Billing Workshop
Non-Emergency Transportation

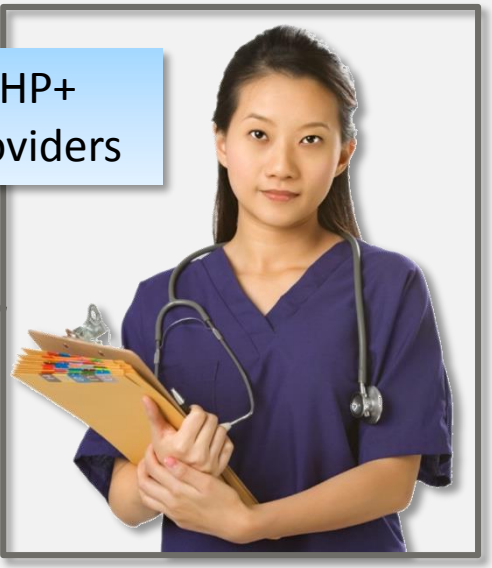
Colorado Medicaid
2014

Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing

Medicaid

Medicaid/CHP+ Medical Providers



Xerox State Healthcare

Training Objectives

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

What is an NPI?

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

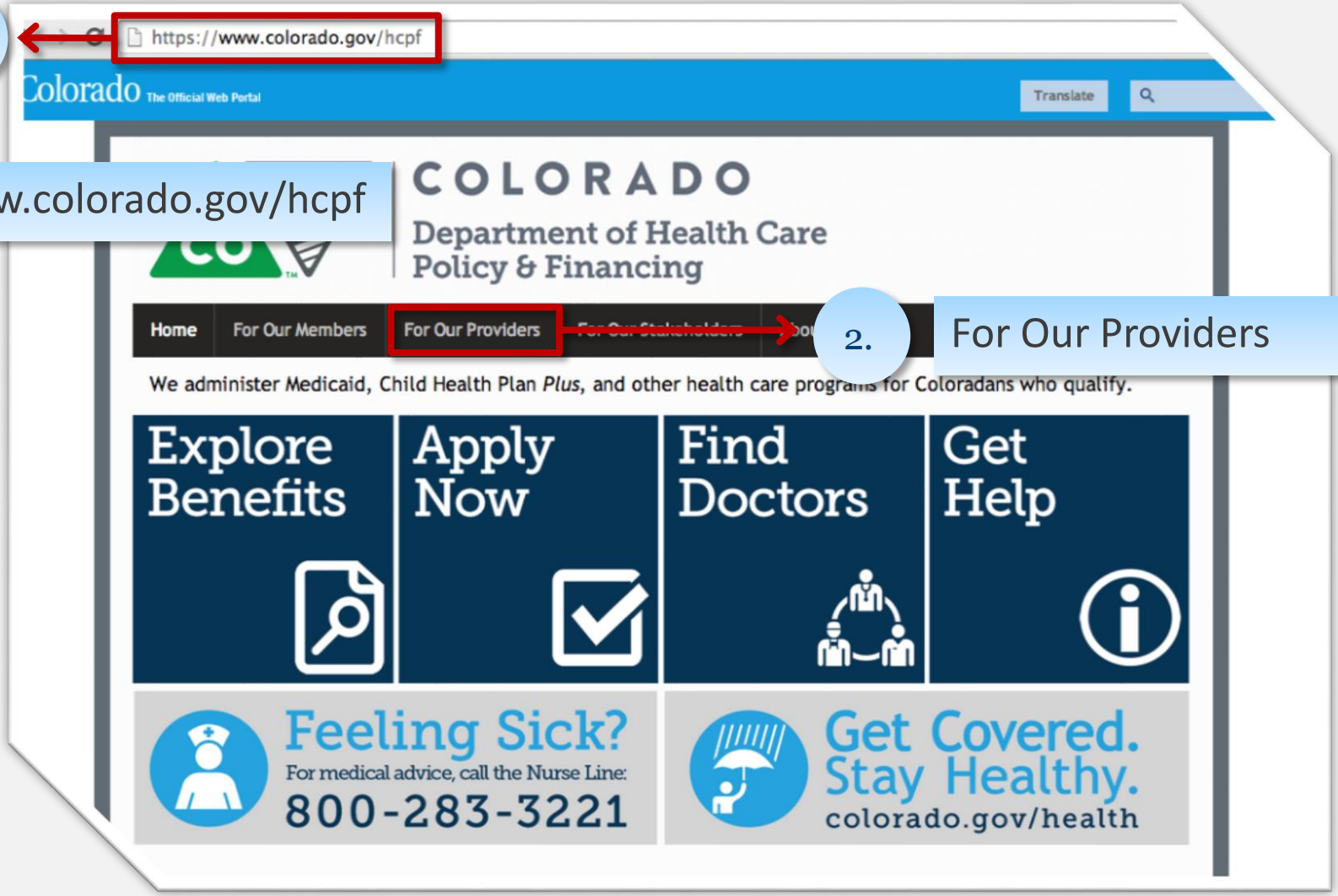
What is an NPI?

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

NEW! Department Website

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

www.colorado.gov/hcpf

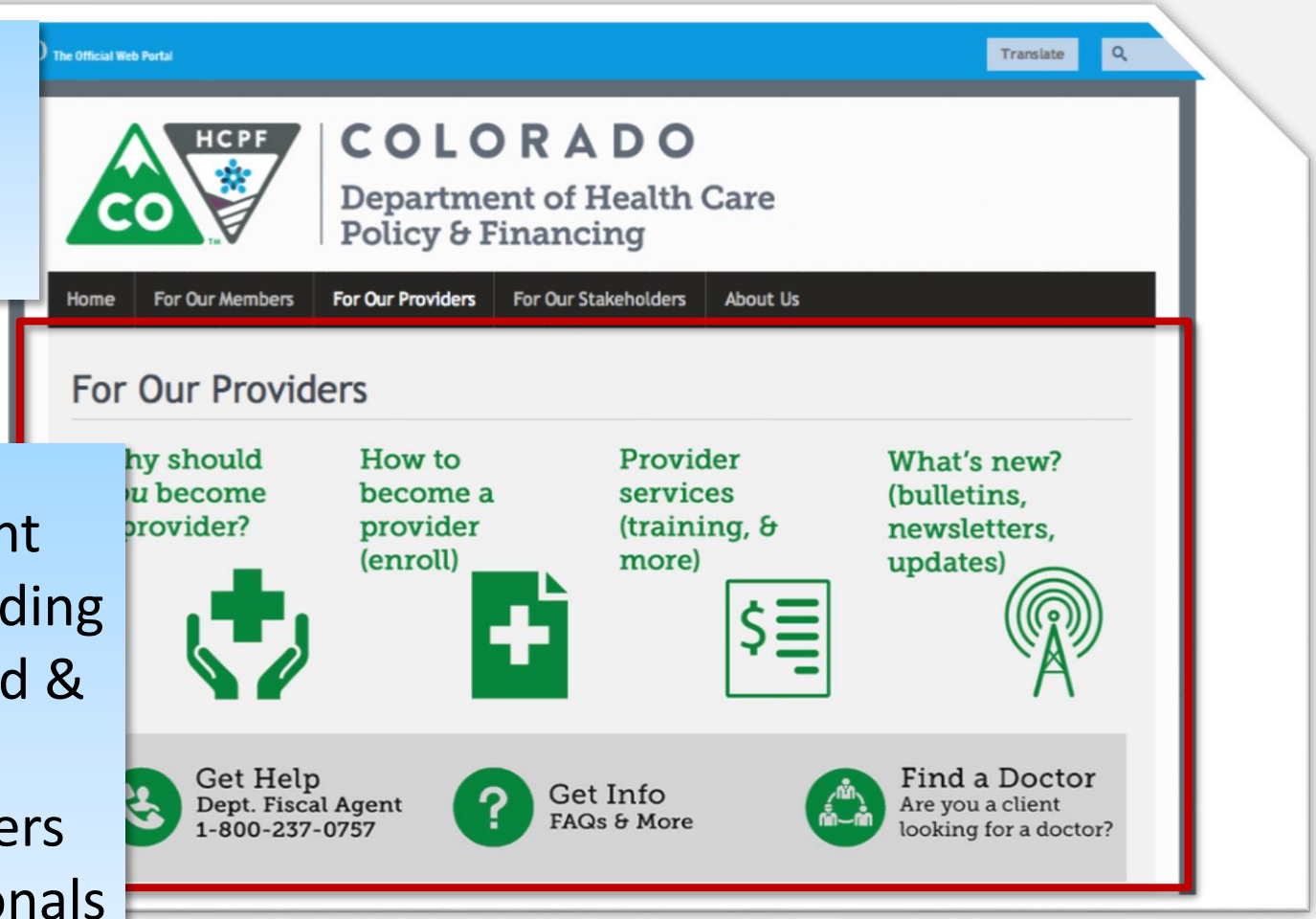


2. For Our Providers

NEW! Provider Home Page

Find what you need here

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



Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

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

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Rendering Versus Billing

Rendering Provider

- Individual that provides services to a Medicaid member

Billing Provider

- Entity being reimbursed for service

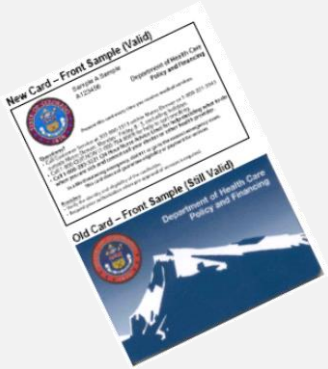
Verifying Eligibility

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

Web Portal

Fax Back
1-800-493-0920

CMERS/AVRS
1-800-237-0757

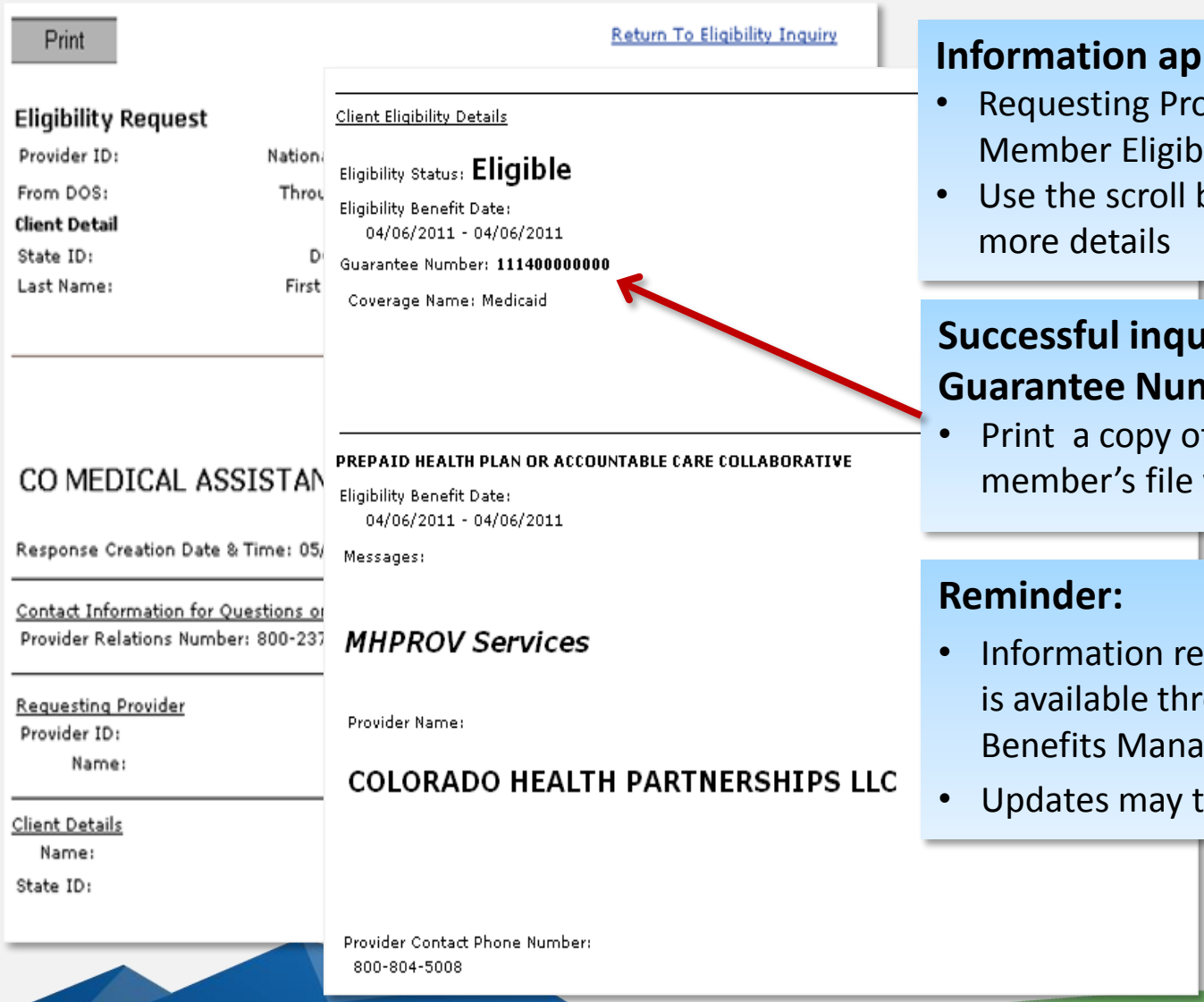


Medicaid ID Card with Switch Vendor

Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number

Eligibility Request Response (271)



Information appears in sections:

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

Successful inquiry notes a Guarantee Number:

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

Reminder:

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

Medicaid Identification Cards

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

Sample A Sample
A123456

Department of Health Care Policy and Financing

Present this card every time you receive medical services.

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

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

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

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

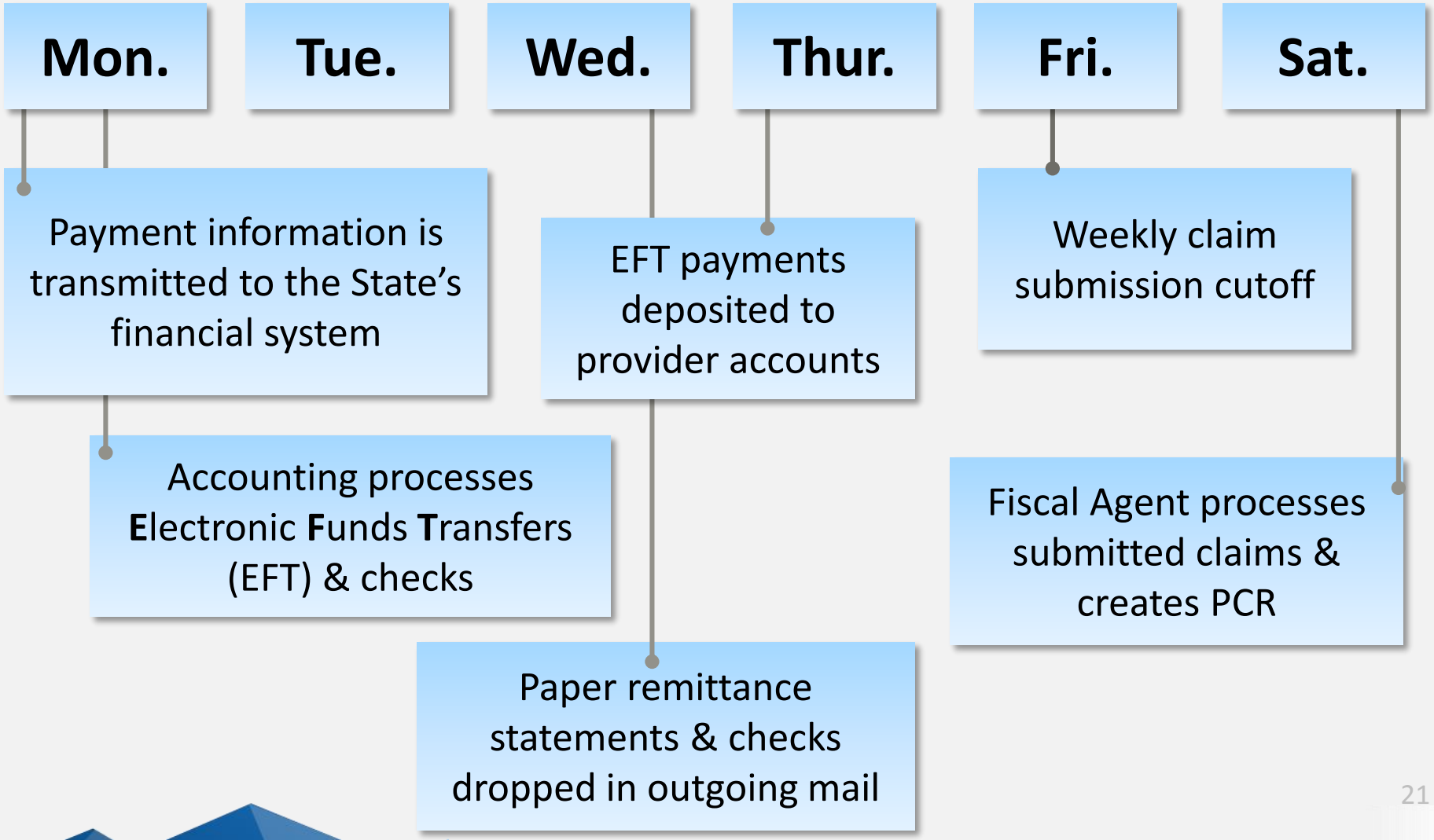
Submitting Claims

- 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

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

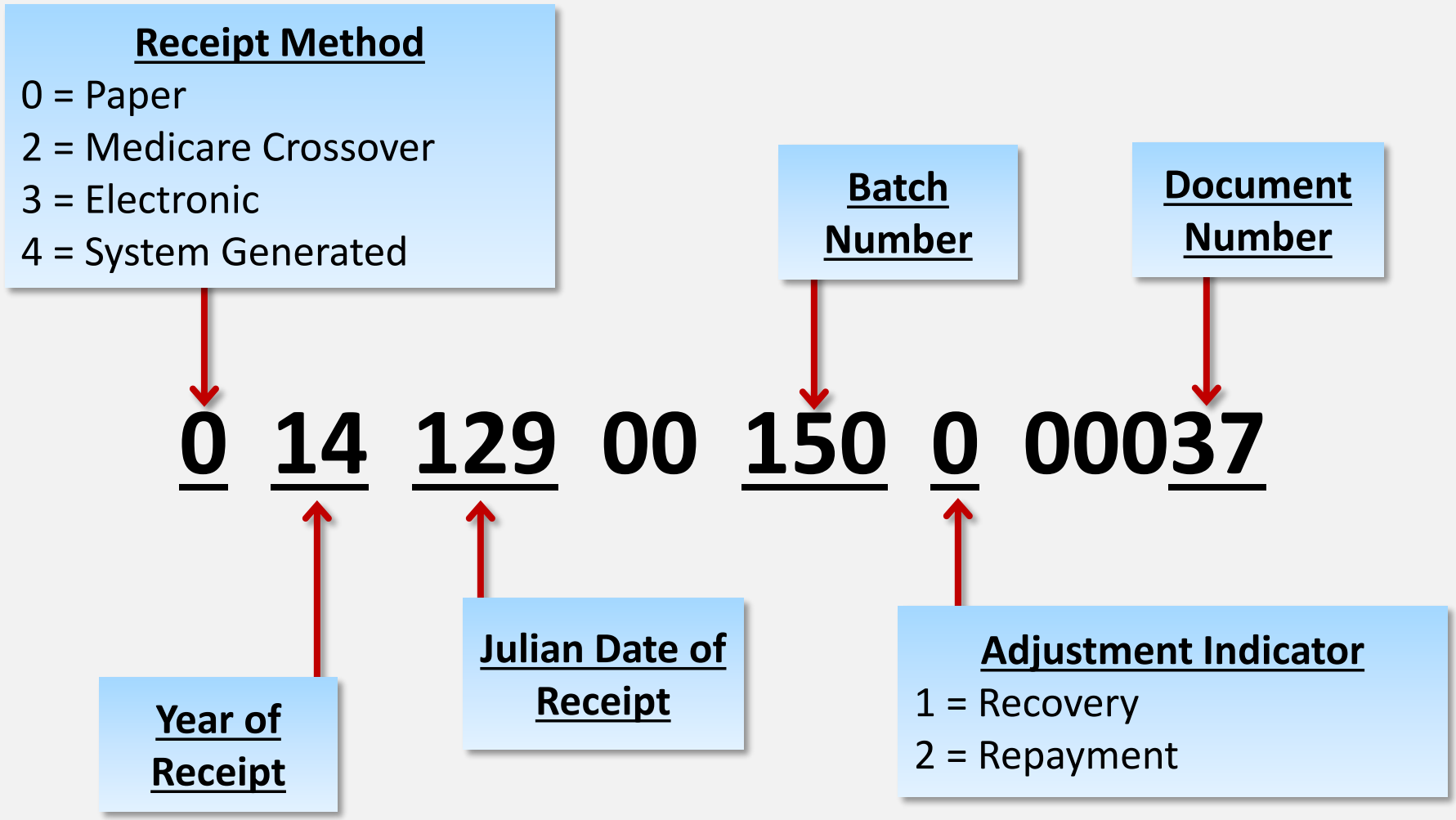
Electronic PAR Information

- 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

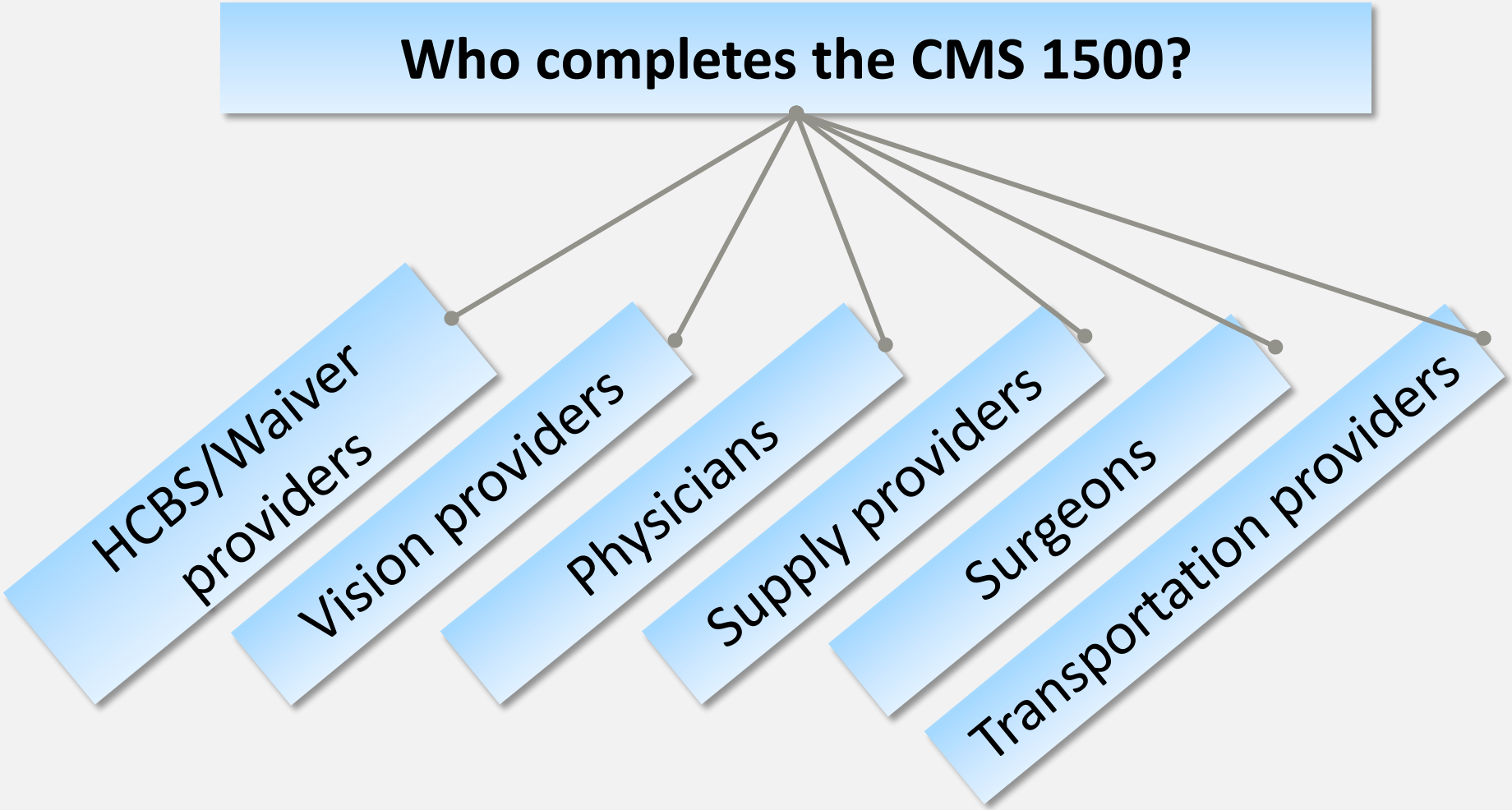
Extensions – **Delayed Notification**

- 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

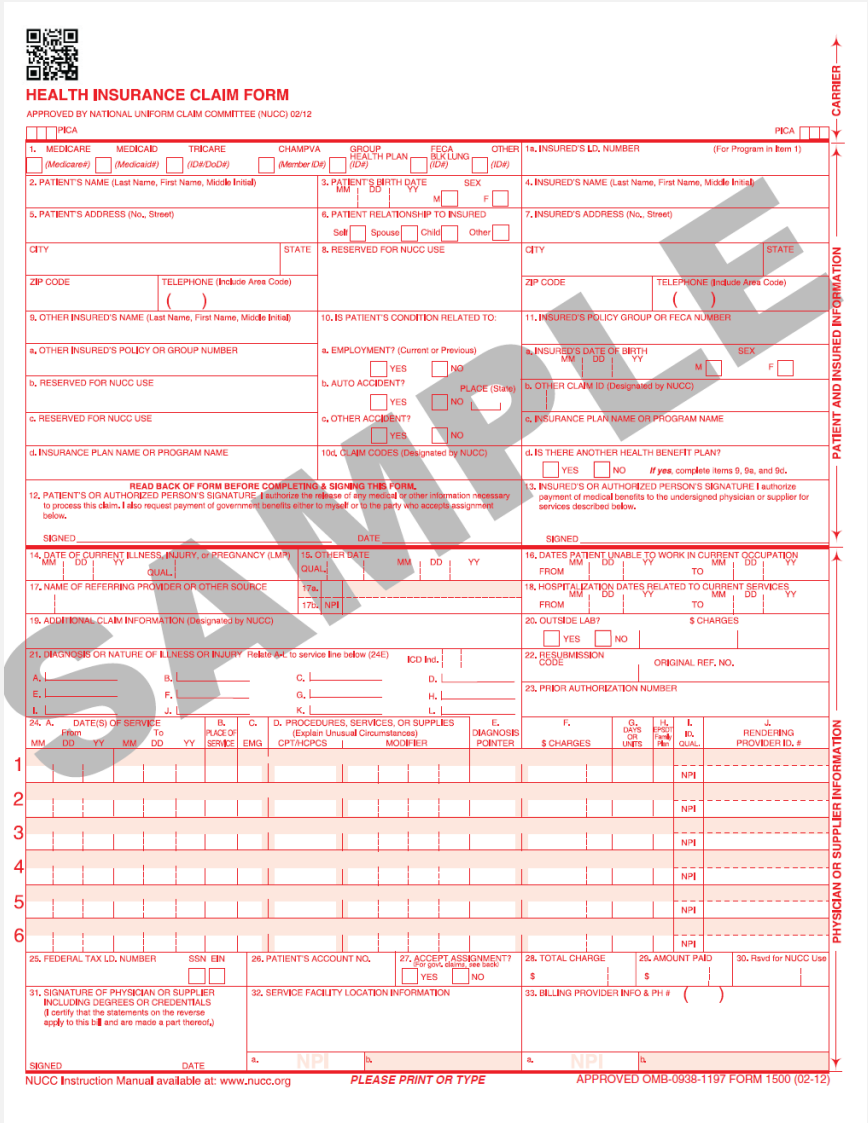
Extensions – **Backdated Eligibility**

- 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

CMS 1500


Who completes the CMS 1500?
HCBS/Waiver providers
Vision providers
Physicians
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 6 years
- Emergency transportation includes:
  - Ambulance
  - Air Ambulance

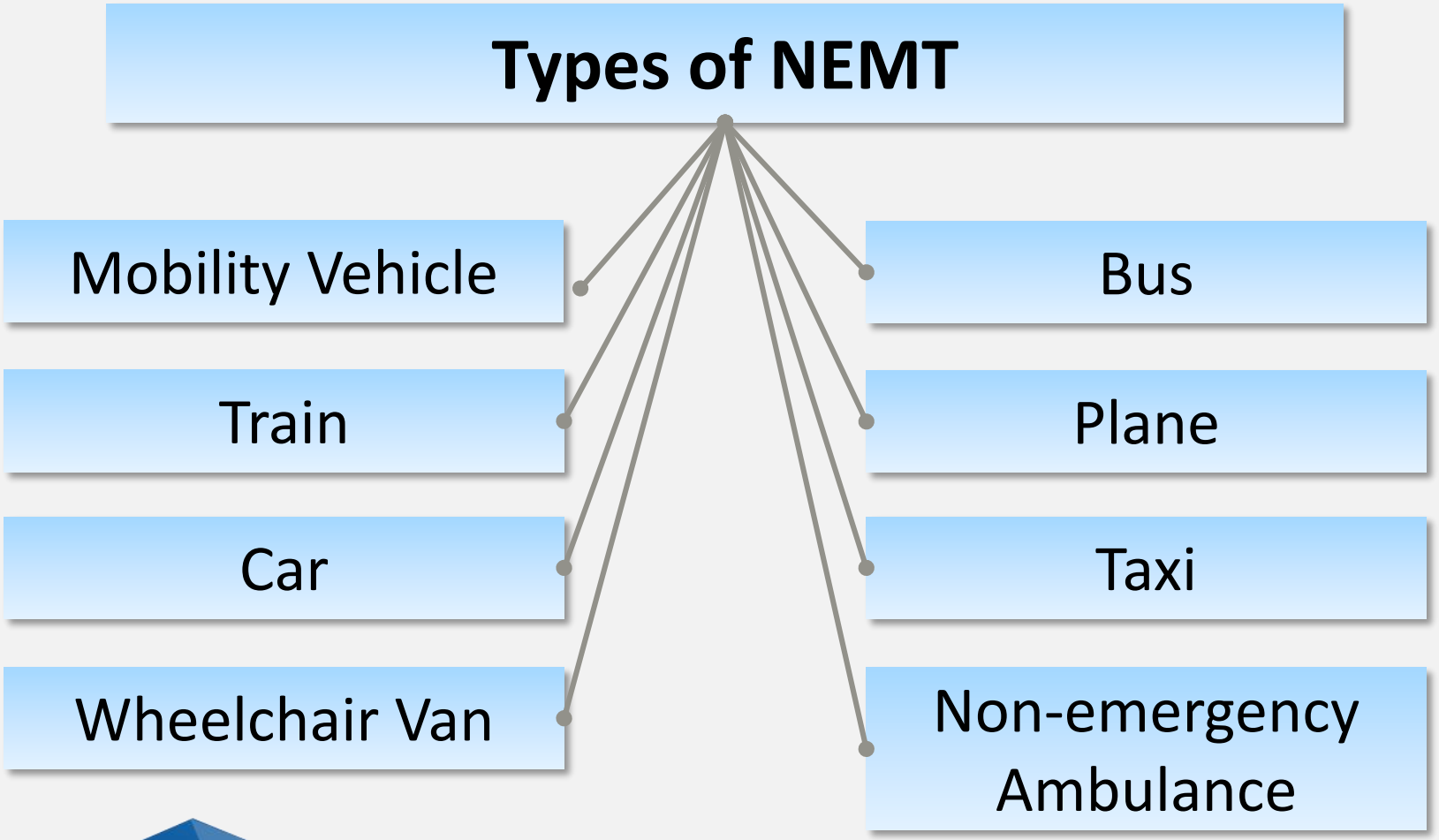
What Defines an "Emergency"?

- **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)



Non-Emergency Medical Transportation (NEMT)

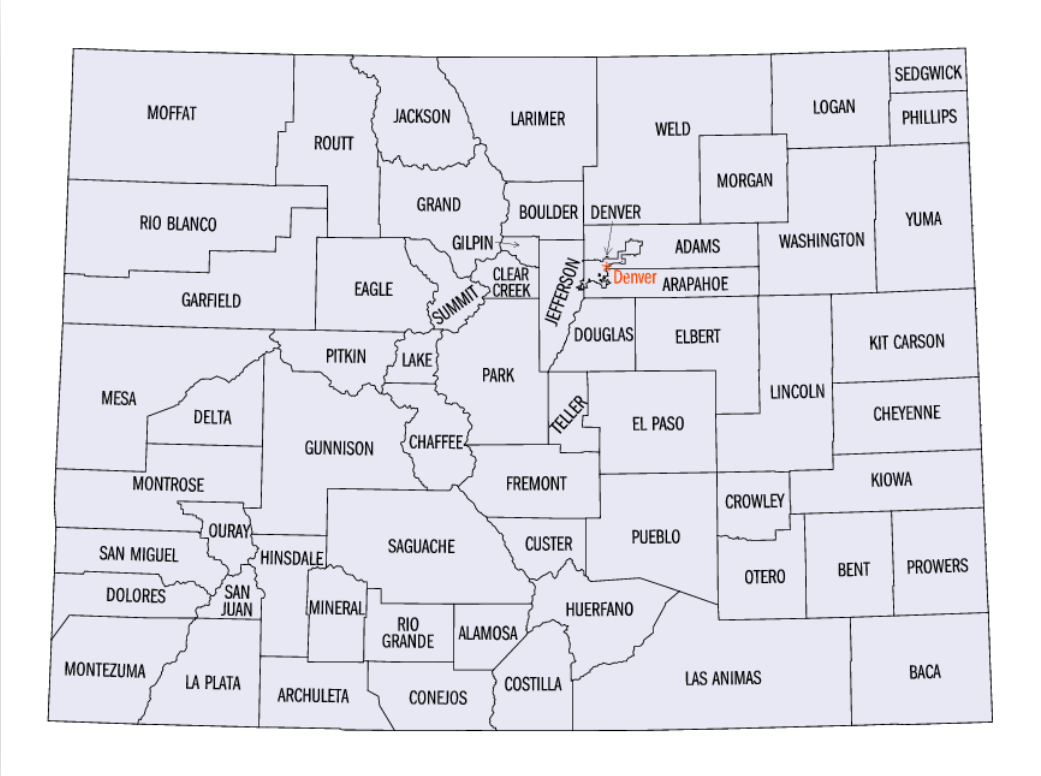
- The following are **not** benefits of Colorado Medical Assistance Program:
  - Waiting time
  - Charges when member is not in vehicle
  - Transportation when not medically necessary
  - Trips to a pharmacy (counties officially designated as “Rural” may use NEMT for trips to a pharmacy)

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

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
- Rio Grande
- Mineral
- Saguache

North Eastern Colorado Transportation Authority
970.522.6440

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

Timely Filing	Claim was submitted more than 120 days without a LBOD
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has already been paid.
Bill Medicare or Other Insurance	Medicaid is always the "Payor of Last Resort". Provider should bill all other appropriate carriers first
PAR not on file	No approved authorization on file for services that are being submitted
Total Charges invalid	Line item charges do not match the claim total

Claims Process - Common Terms

Reject

Claim has primary data edits – **not** accepted by claims processing system

Denied

Claim processed & denied by claims processing system

Accept

Claim accepted by claims processing system

Paid

Claim processed & paid by claims processing system

Claims Process - Common Terms

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

Adjustment

Re-bill previously denied claim

Rebill

Claim must be manually reviewed before adjudication

Suspend

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

Void

Adjusting Claims

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

Adjust a claim when:

- Provider billed incorrect services or charges
- Claim paid incorrectly

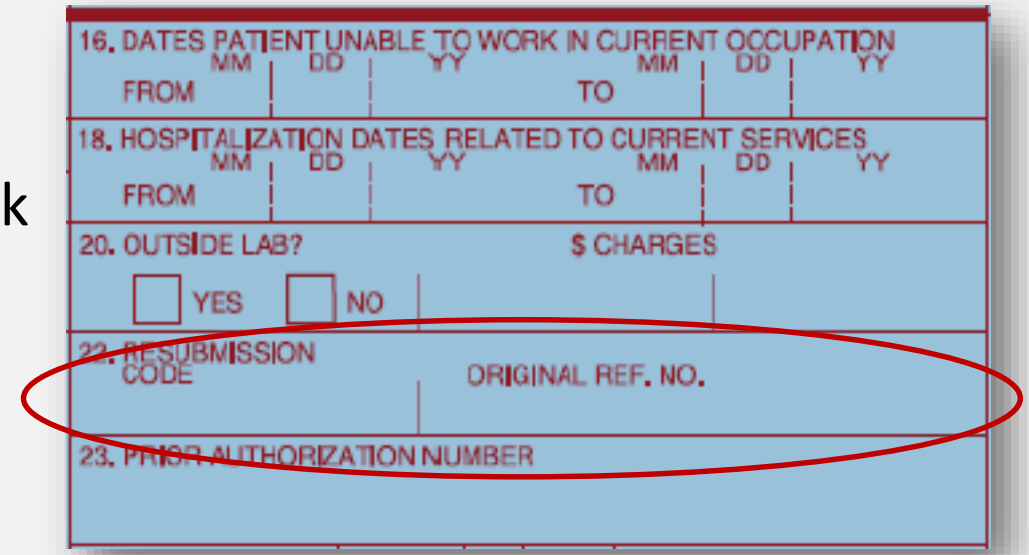
Do not adjust when:

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

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track



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

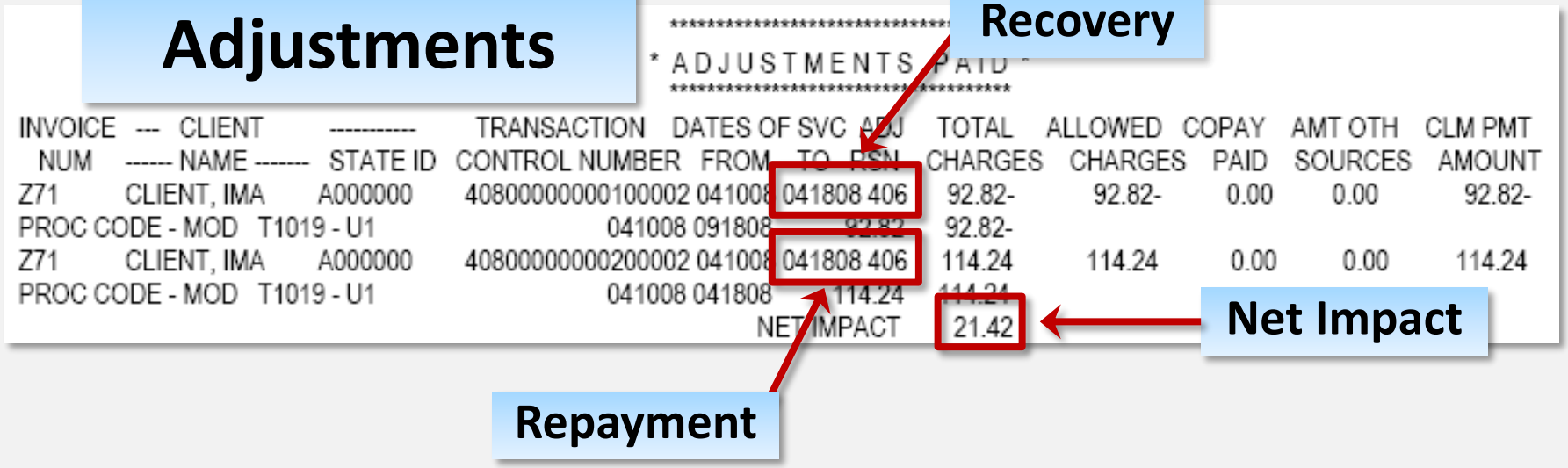
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

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!