

Billing Workshop

Non-Emergency Transportation

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



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>

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



NEW! Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

The Official Web Portal

Translate

CO **HCPF** | **COLORADO**
Department of Health Care Policy & Financing

Home For Our Members **For Our Providers** For Our Stakeholders About Us

For Our Providers

Why should you become a provider?

How to become a provider (enroll)

Provider services (training, & more)

What's new? (bulletins, newsletters, updates)

Get Help
Dept. Fiscal Agent
1-800-237-0757

Get Info
FAQs & More

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

Rendering 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:



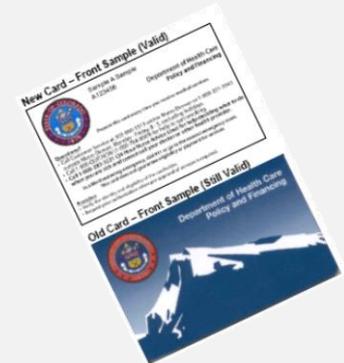
Web Portal



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 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

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.

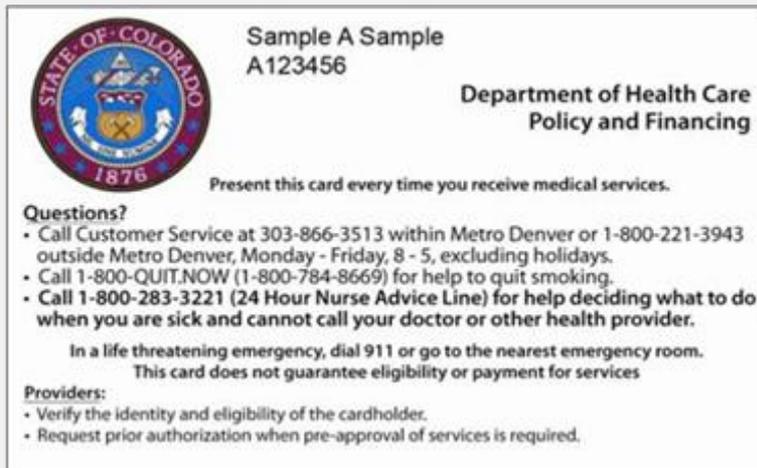
A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

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



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**



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

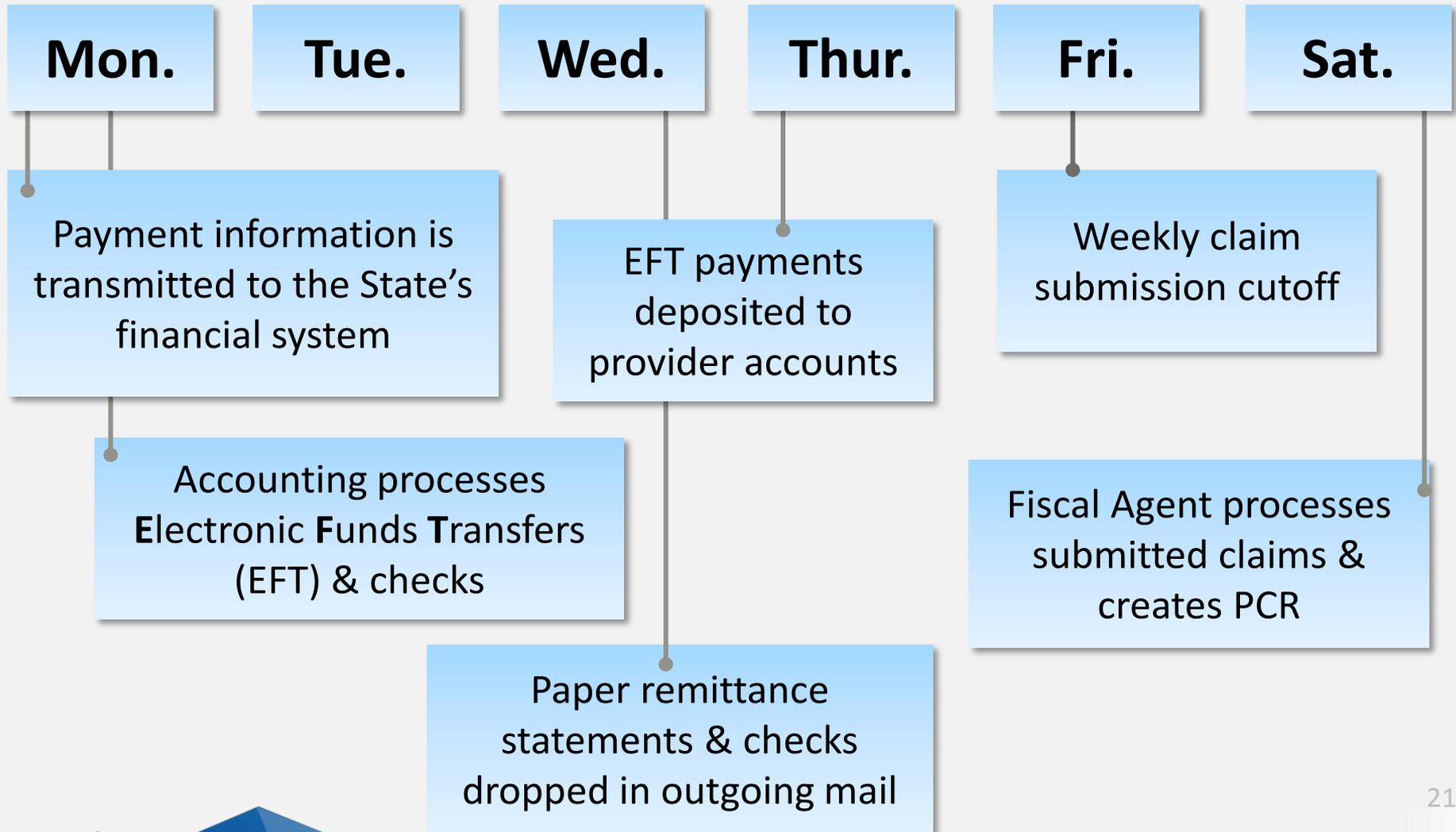


ICD-10 Implementation Delay

- 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



Payment Processing Schedule



Electronic Funds Transfer (EFT)

- Several Advantages:

- Free!
- No postal service delays
- Automatic deposits every Friday
- 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



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



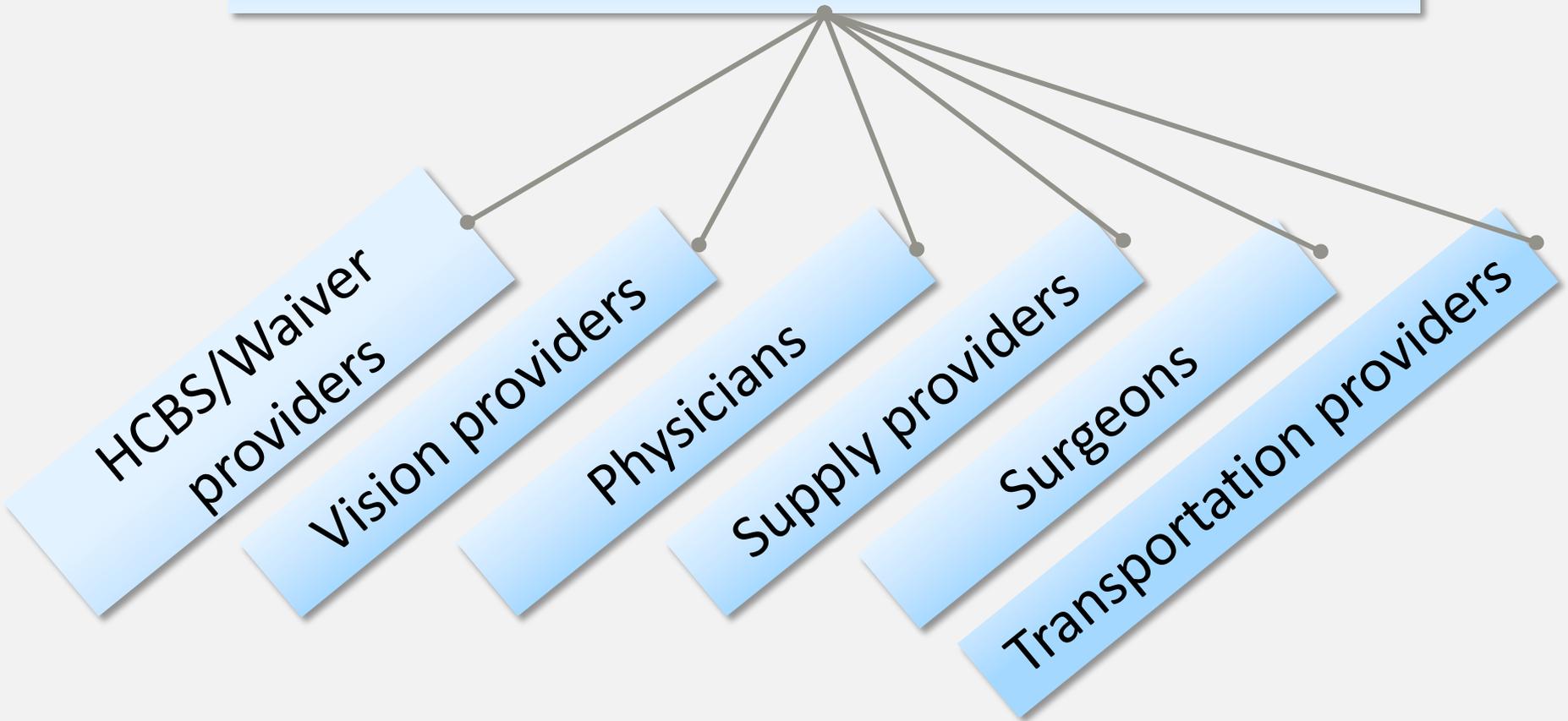
What is the Colorado 1500?

- 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



Colorado 1500

Who completes the Colorado 1500?



Emergency Transportation

- Emergency services require a physician's statement of medical necessity or trip report
 - Subject to audit for 6 years
- Emergency transportation includes:
 - Ambulance
 - Air Ambulance



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



Non-Emergency Medical Transportation (NEMT)

- Non-Emergency Medical Transportation
 - Defined as transportation to and/or from a medical treatment that is not emergent in nature
 - Non-Emergency care is scheduled
 - NEMT is only available when member has no other form of transportation



Non-Emergency Medical Transportation (NEMT)

Types of NEMT

Mobility Vehicle

Train

Car

Wheelchair Van

Bus

Plane

Taxi

Non-emergency
Ambulance



Non-Emergency Medical Transportation (NEMT)

- The following are **not** benefits of Colorado Medical Assistance Program:
 - Waiting time
 - Charges when member is not in vehicle
 - Transportation when not medically necessary
 - Trips to a pharmacy (counties officially designated as “Rural” may use NEMT for trips to a pharmacy)



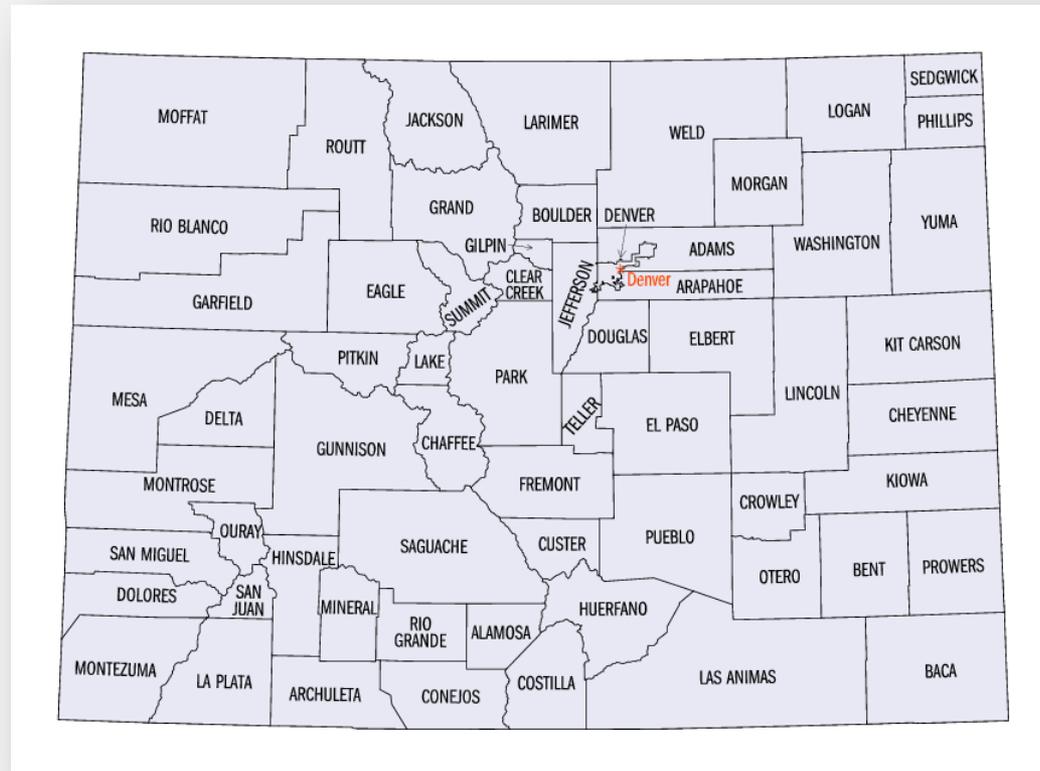
Colorado Rural Counties

- Alamosa
- Archuleta
- Chaffee
- Conejos
- Crowley
- Delta
- Eagle
- Fremont
- Garfield
- Grand
- Lake
- La Plata
- Logan
- Montezuma
- Montrose
- Morgan
- Otero
- Ouray
- Phillips
- Pitkin
- Prowers
- Rio Grande
- Routt
- Summit



NEMT

- NEMT is administered in each member's respective county, except for members residing within the front range area



Transportation Broker

- Transportation providers serving the nine front range counties can no longer directly bill the Colorado Medical Assistance Program for NEMT
- All NEMT services for the nine front-range counties must be:
 - Authorized
 - Approved
 - Arranged &
 - Paid, through First Transit
- Note: First Transit is the only NEMT broker contracted with Medicaid



Transportation Broker

- First Transit manages Non-Emergency Medical Transportation (NEMT) program for providers whose members reside within the following nine front range counties:

- Adams

- Arapahoe

- Boulder

- Broomfield

- Denver

- Douglas

- Jefferson

- Larimer

- Weld



Transportation Broker

If you are a transportation provider wanting to provide
NEMT services

or

Have a member in need of transportation within the nine
counties listed, please contact:

First Transit – Colorado NEMT

1-855-677-6368

Or visit their website at: www.medicaidco.com

NEMT

- Members in the following programs do not qualify for non-emergency transportation benefits:
 - CHP+
 - OAP-state only (Old Age Pension)
 - Qualified Medicare Beneficiary (QMB)
 - QI-1 (Qualified Individuals-1)
 - SLMB (Specified Low Income Medicare Beneficiaries)



County Responsibilities

- As the State Designated Entity (SDE), the Department of Human/Social Services (DHS) in each county is responsible for:
 - approving services
 - arranging NEMT for Medicaid members
- The SDE is required to query members requesting NEMT:
 - To determine that the member is being transported to a Medicaid covered service
 - To ensure that the member has exhausted all means of accessing free transportation



County Responsibilities

- SDEs are required to inform members in writing of any requested transportation service that is being denied
 - Denial letter must include:
 - reason for denial
 - “Member Appeal Right” language & instructions
 - same language that is included on the back of all formal claim denials sent from the Department’s Fiscal Agent



County Responsibilities

- Some counties have elected to opt out of their transportation administration duties by contracting with private transportation brokers
 - This option for counties is valid as long as there is no additional cost to Colorado Medical Assistance Program



County Responsibilities

- Private transportation brokers & the counties they represent are:

Red Willow, Inc. (San Luis Valley Transportation)
719.589.5734



Counties:

- Alamosa
- Costilla
- Conejos
- Rio Grande
- Mineral
- Saguache

North Eastern Colorado Transportation Authority
970.522.6440



Counties:

- Sedgwick
- Phillips
- Yuma
- Logan
- Morgan
- Washington



County Responsibilities

- Although SDEs may be notified of changes or updates to programs, appeals and rules, rates, etc., the SDE is responsible for staying informed
- For updates and changes, refer to:
 - Provider Bulletins
 - Agency Letters
 - Web Portal messages



Modes of Transportation

Mobility Vehicles

- **Provided when:**
 - member has no transportation
 - this option is least costly
 - most appropriate mode for member's condition
- May transport multiple parties at the same time
- Does not calculate charges based upon a meter
- May use wheelchair van billing codes only when:
 - member is a physician-certified wheelchair user and
 - vehicle has appropriate wheelchair equipment



Modes of Transportation

Wheelchair Van

- **Only a benefit when:**
 - member is physician-certified wheelchair user
 - vehicle has been appropriately modified
- Oxygen administration is allowed
 - when medically necessary
- Unlike mobility vehicles, wheelchair van service is not regulated by Public Utilities Commission (PUC)
- May use mobility vehicle billing codes only when:
 - member isn't physician-certified wheelchair user



Modes of Transportation

Bus or Train

- **Benefits are provided when:**
 - member is traveling a great distance
 - it is the least costly means of transportation
 - member's health condition is poor
 - appropriate for in-state and out-of-state travel
 - no PAR required
 - for train, use procedure code A0110



Modes of Transportation

Air

- **For air ambulance, helicopter & commercial air**
 - PAR required
 - PAR must be:
 - completed by the SDE &
 - submitted to ColoradoPAR Program



Non-Emergency Air Transportation

- NEMT Benefits are provided when:
 - Point of pickup is inaccessible by land vehicle
 - Point of pick up is accessible by a land vehicle
 - But great distances prohibit transporting
 - Great distances prohibit transporting member to the nearest appropriate location and member needs immediate attention
 - Patient is suffering from an illness that makes other forms of transportation inadvisable



Mileage Reimbursement

- For mileage reimbursement, you must provide the SDE with:
 - Name & address of vehicle owner
 - Destination address
- Reimbursement Rules
 - SDEs should route trip using mapping or similar GPS program to determine mileage
 - Print map page for documentation
 - Trip must be most direct route to and/or from medical appointment with closest qualified provider
 - Service must be a benefit of the Colorado Medical Assistance Program



Multiple Riders

- When NEMT services are:
 - Provided by multi-passenger vehicle
 - For more than one member at a time:
 - Member traveling furthest distance is reimbursed at full rate
 - Member traveling second furthest distance is reimbursed at $\frac{1}{2}$ rate
 - Any additional member(s) shall be reimbursed at $\frac{1}{4}$ rate of the first member
 - No PAR required



Out-Of-State Transportation

- Requirements
 - Provider must verify that out-of-state service has been authorized
 - Medical necessity requirements must be certified by member's physician
 - SDE must obtain the prior approval from the ColoradoPAR Program
- If member requires out-of-state transportation, contact ColoradoPAR Program
 - 1-888-454-7686



Ancillary Services

- All ancillary services require prior authorization by The ColoradoPAR Program:

Meals and lodging

- Only authorized if trip cannot be completed in one calendar day

Escort

- May accompany at-risk adults or children



Units of Service

- Units may represent the number of one-way trips or number of miles

For meals and lodging

- 1 unit = 1 day of lodging
- 1 unit = total meals for 1 day
- Lodging per day = \$35.03
- Meals per day = \$15.41

Note: Only 1 meal (1 unit) allowed per day

For transportation by bus, train or air

- Units represent number of one-way trips taken
- Do not bill mileage
- Must provide receipt



Over-the-Cap Expenses

- Over-the-cap expenses are expenses exceeding maximum allowable
- Mental health hold members only qualify when being transported to Fort Logan or the State facility in Pueblo
- PAR documentation must indicate:
 - that requested mode is most appropriate and least costly method of transportation for member
 - medical condition and extenuating circumstances (in detail) to support approving an over-the-cap request
- PAR must include documentation that:
 - care is not available in member's local community
 - member is seeing closest, appropriate, Colorado Medical Assistance Program provider



Over-the-Cap Expenses (cont.)

- Expenses exceeding maximum allowable cap
 - Mental health hold members only qualify if being transported to:
 - Fort Logan
 - State facility in Pueblo
 - PAR documentation must indicate that the requested mode is:
 - Most appropriate
 - Least costly method of transportation



Over-the-Cap Expenses (cont.)

- PAR must include documentation that:
 - Indicates (in detail) the medical condition and extenuating circumstances to support approving an over-the-cap request
 - Care is not available in member's local community
 - Member is seeing closest, appropriate, Colorado Medical Assistance Program provider



Transportation Billing Instructions

- Use diagnosis code 780 for all NEMT claims
 - Regardless of diagnosis
- For Place of Service Code
 - Enter '41' for land transportation
 - Enter '42' for air transportation
- Span dating is not allowed
- Claims that require attachments must be billed on paper



Benefit and Billing Information

- For detailed benefit and billing information refer to the Transportation Billing Manual:
 - colorado.gov/pacific/hcpf/billing-manuals



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

A sample of a paper Adjustment Transmittal form from the Colorado Medical Assistance Program. The form includes fields for Provider Name, Street Address, City, State, Zip Code, Telephone Number, Billing Provider Medicaid ID Number, Billing Provider National Provider Identifier (NPI), Client ID Number, Client Name, Date of Service, and Provider Claim Report (PCR) Date. It also contains instructions for completing the form, including attaching a copy of the replacement claim, a copy of the Provider Claim Report (PCR), and a copy of the Standard Paper Remittance (SPR). The form is titled "Adjustment Transmittal" and includes a "FISCAL AGENT USE ONLY" section at the bottom.

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 091808	041808 406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1									
Z71 CLIENT, IMA	A000000	40800000000200002	041008 041008 041808	041808 406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1									
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									
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!

