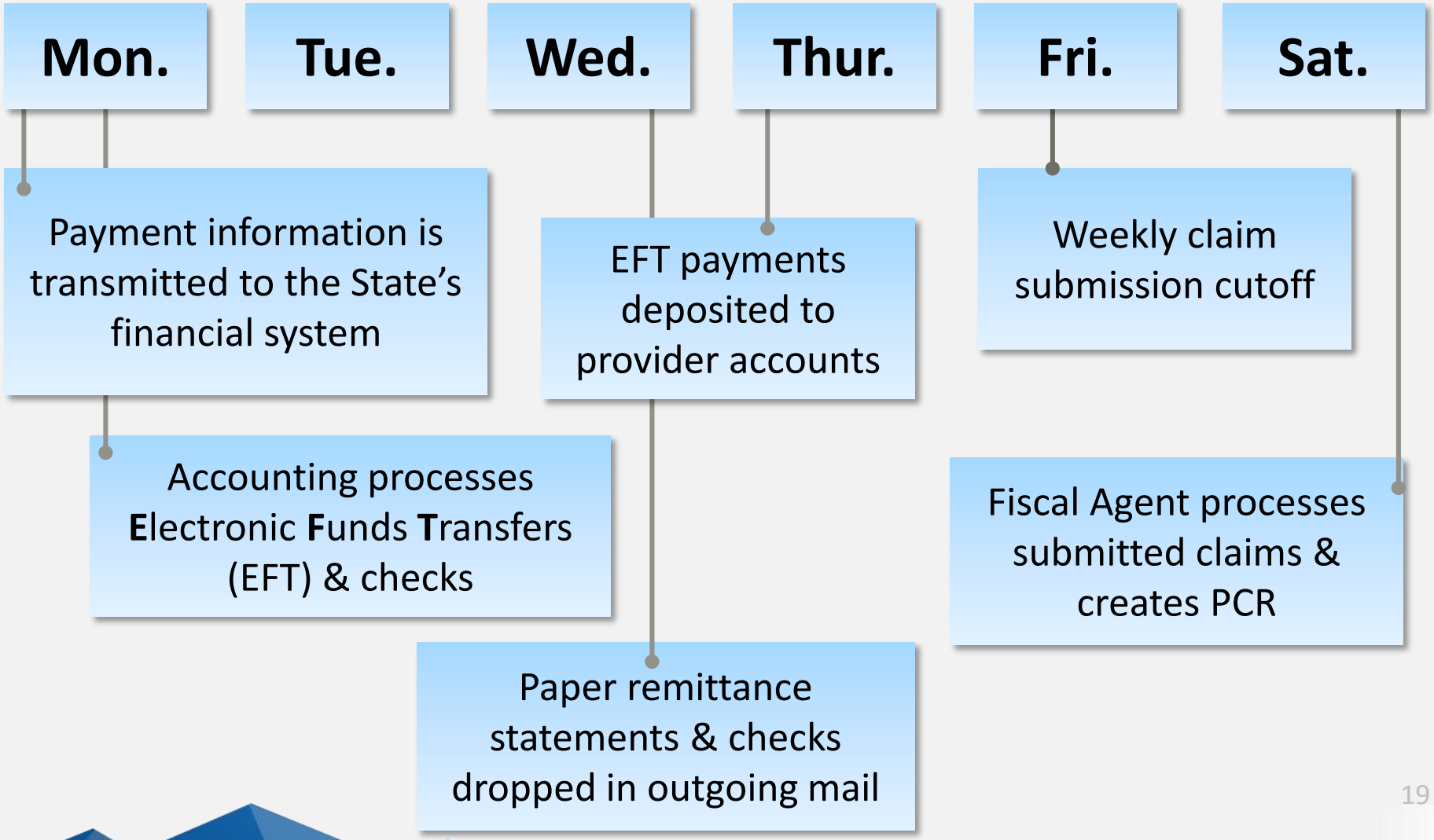
Record Retention

- 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

Payment Processing Schedule



Electronic Funds Transfer (EFT)

- Several Advantages:
  - Free!
  - No postal service delays
  - Automatic deposits every Friday
  - Safest, fastest & easiest way to receive payments
  - Located in Provider Services Forms section on Department website

Waiver PARs

CCB →

Adult w/ DHS Waivers

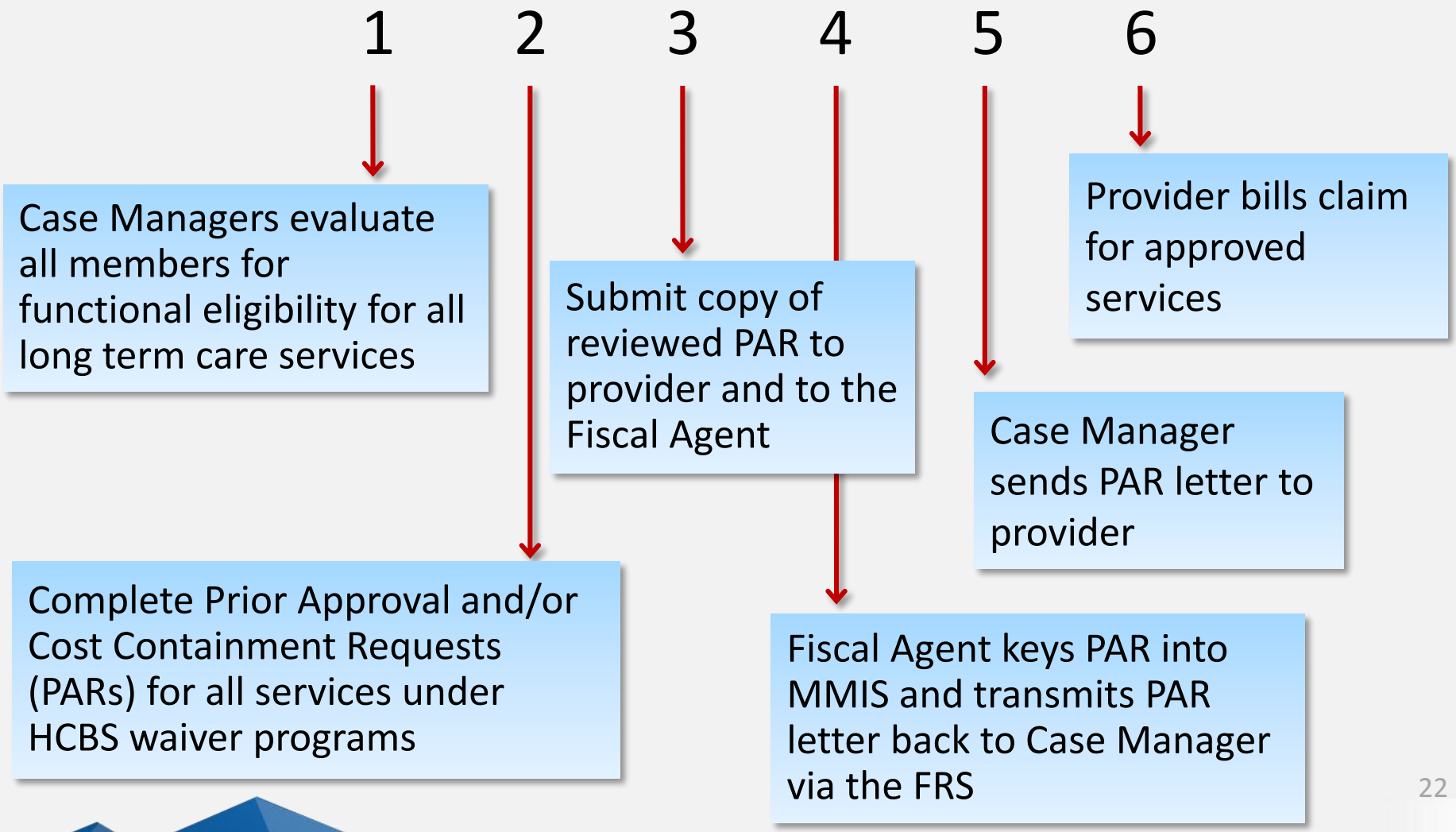
- Supported Living Services (SLS)
- Developmentally Disabled (DD)
- Children's Extensive Support (CES)
- Day Habilitation Services and Support (DHSS)

CMA / SEP →

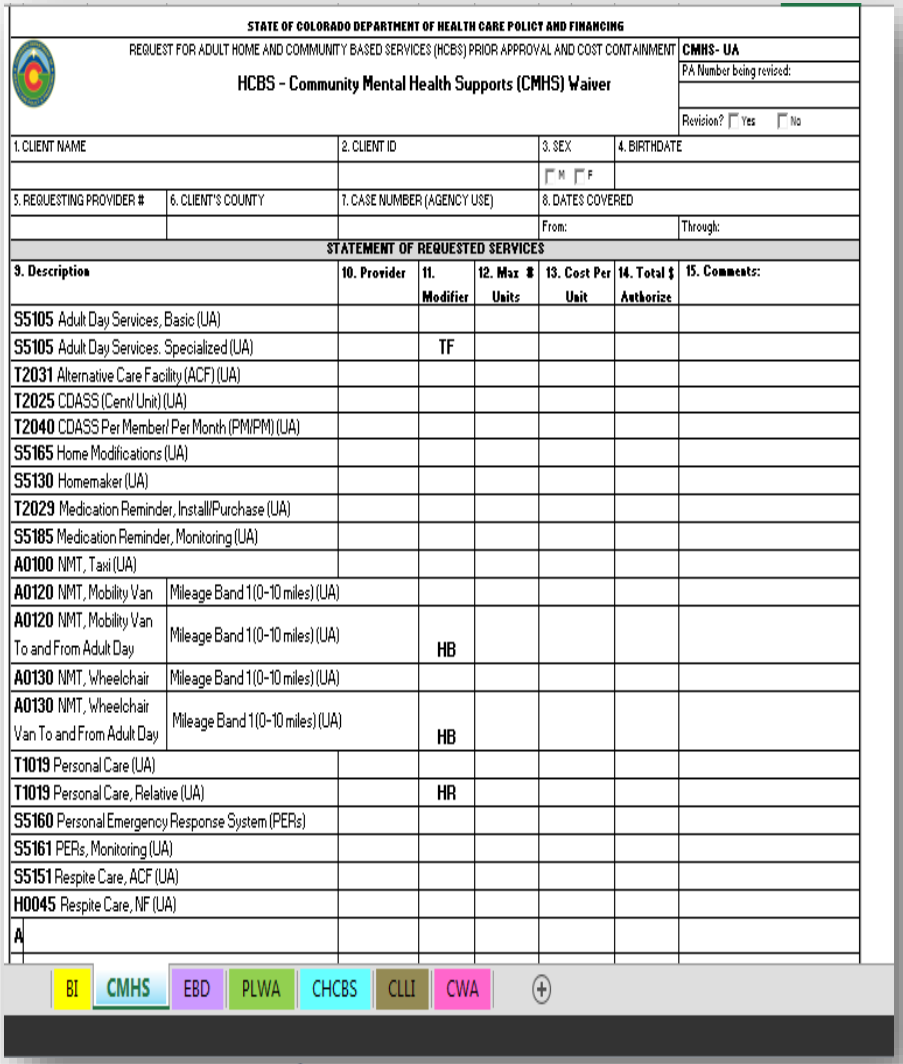
Adult with or without HCPF Waivers

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

Prior Authorization Flow



Waiver Prior Authorization Form



STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT — CMHS- UA

HCBS - Community Mental Health Supports (CMHS) 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 $ Authorize	15. Comments:
S5105 Adult Day Services, Basic (UA)							
S5105 Adult Day Services, Specialized (UA)			TF				
T2031 Alternative Care Facility (ACF) (UA)							
T2025 CDASS (Cent/ Unit) (UA)							
T2040 CDASS Per Member/ Per Month (PM/PM) (UA)							
S5165 Home Modifications (UA)							
S5130 Homemaker (UA)							
T2029 Medication Reminder, Install/Purchase (UA)							
S5185 Medication Reminder, Monitoring (UA)							
A0100 NMT, Taxi (UA)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (UA)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)		HB				
A0130 NMT, Wheelchair	Mileage Band 1 (0-10 miles) (UA)						
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (UA)		HB				
T1019 Personal Care (UA)							
T1019 Personal Care, Relative (UA)			HR				
S5160 Personal Emergency Response System (PERs)							
S5161 PERs, Monitoring (UA)							
S5151 Respite Care, ACF (UA)							
H0045 Respite Care, NF (UA)							
A							

BI | CMHS | EBD | PLWA | CHCBS | CLLI | CWA

- Find Adult HCBS Prior Approval and Cost Containment workbook for Waiver programs on the Department's website
  - ➤ www.colorado.gov/hcpf
    - Provider Services → Forms → Prior Authorization Request

Timely Filing – Medicare/Medicaid Enrollees

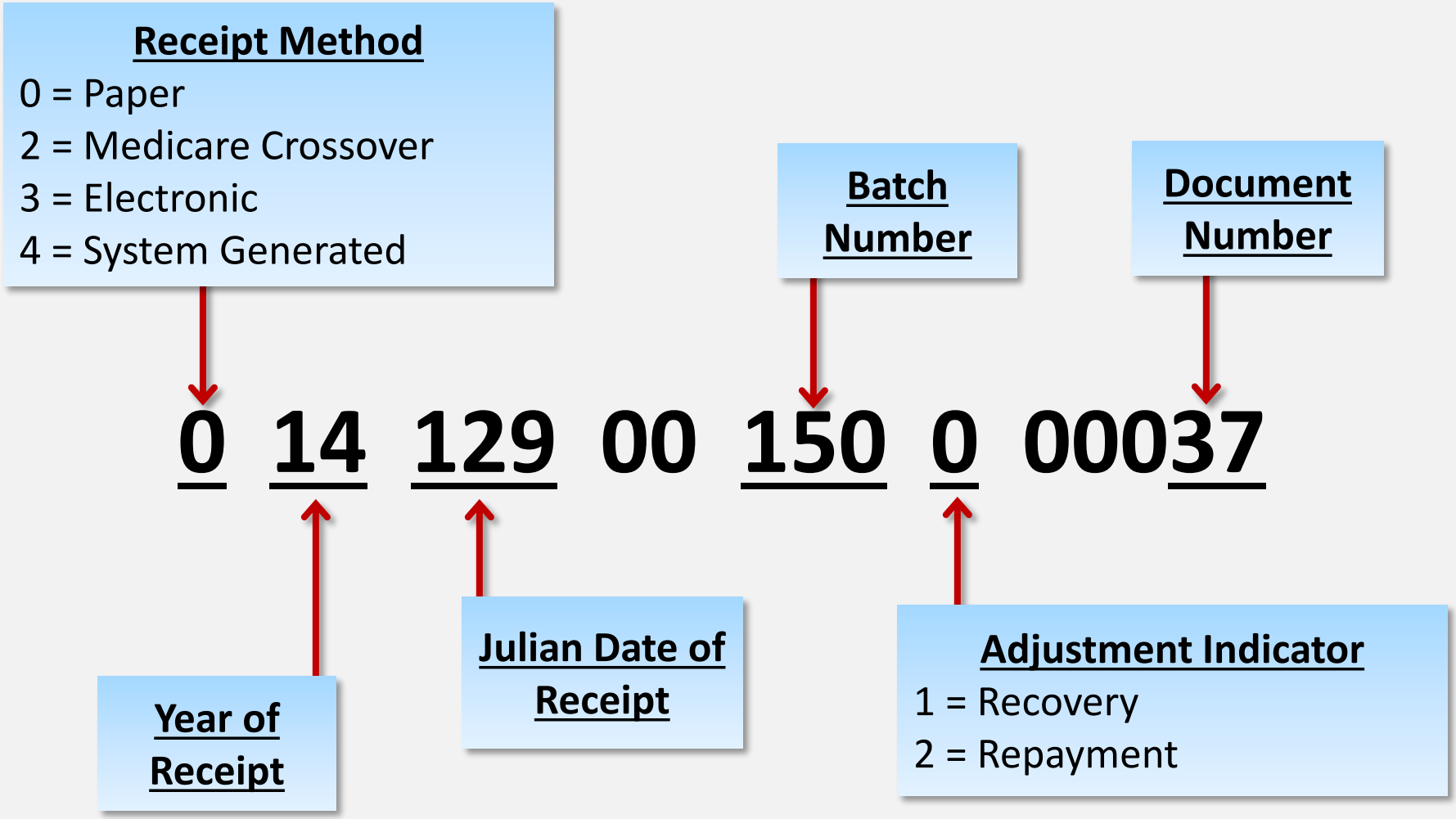
Medicare **pays** claim

- **120 days from Medicare payment date**

Medicare **denies** claim

- **60 days from Medicare denial date**

Transaction Control Number



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 DOS

- FQHC Separately Billed and additional Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date

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) & the date of the last adverse action in Field 19 (Additional Claim Information)

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

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

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

Extensions – **Backdated Eligibility**

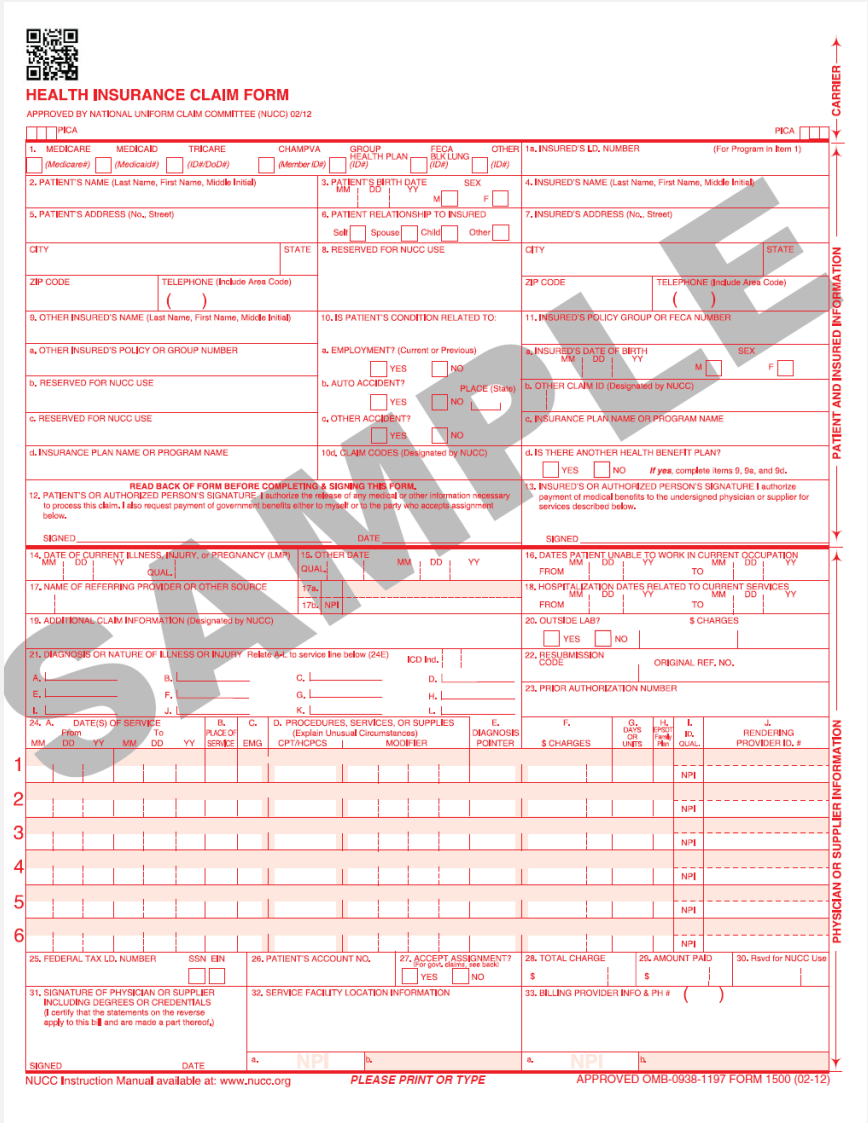
- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
  - County technician
  - Member name
  - Delayed or backdated
  - Date eligibility was updated

CMS 1500

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 TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

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)

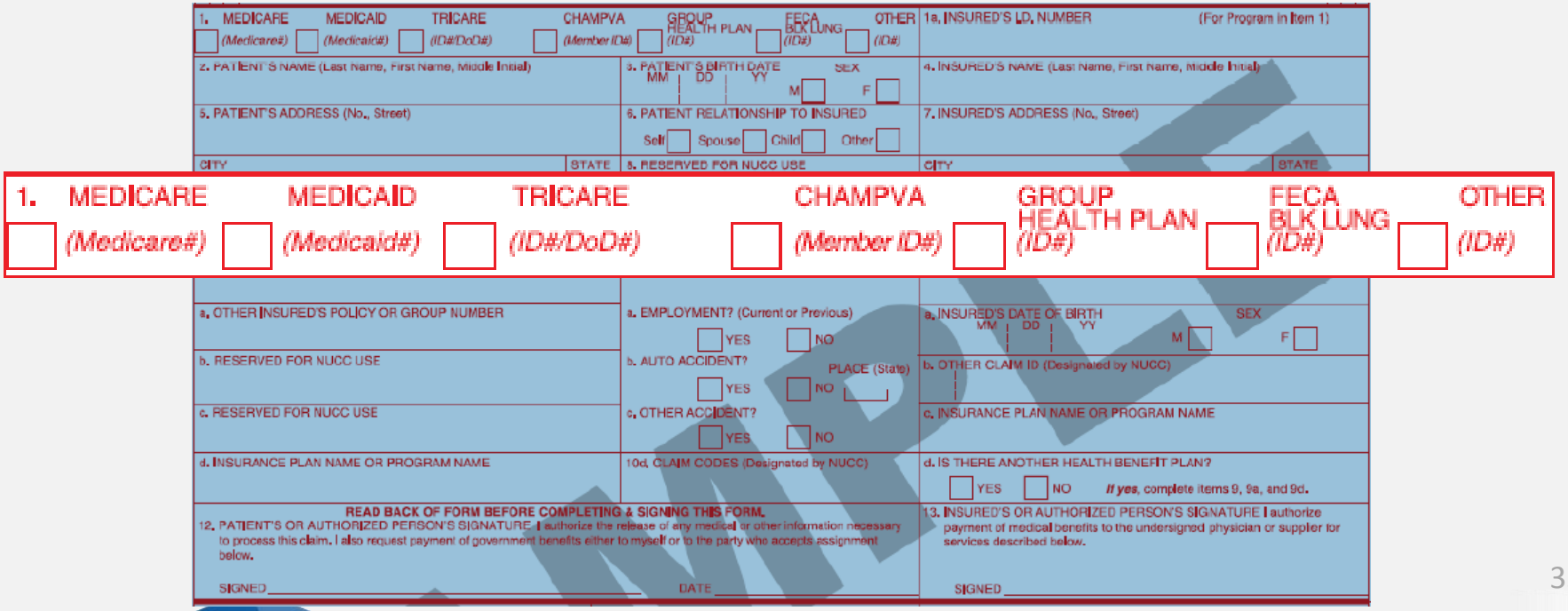
CARRIER

PATIENT AND INSURED INFORMATION

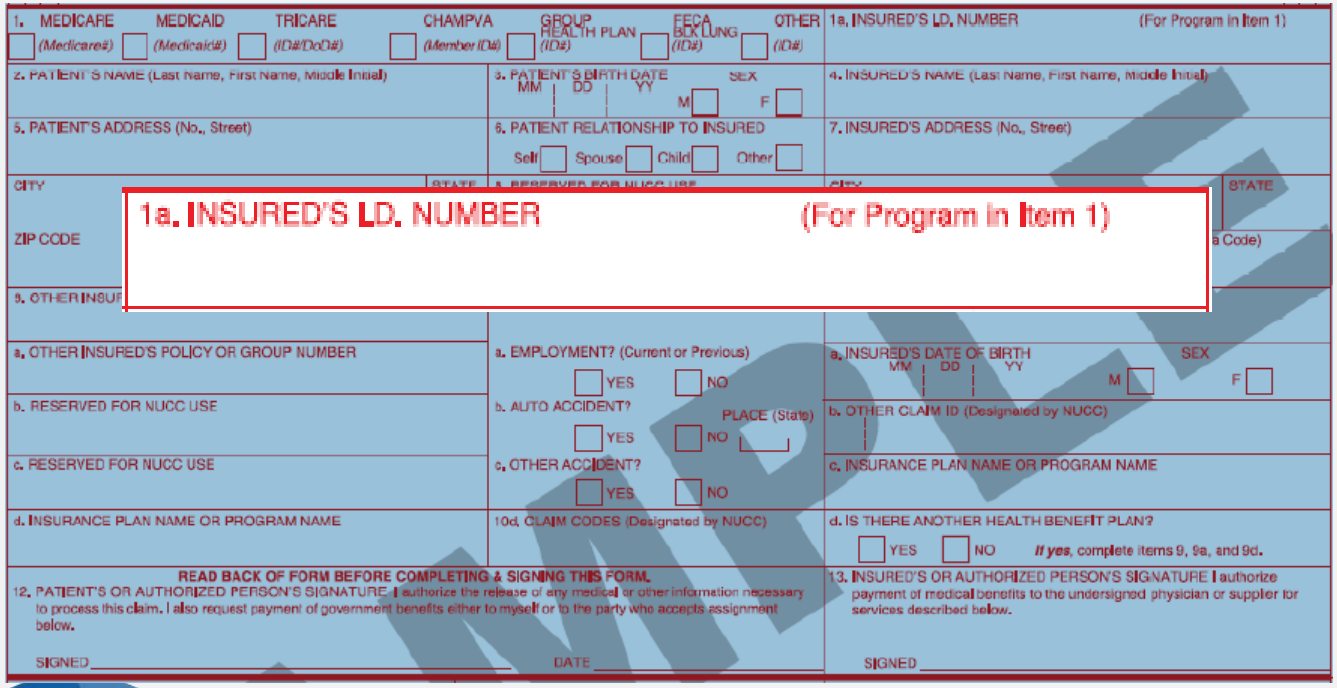
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

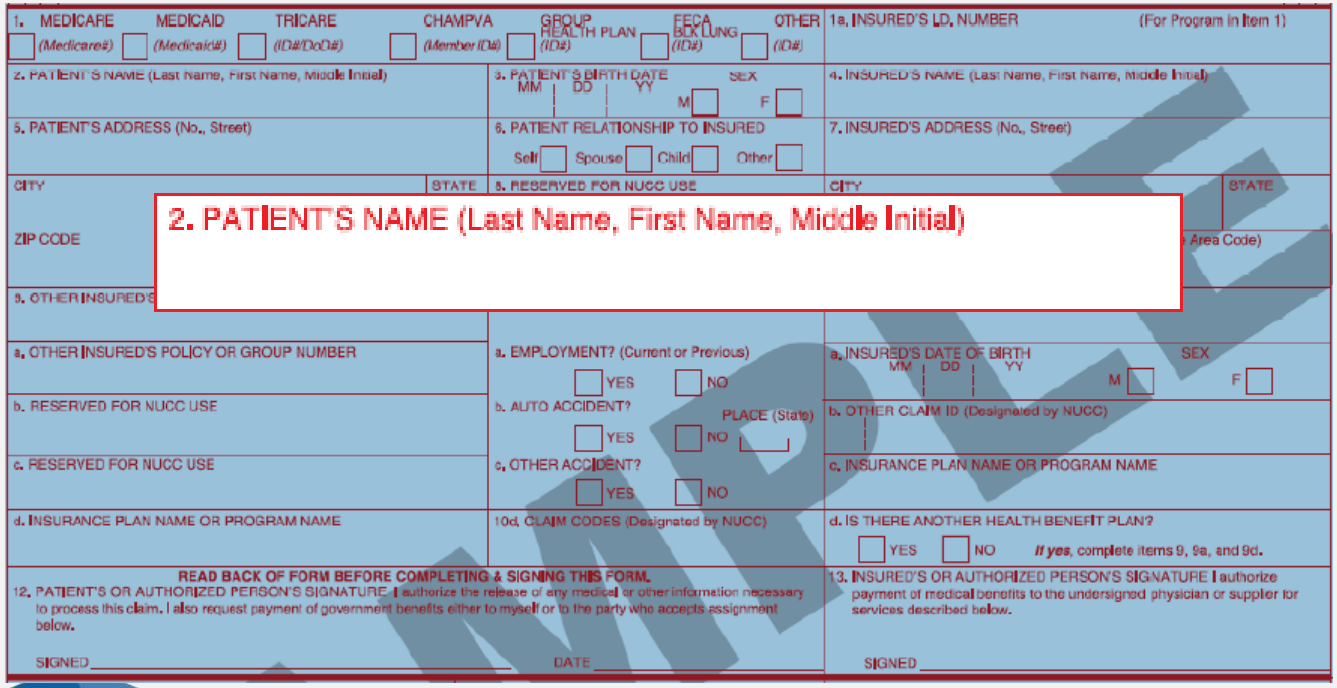
CMS 1500 Field Number	1
Field Title	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other
Requirement	Required
Instructions	Indicate the type of health insurance coverage applicable to this claim by placing an “X” in the appropriate box. Only one box can be marked.



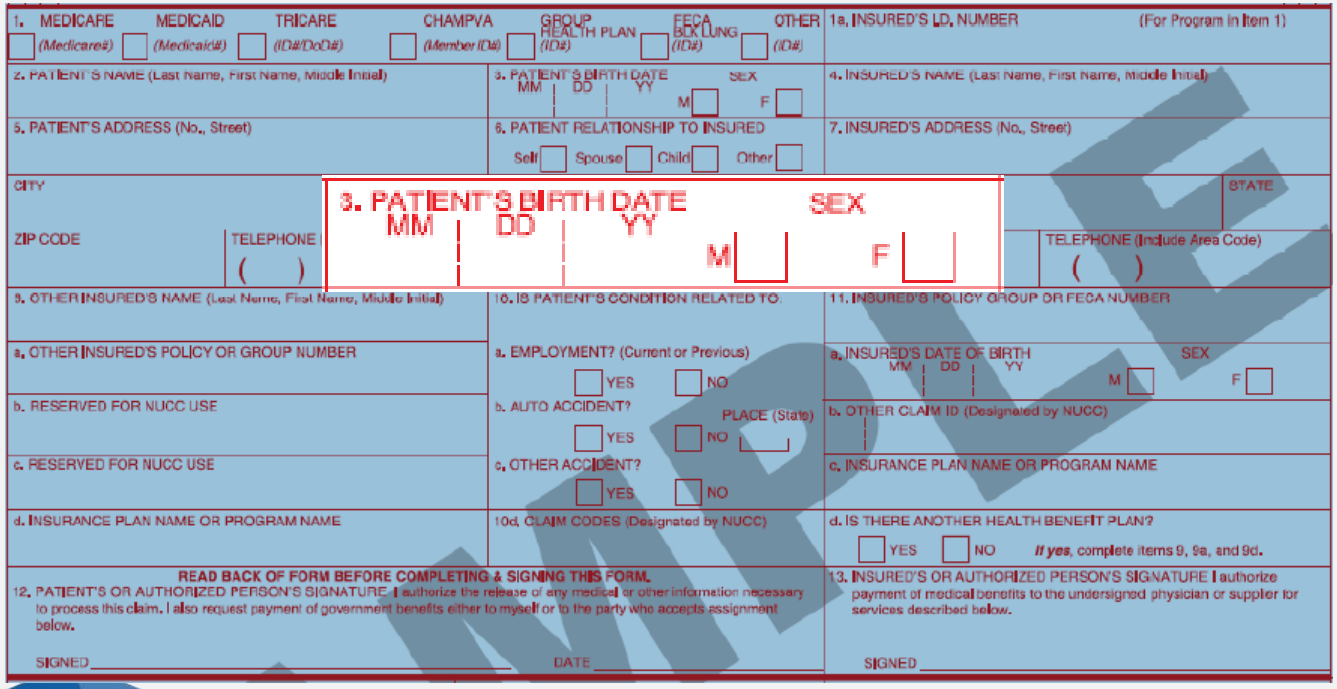
CMS 1500 Field Number	1a
Field Title	Insured's ID Number
Requirement	Required
Instructions	Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted.



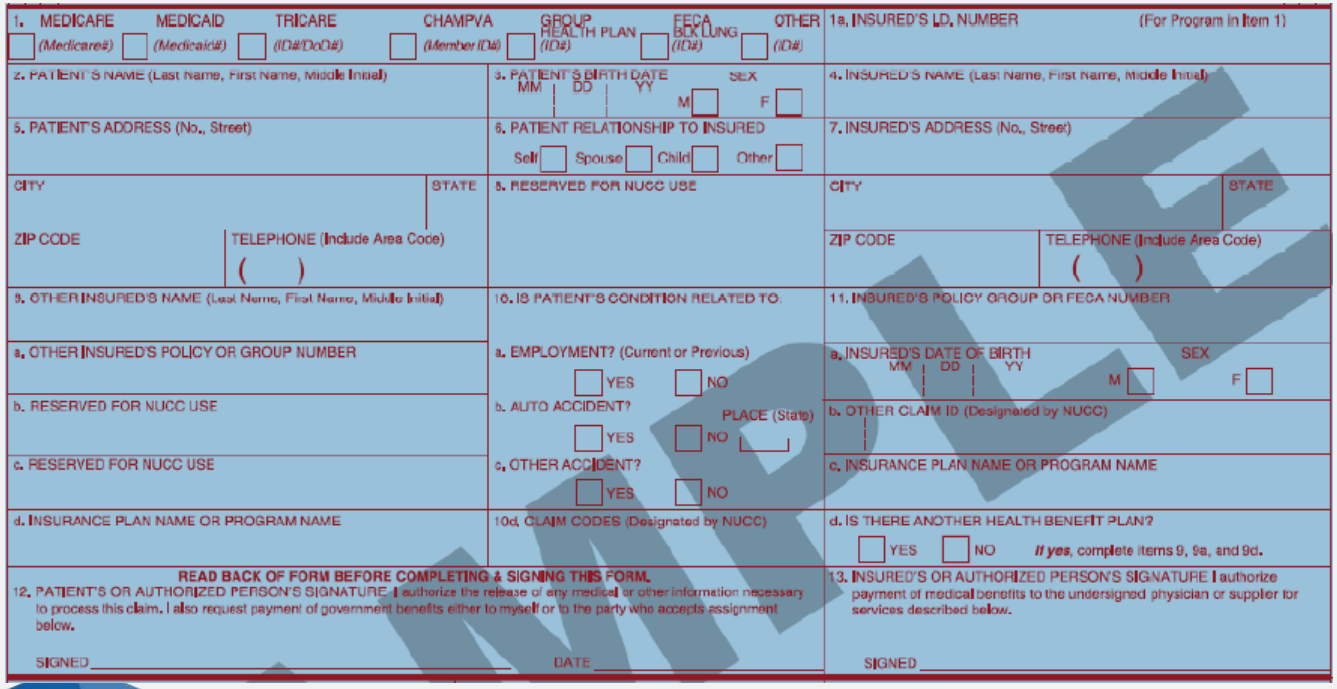
CMS 1500 Field Number	2
Field Title	Patient's Name
Requirement	Required
Instructions	Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.



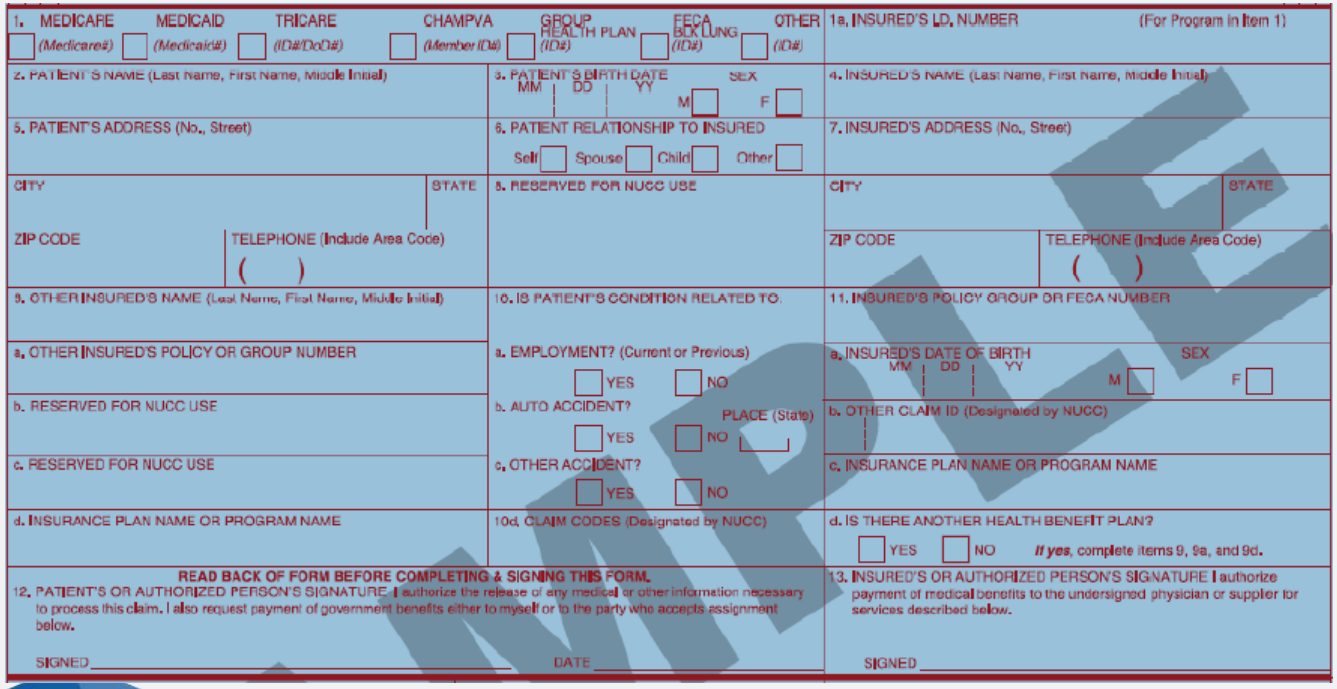
CMS 1500 Field Number	3
Field Title	Patient's Birth Date, Sex
Requirement	Required
Instructions	Enter the patient's eight-digit birth date MM/DD/YY). Place an "X" in the correct box to indicate the sex (gender) of the patient.



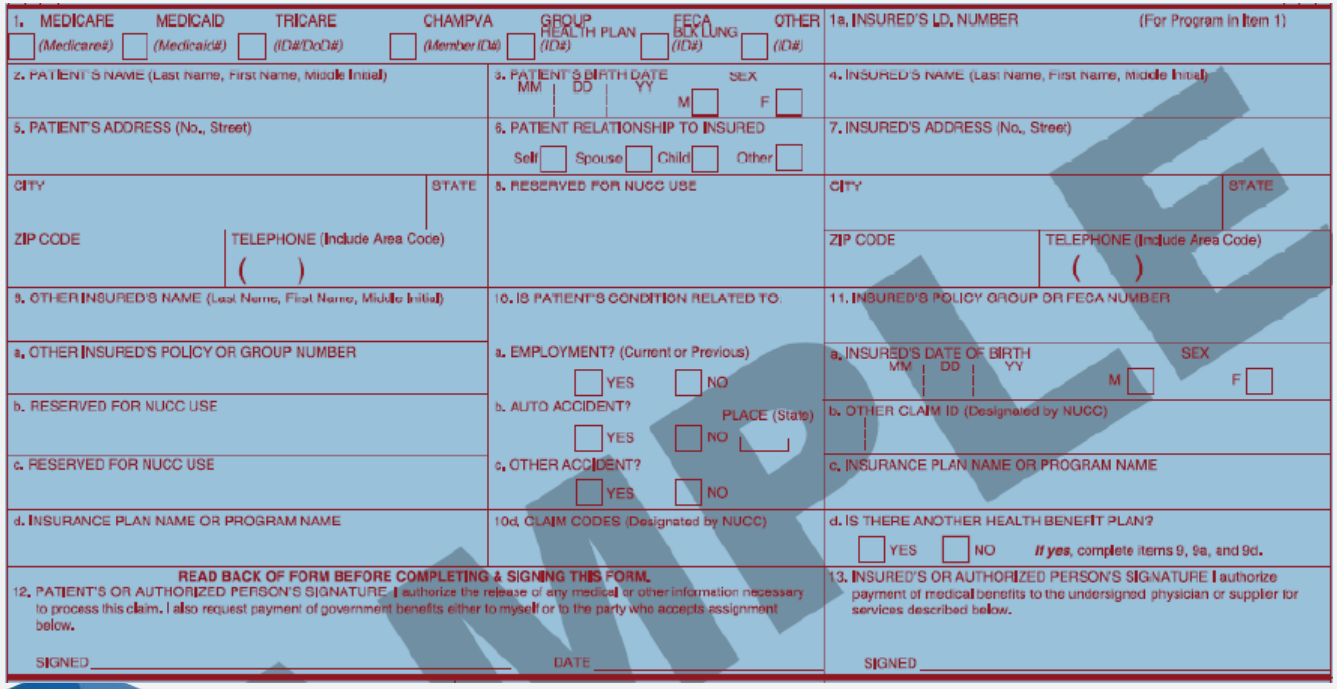
CMS 1500 Field Number	4
Field Title	Insured's Name
Requirement	Not Required
Instructions	



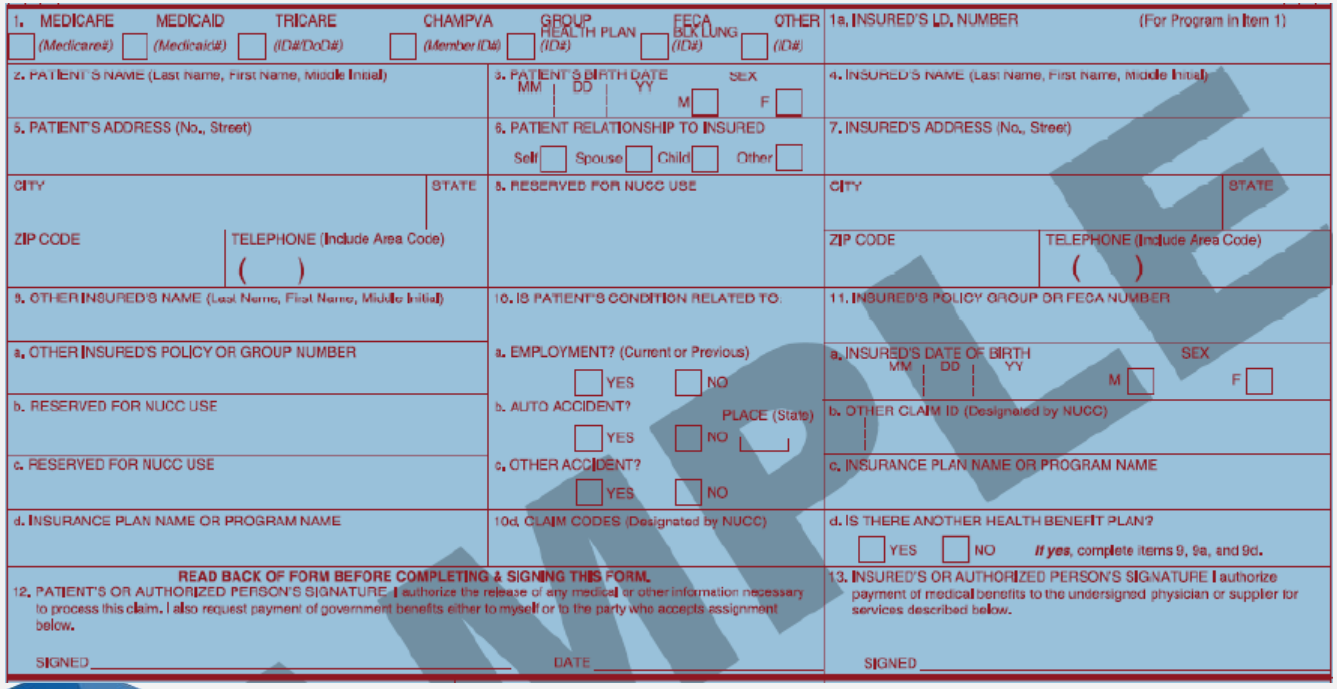
CMS 1500 Field Number	5
Field Title	Patient's Address
Requirement	Not Required
Instructions	



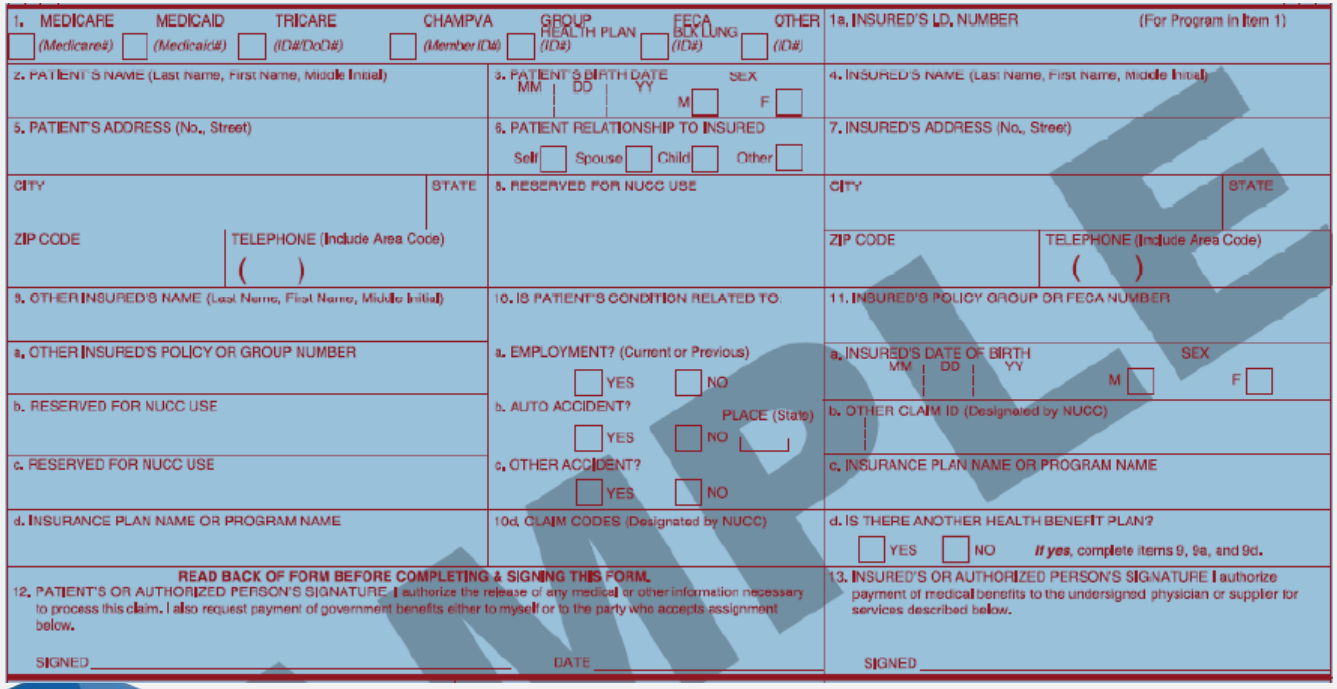
CMS 1500 Field Number	6
Field Title	Patient's Relationship to Insured
Requirement	Not Required
Instructions	



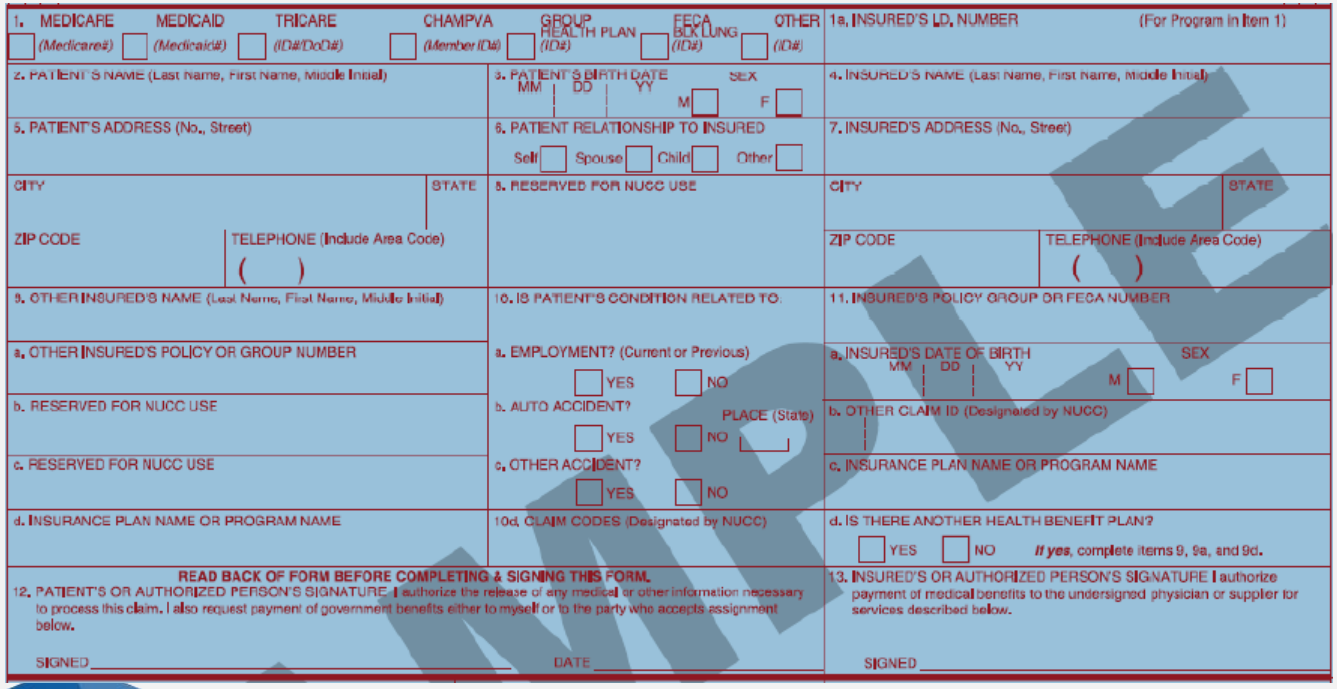
CMS 1500 Field Number	7
Field Title	Insured's Address
Requirement	Not Required
Instructions	



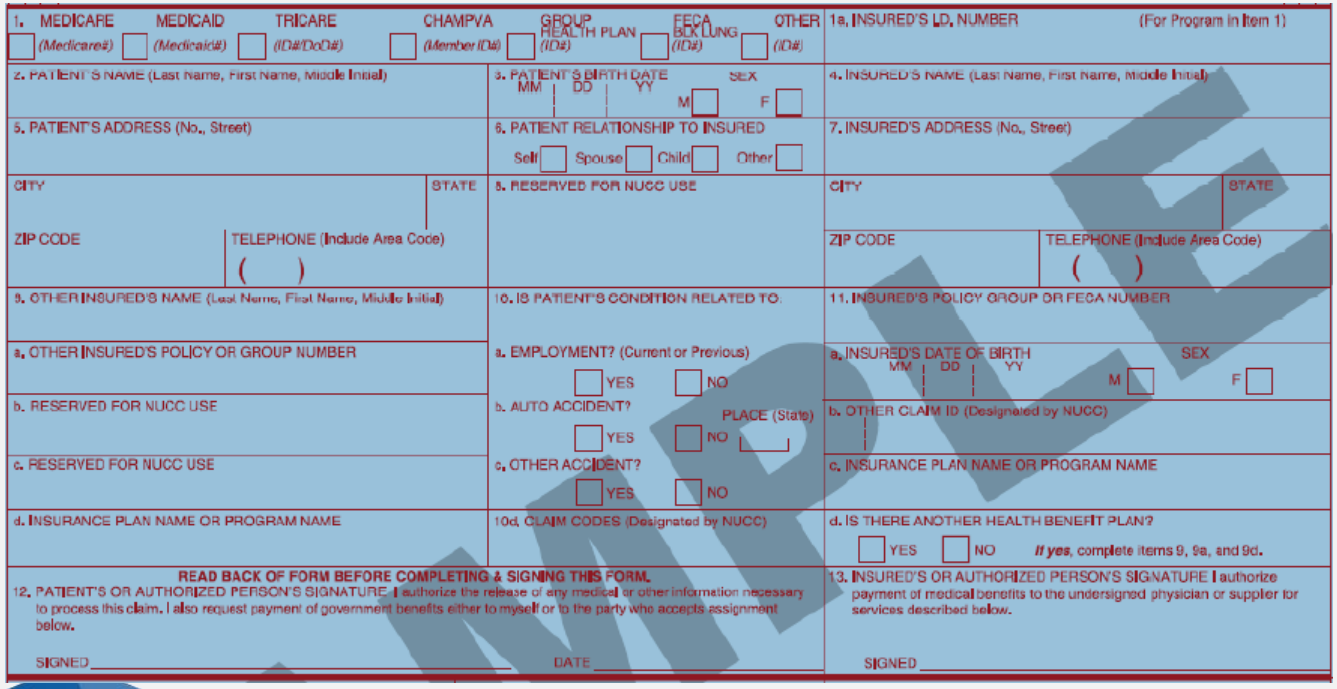
CMS 1500 Field Number	8
Field Title	Reserved for NUCC Use
Requirement	
Instructions	



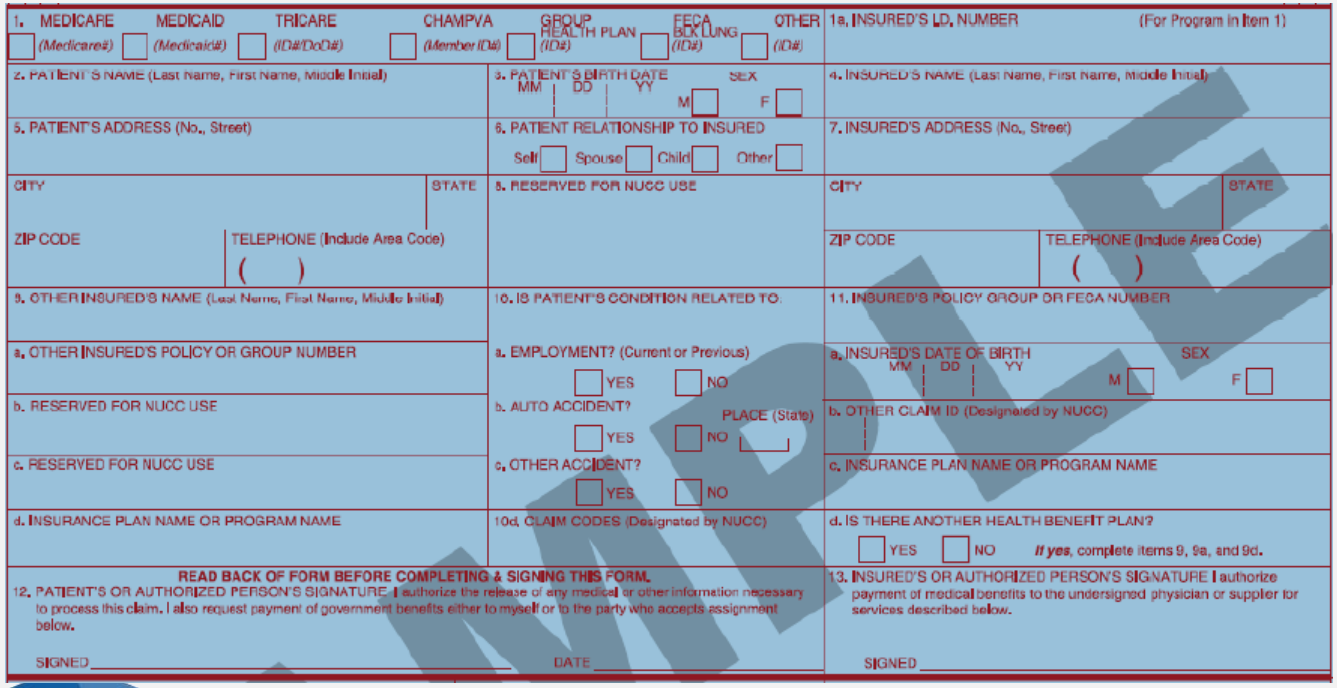
CMS 1500 Field Number	9
Field Title	Other Insured's Name
Requirement	Not Required
Instructions	



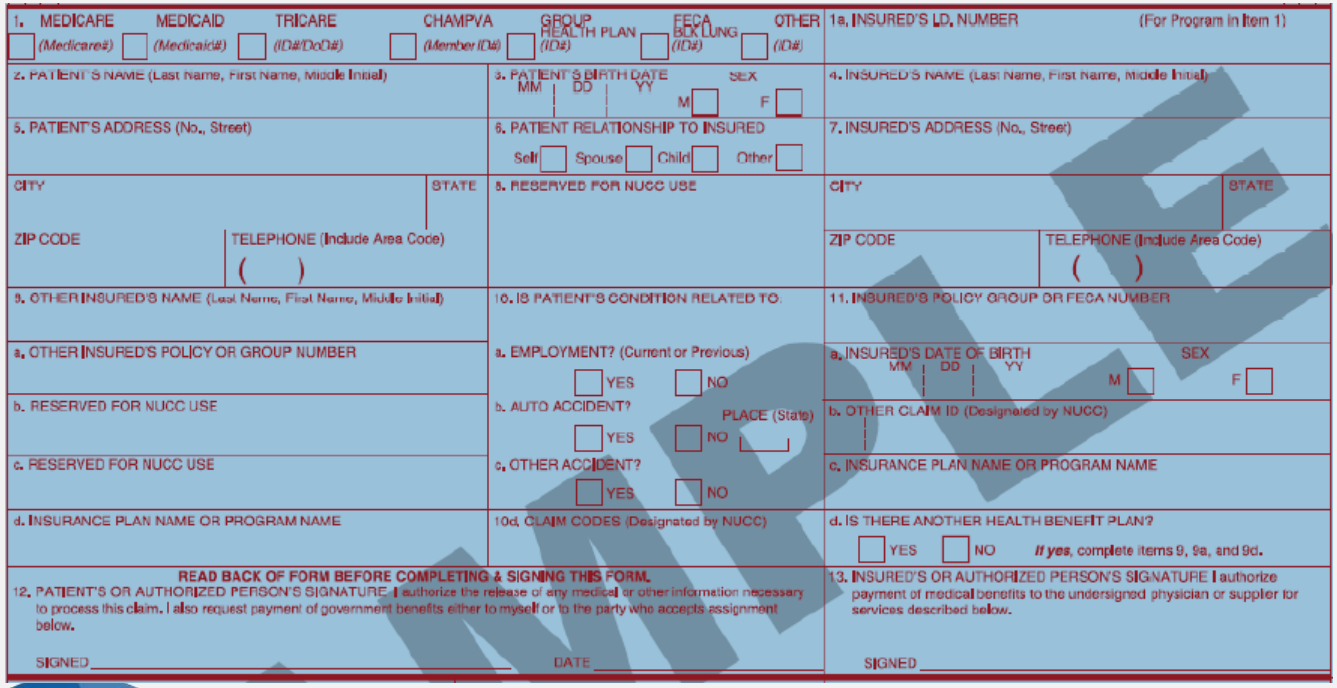
CMS 1500 Field Number	9a
Field Title	Other Insured's Policy or Group Number
Requirement	Not Required
Instructions	



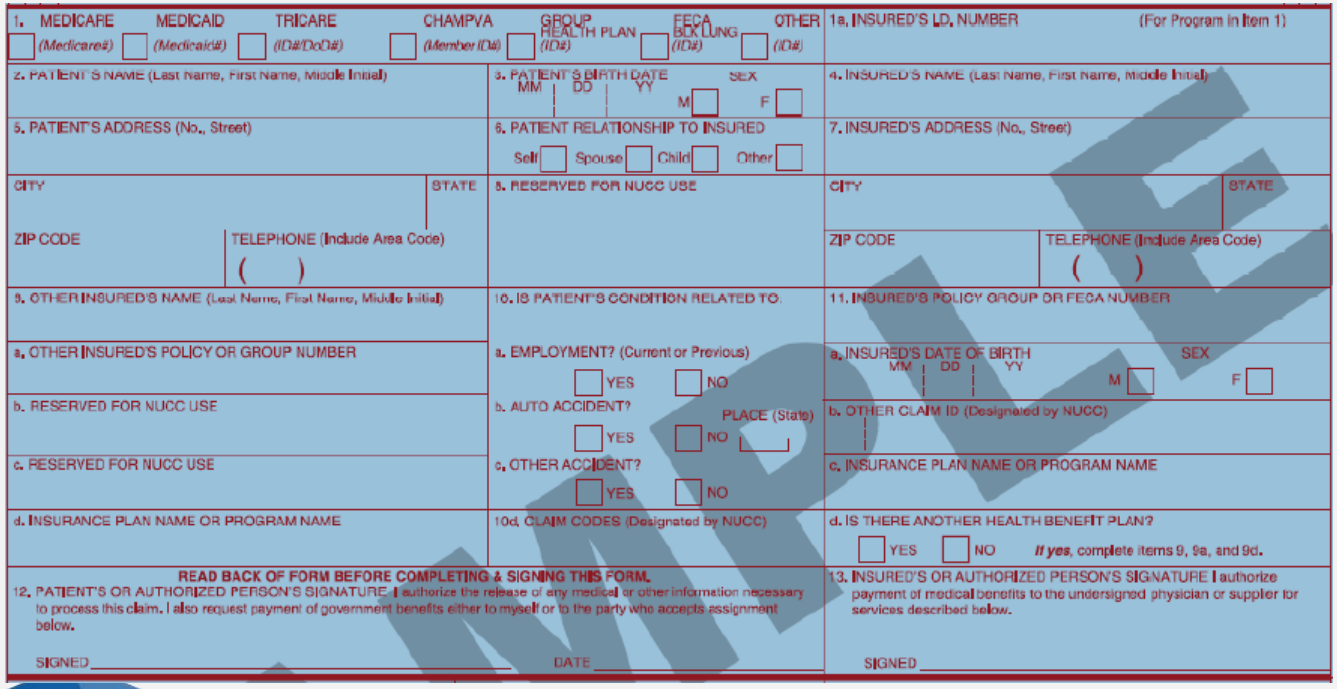
CMS 1500 Field Number	9b
Field Title	Reserved for NUCC Use
Requirement	Not Required
Instructions	



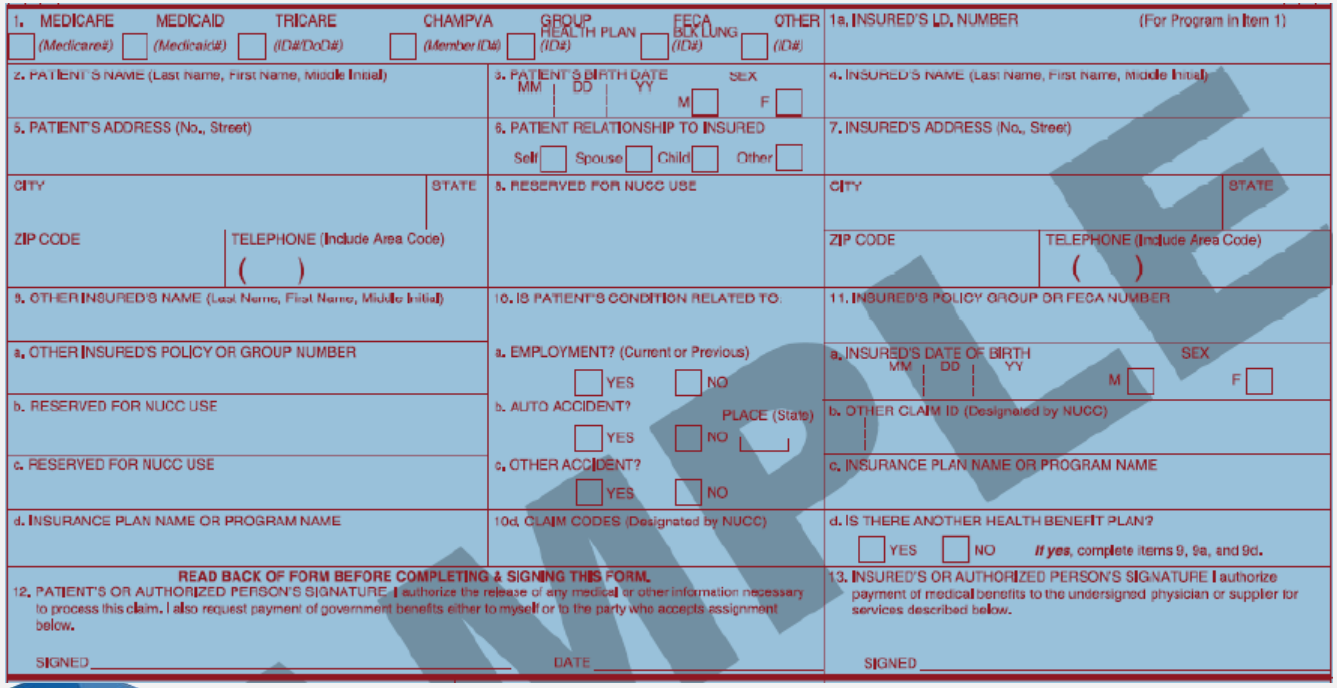
CMS 1500 Field Number	9c
Field Title	Reserved for NUCC Use
Requirement	Not Required
Instructions	



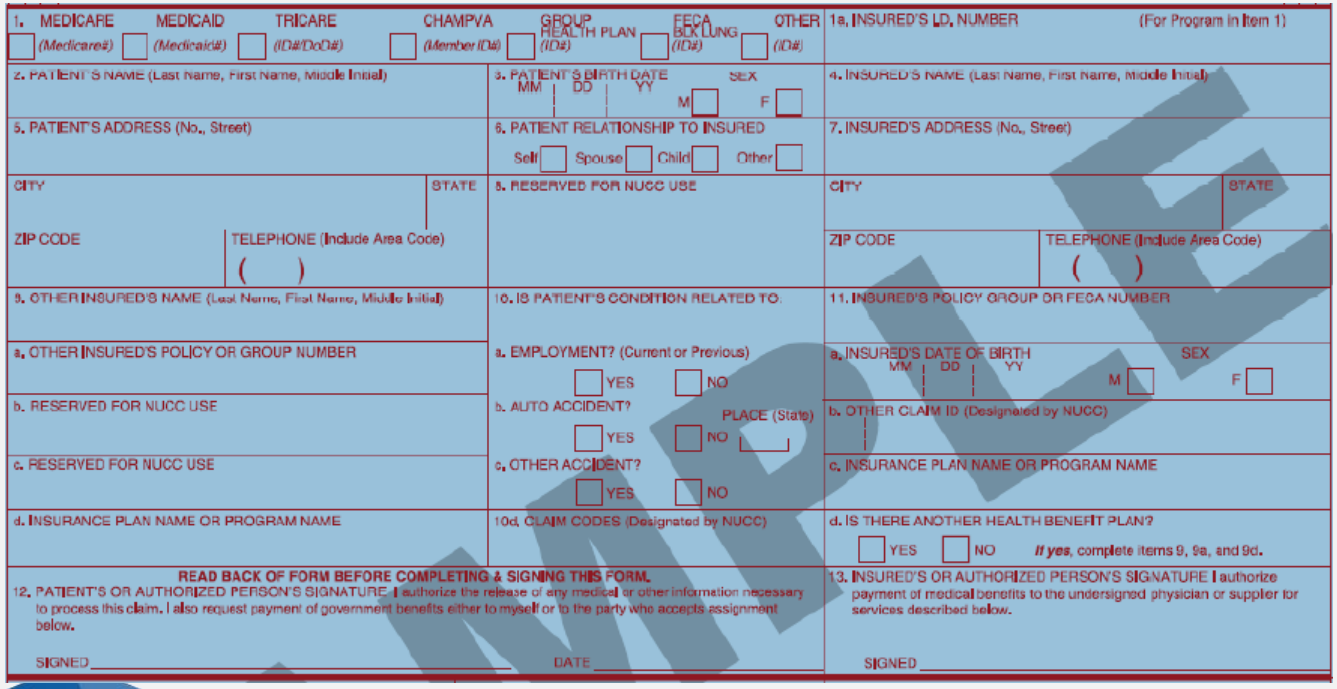
CMS 1500 Field Number	9d
Field Title	Insurance Plan Name or Program Name
Requirement	Not Required
Instructions	



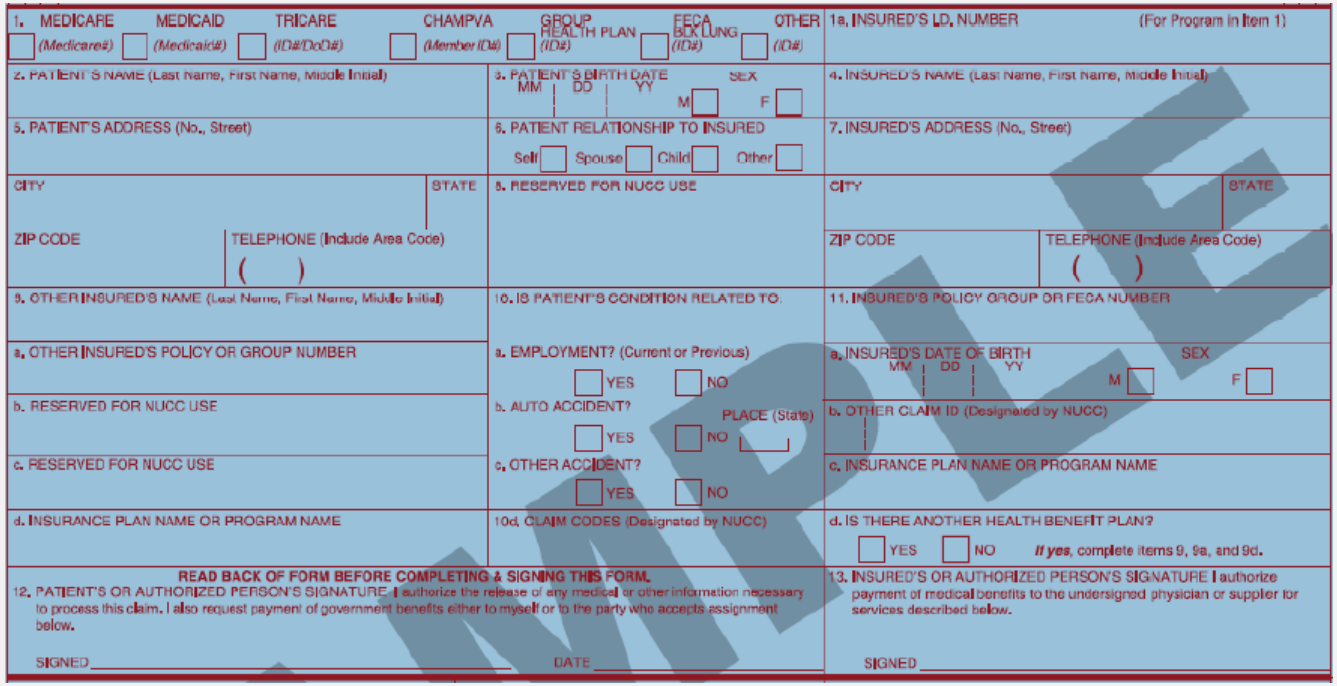
CMS 1500 Field Number	10a-c
Field Title	Is Patient's Condition Related To:
Requirement	Not Required
Instructions	



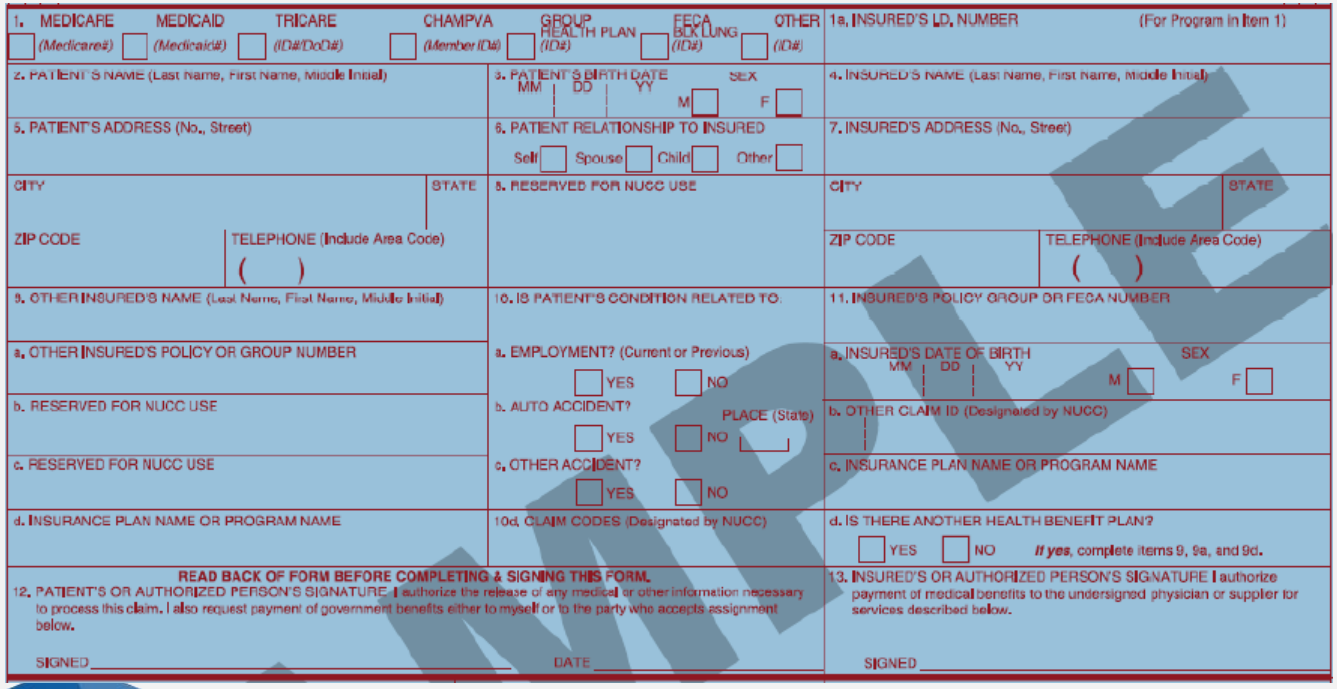
CMS 1500 Field Number	10d
Field Title	Reserved for Local Use
Requirement	Not Required
Instructions	



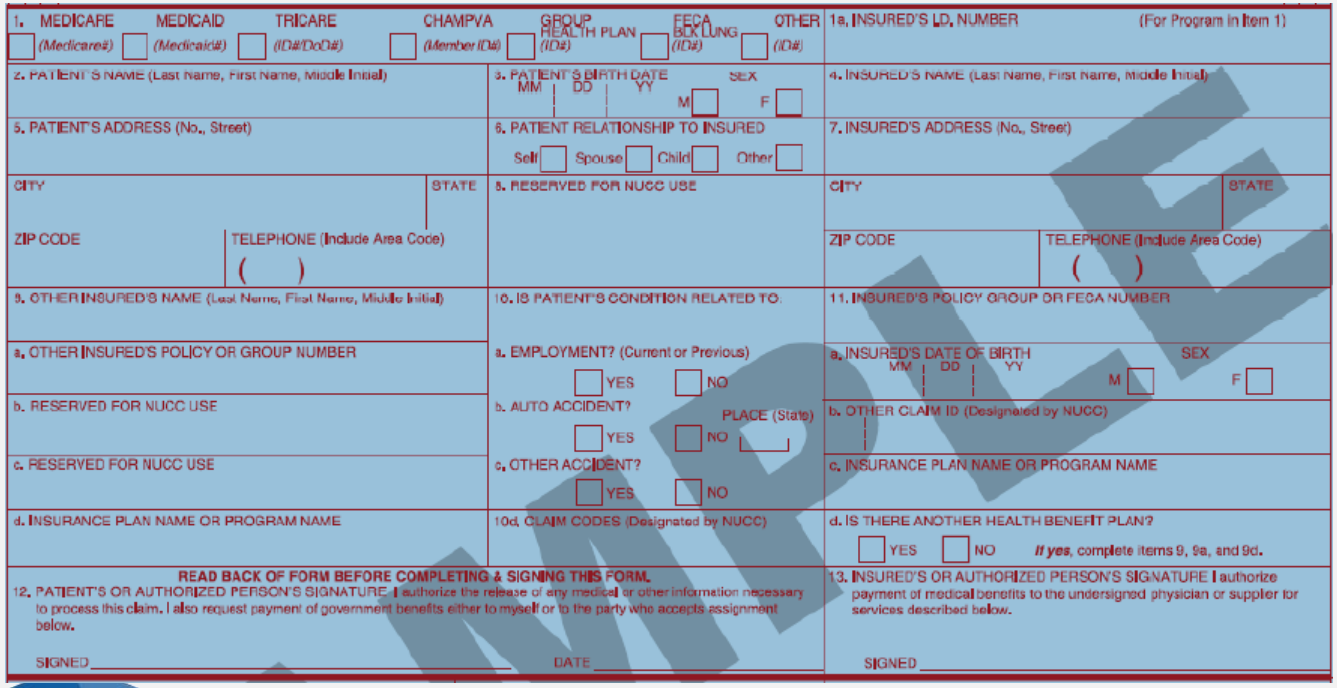
CMS 1500 Field Number	11
Field Title	Insured's Policy, Group, or FECA Number
Requirement	Not Required
Instructions	



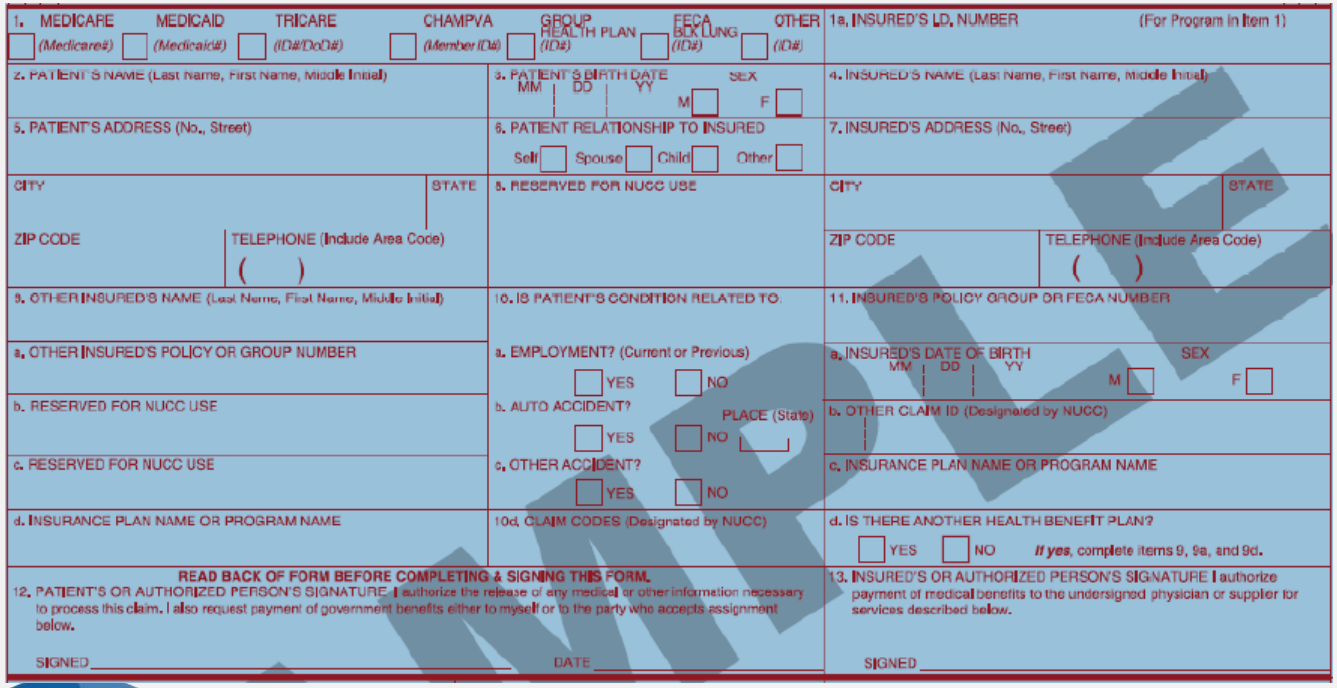
CMS 1500 Field Number	11a
Field Title	Insured's Date of Birth, Sex
Requirement	Not Required
Instructions	



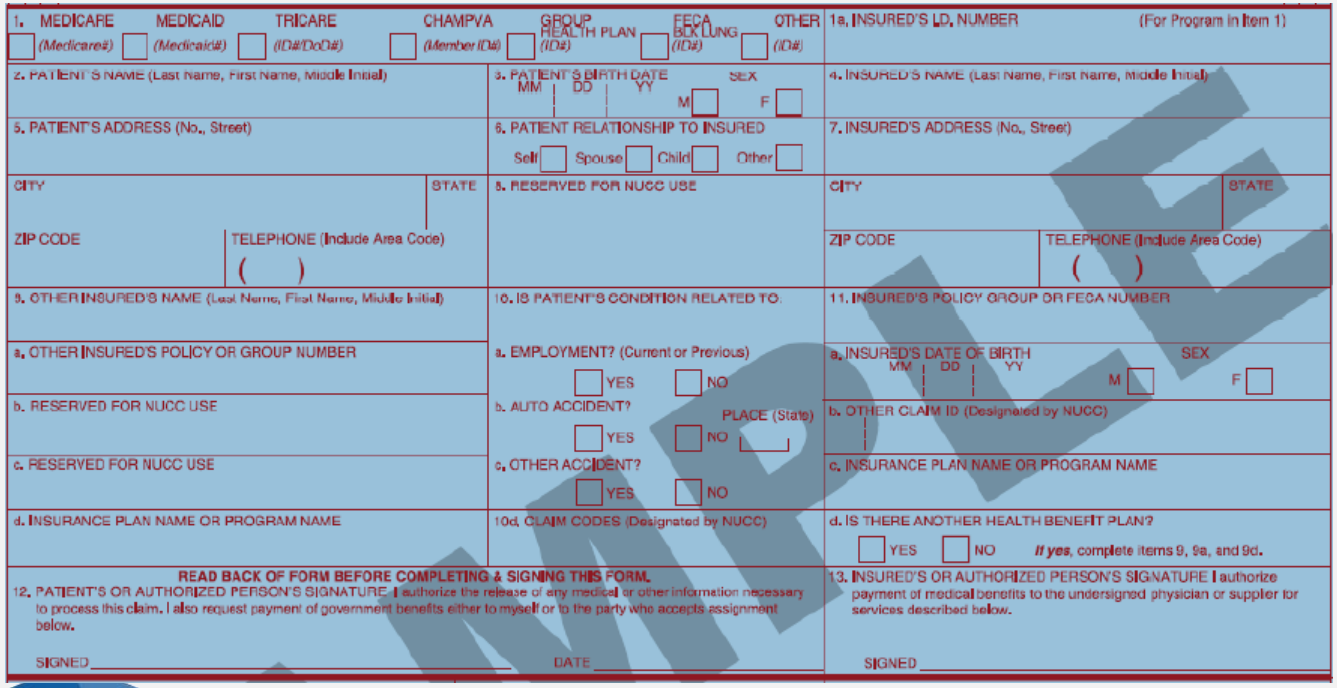
CMS 1500 Field Number	11b
Field Title	Other Claim ID
Requirement	Not Required
Instructions	



CMS 1500 Field Number	11c
Field Title	Insurance Plan Name or Program Name
Requirement	Not Required
Instructions	

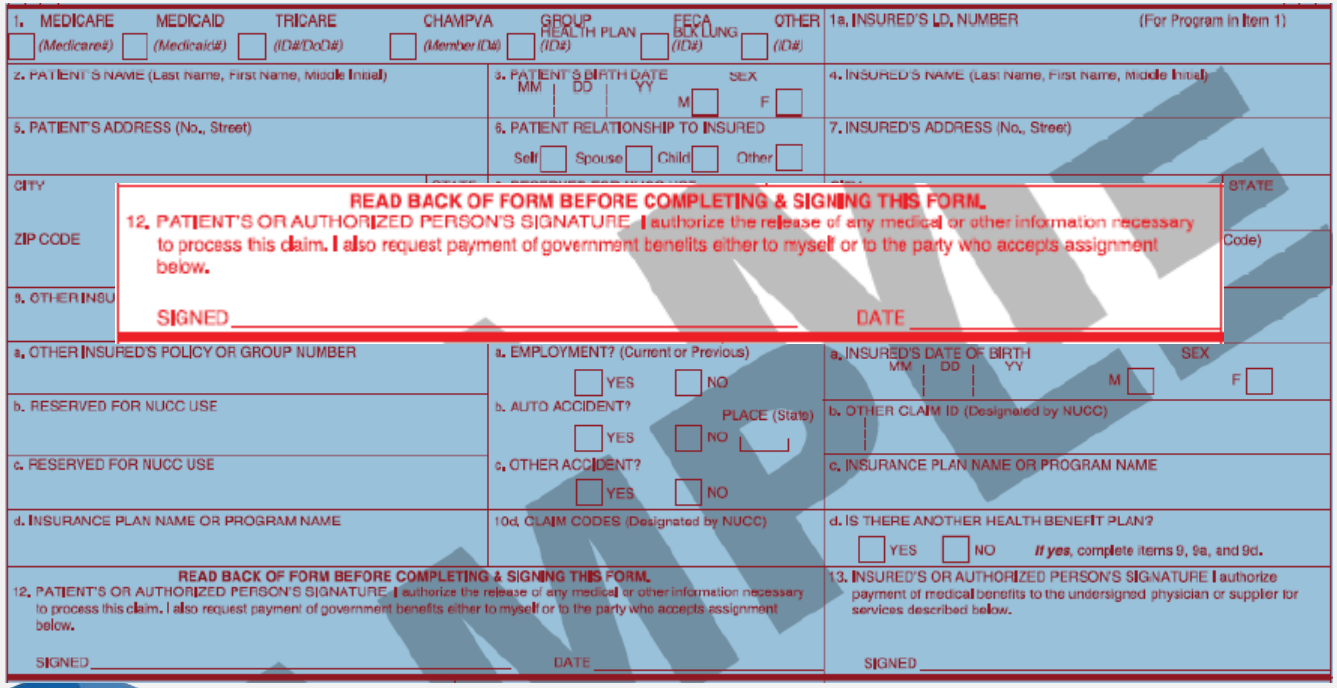


CMS 1500 Field Number	11d
Field Title	Is there another Health Benefit Plan?
Requirement	Not Required
Instructions	

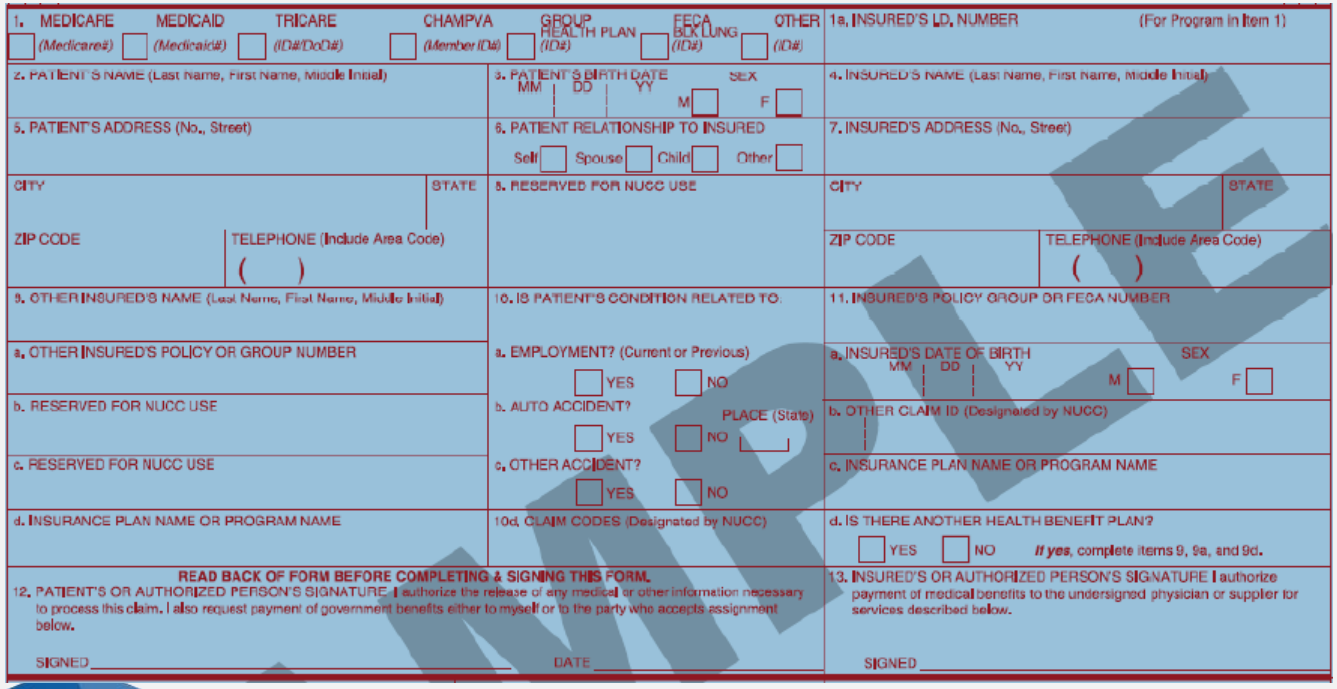


SAMPLE

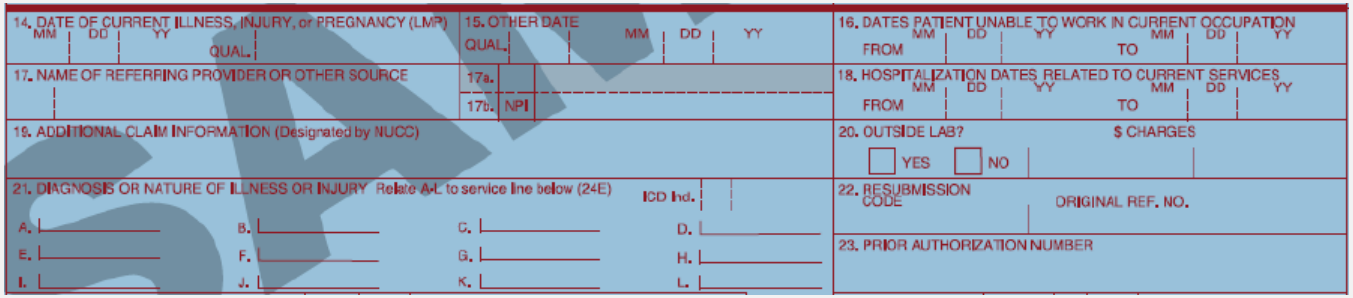
CMS 1500 Field Number	12
Field Title	Patient's or Authorized Person's Signature
Requirement	Required
Instructions	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.



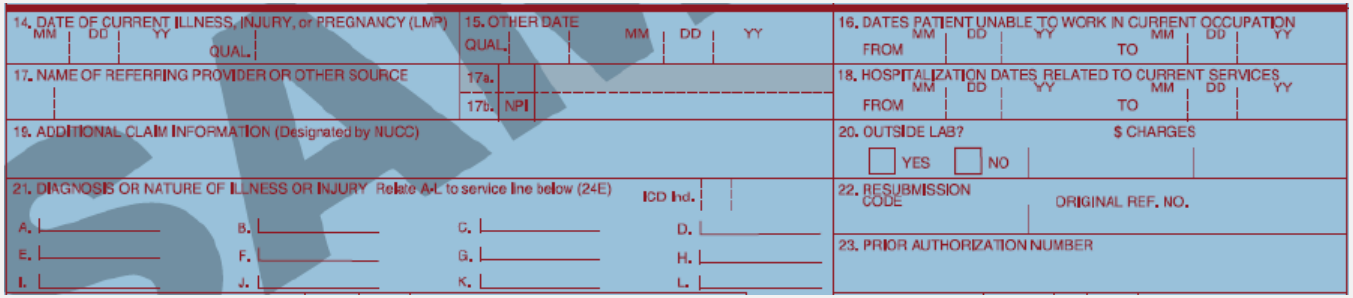
CMS 1500 Field Number	13
Field Title	Insured's or Authorized Person's Signature
Requirement	Not Required
Instructions	



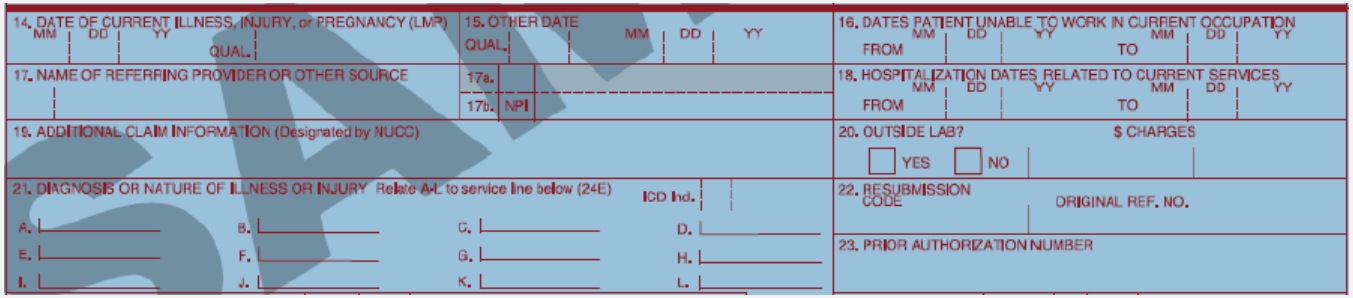
CMS 1500 Field Number	14
Field Title	Date of Current Illness, Injury, or Pregnancy
Requirement	Not Required
Instructions	



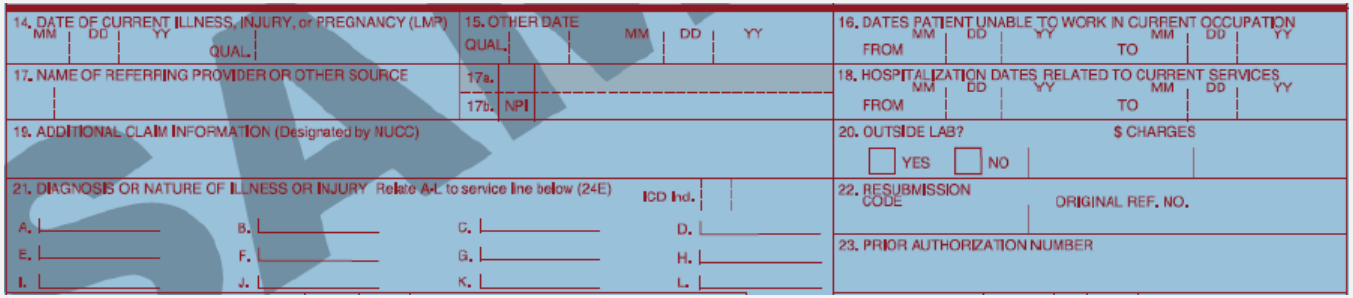
CMS 1500 Field Number	15
Field Title	Other Date
Requirement	Not Required
Instructions	



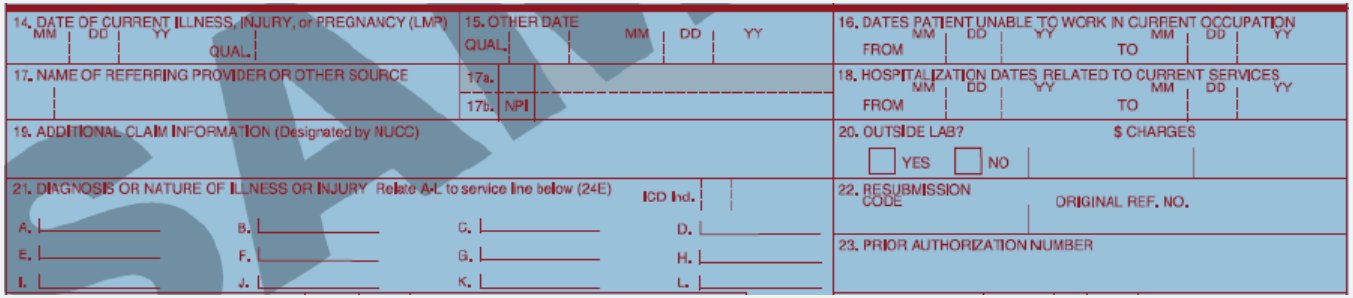
CMS 1500 Field Number	16
Field Title	Dates Patient Unable to Work in Current Occupation
Requirement	Not Required
Instructions	



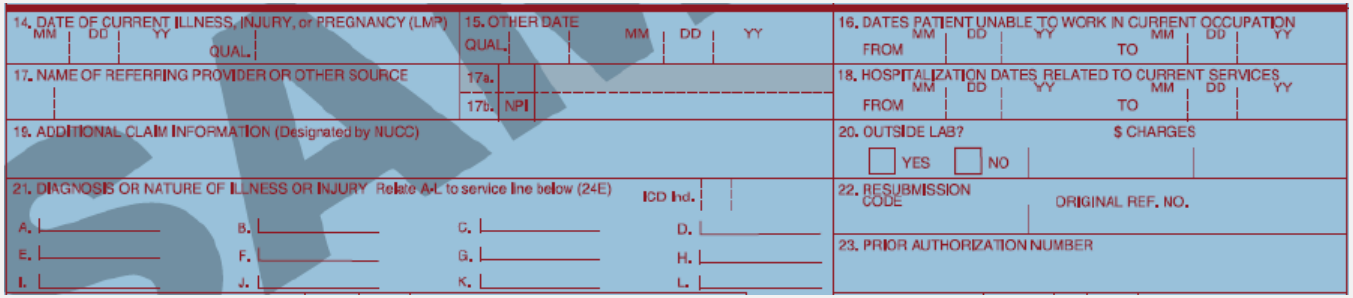
CMS 1500 Field Number	17
Field Title	Name of referring Provider or Other Source
Requirement	Not Required
Instructions	



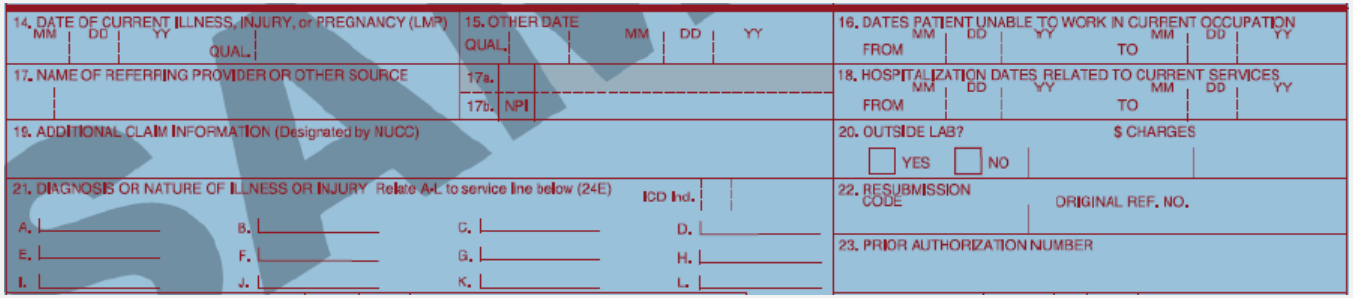
CMS 1500 Field Number	17a
Field Title	Other ID#
Requirement	Not Required
Instructions	



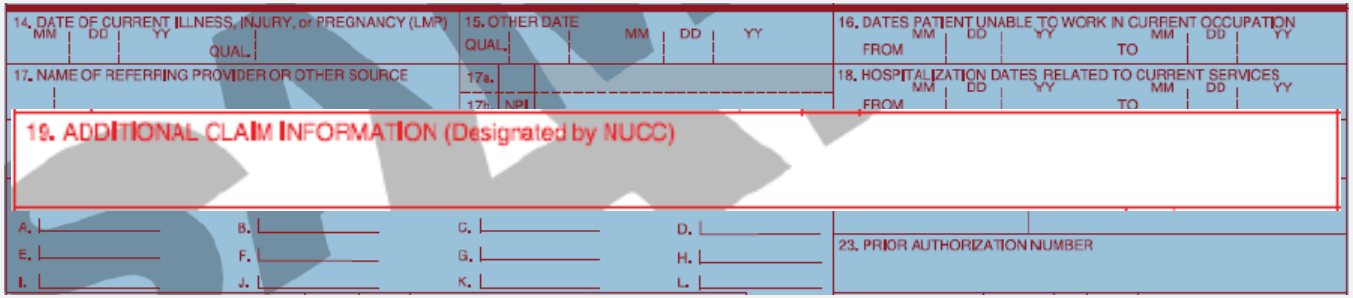
CMS 1500 Field Number	17b
Field Title	NPI #
Requirement	Not Required
Instructions	



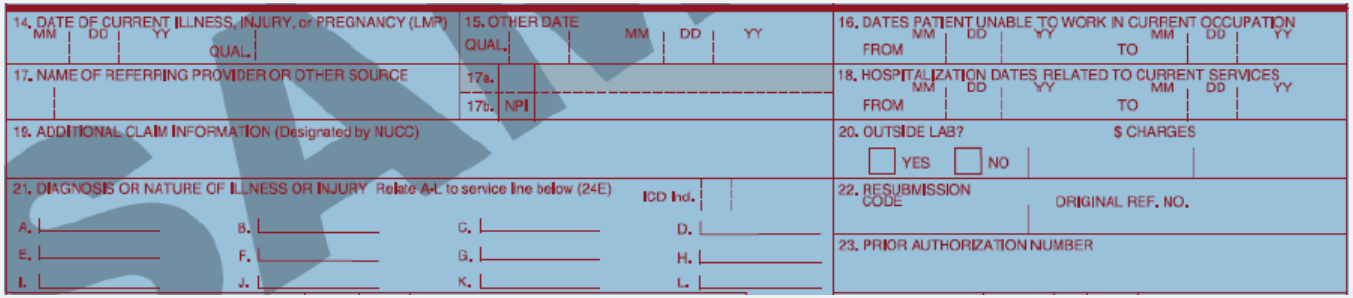
CMS 1500 Field Number	18
Field Title	Hospitalization Dates Related to Current Services
Requirement	Not Required
Instructions	



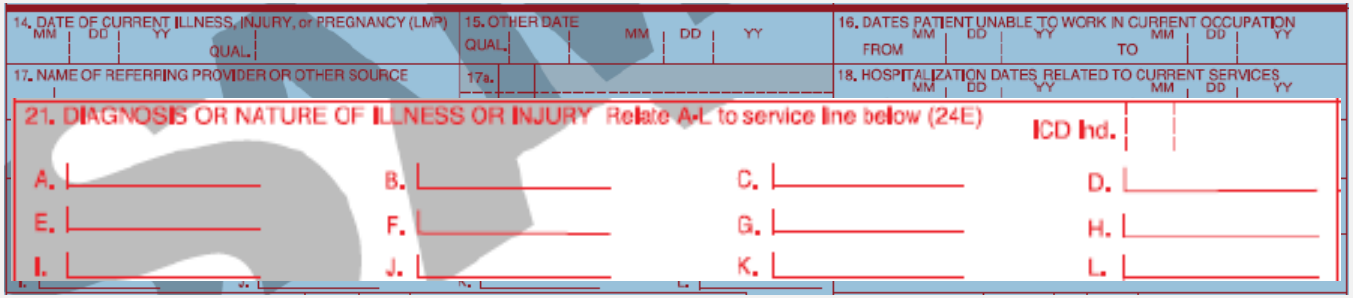
CMS 1500 Field Number	19
Field Title	Additional Claim Information
Requirement	Conditional
Instructions	Use to document the Late Bill Override Date for timely filing.



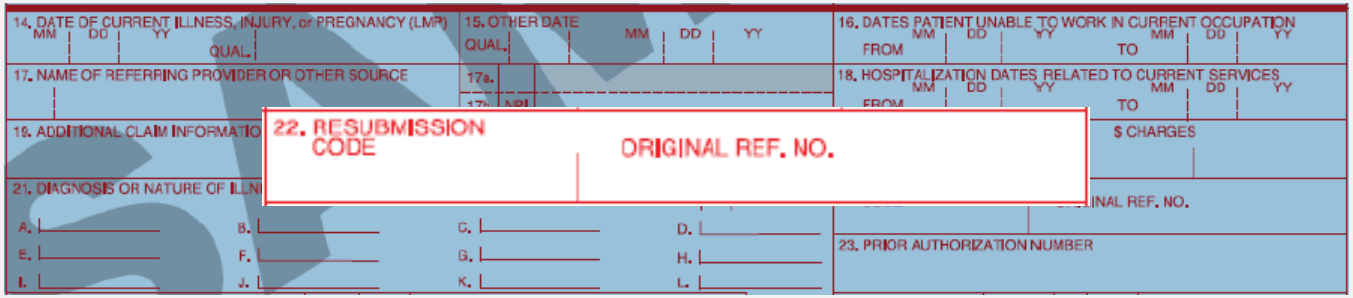
CMS 1500 Field Number	20
Field Title	Outside Lab? $ Charges
Requirement	Not Required
Instructions	



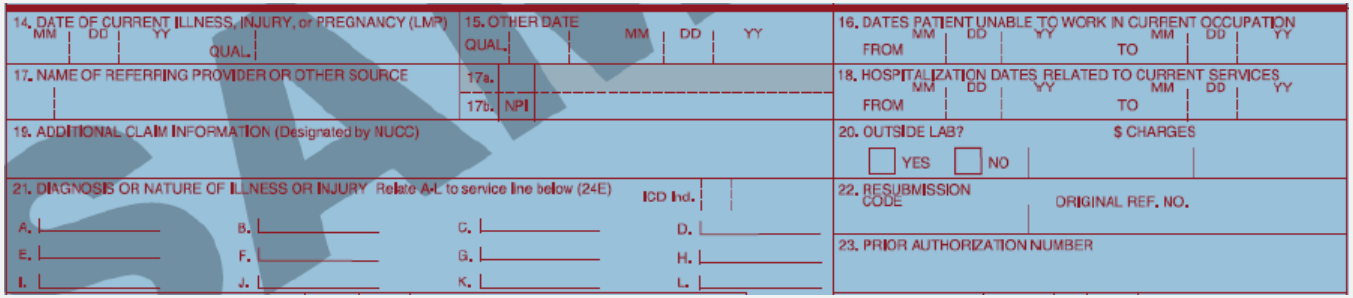
CMS 1500 Field Number	21
Field Title	Diagnosis or Nature of Illness or Injury
Requirement	Required
Instructions	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter the applicable ICD indicator to identify which version of ICD codes is being reported.



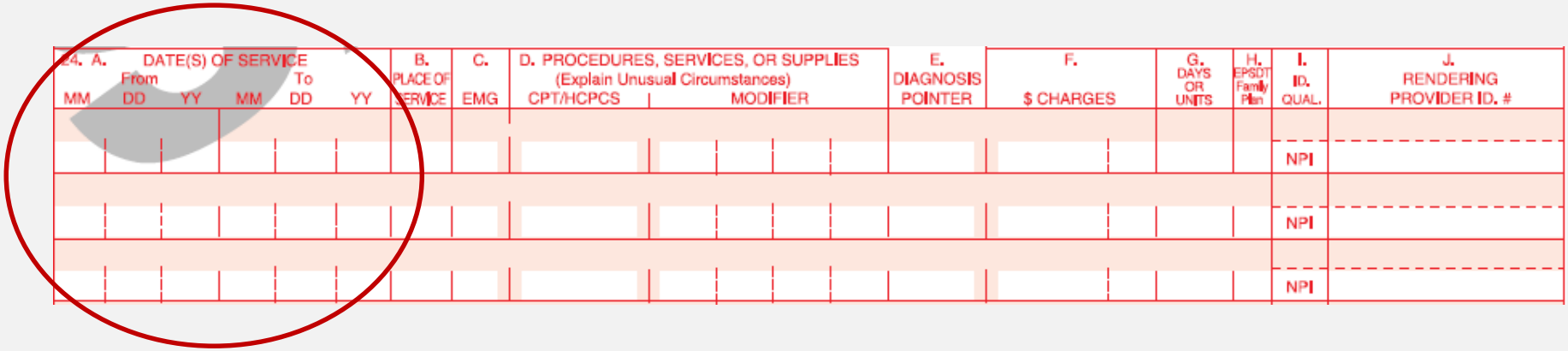
CMS 1500 Field Number	22
Field Title	Resubmission and/or Original Reference Number
Requirement	Conditional
Instructions	List the Original reference number for the resubmitted claim. This field is not intended for use for original claim submissions.



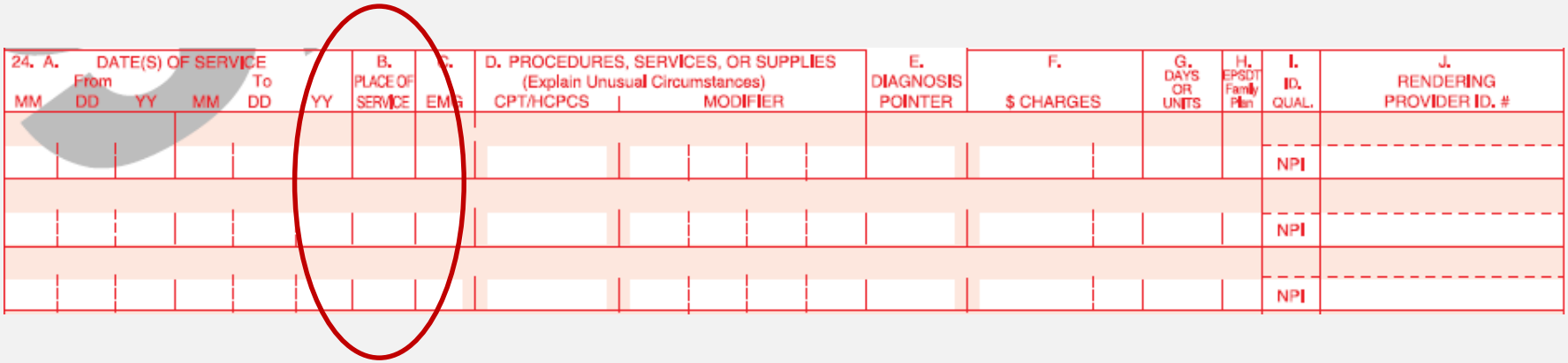
CMS 1500 Field Number	23
Field Title	Prior Authorization Number
Requirement	Not Required
Instructions	



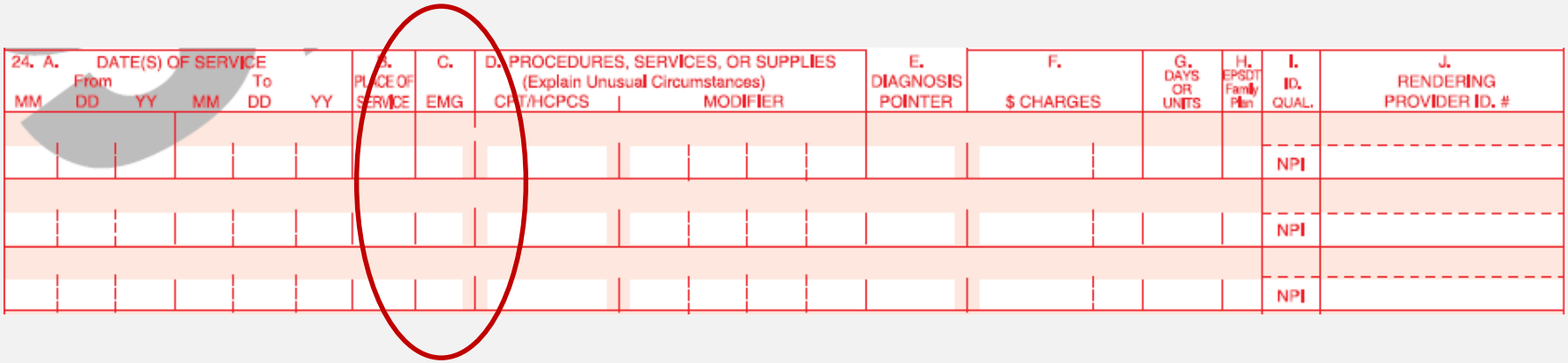
CMS 1500 Field Number	24A
Field Title	Date(s) of Service
Requirement	Required
Instructions	Enter date(s) of service, both the “From” and “To” dates. If there is only one date of service, enter the date under “From”. Leave “To” blank or re-enter “From” date. This field allows for data to be entered in the MM/DD/YY format.



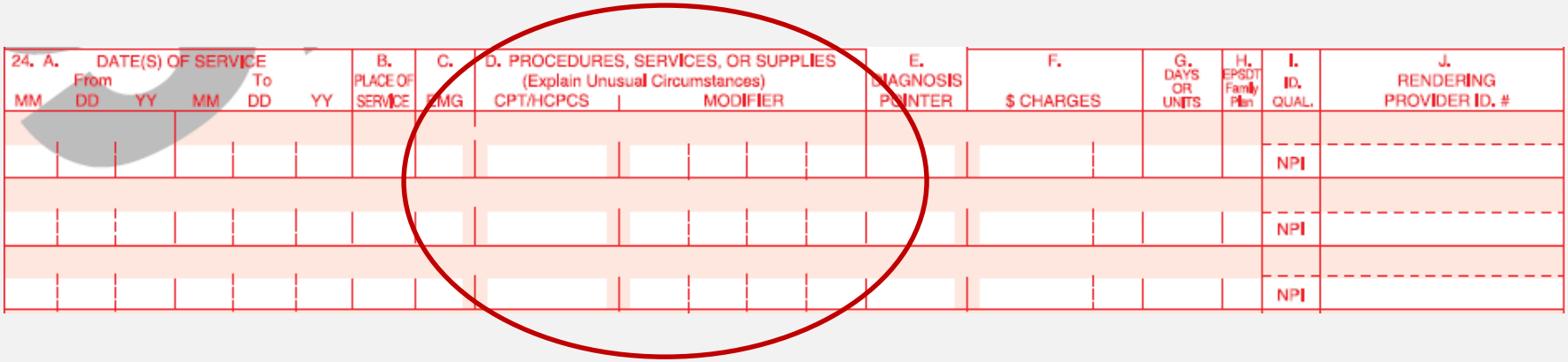
CMS 1500 Field Number	24B
Field Title	Place of Service
Requirement	Required
Instructions	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.



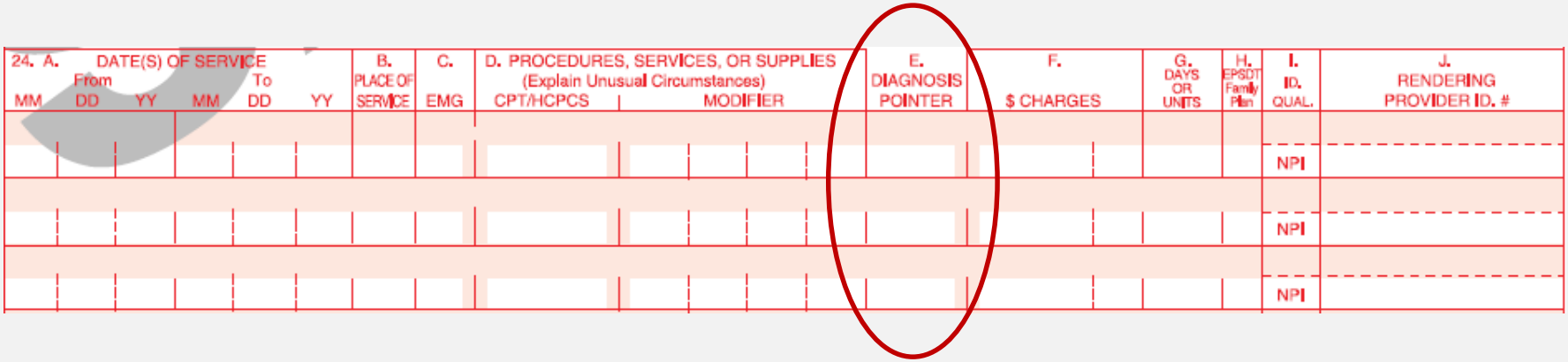
CMS 1500 Field Number	24C
Field Title	EMG
Requirement	Not Required
Instructions	



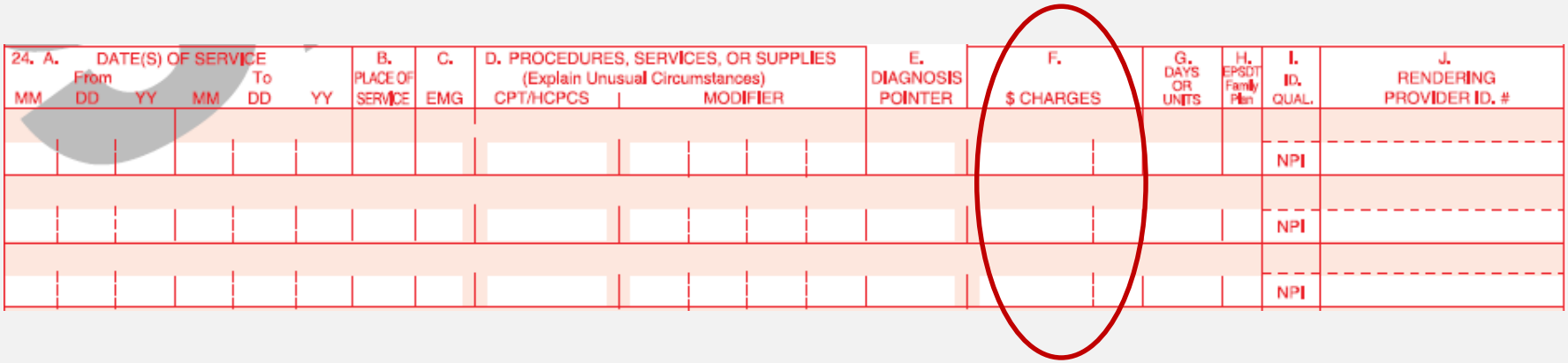
CMS 1500 Field Number	24D
Field Title	Procedures, Services, or Supplies
Requirement	Required
Instructions	Inter the CPT or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four two-digit modifiers.



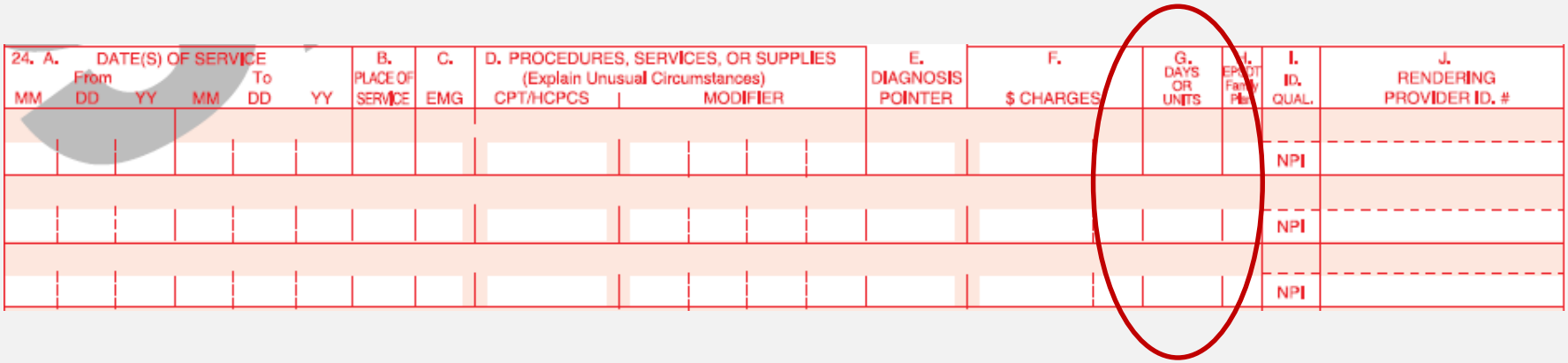
CMS 1500 Field Number	24E
Field Title	Diagnosis Pointer
Requirement	Required
Instructions	Enter the diagnosis code reference letter as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first.



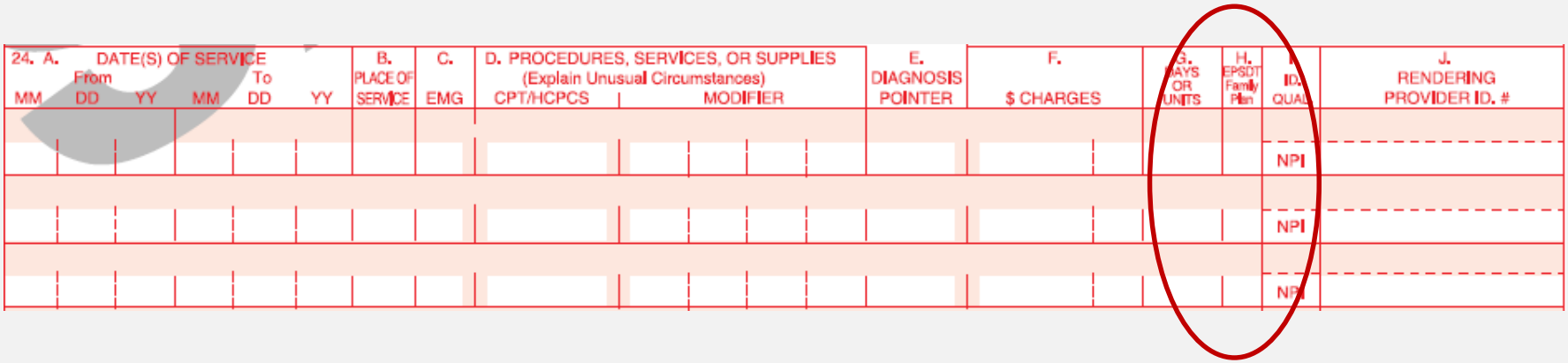
CMS 1500 Field Number	24F
Field Title	$ Charges
Requirement	Required
Instructions	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.



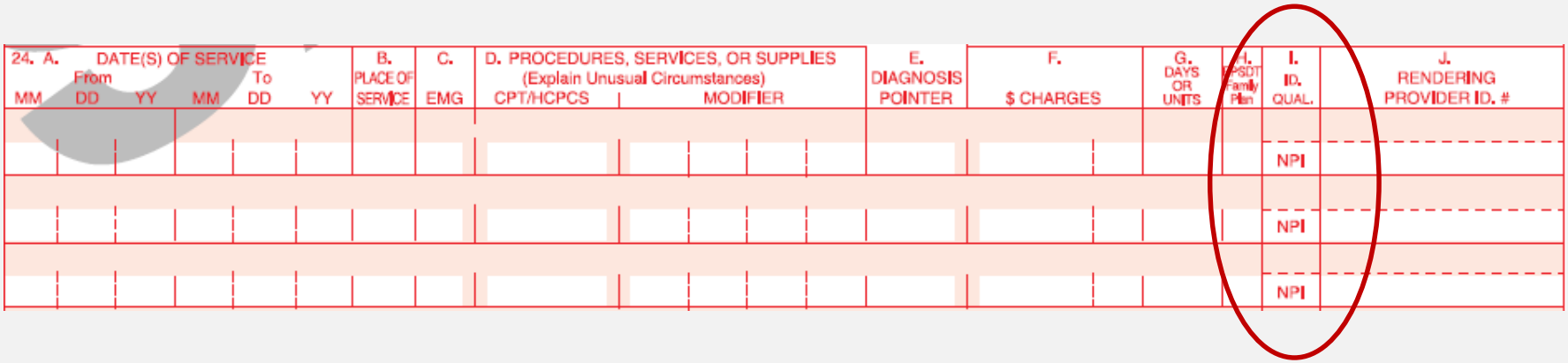
CMS 1500 Field Number	24G
Field Title	Days or Units
Requirement	Required
Instructions	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.



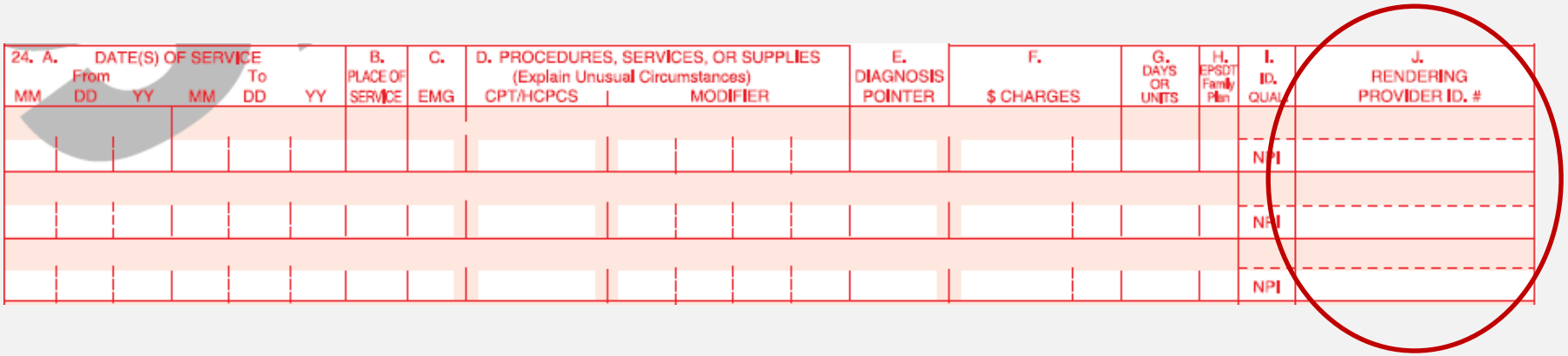
CMS 1500 Field Number	24H
Field Title	EPSDT/Family Plan
Requirement	Not Required
Instructions	



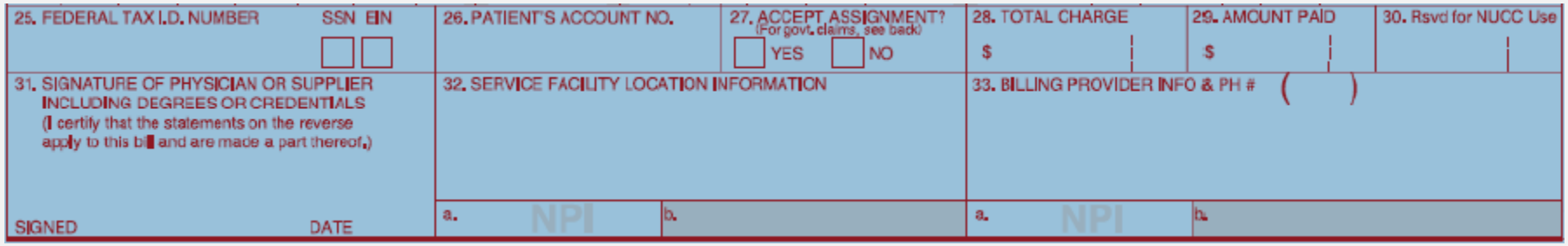
CMS 1500 Field Number	24I
Field Title	ID Qualifier
Requirement	Not Required
Instructions	



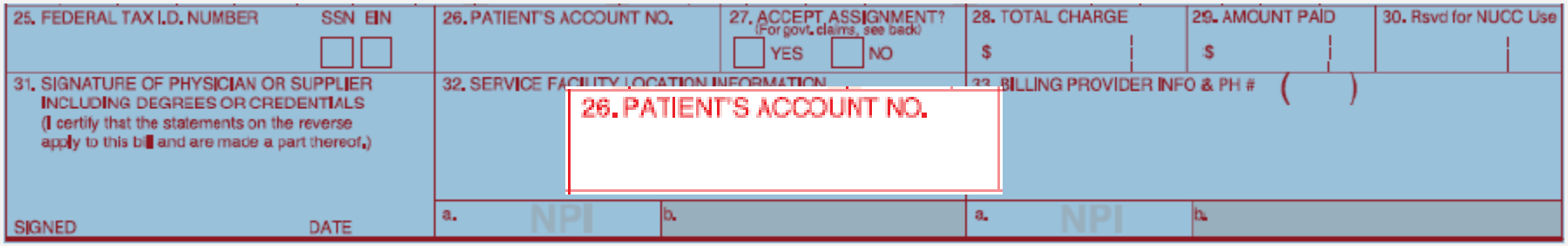
CMS 1500 Field Number	24J
Field Title	Rendering Provider ID #
Requirement	Not Required
Instructions	



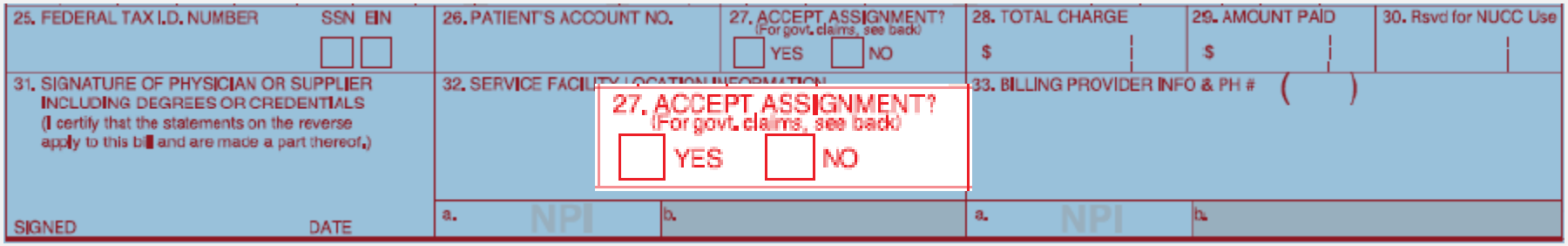
CMS 1500 Field Number	25
Field Title	Federal Tax ID Number
Requirement	Not Required
Instructions	



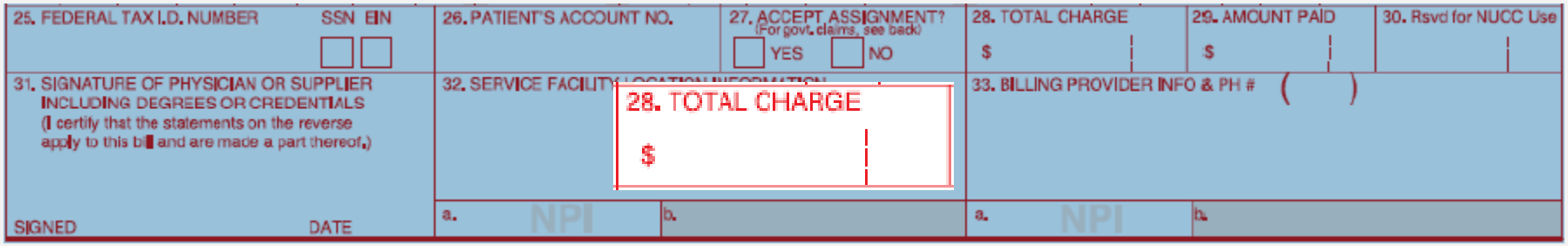
CMS 1500 Field Number	26
Field Title	Patient's Account Number
Requirement	Optional
Instructions	Enter the information that identifies the patient or claim in the provider's billing system.



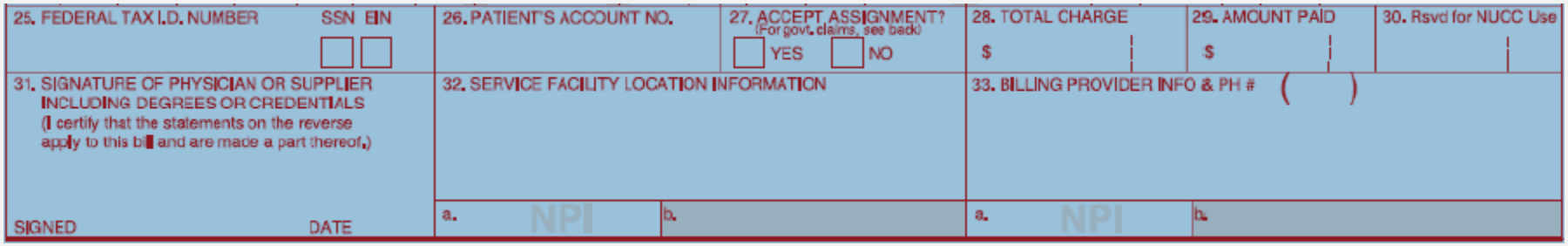
CMS 1500 Field Number	27
Field Title	Accept Assignment?
Requirement	Required
Instructions	The accept assignment indicates that the provider agrees accept assignment under the terms of the payer's program.



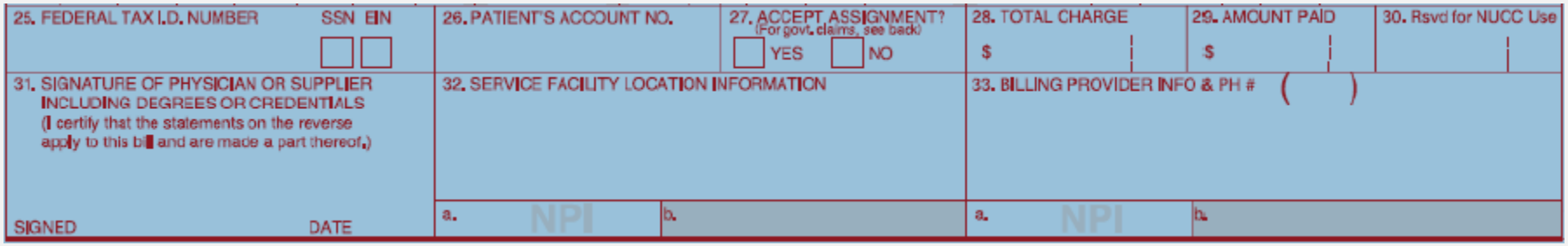
CMS 1500 Field Number	28
Field Title	Total Charge
Requirement	Required
Instructions	Enter the sum of all charges listed in field 24F.



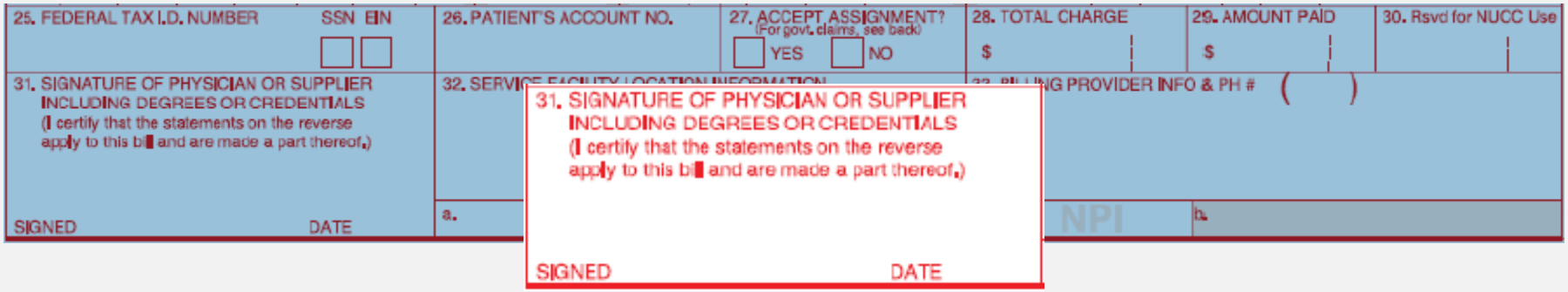
CMS 1500 Field Number	29
Field Title	Amount Paid
Requirement	Not Required
Instructions	



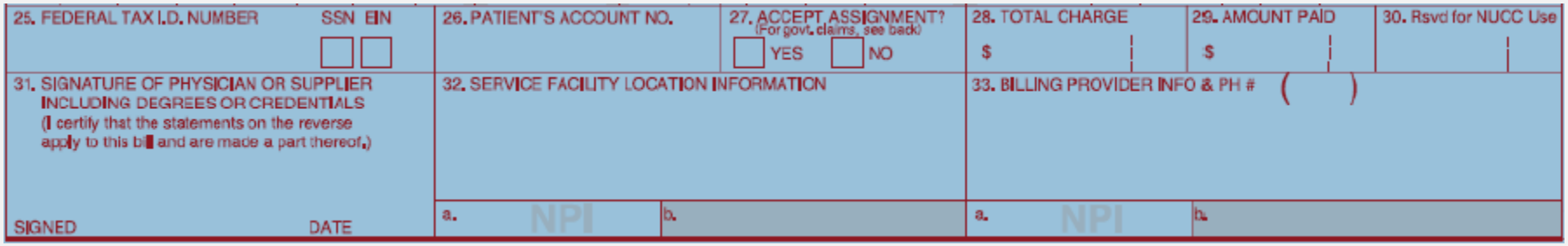
CMS 1500 Field Number	30
Field Title	Rsvd for NUCC Use
Requirement	Not Required
Instructions	



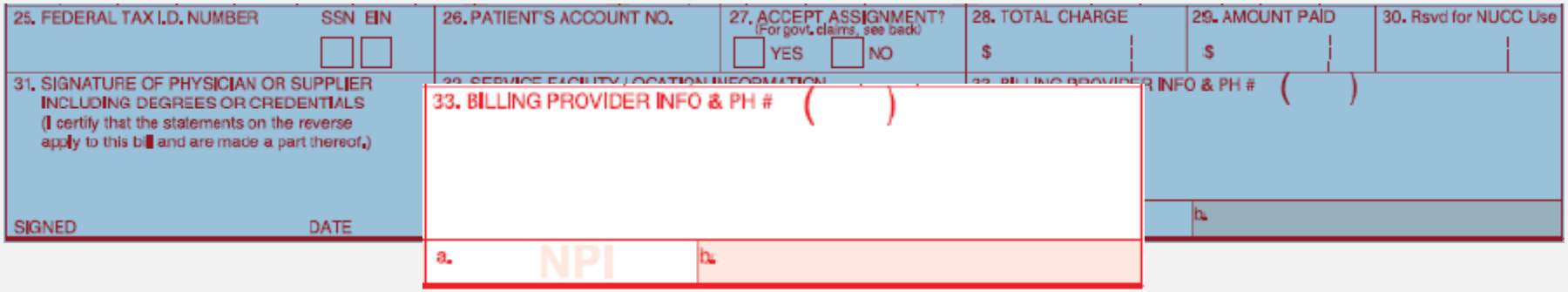
CMS 1500 Field Number	31
Field Title	Signature of Physician or Supplier Including Degrees or Credentials
Requirement	Required
Instructions	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. Enter the date the claim form was signed.



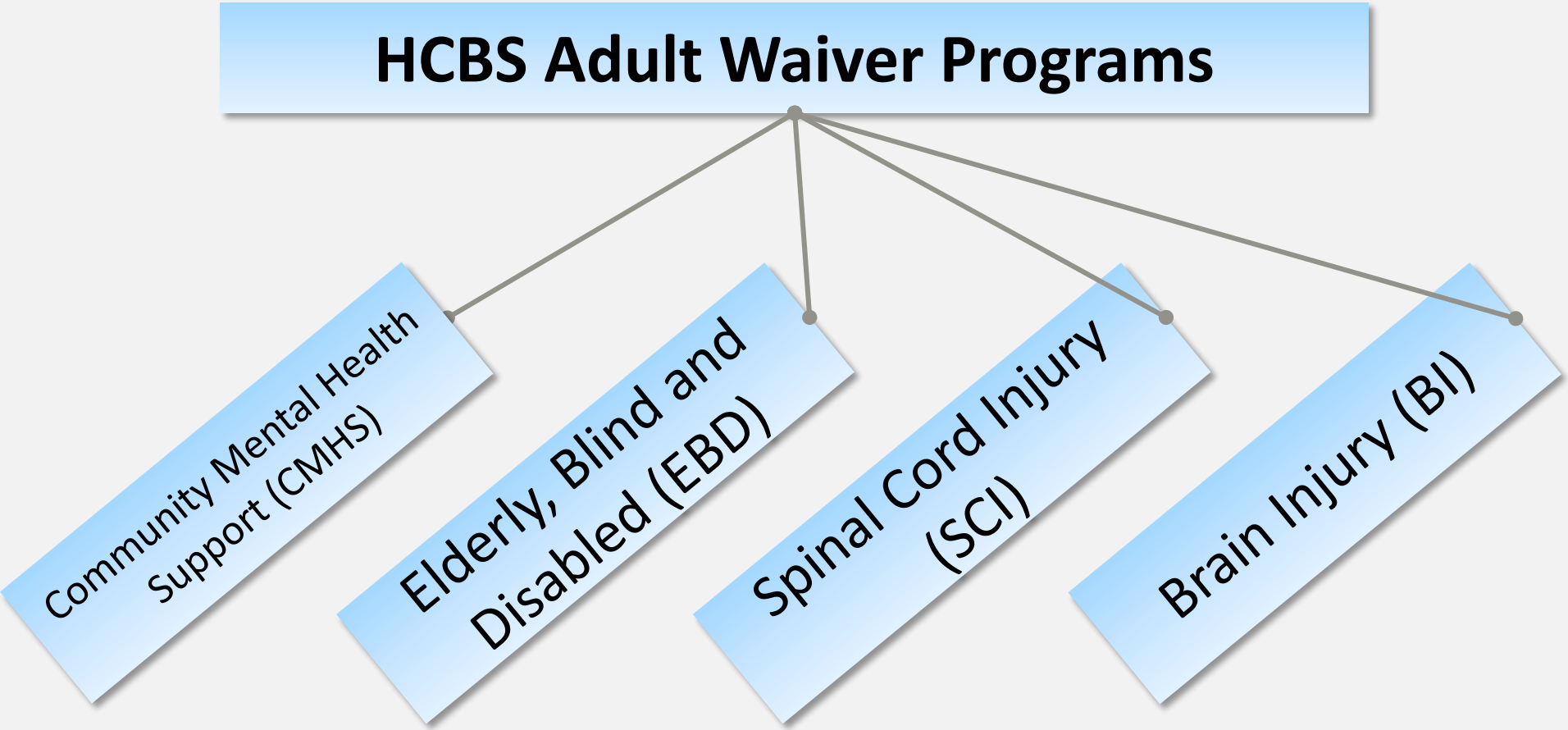
CMS 1500 Field Number	32
Field Title	Service Facility Location Information
Requirement	Not Required
Instructions	



CMS 1500 Field Number	33
Field Title	Billing Provider Info & Ph #
Requirement	Required
Instructions	Enter the name of the individual or organization that will receive payment for the billed services. 33a- enter the NPI of the billing provider 33b- enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.



Waiver Programs



Waiver Programs

Special Program Codes

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

HCBS-BI Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility 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 DSM-IV diagnostic codes
- Level of Care Requirements
  - Nursing Facility and 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 +
  - 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 DSM-IV diagnostic codes
- Level of Care Requirements
  - Nursing Facility Level of Care

HCBS-SCI Requirement

- Primary Purpose of Program
  - To provide a home or community based alternative to nursing facility level of 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 diagnostic codes
  - Residing in the Denver/Metro area
    - Adams, Arapahoe, Douglas, Denver, Jefferson
- Level of Care Requirements
  - Nursing Facility Level or Hospital Level 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

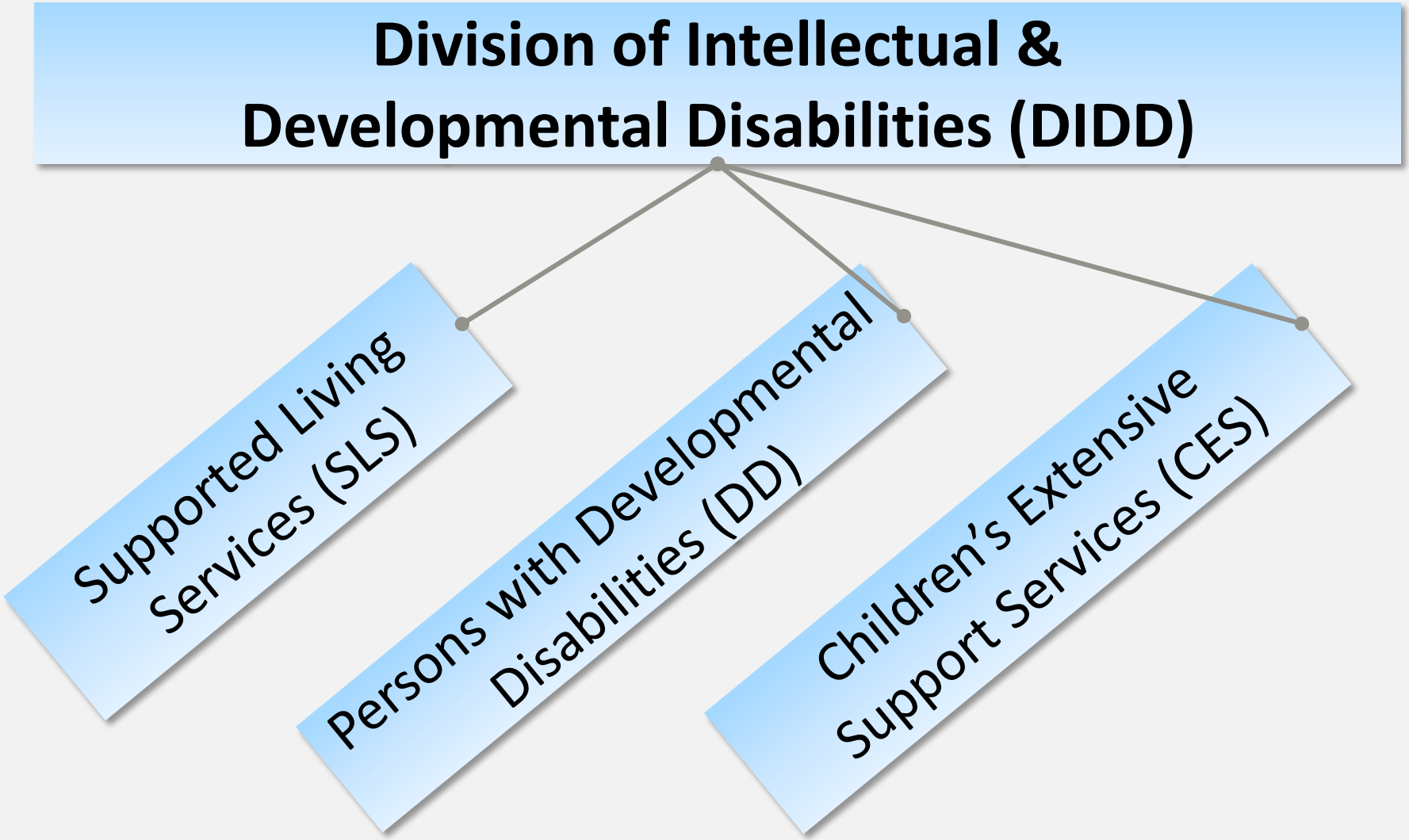
Colorado Choice Transitions (CCT)

- Helps transition Medicaid members from nursing and other long-term care (LTC) facilities back to the community
  - Participants of the program will have access to:
    - Qualified waiver services
    - Demonstration services

Colorado Choice Transitions (CCT)

- The CCT program compliments the:
  - Elderly, Blind and Disabled Waiver
  - Persons with Brain Injury Waiver
  - Community Mental Health Supports Waiver
  - Persons with Developmental Disabilities Wavier
  - Supported Living Services Waiver
- For more information, please visit www.colorado.gov/hcpf
  - Member's & Applicants→ Long Term Care→ Colorado Choice Transitions

Waiver Programs



Waiver Programs

Special Program Codes

Program	Modifier	Program Code
DD	U3	85
SLS	U8	92
TCM	U4	87
CES	U7	90
CHRP	U9	93

HCBS-DD Requirement

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support outside family home, allowing them to continue to live in the community
- Members Served
  - Age 18+
  - Persons who are in need of 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/IID)

HCBS-SLS Requirement

- Primary Purpose of Program
  - Provides persons with developmental disabilities services and support outside family home, 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/IID)

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/IID)
    - Additional program criteria needed

Waiver Programs

Department of Human Services (DHS)

Children's Habitation Residential Program (CHRP)

Waiver Programs

Special Program Codes

Program	Modifier	Program Code
CHRP	U9	93

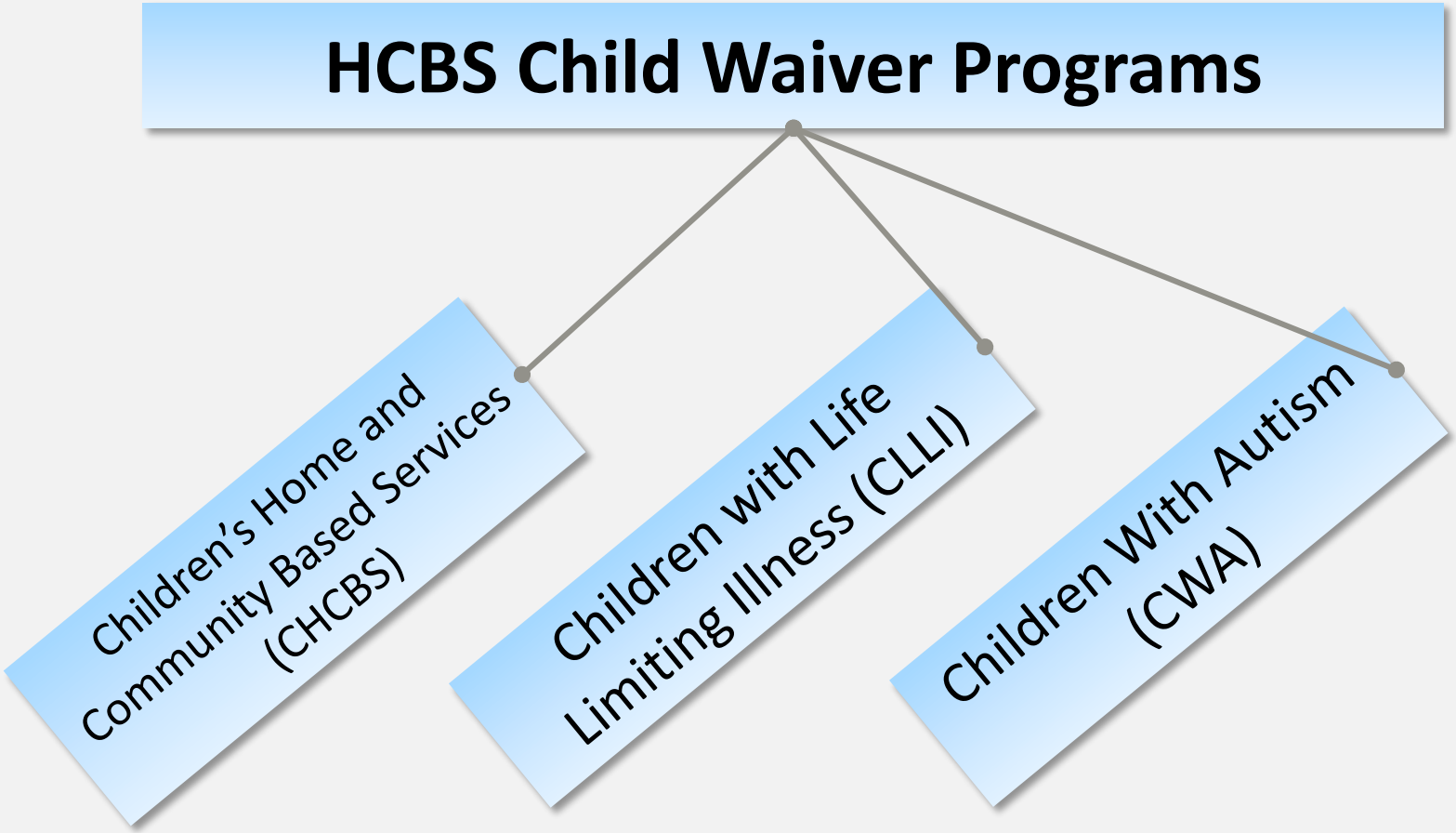
HCBS-CHRP Requirement

- 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)

Targeted Case Management (TCM)

- TCM is an optional benefit for members enrolled in the following programs
  - HCBS-DD/Comprehensive Waiver
  - HCBS-SLS (Supported Living Services Waiver)
  - HCBS-CES (Children's Extensive Support Waiver)
  - Early Intervention Services (EI)

Waiver Programs



Waiver Programs

Special Program Codes

Program	Modifier	Program Code	Administered By:
CHCBS	U5	88	HCPF
CLLI	UD	97	HCPF
CWA	UL	96	HCPF

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
- 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 care 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)

Occurrence 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

Occurrence 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
  - Should also report applicable incidents to appropriate authorities
    - 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.
Bill Medicare or Other Insurance	Medicaid is always the "Payor of Last Resort". Provider should bill all other appropriate carriers first
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

Claims Process - Common Terms

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

Adjustment

Re-bill previously denied claim

Rebill

Claim must be manually reviewed before adjudication

Suspend

"Cancelling" a "paid" claim (wait 48 hours to rebill)

Void

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

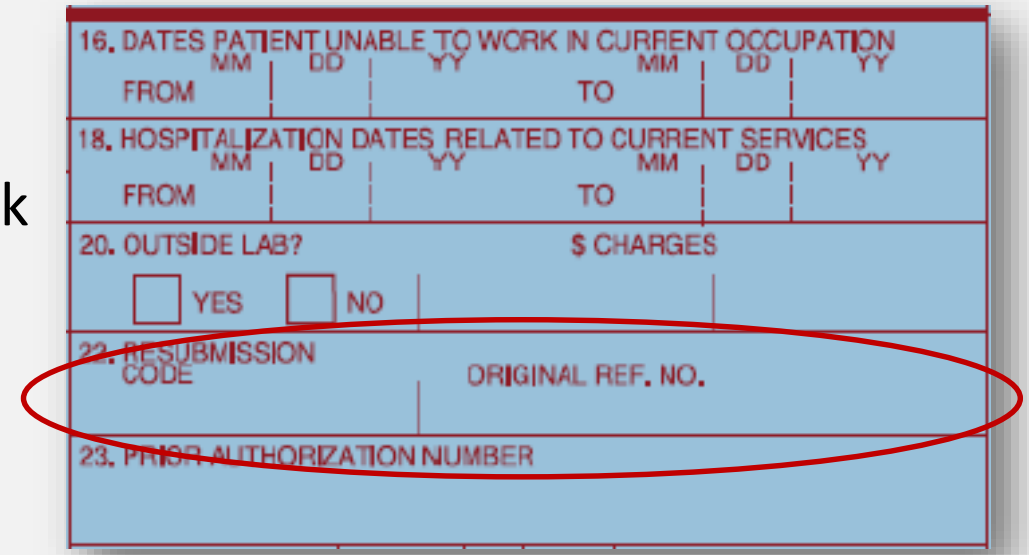
Do not adjust when:

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

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track



Paper

- Use Medicaid Resubmission **Reason Code 7** to **replace** a prior claim or **Reason Code 8** to **void/cancel** a claim. The TCN that needs to be **replaced or voided** is the original reference number. Providers will continue to see Reason Code 406 for replacement claims and Reason Code 412 for voided claims on the Provider Claim Reports.

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	04080000000000001	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

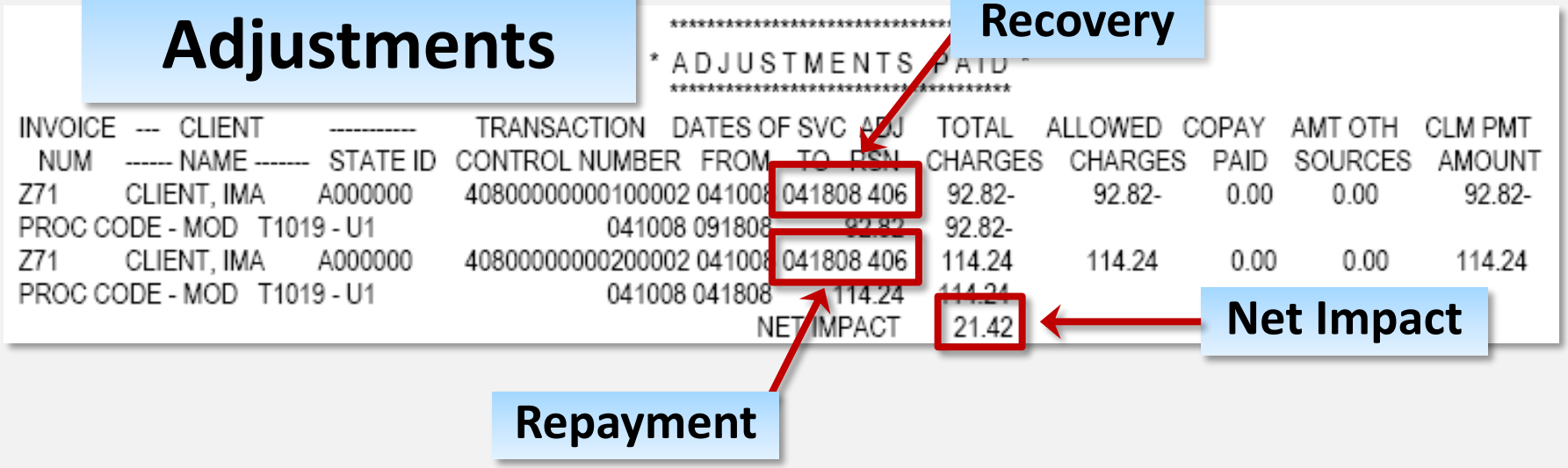
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

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'. COUNT 0001

Provider Claim Reports (PCRs)

Adjustments



****
* ADJUSTMENTS PAID *
****

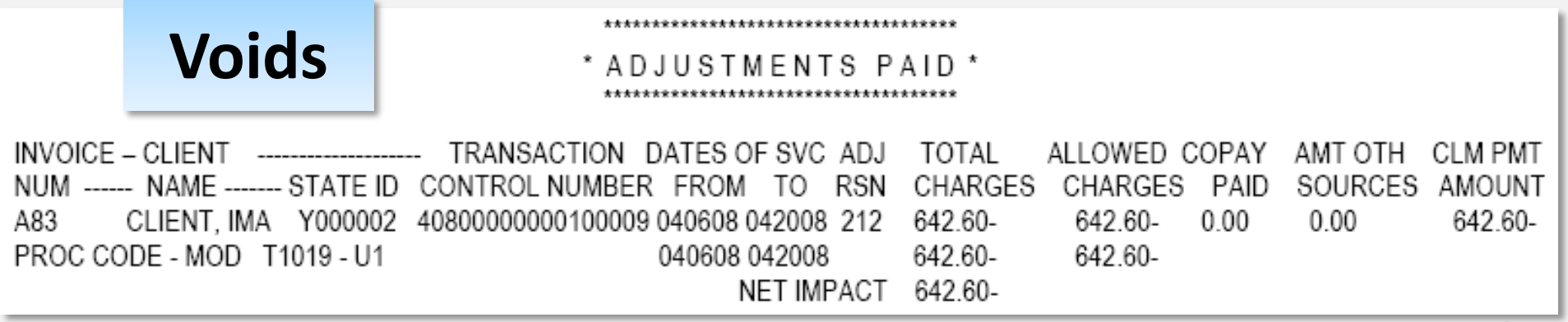
INVOICE NUM	CLIENT ------ NAME -------	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1				041008	091808		92.82	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	114.24			
						NET IMPACT	21.42				

Recovery

Net Impact

Repayment

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
- Enrolling New Providers
- 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!