Billing Workshop
Rehabilitative OT/PT/ST

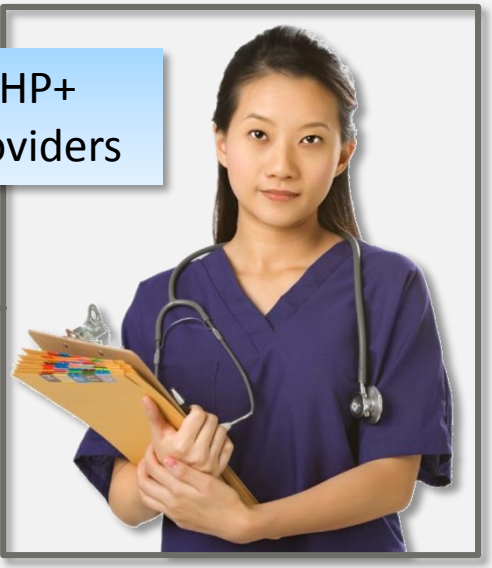
Colorado Medicaid
2014

Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing

Medicaid

Medicaid/CHP+ Medical Providers



Xerox State Healthcare

Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types
- Billing Basics
  - How to ensure your claims are timely
  - When to use the CMS 1500 paper claim form
  - How to bill when other payers are involved

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - Regardless of job/location changes

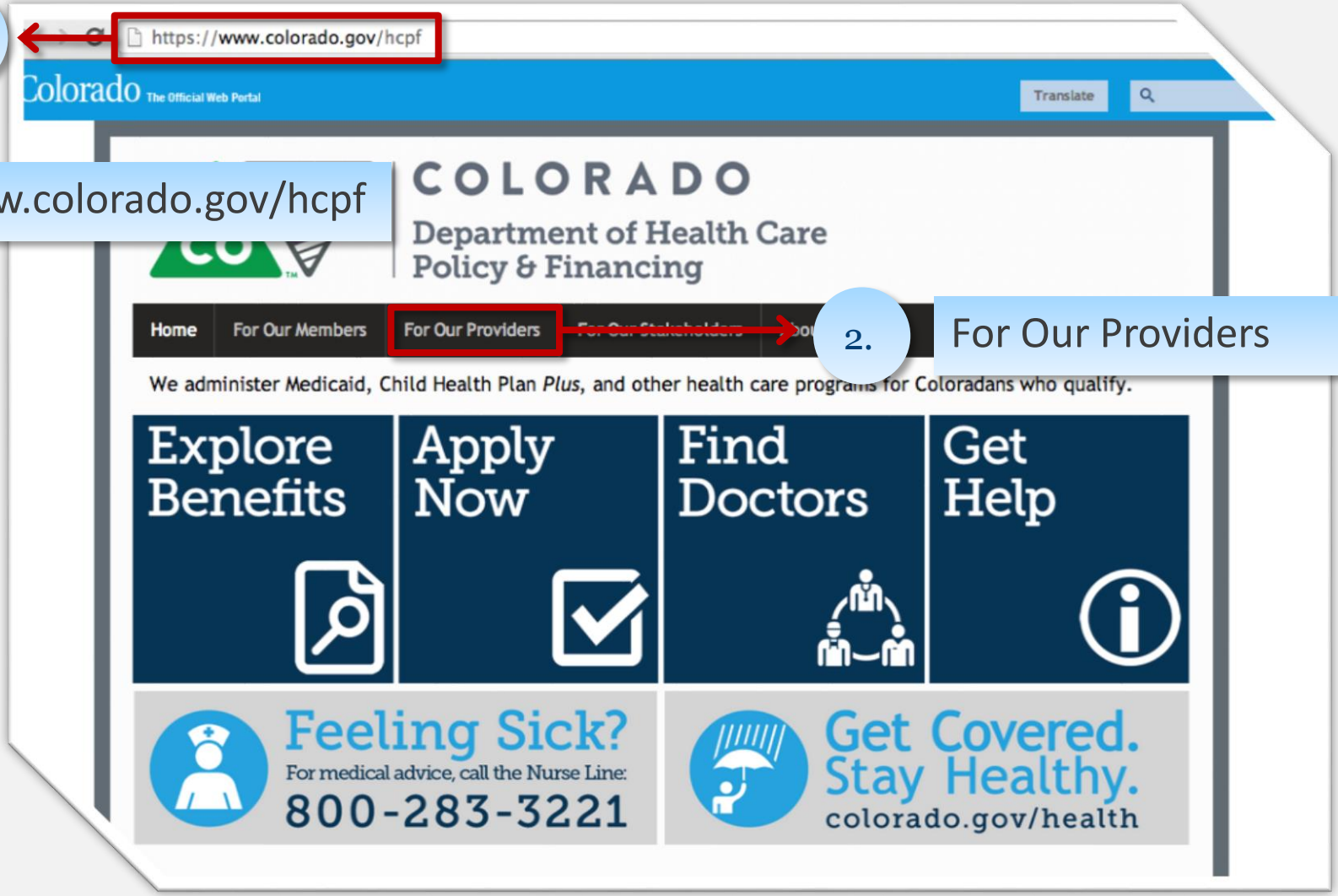
What is an NPI?

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

NEW! Department Website

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

www.colorado.gov/hcpf

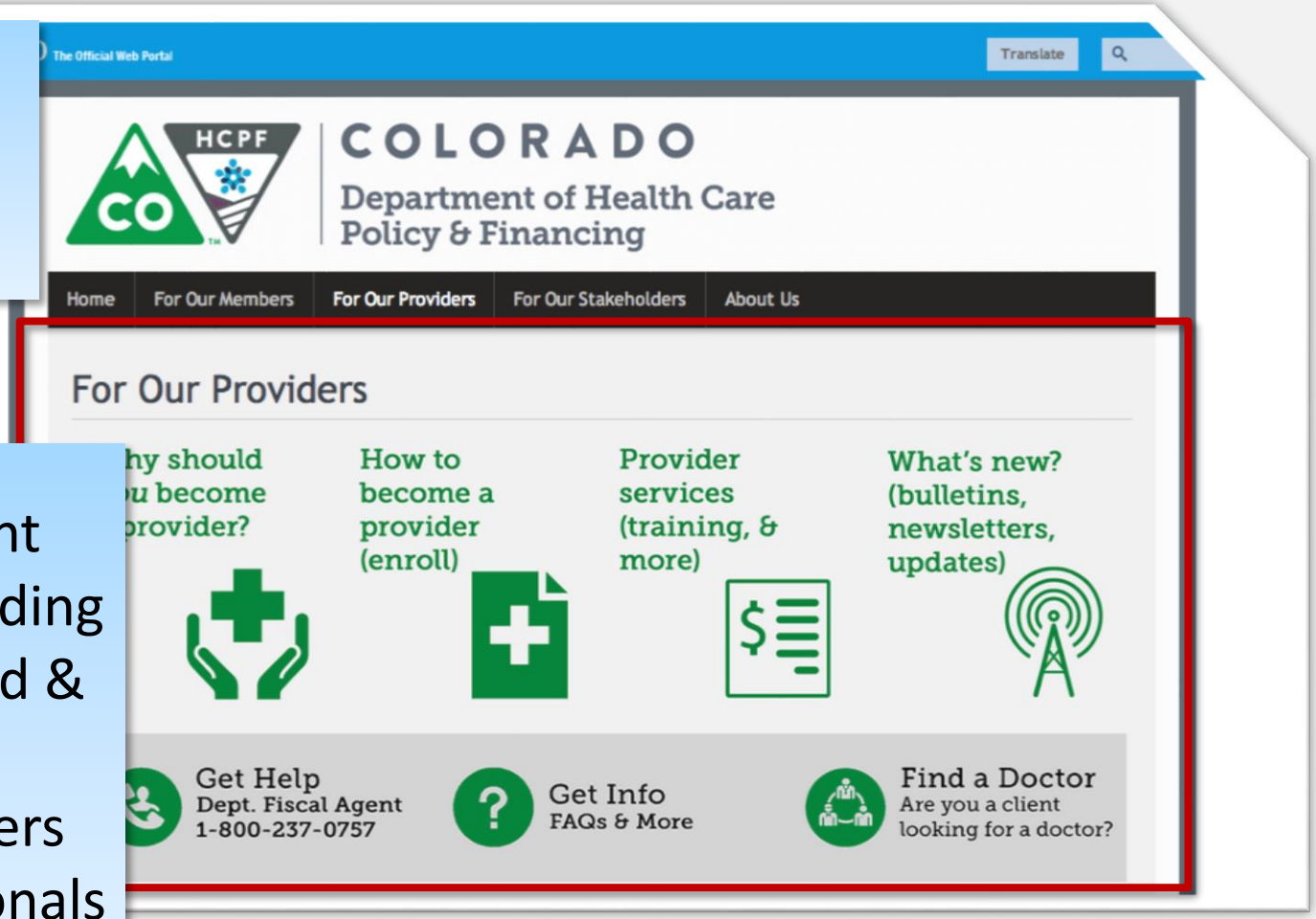


2. For Our Providers

NEW! Provider Home Page

Find what you need here

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



Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

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

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Rendering Versus Billing

Rendering Provider

- Individual that provides services to a Medicaid member

Billing Provider

- Entity being reimbursed for service

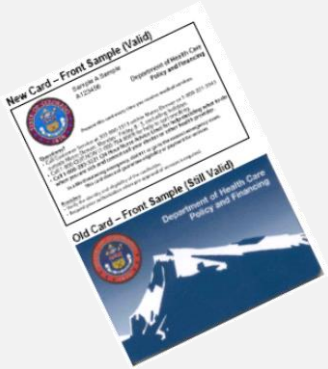
Verifying Eligibility

- 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

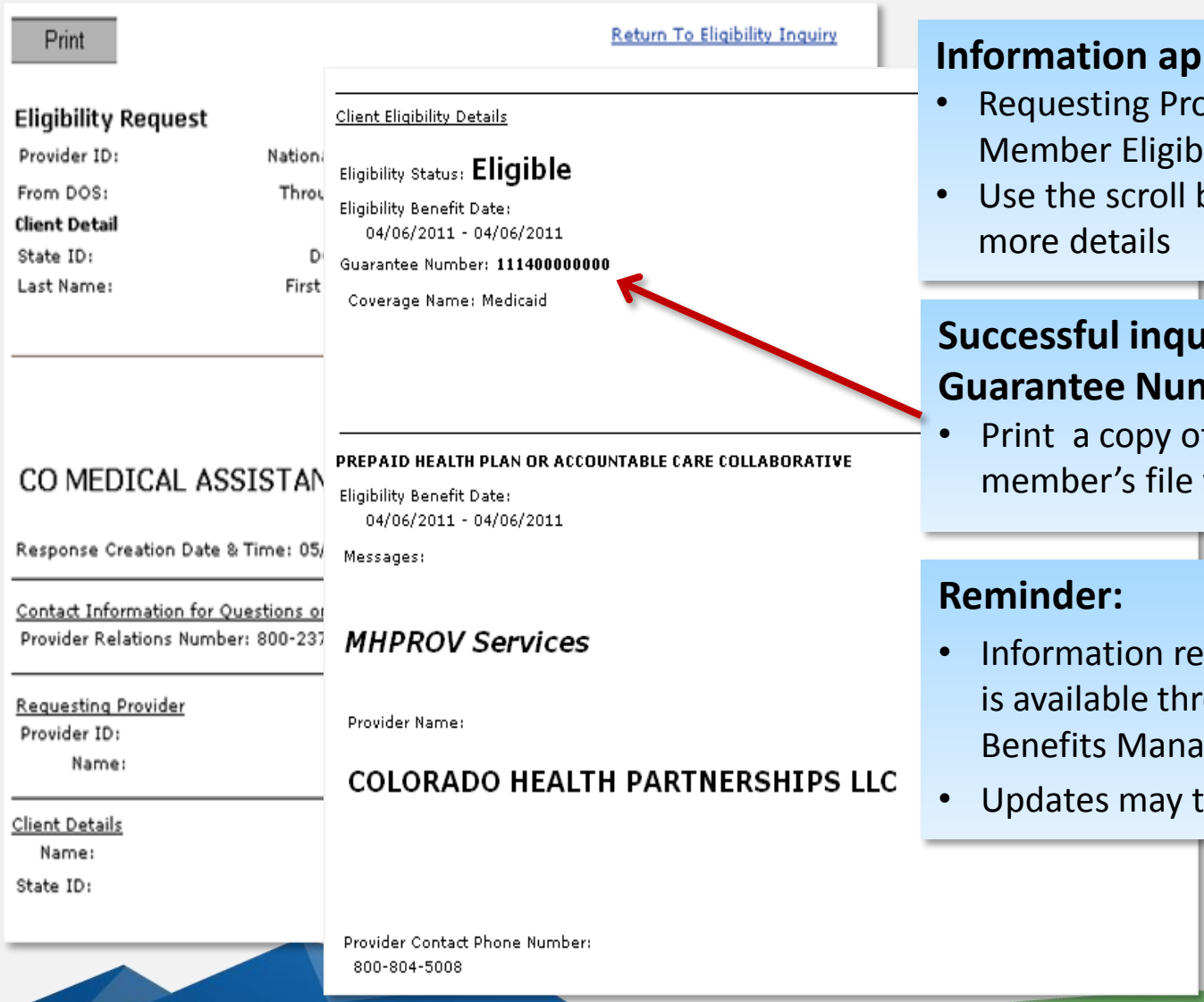


Medicaid ID Card with Switch Vendor

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)



Information appears in sections:

- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use the scroll bar to the right to view more details

Successful inquiry notes a Guarantee Number:

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

Reminder:

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

Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility

Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

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
  - Connects Medicaid members to:
- 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

	$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

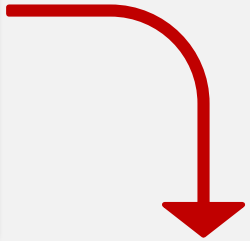
Image courtesy of FreeDigitalPhotos.net & David Castillo Dominici

Co-Payment Facts

- Auto-deducted during claims processing
  - Do not deduct from charges billed on claim
- Collect from member at time of service
- Services that do not require co-pay:
  - Dental
  - Home Health
  - HCBS
  - Transportation
  - Emergency Services
  - Family Planning Services

Specialty Co-Payments

Speech Therapy
Occupational Therapy
Physical Therapy



$3.00 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

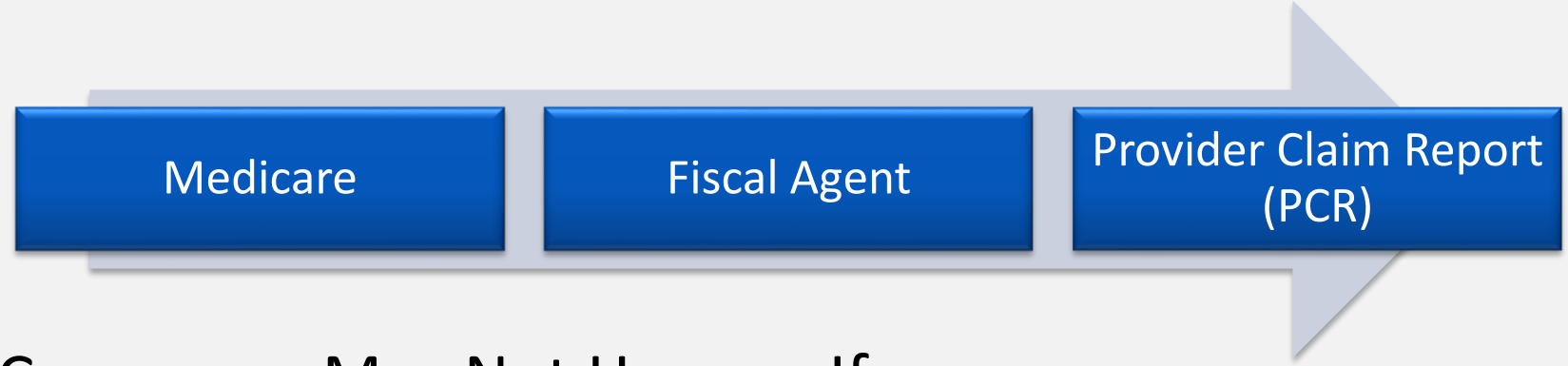
- Methods to submit:
  - Electronically through **Web Portal**
  - Electronically using **Batch Vendor**, **Clearinghouse**, or **Billing Agent**
  - **Paper** only when
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

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

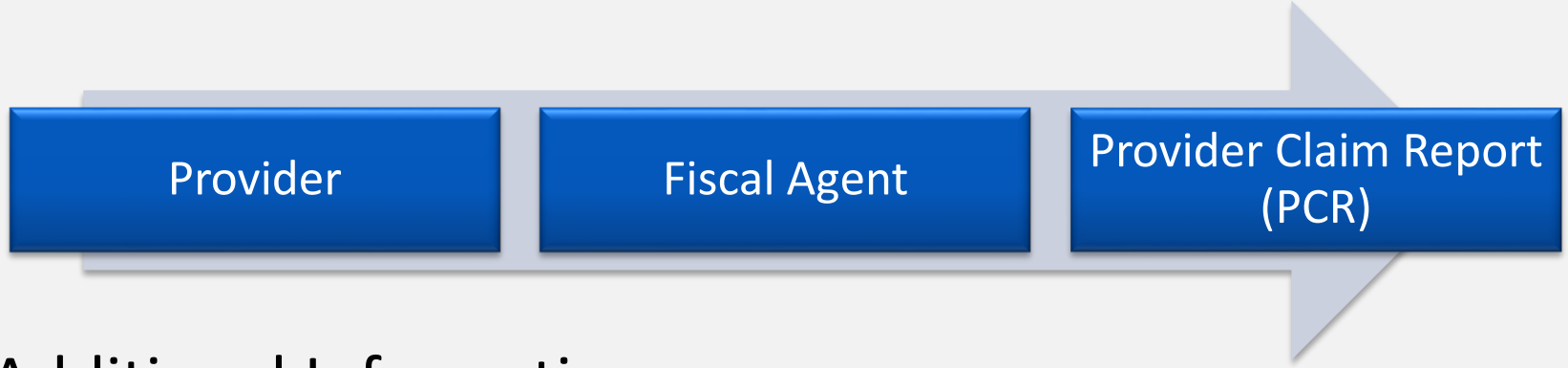
- Automatic Medicare Crossover Process:



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

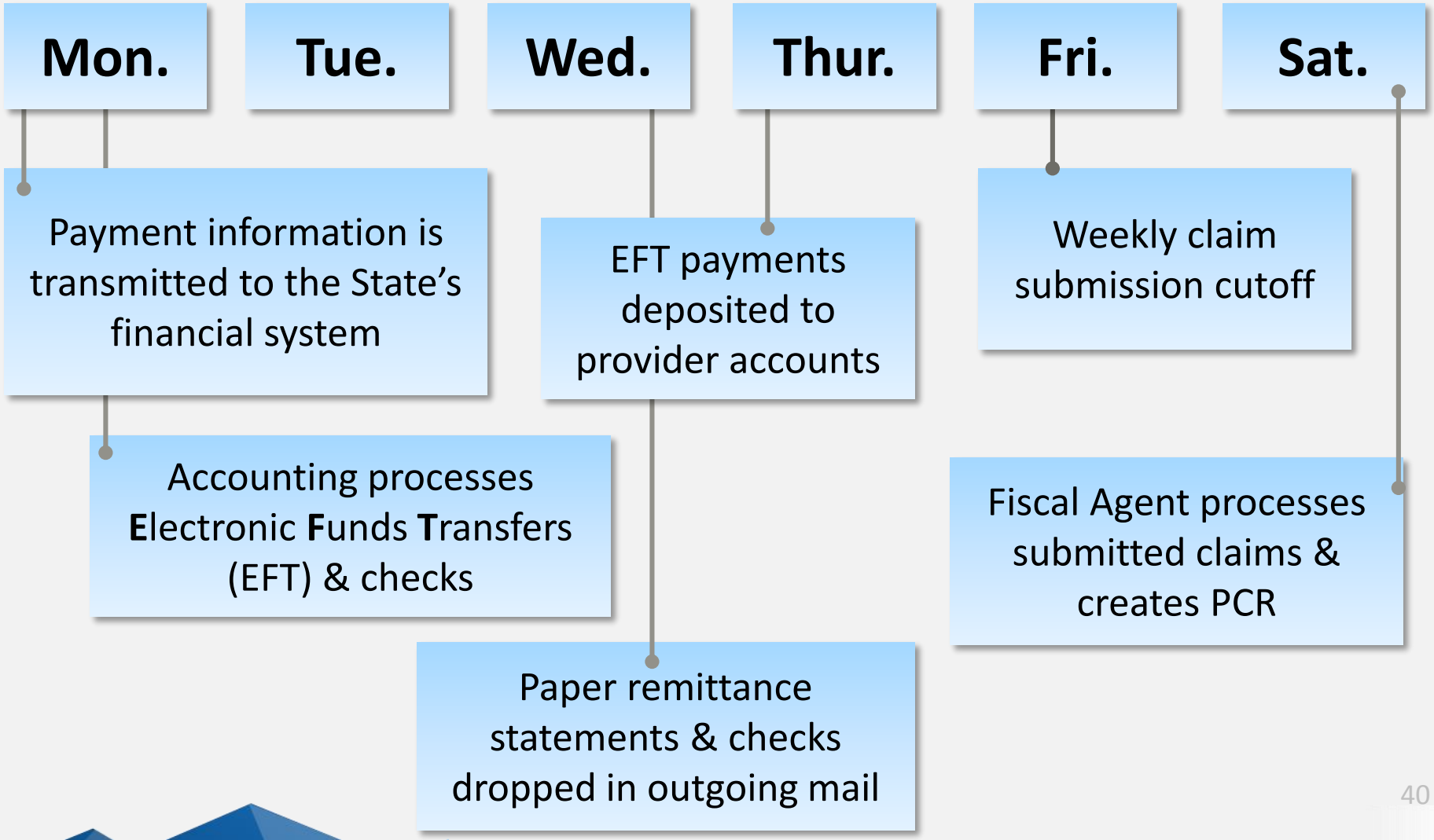
Crossover Claims

- 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

PARs Reviewed by ColoradoPAR

- With the <u>exception of Waiver and Nursing Facilities:</u>
  - ColoradoPAR processes all PARs including revisions
  - Visit coloradopar.com for more information

<u>Mail</u>:
Prior Authorization Request
55 N Robinson Ave., Suite 600
Oklahoma City, OK 73102

<u>Phone</u>:
1.888.454.7686
<u>FAX</u>:
1.866.492.3176
<u>Web</u>:
ColoradoPAR.com

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)
- The ColoradoPAR Program will process PARs submitted by phone for:
  - emergent out-of-state
  - out-of area inpatient stays
  - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

PAR Letters/Inquiries

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is only number accepted when submitting claims
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the ColoradoPAR Program
  - ensure you have the right PAR type
  - e.g. Medical PAR may have been requested but processed as a Supply PAR

PAR Requirements

"Certification"

- Indicated by Physician's or Non-Physician Practitioner's (NNP) approval
- Requires dated signature on plan of care submitted by therapist

Or

Requesting physician submits a prescription with the therapist's plan of care

- Submitted with PAR
- Must be written within 60 days of start date on PAR

PAR Facts

- Member may receive PT & OT services during same time period/service dates
- Duplicate therapy may not be performed on same dates of service (DOS)
- Members may not receive the same service for habilitative & rehabilitative therapy on the same DOS
  - e.g. member may not have habilitative (97110) & rehabilitative (97110) on the same DOS
- Separate PAR & necessary documentation required for each request

PAR Facts (continued)

- PAR effective dates cannot exceed twelve (12) month span
- Approval depends on medical necessity, deemed by authorizing agent
- PAR requests must include legibly written & signed M.D./D.O. prescription
- Must include all of the following:
  - Diagnosis with ICD-9 code
  - Medical necessity for therapy
  - Number of therapy sessions needed per week

PAR Facts (continued)

Adults:

- PAR required for any Rehabilitative or Habilitative PT/OT units
- Maximum amount Rehabilitative PT/OT in 12 month period is 24 PT and 24 OT
- Maximum amount Habilitative PT/OT in 12 month period is 24 PT and 24 OT

Children:

- Require a PAR only after 24 units PT and 24 units OT

Habilitative speech therapy:
requires PAR for both children and adults

Within 365 day period, another evaluation can be requested if:

- Change in provider rendering services
- Change in diagnosis

PAR Facts (continued)

- If member's medical condition requires more treatments than listed & authorized on original PAR:
  - New PAR is required
  - PAR must:
    - Include all required information previously noted
    - must show continued need, ongoing deficits, & progress toward treatment goals
  - No retroactive PARs allowed
  - Any claims submitted after 24 units of PT and/or 24 units of OT without PAR will not be reimbursed
  - All Habilitative services require PAR prior to treatment

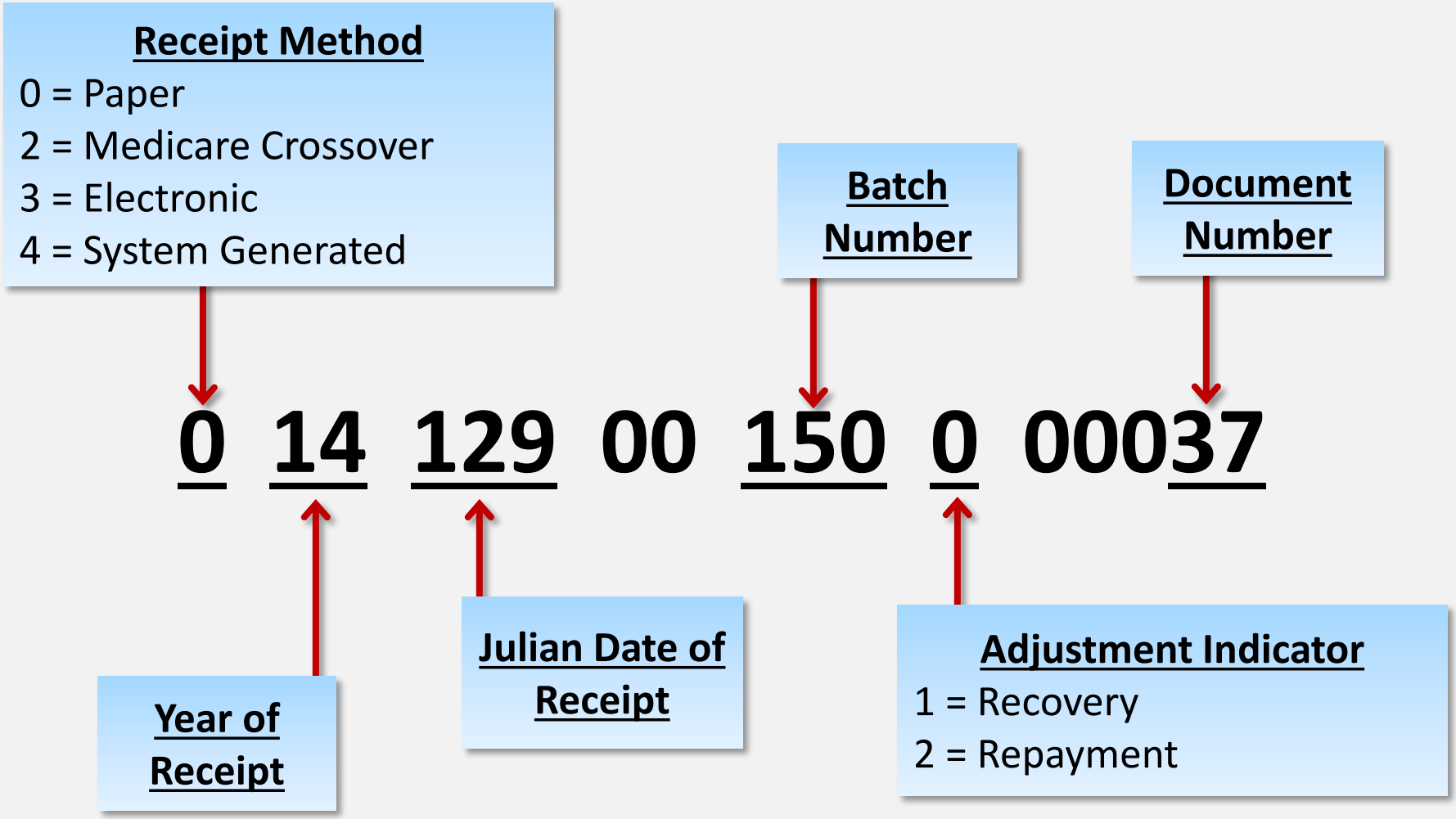
PAR Errors

If billing provider is not the rendering provider, make sure to:

- List name/address of prescribing provider in Box 2
  - Corresponds with Medicaid number in box 28
- Enter billing provider name/address in field # 25
- Enter billing provider number in field # 29

Note: If any necessary information is missing or invalid, PAR may be returned to provider or denied for lack of information

Transaction Control Number



Timely Filing

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

Timely Filing

From "through" DOS

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

From DOS

- FQHC Separately Billed and additional Services

From delivery date

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

Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CMS 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in Field 19 (Additional Claim Information)

Timely Filing – 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

Physical and Occupational Therapy

- Services must be provided by:
  - State of Colorado licensed physical or occupational therapist who is an approved Medical Assistance Program provider
- Occupational Therapy Assistants (OTAs) & Physical Therapy Assistants (PTAs) are eligible to provide services:
  - under supervision of an approved, licensed physical or occupational therapist
- Services provided in the Home Health benefit:
  - must conform to Home Health benefit rules

Physical and Occupational Therapy (PTAs/OTAs)

- PTAs must:
  - be certified by DORA pursuant to Title 12 Article 41.204
  - work under supervision of a licensed physical therapist
    - as defined in Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) & accompanying rules as promulgated by State Board of Physical Therapy
- OTAs must:
  - practice under general supervision of a Colorado registered occupational therapist
  - Must be licensed

Medical Necessity

- **PT/OT/ST must be:**
  - in accordance with generally accepted standards of medical practice
  - clinically appropriate in terms of type, frequency, & duration
  - not primarily for the convenience of the child, parent or legal guardian, physician, or other health care provider
  - cost effective

- **Not covered benefits of fee-for-service PT/OT/ST for any member, regardless of age:**
  - Education
  - Personal need
  - Comfort therapy
  - Experimental
  - Investigational

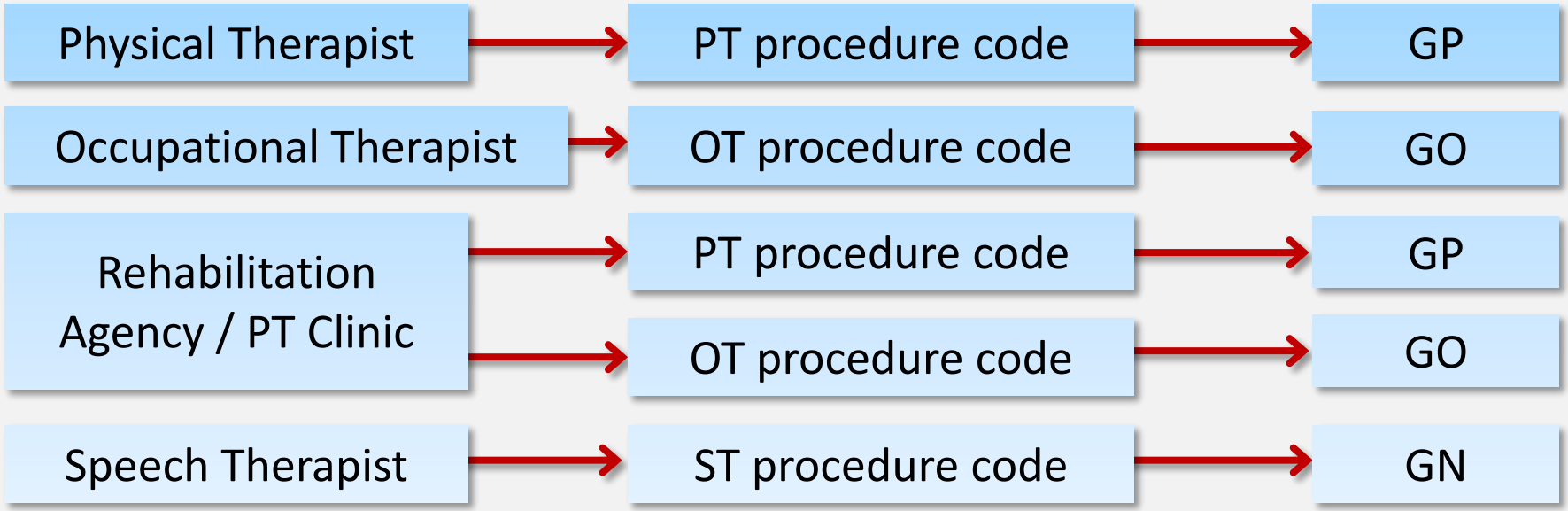
- **Fee-for-service PT/OT/ST requires:**
  - A medical (physiological) reason to perform services

Units of Service

- PTs & OTs have a combined daily limit of 5 units, which is separate from ST daily limit of 5 units
  - Member may receive 5 units of PT/OT & 5 units of ST on same Date of Service (DOS) as long as they are not duplicative services
- Consult Current Procedural Terminology (CPT) Manual for definitions for each coded service
  - Some codes represent a treatment session without regard to its length of time (1 unit maximum)
  - Some codes may be billed incrementally as “timed” units

Procedure Modifiers

Providers must use the appropriate modifier:



Note:

- May use additional modifiers as appropriate
- All Habilitative claims must have modifier HB in addition to the modifiers above
- Early Intervention providers: in addition to modifiers GO, GO, and GN, modifier TL must be attached to all claims for Early Intervention PT/OT/ST

Speech-language Therapy

- Services must be provided by or under supervision of certified speech pathologist or audiologist
- Services must be medically necessary
- Habilitative ST services require PAR
- Rehabilitative ST services do not require PAR
  - With exception of members determined to need a speech generating device (E2500-2512, E2351, E2599)
    - should be referred to a Medicaid-participating medical supplier for a PAR

Speech-language Therapy Providers

- Qualified Speech-language Pathologist or Audiologists
  - Must meet qualifications prescribed by federal regulations for participation at 42 CFR 484.4
  - Must meet all requirements under state law
  - Must be an approved Medical Assistance Program provider
  - As of July 1, 2013, all Speech-language Pathologists must be Department of Regulatory Agencies (DORA) certified

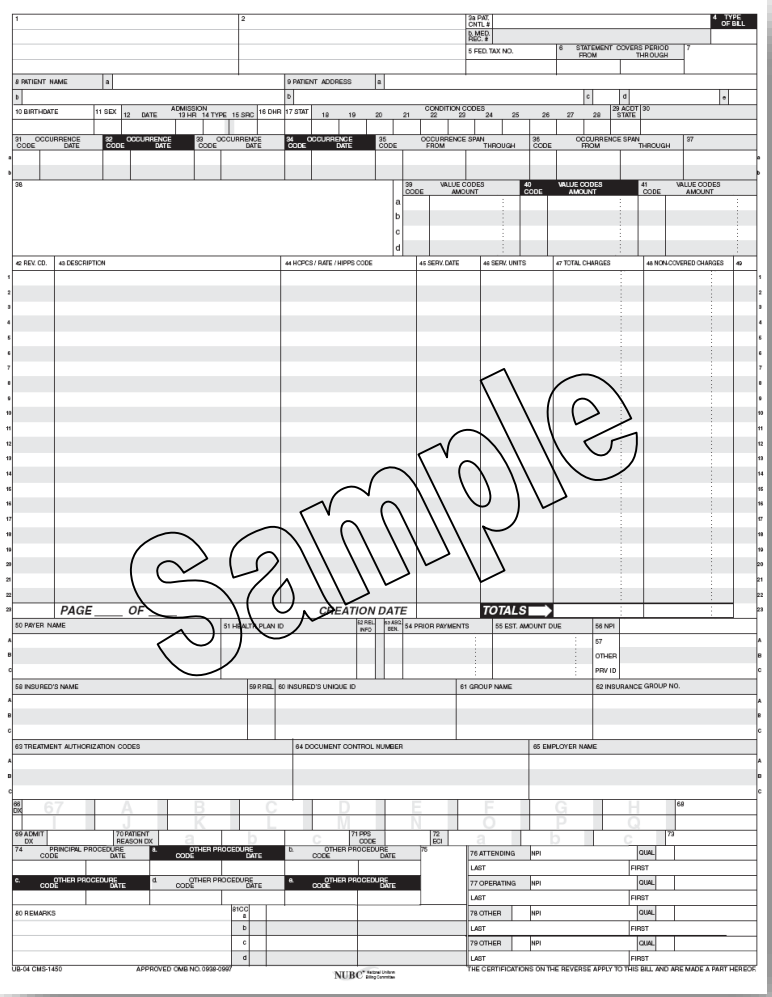
Speech Therapy Limitations

- Non-benefit procedures for adults:
  - Diagnostic procedures provided by an audiologist for purpose of determining general hearing levels
  - Diagnostic procedures for distribution of hearing device
  - Services provided for simple articulation or academic difficulties that are not medical in origin are non-benefit services

Speech Therapy Limitations (Continued)

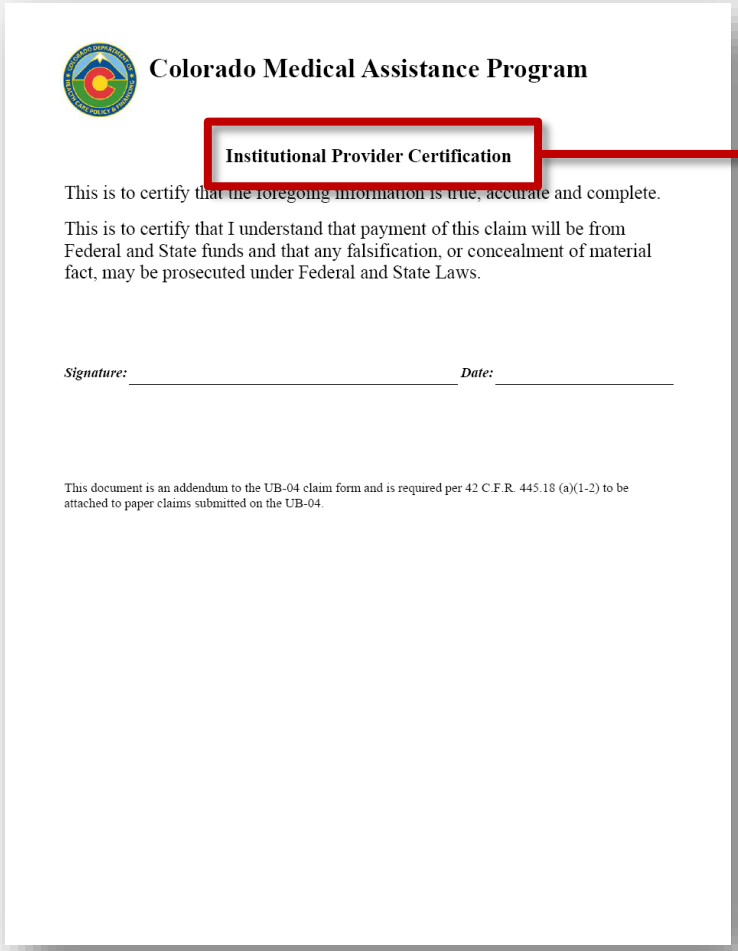
- Maximum of 5 units service is allowed per date of service
- Services must be medically necessary
- Services must be prescribed/Approved by an M.D. or D.O.
- For more information on audiology services:
  - refer to the Audiology Billing Manual:
    - www.Colorado.gov/hcpf/ProviderServices
  - New website
    - www.Colorado.gov/hcpf/billing-manuals

UB-04



- **<u>PT and OT outpatient hospital</u>** paper claims must be submitted on UB-04 claim form or as an 837I transaction
- 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

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

Claim processed & paid by claims processing system

Claims Process - Common Terms

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

Adjustment

Re-bill previously denied claim

Rebill

Claim must be manually reviewed before adjudication

Suspend

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

Void

Adjusting Claims

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

Adjust a claim when:

- Provider billed incorrect services or charges
- Claim paid incorrectly

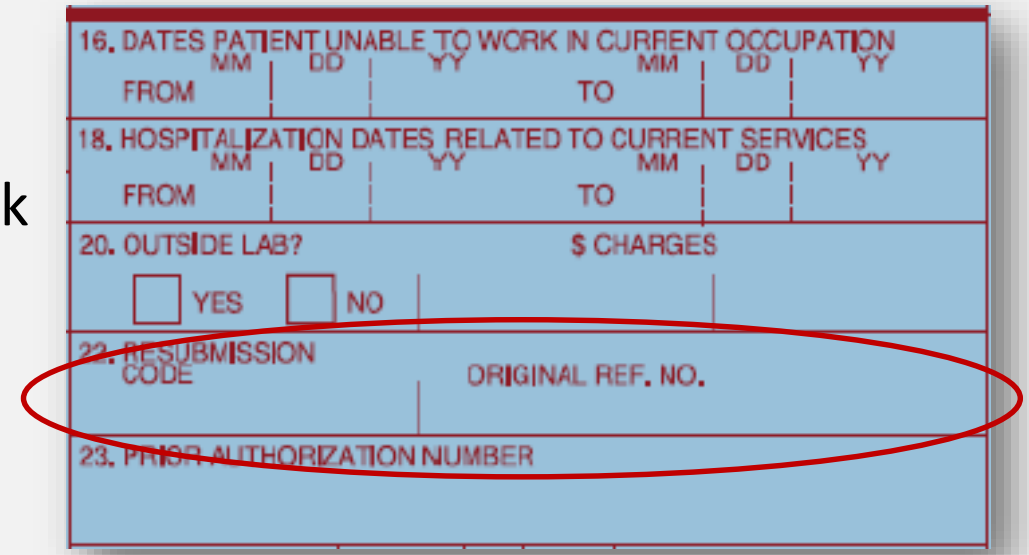
Do not adjust when:

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

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track



Paper

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

Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal

Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

Provider Claim Reports (PCRs)

Paid

****
* CLAIMS PAID *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	DATES OF SVC TO	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
7015	CLIENT, IMA	Z000000	04080000000000001	040508	040508	132.00	69.46	2.00	0.00	69.46
PROC CODE - MODIFIER 99214 -				040508	040508	132.00	69.46	2.00		

TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46

Denied

* CLAIMS DENIED *
****

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SERVICE FROM	DATES OF SERVICE TO	TOTAL DENIED	DENIAL REASONS ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	30800000000000003	03/05/08	03/06/08	245.04	1348

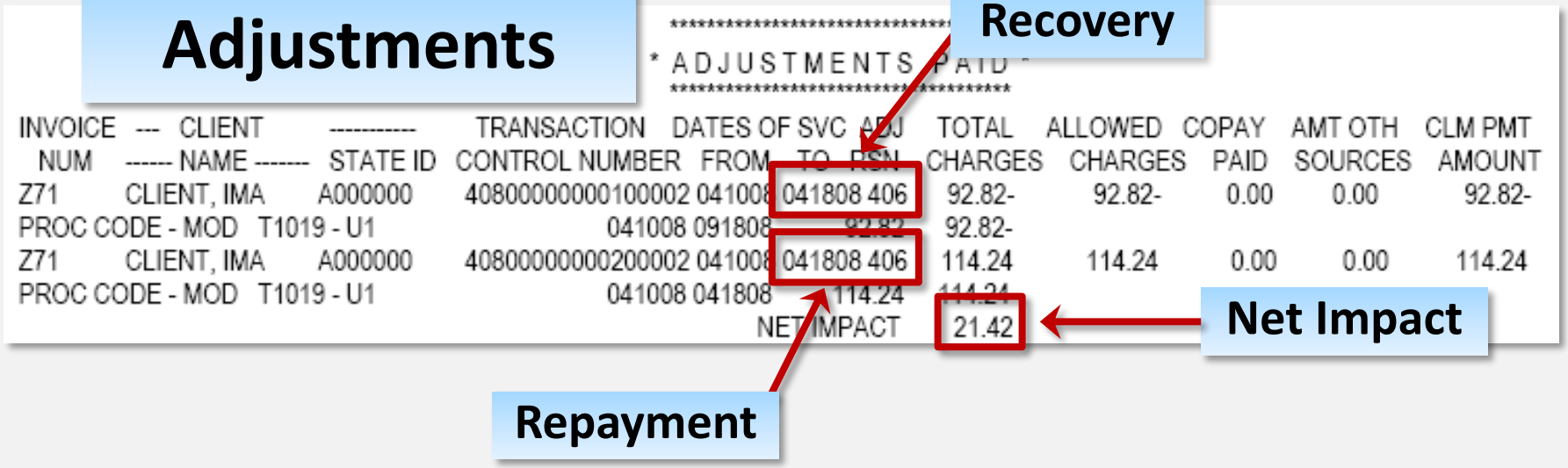
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'. COUNT 0001

Provider Claim Reports (PCRs)

Adjustments



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

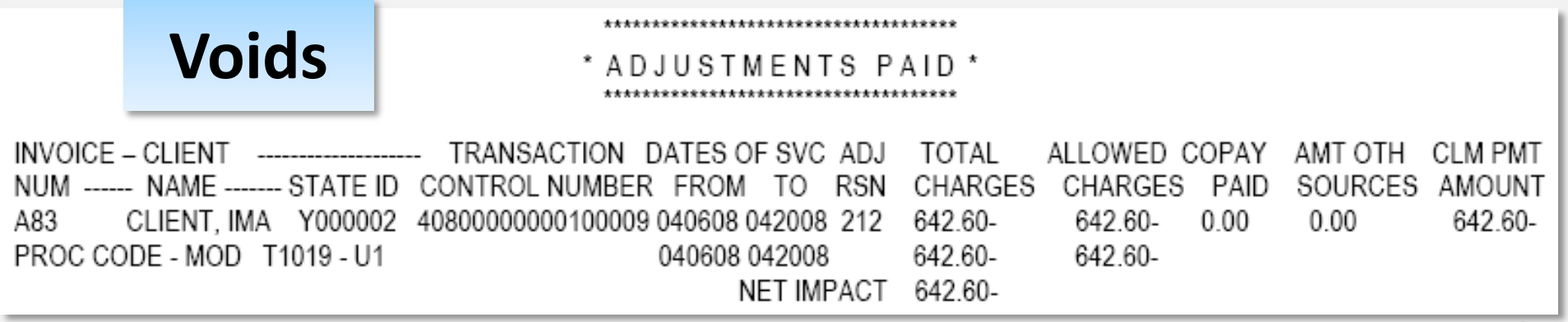
INVOICE NUM	CLIENT ------ NAME -------	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808	406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1				041008	091808		92.82-				
Z71	CLIENT, IMA	A000000	40800000000200002	041008	041808	406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1				041008	041808		114.24	114.24			
						NET IMPACT	21.42				

Recovery

Net Impact

Repayment

Voids



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

INVOICE NUM	CLIENT ------ NAME -------	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00	642.60-
PROC CODE - MOD T1019 - U1				040608	042008		642.60-	642.60-			
						NET IMPACT	642.60-				

Provider Services

Xerox
1-800-237-0757

- Claims/Billing/ Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank You!