

Beginning Billing Workshop DME Supply

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 CO 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/
 - 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

COLORADO

Department of Health Care
Policy & Financing

Home

For Our Members

For Our Providers

For Our Stakeholders

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



NEW! Provider Home Page

Find what you need here



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

The Official Web Portal

Translate

CO HCPF | **COLORADO**
Department of Health Care Policy & Financing

Home For Our Members **For Our Providers** For Our Stakeholders About Us

For Our Providers

- Why should you become a provider?

- How to become a provider (enroll)

- Provider services (training, & more)

- What's new? (bulletins, newsletters, updates)


 **Get Help**
Dept. Fiscal Agent
1-800-237-0757

 **Get Info**
FAQs & More

 **Find a Doctor**
Are you a client looking for a doctor?



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:



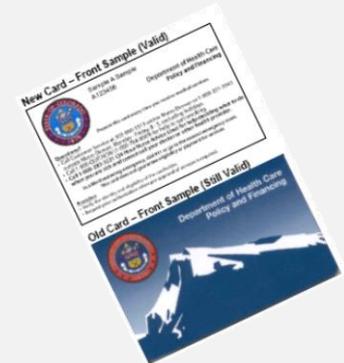
Web Portal



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](#)

Eligibility Request

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

CO MEDICAL ASSISTAN

Response Creation Date & Time: 05/

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

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

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

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

Information appears in sections (Requesting Provider, Member Details, Member Eligibility Details, etc.). Use the scroll bar to the right to view more details.

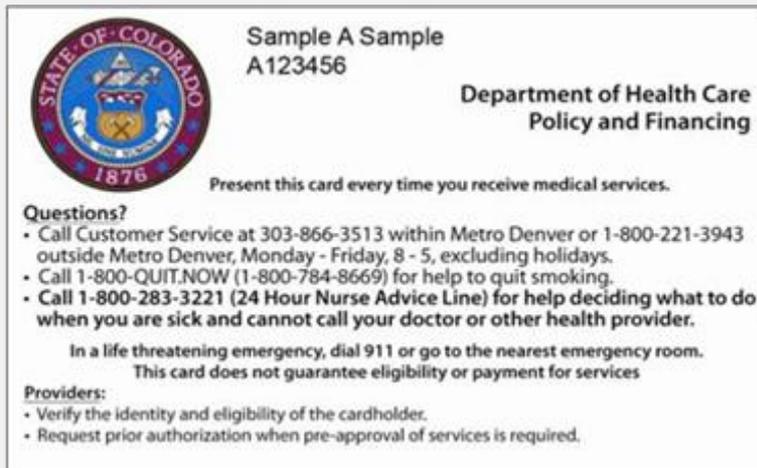
A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

As a 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



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
- 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**



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

Third Party Liability



- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

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

\$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

DME / Supply



\$1.00 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



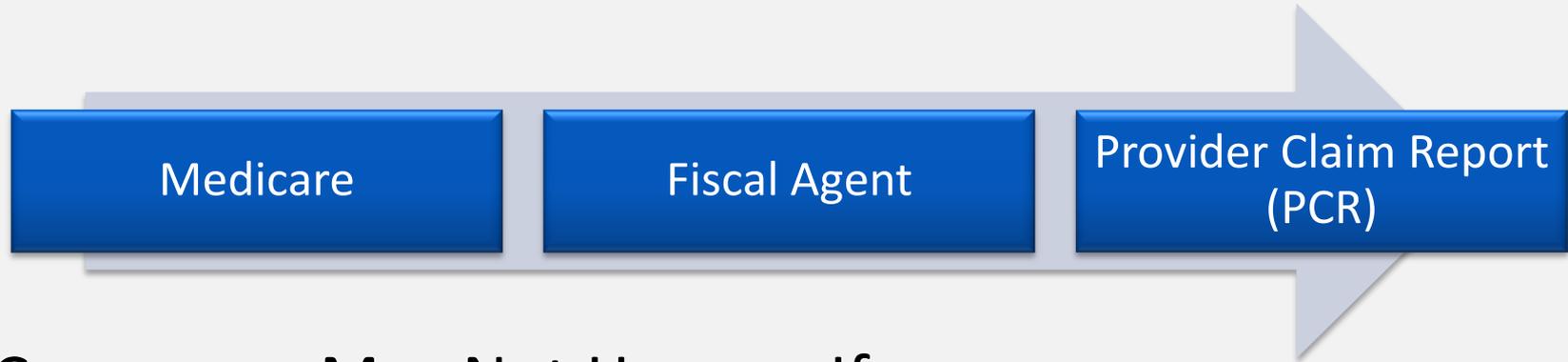
ICD-10 Implementation Delay

- 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:

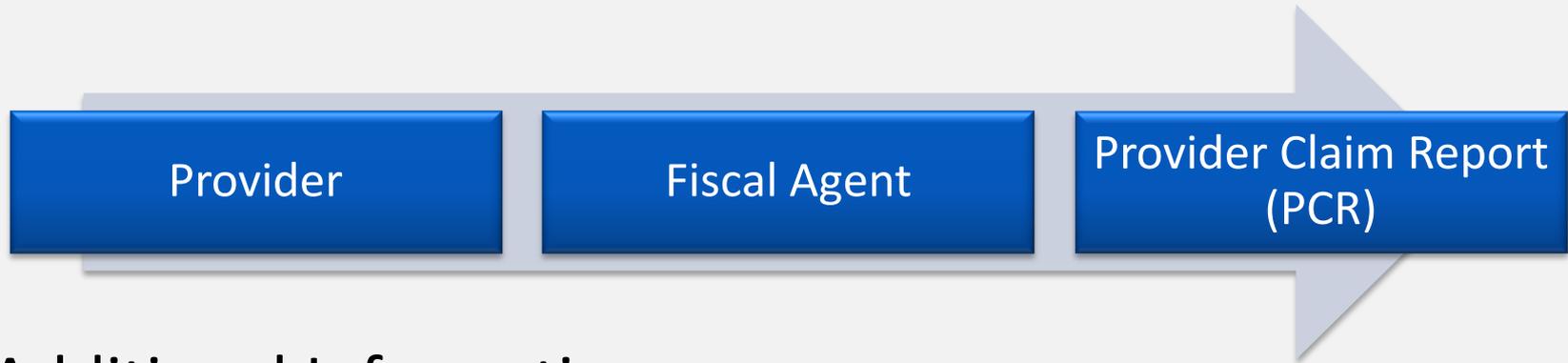


- Crossovers May Not Happen If:

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

Crossover Claims

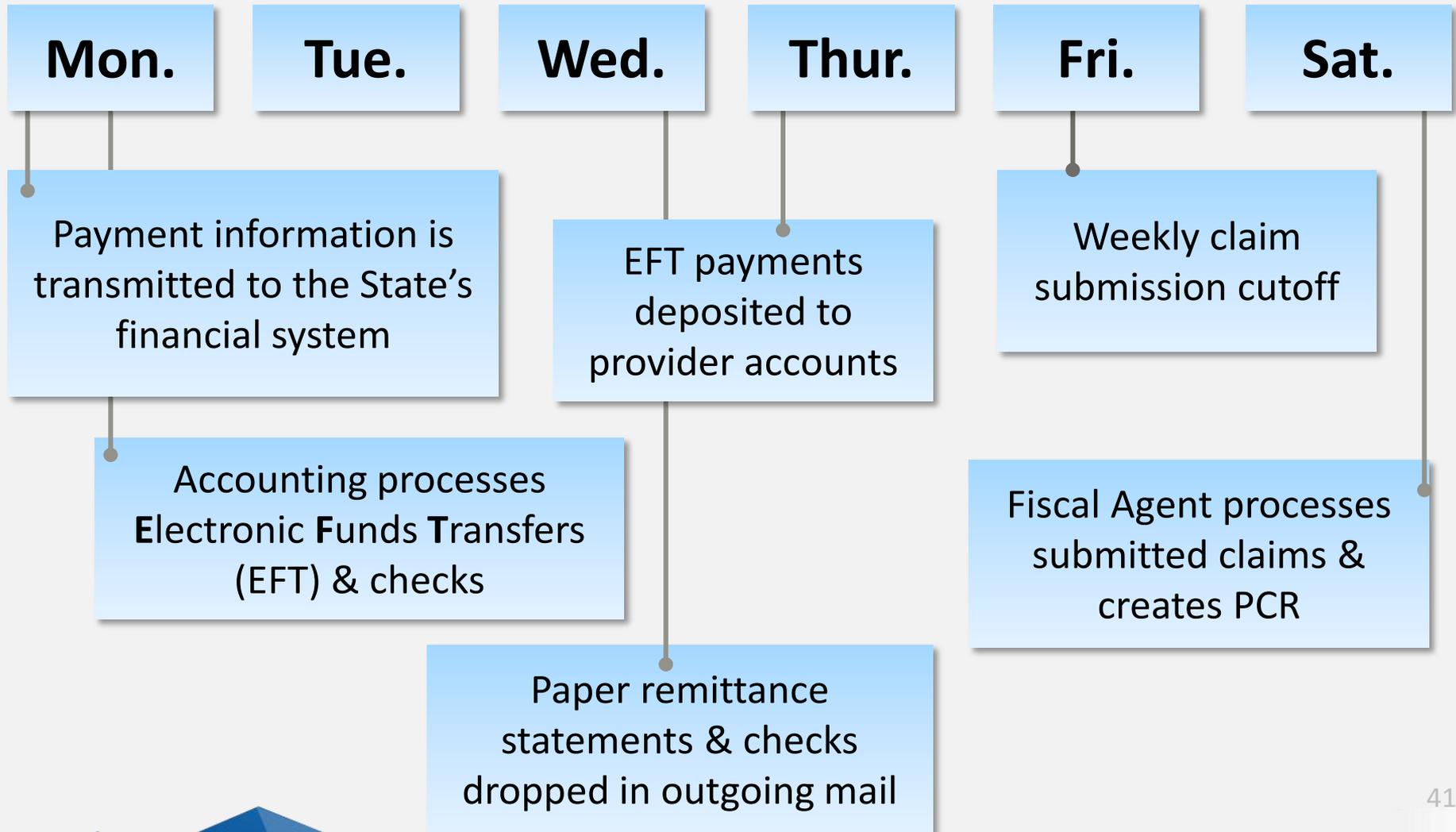
- Provider Submitted Crossover Process:



- 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:
 - 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:

1.888.454.7686

FAX:

1.866.492.3176

Web:

ColoradoPAR.com



Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI ([CWQI](#))
- The ColoradoPAR Program will process PARs submitted by phone for:
 - emergent out-of-state
 - out-of area inpatient stays
 - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints



PAR Letters/Inquiries

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



Transaction Control Number

Receipt Method

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

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
 - CO 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in the Remarks



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



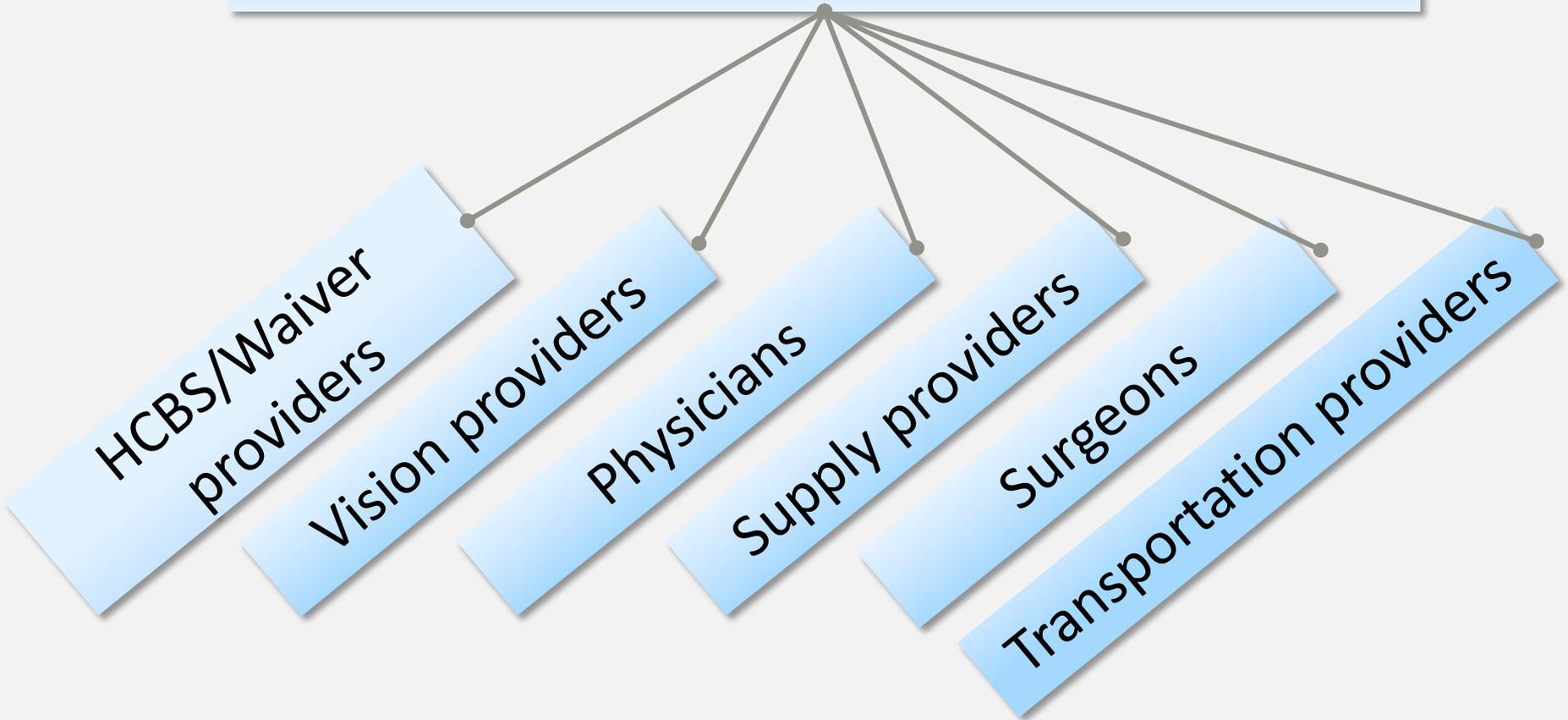
What is the Colorado 1500?

- Colorado specific paper claim form
 - Available in the Provider Services Forms section of the Department's website
 - Print and complete by hand or complete the electronic version online, then print and submit
- Similar to the national CMSa 1500
- The Colorado Medical Assistance Program does not currently accept the CMS 1500
- Any claim submitted on the CMS 1500 will be returned without processing



Colorado 1500

Who completes the Colorado 1500?



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: Fee-for-Service

- Cannot bill Colorado Medicaid more than amount charged to non-Medicaid members
- Providers should submit their Usual and Customary charges



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



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



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



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 “Remarks” section of the CO 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 “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



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

Colorado Medical Assistance Program
PO Box 90
Denver, Colorado 80201-0090



Adjustment Transmittal

Complete a separate Adjustment Transmittal for each claim and include the following:
1) Attach a copy of the replacement claim (when applicable - see directions)
2) A copy of the Provider Claim Report (PCR) showing the most recent payment
3) Medicare TPL - A copy of the Standard Paper Remittance (SPR) (when applicable)
Do not use to rebill denied claims.

Provider Name	Claim Type:
Street Address (Address used to Return To Provider (RTP))	<input type="checkbox"/> Colorado 1500 <input type="checkbox"/> 837P
City, State, Zip Code	<input type="checkbox"/> Pharmacy <input type="checkbox"/> EPSDT
Telephone Number	<input type="checkbox"/> Dental <input type="checkbox"/> 837D
Billing Provider Medicaid ID Number	<input type="checkbox"/> UB-04 <input type="checkbox"/> 837I
Billing Provider National Provider Identifier (NPI)	

ALL FIELDS BELOW MUST BE COMPLETED

Client ID Number	Client Name
Date of Service	Provider Claim Report (PCR) Date

Do not use the Adjustment Transmittal to rebill denied or already voided claims. Adjustment Transmittals are used to adjust paid claims only.
Enter the Transaction Control Number (TCN) below (14 or 17 characters):

Three-digit reason code indicating the reason for the Adjustment

406 claim replacement - Requires a replacement claim to include original claim data plus amended and/or additional services and charges (on the replacement claim, please highlight the amended information). For example, if you are adding a line to the claim, include the original claim information plus the additional line and charges associated. If the original claim had one line, the replacement claim should now show two lines.

412 claim credit (recovery) - Replacement claim not required. This will void the entire claim and produce a take back for the entire amount. Rebill when appropriate.

Date: _____ By (Provider Signature): _____

FISCAL AGENT USE ONLY

Reply (notes) and RTP reason code

Unarchive required Yes No

Form #04336 (REV. 12/10) Page 1

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



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	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 041808		114.24				
NET IMPACT					21.42				

Net Impact

Repayment

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			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!

