

# Billing Workshop Vision

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/nationalproidentstand/](http://www.dms.hhs.gov/nationalproidentstand/)
  - National Plan and Provider Enumeration System (NPPES)-
    - [www.nppes.cms.hhs.gov](http://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](http://www.colorado.gov/hcpf)

2.

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore Benefits



Apply Now



Find Doctors



Get Help



Feeling Sick?

For medical advice, call the Nurse Line:

800-283-3221



Get Covered.

Stay Healthy.

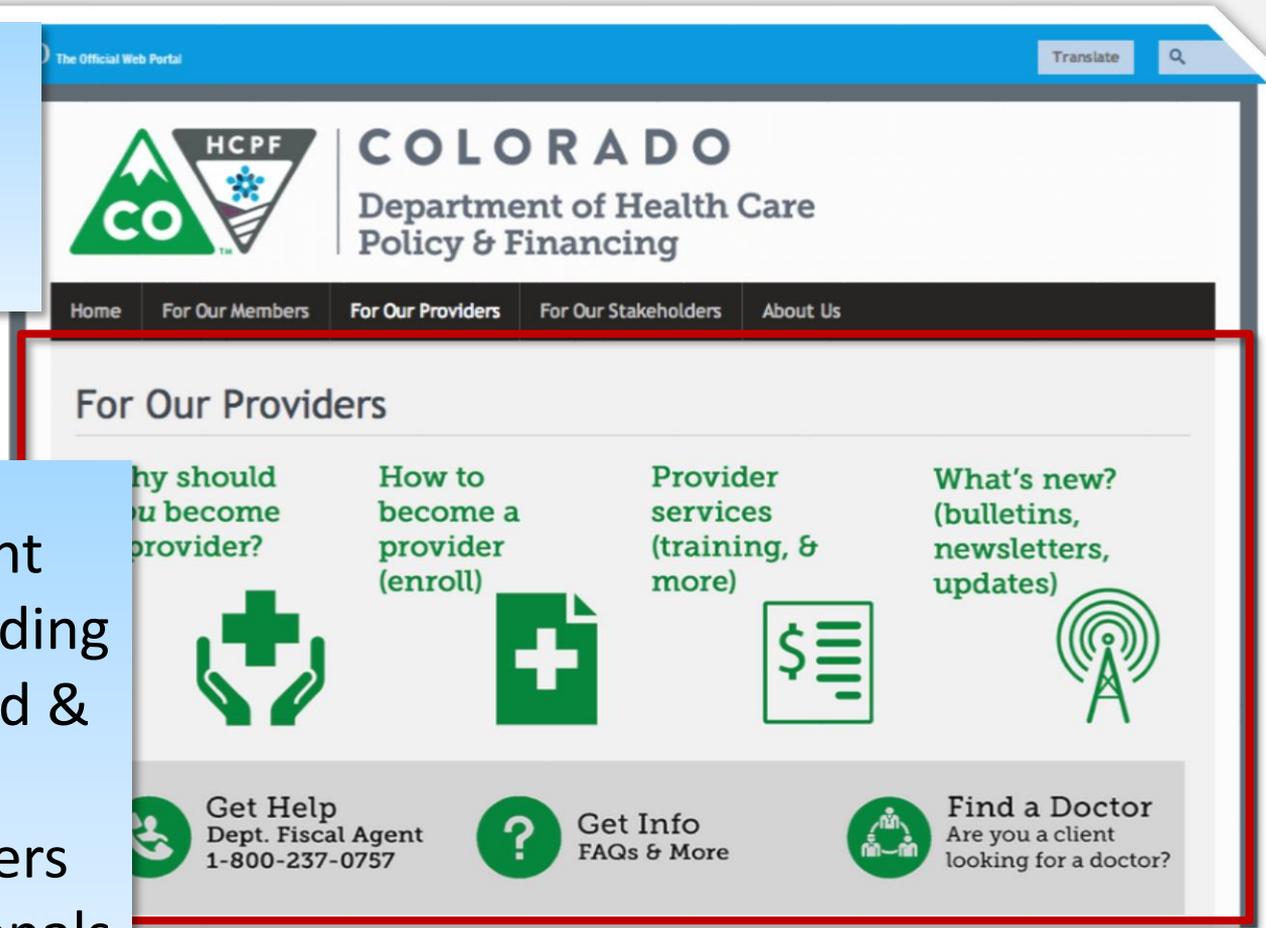
[colorado.gov/health](http://colorado.gov/health)



# 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:



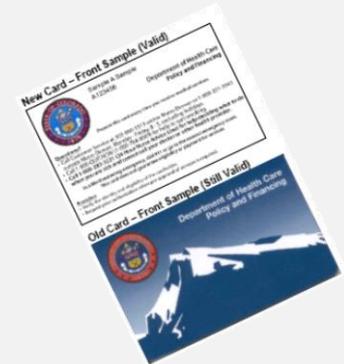
Web Portal



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](#)

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**Eligibility Request**

Provider ID:                      Nation:  
From DOS:                      Throu:  
**Client Detail**  
State ID:                      D:  
Last Name:                      First

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**CO MEDICAL ASSISTAN**

Response Creation Date & Time: 05/

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[Contact Information for Questions or](#)  
Provider Relations Number: 800-237

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[Requesting Provider](#)  
Provider ID:  
Name:

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[Client Details](#)  
Name:  
State ID:

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**Client Eligibility Details**

Eligibility Status: **Eligible**  
Eligibility Benefit Date:  
04/06/2011 - 04/06/2011  
Guarantee Number: **111400000000**  
Coverage Name: Medicaid

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**PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE**

Eligibility Benefit Date:  
04/06/2011 - 04/06/2011  
Messages:

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**MHPROV Services**

Provider Name:  
**COLORADO HEALTH PARTNERSHIPS LLC**

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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

**Successful inquiry notes a Guarantee Number:**

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

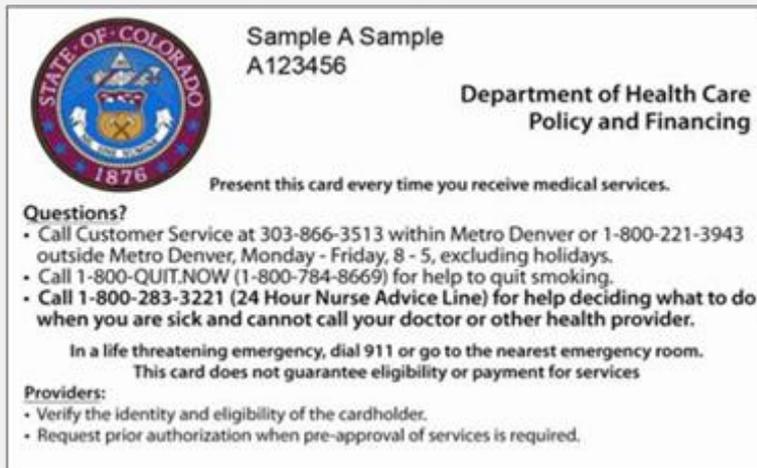
**Reminder:**

- 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



# Eligibility Types

- Most members= Regular Colorado Medicaid benefits
- Some clients= different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members= additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance



# Eligibility Types

## Modified Medical Programs



- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is \$300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services



# Eligibility Types

## Non-Citizens



- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only



# What Defines an “Emergency”?

- **Sudden, urgent, usually unexpected** occurrence or occasion requiring immediate action such that of:
  - Active labor & delivery
  - Acute symptoms of sufficient severity & severe pain-
    - Severe pain in which, the absence of immediate medical attention might result in:
      - Placing health in serious jeopardy
      - Serious impairment to bodily functions
      - Dysfunction of any bodily organ or part



# Eligibility Types

## Presumptive Eligibility



- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental



# Presumptive Eligibility

## Presumptive Eligibility



- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101

# Managed Care Options

- Types of Managed Care options:
  - Managed Care Organizations (MCOs)
  - Behavioral Health Organization (BHO)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Accountable Care Collaborative (ACC)



# Managed Care Options

## Managed Care Organization (MCO)



- Eligible for Fee-for-Service if:
  - MCO benefits exhausted
    - Bill on paper with copy of MCO denial
  - Service is not a benefit of the MCO
    - Bill directly to the fiscal agent
  - MCO not displayed on the eligibility verification
    - Bill on paper with copy of the eligibility print-out



# Managed Care Options

## Behavioral Health Organization (BHO)



- **Community Mental Health Services Program**
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider

# Managed Care Options

## Accountable Care Collaborative (ACC)



- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
  - Connects Medicaid members to:
- Helps coordinate Member care
  - Helps with care transitions



# Medicare

## Medicare



- Medicare members may have:
  - Part A only- covers Institutional Services
    - Hospital Insurance
  - Part B only- covers Professional Services
    - Medical Insurance
  - Part A and B- covers both services
  - Part D- covers Prescription Drugs

# Medicare

## Qualified Medicare Beneficiary (QMB)



- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid- members also receive Medicaid benefits
  - QMB Only- members do not receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim



# Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always **payer of last resort**
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - **Submission to Medicare prior to** Colorado Medical Assistance Program
  - Medicare denials(s) for **six years**



# Third Party Liability

## Third Party Liability



- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

- Charge = \$500
- Program allowable = \$400
- TPL payment = \$300
- Program allowable – TPL payment = LOP

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**\$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**

# 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

Optometrist



**\$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



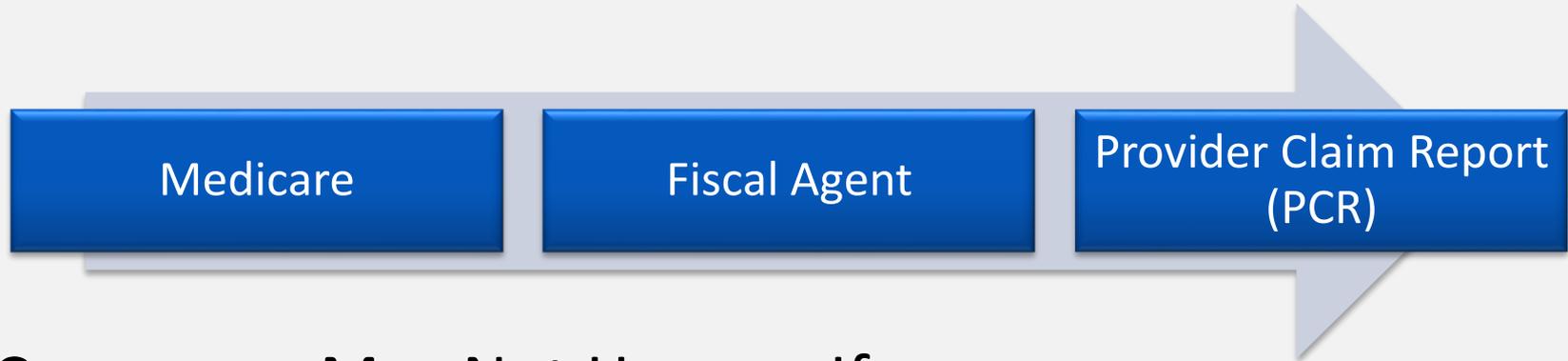
# ICD-10 Implementation Delay

- 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:

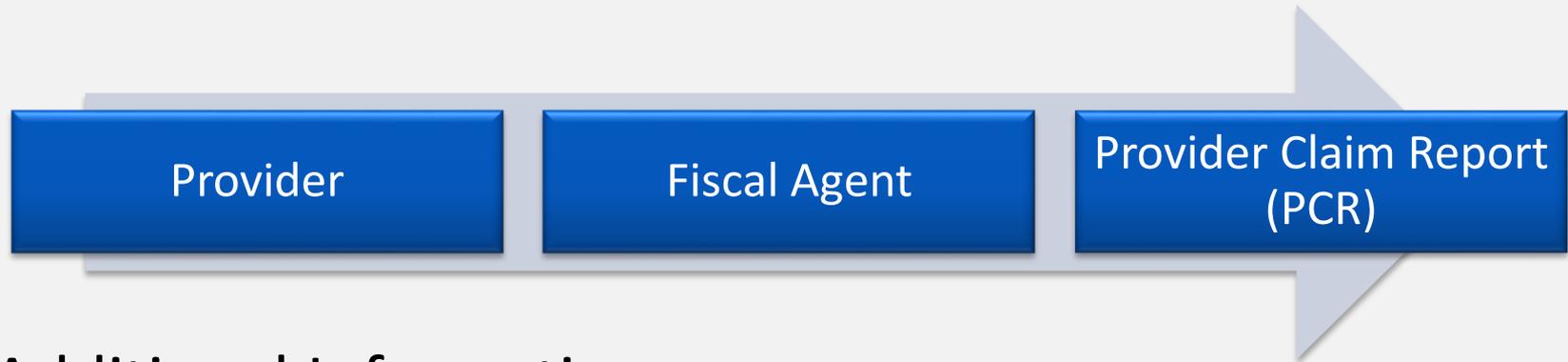


- Crossovers May Not Happen If:

- NPI not linked
- Member is a retired railroad employee
- Member has incorrect an Medicare number on file

# Crossover Claims

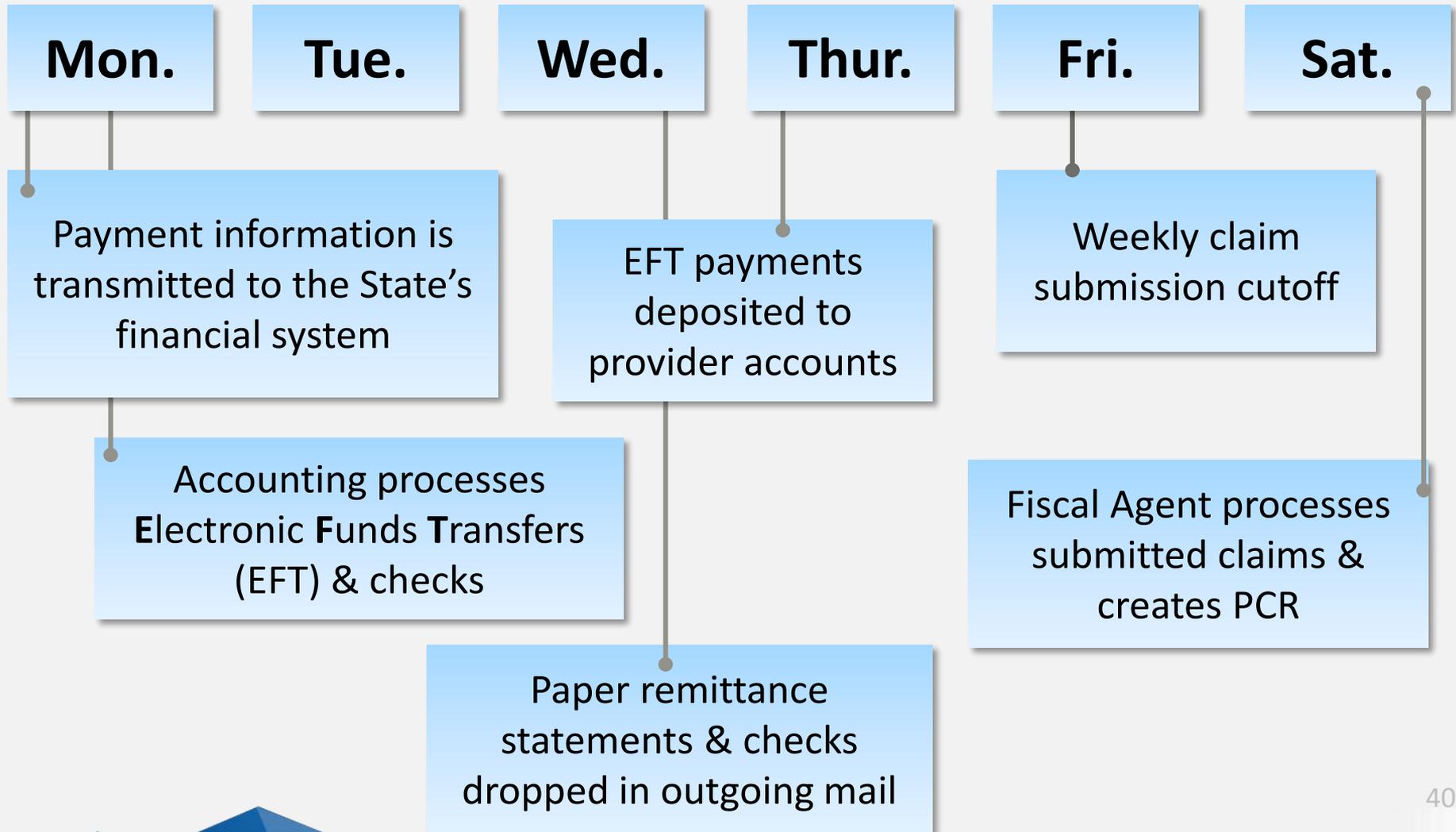
- Provider Submitted Crossover Process:



- Additional Information:

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

# Payment Processing Schedule



# Electronic Funds Transfer (EFT)

- Several Advantages:

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



# PARs Reviewed by ColoradoPAR

- With the exception of Waiver and Nursing Facilities:
  - ColoradoPAR processes all PARs including revisions
  - Visit [coloradopar.com](http://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](http://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



# Vision PARs

- Not required for vision correction (eyeglasses, contact lenses) after surgery
  - Must identify surgery related eyewear with modifier 55
- Prior Authorizations required for
  - Contact Lenses
  - Low Vision Aids
  - Ocular Prosthetics (EPSDT members only)
  - Tint, anti-reflective coating, U-V, oversize, occluder, and progressive lenses



# What Requires a PAR

- To find most current list of procedures that require a PAR:
  - Medicaid Fee Schedule
    - Colorado.gov/Provider Services
    - Look under Medicaid Fee Schedule for most current schedule
  - (Colorado.gov/hcpf) → For Our Providers → Provider Services → Billing Manuals → Reference Appendix M



# PAR Letters

- Xerox generates PAR Letters daily
  - If a billing provider sends a request one a week/month, PAR letter will be generated once a week/month
- Who receives a PAR letter?
  - Billing Providers retrieve directly from the FRS
  - Requesting Provider and Member receives by mail
- Letters are available for 60 days



# Transaction Control Number

## Receipt Method

- 0 = Paper
- 2 = Medicare Crossover
- 3 = Electronic
- 4 = System Generated

## Batch Number

## Document Number

0 14 129 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 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



# Timely Filing Extensions

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  - Commercial insurance has yet to pay/deny
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    - 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



# Vision Services

## Inclusion of services is dependent on:

- Age
- Medical necessity
- Previous eye surgery



## The following services may be included:

- Eyeglasses
- Repairs
- Contact lenses
- Ocular prosthetics
- Vision treatment

# Vision Benefits - 20 and under:

## Examinations



- No Limitations
- \$2.00 co-pay for ages 19 & 20 not enrolled in an MCO

## Eyeglasses



- One or two single or multi-focal clear plastic lenses & one standard frame
- \$0 co-pay

## Contacts



- Must be medically necessary & prior authorized unless provided for vision correction after surgery
- Contact lenses, supplies, & contact lens insurance not a benefit



# Vision Benefits - 21 and over:

## Examinations

- Must be medically necessary
- \$2.00 co-pay

## Eyeglasses

- A benefit only following eye surgery
  - limited to single or multi-focal clear plastic lenses & one standard frame
- \$0 co-pay

## Contacts

- Must be medically necessary & prior authorized unless provided for vision correction after surgery
  - Indicated by using modifier 55
- Contact lenses, supplies, & contact lens insurance not a benefit



# Procedure Coding

- Lens Materials

- Glass, plastic or polycarbonate lenses may be used
  - V2784 must be used for polycarbonate lenses
- Each lens is 1 unit
  - Dispense 2 lenses of same strength
    - bill 1 line with 2 units
  - Dispense 2 lenses of different strengths
    - bill 2 lines with 1 unit



# Procedure Coding (cont.)

- Lens Dispensing
  - Dispensing fee is allowed for each lens
  - Use CPT codes in range 92340-92355
- Partial visit
  - Use code 92015 as partial vision screening for members
    - 20 years of age and younger



# Vision Billing

- To identify surgery-related eyewear
  - Modifier -55
- Deluxe frames
  - Member pays for non-covered costs
    - Non-covered = difference between provider's retail charges for allowable frames and retail for upgraded frames requested
    - Provider must have written agreement from member authorizing the deluxe frames



# CMS 1500



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>															
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LNG) <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (DoD/DoD) (Member ID) (ID#) (ID#) (ID#)</small>				1a. INSURED'S LD. 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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)								
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
8. RESERVED FOR NUCC USE				8. RESERVED FOR NUCC USE		8. RESERVED FOR NUCC USE									
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 <input type="checkbox"/> NO <input type="checkbox"/>			a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)			b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME			10a. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> #yes, complete items 9, 9a, and 9c.									
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.					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 _____ DATE _____					SIGNED _____ DATE _____										
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE QUAL. MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____ 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17c. _____ 17d. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				ICD Ind.		19. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS MODIFIER		D. DIAGNOSIS POINTER		E. \$ CHARGES		F. Q. UNITS G. UNITS H. UNITS I. UNITS		J. RENDERING PROVIDER ID.#	
1				2		3		4		5		6			
25. FEDERAL TAX ID. NUMBER <input type="checkbox"/> SSN <input type="checkbox"/> EIN <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov't assign, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Reserved 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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ( )							
SIGNED _____ DATE _____				a. NPI b.				a. NPI b.							

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION



# 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



16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
MM	DD	YY	MM	DD	YY
FROM			TO		
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
MM	DD	YY	MM	DD	YY
FROM			TO		
20. OUTSIDE LAB?			\$ CHARGES		
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
22. RESUBMISSION CODE			ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER					

## 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 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 TO	TOTAL DENIED	DENIAL REASONS ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	308000000000000003	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

## Recovery

\*\*\*\*\*  
\* ADJUSTMENTS PAID \*  
\*\*\*\*\*

INVOICE --- CLIENT	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 041008 091808	041808 406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1									
Z71 CLIENT, IMA	A000000	40800000000200002	041008 041008 041808	041808 406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1									
NET IMPACT					21.42				

## Repayment

## Net Impact

## Voids

\*\*\*\*\*  
\* ADJUSTMENTS PAID \*  
\*\*\*\*\*

INVOICE - CLIENT	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									
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](mailto:helpdesk.HCG.central.us@cgi.com)

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

# Thank You!

