Beginning Billing Workshop Transportation

Colorado Medicaid
2016

COLORADO
Department of Health Care Policy & Financing

Centers for Medicare & Medicaid Services

Xerox State Healthcare

COLORADO
Department of Health Care Policy & Financing

Medicaid/CHP+
Medical Providers

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? (cont.)

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

Department Website

1

www.colorado.gov/hcpf

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:

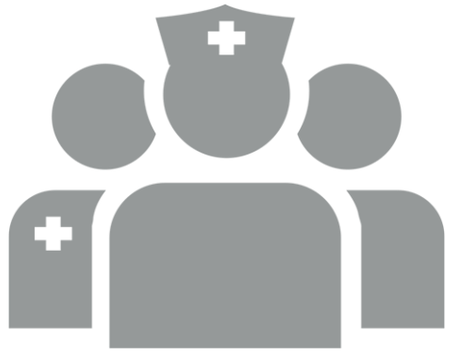
Everyone who provides services for Medical Assistance Program members

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

Rendering Versus Billing

Rendering Provider

Individual that provides services to a Medicaid member



Billing Provider

Entity being reimbursed for service

From the Noun Project:
"Medical-Team" icon created by Pieter J. Smits
"Hospital" icon created by Carlotta Zampini

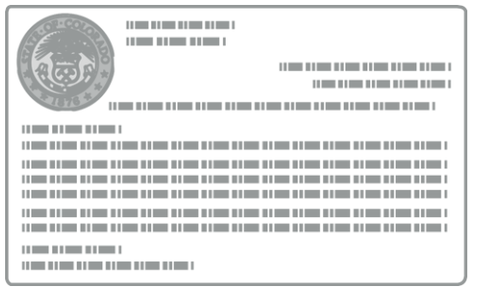
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Colorado Medical Assistance Web Portal

Fax Back 1-800-493-0920

CMERS/AVRS 1-800-237-0757



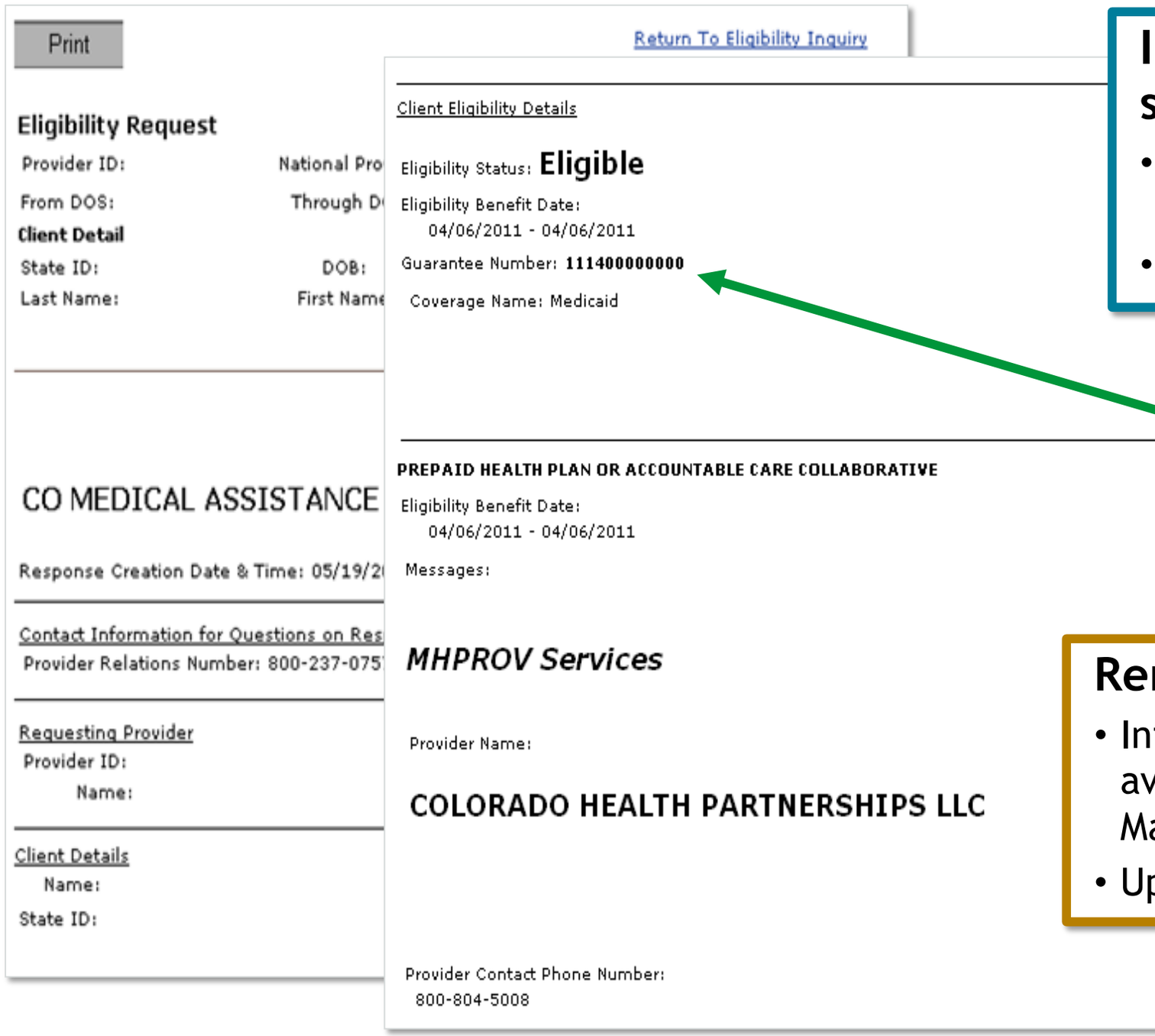
Medicaid ID Card with Switch Vendor

From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

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 scroll bar on right to view details

Successful inquiry notes a Guarantee Number:

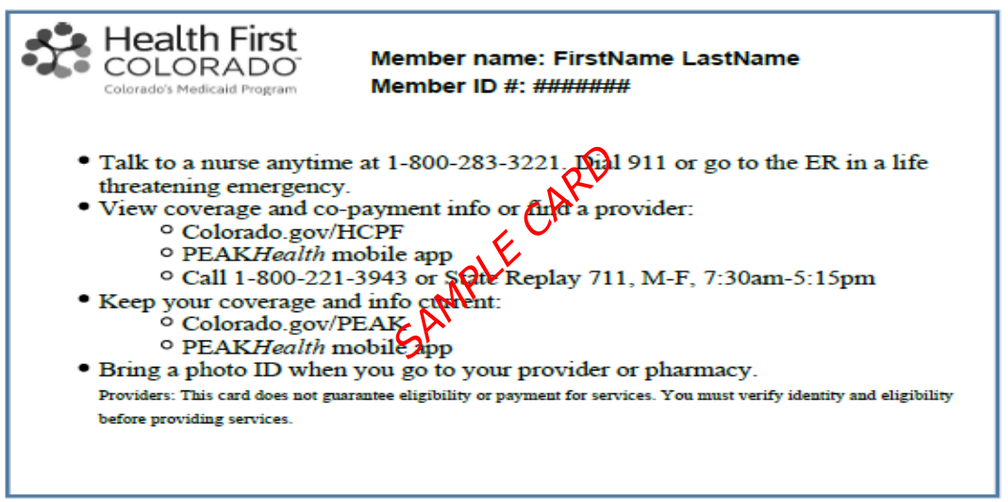
- Print copy of response for member's file when necessary

Reminder:

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

Medicaid Identification Cards

- Providers may begin seeing the newly branded cards as early as March 20, 2016



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

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 six (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

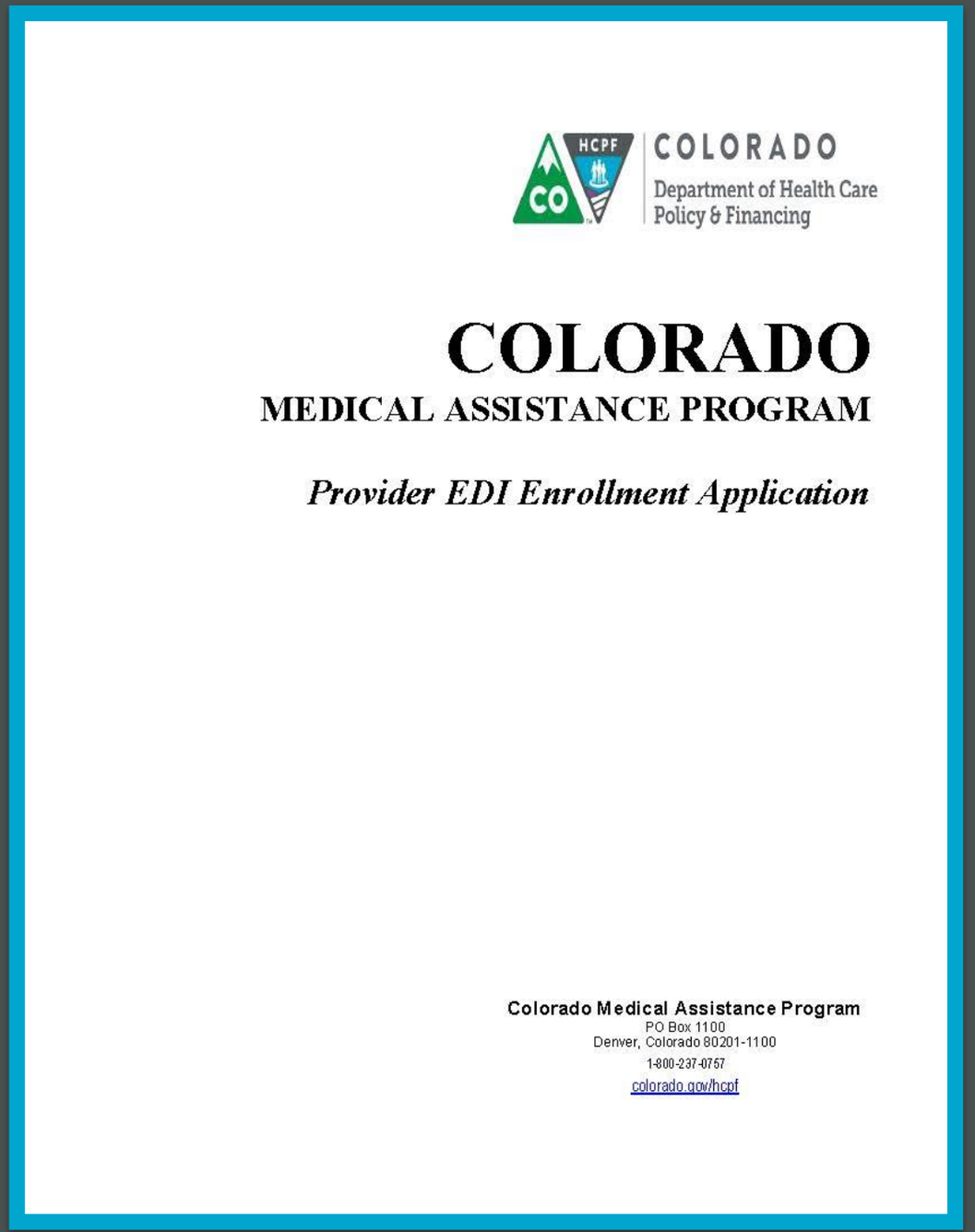
Submitting Claims

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

ICD-10 Implementation

Claims with Dates of Service (DOS) **on** or **before** 9/30/15	**Use ICD-9 codes**
Claims with Dates of Service (DOS) **on** or **after** 10/1/2015	**Use ICD-10 codes**
Claims submitted with both ICD-9 and ICD-10 codes	**Will be rejected**

Providers Not Enrolled with EDI



COLORADO
Department of Health Care Policy & Financing

COLORADO
MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

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

Providers must be enrolled with EDI to:

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

Colorado.gov/hcpf/EDI-Support

Payment Processing Schedule

Mon.

- Payment information is transmitted to the State's financial system
- Accounting processes **E**lectronic **F**unds **T**ransfers (EFT) & checks

Tue.

Wed.

- Paper remittance statements & checks dropped in outgoing mail

Thur.

- EFT payments deposited to provider accounts

Fri.

- Weekly claim submission cutoff

Sat.

- Fiscal Agent processes submitted claims & creates PCR

Electronic Funds Transfer (EFT)

Advantages

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

PARs Reviewed by ColoradoPAR

- The ColoradoPAR Program reviews PARs for the following categories or services and supplies: diagnostic imaging, durable medical equipment, inpatient out-of-state admissions, medical services (including transplant and bariatric surgery), physical and occupational therapy, pediatric long term home health, private duty nursing, Synagis®, vision, audiology, and behavioral therapy
  - Please note: for the above categories, all PARs for members age 20 and under are reviewed according to EPSDT guidelines
  - ColoradoPAR does not process PARs for dental, transportation, pharmacy, or behavioral health services covered by the Behavioral Health Organizations
  - Visit www.ColoradoPAR.com for more information

Website:	Phone:
www.ColoradoPAR.com	Phone: 888-801-9355 FAX: 866-940-4288

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via eQSuite®
- The ColoradoPAR Program will process PARs submitted by phone only if provider fills out the eQSuite® Exception Request Form and has been granted an exception from using eQSuite® when:
  - Provider is out-of-state, or the request is for an out-of-area service
  - Provider submits, on average, five or fewer PARs per month and would prefer to submit a PAR by telephone or facsimile
  - Provider is visually impaired

PAR Letters/Inquiries

- Final PAR determination letters are mailed to members and providers by the Department's fiscal agent
- Letter inquiries should be directed to the fiscal agent, not ColoradoPAR
- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the fiscal agent
  - ensure you have the right PAR type
    - e.g. Medical PAR may have been requested but processed as a Supply PAR

Transaction Control Number

Receipt Method
0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

Batch Number

Document Number

0 15 129 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 delivery date

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

From DOS | FQHC Separately Billed and additional Services

Documentation for Timely Filing

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

Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county

Timely Filing Extensions

Commercial Insurance

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

Timely Filing Extensions

Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member

Timely Filing Extensions

Backdated Eligibility

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

CMS 1500

Who completes the CMS 1500?

HCBS/Waiver providers

Vision providers

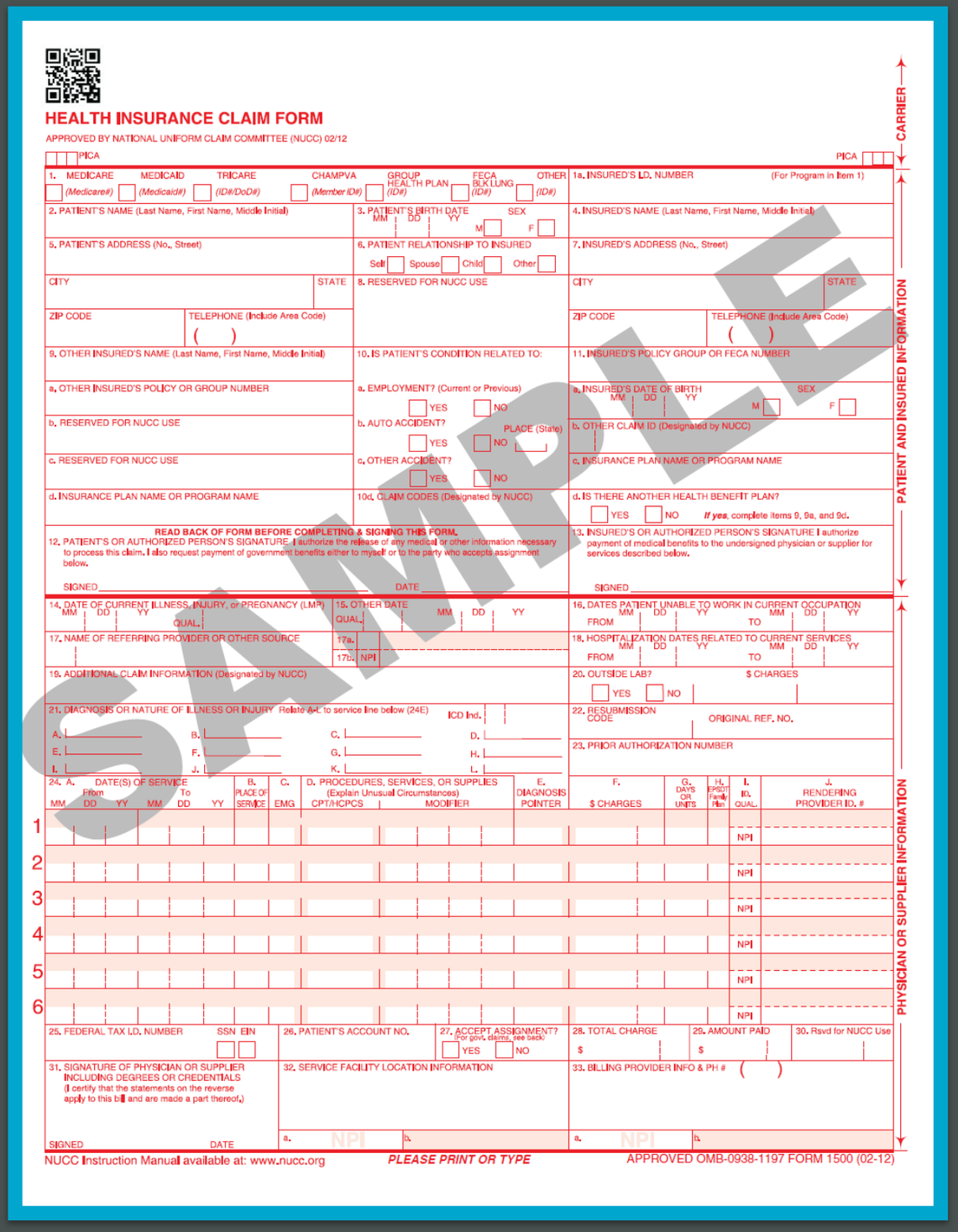
Physicians/Other Practitioners

Supply providers

Surgeons

Transportation providers

CMS 1500



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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 NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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

SAMPLE

Emergency Transportation

- Emergency services require a physician's statement of medical necessity or trip report
  - Subject to audit for six (6) years
- Emergency transportation includes:
  - Ambulance
  - Air Ambulance

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 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

Non-Emergent Medical Transportation (NEMT)

- Non-Emergent Medical Transportation
  - Defined as transportation of eligible Medicaid members to and/or from a Medicaid enrolled provider to receive a Colorado Medicaid covered service.
    - Non-Emergent care is scheduled
  - NEMT is only available when member has no other form of transportation

Non-Emergent Medical Transportation

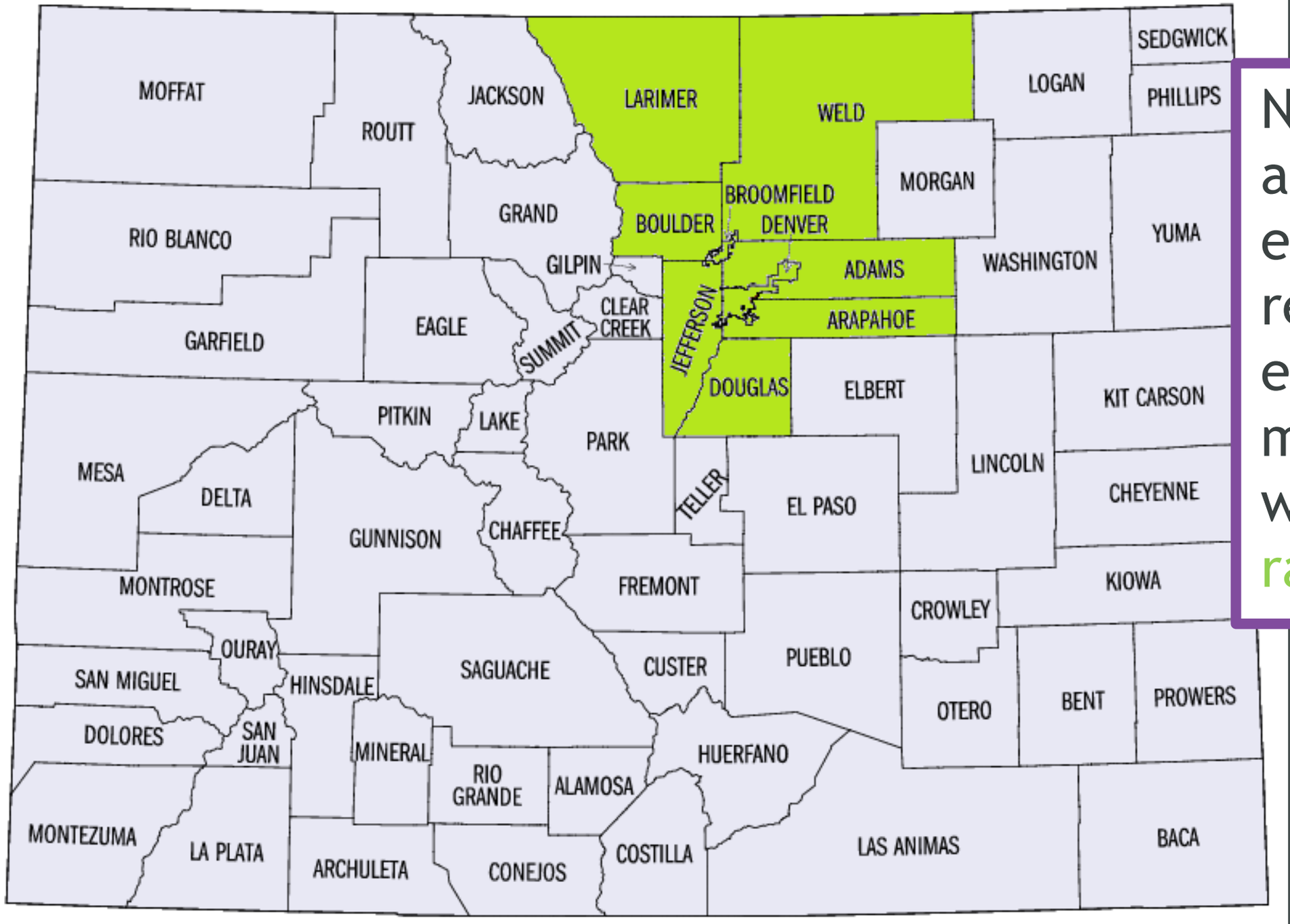
Types of NEMT

- Mobility Vehicle
- Train
- Car
- Wheelchair Van
- Personal Vehicle
- Bus
- Plane
- Taxi
- Non-Emergency Ambulance

Non-Emergent Medical Transportation (NEMT)

- The following are not benefits of NEMT:
  - Waiting time
  - Cancellations
  - Charges when member is not in vehicle
  - Transportation to/from non-covered medical services

NEMT



NEMT is administered in each member's respective county, except for members residing within the front range area

Transportation Broker

- Transportation providers serving the nine (9) front range counties can no longer directly bill the Colorado Medical Assistance Program for NEMT
- All NEMT services for the nine front-range counties must be:
  - Authorized
  - Approved
  - Arranged &
  - Paid, through Total Transit

Note:
Total Transit is the only NEMT broker contracted with Medicaid

Transportation Broker

- Total Transit manages the Non-Emergent Medical Transportation (NEMT) program for members who reside within the following nine (9) front range counties:

Adams	Arapahoe	Boulder
Broomfield	Denver	Douglas
Jefferson	Larimer	Weld

Transportation Broker

If you are a transportation provider wanting to provide NEMT services

or

Have a member in need of transportation within the nine (9) counties listed, please contact:

Total Transit

855-264-6368

Or visit their website at: www.MedicaidCO.com

NEMT

- Members in the following programs do not qualify for non-emergency transportation benefits:
  - CHP+
  - OAP-state only (Old Age Pension)
  - Qualified Medicare Beneficiary-only (QMB-only)
  - QI-1 (Qualified Individuals-1)
  - SLMB (Specified Low Income Medicare Beneficiaries)

County Responsibilities

- Outside of the Transportation Broker area, the State Designated Entity (SDE), the Department of Human/Social Services (DHS) in each county is responsible for:
  - approving services
  - arranging NEMT for Medicaid members
- Some SDEs have established Multi-County Collaboratives for NEMT.
- The SDE should ensure:
  - The member is eligible for NEMT;
  - The member is being transported to a Medicaid covered service;
  - There are no free transportation resources available; and
  - The mode selected is the least costly, and most appropriate.

County Responsibilities

- SDEs are required to inform members in writing of any requested transportation service that is being denied
- Denial letter must include:
  - Reason for denial
  - "Member Appeal Right" language & instructions
    - same language that is included on the back of all formal claim denials sent from the Department's Fiscal Agent

County Responsibilities

- Although SDEs may be notified of changes or updates to programs, appeals and rules, rates, etc., the SDE is responsible for staying informed
- For updates and changes, refer to:
  - Provider Bulletins
  - Agency Letters
  - Web Portal messages

Modes of Transportation

Mobility Vehicle

- Provided when the option:
  - Is least costly; and
  - The most appropriate mode for the member's condition
- May transport multiple parties at the same time
- Does not calculate charges based upon a meter

Modes of Transportation

Wheelchair Van

- Only a benefit when:
  - Member is a physician-certified wheelchair user
  - Vehicle has been appropriately modified
- Oxygen administration is allowed
  - When medically necessary
- Unlike mobility vehicles, wheelchair van service is not regulated by Public Utilities Commission (PUC)
- May use wheelchair van billing codes only when:
  - Member is a physician-certified wheelchair user
  - Vehicle has appropriate wheelchair equipment

Modes of Transportation

Bus or Train

- Benefits are provided when:
  - Member is traveling a great distance; and
  - It is the least costly means of transportation
- Appropriate for in-state and out-of-state travel
- No PAR required for transportation; however, all train, air, and out-of-state transportation must be prior authorized by the state authorizing agent at the request of the transportation broker or the SDE.

Modes of Transportation

Air

- Services are provided when:
  - It is the least costly means of transportation;
  - Point of pickup is **inaccessible** by land vehicle;
  - Point of pickup is **accessible** by a land vehicle **but** great distances prohibit transporting; or
  - Member is suffering from an illness that makes other forms of transportation inadvisable.
- Requires HCPF Medical Director approval
- Refer to the Transportation Billing Manual for procedure to request air transportation

Modes of Transportation

Non-Emergent Ambulance Services

- May be provided as a last resort when:
  - A member requires basic or advanced life support in order to be transported safely
  - When other modes of transportation would endanger the member's life; and
  - It is the least costly, most appropriate mode for the member's condition
- Oxygen administration is allowed when medically necessary
- Reimbursed mileage using the most direct route to the appointment/service.

Modes of Transportation

Private Vehicle/Mileage Reimbursement

- May be provided by:
  - A volunteer (individual or organization with no member vested interest); or
  - A vehicle provided by a member, a family member, friend, or neighbor, with a member vested interest.
- Reimbursed mileage using the most direct route to and/or from the closest qualified provider of the covered service.
- SDE and Transportation Broker requirements for reimbursement vary.

Ancillary Services

Meals and lodging

- Only authorized if trip cannot be completed in one (1) calendar day
- Only authorized if not included as part of inpatient stay
- May be covered for authorized escort

Escort

May accompany a child or at-risk adult

Transportation Billing Instructions

- Use diagnosis code 780 for all NEMT claims
  - Regardless of diagnosis
- For Place of Service Code
  - Enter ‘41’ for land transportation
  - Enter ’42’ for air transportation
- Span dating is not allowed
- Claims that require attachments must be billed on paper

Non-Medical Transportation (NMT)

- NMT is a service available to Medicaid members who are on a Home and Community Based Services (HCBS) waiver
- HCBS Waivers allow states to:
  - Waive certain income/eligibility criteria
  - Provide specific services to target groups
  - Target specific geographic regions
- Colorado has six adult HCBS Waivers, each serving a different population with different eligibility criteria
  - All six waivers offer NMT as a service, but have various restrictions on its usage

Non-Medical Transportation by Waiver

- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Elderly, Blind and Disabled (EBD)
- Community Mental Health Supports (CMHS)
- Non-medical transportation services for the above waivers means transportation which enables eligible members to gain personal physical access to non-medical community services and resources to prevent institutionalization

Inclusions and Exclusions of NMT

- Non-medical transportation services provides access to the community: transportation between the member's home and non-medical services or resources such as adult day services, shopping, therapeutic swimming, counseling sessions and other services as required by the care plan to prevent institutionalization
- Non-medical transportation services shall not be used to substitute for Non-Emergency Medical Transportation

Non-Medical Transportation and Billing Information

- Provider must bill off of Prior Authorization Request (PAR) provided by the Case Manager (CM)
- Procedure Codes for the service vary depending on the mode of transportation being provided (Mobility van, taxi or wheelchair van)
- NMT for Adult Day transportation have specific modifiers

Division of Intellectual and Developmental Disabilities (DIDD) Waivers

- Developmental Disabilities (DD)
  - Service offered in order to enable waiver participants to gain access to Day Habilitation and Supported Employment services as specified by the Service Plan that are not related to medical interventions as covered in the State Plan
- Supported Living Services (SLS)
  - Service provided in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the Service Plan

Waiver PARs

Division for Intellectual & Developmental Disabilities (DIDD) Waivers

- Supported Living Services (SLS)
- Developmental Disabilities (DD)
- Children's Extensive Support (CES)

Local County Department of Human Services DHS Waiver

- Children's Habilitation Residential Program (CHRP)

Waiver PARs (cont.)

Case Management Agency Adult & Children HCPF Waivers

- Elderly Blind and Disabled (EBD)
- Community Mental Health Services (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Children's Home Community Based Services (CHCBS)
- Children With Autism (CWA)
- Children with Life Limiting Illness (CLLI)

Waiver Prior Authorization Form

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO
Department of Health Care Policy & Financing

QUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINME **EBD-U1**

HCBS - Persons who are Elderly, Blind, and Disabled (EBD) Waiver

PA Number being revised:

Revision? ☐ Yes ☐ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE
		☐ M ☐ F	

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED	
			From:	Through:

STATEMENT OF REQUESTED SERVICES

9. Description		10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (U1)							
S5105 Adult Day Services, Specialized (U1)			TF				
T2031 Alternative Care Facility (ACF) (U1)				1	$50.95	$50.95	
T2038 Community Transition Services, Coordinator (U1)							
A9900 Community Transition Services, Items Purchased (U1)							
T2025 Consumer Directed Assistance Support Services (CDASS) (Cent/ Unit) (U1)							
T2040 CDASS Per Member/ Per Month (PM/PM) (U1)	Fiscal Employer Agent (FEA) (U1)						
S5165 Home Modifications (U1)							
S5130 Homemaker (U1)							
H0038 IHSS Health Maintenance Activities (U1)							
S5130 IHSS Homemaker (U1)			KX				
T1019 IHSS Personal Care (U1)			KX				
T1019 IHSS Relative Personal Care (U1)			HR, KX				
T2029 Medication Reminder, Install/Purchase (U1)							
S5185 Medication Reminder, Monitoring (U1)							
A0100 NMT, Taxi (U1)							
A0120 NMT, Mobility Van	Mileage Band 1 (0-10 miles) (U1)						
A0120 NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)		HB				
A0130 NMT, Wheelchair Van	Mileage Band 1 (0-10 miles) (U1)						
A0130 NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles) (U1)		HB				
T1019 Personal Care (U1)							
T1019 Personal Care, Relative (U1)			HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (U1)							
S5161 PERs, Monitoring (U1)							
S5151 Respite Care, ACF (U1)							
S5150 Respite Care, In Home (U1)							
H0045 Respite Care, NF (U1)							
A							

Find Adult HCBS Prior Approval and Cost Containment workbook for Waiver programs on the Department's website

Colorado.gov/hcpf/provider-forms

Benefit and Billing Information

For detailed benefit and billing information refer to:

www.colorado.gov/hcpf/ProviderServices

Billing Manuals → Transportation

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

Common Denial Reasons

PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total

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

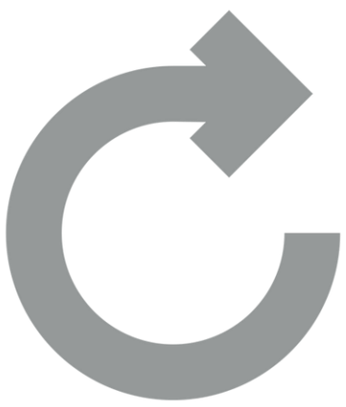
Claim processed & paid by claims processing system

From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

Claims Process - Common Terms

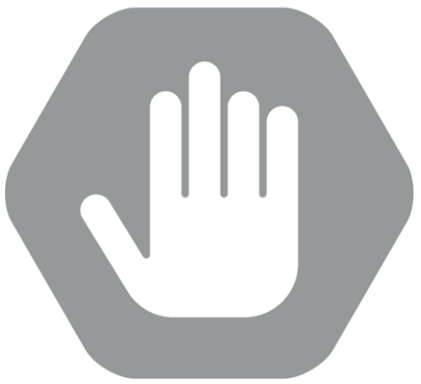
Adjustment

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



Rebill

Re-bill previously denied claim



Suspend

Claim must be manually reviewed before adjudication

Void

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

From the Noun Project:
“Delete” by Ludwig Schubert
“Stop” by Chris Robinson
“Check-Mark” by Muneer A.Safiah
“Money” by Nathan Thomson

Adjusting Claims

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

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when

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

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete field 22 on the CMS 1500 claim form

From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Paper" by Kristina

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	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	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'.

Provider Claim Reports (PCRs)

Adjustments

Recovery

Repayment

Net Impact

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* 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	041008		114.24				
						NET IMPACT	21.42				

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 800-237-0757	CGI 888-538-4275
Claims/Billing/Payment	Email helpdesk.HCG.central.us@cgi.com
Forms/Website	CMAP Web Portal technical support
EDI	CMAP Web Portal Password resets
Updating existing provider profile	CMAP Web Portal End User training

Thank you!