

Beginner Billing Training: Professional Claims (CMS 1500)

Health First Colorado
(Colorado's Medicaid Program)

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

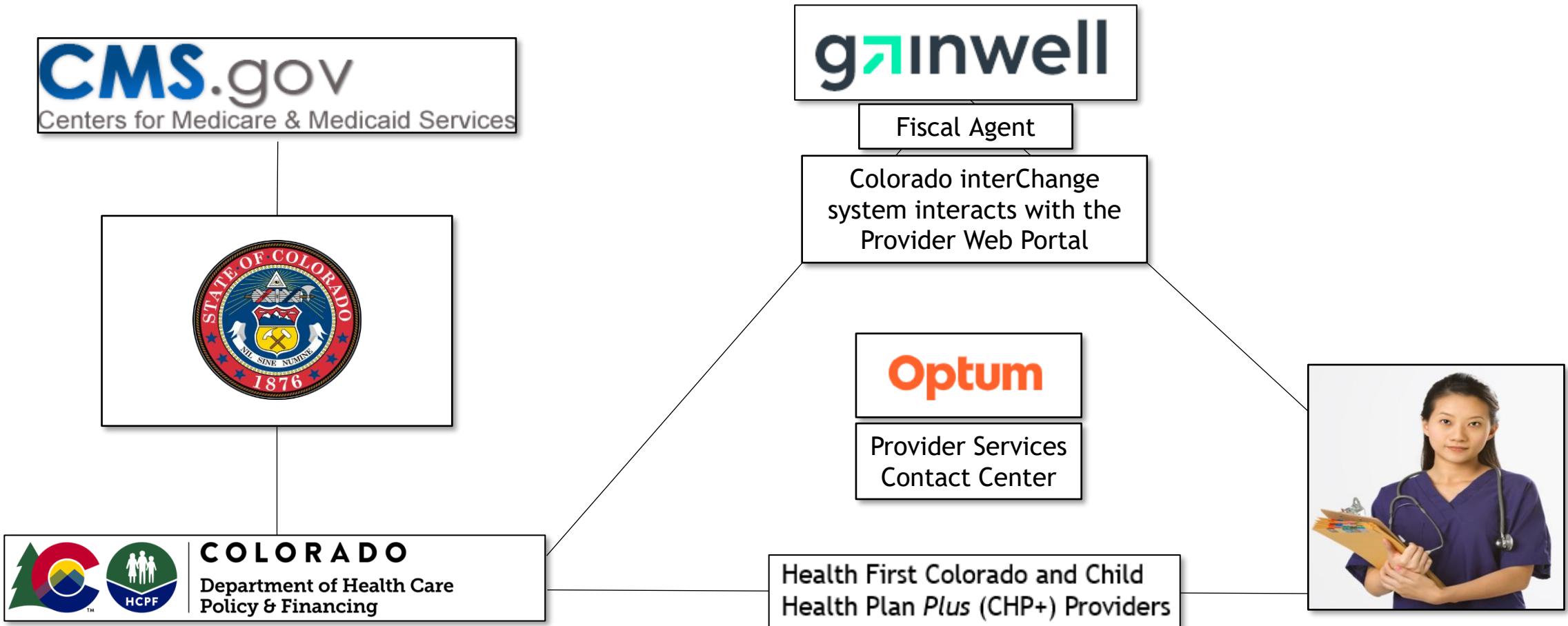
Prior
Authorizations

Billing and
Payment

Claim
Submission

Resources

Program Overview



Department Website

Department of Health Care Policy & Financing

Website

https://hcpf.colorado.gov

1

2

For Our Providers

For Our Members For Our Providers For Our Stakeholders About Us

We administer Health First Colorado (Colorado's Medicaid program), Child Health Plan Plus, and other health care programs.

hcpf.colorado.gov

Apply Now Explore Programs Find a Doctor Get Help

Health First COLORADO™
Colorado's Medicaid Program

We can #KeepCOCovered



Department of Health Care Policy & Financing

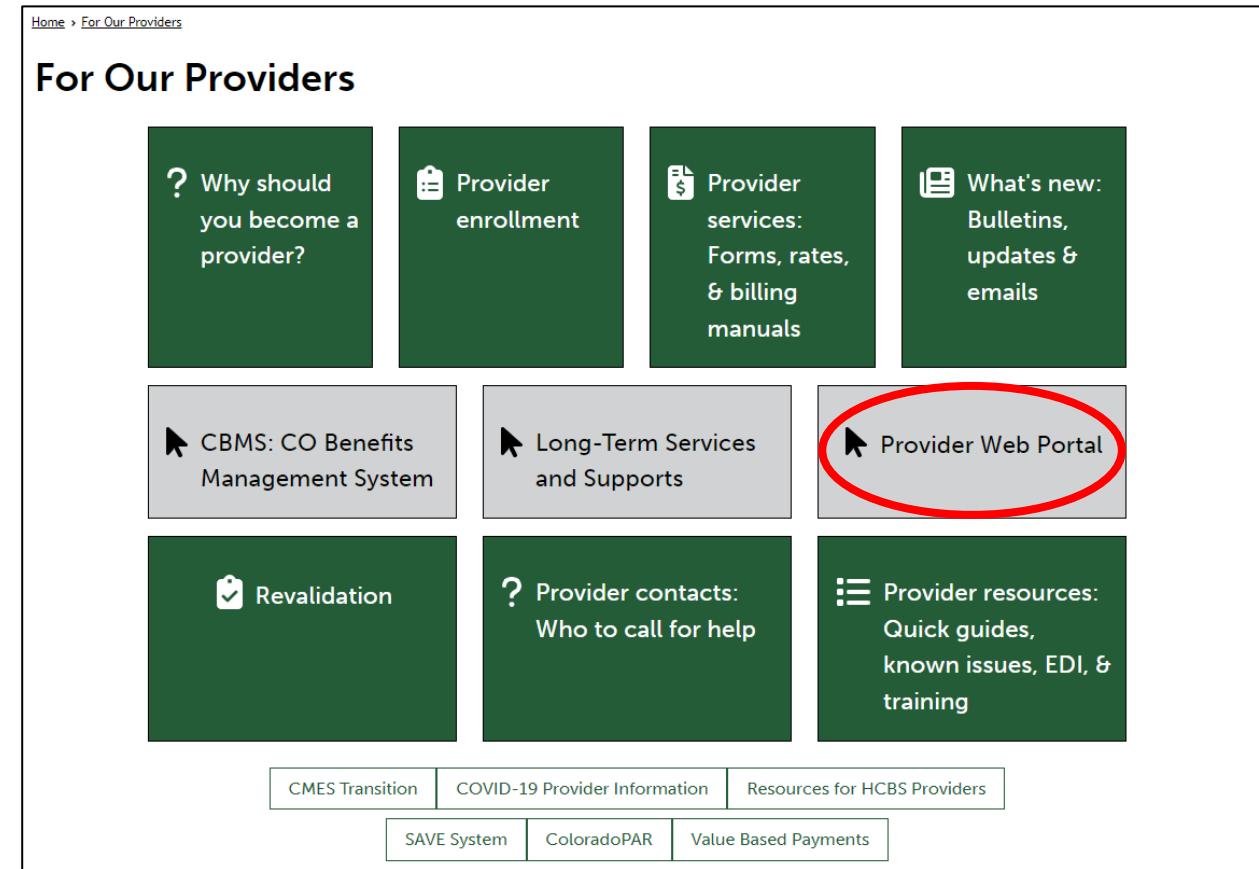
Website

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

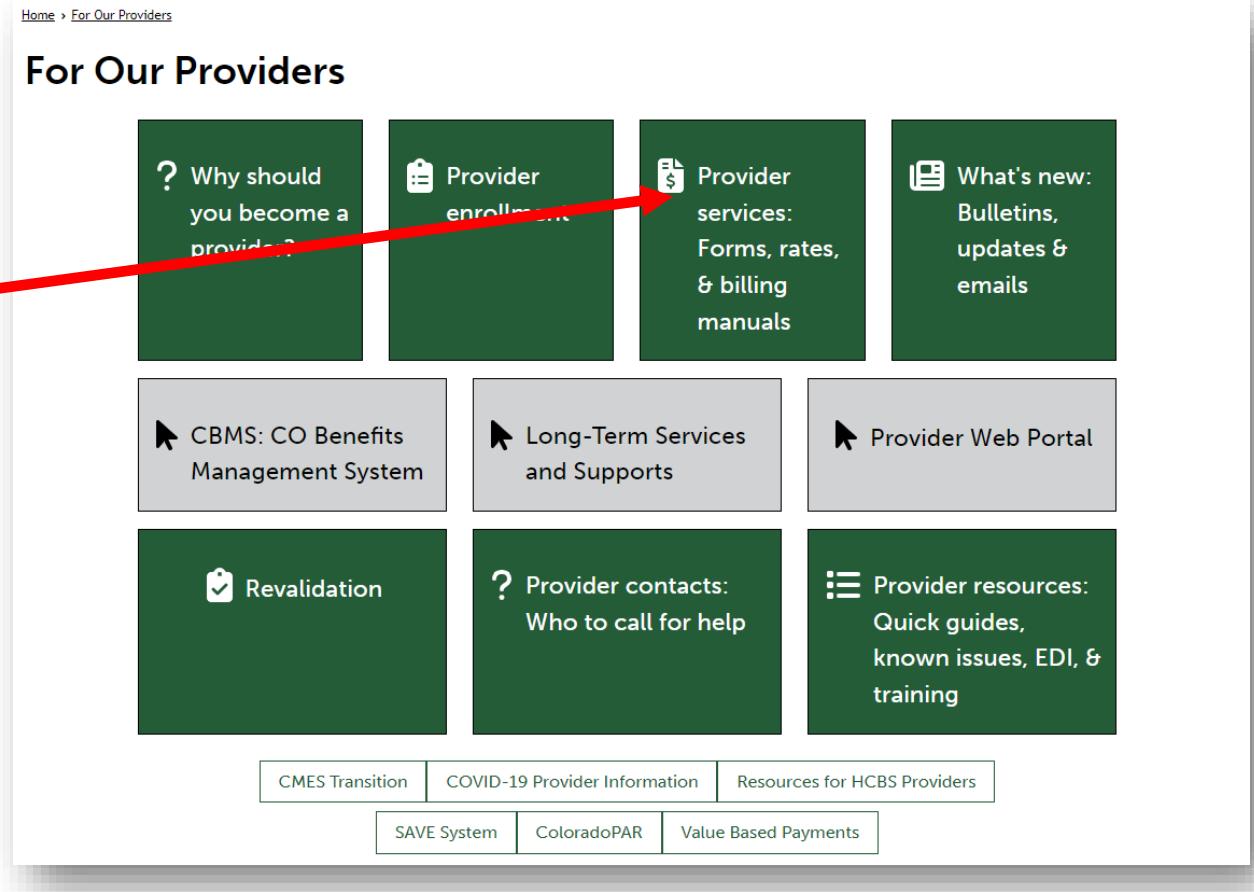


To Bookmark A Web Page:

- On a PC desktop using Chrome, Edge or Firefox, click “Ctrl” and “D.”
- On a Mac desktop using Safari, click “Cmd” and “D”

Provider Services

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



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

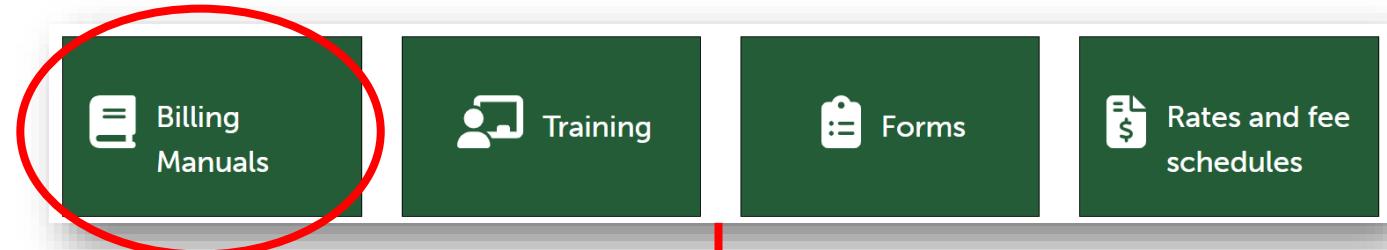
[CMES Transition](#) [COVID-19 Provider Information](#) [Resources for HCBS Providers](#)

[SAVE System](#) [ColoradoPAR](#) [Value Based Payments](#)

Provider Services

General Provider Information Manual

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



Billing Manuals

[Which billing manual should I use based on my provider type?](#)

General Provider Information

- [General Provider Information Manual \(6/24\)](#)

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:

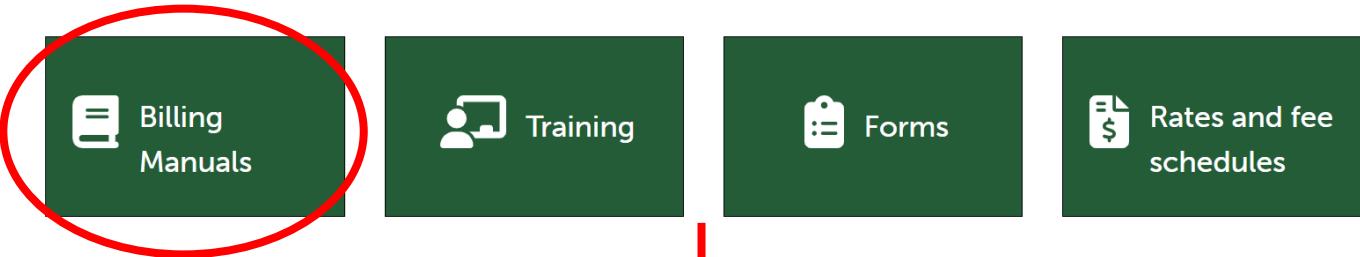


The screenshot shows the Colorado Department of Health Care Policy & Financing website. At the top, there are two circular logos: one with a stylized 'C' and mountain peaks, and another with three stylized human figures. To the right of these logos, the text 'COLORADO' is in large, bold, uppercase letters, followed by 'Department of Health Care Policy & Financing' in a smaller, regular font. Below this is a dark blue horizontal menu bar with three items: 'Home', 'For Our Members', and 'For Our Providers'. Underneath the menu bar, a breadcrumb navigation path is displayed: 'Home > For Our Providers > Provider Services > Billing Manuals > General Provider Information Manual'. The word 'Billing Manuals' is circled in red.

Provider Services

Provider-Specific Billing Manuals

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



Billing Manuals

[Which billing manual should I use based on my provider type?](#)

General Provider Information

- [General Provider Information Manual \(6/24\)](#)

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.

- ▼ Appendices
- ▼ CMS 1500 (Professional)
- ▼ Dental
- ▼ HCBS
- ▼ Pharmacy
- ▼ State Behavioral Health Services
- ▼ UB-04 (Institutional)

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

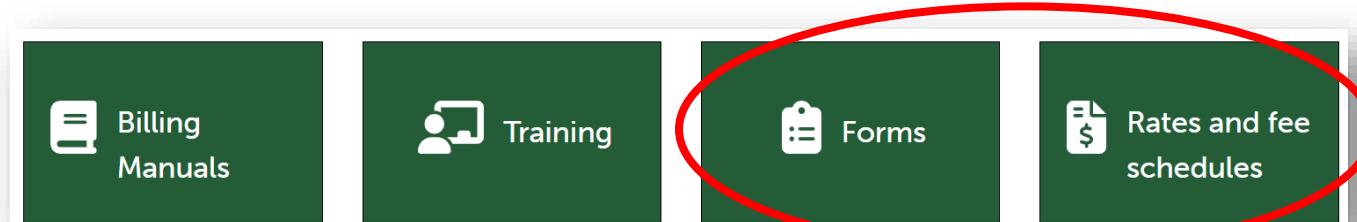
- [Policy Statement: Billing Health First Colorado Members for Services](#)
- [Policy Statement: Charging Health First Colorado Members For Missed Appointments](#)
- [Policy Statement: Dismissing Health First Colorado Members From a Provider's Practice](#)
- [Policy Statement: Member Co-Pays and Provision 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



Home > **For Our Providers** > Provider Services

Provider Services

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

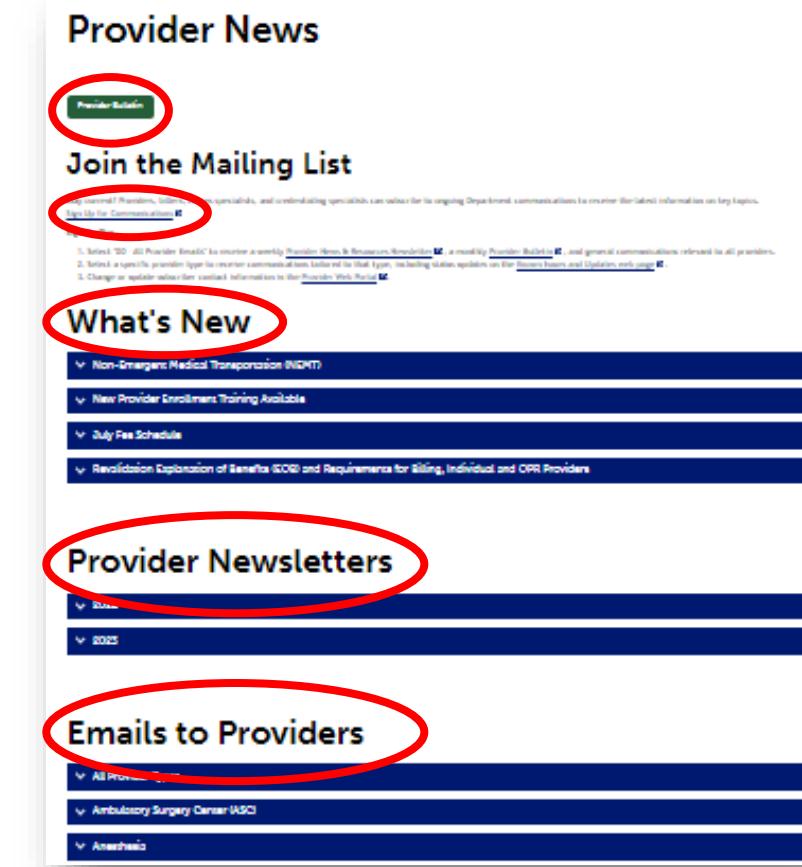
SAVE System

ColoradoPAR

Value Based Payments

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 News

Provider Bulletins

Join the Mailing List

Join current Providers, Intermediaries, specialists, and credentialed specialists via email for ongoing Department communications to receive the latest information on key topics. [Sign Up for Communications](#)

1. Select 'All' to receive monthly [Provider News & Resources](#), [Hospital](#), a monthly [Provider Bulletin](#), and general communication relevant to all providers.

2. Select a specific provider type to receive communications relevant to that type, including state updates on the [Health Issues and Updates](#) page.

3. Change or update contact information in the [Provider Web Portal](#).

What's New

- Non-Emergent Medical Transportation (INERT)
- New Provider Enrollment Training Available
- July Fee Schedule
- Revitalization Exploration of Benefits (REB) and Requirements for Billing, Individual and CRR Providers

Provider Newsletters

2024

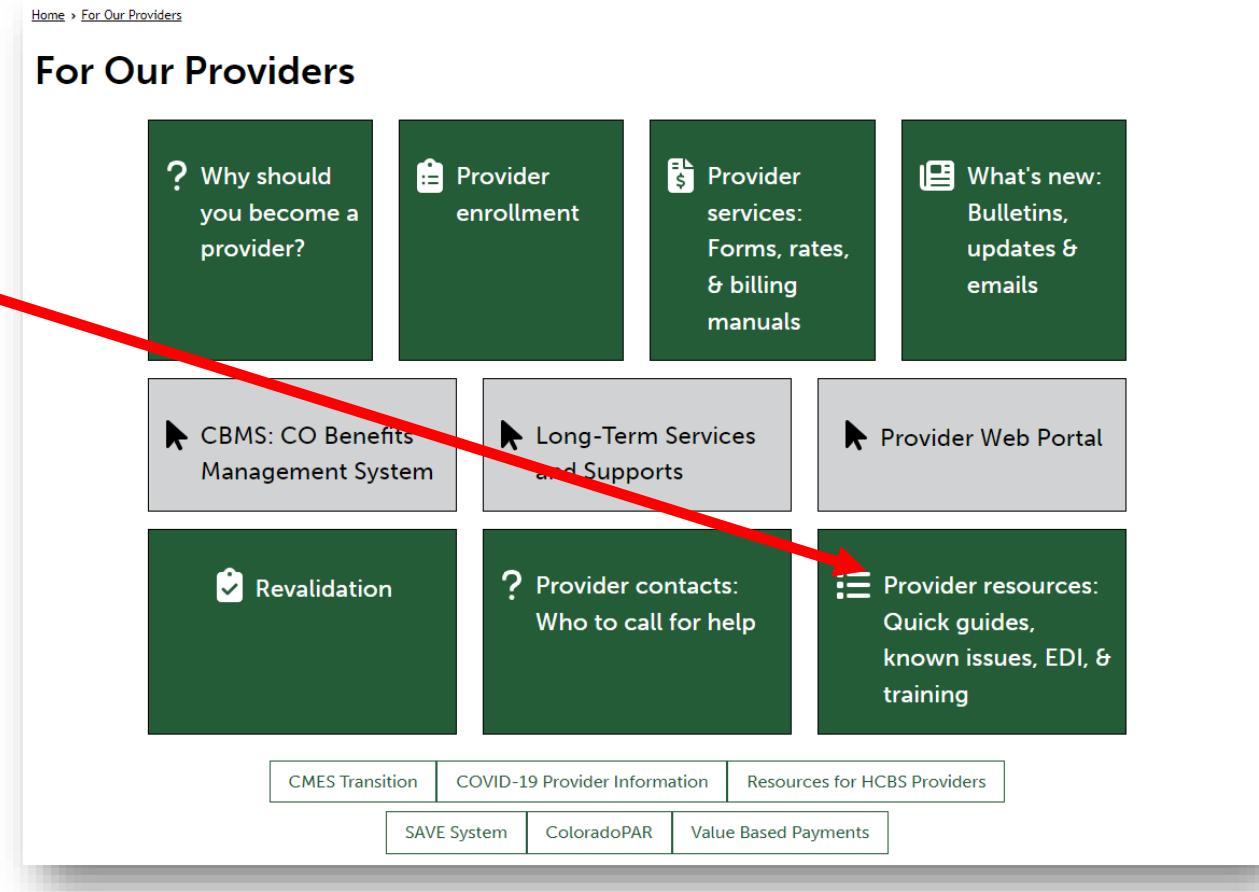
2023

Emails to Providers

- All Providers
- Ambulatory Surgery Center (ASC)
- Anesthesia

Provider Resources

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



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 Resources

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

Known Issues Web Page

Provider Enrollment

Quick Guides & Portal Help

Regional Provider Support Representatives

Contact Information

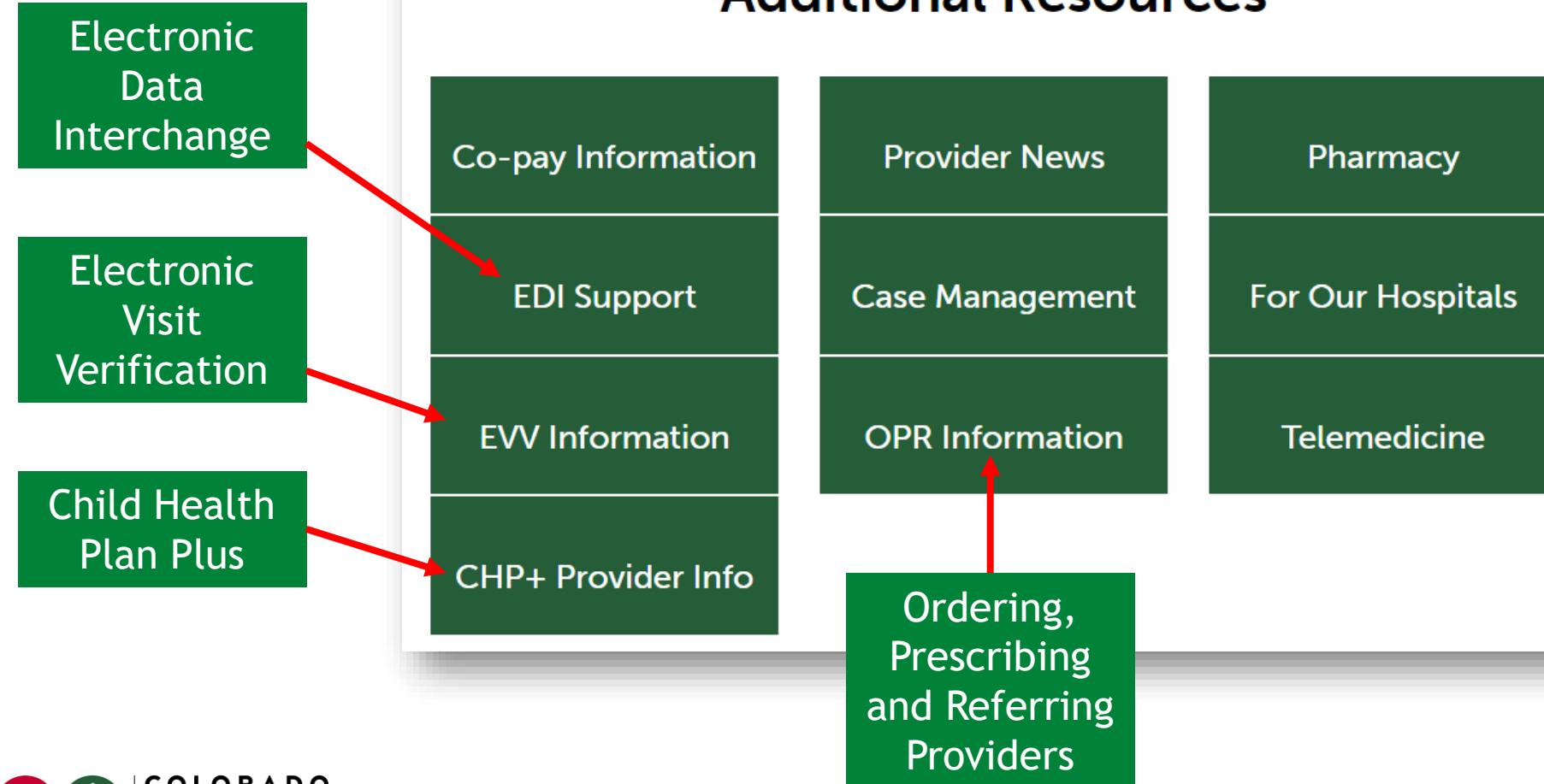
Frequently Asked Questions

Provider Training

Accountable Care Collaborative

Provider Resources

Additional Resources



Provider Enrollment

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



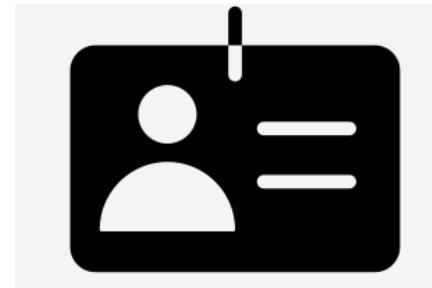
Billing Provider

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

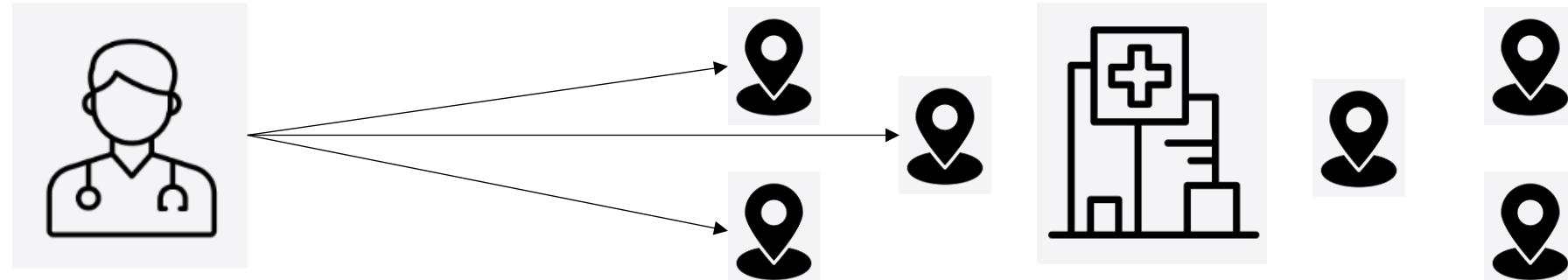
(Individuals Within a Group, Billing Individuals or Ordering/Prescribing/Referring)

- One National Provider Identifier (NPI) can be affiliated with multiple locations
- Tied to Social Security Number (SSN)

Organizational Providers

(Groups, Facilities)

- 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

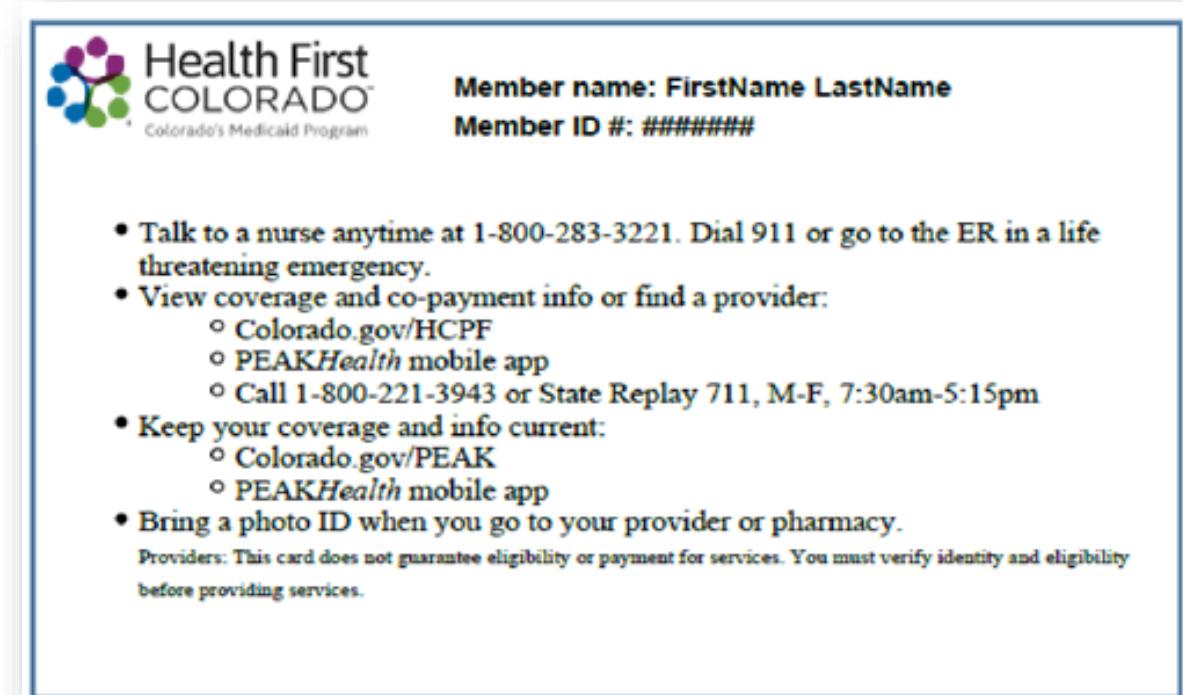
How do providers verify member eligibility?

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.



Health First
COLORADO
Colorado's Medicaid Program

Member ID:
Z999999

Name:
Ima
Member

Your PCP is available to help.

Primary Care Provider (PCP): (303) 555-1212

HEALTH COLORADO, INC. RAE 4

Emergencies or medical advice

If you aren't sure if it's an emergency, call your PCP or the Nurse Advice Line. If it's an emergency, call 911 or go to the emergency room.

24/7 Nurse Advice Line: 800-283-3221

24/7 Mental health crisis: 844-493-TALK (8255)

ColoradoCrisisServices.org text TALK to 38255

If you need help getting an appointment call 1-888-502-4185.

See if you're active on the PEAK Health App



Health First
COLORADO
Colorado's Medicaid Program

ID de miembro: **Z999999** **Nombre:**
Ima
Member

Su PCP está a su disposición para ayudarle.

Médico de cabecera (Proveedor de atención primaria o PCP): 303-555-1212

DENTAQUEST USA

Emergencias o asesoramiento médico

Si no está seguro de si se trata de una emergencia, llame a su PCP o a la Línea de asesoramiento de enfermería. Si es una emergencia, llame al 911 o vaya al servicio de emergencias.

Línea de asesoramiento de enfermería las 24 horas del día, los siete días de la semana: 800-283-3221

Crisis de salud mental las 24 horas del día, los siete días de la semana: 844-493-TALK (8255)

ColoradoCrisisServices.org envíe TALK al 38255

Si necesita ayuda para hacer una cita, llame al 1-855-384-7926.

Consulte si está activo en la aplicación PEAK Health

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 Verification Information for	
Member ID	Birth Da
	Coverage
Medicaid State Plan	
Medicaid Behavioral Health Benefits	
HCBS Elderly, Blind, & Disabled Waiver	

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:

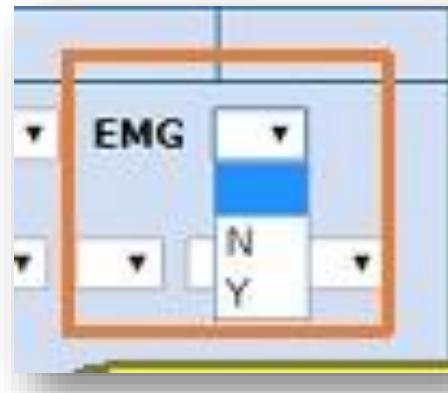
- Behavioral health through the Regional Accountable Entities (RAEs)
- Managed Care Organizations (MCOs)
- Program of All-Inclusive Care for the Elderly (PACE)

Additional insurance:

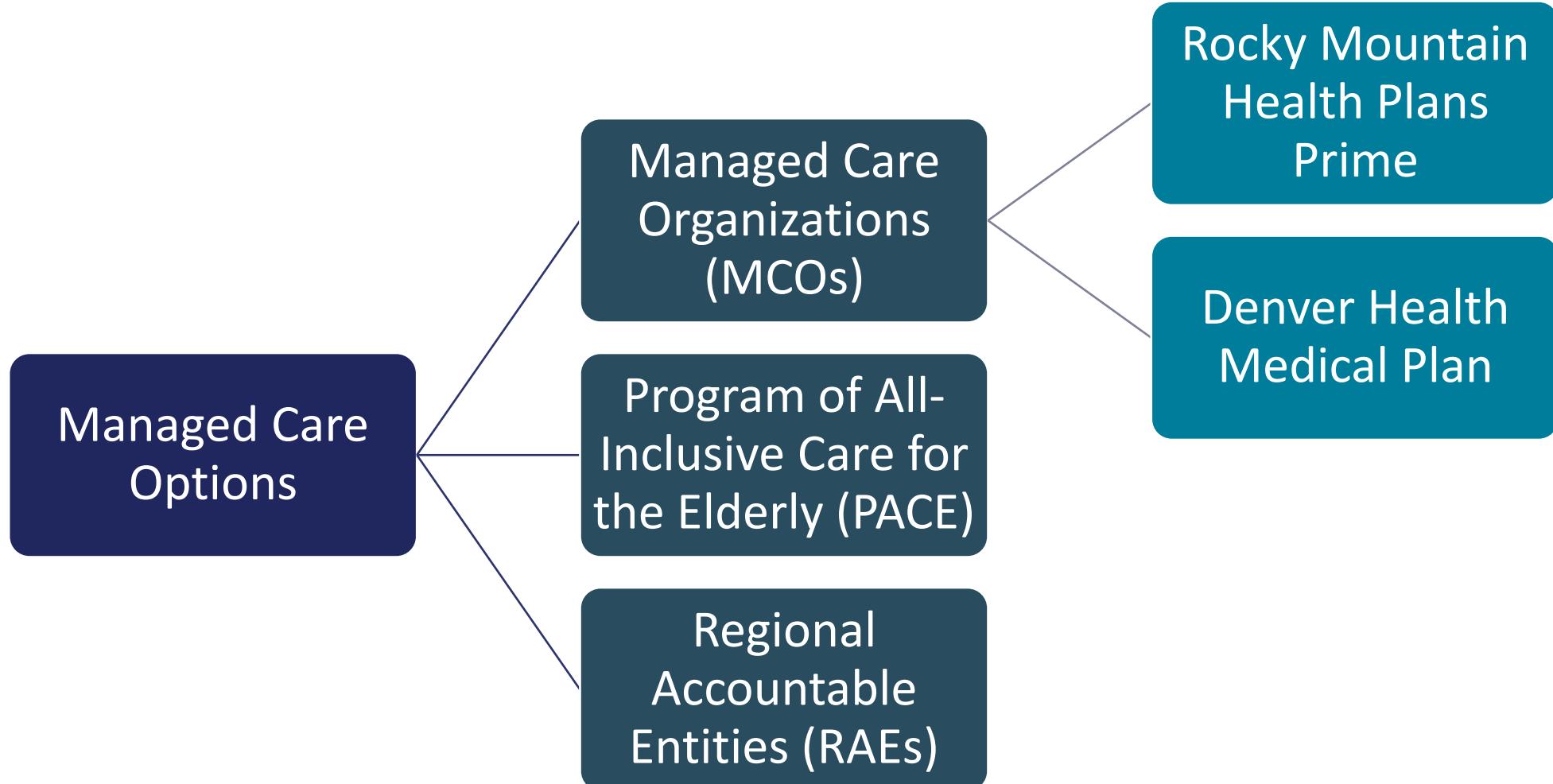
- Medicare
- Third-party liability (TPL)

Who Defines an Emergency?

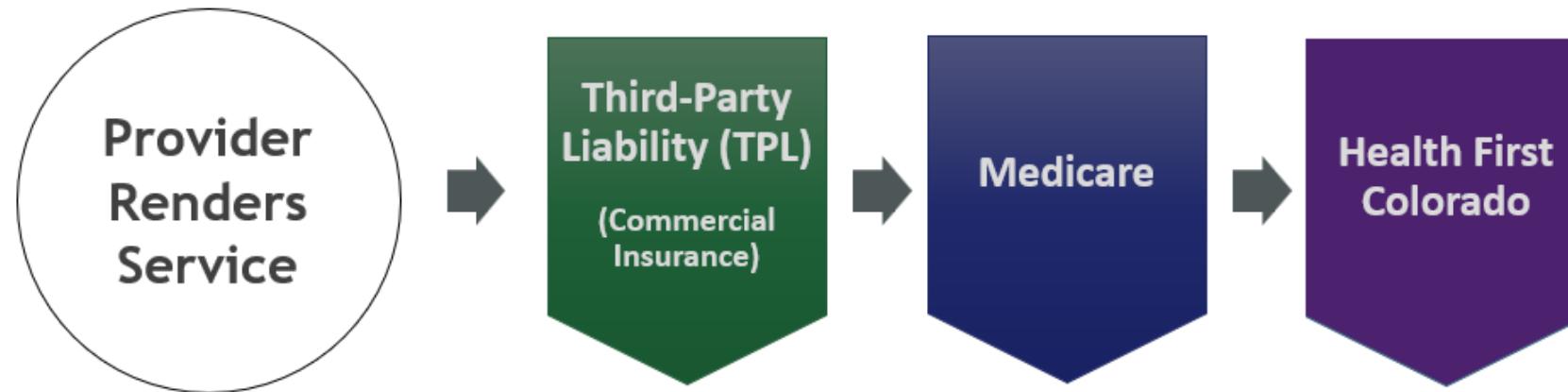
- The provider determines whether the service is considered an emergency and marks the claim appropriately by checking box 24C on the CMS 1500 paper claim or selecting “Y” for the EMG field on the Provider Web Portal.
- Health First Colorado does not determine emergency status based on diagnosis or procedure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

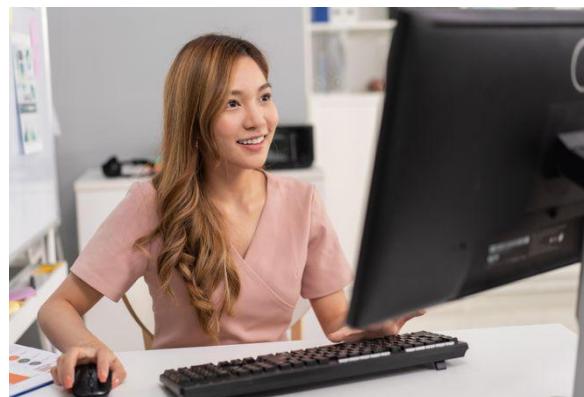
- All Prior Authorization Requests (PARs) for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child/youth.
- ColoradoPAR 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

Mon.

Tue.

Wed.

Thur.

Fri.

Sat.

Providers bill claims

Weekly claim submission cutoff

Mon.

Tue.

Wed.

Thur.

Fri.

Sat.

Remittance Advices (RAs) and 835s are posted to the Provider Web Portal

Electronic Fund Transfer (EFT) payments are deposited to provider accounts

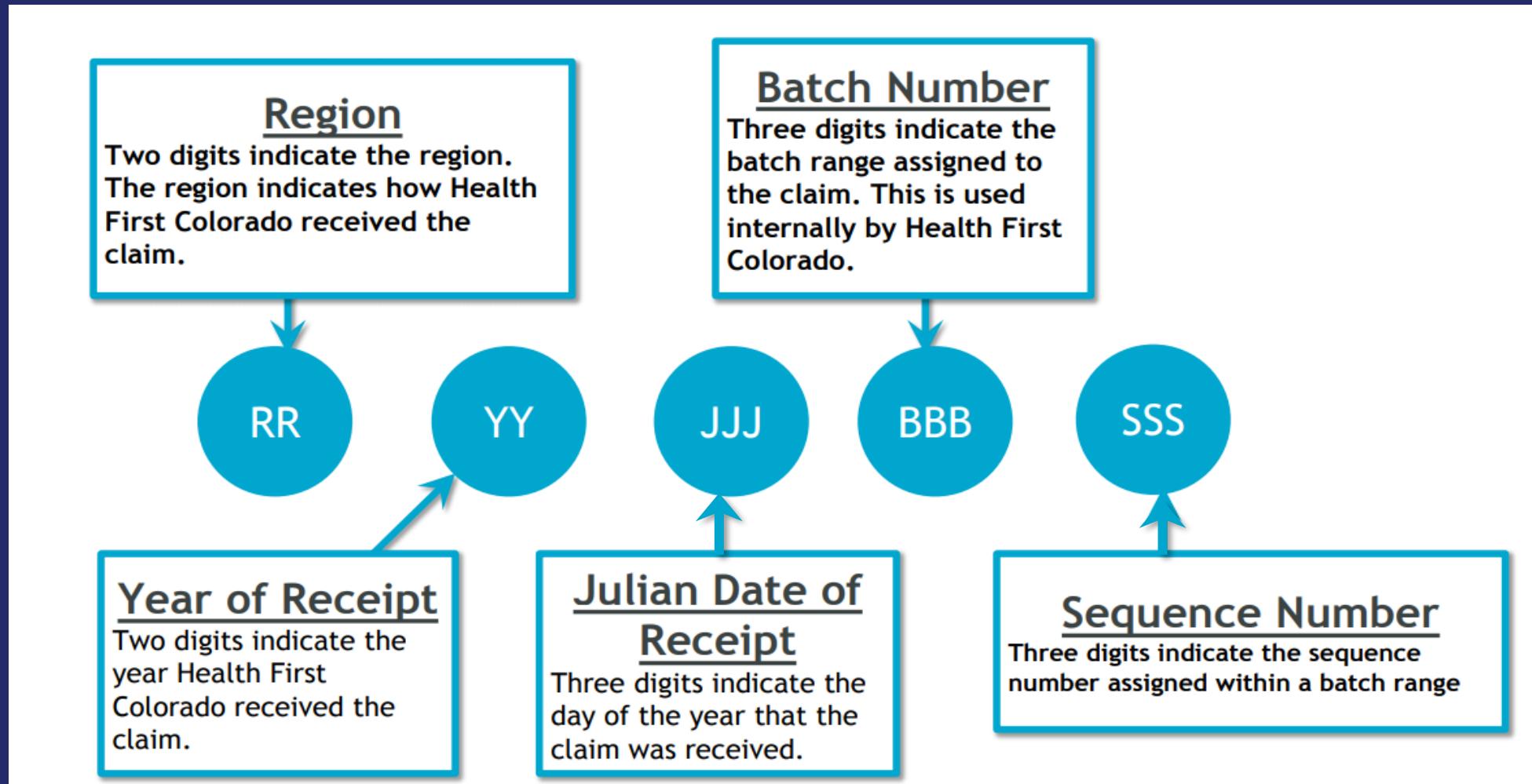
Remittance

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

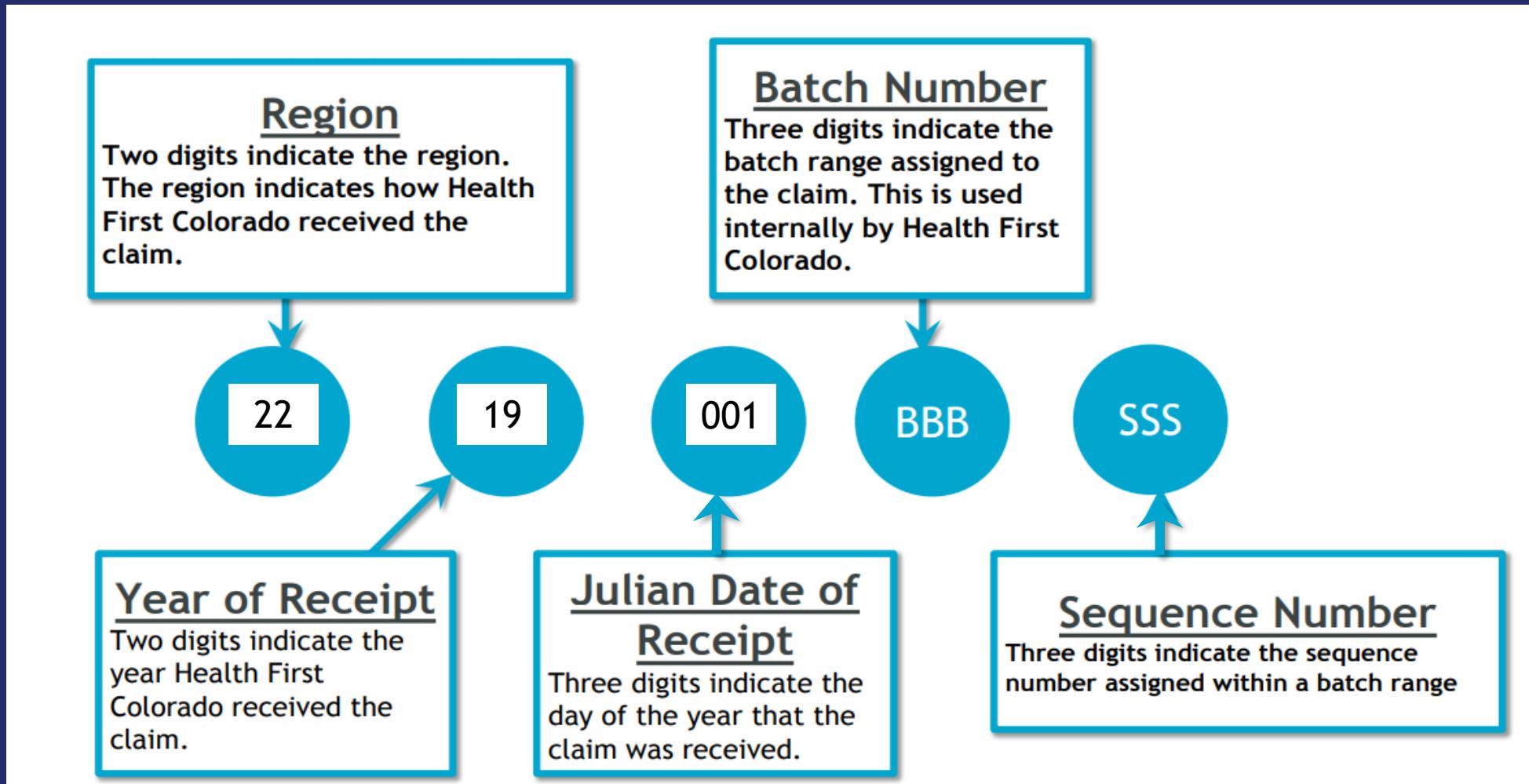
Region Codes

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)

--ICN--	PCN	MRN	SERVICE DATES FROM TO	BILLED AMT ALLOWED AMT	OTH INS AMT SPENDDOWN AMT	COPAY AMT CO-INS CB	PAID AMT OUTPAT DED
MEMBER NAME: JOHN DOE			MEMBER NO.: J123456				
67111111111111	1122334455		081622 081622	(150.00) (150.00)	(0.00) (0.00)	(0.00) (0.00)	(128.00) (0.00)
59111111111111	1122334455		081622 081622	175.00 175.00	0.00 0.00	0.00 0.00	175.00 0.00
ADJUSTMENT EOB: 0000							

PROC CD MODIFERS	SERVICE DATES	ALLW UNITS	RENDERING PROVIDER	PA NUMBER		
BENE PLAN	FROM TO	COPAY AMT	BILLED AMT	ALLOWED AMT	PAID AMT	DETAIL EOBS
93458 26	081622 081622	1.00	MCD 11223344			
TXIX		0.00	175.00	175.00	175.00	
						ADDITIONAL PAYMENT
						REFUND AMOUNT REVERSED
						47.00
						22.00



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

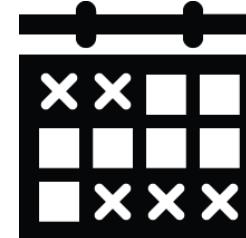
Type of Service	Timely Filing Calculation
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500 professional claim form	From the date of each service (line item)
Home & Community-Based Services (HCBS)	From the “through” (last) date of service
Obstetrical services professional fees, Global 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

1. MEDICARE MEDICAID CHAMPVA GROUP HEALTH PLAN FICA BUCKING (DIA) OTHER
Medicare Medicaid (DIA/DOD) Member (DIA) (DIA) (DIA) (DIA) (DIA) (DIA)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S ID. NUMBER
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)

8. CITY STATE 9. RESERVED FOR NUCC USE
ZIP CODE TELEPHONE (Include Area Code) ()

10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FICA NUMBER
12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 13. INSURED'S DATE OF BIRTH MM DD YY M F
14. OTHER INSURED'S POLICY OR GROUP NUMBER 15. EMPLOYMENT? (Current or Previous)
16. RESERVED FOR NUCC USE 17. AUTO ACCIDENT?
18. RESERVED FOR NUCC USE 19. OTHER ACCIDENT?
20. RESERVED FOR NUCC USE 21. OTHER ACCIDENT?
22. INSURANCE PLAN NAME OR PROGRAM NAME
23. IS THERE ANOTHER HEALTH BENEFIT PLAN?
24. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who also accepts assignment below.
25. SIGNATURE DATE
26. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 27. OTHER DATE MM DD YY
28. NAME OF REFERRING PROVIDER OR OTHER SOURCE 29. HOSPITAL/CLINIC/DOCTOR'S NAME
30. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 31. OUTSIDE LAB? \$ CHARGES
32. DATE OF CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
33. HOSPITAL/CLINIC/DOCTOR'S ADDRESS
34. DATES OF SERVICE FROM MM DD YY TO MM DD YY
35. PLACE OF SERVICE EMR C. D. PROCEDURES, SERVICES, OR SUPPLIES
36. ICD-9-CM CODES
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38. DIAGNOSIS CODE
39. CHARGES
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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

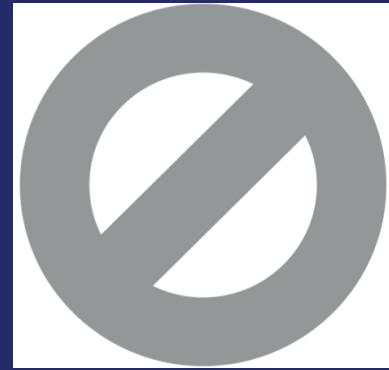
Claim Status

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

- Claim was denied

Do not resubmit claim when

- Claim was paid
- Claim is suspended

Resubmission Codes

Rebilled Claims: Date of Service Past 365 Days

Provider Web Portal:

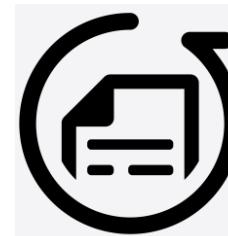
- Search for original claim
- Click “Copy” at the bottom; include original Internal Control Number (ICN) in “Previous Claim ICN” field

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

- Provider billed incorrect services or charges
- Claim paid incorrectly

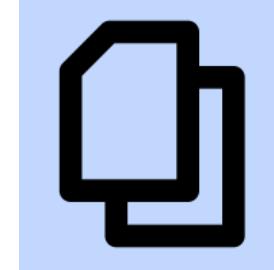
Do not adjust claim when

- 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



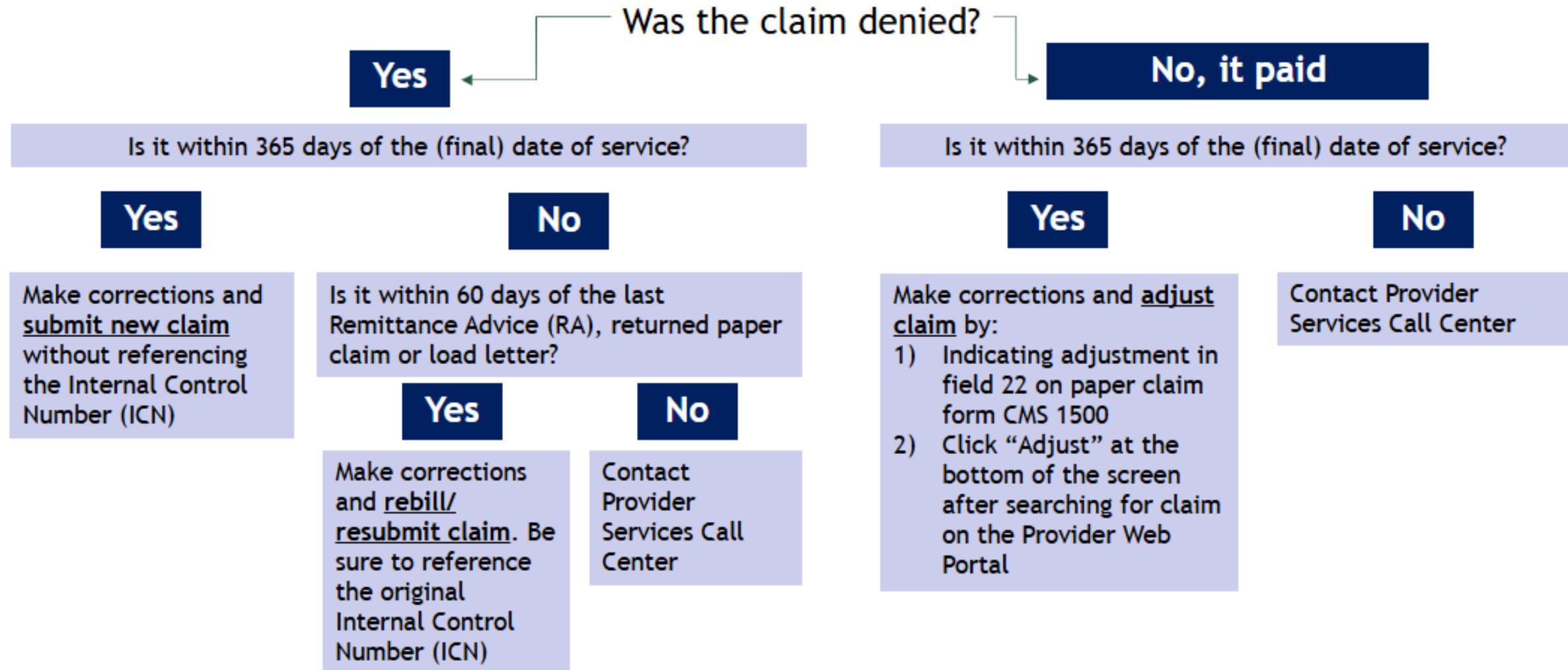
Batch:

- 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?



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



?

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



COLORADO
Department of Health Care
Policy & Financing

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

- 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?

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

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