

Beginning Billing Workshop

DME Supply

Colorado Medicaid
2015



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Policy & Financing



Centers for Medicare & Medicaid Services



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Medicaid

Medicaid/CHP+
Medical Providers



Xerox State Healthcare



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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



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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



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What is an NPI? (cont.)

How to Obtain & Learn Additional Information:

- CMS web page (paper copy)-
 - www.dms.hhs.gov/nationalproidentstand/
- National Plan and Provider Enumeration System (NPPES)-
 - www.nppes.cms.hhs.gov
- Enumerator-
 - 1-800-456-3203
 - 1-800-692-2326 TTY



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NEW! Department Website

The screenshot shows a web browser at the URL <https://www.colorado.gov/hcpf>. The page header includes the Colorado logo and the text "Colorado The Official Web Portal". The main content area features the HCPF logo and the text "COLORADO Department of Health Care Policy & Financing". A navigation menu includes "Home", "For Our Members", "For Our Providers", and "For Our Stakeholders". A callout box labeled "1" points to the URL in the browser's address bar. Another callout box labeled "2" points to the "For Our Providers" menu item. Below the navigation menu, there is a sub-header: "We administer Medicaid, Child Health Plan Plus, and other health care programs for Coloradans who qualify." The main content area is divided into four columns: "Explore Benefits" (with a magnifying glass icon), "Apply Now" (with a checkmark icon), "Find Doctors" (with a group of people icon), and "Get Help" (with an information icon). At the bottom, there are two promotional banners: "Feeling Sick? For medical advice, call the Nurse Line: 800-283-3221" (with a nurse icon) and "Get Covered. Stay Healthy. colorado.gov/health" (with an umbrella icon).



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NEW! Provider Home Page

Find what you need here

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

The screenshot shows the website's header with the Colorado logo and HCPF logo, followed by the text "COLORADO Department of Health Care Policy & Financing". A navigation bar includes links for Home, For Our Members, For Our Providers, For Our Stakeholders, and About Us. The main content area is titled "For Our Providers" and features four columns of information: "Why should you become a provider?" with a cross icon, "How to become a provider (enroll)" with a document icon, "Provider services (training, & more)" with a dollar sign icon, and "What's new? (bulletins, newsletters, updates)" with a radio tower icon. At the bottom, there are three service boxes: "Get Help Dept. Fiscal Agent 1-800-237-0757" with a phone icon, "Get Info FAQs & More" with a question mark icon, and "Find a Doctor Are you a client looking for a doctor?" with a doctor icon.



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Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:

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

Question:

Who needs to enroll?

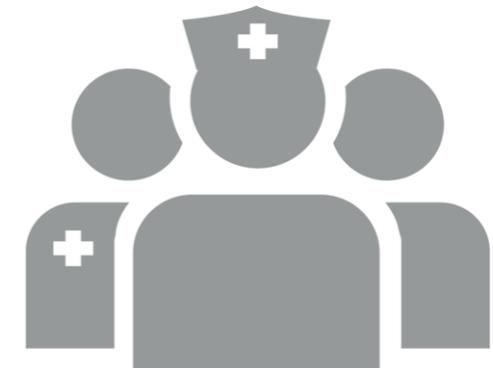
Answer:

Everyone who provides services for Medical Assistance Program members

Attending Versus Billing

Attending 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:



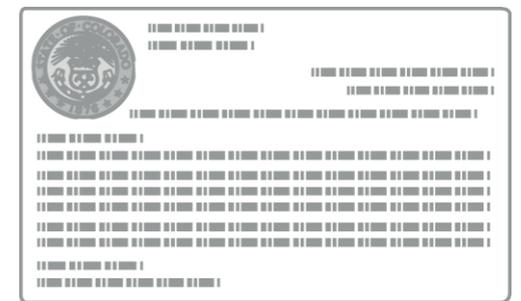
**Colorado Medical
Assistance Web Portal**



**Fax Back
1-800-493-0920**



**CMERS/AVRS
1-800-237-0757**



**Medicaid ID Card
with Switch Vendor**

Eligibility Response Information

Eligibility
Dates

Co-Pay
Information

Third Party
Liability
(TPL)

Prepaid
Health Plan

Medicare

Special
Eligibility

BHO

Guarantee
Number



Eligibility Request Response (271)

[Print](#) [Return To Eligibility Inquiry](#)

Eligibility Request

Provider ID: National Pro
From DOS: Through D
Client Detail
State ID: DOB:
Last Name: First Name

Client Eligibility Details

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

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

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

MHPROV Services

Provider Name:
COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number:
800-804-5008

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/2011

Contact Information for Questions on Res
Provider Relations Number: 800-237-075

Requesting Provider

Provider ID:
Name:

Client Details

Name:
State ID:

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

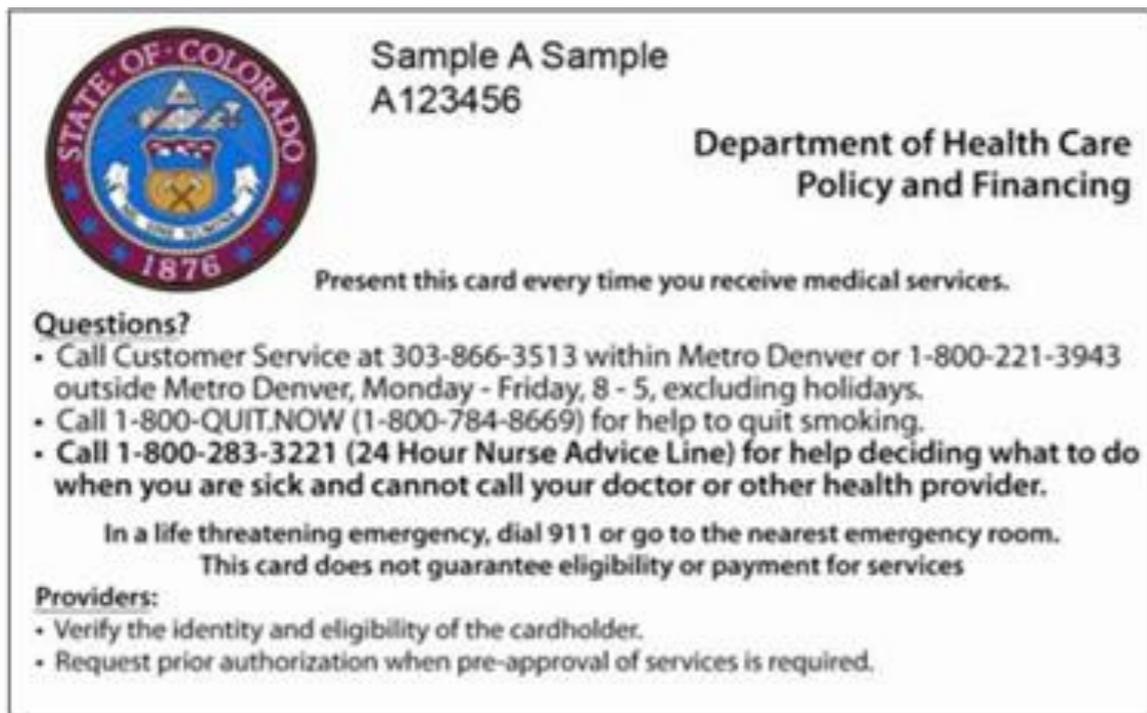
Reminder:

- 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

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



Eligibility Types

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



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



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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



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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

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



Eligibility Types

Presumptive Eligibility (cont.)

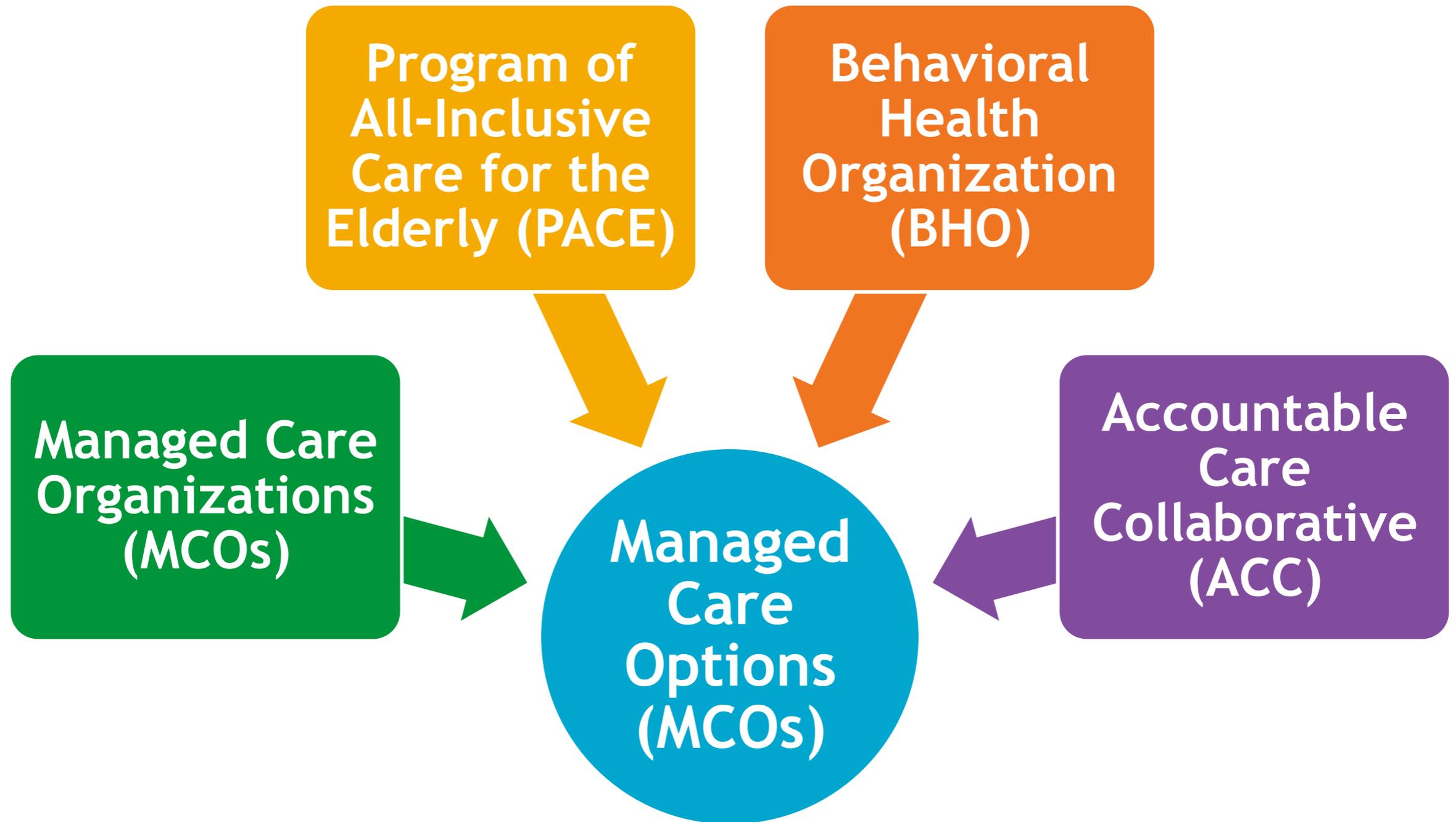
- Verify Medicaid Presumptive Eligibility through:
 - Web Portal
 - Faxback
 - CMERS
 - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
 - Submit to the Fiscal Agent
 - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
 - Colorado Access-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



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Managed Care Options



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



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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



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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



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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



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Medicare

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



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Eligibility

- Regular Medicaid does not cover DME benefits for all eligibility types
 - Emergency Medicaid
 - Coverage for non-citizens
 - Life or limb emergency, including labor and delivery, as determined by qualified provider in qualified place of service
 - No outpatient services
 - CHP+ Presumptive Eligibility
 - Coverage through Colorado Access
 - QMB-Only (without Medicaid)

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

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

$$\begin{array}{r} \$400.00 \\ - \$300.00 \\ = \$100.00 \end{array}$$

Commercial Insurance

- Colorado Medicaid always payer 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



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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



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Specialty Co-Payments

DME / Supply

\$1.00 per date of service



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Billing Overview

**Record
Retention**

**Claim
submission**

**Prior
Authorization
Requests (PARs)**

Timely filing

**Extensions for
timely filing**



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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



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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



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ICD-10 Implementation Delay

ICD-10 Implementation delayed until 10/1/2015

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 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

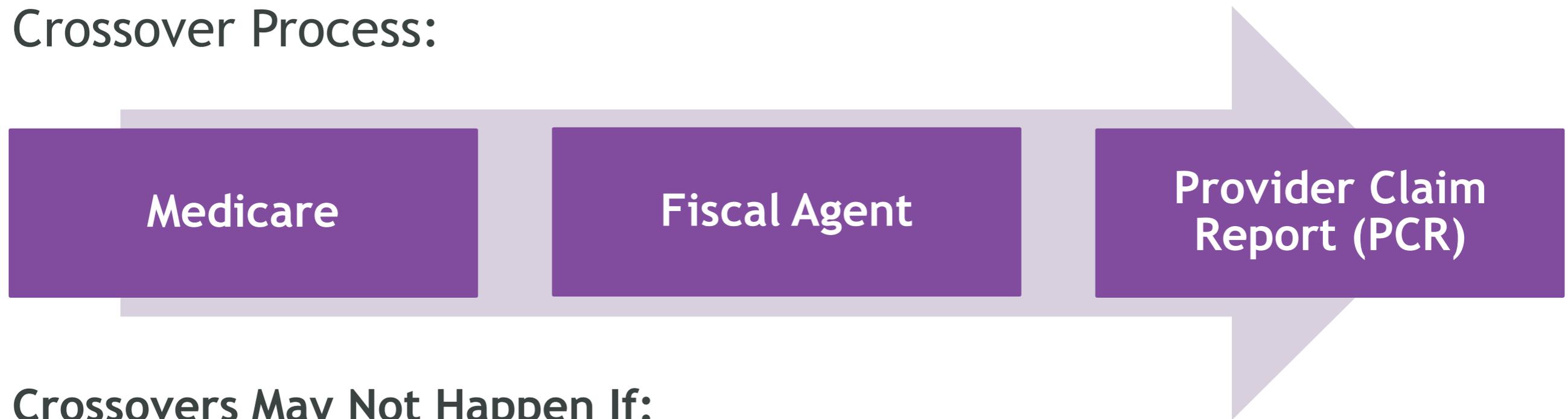
Colorado.gov/hcpf/EDI-Support



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Crossover Claims

Automatic Medicare Crossover Process:



Crossovers May Not Happen If:

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

Crossover Claims

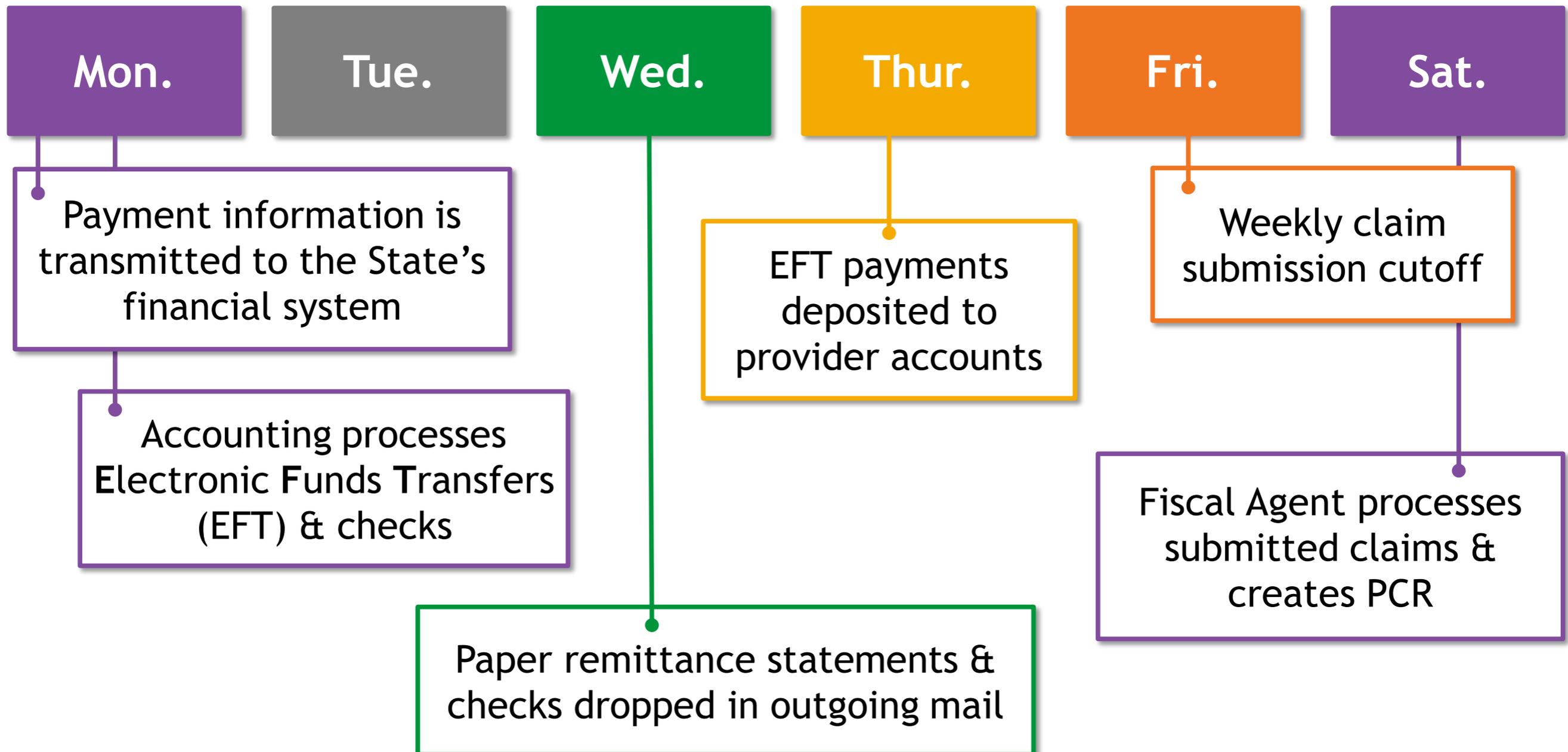
Provider Submitted Crossover Process:



Additional Information:

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

Payment Processing Schedule



Electronic Funds Transfer (EFT)

Advantages

- Free!
- No postal service delays
- Automatic deposits every Friday
- Safest, fastest & easiest way to receive payments
- [Colorado.gov/hcpf/provider-forms](https://colorado.gov/hcpf/provider-forms) → Other Forms

PARs Reviewed by ColoradoPAR

With the exception of Waiver and Nursing Facilities:

- The ColoradoPAR Program 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:

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

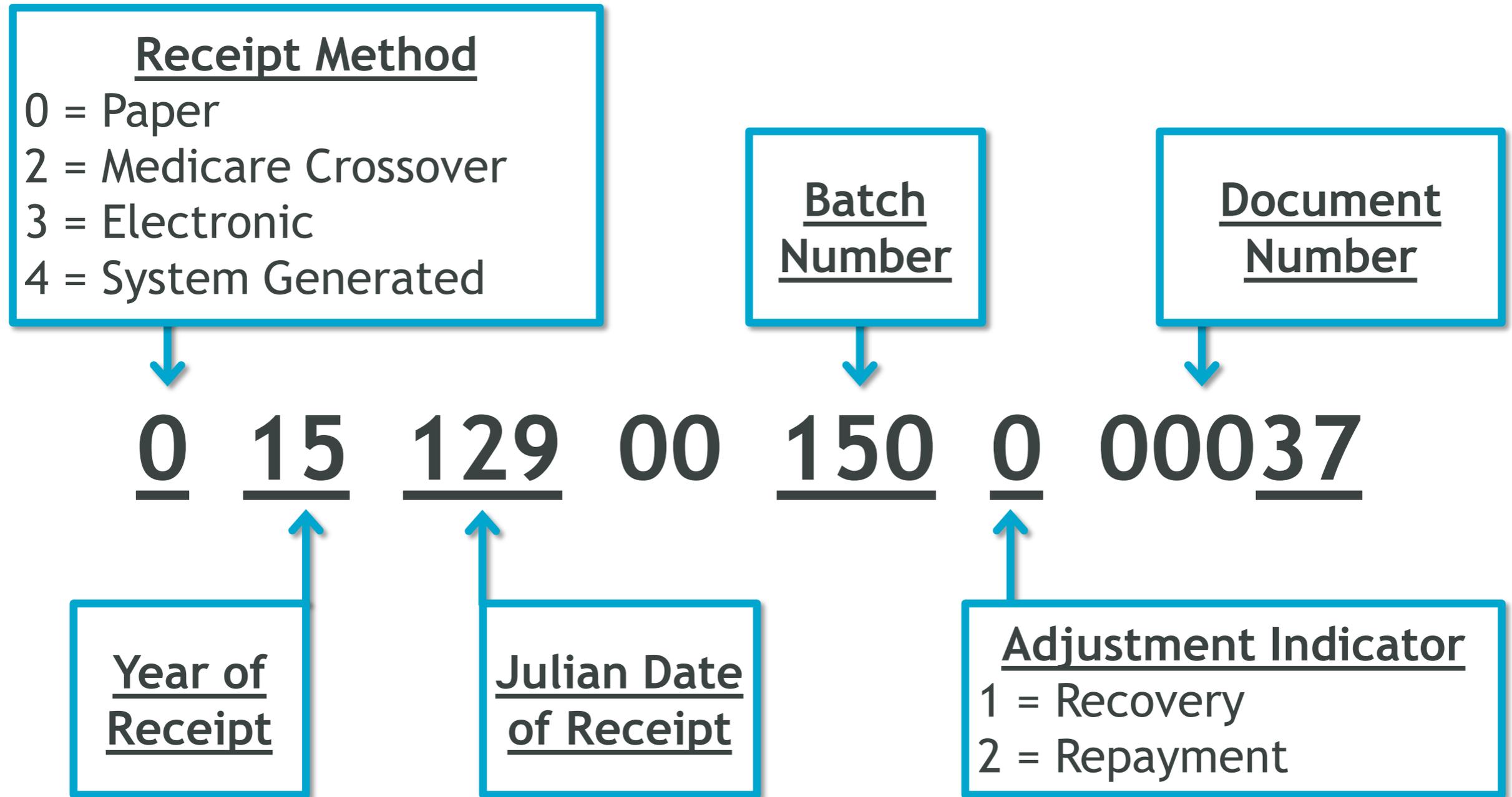
- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is only number accepted when submitting claims
- If a PAR Inquiry is performed and you cannot retrieve the information:
 - contact the ColoradoPAR Program
 - ensure you have the right PAR type
 - e.g. Medical PAR may have been requested but processed as a Supply PAR



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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)



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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 837I transaction
- Keep supporting documentation

Paper Claims

- UB-04- Enter Occurrence Code 53 and the date of the last adverse action



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Timely Filing

Medicare/Medicaid Enrollees

Medicare pays claim

120 days from Medicare
payment date

Medicare denies claim

60 days from Medicare
denial date



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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



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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

What are some of the DME services billed on the CMS 1500?

Wheelchairs

Walkers

Repairs

Disposable
Supplies

Incontinence
Products

Fraud and Abuse

False Claims Act

- Submitting claim for services or items not provided
- Falsifying elements on a claim (e.g. DOS, Units, etc.)
- See CRS 25.5-4-303.5 et seq

Anti-Kickback Statute

- Prohibits exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) referral of federal health care program business
- See 42 U.S.C. 1320a-7b

Stark Law

- Prohibits physicians from referring patients to medical facilities in which physician has a financial interest
- See 42 U.S.C. 1395nn

Fraud and Abuse

- Failure to use proper coding when billing may:
 - Result in claims being denied
 - Place provider in jeopardy of recovery actions and/or state or federal civil sanctions
 - To avoid improper coding, use procedure codes & modifiers as instructed in Provider Bulletins and Provider Manuals

DME Reimbursement Billing: By-Invoice-Services

- Cannot receive more for item than maximum purchase price (MPP) as identified in fee schedule
- For items without MPP:
 - Reimbursement rate = manufacturer's suggested retail price (MSRP) less set percentage
 - Percentage includes DME handling
 - Copies of invoices & documented MSRP shall be submitted with claims



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DME Reimbursement Billing: By-Invoice-Services

- Acceptable MSRP documentation:
 - MSRP, LIST Price, Retail Price. Originals must be maintained in provider's files
 - per Department regulations
 - Providers cannot bill for state sales tax collection



Supplies / Disposables Reimbursement

- For items without maximum purchase price:
 - Reimbursement rate = the actual acquisition invoiced cost
 - Actual acquisition costs are manufacturer's list price for the item, minus any standard trade discount applied to lower the actual cost to provider
 - Does not include any time-sensitive or otherwise conditional discounts available to provider
 - If billing for handling, it should be at percentage of actual acquisition cost of the products



Unrelated Manufacturer

- Only invoices from unrelated manufacturers or wholesale distributors shall be allowed
- Invoices are not allowed from
 - Related owners
 - Related parties
- See rule 10 CCR 2505-10 Section 8.590.7.A



Related Owner

- Individual with 5% or more ownership interest of a manufacturer
- One entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business
- DME supplier has control of or is affiliated with manufacturer

Related Party

- Member of owner's immediate family, including:
 - Spouse
 - Natural, adoptive parent, or step-parent
 - Natural, adoptive child, or stepchild
 - Sibling or stepsibling
 - In-laws
 - Grandparents and grandchildren

Custom Manufacturing

- Invoices for Supplies or DME manufactured by provider must include detailed cost information for
 - Acquisition
 - Material
 - Time and labor

Used Equipment

- Written, signed and dated agreement from the member accepting the equipment
- Members and providers may negotiate trade-in amount on member-owned used equipment
- Medicaid will pay up to 60% of the new cost for used pieces of equipment
 - On PAR or claim, list serial number in “Additional Information” section of the CMS 1500
 - Providers are not required to take trade-ins
- See 10 CCR 2505-10 8.590.7.D & 8.590.7.G



Date of Death

- Following are allowable the month of member's death:
 - Durable medical rental equipment
 - Oxygen
 - Bulk supplies drop-shipped to member's home
- Following date of death, recoveries will be made for:
 - Other services
 - Rental and bulk supplies billed after the month of member's death

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 “Payer of Last Resort” - Provider should bill all other appropriate carriers first

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

Type of Bill

Claim was submitted with an incorrect or invalid type of bill

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

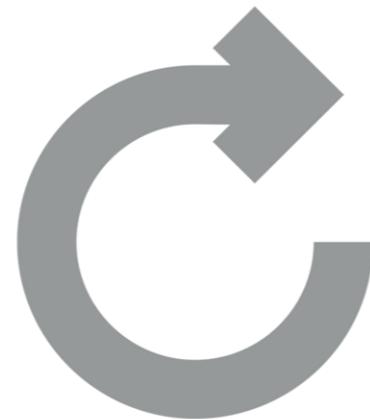
Claim processed & paid by claims processing system

Claims Process - Common Terms



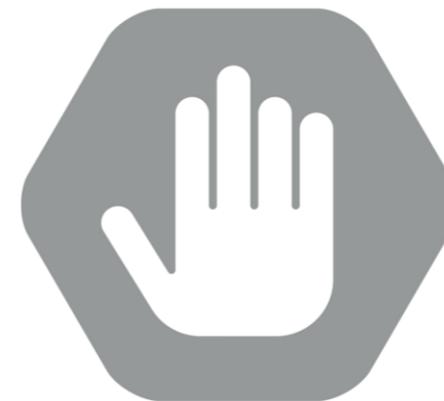
Adjustment

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



Rebill

Re-bill previously denied claim



Suspend

Claim must be manually reviewed before adjudication



Void

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

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 Adjustment Transmittal form
- Be concise & clear

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



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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	04080000000000000001	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	30800000000000000003	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

* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO 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			

Repayment

Net Impact

Voids

* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO 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-			
						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!



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Policy & Financing