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 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/nationalproldentstand/
  ➤ National Plan and Provider Enumeration System (NPPES)-
    ▪ www.nppes.cms.hhs.gov
  ➤ Enumerator-
    ▪ 1-800-456-3203
    ▪ 1-800-692-2326 TTY
NEW! Department Website

1. www.colorado.gov/hcpf

2. For Our Providers

Department Website

www.colorado.gov/hcpf

For Our Providers

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

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

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
  1-800-493-0920

  Fax Back
  1-800-237-0757

  Medicaid ID Card
  with Switch Vendor

  CMERS/AVRS
Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number
Eligibility Request Response (271)

Information appears in sections:
- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use 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 client 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)
  - Client health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Client may not receive medical identification care before services are rendered
- Client must submit statement to county case worker
- County enrolls client 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**
  - Client 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

- 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 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
Home Health Medicare-Medicaid Enrollees

• If Medicare reimbursement for services are doubtful:
  ➤ Give Medicare-Medicaid Enrollees Advance Beneficiary Notice (ABN)
    ▪ Notice must be in CMS required format
    ▪ Reason Medicare is expected not to pay must be specified and detailed
  ➤ Instruct members to select third checkbox (“Option 3”) indicating Medicare will be billed unless client chooses to self pay or not receive care
    ▪ Member may then select option to not bill Medicare or any other insurance
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

- Colorado Medicaid always payor of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill client 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:

  Medicare  Fiscal Agent  Provider Claim Report (PCR)

• 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:

  - Provider
  - Fiscal Agent
  - Provider Claim Report (PCR)

• 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

**Mon.**
- Payment information is transmitted to the State’s financial system

**Tue.**
- Accounting processes Electronic Funds Transfers (EFT) & checks

**Wed.**
- Paper remittance statements & checks dropped in outgoing mail

**Thur.**
- EFT payments deposited to provider accounts

**Fri.**
- Weekly claim submission cutoff

**Sat.**
- Fiscal Agent processes submitted claims & creates PCR
Electronic Funds Transfer (EFT)

• Several Advantages:
  ➤ Free!
  ➤ No postal service delays
  ➤ Automatic deposits every Thursday
  ➤ 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 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 Colorado PAR Program
  ➢ ensure you have the right PAR type
  ➢ e.g. Medical PAR may have been requested but processed as a Supply PAR
# Adult Long Term Home Health PAR

## STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

### Medical Assistance Program Prior Authorization

#### Adult Long Term Home Health

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tr>
<td>1. CLIENT NAME</td>
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<tr>
<td>2. CLIENT ID</td>
<td></td>
</tr>
<tr>
<td>3. BIRTHDATE</td>
<td></td>
</tr>
<tr>
<td>4. HCRS ELIGIBLE</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>5. REQUESTING PROVIDER #</td>
<td></td>
</tr>
<tr>
<td>6. REQUESTING AGENCY</td>
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<td>7. CASE MANAGEMENT AGENCY #</td>
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<td>8. DATES COVERED</td>
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### STATEMENT OF REQUESTED SERVICES

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### CASE MANAGER USE

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<td>DATE</td>
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### CASE MANAGER SIGNATURE

**DO NOT WRITE BELOW - AUTHORIZING AGENCY USE ONLY**

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<th>Field</th>
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<td>DENIED DATE</td>
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<tr>
<td>28.</td>
<td>DEPARTMENT APPROVAL SIGNATURE</td>
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</table>
Long Term Home Health PAR

Community Center Board
Adult w/ DD

- Supported Living Services (SLS)
- Developmentally Disabled (DD)
- Children’s Extensive Support (CES)
- Day Habilitation Services and Support (DHSS)
<table>
<thead>
<tr>
<th>Elderly Blind and Disabled (EBD)</th>
<th>Children's Home Community Based Services (CHCBS)</th>
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</thead>
<tbody>
<tr>
<td>Community Mental Health Services (CMHS)</td>
<td>Children With Autism (CWA)</td>
</tr>
<tr>
<td>Brain Injury (BI)</td>
<td>Children with Life Limiting Illness (CLLI)</td>
</tr>
<tr>
<td>Spinal Cord Injury (SCI)</td>
<td></td>
</tr>
</tbody>
</table>
Transaction Control Number

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

**Year of Receipt**
- 00 = 2014
- 129 = 2015

**Julian Date of Receipt**
- 00 = 14 June
- 150 = 00

**Batch Number**
- 0

**Document Number**
- 000037

**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 837I transaction
  ➢ Keep supporting documentation

• Paper Claims
  ➢ 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 client 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 client
Extensions – Backdated Eligibility

• 120 days from date county enters eligibility into system
• Report by obtaining State-authorized letter identifying:
  ➤ County technician
  ➤ Client name
  ➤ Delayed or backdated
  ➤ Date eligibility was updated
What Services are billed on the UB-04?

- Uncomplicated Nursing Visit
- CNA Services
UB-04

- 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 stores
  - Sometimes provided by payers
UB-04 Certification

**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 attachment to the UB-04 claim form and is required per 42 C.F.R. 441.11 (a)(3)-2 to be attached to paper claims submitted on the UB-04.

Print a copy of the certification at: colorado.gov/hcpf/provider-forms

UB-04 certification must be completed & attached to all claims submitted on the paper UB-04
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**
Use Value Codes to indicate -

Patient Liability (Patient Payment)
- Value Code 31

Covered Days
- Value Code 80

Non-Covered Days
- Value Code 81
**UB-04 Coding Reminders**

**Statement Covers Period** –
“From” and “Through” dates must be within
same calendar month

<table>
<thead>
<tr>
<th>Statement Covers Period From</th>
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<tbody>
<tr>
<td>3/15/14</td>
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<td>4/1/14</td>
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</tr>
<tr>
<td>3/15/14</td>
<td>4/15/14</td>
</tr>
</tbody>
</table>
Acute Home Health

When client transfers from one home health provider to another, new provider must contact previous provider to learn:

- If acute services were billed
- First & last date of service of most current acute episode
  - This information allows provider to perform and bill acute services according to 60-day rule
Acute episode:

Does not mean 60 days of services

 Starts on first date of service billed & continues for:
  - 60 calendar days
  - or until condition stabilizes or resolves

 Hospitalizations or discharges do not restart episode

 Acute episode may start on Julian date 001 & may last through Julian date 060
  - Next episode cannot start until Julian date 071 (10 calendar days)
  - Must be new or change in condition

 When client needs more than 60 calendar days of care:

 ➤ provider must complete Long-Term Home Health (LTHH) prior authorization request near end of 60 day acute period
Long Term Home Health

Submit claims for LTHH & Acute HH revenue codes on separate claims

- If LTHH and Acute HH services are submitted on same claim (or same dates of service) claim will deny
- Processing system counts denied services as part of an acute 10-day break period

Dates on CMS 485 must include PAR start-of-care dates
Common Home Health Denial Reasons

- Prior Authorization / Service date conflict
- EPSDT PDN Condition Code is missing or invalid
- LTHH and Acute HH revenue codes on same claims
- HH LTC / Acute care conflict
- If client in Managed Care Organization (MCO), bill Acute HH to the MCO
- LTC HH is over daily limit
- Acute and Long Term Care billed for same date of service
- Total Charge conflict
Claims Process - Common Terms

Accept

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

Denied

Claim processed & denied by claims processing system

Paid

Claim processed & paid by claims processing system
Claims Process - Common Terms

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

**Void**
- Voiding a claim (wait 48 hours to rebill)

**Rebill**
- Re-billing previously denied claim
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
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

<table>
<thead>
<tr>
<th>PROVIDER REPORTING UNIT</th>
<th>TRANSACTION</th>
<th>DATES OF SERVIC</th>
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<tr>
<td></td>
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<td>TOTAL ALLOWED</td>
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<td>COPAY AMT OTH</td>
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<tr>
<td></td>
<td></td>
<td>CLM PMT</td>
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<td>15 CLIENT, IMA</td>
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#### Denied

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**Following is a description of the denial reason (EXC) codes that appear above:**

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

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<thead>
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<th>CLIENT</th>
<th>NAME</th>
<th>STATE ID</th>
<th>TRANSACTION</th>
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### Recovery

- **Repayment:**
  - Net Impact: 21.42

### Voids

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<th>ALLOWED CHARGES</th>
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### Net Impact

- **Net Impact:** 21.42
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!