

Beginning Billing Workshop Hospice

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. A blue circle with the number '1' is positioned above the browser's address bar, which contains the URL <https://www.colorado.gov/hcpf>. A blue box highlights this URL, and an arrow points from the '1' to it. Below the browser window, another blue box contains the text www.colorado.gov/hcpf, with an arrow pointing from the '1' to this box. The website header features the Colorado state logo and the text 'COLORADO Department of Health Care Policy & Financing'. A navigation menu includes 'Home', 'For Our Members', 'For Our Providers', and 'For Our Stakeholders'. A blue circle with the number '2' is placed over the 'For Our Providers' link, and a blue box highlights it with an arrow pointing from the '2' to the link. Below the navigation menu, a text line reads: 'We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.' The main content area consists of four dark blue tiles: '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 light blue boxes: 'Feeling Sick?' with a nurse icon and the phone number '800-283-3221', and 'Get Covered. Stay Healthy.' with an umbrella icon and the URL '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 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



Attending Versus Billing

Attending Provider

- Individual that provides services to a Medicaid member



Billing Provider

- Entity being reimbursed for service



Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:



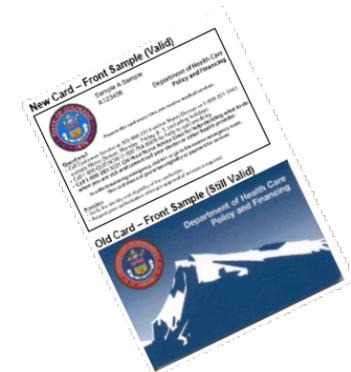
Web Portal



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

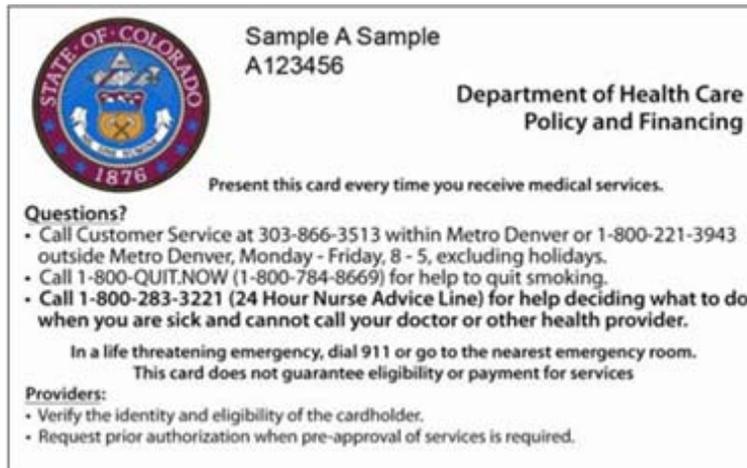
Reminder:

- 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 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
 - Connects Medicaid members to:
- 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

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

27



Commercial Insurance

Commercial Insurance



- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
 - Bill member difference or commercial co-payments
 - Place lien against members right to recover
 - Bill at-fault party's insurance



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



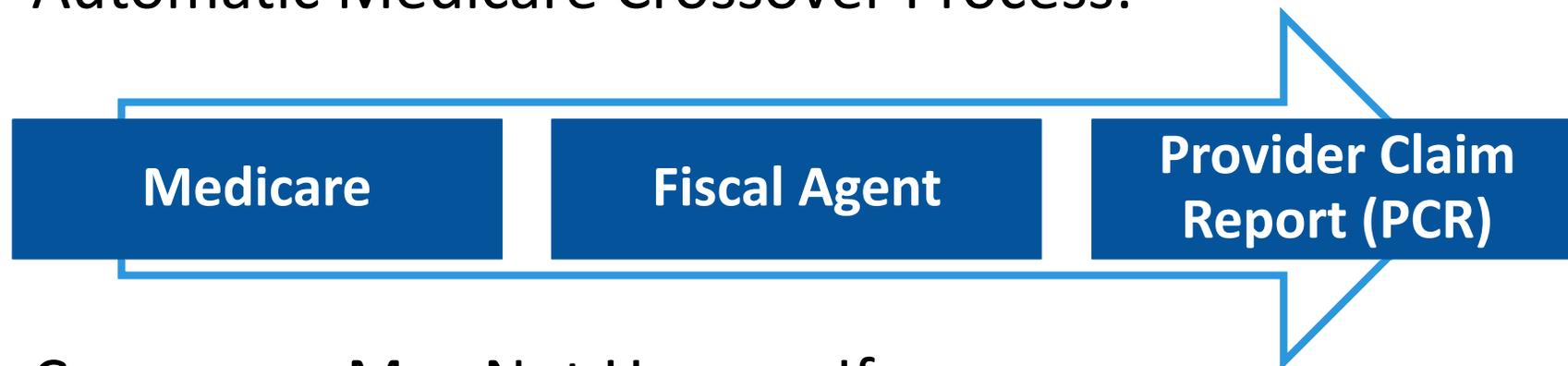
ICD-10 Implementation Delay

- 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:

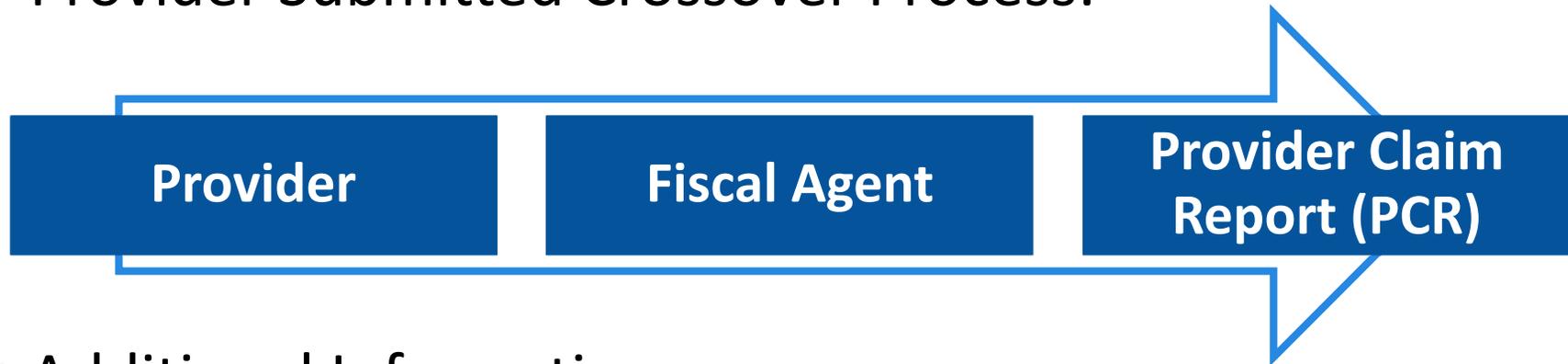


- Crossovers May Not Happen If:
 - NPI not linked
 - Member is a retired railroad employee
 - Member has incorrect Medicare number on file



Crossover Claims

- Provider Submitted Crossover Process:

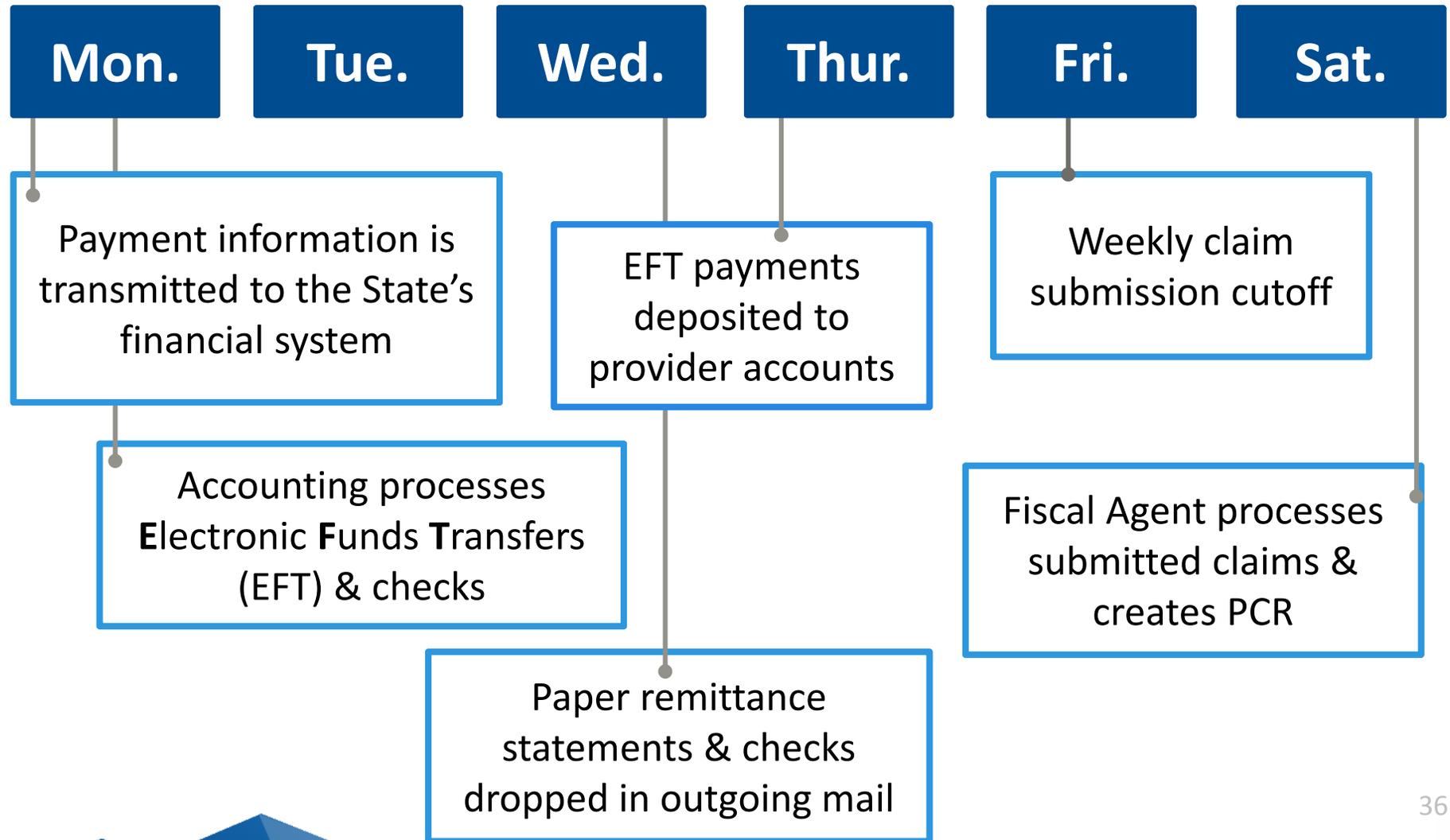


- Additional Information:

- 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

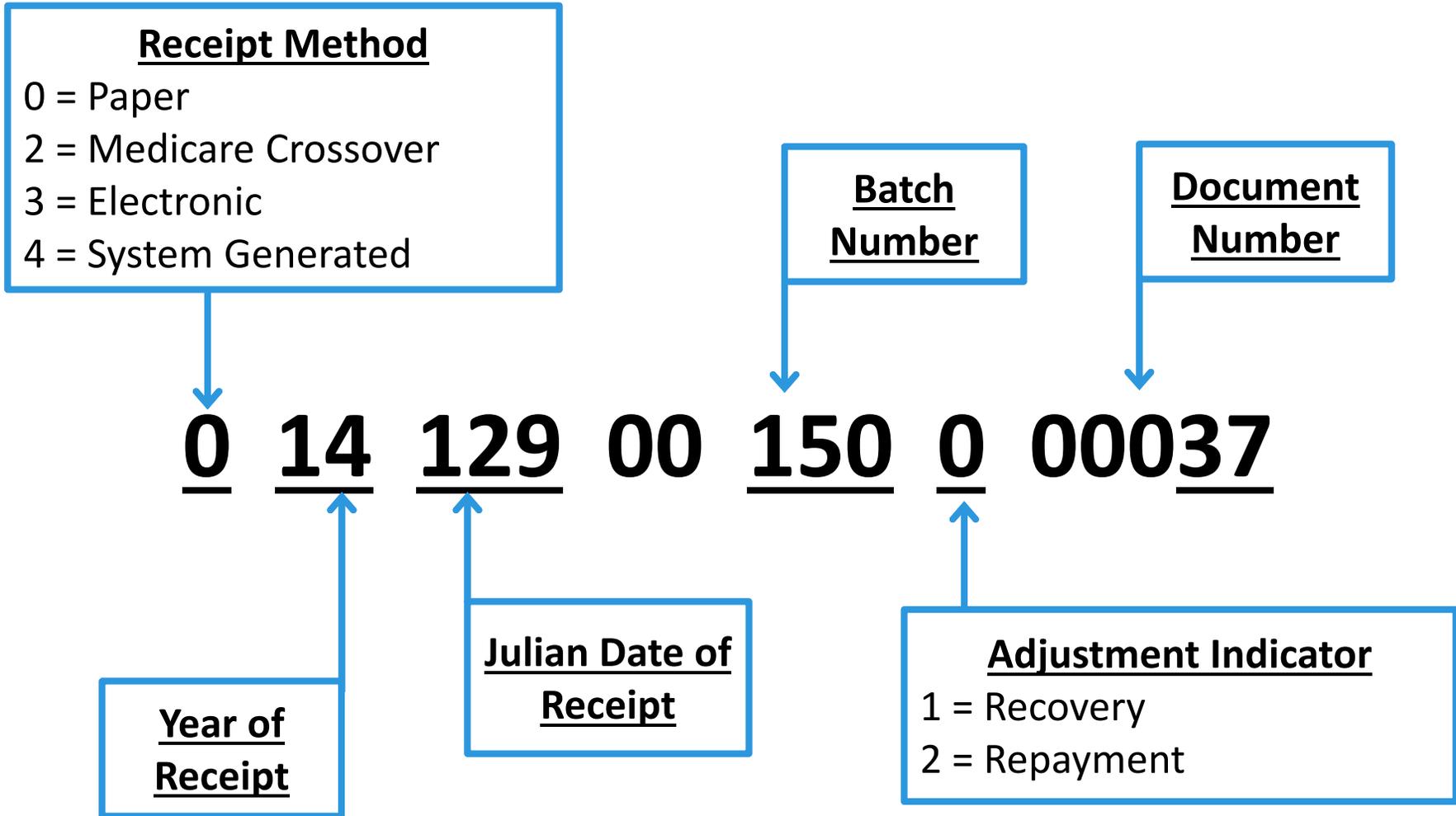


Electronic Funds Transfer (EFT)

- 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



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 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



Hospice

- Hospice services are available to Medical Assistance Program members with a terminal illness
 - Life expectancy of 9 months or less
 - Palliative treatments include:
 - hospice services & interventions that are not curative
 - but provide the greatest degree of relief & comfort for symptoms of terminal illness



Hospice Members in a Nursing Facility

- ULTC 100.2
 - Not required if member has already been determined eligible for Medicaid when hospice member enters a nursing facility (NF)
 - Required if Medicaid eligibility for hospice member is pending
 - Required if member does not have an active ULTC 100.2 & leaves hospice status and remains in NF



Nursing Facility Patient Pay

- If member expires during the month
 - Patient pay goes to NF if patient pay is equal to or less than NF charge
 - Amount is pro-rated if patient pay is greater than NF charge
- Nursing Facility is responsible for collecting the patient payment & Hospice rate and to report it on the claim
- Obtain patient pay amount from NF & always include amount on claim



Post Eligibility Treatment of Income (PETI)

If a member does not make a patient payment -
there is No PETI!!



Post Eligibility Treatment of Income (PETI)

- Reduction of resident payment to an NF for costs of care provided to the resident for services that are:
 - Medically necessary
 - Not covered by Medicaid
- Reduced by amount that remains after certain County-approved deduction are applied, as reflected on the 5615
 - Reimbursement by Medicaid is subject to reasonable limits set by the Department



To Access PETI

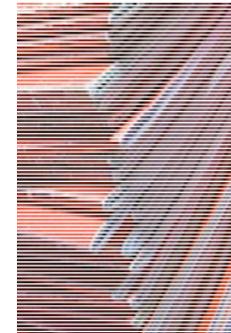
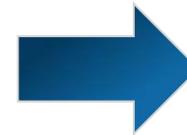
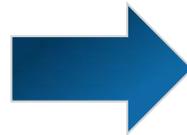
- **All** other payer sources must have been exhausted
- **Cannot** be a covered Medicaid service

OR

- Must have Medicaid denial
 - You must first submit a claim to the Colorado Medical Assistance program



PETI Process Overview



- NF or family pays provider
 - Usually done once PETI approval received

- NF reports PETI on:
 - 837I
 - UB 04



To Submit PETI Request

- All NF PETI requests must include the following two forms
 - Nursing Facility Post Eligibility Treatment of Income Request (NF PETI) Program form
 - NF PETI Medical Necessity Certification form
- All required signatures
- All supporting documents
- Provider statement
- Provider's invoice
- Medicaid Program denial PCR (if applicable)



PETI – Submit to Fiscal Agent

- May submit NF PETI directly to the Department's fiscal agent, without first submitting to the Department if:
 - All combined request(s) per calendar year are under \$400
 - Requested service is not an adult benefit of Medicaid per PETI fee schedule



PETI – Submit to Department

- Submit to the Department first if:
 - Charges exceeding \$400 per year and all health insurance charges must be prior authorized by Department
 - If the fee schedule notes an MP (Manually Priced) then submit to the department



PETI Billing

- Provider is not required to be enrolled in Medicaid in order to provide services to PETI-eligible residents
- Submit claims for approved NF PETI amounts on claim with:
 - member's room and board amount
 - patient liability amount
- Claims processing system automatically completes the calculations
- PETI documentation shall be retained by NF for 6 years for audit purposes



PETI – If...Then

If: provider is requesting more than what is allowed on PETI fee schedule



Then: this amount must be amended to what is allowable on the PETI fee schedule

If: member has medical trust



Then: PETI charges must be paid from medical trust



PETI Revenue Codes

- 999 – Health Insurance Premiums & Other Services
 - All premiums must first be approved by State
- 962 – Vision & Eye Care
- 479 – Hearing & Ear Services
- Claims must have Accommodation Revenue Code:
 - 119 Private
 - Must be approved by Colorado Medicaid
 - 129 Semi-Private
- Claims must have a patient liability



PETI Occurrence Span Dates

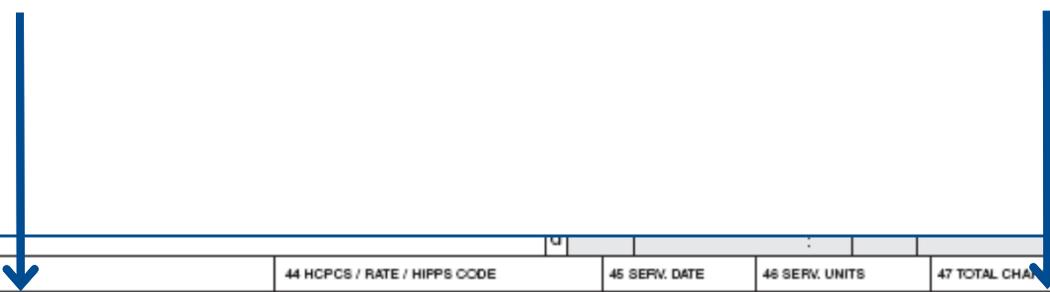
- Date(s) services rendered or insurance payments made
 - May be single dates
 - No future dates
- Span dates do not have to fall within Statement Covers Period

36	OCCURRENCE SPAN	
CODE	FROM	THROUGH
76	03/06/2014	03/06/2014



PETI Services

- Enter approved amount paid to service providers



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	129 Semi-Private	90.05		30	2701.50		1
2	479 Hearing and Ear Care			1	35.00		2
3	962 Vision Care			1	30.00		3



PETI Services

- Charges must be less than or equal to patient payment entered for Value Code 31 (Patient Liability Amount)

38				39	40	41	
				CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT
				a	80		30:00
				b	31		103:00
				c			
				d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
129	Semi-Private	90.05		30	2701:50		
479	Hearing and Ear Care			1	35:00		
962	Vision Care			1	30:00		



Nursing Facility Contacts

To send NF PETI requests to the Department

Nursing Facility PETI Program
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203
Fax: 303.866.3991

For NF PETI related questions
not directly related to billing
please contact Susan Love at 303-866-4158



Colorado 1500

What services are billed on the Colorado 1500?

Medical Director

Interventions



UB-04

What services are billed on the UB-04?

Hospice Routine
Home Care

Hospice Inpatient
Respite

Continuous Home
Care

Hospice Physician
Service (Visit)



UB-04

The image shows a sample UB-04 institutional claim form. A large, semi-transparent watermark with the word "Sample" is written diagonally across the center of the form. The form is divided into several sections:

- Section 1-4:** Patient and provider information, including patient name, address, birth date, sex, and admission/discharge dates.
- Section 5-10:** Insurance information, including payer name, insured name, and insurance group number.
- Section 11-16:** Procedure codes, including ICD-9-CM procedure codes and HCPCS codes.
- Section 17-20:** Charges, including total charges and non-covered charges.
- Section 21-24:** Additional procedure codes and dates.
- Section 25-28:** Remarks and other notes.

 At the bottom of the form, there is a footer with the text "UB-04 CMS-1483" and "APPROVED CMS FORM 09/98".

- 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 Claims Submission

1 Hospice Agency 100 Saginaw Street Anytown, CO 80201 303-333-3333		2		3a PAT. CNTL # SM000123		4 TYPE OF BILL 812	
8 PATIENT NAME a Client, Ima D.		9 PATIENT ADDRESS a 123 Main Street		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 01/06/08 THROUGH 01/31/08	
b Anytown		c CO		d 88888		e	
10 BIRTHDATE 02/13/1980	11 SEX F	12 DATE 12/06/03	ADMISSION 13 HR 14 TYPE 15 SRC 1	16 DHR	17 STAT 30	CONDITION CODES 22 23 24 25 26 27 28	
29 ACDT STATE 30		31 OCCURRENCE CODE 27		32 OCCURRENCE DATE 01/01/08		33 OCCURRENCE CODE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH	

Occurrence Code 27
Hospice plan established

30 – Still patient
40 – Expired at home
41 – Expired - SNF/other facility
42 – Expired – Place unknown



UB-04 Claims Submission

Rev Codes
calculated in
days -

- 651
- 655
- 656
- 659

Rev Codes
calculated in
hours -

- 652

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Hospice Routine Home Care		01/06/08	8	624:00		1
652	Hospice Continuous Home Care		01/18/08	24	480:00		2
652	Hospice Continuous Home Care		01/19/08	16	320:00		3
652	Hospice Continuous Home Care		01/20/08	8	160:00		4
655	Hospice Inpatient Respite		01/21/08	3	249:00		5
656	Hospice General Inpatient Care		01/24/08	1	350:00		6
651	Hospice Routine Home Care		01/25/08	9	702:00		7
659	Nursing Facility R & B Per Diem		01/06/08	20	1100:00		8



UB-04 Claims Submission

- Common Billing Issues
 - Hospice units of service are invalid if
 - More than 5 days of respite care (655) is billed
 - Less than 8 or more than 24 hours of continuous home care (652) are billed on single date
 - Units greater than total days
 - Units of service total more than statement covered days
 - Payment is made for date of death and day of discharge for all rev codes, excluding 659
 - Payment for rev code 659 includes day of death, but not day of discharge



Date of Death

- Payment is made for date of death and day of discharge (DOD).
 - Home care rate applies if discharge is from general or respite inpatient care
 - unless member dies at an inpatient level of care
 - Inpatient level of care – the applicable general or respite rate is paid for discharge rate



Date of Death

- Payment for NF residents is made for services delivered up to date of discharge (alive or deceased)
 - Includes applicable per diem payment for DOD
- For the month of the member's death, the following are allowable
 - Durable medical rental equipment
 - Oxygen



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



Common Denial Reasons

PAR not on file



No approved authorization on file for services that are being submitted

Total Charges invalid



Line item charges do not match the claim total

Type of Bill



Claim was submitted with an incorrect or invalid type of bill



Claims Process - Common Terms



Reject

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



Denied

Claim processed & denied by claims processing system



Accept

Claim accepted by claims processing system



Paid

Claim processed & paid by claims processing system



Claims Process - Common Terms



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

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

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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

* ADJUSTMENTS PAID

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808 406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1						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						114.24				
						NET IMPACT	21.42			

Recovery

Net Impact

Repayment

Voids

* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM	ADJ TO RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008 212	642.60-	642.60-	0.00	0.00	642.60-
PROC CODE - MOD T1019 - U1						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!

