Beginner Billing Training: Professional Claims (CMS 1500)

Health First Colorado

(Colorado's Medicaid Program)

COLORADO
Department of Health Care Policy & Financing

Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
  - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.

Welcome!

Health First Colorado = Colorado's Medicaid Program (under Title XIX)

Who Completes a Professional Claim?

- Audiology
- Doula & Lactation
- Home and Community-Based Services
- Imaging & Radiology
- Laboratory Services
- Pediatric Behavioral Therapy
- Physical, Occupational & Speech Therapy
- Physicians and Practitioners
- School-Based Services
- Supply / Durable Medical Equipment (DME)
- Transportation Providers
- Vision

Behavioral Health Providers

Benefits of Attending This Training

- Beginner billing trainings provide:
  - Resources that can be found on the Department's website
  - Guidance on how to use the Provider Web Portal and Provider Services Call Center
  - Direction on provider enrollment, revalidation and Provider Web Portal maintenance
  - Instructions for verifying member eligibility
  - Guidelines for fee-for-service claim submissions

- All of these functions are completed through the Department's fiscal agent Gainwell Technologies

Program Overview

Program Overview

Department Website

Provider Enrollment

Member Eligibility

Prior Authorizations

Billing and Payment

Claim Submission

Resources

Program Overview

CMS.gov
Centers for Medicare & Medicaid Services

COLORADO
Department of Health Care Policy & Financing

gainwell

Fiscal Agent

Colorado interChange system interacts with the Provider Web Portal

Optum

Provider Services Contact Center

Health First Colorado and Child Health Plan *Plus* (CHP+) Providers

Department Website

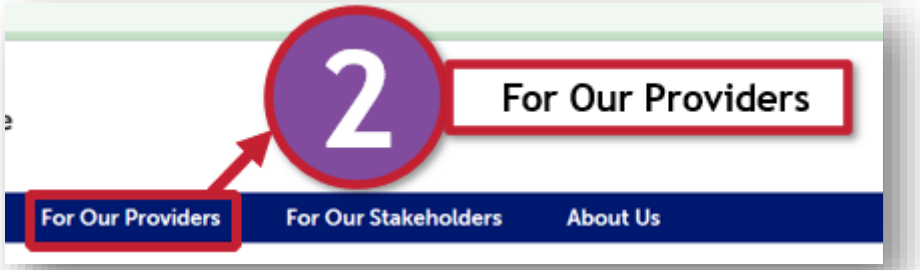
Department of Health Care Policy & Financing

Website

Department of Health Care Policy & Financing

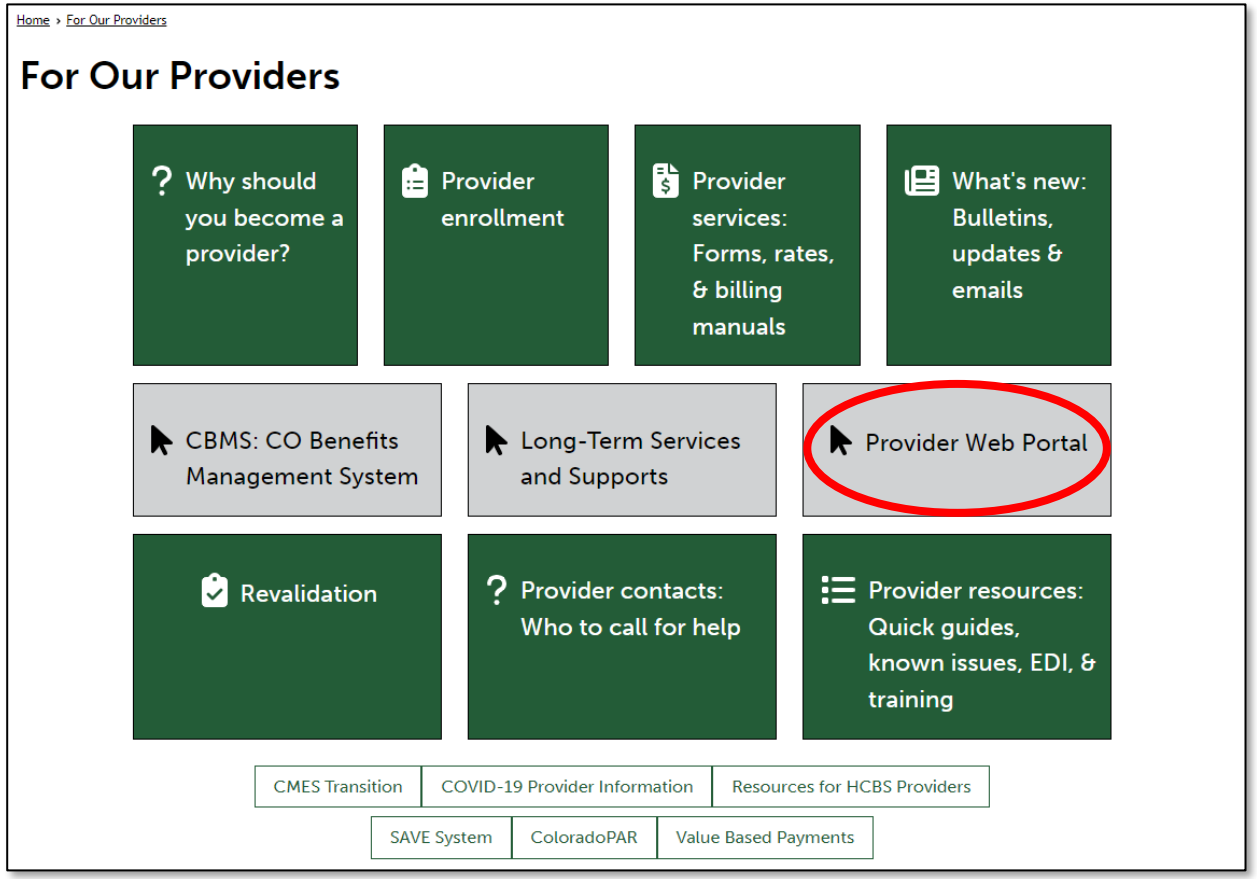
Website

hcpf.colorado.gov



For Our Providers Home Page

- Access to billing manuals, fee schedules, enrollment, revalidation, Provider Web Portal, contacts and resources
- Contains important information regarding Health First Colorado and other topics of interest to providers and billing professionals



To Bookmark A Web Page:
- On a PC desktop using Chrome, Edge or Firefox, click “Ctrl” and “D.”
- On a Mac desktop using Safari, click “Cmd” and “D”

COLORADO
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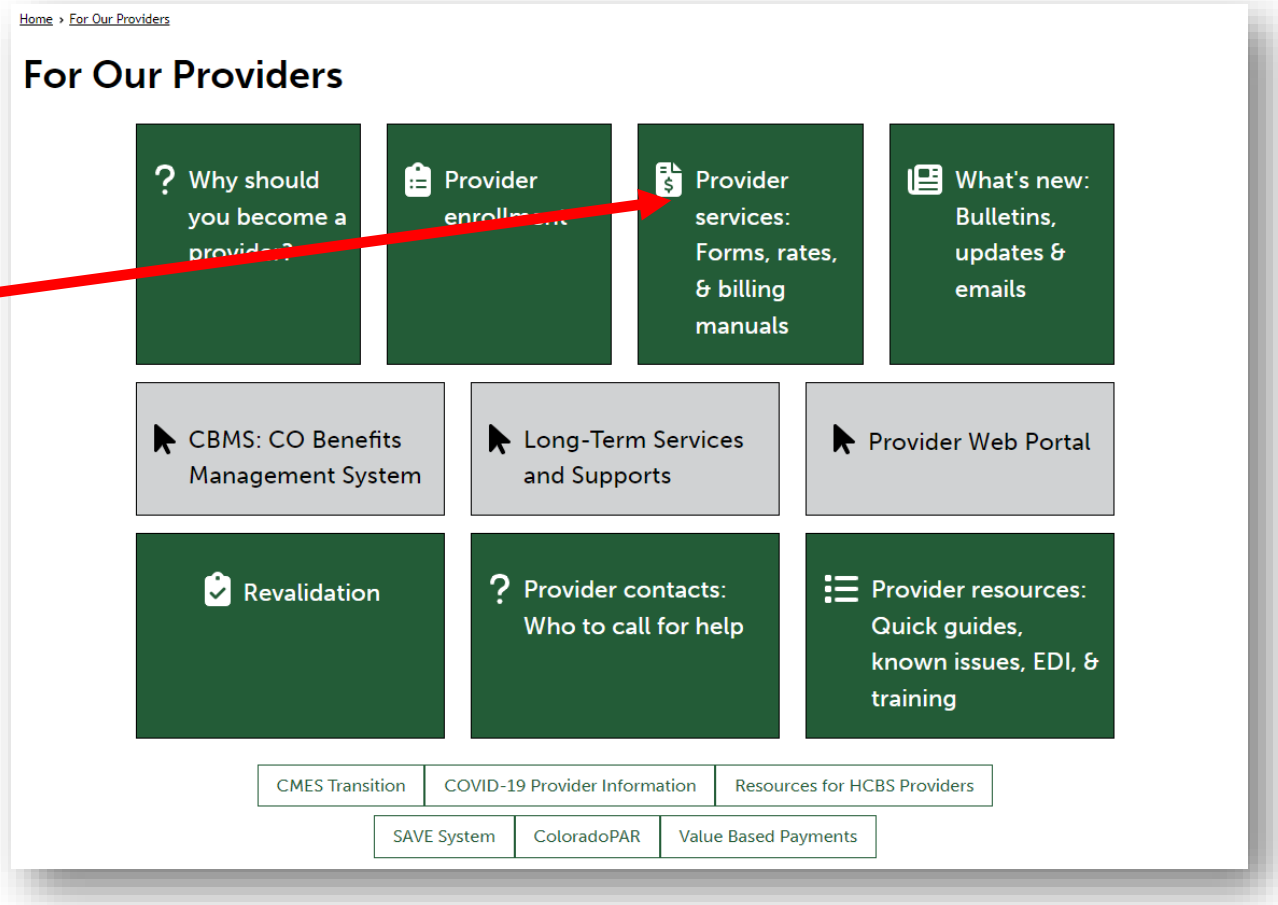
Provider Services

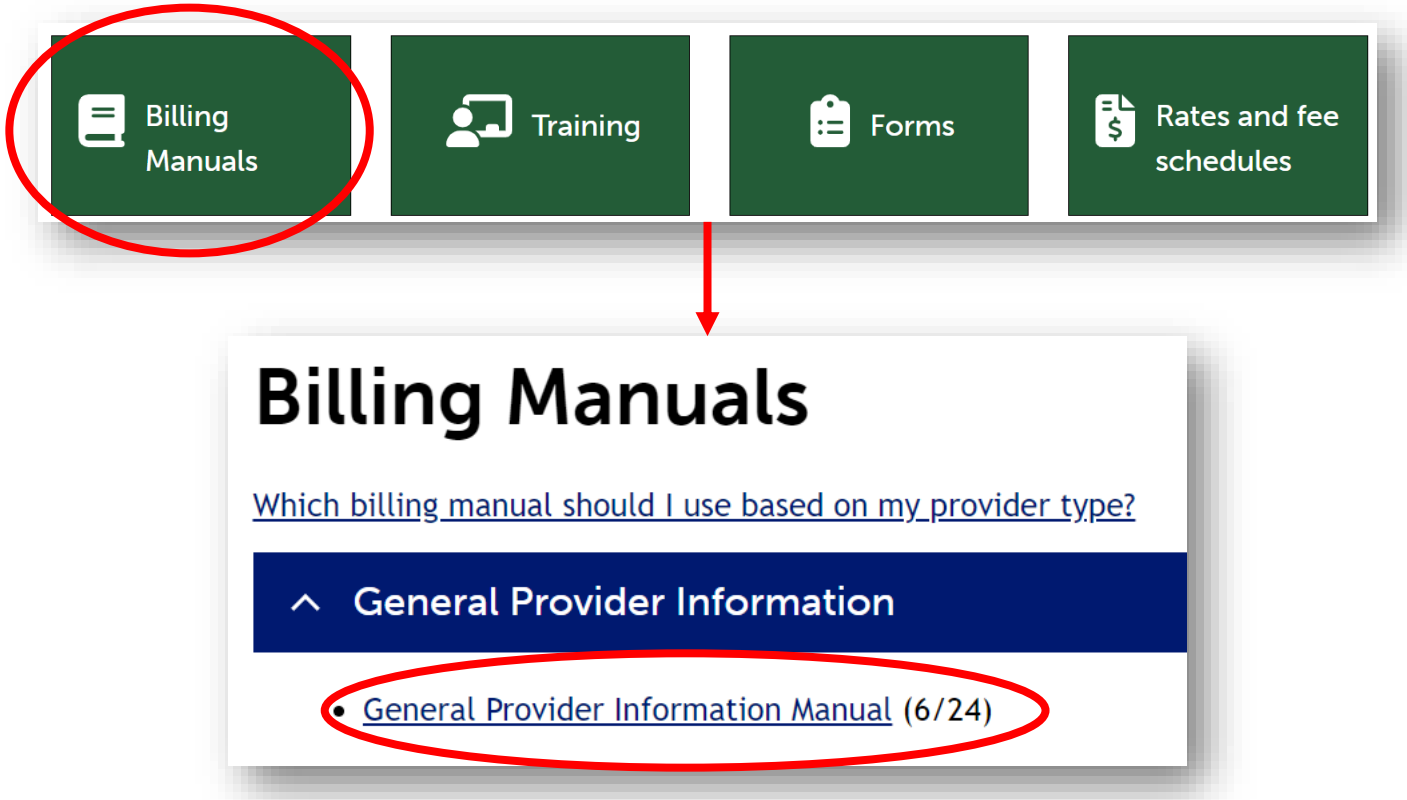
Forms, fee schedules and billing manuals can be found on the Provider Services web page



Provider Services

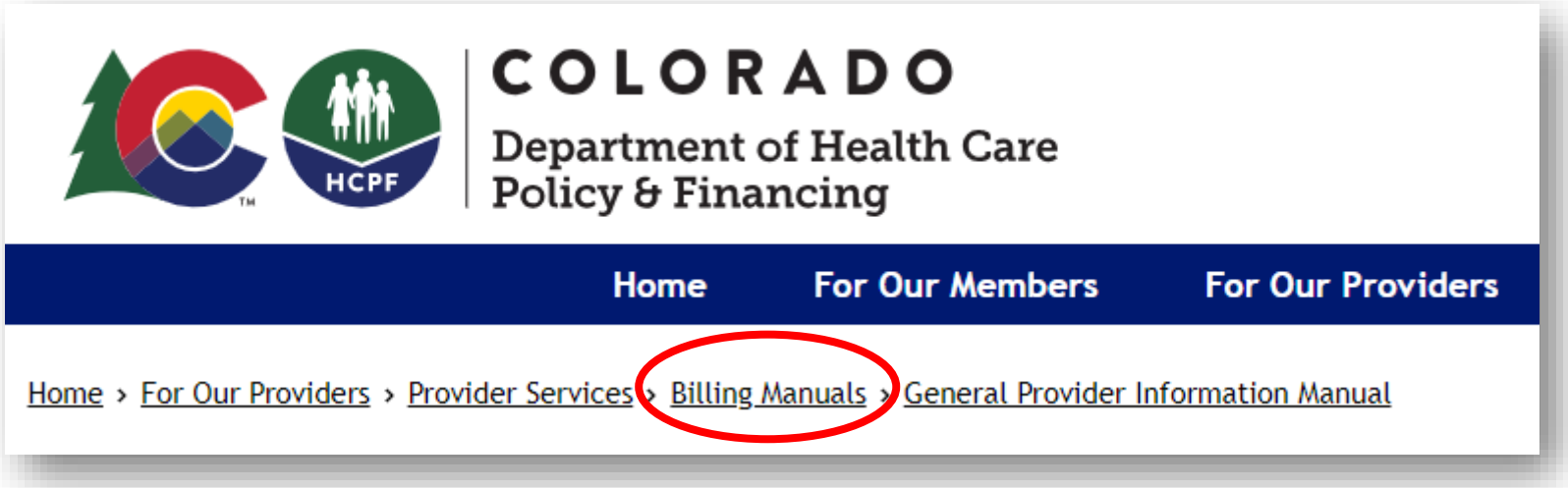
General Provider Information Manual

The General Provider Information manual is an overview of the program, including billing and policy information



Provider Services

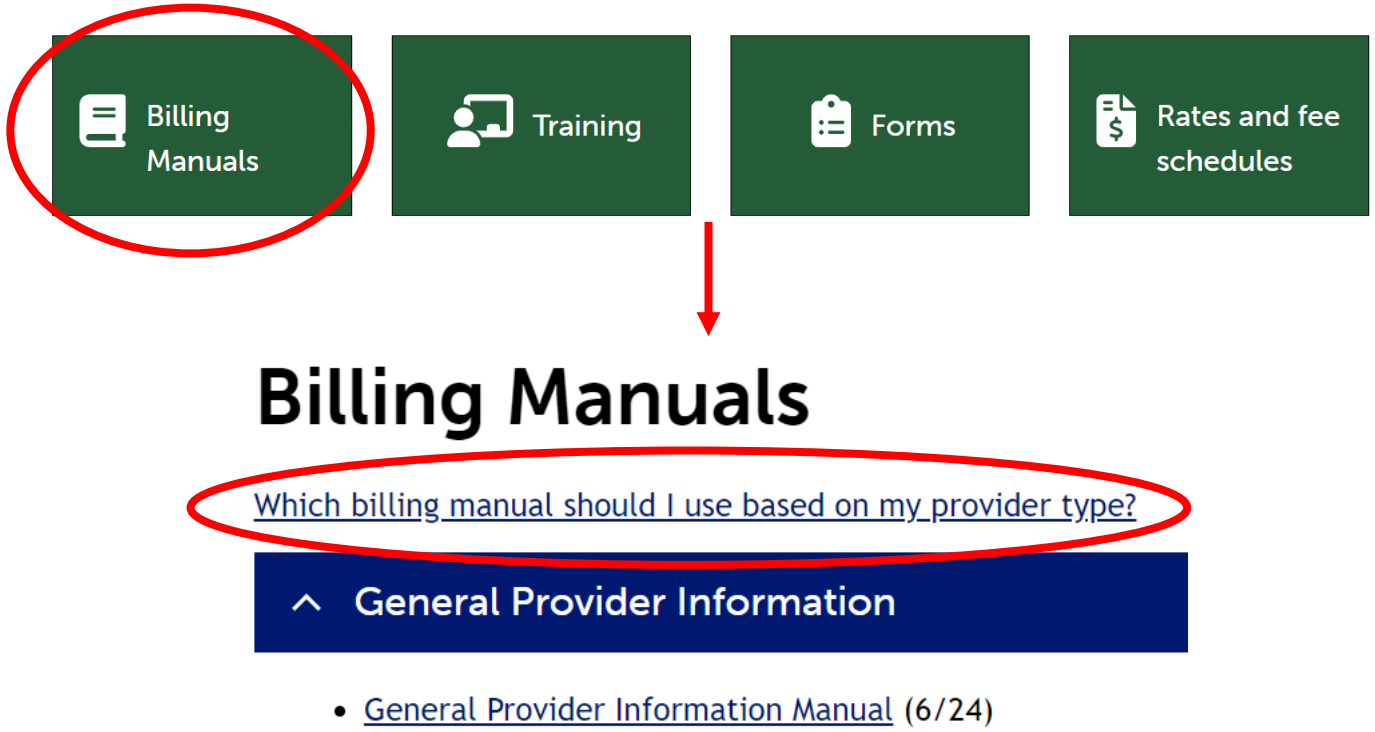
If you ever need to get back to a particular web page, use the links at the top of the page under the main menu:



Provider Services

Provider-Specific Billing Manuals

Provider-specific billing manuals contain important information for specific benefits, including appropriate codes and modifiers and billing requirements.



Provider Services

Provider-Specific Billing Manuals

Most providers who submit professional claims find the billing manuals under the CMS 1500 (Professional) drop-down menu.

Home and Community-Based Services providers find the billing manuals under the HCBS drop-down menu.

Provider Services

Provider-Specific Resources

At the bottom of the billing manuals web page are more provider-specific resources, as well as national billing guidelines and policy statements.

National Billing Guidelines

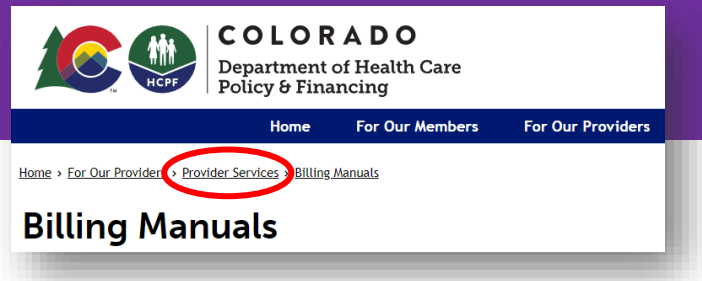
- National Correct Coding Initiative (NCCI)

Policy Statements

- Policy Statement: Billing Health First Colorado Members for Services
- Policy Statement: Charging Health First Colorado Members For Missed Appointments
- Policy Statement: Dismissing Health First Colorado Members From a Provider's Practice
- Policy Statement: Member Co-Pays and Provision of Services
- Policy Statement: Billing for Members who Receive Retroactive Health First Colorado Eligibility

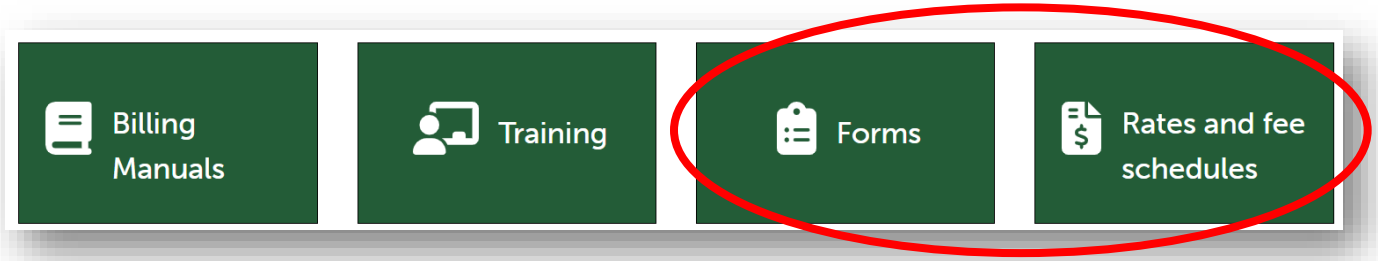
Provider Services

Forms & Rates and Fee Schedules



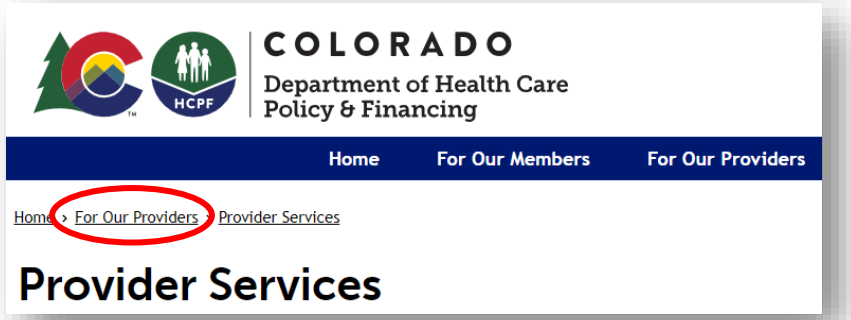
Forms are included for many functions, including accounting, claim submission, prior authorization requests, enrollment and account maintenance.

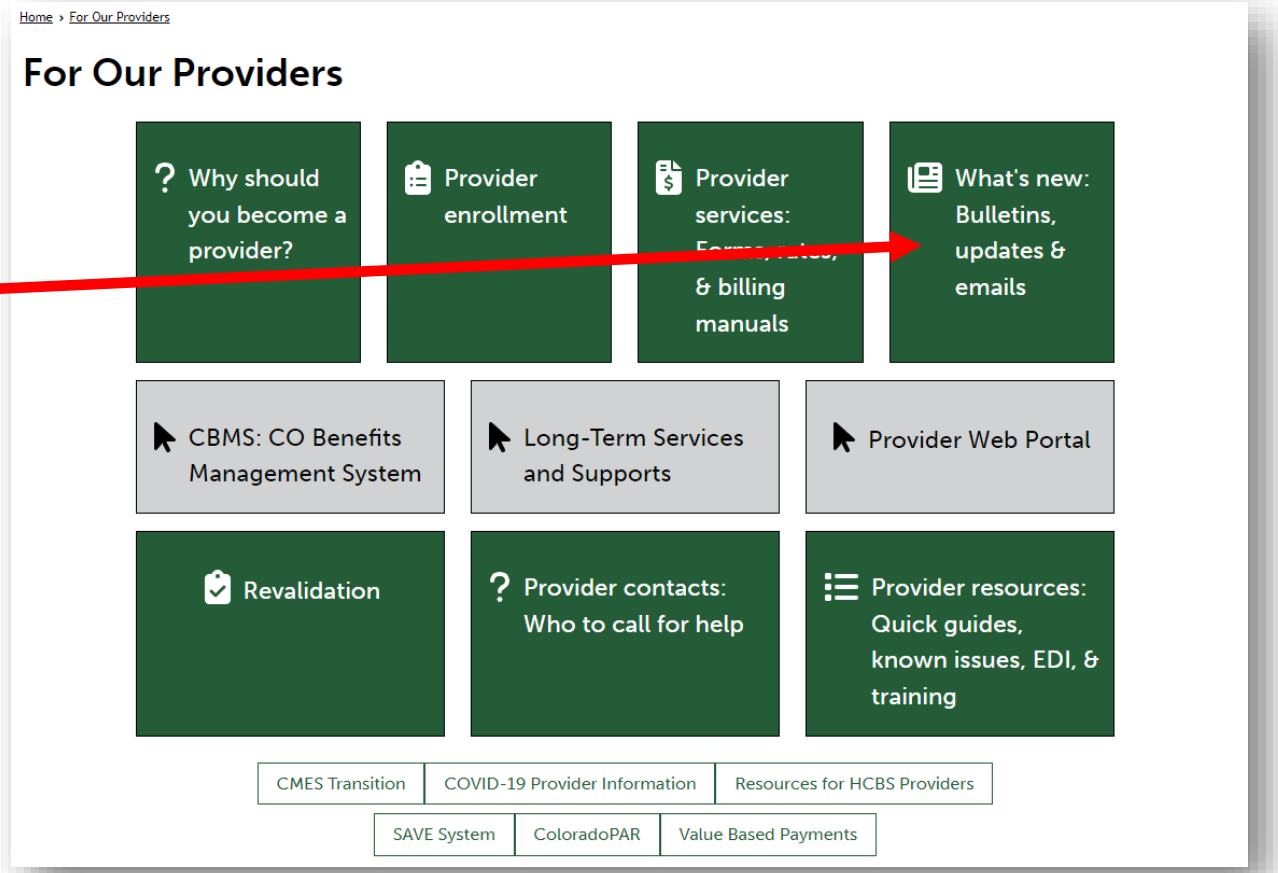
Provider communications are sent when new fee schedules are available.



What's New: Bulletins, Updates & Emails

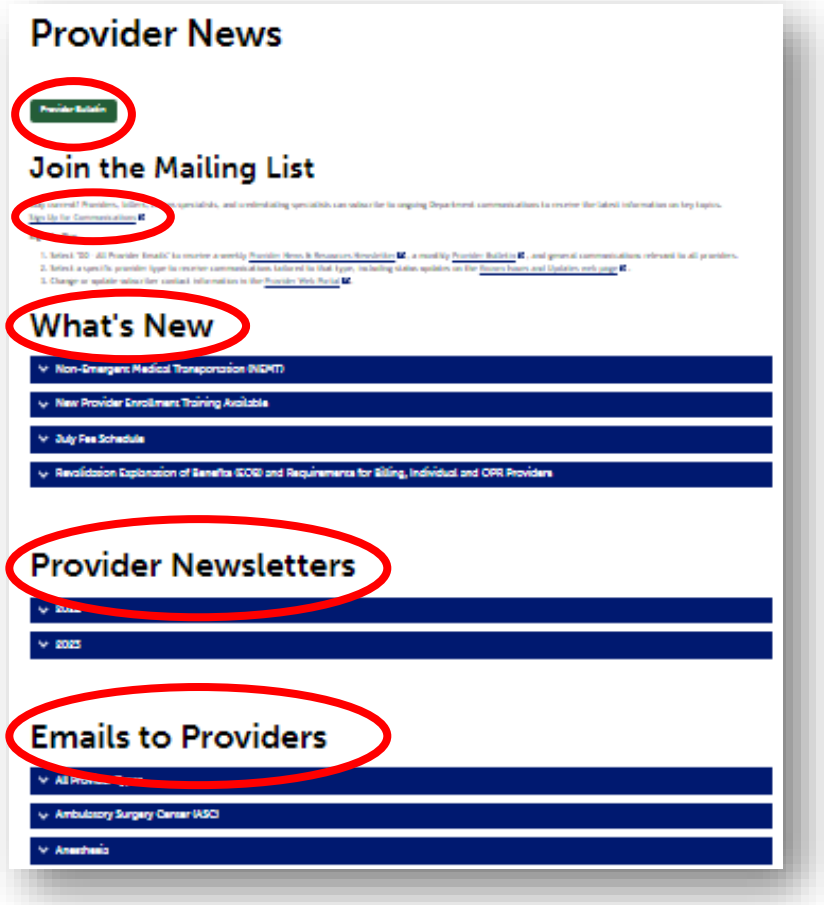
Sign up for publications





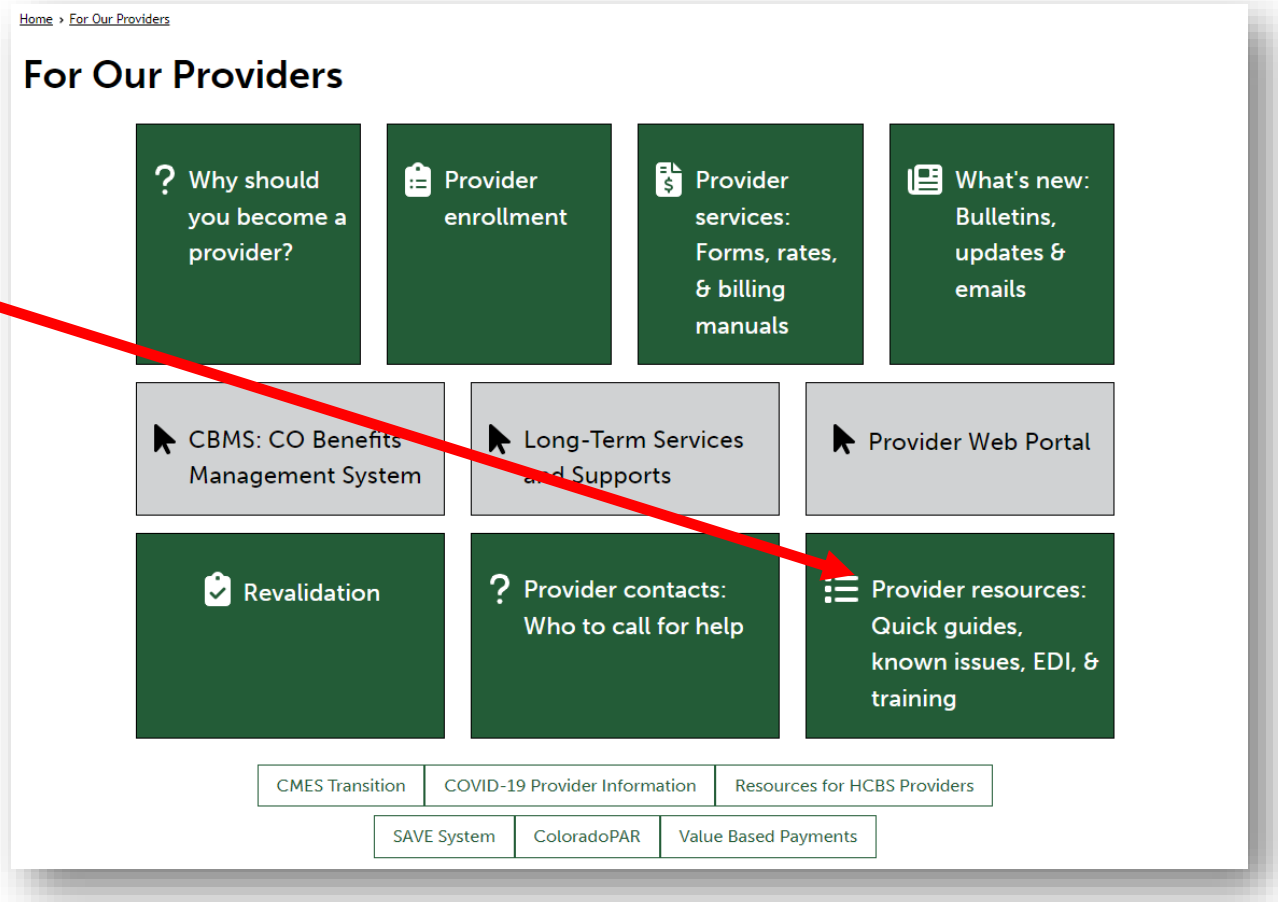
What's New: Bulletins, Updates & Emails

- Provider bulletins are produced monthly
- Provider newsletters are sent more frequently and include timely reminders and resources
- What's New includes information on current topics
- Emails to Providers catalogs all of the communications sent to providers via email



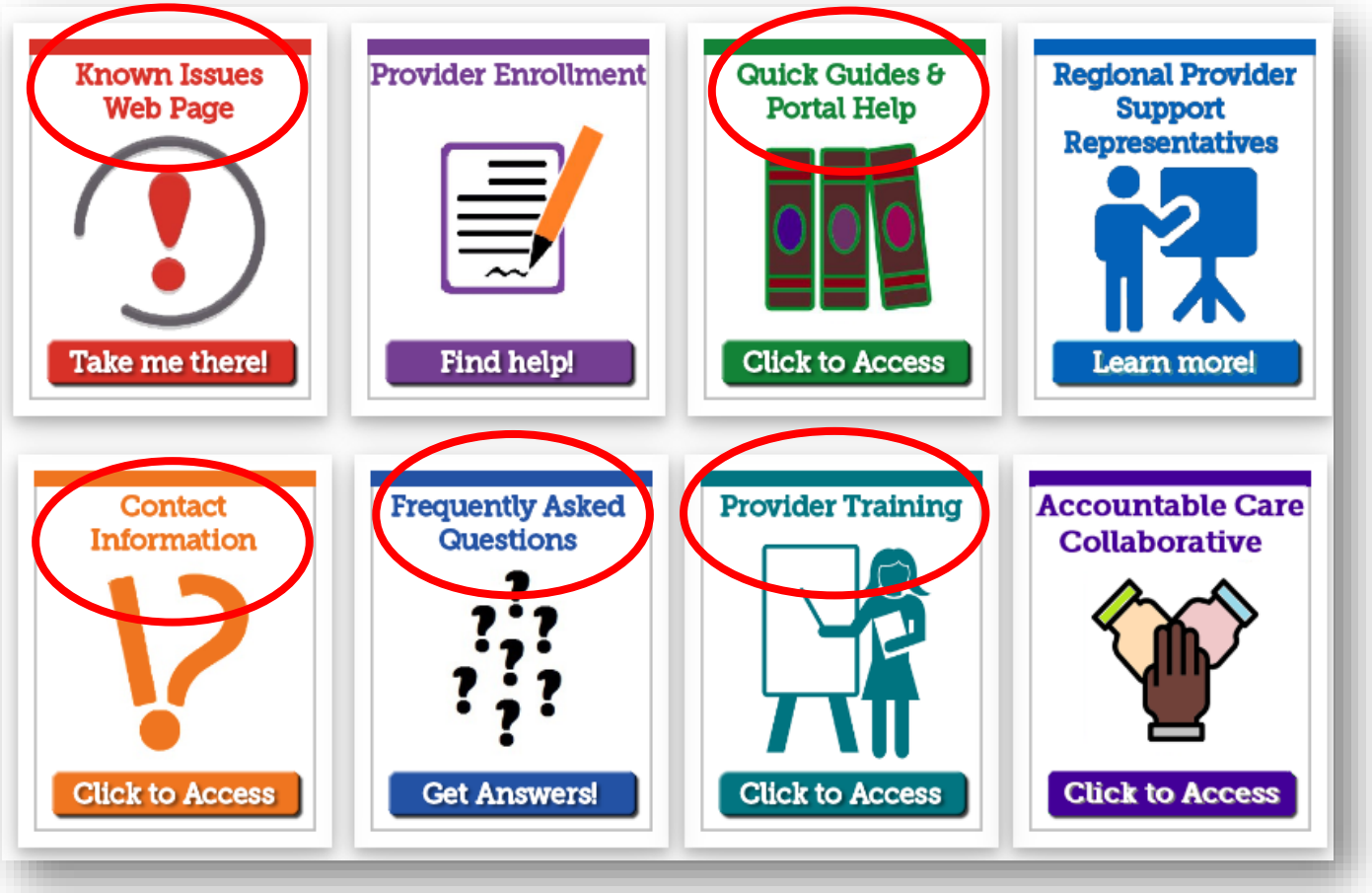
Provider Resources

Provider Web Portal Quick Guides, Electronic Data Information (EDI) for batch billing information, training presentations, field representatives and more



Provider Resources

- Current and resolved known issues
- Quick Guides for the Provider Web Portal
- Contact information
- Frequently Asked Questions
- Provider Training calendar and materials

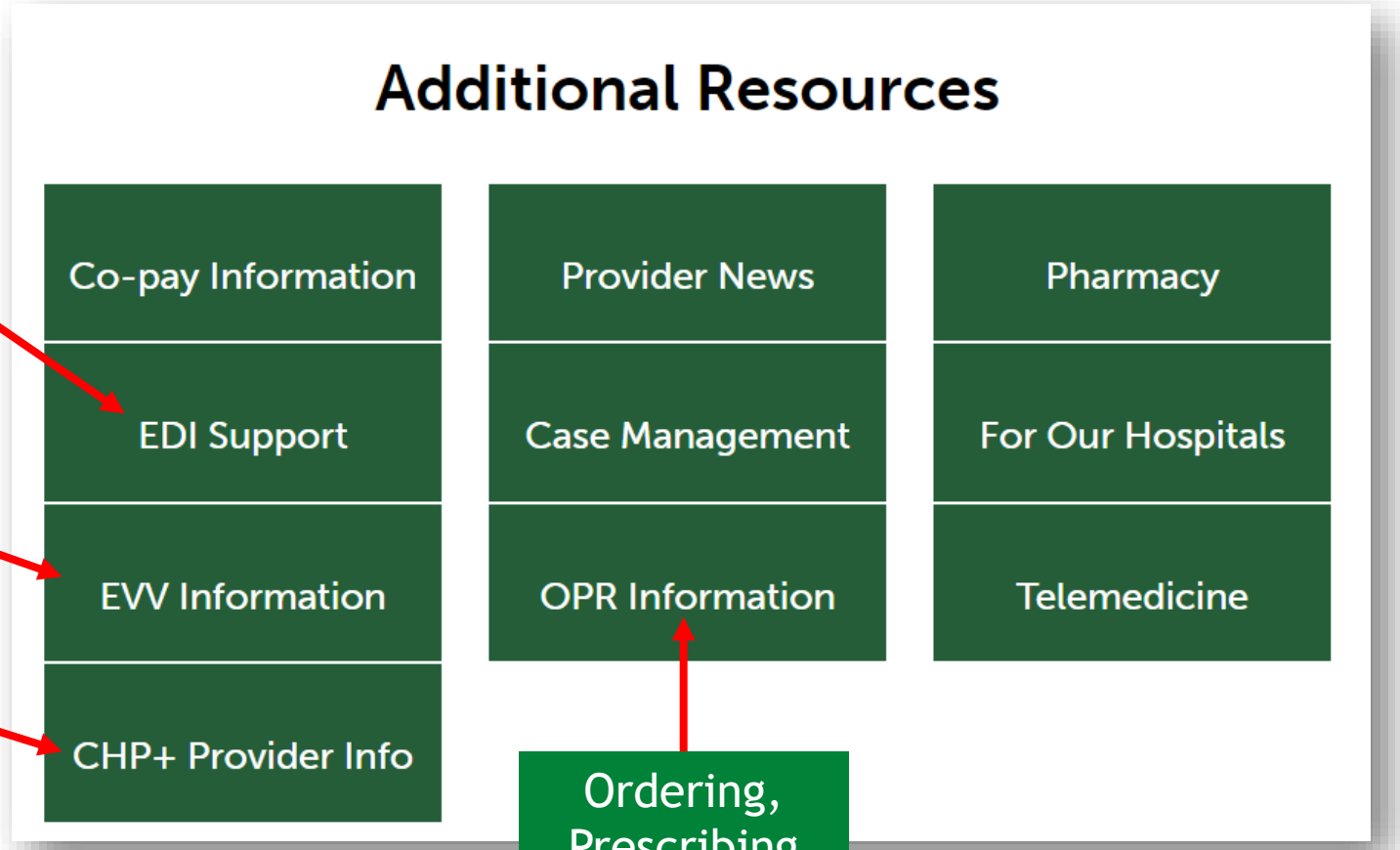


Provider Resources

Electronic Data Interchange

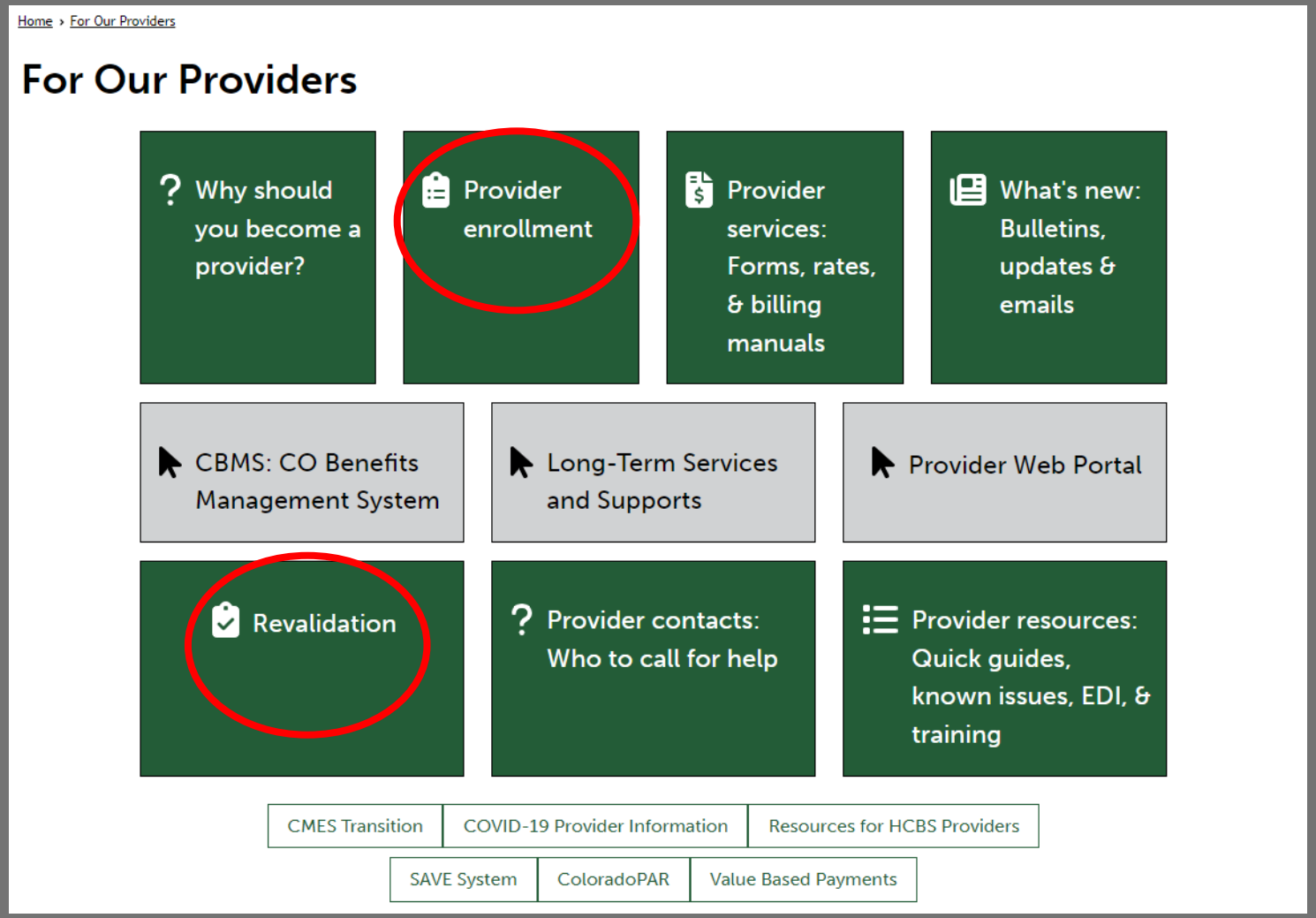
Electronic Visit Verification

Child Health Plan Plus



Ordering, Prescribing and Referring Providers

Provider Enrollment


Home › For Our Providers
For Our Providers
Why should you become a provider?
Provider enrollment
Provider services: Forms, rates, & billing manuals
What's new: Bulletins, updates & emails
CBMS: CO Benefits Management System
Long-Term Services and Supports
Provider Web Portal
Revalidation
Provider contacts: Who to call for help
Provider resources: Quick guides, known issues, EDI, & training
CMES Transition
COVID-19 Provider Information
Resources for HCBS Providers
SAVE System
ColoradoPAR
Value Based Payments

Provider Enrollment

Website

Who needs to enroll?

- **Any provider who provides services to Health First Colorado members**
- Any provider listed on a claim

Some services require an Ordering, Prescribing or Referring (OPR) Provider:

- Audiology
- Durable Medical Equipment (DME)/Supply
- Independent Laboratory
- Occupational, Physical & Speech Therapy
- X-Ray Facility

Provider Enrollment

Website

Professional claims require rendering and billing providers

- The *rendering* provider and *billing* provider are the same for Home and Community-Based Services (HCBS) providers

Rendering Provider (Individual Within a Group)

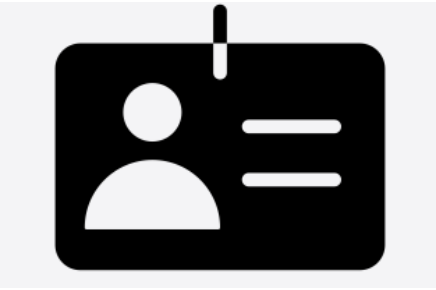
Individual that provides services to a Health First Colorado member

Billing Provider

Entity being reimbursed for service

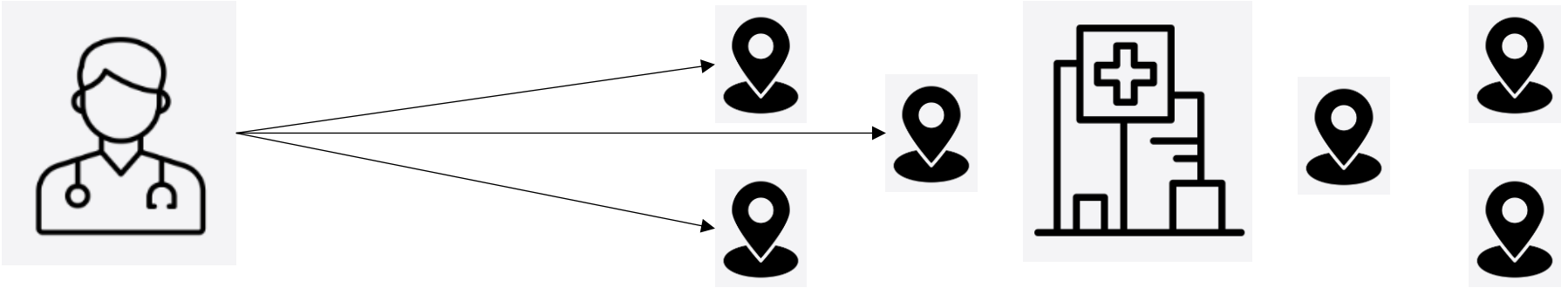
National Provider Identifier (NPI)

- **Most providers require a National Provider Identifier (NPI) for billing transactions.**
- Non-medical providers, such as some Home and Community-Based Services (HCBS) and Non-Emergent Medical Transportation (NEMT) providers, do not need a National Provider Identifier (NPI) and use the Health First Colorado Provider ID for billing transactions.
- Providers who bill Medicare need to ensure each National Provider Identifier (NPI) for Health First Colorado is also enrolled with Medicare.



National Provider Identifier (NPI)

Individual Providers (Individuals Within a Group, Billing Individuals or Ordering/Prescribing/ Referring)	**Organizational Providers** (Groups, Facilities)
• One National Provider Identifier (NPI) can be affiliated with multiple locations • Tied to Social Security Number (SSN)	• Separate National Provider Identifier (NPI) for each service location and provider type • Tied to Employer Identification Number (EIN)

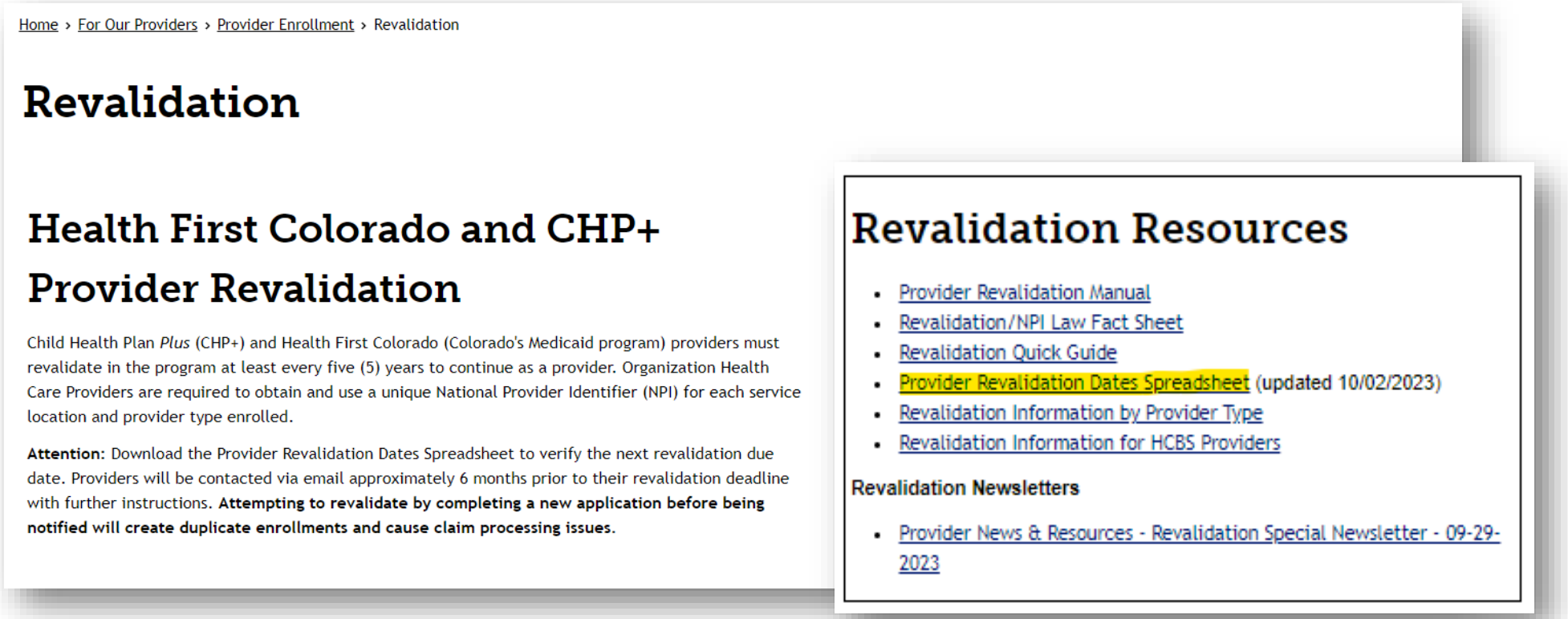


Revalidation

- All Health First Colorado and Child Health Plan *Plus* (CHP+) providers must revalidate in the program at least every five (5) years to continue as a provider.
- **Providers who do not complete the revalidation process by their revalidation due date will be subject to claim denials and disenrollment.**
- Each provider will be notified via email six (6) months in advance of their revalidation deadline. The deadline is based on the date the enrollment application was approved.

Revalidation

- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.



Home › For Our Providers › Provider Enrollment › Revalidation

Revalidation

Health First Colorado and CHP+ Provider Revalidation

Child Health Plan *Plus* (CHP+) and Health First Colorado (Colorado's Medicaid program) providers must revalidate in the program at least every five (5) years to continue as a provider. Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.

Attention: Download the Provider Revalidation Dates Spreadsheet to verify the next revalidation due date. Providers will be contacted via email approximately 6 months prior to their revalidation deadline with further instructions. **Attempting to revalidate by completing a new application before being notified will create duplicate enrollments and cause claim processing issues.**

Revalidation Resources

- Provider Revalidation Manual
- Revalidation/NPI Law Fact Sheet
- Revalidation Quick Guide
- Provider Revalidation Dates Spreadsheet (updated 10/02/2023)
- Revalidation Information by Provider Type
- Revalidation Information for HCBS Providers

Revalidation Newsletters

- Provider News & Resources - Revalidation Special Newsletter - 09-29-2023

Revalidation for Individual Providers

- **Each individual provider within a group has a separate account for the Provider Web Portal.**
  - Different from the group or facility account and login credentials

- Individuals, or their delegate(s), **must revalidate using the account for the individual provider.**
  - Refer to the Delegates - Provider Web Portal Quick Guide for more information on managing delegates.

- Even if the billing provider has revalidated, claims will deny if an individual provider has not revalidated.

Revalidation for Individual Providers

- **All Ordering, Prescribing and Referring (OPR) providers indicated on a claim must be actively enrolled with Health First Colorado.**
  - Groups are encouraged to coordinate with all Ordering, Prescribing and Referring (OPR) providers to ensure that those provider IDs have been revalidated.
  - Refer to the Ordering, Prescribing and Referring Claim Identifier Project for more information about Ordering, Prescribing and Referring (OPR) issues on claims.

Member Eligibility

Verifying Member Eligibility

It is the provider's responsibility to check eligibility on each date of service

How do providers verify member eligibility?

There are three ways to verify member eligibility:

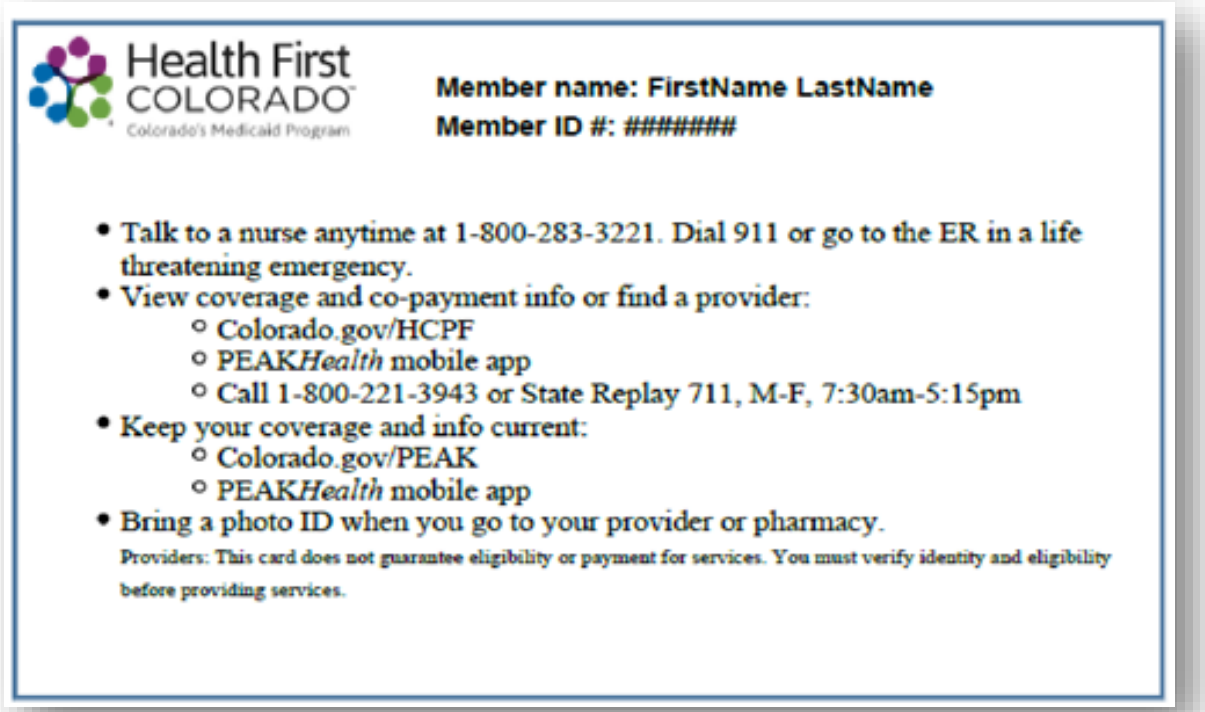
1. Provider Web Portal
2. Batch 270
3. Interactive Voice Response (IVR) via the Provider Services Call Center

Health First Colorado Identification Cards

This page shows two older branded cards that are still valid.

Identification card does not guarantee eligibility.

Only the front is shown below.

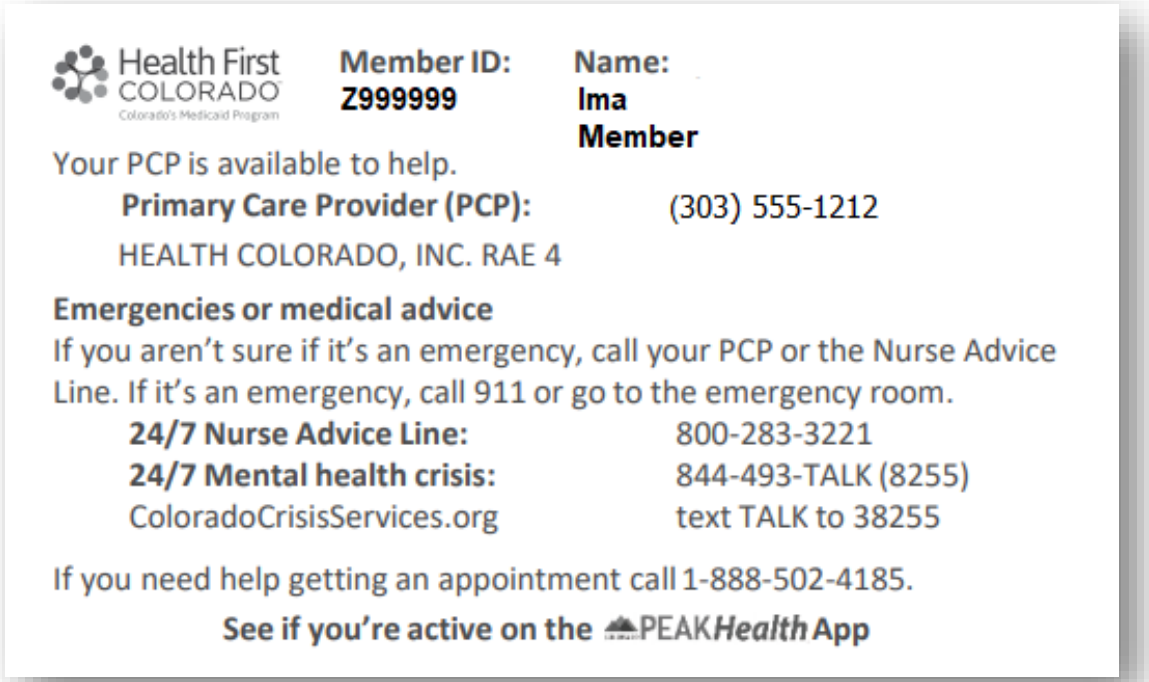


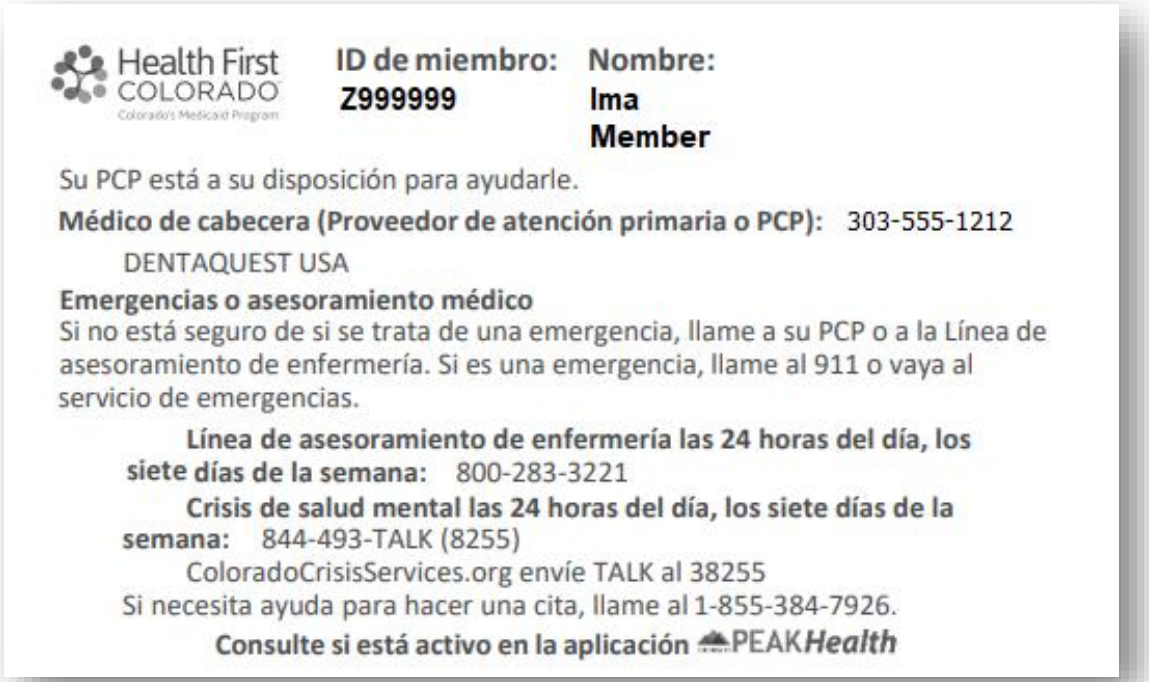
Health First Colorado Identification Cards

This page depicts newer branded cards in English and Spanish.

Identification card does not guarantee eligibility.

Only the front is shown below.





Eligibility Types

- Providers must confirm coverage types before rendering any Medicaid or Child Health Plan *Plus* (CHP+) services or submitting claims

- Eligibility coverage types listed in the Provider Web Portal (not an all-inclusive list):
  - Medicaid: "Medicaid State Plan" and "TXIX" (Title XIX [Title 19])
  - Child Health Plan *Plus*: “CHP+B”
  - Behavioral Health Coverage through the Regional Accountable Entities (RAEs): "Medicaid Behavioral Health Benefits" and "BHO+B"

Eligibility Types

Most members have Health First Colorado benefits (Title XIX)

Some members have…

Limited benefits:

- Emergency Medicaid Services (EMS)
- Family Planning Limited (FAMPL)
- Presumptive Eligibility (PE)

Additional benefits:

- Alternative Benefits Plan (ABP)
- Home and Community-Based Services (HCBS) waivers

Benefits administered by other organizations:

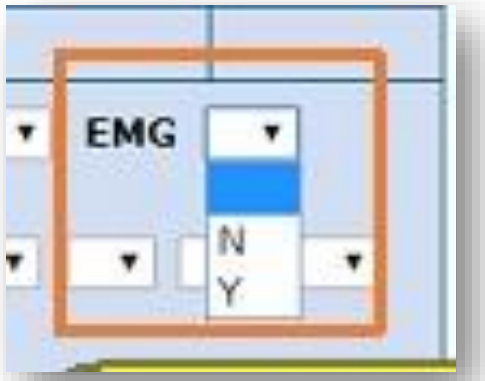
- Behavioral health through the Regional Accountable Entities (RAEs)
- Managed Care Organizations (MCOs)
- Program of All-Inclusive Care for the Elderly (PACE)

Additional insurance:

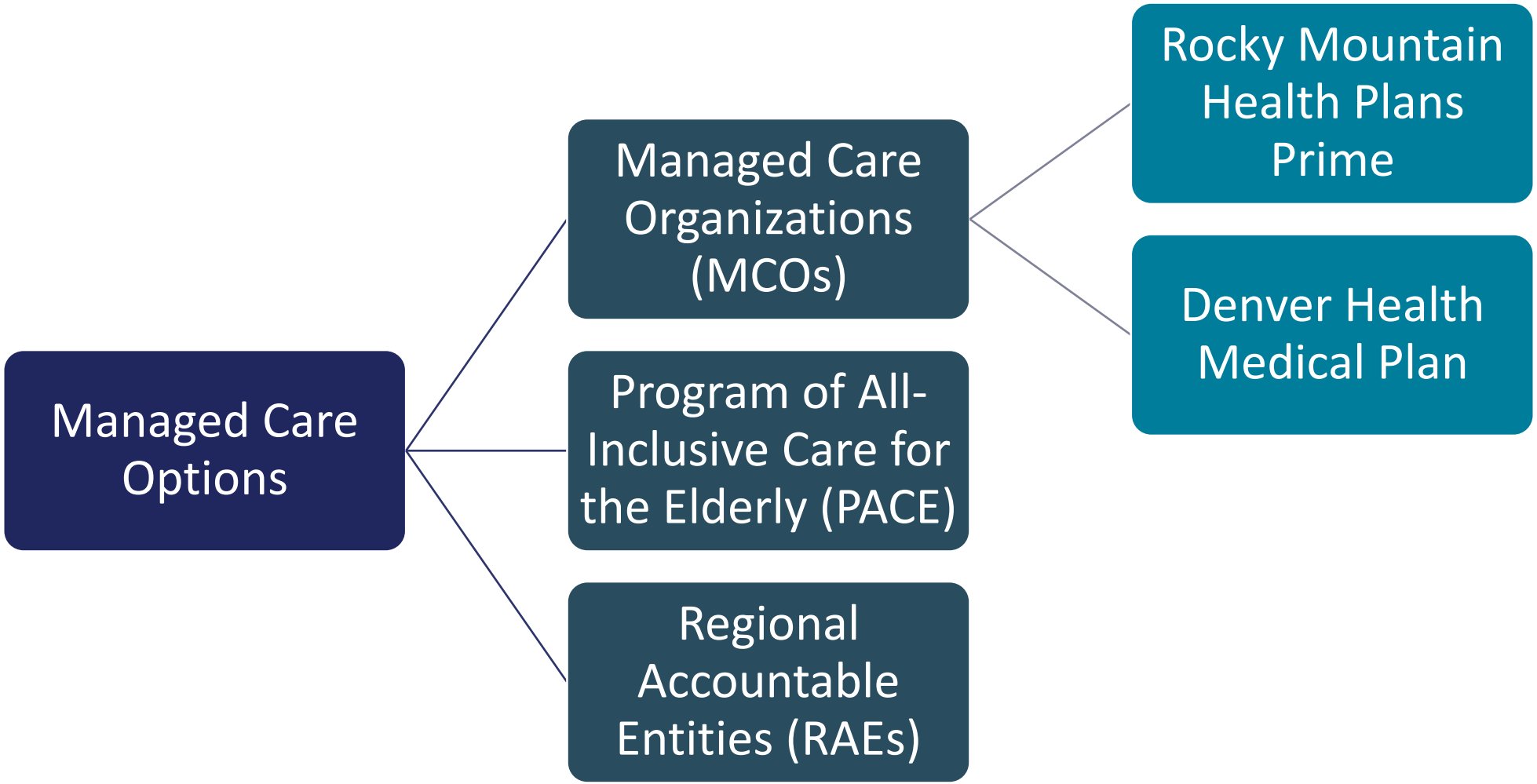
- Medicare
- Third-party liability (TPL)

Who Defines an Emergency?

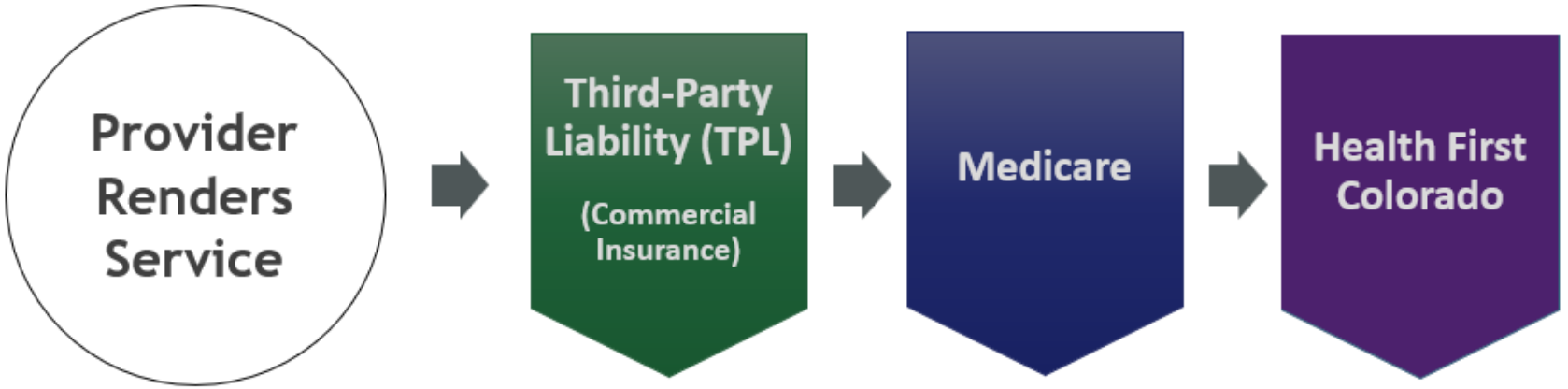
- **The provider determines whether the service is considered an emergency** and marks the claim appropriately by checking box 24C on the CMS 1500 paper claim or selecting “Y” for the EMG field on the Provider Web Portal.
- Health First Colorado does not determine emergency status based on diagnosis or procedure codes used on the claim. The box must be checked to indicate emergency.



Managed Care Organizations



Third-Party Liability



- **Health First Colorado is the payer of last resort**
- Providers must bill third-party liability (TPL) and Medicare before submitting claims
  - Include EOB date(s) and payment amount(s) on Health First Colorado claim
  - Retain EOB but do not attach to claim

Co-Pay

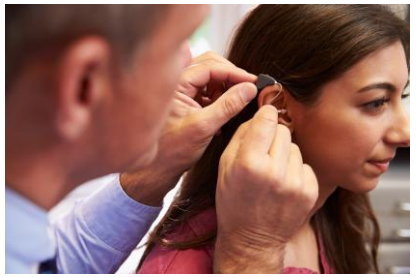
- Most member copays are $0
  - Exceptions to this change are special programs administered by the Department, such as Child Health Plan *Plus* (CHP+)
  - Outpatient hospital non-emergent emergency room visits continue to carry an $8 co-pay per visit
- Providers can check co-pay amounts when verifying member eligibility on the Provider Web Portal
  - A provider may not deny services to individuals when such members are unable to immediately pay the co-pay amount
  - The co-pay maximum is 5% of the household monthly income

Prior Authorizations

Prior Authorization Requests (PARs)

The ColoradoPAR Program reviews Prior Authorization Requests (PARs) for the following services or supplies:

- Audiology (Cochlear implant repairs and supplies)
- Diagnostic imaging
- Durable medical equipment and supplies
- Early intervention services
- Gender affirming care
- Home health (includes private duty nursing)
- Inpatient (out-of-state admission only)
- Laboratory services
- Pediatric behavioral therapy
- Pediatric personal care
- Physical, occupational and speech therapy
- Physician Administered Drugs (PADs) (Appendix Y)
- Surgery (including back, bariatric, organ transplant, reconstructive)
- Synagis (seasonal)



Prior Authorization Requests (PARs)

- Prior Authorization Requests (PARs) and PAR revisions processed by the ColoradoPAR Program must be submitted via the vendor utilization management portal managed by Acentra Health (formerly Kepro).
- Final Prior Authorization Request (PAR) determination letters are mailed to members. Letter inquiries should be directed to ColoradoPAR.
- Providers can review Prior Authorization Requests (PARs) via the Provider Web Portal.

Website:
ColoradoPAR website

Phone:
Phone: 1-888-801-9355 FAX: 1-866-940-4288

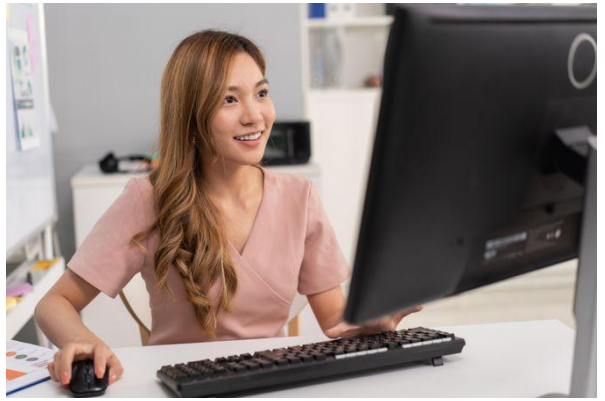
Prior Authorization Requests (PARs)

- All Prior Authorization Requests (PARs) for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child/youth.
- ColoradoPAR does not process Prior Authorization Requests (PARs) for dental, pharmacy, transportation or behavioral health services covered by the Regional Accountable Entities (RAEs).

Prior Authorization Requests (PARs)

Home and Community-Based Services

- For Home and Community-Based Services (HCBS) Waiver programs, contact the case manager to obtain the member's service plan and prior authorization information before delivering services on behalf of the member.
- Home and Community-Based Services (HCBS) providers must have the Prior Authorization Request (PAR) number to view a PAR on the Provider Web Portal.



Billing and Payment

Billing and Payment

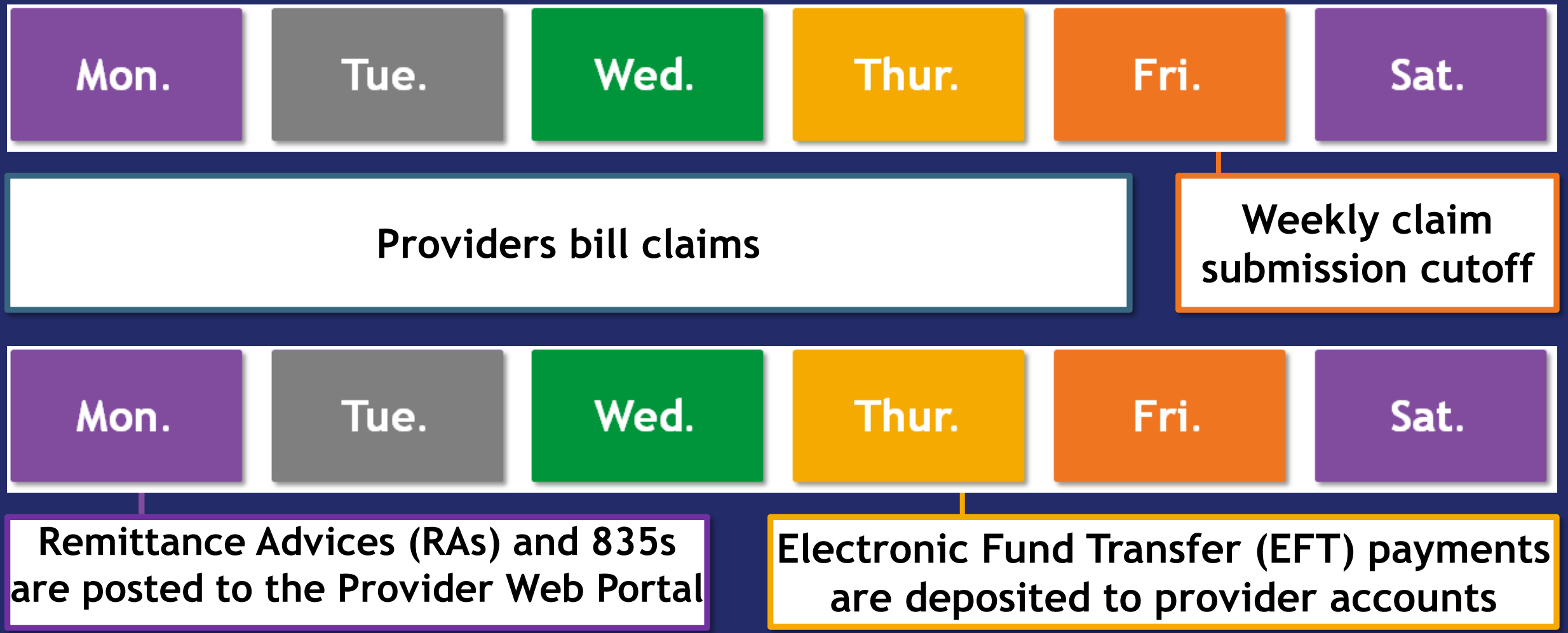
Record Retention

Payment Processing and Remittance

Timely Filing

Overrides for Timely Filing

Payment Processing Schedule



Remittance

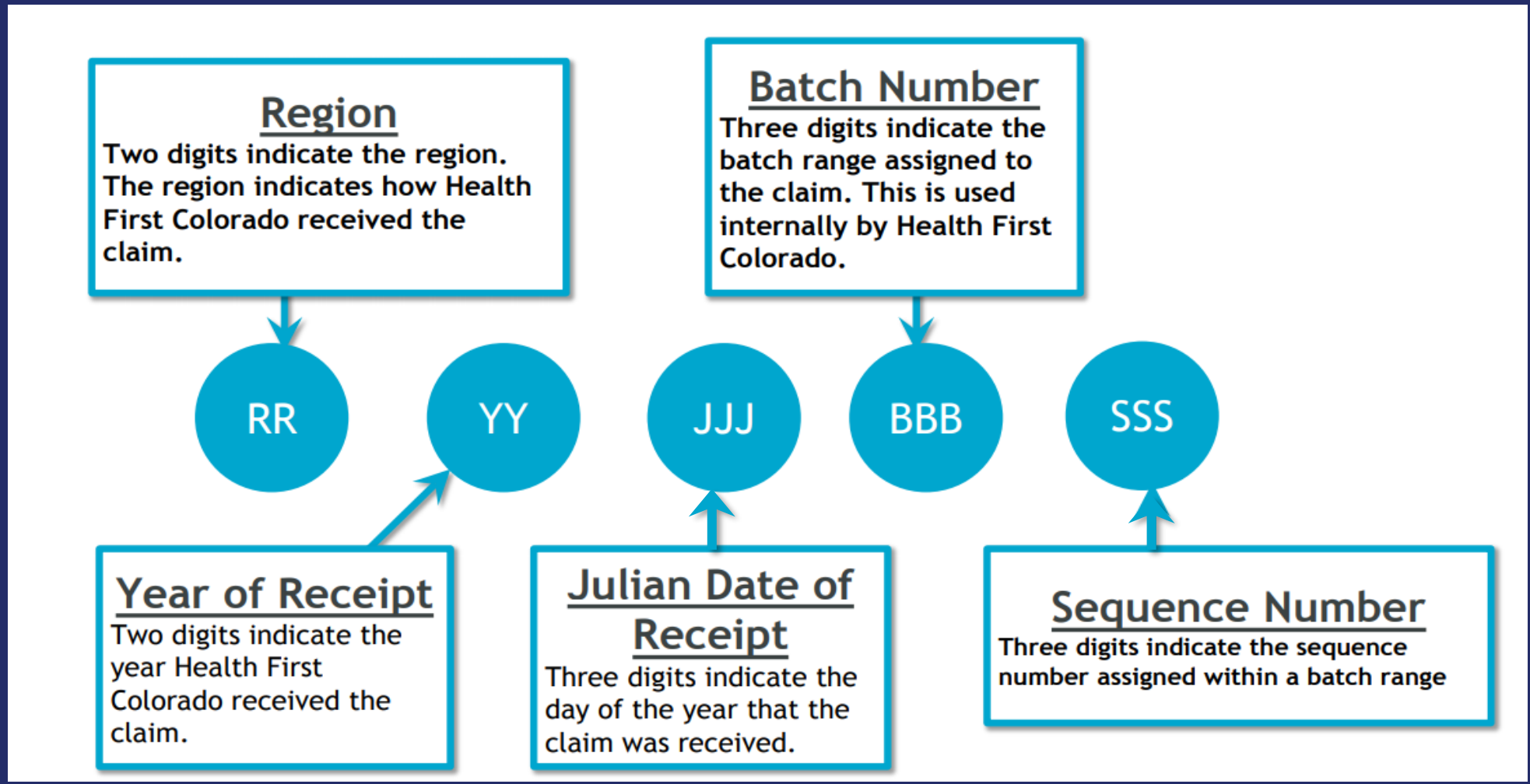
Remittance Advice (RA)

- A Remittance Advice (RA) contains claims status and information about claim payments, as well as general announcements (banner messages) from the Department.

- Each week, providers should reconcile the Remittance Advice (RA) by matching individual claims with the total payment received.
  - Remittance Advice (RA) reports are posted on Monday and the corresponding payment usually is deposited on the following Thursday.
  - The second page of the Remittance Advice (RA) lists financial transactions that make up the total payment.
  - Denied claims will be listed with an Explanation of Benefits (EOB).

Remittance

Internal Control Number (ICN)



Remittance

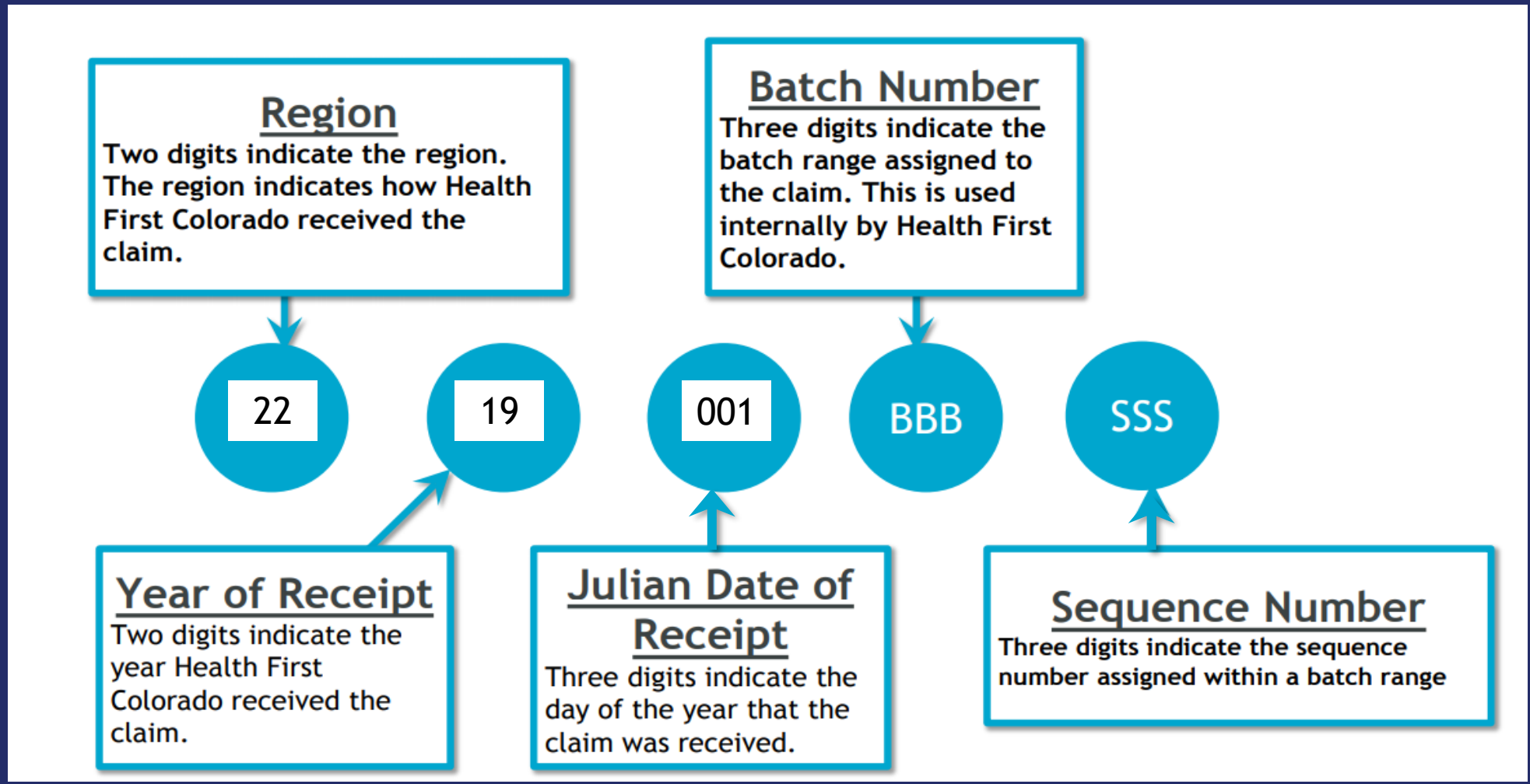
Region Codes

The Region Code, the first two digits of the claim Internal Control Number (ICN), indicates how Health First Colorado received the claim.

10 - Paper Claims with No Attachments
11 - Paper Claim with Attachments
20, 21 - Batch Claim
22 - Web Portal Claim with No Attachments
23 - Web Portal Claim with Attachments
25 - PBM Pharmacy Claims
30, 31, 40 - Claims Converted from Old MMIS
50 - Provider Initiated Adjustment (via paper)
51, 52, 53, 55, 58 - System Initiated Adjustments
54 - Mass Void
56 - Mass Void Request or Single Claim Void
57 - Cash Void
59 - Provider Initiated Electronic Adjustment
67 - Cash Adjustments
80 - Claim Resubmission by Gainwell
92 - Batch Reconsideration Claims with Attachments
93 - Provider Initiated Batch Reconsideration Adjustment with Attachments
94 - Web Portal Reconsideration Claims with Attachments
95 - Provider Initiated Web Portal Reconsideration Adjustment with Attachments

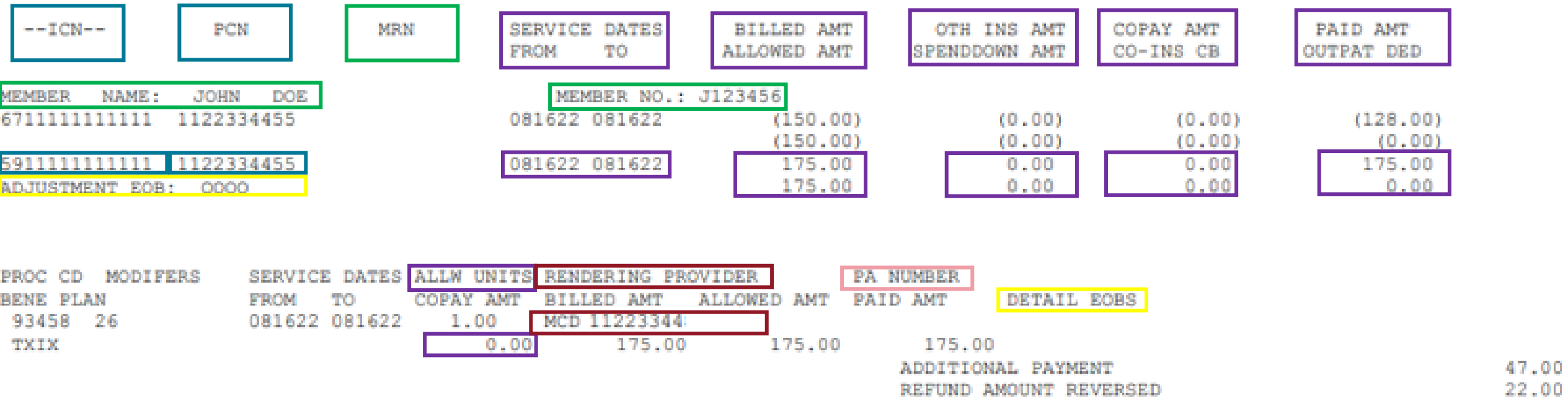
Remittance

Internal Control Number (ICN)



Remittance

Remittance Advice (RA)



COLORADO
Department of Health Care Policy & Financing

Remittance

Retrieval of Remittance Advice or 835

- To pull a Remittance Advice (RA), log into the Provider Web Portal and click on Resources and then Report Download.
- To pull an Electronic Remittance Advice (ERA) X12 835, click on File Exchange and then Download Reports.

- Resources:
  - Provider Web Portal Quick Guide – Reading the Remittance Advice (RA)
  - Provider Web Portal Quick Guide – Pulling Remittance Advice (RA)
  - Provider Web Portal Quick Guide – Linking the TPID and Pulling an 835

Timely Filing

- Claims must be submitted 365 days from date of service to keep them within timely filing guidelines, even if the result is a denial
  - Date of Service (DOS) determined by date of receipt of the claim

Circumstances that are not proof of timely filing include

- Certified mail
- Prior Authorization Requests (PARs)
- Contacting the Fiscal Agent (Gainwell Technologies) or waiting for response to a verbal inquiry
- Provider staffing changes
- Issues between providers and their software vendors, billing agents or clearinghouses
- Holidays, weekends and dates of business closure

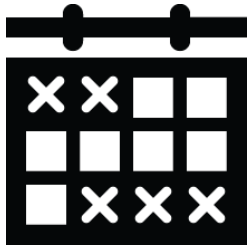
Timely Filing
Dates of Service

Type of Service	Timely Filing Calculation
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500 professional claim form	From the date of each service (line item)
Home & Community-Based Services (HCBS)	From the "through" (last) date of service
Obstetrical services professional fees, Global procedure codes	From the delivery date
Equipment rental	From the date of service, which is the last day of the rental period

Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.

Timely Filing
Provider Enrollment

- Providers must complete the enrollment process and submit claims within 365 days.
- Backdated Approval
  - The Requested Enrollment Effective Date on the enrollment application can be entered as a previous date if services were previously rendered. Providers can be backdated up to 10 months from the enrollment approval date.
- Providers are encouraged to wait until they have a Health First Colorado Provider ID before submitting any claims.



Timely Filing Overrides

If claim is denied, adjusted or voided by fiscal agent for third-party liability (TPL) primary:

Providers may resubmit the claim within 60 days

- Include TPL information on claim
- Reference last internal control number (ICN)
- **NO** attachments on claim

If Medicare is primary:

Providers have additional 120 days from Medicare EOB

- Claims involving Medicare must be filed within 365 days of the date of service or within 120 days of the Medicare denial date, whichever is longer

Timely Filing Overrides

Backdated Member Eligibility

- Backdated Member Eligibility
  - Providers can request load letters when a county backdates member eligibility farther than 365 days from date of service. Once a load letter is received, a **provider has 60 days from the load letter date to submit claims**.
    - Submit claims with copy of load letter via the Provider Web Portal.

- Delayed Notification of Member Eligibility
  - Providers are responsible for determining member eligibility within 365 days of date of service even if the member does not notify them of Health First Colorado eligibility. **There are no timely filing overrides given for delayed notification of eligibility.**

Timely Filing

Is the claim within 365 days of the (final) date of service?

Yes

Health First Colorado: Check member's eligibility (and continue checking in case of retroactive eligibility) and submit claim

Health First Colorado + Third-Party (Commercial Insurance): Bill commercial insurance as soon as possible and follow up to ensure prompt payment

Health First Colorado + Medicare: Bill Medicare first

No

✗ Claim cannot be submitted after 365 days from the date of service unless:

✓ **Member's eligibility backdated by county?** Request load letter and attach to claim submitted within 60 days of letter.

✗ **Delayed in submitting claim and just received Explanation of Benefits (EOB) from Third-Party (Commercial Insurance)?** Claim cannot be submitted after 365 days from the date of service.

✓ **Claim voided or adjusted by fiscal agent for Third-Party Liability?** Providers have 60 days from date of void or adjustment to resubmit claim.

✓ **Just received Explanation of Benefits (EOB) from Medicare?** Providers have 120 days from Medicare Explanation of Benefits (EOB) to submit claims to Health First Colorado

Claim Submission

Claim Submission

Claim Submission Methods

Claim Submission Information

CMS 1500 Paper Claim Form & Example

Claim Status & Common Terms

Common Denial Reasons

Claim Adjustments & Voids

Claim Submission Methods

- Electronically through the Fiscal Agent's (Gainwell Technologies) Provider Web Portal (free of charge)
    - Interactive, one claim at a time, immediate response with claim status
- Electronically using a batch vendor, clearinghouse or software
- Paper
    - Only when pre-approved due to consistently submitting less than five (5) per month
    - Request form must be mailed to the Fiscal Agent (Gainwell Technologies) to request paper claim submission approval

Claim Submission Methods

Electronic Data Interchange (EDI)

- Providers do not need to obtain a trading partner ID/submitter ID to access the Provider Web Portal.
- Only a submitter who sends batch transactions or receives batch reports needs to enroll in the Electronic Data Interchange (EDI) for a trading partner ID.
- Submitters must test batch transactions before approval to submit.
- Visit the Electronic Data Interchange (EDI) Support web page for more information.

Claim Submission Information

Rendering Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member

Billing Provider

Entity being reimbursed for service

Claim Submission Information
Ordering, Prescribing and Referring (OPR) Providers

- Indicating the OPR provider on CMS 1500 Professional Claims:
  - Paper claims use Referring Provider field 17.b
  - Electronic submissions use loop 2420 with qualifier DK (Ordering), DN (Referring) or DQ (Supervising)

- This field may be labeled as Referring Provider in the Provider Web Portal.

- All Ordering, Prescribing and Referring (OPR) providers indicated on a claim must be actively enrolled with Health First Colorado.
  - Groups are encouraged to coordinate with all Ordering, Prescribing and Referring (OPR) providers to ensure that those provider IDs have been enrolled.

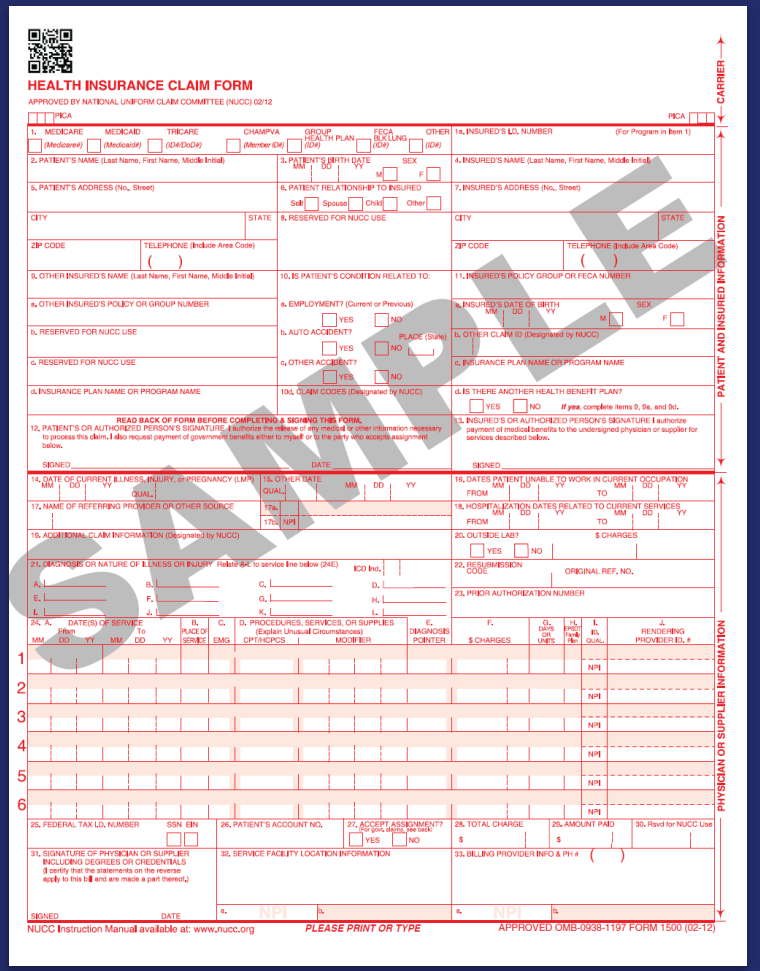
CMS 1500

Paper Claim

CMS 1500 is the standard professional claim form used by Health First Colorado and Medicare programs.

Where can a provider get the CMS 1500?

Information is available on the Centers for Medicare and Medicaid Services website.


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CMS 1500
Resources

Billing Manuals (Provider-Specific)

- CMS 1500 Paper Claim Reference Table
  - Indicates which fields are required, conditional and optional (differ based on provider type)
- CMS 1500 Claim Example
  - Often show various scenarios, such as members with Medicare
- Codes and Modifiers
  - Often in the format of a code table

Provider Web Portal

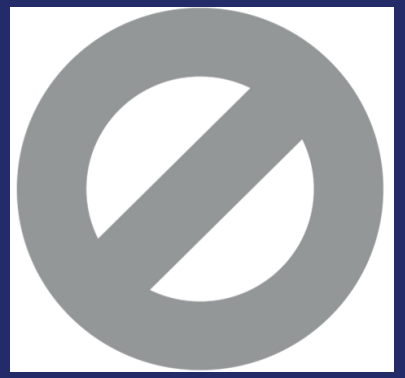
- Red asterisks (*) will denote required fields

Claim Status

Common Terms

Paid

Claim processed & paid by claims processing system. Claims paid at zero due to lower of pricing are still considered paid.



Denied

Claim processed & denied by claims processing system. Denied claims may not be adjusted but may be resubmitted after corrections have been made.

Common Denial Reasons

Timely Filing	Claim was submitted more than 365 days without reference to a previous Internal Control Number (ICN).
Duplicate Claim	A subsequent claim was submitted after a claim for the same service had already been paid.
Bill Medicare or Other Insurance	Health First Colorado is always the payer of last resort. Provider should enroll with and bill all other appropriate carriers first. Primary information must be reported on the claim form.

Common Denial Reasons

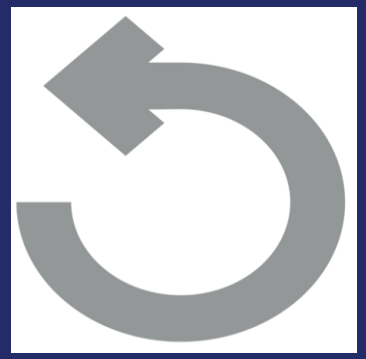
Prior Authorization (PAR) Not on File	No approved prior authorization on file for services that are being submitted, OR member ID, dates of service, modifiers, units or Prior Authorization Request (PAR) type may not match.
Total Charges Invalid	Line-item charges do not match the claim total.
Member Not Eligible for Title XIX (Title 19)	Member ID entered does not include “Medicaid State Plan” or “TXIX” (Title 19) coverage on the date of service.

Claim Status

Common Terms

Adjustment

Correct paid claim



Resubmit

Rebill a previously denied claim

Suspend

Claim must be manually reviewed before final decision

Void

Cancel a paid claim

Providers should only void claims if accidentally submitted OR there is an incorrect Member ID or Provider ID

Claim - Resubmission

- Providers may resubmit, also known as rebill, claims that have been denied.
  - If the resubmitted claim is outside of timely filing, the original Internal Control Number (ICN), or Claim ID, must be referenced.

Resubmit a claim when	Do not resubmit claim when
• Claim was denied	• Claim was paid • Claim is suspended

Resubmission Codes

Rebilled Claims: Date of Service Past 365 Days

Provider Web Portal:

- Search for original claim
- Click “Copy” at the bottom; include original Internal Control Number (ICN) in “Previous Claim ICN” field

Batch:

- Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with 1 code in the 2300/CLM segment

Paper:

- Use code 1 in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box

Claim - Adjustments

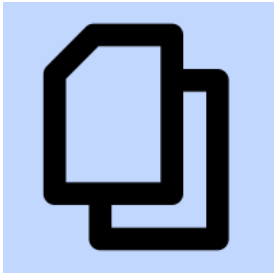
- What is an adjustment?
  - An adjustment creates a replacement claim.
  - Two step process: Credit & Repayment

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

Adjustment & Void Codes

Provider Web Portal:

- Search for original claim and
  - Adjustment: Click “Adjust” at the bottom
  - Void: Click “Void” at the bottom



Batch:

- Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with
  - Adjustment: 7 code in the 2300/CLM segment
  - Void: 8 code in the 2300/CLM segment

Paper:

- Adjustment: Use code 7 in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box
- Void: Use code 8 in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box

Claim Submission: Resubmit or Adjust?

Was the claim denied?

Yes

Is it within 365 days of the (final) date of service?

Yes

Make corrections and <u>submit new claim</u> without referencing the Internal Control Number (ICN)

No

Is it within 60 days of the last Remittance Advice (RA), returned paper claim or load letter?

Yes

Make corrections and <u>rebill/ resubmit claim</u>. Be sure to reference the original Internal Control Number (ICN)

No

Contact Provider Services Call Center

No, it paid

Is it within 365 days of the (final) date of service?

Yes

Make corrections and <u>adjust claim</u> by:

1) Indicating adjustment in field 22 on paper claim form CMS 1500
2) Click "Adjust" at the bottom of the screen after searching for claim on the Provider Web Portal

No

Contact Provider Services Call Center

Quick Guides

- Copy, Adjust or Void a Claim
- Pulling Remittance Advice (RA)
- Reading the Remittance Advice (RA)
- Submitting a Professional Claim

- All Provider Web Portal Quick Guides can be found on the Department's Quick Guides web page.

Resources

Billing Manuals web page

- General Provider Billing Manual
- Provider-Specific Billing Manuals
- Appendix R (for a detailed list of Explanation of Benefits [EOB] codes)

Provider Web Portal Quick Guides

- Technical help for the Provider Web Portal

Provider Training web page

- Training schedule and sign-up
- Training presentations and materials

Provider Contacts web page

- Contact information for Fiscal Agent (Gainwell Technologies) and Health First Colorado vendors
- Contact information for Regional Accountable Entities (RAEs)
- Virtual Agent Fact Sheet

hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
  - Prior Authorization Requests (PARs)
  - Load letters
  - Request to use paper claim form

- Newsletters
- What's New?

Why should you become a provider?

Provider enrollment

Provider services: Forms, rates, & billing manuals

What's new: Bulletins, updates & emails

CBMS: CO Benefits Management System

Long-Term Services and Supports

Provider Web Portal

Revalidation

Provider contacts: Who to call for help

Provider resources: Quick guides, known issues, EDI, & training

Where can I…?

- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV

COLORADO
Department of Health Care Policy & Financing

COVID-19 Provider Information | Resources for HCBS Providers | SAVE System | ColoradoPAR | DDDWeb | Value Based Payments

Thank you for the services you provide to Health First Colorado members!