

# Nurse Home Visitor Program

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Colorado Medicaid  
2014





Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing



**Medicaid**

Medicaid/CHP+ Medical Providers



Xerox State Healthcare



# Training Objectives

- Billing Pre-Requisites

- ▶ National Provider Identifier (NPI)

- What it is and how to obtain one

- ▶ Eligibility

- How to verify
- Know the different types

- Billing Basics

- ▶ How to ensure your claims are timely

- ▶ When to use the CO 1500 paper claim form

- ▶ How to bill when other payers are involved



# Nurse Home Visitor Program

- Who's involved?

- Colorado Department of Health Care Policy and Financing (Medicaid)
- Colorado Department of Human Services
- Invest in Kids

- Statutes, Rules, Guidance

- 26-6.4-101 C.R.S
- 10 C.C.R 2505-10 § 8.749
- Medicaid Billing Manual
- State Plan Amendment



# 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)

**COLORADO**

Department of Health Care  
Policy & Financing

Home

For Our Members

**For Our Providers**

For Our Stakeholders

2.

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore  
Benefits



Apply  
Now



Find  
Doctors



Get  
Help



**Feeling Sick?**

For medical advice, call the Nurse Line:

**800-283-3221**



**Get Covered.  
Stay Healthy.**

[colorado.gov/health](http://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 Department of Health Care Policy & Financing logo and navigation menu. The main content area, titled 'For Our Providers', features four columns of information:

- Why should you become a provider?** (Icon: hands holding a cross)
- How to become a provider (enroll)** (Icon: green document with a cross)
- Provider services (training, & more)** (Icon: dollar sign with horizontal lines)
- What's new? (bulletins, newsletters, updates)** (Icon: radio tower)

Below these columns is a row of three service links:

- Get Help** Dept. Fiscal Agent 1-800-237-0757 (Icon: person with a question mark)
- Get Info** FAQs & More (Icon: question mark)
- Find a Doctor** Are you a client looking for a doctor? (Icon: person with a magnifying glass)



# 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 members



## 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:



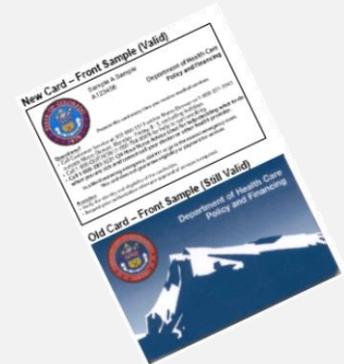
Web Portal



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

---

**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:

---

**Client Eligibility Details**

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

---

**PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE**

Eligibility Benefit Date:  
04/06/2011 - 04/06/2011  
Messages:

---

**MHPROV Services**

Provider Name:  
**COLORADO HEALTH PARTNERSHIPS LLC**

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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.

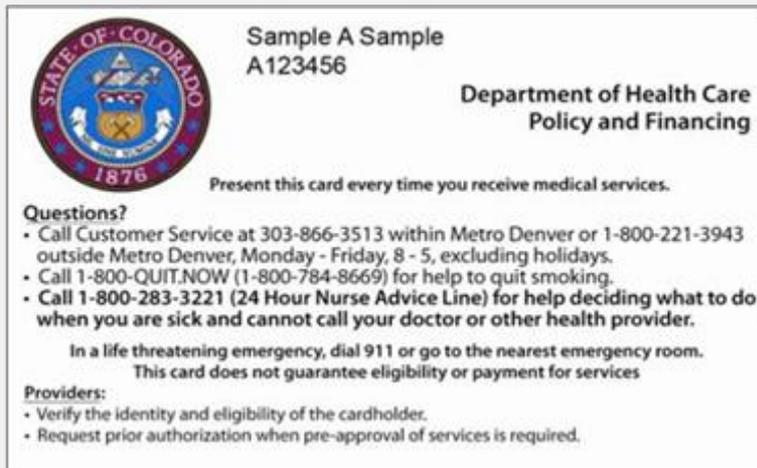
A successful inquiry notes a Guarantee Number. Print a copy of the response for the Member's file when necessary.

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
  - Presumptive Eligibility
- Some members = additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance



# 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:
  - Behavioral Health Organization (BHO)
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Accountable Care Collaborative (ACC)



# 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-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



# Commercial Insurance

## Commercial Insurance



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



# Co-Payment Exempt Members



**Pregnant Women**

# 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



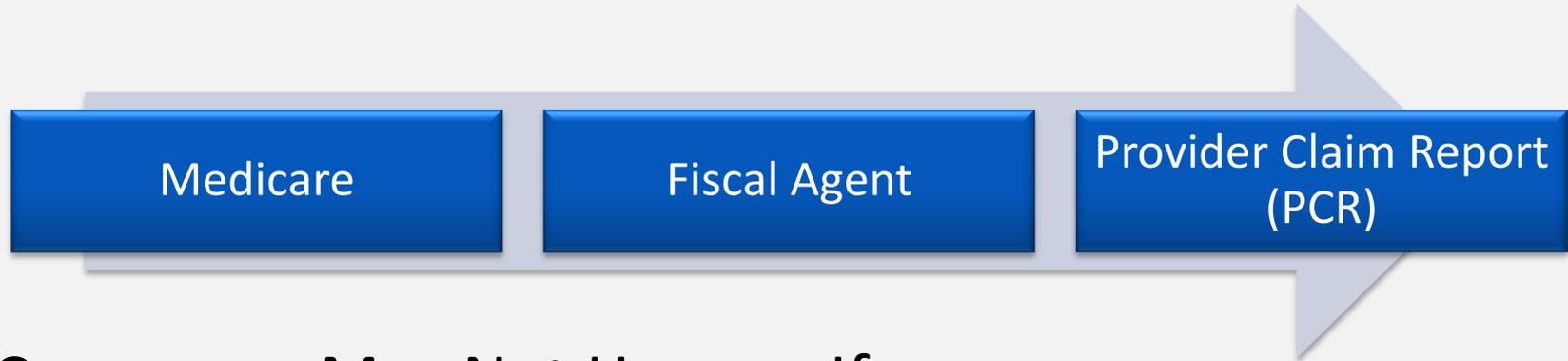
# ICD-10 Implementation Delay

- 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:

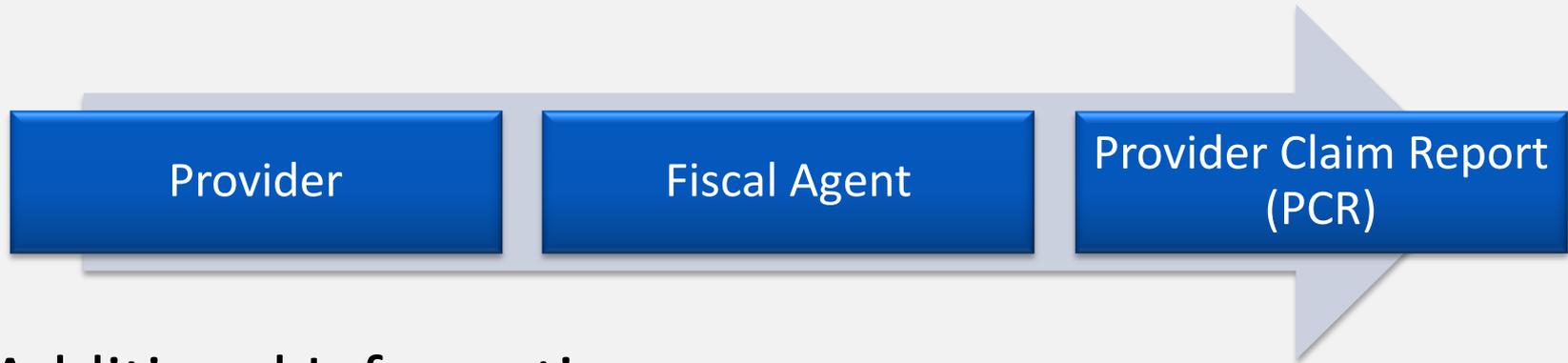


- Crossovers May Not Happen If:

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

# Crossover Claims

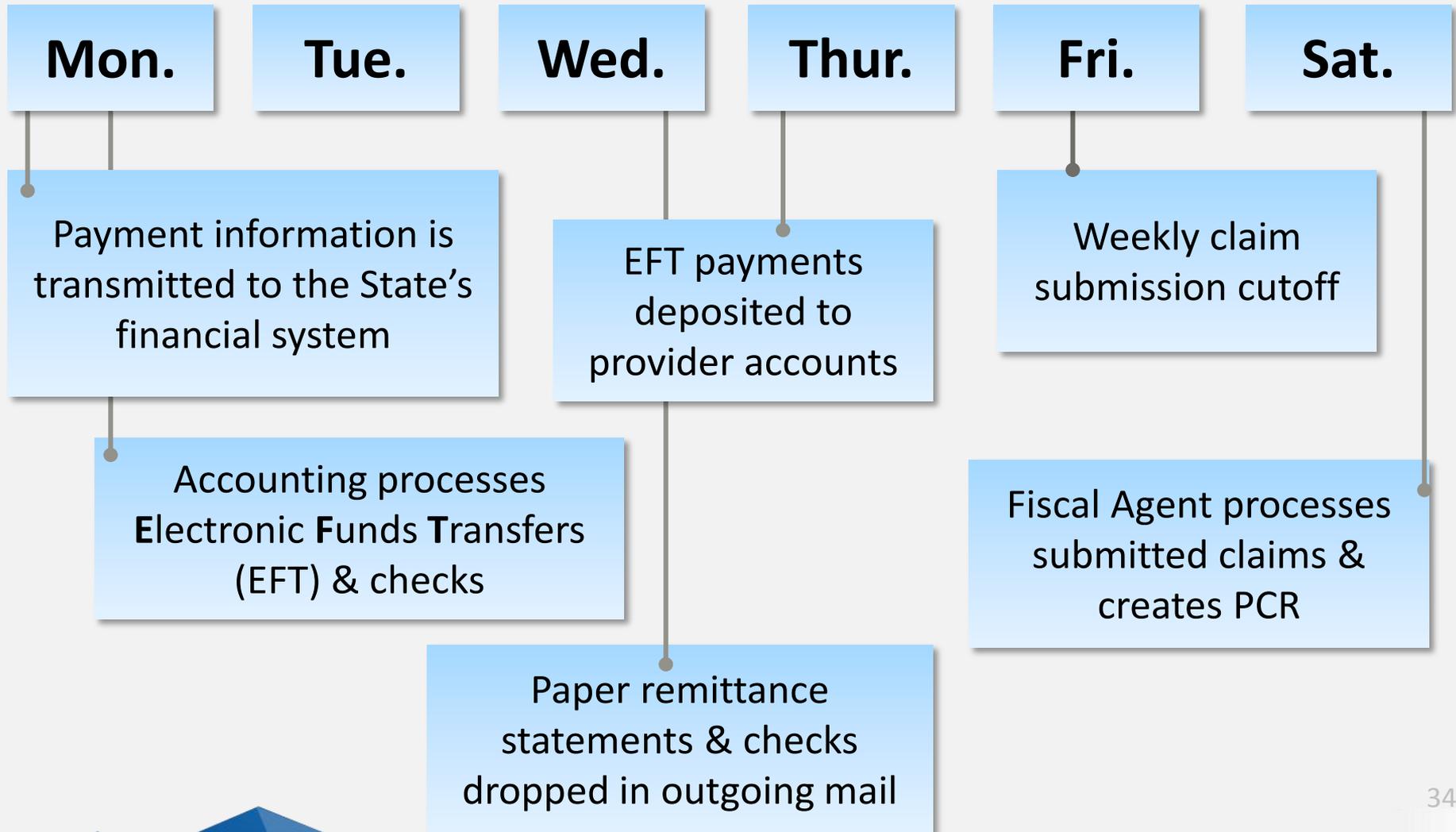
- Provider Submitted Crossover Process:



- 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



# Transaction Control Number

## Receipt Method

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

## Batch Number

## Document Number

0 14 129 00 150 0 00037

## Year of Receipt

## Julian Date of Receipt

## Adjustment Indicator

- 1 = Recovery
- 2 = Repayment



# Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)



# Timely Filing

## From “through” DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

## From DOS

- FQHC Separately Billed and additional Services

## From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date



# Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837P transaction
  - Keep supporting documentation
- Paper Claims
  - CO 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in the Remarks



# Timely Filing – Medicare/Medicaid Enrollees

Medicare pays claim



- **120 days from Medicare payment date**

Medicare denies claim



- **60 days from Medicare denial date**



# Timely Filing Extensions

- Extensions may be allowed when:
  - Commercial insurance has yet to pay/deny
  - Delayed member eligibility notification
    - Delayed Eligibility Notification Form
  - Backdated eligibility
    - Load letter from county



# Extensions – Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
  - File claim with Colorado Medicaid
    - Receive denial or rejection
  - Continue re-filing every 60 days until insurance information is available



# Extensions – Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD
- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
  - Review past records
  - Request billing information from member



# Extensions – Backdated Eligibility

- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
  - County technician
  - Member name
  - Delayed or backdated
  - Date eligibility was updated



# What is the Colorado 1500?

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





# Procedure Codes

- G9006
  - Coordinated Care Fee, Home Monitoring
  - Use this code when billing services for the mother
- T1017
  - Targeted Case Management
  - Use this code when billing services for the child
- Services for the mother and services for the child must be billed on separate claims.



# Places of Service

- Reimbursement rate is dependent on Place of Service
  - Bill Place of Service Code 12 (Home) for any TCM that occurs away from the office/agency
  - Bill other Place of Service codes for TCM that occurs at our office/agency including but not limited to:
    - 11 (Office)
    - 50 (FQHC)
    - 71 (Public Health Agency)
    - 72 (RHC)



# Units of Service

- 1 unit equals 15 minutes of TCM
- A maximum of fifteen (15) units will be reimbursed in any calendar month per mother/child couple
- May be divided between the mother and child if both are Medicaid-eligible in the same month
- May be provided:
  - in the home/off-site setting
  - in the office
  - a combination of both



# Units of Service (cont.)

- Time spent on TCM should be rounded to the nearest whole unit. For example:

Service Time	Units Billed
5 minutes	No units may be billed
10 minutes	1 unit may be billed
23 minutes	2 units may be billed

- Documentation in the chart should support the number of units billed.



# Modifiers

- 1st modifier field must always be HD (pregnant/parenting program)
- If Home TCM and Office TCM on the same date of service or span:
  - Line Item 1: Procedure code, Modifier 1 is HD, first place of service code
  - Line Item 2: Procedure code, Modifier 1 is HD, Modifier 2 is 76 (duplicate service), other place of service code



# Diagnosis Codes

- Diagnosis codes that are appropriate for this program include but are not limited to the following:

Member Description and Stage	Diagnosis Code	Description
Pregnant Woman	V22	Normal pregnancy
	V22.0	Supervision of normal first pregnancy
	V22.1	Supervision of other normal pregnancy
	V23	Supervision of high-risk pregnancy
Mother from Delivery through 2-3 Months Postpartum	V24.2	Routine postpartum follow-up
Mother After 2-3 Months Postpartum to Child's 2 <sup>nd</sup> B-day	V68.9	Encounter for unspecified administrative purpose
Child –Infancy through 2 <sup>nd</sup> B-day	V20	Health supervision of infant or child
	V20.1	Other healthy infant or child receiving care



# Span Billing

- Alternative billing method allowed for some services, including NHVP
  - Rather than billing each encounter separately with individual dates of service, Span Billing allows you to bill one line item for:
    - the same service provided to the same member
    - over a period of time on multiple dates of service
  - For instance if TCM was provided to the same member on three different dates of service:
    - span of dates can be entered in the “From Date” field and the “To Date” field on one line item
    - rather than billing three line items for each separate date of service



# Span Billing

- The span “From Date” and the span “To Date” should be within the same month
  - ie. 10/1/14 – 10/31/14
  - not 10/15/14 – 11/15/14
- No additional claims for that specific service for that member during that span will be paid once the span claim is paid
- If you need to add units, you must adjust the span claim
  - do not submit an additional claim



# 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



# Adjustment Methods



## Web Portal

- Preferred method
- Easier to submit & track

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



**Adjustment Transmittal**

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

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

**ALL FIELDS BELOW MUST BE COMPLETED**

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

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

\_\_\_\_\_

Three-digit reason code indicating the reason for the Adjustment

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

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

Date: \_\_\_\_\_ By (Provider Signature): \_\_\_\_\_

**FISCAL AGENT USE ONLY**

Reply (notes) and RTP reason code

\_\_\_\_\_

\_\_\_\_\_

Unarchive required  Yes  No

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

## Paper

- Complete Adjustment Transmittal form
- Be concise & clear



# Provider Claim Reports (PCRs)

- Contains the following claims information:
  - Paid
  - Denied
  - Adjusted
  - Voided
  - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - Via Web Portal



# Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - \$2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- \$2.61/ page for business address
    - \$2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not



# Provider Claim Reports (PCRs)

## Paid

\*\*\*\*\*  
 \* CLAIMS PAID \*  
 \*\*\*\*\*

INVOICE NUM	CLIENT NAME	STATE ID	TRANSACTION CONTROL NUMBER	DATES OF SVC FROM TO	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
7015	CLIENT, IMA	Z000000	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 TO	ADJ RSN	TOTAL CHARGES	ALLOWED CHARGES	COPAY PAID	AMT OTH SOURCES	CLM PMT AMOUNT
Z71 CLIENT, IMA	A000000	40800000000100002	041008 041008	041808 406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1			041008 091808		92.82-				
Z71 CLIENT, IMA	A000000	40800000000200002	041008 041008	041808 406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1			041008 041808		114.24				
NET IMPACT					21.42				

## Repayment

## Net Impact

## Voids

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

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



# Provider Services

## Xerox

**1-800-237-0757**

Claims/Billing/ Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

## CGI

**1-888-538-4275**

Email [helpdesk.HCG.central.us@cgi.com](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!**  
**Kirstin.Michel@state.co.us.**  
**(303) 866-2844**

