

# Dialysis Billing Workshop

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 and the UB-04 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

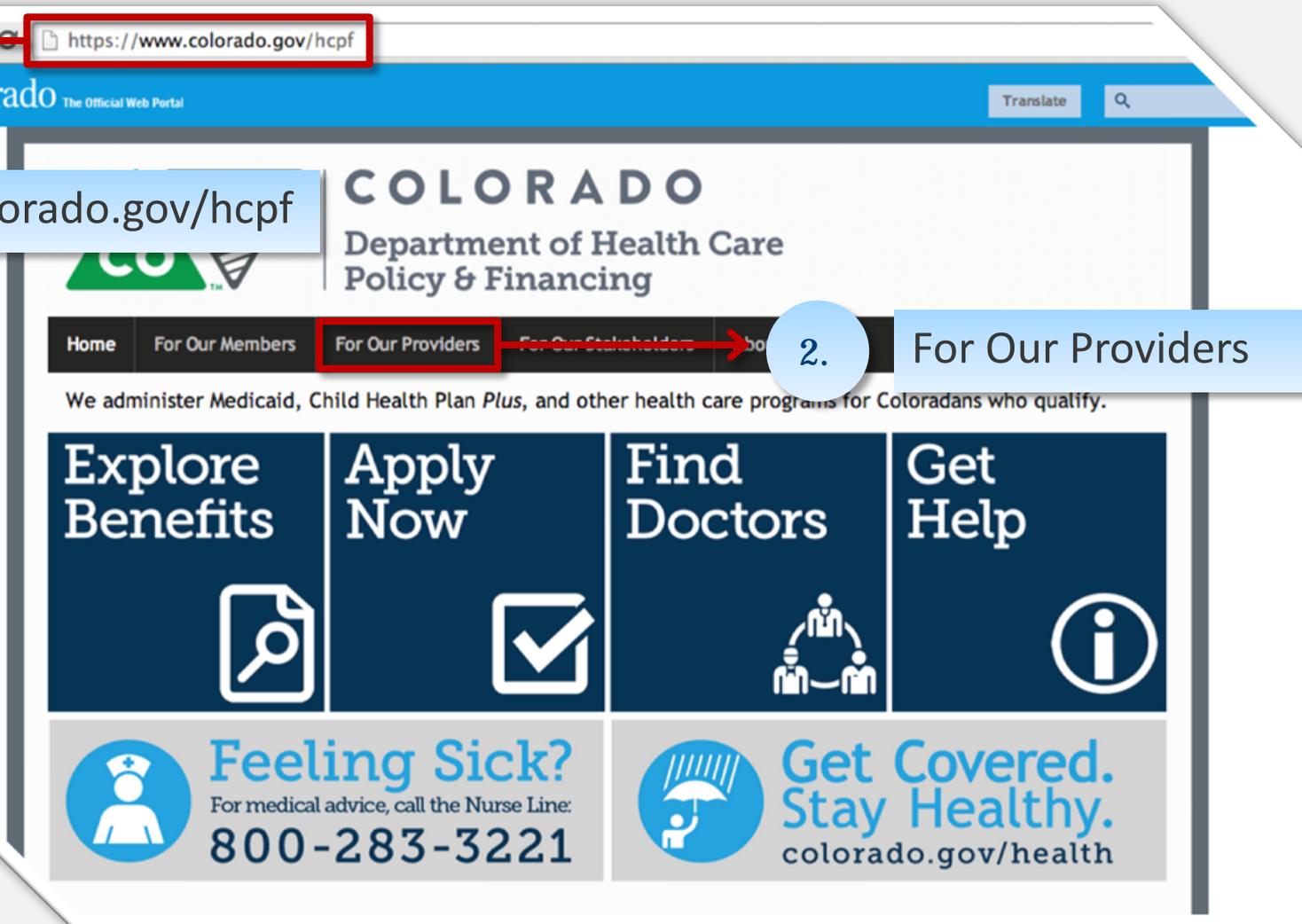


# NEW! Department Website

1.

<https://www.colorado.gov/hcpf>

[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



2.

For Our Providers



# 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 Department of Health Care Policy & Financing logo and name. A navigation bar includes links for Home, For Our Members, For Our Providers (highlighted), For Our Stakeholders, and About Us. The main content area is titled 'For Our Providers' and contains four columns of links with icons: 'Why should you become a provider?' (cross icon), 'How to become a provider (enroll)' (cross on document icon), 'Provider services (training, & more)' (dollar sign icon), and 'What's new? (bulletins, newsletters, updates)' (radio tower icon). Below these are three service boxes: 'Get Help Dept. Fiscal Agent 1-800-237-0757' (person icon), 'Get Info FAQs & More' (question mark icon), and 'Find a Doctor Are you a client looking for a doctor?' (doctor icon).



# 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:



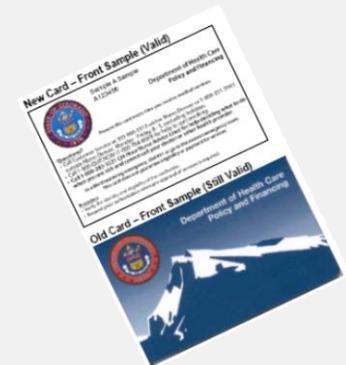
Web Portal



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/

---

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

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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

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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.

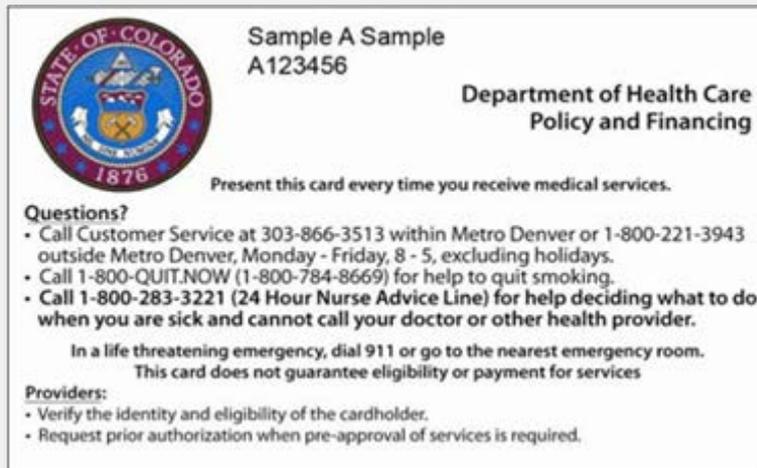
A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

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



# Eligibility Types

## 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**



# 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

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# 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





# 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

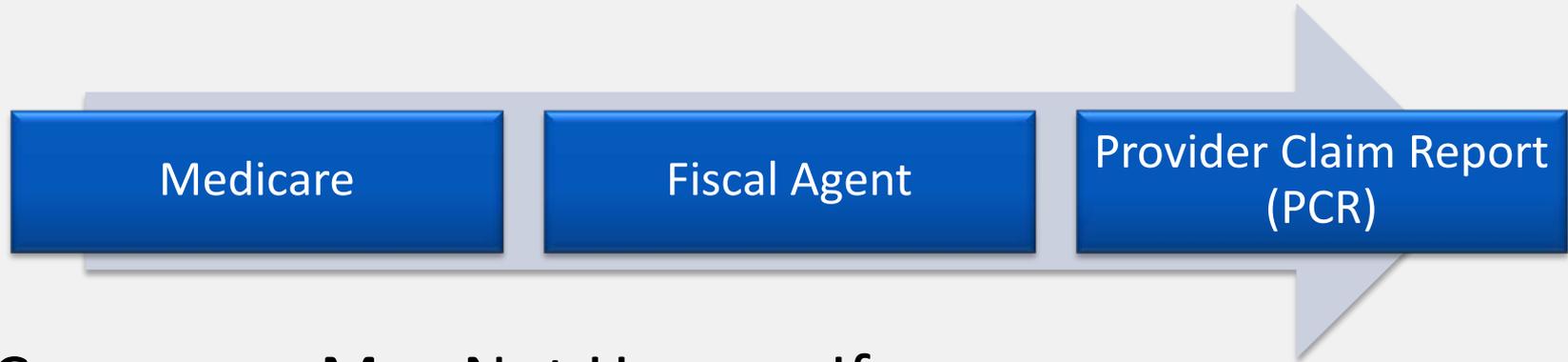
- ICD-10 Implementation delayed until 10/1/2015
  - ICD-9 codes: Claims with Dates of Service (DOS) on or before 9/30/15
  - ICD-10 codes: Claims with DOS 10/1/2015 or after
  - Claims submitted with both ICD-9 and ICD-10 codes will be rejected





# 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:

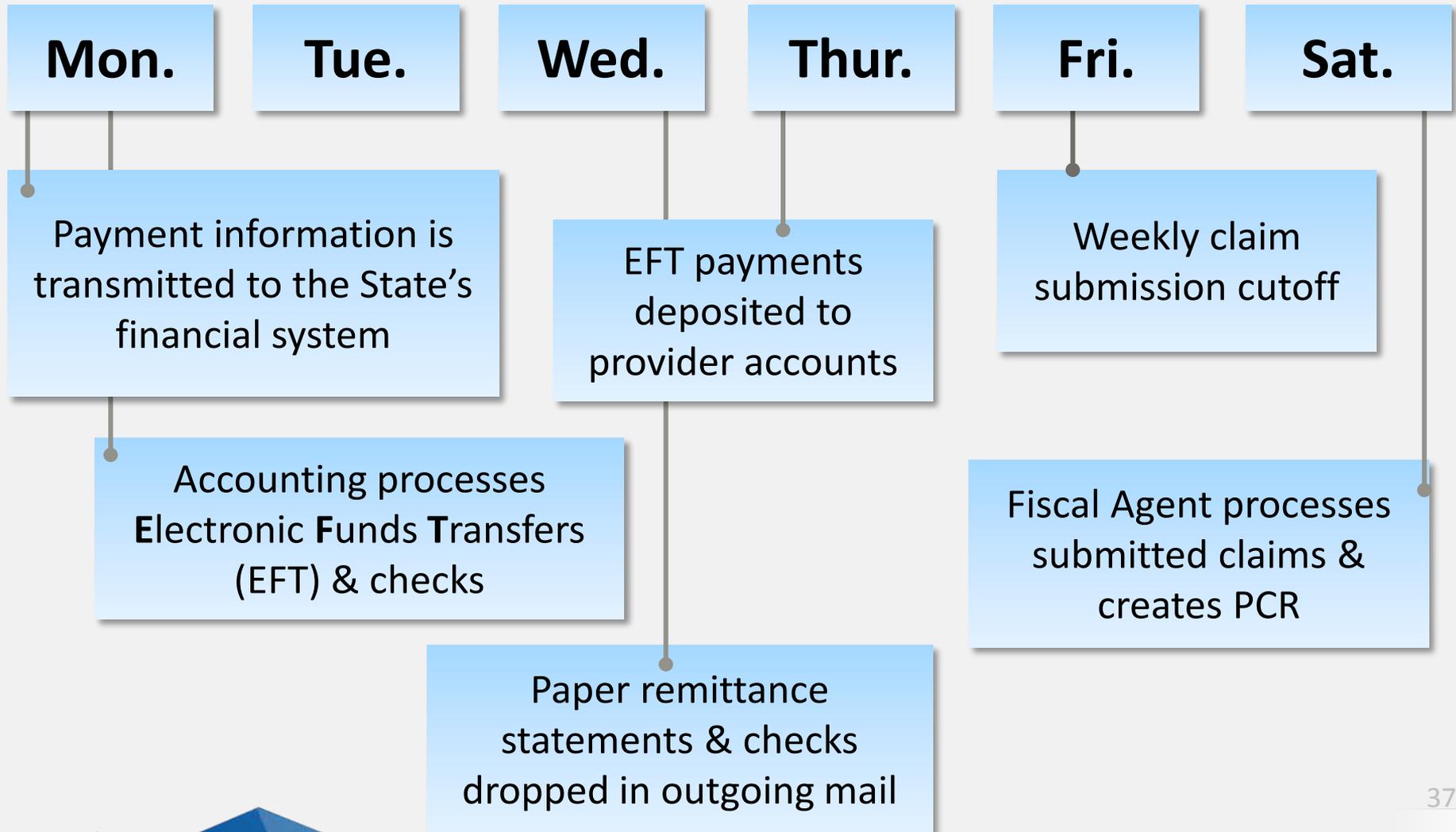


- Additional Information:

- 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



# 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 or 837I 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
  - UB-04- Enter Occurrence Code 53 and the date of the last adverse action





# 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



# Dialysis

- The Colorado Medical Assistance Program provides dialysis benefits to eligible members in:
  - Inpatient settings
  - Outpatient settings
  - State-approved independent dialysis treatment centers
  - Home settings



# Inpatient Benefits

- Hospitalization is required for
  - Acute medical condition requiring hemodialysis treatment
  - Covered medical condition when member receives regular maintenance outpatient dialysis
  - Placement or repair of vascular access
- Payment
  - Inpatient hemodialysis is included as part of All Patient Refined Diagnosis Related Group (APR-DRG)
  - Hospital admissions solely for hemodialysis are not a covered benefit



# Outpatient Hospital State-Approved Dialysis Treatment Center

- **Outpatient in-facility hemodialysis is a benefit when:**
  - Eligible member is not a proper candidate for self-treatment in home
  - Home environment of eligible member contraindicates self-treatment
  - Eligible member is awaiting a kidney transplant



# Dialysis Treatment Centers

- Dialysis Treatment Center is:
  - An Independent facility
  - Department of a licensed hospital
  - Facility approved to provide outpatient dialysis services and /or training for home or self dialysis



# Self or Home Dialysis

- All eligible members approved for self or home dialysis treatment must be:
  - Trained in use of dialysis equipment
  - Training must be provided by qualified personnel from either:
    - Hospital with separate dialysis unit
    - Qualified personnel from independent dialysis treatment center



# Home Dialysis

- Participating hospital or home dialysis treatment center:
  - Responsible for equipment and necessary fixtures
  - Must provide and install quality dialysis equipment
  - Must provide any necessary member training
  - Must provide routine medical surveillance of member's adjustment to self-treatment



# Independent and Outpatient Reminders

Routine laboratory services



Dialysis service reimbursement

Non-routine drugs & drugs dispensed outside the facility



Reimbursed to dispensing pharmacy

Charges for routine drugs EKG's & x-rays



Considered part of dialysis treatment

Blood, including storage & processing



Not reimbursable independent of dialysis service

Physician's charges for EKG or x-ray services



Must be billed by the physician



# Dialysis Revenue Codes

## Outpatient or home revenue codes:

082X (Hemodialysis)

083X (Peritoneal)

084X (CAPD)

085X (CCPD)

088Z (Misc. Dialysis)

## Where X represents the following:

0 - General Classification

1 - Composite or other rate

2 - Home Supplies

3 - Home Equipment

4 - Maintenance

5 - Support Services

9 - Other Dialysis

## Where Z represents the following:

0 - General Classification

1 - Ultrafiltration

2 - Home Dialysis Aid Visit

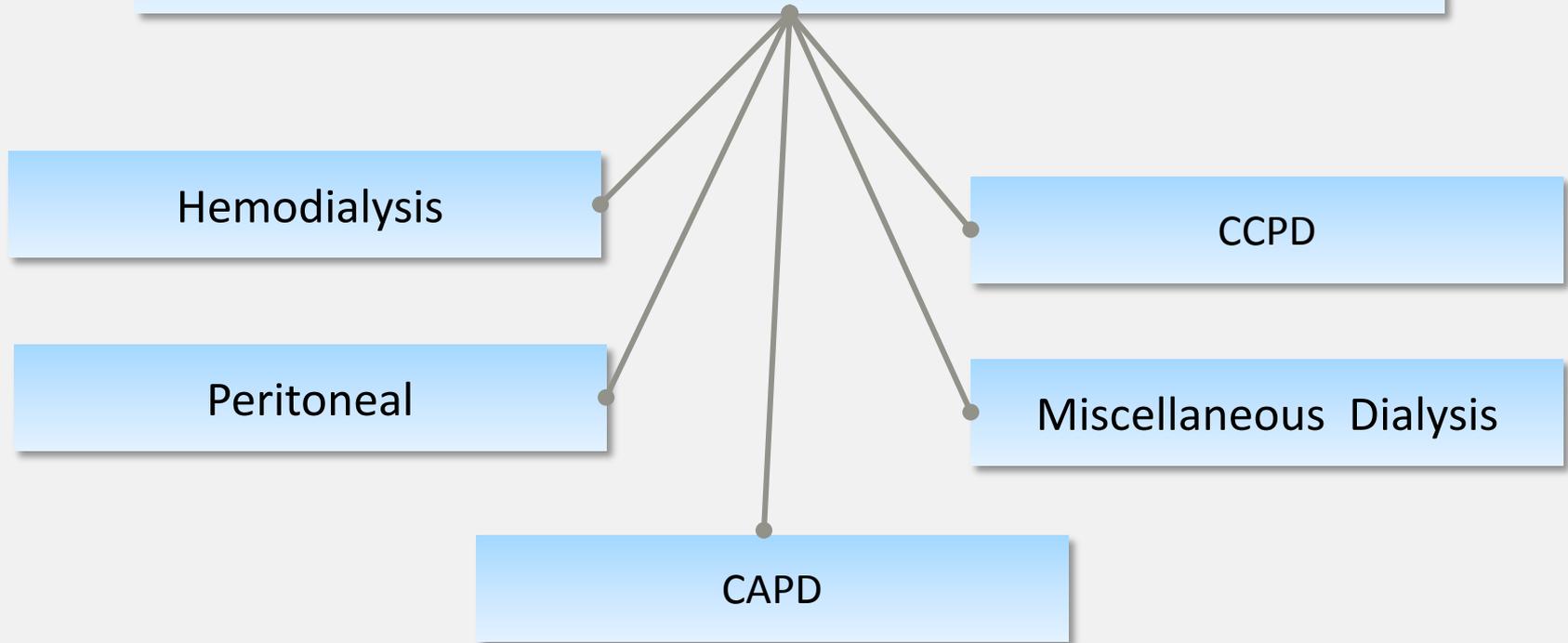
9 - Other Misc. Dialysis





# UB-04

**What Dialysis services are billed on the UB-04?**



# UB-04

- **Dialysis** paper claims must be submitted on UB-04 claim form or as an 837I transaction
- UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs
- Where can a Colorado Medical Assistance provider get the UB-04?
  - Available through most office supply store
  - Sometimes provided by payers

The image shows a sample UB-04 institutional claim form. The form is divided into several sections:
 

- Header:** Includes fields for patient name, address, and admission information (date, type, status).
- Condition Codes:** A grid for reporting condition codes.
- Occurrence Codes:** A grid for reporting occurrence codes.
- Value Codes:** A grid for reporting value codes.
- Description:** A large grid for reporting procedure codes and descriptions.
- Summary:** Includes fields for total charges, net amount, and other summary data.
- Payer Information:** Fields for health plan ID, group name, and insurance group.
- Authorization:** Fields for treatment authorization codes and document numbers.
- Remarks:** A section for additional notes.

 A large, diagonal watermark reading "Sample" is overlaid on the form. At the bottom, there is a logo for NUBC (National Uniform Billing Committee) and a note about certifications on the reverse side.



# UB-04 Certification



**Colorado Medical Assistance Program**

**Institutional Provider Certification**

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

UB-04 certification must be completed and attached to all claims submitted on the paper UB-04

Print a copy of the certification at:  
[colorado.gov/hcpf/provider-forms](http://colorado.gov/hcpf/provider-forms)



# UB-04 Tips

Do

- Submit multiple-page claims electronically

Do not

- Submit “continuous” claims
- Add more lines on the form
  - Each claim form has set number of available billing lines
  - Billing lines in excess of designated number are **not processed or acknowledged**



# 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







# 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	0408000000000000001	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	3080000000000000003	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	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-	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				

## Repayment

## Net Impact

## Voids

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

INVOICE - CLIENT	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-	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](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!

