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.**
  - Includes provider types:
    - 37 (Licensed Psychologist)
    - 38 (Licensed Behavioral Health Clinician)
    - 83 (Behavioral Therapy Clinic)
    - 84 (Board Certified Behavior Analyst)

    - Some providers enrolled as types 24 (Non-Physician Practitioner Individual) and 25 (Non-Physician Practitioner Group) and will need to enroll as type 83 or 84 during revalidation.

Behavioral Therapy vs. Behavioral Health

- 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, including Common Procedural Terminology [CPT] codes:
  - 97151
  - 97153
  - 97154
  - 97155
  - 97158

Behavioral Therapy vs. Behavioral Health

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.

Includes (but is not limited to) provider types:

- 5 (Physician)
- 25 (Non-Physician Group Practitioner)
- 35 (Community Mental Health Center)
- 37 (Licensed Psychologist)
- 38 (Licensed Behavioral Health Clinician)
- 39 (Physician Assistant)
- 41 (Nurse Practitioner)
- 64 (Substance Use Disorder Clinic)
- 68 (Qualified Residential Treatment Program)

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.
- **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

CMS.gov
Centers for Medicare & Medicaid Services

STATE OF COLORADO
NIL SINE NUMINE
1876

COLORADO
Department of Health Care Policy & Financing

gainwell

Fiscal Agent

Colorado interChange system interacts with the Provider Web Portal

Health First Colorado and CHP+ Providers

Department Website

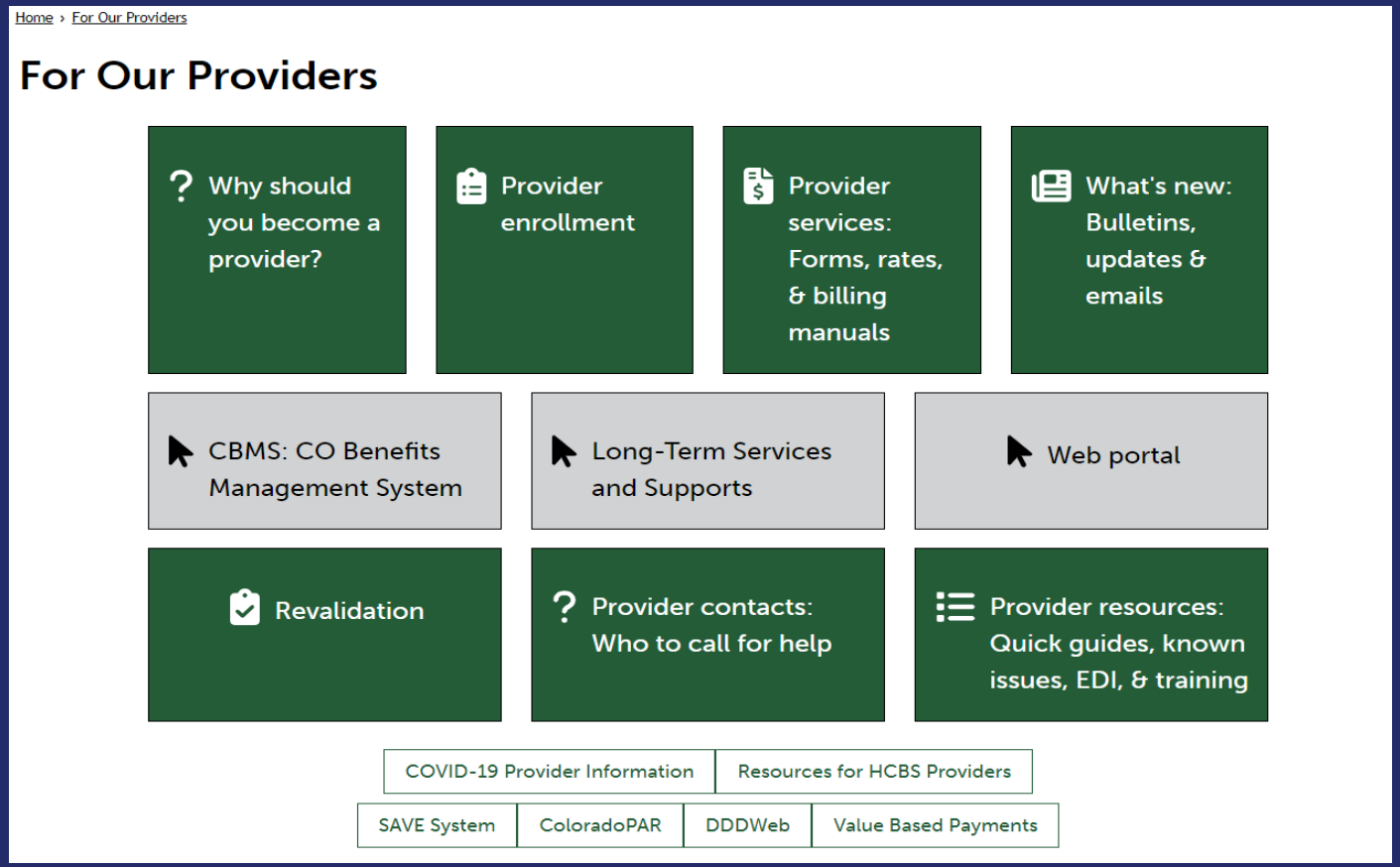
Department of Health Care Policy & Financing

Website

For Our Providers Home Page

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

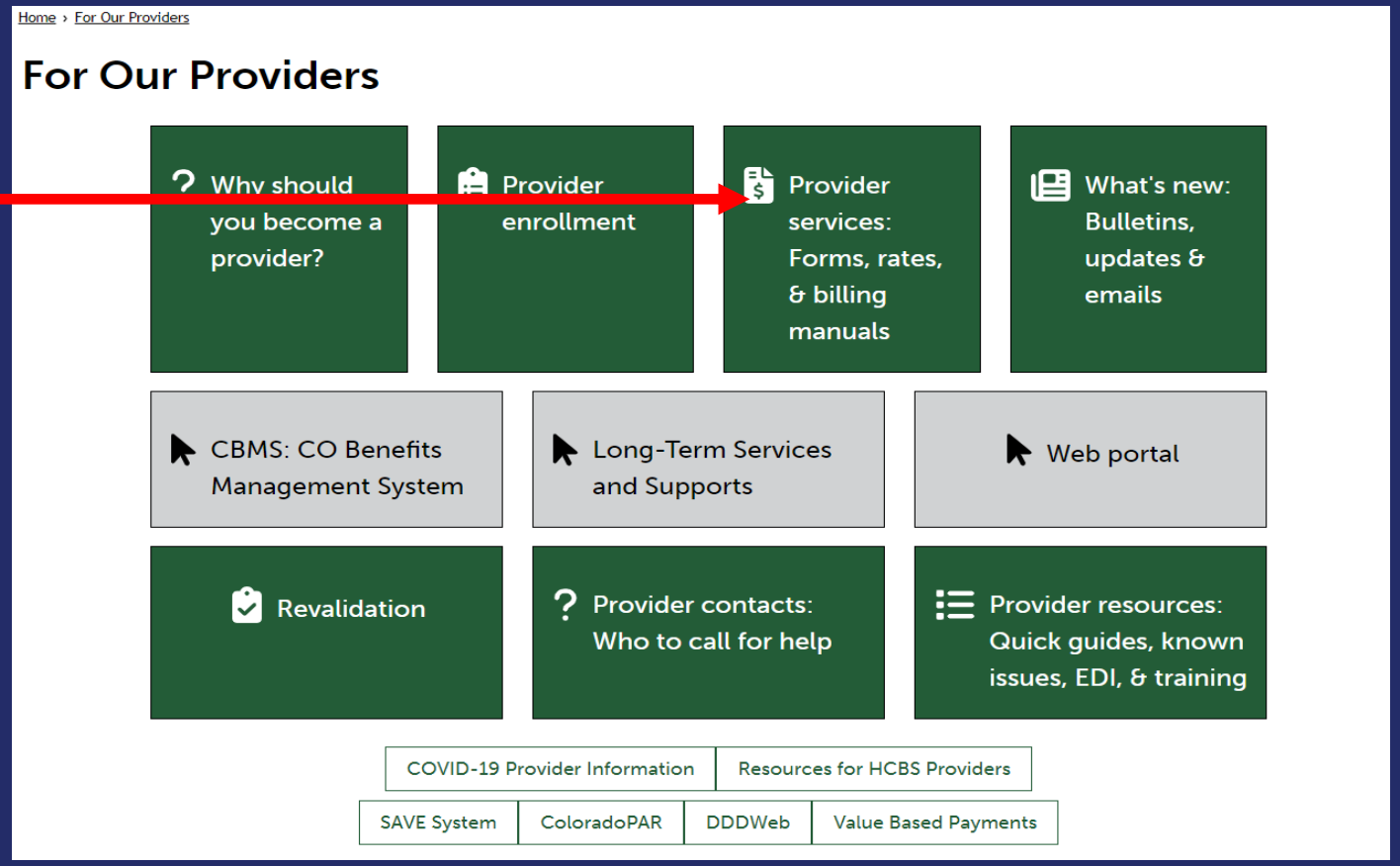
Contains important information regarding Health First Colorado (Colorado's Medicaid program) & other topics of interest to providers and billing professionals



Provider Services

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

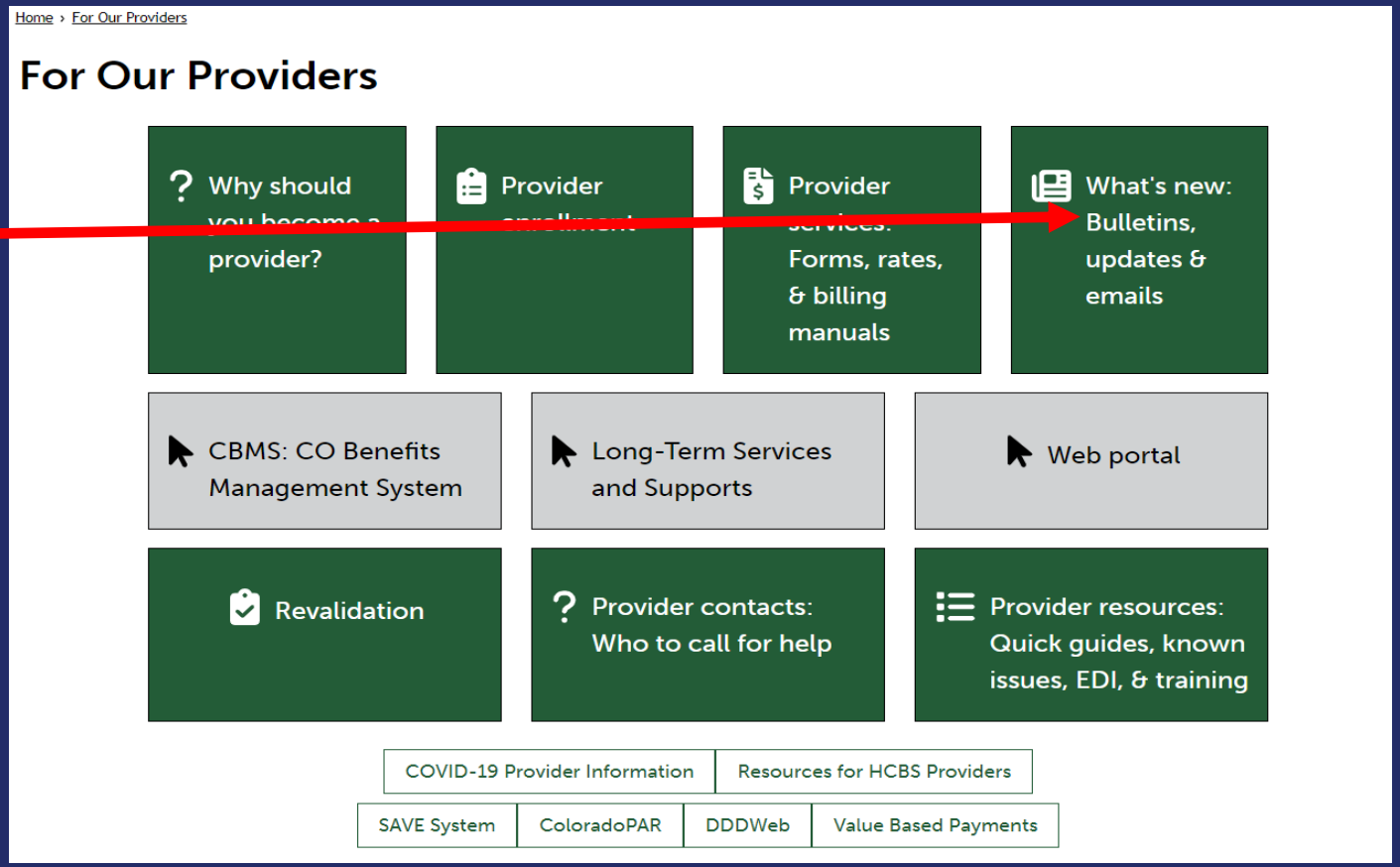
The General Provider Information manual is an overview of the program, including billing and policy information



What's New: Bulletins, Updates & Emails

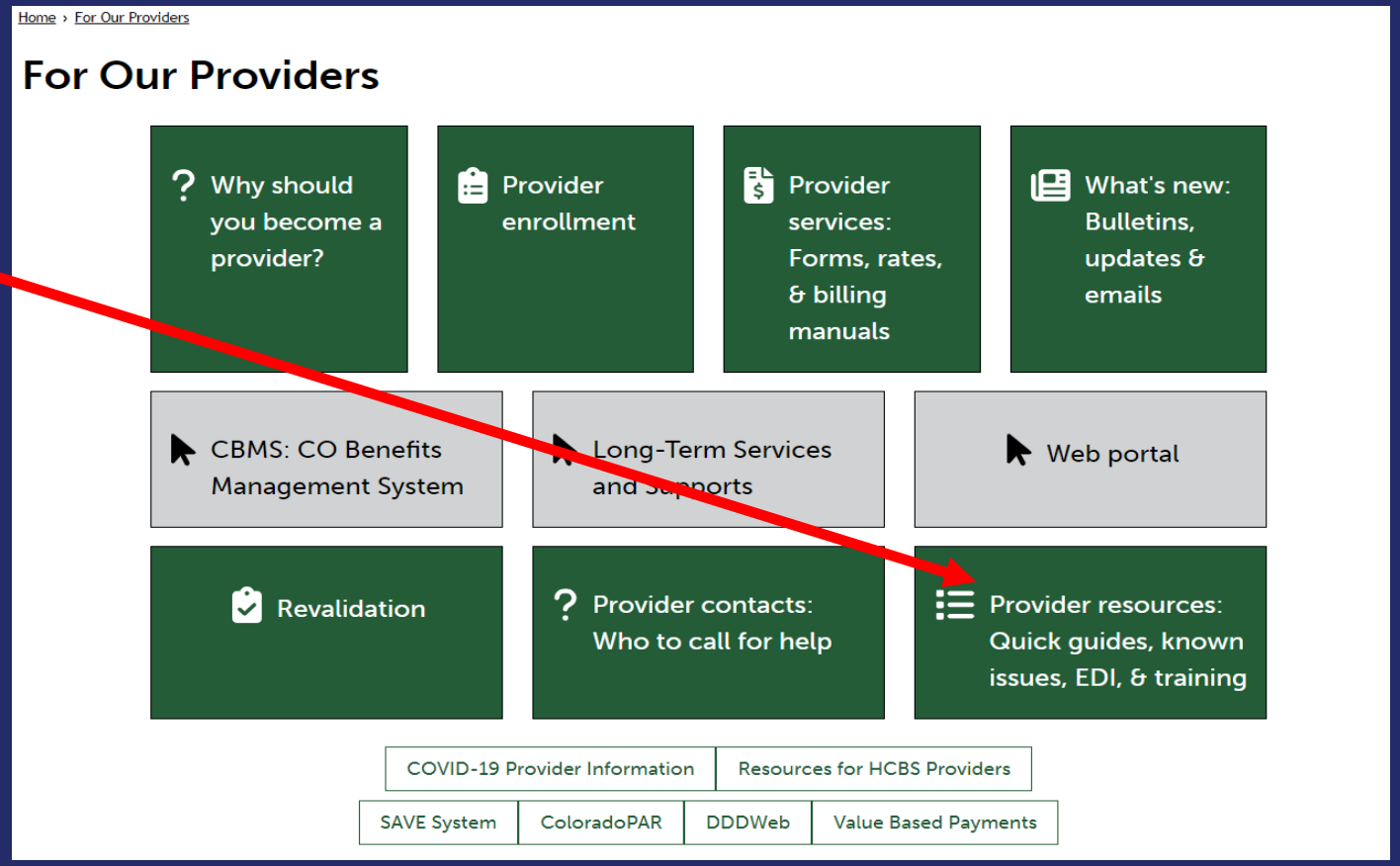
Sign up for publications

Weekly newsletters and monthly bulletins



Provider Resources

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



Provider Enrollment

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

- **The professional claim requires rendering and billing providers.**
- The rendering and billing providers are the same for Home and Community-Based Services (HCBS) providers.

Rendering Provider (Individual Within a Group)

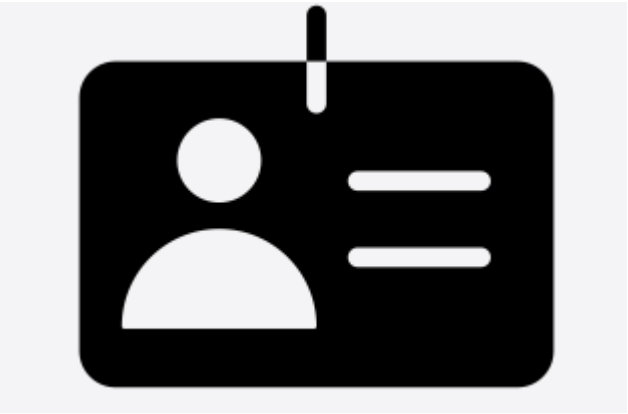
Individual that provides services to a Health First Colorado member

Billing Provider

Entity being reimbursed for service

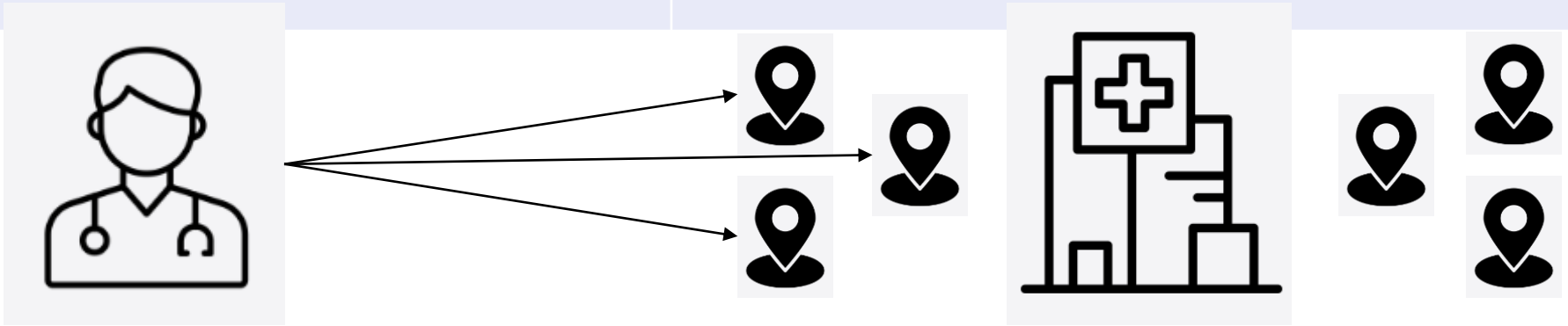
National Provider Identifier (NPI)

- **Most providers require an 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 an NPI and use the Health First Colorado Provider ID for billing transactions.
- Providers who bill Medicare need to ensure each NPI for Health First Colorado is also enrolled with Medicare.



National Provider Identifier (NPI)

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

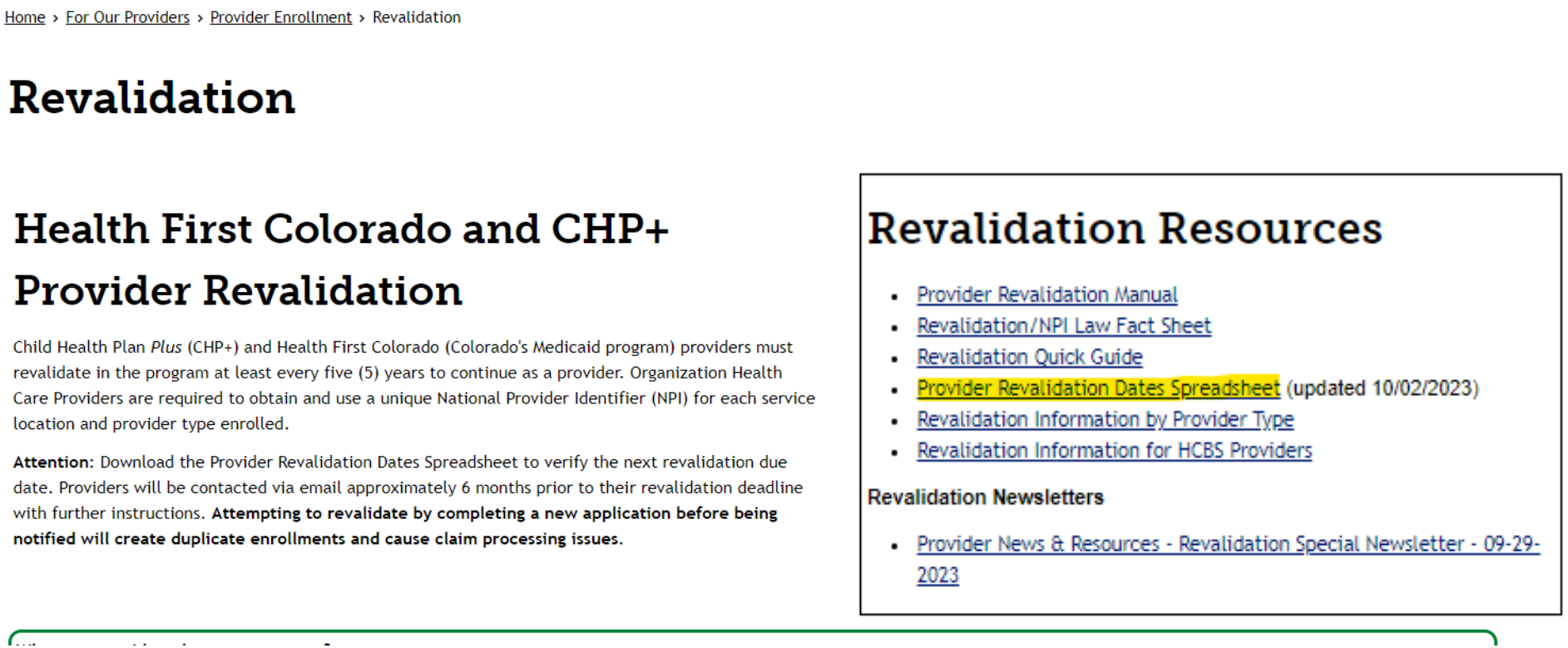


Revalidation

- 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 may suspend or deny if an individual provider has not revalidated.

Revalidation for Individual Providers

- **All 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 OPR issues on claims.

Member Eligibility

Member Eligibility

Verifying Member Eligibility

Viewing Member Information

Health First Colorado Member ID Cards

Eligibility Types

Managed Care

Medicare

Third Party Liability

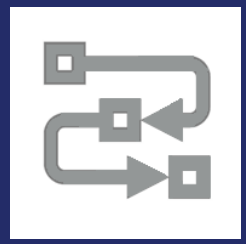
Co-Pay

Verifying Member Eligibility

- Member's eligibility must be checked on each date of service.
  - Facilities that bill monthly: Eligibility can change throughout the month. Therefore, it is recommended that providers check eligibility more than once a 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

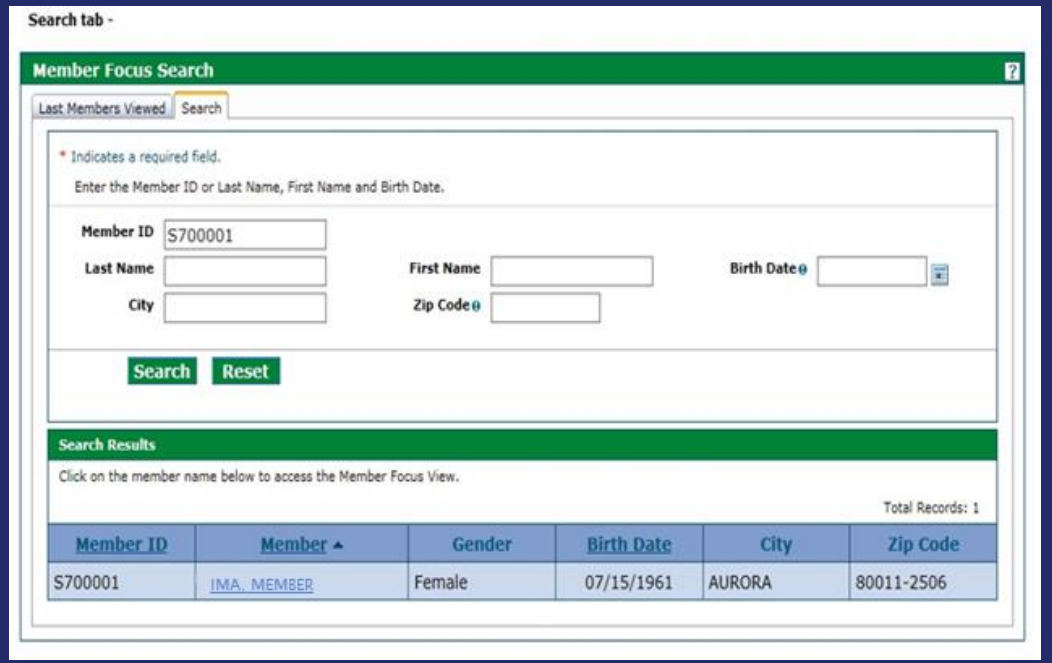
Providers with multiple locations should ensure that the correct location is being used. Having the incorrect location can impact whether a claim will adjudicate—or process a decision—correctly.

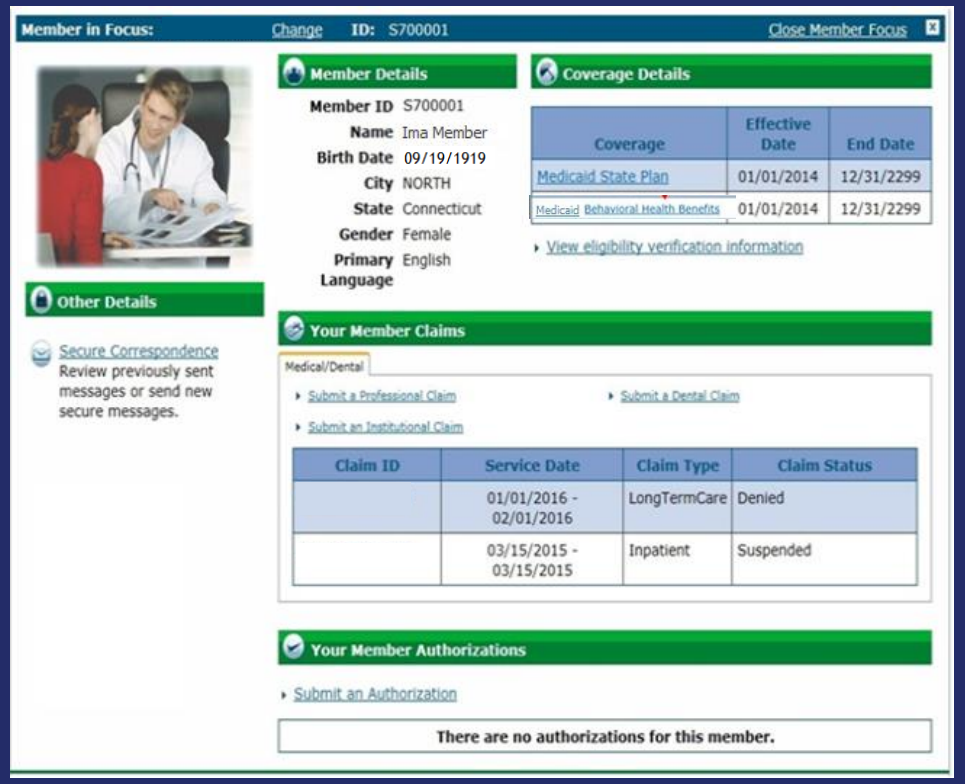
Providers with separate National Provider Identification (NPI) numbers are encouraged to verify their NPI before moving past this home page screen.

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.

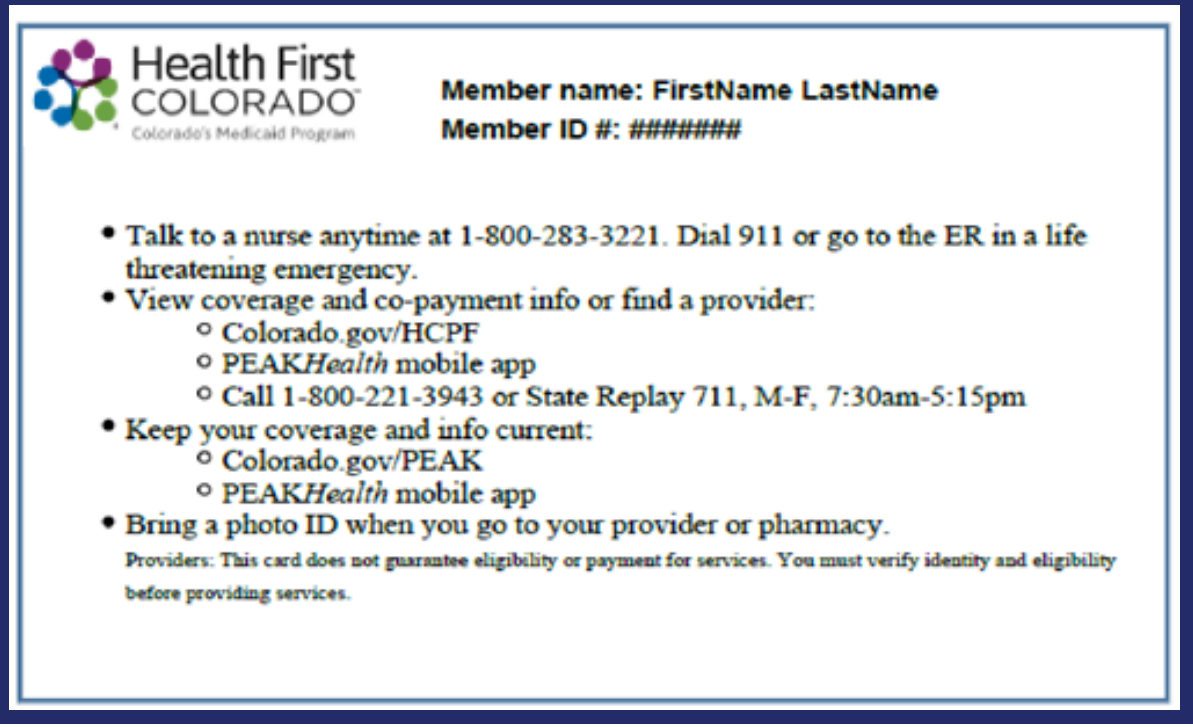




This search will display the Member in Focus page which provides Member Details, Coverage Details, Member Claims and Authorizations.

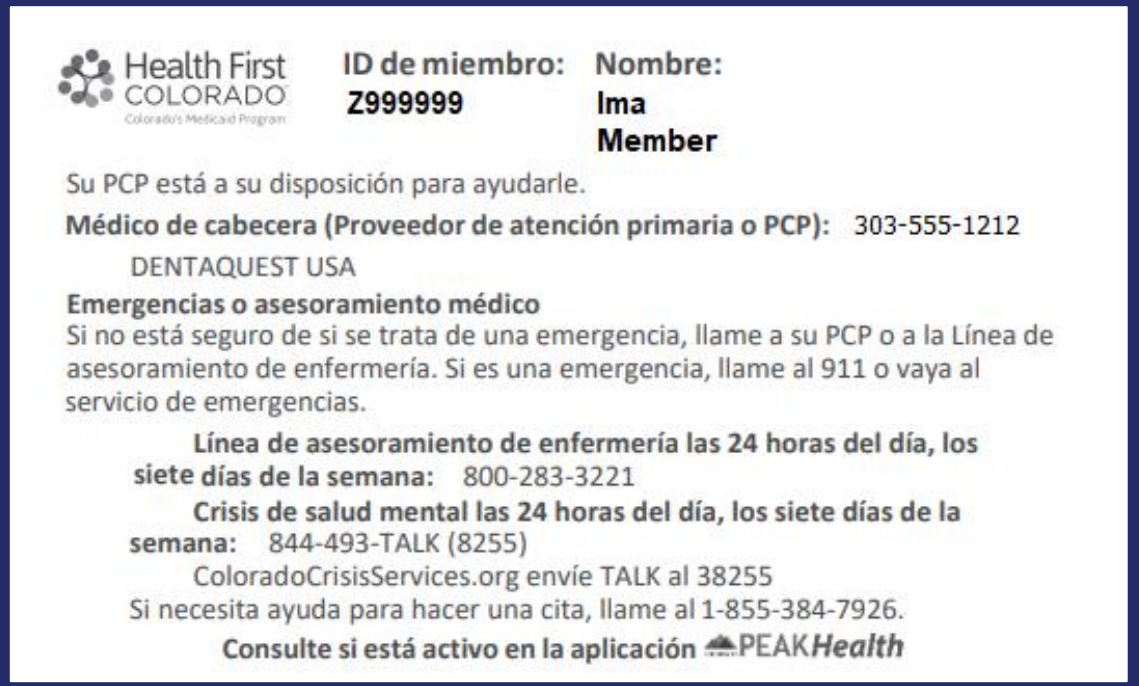
Health First Colorado Identification Cards

- 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.



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

- Providers must confirm coverage types before rendering any Medicaid or 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)
  - Child Health Plan Plus: “CHP+B”
  - Behavioral Health Coverage through the Regional Accountable Entities (RAEs):

    "Medicaid Behavioral Health Benefits" and "BHO+B"

Eligibility Types

Old Age Pension (OAP) - State Only

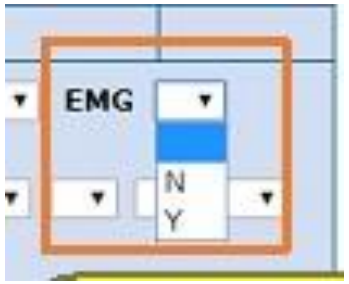
- Members are not eligible for Title XIX due to income.
- Claims will have reduced reimbursement amounts since the program only gets state funds and no federal match.
- Providers cannot bill the member for the difference between the billed amount and the reimbursement amount.
- Does not cover:
  - Home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

Eligibility Types
Family Planning and Non-Citizens

- Family Planning Expansion (FAMPL)
  - 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+)

CHP+
Child Health Plan *Plus*

- Members 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.
  - Before MCO assignment: Services must be billed as fee-for-service to the Fiscal Agent, Gainwell Technologies (or Magellan for pharmacy services)
  - After MCO assignment: Services must be billed to the MCO

colorado access

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DENVER HEALTH™
est. 1860
FOR LIFE'S JOURNEY

United Healthcare | Rocky Mountain Health Plans

Eligibility Types
Child Health Plan *Plus* (CHP+)

- Providers should contact the MCO for further benefit details. 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

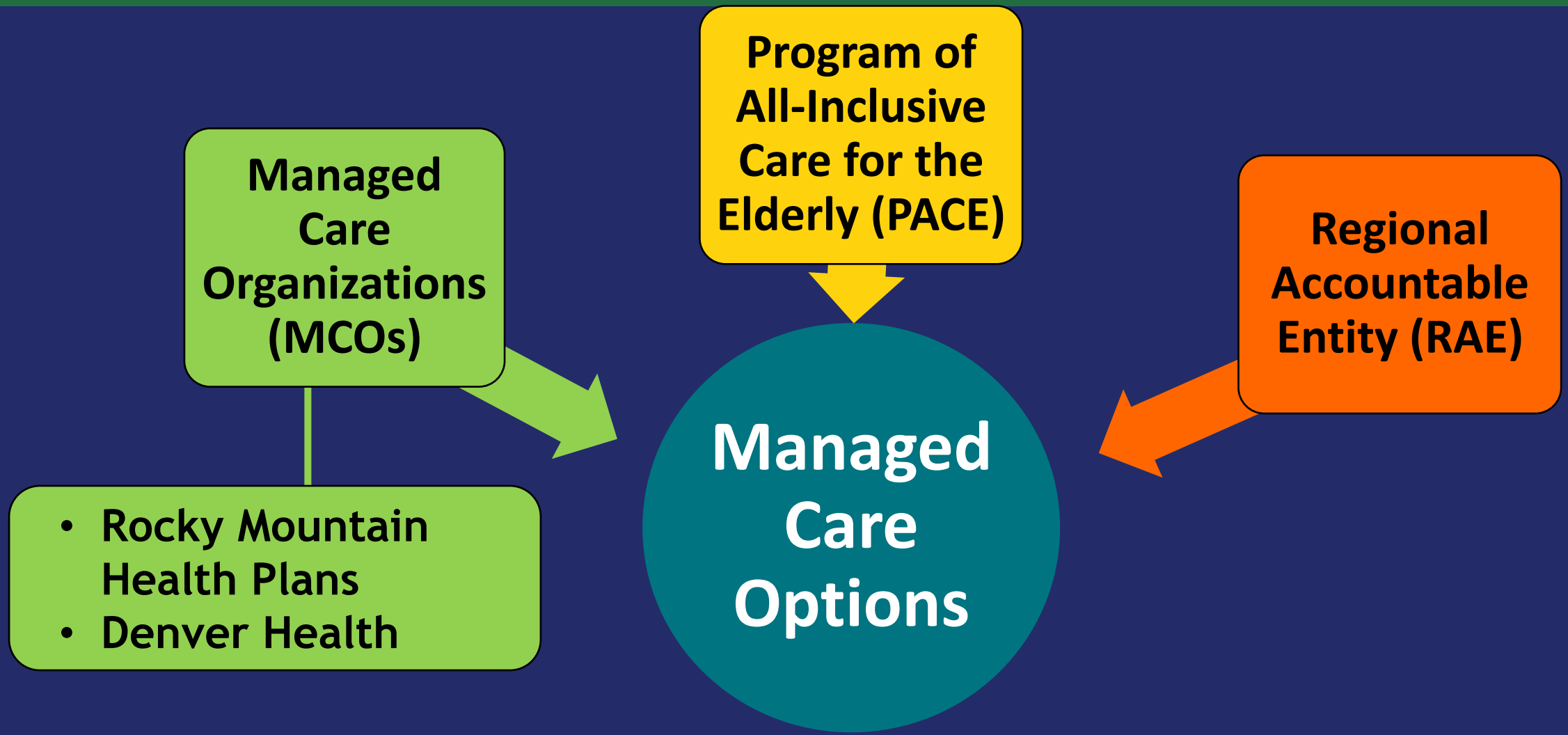
- Temporary coverage of Health First Colorado or Child Health Plan *Plus* (CHP+) services until eligibility is determined
- Presumptive Eligibility (PE) is only available to those listed in the table:

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

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+).**
    - In the Provider Web Portal, providers may see the "Coverage" type "BHA Benefit Plan" and "BHAB."
    - "BHAB" is not the same as "BHO+B" benefits (Medicaid Behavioral Health Benefits through the Regional Accountable Entities [RAEs]).

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)

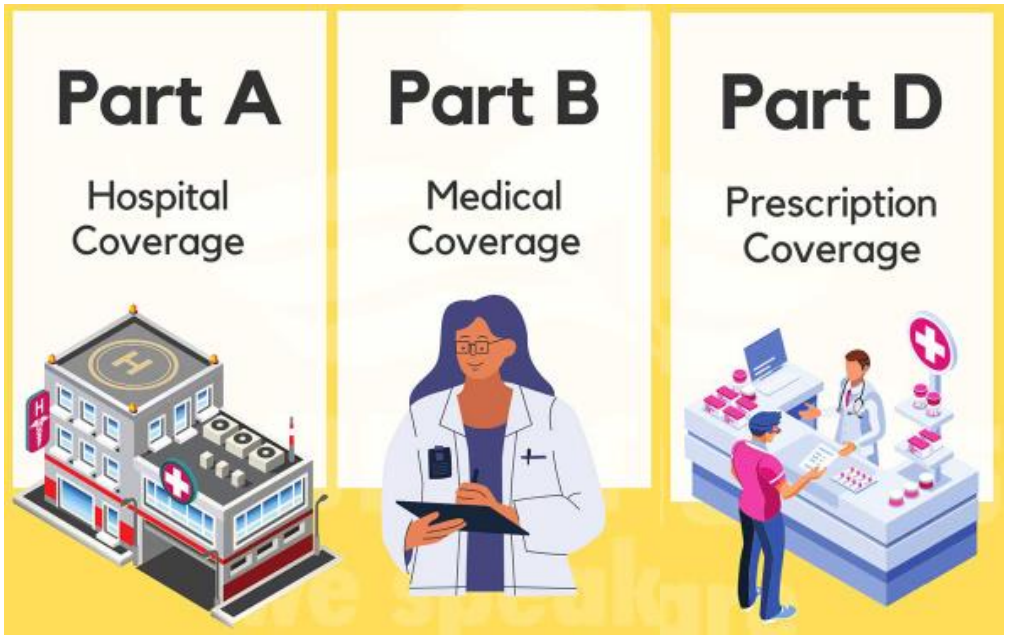
- Members are assigned to the Regional Accountable Entity (RAE) for their geographic area for behavioral **health**.
  - Most behavioral health claims are submitted to the RAEs.
  - Contact the RAE in your area to enroll as a Behavioral Health Provider.
- Regional Accountable Entities do not pay for pediatric behavioral therapy. Pediatric behavioral **therapy** claims should be submitted to the Fiscal Agent (Gainwell Technologies).

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.

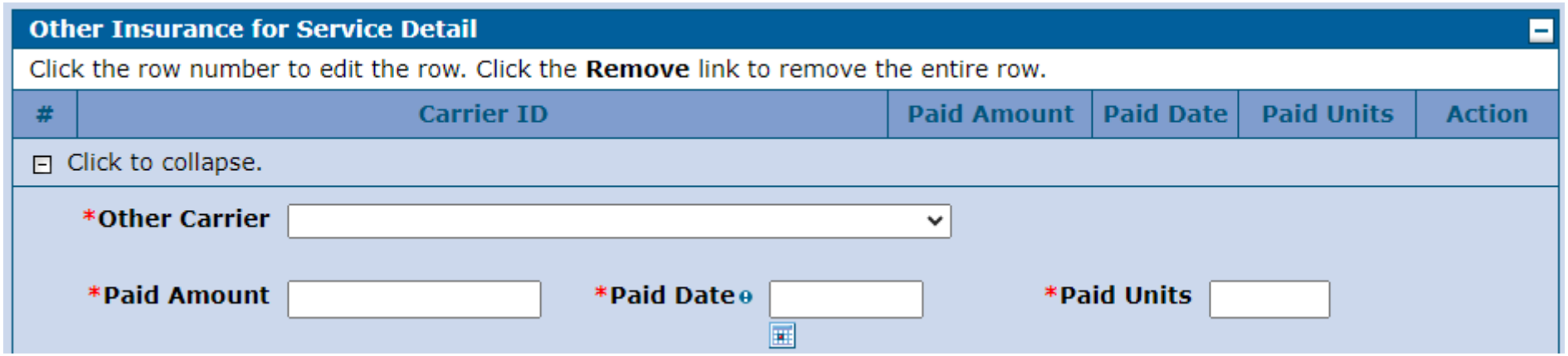
Medicare
Qualified Medicare Beneficiary (QMB)

- 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.

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

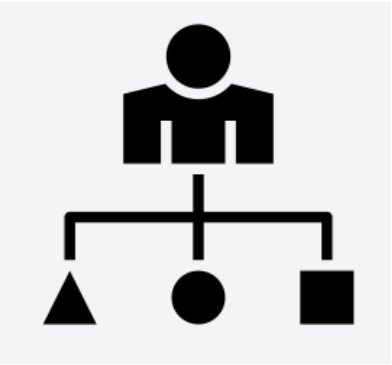
Third Party Liability
(Commercial Insurance)

- **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.



Third Party Liability
(Commercial Insurance)

- 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**

$400.00 - $300.00 = $100.00

Example 2:

Charge = $500

Program allowable = $400

TPL payment = $400

Program allowable – TPL payment = **Reimbursement**

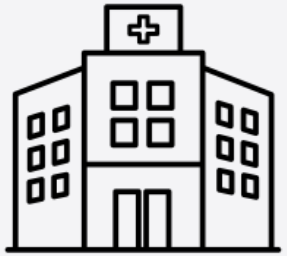
$400.00 - $400.00 = $0.00

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.**



Co-Pay

Website

- 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)
- 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.

Co-Pay Exempt Members

Full List

Nursing Facility Residents

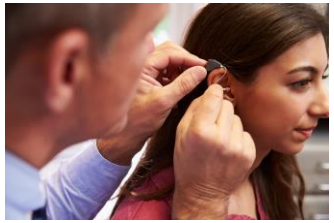
Pregnant Women

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

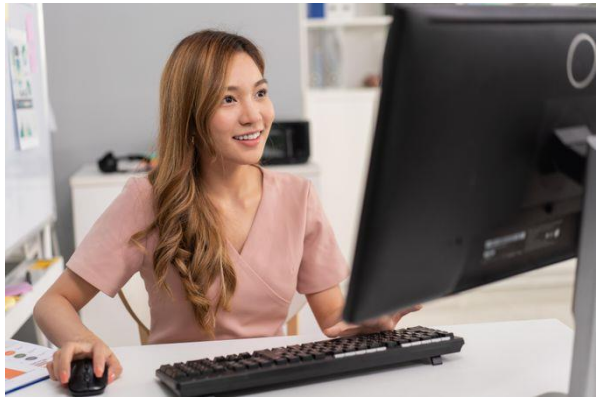
Prior Authorization Requests (PARs)

- All PARs for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if 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

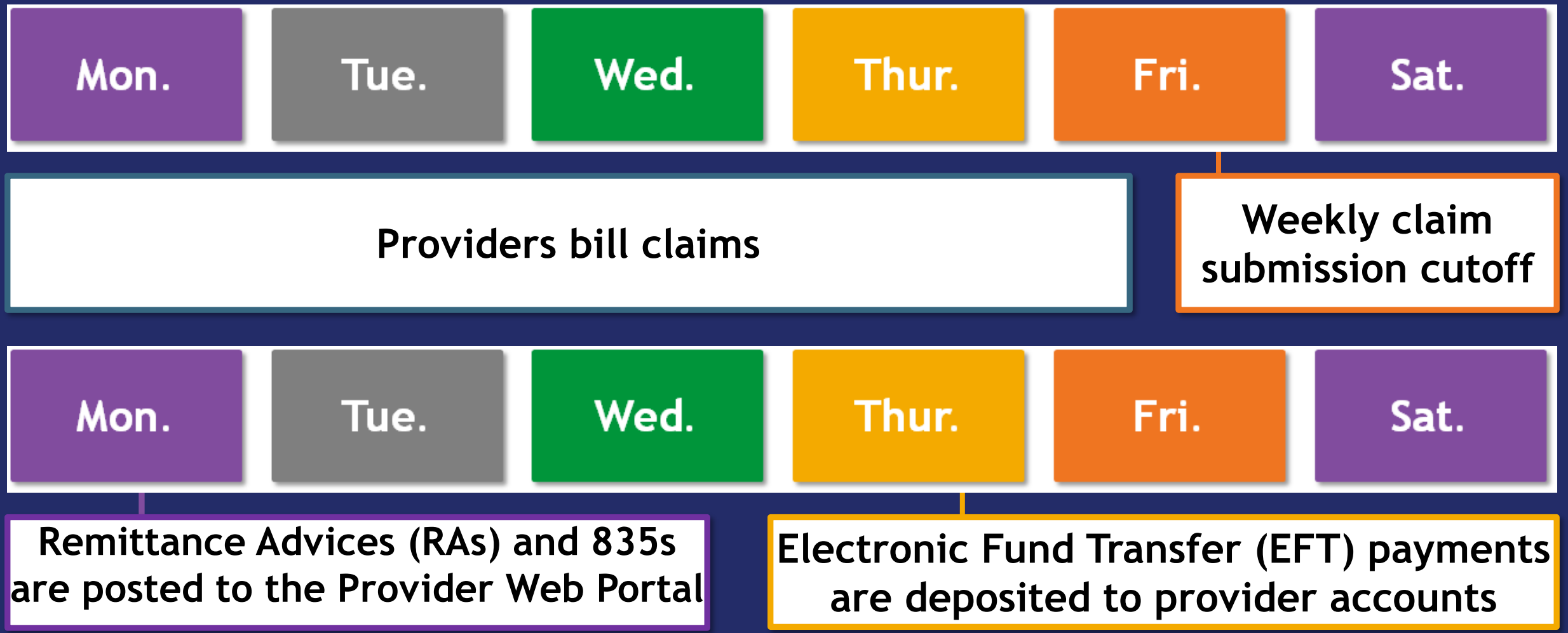
Record Retention

Payment Processing and Remittance

Timely Filing

Extensions for Timely Filing

Payment Processing Schedule



Remittance

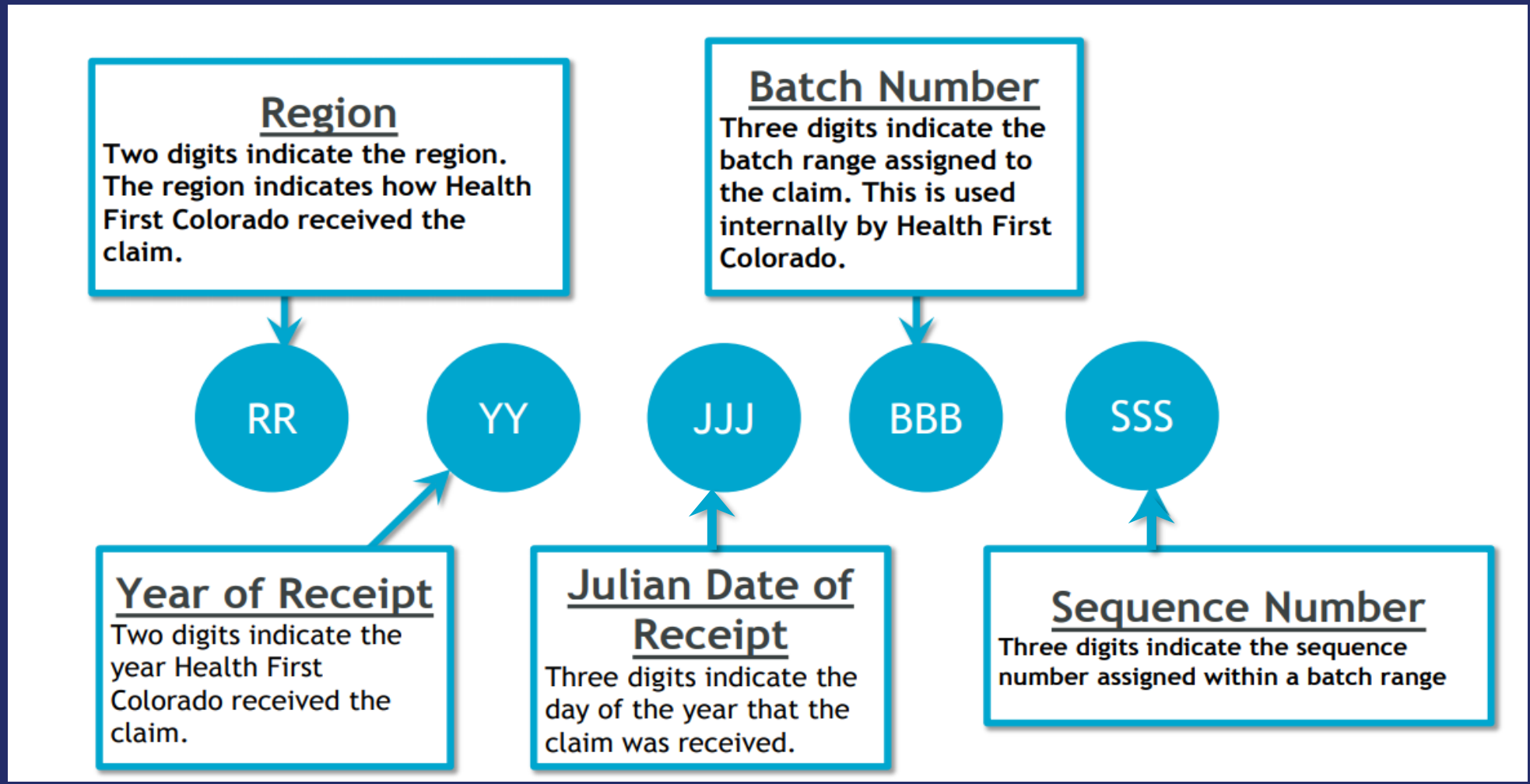
Remittance Advice (RA)

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

- Each week, providers should reconcile the RA by matching individual claims with the total payment received.
  - RAs are posted on Monday and the corresponding payment usually is deposited on the following Thursday.
  - The second page of the 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

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

- 365 days from Date of Service (DOS) determined by date of receipt of the claim
- Circumstances that are **not** proof of timely filing include, but are not limited to:
  - 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

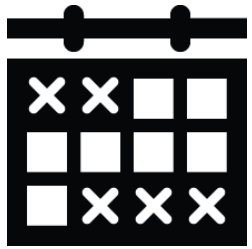
Timely Filing
Dates of Service

Type of Service	Timely Filing Calculation
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	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

- 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.
- Claims do not need to be submitted while waiting for provider enrollment to be approved.
- 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.



Timely Filing

Primary Payers: Commercial Insurance (Third Party Liability)

- Members who are enrolled with commercial insurance and Health First Colorado:
  - **Timely filing extensions cannot be given for claims including commercial insurance if the date of service is past 365 days** per state and federal regulation (42 CFR § 447.45(d), 10 CCR 2505-10-8.043.01 and .02A).
    - Providers should submit these claims as soon as possible and then **follow up to ensure prompt response.**
    - Insurance companies are bound by the Prompt Pay Law (CRS § 10-16-106.5), which requires payment within certain timeframes.

Timely Filing Extensions

Primary Payers: Commercial Insurance (Third Party Liability)

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

Timely Filing Extensions

Denials, Adjustments & Voids by Fiscal Agent

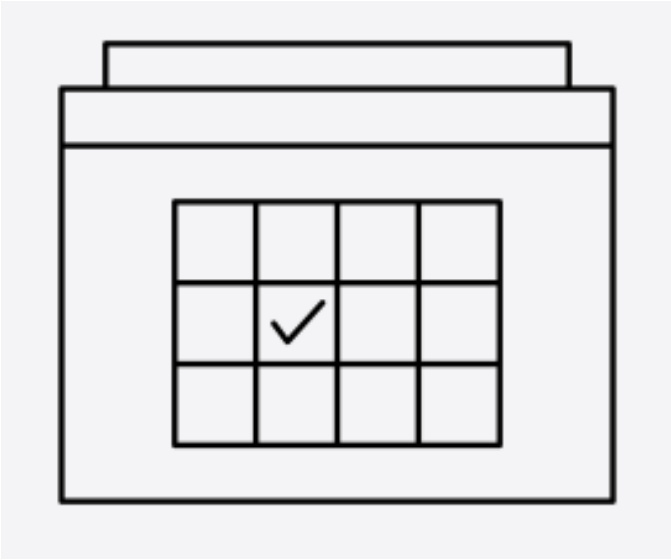
- If a claim is denied, adjusted or voided by the fiscal agent after the initial timely period of 365 days, providers have an additional 60 days from the date of the last Remittance Advice (RA) or returned paper claim to submit.
  - Reference the last Internal Control Number (ICN) from denied claims
  - Do not attach copy of Remittance Advice (RA) with claim
  - Keep supporting documentation

- Providers should continue submitting the claim every 60 days—even if the result is a denial—in order to keep it within timely filing.

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

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. **No further extensions are 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
    - 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

Billing Provider

Entity being reimbursed for service

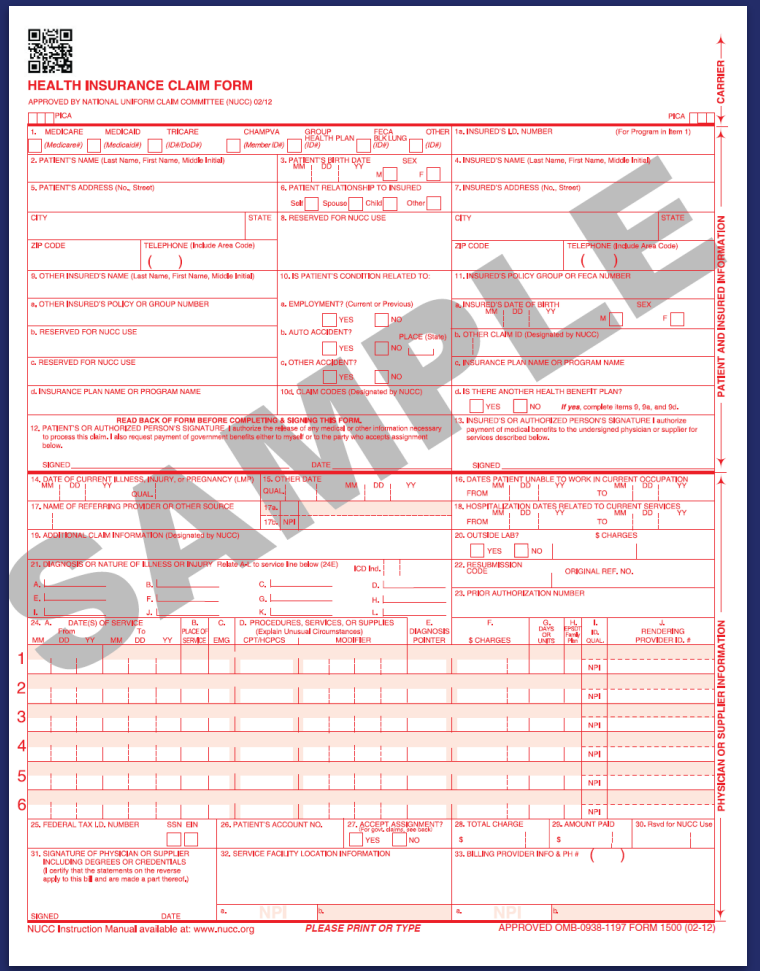
CMS 1500

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For 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)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ 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 DATE

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

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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 to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES NO

28. TOTAL CHARGE $

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

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

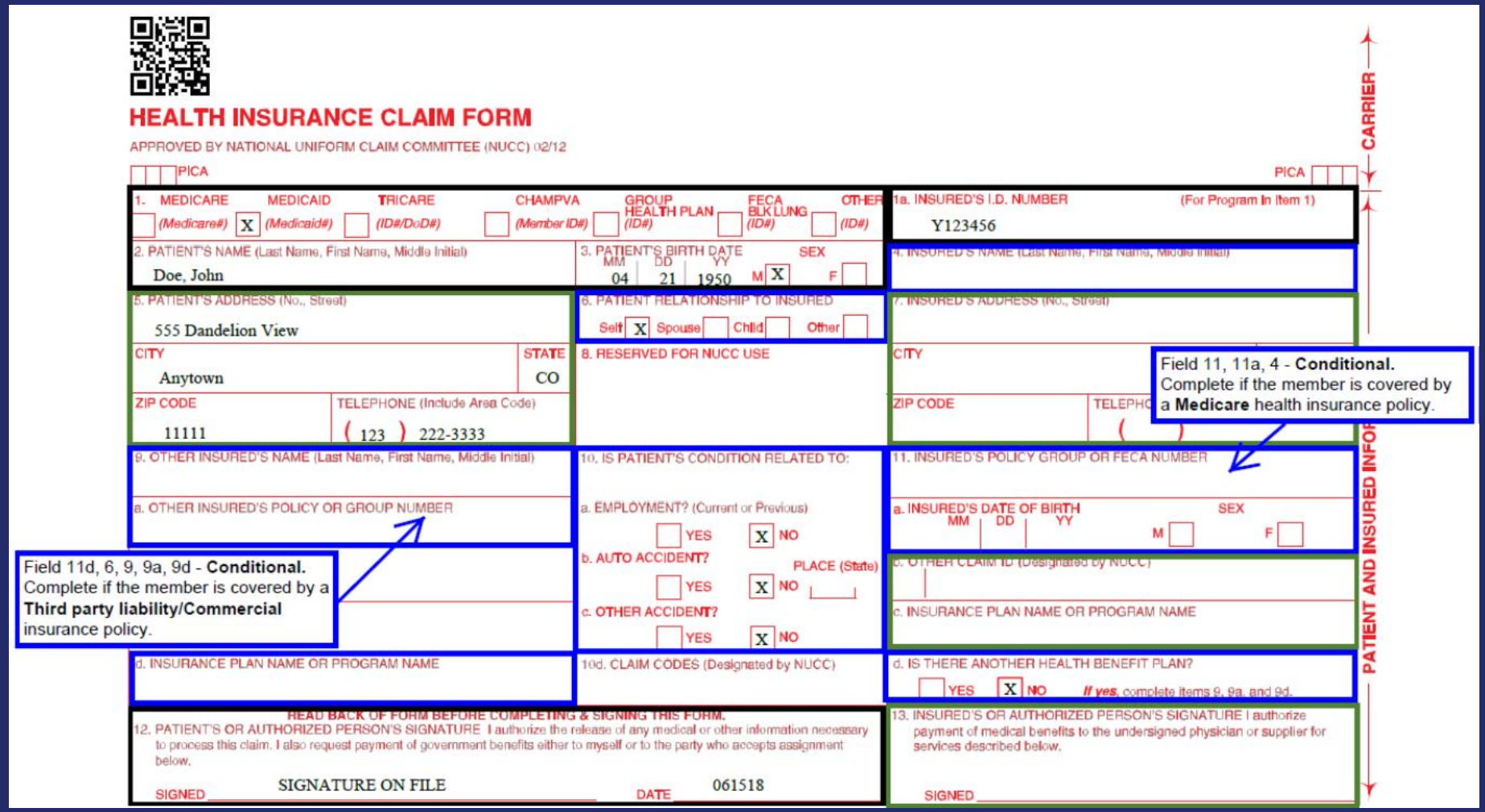
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Paper Claim - Example 1



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID X (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (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 04 DD 21 YY 1950 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 555 Dandelion View

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: CO

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 11111 TELEPHONE (Include Area Code): (123) 222-3333

ZIP CODE TELEPHONE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES | X NO

b. AUTO ACCIDENT? YES | X NO PLACE (State)

c. OTHER ACCIDENT? YES | X NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO *If yes*, complete items 9, 9a, and 9d.

READ 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 undersigned physician or supplier for services described below.

SIGNED

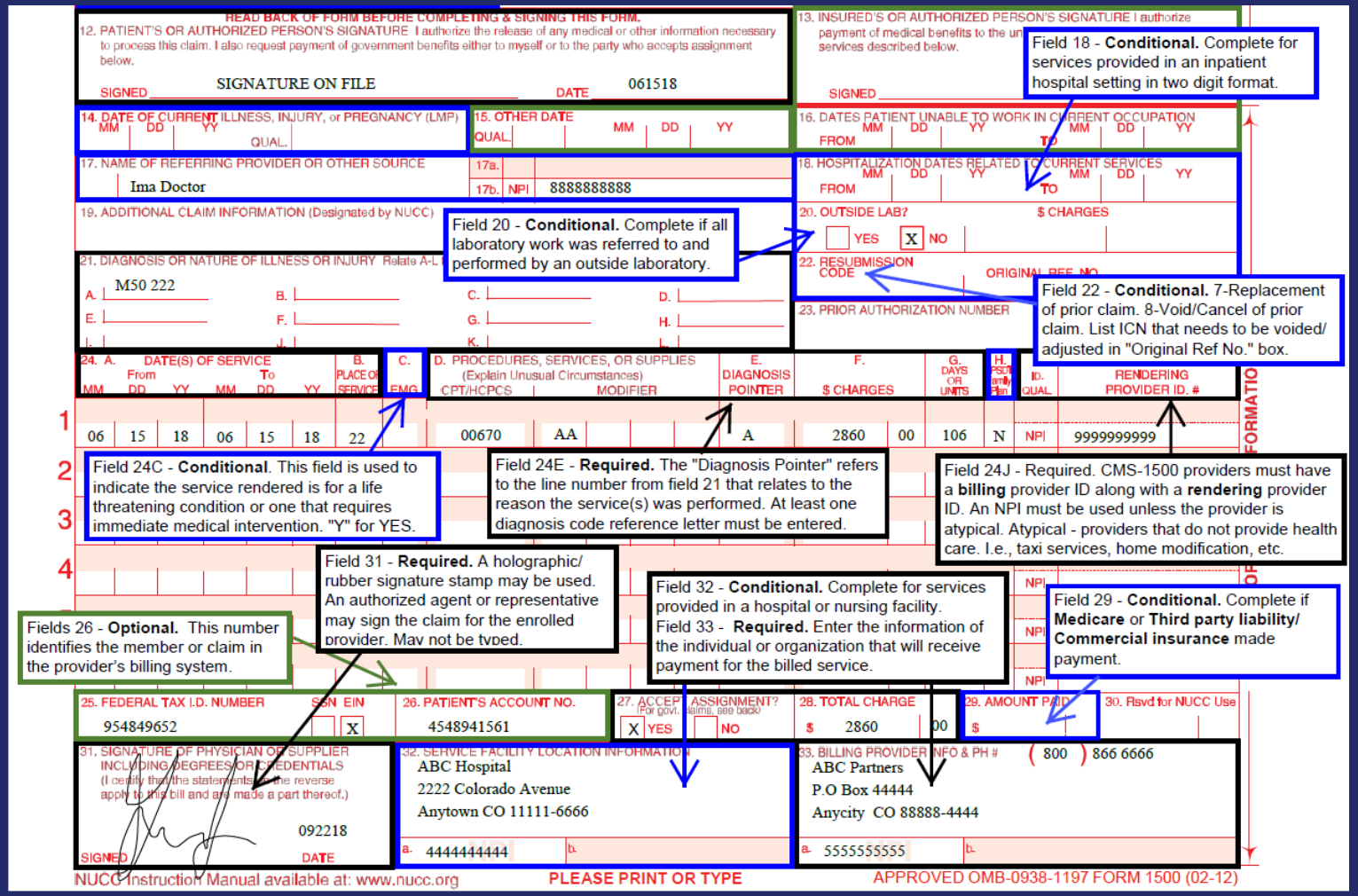
CARRIER

PATIENT AND INSURED INFOR

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.

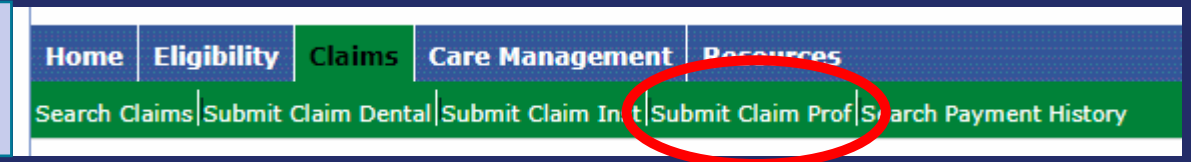
Paper Claim - Example 2



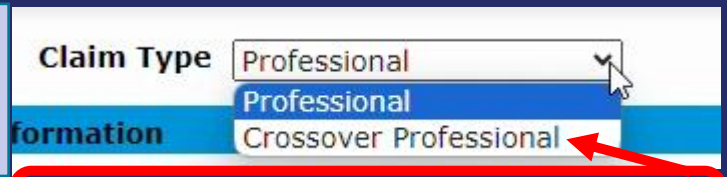
Provider Web Portal Demo

Step 1: Member and Claim Information

1



2

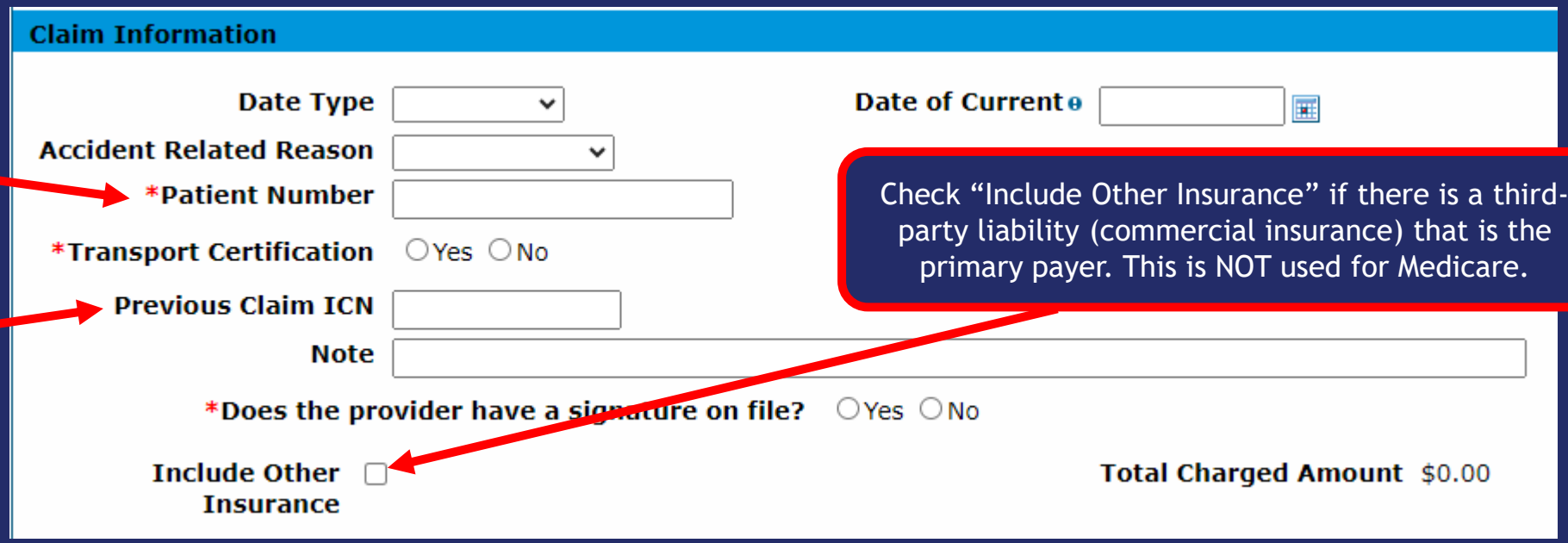


The Crossover Professional claim is used when Medicare is the primary payer.

3

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

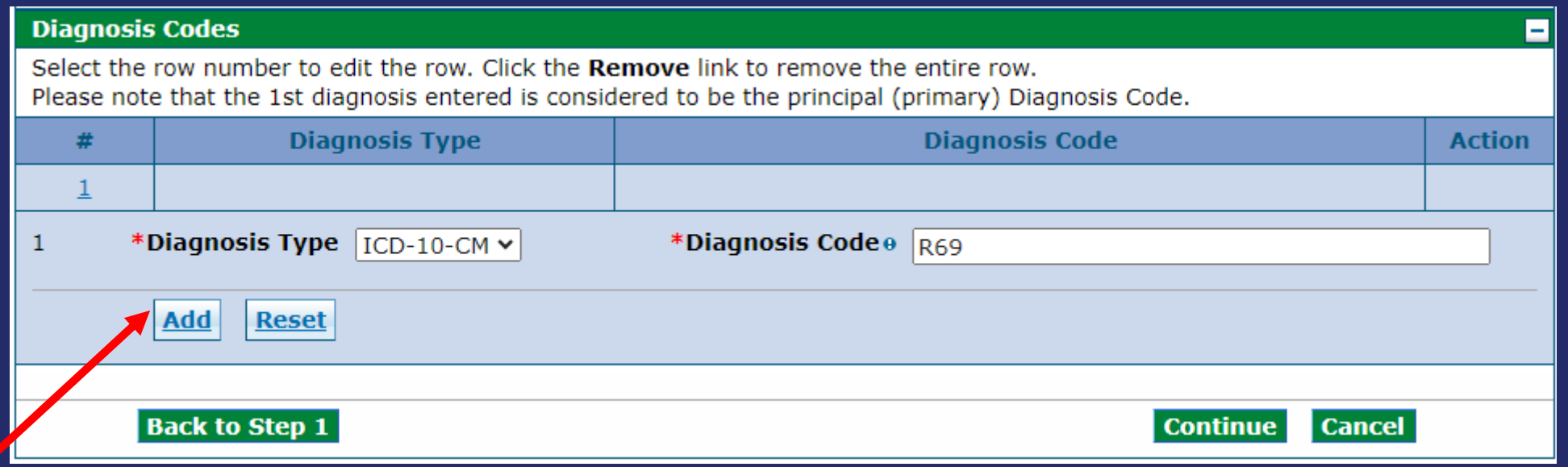
Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.



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

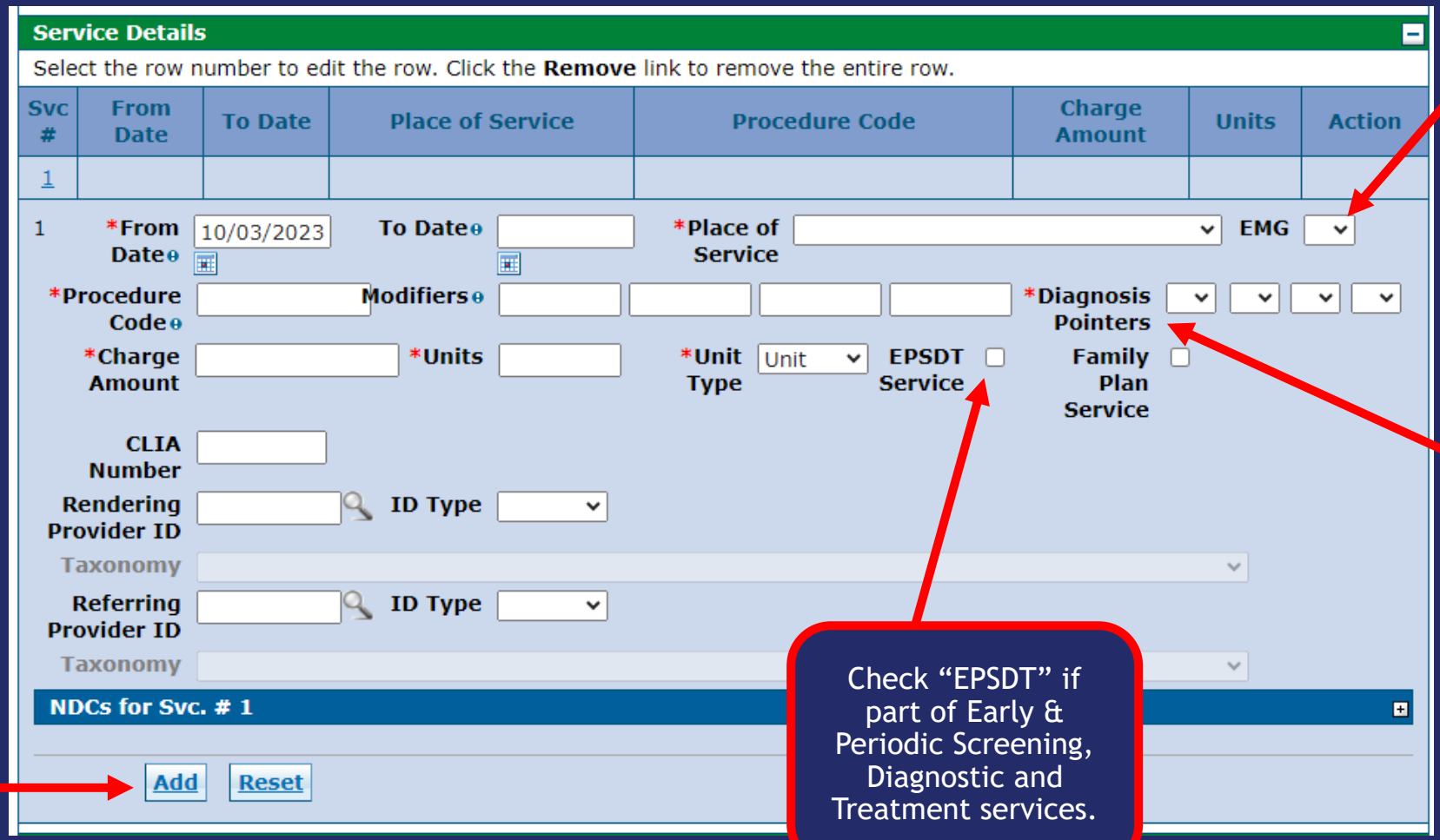
Step 2: Diagnosis Panel



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

Provider Web Portal Demo

Step 3: Service Details Panel



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.

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

Click on blue numbers to expand and change information within that 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
1	10/03/2023	10/03/2023	11-Office	99213-OFFICE O/P EST LOW 20-29 MIN	$500.00	1.000 Unit	Remove

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."

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

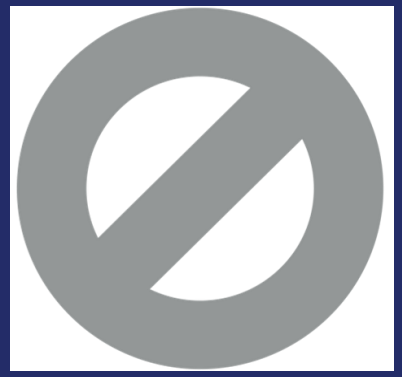
- Red asterisks (*) will denote required fields

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

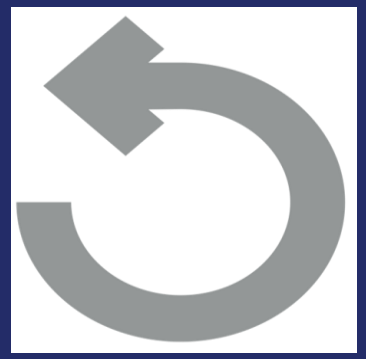
Prior Authorization (PAR) Not on File	No approved prior authorization on file for services that are being submitted, OR member ID, dates of service, modifiers, units or PAR type may not match.
Total Charges Invalid	Line-item charges do not match the claim total.
Member Not Eligible for Title XIX	Member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

Claim Status

Common Terms

Adjustment

Correct paid claim



Resubmit

Rebill a previously denied claim

Suspend

Claim must be manually reviewed before final decision

Void

Cancel a paid claim

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

Claim - Resubmission

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

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

Resubmission Codes

Rebilled Claims: Date of Service Past 365 Days

Provider Web Portal:

- Search for original claim
- Click “Copy” at the bottom; include original ICN in “Previous Claim ICN” field

Batch:

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

Paper:

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

Claim - Adjustments

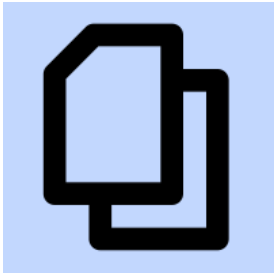
- What is an adjustment?
  - An adjustment creates a replacement claim.
  - Two step process: Credit & Repayment

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

Adjustment & Void Codes

Provider Web Portal:

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



Batch:

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

Paper:

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

Claim Submission: Resubmit or Adjust?

Was the claim denied?

Yes

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

Yes

Make corrections and **submit new claim** without referencing the Internal Control Number (ICN)

No

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

Yes

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

No

Contact Provider Services Call Center at 1-844-235-2387

No, it paid

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

Yes

Make corrections and **adjust claim** by:

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

No

Contact Provider Services Call Center at 1-844-235-2387

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

Provider Services Call Center

1-844-235-2387

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

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	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	

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!