Clinic Practitioner Specialty Training

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.

Agenda

- Early Intervention
- EPSDT
- Laboratory Services
- Medical Services
- Outpatient Imaging and Radiology
- SBIRT
- Surgery and Anesthesia
- Telemedicine
- Vaccines and Immunizations

Universal Procedure and Diagnosis Coding

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to use universal Current Procedural Terminology (CPT) coding guidelines
  - Providers should consult CPT manual definitions for each code submitted for reimbursement
  - Health First Colorado payment policies are based on CPT descriptions
- Providers must also use International Classifications of Diseases 10th Revision, Clinical Modification diagnosis codes (ICD-10)
- Refer to provider-specific billing manuals located on the Department website for more detailed benefit and billing information
  - For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500)

Early Intervention

Early Intervention

- Early Intervention services are provided to children birth to age three (3) who have or are at risk for developmental disabilities or special needs
  - Some children remain in early intervention until preschool special education services begin
- All codes billed for children who are receiving services as part of an approved Individualized Family Service Plan (IFSP) should include the TL modifier
  - Assistive Technology
  - Audiology services
  - Nurse visit
  - Nutrition services
  - Sick care
  - Therapies
- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Early Intervention

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

EPSDT
Overview

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program
- Federally-mandated health care benefits package for all Health First Colorado members ages birth through 20 years
- Emphasizes preventive care
  - Focuses on early identification and treatment of medical, dental, vision, hearing and developmental concerns
  - Establishes a regular pattern of health care through routine health screenings, diagnostic and treatment services
    - See the AAP Bright Futures periodicity for recommended well child visits
    - https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

EPSDT
Screening

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program well child screenings must include testing for lead poisoning
  - At 12 and 24 months of age or between 36 and 72 months of age if not previously tested
  - Will continue to be a Centers for Medicare & Medicaid Services (CMS) requirement for all Health First Colorado eligible children until Colorado can provide enough data to show it is not a concern in this region

EPSDT
Diagnostic

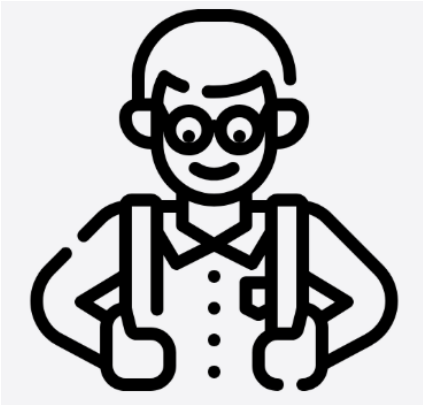
- When a screening indicates the need for further evaluation, diagnostic services must be provided
  - Referrals should be made without delay
  - Providers should follow up to make sure that the child receives a complete diagnostic evaluation

EPSDT
Treatment

- Diagnostic evaluations should lead to treatment or other measures to correct or improve illness or conditions discovered by screenings
- All services must be provided if:
  - Covered by Health First Colorado
  - Medically necessary, even if not covered by Health First Colorado for members over the age of 20
- Health First Colorado is not an insurance plan with an exclusions list
  - Providers should ask for services and items if members need it

EPSDT
Medical Necessity

- Additional services beyond what is covered by Health First Colorado must be allowed for any member ages 20 and under when medically necessary
  - Services must be covered as listed in 1905(a)(c) of the Social Security Act
- Health First Colorado may determine which treatment it will cover among equally effective and available treatments
  - As long as the determination is specific to the individual members
  - No arbitrary limitations on series allowed (e.g., 1 pair of eyeglasses or 10 physical therapy visits per year)



EPSDT
Limitations

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) does NOT include:
  - Experimental or investigational treatments
  - Services or items not in accordance with professionally recognized standards for health care in the United States
  - Services or items when an equally effective but less expensive option is available
  - Services primarily for provider or caregiver convenience

EPSDT
Prior Authorization Requests

- Providers should submit Prior Authorization Requests (PARs) for non-covered services or items to be reviewed under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines
- Requests must include a letter of medical necessity
- All requests will be reviewed by the appropriate entity for medical necessity
- Determination will be returned to the requesting provider

EPSDT
Letter of Medical Necessity

- Prior Authorization Requests (PARs) must include a letter of medical necessity which states:
  - Appropriate Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, units and other related details
    - Services or items not listed on the Health First Colorado fee schedule can still be requested (e.g., glucose monitoring equipment)
  - Detailed information about how the service or item will improve or maintain the member's health, prevent it from worsening or prevent the development of additional health problems
  - Duration and treatment goals for the request, as well as any previous treatments and responses

EPSDT
Letter of Medical Necessity, cont.

- Letters of medical necessity must also include:
  - answers to the questions: “Is the service or item safe?” and “How does the provider believe the item to be effective?”

- Include relevant documents and manufacturer information with the request

Laboratory Services

Laboratory Services

- Providers who perform laboratory tests are the only ones eligible to bill and receive payment
  - Providers may only bill for tests performed in their office or clinic
  - Testing performed by independent laboratories or hospital outpatient laboratories must be billed by the laboratories
- In order to receive payment, all laboratory service providers must be:
  - Enrolled in Health First Colorado
  - Clinical Laboratory Improvement Act (CLIA) certified
- All claims with services rendered by **any type of provider** must contain the National Provider Identifier (NPI) of the Ordering, Prescribing and Referring (OPR) provider who ordered the services
  - OPR providers must be actively enrolled with Health First Colorado

Laboratory Services

- Clinical Laboratory Improvement Act (CLIA) Claims
  - Pass-through billing is not allowed
  - Only one (1) CLIA number can be included on the claim
- Collection, Handling and Conveyance Charges
  - Specimen collection, handling and conveyance is generally not reimbursable as a separate charge
    - Exception: Member is homebound, bedfast or otherwise non-ambulatory and specimen cannot be conveyed by mail
  - Transfer of specimen is a benefit only if the first laboratory's equipment is not functioning or certified to perform ordered tests (Use modifier KX with procedure code 99001)

Laboratory Services

- Papanicolaou (Pap) Smears
  - Health First Colorado covers one (1) screening and examination per 12-month period for women under 40 years of age
  - More than one (1) screening and examination is allowed for women ages 40 and over and those with medical necessity determined by physician
- Breast Cancer (BRCA) Screening and Testing
  - Screening must be conducted prior to genetic testing
  - Screening, genetic counseling and testing only covered for members over the age of 18
- Newborn Metabolic Screening
  - Code S3620 may only be billed by providers not reimbursed for delivery who submit a second specimen screen that cannot be linked to an initial specimen

Laboratory Services

- Drug Testing
  - Codes 80305, 80306 and 80307 have unit limit of four (4) per month per member

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Laboratory Services

Medical Services

Medical Services
Benefits & Limits

- Providers should use an Evaluation and Management code that represents where a consultation occurs and the complexity of the visit
  - Consultation codes (99241-99245 outpatient and 99251-99255 inpatient) are not covered
  - Consultations by phone are not covered
- Adult members are limited to 1 physical examination per year
  - Sports physicals are not a covered benefit
- New member visits are limited to 1 per member per provider
- Office and nursing facility visits are limited to 1 visit per day per member by the same provider for the same diagnosis
- Non-routine supplies provided by physicians are a benefit when listed in the Centers for Medicare & Medicaid Services (CMS) most current publication for practitioners

Medical Services
Services Not Covered

- Services not covered include:
  - Cosmetic surgery solely for aesthetic reasons
  - Travel vaccines
  - Missed appointments
  - Medical testimony
  - Report preparation
  - Acupuncture
  - Homeopathic services
  - Chiropractic services (except for Medicare members)
- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Medical-Surgical

Medical Services
Foot Care

- Foot care is a benefit when provided by physicians or licensed podiatrists
- Claims for members with Medicare should be billed directly to Health First Colorado
  - Use the GY modifier to identify routine podiatric foot care that is not covered by Medicare
  - Complete the Medicare non-covered services field on the claim

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Medical-Surgical

Medical Services
Skin Substitutes

- Skin substitute products are reimbursed based on composition
  - Allogenic acellular (contains human non-living cells)
  - Allogenic cellular (contains human whole or living cells)
  - Xenogenic (contains non-human cells)
  - Injections
- Providers are encouraged to view the Provider Rates and Fee Schedule web page to view covered products and rates
- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Medical-Surgical

Outpatient Imaging and Radiology

Outpatient Imaging and Radiology
Prior Authorization

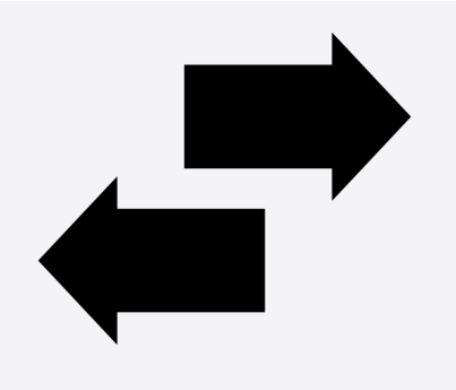
- Outpatient settings need to obtain prior authorization for:
  - Non-emergent Computerized Tomography (CT)
  - Non-emergent Magnetic Resonance Imaging (MRI)
  - All Positron Emission Tomography (PET) and Single Photon Emission Computed Tomography (SPECT) scans
- CT and MRI tests are exempt from prior authorization if the emergency indicator box is checked on the professional claim form
- Prior Authorization Request (PAR) revisions due to a change of test need to be submitted within 48 hours

Outpatient Imaging and Radiology
Billing Guidelines

- All claims with services rendered by **any type of provider** must contain the National Provider Identifier (NPI) of the Ordering, Prescribing and Referring (OPR) provider who ordered the services
  - OPR providers must be actively enrolled with Health First Colorado
- National Correct Coding Initiative (NCCI) billing edits affect this benefit

Outpatient Imaging and Radiology
Modifiers

- Component modifiers must be indicated on the claim if reimbursement is split between the professional and technical components
  - Professional component – modifier 26
  - Technical component – modifier TC
  - Bilateral radiology procedures should be reported using modifiers RT and LT
  - Claims using modifier 50 for bilateral radiology will be denied



Outpatient Imaging and Radiology
Limitations

- The following procedures are NOT covered by Health First Colorado:
  - Not ordered by the member's rendering physician
  - For the purposes of cosmetic treatment
  - For the purposes of infertility treatment
  - Considered experimental or not approved by the Food and Drug Administration (FDA)
  - Part of a clinical study

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Outpatient Imaging and Radiology

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SBIRT

- Screening, Brief Intervention and Referral to Treatment
  - Used to identify and treat drug and alcohol abuse for members ages 12 and above
  - Requires special certification and training that can be completed online or in person
  - The following providers are eligible to provide SBIRT:
    - Physician
    - Psychiatrist
    - Psychologist (PsyD and PhD)
    - Nurse Practitioner
    - Physician Assistant
    - Master's level clinicians: Licensed clinical social worker (LSCW), Licensed marriage and family therapist (LMFT), Licensed professional counselor (LPC)

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Screening, Brief Intervention and Referral to Treatment (SBIRT)

Surgery & Anesthesia

Surgery
Global Billing

- Surgical reimbursement includes:
  - Pre- and intra-operative services
  - Local infiltration
  - Digital block or topical anesthesia
  - Normal, uncomplicated follow-up care (post-operative periods defined in the Medicare Physician Fee Schedule Database (MPFSDB)

- Claims will deny if surgery has 30, 60 or 90 post-operation days and providers bill an office visit within those time periods
  - Providers should bill surgery before post-operative office visits
  - Providers should use modifier 24 to report unrelated Evaluation & Management (E&M) during the global period

Surgery
Global Billing

- Claims with unlisted surgery codes must include as attachments:
  - Operating report
  - Unlisted Procedure Code Form

- Each rendering provider's procedures should be submitted on a separate claim, even if the claims are submitted by the same billing provider

Surgery
Multiple Providers: Assistant Surgery

- Assistant surgery and co-surgery are only reimbursable for procedures listed on the Medicare Physician Fee Schedule Database (MPFSDB) with assistant or co-surgery indicators of 2
- Assistant surgery is defined as one (1) primary surgeon and an assistant surgeon
- The Prior Authorization Request (PAR) needs to include two (2) line items with one (1) unit on each line
  - 1st line (primary surgeon): surgical procedure code
  - 2nd line (assistant surgeon): surgical procedure code
- The claim needs to include two (2) line items with one (1) unit on each line
  - 1st line (primary surgeon): surgical procedure code
  - 2nd line (assistant surgeon): surgical procedure code and modifier code 80, 81 or 82
    - Services rendered by non-physician practitioners should be reported using modifier AS in addition to 80, 81 or 82

Surgery
Multiple Providers: Co-Surgery

- Co-surgery is defined as two (2) primary surgeons performing distinct part(s) of the procedure
- One (1) provider may request prior authorization on behalf of both surgeons
- The Prior Authorization Request (PAR) needs to include two (2) line items with one (1) unit on each line
  - 1st line (first co-surgeon): surgical procedure code
  - 2nd line (second co-surgeon): surgical procedure code
- The claim needs to include two (2) line items with one (1) unit on each line:
  - 1st line (first co-surgeon): surgical procedure code and modifier code 62
  - 2nd line (assistant surgeon): surgical procedure code and modifier code 62

Surgery
Multiple Surgeries and Procedures

- Multiple surgeries rendered on the same date of service, for the same member, by the same rendering provider should be billed on one (1) claim

- Multiple surgery and bilateral procedures should be billed with one (1) unit of service on (1) line using the 50 modifier for additional reimbursement

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Medical-Surgical

Surgery
Covered Benefits

- Providers are encouraged to view the billing manual for specific information on surgery types covered by Health First Colorado, including:
  - Abortion
  - Bariatric surgery
  - Breast reconstruction
  - Endoscopy
  - Hysterectomy
  - Reconstructive surgery
  - Sterilization
  - Transplantation

Anesthesia

- Anesthesia benefit for medical, surgical and radiological procedures
  - Nerve blocks for anesthetic purposes are processed as general anesthesia, all other nerve blocks are processed as surgical procedures
- Reimbursement based on actual anesthesia time, from member preparation through placement in post-operative care (1 unit on claim = 1 minute)
- No additional benefits for:
  - Emergency conditions
  - Total body hypothermia with procedures described as “open” or “bypass”
  - Endotracheal intubation and extubation
  - Anesthesia administered by surgeon, excluding intravenous valium and pentothal (included in surgical reimbursement)
  - Local pudendal and paracervical blocks for obstetrical deliveries (included in obstetrical reimbursement)

Anesthesia

- Standby anesthesia is a benefit in conjunction with:
  - Obstetrical deliveries
  - Subdural hematomas
  - Femoral or brachial artery ambolectomies
  - Members with a physical status of 4 or 5
  - Insertion of a cardiac pacemaker
  - Cataract extraction
  - Lens implant
  - Percutaneous transluminal angioplasty
  - Corneal transplant
  - Exceptions that are fully documented and submitted with claim
- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Medical-Surgical

Telemedicine

Telemedicine

- Telemedicine is not a unique service but a means of providing approved services through interactive audio and video telecommunications
- Requirement for initial face-to-face contact between provider and member may be waived if provider complies with requirements posted under Waiving the Face-to-Face Requirement & Required Disclosure Statements section of the Telemedicine billing manual
  - Providers must document member's consent to receive telemedicine services for subsequent visits

Telemedicine

- Prior Authorization Request (PAR) requirements remain the same
- Bill all telemedicine services on the professional claim form (CMS 1500)
  - Providers are only able to bill procedure codes for which they are eligible to bill
- Bill Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs) when appropriate
- Telehealth monitoring is available for members eligible for the Home Health benefit and should not be billed as telemedicine

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Telemedicine

Telemedicine
Originating Providers

- Providers who may bill procedure code Q3014 with modifier GT:
  - Clinic
  - Physician/Osteopath
  - Physician Assistant
  - Nurse Practitioner
  - Psychologist (Doctorate and Masters levels)
  - Federally Qualified Health Center (FQHC)
  - Rural Health Clinic (RHC)
    - Claim must include modifier GT on claim line(s) identifying service when FQHC or RHC provides care through telemedicine

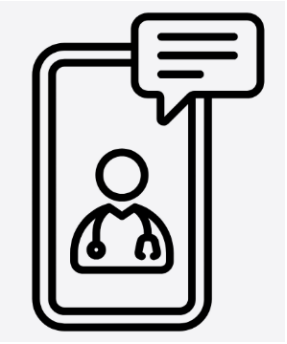
- Provider types not listed may facilitate telemedicine services but may not bill procedure code Q3014 or use the GT modifier

Telemedicine
Distant Providers

- All distant providers should bill procedure code and Place of Service 02 (other than member's home) or 10 (member's home)
  - Appropriate place of service code should be used when member is located in a hospital
- FQ modifier should be added if service was furnished using audio-only communication technology
- FR modifier should be used if supervising practitioner was present through two-way audio/video communication technology

Telemedicine
Primary Care

- Primary care providers can be reimbursed as originating providers for any eligible services where the member is present with the provider at the originating site
  - Use procedure code Q3014 if originating provider is only providing site and telecommunications equipment
- Reimbursement as the distant provider is available if primary care provider is able to facilitate an in-person visit in the state of Colorado if necessary for treatment of the member's condition



Telemedicine
Specialty Care

- Specialist providers can be reimbursed as originating providers for any services where the member is present with the provider at the originating site
- Specialist providers can be reimbursed as distant providers

Telemedicine
eConsults

- An eConsult is an asynchronous dialogue initiated by a Treating Practitioner seeking a Consulting Practitioner's expert opinion without seeing the member
  - Treating Practitioner is defined as the member's primary care provider
    - Effective July 1, 2025, a Treating Practitioner may also be a member's treating provider who has education, training or qualification in a specialty field other than primary care and is a Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP) or Physician Assistant (PA)
    - Treating practitioners bill using procedure code 99452
  - Consulting Practitioner is defined as a provider who has qualifications in a specialty field other than primary care
    - Consulting practitioners bill using procedure code 99451

Telemedicine
eConsults

- Providers can utilize the Department's eConsult platform (Colorado Medicaid eConsult) or a third-party platform that meets Department criteria
- eConsult dialogues do not meet the definition of a Federally Qualified Healthcare Center or Rural Health Clinic visit

Telemedicine
Remote Patient Monitoring

- Remote Patient Monitoring (RPM) is the continuous use of technology to track a member's clinical data, enabling early detection of health changes and timely medical interventions to prevent emergency intervention or inpatient hospitalization

- RPM must be rendered and supervised in accordance with the scope of practice for the enrolled provider and performed by one of the following licensed health care professionals:
  - Physician
  - Podiatrist
  - Advanced Practice Registered Nurse
  - Physician Assistant
  - Respiratory Therapist
  - Pharmacist
  - Licensed healthcare professional working under the supervision of a Medical Director

Telemedicine
Remote Patient Monitoring

- A member is eligible for Remote Patient Monitoring (RPM) if:
  - the health care provider determines that RPM is medically necessary and can prevent admission or readmission to an emergency department, hospital, nursing facility or other clinical setting **and**
  - the member has one of the qualifying conditions:
    - Asthma
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Diabetes
    - Heart Failure
    - High-Risk Pregnancy
    - Pneumonia

Telemedicine
Limits

- Telemedicine does not include provider-to-provider consultations through telephone, email or facsimile machines
- Health First Colorado does not pay for provider education via telemedicine.

Vaccines and Immunizations

Vaccines and Immunizations

Immunizations for children:

- A benefit when recommended by Advisory Committee on Immunization Practices (ACIP)
  - For members aged 18 and under
  - Only administration fee reimbursed
- Available from federal Vaccines for Children Program (VFC)

Immunizations for adults:

- A benefit when recommended by ACIP (subject to Health First Colorado rules)
  - Administration fee and vaccine reimbursed

- For Our Providers → Provider Services → Billing Manuals → Professional (CMS 1500) → Immunization

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

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.” Be sure to sign up for Provider Type 00.

- Interested in more training? Sign up or view training materials by visiting the website and clicking “Provider Resources” and then “Provider Training.” Presentations are listed under the calendar in the “Billing Training – Resources” section.

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

Thank you!