

# 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

	Benefit	Claim Submission
<b>Behavioral Therapy</b>	Services for children/youth ( <b>under age 21</b> ) who have autism spectrum disorder or a similar condition	<ul style="list-style-type: none"> <li>All behavioral <b>therapy</b> claims submitted to fiscal agent Gainwell Technologies</li> </ul>
<b>Behavioral Health</b>	Comprehensive mental health and substance use disorder services for <b>all ages</b>	<ul style="list-style-type: none"> <li>Most behavioral <b>health</b> claims submitted to the Regional Accountable Entities (RAEs) (<i>Requires separate enrollment with the RAEs</i>)</li> <li>Only <u>fee-for-service</u> behavioral <b>health</b> claims submitted to fiscal agent Gainwell Technologies</li> </ul>

Note: Both Behavioral Therapy and Behavioral Health providers complete Health First Colorado provider enrollment and revalidation through the fiscal agent Gainwell Technologies and use the Provider Web Portal (managed by Gainwell Technologies) to check member eligibility.

# 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 Care and Case Management (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

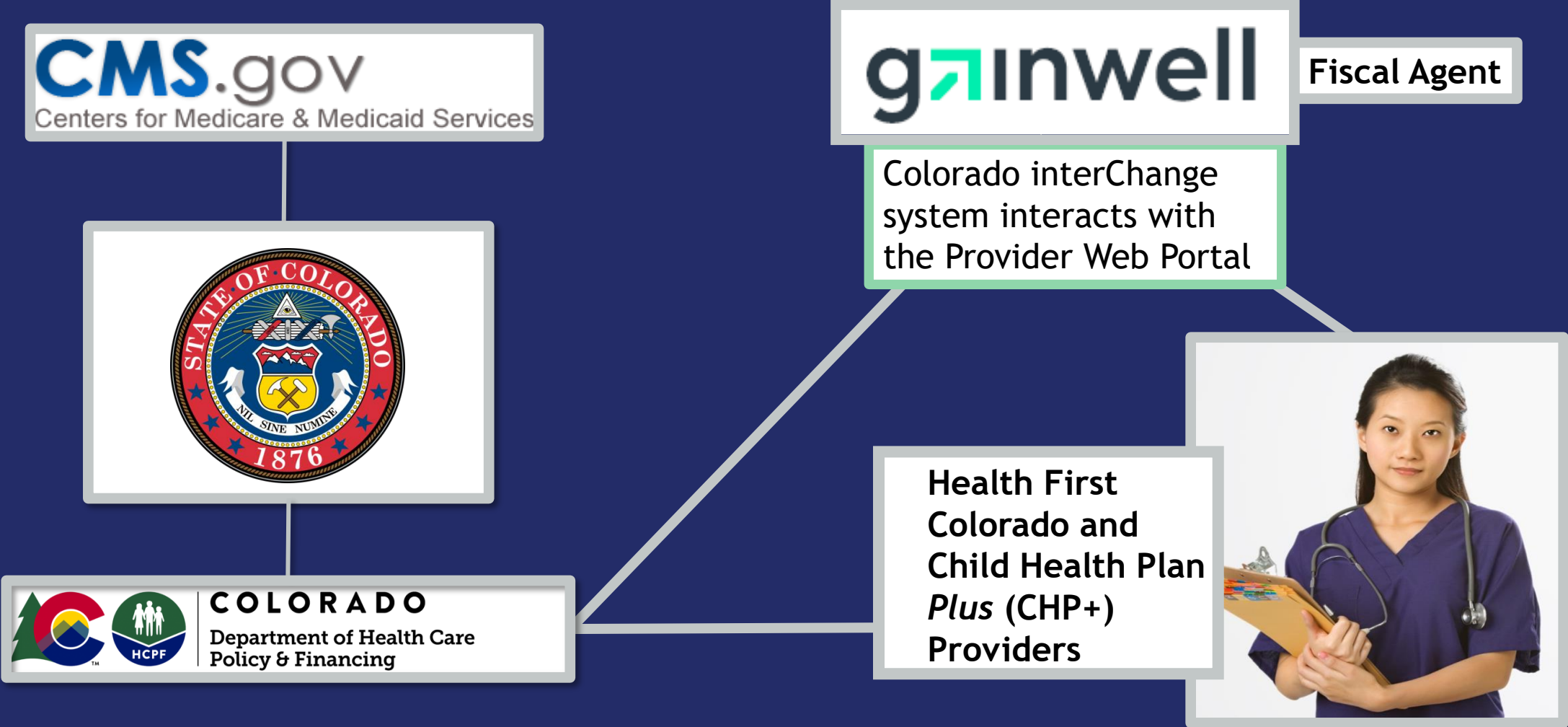
Billing and  
Payment

Resources

Claim  
Submission



# Program Overview



# Department Website





# Department of Health Care Policy & Financing

## Website

https://hcpf.colorado.gov

1

hcpf.colorado.gov



**COLORADO**  
Department of Health Care  
Policy & Financing

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.

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

The screenshot shows a grid of navigation tiles for providers. The tiles include: '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' (circled in red), 'Revalidation', 'Provider contacts: Who to call for help', and 'Provider resources: Quick guides, known issues, EDI, & training'. At the bottom, there are links for 'COVID-19 Provider Information', 'Resources for HCBS Providers', 'SAVE System', 'ColoradoPAR', 'DDDWeb', and 'Value Based Payments'.

# 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

## For Our Providers

- Why should you become a provider?
- Provider enrollment
- Provider services: Forms, rates, & billing manuals**
- What's new: Bulletins, updates & emails
- CBMS: CO Benefits Management System
- Long-Term Services and Supports
- 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 | Value Based Payments

# What's New: Bulletins, Updates & Emails

*Sign up for  
publications*



Weekly newsletters  
and monthly bulletins

Home > For Our Providers

## For Our Providers

- ? Why should you become a provider?
- Provider enrollment
- Provider services: Forms, rates, & billing manuals
- What's new: Bulletins, updates & emails**
- CBMS: CO Benefits Management System
- Long-Term Services and Supports
- 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    Value Based Payments

# 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

The screenshot shows a grid of tiles for provider resources. The tiles are:

- Why should you become a provider?
- Provider enrollment
- Provider services: Forms, rates, & billing manuals
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- CBMS: CO Benefits Management System
- Long-Term Services and Supports
- Web portal
- Revalidation
- Provider contacts: Who to call for help
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At the bottom, there are two rows of links:

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

# 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

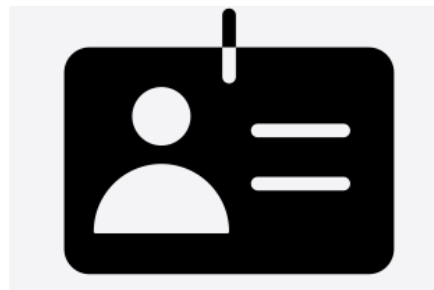
Entity being reimbursed for service





# National Provider Identifier (NPI)

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



# National Provider Identifier (NPI)

## Individual Providers

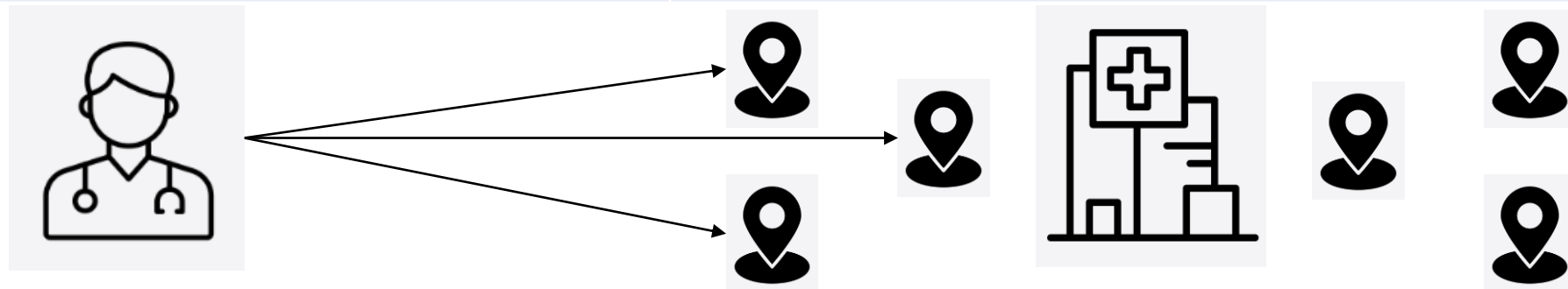
(Individuals Within a Group, Billing Individuals or Ordering/Prescribing/Referring)

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

## Organizational Providers

(Groups, Facilities)

- Separate National Provider Identifier (NPI) for each service location and provider type
- Tied to 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 Ordering, Prescribing and Referring (OPR) providers indicated on a claim must be actively enrolled with Health First Colorado.
  - Groups are encouraged to coordinate with all Ordering, Prescribing and Referring (OPR) providers to ensure that those provider IDs have been revalidated.
  - Refer to the [Ordering, Prescribing and Referring Claim Identifier Project](#) for more information about Ordering, Prescribing and Referring (OPR) issues on claims.



# Member Eligibility

# 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

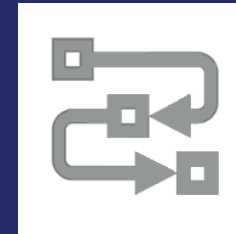
- Member's eligibility must be checked on each date of service.
  - Facilities that bill monthly: Eligibility can change throughout the month. Therefore, it is recommended that providers check eligibility more than once a month.
  - Ways to verify eligibility:



**Provider Web  
Portal**



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



**Batch 270**

# Log In to View Member Information

## Provider Web Portal

**Colorado Department of Health Care Policy & Financing** | **Health First COLORADO**  
Colorado's Medicaid Program | [Contact Us](#) | [Logout](#)

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

City

First Name

Birth Date

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

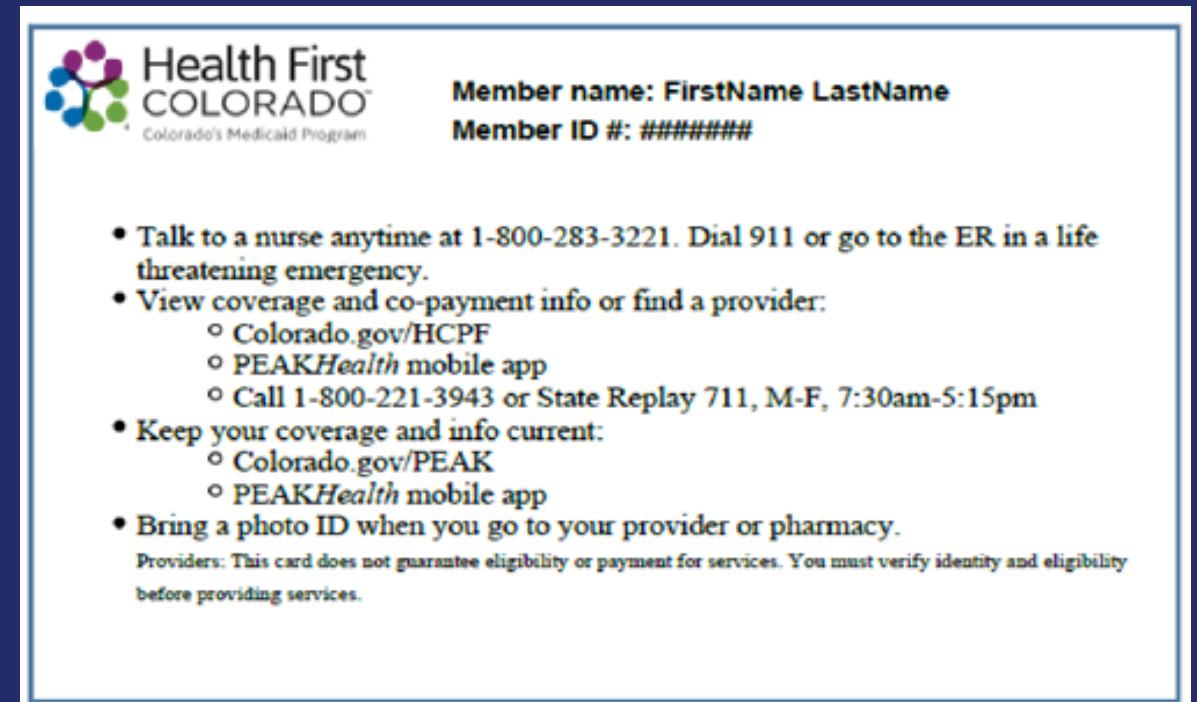
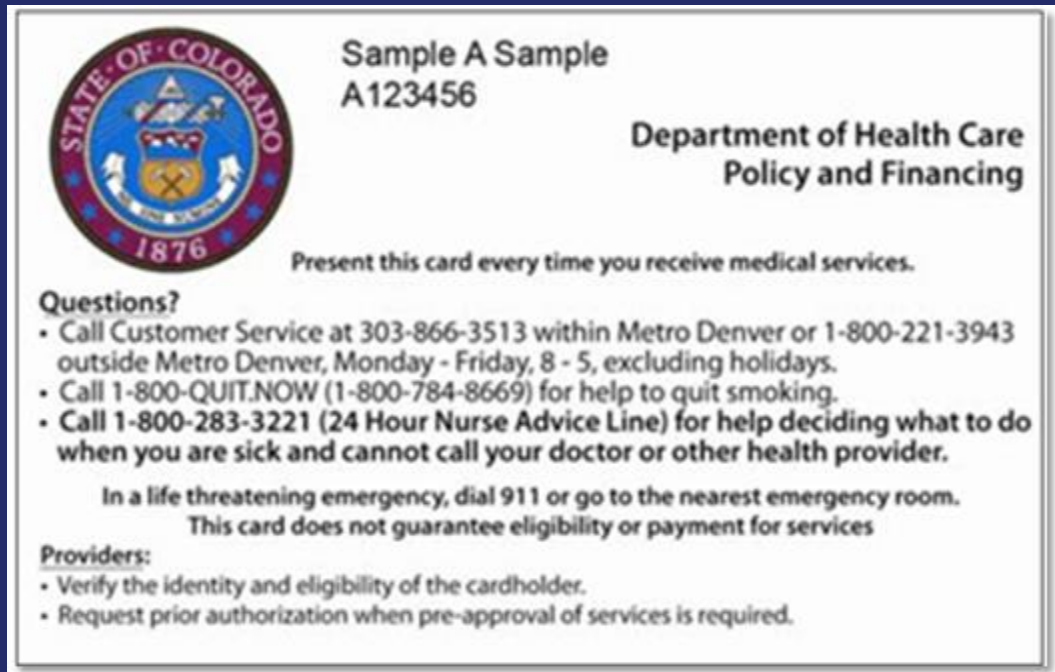
[Submit an Authorization](#)

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 ayudarle.  
**Médico de cabecera (Proveedor de atención primaria o PCP):** 303-555-1212  
DENTAQUEST USA

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

**Línea de asesoramiento de enfermería las 24 horas del día, los siete días de la semana:** 800-283-3221  
**Crisis de salud mental las 24 horas del día, los siete días de la semana:** 844-493-TALK (8255)  
ColoradoCrisisServices.org envíe TALK al 38255  
Si necesita ayuda para hacer una cita, llame al 1-855-384-7926.  
**Consulte si está activo en la aplicación  PEAK Health**

# Eligibility Types

- Most members: Health First Colorado benefits (Title XIX [Title 19])
- Some members have **different** eligibility types:
  - Old Age Pension, state only
  - Non-Citizens (individuals without documentation)
  - Child Health Plan *Plus* (CHP+)
  - Presumptive Eligibility
  - Managed Care
- Some members have **additional** benefits:
  - Medicare
  - Third-party commercial insurance



# Eligibility Types

- Providers must confirm coverage types before rendering any Medicaid or Child Health Plan *Plus* (CHP+) services or submitting claims.
- Eligibility coverage types listed in the Provider Web Portal (not an all-inclusive list):
  - Medicaid: "Medicaid State Plan" and "TXIX" (Title XIX [Title 19])
  - Child Health Plan *Plus*: "CHP+B"
  - Behavioral Health Coverage through the Regional Accountable Entities (RAEs): "Medicaid Behavioral Health Benefits" and "BHO+B"



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

# Eligibility Types

## Old Age Pension (OAP) - State Only

- Members are not eligible for Title XIX (Title 19) 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





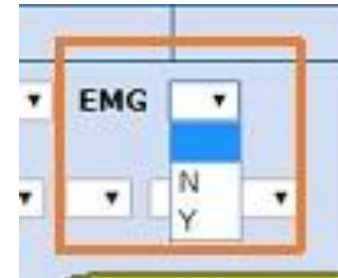
# Eligibility Types

## 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)
  - 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 determined to be eligible are later assigned to one of the four Child Health Plan *Plus* (CHP+) Managed Care Organizations (MCOs): Colorado Access, Denver Health, Kaiser Permanente or Rocky Mountain Health Plans.
  - Before Managed Care Organization (MCO) assignment: Services must be billed as fee-for-service to the Fiscal Agent, Gainwell Technologies (or Magellan for pharmacy services)
  - After Managed Care Organization (MCO) assignment: Services must be billed to the Managed Care Organization (MCO)



# Eligibility Types

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



- Providers should contact the Managed Care Organization (MCO) for further benefit details. Benefits through Child Health Plan *Plus* (CHP+) may vary from the Title XIX ([Title 19] 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 Presumptive Eligibility (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 Child Health Plan <i>Plus</i> (CHP+) Presumptive Eligibility (PE) requirements	<u>Child Health Plan <i>Plus</i> (CHP+) Eligibility Criteria</u>	All <u>Child Health Plan <i>Plus</i> (CHP+) benefits</u> excluding dental services
Family Planning Limited (FAMPL) Benefit	<u>Family Planning Limited (FAMPL) Eligibility Criteria</u>	Birth control, sexually transmitted infection testing and treatment, cervical cancer screening and prevention, related counseling and preventative services
Breast and Cervical Cancer Program (BCCP)	<u>Breast and Cervical Cancer Program (BCCP) Eligibility Criteria</u>	All <u>Health First Colorado benefits</u>



# 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 Regional Accountable Entities (RAEs).
  - Contact the Regional Accountable Entity (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).





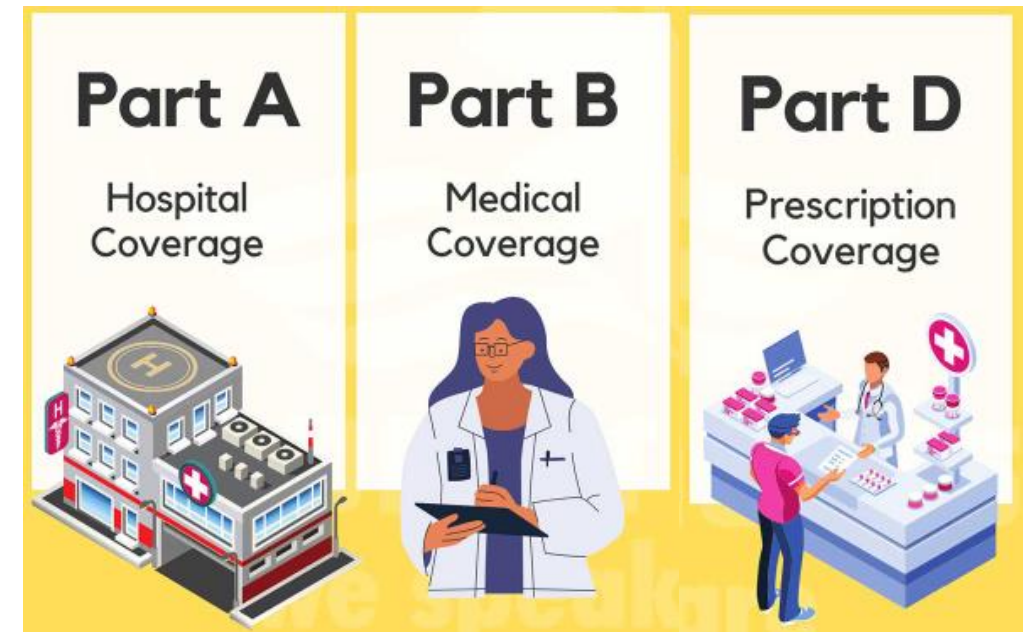
# Dual Eligibility

- 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)

- Qualified Medicare Beneficiary (QMB) programs cover any service covered by Medicare.
  - Qualified Medicare Beneficiary Plus Medicaid (QMB+): Members also receive Health First Colorado benefits (Title XIX [Title 19]).
  - Qualified Medicare Beneficiary (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)

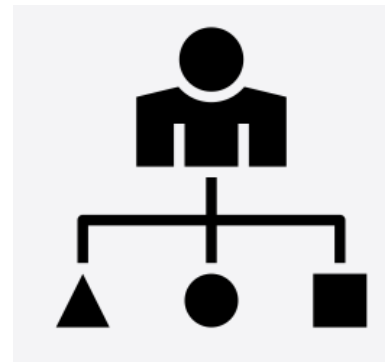
- **Health First Colorado is always the payer of last resort.**
  - Indicate the date the Third-Party Liability (Commercial Insurance) paid or denied on each claim.
  - The Explanation of Benefits (EOB) does not need to be attached to the claim.

Other Insurance for Service Detail					
#	Carrier ID	Paid Amount	Paid Date	Paid Units	Action
Click the row number to edit the row. Click the <b>Remove</b> link to remove the entire row.					
<input type="checkbox"/> Click to collapse.					
*Other Carrier <input type="text"/>					
*Paid Amount <input type="text"/>		*Paid Date <input type="text"/>		*Paid Units <input type="text"/>	

# 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**

Third-Party Liability payment = **\$300**

Program allowable - Third-Party Liability payment = **Reimbursement**

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

Example 2:

Charge = \$500

Program allowable = **\$400**

Third-Party Liability payment = **\$400**

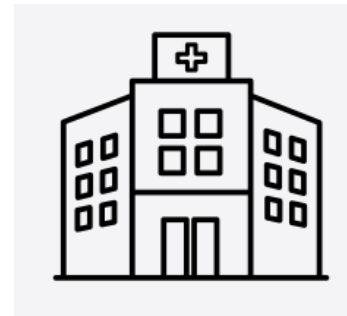
Program allowable - Third-Party Liability payment = **Reimbursement**

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

# Co-Pay

## Website

- Effective July 1, 2023, most member co-pays were reduced to \$0.
  - Change effective for members eligible for Title XIX ([Title 19] 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

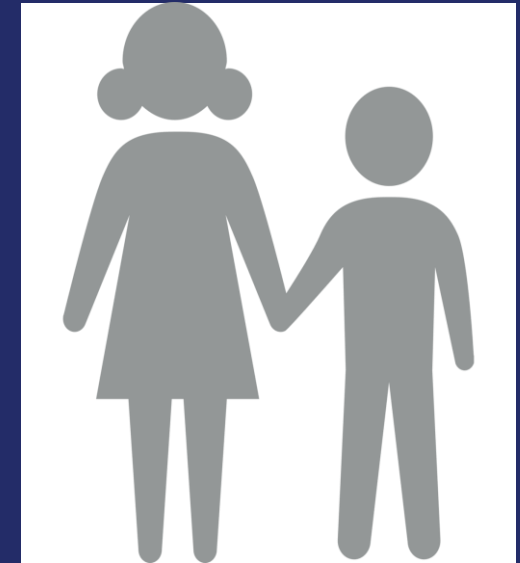
## Full List



**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)

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

## Website:

ColoradoPAR website

## Phone:

Phone: 1-888-801-9355

FAX: 1-866-940-4288

# Prior Authorization Requests (PARs)

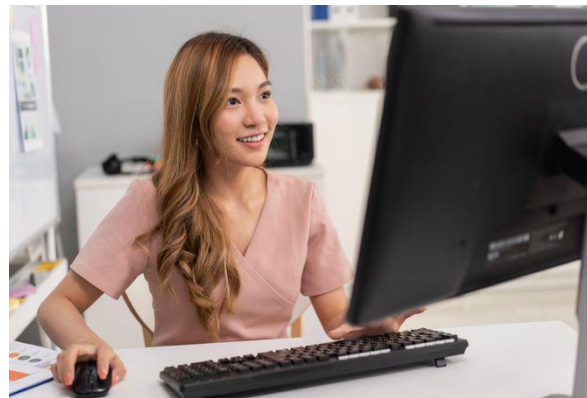
- All Prior Authorization Requests (PARs) for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child/youth.
- ColoradoPAR does not process Prior Authorization Requests (PARs) for 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.
- Home and Community-Based Services (HCBS) providers must have the Prior Authorization Request (PAR) number to view a PAR on the Provider Web Portal.



# Billing and Payment



# Billing and Payment

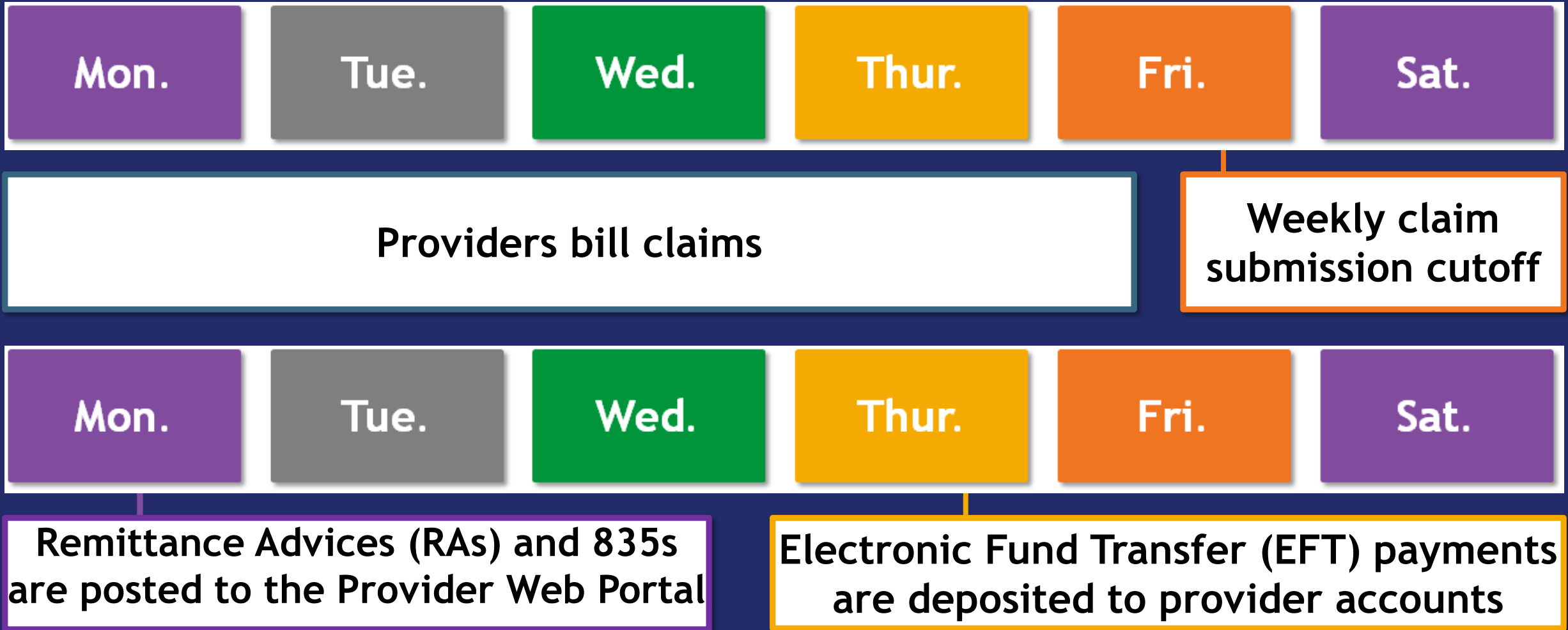
Record Retention

Payment Processing  
and Remittance

Timely Filing

Extensions for  
Timely Filing

# Payment Processing Schedule



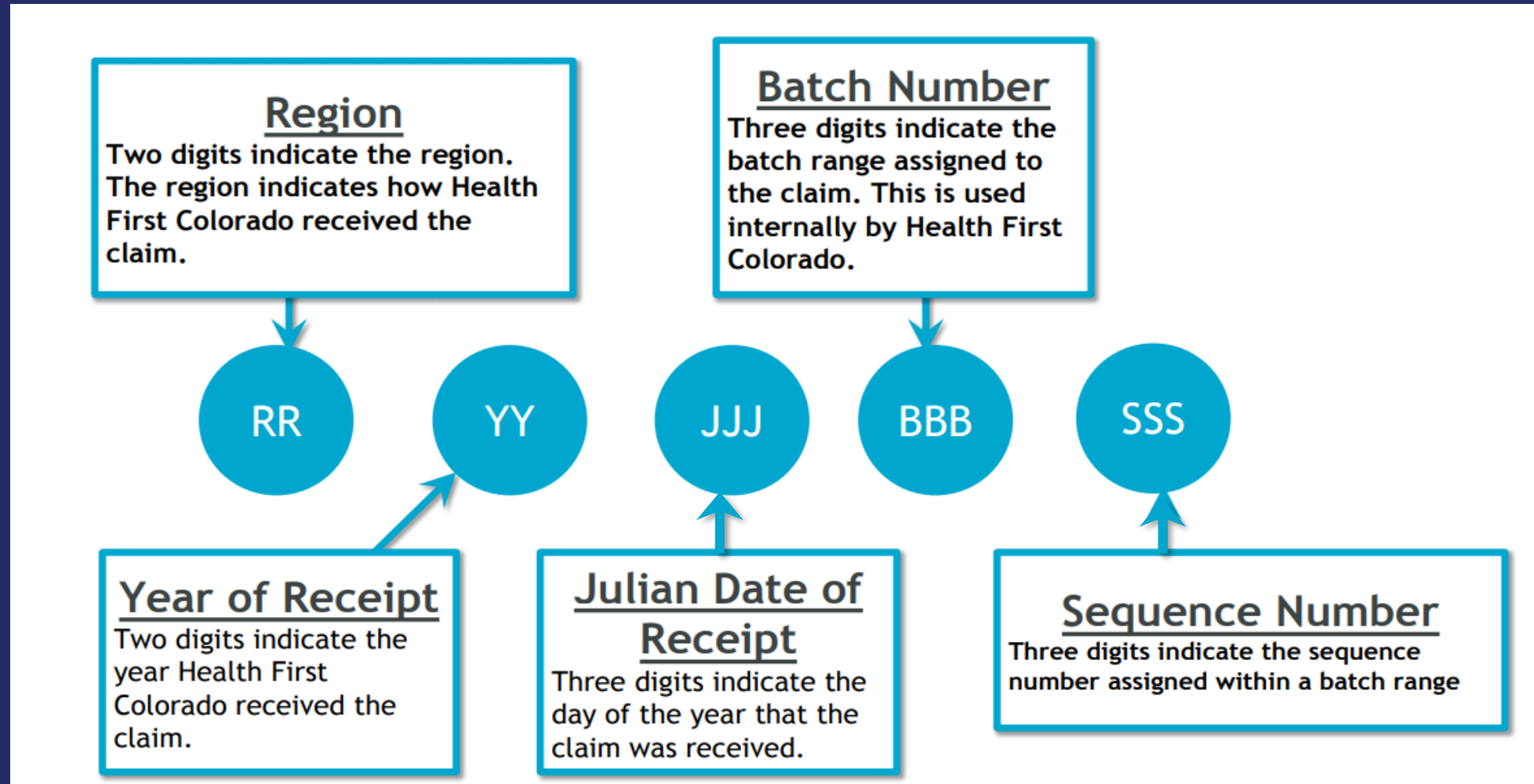
# Remittance

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

# Remittance

## Internal Control Number (ICN)



# Remittance

## Region Codes

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

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



# Remittance

## 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 professional claim form	From the date of each service (line item)
Home & Community-Based Services (HCBS)	From the “through” (last) date of service
Obstetrical services professional fees, Global procedure codes	From the delivery date
Equipment rental	From the date of service, which is the last day of the rental period

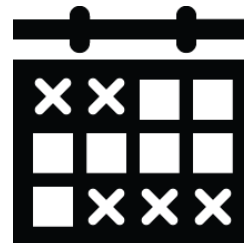
- Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.



# Timely Filing

## Provider Enrollment

- Providers must complete the enrollment process and submit claims within 365 days.
- 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

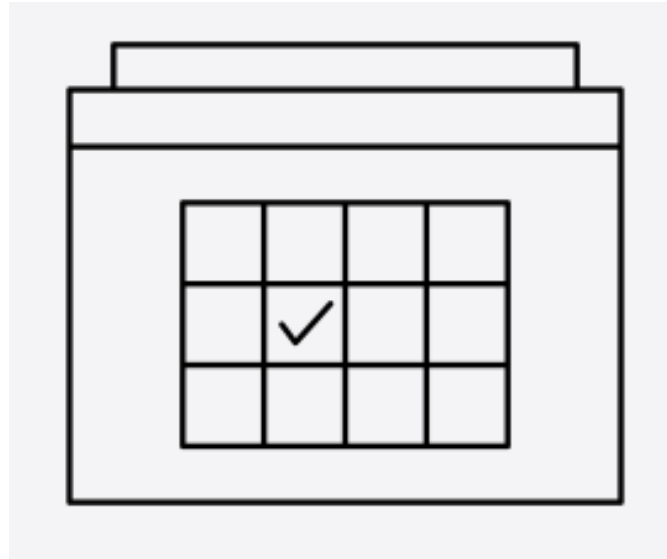
- If a claim is denied, adjusted or voided by the fiscal agent after the initial timely period of 365 days, providers have an additional 60 days from the date of the last Remittance Advice (RA) or returned paper claim to submit.
  - Reference the last Internal Control Number (ICN) from denied claims
  - 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 [Electronic Data Interchange \(EDI\) 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:
  - National Provider Identifier (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

**PATIENT AND INSURED INFORMATION**

1. MEDICARE (Medicare)  MEDICAID (Medicaid)  TRICARE (TRICARE)  CHAMPVA (Member (Do))  GROUP (GROUP)  FECA (FECA)  OTHER (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.)

**PHYSICIAN OR SUPPLIER INFORMATION**

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. RESUBMISSION CODE ORIGINAL REF. NO. 22. PRIOR AUTHORIZATION NUMBER

23. A. DATES OF SERVICE (From | To) (MM | DD | YY | MM | DD | YY) B. PLACE OF SERVICE (EMG) C. D. PROCEDURES, SERVICES, OR SUPPLIES (Identify Unusual Circumstances) E. DIAGNOSIS (ICD Incl.) F. \$ CHARGES G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.

25. FEDERAL TAX ID NUMBER (SSN EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES | NO) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Ref 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 a. NPI b. NPI c. NPI d. NPI

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



# 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 PROCEDURE CODE	I. ICD-9-CM DIAGNOSIS CODE	J. NPI	K. RENDERING PROVIDER ID. #
06 15 18 06 15 18 22			00670 AA	A	2860 00	106	N	NPI	999999999	

25. FEDERAL TAX I.D. NUMBER: 954849652

26. PATIENT'S ACCOUNT NO.: 4548941561

27. ACCEPT ASSIGNMENT?  YES  NO

28. TOTAL CHARGE: \$ 2860

29. AMOUNT PAID: \$ 00

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

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

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

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 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.

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

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



# CMS 1500

## Resources

### Billing Manuals (Provider-Specific)

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

### Provider Web Portal

- Red asterisks (\*) will denote required fields

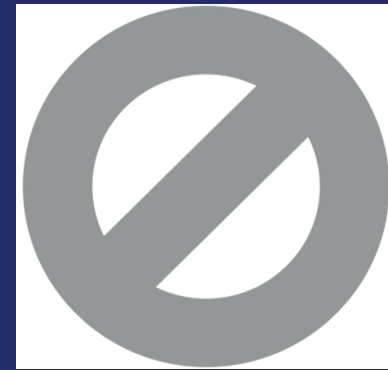
# Claim Status

## Common Terms



### Paid

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



### Denied

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

# Common Denial Reasons

## Timely Filing

Claim was submitted more than 365 days without reference to a previous Internal Control Number (ICN).

## Duplicate Claim

A subsequent claim was submitted after a claim for the same service had already been paid.

## Bill Medicare or Other Insurance

Health First Colorado is always the payer of last resort. Provider should enroll with and bill all other appropriate carriers first. Primary information must be reported on the claim form.

# Common Denial Reasons

## Prior Authorization (PAR) Not on File

No approved prior authorization on file for services that are being submitted, OR member ID, dates of service, modifiers, units or Prior Authorization Request (PAR) type may not match.

## Total Charges Invalid

Line-item charges do not match the claim total.

## Member Not Eligible for Title XIX (Title 19)

Member ID entered does not include “Medicaid State Plan” or “TXIX” (Title 19) coverage on the date of service.

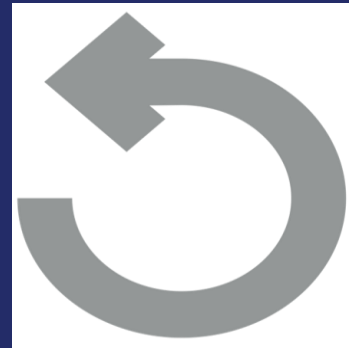
# Claim Status

## Common Terms



### Adjustment

Correct paid claim



### Resubmit

Rebill a previously denied claim



### Suspend

Claim must be manually reviewed before final decision



### Void

Cancel a paid claim

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

# Claim - Resubmission

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

## Resubmit a claim when

- Claim was denied

## Do not resubmit claim when

- Claim was paid
- Claim is suspended

# Resubmission Codes

Rebilled Claims: Date of Service Past 365 Days

## Provider Web Portal:

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

## Batch:

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

## Paper:

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



# Claim - Adjustments

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

## Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

## Do not adjust claim when

- Claim was denied
- Claim is suspended

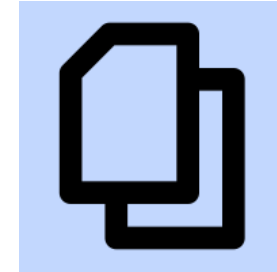




# Adjustment & Void Codes

## Provider Web Portal:

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



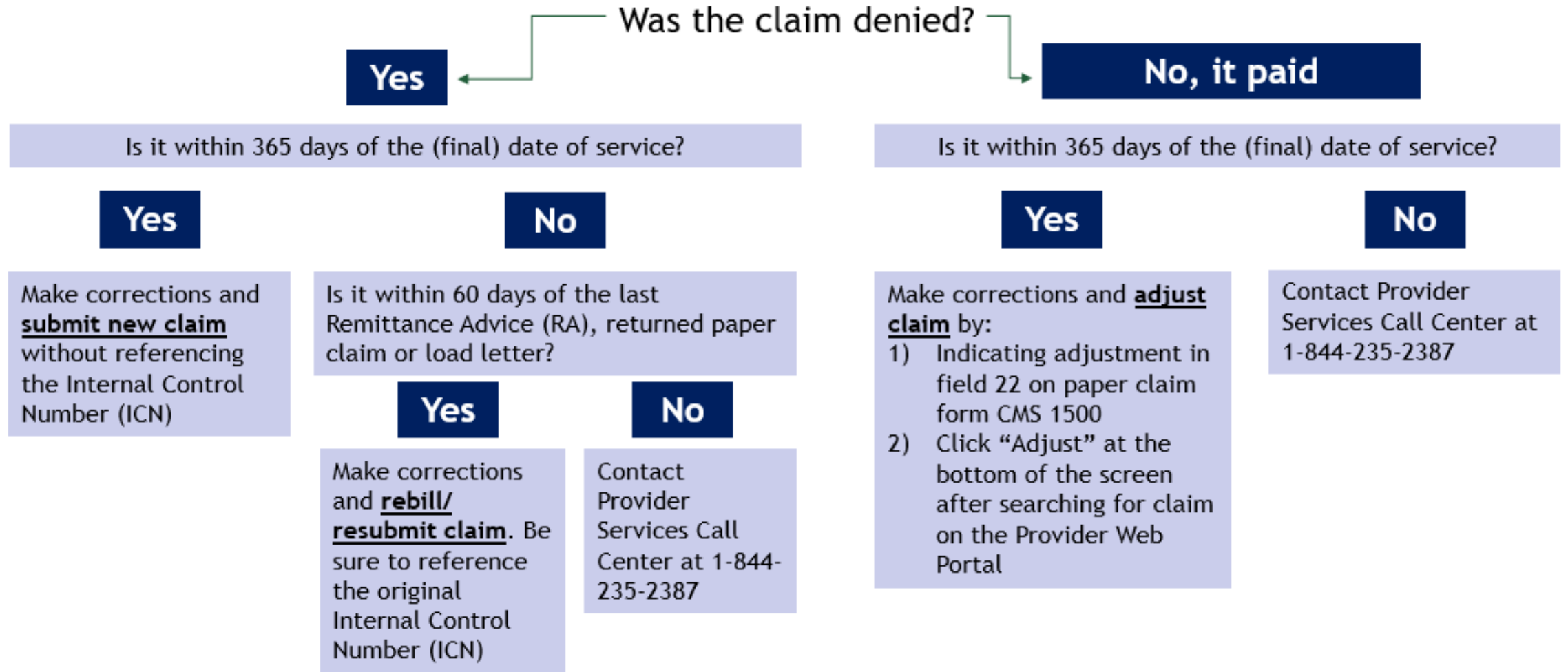
## Batch:

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

## Paper:

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

# Claim Submission: Resubmit or Adjust?



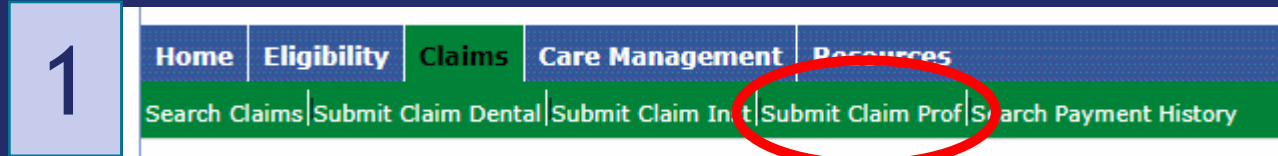
# Quick Guides

- Copy, Adjust or Void a Claim
  - Pulling Remittance Advice (RA)
  - Reading the Remittance Advice (RA)
  - Submitting a Professional Claim
- All Provider Web Portal Quick Guides can be found on the Department's Quick Guides web page.



# 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 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** 10/03/2023 **To Date**  **\*Place of Service**  **EMG**

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

**\*Charge Amount**  **\*Units**  **\*Unit Type** Unit  **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
- 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

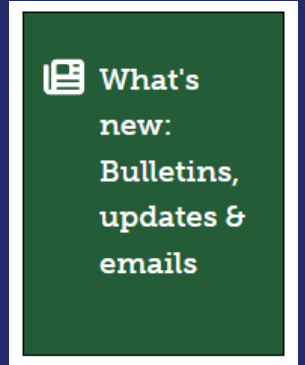
Provider contacts: Who to call for help

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



# 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!