

Beginning Billing Workshop Nursing Home Visitor Program

Colorado Medicaid
2016



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Centers for Medicare & Medicaid Services



Xerox State Healthcare



Medicaid/CHP+ Medical Providers



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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



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Nurse Home Visitor Program

- Who's involved?
 - Colorado Department of Health Care Policy and Financing
 - Colorado Department of Human Services
 - Invest in Kids
 - What it is and how to obtain one
- Statutes, Rules, Guidance
 - 26-6.4-101 C.R.S
 - 10 C.C.R 2505-10 § 8.749
 - Medicaid Billing Manual
 - State Plan Amendment



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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



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What is an NPI? (cont.)

- How to Obtain & Learn Additional Information:
 - CMS web page (paper copy)-
 - www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvdentStand/index.html?redirect=/nationalprovide ntstand/
 - National Plan and Provider Enumeration System (NPPES)-
 - www.nppes.cms.hhs.gov
 - Enumerator-
 - 1-800-456-3203
 - 1-800-692-2326 TTY



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Department Website

A screenshot of the Colorado Department of Health Care Policy & Financing website. The browser address bar shows <https://www.colorado.gov/hcpf>. A purple circle with the number '1' and a downward arrow points to this address bar. A callout box below it contains the text www.colorado.gov/hcpf. The website header includes the Colorado logo and the text 'Colorado The Official Web Portal'. The main content area features the HCPF logo and the text 'COLORADO Department of Health Care Policy & Financing'. A navigation menu has 'For Our Providers' highlighted with a purple box and a purple circle with the number '2' and a rightward arrow. A callout box to the right of this menu contains the text 'For Our Providers'. Below the navigation menu, there is a sub-header: 'We administer Medicaid, Child Health Plan Plus, and other health care programs for Coloradans who qualify.' The main content area is divided into four columns: 'Explore Benefits' (with a magnifying glass icon), 'Apply Now' (with a checkmark icon), 'Find Doctors' (with a group of people icon), and 'Get Help' (with an information icon). At the bottom, there are two promotional banners: 'Feeling Sick?' with a nurse icon and the phone number '800-283-3221', and 'Get Covered. Stay Healthy.' with an umbrella icon and the URL 'colorado.gov/health'.



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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 official web portal for the Colorado Department of Health Care Policy & Financing. The page is titled "The Official Web Portal" and includes a "Translate" button and a search icon. The main header features the Colorado Department of Health Care Policy & Financing logo and name. A navigation menu is located below the header, with "For Our Providers" selected. The "For Our Providers" section contains four main categories: "Why should you become a provider?", "How to become a provider (enroll)", "Provider services (training, & more)", and "What's new? (bulletins, newsletters, updates)". Below these categories are six tiles: "CBMS Colorado Benefits Mgmt. System", "DDweb", "Web Portal", "Get Help", "Get Info", and "Find a Doctor".



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Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

Enrolls **providers** into the Colorado Medical Assistance Program, not members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

- Additional information for provider enrollment and revalidation is located at the Provider Resources website



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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:



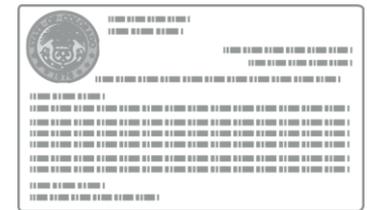
Colorado Medical
Assistance Web Portal



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



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Eligibility Request Response (271)

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

Eligibility Request
Provider ID: National Pro
From DOS: Through D
Client Detail
State ID: DOB:
Last Name: First Name

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:

CO MEDICAL ASSISTANCE
Response Creation Date & Time: 05/19/2011

[Contact Information for Questions on Res](#)
Provider Relations Number: 800-237-075

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

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

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 scroll bar on right to view details

Successful inquiry notes a Guarantee Number:

- Print copy of response for member's file when necessary

Reminder:

- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours



Medicaid Identification Cards

- Provider may begin seeing the branded cards as early as 20, 2016



Member name: FirstName LastName
Member ID #: #####

- Talk to a nurse anytime at 1-800-283-3221. Dial 911 or go to the ER in a life threatening emergency.
- View coverage and co-payment info or find a provider:
 - Colorado.gov/HCPF
 - PEAHealth mobile app
 - Call 1-800-221-3943 or State Replay 711, M-F, 7:30am-5:15pm
- Keep your coverage and info current:
 - Colorado.gov/PEAK
 - PEAHealth mobile app
- Bring a photo ID when you go to your provider or pharmacy.

Providers: This card does not guarantee eligibility or payment for services. You must verify identity and eligibility before providing services.

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



Sample A Sample
A123456
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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.



Eligibility Types

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



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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 Durable Medical Equipment (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



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Eligibility Types

Presumptive Eligibility (cont.)

- 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



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Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

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

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



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Commercial Insurance

- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
 - Bill member difference or commercial co-payments
 - Place lien against members right to recover
 - Bill at-fault party's insurance



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Billing Overview

Record
Retention

Claim
submission

Prior
Authorization
Requests (PARs)

Timely filing

Extensions for
timely filing



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Record Retention

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



Record Retention

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



Submitting Claims

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



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ICD-10 Implementation

Claims with Dates of Service (DOS) on or before 9/30/15

Use ICD-9 codes

Claims with Dates of Service (DOS) on or after 10/1/2015

Use ICD-10 codes

Claims submitted with both ICD-9 and ICD-10 codes

Will be rejected



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Providers Not Enrolled with EDI



COLORADO MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-231-4767
colorado.gov/hcpf

Providers must be enrolled with EDI to:

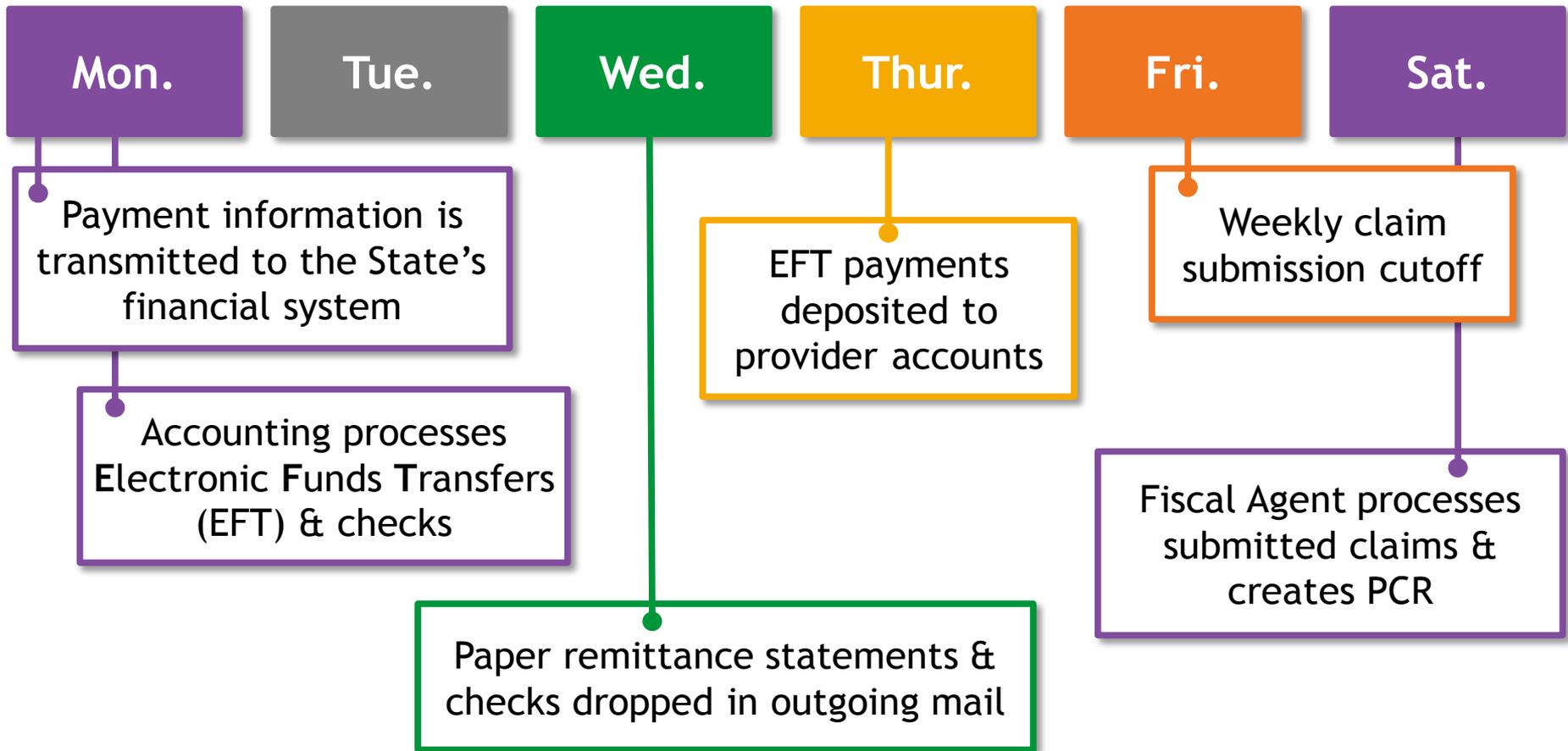
- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
 - Select Provider Application for EDI Enrollment

Colorado.gov/hcpf/EDI-Support



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Payment Processing Schedule



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Electronic Funds Transfer (EFT)

Advantages

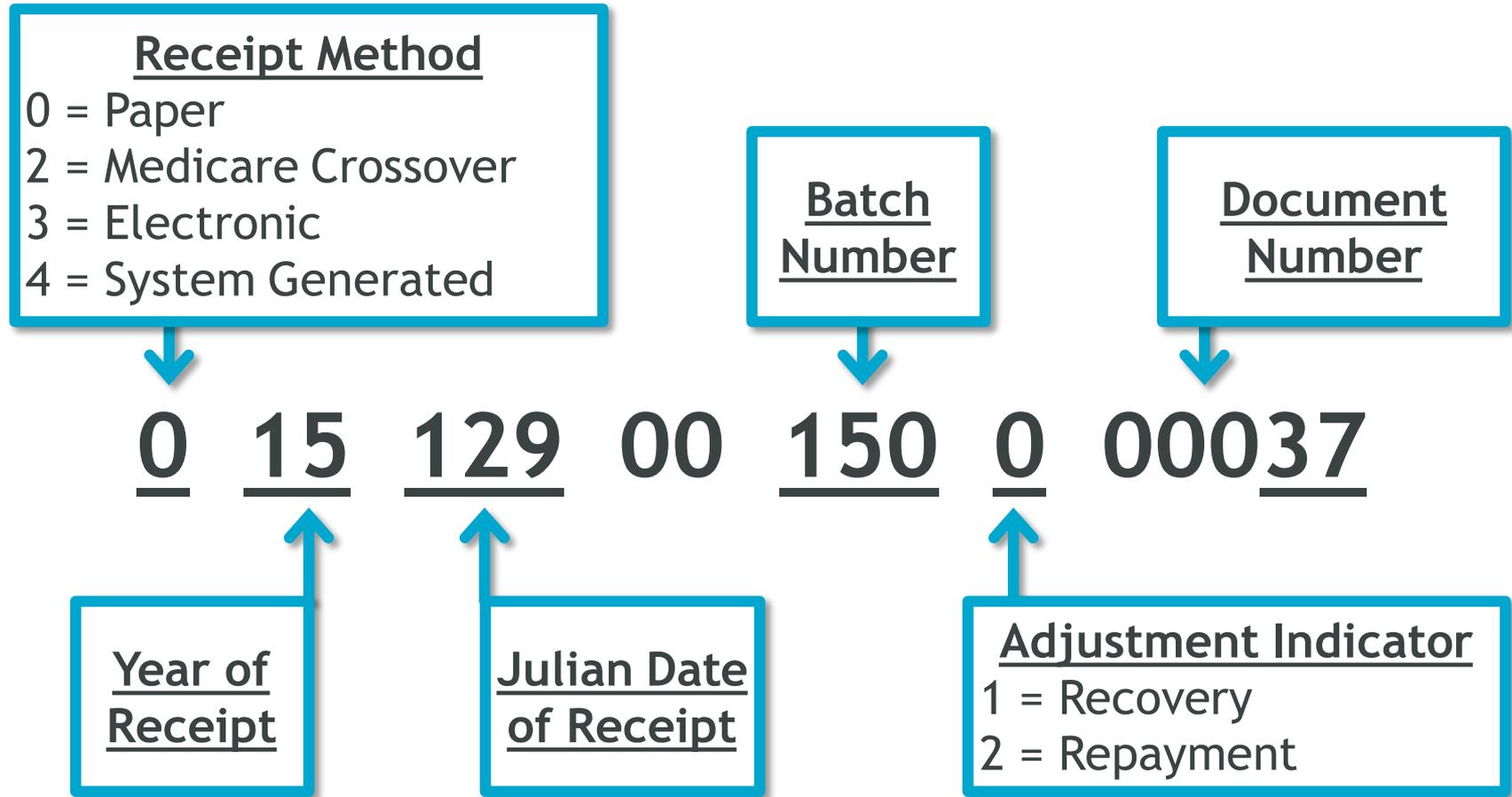
- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- [Colorado.gov/hcpf/provider-forms](https://colorado.gov/hcpf/provider-forms) → Other Forms



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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)



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Timely Filing

From “through” DOS

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

From delivery date

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

From DOS

FQHC Separately Billed and additional Services



Documentation for Timely Filing

- 60 days from date on:
 - Provider Claim Report (PCR) Denial
 - Rejected or Returned Claim
 - Use delay reason codes on 837I transaction
 - Keep supporting documentation
- Paper Claims
 - UB-04- enter Occurrence Code 53 and the date of the last adverse action



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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



Timely Filing Extensions

Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
 - File claim with Colorado Medicaid
 - Receive denial or rejection
 - Continue re-filing every 60 days until insurance information is available



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Timely Filing Extensions

Delayed Notification

- 60 days from eligibility notification date
 - Certification & Request for Timely Filing Extension - Delayed Eligibility Notification Form
 - Located in Forms section
 - Complete & retain 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



Timely Filing Extensions

Backdated Eligibility

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



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Procedure Codes

- G9006
 - Coordinated Care Fee, Home Monitoring
 - Use this code when billing services for the mother
- T1017
 - Targeted Case Management
 - Use this code when billing services for the child
- Services for the mother and services the child must be billed on separate claims



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Places of Service

- Reimbursement rate is dependent on Place of Service
 - Bill Place of Service Code 12 (Home) or any TCM that occurs away from the office/agency
 - Bill other Place of Service codes for TCM that occurs at your office/agency including but not limited to:
 - 11 (Office)
 - 50 (FQHC)
 - 71 (Public Health Agency)
 - 72 (RHC)



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Units of Service

- 1 unit equals 15 minutes of TCM
- A maximum of fifteen (15) units will be reimbursed in any calendar month per mother/child couple
- May be divided between the mother and child if both are Medicaid-eligible in the same month
- May be provided:
 - In the home/off-site setting
 - In the office
 - A combination of both



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Units of Service

- Time spent on TCM should be rounded to the nearest whole unit
- Documentation in the chart should support the number of units billed

Service Time	Units Billed
5 minutes	No units may be billed
10 minutes	1 unit may be billed
23 minutes	2 units may be billed



Modifiers

- 1st modifier field must always be HD (pregnant/parenting program)
- If Home TCM and Office TCM on the same date of service or span:
 - Line Item 1: Procedure code, Modifier 1 is HD, first place of service code
 - Line Item 2: Procedure code, Modifier 1 is HD, Modifier 2 is 76 (duplicate service), other place of service code



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Diagnosis Codes

- Diagnosis codes that are appropriate for this program include but are not limited to the following:

Member Description and Stage	Diagnosis Code	Description
Pregnant Woman	V22 V22.0 V22.1 V23	Normal pregnancy Supervision of normal first pregnancy Supervision of other normal pregnancy Supervision of high-risk pregnancy
Mother from Delivery through 2-3 Months Postpartum	V24.2	Routine postpartum follow-up
Mother after 2-3 Months Postpartum to Child's 2 nd B-day	V68.9	Encounter for unspecified administrative purpose
Child-Infancy through 2 nd B-day	V20 V20.1	Health supervision of infant or child Other healthy infant or child receiving care



Span Billing

- Alternative billing method allowed for some services, including NHVP
 - Rather than billing each encounter separately with individual dates of service, Span Billing allows you to bill one line item for:
 - The same service provided to the same member
 - Over a period of time on multiple dates of service
 - For instance if TCM was provided to the same member on three different dates of service:
 - Span of dates can be entered in the “From Date” field and the “To Date” field on one line item
 - Rather than billing three line items for each separate date of service



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Span Billing

- The span “From Date” and the span “To Date” should be within the same month
 - ie. 10/1/15 - 10/31/15
 - not 10/15/15 - 11/15/15
- No additional claims for that specific service for that member during that span will be paid once the span claim is paid
- If you need to add units, you must adjust the span claim
 - Do not submit an additional claim



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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 “Payer 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



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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

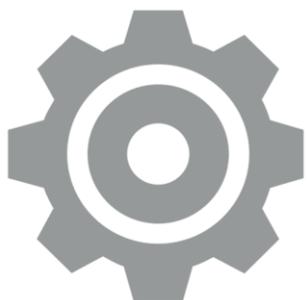
Claim accepted by claims processing system



Paid

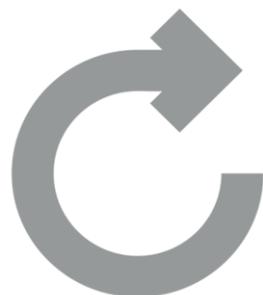
Claim processed & paid by claims processing system

Claims Process - Common Terms



Adjustment

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



Rebill

Re-bill previously denied claim



Suspend

Claim must be manually reviewed before adjudication



Void

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

Adjusting Claims

- What is an adjustment?
 - Adjustments create a replacement claim
 - Two-step process: Credit & Repayment

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

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

Adjustment Methods



Web Portal

- Preferred method
- Easier to submit & track



Paper

- Complete field 22 on the CMS 1500 claim form

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



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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 one month of PCR issue date or not



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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'.



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Provider Claim Reports (PCRs)

Adjustments

Recovery

* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO 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						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						114.24				
						NET IMPACT	21.42			

Repayment

Net Impact

Voids

* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO 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						642.60-	642.60-			
						NET IMPACT	642.60-			



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Provider Services

Xerox
1-800-237-0757

Claims/Billing/Payment

Forms/Website

EDI

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!



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