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 CMS 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? (cont.)

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

[Image of the Colorado HCPF website]

1. www.colorado.gov/hcpf

2. For Our Providers

Department of Health Care Policy & Financing

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

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:

  - Colorado Medical Assistance 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)

Reminder:
- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

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
Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility
Eligibility Types

• Most members = Regular Colorado Medicaid benefits
• Some members = different eligibility type
  ➢ Modified Medical Programs
  ➢ Non-Citizens
  ➢ Presumptive Eligibility
• Some members = additional benefits
  ➢ Managed Care
  ➢ Medicare
  ➢ Third Party Insurance
Eligibility Types

Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services
Eligibility Types

Non-Citizens

- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only
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 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
Eligibility Types

Presumptive Eligibility

• Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  ➢ Member eligibility may take up to 72 hours before available

• Medicaid Presumptive Eligibility is only available to:
  ➢ Pregnant women
    • Covers DME and other outpatient services
  ➢ Children ages 18 and under
    • Covers all Medicaid covered services
  ➢ Labor / Delivery

• CHP+ Presumptive Eligibility
  ➢ Covers all CHP+ covered services, except dental
Eligibility Types

Presumptive Eligibility (cont.)

• Verify Medicaid Presumptive Eligibility through:
  ➢ Web Portal
  ➢ Faxback
  ➢ CMERS
    ▪ May take up to 72 hours before available

• Medicaid Presumptive Eligibility claims
  ➢ Submit to the Fiscal Agent
    ▪ Xerox Provider Services- 1-800-237-0757

• CHP+ Presumptive Eligibility and claims
  ➢ Colorado Access- 1-888-214-1101
Managed Care Options

Program of All-Inclusive Care for the Elderly (PACE)

Behavioral Health Organization (BHO)

Managed Care Organizations (MCOs)

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
  ➢ Connects Medicaid members to:

• Helps coordinate Member care
  ➢ Helps with care transitions
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 denial(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
Co-Payment Exempt Members

- Nursing Facility Residents
- Children
- Pregnant Women
Co-Payment Facts

• Auto-deducted during claims processing
  ➢ Do not deduct from charges billed on claim
• Collect from member at time of service
• Services that do not require co-pay:
  ➢ Dental
  ➢ Home Health
  ➢ HCBS
  ➢ Transportation
  ➢ Emergency Services
  ➢ Family Planning Services
Specialty Co-Payments

DME / Supply

$1.00 per date of service
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

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**

- **Mon.**
  - Payment information is transmitted to the State’s financial system
  - Accounting processes Electronic Funds Transfers (EFT) & checks

- **Tue.**

- **Wed.**
  - Paper remittance statements & checks dropped in outgoing mail

- **Thur.**
  - EFT payments deposited to provider accounts

- **Fri.**
  - Weekly claim submission cutoff
  - Fiscal Agent processes submitted claims & creates PCR

- **Sat.**

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 ColoradoPAR

- With the **exception of Waiver and Nursing Facilities:**
  - The ColoradoPAR Program 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:

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

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 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 837P transaction
  ➢ Keep supporting documentation

• Paper Claims
  ➢ CMS 1500- Note the Late Bill Override Date (LBOD) and the date of the last adverse action in field 19 (Additional Claim Information)
Medicare/Medicaid Enrollees

Timely Filing

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
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
What are some of the DME services billed on the CMS 1500?

- Wheelchairs
- Walkers
- Repairs
- Disposable Supplies
- Incontinence Products
**CMS 1500**

This is a photo of a CMS 1500 health insurance claim form. The form is used to submit claims to insurance companies for reimbursement of medical services. The form contains various sections for patient information, provider information, and medical services rendered. It is a standard form used in the healthcare industry for billing and reimbursement purposes.
Fraud and Abuse

**False Claims Act**
- Submitting claim for services or items not provided
- Falsifying elements on a claim (e.g. DOS, Units, etc.)
- See CRS 25.5-4-303.5 et seq

**Anti-Kickback Statute**
- Prohibits exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) referral of federal health care program business
- See 42 U.S.C. 1320a-7b

**Stark Law**
- Prohibits physicians from referring patients to medical facilities in which physician has a financial interest
- See 42 U.S.C. 1395nn
Fraud and Abuse

• Failure to use proper coding when billing may:
  ➢ Result in claims being denied
  ➢ Place provider in jeopardy of recovery actions and/or state or federal civil sanctions
  ➢ To avoid improper coding, use procedure codes & modifiers as instructed in Provider Bulletins and Provider Manuals
DME Reimbursement Billing: By-Invoice-Services

• Cannot receive more for item than maximum purchase price (MPP) as identified in fee schedule

• For items without MPP:
  ➢ Reimbursement rate = manufacturer’s suggested retail price (MSRP) less set percentage
    ▪ Percentage includes DME handling
  ➢ Copies of invoices & documented MSRP shall be submitted with claims
DME Reimbursement Billing: By-Invoice-Services

• Acceptable MSRP documentation:
  - MSRP, LIST Price, Retail Price. Originals must be maintained in provider’s files
    - per Department regulations
  - Providers cannot bill for state sales tax collection
Supplies / Disposables
Reimbursement

• For items without maximum purchase price:
  ➢ Reimbursement rate = the actual acquisition invoiced cost
    ▪ Actual acquisition costs are manufacturer’s list price for the item, minus any standard trade discount applied to lower the actual cost to provider
    ▪ Does not include any time-sensitive or otherwise conditional discounts available to provider
  ➢ If billing for handling, it should be at percentage of actual acquisition cost of the products
Miscellaneous Supply Codes

- Miscellaneous codes are manually priced and require MSRP documentation or an invoice, must be billed on paper, and must include the appropriate HCPCS code.

**Note:**
For new equipment please include:
- Make
- Model
- Serial #

**Appropriate HCPCS code**

**Copy of MSRP invoice**
Unrelated Manufacturer

• Only invoices from unrelated manufacturers or wholesale distributors shall be allowed
• Invoices are not allowed from
  ➢ Related owners
  ➢ Related parties
• See rule 10 CCR 2505-10 Section 8.590.7.A
Related Owner

• Individual with 5% or more ownership interest of a manufacturer
• One entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business
• DME supplier has control of or is affiliated with manufacturer
Related Party

• Member of owner’s immediate family, including:
  ➢ Spouse
  ➢ Natural, adoptive parent, or step-parent
  ➢ Natural, adoptive child, or stepchild
  ➢ Sibling or stepsibling
  ➢ In-laws
  ➢ Grandparents and grandchildren
Custom Manufacturing

• Invoices for Supplies or DME manufactured by provider must include detailed cost information for
  ➢ Acquisition
  ➢ Material
  ➢ Time and labor
Used Equipment

• Written, signed and dated agreement from the member accepting the equipment
• Members and providers may negotiate trade-in amount on member-owned used equipment
• Medicaid will pay up to 60% of the new cost for used pieces of equipment
  ➢ On PAR or claim, list serial number in “Additional Information” section of the CMS 1500
  ➢ Providers are not required to take trade-ins
• See 10 CCR 2505-10 8.590.7.D & 8.590.7.G
Date of Death

• Following are allowable the month of member’s death:
  - Durable medical rental equipment
  - Oxygen
  - Bulk supplies drop-shipped to member’s home

• Following date of death, recoveries will be made for:
  - Other services
  - Rental and bulk supplies billed after the month of member’s death
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.
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

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

• 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

Paper
• Complete field 22 on the CMS 1500 claim form
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

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**PROC CODE - MODIFIER 99214 -**

**TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE.... TOTAL CLAIMS PAID** 1 **TOTAL PAYMENTS** 69.46

#### Denied

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**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'.

---

**COLORADO**

Department of Health Care Policy & Financing
### Provider Claim Reports (PCRs)

#### Adjustments

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#### Recovery

- Net Impact: 21.42

#### Repayment

- Repayment: 421.29

#### Voids

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HCPF
Department of Health Care Policy & Financing

COLORADO

77
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!