Beginning Billing Workshop Practitioner

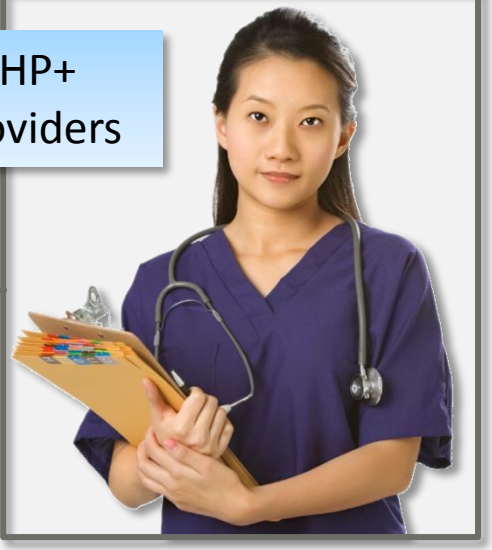
Colorado Medicaid
2014

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

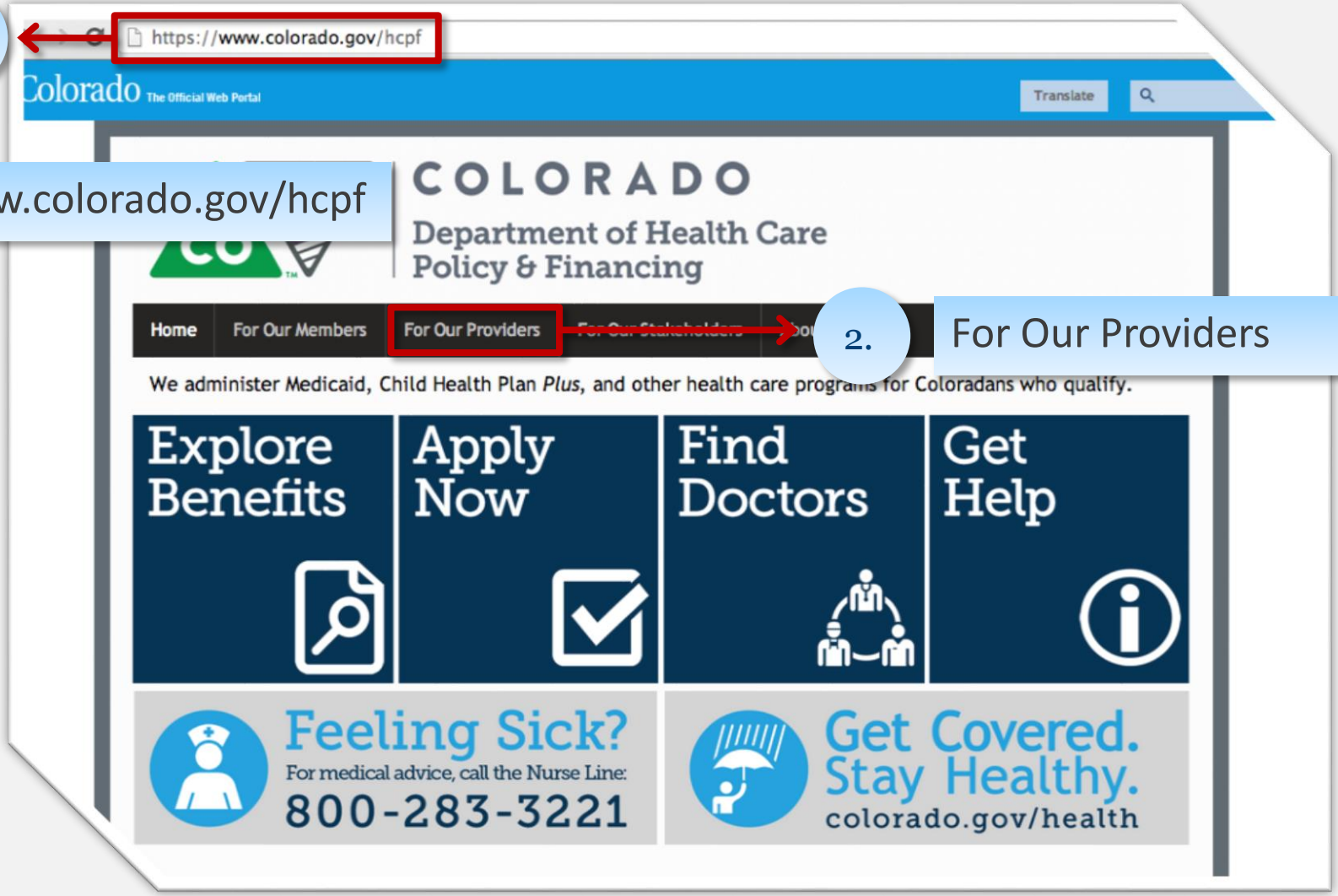
What is an NPI?

- 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

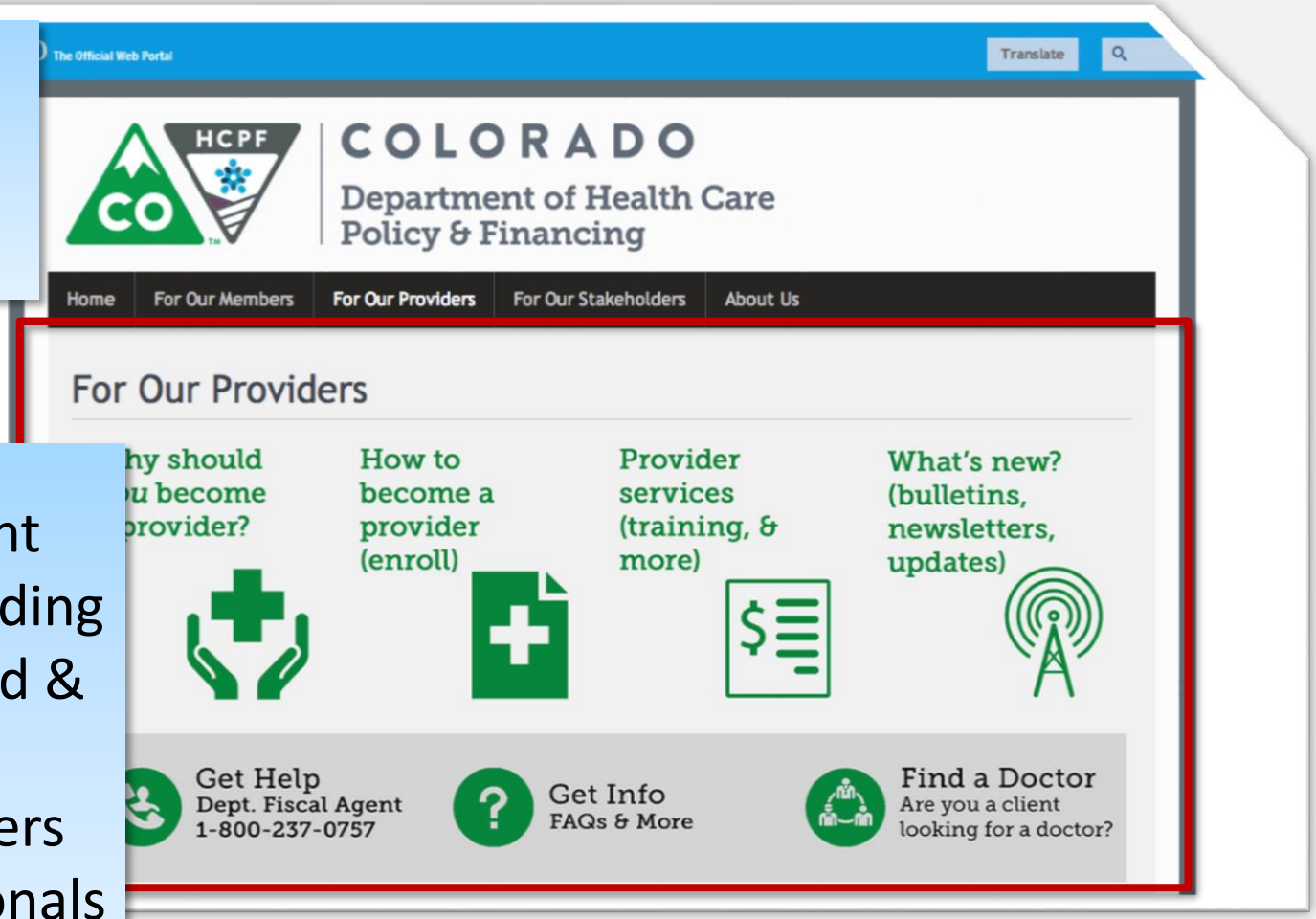


2. For Our Providers

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

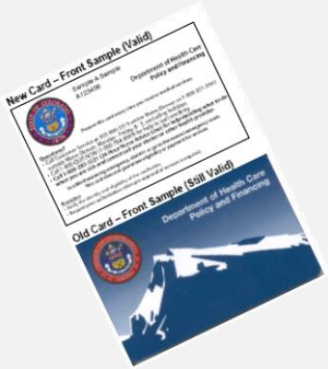
Verifying Eligibility

- 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)

Print

Return To Eligibility Inquiry

Eligibility Request

Provider ID:

From DOS:

Client Detail

State ID:

Last Name:

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.

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

As a reminder, information received is based on what is available through the Colorado Benefits Management System (CBMS). Updates may take up to 72 hours.

Medicaid Identification Cards

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

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

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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

	$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

Practitioner

- **$2.00 per date of service**

Billing Overview

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

Record Retention

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

Record Retention

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

Submitting Claims

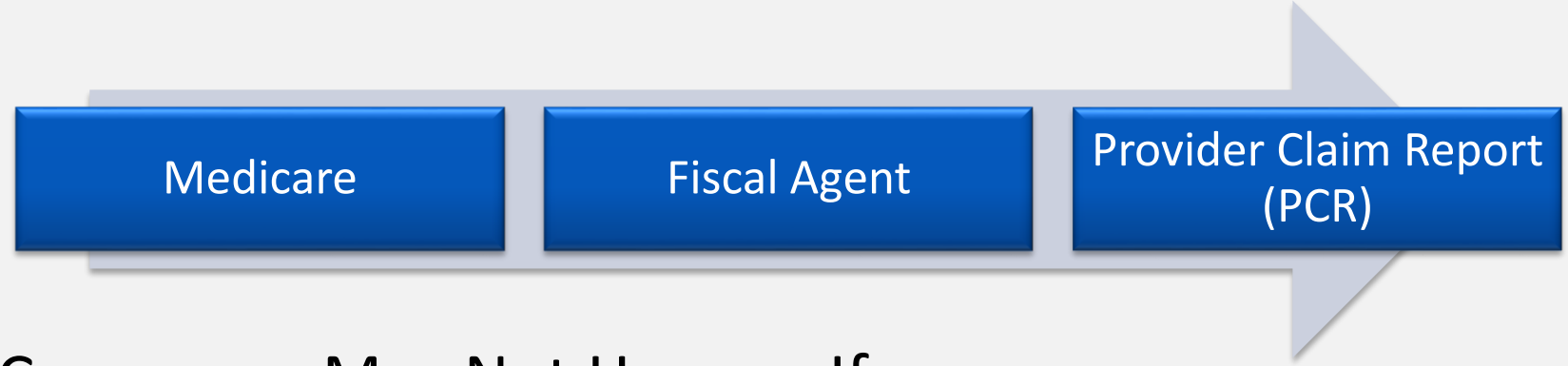
- Methods to submit:
  - Electronically through **Web Portal**
  - Electronically using **Batch Vendor**, **Clearinghouse**, or **Billing Agent**
  - **Paper** only when
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

ICD-10 Implementation Delay

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

Crossover Claims

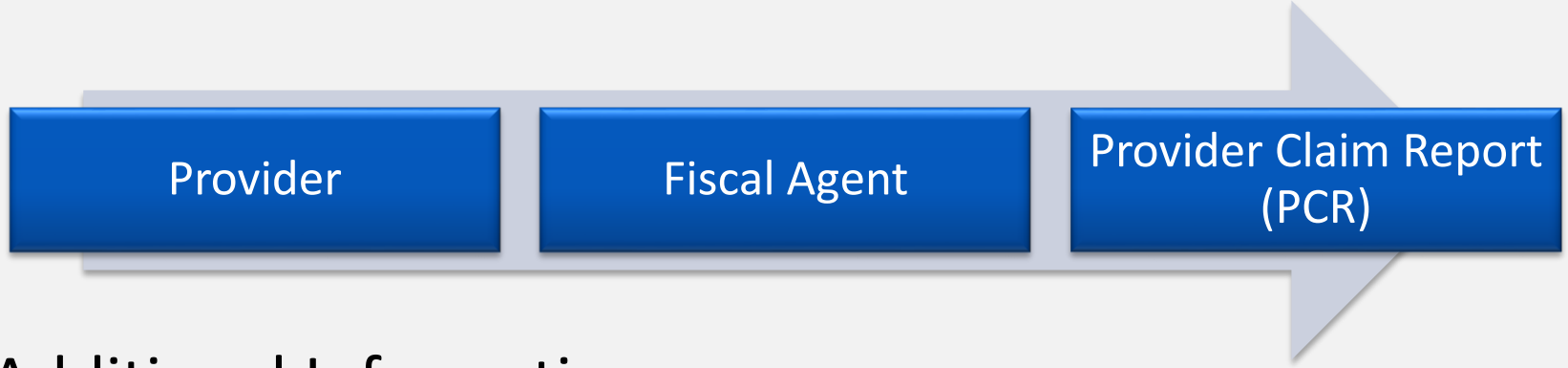
- Automatic Medicare Crossover Process:



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

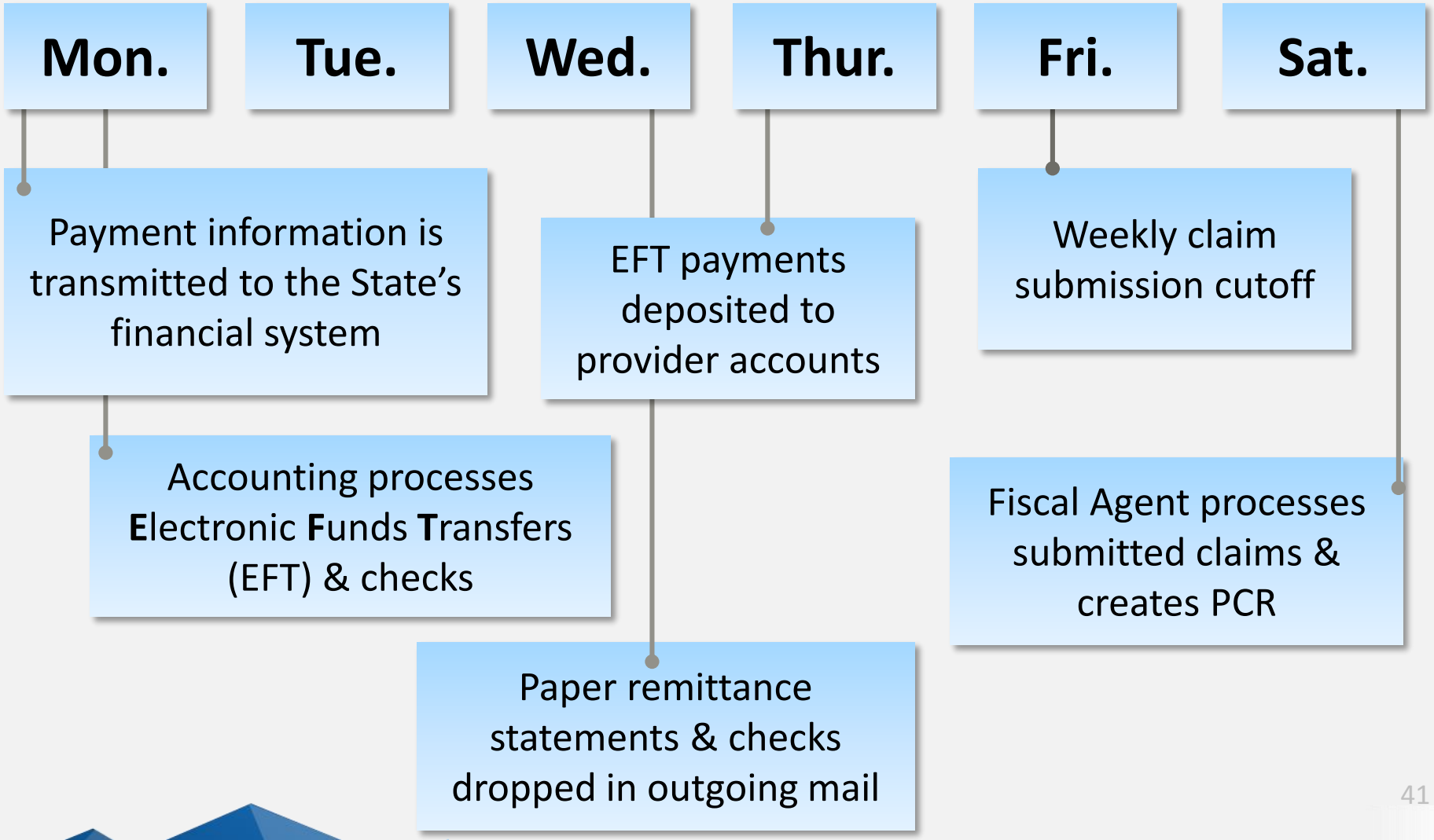
Crossover Claims

- Provider Submitted Crossover Process:



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

Payment Processing Schedule



Electronic Funds Transfer (EFT)

- Several Advantages:
  - Free!
  - No postal service delays
  - Automatic deposits every Friday
  - Safest, fastest & easiest way to receive payments
  - Located in Provider Services Forms section on Department website

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

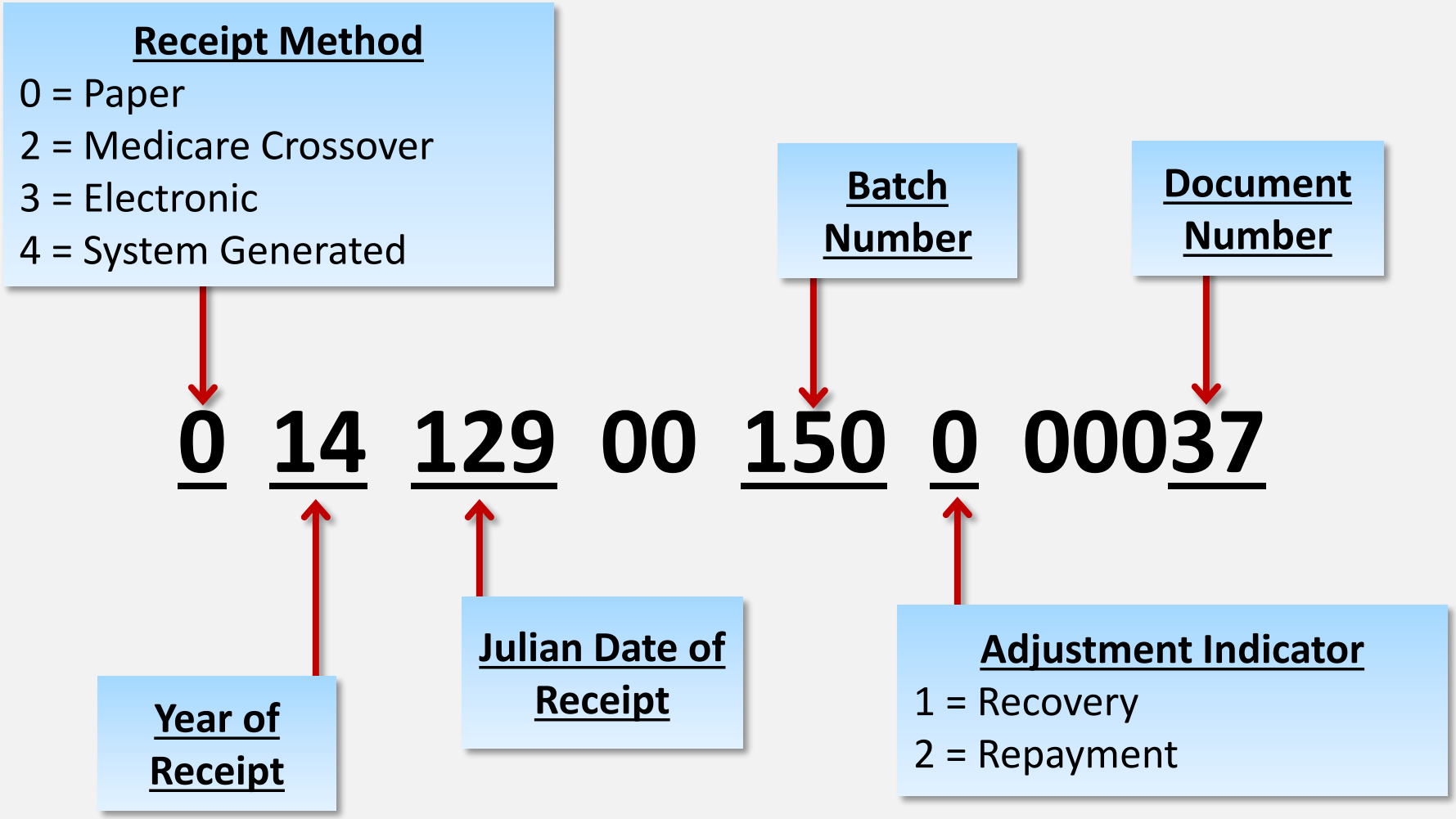
Electronic PAR Information

- 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

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

EPSDT Program

- **E**arly and **P**eriodic **S**creening, **D**iagnostic, and **T**reatment (EPSDT) Program
  - Federally mandated health care benefits package for essentially all Colorado Medical Assistance Program children
    - Ages birth through 20 years
  - Emphasizes preventive care
    - Focuses on early identification and treatment of medical, dental, vision, hearing, and developmental concerns

EPSDT Program

- EPSDT establishes a regular pattern of healthcare through routine health screenings, diagnostic, treatment services
  - See Colorado Periodicity Schedule for recommended well child visits
  - EPSDT well child screenings must include testing for lead poisoning
    - at 12 and 24 months or between 36 and 72 months if not previously tested
    - This is still a CMS requirement for all Medicaid eligible children until Colorado can provide enough data to show it is not a concern in this region

EPSDT - D = Diagnostic

- When a screening indicates the need for further evaluation, diagnostic services must be provided
  - The referral should be made without delay
  - Provide follow-up to make sure that the child receives a complete diagnostic evaluation

EPSDT - T = Treatment

- Health care must be made available:
  - Treatment or other measures to correct/improve illnesses or conditions discovered by the screening
- All services must be provided:
  - If Medicaid coverable
  - If medically necessary
  - Even if the service is not available under the State plan to other Medicaid eligibles

EPSDT - Medical Necessity

- No arbitrary limitations on services allowed
  - e.g., one pair of eyeglasses or 10 PT visits per year
- Additional services above what is covered in State plan must be allowed:
  - when medically necessary
    - still must be Medicaid coverable
- State may determine which treatment it will cover:
  - among equally effective & actually available alternative treatments
  - as long as the determination is specific to the individual child

EPSDT - Medical Necessity

- EPSDT does NOT include:
  - Experimental/Investigational Treatments
  - Services or items not generally accepted as effective
  - Services solely for caregiver or provider convenience
  - Services or items in which an equally effective but less expensive option is available

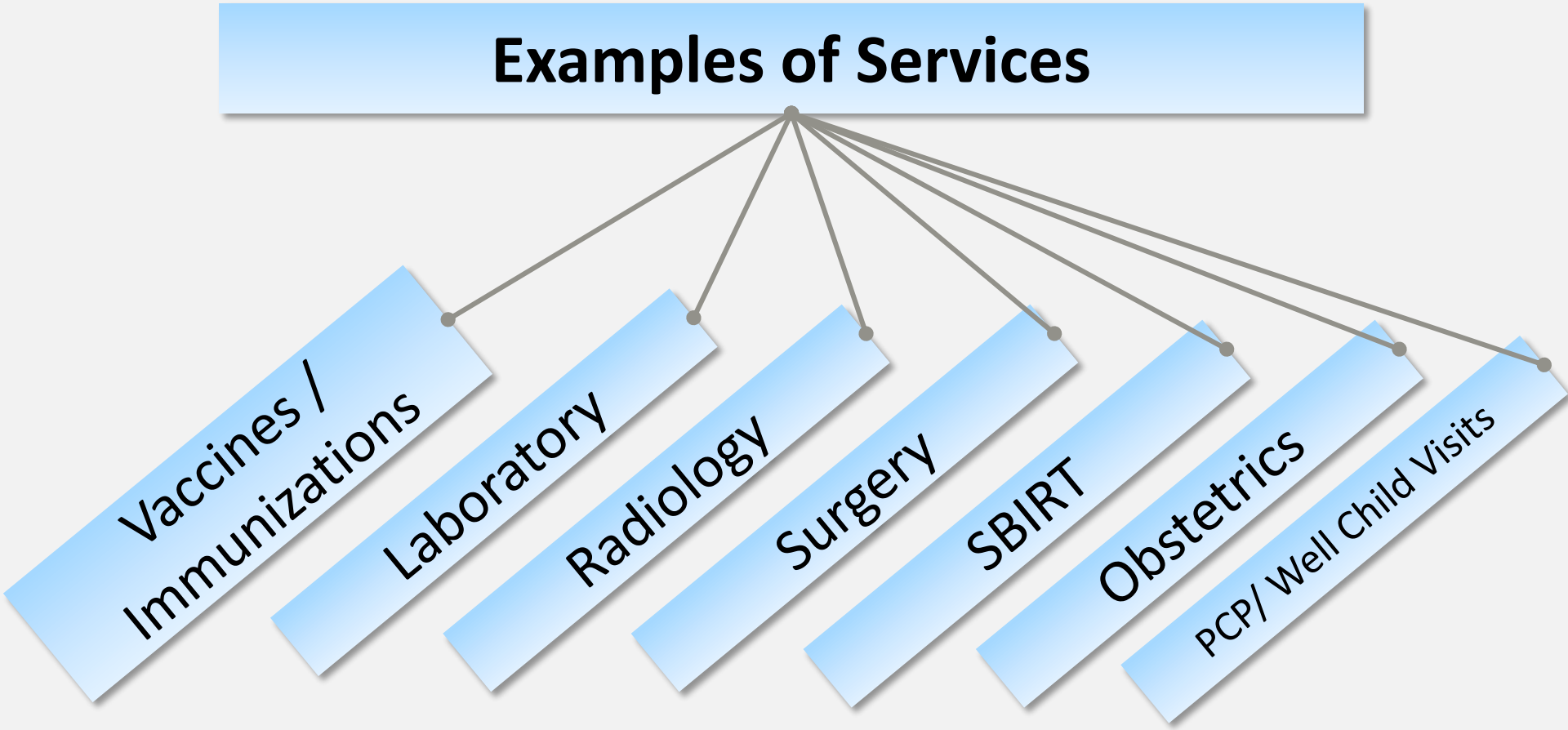
Request Services or Items

- Use PAR process outlined earlier in this presentation
- You can requests services or items where the code list shows it is not a benefit of Colorado Medicaid
- Must include a letter of medical necessity with request
- All requests for services or items will be reviewed by the ColoradoPAR Program for medical necessity

ABCD Program

- Assuring Better Child Health and Development through the Use of Improved Screening Tools Project
  - ABCD helps Primary Care Providers improve identification of developmental delays through standardized testing
    - Assists in implementing efficient & practical office screenings
    - Helps practices learn about reimbursement for development screenings
    - Promotes early identification and referral
    - Facilitates links to other community services
    - More information at www.coloradoabcd.org

Colorado Medicaid



Surgery

- Surgical reimbursement includes
  - Payment for the operation
  - Local infiltration
  - Digital block or topical anesthesia
  - Normal, uncomplicated follow-up care
- If surgery has 30 post operation days and you bill an office visit within those 30 days, it will deny
  - Office visit is included in your surgical reimbursement

Modifiers on Multiple Procedures

- **Modifier 59** – Distinct Procedural Service
  - Used to identify procedures/services:
    - that are not normally reported together
    - but are appropriate under the circumstances
  - Modifier 59 should be used only if:
    - a more descriptive modifier is un-available
    - the use of modifier 59 best explains the circumstances
      - Clinical documentation **MUST** justify usage
  - Please see the Department's NCCI web page regarding Modifier 59 for more information
    - Colorado.gov/hcpf → Provider Information → NCCI
    - New Website- Colorado.gov/hcpf/ncci

Vaccines / Immunizations

Immunizations for children:

- A benefit when recommended by Advisory Committee on Immunization Practices (ACIP)
  - ➤ for children ages 20 and under
- Available from federal Vaccines for Children Program (VFC) for children ages 19 and under

Immunizations for adults:

- A benefit when recommended by ACIP (subject to Colorado Medical Assistance Program rules)
  - ➤ or when needed to enter school/work force for adults 21+
- Providers can receive Administration, Record keeping, and Tracking (ART) fee

For more information:
Colorado.gov/hcpf/billing-manuals

Billing Procedures for Immunizations

- To be reimbursed for an immunization claim:
  - Bill BOTH administration code & vaccine product

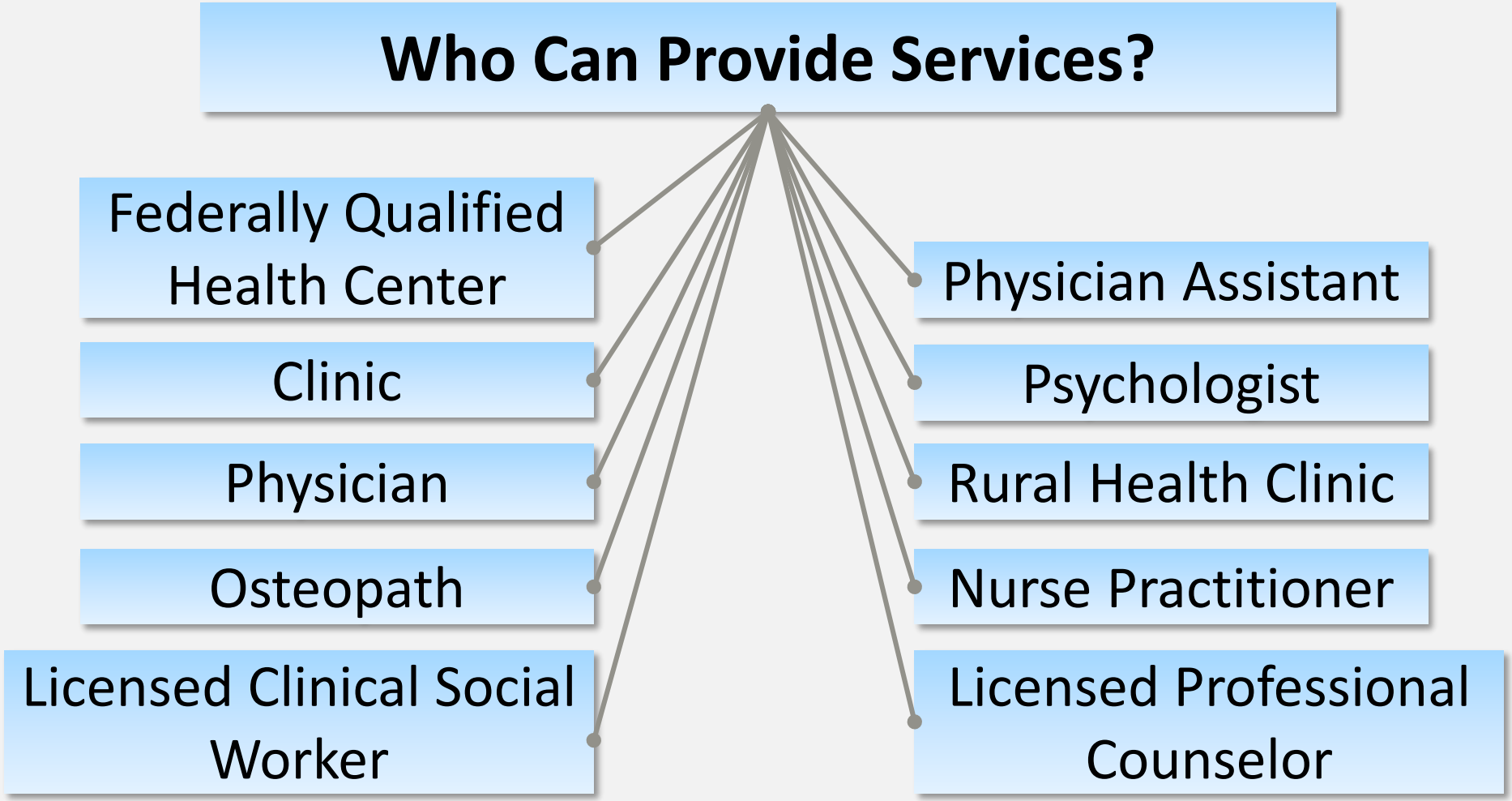
Vaccine Products

- Bill vaccine product as separate line item
- Vaccines are reimbursed at set rate
- Vaccines obtained through Vaccines for Children (VFC) are reimbursed at $0
  - as they are available at no cost to provider

Administration Code

- Bill administration codes as one line item

Telemedicine



Telemedicine Billing

- Bill all Telemedicine services electronically as a 837P or on the CMS 1500 claim form
- Providers may only bill procedure codes for which they are eligible to bill
- PAR requirements remain the same
- Bill Managed Care when appropriate
- For further information
  - Telemedicine Billing Manual
  - Volume 8, section 8.200.4

Laboratory

- Provider who actually performs the laboratory test is the only one eligible to bill & receive payment
  - Providers may only bill for tests actually performed in their office or clinic
  - Testing performed by independent laboratories or hospital outpatient laboratories must be billed by the laboratory
  - In order to receive Medical Assistance Program payment, All laboratory service providers must be:
    - Clinical Laboratory Improvement Act (CLIA) certified
    - Medical Assistance Program enrolled

Radiology

Professional vs. Technical components

- **Professional** Component is the analysis and reading of the x-ray
  - Use 26 modifier to show Professional Component

- **Technical** Component is the actual taking of the x-ray
  - This is the facility usage for the x-ray
  - Use TC modifier to show Technical Component

Only report both when:

- Different providers perform professional and technical components of procedure

Radiology

Billing bilateral services

- For **bilateral** code
  - Use 1 unit with correct procedure code

- For **non bilateral** codes
  - 1st line – Use just HCPCS code with 1 unit
  - 2nd line – Use 1 unit, HCPCS code, and modifier 50

Radiology

- PAR Requirements
  - Outpatient hospitals need to obtain a prior authorization for:
    - Non-emergent CT
    - Non-emergent MRI
    - All PET and SPECT scans
      - If the emergency indicator box is checked on the claims, CT and MRI tests are exempt from prior authorization
  - PAR Revisions due to the test changing just prior to the time of the service need to be submitted within 48 hours
  - For a list of all the procedure codes requiring PARs, visit the Radiology Manual:
    - Colorado.gov/hcpf/Provider Services → Billing Manuals → Radiology
    - New Website- Colorado.gov/hcpf/billing-manuals

SBIRT

- Screening, Brief Intervention and Referral to Treatment
  - Technique used to identify and treat drug/alcohol abuse for members ages 12 +
  - All primary care providers can render services and bill for SBIRT
  - Requirements for SBIRT are limited only to completing training
  - Training can be done through free or paid online services
  - See Billing Manual for more information
    - Colorado.gov/hcpf/Provider Services → Billing Manuals
    - New Website- Colorado.gov/hcpf/billing-manuals

Obstetrical Care

- Pregnant women under age 21 are also eligible for EPSDT services, including dental, vision care, and health checkups
- Woman in maternity cycle are exempt from co-payment
  - Provider must mark co-payment indicator on the electronic format or on the paper claim form
- Undocumented women are eligible for emergency services only
  - Labor and delivery are considered emergency services

Procedure Coding: Obstetrics

Global Care

- Providers should bill medical care provided during pregnancy, labor and delivery, and postpartum period using the global OB codes
- Use delivery date as date of service

Non-Global Care

- Unusual Services
- Services/Conditions unrelated to pregnancy or delivery
- Complications of pregnancy
- Certain adjunctive services

Separate Procedures

These services should be billed in addition to global obstetrical care charges:

- Prenatal testing
- Testing, including ultrasound
- Clinical laboratory testing
- Adjunctive services
- Initial antepartum visit
- Conditions requiring additional treatment
- Case management
- Medical or surgical complications

Separate Procedures (cont.)

These services should be billed in addition to global obstetrical care charges:

Anesthesia	Epidural anesthesia	Assistant surgeon at cesarean delivery	Family planning
Surgical sterilization	Newborn care in the hospital	Examination & evaluation of healthy newborn	Newborn resuscitation or care of high-risk newborn
	Conditions unrelated to pregnancy		

Common Billing Issues

- Most common denial for OB care
  - Edit 1026 – OB Service Billed Incorrectly
- When does this edit deny claims?
  - Billing for antepartum + global care
  - Billing for postpartum care + global care
- There are many codes for billing OB services
  - Choose appropriate procedure code and modifier for your service
- Remember: you cannot bill for both global care and antepartum and/or postpartum care

Modifiers: Multiple Infants

- Modifier 22 - Use appropriate Vaginal or Cesarean delivery procedure code and bill one unit of service
  - Additional infants may be billed using modifier 22 for codes 59409 and 59514
  - Indicate number of additional infants in unit field on claim
- Use appropriate ICD-9-CM diagnosis code to indicate multiple infants
  - Date of service must be delivery date

Modifiers: Multiple Infants

- Modifier UK – When billing newborn care under mother's State ID number use
  - Mother's name
  - Mother's date of birth
  - UK modifier with each procedure code to identify that services were provided while mother and baby were hospitalized

Modifiers: Newborn Services

Use Modifier UK when:

- **Both** mother and newborn must be in the hospital to bill this charge

Don't use Modifier UK when:

- If mother has been discharged or infant is transferred to a different hospital
  - Charges must be submitted under newborn's State ID
  - You can no longer use the mother's State ID and modifier UK

Obtaining an Infant's Medicaid ID

- In order for county to enroll newborn, notify county Department of Human/Social Services of all the following:
  - infant's full legal name
  - birth date
  - gender
  - mother's State ID
- Anyone can report the birth of a newborn
  - This can be done online at the Department's Add-a-Baby web page
- Local Healthy Communities Outreach Coordinators can also assist with this process

Ultrasound Restrictions

- Limited to 3 per low-risk or uncomplicated pregnancy
- Billed as separate CPT codes

Sterilizations

- Claims must be filed on paper
- MED-178 Sterilization Consent Form (MED-178) must be attached to each claim
- member must
  - Be at least 21 years of age
  - Be mentally competent
  - Give informed consent
- At least 30 days, but not more than 180 days, must pass between date MED-178 was signed by member and the date of the sterilization procedure (except in specific circumstances of preterm delivery or emergency abdominal surgery)

Sterilization Form

Colorado Medical Assistance Program Sterilization Consent Form
MED 178

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or the Medical Assistance Program that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ Month Day Year.

I, _____, hereby consent of my own free will to be sterilized by _____ (Doctor), by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining of Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature — Month Day Year

Client's Medical Assistance Program ID #:_____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

☐ American Indian or Alaska Native
☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin)
☐ Hispanic
☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter Signature

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (Name of Individual) signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent — *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name of individual to be sterilized) on _____ (Date of sterilization operation), I explained to him/her the nature of the sterilization operation _____ (Specify Type of Operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. **Cross out the paragraph, which is not used.**)

(1) At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (**check applicable box and fill in information requested**):

☐ Premature delivery:
☐ Individual's expected date of delivery: _____
☐ Emergency abdominal surgery: _____
(Describe circumstances) _____

_____ _____
Physician's Signature — *Date*

REV. 10/2004

Common Sterilization Errors

- Common Errors
  - Missing member's signature
  - Type of operation entered in Consent differs from that in Physician's Statement
  - Incomplete facility address
    - Must include zip code
  - Operation performed less than 30 days or more than 180 days from signature date

Universal Procedure and Diagnosis Coding

- HIPAA requires providers to use universal Current Procedural Terminology (CPT) coding guidelines
  - Medicaid payment policies are based on CPT descriptions
  - Providers are required to consult CPT manual definitions for each code they submit for reimbursement
- Providers must also use International Classification of Diseases, 9th Revision, Clinical Modification diagnosis codes (ICD-9)

CPT Coding Guidelines

- Some codes represent a treatment session, regardless of length of time, so each code is correctly billed as one session or one (1) billable unit
  - Do not bill non-timed codes with greater than one (1) unit
  - Bill non-timed codes such as 92507, and 92508 (otorhinolaryngology services) with one (1) unit per date of service
- Other codes may be billed as number of "timed" units
  - For example, 92607 and 92608 (evaluation and therapeutic services)
- Note: Do not bill 92607 without 92608 if the time is beyond one (1) hour

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

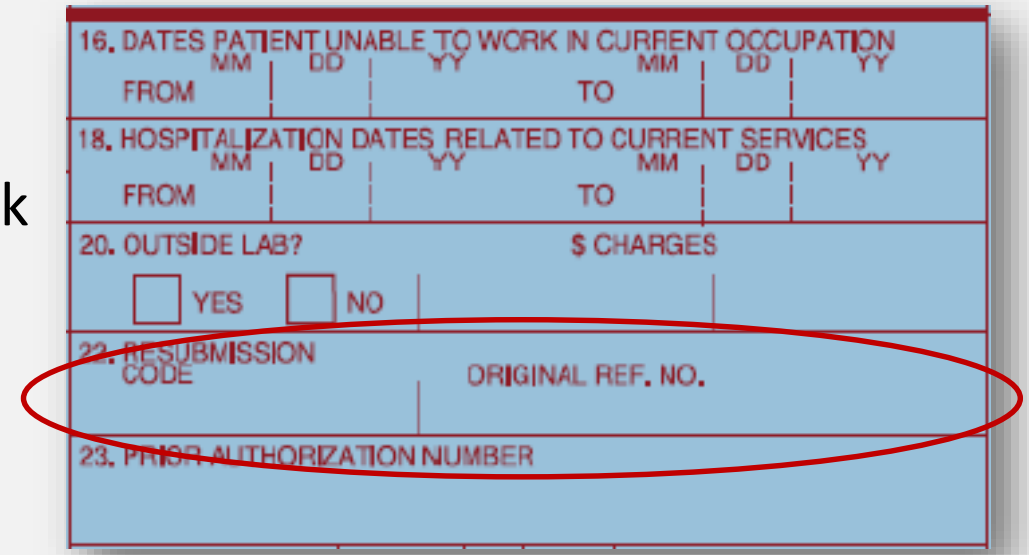
Do not adjust when:

- 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

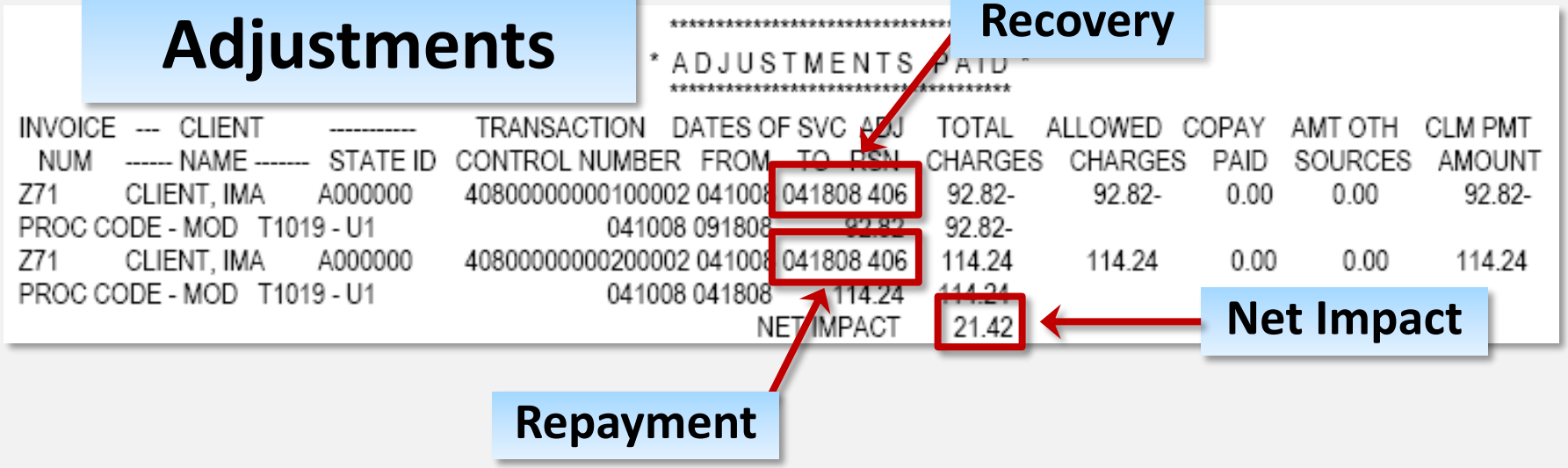
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

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	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!