Billing Workshop
Non-Emergency Transportation

Colorado Medicaid
2015
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/nationalprolidentstand/
  ➤ 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. 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
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**
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
Providers Not Enrolled with EDI

Providers must be enrolled with EDI to use the Web Portal to submit HIPAA compliant claims, make inquiries and retrieve reports electronically

- Select Provider Application for EDI Enrollment
  - Colorado.gov/hcpf → Providers → EDI Support
**Payment Processing Schedule**

- **Mon.**
  - Payment information is transmitted to the State’s financial system

- **Tue.**
  - Accounting processes Electronic Funds Transfers (EFT) & checks

- **Wed.**
  - EFT payments deposited to provider accounts

- **Thur.**
  - Paper remittance statements & checks dropped in outgoing mail

- **Fri.**
  - Weekly claim submission cutoff
  - Fiscal Agent processes submitted claims & creates PCR

- **Sat.**

**Payment Processing Schedule**

<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>Mon</td>
<td>Payment information is transmitted to the State’s financial system</td>
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</tr>
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<td>Weekly claim submission cutoff</td>
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<tr>
<td>Sat</td>
<td>Fiscal Agent processes submitted claims &amp; creates PCR</td>
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</table>
Electronic Funds Transfer (EFT)

• Several Advantages:
  ➤ Free!
  ➤ No postal service delays
  ➤ Automatic deposits every Thursday
  ➤ Safest, fastest & easiest way to receive payments
  ➤ Located in Provider Services Forms section on Department website
PARs Reviewed by ColoradoPAR

• With the exception of Waiver and Nursing Facilities:
  ▶ ColoradoPAR processes all PARs including revisions
  ▶ Visit coloradopar.com for more information

**Mail:**
Prior Authorization Request
55 N Robinson Ave., Suite 600
Oklahoma City, OK 73102

**Phone:**
1.888.454.7686

**FAX:**
1.866.492.3176

**Web:**
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

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

Year of Receipt 0 14 129 00

Julian Date of Receipt

Batch Number 150 0

Document Number 000037

Adjustment Indicator
1 = Recovery
2 = Repayment
Timely Filing

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

From “through” DOS:
- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From DOS:
- FQHC Separately Billed and additional Services

From delivery date:
- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date
Documentation for Timely Filing

• 60 days from date on:
  ➤ Provider Claim Report (PCR) Denial
  ➤ Rejected or Returned Claim
  ➤ Use delay reason codes on 837P transaction
  ➤ Keep supporting documentation

• Paper Claims
  ➤ CMS 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in Field 19 (Additional Claim Information)
Timely Filing – Medicare/Medicaid Enrollees

Medicare **pays** claim

- 120 days from Medicare payment date

Medicare **denies** claim

- 60 days from Medicare denial date
Timely Filing Extensions

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

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

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

- **Bill electronically**
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form

- **Steps you can take:**
  - Review past records
  - Request billing information from member
Extensions – Backdated Eligibility

• 120 days from date county enters eligibility into system
• Report by obtaining State-authorized letter identifying:
  ➤ County technician
  ➤ Member name
  ➤ Delayed or backdated
  ➤ Date eligibility was updated
Who completes the CMS 1500?

- HCBS/Waiver providers
- Vision providers
- Physicians
- Supply providers
- Surgeons
- Transportation providers
# CMS 1500

![CMS 1500 Claim Form](image)

The CMS 1500 is a Health Insurance Claim Form used in the United States for submitting claims to insurance companies or other third-party payers. It is widely used in the healthcare industry for billing purposes. The form is designed to be filled out by healthcare providers to submit claims for services rendered to patients covered by insurance.

The form contains sections for patient information, provider information, and claim details. It is structured to ensure the accurate submission of claim data, enabling efficient processing by insurance companies.

The CMS 1500 is approved by the Centers for Medicare & Medicaid Services (CMS) and is designed to streamline the billing process, reducing errors and improving the accuracy of claim submissions.

For more detailed information and instructions on how to fill out the CMS 1500 Form, please refer to the CMS Instruction Manual available at [www.cms.gov](http://www.cms.gov).
Emergency Transportation

• Emergency services require a physician’s statement of medical necessity or trip report
  ➤ Subject to audit for 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-
    - 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-Emergency Medical Transportation (NEMT)

- Non-Emergency Medical Transportation
  - Defined as transportation to and/or from a medical treatment that is not emergent in nature
    - Non-Emergency care is scheduled
  - NEMT is only available when member has no other form of transportation
Non-Emergency Medical Transportation (NEMT)

Types of NEMT

- Mobility Vehicle
- Train
- Car
- Wheelchair Van
- Bus
- Plane
- Taxi
- Non-emergency Ambulance
Non-Emergency Medical Transportation (NEMT)

• The following are **not** benefits of Colorado Medical Assistance Program:
  ▶ Waiting time
  ▶ Charges when member is not in vehicle
  ▶ Transportation when not medically necessary
  ▶ Trips to a pharmacy (counties officially designated as “Rural” may use NEMT for trips to a pharmacy)
Colorado Rural Counties

- Alamosa
- Archuleta
- Chaffee
- Conejos
- Crowley
- Delta
- Eagle
- Fremont
- Garfield
- Grand
- Lake
- La Plata
- Logan
- Montezuma
- Montrose
- Morgan
- Otero
- Ouray
- Phillips
- Pitkin
- Prowers
- Rio Grande
- Routt
- Summit
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 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 First Transit

• Note: First Transit is the only NEMT broker contracted with Medicaid
Transportation Broker

• First Transit manages Non-Emergency Medical Transportation (NEMT) program for providers whose members reside within the following nine 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 counties listed, please contact:

**First Transit – Colorado NEMT**

1-855-677-6368

Or visit their website at: [www.medicaidco.com](http://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 (QMB)
  ➤ QI-1 (Qualified Individuals-1)
  ➤ SLMB (Specified Low Income Medicare Beneficiaries)
County Responsibilities

• As 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

• The SDE is required to query members requesting NEMT:
  ➤ To determine that the member is being transported to a Medicaid covered service
  ➤ To ensure that the member has exhausted all means of accessing free transportation
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

• Some counties have elected to opt out of their transportation administration duties by contracting with private transportation brokers
  ▶ This option for counties is valid as long as there is no additional cost to Colorado Medical Assistance Program
County Responsibilities

- Private transportation brokers & the counties they represent are:
  - Red Willow, Inc. (San Luis Valley Transportation) 719.589.5734
    - Counties: Alamosa, Costilla, Conejos
  - North Eastern Colorado Transportation Authority 970.522.6440
    - Counties: Alamosa, Costilla, Conejos, Rio Grande, Mineral, Saguache
    - Counties: Sedgwick, Phillips, Yuma, Logan, Morgan, Washington
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 Vehicles

• Provided when:
  - member has no transportation
  - this option is least costly
  - most appropriate mode for member’s condition

• May transport multiple parties at the same time

• Does not calculate charges based upon a meter

• May use wheelchair van billing codes only when:
  - member is a physician-certified wheelchair user and
  - vehicle has appropriate wheelchair equipment
Modes of Transportation

Wheelchair Van

- **Only a benefit when:**
  - member is 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 mobility vehicle billing codes only when:**
  - member isn’t physician-certified wheelchair user
 Modes of Transportation

Bus or Train

• **Benefits are provided when:**
  - member is traveling a great distance
  - it is the least costly means of transportation
  - member’s health condition is poor
  - appropriate for in-state and out-of-state travel
  - no PAR required
  - for train, use procedure code A0110
Modes of Transportation

Air

- For air ambulance, helicopter & commercial air
  - PAR required
  - PAR must be:
    - completed by the SDE &
    - submitted to ColoradoPAR Program
Non-Emergency Air Transportation

• NEMT Benefits are provided when:
  ➤ Point of pickup is inaccessible by land vehicle
  ➤ Point of pick up is accessible by a land vehicle
    ▪ But great distances prohibit transporting
  ➤ Great distances prohibit transporting member to the nearest appropriate location and member needs immediate attention
  ➤ Patient is suffering from an illness that makes other forms of transportation inadvisable
Mileage Reimbursement

• For mileage reimbursement, you must provide the SDE with:
  ➤ Name & address of vehicle owner
  ➤ Destination address

• Reimbursement Rules
  ➤ SDEs should route trip using mapping or similar GPS program to determine mileage
  ➤ Print map page for documentation
  ➤ Trip must be most direct route to and/or from medical appointment with closest qualified provider
  ➤ Service must be a benefit of the Colorado Medical Assistance Program
Multiple Riders

• When NEMT services are:
  ➤ Provided by multi-passenger vehicle
  ➤ For more than one member at a time:
    ▪ Member traveling furthest distance is reimbursed at full rate
    ▪ Member traveling second furthest distance is reimbursed at ½ rate
    ▪ Any additional member(s) shall be reimbursed at ¼ rate of the first member
    ▪ No PAR required
Out-Of-State Transportation

• Requirements
  ➤ Provider must verify that out-of-state service has been authorized
  ➤ Medical necessity requirements must be certified by member’s physician
  ➤ SDE must obtain the prior approval from the ColoradoPAR Program

• If member requires out-of-state transportation, contact ColoradoPAR Program
  ➤ 1-888-454-7686
Ancillary Services

- All ancillary services require prior authorization by The ColoradoPAR Program:

  **Meals and lodging**
  - Only authorized if trip cannot be completed in one calendar day

  **Escort**
  - May accompany at-risk adults or children
Units of Service

• Units may represent the number of one-way trips or number of miles

For meals and lodging
• 1 unit = 1 day of lodging
• 1 unit = total meals for 1 day
• Lodging per day = $35.03
• Meals per day = $15.41

Note: Only 1 meal (1 unit) allowed per day

For transportation by bus, train or air
• Units represent number of one-way trips taken
• Do not bill mileage
• Must provide receipt
Over-the-Cap Expenses

• Over-the-cap expenses are expenses exceeding maximum allowable
• Mental health hold members only qualify when being transported to Fort Logan or the State facility in Pueblo
• PAR documentation must indicate:
  ➢ that requested mode is most appropriate and least costly method of transportation for member
  ➢ medical condition and extenuating circumstances (in detail) to support approving an over-the-cap request
• PAR must include documentation that:
  ➢ care is not available in member’s local community
  ➢ member is seeing closest, appropriate, Colorado Medical Assistance Program provider
Over-the-Cap Expenses (cont.)

- Expenses exceeding maximum allowable cap
  - Mental health hold members only qualify if being transported to:
    - Fort Logan
    - State facility in Pueblo
  - PAR documentation must indicate that the requested mode is:
    - Most appropriate
    - Least costly method of transportation
Over-the-Cap Expenses (cont.)

• PAR must include documentation that:
  ➢ Indicates (in detail) the medical condition and extenuating circumstances to support approving an over-the-cap request
  ➢ Care is not available in member’s local community
  ➢ Member is seeing closest, appropriate, Colorado Medical Assistance Program provider
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
Benefit and Billing Information

For detailed benefit and billing information refer to:

www.colorado.gov/hcpf/ProviderServices

Billing Manuals ➔ Transportation
# Common Denial Reasons

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<tr>
<th>Reason</th>
<th>Description</th>
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<tbody>
<tr>
<td>Timely Filing</td>
<td>Claim was submitted more than 120 days without a LBOD</td>
</tr>
<tr>
<td>Duplicate Claim</td>
<td>A subsequent claim was submitted after a claim for the same service has already been paid.</td>
</tr>
<tr>
<td>Bill Medicare or Other Insurance</td>
<td>Medicaid is always the “Payor of Last Resort”. Provider should bill all other appropriate carriers first</td>
</tr>
<tr>
<td>PAR not on file</td>
<td>No approved authorization on file for services that are being submitted</td>
</tr>
<tr>
<td>Total Charges invalid</td>
<td>Line item charges do not match the claim total</td>
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</table>
Claims Process - Common Terms

- **Reject**: Claim has primary data edits – **not** accepted by claims processing system
- **Denied**: Claim processed & denied by claims processing system
- **Accept**: Claim accepted by claims processing system
- **Paid**: Claim processed & paid by claims processing system
Claims Process - Common Terms

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

**Suspend**
- Claim must be manually reviewed before adjudication

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

**Rebill**
- Re-bill previously denied claim
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

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**TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE**

**TOTAL CLAIMS PAID** 1

**TOTAL PAYMENTS** 69.46

## Denied

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<th>CLIENT</th>
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**TOTAL CLAIMS DENIED** - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

**COUNT** 0001

The following is a description of the denial reason (exc) codes that appear above:

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

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#### Recovery

- Repayment: 21.42
- Net Impact: 21.42

#### Voids

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*ADJUSTMENTS PAID*
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!