Beginning Billing Workshop Nursing Facility

Colorado Medicaid
2015

COLORADO
Department of Health Care Policy & Financing

Centers for Medicare & Medicaid Services

COLORADO
Department of Health Care Policy & 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

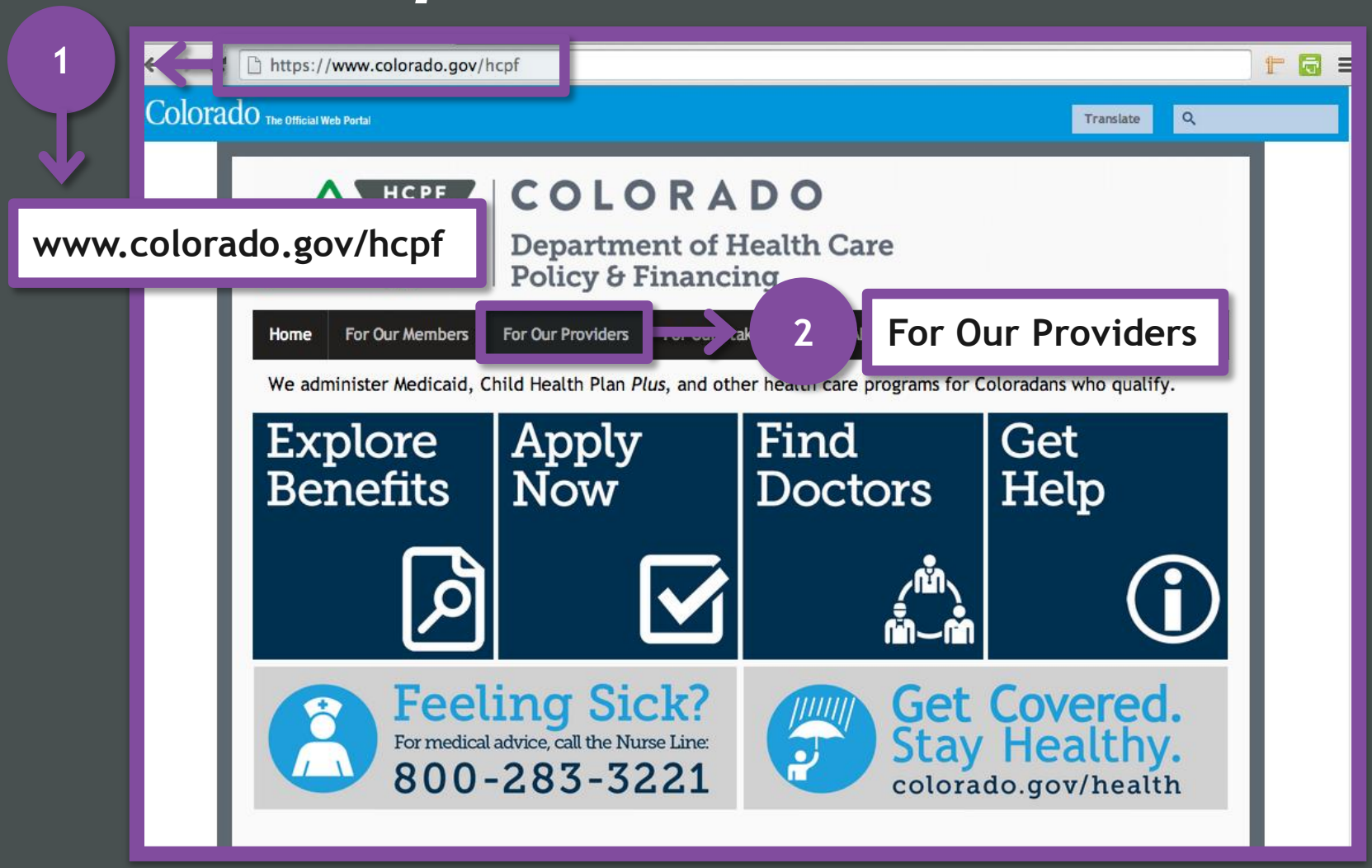
What is an NPI?

- 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

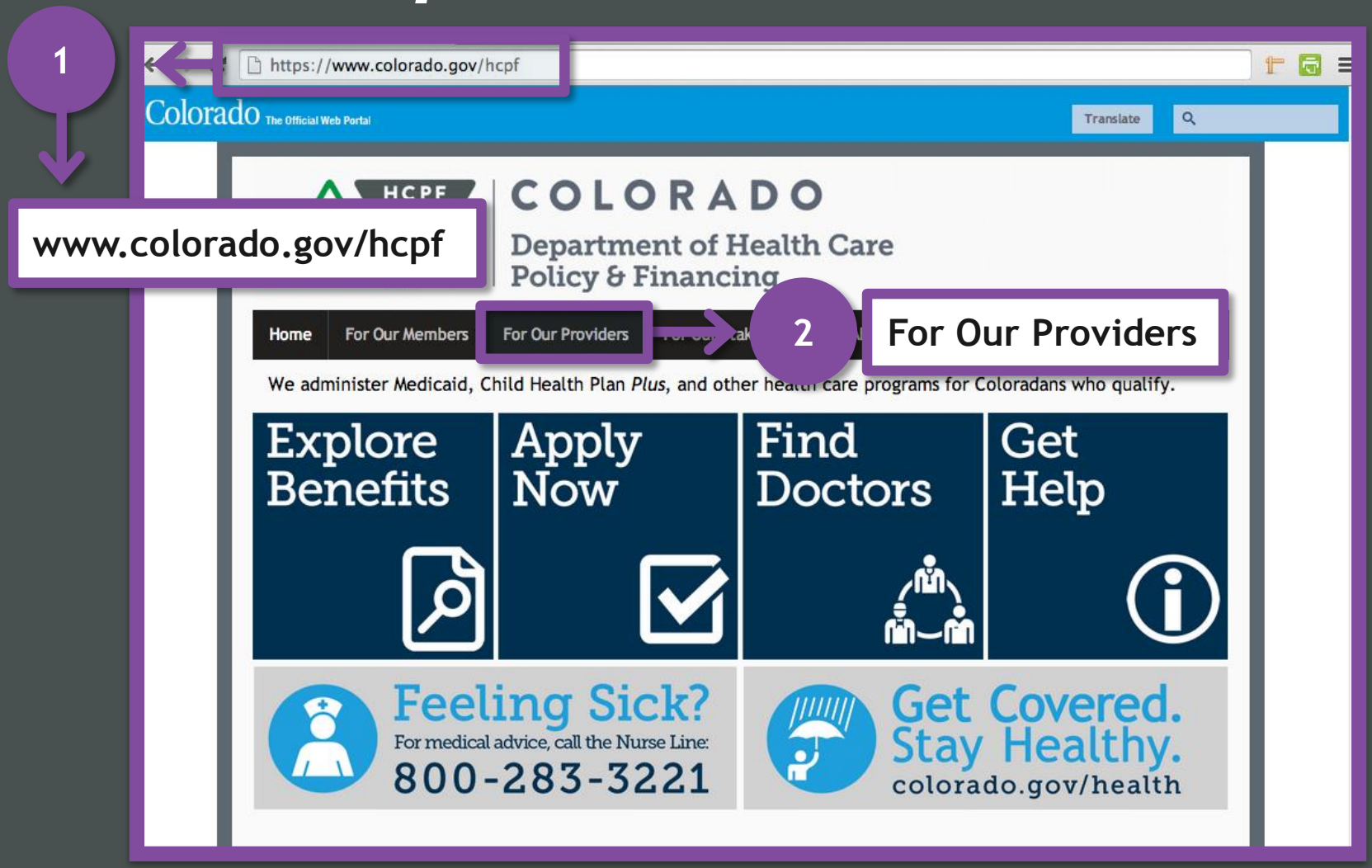
What is an NPI? (cont.)

- How to Obtain & Learn Additional Information:
  - CMS web page (paper copy)-
    - www.dms.hhs.gov/nationalproldentstand/
  - National Plan and Provider Enumeration System (NPPES)-
    - www.nppes.cms.hhs.gov
  - Enumerator-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

Department Website



Department Website



Provider Home Page

Find what you need here

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

Provider Enrollment

Question:

What does **Provider** Enrollment do?

Answer:

Enrolls **providers** into the Colorado Medical Assistance Program, *not* members

Question:

Who needs to enroll?

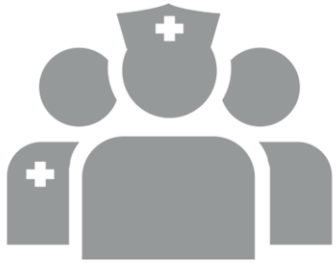
Answer:

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

From the Noun Project:
"Medical-Team" icon created by Pieter J. Smits
"Hospital" icon created by Carlotta Zampini

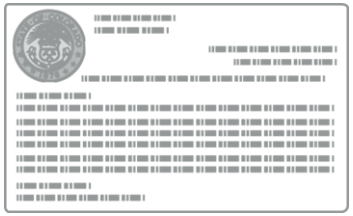
Verifying Eligibility

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

Colorado Medical Assistance Web Portal

Fax Back 1-800-493-0920

CMERS/AVRS 1-800-237-0757



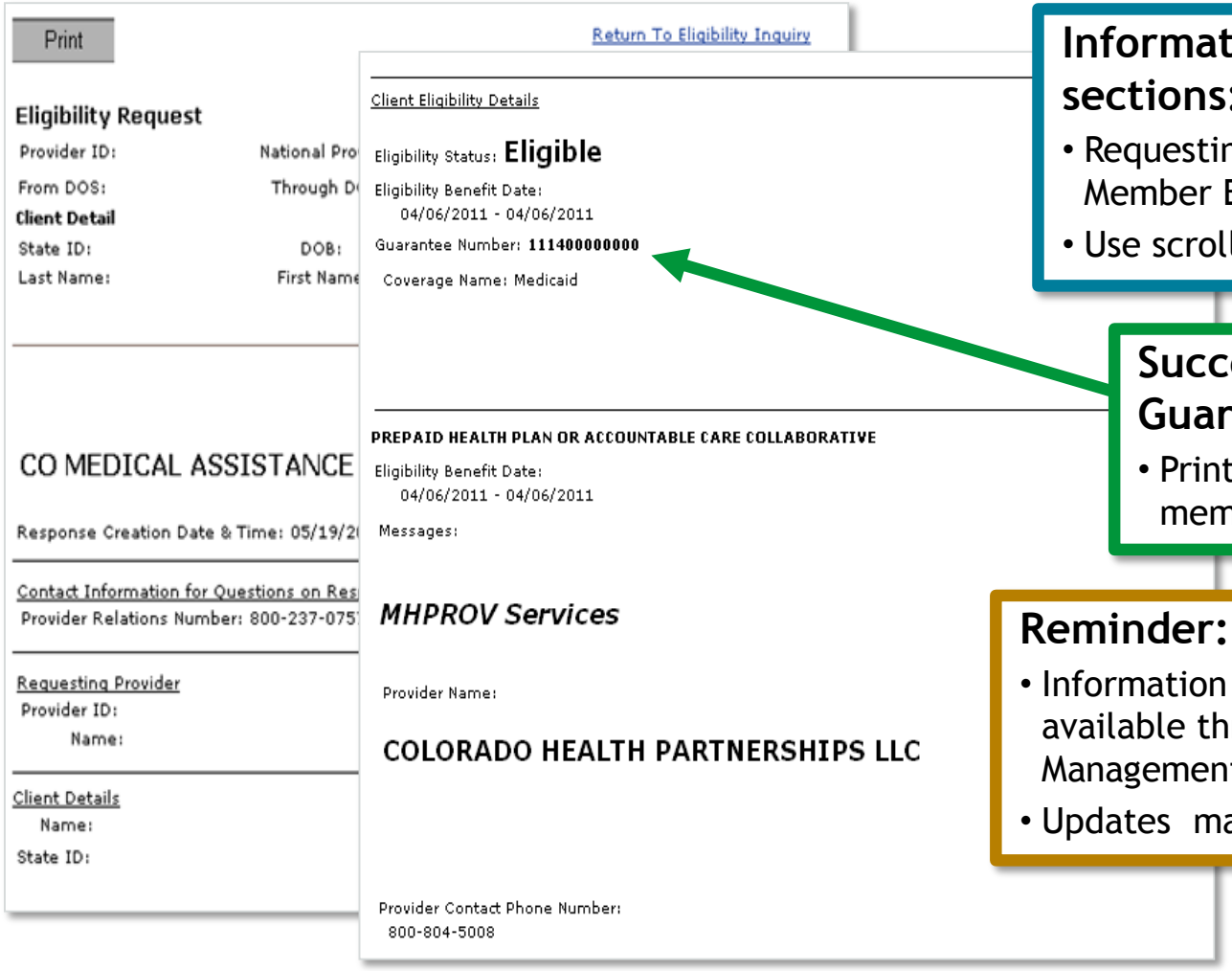
Medicaid ID Card with Switch Vendor

From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

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)



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

Sample A Sample
A123456

Department of Health Care
Policy and Financing

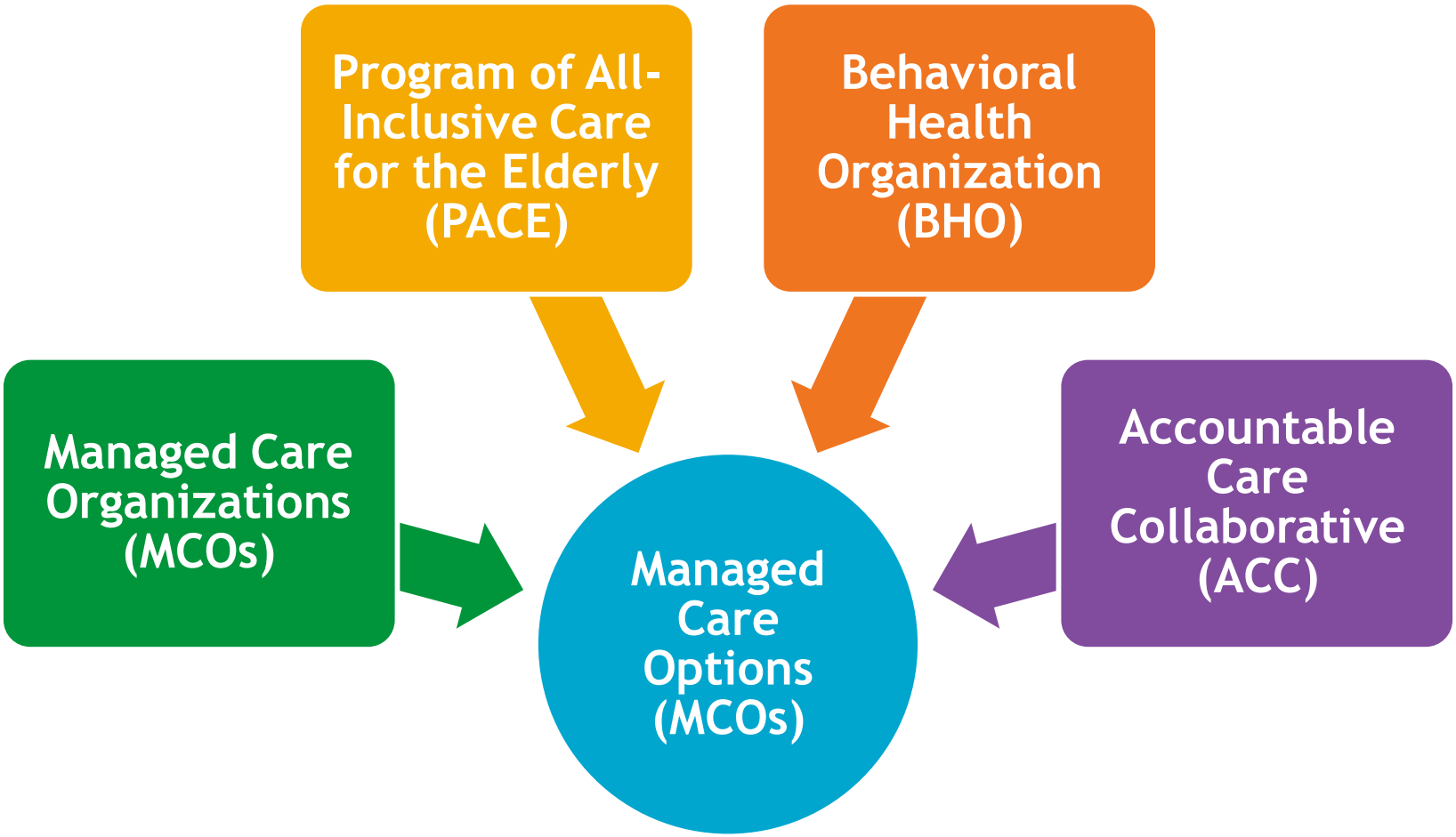
Present this card every time you receive medical services.

Questions?
- Call Customer Service at 303-866-3513 within Metro Denver or 1-800-221-3943 outside Metro Denver, Monday - Friday, 8 - 5, excluding holidays.
- Call 1-800-QUIT.NOW (1-800-784-8669) for help to quit smoking.
- **Call 1-800-283-3221 (24 Hour Nurse Advice Line) for help deciding what to do when you are sick and cannot call your doctor or other health provider.**

In a life threatening emergency, dial 911 or go to the nearest emergency room.
This card does not guarantee eligibility or payment for services

Providers:
- Verify the identity and eligibility of the cardholder.
- Request prior authorization when pre-approval of services is required.

Managed Care Options



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 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

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

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

$400.00
- $300.00
= $100.00

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

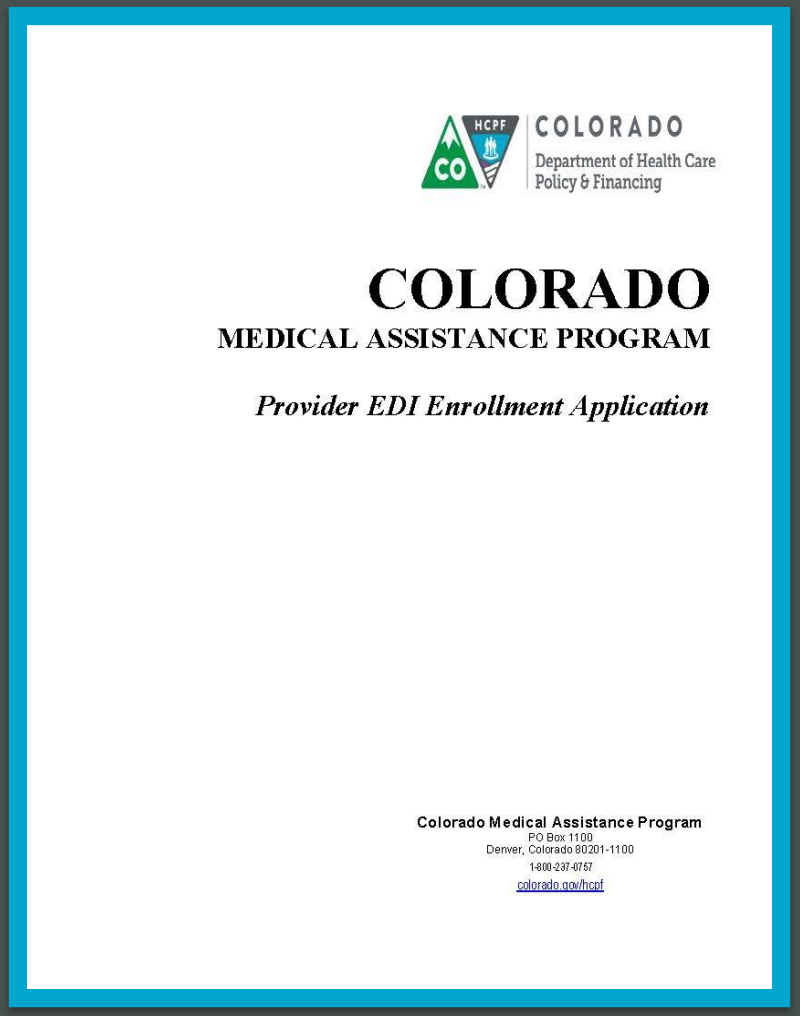
- Methods to submit:
  - Electronically through Web Portal
  - Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  - Paper only when:
    - Pre-approved (consistently submits less than 5 per month)
    - Claims require attachments

ICD-10 Implementation Delay

ICD-10 Implementation delayed until 10/1/2015

Claims with Dates of Service (DOS) **on** or **before** 9/30/15	**Use ICD-9 codes**
Claims with Dates of Service (DOS) **on** or **after** 10/1/2015	**Use ICD-10 codes**
Claims submitted with both ICD-9 and ICD-10 codes	**Will be rejected**

Providers Not Enrolled with EDI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COLORADO
MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

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

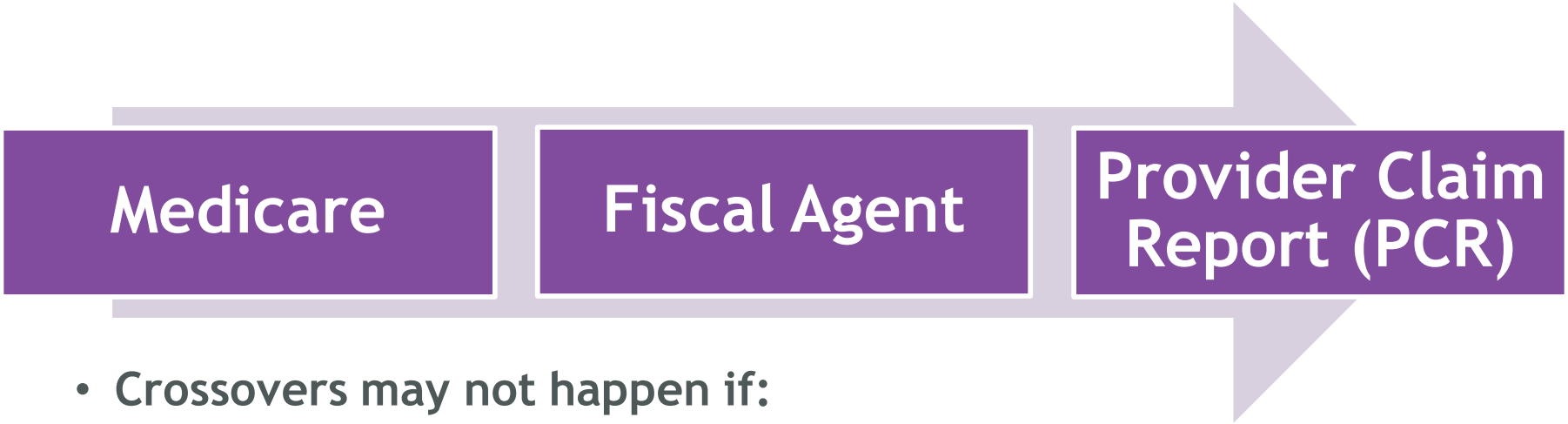
Providers must be enrolled with EDI to:

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- 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

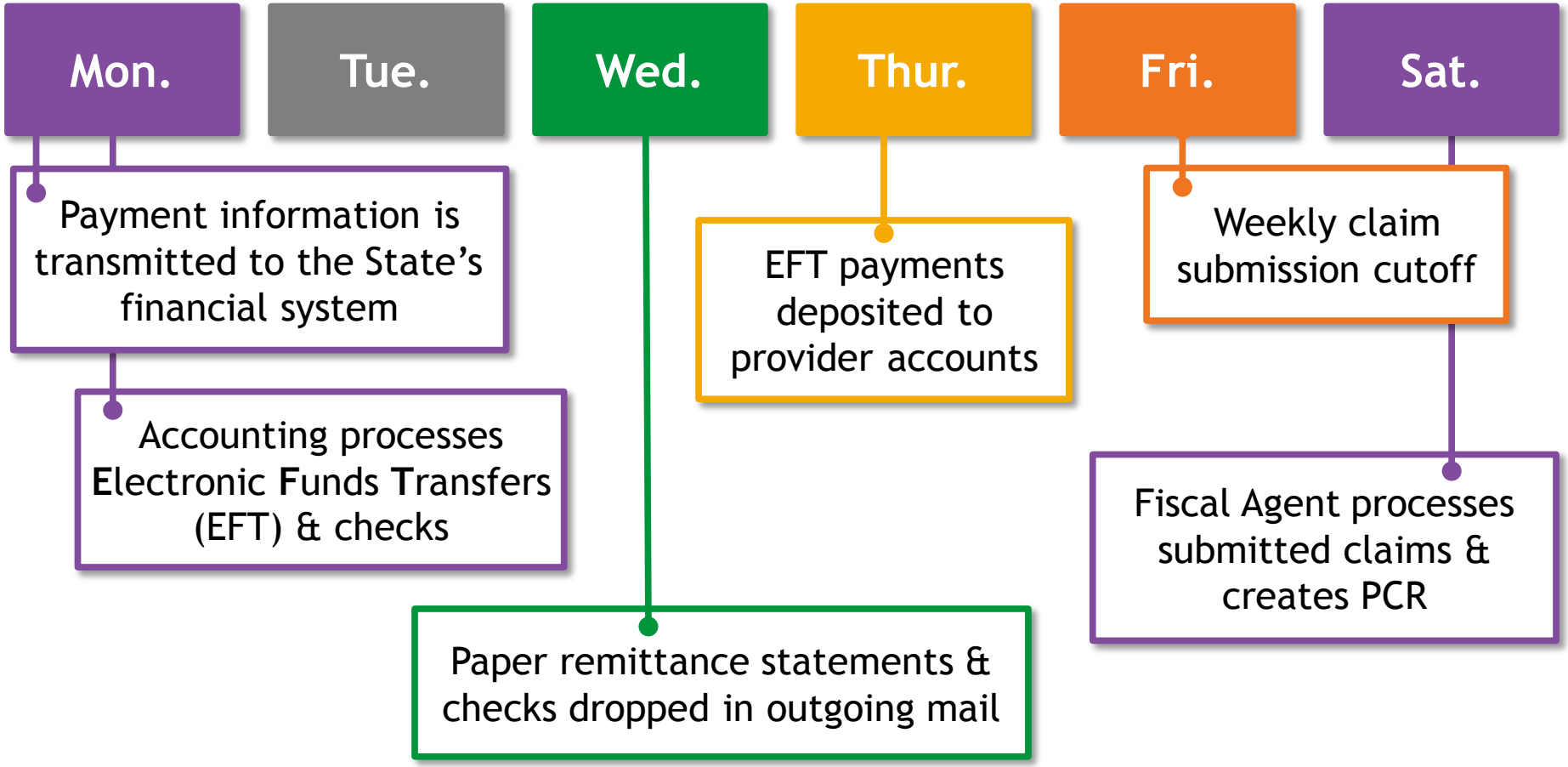
Crossover Claims

Provider Submitted Medicare Crossover Process:

Medicare → **Fiscal Agent** → **Provider Claim Report (PCR)**

- **Additional Information:**
  - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - Crossovers may be submitted on paper or electronically
  - Provider must submit copy of SPR with paper claims
  - Provider must retain SPR for audit purposes

Payment Processing Schedule



Electronic Funds Transfer (EFT)

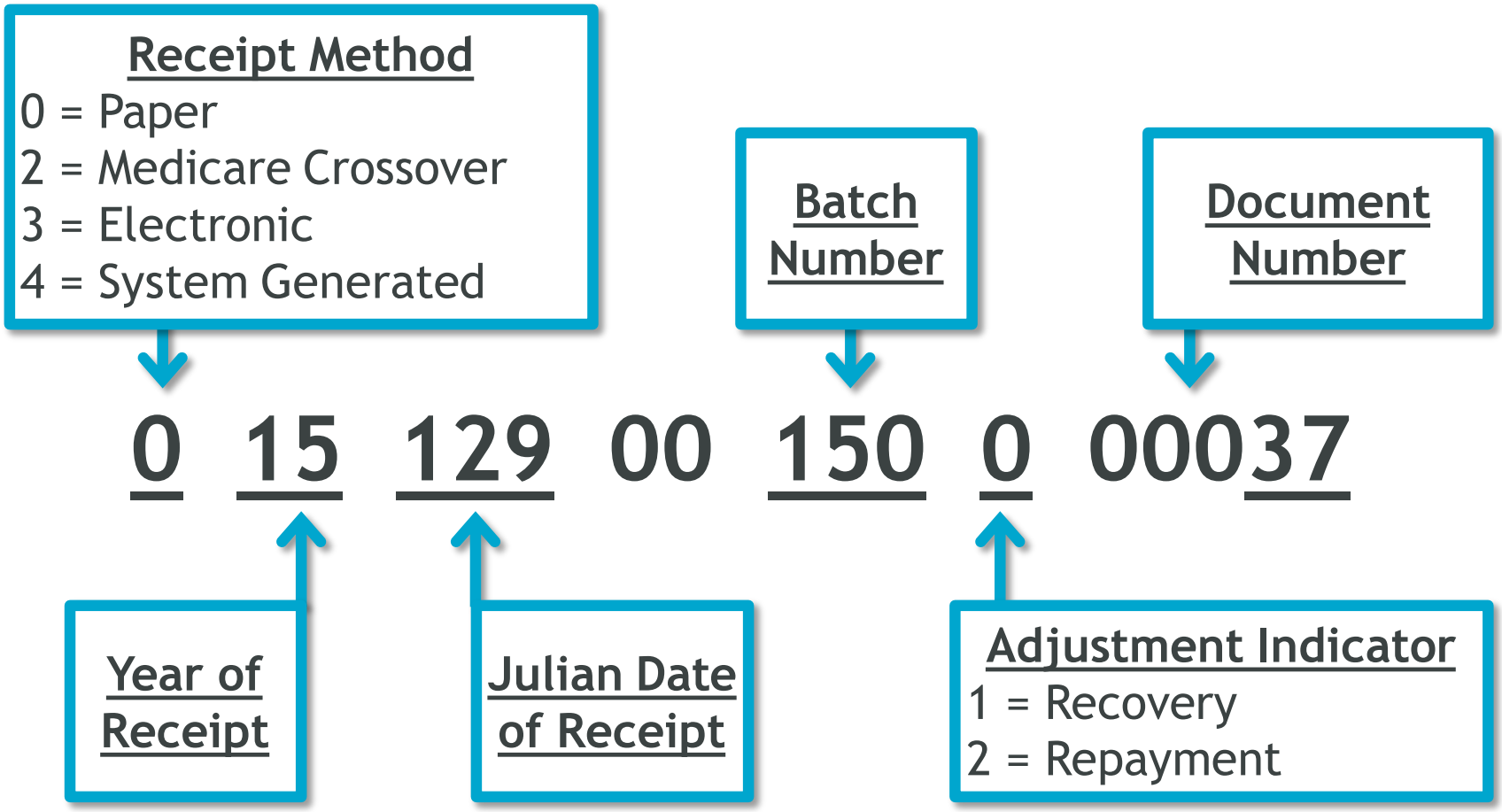
Advantages

- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- Colorado.gov/hcpf/provider-forms → Other Forms

PARs Reviewed by the Department

- 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**

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 delivery date

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

From DOS FQHC Separately Billed and additional Services

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	Medicare denies claim
120 days from Medicare payment date	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

Timely Filing 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

Timely Filing 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

Timely Filing Extensions

Backdated Eligibility

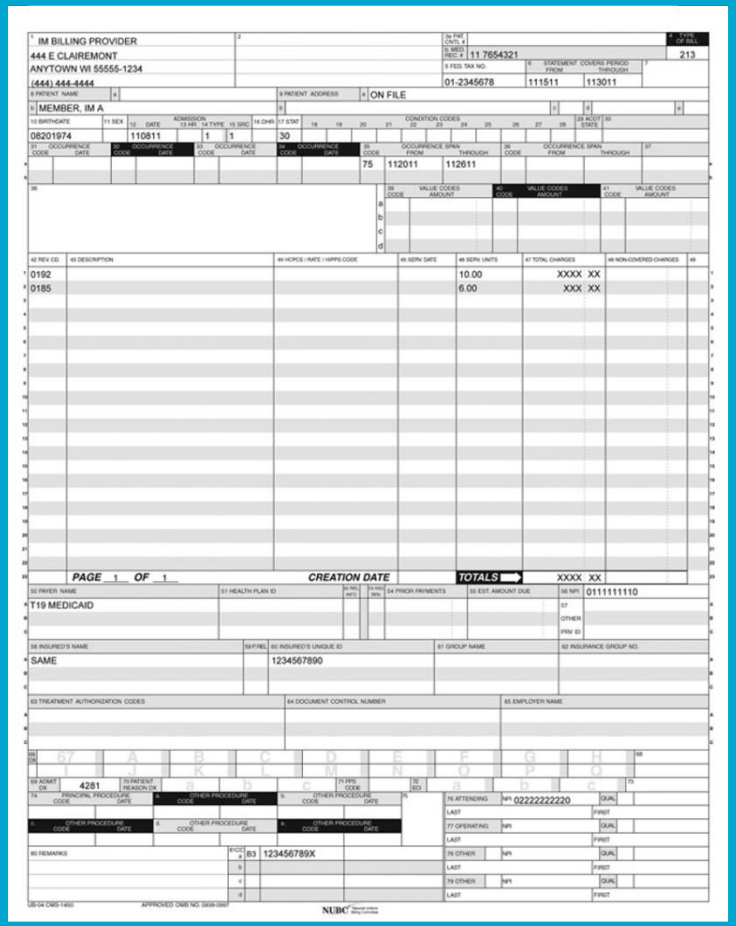
- 120 days from date county enters eligibility into system
  - Report by obtaining State-authorized letter identifying:
    - County technician
    - Member name
    - Delayed or backdated
    - Date eligibility was updated

UB-04

Examples of NF Services Billed on UB-04

- Class 1 Services
- Crossover
- 119-Private Room (with Department approval)
- 129-Semi Private Room
- 182-Non-Medical Leave
- 185-Medical Leave
- 479-PETI Hearing & Ear Services
- 962-PETI Vision & Eye Care
- 969-PETI Dental Services
- 999-PETI Health Insurance Premiums & Other Services

UB-04

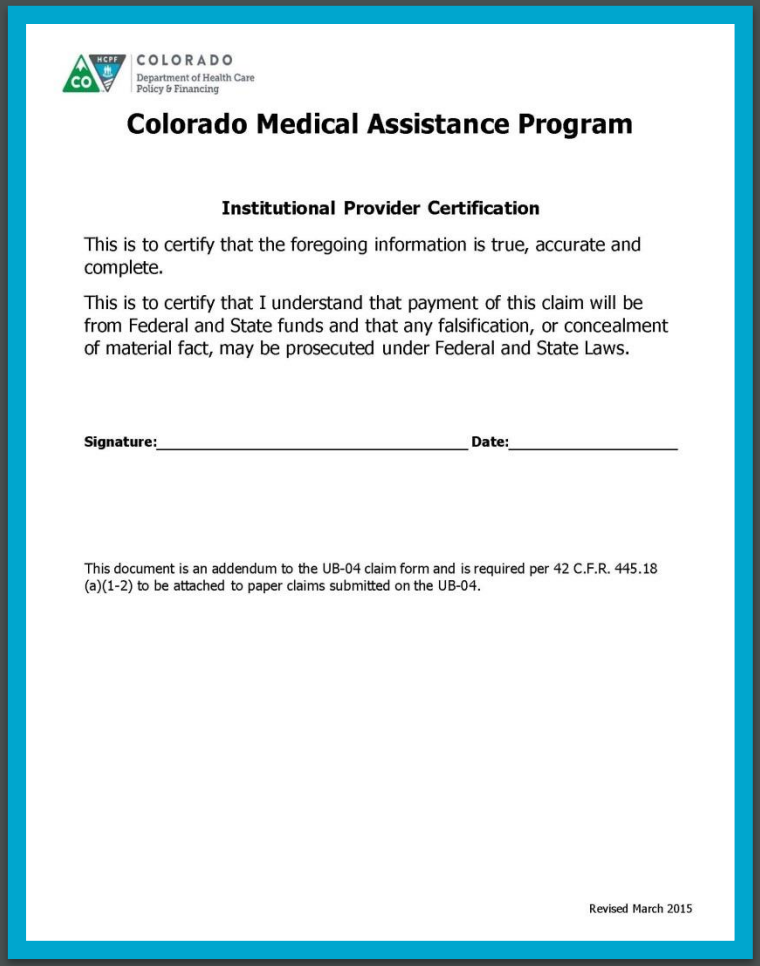


UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs

Where can a Colorado Medical Assistance provider get the UB-04?

- Available through most office supply stores
- Sometimes provided by payers

UB-04 Certification



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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.

Revised March 2015

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/billing-manuals

UB-04 Tips

Use Value Codes to Indicate

Member Liability (Member Payment

- Value Code 31

Covered Days

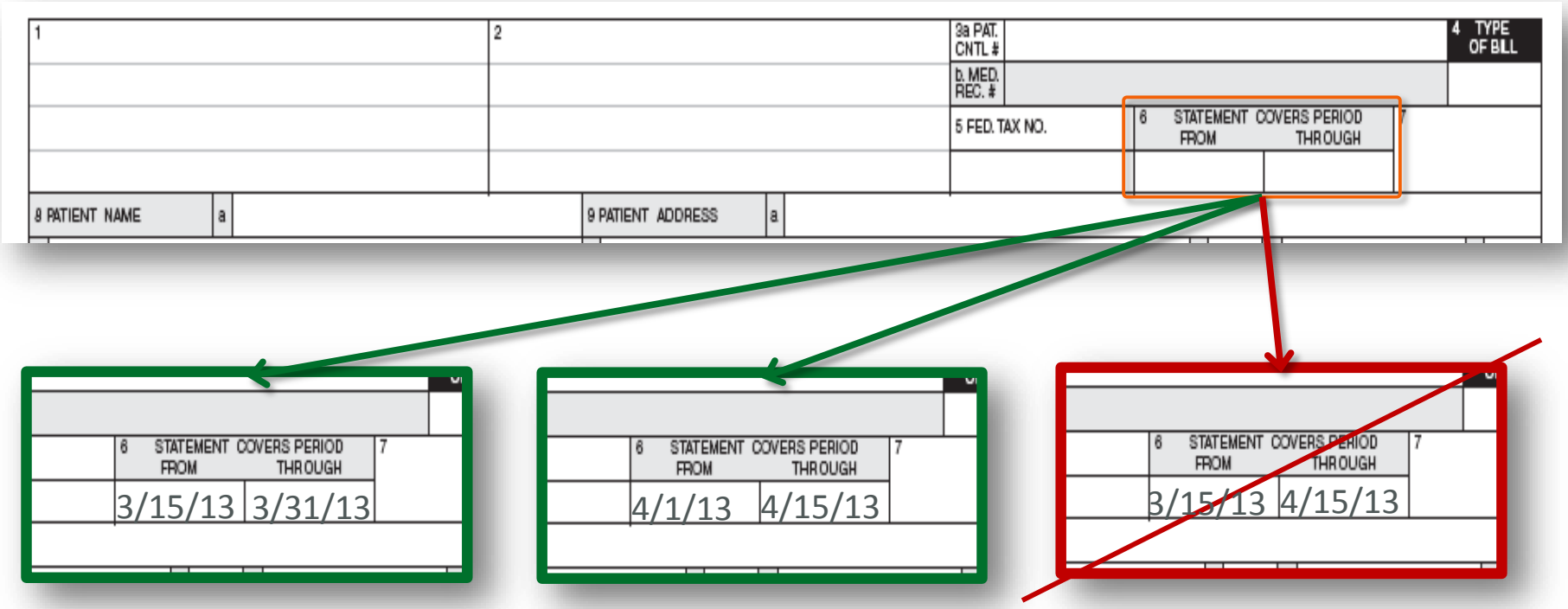
- Value Code 80

Non-Covered Days

- Value Code 81

UB-04 Coding Reminders

- Statement Covers Period-
  - "From" and "Through" dates must be within same calendar month



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 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 1 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 with 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 the Fiscal Agent, the Single Entry Point (SEP) agency, and the county
    - Fiscal Agent end dates the PAR

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, leave 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 redermination

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 certificate 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 member payment - there is No PETI!!

To Access PETI

All other payer sources must have been exhausted

AND

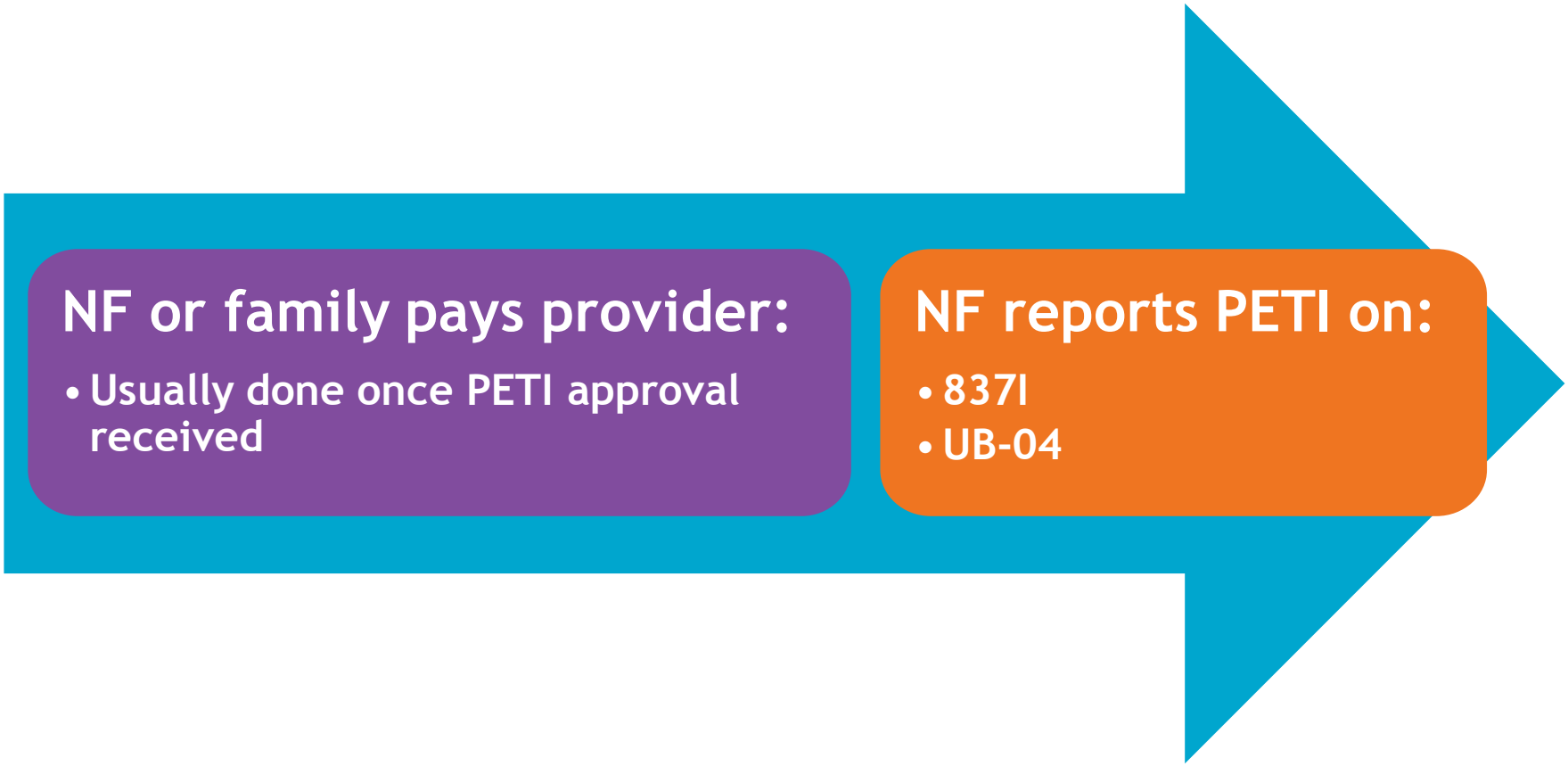
Cannot be a covered Medicaid service

OR

Must have Medicaid denial

(You must first submit a claim to the Colorado Medical Assistance program)

PETI Process Overview



From the Noun Project:
"Payment" icon created by Doug Cavandish
"Hospital" icon created by Carlotta Zampini

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 Class 1 services amount
  - Member 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	Then
Provider is requesting more than what is allowed on PETI fee schedule	This amount must be amended to what is allowable on the PETI fee schedule

If	Then
Member has medical trust	PETI charges must be paid from medical trust

Dental PETI

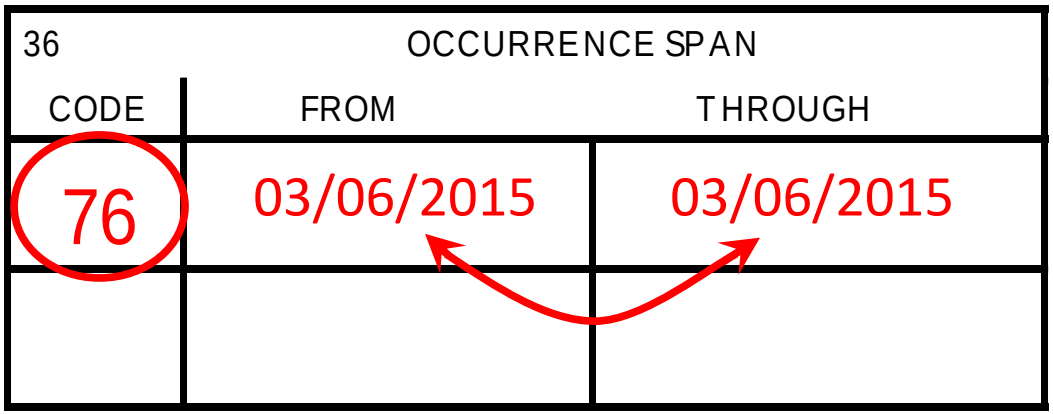
- Starting April 1, 2014 there is a new adult dental benefit
- All Medicaid adults now have an annual $1000 benefit
- Nursing Facilities will no longer be required to submit PETI requests for routine dental services
  - Refer to Dental Billing Manual
- The new benefit will have no impact on other PETI 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 member liability

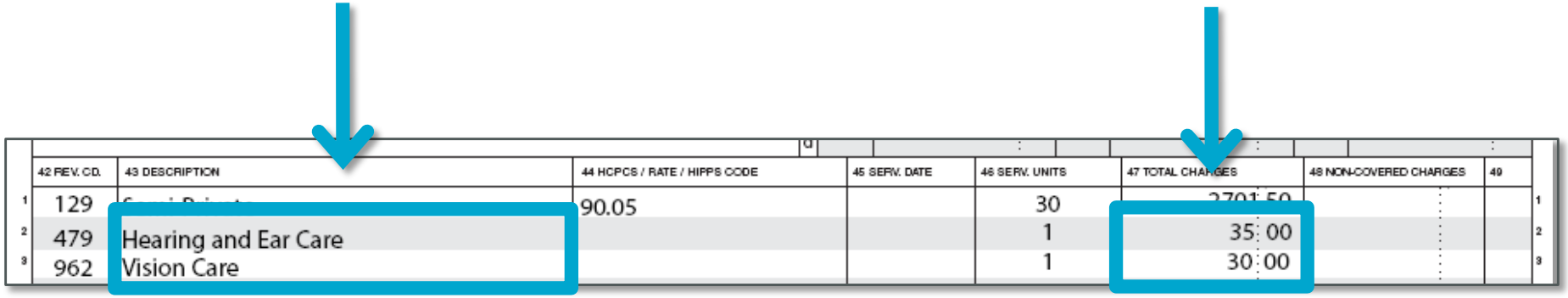
PETI Occurrence Span Dates

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



PETI Services

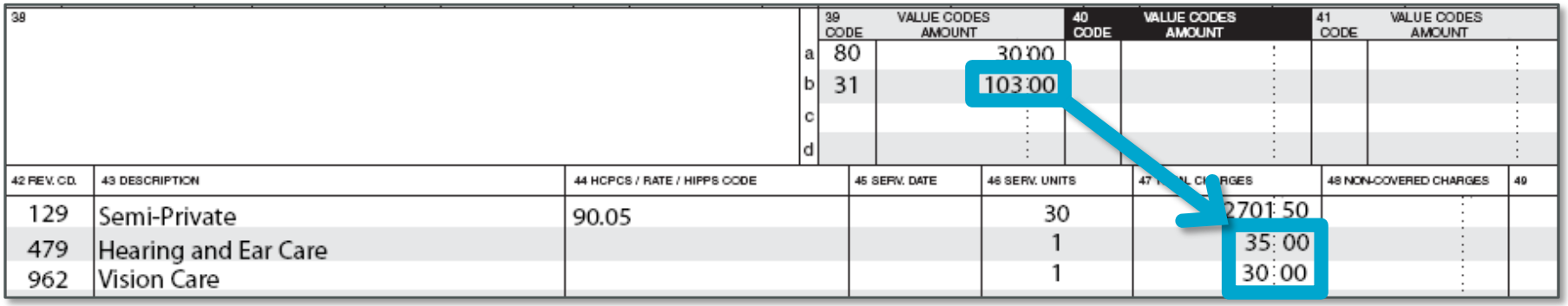
- Enter approved amount paid to service providers



	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		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 member payment entered for Value Code 31 (Patient Liability Amount)



38			39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
			a	80				
			b	31				
			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

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 "Payer 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

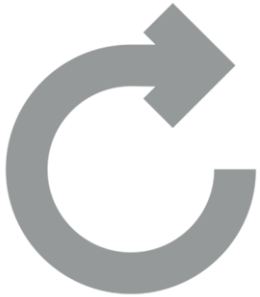
Claim processed & paid by claims processing system

From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

Claims Process - Common Terms

Adjustment

Correcting under/overpayments, claims paid at zero & claims history info



Rebill

Re-bill previously denied claim

Suspend

Claim must be manually reviewed before adjudication

Void

"Cancelling" a "paid" claim (wait 48 hours to rebill)

From the Noun Project:
"Delete" by Ludwig Schubert
"Stop" by Chris Robinson
"Check-Mark" by Muneer A.Safiah
"Money" by Nathan Thomson

Adjusting Claims

- What is an adjustment?
  - Adjustments create a replacement claim
  - Two step process: Credit & Repayment

Adjust a claim when	Do not adjust when
• Provider billed incorrect services or charges • Claim paid incorrectly	• 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

From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Paper" by Kristina

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	040800000000000001	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	30800000000000003	03/05/08	03/06/08	245.04	1348

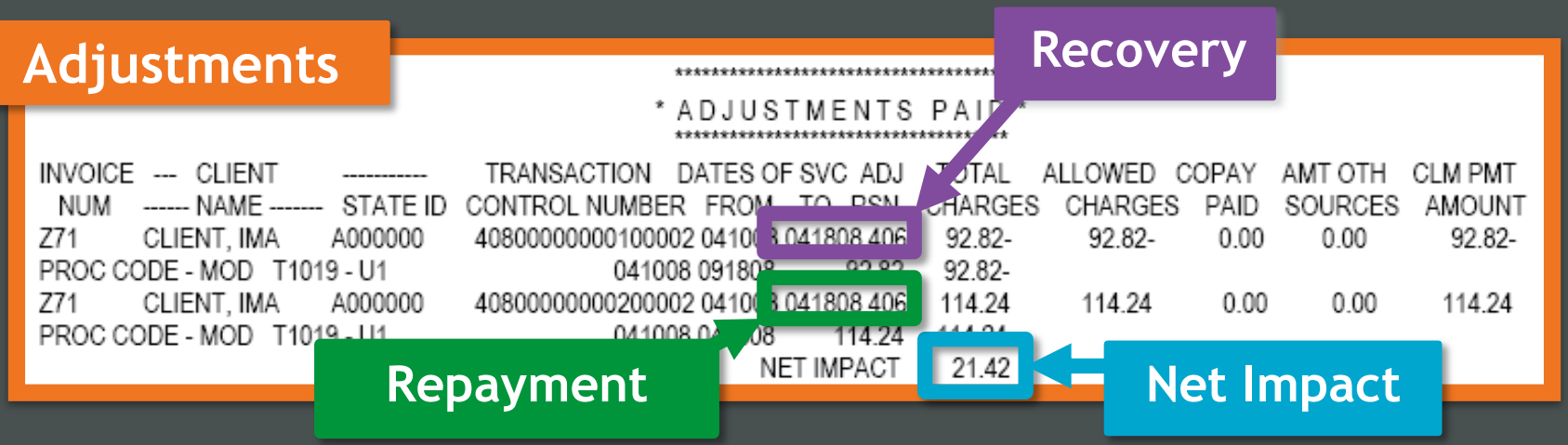
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE 1

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'.

Provider Claim Reports (PCRs)

Adjustments



* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	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	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	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				

Recovery

Repayment

Net Impact

Voids

* ADJUSTMENTS PAID *

INVOICE NUM	CLIENT NAME	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
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank you!