

Nurse Home Visitor Program

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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



Nurse Home Visitor Program

- Who's involved?

- Colorado Department of Health Care Policy and Financing (Medicaid)
- Colorado Department of Human Services
- Invest in Kids

- Statutes, Rules, Guidance

- 26-6.4-101 C.R.S
- 10 C.C.R 2505-10 § 8.749
- Medicaid Billing Manual
- State Plan Amendment



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

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.**

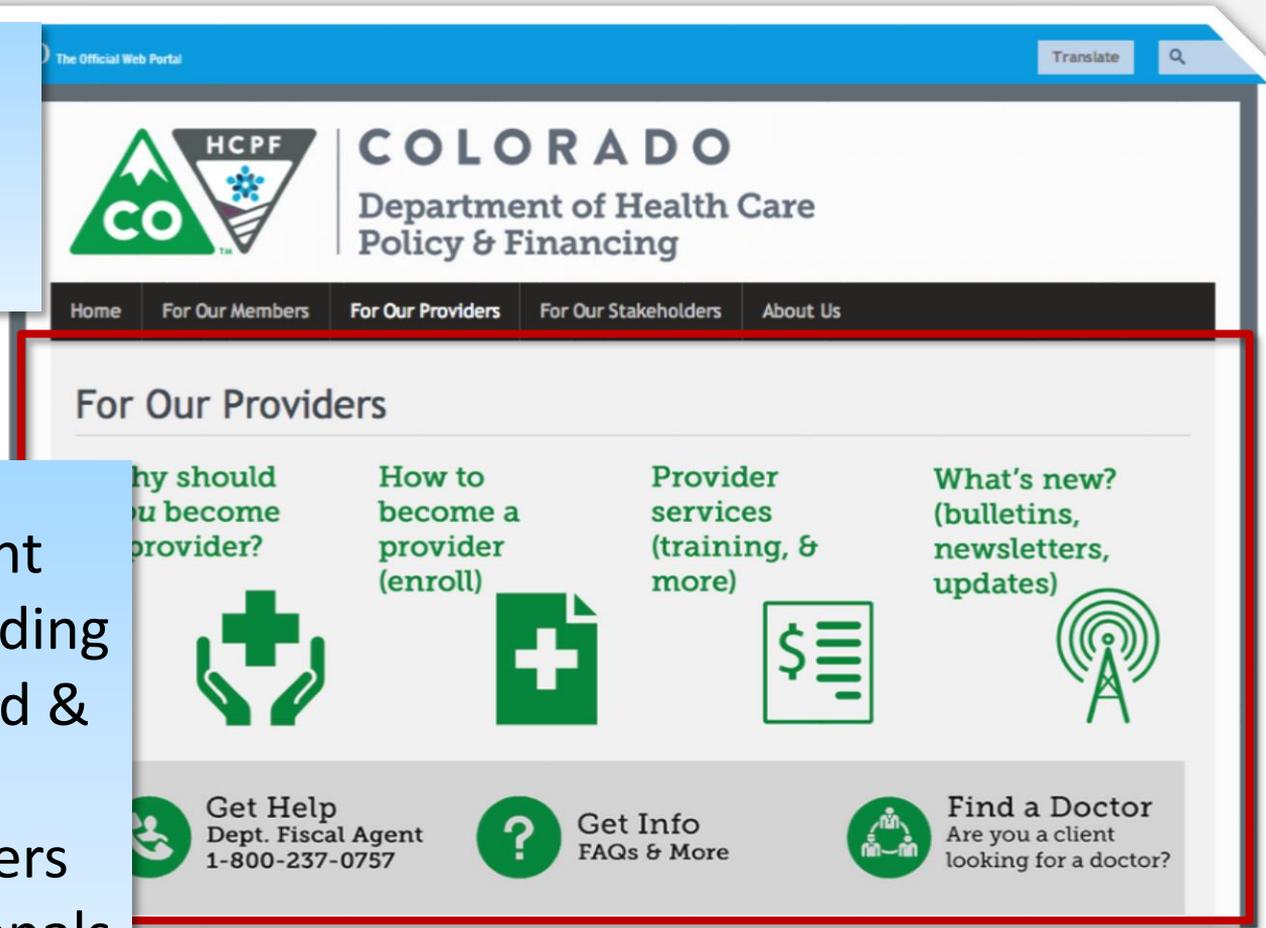
colorado.gov/health



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 members



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:



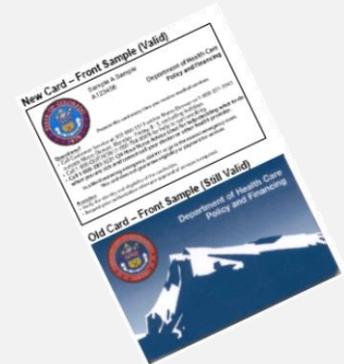
Web Portal



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:

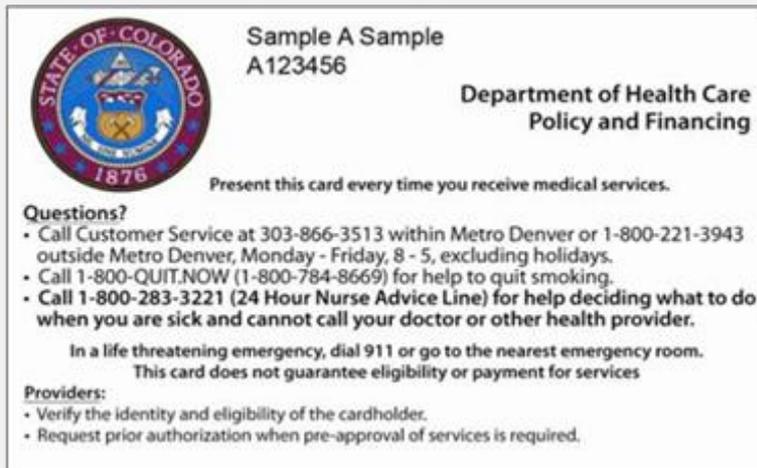
- Print a copy of the response for the member's file when necessary

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
 - Presumptive Eligibility
- Some members = additional benefits
 - Managed Care
 - Medicare
 - Third Party Insurance



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



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-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

\$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



Pregnant Women

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



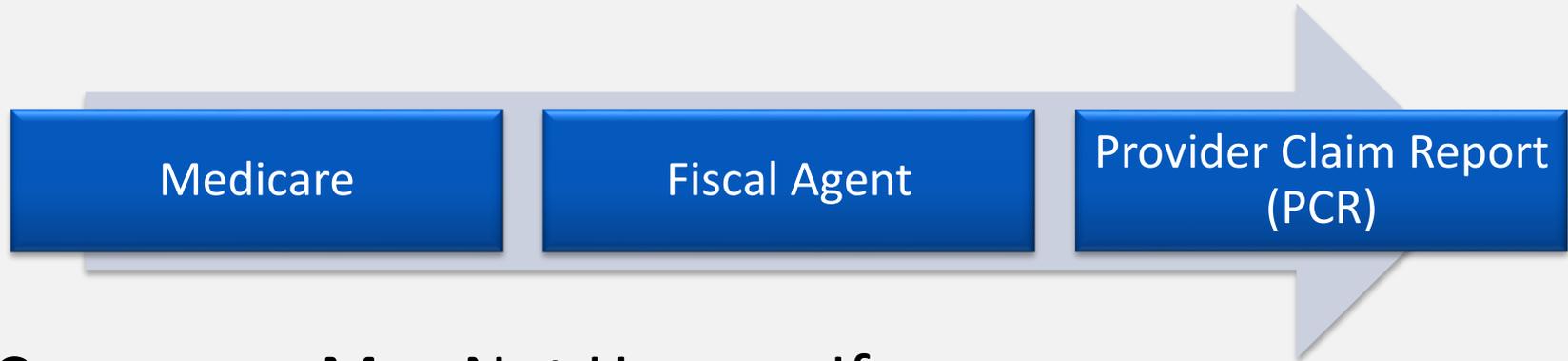
ICD-10 Implementation Delay

- 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:

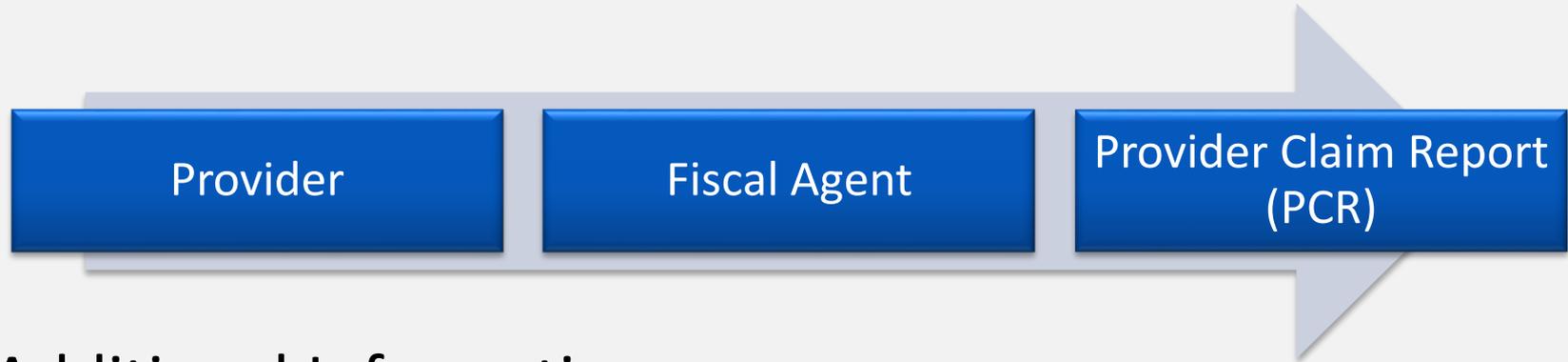


- Crossovers May Not Happen If:

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

Crossover Claims

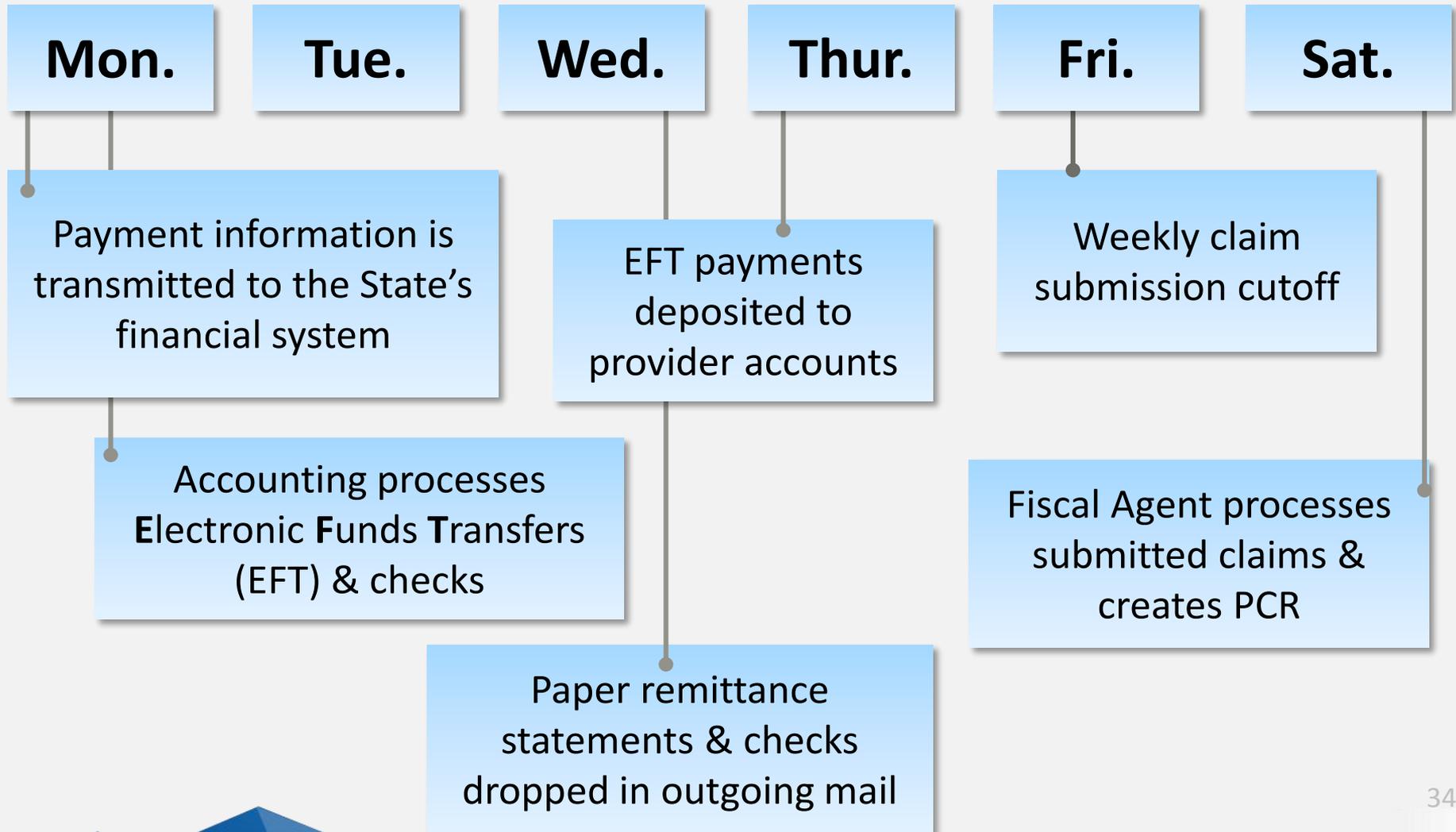
- Provider Submitted Crossover Process:



- 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



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 Field 19 (Additional Claim Information)



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



CMS 1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <input type="checkbox"/> PICA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> RUG <input type="checkbox"/> LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (For Program in Item 1)				1a. INSURED'S LD. NUMBER							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)					
8. RESERVED FOR NUCC USE				8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE					
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 <input type="checkbox"/> NO <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10a. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> #yes, complete items 9, 9a, and 9c.					
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.											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE QUAL. MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to C to service line below (24E)) A. ICD Ind. B. ICD Ind. C. ICD Ind. D. ICD Ind. E. ICD Ind. F. ICD Ind. G. ICD Ind. H. ICD Ind. I. ICD Ind. J. ICD Ind. K. ICD Ind. L. ICD Ind.					20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) D. DIAGNOSIS POINTER E. \$ CHARGES F. Q. UNITS G. UNITS H. UNITS I. UNITS J. RENDERING PROVIDER ID.#					22. RESUBMISSION CODE ORIGINAL REF. NO.						
25. FEDERAL TAX ID. NUMBER SSN EBN					23. PRIOR AUTHORIZATION NUMBER						
26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov't assign, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>						
28. TOTAL CHARGE \$					29. AMOUNT PAID \$						
30. Reserved 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.)						
32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()						
SIGNED DATE					SIGNED DATE						

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



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 for the child must be billed on separate claims.



Places of Service

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



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



Units of Service (cont.)

- Time spent on TCM should be rounded to the nearest whole unit. For example:

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

- Documentation in the chart should support the number of units 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



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	Normal pregnancy
	V22.0	Supervision of normal first pregnancy
	V22.1	Supervision of other normal pregnancy
	V23	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	Health supervision of infant or child
	V20.1	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



Span Billing

- The span “From Date” and the span “To Date” should be within the same month
 - ie. 10/1/14 – 10/31/14
 - not 10/15/14 – 11/15/14
- 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



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



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

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

Thank you!
Kirstin.Michel@state.co.us.
(303) 866-2844

