

# Beginning Billing Workshop FQHC / RHC

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 or UB 04 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/nationalproidentstand/](http://www.dms.hhs.gov/nationalproidentstand/)
  - 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



# NEW! Department Website

1.

<https://www.colorado.gov/hcpf>

[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)

**COLORADO**  
Department of Health Care  
Policy & Financing

Home

For Our Members

**For Our Providers**

For Our Stakeholders

2.

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore  
Benefits



Apply  
Now



Find  
Doctors



Get  
Help



**Feeling Sick?**

For medical advice, call the Nurse Line:

**800-283-3221**



**Get Covered.  
Stay Healthy.**

[colorado.gov/health](http://colorado.gov/health)

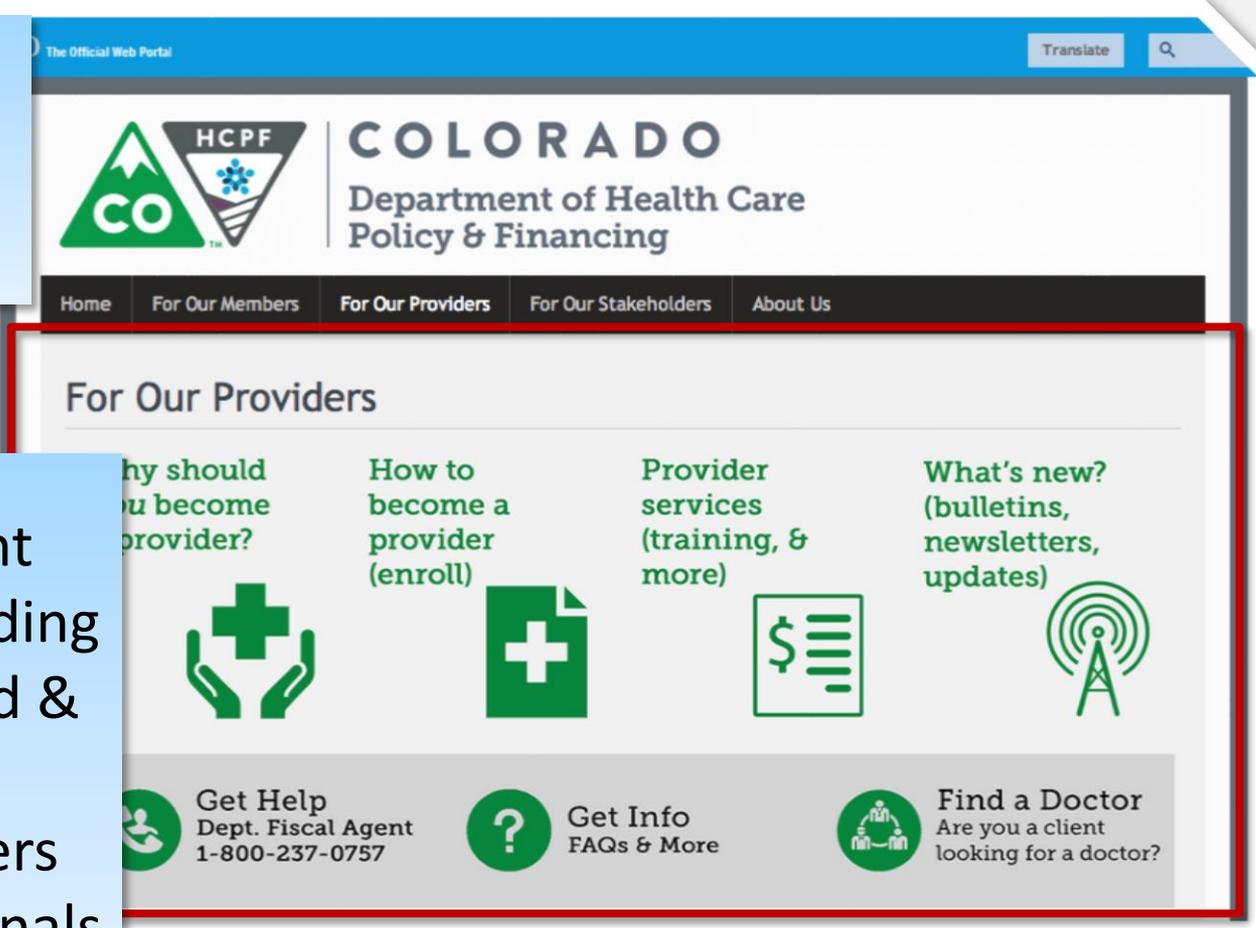


# NEW! Provider Home Page

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



# Rendering Versus Billing

## Rendering Provider

- Individual that provides services to a Medicaid member



## 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:



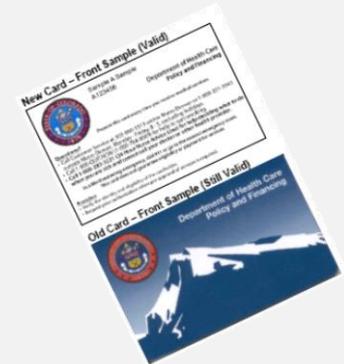
Web Portal



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)

[Print](#) [Return To Eligibility Inquiry](#)

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**Eligibility Request**

Provider ID:                      Nation:  
From DOS:                      Throu:  
**Client Detail**  
State ID:                      D:  
Last Name:                      First

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**CO MEDICAL ASSISTANT**

Response Creation Date & Time: 05/

---

[Contact Information for Questions or](#)  
Provider Relations Number: 800-237

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[Requesting Provider](#)  
Provider ID:  
Name:

---

[Client Details](#)  
Name:  
State ID:

---

**Client Eligibility Details**

Eligibility Status: **Eligible**  
Eligibility Benefit Date:  
04/06/2011 - 04/06/2011  
Guarantee Number: **111400000000**  
Coverage Name: Medicaid

---

**PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE**

Eligibility Benefit Date:  
04/06/2011 - 04/06/2011  
Messages:

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**MHPROV Services**

Provider Name:  
**COLORADO HEALTH PARTNERSHIPS LLC**

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Provider Contact Phone Number:  
800-804-5008

Information appears in sections (Requesting Provider, Member Details, Member Eligibility Details, etc.). Use the scroll bar to the right to view more details.

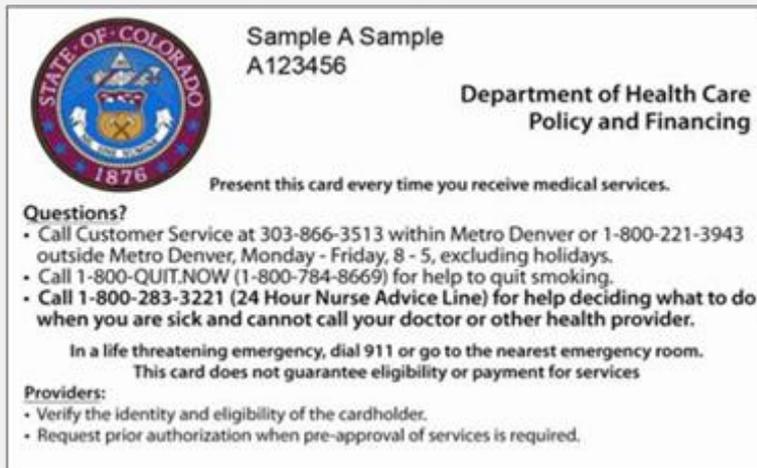
A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

As a 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



# Eligibility Types

- Most members= Regular Colorado Medicaid benefits
- Some members= different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members= additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance



# Eligibility Types

## Modified Medical Programs



- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is \$300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services



# Eligibility Types

## Non-Citizens



- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only



# What Defines an “Emergency”?

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



# Eligibility Types

## Presumptive Eligibility



- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental



# Presumptive Eligibility

## Presumptive Eligibility



- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101

# Managed Care Options

- Types of Managed Care options:
  - Managed Care Organizations (MCOs)
  - Behavioral Health Organization (BHO)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Accountable Care Collaborative (ACC)



# Managed Care Options

## Managed Care Organization (MCO)



- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out



# Managed Care Options

## Behavioral Health Organization (BHO)



- **Community Mental Health Services Program**
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - **Colorado Medical Assistance Program Providers**
    - Contact BHO in your area to become a Mental Health Program Provider

# Managed Care Options

## Accountable Care Collaborative (ACC)



- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
- Helps coordinate Member care
  - Helps with care transitions



# Medicare

## 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 TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim



# Medicare-Medicaid Enrollees

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



# Third Party Liability

## Third Party Liability



- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

- Charge = \$500
- Program allowable = \$400
- TPL payment = \$300
- Program allowable – TPL payment = LOP

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**\$400.00**

- \$300.00

---

= \$100.00

# Commercial Insurance

## Commercial Insurance



- Colorado Medicaid always payor 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**



**Pregnant  
Women**

# Specialty Co-Payments

FQHC / RHC



**\$2.00 per date of service**



# Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing



# Record Retention

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



# Record Retention

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



# Submitting Claims

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



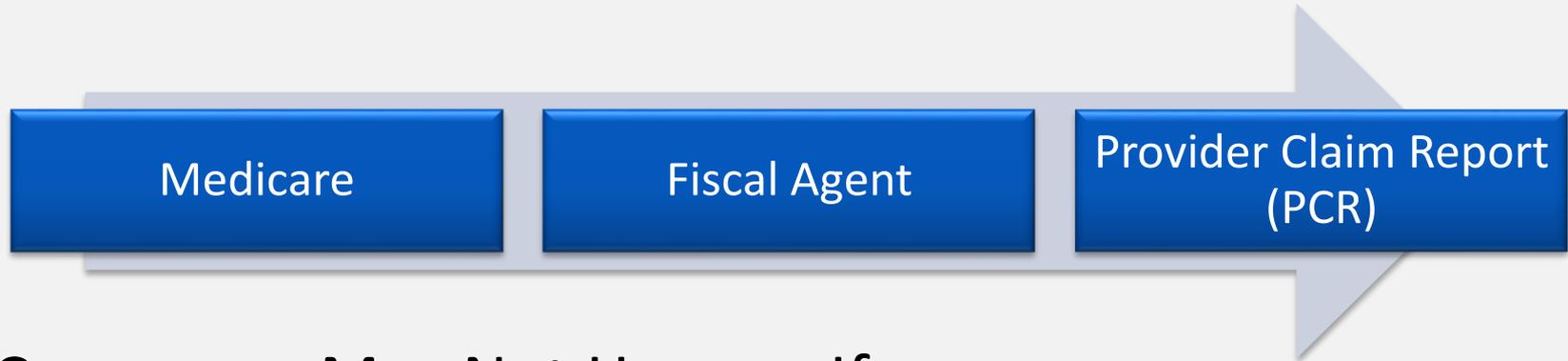
# ICD-10 Implementation Delay

- ICD-10 Implementation delayed until 10/1/2015
  - ICD-9 codes: Claims with Dates of Service (DOS) on or before 9/30/15
  - ICD-10 codes: Claims with DOS 10/1/2015 or after
  - Claims submitted with both ICD-9 and ICD-10 codes will be rejected



# Crossover Claims

- Automatic Medicare Crossover Process:

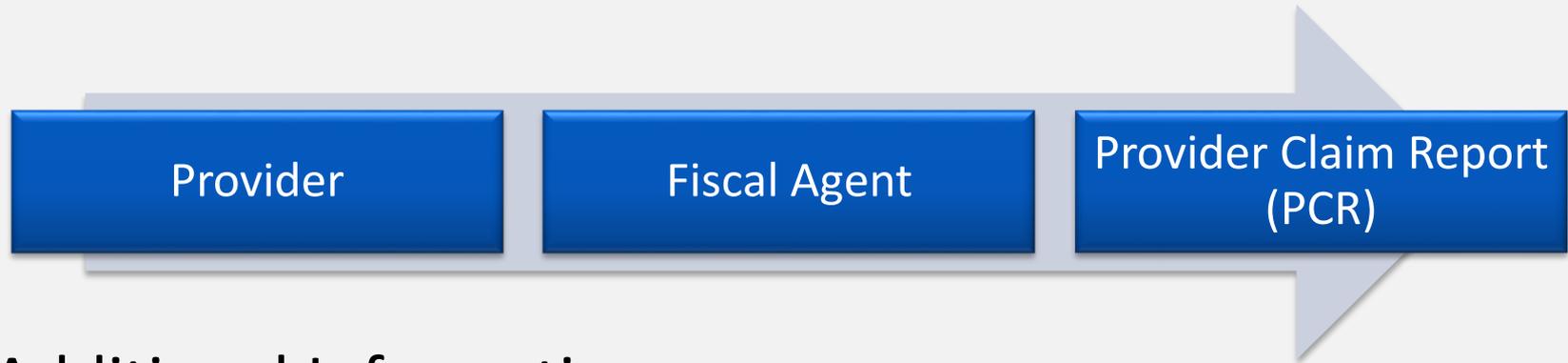


- Crossovers May Not Happen If:

- NPI not linked
- Member is a retired railroad employee
- Member has incorrect Medicare number on file

# Crossover Claims

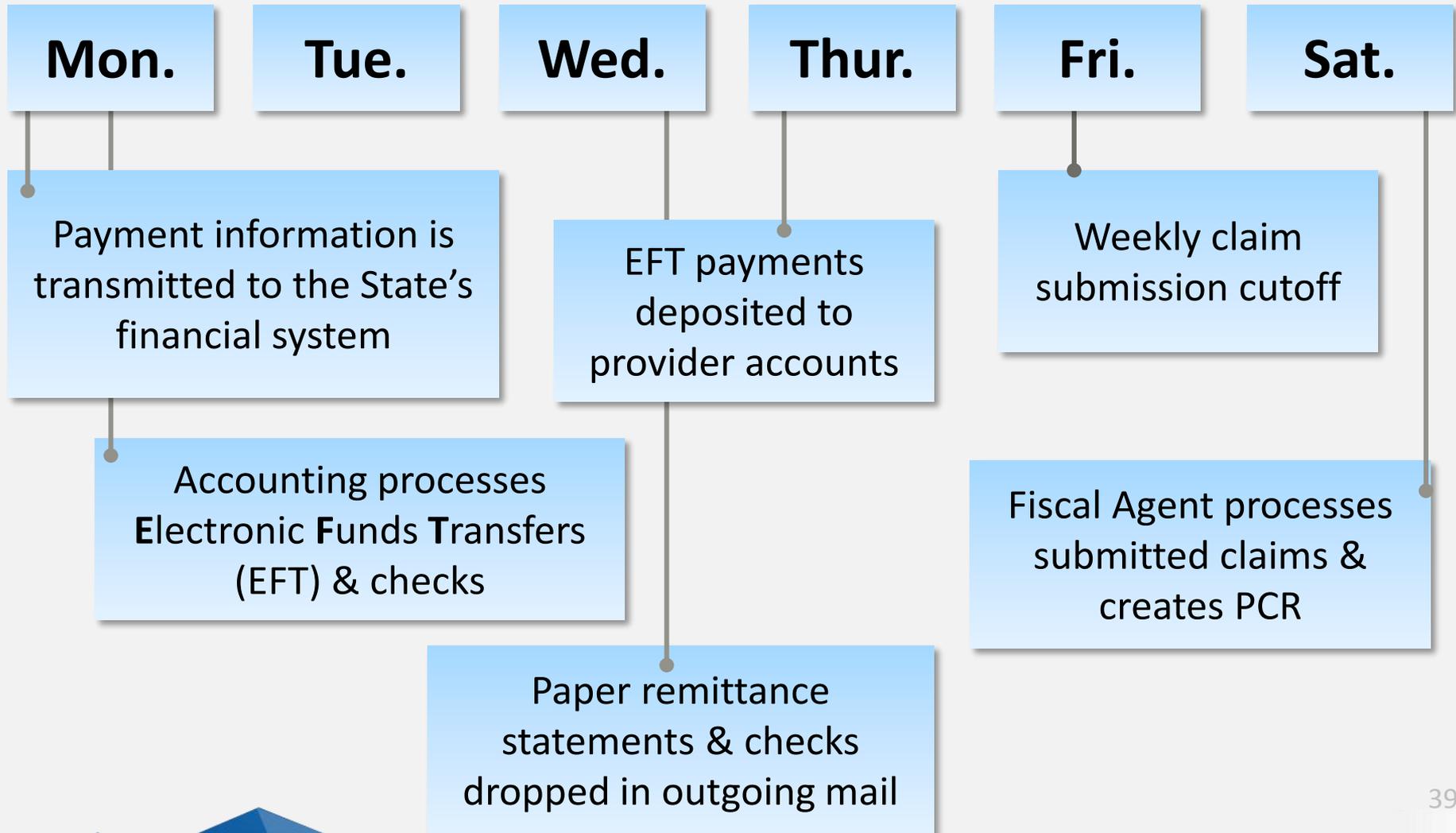
- Provider Submitted Crossover Process:



- Additional Information:

- Submit claim yourself if Medicare crossover claim not on PCR within 30 days
- Crossovers may be submitted on paper or electronically
- Providers must submit copy of SPR with paper claims
- Provider must retain SPR for audit purposes

# 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



# Transaction Control Number

## Receipt Method

0 = Paper  
2 = Medicare Crossover  
3 = Electronic  
4 = System Generated

## Batch Number

## Document Number

0 14 129 00 150 0 00037

## Year of Receipt

## Julian Date of Receipt

## Adjustment Indicator

1 = Recovery  
2 = Repayment



# Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)



# Timely Filing

## From “through” DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

## From 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 the Remarks



# Timely Filing – Medicare/Medicaid 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



# 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



# UB-04

**What are some of the services billed on the UB-04?**

FQHC

Rural Health  
Clinics

• Outpatient Primary Care

- Physician services
- PA, NP, nurse mid-wife services
- Incidental related services and supplies, including visiting nurse care, and related medical supplies



# UB-04

- UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs
- Where can a Colorado Medical Assistance provider get the UB-04?
  - Available through most office supply stores
  - Sometimes provided by payers



# UB-04 Certification



**Colorado Medical Assistance Program**

**Institutional Provider Certification**

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

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Print a copy of the certification at:  
[Colorado.gov/hcpf/provider-forms](https://colorado.gov/hcpf/provider-forms)



# National Drug Codes (NDC)

- States must:
  - Collect rebates for physician administered drugs
    - Required by Deficit Reduction Act of 2005
    - Required for federal financial participation funds to be available for these drugs
  - Collect 11-digit NDC on all outpatient claims
    - For drugs administered during course of patient's clinic visit
- NDC located on medication's packaging
  - Must be submitted in 5digit-4digit-2digit format



# UB-04 Tips

Do

- Submit multiple-page claims electronically

Do not

- Submit “continuous” claims
- Add more lines on the form
  - Each claim form has set number of available billing lines
  - Billing lines in excess of designated number are **not processed or acknowledged**



# Type of Bill 71X

- FQHCs and RHCs must use type of bill 71X
  - FQHC and RHC claims submitted with type of bill 73X will be denied
- For more information refer to FQHC/RHC specialty manual on Department's website:
  - [www.Colorado.gov/hcpf/](http://www.Colorado.gov/hcpf/) → For Our Providers → Provider Services → Billing Manuals
  - **New website:** [www.Colorado.gov/hcpf/billing-manuals](http://www.Colorado.gov/hcpf/billing-manuals)



# Sending Physicians Off-Site

## Physicians providing services at hospitals:

- Services are billed as carved-out services on CMS 1500 or as 837P transaction
- If physician is reimbursed under their salary for off-site service, then off-site service is to be billed by FQHC/RHC

## Physicians providing services at home or nursing facility:

- Services are billed as encounters on UB-04/837I
- Physicians should not bill Fee-For-Service for services when billed by FQHC/RHC

# Carved-Out Services

- Services not included in the encounter rate
- Delivery codes:
  - Do not bill for rev codes 152 and 151
  - Bill CPT codes 59409, 59410, 59412, 59414, 59515
- Hospital visits



# Carved-Out Services (cont.)

- Implanon Contraceptive – See Billing Manual
- Gardasil® – Eligible women ages 21 – 26
  - Bill CPT code 90649
  - This code includes AWP of vaccine plus 10% plus an administration fee
  - See Billing Manual



# Revenue or Diagnosis Code

## Revenue Code Use:

- All FQHCs should use 529 on first line of UB-04 claim
- All RHCs should use 521 on first line of UB-04 claim

## Diagnosis Code Use:

- Diagnosis code for preventive EPSDT visits is V20.2
- All vaccine administrations, including influenza, can be billed as encounters if they meet encounter criteria



# 837I

- Institutional Claim Changes

- ▶ Some Value Codes have been restricted by the National Uniform Billing Committee (NUBC)
- ▶ The following cannot be billed electronically but can be billed on paper:
  - A1, A2, A7, B1, B2, B7, C1, C2, and C7



# EPSDT

- EPSDT must be billed on UB-04 claim form
- Different services, same day: Dental and Medical
  - Bill different diagnosis codes
  - Will receive up to two encounter payments when billed separately
  - Mental health services can be billed as an encounter to BHO, not to MMIS, on same date of service as Dental\* or Medical

\*Note: Effective July 1, 2014, Dental Services are build through DentaQuest.



# Dental Services

- Bill 837D via or 2006 ADA Paper Claim Form via DentaQuest
- Dental services are paid at an encounter rate
- Use dental CDT codes
- Dental services done at a FQHC or RHC do not require dental PAR
- Must follow Colorado Medical Assistance Program guidelines to determine if services are a benefit
- Medicaid children and adult benefits are outlined in Dental Billing Manual



# Behavioral Health Organization (BHO)

- For Medicaid member who is:
  - Enrolled in BHO & seen at FQHC/RHC by a mental health professional
- Claim for Mental Health services must be billed to BHO by FQHC/RHC if:
  - Diagnosis & all procedures during visit, are listed in Appendix T
    - Community Mental Health Services Program (Covered Diagnoses and Procedures)
    - [www.Colorado.gov/hcpf](http://www.Colorado.gov/hcpf) -> For Our Providers -> Provider Service -> Billing Manuals -> [Appendices](#)
    - New Website: [www.Colorado.gov/hcpf/billing-manuals](http://www.Colorado.gov/hcpf/billing-manuals) -> Appendices



# Mental Health Services

- For Medicaid member who is:
  - Seen at FQHC/RHC and primary diagnosis is a mental health condition
    - Condition listed in Appendix T  
(Community Mental Health Services Program)
- If treatment includes a procedure code not listed in Appendix T:
  - FQHC/RHC may bill Medicaid for “Encounter Rate”



# Lock In Program

- Designed to prevent misuse of pharmaceuticals
- For members who:
  - have been prescribed narcotics by three or more prescribers and,
  - used three or more pharmacies in three months
- Any provider can ask for a member to be reviewed by contacting the Department
  - Ask for the Lock-in Specialist at 303-866-3672



# Lock In Program

Only **one** prescriber will be allowed to submit claims



With a referral, member may be allowed to see two prescribers

Only **one** Pharmacy will be allowed to submit claims



If you are not the Pharmacy (or physician) listed you will receive error:

- NCPDP Reject 50 (Non-matched Provider Number)
- NCPDP Reject 56 (Non-matched Prescriber ID)



# SBIRT

## Screening, Brief Intervention and Referral to Treatment

See Billing Manual for more information



# 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



# Common Denial Reasons

**PAR not on file**



No approved authorization on file for services that are being submitted

**Total Charges  
invalid**



Line item charges do not match the claim total

**Type of Bill**



Claim was submitted with an incorrect or invalid type of bill



# Claims Process - Common Terms



## Reject

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



## Denied

Claim processed & denied by claims processing system



## Accept

Claim accepted by claims processing system



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



16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
MM	DD	YY	MM	DD	YY
FROM			TO		
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
MM	DD	YY	MM	DD	YY
FROM			TO		
20. OUTSIDE LAB?			\$ CHARGES		
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
22. RESUBMISSION CODE			ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER					

## 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 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 TO	TOTAL DENIED	DENIAL REASONS ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	308000000000000003	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

## Recovery

\*\*\*\*\*  
\* ADJUSTMENTS PAID \*  
\*\*\*\*\*

INVOICE --- CLIENT	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 041008 091808	041808 406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1									
Z71 CLIENT, IMA	A000000	40800000000200002	041008 041008 041808	041808 406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1									
NET IMPACT					21.42				

## Repayment

## Net Impact

## Voids

\*\*\*\*\*  
\* ADJUSTMENTS PAID \*  
\*\*\*\*\*

INVOICE - CLIENT	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									
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](mailto:helpdesk.HCG.central.us@cgi.com)

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

# Thank You!

