

Beginning Billing Workshop FQHC / RHC

Colorado Medicaid
2015





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/
 - National Plan and Provider Enumeration System (NPPES)-
 - 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

2.

For Our Providers

Home For Our Members **For Our Providers** For Our Stakeholders

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		



NEW! Provider Home Page

Find what you need here



Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

The screenshot shows the Colorado Department of Health Care Policy & Financing website. The header includes the state logo, HCPF logo, and the text 'COLORADO Department of Health Care Policy & Financing'. A navigation menu is visible with 'For Our Providers' highlighted. The main content area is titled 'For Our Providers' and contains four columns of information: 'Why should you become a provider?' with a cross icon, 'How to become a provider (enroll)' with a document icon, 'Provider services (training, & more)' with a dollar sign icon, and 'What's new? (bulletins, newsletters, updates)' with a radio tower icon. Below this are three quick links: 'Get Help Dept. Fiscal Agent 1-800-237-0757', 'Get Info FAQs & More', and 'Find a Doctor Are you a client looking for a doctor?'.



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:



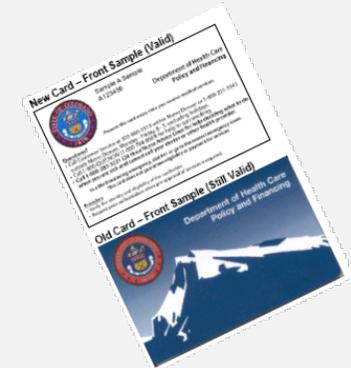
Web Portal



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](#)

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

CO MEDICAL ASSISTAN
Response Creation Date & Time: 05/

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

[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:

MHPROV Services
Provider Name:
COLORADO HEALTH PARTNERSHIPS LLC

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

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



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

$$\begin{array}{r} \underline{\underline{\$400.00}} \\ - \$300.00 \\ \hline = \$100.00 \end{array}$$



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



Providers Not Enrolled with EDI



COLORADO MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757 or 1-800-237-0044
colorado.gov/hcpf

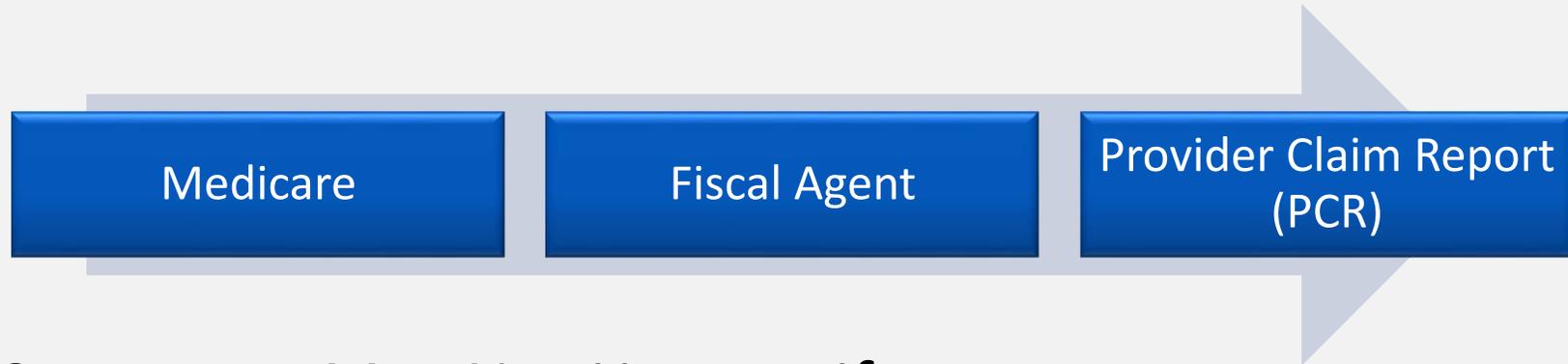
Providers must be enrolled with EDI to use the Web Portal to submit HIPAA compliant claims, make inquiries and retrieve reports electronically

- Select Provider Application for EDI Enrollment
 - Colorado.gov/hcpf → Providers → EDI Support
 - **New Website:** Colorado.gov/hcpf/provider-information → EDI Support



Crossover Claims

- Automatic Medicare Crossover Process:



- Crossovers May Not Happen If:
 - NPI not linked
 - Member is a retired railroad employee
 - Member has incorrect Medicare number on file



Crossover Claims

- Provider Submitted Crossover Process:

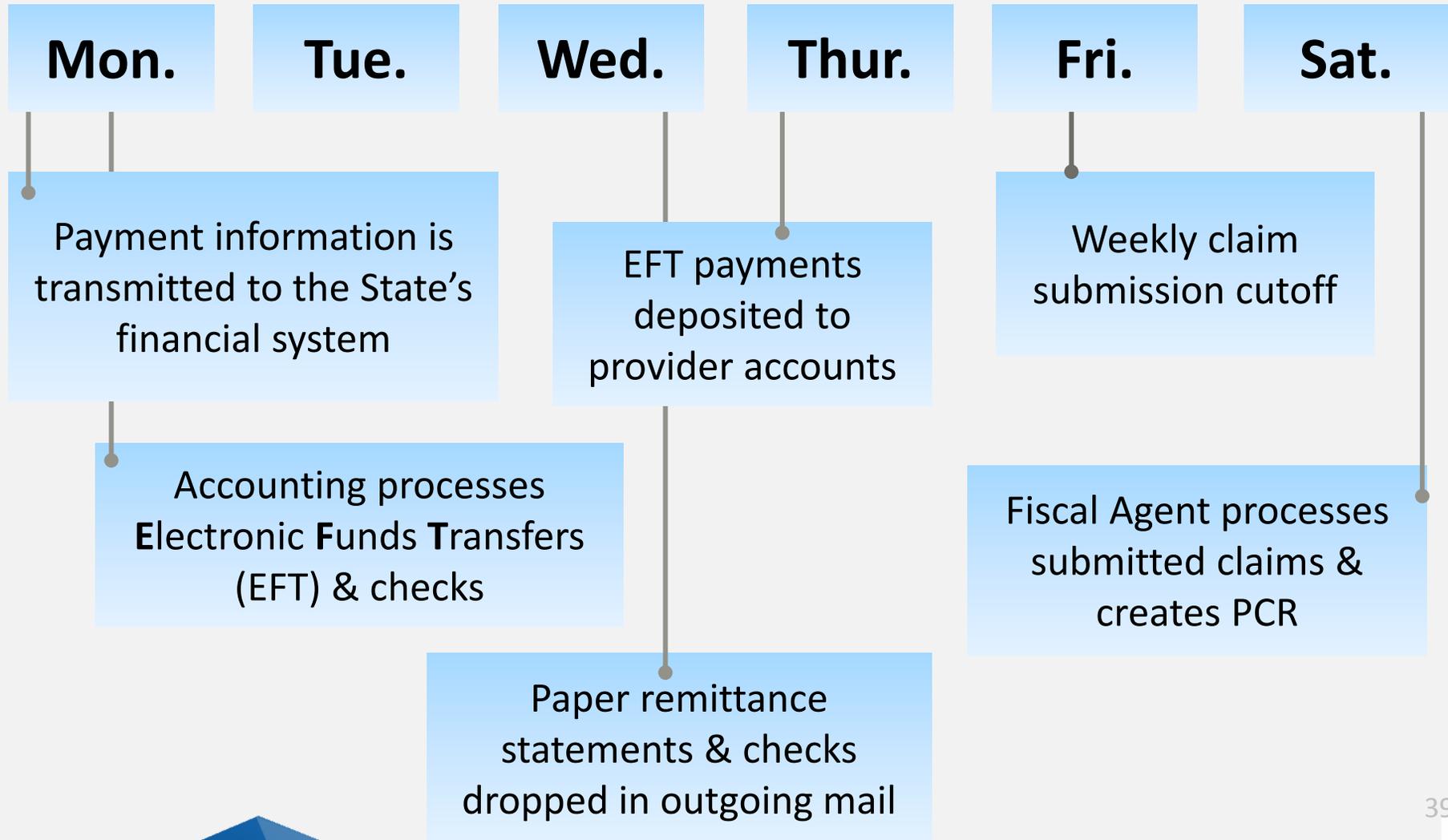


- Additional Information:

- 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 Thursday
 - 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



• Outpatient Primary Care

Rural Health
Clinics



- 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



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/ → For Our Providers → Provider Services → Billing Manuals
 - **New website:** 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 -> For Our Providers -> Provider Service -> Billing Manuals -> [Appendices](#)
 - New Website: 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	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 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				

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			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!

