COLORADO
School Health Services Program

SCHOOL HEALTH SERVICES PROGRAM PROGRAM MANUAL

Section 4

Fee-For-Service, Claims and Reimbursement

The School Health Services Program is a joint effort between the Colorado Department of Education and Department of Health Care Policy and Financing.
www.cde.state.co.us
www.colorado.gov/hcpf

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Section 4: Fee-For-Service Claims and Reimbursement

4.1 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 student. 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 assigned rate schedule as established by The Department of Health Care Policy and Financing (the Department). Districts bill at an assigned $0 rate and alternatively are reimbursed through the one-twelfth interim payment methodology detailed in Section 4.3 below 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 student 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 (span billing). 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 student, 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 student or the student's guardian a written informed consent to submit Medicaid claims on behalf of the student.

Section 7.3 provides a checklist for appropriate claiming. All claims must be submitted and processed through the Medicaid Management Information System (MMIS).

All claims submitted through the MMIS system will be processed at a zero dollar ($0.00) rate, meaning, reimbursement will not be given according to individual paid claims. Rather, reimbursement will be calculated according to a one-twelfth methodology, where interim payments are pre-determined for each district prior to the onset of the fiscal year. The interim payments are calculated according to each district's historical Certified Public Expenditure amounts and paid in twelve equal monthly installments. Districts are provided the opportunity to lower monthly interim payment rate should they see fit and the Department approves. See **Section 5.3** for further detail regarding interim payments.

4.2 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
- Companion Guides for the 837P, 837I or 837D (via Provider Services page on the Department's website)
- Web Portal User Guide

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

To obtain additional information regarding claims submission or claims software, go to the Frequently Asked Questions page on the Department's website.

4.3 Interim Payments

Participating districts are reimbursed interim payments based on a monthly rate calculated according to a one-twelfth methodology. The monthly rate shall be based on the districts actual, certified costs identified in their most recently filed annual cost reports from prior fiscal years. 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 may 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.

Interim payments under the Colorado School Health Services (SHS) Program are calculated prior to the school year beginning and are divided into twelve equal monthly installments, to be paid July 1 through June 30. Districts may either accept the recommended rate or reduce the amount. Choosing a rate lower than the recommended rate decreases a district's risk of being in a recoupment situation at the time of cost settlement. 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**).

Interim Payment Calculation

Interim payments are calculated according to the following methodology in March and April prior to the onset of the fiscal year:

1. Find the cost base by first collecting the Certified Public Expenditure (CPE) amounts for the prior three (3) fiscal years.
    a. The CPE for the most recent fiscal year (the fiscal year occurring in real-time) is estimated using quarterly financial submission information for direct service providers from the July to September and October to December quarters as well as recent statistical information.
2. Calculate the cost base by taking the average CPE of the prior fiscal years.
3. Take a percentage (%) of the cost base. Districts may have 70%, 80% or 90% applied to the calculated amount.
    a. 70% of the calculated interim payment amount (for newly participating districts or districts previously in a recoupment situation)
    b. 80% of the calculated interim payment amount (for districts at medium risk for a recoupment)

c. 90% of the calculated interim payment amount (for districts at a lower risk for a recoupment)

4. This percent is the district's **recommended interim payment amount** for the fiscal year and is divided by 12 for one payment per month. The amount is presented to the district prior to the start of the fiscal year (July 1).

Interim Payment Calculation Example

In this example, we will calculate the recommended interim payment amount for Snowy County School District 1 for School Year D.

STEP 1: Find the cost base by first collecting the CPE amounts for the prior three (3) fiscal years.

School Year A, CPE Amount: **$8,000**
School Year B, CPE Amount: **$9,000**
School Year C, CPE Amount: **$8,500**

STEP 2: Calculate School Year D's cost base by taking the average CPE amount for the three prior fiscal years.

($8,000 + $9,000 + $8,500) ÷ 3 = $8,500 (this is the average of School Year A, B, and C's CPE amounts)

STEP 3: Take a percentage of the cost base for School Year D by taking this percentage of the average calculated in Step 2. In this example, we will take 90%.

$8,500 × .9 = **$7,650** (this is 90% of the average of School Year A, B, and C's CPE amounts)

STEP 4: Divide the 90% of the cost base by 12, to get 12 equal monthly payments for School Year D. Note, this is both the federal and state share.

$7,650 ÷ 12 months = **$637.50** per month (this is the 90% of the cost base divided by 12 months)

STEP 5: Determine the federal share by applying the 50.00% FMAP (Note, beginning October 1, 2014, the FMAP will change to 51.01%.).

$637.50 ÷ .5 = **$318.75**

STEP 6: Calculate and subtract the 8% State Administrative Withhold.

$318.75 × .08 = $25.00
$318.75 - $25.00 = **$293.25 Monthly Interim Payment Federal Share less Withhold**

Variations to the above interim payment calculation occur if it is determined that a district may be at higher risk for a recoupment situation. This includes grouping districts by size according to average historical CPE amounts (i.e., large or small districts). For example, if a district's average CPE exceeds a certain threshold, it will be grouped as a large district. If the district's average CPE is below this threshold, it will be grouped as a small district. Additionally, the percent CPE variance across fiscal years is calculated. If it appears that a

district's cost vary greatly from year-to-year, the interim payments are calculated more conservatively.

Monitoring Interim Payments

Districts are monitored throughout the year for unusual changes in costs or in Random Moment Time Study (RMTS) participation. The Department closely reviews this information mid-year sometime between January 1 and March 31. Should a district's costs or RMTS participant counts change drastically from the prior fiscal year, then the Department will contact the district to discuss lowering the currently interim payment amount.

Districts are encouraged to monitor their own costs and RMTS participant counts. Should an impactful change either occur or be anticipated, districts may contact the Department and request a lower interim payment amount at any point during the fiscal year. If approved by the Department, doing so may reduce a district's risk of being in a recoupment situation at the time of cost settlement.