

Beginning Billing Workshop Nursing Facility

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 CO 1500 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

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

Colorado The Official Web Portal

Translate

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		



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 Colorado Department of Health Care Policy & Financing website. The header includes the state logo, HCPF logo, and the text 'COLORADO Department of Health Care Policy & Financing'. A navigation menu is visible with 'For Our Providers' highlighted. The main content area is titled 'For Our Providers' and contains 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 this are three quick links: '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:



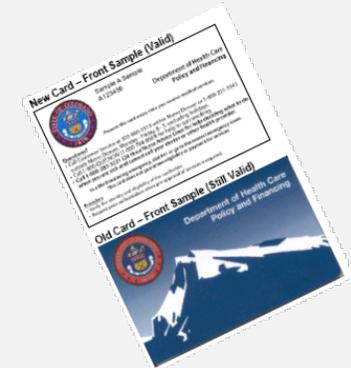
Web Portal



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: Nation:
From DOS: Throu:
Client Detail
State ID: D:
Last Name: First

CO MEDICAL ASSISTAN
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

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

Successful inquiry notes a Guarantee Number:

- Print a copy of the response for the 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



Managed Care Options

- Types of Managed Care options:
 - Managed Care Organizations (MCOs)
 - Behavioral Health Organization (BHO)
 - Program of All-Inclusive Care for the Elderly (PACE)
 - Accountable Care Collaborative (ACC)



Managed Care Options

Managed Care Organization (MCO)



- Eligible for Fee-for-Service if:
 - MCO benefits exhausted
 - Bill on paper with copy of MCO denial
 - Service is not a benefit of the MCO
 - Bill directly to the fiscal agent
 - MCO not displayed on the eligibility verification
 - Bill on paper with copy of the eligibility print-out



Managed Care Options

**Behavioral Health
Organization (BHO)**



- **Community Mental Health Services Program**
 - State divided into 5 service areas
 - Each area managed by a specific BHO
 - Colorado Medical Assistance Program Providers
 - Contact BHO in your area to become a Mental Health Program Provider



Managed Care Options

Accountable Care Collaborative (ACC)



- Connects Medicaid members to:
 - Regional Care Collaborative Organization (RCCO)
 - Medicaid Providers
- Helps coordinate Member care
 - Helps with care transitions



Medicare

Medicare



- Medicare members may have:
 - Part A only- covers Institutional Services
 - Hospital Insurance
 - Part B only- covers Professional Services
 - Medical Insurance
 - Part A and B- covers both services
 - Part D- covers Prescription Drugs



Medicare

Qualified Medicare Beneficiary (QMB)



- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
 - QMB Medicaid- members also receive Medicaid benefits
 - QMB Only- members do not receive Medicaid benefits
 - Pays only coinsurance and deductibles of a Medicare paid claim



Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always **payer of last resort**
 - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
 - **Submission to Medicare prior to** Colorado Medical Assistance Program
 - Medicare denials(s) for **six years**



Third Party Liability

Third Party Liability



- Colorado Medicaid pays Lower of Pricing (LOP)
 - Example:
 - Charge = \$500
 - Program allowable = \$400
 - TPL payment = \$300
 - Program allowable – TPL payment = LOP

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



Commercial Insurance

Commercial Insurance



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



Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing



Record Retention

- Providers must:
 - Maintain records for at least 6 years
 - Longer if required by:
 - Regulation
 - Specific contract between provider & Colorado Medical Assistance Program
 - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services



Record Retention

- Medical records must:
 - Substantiate submitted claim information
 - Be signed & dated by person ordering & providing the service
 - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements



Submitting Claims

- Methods to submit:
 - Electronically through **Web Portal**
 - Electronically using **Batch Vendor, Clearinghouse, or Billing Agent**
 - **Paper** only when
 - Pre-approved (consistently submits less than 5 per month)
 - Claims require attachments



ICD-10 Implementation Delay

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



Providers Not Enrolled with EDI



COLORADO MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757 or 1-800-237-0044
colorado.gov/hcpf

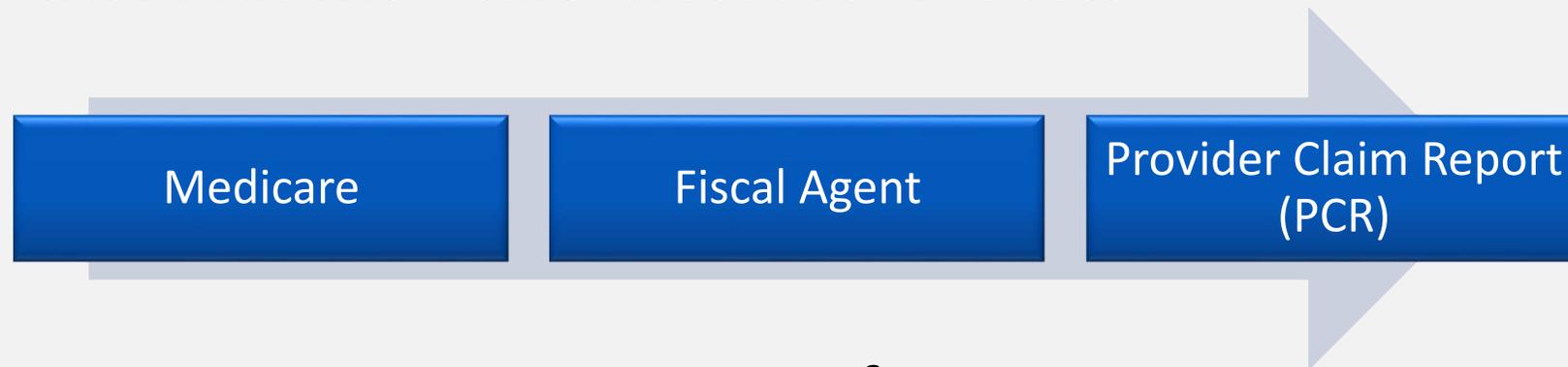
Providers must be enrolled with EDI to use the Web Portal to submit HIPAA compliant claims, make inquiries and retrieve reports electronically

- Select Provider Application for EDI Enrollment
 - colorado.gov/hcpf/edi-support



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:

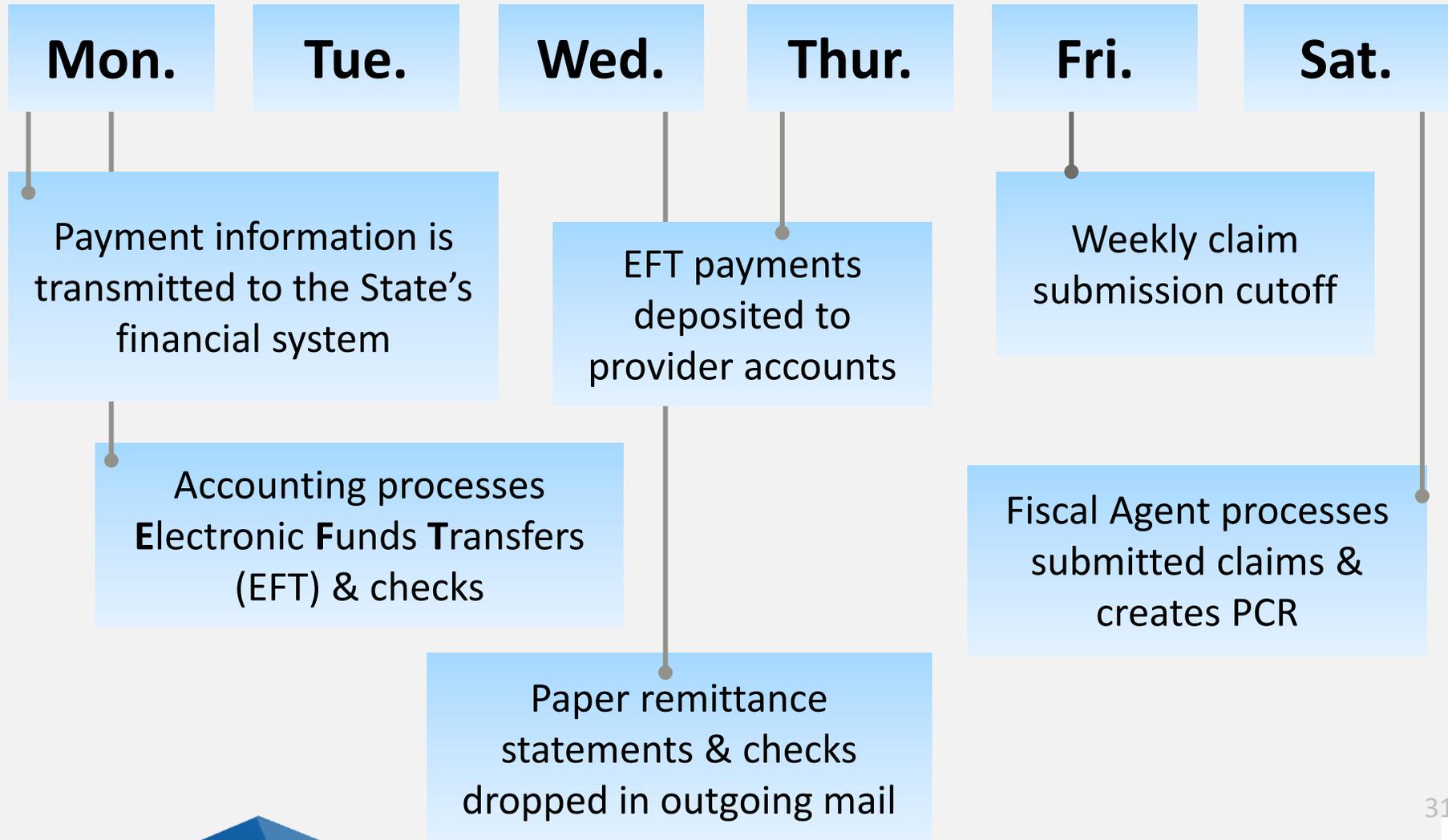


- Additional Information:

- 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 Masspro

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries
- PAR number on PAR letter is the ONLY number accepted when submitting claims
- Long Term Care Nursing Facility PARs only

Mail:

Masspro
CO Long Term Care Manager
245 Winter Street
Waltham, MA, 02451

Phone:

1.855.222.5250

Fax:

1.855.222.5257

Email:

coltc@masspro.org



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 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



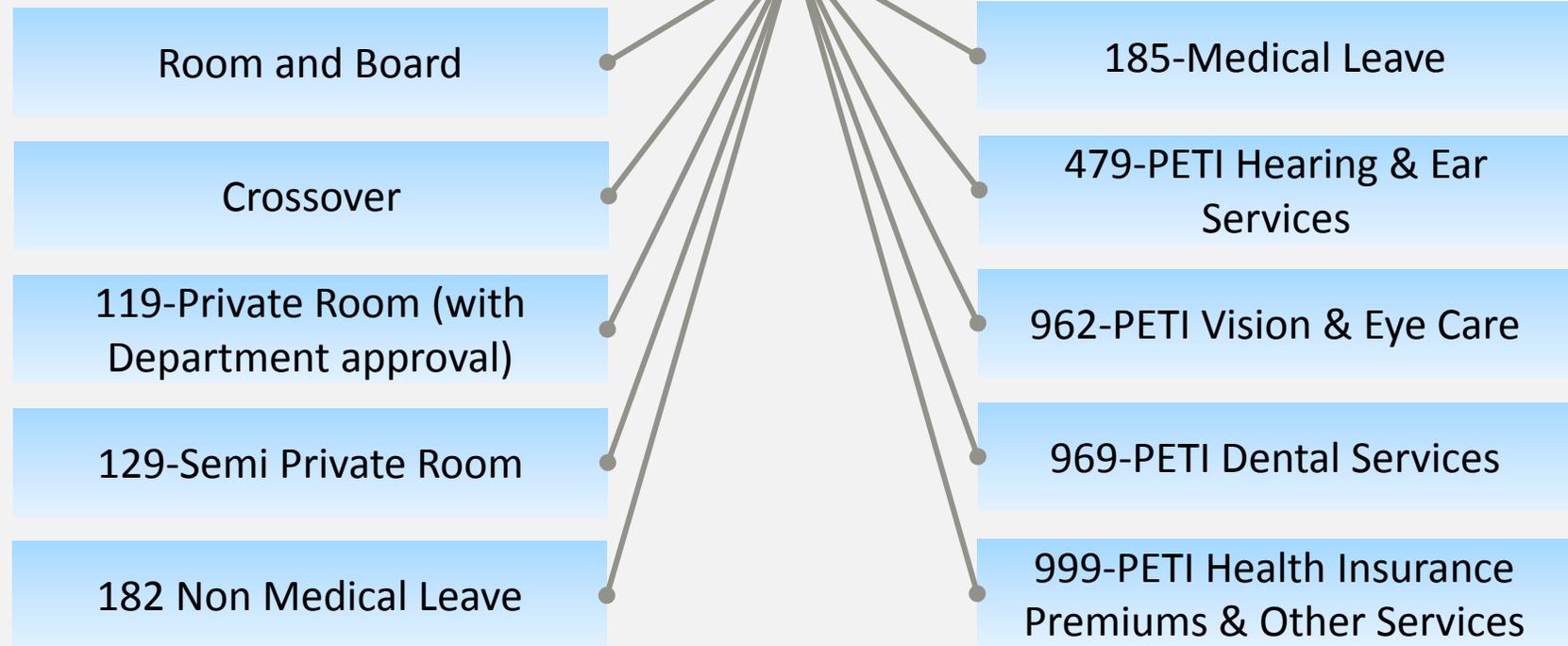
Extensions – Backdated Eligibility

- 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



UB-04

Examples of NF Services Billed on UB-04



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 and 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

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a

6 STATEMENT COVERS PERIOD FROM THROUGH	7
3/15/13 3/31/13	

6 STATEMENT COVERS PERIOD FROM THROUGH	7
4/1/13 4/15/13	

6 STATEMENT COVERS PERIOD FROM THROUGH	7
3/15/13 4/15/13	



UB-04 Coding Reminders

- If member is admitted and discharged on same date:
 - that date should appear as both the “From” and “Through” dates of service
- NFs are paid:
 - for date of admission
 - but not date of discharge
- Using Medicaid billing codes incorrectly can result in losing important member data
- Do not to code claims as discharges if member is expected to return
- Discharge can generate Occurrence Code 42
 - This code can automatically end date Nursing Facility PARs



Medical Leave Days

- When member is in nursing facility and has a hospital inpatient stay during the same month:
 - Only one of the providers may be reimbursed for a given calendar day
 - NF - submit medical leave claim for days member was in hospital
 - including date of hospital admission
 - Hospital receives payment for services on date of admission without overlapping nursing facility payment dates
 - If NF bills per diem for days in the hospital
 - Second claim processed will deny
 - NF must adjust its claim so hospital can be paid



Medical Leave Days Example

- Member is admitted to hospital, but expected to return
 - To indicate medical leave days:
 - Use Value Code 81 with number of days member is in hospital
 - Use Revenue Code 185
 - To indicate that member is expected to return
 - Use Type of Bill (TOB) 223 or 623
 - Use Status Code 30 (still a patient)



Non-Medical Leave Days Example

- Member leaves to visit family, but is expected to return
 - NF can be paid for 42 non-medical leave days per calendar year
 - Non-medical leave days must be approved by member's physician
 - To indicate paid non-medical leave days
 - Use Revenue Code 182 for non-medical leave days
 - To indicate unpaid non-medical leave days
 - Use Value Code 81 with number of non-covered days
 - Use Revenue Code 182 for non-medical leave days



Discharge Reminders

- If member is discharged to another facility, to home, or expires:
 - Type of Bill should end in 1 (221 or 621) or 4 (224 or 624)
 - Discharge date not covered by Medicaid
 - Status Code should reflect the discharge
 - NF must report the discharge to Masspro, the Single Entry Point (SEP) agency, and the county
 - Masspro end dates the PAR and sends a revised PAR to the Department's fiscal agent



Hospital Members in a Nursing Facility

- ULTC 100.2 required for admission if:
 - Medicaid eligibility for hospice member is pending
 - Member's type of eligibility is HCBS
 - Required prior to 30th day of member not using HCBS services, which could be prior to 30 days in the nursing facility
 - In most cases, will not be required prior to admission
 - Single Entry Point Agency (SEP) can verify when HCBS services will expire



Hospital Members in a Nursing Facility

- ULTC 100.2 not required for admission if
 - Member's eligibility type is NF and ULTC 100.2 is not expired
 - Member has a type of eligibility that will continue while in the NF
 - Check with county or eligibility site to determine if types of eligibility (other than NF or HCBS) will require a ULTC 100.2



Hospital Members in a Nursing Facility

- **ULTC 100.2 required later** for admission if:
 - Member does not have active ULTC 100.2, leaves hospice status, and remains in the nursing facility
 - Member's eligibility type is NF and the ULTC 100.2 expires
 - Current ULTC 100.2 is required for annual eligibility redetermination



Continued Stay Reviews

- Tracking ULTC 100.2 End Dates
 - Official member length of stay end dates are on the ULTC 100.2 located on the certification page
 - Notify authorization agent with any errors on notification letter
 - Notify SEP of need for re-certification at least 10 days before length of stay end date
 - Refer to Nursing Facility Billing Manual
 - Member is not responsible to pay privately if recertification is delayed due to NF error



Post Eligibility Treatment of Income (PETI)

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



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



Dental PETI

- Starting April 1st, 2014 there is a new adult Dental benefit
- All Medicaid Adults now have an annual \$1000 benefit
- Nursing Facilities will no longer be required to submit PETI requests for routine dental services
 - Refer to Dental Billing Manual
- The new benefit will have no impact on other PETI benefits, such as:
 - Hearing aids
 - Eyeglasses
 - Health insurance premiums



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 CODE VALUE CODES AMOUNT		40 CODE VALUE CODES AMOUNT		41 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	2700:50		
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



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

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)) _____ Colorado 1500 837P
City, State, Zip Code _____ Pharmacy EPSDT
Telephone Number _____ Dental 837D
Billing Provider Medicaid ID Number _____ UB-04 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 show three 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 #04236 (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	04080000000000000001	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	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:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65' for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'. COUNT 0001



Provider Claim Reports (PCRs)

Adjustments

Recovery

* ADJUSTMENTS PAID *

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

Repayment

Net Impact

Voids

* ADJUSTMENTS PAID *

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



Provider Services

Xerox

1-800-237-0757

Claims/Billing/ Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

CGI

1-888-538-4275

Email helpdesk.HCG.central.us@cgi.com

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training



Thank You!

