

Billing Workshop Home Health

Colorado Medicaid
2015





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 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/
 - 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

The image shows a screenshot of the Colorado Department of Health Care Policy & Financing website. Callout 1 points to the browser address bar containing the URL <https://www.colorado.gov/hcpf>. Callout 2 points to the 'For Our Providers' link in the navigation menu. The website header includes the Colorado logo and the text 'Colorado The Official Web Portal'. The main content area features the department name and a navigation menu with options: Home, For Our Members, For Our Providers, and For Our Stakeholders. 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).



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. Below these are three service boxes: 'Get Help Dept. Fiscal Agent 1-800-237-0757', 'Get Info FAQs & More', and '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

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:



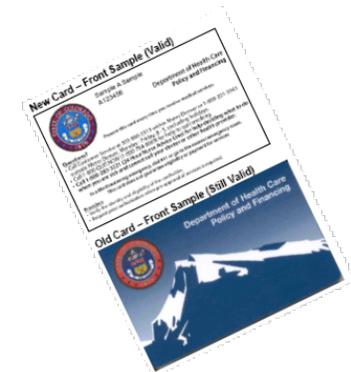
Web Portal



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:
From DOS:
Client Detail
State ID:
Last Name:

Nation:
Throu:
D:
First

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

CO MEDICAL ASSISTANT
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:

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE
Eligibility Benefit Date:
04/06/2011 - 04/06/2011
Messages:

MHPROV Services
Provider Name:
COLORADO HEALTH PARTNERSHIPS

Provider Contact Phone Number:
800-804-5008

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

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**



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

Third Party Liability



- Colorado Medicaid pays Lower of Pricing (LOP)

- Example:

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

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



Commercial Insurance

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



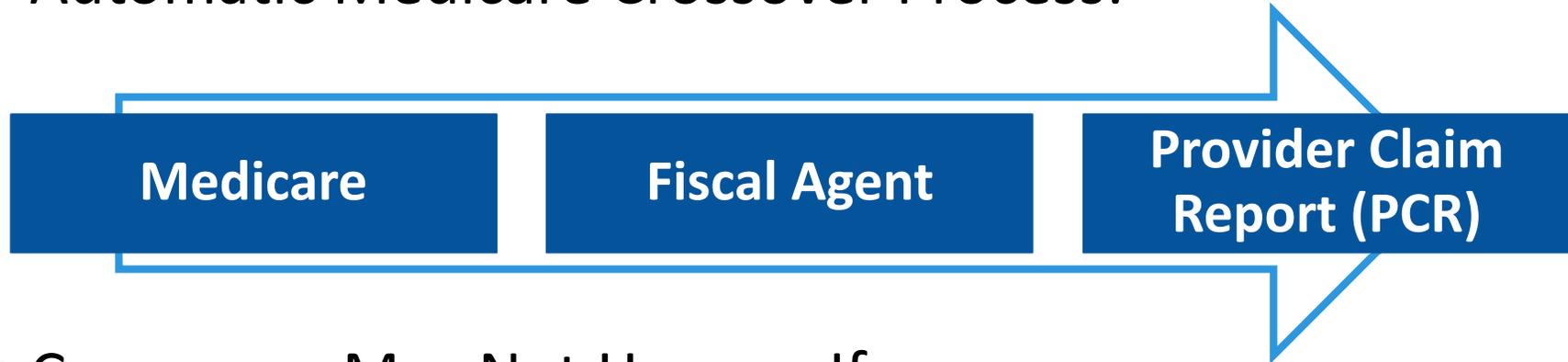
ICD-10 Implementation Delay

- 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:

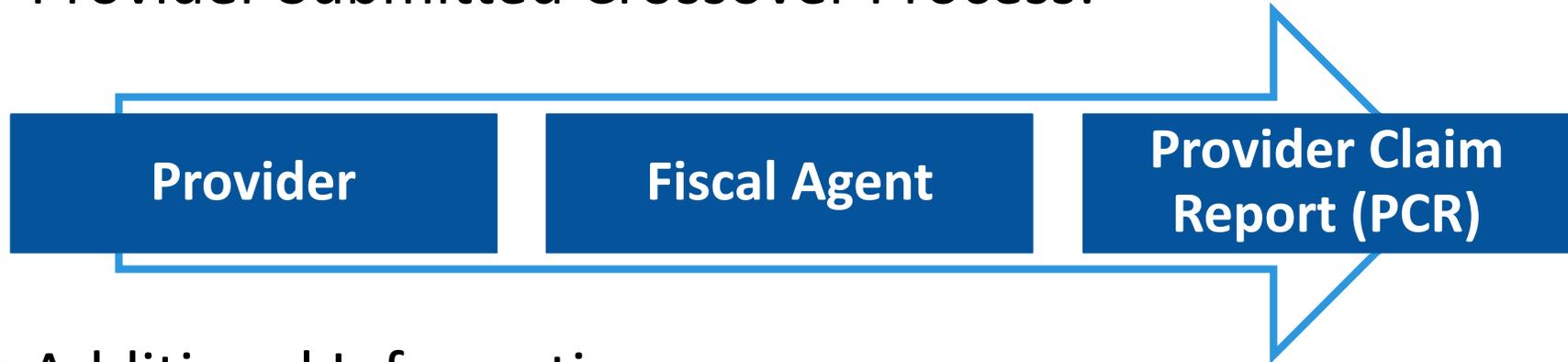


- Crossovers May Not Happen If:
 - NPI not linked
 - Member is a retired railroad employee
 - Member has incorrect Medicare number on file



Crossover Claims

- Provider Submitted Crossover Process:

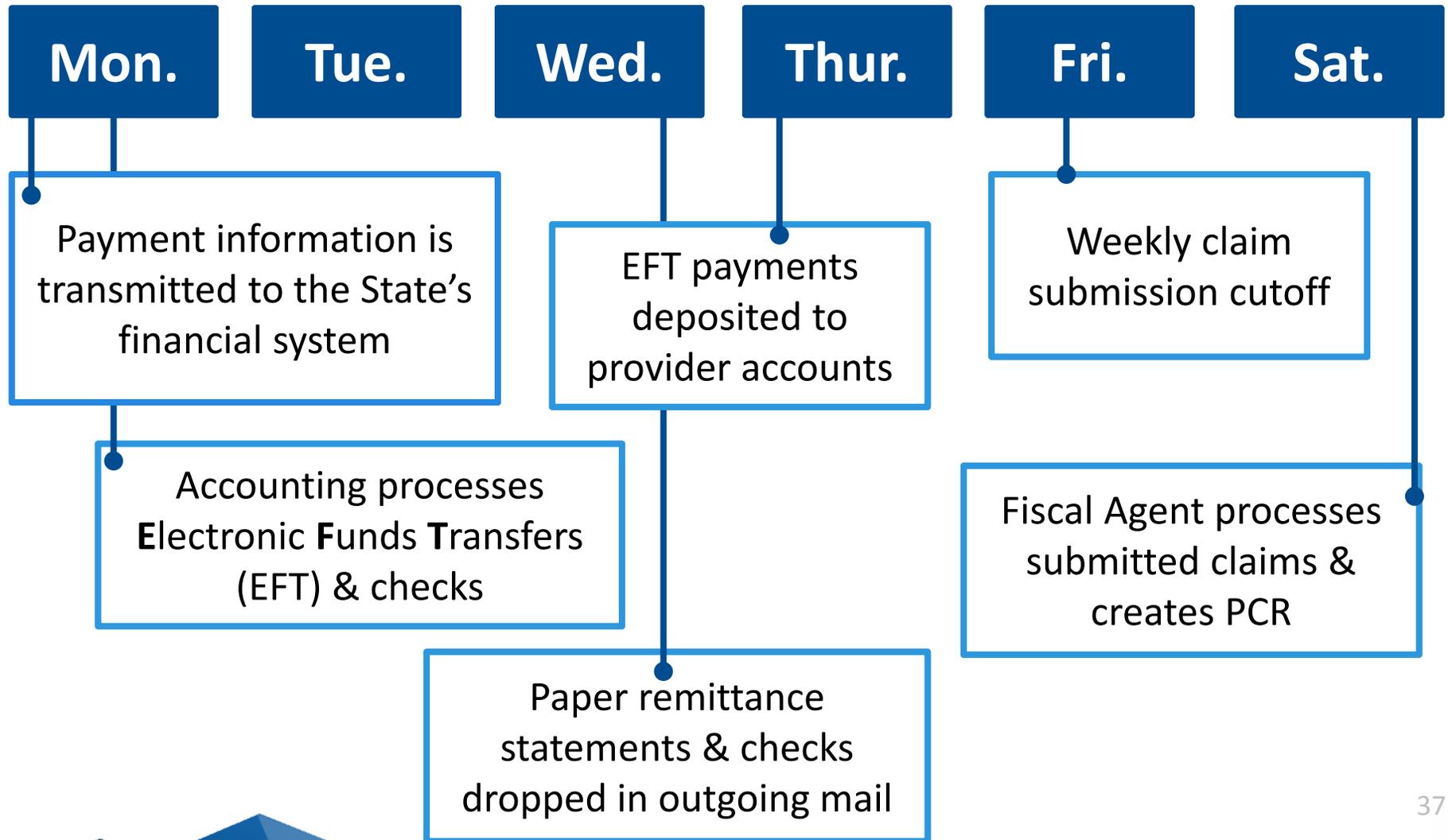


- Additional Information:

- 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 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 ColoradoPAR 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							
 <div style="background-color: #90EE90; padding: 5px; display: inline-block;">Adult Long Term Home Health</div>						PA Number being revised:	
						Revision? <input type="checkbox"/> Yes <input type="checkbox"/> No	
1. CLIENT NAME		2. CLIENT ID		3. BIRTHDATE		4. HCBS ELIGIBLE	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. REQUESTING PROVIDER #		6. REQUESTING AGENCY		7. CASE MANAGEMENT AGENCY #		8. DATES COVERED	
						From: Through:	
STATEMENT OF REQUESTED SERVICES							
9. Revenue Code/Description	10. Specify Frequency	11. # Units	12. Cost Per Unit	13. Total \$ Requested	14. Total Units Authorized	15. PAR Determination	16. Comments
551 RN/LPN			\$101.09				
590 Uncomplicated Nursing Visit, 1			\$70.76				
599 Uncomplicated Nursing Visit, 2+			\$49.53				
571 Certified Nursing Assistant (CNA), Basic			\$35.95				
579 Certified Nursing Assistant (CNA), Extended			\$10.75				
A							
B							
C							
D							
E							
F							
G							
H							
17. TOTAL REQUESTED ADULT LONG TERM HOME HEALTH EXPENDITURES (SUM OF AMOUNTS IN COLUMN 13 ABOVE)						\$0.00	
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)							
19. ADDITIONAL INFORMATION:							
CASE MANAGER USE							
20. CASE MANAGER NAME		21. AGENCY		22. PHONE #		23. EMAIL	
20A. CASE MANAGER SIGNATURE:							
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY							
25. HOME HEALTH PAR: <input type="checkbox"/> Approved Date: <input type="checkbox"/> Denied Date: Return for correction- Date:							
26. DENIAL REASON:							
27. DEPARTMENT APPROVAL SIGNATURE:						28. DATE:	



Long Term Home Health PAR

Community Center Board Adult w/ DIDD

Supported Living Services (SLS)

Developmentally Disabled (DD)

Children's Extensive Support (CES)

Day Habilitation Services and Support (DHSS)



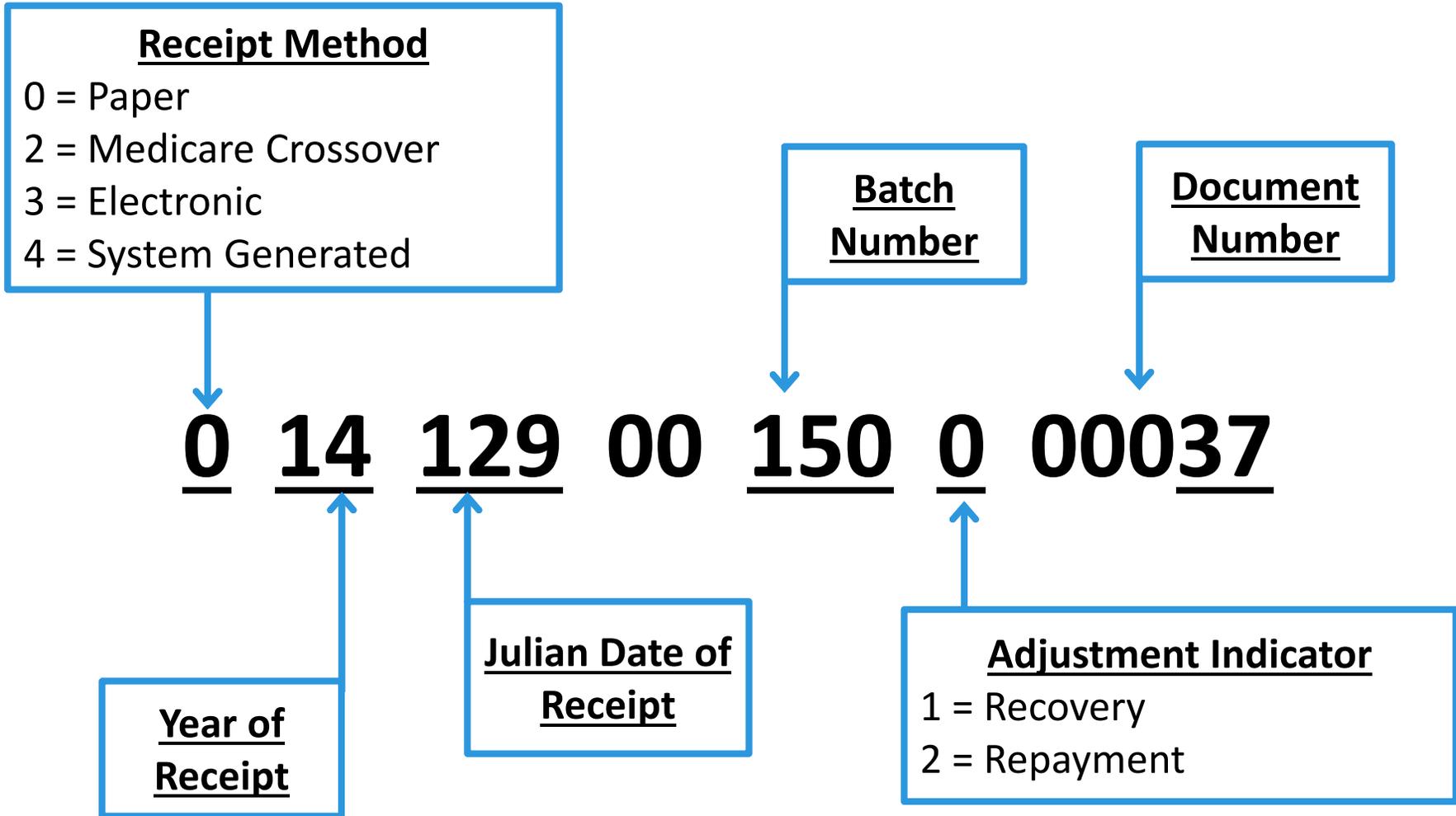
Long Term Home Health PAR

Case Management Agency Adult & Children HCPF Waivers

Elderly Blind and Disabled (EBD)	Children's Home Community Based Services (CHCBS)
Community Mental Health Services (CMHS)	Children With Autism (CWA)
Brain Injury (BI)	Children with Life Limiting Illness (CLLI)
Spinal Cord Injury (SCI)	



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)



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



UB-04

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



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 & attached to all claims submitted on the paper UB-04

Print a copy of the certification at:
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**



UB-04 Coding Reminders

**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

2		3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
9 PATIENT ADDRESS			

6 STATEMENT COVERS PERIOD FROM THROUGH		7
3/15/14	3/31/14	

6 STATEMENT COVERS PERIOD FROM THROUGH		7
4/1/14	4/15/14	

6 STATEMENT COVERS PERIOD FROM THROUGH		7
3/15/14	4/15/14	

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 Home Health

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



ject

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

Stop Spend



“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

Paper

- Complete Adjustment Transmittal form
- Be concise & clear

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 #04230 (REV. 12/10) Page 1

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 *

SERVICE	CLIENT	TRANSACTION	DATES OF SVC	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT		
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	CHARGES	CHARGES	PAID	SOURCES	AMOUNT
15	CLIENT, IMA	Z000000	04080000000000000001	040508	040508	132.00	69.46	2.00	0.00	69.46
				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 *

CLIENT	TRANSACTION	DATES OF SERVICE	TOTAL	DENIAL REASONS		
NAME	STATE ID	CONTROL NUMBER	FROM	TO	DENIED	ERROR CODES
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:
 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

* ADJUSTMENTS PAID

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
CLIENT, IMA	A000000	40800000000100002	041008	041808 406	92.82-	92.82-	0.00	0.00	92.82-
DE - MOD T1019 - U1			041008	091808	92.82-				
CLIENT, IMA	A000000	40800000000200002	041008	041808 406	114.24	114.24	0.00	0.00	114.24
DE - MOD T1019 - U1			041008	041808	114.24				
NET IMPACT					21.42				

Recovery

Net Impact

Repayment

Voids

* ADJUSTMENTS PAID *

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
CLIENT, IMA	Y000002	40800000000100009	040608	042008 212	642.60-	642.60-	0.00	0.00	642.60-
DE - 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!

