

# 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.



# Professional Claim - Who Completes It?

Audiology

Home and  
Community-Based  
Services (HCBS)

Imaging &  
Radiology

Laboratory  
Services

Pediatric  
Behavioral Therapy

Physical,  
Occupational &  
Speech Therapy

Physicians &  
Practitioners

School-Based  
Services

Supply/Durable  
Medical Equipment  
(DME)

Transportation  
Providers

Vision



# Behavioral Therapy vs. Behavioral Health

- **Behavioral therapy includes services for children/youth under age 21 who have autism spectrum disorder or a similar condition.** More information can be found on Health First Colorado Criteria for Behavioral Therapy.
  - Behavioral therapy includes provider types 37 (Licensed Psychologist), 38 (Licensed Behavioral Health Clinician), 83 (Behavioral Therapy Clinic) and 84 (Board Certified Behavior Analyst).
  - Pediatric behavioral therapy providers submit claims to the Fiscal Agent (Gainwell Technologies).
  - Child Health Plan *Plus* (CHP+) does not cover Applied Behavior Analysis (ABA) therapy (Common Procedural Terminology [CPT] codes 97151, 97153, 97154, 97155, 97158).
- **Behavioral health includes comprehensive mental health and substance use disorder services.**
  - Behavioral health providers submit most claims through the Regional Accountable Entities (RAEs). More information on the RAEs can be found on the Accountable Care Collaborative web page.

# Case Management

- Case Management Agencies (CMAs) provide case management for individuals with disabilities in the ten (10) Home and Community-Based Services waiver programs.
- The Care and Case Management (CCM) System is the name used to describe MedCompass®, a configurable care management platform by AssureCare, that will be customized to meet Colorado's unique care management needs.
  - Used for documenting case management activities and members' case management records
  - Consolidates case management functions currently existing in separate applications, such as the Benefits Utilization System (BUS)
  - Interfaces with the Colorado interChange, the claims processing system used by Health First Colorado
- **Training for the new CCM system is not covered in this training.** More information, including CCM-specific training and resources, can be found on the Care and Case Management System web page.

# Training Overview

Program  
Overview

Department  
Website

Provider  
Enrollment

Member  
Eligibility

Prior  
Authorizations

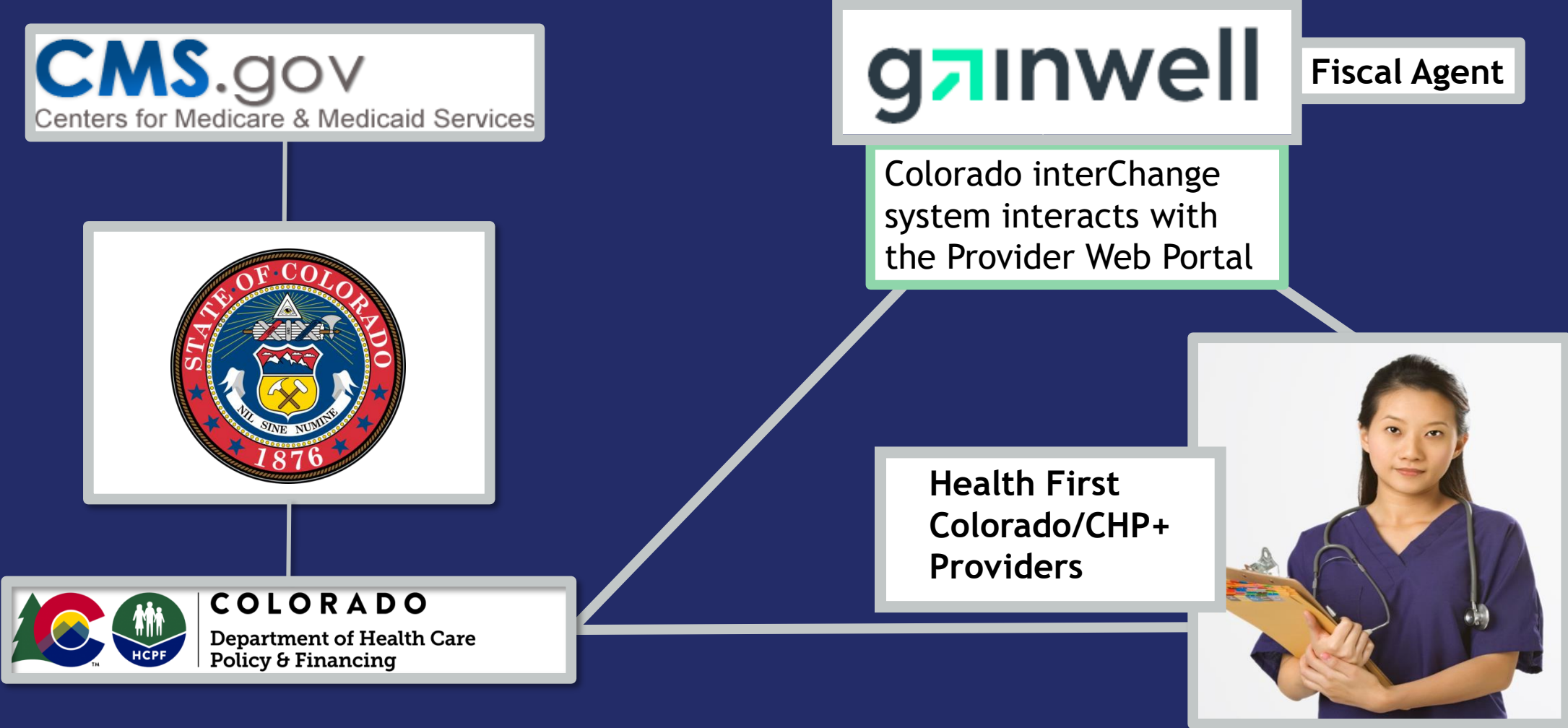
Billing and  
Payment

Resources

Claim  
Submission



# Program Overview



# Department Website





# Department of Health Care Policy & Financing

## Website

The screenshot shows the website's header and main navigation. A red box labeled '1' points to the URL 'https://hcpf.colorado.gov' in the browser's address bar. Another red box labeled '2' points to the 'For Our Providers' link in the top navigation bar. Below the navigation bar, there is a blue bar with links for 'For Our Members', 'For Our Providers', 'For Our Stakeholders', and 'About Us'. The 'For Our Providers' link is highlighted with a red box. Below this bar, there is a paragraph of text: 'We administer Health First Colorado (Colorado's Medicaid program), Child Health Plan Plus, and other health care programs.' Below the text are four blue buttons: 'Apply Now', 'Explore Programs', 'Find a Doctor', and 'Get Help'. At the bottom, there is a white box with the 'Health First COLORADO' logo and the text 'Colorado's Medicaid Program', and a green box with the text 'We can #KeepCOCovered'.

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

# For Our Providers Home Page

Access to billing manuals, fee schedules, enrollment, revalidation, the Provider Web Portal, contacts and resources like Quick Guides

Contains important information regarding Health First Colorado (Colorado's Medicaid program) & other topics of interest to providers and billing professionals

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
- Care and Case Management
- Web portal
- Revalidation
- Provider contacts: Who to call for help
- Provider resources: Quick guides, known issues, EDI, & training

COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb

# Provider Services

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

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

Home > For Our Providers

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# What's New: Bulletins, Updates & Emails

*Sign up for publications*



Weekly newsletters and monthly bulletins

Home > For Our Providers

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# 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

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# Provider Training

## Provider Resources

### Upcoming Holidays

Memorial Day - Monday, May 29, 2023 - State Offices, the ColoradoPAR Program, Gainwell Technologies and DentaQuest will be closed.

Capitation cycles for managed care entities may potentially be delayed. The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.

## Additional Resources

## Billing Training - Schedule and Signup

Sign up for live webinar training sessions below.

Note: Trainings may end prior to 11:30 a.m. MT. Time has been allotted for questions at the end of each session.

November 2023 Training Schedule						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2 <a href="#">Beginner Billing Training: Professional Claims (CMS 1500) - Thursday, November 2, 2023, 9:00 a.m.-11:30 a.m. MT</a>	3	4
5	6	7	8	9 <a href="#">Beginner Billing Training: Institutional Claims (UB-04) - Thursday, November 9, 2023, 9:00 a.m.-11:30 a.m. MT</a>	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December 2023 Training Schedule						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5	6	7 <a href="#">Beginner Billing Training: Professional Claims (CMS 1500) - Thursday, December 7, 2023, 9:00 a.m. - 11:30 a.m. MT</a>	8	9
10	11	12	13	14 <a href="#">Beginner Billing Training: Institutional Claims (UB-04) - Thursday, December 14, 2023, 9:00 a.m. - 11:30 a.m. MT</a>	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

# Provider Enrollment

# Provider Enrollment

## Website

### Question:

Who enrolls providers?

### Answer:

Gainwell Technologies enrolls providers, not members, for Health First Colorado

*\* Some applications require final state approval.*

### Question:

Who needs to enroll?

### Answer:

Everyone who provides services for Health First Colorado members, including Ordering, Prescribing and Referring (OPR) Providers



# Provider Enrollment

- To prepare for enrollment as a new provider, go to the Provider Enrollment web page and click the Enrollment Instructions & Application button.
- There is a list of resources, as well as forms, for enrolling providers.

**Provider Enrollment**

Attention: Application fees, fingerprinting, and site visits are required for enrollment. If any of these requirements were waived for the public health emergency, they will be required to continue enrollment.

Revalidation Information | NPI Law Web Page

**Enrollment Instructions & Application**

**Enrollment Resources**

- [Enrollment Best Practices](#)
- [Trading Partner Enrollment Information](#)
- [Enrollment and Web Portal Quick Guides](#)
- [Information for Ordering, Prescribing, Referring \(OPR\) Providers](#)
- [Paying a Previously Waived Enrollment Application Fee](#)
- [Provider Enrollment Manual](#)

Need help with your enrollment? Visit the [Provider Contacts web page](#) for options.

Completed your application? Click here for next steps

Provider Enrollment Forms can be found on the Provider Forms web page under the "Provider Enrollment & Update Forms" heading.

Provider Enrollment & Update Forms

- [Affidavit of Lawful Presence](#)
- [Attestation Form for Facilities Enrolling with Health First Colorado](#) - RCCF/Q RTP
- [Backdate Enrollment Form](#) - Do not submit any attachment with this form (such as a claim form). Note: The backdate form is only for fee-for-service billing. CHP+ and behavioral health providers need to contact their MCO/RAE to determine rules as they may have different restrictions.
- [Behavioral Therapy Provider Attestation Form](#)
- [Change of Ownership \(CHOW\) Form](#)
- [Disclosure Instructions EIN](#)
- [Disclosure Instructions SSN](#)
- [Electronic Visit Verification Attestation Form](#)
- [Legal Name Change Form](#) - Do not mail to Gainwell Technologies. Follow instructions on the form to submit via the Provider Web Portal.
- [National Provider Identifier \(NPI\) Backdate Form](#) - Do not mail to Gainwell Technologies. Follow instructions on the form to submit via the Provider Web Portal.
- [Network Participation Verification Form](#) - Instead of uploading a copy of the entire contract, providers can complete and upload this form to the *Attachments and Fees* page of the Online Provider Enrollment tool.
- [Provider Application Fee Refund Request Form](#)
- [Provider Participation Agreement](#) - Can only be signed from within the Online Provider Enrollment tool.
- [Provider Participation Agreement - Effective March 1, 2023](#) - Can only be signed from within the Online Provider Enrollment tool.
- [FT Exemption Instructions](#) - Used only for Case Managers, Out of State providers, and Colorado State Government Entities.
- [RN Supervision Form](#)
- [W9](#) - Required for Taxpayer Identification Number (TIN) verification.

Visit the [Provider Enrollment](#) web page for more provider enrollment instructions and information.

# Provider Types

- Enrollees will need to pick the appropriate provider type based on the services rendered before starting an application.
  - A provider type is a two-digit number that indicates what type of provider is billing.
  - Providers can be individuals, organizations and vendors.
  - Provider types can be found on the [Find Your Provider Type](#) web page.
- Providers will be assigned an 8- to 10-digit Health First Colorado Provider ID when the enrollment is approved.



# Licensure

- Some providers must obtain licensing through the Colorado Department of Public Health and Environment (CDPHE).
- All providers, including those who obtain licensure through CDPHE, must enroll with Health First Colorado in order to provide and bill for services. CDPHE and the Colorado interChange system do not share information so any changes a provider makes with one entity must be made with the other.
- The Colorado interChange does take in information from the Department of Regulatory Agencies (DORA) to update licenses. Providers are encouraged to ensure the name and all demographic information matches so the licenses can be automatically updated.

# Home and Community-Based Services (HCBS)

- HCBS providers must choose a specialty depending on the types of services they provide to members. A list of waivers and their respective provider specialties is available on the [Information by Home and Community-Based Services Provided](#) web page.

## Adult HCBS Waivers

Select a waiver to learn more:

- [Brain Injury Waiver \(BI\)](#)
- [Community Mental Health Supports Waiver \(CMHS\)](#)
- [Complementary and Integrative Health Waiver \(CIH\)](#)
- [Developmental Disabilities Waiver \(DD\)](#)
- [Elderly, Blind and Disabled Waiver \(EBD\)](#)
- [Supported Living Services Waiver \(SLS\)](#)



## Children's HCBS Waivers

Select a waiver to learn more:

- [Children with Life Limiting Illness Waiver \(CLLI\)](#)
- [Children's Extensive Support Waiver \(CES\)](#)
- [Children's Habilitation Residential Program Waiver \(CHRP\)](#)
- [Children's Home and Community Based Services Waiver \(CHCBS\)](#)

# Enrolled Providers

- Enrolled providers are encouraged to review the Provider Enrollment web page often as there are updates, frequently asked questions and information on revalidation.

## Provider Enrollment

**ATTENTION:** The state has imposed a moratorium on new enrollments for Non-Emergent Medical Transportation (NEMT) due to a significant potential for fraud, waste, or abuse to the Medicaid program. The moratorium will be in place for a minimum of 6 months and may extend beyond that. Additional information will be announced as it becomes available.

**ATTENTION:** Providers that do not complete the revalidation process by their revalidation due date will be subject to claim denials or disenrollment. Providers can locate their new revalidation date on the revalidation spreadsheet located on the [Revalidation web page](#) under the Revalidation Resources section.

**ATTENTION:** Application fees, fingerprinting, and site visits are required for enrollment. If any of these requirements were waived for the public health emergency, they will be required to continue enrollment.

Revalidation Information

NPI Law Web Page

# 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.**
- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.
- 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 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](#)

# National Provider Identifier (NPI)

- A National Provider Identifier (NPI) is a unique 10-digit identification number issued to U.S. health care providers by Centers for Medicare and Medicaid Services (CMS).
- All providers except for some Home and Community-Based Services (HCBS) require an NPI for billing transactions. If you are unsure, please check the [Find Your Provider Type](#) web page. If an organization is not required to have an NPI, it will use its Health First Colorado Provider ID in all billing transactions.
- Providers who bill Medicare need to ensure each NPI for Health First Colorado is also enrolled with Medicare.

<b>Individual Providers</b> (Individuals Within a Group, Billing Individuals or Ordering/Prescribing/Referring)	<b>Organizational Providers</b> (Groups, Facilities)
<ul style="list-style-type: none"><li>• NPI is permanent regardless of rendering provider location or affiliation</li><li>• Only one NPI and one Health First Colorado ID is needed</li></ul>	<ul style="list-style-type: none"><li>• Need to use a unique NPI for each service location and provider type enrolled in the Colorado interChange</li></ul>

# National Provider Identifier (NPI)

- How to obtain and learn additional information
  - Centers for Medicare and Medicaid Services (CMS) web page
  - National Plan and Provider Enumeration System (NPPES) website
    - 1-800-456-3203
    - 1-800-692-2326 TTY





# Member Eligibility

# Member Eligibility

Verifying Member Eligibility

Viewing Member Information

Health First Colorado Member ID Cards

Eligibility Types

Managed Care

Medicare

Third Party Liability

Co-Pay

# Verifying Member Eligibility

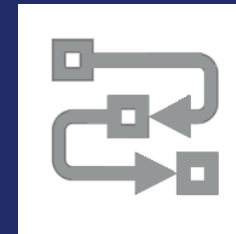
- Member's eligibility must be checked on each date of service.
  - Facilities that bill monthly: Eligibility extends through end of the month. It is recommended that providers check eligibility on the first of each month.
- Ways to verify eligibility:



**Provider Web  
Portal**



**Virtual Agent  
1-844-235-2387**



**Batch 270**

# Log In to View Member Information

## Provider Web Portal

**Colorado Department of Health Care Policy & Financing** | **Health First COLORADO**  
Colorado's Medicaid Program

Home | **Eligibility** | Claims | Care Management | Resources

Home Tuesday 10/03/2023 04:11 PM MST

Provider Name	Provider ID	Location
MFCU PROVIDER	Providers - 1669775326 (NPI)	MFCU PROVIDER
	Taxonomy 261Q00000X	

**User Details**  
Welcome 9000203639\_PRV  
My Profile  
Manage Accounts

**Provider**  
Name MFCU PROVIDER  
Provider ID 1669775326 (NPI)  
Location ID  
Revalidation Date 8/11/2027  
Provider Maintenance  
EFT/ERA (835) Enrollment  
Disenroll

**Provider Services**  
Member Focused Viewing  
Search Payment History  
Search Accounts Receivable  
BIDM

Welcome Health Care Professional!

Contact Us  
Notify Me  
Alerts  
Secure Correspondence

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

**Provider Portal News**  
You are connected to the UAT system

Providers with multiple locations should ensure that the correct location is being used. Having the incorrect location can impact whether a claim will adjudicate—or process a decision—correctly.

Providers with separate National Provider Identification (NPI) numbers are encouraged to verify their NPI before moving past this home page screen.

# Viewing Member Information

## Provider Web Portal

“CAPTCHA” verification is required to ensure the provider is not a robot. On the Search tab, enter the Member ID or Last Name, First Name and Birthdate.

Search tab -

### Member Focus Search

Last Members Viewed Search

\* Indicates a required field.  
Enter the Member ID or Last Name, First Name and Birth Date.

Member ID

Last Name

First Name

Birth Date

City

Zip Code

### Search Results

Click on the member name below to access the Member Focus View.

Total Records: 1

Member ID	Member	Gender	Birth Date	City	Zip Code
S700001	<a href="#">IMA_MEMBER</a>	Female	07/15/1961	AURORA	80011-2506

Member in Focus: [Change](#) ID: S700001 [Close Member Focus](#)

### Member Details

Member ID S700001  
Name Ima Member  
Birth Date 09/19/1919  
City NORTH  
State Connecticut  
Gender Female  
Primary English Language

### Coverage Details

Coverage	Effective Date	End Date
<a href="#">Medicaid State Plan</a>	01/01/2014	12/31/2299
<a href="#">Medicaid Behavioral Health Benefits</a>	01/01/2014	12/31/2299

[View eligibility verification information](#)

### Other Details

[Secure Correspondence](#)  
Review previously sent messages or send new secure messages.

### Your Member Claims

Medical/Dental

[Submit a Professional Claim](#) [Submit a Dental Claim](#)  
[Submit an Institutional Claim](#)

Claim ID	Service Date	Claim Type	Claim Status
	01/01/2016 - 02/01/2016	LongTermCare	Denied
	03/15/2015 - 03/15/2015	Inpatient	Suspended

### Your Member Authorizations

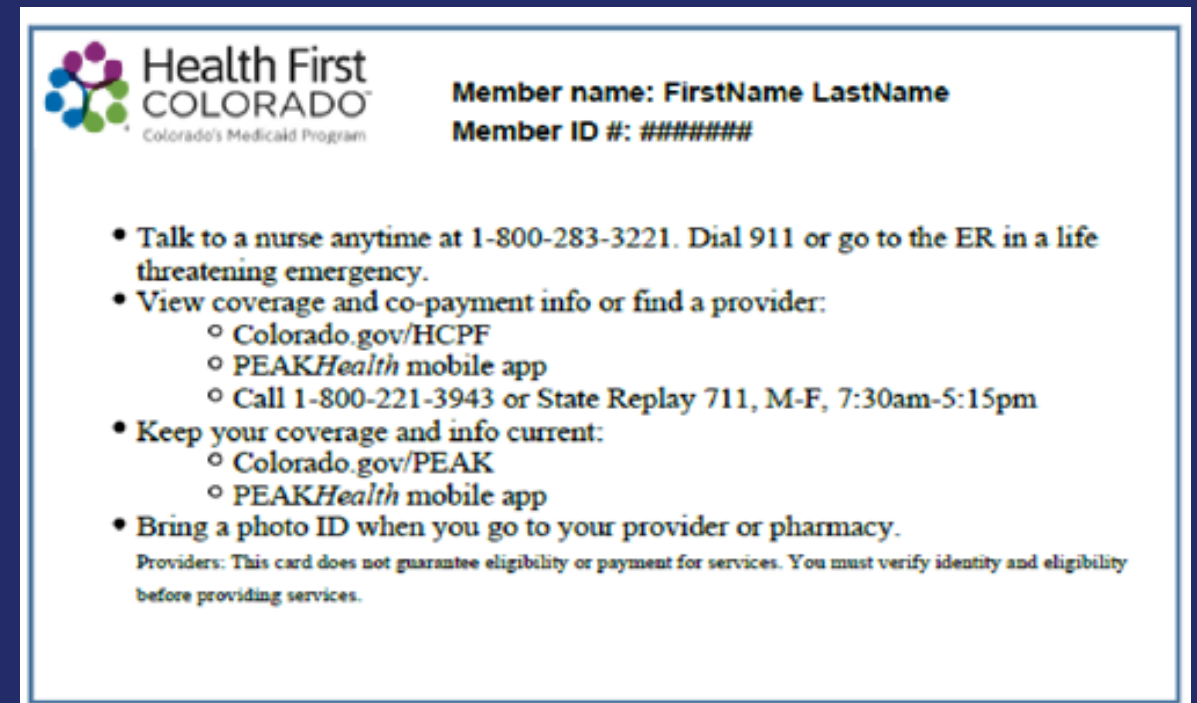
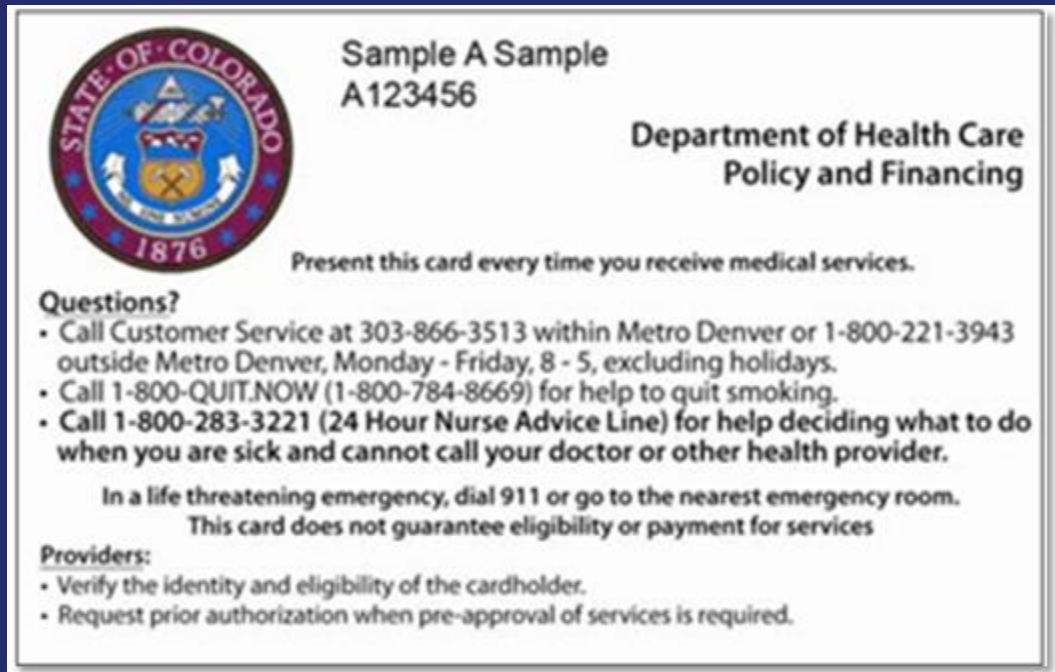
[Submit an Authorization](#)

There are no authorizations for this member.

This search will display the Member in Focus page which provides Member Details, Coverage Details, Member Claims and Authorizations.


# 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.


 **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**

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

Su PCP está a su disposición para ayudarlo.  
**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

- Most members: Health First Colorado benefits (Title XIX)
- Some members have different eligibility types:
  - Old Age Pension, state only
  - Non-Citizens (individuals without documentation)
  - Child Health Plan *Plus* (CHP+)
  - Presumptive Eligibility
  - Behavioral Health Administration (BHA)
  - Managed Care
- Some members have additional benefits:
  - Medicare
  - Third-party commercial insurance





# Eligibility Types

## Old Age Pension (OAP) - State Only

- Members are not eligible for Title XIX due to income.
- Claims will have reduced reimbursement amounts since the program only gets state funds and no federal match.
- Providers cannot bill the member for the difference between the billed amount and the reimbursement amount.
- Does not cover:
  - Home and Community-Based Services (HCBS)
  - Inpatient, psychiatric or nursing facility services



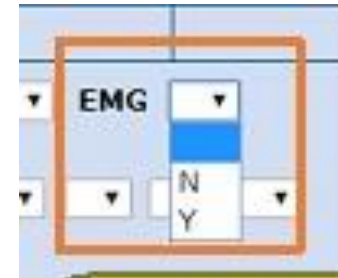
# Eligibility Types

## Family Planning and Non-Citizens

- Family Planning Expansion
  - Applies to individuals with a higher income than the standard Medicaid limit (between 133%-260% of the federal poverty level [FPL])
  - Covers up to a 12-month supply of contraceptives
  - Family planning coverage for non-citizens available from July 1, 2022
- Non-Citizen Emergency Medicaid Services (EMS)
  - Eligibility type only covers emergency services, including labor and delivery
  - Claim must indicate emergency
  - Emergency services must be certified in writing by the provider and kept on file, but does not need to be submitted with the claim

# 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.
- Examples of an emergency are:
  - Active labor and delivery
  - Sudden, urgent occurrences requiring immediate action
  - Acute symptoms of sufficient severity and severe pain in which the absence of medical attention might result in serious impairment to bodily functions and/or dysfunction of any bodily organ or part



# Eligibility Types

## Child Health Plan *Plus* (CHP+)



- Members that are determined to be eligible are later assigned to one of the four CHP+ Managed Care Organizations (MCOs): Colorado Access, Denver Health, Kaiser Permanente or Rocky Mountain Health Plans.
  - Services must be billed as fee-for-service to the Fiscal Agent, Gainwell Technologies, or Magellan for pharmacy services if there is an interim period between the eligibility determination and the MCO assignment
  - Services provided after MCO assignment must be submitted to the MCO
- Providers should contact the MCO for further benefit details once a member is assigned. Benefits through CHP+ may vary from the Title XIX (Medicaid) benefit plan.
  - Applied Behavior Analysis (ABA) therapy is not covered by CHP+
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is not covered by CHP+
  - CHP+ does not divide behavioral health from other services

# Eligibility Types

## Presumptive Eligibility



- Temporary coverage of Health First Colorado or Child Health Plan *Plus* (CHP+) services until eligibility is determined
- Presumptive Eligibility (PE) is only available to those listed in the table:

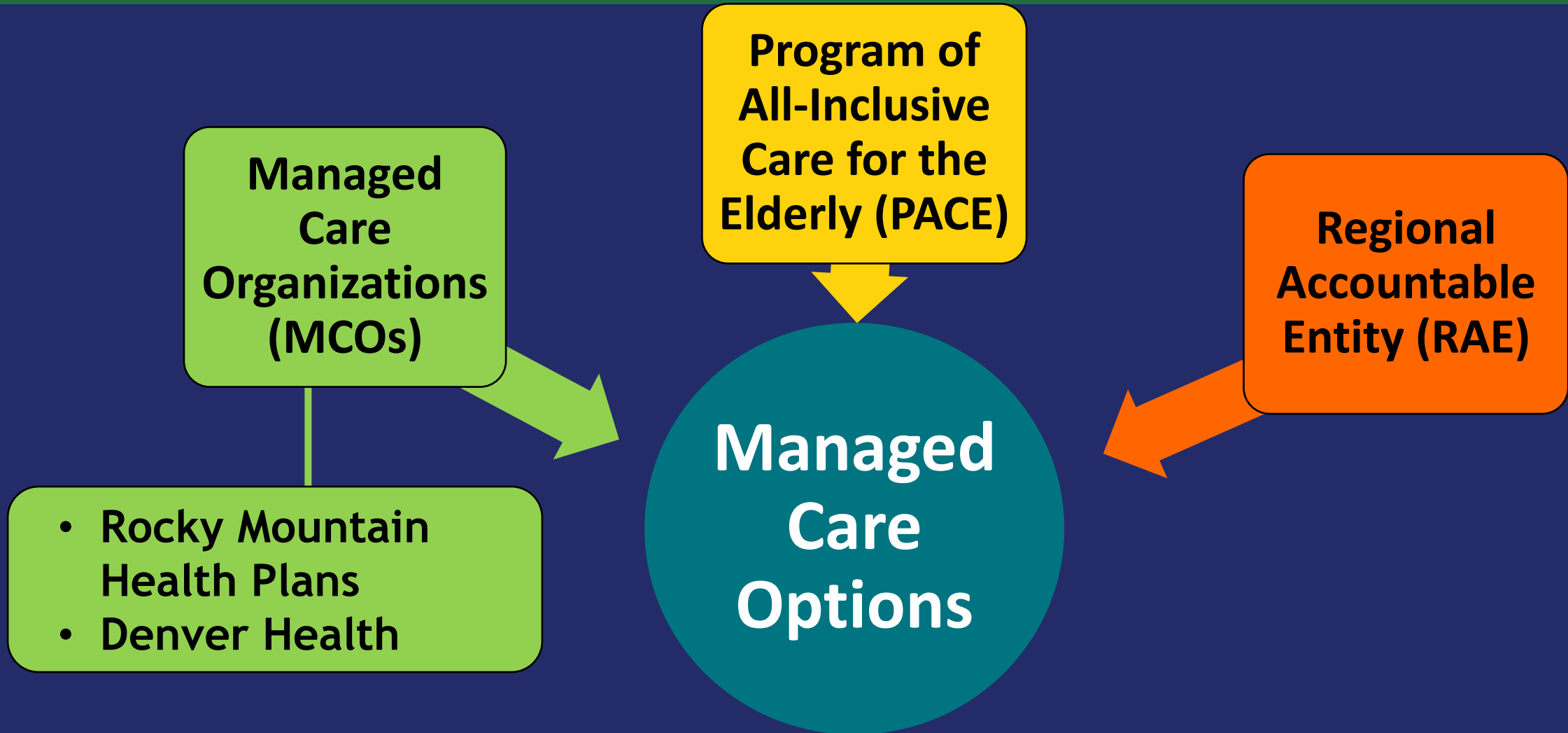
Population	Eligibility	Covered Benefits
Child or pregnant person that meets Health First Colorado PE requirements	<u>Health First Colorado Eligibility Criteria</u>	All <u>Health First Colorado benefits</u> ; includes labor and delivery, excludes inpatient (hospital) care
Child or pregnant person that meets CHP+ PE requirements	<u>CHP+ Eligibility Criteria</u>	All <u>CHP+ benefits</u> excluding dental services
Family Planning Limited (FAMPL) Benefit	<u>FAMPL Eligibility Criteria</u>	Birth control, STI testing and treatment, Cervical cancer screening and prevention, Related counseling and preventative services
Breast and Cervical Cancer Program (BCCP)	<u>BCCP Eligibility Criteria</u>	All <u>Health First Colorado benefits</u>

# Eligibility Types

## Behavioral Health Administration (BHA)

- The Behavioral Health Administration (BHA) is an evolving entity that is addressing behavioral health needs of individuals not covered by other medical assistance programs. **This program is not part of Health First Colorado or Child Health Plan *Plus* (CHP+).**
  - Providers may see a “Coverage” type in the Provider Web Portal: “BHA Benefit Plan” and “BHAB”
    - **People who ONLY have state-funded Behavioral Health Administration Benefits (BHAB) are not eligible for any service under Medicaid**
- Providers must confirm coverage types before rendering any Medicaid or CHP+ services or submitting claims.
  - Eligibility coverage types (not an all-inclusive list):
    - Medicaid: "Medicaid State Plan" and "TXIX" (Title XIX)
    - Child Health Plan Plus: “CHP+B”
    - Behavioral Health Coverage through the Regional Accountable Entities (RAEs): "Medicaid Behavioral Health Benefits" and "BHO+B"
      - Note: BHAB “benefits” are not the same as BHO+B benefits

# Managed Care



# Managed Care

## Managed Care Organizations (MCOs)

- Some services are not included in the managed care contract for Rocky Mountain Health Plans or Denver Health.
  - Those fee-for-service claims can be billed directly to the Fiscal Agent (Gainwell Technologies)

### Example:

- Denver Health does not pay for hospice. Hospice claims for a member with Denver Health enrollment would be billed directly to Gainwell Technologies.





# Managed Care

## Regional Accountable Entity (RAE)



- Members are assigned to the Regional Accountable Entity (RAE) for their geographic area.
  - Contact the RAE in your area to enroll as a Behavioral Health Provider
- Regional Accountable Entities do not pay for pediatric behavioral therapy. Pediatric behavioral therapy claims should be submitted to the Fiscal Agent (Gainwell Technologies). More information on the difference between Behavioral Health and Behavioral Therapy can be found earlier in this presentation.

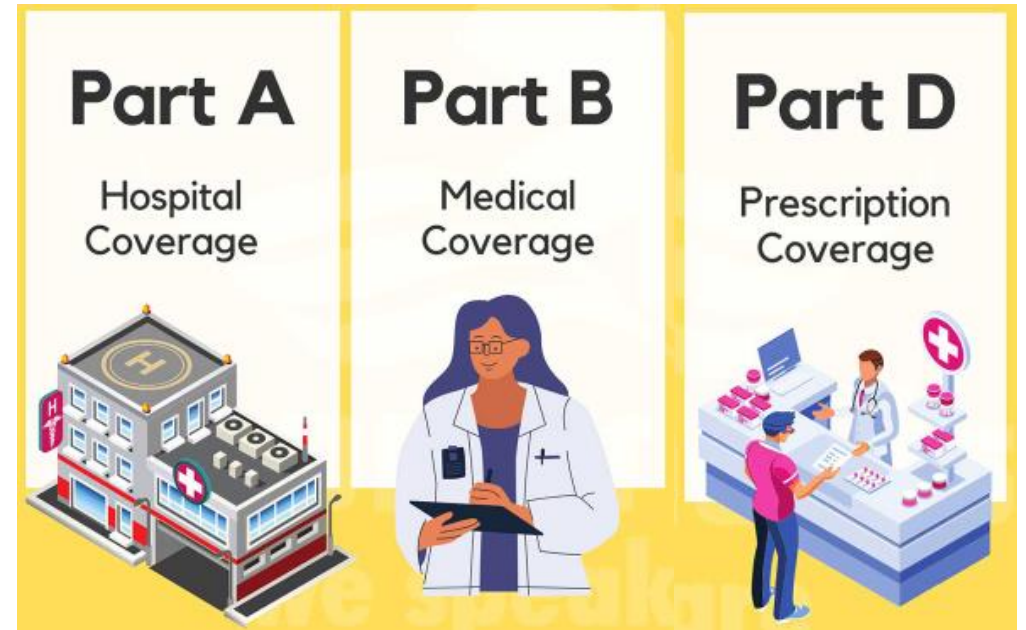
# Dual Eligibility

- Members may be eligible for both Medicare and Health First Colorado.
- Health First Colorado is always the payer of last resort.
  - Bill Medicare first for members with Medicare and Health First Colorado
- Retain proof of:
  - Submission to Medicare prior to Health First Colorado
  - Medicare denials(s) for seven (7) years
- Medicare Explanation of Benefits does not need to be attached to claim submission.



# Medicare

- Medicare members may have:
  - Part A only covers institutional services
    - Hospital insurance
  - Part B only covers professional services
    - Medical insurance
  - Part A and B covers both services
  - Part D covers prescription drugs



<https://boomerbenefits.com/wp-content/uploads/2021/04/parts-of-medicare-1.png>

# Medicare

## Qualified Medicare Beneficiary (QMB)

- QMB programs cover any service covered by Medicare.
  - QMB Plus Medicaid (QMB+): Members also receive Health First Colorado benefits (Title XIX)
  - QMB Only: Members do not receive Health First Colorado benefits. Health First Colorado will only pay if Medicare pays primary.
- Members are only responsible for Health First Colorado co-pay.
- Health First Colorado uses “lower of pricing” logic - either coinsurance and deductible or difference between Medicare paid amount and Health First Colorado allowed amount, whichever is lower.

$$\begin{array}{l} \text{Coinsurance} \\ + \text{ Deductible} \\ = \text{ } \end{array}$$



$$\begin{array}{l} \text{What Medicare paid} \\ - \text{ Health First Colorado} \\ \text{allowable} \\ = \text{ } \end{array}$$

Which side is lower? That's what is paid by Medicaid.

# Third Party Liability

## (Commercial Insurance)

- Health First Colorado is always the payer of last resort.
- Indicate the date the Third-Party Liability (Commercial Insurance) paid or denied on each claim.
- The Explanation of Benefits (EOB) does not need to be attached to the claim.
- When a provider agrees to render service to a member, they agree to work with all the member's forms of insurance. Providers working with Health First Colorado members cannot:
  - Bill the member the difference between the amount billed and the amount reimbursed
  - Bill the member for the co-pay or deductible assessed by the Third-Party Liability (Commercial Insurance)

# Third Party Liability

## (Commercial Insurance)

- Health First Colorado pays the difference between Third-Party Liability payment and Program Allowable.

Example 1:

Charge = \$500

Program allowable = **\$400**

TPL payment = **\$300**

Program allowable - TPL payment =  
**Reimbursement**

$$\text{\$400.00} - \text{\$300.00} = \text{\$100.00}$$

Example 2:

Charge = \$500

Program allowable = **\$400**

TPL payment = **\$400**

Program allowable - TPL payment =  
**Reimbursement**

$$\text{\$400.00} - \text{\$400.00} = \text{\$0.00}$$

# Co-Pay

## Website

- Effective July 1, 2023, most member co-pays were reduced to \$0.
  - Change effective for members eligible for Title XIX (Medicaid), the Alternative Benefits Plan and the Old Age Pension
  - 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. However, the member remains liable for the co-pay at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)

# Co-Pay

- The co-pay maximum is 5% of the household monthly income.
  - The head of household will receive a letter showing the household has reached the monthly limit.
- The Provider Web Portal tracks co-pays only when claims have been submitted.
  - Providers are encouraged to submit claims as soon as possible to ensure a co-pay does not need to be refunded to the member.





# Co-Pay Exempt Members

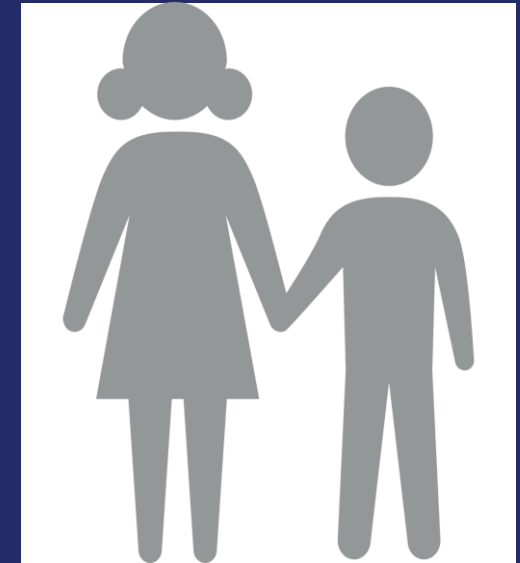
## Full List



**Nursing Facility  
Residents**



**Pregnant  
Women**



**Children and Former  
Foster Care Eligible**

# Prior Authorizations

# Prior Authorization Requests (PARs)

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

- Audiology
- Diagnostic imaging
- Durable medical equipment
- Some inpatient admissions (including out of state)
- Medical services (including transplant, back and bariatric surgery)
- Physical, occupational and speech therapy
- Physician Administered Drugs (PADs)
- Pediatric behavioral therapy
- Pediatric home health care
- Pediatric personal care
- Synagis (seasonal)



# Prior Authorization Requests (PARs)

- PAR 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 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 PARs for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if it is 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 adult home health, 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.
- HCBS providers must have the PAR number to view a PAR on the Provider Web Portal.



# Billing and Payment

# Billing and Payment

Record Retention

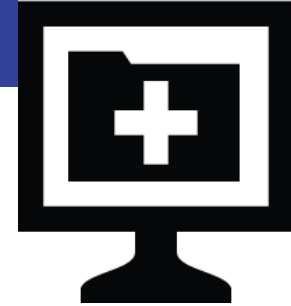
Payment Processing  
and Remittance

Timely Filing

Extensions for  
Timely Filing

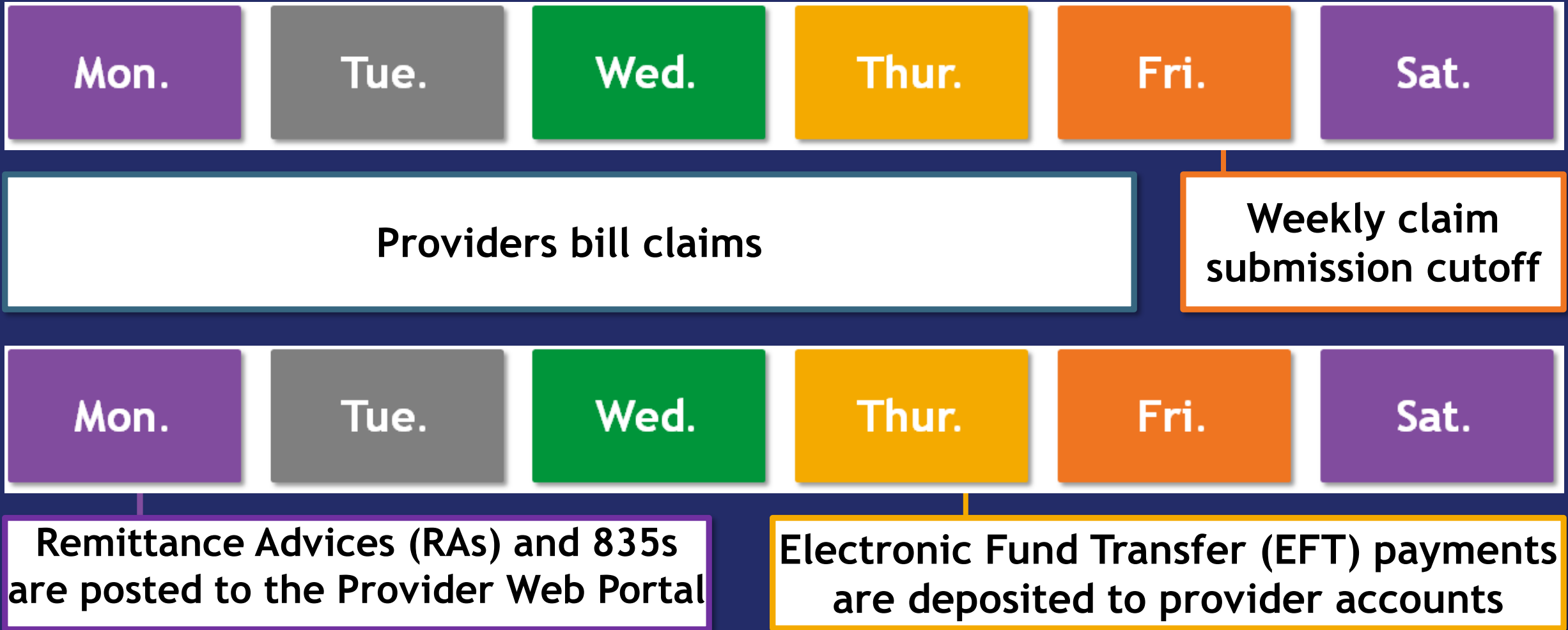


# Record Retention



- Electronic record keeping is allowed and encouraged.
- Providers must:
  - Maintain records for at least seven (7) years (or longer if required by specific contract between provider and Health First Colorado)
  - Furnish information upon request about payments claimed for Health First Colorado services
- Medical records must:
  - Substantiate submitted claim information
  - Be signed and dated by person(s) ordering and providing the service

# Payment Processing Schedule



# Remittance

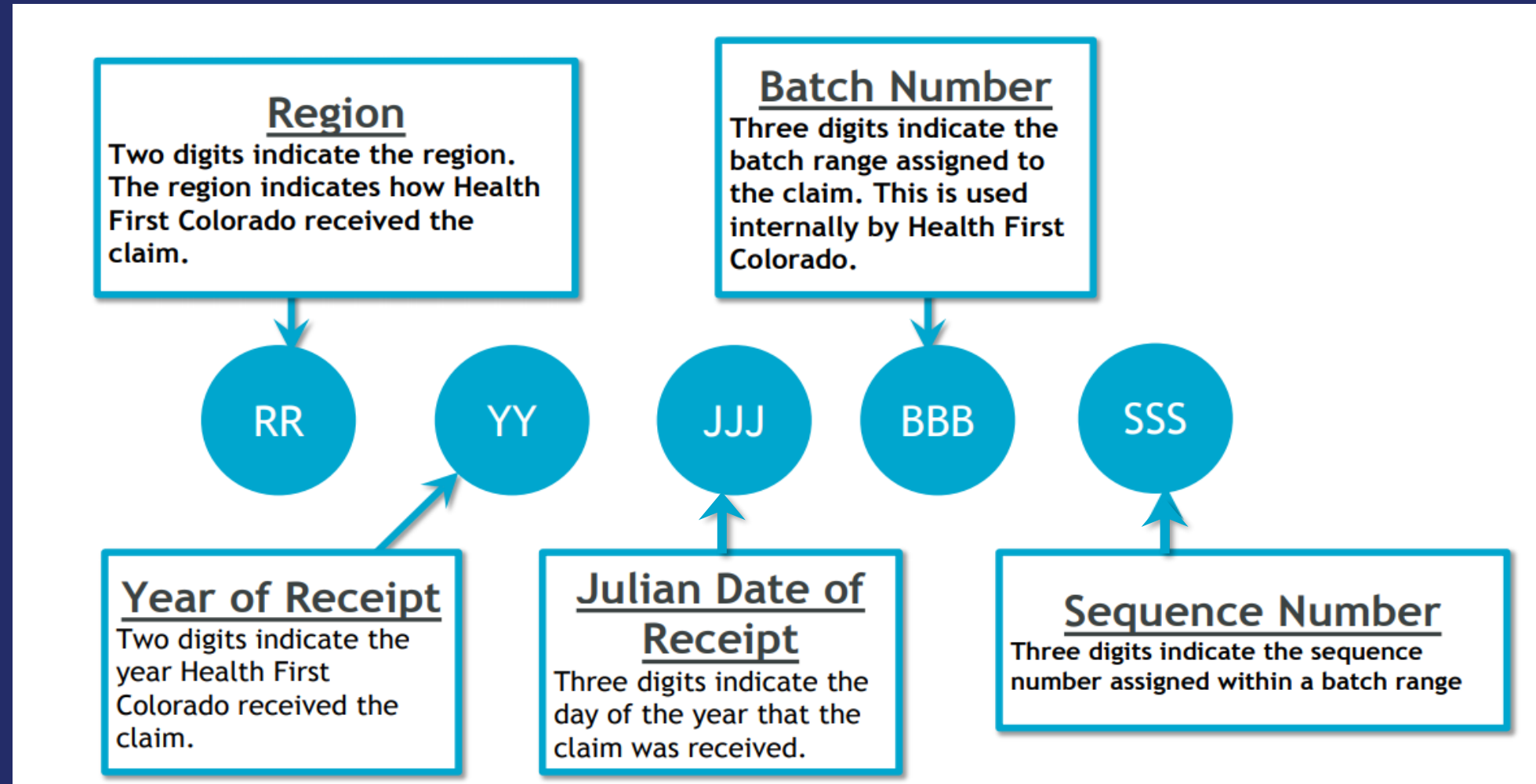
## Retrieval of Remittance Advice or 835

- 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 - Pulling Remittance Advice \(RA\)](#)
  - [Provider Web Portal Quick Guide - Linking the TPID and Pulling an 835](#)



# 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



# Timely Filing

- 365 days from Date of Service (DOS) determined by date of receipt of the claim.
  - Certified mail is not proof of timely filing.
  - Prior Authorization Requests (PARs) are not proof of timely filing.
  - Contacting the Fiscal Agent (Gainwell Technologies) or waiting for response to a verbal inquiry is not proof of timely filing.
  - Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.



# Timely Filing

## Dates of Service

Type of Service	Timely Filing Calculation
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)
Home & Community-Based Services	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

# Timely Filing Extensions


## Rebilled Claims

- Providers always have the initial timely filing period of 365 days from the date of service to submit claims. If a claim is denied within the initial 365-day period, providers can resubmit without referencing the Internal Control Number (ICN).
- **If a claim is denied after the 365-day period has expired, providers have an additional 60 days from the date of the last Remittance Advice (RA) or returned paper claim to resubmit. Similarly, if a claim is adjusted or voided by the fiscal agent, providers have an additional 60 days from the date of the last Remittance Advice (RA) to resubmit.**
  - Reference the last Internal Control Number (ICN)
  - Do not attach copy of Remittance Advice (RA) with claim
  - Keep supporting documentation



# Timely Filing Extensions

## Rebilled Claims

	Provider Web Portal	Batch	Paper
<b>Resubmission (Date of service past 365 days)</b>	Search for original claim and	Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with	Use code listed below in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box
	Click “Copy” at the bottom; include original ICN in “Previous Claim ICN” field	1 code in the 2300/CLM segment	Code 1 in box 22

# Timely Filing Extensions

## Primary Payers: Commercial Insurance (Third Party Liability)

- Health First Colorado is always the payer of last resort.
  - **Timely filing waivers cannot be given if the date of service is past 365 days, per federal statute.**
    - Per state and federal regulation (42 CFR § 447.45(d), 10 CCR 2505-10-8.043.01 and .02A), all claims which include commercial insurance (third-party liability) information that are received more than 365 days from the date of service must be denied. The provider is responsible for pursuing available third-party resources in a timely manner.
    - Insurance companies are bound by the Prompt Pay Law (CRS § 10-16-106.5), which requires payment within certain timeframes.
    - Providers should submit these claims as soon as possible and then **follow up to ensure prompt payment.**

# Timely Filing Extensions

## Primary Payers: Commercial Insurance (Third Party Liability)

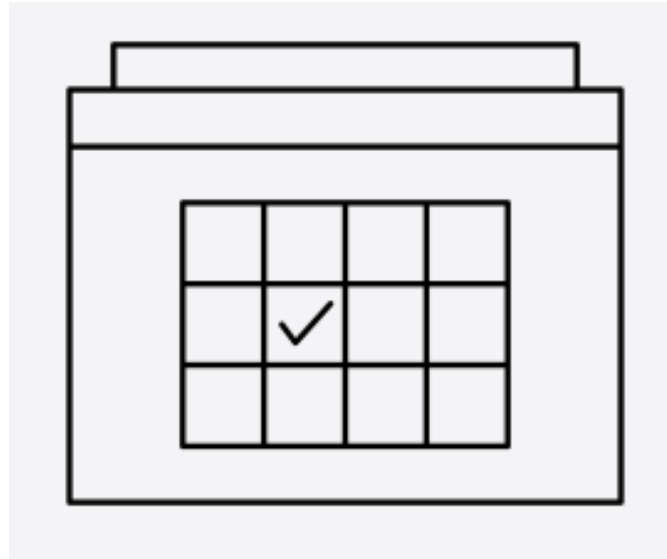
- If a claim is voided or adjusted because a third-party liability is primary
  - **Providers may resubmit the claim within 60 days of the date of void or adjustment by the fiscal agent**
    - Include commercial insurance information on claim, if applicable
    - Reference the last Internal Control Number (ICN) of the claim that was voided or adjusted
    - Do not attach copy of commercial insurance Explanation of Benefits (EOB) or the Remittance Advice (RA)



# Timely Filing Extensions

## Primary Payers: Medicare

- Members who are enrolled with both Medicare and Health First Colorado
  - Providers have an **additional 120 days from Medicare Explanation of Benefit (EOB) date.**



# Timely Filing Extensions

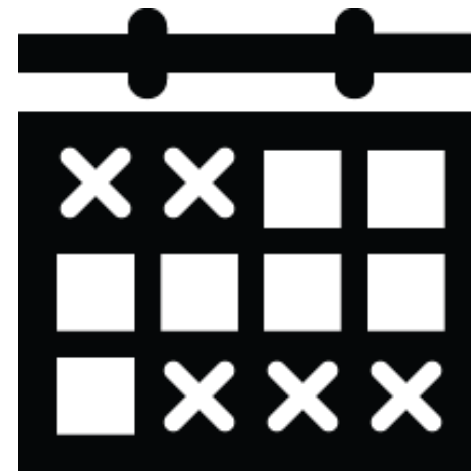
## Delayed Notification & Backdated Eligibility

- Delayed Notification
  - 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. **No further extensions are given for delayed notification of eligibility.**
- Backdated 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.

# Timely Filing Extensions

## Provider Enrollment

- Backdated Approval
  - Claims do not need to be submitted while waiting for provider enrollment to be approved.
  - If the date of service is beyond the initial timely filing period of 365 days, providers have 60 days from the date of the enrollment letter to submit a claim.
    - The enrollment letter showing backdated approval must be attached to the claim via the Provider Web Portal.



# 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 and Refunds

# 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
  - Submitters must test batch transactions before approval to submit
- 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.
- Visit the [EDI Support](#) web page for more information.



# Claim Submission Methods

## Medicare Crossovers

- **Automatic Medicare Crossover Process:**



- Claims not automatically crossed over must be submitted directly by the provider.
- Crossovers may not be processed by Health First Colorado if:
  - NPI used on Medicare claim does not match NPI enrollment with Health First Colorado
  - Member is a retired railroad employee
  - Member has incorrect or missing Medicare information on file

# Claim Submission Information

## Rendering Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member



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## Billing Provider

Entity being reimbursed for service



# 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

**CARRIER**

**PATIENT AND INSURED INFORMATION**

**PHYSICIAN OR SUPPLIER INFORMATION**

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA  OTHER  14. INSURED'S ID NUMBER (If or Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM | DD | YY) SEX (M | F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED (Self | Spouse | Child | Other) 7. INSURED'S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE 9. RESERVED FOR NUCC USE 10. IS PATIENT'S CONDITION RELATED TO: (a. EMPLOYMENT? (Current or Previous) YES | NO; b. AUTO ACCIDENT? YES | NO; c. OTHER ACCIDENT? YES | NO) 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. 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 accepts assignment.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) (MM | DD | YY) QUAL. 15. OTHER DATE (MM | DD | YY) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM | TO) (MM | DD | YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (MD | DO | NPI) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM | TO) (MM | DD | YY)

19. ADDITIONAL CLAIM INFORMATION (designated by NUCC) 20. OUTSIDE LAB? (YES | NO) \$ CHARGES

21. BELONGS OR NATURE OF ILLNESS OR INJURY (Relate to service line below) (ICD Incl.) 22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From | To) (MM | DD | YY | MM | DD | YY) B. PLACE OF SERVICE (EMG | OP | H | O) C. PROCEDURES, SERVICES, OR SUPPLIES (Identify Unusual Circumstances) D. MODIFIER E. DIAGNOSIS CENTER F. \$ CHARGES G. PAYOR CODES H. ICD INCL. I. BILL CODES J. REFERRING PROVIDER ID, #

25. FEDERAL TAX ID NUMBER SSN/EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES | NO) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Paid for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PII #

SIGNED DATE 34. NPI 35. NPI


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

# Paper Claim - Example 1

CARRIER

PATIENT AND INSURED INFO

PICA



## HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> PICA		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input checked="" type="checkbox"/> (Medicaid#)	
TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)	
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)	
OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) Y123456	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John		3. PATIENT'S BIRTH DATE MM DD YY 04 21 1950	
		SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 555 Dandelion View		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY Anytown		7. INSURED'S ADDRESS (No., Street)	
STATE CO		CITY	
ZIP CODE 11111		8. RESERVED FOR NUCC USE	
TELEPHONE (Include Area Code) ( 123 ) 222-3333		ZIP CODE ( )	
TELEPHONE ( )		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) _____		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
12. 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 accepts assignment below.  SIGNED _____ SIGNATURE ON FILE _____ DATE 061518		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____	

Field 11, 11a, 4 - Conditional. Complete if the member is covered by a Medicare health insurance policy.

Field 11d, 6, 9, 9a, 9d - Conditional. Complete if the member is covered by a Third party liability/Commercial insurance policy.

# Paper Claim - Example 2

**HEAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. 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 accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 061518

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the insured for the services described below.

SIGNED: \_\_\_\_\_

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL: \_\_\_\_\_

15. OTHER DATE: MM DD YY QUAL: \_\_\_\_\_

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Ima Doctor

17a. \_\_\_\_\_ 17b. NPI: 8888888888

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): \_\_\_\_\_

20. OUTSIDE LAB?  YES  NO \$ CHARGES: \_\_\_\_\_

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L  
A. M50 222 B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_  
E. \_\_\_\_\_ F. \_\_\_\_\_ G. \_\_\_\_\_ H. \_\_\_\_\_  
I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_

22. RESUBMISSION CODE: \_\_\_\_\_ ORIGINAL REF. NO.: \_\_\_\_\_

23. PRIOR AUTHORIZATION NUMBER: \_\_\_\_\_

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR LIMITS	H. ICD-9-CM PROC. CODE	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06 15 18 06 15 18 22			00670 AA	A	2860 00	106	N	NPI	9999999999

25. FEDERAL TAX I.D. NUMBER: 954849652 SSN EIN:   X

26. PATIENT'S ACCOUNT NO.: 4548941561

27. ACCEPT ASSIGNMENT? For prov.  YES  NO

28. TOTAL CHARGE: \$ 2860 00

29. AMOUNT PAID: \$ \_\_\_\_\_

30. Rsvd for NUCC Use: \_\_\_\_\_

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  
SIGNED: \_\_\_\_\_ DATE: 092218

32. SERVICE FACILITY & LOCATION INFORMATION: ABC Hospital, 2222 Colorado Avenue, Anytown CO 11111-6666  
a. 4444444444 b. \_\_\_\_\_

33. BILLING PROVIDER INFO & PH #: ABC Partners, P.O. Box 44444, Anycity CO 88888-4444  
a. 5555555555 b. \_\_\_\_\_

Field 18 - Conditional. Complete for services provided in an inpatient hospital setting in two digit format.

Field 20 - Conditional. Complete if all laboratory work was referred to and performed by an outside laboratory.

Field 22 - Conditional. 7- Replacement of prior claim. 8-Void/Cancel of prior claim. List ICN that needs to be voided/adjusted in "Original Ref No." box.

Field 24C - Conditional. This field is used to indicate the service rendered is for a life threatening condition or one that requires immediate medical intervention. "Y" for YES.

Field 24E - Required. The "Diagnosis Pointer" refers to the line number from field 21 that relates to the reason the service(s) was performed. At least one diagnosis code reference letter must be entered.

Field 24J - Required. CMS-1500 providers must have a billing provider ID along with a rendering provider ID. An NPI must be used unless the provider is atypical. Atypical - providers that do not provide health care. I.e., taxi services, home modification, etc.

Field 29 - Conditional. Complete if Medicare or Third party liability/ Commercial insurance made payment.

Field 31 - Required. A holographic/ rubber signature stamp may be used. An authorized agent or representative may sign the claim for the enrolled provider. May not be voided.

Field 32 - Conditional. Complete for services provided in a hospital or nursing facility.

Field 33 - Required. Enter the information of the individual or organization that will receive payment for the billed service.

Fields 26 - Optional. This number identifies the member or claim in the provider's billing system.

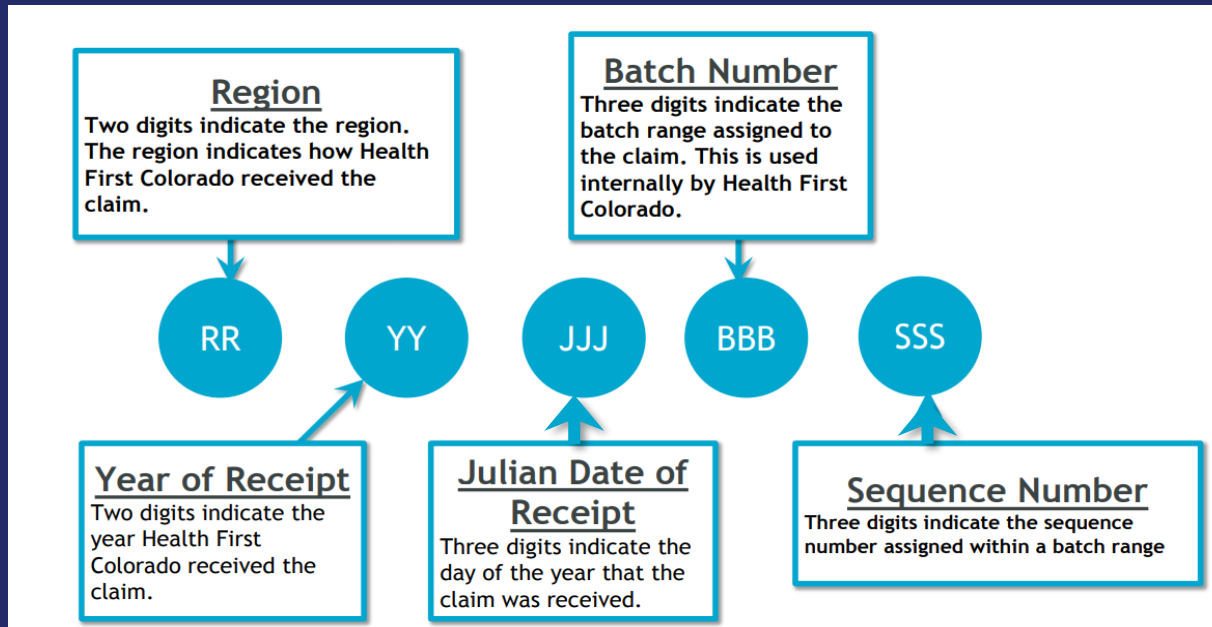
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)





# Claim Status

## Internal Control Number (ICN) & 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

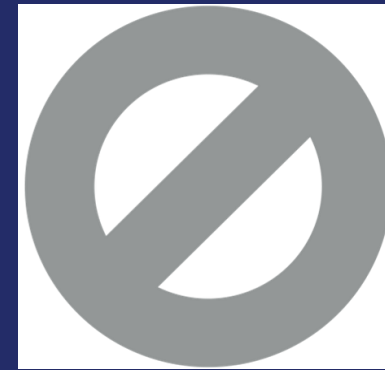
# Claim Status

## 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 PAR type may not match

## Total Charges Invalid

Line-item charges do not match the claim total

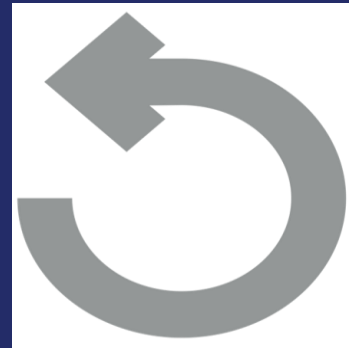
# Claim Status

## 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

# Claim - Adjustments

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

## Adjust a claim when

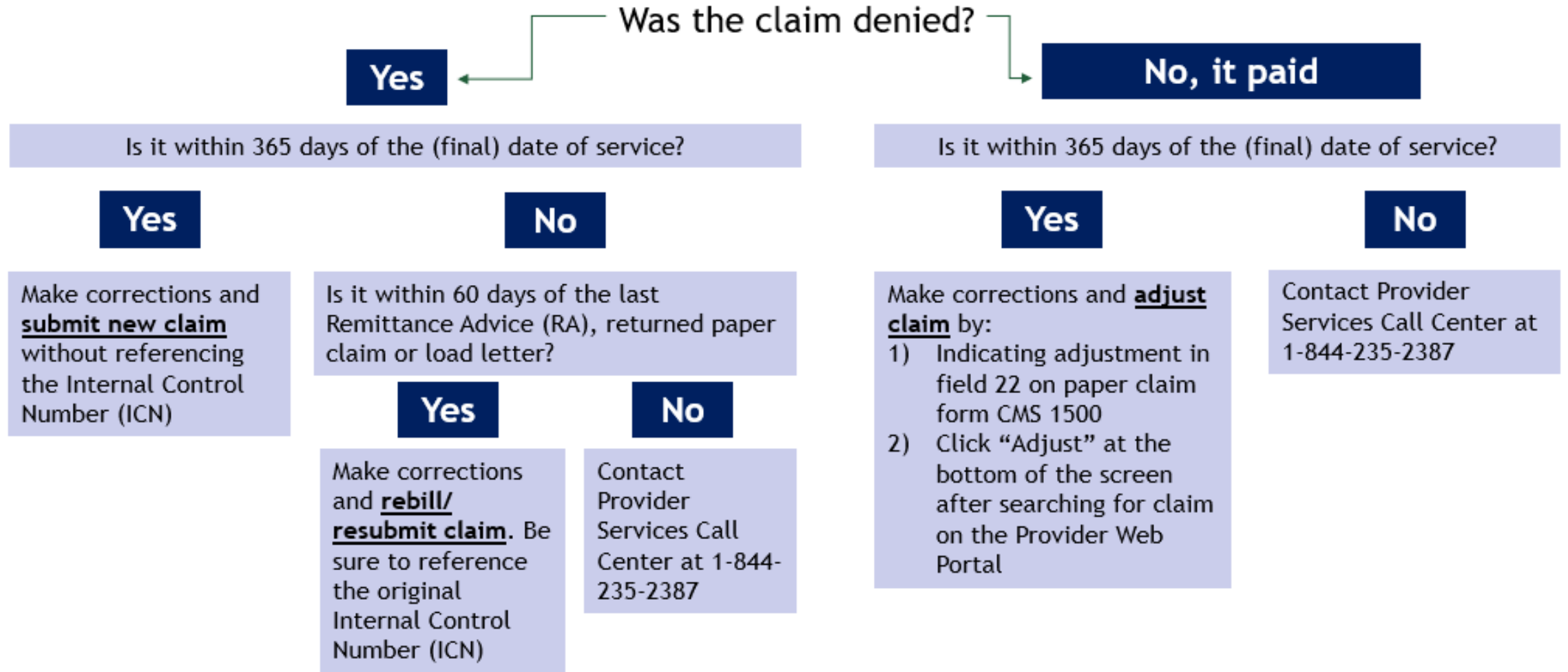
- Provider billed incorrect services or charges
- Claim paid incorrectly

## Do not adjust claim when

- Claim was denied
- Claim is suspended

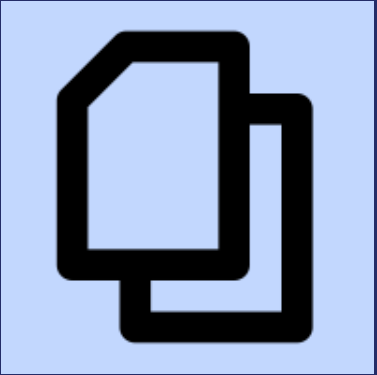


# Claim Submission: Resubmit or Adjust?





# Adjustment & Void Codes

	<b>Provider Web Portal</b>	<b>Batch</b>	<b>Paper</b>
<b>Adjustment</b>	Search for original claim and	Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with	Use code listed below in box 22 and the original Internal Control Number (ICN) in the adjacent 22 box
<b>Void</b>	Click “Adjust” at the bottom	7 code in the 2300/CLM segment	Code 7 in box 22
	Click “Void” at the bottom	8 code in the 2300/CLM segment	Code 8 in box 22

# Quick Guides

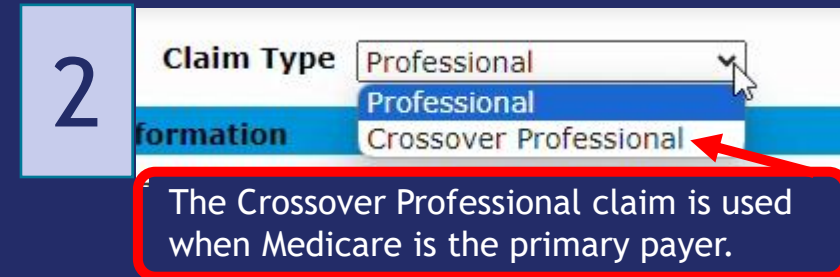
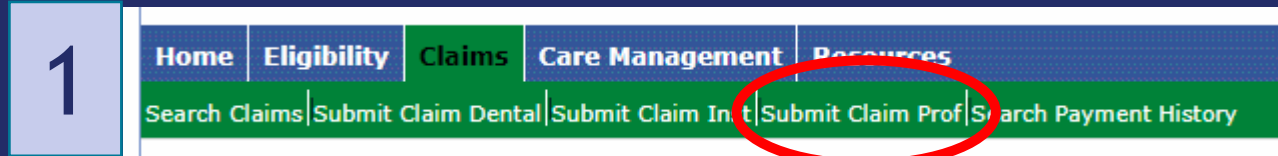
- Copy, Adjust or Void a Claim
- Pulling Remittance Advice (RA)
- Reading the Remittance Advice (RA)
- Submitting a Professional Claim



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

# Provider Web Portal Demo

## Step 1: Member and Claim Information



3

Patient number can be any number the provider assigns for internal records.

Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.

### Claim Information

Date Type

Date of Current

Accident Related Reason

\*Patient Number

\*Transport Certification  Yes  No

Previous Claim ICN

Note

\*Does the provider have a signature on file?  Yes  No

Include Other Insurance

Total Charged Amount \$0.00

Check "Include Other Insurance" if there is a third-party liability (commercial insurance) that is the primary payer. This is NOT used for Medicare.

# Provider Web Portal Demo

## Step 2: Diagnosis Panel

**Diagnosis Codes**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.  
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
<u>1</u>			

1 \*Diagnosis Type  \*Diagnosis Code

Be sure to click “Add” after inputting the Diagnosis Code and before clicking “Continue.”

# Provider Web Portal Demo

## Step 3: Service Details Panel

**Service Details**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
<u>1</u>							

1    **\*From Date**     **To Date**

**\*Place of Service**     **EMG**

**\*Procedure Code**     **Modifiers**        **\*Diagnosis Pointers**

**\*Charge Amount**     **\*Units**     **\*Unit Type**     **EPSDT Service**     **Family Plan Service**

**CLIA Number**

**Rendering Provider ID**      **ID Type**

**Taxonomy**

**Referring Provider ID**      **ID Type**

**Taxonomy**

**NDCs for Svc. # 1**

The "EMG" field is for providers to indicate whether the member requires emergency service. Select "Y" to mark emergency status.

Diagnosis pointers connect the diagnosis with the service. They answer the question, "Which diagnosis goes with which service?" The first pointer designates the primary diagnosis for the service line.

Be sure to click "Add" after inputting the Service Details and before clicking "Continue."

Check "EPSDT" if part of Early & Periodic Screening, Diagnostic and Treatment services.

# Provider Web Portal Demo

## Correcting Denied Claims

Check the "Adjudication Errors" for information on why claim denied.

1

Adjudication Errors		
Header / Detail	EOB	Description
Service # 1	1599	Rendering Provider Type and/or Specialty is not allowable for the service billed.

Click on blue numbers to expand and change information within that panel.

2

### Copy Professional Claim

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

Member Information  
 Member ID  
 Last Name  
 First Name  
 Birth Date  
 Patient Number  
 Address

Service Information  
 Service Facility Location  
 Diagnosis Code(s)  
 Place(s) of Service  
 Procedure Code(s)  
 Modifier(s)  
 Diagnosis Pointer(s)  
 Detail Charge Amount(s)  
 Units  
 NDC Code(s)  
 NDC Unit Price(s)  
 NDC Quantity(s)  
 NDC Unit of Measure(s)

Member and Service Information  
 Copies data listed in previous 2 columns.  
 Entire Claim  
 Copies data listed in columns 1 and 2 PLUS:  
 Referring Provider  
 Supervising Provider  
 Accident Related Reason  
 Accident State  
 Accident Country  
 Emergency Indicator(s)  
 EPSDT Indicator(s)  
 Family Plan Indicator(s)  
 Other Insurance  
 All Dates

Copy Cancel

Copy the entire claim to make necessary changes.

3

### Service Details

Select the row number to edit the row. Click the Remove link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1	10/03/2023	10/03/2023	11-Office	99213-OFFICE O/P EST LOW 20-29 MIN	\$500.00	1.000 Unit	<a href="#">Remove</a>

1 \*From Date: 10/03/2023 To Date: 10/03/2023 \*Place of Service: 11-Office EMG N  
 \*Procedure Code: 99213-OFFICE Modifiers: \*Diagnosis Pointers: 1  
 \*Charge Amount: 500.00 \*Units: 1.000 \*Unit Type: Unit EPSDT Service Family Plan Service

CLIA Number  
 Rendering Provider ID ID Type: NPI  
 Taxonomy: Obstetrics Gynecology  
 Referring Provider ID ID Type  
 Taxonomy

NDCs for Svc. # 1

Save Reset Cancel

After copying the entire claim and making necessary changes, be sure to click "Save" before clicking "Continue."



# Resources

## Billing Manuals web page

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

## Provider Web Portal Quick Guides

## Provider Training web page

## Provider & Care and Case Manager Contacts web page

## Provider Services Call Center 1-844-235-2387

## Regional Field Representatives web page



# 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?

Where can I...?

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

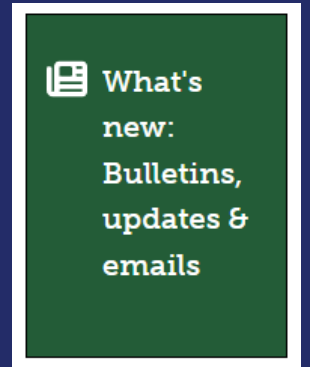
- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV





# Reminders

- Remember to sign up for Department of Health Care Policy & Financing communications by visiting the website and clicking “For Our Providers” and then “What’s new: Bulletins, updates & emails.”
- Interested in more training? Sign up by visiting the website and clicking “Provider Resources” and then “Provider Training.”



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

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