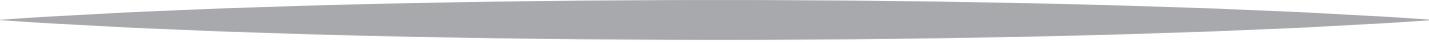


SCHOOL HEALTH SERVICES PROGRAM PROGRAM MANUAL



SECTION 5 FEE-FOR-SERVICE CLAIMS AND REIMBURSEMENT

Section 5: Fee-For-Service Claims and Reimbursement

5.1 Claims Requirement

[The Centers for Medicare and Medicaid Services \(CMS\)](#) requires that participating districts submit fee-for-service claims for each school health service provided to a client. Claims for all Medicaid allowable school health services must be submitted within 120 days of the date of service. All claims for services should be submitted according to the district's assigned rate schedule as established by [The Department of Health Care Policy and Financing \(the Department\)](#). Annually, the Department shall notify each district of the assigned rate schedule. Units of service identified in the claims submission are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant Current Procedural Terminology (CPT) or Healthcare Common Procedural Coding System (HCPCS) code. Services may be claimed according to encounter based or 15 minute unit increments, as specified in [Section 2](#).

Each claims submission is assigned a unique Transaction Control Number (TCN) that acts as an identifier for reimbursement and auditing purposes. A separate claim must be submitted for each service on each date of service. For example, if a client received 1 hour of nursing services every day for five consecutive days, 5 claims must be submitted for 1 hour of nursing services for each date. Billing for multiple dates of service on one claim is not allowed for any service. Specialized transportation services must be billed as one-way trips to and from the destination. The claims need to contain enough detail to clearly identify the client, the service provided (including number of units), the reason for the service, the provider type and the date of service.

Each participating district shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client. Reimbursement for claims submitted shall be based on the assigned rate schedule and paid as a fee-for-service. Reimbursement shall serve as an interim payment for school health services provided.

[Appendix A.3](#) provides a checklist for appropriate claiming. All claims must be submitted and processed through the Medicaid Management Information System (MMIS).

5.2 Claims Submission

HIPAA requires that Medicaid providers, including districts, use National Provider Identifiers (NPIs) in standard transactions.

Medicaid providers may submit claims in a paper form or through an electronic submission. Electronic submission is required in most circumstances and paper claims are only processed for:

- Claims from providers who consistently submit 5 claims or fewer per month.
- Claims that, by policy, require attachments.
- Reconsideration claims.

Paper claims do not require an NPI, but do require the district's assigned Medicaid provider identification number.

Electronic Claims

Instructions for completing and submitting electronic claims are available by contacting EDI Enrollment Services at 1-800-237-757 or through the following:

- X12N Implementation Guides for the 837P, 837I or 837D
(<http://www.wpc-edi.com/hipaa>)
- Companion Guides for the 837P, 837I or 837D (via Provider Services page on the Department's website)
- Web Portal User Guide
(<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542697178>)

Interactive Processing

Interactive claim submission is a real-time exchange of information between the provider and the Colorado Medical Assistance Program. Interactive claims are created one-at-a-time and transmitted through the Colorado Medical Assistance Program OnLine Transaction Processor (OLTP).

The Colorado Medical Assistance Program OLTP reviews the claim information for compliance with the Colorado Medical Assistance Program billing policies and returns a response to the provider's personal computer about that single transaction. If the claim is rejected, the OLTP sends a rejection response that identifies the rejection reason.

If the claim is accepted, the provider receives an acceptance message and the OLTP passes accepted claim information to the Colorado Medical Assistance Program claim processing system for final adjudication and reporting on the Colorado Medical Assistance Program Provider Claim Report.

Interactive Claims Submission

The Web Portal component contains online training, user guides and help that describe claims completion requirements, a mechanism that allows the user to create and maintain a data base of frequently used information, edits that verify the format and validity of the entered information, and edits that assure that required fields are completed.

Additional details regarding claims submission processes for school health services can be found in the Colorado Specialty Billing Manual located at
(<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542320888>)

To obtain additional information regarding claims submission or claims software, go to the Frequently Asked Questions page at
(<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542696399>)

5.3 Interim Payments

Participating districts are reimbursed interim payments based on a monthly rate. The monthly rate shall be based on the districts actual, certified costs identified in their most recently filed annual cost report. For a new Participating District, the monthly rate shall be calculated based on historical data. Interim payments shall be tied to claims submissions by the district. Claims shall be monitored by the Department and if claim

volume decreases significantly or drops to zero in any two consecutive months while school is in session, interim payments shall be withheld until the issue has been resolved. The interim payment rate will be given to participating districts each year no later than 30 days prior to July 1 of that state fiscal year.

The interim payment amount a district receives is equal to the federal share, not to exceed 100% of the federal match rate. Interim payments are reconciled during the cost reporting process against each district's Medicaid allowable cost identified in the district's annual cost report (refer to [Section 6](#)).

